Leicestershire and Rutland Sexual Health Needs Assessment October 2015

Vivienne Robbins, Janet Hutchins,

Katie Philips and Natalie Greasley

Leicestershire County Council

Rutland County Council

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1. Introduction

Sexual relationships are essentially private matters, however good sexual health is important to individuals and to society. WHO, 2002 defines sexual health as;

*'… a **state of physical, emotional, mental and social well-being in relation to sexuality**; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.'(Page 5, WHO, 2002)*[1]

Therefore good sexual health is more than the absence of disease. 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.[2]

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 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 and Rutland (LCR).

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.

The Health and Social Care Act (2012)[3] has created a number of changes to the commissioning of sexual health services. Key services are now commissioned via public health within local authorities, however clinical commissioning groups and NHS England are also important commissioners of services. Therefore it is important to note that investing in sexual health is also cost effective, with the consequences of poor sexual health costing the NHS an estimated £193m in unintended pregnancies in 2010 and approximately £630m in Human Immunodeficiency Virus (HIV) treatment and care in 2012/13. Evidence also suggests that every **one pound invested in contraception saves £11.09** in averted outcomes, an increase in Long Acting Reversible Contraception (LARC) usage could save

£102 million and increasing HIV testing among men who have sex with men (MSM) and black Africans in England would prevent 3,500 cases of HIV transmission within five years and save £18million in treatment costs per year[4],[5].

This LCR Sexual Health Needs Assessment triangulates national and local policy and quantitative data with feedback from our local population to provide an overview of the sexual health needs of the local population. The results of this will be used to inform the wider Leicester, Leicestershire and Rutland future direction for sexual health commissioning and services.

1.1 National Context

1.1.1 Health and Social Care Act (2012)

The Health and Social Care Act (2012) generated significant changes to the local health system. Key policy areas in the Act included;

- **Clinically led commissioning** - Development of Clinical Commissioning Groups (CCGs) that are clinically led by local clinicians and give General Practitioners (GP) and other clinicians the primary responsibility for commissioning health care. Unlike previous approaches to GP-led commissioning, this is a universal system involving all practices. CCGs hold real budgets and are able to reinvest any savings they generate in patient care. NHS England ensures accountability of CCGs for improving patient outcomes and getting the best value for money from the public's investment.

- **Provider regulation to support innovative services -** Including an increased role for Monitor and to support innovative and efficient services. It will ensure NHS services are licenced and ensure fair and effective competition in the market for some services. There is also a drive to ensure NHS trusts can become autonomous and accountable Foundation Trusts.

- **Greater voice for patients -** The Government aims for there to be "no decision about me, without me" for patients and their own care. The same goes for the design of health and social care services at both a local and a national level. Healthwatch England was established as a statutory committee of the Care Quality Commission. This is funded by the local authorities and builds on the work previously undertaken by Local Involvement Networks (LINks).

- **New focus for public health -** Major changes occurred to the public health system due to the Government's commitment to put the public's health at centre stage. This included the development of Public Health England (PHE) as executive agency of the Department of Health to nationally lead the agenda. The reforms give the Secretary of State a duty to take steps to protect the health of the people of England. Locally, the majority of public health functions moved into upper tier local authorities, with a ring fenced public health grant. Other parts of the public health system were moved to bodies including NHS England.

- **Greater accountability locally and nationally** - The Act aims to strengthen and clarify accountability for and within the NHS nationally by introducing new mechanisms for local

accountability within the health system. These include the development of local Health and Wellbeing Boards (to together locally elected and accountable councillors, directors of adult social services, children's services and public health, CCGs and Healthwatch), NHS England, CCGs, Healthwatch, Monitor and the Care Quality Commission.

- **Streamlined arms-length bodies -** Parts 7 to 10 of the Act make a number of changes to create fewer, better organisations and to release more money to the frontline. This includes reducing the number of arm's length bodies and reiterating the role of National Institute for Health and Care Excellence (NICE) and the Information Centre.

One of the key implications of the Act on sexual health services was the development of the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) 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*'[6].

Other implications of this Act are detailed in the national to sexual health policies below.

1.1.2 Healthy lives, healthy people – our strategy for public health in England (DH, 2010)

The Public Health White Paper (2010) Healthy lives, healthy people – our strategy for public health in England"[7] identified a new era for public health, with increased priority and dedicated resources. It aimed to create a 'wellness' service (Public Health England) and to strengthen both national and local leadership. The paper details the government's commitment to protecting the population from serious health threats, supporting the population to live longer, healthier and more fulfilling lives, and improving the health of the poorest, fastest, building on results from Marmot's Fair Society, Healthy Lives[8] and the NHS White Paper 'Equity and Excellence: Liberating the NHS.[9] The paper laid the way for the significant system changes that are described in the Health and Social Care Act 2012 (see section 1.1.1). It also confirmed the intent of the DH to publish documents that build on the new approach on a range of public health areas including sexual health which is described in section 1.1.3-5).

Following on from the this White Paper, the increased priority on prevention has been re-emphasised in Steven's (2014) Five Year Forward Plan[10], which states,

'…that the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health…..if the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, [and] health inequalities will widen' (page 4 & 8 Stevens, 2014)[10]

1.1.3 A Framework for Sexual Health Improvement in England (DH, 2013)

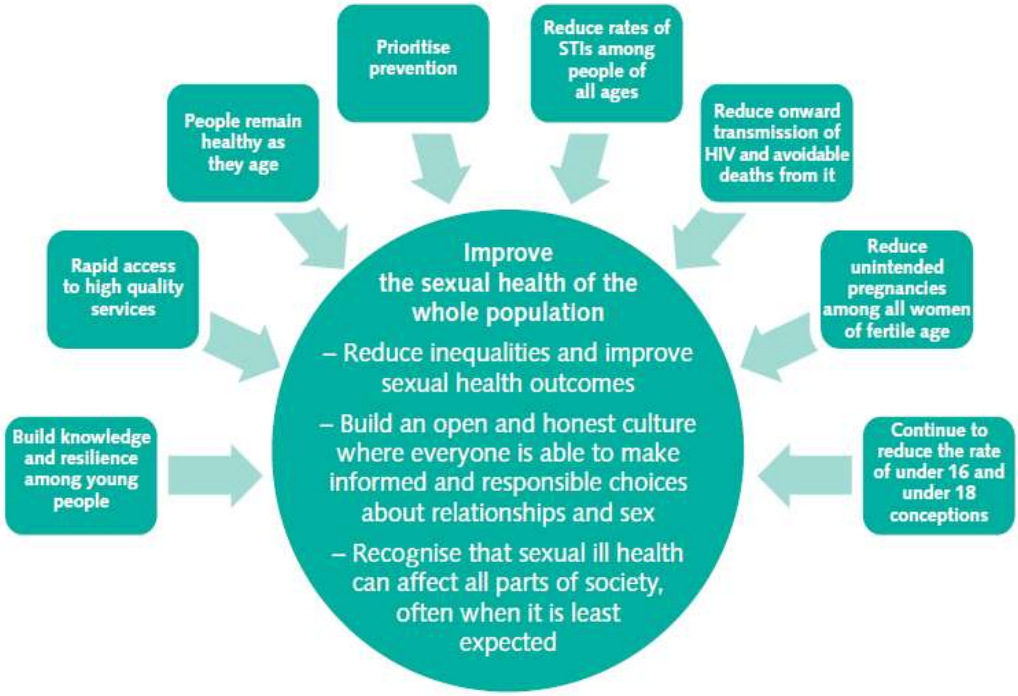
The National Framework for Sexual Health Improvement[4] identifies the ambition that the whole population have access to high quality sexual health services and information. It highlights the importance of people understanding contraceptive options and where they are available, being able to provide guidance to their children about relationships and sex, and having information and support to access testing and early diagnosis to prevent transmission of HIV and STIs.

Figure 1 shows a summary of the key objectives of the sexual health framework. The overall aim is to improve the sexual health of the whole population and the need to;

- reduce sexual health inequalities
- to build an open and honest culture around sexual health
- the need to recognise that sexual health affects all parts of society –often when it is least expected.

The framework provides guidance around key areas to focus on including building knowledge and rapid access to sexual health services, prioritising prevention, tackling stigma, discrimination and prejudice often associated with sexual health, continuing to reduce STIs and unwanted pregnancies, providing support for those who face unwanted pregnancies, access to high quality HIV prevention and treatment services and the need to promote integration, quality, value for money and innovation in the development of sexual health interventions and services. The framework also highlights the importance of considering varying sexual health needs according to factors such as age, gender, sexuality and ethnicity, and recognising that some groups are particularly at risk of poor sexual health. Hence a life course approach must be considered to sexual health services.

Figure 1: Summary of the key objectives of the national sexual health framework (taken from DH, 2013, Page 10.)[4]



To achieve these ambitions the framework highlights the importance of effective commissioning, strong leadership and joint working across local authorities, NHS England and CCGs. The specific roles and responsibilities are described more thoroughly in the relevant each section of the needs assessment.

N.B. PHE are currently consulting on a Health Promotion Strategic Plan For Sexual And Reproductive Health & HIV 2015-18 to be published in late 2015. Early consultation suggests that PHE's four priority areas for action to improve sexual health are:

- to reduce onward HIV transmission, acquisition and avoidable deaths
- to reduce rates of sexually transmitted infections
- to reduce unplanned pregnancies
- to reduce rate of under 16 and under 18 conceptions (i.e. building on previous Teenage Pregnancy national strategies).

PHE states it will concentrate on providing data, surveillance, evidence and support interventions in these areas. PHE's activities will focus on three main population groups who are particularly affected by poor sexual and reproductive health: young people, MSM and Black and minority ethnic (BME) populations.

1.1.4 Making it Work: A Guide to whole system commissioning for sexual health, reproduction health and HIV (PHE, 2015)

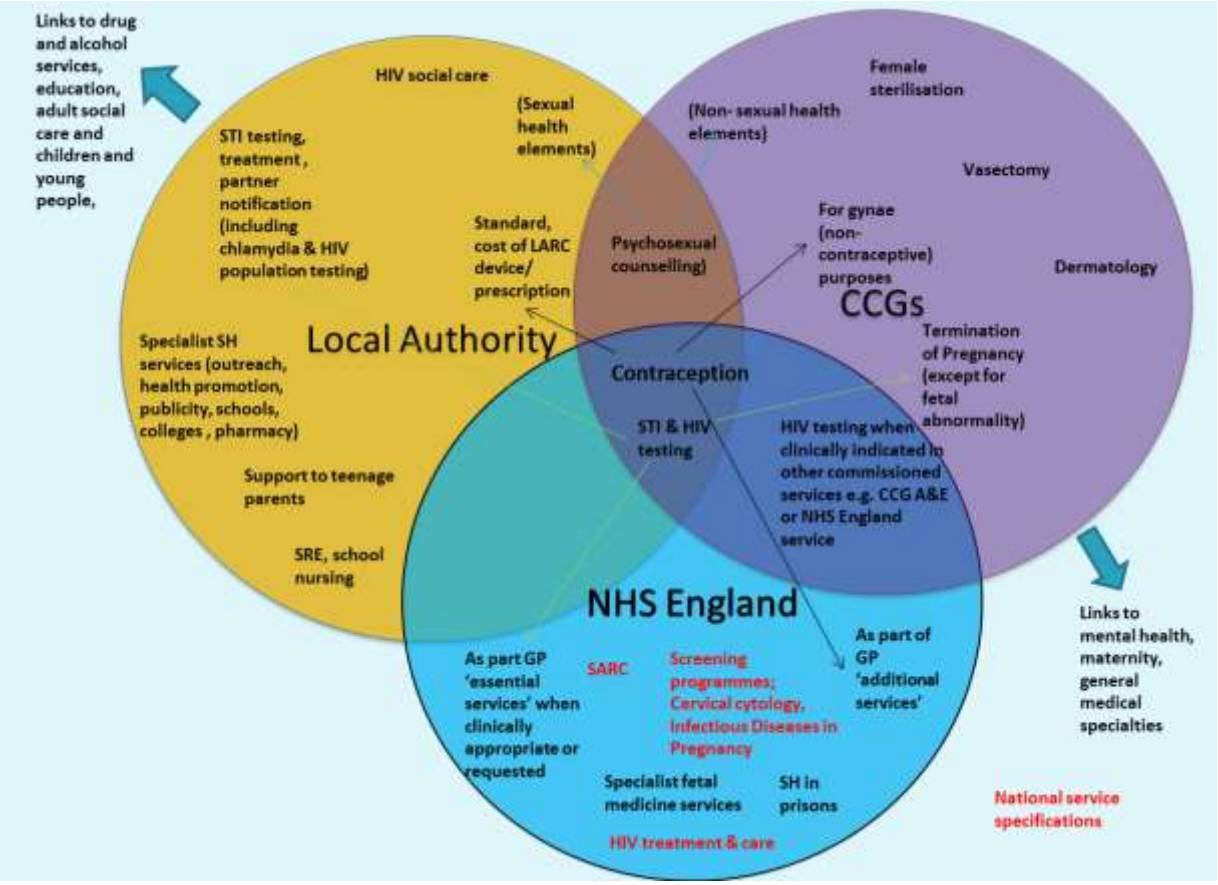
Making it Work PHE commissioning guide discusses the interfaces in commissioning responsibility caused by the 2012 Health and Social Care Act and the need for commissioning bodies to work together to ensure that the individual experiences seamless delivery of services to meet their needs.

The guide highlights the importance of putting service users at the centre of commissioning decisions that are based on up to date needs assessments, clinicians expertise and service user views. Collaborative relationships are needed between the key commissioning organisations (local authorities, CCGs and NHS England) to provide a larger commissioning footprint that can generate a sustainable sexual health system as well as innovation, improvements in patient outcomes and efficiency savings. The document acknowledges the economic pressures on the system and that there is no right way to overcome some of the system fragmentation issues, therefore commissioning teams need to identify the best approach locally.

Across Leicester, Leicestershire and Rutland (LLR) work has started on how the 'Making it Work' document can influence local sexual health commissioning. Figure 2 shows the key commissioning responsibilities for the sexual health system. It can be seen that from April 2013 the majority of core sexual health services (including open access delivery of contraception, Sexual Transmitted Infection (STI) testing and treatment) moved into the local authority. However many other sexual health services are currently commissioned by CCGs and NHS England. For example GP contraception and STI testing, HIV services, cervical screening and sexual assault referral services are commissioned by NHS England and termination of pregnancy, dermatology and gynaecology services are commissioned by

CCGs. There are further complexities where some services are commissioned by local authorities and CCGs depending on the patient's reason for the attendance. For example intra-uterine systems (IUSs) and psychosexual counselling are both commissioned by the local authority; however CCGs have the responsibility for Inter uterine devices (IUDs) for non-contraceptive use and for psychosexual counselling for non-sexual health issues such as sex addiction. These complexities have resulted in confusing and fragmented patient pathways, and potential gaps in current commissioning arrangements. Hence the Director of Public Health's local leadership role is needed to '*pull the whole commissioning system together*' (page 8, PHE 2015) and ensure commissioning tackles the causes of poor sexual health (i.e. wider determinants of health.)

Figure 2: Sexual Health System from April 2013, following implementation of the Health and Social Care Act, 2012.



1.1.5 All-Party Parliamentary Group on Sexual and Reproductive Health in the UK (2015)

The All-Party Parliamentary Group on Sexual and Reproductive Health in the UK (APPGSRH) conducted an inquiry ' Breaking down the barriers: The need for accountability and integration in sexual health, reproduction health and HIV service in England'[11] into the impact of the Health and Social Care Act (2012) reforms on sexual health services and patient outcomes. The inquiry concluded;

- **Accountability** - the need for national accountability and clarification across a range of sexual health commissioning responsibilities

- **Commissioning Responsibilities** - A whole system approach to sexual health commissioning is needed to mitigate against the profound impact of the Health and Social Care Act and avoid silo services that do not meet patients' needs. These must be informed by regular sexual health needs assessments and epidemiological data.

- **Monitoring, evaluation and data** - Further work is needed to monitor performance against the national sexual health framework, to develop the PHE sexual and reproductive sexual health profiles to become more comprehensive and to ensure effective public and patient feedback supplements other data sources in commissioning decisions.

- **Payment, tendering and contracting barrier** - Commissioners are advised to use a single funding mechanism (tariff or block) within integrated services. Concerns were raised about the instability that short tendering rounds can have on services and the need to complete a sexual health needs assessment before any re-tendering to ensure the most appropriate service is commissioned. Service specifications should follow a common national quality and standards framework.

- **Future funding** - Sexual health services account for about a quarter of the public health budget. The inquiry urges the government to maintain the ring fence around the public health budget and ensure there is sustainable funding for sexual health services following the announced £200M cuts from the national public health budget in summer 2015.

- **Workforce education and training** - There is a need to ensure education and training are fundamental, mandatory aspects of sexual health provider contracts. Local education and training boards (LETBs) are encouraged to complete a local needs assessment and Health Education England should take a stronger national lead on sexual health and HIV training and development.

- **School and population wide education** - A high quality, tailored, life course approach to sexual health education and awareness is key to ensuring individuals make well informed choices about their sexual health. The inquiry recommends the government implements the February 2015 recommendation of the Education Select Committee that sex and relationships education and PHSE should be statutory subjects in all primary and secondary schools.

- **Patient and user involvement** - Patient and user involvement must be established to help commissioners and service users to help build local services around practical considerations of service users.

N.B. there are other various PHE and NICE guidelines around sexual health which have been interwoven into the relevant sections of the health needs assessment.

1.2 Local Context

1.2.1 Leicestershire County Council Strategic Plan - 2014 to 2018 (LCC, 2014)[12]

Local government is facing its most difficult funding position since World War II, with significant reductions needed in local authority spending, due to government plans for national budget deficit reduction.

Leicestershire County Council (LCC) is facing its biggest ever challenge – how to save £110 million by 2018. Therefore during the summer of 2013, the council asked the public for their thoughts on what the council could reduce and prioritise. As a result the council produced the LCC Strategic Plan 2014-18, Medium Term Financial Strategy and Transformation Programme. These three key documents set out our future direction, how the council must change and the money it needs to save. The Strategic Plan sets out the council's priorities and high level targets to May 2018. The plan sets out 69 priority areas under five themes:

- Leadership and transformation
- Enabling economic growth
- Better care - health and care integration
- Supporting children and families
- Safer communities - a better environment / place

1.2.2 Rutland County Council – Strategic Aims and Objectives – 2012 to 2016 (Rutland CC, 2012)

Rutland County Council like other local authorities also faces financial challenges due to reduced national funding. The council's overall aim is to ensure that 'Rutland is a great place to live, learn, work, play and visit'. The council plans to make it better by delivering, developing and supporting existing services and developing council services – including harnessing technology. Rutland's corporate and council wide priorities for 2012-2016 include[13];

- Encouraging business growth and employment
- Protecting vulnerable people within our community
- Supporting affordable living
- Embracing our Armed Forces community
- Understanding and responding to our demographic growth
- Expanding and developing the reach of volunteering and community involvement using the Localism Act as a mechanism

- Championing a positive image for young people
- Delivering council services within the medium term financial plan

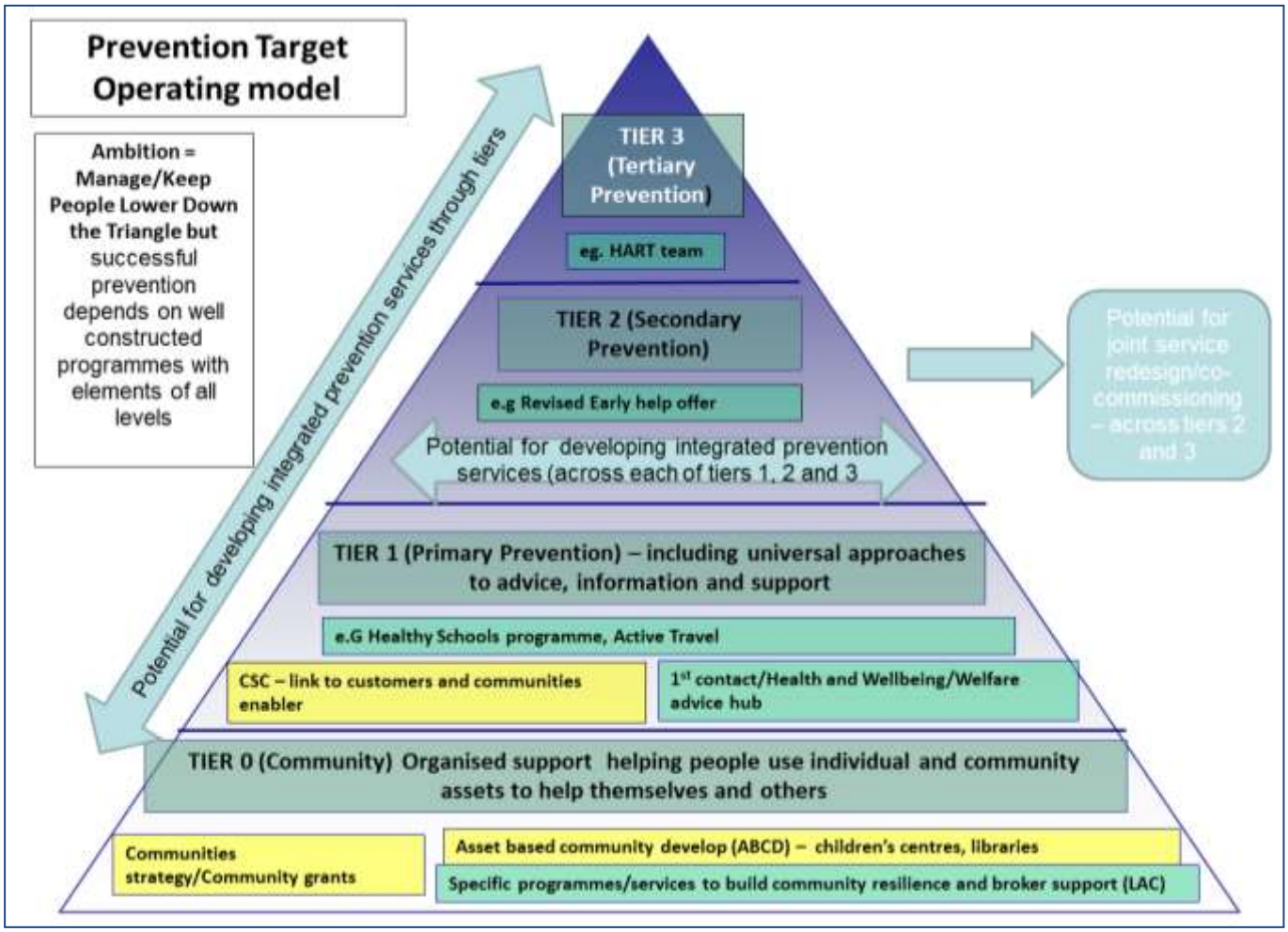
1.2.3 Prevention Review

As part of the LCC transformation programme, the council has completed a review of all prevention services. The prevention review highlighted the need for an evidence based prevention delivery model which delivered a consistent prevention offer across LCC which focussed on delivering maximum value for money.. Hence the prevention target operating model (TOM) was developed (Figure 3) and takes into account the following tiers of prevention:

- **TIER 0** (Community) organised support helping people use individual and community assets to help themselves and others
- **TIER 1** (Primary Prevention) – including universal approaches to advice, information and support
- **TIER 2** (Secondary Prevention)- identifying people already at risk, and aiming to halt or slow down any deterioration
- **TIER 3** (Tertiary Prevention)- enabling people with established problems to return to as 'normal' a position as possible

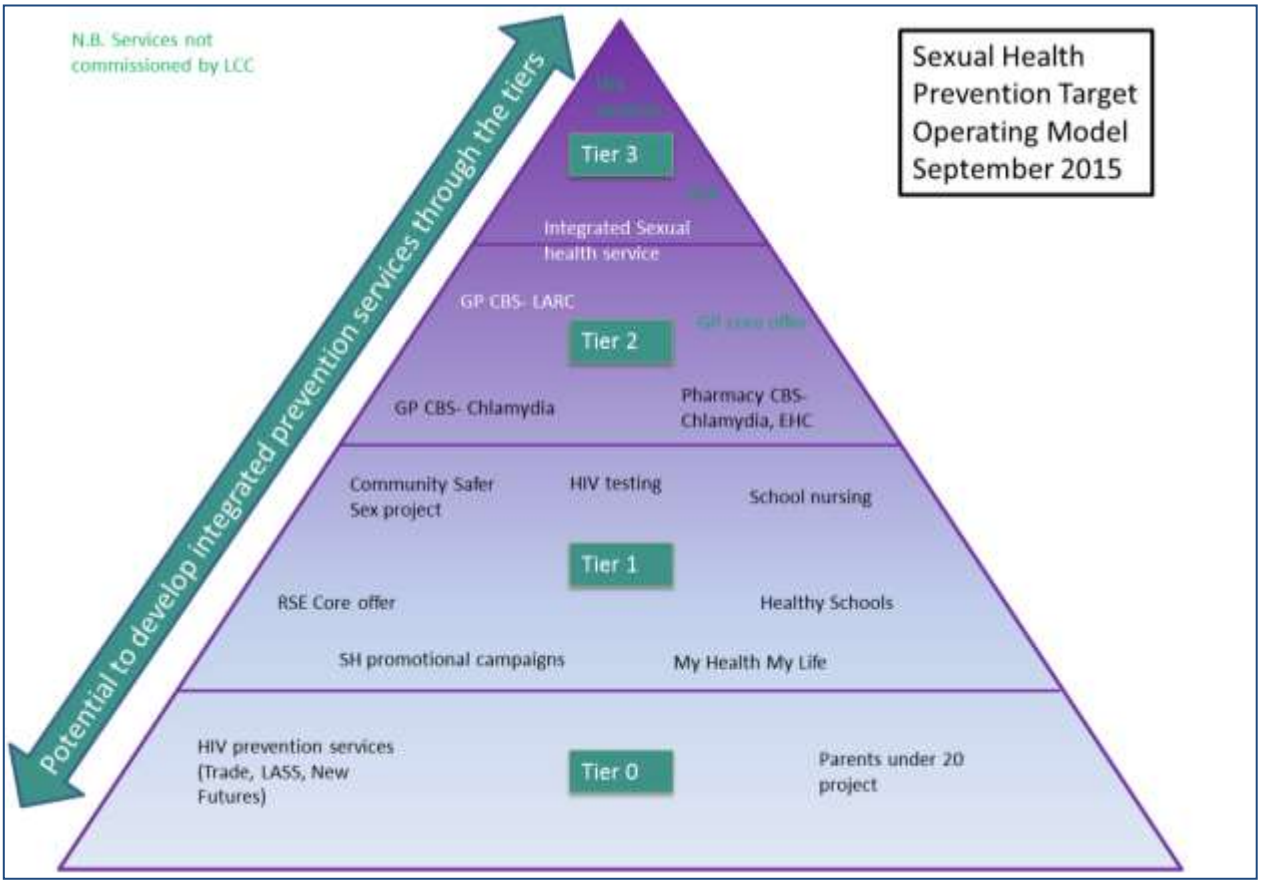
The aim of the TOM is to show the overall aim to increase prevention services to reduce demand to more costly services in the longer term. The prevention TOM also includes the level 0 community tier which builds on the a key priority from the LCC communities strategy to '*unlock the capacity of communities to support themselves and vulnerable individuals and families*.'[14].

Figure 3: LCC Prevention Target Operating Model.



This model has been adapted in Figure 4 to highlight the current tiers of sexual health services across Leicestershire and Rutland as of September 2015. It can be seen that as the services increase up the prevention TOM, they become more specialist/ targeted, hence the number of people accessing them reduces. The overall aim of the model is to equip the population with the correct information, advice and prevention services to make informed choices about their sexual health. This would reduce unwanted pregnancies and STI transmission, hence reducing demand on level 3 services. This TOM will be developed following the sexual health needs assessment as part of a wider direction for sexual health services across LLR.

Figure 4: Summary of Sexual Health services against the LCC prevention TOM.



1.2.4 Implications on sexual health

There have been unprecedented changes to the health system since the implementation of the Health and Social Care Act 2012. This has created significant fragmentation across the sexual health system with three main commissioners (local authorities, CCGs and NHS England.) National guidance suggests the need to take a patient- centred, systematic approach to sexual health commissioning to 'pull the system back together' around patient pathways. On top of this local government are facing significant financial challenges with all local authorities developing difficult medium term financial strategies to deliver cost savings. Although the public health grant is currently ring-fenced, it is not known how long this will remain. With predicted 7% in year cuts to the public health budget in 2015/16 there is a need to develop strong collaborative approaches across commissioning organisations to ensure that seamless, high quality, evidence based services are available to the local population.

2. Methodology

2.1 Aim & objectives

The aim of this document is to complete a comprehensive needs assessment to help understand the sexual health needs of Leicestershire and Rutland. This will inform the development of a sexual health and HIV future direction and commissioning intentions for 2016-2019.

This aim will be achieved through the following objectives;

- To develop and complete a validated needs assessment methodology that encompasses epidemiological, comparative and corporate tools and data sources across the full range of sexual health services. This will include both quantitative and qualitative data.
- To use national, regional and local research and data to identify baseline needs and compare Leicestershire and Rutland's current performance with other areas.
- To consult with a range of service users and professionals from across Leicester, Leicestershire and Rutland to identify the strengths and weaknesses of existing service provision and areas for future development.
- To understand the needs of specific groups at higher risk of poor sexual health.
- To triangulate data on need, demand and supply to identify any gaps in service provision and inform comprehensive, credible recommendations that will inform the future direction of sexual health services across LCR.

To achieve these aims and objectives the following methodology was used adapted from the '*Sexual Health Needs Assessments (SHNA)- A 'How To Guide'.*[15] A project group including public health consultants, managers and analysts was established to develop and implement the methodology.

The approach taken in this sexual health needs assessment (SHNA) ensures that national, regional and local research and data sources are triangulated to map and understand the sexual health needs, demands and services across LCR. This was completed in the following way;

i. **Needs-** To ensure a the true sexual health needs of the population are demonstrated a thorough understanding the LCR demography and sexual health high risk groups was completed using national and local data sources including the Public Health Outcomes Framework, Sexual Health and Reproductive Health Profiles and Public Health England's HIV and STI web portal. Needs were also identified by comparing LCR performance with our regional, national and comparator local authorities.

ii. **Demands-** A range of qualitative data sources were used in combination with quantitative service uptake data to understand the local demands of the population. Qualitative data concentrated on understanding what service people have accessed,

their experience of the service and where and when they would like to access services in the future. Qualitative methods included;

- **Service user surveys** For example a service user survey was facilitated by New Futures from June- July 2015with sex workers. Public consultation responses relating to prevention services (2014) and integrated sexual health services (2012) were also reviewed. Results from local provider's service user engagement was also included, for example from the integrated sexual health service.

- **Semi structured focus groups** were completed by two public health managers between May and September 2015 with a range of local groups of people identified as having vulnerabilities around sexual health including young people, teenage parents, lesbian and gay men, people with learning disabilities. Focus groups with some professional groups were also completed within this timescale. These included health visitors, school nurses, general practitioners.

- **An Engagement workshop** was also held at the sexual health clinical network in May 2015 with a range of sexual health stakeholders to understand was is working well and whatcould be improved across LLR sexual health services.

- **A Sexual Health Visioning Event** was held attended by over 70 local sexual health commissioners and providers in July 2015. Initial results from the SHNA were presented and workshops were completed on integrating sexual health into other services, opportunities for co-commissioning, exploring links with CCGs and NHS England, young people's sexual health services, HIV future service delivery, making it work for Rutland, contraception and STI services and termination of pregnancy pathway.

iii. **Services -** local performance data from all sexual health providers has been used to assess the local performance and access to local provision. Specific data was collated from the integrated sexual health service, community based contracts (for GP and pharmacy), voluntary sector HIV promotion contracts (with Leicestershire Aids Support Service, Trade and New Futures), community safer sex project and parents under 20.

iv. **Gap Analysis -** The results from section i to iii were triangulated to identify what are the key gaps in sexual health provision across LCR. Recommendations were developed and discussed with the project team. The draft recommendations were used to inform the future sexual health direction for 2016-19.

To make the SHNA a practical tool for commissioners and providers of sexual health services the report has been segmented into the following chapters;

- Demography of Leicestershire and Rutland
- Groups at high risk of poor sexual health
- Sexually Transmitted Infections

- HIV
- Sexual and Reproductive Health
- Sexual Violence
- Engagement

The results from these chapters will be collated and summarised in the gap analysis, generating recommendations for action. Each chapter includes a summary of key points and implications for the LCR sexual health system.

Once completed the draft SHNA was circulated for consultation with all stakeholders from X to X November 2015. This included consultation at a number of meetings including departmental and senior management teams and scrutiny. Amendments to the SHNA and directions were made and the final SHNA and directions were presented the Leicestershire and Rutland Health and Wellbeing Boards in early 2016.

3. Demography of Leicestershire and Rutland

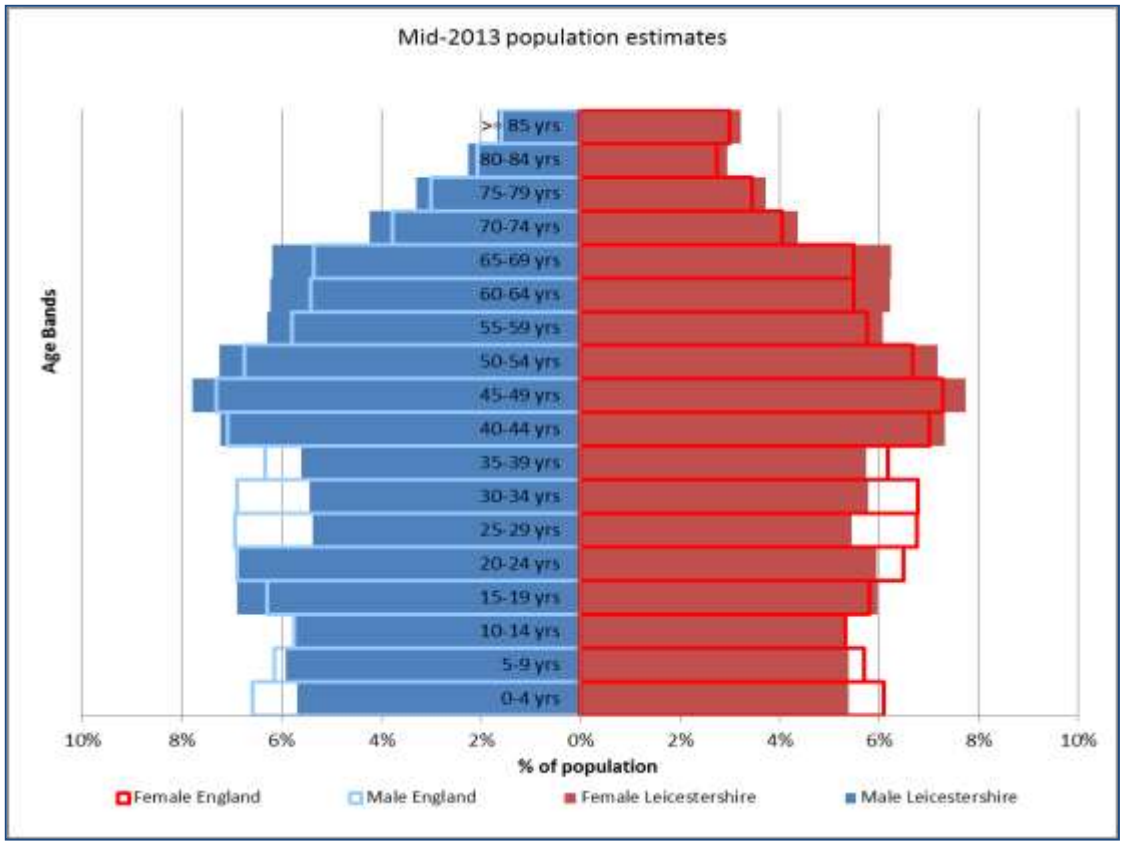
The following chapter summarises the current and future demographics of Leicestershire and Rutland. These need to be considered when predicting current and future sexual health needs.

3.1 Age

The total population of Leicestershire in 2013 was 661,575.[16] Figure 5 examines the age of the population in Leicestershire. The figure shows compared to nationally, Leicestershire has an older population. In the county, there is higher percentage of adults aged 40 years and above and a smaller percentage of children aged under 10 years and adults aged between 25 and 39 years.

The population in Leicestershire is projected to rise to 682,300 by 2018 and 724,200 by 2028. This represents an increase from 2013 of 3.1% to 2018 and by 9.5% to 2028. Between 2013 and 2028, the greatest percentage decrease is experienced in the 45-49 age band (16%) while the greatest increase is experienced in the elderly population; 90+ (115%), 80-84 (78%), 85-89 (60%) and 75-79 (52%) age bands.[16] There is also expected to be a general upward trend in the overall number of young people between 2013 and 2028 in the county. The number of 0-19 year olds is expected to increase from 153,700 to 164,600 throughout this time.

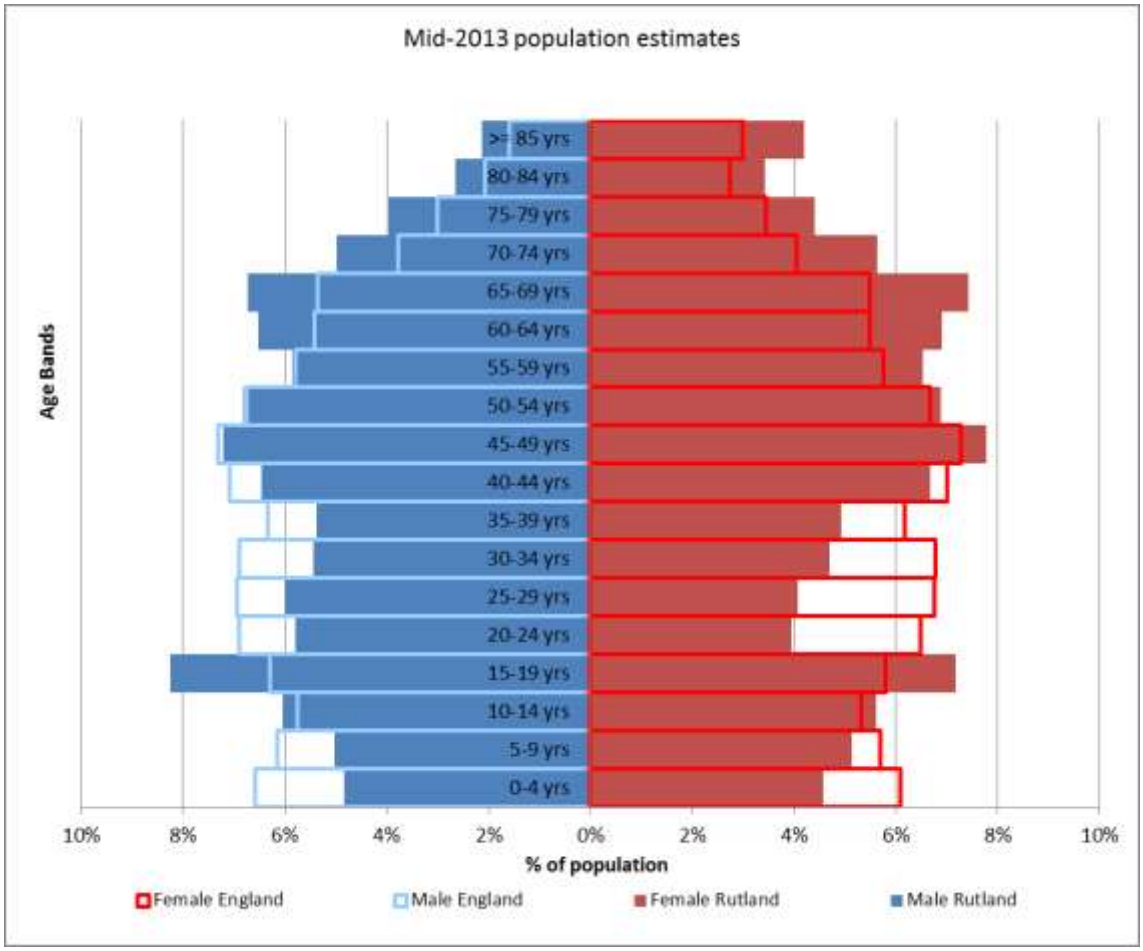
Figure 5: Population Pyramid of Mid-2013 Population in Leicestershire



The total population of Rutland in 2013 was 37,606.[16] Figure 6 examines the age of the population in Rutland. The figure shows compared to the national population, Rutland has an older population. In the county there is higher percentage of adults aged 60 years and above and a smaller percentage of children aged under 10 years and adults aged between 20 and 44 years. A higher proportion of children aged between 10 and 19 years were seen compared to the national average, it is likely this increase is due to the independent boarding schools in the county.

The population in Rutland is projected to rise to 37,400 by 2018 and 39,400 by 2028. This represents an increase from 2013 of 1.4% to 2018 and by 6.8% to 2028. Between 2013 and 2028, the greatest percentage decrease is experienced in the 20-24 age band (38%) while the greatest increase is experienced in the elderly population; 90+ (150%), 85-89 (86%) and 80-84 (83%) age bands.[16] There is also expected to be a general upward trend in the overall number of young people between 2013 and 2028 in the county.

Figure 6: Population Pyramid of Mid-2013 Population in Rutland



3.2 Ethnicity

In Leicestershire, the White ethnic group accounts for 91% of the overall population and the Asian or Asian British ethnic group makes up 6%. Within the districts, Oadby and Wigston has the highest proportion of Asian or Asian British making up 22% of the borough's population respectively. Throughout the county, there are 16,000 young people, 36,000 people of 'working age' and 3,500 older people from BME groups. In general, BME groups

tend to be younger than the White group.[17] In Rutland, the White ethnic group accounts for 97% of the overall population. In Leicester City, 51% of the population are from the white ethnic group. 37% of the population in the City is made up of Asian or Asian British and 6% is from British and Black ethnic groups.[17]

3.3 Sexual Orientation

In 2013, the Office of National Statistics reported that 1.6% of adults in the UK identified themselves as gay, lesbian or bisexual.[18]

This comprised of:

- 1.2% of adults identified themselves as gay or lesbian
- 0.5% of adults identified themselves as bisexual

If this rate is applied to the population of Leicestershire, it means that there are approximately 10,000 people in the county who identify themselves as gay, lesbian or bisexual in 2013. This compares with 1.5% of adults who identified themselves as gay, lesbian or bisexual in 2012, which represents a small increase in 2013 though not statistically significant. In Rutland, applying these estimates approximates there are 600 people who are gay, lesbian or bisexual in the county in 2013.[18]

Males were twice as likely as females to consider themselves gay or lesbian:

- 1.6% of adult males identified themselves as gay or lesbian compared to 0.8% of adult females.
- Adult females were more likely to identify themselves as bisexual (0.6%) compared to adult males (0.4%).

Natsal-3 study found that a higher proportion of the population have had a same-sex experience compared to those who identified themselves as gay, lesbian or bisexual. The Natsal-3 showed that 4.8% of males and 7.9% of females aged 16-44 years have had a same-sex experience with genital contact.[2] In Leicestershire this equates to over 9,000 females and nearly 5,700 males estimated to have had a same sex experience whereas in Rutland the numbers are much smaller at 435 females and 328 males. It is important to remember that all surveys are susceptible to different forms of reporting bias (e.g., social acceptability and recall bias), which can result in under-reporting or over-reporting of sensitive behaviours so these estimated counts must be viewed cautiously.

3.4 Area Classification

According to the 2011 ONS Output Area Classification[19], the highest proportion of Leicestershire's population live within areas classed as "Suburbanites" (43%) and as "Urbanities" (17%). "Suburbanites" are most likely to be located on the outskirts of urban areas. They are more likely to own their own home and to live in semi-detached or detached properties and the population tends to be a mixture of those above retirement age and middle-aged parents with school age children. In Leicester City, 62% of the population are

defined as “Multicultural Metropolitans” whereas in Rutland, 54% of the population is categorised “Rural Residents”.

3.5 Migration

Between 2012 and 2013, the population in Leicestershire was estimated to increase by almost 5,000 persons. The surplus of births to deaths and net international migration both accounted for an increase of approximately 1,000 persons. Net internal migration (specifically domestic migration) accounts for the majority of the projected population change between this time.[20] Net internal migration is also expected to provide a substantial increase in population over the next five and fifteen years.

3.6 Deprivation

The wider determinants of health are described and measured within the English Indices of Deprivation 2015.[21] These are a group of measures which gauge different aspects of deprivation. Deprivation is a general lack of resources and opportunities, which includes financial poverty and a range of other aspects such as lack of access to education or good quality housing. The measures are combined into an overall measure of the amount of deprivation in an area called the Index of Multiple Deprivation (IMD), which can be used to compare different local areas.

Figure 7 presents the level of deprivation in different areas of Leicestershire according to the IMD 2015. The data is presented as “quintiles” of deprivation. Areas of Leicestershire that fall into the most deprived fifth (20%) of areas in England are quintile 1, those in the second most deprived fifth of areas are quintile 2, and so on, through to quintile 5 which are areas that are within the least deprived fifth (20%) in England. Figure 8 shows how much of the population of Leicestershire lives in each deprivation quintile, and demonstrates that:

- 2% of the population of Leicestershire (12,130) people live in areas categorised within the most deprived 20% of areas in the country.
- Three districts in Leicestershire, Charnwood, Hinckley and Bosworth and North West Leicestershire have areas which are in the most deprived 20% in the country.
- 11% of the Leicestershire population live in the second quintile of deprivation (in the most deprived 20-40% of areas in England), accounting for over 75,000 people affected by deprivation. All seven districts in Leicestershire have people in this category of deprivation.
- Over half of the population living in Harborough live in the least deprived 20% of areas in the country.
- Three quarters of all residents in Leicester City live in the most deprived 40% of areas in the country. This accounts for over 250,000 people.

Figure 7: English Indices of Multiple Deprivation 2015 by national quintile for Leicestershire and Rutland[21]

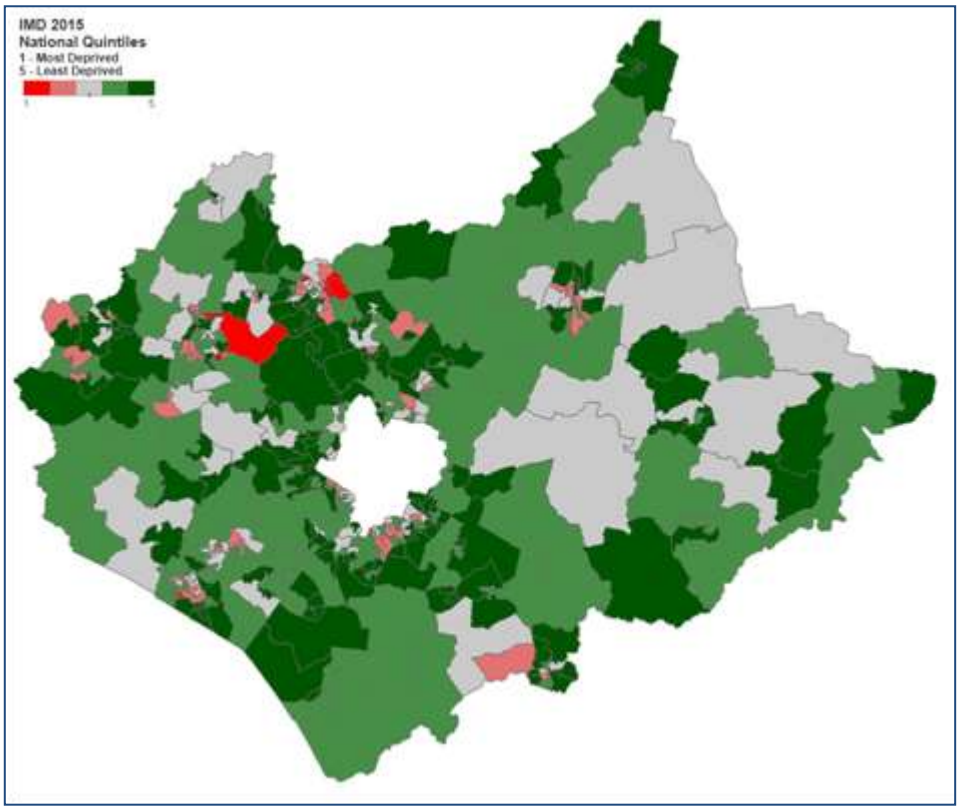
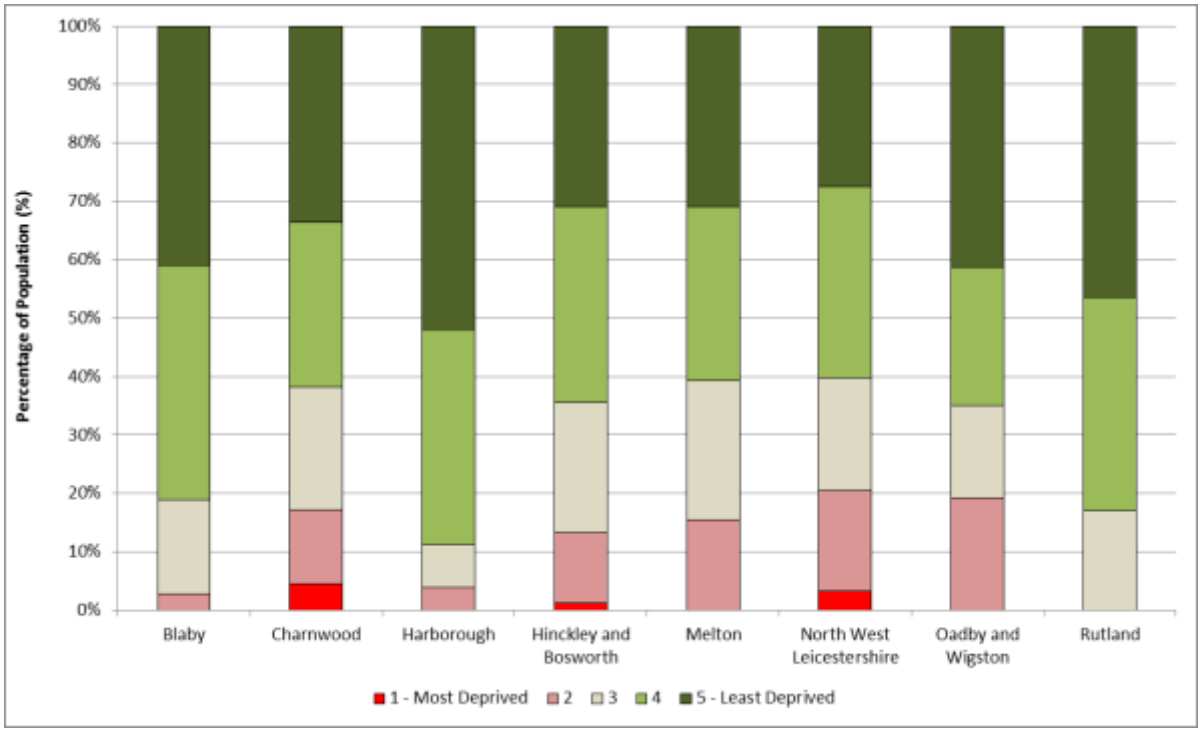


Figure 8: Proportion of population in each deprivation quintile in Leicestershire, Leicester and Rutland, 2015[21]



3.7 Education

The school years are an arena where children have the potential to develop the skills for life and work, attain qualifications and gather aspirations that are crucial in determining their future life paths. Without learning these essential skills for school, the workplace or for further study, young people will fail to reach their potential to flourish and take charge of their lives.

In 2013/14, 58.0% of children in Leicestershire achieved a good level of development at the end of reception, significantly worse than the national average (60.4%). For those receiving free school meals, only a third (34.6%) achieved the necessary level, also significantly worse than the national average (44.8%). Rutland as a county performs better than Leicestershire in this area. In the same year, 61.8% of children in Rutland achieved a good level of development at the end of reception, and for those on free school meals, 40.9% achieved the necessary level. Both these indicators for Rutland are similar to the national average.[22]

In 2013/14, 56.5% of pupils attending schools maintained by Leicestershire local authority achieved 5A*-C in GSCE examinations, similar to the national percentage of 56.8%. In the same year, Rutland performed significantly better than the national average with 62.7% of pupils achieved this standard.[23]

For the past three years, both Leicestershire and Rutland have had significantly better percentages of 16-18 year olds who are not in education, employment or training (NEET) than the national figure. In 2013, only 3.4% and 1.8% of 16-18 year olds in Leicestershire and Rutland were not in education, employment or training, lower than the national percentage of 5.3%. Throughout 2011 and 2013, the percentage of 16-18 year olds not in education, employment or training (NEET) in Leicestershire and Rutland has remained static and significantly better than the national average.[22]

Key groups with a significantly greater risk of NEET above the general cohort are below. These individuals should be targeted with interventions to see further improvements in the rates.

i) Children in Care

ii) Teenage Parents

iii) Young Offenders

iv) Young people with Special Education Needs

3.8 Employment

Social and environmental factors are powerful influences in shaping sexual behaviour and its consequences for sexual health. Poverty, deprivation and unemployment contribute markedly to sexual ill health. Unemployment is associated with an increased risk of ill health and mortality. Early unemployment has a particularly damaging effect on later chances of employment, decent wages, and good quality work, all of which are important for good health. Young adults aged 16-18 year olds not in education, employment or training are associated with an increase in unhealthy behaviours such as drinking, smoking, drug use or becoming a teenage parent[24]

In 2014, 3.1 per 1,000 working age population in Leicestershire were in long-term unemployment. This is significantly better than the national average (7.1 per 1,000 population). The rate in Leicestershire has remained significantly better than the national average between 2012 and 2014.[23]

3.9 Implications for sexual health

People have different sexual health needs at different stages of life. The 2010 Health Survey for England[25] and Sexual Attitudes and Lifestyles in Britain Survey (2013)[26] found that most adults are sexually active with some different behaviours and views across the life course. The Framework for Sexual Health Improvement identifies the need to build knowledge and resilience among young people up to 16 by delivery of good-quality sex and relationships education and confidential advice and support. The framework suggests that to improve sexual health outcomes for 16-24s by prioritising prevention and ensuring good access to appropriate services, ensuring all adults have access to high quality services and information and that over 45s are equipped to remain healthy as they age.

As people get older, their need for sexual health services may reduce. (The female fertile age group is typically defined as 15-49 years old.) Leicestershire and Rutland have older and aging populations when compared to England overall. Both populations are due to increase in number by 2028. In Leicestershire there are currently similar or lower proportions of the population aged under 40 years than the England in all age groups except 15-19 year olds. Rutland has a similar picture with similar or lower proportions of the population aged under 45years than England in all age groups except those aged 10-19years (which are likely to be due to the number of independent boarding schools in the county). Due to these similar or lower proportions of women of fertile age, contraceptive needs across LCR are likely to be similar or slightly lower than the England average.

However, whilst STI rates in the 45s and over only accounted for 8.0% of all new STIs diagnosed in GUM in LCR in 2014, they rose by 59% between 2010-2014.[27] Older age groups are more likely to be living with long-term health conditions that may cause sexual health problems[4]. This is supported by the Natsal-3 survey[28] findings indicating that sexual difficulties were more likely to cause distress or worry in older age groups. Therefore as the population ages, demand for services such as psychosexual services may increase. The effectiveness of HIV treatment has increased life expectancy for people diagnosed with HIV. Care services have to take into account the needs of an aging population living with HIV.

Natsal-3 identified earlier sexual debut amongst the population[2]. With higher proportions of 15-19 year olds and predicted increases in this age group across LCR, further consideration may be needed to ensure young people's sex and relationships education across LCR (including independent schools in Rutland) is improved to encourage young people to make informed choices about their sexual health including delaying sexual debut. 15-19 year olds are known to have increased needs in relation to STI and contraception, which will need to be considered in the development of young people's services.

People of different ethnicities may have different needs in relation to their sexual health, for example, in relation to cultural norms, stigma and discrimination and risk factors. For example Black Africans are one of the groups most at risk from HIV and black Caribbean's are one of the groups at higher risk from STIs[29]. Although LCR has a predominantly White population (accounting for 91% in Leicestershire and 97% in Rutland), service provision and prevention work needs to be sensitive to these issues to ensure that that the needs of BME populations of Leicestershire and Rutland are addressed.

The Framework for Sexual Health Improvement in England[4] identifies that lesbian, gay, bisexual and trans (LGBT) people experience a number of health inequalities that may prevent appropriate access to services, including sexual health services. In addition, an increasing proportion of STI diagnoses, including HIV are diagnosed among men who have sex with men (MSM). MSM appear to bear a disproportionate burden of ill health in three distinct but overlapping areas of sexual health, mental health and substance misuse. There is growing concern that sexual risk taking behaviour (combined with use of illicit substances) is increasing in this population which may lead to increased transmission of STIs. Therefore appropriate prevention strategies, (including increasing access to HIV and STI testing) are required. Sexual health services for MSM must also consider how they can work in partnership to support this client group to address substance misuse and mental health issues.

Internal migration (specifically domestic migration) accounts for the majority of the projected population increases. Therefore services must also adapt to ensure they are responding to these new populations that may have access barriers due to language, culture, religion etc.

The Marmot Review (2010)[8] 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 LCR are at greater risk of poorer sexual health. It is therefore important to ensure that all sexual health services are equitably distributed across LCR 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 areas in the most deprived 20% in the country, these areas should be prioritised for sexual health service delivery.

Teenage parents are at greater risk of NEET and hence subsequent longer term unemployment than the rest of the population. Therefore support is needed to ensure that teenage parents receive the support they require to remain in EET, to improve the outcomes of the parent and child.

4. Groups at High Risk of Poor Sexual Health

As discussed in chapter 3, the Framework for Sexual Health Improvement 2013 identifies three main population groups (young people, MSM and some BME) populations who are particularly affected by poor sexual health[4]. In addition to these there are other vulnerable groups that are more likely to experience sexual ill health or sexual violence. This chapter provides more details on some of these key groups.

4.1 Drug users

The use of illegal drugs often affects the most vulnerable and socially excluded individuals in our communities, bringing a range of problems and areas of public concern. The health and social harms caused by drug misuse are significant and wide-ranging.[30]

In 2011/12, the estimated prevalence of opiate and/or crack cocaine users aged 15-64 in Leicestershire was 4.4 per 1,000 population, significantly better than the national rate of 8.1 per 1,000 population. In Rutland, the rate was 1.9 per 1,000 population, also significantly better than the national rate. The prevalence of drug injectors aged 15-64 years in Leicestershire was 1.0 per 1,000 population and in Rutland was 0.3 per 1,000 population, both significantly better than the national rate of 2.6 per 1,000 population.[31]

In 2012 in Leicestershire and Rutland (combined), 8.9% opiate drug users that left drug treatment successfully did not re-present to treatment within 6 months, this is similar to the national percentage of 8.6%. For non-opiate users in Leicestershire and Rutland, 29.2% of non-opiate drug users that left treatment successfully did not re-present to treatment within 6 months. This is significantly worse than the national percentage of 42.4%.[22]

Evidence suggests that gay and bisexual men who use particular illegal drugs (as well as alcohol) are more likely to engage in risky sex[32]. A survey found that 51% of gay men had taken illegal drugs in the previous year, compared with 12% of men in the wider population[33]. Sex workers are also at greater risk of illicit drug use, with 9 out of 25 (36%) of sex workers stating they used drugs in a LLR sex workers survey completed over summer 2015. The use of image and performance enhancing drugs can also impact on sexual function and increase risky sexual behaviour[34].

4.2 Alcohol

Research undertaken by North West Public Health Observatory[35] found that:

- There was an association between alcohol attributable hospital admissions with teenage pregnancy and also with the more common STIs;
- There is evidence that alcohol consumption can result in lower inhibitions and poor judgements regarding sexual activity, vulnerability and risky behaviour, such as not using contraception or condoms;

- Alcohol consumption by young people leads to an increased likelihood that they will have sex at a younger age, and alcohol misuse is linked to greater number of sexual partners and more regret or coerced sex; and

- Alcohol also increases the risk of sexual aggression, sexual violence and sexual victimisation of women.

In 2013/14, there were 3,897 hospital stays for alcohol related harm for adults in Leicestershire. This equates to an admission rate of 573 per 100,000 population which is significantly better than the England average of 645 per 100,000 population.[23] Between 2011-13, Leicestershire had a rate of 10.3 per 100,000 population where the underlying cause of death was from alcohol-specific conditions, this is significantly better than the national rate of 11.9 per 100,000 population.[36]

Alcohol use has been shown to be linked with increased risk taking sexual behaviour in particular for MSM and sex workers. Alcohol consumption can result in lower inhibitions resulting in risky sexual health behaviour, especially in young people. Although Leicestershire and Rutland has lower estimated prevalence of opiate and/or crack cocaine users aged 15-64 than England and alcohol hospital admissions, sexual health services must consider how they work in partnership with substance misuse services to support service users to reduce their risk taking behaviour. For example sex and relationships education should consider the links between alcohol and poor sexual health as a key component of the RSE curriculum.

4.3 Sex Workers

Some prostitutes are at higher risk of poor sexual health outcomes.[37] Prostitutes also experience vulnerabilities such as violence, rape and sexual assault, homelessness, and drug and alcohol problems that may impact on their sexual health needs.[38]

Findings from the Natsal-3 survey identifies men who pay for sex (MPS) as a bridging population for STIs and concludes that MPS in Britain remain at greater risk of STI acquisition and onward transmission than men who do not pay for sex. The study estimated that one in 10 of all men reported ever paying for sex.[39]

Detailed information is not available in relation to numbers of sex workers operating or living in LCR. Sex worker activity and sites are transient. Currently (September 2015) there are 6 sauna/parlours and at least 5 flats known to Police services in Leicestershire. There has been some indication of street work in Loughborough although evidence is limited. There also has been an increase in sex work from flats due to increased internet use to access sex worker services. Police report that there is often a high turnover of women working from houses/flats with some moving on a weekly basis. One adult website indicated 40 women and 12 men working across the Loughborough, Melton, Hinckley, Lutterworth and Coalville areas. An increase in Eastern European women working locally has been observed, although police work has focused on this community and hence details from other communities are less known.

There are currently no known parlours in Rutland.

New Futures project operates from a Leicester city service location and delivers sexual health information and support predominantly to sex workers working streets and saunas in Leicester City. Outreach work includes some sessions to Leicestershire saunas.

Research findings identify health inequalities for sex workers with street sector workers facing the poorest health and greatest risks, particularly in relation to IV drug use and trafficking.[40] Appropriate use of mainstream services by sex workers tends to be poor. Stigma, unpredictable attendance at services, potential difficulties with language and understanding how to access services are all cited as barriers. Outreach services are considered a means to help to overcome barriers, however use of mainstream services remain necessary and service development to improve access is important.

4.4 Mental Health Conditions and Wellbeing

Sexual health is defined by WHO as *'… a **state of physical, emotional, mental and social well-being in relation to sexuality**;'(Page 5, WHO, 2002).*[1] 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.[41]

In 2013/14, 4,537 people within the registered population were diagnosed with a mental health problem (0.7%) in Leicestershire and 235 (0.7%) in Rutland. Both these areas have a significantly lower percentage than the England average (0.9%).[42]

4.4.1 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.[4]

- Discrimination resulting from sexual health status can have an effect on quality of life and mental health;[43]
- 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; and
- Some healthcare professionals feel embarrassed to offer an HIV (or STI) test, even if a patient is presenting with possible symptoms.

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

4.4.2 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 2013/14 408 LLR adults accessed SARC services. This increased to 583 in 2014/15. 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.

4.4.3 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.[4]

4.5 Physical Disabilities

Sexual health is recognized as a human right by many international health organizations including the World Health Organization. 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 and 12.0% of 16-64 year olds in Rutland had a moderate to severe physical disability. Both areas have a higher prevalence than nationally (11.1%).[44] The level of moderate and severe physical disabilities in 18-64 year olds is predicated to stay reasonably constant to 2030 in both Leicestershire and Rutland. In Leicestershire, moderate physical disabilities are estimated to increase marginally from 32,188 in 2014 to 32,725 in 2030 while estimates for severe physical disability are expected to increase, but again only marginally, from 9,658 in 2014 to 10,033 in 2030. In Rutland, counts of both moderate and severe physical disabilities are estimated to decrease marginally from 2014 to 2030. Moderate physical disabilities are estimated to decrease from 1,735 in 2014 to 1,651 in 2030 while for severe physical disability are estimated to decrease from 534 in 2014 to 524 in 2030.[45]

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.[46] These activities contribute to people with disabilities experiencing increased rates of STIs, unintended pregnancies, and sexual violence than those without disabilities.[47] Therefore additional work is needed to ensure that sexual health information and services are available for people with physical disabilities.

4.6 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. The Department of Health's report No voice unheard, no right ignored – a consultation for people with learning disabilities, autism and mental health conditions (2015) sets out the aim to give people with learning disabilities the same life as any other member of the community and an end to institutional care by default.[48]

Research has found that young people with learning disabilities do not have good access to sex and relationship education or information.[49] 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 2013/14, 2,140 people within the registered population (18+) were diagnosed with a learning disability (0.4%) in Leicestershire and 122 (0.4%) in Rutland. In England, 0.5% of the registered population have a learning disability.[42]

There is no data on contraceptive uptake or STI prevalence in people with learning disabilities; however local focus groups have taken place with this group to gain a local understanding of this group. See Engagement chapter 9.

4.7 Homelessness

Homelessness is a social determinant of health associated with severe poverty, adverse health, education and social outcomes, particularly for children. To be deemed statutorily homeless a household must have become unintentionally homeless and must be considered to be in priority need. Households that are accepted as being homeless or are in temporary accommodation can have greater public health needs than the population as a whole. As such, statutorily homeless households contain some of the most vulnerable and needy members of our communities. Preventing and tackling homelessness requires sustained and joined-up interventions by central and local government, health and social care and the voluntary sector.

In 2013/14, 430 households in Leicestershire and 27 in Rutland were categorised as statutory homeless. The rate of homelessness acceptances in 2013/14 in Leicestershire was 1.6 per 1,000 households, significantly lower than the national rate (2.3 per 1,000 households). In Rutland, the rate of 1.7 per 1,000 households was similar to the national

rate.[22] In the same year, 70 homeless households in Leicestershire and, 3 households in Rutland were in temporary accommodation awaiting a settled home. The rate of households in temporary accommodation in Leicestershire was 0.3 per 1,000 households in Leicestershire and 0.2 per 1,000 households in Rutland. Both areas have a significantly better rate than nationally (2.6 per 1,000 households).[22]

Homeless people are at increased risk of STIs and unwanted pregnancies and can come under pressure to exchange sex for food, shelter, drugs and money.[4] This pressure means they may also be members of the other vulnerable groups as previously discussed, hence the need to ensure services are accessible to this group.

4.8 Looked After Children (LAC)

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.[50]

In 2013/14, 455 children in Leicestershire and 35 children in Rutland under the age of 18 were classified as looked after children. The rate of looked after children was 33.8 per 10,000 population in Leicestershire and 45.1 per 10,000 population in Rutland. The rate in Leicestershire was significantly better than then national average (59.8 per 10,000 population), while the rate in Rutland was similar to the national average.[51]

Young people who are looked after are recognised as being vulnerable to risk taking behaviour[52] 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. Both young women and young men 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.[53]

4.9 Children with a Protection Plan (CPP)

Children who are identified as being at serious risk of maltreatment are placed under a child protection plan in order to safeguard them from significant harm. More often, significant harm is a compilation of significant events, both acute and long-standing, which interrupt, change or damage the child's physical and psychological development. Some children live in family and social circumstances where their health and development are neglected. For them, it is the corrosiveness of long-term emotional, physical or sexual abuse that causes impairment to the extent of constituting significant harm.

Nationally, child maltreatment has a prevalence of between 1 in 10 and 1 in 25 children.[54] The self-reported figures for maltreatment are estimated to be much higher and the rate of maltreatment increases with age: 5.9% in children aged under 11 years, 18.6% of 11−17 year olds, and 25.3% of 18−24 year olds.[55]

In 2013/14, 629 children in Leicestershire and 44 children in Rutland became the subject of a child protection plan during the year. In this year, the rate of new child protection cases in Leicestershire was 46.7 per 10,000 population aged under 18 years and in Rutland, the rate was 56.6 per 10,000 population aged under 18 years. Leicestershire had a significantly better rate than the national rate (52.0 per 10,0000 population aged under 18 years) whereas the rate for Rutland was similar to the national rate.[51]

In 2014, 79 children (12.6%) became subject of a child protection plan for a second or subsequent time in Leicestershire. These represent individuals with extreme levels of need. This percentage is significantly better than the England average of 15.8%. No data is available for Rutland.[51]

4.10 Implications for Sexual Health Services

As discussed there are a number of vulnerable groups (including those that misuse drugs and alcohol, sex workers, people that are homeless, those with mental health, learning or physical disabilities and children with protection plans or that are looked after) that are at risk of poorer sexual health outcomes as compared to the general population. Each group has diverse requirements and therefore sexual health services should regularly complete an equalities impact assessment to review how they are meeting the diverse needs of these vulnerable groups. This may also include targeted work or information for some groups including sex workers, looked after children and those with learning or physical disabilities.

5. Sexually Transmitted Infections (STIs)

5.1 Burden and Trend Of New STIs

Figure 9 shows the incidence rate of five key sexually transmitted infections (STIs) in Leicestershire and Rutland. Chlamydia is the most prevalent STI across the counties and the overall rates of new acute STIs are heavily driven by the chlamydia rates in young people, a pattern seen both locally and nationally. Genital warts were the second most prevalent infection in 2014.

In 2014, there were 3,667 new STIs diagnosed in residents of Leicestershire (1808 in males and 1854 in females), at a rate of 554.3 per 100,000 residents. In residents of Rutland, there were 193 new STIs diagnosed (119 in males and 74 in females), at a rate of 515.9 per 100,000 residents. These rates of new STIs in both Leicestershire and Rutland were significantly better than the national rate of 796.1 per 100,000 population in 2014.[56]

Throughout Leicester, Leicestershire and Rutland and England,

Figure 10 shows the highest rate of STI diagnoses were in the 20-24 age band. The second highest diagnoses rate in Leicester, Leicestershire and England occurred in the 15-19 age band whereas in Rutland this occurred in the older age band of 25-34 years.

Figure 9: Rates per 100,000 population of new STIs in LLR and England: 2014[56]

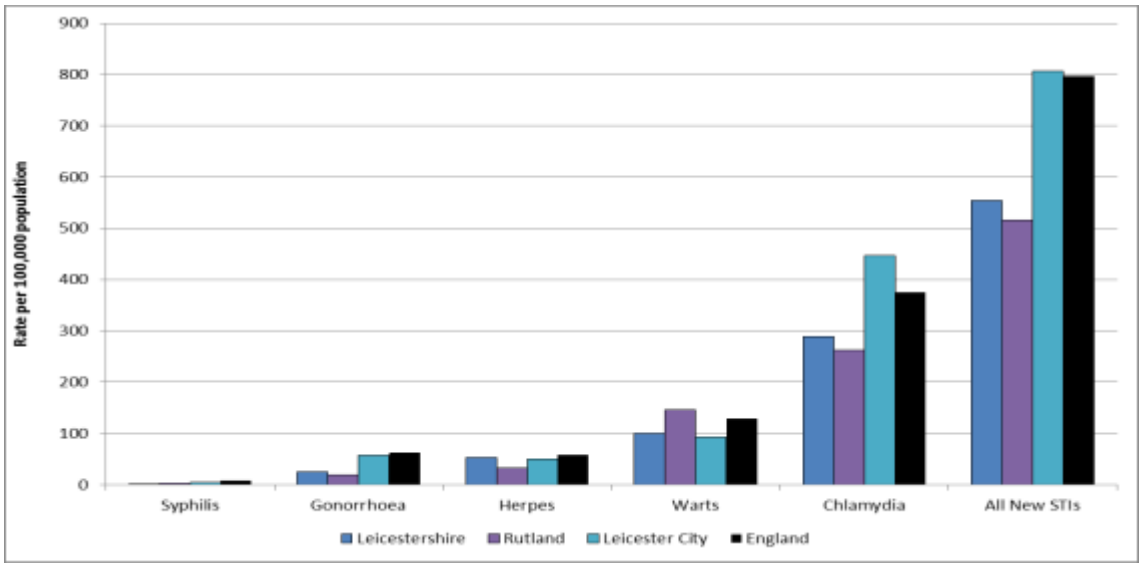


Figure 10: Rates per 100,000 populations of all new STIs in LLR and England by Age band: 2014

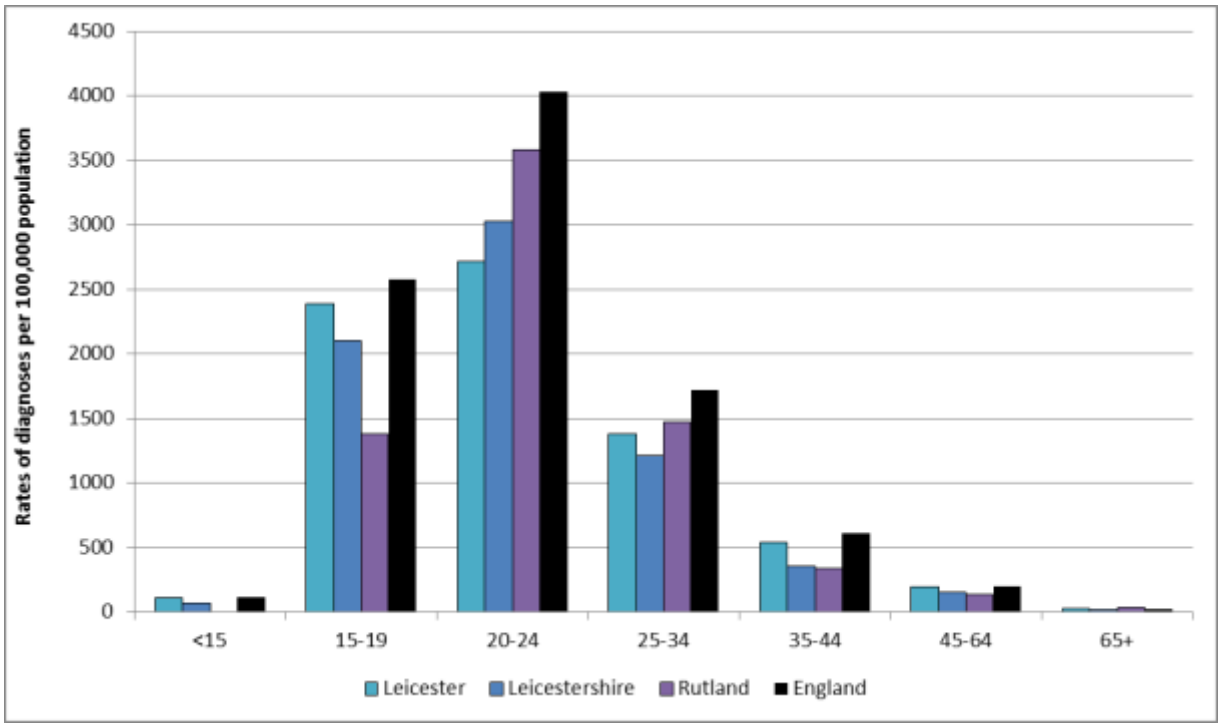


Figure 11 examines the rate of new STIs (excluding Chlamydia diagnoses aged under 25) by district across the East Midlands in 2014. All districts in Leicestershire and Rutland have a rate significantly better than the national average and Melton, Harborough, North West Leicestershire, Oadby and Wigston, Hinckley and Bosworth and Blaby all have a significantly better rate than the regional average. Throughout Leicestershire, Charnwood has the highest rate of new STIs and Melton, the lowest.[57] It should be noted that this data excludes diagnoses in Prison settings; hence the data is not distorted by prison populations in some districts.

Figure 11: Rates of new STIs (excluding Chlamydia aged under 25) in each local authority in East Midlands, 2014[57]

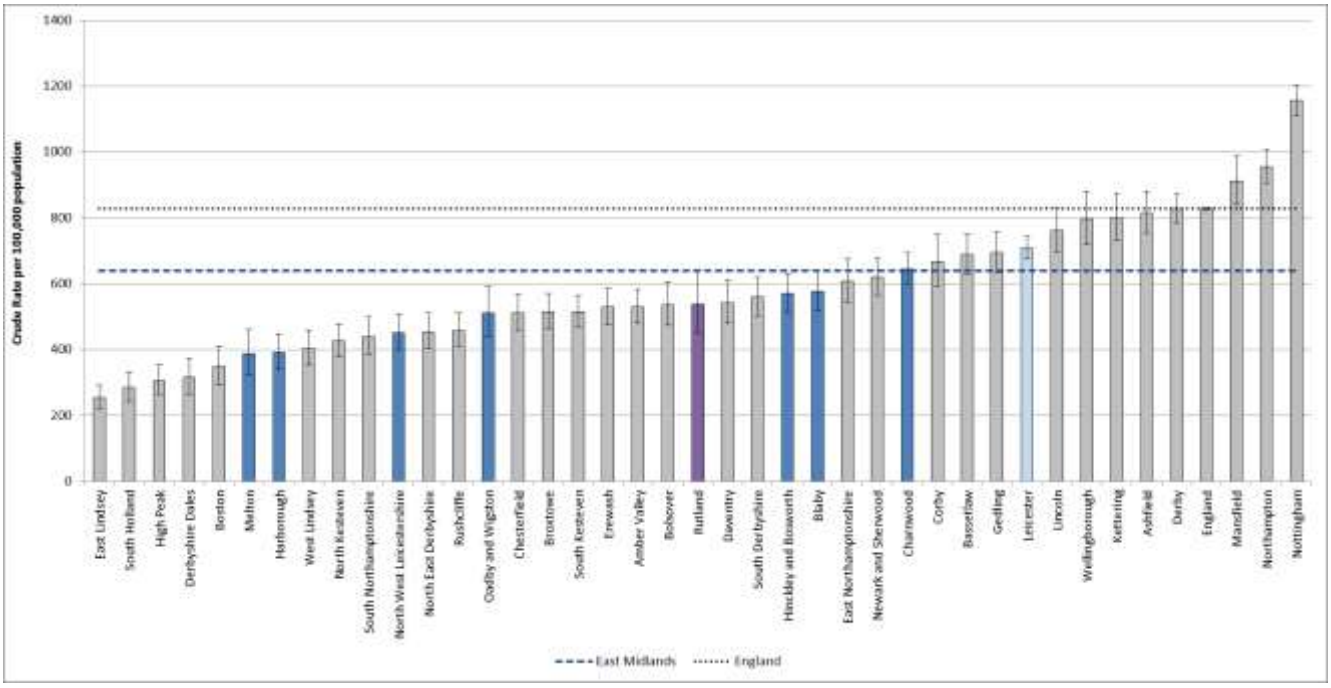


Figure 12 shows that nationally there has been a year on year increase in the rate of gonorrhoea diagnoses over time. High rates of gonorrhoea and syphilis in a population reflects high levels of risky sexual behaviour. It is also hypothesised that any increase in gonorrhoea diagnoses may be due to increased use of highly sensitive Nucleic Acid Amplification Tests (NAATs) and additional screening of extra-genital sites in men who have sex with men (MSM). Throughout this time, the rate of gonorrhoea diagnoses in Leicestershire have increased, but remained consistently lower than the national average.

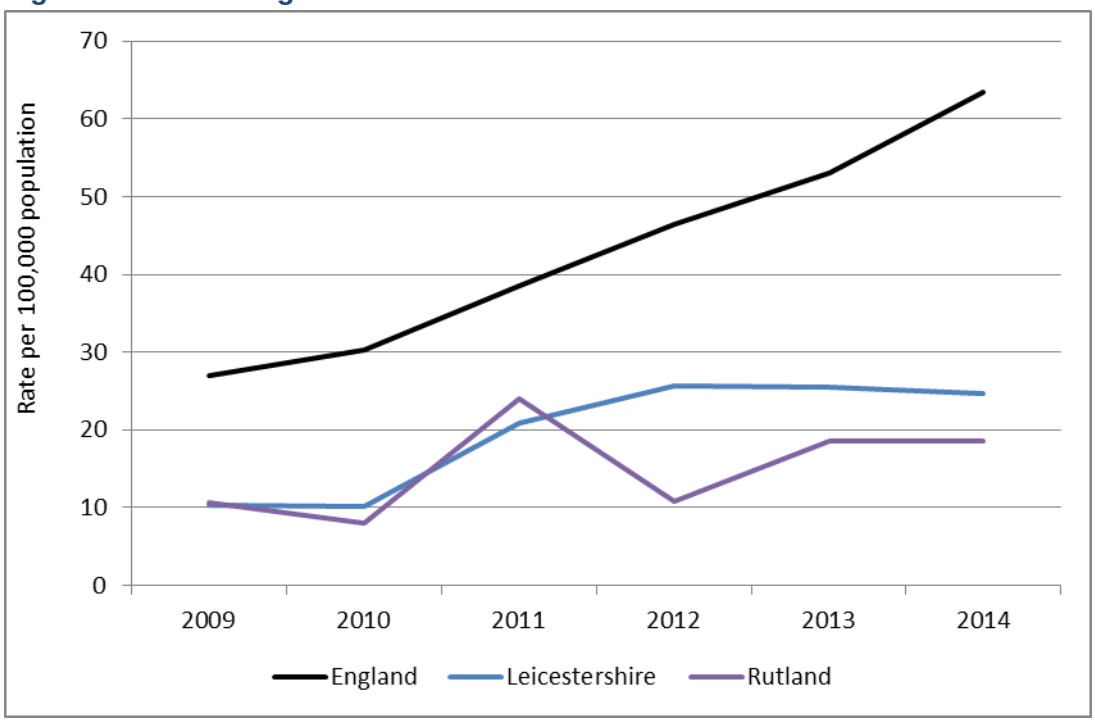
Syphilis has the lowest rate of new STIs both nationally and locally. Figure 13 shows that the rate of syphilis nationally has increased over time. In Leicestershire, increases were seen between 2009 and 2012, but the latest data for 2014, shows the local rate has declined to lowest rate since recordings. The rate in Rutland is open to much fluctuation due to small numbers.

Genital warts are the second most common STI in both Leicestershire and Rutland. Figure 14 examines the trend of new diagnoses over time. In Leicestershire, the rate of genital warts has remained significantly better than the national average since 2009. From 2012, the rate of genital warts in Rutland was higher (although not significantly) than the national average.[57]

Nationally, the rate of genital herpes has risen year on year since 2009. In Leicestershire over this time, the rate has remained continuously lower than the national rate.

Figure 15 shows that between 2009 and 2012, the rate in Leicestershire increased year on year. The latest data has shown an increase compared to the previous year. The rate in Rutland has remained consistently lower than the national and Leicestershire rate over time but shows fluctuations due to small numbers involved.

Figure 12: Rates of gonorrhoea*[57]



*Any increase in gonorrhoea diagnoses may be due to increased use of highly sensitive Nucleic Acid Amplification Tests (NAATs) and additional screening of extra-genital sites in men who have sex with men (MSM)

Figure 13: Rates of syphilis[57]

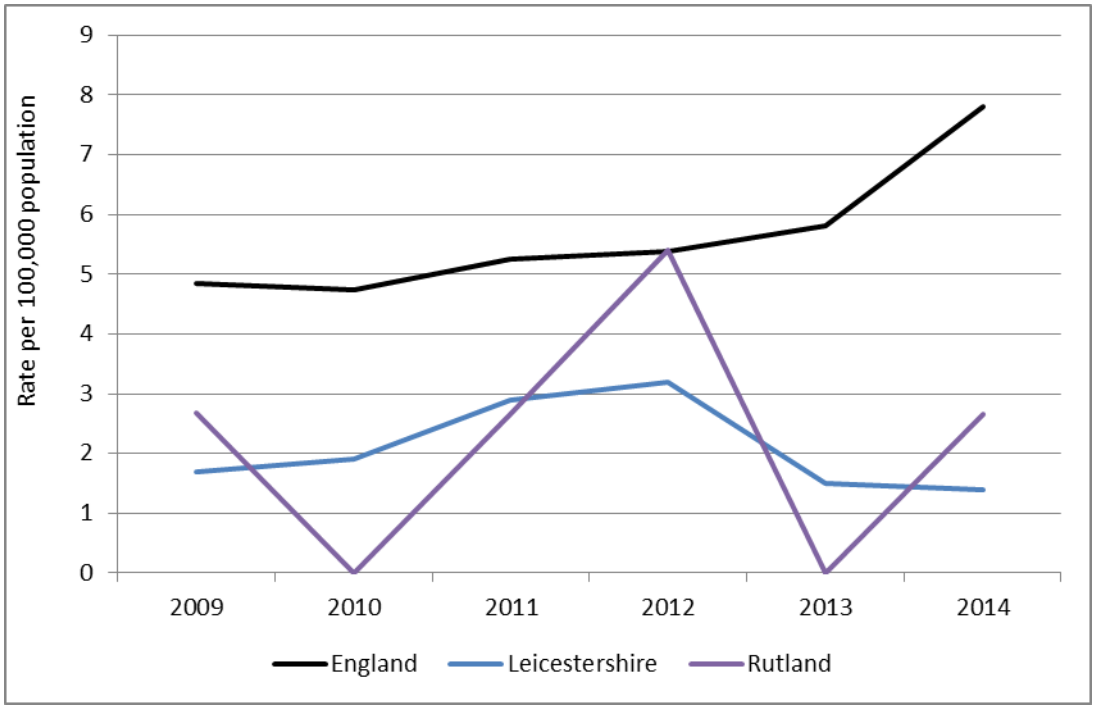


Figure 14: Rates of genital warts[57]

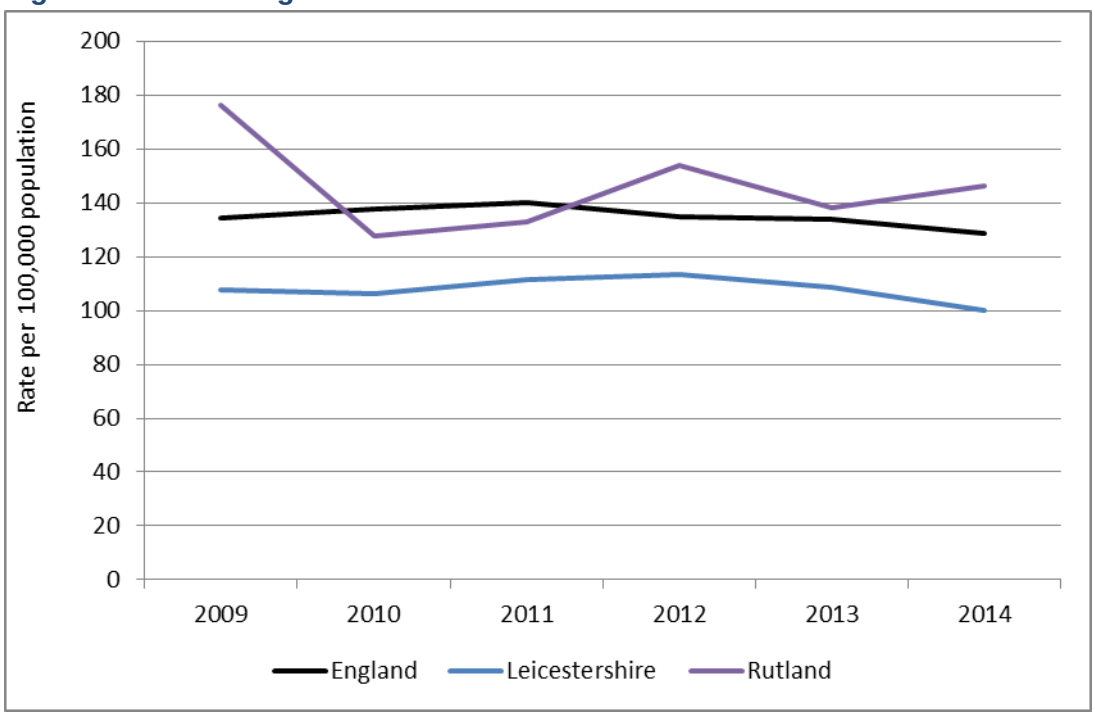
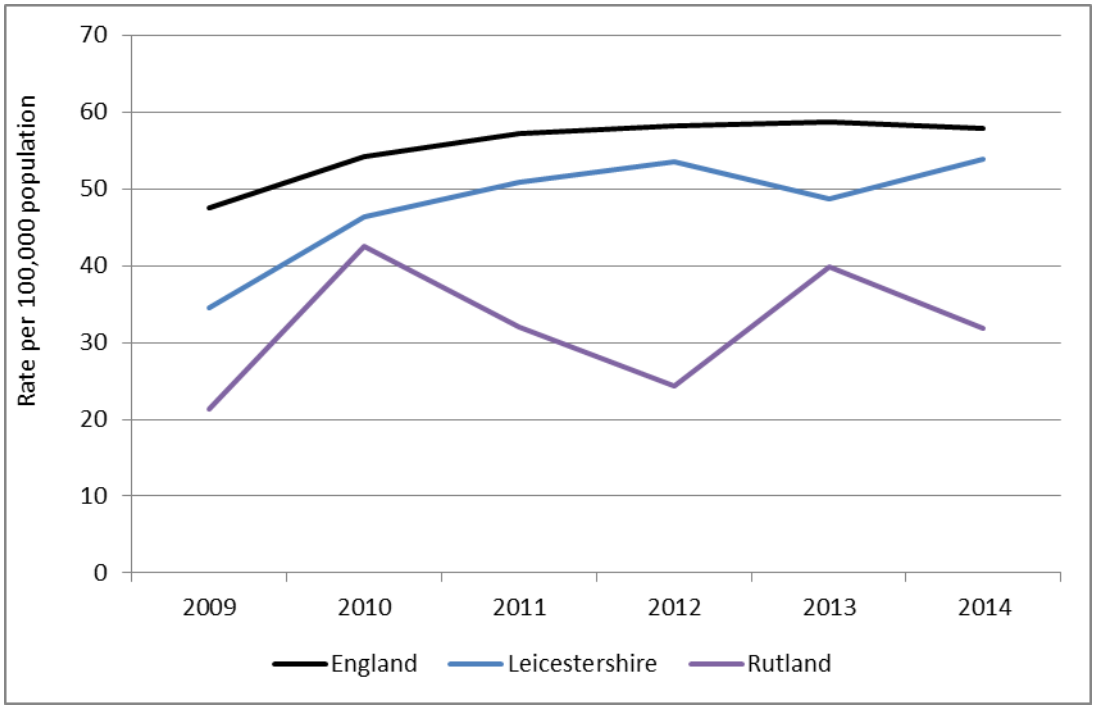


Figure 15: Rates of genital herpes*[57]

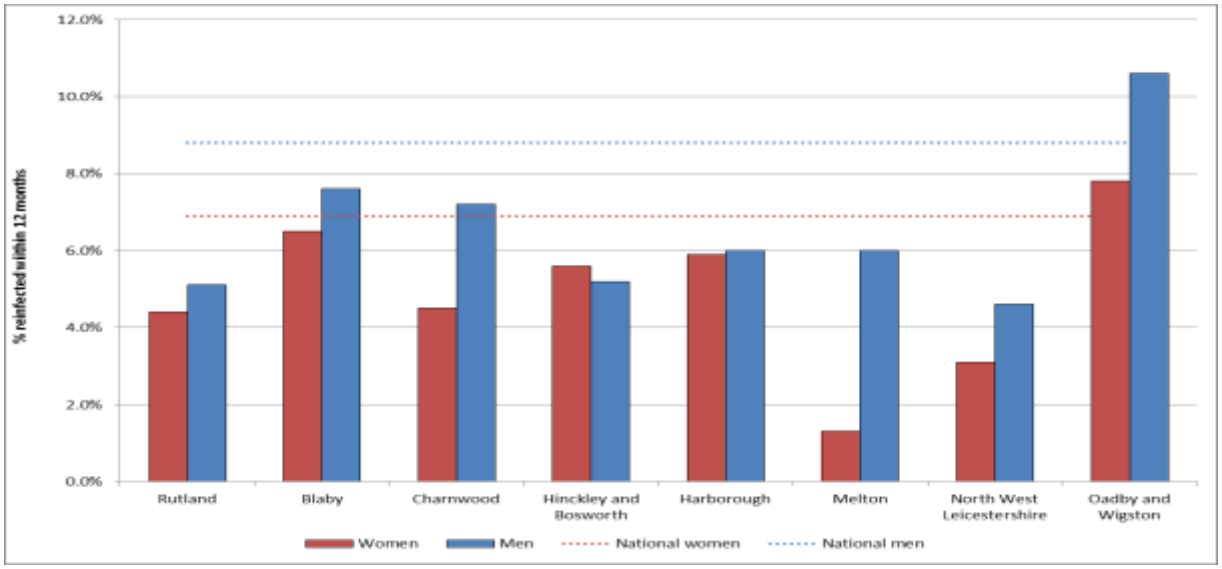


*Any increase in genital herpes diagnoses may be due to increased use of highly sensitive Nucleic Acid Amplification Tests (NAATs)

5.2 Reinfection of STIs

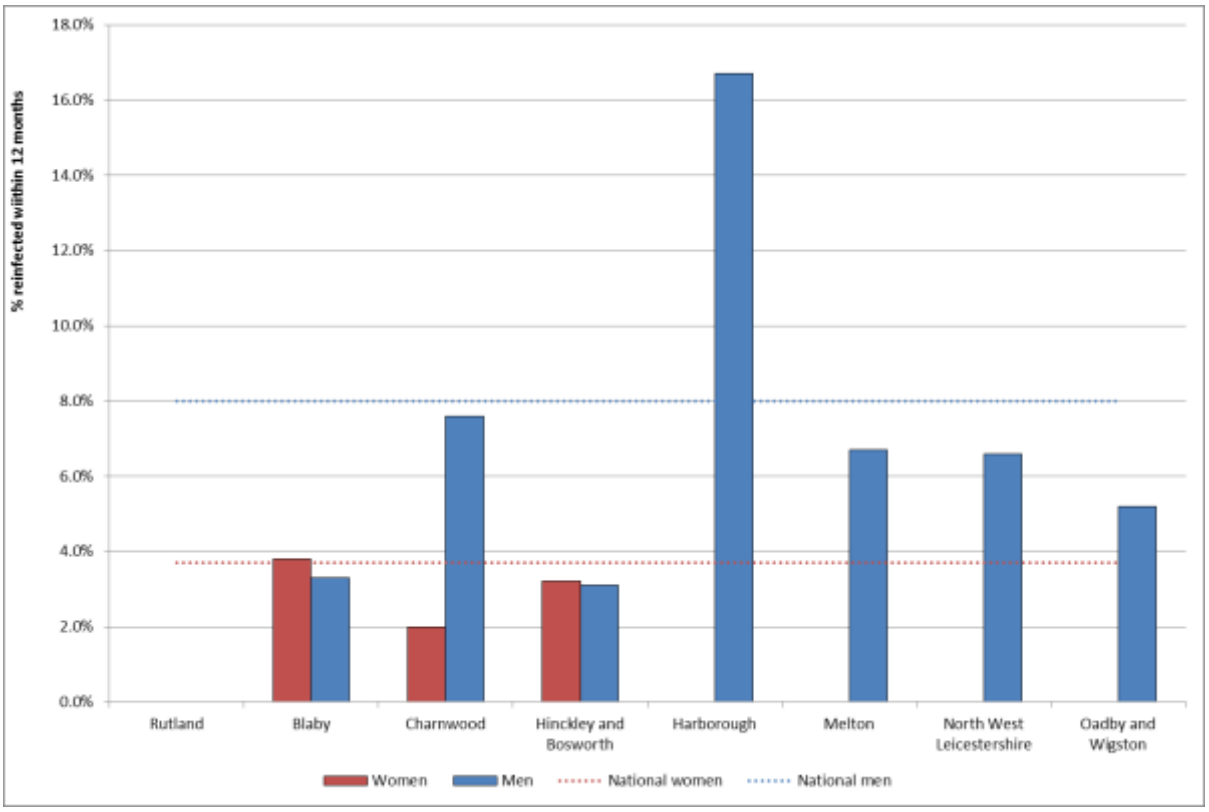
Reinfection with an STI is a marker of persistent risky behaviour. Nationally, during the five year period from 2009 to 2013, an estimated 6.9% of women and 8.8% of men presenting with a new STI at a GUM clinic became reinfected with a new STI within twelve months. Throughout Leicestershire, Oadby and Wigston had the highest percentage of both sexes who became reinfected, with an estimated 7.8% of women and 10.6% of men presenting with a new STI at a GUM clinic reinfected with a new STI within twelve months. North West Leicestershire had the lowest percentage of men becoming reinfected (4.6%) and Melton the lowest percentage of women (1.3%).[58]

Figure 16: Percentage of individuals reinfected with a new STI within twelve months (at a GUM clinic)[58]



Furthermore, nationally, an estimated 3.7% of women and 8.0% of men diagnosed with gonorrhoea at a GUM clinic between 2009 and 2013 became reinfected with gonorrhoea within twelve months. Figure 17 highlights in Leicestershire, men were more likely to become reinfected with gonorrhoea. Harborough had the highest percentage of reinfection with an estimated 16.7% of men becoming reinfected with gonorrhoea within twelve months, this is twice as high as the national average.[58]

Figure 17: Percentage of individuals reinfected with gonorrhoea within twelve months (at a GUM clinic)[58]



5.3 STI Prevention Groups

Nationally, young people aged 15-24 years, MSM and black Caribbean ethnic groups have been shown to have higher rates of new STIs.

5.3.1 Men who have sex with men (MSM)

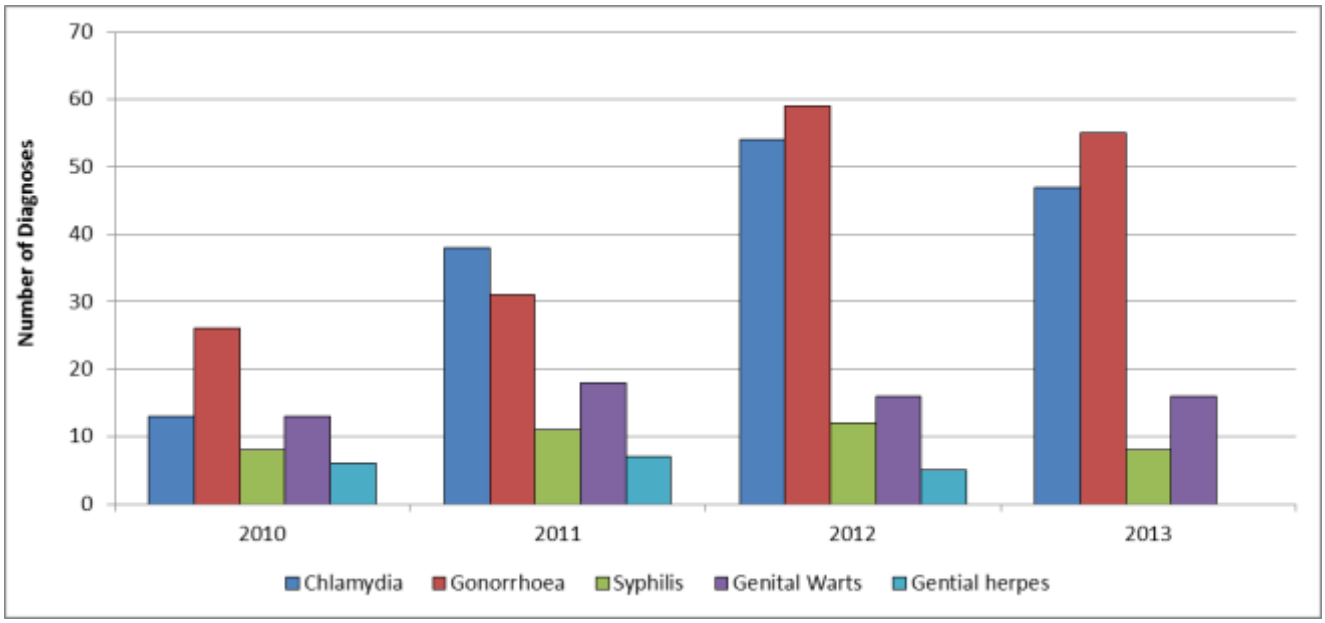
In 2013, for cases in men where sexual orientation was known, 10.9% (n=180) of new STIs in Leicestershire and 7.6% (n=8) in Rutland were among MSM. The number and proportion of new STIs among MSM has increased from 2010, where MSM accounts for 8.6% (n=108) and 5.5% (n=6) of the diagnoses in Leicestershire and Rutland. Please note that the numbers for MSM presented in this report include homosexual and bisexual men.[58]

Figure 18 examines the differences in STI diagnoses by sexual orientation in males. The figure highlights, throughout Leicestershire and Rutland, the most prevalent STIs among MSM were gonorrhoea and chlamydia whereas in heterosexual men, chlamydia and genital

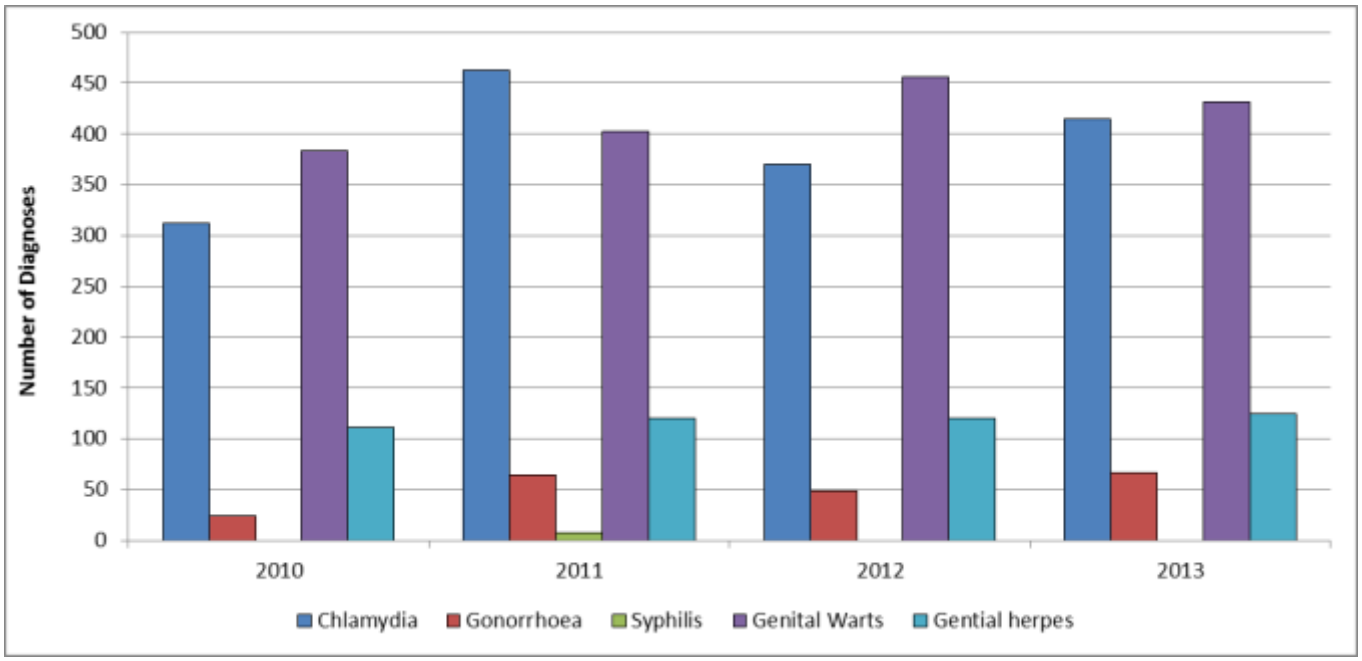
warts were the most dominant. The figure also shows in Leicestershire and Rutland, Syphilis is more prevalent in MSM compared to heterosexual men.

Figure 18: Number of new STIs, chlamydia, gonorrhoea, syphilis, genital warts and genital herpes in MSM and in Heterosexual men in Leicestershire and Rutland combined (GUM diagnoses only): 2010-2013[58]

MSM



Heterosexual men



5.3.2 Ethnic group and county of birth

The proportion of new STIs diagnosed in GUM clinics by ethnic group is shown in Table 1. The table reveals that the majority of STIs are diagnosed from white individuals; this is representative of the Leicestershire and Rutland population. The Black ethnic group is overrepresented in STI diagnoses as in Leicestershire this ethnic group make up 0.6% of the

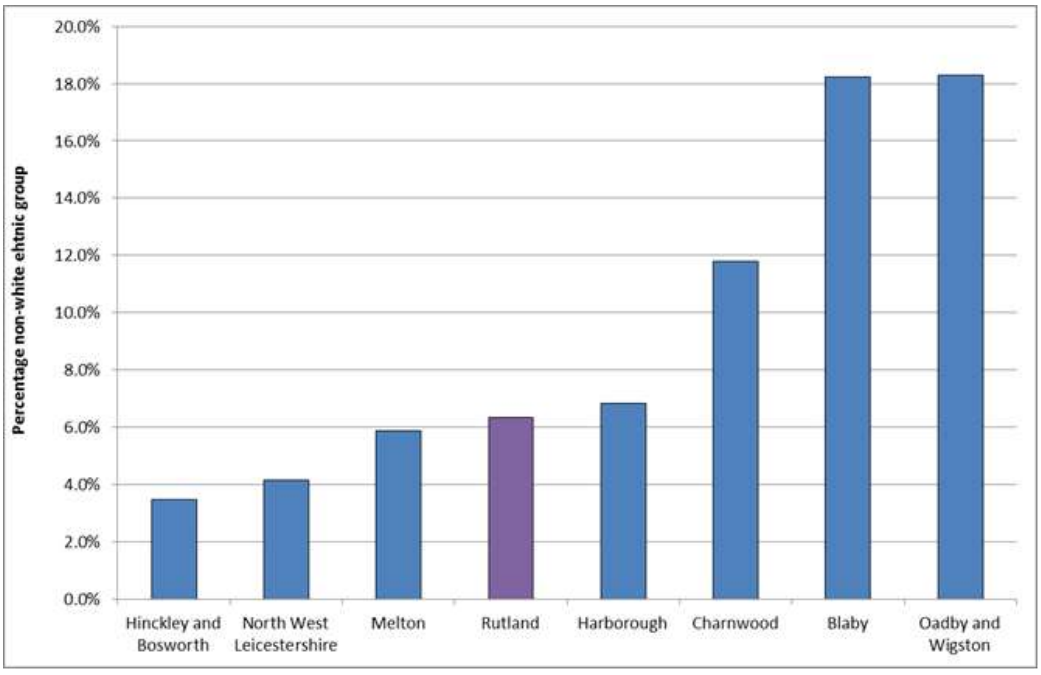
population but represents 2.0% of all diagnoses. In contrast, the Asian ethnic group is underrepresented in STI diagnoses. In Leicestershire this ethnic group make up 6% of the population but only represent 3.1% of all diagnoses, this could potentially highlight a population that is not actively being screened for STIs. Figure 19 reveals the highest percentage of non-white ethnic groups diagnoses were in Oadby and Wigston, Blaby and Charnwood, this is in accordance with those districts with the highest ethnics mix in the county.[58]

Table 1: Number and proportion of new STIs by ethnic group in Leicestershire and Rutland (GUM diagnoses only): 2013[58]

Ethnic group	Number	%
White	2,733	90.0%
Asian	95	3.1%
Mixed	64	2.1%
Not specified	63	2.1%
Black	61	2.0%
Other	22	0.7%

Excludes chlamydia diagnoses made outside GUM

Figure 19: Percentage of new STIs diagnosed in non-white ethnic group in Leicestershire and Rutland (GUM diagnoses only): 2013[58]



5.4 Chlamydia Screening Programme

Since chlamydia is most often asymptomatic, a high diagnosis rate reflects success at identifying infections that, if left untreated, may lead to serious reproductive health consequences. Chlamydia can cause a number of complications, including: pelvic inflammatory disease (PID), ectopic pregnancy and infertility in women; epididymitis (swelling of one of the tubes in the testicles) in men and conjunctivitis and pneumonia in

babies born to mothers with chlamydia. These complications result in costs to the healthcare system and reduced quality of life among those affected.[59]

Public Health England recommends that local areas achieve a detection rate of at least 2,300 per 100,000 resident 15-24 year olds, a level which is expected to produce a decrease in chlamydia prevalence. Such a level can only be achieved through the ongoing commissioning of high-volume, good quality screening services across primary care and sexual health services.

The National Chlamydia Screening Programme (NCSP) aims to diagnose and treat chlamydia in the 15-24 age group, to achieve this PHE recommendation. There is evidence to suggest that the screening programme also provides opportunity to deliver safer sex messages to young adults with higher risk of poor sexual health and to normalise testing for STIs. The NCSP relates to opportunistic screening for 15-24 year olds. The NCSP collates information of screening from several sources:

- Testing as part of a wider sexual health service offer (SHS)
- Testing in other healthcare settings as part of a clinical service
- Opportunistic screening from various community settings including outreach[60]

Figure 20 examines the significance levels in the proportion of the population aged 15-24 years screened for chlamydia and the chlamydia detection rate (rate of positive diagnoses per 100,000 15-24 year population) in the same age bracket throughout the country. In Leicestershire, 22.1% of 15-24 year olds were screened for chlamydia in 2014, a significantly worse percentage than the national average of 23.9%. The chlamydia diagnosis rate for 15-24 year olds in Leicestershire was 1,616 per 100,000 population, significantly lower than the national average of 1,978 per 100,000 population.[57] In this year, the percentage positivity (the percentage of screens undertaken that resulted in a positive diagnosis) in Leicestershire was 7.3%, lower than the national percentage of 8.3%.[27] Rutland performs significantly worse than the national average for the percentage of young adults screened for chlamydia (18.9%) and also significantly lower for the rate of chlamydia diagnoses in the county (1,390 per 100,000 population). The positivity percentage in Rutland was 7.8%, lower than the national average.[57]

5.4.1 Chlamydia Screening Programme by Age and Gender

The percentage of the population screened for chlamydia varies by age and gender. Figure 21 shows that both nationally and locally, females have a higher percentage of the population screened and across genders, those aged 20-24 have a higher percentage of the population screened than those aged 15-19 years. In Leicestershire, males aged 15-19 years have a significantly higher percentage of the population tested compared to the national average. The older age bands in males and both age bands in females have significantly lower percentage of the population tested. Rutland has a significantly higher percentage of males aged 20-24 years tested for chlamydia, whereas the younger age band in both genders in significantly worse than the national average.

The percentage positivity also shows variability across age and genders. Nationally, males aged 20-24 years have the highest percentage of tests with a positive result, followed by

females aged 15-19 years. This pattern is also reflected in Leicestershire. Throughout Leicestershire county, males aged 15-19 and females aged 15-19 and 20-24 years have a significantly lower percentage positivity to the national average. Males aged 20-24 years have a similar positivity percentage to England. In Rutland due to the small numbers involved, all age bands throughout both genders have a positivity percentage similar to national.

Figure **22** and Figure 23 show the difference in chlamydia detection rates for males and females. Both nationally and locally, the chlamydia detection rates are higher in females than males. The latest data shows in Leicestershire, the detection rate for females is 2,071 per 100,000 females aged 15-24 whereas the rate for males is 1,204 per 100,000 males aged 15-24. In Rutland, the distinction is even more marked. The rate for males is 888 per 100,000 males aged 15-24 whereas the female rate is 2,054 per 100,000 females aged 15-24.

In 2012 several significant changes were made in the way chlamydia data was reported. The main change was the introduction of the chlamydia testing activity dataset (CTAD) to collect community (non-GUM service) data. These changes mean that data for 2012 onwards are not directly comparable with the data reported in earlier years and so only three years' worth of data is presented. From 2012, the chlamydia detection rate for males in Leicestershire has remained significantly worse than the national average. In Rutland, in 2012, the rate for males was similar to the national average, but from 2013, the rate has dropped to be significantly worse than the national average. The detection rate for chlamydia for females in Leicestershire between 2012 and 2014 is significantly lower than national average. In Rutland, the rate has improved from being significantly lower than the national average in 2012, to being similar to the national average in 2013 and 2014.[22] Diagnosis rate in local authority areas of similar geography and demographics (statistical neighbours) are also typically significantly worse than the England average suggesting that these populations may have lower prevalence than the England average.

Figure 20: Chlamydia i) proportion screened and ii) chlamydia detection rate per young adults aged 15-24, 2014[57]

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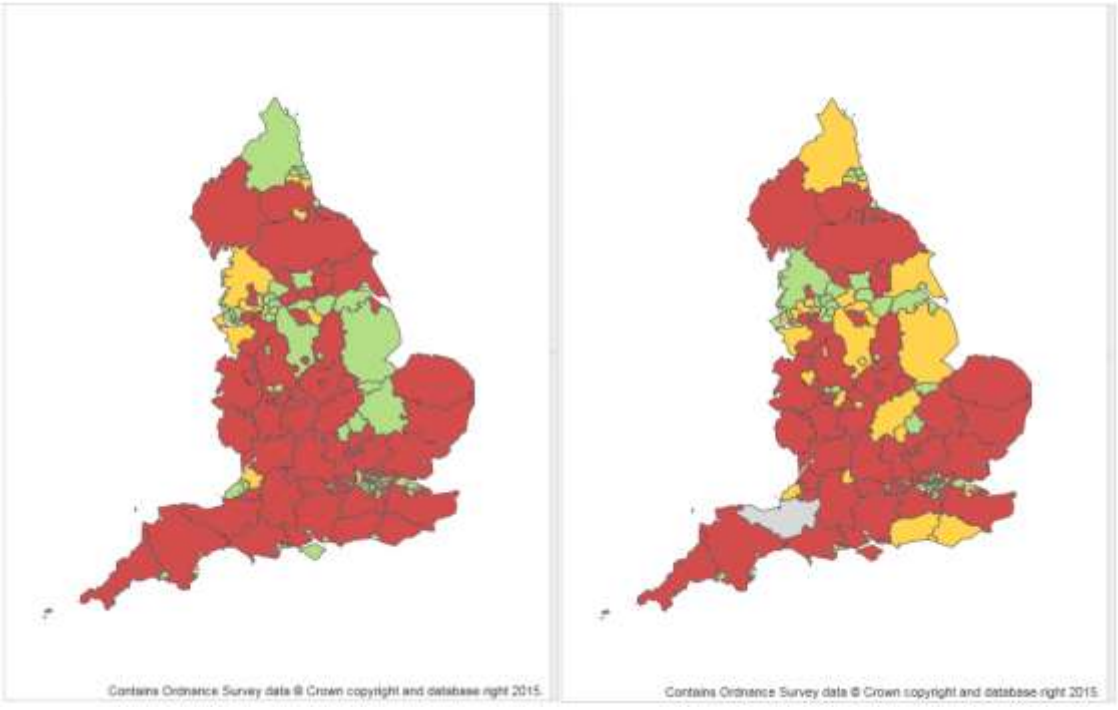


Figure 21: Percentage of Population Screened for Chlamydia by Age and Sex, 2014

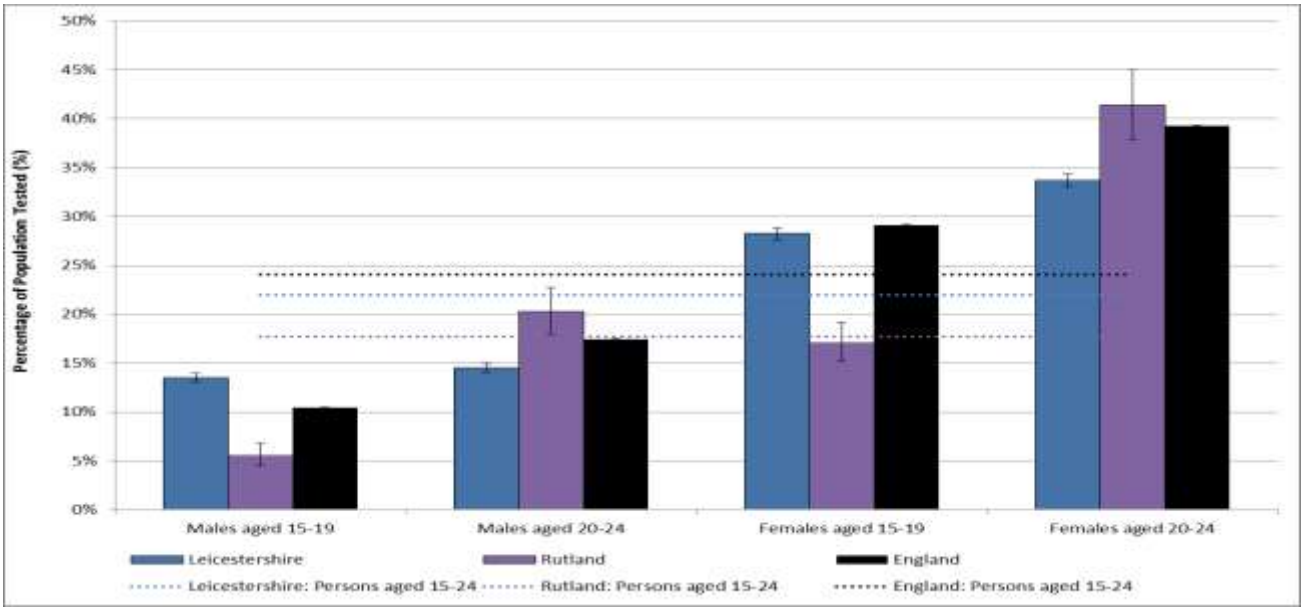


Figure 22: Crude rate of chlamydia detection per 100,000 young adults aged 15-24 using CTAD data, Males, 2012-2014[22]

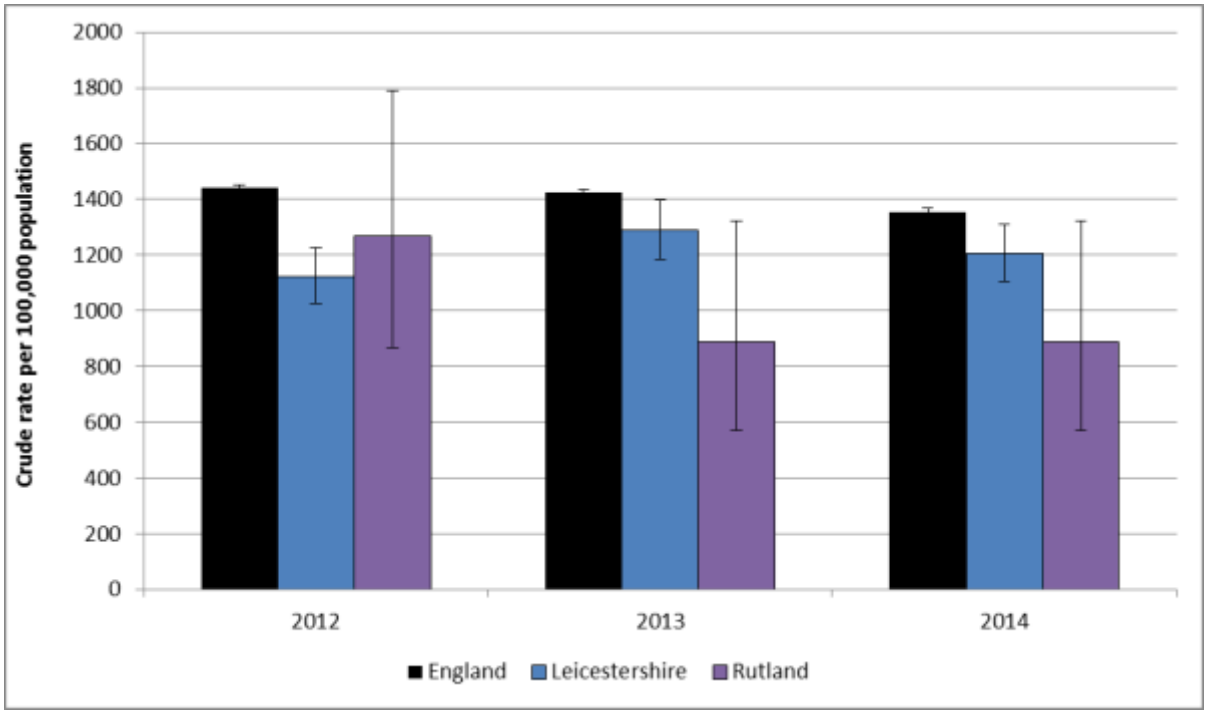
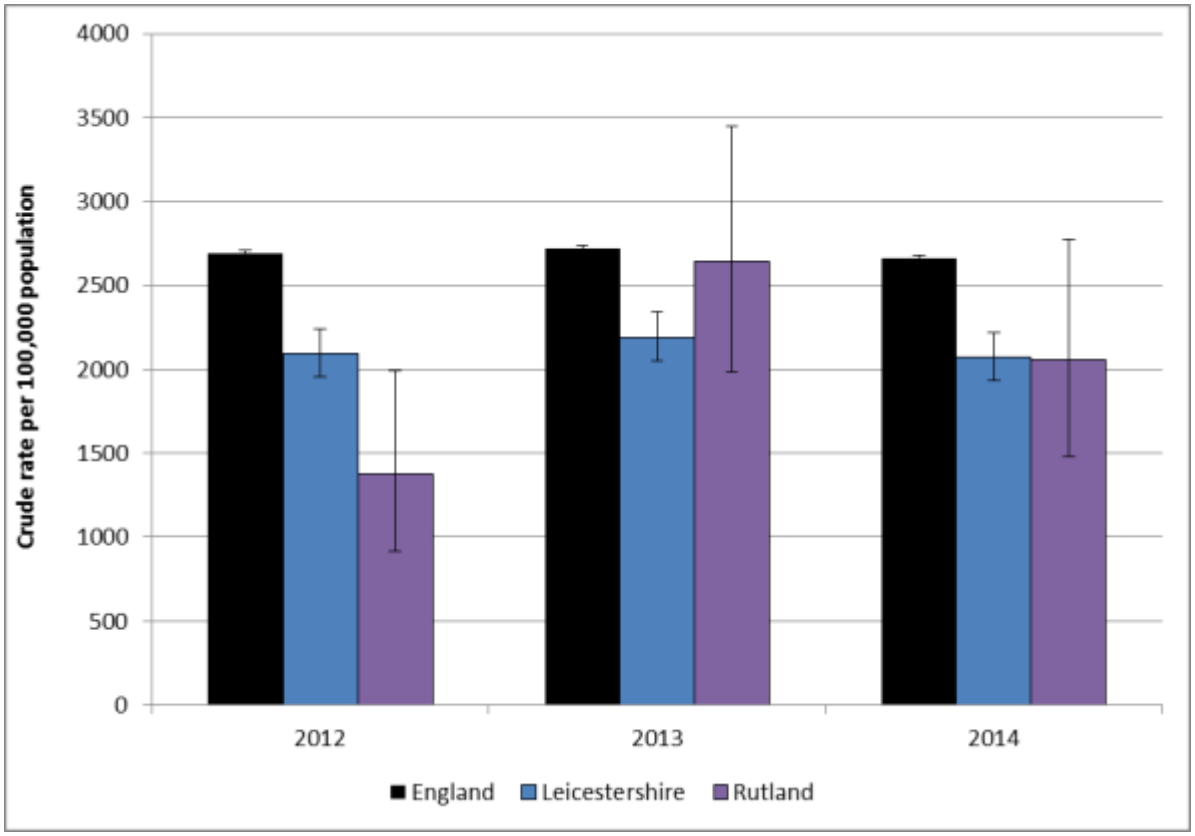


Figure 23: Crude rate of chlamydia detection per 100,000 young adults aged 15-24 using CTAD data, Females, 2012-2014[22]



5.4.2 Chlamydia Screening Programme by Location of Tests

Table **2** highlights the majority of chlamydia tests in Leicestershire, Leicester and Rutland occurred in non-GUM locations and

Table **3** specifies the locations of these tests. In Leicestershire, the highest percentage of 15-24 year olds were tested for chlamydia in GPs, followed by GUM clinics and then other locations. In Rutland, the pattern differs slightly. The highest percentage of tests occurred in other locations, GPs and GUM. Nationally, a higher percentage of tests occur in GUM clinics, Community Sexual Health Services (CSHS) and Pharmacies compared with local activity.

Between 2013 and 2014, the numbers of chlamydia tests performed have decreased in both Leicestershire and Rutland.

Figure **24** shows the majority of the decrease in tests in Leicestershire was from 'Other' testing locations. Tests from GUM have remained fairly stable and tests in GPs and via the Internet have seen an increase.Table **4** shows the percentage positivity varies by testing service type. In Leicestershire in 2014, the highest percentage positivity was found in GUM clinics (9.6%) followed CSHS (9.4%). This pattern is reflected nationally. In Rutland however, CSHS has the highest percentage positivity (17.0%) followed by GUM clinics

(11.3%). It must be noted that these high positivity percentages are likely to fluctuate due to smaller numbers involved.

Table 2: Chlamydia testing data for 15-24 year olds in Leicestershire and Rutland: 2014[27]

	Non-GUM Tests	Gum Tests	Total Tests	Number of positives (all settings)	Percentage of population tested (all settings)	Rate of diagnoses	Rate in England
Leicester	8,222 (71%)	3,423 (29%)	11,645	1,048	19.5%	1,757	2,012
Leicestershire	13,364 (76%)	5,400 (24%)	18,764	1,373	22.1%	1,616	
Rutland	643 (71%)	203 (29%)	846	66	17.8%	1,390	

Table 3: Chlamydia testing data for testing service type for 15-24 year olds in Leicestershire and Rutland: 2014[2758]

	GUM	CSHS	GP	Pharmacy	TOP	Internet	Not Known	Other
Leicester	29.4%	2.8%	36.5%	0.5%	1.0%	7.6%	0.0%	22.1%
Leicestershire	28.8%	2.2%	33.9%	0.4%	0.9%	7.5%	0.0%	26.3%
Rutland	24.0%	5.6%	27.0%	0.1%	0.1%	7.7%	0.1%	35.5%
England	34.6%	19.3%	17.8%	1.0%	1.3%	4.0%	1.7%	20.3%

Figure 24: Chlamydia testing data for testing service type for 15-24 year olds in Leicestershire, 2012-14

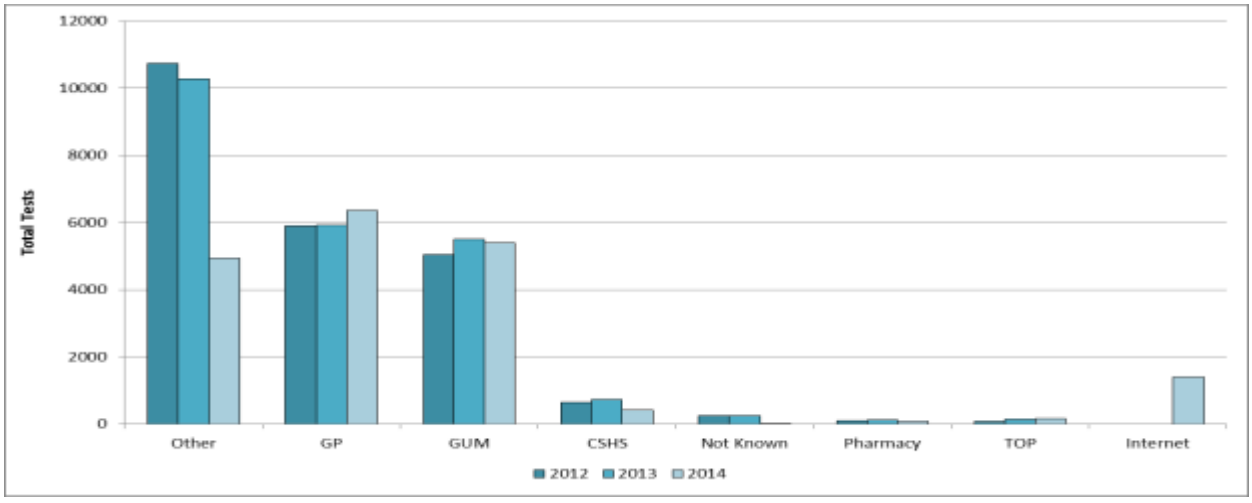


Figure 25: Chlamydia testing data for testing service type for 15-24 year olds in Rutland, 2012-14

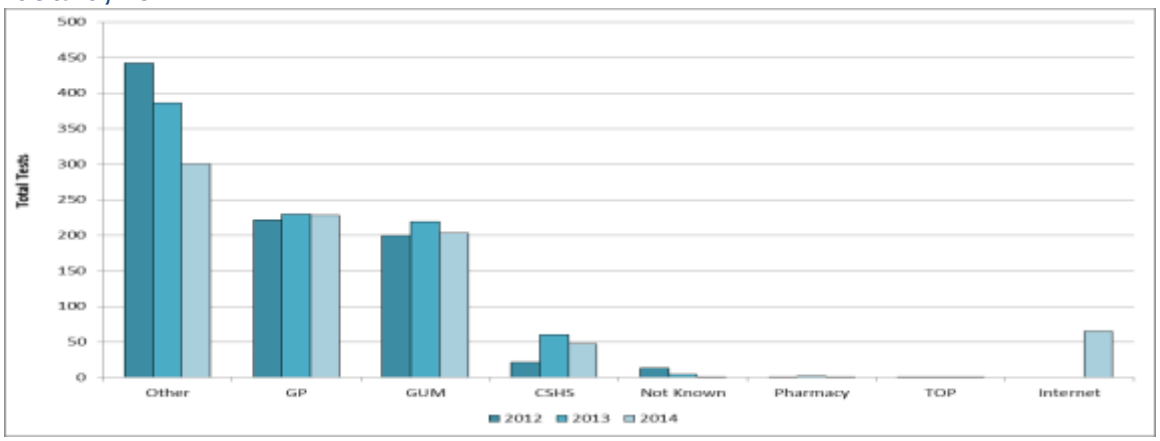


Table 4: Percentage positivity of chlamydia testing data for testing service type for 15-24 year olds in Leicestershire and Rutland: 2014[2758]

	GUM	CSHS	GP	Pharmacy	TOP	Internet	Not Known	Other
Leicester	13.5%	11.1%	7.4%	6.5%	12.2%	7.9%	0.0%	5.6%
Leicestershire	9.6%	9.4%	7.3%	7.2%	5.6%	6.6%	0.0%	4.9%
Rutland	11.3%	17.0%	5.3%	0.0%	0.0%	3.1%	0.1%	7.0%
England	10.7%	8.8%	5.8%	8.3%	6.5%	7.8%	6.7%	6.2%

Figure 26 and Figure 27**Error! Reference source not found.** examines the percentage positivity in chlamydia testing data throughout different service types varies over time. In Leicestershire, the percentage positivity in GUM and TOP clinics have declined year on year between 2012 and 2014 whereas Other locations have increased their percentage positivity year on year within the same period. In 2014, both GPs and the CSHS have seen increases in the positivity percentage.

In Rutland due to the small numbers involved, the percentage positivity varies considerably highlighted by the large confidence intervals. The percentage positivity in GP clinics have declined year on year between 2012 and 2014 whereas other locations have increased their percentage positivity year on year within the same period. The latest positivity percentage in CSHS has increased substantially compared to the previous year.

In both counties, the chlamydia detection rate varies by testing service type. In Leicestershire, Figure 28 shows GUM clinics followed by GP and Other locations have the highest detection rate. In 2014, both GP and Internet have seen a rise compared to the previous year, whereas Other locations saw a significant decline. Like Leicestershire, the highest detection rates in Rutland were in GUM clinics, GPs and Other locations. From 2012 onwards, GPs in Rutland have witnessed a year on year decline in detections rate whereas CSHS detection rates have improved throughout this time.

Figure 26: Percentage positivity in chlamydia testing data by testing service type for 15-24 year olds in Leicestershire, 2012-14[27]

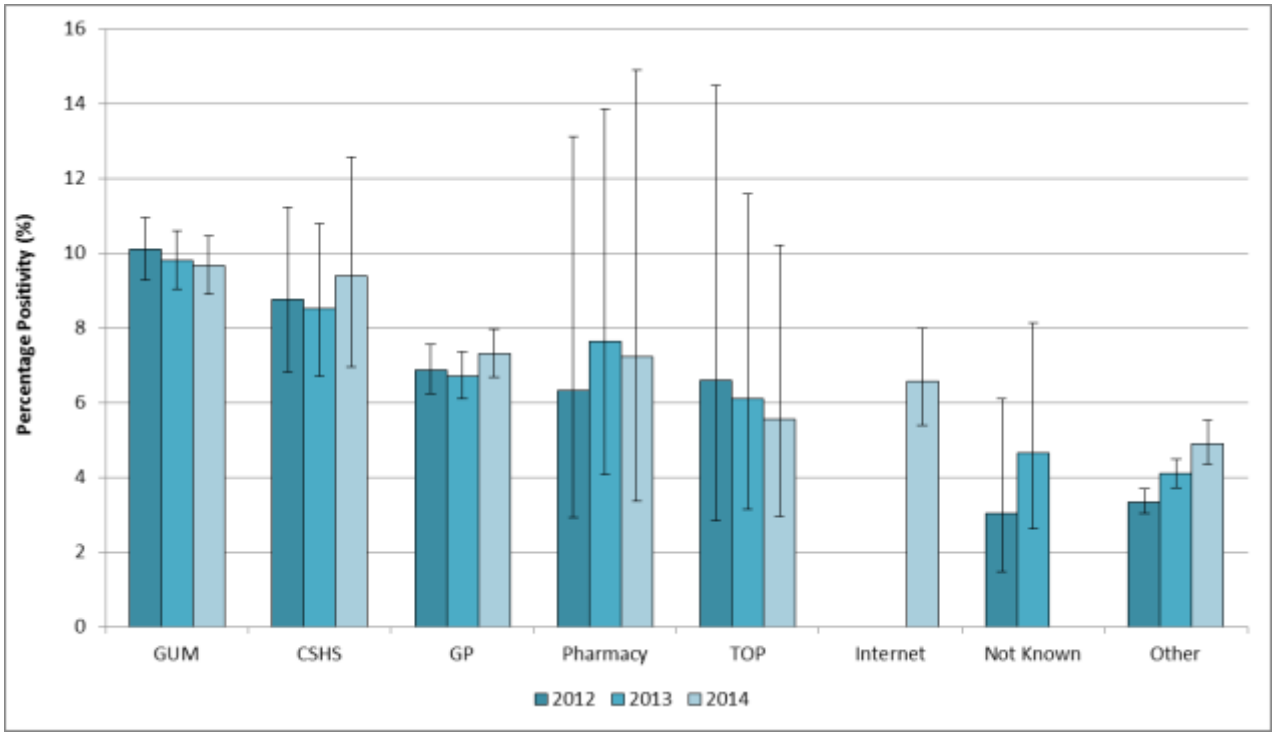


Figure 27: Percentage positivity in chlamydia testing data by testing service type for 15-24 year olds in Rutland, 2012-14[27]

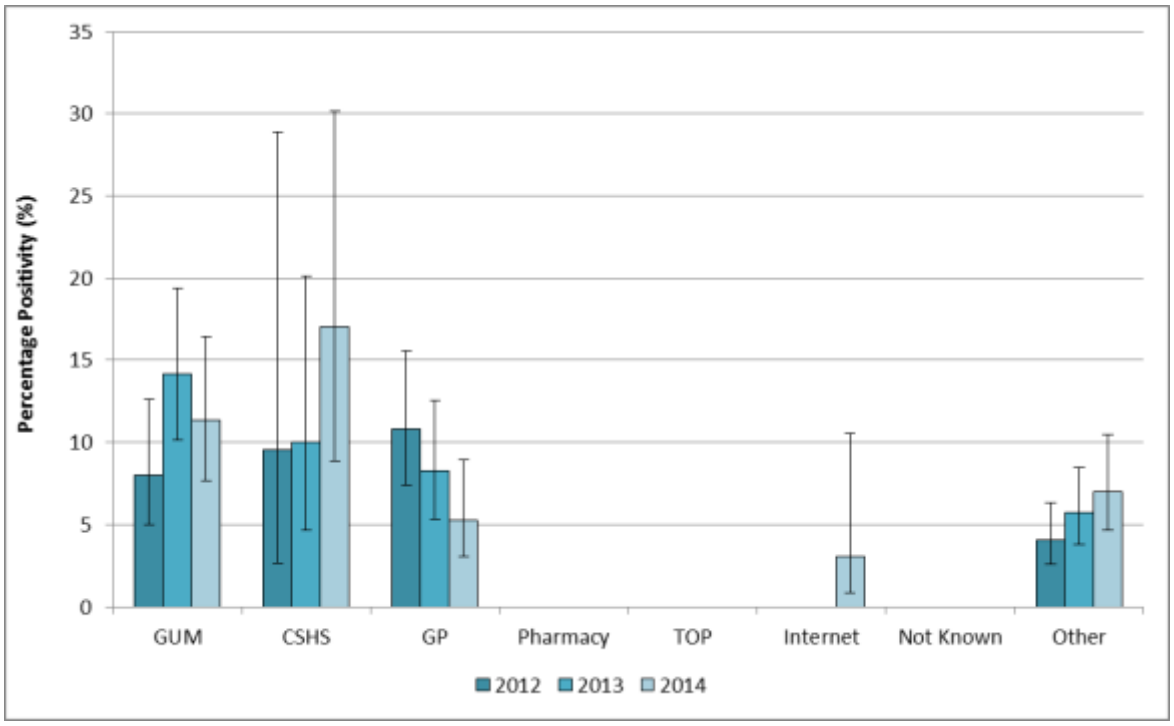


Figure 28: Chlamydia detection rate by testing service type for 15-24 year olds in Leicestershire, 2012-14[27]

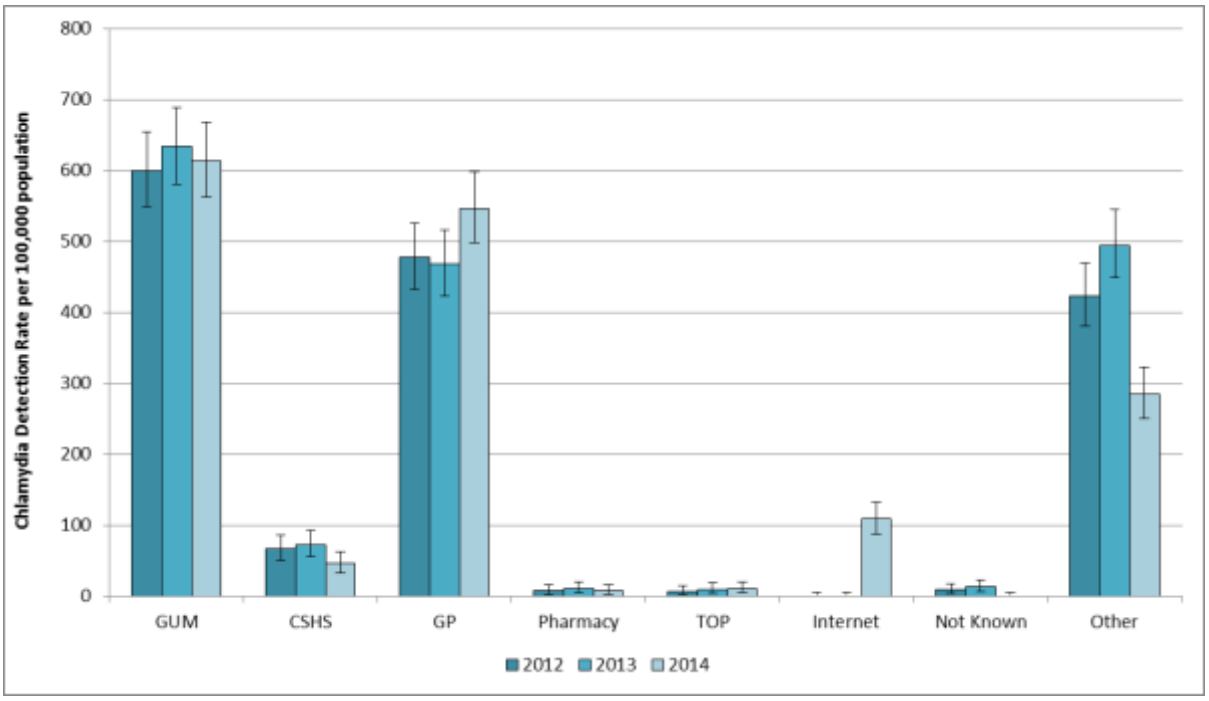
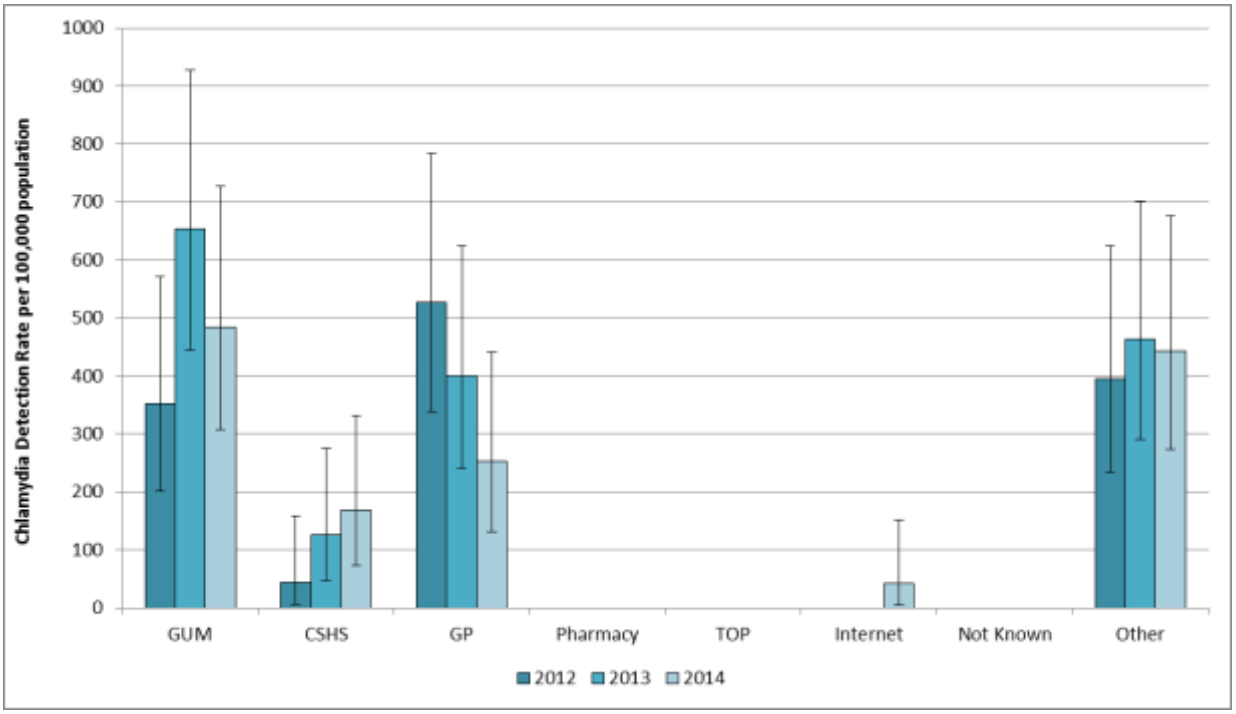


Figure 29: Chlamydia detection rate by testing service type for 15-24 year olds in Rutland, 2012-14[27]

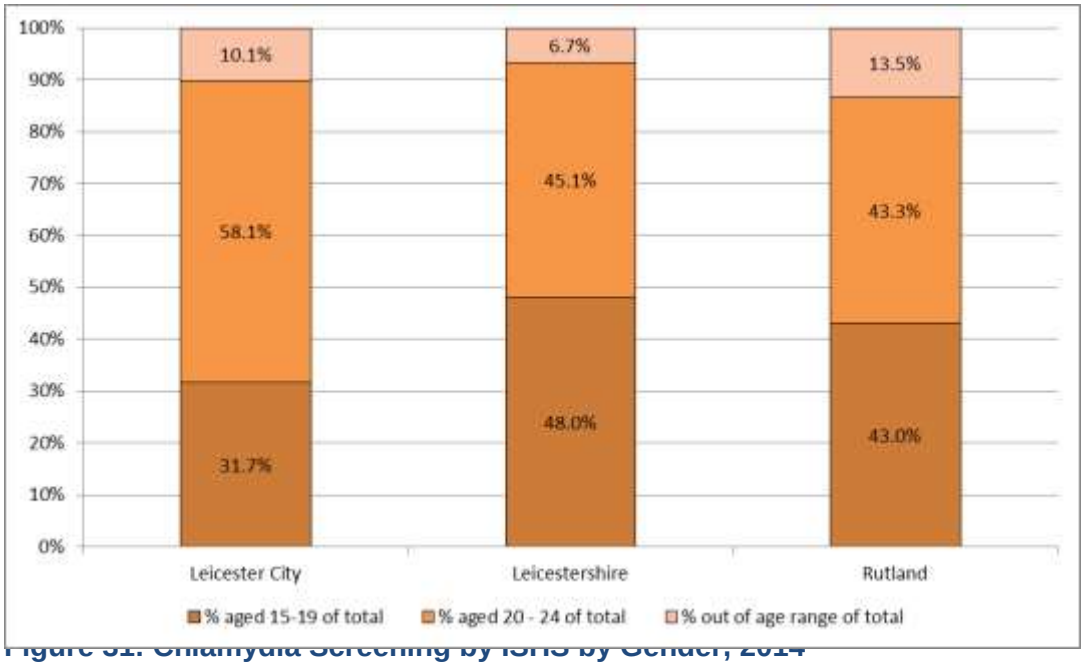


5.4.3 Opportunistic Chlamydia Screens in the Integrated Sexual Health Service (ISHS)

In Leicestershire and Rutland the Integrated Sexual Health Service (ISHS) undertakes chlamydia screening as part of the clinical service and is also commissioned to manage opportunistic screening from a range of sources. In 2014 the ISHS was commissioned to deliver a specific volume of screens and to achieve a specified number of positive diagnoses. For Leicestershire, this contributed 9439 screens of which there were 638 positive diagnoses. For Rutland there were 342 screens undertaken, of which there were 32 positive diagnoses.

Figure 30 shows in Leicestershire, almost half of all chlamydia screens undertaken as opportunistic screens via the ISHS prevention services were for individuals aged 15-19 years. In Leicestershire 45.1% of all individuals screened for chlamydia via ISHS prevention services were in the 20-24 age band, a higher percentage compared to Rutland (43.3%). The majority of these chlamydia screens by the ISHS were to females (both 61%)[61] for Leicestershire and Rutland.

Figure 30: Chlamydia Screening by ISHS by Age, 2014[61]



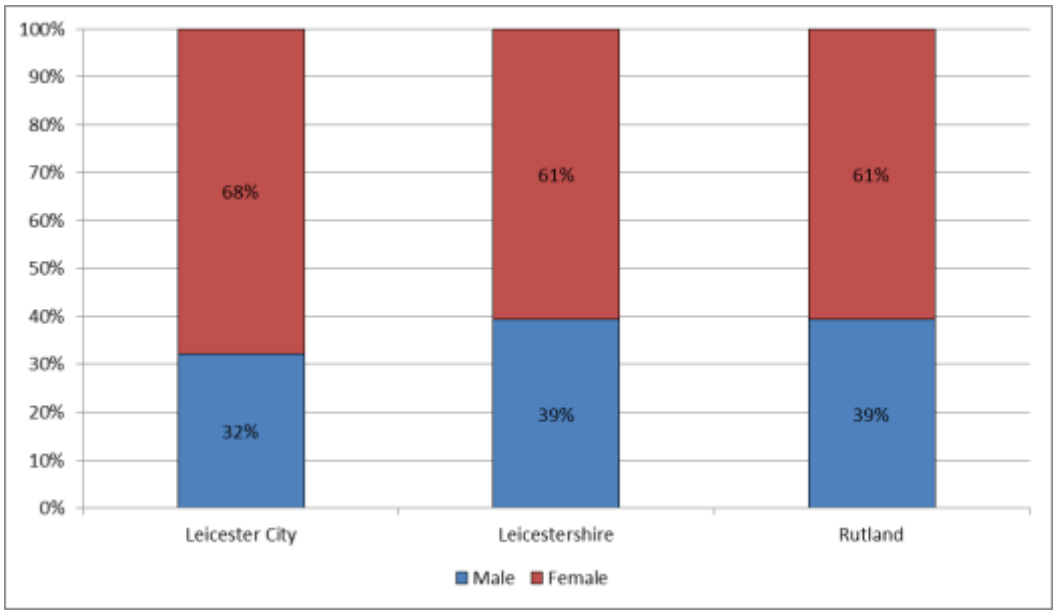


Figure 32: Chlamydia Screens by ISHS by Clinic Type, LLR, 2014[61]

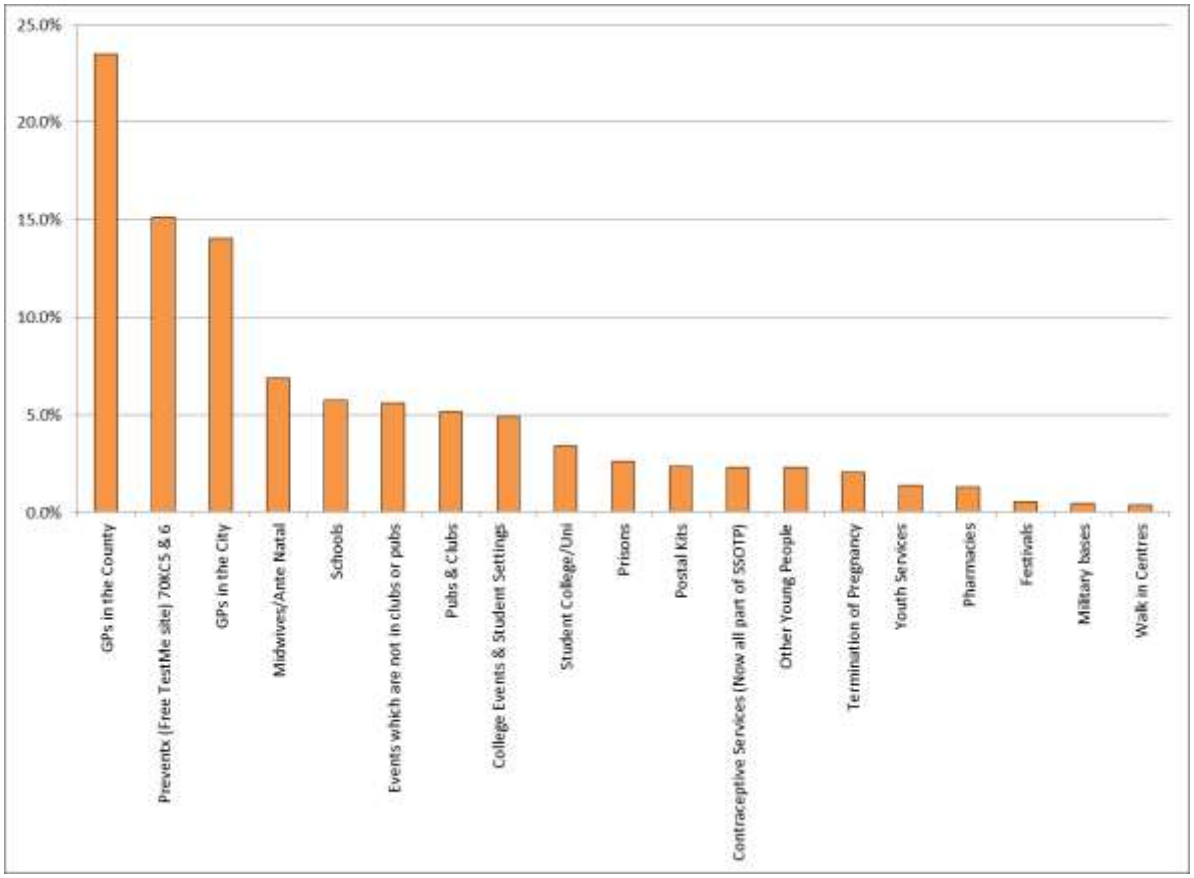


Figure 33 shows the highest percentage positivity was seen in Leicester City residents (7.3%) followed by Rutland and Leicestershire (both 6.8%), although all positivity percentages show no significant difference. In Leicester City, a higher percentage of positivity was seen in females, whereas in Leicestershire and Rutland, males had the higher positivity percentage. The difference in positivity percentages showed no significant differences across gender for each authority. The positivity percentage is examined by age in Figure 34. In Leicester City and Rutland, individuals aged 15-19 years had a higher positivity percentage compared to those age 20-24 years, although the difference is not significant. However, in Leicestershire, individuals aged 20-24 years have a significantly higher positivity percentage (7.8%) compared to individuals aged 15-19 years (5.9%).[61]

Figure 33: Percentage Positivity of Chlamydia Screening by Gender, 2014[61]

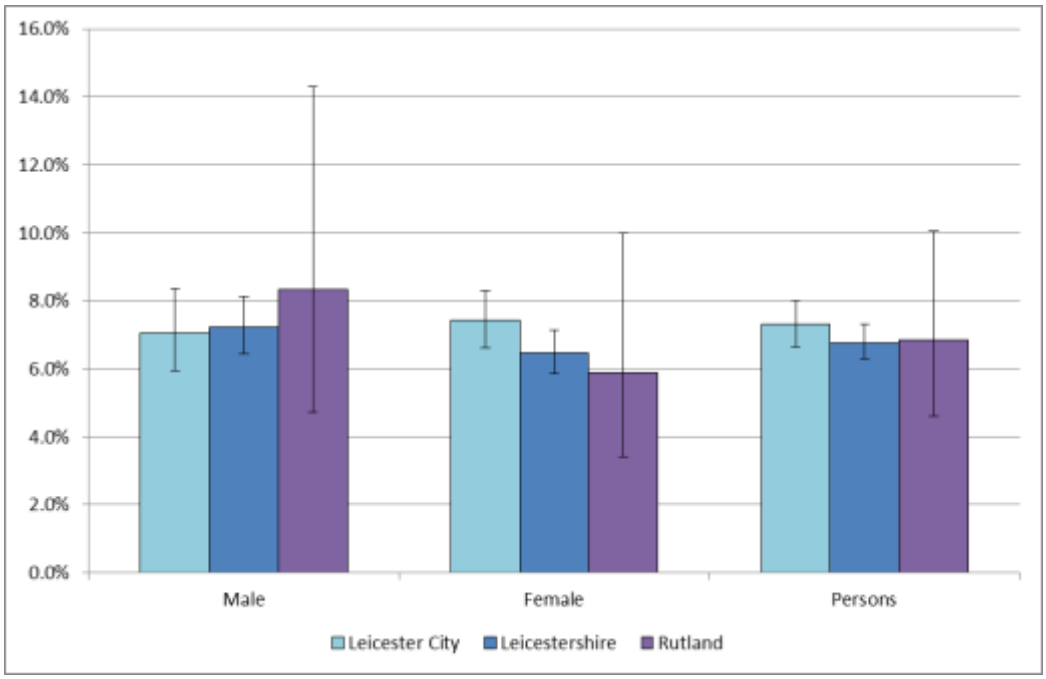
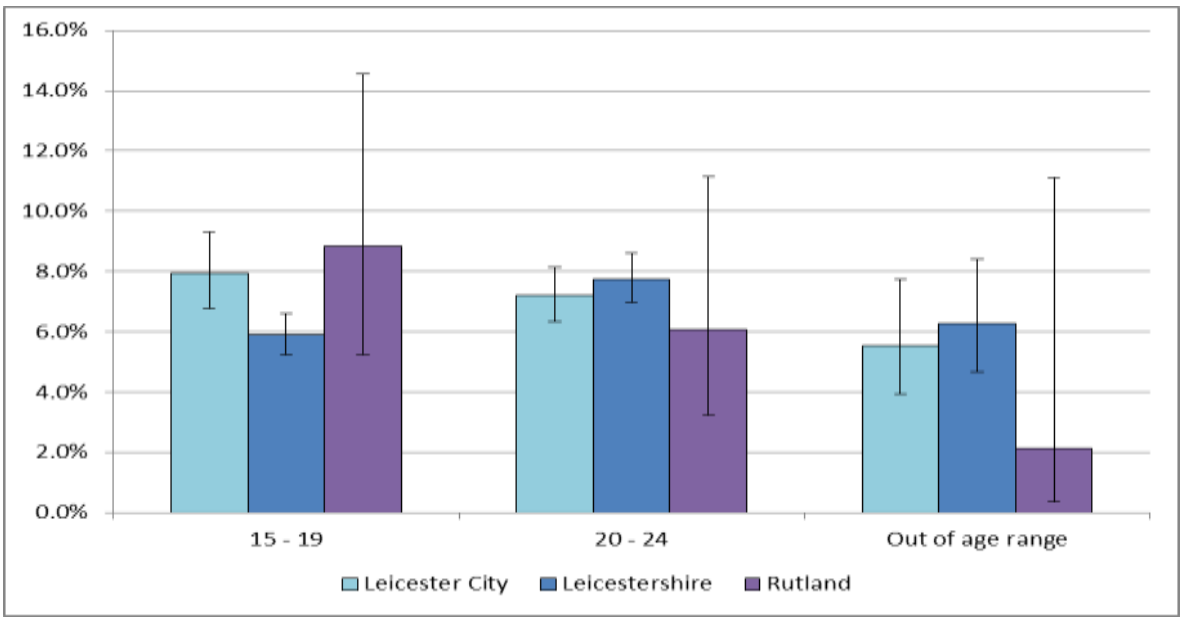


Figure 34: Percentage Positivity of Chlamydia Screening by Age, 2014[61]



The above data includes opportunistic Chlamydia screening by young people who access a screening kit from general practice. Practices are commissioned to offer this screening to their 15-24 year practice population.

Figure **35** details the counts of such screens across LCR. Three practices deliver volumes of more than 150 screens. The Loughborough University practice supports the highest volume. Figure 36 and Figure 37 show the chlamydia screening activity from general practice in Leicestershire increased in 2014/15 compared to 2013/14, although there was a decrease in Rutland practices. Screening from this source contributed approximately 40% of all of the positive diagnoses through the ISHS opportunistic screening route in 2014.

Figure 35: Counts of Chlamydia Screens by GP Practice, Leicestershire and Rutland, 2014/15

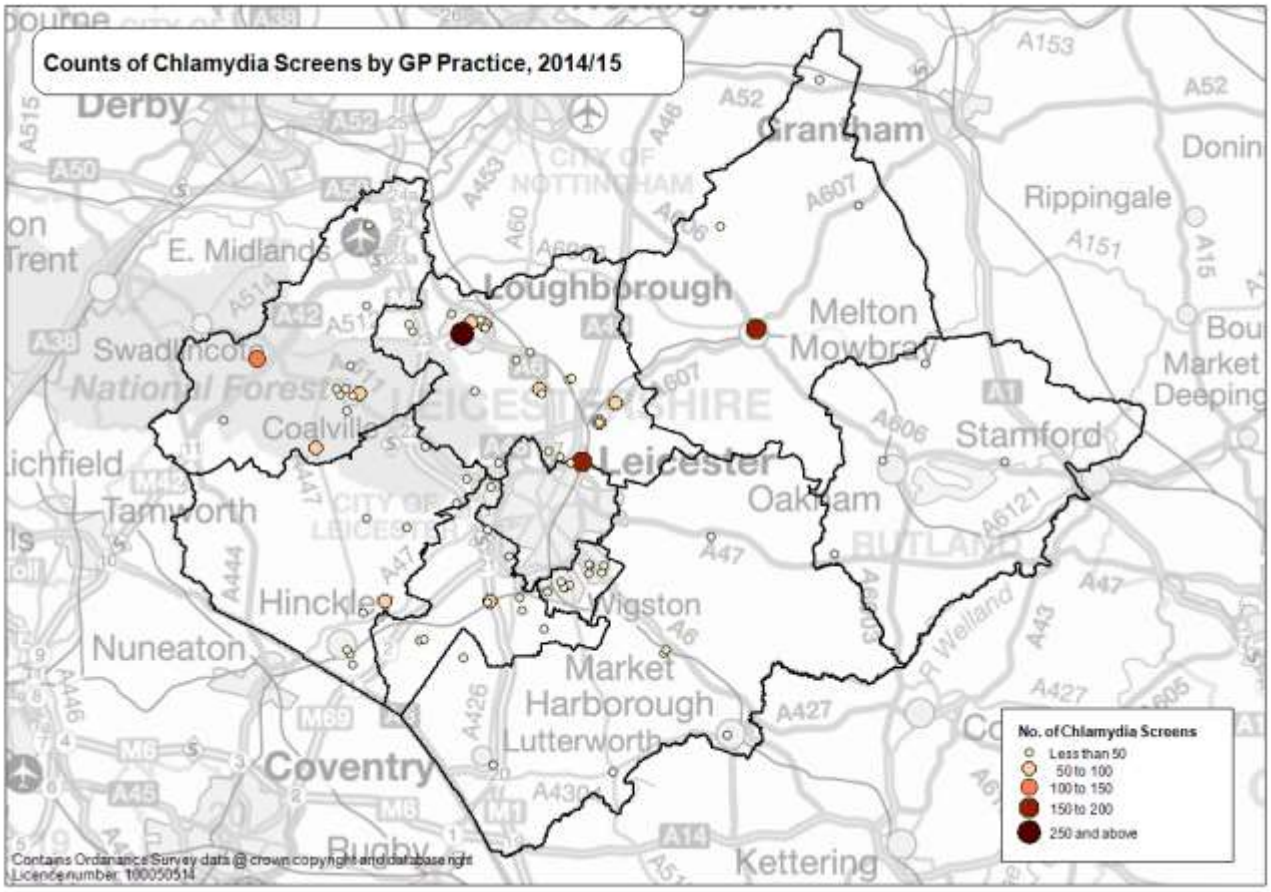


Figure 36: Counts of GP Local Enhanced Services for opportunistic chlamydia screening in Leicestershire, 2013/14-2014/15[62]

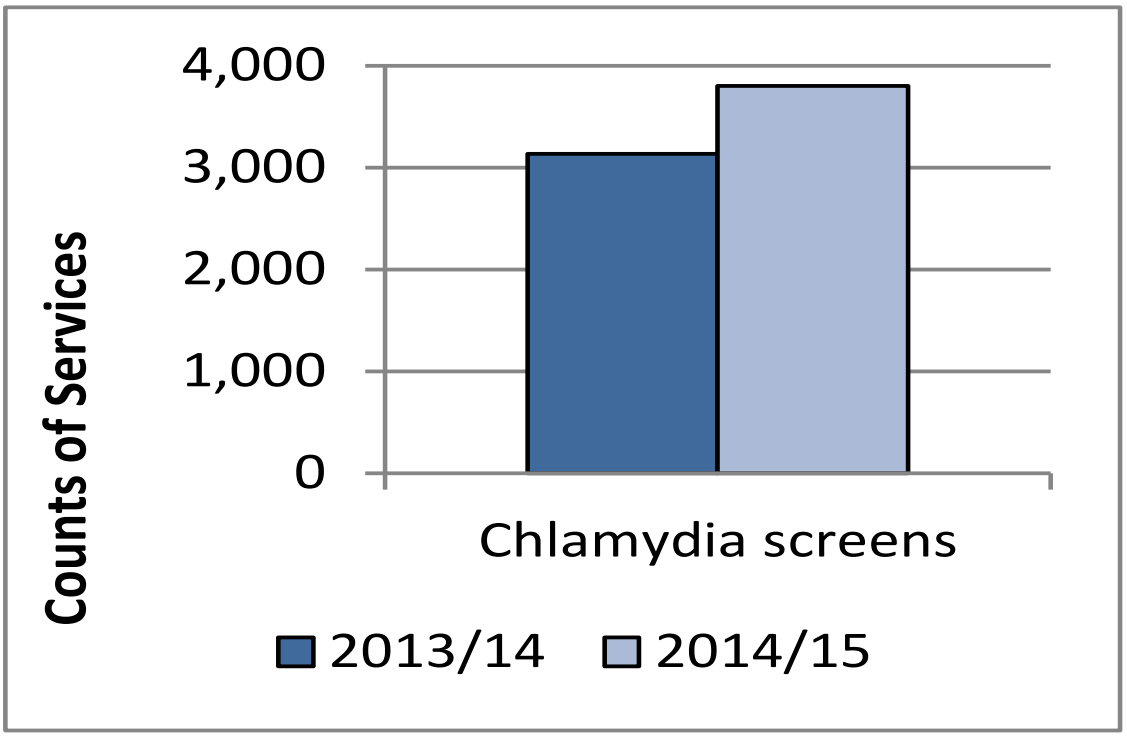
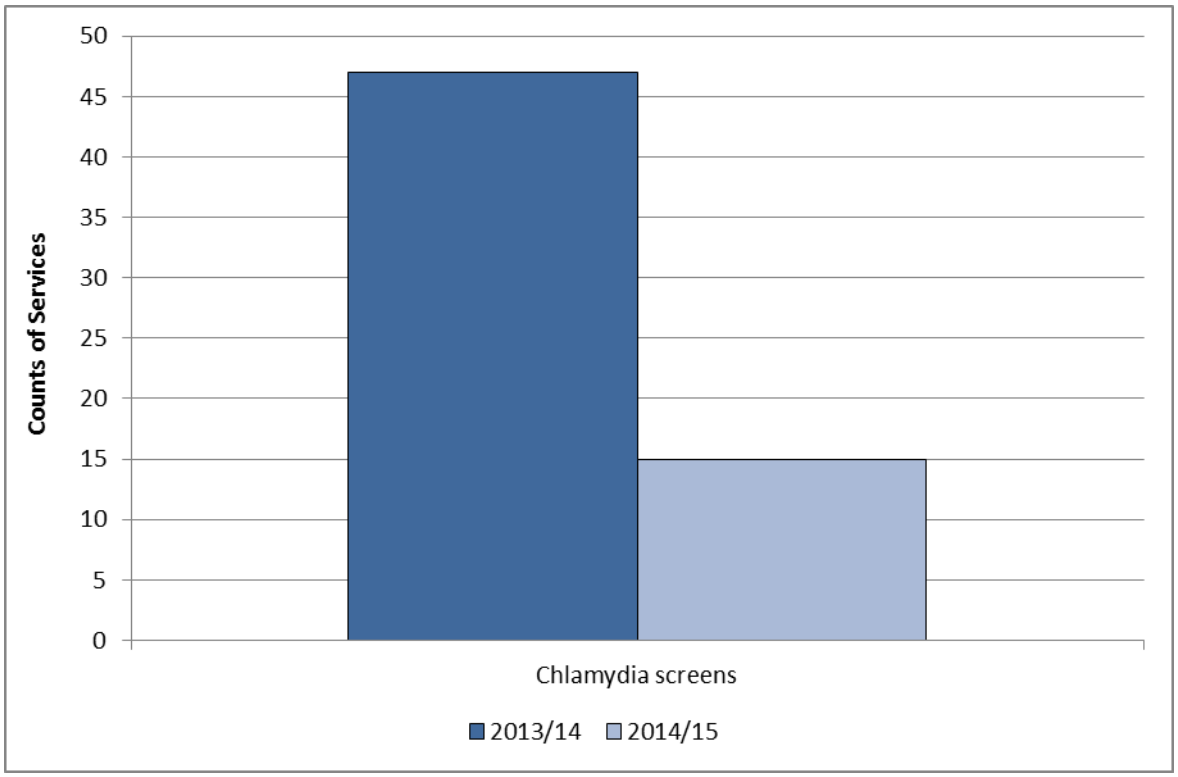


Figure 37: Counts of GP Local Enhanced Services for opportunistic chlamydia screening in Rutland, 2013/14-2014/15[62]



5.5 GUM clinic service use

5.5.1 Residents of Leicestershire and Rutland

Robust epidemiological information to inform local commissioning is reliant on good quality data from GUM clinics. Information on the clinics attended by residents of Leicestershire and Rutland are shown below. The counts of attendances and patients of the ten most popular GUM clinics for Leicestershire residents and the most popular GUM clinics for Rutland residents are shown below.

Of the total Leicestershire residents attending a GUM clinic in 2013, over half attended Leicester Royal Infirmary and just under a quarter attended Loughborough General Hospital. The remaining patients attended clinics outside of Leicestershire city and county. In Rutland, the most popular GUM clinic was Edith Cavell in Peterborough followed by Leicester Royal Infirmary in Leicester City.[27]

Table 5: Attendances by Leicestershire Residents at GUM clinics, 2013[27]

Clinic	Area of Clinic	Number of patients	% of total patients	New Attendances	Follow-up Attendances
Leicester Royal Infirmary	Leicester	6,383	56.5	8,037	1,371
Loughborough General Hospital	Leicestershire	2,625	23.2	3,196	846
George Eliot Hospital	Warwickshire	825	7.3	931	557
Delia Morris Centre	Staffordshire	305	2.7	419	204

Clinic	Area of Clinic	Number of patients	% of total patients	New Attendances	Follow-up Attendances
Ashwood Centre	Northamptonshire	203	1.8	221	106
William Donald Clinic	Derby	148	1.3	190	55
Hospital of St Cross	Warwickshire	131	1.2	167	118
Nottingham City Hospital (GUM)	Nottingham	110	1.0	118	39
Coventry & Warwickshire Hospital	Coventry	67	0.6	80	40
Grantham Sexual Health Clinic	Lincolnshire	61	0.5	80	59

Table 6: Attendances by Rutland Residents at GUM clinics, 2013[27]

Clinic	Area of Clinic	Number of patients	% of total patients	New Attendances	Follow-up Attendances
Edith Cavell	Peterborough	216	42.9	249	64
Leicester Royal Infirmary	Leicester	141	28.0	163	10
Grantham Sexual Health Clinic	Lincolnshire	65	12.9	27	120

In 2014, an integrated sexual health service began in Leicester, Leicestershire and Rutland which represents the change in locations delivering GUM clinic services. The new service model has increased access to GUM services by provision from a range of sessional spoke sites as well as two relocated main hubs. The data allocated to Loughborough Health Centre represents activity from the main Hub at Loughborough HC and 5 spoke locations (4 in Leicestershire and 1 in Rutland). The data allocated to St Peters Health Centre represents activity from the main hub and a range of spoke locations within Leicester City. The number of attendances by Leicestershire residents to the county sites has doubled from 2013 to 2014, whereas the attendances to the sites in Leicester City has declined. The change of clinic sites and establishment of the new service may have impacted on activity levels in 2014 as the new service established from new locations. However there was an overall increase in attendances for GUM purposes to LLR sexual health sites by 800 patients for Leicestershire and 44 for Rutland. In Rutland in 2014, Loughborough Health Centre (hub and spokes) had the highest counts of patients attending a GUM clinic. This is likely to reflect increased use of the Oakham spoke for STI testing and GUM services, previously being a contraceptive service only.

For Leicestershire residents in 2014, 22% of all GUM clinic attendances were outside LLR commissioned clinics. In the same year for Rutland residents, 67% of all GUM clinic attendances were outside LLR commissioned clinics. In 2013 for Leicestershire residents, 23% of all GUM clinic attendances were outside LRI and the Loughborough clinic. In the same year for Rutland residents, 77% of all GUM clinic attendances were outside LRI and Loughborough.

Table 7: Attendances by Leicestershire Residents at GUM clinics, 2014[27]

Clinic	Area of Clinic	Number of patients	% of total patients	New Attendances	Follow-up Attendances
Loughborough Health Centre	Leicestershire	5,361	43.3	6,410	1,723
St Peter's Health Centre	Leicester	4,447	35.9	5,163	1,111
George Eliot Hospital	Warwickshire	880	7.1	985	570
Delia Morris Centre	Staffordshire	321	2.6	427	161
Ashwood Centre	Northamptonshire	206	1.7	236	108
William Donald Clinic	Derby	150	1.2	172	54
Hospital of St Cross	Warwickshire	150	1.2	188	110
Choices Young people sexual health services	Leicester	127	1.0	129	61
Nottingham City Hospital (GUM)	Nottinghamshire	107	0.9	122	20
Grantham Sexual Health Clinic	Lincolnshire	59	0.5	69	33

Table 8: Attendances by Rutland Residents at GUM clinics, 2014[27]

Clinic	Area of Clinic	Number of patients	% of total patients	New Attendances	Follow-up Attendances
Loughborough Health Centre	Leicestershire	123	23.4	140	46
Edith Cavell Campus	Peterborough	110	20.9	118	32
Kings Cambers	Peterborough	101	19.2	115	21
St Peter's Health Centre	Leicester	62	11.8	68	1
Grantham Sexual Health Centre	Lincolnshire	40	7.6	26	62
Ashwood Centre	Northamptonshire	38	7.2	42	22

5.5.2 Clinics in Leicestershire, Leicester and Rutland

Figure 38 shows in 2014, 83% of the patients attending the Leicestershire clinics were residents of Leicestershire and 7% lived in Leicester City. Of all persons attending the Leicestershire clinic, 1.9% were residents in Rutland. Figure 39 examines the patient flow of those attending the GUM clinic in Leicester City. Almost two-thirds of all patients at St. Peter's were resident in the City and 31% were resident in the Leicestershire.

Figure 38: Percentage Attending a Leicestershire GUM Clinic by Area of Residence, 2014[27]

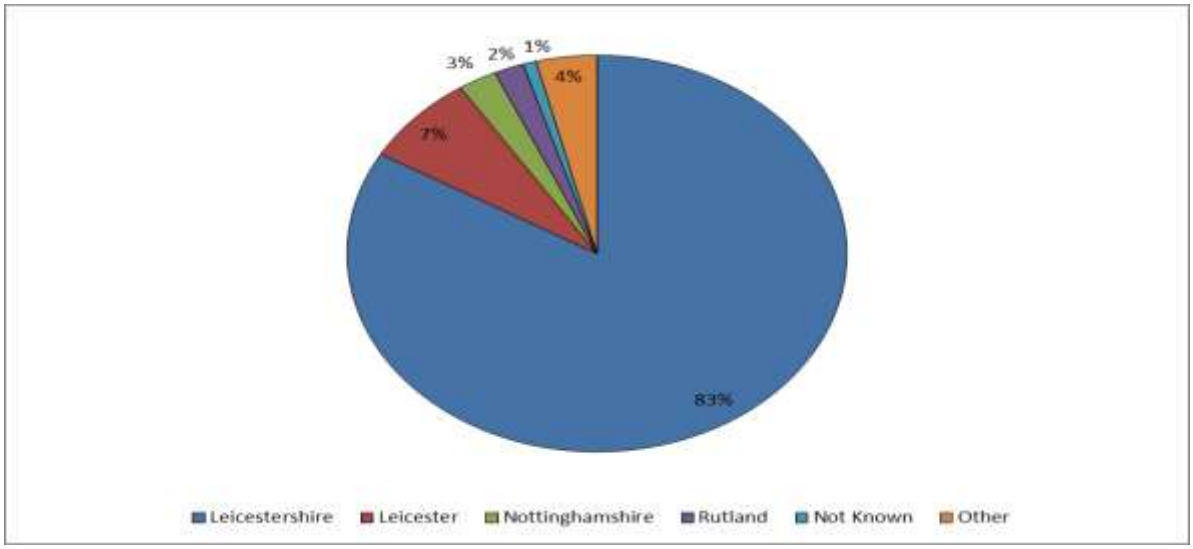
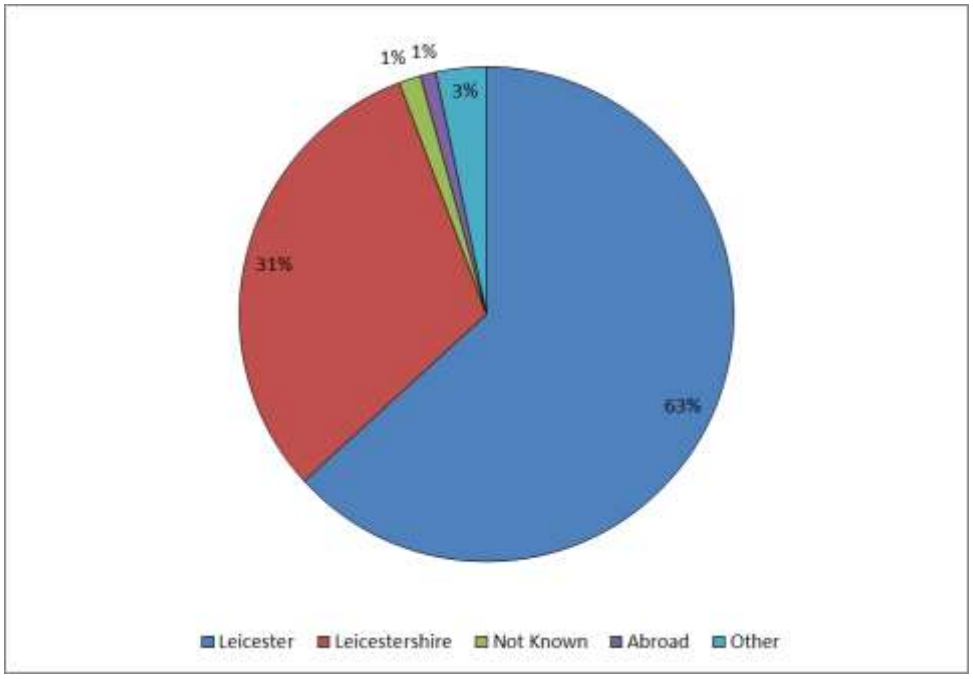


Figure 39: Percentage Attending a Leicester City GUM Clinic by Area of Residence, 2014[27]



5.6 Sexual Health Screens

In 2014, there were 14,702 first time attendees from Leicestershire attending any sexual health clinic in England, of these 44% were male. This is an increase in first time attendees from 14,122 in 2013. For Rutland residents, there were 684 first time attendees in 2014 and 63% of these attendees were male. This is also represents a small increase from 2013 where there were 677 first time attendees. Figure 40 shows counts of first time attendees for both males from Leicestershire and females from Rutland have decreased compared to the previous year. Male first time attendees from Rutland and female first time attendances from Leicestershire have seen a year on year increase since 2011.

The number of first time attendees by age is shown in

Figure 41. In Leicestershire, the peak of first time attendees were seen in the 20-24 age-band, in Rutland the highest number of first time attendees were seen at a later age, of 25-34 years. Figure 42 examines the sexual orientation of first time attendees from Leicestershire and Rutland. In 2014, for Leicestershire, 95% of all female first time attendees were heterosexual sexual orientation and for Rutland this rose to 97%. In males, there were a smaller proportion of those with heterosexual sexual orientation, 85% in Leicestershire and 89% in Rutland. In Leicestershire, homosexual male attendees made up 10% of all first time attendees, a larger percentage compared to Rutland (8%). Regular outreach clinics held at male saunas and annually at Leicester Pride event, in collaboration with Trade Sexual Health Project and other partners, contribute to improving access for MSM communities. In 2014-15 there were 72 new patients seen at male saunas with safer sex advice provided by Trade, alongside access to full screening clinics.

Figure 43 examines the percentage of sexual health screens taken from first attendees resident in Leicestershire and Rutland by sexual orientation in 2014. The figure shows that Leicestershire has a higher percentage of sexual health screens compared to Rutland

across all groups. Examining by sexual orientation, heterosexual patients have the highest percentage of screens in Rutland (73%) whereas in Leicestershire the highest percentage of screens were from by bisexual patients in Leicestershire (77%).[27]

Figure 40: Trend of First Time Attendees for a Sexual Health Screen resident in Leicestershire and Rutland[27]

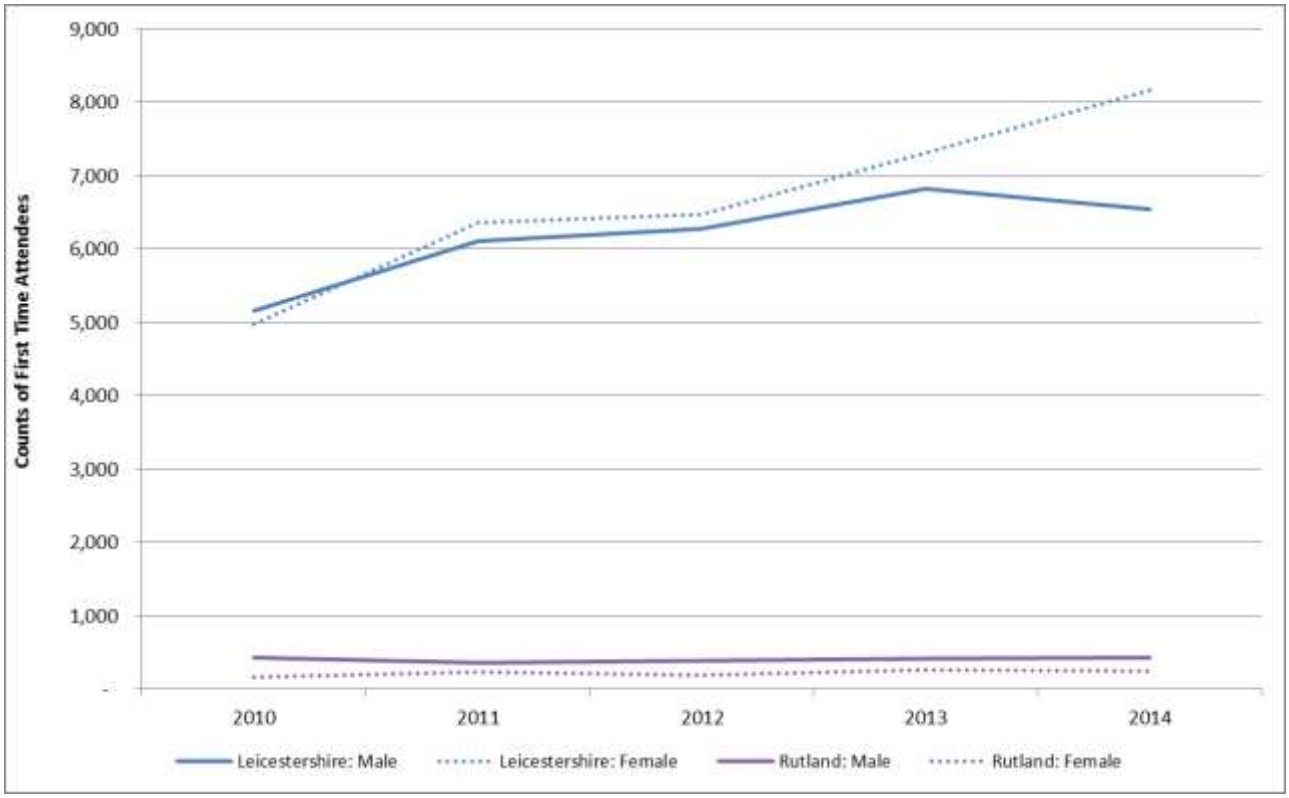


Figure 41: Counts of First Time Attendees for a Sexual Health Screen in Leicestershire and Rutland by Age, 2014[27]

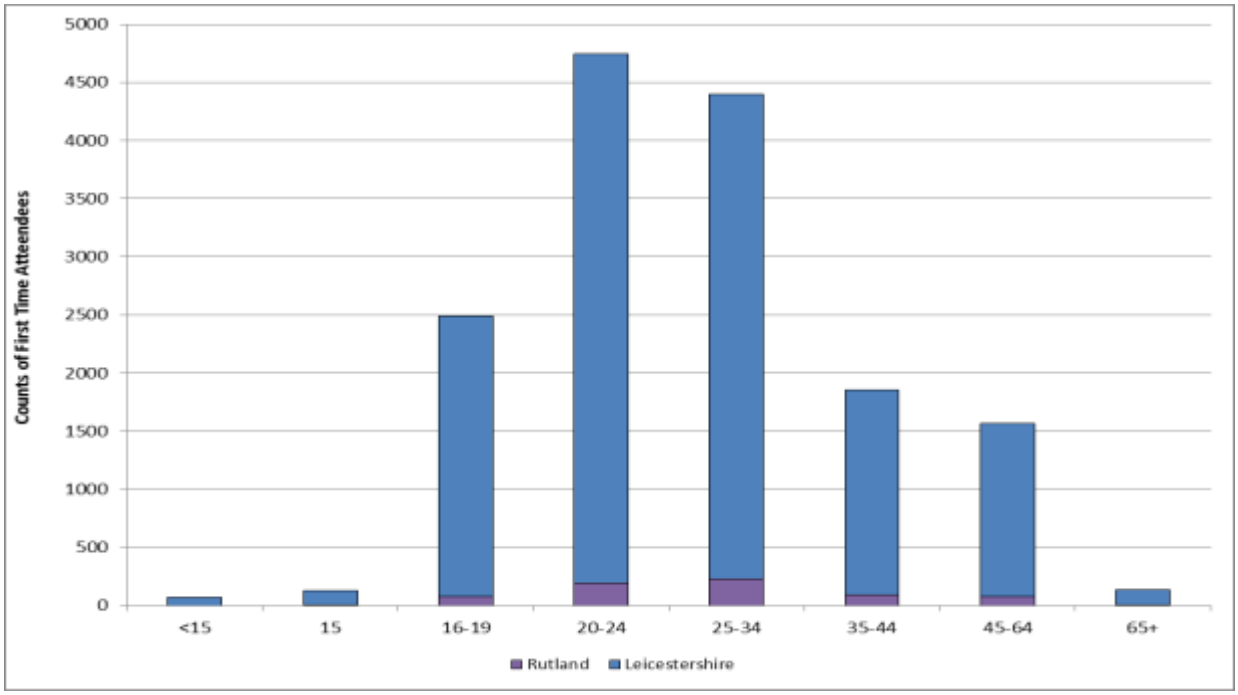


Figure 42: Percentage of First Time Attendees for a Sexual Health Screen by Sexual Orientation, Leicestershire, 2014[27]

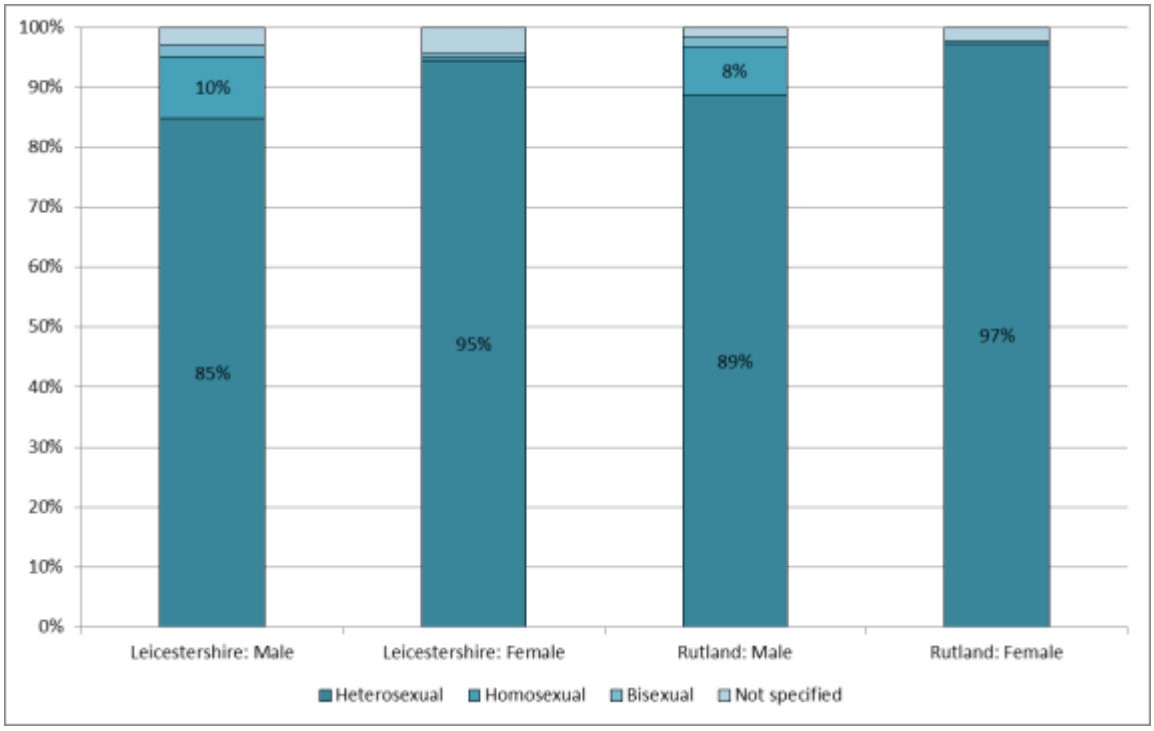
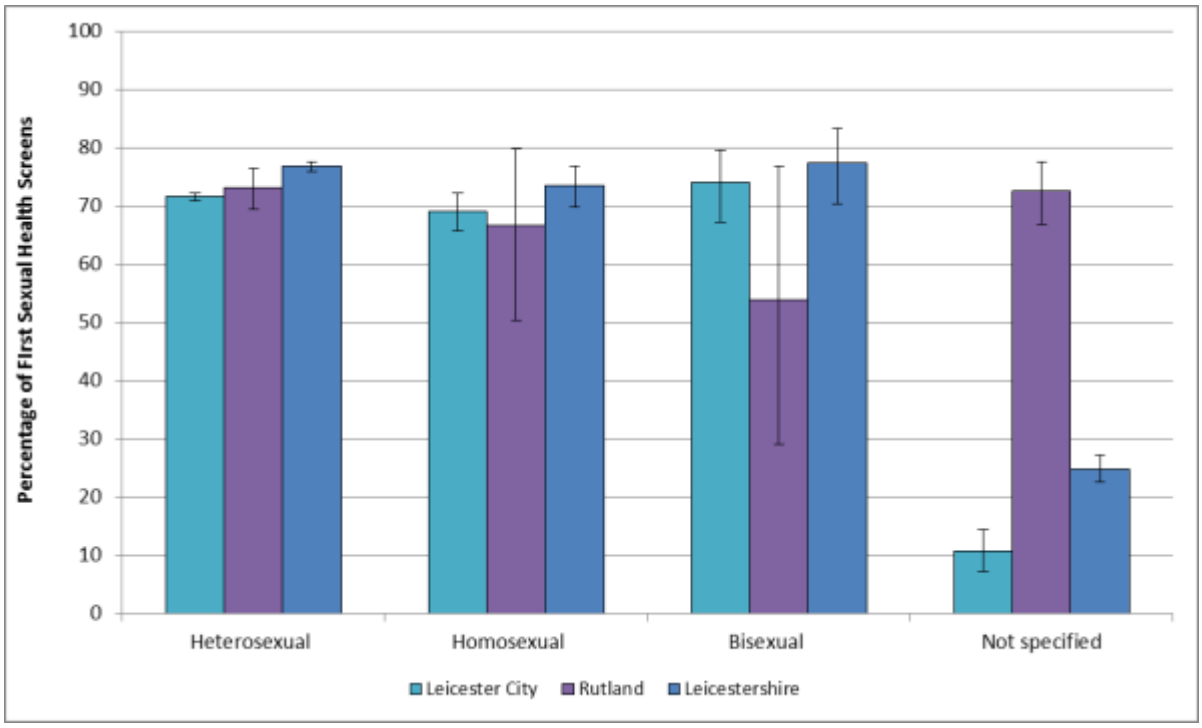


Figure 43: Percentage of first sexual health screens by sexual orientation in Leicestershire and Rutland, 2014[27]



5.7 LLR Integrated Sexual Health Service (ISHS)

A new integrated sexual health service (ISHS) provided by Staffordshire & Stoke on Trent NHS Partnership Trust (SSOTP) commenced from 1 January 2014 across LLR. This service provides both STI and sexual and reproduction healthcare to enable people to more often access services for both aspects of sexual health at a single appointment. The service is open access and provides the following key elements of service:

- Genito-urinary medicine (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

The change in model means that it is difficult to compare activity in 2014 with previous years.

The service is delivered from two hubs (St Peters Health Centre, Leicester and Loughborough Medical Centre) and via a series of sessions in 'spokes', of which there are four in Leicestershire (Market Harborough, Hinckley, Coalville, Melton Mowbray) and one in Rutland (Oakham). The hours of service have been extended to offer services between 9am – 8pm (Monday to Friday) and 9am -2pm (Saturday) from hub sites. Details of services and clinics can be found on www.leicestersexualhealth.nhs.uk

Specific young people's service sessions are delivered from community based settings such as selected further education (FE) colleges. A domiciliary service is available for residents unable to access local services. The service also coordinates local delivery of opportunistic chlamydia screening of 15-24 year olds as part of the National Chlamydia Screening Programme and offers a range of training and support to the wider sexual health workforce. Other providers also offer sexual health services for the local population. More detail in relation to contraceptive service provision from the ISHS is considered in section 6

Table 9 shows that the majority of individuals accessing the services in 2014 were from Leicester City, closely followed by residents of Leicestershire. The age profiles differ slightly between the two authorities, likely due to the varying demographics in the areas.

Figure 44 shows in Leicestershire and Rutland the highest percentage of attendances were in the 15-24 age band. In Leicester City, the peak in activity was seen in the elder age band, aged 25-34 years. In general as age increases, the percentage of individuals accessing the service declines. Figure 45 shows in Leicestershire and Leicester City, two-thirds of all first attendance activity is by females. In Rutland, this rises to three quarters.[61]

Table 9: Counts of ISHS Activity by Age Band, 2014[61]

Age Group	Leicester City	Leicestershire	Rutland
Under 15	71	138	*
15-24	6,566	8,464	169
25-34	6,975	5,083	95
35-44	3,930	2,498	53
45-54	1,929	1,674	27
55-64	501	462	10
65 and over	146	177	*
Total	**20,118**	**18,496**	**354**

Figure 46 examines the ethnicity of individuals accessing the ISHS. In Leicestershire and Rutland, the majority of individuals accessing the service were of white ethnicity. Residents from Leicester City have a greater ethnic mix compared to Leicestershire and Rutland; this is demonstrated in the individuals accessing the service. The percentage of males identifying themselves as homosexual or bisexual and accessing the ISHS is presented in Figure 47. In Leicester City, 15.1% of all males accessing the service were homosexual or bisexual males, a higher percentage than Leicestershire (14.2%) and Rutland (13.8%).[61]

Figure 44: Percentage of ISHS Activity by Age Band, 2014[61]

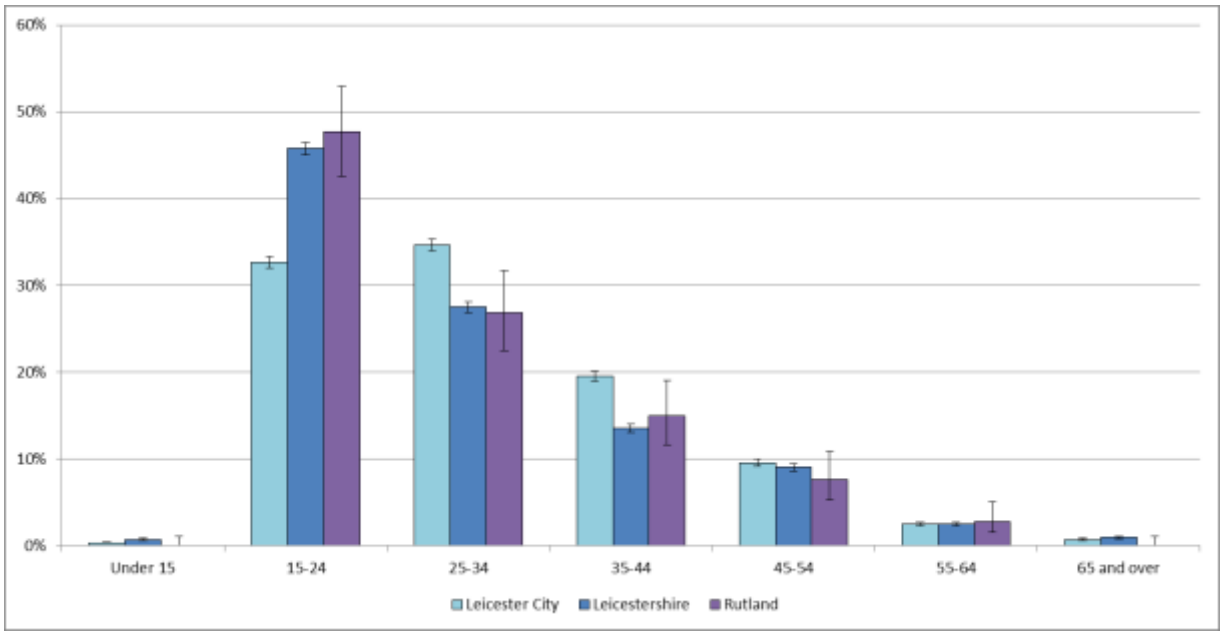


Figure 45: Percentage of ISHS Activity by Gender, 2014[61]

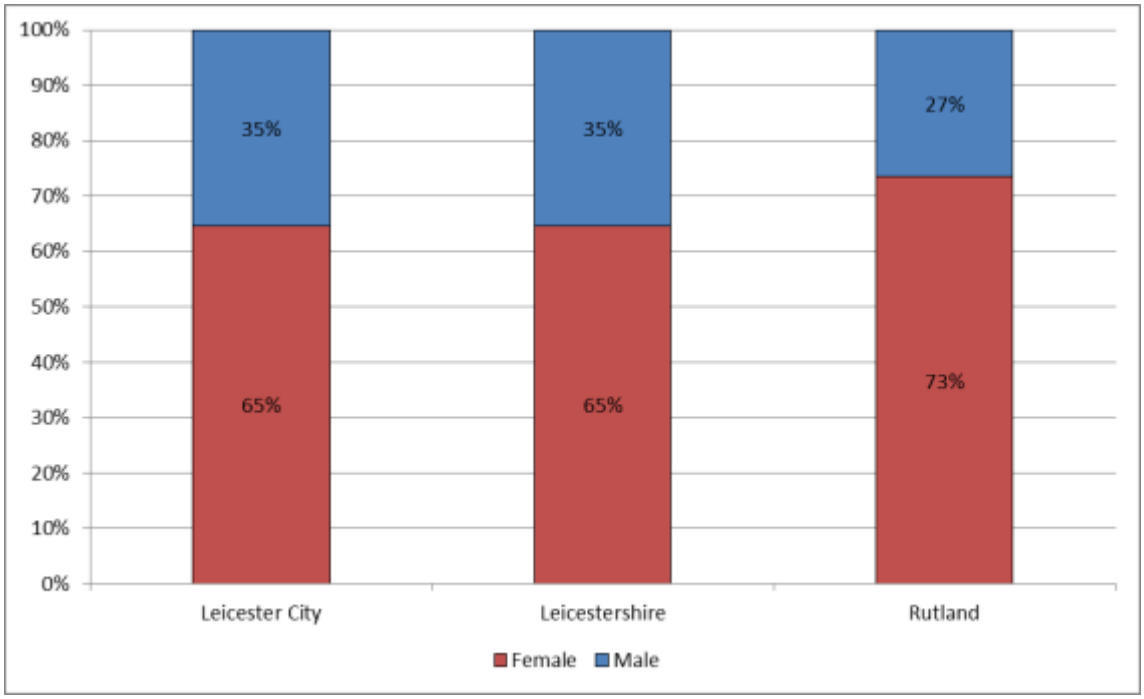


Figure 46: Percentage of ISHS Activity by Ethnicity, 2014[61]

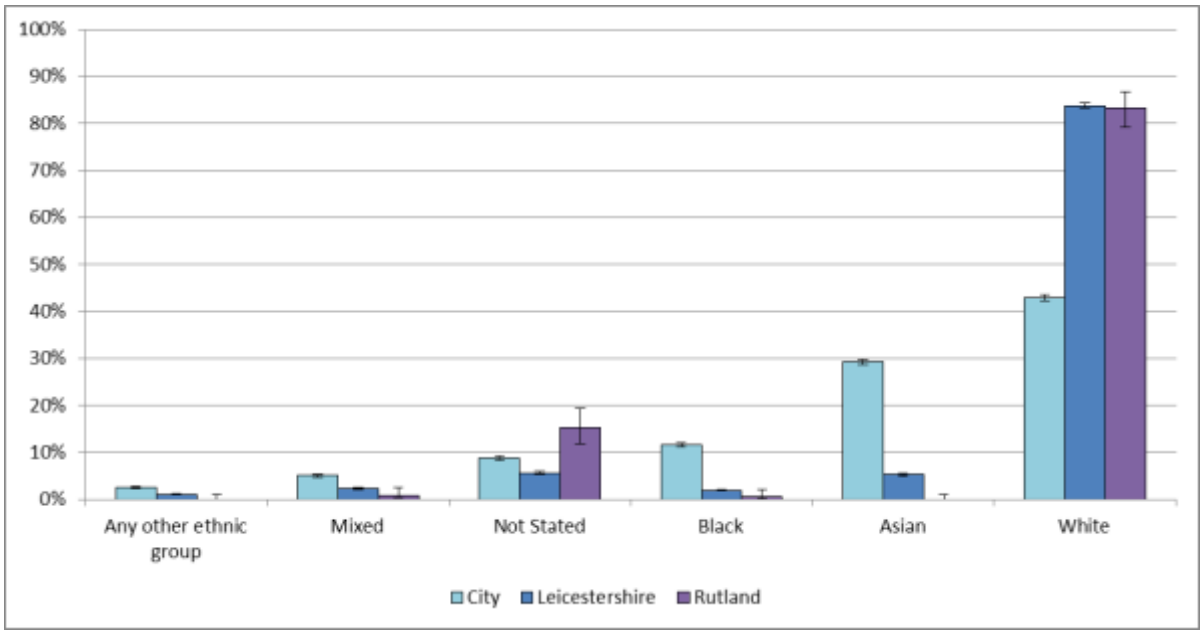
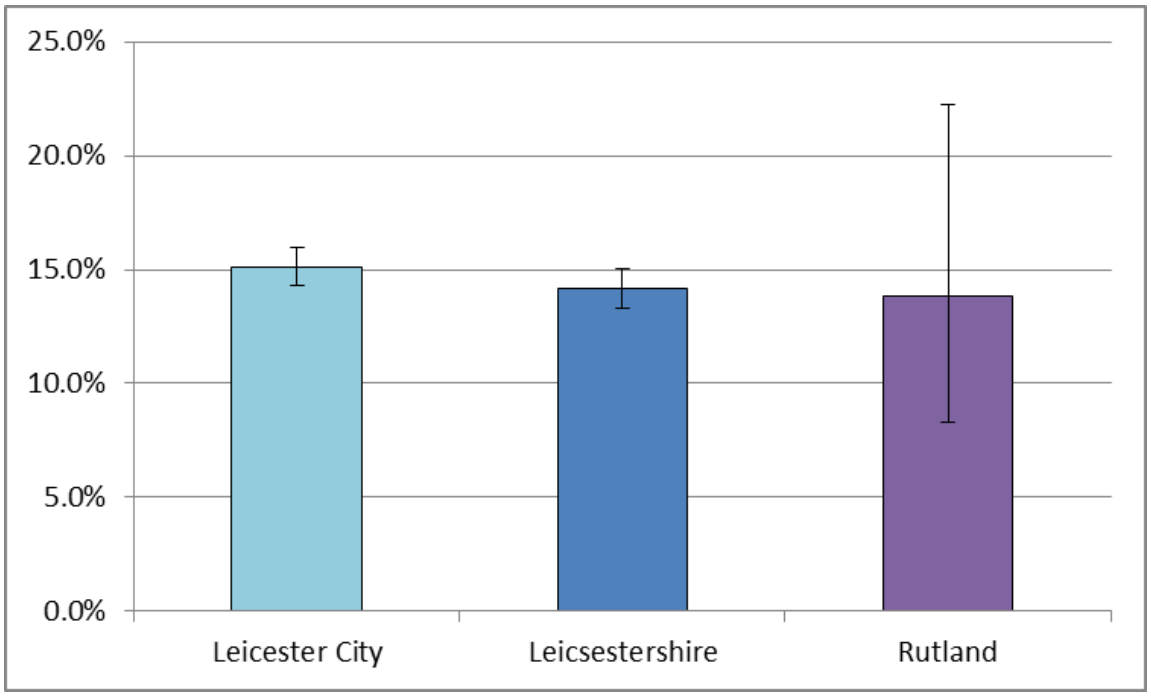


Figure 47: Percentage of Males Self-Identifying as Homosexual or Bisexual, 2014[61]



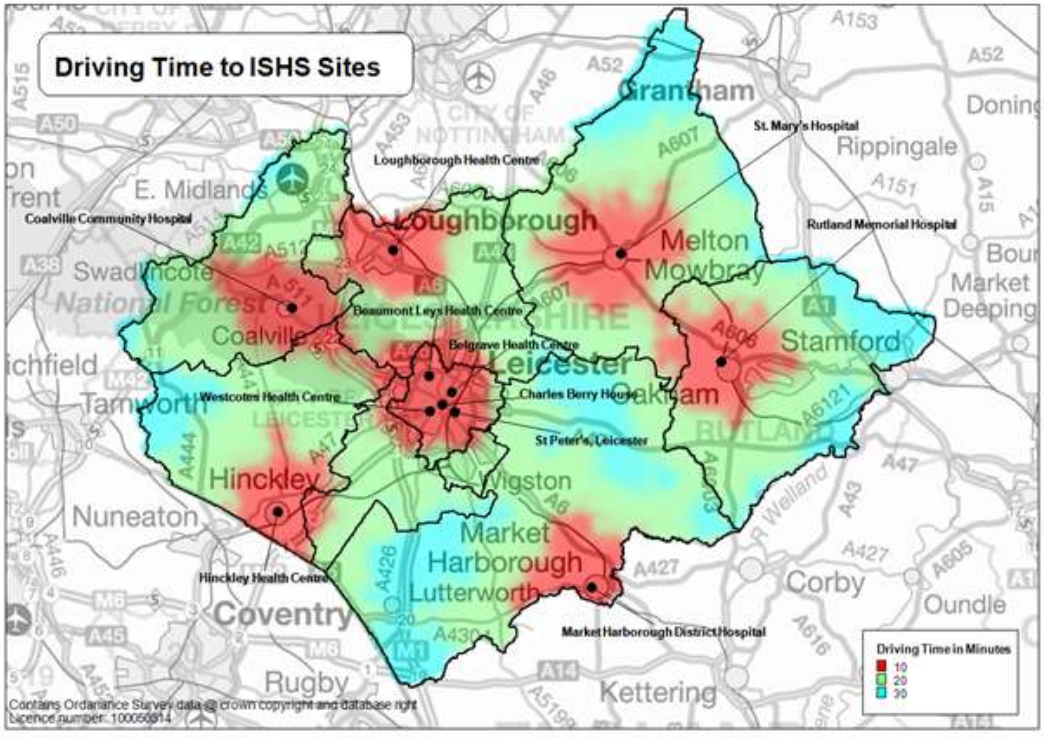
Using Geographical Information Systems (GIS) it is possible to analyse how long it takes to drive from any postcode to the ISHS sites. Figure 48 and Table 10 illustrates the drive time to an ISHS site. Overall, just under half of Leicestershire's population live less than a 10 minute drive from an ISHS site, 44% live between 10 and 20 minutes' drive and 6.5% live more than a 20 minute drive. In Rutland, due to the rural nature of the county, a higher proportion of residents in Rutland have to travel a longer distance to attend an ISHS site. 40% of Rutland residents live less than a 10 minute drive away, 41% live between 10 and 20 minutes' drive and 19% live more than a 20 minute drive.

Hinckley and Bosworth has the highest proportion of its population less than 10 minutes' drive from an ISHS site, pharmacy or dispensing GP practice, at 72%%, and almost 68% of Melton's population live this far from a ISHS site practice. In contrast, less than a third of Harborough's population live within a 10 minute drive of an ISHS site.

Table 10: Population by Drive Time to ISHS Site

Local Authority	Driving Time							
	Less than 10 minutes		10-20 minutes		20-30 minutes		More than 30 minutes	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Blaby	29,121	30.5%	63,202	66.3%	3,047	3.2%		0.0%
Charnwood	108,419	63.1%	63,130	36.7%	260	0.2%		0.0%
Harborough	26,107	30.0%	37,296	42.8%	23,702	27.2%		0.0%
Hinckley and Bosworth	76,764	71.9%	27,624	25.9%	2,342	2.2%		0.0%
Melton	34,542	67.7%	9,637	18.9%	3,239	6.3%	3,619	7.1%
North West Leicestershire	44,889	47.5%	42,085	44.5%	7,529	8.0%		0.0%
Oadby and Wigston	7,285	12.8%	49,599	87.2%		0.0%		0.0%
Leicestershire	**327,127**	**49.3%**	**292,573**	**44.1%**	**40,119**	**6.0%**	**3,619**	**0.5%**
Rutland	14,839	39.6%	15,447	41.2%	7,173	19.1%	17	0.0%

Figure 48: Driving Time to Integrated Sexual Health Service Sites, 2015



5.8 Implications for sexual health

Overall LCR experiences lower rates of STI diagnosis than the England average. Chlamydia is the most common STI across LCR, followed by genital warts. Although lower than the national rates, there have been year on year increases in gonohorrea , genital herpes and syphilis across Leicestershire. This may be due to increased access to STI testing or increases in STI prevalence across LCR.

Oadby & Wigston, Blaby, Charnwood have been identified as areas of higher STI reinfection within 12 months and Harborough reinfection percentage for men with Gonorrhoea specifically was twice the national average. Therefore additional priority to STI prevention and contract tracing may be beneficial in these districts, in particular with men.

Young people aged 15-24 years, MSM and black Caribbean ethnic groups have been shown to have higher rates of new STIs across LCR, which is aligned with the national picture. Increases have been seen in the proportion of STIs diagnosed in MSM across LCR. This may be due to increased uptake of STI screening or higher STI prevalence. Either way targeted work must be maintained with MSM due to the high level of sexual health need.

LCR does not perform well against the national average for Chlamydia screening in 15-24year olds. This has been particularly apparent since changes have occurred in the national data collection from 2012. However comparator local authorities perform similarly to LCR, which may indicate that the overall prevalence of chlamydia is lower than the national average. Either way chlamydia screening is a useful tool in normalising STI screening with young adults, therefore opportunistic screening should be increased in core sexual health services.

Increases in GUM attendance by Leicestershire and Rutland residents has been seen locally in the new ISHS as well as across the country. The percentage accessing local services has increased by 1% for Leicestershire and 10% for Rutland between 2013 and 2014. This may reflect increased access due to the new LLS ISHS, increased awareness of STI screening, but also reflects the increased STI need across LCR. Slightly older populations (25-29year olds) are most frequently accessing the ISHS from Rutland as compared to Leicestershire (20-24year olds) which may reflect reduced access or the demography of the population. In 2014 there was an increase in women and decrease in men accessing sexual health services locally. The opposite was seen in Rutland, where reductions in women's access were seen. This may be due to changes in the ISHS service model. Therefore further work is needed to increase sexual health access to high risk groups (including MSM), female and younger populations in Rutland and male populations in Leicestershire.

Rural access is a particular difficulty for areas of LCR due to limited access to some hub and spoke sites via public transport. The use of clinics outside of LLR by Leicestershire and particularly by Rutland residents reflects access issues as some residents may choose to go to other open access sexual health services perhaps closer to workplaces and colleges. The difficulty of accessing specialist sexual health services highlights the importance of alternative local service provision such as general practice and pharmacy for elements of sexual health care.

6. Human Immunodeficiency Virus (HIV)

HIV or human immunodeficiency virus attacks the immune system and weakens the body's ability to fight infections and disease. There is currently no cure for HIV, but there are treatments to enable people with the virus to live a longer and healthier life.

Primary prevention of HIV remains a priority, through evidence-based interventions including health promotion and support for sustained behavioural change including condom use. This is challenging, and interventions should include support for people with diagnosed HIV both to protect their sexual health (for example to avoid STIs) and reduce onward transmission.[63]

6.1 Diagnosed HIV prevalence

HIV testing is integral to the treatment and management of HIV. Knowledge of HIV status increases survival rates, improves quality of life and reduces the risk of HIV transmission.

In 2013, the diagnosed HIV prevalence in Leicestershire was 0.71 per 1,000 population aged 15-59 years and in Rutland, was 0.73 per 1,000 population aged 15-59 years. Both areas have a significantly lower rate compared to the national rate (2.1 per 1,000 population aged 15-59). Figure 49 shows the rates for Rutland have steadily increased over the last few years, but despite this, the rate for both Leicestershire and Rutland have remained consistently lower than the national average over time. In the Leicestershire districts in 2103, Figure 50 shows that Melton has the lowest rate of diagnosed HIV (0.2 per 1,000 aged 15-59 years) and Oadby and Wigston the highest (1.1 per 1,000 aged 15-59 years). In 2013, all districts had a rate significantly lower than the national and regional averages. The highest absolute counts of people diagnosed with HIV in Leicestershire were found in Charnwood (84) followed by Blaby (47).[57]

Developments in HIV treatment over the last decade have resulted in improved life expectancy for people living with HIV, changing treatment and care to reflect HIV as a long term condition. Reduced numbers of deaths also contributes to increased prevalence rates as people live with HIV into older age.

Figure 49: Trend of HIV diagnosed prevalence rate per 1,000 aged 15-59[57]

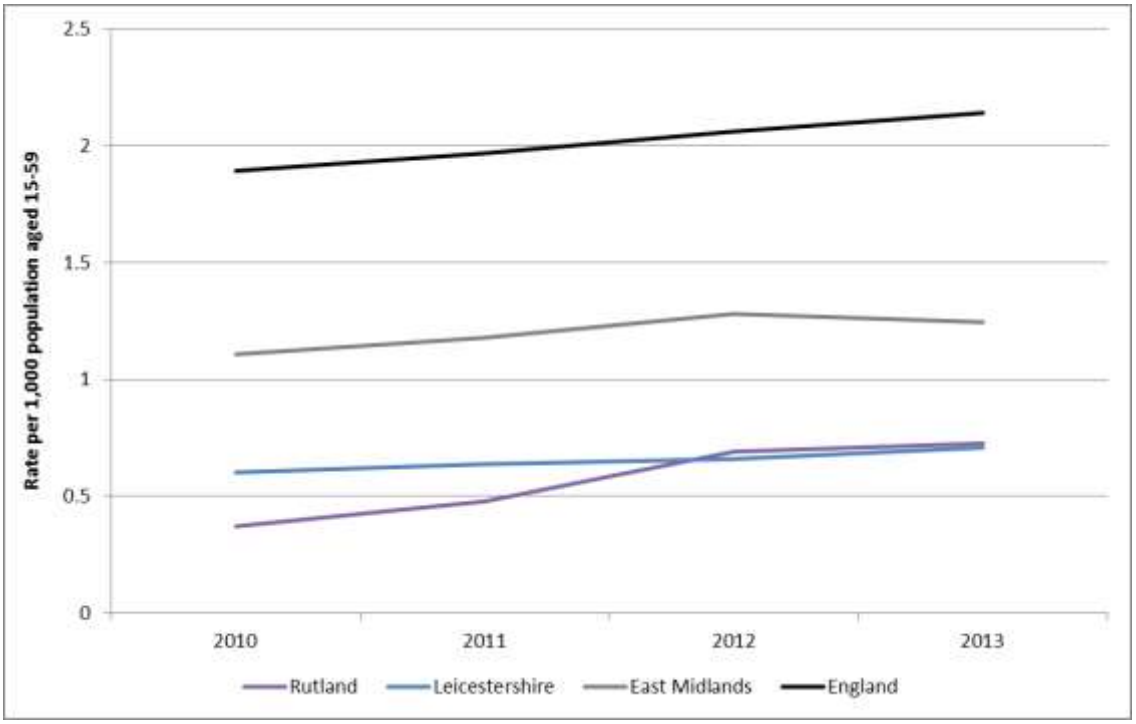
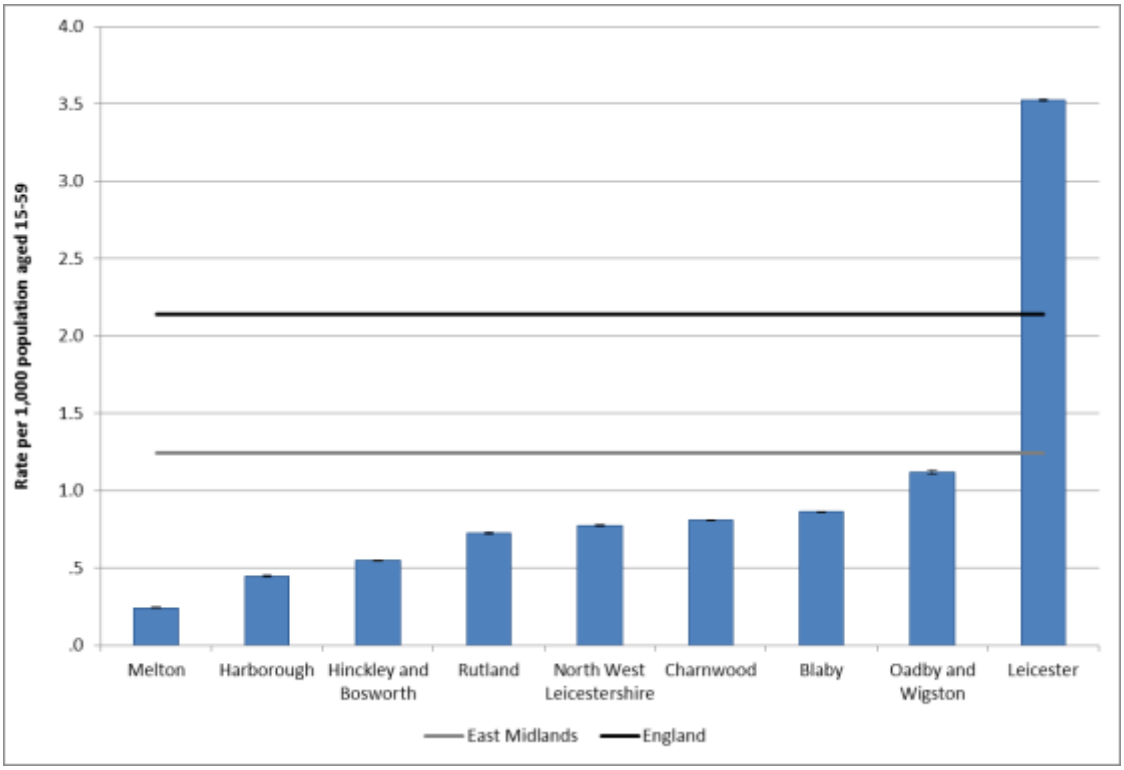


Figure 50: HIV diagnosed prevalence rate per 1,000 aged 15-59 by District, 2013[57]



6.2 People living with diagnosed HIV

In 2013, 305 adult residents (aged 15 years and older) in Leicestershire received HIV-related care: 216 males and 89 females. Among these, 63.9% were white and 25.2% black African. With regards to exposure, 43.0% probably acquired their infection through sex between men and 50.5% through sex between men and women.[64]

Table 11: Number of adults living with diagnosed HIV by ethnicity and exposure group in Leicestershire: 2009 and 2013[64]

		2009	%	2013	%
Ethnicity	White	139	64.4%	195	63.9%
	Black African	49	22.7%	77	25.2%
	Other	28	13.0%	33	10.8%
Probable route of infection	Sex between men	81	37.5%	131	43.0%
	Sex between men and women	102	47.2%	154	50.5%
	Injecting drug use	9	4.2%	8	2.6%
	Other/Not known	24	11.1%	12	3.9%
Total		**216**		**305**	

In 2013, 15 adult residents (aged 15 years and older) in Rutland received HIV-related care: 10 males and 5 females. Among these, 53.3% were white and 40.0% were black African. With regards to exposure, 53.3% probably acquired their infection through sex between men and 46.7% through sex between men and women.[64]

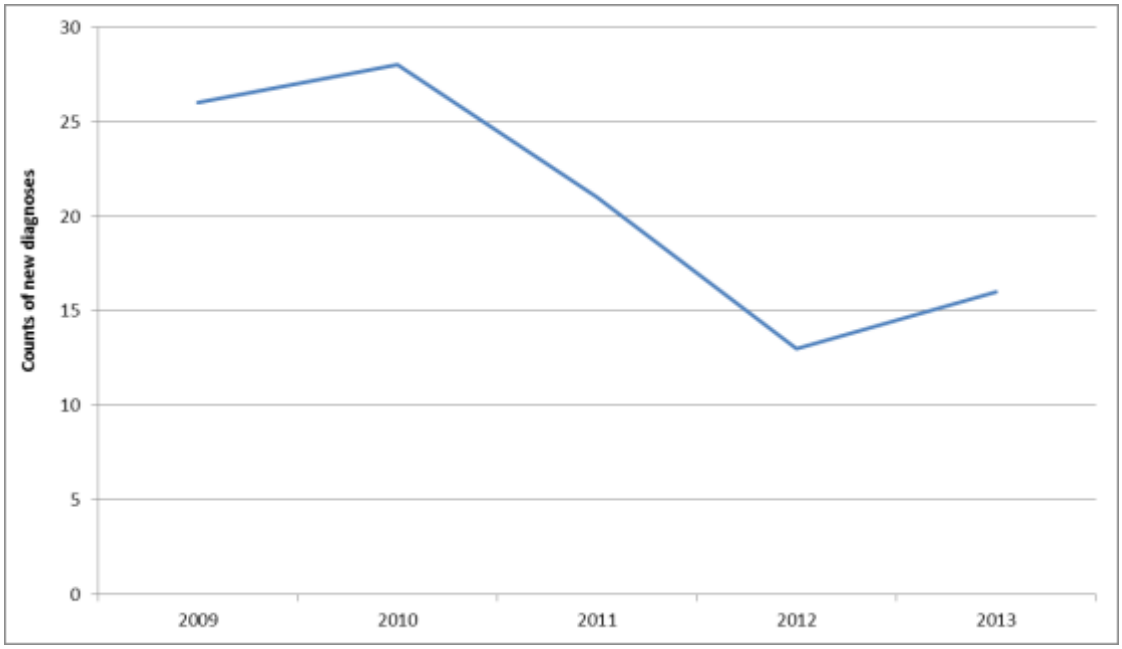
6.3 New HIV diagnoses

In England, of those diagnosed with HIV infection in 2013, 80% had residence information available through linkage with The Survey of Prevalent HIV Infections Diagnosed (SOPHID).

Where residence information was available in 2013, 16 adult residents of Leicestershire were newly diagnosed with HIV. Despite year on year decreases between 2010 and 2012, the latest number of new diagnoses shows an increase compared to the previous year.

Among those who acquired their HIV through sex, since 2009, the majority of new diagnoses occurred through the MSM route. In Rutland in 2013, no residents were newly diagnosed with HIV.[58]

Figure 51: Trend of New Diagnoses of HIV per year in Leicestershire

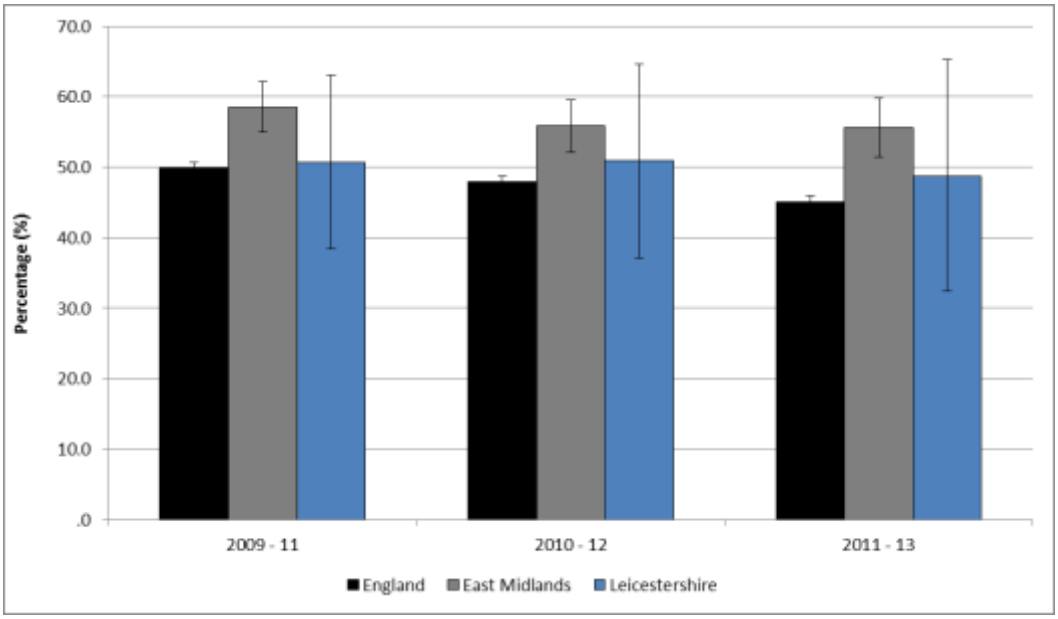


6.4 HIV late diagnoses

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 expanded HIV testing.

In Leicestershire, between 2011 and 2013, 48.7% of HIV diagnoses were made at a late stage of infection (CD4 count <350 cells/mm³ within 3 months of diagnosis) compared to 45% in England. This accounts for 19 individuals in Leicestershire. Throughout this same time period, in Rutland, 67% of HIV diagnoses were made at a late stage of infection. 0% of men who have sex with men (MSM) and 67% of heterosexuals were diagnosed late.[22]

Figure 52: Percentage of adults (aged 15 or above) newly diagnosed with HIV with a late diagnosis[22]

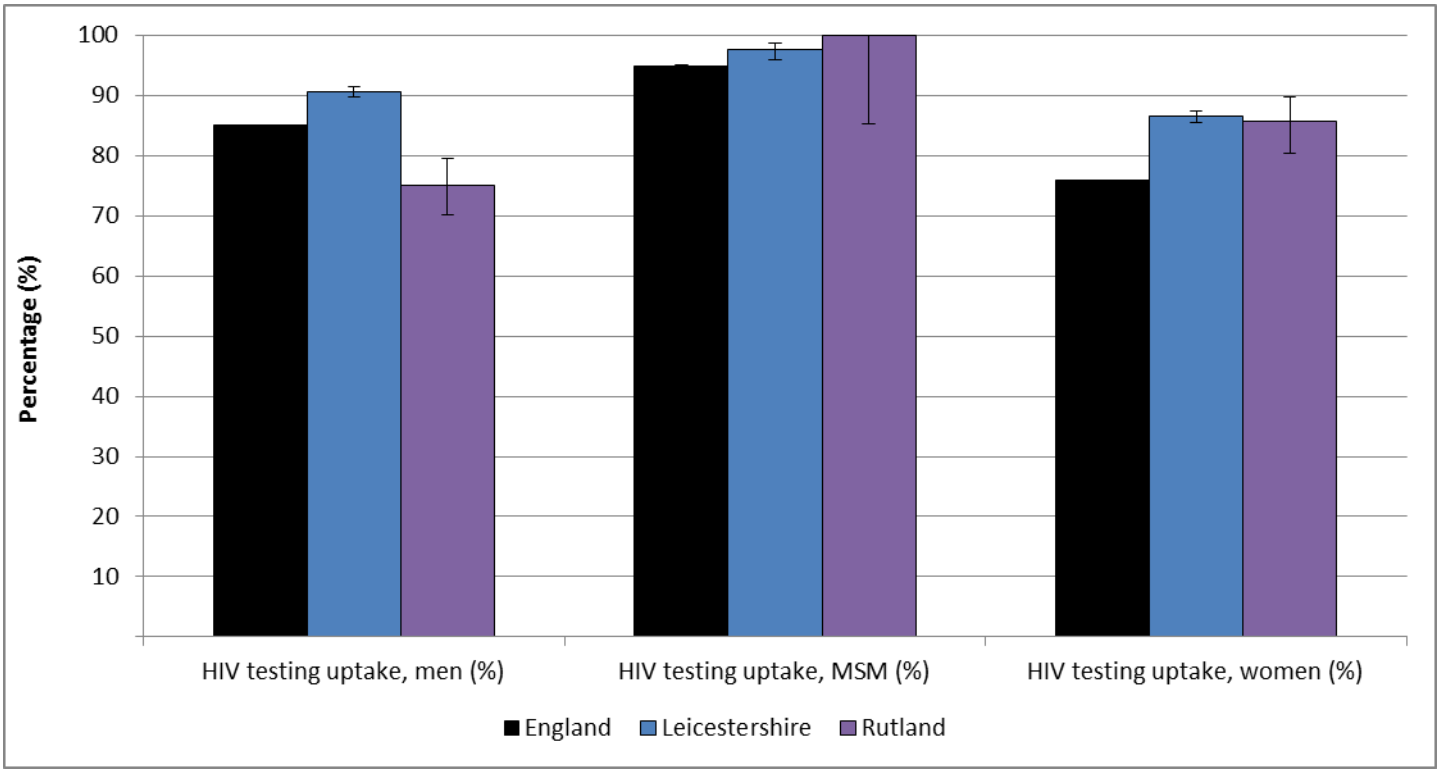


6.5 Uptake of HIV testing at eligible attendances in GUM clinics

Early diagnosis of HIV is an important aspect of prevention. Early diagnosis enables faster access to treatment which improves the health outcome for the individual and reduces likelihood of onward transmission. As well as benefits to the individual, there is a clear health economic argument for early diagnosis of HIV. Treatment costs are reduced from £23,442 with a later diagnosis to £12,600 per annum per patient. Increasing uptake of HIV testing among MSM and black Africans in England would prevent 3,500 cases of HIV transmission within five years and **save £18 million** in treatment costs per year. Good access to and uptake of HIV testing are therefore important issues. Improving uptake of HIV testing in sexual health clinics contributes to increased testing, alongside a range of other testing opportunities.[4,5] In 2013, a HIV test was performed in 88.5% and 79.4% of eligible attendances at GUM services by Leicestershire and Rutland residents respectively. Nationally, a HIV test was performed in 80.0% of attendances where offered.

Nationally, MSM have the highest uptake of HIV testing followed by men, then women. This pattern is reflected in Leicestershire but differs in Rutland. Figure 53 shows in the Leicestershire population, men, MSM and women all have a significantly higher uptake of HIV testing compared to the national uptake. In Rutland, women have a significantly higher uptake of HIV testing (85.6%) compared to the national average (75.8%), however HIV uptake in men is significantly worse (75.1%) compared to the national percentage (84.9%).[57]

Figure 53: Uptake of HIV testing measured in GUM among men, men who have sex with men (MSM) and women, 2013[57]

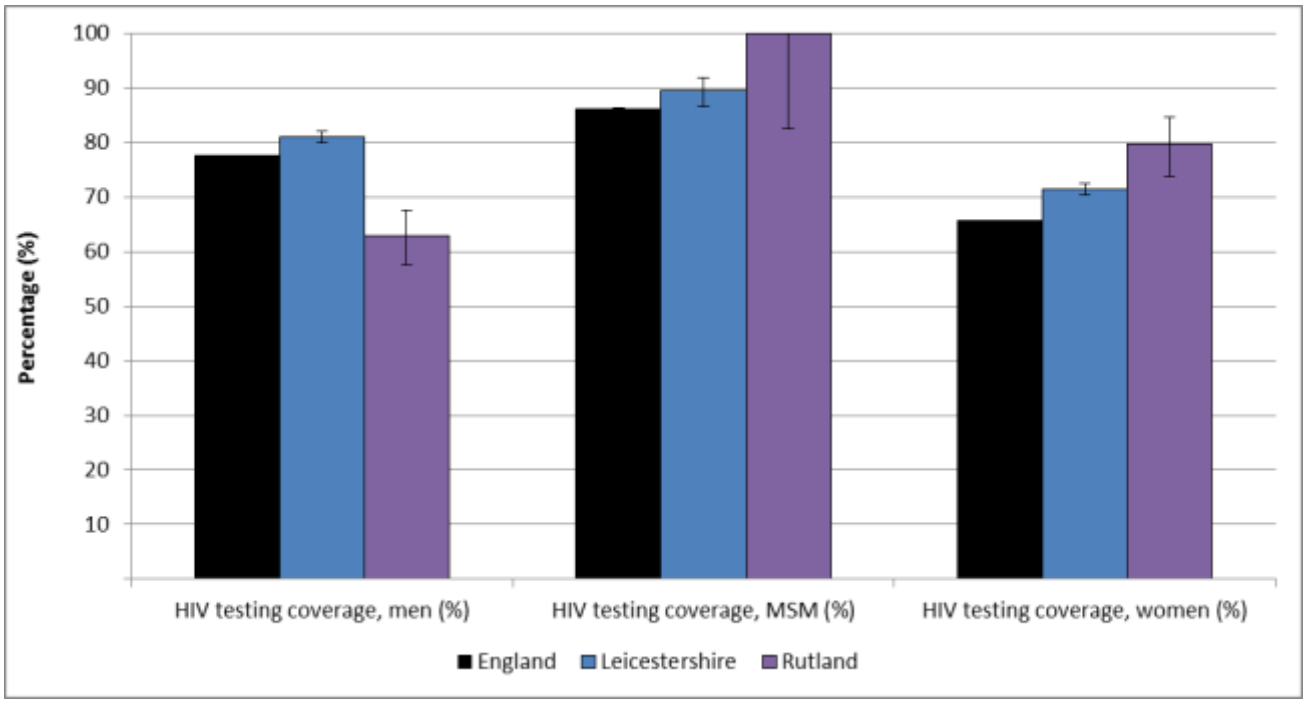


6.6 Coverage of HIV testing among patients at GUM clinics

HIV test coverage data represent the number of persons tested for HIV and not the number of tests reported. Some patients may test more than once annually. In 2013, among GUM clinic patients from Leicestershire who were eligible to be tested for HIV, 76.0% were tested. Among GUM clinic patients from Rutland who were eligible to be tested for HIV, 69.1% were tested. Nationally, 71.0% of GUM clinic patients were tested for HIV.

Nationally, MSM have the highest coverage of HIV testing followed by men, then women. This pattern is reflected in Leicestershire but differs in Rutland. Figure 54 shows in the Leicestershire population, men, MSM and women all have a significantly higher coverage of HIV testing compared to the national coverage. In Rutland, women have a significantly higher coverage of HIV testing (79.7%) compared to the national average (65.6%), however HIV coverage in men is significantly worse (62.8%) compared to the national percentage (77.5%).[57]

Figure 54: Coverage of HIV testing measured in GUM among men, men who have sex with men (MSM) and women, 2013[57]



Non GUM HIV testing

HIV testing is also available in primary care and in relevant secondary care settings as clinically indicated or as part of routine testing such as in ante-natal care.

HIV testing is also available in some community settings to reach communities at higher risk of HIV infection and potentially less likely to access services. Commissioning guidance[65] suggests that lower prevalence areas such as Leicestershire and Rutland would best focus on population groups and areas where reported diagnoses of HIV are greatest.

Some community HIV testing has been delivered by voluntary sector sexual health projects working with HIV positive people, Black African communities and MSM groups. In 2014/15 Trade Sexual Health Project undertook 51 point of care HIV tests and LASS undertook 52 tests with residents of Leicestershire. This testing is now commissioned by Public Health.

In addition changes in the law on the sale of self-sampling and self-testing kits for HIV within the UK, now means that individuals can purchase an HIV self-test kit for personal use[66]. Self -sampling requires a person to take a sample (saliva or blood from a finger prick) and send the sample to a laboratory for testing. Results are then given by the service, together with advice on what to do next. Self-testing is different in that the sample is tested by the individual themselves using the kit and a result is obtained immediately. Self- testing and self-sampling have both been shown to be acceptable among those who have never tested for HIV before. Public Health England supported two self-sampling pilots in England in 2013/14 which indicated acceptance of the screening method and high uptake by those not previously tested[67]. A small number of Leicestershire and Rutland residents accessed the self-sampling in these pilots via online request. Following on from this, Leicestershire and Rutland are participating in a national procurement of self-sampling HIV tests targeting MSM and black African communities to pilot this locally. Community Based Sexual Health Promotion & HIV Prevention

A new model of delivery for community based sexual health promotion and HIV prevention was commissioned from April 2015 by Leicester City, Leicestershire County and Rutland County Councils. The four elements of prevention work is as follows:

- Men who have Sex with Men (MSM). This service is provided across LLR by Trade Sexual Health Project.
- HIV positive people. This service is provided across LLR by LASS.
- People of African Heritage. This service is provided across Leicester and Leicestershire by LASS.
- Sex workers. This service is provided across Leicester and Leicestershire by New Futures.

The services include provision of;

- Safer sex information and resources in community settings
- Behaviour change interventions
- HIV/STI testing including promotion and provision of community HIV testing
- Work to reduce stigma and discrimination for this population including contribution to delivery of a co-ordinated training programme.
- Provision of links and referrals to appropriate services.
- A co-ordination element which supports joint working on delivery of training, Community HIV testing and campaign work. This element is provided via the ISHS.

6.7 Treatment as Prevention

Early access to treatment is an important element of a prevention strategy as HIV positive people in treatment are less likely to transmit the virus to partners than those not accessing antiretroviral treatment.

Evidence is emerging that pre-exposure prophylaxis (PrEP) has potential as a component of an HIV prevention approach. PrEP uses antiretroviral (ARV) drugs to protect HIV negative people from HIV infection. ARV is taken to lower the risk of infection. The PROUD study recruited over 500 MSM in England and compared use of PrEP with a control group not using PrEP. The use of PrEP reduced the number of HIV infections by 86%[68]. Although PrEP is an expensive HIV prevention method, studies indicate that PrEP could be cost effective if prioritised for use by those at very high risk of HIV. There is currently no NHS policy on use of PrEP, however this alongside other emerging prevention methods need to be considered[69].

6.8 Implications for sexual health

There is significantly lower HIV diagnosis rates across LCR compared to the national rate. However HIV prevalence overall is increasing locally and nationally largely due to increased life expectancy as treatment has improved to make HIV a long term condition. There are implications for health and social care providers as the HIV positive group increases in number and becomes an aging population with changing health needs.

Early HIV diagnosis is important to improve health outcomes for the individual, reduce risk of onward transmission and lower treatment and care costs. Leicestershire and Rutland both have higher rates for late HIV diagnosis than the England average. This is particularly apparent in heterosexual transmission. Therefore further work is needed to educate the heterosexual population about HIV and increase access and uptake of HIV testing, for example in Rutland males accessing GUM. Referral pathways between sexual health and HIV services must also be reviewed to ensure there are seamless pathways to prevent unnecessary delay between diagnosis and treatment, Commissioning of alternative HIV testing methods such as home testing and home-sampling are important options to consider for increasing HIV testing of higher risk groups, including MSM and black African communities.

Changes in national policy in relation to pre-exposure prophylaxis and other emerging evidence may influence future HIV prevention strategies considered for LCR.

7. Sexual and Reproductive Health

7.1 Contraception

The increasing number of years between sexual debut and childbearing means that, on average, women in Britain have a thirty year period in which they have contraceptive needs to prevent unplanned conception Findings from the national survey of sexual attitudes and lifestyles (Natsal -3) estimates that 16% of pregnancies recorded in Britain would be classed as unplanned, 29% as ambivalent and 55% as planned. The study recorded strong associations between unplanned pregnancy and health related factors, lower educational attainment and aspects of sexual behaviour across age groups.[70]

Whilst contraceptive care is available from specialist sexual health services (as commissioned by local authorities), general practice (GP) is the largest provider and is the most frequently chosen first point of contact for those with sexual health concerns and contraceptive needs. GP provision of short-acting contraceptive methods, emergency contraception and the contraceptive injection are part of the general GP contract. In LCR, local authorities also commission the provision of the sub dermal implant (SDI) and intrauterine devices (IUDs) from primary care. Specific training is required for practitioners to deliver this service.

7.1.1 Specialist Sexual & reproductive health services

In 2013, of 1,258,049 residents in England who attended Sexual and Reproductive Health (SRH) services, 61,460 were from East Midlands PHE Centre, of which 5,000 residents were from Leicestershire and 162 residents were from Rutland. While SRH services attendees are predominantly females, male attendees comprise of 16.0%, 9.3% and 10.2% of residents at Leicestershire, Rutland and England respectively.[58]

The charts below describe the range of sexual and reproductive services provided by open access specialist sexual health services to residents of Leicestershire and Rutland. The reason for attendances at SRH services is presented in Figures 55 and 56, detailing that the highest proportion of service use relates to contraceptive care.

Figure 55: Proportion of contraceptive and other SRH services provided among residents of Leicestershire by service provided: 2013[58]

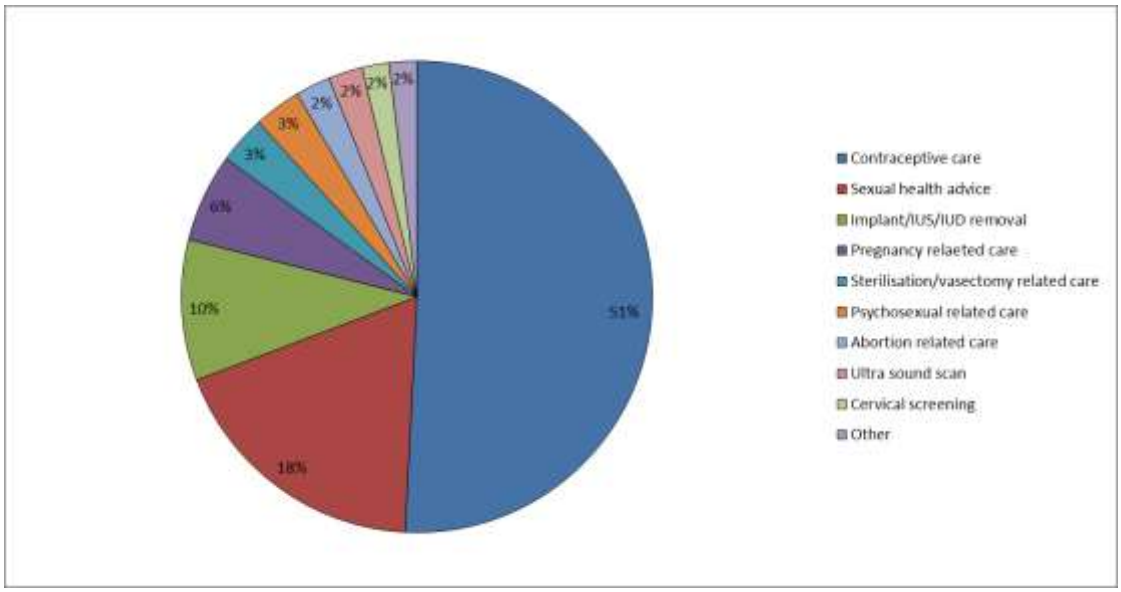


Figure 56: Proportion of contraceptive and other SRH services provided among residents of Rutland by service provided: 2013[58]

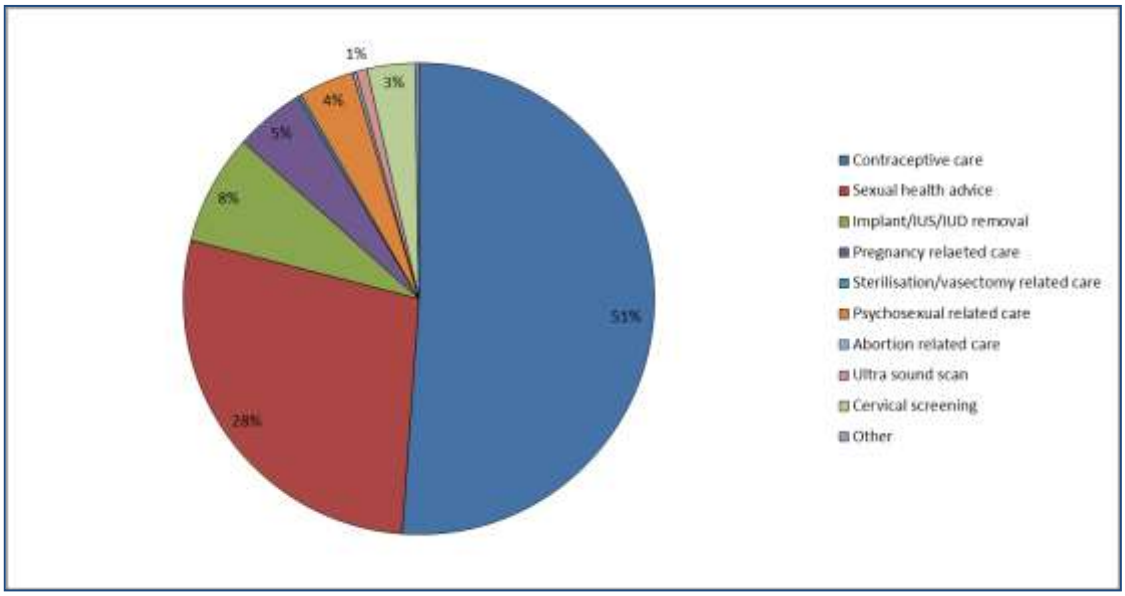
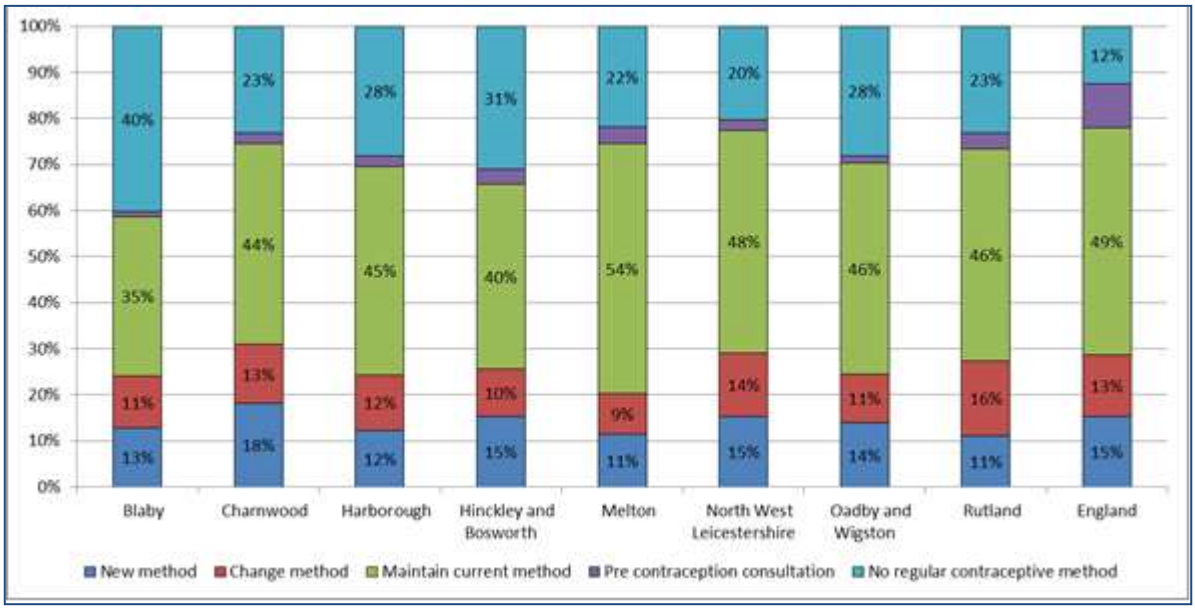


Figure 57: Sexual and Reproductive Health Service attendees by contraception method status, Leicestershire and Rutland, 2013



In 2013, of 1,485,812 attendances at SRH services by residents in England where regular contraception was prescribed, 5,164 were by residents from Leicestershire and 193 were by residents from Rutland. Each contraceptive method prescribed by SRH services, to residents in Leicestershire and Rutland is tabulated in Table 12.

Table 12: Number of contraceptive methods prescribed at SRH services by age group, among residents of Leicestershire and Rutland: 2013[58]

** Counts less than five have not been displayed*

Choice	Method	<18	18-19	20-24	25-34	35-44	45+	Total
LARCs	IU Device	*	9	70	138	111	19	351
	IU System	*	*	52	128	300	155	645
	Injectable Contraceptive	75	82	168	124	109	54	612
	Implant	215	160	271	211	95	27	979
	Total LARCs	**296**	**259**	**561**	**601**	**615**	**255**	**2,587**
UDM	Oral Contraceptive	279	293	511	400	166	100	1,749
	Male Condom	295	244	354	322	297	318	1,830
	Other	7	*	14	16	6	12	58
	Total UDM	**581**	**540**	**879**	**738**	**469**	**429**	**3,636**

Table 12 shows for residents of Leicestershire and Rutland in 2013, a higher amount of user dependent methods (UDM) were prescribed to residents compared to Long Acting Reversible Contraceptive (LARC) methods. This pattern is apparent throughout all age-bands, apart from those residents aged 35-44 years.

Figure 58 and Figure 59 compares the proportion of each contraceptive method prescribed to residents in Leicestershire, Rutland and England. Of all contraceptive methods prescribed, the main methods of contraception for residents in Leicestershire were 48.1% LARC and 51.9% user dependent method (UDM), 52.8% LARC and 47.2% UDM in Rutland

and 34.2% LARC and 65.8% UDM for residents in England.[58] It can be seen that LCR delivers similar or lower proportions of LARC than the England average in all age groups except for the 35 years and above age group in Leicestershire and the 18-19 and 25-34 year age groups in Rutland. Please note, emergency contraception is not included in the LARC or UDM totals in Table 11 and Figure 58 and Figure 59.

Figure 58: Proportion of LARC prescribed by age group among residents of Rutland, Leicestershire and England: 2013[58]

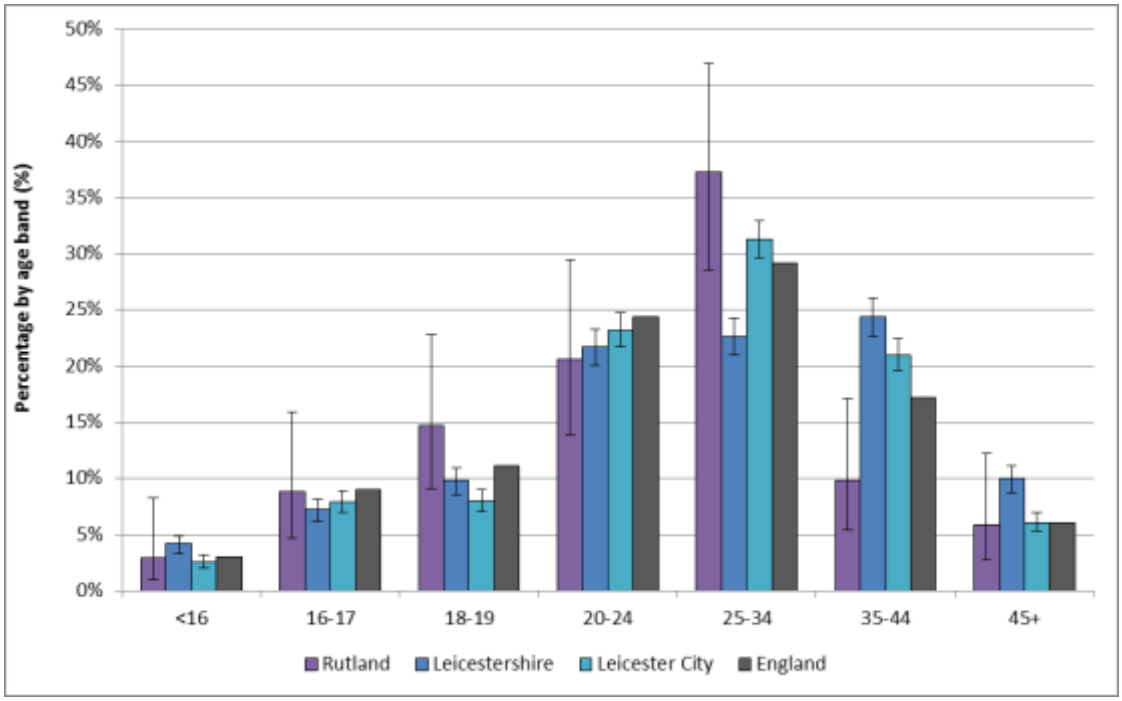
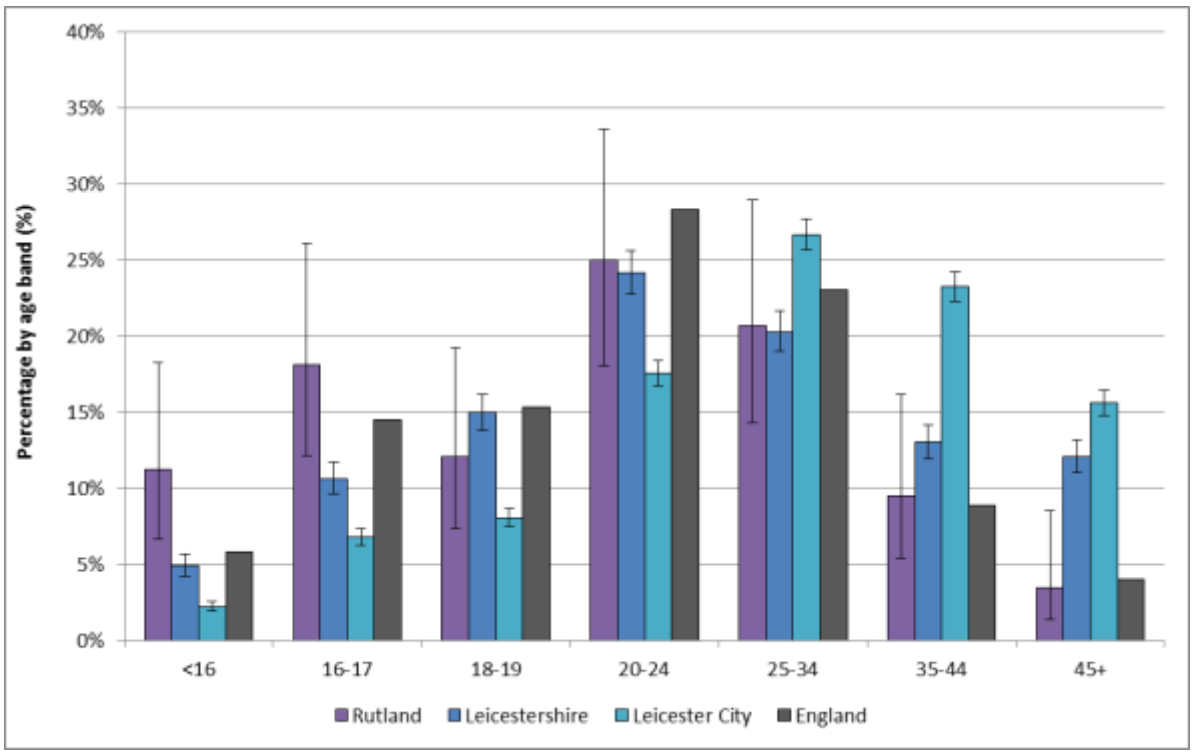


Figure 59: Proportion of UDM prescribed by age group among residents of Rutland, Leicestershire and England: 2013[58]



7.1.2 General practice activity: Prescribing data on contraception provision

Prescribing Analysis and Cost data used in Figure 60 and Figure 61 mainly refers to prescriptions made in general practice, with only 1% of prescriptions being made in other services such as walk in centres, out of hours services, prison prescribing cost centres and others. Care should be taken when interpreting this information as the total number of prescriptions is not representative of the number of women who have received each contraceptive method The data shows the majority of contraception prescribed in primary care settings throughout Leicestershire, Rutland and nationally are UDMs. In Leicestershire, a higher percentage of patients are prescribed LARCs (16.6%) compared to nationally (15.3%), whereas in Rutland, the percentage is smaller (15.0%).[58] It should be noted that these figures are likely to under-represent LARC prescribing as not all devices fitted are via the prescribing route.

Figure 60: Percentage of total contraception prescribed within a primary care setting in Leicestershire: 2013[58]

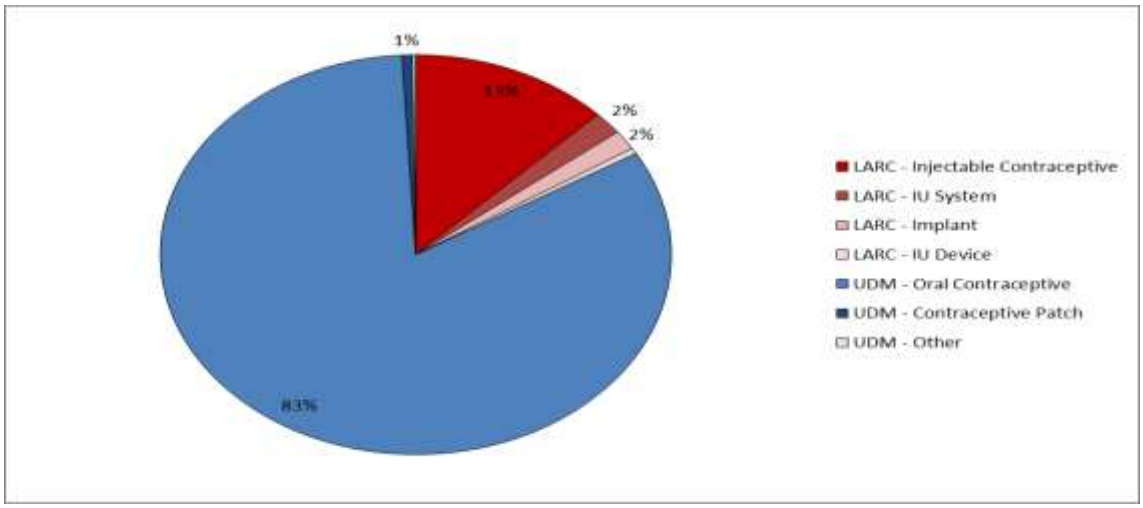
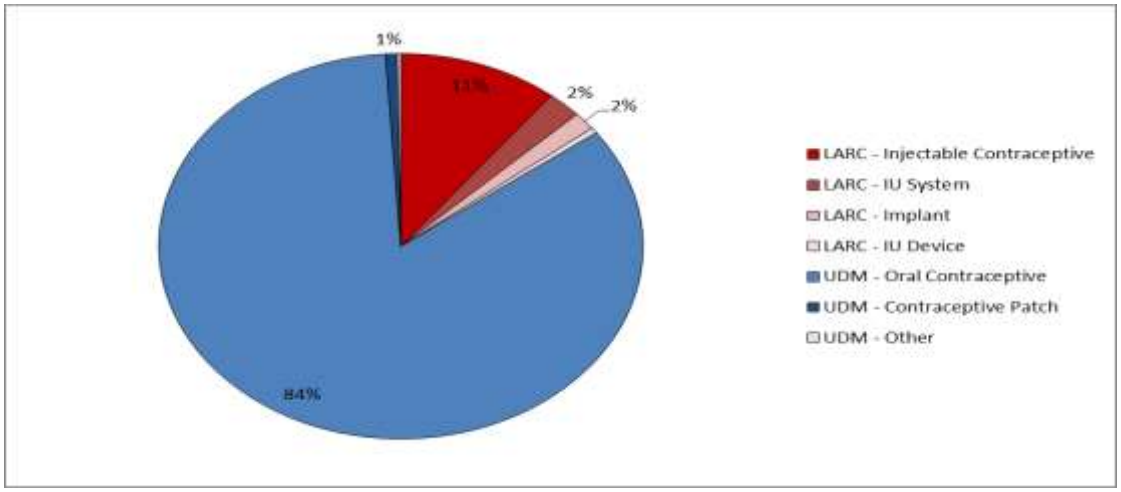


Figure 61: Percentage of total contraception prescribed within a primary care setting in Rutland: 2013[58]



7.1.3 Long acting reversible contraceptives (LARCs)

Long acting reversible contraception (LARC) methods such as contraceptive injections, implants, intra-uterine system (IUS) or intrauterine device (IUD) are more effective as they do not depend on daily concordance. They are also considered to be more cost effective than User Dependent Methods (UDM), and their increased uptake could further help to reduce unintended pregnancy.[71] All currently available LARC methods are more cost effective than the combined oral contraceptive pill even at 1 year of use.. The duration of use is 3 years for the Implant, 3-5 years for the IUS and 5-10 years for the IUD, dependent on the specific device. The injectable contraceptive method requires repeat injection every 8 or 12 weeks dependent on type. LARC methods are suitable for most women. However, for adolescents, the injectable method is only recommended if other methods are unacceptable or not suitable, primarily due to potential effect on bone density in this age group[72]. The rate of LARC prescribed in a primary care setting between 2011 and 2013 is shown in Figure 62. Between these years ,Leicestershire and Rutland have a consistently higher rate of prescribed LARCs compared to national. In 2013, the rate of GP prescribed LARCs in Leicestershire is 61.5 and in Rutland in 76.1 per 1,000 women aged 15 to 44 years, significantly higher than the national rate of 52.7 per 1,000 women aged 15 to 44 years.[57]

It is important to note that this data is derived from prescribing data and will under estimate activity locally as not all LARC devices are via the prescribing route. Some GPs buy implants direct and recharge to the local authority under the Public Health Community Based Services contract arrangements. GPs in the Sexual Health and Contraception Clinic (SHACC) scheme (2011-13) will also not use prescribing route, although this is predominantly GPs located in Leicester City.

Figure 62: Rates per 1,000 women aged 15 to 44 years of LARCs prescribed in general practice for Leicestershire, Rutland and England: 2011 to 2013[57]

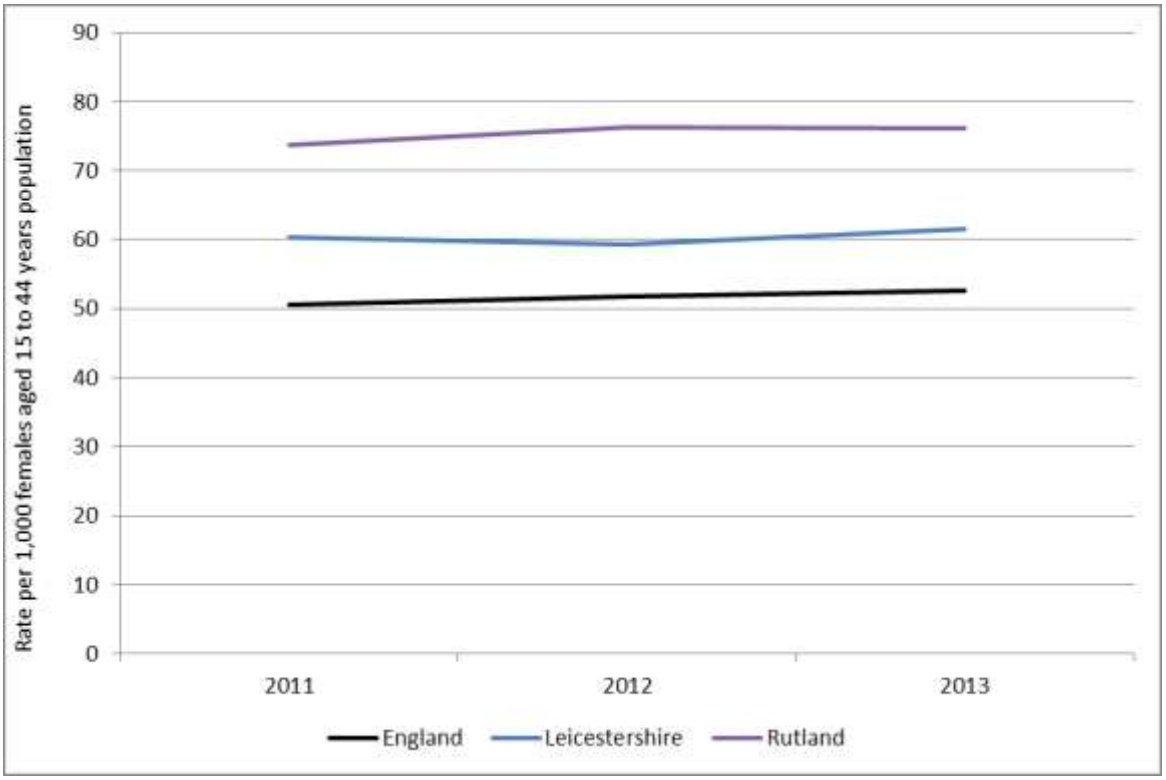
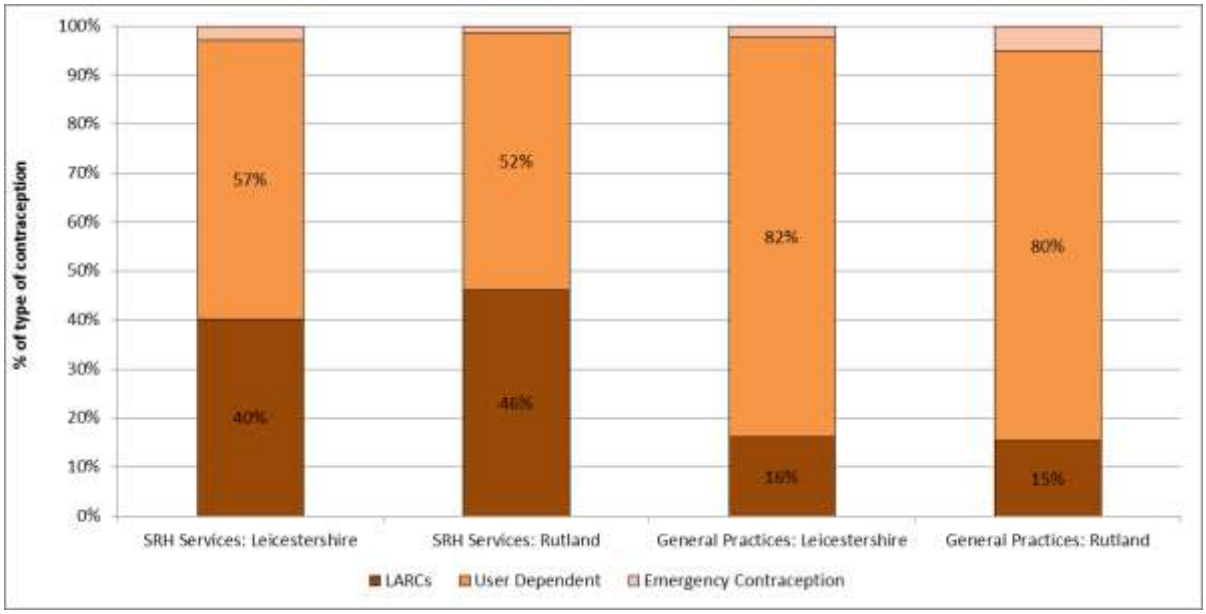


Figure **63** describes the percentage of contraceptives prescribed in general practice versus the percentage of selected contraceptives prescribed in SRH Services. Care should be taken when interpreting this information as this is the total number of prescriptions, this will not be representative of the number of people who have received each contraceptive method. The figure highlights that in SRH services just over half of all contraception prescribed was for user dependent methods. In General Practices, this percentage rose to 80% in Leicestershire and Rutland.[58]

Figure 63: Type of contraception provided by SRH services and general practice in Leicestershire and Rutland: 2013[58]



7.1.3.1 GP LARC provision

From 2013, local authorities have had commissioning responsibility for the provision of IUD, IUS and SDI methods of long-acting reversible contraception (LARC), for contraceptive purposes in primary care. N.B. The IUS is also used for non-contraceptive purposes e.g. control of heavy menstrual bleeding. This is the commissioning responsibility of Clinical Commissioning Groups. The number of fits for this purpose is difficult to determine from available data sources.

Figure 64 examines the provision of IUD/S by GP Practice in Leicestershire and Rutland in 2014/15. Throughout this period there were 2472 IUD/S fits, 2491 Implant insertions and 1903 implant removals. Four GP practices provided over 100 IUD/S. These were Latham House in Melton Mowbray, the Market Harborough Medical Centre, Ashby Health Centre and Rosebery Medical Centre in Loughborough. Figure 65 and

Figure 66 examines the counts of implant insertions and implant removals in the same time period. Latham House in Melton Mowbray has the highest counts of both insertions and removals throughout the county and Rutland. Of 72 GP practices proving implants via the Local Enhanced Services, only 6 removed more implants than they provided.

Specialist training is required before doctors and nurses can undertake IUD/S and SDI fitting and removal. Audit details relating to LARC fitting in primary care in 2014/15 have been received from 101 practitioners undertaking IUD/S procedures and 98 practitioners undertaking Implant provision. The audit returns are currently incomplete. However, the returns identified that approximately 60% of practitioners hold a national Faculty of Sexual & Reproductive Health Letters of Competence for LARC procedures. Work is in progress to identify training options to maintain good access to LARC methods from primary care.

Figure 64: Counts of Provision of IUD/S by GP Practice, Leicestershire and Rutland, 2014/15

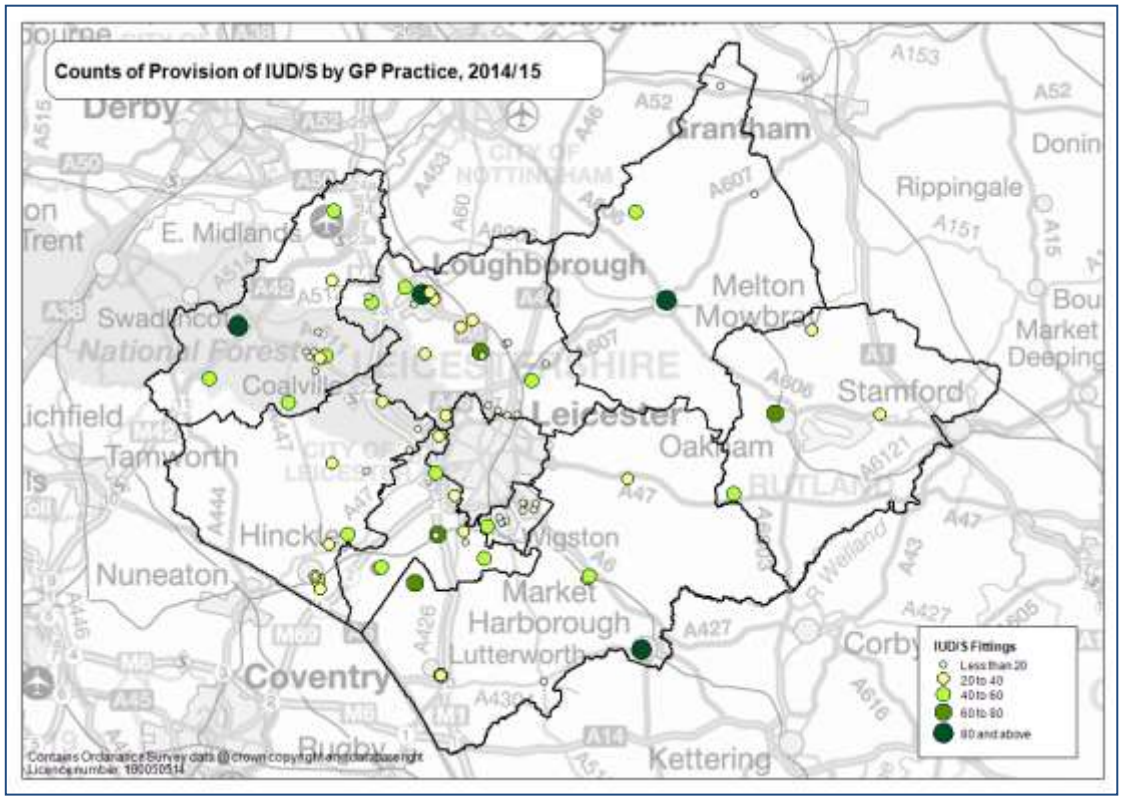


Figure 65: Counts of Implant Insertions by GP Practice, Leicestershire and Rutland, 2014/15

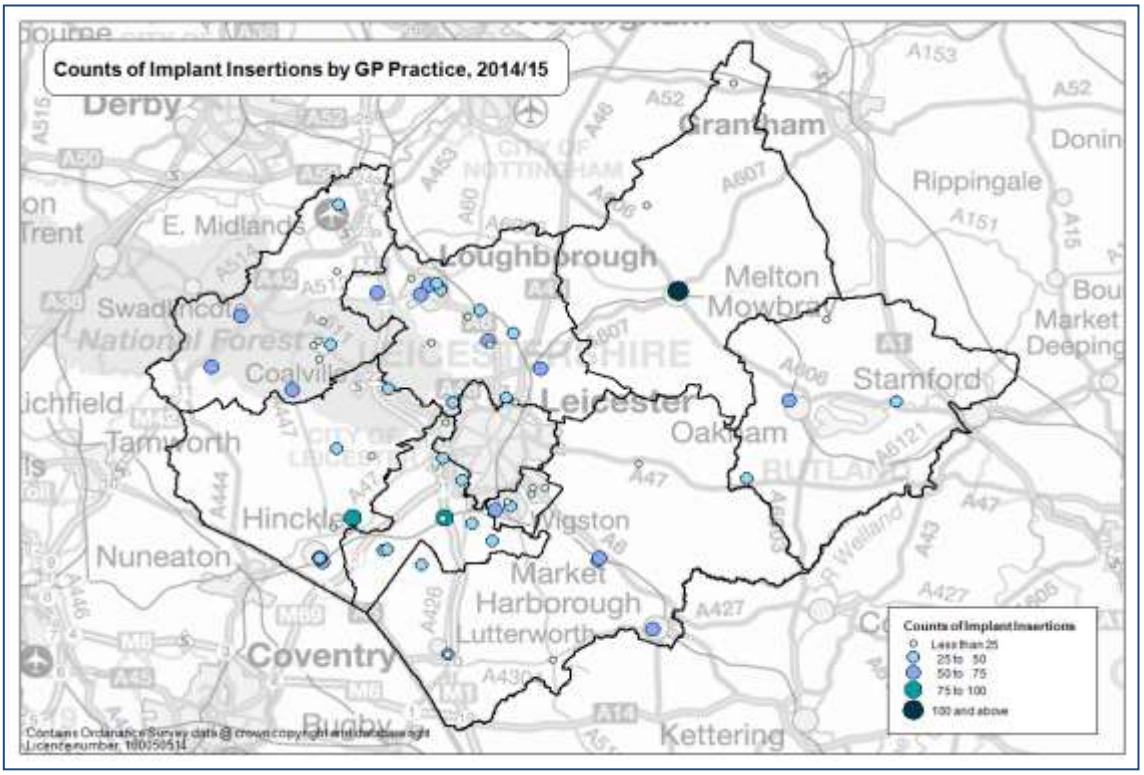


Figure 66: Counts of Implant Removals by GP Practice, Leicestershire and Rutland, 2014/15

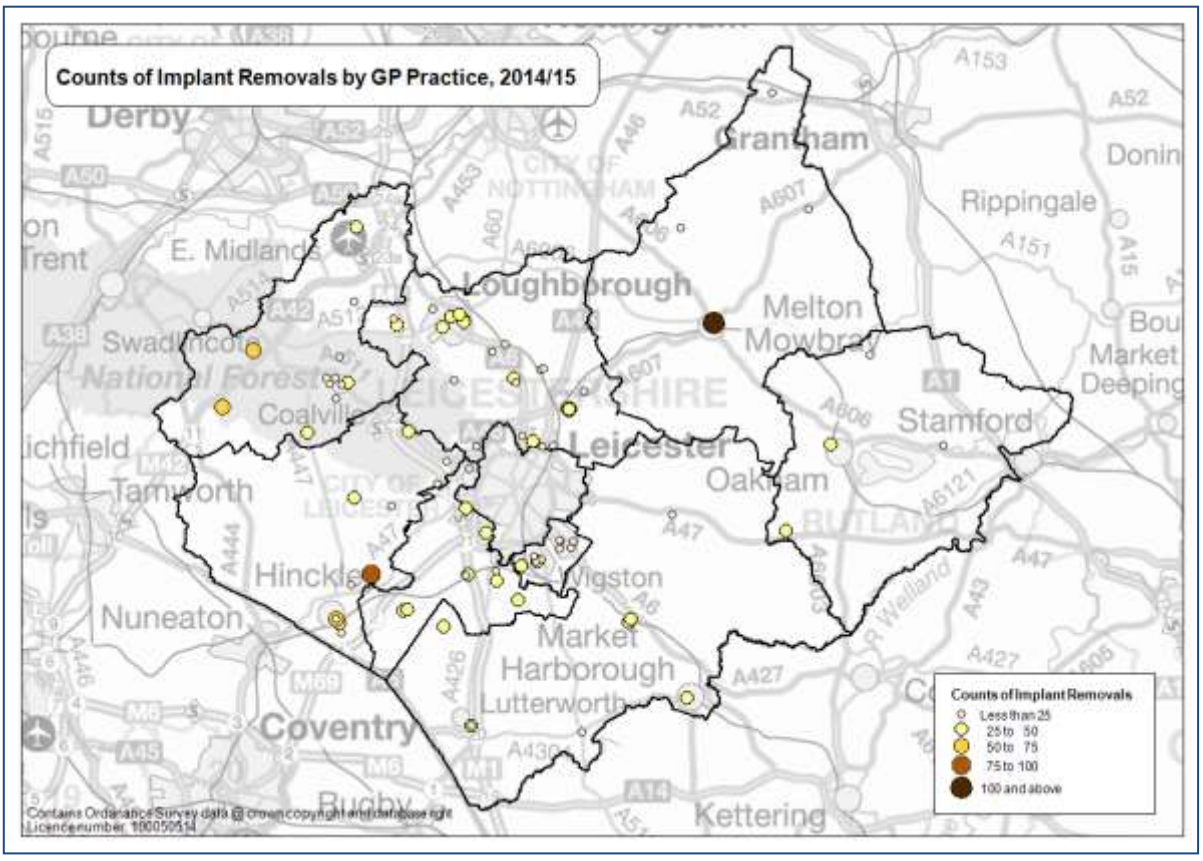


Figure 67: Counts of Local Enhanced Services in Leicestershire, 2013/14-2014/15[62]

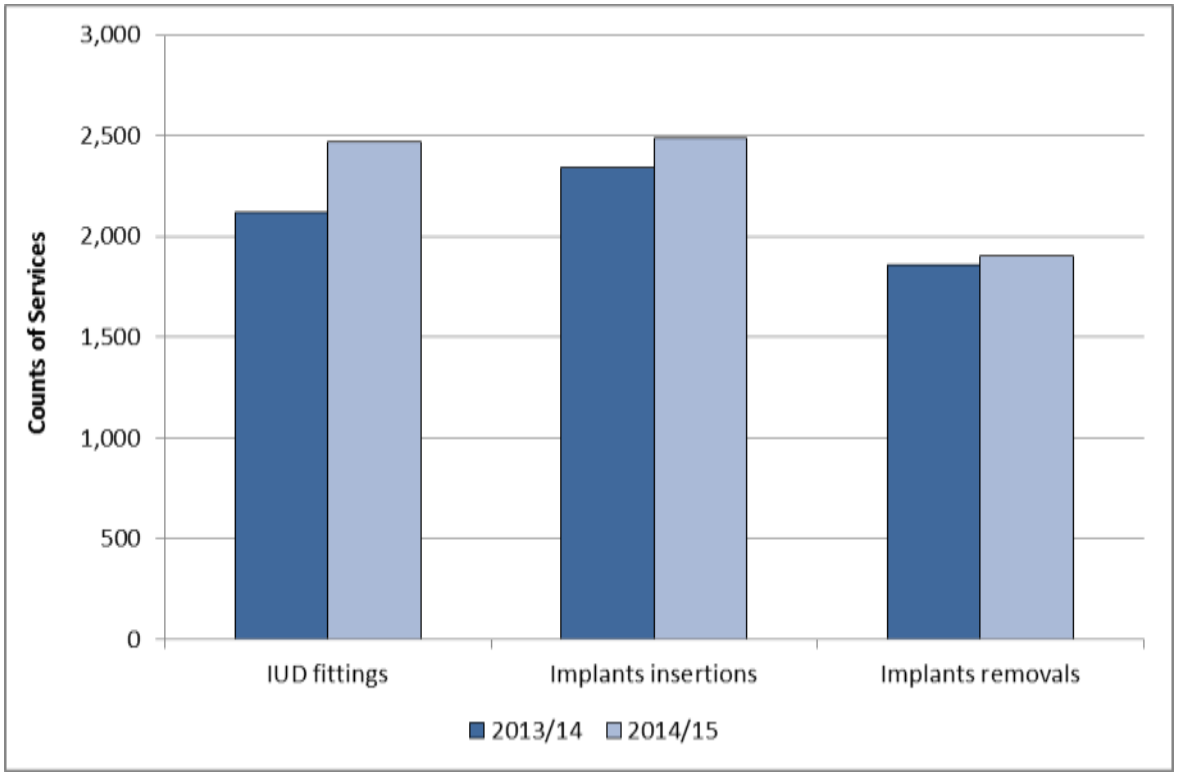
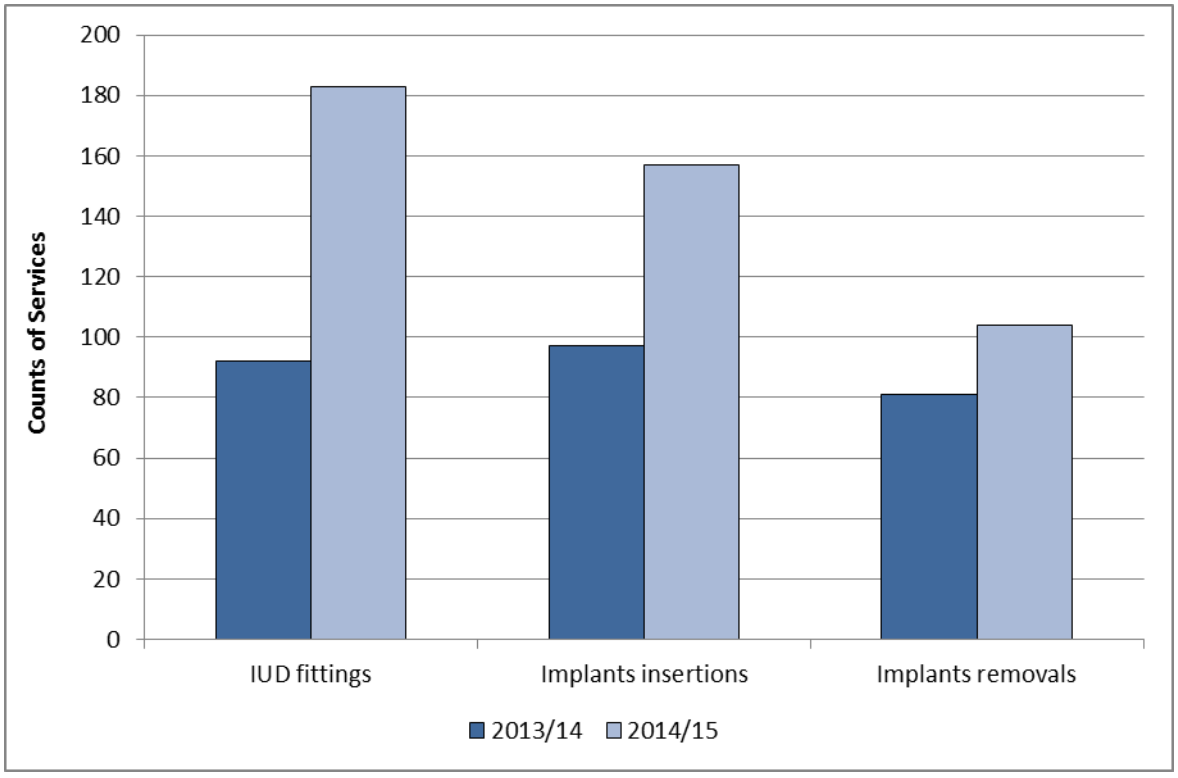


Figure 68: Counts of Local Enhanced Services in Rutland, 2013/14-2014/15[62]



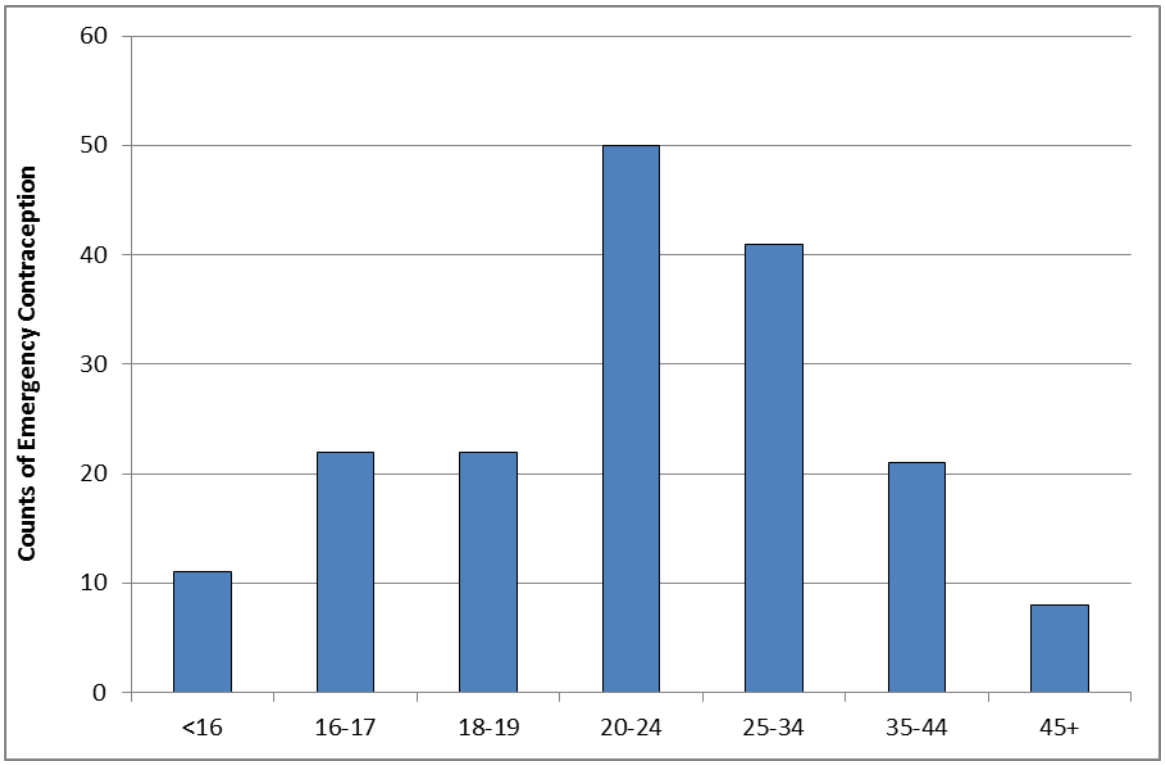
7.1.4 Emergency contraception

Emergency contraception (EC) is used to reduce the risk of pregnancy following unprotected intercourse or contraceptive failure. There are two types of emergency contraception available; emergency hormonal contraception (EHC) and non-hormonal (IUD). EHC is

sometimes known as the 'morning-after pill'. Taking emergency hormonal contraception within a window of time following unprotected sexual intercourse (UPSI) can help prevent pregnancy. Levonogestrel (LNG) is licensed for use within 72 hours of UPSI or contraceptive failure; Ulipristal Acetate (UPA) is licensed for use within 120 hours of UPSI or contraceptive failure. There is some evidence that increasing access to UPA is cost effective[73]. However the most effective form of Emergency contraception is the Cu IUD which has the lowest documented failure rate[74]. All forms of EC are available from the ISHS and from those general practices commissioned to provide IUDs. To improve access to EC, Leicestershire and Rutland County Councils have commissioned community pharmacies to provide LNG free of charge for under 25s. LNG is also available to purchase from Pharmacies. Data relating to EHC bought over the counter at Pharmacy and supply of EC from primary care is not available and is therefore not included in this report. Data from SRH services provides information on both emergency contraceptive pills and emergency IUD.

In 2013, 173 women resident in Leicestershire and Rutland were prescribed emergency contraception at SRH services. The figure below describes emergency contraception by age group and residency in Leicestershire. It shows in 2013, emergency contraception was prescribed to patients aged 20 to 34 years most frequently.[58]

Figure 69: Emergency contraception by age group, among female residents in Leicestershire attending SRH Services, 2013[58]



7.1.4.1 EHC provision in Pharmacy

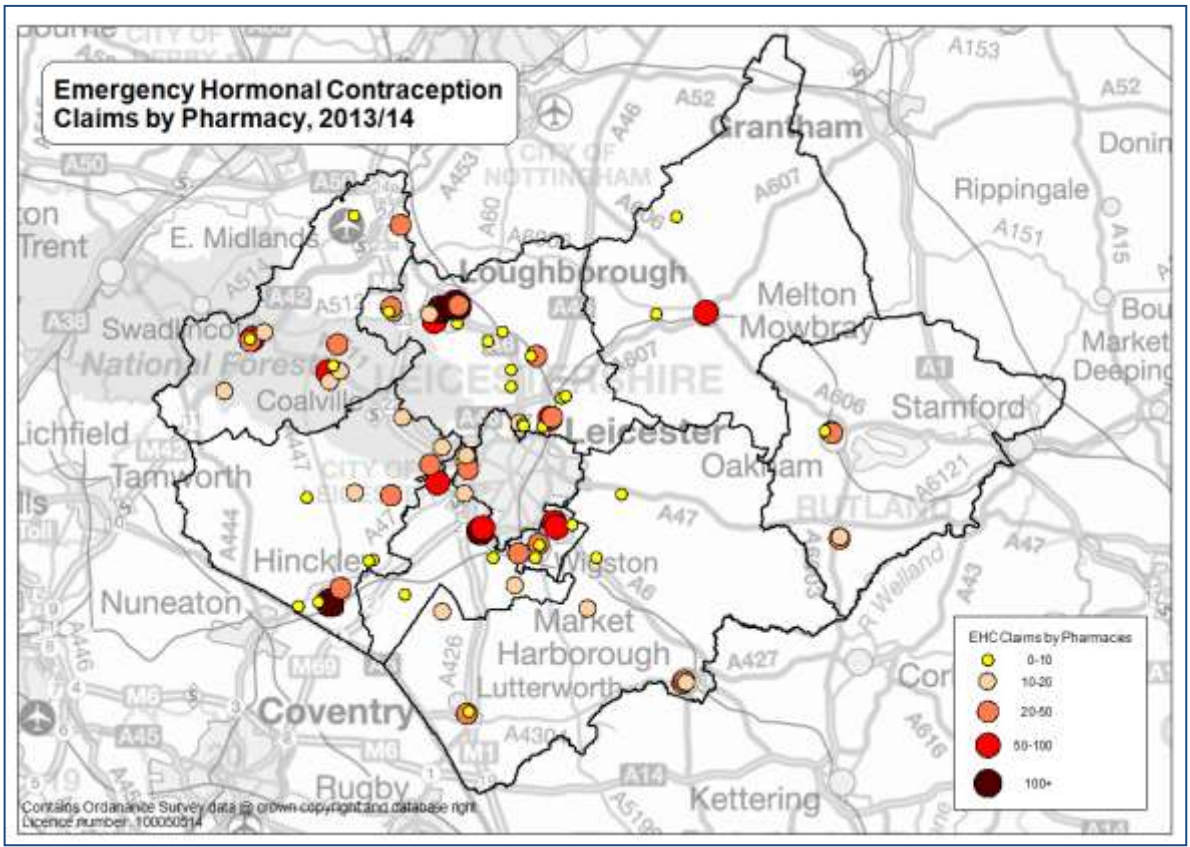
Pharmacy contractors are required to provide an essential set of services and may choose to provide one or more advanced services. Before 1 April 2013 Primary Care Trusts (PCTs) commissioned enhanced services from pharmacy contractors in line with the needs of their population. From 1 April 2013 those public health enhanced services previously commissioned by PCTs transferred to local authorities. The remaining enhanced services may be commissioned by NHS England. The commissioning of Emergency Hormonal Contraception (EHC) services through patient group directions now lies under the responsibility of the local authority.

Pharmacists will supply levonorgestrel (LNG) 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 and 25 years. Those aged 16 years or under may be supplied levonorgestral 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.

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 70 and Figure 71 shows the number of EHC claims by pharmacies in 2013/14 and 2014/15 in Leicestershire and Rutland. The Medicine Box in Loughborough Student Union had the highest number of EHC claims in 2013/14 and 2014/15, increasing from 381 claims in 442 throughout this time. Over both years, the three Pharmacies with the highest volume of EHC consultations in Leicestershire and Rutland occurred in the Loughborough area, likely due to the university site in this location with a high population at risk. Three other pharmacies in Leicester, Thurmaston and Oadby had over 100 EHC claims in 2014/15.[75]

Figure 70: Claims of Emergency Hormonal Contraception by Pharmacy Location,



2013/14[75]

Figure 71: Claims of Emergency Hormonal Contraception by Pharmacy Location, 2014/15[75]

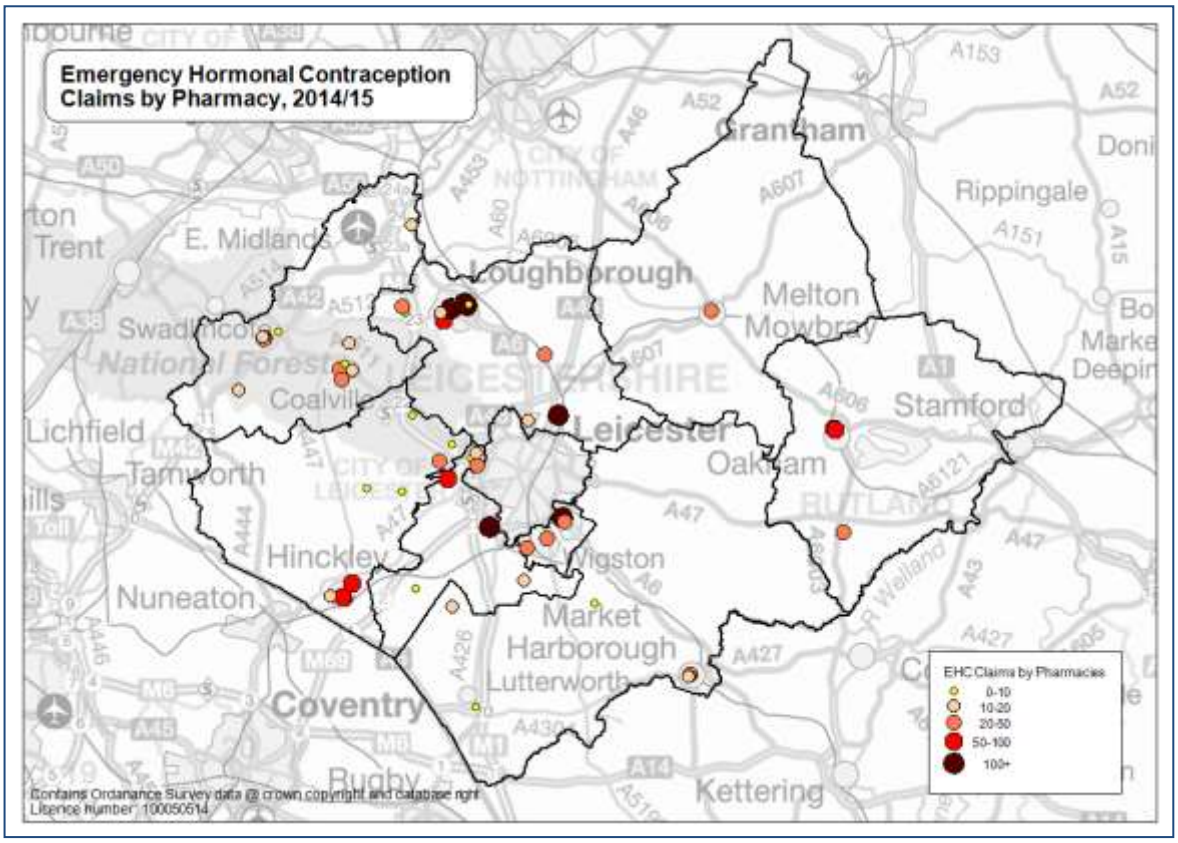


Figure 72 shows in 2014/15, the majority of EHC consultations occur with females aged 19 years and above and 16% of all consultations were with females aged between 16 to 18 years. In this year, 5% of consultations occurred between females aged under 16, accounting for 124 consultations.

Figure 73 examines the ethnic make-up of those using EHC in Leicestershire and Rutland. 79% of all EHC consultations in 2014/15 occurred with females from the white ethnic group. Asian and/or Asian British females made up 9% of all consultations, higher than the percentage of the Asian population in Leicestershire (6%).

Figure 74 shows in 2014/15, almost half (46%) of all requests for Levonelle was due to a split condom, followed by 40% due to using no contraception. These counts and percentages are similar as in 2013/14.

Figure 75 and

Figure 76 shows a higher percentage of females were signposted to pregnancy sites and referred to the Sexual Health Service in 2014/15 compared to 2013/14.[75]

Figure 72: Counts of EHC Consultations by Age in Leicestershire and Rutland[75]

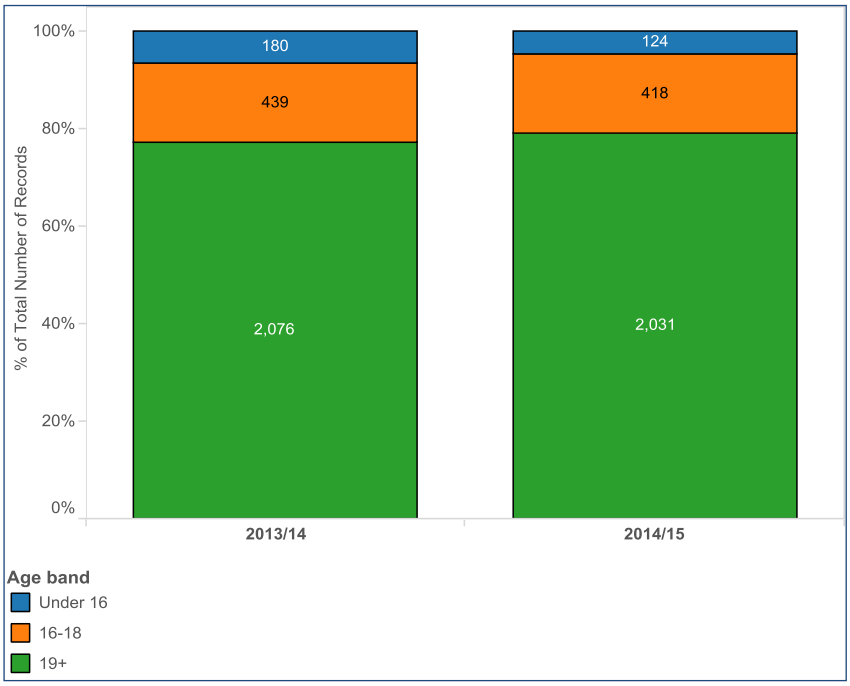


Figure 73: Percentage of EHC Consultations by Ethnicity in Leicestershire and Rutland, 2014/15[75]

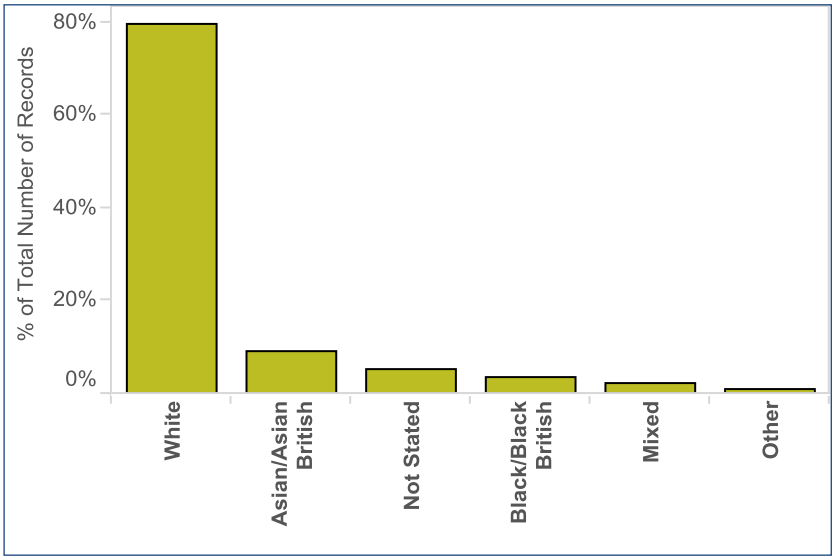


Figure 74: Percentage of EHC Consultations supplied with Levonelle by Reason of Request in Leicestershire and Rutland[75]

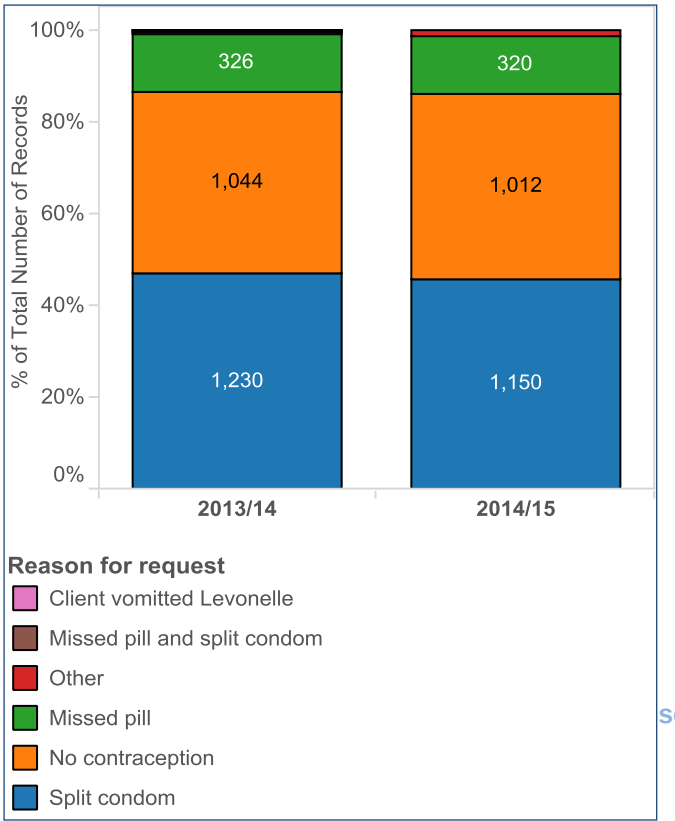


Figure 75: Percentage of EHC Consultations Signposted to Pregnancy Sites in Leicestershire and Rutland[75]

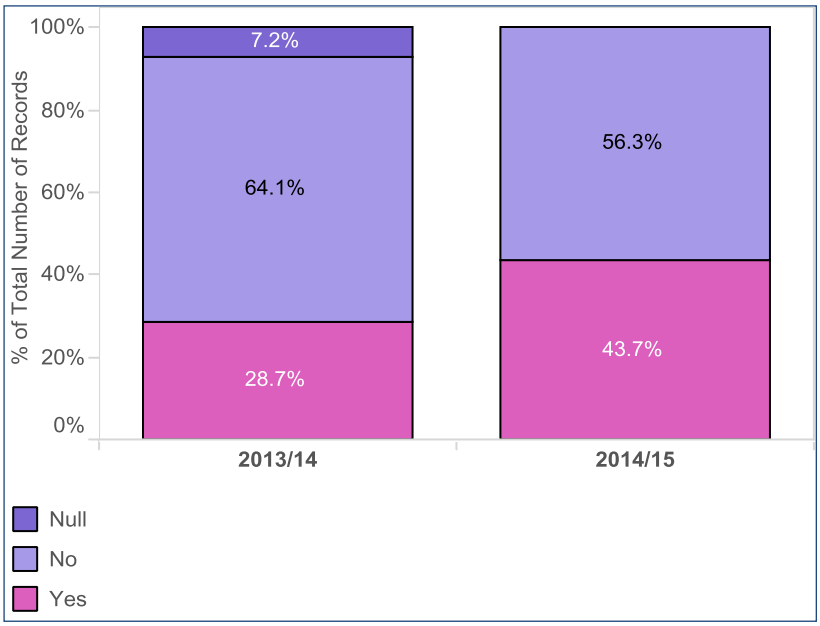
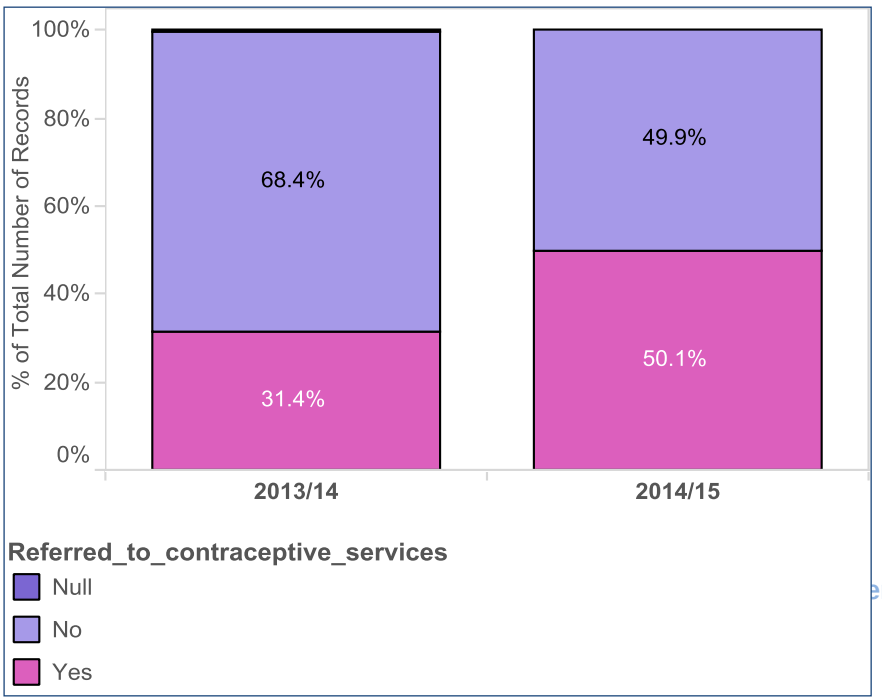


Figure 76: Percentage of EHC Consultations Referred to the Sexual Health Services in Leicestershire and Rutland[75]



7.2 Psychosexual/ sex addiction

Psychosexual counselling service is available as part of the ISHS. The service is referral only from general practice and covers the following sexual health aspects of psychosexual conditions:

- Lack/Loss of libido
- Non-consummation
- Orgasm problems
- Vaginismus
- Dyspareunia
- Erectile dysfunction, ejaculatory problems and other penile problems such as pain and anxiety

In Leicestershire there were 101 referrals in 2014 and 83 to date in 2015. There have been no referrals for Rutland residents.

Table 13: Psychosexual Counselling Referrals in Leicestershire 2014 & 2015 (January to September)

Reason for referral	2014	2015 (9 month part year)
Early Ejaculation	0	3
Erectile Dysfunction	43	28
Loss of Sexual Interest - Female	1	1
Loss of Sexual Interest - Male	1	1
Orgasmic Dysfunction	1	1
Other - Female	1	2
Other - Male	0	2
UNKNOWN	1	1
Vaginsmus/Dyspareunia	53	44
TOTAL	101	83

The Natsal-3 sexual attitudes and lifestyles in Britian survey (2010-12) indicated that sexual difficulties were common, even in young people. 51% of men and 42% of women surveyed experienced one of more sexual difficulties lasting more than three months in the past year, including lack of interest in having sex, feeling anxious during sex, pain during sex, vaginal

dryness and problems getting or keeping an erection[76]. There is potential for an increase in service demand due to current unmet demand, increased need as the local population ages and increased awareness of the service offer.

A small number of referrals have related to sex addiction which requires specialist mental health treatment. There is currently a lack of such service provision in LCR.

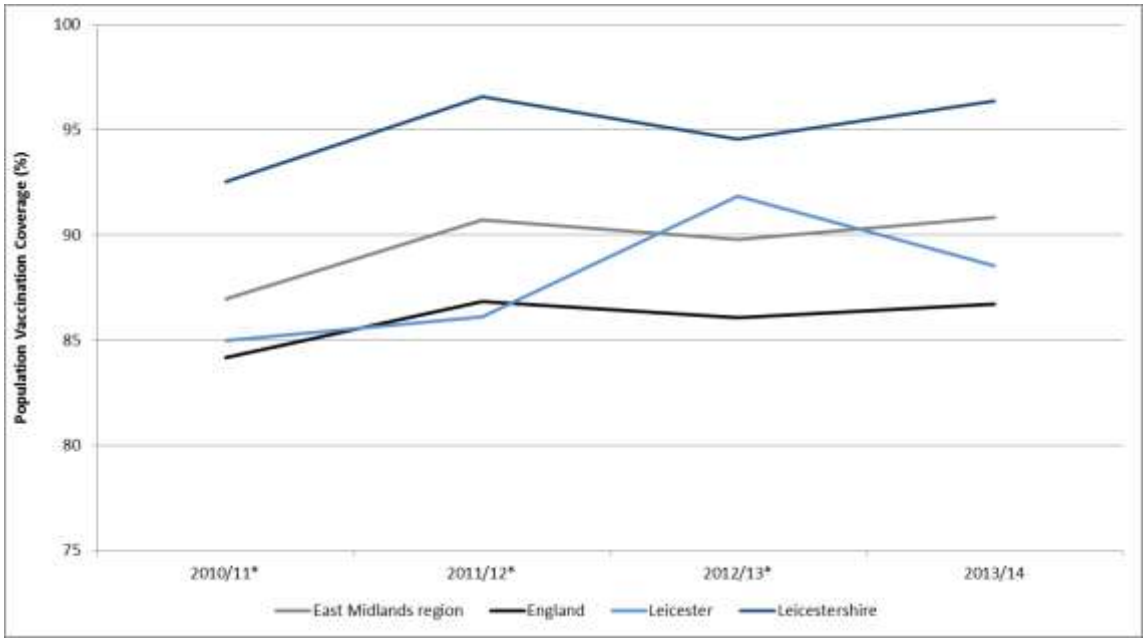
7.3 HPV Vaccination

The Human Papillomavirus (HPV) is a virus that infects the deepest layer of the skin or genital surfaces. Infection with a high-risk type of HPV is detected in the vast majority of cervical cancers and is understood to be necessary for the development of cervical cancer. The HPV vaccine protects against the two high-risk HPV types, HPV 16 and HPV 18, which cause over 70% of cervical cancers.

Vaccination coverage is the best indicator of the level of protection a population will have against vaccine preventable communicable diseases. Coverage is closely correlated with levels of disease. Monitoring coverage identifies possible drops in immunity before levels of disease rise. In the UK, all 12-13 year old girls (school year 8) are offered HPV vaccination through the national HPV immunisation programme.

Figure 77 shows the population vaccination coverage of HPV in Leicestershire has remained higher than the East Midlands and national average from 2010/11. In 2013/14, 96.4% of all 12-13 year old girls in Leicestershire were vaccinated for HPV.

Figure 77: Trend of population vaccination coverage of HPV in Leicester, Leicestershire and Rutland



**Value for Leicestershire and Rutland combined*

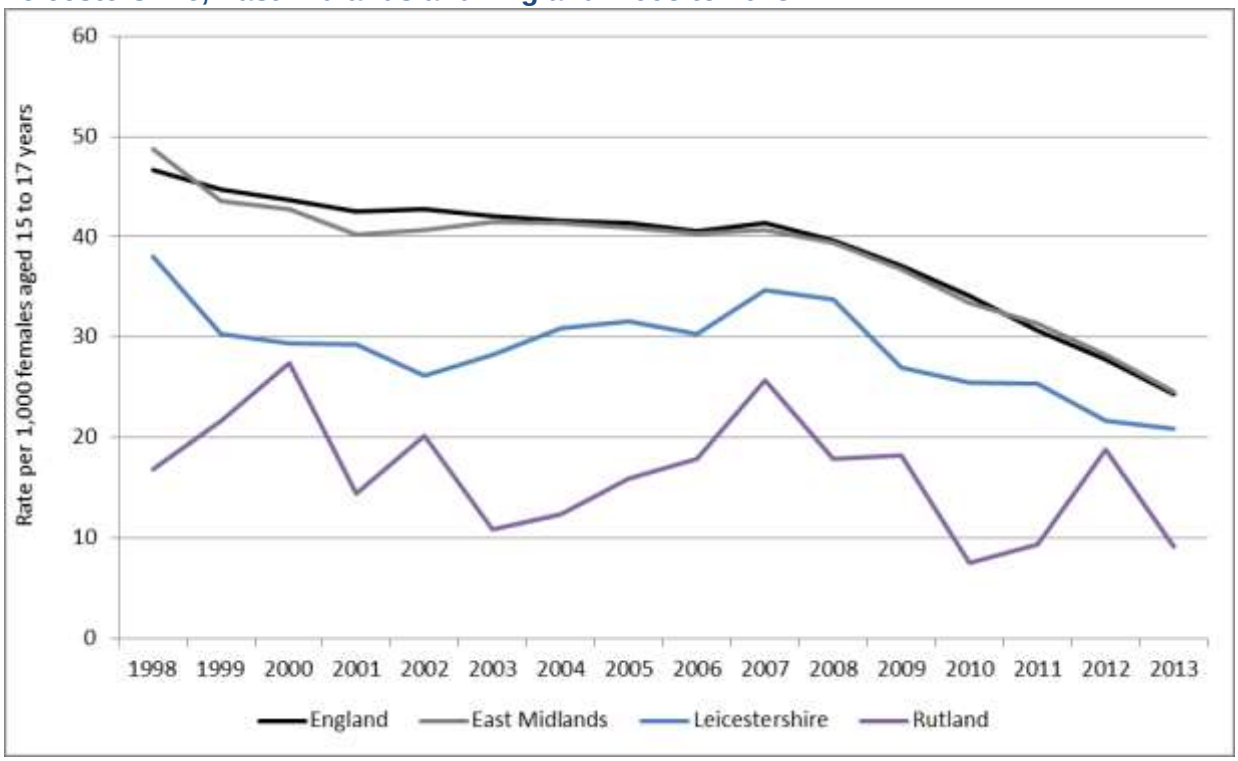
N.B. Until September 2015, the ISHS completed some cervical cytology in women choosing not to access their GP. In 2014 the service completed 135 screens of Leicestershire and 9 in Rutland. As of September 2015 no further screens were completed for LCR.

7.4 Teenage Pregnancy

In 2013, the under 18 conception rate per 1,000 female aged 15 to 17 years was 20.9 in Leicestershire and 9.2 in Rutland, while in England the rate was 24.3. Between 1998 and 2013, Leicestershire achieved a 45.0% reduction in the under 18 conception rate and in Rutland, a 45.6% reduction. Nationally the rate reduced by 47.9% throughout this time. As Figure 78 shows, since the baseline, the rate of teenage pregnancies in both Leicestershire and Rutland has remained consistently better than the national and regional rate.[57]

Of those females who conceived under the age of 18, the proportion of those leading to abortion in Leicestershire was 56.1%, higher than the national percentage of 51.1%. Please note, no data not available for Rutland due to small numbers.[57]

Figure 78: Under 18 conception rates per 1,000 females aged 15 to 17 years, in Leicestershire, East Midlands and England: 1998 to 2013[57]



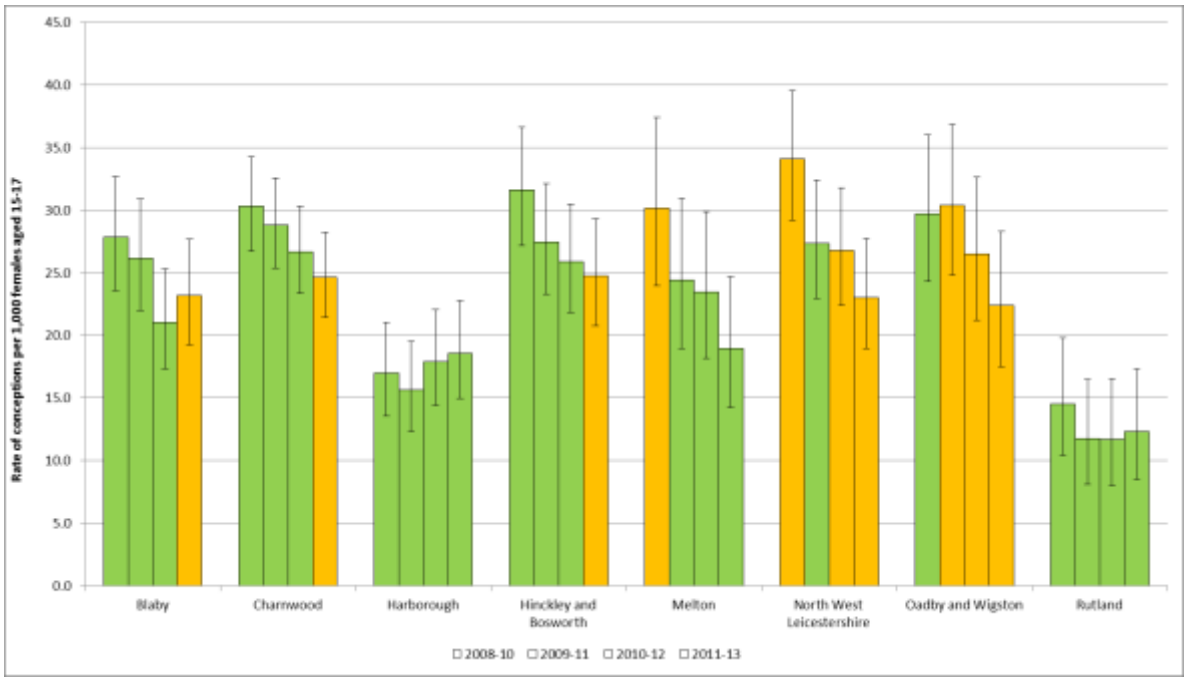
7.4.1 District level data

The district level data in Leicestershire and the data for Rutland is open to fluctuations due to the small numbers involved so three year aggregates have been used to smooth any instabilities. Figure 79 shows over the four time periods examined, all Leicestershire districts, with the exception of Harborough, follow a downward trend in under 18 conceptions rate. It must be noted that Harborough has the consistently lowest rate over time of all Leicestershire districts.

Between 2011-2013, the highest rate in Leicestershire was seen in Hinckley and Bosworth (24.8 per 1,000 population) and the lowest in Harborough (18.6 per 1,000 population). Three districts in Leicestershire saw an increase in their conception rate between 2010-12 and 2011-13. Blaby rose from 21.0 per 1,000 15-17 aged females in 2010-12 to 23.2 per 1,000 in 2011-13, while Harborough increased from 17.9 to 18.6 per 1,000 aged 15-17 females. All other districts decreased in their rate over this time period. In Rutland, the rate of under 18 conceptions has remained consistently lower compared to all Leicestershire districts over time. Rutland saw an increase in their conception rate 11.7 per 1,000 15-17 aged females in 2010-12 to 12.3 per 1,000 in 2011-13.[77]

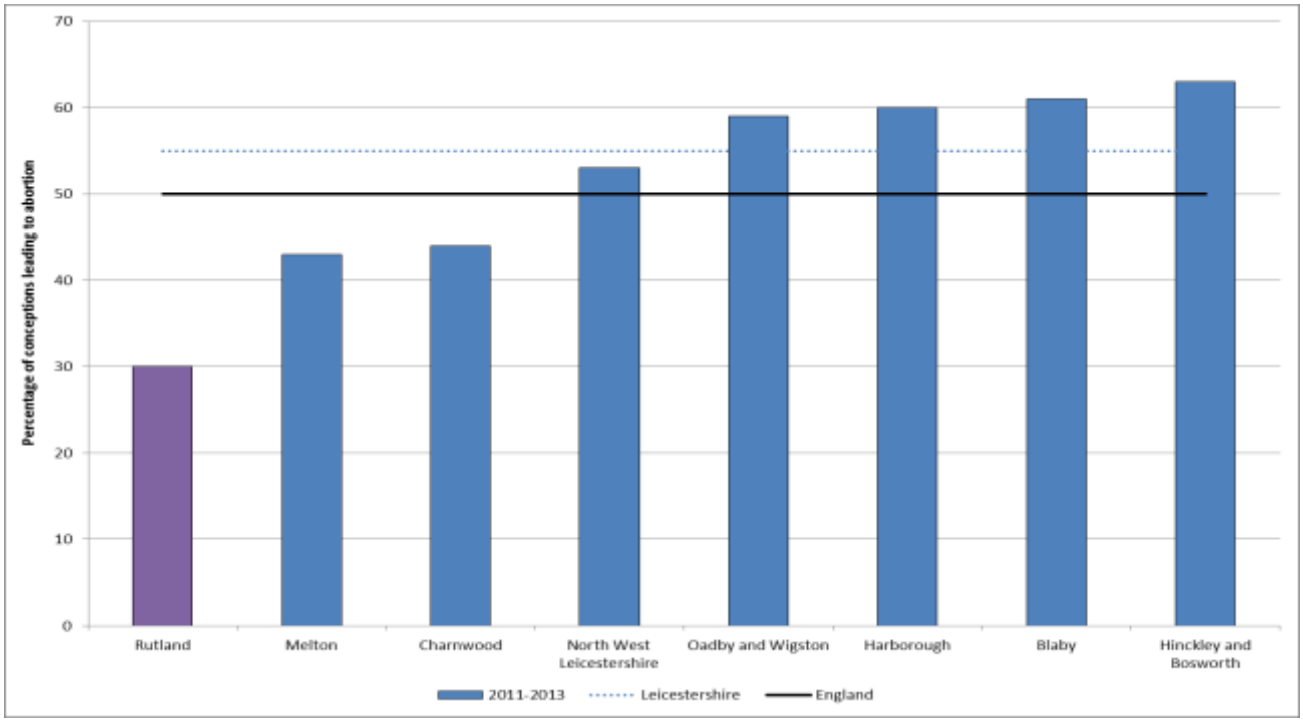
Figure 80 examines the percentage of under 18 conceptions that led to abortions between 2011-13. Throughout this period, Leicestershire had a higher percentage of under 18 abortions (55.0%) compared to the national percentage (50.0%). In the county, Hinckley and Bosworth have the highest percentage leading to abortions (63.0%) and Melton the lowest (43.0%). Five districts in Leicestershire have a higher percentage of abortions than the national average, with only the percentage in Charnwood and Melton lower. Since 2008-10, Rutland has witnessed a year on year decrease in the percentage leading to abortions from 50.0% in 2008-10 to 30.0% in 2011-13.[77]

Figure 79: Three year aggregates of under 18 conception rates per 1,000 females aged 15 to 17 years in Leicestershire districts and Rutland with statistical significance compared to the England average [77]



Green – significantly lower to the England average
Amber – no significant difference to England average
Red – significantly higher to the England average

Figure 80: Three year aggregate of percentage of under 18 conceptions leading to abortion in Leicestershire district and Rutland, 2011-13[77]



7.4.2 Ward level data

Between 2010-12, two wards in Leicestershire had a rate of under 18 conceptions significantly higher than the national average. These are Loughborough Hastings and Loughborough Lemyngton wards. Improvements have been made at ward level in Leicestershire since 2009-11 where five wards had rates significantly higher than the national average.[78]

To determine local hotspots, the ward level data was compared to the Leicestershire average, to examine areas which were higher or lower than the county rate. Throughout Leicestershire, 11 wards had a significantly higher rate than the Leicestershire average, these are displayed in

Figure 82. These include one ward in Blaby, three wards in Charnwood, one ward in Harborough, two in Hinckley and Bosworth, one in Melton, one in North West Leicestershire and two in Oadby and Wigston. Please note a majority of the wards in the county have their data suppressed due to small numbers.[78]

Figure 81: Significance of under 18 teenage pregnancy ward rates compared to England average, 2010-12[78]

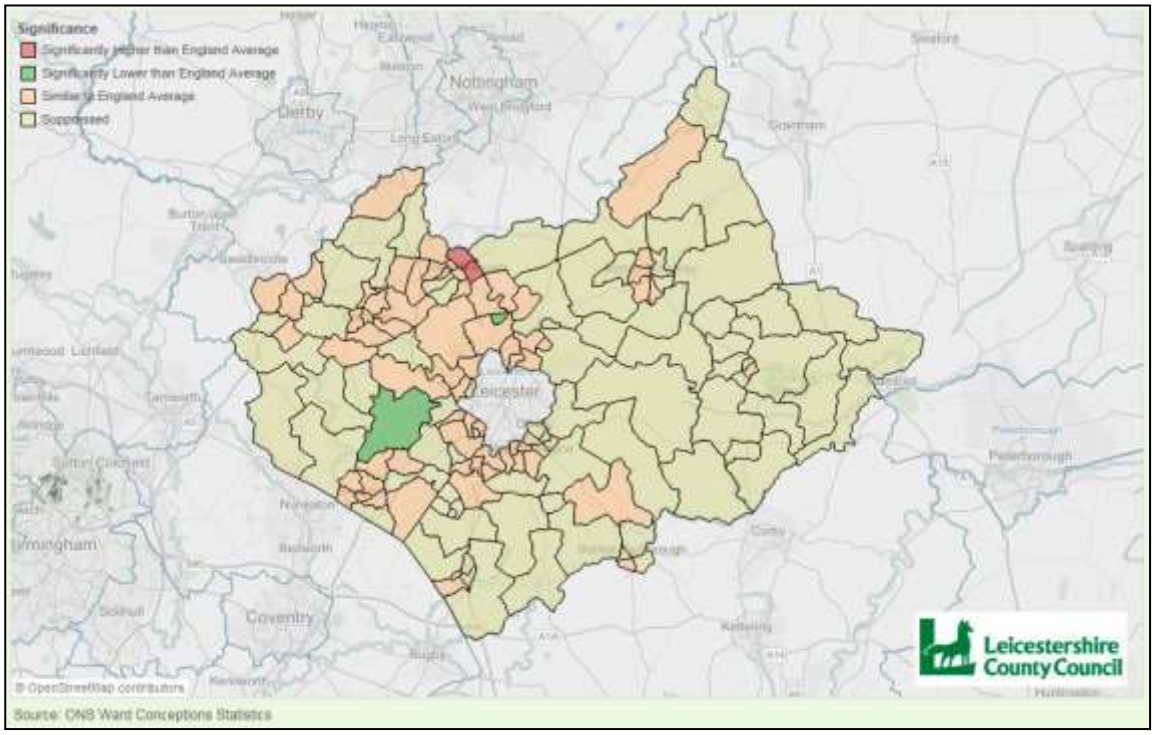
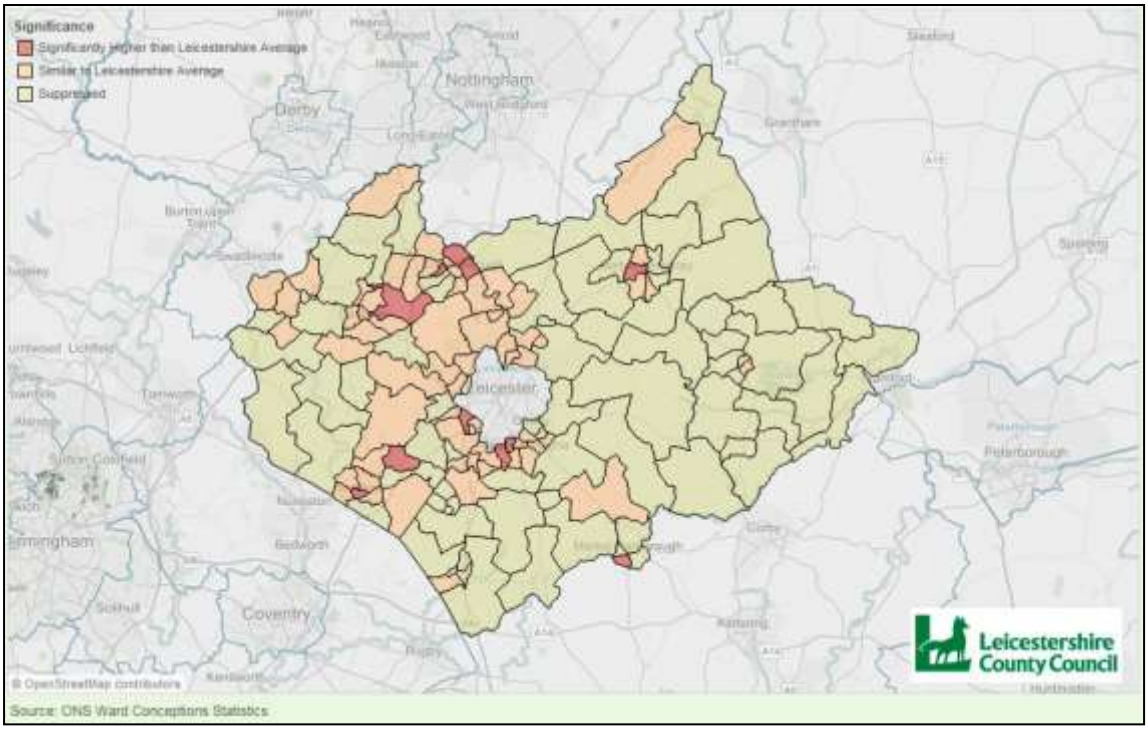


Figure 82: Significance of under 18 teenage pregnancy ward rates compared to Leicestershire average, 2010-12[78]



7.4.3 Births

The Office of National Statistics holds the data on birth registrations in the United Kingdom by usual area of residence of the mother. Counts of live births can be examined by the age of mother at birth. In Leicestershire, the latest data for 2013 shows there were 69 births in county where the mother was aged under 18 years. This count has decreased from 2010, where there were 87 births from teenage mothers in Leicestershire. Table 14 shows that Charnwood has the highest counts of under 18 births in the county, making up 43% of all under 18 births in Leicestershire in 2013. Please note for the majority of the districts, small numbers are involved so fluctuations are likely.[79]

Table 14: Count of live births by administrative area of usual residence where mother age is under 18[79]

	2010	2011	2012	2013
Leicestershire	**87**	**85**	**73**	**69**
Blaby	8	11	7	6
Charnwood	35	23	23	30
Harborough	*	9	9	6
Hinckley and Bosworth	14	11	14	4
Melton	6	8	5	9
North West Leicestershire	12	14	6	9
Oadby and Wigston	*	9	9	5
Rutland	**3**	*****	**5**	**5**

Figure 83 examines the percentage of births where the mother is aged under 18 years. Nationally, the percentage of under 18 births have decreased year on year from 2010, whereas in Leicestershire, a decrease was seen between 2010 and 2012. In 2013, 1.0% of all live births in Leicestershire were born to mothers aged under 18 years, similar to the

national percentage of 1.1%. Figure 84 shows the percentage of live births aged under 20 years have decreased year on year, both locally and nationally since 2010. In 2013, 3.5% of all live births in Leicestershire were born to mothers aged under 20 years, significantly lower than the national percentage of 4.1%.[79]

Figure 83: Percentage of live births where the mother is aged under 18 years, Leicestershire[79]

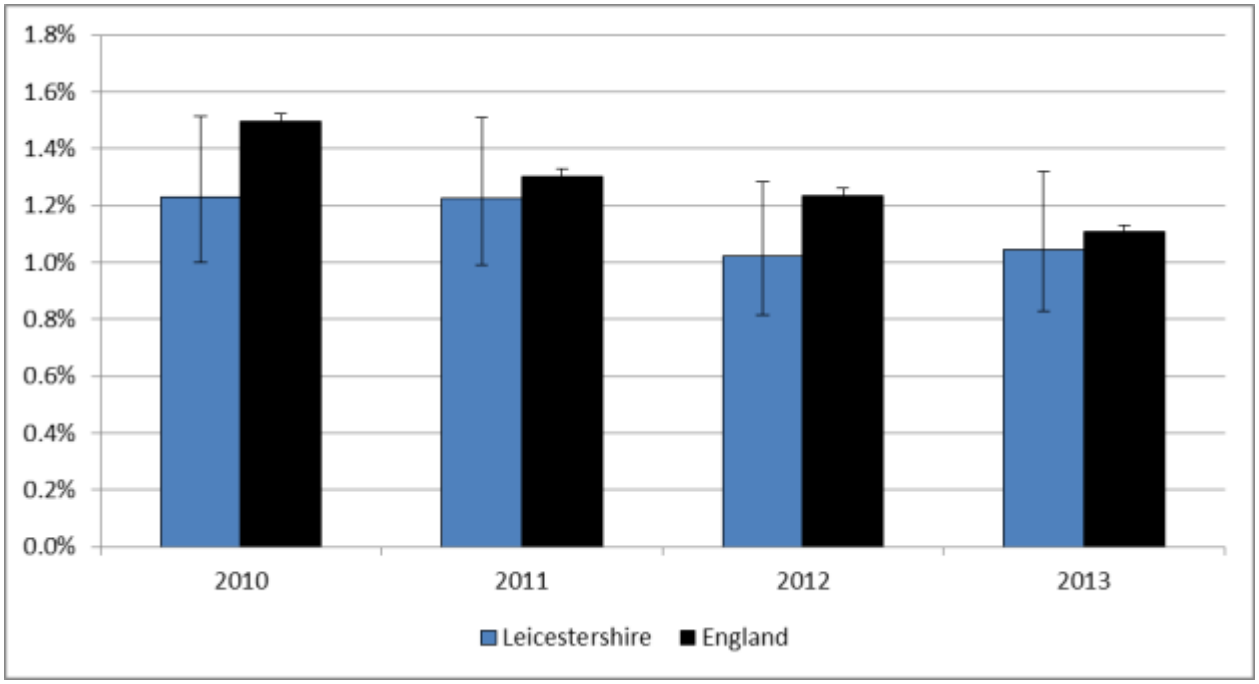
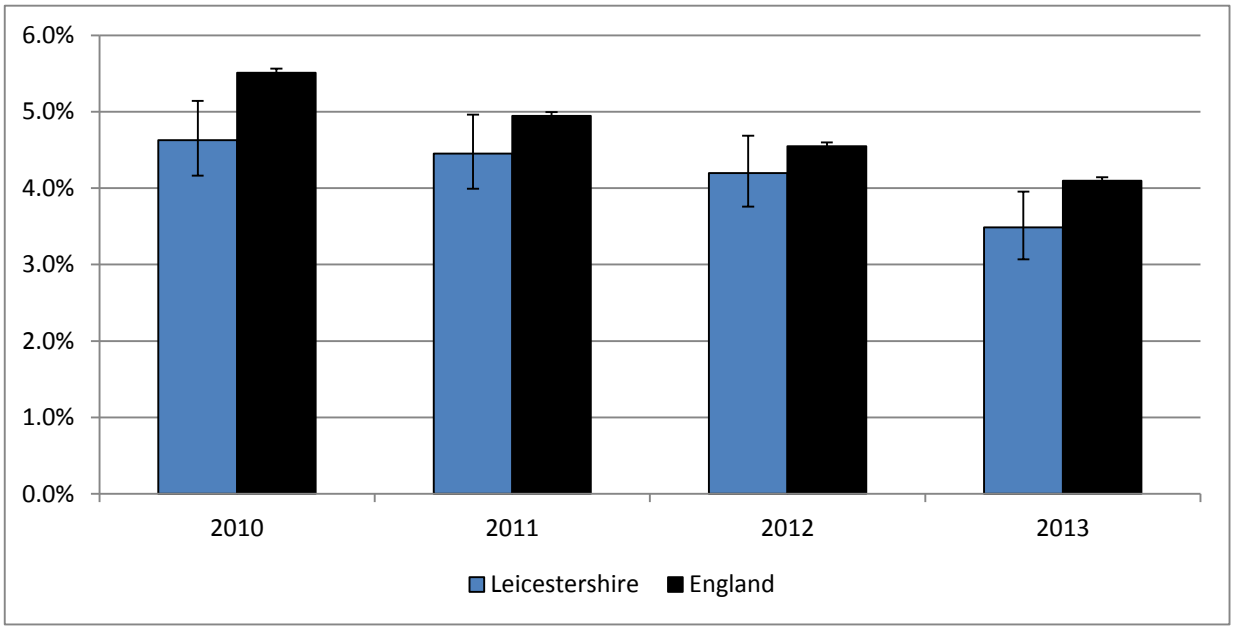


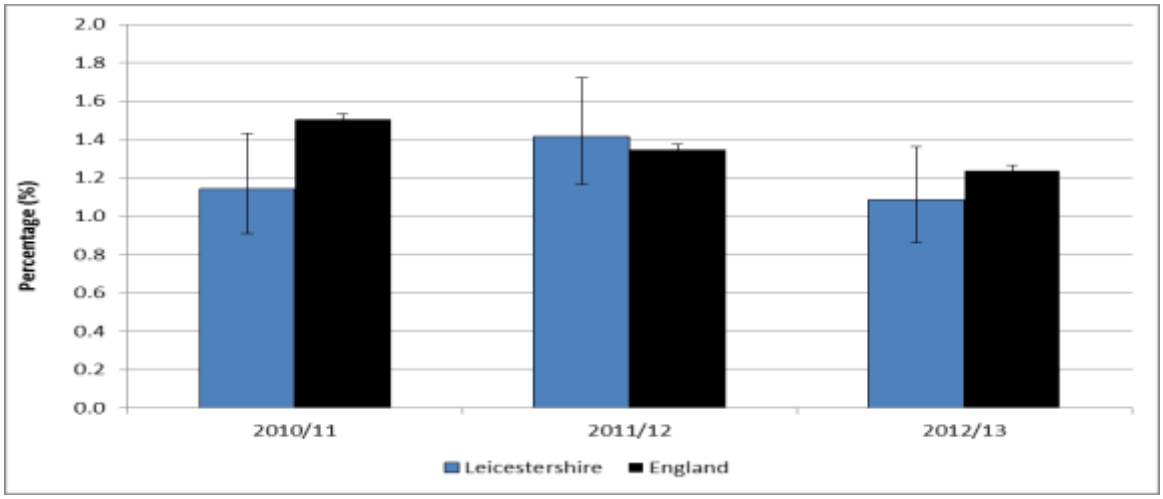
Figure 84: Percentage of live births where the mother is aged under 20 years, Leicestershire[79]



7.4.4 Delivery episodes

In 2012/13, the mother was aged under 18 years for 1.1% of all delivery episodes in Leicestershire. This was similar to the national average of 1.2%. In this financial year, there were 72 delivery episodes when the mother was aged under 18 years. This has decreased from 2011/12 where there were 98 delivery episodes of mothers in this age range and 74 in 2010/11.[80]

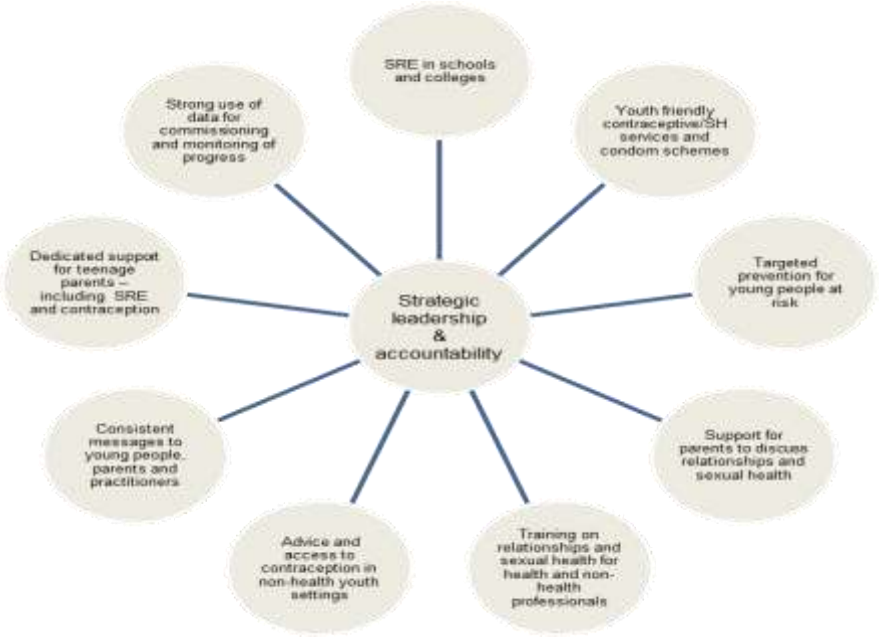
Figure 85: Percentage of delivery episodes where the mother is aged under 18 years, Leicestershire[80]



7.4.5 Leicestershire's Teenage Pregnancy Strategy

Figure 86 below has been developed by the Teenage Pregnancy Knowledge Exchange to show the factors required to ensure an effective Teenage Pregnancy Strategy.[81] The Leicestershire Teenage Pregnancy plan for 2015-16 addresses each of the 10 factors to ensure that delivery is holistic and takes in to account all elements this approach.

Figure 86: Key factors that influence teenage pregnancy[81]



7.4.5.1 Advice and access to contraception

The integrated sexual health service provides special sexual health clinics for anyone under 25. Young people are welcome at any of the clinics, but the under 25 clinics are exclusively for young people and held at venues and at times that work better for young people. For information on what is provided at these clinics see the sexual health services chapter.

7.4.5.2 Young people's sexual health campaigns

To ensure young people are aware of local sexual health services campaign work has been a key component of Leicestershire's teenage pregnancy plan. Campaigns have had their own discreet aims but in general have aimed to;

- Communicate positive messages about different contraceptive methods
- Promote local services to young people
- Highlight the risks associated with sex when drinking
- Promote the right of young people to delay having sex until they are ready.

Campaigns have used a range of media to develop and promote messages e.g. viral videos, on-line games and supporting materials for use in RSE sessions. Some of the headline outcomes of campaigns over the last 4 years have been;

- Winning the 'Most effective use of social marketing' at the How Do Awards in 2011
- A 47% increase in students who think it's positive for girls to carry condoms
- 650,000+ hits on youtube
- Increased access of local services

7.4.5.3 The Community Safer Sex Project

The Community Safer Sex Project (CSSP) supports community based sexual health services across LCR to help young people avoid unplanned pregnancy and to maintain a safe and responsible approach to their sexual health. The Project provides training, professional support and resources to the 400+ practitioners who deliver the project in community colleges, youth service settings, children's centres and community housing and residential projects. The combined services are accessed by over 5,000 young people each year for condom services, pregnancy testing, chlamydia screening and sexual health information and support. The CSSP prioritises services in teenage pregnancy hotspots and to those young people identified in at risk groups including youth offender and young people in and leaving care.

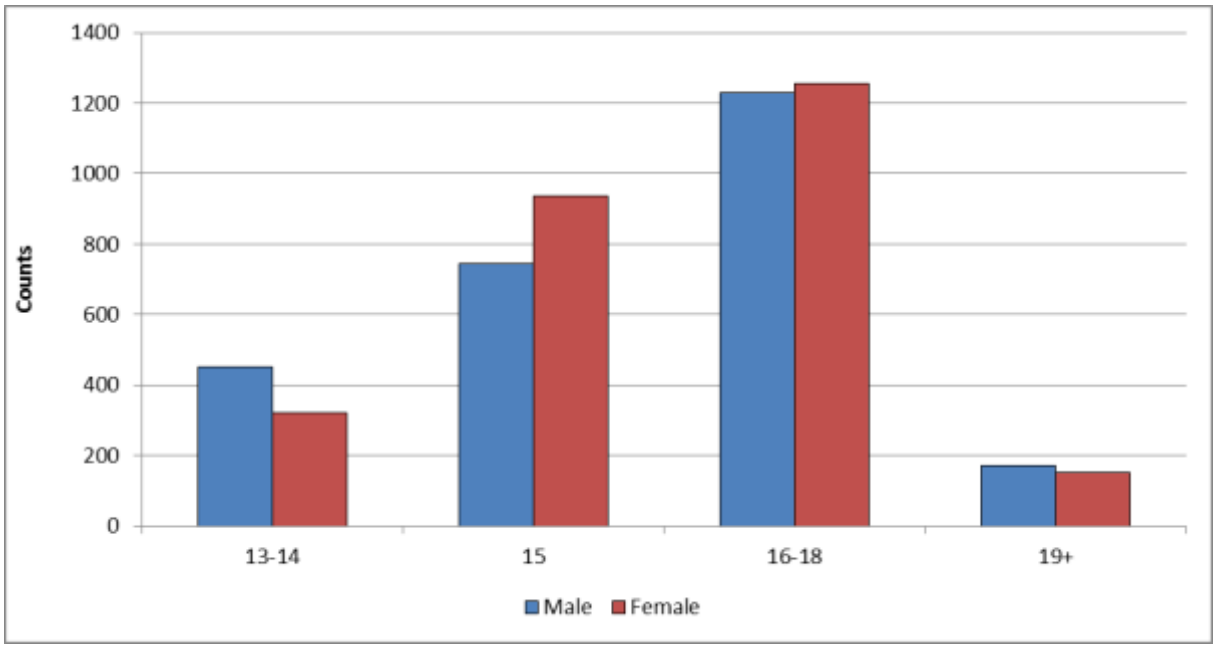
In 2014/15, there were over 5,000 interventions to young people by the CSSP in Leicestershire, with the majority of interventions, 46%, occurring through school nurses. Table 15 shows the youth service, independent providers and further education college sites all provided a sizable number of interventions in 2014/15.

Table 15: Total Interventions by CSSP in 2014/15 by Type of Service[82]

Type of Service	Total Number of Interventions
School Nurses	2,423
Youth Service	1,212
Independent	824
Further Education	681
Children's Centre	53
Youth Offending	41
Other	28
Total	5,262

Figure 87 examines the total number of interventions by the CSSP by age and gender of individuals in 2014/15. The figure shows the total number of interventions increase with age up to the age of 18. Young people aged 19 and above had the smallest counts of interventions from the project, which is likely to be due to the age young people leave full time education. In the youngest age group, aged 13-14 years, and the oldest age group, 19 years and above, more males than females were accessing the project.[82]

Figure 87: Total Interventions by CSSP in 2014/15 by Age and Gender[82]



There has been an overall reduction in the numbers of young women presenting for pregnancy tests through the CSSP since 2001 and unplanned positive results remain low at approximately 20 annually. However, in June 2014 local intelligence suggested a "spike" in pregnancy testing interventions (with negative results) in some settings (especially FE colleges). Hence a pregnancy testing audit was completed on eight sites. The 12 month results from September 2014 to September 2015 showed a total of 79 pregnancy tests had been completed in mainly 16 and 17 year olds. The 2 most commonly cited reasons for a pregnancy test included risk taking and contraception concerns (predominantly related to misunderstandings about the implant and its effect on periods).

7.4.5.4 Rutland C-Card pilot

Since April 2015 the C-Card scheme has been piloted in Rutland. This approach builds on the CSSP but intends to provide additional access to condoms for young people aged 13-24 via community venues (including youth services, pharmacists, schools and GPs). 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).

Since the project was launched in April 2015, 7 registration and a further 5 pharmacy distribution sites have been signed up to the scheme. As of September 2015, 106 young people have registered for the C-Card scheme and 7 young people have accessed a distribution site since registering. Table 16 provides a breakdown of these registrations and shows that over 50% of registrations occurred in Rutland County College. . Further evaluation of this pilot is due in 2015/16.

Table 16: Breakdown of Rutland C-Card registrations from April-September 2015

Venue	Registration Count
CBEC College	5
Jules House - Rutland Youth Service	13
Rutland County College	54
Uppingham Town Hall - One off Event	28
Uppingham Youth Club	6
Grand Total	**106**

7.4.5.5 Relate –post termination Counselling

Approximately half of under-18 conceptions in England and Leicestershire end in abortion. Around 150 young women access a termination in Leicestershire each year. For many, the support of their family, support workers and peers is adequate but some young people find it hard to get back to normal after a termination and talking to a counsellor can be a key part of their recovery and acceptance of what has happened.

Over the last 5 years, a referral based post termination counselling service has been delivered across Leicestershire. Referral numbers have varied but on average 10 young people per year have accessed this service with half requiring face to face counselling and half accessing support over the phone. Referrals have predominantly been received from school nurses and youth workers.

Post counselling questionnaires have reported an increase in hopefulness for the future amongst service users as well as an increase in self-confidence and self-esteem. Provision of this service has also ensured that young people are signposted to contraceptive services in a proactive way post termination.

7.4.5.6 The Specialist Teenage Pregnancy Midwifery Service

As part of the midwifery service in LLR there is a 60 hours per week specialist service for teenage mothers. This service provides more intensive midwifery support for mothers aged

18 and under. In 2014-2015, 64 mothers under 18 were booked by the Specialist TP midwives.54 (84%) of these were case loaded by the Specialist TP Midwives. (Case loading is based on an assessment which is undertaken at booking. Mothers are case loaded if their vulnerability score is 10 or more.) Of the 64 who were booked, 49 (77%) were not using contraception at the time of conception. In the majority of cases, the young women had not intended to get pregnant.

7.4.6 Sex and Relationships Education (SRE)

Effective sex and relationship education (SRE) is essential if young people are to make responsible and well informed decisions about their lives. Sex and relationship education should contribute to promoting the spiritual, moral, cultural, mental and physical development of young people at school and within society and preparing them for the opportunities, responsibilities and experiences of adult life.

In consultation with young people in Leicestershire (detail in Engagement chapter) showed that young men and women looked to school to provide this teaching and learning. Hence work with schools and the range of professionals who support young people to improve access and parity of SRE to young people is therefore a key priority in Leicestershire's Teenage Pregnancy plan.

In 2014, Public Health developed a coordinated offer of support and training on SRE with the aim of;

- Broadening knowledge and skills in relation to providing advice and support on issues pertaining to teenage pregnancy and sexual health
- Providing a working understanding of providing sexual health services to under 16s
- Providing skills to provide condom and pregnancy testing services

The offer was promoted to schools and revised in 2015. In 14/15, over 500 practitioners attended training delivered by the Teenage Pregnancy Partnership and the training has received positive evaluation.

7.4.7 Young Parents

Children born to teenage mothers have 60% higher rates of infant mortality and are at increased risk of low birth-weight which impacts on the child's long-term health. Teenage mothers are three times more likely to suffer from post-natal depression and experience poor mental health for up to three years after the birth.[83] Teenage parents and their children are at increased risk of living in poverty and teen parents are one of the vulnerable groups who are most likely to be NEET (not in employment, education or training). As a result, teenage parents are one of the groups that are focused on in Leicestershire's 2015 not in education, employment or training (NEET) Strategy.

Evidence shows that not being in education, employment or training between the ages of 16 and 18 is a major predictor of later unemployment, low income, depression and poor physical and mental health. Young people who are NEET are at risk of not achieving their potential; economically and socially.

Prospects are commissioned by Leicestershire County Council to track all young people aged under 19 and record their 'destination'. Data from Prospects examines the number of young people in Leicestershire who are teenage parents or parents to be. Table 17 shows the Charnwood district has the highest count of female teenage parents in the county. In March 2015, North West Leicestershire has the second highest counts with 24 females being teenage parents, while in March 2014, Hinckley and Bosworth had the second highest counts, with 18 females. The small numbers involved mean fluctuations are likely. Figure 88 shows for the latest data for Leicestershire, the number of teenage parents (including both male and female parents) increase with age, however data for the previous year reveals the highest peak in teenage parents were seen in 18 year olds. In March 2015, over half (54%) of the teenage parents in Leicestershire were not in education, employment or training.[84]

Leicestershire faces a challenge in the proportion of 16-19 year olds who are NEET from disadvantaged backgrounds or from vulnerable groups including teenage parents. NEET figures are calculated on the three academic years after year 11 and report on 16 to 19 year old young people. Each local authority submits information to the Department for Education each month and this data informs both local and national figures.

Table 17: Counts of Female Teenage Parents by District of Residence in Leicestershire[84]

District	Mar-14	Mar-15
Blaby	13	15
Charnwood	65	46
Harborough	18	*
Hinckley and Bosworth	20	16
Melton	14	12
North West Leicestershire	15	24
Oadby and Wigston	10	9
Unknown	0	*
Grand Total	**155**	**129**

Figure 88: Counts of Female Teenage Parents by Age in Leicestershire[84]

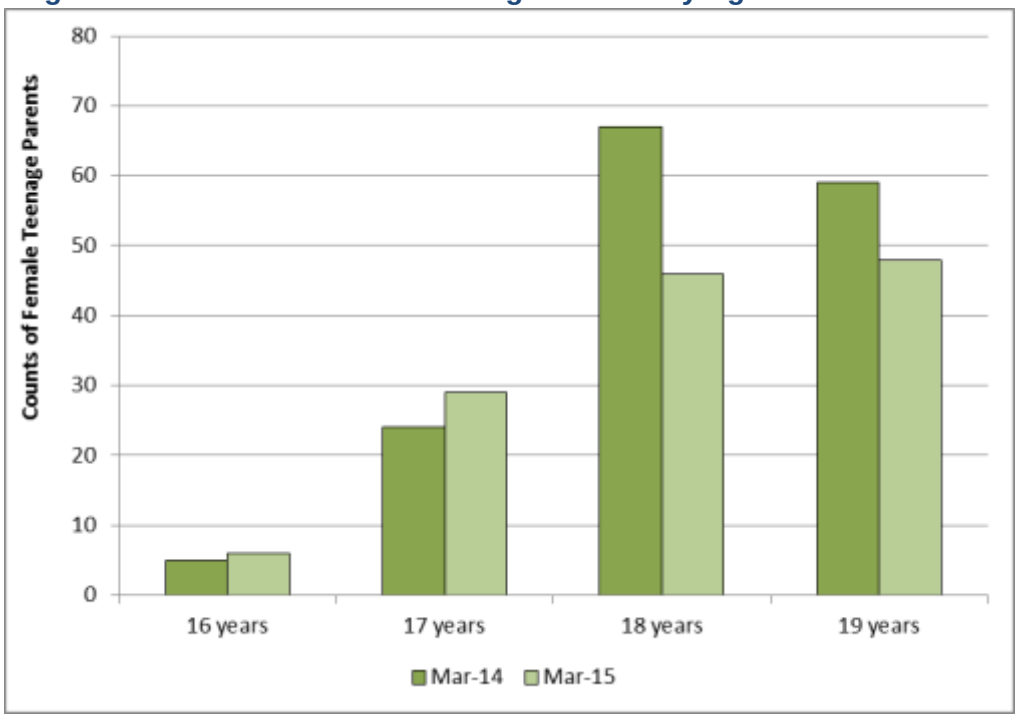
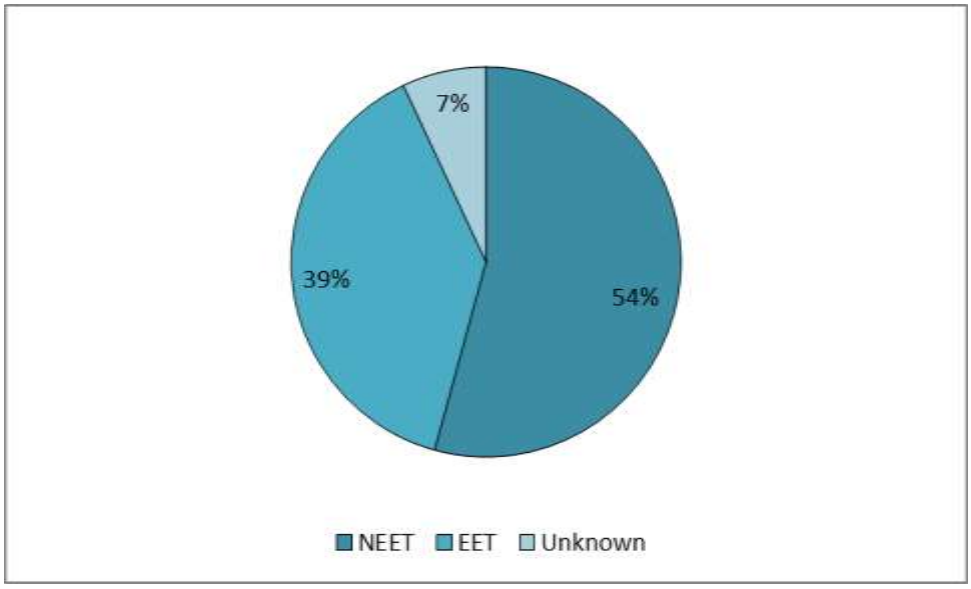


Figure 89: Percentage of Female Teenage Parent by Destination, March 2015[84]



7.4.8 Targeted prevention for young parents

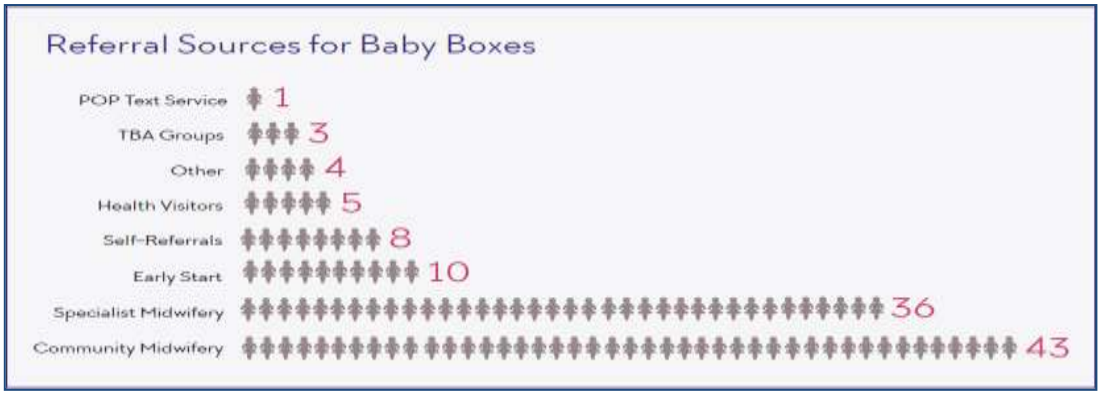
7.4.8.1 Dedicated support for Parents under 20

Effective approaches to support teenage parents into Education, Employment or Training (EET) need to tackle both the underlying issue that led to disengagement, and the practical challenges of having a young child. Many of the approaches used to encourage engagement with other NEET groups are valid for teen parents.

Local priorities in the teenage pregnancy action plan focus on provision of support for young parents. The following are delivered as part of the parents under 20 project;

- Providing baby boxes to young-mums-to-be at 24 weeks or beyond to enable them to raise concerns and make links into their local service pathway. The scheme takes referrals from a range of sources (See Figure 90) and ensures mums under 20 years old receive a home visit and baby box from 24 weeks pregnancy. During the visit the young woman is informed of local services and (if consent is given) referred onto the children's centre programme is made. A key aim of this project is to enable consistent identification of the young parent cohort and to facilitate mums-to-be to access local support services.

Figure 90: Baby Box referral sources from September 2014 to August 2015.



- Development of a quality framework for education providers to enable the needs of school aged parents to be met.

- Developing (Teenagers and babies action group (TBAG)) locality forums to enable the sharing of information on teenage parents thus improving the quality of data on young parents and facilitating better access of the available support. The TBAG meetings are now set up across all districts and have identified the issue of social isolation and the significant numbers of teenage mothers in Leicestershire who are over 19 and are now in a position to consider EET, with less support available.

- Developing localised information on the support that is available for teen parents to access.

- Providing training for staff groups to enable them to ensure that their services meet the needs of and take account of young parents/parents-to-be.

The project has identified that flexible learning with personalised timetables, childcare provision, distance learning and short term courses in accessible settings such as children's centres have all been successful in engaging teenage mothers into EET. Parenting skills sessions and peer support groups can help to keep young parents engaged, reduce the feelings of isolation and make it easier for them to re-engage in mainstream provision when they are ready to do so.

A further priority in supporting teenage mothers into EET is to ensure that the benefits of this are recognised by all services that support young parents. Key actions to further reduce NEET amongst teenage parents include the ability to;

- influence FE colleges and schools to provide more adaptable and flexible modes of learning that match the turbulent life of a teenage parent

- integrate more consistent support mechanisms to assist a teenage parent in attending an education or training provider

7.4.8.2 Care to Learn (C2L)

Care to Learn (C2L) helps young parents (under 20 years old when their course starts) to continue in or return to learning by assisting with the costs of childcare and associated travel. Any publicly-funded learning in England can be undertaken. The scheme pays up to £160 per week per child directly to the childcare provider on behalf of the learner. The childcare provider must be registered with Ofsted or the Care Quality Commission. The costs of travel between the student's home and their childcare provider may also be paid if the combined cost of childcare and the travel does not exceed the maximum weekly amount.

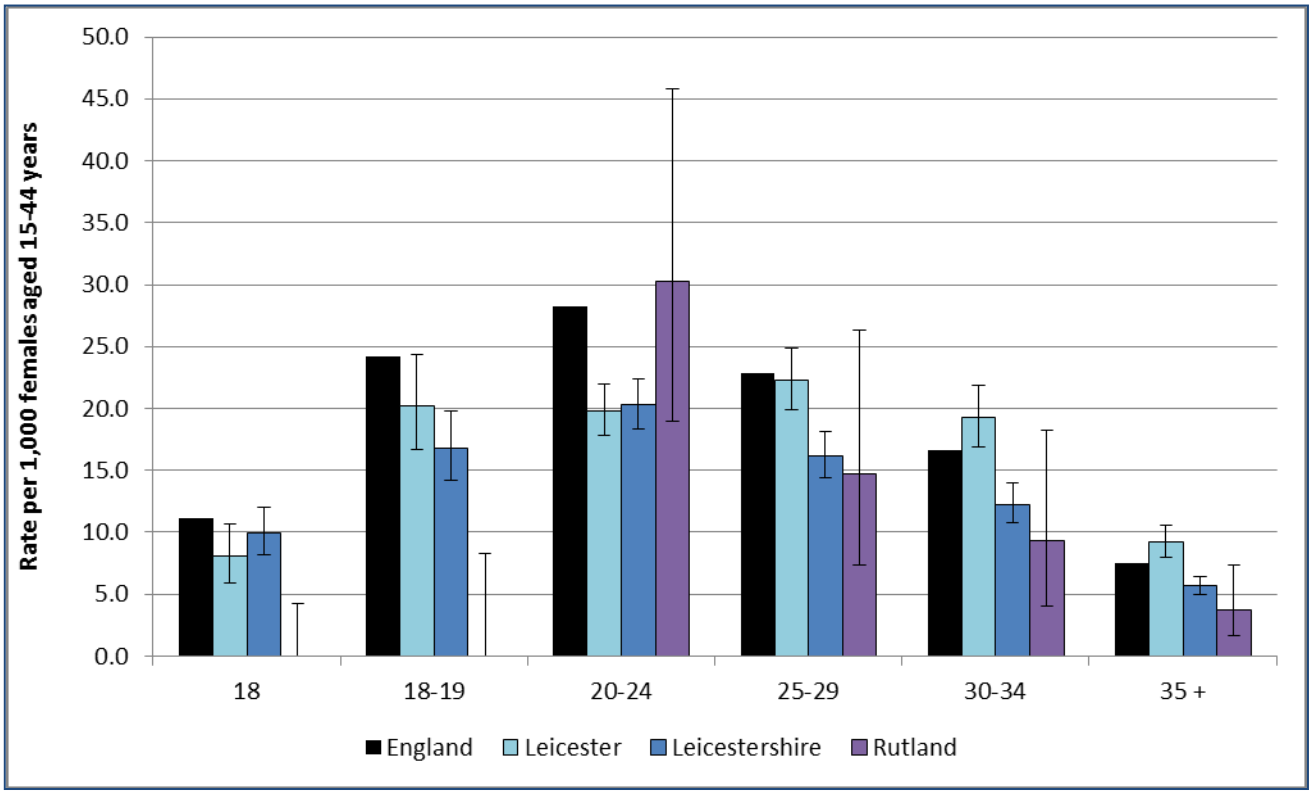
C2L take up has been defined as the number of young parents who have been assessed as eligible, received at least one C2L payment and confirmation of attendance at the Learning Provider has been received. The latest results in Leicestershire show that 53 young parents took up the C2L services in February 2015, of which 36 attended further education. In Rutland, only 1 individual used C2L funding. Of all parents aged under 20 years, 10.8% were estimated to use C2L funding in Leicestershire and 6.3% in Rutland.[85]

7.5 NHS Funded Abortions

The increasing intervals between first sexual intercourse, cohabitation, and childbearing means that, on average, women in Britain spend about 30 years of their life needing to avert an unplanned pregnancy. Natsal-3 study estimated that 10% of women aged 16-44 had been pregnant in the past year (given birth, miscarried, or had an abortion in the past year). Of these pregnancies, an estimated one in six of these pregnancies were unplanned, two in six were ambivalent and three in six were planned. This gives an annual prevalence estimate for unplanned pregnancy of 1.5%. Pregnancies in women aged 16–19 years were most commonly unplanned (45.2%) however, most unplanned pregnancies were in women aged 20–34 years (62.4%).[2]

In 2014, in Leicestershire the total abortion rate per 1,000 female population aged 15-44 years was 11.9, significantly better than the national rate of 16.5 per 1,000 female population aged 15-44 years. Figure 91 shows the rate of abortions is highest in females aged 20-24 years throughout England and in Leicestershire and Rutland. In Leicester City, the highest rate of abortions was seen an older age band, the 25-29 age category. In 2014, in Leicestershire there were a total of 1,439 abortions and Rutland, there were 55 abortions.[86]

Figure 91: Rate of abortions per 1,000 females aged 15-44 years by age-band, 2014[86]



Among women aged under 25 years who had an abortion in 2014, 20.9% in Leicestershire and 21.4% in Rutland had had a previous abortion, while in England the proportion was higher at 27.0%. Among women aged 25 and over, the proportion of those who had had a previous abortion rose to 42.8% in Leicestershire and 37.0% in Rutland. In England the proportion was higher at 45.6%.[86]

The earlier abortions are performed, the lower the risk of complications. Prompt access to abortion enabling provision earlier in pregnancy is also cost-effective, an indicator of service quality and increases choices around procedure. Figure 92 shows among NHS funded abortions, in 2014 the proportion of those performed under 10 weeks gestation in Leicestershire was 72.6% and in Leicester City was 70.8%, both significantly worse than the national proportion of 80.4%. In Rutland, 85.2% of abortions were performed under 10 weeks gestation, similar to England average. Improvements have been seen in Leicestershire, Leicester City and Rutland compared to the previous year.[86]

Figure 92: Percentage of abortions under 10 weeks[86]

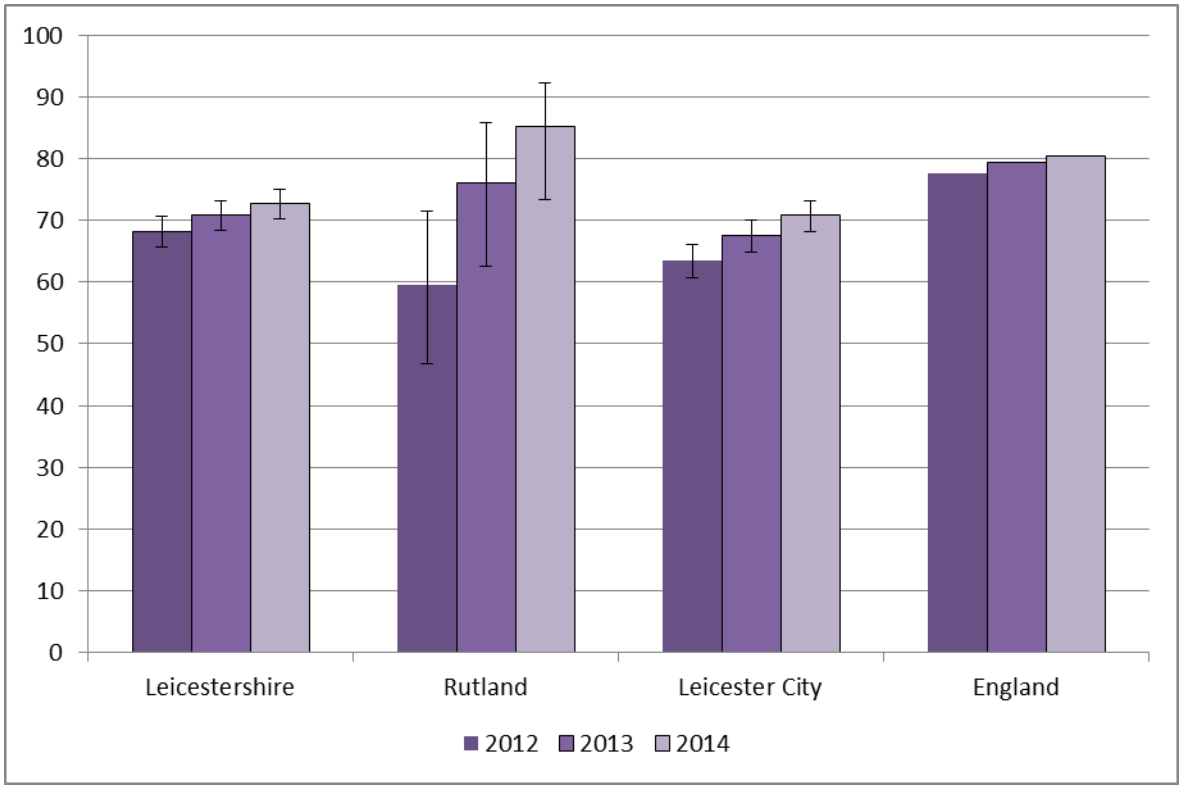


Figure 93 shows 16% of all abortions in Leicestershire were 13 weeks or over in gestation, whereas in England, only 8% of all abortions occurred in this time frame. Rutland has a similar percentage to England for the time (9%). Both nationally and in Leicestershire, 11% of abortions occurred between 10-12 gestation weeks. In Rutland, only 5% of abortions occurred between these weeks.

There are different types of abortion procedures available and the choice will depend on several factors including gestation period. Whilst abortion is a safe procedure, the earlier an abortion takes place, the fewer complications are likely. Early Medical Abortions are only available under 10 weeks gestation period and therefore it is important for women to have early access to services, including pregnancy testing, to provide information and support in decision making to enable women to have time to make decisions and the option to choose from the range of abortion methods[87],[88].

Nationally, half of all abortions occurred via the medical route and the other half, via surgical route in 2014. Figure 94 shows in Leicestershire, over half (53%) of all abortions occurred by the surgical route, whereas in Rutland, only a third of all abortions occurred this way.

Figure 93: Percentage of NHS funded abortions by Gestation Weeks, 2014

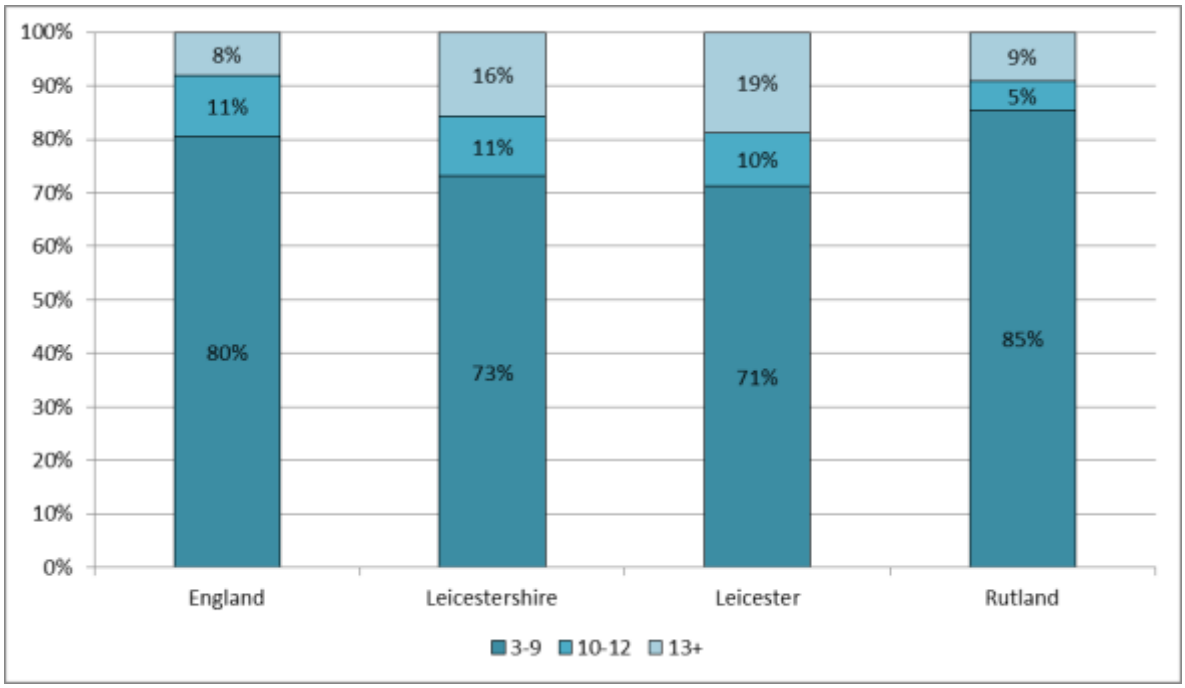
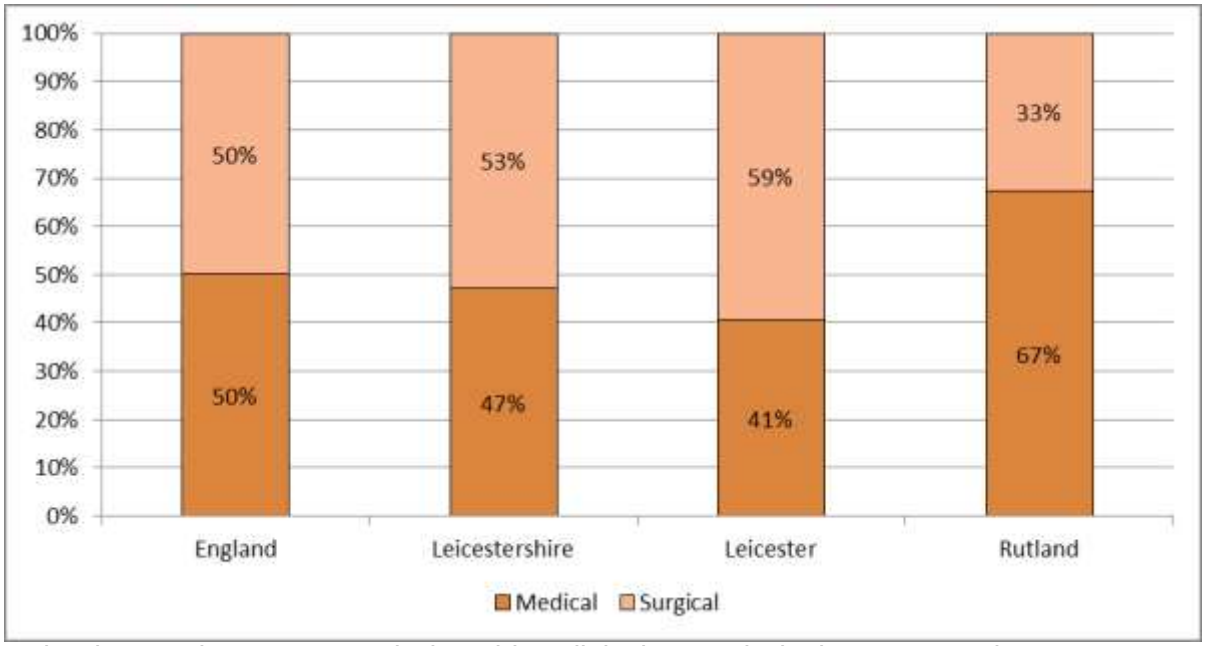


Figure 94: Percentage of NHS Abortions by Method of Abortion, 2014



Abortion services are commissioned by Clinical Commissioning groups. There are currently two providers across LCR. University Hospitals of Leicester provides services up to 12 weeks gestation and British Pregnancy Advisory Service (BPAS) provides services up to 24 weeks gestation. BPAS services are located outside of LLR with the exception of a clinic providing pre termination counselling and medical termination located in Thurmaston, Leicestershire. Women can self-refer to BPAS services only.

7.6 Implications for Sexual Health

Contraception is a cost effective intervention the whole of society. LARC is shown to be the most cost effective method available. Across LCR LARC prescribing rates are above the national average for primary care, however contribute to a lower proportion of total

contraception use overall. Therefore additional work is needed to maintain the level of GP provision and increase the proportion of LARC procedures completed in the ISHS, in particular in the under 35year old age group. This will include working with GPs to increase the proportion of LARC fitters accredited via the national Letter of Competence and to undertake an audit to gain a better understanding of how long LARC devices are being retained by women.

It is important to maintain easy access to EC to allow women to access services as soon as possible after they have had unprotected sex. There is good access to EC across LCR provided by the ISHS, GP and local pharmacy. Consideration should be given to new forms of EHC such as UPA (which has a longer effective window) and ensuring women accessing EHC are referred in contraceptive services to establish a longer term contraceptive regime (in particular LARC).

The Natsal-3 sexual attitudes and lifestyles in Britain survey (2010-12) indicated 51% of men and 42% of women surveyed experienced one of more sexual difficulties lasting more than three months in the past year.[76] Hence there is likely to be some unmet demand for psychosexual services across LCR. With an aging population, this demand is likely to increase. Therefore commissioners should consider increasing awareness of the existing service and increasing the activity levels in the future. Discussions are also needed with the local CCGs to identify services for patients with sex addiction.

The under 18year conception rate continues to fall across LCR. However there is district variation in rates with Hinckley and Bosworth having the highest rate in 2011-13 and increases seen in Blaby, Harborough and Rutland in 2011-13. However due to smaller number these increases are not statistically significant. The proportion of under 18 conceptions leading to abortion is higher in Leicestershire than the England average. This suggests that there are still significant numbers of young people who continue to take risks and not use contraception despite not wanting to become pregnant. Therefore continued easy access to relationships and sex education and community based sexual health services is important to maintain and improve current progress. Training on teenage pregnancy and related issues is important to ensure a high quality children's workforce who feel competent to discuss a range of issues and support young people's access of health services.

Over 50% of Leicestershire teenage parents are not currently accessing education, employment or training. This will impact on their life longer opportunities, which will impact on the health and wellbeing of themselves and their child. Therefore a coordinated response to the support of young parents is important to ensure a range of needs are addressed.

Leicestershire and Rutland both have lower abortion rates than the national average. However a fifth of women had previously had an abortion and greater proportions of women are accessing services at a later gestation, which reduces the choice of procedure and increases risk of complications and healthcare costs. There is also limited local availability for procedures over 12 weeks across LCR and self-referral is only available in one provider. Therefore additional work is needed to increase access to local abortion services and ensure that all abortion patients are supported to establish a long term contraceptive plan to avoid repeat abortions.

8. Sexual Abuse

8.1 Domestic Abuse

The Government's definition of domestic abuse now encompasses all forms of abuse;

'Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional), between two adults who are, or who have been, intimate partners or family members, regardless of gender or sexuality.'[89]

Domestic Abuse is a widespread issue, nationally, 76 women and 15 men were killed by their current or former partner in 2012/13. It costs the tax payer an estimated £3.9bn per year, of which nearly £2.4bn is caused by high risk domestic abuse. In Leicestershire it is estimated that the total cost of domestic abuse in Leicestershire is £66m a year[i]. This includes cost to public services and economic output cost, but not emotional and personal cost, estimated at a further £113.8m.

Domestic abuse has adverse impacts on the health and wellbeing of victims, and is closely associated with child abuse and neglect, as well as a range of other social issues including homelessness and substance abuse. It can cause long-term problems for children, families and communities and has inter-generational consequences in terms of the repetition of abusive and violent behaviours[90],[i].

Every year around 7,600 incidents of domestic abuse are reported to the police, around 2,000 of these are violence against the person crimes. In 2013/14 over 1,250 referrals were made to domestic abuse specialist support services in Leicestershire, and almost 300 individuals called the county helpline for advice or support for themselves or someone they knew. Of these approximately 1,100 children were in families that received support from domestic abuse services (2013/14) and over 300 in families referred to multi agency risk assessment conference (MARAC) in 2013/14.

Whilst monitoring of domestic abuse within children's services is developing, domestic abuse was identified as a significant factor in at least half of child protection conferences in 2012/13, and has been an issue for almost two thirds of families supported through Supporting Leicestershire Families in 2013/14. Training and awareness work locally has contributed to an increasing recognition of domestic abuse and the significant impact it has on adults and children which may have contributed to recent increases in referrals to services.

8.2 Sexual Offences

In 2013/14, there were 475 reported sexual offences in Leicestershire and 14 in Rutland. In this year, the rate of sexual offences in Leicestershire was 0.72 per 1,000 population and in Rutland, the rate was 0.38 per 1,000 population. Both these rates are lower than the national rate of 1.01 per 1,000 population. Since 2011/12, the rate for sexual offences in Leicestershire has increased year on year, while the rate for Rutland has decreased year on year.[22]

Nationally 1 in 5 women (aged 16 - 59) have experienced some form of sexual violence since the age of 16.[91] In Leicestershire County 175 rapes and 380 other sexual offences were reported to the police in 2013/14, both are steadily increasing year on year. Rape Crisis received 190 referrals from Leicestershire residents in 2013/14. A quarter of these related to sexual offences within the previous year. 45% of individuals referred had been victims of sexual violence and abuse both as adults and children.

8.3 Non-volitional Sex.

Natsal-3 found that 1 in 10 women and 1 in 71 men said they had experienced non-volitional sex since age 13. The study found that experiencing sex against your will could happen at any age but was more common at younger ages. The median age for males was 16 and for females was 18.[26]

The study found that people who said that they had experienced sex against their will were more likely to report potentially harmful health behaviours and poorer physical, mental and sexual health, including treatment for depression or another mental health condition in the past year, a long-term illness or disability, and a lower sexual function score. It is not known whether these things happened before or after experiencing sex against their will. It must be noted that not all non-volitional sex will result in reporting of a sexual offence.

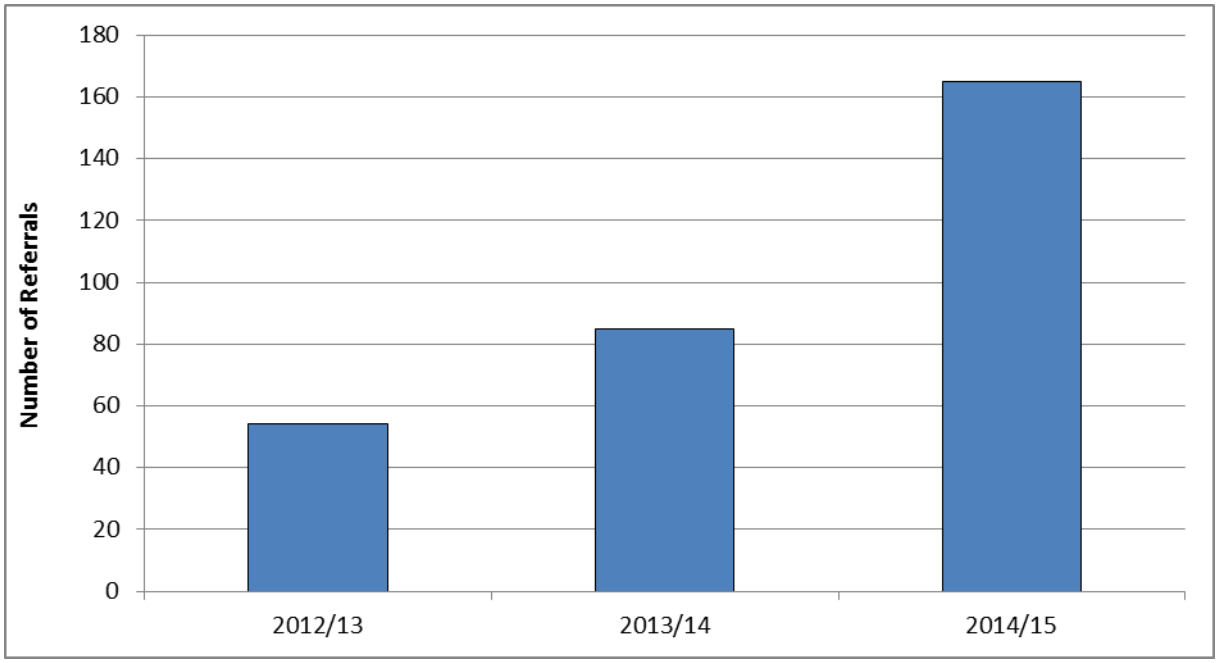
8.4 Child Sexual Exploitation (CSE)

The sexual exploitation of children and young people is a form of sexual abuse and already vulnerable children are often targeted. Child sexual exploitation can have a devastating impact on the social integration, economic well-being and life chances of young people. The NSPCC report Child Maltreatment in the United Kingdom[92] found that 11% of respondents had been abused in childhood against their wishes when they were 12 years old or younger, the prevalence being 7% for males and 16% for females. Difficulties faced by victims of child sexual exploitation include isolation from family and friends, teenage parenthood, failing examinations or dropping out of education altogether, unemployment, mental health problems, suicide attempts, alcohol and drug addiction, aggressive behaviour and criminal activity.[93]

In 2014, the estimated numbers of people the adult population aged 18-64 who report having been sexually abused during their childhood was 32,080 in females and 13,972 in males in Leicestershire and 735 in females and 1,600 in males in Rutland. These counts are estimated to remain stable in Leicestershire and decrease slightly in Rutland over the next fifteen years.[45]

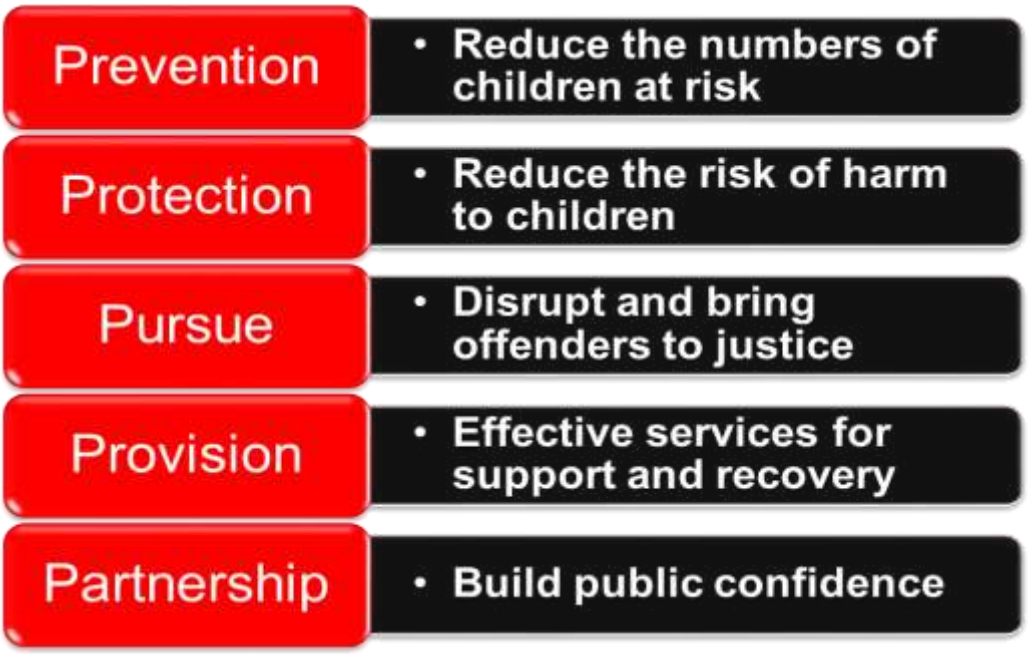
In 2012/13 the Child Sexual Exploitation (CSE) team for Leicester, Leicestershire and Rutland received 54 referrals, increasing to 85 referrals in 2013/14 and 165 in 2014/15. This increase in referrals partly reflects publication of the Rotherham Inquiry as well as an improved local awareness due to the Local Safeguarding Children's Board's awareness campaign 'Spotting the signs'.

Figure 95: Counts of Child Sexual Exploitation Referrals in Leicester, Leicestershire and Rutland, 2012/13-2014/15



The local authorities throughout Leicester, Leicestershire and Rutland, police, NHS, schools and other partner agencies have developed a local strategy. They are working together to create an environment where CSE is prevented, identified and challenged in order to keep children and young people safe. Figure 96 summarises the LLR CSE priorities, prevention, protection, pursue, provision and partnership.

Figure 96: LLR CSE strategy priorities.



8.5 Female Genital Mutilation (FMG)

Female genital mutilation (also referred to as FGM, female circumcision or cutting) is defined as all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons.[94] 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. [4],[95]

FGM can have long-lasting physical and psychological effects, such as chronic pain, sexual difficulties and complications in pregnancy and childbirth and can increase the risk of HIV and other STIs.[4] Between September 2014 to March 2015, 34 new cases of FGM were identified at University Hospitals of Leicester NHS Trust with 86 care contacts for any patient identified with FGM. In March 2015, there were 25 current caseloads of FGM by the University Hospitals of Leicester NHS Trust.[96]

8.6 Implications for sexual health services

Domestic abuse is a wide spread issue and can take place in a range of relationships. There is a lack of understanding around what constitutes domestic abuse. The national coverage on historic abuse and current approaches to raise awareness about CSE are likely to lead to increases in the number of victims coming forward and seeking help. It is therefore important that staff who work in sexual health services are aware of the prevalence of domestic abuse and CSE and are equipped to ask appropriate questions when seeing patients to allow disclosures to be made and appropriate referral onto specialist services.

9. Engagement

9.1 National Data

9.1.1 The National survey of sexual attitudes and lifestyles (NATSAL) 2013

The Natsal survey is completed every 10 years. The third Natsal survey completed in 2013 identified some significant changes in behaviours and attitudes towards sexual health. An outline of the headline findings is below;

⇩ Reducing age of first sex

⇧ Increase in number of sexual partners

More varied sexual practices (e.g. oral and anal sex)

⇧ Increased acceptance of same sex partnerships

⇧ More disapproval of non-exclusivity in marriage

1 in 6 people thought that their wider health affected their sex life

Sexual activity was increasingly continuing in to peoples 8th decade

⇧ Increase in chlamydia diagnoses – this affects just over 1% of the population and peaks in younger age groups

Gonnorhoea and HIV affects less than 1 in 1000 people

⇧ Significant rise in attendance of SH clinics and HIV testing over the last decade

I in 10 women aged 16-24 had had a pregnancy. Of these, 16.2% were unplanned and 29% were ambivalent about the pregnancy

9.8% of women and 1.4% of men recorded sex against your will (non-volitional sex) this. In most cases the perpetrator was known to the victim.

9.2 Local Consultation & Insight undertaken in 2015

9.2.1 Professional and stakeholder engagement

Two key partnership events and some targeted focus groups were completed to gain the views of over 100 LLR sexual health partners and stakeholders about current sexual health services and priorities for the future. The views and feedback gathered at these events are summarised below.

9.2.1.1 The Sexual Health Visioning Event

On 8th July 2015 over 70 stakeholders attended the LLR Sexual Health Visioning Event. The focus of this event was to involve partners from across the spectrum of sexual health delivery in LLR to inform the future vision and priorities for sexual health. Attendees were asked what their aims and objectives for the day were. The common themes from groups included developing a clear LLR sexual health strategy and priorities, making pathways simpler, clarifying commissioning processes, roles and responsibilities across the system, parity across LLR and exploring the role of a broader range of providers in delivery of sexual health provision.

Groups were asked to prioritise sexual health priorities for LLR – the top priorities from the nine groups are summarised as;

- Equity of provision and funding - ensuring parity of services/service accessibility.
- Improve access to services – develop seamless pathways through all commissioned elements.
- Prioritising prevention including a consistent RSE offer.
- Funding as a priority - Considering funding across the system to ensure all needs continue to be met.
- Reducing fragmentation - developing a 'truly' integrated service for sexual health and better more robust pathways between GPs and GUM
- Improving chlamydia detection across LLR/identifying ways to achieve this
- Increase access to STI screening across all ages

The afternoon was spent in workshop groups exploring particular elements of the SH pathway. Table 18 summarises the key desired outcome from each workshop.

Table 18: Summary of desired outcomes from each sexual health workshop

Workshop	Desired Outcomes
Co-commissioning – exploring links with CCGs and NHS England	• Confirm commissioning arrangements for some services i.e. cervical cytology, IUS for menorrhagia • Develop the sexual health primary care workforce in particular review LARC provision • Follow up meeting with all CCG commissioners and contracting leads for sexual health
Opportunities for young people's sexual health services	• A consistent RSE offer across LLR • A more coordinated strategy for using social media as a platform for Sexual health messages • Expanding SHACC model in to county • Reduced waiting times at ISHS Clinics

Workshop	Desired Outcomes
HIV future service delivery models	• Introduce training on HIV patient pathways for clinicians • Address key gaps/issues with patient pathways e.g. could pregnant women who are HIV positive be seen at the LRI instead of St Peters? • Consult with patients regarding how accessible St Peters is for accessing their treatment • Explore a specific mental health pathway for HIV patients due to 72% of people with HIV having mental health issues • Increase access to HIV testing e.g. asking 'have you tested for HIV?' at the bottom of results for associated tests
Making it work for Rutland	• Undertake a SHNA to get a better understanding of local need. Including sexual violence, the needs of the military base and local consultation with service users • Workforce training & development including primary care and sexual health brief interventions in the wider workforce • Improving access to service including exploring models to increase access to rural population such as GP delivery, virtual clinics and postal screening options. • School nurse provision of EHC • Increase c-card availability/outlets • Improve awareness and promotion of services • Parity of RSE support offer across LCR
Contraception and STI Services	• Workforce training plan & support for SH delivery at all levels (0-3) including LARC in primary care • Improving access for all including potential risk of LARC provision in GP. • Improve access to condoms across LLR for all ages. Expansion of C-card, including for MSM • Improve access to STI screening for over 24s • Provide parity of access to EHC provision via School Nurses. • Continue to promote services. Improve sexual health website & promote as central source of information • Improve efficiencies/cost reduction across the system e.g. bulk purchase of LARC devices. • Pathways including partner notification systems across organisations/services. • Commissioners to collaboratively to secure good quality sexual health services. Consider increasing length of contracts to allow services to establish and innovate.
Termination of pregnancy pathways	• Develop an LLR central booking system and TOP service for all gestations • Develop a TOP patient leaflet to cover all TOP services across LLR • Consider ways to increase contraceptive use following a TOP e.g. systematic referral/ signpost into SSOTP • Commission consistent TOP services across LLR e.g. all to have a full STI screen

Workshop	Desired Outcomes
Integration of sexual health services in to other services	• Better integration of sexual health into public health department • Better integration of sexual health into other local authority and wider LLR system services

9.2.1.2 Feedback on the current service offer

At a Sexual Health Network Event in May 2015 (attended by 50+ people) and in a number of focus groups undertaken in June 2015 (with Health Visitors, Staff from Further Education Colleges, School Nurses and Specialist Midwives) attendees were given an overview of the current service offer and in relation to this were asked 3 questions;

- What is working well?
- What needs resolving?
- What would you like to see?

The responses to these questions are summarised in Table 19 below.

Table 19: Summary of feedback from LLR professionals in May –June 2015

What is working well?	• Community HIV Testing • Better coordination in the ISHS service • The Sexual Health Clinical Network • Advertising and extended opening at ISHS Hubs (St Peters and Loughborough) • GPs with extended services • School nurse delivery of sexual health provision • Sexual health integration in to schools – including those with changing cohorts • Community Safer Sex Sites and their support of local networks • Family Nurse Partnership – supports the teenage pregnancy agenda
What needs resolving?	• Lack of parity across LLR – postcode lottery for services and inconsistent RSE delivery • Knowledge of services is very localised and quite minimal • Training on sexual health is not compulsory and not current for GPs, health visitors and midwives. This leads to a lack of knowledge on current issues e.g. Child Sexual Exploitation (CSE) • Gaps in knowledge and replication of myths amongst some practitioners • Lack of promotional materials for services • Quicker access to contraception for new mums under 20 needed • Local access of sexual health services is not always possible which causes issues for some groups of people • Issues with the on-line booking system for ISHS • Lack of knowledge of EHC Pharmacy Scheme • Lack of HIV testing in GP settings • Lack of information re how to flag complaints

What would you like to see?	• Better partnership working and communication between professionals • An uncomplicated structure with simpler patient pathways – one appointment where all issues can be addressed • School Nurse delivery of SRE in Schools • Further enhancement of school nurse clinics to delivery oral contraception, implants etc • More training for staff including cross organisation training and upskilling between voluntary sector/statutory/medical orgs. • RSE – parity across LLR and work with parents in Primary Schools • An EHC offer by School Nurses in Rutland • Something that takes into account budget restraints and an ability to enable community ownership • Better integration of sexual healthy into other services e.g. voluntary agencies, Police, Social Workers, Schools, Colleges and Universities

9.2.2 Service Users Engagement

Between May and September 2015, 8 focus groups were undertaken with 94 service users to find out what they thought about the current sexual health service offer. Groups consulted included;

- The Leicestershire Young Parent Forum (2 people)
- Coalville Young Parents Group (8 people)
- Families at Boulter Crescent, Wigston (20+ people)
- The Angels and Monsters Group, Braunstone Town(5 people)
- New Futures Project, Leicester City (38 people of which 10 were resident in Leicestershire)
- Trade LGBT Project, Leicester City(7 people)
- Oakham Youth Group, Rutland(4 people)
- Learning Difficulties and Disabilities (LDD) Partnership Group (10 people)

The responses to these questions are summarised in Table 20 below.

Table 20: Summary of feedback from LCR service users in May –September 2015

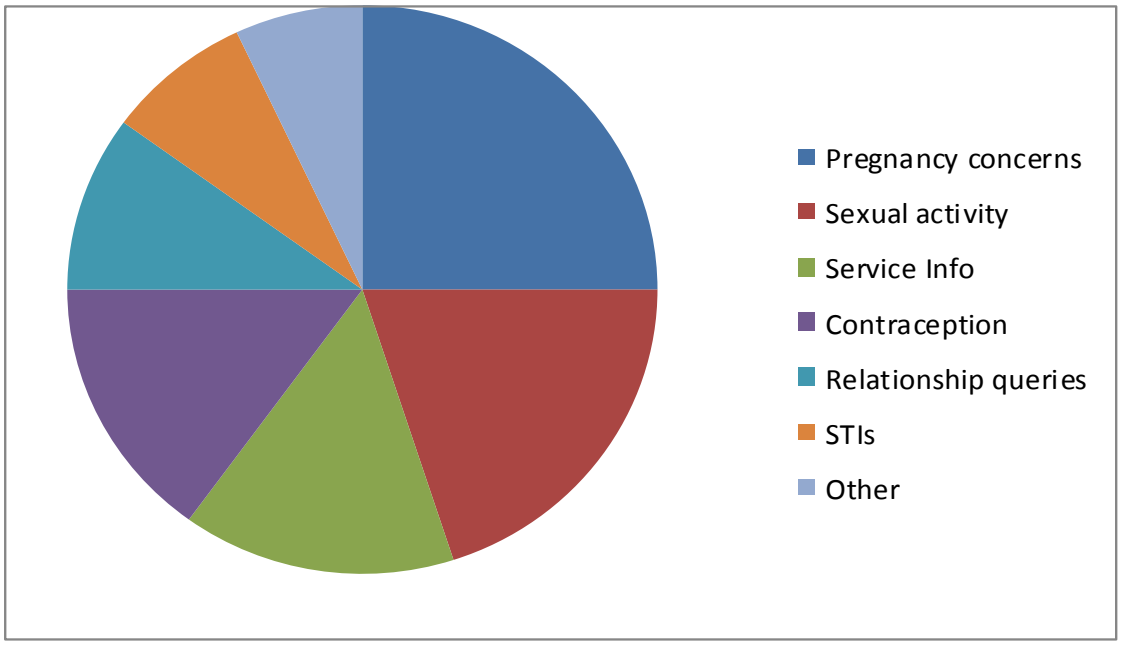
What is working well?	• **Extended opening hours at ISH hubs** • **Community access to Sexual health services** • **Provision of sexual health services from services used for a range of purposes (e.g. youth centres)** • **Sauna and pride clinics are quick, easy and discreet**
What needs resolving?	• Better advertising of services so you know what is available and when • St Peters – not a convenient venue

- Issues with waiting times and space at ISHS
- Issues with on-line booking of appointments & telephone access at ISHS
- Hesitant to use GPs for sexual health issues e.g. concerns re: stereotyping eg LGBT and sex workers
- Keen to have greater access to sexual health provision (e.g. contraception and screening) in community venues
- Specifically for LDD service users:
  - A range of training needs for GPs, support staff, residential home staff and specialist sexual health staff to support those with LDD
  - Support for LDD patients who want to be parents
  - Consideration on how services respond to the spectrum of LDD from those with minor to more profound LDD needs
  - Support for LDD parent/carers around sexual health issues
  - Myth busting around LDD and sexual health
  - Easy read leaflets developed for people with LDD

9.2.2.1 Sexual health service engagement

The POP Text service is text service provided to young people in Leicestershire as part of the community safer sex project. Between August 1st 2014 and 31st July 2015 292 texts were received from young people. Key themes from 265 texts received over a 3 month period from October to December 2014 were analysed in more detail. Figure 97 summaries the key themes identified through the texts.

Figure 97: Key themes identified from POP text service from October to December 2014.



It can be seen that key themes and examples of queries include;

- **25% pregnancy concerns** e.g. *'Can you get pregnant if you have sex on your period?'*

- **20% questions about sexual activity** e.g. '*Is it normal to bleed when you have sex the first time?'*

- **15% local service information** e.g. '*If I go to the clinic at Syston will they tell my parents cuz I am 15?'*

- **15% contraception queries** e.g. '*I got the implant last year but I am still having very irregular/constant periods but I thought they should have stopped by now?'*

- **10% relationship issues** e.g. '*I have just found out I am pregnant – I am 17 – and I really want to keep the baby. My boyfriend was horrid last night and said that if I don't have an abortion I will ruin his life. He made me say I wouldn't have the baby but I don't want an abortion. I hate this no one understands how hard this is for me. I feel so trapped! Xxxxxx'*

- **8% STI queries** e.g. '*Can I get an std from my girlfriend…btw I'm gay'*

- **7% other** (e.g. queries re menstruation or the law)

9.3 Previous research and consultation exercises

Over the last few years there has been a range of local sexual health research and consultation to inform local commissioning of services. Although this evidence is less timely, there are still important themes that must be considered as part of the wider SHNA. This section summarises these key themes.

9.3.1 LLR Sexual health promotion and HIV prevention, 2014

In June 2014, two meetings of the LLR Sexual Health and HIV Prevention and Engagement group were held. The aim of these wide partnership meetings was to develop a new prevention model of SH and HIV services for LLR. The consultation confirmed that the prevention services should focus on known groups vulnerable to poor sexual health outcomes including MSM, black African communities, sex workers and HIV positive people. Key priorities for the service included;

- Outreach work with identified high risk populations in community settings

- Information and advice services

- Counselling and support services for groups and 1:1

- Rapid HIV +/- STI testing with target populations in non NHS settings

- Training for clients and professionals

- Education in schools and with families

- Effective working with other health services eg ISH, Mental health and drug/alcohol services

- Seamless pathways between services and areas of specialism

The outcomes of this consultation informed the commissioning of HIV Prevention services for LLR for 2014-2016.

9.3.2 Consultation on young people's experience of Relationships and Sex Education (RSE), 2013

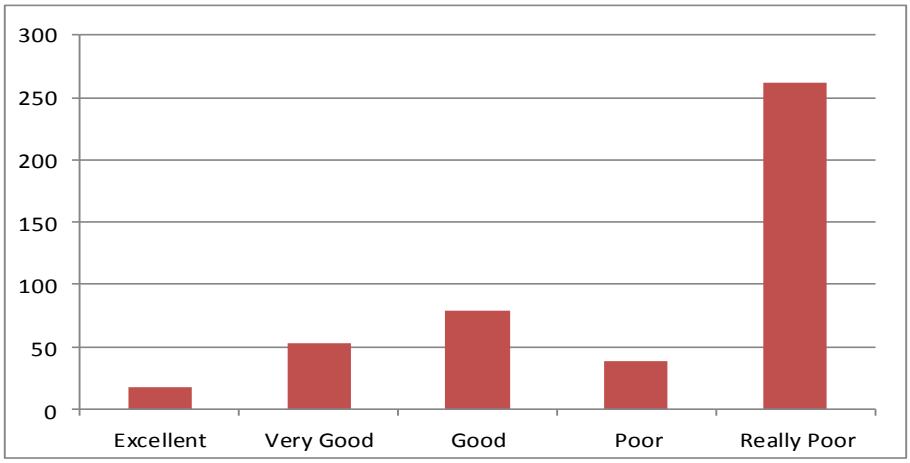
In the summer of 2013, a consultation was carried out with 451 young people aged 13-17 who live and attend school/college in Leicestershire. The aim of the consultation was to;

- Understand young people's experience of relationships and sex education (RSE)
- Gain their views on the issues that should be prioritised in lessons
- To understand what makes learning on RSE effective (or not!).

The consultation identified the following themes;

- The key sources of information on RSE were School and Internet Porn for males and schools and Friends/social groups for females.
- 66.7% (301/415) of respondents rated their RSE as poor or very poor. (See Figure 98).
- Strengths in current RSE delivery included the preference to teach about relationships (not just diseases and the 'bad' things about sex) and learning in more interactive ways such as quizzes and activities.
- Weaknesses in current delivery included embarrassed teachers, dated videos and an approach that seemed intent to scare not inform (e.g. the use of horrible images of end stage STIs). Areas missing from the RSE provision included not enough on relationships or homosexuality.
- The top five RSE topics included safer sex and contraception, STIs, sex, the law and consent, pregnancy and abortion and developing and maintaining healthy relationships

Figure 98: Response to 'How good was your RSE?'



These findings were used to inform the development of a new RSE toolkit called 'Healthy Lives, Positive Relationships'. Over the last 2 years, 50 out of 60 secondary schools in Leicestershire and Rutland have accessed training to implement this toolkit.

9.3.3 Knowledge, perceptions & attitudes of sexual health services amongst young people in Leicester, Leicestershire & Rutland, 2012

In 2012 590 surveys were completed by young people aged 16-22 across LLR to explore young people's knowledge, perceptions and attitudes towards sexual health services. Overall, 46% (272) respondents were male, and 54% (318) were female. The following headlines are taken from this research, these were used when procuring the ISHS;

- The majority (77%) of young people were aware of sexual health services via their own GP.
- 48% of respondents had not actually accessed any sexual health services; however of those that had, 32% had used their own GP. A further 6% had used a condom and pregnancy testing site based at a school or college. Males were significantly more likely than females to state that they had not used any services (61% vs. 36%).
- The majority (68%) of respondents stated that there was nothing preventing them from accessing sexual health services. Of the barriers that respondents were experiencing, lack of awareness of where to access (13%), location (10%) and lack of awareness of what services are provided (10%) were mentioned most frequently.
- Overall, respondents stated a preference for appointments (55%) over drop-in (44%).
- In relation to the time of day, there was a general preference for services to be made available during the week on an evening between 5pm and 9pm.
- The majority (61%) of respondents felt that sexual health services across Leicestershire and Rutland met the needs of young people aged 16-24.
- 12% of young people identified a need for more advice on relationships and general emotional support. A further 12% noted a need for more opportunities to get contraception quickly.

9.3.4 Understanding young people's behaviour, attitudes, perceptions and influences in relation to sex, sexual health and teenage pregnancy, 2010

Research was undertaken by Coventry University on behalf of Leicestershire Teenage Pregnancy Partnership in 2010. A total of 561 14-16 year olds completed questionnaires in Leicestershire schools.

The research findings are summarised below;

a) Young people, sexual experience and relationships

- 65% of young people have not had sex – 50.8% of young people reported having no sexual experience.
- Young people have a strong intention to be safe when they do have sex.
- Young people often feel as though their relationships aren't adequately acknowledged by adults who are seen to trivialise or dismiss their feelings: 'They look down on you, like you couldn't know what love is but everyone has got to start somewhere and I'm starting here'
- When asked about the reasons for having sex, 83.8% cited 'being in a relationship' as a reason for having sex, 41.9% cited 'sexual pleasure' as the main reason.
- Young people demonstrated that the safe sex message is prominent but 'being caught in the moment' is often a reason why contraception isn't used.
- Young people had a good knowledge of where sexual health services are
- The data indicated that young people do recognise the risks associated with alcohol: 'Sometimes a lot of people are having sex when they're drunk so when you're drunk you're not thinking about contraception'
- The role of the media was identified as influential resulting from their depiction of all young people as sexually active.

b) Sex and relationships education (SRE)

- 94% of young people reported having received SRE – and SRE was viewed by young people as very important.

  'I think it's more important than geography or history, not everyone will travel the world…..but everyone will encounter love and relationships

- Overall young people's experience of SRE was reported as positive; 57.8% reported they could ask any question they wanted and 6.5% reported learning things they didn't know before.
- An over focus on some areas of SRE leaves critical gaps in young people's knowledge e.g. contraception
- How SRE is taught rather than who teaches SRE is critical to effective delivery. The confidence and competence of those delivering is paramount.
- Young people had a good knowledge around contraception but there were inconsistencies relating to their awareness and knowledge of the different types of contraception available.

c) Young people and teenage pregnancy

- The majority of young people do not like the idea of getting pregnant or getting their girlfriend pregnant at this stage in their life. Young people generally saw becoming a teenage parent as *'unlucky, just an accident'*

- Some young people aspire to become a parent. In one of the focus groups, young parents talked the positive aspects of becoming a parent:

  'It's your own creation of life, … actually done something good in your life'

- Young people were asked if they would consider an abortion; About 50% said probably or definitely yes, 25% said they didn't know and 12.1% reported definitely no.

- Young people were asked to select the words they felt related to the life of a teenage parent, 82.2% said 'hard' and 79% 'life changing'.

This research was used to inform the forward strategy for teenage pregnancy and a number of key actions were implemented as a result of this research. These included the following;

- Sexual health training needs to reflect a holistic approach to young people, sex and relationships and the importance young people place upon relationships alongside the safe sex messages.

- Pilot a campaign via the FE Network which works to normalise young women carrying condoms

- Leicestershire's Children's Trust to move from calling SRE to RSE to put relationships first.

- In order to ascertain the extent to which young people may benefit from support following a termination, the piloting of post termination counselling for young people should be considered. Research indicates that for some young people, support following a termination may assist in minimising potential negative outcomes.

9.3.5 Exploring young people's access of LARC, 2010

The following points are drawn following the undertaking of research and scoping work done to investigate the knowledge, awareness of availability and attitudes in Leicestershire in relation to LARC.

- Young people (specifically young women) within the target group (i.e. under 20 and living in Leicestershire) are open to using LARC

- Young people are attracted by the idea of reliable and long lasting contraception – whilst this offers a strong benefit to using LARC it could weaken young people's motivation to use condoms to prevent STIs. Evidence from the study conducted by Janet Hutchins (2009) supports this:

  "Reliability, giving protection against STIs and having good information about the contraception were the factors with which respondents agreed most strongly, followed by local availability,"

- Young people are concerned about side effects, particularly where they may impact on their lifestyle (e.g. heavy periods, weight gain, acne). Evidence from the study conducted by Janet Hutchins (2009) supports this:

  "The highest proportions of respondents indicated concern in relation to possible side effects of a contraceptive were for putting on weight (70.6%), followed by acne (70.6%), heavier periods (68.8%), and risk of osteoporosis (67.5%)…"

- Young people prefer to seek advice from health professionals or workers they engage with in informal educational settings

- There is a strong need for clear, unambiguous, engaging, colourful, positive and consistent information to be produced and distributed to young people in a range of settings, including school, Connexions services, community settings etc. Evidence from the study conducted by Janet Hutchins (2009) supports this:

  "…the wider social network and cultural environment in which young people exist has significant impact on young people's behaviour. Improved provision of accurate, reliable and appropriate information about LARC across all of the information sources will be necessary to enable informants to cascade accurate and appropriate information to young people to support decision making based on the range of contraceptive options available…"

- Young people seek access to sexual health services on their terms – e.g. they prefer drop in clinics to fixed appointments

- Service providers would benefit from having clear and consistent information available. Evidence from the study conducted by Janet Hutchins (2009) supports this:

  "Awareness of availability of contraceptive methods from different service providers was not always accurate and awareness of LARC availability was low. Sexual health service provision in Leicestershire is via a range of levels of service and settings. Whilst this attempts to improve access to a service for young people at a local level it also has the potential to make it difficult to understand what services are available from any particular service."

- Service providers are concerned about the additional time they need to effectively support LARC in consultations with young people

- Lack of availability (or promotion) of LARC in all primary care settings creates potential barriers to access, requiring young people to travel further or visit clinical settings that are less familiar to them – this may be more perceptual (as evidenced by young people in the focus groups) than actual, as the number of GPs fitting LARC are significant in terms of coverage. Evidence from the study conducted by Janet Hutchins (2009) supports this:

  "…Lack of knowledge about where LARC is available, together with inconsistent availability from general practice and contraceptive services clinics is likely to increase barriers to LARC use".

This work informed some targeted projects to promote LARC.

9.4 Implications for sexual health

National data and local engagement work highlighted the critical exploration of relationships in both RSE and in the delivery sexual health services. With the impact of social media, evolving sexual practices and a reducing age of first sex, promotion of consensual, informed and respectful relationships is important to balance against other messages.

Services need to take account of the role the media plays in influencing decisions about sex and relationships and make attempts to counter negative or unhelpful overt messages with positive ones e.g. promotion of consent, how to access confidential services and what a healthy relationship looks like.

Service users value the importance of having local, community based sexual health provision. Service providers and users both highlighted gaps in information about the sexual health services that are available, how they can be accessed and how complaints can be raised. Clear and consistent information is required to ensure practitioners and service users know which services they can access and how they do this.

Despite there being a wider choice of contraception available, there continues to be a lot of confusion over how contraceptive methods work and myths about their reliability and use. Messages about relationships and sex (in school and beyond) need to include clear and concise information about contraceptive methods. In order to promote the LARC methods it is important that the benefits and implications of these methods are understood and communicated to the women who choice to use them.

From the perspective of Sexual Health Service Providers, key priorities to address are clarifying the priorities for sexual health delivery, commissioner and provider roles and responsibilities, integrating sexual health services across the system and further development of the wider sexual health workforce (including primary care and school nursing). Areas which both providers and service users highlighted including wanting more equitable and timely provision across LLR, wanting easier access in to services, seamless patient pathways, prioritising education on relationships and sex and ensuring clear information about local services.

10. Conclusion

Overall Leicestershire and Rutland (LCR) is meeting the majority of the sexual health needs of their local populations. This is evidenced by continuing lower rates for all STIs (including HIV), under 18 conceptions and sexual abuse than the England average. Nevertheless absolute numbers some STIs (including gonohorrea) and patient led demand is increasing across LCR. This consistent with the national picture, where more people are accessing specialist sexual health services. However locally is likely to also be linked to the increased access caused by the new integrated sexual health service and community based contracts, which have increased numbers and proportions of residents accessing local services across LCR. Further work has also been completed to establish high quality relationships and sex education across all schools which allow young people to develop positive healthy relationships.

Each section of the needs assessment (demography, high risk groups, STIs, HIV, sexual reproductive health, sexual abuse and engagement) provides specific implications for sexual health services following the review of evidence of need. When triangulating these sections together key areas for improvement across LCR include bringing the sexual health commissioning system together, prioritising prevention and access for vulnerable groups (including young people, men who have sex with men (MSM) followed by sex workers, black African communities and people with physical disabilities), developing the sexual health workforce (including non-specialist provision including primary care, school nursing and substance misuse). The recommendations from this triangulation are set out below. These will be translated into a sexual health strategy for LCR and reported to local authority departmental management teams, Health and Wellbeing Boards and other appropriate meetings for approval and implementation.

Key strengths of the needs assessment include the breadth and depth of validated quantitative national data sources that deliver reliable accurate data on service utilisation. This is a good reflection of need for conceptions and STIs that have symptoms, however is less effective for symptomless or latent STIs such as chlamydia and HIV. Although recent media interest will increase presentation, there is also likely to be underreporting for psychosexual issues and sexual abuse including Female Genital Mutilation (FMG) and Child Sex Exploitation (CSE). High quality information on specific vulnerable groups (e.g. sex workers, MSM, FGM etc.) was difficult to ascertain. Due to small numbers in many indicators (especially for Rutland) numbers can fluctuate widely across years, making trends more difficult to interpret. There were also different time lags in data sources which must be considered when comparing sections. Qualitative feedback with nearly 200 people was also completed as part of the needs assessment to add additional local detail and identify themes from the results, however fully validated thematic analysis using NVivo was not completed. The consultation with representatives from services was also undertaken at a time of year that made it difficult for certain sectors to be involved e.g. teachers and representatives from education and the service user consultation was quite targeted and in the main was with individuals under 25. Wider consultation with the general population would provide a broader perspective of views and this will be completed as part of the consultation on the needs assessment and strategy. Results from the needs assessment may be similar to that seen in other affluent counties across England, however is less generalisable to more urban cities.

The LCR sexual health needs assessment provides commissioners with a clear evidence base on sexual health need, supply and demand. With the increasing and aging populations, the changing sexual health needs, and pressure on public sector budgets; innovative integrated service models must evolve to meet this demand.

11. Recommendations

The following section summarises the key recommendations for sexual health commissioners and service providers across LCR;

11.1 Sexual Health Commissioners

1. **Development a sexual health strategy for Leicester, Leicestershire and Rutland**. Ensure that this engages and integrates the whole sexual health system, has clearly defined priorities, roles and responsibilities and considers sexual health across the life course.

2. **Explore co-commissioning opportunities to integrate sexual health patient pathways across commissioning organisations.** For example CCGs for primary care, menorrhagia, sex addiction, abortion services and NHS England for HIV services (including the implications of the PROUD study). Also consider how sexual health services can be further integrated into other local authority services such as substance misuse, school nursing, health visiting and social services (for HIV positive patients).

3. **Monitor demand for psychosexual service** and potentially increase provision as awareness and need increases with an aging population.

4. **Identify services for people with sex addiction**. Work with CCG mental health commissioners to consider access to treatment for sex addiction across LCR.

5. **Development of an LLR sexual health marketing and communications strategy** to promote consistent brands and messages about healthy relationships, reducing stigma and how to access services. Additional service promotion is needed to target groups and areas at higher risk of poor sexual health including young people, MSM, sex workers, black African communities and Charnwood, Oadby and Wigston. The implications of late HIV diagnosis should be raised with the heterosexual population.

6. **Assess the cost effectiveness of UPA emergency hormone contraception** by completing a cost benefit analysis of increasing access to UPA locally. This should then inform future emergency contraception provision across LCR.

7. **Undertake an audit of LARC retention rates in primary care and ISHS** to ascertain how well informed women are of the implications of these methods and how long women are retaining them for. This should focus particularly on younger women aged 15-34years.

8. Consider **locality priorities to address the differing trends in teenage pregnancy** across the 7 Districts.

9. Additional work is needed with the police to **understand the causes of the increases in sexual offences** in Leicestershire and interventions to help reduce these offences.

11.2 Sexual health services

10. **Equality impact assessment should be completed in all sexual health services** to ensure the services are meeting the needs of whole population including those with protected characteristics as determined in the 2010 Equality Act.[97] Particular attentions should be placed on sexual orientation, BME (including Asian populations that have under representative STI diagnosis), English not as a first language and people with learning and physical disabilities.

11. **Investigate the current barriers to accessing sexual health services from GPs**, in particular young people, LGBT and Sex Workers.

12. **Increase chlamydia screening as part of the core ISHS** (i.e. GUM and CSHS) due to high positivity rates and prioritise opportunistic screening to areas of highest positivity such as preventex postal kits.

13. Explore more **innovative models of ISHS service delivery to improve access in more rural areas** including Melton and Rutland .e.g. implementing virtual clinics, online testing etc. Priority should be given to increasing access to sexual health screening to men across Leicestershire and women and those aged 20-24years in Rutland.

14. **Improvements are needed to the appointment booking system for ISHS**. The service should continue to offer both appointments and drop-in appointment options.

15. **Sexual health services should further develop effective and efficient pathways between domestic abuse, substance misuse and mental health** services to address the root causes of the risk taking behaviour.

16. **Ensure sex workers and men who pay for sex need to have access to condoms and regular STI screening** to reduce bridging of STIs into the wider population.

17. **Increase access to community and home based HIV testing for specific groups at higher risk of HIV** (MSM, sex workers, young people, African heritage.) This includes developing robust protocols and pathways for local HIV testing to ensure rapid access to support and treatment people with reactive test results. Attention should also be given to increasing HIV testing within ISHS for men in Rutland.

18. **Health and social care providers should consider future needs of HIV positive population.** This includes implications of an ageing HIV population and assurance for patients that confidentiality is maintained as the group of care providers extends beyond specialist HIV care providers.

19. **Maintain good access to emergency contraception**, particularly for young people and Asian women. Improve pathways between emergency contraception providers and other sexual health services to ensure longer term sexual health needs are met.

20. **Improve information and access to range of contraception methods to young women aged 15- 25years**, including LARC. This includes reviewing the current model of LARC delivery in primary care to reduce the proportion of women using user defined methods through GPs and ensuring community provision is available for young people.

21. **Increase access to abortion services by developing a LLR single point of access** (including self-referral) to improve the proportion on women accessing services under 10weeks gestation. Consideration is also needed to improve local access to abortion services over 12 weeks gestation.

22. **Review of the specialist teenage pregnancy and community midwifery service pathways** to identify opportunities for further integration with sexual health services and to determine the extent to which they are meeting current need.

23. **Review the support needs of teenaged parents and mothers aged 19-21** to ensure that they can progress into education, employment and training at a point that is timely for them and their families.

24. **All sexual health services should support the LLR CSE strategy.** Consultation with the CSE Team and if possible, victims of CSE needs to explore to what extent the current SHS offer meets the needs of this vulnerable cohort

11.3 Training

25. **Complete a sexual health training analysis to develop a workforce plan** to improve all levels of sexual health competencies across LCR. LARC provision and primary care is a key priorities for this plan.

26. **Ensure high quality RSE training/ provision is delivered across LCR** to ensure young people can make informed choices about their sexual health. Materials should give greater emphasis on healthy relationships, consent, domestic abuse, how to seek help, all contraceptive methods and the links between alcohol and risk taking sexual behaviour.

27. **CSE and domestic abuse training for all sexual health providers** to ensure they identify what it is and understand local support pathways available.

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13. Glossary

BME	Black and minority ethnic groups
CSE	Child Sexual Exploitation
CSHS	Community Sexual Health Service
CSSP	Community Safer Sex Project
DA	Domestic Abuse
EC	Emergency contraception
EHC	Emergency hormonal contraception.
GUM	Genito –urinary Medicine
HIV	Human Immunodeficiency Virus
HPV	Human Papillomavirus
ISHS	Integrated Sexual Health Service
IUD	Inter uterine device
IUS	Inter uterine system
LARC	Long Acting Reversible Contraception
LCC	Leicestershire County Council
LCR	Leicestershire County & Rutland
LNG	Levonogestrel is a form of emergency hormone contraception that is licensed for use within 72 hours of after unprotected sexual intercourse or contraceptive failure.
LLR	Leicester, Leicestershire and Rutland
MARAC	A Multi Agency Risk Assessment Conference
MPS	Men who pay for sex
MSM	Men who have sex with Men (this term is intended to encompass the full range of men who engage in same sex sexual activity, regardless of their expressed sexual orientation or identity)
Natsal	National Survey of Sexual Attitudes and Lifestyle
NCSP	National Chlamydia Screening Programme

NICE	National Institute for Health and Care Excellence
PHE	Public Health England
RSE	Relationships and Sex Education
SLF	Supporting Leicestershire Families Service
SRE	Sex and relationship education
STI	Sexually Transmitted Infection
TOM	Target operating model
TOP	Termination of Pregnancy
UDM	User dependent method
UPA	Ulipristal Acetate is a form of emergency hormone contraception that is licensed for use within 72 hours of after unprotected sexual intercourse or contraceptive failure; (UPA) is licensed for use within 120 hours of UPSI or contraceptive failure

[i] REF properly
http://www.avaproject.org.uk/media/60461/costs%20of%20dv%20by%20local%20authority.pdf