A JOINT SPECIFIC NEEDS ASSESSMENT ON SEXUAL HEALTH

IN LEICESTER 2017

NHS
Leicester City
Clinical Commissioning Group

Leicester
City Council

Contents

Summary

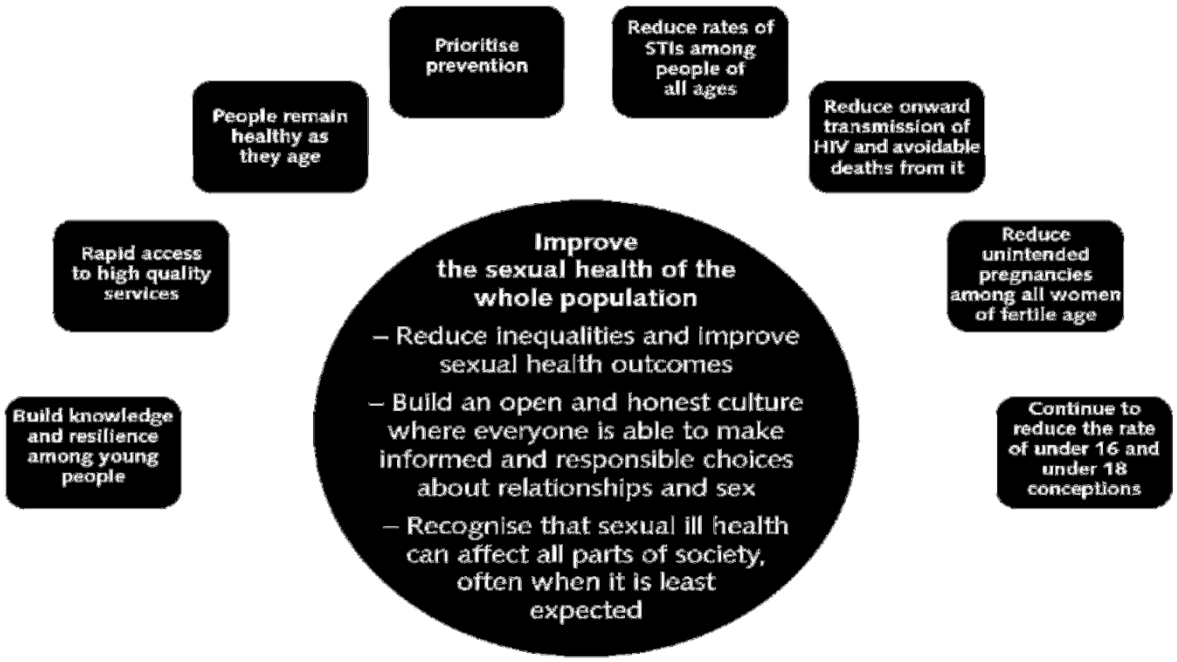
Sexual health affects our physical and psychological wellbeing, it is a key part of our identity as humans, and can have an enduring impact on our overall quality of life. The core elements of good sexual health are equitable relationships and sexual fulfilment with access to information and services to avoid the risk of unintended pregnancy, illness or disease.[1]

The scope of this document includes the promotion and maintenance of good sexual health including; the provision of services for all forms of contraception, detection and treatment of infections that are transmitted sexually (where sexual intercourse is the most common mode of transmission). Some infections that can be transmitted sexually, but sexual intercourse is not the main method of spread are not covered in this chapter e.g. Hepatitis B and C.

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

In 2013 the Department of Health published a *Framework for Sexual Health*[2] setting out the nation's ambition and objectives as shown below.

Figure 1: Framework for Sexual Health



The responsibilities for commissioning sexual health services are split across the three main commissioners and this is detailed in the table below.

Table 1: Sexual Health Commissioning Responsibilities

Commissioning Responsibilities		
Local authorities	**Clinical Commissioning Groups**	**NHS England**
Comprehensive, open access sexual health services including • contraceptive services • STI testing and treatment • HIV testing • National Chlamydia Screening Programme • Psychosexual counselling • Sexual Health specialist services (including young people's services, teenage pregnancy services, outreach, prevention and promotion, services in educational establishments and pharmacies)	• Abortion services • Sterilisation • Vasectomy • Non sexual health elements of psychosexual services • Gynaecology, including contraception for non-contraceptive purposes	• Contraception as provided as additional service of GP contract • HIV treatment and care (including post-exposure prophylaxis) • Promotion of opportunistic testing and treatment for STIs and patient requested testing by GPs • Sexual health elements of prison health services • Sexual Assault Referral Centres • Cervical screening • Specialist foetal medicine services

Key Issues and Gaps

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

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

Like many other urban areas, Leicester continues to be an area with significant sexual ill health as evidenced by the high rates of acute STIs and HIV compared to the national picture. The *Framework for Sexual Health*[2] acknowledges the relationship between sexual ill-health, poverty, social exclusion as well as the disproportionate burden of HIV infection on gay and bisexual men and some Black and Minority Ethnic (BME) groups. Many of these factors contribute to the high levels of sexual health need in Leicester, including deprivation and social inequality along with a

relatively young and ethnically diverse population. Young people, men who have sex with men and certain BME communities are disproportionately affected by poor sexual health and require enhanced service provision. (Recommendation 1)

When mapping some elements of sexual health in the City, there is a disparity between the east and west; with the west side of Leicester carrying more of the burden of under 18 conceptions. This should be taken into account when procuring and planning services, (Recommendation 2)

Leicester is the 5th highest prevalent area for HIV outside London. New diagnoses are identified every year both in clinical and non-clinical services. It is important that these diagnoses are made early to ensure effective treatment and to reduce onward transmission in the population. Those from black African and MSM communities are the two population groups in Leicester who are most affected by this infection given their relative proportions within the population. (Recommendation 3)

Leicester has a high late HIV diagnosis rate. A retrospective audit of HIV late diagnosis between 2010 and 2012 in Leicester showed that many late diagnoses where due to late presentation to services. Research by Lee et al (2012)[3] showed: that these groups have distinct characteristics, non-nationals, many have clinical indicator conditions, psychiatric co- morbidities, social care issues and history and this was consistent with individuals in Leicester. There are some actions that could be taken to improve late diagnosis rate however many are beyond the scope of local area e.g. transferring care and religious views. Ongoing review of all HIV diagnosis and annual report to identify that screening and testing is in the places that will offer to those who may be positive. (Recommendation 4)

The overall number of new STI diagnoses has decreased in Leicester between 2013 and 2016 however young people under the age of 25 continue to be disproportionately represented in these figures. Greater emphasis needs to be placed on targeting areas where the likelihood of a positive result is increased. There also needs to be a continuation of the focus on embedding chlamydia screening in services, and emphasizing the need for repeat screening as appropriate. (Recommendation 5)

The termination of pregnancy rate in Leicester has increased between 2012 and 2015 which is contrary to the national trend. The reasons for this are unclear and need to be explored, to ensure that this is a result of service improvements such as improved access to TOP services, provision of contraception post TOP and earlier access via increased access to pregnancy tests. These should be in line with new national TOP Service specification
(Recommendation 6)

Relationships and sex education is provided in many schools. A mapping against standards is required to ensure that all children receive at least the minimum requirements as set out in guidance to be released in 2018 and ensure that teachers have the skills to provide the recommendations in the proposed amendments to the Children and Social Work Act (2017) (Recommendation 7)

There have been significant developments in technology and sexual health services and communications need to keep pace with this ever changing technology. This includes an increase in self-care via self-testing and home sampling, the use of self-service machines and text messages. (Recommendation 8)

Long Acting Reversible Contraception (LARC) is cited by the National Institute for Health and Care Excellence (NICE) as being the most reliable form of contraception and is recommended for preventing teenage pregnancy and reducing the demand upon abortion services by women of all ages. Data in Leicester is indicating a fall in provision in general practice and an increased demand in the specialist service. Reasons for this need exploration
(Recommendation 9)

Increasing demand on the psychosexual service has been noted and clear pathway needs to be developed including links to mental health services.
(Recommendation 10)

Emerging STIs such as Zika virus and new recommendations for treatment of Zika virus and immunization for HPV and Hep A in MSM is recommended.
(Recommendation 11)

Leicester should develop a clear response to the provision of Pre-exposure Prophylaxis (PreP) for people at very high risk of HIV.
(Recommendation 12)

Table 2 summarises the recommendations for commissioners

Table 2: Summary recommendations for considerations by Commissioners in 2017

No.	Recommendation	Commissioners		
		Leicester City Council	Clinical Commissioning Group	NHS England Area
1.	Ensure commissioning of sexual health services for people identified as high risk, specifically MSM, BME especially African Heritage, Sex workers and vulnerable young people.	√		
2.	Ensure that geographical differences in conceptions under 18 are taken into consideration when developing services.	√	√	
3.	Commission services to increase early testing and diagnoses of HIV including annual report of all services to indicate trends or service need.	√	√	
4.	There should be an ongoing review of HIV testing, new diagnoses to inform an annual report which identifies gaps and opportunities for early diagnosis and prevention.	√	√	
5	Continue to embed chlamydia, screening in services e.g. TOP, Gynaecology and midwifery	√	√	
6.	Ensure TOP service compliant with National TOP service specification and delivers post TOP LARC and self-referral service and tests for chlamydia and		√	
7.	Map RSE provision against new recommendations to identify gaps in provision.	√		
8	Internet developments, self-service machines and other technological developments should be implemented.	√		
9..	Investigate reason for fall in LARC in primary care and develop media campaign promoting this method of contraception.	√		
10	Develop clear pathway to mental health service for some psychosexual health patients.		√	
11	Emerging STIs such as Zika virus, Hepatitis A should be appropriately prevented, tested for and treated.	√		
12.	Develop a clear response to provision to PREP.	√		√

Who is at risk and why?

There has been a change in the sexual health behaviour of the population of England over the last 60 years. This has been evidenced in the National Sexual Health attitudes Surveys (Natsal)[4] undertaken in 1991, 2001 and 2011. The Natsal survey reveals an increase in;

- The average number of sexual partners over a person's lifetime, particularly for women (3.7 in 1991 compared to 7.7 in 2011
- The sexual repertoire of heterosexual partners, particularly with oral and anal sexual intercourse.

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

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

There is also a clear correlation between the acquisition of STIs and deprivation. There could be multiple reasons for this including:[5]

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

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

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

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

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

Sexual Orientation

The term MSM encompasses a diverse group comprising gay, bisexual and other men who have sexual contact with men. Some MSM do not identify as gay or bisexual and may present

as heterosexual to healthcare services to preserve their anonymity. The reasons for this are diverse but include a backdrop of stigmatization. Societal attitudes to homosexuality remain markedly less liberal than attitudes to premarital sex. Although less than 3% of men in the UK are MSM, this group bears a disproportionate burden of acute STIs and HIV. In England 84% of syphilis and 70% of gonorrhoea diagnoses in 2015, and 50% of new HIV diagnoses in 2015, were in MSM. In Leicester in 2015 18.5% of new STI diagnoses were in MSM. This has risen from 11.4% in 2011 but is lower than in 2014. Strategies to limit the rate of STI transmission in this group include regular screening, health promotion and outreach work to target the most at-risk groups. Use of internet applications such as GRINDR to facilitate sexual encounters is becoming increasingly popular among MSM. Such anonymous encounters present a particular challenge for limiting the spread of transmission and there may be a place for using such applications to facilitate partner notification. Sex between men which occurs under the influence of recreational drugs ("Chemsex") is becoming increasingly common. Chemsex enhances transmission of a number of infections, including HIV, as a result of limited condom use, multiple partners, prolonged sex sessions, anogenital trauma and injecting practices. [6]

The term "trans*" or transgender, refers to people whose gender identity does not match the one they were assigned at birth. Up to 1% of the population experiences some degree of gender variance.[7] It is increasingly recognized that members of the trans* community are at high risk of sexual ill-health due to stigma, isolation and social disadvantage. In a meta-analysis 21.9% of transwomen in high income countries were HIV positive, and transwomen worldwide had an almost 50-fold increase in HIV risk compared to the general population.[8]

Ethnicity

The link between ethnicity and sexual health is complex and confounded by culture, faith, esteem and power. Where ethnicity was recorded, 28% of new STIs were diagnosed in people who were born overseas. Leicester mirrors England with the pattern of distribution of STIs across ethnicities'. This shows that people of black ethnicity have the highest rate of STIs followed by those of mixed ethnicity and then white ethnicity. In Leicester people of Asian ethnicity have the lowest rate of STI diagnosis. Despite Leicester having a large Asian population the rate of STIs in people of Asian ethnicity is lower than the national at 211 per 100,000 compared to 324 per 100,000 for England.

The level of need in Leicester

Sexually Transmitted Infections (STIs)

Leicester is currently ranked 112 out of 326 local authorities (where 1 is the highest) for diagnosis of new STIs excluding chlamydia. The rate is 881.4 per 100.000 (2976 infections) compared to 767.6 per 100,000 in England. The group of infections conventionally considered as acute STIs are:

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

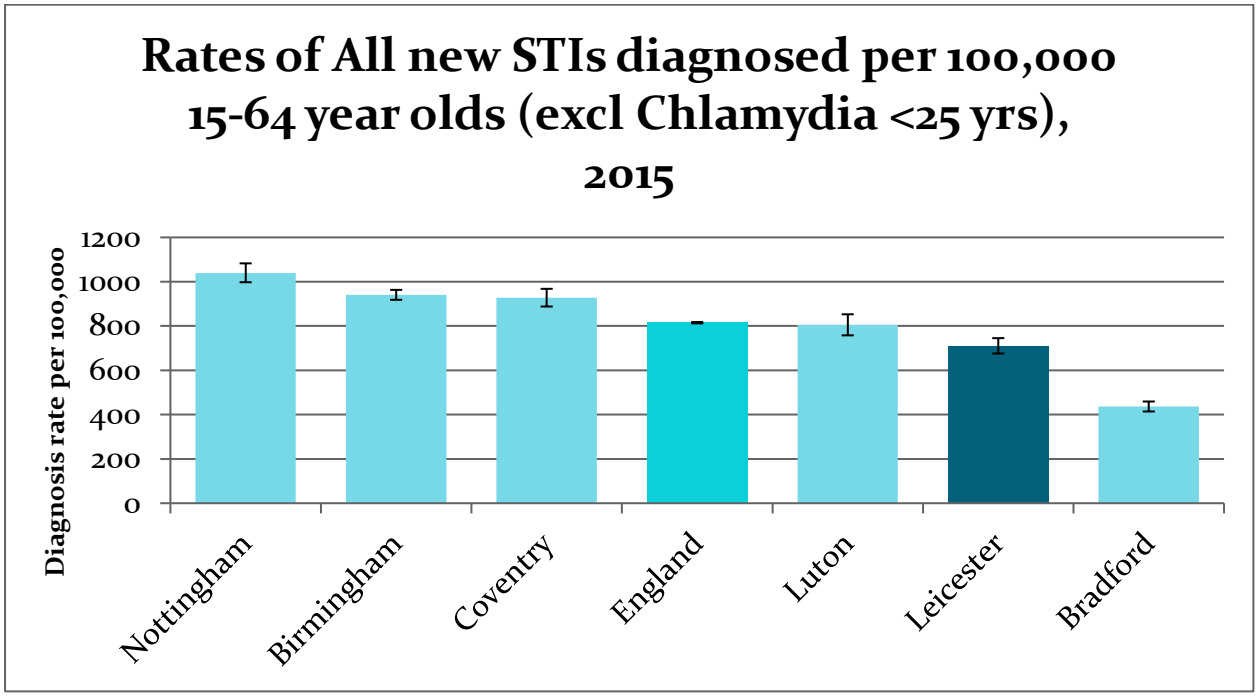
Sexually transmitted infections often do not occur in isolation, and a person may be affected by a number of STIs at any one time. The presence of one STI may facilitate the acquisition of others, as in the case of ulcerative conditions and HIV. STI testing has progressed dramatically

in the past few years with the advent of PCR (polymerase chain reaction) DNA based testing, and the majority of STI screening is now performed with self-taken samples, negating the need for clinical examination which may have been a barrier to screening in the past. Point of care testing for infections such as HIV provides rapid results on site and may be useful in outreach settings. Newer PCRs, such as those for Trichomonas vaginalis and syphilis testing, provide an opportunity to increase the speed and accuracy of diagnosis.

The Leicester Health and Wellbeing Survey (2015)[9] asked specifically about where Leicester residents would seek advice or treatment for sexual health concerns. Seventy-nine percent would use public services; with residents aged 35-64 more likely to consult their GP (74% vs 68% of the group surveyed) and residents aged 16-34 more likely to attend a sexual health service (22% vs 15% of total population surveyed). Ten percent of Leicester residents would opt to use the internet for advice, and use of new technologies for STI testing, patient information, health promotion and partner notification is growing.

Both nationally and locally there is a downward trend in new STIs. Figure 2 shows the rate of acute STIs per 100,000 residents for Leicester and similar cities for 2015, which show that Leicester is below the national average and takes the second lowest position when compared against its peers. This is an improvement on previous years.

Figure 2: Rates of all new STIs per 100,000 (15-64 year olds) by ONS Comparator Group 2015



Source: Public Health England, Sexual and Reproductive Health Profiles, 2016

Re-infection rates

In the period 2010-2015, 9.9% of women and 9.8% men presenting with an STI at a Genito-Urinary Medicine (GUM) clinic in Leicester were re-infected. This is slightly higher than the national picture of 7.0% of women and 9.0% of men. For gonorrhoea, the reinfection rate in Leicester has increased from previous years. It is now 6.3% for women and 7.3% for men compared to the national figures of 3.7% for women and 8.0% for men.

Risk Groups

Ethnicity data for diagnosed STIs (2015) shows that the highest rates of all diagnosed STIs are in the following ethnicities: Mixed White and Black African, Black African, Mixed White and Black Caribbean and Black Caribbean. These groups also had the highest rates in 2014. However there has been a steepest rate rise in the Black African group. Although not such a high rate there is also steep rise in rate in the White and Asian ethnic group. This rate is based upon the 2011 census populations and may underestimate this number of the African and mixed ethnicity populations living in Leicester and hence overestimate the rate, however it does show that there is a need to work with these groups.

Young people

Diagnosed STIs in Leicester are more common in the younger age groups; this is as shown in the table 3 for the years 2014 and 2015. Chlamydia is the most frequently diagnosed STI in Leicester and is most common between the ages of 16 and 34 years.

Table 3 Numbers of STI diagnoses by Age in Leicester 1st January 2014- 31st December 2015

Age Group years	Chlamydia	Gonorrhoea	Herpes	Syphilis	Warts
<15	3	1	1	0	0
15	15	3	4	0	0
16-19	368	62	37	1	67
20-24	604	125	89	6	191
25-34	387	109	96	15	189
35-44	75	48	47	11	62
45-64	26	20	39	4	45
65+	1	1	2	2	5
Total	1479	369	315	39	559

Chlamydia

Chlamydia infection is often asymptomatic or goes undiagnosed leading to complications such as pelvic inflammatory disease. Screening for Chlamydia detects asymptomatic infection, allowing for treatment with antibiotics. Chlamydia is the most common bacterial STI in England, and is most prevalent in the young adult population aged 15-24 years. Leicester is part of the National Chlamydia Screening Programme which provides opportunistic screening to all sexually

active young people aged 15-24 years. This programme is delivered in a variety of settings in Leicester such as, Further Education colleges and universities. In 2015, 21.6% of young people in Leicester aged 15-24 years were screened, which is lower than the national average of 22.5%.

The diagnosis rate for Chlamydia has been included as an indicator in the Public Health Outcomes Framework with an ambition to achieve a diagnosis rate of 2,300 per 100,000 of the 15-24 year old population. In 2013 Leicester's diagnosis rate was 2190 per 100,000 this is higher than the national rate of 1887 per 100,000 (2015). Leicester is ranked 54 out of 326 local authorities with 1 being the highest. The source of chlamydia tests and positives is shown in table 4

Table 4: Source of Chlamydia tests and positives

Number of chlamydia tests in Sexual health clinics	Number of chlamydia tests in other settings	Total number of tests	Number of positives all settings	Percentage of the population tested
4278	8687	12965	1317	21.6

Source: Public Health Outcomes Framework 2015

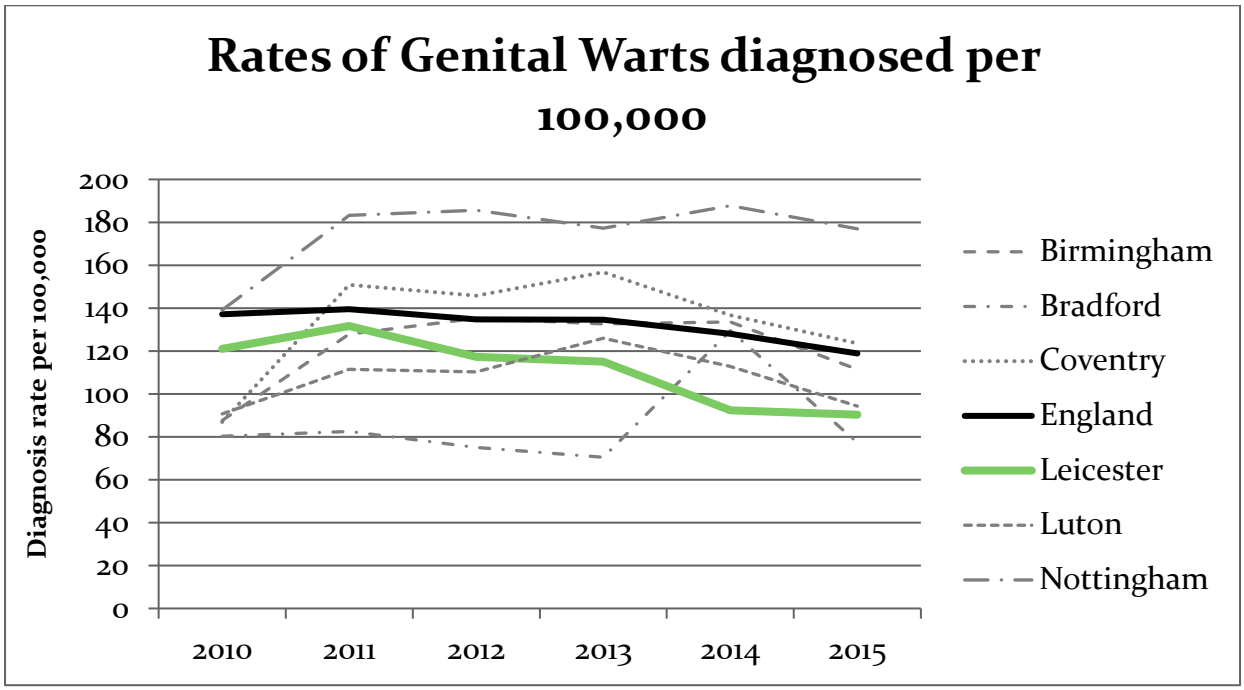
Human Papilloma Virus (HPV)

There are more than forty types of the HPV which can be transmitted sexually. Certain HPV infections can cause cancers, such as cervical cancer, and genital warts. In the UK, all 12-13 year old girls are offered HPV vaccination through a national HPV immunisation programme which confers protection against most virus types for cervical cancer and genital warts. The uptake of the HPV vaccination in Leicester is 88.6% (2014) compared to 86.7% (England). There is a National trial of HPV vaccination for MSM currently underway in 15 clinics across England. This is to confer protection from HPV on MSM who have a high risk for HPV and from cancers associated with it. Leicester is not part of this trial.

Genital warts

Genital warts are the second most common STI. Diagnoses of genital warts have started to decrease since the introduction of HPV vaccination in girls. Figure 3 compares Leicester with its peer comparators and shows that Leicester has a lower rate than most statistical comparators and a lower rate than England and has decreased by 2% in the last year.

Figure 3: Rates of genital warts diagnosed per 100,000 population (2010-2015) by ONS Comparator Group



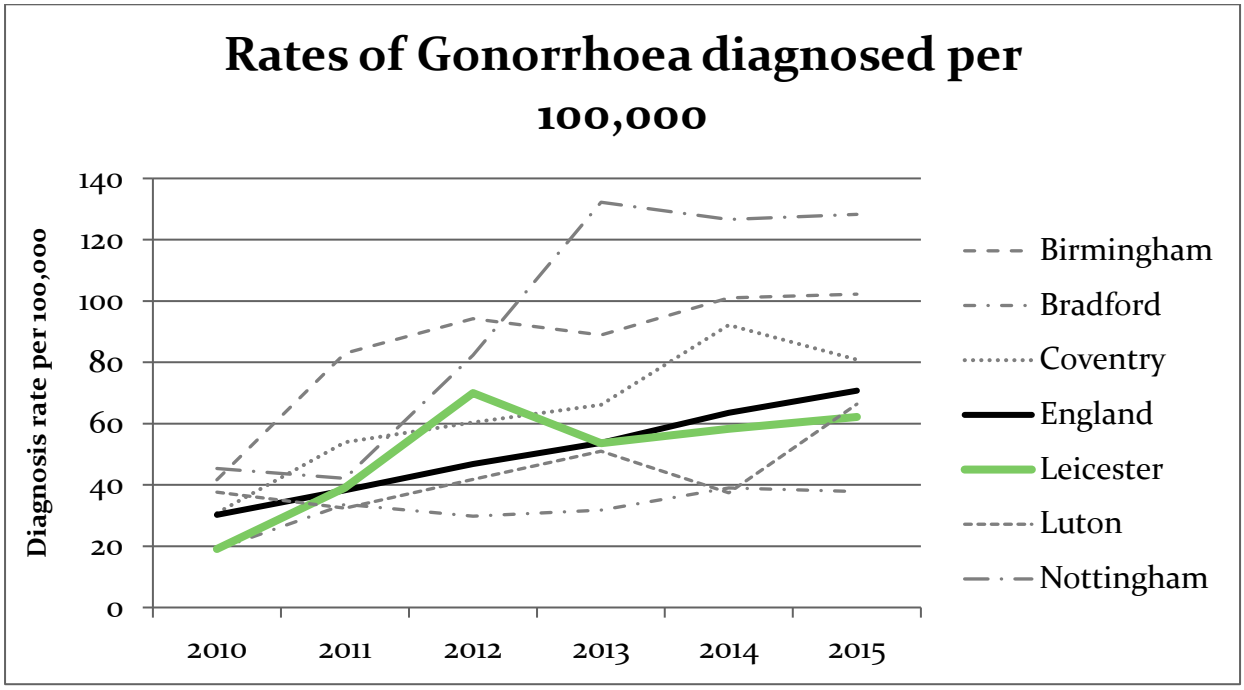
Source: Public Health England, Sexual and Reproductive Health Profiles, 2016

Gonorrhoea

Nationally, the rates of Gonorrhoea infection have been increasing and there is an increase in the rates of gonorrhoea infection in Leicester for 2015. Gonorrhoea is becoming more difficult to treat, as it can quickly develop resistance to antibiotics. There has recently been an outbreak of azithromycin-resistant gonorrhoea amongst heterosexuals in the north of England and there are concerns that such resistance could become widespread. Figure 4 compares Leicester with its peer comparators and illustrates higher rises in gonorrhoea rates occurring in urban areas (Birmingham and Nottingham) where more testing occurs and there are higher STI rates overall.

Gonorrhoea is a marker of high risk sexual activity. Leicester ranks 60 out 326 local authorities in England (where 1 is the highest). The rate of gonorrhoea diagnosis per 100,000 in Leicester was 62.2 per 100,000 (70 per 100,000 in England.

Figure 4: Rates of Gonorrhoea diagnoses per 100,000 population (2010-2015) by ONS Comparator Group

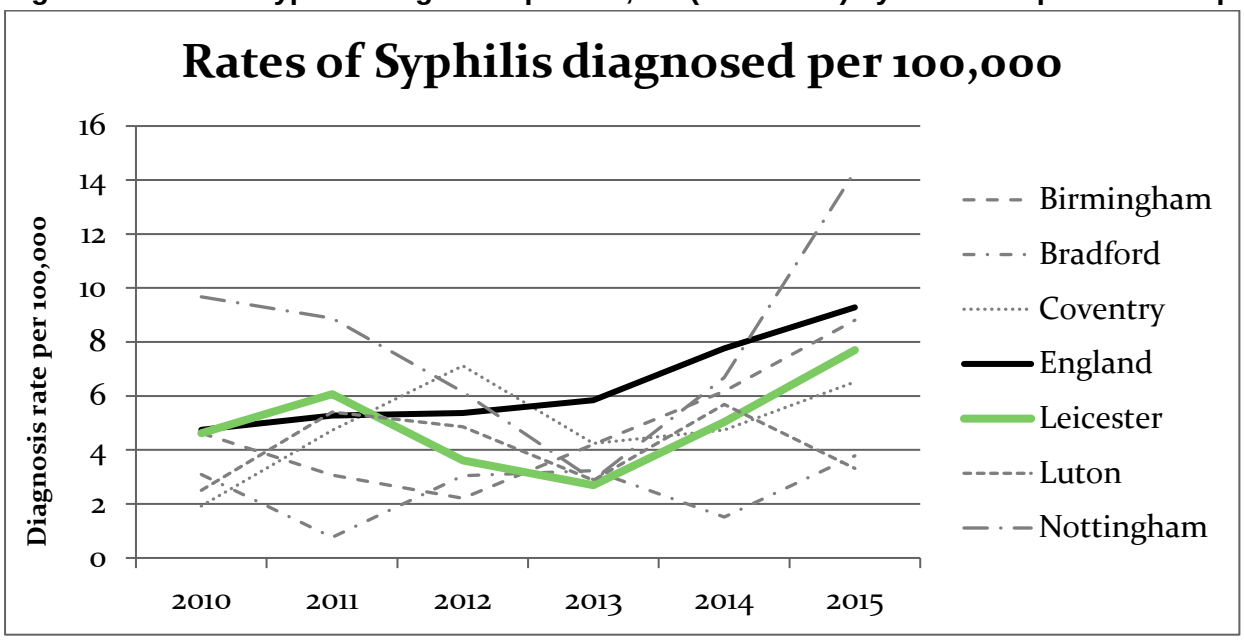


Source: Public Health England, Sexual and Reproductive Health Profiles, 2016

Syphilis

Syphilis is one of the least common STIs with low rates reported locally and nationally. The rate in Leicester and England has risen since 2013. Leicester ranks 58th out of 326 local authorities in England with a 54% increase between 2014 and 2015. Public Health England continues to investigate the recent steep rises in Nottingham. The rate in Leicester should be kept under close scrutiny due to its physical proximity to Nottingham and potential mixing of populations.

Figure 5: Rates of Syphilis diagnoses per 100,000 (2010-2015) by ONS Comparator Group



Source: Public Health England, Sexual and Reproductive Health Profiles, 2016

New and emerging STIs

In a subgroup of MSM, particularly those who are HIV positive and engage in risky practices such as Chemsex, STIs such as hepatitis C and lymphogranuloma venereum (LGV) are increasing in incidence. In Leicester all positive rectal Chlamydia samples are sent for LGV testing in order to identify the infection. MSM outreach services routinely test for hepatitis C in their clients. Collaborate health promotion work with LGBT substance misuse services will be important in controlling the transmission of such infections.

It is now recognised that Zika virus, while causing a benign self-limiting illness in most adults, can lead to congenital abnormalities in the foetus if it is acquired during pregnancy. The Zika outbreak is centred in the Caribbean and Central and South America, and thus may be encountered in travellers returning to the UK. Although Zika is mosquito-borne, it can be transmitted sexually. Current advice is that pregnant women should avoid Zika-infected areas and that conception should be delayed if there has been the possibility of Zika exposure in either men or women. It is possible that patients will attend sexual and reproductive health services for advice on Zika as the epidemic continues.

A significant emerging challenge is antibiotic resistance particularly in gonorrhoea but also identified in syphilis and Mycoplasma as well as possible case reports for Chlamydia. The ready availability of antibiotics such as Azithromycin online (through reputable companies such as large pharmacy chains) mean that patients can obtain treatments without prior testing thereby facilitating the emergence of resistant strains. Clinicians in sexual health services are now confronted with patients with ongoing symptoms who have already self-treated and hence have reduced sensitivity to treatment.

Testing for Mycoplasma genitalium is now offered in Europe, Australia and USA and being identified as a significant cause of NSU, cervicitis and PID. European guidelines recommend Mycoplasma testing in high risk asymptomatic individuals such as MSM. New testing platforms may offer testing for this in the U.K. In the near future, ideally including resistance profiles as antibiotic resistance is an increasing problem with Mycoplasma infections.

Human Immunodeficiency Virus (HIV)

The HIV epidemic has evolved significantly over the past few years. HIV is now primarily a sexually transmitted long term condition, with the majority of patients leading productive lives and remaining well under outpatient surveillance. Non sexual modes of transmission including mother to child transmission, blood products and intravenous drug use are now rare due to a variety of successful public health interventions including antenatal testing, blood screening and needle exchange schemes. HIV infection can still be associated with serious physical and mental ill health and reduced life expectancy, particularly in people who are diagnosed late or who do not engage with care. Discrimination and poverty also contribute to disparities in health outcomes in people living with HIV.

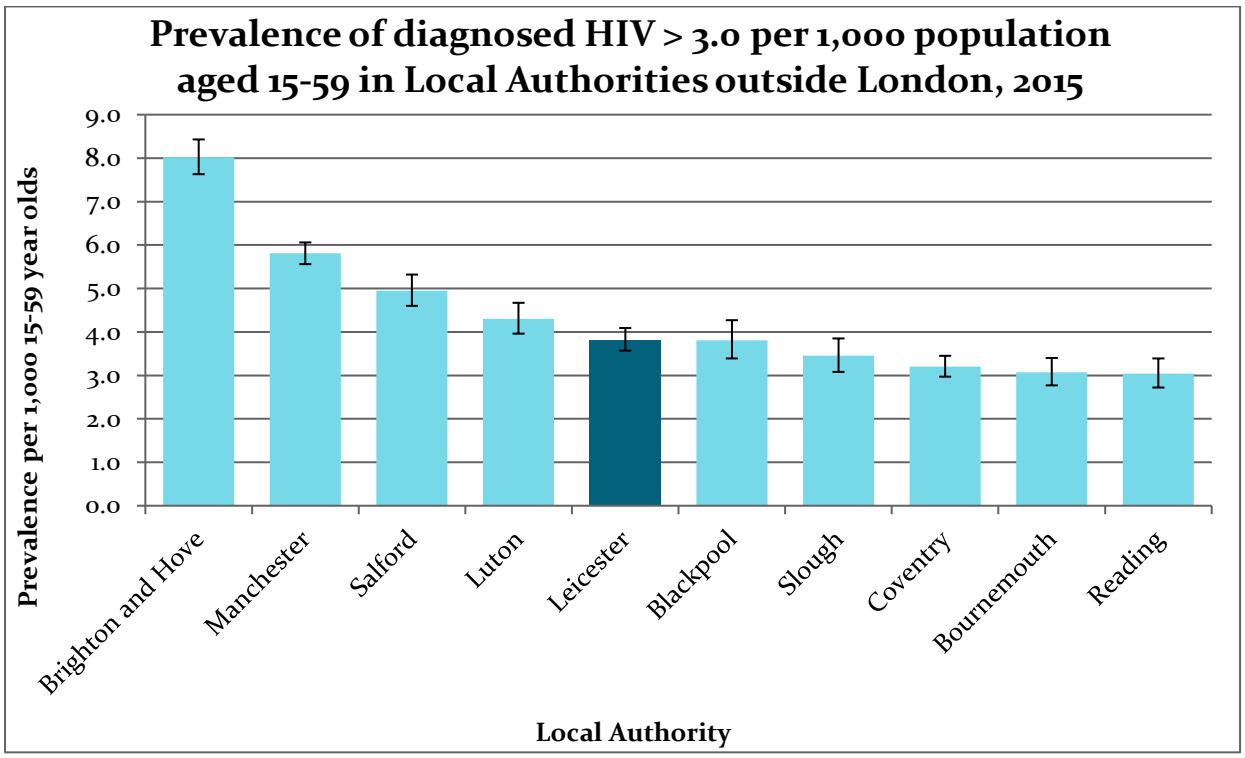
Public Health England estimates that 101,200 people in the UK were living with HIV in 2015, with 13% being undiagnosed and unaware of their infection. The two groups most affected by HIV in

the UK are MSM and people who have migrated from regions of the world where HIV is common, such as sub-Saharan Africa. There has been a 27% increase of HIV infections acquired within the UK from 2002-2011. In 2015, nearly half of newly diagnosed HIV was in MSM. 52% of people newly diagnosed with HIV in the UK in 2015 had been infected heterosexually with 20% of those being of Black African Ethnicity.

Areas with a diagnosed HIV rate of more than 2.0 per 1,000 population aged 15-59 years are defined as areas of high prevalence. Leicester has a diagnosed HIV prevalence rate of 3.8 and is ranked as the 5th highest prevalent area outside London as shown in Figure 7

In 2015 there were 898 people living in Leicester with HIV, a rate of 3.82 per 1000 this is a rise from 2012 when the figures were 3.6 per 1000 (807 people). In 2012 65% of people diagnosed in Leicester were of African ethnicity this has reduced to 62% in 2015.The rate is rising amongst the MSM group from14% in 2011 to 16% in 2015. Heterosexual sex is still the most likely mode of transmission accounting for 77% of cases. The number of newly diagnosed cases per year has begun to slow.

Figure 7: HIV Prevalence (>3.0 per 1,000 population aged - 15-59) in Local Authorities outside London - 2015



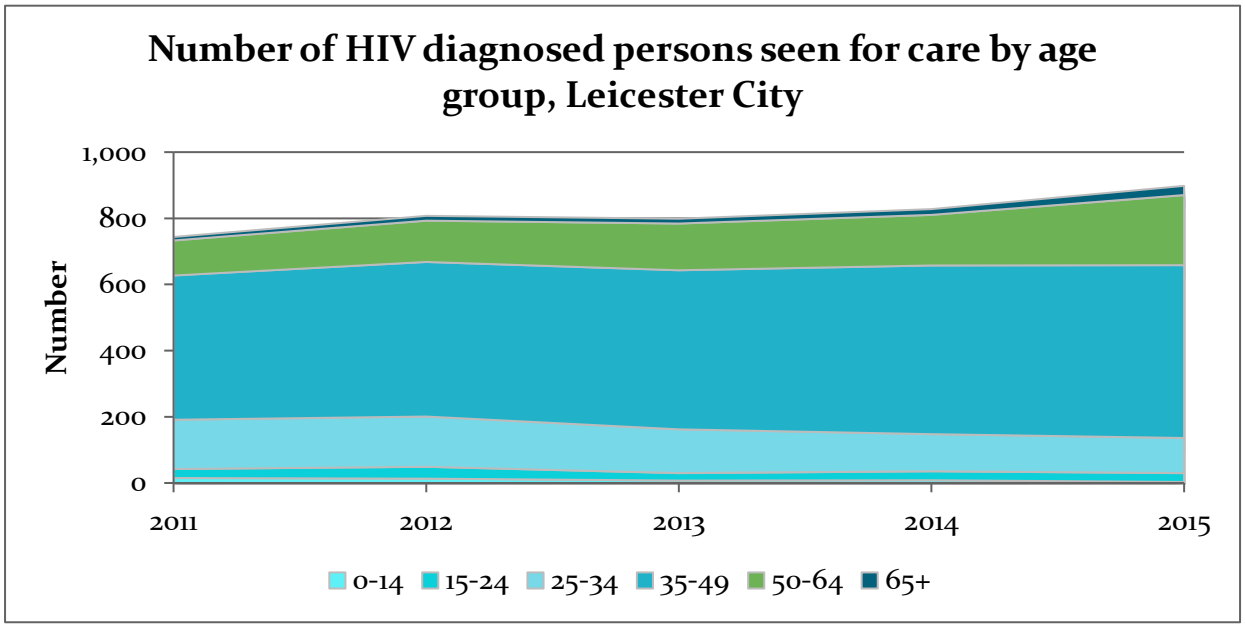
Source: Public Health England, Sexual and Reproductive Health Profiles, 2016

The HIV service is based at the Leicester Royal Infirmary and provides inpatient and outpatient care to individuals from across the East Midlands. As a result, the demographics of the HIV positive cohort accessing care in Leicester may differ from those of the patients' resident in Leicester City. Similarly, a small number (57/889 of HIV positive patients of all ages) of Leicester City residents accessed HIV care outside Leicester in 2015.The number of people accessing HIV-related care in Leicester continues to increase. In 2014, the incidence of HIV in

Leicester among people aged 15 or above was 16.72 per 100, 000 population, higher than the national average of 12.34 per 100 000.

Both chronic HIV and antiretroviral treatment increase the risk of age-related disorders such as cardiovascular disease, osteoporosis and neurocognitive impairment[10]. In Leicester, the median age of those seeking care for HIV is between 35 and 44 years. The age of the HIV positive cohort in Leicester is increasing Figure 8 shows how the population of people living with HIV is aging. It is likely that an ageing population of people living with HIV will require increased social care input in future. Social care for people living with HIV is provided in the same manner as social care for all other groups in Leicester with no specialized HIV social care provision.

Figure 8: Number of HIV diagnosed persons seen for care by age group



Source: Public Health England, Sexual and Reproductive Health Profiles, 2016

There is a strong link between HIV status and socioeconomic factors. In Leicester 82% of people diagnosed with HIV live in the wards with the highest levels of multiple deprivation.

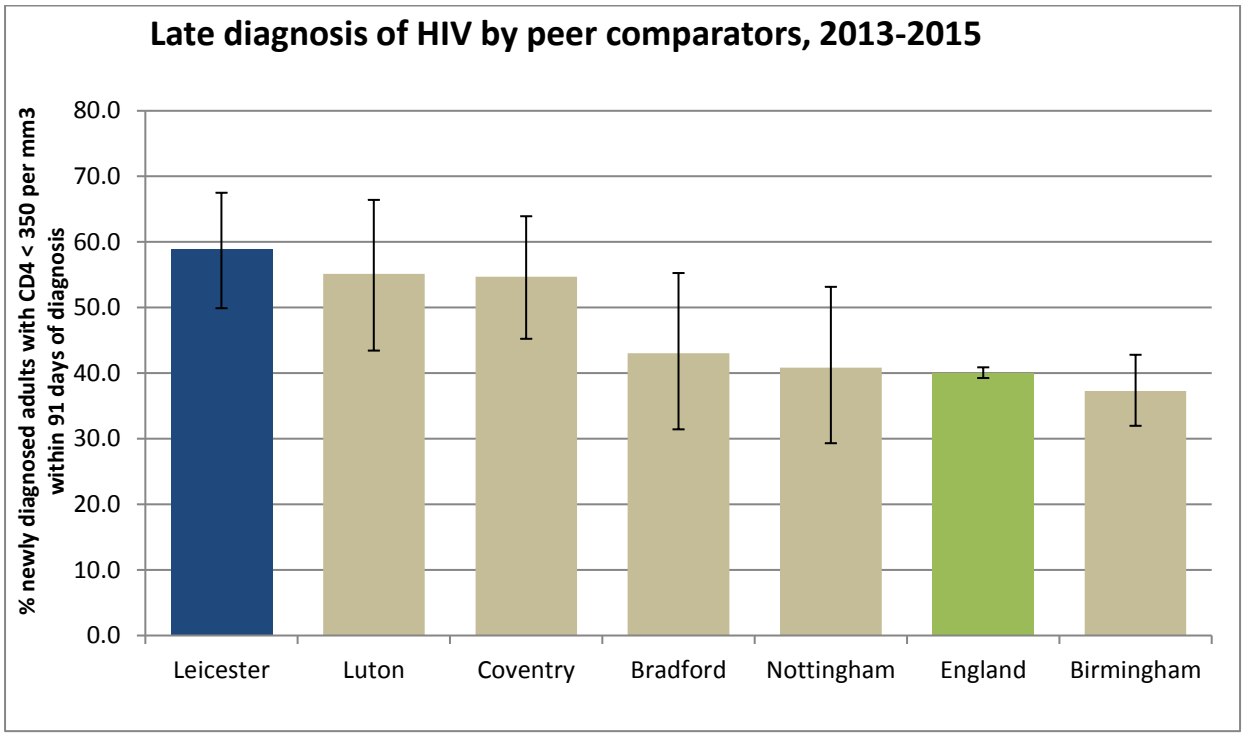
Late Diagnosis of HIV

The *Public Health Outcomes Framework* includes an indicator for the reduction in the number of people presenting with HIV at a late stage of infection. A person is considered to have been diagnosed late if the number of particular immune cells (CD4 cells) in their bloodstream has dropped below 350/ul. Late diagnosis of HIV increases the risk of illness and death, with those diagnosed late having a tenfold increased risk of dying within a year of diagnosis. In England late diagnosis between 2009 and 2012 was higher amongst:

- older people
- women
- black ethnicity
- Those who inject drugs.

Early diagnosis enables the provision of antiretroviral medication with benefits to the health of the individual as well as a reduction in risk of onward transmission. Between 2013 and 2015, 59% of adults diagnosed with HIV in Leicester were diagnosed late. This is higher than the England average of 40.3 %. Several factors may mean that local figures on late diagnosis are inaccurate. In early HIV infection CD4 count may dip temporarily, meaning that early infections may be misclassified as late. Patients with known HIV may also appear in late diagnosis figures, as demonstrated by an audit of late HIV diagnoses in Leicester (2010 – 2012) carried out in 2015 [Audit presented to Leicester City Council Clinical Governance Group 2015].[11] Of 85 apparently late HIV diagnoses in this time period, 27 had actually been diagnosed previously, and 11 had been diagnosed elsewhere and had transferred to Leicester. The true late diagnosis rate between 2010 and 2012 was therefore only 26% (47/180). Ongoing analysis of all newly diagnosed positive patients and the opportunities to test or diagnose earlier is recommended.

Figure 9: HIV late diagnosis by ONS Comparator Group (2013-2015)



Source: Public Health England, Sexual and Reproductive Health Profiles, 2017

Inpatient and outpatient HIV treatment and care is provided by the Infectious Diseases/HIV service at University Hospitals of Leicester. Post exposure prophylaxis can be accessed at the ISHS and the Accident and Emergency department. There is 100% compliance with the 48 hour access requirements; with the provision of 24 hour medical advice for HIV management.

HIV testing at the Integrated Sexual Health Services (ISHS)

The uptake (proportion of HIV tests offered which are accepted) of HIV testing at the ISHS remains higher than the national average, although it is at its lowest rate for over 5 years. Coverage of HIV testing is the proportion of eligible attendees at the ISHS who have an HIV test. This has fallen dramatically since 2013. As Leicester is a high prevalence area for HIV measures should be taken to increase HIV testing coverage locally. It is thought that some of

this apparent fall is related to coding issues within the sexual health service and this will be addressed in the next 6 months and new data submitted.

Table 5a: HIV testing uptake at GUM (2015)

	Leicester	*England*
Total	86.3%	76.2%
Men who have sex with men	97.7%	93.4%
Women	81.5%	69.2%
Men	92.6%	84.8%

It is worthy of note that although the HIV uptake rate is higher than the national rate this is the lowest that it has been for over 5 years.

Table 5b: Coverage of HIV testing at GUM (2015)

	Leicester	England
Total	46.4%	67.3%
Men who have sex with men	90.8%	88.0%
Women	37.3%	59.2%
Men	64.9%	78.3%

Source: Taken from GUMCAD data PHE 2016

It is known that the majority of HIV infections occur in high-risk groups in the UK. More work is needed to identify the demographics of those with incident HIV in Leicester so that these groups can be targeted for testing. BHIVA (British HIV Association) recommends that patients with indicator conditions should be tested for HIV. In Leicester, blood results which are negative for infectious mononucleosis are now appended with a comment recommending the practitioner considers an HIV test. Extending this successful approach to cover other indicator conditions such as lymphoma, thrombocytopenia and cervical intraepithelial neoplasia grade II or above may increase testing rates in high risk groups.

Contraception

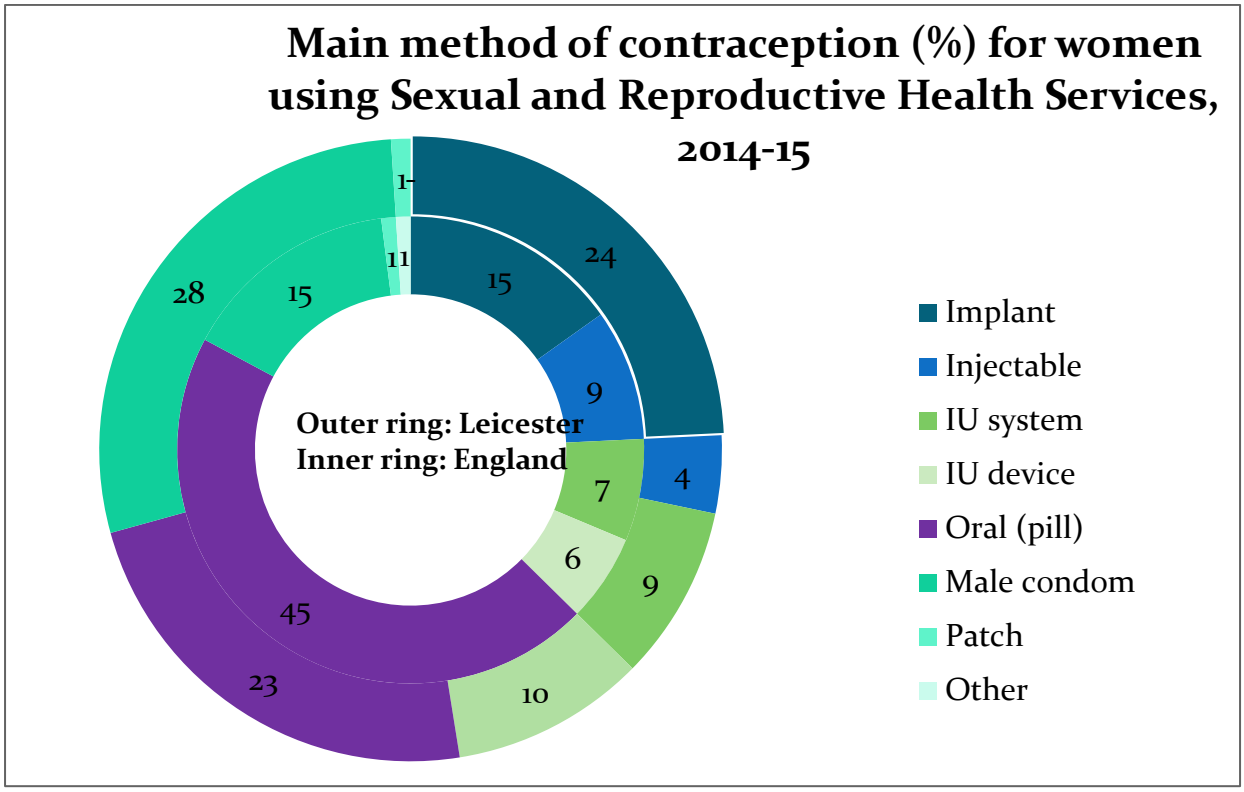
Contraception is provided by many providers for men and women. GPs are commissioned to provide contraception through the additional part of the GMS (General Medical Services) contract. In Leicester all GPs provide services under this scheme. This does not include Intrauterine Devices and Systems or Subdermal Implants. These are contracted from GPs via the Community Based services contract. The integrated sexual health service is also commissioned to provide open access contraception.

Sexual and Reproductive Health (SRH) services across England had 2.03 million contacts with 1.26 million individuals in 2015/16[12] . This is a decrease of 4 per cent in both the number of contacts and the number of individuals attending SRH services from 2014/15. 7% of women between the ages of 13 and 54 had at least one contact with an SRH service. For men in the same age group, 1% of the resident population had at least one contact.

Women aged 18 to 19 were most likely to use an SRH service, with 19% having at least one contact. 38% of women contacting SRH services for reasons of contraception were using long acting reversible contraceptives. Over the last ten years, this proportion has been increasing

and the proportion using user dependent methods has been decreasing. However, oral contraceptives (a user dependent method) is still the most common form of contraception item in use, being the main method for 45% of women contacting SRH services for contraception.

Figure 10: Method of Contraception for Women using SRH in Leicester and England – 2014/15



Source: NHS Digital, Sexual and reproductive Health Services data

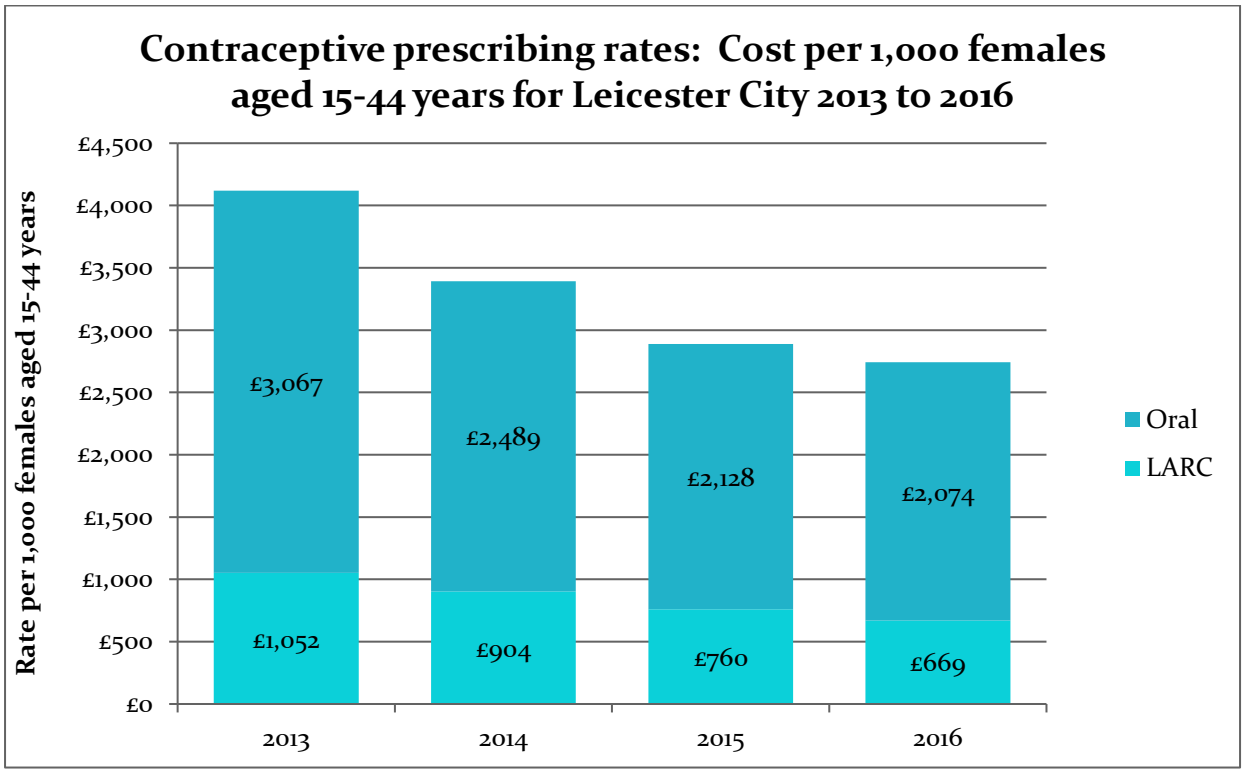
Nearly half of contraceptive methods provided at the Leicester ISHS were long acting reversible contraceptives (LARC). This is higher than the England average of 37%. In both England and Leicester there has been an increase compared to previous years. User dependent contraception (condoms, pill, cap etc.) was provided 54% of the time in Leicester compared to 64% for England. 23% of contraception provided at the ISHS is short acting hormonal contraception this is the lowest percentage amongst statistical neighbours and lower than the national average of 47%. It is interesting to note that Leicester has a very high percentage of male condom use (28%) as a form of short acting contraception.
In the over 25s Leicester has the 2nd lowest percentage uptake of injectable contraceptives 43% compared to an average of 54% in similar cities but still higher than the England average of 35.2%. Injectable contraception is less used in the under 25 age group both locally (37%) and nationally (20%).

General Practice prescribing data gives some indication of the types and patterns of contraception provided within general practice. It is difficult to show the exact rate per woman from the prescribing data as different GPs have different prescribing patterns e.g. one GP may give three months of oral contraception whilst another will give six months. These are each

recorded as one event on the prescribing data. The data shown therefore compares one year with another.

The overall amounts spent on contraception from 2013 – 2016 is shown in Figure 11. This mirrors the national trend with reducing amounts spent on contraception in general practice. There is a reduction in both oral contraception spending and spending on LARC. The reason for this is unknown and needs further exploration and discussion with local GPs.

Figure 11: Total Contraceptive Prescribing Spend 2013 – 2016 for Leicester City



Source: ePACT Data 2013 to 2016

Long acting reversible contraception (LARC)

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

- Intrauterine Devices and Systems (IUD/S) also called coils
- Sub Dermal implants(SDi) also called implants
- Depo-Provera Injections

In 2015/16 43 practices in Leicester, 90% of GP practices, were signed up to provide IUD/S and 87% of GP practices were signed up to provide SDi through a Community Based Services Contract. There were also 7 GP practices providing an integrated open access sexual health service where contraception could be accessed. Prescribing data from 2016 shows that only 22 practices provided IUS/Ds to their patients. This reflects the performance data that Leicester City Council holds with GPs who are contracted to provide this service for their patients.

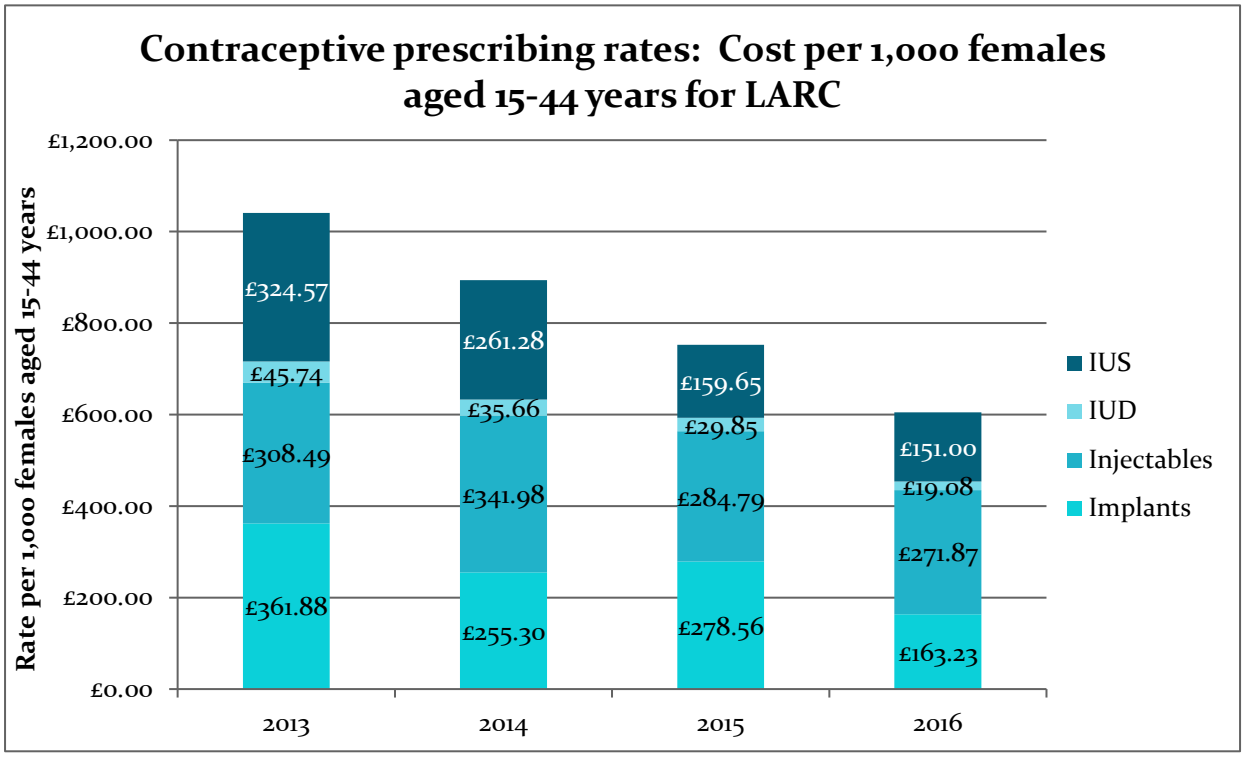
Anecdotally this is due to:-

- Reduced trained clinicians in general practice

- Reduced time available to provide the service in general practice
- Using the ISHS as an alternative source of this service
- Increasing costs of indemnity insurance for nurses

Figure 12 showing contraceptive prescribing spend and illustrates a year on year reduction in all types of LARC.

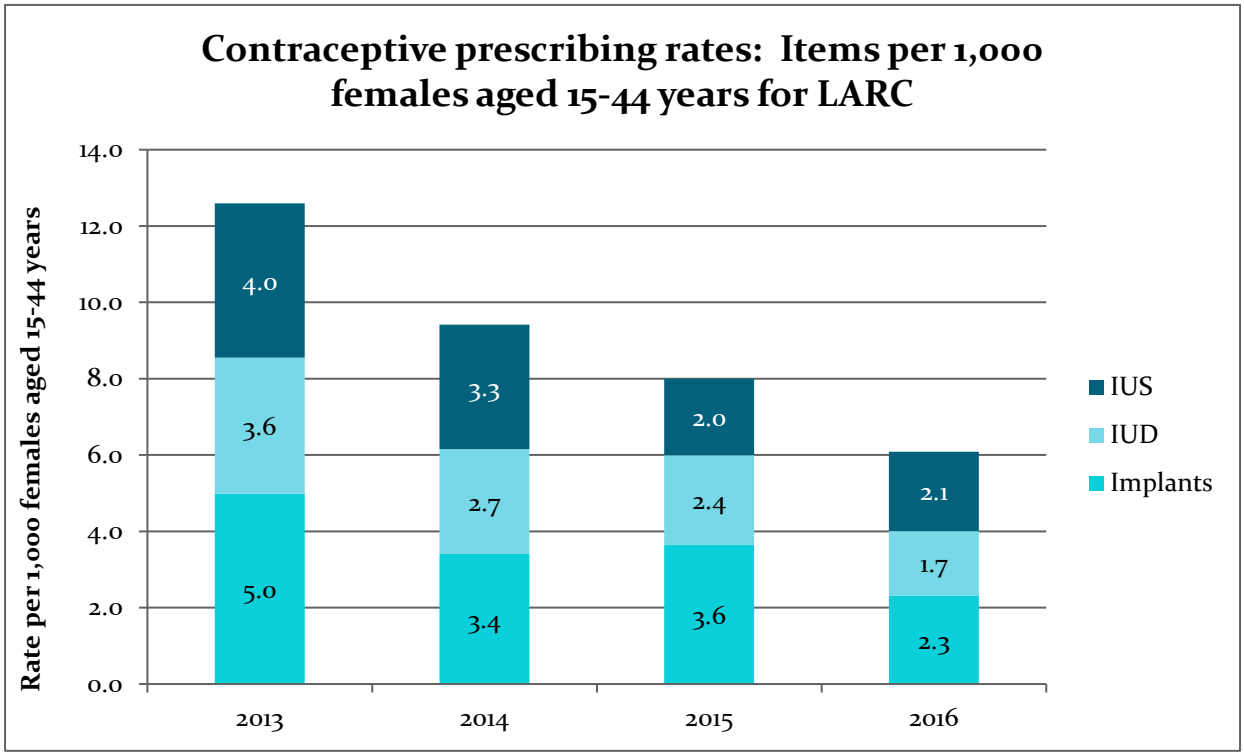
Figure 12: Contraceptive Prescribing Spend for LARC 2013 – 2016 for Leicester City



Source: epact Data 2013 to 2016

Figure 13 shows the reduction in rate of item rather than costs per type of LARC. Since March 2015 GPs have been able to claim for the costs of the implant device from Leicester City Council's sexual health budget and hence it would be expected that the prescribing costs would fall. It is concerning that despite the reduced costs to GP's the rate of injectable contraception, implants IUDs and IUS continue to fall year on year since 2014.

Figure 13: Contraceptive Prescribing Items for LARC 2013 – 2016 for Leicester City



Source: ePACT Data 2013 to 2016

Emergency Contraception

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

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

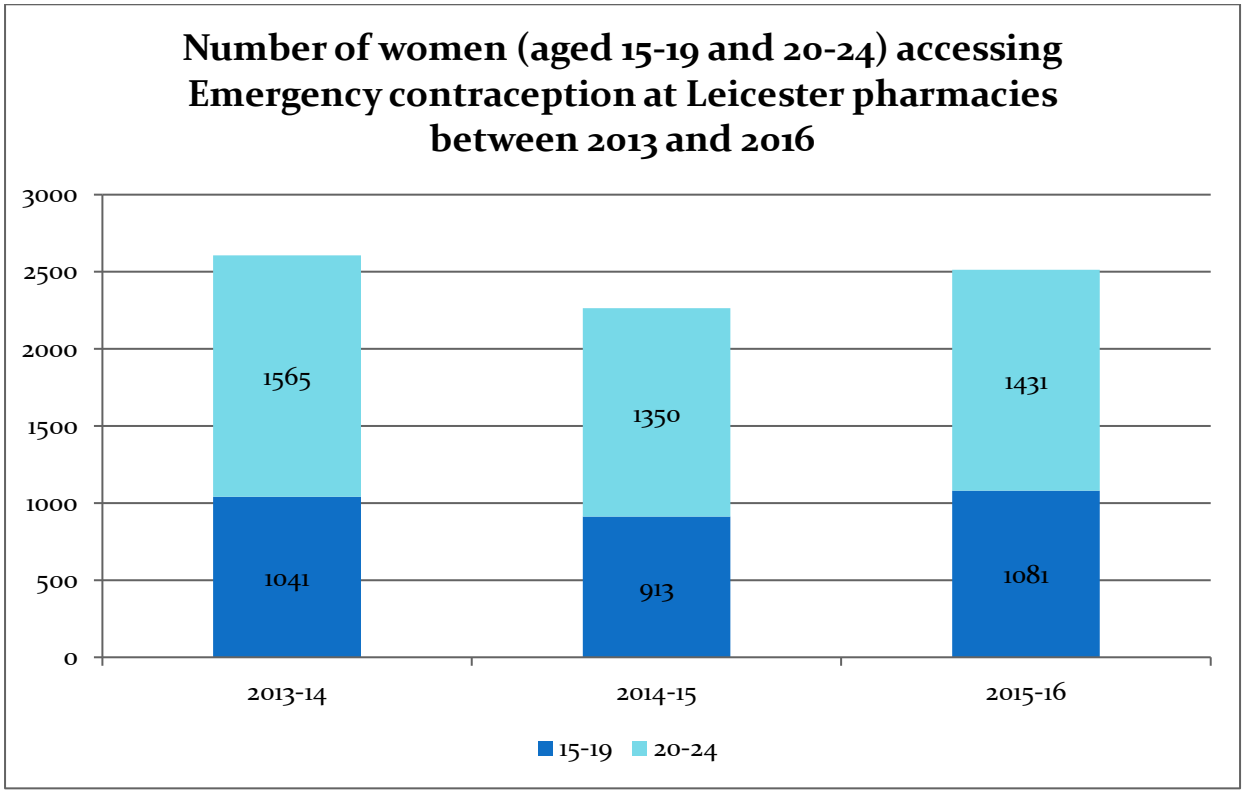
Emergency contraceptive pill

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

The type of emergency contraceptive pill offered and provided is dependent on the patient's suitability. Levonelle is currently provided as a free scheme 7 days a week for those under 25 years by 71 local pharmacies across Leicester. The community pharmacy scheme saw 2,450 women in 2015/16 who qualified for Levonelle as shown in Figure 14. The majority of these consultations were provided in five local pharmacies contracted under the scheme. Women attending after 72 hours of unprotected sexual intercourse are redirected to their GP or the Contraceptive and Reproductive Health service where either EllaOne or the IUD can be provided. Data on the number of women not qualifying for Levonelle and requiring

redirection to their GP or the Contraceptive and Reproductive Health service is not currently recorded. Figure 14 also shows that more women are aged over 19 compared to 15-19 years of age.

Figure 14: Number of Women accessing EHC by age group (2013 -16)

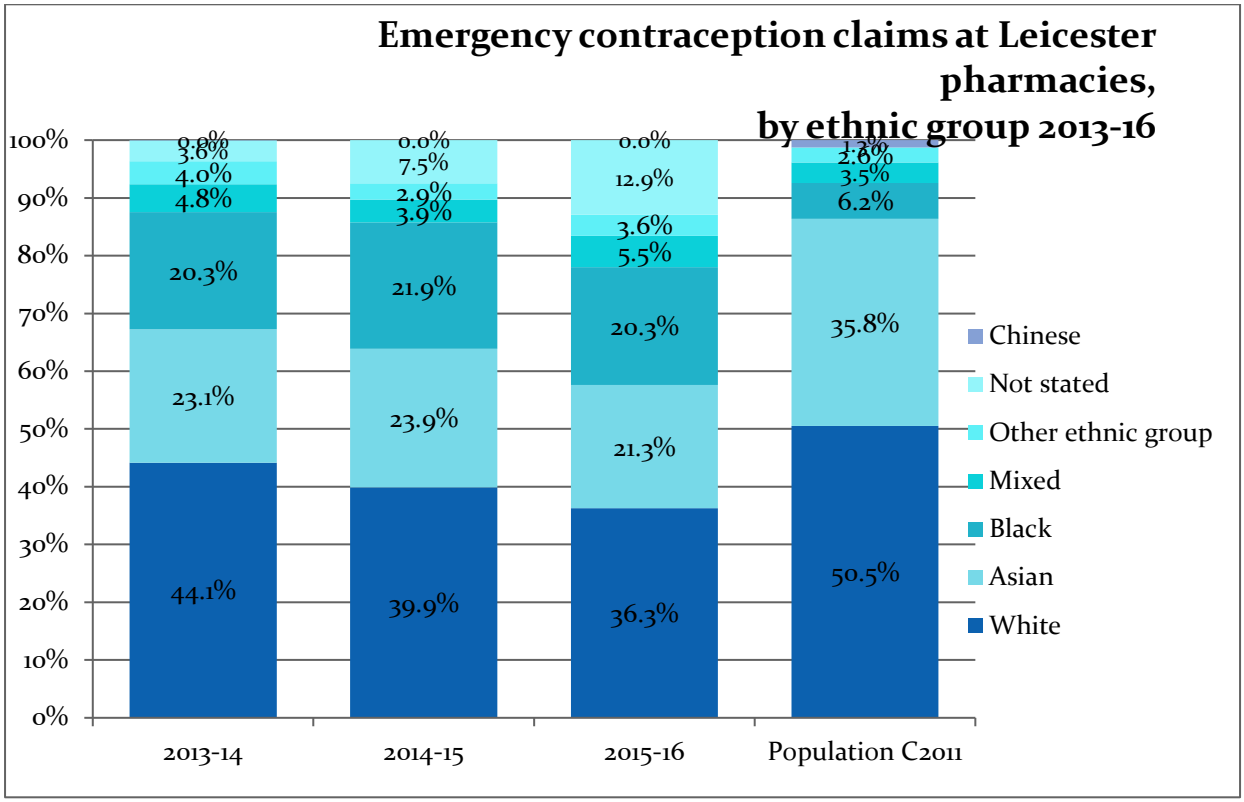


Source: Data provided by Leicester City pharmacies

Most community pharmacists 'consultations result in dispensing of Levonelle.

Ethnicity data for young women accessing this service (Figure 15) shows that there are a higher proportion of women identifying as Black or mixed ethnicity than the proportion in the population. This could indicate an unmet contraceptive and knowledge need in this part of the community. The proportion of women identifying as white or Asian is smaller than the proportion in the community.

Figure 15: Emergency Contraception Claims at Leicester Pharmacies by Ethnic group – 2013/14 to 2015/16



Source: EHC data provided by Leicester City pharmacies, Population Census 2011

Copper intrauterine device (IUD)

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

Condom and pregnancy testing provision

Free condoms and pregnancy tests are available across Leicester to all young people under 25 in Further Education colleges and Universities as well as some youth and community settings. Trained workers provide these along with instructions on their use.

Teenage Pregnancy

Teenage pregnancy is a significant public health issue. The UK still has one of the highest rates of teenage pregnancy in Western Europe. However the teenage pregnancy rate in England and Wales has fallen to its lowest level on record.

In 2015 the under 18 conception rate nationally was 21 per 1,000 (20,351 conceptions) , a 10% decrease on the previous year. Records began in 1969, when the under-18 conception rate was 47.1 conceptions per 1,000 girls, or 45,495 teenage pregnancies. The highest recorded year

was 1971 when there were 54.9 conceptions per 1,000 girls. The conception rate takes into account all registered births and abortion notifications.

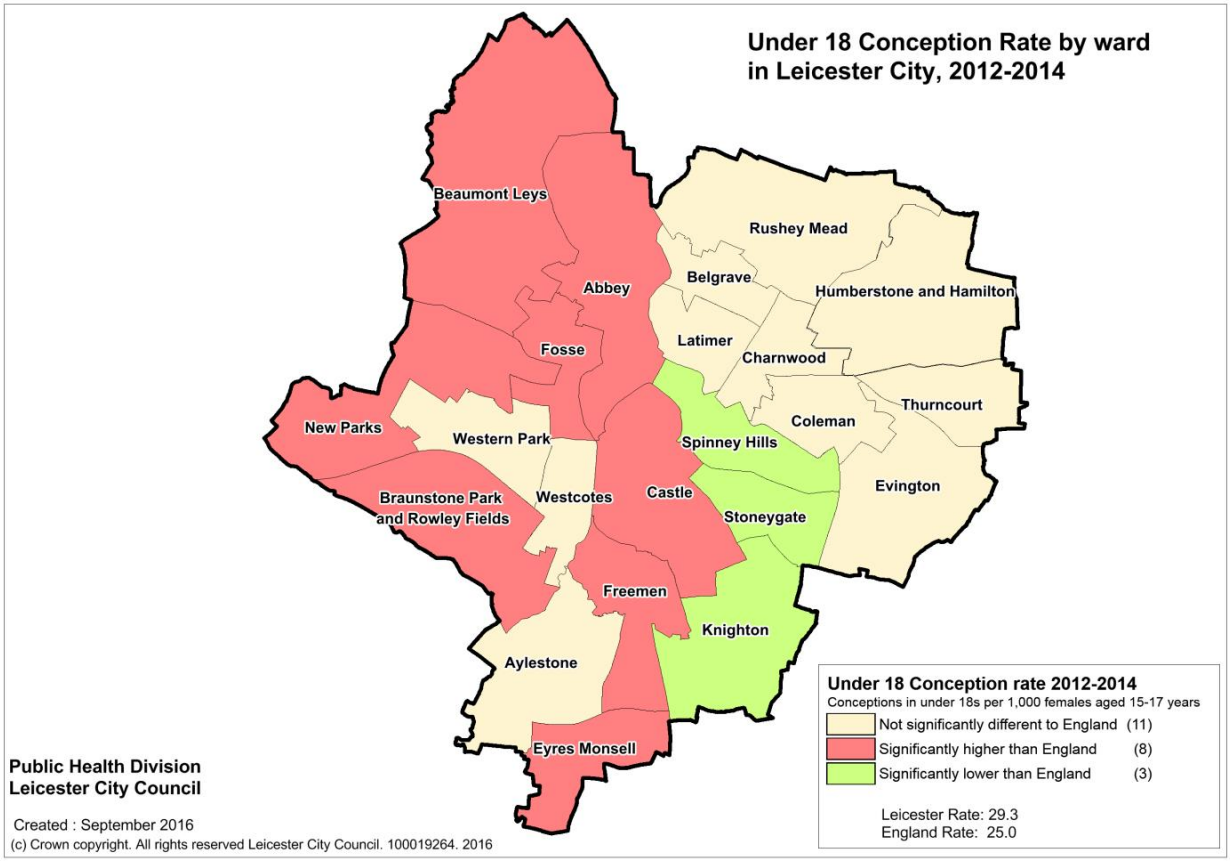
A number of factors may be contributing to the falling rates including, a shift in aspirations of young women towards education, a stigma associated with being a teenage mother, better sex education and improved access to contraceptives

A partnership strategy has been implemented in Leicester over the last 10 years to support the reduction in under 18 conceptions. This has included an increased effort in improving education in schools along with information on access to contraception and sexual health services. In 2014 the teenage pregnancy rate in Leicester fell to 25.3 per 1,000 15-17 year-olds compared to the national rate of 22.8 per 1,000 15-17 year-olds. The fall in Leicester between 1998 and 2014 is 60.8 % compared to the 51.1% reduction in England. Under 18 conceptions are not evenly distributed across Leicester. The following characteristics are more common amongst women who conceive below the age of 18 in Leicester:

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

Figure 16 shows the areas of Leicester with higher or lower rates of under 18 conceptions compared to the UK average. The pattern of distribution has been unchanged for many years and reflects the distribution of the risk factors for under 18 conceptions in the community.

Figure 16: Under 18 conception rates by ward, Leicester (2012-2014)

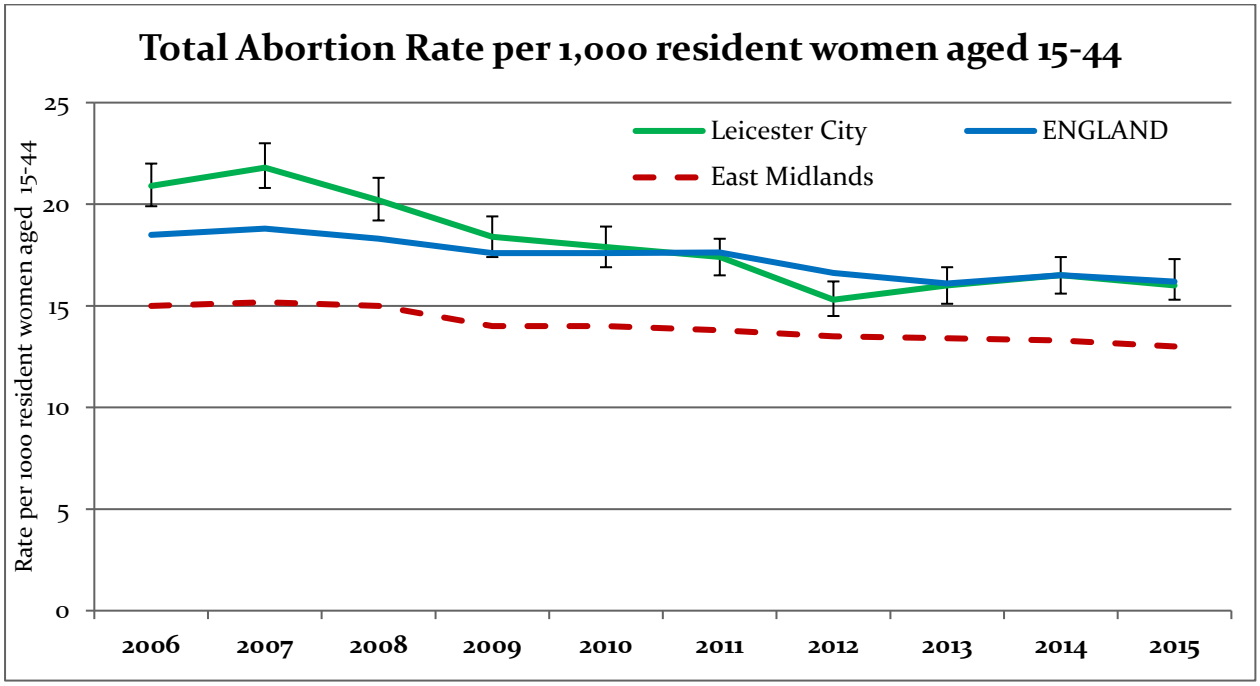


Source: Office for National Statistic Conceptions data 2012-14

Termination of Pregnancy

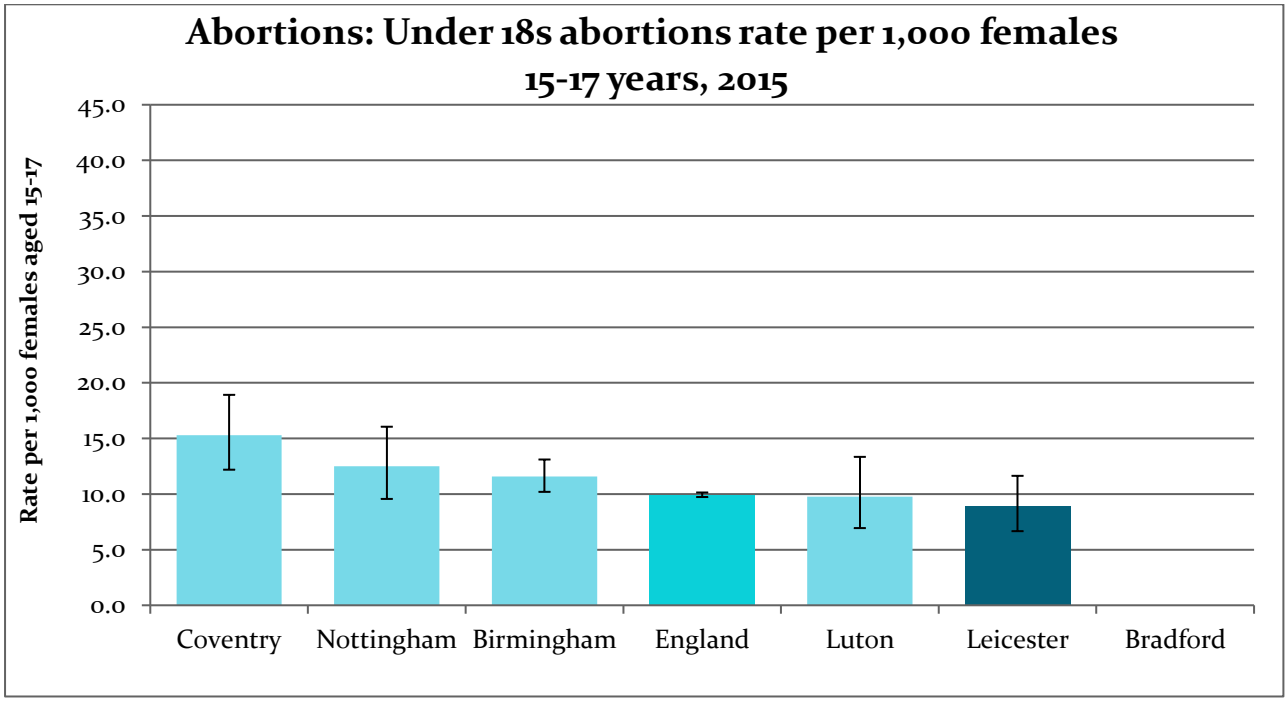
Termination of Pregnancy (Abortion) is governed by the Abortion Act of 1967 which permits terminations up to the 24th week of gestation by regulated providers. Women can self-refer to these services available at University Hospitals of Leicester (up to 12 week's gestation), and at the British Pregnancy Advisory service (BPAS) (up to 24 weeks gestation). BPAS provides service outside Leicestershire and women need to travel to their clinics. Contraception (including LARC methods) is discussed with patients who require any termination in order to reduce the need for a repeated abortion in the future. The total abortion rate in Leicester (Fig 17) has increased since 2012, and is at 16.0 per 1,000 females aged 15-44 in 2015, this is similar to the national rate of 16.2 per 1,000 females aged 15-44.

Figure 17: Total Abortion Rate per 1,000 women aged 15-44



Source: Department of Health 2015

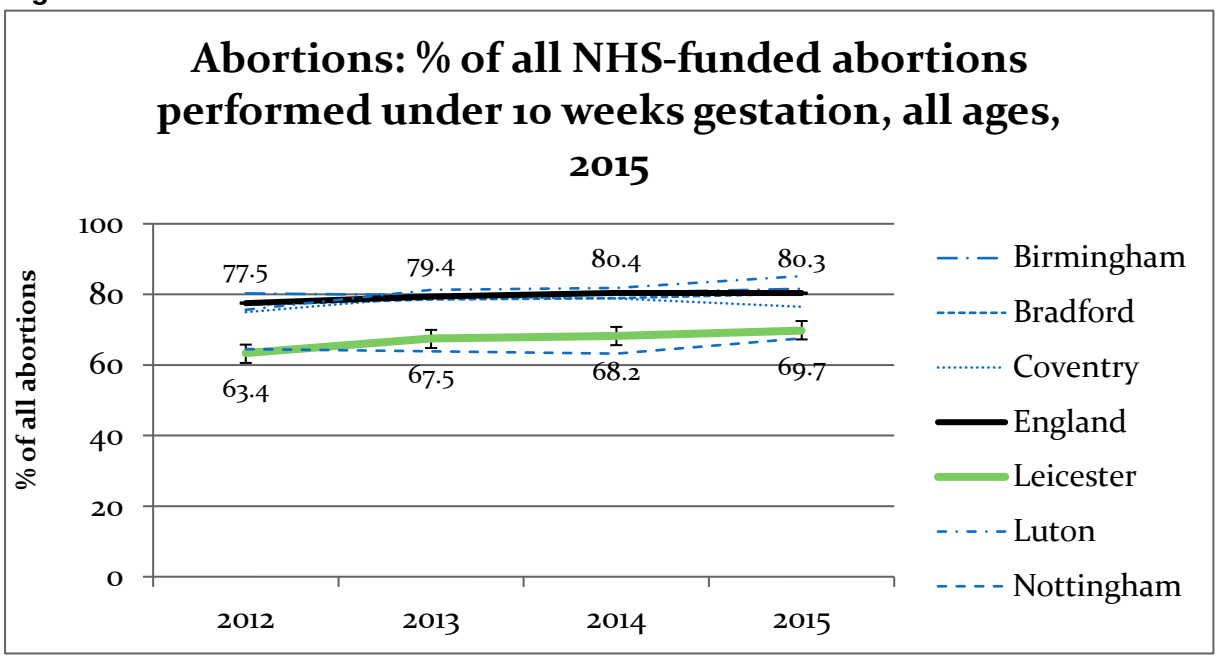
Figure 18: Under 18 Abortion Rate per 1,000 women aged 15-17 by ONS Comparator Group - 2015



Source: Public Health England, Sexual and Reproductive Health Profiles, 2016

The rate of under 18 abortions in Leicester is similar to the national rate and that of statistical comparators. Early access to termination is preferable to allow choice of medical termination which is clinically safer. It is preferable that this is before 10 weeks gestation. The percentage of TOPs provided prior to 10 weeks has been increasing year on year, both nationally and locally. Despite this Leicester still has a statistically lower percentage of TOPS provided prior to 10 weeks gestation.

Figure 19: NHS funded abortions under 10 weeks



Source: Public Health England, Sexual and Reproductive Health Profiles, 2016

Sterilisation

It was not possible to obtain information on these services.

Vasectomy

It was not possible to obtain information on these services.

Psychosexual counselling

The Psychosexual Service provision is based at the ISH and provided by SSOTP through one consultant and a trained counsellor. The data below describes all patients accessing the service in 2014 and are not limited to Leicester City residents. The numbers of referrals continue to increase, from 105 in 2012 to 210 in 2014. Additional sessions have been offered which have reduced the average waiting list times from 5-7 months (2014) to 6 weeks in 2015. There is a near equal split between male and female attendees and the age range is 17-69, with a median age of 20-29 for women and 30-39 for men. Although diagnoses were not routinely captured in 2014, the therapists commented that "females typically attended with vaginismus and dyspareunia and males with erectile dysfunction and premature ejaculation (and, to a lesser degree, delayed ejaculation). Both genders present with loss of desire. Numbers of appointments in the psychosexual service ranged from 1 to 18, with 7/201 (3%) patients requiring therapy for greater than 18 months. Approximately one third of patients "drop out" of therapy before completion and the reasons for this are unclear. There is a very small but important group of patients with Psychosexual issues that need different services to those provided in the integrated sexual health services. These can be addressed by the Medical psychology service in UHL and there are discussions about developing appropriate care pathways and funding routes.

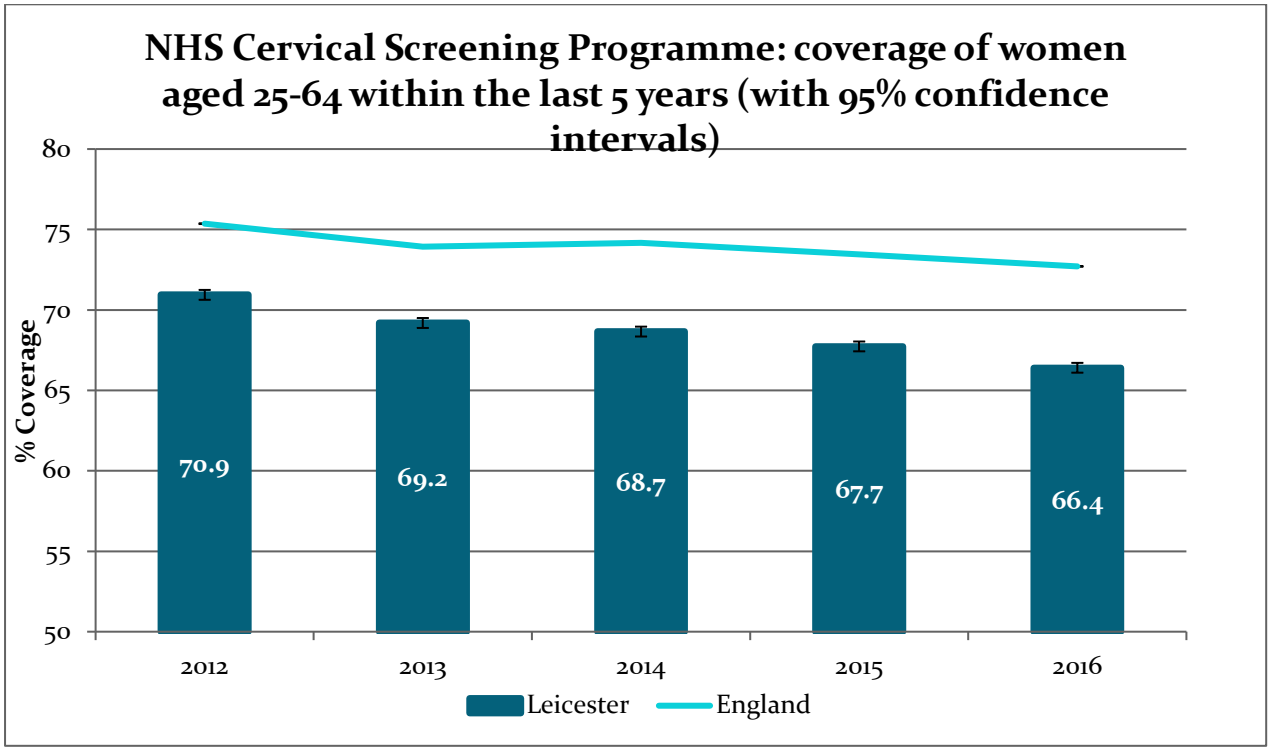
Cervical screening

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

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

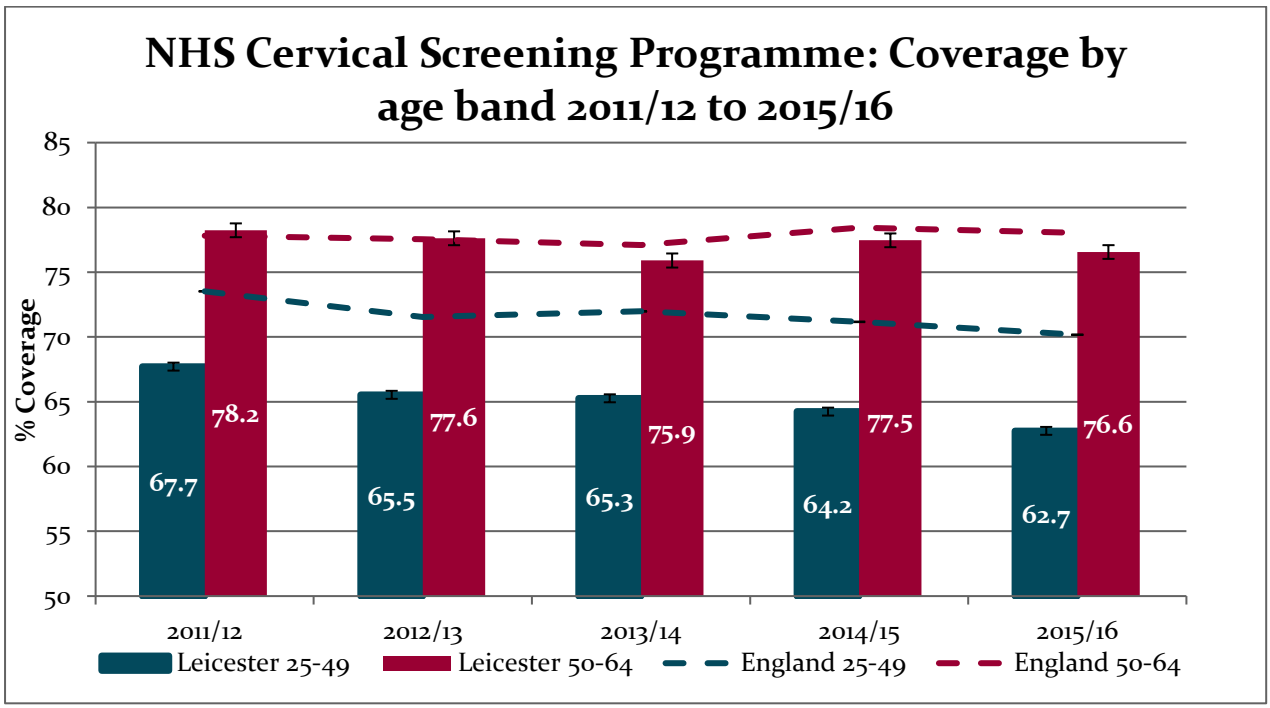
The test, known as the 'cervical smear' is designed to ascertain the health of the cervix (the lower part of the uterus) which gives an assessment of the risk of developing cancer. Testing for HPV (human papilloma virus) is also now part of the programme. The majority of cervical screening is undertaken in general practice. Historically, Leicester has had low uptake rates of cervical screening compared to the England average. Coverage in Leicester has also been falling steadily since 2009, with coverage in 2015 being statistically significantly lower than the coverage obtained in 2012 (Figure 20). When analysing coverage by age, over the last 5 years, there is a significantly lower uptake on screening locally by younger women (25-49 years) in comparison to the national average. For those over the age of 50 (Figure 21), the coverage in Leicester has remained significantly lower in comparison to the national average since 2013/14. There is no evidence that low screening rates are directly related to deprivation or ethnicity.

Figure 20: Trend in cervical screening coverage (women aged 24-64, screened within 5 years) in Leicester and England



Source: Public Health Outcomes Framework

Figure 21: Trend in cervical screening coverage (by age band) in Leicester and England



Source: NHS Cancer Screening Programme – NHS Digital

Cervical screening in HIV positive women

Women living with HIV are advised to have annual cervical screening as they are at increased risk of cancerous and precancerous changes in the cervix associated with HPV. The HIV and ISH clinics are not commissioned to perform cervical smears, and women must obtain these with their GP. A small group of women who have not disclosed their HIV status to their GP have difficulty accessing smears. In addition, annual recall for smears will not be triggered if the woman's HIV status is not made clear on the request. A review of commissioning of cervical screening in HIV positive women is underway. NHS England has recently commissioned the ISHS to provide Cervical screening to women who attend opportunistically.

IUS provision for non-contraceptive reasons

The intrauterine system, Mirena, is licensed for use in the treatment of heavy menstrual bleeding (menorrhagia) and as part of hormone replacement therapy. At present the ISH is commissioned only to provide IUSs for women requiring contraception. It has been identified that the pathway for women requiring an IUS for non-contraceptive purposes is unclear, resulting in patients visiting several different services such as gynaecology, the ISH and their GP. A review of this pathway is currently underway and an alternative commissioning model is being put in place.

Treatment of genital skin conditions

The ISH is no longer commissioned to manage long-term genital dermatological conditions. This led to deficiencies in training of GUM staff and difficulty for patients wishing to access treatment. As a result, a vulval dermatology clinic was created within UHL to which a GUM trainee is seconded. Male patients can be referred to a dermatologist in UHL with an interest in penile conditions. Referral of patients to the dermatology department requires disclosure to their GP, which discourages some patients from accessing care outside of the ISH.
Despite not being commissioned to undertake this work, it is inevitable that a significant number of non-sexually transmitted dermatological conditions get managed at the sexual health service as patients (often referred by GPs) choose to attend the ISHS as GPs are not in a position to distinguish between STIs and non STIs. Some dermatological conditions may mimic STIs and are biopsied for diagnostic purposes within the sexual health service rather than being referred to dermatology. The extensive role of GU physicians in managing genital dermatology needs recognition and referral pathways further clarified. This could be an area for co-commissioning.

Non sexual health elements of psychosexual services

The psychosexual service at the ISH covers a specific range of conditions such as erectile dysfunction and sexual pain. Problems which have a wider psychological basis, such as sex addiction, chem sex and difficulties adjusting to sexual orientation, are not commissioned by the Local Authority. At present the medical psychology service at UHL has clinicians who are able to treat such problems but are able to accept referrals only from within UHL. Patients presenting to the ISH or their GP therefore have difficulty accessing these services. Work is currently underway to clarify referral pathways and commissioning arrangements for such services.

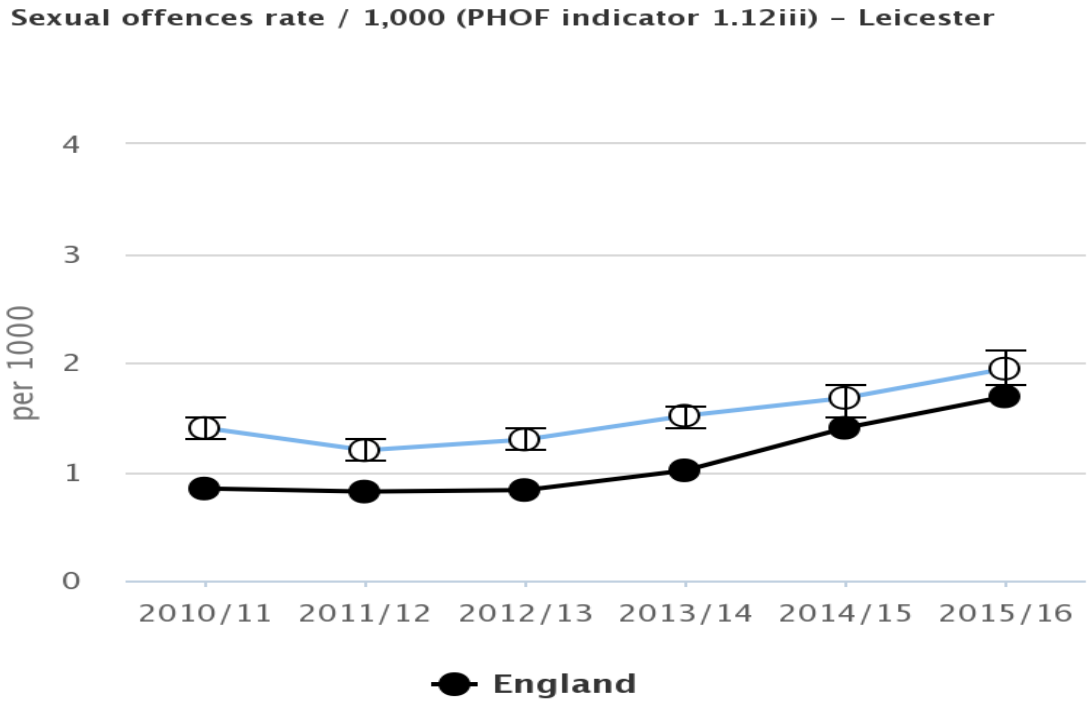
Sexual Violence

The Natsal survey (2011)[13] reports that 9.8% of women and 1.4% of men had experienced non-consensual sex in the previous year. The median age was 18 years for women and 16 years for men. In most cases the perpetrator was known to the individual. It was also shown that younger people are more likely to have reported to either the police or another individual.

A Sexual Violence Needs Assessment was undertaken for Leicester in May 2013, details of which can be found here: https://consultations.leicester.gov.uk/city-development-and-neighbourhoods/sas/supporting_documents/Sexual%20Violence%20Assessment%20May%202013.pdf

The rate of sexual offences in England is growing and Leicester mirrors this trend with a statistically significantly slightly higher rate

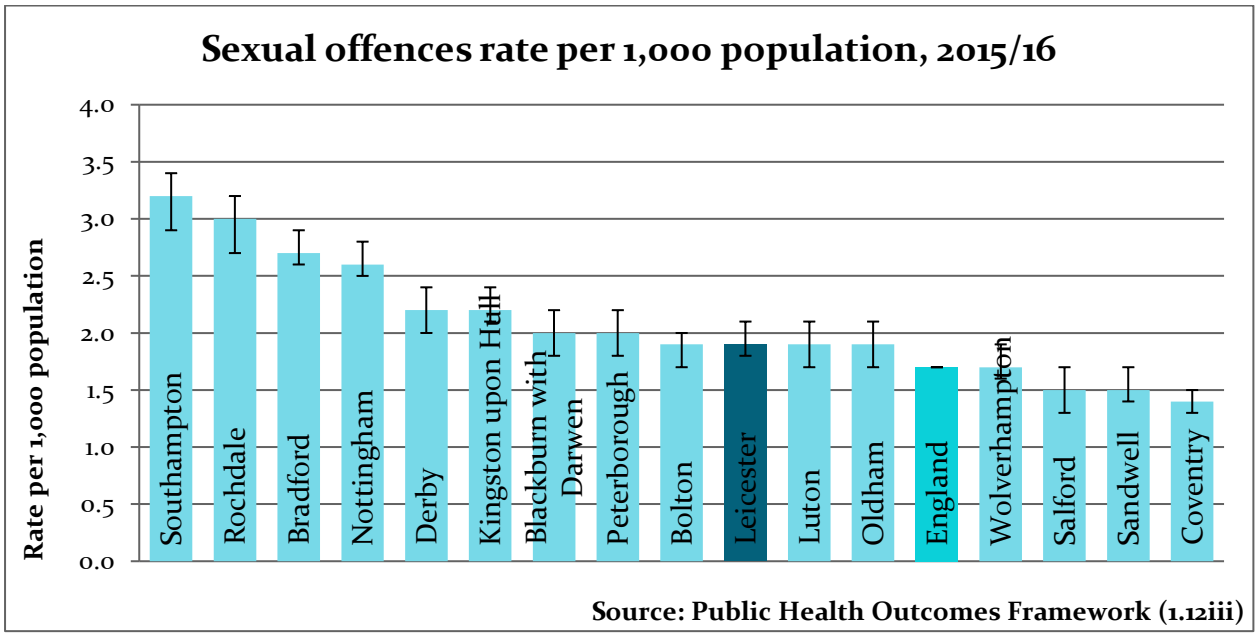
Figure 22: Sexual Offences Rate 2010/11 to 2015/16



Source: *Public Health Outcomes Framework*

Data collected as part of the national Violence Indicator Profiles in the English Regions (VIPER) data set indicate that the 2015/16 crude rate of recorded sexual offences (1.9 per 1,000 population) for Leicester City is the higher than the national rate and 10th amongst statistical neighbours in the East Midlands (Figure 23). The number of sexual offences recorded in Leicester during 2015/16 was 656. As per the national picture, local intelligence suggests that there is significant levels of under reporting of rape and other forms of sexual violence in Leicester. The confidential nature of the services provided means that it is difficult to establish whether the clients seen at the various services are all unique i.e. it cannot be established whether some clients are receiving support from more than one source.

Figure 23: Sexual Offences Rate per 1,000 population – 2015/16



Source: Figures calculated by PHE Knowledge and Intelligence Team (North West) using crime data supplied by the Home Office and population data supplied by Office for National Statistics (ONS).

NHS England have commissioned a new Sexual Assault Referral Centre (SARC) in Leicester that opened in 2017. This provides forensic examination and support to victims of sexual abuse. In addition men and women who may have been exposed to HIV are assessed and offered Post Exposure prophylaxis dependent upon the 72 hour window period and the risk.

Current services and assets in relation to need

There are a variety of sexual health providers within Leicester, covering various levels of service provision. The community of sexual health providers across Leicester, Leicestershire and Rutland is supported by several networks including the Sexual Health and HIV network which meets twice a year in order to share developments and good practice an HIV forum for community and statutory organisations.

The Integrated Sexual Health Services (ISHS)

These service were commissioned by the 3 local authorities (Leicester City, Leicestershire County and Rutland County). The services commenced on January 1st 2014 and provides the following services:

- GUM services
- Contraceptive and Reproductive Health services
- Chlamydia screening programme
- Specific Young People services(Choices)
- C card scheme
- Psychosexual services
- Outreach for high risk groups e.g. MSM (Trade etc.) CSWs…

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

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

Young people's services

The times and locations for young people's services are monitored through regular consultation with young people across LLR in order to maximise their possible access. Services for under 25s are currently offered in spokes operating in 'young person specific' locations:

- Three youth centres,
- Further Education colleges,
- Leicester University
- Health centres.

One evening session and one daytime session are allocated at each Hub for the provision of young person specific clinics.

Outreach services:

Outreach clinics/activities are delivered at a variety of locations, including male saunas, Leicester prison, colleges and universities, voluntary sector organization premises and through

a mobile unit. Evening working is included, and support is provided to voluntary sector organisations within their established networks.

Relationships and Sex education (RSE)

This is also commissioned from SSOTP. RSE is learning about the emotional, social and physical aspects of growing up, relationships, sex, human sexuality and sexual health. It should equip children and young people with the information, skill and values to have safe, fulfilling and enjoyable relationships and to take responsibility for their sexual health and wellbeing.
There is some basic sex education such as puberty and reproduction in primary science and the menstrual cycle and reproductive system in secondary science. This is part of the National Curriculum and academies and free schools don't have to follow it. State secondary schools (other than academies and free schools) have to provide sex education but the only topic they must cover is HIV, AIDS and other sexually transmitted infections. The independent report into Child Sexual Exploitation in Greater Manchester, Rotherham and Birmingham recommends that SRE is provided in schools by trained educators. Over[14] the past 20 years, young people although they continue to report needing more information on a broad range of topics. The findings support the expressed need for improved sex and relationships education in schools alongside greater involvement of parents and health professionals. In 2015 Leicester City Council commissioned a service to coordinate the offer of RSE to secondary schools and FE colleges and already has two PHSE advisory teachers that support schools.

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

General Practice

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

Pharmacy

EHC is currently available free of charge to those under 25 in 71 community pharmacies in Leicester. Only pharmacists who have undertaken training for the Patient Group Direction are allowed to participate in this scheme. Service provision may not always be consistent or available every day (as not all pharmacists in each pharmacy are trained). Most of the provision for this service has been delivered by 12 pharmacies contracted in the scheme.

Termination of pregnancy services

These services are commissioned by the CCG. Commissioned services are provided by University Hospitals of Leicester up to 12 weeks gestation and by the British Pregnancy Advisory service (BPAS) up to 24 weeks. BPAS service provision is located outside of Leicestershire and therefore women need to travel in order to gain access to the clinics. The service is open to self-referrals or a referral from a health professional (e.g. GP, community based nurse the ISHS).

Vasectomy services

These services are commissioned by the CCG and currently provided in a variety of settings: GP practices using a scalpel-less service or University Hospitals of Leicester where treatment is provided under general anaesthesia (for complex cases) via their Urology Services.

Sterilisation services

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

HIV treatment and care

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

- Medical specialists
- HIV specialist midwifery
- HIV Health Advisory service
- Clinical HIV psychology service
- HIV Pharmacology service
- Specialist hepatitis C nursing for co-infected Hepatitis/HIV patients,
- HIV clinical nursing for community-based care
- Paediatrics-HIV care with family clinics

Social care is provided by the adult and social care team at the local authority where housing advice and social care support can be accessed by those living with HIV. Additional information, advice and guidance can also be accessed through the voluntary sector organisations (LASS and Faith in People).
There are no general practices providing enhanced care for HIV in primary care. The delivery of post-exposure prophylaxis is commissioned by the local authority, although NHS England funds the costs for the drugs.

Sexual Assault Referral Centres (SARC)

Sexual Assault Referral Centres (SARC) are commissioned by NHS England.
The Juniper Lodge SARC in Leicester provides services to people aged 14 and over (Unless there are child protection issues in those aged under 18). The service offers a forensic medical examination, emergency medicine and aftercare (PEPSE, Hep 'B' Emergency contraception and controlled medication).This is provided by MITIE Care and Custody who supply a Forensic Medical/Nurse Examiner to complete the medical examination and complete the aftercare and safeguarding procedures. The SARC also has three video interview suites, equipped with cameras enabling the victims to provide a visually recorded interview (VRI) to the Police. There is also a photographic studio and a remote link where the vulnerable witnesses can provide their evidence directly to any court in England.
Once seen, the client will be referred to other services such as an Independent Sexual Violence Advisor (ISVA) and specialist organisations (Counselling, Mental Health, Alcohol etc) if they consent. This can all be done with or without involving the Police.

The Paediatric SARC – Serenity – is based in Northamptonshire. Serenity provides the forensic medical examination of all male and female children aged 13 years and below. They will be examined by a Paediatric doctor and referred to services as the adult SARC in Leicester if needed. Serenity have VRI suites and access to emergency medicine if required.
Prison sexual health services are commissioned by NHS England Area Team. Leicester has one prison, with current provision consisting of *'GP related sexual health services'* for prisoners. Those requiring more complex STI or HIV treatment and care are referred to the services at University Hospitals of Leicester. It has not been possible to obtain further information on the level or nature of sexual health service provision at HMP Leicester. LASS (voluntary sector organisation) provide some support to HIV individuals in prison and some testing for prisoners.

Relationship and Sex Education (RSE)

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

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

Health Shops

These are enhanced school nurse sessions offering weekly scheduled and/or drop-in appointments in participating secondary schools. The health shops operate flexibly with opening times that are convenient to young people. There is no current data available on the number of contacts made with the health shop.

Independent voluntary organisations

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

TRADE

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

Leicestershire AIDS Support Service (LASS)

This service provides direct support and advocacy to those affected by HIV/AIDS, rapid HIV testing as well as education and awareness rising to promote positive sexual health. This includes drop in and women's groups, help with managing HIV and social support. Rapid testing

services are also offered in community settings. Due to low HIV testing uptake in some African communities, LASS trains volunteers from these communities as champions who can provide testing and information. The service also provides regular health education sessions in schools, colleges and a variety of community groups. LASS also work closely with nationally funded HIV and sexual health organisations including Public Health England.

The New Futures project

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

Sexpressions

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

New Dawn New Day

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

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

There is a clear relationship between sexual ill health, poverty and social exclusion. Leicester is the 21st most deprived local authority in England, with almost half of the population living in areas of very high deprivation. It is also one of the most ethnically diverse cities in the country and has a relatively young population, with 45% of the local population being under 29 years of age. According to Census figures, Leicester saw the highest growth in its local population by 47,100 people (almost 17% increase) between 2001 and 2011. Leicester's population growth is expected to continue to rise, with the elderly population being predicted to increase at a much slower pace compared to the increase in the young and working age population.

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

Although the full impact of economic migration into Leicester is difficult to quantify, areas in which poverty levels are high are generally those that have the most rapid increases in population and the highest fertility levels. Evidence suggests that halting population growth by investing in sexual and reproductive health and HIV prevention (particularly among adolescents), education, personal empowerment and gender equality can reduce poverty. With a significant continual growth expected in the young adult population in Leicester, a continued increase in the focus on

sexual and reproductive health services is required. There is also an increased need to ensure that relationship and sexual health programmes address the greater vulnerability of adolescents to unprotected sex, sexual coercion (including grooming), HIV and other STIs and unintended pregnancies (whilst enabling them to delay pregnancy) as these are also important factors in breaking the intergenerational cycle of poverty.

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

Evidence of what works

STIs

The cost of treating STIs nationally (excluding HIV) is estimated at £170 million. Evidence demonstrates that spending on sexual health interventions and services is cost effective.
Home testing for STIs is increasingly available online. HIV home testing kits are now available to those residents of Leicester who would prefer not to test in a clinic setting. Services could be developed to include home testing for other STIs, although it would be important to establish robust pathways for treatment and partner notification in those who test positive.
Improvements in the rates of partner notification reduces the cost per chlamydia infection detected[15] Interventions that are evidence-based and lead to behaviour change are cost effective (e.g. free condom provision, assertive outreach health promotion, needle exchanges, sex and relationship education targeted at specific groups). Early treatment of STIs and partner notification are cost effective interventions. Screening strategies targeting high risk populations that lead to early identification and treatment are cost effective as they avert future costs of dealing with complications and onward transmission

HIV

HIV treatment is estimated to cost the NHS £770m per annum (2014) this equates to £9000 per person. Preventing one case of HIV could save £0.36m over a person's lifetime.

Those diagnosed late incur twice the direct medical costs for HIV care in the first year after diagnosis compared to those diagnosed early.[16] Increasing levels of HIV testing amongst MSM can reduce HIV incidence if condom less sex is not increased[17]

Partner notification is an effective method of diagnosing HIV[18]

Prep has been shown to be highly effective in reducing HIV transmission in MSMs who are having unprotected intercourse with partners of unknown HIV status.[19]

Treatment costs for HIV are approximately£12,600 per annum per patient if diagnosed early compared to £23,442 per annum per patient if diagnosed late. Early access to HIV treatment also

significantly reduces the risk of HIV transmission to an uninfected person with consequential cost savings[20]

Contraception

It is estimated that just over half of all pregnancies are planned and that the annual direct costs to the NHS of unintended pregnancy is £240m. For every £1 spent on contraception, £11 is saved in other healthcare costs[21]This means that the provision of contraception saves the NHS £5.7 billion in healthcare costs that would otherwise have been spent if no contraception was provided[22]
There is increasing evidence that unintended pregnancies have poorer pregnancy outcomes with children that are born tending to have a more limited vocabulary with poorer non-verbal and spatial abilities. These differences are almost entirely explained by deprivation and inequalities.[23]

Under 18 conceptions

The national Sexual Health Strategy has resulted in a fall in under 18 conceptions and as rates of teenage pregnancy are influenced by a web of inter-connected factors, the national strategy was necessarily multi-faceted in its approach. As such, it is not possible to identify causative pathways or estimate the relative contributions of each constituent part. However, six key features contributed to the success:

- creating an opportunity for action;
- developing an evidence based strategy;
- effective implementation;
- regularly reviewing progress;
- embedding the strategy in wider government programmes and
- Providing leadership throughout the programme.

The learning remains relevant for the UK as England's teenage birth rate remains higher than in other Western European countries. It also provides important lessons for governments and policy makers in other countries seeking to reduce teenage pregnancy rates.[24]
Although teenage conception may result from a number of causes or factors, the strongest empirical evidence for prevention are;

- high-quality education about relationships and sex[25]
- access to and correct use of effective contraception[26]
- Educational attainment which has a strong correlation with planned pregnancies.

LARC methods are much more effective at preventing pregnancy than other methods, although a condom should also always be used to protect against STIs[27]. Joined-up provision that enables seamless patient journeys across a range of sexual health and other services – this includes community gynaecology, antenatal and HIV treatment and care services in primary, secondary and community settings[28].
Cost savings can be realised if the utilisation of LARC methods is increased[29]
However there is no nationally recommended rate of LARC provision for the female fertile population
Sexual health needs vary according to factors such as age, gender, sexuality and ethnicity; with some groups being at particular risk of poor sexual health. The overall cost of sexual health promotion is minor compared to the costs of treating STIs and unintended pregnancies. There is ample evidence that sexual health outcomes can be improved by: accurate, high-quality and timely information that enables people to make informed decisions about relationships, sex and

sexual health[18] preventative interventions that build personal resilience and self-esteem whilst promoting healthy choices[16] rapid access to confidential, open-access, integrated sexual health services in a range of settings that are accessible at convenient times[30] early, accurate and effective diagnosis and treatment of STIs (including HIV), combined with partner notification[16] (in order to manage and control STIs by protecting patients from re-infection, partners from long-term consequences from untreated infection and the wider community from onward transmission)[31]

There is also evidence[32] to show that preventative interventions that focus on behaviour change and are based on behaviour-change theory have been effective in promoting sexual health. NICE has also suggested that helping people to work through their own motivations by encouraging them to question and change their behaviour can form a key part of preventative interventions in reducing STIs (including HIV) and reducing the rate of under 18 conceptions, especially among vulnerable and at risk groups.[33]

Effective behaviour change interventions:-

- draw on a robust evidence base are targeted at specific groups and take account of their specific influences and motivations to change include provision of basic accurate information with clear messages
- promote individual responsibility and focus on motivating the individual to change
- make use of 'changing contexts' models for 'nudging' people into healthier choices while recognising that such choices are influenced by complicated drivers of human action, including gender roles, inequality and norms around sexuality[34]

Sexual Health in the over 50s.

Although the vast majority of sexual ill health is amongst the younger population there is a worrying rise in the incidence of STIs amongst the over 50s. It is thought that women who are no longer fertile may not use condoms and an increase in the divorce rate in this age group resulting in new sexual relationships may also be a contributing factor. In 2014 16% of all new HIV diagnoses was amongst the 50-70 year old population of this 56% was in 50-54 year olds and 70% was amongst men – mainly white and heterosexual[35] .

HIV

Nationally, preventing HIV infection among black Africans in England and MSM[36] is a priority. A recent review also suggests that rapid testing in community settings and intensive peer counselling (where appropriate) can increase the uptake of HIV testing among gay and bisexual men.[37]

This guidance also emphasises HIV testing in acute settings where a blood test may already be being taken, within 72 hrs of reception to a prison, where they are indicator conditions (see list) and consideration of testing in general practice.

Furthermore, services for those people living with HIV infection should meet national specialist service standards and quality indicators outlined by the British HIV Association. Secondary care services should provide confidentiality and ease of access to newly diagnosed patients, and reflect the changing demographics and aging of people living with HIV infection.

each onward transmission of HIV could save £1million in health benefits and treatment costs, with key recommendations as follows:-

-increasing the number of HIV tests in non-specialist healthcare in areas with a high prevalence of HIV.[38]
-increasing the uptake of HIV testing

Unmet needs and service gaps

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

HIV testing, diagnosis and care:

Significant numbers of HIV cases remain undiagnosed, particularly in MSM and black African communities, and access to HIV testing requires further improvement. Since the inception of the ISH service in Leicester rates of HIV tests being offered have fallen significantly. Uptake of HIV tests which are offered remains good, although this has also fallen in recent years

HIV testing has been commissioned from specific voluntary sector organizations since March 2015 this is to specifically be provided to people of African heritage, partners of those who are HIV positive and MSM. HIV home sampling could be expanded and more information about its availability should be made available.

Once HIV positive people are engaged in care they may experience difficulties in accessing particular services. Women living with HIV are recommended to have a cervical screening test annually as they are at increased risk of cervical abnormalities. Although annual testing is commissioned through GPs, some women with HIV choose not to disclose their status to their primary care provider. As cervical screening is no longer commissioned in the ISH or HIV outpatient services these women are unable to have annual smears.
HIV positive people should have a sexual health screen annually, or every 3 months in those at higher risk. Asymptomatic screening can be performed in the HIV service, but the commissioning arrangements for this are unclear. STI treatment is provided by the ISH. As the ISH is geographically and managerially separate from the HIV service it may be difficult for people living with HIV to access regular STI screening and treatment. Untreated STIs may contribute to onward transmission of HIV in this group.

HIV positive individuals may be accompanied to clinic appointments in the main HIV service or maternity services by their sexual partners.

HIV prevention:

The use of Pre-exposure prophylaxis (PrEP) against HIV offers an excellent opportunity to test individuals at high risk of HIV infection and to engage them in care if they are HIV positive. Unfortunately clinics treating HIV positive patients are not commissioned to test partners and must direct the partners to the ISH for testing. Often partners do not subsequently present to ISH, representing a missed opportunity to diagnose HIV in Leicester City.

At present PrEP is not commissioned in the UK but is accessible for purchase online. MSM seeking PrEP are a particularly high risk subgroup (with an HIV incidence of 9/100 person years in one study) and it is important to engage them in sexual health services. Offering monitoring of

PrEP to those purchasing the drugs online would be a method of engaging them in regular STI screening and allow opportunities for targeted health promotion,

HPV vaccination:

As MSM are not protected by the herd immunity conferred by vaccinating girls, a pilot project of provision of HPV vaccination to MSM aged up to 45 is underway in a small number of sites in England, not including Leicester. The results of this may lead to a recommendation of a roll-out of HPV vaccination to all MSM in future.

Increasing service provision for at-risk groups

A number of groups are known to be at increased risk of sexual ill-health. These include sex workers, members of the LGBT community, substance misusers and those with poor mental health. Many of these groups may find it difficult to access care from mainstream services. The increasing number of outreach clinics available in Leicester is a positive step towards maximizing contact with high risk groups. Further work is needed to develop most appropriate methods of targeting other high-risk groups, including improved referral pathways, training for non-specialist staff and clearer channels of communication between specialties.

Chlamydia screening:

Leicester has successfully moved its chlamydia screening programme to be an online service. There is also provision in services such as the ISHS .This should also be provided in other sexual health related service such as TOP service.

Termination of pregnancy services:

Termination of pregnancy services are currently provided by two different providers. There has been a reduction in the number of TOPs that are provided by UHL and an increase in the number provided by BPAS. Access to TOP can be via self -referral however there is no centralized booking system to ensure that people are accessing the timeliest service.

Long Acting Reversible Contraception:

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

Emergency Hormonal Contraception:

Emergency contraception can be provided by a patient's GP, at the Community Sexual and Reproductive Health Service (CSRHs), based at St. Peter's Health Centre provides a good service. This provides a six day a week service including some after 5pm provision.
There is a pharmacy provided free EHC scheme for under 25s in the Leicester and although 71 pharmacies have signed up to the scheme, service provision has not been consistent with only 15 pharmacies providing a regular service. These services do not provide free pregnancy testing due to various issues e.g. accessibility to toilets etc.

Contraceptive provision in General Practice:

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

Community contraception:

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

C Card scheme

This has been developed by the ISHS and has been replacing the Safer Sex project. This scheme allows the provision of free condoms to under 25s .There are two stages: Registration where a young person presents themselves at a registration site and receives health promotion advice about use of condoms and safeguarding checks are undertaken. There were over 500 registrations for the scheme in 2016, once registered a young person can go to any of the distribution points around the city.

Relationships and Sex Education:

Leicester City schools play an important contribution in influencing and developing young peoples' sexual health and wellbeing through their responsibility to provide effective RSE. Further and Higher Education establishments also have a key role to play in ensuring that students have access to sexual health information, advice and services. Although there is guidance on RSE, there is no standardisation in terms of RSE delivery in the City.
The Healthy Child Programme team provide help and support to parents, governors and teachers to ensure schools understand the importance of, and support the provision of, age appropriate PHSE / RSE within all school settings.
Support will include:

- Providing expert advice and training using the current evidence base to enable school staff to confidently and successfully deliver age appropriate PHSE / RSE.
- Working with schools and other stakeholders to ensure that an equitable offer is available across all schools in the city.
- Establishing clear pathways and joint working with experts and other stakeholder to ensure seamless support for children and young people.
- Ensuring schools have a PHSE / RSE policy as part of their Healthy Setting Programme (found in Community offer).

The PHCP is expected to work in partnership with the Integrated Sexual Health Service to define the RSE core-offer and ensure that all HCP staff receives regular sexual health training.

Cervical screening:

There is a need to improve uptake for cervical screening, particularly for younger women aged 25 -34 years and older women aged 55 and over.

Teenage pregnancy:

There should be a continued focus on reducing teenage conceptions.

Psychosexual services:

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

Sterilisation and Vasectomy:

The service delivery and patient pathways are not currently understood.

Prison Sexual Health services:

Leicester has one male remand prison. The sexual health element of the care in the prison is commissioned by NHS England Justice Team. It is currently provided by Leicestershire Partnership Trust who sub contract SSOTP.

Voluntary care organisations:

Behaviour change interventions:

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

Service user input:

Integrated Sexual health services

From April 2017 to June 2017, the Staffordshire and Stoke on Trent Partnership NHS Trust has captured the experience of 8,758 service users and carers who have accessed their services. The Friends and Family Test sample for this time period for the Leicester Sexual Health had responses from 894 service users and 1 carer providing feedback relating to the Leicester Sexual Health Services (total of 895), no service users declined to take part.

During quarter one, there has been a 24% (171 surveys and comment cards) increase of feedback received from our service users and carers (894 in Q1 compared with 723 in Q4).

From April 2017 to June 2017 the average FFT score is 97% for the Leicester Sexual Health Services. This exceeds the national target of 90% and has seen an increase of 2% compared to quarter four's average score of 95%. Family and Friends Test (FFT)

A total of 62 service improvements have been received and implemented across the Service between April 2017 and June 2017. The top three service improvement categories for the service are

- Access to treatment 37
- Appointments 10
- Communication 4

Reception staff regularly reminds patients of current waiting times and we have purchased a TV to put up in the waiting area which will be going live from 24th July at St Peters City Hub

Compliments

133 compliments have been received for services within the Leicester Sexual Health services between April 2017 and June 2017

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Additional recommendations for consideration by commissioners -

- Establish routine monitoring for azithromycin resistance in gonorrhoea cultures –
- Clarify menorrhagia pathway
- Clarify pathway for non-sexual health psychosexual work
- Fine tune genital dermatology pathway
- Clarify commissioning of cervical smears in HIV positive women
- Increase accessibility of services for trans* individuals
- Improve pathway for STI testing and management in HIV positive patients
- Label positive results from indicator conditions to prompt HIV testing

Recommendations for needs assessment work

- Audit of HIV testing in AMU
- Need for support with Chemsex in MSM population
- PrEP intentions in HIV negative MSM
- Contraception services equality access audit.
- Sexual Health Equity Audit.

Key contacts
Julie O'Boyle Consultant in Public Health
Liz Rodrigo, Lead Commissioner for Public Health
Helen Reeve Senior Public Health Analyst
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Acknowledgements

Dr Helen Colver, Specialist Registrar in GUM, Staffordshire and Stoke-on –Trent NHS Partnership Trust

Dr Vendela Mac Namarra, Clinical Lead ISHS, Staffordshire and Stoke-on –Trent NHS Partnership Trust

Mr Emeka Oloto, Consultant in Reproductive and Sexual Health, Staffordshire and Stoke-on –Trent NHS Partnership Trust

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Jenny Hand, Chief Executive Officer and Director, Leicestershire Aids Support Services Social Enterprise Ltd

Jo Fores, Team Manager and Coordinator 'Choices' Young People's Contraceptive & Sexual Health Service and Chlamydia Screening Programme Staffordshire and Stoke-on-Trent Partnership Trust

Millicent Gant, SARC Manager, Leicestershire Constabulary Leicester, Leicestershire & Rutland

Barry O'Neill, Local Service Specialist, NHS England (Leicestershire and Lincolnshire AT)

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