Project:	Sexual and Reproductive Health services		
Profile Title:	Sexual Health		
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Date of Submission:	30th March 2018		
Document Reference nº:	[insert reference nº here]	**Version nº:**	1

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Version	Comments	Author	Date Issued	Status
Draft Version 1	Sections to be updated include service review and results from public survey	Chris Allan	19/01/2018	Draft for review
Draft Version 2	Includes summary of findings from previous engagement exercises	Chris Allan	31/01/2018	Draft for review
Draft Version 3	Proof reading and quality assurance	Lorraine Hughes	23/2/18	Chlamydia data to be included
Final Version	Chlamydia data included	Lorraine Hughes	30/3/18	Awaiting update of stakeholder engagement when completed.
Final Version	Sexual and Reproductive Health Profile Updated following national data release on 5th June 2018. Inclusion of syphilis data from 2016 LASER report.	Lorrain Hughes	7/6/18	
Final Version	Stakeholder engagement section updated	Nicola Cummings	8/6/18	To be published
Final Version	Sunderland Local Authority HIV, Sexual and reproductive health epidemiology report (LASER) 2017 released on the 7th January 2019.	Nicola Cummings	7/01/2019	
Final Version	Quarter 3 STI information included	Nicola Cummings	27/03/2019	

This should be read in conjunction with: Teenage Pregnancy Strategy and Action Plan

Executive Summary

Demography

The local population is predicted to grow over the next 20 years, with the largest increase being in those aged 65 and above. This will place greater demands on the working-age population, including fertile women (aged 15-44).

Total fertility rates in England have fallen below a level at which the population can reproduce itself through childbirth alone. This is due to a range of factors including socioeconomic factors, increasing proportions of women delaying fertility and choosing not to have children.

Sunderland has one of the lowest total fertility rates within the North East of England. In 2015 this was 1.62 births per female aged 15-44, against a regional average of 1.71 and an England average of 1.82.

Increases in conception rates are strongly associated with increases in area-level deprivation. This is also the case for under-18 conceptions.

The introduction of a two-child limit for Child Tax Credit, Housing Benefit and Universal Credit from 6 April 2017 may lead to a reduction in conception rates for people in groups who would previously have been eligible, and Brexit may affect inward migration for the population as a whole.

These combined factors may require positive and context-sensitive sexual health promotion in the local area, with a focus on the areas of greatest need.

Sexual health and behaviours

Young people and men who have sex with men (MSM) are amongst the groups most at risk of being diagnosed with a Sexually Transmitted Infection (STI). In 2017, 58% of diagnoses of new STIs in Sunderland were in young people aged 15-24 years although people aged 15-24 represent 12% of the local population. Of new STIs in Sunderland in 2017 12.9% were among gay, bisexual and other men who have sex with men, although the prevalence of men having a male partner may be as low as 3%.

Analysis of local service activity data suggests that gay mean accessing HIV-related care are amongst the most frequent users.

In England the age at first heterosexual intercourse has declined to an average of 16 years amongst 16- 24 year olds, with about 3 in 10 people reporting having first sex before the average age of 16. This supports offering sexual health education and information and contraception to younger people. The forthcoming changes to Relationships and Sex Education (RSE) offer an

opportunity to engage and shape the local offer, and build on previous partnership work that produced an accessible syllabus.

Compared with England, Sunderland has a relatively low rate of STI diagnoses including Chlamydia. Sunderland also has a relatively low recorded testing rate. Commissioners may need to consider ways of increasing access and take-up of STI screening and testing, particularly amongst those most at risk (including those who may not have access to the internet or postal services).

Increases in area-level deprivation are also associated with increases in rates of sexually transmitted and blood-borne infections including Chlamydia, Hepatitis B and C, HIV, Gonorrhoea, Syphilis, and genital warts. Analysis of local data has shown this for new gonorrhoea diagnoses (which appear to be relatively high as compared to the national average). Service delivery should therefore take account of this relationship.

According to national survey data, the proportion of the population performing anal sex is increasing including amongst the heterosexual population. Between 2010 and 2012, 18.5% of males and 17% of females aged 16-24 reported having anal sex in the year prior to interview. Sexual health education should include information on the risks associated with anal sex including sexually transmitted enteric infections (STEIs).

Sexual health interventions have to date focused primarily on female use and preventing conceptions rather than STI prevention. Qualitative data suggests that young men with complex needs may discount the use of condoms, use STI testing and treatment as a form of behaviour maintenance, and place responsibility for contraception with female partners, who in turn may struggle to comply with the daily regimen of the Pill. This complex and adaptive behaviour results in increased risk both of unwanted pregnancy and STI transmission. Promoting long-acting reversible contraceptives (LARC) to women with poor sexual health literacy is just one part of the solution.

New technological platforms used by young people (e.g., Tinder and Instagram) may be facilitating risky behaviours and eroding what would previously have been considered private/ boundaried space. Qualitative information has also suggested that there are increases in perfunctory, casual sex, experimentation and exposure to pornography as a form of sex education. The development of the local RSE offer will be important to help young people navigate such new exposures but may also require more systemic approaches.

Commissioned services and quality

Local sexual health services are mainly commissioned and modelled in line with national specifications, standards and guidelines. They are comparatively cost-effective, achieving similar outcomes per capita spend as the national average.

The quality of service offered by staff is highly praised, although the Genitourinary Medicine (GUM) clinic has received some criticism regarding access and relevance. Qualitative work suggests that young women may have accessed CaSH in preference to GUM due to perceived stigma associated with the GUM clinic.

There is some evidence of good interfaces between the commissioned services and those who serve vulnerable groups, although this is not consistent. Capacity building, improved networking and outreach could help to fill perceived shortfalls.

Services are accessed mostly by younger people, who are expected to be in the greatest need.

97% of CaSH and 52% of Genitourinary Medicine (GUM) service users were female. This raises the question of whether the STI prevention element of CaSH has been effective, and shows in service activity the effect of some young women opting to use the CaSH services rather than GUM. An integrated, universal, open and accessible service could address such anomalies.

59.9% of C-Card service users were male with the highest usage seen in 14-year-olds. Qualitative work suggests there may have been some wastage, and that the data burden of the scheme was considered to be too costly, which impacted on access and opportunity costs.

The Chlamydia detection rate has been declining since 2013, although positivity remains high particularly amongst males aged 20-24 years. This indicates the need to increase throughput for chlamydia screening whilst continuing to target those most at risk. Broader approaches to increasing throughput may reduce overall positivity, but would still improve the detection rate.

New Gonorrhoea infections were more likely to be experienced by younger women and older men, possibly indicating a greater need for STI prevention work with younger women and men outside of the eligible age for C-Card.

Data from Public Health England suggests that Sunderland has a high rate of late HIV diagnoses which, given the low numbers involved, may present an opportunity for further investigation (deep dive).

People from BAME backgrounds appeared to be well served by local SRH services.

Whilst access to C-Card reflected a strong relationship with deprivation, this was not the case for access to CaSH or GUM on the whole, although further analysis of service activity data may show correlations with particular interventions or conditions (such as gonorrhoea diagnoses noted above).

Data suggests residents of the Millfield ward may be underserved by the C- Card scheme although proportional lack of take-up may have been affected by a relatively affluent local student population. On the other hand, residents of Millfield disproportionately accessed the GUM service, which may be reflective of the location of the sexual health services.

Residents of Washington locality may have been underserved by C- Card and GUM services, but take-up might have been affected by the relative affluence or lower deprivation faced by residents in the area.

Residents of the Coalfields may be underserved by CaSH and GUM services, representing around 12% of service users but 17% of the local population.

Given the variation in access by location, commissioners should consider how underserved populations and groups can be equitably addressed through positive health promotion, dedicated outreach and/ or pop-up services. However, it is generally accepted that some people may prefer to access services out of the local area to preserve anonymity.

Joint Strategic Needs Assessment

1) Sexual and Reproductive Health

The purpose of this document is to present a strategic Sexual and Reproductive Health (SRH) needs assessment for the population of Sunderland, with a focus on the need for sexual health services.

The primary aims of this JSNA chapter are to:

1. describe the distribution and determinants of sexual and reproductive disease and ill-health in the population within the City of Sunderland and
2. identify the appropriate means to prevent such disease and promote good sexual and reproductive health for the people of the City of Sunderland.

The chapter is structured around key questions that are used to frame a needs assessment:

- What is the need locally, both now and in the future? This question is answered by seeking evidence on the distribution and determinants (risk and protective factors) of sexual health in Sunderland, including demographic profiles. Need is considered as the capacity to benefit from an intervention, as well as the demands placed on services.
- What are the effective interventions? This question is answered by seeking evidence of interventions (primary, secondary and tertiary) that can be judged to be clinically and cost-effective, acceptable and accessible, relevant and equitable.
- What is being done to locally to address this issue and how do we know this is making a difference? This question is answered by reviewing existing sexual health structures (i.e., systems and services), processes (i.e., pathways and interventions) and outcomes (i.e., in promoting good sexual health, and preventing sexual ill health, measured by mortality and morbidity).
- What is the perspective of the public on this issue? This question is answered by seeking the views of residents and service users on their expectations and needs, how this compares with service provision, and using any gaps to formulate ideas on future service provision.

Finally, analysis of the answers to each of the questions listed above provides evidence to inform the development of recommendations for commissioning and further needs assessment work.

2) What is the need locally, both now and in the future?

People's sexual and reproductive health needs vary at different stages in their lives. Sexual and reproductive and HIV services are used by people of all ages. However, high risk and vulnerable groups will have specific needs that may require targeted and tailored services.

These include young people, people with learning and physical disabilities, homeless people, MSM, gay people and people who identify as bisexual and transgender (LGBT), people living with HIV, sex workers, substance users, survivors of sexual abuse/domestic violence, people whose first language is not English, and people with chronic medical conditions. It is important to note that these groups may not be homogeneous or distinct from one another.

Demographic profile and trends in reproduction and conceptions

At a population level, an indicator of positive sexual and reproductive health and need is the size and composition of the population itself, and the extent to which it is sustained, including by reproduction. This is affected by both fertility and mortality rates, and by migration.

In order to sustain itself through childbirth, the population of England requires 2.075 children born to each female aged 15 to 44. In the UK the number of children within an average family (total fertility) has fallen steadily from 2.45 in the mid-1930s to 1.90 in 2014 (ONS, 2016)[1].

Factors affecting this include the socioeconomic context (including improving equality), delayed childbirth, increasing proportions of women who choose not to give birth, and public health interventions such as the introduction of 'the pill' in 1961.

ONS report that the mean age at motherhood for the UK is assumed to rise gradually from 28.4 years for women born in 1965 to 30.6 years for those born from 2005 onwards. The proportion of women who remain childless by age 45 in England and Wales has been increasing in recent years, from an estimated 14% of the 1950 cohort to 20% of women born in 1965.

Migration is expected to account for a greater proportion of population growth than reproduction. Setting aside speculation on the possible consequences of Brexit, over the next 10 years, 46% of UK population growth is projected to result from more births than deaths, with 54% resulting from net international migration.

In 2015, the City of Sunderland had one of the lowest total fertility rates within the North East of England[2]. This was 1.62 births per female aged 15-44, against a regional average of 1.71 and England average of 1.82. This suggests that the local population cannot be sustained by childbirth alone. The recent draft Local Plan intends to address this in part by including strategies to promote inward migration and reduce outward migration. Sexual health services can also play a part by promoting good sexual and reproductive health.

[1] ONS, https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/compendium/nationalpopulationprojections/2015-10-29/fertilityassumptions. Note that this is based on the cohort of women who are judged to have 'completed' their fertility by age 45 in 2014, i.e., were born in 1969.

[2] ONS, https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/datasets/birthsbyareaofusualresidenceofmotheruk

In tandem with the trends in fertility, the population is ageing, which in turn places greater economic demands on the working age population (including females of child bearing age). In Sunderland in 2016, 19% of local population was aged over 65. This is expected to rise to 22% by 2026 and reach 25% by 2036. In the shorter term, ONS have calculated that the number of fertile women in the local population is projected to fall by approximately 2,000 between 2014 and 2018[3] and to level off at around 51,000 thereafter.

Analysis of local conceptions data has shown that the rate of conceptions (for the population as a whole and for under-18 year olds) has a positive and linear relationship with deprivation scores. As deprivation increases, so do conception rates.

Figure 1: Scatter plot of conceptions in Sunderland by Ward and 2015 IMD score

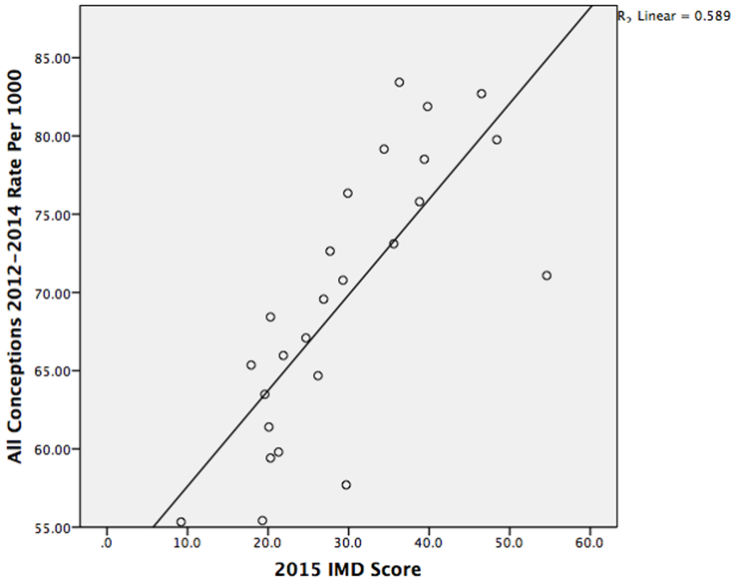
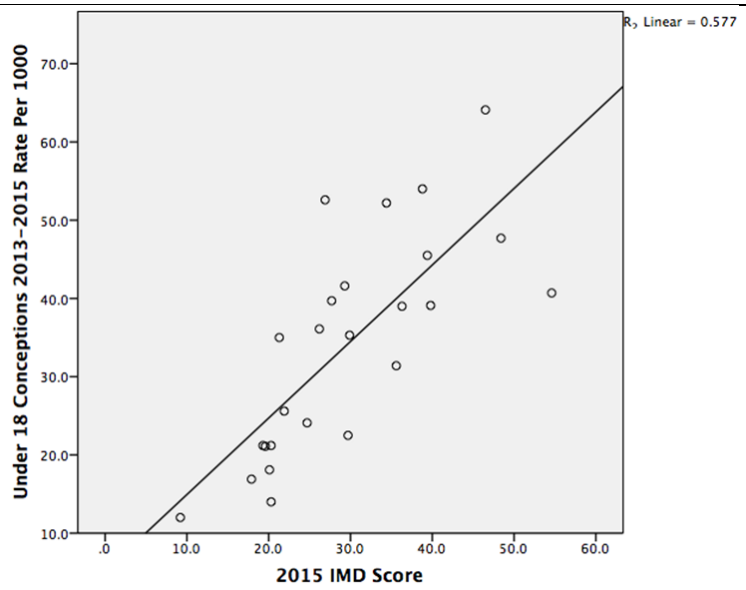


Figure 2: Scatter plot of Under-18 conceptions in Sunderland by Ward and 2015 IMD score

[3] ONS, https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandtable2



Tables 1 to 3 summarise the general demographic picture for Sunderland, including the overall growth of the local population over the next 20 years (again excluding any speculative impact of Brexit).

Table 1: Population projections for the City of Sunderland by age group (ONS, 2016)[4]

Age Group	2017	2027	% Change 2017-2027	2037	% Change 2027-2037
<10 years	30,900	30,500	-1.3%	29,700	-2.62%
10-14 years	14,700	15,300	4.1%	15,300	0.00%
15-19 years	15,100	16,300	7.9%	15,900	-2.45%
20-24 years	19,300	17,500	-9.3%	18,400	5.14%
25-44 years	68,500	71,000	3.6%	70,000	-1.41%
45-64 years	76,600	68,800	-10.2%	64,300	-6.54%
> 65 years	53,400	64,200	20.2%	73,400	14.33%
Grand Total	**278,500**	**283,600**	**1.8%**	**287,000**	**1.20%**

Table 2: Population projections for the City of Sunderland by sex (ONS, 2016)

Sex	2017	2027	% Change 2017-2027	2037	% Change 2027-2037
Male	136,200	139,600	2.5%	142,100	1.79%

4 https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandtable2

	Female	142,300	143,800	1.1%	145,000	0.83%
	Sex ratio (M/F)	0.96	0.97		0.98	0.47

Ethnicity

ONS no longer provides population projections for ethnic groups at local authority level. A suggested method is limited to estimating UK- and non-UK born populations[5].

In the local 2017 Adult Lifestyle Survey (ALS), just over 4% of respondents described themselves as having a non-White ethnic background.

Table 3: Ethnic profile (ALS, 2017)

Which of the following best describes your ethnic origin?	Total
Asian or Asian British	1.85%
Black or Black British	1.15%
Don't know	0.05%
Mixed	0.50%
Other Ethnic Group	0.57%
Refusal	0.11%
White	95.76%

Sexuality

The 2017 ALS asked respondents about their sexual orientation, and about 3% of females and 5% males described themselves as other than heterosexual. As the ALS was targeted at people aged 18 and over, there is no quantitative local information on the eligible population aged 13-17.

Table 4: Sexual orientation by sex (ALS, 2017)

Which of the following best describes your sexual orientation?	Female	Male
A. Heterosexual or straight	96.99%	95.39%
B. Gay	0.17%	2.15%
C. Lesbian	0.75%	0.00%
D. Bisexual	0.62%	0.60%
E. Other	0.34%	0.34%
Don't know	0.34%	0.34%

5 https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/methodologies/researchreportonpopulationestimatesbycharacteristics

Refusal	0.79%	1.17%

Younger people were more likely to describe themselves as other than heterosexual, with the exception of the oldest age group unsure of their sexuality.

Table 5: Sexual orientation by age group (ALS, 2017)

Which of the following best describes your sexual orientation?	18 - 24	25 - 34	35 - 44	45 - 54	55 – 64	65 - 74	75 – 84	85 +
A. Heterosexual or straight	93.61 %	94.12 %	97.25 %	97.04 %	96.51 %	98.06 %	97.30 %	95.74 %
B. Gay	2.23%	2.26%	0.62%	0.59%	1.01%	0.69%	0.22%	0.71%
C. Lesbian	1.04%	0.45%	0.62%	0.49%	0.11%	0.00%	0.00%	0.00%
D. Bisexual	2.08%	1.58%	0.25%	0.20%	0.23%	0.00%	0.00%	0.00%
E. Other	0.00%	0.23%	0.25%	0.69%	0.68%	0.14%	0.00%	0.71%
Don't know	0.30%	0.23%	0.12%	0.30%	0.23%	0.28%	0.90%	2.13%
Refusal	0.74%	1.13%	0.87%	0.69%	1.24%	0.83%	1.57%	0.71%

In the National Survey of Sexual Attitudes and Lifestyles (Natsal-3[6]) study, 97% of men and women defined themselves as heterosexual. Between 1-1.5% described themselves as gay or lesbian, and a further 1-1.4% identified as bisexual.

Amongst men, identifying as gay and having at least 1 male partner in the past 5 years were highest in the 25-24 year old age group, with 2.4% and 3.5% respectively. On average, 2.6% of men reported having at least 1 male partner in the past 5 years.

Amongst women, identifying as bisexual and having at least one female sexual partner in past 5 years was highest amongst 16-24 year olds, at 2.5% and 6.2% respectively. On average, 3.2% of women reported having at least 1 female partner in the past 5 years.

Sexual activity and first sexual intercourse

Natsal-3 has shown that age of first sexual intercourse has been decreasing across generations. 4.0% of 65-74 year olds reported having heterosexual intercourse before age 16. For 16-24 year olds this is 29% (29.2% of women, 30.9% of men).

The frequency of recent sexual activity and numbers of partners were highest amongst the younger age groups.

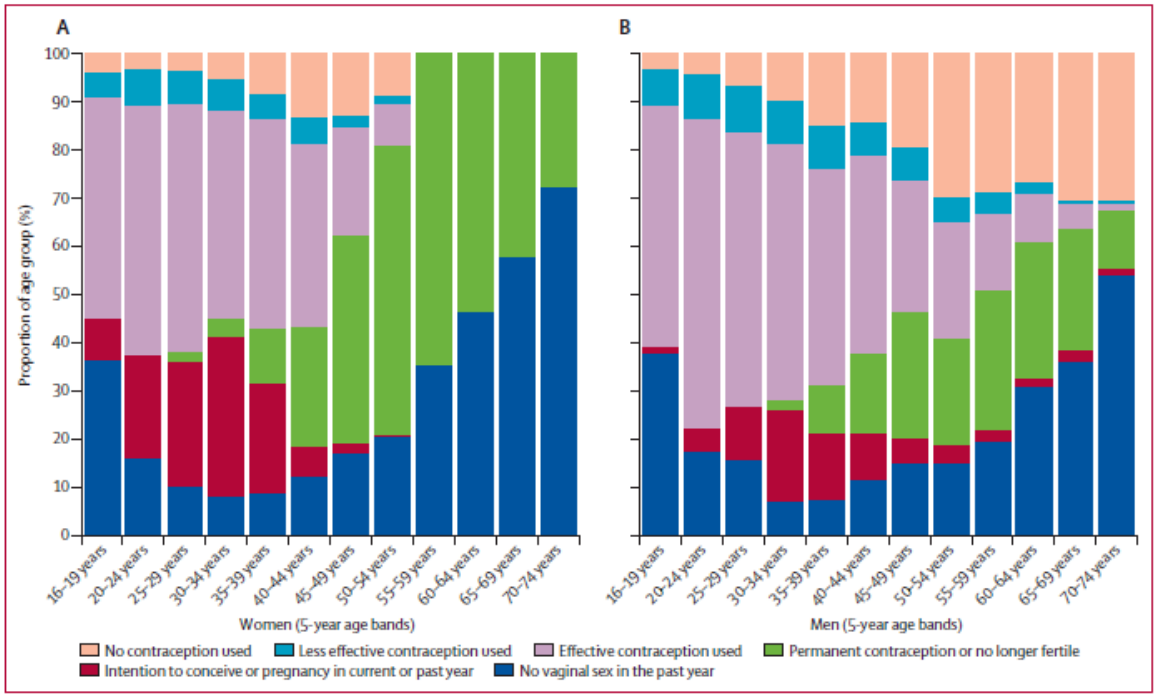
[6] The Natsal is a household survey, with many questions answered by self-report. As such, the survey may exclude the groups most at risk of sexual ill health, including travellers, people in contact with criminal justice services and those without homes. The survey generated a large number of published articles. A key publication used for this section is as follows: Mercer, Catherine H., et al. "Changes in sexual attitudes and lifestyles in Britain through the life course and over time: findings from the National Surveys of Sexual Attitudes and Lifestyles (Natsal)." The Lancet 382.9907 (2013): 1781-1794.

On the whole, males appeared to report higher levels of sexual activity. On average, 63% of males reported having vaginal sex in the past 4 weeks. 67% had given or received oral sex in the past year, and 13% had anal sex in the past year (rising to 18.5% in those aged 16-24). On average, 58% of females reported having vaginal sex in the past 4 weeks. 60% had given or received oral sex in the past year, and 10.5% had anal sex in the past year (rising to 17% in those aged 16-24).

Amongst males, it was most common to report having 1 partner or less in the previous year (67.1% within all age groups). 33% of 16-24-year-old males reporting having 2 or more partners in the previous year, as compared with 20% or less in other age groups. Amongst females, the picture was similar. 68.4% if all female respondents reported having 1 partner or less in the previous year. 27% of 16-24-year-old females reported have 2 or more partners in the previous year, as compared with 13% or less in other age groups.

Although younger people were more likely to report more frequent recent sexual activity and higher partner numbers (i.e., indicating increasing risk of disease transmission and need for health protection), the prevalence of vaginal sex within the past year was highest amongst those aged 30-34 years (perhaps indicating greater need for reproductive health promotion and services within this age group). See **Figure 3**.

Figure 3: Behaviours relating to pregnancy risk in the year before interview. Source: Natsal-3.[7]



[7] Wellings, Kaye, et al. "The prevalence of unplanned pregnancy and associated factors in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3)." The Lancet 382.9907 (2013): 1807-1816.

Burden of disease

Natsal-3[8] provided national prevalence estimates for 4 key STIs:

- Chlamydia trachomatis (1.5% in women and 1.1% in men)
- Human Papillomavirus (HPV) (15.9% in women)
- Gonorrhoea (Neisseria gonorrhoeae) (<0.1% prevalence in women and men)
- Human Immunodeficiency Virus (HIV) (0.1% prevalence in women and 0.2% in men)

Public Health England (PHE) produces the Sexual and Reproductive Health Profile[9] for local authorities (see **Figure 4**). The latest data STI data release shows that Chlamydia and late HIV diagnoses, abortions under 10 weeks and under 18 conceptions are significantly worse than the national benchmark. Gonorrhoea diagnoses has been increasing over recent years and was significantly worse than the national benchmark, but latest data shows some improvement and a rate similar to the national benchmark, although the local rate continues to be higher than the regional rate. Diagnoses of genital herpes is similar to the national benchmark, but has seen a decrease of 24 % between 2017 and 2018.

[8] Sonnenberg, Pam, et al. "Prevalence, risk factors, and uptake of interventions for sexually transmitted infections in Britain: findings from the National Surveys of Sexual Attitudes and Lifestyles (Natsal)." The Lancet 382.9907 (2013): 1795-1806.

[9] https://fingertips.phe.org.uk/profile/sexualhealth/data

Figure 4: Sexual and Reproductive Health Profile for Sunderland: PHE, 2018

Compared with benchmark: Better | Similar | Worse — Lower | Similar | Higher — Not compared

Indicator	Period	England	North East region	Sunderland	Stockton-on-Tees	South Tyneside	Redcar and Cleveland	Northumberland	North Tyneside	Newcastle upon Tyne	Middlesbrough	Hartlepool	Gateshead	Darlington	County Durham
Syphilis diagnostic rate / 100,000	2017	12.5	7.7	3.6	7.1	14.7	4.4	5.7	12.3	16.3	4.3	8.6	9.9	4.7	3.8
Gonorrhoea diagnostic rate / 100,000	2017	78.8	67.4	81.5	60.2	52.3	48.0	37.5	61.9	136.5	67.7	56.0	75.0	67.7	52.3
Chlamydia detection rate / 100,000 aged 15-24 (PHOF indicator 3.02) <1,900 1,900 to 2,300 ≥2,300	2017	1882	2033	1699	2091	2084	2319	1826	2440	2501	1888	2716	1979	1992	1620
Chlamydia proportion aged 15-24 screened	2017	19.3	19.5	16.0	15.5	20.7	14.3	21.0	25.6	28.2	13.4	19.6	17.5	16.5	16.3
New STI diagnoses (exc chlamydia aged <25) / 100,000	2017	794	644	709	467	704	483	470	659	986	582	541	682	817	569
HIV testing coverage, total (%)	2017	65.7	62.4	77.4	62.1	65.8	58.0	62.9	50.7	55.8	60.6	56.8	65.6	76.9	71.8
HIV late diagnosis (%) (PHOF indicator 3.04) <25% 25% to 50% ≥50%	2014 - 16	40.1	46.7	52.5	35.3	30.0	*	57.6	47.4	44.9	70.0	*	43.3	45.5	36.5
New HIV diagnosis rate / 100,000 aged 15+	2016	10.3	6.2	6.9	4.4	3.2	2.7	7.1	3.0	10.1	5.3	6.6	8.3	1.2	6.9
HIV diagnosed prevalence rate / 1,000 aged 15-59 <2 2 to 5 ≥5	2016	2.31	1.03	0.88	0.84	0.61	0.33	0.65	1.11	2.15	1.48	0.60	1.55	0.90	0.70
Population vaccination coverage – HPV vaccination coverage for one dose (females 12-13 years old) (PHOF indicator 3.03xii) <80% 80% to 90% ≥90%	2016/17	87.2	89.8	93.4	88.7	93.7	85.9	88.0	91.6	89.8	84.0	85.0	91.7	89.4	90.7
Under 25s repeat abortions (%)	2016	26.7	23.6	22.3	29.0	27.0	24.5	20.7	23.1	18.2	32.2	25.8	22.0	22.3	22.3
Abortions under 10 weeks (%)	2016	80.8	77.3	74.6	79.2	83.6	79.6	78.8	77.1	72.7	77.0	80.1	83.0	71.2	76.4
Total prescribed LARC excluding injections rate / 1,000	2016	46.4	42.1	48.3	6.1	54.3	16.4	61.0	70.4	51.0	11.2	9.6	52.1	37.9	39.6
Under 18s conception rate / 1,000 (PHOF indicator 2.04)	2016	18.8	24.6	31.9	27.7	24.0	31.6	21.0	15.4	20.8	36.5	34.9	20.6	24.1	21.6
Under 18s conceptions leading to abortion (%)	2016	51.8	41.6	48.1	54.4	44.8	35.7	38.1	43.8	39.1	34.4	32.8	55.4	36.4	37.0
Sexual offences rate / 1,000 (PHOF indicator 1.12iii)	2016/17	1.9	2.2	2.4	2.0	2.1	1.7	1.7	2.0	3.2	3.5	2.0	2.0	2.4	2.0

In addition to the SRH Profile, PHE North East Centre produces an annual HIV, sexual and reproductive health epidemiology report (LASER). This is based upon data collected through the Chlamydia Testing Activity Dataset (CTAD) and the Genitourinary Medicine Clinic Activity Dataset (version 2) (GUMCAD). These are surveillance systems populated by local clinics and managed by PHE.

Key findings from the latest report (using 2017 data unless otherwise specified) include the following:

- Overall 1,875 new sexually transmitted infections (STIs) were diagnosed in residents of Sunderland, a rate of 676.1 per 100,000 residents (compared to 743 per 100,000 in England).Sunderland has the 90th highest rate (out of 326 local authorities in England) of new STIs excluding chlamydia diagnoses in 15-24 year olds; with a rate of 708.8 per 100,000 residents (compared to 794 per 100,000 in England).58% of diagnoses of new STIs in Sunderland were in young people aged 15-24 years (compared to 50% in England).For cases in men where sexual orientation was known, 12.9% of new STIs in Sunderland were among gay, bisexual and other men who have sex with men (MSM).
- The Chlamydia detection rate per 100,000 young people aged 15-24 years in Sunderland was 1,699 (compared to 1,882 per 100,000 in England).
- Sunderland has the 45th highest rate (out of 326 local authorities in England) for gonorrhoea, which is a marker of high levels of risky sexual activity. The rate of gonorrhoea diagnoses per 100,000 in this local authority was 81.5 (compared to 78.8 per 100,000 in England).The rate of Syphilis diagnoses per 100,000 in this local authority was 4.0 (compared to 10.6 per 100,000 in England).
- In Sunderland, an estimated 6.4% of women and 8.1% of men presenting with a new STI at a sexual health service (SHS) during the 5 year period from 2013 to 2017 were re-infected with a new STI within 12 months..

Among specialist SHS patients from Sunderland who were eligible to be tested for HIV, 77.4% were tested compared to 65.7% in England (HIV testing coverage).There were 9 new HIV diagnoses in individuals aged 15 years and above in Sunderland. The diagnosed HIV prevalence was 0.9 per 1,000 population aged 15-59 years in people being seen for HIV care resident in Sunderland (compared to 2.3 per 1,000 in England).In Sunderland, between 2015 and 2017, 38.2% (95% confidence interval [CI] 22.2%-56.4%) of HIV diagnoses were made at a late stage of infection (CD4 count =<350 cells/mm³ within 3 months of diagnosis) compared to 41.1% (95% CI 40.2-42.1) in England. (Please note that the number of late diagnoses (and new HIV diagnoses) are small therefore these figures must be interpreted with caution).The total rate of long-acting reversible contraception (LARC) excluding injections prescribed in primary care, specialist SHSs and non-specialist SHSs was 49.8 per 1,000 women aged 15-44 years in Sunderland, and 47.4 per 1,000 women in England. The rate prescribed in primary care was 15.9 in Sunderland and 29.2 in England. The rate prescribed in the other settings was 33.9 in Sunderland and 18.2 in England. In Sunderland upper tier local authority, the total abortion rate per 1,000 female population aged 15-44 years was 12.5, while in England the rate was 17.2 per 1,000. Of those women under 25 years who had an abortion in that year, the proportion who had had a previous abortion was 19.0%, while in England the proportion was 26.7%.In 2016, the conception rate for under-18s in Sunderland was 31.9 per 1,000 females aged 15-17 years, while in England the rate was 18.8.

Further analysis of the GUM data has shown that during 2014-2017, new Gonorrhoea diagnoses were fairly evenly split between males and females. However, about a third of female presentations had previously been diagnosed elsewhere - this was less than 5% in male attendances. Of the male attendances, almost a third of patients identified as gay or bisexual, whereas 97% of females identified as heterosexual. Male patients appeared to be older, as the peak age of male attendances was 22 against 18 for females. Of the cases resident in Sunderland, Hendon ward represented the highest number. Further analysis showed that diagnoses in the local population had a moderate

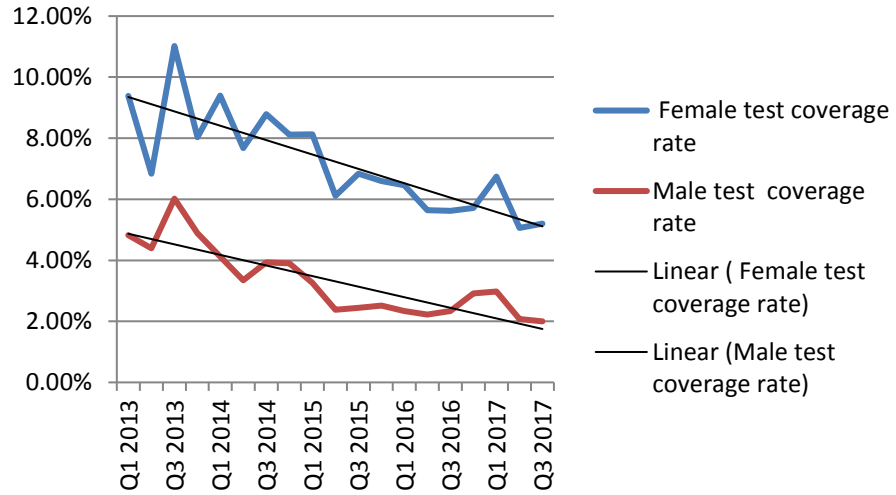
association with area level deprivation (56% of geographical variations explained by deprivation). Nearly 1 in 10 of all Gonorrhoea diagnoses were for people who lived in County Durham (13% male, 8% female). The data suggests that targeted work may be required to meet the varying needs of each group (e.g., younger women, relatively older men, gay and bisexual men, and people exposed to higher levels of area deprivation).

Chlamydia is the most common bacterial sexually transmitted infection in England, with rates substantially higher in young adults than any other age group. Most affected people display no symptoms. By diagnosing and treating asymptomatic Chlamydia infections Chlamydia screening can reduce the duration of infection, which will reduce an individual's chance of developing complications, and also reduce the period of time when someone is at risk of passing the infection on, helping to reduce the spread of Chlamydia in the population. Untreated Chlamydia causes sexual and reproductive ill-health, including symptomatic acute infections and complications such as pelvic inflammatory disease, ectopic pregnancy and tubal-factor infertility.

The National Chlamydia Screening Programme (NCSP) offers opportunistic screening of sexually active young people aged 15 to 24 years with the aim of increasing the detection of Chlamydia and reducing the prevalence of associated sequelae. It is recommended that all sexually active young people under 25 are screened annually or on change of partner (whichever is more frequent).

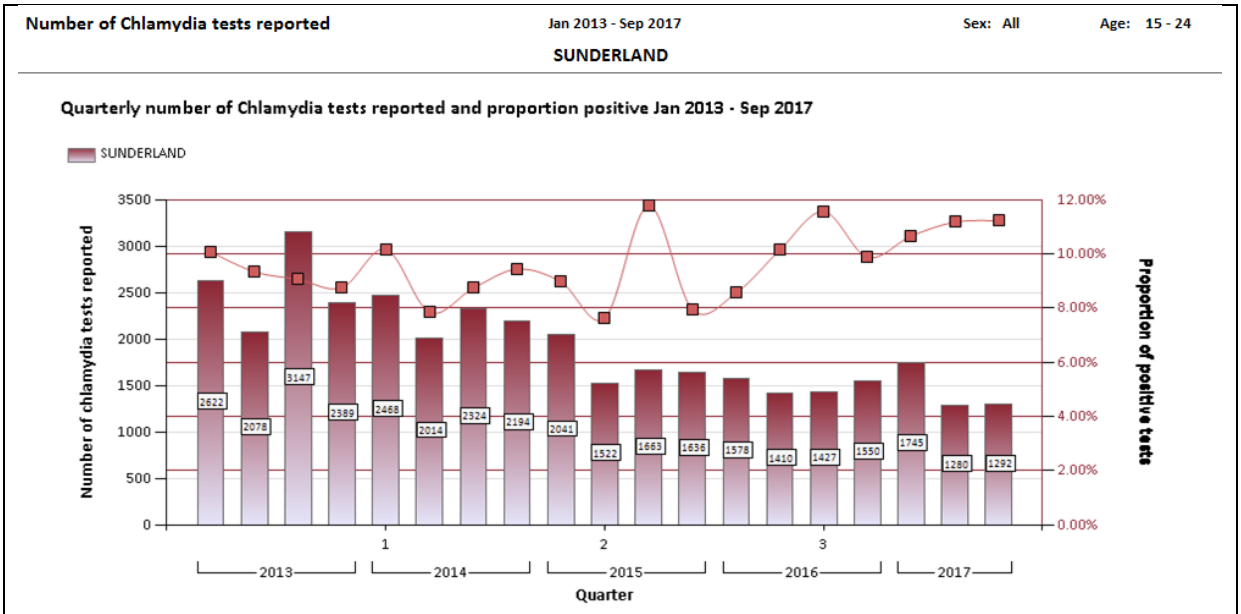
The proportion of the population aged 15-24 who were screened for Chlamydia in Sunderland in 2016 was 16.6%, compared with 19.7% regionally and 20.7% nationally. Sunderland ranks third lowest amongst statistical neighbours, and fifth lowest in the region for Chlamydia screening. There has been a downward trend in the proportion of people aged 15-24 who are screened both locally and regionally since 2013. In Sunderland, the proportion screened in 2013 was 27.7% and this has dropped to 16.6% in 2016. Chlamydia testing coverage rates have fallen for both males and females (see **Figure 5**).

Figure 5: Chlamydia testing coverage rates and trend lines in Sunderland for males and females



The Chlamydia detection rate is a measure of the level of control activity rather than a measure of morbidity. Public Health England recommends that local authorities should be working towards a detection rate of at least 2,300 per 100,000 population aged 15-24. The Chlamydia detection rate has been falling in Sunderland since a peak of 2,572 per 100,000 population aged 15-24 in 2013. In 2016 the Chlamydia detection rate was 1,654. This is significantly worse than the regional (1,836) and national (1,882) positions. Sunderland ranks second worst for this amongst statistical neighbours and fourth lowest regionally. The Chlamydia detection rate for females has fallen from 3,536 per 100,000 population in the first quarter of 2013 to 2,088 per 100,000 population in the quarter to September 2017. For males, the Chlamydia detection rate has fallen from 2,183 per 100,000 population in the first quarter of 2013 to 1,143 per 100,000 population in the quarter to September 2017. Data from January 2013 to end September 2017 (see **Figure 6**) shows that whilst the number of Chlamydia tests reported has been falling, the proportion that are positive has fluctuated around 9.5% overall for all persons aged 15-24. At September 2017, the proportion of tests that were positive in Sunderland was 11.2%. This suggests appropriate targeting for testing, but not enough throughput of screening to achieve the required detection rate of at least 2,300 per 100,000 population.

Figure 6: Quarterly Chlamydia Tests and Positivity, CTAD, 2018



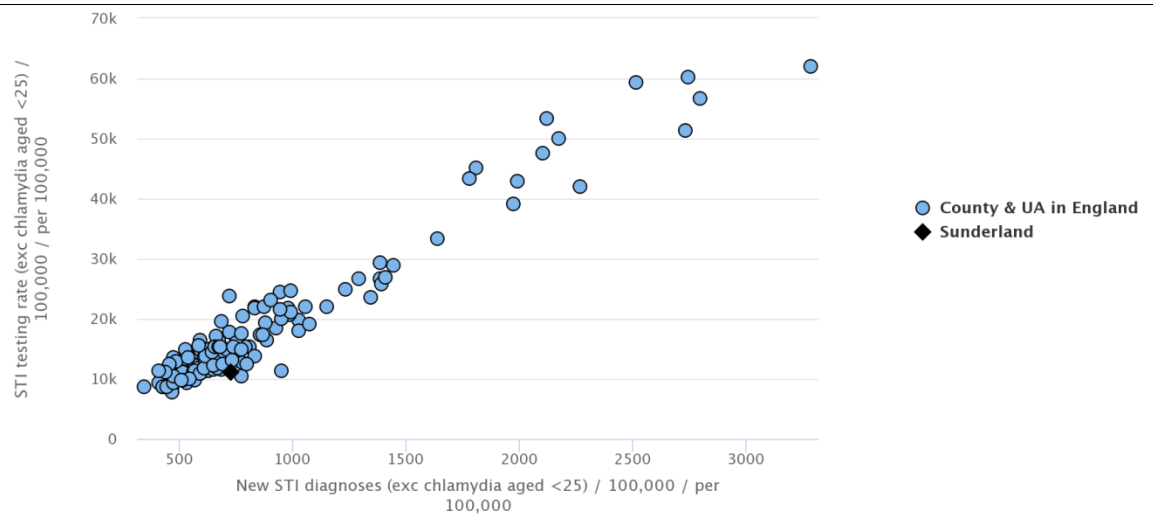
It was not possible to analyze local data on late HIV diagnoses without access to the HIV and AIDS Reporting System (HARS). Further local investigation may be necessary.

PHE's recent publication on HIV and AIDs found an 18% decline in new HIV diagnoses between 2015 and 2016, due to range of factors including STI prevention and availability of pre-exposure prophylaxis (PrEP)[10].

The rate of positive STI diagnoses as published in the SRH Profile and LASER may not be a good indicator of the burden of disease in the local community, as this depends on underlying prevalence as well as the rate of testing. The SRH profile data shows that excluding Chlamydia, Sunderland tests around 11% of the eligible population for STIs – having fallen from 12% in 2012 and risen to nearly 13% in 2014 (see **Figure 7**).

Figure 7: Rates of STI testing and diagnoses for under-25s (excluding Chlamydia): PHE, 2017

[10] https://www.gov.uk/government/statistics/hiv-annual-data-tables



Risk and protective factors

In general, health outcomes are affected by the interaction of 4 key determinants that can be positive or negative: biology, behaviour, environment and the quality of services. People who are exposed to a lasting and frequent combination of negative biological, behavioural, environmental and service-related factors will be more vulnerable to poor health (including sexual health) than those less exposed.

Sexual and reproductive health varies according to sex, because certain conditions are sex-specific, such as cervical cancer caused by some strains of Human Papillomavirus (HPV). Some consequences are also sex-specific such as Pelvic Inflammatory Disease (PID) arising from Chlamydia or Gonorrhoea infection.

Most technologies for protecting and improving SRH have been developed for use by women only, such as the pill, injections, LARC, HPV vaccination and certain screening programmes (e.g., Infectious Diseases in Pregnancy). As such, contraceptive interventions have largely focused on preventing pregnancy rather than STI transmission. This was reflected in the large proportion of women accessing CaSH services (see the subsection on Health Equity Audit).

Younger people are at greater risk of sexual ill health due to increased sexual and risk-taking activity, higher partner numbers and lower sexual health literacy and experience. As noted above, in 2016 60% of new STI diagnoses were in people aged 15-24 though representing around 12% of the local population.

Older people are at greater risk of sexual dysfunction though less likely to seek services for support[11].

[11] Mitchell, Kirstin R., et al. "Sexual function in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3)." The Lancet 382.9907 (2013): 1817-1829.

Poor health is independently associated with decreased sexual activity and satisfaction at all ages and mental ill health such as depression is associated with poorer sexual health[12].

People with learning disabilities may be less likely to engage in sexual activity in part due to protection from perceived risks by social agents (information sourced from conversation with local service provider).

Men who pay for sex are at greater risk of STI acquisition and onward transmission than men who do not[13].

People who engage in anal sex (oral and genital) are at risk of contracting Sexually Transmitted Enteric Infections (STEIs) such as shigella, giardia, campylobacter and salmonella.

As noted above, cases involving MSM represent almost 13% of new STI diagnoses, but the prevalence of men having a male partner may be as low as 3%.

Many health outcomes have a clear association with area-level deprivation, including overall life expectancy and premature mortality, obesity in children, alcohol-related harms, smoking prevalence and smoking-related deaths, and conception rates (as noted above)[14]. This relationship has also been observed for many sexually transmitted and blood-borne infections such as Chlamydia[15], hepatitis B and C, HIV, Gonorrhoea, syphilis, and genital warts[16].

There is evidence that circumcision can reduce the risk of disease including HIV, HPV, chancroid and syphilis[17].

Receiving relationships and sexual health information at school is associated with reporting better sexual health outcomes, including later age of first sexual intercourse and sexual competence[18].

Research undertaken by Changing Lives on women involved in sex work in 2011[19] (in Sunderland and Newcastle) and 2015[20] (in Durham and Darlington) has shown that many worked opportunistically to

[12] Field, Nigel, et al. "Associations between health and sexual lifestyles in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3)." The Lancet 382.9907 (2013): 1830-1844.
[13] Jones, Kyle G., et al. "The prevalence of, and factors associated with, paying for sex among men resident in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3)." Sex Transm Infect (2014): sextrans-2014.
[14] The PHE fingertips tool can be used to create a scatter plot showing the correlation (or lack of) between deprivation and any selected health outcome.
[15] Sonnenberg, P., et al. "Prevalence, risk factors, and uptake of interventions for sexually transmitted infections in Britain: findings from the National Surveys of Sexual Attitudes and Lifestyles (Natsal) Lancet. 2013; 382 (9907): 1795–806. doi: 10.1016." S0140-6736 (13) (1795): 61947-9.
[16] Hughes, G. J., and R. Gorton. "Inequalities in the incidence of infectious disease in the North East of England: a population-based study." Epidemiology & Infection 143.1 (2015): 189-201.
[17] Homfray, Virginia, et al. "Male circumcision and STI acquisition in Britain: evidence from a national probability sample survey." PLoS One 10.6 (2015): e0130396.
[18] Macdowall, Wendy, et al. "Associations between source of information about sex and sexual health outcomes in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3)." BMJ open 5.3 (2015): e007837.

pay for drugs, food or receive accommodation. Childhood trauma, mental health problems, substance misuse, homelessness, domestic abuse and loss of custody of children were all common features of these women's lives. Although escorts were less likely to have complex needs violence, sexual assault and rape were commonly experienced by all of the women interviewed regardless of the type of sex work they conducted. Few women reported negative impacts on sexual health in terms of communicable disease infection. High levels of condom use and accessing GUM were reported. Participants reported that sex work had impacted negatively on sexual relationships with partners, finding sex work had devalued their self-esteem and made intimacy difficult and intercourse unfulfilling. There was a tendency to use substances whilst working . Most were accessing substance misuse treatment services. Women subject to child exploitation often showed low levels of understanding about what exploitation is and how they had been groomed as part of their exploitation.

In summary of the above:

- The total fertility rate in the local population is insufficient to reproduce the population by itself.
- The fall in fertility rates is due to a combination of general factors that could be outside the control of the local authority.
- Higher conception rates (including under-18s) are associated with increasing area-level deprivation.
- Poorer health including sexual health is associated with increasing deprivation, including education, income and employment.
- Certain groups are more vulnerable to poorer health and sexual health outcomes due to a combination of biological, behavioural, environmental and service-related factors. This includes people who experience higher area-level deprivation, engage in other risk taking behaviours and lack sexual health literacy and agency for various reasons. Specific groups include young people, asylum seekers, people with learning disabilities, people in contact with CJS, sex workers, communities exposed to high levels of deprivation. The complex needs of individuals in such groups may require capacity building within their primary service provider, and an improved interface with SRH services including outreach.
- There is anecdotal evidence of increasingly experimental sexual behaviours, especially amongst young people.
- Sunderland has a relatively high rate of teenage pregnancies, which is being addressed through a renewed local strategy.
- The City has a relatively low rate of LARC prescribing in primary care settings, which may be slightly offset by fitting in specialist settings.
- Sunderland has a comparatively low rate of STI testing, which in turn may lead to relatively low rates of positive diagnosis including Chlamydia.
- There is a continuing decline in the Chlamydia diagnostic rate, which needs to be considered in any future commissioning models.
- Sunderland has a relatively high rate of late HIV diagnoses which, although the numbers are small, may require further local investigation.

[19] Irving, Adele and Laing, Mary (2013) PEER: Exploring the Lives of Sex Workers in Tyne and Wear. Project Report. The Cyrenians, Newcastle-upon-Tyne. (Unpublished)
[20] http://www.changing-lives.org.uk/news/peer-research-sex-durham-darlington/

- As reproductive rates fall, there may be a greater demand for contraceptive services.
- As fertility is delayed, there may be a greater demand for more complex gynaecological, obstetric and reproductive services.
- There may be an increasing need for positive sexual health promotion due to an increasingly ageing population living with multiple comorbidities and LTCs such as diabetes.

Access to services and service quality will be covered in later sections, including Health Equity Audit (HEA) of CaSH, GUM and C-Card.

3) What are the effective interventions?

The local authority is responsible for commissioning "open access" sexual health services to meet local need in respect of:

1. Comprehensive sexual health services. These include:

a. Contraception (including the costs of LARC devices and prescription or supply of other methods including condoms) and advice on preventing unintended pregnancy, in specialist services and those commissioned from primary care (GP and community pharmacy) under local public health contracts (such as arrangements formerly covered by LESs and NESs)
b. Sexually transmitted infection (STI) testing and treatment in specialist services and those commissioned from primary care under local public health contracts, Chlamydia screening as part of the National Chlamydia Screening Programme (NCSP), HIV testing including population screening in primary care and general medical settings, partner notification for STIs and HIV
c. Sexual health aspects of psychosexual counselling, and
d. Any sexual health specialist services, including young people's sexual health services, outreach, HIV prevention and sexual health promotion, service publicity, services in schools, colleges and Pharmacies

2. Social care services (for which funding sits outside the Public Health ring-fenced grant and responsibility did not change as a result of the Health and Social Care Act 2012), including:

a. HIV social care, and
b. Wider support for teenage parents[21]

Note that the latter sits outside the scope of this JSNA.

Outside of local authority-commissioned services, NHS England and CCGs are responsible for commissioning related interventions such as sterilisation and clinically-indicated contraception, screening and immunisation programmes, Sexual Assault Referral Centres and termination services (see **Appendix A**).

While comprehensive open access services are mandated, the way they are delivered and the care pathways they are modeled around are not.

[21] https://www.gov.uk/government/publications/commissioning-sexual-health-reproductive-health-and-hiv-services

The National Institute for Clinical Excellence (NICE) provides clinical guidelines on the following:

- Contraceptive services for under 25s (PH51) (March 2014, reviewed October 2017)
- Long-acting reversible contraception (CG30) (October 2005)
- Preventing sexually transmitted infections and under-18 conceptions: prevention (PH3) (February 2007)

In addition to the guidelines, NICE has published four quality standards for contraceptive services:

1. Contraceptive information and methods: Women asking for contraception from contraceptive services are given information about, and offered a choice of, all methods including long-acting reversible contraception.
2. Emergency Contraception: Women asking for emergency contraception are told that an intrauterine device is more effective than an oral method.
3. Contraception after an abortion: Women who request an abortion discuss contraception with a healthcare practitioner and are offered a choice of all methods when they are assessed for abortion and before discharge.
4. Contraception after childbirth: Women who give birth are given information about, and offered a choice of, all contraceptive methods by their midwife within 7 days of delivery.

In the future, NICE hopes to publish quality standards on:

- HIV testing: encouraging uptake
- Reducing sexually transmitted infections
- Sexual health across the life course

In addition to NICE guidelines, the British Association for Sexual Health and HIV (BASHH) produces best practice guidelines and standards on the screening, treatment and management of STIs and HIV. The Faculty of Sexual and Reproductive Health (FSRH) also publishes clinical guidance and service standards.

PHE produces evidence summaries, such as 'Addressing Late HIV Diagnosis through Screening and Testing: An Evidence Summary' (2014) and 'Opportunistic Chlamydia Screening of Young Adults in England: An Evidence Summary' (2014).

In summary of this section:

There is much information on evidence-based clinical practice for sexual and reproductive health services which will need to be taken into account when developing service specifications for the local model. Much is prescribed, leaving some room for local determination. This is where the specific needs of the local population will need to be taken into account, bearing in mind inequalities in the disease burden. This will require linking up with other strategies that affect related health determinants and risk factors including for the most vulnerable.

4) What is being done to locally to address this issue and how do we know this is making a difference?

In addition to this section, please see the segment below providing feedback on the views of the public.

Structures and processes

Local services have been structured around the 3-tier model described in the 2001 *National Strategy for Sexual Health and HIV* in 2001[22] (items in red font are from the original text, but are the responsibility of other organisations):

Box 1: Structure of sexual and reproductive health services

<----- Health Promotion ----->	**Tier 1**
	sexual history and risk assessment
	contraceptive information and services
	STI testing for women
	assessment and referral of men with STI symptoms
	HIV testing and counselling
	cervical cytology screening and referral
	pregnancy testing and referral
	hepatitis B immunisation
	Tier 2
	intrauterine device insertion (IUD)
	contraceptive implant insertion
	testing and treating sexually transmitted infections
	partner notification
	vasectomy
	invasive sexually transmitted infection testing for men (until non-invasive tests are available)
	Tier 3
	outreach for sexually transmitted infection prevention
	outreach contraception services
	specialised infections management, including co-ordination of partner notification
	highly specialised contraception
	specialised HIV treatment and care

To support the new commissioning responsibilities of local authorities in 2013, DH published a suggested service specification for integrated sexual health services[23]. It was this that the current

22 http://webarchive.nationalarchives.gov.uk/20130123203808/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003133

local specification was based upon. Although the vision was of an integrated service, core CaSH and GUM services currently operate over two sites on the hospital grounds.

CaSH and GUM services are provided by City Hospitals Sunderland. This includes a range of services including HIV tests, STI screening, contraception and termination of pregnancy services (the latter being commissioned by Sunderland Clinical Commissioning Group). The provider is also commissioned to offer outreach and young person's clinics. The C-Card scheme operates throughout Sunderland, with community services such as schools and colleges and support services able to participate voluntarily. The local authority also commissions a pregnancy options adviser and a young person's nurse.

Outputs and outcomes

PHE's Spend and Outcome Tool[24] suggests that programme spend on sexual health in Sunderland is cost-effective when compared with spend and outcomes in local authorities in England (**Appendix B**).

Indicators from the Public Health Outcomes Framework and some findings from the LASER reports from PHE have been considered in section 2. These are largely based on service activity data and so may not represent the true extent of need or a true measure of effectiveness for the local population.

Further data collection and analysis has been or will be undertaken, comprising of:

- A Health Equity Audit of C-CARD and CaSH and GUM services
- A survey of the general public incorporating a service user questionnaire
- A process and value mapping exercise to analyse existing pathways and help determine the most efficient models of future care

The views of the public are covered in section 5.

Health Equity Audit (HEA)

Data was collected from C-CARD and CaSH and GUM systems covering 3 financial years from 2014/15 to 2016/17. For the purposes of the HEA, non-residents of Sunderland were excluded from analysis. The proportion of service users accessing the services with each protected characteristic was compared with population estimates where available. The distribution of service users by Ward of residence was compared with the distribution of area-level deprivation within the City.

C-CARD

Data on C-CARD activity was obtained from local services.

[23] https://www.gov.uk/government/publications/public-health-services-non-mandatory-contracts-and-guidance-published

[24] https://www.gov.uk/government/publications/spend-and-outcome-tool-spot

Over the three-year period, 3,159 residents of Sunderland accessed the service, recording 7,628 activities.

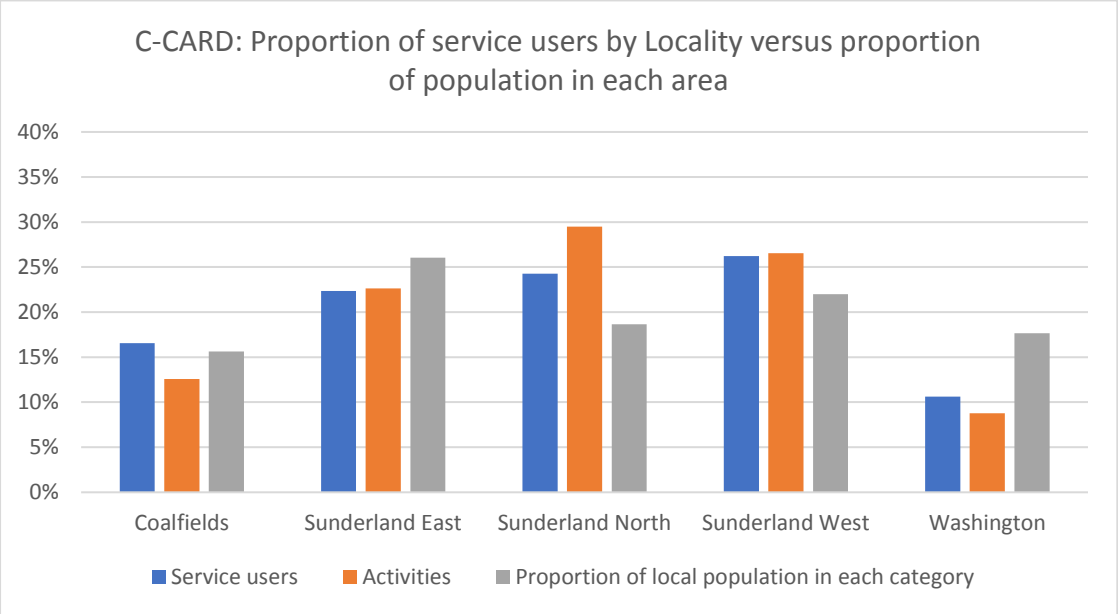
59.9% of service users were male, as compared to 50.9% of the local population.

The highest consuming age group were 14 year olds, representing 25% of service users and 28% of activity. However, 14 year olds represent about 6% of the local population aged between 13 and 25 (the minimum and maximum age range of service users).

96% of service users were White British, which was very close to the estimated population proportion.

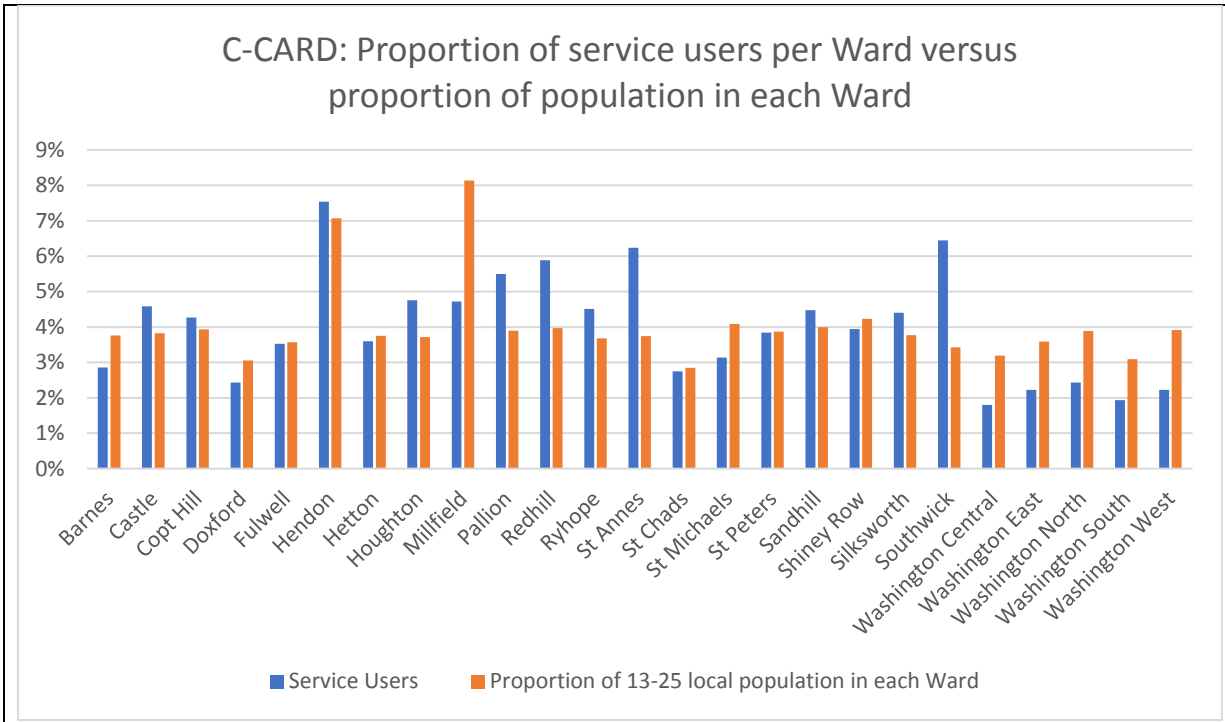
Sunderland East and Washington were the two localities where the proportion of service users accessing the services was lower than the proportion of residents living in each area.

Figure 8: Access to C-CARD by Locality, 2014-2017



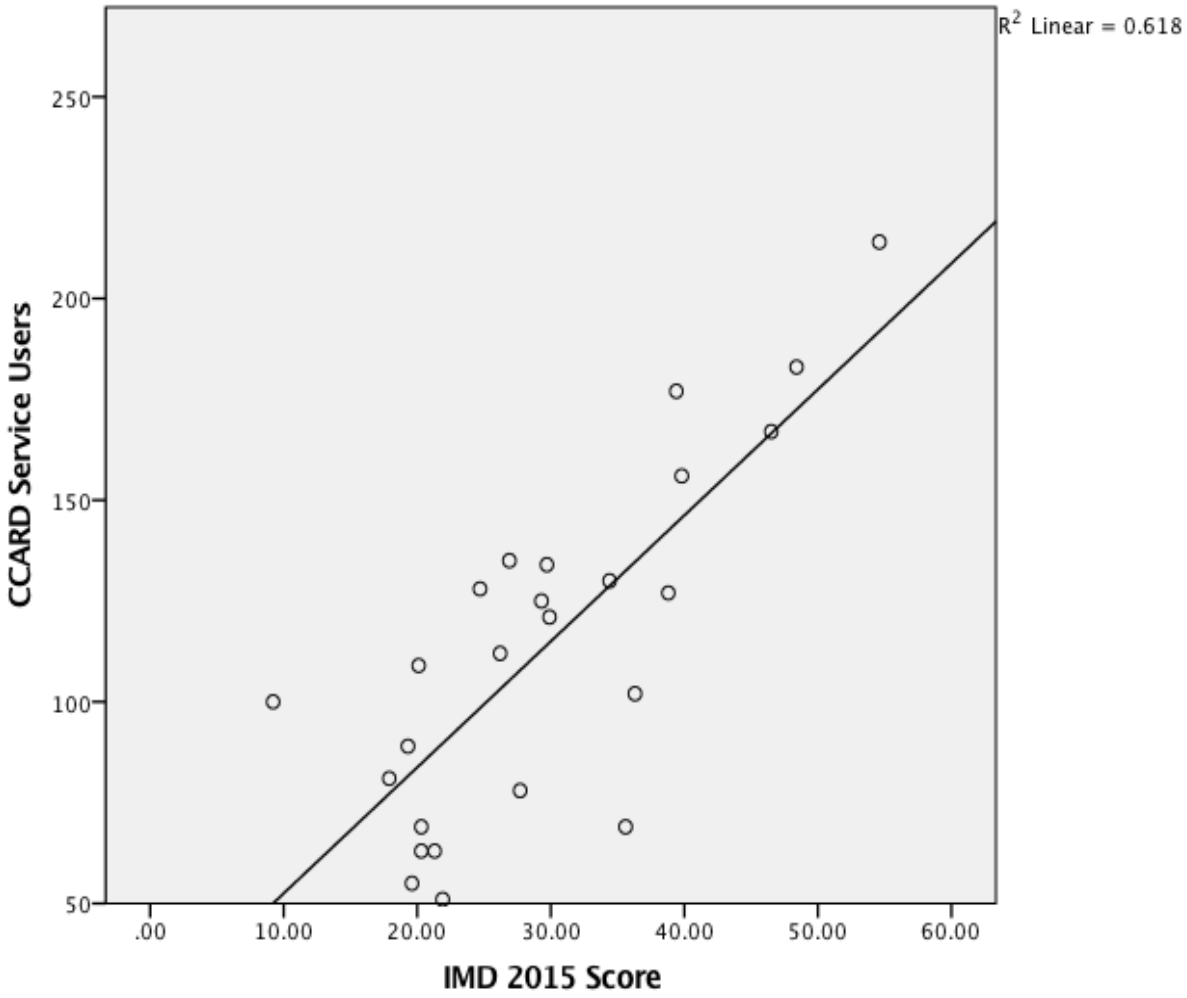
Millfield in particular was a ward where the proportion of service users fell short of the proportion of the population resident in the area. Southwick was an area of exceptional service use - perhaps due to the presence of the Southwick Youth Neighbourhood Project (SNYP).

Figure 9: Access to C-CARD by Ward, 2014-2017



The distribution of C-CARD service users was strongly associated with area-level deprivation. (61% of the variation in service user residence by ward was explained by area-level deprivation as measured by IMD 2015 score.)

Figure 10: Association between residence of C-CARD users 2014-2017 and area-level deprivation at Ward level



CaSH

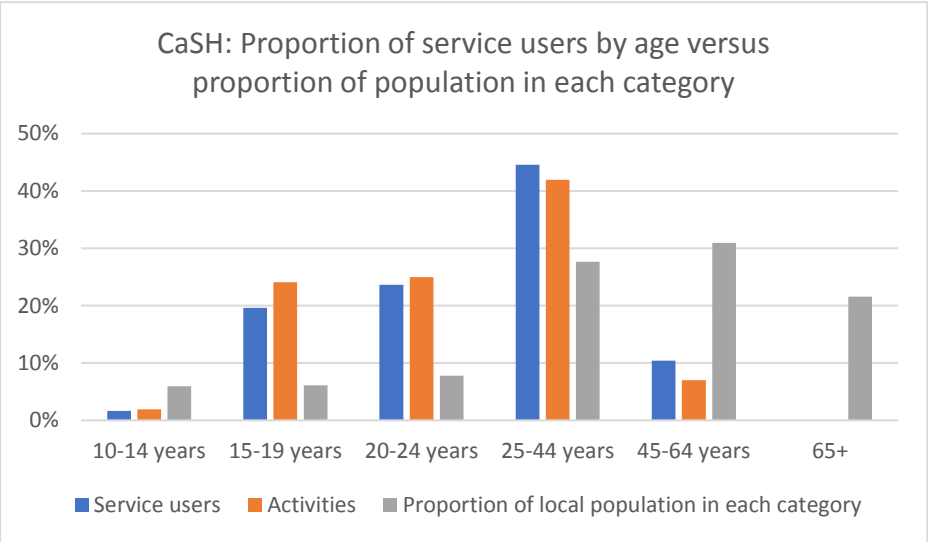
Data on CaSH service activity 2014-22017 was obtained from the Sexual and Reproductive Health Activity Data Set (SRHAD) via local SRH services.

Over the three-year period, 15,537 residents of Sunderland accessed the service, recording 44,089 activities.

97.1% of service users were female, as compared to 49.1% of the local population.

The highest consuming age group were 25-44 year olds, representing 44.6% of service users and 42% of activity. 25-44 year olds represent 27.7% of the local population. Proportionately speaking, 15-19 year olds were the relatively largest consumers, representing almost 20% of service users, though just 6% of the local population.

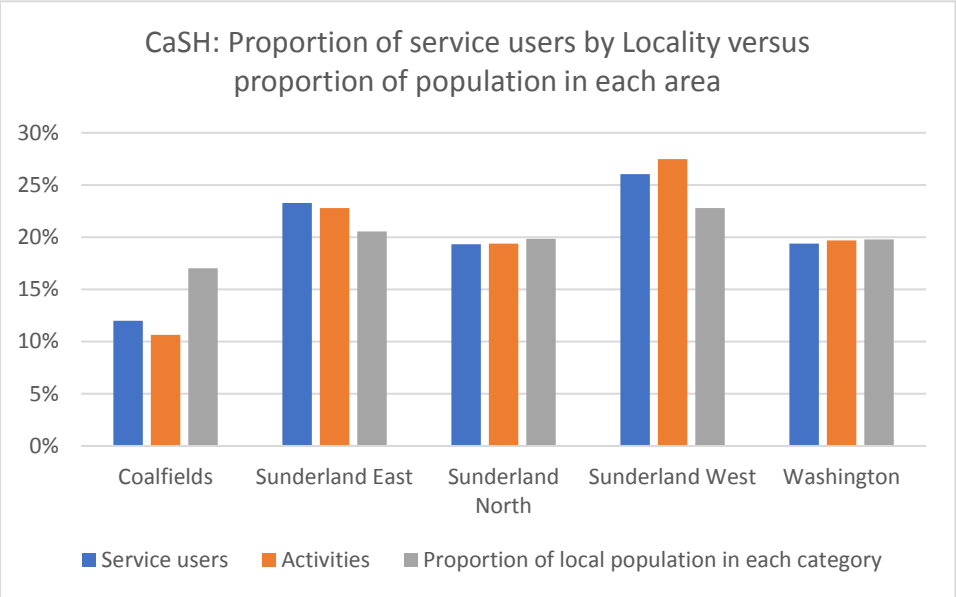
Figure 11: Access to CaSH by age group, 2014-2017



91% of service users were White British. People from White British ethnic backgrounds represent an estimated 95.9% of the local population.

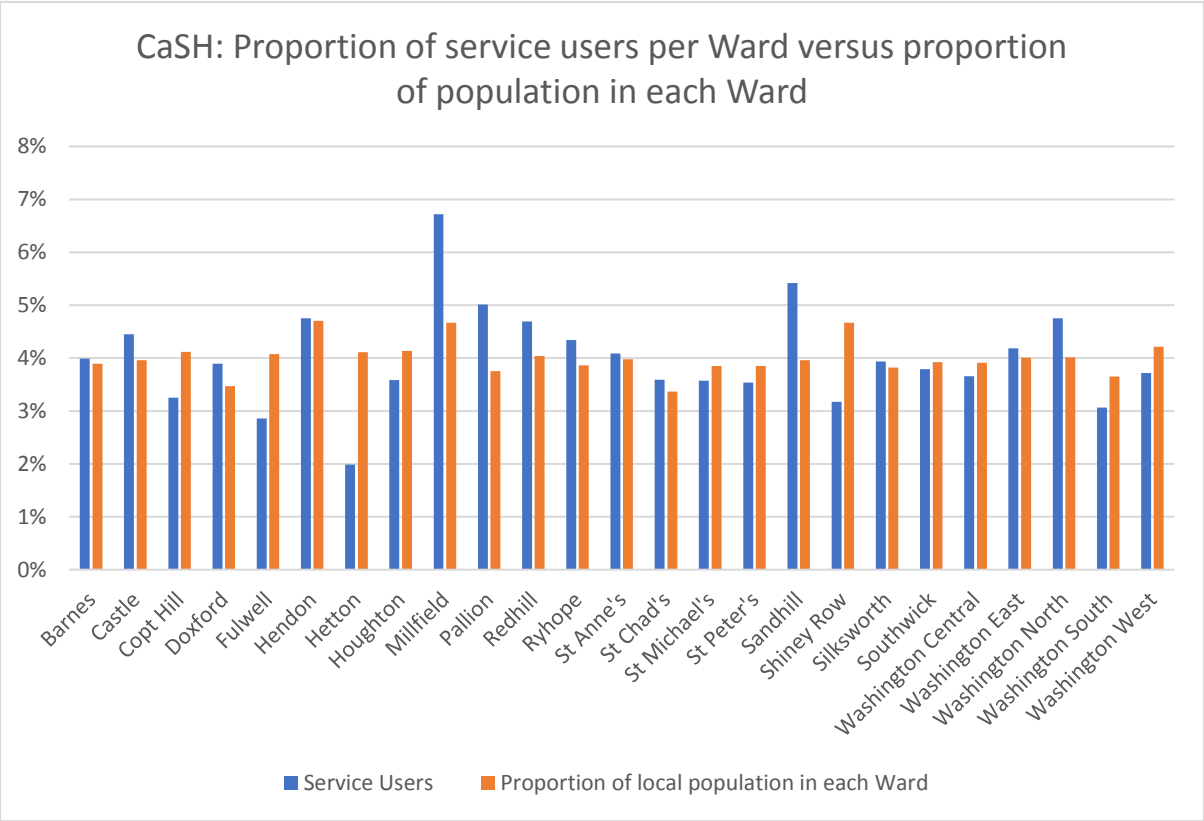
The Coalfields was a locality where the proportion of service users accessing the services was visibly lower than the proportion of residents living in the area (12% and 17% respectively).

Figure 12: Access to CaSH by Locality, 2014-2017



Hetton in particular was a ward where the proportion of service users fell short of the proportion of the population resident in the area (2% and 4.1% respectively, or 50% lower than what might be expected). Millfield was an area of exceptional service use as compared with the proportion of the population resident in the area (with 6.7% of service users resident in the local area and 4.7% of local people resident in the ward)- perhaps due to the proximity of local SRH services.

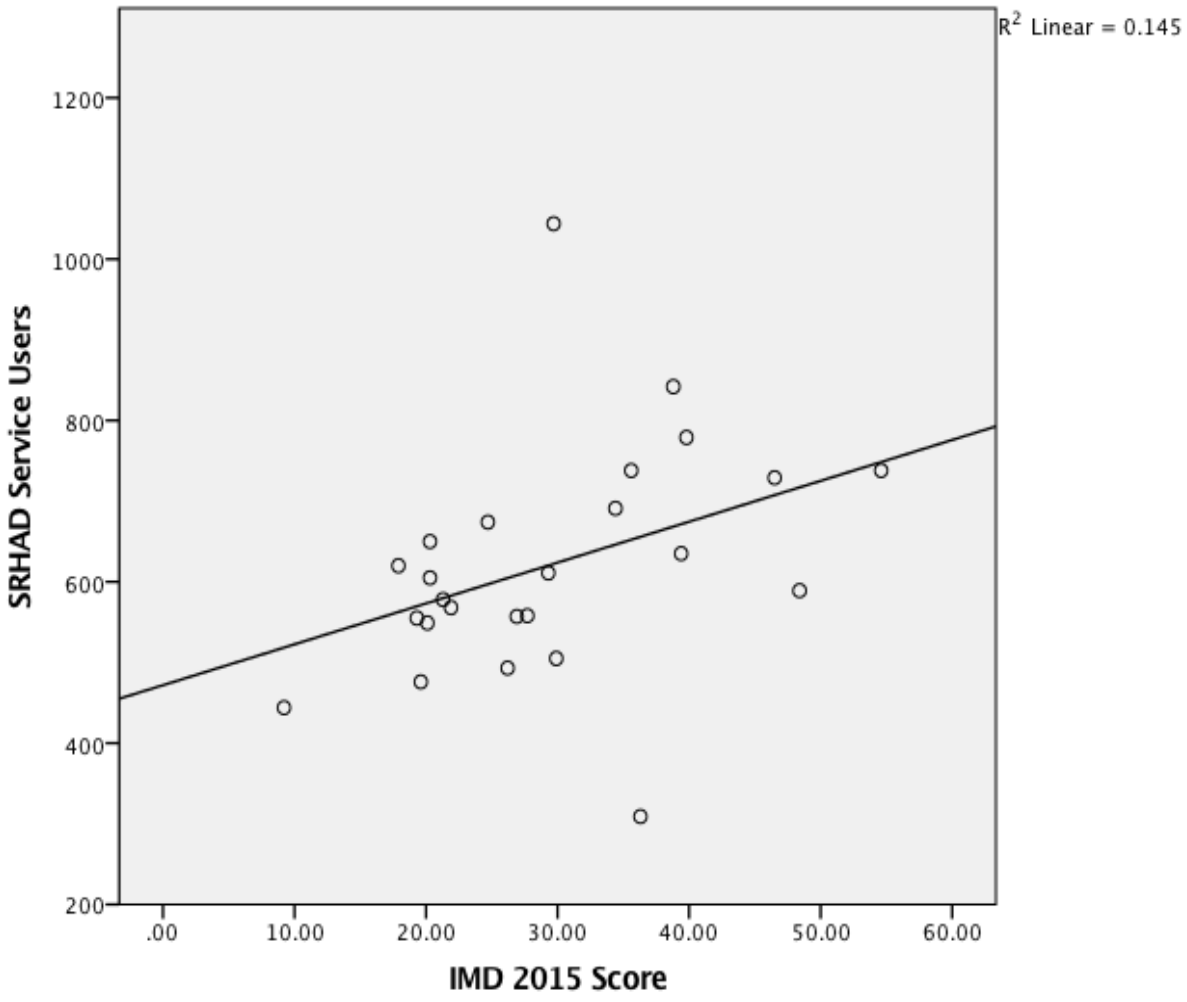
Figure 13: Access to CaSH by Ward, 2014-2017



The distribution of CaSH service users was weakly associated with area-level deprivation. (15% of the variation in service user residence by ward was explained by area-level deprivation as measured by IMD 2015 score.)

Figure 14: Association between residence of CaSH users 2014-2017 and area-level deprivation at

Ward level



GUM

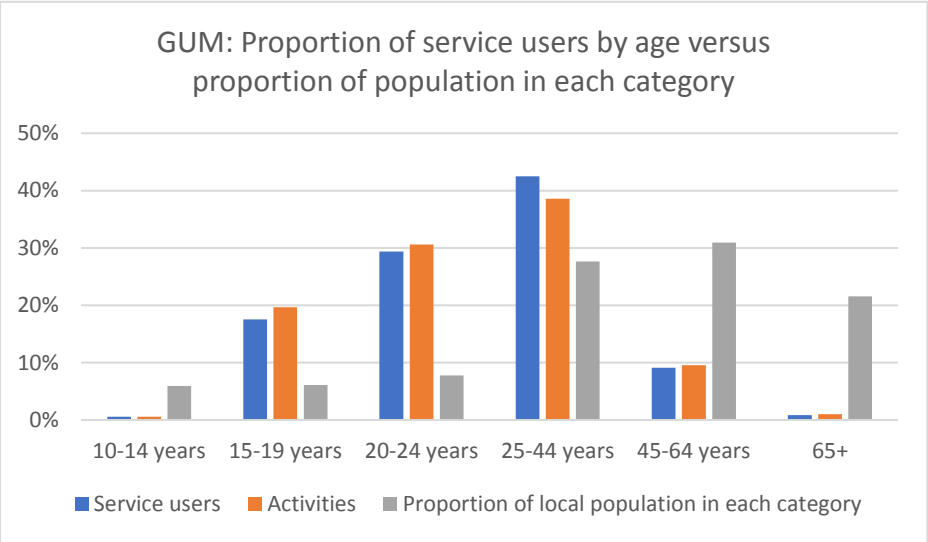
Data on GUM service activity 2014-22017 was obtained from the Genitourinary medicine clinic activity dataset (GUMCADv2) via local SRH services.

Over the three-year period, 10,472 residents of Sunderland accessed the service, receiving 36,539 recorded activities.

51.5% of service users were female, as compared to 49.1% of the local population.

The highest consuming age group were 25-44 year olds, representing 42.5% of service users and 38.6% of activity. 25-44 year olds represent 27.7% of the local population. Proportionately speaking, 20-24 year olds were the relatively largest consumers, representing almost 30% of service users, though just 8% of the local population.

Figure 15: Access to GUM by age group, 2014-2017

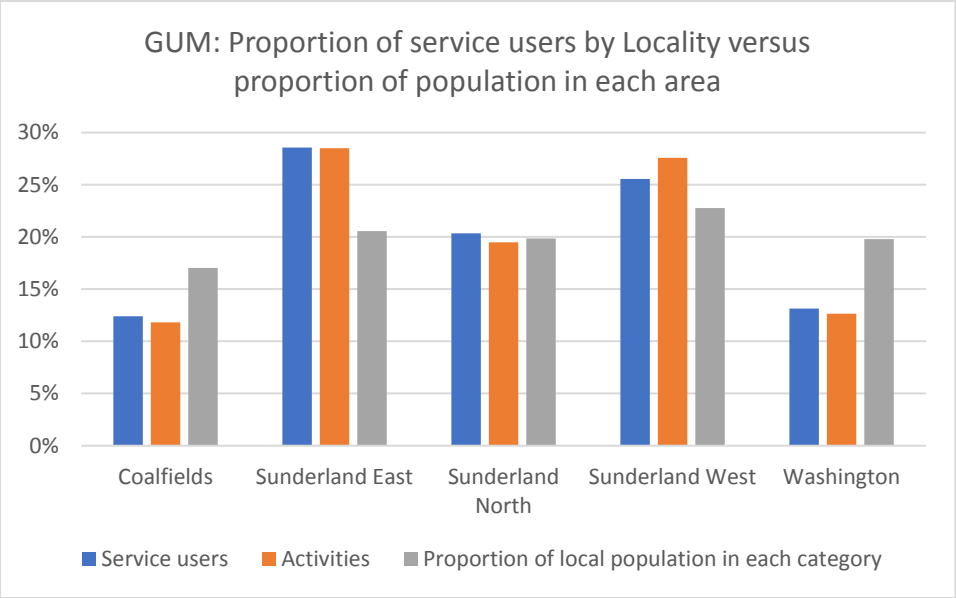


92% of service users were White British. People from White British ethnic backgrounds represent an estimated 95.9% of the local population.

The Coalfields and Washington were two Localities where the proportion of service users accessing

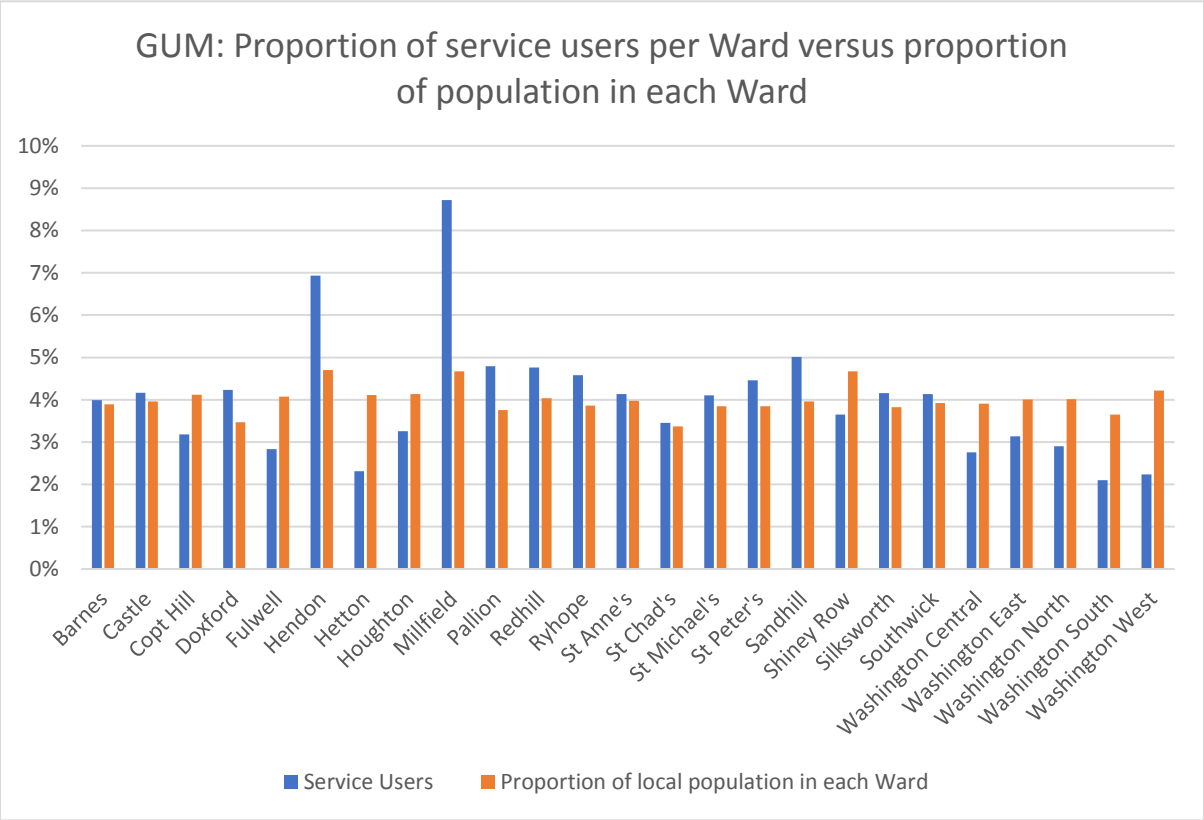
the services was visibly lower than the proportion of residents living in the area. 12.4% of service users were from the Coalfields whereas 17% of the local population lived in the area. For Washington this was 13.1% and 19.8%.

Figure 16: Access to GUM services by Locality, 2014-2017



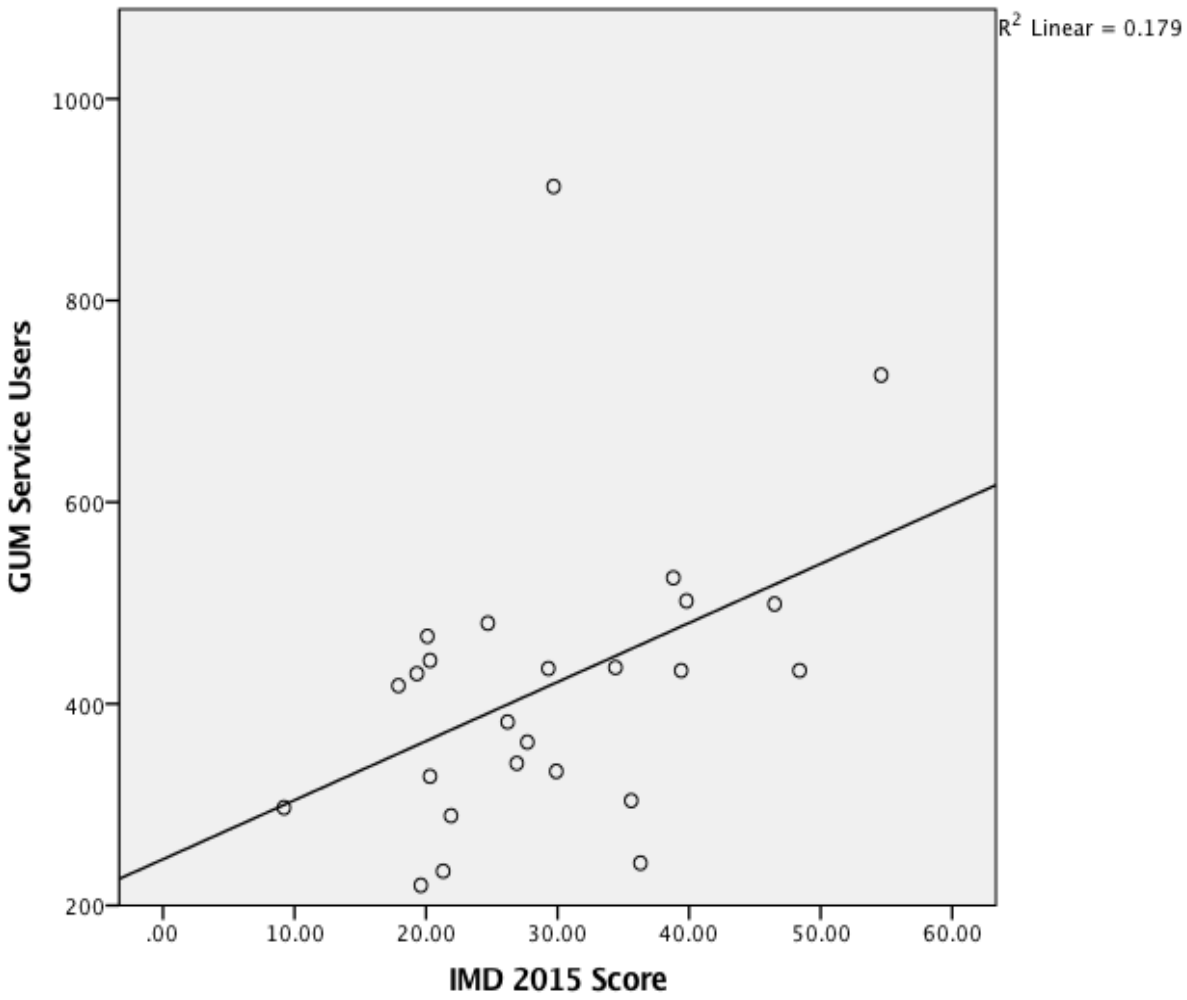
Hetton in particular was a ward where the proportion of service users fell short of the proportion of the population resident in the area (2.3% and 4.1% respectively, or almost 50% lower than what might be expected). All of the Wards in Washington appeared to be proportionately underserved by GUM. Millfield and Hendon were areas an area of exceptional service use as compared with the proportion of the population resident in each area perhaps due to the proximity of local SRH services and related services based in Hendon.

Figure 17: Access to GUM services by Ward, 2014-2017



The distribution of GUM service users was weakly associated with area-level deprivation. (18% of the variation in service user residence by Ward was explained by area-level deprivation as measured by IMD 2015 score.)

Figure 18: Association between the residence of GUM users 2014-2017 and area-level deprivation at Ward level



Summary of findings

The vast majority of CaSH service users were female - but this may be due to the inherent bias of interventions aimed at women and a preference for using CaSH rather than GUM.

Levels of access to CaSH and GUM appeared proportionate to relative risk in younger age groups.

There were higher than expected levels of access by BAME groups to CaSH and GUM, which may reflect higher levels of need.

Residents of the Coalfields may be underserved by local SRH services, with those either resident in proximity to sites or supported by community services having larger shares of service use.

Residents of Washington appeared to be underserved by GUM, but relatively lower area deprivation may partly explain this.

Residents of Hendon and Millfield may have accessed GUM more than expected, whereas residents of Millfield may have underused CaSH.

5) What is the perspective of the public on this issue?

3 separate pieces of work provide information for this section:

1. Engagement activities undertaken previously
2. Semi-structured interviews with those providing services to vulnerable groups, undertaken in winter 2017/18
3. An online survey for the whole population seeking views on service need and quality

It is of note that patient-reported outcome measures for SRH services were not available at the time of writing.

Previous engagement activities

1. **Sexual Health Engagement exercise 2013**

In 2013, Designrevel Ltd undertook a public engagement exercise to support the sexual health review. This comprised qualitative research with staff, service providers, service users, non-service users and members of the community and an online survey which was completed by 776 respondents.

In the concluding remarks, the study found that although some people thought their experience of sexual health services was 'good', a large number of respondents described their experience as 'bad'. Providers were often seen as judgmental and sometimes uncomfortable in offering services to particular groups such as young people, people with disabilities and an older population. This feedback was for all sexual health services.

The research highlighted accessibility (to information and services) as a major issue, and made note of long waiting times and opening times and venues that were not always relevant to potential service users. People expressed the need for an engaging multimedia campaign to provide them with accurate and accessible sexual health information. There were concerns about the internal design, location and environment of the GUM clinic, with a recognition of how each factor contributed to privacy and confidentiality. Drop-in clinics and outreach services were considered as ways to improve accessibility to services.

In support of the conclusion, the report included the following key findings:

- Common complaints were that information on service availability was not readily available in the community. 37% of the open comments identified awareness raising and promotion of sexual health services as an area for improvement.
- Most people would prefer to find out about sexual health services through a health professional followed by non-face-to-face contact of internet, social media and telephone helpline.

- Most people would prefer to access sexual health services from a healthcare venue, with a local community venue being the next preferred option.
- The majority of respondents would prefer to access a medical-based service with GP being the preferred option, closely followed by the GUM clinic.
- People value a more local service and flexibility of opening times either booked by appointment or as drop-in facility the highest.
- People felt that there should be more drop-ins available and flexibility around appointments including evenings and weekends.
- Most people would prefer to access a service on a weekday service followed by Saturdays and on an evening. Inconvenient opening hours featured highly as a barrier to accessing services.
- The largest barrier in accessing services was found to be embarrassment, suggesting more consideration needs to be given to marketing the service and reducing the stigma attached to sexual health.
- The majority of people want a more local service with a community centre or youth centre featuring quite highly. People value the GUM clinic as an excellent resource but would like it available as an outreach facility across Sunderland. However, a number of people said they would travel for the best service if they needed treatment.
- People stressed that off-putting and judgemental staff attitude was by far and wide the thing that would be likely to stop them accessing or returning to a service. This was particularly relevant to young and disabled people who felt staff could be patronising because of their age and condition (again, this was for all services).

2. Review of 0-19 Public Health Services

In 2016, NWA undertook a Service User and Stakeholder Engagement exercise to support the review of 0-19 public health services in Sunderland.

On the theme of sexual health, the report found that:

- There was a strong opinion amongst stakeholders that sex and relationship education was currently not adequately covered.
- Parents suggested that sexual health discussions should take place in primary school at the age of 9 or 10.
- 51% of pupils in primary schools identified a need for advice about relationships and sexual health.
- Important issues for secondary school pupils included sexual health and gender identity - what is 'OK' and what is not and where to get help. Participants sought information on what to do if things go wrong for them, and some general advice on acceptable treatment in relationships - what is ok and acceptable? They also identified teenage pregnancy issues and advice on options and most importantly the issue of rights, for example pupils wanted to

know if parents could make them abort a pregnancy.

- Priority areas for students in college and those in the Youth Parliament included sexual health and advice about C Card registration and Chlamydia testing.
- Public Health Maternity services identified sexual health as a key issue for patients.
- Aspects of the work of Family Nurse Partnership (FNP) which stakeholders felt could be improved included sexual health screening.
- Main health needs for children, young people and their family identified by the FNP included sexual health and contraception.
- Barriers to services identified by the FNP were lack of sexual health services for young people (drop-ins / young people friendly).
- Suggested improvements to the School Nursing Service (SNS) included sexual health training and discussion of issues such as same sex partnerships, although talks on puberty and sexual health delivered by SNS were highly valued.
- It was thought that sexual health services including the Young Person's Nurse could work more closely with the SNS.
- Stakeholders generally felt that there were few services in regard to sexuality. LGBT issues were not felt to be adequately covered, and it was important that issues such as same sex partnerships were discussed in schools. It was noted that in the absence of a good local offer for LGBT issues, young people travelled to Newcastle to access support.
- Stakeholders identified the importance of providing 'confidential services' which are 'easy to access' and 'non-judgmental' and it was described 'as a key issue, need and challenge' – these were deemed as essential elements of services to young people, but particularly with respect to sexual health services.

Semi-structured interviews, December 2018-January 2019

In this round, interviews were undertaken with providers of local services to vulnerable groups, including young people living in areas of high deprivation, teenage parents and pupils excluded from school, young people in contact with criminal justice services, people with learning difficulties, and homeless people.

Key findings from this exercise included:

- High praise for staff from existing SRH services where contact had been made
- High praise for best practices, which were sometimes thought to be more current than they were (e.g., locally-developed RSE materials)
- High praise for the sexual health service for the work around positive relationships
- Variation in knowledge of existing SRH services and their role/ scope
- Evidence of stronger relationships with organisations operating outside the local authority commissioning arrangements and the local area (e.g., CCG, Mesmac, Body Positive North East)
- Variation in capacity to provide high quality sexual health advice and information, with a

common call to improve access to more advanced (level 3) CaSH training
- Common perception of stigma associated with the GUM clinic
- Perception of too high a data collection burden of the C-Card system
- Many people with complex needs tend to discount sexual health due to a focus on primary socioeconomic and health needs
- Commonly held beliefs amongst vulnerable young people that indicated poor sexual health literacy
- Increasing use of technology and associated sexual health risks amongst young people (e.g sexting)
- Increasing sexual experimentation and frequency of functional sex amongst vulnerable young people
- Reliance on women to have responsibility for contraception
- Moral hazard associated with STI testing and the perception of simple and effective treatments especially amongst young men
- STI's are not viewed as an issue amongst young people (e.g. Chlamydia seen as a 'badge of honour')
- People with learning disabilities having limited opportunities to develop sexually due to being protected from perceived vulnerabilities
- The location of the service is viewed as a barrier for young people to access
- There is a lack of assertive outreach and service provision in Washington and the coalfields
- Poor disability access in GUM service
- Administration of C – Card registration is viewed as burdensome
- Young women should have all their needs met within one appointment and not made to come back.
- Options advisor role viewed as important for young woman

The full report from the second workstream is provided in **Appendix C**.

At the time of writing, there was a lack of local information on the sexual health needs of people who identify as LGBTI, travellers, sex workers, MSM, people from BAME backgrounds other than asylum seekers, older people and people living with long term conditions.

Interviews with the Sexual and Reproductive Health Workforce

The Public Health Team undertook a Workforce Engagement exercise to support the review of the GUM Service and CaSH Service.

Key findings from the Workforce Engagement included:

- There is a lack of integration between CaSH and GUM services
- Staff from both services felt that the service was under resourced with skilled sexual health staff
- There is the need for more service provision specifically for young people in the City Centre
- Both services need to be visible with better marketing and promotion of the services and what they offer
- Sexual Health Training should be rolled out across the wider workforce so all services are

promoting the same messages around sexual health
- There is a lack of career progression for the sexual health workforce
- There is the need for more walk in and appointment slots to address patient flow
- There is the need for a discreet service to reduce stigma for services users accessing GUM
- Staff felt that there should be more assertive outreach across Sunderland

6) Recommendations for commissioning and further needs assessment work

Please note – an EIA must be undertaken as recommendations are implemented.

Bearing in mind that the JSNA is a live document, the assessment has led to the following recommendations:

A. For commissioning

- In order to provide open access, and truly universal services, seek to address the perceived stigma associated with the GUM clinic and related overuse of CaSH, and develop relevant alternatives with patients and the public.
- Improve the education and training offer to help develop capacity within related community services that are likely to be accessed by the same clients (especially vulnerable people).
- Broker improved relationships between LA-commissioned SRH and other service providers.
- Use mechanisms to ensure that access to services is socially and geographically equitable, e.g. outreach and drop-in/ pop-up clinics.
- Improve PPI through engagement and also the development of patient outcome reported/ experience measures.
- Investigate the effectiveness of online testing, paying regard to those who may not have appropriate access to the internet (e.g., asylum seekers and homeless people).
- Undertake joint work with Education to develop RSE infrastructure and offer.
- Improve local data capture on LLDD and consider other characteristics such as education and income.
- Improve Chlamydia testing and surveillance
- Consider cost-effectiveness of C-Card, including opportunity cost of data collection and consumption of condoms

B. For further needs assessment

- Map VCS offer on CaSH education and training in addition to core SRH provision
- Engage directly with members of vulnerable groups, for example to understand the values and beliefs that drive high risk appetite and low sexual health literacy amongst young people with complex needs
- Investigate the epidemiology of local gonorrhoea cases
- Investigate the relatively high rate of late HIV diagnoses

C. For advocacy and policy

- Redress the imbalance of responsibility for contraception between the sexes

7) Key contacts

Nicola Cummings, Public Health Commissioning Specialist
Lorraine Hughes, Acting Consultant in Public Health

References

See web links in main document

Appendix A: System-wide SRH Commissioning Responsibilities (PHE, *Making it Work*)

Who	What
LA	Contraception
LA	STI testing and treatment
LA	Sexual health aspects of psychosexual counselling
LA	Specialist services and health promotion
LA	Social care
CCG	Terminations of pregnancy and testing in abortion pathway
CCG	Sterilisation
CCG	Non-sexual health elements of psychosexual health services
CCG	Contraception primarily for gynaecological (non-contraceptive) purposes
CCG	HIV testing when clinically indicated in CCG-commissioned services
NHSE	Contraceptive services provided as an ”additional service”
NHSE	HIV treatment and care services
NHSE	HIV testing when clinically indicated
NHSE	Services in CJS
NHSE	SARC
NHSE	Screening and Imms
NHSE	Specialist fetal medicine services

Appendix B: PHE Spend and Outcomes Tool (SPOT)

The SPOT is a health economic tool based on the methods of Programme Budgeting and Marginal Analysis. This compares programme spend per head of population with associated outcomes for each local authority and calculates how similar or different this to the average. Programme spend is taken from the revenue account allocation (RA) and Revenue Outturn (RO) data from DCLG. Outcome data are sourced mainly from the Public Health Outcomes Framework with weightings applied.

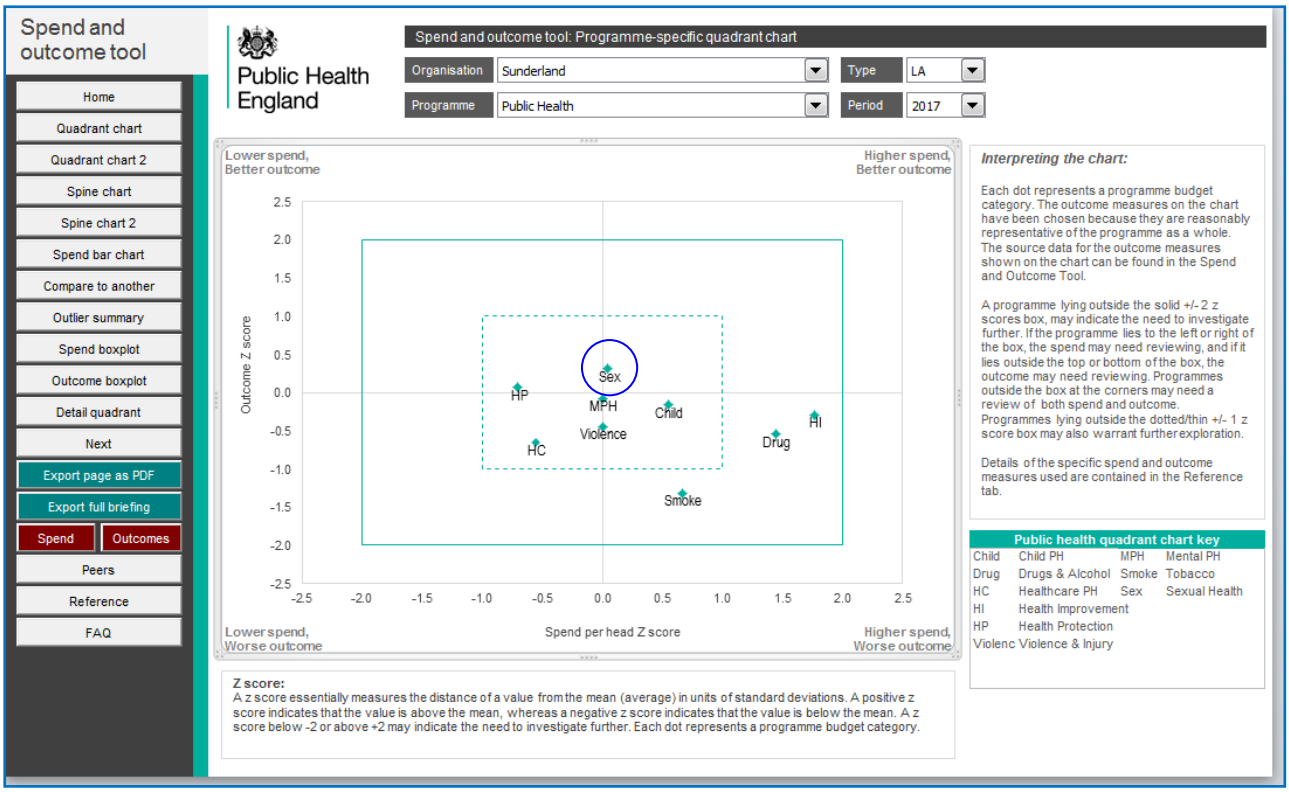
In the 2017 version of the SPOT, the financial data for SH spend in Sunderland was as follows:

Programme Name	**Spend (£m)**
Sexual health services - STI testing and treatment (prescribed functions)	1.423
Sexual health services - Contraception (prescribed functions)	1.267
Sexual health services - Promotion, prevention and advice (non-prescribed functions)	0.01

26 outcome measures were included:

Abortions under 10 weeks	Gonorrhoea diagnosis rate	HIV testing uptake, women
Cervical cancer registrations rate	GP prescribed LARC rate	Pelvic inflammatory disease (PID) admissions rate
Chlamydia detection rate (15-24 year olds - Female)	HIV diagnosed prevalence rate, Adults	Syphilis diagnosis rate
Chlamydia detection rate (15-24 year olds - Male)	HIV late stage presentation (15+ yrs, Persons)	Total abortions rate
Chlamydia detection rate (15-24 year olds - Persons)	HIV testing coverage, men	Under 18s abortions rate
Chlamydia proportion aged 15-24 screened	HIV testing coverage, MSM	Under 18s births rate
Ectopic pregnancy admissions rate	HIV testing coverage, women	Under 18s conceptions leading to abortion
Genital herpes diagnosis rate	HIV testing uptake, men	Under 25s repeat abortions
Genital warts diagnosis rate	HIV testing uptake, MSM	

The result (highlighted in the figure below) showed that Sunderland spent about the same on sexual health per capita than other local authorities, but also achieved marginally better outcomes. This was not significantly different to the national average. The box in the upper left quadrant (representing lower spend and better outcomes) may suggest room for improvement, and could form the basis of initial investigations (e.g., to identify local authorities with values in that quadrant to start investigating best practices).


Spend and outcome tool
Home
Quadrant chart
Quadrant chart 2
Spine chart
Spine chart 2
Spend bar chart
Compare to another
Outlier summary
Spend boxplot
Outcome boxplot
Detail quadrant
Next
Export page as PDF
Export full briefing
Spend
Outcomes
Peers
Reference
FAQ
Public Health England
Spend and outcome tool: Programme-specific quadrant chart
Organisation
Sunderland
Type
LA
Programme
Public Health
Period
2017
Lower spend, Better outcome
Higher spend, Better outcome
Outcome Z score
Spend per head Z score
Lower spend, Worse outcome
Higher spend, Worse outcome
Sex
HP
MPH
Child
HI
Violence
HC
Drug
Smoke
Interpreting the chart:
Each dot represents a programme budget category. The outcome measures on the chart have been chosen because they are reasonably representative of the programme as a whole. The source data for the outcome measures shown on the chart can be found in the Spend and Outcome Tool.
A programme lying outside the solid +/- 2 z scores box, may indicate the need to investigate further. If the programme lies to the left or right of the box, the spend may need reviewing, and if it lies outside the top or bottom of the box, the outcome may need reviewing. Programmes outside the box at the corners may need a review of both spend and outcome. Programmes lying outside the dotted/thin +/- 1 z score box may also warrant further exploration.
Details of the specific spend and outcome measures used are contained in the Reference tab.
Public health quadrant chart key
Child Child PH
MPH Mental PH
Drug Drugs & Alcohol
Smoke Tobacco
HC Healthcare PH
Sex Sexual Health
HI Health Improvement
HP Health Protection
Violenc Violence & Injury
Z score:
A z score essentially measures the distance of a value from the mean (average) in units of standard deviations. A positive z score indicates that the value is above the mean, whereas a negative z score indicates that the value is below the mean. A z score below -2 or above +2 may indicate the need to investigate further. Each dot represents a programme budget category.

Appendix C: The sexual health needs and experiences of vulnerable people in Sunderland: perspectives from specialist service providers

Chris Allan, Public Health Specialty Registrar
17th January 2018

Aim

The purpose of this exercise was to gather qualitative information from providers of services to vulnerable people in the City of Sunderland on the sexual health needs and experiences of their client group. This was to be used to inform a sexual health needs assessment for the population as a whole, which would in turn form the basis of a chapter in the local Joint Strategic Needs Assessment and inform future commissioning decisions. The rationale was to get as close as possible to the views of the population whilst a survey was simultaneously developed for public consultation on sexual and reproductive health services in the City. Findings could be further explored in future research if resources became available.

Methods

Key lines of enquiry (KLOEs) were developed with a project team assembled from key members of the Public Health service in City Sunderland Council: the consultant portfolio Lead; commissioning specialist with the lead for sexual health; engagement lead; public health practitioner with a focus on children and young people and sexual health, and a public health specialty registrar who coordinated the activity. The discussion was informed by a review of the literature on those most at risk of sexual ill-health, which was undertaken by the coordinator. The KLOEs were refined into a topic guide to be used to undertake semi-structured interviews with identified service providers (available on request). A convenience sample of contacts was developed in consultation with members of the project group. Consent was sought and received for audio recording interviews (except in one instance, where contemporaneous notes were taken), and they were subsequently transcribed by interviewees. All but 4 participants took part in interviews conducted by the coordinator. Transcriptions were analysed by the coordinator and coded into themes as prompted by the KLOEs.

Results

11 local practitioners working for services provided to vulnerable people were recruited and all participated in semi-structured interviews or group interviews. Service user groups included people with learning disabilities; young people with experience of substance misuse (aged 10-18) ; young people in contact with Criminal Justice Services (aged 10-18); women conceiving under the age of 18; asylum seekers, and young people aged 8-25 living in the second most deprived ward in Sunderland (as measured by IMD 2015 score). The collection of interviews resulted in a rich information resource for local practitioners and decision makers, and provided lines of enquiry for further research.

Findings

Knowledge and experience of existing services

There was variation in familiarity with the local offer of sexual health services. Where there was familiarity with sexual health services, the staff were praised for providing a professional and high quality service.

Take-up of Chlamydia and gonorrhoea testing "grab packs" was judged to be good as this did not involve physical contact with sexual health services and results were sent by text.

Many participants cited examples of good practice, such as a drama-based intervention called "Chelsea's Choice", and an educational programme developed in partnership with public health initially aimed at young people with learning disabilities.

Variation was linked with professional education and training and attending to service user's primary health needs. For example, people seeking asylum may in the first instance require money, food and shelter and access to primary and dental care before considering sexual needs, and practitioners supporting clients will attend to those needs. People with learning disabilities may face barriers in access to general health services and so local efforts were partly concentrated on improving access to primary care, information resources and the equity of national screening programmes.

Lack of familiarity with local sexual health services was also associated with existing and fortuitous relationships. For example, practitioners may have strong links with the local Clinical Commissioning Group and regional organisations, but little knowledge of sexual health services commissioned by the local authority.

Commissioning arrangements played a role in awareness of services. For example, the specific health needs of people with learning disabilities was addressed by Community Nurses provided by the mental health trust, NTW. Young people in contact with criminal justice services would be referred to the Young Person's Nurse if a sexual health need was identified. The options advisor post based in CaSH was viewed as an important role for young women, as younger woman.

One participant observed a rising trend in young people questioning their gender, but thought that they would have to travel to access support services, e.g. in neighbouring Newcastle, approximately 14 miles away. A return journey on public transport could at the time incur a financial cost of around £4 to £5, and an opportunity cost of the time spent travelling. At the time of writing, no interviews had been held with providers of services to people who identified as LGBTI.

The C-Card training was generally held in high esteem, although practitioners with greater knowledge of SRH suggested that more time could be spent on operational issues than general SRH issues. Practitioners with greater sexual health literacy suggested that there was a demand for more specialised SRH training so that clients' needs could be responded to in-house.

Every practitioner with familiarity of the C-Card scheme commented that the data collection requirement was too high, which presented a barrier to access and opportunity costs for providers. One interviewee suggested that they would prefer to have condoms available truly free at the point of access, i.e. without the data collection requirement, and without a need for a gateway. Another suggested that the data collection requirement should be greatly reduced. It was noted that there had been occasions when supply of condoms had ceased altogether.

One interviewee remembered a recent experience of taking a wheelchair-bound client to the GUM clinic, and found that staff had difficulties making the environment readily accessible.

Stigma was a key issue for participants, which provided both a barrier and a perverse incentive to access for clients. Experience of local services was thought to be commonest amongst young women, who were likely to access CaSH rather than GUM for testing and treatment. The GUM clinic (colloquially known by many as “the Clap clinic” was often seen as a site that inspired felt stigma because of the perception that all attendees had a disease and were there for treatment. One participant noted that for young women the reason for attending CaSH was that "Going to the GUM clinic means you've got the Clap ... or something really bad and dirty". "Any women of any age " could be accessing CaSH, "so there was no stigma attached".

On the other hand, young men were more likely to display what could be seen as internalised enacted stigma. Going to the GUM clinic or being diagnosed with an STI could mean "I can shag around", i.e. a badge of honour. Infections may have been considered as easily treatable and longer-term consequences were not on their risk radar. One participant remarked “Chlamydia it’s not seen as anything bad it well I will just get some tablets”.

If outreach was offered in doctor’s surgeries or health centres, it was thought that stigma was also attached and the settings were too formal and imposing to people with low self-esteem. Some participants thought that outreach was considered to be best delivered in community youth groups, centres or services because “if you are in a youth service or other community based building you could be going in there for anything”. Participants felt that there was a lack of outreach and access to clinics in the Washington area and coal fields.

Some participants thought that a health professional may find it difficult to develop a trusting relationship with clients and vice versa, and perceived medical staff and language to be removed from the lived experience of service users. The nomenclature of existing sexual health services (e.g., “Family Planning” was regarded as outdated.

Sexual and reproductive health needs

In general, service users were perceived as having experienced a form of social suffering that made them vulnerable to poor ill health, and individual experience and circumstances meant that their needs were could be highly specific. That was especially the case for asylum seekers, due to factors including diverse cultural backgrounds and beliefs, pathways into the UK and language differences. People seeking asylum were thought to experience a mental slump following the initial elation of arriving in the UK and having to face realities.

Experience of poor mental health was thought to be common amongst servicer users, particularly people exposed to homelessness, substance misuse, and involved with criminal justice services. Many were thought to have undiagnosed learning disabilities or difficulties.

Tending to basic needs such as functional skills, income, housing, physical and mental health were commonly seen as being a priority above sexual health needs. As one participant remarked of their client group, “when they have got offending issues, substance misuse issues and mental health issues the sexual health goes down the list”.

Experience of disrupted formal education was often cited. Some interviewees said they had witnessed an increase in home schooling.

Having multiple “partners” was considered common although partnership was not associated with having emotional ties or shared responsibility. Many participants noted the practice of casual sex amongst young people which had no meaning as a relationship between people. Those who wanted to have “a loving relationship that is based on mutual trust and respect” were “few and far between”. Sex was sex. It was “something you do on a weekend”.

The extent of partner sharing was informed by familiarity and risk perception. If x person in the community was considered clear after sleeping with y, then z may think x was a risk-free partner.

Use of technology to mediate sexual relationships was felt to have become normalised for some young people e.g. sexting was popular amongst young people. Access to information on and for sexual relationships for some was perceived to be restricted to social media, pornography, and mobile phone applications, for example Tinder.

It was a common perception that young men in particular were averse to using condoms, citing loss of sensation and immediacy. For some young men, “in terms of lads it hasn’t even come in to their heads that they can get someone pregnant”. Instead, they tended to rely on women for contraception, reportedly checking if they were “on the pill”. Young women with complex social needs however, might have struggled to comply with the regimen.

Lack of sexual health literacy extended in some cases misconceptions about biological processes. For example, one interviewee had observed young girls unsure about the existence of a separate urethra and vagina. Another participant had witnessed young women discussing how Coca Cola could make a pregnancy test show a positive result.

Some inherited beliefs and behaviours relating to social support were seen to affect pregnancy risk. For example, some young women may have believed that pregnancy was a route to a guaranteed income.

Almost all clients in contact with the homeless service had prior contact with social services.

Conclusions and implications for local policy and practice

In general, with the exception of people seeking asylum, service users were considered to come from all parts of the City. To address their sexual health needs, as one participant hoped, the ideal would be to have “a member of staff in every locality and in every school”.

Current guidance states that local authorities have a mandate for providing open access, universal sexual health services. Whilst it may not be possible or desirable for commissioners to fund specialist sexual health practitioners in so many settings, it may however be possible to build capacity within organisations serving those populations. Commissioners may want to consider developing a local education and training offer to help meet those needs which could take the form of level 3 CaSH training. The benefits of this could be manifold. Developing such capacity would help to bridge the perceived gap between members of the community most in need and those most capable of addressing their needs (i.e., the medical profession). It would also help to build upon the trusting

relationships between providers of non-sexual health services and their clients, and improve individual needs/ risk assessments. It could also help to reduce the reliance on individuals within specialised roles.

Commissioners may want to consider improving local partnerships to facilitate and promote the sharing of information, best practice and resources. This could develop out of the recently-established Teenage Pregnancy Action Group and the existing Sexual Health Partnership, with membership extending to organisations identified for this exercise. Involvement of the CCG should be considered. Improved relationships should help to reduce the variability in practitioners' awareness of commissioned services.

Engagement with patients and the public in the shaping of local services and health promotion materials could help to prevent stigma, improve access and longer-term health equity.

There is evidence of existing good practice locally that commissioners could use to inform the consultation on RSE. Public Health may also consider working with the Education department to identify learners at risk of illiteracy and work once again with partners to develop an RSE programme that is accessible to them.

Given the general feedback on perceived stigma attached to the GUM clinic and the use of CaSH by young females as an alternative, commissioners may seek to influence a change of site and name, and collaborate with clients on the optimal solution.

Commissioners may want to consider reducing the data collection burden of the C-Card system, which could free up time for practitioners to develop better relationships with clients and remove perceived barriers to access. Commissioner may also wish to investigate the cost-effectiveness of the scheme, given the observed occasional problems with supply and under-use in appropriate groups.

Removing physical barriers to interventions such as condoms and testing kits may improve uptake. However, it may also increase the opportunity for moral hazard for people with poor sexual health hygiene, i.e., those less able or motivated to take responsibility for their actions. It may also reduce the opportunity for an educational intervention to be delivered at the point of access.

Public health may wish to investigate the possibility of network analysis and qualitative work to help understand the epidemiology of partner sharing within communities, with a view to assessing risk and developing appropriate interventions if needed. Public health may wish to use the opportunity to establish and address locally-held lay beliefs about sexual and reproductive health.

The local system/ sexual health ecology should promote the choice of LARC for sexually active women who may struggle to comply with oral medicine.

In the light of the burden placed on women, and the opportunity for moral hazard that it creates for men, Public health may wish to advocate for research into alternative contraceptive interventions for men.

Since many vulnerable young people have prior contact with social services, linkages between SRH services and safeguarding should continue to be supported.

Limitations

There are a number of limitations to this study. The foremost is that service providers were identified as a proxy for service users, which may result in skewed views. There is a related potential bias of more willing and engaged providers coming forward to participate. There is a possibility of duplication between young people living in deprived areas, at risk of homelessness, in contact with criminal justice and substance misuse services. Views and perceptions may have been biased by the use of KLOEs developed by the commissioning unit.