Sexual Health Joint Strategic Needs Assessment

Sexual health is an important part of our physical and mental health. There are real population benefits for improving both sexual and reproductive health. The health impacts of sexual ill health are complex, especially if left untreated. It is important that our resident population have knowledge, access to information, access to services, and choice in relation to their sexual health needs across their life course.

Contents

1. Why is sexual health a priority?

Most adults are sexually active. Sexual health represents a key component of our identity. The World Health Organisation (WHO) defines sexual health as:
"…a state of physical, mental and social wellbeing in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence."[1]

Essential elements of good sexual health are equitable relationships, sexual fulfilment and access to information and services to avoid the risk of unintended pregnancy, illness and disease.[2]

Improving sexual health is a public health priority. The local authority has a mandated responsibility to commission comprehensive, open access sexual and reproductive health services. Open access services are essential to control infection, prevent outbreaks and reduce unwanted pregnancies.

According to Public Health England[3], the consequences of poor sexual health include sexually transmitted infections (STIs), HIV, and unintended pregnancies and abortions which can lead to an increase in transmission rates, life-long treatment, infertility, complications in pregnancy, increased vulnerability to some cancers, discrimination and stigma, and poor educational, social and economic opportunities for young parents and their children. Poor sexual health also has major impacts on population health and wider wellbeing, and results in significant costs for the health service and local authority.

Sexual ill health is not equally distributed among the population and these health inequalities need to be addressed. Those at highest risk of poor sexual health are often from specific population groups with varying needs; often those most vulnerable and marginalised. These groups include; young people, men who have sex with men (MSM), transgender people, people from African communities, those living with HIV, sex workers, the homeless, substance users, victims of trafficking, and victims of sexual and domestic abuse.

2. Current context

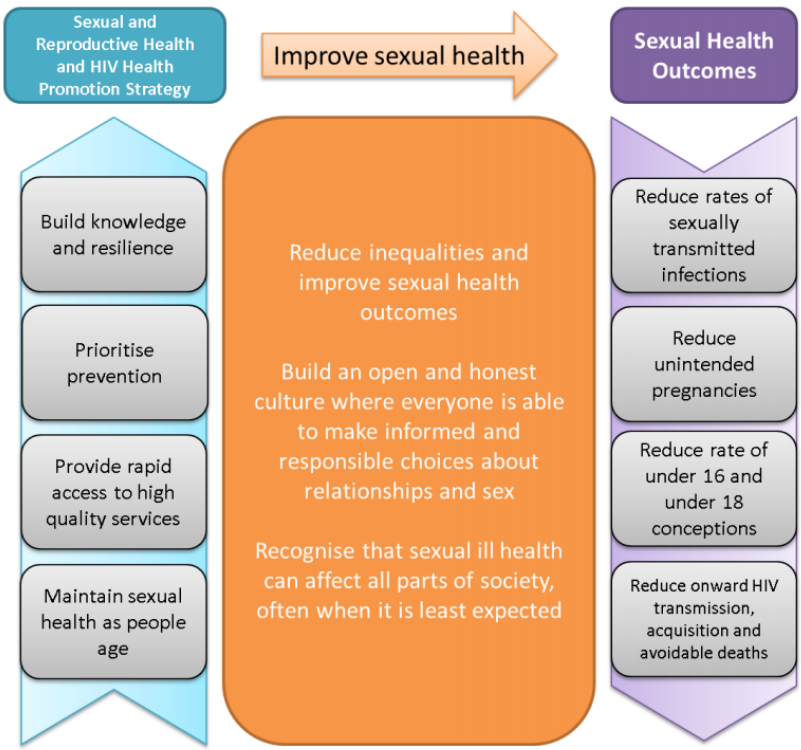
The Sexual Health JSNA plays a vital role in describing patterns of local need and the essential evidence resources to ensure that our services and strategies are the best possible response to the challenges and opportunities we face in Cheshire West and Chester.

Although the past decade has seen improvements in sexual and reproductive health with advances in health promotion and HIV prevention, Public Health England recognises the need for increased interventions to ensure the health and wellbeing of the population and address health inequalities.

In 'A Framework for Sexual Health Improvement in England'[4], The Department of Health sets out steps towards achieving a reduction in sexual health inequalities, building an open and honest culture around sex and relationships, and recognising that sexual ill health can affect all ages and parts of society. Four priorities for sexual health improvement are identified. These are to reduce rates of:

- onward HIV transmission, acquisition and avoidable deaths
- sexually transmitted infections (STIs)
- unplanned pregnancies
- teenage conceptions (under 16 and under 18)

Key objectives to be addressed in Public Health England's Strategic Action Plan for Sexual and Reproductive Health and HIV



The framework and action plan describes how people's sexual health needs, risks and challenges vary with age, and health promotion activities should support people as they pass through different stages of life. However, an emphasis on education and early prevention will achieve the greatest improvements in sexual health and reductions in health inequalities.

Social and criminal issues also have serious impacts on sexual and reproductive health which must be considered in interventions and health promotion. These include victims of domestic abuse and assault, sexual exploitation of children, and alcohol and drug use which is associated with sexual risk taking behaviour.

Costs

Nationally it is estimated that every £1 invested in contraception saves £11 in costs to the health service. An increase in unplanned pregnancies results in increased healthcare costs of abortions, miscarriages, births, post natal care and child health. There are also the increased costs of social welfare. Effective contraception is estimated to deliver welfare savings more than nine times higher than the healthcare savings. In addition there will be costs to social services, housing and education (The Family Planning Association)[5]. NICE Clinical Guideline 30[6] on long acting reversible contraception indicates that a switch from oral contraception to LARC could save £102.3 million per annum.

Early testing and diagnosis of HIV reduces treatment costs to £12,600 per annum per patient compared to £23,442 with a later diagnosis. It has been estimated that a 25% reduction in HIV incidence could save the NHS £500 million annually (Halve It Coalition, 2010)[7].

Developments

Chlamydia

The National Chlamydia Screening Programme was implemented 2008 to facilitate early detection and treatment of asymptomatic Chlamydia in the under 25s. Despite this, Chlamydia infection rates have changed little and re-infection rates are high. Chlamydia remains the most common bacterial sexually transmitted infection in England and up to 70% of women and 50% of men with the infection have no symptoms. Evidence suggests that interventions have so far had little success in reaching people at highest risk. Two-thirds of people testing positive for chlamydia in the third National Survey of Sexual Attitudes and Lifestyles had not had a test in the past year, and over three-quarters had not accessed sexual health services in the past year. Furthermore, although chlamydia disproportionately affects economically disadvantaged populations, this increased risk is not reflected in higher rates of attendance at sexual health services[8].

HPV (Human Papillomavirus)

HPV is a virus transmitted through sexual contact. There are over 100 different types of HPV, 13 of which are known to be associated with cervical cancer, with 2 types (HPV16 and HPV18) responsible for about 80% of all cervical cancers in the UK. HPV strain types 6 and 11 can also cause genital warts. In 2008, a HPV immunisation programme was introduced across the UK to routinely offer a course of vaccine to all girls aged 12-13 to help protect them against cervical cancer[9]. Early findings from PHE support the expectation that vaccination will impact on cervical cancer and other HPV-related diseases in due course and it is anticipated that, with the two-dose schedule, higher coverage of the completed course should be achievable, thus increasing the potential impact of the programme; the number of genital infections in the UK has already fallen in both girls and boys[10].

Other cancers such as cancer of the anus, penis, mouth and throat are also linked to infection with HPV 16 and 18. The programme protecting girls in the longer term offers indirect protection to heterosexual males, however, a gap was identified in relation to men who have sex with men (MSM). Following reviews of all the epidemiological and economic evidence, as well as vaccine safety and efficacy, a targeted HPV vaccination programme for MSM is considered an effective way to reduce the number of preventable HPV infections and their onward transmission in the MSM population[11]. Subsequently, a pilot of HPV vaccination for MSM commenced in 2016 with the purpose being to evaluate whether it is operationally possible and cost effective to deliver such a programme through Genitourinary Medicine (GUM) and HIV clinics. At present, there is no national HPV vaccine programme for MSM, and the vaccine is not available outside of the pilot clinics[12].

HIV

England has an outstanding record of achievements in HIV prevention, treatment and care. Increasing numbers of people with HIV have normal life expectancy so there are now more older people living with HIV who may have other care needs associated with ageing such as dementia. Developments in the integration of the health and social care system offers opportunities for co-ordination of care between services and commissioners across the HIV pathway[13].

The HIV prevention initiative is a collaboration between NHS England and Public Health England (PHE), and follows the Court of Appeal ruling that NHS England, alongside local authorities, have the power, although not the obligation, to fund the provision of anti-retroviral drugs for the prevention of HIV, known as pre-exposure prophylaxis (PrEP). PrEP is a course of HIV drugs taken before sex to reduce the risk of acquiring HIV. The UK's PROUD study reported an 86 per cent reduction in HIV infections in gay men taking PrEP. NHS England is working in partnership with PHE to run a number of early implementer test sites to research how PrEP could be commissioned in the most clinically and cost effective way. Cheshire West and Chester's sexual health service is one such site[14].

Cervical screening

The NHS cervical screening programme is available to women aged 25 to 64 in England. All eligible women who are registered with a GP automatically receive an invitation by mail. Despite the success of the programme, screening coverage has fallen over the last 10 years and attendance is now at a 19-year low across all age groups. Not going for cervical screening is one of the biggest risk factors for developing cervical cancer. A study on the impact of cervical screening on cervical cancer mortality estimated that in England cervical screening currently prevents 70% of cervical cancer deaths. However, if everyone attended screening regularly, 83% could be prevented. The declining coverage of cervical screening has serious implications not just for cervical cancer diagnosis rates and mortality, but also financial implications for the NHS, and the wider economy[15].

Teenage conceptions

The conception rate for young women aged 15 to 17 has been halved since 1998 and is now the lowest it has been since record-keeping began in the late 1960s. However, the conception rate still remains higher than a number of other western European countries and the progress made has been uneven across England. About a third of local authorities have a rate significantly higher than the England average and even in those areas that have low rates, inequalities exist between wards[16].

Sexual violence and exploitation

Over the last few years, there has been a shift in cultural attitudes around child sexual exploitation resulting in increased accountability and identification of victims of abuse[17]. Similarly there has been increased understanding and identification of trafficking, modern slavery, female genital mutilation and forced marriage. The Home Office's Action Plan For Ending Violence Against Women and Girls in the UK includes actions specifically to address female genital mutilation and sexual exploitation of children. The Department for Education's Action Plan for Tackling Child Sexual Exploitation sets out actions to address sexual exploitation and alcohol and drug use associated with the sexual risk-taking behaviour.

3. What are the key issues locally?

Key issues locally in Cheshire West and Chester include low STI and HIV testing rate, late identification of HIV, repeat abortions in the under 25s, and those living in areas of deprivation being disproportionally affected by poor sexual health. Issues should be considered alongside the what needs might be unmet and the challenges the local area, commissioners, providers and service users are facing which can be seen on pages 23 to 26.

Although the rate of new STIs in Cheshire West and Chester is lower than the England average, the STI testing rate (excluding Chlamydia) in Cheshire West and Chester is also lower, within the worst performing quartile of all English local authorities. While the low STI rate could reflect a lower prevalence of STIs in the Cheshire West and Chester population, there may also be a proportion of STIs which are undetected.

Those living in areas with high levels of deprivation are disproportionality affected by STIs, particularly those aged under 25. Service data suggests that in Cheshire West and Chester people living in these areas are not being effectively reached, as targets for Chlamydia and Gonorrhoea outreach screens of 15 to 24 years olds and outreach sessions are not being achieved.

Cheshire West and Chester has significantly lower HIV test coverage and HIV test uptake than the national average. Cheshire West and Chester are in the worst performing quartile of English local authorities for HIV test coverage. Coverage and uptake is especially low for women.

Late identification of HIV is over 40% which is similar to the England average, a value that needs reducing. Effective treatment and the ability to live a long life is dependent on prompt diagnosis[18]. HIV treatment costs at a late stage of diagnosis are almost double the cost of HIV diagnosed early[19].

Under 18s conceptions have decreased in Cheshire West and Chester and nationally over the last few years. However there are wards in Cheshire West and Chester that have a significantly higher rate of teenage conceptions than the England average and these areas are all within the most deprived neighbourhoods in the borough.

There are some areas of Cheshire West and Chester that although have significantly higher rates of teenage conception, there is lower uptake of the emergency hormonal contraception (EHC). Although it must be ensured that the EHC service is not used inappropriately as a regular form of contraception, knowledge of the service should be increased hand in hand with increased targeting of information about contraception choices and methods. The Pharmaceutical Needs Assessment for Cheshire West and Chester highlighted that it would be advantageous if all pharmacies in Cheshire West and Chester guaranteed a EHC service during all opening hours[20].

Abortions carried out in hospital are twice as expensive as those carried out by British Pregnancy Advisory Services[21]. Nationally and in West Cheshire CCG just over a quarter of abortions take place in hospital. However over half of abortions in Vale Royal CCG take place in hospital. This may be because Vale Royal CCG carries out a higher percentage of surgical abortions and fewer medical abortions although medical abortions have particular benefits, including increasing abortions performed at under 10 weeks, being less invasive and less risk to the patient.

In Cheshire West and Chester CCGs, there has been an overall increase in repeat abortions for the under 25s over the last five years. This is an indicator that access to and uptake of contraception provision could be improved.

4. Who is most at risk – What national research tells us

Socioeconomic status

A lower socioeconomic and educational status has shown to be a consistent risk factor for early pregnancy and STIs[22]. Those living in the most disadvantaged areas are most likely to engage in unprotected sex and other associated risk behaviour such as substance misuse. They are also less likely to access emergency hormonal contraception and sexual health services.

Age

Young people who engage in early sexual intercourse are more likely to display risky sexual behaviours which may result in an STI or pregnancy. Sex is more likely to be a result of intoxication leading to unprotected sex[22]. Young people may face pressure to partake in activities they are not comfortable with to please someone else. There may also be a lack of understanding around sexual health and the support and advice available, although evidence shows that young people often do have the knowledge but have a sense of invulnerability. They may also use contraception incorrectly and have poor communication skills[23].

Vulnerable children

Although all young people are at risk of poor sexual health, vulnerable young people are more likely to portray risky sexual behaviours. This includes young men who have sex with men, those who truant, children with low educational attainment, looked after children and young offenders. These young people may also display other risky behaviours such as substance misuse. Vulnerable young people are at increased risk of child sexual exploitation.

Men who have sex with men and Trans women

Men who have sex with men are disproportionately affected by HIV and STIs due to increased condomless sex and a greater number of sexual partners[24]. They are also more likely to take illegal drugs and to have poor emotional health and wellbeing which can lead to high risk behaviours. Men who have sex with men but identify as heterosexual may in addition partake in risky sexual activity such as having sex with someone they have just met and cruising. Trans women can face additional issues around sexual violence[25].

Drug misuse

Drug users are an at risk group due to their chaotic lifestyle which makes them vulnerable to a range of health problems including poor sexual health and unwanted pregnancies. They are also less likely to be able to use services when they need them. There is also a risk that those who misuse drugs will become involved in the sex industry to fund their habit[26].

Ethnicity

Certain black and minority ethnic groups are at disproportionate risk of poor sexual health. Culture, peer norms, religion and inequalities in education to healthcare all have an impact on sexual health behaviours. An individuals culture may prohibit the use of birth control or protection, and/or discourage sex education and discussion about healthy sexual behaviours with a health professional or other. There may also be barriers around language. BME groups are more likely to face poverty and live in areas of high deprivation. Some BME groups may face particular issues around female genital mutilation and forced marriage[27].

Sex workers

Sex workers work in different settings including on the street, parlours and saunas. They are an increased risk of poor sexual health due to a higher number of sexual partners and risk of rape and sexual assault. They may have a drug addiction, been a victim of trafficking or child sexual exploitation, or faced other difficulties in life such as living in care, being homeless or living in poverty. They may feel unable to access services due to stigma, knowledge or language barriers.

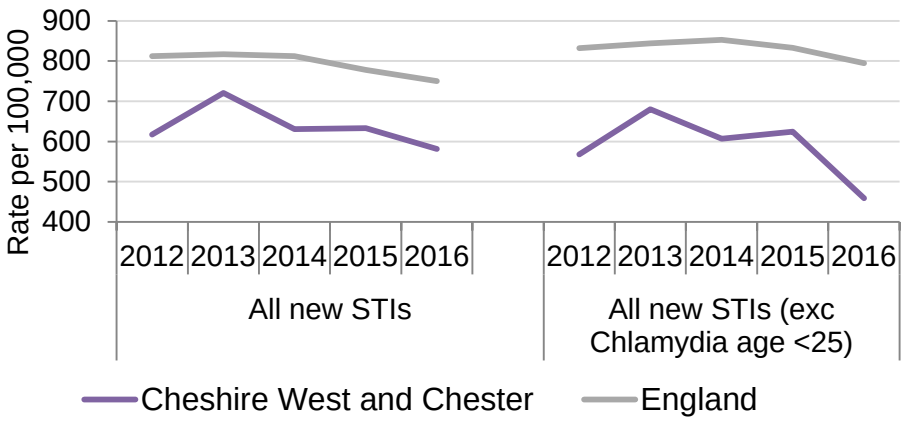
5. Sexual transmitted infections

Undiagnosed STIs can lead to further transmission, risk of infertility, pain and increased risks of some cancers[3]. Most are the result of unprotected sex which is also associated with risky and/or unhealthy behaviors. Vulnerable young people, those living in the most deprived areas, men who have sex with men, and victims of abuse are most at risk of acquiring an STI. The rate of new STIs has decreased in Cheshire West and Chester, however so has the rate of STI testing. Although improvements have been made in Chlamydia screening and detection.

Sexually transmitted infections (STIs) are most commonly transmitted via unprotected penetrative vaginal or anal sex, but can also be transmitted through oral sex, shared sex toys, urine and faeces[28]. Chlamydia is the most common STI in the UK followed by genital warts. Some STIs have no symptoms which can lead to long lasting impacts if left undiagnosed.

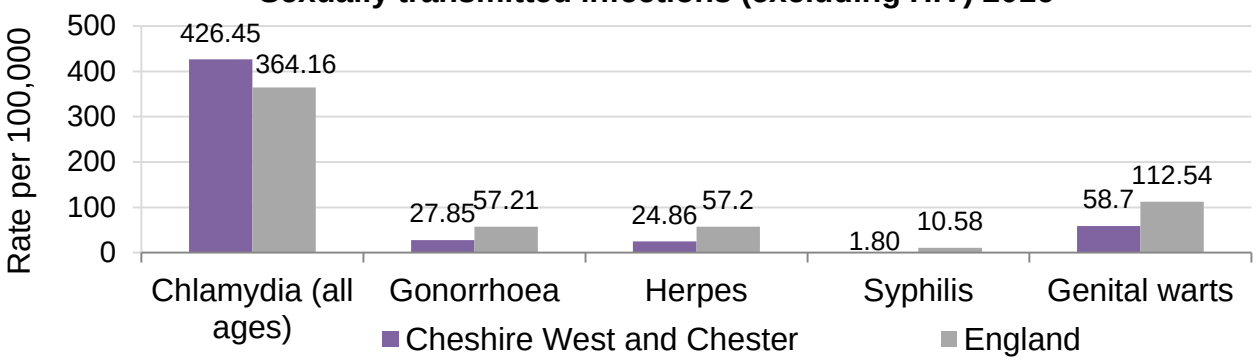
In 2016, there were 1,939 new diagnoses of an STI in Cheshire West and Chester, a rate of 581 per 100,000 population which is lower than the England average of 750 per 100,000. This included 1,424 diagnoses of Chlamydia, 196 of genital warts, 83 of Herpes, 93 of Gonorrhea and 6 of Syphilis. The rate of Syphilis, Gonorrhea, genital warts and Genital Herpes have all decreased.

Trend in new STI diagnosis



Source: Public Health England 2017

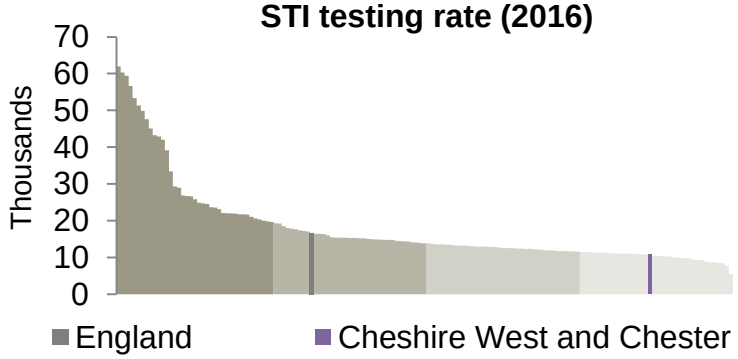
Sexually transmitted infections (excluding HIV) 2016



Source: Public Health England 2017

However, the STI testing rate (excluding Chlamydia) is significantly worse in Cheshire West and Chester than the England average, as it has been historically. The rate of STI testing in Cheshire West and Chester was 10,812 per 100,000 population in 2016 compared to an England average of 16,722 per 100,000. This places Cheshire West and Chester in the worst performing quartile of English Local Authorities.

STI testing rate (2016)



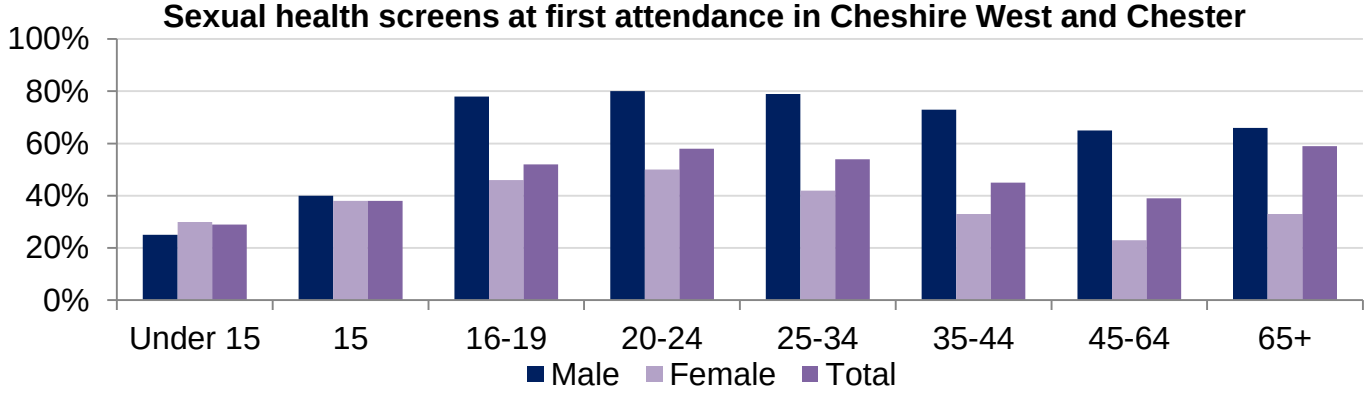
English Local Authorities with local geographical areas

Source: Public Health England 2017

Data shows that although males and females are equally vulnerable to STIs, males are more likely to have genital warts, gonorrhea and Syphilis, and females are more likely to have herpes and chlamydia. Those aged 20-24 have the highest rates of STIs, though for females the highest rate is seen in 15-19 year olds. For all age groups, the highest STI rates were seen for Chlamydia.

In 2016, 56% of sexual health screens were taken at first attendance. Despite young women facing the most serious long-term health consequences of STIs, data shows that men are more likely than women to take a sexual health screen at first attendance, 76% compared to 42%. For both men and women, screening peaks at aged 20-24 and then begins to decrease until the aged of 65 when there is an increase in screenings. Those aged under 16 are less likely to be screened.

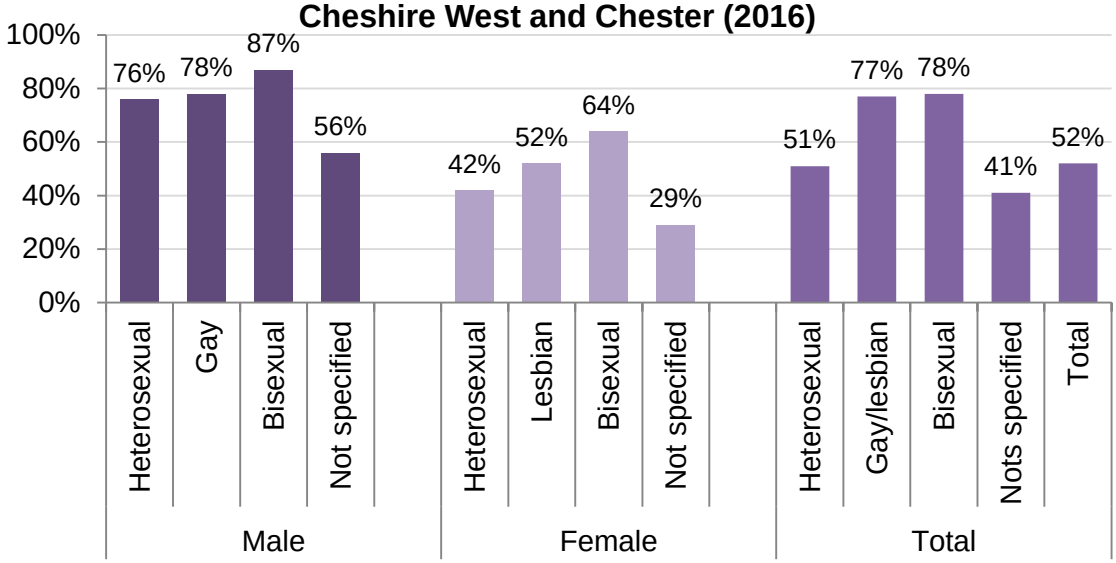
Sexual health screens at first attendance in Cheshire West and Chester



Source: HIV and STI Web Portal, 2017

Both in Cheshire West and Chester and nationally, those who identify as gay/lesbian or bisexual are more likely than those who identify as heterosexual, or those who did not disclose their sexual orientation, to take a sexual health screen at first attendance. Nationally, men who have sex with men are disproportionality affected by STIs although it is unknown if this is due to increased testing or higher levels of unprotected sex. In Cheshire West and Chester, men who have sex with men make up around 1 in 5 new STI diagnoses. In Cheshire West and Chester, 78% of those who identify as a gay man and 87% of those who identify as a bisexual man had a sexual health screening at first attendance (2016). This is compared to 76% of those who identify as a heterosexual man and 56% of those whose sexual orientation was not specified. However, only 42% of heterosexual women had a sexual health screening at first attendance.

% of sexual health screens taken at first attendance - Cheshire West and Chester (2016)

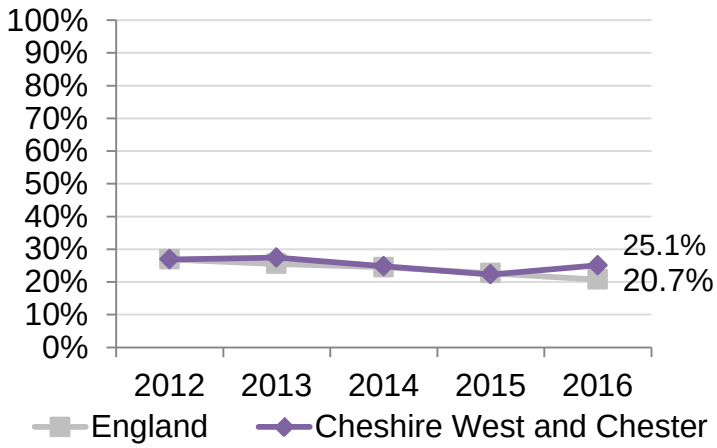


Source: HIV and STI Web Portal

Cheshire West and Chester has increased the Chlamydia screening of 15-24 year olds. In 2016, a quarter of all 15-24 year olds were screened which is significantly better than the England average (20.7%). The National Chlamydia Screening Programme recommends screening for all sexually active young people under the age of 25 annually or on change of a partner. Chlamydia is the most common STI, can show no symptoms, and causes pelvic inflammatory disease (PID) in one in five women which is the main cause of infertility[29].

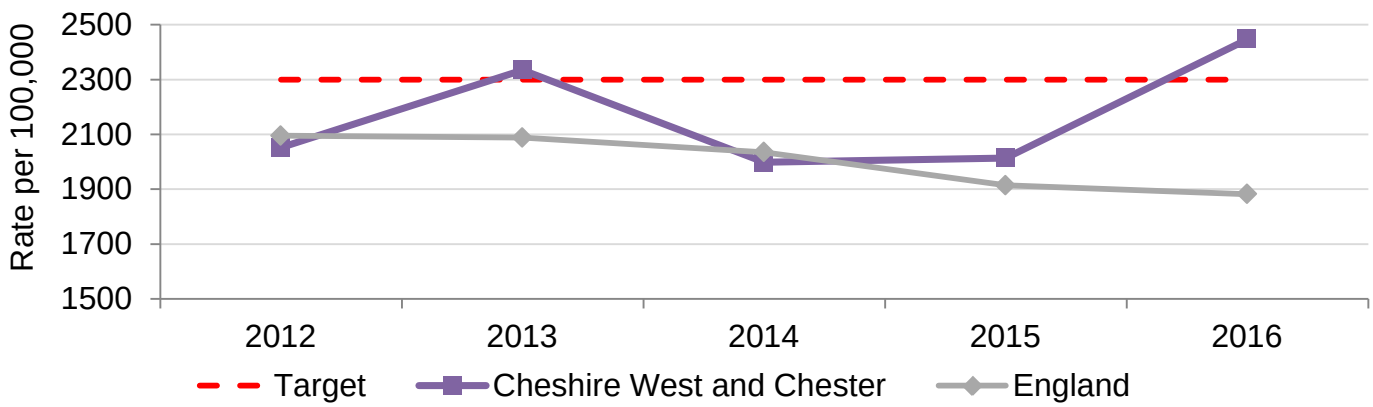
The Department of Health recommends that local areas aim to achieve a chlamydia detection rate among 15 to 24 year olds of at least 2,300 per 100,000 population[21]. In 2016, Cheshire West and Chester achieved 2,447 per 100,000 population, higher than the target and significantly better than the England average (1,882 per 100,000). In 2016, there were 1,424 diagnoses of Chlamydia in Cheshire West and Chester, a rate of 426 per 100,000. This is an increase from 2015 and higher than the England average reflecting improved screening and detection.

Chlamydia screening aged 15-24



Source: Public Health England 2017

Diagnoses of Chlamydia in persons aged 15-24



Source: Public Health England 2017

Local service data reports that the percentage of new sexually active service users aged 15-24 who accepted a chlamydia test was 86.1% in 2015/16 which is better than the target set of 80%.

Evidence shows that those living in areas with high levels of deprivation tend to display more risky sexual behaviour[22]. In Cheshire West and Chester, the percentage of outreach screens of 15 to 24 year olds for Chlamydia and gonorrhea targeted to lower super output areas which are in the 20% most deprived nationally is 26.9%, lower than the England average and below the target of 40%.

6. HIV

Knowledge of HIV status increases survival rates, improves quality of life and reduces the risk of HIV transmission[21]. The rate of HIV infection in Cheshire West and Chester is lower than the national average. However, historically, Cheshire West and Chester has significantly lower HIV test coverage and test uptake. Effective treatment and the ability to live a long life is reliant on prompt diagnosis. However both locally and nationally late identification is over 40%.

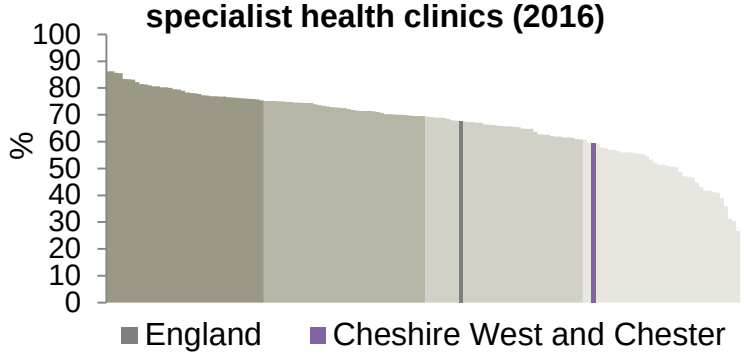
Human Immunodeficiency Virus (HIV) damages the cells in the immune system, weakening the bodies ability to fight infection and disease. HIV is transmitted via bodily fluids, most commonly through having vaginal or anal sex without a condom. HIV may not cause symptoms for many years meaning people can be unaware they are infected. AIDS (Acquired Immune Deficiency Syndrome) is the name given to life threatening infections that happen when the immune system is severely damaged. With an early diagnosis and effective treatments, most people with HIV won't develop any AIDS-related illnesses and will live a normal lifespan. HIV tests are available from a wide range of services including sexual health clinics, GP practices, secondary care services and some pharmacies[30].

In 2016, there were 213 people living with HIV in Cheshire West and Chester, a rate of 1.12 per 1,000 people. Less than 10 people were newly diagnosed with HIV infection, a rate of 2.9 per 100,000 people. This is significantly better than the England rate of 10.3 per 100,000 people. It is unknown whether this reflects lower levels of infection locally or lack of identification.

However, HIV test coverage and test uptake in Cheshire West and Chester is significantly worse than the England average, as it has been historically. This can lead to undiagnosed infection and late diagnosis. Among eligible people attending specialist sexual health clinics in Cheshire West and Chester, test coverage was 59.5% compared to the England average of 67.7%. This places Cheshire West and Chester in the worst performing quartile of English Local Authorities. HIV testing uptake for each eligible new episode was 71.9% compared to 76.5% nationally. (Note: coverage data represents the number of persons tested for HIV and uptake data represents the number of episodes where a test was accepted).

Coverage and uptake is especially low for women, 48.8% and 60.6% respectively. After men who have sex with men, women are most likely to acquire HIV. National evidence suggests women are less likely to be offered a HIV test. Coverage and uptake is similar to the England average for men who have sex with men. Test uptake has been increasing for men who have sex with only women.

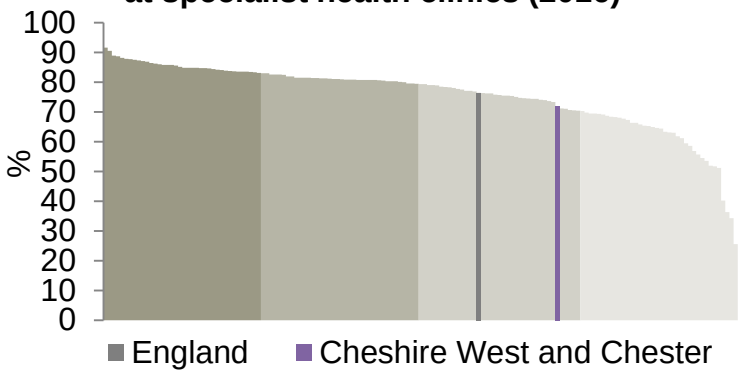
HIV test coverage of eligible people attending specialist health clinics (2016)



English Local Authorities with local geographical areas

Source: Public Health England 2017

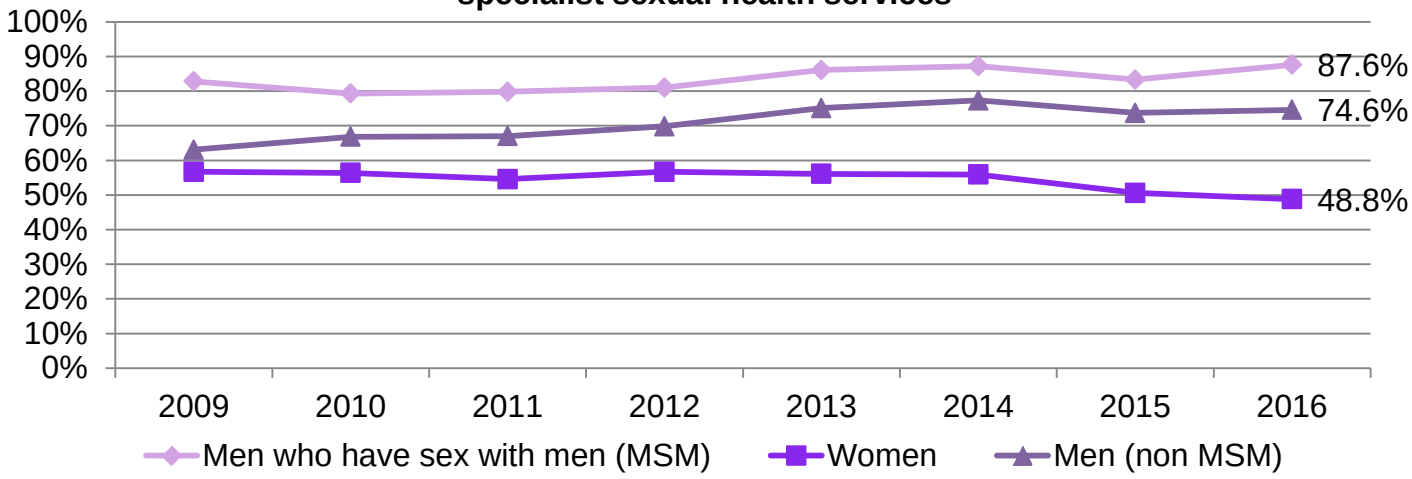
HIV test uptake of each eligible new episode at specialist health clinics (2016)



English Local Authorities with local geographical areas

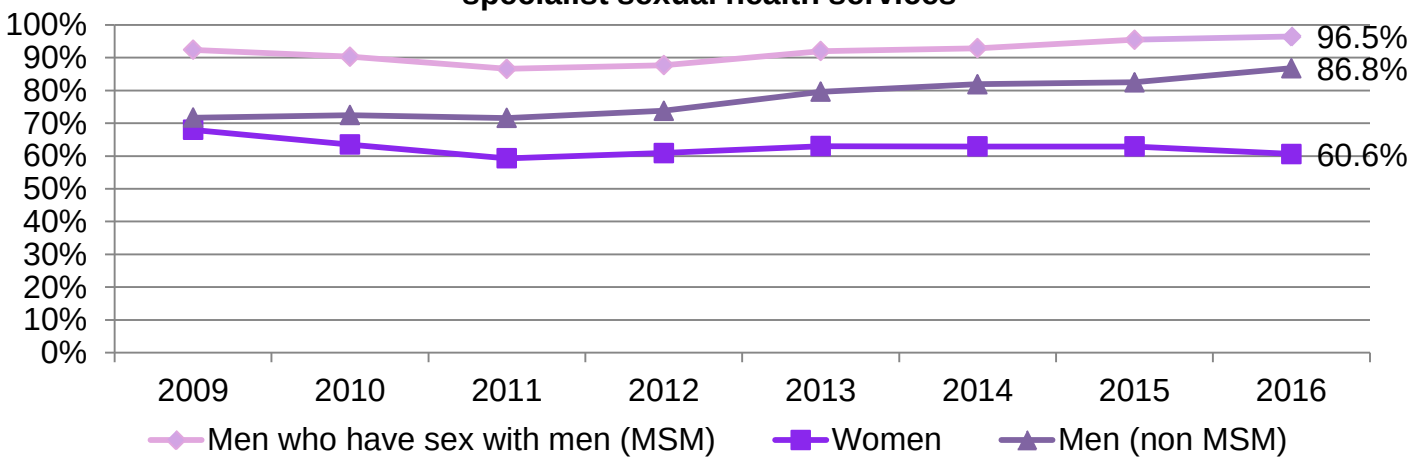
Source: Public Health England 2017

Coverage of HIV testing measured in Cheshire West and Chester specialist sexual health services



Source: Public Health England 2017

Uptake of HIV testing in Cheshire West and Chester specialist sexual health services

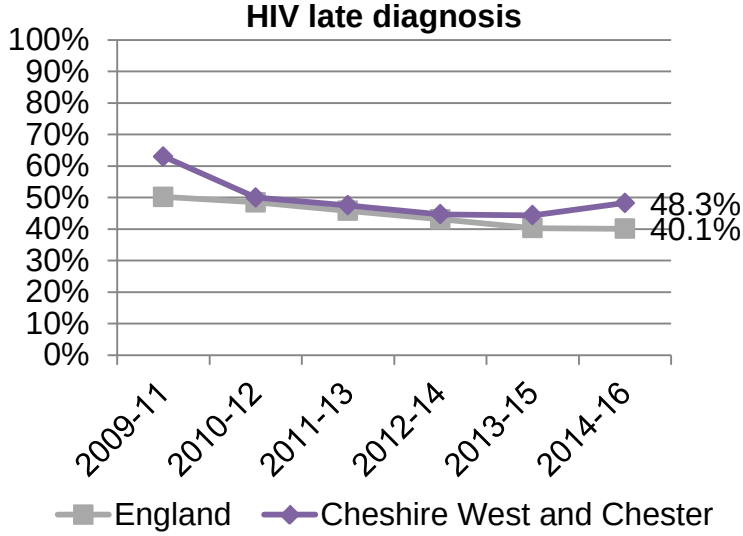


Source: Public Health England 2017

Early diagnosis and effective treatment of HIV means that those diagnosed are able to live a normal life well into old age. However 48.3% of new diagnoses between 2014-16 in Cheshire West and Chester were diagnosed at a late stage of infection. This has been improving and is similar to the England average.

People living with HIV who are diagnosed late have a tenfold increased risk of death in the year following diagnosis compared to a diagnosis made promptly. According to Public Health England, late HIV diagnoses are more common among those diagnosed over the age of 50. Almost two thirds of those aged 65 and over will be diagnosed late. It is estimated that about half of people diagnosed with HIV at age 50 years and over acquired their infection whilst aged over 50[31].

HIV late diagnosis



Source: Public Health England 2017

7. Contraception

Long acting reversible contraception (LARC) is to be encouraged as a reliable form of contraception that is not user dependent. Both nationally and in Cheshire West and Chester, communicating the benefits of LARC to females, particularly young females, should help to reduce the number of unplanned pregnancies[21].

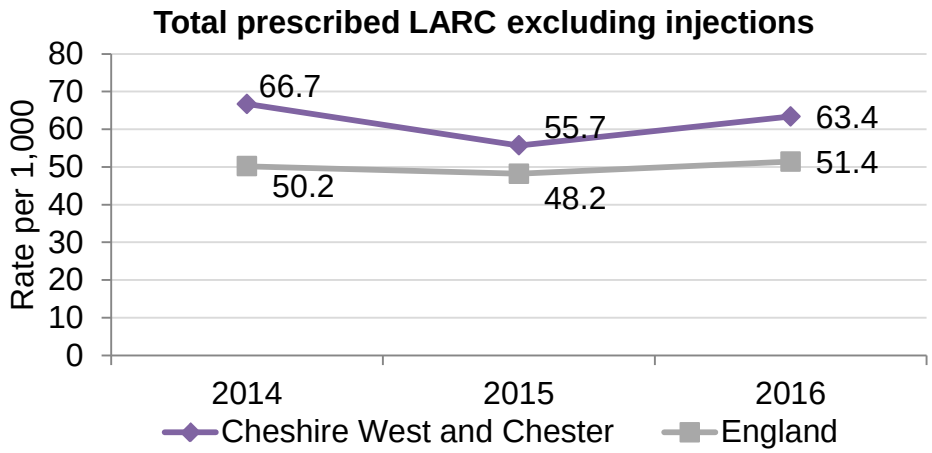
The Department of Health's Framework for Sexual Health Improvement in England calls for increased knowledge and awareness of all methods of contraception among all groups in the local population, and increased access to all methods of contraception including long-acting reversible contraception (LARC) methods[4].

Methods of contraception generally fall under those that are user dependent such as condoms, the pill or patch, and those that are long acting reversible contraceptives such an implant, injection, IU device or IU system. LARC will protect against pregnancy but will not protect against sexually transmitted infections so condoms will still need to be used.

In Cheshire West and Chester, during 2016/17 5,200 women accessed Sexual and Reproductive Health Services who were using some method of contraception during 2016/17. 62% had a user dependent contraception and 38% were using a long acting reversible contraception, similar to the England average (61% and 39% respectively). The oral pill (49%) was the most popular user dependent method of contraception, and an implant (15%) was the most popular LARC.

The National Institute for Health and Clinical Excellence (NICE) advises that LARC methods are highly effective as do not rely on daily compliance and are more cost effective than condoms and the pill[32]. The encouragement of these as a method of choice is recommended rather than the promotion of LARC at the expense of other contraceptive methods. An increase in the provision of LARC is however a proxy measure for wider access to the range of possible contraceptive methods and should lead to a reduction in rates of unintended pregnancy[21].

In Cheshire West and Chester, use of LARC (excluding injections) was 28%, an increase from 2015/16, though it is still below the rate seen in 2014/15. Sexual health services report that LARC clinic appointments are filled to capacity on a regular basis with ongoing demand. The prescription rate per 1,000 women aged 15 to 44 is higher via GP prescribing (38.4 in 2016) compared to Sexual and Reproductive Health Services (24.1 in 2016). Females aged 25 and over are more likely to choose LARC as their main method of contraception compared to females aged under 25. Increasing LARC usage in under 25s may help reduce under 25s unplanned pregnancy.



Source: Public Health England 2017

8. Unplanned pregnancy

Unplanned pregnancy is a key public health indicator. The increasing intervals between first sex, cohabitation, and childbearing means that, on average, women in Britain spend about 30 years of their life needing to avert an unplanned pregnancy. Available evidence shows that unplanned pregnancies can have a negative effect on women and children's lives and result in poorer outcomes than those that are planned[33].

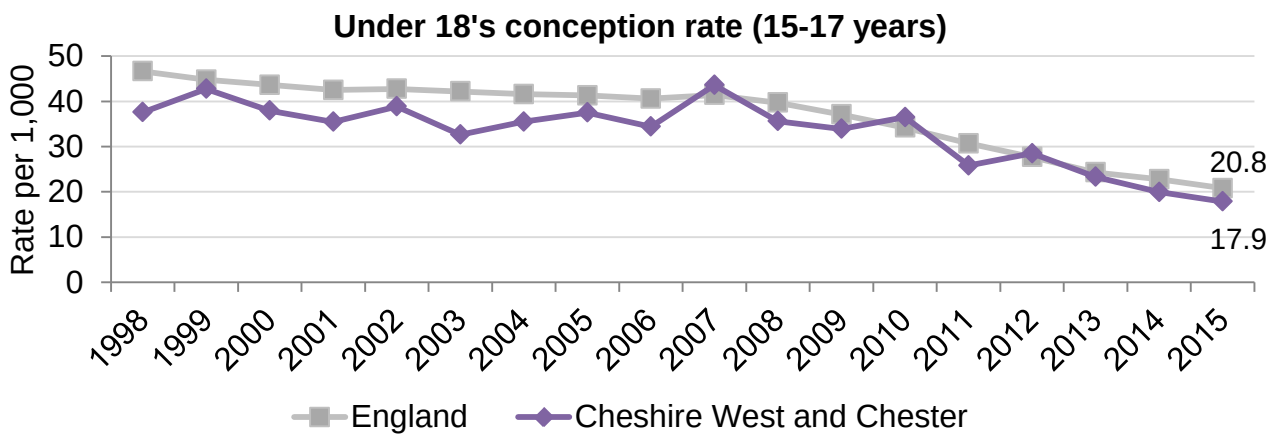
In Cheshire West and Chester, although the rate of teenage pregnancies is similar to the England rate, there are wards that have a significantly higher rate and these areas are amongst the most deprived in the borough. Some of these areas also have low uptake of emergency hormonal contraception which could help prevent unintended pregnancy. In 2016 Cheshire West and Chester saw an increase in repeat abortions with the rate of repeat abortions for under 25s higher than the England average.

8.1 Teenage conceptions

Both nationally and locally the age profile of mothers shows that females aged 30 to 34 are most likely to give birth followed by those aged 25 to 29. Unplanned pregnancies at any age can have a negative effect on both the women's lives, and child's lives if they choose to have the baby. However young women who become pregnant can face significantly poorer outcomes[21].

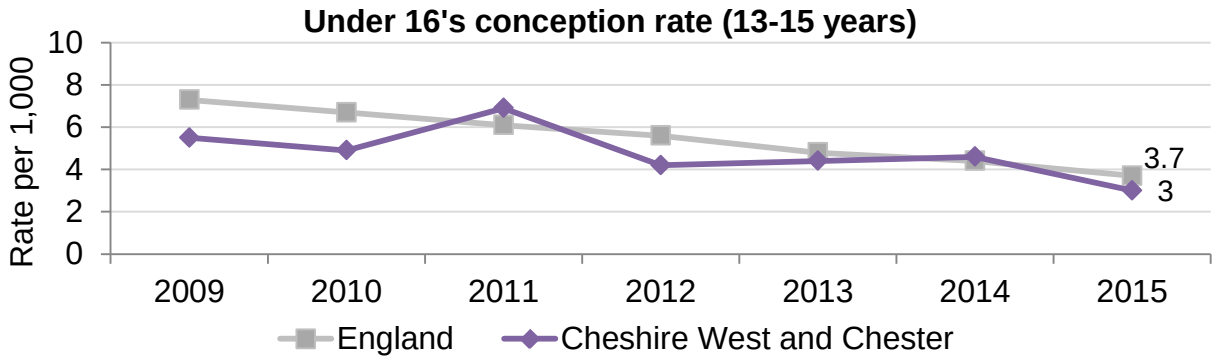
Most teenage pregnancies are unplanned and around half end in abortion. As well as it being an avoidable experience for the young woman, abortions represent an avoidable cost to the NHS. And while for some young women, having a child when young can represent a positive turning point in their lives, for many more teenagers bringing up a child is extremely difficult and often results in poor outcomes for both the teenage parent and the child, in terms of the baby's health, the mother's emotional health and the likelihood of both the parent and child living in long-term poverty. It is often those most vulnerable that are at risk of becoming teenage parents including young people in or leaving care, those underperforming at school, homeless, children of teenage mothers and those involved in crime[21].

Both nationally and locally, teenage conception rates have generally reduced since the late nineties. The latest data available is for 2015. In 2015, 98 females aged 15-17 in Cheshire West and Chester became pregnant, a rate of 17.9 per 1,000 which is similar to the England rate of 20.8 per 1,000. 60% of these conceptions led to abortion.



Source: Office for National Statistics

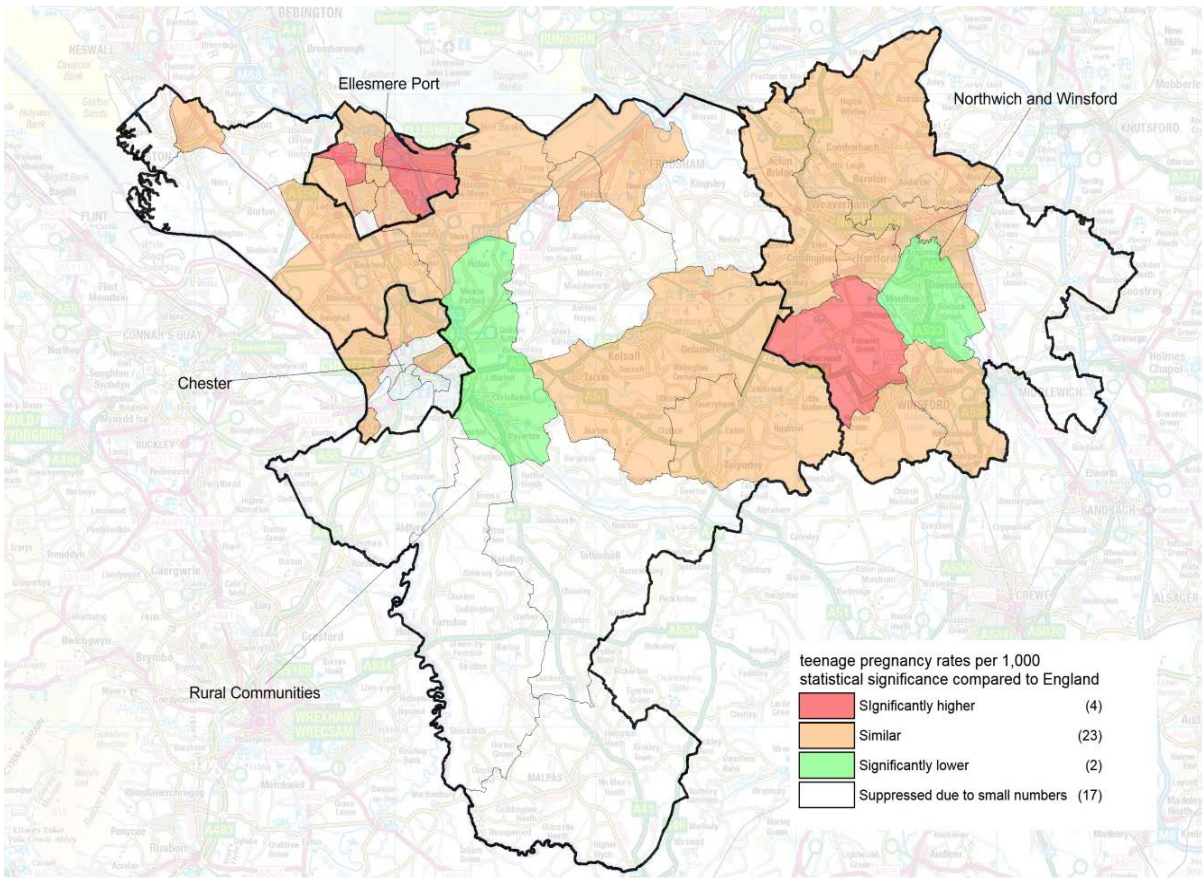
There were 15 females aged 13-15 who became pregnant in 2015, a rate of 3 per 1,000 which is similar to the England rate of 3.7 per 1,000, and a reduction from 2014.



Source: Office for National Statistics

Although overall teenage conception rates are similar to the England average, at ward level there is variation across the borough, with some areas experiencing teenage pregnancy rates which are significantly higher than the England average. Teenage pregnancy is strongly associated with deprivation and social disadvantage, and higher rates of teenage pregnancy are seen in those areas of Cheshire West and Chester that contain neighbourhoods that are within the top 20% most deprived nationally, reflecting the national trend.

The map below shows the variation of teenage pregnancy across the borough. Wards with significantly higher rates are Over and Verdin in Winsford, and Rossmore and St Paul's in Ellesmere Port. These wards were identified as hotspots of deprivation in the Indices of Multiple Deprivation 2015 (available in Cheshire West and Chester JSNA). There were two wards that had teenage pregnancy rates that are significantly lower than England, Chester Villages in Chester, and Davenham and Moulton in Winsford.

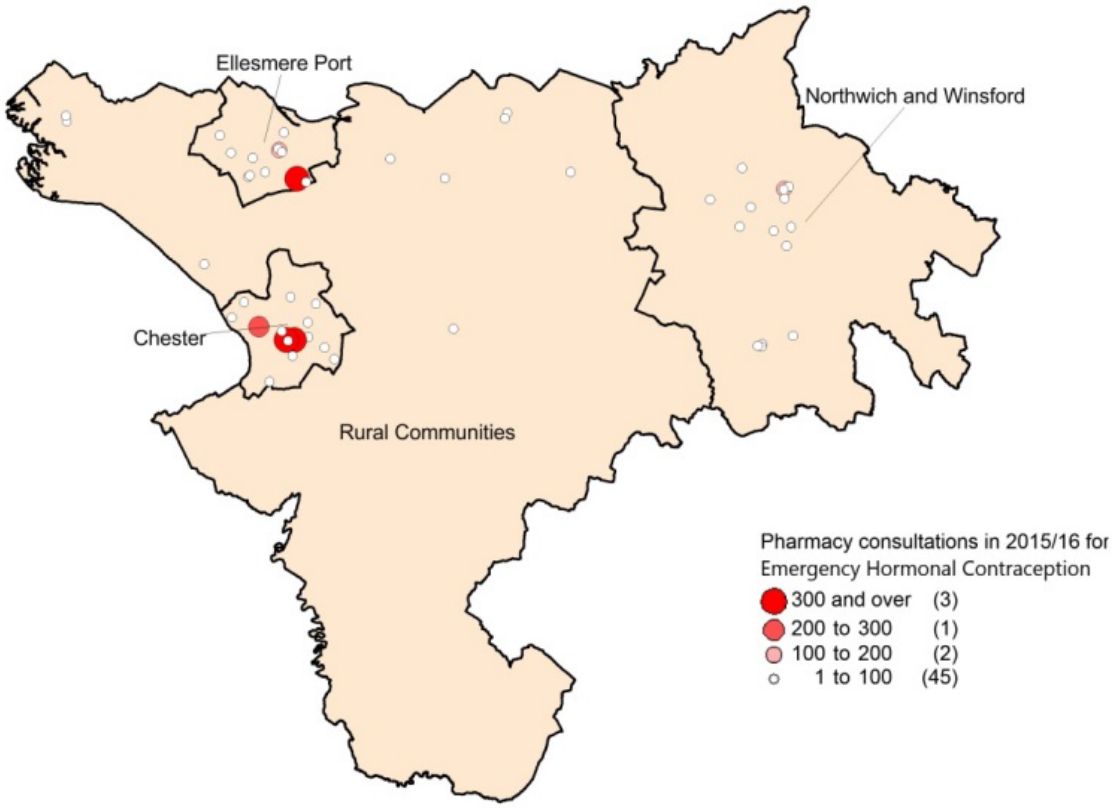


Under 18 conception rate in Cheshire West and Chester significance compared to England by ward (2012-2014)

8.2 Emergency hormonal contraception (EHC)

Emergency contraception can be used by females following an incident that resulted in unprotected sex. It is vital in reducing the number of unplanned pregnancies for women of all ages but is not to be used as a regular form of contraception.

EHC is available free of charge to all women from 55 of the 79 pharmacies in Cheshire West and Chester. Between April 2016 and March 2017 there were 2,995 consultations for EHC carried out in Cheshire West and Chester of which 53% were with women aged under 25. The map below show the number of Emergency Hormonal Contraceptive (EHC) consultations performed by pharmacies in Cheshire West and Chester in 2015/16. The highest numbers of consultations are denoted by the largest red dots. Compared to other populous areas there appears to be a lower uptake of the service in the Winsford area, with no pharmacies providing over 100 consultations within the year. This could be of concern as Over and Verdin in Winsford has significantly higher rates of teenage pregnancy compared to the borough average and is also a deprivation hotspot.



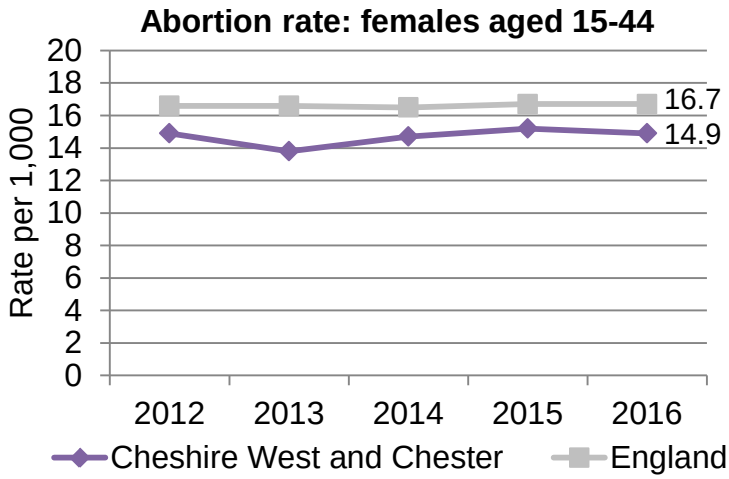
Pharmacy consultations for emergency hormonal contraception in Cheshire West and Chester by postcode of pharmacy (2015/16)

The Pharmaceutical Needs Assessment for Cheshire West and Chester highlights that the EHC service is not guaranteed in participating pharmacies during all opening hours because there may not be an accredited pharmacist on duty. However all pharmacies can still sell EHC over the counter although its indications are limited and does not give the wrap around service they would receive such as follow on contraception and STI screens. Faster access to EHC particularly at weekends significantly improves effectiveness and thus reduces unwanted pregnancies. Therefore, it would be advantageous if all pharmacies in Cheshire West and Chester guaranteed an EHC service for all of their contracted hours. Further, if all pharmacies in the Borough provided this service, apart from increasing access even more, it would have the added benefit that women requesting EHC could do so from outside their locality and thus maintain their anonymity if desired[20].

8.3 Termination of pregnancy

One proxy for unintended pregnancy is information on abortion which can help us to understand which women are most at risk of an unintended pregnancy. It is also a good indicator of lack of access to contraception services and advice, and problems with individual use of contraceptive methods[21]. No clinical procedure is entirely risk-free and procedures come at a cost to the NHS, therefore it is in everyone's interests that all women have access to and use reliable contraceptive methods that prevent unplanned and unwanted pregnancy.

In Cheshire West and Chester there were 891 abortions in 2016, a rate of 14.9 per 1,000 women aged 15-44 years which is significantly better than the England average (16.7 per 1,000). Cheshire West and Chester has seen no significant changes in the overall rate of termination of pregnancy over the last five years but rates have stayed consistently better than the England average. The abortion rate was slightly higher in West Cheshire CCG area (15.4 per 1,000 women aged 15-44 years) compared to Vale Royal CCG area (13.2 per 1,000). However, Vale Royal CCG area had a higher rate of under 18 abortions than both West Cheshire CCG and the national average (12 per 1000 women compared to 7 per 1000 women in West Cheshire CCG).



Source: Department of Health abortion clinic data

There were more women aged 25 and over who had an abortion compared to those aged under 25, however abortion rate was highest for those aged 20-24.

	Under 18	18-19	20-24	25-29	30-24	35+
Number of abortions in Cheshire West and Chester	48	84	264	197	143	155
Rate of abortions in Cheshire West and Chester (per 1,000)	9	21	26	21	15	7
Rate of abortions in England (per 1,000)	8.9	23.2	27.2	23.7	17.5	8.2

Source: Office for National Statistics, Abortion statistics England and Wales: 2016

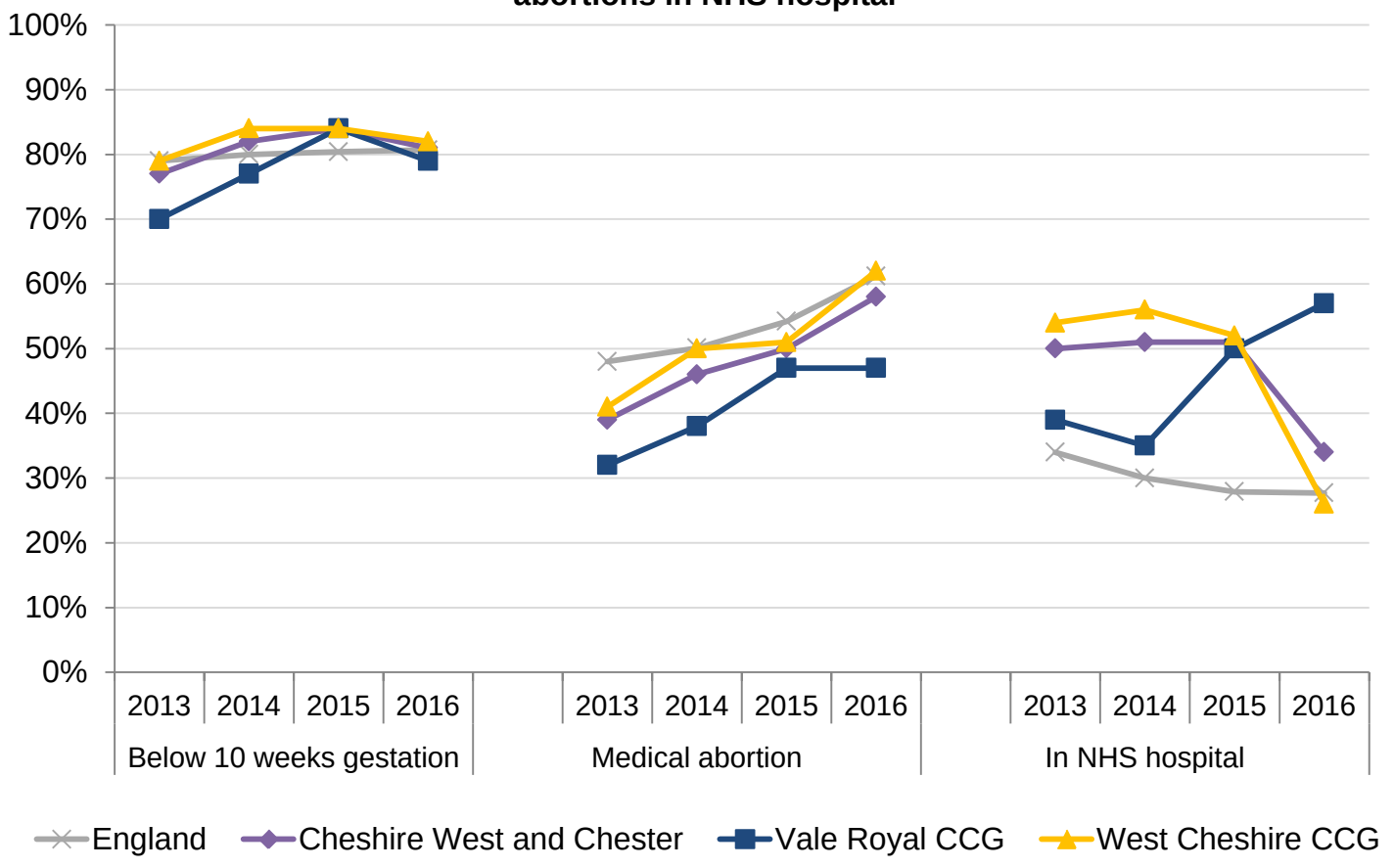
It is important for the health of the mother that abortions are performed as early as possible to lower the risk of complications. In Cheshire West and Chester, 91% of abortions were carried out at under 13 weeks gestation with 81% carried out under 10 weeks. This is the same as the England rates of 91.5% 13 weeks gestation and 80.9% 10 weeks gestation. At a CCG level, Vale Royal CCG has a lower percentage of abortions carried out at under 10 weeks (79%) compared to West Cheshire CCG (82%).

According to Public Health England, the choice of early medical abortion as a method of abortion is likely to have contributed to an increase in the overall percentage of abortions performed at under ten weeks gestation[21]. A medical abortion is taking medication to end the pregnancy as opposed to a surgical abortion which is a minor procedure to remove pregnancy.

Early medical abortion is less invasive than a surgical procedure and carries less risk as it does not involve instrumentation or use of anesthetics. Fewer abortions in Vale Royal CCG are medical abortions though they have seen an increase. In 2016, 47% of abortions were medical abortions in Vale Royal CCG compared to 62% in West Cheshire CCG and England.

In addition, a higher proportion of surgical abortions means that more abortions take place in hospital which is costly. Abortion carried out at hospital is twice as expensive as those carried out by the British Pregnancy Advisory Service[21]. In Cheshire West and Chester, a higher percentage of abortions are carried out in hospitals than nationally, 34% compared to 27.7%. At CCG level, it is Vale Royal CCG where over half of all abortions are carried out at hospital (57%) compared to just over a quarter in West Cheshire CCG (26%). This could be in relation to a higher proportion of abortions being surgical.

Trends: Abortions below 10 weeks gestation, medical abortions and abortions in NHS hospital

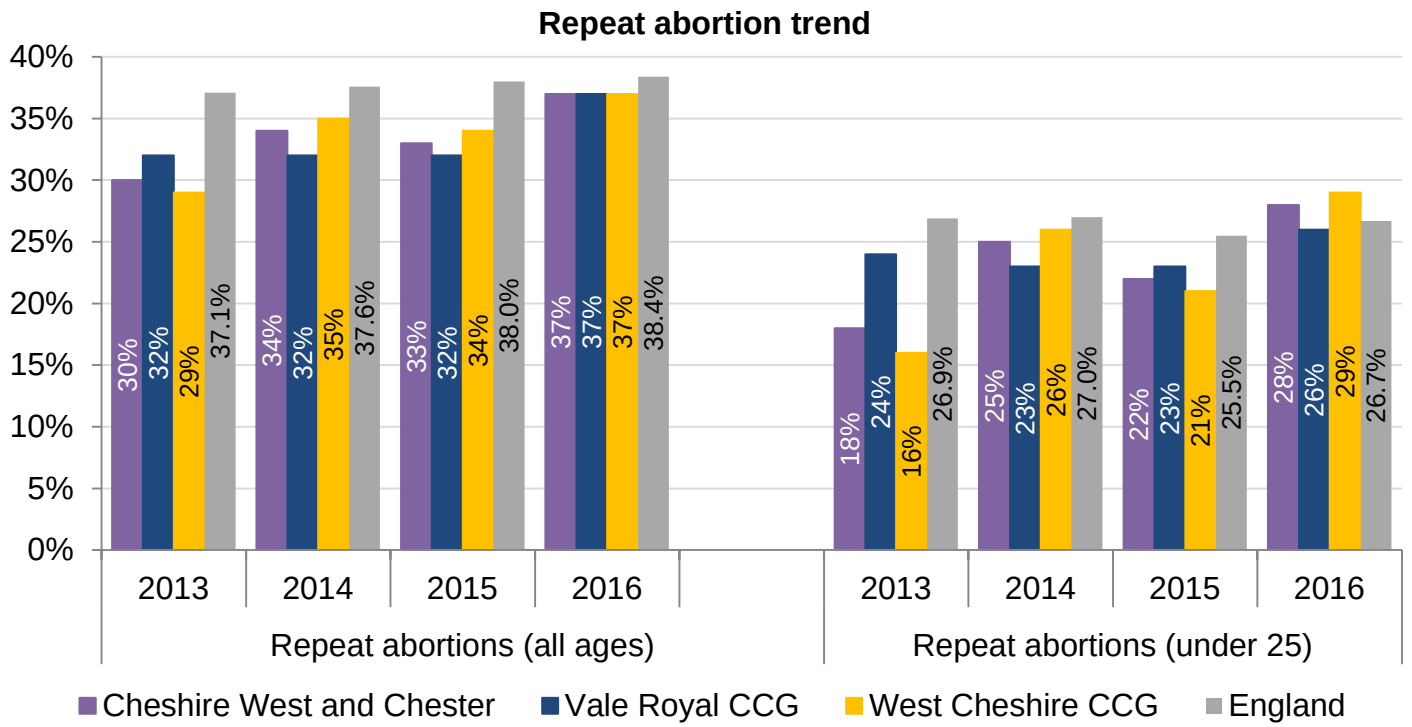


Source: Office for National Statistics, Abortion statistics England and Wales: 2016

When a woman presents to request abortion, it is standard practice to discuss her past contraceptive methods and plans for future contraception. The healthcare professional will advise on effective contraceptive methods to ensure the women is fully aware of the choices available to her and understands the importance of good sexual health in an attempt to prevent future unintended pregnancy. Although the intention is to reduce repeat abortion it must be kept in mind that individuals lives and relationships are complex and multifaceted[34].

Looking at all age repeat abortion, numbers in 2016 have increased both locally and nationally but Cheshire West and Chester rates have stayed below the national average. In 2016, 37% of abortions were repeat abortions in Cheshire West and Chester compared to a national average of 38.4%.

However, 28% of abortions for those aged under 25 were repeat abortions in Cheshire West and Chester which is higher than the national average of 26.7%. At CCG level, Vale Royal CCG is below the England average at 26%, but West Cheshire CCG under 25 repeat abortions was 29%. Repeat abortions in the under 25s has risen significantly in Cheshire West and Chester compared to 2015.



Source: Office for National Statistics, Abortion statistics England and Wales: 2016

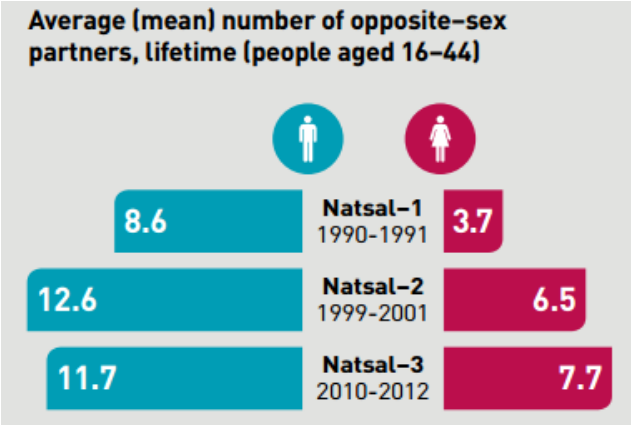
9. Attitudes to sex

Behaviours and attitudes to sex are changing and will continue to change as society evolves. Sexual Health Services need to adapt to this and encourage open and non judgemental services, encouraging people to speak honestly about their experiences and seek help for their sexual health needs across the lifespan.

Local data is not available on peoples behaviours and attitudes to sex. However information can be drawn from national studies. The National Survey of Sexual Attitudes and Lifestyles (2013) gives insight into the changing pattern in peoples sexual behaviours.

The survey shows that over the 1990s there was an increase in the number of opposite-sex partners people reported for both men and women, narrowing the gender gap. There were also more people reporting same-sex experience, 16% of women and 7% of men.

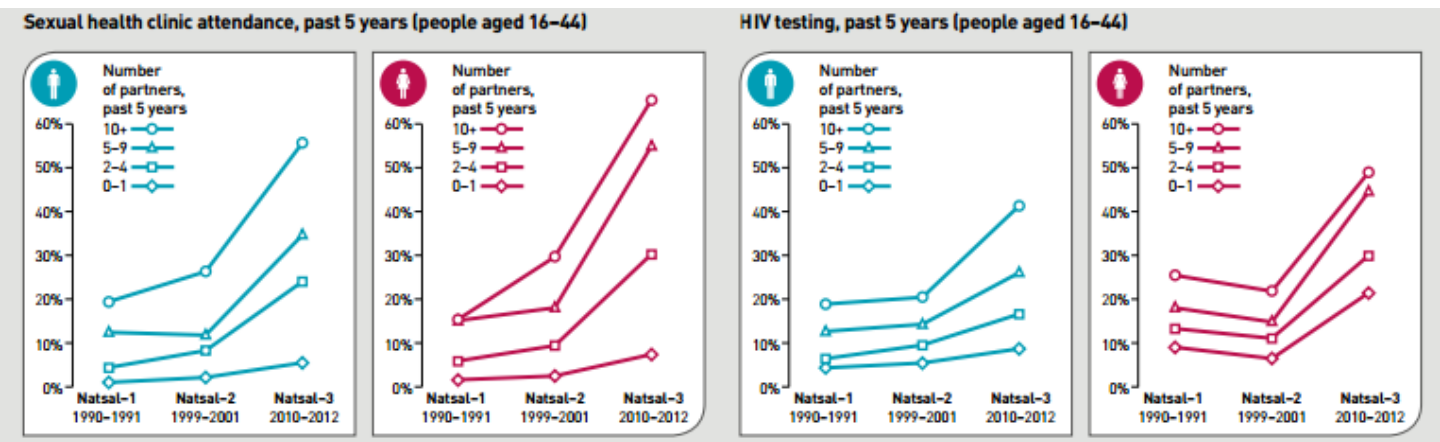
Approximately 1 in 3 young people report having sexual intercourse with someone of the opposite sex before the age of 16; this has not increased substantially since the mid 1990s.



Source: National Survey of Sexual Attitudes and Lifestyles, Natsal-3

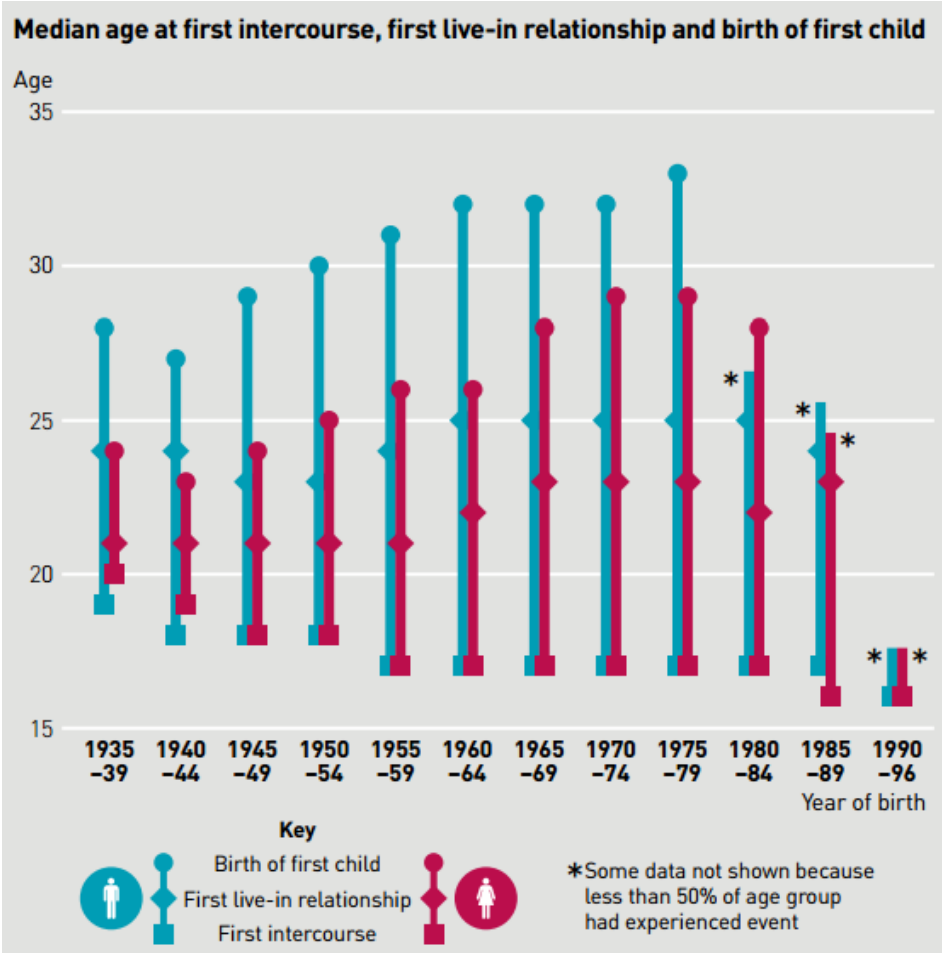
Almost one in six people said that they had a health condition that affected their sex life in the past year, yet only 24% of these men and 18% of these women get help or advice from a health care professional. Sexual difficulties were common even in young people. 42% of men and 51% of women said they had experienced a sexual difficulty lasting 3 months or more in the past year, although only around 10% were worried about their sex life.

Over the past decade, national sexual health strategies in Britain have aimed to increase access to sexual health services and STI / HIV testing. Compared with the previous survey (1999-2001), more people reported having an HIV test or going to a sexual health clinic in the past five years. These increases were even larger in those at highest risk, such as people who reported more partners.



Source: National Survey of Sexual Attitudes and Lifestyles, Natsal-3

Over the past 60 years, the gap between the age people start having sex, the age they first live with a partner, and the age they have their first child has widened. There has been an increase in older mothers.

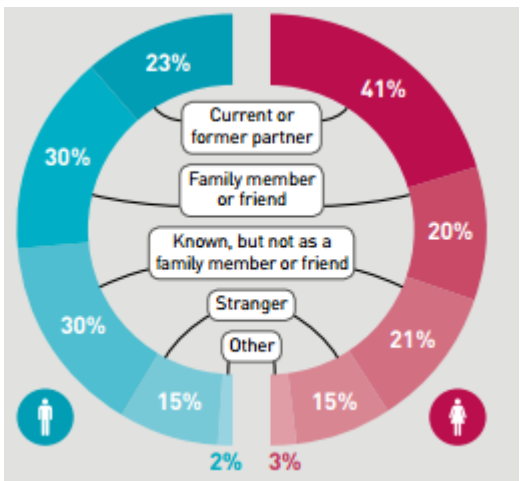


Source: National Survey of Sexual Attitudes and Lifestyles, Natsal-3

One in 10 women revealed that they had been made to have sex against their will and one in 71 men said they had experienced this. This was most likely to occur at a young age, on average aged 18 for women and aged 16 for men. Women were most likely to report the person responsible was a current or former partner, men were more likely to report a family member or friend, or someone known to them but not as a family member or friend.

People who had experienced sex against their will were more likely to report potentially harmful health behaviours and poorer physical, mental and sexual health including treatment for depression or another mental health condition although it is unknown if these things happened before or after experiencing sex against their will.

People responsible at most recent occurrence of non-volitional sex



Source: National Survey of Sexual Attitudes and Lifestyles, Natsal-3

10. Emerging risks

Changes in sexual behaviour patterns for individuals and communities are associated with increased use of technology, social networking, dating applications and the growing use of new substances for Chemsex. Emerging trends in sexual activity may give cause for concern if they put those who partake at increased risk of harm and include any degree of coercion. These increase the risk of sexual violence and child sexual exploitation and can have far reaching impacts on physical health and emotional wellbeing. Unfortunately data is not collected locally on these issues.

Sexting

Sexting is usually defined as sending sexual/naked photos or videos by text message or other social media messenger. This has become an increasing problem, particularly for children and young people, who may feel coerced into sending photos of themselves or not consider the implications[35]. Police report that during 2016/17 there were over 6,200 reported incidents of sexting, in England, a 131 percent increase from 2014/15 and these are just those incidents reported[36].

Not only is it an offence to have and/or share photos of underage young people, the consequences can include further sharing of photos leading to humiliation, blackmail, stigma, bullying, sexual harassment and sexual violence. This can have wider impacts such as truanting, child sexual exploitation, self-harm and risk of suicide. According to the NSPCC there are many reasons why a young person may consider sending a picture, video or message to someone else:

- joining in because they think that 'everyone is doing it'
- boosting their self-esteem
- flirting with others and testing their sexual identity
- exploring their sexual feelings
- to get attention and connect with new people on social media
- they may find it difficult to say no if somebody asks them for an explicit image, especially if the person asking is persistent[35].

Schools have been sent guidance on how to deal with incidents of sexting and are educating young people on the dangers of this and social media. Parents are also able to access advice on how to discuss sexting with their children.

Although sexting can be harmless, adults can also put themselves at risk of humiliation, blackmail and 'revenge porn'. A growing number of revenge porn cases stem from the popularity of sexting and has triggered the introduction of new laws to protect people from explicit images being maliciously made public.

Dating apps

Dating apps allow users to easily connect with others. Some dating apps provide GPS which allows users to quickly find interested people in their location who want to meet. Although the use of dating apps is mostly harmless and a simple way for people to find a date, they do highlight the need for the continued awareness raising of safe sex practices. Dating apps, as well as other changes in sexual behaviours, allows access to casual sex and more sexual partners which can result in increasing rates of STIs[37]. Nationally there has been an increase is the rate of syphilis, and Gonorrhoea was increasing until 2016 followed by a slight drop in rate[21]. Users also put themselves at risk of harm if they do not follow precautions when meeting a stranger face to face, this can include sexual assault, physical attack and pressure to do things they are not comfortable with.

Chemsex

Chemsex is a commonly used term to describe sex under the influence of drugs taken immediately before and/or during sexual contact to enhance sexual activity. It is a rapidly emerging pattern of drug use, and not just amongst men who have sex with men as often assumed though it is more common[38].

Chemsex refers to a combination of drugs that most often include mephedrone, GHB/GHL and methamphetamine (crystal meth). As well as the dangers related to drug use including harm to health, risk of overdose, and possibility of addiction, chemsex that takes place between people who do not know each other are putting themselves at increased risk of sexual violence and contracting a sexually transmitted infection. Those who experience sexual violence are reluctant to go to the police due to the shame and stigma of illicit drug use. The use of social media and dating apps has made it easier to arrange private parties and source sexual partners with the explicit intention to use drugs together. Chemsex is becoming increasingly widespread and The British Medical Journal are urging the government to make chemsex a public health priority[38].

11. Discussion

11.1 What needs might be unmet?

Menopause

The menopause refers to the time in every woman's life when her periods stop and her ovaries lose their reproductive function. Usually, this occurs between the ages of 45 and 55 though premature menopause can occur in those under 40. In the UK the average age is 51. Menopause leads to estrogen deficiency and fluctuations in hormone levels which can lead to a range of symptoms including hot flushes, trouble sleeping, low energy, reduced libido and mood changes. Duration of symptoms is now understood to be, on average, 7 years with 42% of women feeling that their menopause symptoms were 'worse' or 'much worse' than expected[39].

A local survey of health care practitioners regarding menopause care and relevant training and skills within Primary care was undertaken in 2015. The results revealed that significant numbers of women were presenting with a menopause-related issues to Primary Care clinicians but also that many of the clinicians had self-reported learning needs and that two thirds felt that their patients should be able to access a specialist menopause service. This is currently not commissioned locally as a specific service, though some menopause care is provided within general gynaecology services[40].

Proactive management of the menopause could help to prevent much distress for women and reduce the impact on families and at work. The impact of menopause on women in both their personal and working lives has been highlighted by Professor Dame Sally Davies in her report of 2014 'The Health of the 51%:women'[41]. Subsequently, the Faculty of Occupational Health Medicine has produced guidance for employers and managers. There is a need for improved awareness amongst women, increased access to training for health care professionals, together with further work in reinforcing the positive benefits of providing women with appropriate advice and care around this time in their lives, in order to enhance wellbeing in later years. Specific groups, for example the increasing number of breast cancer survivors, may require particular and focussed advice[42]. A further review of local provision of menopause care and the pathways for collaborative working is suggested with an urgent need to address the lack of a commissioned specialist menopause service[42].

Sex in older age

Cheshire West and Chester has a high proportion of people in their 50s and 60s (27%), compared to England (24%). Around 19% of our residents are over the age of 65 compared with England (16%). People remain sexually active throughout their lifetime and sexual health is a concern for men and women beyond the reproductive years.

The need for sexual health messages aimed specifically at older men and women was stated in the Department of Health Framework for Sexual Health Improvement in England (2013)[4]. Although the Framework notes that there is a small, but increasing, incidence of sexually transmitted infections (STIs) in people over 50, the latest local data available does not reflect this trend. However, it is important to note the suggestion that better communication is needed to inform older people of sexual health risks.

The known sexual health problems in this age group may well be underestimated because of their reluctance to seek help, due to embarrassment or stigma. This underlines the need to raise awareness to support adults in this age group seeking help for problems related to sexual activity and function, which may have important impacts on quality of life[43].

The sexual problems older people face must be acknowledged and considered, whether it is because they are exploring relationships or starting a new one, due to the menopause (and perimenopause which starts for many women in their 40s), or the presence of psychosexual health problems as a result of ageing or long-term health conditions which can adversely affect sexual activity and satisfaction. It is therefore important to ensure the right services are there to treat and support people and they know how to access advice and services without any feelings of awkwardness and embarrassment of approaching health care professionals for help.

Sexual health of LGBT+ people

Sexual health information often concentrates on men who have sex with men but there are a number of issues effecting the LGBT+ community.

Messages and information

- 37% of lesbians had been told they didn't need a cervical screening test in a study conducted by The LGBT Foundation highlighting the risk of misinformation[44].
- GP practices must keep accurate records of peoples gender status to appropriately invite them to cancer screening and computer systems cannot deal with this. Trans people may feel uncomfortable attending screening and fear negative attitudes[45].
- Sex education can be poor for young people around LGBT issues[46].
- Women who have sex with women are often invisible in health promotion[47].

Unsafe sex

- 'Chemsex' is an emerging trend in the LGBT+ community which can lead to unprotected sex, sexual violence, overdose and addiction[38].
- Men who have sex with men who don't identify as gay or bi (and might be married or in a heterosexual relationship) are more likely to display high risk behaviours[24].
- Social media and dating apps can lead to risky situations. The leading gay dating app includes GPS to locate a partner quickly in the vicinity[37].
- Younger MSM are more likely to have unprotected sex and to meet a partner online[24].

Infections

- New diagnoses of HIV continue to rise nationally for MSM (though it is unclear if this is reflecting higher rates of transmission or an increase in testing). The greatest reason for not having a test is still fear of a positive result[48].
- It is expected that HIV prevalence is higher amongst trans women than the rest of the population but data collection currently does not collect gender identity[49].

Health professional knowledge and accessibility

- There is the perception and evidence to suggest that there is limited knowledge of transgender health and the transition process by health professionals[50].
- LGBT people may not be out to their GP which can make appropriate health information difficult to access. There is still a perception of GPs as homophobia/transphobic and unable to meet the needs of the LGBT community. This tends to be based on a previous negative experience[51].
- There is often a presumption from health professionals of heterosexuality which can make an LGBT person feel uncomfortable or needing to disclose their sexual orientation[51].
- Feeling uncomfortable, assumptions of heterosexuality, having a previous negative experience and the belief that the health professional does not understand LGBT needs can all reduce the likelihood of an LGBT individual accessing a service when needed until an issue escalates.

Older LGBT

- Older LGBT individuals are less likely to be open about their sexual orientation to health and social care professionals perhaps due to a previous negative experience or a historical belief meaning they may not get the sexual health advice needed or access screening[52].
- The proportion of people in UK aged over 50 with HIV is increasing which will impact social care. Considerations such as dementia and HIV especially around medication will be needed[31].

Other issues

- Sexual health is not just the absence of STIs but the ability to be in a loving relationship. LGBT people may feel unable to express emotional intimacy in public due to fear of hate crime.
- Some research suggests that MTF trans and MSM have high rates of being forced to have sex[47].

11.2 Challenges

1. Funding for sexual health services and HIV

Nationally HIV support services across England have seen big cuts to funding or were scrapped altogether. With ever more cuts to public health budgets and the ring-fence ending in 2018, HIV and sexual health services will continue to be threatened which will not only impact on individuals but could lead to increased costs to the NHS and local authorities in the long term[6].

2. Access to services for those at greatest risk

With the impact of cuts, commissioners need to 'do more with less' directing services to groups in greatest need but exploring a universal offer of support. Commissioning would need to consider wider issues including how to affect behavioural change to reduce pressure on services.

3. Ageing with HIV

The availability of effective HIV treatment means that the first generation of people living with HIV are living into older age. It is important that the needs of over 50s living with HIV are met. This also needs to be considered in regards to illness associated with ageing, for example dementia and the impact on managing HIV medication[31].

4. PrEP

There is much debate about the potential availability of PrEP from NHS England, Public Health England and lobbying groups. Over the next 12 months the NHS England study of PrEP which involves 10,000 people accessing PrEP will be drawing conclusions[14].

5. Addressing new and emerging trends in sexual activity

Sexual activity and behaviour has changed as the world embraces technology and instant communication giving rise to easy accessible sex. Drug use and the types of drugs available have also evolved with new psychoactive substances (NPS) available. Health professionals not only need to be aware of what new practices exist, what they entail and the risks involved, but need to adapt services and communications to be able to offer effective support on a limited budget.

6. Digital offer

With cuts in funding and advances in technology, sexual health services may become 'digitalised'. This has many benefits depending on what form the digital offer takes, but consideration must be given to those who are unlikely to use technology. These are most often those at higher risk and in need of services including those living in areas of high deprivation. For these individuals, a digital offer may need to be offered alongside more traditional methods.

7. Home testing
Currently in Cheshire West and Chester home testing kits are available for HIV and Chlamydia. Home testing kits can increase accessibility to screening and help to target certain areas. However there are also issues with tests not being completed properly or at all, knowing if the right people have been reached, and issues with data collection and receiving the correct information.

8. Accessibility to appropriate services
To encourage people to access a sexual health service and target the right people, provision should be provided in a range of settings and locations. However, it is desirable that the service operates in a clinical setting which is not always possible. Therefore discussions around which services are appropriate to operate in a non clinical setting are needed.

9. Whole system approach
Complications in the provision of a sexual health service can arise with different elements of the service being commissioned by different bodies including Clinical Commissioning Groups, NHS England and Public Health England. For an effective sexual health service to be provided, a whole system approach will need to be taken.

12. Evidence of what works

The Department of Health Framework for Sexual Health Improvement in England set out the ambitions for good sexual health and identifies evidence based interventions to improve sexual health outcomes[4]. In addition, the National Institute for Health and Care Excellence (NICE) have produced a suite of guidelines and standards which provide recommendations based on the best possible evidence . This guidance is listed in the table below.

NICE Guidance on sexual health Title	Guidance (year)
Long-acting reversible contraception	CG 30 (2005)
Sexually transmitted infections: condom distribution schemes	NG 68 (2017)
HIV testing: increasing uptake among people who may have undiagnosed HIV	NG 60 (2016)
Contraceptive services for under 25s	PH 51 (2014)
Contraception	QS 129 (2016)
HIV testing: encouraging uptake	QS 157 (2017)

CG= Clinical Guideline. **NG** = National Guideline. **PH** = Public Health Guideline. **QS** = Quality Standard

Source: National Institute for Health and Care Excellence (NICE) guidance accessed online at www.nice.org.uk

Among other national documents are the British HIV Association Standards of care for people living with HIV in 2013[53] , the British Association of Sexual Health and HIV Standards for the management of sexually transmitted infections[54] and the Faculty of Sexual and Reproductive Healthcare Service Standards for Sexual and Reproductive Healthcare[55] and Workload[55] .

Making it work: a guide to whole system commissioning for sexual health, reproductive health and HIV[57] looks at how to pull the whole commissioning system together and provides very clear and practical examples of how to ensure commissioners improve pathways, the patient's journey and patient care.

The importance of increased investment in prevention to reduce future costs associated with poor sexual health is highlighted in the Public Health England Health promotion for sexual and reproductive sexual health and HIV/ Strategic action plan (2016 to 2019)[3]. The action plan reaffirms the concept of providing the right services for the right people, in the right place at the right time. Consideration should be given to:-

- Population groups who are likely to be negatively affected by sexual and reproductive ill-health.
- Delivering interventions in those populations and areas with greatest need.
- Recognising changing needs and challenges across the life course.
- Building resilience and targeting other risk behaviours; linking with areas including domestic and sexual violence and sexual exploitation.

This sexual health promotion plan is a reminder that sexual ill-health can affect all parts of society, often when least expected, and so the sexual health system needs to be responsive and build client knowledge & resilience at every contact.

Key evidence based interventions

A summary of the key interventions distilled from these publications is given below:-

1. Universal and targeted prevention and support for behaviour change e.g. condom use and condom schemes , especially in young people and men who have sex with men (MSM).

2. Reduction in sexually transmitted infections through increased testing and screening. STI services aimed at high risk groups and HPV programmes.

3. Contraception services provide good information and are highly visible with easy access - especially long acting reversible contraception which is one of the most cost effective methods.

4. Raising HIV awareness. This is linked to early and regular testing, risk counselling and condom promotion, with rapid access to treatment as appropriate.

5. Preventing unplanned conceptions through high quality sex and relationship education (SRE) and easy access to emergency and other contraception (identifying and targeting those at risk).

6. Dealing with unwanted repeat conceptions through contraception advice in abortion, pregnancy loss and maternity care services.

7. Early access to Abortion Services with quality counselling at all stages.

8. Maintaining an awareness of the wider determinants of health such as mental health, alcohol and drug use, sexual and domestic violence and sexual exploitation.

13. Recommendations

Conclusion

This needs assessment provides an illustration of the current status of sexual health in Cheshire West and Chester, and the data behind it will continue to be updated. Some of the key challenges which have been highlighted are:

- Sexually transmitted infections
- Targeted outreach including areas of deprivation
- HIV and late diagnoses
- EHC availability
- Abortions and repeat abortions

Recommendations

Based on the needs assessment, the following recommendations have been highlighted for consideration:

1. Sexually transmitted infections

- Increase access to community and primary based STI testing, treatment and care, in particular to ensure early treatment and contact tracing for other STIs
- Ensure young people under 25 are aware of the services available to them
- Extend targeted testing and interventions to groups who are vulnerable to higher-risk sexual behaviours i.e. substance users and sex workers
- Work in collaboration with partner agencies to provide outreach services to young people not engaging with services, for example looked-after young people
- Develop digital access and self-management for asymptomatic individuals
- Ensure information, including harm reduction messages, are made available and especially promoted to high risk groups

2. HIV testing and late diagnoses

- Increase awareness and uptake of HIV testing, ensuring HIV testing is accessible through secondary care, primary care, community settings, integrated sexual health services and on-line self-sampling
- Increase access to community and primary based HIV testing, treatment and care, in particular to address the late diagnosis of HIV and to ensure early treatment and partner notification
- Investigate cases of late diagnoses to identify missed opportunities for testing in primary care
- Work with primary care, offering training and support, to increase HIV testing in line with the British Association for Sexual Health and HIV (BASHH) guidance
- Develop targeted services for men who have sex with men (MSM), including the pilot of a ‘men only’ clinic

3. EHC availability (Pharmacy provision)

- It is recommended that all pharmacies in Cheshire West and Chester offer a guaranteed EHC service available during all opening hours
- The pathways between pharmacies and contraceptive offers within the local integrated sexual health service and primary care (GPs) should be reviewed

4. Abortions and repeat abortions

- Strengthen the provision of contraception, including LARC for all women of fertile age
- Develop follow up pathways between contraceptive/termination of pregnancy services
- Develop targeted approaches for females under 18 years old and women at risk of unplanned pregnancy
- Utilise opportunities to promote LARC through collaborative working – targeting women with complex needs
- Work more closely with the Substance Misuse Service to identify opportunities for the provision of LARC
- Better understand the disparity between surgical and medical abortions

Next steps

Moving forwards there is a need to further develop collaborative working with partners such as CCGs, NHS England, BPAS and the integrated sexual health service to better understand sexual health pathways. This will provide clarity in understanding a number of the issues highlighted within this needs assessment, such as the reasons behind the reduction in rates of cervical screening, and the factors contributing to the increased number of repeat abortions. This will also provide an opportunity to explore current and future provision of psychosexual services.

Furthermore, Cheshire West and Chester will continue to contribute to the ongoing Cheshire and Merseyside sexual health feasibility study which aims to explore the possibilities of co-commissioning and pathway development based on current evidence and best practice.

14. References

1. Defining sexual health, World Health Organisation, 2006
2. National Strategy for Sexual Health and HIV, Department of Health, 2001
3. Health promotion for sexual and reproductive health and HIV, Strategic action plan 2016- to 2019, Public Health England
4. A framework for sexual health improvement in England, Department of Health, 2013
5. eSexual health interventions: promising, but more evidence needed, Welling's et al, March 2017
6. Lucas, S., 2015. Unprotected Nation: the financial and economic impacts of restricted contraception and sexual health services, The Family Planning Association (FPA)
7. National cost-impact report: Implementing the NICE clinical guideline on long-acting reversible contraception, NICE clinical guideline 30, National Institute for Health and Clinical Excellence
8. Early Testing Saves Lives: HIV is a public health priority, Halve it Coalition, 2010
9. HPV MSM pilot clinical and operational guidance, 2016
10. PHE, Human Papillomavirus (HPV) Vaccine Coverage in England, 2008/09 to 2013/14. A review of the full six years of the three-dose schedule, March 2015
11. HPV vaccination pilot for men who have sex with men (MSM), Information for healthcare professionals, Public Health England, 2016 Information for healthcare professionals
12. HPV vaccination pilot for men who have sex with men , Public Health England , 2016
13. The future of HIV services in England: Shaping the response to changing needs, The Kings Fund, April 2017
14. Pre-exposure prophylaxis to prevent the acquisition of HIV-1 infection (PROUD): effectiveness results from the pilot phase of a pragmatic open-label randomised trial McCormack, Sheena et al. The Lancet , Volume 387 , Issue 10013 , 53 – 60
15. Health Matters: Making cervical screening more accessible, Public Health England, 2017
16. Good progress but more to do: teenage pregnancy and young parents, Local Government Association (LGA),Public Health England, 2016
17. Tackling Child Sexual Exploitation, HM Government, 2017
18. Health matters: Increasing the uptake of HIV testing, Public Health Matters, 2016
19. A facility location model for analysis of current and future demand for sexual health services, NCBI, 2017
20. Pharmaceutical Needs Assessment, Cheshire West and Chester Council, Joint Strategic Needs Assessment
21. Sexual and reproductive health profiles, Public Health England, accessed online Nov 2017
22. Imamura, M., Tucker J, Hannaford, P., Oliveira da Silva, M, Astin, M., Wyness, L., Bloemenkamp, K.W.M., Jahn, A., Karro, H., Olsen, J., and Temmerman, M, 2007. Factors associated with teenage pregnancy in the European Union Countries: a systematic review. European Journal of Public Health, vol 17, no. 6, 630-636.
23. Jones, N., and Haynes, R., (2006). The association between young people's knowledge of sexually transmitted diseases and their behaviour: A mixed methods study. Health, Risk & Society, September 2006, 8(3): 293-303.

24. Sexually transmitted infection risk in England is greatest in gay men and young adults, Public Health England, Press release, 2014
25. Sexual violence and abuse, Scottish Trans Organisation, accessed online Nov 2017
26. Mellor, R., Lovell, A. 2011.The lived experience of UK street-based sex workers and the health consequences: an exploratory study, Health Promotion International
27. Sinha, S., Curtis, K., Jayakody, A., Viner, R., & Roberts, H., 2007. 'People Make Assumptions About Our Communities': Sexual Health Amongst Teenagers from Black and Minority Ethnic Backgrounds in East London. Ethnicity and Health, vol.12, No. 5, 423-441
28. Sex activities and risk, NHS Choices, accessed online Nov 2017
29. Chlamydia, FPA The Sexual Health Charity, accessed online Nov 2017
30. HIV and AIDS, NHS Choices, accessed online Nov 2017
31. Health matters: Increasing the uptake of HIV testing, Public Health England, 2016
32. Long acting reversible contraception, National Collaborating Centre for Women's and Children's Health. National Institute for Health and Care Excellence, October 2005
33. Sexual and reproductive health and HIV: Applying all our health, Public Health England, 2017
34. Repeat abortion: Is it really a problem? Reproductive Health Matters, 2014
35. Sexting, NSPCC, accessed online Nov 2017
36. Police dealing with rising number 'sexting' cases involving children, National Police Chiefs' Council, accessed online Nov 2017
37. Dating apps increasing rates of sexually transmitted infections, say doctors, BBC Newsbeat article, Nov 2015
38. What is chemsex and why does it matter?, 2015, BMJ Editorial, 351:h5790
39. National survey – The results, British Menopause Society, 2016
40. Wilson, J.F., Short, H.L., Wilkinson, S., Mander, A. 2015. Commissioning for menopause specialist services: A local perspective: An internet-based survey to assess the potential demand for menopause care in West Cheshire and the skills of local primary care clinicians in this field with a view to informing future commissioning locally, Post Reprod Health, 21(3):98-104
41. Annual Report of the Chief Medical Officer 2014 – The Health of the 51%: Women, Department of Health, 2015
42. Guidance on menopause and the workplace, Faculty of Occupational Medicine of the Royal College of Physicians, 2016
43. Annual Report of the Chief Medical Officer, 2015, On the state of the Public's Health, Baby Boomers: Fit for the Future. Department of Health 2016
44. Are you ready for your screen test? Raising awareness of cervical screening for lesbian and bisexual women, The Lesbian and Gay Foundation, 2011
45. NHS population screening: Working with minority or hard to reach groups, Public Health England, 2016
46. LGBT young people are saying #weexist in sex education, Blog 21-04-2016, National AIDs Trust (NAT), accessed online Nov 2017

47. Sexual health of the lesbian, gay, bisexual and trans population: A review of the literature, research carried out by John Moores University, Warrington Sexual Health Needs Assessment, 2014

48. I'm worried about HIV and AIDS, Avert, accessed online Nov 2017

49. Trans people and HIV: How can policy work improve for HIV prevention, treatment and care for trans people in the UK?, National AIDS Trusts (NAT), 2017

50. Transgender Equality: First report of session 2015-16, House of Commons Women and Equalities Committee, 2015

51. Experiences of healthcare, Stonewall health briefing, Stonewall, 2012

52. Lesbian, gay and bisexual people in later life, Stonewall, 2011

53. Standards of care for people living with HIV in 2013, British HIV Association, 2012

54. Standards for the management of sexually transmitted infections, British Association for Sexual Health and HIV, 2014

55. Service Standards for Sexual and Reproductive Healthcare, The Faculty of Sexual and Reproductive Healthcare, 2016

56. Service Standards for Workload in Sexual and Reproductive Health, The Faculty of Sexual and Reproductive Healthcare, 2017

57. Making it work: a guide to whole system commissioning for sexual health, reproductive health and HIV, Public Health England, 2014