



# **Sexual Health Needs Assessment for Gloucestershire**

**Commissioned by Gloucestershire Sexual Health Strategic Partnership Group**

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Cover Notes

Title	Sexual Health Needs Assessment for Gloucestershire
Author	Karen Pitney
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Document Type	Health Needs Assessment – Quantitative data combined with qualitative observations from key local stakeholders (Sexual Health Staff & Service Users).
Description	<p>This needs assessment is a refresh of the Sexual Health Needs Assessment 2009 and provides an understanding of the sexual health needs of the people of Gloucestershire and to determine where current services are meeting those needs.</p> <p>The work on the needs assessment has been led by the Public Health team within Gloucestershire County Council as part of the Gloucestershire Sexual Health Strategy (GSHS) (2012-2017) Action Plan which is overseen by the Gloucestershire Sexual Health Strategic Partnership Group (GSHSPG).</p>
Purpose	This needs assessment is a commissioning tool for all organisations involved in the commissioning of sexual health services in Gloucestershire and it is intended that it inform commissioning intentions until 2020.
Data	<p>The latest available data used within this needs assessment is 2013-14</p> <p>The needs assessment uses data from a range of sources including local sexual health service provider data, as well a regional and national datasets.</p>
Audience	Public Health Commissioners, NHS Gloucestershire CCG, NHS England
Links	

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## **Acknowledgements**

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## **Executive Summary**

Improving sexual health is a key national public health priority<sup>1</sup>. Sexual ill health presents a significant cost to the public purse as well as to the individual with consequences ranging from brief episodes of discomfort and embarrassment to serious long-term disability and illness, infertility and in some cases death.

This health needs assessment has been produced in order to gain an understanding of the sexual health needs of the people of Gloucestershire and to determine where current services are meeting those needs. This health needs assessment aims to be a commissioning tool for all organisations involved in the commissioning of sexual health services in Gloucestershire.

Since the last sexual health needs assessment was completed in Gloucestershire in 2009 there has been a significant change within the National Health Service (NHS). The Health and Social Care Act 2012 brought about a change in the commissioning landscape in England. The impact of the NHS transition for sexual health services nationally saw a move from a single commissioning body (the NHS) to three separate organisations. In Gloucestershire responsibility was divided between:

- Gloucestershire County Council (GCC),
- The Gloucestershire Clinical Commissioning Group (GCCG) and,
- NHS England (Area Teams and Specialised Commissioning).

To ensure a joined up approach to sexual health in the county, the Gloucestershire Sexual Health Strategic Partnership Group provides a leadership role in relation to strategy planning, implementation and the oversight of performance. This group will also oversee the implementation of the recommendations made in this report.

## **Methodology**

This health needs assessment adopted a mixed methodology approach in order to elicit as much information as possible. The report features quantitative data from a number of sources to describe the population demographics and level of sexual ill health within the county and thus describing the level of sexual health need. Service use data from sexual health services has been used to describe the level of demand for services. The level and geographical spread of services has been mapped in order to show the supply of sexual health services and help identify any potential gaps. In addition, this assessment was able to draw upon specific pieces of work, undertaken in the county that focused on areas such as the provision of emergency hormonal contraception (EHC) and long acting reversible contraception (LARCs).

The assessment also sought information through qualitative sources as well. For example a stakeholder event for service providers and users was held using the 'Open Space' methodology. In addition to this questionnaires were used to reach groups that were not represented adequately at the 'Open space' event and the broader population of Gloucestershire.

We built up a picture of sexual health in the county by combining a number of recognised approaches to assessing needs. Statistics provide information about how common sexual ill health is locally and, importantly, whether people in different parts of the county had the same chances of having good sexual health. This involved comparing local data with that of the South West region and England. This data set revealed trends regarding levels of sexual ill health, but also about how well local services are performing to meet sexual health needs.

Those who provide sexual health services or who use (or might use) those services were asked about their experiences and where they see opportunities to change things for the better. Through combining these approaches we can get a clearer perspective on how well current services are meeting local needs. Having reviewed the numbers, listened to what people told us, and taken account of new policy developments and best practice guidelines, we can identify what should drive changes (if any are indicated) to the way we commission services in future. This enables us to make recommendations to commissioners that are informed by the best available evidence. This information was then triangulated to determine the recommendations and conclusions.

### **What does this tell us?**

Gloucestershire is a large diverse county with over 600,000 inhabitants. It has a mix of urban and rural areas with 60% of the population living outside of the two main urban centres. The information presented in this report describes the diversity in the need, supply and demand for sexual health services seen across the districts in Gloucestershire. The impact of rurality on planning and accessing services has been well documented.

The Gloucestershire Sexual Health Strategy 2012-17 identified a number of priority groups who traditionally experience poorer sexual health. It is clear that there are some gaps in our knowledge regarding the sexual health needs of these groups particularly in relation to children in care, offenders, people who have been trafficked, sex workers and substance users. There are challenges associated with collecting insightful local data, such as some of these groups are not readily identifiable. However the stakeholder engagement event and service user questionnaire have captured feedback from some of the priority groups but further work is needed to better understand the needs of these groups.

### **Contraception**

Contraception is available in a variety of forms from a wide range of venues. Feedback from service users indicates that there is still a preference to access services through a specialist sexual health service despite the range of services offered through primary care. There is therefore potential to do more to publicise all venues for accessing contraception to help people access the right service for them.

### **Sexually Transmitted Infections**

The prevalence of STIs in Gloucestershire is generally lower than that of the South West and England. However, further work is required to understand the impact of extending access to GUM services throughout the county and the impact on communities identified as more at risk.

## **Access**

Accessible sexual health services are critical to improving the sexual health of the Gloucestershire population. Good transport links in the more urban areas of Gloucestershire facilitate access to services. However, access to regular public transport in parts of the Cotswolds and Forest of Dean hinders access to services. Feedback from stakeholders and service users raised issues not only about geographical location of services but also the timing and availability of appointments, for example pre-bookable and drop in appointments. The potential use of GPs as a setting to provide sexual health services was also discussed.

There are a large number of Gloucestershire residents who access sexual health services outside of the county. Whilst this may be due to personal choice or convenience it could also be a reflection of a lack of accessible services available to them. Further work is needed to understand how the needs of this population can be best met.

## **Working across the system**

The implications of the Health and Social Care Act 2012 are far reaching. The commissioning of sexual health services is now split between four groups of commissioners and therefore good collaborative working is needed more than ever before. Since work on this needs assessment began a number of other issues have emerged, led by other stakeholders that have a strong sexual health component. For example, the new Domestic Abuse and Sexual Violence Strategy and the Child Sex Exploitation strategy and action plan. There is potential to influence sexual health outcomes outside of normal sexual health commissioning boundaries.

## **Conclusion**

This report has detailed the challenges the sexual health system in Gloucestershire is facing when commissioning and delivering high quality patient centred sexual health services. This will involve strengthening insights into the best ways to facilitate healthy behaviours, being responsive to changing patterns of disease and disability, the development of an active sexual health workforce and making effective use of medical advances and information technologies. It is also critical that when developing services that we are mindful of public attitudes and expectations whilst making wise choices in response to economic pressures.

## **Recommendations**

### **1. Introduction**

1.3 To consider all recommendations and actions from this document in line with the 'Making It Work' guidance produced in September 2014 by Public Health England.

### **2. Gloucestershire Profile**

2.2.1 A full review of sexual health services for BME groups, including identifying access barriers and the needs of these communities be undertaken.

2.2.2 A full review of service use including identifying access barriers and the needs of Gypsies and Travellers be undertaken.

2.2.3 A full review of service use including identifying access barriers and the needs of people considered as homeless be undertaken.

2.2.4 A full review of service currently available for victims of sexual coercion, rape and sexual abuse (to include prevention interventions) be undertaken in line with the recommendations of the SARC review and the Gloucestershire Domestic Abuse and Sexual Violence Strategy 2014.

2.2.5 Information about the number, type and range of disabilities is better understood in the county.

2.2.6 A full review of service use including identifying access barriers and the needs of LGB and MSM be undertaken.

2.2.7

a) A recommendation from this needs assessment is that a full review of service use including identifying access barriers and the needs of children and young people be undertaken.

b) An additional recommendation is to ensure that learning from Child Sexual Exploitation enquiries eg Rotherham and Oxford are incorporated within the sexual health services in Gloucestershire.

2.2.8 A full review of service use including identifying access barriers and the needs of migrants be undertaken.

2.2.9 A full review of service use including identifying access barriers and the needs of older people be undertaken.

2.2.10 The service provided by the Eddystone Trust is required to assess the needs of people living with HIV every two years. The next assessment is due in 2015 and should be reviewed in the broader context of sexual health services and prevention at this time.

2.2.12 A full review of service use including identifying access barriers and the needs of sex workers, including people who have been trafficked be undertaken.

2.2.14 To analyse the results of the Gloucestershire transgender health questionnaire as they relate to sexual health services and propose any related actions to the Sexual Health Strategic Partnership Board for consideration

2.2.15 To further explore the link between mental health and sexual health.

### **3. Reproductive Health**

3.1.1

- A comprehensive review of LARC availability, by district is completed and the outcomes shared.
- Review current practice and develop a plan to ensure a robust recall system is part of the LARC pathway within both GP and community and sexual health settings.

- Work is undertaken immediately to identify a process to gather and share sexual health prescribing information for contraception, particularly LARC.

### 3.1.4

- Conclusions of the 2012 community pharmacy review and 2014 Pharmaceutical needs assessment be considered in line with recommendations of this assessment
- Work be undertaken with the Gloucestershire Clinical Commissioning Group Medicine Management Team and NHS England to analyse GP prescribing of EHC over the preceding 5 years to identify and understand variances in provision. This review to include community pharmacy provision as concluded by the 2012 Audit of Pharmacy EHC delivery.

3.3 Further investigation is required to determine the consistent variants between the Gloucestershire and both the South West and England rate of under-10 week abortions.

## 4. Sexually Transmitted Infections

4.1 Public Health in Gloucestershire reviews the current approach to Chlamydia Screening within the county with a view to the achievement of the Public Health Outcome Framework requirements.

4.7 A project group is set up to review out of county attendances at GUM clinics in line with access to current service sites.

## 5. Blood-Borne Viruses

5.1 It is a recommendation from this needs assessment that the GSHSPG works with the GHPAG to ensure progress is made regarding the commissioning responsibilities for Hepatitis B and C.

5.2.3 Undertake a review to assess testing availability with a view to identifying opportunities to increase access to testing.

## 6. Sexual Violence

6.1 A review into the reporting and non reporting of sexual violence and assault against men.

6.2 The GSHSPG ensures it is engaged with the progress of the work around FGM, and acts as a conduit to ensure those working in the field of sexual health contribute to the full in the identification and prevention of incidences of FGM.

## 7. Child Sexual Exploitation

7 A formal link be developed between the GSHSPG and the CSE strategic working group

## 8. Description of current services

### 8.1 Location of services

- Access to services in the North of the county, both in Cotswold and Cheltenham

Districts requires review.

- Public Transport issues within the rural areas of the county need to be taken into account regarding access to services.
- Access to LARC and GP services in the Forest of Dean require review.
- Review access to Public Health Nursing Service extended drop-in services in Gloucester and Cheltenham
- Review of access to contraception within GP Practices in the Forest of Dean, including specialist young person sexual health drop in.

## 8.2 Access to services

- Investigation to be undertaken into increase in attendances at specialist sexual health services, in particular to understand the number of people attending Gloucestershire clinics from outside of the county and the number of people from Gloucestershire choosing clinics outside of the county.
- Steps to be put in place to accurately determine the level of sexual health activity undertaken within GP Practices and Community Pharmacy.

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# 1 Introduction

## 1.1 Purpose

This document has been produced in order to gain an understanding of the sexual health needs of the people of Gloucestershire and to determine where current services are meeting those needs. This needs assessment aims to be a commissioning tool for all organisations involved in the commissioning of sexual health services in Gloucestershire.

## 1.2 Background

This Sexual Health Needs Assessment (SHNA) has been produced as a refresh of the Gloucestershire SHNA 2009. The document takes an overarching view of all sexual health provision within the county and is intended to inform commissioning intentions for the next five years. The work on the needs assessment has been led by the Public Health team within Gloucestershire County Council as part of the Gloucestershire Sexual Health Strategy (GSHS) (2012-2017) Action Plan which is overseen by the Gloucestershire Sexual Health Strategic Partnership Group (GSHSPG) (see Appendix 1 for membership).

Since the last SHNA was completed in Gloucestershire in 2009 there has been a significant change within the National Health Service (NHS). The Health and Social Care Act 2012 brought about a change in the commissioning landscape in England. In summary Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) were abolished. Public Health teams were transferred into local authorities along with the responsibility for improving the health and wellbeing of their populations. NHS England was created as the main commissioning body for the NHS and Clinical Commissioning Groups (CCGs) were formed to enable clinicians to have greater involvement in the commissioning of health services for their population. Prior to the transition all sexual health services in Gloucestershire were commissioned by the Public Health Directorate in NHS Gloucestershire.

The impact of the NHS transition for sexual health services nationally saw a move from a single commissioning body (the NHS) to three separate organisations. In Gloucestershire responsibility was divided between:

- Gloucestershire County Council (GCC),
- The Gloucestershire Clinical Commissioning Group (GCCG) and,
- NHS England.

The specific details are described below:

### **Gloucestershire County Council (GCC) are responsible for the commissioning of:**

- Contraception, including Locally Enhanced Services (LESS) for implants and Nationally Enhanced Services (NESs) for intrauterine contraception. This includes all prescribing costs – but excludes contraception provided as an additional service under the GP contract
- Testing for sexually transmitted infections (STIs) and treatment, Chlamydia testing as part of the National Chlamydia Screening Programme and HIV testing

- Sexual health aspects of psychosexual counselling
- Any sexual health specialist service, including young people's sexual health and teenage pregnancy services, outreach, HIV prevention and sexual health promotion work, services in schools, colleges and pharmacies
- HIV Social Care
- Wider responsibility for teenage parents

**Gloucestershire Clinical Commissioning Group (GCCG) are responsible for the commissioning of:**

- Most abortion services (with further consultation about best commissioning arrangements in the longer term) and sterilisation
- Vasectomy
- Non-sexual health elements of psychosexual health services
- Gynaecology, including any use of contraceptive for non-contraceptive purposes

**NHS England are responsible for the commissioning of:**

- Contraception provided as an additional service under the General Practitioner (GP) contract
- HIV treatment and care, including post-exposure prophylaxis after sexual exposure
- Promotion of opportunistic testing and treatment for STIs, and patient requested testing by GPs
- Sexual health elements of prison health services (not applicable for Gloucestershire)
- Sexual assault referral centres (SARC)
- Cervical screening
- Specialist foetal medicine

The potential implications of such wide spread changes to the commissioning of sexual health services are significant and therefore it is vital that commissioners of all sexual health services in Gloucestershire work closely to ensure provision remain cohesive and patient centred through any commissioning processes. There are a number of safeguards in place to support this;

- The Gloucestershire Sexual Health Strategic Partnership Group (GSHSPG) that will continue to facilitate good partnership working across all partners in the county
- The provision of accurate and timely information to support commissioning decisions, including this needs assessment
- The GCC Outcome Manager with responsibility for Sexual Health also represents the GCCG on the day to day commissioning of abortion services in collaboration with Health and Social Care Commissioning Manager

- Gloucestershire works closely with the South West Office of Sexual Health sponsored by South West Directors of Public Health (DPH's) in the region the Office works to ensure collaboration between service commissioners and providers across the South West

### 1.3 Policy context

Improving sexual health is a key national public health priority<sup>2</sup>. Sexual ill health presents a significant cost to the public purse as well as to the individual with consequences ranging from brief episodes of discomfort and embarrassment to serious long-term disability and illness, infertility and in some cases death.

Sexual ill health and unintended teenage pregnancies are strongly linked with deprivation and health inequality. There is a 6-fold difference in teenage conception and birth rates between the poorest areas in England and the most affluent. There is a clear link between sexual ill-health, deprivation and social exclusion; unintended pregnancies can have a long-term impact on people's lives. Under-18 conceptions can lead to socioeconomic deprivation, mental health difficulties and lower levels of educational attainment. In addition, resulting children are at greater risk of low educational attainment, emotional and behavioural problems, maltreatment or harm, and illness, accidents and injuries<sup>3</sup>.

In 2013 the coalition government published *A Framework for Sexual Health Improvement*<sup>4</sup>, whilst recognising major successes from the previous decade the publication set out the future ambitions to improve the sexual health and wellbeing of the whole population. The framework states that we must:

- Reduce inequalities and improve sexual health outcomes
- Build an honest and open culture where everyone is able to make informed and responsible choice about relationships and sex; and
- Recognise that sexual ill health can affect all parts of society – often when it is least expected

To achieve this, eight ambitions are identified by the framework. These are:

1. Build knowledge and resilience among young people
2. Rapid access to high quality services
3. People remain healthy as they age
4. Prioritise prevention
5. Reduce rates of STIs among people of all ages
6. Reduce onward transmission of HIV and avoidable deaths from it
7. Reduce unintended pregnancies among all women of fertile age
8. Continue to reduce the rate of under 16 and under 18 conceptions

This framework was published at the same time as changes in commissioning detailed earlier in this document and provides a supporting framework for joined up service development.

Coinciding with the completion of this needs assessment Public Health England (PHE) have issued the 'Making It Work' framework which is intended to safeguard collaboration between commissioners. The GSHSPG will consider the recommendations of the 'Making it Work' framework when prioritising actions from this needs assessment.

To ensure a joined up approach to sexual health in the county, the GSHSPG provides a leadership role in relation to strategy planning, implementation and the oversight of performance. In January 2012 this group led the development of the 2012 Gloucestershire five year Sexual Health Strategy which identifies six strategic objectives, these are:

1. Improve knowledge, skills and understanding of sexual health and relationships through targeted prevention and educational interventions;
2. Provide high quality, comprehensive, integrated sexual health services for Gloucestershire which deliver equitable access to care;
3. Reduce unintended pregnancy, particularly among young women under 18;
4. Reduce the transmission and prevalence of STIs including HIV;
5. Improve access to social and specialist care for those living with HIV; and
6. Develop a systematic approach to performance monitoring and review

This needs assessment is intended to drive the delivery of these objectives by:

- Presenting and analysing the trends in sexual health in Gloucestershire
- Identifying sexual health needs of the most vulnerable and at risk groups
- Identifying gaps in provision of sexual health services across the county
- Understanding the potential barriers to accessing sexual health services
- Engaging stakeholders delivering or using sexual health services

Included as an action within the Sexual Health Strategy, the recommendations from this needs assessment will form the basis for future delivery plans for the county.

#### **1.4 Methodology**

This needs assessment followed a similar methodology as that used for the 2009 Sexual Health Needs Assessment. The methodology used quantitative data from a number of sources to describe the population demographics and level of sexual ill health within the county and thus describing the level of sexual health need. Service use data from sexual health services has been used to describe the level of demand for services. The level and geographical spread of services has been mapped in order to show the supply of sexual

health services and help identify any potential gaps. In addition, this assessment was able to draw upon specific pieces of work, undertaken in the county, that focused on areas such as the provision of emergency hormonal contraception (EHC) and long acting reversible contraception (LARCs).

The assessment also sought information through qualitative sources as well. For example a stakeholder event for service providers and users was held using the 'Open Space' methodology (see 1.4.2). In addition to this questionnaires were used to reach groups that were not represented adequately at the 'Open space' event and the broader population of Gloucestershire.

We built up a picture of sexual health in the county by combining a number of recognised approaches to assessing needs. Statistics provide information about how common sexual ill health is locally and, importantly, whether people in different parts of the county had the same chances of having good sexual health. This involved comparing local data with that of the South West region and England. This data set revealed trends regarding levels of sexual ill health, but also about how well local services are performing to meet sexual health needs.

Those who provide sexual health services or who use (or might use) those services were asked about their experiences and where they see opportunities to change things for the better. Through combining these approaches we can get a clearer perspective on how well current services are meeting local needs. Having reviewed the numbers, listened to what people told us, and taken account of new policy developments and best practice guidelines, we can identify what should drive changes (if any are indicated) to the way we commission services in future. This enables us to make recommendations to commissioners that are informed by the best available evidence. This information was then triangulated to determine the recommendations and conclusions.

#### **1.4.1 Sources of sexual health data and surveillance**

- Genitourinary Medicine Clinic Activity Dataset for STIs (GUMCAD)
- Chlamydia Testing Activity Dataset (CTAD)
- Survey of Prevalent HIV Infections Diagnosed (SOPHID)
- HIV/ Acquired Immunodeficiency Syndrome (AIDS) new diagnoses
- HIV and AIDS Reporting System (HARS)
- Office for National Statistics (ONS) Conception Data
- Service use data

Further information on the data sets can be found in Appendix 2.

#### **1.4.2 Engagement - Open Space Community Event**

Open Space is a methodology which brings together a range of people to discuss issues around a central theme – in this case sexual health. Participants create their own agenda holding discussions with people who wish to contribute to the issues raised. The structure leads to a number of self-directed, but structured discussions around a particular theme.

The Sexual Health Open Space Event held in March 2012 was attended by over 80 people. Given the vulnerability of some service clients all those attending did so on a first name only basis to preserve the anonymity of those who wanted it and to remove the potential for health professional hierarchies influencing decisions. Attending were a cross section of service clients, people living with a life limiting illness relating to sexual health, representation from young and older people, disability groups and clinicians and providers of sexual health services. A number of separate discussions took place which focused around the areas of:

- Access to services
- Ways to reduce sexually transmitted infection
- Access to support for clinicians and allied professionals supporting people with sexual health needs.
- Access to information about sexual health and service availability
- Human papillomavirus vaccination for boys to reduce Genital Warts
- Addressing stigma
- Postnatal contraception especially for vulnerable clients
- Addressing the link between sexual health in young people and low self esteem
- Reaching out to vulnerable people and encouraging access for people less likely to attend services.
- Relationships
- Improving psychology in sexual health
- The role of the GPs in diagnosing people

Each discussion group included the thoughts and opinions of people at the event and delivered a number of actions or questions for further investigation. A significant number of these included common themes around choice, access to services, education, communication and attitudes.

As a result, further engagement took place in the form of two questionnaires, one for service users or people who may use the service and a second questionnaire for clinicians and service providers. The results of the questionnaires can be found in Section 9. Copies of the questionnaires can be found in Appendix 3 and 4.

#### **1. Summary of Recommendations:**

1.3 To consider all recommendations and actions from this document in line with the 'Making It Work' guidance produced in September 2014 by Public Health England.

## 2 Gloucestershire Profile

Sexual health is influenced by a complex web of factors ranging from sexual behaviour, attitudes and societal factors such as deprivation, to biological risk and genetic predisposition. Education is a known factor with direct links between higher educational achievement and improved attitudes to sexual health<sup>5</sup>. These all include issues associated with unintended conception/pregnancy, abortion and STIs. While it is important to recognise that people may be sexually active from teenage years throughout the life course, young people and young adults are at higher risk of acquiring STIs compared to other age groups. The National Survey of Sexual Attitudes and Lifestyles (Natsal 2013)<sup>6</sup> reported that one in three 16 – 24 year olds had two or more sexual partners in the last year compared to one in five 25 – 34 year olds and one in ten 35 – 44 year olds. The 16–24 age group was also more likely to have had at least two sexual partners with whom no condom was used in the past year compared to older groups.

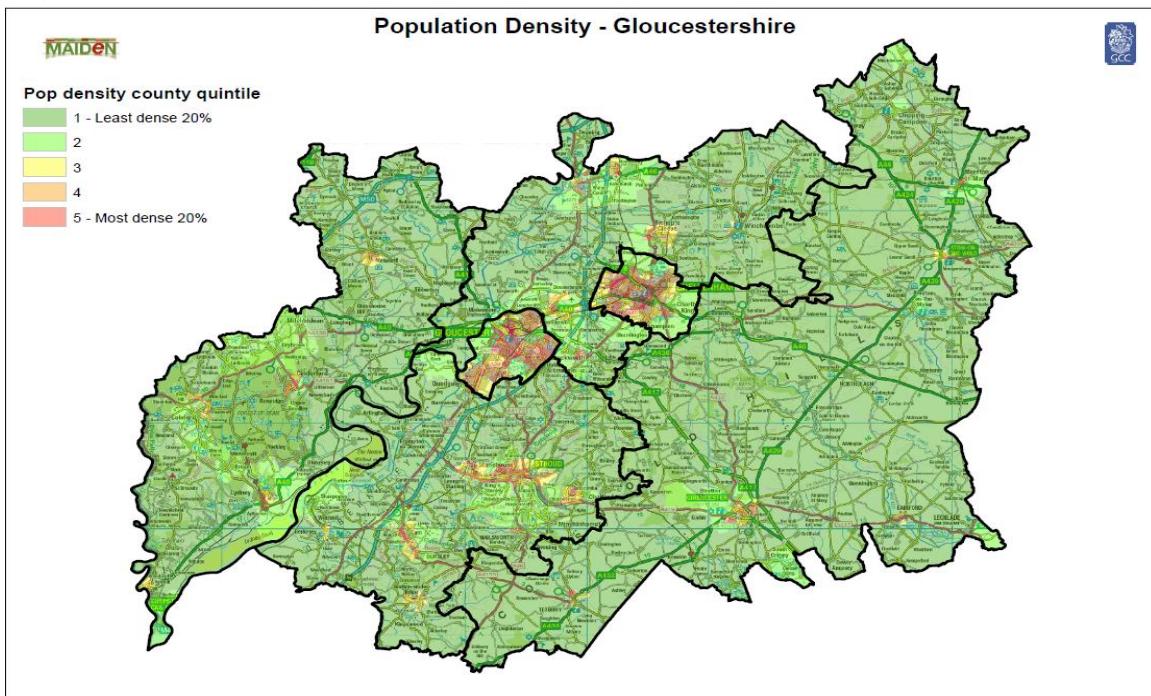
This section will describe some of the demographic issues within Gloucestershire that are pertinent to the sexual health status of the county's population. It will also highlight some of the communities that have been identified as priority groups in the Gloucestershire Sexual Health Strategy.

General information and the demographic profile of Gloucestershire is available within the context of the Joint Strategic Needs Assessment (JSNA). In terms of sexual health it is important to note:

### 2.1 Demographic data

Gloucestershire is a two tier county, having a county council and six district councils. Gloucestershire covers an area of 1,220 square miles. Whilst Gloucester and Cheltenham, are the two main urban centres, there are conurbations in each of the districts, Gloucestershire is a predominantly rural county. Almost 80% of the county comprises of Lower Super Outputs Areas (LSOAs)<sup>7</sup> areas classified as a being a village, hamlet, or containing isolated dwellings; however 20% of the county's population reside in these areas, compared to 40% living in Gloucester and Cheltenham (Figure 1).

Figure 1 Map showing the population density for Gloucestershire



### 2.1.1 Age profile

The population of Gloucestershire is approximately 602,000 (ONS, 2012) with; 22.9% aged 0-19; 58.5% aged 20-64 and 18.7% aged 65 and over. Gloucestershire has a lower proportion of 0-19 year olds and 20-64 year olds compared to the national average but the 65+ population exceeds the national average (table 1).

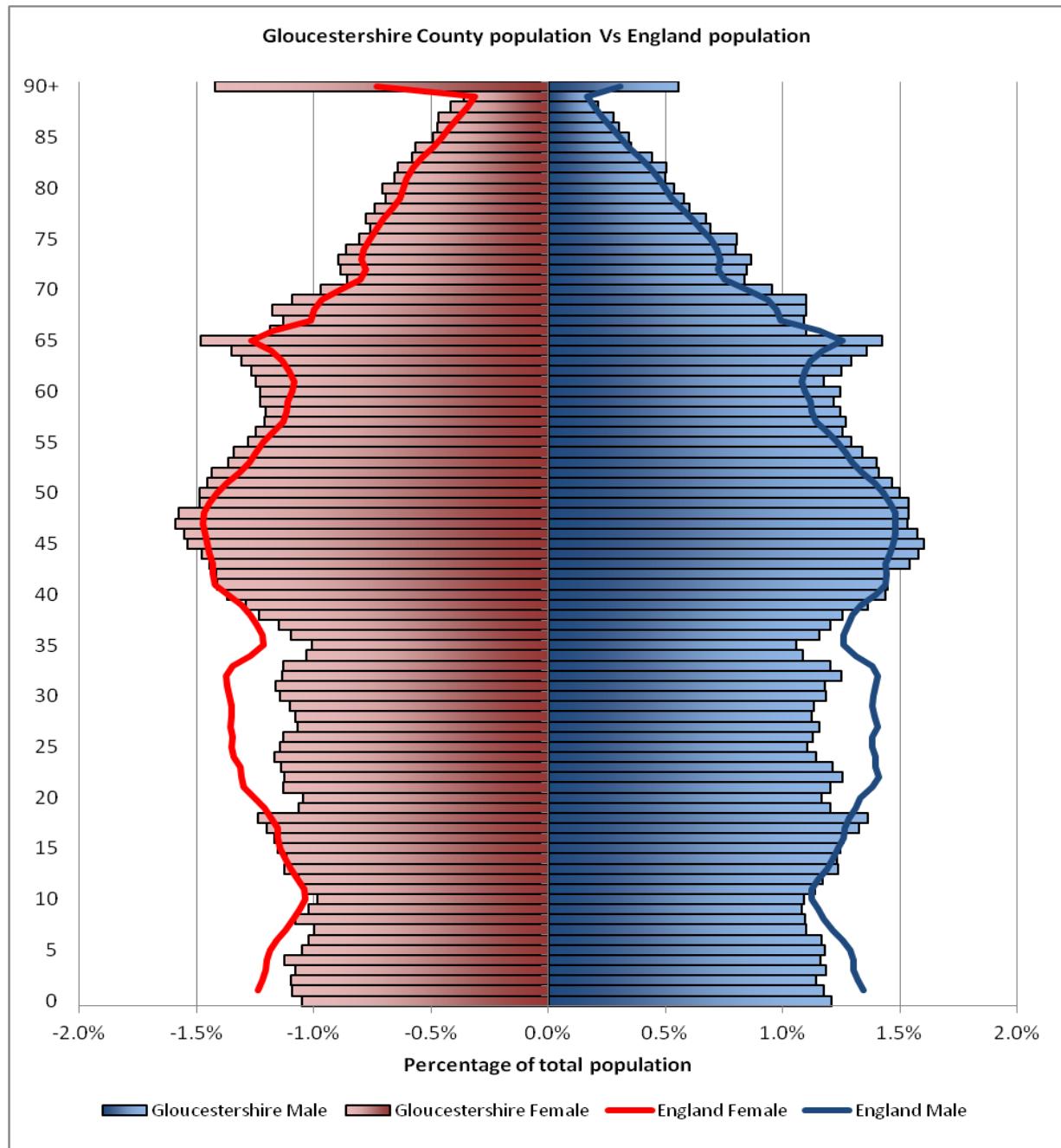
Table 1 - Population by broad age group

	Total Population (Number)	% 0-19	% 20-64	% 65+
<b>Cheltenham</b>	115,732	22.4	60.9	16.7
<b>Cotswold</b>	82,881	21.2	56.5	22.3
<b>Forest of Dean</b>	81,961	22.5	56.7	20.7
<b>Gloucester</b>	121,688	25.1	60.1	14.8
<b>Stroud</b>	112,779	23.0	57.5	19.5
<b>Tewkesbury</b>	81,943	22.1	57.8	20.1
<b>Gloucestershire</b>	596,984	22.9	58.5	18.7
<b>England</b>	53,012,456	24.0	59.7	16.3

Source: Census 2011

There are slightly more females (51.0%) than males (49.0%), which is similar at the district, regional and national level. As age increases females outnumber males by an increasing margin, for people aged 85+ females account for 67.4% of the total population (Figure 2).

Figure 2 Population pyramid of Gloucestershire Vs England Population 2012



Source: ONS 2012

### 2.1.2 Disability

According to the 2011 Census 16.7% of Gloucestershire residents reported having a long term limiting illness. This was below the national average. The Forest of Dean had the

highest proportion of residents reporting a long term limiting illness (19.6%) and was the only district that exceeded the national average (see Table 2 below).

*Table 2 - Long Term Limiting Illness or Disability*

<b>Location</b>	<b>With a long term illness or disability (%)</b>
<b>Cheltenham</b>	15.1
<b>Cotswold</b>	16.1
<b>Forest of Dean</b>	19.6
<b>Gloucester</b>	16.8
<b>Stroud</b>	16.7
<b>Tewkesbury</b>	16.5
<b>Gloucestershire</b>	16.7
<b>England</b>	17.6

Source: Census 2011

### **2.1.3 Ethnicity**

According to the 2011 Census 95.4% of Gloucestershire's population was white. Black or Ethnic Minorities make up the remaining 4.6% of the population, which is considerably lower than the 14.6% reported for England as a whole. Gloucester has the highest proportion of people from a Black or Ethnic Minority, at 10.9% of the total City's population (see Table 3).

*Table 3: Population by broad ethnic group*

	<b>White (%)</b>	<b>Black or Ethnic Minority (%)</b>
<b>Cheltenham</b>	94.3	5.7
<b>Cotswold</b>	97.8	2.2
<b>Forest of Dean</b>	98.5	1.5
<b>Gloucester</b>	89.1	10.9
<b>Stroud</b>	97.9	2.1
<b>Tewkesbury</b>	97.5	2.5
<b>Gloucestershire</b>	95.4	4.6
<b>England</b>	85.4	14.6

Source: Census 2011

In 2011 the Asian/Asian British ethnic group accounted for the largest proportion of Black or Ethnic Minorities in the County (see Table 4).

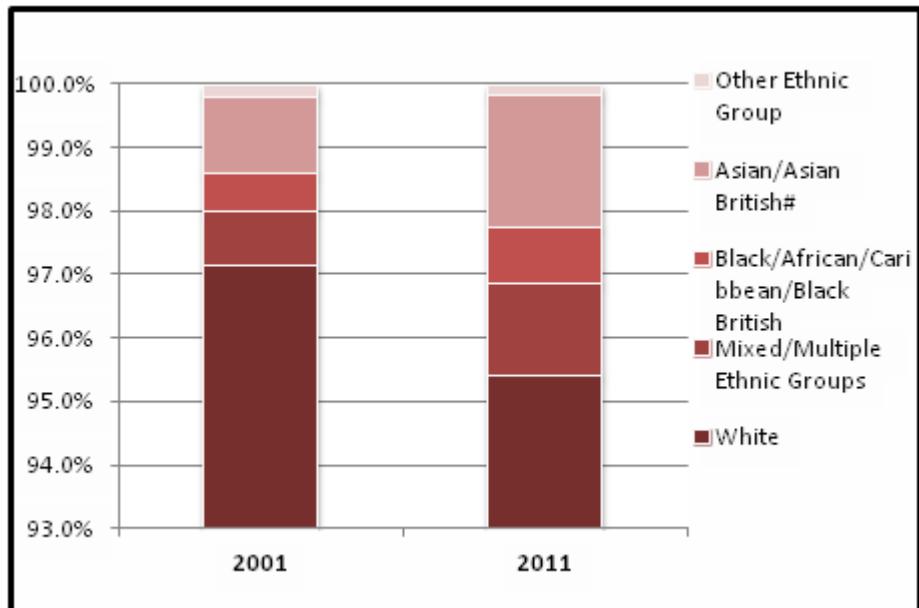
*Table 4 - Breakdown of black and ethnic minority population*

	<b>Total Black or ethnic Minority</b>	<b>Mixed / Multiple Ethnic Group</b>	<b>Asian / Asian British</b>	<b>Black / African / Caribbean / Black British</b>	<b>Other Ethnic Group</b>
<b>Cheltenham</b>	6,648	1,878	3,675	721	374
<b>Cotswold</b>	1,806	698	794	229	85
<b>Forest of Dean</b>	1,262	528	473	199	62
<b>Gloucester</b>	13,226	3,565	5,839	3,486	336
<b>Stroud</b>	2,353	1,216	751	260	126
<b>Tewkesbury</b>	2,042	776	901	255	110
<b>Gloucestershire</b>	27,337	8,661	12,433	5,150	1,093
<b>England</b>	7,731,314	1,192,879	4,143,403	1,846,614	548,418

Source: Census 2011

Figure 3 shows the ethnic composition of the County in 2011 compared to 2001. By 2011 the non white population had increased by 1.8% and made up 4.6% of the total population. The non white ethnic groups showing the biggest growth were other Asians.

*Figure 3 - Ethnic Composition in Gloucestershire 2001 and 2011*

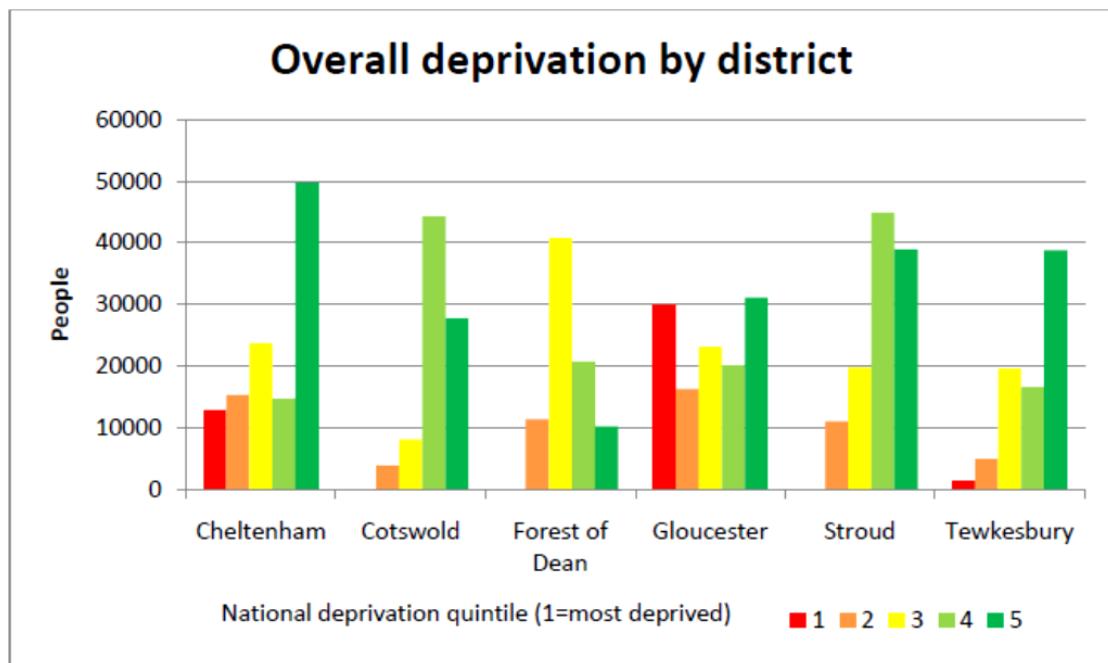


Source: Census 2001 and 2011

#### **2.1.4 Deprivation**

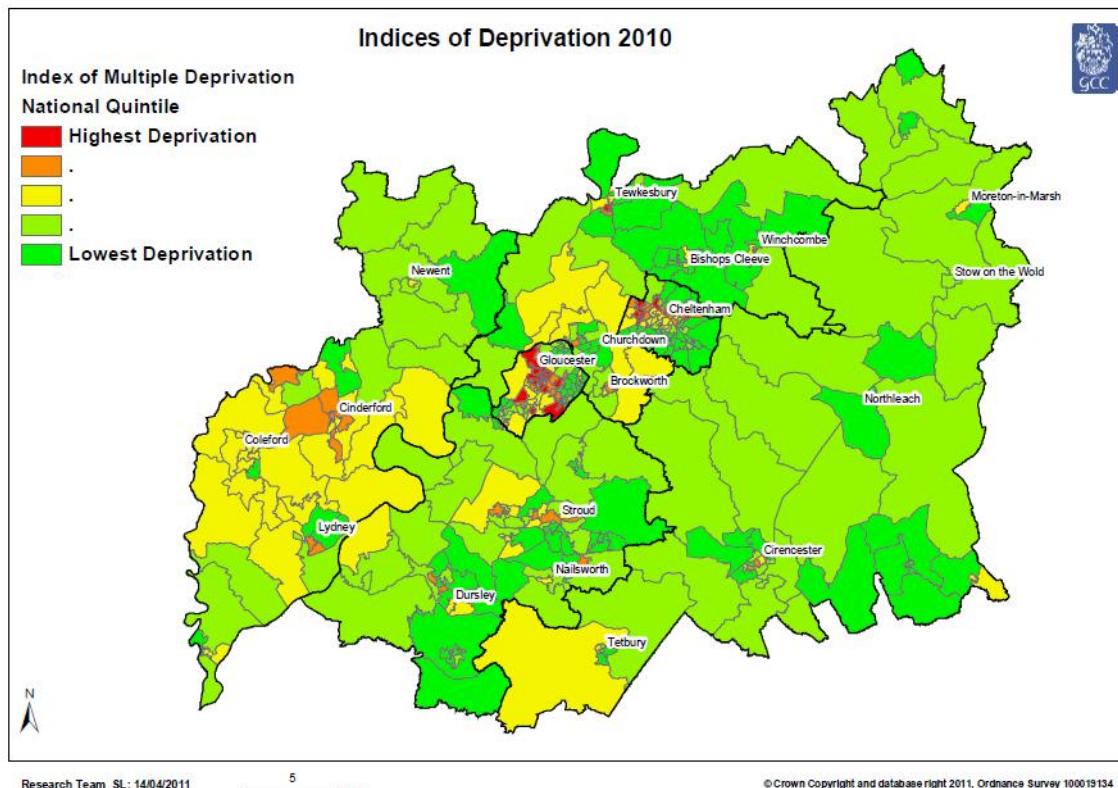
Gloucestershire is a relatively affluent county, with pockets of deprivation mostly clustered around the urban centres. It has eight neighbourhoods (Lower Super Output Areas) amongst the most deprived 10% in England calculated using the Indices of Multiple Deprivation (IOMD) 2010. These cover the wards of Podsmead, Matson and Robinswood, Kingsholm and Wotton and Westgate in Gloucester and St. Pauls, St Marks and Hesters Way in Cheltenham (Figure 4 and 5).

Figure 4 Overall deprivation by district



Source: Index of multiple deprivation 2010

Figure 5 – District Map of overall deprivation – National Quintile



## 2.2 Priority population groups

The incidence of sexually transmitted illnesses is determined by the prevalence of infection, the probability of transmission (infectivity) and the number of exposures. Therefore sexual behaviour is a key factor in determining exposure and thus the need and location for sexual health services.

Whilst the sexual health of the general population is a priority, the sexual health strategy identifies a number of specific priority groups. These groups are generally at higher risk of infection and/or exclusion from services due to sexual behaviour, social exclusion, or service inequalities.

Inequalities in sexual health may vary widely in severity and impact. Addressing the needs of these groups will require a variety of approaches and interventions. It is not only the inequality itself which must be identified and addressed wherever possible, but also how that inequality is perceived by the person experiencing it and those providing support.

The types of inequality that may be encountered are not restricted to the physical aspects of sexual health. Mental health, emotional, social, and environmental factors are equally important. Stigma and discrimination surrounding sex, sexual orientation, and sexual health are key inequalities which require to be challenged.

The safeguarding of all users of sexual health services is of paramount importance. All services will need to ensure that policies and procedures relating to the safeguarding of children, young people<sup>8</sup> and vulnerable adults<sup>9</sup> are adhered to, that staff have undertaken training appropriate for their profession and role, and that there is the appropriate representation on the local safeguarding boards. All staff working within sexual health services will have undertaken an enhanced disclosure and barring service (DBS) checks.

The priority groups, along with an overview of why they are likely to have poorer levels of sexual health, can be seen below:

### 2.2.1 Black and Minority Ethnic Communities (BME)

Sexual health within this group is frequently perceived to be poorer compared to the general population and to their White British counterparts. Various studies have looked at this topic and found a number of barriers to accessing services. In particular, *A Systematic review of ethnicity and health service access for London (2001)*<sup>10</sup> ; identified the following three dimensions of inequitable access:

- having equal access via appropriate information;
- having access to services that are relevant, timely, and sensitive to the person's needs;
- being able to use the health service with ease, and having confidence that you will be treated with respect

Black African ethnic groups have been shown to have higher rate of new HIV diagnoses. National Institute for Health and Care Excellence (NICE) guidance produced in 2012 aimed to increase testing within these communities.<sup>11</sup> In 2012, 28% of Gloucestershire residents

receiving treatment for HIV were from Black African communities. 7% were from other ethnic minority groups.

There has been no specific analysis of sexual health services as they relate to BME groups. A recommendation from this needs assessment is that a full review of service use including identifying access barriers and the needs of these communities be undertaken.

### **2.2.2 Gypsies and Travellers**

Given their transient lifestyle, gypsies and travellers are less likely to access sexual health and GP services. The Office for National Statistics 2011 and the 2011 Census tells us that 0.1% of the Gloucestershire population are within this community, this is around 731 residents. The 2002 Health and Wellbeing Report on Travellers and Gypsies in the South West, produced by the South West Public Health Observatory highlighted concerns with the provision of a number of services to these communities. Whilst most had improved, the 2011 updated report<sup>12</sup> named Sexual Health Services, including access to contraception, as an area where provision and access was still poor. In addition, the report noted that there was anecdotal evidence concerning the risks of HIV, injecting drug users and sex workers within these communities, though there is a lack of data to support this<sup>13</sup>.

There has been no specific analysis of sexual health services as they relate to travelling communities. A recommendation from this needs assessment is that a full review of service use including identifying access barriers and the needs of these communities be undertaken.

### **2.2.3 Homeless people.**

In 2012 Gloucestershire produced a Homeless Needs Assessment, at that time there were 17,168 householders in Gloucestershire who, whilst not necessarily homeless, identified themselves as having a housing need; 267 householders in the county were homeless and in priority need and there was an estimated 30 rough sleepers in the county.

The Needs Assessment included sexual health in their review of needs for this priority group. It found:

- Evidence reviews identified high partner turnover rates among drug users and homeless young people, with sex often offered in exchange for drugs or money. It found little research into the effectiveness of interventions, including into contraception<sup>14</sup>.
- Over 50% of homeless young people reported being the victims of sexual abuse and 12% reported it as a reason for leaving home.<sup>15</sup>
- Abuse, including violence, by partners or neighbours was the main reason for a sample of Birmingham families becoming homeless.<sup>16</sup>

Participants in the homeless health care needs assessment qualitative study were asked whether they had had a sexual health check in the last 12 months. Although the majority (60%) had not been for a check, (31% had received a check and 9% did not know), 82% stated that they did know where to access contraception or services around sexual health.

48% of participants (N=50) would access sexual health information and services by using a Genitourinary Medicine (GUM) / sexual health clinic or a GP / nurse (38%). A smaller number would go to their homeless / housing project (8%) or their key worker (6%).

More local information is required to fully assess the needs of this community. A recommendation from this needs assessment is that a full review of service use including identifying access barriers and the needs of people considered as homeless be undertaken.

#### **2.2.4 Individuals who have experienced sexual coercion, rape and sexual abuse**

The South West SARC evidence review and needs assessment, produced by NHS England in 2014 states that:

Sexual violence affects large numbers of people, particularly women and children; it is estimated that in the South West 42,900 people over the age of 16 years experience some kind of sexual assault every year, and 8,108 children experience contact sexual abuse. The majority of victims choose not to report it to the police.

Between 2010-11 and 2012-13 there was an average of 3,868 sexual offences recorded by the police each year in the South West. This represents less than a tenth of estimated prevalence. Rates of police recorded sexual offences in the South West are not significantly different to the overall England average, but are higher in cities and urban areas (Bristol, Plymouth, Torbay) than in the more rural counties.

Rape, which is the most serious type of sexual offence, accounts for around 1,400 reported cases of sexual offence reported in the South West each year, of which 92% are rape of a female. There are over 500 child rapes reported each year.

A more detailed breakdown of the impact on sexual violence in Gloucestershire can be found in the Sexual Assault Referral Centre (SARC) section, found within this Needs Assessment in section 6.1.

The World Health Organisation is clear to define sexual health as it relates to sex 'free of coercion' and as such victims of sexual violence and abuse are a considered a priority for Gloucestershire.

The county is home to the Hope House SARC through which psychological and medical support is provided to victims. In addition the 'People in the Know' PinK curriculum, complied by the GCC Gloucestershire Healthy Living and Learning Team (GHLL) – due to be launched in June 2015 – has been developed to assist schools and other educational establishments embed the safeguarding message and is intended as a universal prevention tool.

Regardless of this more local information is required to fully assess services and the preventative needs of this group and as such a recommendation from this needs assessment is that a full review of service currently available be undertaken in line with the recommendations of the SARC review and the Gloucestershire Domestic Abuse and Sexual Violence Strategy 2014.

#### **2.2.5 Individuals with a physical, sensory or learning disability.**

Access to services has a significant impact on an individual's sexual health and the ability to choose how they would like to manage their choices regarding contraception, treatment, care and information.

Ease of access is further influenced by an individual's mobility in relation to finding and funding appropriate transport, confidentiality, where accessing services requires the assistance of another person, appropriate equipment for individuals needs within services and understanding of information either due to sensory conditions which require alternatives to traditional signs, leaflets and the written/spoken word or a lack of easy read signage and information.

In January 2014, data produced by Gloucestershire County Council Strategic Needs Analysis Team, in response the Building Better Lives Policy<sup>17</sup>, shows there were a total of 3,618 adults aged 18-64 receiving social care services, including reablement and other short term services. Of these, 36% (1,319) had a primary care need of learning disability, 50% (1,825) physical disability and 5% (169) mental health. Of these adults 9.4% were aged 18-25 (340 people) and 90.6% were aged 26-64 (3,278 people).

There are various sources of information around the numbers of children and young people within Gloucestershire who live with physical, sensory or learning disability. This is reinforced in the Gloucestershire Children and Young People's Needs Analysis which states: "Arriving at an accurate figure for the number of children and young people with a disability in Gloucestershire is problematic. A major challenge is that there is no one method to identify disabled children; each agency or service works to a different definition." As a result, it is a recommendation of this needs assessment that more information is sought about the number, type and range of disabilities to enable the sexual health needs of this group to be better understood.

## **2.2.6 Lesbian, Gay, Bisexual individuals and men who have sex with men (MSM).**

There is no definitive data on sexual orientation at a local or national level. A number of studies have attempted to provide estimates for the proportion of people who may identify as Lesbian, Gay or Bisexual, generating a range of different results. Estimates used by the Government Treasury, and quoted by Stonewall, suggest around 5-7% of the population aged 16+ are Lesbian, Gay or Bisexual. This would mean somewhere between 24,700 and 34,600 people in Gloucestershire are Lesbian, Gay or Bisexual (LGB). However, a more recent estimate from the ONS Integrated Household Survey suggests that nationally Lesbian, Gay and Bisexuals represent 1.5% of people aged 16 and over. If this figure applied to Gloucestershire it would mean there were around 7,400 Lesbian, Gay and Bisexuals in the county. This data source features experimental statistics, which are in the testing phase, not yet fully developed and have not been submitted for assessment to the UK Statistics Authority. It is important to note that there is concern of likely underestimated figures from this data due to reluctance of people living in a 'household environment', particularly young people, to disclose their sexual orientation in the context of a shared survey which would be seen by others in the household.

Men who have Sex with Men, (MSM) is the term is used to define men who have sex with other men but do not necessarily identify themselves as gay or bisexual, (whilst still including men who do identify themselves as gay or bisexual). MSM activity can result from periods spent in all male environments such as prison, boarding schools or via experimentation and/or fascination with high risk activity which will often occur within Public Sex Environments (PSE). There are a number of PSE sites in Gloucestershire.

We know that in particular MSM are at higher risk of sexually transmitted infection, including HIV, with 1 in 10 MSM living with HIV and 1 in 3 HIV positive men (in major UK cities) have undiagnosed HIV infection<sup>18</sup>. In Gloucestershire 41% of people living with HIV are MSM. Research also shows that gay men and lesbians are less likely to have routine screening tests than heterosexuals<sup>19</sup> and that less than half of LGB people are out to their GP<sup>20</sup>.

Whilst there are LGB support organisations within our county we do not have a thorough understanding of the needs of this group. A recommendation from this needs assessment is that a full review of service use including identifying access barriers and the needs of these communities be undertaken.

### **2.2.7 Children and young people in care and care leavers.**

Young people in general experience a higher burden of STIs and are more likely to have poorer sexual health outcomes than those over 25. Young people in care and care leavers often enter care with worse levels of health than their peers in part due to the impact of poverty, abuse and neglect with the often transient nature of their lives in care impacting on continuity with GP's, teachers and advocates.<sup>21</sup> They then go on to share many of the same health risks (including poor sexual health) and problems as their peers but often to a greater degree.<sup>22</sup>

In 2013 there were almost 480 Children in Care in Gloucestershire with 293 leaving care. Whilst this remains higher than average, over the last 10 years it does represent a slight fall on the numbers of children in and entering care in 2012. Support, including advice on sexual health issues, Chlamydia screening and C-Card registration is available to those accessing the Prospects Youth Service. Those in education are able to attend sexual health services in further education colleges or in some secondary schools in the county; there are no specific services for young people in care and no local data on their sexual health.

This evidence, in addition to the NICE Public Health Guidance 28<sup>23</sup>, Looked after Children and Young People, raises the risk of sexual exploitation for unaccompanied asylum seekers highlights the need to undertake a thorough review of service access and sex and relationship advice for Children in Care. A recommendation from this needs assessment is that a full review of service use including identifying access barriers and the needs of children and young people be undertaken. An additional recommendation is to ensure that learning from Child Sexual Exploitation enquiries eg Rotherham and Oxford are incorporated within the sexual health services in Gloucestershire.

### **2.2.8 Migrants.**

A 2014 briefing by the Migration Observatory at the University of Oxford<sup>24</sup> provides an overview of evidence around the health of migrants in the UK. The briefing highlights children and women who have suffered physical and sexual abuse and includes details from a rare quantitative study (Zimmerman et al. 2008). It found that 70% of women internally or internationally trafficked for sex work or domestic service in selected European countries including the UK had experienced both physical and sexual abuse during trafficking.

The briefing also looks at evidence around barriers to attending services which include inadequate information, particularly for new migrants unfamiliar with health care systems in the UK, insufficient support in interpreting and translating for people with limited English fluency, lack of access to reliable transport because of poverty and poor services in areas of

deprivation where many recent migrants live, confusion around entitlement to some types of services particularly among migrants with insecure immigration status as well as among service providers and cultural insensitivity of some front line health care providers (Phillimore et al. 2010; Johnson 2006). Some of these barriers, such as information, language and transport, appear to cut across length of residence, affecting longer established migrants as well.

In Gloucestershire, the Gloucestershire Action for Refugees and Asylum Seekers (GARAS) see around 800 clients who between them attend GARAS services just over 10,000 times in a year. These clients come from 90 different countries with Iran, Afghanistan, Iraq and Eritrea having the highest representation.

GARAS provide help and support for clients requiring sexual health services, which includes attending services with clients when requested. GARAS also provide support for people living with HIV and their friends, families and carers and are able to offer HIV testing when needed.

As with other priority groups more work is required to understand the specific sexual health needs of migrants and what barriers to service access may exist within the county. A recommendation from this needs assessment is that a full review of service use including identifying access barriers and the needs of these communities be undertaken.

### **2.2.9 Older people.**

A frequent, incorrect, assumption is that issues around sexual orientation, sexual behaviour and sexual health belong to young people. This is not the case. Men and women continue to participate in sexual activity throughout their lives, infection and illness occurs in all ages and whilst some are sexually transmitted, others, which are not, can have a significant impact on a healthy sex life.

The 2014 National Survey of Sexual Attitudes and Lifestyles (NATSAL) included people up to aged 75. The survey states that 75% of men and 59% of women aged between 55 and 64 reported regular sexual activity with these percentages being 57% men and 37% women aged between 65 and 74 reporting likewise.

Perception and stigma around sexual health and young people focused services are seen as a barrier to access for older people. Gloucestershire recently published a sex and relationship guide for over 50's with a view to normalising sexual activity and health and to advise where and how support and services can be found. With an increasing number of over 50's in the county a review of need and services access should be undertaken to ensure this priority group is appropriately served. A recommendation from this needs assessment is that a full review of service use including identifying access barriers and the needs of these communities be undertaken.

### **2.2.10 People living with HIV.**

The Public Health England HIV in the United Kingdom 2014 report estimates there to be 107,800 people living with HIV (PLWHIV) in the UK. As at December 2012 there were 341 residents of Gloucestershire were living with HIV (more information on prevalence rates within districts can be found later in this assessment). Since the significant development of antiretroviral treatment (ART) PLWHIV can expect a near normal lifespan if they are

diagnosed promptly. That said, treatment regimes are complex and the impact of this plus the stigma still associated with HIV can have a significant impact on quality of life. People diagnosed with HIV late continue to have a ten-fold increased risk of death in the year following diagnosis compared to those diagnosed promptly. Late diagnoses rates are calculated over three rolling years with the current rate for Gloucestershire telling us that 44.3% of people diagnosed with HIV in Gloucestershire were considered as after a point treatment should have begun and as such defined as 'late'.

While the vast majority do not have HIV, gay, bisexual men and other men who have sex with men (MSM) continue to be the group most affected by HIV infection with African men and women also significantly affected. One in four people living with a diagnosed HIV infection is now aged 50 years and over. This is due to improved survival and continued transmission and signals a need to develop services appropriate to an ageing population.

Early identification of HIV can be influenced by improved access to testing and improved awareness of HIV prevention, in addition access to condoms and partner notification (a system where, with consent, partners of people diagnosed with a sexually transmitted infection such as HIV and notified and treated) has a significant impact on reducing the transmission of HIV.

In Gloucestershire the Eddystone Trust work closely with the HIV treatment and Sexual Health services to increase testing and awareness of HIV within the county including working closely with communities known to be most at risk. The service provided by the Eddystone Trust is required to assess the needs of people living with HIV every two years. The next assessment is due in 2015 and should be reviewed in the broader context of sexual health services and prevention at this time.

### **2.2.11 Rural or deprived communities.**

Access to sexual health services is known to be vital when it comes to preventing poor sexual health and supporting the community.

Gloucestershire has significant areas of rurality, within these and within urban areas are a number of communities which would be considered amongst the most 20% deprived in the county (see section 2.1.4 for a more detailed breakdown). People living in areas of deprivation are often most at risk of negative outcomes in relation to sexual health such as sexually transmitted infections and unwanted pregnancies.

Within Gloucestershire sexual health services are available within each district to reduce the need to travel to urban centres and additional services are provided from further education sites and primary care settings – including GP practices and community pharmacies.

More work is required to assess the location of these services to ensure they are accessible to these communities. A recommendation to this effect has been identified in section 4.7 of this needs assessment.

### **2.2.12 Sex workers, including people who have been trafficked**

There are a number of organisations within Gloucestershire who provide support where possible to sex workers including those who have been trafficked into the sex industry. Most notably the ISIS women's centre in Gloucester provides support for long and short term

needs of women including working with Gloucestershire Care Services (GCS), the main provider of sexual health services in the county. In addition to their work with ISIS GCS provide a range of support to meet the health needs of sex workers, both male and female. Regular testing and Hepatitis vaccination is provided to workers in the adult sex industry.

GCS are in attendance at a monthly 'Street Workers' drop in, where they offer health advice and nurse support. Where possible, testing/treatment and advice, contraception and EHC and pregnancy advisory services are offered. The importance of trust within this vulnerable community is paramount, and a fast track pathway for referral in to level 3 services is offered when required.

Support for this group entails sexual health advice and discussions around safety and assessing risk and an assessment of coercion or potential trafficking. There is onward referral to support services when a worker wishes to exit from sex work along with referral to the national 'Ugly Mug' scheme<sup>25</sup>.

Links to GARAS, the Gloucestershire SARC and other bespoke support networks are utilised where relevant, in particular for people who have been trafficked.

Information and data encompassing a comprehensive view of those working in the sex industry in Gloucestershire is not readily available. A recommendation from this needs assessment is that a full review of service use including identifying access barriers and the needs of this community be undertaken.

### **2.2.13 Substance users including injecting drug users**

It is estimated that at the end of March 2012 there were 1845 people receiving treatment for substance misuse in Gloucestershire, 1494 of these were relating to drug misuse and 351 for alcohol misuse. Of the 1494 clients in drug misuse treatment, 23% were current injectors and 41% had previously injected.

Illegal drug and alcohol use influence decision making and contribute to heightened risk taking behaviour, therefore leading to increased risk of sexually transmitted infection and unplanned pregnancy. In 2011 The Royal College of Physicians, in conjunction with British Association of Sexual Health and HIV<sup>26</sup> (BASHH), published their report 'Alcohol and sex: a cocktail for poor sexual health'<sup>27</sup> suggested that many as 1 in 5 attendees at sexual health services had consumed hazardous levels of alcohol. The report highlights the potential of providers of sexual healthcare as being well placed to respond to problems of both alcohol use and sexual ill health. Since 2014 brief interventions regarding alcohol use has been provided to all those identified as at risk due to alcohol consumption within Gloucestershire sexual health services. These interventions are intended to prevent future risk taking behaviours and are one of the recommendations from the 2011 report.

These individuals do carry a risk of contracting Hepatitis B and C. We are not able to establish the actual prevalence of HCV (Hepatitis C Virus) infection for Gloucestershire, but Hepatitis C among people who inject drugs: Local area estimates of prevalence to guide those who commission services in England estimates that the prevalence of Hepatitis C antibodies within the injecting drug using population is 36% (midpoint 80% credibility interval 28-40%). In 2013-14 approximately 10% of those screened for HCV within specialist drug treatment service were HCV +ve.<sup>28</sup>

In 2013, the coalition government launched Shooting Up: Infections among people who inject drugs in the United Kingdom 2013, and an update November 2014<sup>29</sup>. In relation to sexual health this document stated:

- In England around half (49%) of people who inject psychoactive drugs have been infected with Hepatitis C. However, about half of those infected remain undiagnosed. The data suggest that about two in five of those who inject psychoactive drugs are currently living with Hepatitis C infection in the UK.
- In England and Wales, among those who inject image and performance enhancing drugs, 3.6% had antibodies to Hepatitis C in 2012-13.
- 90% of Hepatitis C exposures are as a result of injecting drug use (sharing used injecting equipment).
- HIV infection among people who inject psychoactive drugs remains low compared to that in many other countries, with 1.2% having HIV in 2013.
- Hepatitis B infection is now rare, 4.4% exposures associated with injecting drug use, due to increased vaccine uptake and a decline in the sharing of injecting equipment.
- 17% of injecting drug users are antibody positive, less than 1% of this group are currently infected.
- The injection of amphetamine-type drugs, which have been associated with higher levels of infection risk, has become more common.

Among those injecting image and performance enhancing drugs (IPED) the level of HIV infection is similar to that among people who inject psychoactive drugs. The proportions of people injecting IPED ever infected with Hepatitis B and C are lower than among people who inject psychoactive drugs, but probably higher than in the general population.

#### **2.2.14 Transgender individuals.**

Trans embraces many different types of people and lifestyles, including:

- People who cross-dress (transvestite people). These people sometimes wear the clothing of the opposite sex, but don't want to live full-time as a member of the opposite sex.
- People who feel that they're both male and female, or neither male nor female.
- Drag queens, drag kings and other people who don't appear conventionally masculine or feminine.
- Transsexual people. These are people who have a strong and constant desire to live and be accepted as a member of the opposite sex. Many transsexual people have gender reassignment treatment to make their appearance more consistent with their preferred gender. This often involves hormone therapy and surgery.

Trans people often have complex gender identities (their idea of who they are), and their gender identity may change over time. For example, a man may begin by cross-dressing occasionally, and then decide later in life that he wants to live full-time as a woman (which is called transitioning).

Some people who live full-time as the opposite gender prefer not to use the term "trans" at all. For example, a trans man (someone who has transitioned from female to male) may simply prefer to be called a man.<sup>30</sup>

There is sparse evidence based research on the number of trans people living in the UK with issues around self identification being a barrier to fully understanding the size of this community.

It is common for trans people to face discrimination and harassment with many experiencing a lack of understanding, extending to rejection and abuse from family, friends, work colleagues and strangers. This can extend to transphobic comments and abuse, bullying and name calling resulting in social isolation and exclusion. Lack of understanding of trans issues extends to health professionals with issues of awkwardness and embarrassment from staff and other service clients adding an additional barrier to trans people accessing services. Insufficient information exists in relation to how this specifically relates to sexual health services. A Health Needs Questionnaire has been circulated within the known trans community in the county and the results of this are expected imminently. As such, it is a recommendation of this assessment to analyse the results of this questionnaire as they relate to sexual health services and propose any related actions to the Gloucestershire Sexual Health Strategic Partnership Group for consideration.

## **2.2.15 Mental Health**

We are made aware of the links between sexual health risk behaviour and mental ill health/lower levels of wellbeing in the 2011 HM Government document *No Health without mental health*<sup>31</sup>.

The publication is also clear in relation to the mental health impact of sexual abuse, violent assault, gender and sexuality issues and, along with the Gloucestershire Suicide Prevention Strategy<sup>32</sup>, identifies the impact this has suicide and self harm rates within these communities.

Whilst some data is provided by the Public Health England Community Mental Health Profiles<sup>33</sup> on the numbers of adults in Gloucestershire with long term mental health problems and the prevalence of depression and anxiety there is no information readily accessible to identify where this may link to sexual health. As a result it is a recommendation of this needs assessment to further explore the link between mental health and sexual health.

### **2.2 Summary of Recommendations and Actions for Priority Population Groups:**

A full review of service use including identifying access barriers and the needs of the following priority groups and communities should be undertaken during.:

2.2.1 A full review of sexual health services for BME groups, including identifying access

barriers and the needs of these communities be undertaken.

2.2.2 A full review of service use including identifying access barriers and the needs of Gypsies and Travellers be undertaken.

2.2.3 A full review of service use including identifying access barriers and the needs of people considered as homeless be undertaken.

2.2.4 A full review of service currently available for victims of sexual coercion, rape and sexual abuse (to include prevention interventions) be undertaken in line with the recommendations of the SARC review and the Gloucestershire Domestic Abuse and Sexual Violence Strategy 2014.

2.2.5 Information about the number, type and range of disabilities is better understood in the county.

2.2.6 A full review of service use including identifying access barriers and the needs of LGB and MSM be undertaken.

2.2.7

a) A recommendation from this needs assessment is that a full review of service use including identifying access barriers and the needs of children and young people be undertaken.

b) An additional recommendation is to ensure that learning from Child Sexual Exploitation enquiries eg Rotherham and Oxford are incorporated within the sexual health services in Gloucestershire.

2.2.8 A full review of service use including identifying access barriers and the needs of migrants be undertaken.

2.2.9 A full review of service use including identifying access barriers and the needs of older people be undertaken.

2.2.10 The service provided by the Eddystone Trust is required to assess the needs of people living with HIV every two years. The next assessment is due in 2015 and should be reviewed in the broader context of sexual health services and prevention at this time.

2.2.12 A full review of service use including identifying access barriers and the needs of sex workers, including people who have been trafficked be undertaken.

2.2.14 To analyse the results of the Gloucestershire transgender health questionnaire as they relate to sexual health services and propose any related actions to the Sexual Health Strategic Partnership Board for consideration

2.2.15 To further explore the link between mental health and sexual health.

### **3 Reproductive Health**

This section of the needs assessment will describe the contraception services available across the county, the evidence base supporting these programmes and identify areas for further development. It will then go on to describe the data around under 18 conceptions and the rationale for the on-going work in this area. Finally, this section will describe the abortion services available and trends associated with this service.

#### **3.1 Contraception**

All available, licensed forms of contraception are available, without access limits, to Gloucestershire residents.

These include:

- Long Acting Reversible Contraception including
  - copper intrauterine devices
  - progesterone-only intrauterine systems (IUS)
  - progesterone-only injectable contraceptives (IUD)
  - progesterone-only subdermal implants
- contraceptive injections - Depot Medroxyprogesterone Acetate (DMPA)
- Condoms
- All forms of licensed contraceptive pills
- Natural family planning/fertility awareness as applied to contraception
- Vaginal ring
- Diaphragms or cap
- Emergency Contraception in the form of:
  - Emergency IUD
  - Levonorgestrel
  - Ullipristal acetate
- Specialist consultant led services are also available for IUD/IUS problem clinics for contraception, difficult implant insertion/ removal, women with complex needs i.e. prescribing, co-morbidity, learning disability.

All forms of contraception are available from Specialist Sexual Health Services and GP Practices offering Enhanced Services whilst GP Practices not offering Enhanced Services provide all contraceptives with the exception of IUD/IUS and implants.

A network of specially trained community pharmacists also provide emergency contraception and condoms, as do some specialist Public Health Nursing Services and sexual health outreach services in selected educational settings. For details of where these are located see Appendix 5.

### 3.1.1 Long Acting Reversible Contraception (LARC)

Increasing access to long-acting reversible contraception (LARC) for women of all ages is one of the priorities identified in the 2013 'Framework for Sexual Health Improvement in England'. NICE has issued guidance which states that LARC is a cost effective method of contraception and increasing uptake will reduce unintended pregnancies. An increase in the provision of LARC is a proxy measure for wider access to the range of contraceptive methods and should also lead to a reduction in rates of unintended pregnancy.<sup>34</sup>

LARC is defined in the NICE guidance as contraceptive methods that require administration less than once per cycle or month.

It is estimated that about 30% of pregnancies are unplanned<sup>35</sup>. The effectiveness of the barrier method and oral contraceptive pills depends on their correct and consistent use. By contrast, the effectiveness of long-acting reversible contraceptive methods does not depend on daily concordance.

LARC devices are available at all specialist sexual health sites with access to these services increased by the commissioning of IUD/IUS and implants from GP Practices throughout the county. To receive required accreditation to perform these procedures clinicians must complete 6 implant and 12 IUD/IUS fits or removals in a 12 month period. Including the provision of contraceptive injections (already part of a GP's service to patients) any practice which fits at or above these numbers is considered as a 'full LARC' practice.

In 2013/14, 83% of LARC device fittings in Gloucestershire were performed within GP practices. In relation to the national picture Gloucestershire has a high level of full LARC delivery from surgeries throughout the county. Public Health England sexual health profiles show us that in the same year Gloucestershire has a rate of 82 per 1000 women aged 15-44yrs receive LARC from their GP compared to a rate of 53 in England and 73 in the South West.

Overall numbers of LARC method for the county are shown below whilst Figure 7 shows a breakdown of LARC methods by district.

In 2013/14 Gloucestershire GP's provided:

- 14845 DMPA injections
- 3151 Intrauterine Contraceptive Device (IUCD) and,
- 2560 contraceptive implants.

\*it is worth noting that DMPA injections are given every 3 months, as such, this number defines the injections given and not the number of women using DMPA as a method of contraception.

Improved uptake of effective contraception has the greatest impact of reducing unplanned pregnancy. One of the most significant aspects of improving uptake is ease of access. Due to this, sexual health clinics in all districts offer LARC fitting and public health enhanced services for the fitting of implants and IUCDs are made available to all GP practices in the county. Where GP surgeries offer all types of LARC they are known as full LARC practices

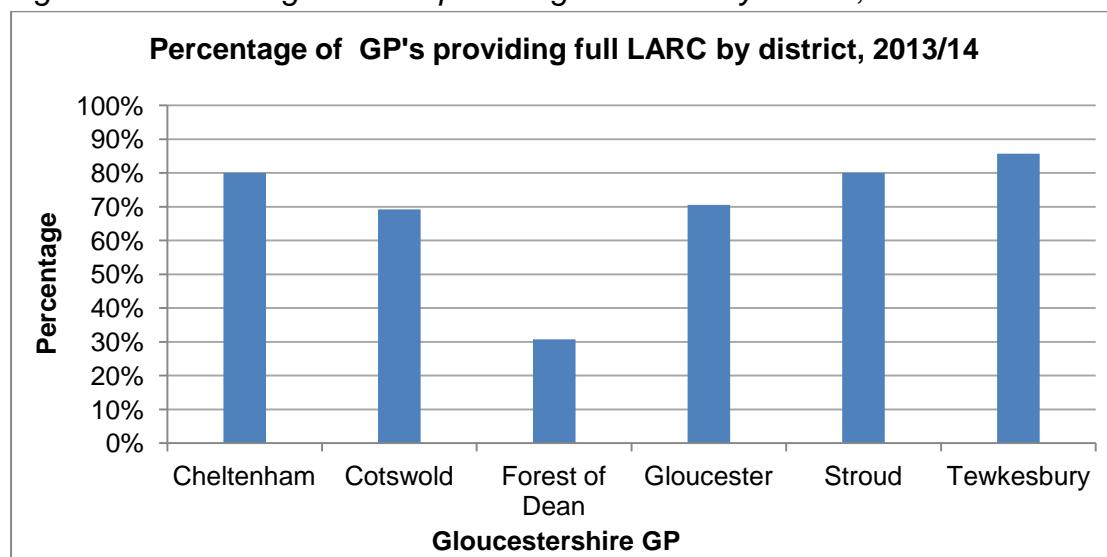
(this means they provide at least the minimum annual number of IUCD (12) and implants (6) per year, plus DMPA injectable contraception which is included as part of the standard GP contract.)

Figure 6 shows us that only the Forest of Dean has the lowest percentage of full LARC practices, with the other districts of the county having the majority of practices providing both implants and IUCD. However, Figure 7 shows us that whilst Forest of Dean practices do provide fewer IUCD and implants the difference is not representative of the difference between full LARC availability. As such, within the Forest of Dean whilst there are fewer practices offering full LARC, those that do fit higher numbers than many practices outside of this District. There is also a much higher percentage of injectable LARC provided in the Forest of Dean which is reflective of the number of practices who do not provide LARC.

Comparing Figure 6 with Figure 7 we can see there is no obvious relationship between the number of practices offering full LARC services and the amount of LARC those practices actually provide. A comprehensive review of LARC availability is under way and a recommendation of this needs assessment is that this work is completed and the outcomes shared.

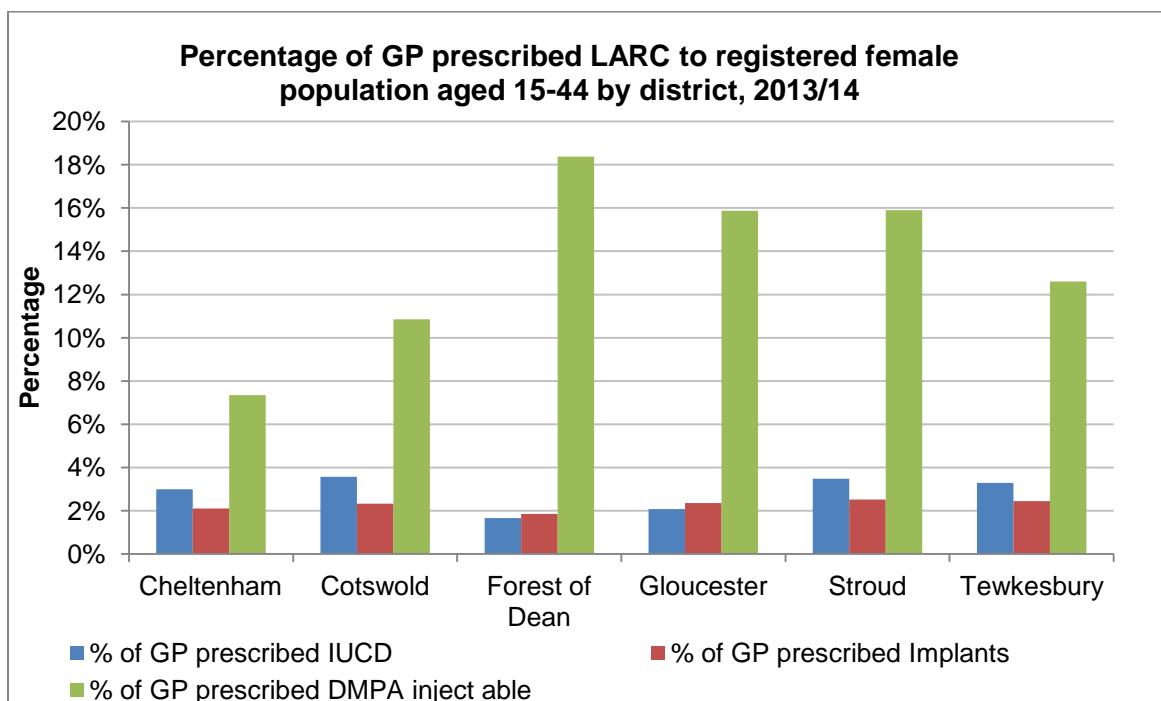
Whilst the NICE guidance evidences the case for LARC it is important to note that each option has a lifetime which ranges from 3 months for injectable contraceptive to 8 years for some IUDs. Outside of their lifetime range LARC options reduce in effectiveness and can result in unplanned pregnancy. Robust recall systems are required to ensure that those choosing LARC are aware of the need to replace or seek alternative contraception. Currently the strength of recall systems within the county is unknown and as such a recommendation of this assessment is to review current practice and develop a plan to ensure LARC methods are consistently effective.

*Figure 6 - Percentage of GP's providing full LARC by district, 2013/14*



Source: NHSGCCG, based on the GP's claims 2013/14

Figure 7 - Percentage of GP prescribed LARC to registered female population aged 15-44 by district, 2013/14



Source: NHS Prescription Service Online 'ePACT'

Access to services for LARC, both to GP Practices and Sexual Health Clinics is challenging from some areas of the county. Early work from the current review of services has shown that in some instances a car journey of over 15 minutes is required to access a provider. The mapping (Figure 8) shows that this impacts the Cotswolds and the Forest of Dean more severely than other parts of the county. Figure 9 shows access by foot or bus which adds in Stroud as an area of need with all three districts showing areas where access to services, for people without their own vehicle, is considered impossible. This assessment recommends that a review of sexual health service availability within the Cotswolds be undertaken as a priority in 2015/16.

Prescribing data for sexual health services is not currently available. To enable a clear picture of access and fitting throughout the county providers and commissioners must work together to identify this information. It is a recommendation of this needs assessment that this work is undertaken immediately on completion of this document.

Figure 8 – Map showing access to LARC services by car in Gloucestershire

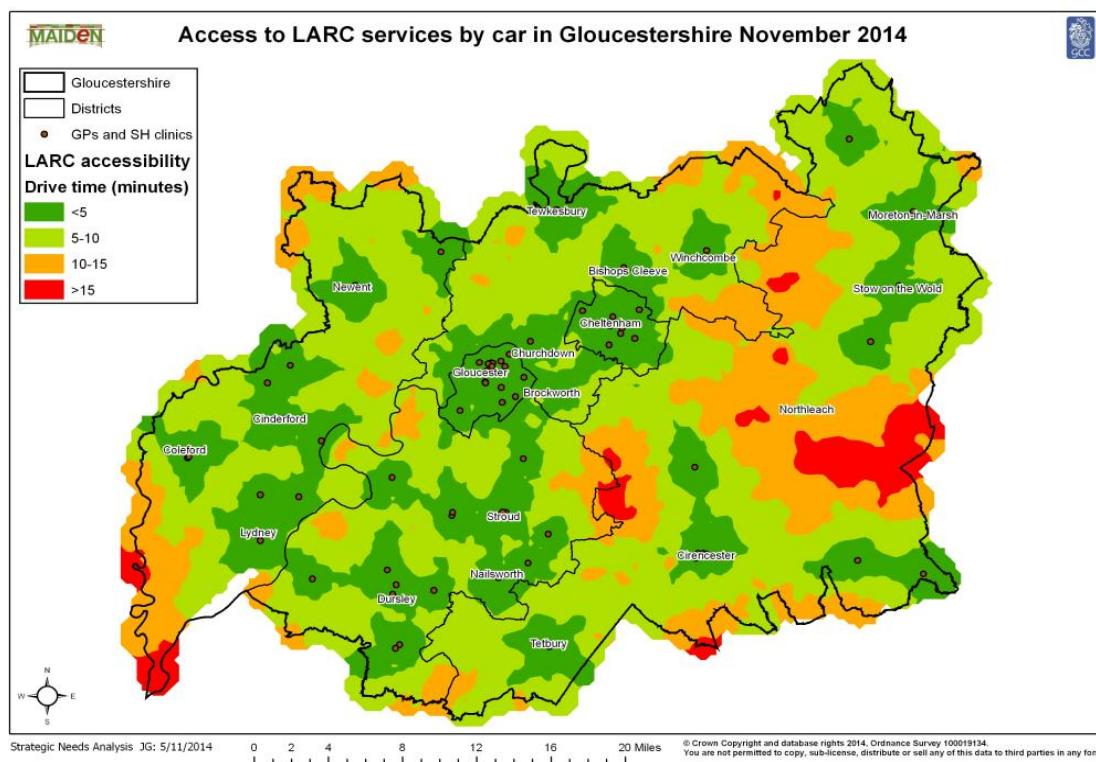
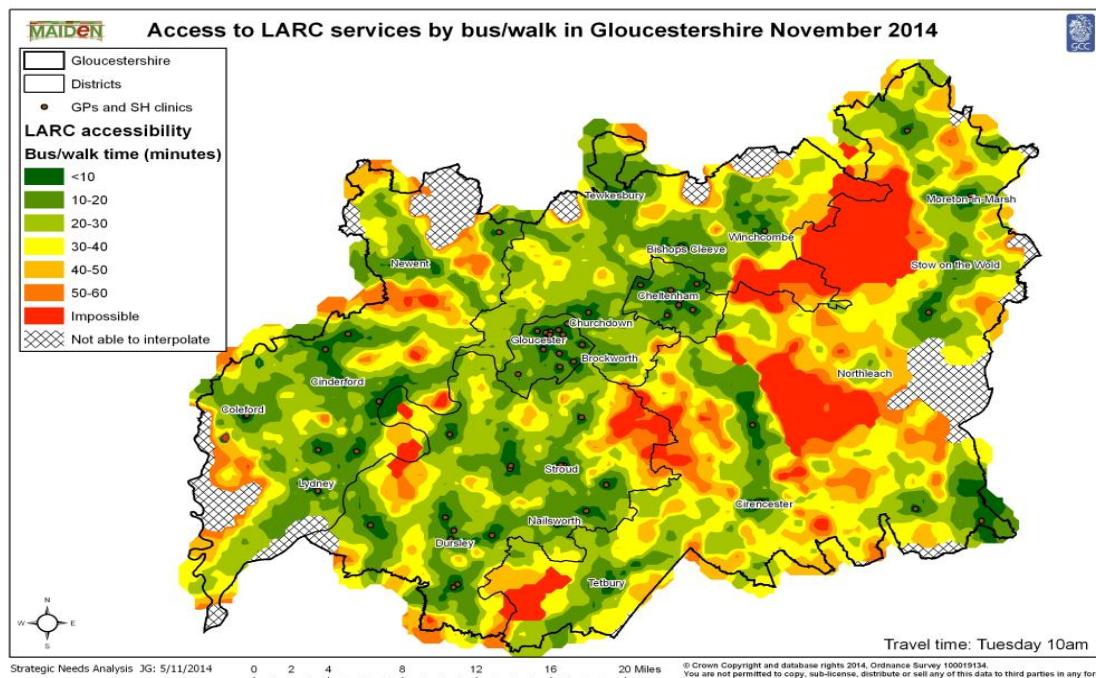


Figure 9 – Map showing access to LARC services by bus/walk in Gloucestershire



### **3.1.2 Condoms**

Condoms are very effective in preventing HIV and many other STIs when used the right way every time. They are the only form of protection against both STIs and unplanned pregnancy. Condoms, and lubricant, are available, free of charge within the county from all Gloucestershire Care Services clinics, the Gloucestershire C-Card Scheme (see below) and The Eddystone Trust. Community pharmacies who offer emergency hormonal contraception and GP Practices who offer Chlamydia screening will also provide free condoms as part of these two services. In addition to this Gloucestershire has a strong C-Card scheme.

### **3.1.3 C-Card**

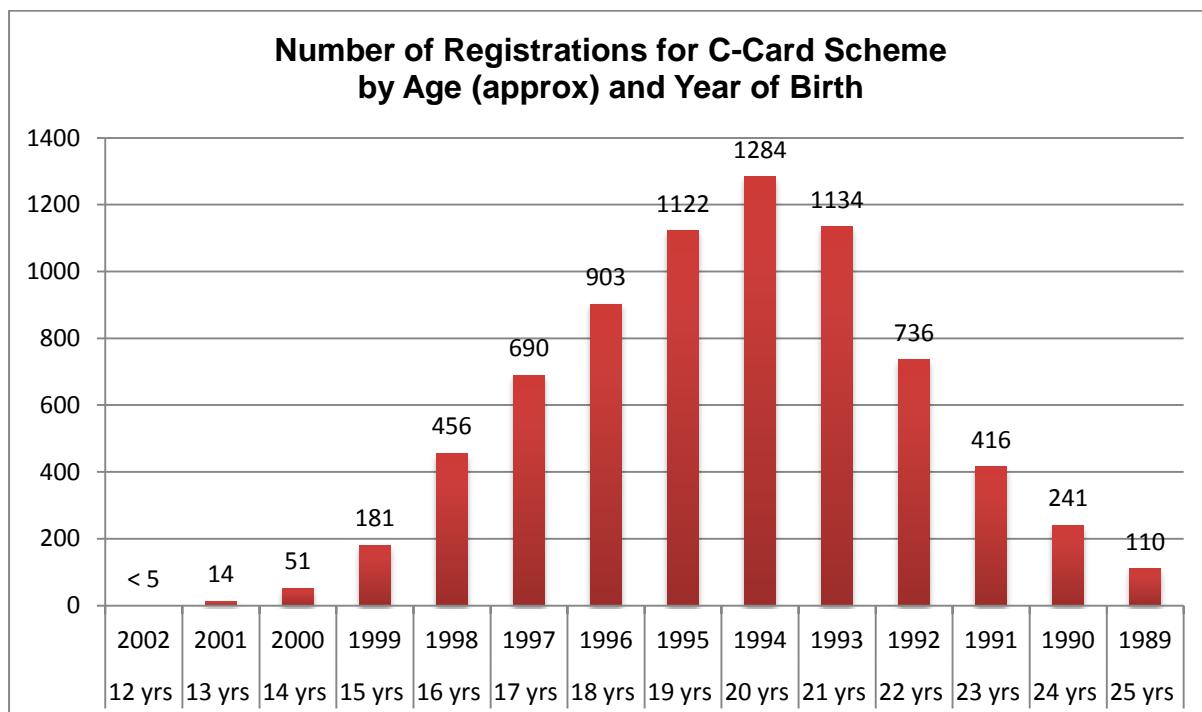
C-Card is a free condom, lubricant and dental dam distribution scheme for young people under 25 who live in Gloucestershire. Whilst not a form of contraception, a dental dam will help to prevent the transmission of STIs during oral sex. Ease of access and correct usage of both dental dams and condoms will help to reduce the prevalence of STIs within the community.

Over 17,000 condoms were issued during 2013/14 to 7,359 registered individuals under 25 years of age (Figure 10). This represents almost 5,000 more condoms issued compared to the previous year (a 40% increase). There was also an increase in registrations compared with 2012/13 with an additional 1,355 registrations in 2013/14 (males and females share a 50/50 split).

79% of young people registered for C-Card classify themselves as heterosexual, with 3% identifying as Lesbian, Gay or Bisexual, and 18% choosing not to specifically share this information. As previously stated, there is concern of likely underestimated figures from this data due to young people's lack of readiness to disclose sexual orientation in this context. This could impact the number accessing or being reached by services.

During the same period, in addition to condoms, the C-Card Scheme issued 186 dental dams and 2414 tubes of lubricant.

Figure 10- Number of Registrations for C-Card Scheme by Year Birth



Source: Prospects Youth Service Monitoring Data

The chart above shows total numbers registering for the C-Card scheme during 2013/14 and split into age and year of birth. 80% of clients were aged between 17 and 22 years old, 10.5 % were aged over 23 years, and 9.5% of clients gave an age either on or under the legal age of consent.

### 3.1.4 Emergency Contraception

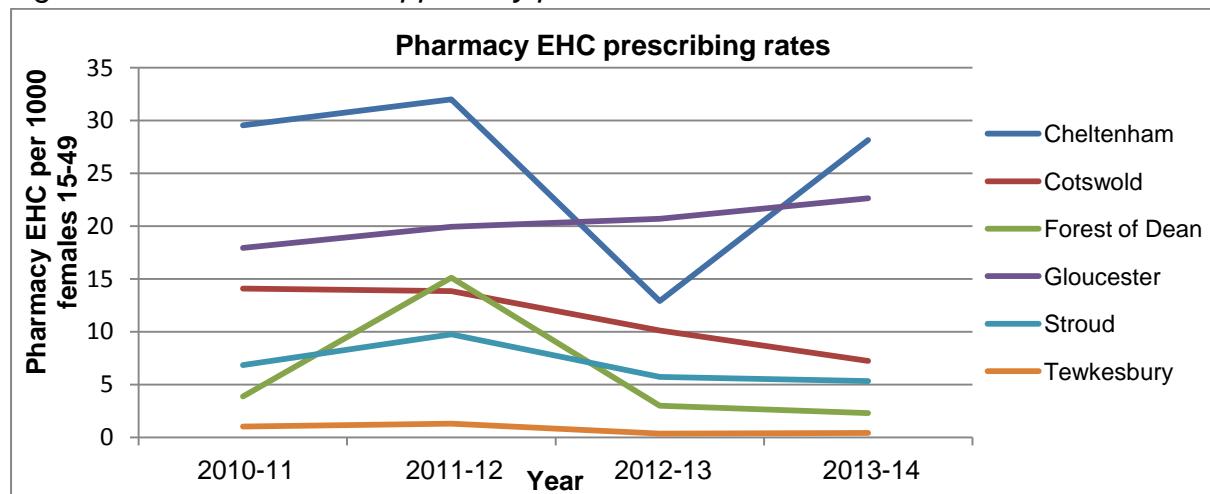
One of the potential outcomes of unprotected sexual intercourse (UPSI) is unplanned pregnancy. In definition this form of contraception is considered emergency as there is a short window of opportunity to prevent an unplanned pregnancy. A copper intrauterine device (Cu-IUD) is considered by the Faculty of Sexual and Reproductive HealthCare (FSRH) as the preferred method of emergency contraception, however, given choice and the nature of the time frame and the clinical requirements to provide a Cu-IUD, two oral forms of emergency hormonal contraception (EHC) are available. These are:

- Levonorgestrel - an emergency contraceptive pill which can be taken within 72 hours (three days) of having unprotected sex, but which is most effective if taken within 12 hours of having unprotected sex.
- Ulipristal acetate – an emergency contraceptive pill which can be taken within 120 hours (five days) of having unprotected sex, but which is most effective if taken as soon as possible after having unprotected sex.

Levonorgestrel and Ulipristil acetate both work by stopping or delaying ovulation. They can be obtained from certain community pharmacies, see Appendix 5, and all GP Practices, with Cu- IUD's being available at those surgeries who also offer LARC fitting and Advanced Sexual Health Services. The sexual health services, at all sites, will provide the full range of emergency contraception.

There are 90 community pharmacies who are commissioned to provide EHC in Gloucestershire. We can see in Figure 11 that the highest provision was in Cheltenham and the lowest in Tewkesbury. This is partly reflective of the number of pharmacies and the population. However, more investigation is required to understand the fluctuation between districts and the significant variation in the number of EHC supplies provided in some areas.

*Figure 11 – Rate of EHC supplied by pharmacies from 2010/11 to 2013/14*



Source: ONS Mid-Year Estimates and Gloucestershire Public Health Prescribing Data

It is important to note that Figure 11 displays the number of EHC supplied by the location of the pharmacy. The fact that more EHC was supplied in Gloucester and Cheltenham does not necessarily mean that these women are resident in these districts. More work is required to understand women's preferences in terms of location of sexual health services within Community Pharmacy. It is generally recognised that anonymity/confidentiality is important to those accessing EHC and a young person may feel more confident in a retail environment where they might have other reasons for being present (if seen by a friend/neighbour). The ability to be seen without an appointment is often quoted as a strong driver for accessing the service from community pharmacy generally.

An audit of EHC provision in Community Pharmacy, carried out in 2012, concluded that Gloucestershire generally has wide coverage of community pharmacies commissioned to provide free EHC as part of a sexual health service. Additionally EHC and condoms are available to purchase (Over the Counter Sales) from the majority of Community Pharmacies. There remain some areas of the county where young women may find it difficult to access free EHC from Community Pharmacy due to distance. Additionally the service may be unavailable at certain times due to lack of trained staff (for example there is a heavy reliance on locum pharmacists to cover days off, holiday and vacancies). Some pharmacies were not

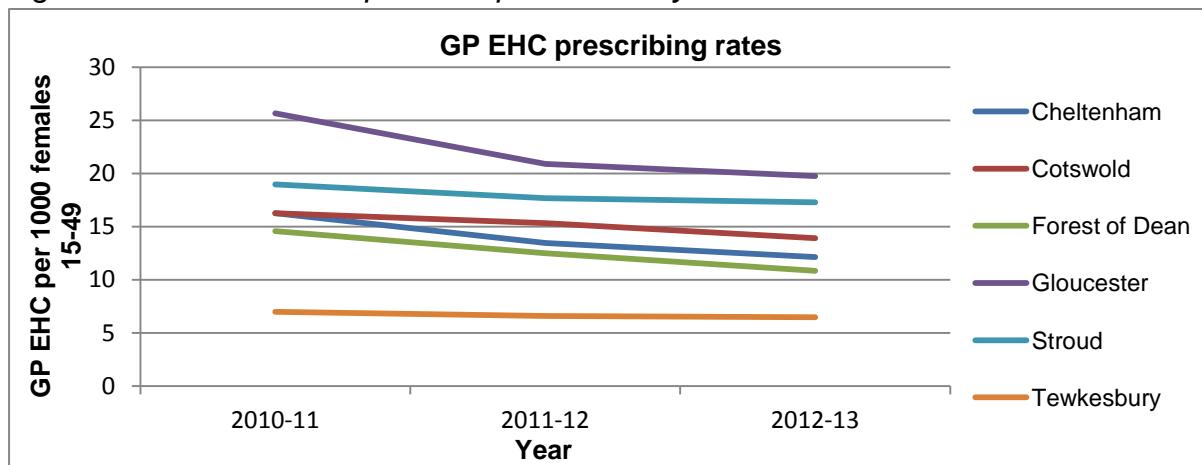
meeting the expected levels of service provision and concern was raised that availability may often be lowest when demand is likely to be highest – eg weekends and Mondays.

Work has already started to address concerns; however these issues and conclusions will be picked up as part of the recommendations from this assessment.

GP provision of EHC is more universally available than through community pharmacies. The main reason for this is that the provision of oral forms of contraception is a requirement of the standard GP General Medical Services contract. Whilst it is recognised that the urgent nature of emergency contraception provision is challenging in a busy surgery environment there are significant numbers of issue across the county.

Work should be undertaken as a result of this needs assessment to determine equitable access to all Gloucestershire residents through their GP practice.

*Figure 12 – Rate of EHC products prescribed by GPs from 2010/11 to 2013/14*



Source: ONS Mid-Year Estimates and Gloucestershire Public Health Prescribing Data

Figure 12 (above) displays the rate of EHC prescribing by GPs by District. This shows quite a variation within the county with a common reducing trend for prescribing between 2010 and 2013.

There is currently insufficient data on provision at individual practice and locality level which is a further area for investigation. It is a recommendation of this needs assessment that work be undertaken with the Gloucestershire Clinical Commissioning Group Medicine Management Team and NHS England to analyse GP prescribing of EHC over the preceding 5 years to identify and understand variances in provision. It would be useful to understand the reasons behind this downward trend. This work should include the recommendations of the pharmacy EHC audit and include pharmacy provision.

### **3.2 Unplanned pregnancy**

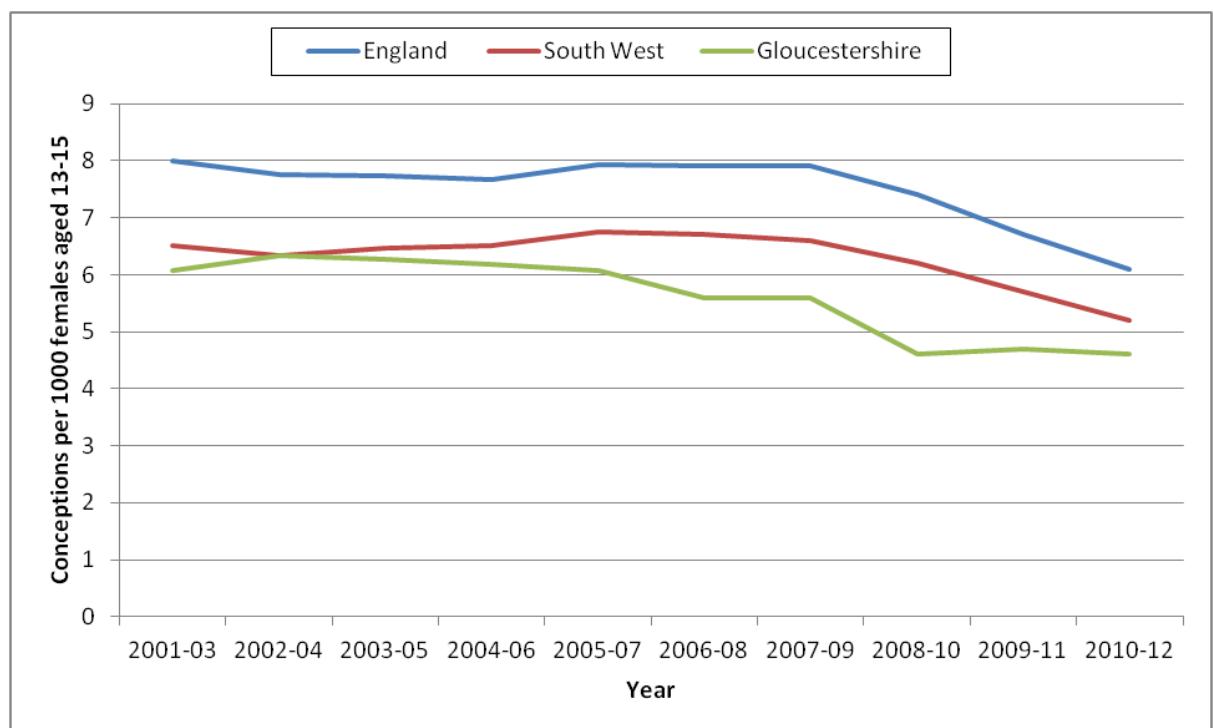
It has been estimated that approximately 1 in 3 pregnancies are unplanned<sup>36</sup>. Internationally comparable data from 1998 suggested that the UK had the highest rates of teenage motherhood in Europe.<sup>37</sup> In 1999, the government launched a 10-year national teenage pregnancy prevention strategy for England, whose aim was to halve under-18 conception rates. There is much evidence available to suggest that teenage pregnancy is associated

with a number of poor outcomes for both mother and child. While there has been a substantial reduction in the rate of teenage conception in England over the last 15 years, it is believed that these rates can be reduced further still.

### 3.2.1 Under 18 conceptions

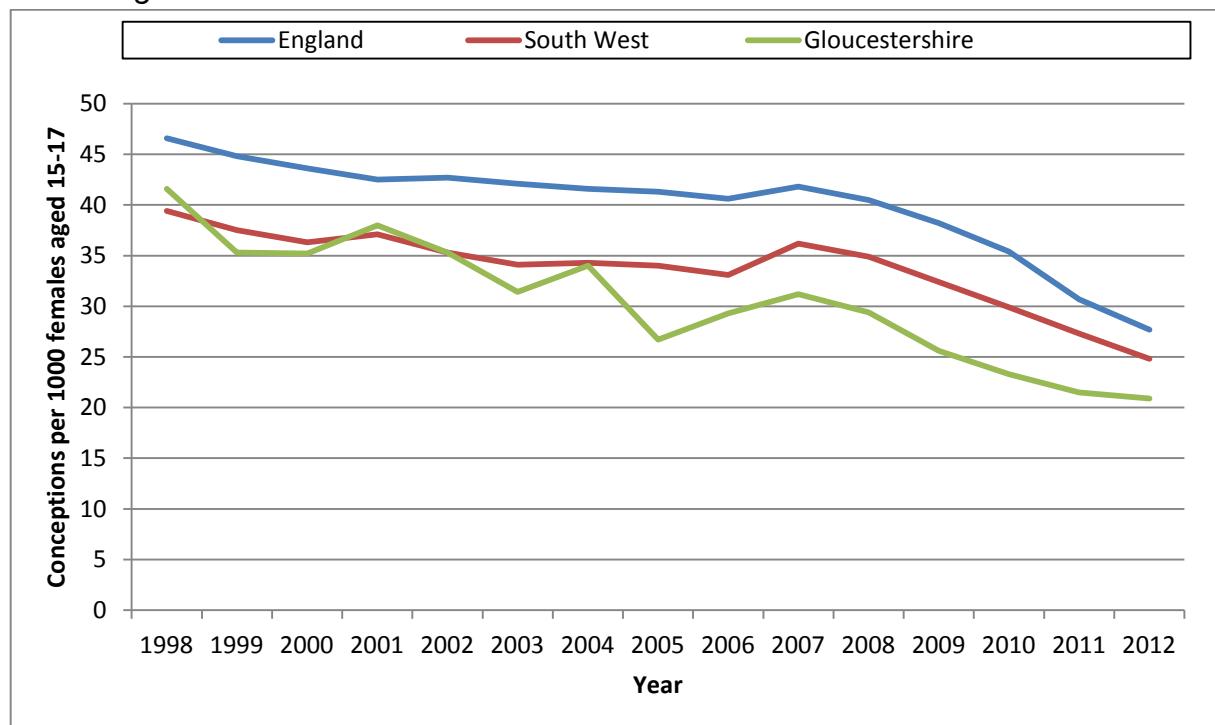
Since 1998, teenage pregnancy (TP) rates have been falling locally, regionally and nationally. Gloucestershire has consistently had a lower TP rate than regional and national comparators. Figures 13 and 14 below show that the rate of conceptions for under-16's and under-18's in Gloucestershire have fallen over the last decade and remain lower than those for England and the South West. However, whilst the rates for under-16's for England and the South West continued to fall between 2008/10 and 2010/12 the rate for Gloucestershire remained almost unchanged (Figure 13).

*Figure 13 – Under-16 conception rates in Gloucestershire per 1000 female population aged 13-15*



Source: Office for National Statistics

Figure 14 – Under-18 conception rates in Gloucestershire per 1000 female population aged 15-17



Source: Office for National Statistics and Department for Education

Gloucestershire's rate of under-18 conceptions has fallen by 50% since 1998 (Figure 14). This reduction puts Gloucestershire in the top 10 most improved counties in the country and sees the rate at the end of 2012 being below both that of the South West and England.

Of the total number of under-18 conceptions in 2010 (262) 145 (55.3%) led to abortion. Figure 15 shows how these percentages varied between districts.

Figure 15 - Percentage of under-18 conceptions in 2010 leading to abortion

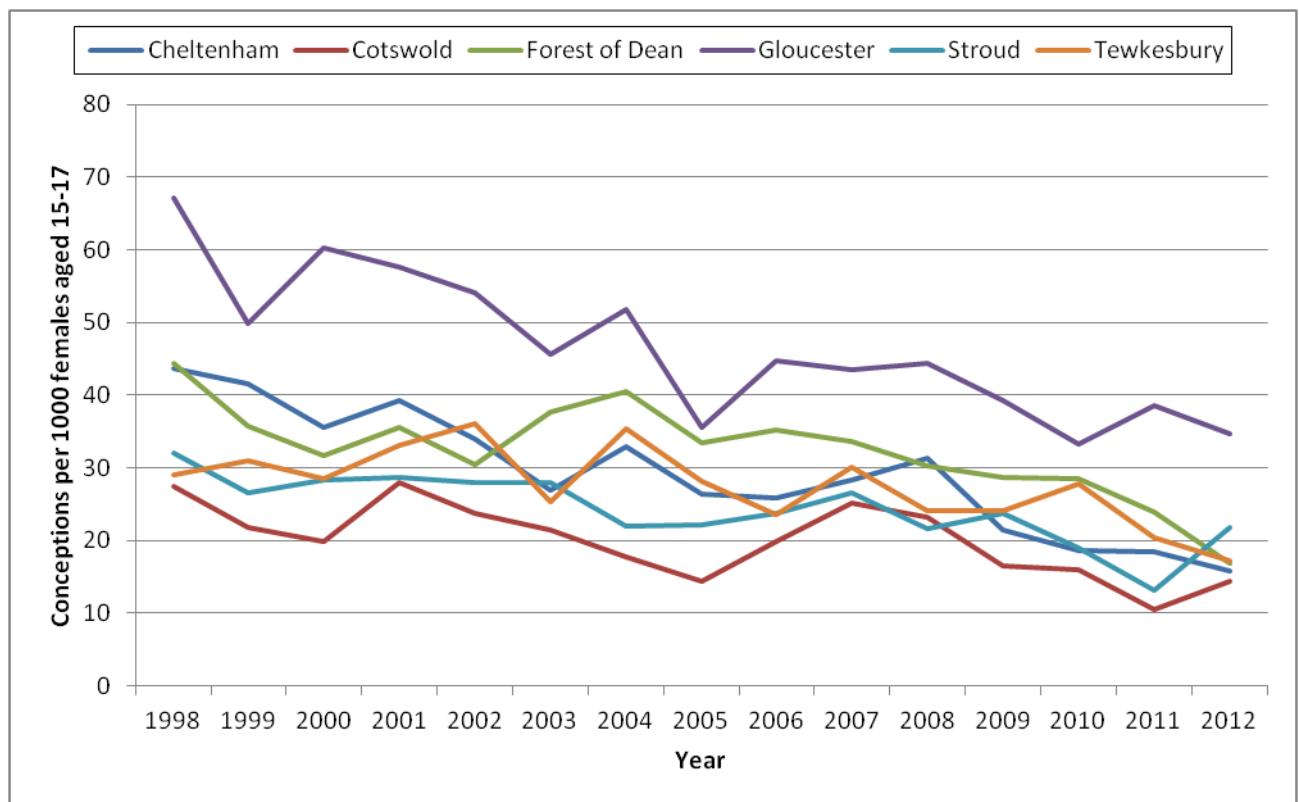


Source: Office for National Statistics and the Department for Education

The Gloucestershire Teenage Pregnancy Board maintains a partnership approach between the Local Authority, NHS, education and voluntary sector organisations to ensure a countywide approach to this work. Data relating to this rate is released annually by the Office of National Statistics and shows complete calendar years which are a minimum of 16 months in arrears. The Teenage Pregnancy Board is working with Gloucestershire Hospitals NHS Foundation Trust, Gloucestershire Care Services, Pharmacies, Youth Support Services, Prospects and Primary Care to achieve local data sets using more real time information.

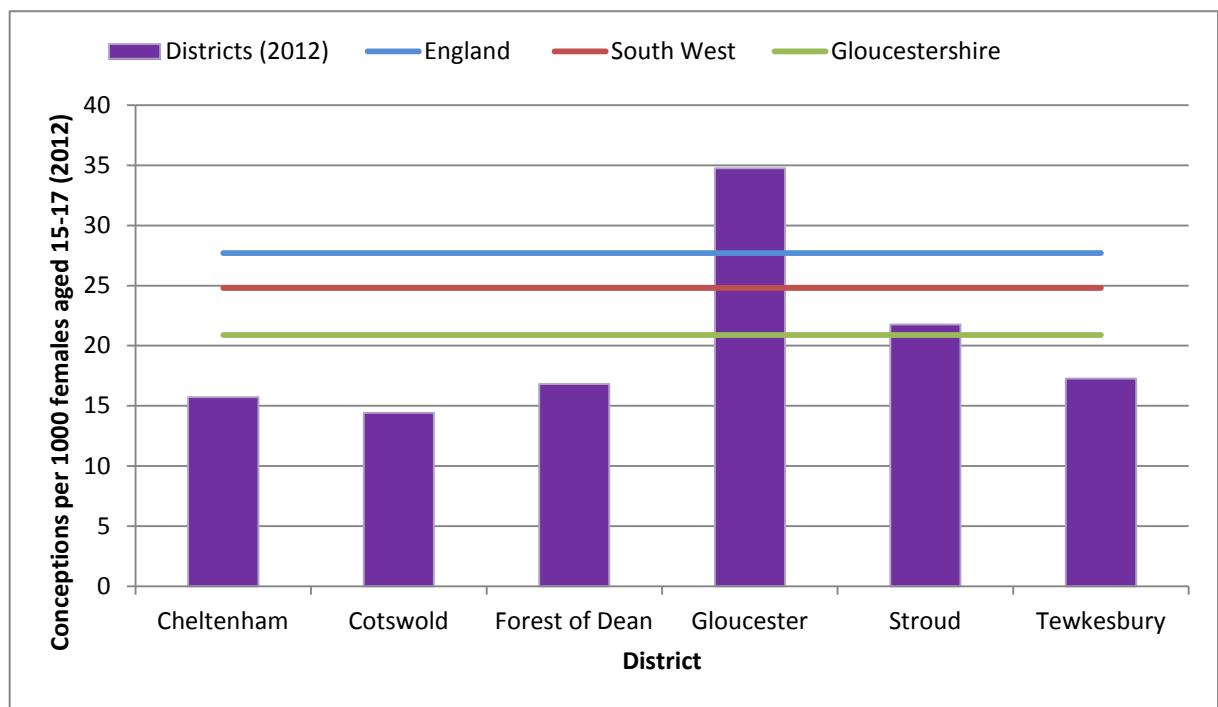
Whilst each district in the county has seen a rate reduction since 1998, as shown in Figure 16, Gloucester City continues to have the highest rate of under-18 conceptions and is the only district in the county where the rate sits above that of the South West and England. Figure 17 below further shows that whilst remaining below the regional and national rate Stroud District is higher than the average rate for the county.

Figure 16 – Under-18 conception rates by districts per 1000 female population aged 15-17



Source: Office for National Statistics (ONS)

Figure 17 - Year 2012 Conceptions per 1000 females aged 15-17 national comparison.



Source: Conception Statistics, England and Wales, 2012, Office for National Statistics

With this in mind the Teenage Pregnancy Board has proposed targets which aim to:

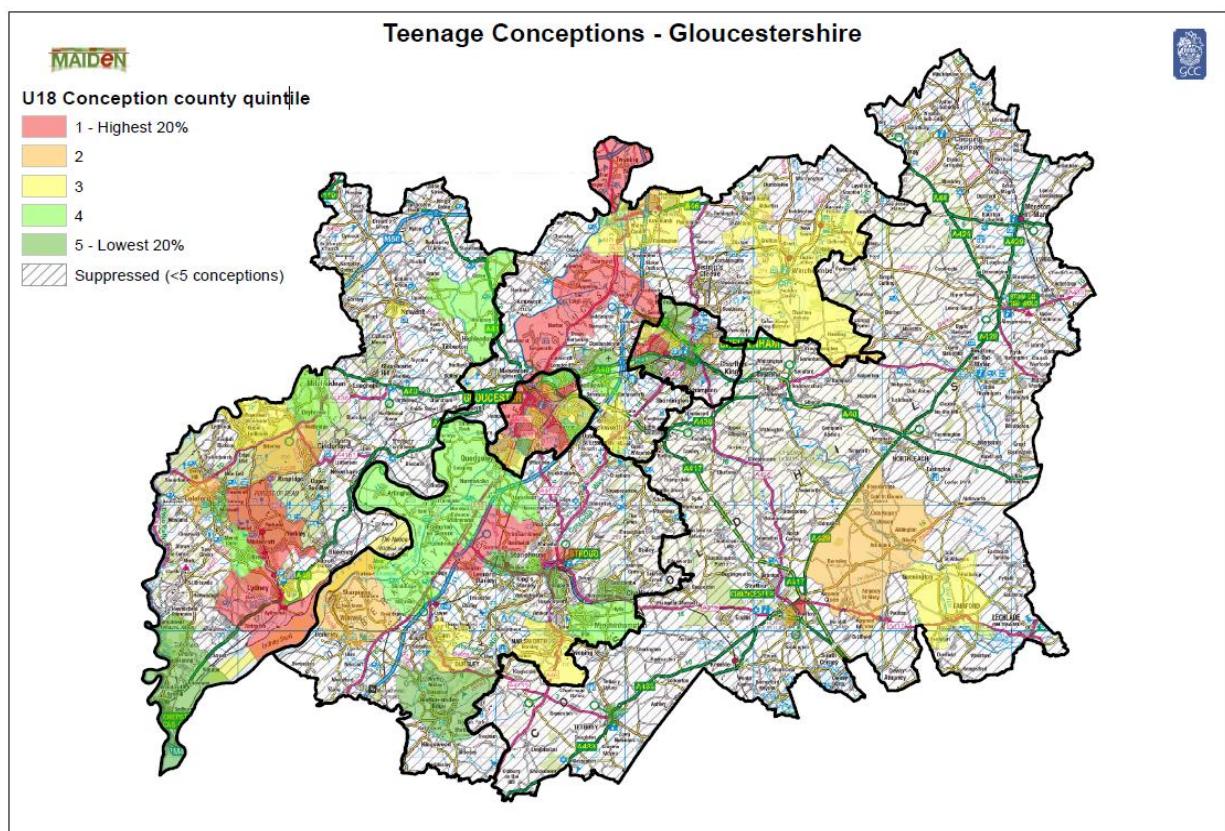
- maintain a rate lower than that of England and the South West on a county basis
- reduce the Gloucester District to a level below the national rate
- Reduce under-16 conceptions.

Services within Gloucestershire currently working towards achieving these aspirations include:

- Teenage Pregnancy Specialist Midwifery
- Targeted Young People Drop-in Sexual Health clinics in GP practices and further education sites
- C-Card
- Emergency Hormonal Contraception via Community Pharmacy Service
- Sexual Health & Teenage Pregnancy targeted co-ordination in the Youth Support Service
- Gloucestershire Hospital Education Service
- Gloucestershire Healthy Living and Learning (supporting educational settings)
- Public Health Nursing Service for school aged children
- Integrated Sexual Health Service

The map below, Figure 18, shows under-18 conception rates at district level identifying where higher rates exist within each district. It should be noted that population density within the county has an impact on rates, rural areas are impacted most by this. Where numbers fall below 5 the information has been suppressed. This map uses 2012 ONS data.

Figure 18 Map showing teenage conceptions across the county in 2012



Source: Source: Office for National Statistics

### 3.3 Abortion

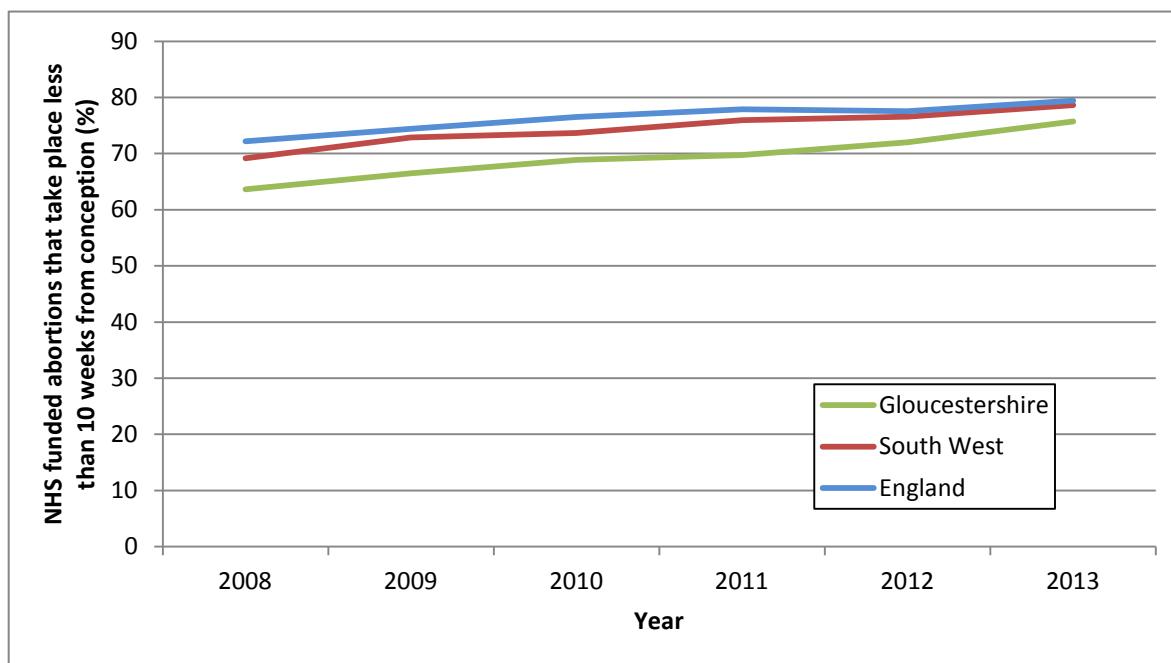
In England abortion, when approved by two doctors, is legal within specific criteria for pregnancies up to 24 weeks in gestation. Gloucestershire Care Services provide full range of pregnancy advisory support including abortion and are able to perform procedures within 18 weeks of gestation. Anyone requiring the procedure beyond this point is referred to specialist services outside of the county.

#### Abortions Under-10 weeks

The sooner an abortion is carried out the lower the risk of complications. For sometime services across England and Wales have strived to maximise, where appropriate both clinically and in relation to choice, the number of procedures performed within 10 weeks of gestation. Figure 19 shows the Gloucestershire performance against this measure. We can see that the percentage of abortions carried out before 10 weeks is lower than the England and the South West. Work has taken place within the service to look at the speed of access and pathways which has resulted in an increase between 2008 and 2013 of 9.4% which is higher than the England increase (6.6%) but lower than the South West rate (8.8%) taking the county over the minimum 70% aspiration with a current rate of 75.7%.

Further investigation is required to determine the low rate of under-10 week procedures in Gloucestershire.

Figure 19 - Percentage of NHS funded abortions that occur under-10 weeks from gestation, 2008-2013



Source: PHE Sexual Health profiles<sup>38</sup>

### 3. Summary of Recommendations

#### 3.1.1

- A comprehensive review of LARC availability, by district is completed and the outcomes shared..
- Review current practice and develop a plan to ensure a robust recall system is part of the LARC pathway within both GP and community and sexual health settings.
- Work is undertaken immediately to identify a process to gather and share sexual health prescribing information for contraception, particularly LARC.

#### 3.1.4

- Conclusions of the 2012 community pharmacy review and 2014 Pharmaceutical needs assessment be considered in line with recommendations of this assessment
- Work be undertaken with the Gloucestershire Clinical Commissioning Group Medicine Management Team and NHS England to analyse GP prescribing of EHC over the preceding 5 years to identify and understand variances in provision. This review to include community pharmacy provision as concluded by the 2012 Audit of Pharmacy EHC delivery.

3.3 Further investigation is required to determine the consistent variants between the Gloucestershire and both the South West and England rate of under-10 week abortions.

## 4 Sexually Transmitted Infections

This section will describe the trends over time of the incidence of sexually transmitted infections. It will include a description of the National Chlamydia Screening Programme and its activity.

Over recent years, rates of Sexually Transmitted Infections (STIs) have been steadily increasing; whilst there is some variability over time, the general trend is that of rising rates of STIs which is in keeping with the national trend. STIs are passed from one person to another through unprotected sexual intercourse, other genital contact or via the exchange of bodily fluids (including blood). There are a wide range of STIs, which commonly include Chlamydia, Gonorrhoea, HIV, Human Papilloma Virus (HPV) and Syphilis. Certain groups within the general population are at higher risk of acquiring an STI, these have been described in section 2.2.

### 4.1 Chlamydia

The National Chlamydia Screening Programme (NCSP) was established in 2003 in England to facilitate early detection and treatment of asymptomatic Chlamydia infection. Chlamydia is the most common bacterial sexually transmitted infection in England. Up to 70% of women and 50% of men with the infection have no symptoms. If these infections remain undiagnosed and hence untreated, complications such as pelvic inflammatory disease, ectopic pregnancy and tubal factor infertility can develop.

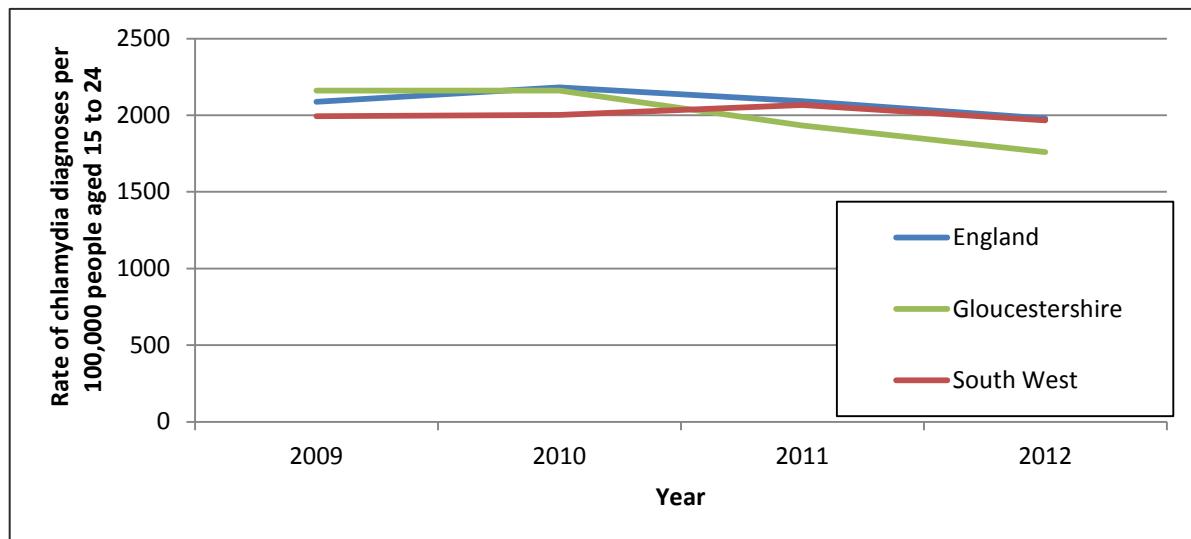
Undiagnosed infections also increase the chances of infecting others. Sexually active young adults under 25 years are targeted in the screening programme because the greatest numbers of cases occur in this group. The use of Genitourinary Medicine (GUM) and non-GUM (e.g. contraception, abortion, Primary Care and youth work settings) settings increases access to this age group.

The Department of Health Public Health Outcomes Framework (2012) recommends that local areas aim to achieve a Chlamydia diagnosis rate among 15 to 24 year olds of at least 2,400 per 100,000 population. In 2013, with the launch of Chlamydia Activity and Testing Dataset (CTAD), this threshold was reduced to 2300 per 100,000.<sup>39</sup>

#### Rate of Chlamydia diagnosis

In 2012 diagnosis rates for Chlamydia in Gloucestershire were lower, therefore worse, than England and the South West (Figure 20). Between 2009 and 2012 rates have decreased in England by 11.4%, the South West by 5.0% and Gloucestershire by 8.0%.

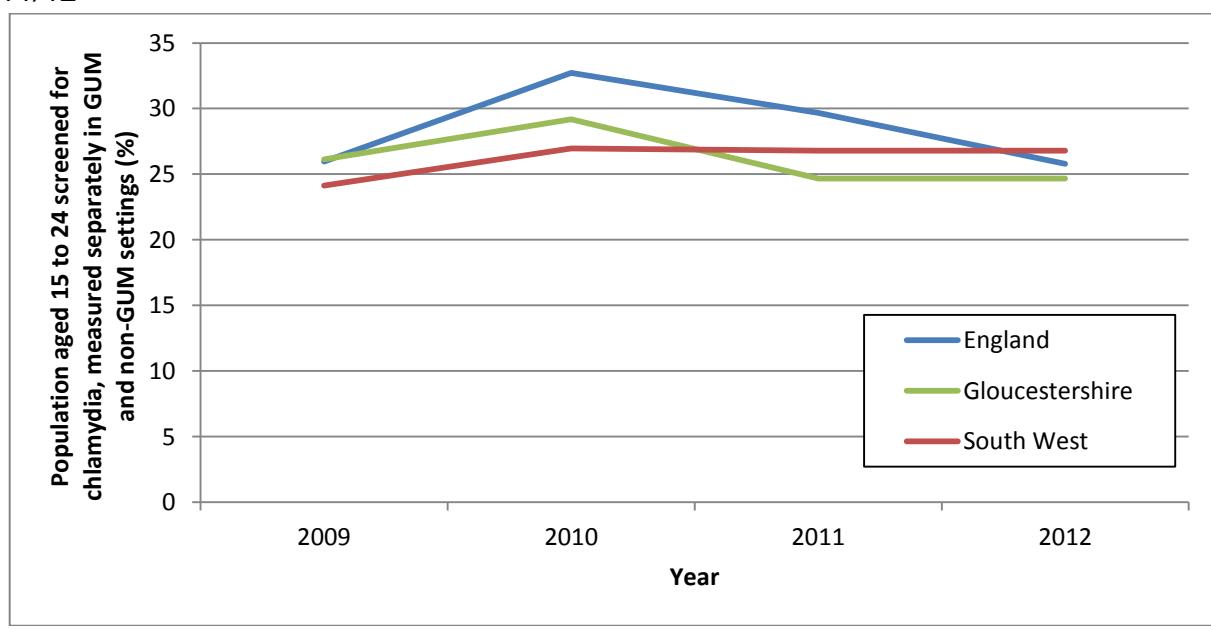
Figure 20 – Chlamydia diagnosis in Gloucestershire per 100,000 of the population



Source: CTAD.

Figure 21 shows that Gloucestershire screened fewer 15-24 year olds than the South West and England in 2011/12. The number of screens has an impact on the rate of diagnosis which from Figure 20 we can see is also lower than England and the South West.

Figure 21 - Percentage of 15-24 year olds that were screened for Chlamydia, 2011/12



Source: CTAD

If we breakdown rates of Chlamydia positivity into ages year bands we can see (Table 5) that consistently since 2011/12 18, 19, 20 and 21 year olds have had the higher percentage of diagnosis. Whilst percentages are lower in other ages, and the lowest at the younger end of the age range for screening (15 to 24yrs) we can see that the higher increases in positivity

are within 15 and 16 year olds. At this time we do not know if this is due to increased prevalence or more targeted screening within these age groups.

*Table 5 Chlamydia positivity rates by age*

Age	2011/12	2012/13	2013/14
15	3.5%	3.0%	5.5%
16	4.8%	3.5%	6.4%
17	5.9%	5.9%	6.3%
18	7.9%	9.9%	8.0%
19	8.6%	9.6%	8.7%
20	10.1%	8.5%	8.8%
21	9.3%	9.5%	8.4%
22	6.7%	8.5%	7.5%
23	7.4%	6.6%	7.4%
24	5.2%	6.2%	6.2%
Total	7.5%	7.9%	7.7%

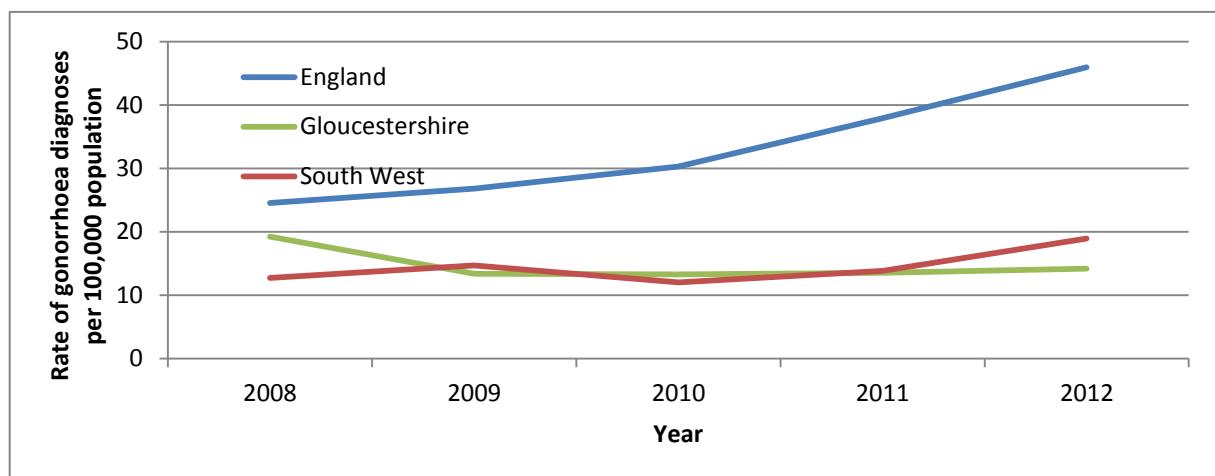
Source: Gloucestershire Care Services – service data

It is a recommendation of this assessment that Public Health in Gloucestershire review the current approach to Chlamydia Screening within the county.

#### **4.2 Gonorrhoea**

Gonorrhoea is the second most common bacterial sexually transmitted infection in the UK. Untreated infections can be associated with significant morbidity. Gonorrhoea tends to be concentrated in core risk groups including young adults, black and minority ethnic populations and MSM. Following a steady rise in diagnoses in the mid 1990s and early 2000s there has been a steady decline in Gonorrhoea diagnoses since 2003. However, between 2008 and 2012 the diagnosis of Gonorrhoea has increased in England and remained relatively constant in the South West. Gloucestershire has not followed the national trend, with the county's rate decreasing overall and remaining steady since 2009 as can be shown in Figure 22.

Figure 22 – Gonorrhoea diagnosis in Gloucestershire per 100,000 of the population



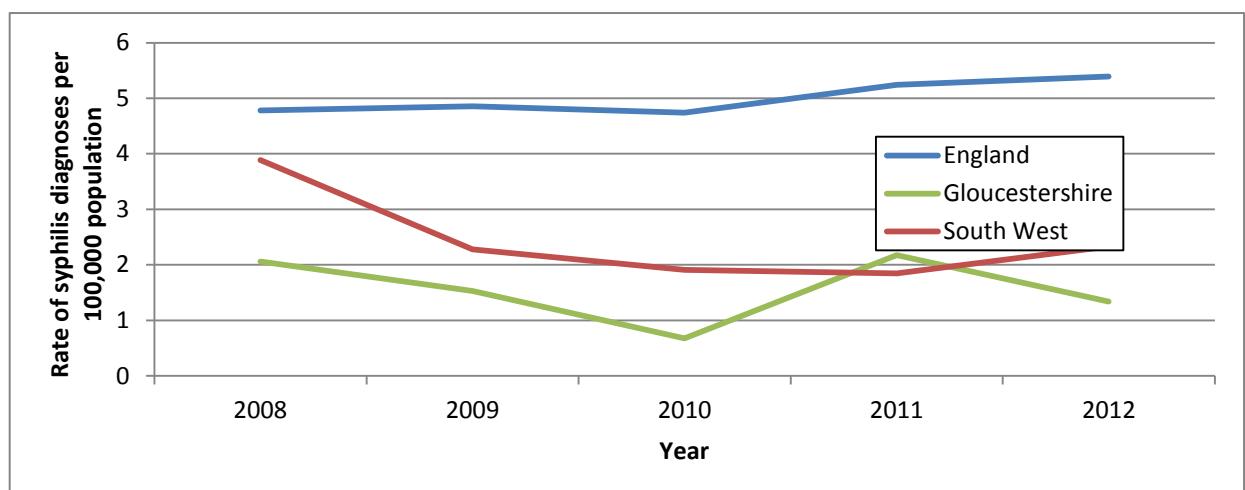
Source: STI and HIV web portal

#### 4.3 Syphilis

The number of cases of Syphilis has been rising quite significantly in the UK over the last decade. The diagnoses of infectious Syphilis declined in the late 1980s and early 1990s as a result of increased HIV awareness through campaigns that led to changes in sexual behaviour at that time. The majority of diagnoses have been made in MSM (men who have sex with men) since the late 1990s and the characteristics of these patients have changed little over the course of the years.

The Syphilis diagnosis rate for England did not change significantly between 2008 and 2011. In the South West there was an overall decrease by 1.96 per 100,000 whilst in Gloucestershire the rate has risen, particularly since 2010 when the county saw an increase from 0.67 to 2.36 per 100,000 of the population (see Figure 23). Since 2011 this rate has decreased once again. There is no specific reason for the 2011 increase, which, given the low numbers of diagnoses could have been caused by an increase of just a few cases.

Figure 23 – Syphilis diagnosis in Gloucestershire per 100,000 of the population



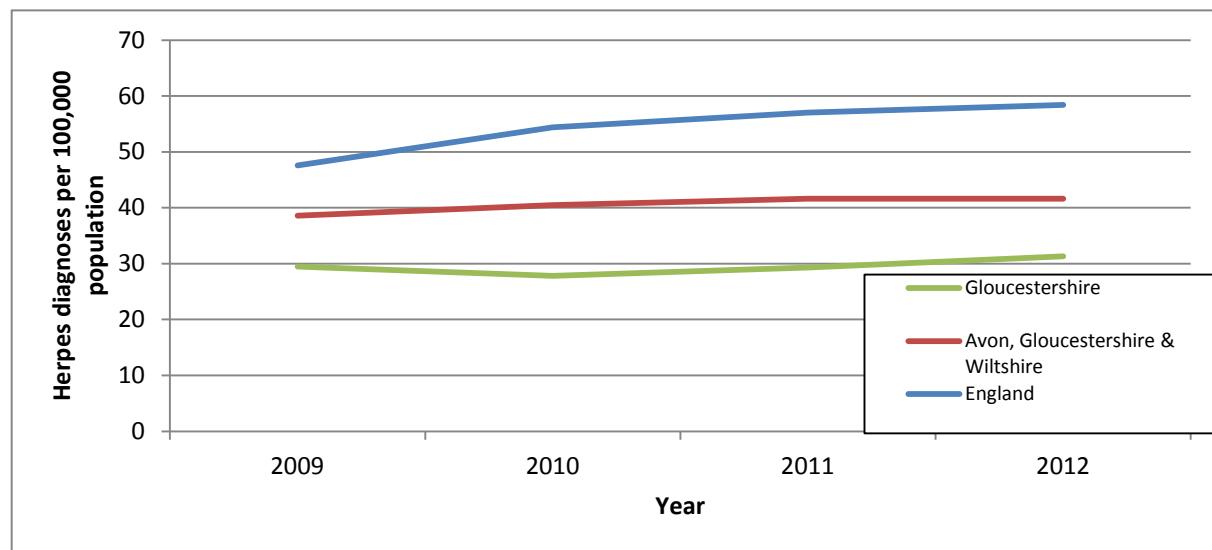
Source: STI and HIV web portal

#### 4.4 Herpes

Genital Herpes is caused by the herpes simplex virus (HSV). It is the most common ulcerative STI in the UK and is associated with physical and psychological morbidity.

The rate for Herpes diagnosis in the county is lower than the South West and England. Between 2008 and 2012 the rate of Herpes being diagnosed has steadily increased in England the South West, with Gloucestershire following a similar trend. (see Figure 24).

*Figure 24 – Herpes diagnosis in Gloucestershire per 100,000 of the population*



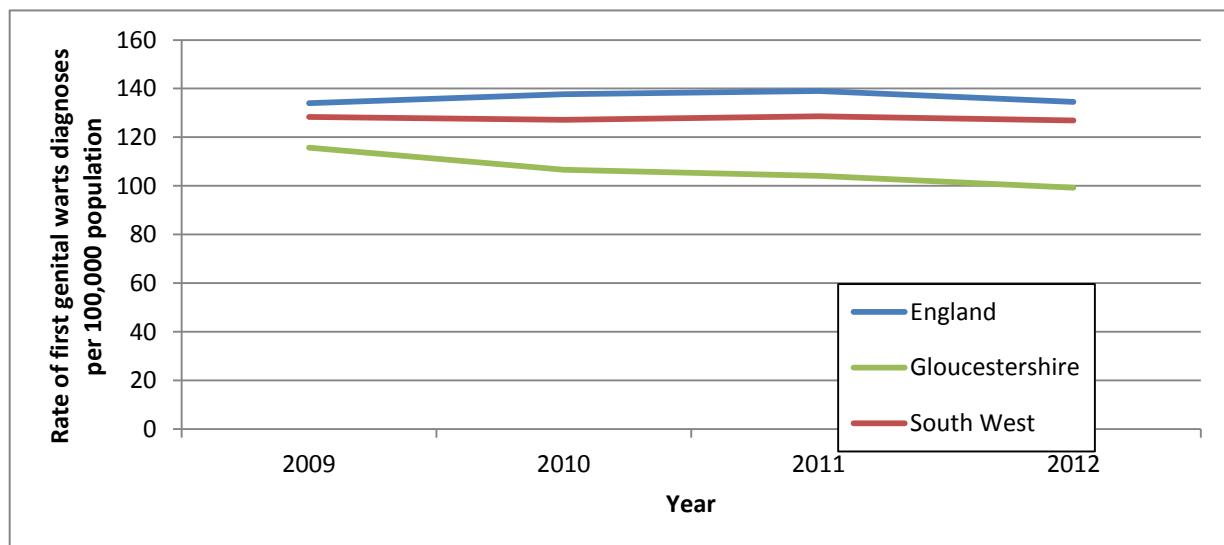
Source: STI and HIV web portal

#### 4.5 Genital Warts

Genital Warts are the most common viral STI in the UK and are caused by the human papillomavirus (HPV). The lifetime risk of infection is high amongst sexually active people.

The rate of Genital Warts in Gloucestershire is lower than the England and South West rates and is the only STI to have fallen between 2008 and 2012 (see Figure 25).

Figure 25 – Genital Warts diagnosis in Gloucestershire per 100,000 of the population



Source: STI and HIV web portal

#### 4.6 Human Papilloma Virus (HPV)

HPV is the name for a group of viruses that affect your skin and the moist membranes lining your body, such as the cervix. It is a common and highly contagious infection, with over three quarters of sexually active women acquiring it at some time in their lives.

There are more than 100 types of HPV. Around 40 types of HPV infection can affect the genital area. Infection with some types of

HPV can cause:

- abnormal tissue growth and other changes to cells within your cervix, which can lead to cervical cancer
- Genital Warts

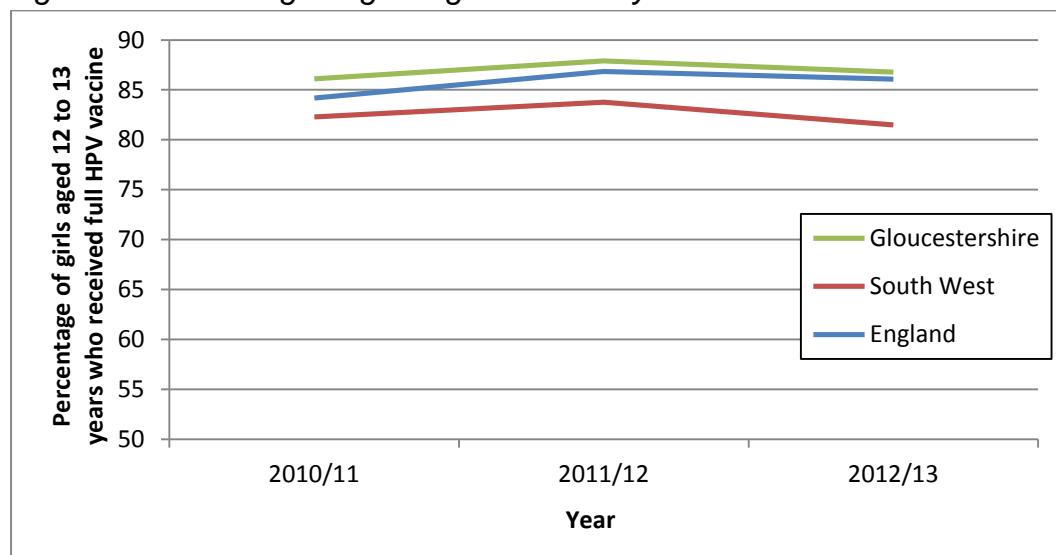
Since autumn 2008 a national vaccination programme of HPV has been in place for girls aged 12 and 13.

The HPV vaccination programme is being delivered mainly through secondary schools with 86.8% of girls taking up the vaccination during 2012/13.

HPV vaccination does not replace the need for regular cervical smear tests in women who are between 25 and 65.

Gloucestershire provides HPV vaccination via the public health nursing service. Figure 26 shows girls aged 12 to 13 years who have received all three doses of the HPV vaccine. Whilst the level of coverage dropped in Gloucestershire between 2011/12 and 2012/13, the percentage of girls receiving full coverage of HPV is higher than England and the South West.

Figure 26 Percentage of girls aged 12 to 13 years who received full HPV vaccine



#### 4.7 Access to services

Prior to 2013/14 access to GUM services in Gloucestershire was limited to two main clinics in Gloucester and Cheltenham and some specialist GP Practices. Gloucestershire, however, has now introduced an integrated sexual health service. This includes contraception and GUM services (to BASHH level 2) (see Standards for the management of sexually transmitted infections – Appendix B<sup>40</sup>) for details of BASHH GUM levels) in all clinics in the county. A number of GP Practices have been trained to deliver to the same, level 2, standards. This has significantly increased access to GUM services throughout the county with the exception of people living in the North Cotswolds – a recommendation to review this area has been highlighted earlier in this assessment.

In 2013 Public Health England produced data for the movement of people between areas to attend sexual health services which showed 358 people travelled into Gloucestershire for their care with 144 follow up appointments required to complete their treatment. 1076 Gloucestershire residents were seen in clinics outside of Gloucestershire of which 247 follow up appointments were required. Personal choice, including location of work place and concerns around anonymity need to be taken into account when determining where an individual receives their care. However, movement can at times be an indication of poor access to services which, in this instance, is still to be determined. Whilst the new integrated clinics should have had an impact on movement this assessment recommends that a project group be set up to review out of county attendances at GUM clinics in line with access to current service sites.

#### 4. Summary of recommendations

4.1 Public Health in Gloucestershire reviews the current approach to Chlamydia Screening within the county with a view to the achievement of the Public Health Outcome Framework requirements.

4.7 A project group is set up to review out of county attendances at GUM clinics in line with access to current service sites.

## 5 Blood-Borne Viruses

Hepatitis B, C and HIV are the most common blood-borne viruses (BBVs) in the UK. They are transmitted from person to person through blood via sexual activity, injecting drug use, from mother to foetus and, more rarely, in other bodily fluids. This section will provide an overview of the findings of the recent Epidemiological Health Needs Assessment for Hepatitis B and C in Gloucestershire<sup>41</sup>. HIV is discussed in the next section.

### 5.1 Hepatitis

Hepatitis is inflammation of the liver. It has a number of causes including excessive alcohol, Hepatitis B and Hepatitis C viruses. Some people have acute infections which clear quickly without any permanent liver damage. Other people have chronic infections which can last for many years. Chronic infections can cause scarring of the liver (cirrhosis) which can develop into liver failure or liver cancer which can be fatal. People with untreated Hepatitis C can also experience fatigue, depression and cognitive issues too.

In the UK, only a small proportion of people who are infected are diagnosed and treated for two main reasons:

- Infected individuals are often symptom-free particularly during acute infections or for the first months or years of chronic infections. Therefore only some of those infected seek help from services.
- Those at greatest risk of infection tend to have less or more complicated contact with health services than the general population, such as people who inject drugs, people new to the UK, and men who have sex with men.

People with an untreated infection are at high risk of developing further liver disease and can also pass the infection to others. Many broader health protection measures can help to protect people from both Hepatitis B and Hepatitis C infections, including condom use, needles exchanges, antenatal screening, testing and treatment. These same measures help to reduce the spread of HIV too.

The data sources for Hepatitis B and C are varied and often only published at a national or regional level. The data therefore described below is a crude estimate of the incidence and prevalence of Hepatitis B and C in Gloucestershire respectively.

#### Hepatitis B

- 6-7 new acute cases reported to Public Health England each year
- 44-45 new acute cases annually, both diagnosed and undiagnosed
- 1,806 people living with chronic Hepatitis
- 23-55 laboratory reports to PHE annually during 2005-12, of both acute and chronic infections

## Hepatitis C

- 1,385 of 15-59 year olds might be living with chronic Hepatitis C, if the England prevalence rate applies. The PHE estimate for Gloucestershire, via their commissioning tool, is 1,529, all ages.
- It is estimated that 135-357 of 15-64 year olds who inject opiates &/or crack cocaine might have Hepatitis C.

Whilst it is recognised that it is difficult to get meaningful, reliable data about Hepatitis B and C, from the data available there is nothing to indicate that Gloucestershire has a larger disease burden than the England average.

The Hepatitis B and C health needs assessment made a number of recommendations. These were varied reflecting the variety of transmission routes and the number of groups at high risk of contracting Hepatitis B and C. The recommendations relevant to sexual health services are listed below. They will be taken forward under the auspices of the Gloucestershire Health Protection Assurance Group (GHPAG).

### Recommendations for Commissioners

- Ensure providers have clear, multiagency clinical pathways for all patient groups affected by Hepatitis B &/or C.
- Update 2015/16 service specifications and manage performance of Hepatitis B and C content in related services e.g. sexual health, HIV, substance misuse, maternity, paediatrics, medicine, and other contracts.
- Work with primary care providers in particular to ensure people at risk are being screened and tested as per NICE guidance.<sup>42</sup>

It is a recommendation from this needs assessment that the GSHSPG works with the GHPAG to ensure progress is made regarding the commissioning responsibilities for Hepatitis B and C.

## 5.2 HIV

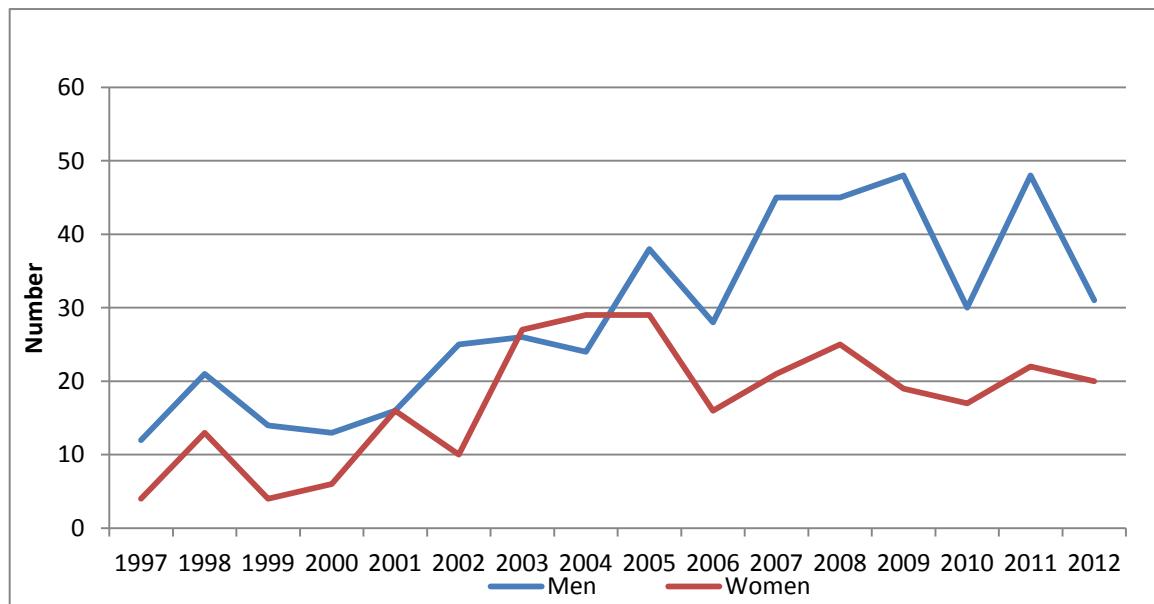
HIV continues to be one of the most important communicable diseases in the UK for several reasons: it is associated with serious morbidity, high costs of treatment and care and high mortality and potential years of life lost. Diagnosed HIV prevalence (those living with HIV) in the UK has been increasing rapidly since the introduction of highly active antiretroviral drugs (HAART) in the mid-1990s due in the main to the success of the treatment leading to longer life.

In 2012, the Health Protection Agency (HPA), now Public Health England (PHE) released their annual HIV report. HIV was estimated to affect 96,000 people living in the UK by the end of 2011, an increase from 91,500 in 2010 with 24% unaware of infection.

The number of new diagnoses both in Gloucestershire and the South West are relatively small and so the data cannot be presented at a level lower than Avon, Gloucestershire and Wiltshire (AGW). Figure 27 shows that the number of new diagnoses are falling with 20 women and 31 men being diagnosed with HIV in 2012 compared with 22 and 48 respectively

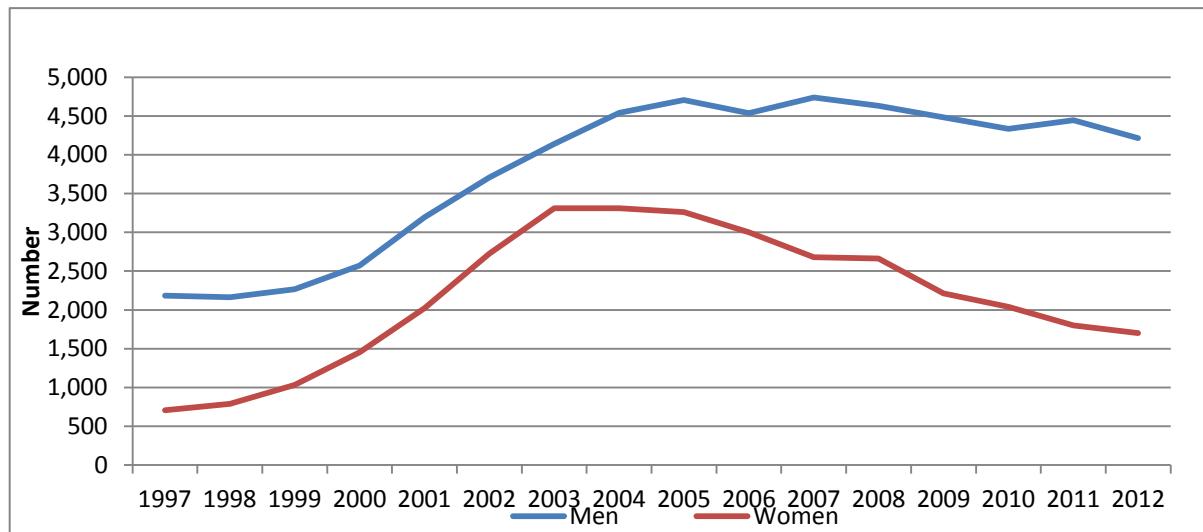
in 2011. The slight decreasing trend seen locally also seems to mirror the national trends seen in Figure 28.

*Figure 27 New HIV diagnoses by year of diagnosis and sex, Avon, Gloucestershire & Wiltshire*



Source: Survey of Prevalent HIV infections diagnosed (SOPHID)

*Figure 28 New HIV diagnoses by year of diagnosis and sex, United Kingdom*



Source: SOPHID

### 5.2.1 Accessing HIV related care

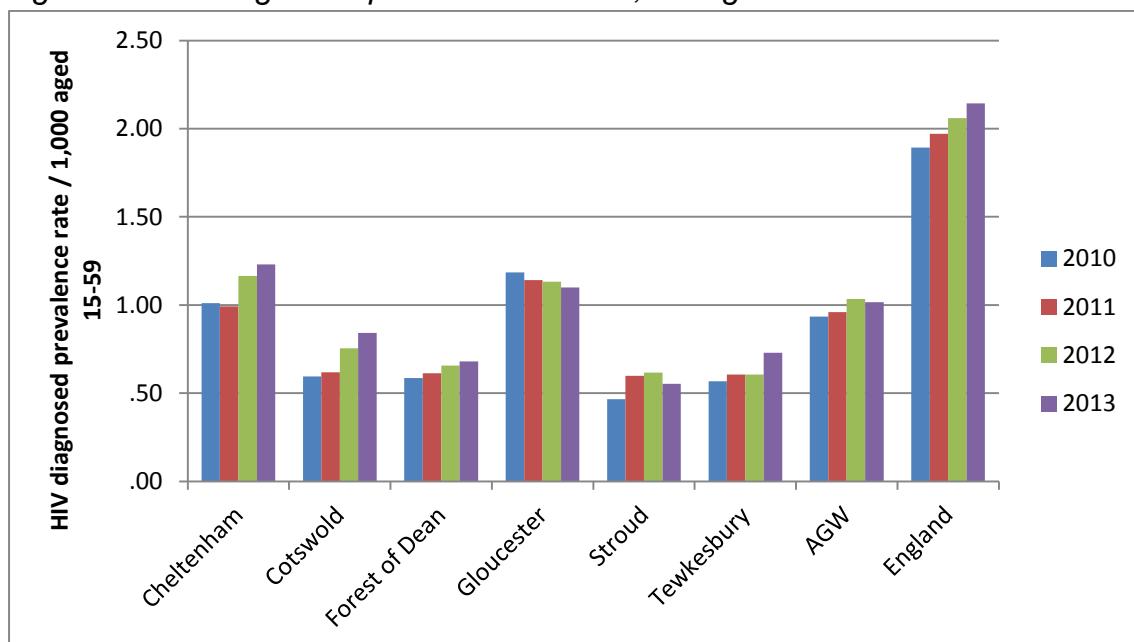
As with all Sexual Health Services those receiving treatment are able to attend services within a location of their choice. For people attending HIV treatment services in Gloucestershire main clinics are held at Hope House in Gloucester with some clients being seen in Cheltenham. At Hope House the HIV treatment service work closely with GCC Adult

Social Care and the Eddystone Trust to ensure that medical and social needs of PLWHIV are met.

Diagnosed prevalence in 2013 were higher than in 2010 within England, the AGW area and within all districts in Gloucestershire with the exception of Gloucester (see figure 29). Whilst Stroud, as with AGW showed a decrease in 2013 from the 2012 level on the whole diagnoses rates are continuing to increase. Whilst new diagnoses continue to be a concern the increase of People Living with HIV also includes those living longer due to advances in medication. For Gloucestershire we also need to take into account people moving into and out of the county due to lifestyle, work or family changes. For Gloucestershire these increases are a combination of people living longer with HIV, new diagnoses and people living with HIV moving into and out of the county.

Based on people aged between 15 and 59 Cheltenham has the highest rate of PLWHIV within Gloucestershire whilst Stroud has the lowest.

*Figure 29 HIV diagnosed prevalence rate / 1,000 aged 15-59*



Source: PHE Fingertips sexual health profiles

### **5.2.2 Late diagnosis HIV**

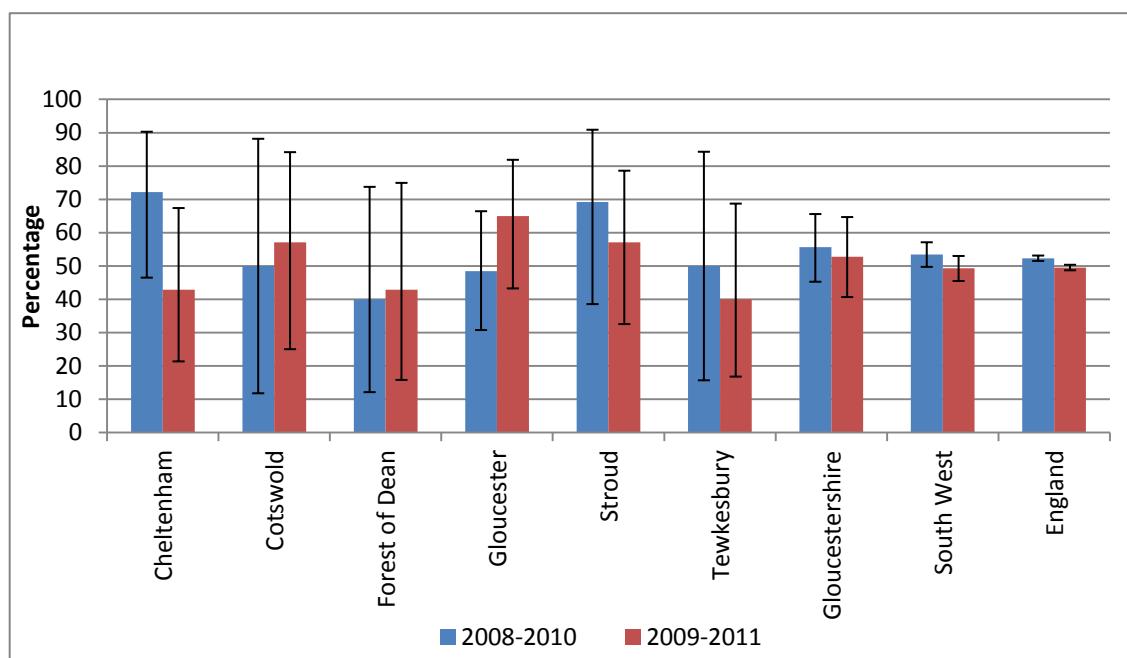
Late diagnosis is most common among black African heterosexual men; black Caribbean men; white heterosexual men, heterosexual women and older people aged 50 and over.

The later HIV is diagnosed, the higher the likelihood of serious damage to the immune system. Someone is said to have been diagnosed late if the number of CD4 cells in their bloodstream has dropped below 350. Late diagnosis is one of the biggest contributing factors to illness and death for people with HIV.

Similar to national and regional trends the percentage of people being diagnosed late in Gloucestershire fell between 2008/10 (55.7%) and 2009/11 (52.3%) (see Figure 30). However the figures for Gloucestershire are higher than for the South West and England.

Nevertheless, over 50% of people diagnosed with HIV were diagnosed late which can have a serious impact on their health outcome.

*Figure 30 Percentage of late diagnoses of HIV, three year averages by Local Authority, Gloucestershire*



Source: SOPHID

### 5.2.3 Preventing HIV

HIV Prevention services in Gloucestershire are delivered, in the main, by The Eddystone Trust. The Trust was set up by people living with HIV in the South West and have been working in the field of HIV prevention and support for over 25 years.

In Gloucestershire the HIV prevention service is delivered alongside services providing social care support for people living with HIV, their carers and anyone impacted by HIV. Group and one to one services are offered from offices throughout the county (see Figure 36 in Section 8), however, the Trust specialises in bespoke care and as such adjusts how they work to fit individual needs.

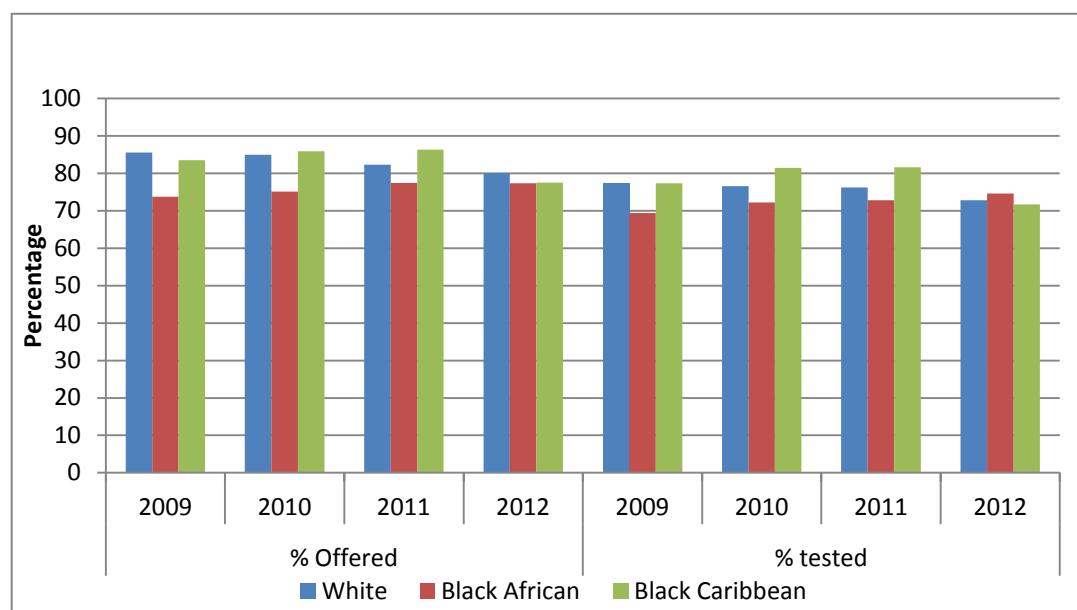
They also operate a free condom distribution scheme for people at risk of HIV.

A large amount of work done by the Eddystone Trust is aimed at educating people as to what HIV is. Since Eddystone took over the contract in April of 2014 their focus has been on providing support to PLWHIV, their families and carers and prevention services, including testing, to people at risk of HIV. Now that these elements of the service are in place the Trust will begin to focus more on broader education. This will include working with schools, within businesses and communities. This work should begin in early 2015.

Prevention is also a significant element of the HIV Treatment Service provided by Gloucestershire Care Services. Partner notification, with the consent of clients using the service, is carried out by the GCS team in an attempt to reduce further transmission of HIV

and in an effort to trace PLWHR who may be unaware of their diagnosis. The service also supports clients to maintain their medication regimes and to learn how to live with HIV. Both the HIV Treatment Team and the Eddystone Trust work closely, with client consent, to support the prevention agenda.

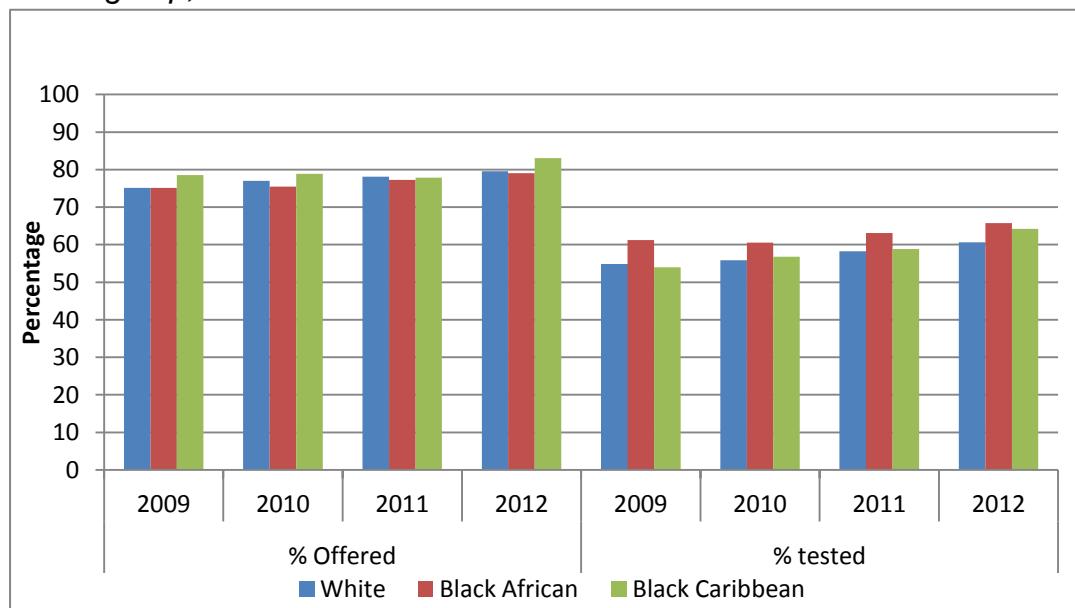
*Figure 31 Percentage of GUM clinic attendees offered and accepting an HIV test by ethnic group, Gloucestershire UTLA*



Source: SOPHID

Figure 31 (above) shows both the percentage of people offered and accepting a HIV test, by ethnic group. The data shows that in Gloucestershire there is a good conversion of tests offered into tests accepted, with over 70% of those offered accepting the test. This compares well with the data in Figure 32 below that displays again the percentage of HIV tests offered and accepted by ethnic group across Avon, Gloucestershire and Wiltshire and Devon, Cornwall, the Isles Scilly and Somerset.

Figure 32 Percentage of GUM clinic attendees offered and accepting an HIV test by ethnic group, AGW & DCS



Source: SOPHID

Figures 32 and 33 present similar information, the percentage of GUM attendees who were offered and then accepted an HIV test by sexual orientation.

Figure 33 Percentage of GUM clinic attendees offered and accepting an HIV test by sexual orientation, Gloucestershire UTLA



Source: SOPHID

Gloucestershire has a good conversion rates of tests offered to tests accepted. The data shows an increase in GUM attendees reporting as MSM over the four years reported and the number of HIV tests accepted by this group has increased.

It is important to note that this data relate only to HIV tests offered during a GUM appointment. It does not reflect the tests offered in other settings e.g. primary care.

BHIVA Standards of Care for People Living with HIV 2013<sup>43</sup> recommend that the following clinics and settings be utilised to maximise HIV testing:

- Contraceptive and sexual health services
- Termination-of-pregnancy services
- Drug-dependency programmes
- Antenatal services
- Services for TB, lymphoma and hepatitis B and C
- All people with symptoms that are consistent with primary HIV infection
- All people presenting with a clinical indicator condition specified in the UK National HIV testing guidelines

It is a recommendation of this needs assessment that a review of HIV testing availability in Gloucestershire is undertaken to identify opportunities to increase access to testing.

## 5. Summary of Recommendations

5.1 It is a recommendation from this needs assessment that the GSHSPG works with the GHPAG to ensure progress is made regarding the commissioning responsibilities for Hepatitis B and C.

5.2.3 Undertake a review to assess testing availability with a view to identifying opportunities to increase access to testing.

## 6 Sexual Violence

Sexual violence is included in the Gloucestershire Domestic Abuse and Sexual Violence Commissioning Strategy and Outcomes Framework (GDASVCSOF) 2014-2018.<sup>44</sup> From this framework a number of action plans will be produced. The outcomes of these Action Plans will be reported directly to the Gloucestershire Health and Wellbeing Board. The GSHSPG will remain aware of the implications of this work.

The GDASVCSOF, whilst bringing together the commonality between domestic abuse and sexual violence (DASV) is separated into two needs assessments, one for sexual abuse and one for sexual violence. This is to reflect sexual crimes occur outside of the domestic environment. Appendix C of the sexual violence framework states:

“Sexual violence is not just within the context of domestic abuse, which is why the two subjects have been split into two separate needs assessments (NA). There will be crossovers, especially in terms of data presented in this NA, where a victim of a sexual offence is also categorised as a victim of domestic abuse. However, this NA will also cover sexual assaults committed by someone the victim knows (e.g. acquaintance) or is a stranger to the victim as well as sexual offences committed by their partner.”

Full details of the strategy can be found at

<http://glostext.goucestershire.gov.uk/ieListDocuments.aspx?CId=653&MId=7708&Ver=4>

### 6.1 Sexual Assault Referral Centre (SARC)

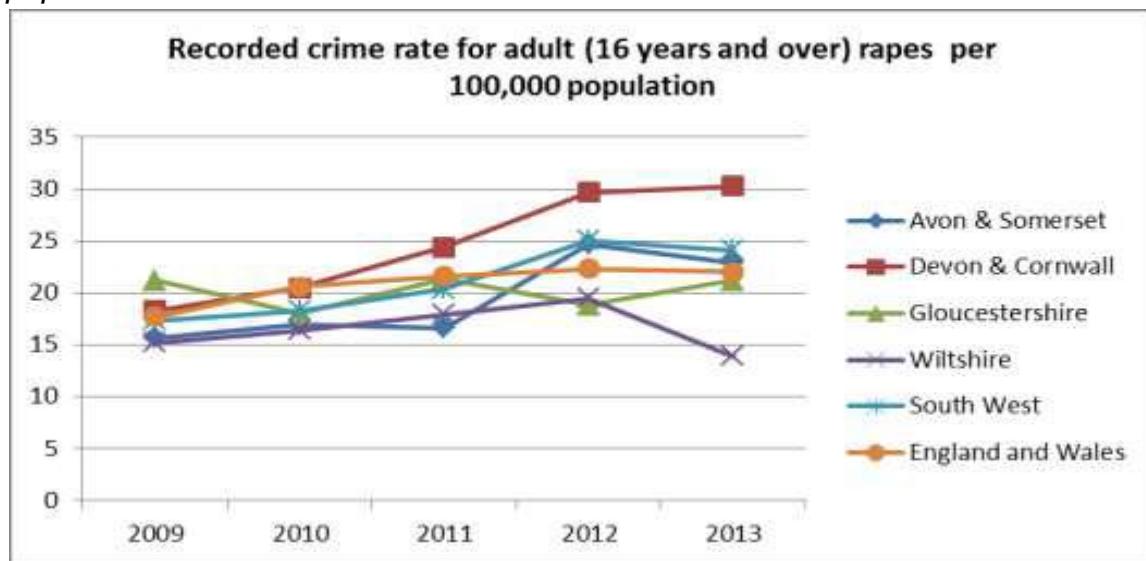
The aim of a SARC is to provide a service to ensure that victims of serious sexual assault, including rape, receive appropriate urgent medical care and access to counselling, and if they choose, forensic examination to provide evidence to assist police in a criminal investigation.

The Gloucestershire SARC was opened in 2009 in a purpose built premises adjoining Hope House on the Gloucester Royal Hospital Site. Hope House is the main county hub for all sexual health centres. Since opening, the SARC has become highly successful at supporting all people who are victims of sexual assault whether it be recent or historical, police reported or not.

In 2013 responsibility for commissioning SARCs moved to NHS England Specialist Commissioning, who in 2014 produced an evidence review and needs analysis of SARCs across the South West<sup>45</sup>.

This showed that the recorded crime rate for adults in Gloucestershire has remained fairly constant between 2009 and 2013 (Figure 34), with a slight reduction in 2012. Gloucestershire has the second lowest rate of recorded crime in this area within the South West.

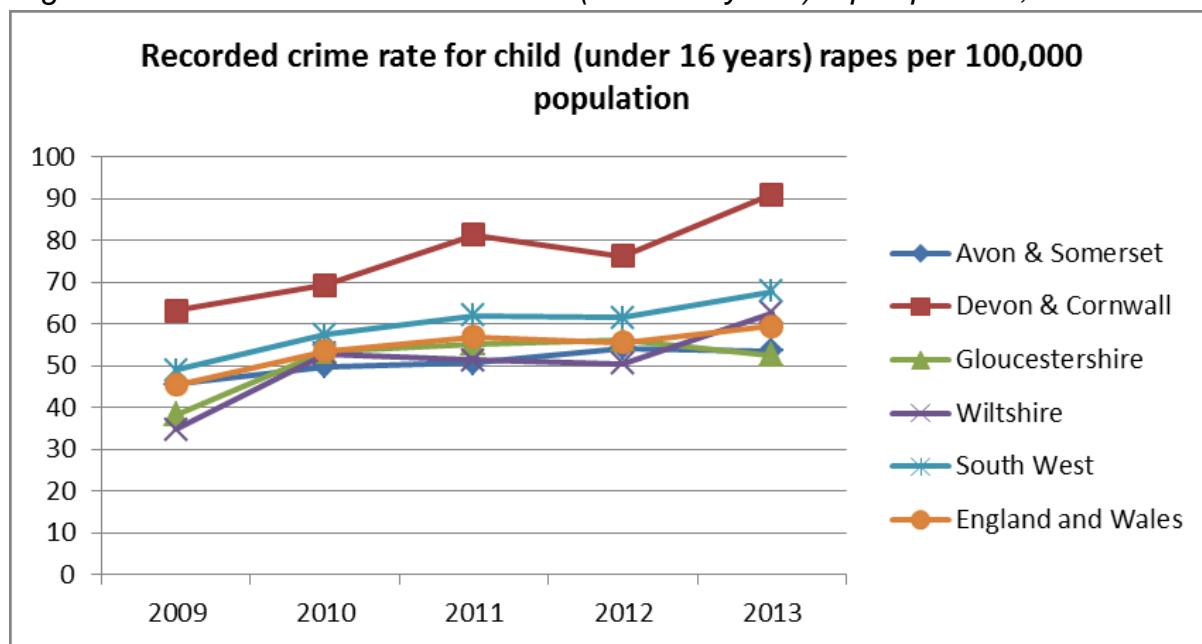
Figure 34: Recorded crime rate for adult (16 years and over) rapes per 100,000 population



Source HMIC Rape Monitoring Group

For children, under 16, whilst the rate of recorded rapes has increased since 2009 it remains the lowest in the South West (Figure 35).

Figure 35 Recorded crime rate for child (under 16 years) rapes per 100,000



Source HMIC Rape Monitoring Group

Information and data relating to recorded rape comes directly from police recording. One of the conclusions from the SARC assessment is the need for improved data sets directly from SARCs, as this would include incidences of assault where the victim chooses not to make a police report.

It is important to note that much of the information available to us relates to reported sexual assault. However, sexual violence must be looked at in the context of % incidences are not reported, particularly in sexual violence against men. Within Gloucestershire information is not readily available in this regard. A recommendation of this needs assessment is that a review of this is undertaken to determine how this information could be captured.

## **6.2 Female Genital Mutilation (FGM)**

While there is no statistically significant difference in terms of ethnicity for those at risk of Domestic Abuse and Sexual Violence, female genital mutilation, forced marriage and so called 'honour' based violence are more prevalent in black and minority ethnic communities. Since April 2014 it is mandatory that all NHS acute hospitals provide information on patients who have undergone Female Genital Mutilation.

FGM is an area of increased awareness and at the time of writing this assessment work is underway in Gloucestershire around this agenda. It is a recommendation of this assessment that the GSHSPG ensures it is engaged with the progress of this work and acts as a conduit to ensure those working in the field of sexual health contribute to the full in the identification and prevention of incidences of FGM.

### **6 Summary of Recommendations**

6.1 A review to determine how to capture information regarding the reporting and non reporting of sexual violence and assault against men.

6.2 The GSHSPG ensures it is engaged with the progress of the work around FGM, and acts as a conduit to ensure those working in the field of sexual health contribute to the full in the identification and prevention of incidences of FGM.

## 7 Child Sexual Exploitation

A strategy for tackling child sexual exploitation (CSE) has been developed by the CSE strategy working group. The Gloucestershire Safeguarding Children Board Child Sexual Exploitation Commissioning Strategy 2014<sup>46</sup>, has been agreed and an action plan is currently being implemented. This is overseen by the CSE and Missing subgroup on behalf of GSCB (Gloucestershire Safeguarding Children Board). The national overview of CSE, from an interim report in November 2012 of the Children's Commissioner's inquiry into Child Sexual exploitation, found that between Aug 2010 and October 2011, 2,409 children and young people were victims of child sexual exploitation. It also found that between April 2010 and March 2011, 16,500 children and young people were a potential high risk of sexual exploitation. The CEOP (Child Exploitation and Online Protection Centre) research "out of minds, out of sight" (2011) found that the ages of victims in contact with voluntary organisations was 14/15years with the majority being female. The majority of perpetrators were male (87%) with most between the ages of 18-25years.

In Gloucestershire, the response to CSE is underpinned by strong partnerships. A number of awareness raising events, training opportunities and multi agency safeguarding protocols have been developed to ensure that all staff who work with children and young people in a range of settings are able to understand the warning signs and develop confident intervention strategies to prevent escalation. The Gloucestershire strategy also identifies that there is a need to develop strong support for and resilience of families and young people. In relation to gang related offences there are limited criminal prosecutions currently; however there is evidence from the Avenger Task Force (ATF) that there is an increase in sexual violence of girls and link to CSE. The ATF is an initiative led by police, set to revolutionise the approach to gangs in Gloucester. The multi agency project, involving representatives from Gloucestershire Constabulary, Gloucester City Council and Gloucestershire County Council's Youth Support Team, aims to reduce the number of youngsters involved in gangs by offering support to those who are or may be vulnerable. For more information on ATF aims and objectives please see Appendix 6.

The Youth Support Team (YST) are developing a range of programmes for young people to address sexual health and relationships and risky behaviours, which can be layered up, depending upon their needs, to focus more on sexual harm, CSE and domestic abuse. These programmes can be tailored to meet the needs of young people who have learning difficulties or a disability.

A programme of work is developing between the YST and the ATF to specifically address girls in gangs, to complement existing programmes on offer from both services. It will be important to check that those young people who have been sexually exploited have easy access to sexual health services appropriate to their needs and circumstance. This is an area which will need to be reflected in any future developments of robust processes, with other local authorities where necessary, if there is increase in the number of identified cases.

It is important that the GSHSPG is kept informed about the work of the CSE strategic working group. As such it is a recommendation of this needs assessment that a formal link be developed between the GSHSPG and the CSE strategic working group.

## 7. Summary of Recommendations for CSE

A formal link be developed between the GSHSPG and the CSE strategic working group.

## 8 Description of current services

This section will describe the services currently provided with Gloucestershire, regardless of the commissioner. It will also present service use data as a proxy for demand for sexual health services.

In a unique model of service, the vast majority of Gloucestershire's specialist Sexual Health Service supply is provided by a single community based provider, Gloucestershire Care Services NHS Trust (GCSNHST).

Working in a 'hub and spoke' model method, as seen in the diagram below, the GCSNHST service is led from the main hub at Hope House in Gloucester. Hope House provides the full range of services provided by the trust, whilst the site in Cheltenham offers a broad range of services and other districts provide BASHH level 1 and 2 GUM integrated with non complex contraceptive clinics. Varying levels of provision ranging from condom distribution to full BASHH level 2 services are offered from services provided by:

- GP Surgeries throughout the county
- Community Pharmacies throughout the county
- Extended sexual health drop in clinics within schools
- The Gloucestershire Youth Support Team
- Gloucestershire NHS Hospital Trust Teenage Pregnancy Midwifery Service
- Public Health Nursing Service

Referral pathways and signposting operate between all services with the intention of assuring a swift transition between services and service providers when required.



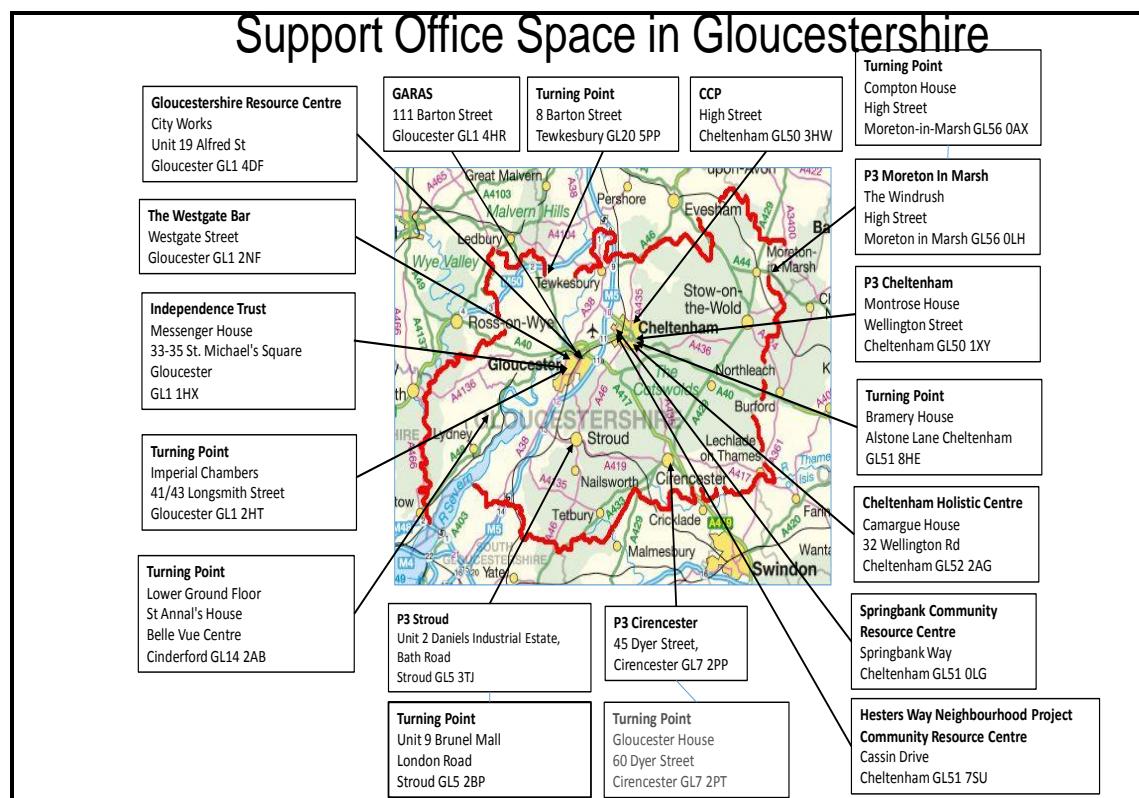
Services provided within this model include:

Service	Where
Chlamydia Screening	Within all services
Genitourinary Medicine (GUM)	In all districts with complex GUM (BASHH level 3) only available at HUB sites.
Health Advising	All services where required
Health Promotion	All services where required
HIV Treatment and Care including testing	Testing in all GUM services and additional drop in facilities outside of Sexual Health Services , HIV treatment at Hub sites only
Partner notification and tracing services	For all positive STI and HIV results
Pregnancy Advisory Services including Abortion	In Hub Services Only
Psychosexual Services	At Gloucester Hub site only
Sexual and Reproductive Health Care (including contraception)	In all services with complex contraception at Hub sites only
Sexual Assault Referral Centre (SARC)	At Gloucester Hope House Hub site only
Sexual Health Outreach clinics in colleges, schools and other educational settings	Throughout the county
Sexual Health Training	Throughout the county

In addition to these services, provision is also available for:

- Condom distribution, via the C-Card Scheme. This scheme, operated in the county by Prospects Youth Services, offers free condoms to anyone under 25. Those signing up to this scheme are required to register at an approved registration site.
- In-school football coaching and sexual health education provided throughout the county via the Cheltenham Town Football Club 'Know Yer Balls' Scheme. The scheme, provided by football coaches is designed to encourage young men to become better informed about sexual health, prevention and self care.
- Specialist contraception initiation services within Gloucestershire Hospital Trust Maternity services. This scheme is designed to increase contraception initiation following birth. The Gloucestershire Pregnancy Advisory Services informs commissioners that almost 20% of women requesting abortion have given birth within the previous 12 months. Many women are unaware of the likelihood of becoming pregnant immediately after delivery which is a contributory factor to unplanned pregnancy.
- Young People's Sexual Health drop in Clinics: These clinics are provided by specially trained clinicians within GP Practices in most parts of the county. The surgeries offer an open access drop in facility for young people aged under 25 in the early evening.
- HIV testing, prevention and support throughout the county provided by the Eddystone Trust. This includes free condom distribution for people at risk of HIV and support for carers and others affected by HIV. (see Figure 36)

Figure 36 Map to show location Eddystone Trust support offices



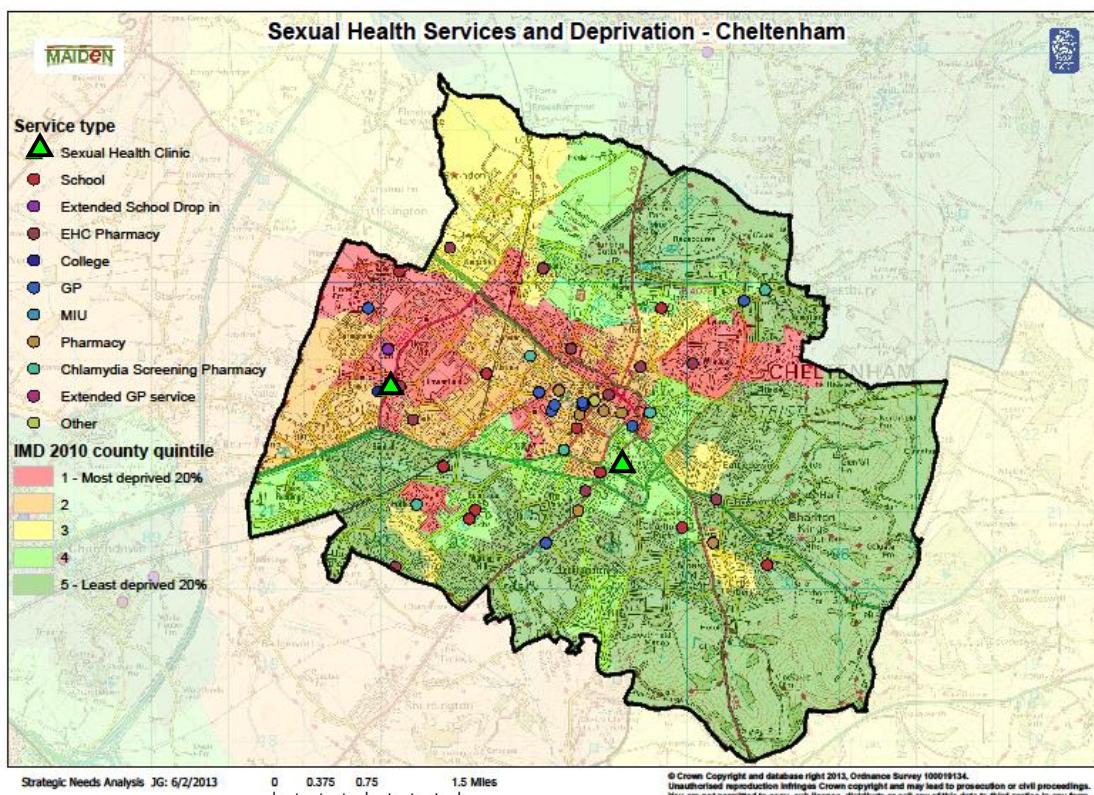
Source: Eddystone Trust

## 8.1 Location of services

The following six maps show the location of sexual health services alongside the indices of multiple deprivation by district. This section will break down each of the 6 districts within Gloucestershire, looking at their populations and the services provided in each area. A detailed breakdown of these services, including address details can be found in Appendix 6.

### 8.1.1 Cheltenham

*Figure 37 Sexual health services and deprivation for Cheltenham*



Source: Gloucestershire County Council Strategic Needs Analysis Team

Cheltenham (Figure 37) has a population of 115,732. Of this population, 73,805 are aged between 18 and 65. The proportion of working residents is higher in Cheltenham than any other part of the county and 5.7% of the population consider themselves as part of Black or Minority Ethnic (BME) groups<sup>47</sup>, this is higher than the countywide average of 4.6%.

The under 18 conception rate for Cheltenham is 15.7 per 1,000 young women aged 15-17. This represents a fall of 64% since 1998 and which is the greatest decrease in the county.

The borough of Cheltenham is home to the highest number of people living with HIV in Gloucestershire with 1.16 people in every 1,000 living with the virus.<sup>48</sup>

Covering the second smallest geographical area in Gloucestershire, the Cheltenham area has:

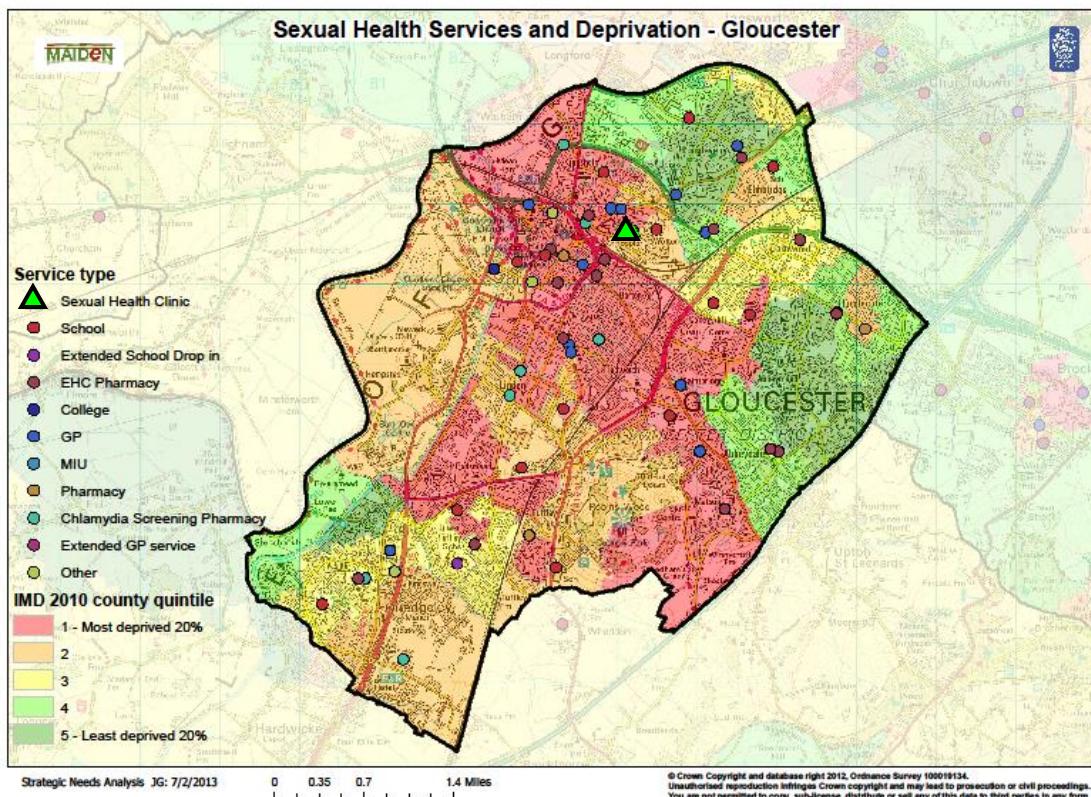
- the second largest sexual health service in the county with the full range of BASHH and contraception services available within the Cheltenham General Hospital site in addition to HIV clinics and Abortion

- a weekly sexual health clinic is available within the Gloucestershire College Cheltenham campus
- 12 GP Practices offering all forms of Long Acting Reversible Contraception (LARC) – this means that 80% of GP practices in Cheltenham offer enhanced contraceptive choices to their patients
- a LARC fitting GP Practice which delivers an additional service, commissioned by the GCCG, to students within the University
- 2 specialist GP Practices offering drop in clinics to young people
- 17 community pharmacies providing emergency hormonal contraception
- 1 secondary school offers a Public Health Nursing Service extended drop-in.. This is the lowest number of this type of provision in the county
- 40 sites in the borough where under 25's can obtain free condoms under the C-Card Scheme, 20 of these, 50%, register new users to the scheme
- 6 Eddystone Trust office premises, shared with other community providers, for HIV testing, prevention and support (see Figure 36)

Good public transport services mean that access from urban parts of the district is good. Rural areas, particularly bordering the North Cotswolds are more challenging with further work required to ensure need is met in these areas.

### 8.1.2 Gloucester

Figure 38 Sexual health services and deprivation for Gloucester



Source: Gloucestershire County Council Strategic Needs Analysis Team

Gloucester, (Figure 38), has a population of 121,688 of whom 76,267 are aged between 18 and 65. 10.9% of residents in Gloucester consider themselves from BME groups. This represented 13,226 people. The proportion of BME residents was higher than the countywide average of 4.6% and the highest in Gloucestershire<sup>49</sup>.

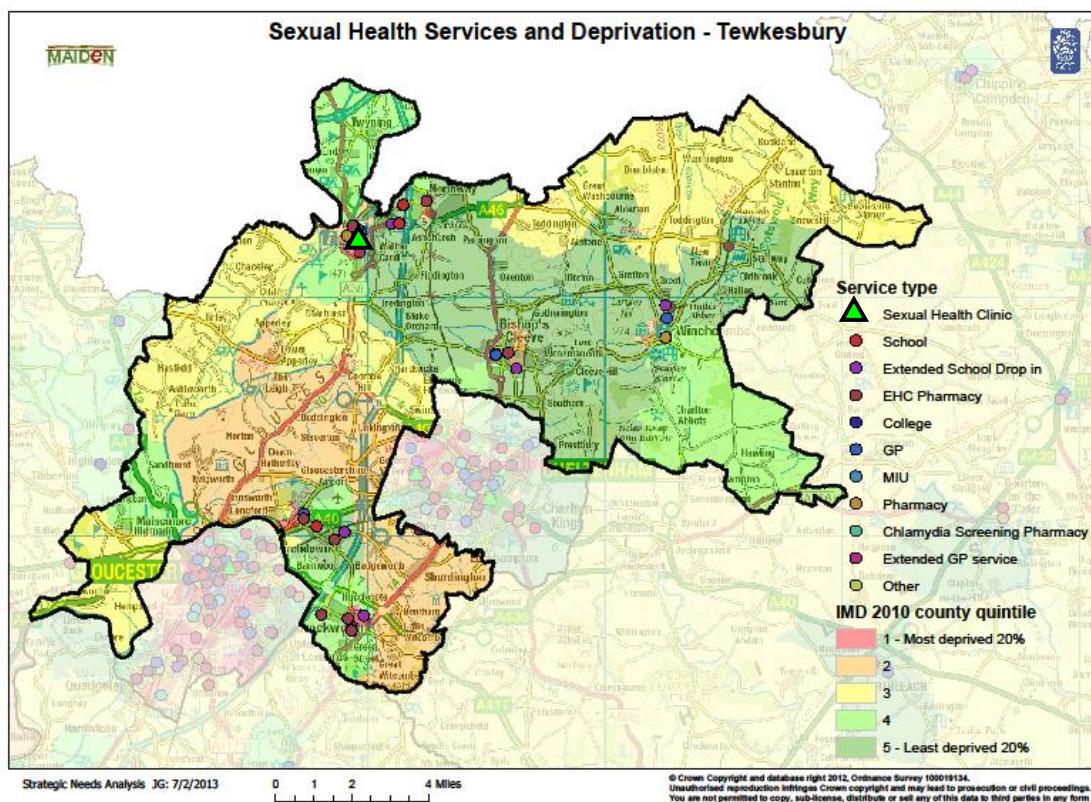
The City of Gloucester has an under 18 conception rate of 34.8 per 1000 young women aged 15-17. Whilst this is a decrease of 48% since 1998 it is still the highest rate in the county and the only district where the rate is higher than that for England (27.7).

- 1.13 people in every 1000 are positive for HIV, this is the second highest rate in the county<sup>50</sup>. Covering the smallest geographical area the district has:the main hub of the Sexual Health Service at Hope House on the Gloucestershire Hospital site. Not only does Hope House offer, daily, the full range of GUM, contraception and HIV services but it also provides Pregnancy Advisory Services (PAS) and abortion, psychosexual medicine and is home to the Gloucestershire Sexual Assault Referral Centre (SARC)
- Gloucester Royal Hospital providing the teenage pregnancy midwifery service
- a weekly sexual health clinic is available within the Gloucestershire College campus
- 12 GP Practices offering full LARC, with 2 providing just IUCD and 1 providing implants as extra services. That means 88% of GP practices offer enhanced contraceptive choices to their patients
- 3 GP Practices who offer enhanced sexual health drop in clinics for young people

- 25 community pharmacies who provide free EHC to under 25's
- 2 secondary schools offer Public Health Nursing Service extended drop-ins., with 2 other schools providing in school Chlamydia screening and advice. This is below average provision of this service given the number of schools in the Gloucester District
- 57 sites offer C-Card of which 35 register new users to the scheme
- 5 Eddystone Trust office premises, shared with other community providers, for HIV testing, prevention and support (see Figure 36)

### 8.1.3 Tewkesbury

Figure 39 Sexual health services and deprivation for Tewkesbury



Source: Gloucestershire County Council Strategic Needs Analysis Team

Tewkesbury (Figure 39) has a population of 81,943 of whom 48,913 are aged between 18 and 65. 2.5% of residents in Tewkesbury are from BME communities. This represents 2,042 people. The proportion of BME residents is lower than the countywide average of 4.6%.<sup>51</sup>

Tewkesbury borough has an under 18 conception rate of 17.3 per 1000 young women aged 15-17. This is a decrease of 40% since 1998.

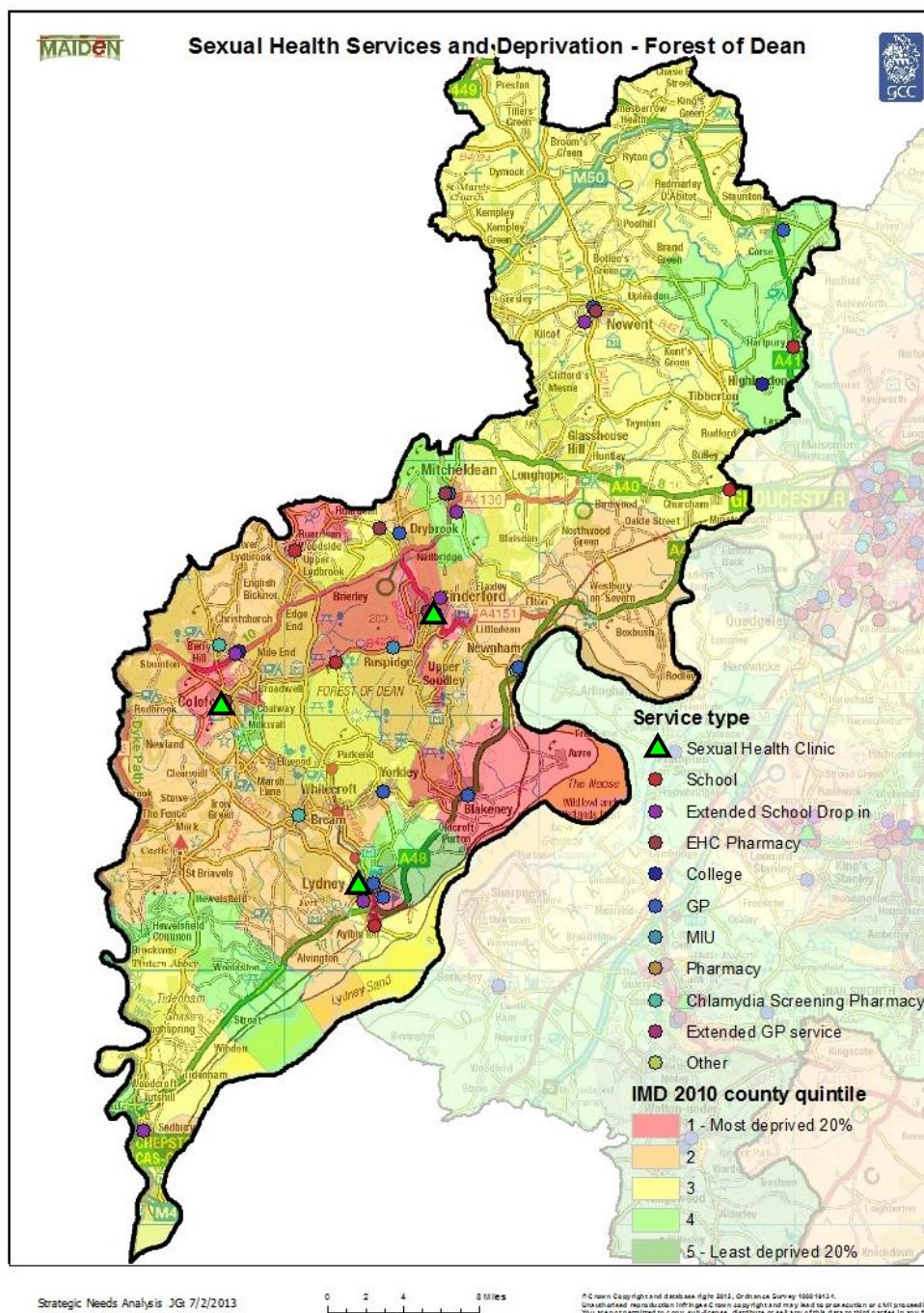
At a rate of 0.61 per 1000 population, Tewkesbury has the lowest rate of people living with HIV in Gloucestershire<sup>52</sup>. The borough has:

- One weekly drop in sexual health clinic offering integrated contraception and GUM services to BASHH level 2
- GP practices offer all LARC options. This means that 86% of Tewkesbury GP Practices offer enhanced contraceptive choices to their patients
- 5 GP Practices who offer a young person's sexual health drop in service
- 11 Community Pharmacies offer Emergency Hormonal Contraception
- 5 secondary schools offer weekly Public Health Nursing Service extended drop-ins.
- 31 sites offering C-Card condoms of which 20 also register young people onto the scheme

- 1 Eddystone Trust office premises, shared with other community providers, for HIV testing, prevention and support. (see Figure 36)

### 8.1.4 Forest of Dean

Figure 40 Sexual health services and deprivation for Forest of Dean



Source: Gloucestershire County Council Strategic Needs Analysis Team

The Forest of Dean (Figure 40) has a population of 81,961 of which 48,552 are aged between 18 and 65. 1.5% of residents in the Forest of Dean were from BME communities. This represented 1,262 people. The proportion of BME residents was lower than the countywide average of 4.6%.

In 2012 the under 18 conception rate for the Forest of Dean was 16.8 per 1000 young women aged 15-17. This represents a fall of 62% since 1998 and was the second highest decrease in the county.

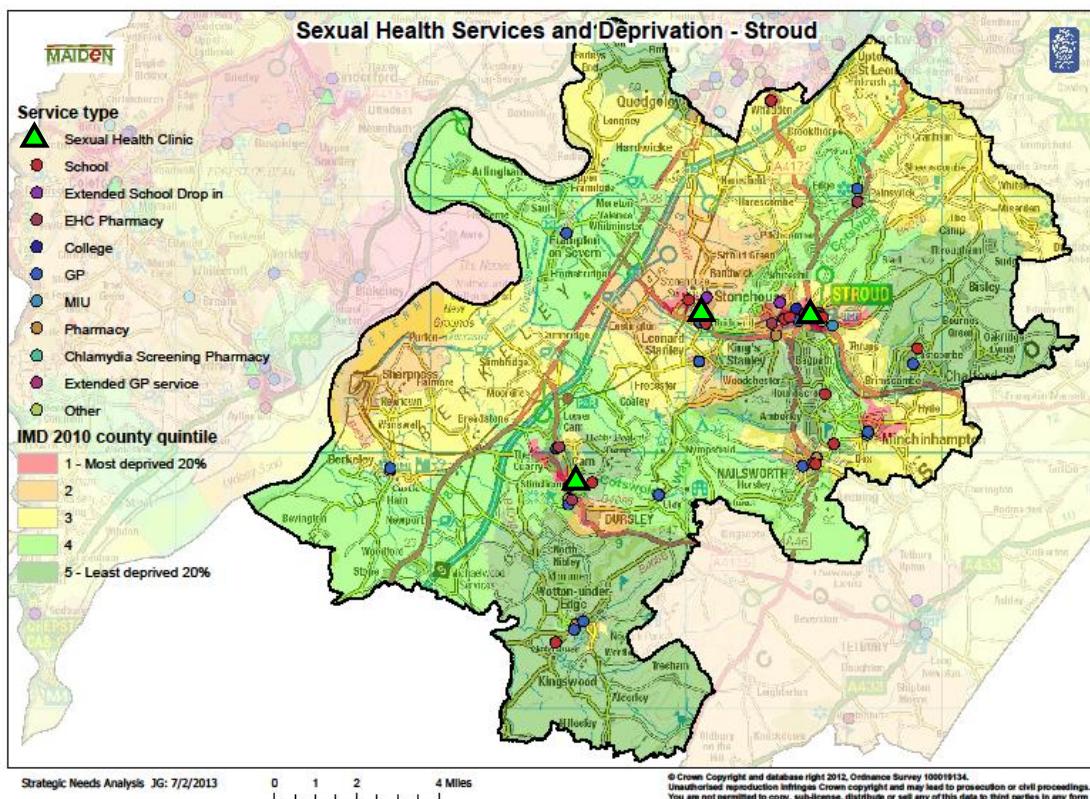
There are 0.66 people per 1000 are living with HIV; this is the third lowest rate in Gloucestershire<sup>53</sup>.

The district has:

- Three weekly drop in sexual health clinic offering integrated contraception and GUM services to BASHH level 2
- A weekly Sexual Health Clinic for students attending both the Gloucestershire College site in Coleford and Hartpury College
- 4 GP Practices offer all LARC devices with 2 offering just IUCD and 1 offering just implants. This means that 54% of Forest of Dean GP Practices offer enhanced contraceptive choices to their patients. This is the lowest available GP access in the county which requires immediate review
- There are no GP Practices currently offering sexual health drop in clinics to young people
- 10 Community Pharmacies offer Emergency Hormonal Contraception
- 6 secondary schools offer weekly Public Health Nursing Service extended drop-ins. This is the highest level of provision in the countyThere are 28 sites offering C-Card with 21 of these also registering new people onto the scheme
- 1 Eddystone Trust office premises, shared with other community providers, for HIV testing, prevention and support (see Figure 36)

### 8.1.5 Stroud

Figure 41 Sexual health services and deprivation for Stroud



Source: Gloucestershire County Council Strategic Needs Analysis Team

Stroud (Figure 41) has a population of 112,779, with 67,219 people aged between 18 and 65. 2.1% of residents in Stroud were from BME communities. This represented 2,353 people. The proportion of BME residents was lower than the countywide average of 4.6%.<sup>54</sup>

The rate of under 18 conceptions for Stroud is 21.8 per 1000 young women aged between 15 and 17. This is a fall of 32% since 1998 which represents the lowest decrease in the county.

There are 0.62 per 1000 residents are HIV positive, this is the second lowest rate in Gloucestershire<sup>55</sup>.

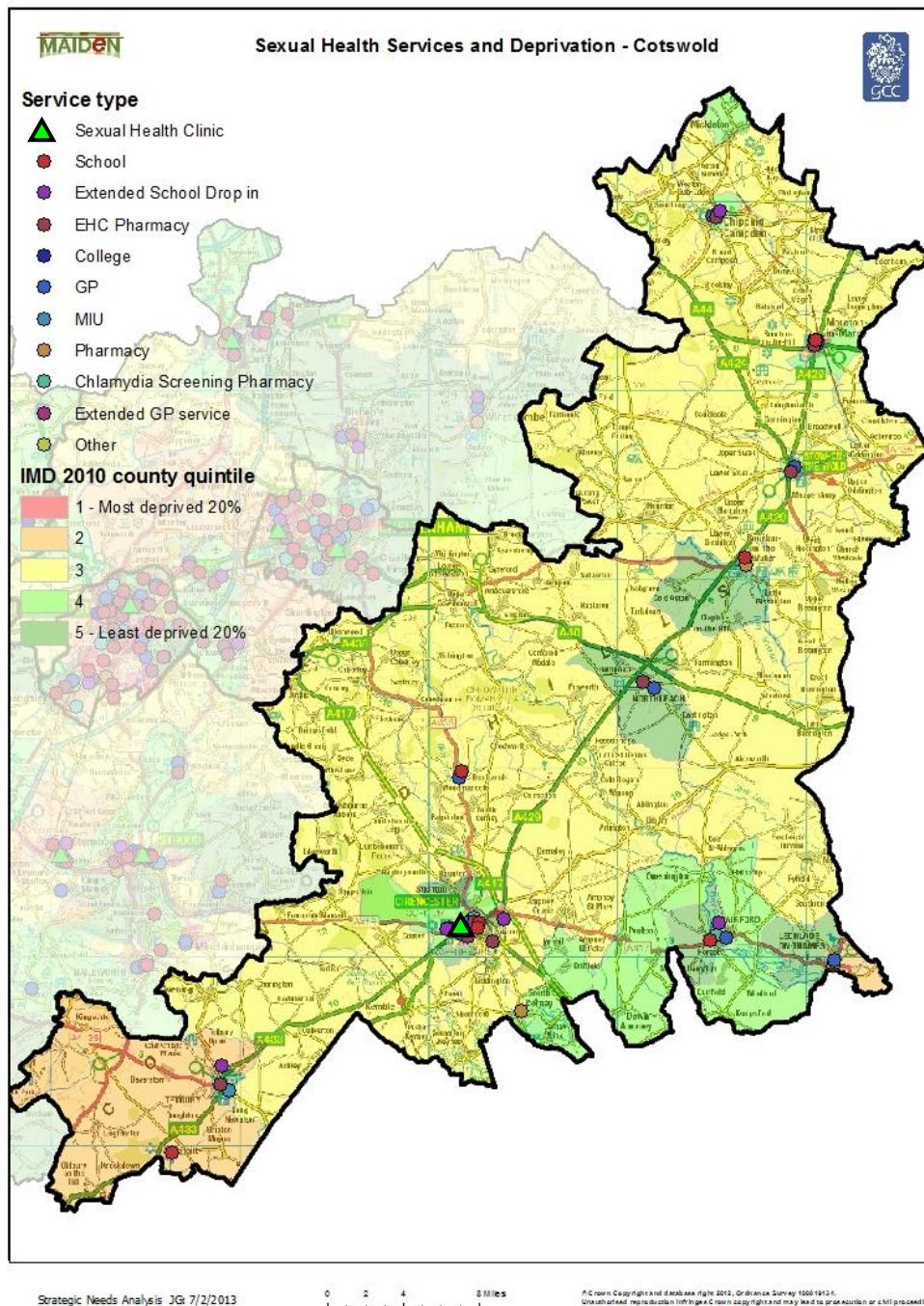
The District has:

- Three weekly drop in sexual health clinics offering integrated contraception and GUM services to BASHH level 2
- A weekly Sexual Health Clinic for students attending Stroud College
- 16 GP Practices offer all LARC devices with 1 just offering IUCD. This means that 85% of Stroud GP Practices offer enhanced contraceptive choices to their patients
- 4 GP Practices provide young people sexual health drop in clinics
- 16 Community Pharmacies offer Emergency Hormonal Contraception

- 2 secondary schools offer weekly Public Health Nursing Service extended drop-ins., with a further 2 schools considering offering this service in 2014 and 1 school holding a specialist sexual health clinic provided by a local GP Practice
- There are 35 sites which distribute C-Card condoms, 23 of these also register people onto the scheme
- 2 Eddystone Trust office premises, shared with other community providers, for HIV testing, prevention and support (see Figure 36)

### 8.1.6 Cotswolds

Figure 42 Sexual health services and deprivation for Cotswolds



Source: Gloucestershire County Council Strategic Needs Analysis Team

The Cotswolds (Figure 42) has a population of 82,881 people living in the district, 48,648 aged between 18 and 65. 2.2% of residents in Cotswold were from BME communities. This represented 1,806 people. The proportion of BME residents was lower than the countywide average of 4.6%.<sup>56</sup>

The District has an under 18 conception rate of 14.4 per 1000 15-17 year olds. This is the lowest rate in the county and represents a fall of 47% since 1998.

There is a prevalence of 0.75 per 1000 population of people living with HIV within the Cotswolds<sup>57</sup>.

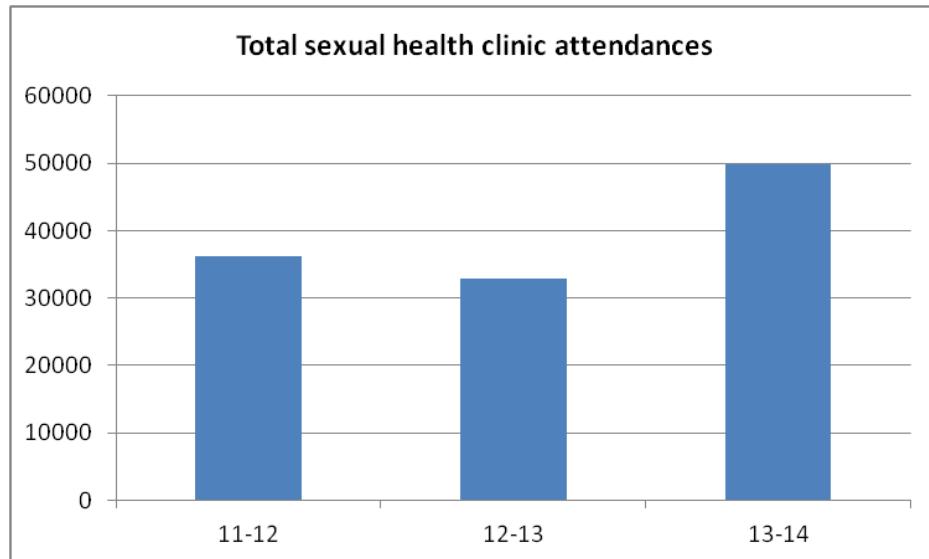
The District has:

- One weekly drop in sexual health clinic offering integrated contraception and GUM services to BASHH level 2 at Cirencester Hospital. There are no sexual health service clinics in the North Cotswolds which, given the geography of the district, leaves residents in this area with challenging distances to travel
- One weekly Sexual Health Clinic for students attending Cirencester College with a second for students at the Royal Agricultural University due to start 2015.
- 9 GP Practices offer all LARC devices, with 3 offering just IUCD and 1 just implant device fitting. This means that all GP Practices offer enhanced contraceptive choices to their patients
- 2 GP Practices offer a young person's sexual health drop in clinic
- 11 Community Pharmacies offer Emergency Hormonal Contraception
- 5 secondary schools offer weekly Public Health Nursing Service extended drop-ins, with 1 of these enhanced further by a service provided by a local GP Practice
- There are 33 sites which distribute condoms via the C-Card scheme with 22 of these registering new people onto the scheme
- 4 Eddystone Trust office premises, shared with other community providers, for HIV testing, prevention and support (see Figure 36)

## 8.2 Access to current services

Just under 50,000 attendances were registered at Specialist Sexual Health Service Clinics (these services are provided by GCSNHST) during 2013/14 (Figure 43). This was a significant increase from previous years which is due to an increase in activity and the introduction of a new computer reporting system which better records the number of attendances.

*Figure 43 Total sexual health clinic attendances*



Source: Gloucestershire Care Services activity reporting

From March 2013 cross county sexual health service attendances information has become available. This allows us to see how many people attend sexual health services within Gloucestershire from other parts of England, and likewise, the number of Gloucestershire residents who choose to attend a clinic outside of our county. This information can be used to inform us as to the appropriateness of our current clinic locations and to the impact on out of county residents attending Gloucestershire clinics.

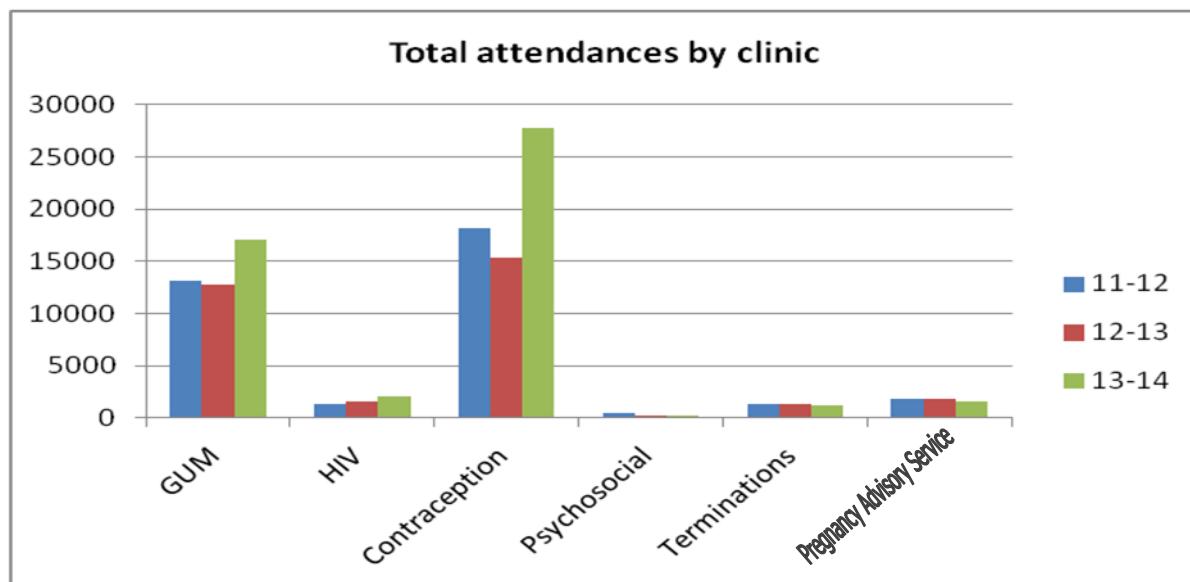
Cross border attendance information was released by Public Health England for 2012/13 as a guide for commissioners. This indicated that Gloucestershire should expect 358 first and 144 follow up attendances from out of county patients whilst 1076 people from Gloucestershire sought their first appointment in another county and 247 attended that service for subsequent appointments.

The data collection has not been repeated by Public Health England since 2013/14 so a recommendation from this assessment, to review the sighting of sexual health clinics in relation to Gloucestershire residents choices of out of county attendances, will be done using the 2012/13 data sets.

The highest number of attendances was for contraceptive services (Figure 44). Whilst this number is significantly higher than other areas of provision it is important to note that many forms of contraception require multiple attendances, for example, people using contraceptive injections are required to attend 4 times per year for administration and as such attendance numbers include a higher repeat attendance percentage. Psychosexual and Abortion saw

reduced activity in 13/14. Whilst improvement in access to contraception has led to a fall in abortion rates more investigation is required into psychosexual and Pregnancy Advisory Service attendances to understand the decrease.

*Figure 44 - Total attendance by clinic*



**Source:** Source: Gloucestershire Care Services activity reporting

The data referred to in this section is for attendances at the specialised Sexual Health Service provided by Gloucestershire Care Services NHS Trust. There are a significant number of attendances for sexual health related conditions at GP Practices and within community pharmacies. Currently this activity is not recorded in sufficient detail to be recorded within this assessment. More work is required to ensure that a full picture of service usage across the county is available.

## **8. Summary of Recommendations for Sexual Health Services:**

### **8.1 Location of services**

- Access to services in the North of the county, both in Cotswold and Cheltenham Districts requires review.
- Public Transport issues within the rural areas of the county need to be taken into account regarding access to services.
- Access to LARC and GP services in the Forest of Dean require review.
- Review access to Public Health Nursing Service extended drop-in services in Gloucester and Cheltenham
- Review of access to contraception within GP Practices in the Forest of Dean, including specialist young person sexual health drop in.

## **8.2 Access to services**

- Investigation to be undertaken into increase in attendances at specialist sexual health services, in particular to understand the number of people attending Gloucestershire clinics from outside of the county and the number of people from Gloucestershire choosing clinics outside of the county.
- Steps to be put in place to accurately determine the level of sexual health activity undertaken within GP Practices and Community Pharmacy.

## 9 Stakeholder feedback

### 9.1 Introduction

This section will discuss the results of the stakeholder and service user engagement. This began with an event (as discussed in section 1.4.2) that used an open space methodology. A large number of issues were raised at that event. These were collated into the following themes:

- Choice
- Access to services across the county
- Education
- Communication
- Attitudes

It was also noted that some specific groups of service users were not represented at the event, such as people with a learning disability. In order to capture feedback from as wide a group of stakeholders as possible and to further investigate the emerging themes, two questionnaires were devised. One was circulated to all stakeholders and the second to the public.

The survey was live for three months (28 May to 29 August 2014) and was completed by 91 members of the public and 139 stakeholders from a range of different organisations. The greatest number of responses for location was from Gloucester (37%) followed by Cheltenham (22%), Stroud (14%), Cotswolds (12%), Tewkesbury (9%) and Forest of Dean (6%). This is not surprising as the main specialist sexual health clinics are based in Gloucester and Cheltenham. A range of responses from across the age groups, 70% of respondents were female and from all localities of county and sexualities.

Whilst the response to the surveys was good there are some caveats to consider when interpreting the information detailed below:

- Not all questions were answered by all the respondents
- Some questions had very low responses therefore inconclusive (this is highlighted in the table below)
- Some questions and subsequent supplementary question were not answered by the same number of respondents to initial question therefore it is very difficult to draw specific conclusions from this
- Where there are options to tick more than 1 option it cannot be determined how many options were ticked by any 1 person
- The data is aggregated therefore we cannot determine who said what i.e. if it was a young person from a specific location or which stakeholder answered
- Data saturation was not achieved due to sample number of responses

- All comments need to be treated with caution as they do not represent a majority view. Furthermore people responding to online questionnaire may be those who are interested, less embarrassed and most likely to look online for information

## 9.2 Main findings

### 9.2.1 Public questionnaire

Question	Top Responses	Comments
1. How comfortable are you talking about your own sexual health?	Fine (56%) OK (30%) Not very comfortable (14%)	Majority of people are comfortable talking about their sexual health. Of those who are not very comfortable it cannot be determined whom.
2. Where would you find out about sexual health?	Internet (66%) GP surgeries (56%) Sexual health specialist nurse or doctor (45%)	Google search engine mentioned the most followed by NHS Choices. Most people felt the option they ticked was their first choice and was available to them today
3. Do you know where the nearest sexual health service is to your home or place of work?	Only 2% answered the first part of the question. However 95% (n=86) responded to the second part. Of the 95% nearly 80% confirmed they knew how to find out how and when the service can be used.	
4. Have you sought advice or received contraception or pregnancy advice while living in Gloucestershire?	71% of respondents had accessed contraception/pregnancy advice. However only 21% went on to confirm where they accessed the advice. The specialist sexual health service (15%) and their own GP surgery (11%) were the common choices.	
5. Have you sought advice or treatment for any	Yes (24%)	

sexually transmitted infections whilst living in Gloucestershire?	No (76%)  Of the yes respondents (89%) chose to go to the specialist sexual health clinic	
6. Have you sought advice or been tested or received treatment for HIV whilst living in Gloucestershire?	Yes (62%)  Specialist sexual health clinic (16%)	Low number of responses but this is to be expected as Gloucestershire has a low prevalence of HIV
7.What other sexual health services have you accessed in Gloucestershire, name as many as you wish	Pregnancy	
8. How would you prefer to use Sexual Health Services?	Booked appointment online (46%)  Booked appointment by phone (41%)  Walk in appointment (36%)	Online service/instant messenger  <i>“Maybe an instant messaging service where you can upload pictures as well... have a video call...service as most people my age are familiar with that layout and I think they would feel more confident to get advice or ask questions that way.”</i>
9. Do you feel comfortable using Sexual Health Services near to your home?	Yes (76%)  No (24%)	Yes respondent themes  Confidentiality  “Services should be easy to access and confidential - if this is the case, have no concerns”

		<p>Convenience (access)</p> <p>“convenience, time and know the area”</p> <p>Comfortable</p> <p><i>“Because sexual health is about prevention not just treatment and also covers contraception etc - I don't think there's a stigma attached to that.”</i></p> <p>No respondent themes</p> <p>Anonymity (stigma)</p> <p><i>“too close if anyone i know saw me, it would be embarrassing.”</i></p> <p>Access (transport, appointments)</p> <p><i>“I would need to go where is convenient. I might go out of area if I wanted to be sure that it was a service used to seeing a lot of people and I was put off by the local service for any reason.”</i></p>
10. What impression do you get about sexual health from the media? (i.e. television, radio, magazines and newspapers)	<p>Generally positive (32%)</p> <p>Generally negative (31%)</p>	

	Don't know (23%)	
11. If you are at school or have recently left school what do you think about sexual health information that you get/or received in school?	Of the 26% of respondents who fell into this group 58% thought that the provision of sexual health information at school generally poor or poor	
12. Do you have any other comments or suggestions on sexual health services in Gloucestershire?	<p>"Teach children that sex can be enjoyable stop teaching just negatives"</p> <p>"How about you teach kids about what sex is actually like, so they don't go in all guns blazing thinking it isn't going to end up as a clumsy sweaty mess."</p> <p>"Instead of just telling people to use protection explain that having a baby is harder to bring up the younger you are as if you haven't sorted your own life out with a job how would you support your own child. Explain more about anal sex but not all about what infections or whatever you can get but the opposite as I believe this is quite common for both heterosexuals and homosexuals to participate in. But mainly how if you are having a child you can't just live off your mum and dad and other implications that come with having a child at a young age as I know a lot of people about my age and early 20s that still live with their parents and because they have been with their partners for like 3 years they suddenly think</p>	<p>Better education</p> <p>Flexible appointment system</p>

	they would make a great family.”	
13. Is enough done to promote safe sexual relationships for people with a disability? Suggestions/comments	<p>7% of people reported having a disability</p> <p>“It needs to be recognise that people with disabilities of any kind are still sexual people at times and should not be marginalised. Needs to become more mainstream in the media etc.”</p> <p>“Awareness of sex for disabled people has increased a lot in recent years and that's a good thing. It's wrong to assume that disabled people can't/don't have sex”</p> <p>“there is not enough support out there for disabled people who want to be parents”</p>	Low response to this question
14. Do you know about our services that support people who are having sexual problems, e.g. erectile dysfunction, vaginal dryness, sexual drive etc. Suggestions/comments	<p>No (66%)</p> <p>“Have leaflets delivered door to door as people too embarrassed to pick them up in GP surgery or may never go there.”</p> <p>“Ensure when someone googles for what is available in Gloucestershire your services appear high up in the results (Search engine optimization)”</p> <p>“Go into sixth forms and colleges tell people to come have a sexual health check, give out little info packs and sexual health packs. Send letters to patients homes of the patient is in a certain age bracket encouraging them for a</p>	<p>Better advertisement</p> <p>Leaflets</p> <p>Internet websites</p> <p>Outreach</p>

	sexual health check.”	
16. Have you had information or received advice on relationships?	No (85%)	
17. Do you have any other comments or suggestions on sexual health services in Gloucestershire?	<p>“The walk-in only service is not accessible for professional people working a full time job. A bookable time slot would be helpful, as would evening and weekend services. If services travelled around gp surgeries of an evening, and you could book an appointment at a location that suited you, it would be much more accessible. I've also experienced on more than one occasion a sense of judgement in a negative light from receptionist staff.”</p> <p>“Opening hours outside of usual working hours would be important to me, as well as the knowledge and attitude of staff.”</p> <p>“They are hidden, I have no idea where I or my teenager would go for support, assume they are for std's and don't feel comfortable taking a relationship problem of a sexual nature into the same environment. I am ,like many somewhat shy of open discussion and would certainly benefit from feeling that someone could help me talk about the issues, prompt me or give</p>	<p>Better access to services</p> <p>Better information sources</p>

	<p>me the language to help me discuss my concerns.”</p> <p>“Improve website. Offer full service for consistent opening times. Offer weekly community clinics advertised on website in alternative locations”</p> <p>“Get out there more and use today technology to get through to today teens and young adults. Best topics to discuss I think are having children at a young age defiantly, dangers of one night stands after getting drunk on the town and the benefits of sex as it's always negative.”</p>	
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## 9.2.2 Stakeholder consultation

Question	Top Responses	Comments
1. If your patient or a client had an urgent need for sexual health advice today, where do you think they would prefer to go?	Sexual health specialist nurse or doctor (55%) GP (42%) Internet (41%)	Google search engine featured highly
2. Where do you think your patients/clients find out about sexual health?	Friends (71%) School/college (52%) Internet (50%)	Google search engine featured highly
3. Do you know where the nearest specialist sexual health service is in relation to your clinic/practice/pharmacy/office/workplace?	Yes (82%)  No (18%) those that answered no, knew how to find out where it is and when it is open.  68% of the stakeholders felt sexual health services are easily accessible to those that need it in the locality they are working in.	Accessibility of appointments , physical location, awareness of services emerged as themes for services not accessible to those that need it

4. Where do you think your patients go to for BASIC sexual health advice e.g. contraception and concerns about STIs?	Their own GP surgery (72%) Specialist sexual health clinic (39%).	Majority of respondents felt the option they ticked was available to their clients. For those that answered no it is not clear what the reason was.
5. Where do you think your patients go to for COMPLEX sexual health advice e.g. complex contraception and treatment for STIs?	Specialist sexual health clinic (71%) Their own GP surgery (60%)	Majority of respondents felt the option they ticked was available to their clients. For those that answered no it is not clear what the reason was.
6. Where do you think your patients go for HIV treatment and advice?	Specialist sexual health clinic (81%) Their own GP surgery (43%)	Although 55% of respondents felt this option was readily available to clients, 37% respondent don't know whether this was the case.
7. How do you think Gloucestershire residents should be able to access sexual health services?	Walk in appointment (85%) booked appointment by phone (65%) Booked appointment online (58%)	
8. Is there anything else you would like to add?	<p>“Although I work in Gloucester I live in the Forest of Dean and I believe that there could be increased service there as it is often increasingly difficult for those who live there to come into Gloucester for appointments.”</p> <p>“I have great concerns of the continuation of the rural clinics, we are letting down vulnerable patients”</p> <p>“mobile clinics visiting rural areas - services aimed specifically at teens (aware of transport/cost/embarrassment/sexuality</p>	<p>Location of services</p> <p>Awareness/ out of date information</p> <p>Access</p>

	<p>issues associated with their age group)"</p> <p>"can the website be updated please, it does not list all pharmacies that provide EHC"</p> <p>"Poor publicity of what is available, why, when or where."</p> <p>"If the mechanisms for accessing the service are not simple and straightforward and discrete and in close proximity - it is likely people will not bother."</p> <p>"Please consider needs of people with Learning Disabilities in service evaluation and the importance of carers' role in determining how access is done for this population group"</p>	
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## 9.3 Thematic analysis

### 9.3.1 Public Response to the Questionnaire

#### Question 8

*The 'other' preferred ways to use sexual health services were grouped into the following themes:*

**Online Service/Instant Messenger**

“Maybe an instant messaging service where you can upload pictures as well and maybe have a video call a bit like the Facebook messenger service as most people my age are familiar with that layout and I think they would feel more confident to get advice or ask questions that way.”

“online chat facility rather than phone”

“Anonymous online advice”

#### Question 9

*Do you feel comfortable using sexual health services near to your home?*

*The yes and no responses were categorised into the following themes:*

**Yes**

**Confidentiality**

“Providing I didn't know the nurse/GP personally, I'd have no problem using a sexual health service near to my home. I trust health professionals to maintain confidentiality.”

“Personally, I am happy to discuss sexual matters with health care professionals, but I can understand that young people would want a more anonymous service when confidentiality is assured.”

“Nothing to be ashamed of, believe the service to be discrete and confidential.”

“They are discreet”

“Services should be easy to access and confidential - if this is the case, have no concerns”

## Convenience

"convenience, and why not?"  
"Mum works at one doctors"  
"Beats travelling"  
"Easy to get to and return if need to"  
"convenience, time and know the area"

## Not embarrassed/

"Sexual health is important and nothing to be ashamed of. I would have no issue using a centre in my home town."  
"Perhaps of an age not to be embarrassed!"  
"Well my sexual health service it just my GP and as I myself work in a doctors surgery I have no issues talking about it"  
"Sexual health is part of a normal life and although it may be embarrassing after having 2 children and being older, I try not to be embarrassed but to have an open conversation with my GP."  
"Because sexual health is about prevention not just treatment and also covers contraception etc - I don't think there's a stigma attached to that."  
"I am comfortable with the choices i make regarding my sexual activity and therefore i have no fear about discussing associated issues with anyone providing these services"

## No

## Anonymity/Privacy / Embarrassed

"Waiting room is not private enough- very open"  
"Might be known to staff and other attendees."  
"might see people I know"  
"Don't know. I wouldn't want to meet neighbours or friends"  
"Too much emphasis on sexual health, it shouldn't be discussed as openly as it is!"

“may be recognised/judged”

“too close if anyone i know saw me, it would be embarrassing.”

“Not happy in discussing it outside doctor confidentiality”

“Known sexual health venues risk being recognised by community members or acquaintances, if the practice has a wide range of facilities that would be preferable as a local location would be more convenient”

“because it’s a complete embarrassment to have a sexual health disease and I never know how I caught it. Generally because it impacts life and people judge”

### Question 13

*Do you have any other comments or suggestions on sexual health services in Gloucestershire?*

*There was one main theme that was drawn out of the responses to this question:*

**Better/  
Different  
education  
for young  
people**

“Teach children that sex can be enjoyable stop teaching just negatives”

“Instead of just telling people to use protection explain that having a baby is harder to bring up the younger you are as if you haven't sorted your own life out with a job how would you support your own child. Explain more about anal sex but not all about what infections or whatever you can get but the opposite as I believe this is quite common for both heterosexuals and homosexuals to participate in. But mainly how if you are having a child you can't just live off your mum and dad and other implications that come with having a child at a young age as I know a lot of people about my age and early 20s that still live with their parents and because they have been with their partners for like 3 years they suddenly think they would make a great family.”

“How about you teach kids about what sex is actually like, so they don't go in all guns blazing thinking it isn't going to end up as a clumsy sweaty mess.”

### Question 16

There were no overall themes that came out under the suggestions/comments for promoting safe sexual relationships for people with disabilities, but many good suggestions were made.

### Question 17

*Do you know about our services which support people who are having sexual problems? If no, what would you suggest?*

Suggestions were categorised broadly into the theme of 'Better advertisement' and sub-categorised into the following themes:

#### Leaflets

"leaflets in my doctors waiting room"  
"leaflets in pharmacies and GP surgeries"  
"Maybe send annual info out by mail."  
"Have leaflets delivered door to door as people too embarrassed to pick them up in GP surgery or may never go there."

#### Websites

"Easy google link and posters in local surgeries, pharmacies, social clubs etc?"  
"Make location of availability of such services accessible from the search feature on your website"  
"More information on websites"  
"Ensure when someone googles for what is available in Gloucestershire your services appear high up in the results (Search engine optimization)"

#### Outreach

"pop-up shops"  
"Go into sixth forms and colleges tell people to come have a sexual health check, give out little info packs and sexual health packs. Send letters to patients homes of the patient is in a certain age bracket encouraging them for a sexual health check."

#### Posters

"Perhaps advertise on bus stops"  
"Ensure information is available via GP practices, pharmacies etc. Ads on back of doors of toilet cubicles in motorway service stations."  
"Posters in GP surgery"

### Question 19

The additional comments were categorised into the following themes:

#### Better Access to services

“The walk-in only service is not accessible for professional people working a full time job. A bookable time slot would be helpful, as would evening and weekend services. If services travelled around gp surgeries of an evening, and you could book an appointment at a location that suited you, it would be much more accessible. I've also experienced on more than one occasion a sense of judgement in a negative light from receptionist staff.”

“The whole process of accessing sexual health clinics is difficult - too complicated and inconvenient.”

“Opening hours outside of usual working hours would be important to me, as well as the knowledge and attitude of staff.”

“They are hidden, I have no idea where I or my teenager would go for support, assume they are for std's and don't feel comfortable taking a relationship problem of a sexual nature into the same environment. I am ,like many somewhat shy of open discussion and would certainly benefit from feeling that someone could help me talk about the issues, prompt me or give me the language to help me discuss my concerns.”

“Hold drop in sessions in discreet buildings with plenty of parking and transport links. Advertise the 15 minute HIV testing more widely.”

“it is difficult to get an appointment at a GUM Clinic within a reasonable time and whenever one is made, it happens late due to the busyness of the clinic. If an appointment is made, it should happen at the right time because time has been taken off work to attend.”

## Better Information (websites/ leaflets)

“Improve website. Offer full service for consistent opening times. Offer weekly community clinics advertised on website in alternative locations”

“Get out there more and use today technology to get through to today teens and young adults. Best topics to discuss I think are having children at a young age definitely, dangers of one night stands after getting drunk on the town and the benefits of sex as it's always negative.”

“Talks in schools”

“Easy read information should be available widely, for people with Learning Disabilities.”

“Leaflets could be given to all residential and supported living providers for people with learning disabilities”

“You should hold an event of some kind, to raise awareness”

“there should be an easy read website with links to places that can help”

“the little yellow book should be publicised more”

### 9.3.2 Stakeholder Response to the questionnaire

#### Question 3c

*Of the providers who thought local sexual health services were not accessible to those that need it in the locality, the following themes emerged as explanations as to why;*

## Accessibility of appointments

“Archaic website and chaotic staffing/opening hours particularly at outlying clinics”

“only available at limited times”

“appointment system difficult to access, clinics closed due to staff shortages, lack of doctors in clinics”

“if the person works they will not have access to Gp or service in work time. Employers do not allow time off for appt.”

“Need more consideration for people with Learning Disabilities”

“only Wednesday evenings at local hospital - otherwise GP surgery and young clients not keen to go there”

## Physical Location (Rural access, transport)

“Nothing in extreme outlying areas of Cotswold”

“Too far away”

“minimal services in the locality which are not generally community based”

“I don't know where the nearest facility is, so don't know how accessible it would be for people with disabilities”

“young people in rural settings lack the means to travel”

“lots of rural villages families without transport”

“distance to clinic”

“they are based centrally and this is a rural area”

## Awareness/ Advertising

“not adequately publicised”

“The service at Church St is not well advertised - I have never referred there.”

“no idea where it is!!!”

“There is only one sexual health clinic that I am aware of.”

“not sure where to look”

“not well advertised”

## Question 8

*Additional comments were broken down into the following themes:*

### Physical Location/Rural Access/Transport

“Although I work in Gloucester I live in the Forest of Dean and I believe that there could be increased service there as it is often increasingly difficult for those who live there to come into Gloucester for appointments.”

“I have great concerns of the continuation of the rural clinics, we are letting down vulnerable patients”

“mobile clinics visiting rural areas - services aimed specifically at teens (aware of transport/cost/embarrassment/sexuality issues associated with their age group)”

“Specialist sexual health services are too few and far between in our locality and we could do with a readily accessible service in The Forest of Dean. Mind you...we could do with decent family planning services and coil fitting services too!!!”

### Awareness/out of date information

“can the website be updated please, it does not list all pharmacies that provide EHC”

“Poor publicity of what is available, why, when or where.”

“for clients I work with they might not necessarily have an awareness of sexual health problems and would possibly go to GP to find out what is wrong and then be referred to relevant service.”

### Accessibility

“If the mechanisms for accessing the service are not simple and straightforward and discrete and in close proximity - it is likely people will not bother.”

“Please consider needs of people with Learning Disabilities in service evaluation and the importance of carers' role in determining how access is done for this population group”

“I think a short access appointment booking would enable more patient to access our service and allow for more walk in slots”

## **9.4 Focus Group**

One group in particular was under represented at the engagement event. It was clear that there was a need to engage with people with a learning disability (LD) and that a questionnaire was not an appropriate way to do this. Instead a focus group was conducted with a group of people with a learning disability in order to gain some insight into their expressed needs with regard to sexual health services. The focus group discussed the themes that emerged from the stakeholder engagement event. However care was taken to develop a series of questions that used the appropriate tone and language for this particular group.

There are some caveats to consider when reading this data:

The people who took part in the focus group were Service User Representatives, i.e. they have experience in representing the views of people with Learning disabilities, and consequently may have given responses which apply generally to the LD population, rather than themselves.

Some people in the focus group felt uncomfortable and therefore did not take part in all of the focus group (some got up and walked in and out).

### **9.4.1 Summary of Results:**

6 people took part in the focus group; all 6 were from the Stroud District. The age range of the participants was 22-45. Two females took part and 4 males.

All participants were generally happy to discuss their sexual health.

Most people reported they found out about sexual health through TV programmes and large events such as the Big Health Check Day for people with Learning Disabilities (annual event run by 2gether Trust).

All people in the group knew where to go if they had an urgent sexual health need. 3 people said they would go to their GP, 2 said a sexual health clinic. Other places that were available to the members of the group were: friends and family, support workers and telephone help lines.

Most people knew where their nearest sexual health clinic was to their home or place of work. They all reported that they knew how to find out how and when they could use it.

Two people reported that stigma has stopped them using the service in the past.

Generally participants knew where to go for contraception, STIs, HIV or other sexual health related issues. However participants suggested many things would be more useful to them, if it were available. This includes; easy read leaflets, easy read websites, Smartphone apps.

The participants generally felt that sexual health was displayed in a negative way in the media.

The entire group felt very strongly that not enough is done to support people with disabilities having sexual relationships. The group reported that there used to be a relationship course run by Guideposts trust which was well attended and highly regarded. Participants reported

that this helped with understanding safety in relationships, how to behave, how to understand others' behaviours towards you, etc. Participants reported a course like this would be helpful. Also that more easy read leaflets would be helpful, and better awareness among staff in residential/supported living and drop in services.

The group also reported that there needs to be better awareness of sexual health services amongst people with LD. I.e. better advertisement of services.

### **9.5 Conclusion**

The stakeholder event, questionnaires and focus group have provided a rich source of information to help shape the findings of this health needs assessment. The main findings are summarised below.

This element of the consultation of stakeholder and public perceptions found that:

- It is clear no one service fits all, different people have different needs depending on the stage of life they are at
- From the results of the questionnaire there is a general consensus that respondents selected they would go to specialist sexual health services or their own GP surgeries and felt those services were accessible to them at the point of when they needed them
- Themes around anonymity, confidentiality and access issues specifically around advertising opening times, transport, rurality, and stigma appeared a lot
- Internet featured highly as a source of information

The next section will consider the data and information from all the previous sections and draw conclusions.

## **10 What does this tell us?**

Gloucestershire is a large diverse county with over 600,000 inhabitants. It has a mix of urban and rural areas with 60% of the population living outside of the two main urban centres. The information presented in this report describes the diversity in the need, supply and demand for sexual health services seen across the districts in Gloucestershire. The impact of rurality on planning and accessing services has been well documented.

The Gloucestershire Sexual Health Strategy 2012-17 identified a number of priority groups who traditionally experience poorer sexual health. It is clear that there are some gaps in our knowledge regarding the sexual health needs of these groups particularly in relation to children in care, offenders, people who have been trafficked, sex workers and substance users. There are challenges associated with collecting insightful local data, such as some of these groups are not readily identifiable. However the stakeholder engagement event and service user questionnaire have captured feedback from some of the priority groups but further work is needed to better understand the needs of these groups.

### **10.1 Contraception**

Contraception is available in a variety of forms from a wide range of venues. Feedback from service users indicates that there is still a preference to access services through a specialist sexual health service despite the range of services offered through primary care. There is therefore potential to do more to publicise all venues for accessing contraception to help people access the right service for them.

### **10.2 Sexually Transmitted Infections**

The prevalence of STIs in Gloucestershire is generally lower than that of the South West and England. However, further work is required to understand the impact of extending access to GUM services throughout the county and the impact on communities identified as more at risk.

### **10.3 Access**

Accessible sexual health services are critical to improving the sexual health of the Gloucestershire population. Good transport links in the more urban areas of Gloucestershire facilitate access to services. However, access to regular public transport in parts of the Cotswolds and Forest of Dean hinders access to services. Feedback from stakeholders and service users raised issues not only about geographical location of services but also the timing and availability of appointments, for example pre-bookable and drop in appointments. The potential use of GPs as a setting to provide sexual health services was also discussed.

There are a large number of Gloucestershire residents who access sexual health services outside of the county. Whilst this may be due to personal choice or convenience it could also be a reflection of a lack of accessible services available to them. Further work is needed to understand how the needs of this population can be best met.

#### **10.4 Working across the system**

The implications of the Health and Social Care Act 2012 are far reaching. The commissioning of sexual health services is now split between four groups of commissioners and therefore good collaborative working is needed more than ever before.

Since work on this needs assessment began a number of other issues have emerged, led by other stakeholders that have a strong sexual health component. For example, the new Domestic Abuse and Sexual Violence Strategy and the Child Sex Exploitation strategy and action plan. There is potential to influence sexual health outcomes outside of normal sexual health commissioning boundaries.

## 11 Conclusion

This report has detailed the challenges the sexual health system in Gloucestershire is facing when commissioning and delivering high quality patient centred sexual health services. This will involve strengthening insights into the best ways to facilitate healthy behaviours, being responsive to changing patterns of disease and disability, the development of an active sexual health workforce and making effective use of medical advances and information technologies. It is also critical that when developing services that we are mindful of public attitudes and expectations whilst making wise choices in response to economic pressures.

## **12 Appendices**

To view the full list of appendices please use the following link:  
<http://www.goucestershire.gov.uk/CHttpHandler.ashx?id=63484&p=0>

## Glossary of abbreviations

Abbreviation	Definition
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Treatment
BASHH	British Association of Sexual Health and HIV
BME	Black and Minority Ethnic
CCG	Clinical Commissioning Group
CEOP	Child Exploitation and Online Protection Centre
CGH	Cheltenham General Hospital
CSE	Child Sexual Exploitation
CTAD	Chlamydia Testing Activity Dataset
Cu-IUD	Copper Intrauterine Device
CYP	Children and Young People
DASV	Domestic Abuse and Sexual Violence
DPMA	Depot Medroxyprogesterone Acetate (contraceptive injection)
EHC	Emergency Hormonal Contraception
FSRH	Faculty of Sexual and Reproductive HealthCare
GARAS	Gloucestershire Action for Refugees and Asylum Seekers
GCC	Gloucestershire County Council
GCCG	Gloucestershire Clinical Commissioning Group
GCSNHST	Gloucestershire Care Services NHS Trust
GHPAG	Gloucestershire Health Protection Assurance Group
GSCB	Gloucestershire Safeguarding Children Board
GSHS	Gloucestershire Sexual Health Strategy
GSHSPG	Gloucestershire Sexual Health Strategic Partnership Group
GUM	Genitourinary Medicine
GUMCAD	Genitourinary Medicine Clinic Activity Dataset
HAART	highly active antiretroviral therapy/drugs
HARS	HIV and AIDS Reporting System
HIV	Human Immunodeficiency Virus
HPA	Health Protection Agency
HPV	Human Papilloma Virus
HSV	Herpes Simplex Virus
IMD	Indices of Multiple Deprivation
IUCD	Intrauterine Contraceptive Device
IUD	Intrauterine Device
IUS	Intrauterine System
JSNA	Joint Strategic Needs Assessment
LARC	Long Acting Reversible Contraception
LES	Locally Enhanced Services
LGB	Lesbian, Gay or Bisexual
LSOA	Lower Super Outputs Areas
MIU	Minor Injuries Unit

MSM	Men who have Sex with Men
MVA	Manual Vacuum Aspiration
NATSAL	National Survey of Sexual Attitudes and Lifestyles
NCSP	National Chlamydia Screening Programme
NES	Nationally Enhanced Services
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
ONS	Office of National Statistics
PAS	Pregnancy Advisory Services
PCT	Primary Care Trusts
PHE	Public Health England
PLWHIV	People Living With HIV
PSE	Public Sex Environments
SARC	Sexual Assault Referral Centre
SHA	Strategic Health Authority
SHNA	Sexual Health Needs Assessment
SOPHID	Survey of Prevalent HIV Infections Diagnosed
STI	Sexually Transmitted Infection
TP	Teenage Pregnancy
UPSI	Un-protected Sexual Intercourse
UTLA	Upper Tier Local Authority
WHO	World Health Organisation
YST	Youth Support Team

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<sup>3</sup> Contraceptive services with a focus on young people up to the age of 25 Issued: March 2014 <https://www.nice.org.uk/guidance/ph51>

<sup>4</sup> Department of Health (2013). A Framework for Sexual Health Improvement in England. (<http://www.dh.gov.uk/health/2013/03/sex-health-framework/>)

<sup>5</sup> Health Impacts of Education – A review-  
<http://www.publichealth.ie/files/file/Health%20Impacts%20of%20Education.pdf>

<sup>6</sup> The National Survey of Sexual Attitudes and Lifestyles  
<http://www.natsal.ac.uk/natsal-3/findings->

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<sup>21</sup> Sexually transmitted infection and Chlamydia report 2012 Health Protection Agency.  
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<sup>22</sup> Statutory guidance on promoting the health and wellbeing of looked after children. Department of Health. Department for schools, children and families

<sup>23</sup> <http://www.nice.org.uk/guidance/ph28/resources/guidance-lookedafter-children-and-young-people-pdf>

<sup>24</sup> [http://www.migrationobservatory.ox.ac.uk/sites/files/migobs/Briefing%20%20Health%20of%20Migrants%20in%20the%20UK\\_0.pdf](http://www.migrationobservatory.ox.ac.uk/sites/files/migobs/Briefing%20%20Health%20of%20Migrants%20in%20the%20UK_0.pdf)

<sup>25</sup> 'Ugly Mug' scheme

<https://uknswp.org/um/>

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<http://www.bashh.org/documents/Standards%20for%20the%20management%20of%20STIs%202014%20FINAL%20WEB.pdf>

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<sup>39</sup>

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