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Executive Summary

Sexual health is a vital part of all individuals' health and wellbeing. Poor sexual health is strongly linked to other disadvantage such as poverty, poor educational outcomes, risky behaviour and other vulnerabilities. It is a key cause of health inequalities across the diverse populations that make up Derby City. The commissioning of open access sexual health services, to tackle these inequalities, remains a statutory function of all Local Authorities.

Our city has a population of around a quarter of a million people. They are relatively young, with a seasonal university population, and a quarter are of a BAME background from around 180 nationalities speaking over 70 languages. Derby is one of the 20% most deprived local authorities in England, almost 28% of the population live in the most deprived areas, and there are significant inequalities in life expectancy and other health outcomes.

There is a consistently high sexually transmitted infection testing rate in the City, although positivity of these tests is lower than the national average, indicating that testing could be more targeted. However, rates of new diagnoses are higher than many comparator authorities. In particular gonorrhoea diagnoses have been increasing, but local data indicates that this is reflective of the national trend. This causes additional concern due to the increasing antimicrobial resistance of gonorrhoea. Chlamydia detection rates remain similar to the national average, but as nationally are below target.

The prevalence of HIV in the City has been increasing over recent years and now sits at 2.49 per 1,000 adult population. This is likely to be due to a combination of improved survival for those living with HIV and an increase in new cases. Diagnosis at a late stage remains a local and national issue at just under 42% of cases. This leads to an increased risk of transmission for those who are unaware that they are infected, along with a reduced opportunity for them to access lifesaving treatment. There are missed opportunities for testing individuals at risk both within specialist services but also at other points of contact such as GP registration and hospital admission.

Long acting reversible contraception is more popular in Derby than other areas of England, with 52% of women using the specialist service choosing this method. 28 out of 30 General Practices also choose to provide LARC across the City providing good coverage, although there is a high level of variability in waiting times. Derby performs comparatively well but the proportion of women choosing LARC nationally has been dropping and this is reflected in our local figures. It is of concern that there has been a recent decline in the number of young people accessing specialist sexual health services in Derby. Currently there are 63 pharmacies in the City that provide free emergency contraception to under 18s, although utilisation of the service is low.

Teenage pregnancy rates in the city have been declining, reflecting the national trend. However, rates remain higher than average, including in the under 16 age group. As in other areas this is strongly linked to deprivation and poor educational attainment. We know that the two most important factors in continuing to reduce teenage pregnancy rates are good quality relationship and sex education and good information about and access to contraception services.
Termination rates in Derby remain lower than the national average. Worryingly fewer than three quarters are carried out at less than 10 weeks gestation, significantly worse than the national average and leading to increased risks for women and costs to the health system. There are concerning statistics regarding women less than 25 years of age undergoing termination of pregnancy. 27% of them have had a previous termination and almost 41% have had a previous birth. This indicates that key opportunities to ensure appropriate contraception is in place are being missed.

A survey of stakeholder views, conducted in 2018, demonstrated it was felt that the model of service provision was efficient, maximising the use of GPs and the specialist service. There were positive views about the services ability to engage with the most vulnerable and that BASHH standards were being met. The main issues raised were concerns regarding waiting times and the accessibility of the service. Digital developments, including online STI testing, have been proposed as a potential model to improve services in the future, along with improved partnership working with other local services.

Currently our ISHS is delivered by Derbyshire Community Health Services, plus subcontracts with voluntary sector organisations. Derby City Council also contracts separately with GPs and Pharmacies for additional contraceptive services.

Key unmet needs and service gaps have been assessed. These include accurate data capture for the C-Card condom distribution service, significant numbers of patients turned away from the specialist service, waiting times for a booked appointment and rates of partner notification for Chlamydia infections. There are also key emerging issues such as the increasing microbial resistance of gonorrhoea, the development of Mycoplasma genitalium, recent outbreaks of Hepatitis A, risks of human trafficking, continued challenges for those moving through Laverstock Court and the increasing risks of chemsex. All our services across Derby also need to include a focus on adverse childhood experiences. Positively there are also upcoming opportunities to improve sexual health including the statutory implementation of relationship and sex education and the introduction of HPV vaccination for boys.

Key recommendations are summarised at the end of this document.
### List of Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACE(s)</td>
<td>Adverse Childhood Experience(s)</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>BASHH</td>
<td>British Association for Sexual Health &amp; HIV</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
</tr>
<tr>
<td>CSEW</td>
<td>Crime Survey for England and Wales</td>
</tr>
<tr>
<td>DCHS</td>
<td>Derbyshire Community Health Services</td>
</tr>
<tr>
<td>EHC</td>
<td>Emergency Hormonal Contraception</td>
</tr>
<tr>
<td>FRSH</td>
<td>Faculty of Sexual and Reproductive Health</td>
</tr>
<tr>
<td>GHB/GBL</td>
<td>Gamma-Hydroxybutyric acid/Gamma butyrolactone</td>
</tr>
<tr>
<td>GUM</td>
<td>Genito-Urinary Medicine</td>
</tr>
<tr>
<td>HAV</td>
<td>Hepatitis A virus</td>
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<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
</tr>
<tr>
<td>HPV</td>
<td>Human papilloma virus</td>
</tr>
<tr>
<td>IAC</td>
<td>Initial accommodation centres</td>
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<tr>
<td>ISHS</td>
<td>Integrated Sexual Health Service</td>
</tr>
<tr>
<td>IUD/IUS</td>
<td>Intrauterine device/Intrauterine System</td>
</tr>
<tr>
<td>JCVI</td>
<td>Joint Committee on Vaccination and Immunisation</td>
</tr>
<tr>
<td>LARC</td>
<td>Long Acting Reversible Contraception</td>
</tr>
<tr>
<td>LGBT</td>
<td>Lesbian, Gay, Bisexual, Transgender</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have sex with men</td>
</tr>
<tr>
<td>NHSE</td>
<td>NHS England</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Health and Care Excellence</td>
</tr>
<tr>
<td>OEC</td>
<td>Oral Emergency Contraception</td>
</tr>
<tr>
<td>ONS</td>
<td>Office for National Statistics</td>
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<tr>
<td>PGD</td>
<td>Patient Group Direction</td>
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<tr>
<td>PHOF</td>
<td>Public Health Outcomes Framework</td>
</tr>
<tr>
<td>PN</td>
<td>Partner Notification</td>
</tr>
<tr>
<td>POC</td>
<td>Point of Care</td>
</tr>
<tr>
<td>RSE</td>
<td>Relationship and Sex Education</td>
</tr>
<tr>
<td>RTT</td>
<td>Referral to treatment</td>
</tr>
<tr>
<td>SARC</td>
<td>Sexual Assault and Rape Centre</td>
</tr>
<tr>
<td>SHS</td>
<td>Specialist Health Services</td>
</tr>
<tr>
<td>STI(s)</td>
<td>Sexually transmitted infection(s)</td>
</tr>
<tr>
<td>TOP</td>
<td>Termination of pregnancy</td>
</tr>
<tr>
<td>UPSI</td>
<td>Unprotected sexual intercourse</td>
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</table>
1. Introduction

Sexual health is a key part of our identity and is essential to our physical and psychological wellbeing. The fundamental aspects of good sexual health are aided by access to services and information and include equitable, positive and safe relationships and sexual fulfilment; supported by human rights to privacy and family life, which are free from discrimination or violence.

Many sexually transmitted infections (STIs), including such as human immunodeficiency virus (HIV) can be symptomless, meaning that many are unaware of their condition. This not only affects the individual and their health and well-being but also increases the risk of onwards transmission. Unplanned pregnancies, particularly in young people can have long term health, social and psychological consequences for both mother and child and sexual dysfunction can affect ones self-esteem and relationships.

However, achieving good sexual health is complex as there are many factors that impact on an individual's health for example, biological and genetic predisposition, exposure to risk and health status and societal and cultural norms. There are some groups however such as men who have sex with men (MSM), certain minority groups; young people (especially those in care), sex workers; injecting drug users and those within the criminal justice system who are at increased risk of poor sexual health. The strong links between deprivation and sexual health mean that these groups are disproportionately affected by poor sexual health. Thus reducing inequalities remains a key national and local issue.
The ambition to improve the sexual health of the population is set out in the national *Framework for Sexual Health and Improvement* below.

**Figure 1: Framework for Sexual Health**

The short and long term health risks of poor sexual health are costly and well documented, and for the most part, are largely preventable; therefore a preventative approach makes good economic sense. The health risks of STIs and unplanned teenage pregnancies include:

- Pelvic Inflammatory Disease, which can lead to infertility or ectopic pregnancy;
- Chronic infection, HIV, or recurrent infections such as genital herpes;
- Cervical cancer, including other genital cancers.

Unplanned teenage pregnancy can affect both the parent and their child, and is associated with the following:

- Poor educational achievement;
- Poor physical and mental health;
- Poverty;
- Social isolation for both parent and their children.

The responsibility for commissioning sexual health and HIV services and interventions is distributed between the following organisations:
Figure 2: Commissioning Responsibilities for sexual health

<table>
<thead>
<tr>
<th>Local Authorities</th>
<th>Clinical Commissioning</th>
<th>NHS England</th>
</tr>
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<tbody>
<tr>
<td>Comprehensive sexual health services, including:</td>
<td>Most abortion services (but there will be a further consultation about the best commissioning arrangement in the longer term)</td>
<td>Contraception provided as an additional service under the GP contract</td>
</tr>
<tr>
<td>Contraception, including LESs (implants) and NESs (intrauterine contraception)</td>
<td>Sterilisation</td>
<td>HIV treatment and care, including di-exposure prophylaxis after sexual exposure</td>
</tr>
<tr>
<td>including all prescribing costs – but excluding contraception provided as an</td>
<td>Vasectomy</td>
<td>Promotion of opportunistic testing and treatment for STIs, and patient requested testing by GPs</td>
</tr>
<tr>
<td>additional service under the GP contract</td>
<td>Non-sexual health elements of psychosexual health services</td>
<td>Sexual health elements of prison health services</td>
</tr>
<tr>
<td>STI testing and treatment, chlamydia testing as part of the National Chlamydia</td>
<td>Gynaecology, including any use of contraception for non-contraceptive purposes</td>
<td>Sexual Assault Referral Centres</td>
</tr>
<tr>
<td>Screening Programme and HIV testing</td>
<td></td>
<td>Cervical Screening</td>
</tr>
<tr>
<td>Sexual health aspects of psychosexual counselling</td>
<td></td>
<td>Specialist foetal medicine</td>
</tr>
<tr>
<td>Any sexual health specialist services, including young people’s sexual health and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>teenage pregnancy services, outreach, HIV prevention and sexual health promotion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>work, services in schools, colleges and pharmacies</td>
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</table>

A fully Integrated Sexual Health Service (ISHS) was commissioned by Derby City Council to commence service delivery on 1\textsuperscript{st} April 2015. Following the national direction of integrated health service delivery it aims to provide a ‘one stop shop’ approach by providing both Genito-Urinary Medicine (GUM) and reproductive health services under one roof, enabling an enhanced patient experience and an opportunity to provide each speciality at a singular point.

\footnote{Clinical Commissioning Groups replaced primary care trusts (PCTs) and are clinically-led NHS organisations responsible for commissioning in their local area. NHS Commissioning refers to the executive non-departmental public body of the Department of Health and Social Care, known as NHS England who are responsible for oversight, planning and delivery of commissioned services and hold the contracts for General Practice (GPs) and NHS Dentists.}
appointment. It operates as a ‘hub’ (specialist service, based within a hospital setting) and ‘spoke’ model (community based clinics).

The provider, Derbyshire Community Health Services (DCHS) also have responsibility for chlamydia screening, condom distribution scheme (C-card), HIV prevention, sexual health promotion and the maintenance and co-ordination of a ‘systems’ approach to communications across services and other professionals that are also involved in delivering and/or providing sexual health services and support; this includes GPs and pharmacy providers.

In order to continue improvements in sexual health, we need to better understand the health needs of our local population. This Sexual Health Needs Assessment (SHNA) aims to review our current and future sexual health needs, including unmet needs, in order to support future commissioned services and inform service provision and design. We know that ensuring access to sexual health information and services has a positive effective on the well-being of the population as well as those individuals at risk. Whilst this SHNA will primarily focus upon areas commissioned by the local authority; it will also provide information and recommendations on related areas of sexual health that are commissioned outside of the local authority.

The effectiveness of sexual health interventions are measured through the Public Health Outcomes Framework (PHOF)vi; which monitors a range of indicators; providing a useful benchmark to assess the sexual health of Derby’s population. Nationally, the three priority indicators are:

- Under-18 conceptions;
- Chlamydia diagnoses (15–24-year-olds); and
- People presenting with HIV at a late stage of infection

A summary of all the indicators that has been used to compare Derby’s position against the national and regional benchmark can be located at the end of this report in Appendix 1.

Unless otherwise stated, data and figures in this report have been extracted from the Public Health England’s fingertips: public health profiles (https://fingertips.phe.org.uk/profile/health-profiles) and are correct as of February 2019
2. Population Profile

Derby has a population of 256,233 (Office for National Statistics (ONS) 2016). It is a relatively young city with a higher proportion of 20-34 year-olds (21.9%) than individuals over 65 years (16.1%). However, the proportion of older people over 65 is expected to increase by 32% by 2039.

Twenty-five percent of the Derby population are from an ethnic minority background, with an estimated 180 nationalities and over 71 languages spoken. The most common used languages other than English are Punjabi, Urdu, and Polish. Nationally, estimates of the Lesbian, Gay, Bisexual and Transgender (LGBT) population vary between 1.7–2.5% depending on the surveys and methodologies used; Stonewall, a gay rights charity believe that 5-7% "is a reasonable estimate"; locally applied, this translates to a population of between 12,811–17,936.

Figure 3: Derby City Population Pyramid (2016)

Derby is comprised of 17 wards that are characterised by varying levels of deprivation and ethnic diversity. Deprivation and ethnic diversity levels are lower within Allestree and Mickleover for example, compared to higher levels across Arboretum and Normanton. Derby is one of the 20% most deprived authorities in England and one-in-five children live in low income families. Life expectancy is 10.2 years lower for men and 8.3 years lower for women in the most deprived areas of Derby than in the least deprived areas (Public Health England
Levels of deprivation in an area can be used to identify those communities who may be in the greatest need of services; as deprivation is linked to poorer sexual health. Derby City also has a university, which results in a significant flow of students, including international students.

Figure 4: Derby City Deprivation Profile

Population Profile – Key findings

- A high proportion of the population in the City (27.6%) are living in the most deprived areas, compared to the national average of 19.8%. Deprivation is generally associated with poorer access to health care.
- Derby City has a higher proportion of younger people (aged <40 years) than England.
- One in every four residents of Derby is a child or young person (aged <18 years).
- 161,500 (63.1%) of the population are aged 16-64 years.
- Derby has an higher proportion of young people under 25, than the regional and England average.
- Derby is a diverse city encompassing over 180 nationalities and over 70 languages spoken.

3. The level of need in our population and key findings

Sexually transmitted infections
Infections that can be passed from one person to another through unprotected sexual intercourse, genital contact and/or sharing sex toys are known as sexually transmitted infections (STIs). There are many different types of infections such as Gonorrhoea, HIV, Syphilis, Warts, Herpes and Chlamydia. Some infections may not show symptoms, so regular screening is recommended. Infections that are left untreated can pose a serious health risk and be unknowingly passed on to others; only the consistent and correct use of condoms can significantly reduce risk of STIs.

Derby City has a consistently high sexually transmitted infection (STI) testing rate which is shown in the summary indicator of all STI testing in the population aged 15 to 64. This includes tests of syphilis, HIV, gonorrhoea and chlamydia (chlamydia tests are only included in people over 25) among people accessing specialist and non-specialist sexual health services. In 2018 the STI testing rate in Derby was 18,201 per 100,000 which is similar to the England benchmark rate of 18,053 per 100,000. Of those accessing sexual health services for STI testing; about 1 in 25 people test positive for a new STI. This translates to 4.2% testing positivity in Derby and 4.7% in England.

Figure 5: STI testing rate (per 100,000) and positivity (%).
The diagnostic rates for syphilis and gonorrhoea in Derby have remained similar or significantly better than the England benchmark. The syphilis rate is based on very small counts (generally less than 25 cases a year in the city) and as such, a small variation between years can dramatically alter the trend. However, after taking this into account, Public Health England emphasise that “syphilis is an important public health issue in men who have sex with men (MSM) among whom incidence has increased over the past decade” and for whom research has shown are less likely to get tested. Although the syphilis diagnostic rate has remained below or similar to the England benchmark, the rate has risen locally in line with the national upward trend from 6.0 per 100,000 to 8.2 per 100,000.

Over the past six years, Derby has had a significantly higher than England diagnostic rate for gonorrhoea but this has reduced in recent years to a comparable rate that is not significantly different to the England average. However, this comparison of Derby to the England average disguises the national average trend of gonorrhoea diagnostic rates rising from 48.6 per 100,000 in 2012 to 78.8 per 100,000 in 2017. Similarly, the diagnostic rate in Derby has followed this upward trajectory but along a shallower gradient: 62.3 per 100,000 to 70.3 per 100,000. The diagnostic rate trend indicates that gonorrhoea persists as a STI issue in the city but it is an increasing issue nationally, which could go on to impact upon local trends in the near future. In addition, there is ongoing global and national concern over its increasing antimicrobial resistance.

Figure 6: Syphilis and gonorrhoea diagnostic rates (per 100,000 population).
Testing and diagnosis rates are closely linked. Overall, 1,921 new STIs (excluding Chlamydia in under 25s) were diagnosed in residents of Derby, a rate of 750 per 100,000 (compared to similar rate of 743 per 100,000 in England). However, figure 7 shows the rate of all new STI diagnoses compared with ONS comparators (areas with similar demographics and areas of deprivation) and shows that Derby has the 3rd highest rate compared to its peers and is above the regional average. Higher diagnosis rates may reflect a higher prevalence in the population or that cases are more likely to be diagnosed (i.e. there are fewer undiagnosed cases than in other areas).

**Figure 7: New diagnoses by comparator groups – 2017**

### Chlamydia

Chlamydia is the most common sexually transmitted infection (STI) with the under-25s bearing the highest burden of risk. Chlamydial infection is often asymptomatic, resulting in an increased risk of serious health conditions such as pelvic inflammatory disease. The National Chlamydia Screening Programme provides opportunistic screening to all sexually active young people aged 15-24 years and is delivered by the Derbyshire Community Health Services Trust (Integrated sexual health service), in a variety of settings such as online home testing kits, GP practices, pharmacies, online and outreach settings, Further Education colleges and the University of Derby.

The programme’s aim is to control chlamydial activity in the population, reduce the incidence of conditions arising as a consequence of chlamydia infection and interrupt its transmission onto others; its effectiveness is monitored through an indicator in the *Public Health Outcomes Framework* with the current target being a detection rate of 2,300 per 100,000 of the 15-24 year old population, which locally translates to a population of 34,678 young people.
Just over 15% of 15-24 year old population was screened in 2017 (n= 5,406), compared to the national average of 19.3% in specialist and non-specialist sexual health services. Although Derby and England share the same chlamydia detection rate of 1,882 per 100,000, Derby appears red (significantly below) for 2017 due to this rate falling below the benchmark rate set; however, the England average itself has remained consistently below this benchmark during the period 2012 to 2017. Locally the rate in Derby fell to the lowest level in 2015 but more recently the rate has shown a slight rise. Nevertheless this improvement has not so far enabled Derby to be placed above the target rate, which may suggest an overestimation of prevalence in the population; change in prevalence over time and/or changing behaviour in young people with regards to sexual risk, or underperformance of the programme.

Figure 8: Chlamydia screening (%) and detection rate (per 100,000) in persons aged 15-24 years.

Of those chlamydia tests reported, the proportion of positive tests from all settings during the same time period was 11.57%.

Table 1: Quarterly number of chlamydia tests reported and proportion positive (Apr 2017 – March 2018)
Human Immunodeficiency Virus (HIV)

HIV (Human Immunodeficiency Virus) is a viral infection that leads to the weakening and inability of the immune system to fight infections and disease. HIV is found in the body fluids of an infected person, this includes semen, vaginal and anal fluids but also blood products and milk (leading to mother to child transmission), however the latter types of transmissions are now either rare or in very low numbers due to a variety of successful public health interventions including needle exchange schemes, antenatal testing and blood screening. AIDS stands for Acquired Immune Deficiency Syndrome and describes the number of potentially life-threatening illnesses and infections contracted when the immune system which has been severely weakened by HIV. As a result of advances in antiretroviral treatment, very few people in the UK develop serious AIDS-related illnesses and life-expectancy is similar to those living without AIDS. However this trend relies on the continued early diagnosis and effective treatment of HIV.

HIV is associated with significant mortality if untreated, serious morbidity and high costs of treatment and care. According to Public Health England*, around 100,000 people are living with HIV infection (diagnosed and undiagnosed) in the UK. Two groups are disproportionately affected by HIV; men who have sex with men (MSM) and people who have
migrated from regions of the world where HIV is prevalent, such as sub-Saharan Africa. However in 2016, for the first time since HIV was detected over 30 years ago, there has been a decline in new cases observed within both groups nationally. HIV infection is associated with higher risks of serious mental and physical ill health, reduced life expectancy (if untreated), discrimination, stigma and poverty. People living with diagnosed HIV infection are growing older due to improved treatment and associated lower mortality rates. In 2016, more than a third (38%) of people accessing HIV care were aged 50 years and above, compared with 17% in 2007.

The National Institute for Health and Care Excellence (NICE) HIV testing guidance defines high HIV prevalence as those local authority areas with a diagnosed HIV prevalence of between 2 and 5 per 1,000 populations. In Derby, the prevalence of HIV has gradually increased each year from 1.67 per 1,000 in 2013 to 2.49 per 1,000 in 2017 in people aged 15 to 59 years; this rate is slightly above, but not significantly higher, than the England average of 2.32.

**Figure 9: Diagnosed HIV Prevalence - Derby**

As previously noted, late diagnosis of HIV is the most important predictor of morbidity and mortality among those with a HIV infection and those diagnosed late have a ten-fold risk of death compared to those diagnosed early. As such, the Public Health Outcomes Framework (PHOF) includes an indicator which monitors the reduction in the number of people presenting with HIV at a late stage of infection; the indicator is also useful in evaluating the success of expanded HIV testing. An individual is considered to have been diagnosed late if the number of particular immune cells (CD4 cells) in their bloodstream has dropped below a certain level. Derby shares the same pattern for late diagnosis with 41.7% being diagnosed
late; as England (41.7%) which is lower (4\textsuperscript{th} lowest in the region) but not significantly different to the regional average (46.3%).

Nationally, declines in HIV diagnosis have been observed for the first time among non-black African and non-black Caribbean heterosexual men, particularly among white heterosexual men (31\%, from 429 in 2016 to 296 in 2017). HIV testing coverage monitors the number of HIV tests accepted as a proportion of those where a test was offered and is an important indicator in reducing prevalence and late diagnosis. It is also said that there are many missed opportunities for testing that continue to occur at specialist health services (SHS)\textsuperscript{xii}. Nearly 350,000 SHS attendees were not offered a test for HIV in 2017\textsuperscript{2}, despite being recorded as eligible for testing. This included over 10,000 gay and bisexual men and over 10,000 black African heterosexual men and women. Uptake of HIV testing in specialist services in the city is showing a slightly declining trend, nevertheless remains significantly higher than the national average (80.4\%/77\%); however, uptake amongst MSM is significantly worse than the England average (92.4\%/94.8\%).

**Figure 10: HIV testing uptake (%) – Derby**

\textsuperscript{2} Eligible SHS attendee: any patient attending a SHS at least once during a calendar year, excluding those patients known to be HIV positive or for whom an HIV test was not appropriate, or for whom the attendance was reported as being related for reproductive healthcare only.
HIV – Key findings

- The prevalence of HIV in Derby has exceeded 2 per 1,000 population, (2.46 per 1,000) the number at which an area is considered to have high HIV prevalence.

- The NICE guidance recommendations for expanded testing should be implemented locally in order to reduce prevalence. This includes new registrants to primary care; A&E and medical admissions and people with indicator conditions.

- Nationally, a decline has been observed of the number in HIV diagnosis acquired through heterosexual sex.

Contraception

Contraception refers to methods used to prevent unplanned pregnancy and almost everyone in the UK uses contraception during his or her lifetime. There are a variety of different methods available, all of which are extremely safe compared with the risks associated with pregnancy and childbirth. Long Acting Reversible Contraception (LARC) methods are some of the most effective methods available\textsuperscript{\textit{xiii}}, meaning that it is effective for a long period of time and does not rely on daily concordance. All currently available LARC methods (intrauterine devices, the intrauterine system, injectable contraceptives and implants) are more cost effective than the combined oral contraceptive pill even at 1 year of use\textsuperscript{\textit{xiv}}. Additionally, as the name suggests they are fully reversible, should the woman wish to return to being fertile.

User dependant methods include the contraceptive Pill (commonly known as the 'pill'), Male condom, Patch, as well as other methods and rely on being used consistently and correctly by the user, some on a daily basis.

Unplanned pregnancy is usually a result of inconsistent or incorrect use of condoms, poor adherence to daily methods of contraceptives, such as the pill or failure to use any method of contraception. Nationally, almost 30% of pregnancies are unplanned\textsuperscript{\textit{sv}}

During 2016/17, the primary method of contraception used by women accessing sexual and reproductive health services was more likely to be a user dependent method (61%), than a LARC method (39%). In the last three years the local Integrated Sexual Health Service has prescribed LARC at a similar rate to England, however, when compared to similar local authorities, ranging between 56% in Sunderland and 24% in Solihull, Derby is within the top 10% for LARC used as the main method of contraception.
Figure 11: Primary method of contraception used

There are 30 General Practices across the city as well as branch practices and, of those, 28 are commissioned by the local authority to provide LARC; this translates to LARC availability at 48 GP locations (branch and main) across Derby. In addition, statistics from the Department for Transport suggests that in 2016, patients were within an average of 10 minutes walking or public transport to their nearest GP; similar to the average for all English unitary authorities (11 mins), \(^{xvi}\) suggesting good coverage and geographical access to LARC provision.

Between April 2017 and August 2018, locally, 3,474 procedures (including insertion, removal and ongoing management) took place via primary care, with implant insertion being the most frequent option chosen. Over half of those who attended for LARC were aged between 24-45 years (58%) with a quarter aged 18-24 (26%)

Table 2: Reason for LARC attendance – Primary Care (2017/18)

<table>
<thead>
<tr>
<th>Reason</th>
<th>Count</th>
<th>Percentage (of total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implant removal only</td>
<td>784</td>
<td>23.4%</td>
</tr>
<tr>
<td>Implant insertion</td>
<td>847</td>
<td>25.3%</td>
</tr>
<tr>
<td>Implant removal and replacement</td>
<td>595</td>
<td>17.7%</td>
</tr>
<tr>
<td>IUCD Insertion, on-going management and removal</td>
<td>492</td>
<td>14.7%</td>
</tr>
<tr>
<td>IUS Insertion, on-going management and removal</td>
<td>628</td>
<td>18.7%</td>
</tr>
<tr>
<td>Total</td>
<td>3346</td>
<td></td>
</tr>
</tbody>
</table>

In 2013, GP Practices in Derby were prescribing LARC at a higher rate than the national average. However, nationally, the rate has slightly fallen since 2014 with Derby tracking this national pattern. In 2016, the rate of GP prescribed LARC in Derby was 40.4 per 1,000 (female population aged 15-44 years). This is the lowest rate across the period 2011 to 2016
and locally and may suggest a number of issues such as accessibility of appointments, number of clinicians trained to fit/clinic capacity, acceptability, or indeed user knowledge.

**Figure 12: LARC prescribed in Primary Care and Specialist Sexual Health Services**

In March 2018, a local pilot 'call' to all GP practices commissioned to provide LARC (n=29) revealed that the average waiting times for LARC fitting at that time was slightly over the 2 week Faculty of Sexual and Reproductive Health (FRSH) quality standard of two weeks\(^{xvi}\) (16.6 days for Implants; 18.1 days for coil fitting). This may be related to the decline in GP prescribed LARC rate and may suggest differences in how the service is delivered within individual practices.

**Figure 13: Attendance rates at specialist contraceptive services, under 25s**
Attendance indicators can be used as a measure of young people’s access to specialist contraceptive services and supports a number of key public health programmes including chlamydia screening and reducing teenage pregnancy. The rate of attendance to specialist contraceptive services by females aged 15-24 years is lower in Derby (95.2 per 1,000) than that of England (147.5 per 1,000 in 2016). In July 2017, the integrated sexual health service provided at Space @ Connexions was suspended pending works to clinic spaces and services transferred to a clinic session at London Road Community Hospital (used by mainly over 18's). In July 2018, attendance data showed a decline in the number of young people accessing services since the transfer.

Contraception – Key Findings

- A slight decline in the rate of GP prescribed LARC may suggest a change in LARC access behaviour; this may be due to inability to access the service, differences in the way the services is provided within practices and/or the number of clinicians trained to fit the device; the types of contraception utilised or user knowledge.

- The integrated sexual health service provides LARC at a similar rate to England, which is also seeing a slight decline. Locally, this may suggest difficulty in accessing services or user choice.

- Local attendance records show a decline in the number of young people accessing sexual health services

Emergency contraception

Emergency contraception can be used to prevent pregnancy after failure to use a contraceptive method (unprotected sexual intercourse; UPSI) or if a method of contraception has failed. There are two methods of emergency contraception, oral emergency contraception (OEC) and intrauterine device (IUD). Levonelle can be taken up to 72 hours (3 days) after UPSI and ellaOne which is effective for up to 120 hours (5 days) and is considered by the Faculty of Reproductive and Sexual Health to be the most effective of the oral methods. The other method is the copper intrauterine device (also known as the “coil”). This is the most effective method of emergency contraception and can be fitted within 5 days after unprotected sex.
There are 63 pharmacies in the area that provide a range of services; which translates to 25 pharmacies to every 100,000 population in Derby, compared to the national average of 22 per 100,000\textsuperscript{xix}. Of these, just under half (n=31) have contracted to provide Levonelle free of charge to under 18’s. Currently, pharmacies are not commissioned to provide ellaOne (Ulipristal Acetate); however both methods are free and available to all women of fertile age through general practice, Derby Urgent Care Centre and the Integrated Sexual Health Service, or can be purchased over the counter at pharmacies (ellaOne may only be available to buy at some pharmacies).

To improve service monitoring; PharmOutcomes, a web-based pharmacy information platform was introduced for all commissioned pharmacy services in April 2017. In all consultations the pharmacist is required to discuss STIs and ongoing contraception needs and signpost as relevant. Data captured shows that between April 2017 and August 2018, 65% of the 31 pharmacies (n=20) supplied Levonelle. A total of 223 OEC consultations took place with 96% of those leading to the supply of Levonelle with 7% performing a pregnancy test. In 81% of cases, Levonelle was supplied to individuals between the ages of 16 and 17. Table 2 shows that in 88.74% of cases of UPSI Levonelle was supplied within 48 hours and 99% within 72 hours. Emergency Oral Contraception is more effective the sooner it is taken after UPSI. This data demonstrates that a significant proportion of young women are delaying seeking help. Younger people tend to be more technologically advanced and aware, therefore utilising digital health promotion and prevention methods may be more effective with this cohort.

Table 3: Time since last UPSI

<table>
<thead>
<tr>
<th>Time since UPSI</th>
<th>Count</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>In last 24 hours</td>
<td>131</td>
<td>58.74%</td>
</tr>
<tr>
<td>24-48 hours</td>
<td>67</td>
<td>30.04%</td>
</tr>
<tr>
<td>48-72 hours</td>
<td>23</td>
<td>10.31%</td>
</tr>
<tr>
<td>over 72 hours - REFER</td>
<td>2</td>
<td>0.90%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>223</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

\textit{Data Source: PharmOutcomes}
The main reason given for requiring emergency contraception was unprotected sexual intercourse; a summary of reasons given can be seen below:

**Table 4: Reason for requiring emergency contraception**

<table>
<thead>
<tr>
<th>Reason</th>
<th>Count</th>
<th>Percentage (of total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unprotected Sex</td>
<td>139</td>
<td>62%</td>
</tr>
<tr>
<td>Failed Condom</td>
<td>67</td>
<td>30%</td>
</tr>
<tr>
<td>Missed, overdue or reduced efficacy contraceptive</td>
<td>17</td>
<td>8%</td>
</tr>
<tr>
<td>Total</td>
<td>223</td>
<td>100%</td>
</tr>
</tbody>
</table>

*Data Source: PharmOutcomes*

**Emergency contraception – Key Findings**

- There is a need to increase the number of commissioned pharmacies being accessed by improving signposting/information
- There is a need to promote early attendance for emergency contraception following UPSI and explore reasons for delay
- There is a need to increase the awareness of C-Card scheme (free condoms to under 25s) to include information on when, where and how to access them
Teenage Pregnancy

In spite of the rates of teenage pregnancy in the UK being halved over the past two decades and currently at their lowest levels since record-keeping began in the late 1960s; the UK remains to have one the highest teenage conception rates in Western Europe with over half of these ending in abortion. Evidence shows that unplanned teenage pregnancies have poorer pregnancy outcomes with children that are born tending to have a more limited vocabulary with poorer non-verbal and spatial abilities. These differences are almost fully explained by deprivation and inequalities.

Teenage motherhood is associated with a range of negative short, medium and long term health and social outcomes such as:

- Increased chance of delivering low weight babies, premature babies and increased infant mortality
- Mothers under 20 are twice as likely to smoke before and during pregnancy and three times more likely to smoke throughout pregnancy
- Higher risk of living in a lone parent household, with greater risk of poverty and poorer nutrition
- Teenage mothers are less likely to complete their education, or to have qualifications in adulthood
- More likely to be in receipt of income-based benefits or in low paid work; so poverty is strongly associated with teenage parenthood
- Teenage mothers living in deprivation tend to remain in poverty.

Between 1998 and 2011, Derby achieved a 57.1% reduction in the number of teenage conceptions, tracking the national picture of a downward trend over the same period. As of 2016, Derby has a population of 4,264 girls aged 15-17 years and the conception rate in 2016 was 26.0 per 1,000 populations; which remains significantly higher than the national average of 18.8 per 1,000. A lower percentage, 37.8%, ended with abortion compared with the national average of 51.8%, a pattern that has persisted for over 10 years.

In the under 16 year olds, the rate was 3.1 per 1,000 population compared to the national rate of 3.0. Inequalities in the under-18 conception rate persist between and within areas with ward-level variations reflecting the pattern of deprivation and poor educational attainment. A

3 For more information visit https://www.beds.ac.uk/knowledgeexchange
comparatively large proportion of the population in the Derby wards of Normanton, Derwent, Arboretum and Sinfin are young children aged 0-4 years.
Figure 14: Under 18 conception rates by ward, Derby (2013-15)
Figure 15: Pupil absence (%) and under 18s birth rate (per 1,000 females aged 15-17 years).

Amongst other factors, such as the changing social interaction of young people, research has shown, that those who evaluate their sex and relationships (SRE) education as good appear likely to delay sexual activity\textsuperscript{xxii}

**Teenage Pregnancy – Key findings**

- There is a need to ensure continued support to deliver appropriate relationship and sex education within schools, particularly those schools located in wards with high teenage pregnancy rates

- There is a continued need to ensure access to contraception, including long acting reversible methods, information about contraception itself and where and how to access services

**Termination of Pregnancy**

A termination of pregnancy (TOP) is the medical process of ending a pregnancy so it does not result in the birth of a baby. It is also known as a therapeutic abortion, commonly shortened to an abortion. The pregnancy is ended either by taking medications or having a minor surgical procedure. Whilst not all unplanned pregnancies are unwanted, each year in the UK about one in five pregnancies end in an abortion. Abortion rates can indicate a lack of access to good quality contraception services and advice as well as problems with individual use of particular contraceptive method. The abortion rate in Derby remains higher (15.2 per 1,000) than the regional rate (14.0 per 1,000) but significantly lower than the national rate (16.7 per
1,000 women aged 15-44 years (2016). The proportion of NHS-funded abortions under 10 weeks in Derby (72.8%) remains significantly lower than England (80.8%).

Figure 16: Rate (per 1,000) and proportion (%) of abortions

Evidence has shown that repeat abortions can be reduced through the provision of contraception, such as LARC methods. However, the success of this measure relies on the provision of contraception by abortion services; previous studies have shown that service users often fail to attend family planning clinics following abortions. The proportion of repeat abortions in women aged under 25 years in Derby (27.0%) is similar to that of England (26.7%). Locally, however, the picture is discouraging. The percentage of repeat abortions has been gradually increasing since 2012 (21.2%), overall abortions following a birth in women aged less than 25 years is significantly higher in Derby (40.5%) than England (27.4%). The proportion of NHS-funded abortions under 10 weeks in Derby (72.8%) remains significantly lower than England (80.8%) and may indicate delays within the TOP pathway; any delays may limit the choice of termination method and increase the cost of care.
Termination of pregnancy – Key Findings

- TOP commissioners may wish to further investigate the reasons for lower numbers of abortions provided in at less than 10 weeks gestation to ensure that poor access to the service is not the cause.

- The increase in the number of repeat abortions in under 25s following a birth indicates a persistent need to provide rapid and accessible contraception, particularly for those women who are most vulnerable.

- All women accessing TOP services, should be given access to a range of contraception prior to discharge and/or bridging methods as well as advice on when pregnancy can occur following a procedure to help reduce the number of repeat abortions

Condom provision
C-Card is the name of the condom distribution scheme managed by DCHS and delivered across Derbyshire. The scheme allows the provision of free condoms to all young people aged 13-24 via a variety of settings. Young people signing up to the scheme are given advice and information and shown how to correctly use condoms. They are then issued a card which can be used to obtain free condoms from anywhere which displays the C-Card sign. There is also a free condom distribution scheme (all ages) for specific at risk groups i.e. MSM, substance misusers and sex workers. Monitoring of the condom schemes is problematic and it is not possible to identify an accurate number of young people accessing the scheme at any one time – section 6.7 highlights these data gaps.

Sexual Health Promotion
A fundamental aspect of reducing the risks of STIs, HIV and unplanned pregnancies is access to good sexual health promotion; through the provision of advice, information and education to individuals, communities and other service providers. Sexual health promotion activities are largely co-ordinated and delivered by the ISHS through a variety of initiatives; RSE work with schools, co-ordination and delivery of two sexual health network events per year; website and social media work, targeted work with at risk communities, training and awareness to universal services. Indicators which contribute to sexual health promotion activities can be found in appendix two.
Sexual Health Promotion - Key findings

- A high proportion of the population in the City (27.6%) are living in the most deprived areas, compared to the national average of 19.8%. Deprivation is generally associated with poorer access to health care and poorer sexual health

- Derby performs significantly worse than average on a number of indicators relevant to sexual health promotion activity (see appendix two)
  In addition, although Derby city is experiencing a downward trend, teenage pregnancy rates/Chlamydia diagnosis are performing worse than England average

Other areas of sexual health need

Psychosexual counselling
Following the exclusion of physical and other psychological conditions, patients are referred into the Integrated Sexual Health Service. Referrals are received through GP’s, ISHS Consultant or other internal referral from ISHS. The actual duration that each individual is seen fluctuates, however sessions are limited to maximum of 8 per referral. In 2018, 23 referrals were made to the service over an 8 month period. Waiting times vary according to availability of specialists. The referral to treatment (RTT) target is 126 days. Currently, there is no data available for waiting times for the psychosexual health service. The level of need in the city is unknown.

Sexual violence
The Crime Survey for England and Wales (CSEW) estimates that 12.1% of adults aged 16 to 59 has experienced sexual assault (including attempts) since the age of 16; locally this is equivalent to 149,653 victims. In 2017/18, the crude rate of recorded sexual offences in the city was 2.4 per 1,000 population, equalling that of the England average and slightly higher, but not significantly different, from the regional average at 2.1 per 1,000. The number of sexual offences in the city has been increasing since 2012/13 up until 2016/17, where the rate can be seen to have plateaued. However, not all sexual violence crimes are reported, it is thought around 5 in 6 victims (83%) did not report their experiences to the police.
Figure 17: Sexual Violence offences – rate per 1,000

Sterilisation

Male and Female sterilisation are commissioned by Southern Derbyshire CCG and data was not available for this assessment.

Cervical Screening

Screening is the process of identifying individuals who appear healthy but may be at increased risk of a disease or condition. The national NHS cervical screening programme is available to women aged 25 to 64 in England. Women aged 25 to 49 receive a screening invitation every 3 years and every 5 years for women aged 50 to 64. In 2018 the local screening programme transitioned to testing for human papilloma virus (HPV) rather than the previously used Smear test as evidence has linked HR-HPV to the development of abnormal cervical cells. Most cervical screening is undertaken in general practice, with opportunistic testing also being conducted within the Integrated Sexual Health Service.

When analysing coverage by age, there is a lower uptake on screening locally from the younger women (25-49 years) compared to those aged over 50. Cervical Screening is commissioned by NHS England and led by the local PHE Screening and Immunisation Teams.
4. Stakeholder Views

A survey was issued to a wide range of stakeholders, such as 0-19 Public Health Nursing Service, schools, GPs, Pharmacies, voluntary sector, acute and community trusts, young people’s services, substance misuse services (Dec 2017-Jan 2018). The survey aimed to systematically assess the sexual health needs of the population of Derby and identify how well stakeholders felt that the current system met those needs; what they felt was and was not working well and suggestions for change. Although a low number of surveys were returned (n=13), a thematic analysis was applied to identify and analyse patterns or themes within the data.

Fig 19: Thematic map showing what is working well
Respondents acknowledged the efficient sexual health offer provided in GP’s with specialist contraception being provided and appointments being regularly filled. In addition, it was felt that services have built trust with vulnerable people through targeted work, thus forming some great working partnerships. It was also highlighted that the integrated sexual health service meets BASHH standards for walk in and booked appointments for STI concerns and contraception needs. In addition it was thought that through improved efficiencies, robust services and tools such as the development of internal dashboards, for example for chlamydia screening, will further help to support improvements.

**Figure 20: Thematic map showing what’s not working well**

Stakeholders felt that there were gaps in relation to accessing mainstream, primary care and voluntary sector sexual health services for some hard to reach groups. Along-side this, accessibility issues were also highlighted, particularly in relation to young people (U25’s) with unsuitable premises (London Road Hospital) being acknowledged as a key issue. Respondents highlighted that waiting times to be seen by a professional need to be reduced for patients; this corresponds to a patient satisfaction survey conducted in early 2018, across the integrated service clinics, where only 54% of patients (44/81 responses) reported that they did not have to wait long between making their appointment and attending their appointment.

It was further noted that patients residing out of the area are accessing the service on a Saturday as Derby City is the only clinic available locally on that day.
Respondents suggest improving accessibility by offering digital/online solutions to access care at home e.g. online testing for STIs and contraception as well as utilising different venues for clients within the City. Proposals included having a hub and spoke model, operating an outreach service for vulnerable people and resuming the service for young people at Space, Connexions in Derby City. A priority for respondents suggested closer joined up working is required between Sexual Health Services and a wide variety of stakeholders including the drug and alcohol service, colleges, children’s homes and Women’s Work etc. with the suggestion of utilising the Sexual Health Network as a springboard for partnership projects/task groups. In addition, they proposed increasing Sexual Health promotion for those at high risk and raise engagement levels by developing a community engagement strategy. Finally there are suggestions to carry out additional training on consent and c-card, in addition to an offer and provision of LARC, within the maternity unit in order to increase the number of women choosing LARC.

5. Service/assets in relation to need

There are a variety of sexual health providers within the city, covering various levels of service provision. An Integrated Sexual Health service (ISHS) was commissioned by the local authority, integrating the previously distinct specialities of contraception and sexual health services and genito-urinary medicine. The integrated service, which is delivered by
Derbyshire Community Health Services, commenced service delivery on April 1st 2015; it provides:

- Contraception and reproductive services
- STI Testing and treatment services
- Chlamydia Screening Programme
- Young peoples services
- Condom distribution scheme
- Sexual health promotion
- Psychosexual health services
- Opportunistic cervical screening
- Training to universal services

The ISHS sub- contracts elements of sexual health promotion work to the local voluntary sector experienced with working with vulnerable and at risk communities. Contracts currently exist with Women’s Work, supporting their work with sex workers and Derbyshire LGBT+ who provide a range of support to the LGBT community. The service also has a remit to provide two sexual health network events per year and is responsible for the co-ordination of communications and media across the sexual health system (including primary care).

In 2017 a procurement exercise was undertaken, which resulted in a high number of GP practices and Pharmacies electing to provide sexual health services namely LARC and emergency contraception for under 18s. As previously noted, termination of pregnancy services are commissioned by the CCG, whilst HIV treatment and care services are commissioned by NHS England.

6. Unmet needs and service gaps

In order to address unmet need there is a need to consider the following improvements to gaps in services/clinic activity:

6.1 Service Gaps

Integrated Sexual Health Service: Service Improvement

6.1.1. Number of patients turned away

Routine recording of ‘turn away’ codes has been a recent addition to the Integrated Sexual Health Service. Since August 2018, ‘turn away’ data has been collected from the 'hub' (London Road clinic) when an individual presents at the clinic, without a pre-booked appointment, and cannot be offered a same-day appointment or consultation.

Between 3 August and 27 September 2018, 284 patients (313 presentations) were turned away from London Road (figure 22).
Further analysis has suggested that 1 in 2 residents from Derby (95 individuals of a total 189), who were previously turned away from the London Road Clinic, went on to re-present at the same clinic at a later date. Of those who re-presented at the service, 80% re-presented within 5 days, including almost half who returned within 1 day. Whilst the term 're-presentation' is used to describe patients returning to service, this does not capture if they were seen. In total, 95 patients subsequently re-presented 126 times; of the 126 re-presentations, 4.8% of re-presentations did not result in either a walk in or booked appointment. We cannot follow the journey of patients outside of the service and therefore cannot know what number, if any, presented to a different provider in person, online or by phone.

It is also important to note that, whilst a valuable source of insight into the level of need within Derby, appropriate caution must be taken when interpreting this data. In particular, the recent introduction to recording these codes may have allowed for data and entry error; in addition the sample of data outlined in this section is limited to seven weeks.

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4 Calculated by subtracting the latest turn away date and the earliest re-presentation date - this provides an estimate of the time between the last time the patient was turned away and subsequent re-presentation to the service as a walk-in or booked appointment.
6.1.2 Waiting time for a booked appointment
The service is open access, with the majority of individuals accessing the ISHS self-referred. The time between a request for an appointment and an appointment is known as the waiting time for a booked appointment. During the first quarter of 2018-19, the average waiting time for a booked appointment was 4.4 days for contraception and 2.1 days for GUM services. However, a very specific calculation\(^5\) was used to derive these figures, therefore it is possible the waiting time for a booked appointment may be longer than this suggests. A review of the same period, using the same calculation in 2016-17 and 2017-18 suggests that there has been a small amount of variation (within 0.5 days).

6.1.3 Partner notification rates
Partner notification (PN) is a process in which sexual contacts of a person with a sexually transmitted infection (known as an "index case") are identified, informed and offered testing. PN is an essential component of STI management and ensures that individuals are made aware of their exposure and offered testing, treatment and education. PN facilitates earlier diagnosis and care; reduces re-infection whilst also limiting the spread of onward infection and promoting behaviour change.

National quality standards\(^{xxv}\) propose that at least 0.4 percent of Gonorrhoea contacts of an index case attend a service within four weeks of the date of the first PN discussion and 0.6 percent of contacts for Chlamydia in order for partner notification to be effective.

Table 4 below shows that the percentage of contacts for Gonorrhoea presenting at the integrated sexual health service is mainly consistent in meeting the quality standard; however more work needs to be done to ensure that the standard for Chlamydia is both met and sustained.

\(^5\) Logic was applied to derive an estimate of time between being turned away and representing. This logic takes the latest turn away date and the earliest re-presentation date, subtracts one from the other to derive the interval between last being turned away and subsequent re-presentation to the service (as a walk in or booked appointment).
Table 5: Partner notification rates per index case of Chlamydia and Gonorrhoea.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Q3 2016/17</th>
<th>Q4 2016/17</th>
<th>Q1 2017/18</th>
<th>Q2 2017/18</th>
<th>Q3 2017/18</th>
<th>Q4 2017/18</th>
<th>Q1 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>PN Rate Per STI Index Of Case (Chlamydia)</td>
<td>0.36</td>
<td>0.53</td>
<td>0.58</td>
<td>0.53</td>
<td>0.65</td>
<td>0.51</td>
<td>0.45</td>
</tr>
<tr>
<td>PN Rate Per STI Index Of Case (Gonorrhoea)</td>
<td>0.35</td>
<td>0.44</td>
<td>0.68</td>
<td>0.66</td>
<td>0.57</td>
<td>0.62</td>
<td>0.44</td>
</tr>
</tbody>
</table>

(Source: DCHS Performance Monitoring Return - please note, data collection began in Q3 2016/17).

6.1.4 Clinic activity (since 2015)

Table 6 shows the overall activity figures for the period 1 April 2015 - 31 March 2018.

The data has been taken from sexual health clinics delivered within Derby City and includes all referral reasons, new and follow up appointments. Attendances are recorded as ‘in area’ if the patient is a Derby City resident. Attendances are recorded as ‘out of area’ if the patient resides outside of the city boundary.

Table 6: Attendances at the Integrated Sexual Health Service.

<table>
<thead>
<tr>
<th>Appointments at Integrated Sexual Health Service (count)</th>
<th>2015/16</th>
<th>2016/17</th>
<th>2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>In area attendances</td>
<td>13,700</td>
<td>13,900</td>
<td>13,289</td>
</tr>
<tr>
<td>Out of area attendances</td>
<td>6,873</td>
<td>5,418</td>
<td>7,427</td>
</tr>
<tr>
<td>Total attendances</td>
<td>20,573</td>
<td>21,081</td>
<td>20,703</td>
</tr>
</tbody>
</table>

Please note that the data is split into financial year (April – March).

As table 6 demonstrates, there has been little variance in the overall number of attendances. However, the number of out of area attendances, where non-residents have accessed Derby City services, declined during 2016-17, but has since risen and exceeded the number accessing since the opening of the integrated service.

It is proposed that a digital service offer could potentially enhance all of these aspects of service delivery through expanding patient choice, improving access, supporting quality improvement and reducing waiting times.
6.2 HIV testing and diagnosis
Access to HIV testing requires further improvement; locally whilst there is good coverage of HIV testing, a number of cases are diagnosed late. In addition, in 2017 whilst HIV testing was offered to 76.2% of attendances attending the Integrated Sexual Health Service, with an uptake of 80.4%, coverage and acceptance amongst MSM was below the national average.

Little is known regarding the total picture of HIV testing (including point of care testing) across the voluntary and statutory sector, this includes HIV testing within TOP services. More needs to be done to identify current and possible venues and to promote these services to the public.

6.3 Chlamydia Screening
Further work needs to be done towards achieving the Public Health Outcomes indicator chlamydia diagnosis rate of 2,300 per 1,000. Services should work to understand and increase testing in high positivity settings. Public Health England has produced a Chlamydia Pathway tool which can be used locally to examine each element of the pathway to identify where improvements might be needed and is currently being used in collaboration with Derbyshire County Council and Derbyshire Community Health Services Foundation Trust. Work needs to continue to target resources at specific young people who are at greatest risk.

6.4 Long Acting Reversible Contraception
The pilot call out discussed earlier in this report involved all practices commissioned to deliver this service. Waiting times ranged between 4 – 121 days (two outliers 120+ days). Excluding the outliers, the waiting times for a LARC appointment was just over the Faculty of Sexual and Reproductive Health (FRSH) recommended standards of two weeks (14.8 days implants 16.8 days for coils). More work needs to be done to understand and address any capacity and workforce issues to ensure service sustainability and coverage and that women have access to long acting methods within the recommended timeframe.

6.5 Emergency Contraception
There is a pharmacy based scheme in operation, to which 31 pharmacies have signed up to deliver. However claims reporting shows that the service provision is patchy. In 2017/18 only 5 pharmacies consistently provided a service (processing activity on 5 or more months in the financial year). More communication is needed to inform both the public and professionals of where and when emergency contraception services can be accessed.
6.6 Psychosexual Health Services
Local authorities are mandated to provide access to the sexual health elements of psychosexual services; whilst the CCG's are responsible for the non-sexual health elements, however, the distinction between the two is not clear and there are no clear diagnostic criteria available.

Evidence of effective interventions relating to psychosexual health is both limited and varies considerably across single disorders; conditions may require psychosexual intervention and/or physical treatment and may be provided by a variety of medical and non-medical health and non-health professionals from a range of agencies. There is however, good evidence for female hypoactive sexual desire disorder and female orgasmic disorder and a number of pharmacological treatments are proven to be efficacious for a large number of men who suffer from erectile dysfunction.

Investigative research undertaken by a Derby City Council Public Health Registrar in 2015 identified a published briefing paper by the British Psychological Society on commissioning psychology sexual dysfunction services which outlined core components, quality standards and resourcing of services. Also uncovered, was a consensus view from experts in the field which has been published as a series of Standard Operating Procedures for individual sexual dysfunctions.

The most recent National Survey of Sexual Attitudes and Lifestyles survey (natsal-3) conducted between 2010- 2012, found that 42% of men and 51% of women aged 16 – 74 interviewed, who had sex in the previous 12 months, had experienced one or more sexual difficulties lasting a minimum of three months. This included lack of interest in having sex,
feeling anxious during sex, pain during sex, vaginal dryness, and problems getting or keeping an erection

Following the exclusion of physical and other psychological conditions, the current service provider is commissioned to provide specialist counselling for up to 8 sessions for the following conditions:

a. Lack/Loss of libido
b. Non-consummation
c. Orgasm problems
d. Vaginismus
e. Dyspareunia
f. Erectile dysfunction, ejaculatory problems and other penile problems such as pain and anxiety

The local prevalence of psychosexual dysfunction varies according to how people are asked and the definition used. Currently, there are no reporting requirements for the service, other than the percentage of referrals seen within 18 weeks, therefore the extent of population need is not fully understood. During 2018/19 (over 8 months), the service saw 23 individuals; who were seen for up to a maximum of 8 clinical sessions. The duration of each intervention fluctuated dependant on patient need.

Due to the lack of robust evidence, across all of the disorders, there is a need to regularly review the literature for interventions that may be considered effective for psychosexual health conditions, in order for services to be commissioned effectively and targeted to those most at need.

6.7 Termination of pregnancy
The overall rate for termination of pregnancy under 10 weeks gestation remains low and the number of repeat abortions is higher than average. Patient pathways should be explored to ensure that there are no barriers to accessing services. It is not known whether STI testing services are provided. Information should be sought on the provision and take up of contraception methods.

6.8 Condom Provision (C-Card)
There is a scheme in operation in the city and has been for several years. The scheme provides access to free condoms, dams and lube alongside advice and information on sexual health to young people aged 13-24 and is managed and co-ordinated by Derbyshire
Community Health Services Foundation Trust who also provide the training. The scheme is delivered through a variety of providers in different settings e.g. school nurses, colleges, The Space @Connexions, MAT teams etc., however at any particular point in time it is not always possible to identify the number of ‘live’ users of the service; the average time that an individual utilises this service or which type of services are utilised the most (registration or distribution/collection only). The monitoring of this service is problematic and data quality is not assured. The ISHS relies on c-card providers to submit manual monthly returns, which are often delayed and there is no provision to record and/or monitor stock levels. A web-based platform could be considered to improve compliance with monitoring, stock control and improvements in data quality. This approach should lead to improvements in targeted service provision.

6.9 Sexual Assault and Rape Centres (SARC)
SARC is a specialist 24/7 service providing a discreet, private, safe and caring environment for all survivors of sexual assault or rape, including men, irrespective of whether the survivor/victim chooses to report the offence to the police or not. There are two centres within our region, which are commissioned by NHS England; one for adults (aged 16 and over) and the other a dedicated paediatric facility. Survivors receive medical care, forensic examination services and counselling. In addition, STI screening, emergency contraception and referral to sexual health services are also offered. Sexual health services should work collaboratively with the Sexual Assault Referral Centre which will include clear pathways for clients being referred in to and out of the SARC to assure integrated seamless care between SARC and ISHS for survivors of sexual assault.

7. Emerging Issues
7.1 National considerations
7.1.1 Gonorrhoea resistance
Gonorrhoea is the second most common bacterial sexually-transmitted infection (STI) in the UK and, if untreated, can lead to complications such as chronic pelvic pain, pelvic inflammatory disease, ectopic pregnancy and infertility in women. Gonorrhoea is most frequently found among specific population groups, especially young adults, people of black Caribbean ethnicity and gay, bisexual and other men who have sex with men (MSM).xxvi The trend of rising gonorrhoea diagnostic rates is compounded by Gonococcal antimicrobial resistance, including to first-line treatments, leading to high levels of concern regarding gonorrhoea transmission. Reducing gonorrhoea transmission and ensuring treatment-
resistant strains of gonorrhoea do not persist and spread remains a public health priority. Further information can be found at https://www.gov.uk/government/publications/gonococcal-resistance-to-antimicrobials-surveillance-programme-grasp-report

7.1.2 Mycoplasma genitalium
Considered a relatively new STI, Mycoplasma genitalium (MG -commonly known as Mgen) is becoming of increasing importance and concern. It is often asymptomatic, which means the infection could be missed or partially treated, resulting in antimicrobial resistance.
Complications of Mgen include pelvic inflammatory disease, leading to issues with fertility, premature and still birth, reactive arthritis and pain and swelling of the testicles. It is more common in people of non-white ethnicity, smokers, those with a greater number of sexual partners and is often present at the same time as other infections such as chlamydia. According to research Mgen affects over 1% of the population, including in older men with high-risk behaviours who are often not included in STI prevention measuresxxvii.

The National Institute of Care and Health Excellence (NICE) has produced treatment guidelinesxxviii as it has often been misdiagnosed as Chlamydia and treated as such. A diagnostic nucleic acid amplification test(s) is required to test for Mgen and, at date of writing this report, there is no comparable currency/tariff11 e.g. pathway analyticsxxix with which to support commissioners or providers to understand the full cost implication; nor is there additional funding available from central government.

Further information can be found at: https://www.bashh.org/guidelines

7.1.3 Hep A - sexual transmission
Hepatitis A is a viral infection that produces a number of symptoms such as mild flu-like symptoms, diarrhoea, nausea, extreme tiredness, stomach pain and jaundice. Initially the symptoms may be mild, so the infected person may be unaware that they have it. Faeco oral transmission occurs when infectious particles (pathogens) from faeces are ingested through the mouth so it’s easy to pass on during sex or get from contaminated food and water.

11 There is no mandatory tariff for sexual health, however commissioners often utilise the non-mandatory NHS tariff payment system and/or integrated sexual health tariff as a basis for their local payment agreements.
In 2017 there were 942 confirmed laboratory reports of hepatitis A virus (HAV) infection in England and Wales xxx, regionally this equated to 29 cases. Between July 2016 and December 17 national outbreak clusters were investigated; during this outbreak MSM with a recent travel history to Spain were highlighted to be an at risk group and an enhanced incident response initiated which was de-escalated to a standard response in January 2018. Hepatitis A is entirely preventable, free vaccinations for those at risk are available via primary care and sexual health services.

7.1.4 Trafficking
Human trafficking can be described simply as the movement or recruitment by deception or coercion for the purpose of exploitation xxxi. It is a human rights issue and individuals are afforded protection via the Modern Slavery Act 2015. According to the National Crime Agency the number of people trafficked for slavery or other exploitation has risen sharply. The number of potential victims referred to the National Referral Mechanism in 2017 was 5145, a 35% increase on 2016 (although not all potential victims referred to the NRM in the UK report modern slavery or human trafficking exploitation that has happened in the UK). xxxii In 2017 the UK Modern Slavery Helpline indicated that 2,288 potential victims of modern slavery cases were men, while 1,547 were women.

Data on the health consequences, including sexual health, is limited and whilst primarily focussed on victims trafficked into the sex industry, a systematic review of self-reported symptoms suggests a high prevalence of sexually transmitted infections xxxiii and may demonstrate a need for comprehensive efforts to identify and support this vulnerable population.

7.1.5 HPV vaccination in boys
Human papillomavirus (HPV) is one of the most common viruses in the world. Four out of five (80%) of us will get some type of HPV at least once in our lives and most immune systems will combat the virus with no issues. There are more than 100 different types of HPV, with around 40 types that affect the genital area. Infection with other types of HPV may cause genital warts, skin warts and verrucae, anal cancer, cancer of the penis and oral cancers that develop on the surface of the tongue, mouth, lips or gums. Following recent recommendations from the Joint Committee on Vaccination and Immunisation (JCVI), the government will be extending the HPV vaccination programme for girls to include boys (aged 12 and 13). According to Public Health England, The vaccine will not only protect men from
HPV-related diseases – such as oral, throat and anal cancer – but also helps reduce the overall number of cervical cancers in women, though a process known as ‘herd immunity’. As of the date of writing this report, the implementation date for the HPV programme for boys in England has yet to be confirmed.

7.1.6 Chemsex
As of the date of writing there is no single nationally agreed definition for chemsex. However a regional (all sexual health commissioners based in the East Midlands) draft working definition describes it as 'the planned use of drugs as an integral part of sex (usually immediately prior to, or during sex)'. The use of psychoactive drugs enhances and prolongs the sexual experience which can often involve multiple partners and, although this not a new phenomenon, its popularity is increasing. Most often used drugs include methamphetamine, mephedrone, GHB/GBL and less commonly ketamine. Due to sexual practices and behaviours, gay, bisexual and men who have sex with men are particularly at risk. Nationally and locally the prevalence of Chemsex is unknown but the potential harms and risks include; actions and implications from drug use, lowered inhibitions, inability to consent, increased likelihood of engaging in risky behaviours which increases the likelihood of STI or blood viruses' transmission.

Focussing on gay and bisexual men, research by the sigma foundation highlights the Chemsex trend and subsequent safety issues:

7.1.7 Relationship and Sex Education (RSE) – statutory implementation
The importance and benefits of age appropriate relationship and sex education is well known\(^{xxxiv}\). However, until recently delivery of such education in schools in England has not been compulsory leading to patchy and inconsistent provision. Young people who report receiving RSE are more likely:

- to delay first sex
- to experience first sex which is consensual and to have a smaller age gap with their partner (a large age gap is associated with intimate partner violence)
- to be aware of, or report sexual abuse
- to protect first sex with contraception and condoms
In March 2017, following years of campaigning from various national and international organisations, the Government laid an amendment via the Children and Social Work Act (2017) to introduce compulsory relationships and sex education in all secondary schools, and relationships education (which includes the importance of healthy relationships) in primary schools, from September 2019. Consultation on the guidance, designed to support governing bodies, head teachers and teachers, ended in February 2018 with the final guidance being due for publication in 2019. Statutory provision in all schools is expected to start in September 2020.

Latest evidence and good practice guidance is available from:
http://www.sexeducationforum.org.uk/

7.1.8 Adverse Childhood Experience(s) – ACE(s)
The importance of the best start in life is crucial to a child's physical and mental development, and the much needed focus on young people's sexual health in recent years demonstrates its significance. Adverse childhood experiences have been described as potentially traumatic events or situations that occur during childhood and/or adolescence (for example, violence & coercion, inhumane treatment, adult responsibilities, household adversity such as relationship breakdown) which can lead to an elevated risk of damaging and negative effects on health and wellbeing, including sexual health and wellbeing, across the life course.

Observed associations between poor health and ACEs exist. For example, exposure to one ACE (versus none) is associated with a significant increase in negative sexual health outcomes such as: early onset of sexual activity, unplanned teenage pregnancy and its consequences, sexually risky behaviour and persistent and low mental well-being. Research shows that individuals experiencing four or more ACEs were:
• 4.5 times more likely than those with no ACEs to be at risk of pregnancy (under 16’s)
• 30.6 times more likely to contract a STI than those with no ACEs.

For more information about ACEs visit https://www.adversechildhoodexperiences.co.uk/
7.2 Local considerations

7.2.1 Local Issues

7.2.2 Laverstock Court

Initial accommodation centres (IAC) are hostels or lodgings for people who have asked for asylum and do not have funds to support themselves. In Derby, the IAC is called Laverstock Court. It caters for 225 people and opened in January 2018. Primarily services are provided in-house during the period of time that users are in the centre; the average length of stay being 21 days. Services provided include:

- Health assessment and health screen
- TB testing (and other conditions if indicated such as Hepatitis A, B, C and HIV)
- Children under 5 years assessed by a Health Visitor for nutrition and development
- Current Medications, and prescribing needs
- Translation and interpreting service
- Maternity services
- Oral health
- Management of minor illnesses
- Referral pathways for mental health, safeguarding, chest clinic, sexual health services, social care etc.

Since the opening of the centre the service that provides HIV treatment and care, which is based alongside the integrated sexual health service at London Road Community Hospital, has seen 15 service users; of those, 12 were new diagnosis and 3 were known to be HIV positive on dispersal; an indicative marker of poorer sexual health.

There is an onus on the individual to register with a GP on transfer and to seek medical care which may not be appropriate in all circumstances e.g. English may not be their first language and/or may have no prior knowledge of British health system. All the relevant commissioners/providers should work closely together to ensure the safety of the patient (health outcomes) and the public (onwards transmission) is maintained in the designing appropriate referral pathways.

7.2.3 Maternity Pathway Pilot

During 2018, Derby City Council, Derbyshire County Council, University Hospitals Derby & Burton and Chesterfield Royal Hospital began working together on a two year pilot that aims to train nursing staff to deliver implant insertions as part of the maternity pathway; to an identified cohort of women with vulnerabilities. Overall, the pilot aims to increase access to and improve knowledge and awareness of LARC methods, promote safer sex practices and contribute to reducing the number of repeat termination of pregnancies (within a 12 month
period) and the number of unplanned pregnancies. The start-up of the pilot will be funded by Derbyshire County Council and Derby City Council.

8. Recommendations

<table>
<thead>
<tr>
<th>No.</th>
<th>Recommendation</th>
<th>Responsible lead commissioner</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Local Authority</td>
</tr>
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<td></td>
<td></td>
<td>Clinical Commissioning Group</td>
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<td></td>
<td></td>
<td>NHS England</td>
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Sexually Transmitted Infections including HIV

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<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Increased STI screening and HIV testing coverage should be sustained with a focus on groups most at risk</td>
<td>✓</td>
</tr>
<tr>
<td>2.</td>
<td>Continue to explore opportunities to increase screening in high positivity</td>
<td>✓</td>
</tr>
</tbody>
</table>
settings in order to achieve the Chlamydia diagnosis rate using NSCP Chlamydia Pathway Tool

3. **Continue to raise awareness to emphasise the need for repeat regular screening/STI testing as appropriate.**
   - In addition, particular attention towards gonorrhoea is needed due to its increasing resistance to antibiotics
   - ✓

4. **Implement expanded testing in acute trusts and primary care, in line with NICE guidance. To reduce prevalence, the costs associated with onwards transmission and to reduce the number of re-presentations to hospital with HIV associated conditions**
   - ✓

5. **Ensure the provision and monitoring of STI (including HIV) testing as well as contraceptive services within the TOP pathway**
   - ✓

6. **The Integrated sexual health service provider should take the clinical lead role in HIV prevention**
   - ✓

7. **Correct and consistent condom use remains the most effective way to prevent STI and HIV transmission. The availability of free condoms should be promoted through all avenues including: media campaigns, including social media as well as via local services.**
   - ✓

8. **Continue working and developing partnerships with the voluntary/community sector and identify champions to support HIV prevention initiatives and people living with HIV**
   - ✓

9. **Identify and raise awareness of where HIV Point of Care Testing is taking place and increase the number of settings where possible**
   - ✓

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**Contraceptive Services**

12. **An assessment of the workforce within primary care should be undertaken to better understand capacity of clinicians**
   - ✓
trained to deliver Long Acting Reversible Contraception (LARC) to identify and address any ongoing workforce issues as a mechanism to improve access and reduce waiting times as appropriate

| 13. | Explore ways to raise public awareness of the availability of LARC via commissioned services | ✓ |
| 14. | Consider the greater efficacy of EllaOne, in line with the local PGD, extending patient choice | ✓ |
| 15. | Continue to develop creative ways to increase public awareness of where and how to access Emergency Hormonal Contraception (EHC), in order to promote early attendance and reduce any delays in accessing services | ✓ |

### Teenage Pregnancy

| 16. | Develop ways to ensure sexual health support is available to assist all schools in their RSE responsibilities. Promote stronger working relationships between sexual health, school nursing service and specialist support services from the voluntary sector | ✓ |
| 17. | Continue efforts to raise the profile of the C-Card scheme and where and how the service can be accessed | ✓ |
| 18. | Develop ways to strengthen partnership working e.g. Derbyshire Integrated Family Service | ✓ |
| 19. | Ensure that all young person services are ‘young person friendly’ in line with the You’re Welcome quality criteria | ✓ |
| 20. | Publish and raise awareness of the local teenage pregnancy pathway as a mechanism which supports both the practitioner and young person | ✓ |
| 21. | The governments’ Teenage Pregnancy Prevention Framework aims to support local areas to identify areas for action | ✓ |

### Termination of Pregnancy
<table>
<thead>
<tr>
<th></th>
<th>Ensure STI testing, including HIV, and the provision of a range of contraception methods are available within the TOP pathway</th>
<th>✓</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Due to the increasing number of repeat abortions/low numbers under 10 weeks consider reviewing the patient pathway to explore whether there are any barriers to accessing services and seek to address where relevant</td>
<td>✓</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th><strong>Sexual Health Promotion/Prevention/Service Provision</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>23.</td>
<td>Target the most vulnerable/most at risk through delivering holistic and integrated harm reduction initiatives</td>
</tr>
<tr>
<td>24.</td>
<td>Ensure the evaluation of all health promotion activities in order to disseminate learning and foster improvements</td>
</tr>
<tr>
<td>25.</td>
<td>Increase sexual health promotion outreach provision specifically aimed at black and ethnic minorities, sex workers, emerging communities, MSM, and drug and alcohol users – working closely with organisations already providing specialist support.</td>
</tr>
<tr>
<td>26.</td>
<td>Continue to ‘piggy back’ onto national campaigns, localising advice and information as relevant</td>
</tr>
<tr>
<td>27.</td>
<td>Explore and ensure the provision of a digital offer in line with the changing ways in which the public now accesses services and information and to enhance service improvement. Also consider additional ways in which digital technologies can aid service improvements e.g. C-Card</td>
</tr>
<tr>
<td>28.</td>
<td>Commissioners and providers of sexual health/young people's services should ensure that staff are appropriately trained and trauma informed in order to provide the correct level of support to patients, including signposting and referral AND explore opportunities where routine enquiry would be appropriate.</td>
</tr>
<tr>
<td>29.</td>
<td>Commissioners and providers of sexual health services should work closely with local Drug and Alcohol commissioners/service providers to ensure</td>
</tr>
<tr>
<td></td>
<td>that the needs of service users are identified and met.</td>
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<td>---------------------------------------------------------------------------</td>
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<tr>
<td>30.</td>
<td>Implement the HPV vaccination programme to include boys</td>
</tr>
</tbody>
</table>
Appendix One – Public Health Outcome Indicators: (Derby compared to its nearest neighbours)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>Derby</th>
<th>Similar</th>
<th>Worse</th>
<th>Not compared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy at birth (Male)</td>
<td>2014 - 16</td>
<td>79.5</td>
<td>80.6</td>
<td>81.2</td>
<td>82.0</td>
</tr>
<tr>
<td>Life expectancy at birth (Female)</td>
<td>2014 - 16</td>
<td>83.1</td>
<td>84.2</td>
<td>84.9</td>
<td>85.7</td>
</tr>
<tr>
<td>Under 75 mortality rate: all causes</td>
<td>2016 - 17</td>
<td>332</td>
<td>347</td>
<td>362</td>
<td>377</td>
</tr>
<tr>
<td>Under 75 mortality rate: cardiovascular</td>
<td>2015 - 17</td>
<td>72.5</td>
<td>73.6</td>
<td>74.7</td>
<td>75.8</td>
</tr>
<tr>
<td>Under 75 mortality rate: cancer</td>
<td>2015 - 17</td>
<td>124.6</td>
<td>126.4</td>
<td>128.2</td>
<td>130.0</td>
</tr>
<tr>
<td>Suicide rate</td>
<td>2015 - 17</td>
<td>9.9</td>
<td>11.0</td>
<td>12.0</td>
<td>13.0</td>
</tr>
<tr>
<td>Injuries and ill health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Killed and seriously injured on roads</td>
<td>2014 - 16</td>
<td>39.7</td>
<td>40.9</td>
<td>41.2</td>
<td>42.3</td>
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<tr>
<td>Hospital stays for self-harm</td>
<td>2016/17</td>
<td>185.3</td>
<td>188.4</td>
<td>191.5</td>
<td>194.6</td>
</tr>
<tr>
<td>Hip fractures in older people (aged 65+)</td>
<td>2016/17</td>
<td>577</td>
<td>594</td>
<td>611</td>
<td>628</td>
</tr>
<tr>
<td>Cancer diagnosed at early stage</td>
<td>2015</td>
<td>52.6</td>
<td>55.0</td>
<td>57.4</td>
<td>59.8</td>
</tr>
<tr>
<td>Diabetes diagnoses (aged 17+)</td>
<td>2017</td>
<td>77.1</td>
<td>79.5</td>
<td>82.0</td>
<td>84.5</td>
</tr>
<tr>
<td>Dementia diagnoses (aged 65+)</td>
<td>2018</td>
<td>67.5</td>
<td>70.0</td>
<td>72.5</td>
<td>75.0</td>
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<tr>
<td>Behavioural risk factors</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol-specific hospital stays (under 10%)</td>
<td>2014/15 - 2016/17</td>
<td>34.2</td>
<td>46.8</td>
<td>56.6</td>
<td>66.2</td>
</tr>
<tr>
<td>Alcohol-related harm hospital stays</td>
<td>2016/17</td>
<td>546</td>
<td>582</td>
<td>619</td>
<td>657</td>
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<tr>
<td>Smoking prevalence in adults (aged 18+)</td>
<td>2017</td>
<td>13.9</td>
<td>14.3</td>
<td>14.5</td>
<td>14.7</td>
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<td>Physically active adults (aged 19+)</td>
<td>2016/17</td>
<td>66.0</td>
<td>66.9</td>
<td>67.6</td>
<td>68.4</td>
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<td>Excess weight in adults (aged 18+)</td>
<td>2016/17</td>
<td>61.3</td>
<td>62.0</td>
<td>62.7</td>
<td>63.4</td>
</tr>
<tr>
<td>Child health</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Under 18 conceptions</td>
<td>2016</td>
<td>18.8</td>
<td>19.3</td>
<td>19.8</td>
<td>20.3</td>
</tr>
<tr>
<td>Smoking status at time of delivery</td>
<td>2017/18</td>
<td>10.8</td>
<td>11.6</td>
<td>12.2</td>
<td>12.8</td>
</tr>
<tr>
<td>Breastfeeding initiation</td>
<td>2016/17</td>
<td>74.5</td>
<td>75.7</td>
<td>76.9</td>
<td>78.1</td>
</tr>
<tr>
<td>Infant mortality rate</td>
<td>2015 - 17</td>
<td>3.9</td>
<td>4.2</td>
<td>4.4</td>
<td>4.6</td>
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<tr>
<td>Obese children (aged 10-11)</td>
<td>2017/18</td>
<td>20.1</td>
<td>20.8</td>
<td>21.5</td>
<td>22.3</td>
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<td>Inequalities</td>
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<td></td>
</tr>
<tr>
<td>Deprivation score (IMD 2015)</td>
<td>2015</td>
<td>21.5</td>
<td>22.8</td>
<td>23.5</td>
<td>24.1</td>
</tr>
<tr>
<td>Smoking prevalence: routine and manual occupations</td>
<td>2017</td>
<td>25.7</td>
<td>26.3</td>
<td>26.9</td>
<td>27.4</td>
</tr>
<tr>
<td>Wider determinants of health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children in low income families (under 106)</td>
<td>2015</td>
<td>16.8</td>
<td>17.0</td>
<td>17.2</td>
<td>17.5</td>
</tr>
<tr>
<td>GCSEs achieved</td>
<td>2016/17</td>
<td>59.8</td>
<td>62.0</td>
<td>63.2</td>
<td>64.5</td>
</tr>
<tr>
<td>Employment rate (aged 16-64)</td>
<td>2017/18</td>
<td>75.2</td>
<td>76.3</td>
<td>77.4</td>
<td>78.6</td>
</tr>
<tr>
<td>Statutory homelessness</td>
<td>2017/18</td>
<td>0.8</td>
<td>0.9</td>
<td>1.0</td>
<td>1.1</td>
</tr>
<tr>
<td>Violent crime (violence offences)</td>
<td>2017/18</td>
<td>23.7</td>
<td>24.7</td>
<td>25.6</td>
<td>26.6</td>
</tr>
<tr>
<td>Health protection</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New sexually transmitted infections</td>
<td>2017</td>
<td>794</td>
<td>807</td>
<td>816</td>
<td>827</td>
</tr>
<tr>
<td>New cases of tuberculosis</td>
<td>2015 - 17</td>
<td>9.9</td>
<td>10.4</td>
<td>10.9</td>
<td>11.4</td>
</tr>
</tbody>
</table>
## Appendix Two – Indicators relevant to sexual health promotion activity

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>England</th>
<th>Region</th>
<th>Derby UA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 16s in poverty (%) (PHOF indicator 1.01ii)</td>
<td>2015</td>
<td>16.8</td>
<td>16.1</td>
<td>20.5</td>
</tr>
<tr>
<td>Pupil absence (%) (PHOF indicator 1.03)</td>
<td>2016/17</td>
<td>4.65</td>
<td>4.61</td>
<td>4.97</td>
</tr>
<tr>
<td>First time entrants to the youth justice system rate / 100,000 (PHOF indicator 1.04)</td>
<td>2017</td>
<td>292.5</td>
<td>276.8</td>
<td>424.6</td>
</tr>
<tr>
<td>16-18 year olds not in education employment or training (%) (PHOF indicator 1.05)</td>
<td>2015</td>
<td>4.2</td>
<td>3.9</td>
<td>4.8</td>
</tr>
<tr>
<td>Sexual offences rate / 1,000 (PHOF indicator 1.12iii)</td>
<td>2017/18</td>
<td>2.4</td>
<td>2.1</td>
<td>2.4</td>
</tr>
<tr>
<td>GCSEs achieved (5 A*-C inc. English and maths) (%)</td>
<td>2015/16</td>
<td>57.8</td>
<td>55.1</td>
<td>44.8</td>
</tr>
<tr>
<td>Percentage people living in 20% most deprived areas in England</td>
<td>2014</td>
<td>20.2</td>
<td>18.3</td>
<td>34.6</td>
</tr>
<tr>
<td>Cervical cancer registrations rate / 100,000</td>
<td>2011-13</td>
<td>9.6</td>
<td>10.5</td>
<td>11.5</td>
</tr>
<tr>
<td>Under 18s alcohol-specific hospital admissions rate / 100,000</td>
<td>2014/15-2016/17</td>
<td>34.2</td>
<td>30.8</td>
<td>*</td>
</tr>
<tr>
<td>HPV vaccination coverage for one dose (females 12-13 years old) (PHOF indicator 3.03xii)</td>
<td>2016/17</td>
<td>87.2</td>
<td>88.8</td>
<td>78.8</td>
</tr>
</tbody>
</table>

*Value suppressed due to deductive disclosure
9. Acknowledgements

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10. References


xi National Institute of Care and Health Excellence (20017) HIV Testing Guidance: Encouraging uptake; available at: https://www.nice.org.uk/guidance/qs157


[https://www.blackburn.gov.uk/Pages/aces.aspx](https://www.blackburn.gov.uk/Pages/aces.aspx)