## Themed Report to Health and Wellbeing Board July 2019: Sexual Health

### 1. Introduction

Sexual health is defined by the World Health Organisation as:

> '*a state of physical, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled*'.[1]

Sexual health is an important and wide-ranging area of public health. Sexual health is a broader topic than sexually transmitted infections and includes areas such as contraception, termination of pregnancy (abortion), healthy relationships, sexual assault and the wider reproductive health of citizens. Good sexual health is an important aspect of health and wellbeing and it is vital that citizens have the information, confidence and the means to make choices that are right for them. It helps people to develop positive relationships and enables them to protect themselves and their partners from infections and unintended pregnancies that can have a long-term detrimental impact on an individual.

Some groups within the population are at higher risk of poor sexual health. The highest burden of sexually related ill-health is borne by groups who often experience other inequalities in health, including young people, men who have sex with men, black and minority ethnic groups, people with diverse gender identities and those living in socio-economically deprived areas. These groups often experience additional stigma, discrimination and obstacles in accessing services, which can further affect their sexual health.

### 2. National and local picture

#### 2.1 Relationships and Sex Education

Relationships and sex education (RSE) is learning about the emotional, social and physical aspects of growing up, relationships, sex, human sexuality and sexual health. Good quality RSE equips children and young people with the information, skills and positive values to have safe, fulfilling relationships, to enjoy their sexuality and to take responsibility for their sexual health and well-being.

From September 2020, there is a requirement that all secondary schools in England will teach RSE and the introduction of the new subject of 'relationships education' in primary school. Sex education will still be an optional element at primary level. There is also a new compulsory subject called health education, which includes preparing children for the changes of adolescence before onset. Parents and carers will still have the option to

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[1] Department of Health. (2013) *A Framework for Sexual Health Improvement in England*. Available at: https://www.gov.uk/government/publications/a-framework-for-sexual-health-improvement-in-england [Accessed 16.07.18]

withdraw their child/ren from sex education, at both primary and secondary school, up until three terms before a child's 16th birthday when they can choose for themselves whether to attend sessions.

The Nottingham RSE Charter was launched in 2016 as a way of ensuring equity of RSE provision in schools. So far, 82 schools (80% of total schools) have signed the Charter to show their commitment to Relationships and Sex Education, with 37 at level 3 (45% of signed up schools) which is where the school has deemed itself to be providing effective provision. The Charter is to be refreshed to re-energise schools in the lead-up to statutory RSE 2020.

Public health funds an RSE consultant to work with schools on policy and programme development focusing on knowledge and skills to enable pupils to make informed decisions about sexual health issues. The work includes sessions for parents, networks, staff training, lesson modelling and resource development. A School Health Improvement Coordinator delivers a range of awareness training for staff in educational settings in addition to direct work with pupils and the NUH outreach team deliver RSE to vulnerable young people in a range of settings. An annual RSE Day celebrating good practice is held on the last Thursday in June each year.

### 2.2 Teenage pregnancy (TP)

In England, the calculation of teenage pregnancy statistics include under-18 conceptions that lead to a legal termination of pregnancy or birth. Teenage pregnancy is an issue of inequality as early parenthood is associated with poor health, wellbeing and wider life chances such as education and economic outcomes as well as increased levels of social exclusion, for both teenage parents and their children.[2]

Action to reduce unplanned teenage pregnancy and support teenage parents has been a local and national priority since 1998. During this time, teenage pregnancy rates have continued to fall, both locally and nationally.

In Nottingham in 2017, the most recent available annual conception data, there was a decrease of two conceptions from 127 in 2016 to 125 in 2017 in the under-18 (15-17) age group. This represents a rate reduction from 26.9 conceptions per 1000 girls aged 15-17 in 2016 to 26.5 in 2017. The rate reduction is illustrated in Figure 1.

[2] Hadley, A, Chandra-Mouli, V and Ingham, R (2016) *Implementing the United Kingdom government's 10-year teenage pregnancy strategy for England (1999-2010): applicable lessons for other countries Journal of Adolescent Health* March pages 1-7.

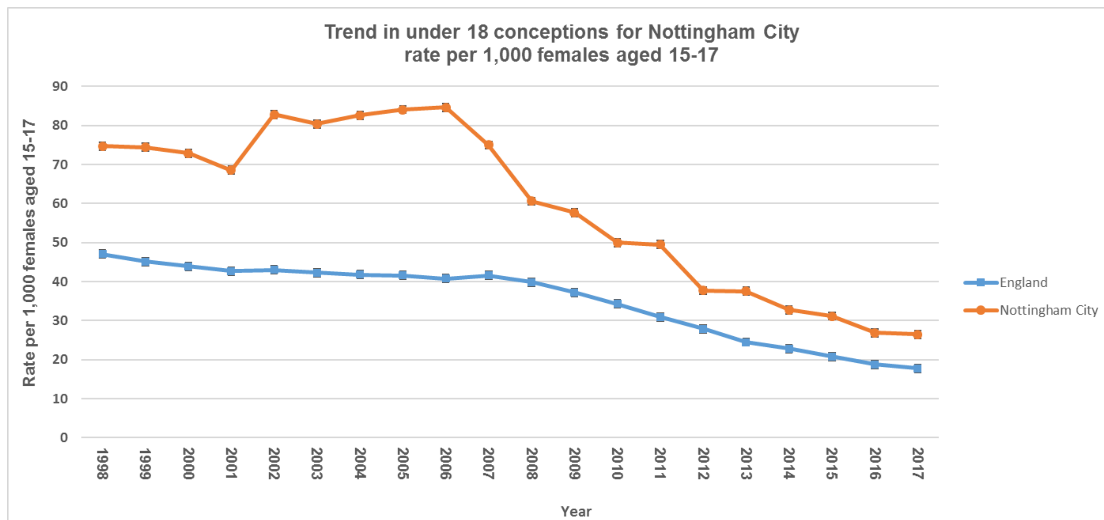


*Figure 1: Teenage Conception Rate trends, 1998 - 2017*
*Source: Office for National Statistics (2019) Dataset of conception statistics, England and Wales 2017*

However, Nottingham's under-18 conception rate is still higher than the England average rate of 17.8 conceptions per 1000 girls aged 15-17 in 2017 and the Core Cities average rate of 23.4 per 1000. The England average remains higher than in other Western European countries. Nationally 80% of under-18 conceptions are to 16 and 17 year olds and around 20% are to under-16s.

### 2.3 Contraception

Contraception is a highly cost-effective intervention, which plays an important public health role in improving the lives of individuals, families and communities.[3] Open access to a choice of contraception can prevent financial and social costs associated with unplanned births and terminations of pregnancy. A number of different contraceptive options are available, including short acting method such as pills, patches and rings and long acting reversible contraceptives (LARCs, these include the implant and 'coils'), barrier methods such as male and female condoms and diaphragms, and emergency contraception.

The rate of LARCS amongst women of all ages in Nottingham in 2017 was 54 per 1000, this was one of the best amongst comparators. LARCs accessed via GP were slightly lower than the national rate whilst those accessed at sexual health clinics was significantly higher than most comparators. User dependent contraception choices were similar to the national rate and the average rate of comparators (Figure 2).

[3] The Faculty of Sexual and Reproductive Healthcare, *A Quality Standard for Contraceptive Services* 2014, http://www.fsrh.org/pdfs/FSRHQualityStandardContraceptiveServices.pdf

| Indicator | Period | England | Neighbours average | 3 - Leicester | 11 - Sandwell | 10 - Wolverhampton | 4 - Salford | 6 - Coventry | 2 - Liverpool | 8 - Sheffield | 12 - Stoke-on-Trent | 14 - Sunderland | 7 - Southampton | 5 - Kingston upon Hull | 1 - Newcastle upon Tyne | Nottingham | 15 - Derby | 13 - Plymouth | 9 - Bristol |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total prescribed LARC excluding injections rate / 1,000 | 2017 | 47.4 | 47.7* | 25.8 | 32.4 | 37.5 | 38.9 | 42.3 | 43.3 | 43.4 | 46.0 | 49.8 | 49.9 | 53.2 | 53.7 | 54.0 | 62.4 | 64.2 | 68.1 |
| GP prescribed LARC excluding injections rate / 1,000 | 2017 | 29.2 | 25.2* | 7.5 | 3.5 | 20.1 | 14.4 | 25.8 | 13.1 | 36.6 | 22.0 | 15.9 | 26.1 | 3.0 | 30.0 | 27.2 | 42.1 | 40.1 | 54.4 |
| SRH Services prescribed LARC excluding injections rate / 1,000 | 2017 | 18.2 | 22.5* | 18.3 | 28.9 | 17.4 | 24.5 | 16.5 | 30.2 | 6.8 | 24.0 | 33.9 | 23.8 | 50.3 | 23.6 | 26.8 | 20.3 | 24.2 | 13.6 |
| Under 25s choose LARC excluding injections at SRH Services (%) | 2017 | 21.6 | 24.4* | 29.6 | 17.0 | 34.1 | 21.0 | 34.0 | 14.0 | 27.8 | 23.3 | 27.9 | 40.2 | 33.1 | 27.5 | 27.7 | 36.3 | 25.1 | 22.7 |
| Over 25s choose LARC excluding injections at SRH Services (%) | 2017 | 38.0 | 41.7* | 37.4 | 40.5 | 56.0 | 38.1 | 59.6 | 26.1 | 54.9 | 33.2 | 45.4 | 58.7 | 47.5 | 47.7 | 43.4 | 56.0 | 49.3 | 40.0 |
| Women choose injections at SRH Services (%) | 2017 | 9.6 | 10.0* | 5.4 | 13.1 | 7.3 | 11.7 | 6.9 | 11.1 | 5.4 | 10.1 | 18.2 | 6.4 | 13.4 | 9.2 | 6.6 | 5.2 | 9.9 | 8.6 |
| Women choose user-dependent methods at SRH Services (%) | 2017 | 60.6 | 57.4* | 60.5 | 56.8 | 44.2 | 58.6 | 45.4 | 69.7 | 57.2 | 61.5 | 44.4 | 44.0 | 46.5 | 56.1 | 58.7 | 49.0 | 54.5 | 61.8 |
| Women choose hormonal short-acting contraceptives at SRH Services (%) | 2017 | 45.3 | 42.9* | 28.5 | 39.2 | 33.8 | 40.6 | 32.3 | 54.6 | 46.5 | 53.9 | 39.0 | 32.4 | 35.7 | 43.7 | 45.1 | 33.5 | 38.1 | 47.1 |

*Figure 2: Contraception uptake rates. Source: Public Health Outcomes Framework*

In 2018, just over 17,000 Nottingham city residents attended sexual health[4] services including outreach services. Approximately, 7% (n1,928) of attendees were aged 13-17 (75% female, 25% male). 75% of all people in this age group attended for contraception (excluding condoms) with around 10% being for emergency contraception.[5]

Clients received a range of other services including sexual health screening, pregnancy testing, termination of pregnancy counselling and other specialist counselling. Figure 3 shows the number of girls aged 11-17 years at ward level and the number of attendances at sexual health services. It should be noted that many girls choose to attend a clinic away from where they live to protect their anonymity.

[4] STI and contraception services
[5] Sexual & Reproductive Health Activity Dataset 2018

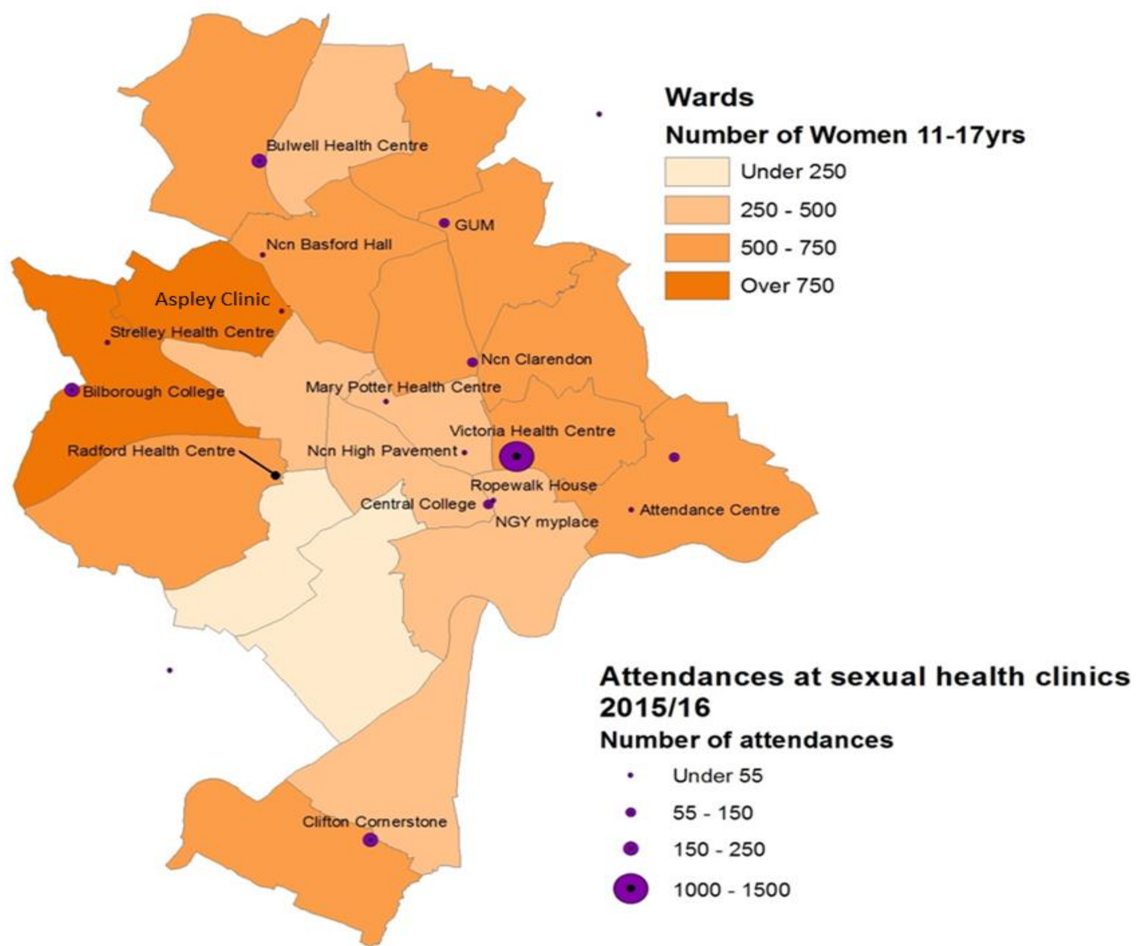


*Figure 3: Attendances at health clinics across Nottingham's wards. Source: Nottingham City Council Service monitoring data.*

In 2019, 29 out of 68 Nottingham pharmacies are signed up to provide free emergency hormonal contraceptive (EHC) to females aged between 13 and 25 years in order to reduce levels of unplanned pregnancy. There is an even geographical spread of pharmacies offering this service across the city.

### 2.4 Abortion/Termination of pregnancy (ToP)

Conceptions that are not planned may continue and become wanted, however many end in termination.

Termination of pregnancy services include counselling and support whilst making a decision, counselling and support after a decision to terminate a pregnancy has taken place and further counselling and support about their decision when a young person has decided to have a termination. Depending on the number of weeks pregnant the citizen is, the pregnancy is ended either by taking medication or by having a surgical procedure. Repeat

and late terminations may be an indicator of social complexities. Late terminations have additional associated medical and health risks and costs.

The abortion rate in Nottingham in 2017 (14.5/1000 women) was significantly lower that most comparators as was the proportion of women under 25 having repeat abortions (19.1%) indicating good access to contraception and exercise of choice of when to become pregnant. Early abortions were however lower than comparators and more women opting for a surgical procedure than in most other cities (Figure 4). A local audit of abortion services in 2018 suggested that late and/or surgical abortions can be an indicator of patient choice.

| Indicator | Period | England | Neighbours average | Nottingham | 1 - Newcastle upon Tyne | 2 - Liverpool | 3 - Leicester | 4 - Salford | 5 - Kingston upon Hull | 6 - Coventry | 7 - Southampton | 8 - Sheffield | 9 - Bristol | 10 - Wolverhampton | 11 - Sandwell | 12 - Stoke-on-Trent | 13 - Plymouth | 14 - Sunderland | 15 - Derby |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| abortion (%) New data | 2017 | 52.0 | 42.1* | 27.8 | 36.0 | 53.4 | 41.5 | 53.8 | 36.4 | 45.4 | 46.0 | 42.9 | 45.7 | 38.1 | 44.9 | 33.0 | 46.3 | 33.0 | 41.5 |
| Under 18s abortions rate / 1,000 | 2017 | 8.4 | 9.8* | 6.7 | 7.7 | 13.3 | 8.4* | 14.7 | 10.0 | 12.8 | 13.6 | 8.2 | 5.2 | 11.2 | 12.6 | 8.2 | 10.6 | 8.0 | 7.4 |
| Under 25s repeat abortions (%) | 2017 | 26.7 | 26.1* | 19.7 | 22.3 | 30.2 | 23.9* | 30.6 | 20.8 | 27.8 | 26.2 | 24.4 | 24.3 | 28.5 | 32.4 | 32.7 | 22.1 | 19.1 | 22.3 |
| Abortions under 10 weeks (%) | 2017 | 76.6 | 75.7* | 71.1 | 75.2 | 76.8 | 74.9* | 82.0 | 74.5 | 67.7 | 79.5 | 74.8 | 79.0 | 68.9 | 69.9 | 83.4 | 83.6 | 79.5 | 76.8 |
| Total abortion rate / 1000 | 2017 | 17.2 | 17.5* | 14.5 | 14.1 | 21.3 | 17.2* | 25.6 | 15.2 | 19.9 | 18.7 | 12.4 | 14.4 | 23.3 | 23.3 | 20.9 | 16.2 | 12.5 | 16.6 |
| Under 25s abortion after a birth (%) | 2017 | 26.7 | 29.3* | 27.4 | 23.5 | 25.9 | 27.2* | 27.8 | 37.1 | 29.9 | 25.1 | 28.3 | 17.8 | 35.3 | 36.6 | 39.9 | 26.9 | 34.4 | 39.3 |
| Over 25s abortion rate / 1000 | 2017 | 15.0 | 15.9* | 14.5 | 14.2 | 19.3 | 17.0* | 21.4 | 12.1 | 18.1 | 18.6 | 10.8 | 13.5 | 21.1 | 19.9 | 18.8 | 13.7 | 10.4 | 14.0 |
| Abortions under 10 weeks that are medical (%) | 2017 | 79.4 | 77.2* | 65.0 | 89.6 | 92.8 | 86.7* | 83.3 | 59.7 | 80.9 | 83.5 | 81.5 | 63.6 | 80.9 | 77.3 | 77.6 | 50.9 | 80.1 | 49.2 |

*Figure 4: Termination of pregnancy. Source: Public Health Outcomes Framework*

Of the 125 under-18 conceptions in Nottingham during 2017, 27.8% led to a termination, the lowest rate in England; this equated to the termination of 35 conceptions in Nottingham. This is not a statistically significant change from 1998 when the under-18 termination rate in Nottingham was 28.4%. This proportion of conceptions resulting in termination is significantly lower than the 2017 England average under-18 termination rate of 52%.

32% of under-16 conceptions in Nottingham in 2017 led to a termination compared to the national average of 60.5%, only Sheffield and North-East Lincolnshire have lower termination rates than Nottingham in this age-group. Further investigation is necessary to establish any potential reasons for these variations in the under-16 conception and termination rates as under-16 year old conceptions are not reducing as rapidly as in the 15-17 year old cohort.

### 2.5 Sexually transmitted infections (STIs) and Human Immunodeficiency Virus (HIV)

STIs are passed from one person to another through unprotected sex or genital contact and can exist without symptoms for long periods.

Some highly prevalent STIs are of particular concern. Chlamydia is the most common STI in the UK and is transmitted easily during sex. Most people do not experience any symptoms, so they are unaware they are infected. Genital warts are caused by the human papilloma

virus (HPV) and are the second most common STI in England after Chlamydia. Gonorrhoea and Syphilis are bacterial STIs which are easily transmitted during sex; they are highly infectious but present very few symptoms in the early stages. Mycoplasma Genitalium (Mgen) has recently been identified as a cause for concern as it is appears to cause similar problems to Chlamydia, but is not routinely tested for at present in most services.

Diverse sexual lifestyles, the growing use of drugs during sex with multiple casual partners (chemsex) and infections that do not respond to general antibiotics (antimicrobial resistance) present challenges to managing the sexual health of the population. Reinfection with an STI within a 12-month period is also of concern and is an indicator of risk taking sexual lifestyles, therefore, preventing STI reinfection continues to be a priority.

In England, in 2018, there were 447,694 diagnoses of sexually transmitted infections (STIs) a 5% increase since 2017. Specifically there were:

- 56,259 diagnoses of Gonorrhoea reported in 2018, a 26% increase since 2017. There were three cases of extensively drug resistant *Neisseria Gonorrhoeae* identified in England in 2018.
- 7,541 diagnoses of Syphilis reported in 2018, a 5% increase since 2017.
- First episode genital warts in 15 to 17 year old young girls and heterosexual boys continued to decline largely due to the National HPV Immunisation programme.
- Chlamydia testing amongst 15 to 24 year olds declined, in 2018. However, the proportion of people testing positive increased, suggesting testing is being targeted appropriately.
- Whilst still significantly lower rates of diagnoses than younger age groups, the largest proportional increase in Chlamydia and Gonorrhoea between 2017 and 2018 was seen in people 65 years and older.
- The population diagnosis rates of syphilis, gonorrhoea and chlamydia are greatest in HIV-diagnosed MSM.

The impact of STIs remains greatest in young heterosexuals 15 to 24 years, black ethnic minorities and gay, bisexual and other men who have sex with men (MSM).

Nottingham has one of the highest STI testing rates (excluding Chlamydia) in the country, this paired with effective targeting of high risk groups has resulted in increased likelihood of detection. There has been no significant change in the STI diagnosis rate in recent years and Nottingham remains amongst the highest in line with comparators. Figure 5 compares Nottingham with the national average as well as similar cities (CIPFA Neighbours[6]).

[6] *Chartered Institute of Public Finance and Accountancy 'Nearest Neighbours' model Developed to aid local authorities in comparative and benchmarking exercises, the models provide a wide range of SSA based, socio-economic indicators upon which the specific family group is calculated.*

| Indicator | Period | England | Neighbours average | Nottingham | 2 - Liverpool | 1 - Newcastle upon Tyne | 4 - Salford | 9 - Bristol | 3 - Leicester | 15 - Derby | 13 - Plymouth | 7 - Southampton | 10 - Wolverhampton | 12 - Stoke-on-Trent | 11 - Sandwell | 6 - Coventry | 8 - Sheffield | 5 - Kingston upon Hull | 14 - Sunderland |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| New STI diagnoses (exc chlamydia aged <25) / 100,000 | 2018 | 851 | 910* | 1003 | 1123 | 946 | 1237 | 1147 | 649 | 790 | 995 | 1227 | 960 | 623 | 809 | 878 | 652 | 869 | 662 |
| STI testing rate (exc chlamydia aged <25) / 100,000 | 2018 | 18053 | 17724* | 22272 | 21386 | 20855 | 20421 | 20413 | 18219 | 18201 | 17854 | 17490 | 16937 | 16335 | 16099 | 15215 | 14974 | 11877 | 11836 |
| STI testing positivity (exc chlamydia aged <25) % | 2018 | 2.3 | 2.4* | 2.4 | 2.3 | 2.0 | 3.5 | 2.4 | 1.9 | 1.9 | 2.1 | 3.4 | 3.0 | 2.0 | 2.8 | 2.1 | 2.3 | 2.6 | 2.3 |

*Figure 5: STI testing and detection rates (exc. Chlamydia). Source: Public Health Outcomes Framework 2019*

In Nottingham, there was a statistically significant increase in Gonorrhoea diagnosis in 2018, which was higher than statistical neighbours and the England average. Based on local data, Gonorrhoea incidence was higher in males than females, with more than twice as many males aged over 25 years being diagnosed than females. Syphilis rates in 2018 were similar to the national rate, after seeing a significant and continuing decline since the 2016 exceedance, diagnoses were more prevalent in men aged 25-34. Genital warts in people of all ages remained higher than statistical neighbours and England average, as in previous years. Local data suggests that most diagnoses were in the 20-24 age group. A high detection rate for Chlamydia is desirable, in that it represents early detection and prevention of STIs. In 2018, Nottingham had a detection rate for Chlamydia amongst 15 to 24 year olds similar to the national rate. There has been a statistically significant drop in this in line with a decrease in the proportion of 15 to 24 year olds screened (Figure 6). Local data shows that Chlamydia diagnoses were around three times higher in males aged 45-64 than females in the same age group.

| Indicator | Period | England | Neighbours average | Nottingham | 2 - Liverpool | 1 - Newcastle upon Tyne | 4 - Salford | 9 - Bristol | 3 - Leicester | 15 - Derby | 13 - Plymouth | 7 - Southampton | 10 - Wolverhampton | 12 - Stoke-on-Trent | 11 - Sandwell | 6 - Coventry | 8 - Sheffield | 5 - Kingston upon Hull | 14 - Sunderland |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Syphilis diagnostic rate / 100,000 | 2018 | 13.1 | 12.0* | 12.8 | 17.1 | 11.2 | 30.6 | 12.8 | 7.9 | 4.7 | 6.5 | 30.5 | 6.2 | 16.1 | 8.0 | 8.1 | 9.5 | 8.4 | 5.4 |
| Gonorrhoea diagnostic rate / 100,000 | 2018 | 98.5 | 108.9* | 182.3 | 129.6 | 131.5 | 179.0 | 88.0 | 85.4 | 93.0 | 81.3 | 130.0 | 142.7 | 62.3 | 106.3 | 92.7 | 91.9 | 87.1 | 74.7 |
| Chlamydia detection rate / 100,000 aged 15-24 <1900 1900 to <2300 ≥2300 | 2018 | 1975 | 1985* | 1928 | 2557 | 1872 | 2477 | 1981 | 1934 | 2226 | 2350 | 2522 | 2165 | 1754 | 1698 | 1482 | 1609 | 1838 | 1651 |
| Chlamydia detection rate / 100,000 aged 15-24 (Male) | 2018 | 1336 | 1326* | 1284 | 1864 | 1281 | 1701 | 1221 | 1238 | 1364 | 1607 | 1549 | 1334 | 1307 | 1149 | 944 | 1062 | 1408 | 1198 |
| Chlamydia detection rate / 100,000 aged 15-24 (Female) | 2018 | 2620 | 2628* | 2578 | 3157 | 2485 | 3266 | 2720 | 2657 | 2782 | 3163 | 3177 | 3051 | 2241 | 2299 | 2087 | 2187 | 2302 | 2123 |
| Chlamydia proportion aged 15-24 screened | 2018 | 19.6 | 19.0* | 18.3 | 24.9 | 21.8 | 23.6 | 26.8 | 16.3 | 15.9 | 24.0 | 20.3 | 13.5 | 18.8 | 11.4 | 13.5 | 18.0 | 10.0 | 16.6 |
| Chlamydia diagnostic rate / 100,000 | 2018 | 384 | 485* | 635 | 619 | 517 | 600 | 562 | 485 | 426 | 510 | 764 | 440 | 348 | 371 | 376 | 408 | 369 | 293 |
| Chlamydia diagnostic rate / 100,000 aged 25+ | 2018 | 213 | 245* | 321 | 277 | 218 | 378 | 353 | 219 | 184 | 221 | 394 | 258 | 184 | 252 | 176 | 197 | 162 | 131 |
| Genital warts diagnostic rate / 100,000 | 2018 | 100.1 | 121.2* | 149.1 | 168.9 | 167.3 | 138.1 | 163.5 | 84.0 | 97.7 | 163.8 | 159.3 | 69.3 | 81.1 | 71.6 | 119.7 | 92.2 | 108.6 | 81.5 |

*Figure 6: STI rates direction of change. Source: Public Health Outcomes Framework 2019*

### 2.5.1 Human Immunodeficiency Virus (HIV)

HIV has now become a long-term condition rather than a fatal infection meaning that timely diagnosis can enable those with HIV to live disability free and for longer. Antiretroviral therapy (ART), improved HIV testing uptake at STI clinics and access to HIV Pre-exposure prophylaxis (PrEP) has led to a reduction in new HIV diagnoses amongst men who have sex with men (MSM) as one of the highest risk groups for HIV for the first time. However, national reporting indicates that guidelines around MSM being tested for HIV every three months were not universally followed and in 2017, 77% of MSM testing positive for a HIV test had not been tested in the preceding 12 months.[7] Nationally, there is a suggestion that some BME groups at high risk of HIV are increasingly declining the offer of HIV tests.[8] There is also a suggestion that HIV positive MSM are being increasingly diagnosed new STIs such as Chlamydia and Gonorrhoea, this may be due to increased condomless sexual contact associated with the use of PrEP or that this group may be more likely to engage in risk taking behaviours.

In Nottingham, 716 people were living with HIV in 2017, which is amongst the highest when compared to similar cities. 42% of all diagnoses were classed as late which is in line and better when compared to similar cities. New diagnoses rate of HIV amongst those aged 15 and over in Nottingham was amongst the highest at 18.1 per 100,000. The national rate was 8.7 per 100,000. The HIV testing coverage amongst the eligible population in Nottingham was amongst the highest in line with comparators (Figure 7).

| Indicator | Period | England | Neighbours average | Nottingham | 2 - Liverpool | 1 - Newcastle upon Tyne | 4 - Salford | 9 - Bristol | 3 - Leicester | 15 - Derby | 13 - Plymouth | 7 - Southampton | 10 - Wolverhampton | 12 - Stoke-on-Trent | 11 - Sandwell | 6 - Coventry | 8 - Sheffield | 5 - Kingston upon Hull | 14 - Sunderland |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| HIV testing coverage, total (%) | 2018 | 64.5 | 62.8* | 71.8 | 72.4 | 56.1 | 47.5 | 72.6 | 52.4 | 71.0 | 62.2 | 63.7 | 67.3 | 53.6 | 42.5 | 72.2 | 81.9 | 63.0 | 76.9 |
| HIV testing coverage, MSM (%) | 2018 | 87.8 | 88.1* | 86.6 | 92.9 | 91.8 | 83.7 | 87.7 | 89.0 | 87.5 | 91.4 | 80.0 | 90.3 | 87.5 | 82.7 | 89.1 | 91.5 | 82.8 | 87.4 |
| HIV testing coverage, women (%) | 2018 | 55.2 | 53.6* | 64.1 | 65.8 | 45.1 | 33.9 | 66.2 | 44.1 | 62.0 | 56.1 | 56.2 | 57.8 | 43.6 | 33.1 | 68.7 | 78.4 | 59.4 | 72.6 |
| HIV testing coverage, men (%) | 2018 | 78.4 | 76.4* | 80.6 | 79.4 | 75.8 | 70.2 | 79.4 | 66.9 | 85.2 | 71.1 | 75.0 | 84.5 | 73.9 | 68.6 | 76.7 | 84.9 | 68.0 | 81.8 |
| HIV late diagnosis (%) <25% 25% to 50% ≥50% | 2015 - 17 | 41.1 | 47.7* | 42.0 | 48.5 | 39.1 | 46.2 | 49.0 | 56.9 | 41.7 | 39.5 | 49.2 | 49.4 | 46.7 | 56.1 | 55.1 | 41.2 | 56.5 | 38.2 |
| New HIV diagnosis rate / 100,000 aged 15+ | 2017 | 8.7 | 11.2* | 18.1 | 13.6 | 11.3 | 16.2 | 12.4 | 13.5 | 11.2 | 6.9 | 12.0 | 16.3 | 7.8 | 14.1 | 10.2 | 6.9 | 6.1 | 3.9 |
| HIV diagnosed prevalence rate / 1,000 aged 15-59 <2 2 to 5 ≥5 | 2017 | 2.32 | 2.51* | 3.25 | 2.15 | 1.99 | 4.71 | 2.55 | 3.93 | 2.49 | 1.45 | 2.43 | 3.41 | 2.13 | 2.75 | 3.22 | 1.72 | 1.27 | 0.91 |

*Figure 7: Nottingham and similar cities (CIPFA) HIV data. Source: Public Health Outcomes Framework 2019*

## 3. Local services/actions/landscape

Under the provisions of the Health and Social Care Act (2012), from April 2013 Local Authorities, Clinical Commissioning Groups (CCGs) and NHS England each have a legal

[7] Public Health England. *HIV Testing in England 2017 Report. Available at:* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/666478/HIV_testing_in_England_2017_report.pdf [accessed 30.08.18]

[8] Public Health England, *Nottingham Local Authority HIV, Sexual and Reproductive Health Epidemiology Report (LASER): 2016*

responsibility for commissioning a range of sexual health services. Figure 8 provides a summary of organisational commissioning responsibility.

| Local Authorities | CCGs | NHS England |
|---|---|---|
| • Contraception<br>• STI testing and treatment<br>• Chlamydia testing as part of the National Chlamydia Screening Programme<br>• HIV testing<br>• Sexual health including aspects of psychosexual counselling<br>• Sexual services including young people's sexual health, teenage pregnancy services, outreach, HIV prevention and sexual health promotion work, services in schools, colleges and pharmacies | • Termination services<br>• Vasectomy<br>• Non sexual health elements of psychosexual health services<br>• Gynaecology including use of contraception for non-contraception purposes | • Contraception provided as an additional service under the GP contract<br>• HIV treatment and care including post-exposure prophylaxis after sexual exposure<br>• Promotion of opportunistic testing and treatment for STIs<br>• Sexual health elements of prison health services<br>• Sexual Assault Referral Centres<br>• Cervical screening<br>• Specialist foetal medicine |

*Figure 8: Summary of Commissioning Responsibilities for Sexual Health Services. Source: Department of Health Commissioning Sexual Health services and interventions: Best practice guidance for local authorities, 2013.*

Nottingham City Council (NCC) has a statutory responsibility to provide, or secure the provision of, open access sexual health services in its area[9] including:

- Preventing the spread of sexually transmitted infections (STIs)
- Treating, testing and caring for people with STIs and partner notification
- Contraceptive services including advice on preventing unintended pregnancy
- Sexual health promotion

As part of this duty, Nottingham City Council commissions a range of sexual health services including:

- Integrated Sexual Health Services (ISHS)
- Chlamydia Screening Programme
- Sexual health Promotion
- Psycho sexual counselling
- A range of Locally Commissioned Public Health Services (LCPHS) in GP practices and pharmacies
- Integrated Substance Misuse and Sexual Health Service (Health Shop)

[9] http://www.adph.org.uk/wp-content/uploads/2016/09/Interpreting-the-ringfenced-grant-conditions-and-mandateGATEWAY.pdf

- HIV community testing service (outreach and point of care testing)
- HIV home sampling
- Online Chlamydia and Gonorrhoea testing
- C-card Condom Distribution Scheme
- Relationships and Sex Education
- Participation in the NHS HIV PrEP impact trial

## 4. Good practice

- Nottingham City Council demonstrates good practice around working in partnership with Nottinghamshire County Council to co-commission sexual health services to maximise efficiency and improve access.
- Good practice around co-commissioning with other services is also seen in the integrated substance misuse and sexual health service providing opportunistic screening and testing for high risk people who inject drugs (Health Shop).
- Positive and constructive relationships are facilitated between primary and secondary care providers to manage demand ensure smooth care pathways for citizens.
- Addressing capacity issues such as shortage of 'coil' fitters by agreeing an inter-practice referral mechanism with the GP Alliance.
- Nottingham's RSE Charter encourages schools to sign up to basic RSE and progress to a 'gold standard'.
- Annual national RSE day led by Nottingham.

## 5. Challenges

- Increasing demand in sexual health services and budget cuts restricting capacity and the ability to pilot new approaches such as digitalisation.
- Community based (not restricted to faith groups) challenges in the lead up to the rollout of mandatory RSE.
- Ongoing high teenage pregnancy rates have continued to pose challenges.
- Skills in general practice to provide some sexual health services are becoming limited thus impacting on demand in specialist sexual health services.
- Fragmentation in commissioning responsibilities leading to fragmented services (see Figure 8).
- Increasing risk taking sexual behaviours such as frequent partner change, increase in numbers of partners, 'chemsex' and group sex facilitated by geosocial networking applications.
- Preventing reinfections due to partner change or non-compliance to treatment.
- Strains of infections resistant to antibiotics.

## 6. Next steps recommendations

- Conduct a sexual health commissioning review to ascertain if and where there are any gaps between local need and provision.
- Aim to protect the sexual health budget from further cuts.
- Health and Wellbeing Board to consider guidance in the House of Commons Health and Social Care Committee report on Sexual Health and identify long term opportunities around integrating commissioning of services mentioned in Figure 9.
- Support the RSE agenda mandatory roll-out and continue to work together to overcome challenges and resistance by addressing local people's concerns.

- Support recommendations from the Teenage pregnancy JSNA chapter upon completion later this year.

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