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# Derby City and Derbyshire County Sexual Health Needs Assessment 2023

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Derby City Council

DERBYSHIRE County Council

Derbyshire Community Health Services
NHS Foundation Trust

# Welcome

This needs assessment aims to present a picture of sexual health in Derby and Derbyshire utilising national and local data, the views of stakeholders working in the sexual health system and the views of the public – service users and non-users. The needs assessment has endeavoured to ensure the voices of individuals and groups most at risk of poor sexual health outcomes are heard.

The needs assessment acknowledges that sexual health depends on wide ranging factors, both local and national and this report endeavours to reflect a system approach with recommendations to support future planning towards the best sexual health for Derby and Derbyshire.

The findings should also be seen as part of a continuous process to inform improvement mindful of continuous change across need, demography, and policy.

It welcomes and invites you to start with a twenty-minute read outlining key findings and summary recommendations. For more detail, the full report then follows.

## Acknowledgements

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**Derby and Derbyshire communities and stakeholders** involved in SHARP, the Planning event 21 June and consultation surveys.

**Members of the Derby and Derbyshire Sexual Health Alliance.**

# Derby and Derbyshire Sexual Health Needs Assessment

# June 2023

# A 20-minute read summary

The World Health Organization defines sexual health as:

"a state of physical, emotional, 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 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."

Sexual health is a key public health agenda because it can add risk to population health whether from diagnosed or undiagnosed sexually transmitted infections (STIs). There is a risk of onward transmission and pregnancies. Some groups in the population are at higher risk of poor sexual health outcomes, these include:

- Young people and vulnerable young people (under 25s)
- Men who have sex with other men (MSM)
- People who identify as lesbian, gay, bisexual and transgender (LGBT)
- People from black and minority ethnic groups
- Adults with vulnerabilities

For sexual health as with many other health areas, there is also an association between poor health outcomes and deprivation.

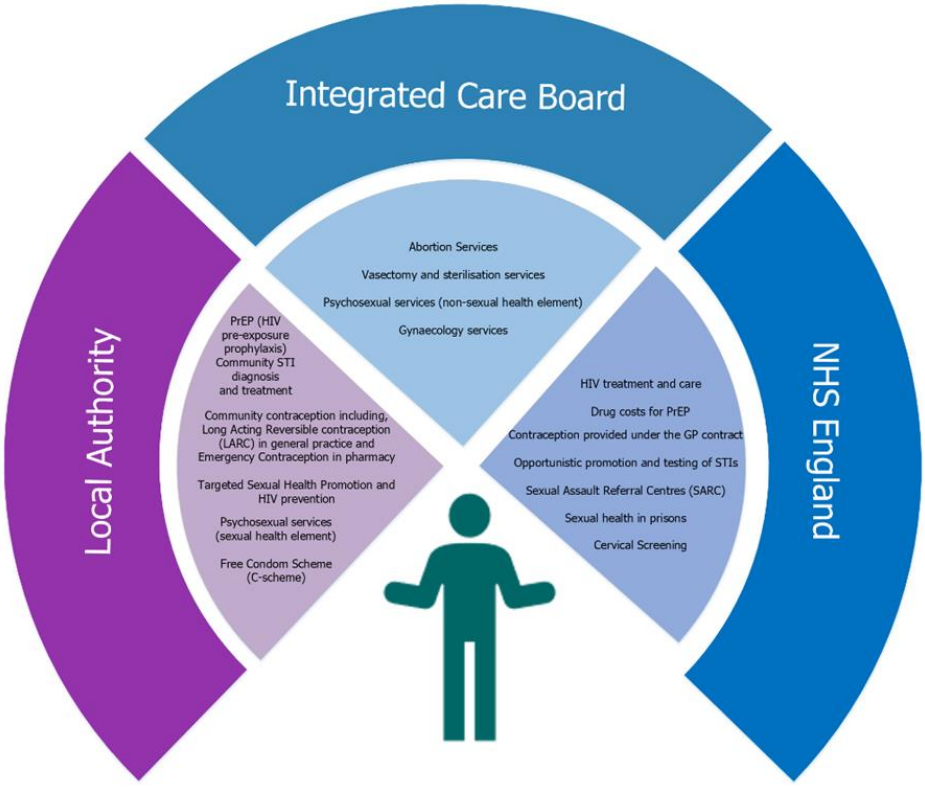
Sexual health should not be seen as "separate" or "alone" due to the way it is connected and related across other aspects of health during a person's lifetime, for example, substance misuse, education, children and young people's services, domestic and sexual violence and women's health.

National and local sexual health services should be viewed from a system-wide perspective. It is a system which at times can be fragmented because aspects of sexual health are commissioned across 3 different commissioning organisations, namely:

- Local Authorities
- Integrated Care Boards
- NHS England

This means that there are lots of different services delivered by different providers (Figure 1).

Figure 1 – Sexual health landscape: commissioners and services




Source: Derbyshire County Council, 2023

This needs assessment aims to outline sexual health need across Derby and Derbyshire populations with population demographics that are important to consider relative to sexual health.

The full report explores need through:

- **Comparative data** across key sexual health indicators, benchmarked against national data and considered against local authority areas with similar demographics. *Readers are asked to be mindful of impact on data due to the pandemic.*
- **Expressed need** through demand and use of local authority commissioned integrated sexual health services (ISHS)
- **Felt need** through conversations and consultation with system staff and stakeholders, individuals and communities with a focus on groups at risk

This needs assessment should be seen as part of **an ongoing process** of opportunity to contribute and monitor need that is subject to continuous change.

Some key recommendations are given in this summary. Additional recommendations are given in the full SHNA report. *Additional contributions from a variety of stakeholders attending the **Planning for the Future, Derby and Derbyshire Populations** event, held on 21 June 2023 will also be considered going forward.*

## Derby and Derbyshire Demography

Key demographic differences are seen between the populations of Derby and Derbyshire specific to the planning of sexual health services going forward. Differences focus on age, ethnicity, migration, gender identity, sexual orientation and deprivation as individuals in these groups may be subject to poorer sexual health outcomes.

Table 1 - Derby and Derbyshire demographics

| Demographic | Derby | Derbyshire |
|---|---|---|
| Age | Younger population 13.4% 15-24yrs; 5-year projected increase by 2028<br><br>Increasing ageing population | 9.7% 15-24yrs higher younger populations in Bolsover, South Derbyshire and Erewash districts. 5-year projected increase in 15-19yrs<br>Increasing ageing population |
| Ethnicity | Greater ethnic diversity:<br>73.8% white<br>15.6% Asian, Asian British, Welsh British<br>4.0% Black, Black British, Black Welsh, Caribbean or African<br><br>19.6% non-UK born or 1:5 people living in Derby are non-UK born (Pakistan and India are the most common birth countries) | 96.3% white<br>1.5% Asian, Asian British, Welsh British<br>0.5% Black, Black British, Black Welsh, Caribbean or African<br><br>4.6% non-UK born |
| Gender Identity (16yrs+) | 0.11% answered as transwoman or man *(0.10% England)* | 0.05% in Derbyshire |
| Sexual Orientation | 3.22% identify as LGB+, similar to England (3.17%) with higher bisexual identification | 2.51% in Derbyshire identify as LGB+ |
| Deprivation | 15.9% of LSOAs in the top 10% most deprived nationally | 4.5% of LSOAs in the top 10% most deprived nationally *situated on the eastern side of the county* |

# Comparative Data: Key Findings[1]

## STIs: new diagnoses, testing and positivity

2022 data shows an **increase in new STI diagnoses of 23.5% in Derby and 31.6% in Derbyshire, compared to 2021**, with chlamydia and gonorrhoea being the most commonly diagnosed STIs. The increase in the total number of new STIs between 2021 and 2022 may be partly explained by an increase in STI testing rates – now higher than pre COVID-19 levels alongside increased diagnoses.

In 2022:

- **Derby had a new STI diagnosis rate** of 815.7 per 100,0000 *(2130 new STIs),* **significantly higher than the England** average of 694.2 per 100,000 and ranked 1st highest amongst its 16 CIPFA[2] neighbours and 37th highest of the 152 upper tier local authorities (UTLAs) in England
- **Derbyshire had a new STI diagnosis rate** of 477.8 per 100,000 in Derbyshire *(3807 new STIs),* **significantly lower than England** and ranked 5th highest amongst its 16 CIPFA neighbours and 103rd highest amongst the 152 UTLAs in England
- Derby has a positivity rate of 6.7% and Derbyshire has 5.9% positivity. **Both have test positivity lower than England** – indicating either low prevalence of STIs in the population or a result of testing people who are less likely to have a STI

Regional data indicates **inequalities** due to higher new STI diagnoses (2019-21) **in women aged 15-24yrs; Black or Black ethnic groups and gay, bisexual and men who have sex with men (GBMSM)**.

**Chlamydia** is the most common STI and is often asymptomatic. Chlamydia detection rates are influenced by differences in prevalence, screening coverage and whether the most at-risk populations are being reached (the proportion testing positive). Increases in the number of infections detected and treated is an indication of improved chlamydia control. **Young women (under 25s) bear the highest burden of health impact due to chlamydia.**

In 2022:

- **Derby had 16% of under 25s screened for chlamydia, better coverage than England** (15,2%) and **unchanging** in recent years
- **Derbyshire had 14.7%, significantly worse coverage than England** and **decreasing** in recent years

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[1] *data focuses on comparison between 2021 and 2022 trends, although some trends are used before COVID-19 years. Data for 2021 and 2022 used the new population estimates based on the 2021 Census, while years prior to this used the population estimates which were originally based on the 2011 Census (OHID, 2023). Revised populations for years prior to 2021 have not yet been published by ONS, therefore it is recommended that comparisons between 2021 and the earlier time periods should be treated with caution (OHID, 2023). It should also be noted that the values for Derby between 2020 and 2022 may have been inflated due to potential duplicate reporting between online and physical reporters, thus these figures should be treated with caution.*

[2] *CIPFA is a group of 16 local authorities which all have similar demographic characteristics and can be used for benchmarking purposes.*

- Derby's detection rate for young males and females was 2,705 per 100,000, significantly higher than England (2,110 per 100,000), indicating a well-targeted screening programme or a high level of chlamydia
- Derbyshire's detection rate for young males and females was 2,204 per 100,000, below England

In 2022, the new National Chlamydia Screening Programme (NCSP) introduced a new additional Chlamydia Detection rate for females of 3,250 per 100,000 female population aged 15-24 years. A detection rate is recommended as a threshold to reach in order to reduce chlamydia prevalence in the local population by 2%. Derby and Derbyshire both have a detection rate lower than this. However, it is noted that only 13 LAs nationally achieved the new national detection rate for females.

**Gonorrhoea** is the second most common STI in England, with **substantial increases in diagnoses nationally, the greatest being within the GBMSM population, however increases are also seen secondly in heterosexual women and thirdly in heterosexual men**. This causes additional concern due to the increasing antimicrobial resistance of gonorrhoea and indicates high levels of risky sexual behaviour within a population, inferring increasing unsafe sex practices. **This national increase has been replicated in Derbyshire, while the increase in Derby has been even greater than the national trend**.
In 2022:

- **Derby had a rate of 157.8 per 100,000, similar to the average for England** (146.1 per 100,000), ranking 1st highest amongst its CIPFA nearest neighbours
- **Derbyshire**, although an increased rate of 89.9 per 100,000 remains **significantly lower than England.** However, it ranks 1st highest amongst its CIPFA nearest neighbours

**Genital Warts** have shown a **significantly declining diagnostic rate** nationally since 2012 with the introduction of the Human papillomavirus (HPV) vaccine offering protection against the viral subtypes responsible for 90% of genital warts cases. Derby and Derbyshire reflect this declining trend.
In 2022:

- Derby had a rate of 54.0 per 100,000, remaining similar to England (46.1 per 100,000)
- Derbyshire had a rate of 36.5 per 100,000, consistently remaining below England.

**Genital Herpes diagnostic rates have decreased both nationally and in Derbyshire compared to Derby where no significant change is seen**.
In 2022:

- Derby had a rate of **57.8 per 100,000 diagnoses, higher and significantly worse than England** (44.1 per 100,000)
- Derbyshire had a rate of **40.9 per 100,000, similar to England**

**Syphilis** diagnostic rates have shown a significant increase nationally, with MSM being disproportionately affected (over 75% of cases.) Rates of syphilis diagnoses have been suggested to indicate levels of unsafe sexual practices in a population.

In 2022:

- **Derby had a rate of 13.4 per 100,000, similar to England** (15.4 per 100,000). This is an increasing rate *although it is based on small numbers where large fluctuations can occur between years*
- **Derbyshire had a rate of 6.5 per 100,000, significantly below England** and an unchanging trend in recent years

**Human Immunodeficient Virus (HIV)** prevalence since 2013 has been increasing in both Derby and Derbyshire. 2021 is the most recent local data available.
In 2021:

- **Derby had a HIV prevalence rate of 2.65 diagnoses per 1000 population, significantly higher than England** (2.34 per 1000) and ranking 2nd highest amongst CIPFA peers
- **Derby's HIV testing coverage is significantly higher** than the England average for the eligible population and males; testing of GBMSM is higher than England and for women it is similar to England
- **Derbyshire had a prevalence rate of 0.83 per 1000 population, significantly below Derby and England** and ranking 14th highest amongst CIPFA peers
- **Derbyshire's HIV testing coverage has been decreasing in recent years,** with a rate significantly below England across eligible populations, except amongst GBMSM populations where coverage was similar to England

It is important for people living with HIV (PLHIV) to receive an early diagnosis to ensure early treatment and therefore better health outcomes.
Between 2019-21:

- In **Derby 34.8% of PLHIV were diagnosed at a late stage**, similar to England (43.4%)
- In **Derbyshire 47.6% of PLHIV were diagnosed late**, greater than Derby but similar to the England average

Large inequalities exist in HIV prevalence, with a disproportionately higher burden of infection amongst MSM and people who have migrated from regions of the world where HIV is more prevalent, such as sub-Saharan Africa. Although confidence is limited around local data by small sample sizes, late diagnosis locally affects some populations disproportionately compared to others:

- In **Derby, 1 in 2 (50.0%) heterosexual men are diagnosed late** (compared to 33.3% in Derbyshire and 58.1% in England), while **in Derbyshire, 2 in 3 (66.7%) heterosexual and bisexual women are diagnosed late** (compared to 33.3% in Derby and 49.5% in England)

Regional data shows a decreasing rate in new HIV diagnoses which has continued post pandemic and may be underpinned by the evolving routine commissioning of Pre-Exposure Prophylaxis (PrEP) preventing HIV transmission. 2021 regional data indicates a recovery of the numbers of people accessing HIV specialist care and treatment to pre-pandemic levels. 59.8% of this cohort are male, 40.1% female, with the most common age groups being 35-49yrs and 50 years or more.

**STI Recommendations**

- Ensure accessibility to STI testing and treatment meets the differing local demographic diversity and differing sexual health need across both Derby and Derbyshire. A multiple model of settings and approaches is recommended
- Higher STI rates in Derby may indicate a need to ensure targeted approaches to populations at risk with a focus on MSM, working with groups to address barriers to services and support self-care
- Lower STI prevalence in Derbyshire may indicate a balance of opportunistic testing in multiple settings such as general practice and emergency departments, especially to support reduction of HIV late diagnoses alongside a level of targeted testing approaches focussed on higher risk populations
- Co-produce promotional materials with groups at risk to ensure appropriate images and messages that address challenges such as perceptions of stigma and judgement
- Ensure communication across the sexual health system is regularly maintained with the most up to date information about service accessibility and pathways for staff, volunteers, users and non-users
- Explore areas that could be jointly commissioned and/or jointly provided for the benefit of population sexual health
- Ensure equitable and fair support is given for self-empowerment and self-care to enable individuals to manage their sexual health and address challenges they may have
- Ensure partner notification is prioritised as key to prevent STI transmission and for it to be seen in the context of individual circumstances and mindful of the population demographic:
- Understanding cultural sensitivities
- Risks around confidentiality and a need for discretion, for example working with victims of domestic violence
- Ensure regular staff training is in place across the sexual health system and to associated staff such as substance misuse staff who may have real or perceived barriers to service access. Training should include:
    - Up to date knowledge of service pathways and provision
    - Understanding for appropriate staff of when to offer an STI test to prevent late diagnoses
    - Understanding of cultural sensitivities and use of appropriate language
    - Understanding of needs across groups with a disability and learning disability
- Ensure people are at the heart of service commissioning and provision, with targeted approaches to eligible populations most at risk of STIs including young heterosexuals, gay, bisexual and men who have sex with men (GBMSM), individuals displaying risky sexual behaviours and men and women working in the sex industry

## Women's Sexual and Reproductive Health

### Cervical Screening

In 2022:

- Derby had a coverage of 66.8% in the 25-49 years age-group, similar to England (67.6%) ranking 14th highest amongst its CIPFA nearest neighbours; and a 74.3% coverage in the older 50-64 years age group, similar to England (74.6%), ranking 7th highest amongst CIPFA neighbours. This indicates **further need to engage younger women**
- Derbyshire showed a decreasing coverage in the 25-49 years age group of 77.6%, 1st highest compared to CIPFA nearest neighbours and above the England rate; and a 78.7% coverage in the older 50-64 years age group, ranking 3rd highest amongst CIPFA neighbours and above the England rate

**Long-Acting Reversible Contraception (LARC)** defined as intrauterine devices (coils) and subdermal contraceptive implants across **Derby and Derbyshire has been significantly higher in local prescribing than England, with an increasing trend** except a reduction during COVID-19 where prescribing was reduced. **2021 prescribing data now shows a return to an increasing trend compared to 2020 although rates have not yet recovered to that of 2019, pre COVID-19.**

In 2021:

- the total prescribing rate of LARC increased, although it remains considerably below the rates seen in 2019. During this period, **Derbyshire (57.3 per 1,000) and Derby (53.1 per 1,000) had the two highest total prescribing rates of LARC seen in the East Midlands, with both areas recording a prescribing rate higher than the England average** (41.8 per 1,000)
- For total prescribed LARC, Derby ranks 3rd highest amongst its CIPFA neighbours, whilst Derbyshire ranks 6th highest
- Historically, **LARC prescribing is greater in General Practice** compared to Integrated Sexual Health Services (ISHS) and this difference continued during the pandemic. In 2021, 69.2% of females in Derby and 69.4% in Derbyshire accessed LARC through their GP, compared to 61.5% in England
- A **lesser proportion of women under 25 years chose LARC as their main method of contraception at ISHS services** compared to older women above 25 years

### Abortion rates

In 2021, the **total abortion rate in Derby (17.7 per 1,000) and Derbyshire (15.7 per 1,000) was significantly lower than England (19.2 per 1,000).** There has been no significant change in this rate in Derby in recent years, while in Derbyshire, it has been increasing year on year since 2015, yet remaining significantly below England.

In 2021, the **proportion of repeat abortions in women aged under 25 years in Derby (26.5%) was similar to that seen in England (29.7%), while performance in Derbyshire (24.9%) was better.** For both Derby and Derbyshire this has been an unchanging rate in recent years, however, this still indicates an average of 1:4 women locally whose

contraception needs are not met, urging exploration of improved access to contraception during the postpartum period to prevent further repeat abortions or unplanned pregnancies.

**Women's Sexual and Reproductive Health (SRH) Recommendations**

- Ensure all women are aware of their contraception choices and have ease of access to services. Particular focus should ensure accessibility for younger women aged under 25s and women of vulnerability. The full menu of contraception choice should be available for women, with LARC encouraged based on its stronger evidence of most effectiveness
- Local LARC capacity should be regularly explored to ensure maintenance and continued offer across general practice, addressing future training needs and adequate numbers of LARC fitters
- Services delivering to women across the sexual health system should consider:
  - Promotion and offer of contraception especially for women with vulnerability across various service settings. Abortion and Maternity services are key in this to ensure prevention of repeat abortions, unwanted pregnancies and pregnancies within a shorter inter-pregnancy interval which is harmful to health of mother and baby
  - Discussion with women of all methods of contraception during pregnancy is advised, and provision of contraception including LARC should be initiated prior to discharge from maternity services
  - Contraception advice should be given alongside STI prevention through use of condoms, with condoms being provided where possible to service users
  - SRH services should work with services for vulnerable women including mental health, substance misuse, domestic violence and support to commercial sex workers
  - Consideration by system commissioners and providers of women's SRH about opportunities to offer women "seamless" access through greater integration across services in a "hub" approach to ensure women's multiple needs are met at one setting or one appointment. Services within a "hub" approach could include:
    - cervical screening
    - contraception for prevention of conception
    - contraception for treatment of gynaecological conditions
    - menstrual care
    - menopausal support and care
    - STI testing e.g. chlamydia prevention

A hub approach should also ensure up to date awareness of patient pathways to and from other SRH services including abortion and abortion care, maternity, postnatal support and care for pregnancy loss, fertility and associated women's health support including mental health, substance misuse and domestic and sexual violence.

## Young People's Sexual Health (under 18)

**HPV vaccinations (**12-14yrs) were significantly disrupted locally due to the impact of COVID-19 and school closures (2019/20). However, **recent data for 2020/21 shows some recovery**:

- the **first dose in females has almost recovered to pre-pandemic levels** (76.2% and 89.0% in Derby and Derbyshire)
- **2-dose performance in females remains significantly lower** than pre-pandemic and under the England goal of ≥90% coverage
- HPV data coverage for **boys** is only available for the first dose, **with coverage for year 8 males being 68.4% in Derby, 84.1% in Derbyshire and 71.0% in England, but all significantly below the goal of ≥90%**. Dose 1 coverage was significantly higher in females than males, in all areas

**Teenage Pregnancy** rates nationally have declined considerably in recent decades and Derbyshire rates reflect this. **Derby also shows decline although rates are still higher than England.**

In 2021:

- **Derby had a rate of 16.8 per 1,000, population, significantly worse than the rate of 13.1 per 1,000 in England**, ranking 9th highest amongst its CIPFA nearest neighbours
- **Derbyshire's rate of 10.9 per 1000 remains consistently lower than England**, ranking 12th highest amongst its CIPFA nearest neighbours. There is some difference at district and borough level with **Chesterfield having the highest rate of all districts (20.3 per 1,000) and significantly higher than England**, while Derbyshire Dales (3.5 per 1,000) and High Peak (6.3 per 1,000) have the lowest rates performing significantly better than England.
- **Derby has the highest proportion of teenage mothers in the East Midlands, significantly higher than England** (0.9% compared to 0.6%). There is a strong association with deprivation and levels of education attainment seen across wards with these inequalities.
- Derbyshire has a proportion of teenage mothers similar to England with 0.6% of deliveries to mothers aged under 18 years. Ward data is not available due to small numbers but the **proportion of deliveries to teenage mothers was highest in Amber Valley (1.0%) and Bolsover (0.8%)** and this reflects an association with deprivation.

**Young People's Recommendations**

- Commissioners and providers should ensure opportunity to engage and co-produce services with young people, also working closely with services supporting children and young people with a focus to understand specific challenges for young people in their access of sexual health services
- Local commissioners should consider collaborative approaches to ensure quality Relationship and Sex Education (RSE) is available to all children and young people in school settings and for those not attending school
- Service design and promotion should be equitable and fair to meet the diverse access needs of young people
- Sexual Health services for young people should ensure they collaborate with associated organisations and services including education, council children's services, NHS services including school health and general practice
- The sexual health system should ensure inclusion of organisations and services that address need of specific groups of children and young people with vulnerability and risk, including community safety and youth justice provision, sexual violence and domestic violence, young people in care and care leavers, substance misuse, prevention of child sexual exploitation risk and harmful sexual behaviour. It is vital to work closely with voluntary organisations who may specifically work with children of vulnerability
- Targeted provision should be utilised to address barriers for some young people at risk who are unwilling to access sexual health and associated services
- Ensure training and awareness is available for all staff working with children and young people to support improved sexual health outcomes
- The sexual health system should support services addressing particular challenges such as the uptake of the HPV vaccine for boys; support to teenage mothers to prevent and mitigate risk of subsequent pregnancies; working collaboratively to help address emerging risks of harm, for example sexting, behaviours, attitudes and messaging through the use of social media

## Expressed Need – Integrated Sexual Health Services

During the pandemic years, there was a decline in clinic attendances for contraception and STI care coinciding with national restrictions on services and in part also to a change in lifestyle and behaviours impacting on demand. However, recent **2022 data indicates an increasing trend in clinic attendance, and this is now similar to pre-pandemic levels**.
In 2021/22:

- **Derby showed highest clinic attendances from areas of higher deprivation across inner city wards.** There was a similar finding in Derbyshire with higher clinic attendances in Chesterfield and North East Derbyshire indicating patterns of use from deprived communities
- **Derby and Derbyshire showed clinic attendance as highest in younger females aged 15-24 years**

- For males, the highest attendances were noted in the 25-34 age group, with the younger age group of 15-24 years following
- Use of online services during the pandemic years and up to 2022 shows a slightly higher rate of returns for STI tests in Derby for all ages compared to Derbyshire, with the **under 25s group having the greatest rate of online service use**

## Felt Need: Key Recommendations with a Focus on ISHS

Consultation with system staff and stakeholders took place through interviews and an online survey. Individuals and communities from groups at risk were engaged through interviews, focus groups and supported by community action researchers. This summary outlines key recommendations that were raised.

**Recommendations Relating to Communications and Marketing**

- Services and system leaders should implement opportunities for engagement with service users and non-users to understand their specific needs relative to sexual health and overall access to services
- Promotion of services should outline that they are free, open access, confidential, non-judgemental and without stigma, with levels of targeted promotion in communities such as those most deprived
- Multiple communication methods and use of social marketing tools to ensure promotion and messaging meets specific cultural sensitivities and the diversity of individual experience

**Recommendations Relating to Service Delivery**

- A multi-model for provision – including clinics, online and outreach provision and collaborative development across different organisational settings such as general practice, maternity, education should be explored to meet diversity of need
- Use of peer support and champions for individuals with specific barriers to service access, for example people identifying as non-binary or trans
- An offer of both appointment and walk-in face2face sessions is advised alongside regular engagement with groups who value walk-ins to ensure maximisation of use
- Clinics should endeavour where possible to maintain consistency of staff at clinics to foster trusted relationships with vulnerable users
- Regular updating of service provision information across system partners working in services associated with sexual health
- Improving self-care for individuals, mindful of their specific needs
- Training for providers to embed understanding of cultural needs and the ways in which language is used in communication – with focus on local need across groups of ethnicity other than white, groups with different gender identification and different sexual orientation

**Recommendations Relating to Groups Experiencing Inequality or Higher Risk of Poor Sexual Health Outcomes**

- Ensure services are promoted with:
    - Positive sexual and relationship messages
    - Reassurance about service values and confidentiality
    - Utilisation of images in promotional material to reflect the different local population diversities across Derby and Derbyshire
- Up to date training and awareness for NHS staff about HIV testing guidelines, care and pathways to ensure patients feel confident in their care
- Training and awareness for all staff to ensure understanding of ethnic and cultural diversities that may impact individuals accessing services due to experiences or perceptions of stigma, discrimination
    - Awareness of ethnicity sensitivities and use of language in the offer of routine or opportunistic HIV testing
    - Understanding of the needs of trans men, women and non-binary
- Engagement of higher risk groups in service co-production to address needs. Specific groups to include may be LGBT individuals, black African communities, people living with HIV and young people
- Regularly review the offer of PrEP through engagement with eligible populations at risk including gay, bisexual and men who have sex with men (GBMSM) to maximise messaging and reach appropriately
- Proactive support for drug and alcohol users from both sexual health and substance misuse staff around both health areas to ensure needs are met. Training for both services' staff to ensure complex drug and alcohol needs are understood and can be addressed alongside their sexual health needs
- Proactive support to commercial sex workers including greater collaborative working with local organisations who work with women and men in the sex industry
- Ensuring services are accessible to people living with a learning disability (LD). This may include staff training and awareness across the sexual health system about the challenges that people with a learning disability may have and also support with training and awareness about sexual and relationship health services for staff working with LD
- Ensuring services meet the needs of people living with physical and mental disability through health literacy and accessibility interventions. It is recommended that services listen to people's experiences and needs to ensure improved accessibility and experience
- Exploration of the needs of trans and non-binary individuals which can result in barriers to service access across the sexual health system:
    - Understanding from sexual health staff across the system about the needs of this group, that might include conception, fertility and family planning needs
    - Ensuring services are in place for trans individuals across sexual health pathways, for example invitation to cervical screening where barriers and non-inclusion have been perceived and/or experienced by trans men or non-binary people assigned female at birth

**Recommendations Offering a System-Wide Perspective**

- Greater collaboration across the sexual health system – building on the work of the Sexual Health Alliance to address current challenges and opportunities
- Continue to strengthen the current membership of the Alliance ensuring opportunity is offered to engage key partners such as general practice, pharmacy and groups working with populations living with inequality
- Build on the positive but "recent" profile of the Sexual Health Alliance within the Integrated Care Partnership - through support and approval on agreed key priorities and the development of a longer-term strategy
- Explore ways to simplify sexual health commissioning and streamline pathways for users
- Expand performance indicators and monitoring to include service user experience and views. To ensure regular inclusion of "data" from users and non-users alongside available health data; with proactive ways to engage vulnerable communities to support development of local service offers
- Explore a system-wide review through the Alliance and evolving partners with focus on
    - Key findings from the SHNA and the evolving priorities
    - Challenges in the system including budget allocation meeting changing demand.

## Conclusions

This needs assessment should be seen as part of a continuous and inclusive process for staff, volunteers, service users and non-users going forward.

Derby and Derbyshire have diverse needs relative to sexual health and within each local authority area there are further challenges experienced by some populations which are harmful to their sexual health and wellbeing. It is important to regularly monitor this different need. It is important to ensure continued engagement with at risk populations and organisations working with them through activity co-production and use of their "stories" alongside health data to really inform service developments and address challenges.

Sexual Health is not an isolated agenda, it is an intrinsic part of life and therefore it is important to ensure our local sexual health system is visible and collaborative across multiple areas of local strategy and provision.

Priorities within this SHNA and from the discussion at a stakeholder event, 21 June 2023 – have raised 4 local priorities going forward:

- Inclusivity
- Joining up and collaboration
- Prevention
- Workforce including the community and voluntary sector

The Sexual Health Alliance will lead the strategic direction for sexual health improvement mindful of the SHNA findings, recommendations and priorities towards a new 3-year strategy.

The Alliance will ensure it evolves at pace to be truly representative of all stakeholders and embed its presence in the developing relationship within the Integrated Care System.

Finally, it is important to ensure Derby and Derbyshire have a skilled and confident sexual health workforce, well-resourced provision across the system, an emphasis on prevention, focus on reduction of sexual health inequalities, efficiency across the system to meet changing demand and always to put the care for patients at the heart of the system.

## Abbreviations used in this report

| | |
|---|---|
| AA | Alcoholics Anonymous |
| ACE | Adverse Childhood Experiences |
| AIDS | Acquired Immune Deficiency Syndrome |
| AMR | Antimicrobial Resistance |
| ART | Anti-retroviral Therapy |
| ASRO | Addressing Substance Related Offending |
| BASHH | British Association for Sexual Health and HIV |
| BHIVA | British HIV Association |
| BBVs | Blood Born Viruses |
| CCGs | Clinical Commissioning Groups |
| CDC | Centre for Control and Disease |
| CSA | Child Sex Abuse |
| CSE | Child Sexual Exploitation |
| CSEW | Crime Survey for England and Wales |
| DHSC | Department of Health and Social Care |
| FGM | Female Genital Mutilation |
| GBL | Gamma-butyrolactone |
| GBMSM | Gay, bisexual, and men who have sex with men |
| GBV | Gender-based Violence |
| GHB | Gamma-hydroxybutyrate |
| HIV | Human Immunodeficiency Virus |
| HNA | Health Needs Assessment |
| HPV | Human Papillomavirus |
| HSB | Harmful Sexual Behaviour |
| ICBs | Integrated Care Boards |
| IDTS | Integrated Drug Treatment Systems |
| ISHS | Integrated Sexual Health Service |
| IUD | Intrauterine Device |

| | |
|---|---|
| IUS | Intrauterine System |
| JCVI | Joint Committee on Vaccination and Immunisation |
| LARC | Long-Acting Reversible Contraception |
| MG | Mycoplasma Genitalium |
| MoJ | Ministry of Justice |
| MSM | Men who have sex with men |
| NA | Narcotics Anonymous |
| NAPAC | National Association for People Abused in Childhood |
| NCSP | National Chlamydia Screening Programme |
| NEET | (young people) Not in Education, Employment or Training |
| NFGMSC | National FGM Support Clinics |
| NICE | National Institute of Clinical Excellence |
| NSPCC | National Society for the Prevention of Cruelty to Children |
| NSU | Non-Specific Urethritis |
| OHID | Office of Health Improvement and Disparities |
| OSAP | Offender Substance Abuse Programme |
| PID | Pelvic Inflammatory Disease |
| PLWHIV | People Living With HIV |
| PrEP | Pre-exposure Prophylaxis |
| PWID | People who inject drugs |
| RSE | Relationship and Sex Education |
| SHNA | Sexual Health Needs Assessment |
| STI | Sexually Transmitted Infection |
| THT | Terrence Higgins Trust |
| UKDPC | UK Drug Policy Commission |
| UKSA | UK Health Security Agency |
| VAWG | Violence Against Women and Girls |
| WHO | World Health Organization |

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# 1. Introduction

The World Health Organization (WHO) defines sexual health as

"a state of physical, emotional, 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 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].

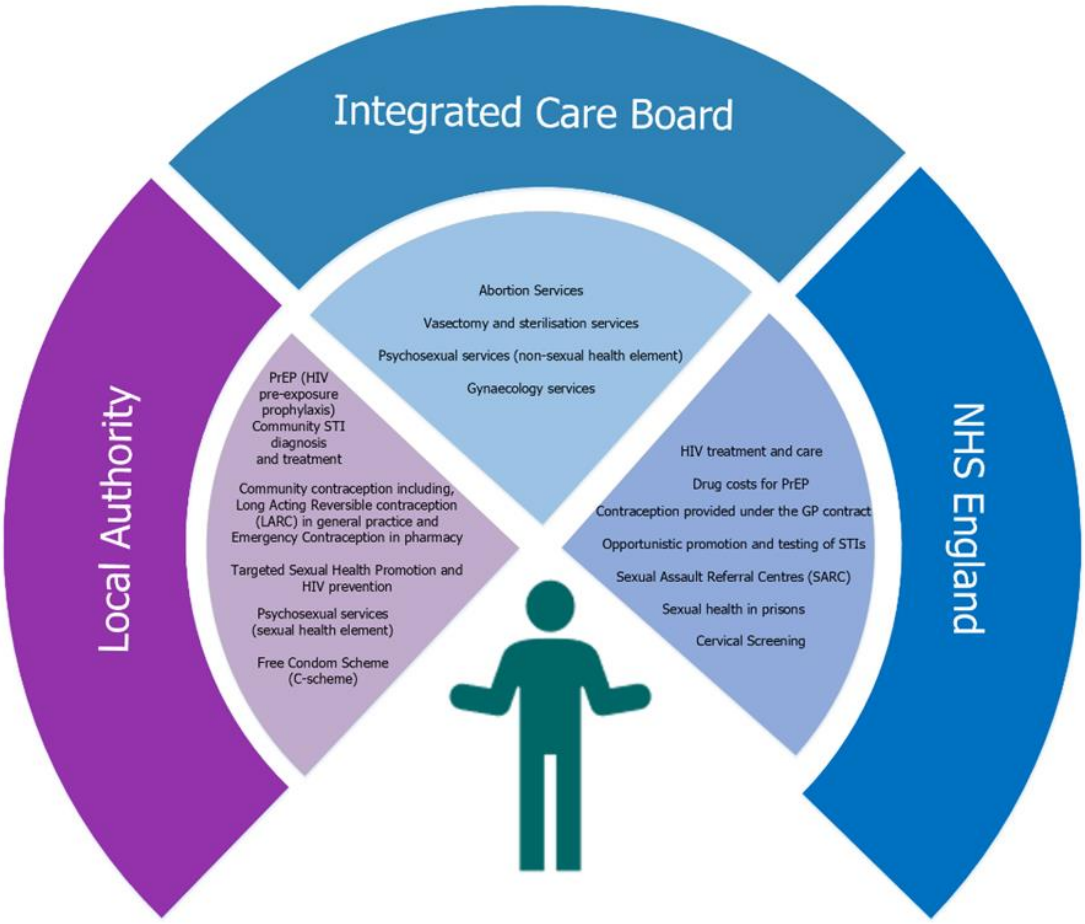
This Health Needs Assessment (HNA) aims to inform current and future planning to support fulfilment of this working definition for optimum sexual health outcomes for Derby and Derbyshire populations. As with many other health areas, good sexual health is varied across a population and some groups are at higher risk of poor health. Groups at risk of sexual health inequality include:

- young people (13 – 25yrs), vulnerable young people including young people within the care system and care leavers, NEET, young people involved in the criminal justice system, young people at risk of sexual exploitation
- adults at higher risk include those who may struggle to access health services including substance misusers, commercial sex workers, prison leavers, adults with disability, adults with poor health literacy and communities living in identified areas of high deprivation
- other vulnerability to poor sexual health outcomes include individuals identifying as MSM (men who have sex with other men), LGBT (lesbian, gay, bisexual and transgender) and PLHIV (people living with HIV)

Individuals and groups living with higher levels of deprivation and associated impact such as lower service access are also at higher risk of poorer sexual health outcomes.

Sexual health is dependent on a system-wide approach due to the way it is commissioned with different commissioning bodies, different providers and associated providers as indicated in Figure 1.

Figure 1 - The sexual health commissioning landscape




Source: Derbyshire County Council, 2023

Associated providers may include organisations that commission or provide services for populations at risk of poor sexual health, for example local authority Children and Young People services, Substance misuse services, Community Safety commissioning, and voluntary sector partners who advocate and work with populations living with significant inequality that may impact on their sexual health and wellbeing.

This multiple and varied landscape requires a collaborative approach to ensure the different aspects of sexual health need are met and to add value to other opportunities for example improved system efficiency, service access, reducing inequality for some groups, strengthening workforce stability and supporting one strategic vision for sexual health locally. It is hoped that this needs assessment will support reflection on greater working together for the benefit of patient health.

The needs assessment was overseen by the Derby and Derbyshire SHNA Group, reporting to the Sexual Health Alliance as required. This was a substantial project beginning September 2022 and ending June 2023.

The findings and key messages aim to underpin the collaboration of a three-year Sexual Health Strategy with identified priorities. It is hoped that it will support future action across Derby and Derbyshire for the maximum benefit of population sexual health.

## 1.1 Scope and Methodology

The needs assessment scope covers Derby and Derbyshire populations, aiming to assess and understand sexual health need in its variation and distribution.

In scope is:

**Comparative need** – quantitative data to indicate current need and offering comparison where possible against national, regional and local authority areas with similar population demographics. Peer authorities are identified using the Chartered Institute of Public Finance and Accountancy (CIPFA) Nearest Neighbours statistical model. The model identifies 15 LAs with similar demographic and socioeconomic characteristics to the LA of interest to aid comparison and benchmarking.

Unless otherwise stated, all comparative need data presented in this report were retrieved from the Office for Health Improvement & Disparities (OHID) Sexual and Reproductive Health Profiles[2] using the Fingertips API package in R. The names Derby and Derbyshire are used to represent the administrative areas of Derby City Council and Derbyshire County Council respectively.

In response to the COVID-19 pandemic, the UK Government implemented several national and regional lockdowns and social distancing measures beginning 23rd March 2020. Following the third national lockdown which ended 7th March 2021, restrictions were slowly lifted in a phased approach[3]. These containment measures affected sexual behaviour and health service provision. Data across this period should be interpreted with this in mind, particularly when comparing with pre-pandemic years.

**Expressed Need** - quantitative data indicating demand and service use is given with specific focus on the local authority commissioned Integrated Sexual Health Service (ISHS). Derby City Council and Derbyshire County Council commission a separate service to meet the different need of their respective populations. Both services are provided by a lead provider, Derbyshire Community Health Services NHS Foundation Trust (DCHS) with additional providers including general practice, pharmacy, a private digital provider and voluntary community sector organisations.

**Felt Need** – qualitative data is included through a commissioned piece of work managed by Unique Improvements, a North West social enterprise. As a key contribution to this needs assessment, Unique Improvements delivered:

- the Sexual Health Action Research Project (SHARP) - a separately commissioned 9-month project (March-November 2022) aimed to engage staff, stakeholders and communities

including identified groups at risk. Preparation to support the identification of groups with vulnerability and a literature review to identify key themes across sexual health was undertaken to support the project consultation. Consultation included staff and stakeholder interviews, resident focus group, patient conversations and a street survey. An additional element of SHARP included working with local people who were recruited to act as community action researchers. The 15 Steps Challenge toolkit was adapted for use by the community action researchers in their visits to sexual health clinics in the engagement of service users

- additional consultation through interviews and an online questionnaire was used to invite system leaders' response. Key themes were explored including:
    - How well the current ISHS offer meets need
    - Accessibility
    - How well the current offer serves those with most vulnerability
    - Role of digital and remote provision
    - Partnership working across the sexual health system
    - Areas across sexual health working that might be done differently
    - Innovative ideas to re-design services to maximise impact on local sexual health

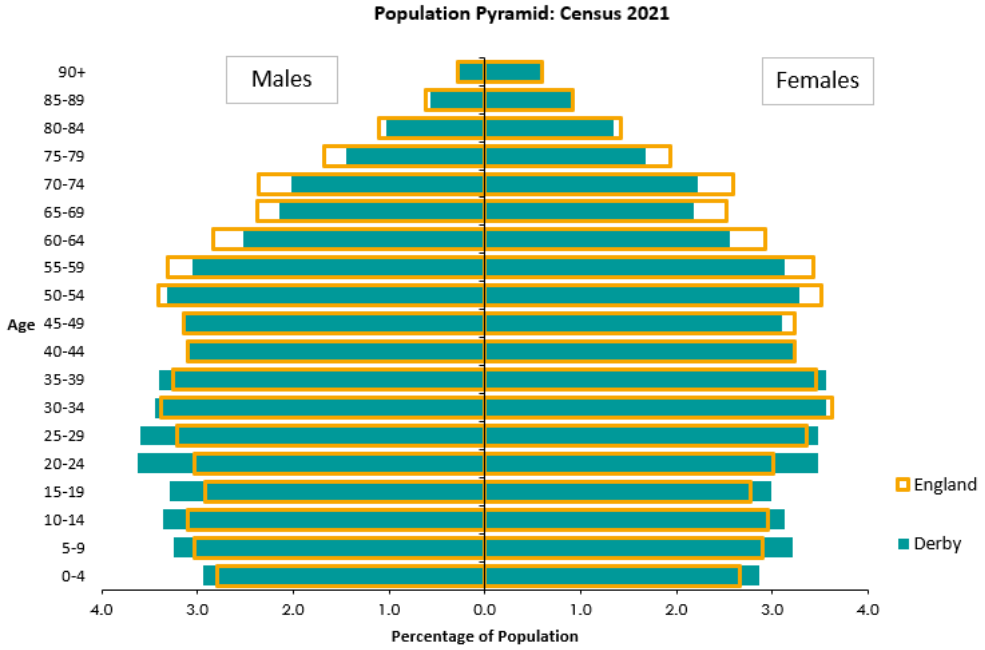
# 2. Derby and Derbyshire Population Profile

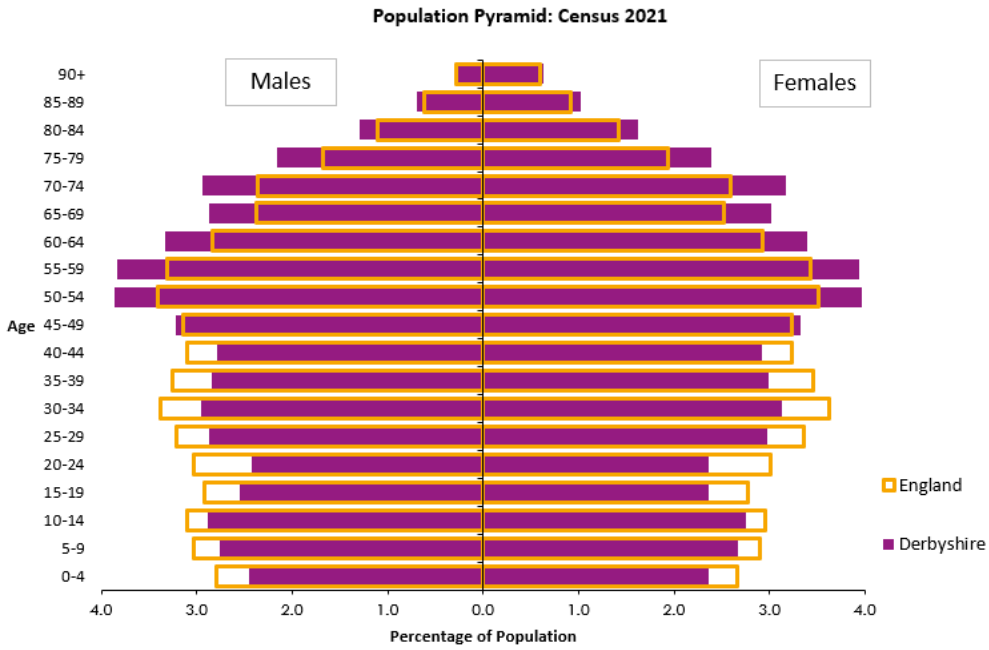
## 2.1 Population Estimates

The latest 10-year census for England and Wales took place in 2021. On Census Day (21 March), the usual resident population across the whole of Derby and Derbyshire was 1.056 million people (261,400 and 794,600 respectively), with a male to female ratio of 49.2%:50.8% (49.5%:50.5% in Derby and 49.1%:50.9% in Derbyshire)[1].

Derby has a relatively younger population compared to the England average, whereas the population of Derbyshire is relatively older (*Figure 2).* In Derby, 13.4% of residents were aged 15-24 years (35,000 people, 51.7% males). In Derbyshire, 9.7% of residents were aged 15-24 years (77,100 people, 51.4% males). South Derbyshire, Erewash and Bolsover have a slightly younger population profile compared to the county overall.

Figure 2 - Percentage of resident population by age and sex, Derby and Derbyshire




## 2.2 Population Projections

The population overall is ageing, but there will be increases in some of the younger age groups in the coming years. The most recent 2018-based population projections[2] estimated that by 2028, the 15-19 year olds population would increase in both Derby and Derbyshire, to just over 64,400 (19,000 and 45,400 respectively). The number of 10-14 year olds in Derbyshire was estimated to increase by 4% to just over 45,400. In Derby, the number of 20-24 year olds by 2028 was estimated at around 20,000 people, a 9% increase. The proportion aged 35-44 years was also set to increase in both Derby and Derbyshire.

Figure 3 - Ten year population projections by five-year age band and sex, Derby

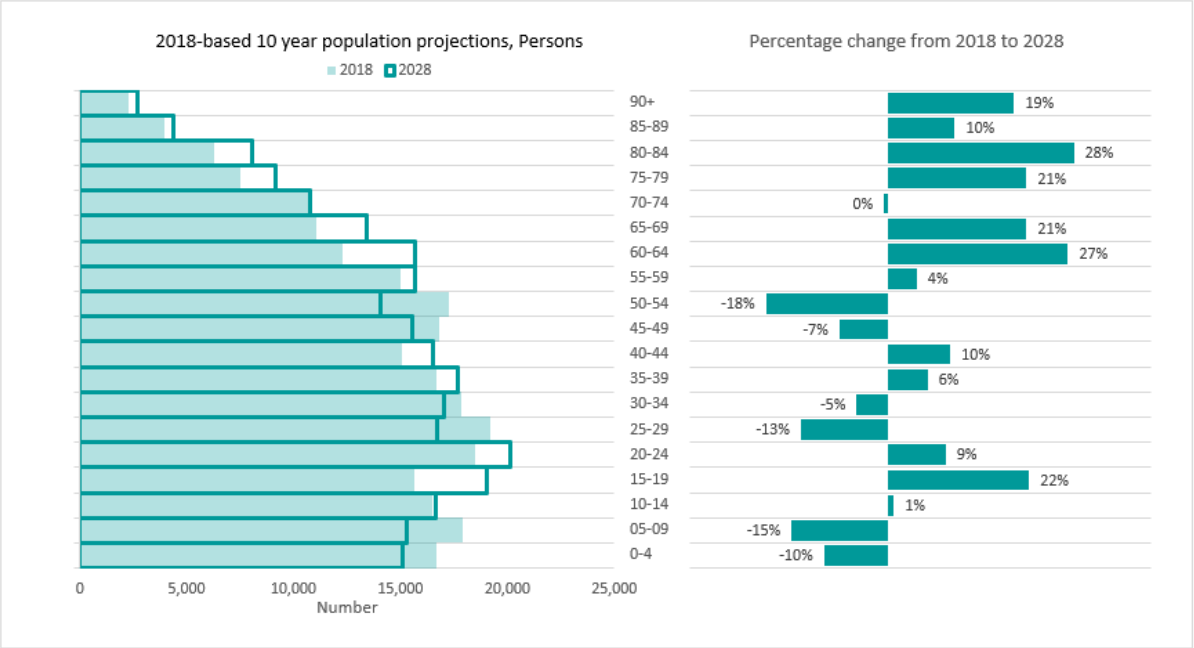
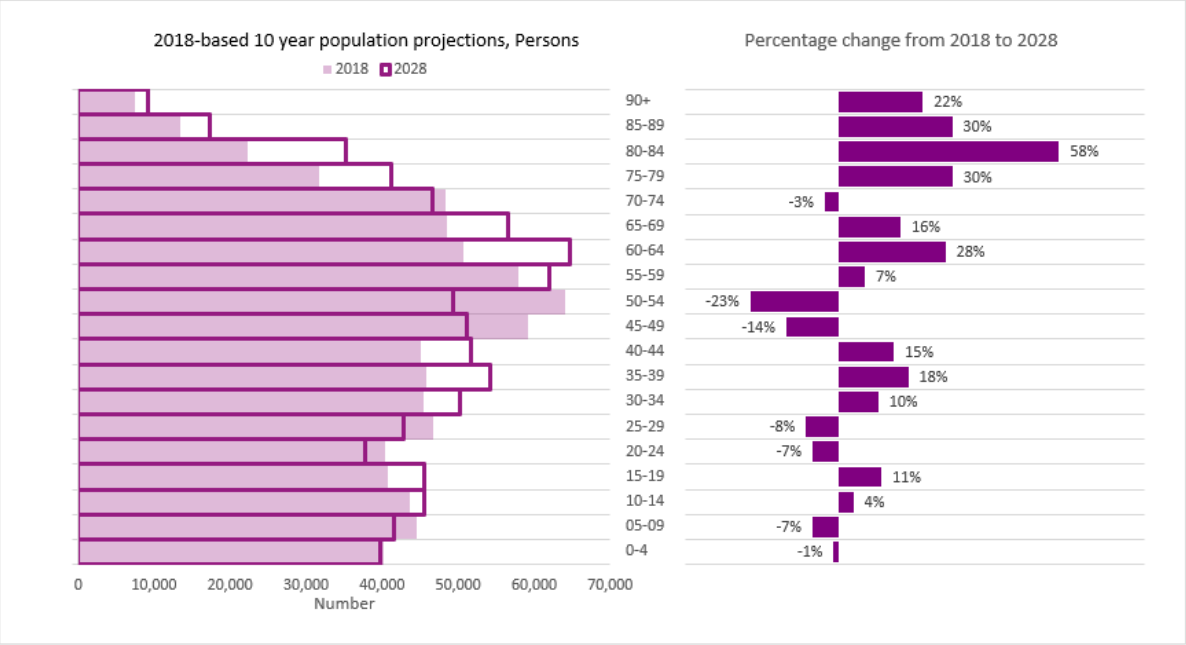



Figure 4 - Ten year population projections by five-year age band and sex, Derbyshire




## 2.3 Ethnic Group

In 2021, 81.0% (45.8 million) of usual residents in England identified their ethnic group within the high-level "White" category, compared to 73.8% in Derby and 96.3% in Derbyshire[3]. The second most common high-level ethnic group for both Derby and Derbyshire was people identifying as “Asian, Asian British or Asian Welsh” at 15.6% (n=40,901) and 1.5% (n=11,670) respectively (*Figure 5)*. In Derby within the 19 ethnic group available response options, 66.2% identified as “White: English, Welsh, Scottish, Northern Irish or British”. The second most common category was people identifying as “Asian, Asian

British or Asian Welsh: Pakistani" (n=21,034, 8.0%) followed by "Asian, Asian British or Asian Welsh: Indian" (n=12,631, 4.8%). In Derbyshire, 93.7% identified as "White: English, Welsh, Scottish, Northern Irish or British". The second most common category was "White: Other White" (n=16,922, 2.1%) followed by "Asian, Asian British or Asian Welsh: Indian" (n=5,621, 0.7%), (*Figure 6)*.

Figure 5 - Usual resident population by high-level ethnic group excluding "White" category

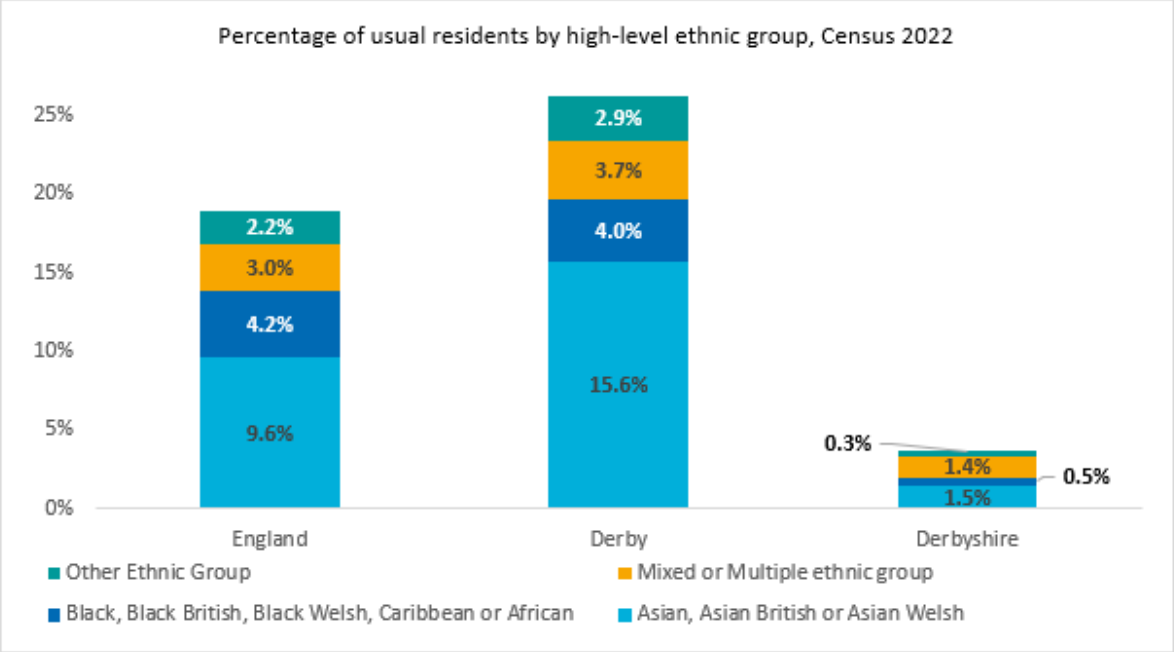
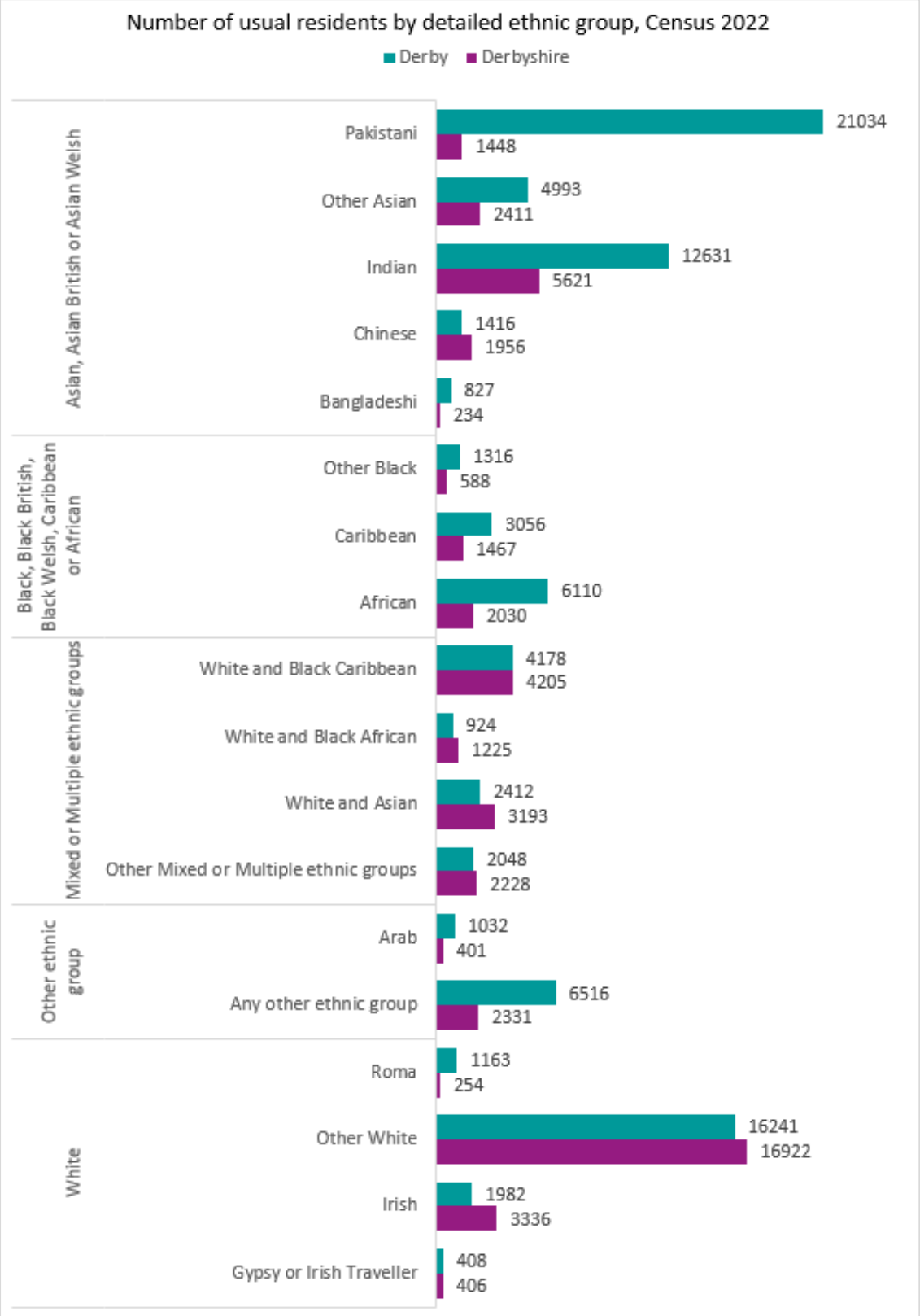


Figure 6 - Usual resident population by high-level ethnic group excluding "White: English. Welsh, Scottish, Northern Irish or British" category



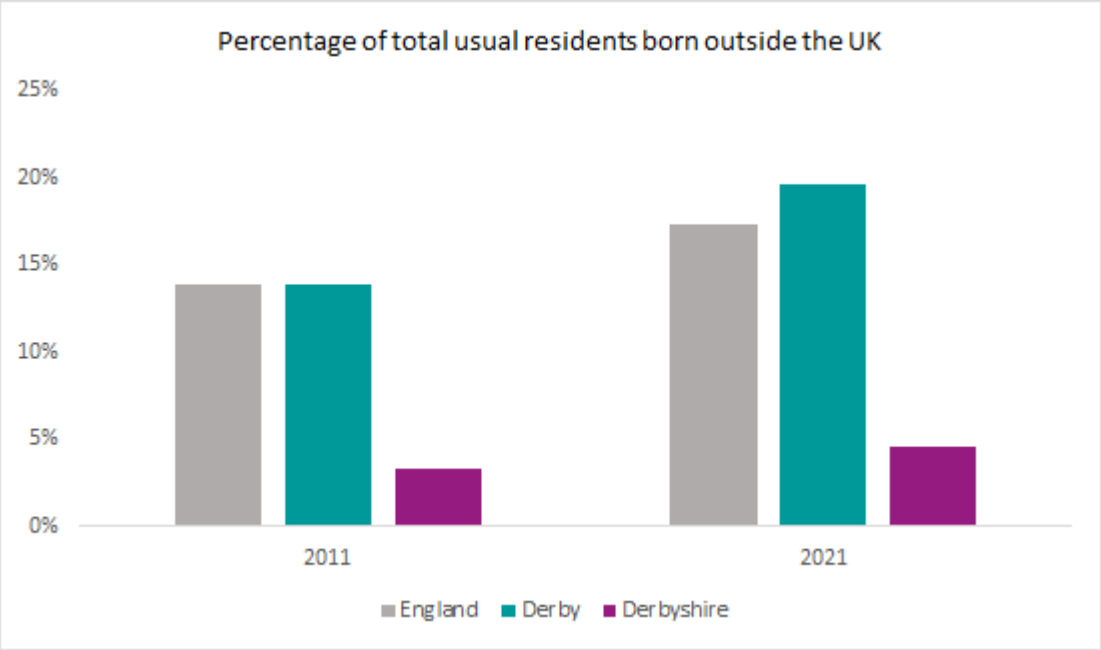
## 2.4 International Migration

Country of birth is often the preferred measure when looking at long-term changes in migration as a person's place of birth does not change. Based on the Census 2021[4], around one in six people (17.4%) in England were born outside the UK (9.8 million usual residents), and of these, 36.2% were born in the European Union (EU). The three most common non-UK countries of birth in 2021 in England were India (1.6% of the population), Poland (1.3%), and Pakistan (1.1%).

In Derbyshire, only 4.6% (n=36,408) of usual residents were non-UK born, around one in twenty-two people, a percentage point increase of 1.3 compared to the Census 2011. Of the non-UK born residents, roughly half were born in the EU (50.7%, n=18,463). Poland was the most common non-UK country of birth (0.7%, n=5,542) followed by India (0.3%, n=2,689).

In comparison, in Derby one in five (19.6%, n=51,194) usual residents were born outside the UK, a percentage point increase of 5.7 compared to 2011. Of the non-UK born residents, 38.4% (n=19,668) were born in the EU. The most common non-UK country of birth was Pakistan (3.1%, n=8,077) followed by India (2.7%, n=7,115).

Figure 7 - Residents born outside the UK, Census 2011 and Census 2022




*Migration in the year prior to census was lower in 2021 than it was in 2011, likely due to the impact of the coronavirus pandemic. The census tells us about the change over a decade – who was living in the UK March 2021, compared with March 2011.

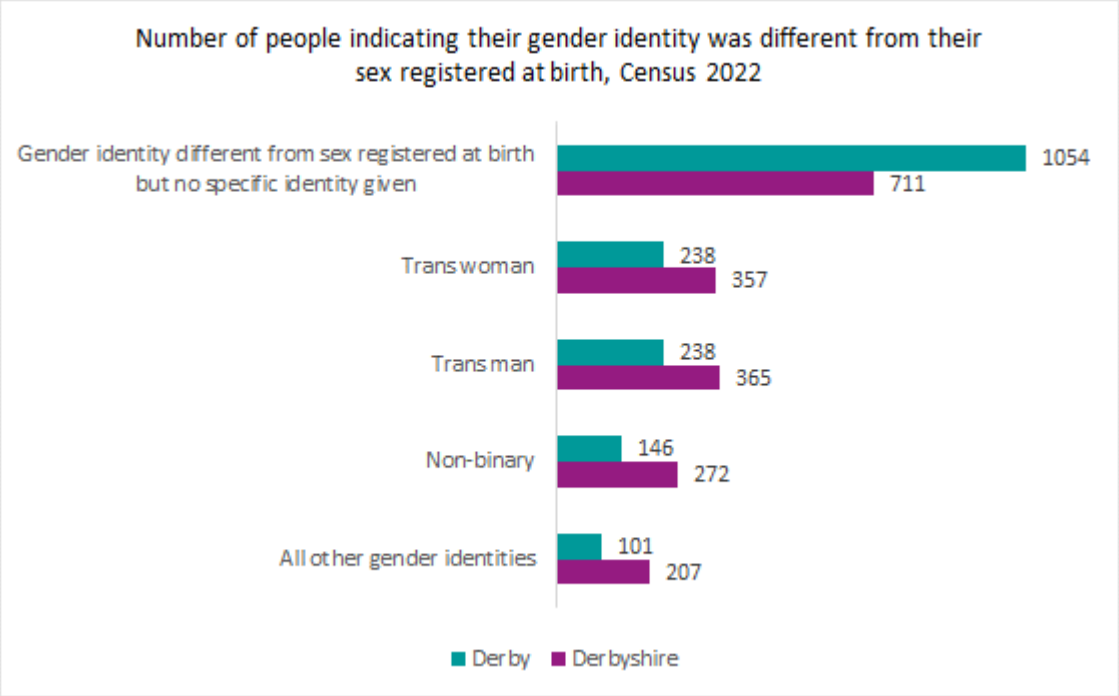
## 2.5 Gender Identity

The Census 2021 was the first to ask a voluntary question on gender identity* to people aged 16 years and over.

In England, 93.5% answered Yes to the question "Is the gender you identify with the same as your sex registered at birth?", compared to 91.7% (n=191,767) in Derby and 94.7% (n=624,585) in Derbyshire[5]. Across England, 6.0% chose not to answer the question, compared to 7.5% (n=15,647) in Derby and 5.1% (n=33,325) in Derbyshire.

Within those that answered No, most people chose not to provide a write-in response with a specific gender identity. Across England, 0.10% identified as either Trans woman or Trans man, compared to 0.11% (n=238) in Derby. In Derbyshire this was lower, with 0.05% (n=357) identifying as Trans woman and 0.06% (n=365) as Trans man (*Figure 8*). Those identifying as Non-binary was 0.06% in England, compared to 0.07% in Derby and 0.04% in Derbyshire. All other gender identities was the least common response, at 0.04% in England, 0.05% in Derby and 0.03% in Derbyshire.

Figure 8 - Gender identity different to sex registered at birth, Derby and Derbyshire




*Gender identity refers to a person's sense of their own gender, whether male, female or another category such as non-binary. This may or may not be the same as their sex registered at birth.

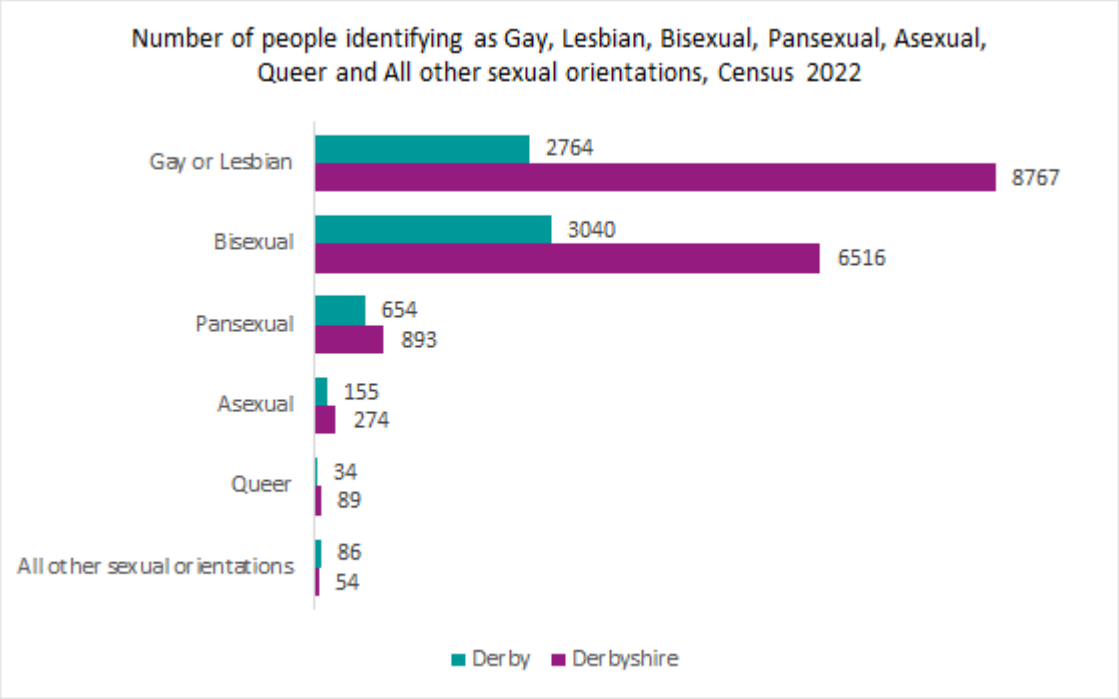
## 2.6 Sexual Orientation

The Census 2021 was the first to ask a voluntary question on sexual orientation* to people aged 16 years and over.

In England, 92.5% answered the question "Which of the following best describes your sexual orientation?". This was slightly lower in Derby at 91.3% (n=18,235 did not answer), and slightly higher in Derbyshire County at 93.6% (n=41,931 did not answer). The majority of those that answered described themselves as Straight or Heterosexual; 89.4% in England, 88.1% (n=184,221) in Derby and 91.1% (n=601,296) in Derbyshire[6].

Across England, 3.17% identified with an LGB+ orientation ("Gay or Lesbian", "Bisexual" or "Other sexual orientation"). Derby was similar at 3.22% (n=6,733) whilst the proportion in Derbyshire was comparatively lower at 2.51% (n=16,593). In Derby, a higher number identified as Bisexual (n=3,040, 1.45%) than Gay or Lesbian (n=2,764, 1.32%), an opposite picture to England (1.29% and 1.54% respectively) and Derbyshire (n=6,516, 0.99% and n=8,767, 1.33% respectively), (*Figure 9*).

Figure 9 - Sexual orientation identified by detailed LGB+, Derby and Derbyshire

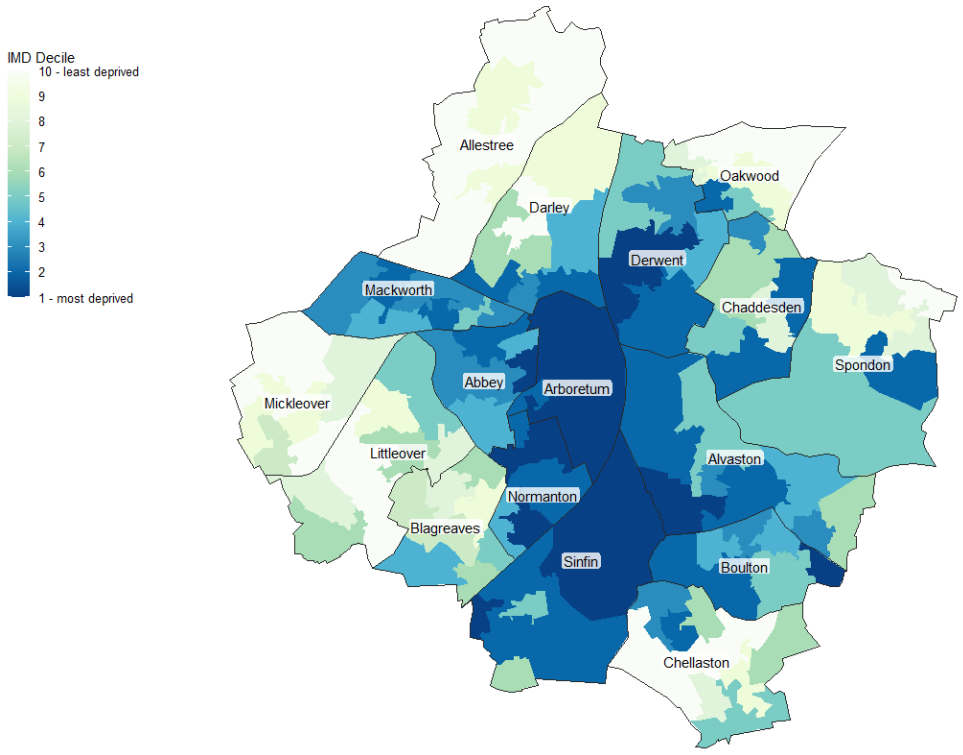



* Sexual orientation is an umbrella term covering sexual identity, attraction, and behaviour. For an individual respondent, these may not be the same. For example, someone in an opposite-sex relationship may also experience same-sex attraction, and vice versa. This means the statistics should be interpreted purely as showing how people responded to the question, rather than being about whom they are attracted to or their actual relationships.

## 2.7 Deprivation

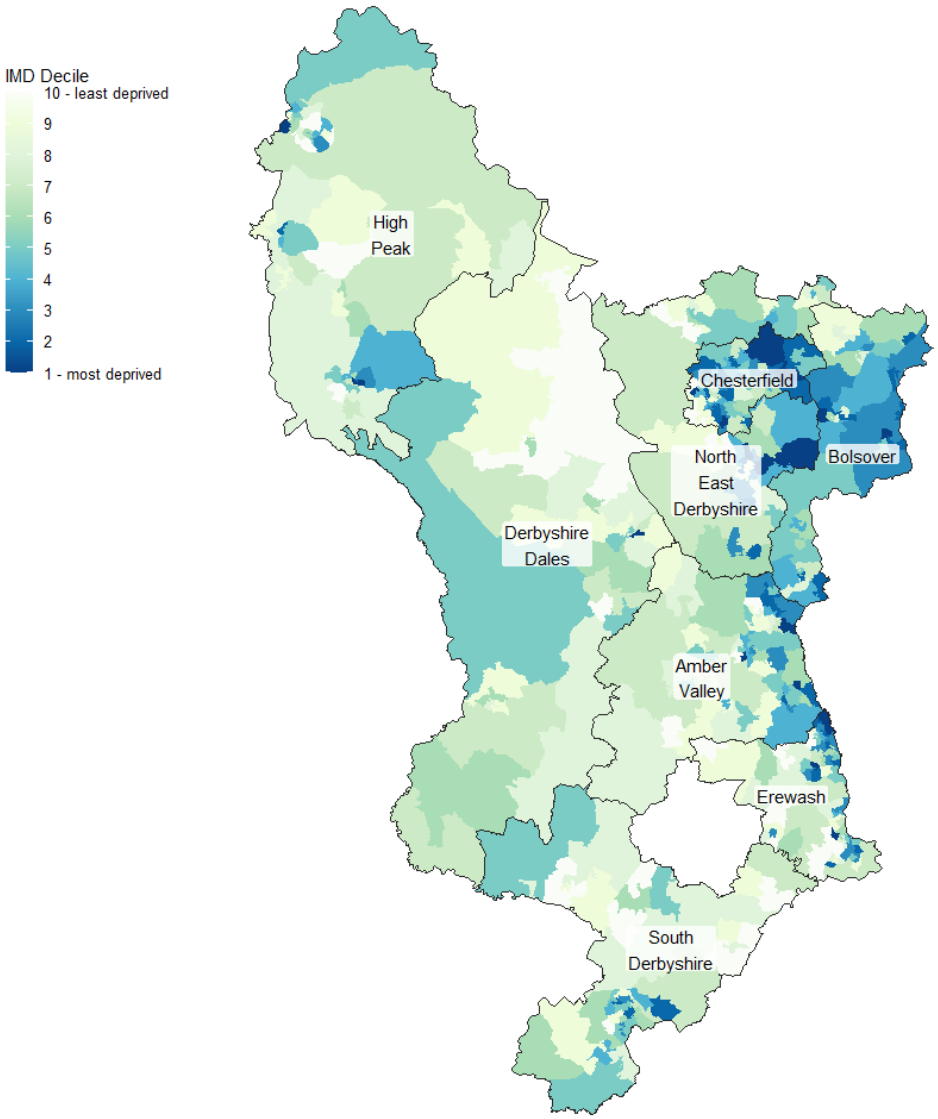
The Index of Multiple Deprivation (IMD) is a measure of relative deprivation between all Lower Super Output Areas (LSOAs) in England[7]. Derby is ranked as the 64/151 most deprived local authority area in England, with 15.9% of LSOAs in the most deprived 10% nationally (*Figure 10*). Pockets of deprivation are mainly concentrated within Arboretum, Sinfin, Normanton, Derwent and Abbey. These wards are characterised by high rates of unemployment and households with a lower-than-average annual income. Conversely, Allestree, Mickleover and Oakwood contain several LSOAs which are amongst the 10% least deprived areas in the country. This translates into significant health inequalities between different wards.

Figure 10 - Lower super output areas (LSOAs) in Derby by Index of Multiple Deprivation (IMD) 2019



Derbyshire is ranked as the 103/151 most deprived local authority in England, with 4.5% of LSOAs in the most deprived 10% nationally (*Figure 11*). These 22 LSOAs are located within all districts and boroughs, primarily concentrated along the eastern side of the county, in and around the larger market towns. These areas generally have significantly worse health outcomes compared to Derbyshire and England averages, particularly in Bolsover and Chesterfield. The rural aspect of the county can also mask pockets of deprivation within sparsely populated areas.

Figure 11 - Lower super output areas (LSOAs) in Derbyshire by Index of Multiple Deprivation (IMD) 2019



# 3. Sexually Transmitted Infections (STIs)

STIs are infections that can be passed from one person to another through sexual contact, including vaginal, anal, oral sex, genital contact, and the use of sex toys. Anyone who is sexually active can contract an STI, however, people who regularly change sexual partners or who do not use a condom are at a greater risk.

Most STIs remain asymptomatic, which increases the risk of onward transmission and if left untreated, STIs can cause complications and serious long-term health problems. Some STIs can also be passed from mother to baby (known as mother to child transmission) during pregnancy, birth, and breastfeeding[1].

STIs can lead to health problems such as pelvic inflammatory disease, ectopic pregnancy, and infertility. STIs can also affect personal wellbeing, mental health, and relationships. It is acknowledged that women burden significant health impact from STI transmission.

The highest rates of STIs are in young people (aged 15-24), people from a black family background and gay, bisexual and men who have sex with men (GBMSM)[2]. The best way to protect against any STI is to consistently use a condom[3].

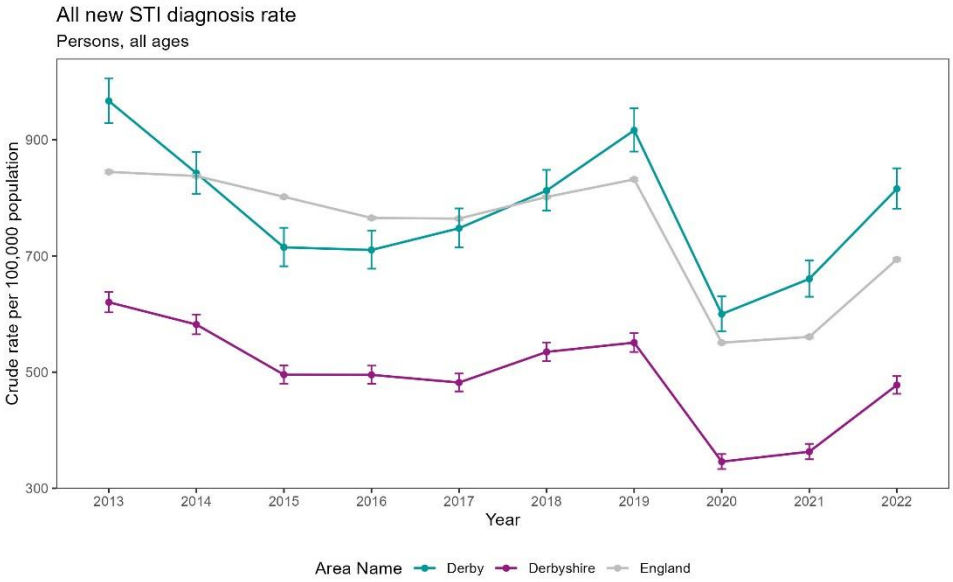
STIs are also considered to be highly stigmatising which may seriously impact the mental wellbeing of affected individuals. All STIs are preventable, which reinforces the importance of public health messaging promoting safe sexual practices.

The data in this section focuses primarily on the trend between 2021 and 2022, although some trends relative to 2019 or earlier are also included to provide a comparison to sexual health service provision and STI diagnoses prior to the COVID-19 pandemic and disruption to service provision in 2020 and 2021. Data for 2021 and 2022 used the new population estimates based on the 2021 Census, while years prior to this used the population estimates which were originally based on the 2011 Census. Revised populations for years prior to 2021 have not yet been published by ONS, therefore it is recommended that comparisons between 2021 and the earlier time periods should be treated with caution[4].

## 3.1 All STIs - New STI Diagnoses

Prior to the start of the COVID-19 pandemic in 2020, the diagnosis rate of all new STIs had been increasing both locally and nationally (*Figure 12*). This is likely due in part to increases in risky sexual behaviours, but also the pattern of increased STI testing observed in the same period. Conversely, these factors are also likely to have contributed to the significant reduction in the rate of new STI diagnoses in 2020.

Figure 12 - Rate of all new STI diagnoses among people accessing sexual health services



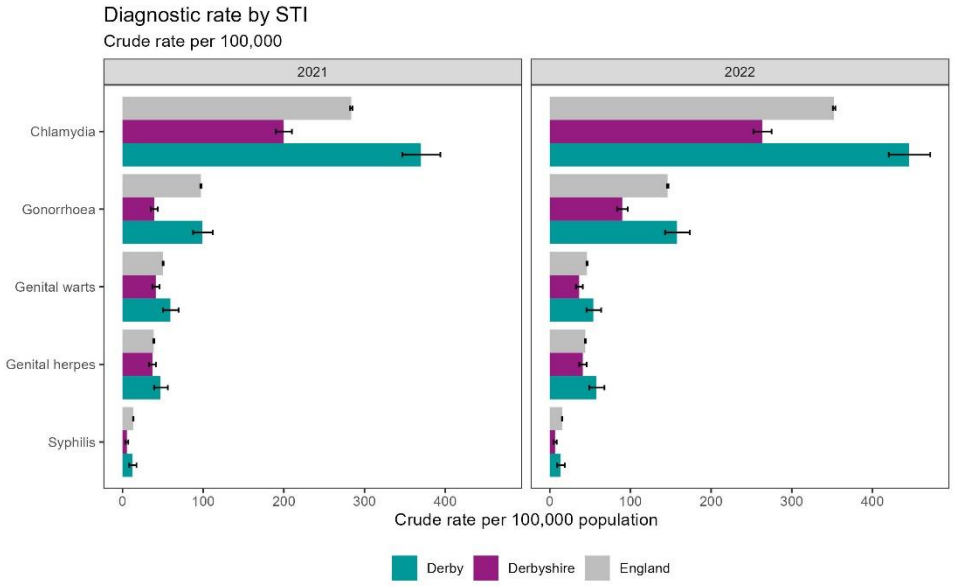

In 2022, there were 2,130 diagnoses of new STIs in Derby and 3,807 in Derbyshire. Despite the rate of new STI diagnoses decreasing in recent years, the figures for 2022 show an increase of 23.5% in Derby and 31.6% in Derbyshire, compared to 2021.

In Derby, the rate of 815.7 new STI diagnoses per 100,000 in 2022 remained significantly higher than the England average of 694.2 and ranked as 1st highest amongst its 16 CIPFA nearest neighbours and 37th highest of the 152 upper tier local authorities (UTLAs) in England. However, it should be noted that the values for Derby between 2020 and 2022 may have been inflated due to potential duplicate reporting between online and physical reporters, thus these figures should be treated with caution.

In comparison, the rate of 477.8 new STI diagnoses per 100,000 in Derbyshire during 2022 remained significantly lower than the national average, ranking as the 5th highest rate compared to its 16 CIPFA nearest neighbours and 103rd highest amongst the 152 UTLAs nationally.

In both 2021 and 2022, chlamydia and gonorrhoea were the most commonly diagnosed STIs (*Figure 13*). The increase in the total number of new STIs between 2021 and 2022 can be partly explained by an increase in diagnoses of chlamydia, gonorrhoea, genital herpes and syphilis, and a large increase in the rate of STI testing.

Figure 13 - Rate of diagnoses by STI in 2021 and 2022

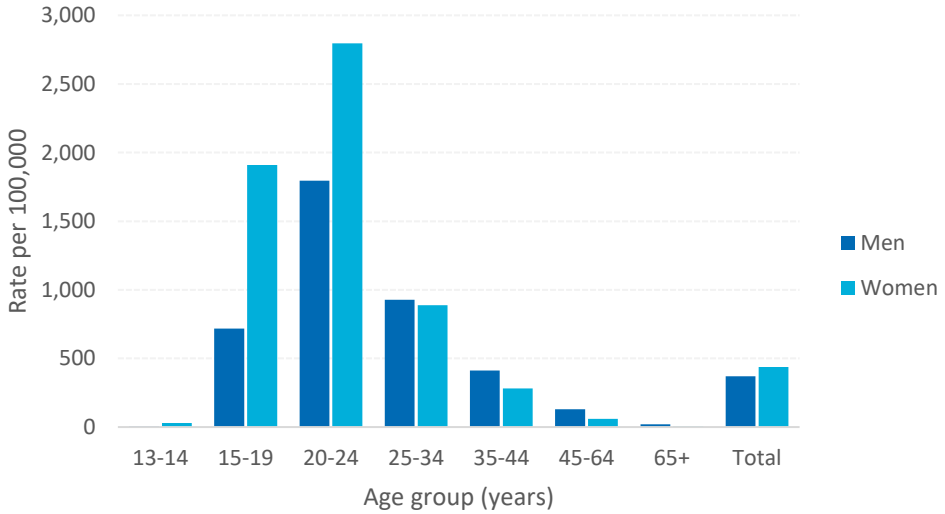



## 3.2 All STIs – Inequalities in Diagnoses

Like many other aspects of sexual and reproductive health, significant variation exists when looking at STI diagnoses between different communities and population groups. Understanding the reasons for this variation is important in order to help reduce health inequalities at a local level[5].

In 2021, the rate of new STI diagnoses in the East Midlands was greater in women than men (438.7 versus 370.3 per 100,000), with the highest rates observed in the 20-24 years and 15-19 years age-groups (2,795.5 and 1,909.0 per 100,000 population, respectively) (*Figure 14*).

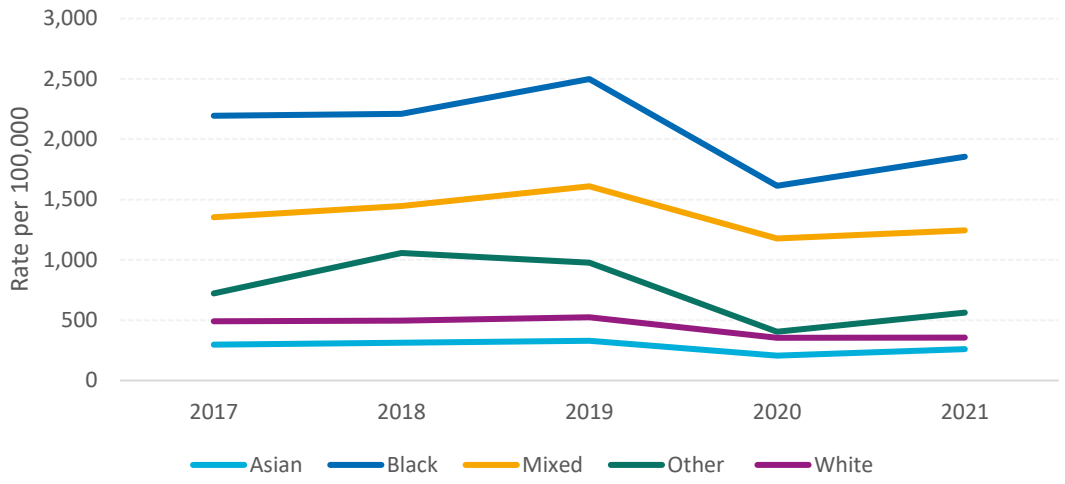
Figure 14 - Rate of new STI diagnoses in East Midlands Public Health England Centre by age-group and sex, 2021




Data sourced from UKHSA Sexually transmitted infections (STIs) annual data tables for 2022

Black or Black ethnic groups have a significantly higher rate of new STI diagnoses than any other ethnic groups in the East Midlands (*Figure 15*).

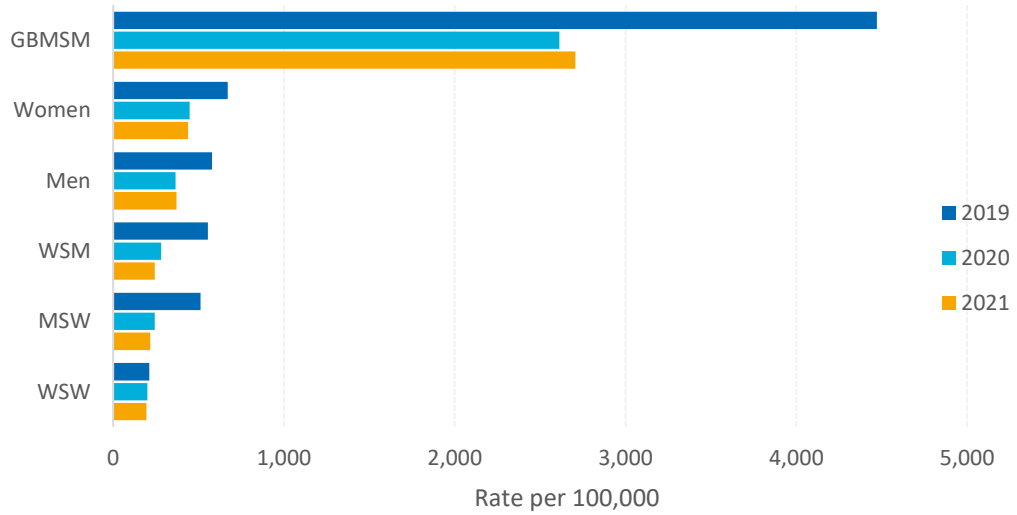
Figure 15 - Rate of new STI diagnoses in East Midlands Public Health England Centre by ethnic group




Data sourced from UKHSA Sexually transmitted infections (STIs) annual data tables for 2022

Despite a reduction in the rate of new STI diagnoses in gay, bisexual and MSM in the East Midlands from 4,472.2 to 2,707.0 per 100,000 between 2019-2021, this rate remains significantly higher than that seen in any other population group and is more than 7 times greater than the rate seen in the total male population (370.3 per 100,000) (*Figure 16*).

Figure 16 - Rate of new STI diagnoses in East Midlands Public Health England Centre by population group between 2019 - 2021




Data sourced from UKHSA Sexually transmitted infections (STIs) annual data tables for 2022

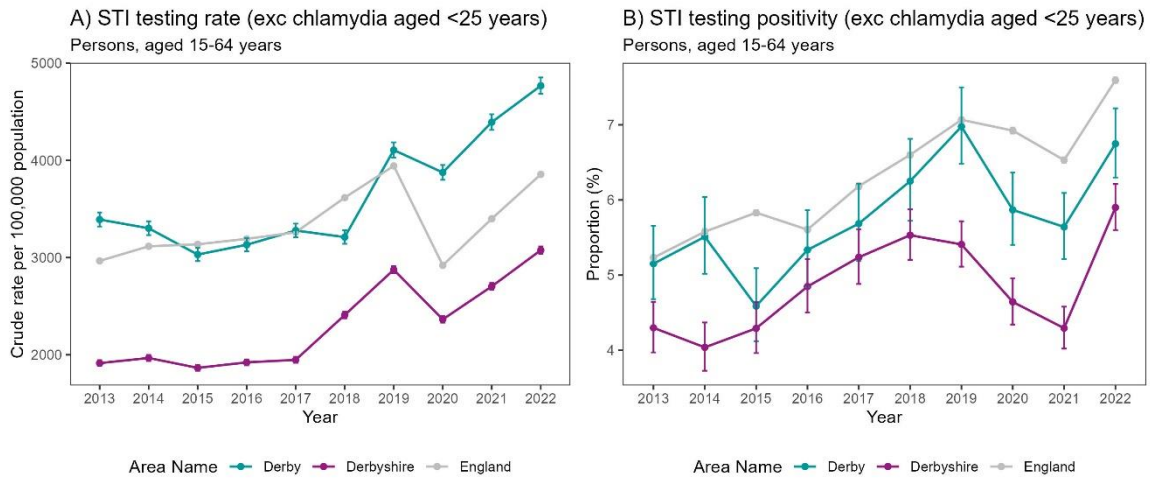
## 3.3 All STIs – Testing

STI testing, diagnoses and positivity are all closely linked. Since 2015, the STI testing rate had been rising year on year until 2020 when there was significant reduction in testing in all areas, although this decrease was smaller in Derby than seen in Derbyshire and England (*Figure 17A*). This decrease in testing during the pandemic may mean many positive cases have been missed, particularly in those people with asymptomatic infections. However, the most recent data shows that in 2022, the testing rate had recovered to pre-pandemic levels in England, while it was significantly higher than the levels seen pre-pandemic in both Derby and Derbyshire.

Historically, significantly fewer STI tests have been conducted per 100,000 population in Derbyshire, compared to Derby and England. The STI testing rate in Derby had been increasing and getting better in recent years and in 2022, the testing rate of 4,767.2 per 100,000 was significantly higher than the national figure (3,856.1 per 100,000), 1st highest amongst CIPFA nearest neighbours and 35th highest of the 152 UTLAs in England.

In Derbyshire, despite a significant increase pre and post 2020, the rate of 3,075.9 per 100,000 for 2022 remained significantly lower than the national figure, although this ranked as 4th highest compared to CIPFA nearest neighbours and 77th highest of the UTLAs in England.

Figure 17A) Testing rate for syphilis, HIV, gonorrhoea and chlamydia (excluding chlamydia in population aged under 25-years) in population aged 15-64 years accessing sexual health services and B) STI testing positivity (excluding chlamydia in population aged under 25-years) in population aged 15 to 64 years




Between 2021 and 2022, test positivity increased from 5.6% to 6.7% in Derby, and from 4.3% to 5.9% in Derbyshire (*Figure 17B*). Test positivity in both Derby and Derbyshire has historically been significantly lower than the England average, which may be related to either a lower prevalence of STIs in the population, or as a result of testing being carried out in people who are less likely to have STIs.

It should be noted that the testing rate and test positivity values for Derby between 2020 and 2022 may have been inflated due to potential duplicate reporting between online and physical reporters, thus these figures should be treated with caution.

## 3.4 Chlamydia Detection

Chlamydia is a bacterial STI which is most often asymptomatic, but if left untreated can result in significant reproductive health complications for women such as pelvic inflammatory disease, ectopic pregnancy, and tubal factor infertility. Complications in men are much rarer.

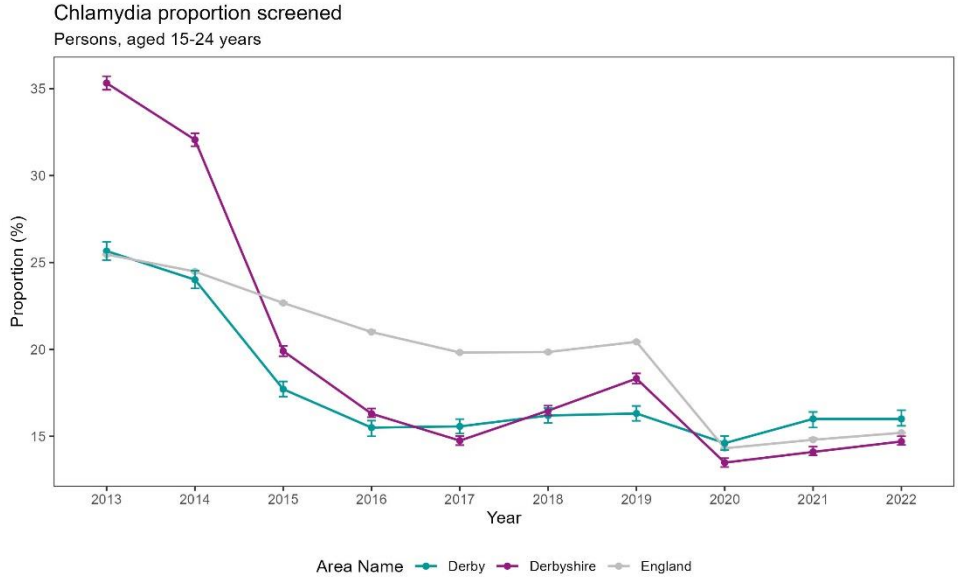
Chlamydia is the most common STI in England with highest prevalence in young sexually active women aged 15-24. Therefore, the National Chlamydia Screening Programme (NCSP) provides opportunistic screening to all sexually active females aged between 15-24 years, either annually or upon change of partner[6]. In June 2021, the programme narrowed its focus from all young people to young women and people with a womb or ovaries, due to this group being most at risk of harm from untreated chlamydia infection. Thus, the new guidance recommends proactive testing in settings where women may visit, for example general practice, abortion and maternity services. Integrated Sexual Health Services (ISHS) are advised to continue with an offer of testing for both men and women or people with a womb or ovaries. Males are still able to get a test, but only if an indication has been identified - such as being a partner of someone with chlamydia or having symptoms.

The aim of the NCSP is to reduce harm caused by untreated infections, reduce reinfection and onward transmission and to raise awareness of good sexual health. The effectiveness of the programme is monitored through an indicator in the Public Health Outcomes Framework and UKHSA recommends that local authorities should be working towards the revised female-only minimum detection rate of 3,250 per 100,000 women aged 15-24 years (a change from the previous detection target of 2,300 cases per 100,000 of the population aged under 25 years). Since chlamydia is most often asymptomatic, the rate of chlamydia detection is influenced by differences in prevalence, screening coverage and whether the most at-risk populations are being reached (i.e. the proportion testing positive). Increases in the number of infections detected and treated is an indication of improved chlamydia control.

While there has been no significant change in chlamydia screening coverage in recent years, there has been a 23.6% decrease in the number of chlamydia tests carried out among young adults in England since 2018[7]. In 2022, 5,526 (16.0%) young people aged 15-24 years were screened for chlamydia in Derby, which was significantly higher than the national average of 15.2% (*Figure 18*). There has been no significant change in this proportion in recent years in Derby, although there was a small decrease observed during 2019, most likely due to reduced access to community screening services during the COVID-19 pandemic.

The proportion of young people aged 15-24 years screened for chlamydia in Derbyshire had been decreasing, although had shown improvement prior to the COVID-19 pandemic, when there was a significant drop in coverage. In 2022, 11,500 (14.7%) young people in Derbyshire were screened for chlamydia, which was significantly lower than the England average.

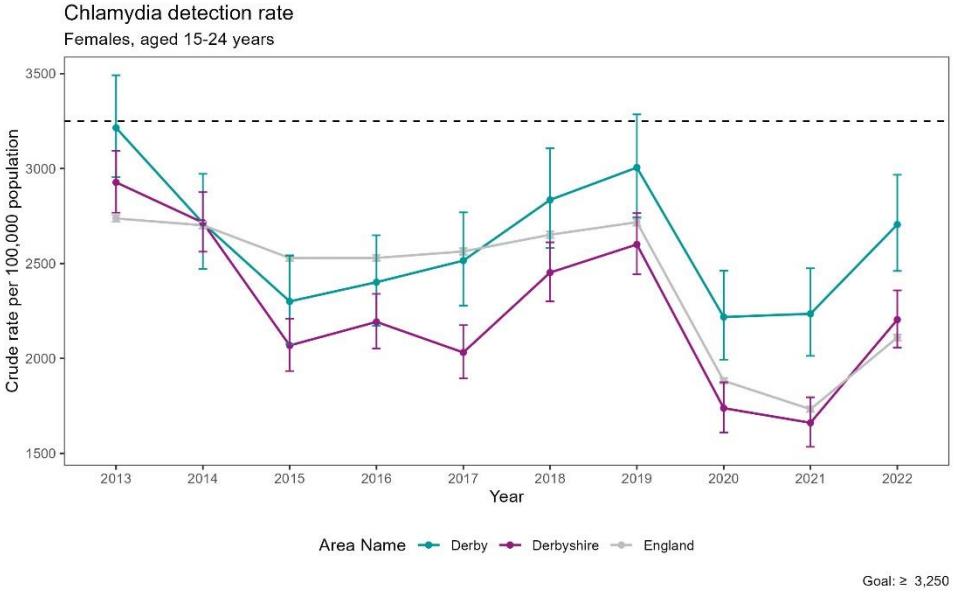
Figure 18 - Proportion of population aged 15 to 24 years screened for chlamydia in sexual health services and community-based settings




In 2022, the chlamydia detection rate was significantly below the NCSP target of at least 3,250 per 100,000 female population aged 15-24 years, in all areas (*Figure 19*). Although, it should be noted that all areas reported a large increase in detection between 2021 and 2022. During 2022, only 13 (8.6%) local authority areas in England achieved the national target, of which Nottingham (3,695.2 per 100,000) was the only area in the East Midlands region to achieve the target.

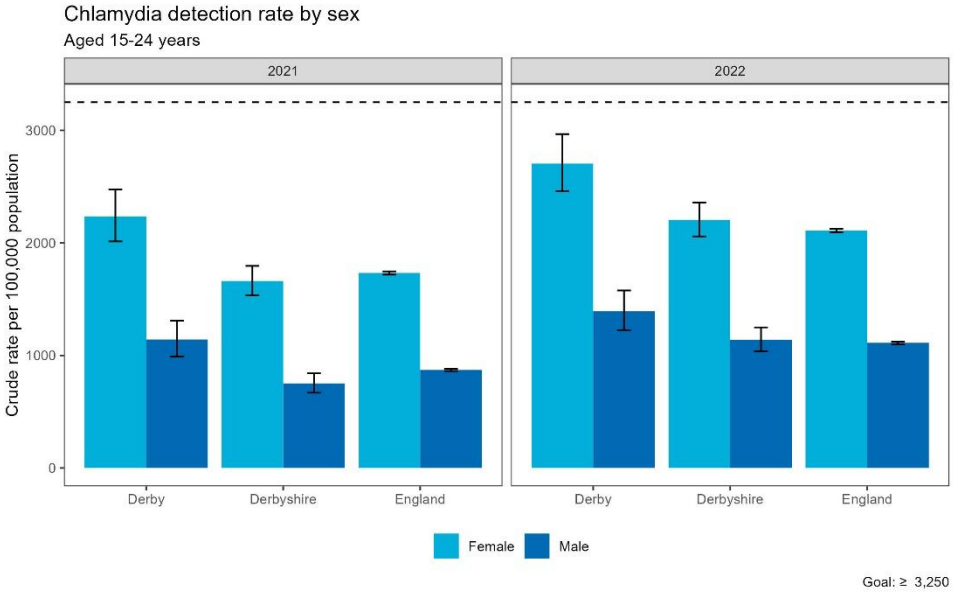
In Derby, the detection rate of 2,705 per 100,000 was significantly higher than that reported in Derbyshire (2,204 per 100,000) and England (2,110 per 100,000). The high chlamydia detection rate in Derby suggests either that there is a particularly well targeted screening programme, or that there are high levels of chlamydia in the area.

Figure 19 - Rate of chlamydia diagnoses in females aged 15-24 years attending sexual health services (SHSs) and community-based settings




Detection rates are significantly higher in females compared to males, which generally reflects the focus of the NCSP to offer screening and testing to females (*Figure 20*).

Figure 20 - Rate of chlamydia diagnoses in population aged 15-24 years attending sexual health services (SHSs) and community-based settings by sex, 2021-2022

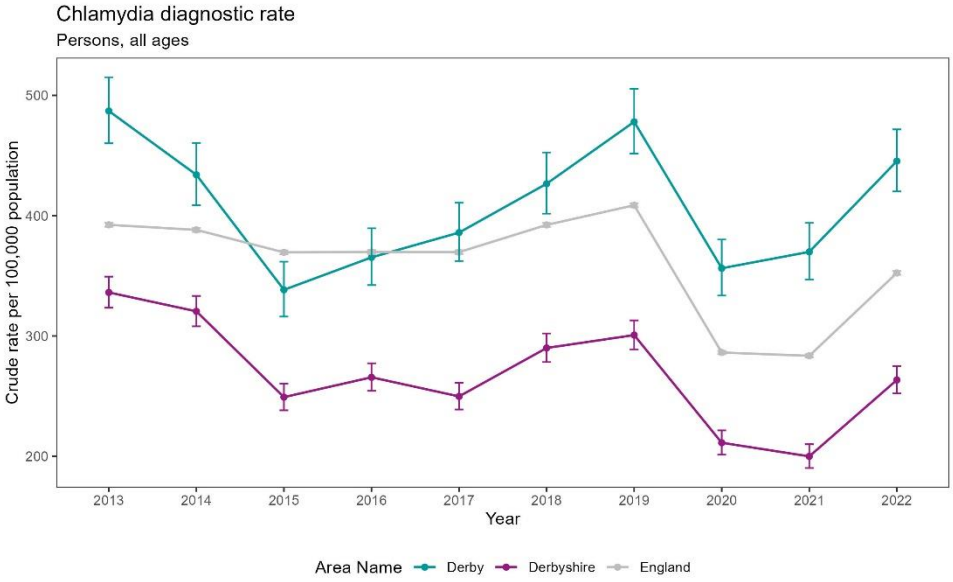



## 3.5 Chlamydia Diagnostic Rate

Prior to the start of the COVID-19 pandemic in 2020, when there was a sharp decline in diagnoses (likely largely a result of reduced testing), the chlamydia diagnostic rate had been gradually increasing in all areas since 2015 (*Figure 21*). This trend had been relatively steady in Derbyshire, and in 2022 despite an increase in rates, remained significantly lower than the national average (352.4 per 100,000). The rate of increase in Derby had been greater

and in 2022 diagnosis rates remained significantly higher than the figure for England. Compared to 2021, the number of chlamydia diagnoses increased by 20.4% and 31.8% in Derby and Derbyshire, respectively, compared to an increase of 24.3% nationally. In 2022, Derby (445.4 per 100,000; n=1,163) had the 1st highest rate of diagnoses amongst its CIPFA nearest neighbours, while Derbyshire (263.4 per 100,000; n=2,099) was 5th highest. Chlamydia infection remains asymptomatic in at least 70% of women and 50% of men, therefore it is possible that the low incidence reported in Derbyshire may actually be a result of low rates of screening and detection in the NCSP rather than a truly low rate within the population[8].

Figure 21 - Rate of chlamydia diagnoses amongst population accessing sexual health services



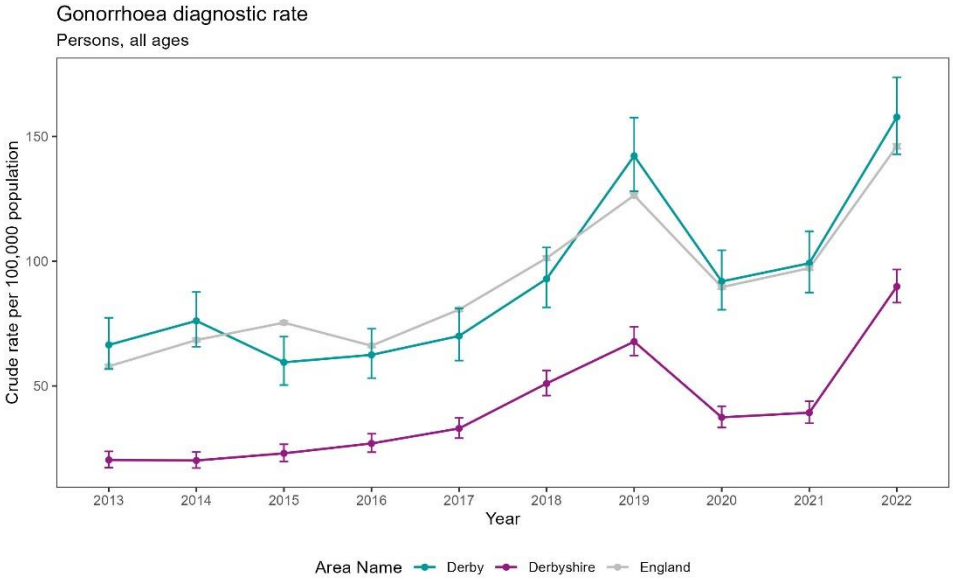

## 3.6 Gonorrhoea Diagnostic Rate

Gonorrhoea, which is caused by the bacterium Neisseria gonorrhoeae, is the second most common bacterial STI in England. Many infected people remain asymptomatic and capable of transmission. However, without timely treatment, gonorrhoea can lead to serious sexual and reproductive health problems such as pelvic inflammatory disease, ectopic pregnancy and infertility[9]. Gonorrhoea is passed on through unprotected sex and the risk of transmission increases with the number of sexual partners.

Nationally, there has been a substantial increase the numbers of gonorrhoea diagnoses in recent years, with the number of gonorrhoea diagnoses in 2022 the largest annual number reported since records began in 1918[10]. The greatest increase in diagnoses has been observed in gay, bisexual, and other MSM (26% increase, n=33,853), however, diagnoses have also increased by 26% in heterosexual women (n=17,826) and 17% in heterosexual men (n=15,253). This increase in cases is estimated to have contributed towards a 5% increase in the total number of STIs diagnosed and causes additional concern due to the increasing antimicrobial resistance of gonorrhoea.

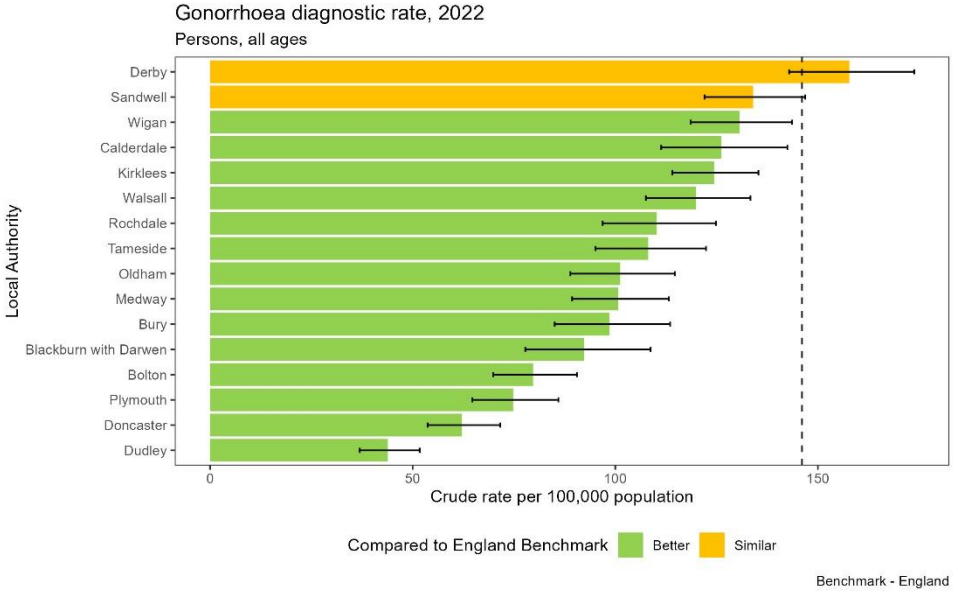
This pattern of increasing gonorrhoea cases seen nationally in recent years has also been replicated in Derbyshire, while the increase in Derby has been even greater than the national trend (*Figure 22*). However, it should be noted that the values for Derby between 2020 and 2022 may have been inflated due to potential duplicate reporting between online and physical reporters, thus these figures should be treated with caution. High prevalence of gonorrhoea is suggested to indicate high levels of risky sexual behaviour within a population, thus inferring increasing unsafe sex practices amongst the local population in Derby and Derbyshire.

Figure 22 - Diagnostic rate of gonorrhoea in people accessing sexual health services



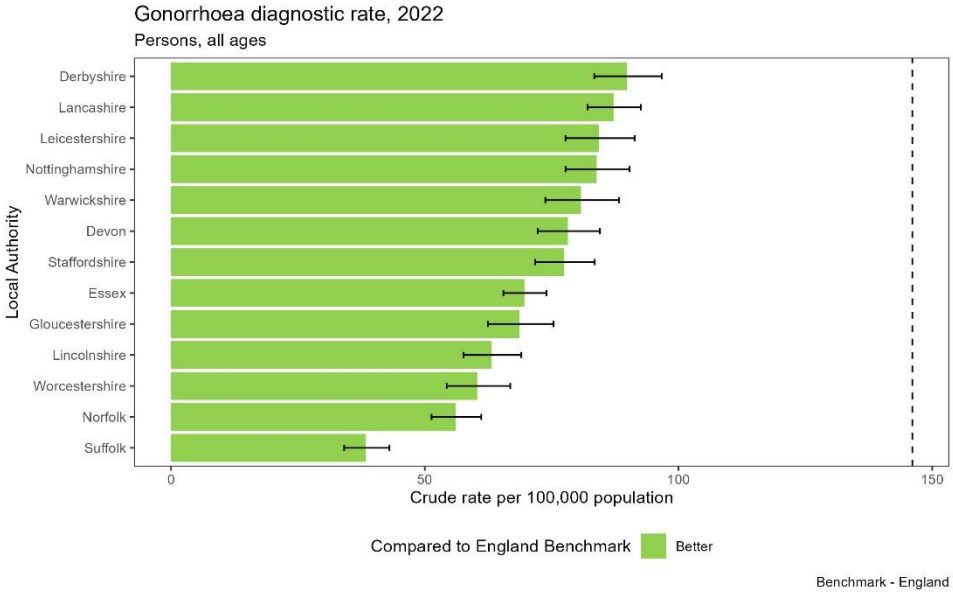

In Derby, there was a 59.1% increase in the number of gonorrhoea diagnoses between 2021 and 2022 (from 259 to 412 diagnoses). This rate of increase in Derby was greater than that seen nationally (50.3%; from 54,961 to 82,592 diagnoses). The rate of 157.8 per 100,000 in Derby during 2022 was similar to the average for England (146.1 per 100,000) and 1st highest amongst its CIPFA nearest neighbours (*Figure 23*).

Figure 23 - Diagnostic rate of gonorrhoea in people accessing sexual health services in Derby and CIPFA nearest neighbour local authorities, in 2022




In Derbyshire, there was a 128.8% increase in the number of gonorrhoea diagnoses in 2022, compared to 2021 (from 313 to 716 diagnoses). Despite this, the rate of 89.9 per 100,000 remained significantly lower than the England average (146.1 per 100,000), although it ranked as 1st highest when compared against its CIPFA nearest neighbours (*Figure 24*). In Derbyshire, South Derbyshire (104.6 per 100,000; n=113), Chesterfield (103.2 per 100,000; n=107) and Amber Valley (99.6 per 100,000; n=126) had the highest rate of gonorrhoea diagnoses in the county.

Figure 24 - Diagnostic rate of gonorrhoea in people accessing sexual health services in Derbyshire and CIPFA nearest neighbour local authorities, in 2022



## 3.7 Genital Warts Diagnostic Rate

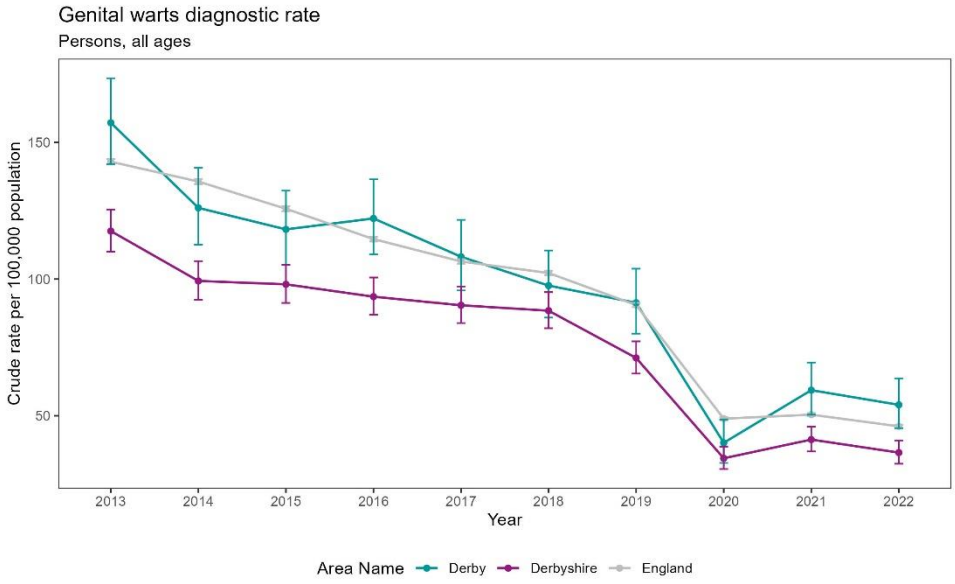
Genital warts, which are caused by infection with specific subtypes of human papillomavirus (HPV), are the most common viral STI in the UK.

In Natsal-3, 3.8% of sexually experienced men and 4.6% of sexually experienced women aged 16–44 years reported ever having a diagnosis, with diagnoses more frequent (around 11%) amongst men and women reporting same-sex behaviour[11]. Recurrent infections are common with many patients returning for treatment, thus representing a significant burden both to the patient and healthcare service. In 2012, the HPV vaccine was changed to also offer protection against the viral subtypes responsible for 90% of genital warts cases, and since 2013, a significant reduction in diagnoses of genital warts has been observed.

This same trend has also been replicated locally, although while the diagnostic rate in Derby has remained similar to the national figure, Derbyshire has consistently had a significantly lower incidence than England.

During 2022, there were 141 (54.0 per 100,000) diagnoses of genital warts in Derby and 291 (36.5 per 100,000) in Derbyshire among people accessing sexual health services, compared to a rate of 46.1 per 100,000 (n=26,079) in England (*Figure 25*).

Figure 25 - Diagnostic rate of genital warts in people accessing sexual health services

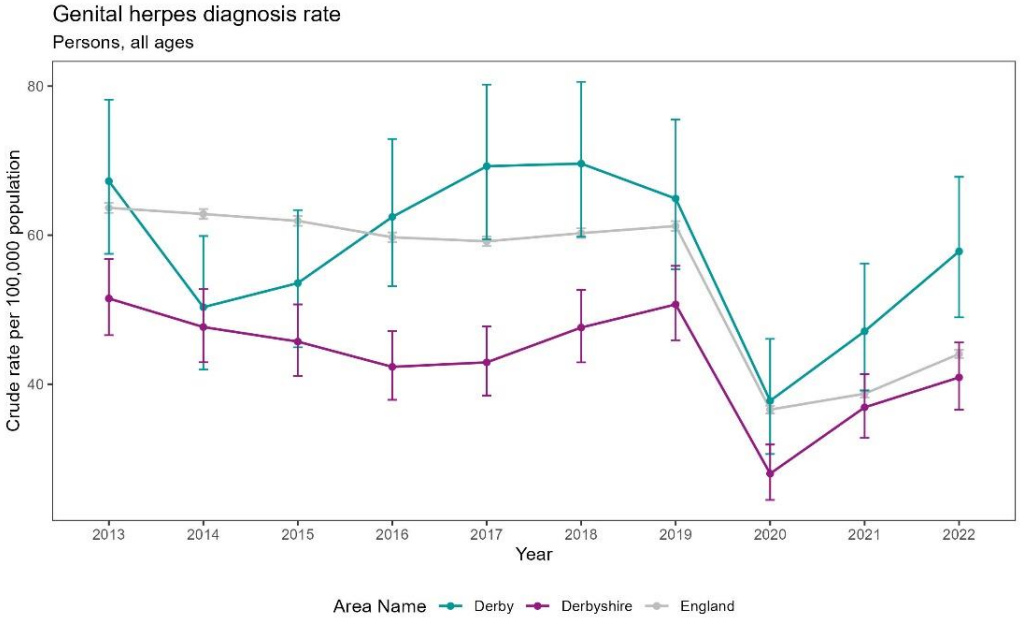



## 3.8 Genital Herpes Diagnostic Rate

Genital herpes is a common STI caused by chronic infection with the herpes simplex virus (HSV). Similar to other STIs, many infected patients will remain asymptomatic following infection, making it challenging to break the chain of forward transmission[12]. Typical clinical symptoms include oral, genital and ocular ulcers, with many patients experiencing recurrent symptoms (as frequently as 6 times per year)[13]. Infection with HSV is also linked to a 2-3-fold increase in the risk of HIV acquisition[14].

Both nationally and in Derbyshire, the rate of genital herpes diagnoses has fluctuated, however there has been no significant change in this rate in Derby (*Figure 26*). Between 2021 and 2022, diagnoses of first episode genital herpes increased by 22.8% in Derby, 10.9% in Derbyshire and 13.8% in England, however, diagnoses remained lower than 2019. In Derby, the rate of 57.8 per 100,000 diagnoses during 2022 was significantly higher than the England average of 44.1 per 100,000, while the rate of 40.9 per 100,000 in Derbyshire was similar to the national figure. All areas reported a large decrease in diagnoses during 2020, which is likely to reflect a combination of reduced access to STI testing as a result of disruption to the delivery of sexual health services during the COVID-19 pandemic and changes to behaviour which may have reduced opportunities for STI transmission.

Figure 26 - Rate of diagnoses of first episode genital herpes in people accessing sexual health services




## 3.9 Syphilis Diagnostic Rate

Syphilis is a bacterial infection caused by the Treponema pallidum subspecies pallidum. Syphilis is highly infectious and is mainly transmitted via direct contact with an infectious lesion during sexual intercourse. The symptoms of syphilis are usually mild; however, untreated infections can lead to serious cardiovascular, ocular and neurological complications including acute hepatitis, meningitis and permanent hearing or vision loss[15]. Syphilis infection is also associated with an increased risk of HIV transmission in MSM and other high-risk populations[16].

PHE published a syphilis action plan in 2019[17] focussing on four prevention pillars:

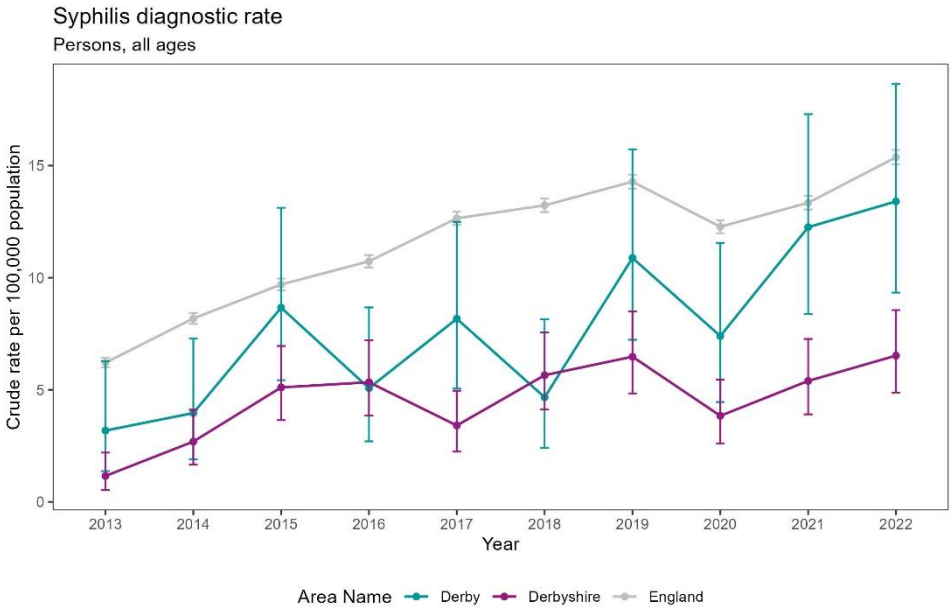
1. Increased testing frequency of high-risk MSM and re-testing of cases after treatment
2. Deliver partner notification to BASHH standards
3. Maintain antenatal screening coverage and vigilance for syphilis throughout antenatal case
4. Sustain targeted health promotion

The action plan outlines individual recommendations under each of these four prevention pillars, with a strong focus on strengthening existing protocols and pathways and ensuring adherence to standards set by professional bodies such as BASHH and BHIVA.

In England, there has been a significant increase in the rate of syphilis diagnoses over the past decade, with the number of diagnoses in 2022 (n= 8,692) the largest annual number reported since 1948 [18, 19]. Syphilis disproportionately affects MSM (over 75% of all diagnoses) and this recent increase in diagnoses observed nationally is largely suggested to have been driven by increased risky sexual behaviours amongst this group (e.g. multiple sexual partners, condomless sex and chemsex)[20]. Therefore, rates of syphilis diagnoses have been suggested to indicate levels of unsafe sexual practices in a population.

In Derby, there has been a significant increase in the rate of syphilis diagnoses in recent years, while Derbyshire has seen no significant change (*Figure 27*). However, it is worth noting that these rates are based on very small numbers which results in large fluctuations between years. The most recent data for 2022 shows that, in line with the national trend, diagnoses of syphilis matched or exceeded the high levels reported in 2019 in both Derby and Derbyshire. In Derby, the rate of 13.4 per 100,000 (n=35) in 2022 was similar to the national average of 15.4 per 100,000, while the rate of 6.5 per 100,000 (n=52) in Derbyshire remained significantly below the national average.

Figure 27 - Rate of syphilis diagnoses among people accessing sexual health services




## 3.10 Mycoplasma Genitalium (MG)

Mycoplasma Genitalium, also known as MG, Mgen or M.genitalium is a relatively new sexually transmitted bacterium. It infects the urinary and genital tracts of both men and women. Those most at risk of MG are people who engage in unprotected sex including oral, anal, and vaginal sex; people who have multiple sexual partners, smokers, and people who have already had a previous STI[21].

Most people with MG are asymptomatic and the infection usually clears up naturally. If left untreated MG can cause several health issues such as Pelvic Inflammatory Disease (PID) in women and Non-Specific Urethritis (NSU) in men which is an inflammation of the urethra[22].

For men, symptoms of NSU often include pain in the testicles and in particular a burning sensation whilst urinating, general irritation, soreness at the tip of the penis and a white or cloudy discharge. Individuals may also experience a symptom known as proctitis (a condition that causes inflammation of the lining of the rectum).

NSU can be caused by masturbation, or irritation from soap or other products which may come into contact with the urethra; however it is mainly caused through sexual contact[23].

For women, symptoms of PID may include pain around the pelvic region and abdomen, pain or discomfort during sex and pain between periods and after urinating. Women can become very ill with PID, suffering from a high temperature and severe pain in the lower abdomen[24].

If an individual experiences a symptom of MG, then it is possible to get tested through a sexual health clinic or at home. Diagnosis involves providing a urine sample or taking a specimen from the vagina or the tip of a penis via a swab. If an individual tests positive for MG, it is important to inform past and current partners as soon as possible in order for them to get diagnosed and prevent further spread of the virus.

Awareness of MG is still low, despite the fact that the infection is more prevalent than gonorrhoea. Furthermore, the problem with MG is that it is highly resistant to antibiotics, with the British Association of Sexual Health and HIV (BASHH) advising that preventative measures and early treatment is the most effective way to prevent MG[25].

Antibiotics are the most effective treatment for NSU or PID if diagnosed early and they can be treated over a 14-day period[26]. Those testing positive for MG should not have sexual relations until after at least 7 days of treatment and should ensure that sexual partner/s are informed so that they can be tested and treated immediately to avoid further spreading the virus.

The best protection against MG is by using protective barriers during sex such as condoms and dental dams, as this will minimise the risk of catching the disease although it is not a guarantee[27]. It is important to note that protective barriers during sexual contact should be used regardless of the participating genders.

## 3.11 STIs Recommendations

**STIs Recommendations**

- To ensure a strong multiple offer of accessibility to STI testing and treatment in order to meet the local diversity of accessibility needs – this may include remote offer, face2 face clinics, outreach across different settings in the Derby and Derbyshire system
- To ensure pathways to sexual health services are promoted and are known about across the system.
- To ensure communication across the sexual health system is regularly maintained with the most up to date information about service accessibility and pathways for service staff and patients

Prevention is a key recommendation and including targeted support and awareness across populations most at risk of STI diagnoses and transmission. Actions to promote to groups include:

- Regular and correct use of condoms
- Access to Sexual Health Services and STI screening
- Effective contact tracing / partner notification especially amongst the highest risk groups
- Raising awareness about risky behaviour and encouraging safe sex
- Improved sexual health services and access
- Improved health promotion and targeted interventions to the most at risk groups
- Individuals who identify as gay, bisexual or men who have sex with men (GBMSM) are at higher risk and therefore should regularly test for MG and other STIs. Guidance suggests that these groups should test at least every 3-6 months, or whenever they change partners, or have sex without a condom

To support patient self-empowerment for their sexual healthcare and accessing services through co-production, mindful of the following:

- Emphasising confidentiality, empathy and a non-judgemental approach
- Highlighting the importance of anonymity and data protection
- Offering access to professional interpreter services instead of waiting for the person to ask, to ensure they are fully able to participate in the appointment
- Ensuring staff know to relay that services are free, confidential and available to everyone regardless of where they live (or are from)
- Supporting people to attend appointments and engage with treatment
- Ensuring services are culturally competent for example where English may not be a first language
- Ensuring services are culturally competent in recognising that people may be engaged in activities that are stigmatised by their communities. Discretion and confidentially are therefore especially important.
- A plan for follow up (for example, repeated contact to review progress or make new plans)

To ensure partner notification is prioritised as key to prevent STI transmission, so that people with STIs are advised of the importance of partner notification and encouraged:

- to notify their own sexual partners
- Sexual health services should consider the individual circumstances of people with STIs including risks around confidentiality and domestic violence
- Where notification of partners is not undertaken by the person with the STI, services should consider other methods - with the consent of the person with the STI

To ensure services and interventions are designed in consultation with groups that have greater sexual health or access needs. This includes targeting interventions and services, co-producing interventions with target groups, specific training for staff to better engage groups and service promotion co-produced with eligible groups – using social marketing approaches.

To ensure education and information are given about STIs to staff and relayed to patients as appropriate, including some or all of the following:

- The impact of alcohol and drugs on sexual decision making
- Rates of STIs to explain why some groups are at higher risk
- The impact of stigma and fear of judgement
- Using sex-positive approaches to provide advice on the consistent and correct use of barrier methods, including the provision of condom schemes
- Risk assessment and risk-reduction activities, for example developing personalised risk-reduction plans, identifying triggers and setting goals with patients
- Information–Motivation–Behavioural skills (IMB) model approaches and motivational interviewing techniques to guide conversations about risk reduction or safer-sex practices and address informational, motivational and skills-based barriers to change activities to increase sexual self-efficacy (for example, talking about sexual consent, negotiating the use of barrier methods and negotiating sexual preferences) and broader self-efficacy (for example, self-esteem)
- Activities exploring the links between emotion and sexual behaviour, and coping skills (for example, using cognitive behavioural approaches)

Health education as early as possible is important, and Relationship and Sex Education (RSE) should be implemented in schools to provide young people with the knowledge and skills to look after their sexual health.

To support increasing of uptake of HPV, Hepatitis A and B vaccines:

- Consult GBMSM specifically to identify barriers to their uptake
- Consider opportunistic promotion of vaccines to GBMSM and consider an offer in other routine health appointments

## STIs - Assets/Services available

**Derby Integrated Sexual Health Service (ISHS) and Derbyshire Integrated Sexual Health Service (ISHS)** are both provided by Derbyshire Community Health Service NHS Foundation Trust (DCHS) as the lead provider working with general practice, pharmacy, a digital provider and voluntary sector partners. A range of sexual health services are provided in clinics, online services, through outreach provision in communities, in general practice, pharmacy and through the support of voluntary organisations working with specific groups. Provision includes:

- STI testing, treatment, partner notification
- All contraception including LARC
- Psychosexual counselling (sexual health element)
- Sexual Health promotion and outreach with specific sexual health support for groups at risk

Visit the central booking line – for both the Derby and the Derbyshire service
Tel: 0800 3283383, Website: https://www.yoursexualhealthmatters.org.uk/

Emergency contraception is available in pharmacies across Derby and Derbyshire. LARC is provided by general practice and in ISHS clinic settings.

**Free Condoms Service**
Your Sexual Health Matters provide a free and confidential condom and lube by post service to people who live in Derby City and Derbyshire. The postal condom service is available to people aged 13 years and upwards. Follow the link to find out more or to place an order. Young people under the age of 16 are required to speak to a clinician and register for this service to ensure safeguarding and understanding.
https://www.yoursexualhealthmatters.org.uk/contraception/condoms/postal-condoms

C-Wallets (small packets of free condoms and lube) are available for people (16yrs+) to pick up from their local community settings. This may be from places like hairdressers or barbers, community/ faith centres, leisure facilities and other local organisations.
https://www.yoursexualhealthmatters.org.uk/contraception/free-condoms

Local voluntary and community sector organisations working closely with sexual health services to support communities who may be at higher risk of poor sexual health outcomes:

**Derbyshire LGBT+** is a voluntary organisation working with individuals and groups who identify as LGBT. Support is offered to adults and young people across general health and wellbeing as well as sexual health. https://www.derbyshirelgbt.org.uk/sexualhealth

**Well for Life Community Health Hub** is a charity based in Derby whose aims are to promote the physical, emotional and mental health of people living with or affected by HIV in Derby and Derbyshire. https://www.wflderby.org/

**Women's Work** is a charity working across Derby and Derbyshire offering support to vulnerable women and families. Sexual Health outreach services are offered.
Free, confidential support: 01332 242525, https://www.womens-ork.org.uk/projects/sexual-health-outreach/

**Sexwise** – a national website with advice on sexual health and support to locate services near you: https://www.sexwise.org.uk/

**National Helpline for Sexual Health:** FREE on 0300 123 7123, Monday to Friday, 9am to 8pm, Saturday and Sunday, 11am to 4pm.

**THT (Terrence Higgins Trust)** offers advice and information about HIV, other sexually transmitted infections and how to maintain good sexual health. Resources for people living with HIV and those newly diagnosed.
Freephone telephone number: 0808 802 1221 for support, advice and information or email info@tht.org.uk. Website: https://www.tht.org.uk/hiv-and-sexual-health

# 4. Human Immunodeficiency Virus (HIV)

Human immunodeficiency virus (HIV) is a preventable viral infection associated with significant morbidity, premature mortality and high healthcare costs. HIV infects and destroys cells of the immune system which leads to a weakened ability of the body to fight off infections and diseases. HIV is found in the bodily fluids of an infected person, including 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.

If untreated, infected individuals become increasingly immunodeficient and may develop a life-threatening condition called acquired immunodeficiency syndrome (AIDS). However, freely available and effective antiretroviral therapy (ART) in the UK has transformed HIV from a fatal infection into a chronic but manageable condition with very few people now going on to develop AIDS and serious AIDS-related illnesses. People diagnosed with HIV in the UK can now expect to have a near normal life expectancy if diagnosed promptly and then adhere to treatment. Those receiving treatment are also unable to pass on HIV, even if having unprotected sex (undetectable = untransmissible [U=U]).

In January 2019, the UK government set a goal to end transmission of HIV by 2030. There are four main objectives as part of this goal: ensuring equitable access and uptake of HIV prevention programmes, scaling up HIV testing, optimising rapid access to treatment and increasing retention in care, and improving quality of life and reducing stigma for those living with HIV[1]. In order to monitor progress to this goal, UKHSA recommends monitoring multiple indicators, including new and late diagnosis, incidence, and undiagnosed prevalence.

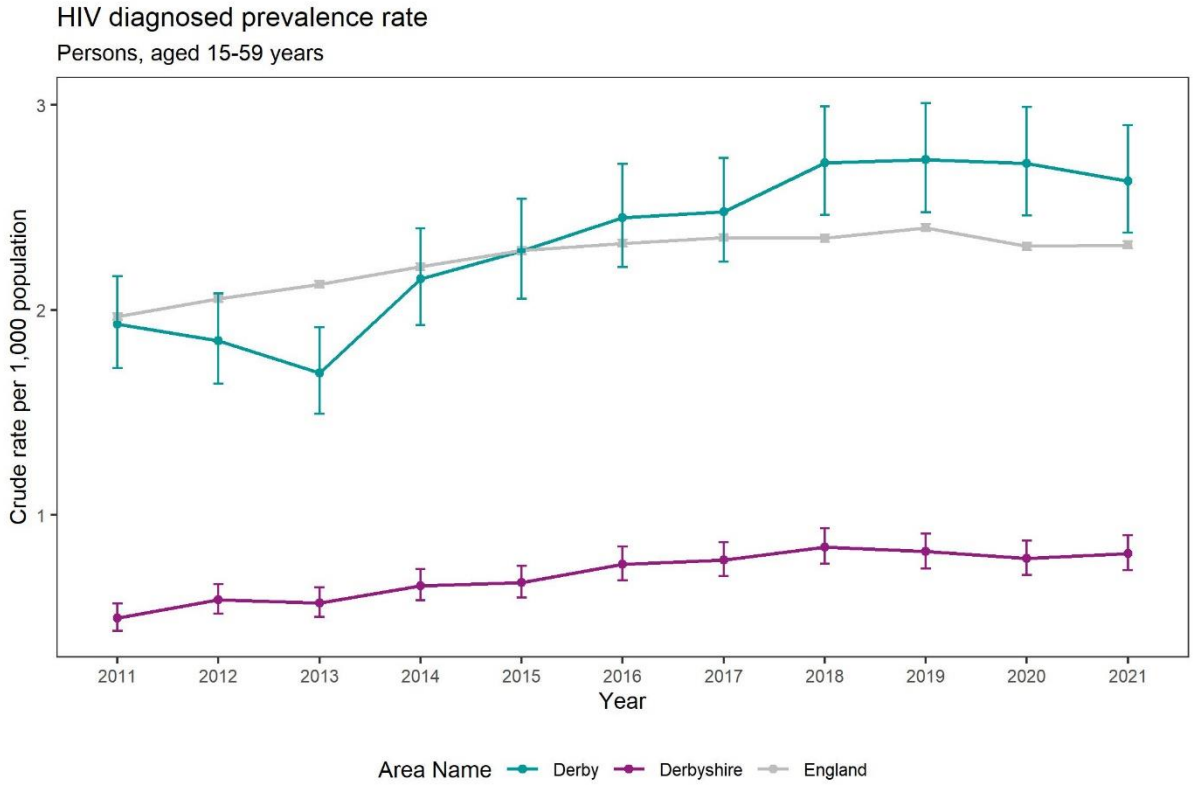
## 4.1 HIV Prevalence

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 cases per 1,000 population[2]. In 2020, it was estimated that 97,740 people were living with HIV in England, with a further 4,660 unaware of their infection[3].

In Derby, the prevalence of HIV had been gradually increasing each year from 1.69 new diagnoses per 1,000 in 2013 to 2.73 per 1,000 in 2019, before appearing to stabilise (*Figure 28)*. In 2021, the rate of 2.65 diagnoses of HIV per 1,000 population was significantly higher than the England average of 2.34 per 1,000 and ranks as 2$^{nd}$ highest when compared to its CIPFA nearest neighbours.

In Derbyshire, the diagnosed prevalence of HIV has also increased during the same time period, from 0.58 per 1,000 in 2013 to 0.82 per 1,000 in 2019. The rate of 0.83 per 1,000 in 2021 remained significantly below the national average, and Derbyshire ranked as 14$^{th}$ highest when compared to its CIPFA nearest neighbours.

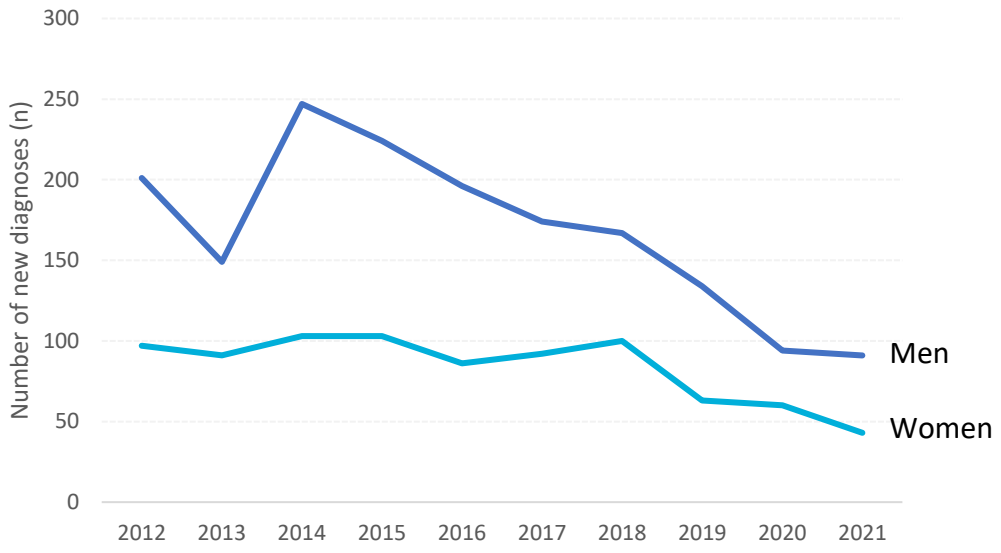
Figure 28 - HIV diagnosed prevalence rate in population aged 15 to 59 years seen at HIV services




## 4.2 Inequalities: New HIV Diagnoses

Since 2014, the number of new HIV diagnoses in the East Midlands has been gradually decreasing year on year. However, most likely as a result of fewer SHS attendances, reduced HIV testing and changed patterns of sexual behaviour during the COVID-19 pandemic, there was a 22% decrease in the number of new HIV diagnoses between 2019 and 2020 (197 vs 154 diagnoses). This number further decreased to 134 new diagnoses in the East Midlands in 2021 (*Figure 29*).

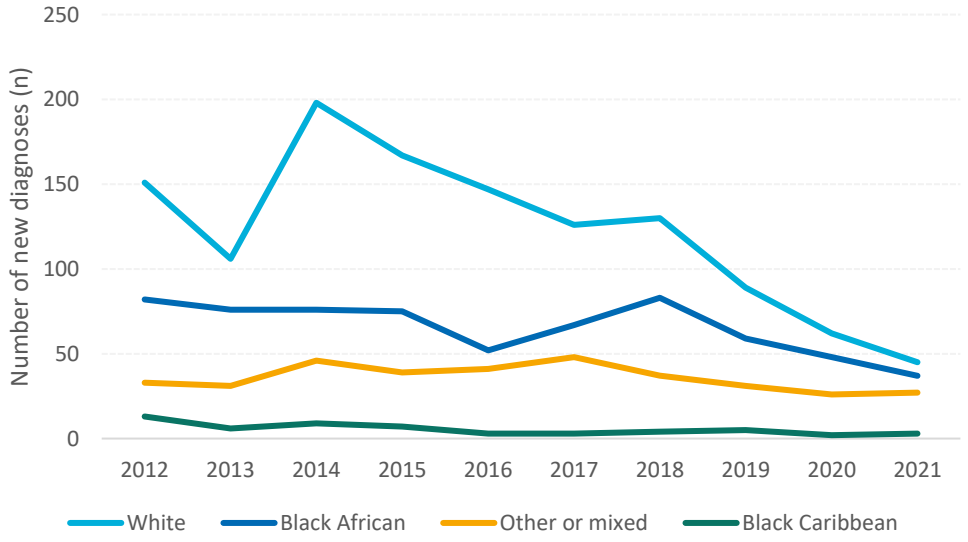
Figure 29 - New HIV diagnoses in the East Midlands between 2012-2021 by sex




Data sourced from UKHSA HIV annual data tables (2022)

Since 2012, incidence of HIV in the East Midlands has been greater in males and in 2021, 67.9% (*n=91)* of new diagnoses were in males compared to 32.1% (*n=43)* in females (*Figure 29)*. In 2021, the greatest proportion of patients were from white (40.2%, *n=45*) or Black African (33.0%, *n=37*) ethnic groups (*Figure 30*).

Figure 30 - Number of new HIV diagnoses in the East Midlands between 2012-2021 by ethnicity




Data sourced from UKHSA HIV annual data tables (2022)

## 4.3 Inequalities: People Accessing HIV Care

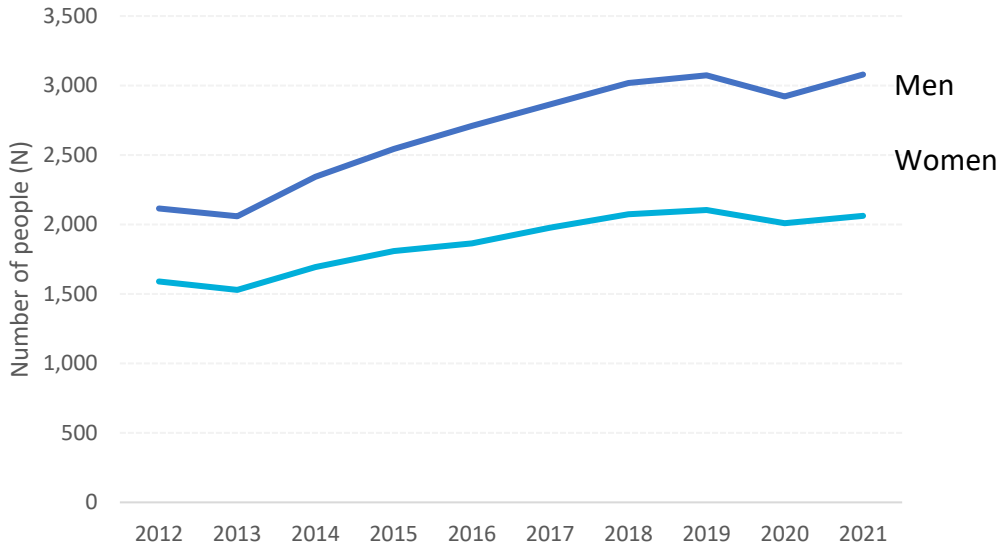
Large inequalities exist in HIV prevalence, with a disproportionate burden of infection amongst MSM and people who have migrated from regions of the world where HIV is more prevalent, such as sub-Saharan Africa.

Since 2013, the number of people accessing HIV care in the East Midlands has been gradually rising, however in addition to fewer diagnoses in 2020, there was also a drop in the number of people accessing HIV care during the same period (*Figure 31*).

Compared to 2019, the number of people seen for HIV care in the region decreased by 4.8% to 4,930 people in 2020. However, data for 2021 has shown that the number of people receiving HIV specialist care in the East Midlands has returned to pre-pandemic levels.

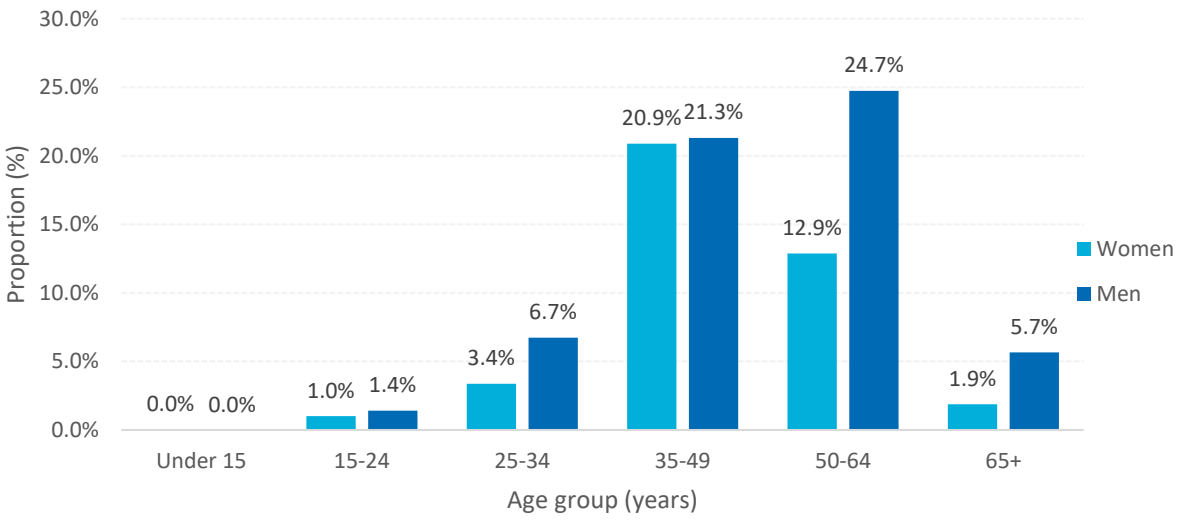
Of this number, in 2021, 59.8% (*n=3,079*) were male and 40.1% were female (*n=2,062*). 42.2% (*n=2,171*) of people seen for HIV care in the East Midlands in 2021 were aged between 35-49 years, while 45.1% *(n=2,323)* were aged 50 years or over (*Figure 32)*.

Figure 31 - Number of people seen for HIV care living in the East Midlands by sex between 2012-2021




Data sourced from UKHSA HIV annual data tables (2022)

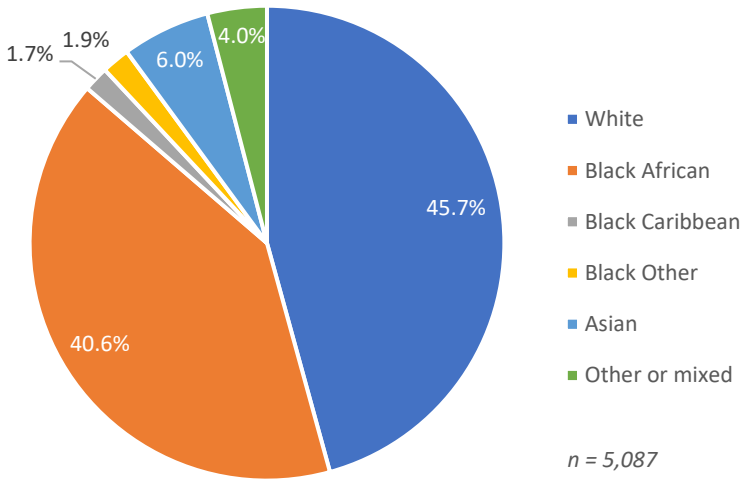
Figure 32 - Percentage of people seen for HIV care living in the East Midlands by sex and age-group in 2021




Data sourced from UKHSA HIV annual data tables (2022)

In 2021, just over 45% of people receiving HIV specialist care in the East Midlands were of White ethnicity (45.7%, *n=2,326*), closely followed by 40.6% who were Black African (*n=2,065)* (*Figure 33)*. Of the remaining 696 people, 6.0% were Asian, 4.0% were of Other/mixed ethnicity, 1.9% were Black Other and 1.7% were Black Caribbean.

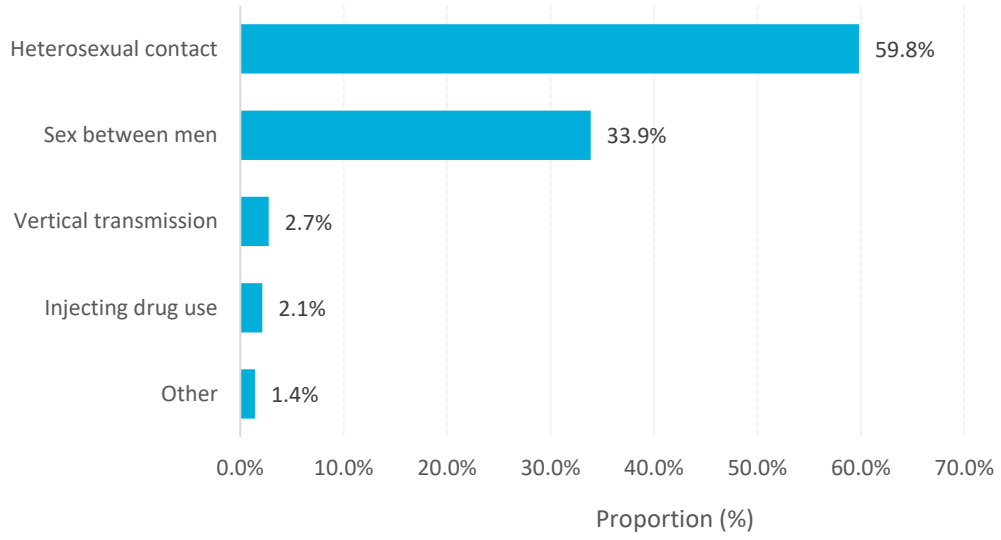
Figure 33 - Percentage of people seen for HIV care living in the East Midlands by ethnicity in 2021




Data sourced from UKHSA HIV annual data tables (2022)

The majority of people accessing HIV care in 2021 acquired HIV through either heterosexual sex (59.8%, *n=2,986)* or sex between men (33.9%, *n=1,692*) (*Figure 34)*. The mode of transmission was unknown for 1.4% *(n=71)* of people, while the remaining number acquired HIV through vertical transmission from mother-to-child (2.7%, *n=137*) or injecting drug use (2.1%, *n=106)*.

Figure 34 - Percentage of people seen for HIV care living in the East Midlands by probable exposure category in 2021




Data sourced from UKHSA HIV annual data tables (2022)

## 4.4 HIV Testing

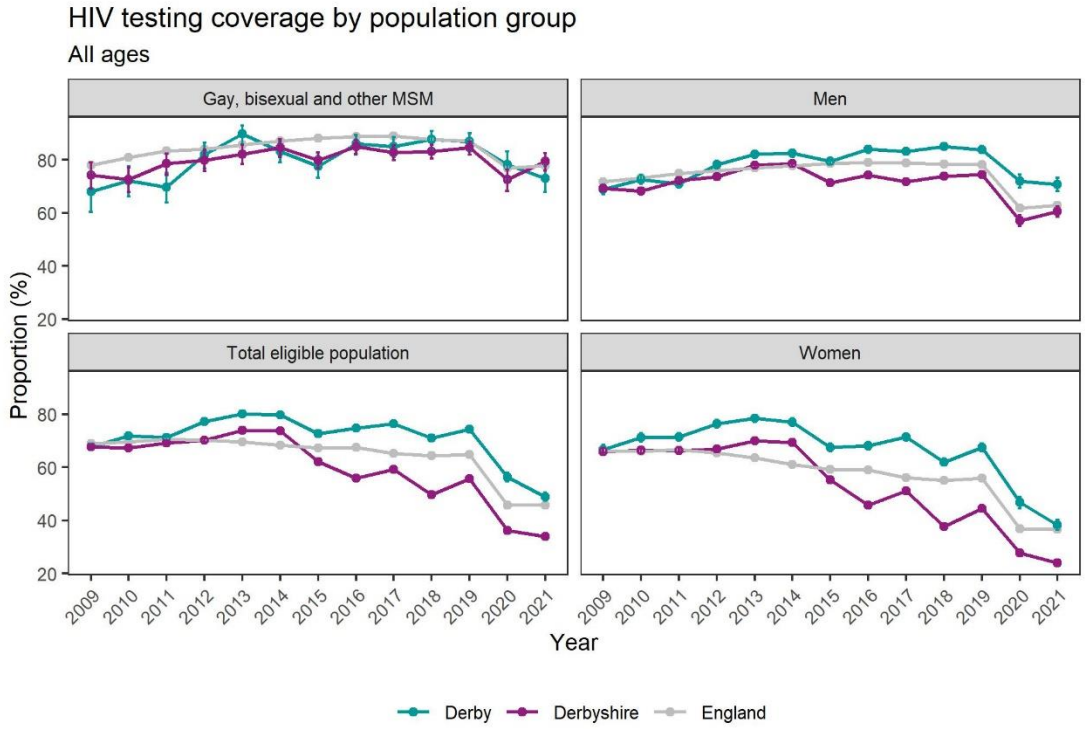
The HIV testing coverage indicator in the PHOF monitors the number of HIV tests accepted amongst the population considered eligible for a HIV test when attending specialist sexual health services. HIV testing is integral to the treatment and management of HIV infection and knowledge of HIV status increases survival rates, improves quality of life and reduces the risk of onward transmission[4].

Prior to 2020, HIV testing coverage in Derby had remained consistently above 70% of the total eligible population; significantly higher than the national average, and coverage in GBMSM had been above 80% (*Figure 35*). However, from 2019 to 2021, the proportion of people tested for HIV decreased from 74.3% to 48.9% in the total eligible population and from 86.8% to 73.0% in GBMSM. As HIV testing coverage decreased across England during this period, Derby remained significantly higher compared to the average amongst the total eligible population and men, while coverage amongst women and GBMSM was similar to England.

Testing coverage of the total eligible population in Derbyshire had already been decreasing and fell from 55.7% in 2019 to 33.8% in 2021, remaining significantly below the average for England. Testing coverage in GBMSM although significantly lower than England, had

remained above 80% in Derbyshire up to 2019. Following a decrease in 2020 to 72.5%, there was a small increase to 79.4% in 2021, with coverage similar to England. Testing coverage of men and women remained significantly lower than England.

Figure 35 - The proportion of eligible attendees at specialist sexual health services (SHS) who accepted a HIV test by population group




Potential stigmatisation is one of the key barriers preventing people from accessing HIV testing and care, and further research should seek to understand the role of HIV-related stigma in access to testing[5]. Increasing testing coverage is critical to ensure that the UK meets its ambition of zero new HIV transmissions by 2030.

## 4.5 HIV Late Diagnosis

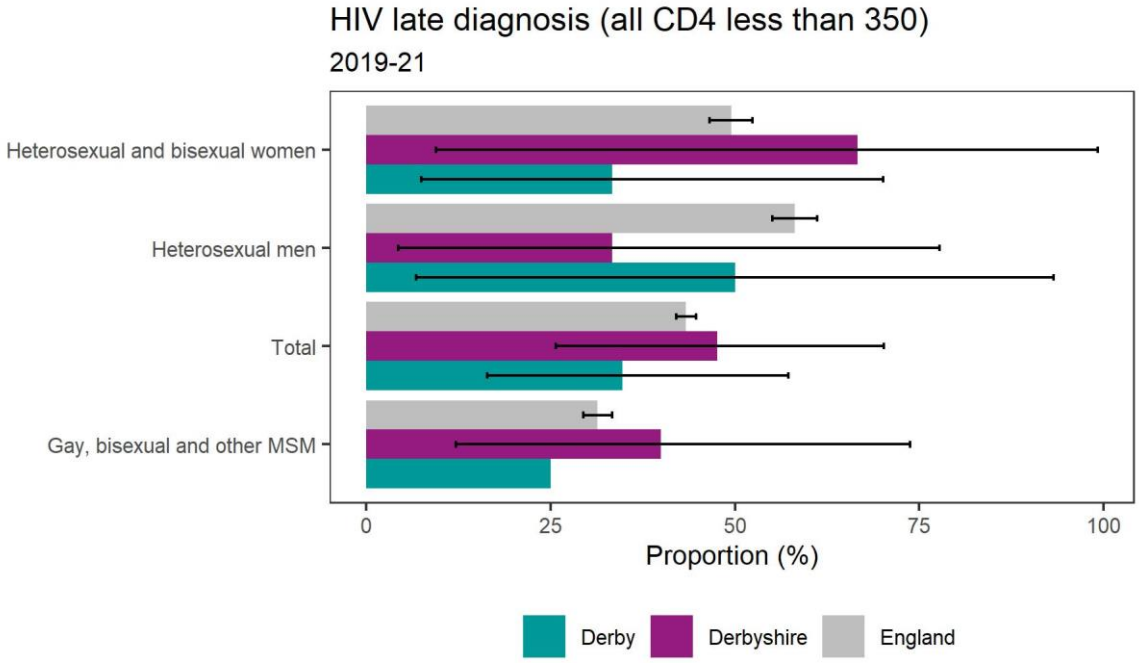
Reducing late diagnosis of HIV is one of the key strategic priorities in public health. Late diagnosis is the most important predictor of morbidity and mortality among those with an HIV infection, with those diagnosed late having a 15-fold higher risk for HIV/AIDS-related deaths within one-year of diagnosis compared to those diagnosed early[6].

The Public Health Outcomes Framework (PHOF) includes an indicator which monitors the proportion of people presenting with HIV at a late stage of infection; this indicator is also useful in evaluating the success of local HIV testing efforts. Late diagnosis is defined as having a CD4 count of fewer than 350 cells/mm$^3$ within 3-months of diagnosis.

Between 2019-21, the proportion of people diagnosed with HIV at a late stage was 34.8% (n=8) in Derby and 47.6% (n=10) in Derbyshire; similar to the England average of 43.4% (*Figure 36*). It should be noted that in Derby, 1 in 2 (50.0%) heterosexual men are diagnosed

late (compared to 33.3% in Derbyshire and 58.1% in England), while in Derbyshire, 2 in 3 (66.7%) heterosexual and bisexual women are diagnosed late (compared to 33.3% in Derby and 49.5% in England), although the confidence around local data is limited by small sample sizes. This increases the risk of onward HIV transmission and the risk of poorer long-term health outcomes.

Figure 36 - Human Papilloma Virus (HPV) and Cervical Cancer/mm$^3$ among all newly diagnosed adults with CD4 cell count available within 91 days of diagnosis



## 4.6 HIV Recommendations

The previously stated STI recommendations support HIV prevention alongside national guidance. Additional recommendations are as follows:

**HIV Recommendations**

Promote the availability of Pre-Exposure Prophylaxis (PrEP) to eligible groups to protect against the acquisition of HIV.

Maintain testing accessibility to ensure timely diagnosis and if required early access into treatment.

Pursue HIV late diagnosis with a sense of urgency to explore action to mitigate risk of ongoing late diagnoses. Action of HIV control may include:

- Planning through a multiagency HIV prevention group
- Outreach action to promote and offer point of care testing in a targeted way to reach communities most at risk
- Improve accessibility to testing through an opportunistic approach in different settings – learning from approaches offered in general practice and emergency departments

Continue engagement of higher risk groups in the co-production of communications and service offer to be mindful of addressing stigma and other barriers some communities may have that hinder their access to STI services.

Training and awareness across staff to support understanding of cultural issues or stigma that diverse groups may face in accessing treatment or receiving a particular diagnosis such as HIV. All services must ensure inclusivity.

## HIV - Assets/Services Available

**Derby Integrated Sexual Health Service (ISHS)** is provided by Derbyshire Community Health Service NHS Foundation Trust (DCHS) as the lead provider working with general practice, pharmacy, a digital provider and voluntary sector partners. A range of sexual health services are provided in clinics, online services, through outreach provision in communities, in general practice, pharmacy and through the support of voluntary organisations working with specific groups. Provision includes:

- STI testing, treatment, partner notification
- All contraception including LARC
- Psychosexual counselling (sexual health element)
- Sexual Health promotion and outreach with specific sexual health support for groups at risk

Visit the central booking line – for both the Derby and the Derbyshire service
Tel: 0800 3283383, Website: https://www.yoursexualhealthmatters.org.uk/

Emergency contraception is available in pharmacies across Derby and Derbyshire. LARC is provided by general practice and in ISHS clinic settings.

**Free Condoms Service**
Your Sexual Health Matters provides a free and confidential condom and lube by post service to people who live in Derby City and Derbyshire. The postal condom service is available to people aged 13 years and upwards. Follow the link to find out more or to place an order https://www.yoursexualhealthmatters.org.uk/contraception/condoms/postal-condoms

The Condom scheme or C-scheme is available at various community settings across Derby and Derbyshire. C-Wallets (small packets of free condoms and lube) are available for people to pick up from their local community settings. This may be from places like hairdressers or barbers, community/faith centres, leisure facilities and other local organisations.
https://www.yoursexualhealthmatters.org.uk/contraception/free-condoms

Local voluntary and community sector organisations working closely with sexual health services to support communities who may be at higher risk of poor sexual health outcomes:

**Derbyshire LGBT+** is a voluntary organisation working with individuals and groups who identify as LGBT. Support is offered to adults and young people across general health and wellbeing as well as sexual health. https://www.derbyshirelgbt.org.uk/sexualhealth

**Well for Life Community Health Hub** is a charity based in Derby whose aims are to promote the physical, emotional and mental health of people living with or affected by HIV in Derby and Derbyshire. https://www.wflderby.org/

**Sexwise** is a national website with advice on sexual health and support to locate services near you: https://www.sexwise.org.uk/

**National Helpline for Sexual Health:** FREE on 0300 123 7123, Monday to Friday, 9am to 8pm, Saturday and Sunday, 11am to 4pm.

**THT (Terrence Higgins Trust)** offers advice and information about HIV, other sexually transmitted infections and how to maintain good sexual health. Resources for people living with HIV and those newly diagnosed.
Freephone telephone number: THT Direct on 0808 802 1221 for support, advice and information or email info@tht.org.uk. Website: https://www.tht.org.uk/hiv-and-sexual-health

## 5. Human Papilloma Virus (HPV) and Cervical Cancer

Human papillomavirus (HPV) is a common, sexually transmitted virus which around 4 in 5 people will come into contact with at some time during their lives. It can be caught through vaginal, oral, or anal sex, any skin-to-skin genital contact and sharing sex toys[1]. There are more than 200 different types of HPV, which can be split into low-risk and high-risk types. Most low-risk types do not cause any disease, although there are a few which can lead to verrucas and genital warts. High-risk HPVs can increase the risk of certain cancers, including cervical, penis and head and neck cancer.

Risk factors for HPV infection include people with an early age at first sexual intercourse, those with multiple sexual partners or who regularly have unprotected sex[2].

In 2008, the HPV national vaccination programme was introduced to protect adolescent females against cervical cancer. At that time, a 3-dose schedule was offered routinely to secondary school year 8 females (aged 12 to 13 years) alongside a catch-up programme targeting females aged 13 to 18 years. This was changed to a 2-dose schedule in September 2014, before expanding eligibility to include males of the same age in September 2019. Recent evidence shows that 1-dose provides excellent protection against HPV, thus the Joint Committee on Vaccination and Immunisation (JCVI) has advised a move from 2-doses to 1 and the government will now consider this advice[3].

The current position from the JCVI is that from 1 September 2023[4], all young people aged 12-13 years will change from a 2 dose to a one dose HPV vaccine schedule.

In addition to the routine adolescent programme, there is also a separate HPV vaccination programme for gay and bisexual men and other men who have sex with men (GBMSM) aged up to 45 years, which is delivered through sexual health clinics. This most recent advice from JCVI for a move to 1 dose applies to everyone aged under 25, including GBMSM. Any GBMSM aged 25 or over will continue to be offered 2 doses. Individuals living with HIV will be offered 3 doses, irrespective of their age.

Thus from September, gay and bisexual men under 25 will only need to receive 1 dose of the human papillomavirus (HPV) vaccine instead of 2 to be fully vaccinated, based on advice from the JCVI.

Since the introduction of the programme, the prevalence of HPV is likely to have decreased and this is evidenced by the significant reduction in the rate of genital warts diagnoses which has been observed both locally and nationally.

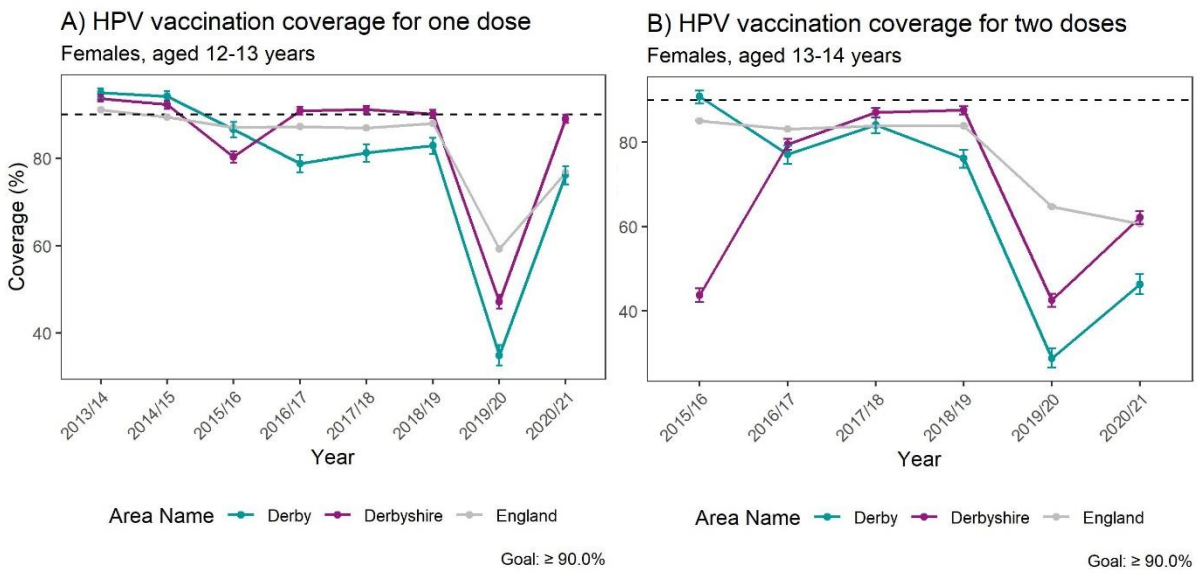
## 5.1 HPV vaccination coverage

In Derbyshire, HPV vaccine coverage in females for 2-doses had increased from only 43.7% in 2015/16* to 87.7% in 2018/19 (*Figure 37B)*. During the same period, 2-dose coverage in Derby decreased from 90.9% in 2015/16 to 76.1% in 2018/19. Both were below the goal of ≥90% coverage, as was England at 83.9%.

In March 2020, all educational settings in England were advised to close by the UK Government as part of COVID-19 pandemic measures. Although the importance of maintaining good vaccine uptake was recognised, operational delivery of all school-aged immunisation programmes was paused for a short period of time as a consequence of school closures limiting access to venues for providers and children who were eligible for vaccination[5]. This inevitably led to disruption of the school-based HPV immunisation programme during 2019/20, with the effects appearing to be even more significant locally, where there was a 62.2% and 51.5% decrease in coverage in Derby and Derbyshire, respectively (compared to a 22.9% decrease in England).

Data for 2020/21 shows that performance for the primer dose in females had almost recovered to pre-pandemic levels (76.2% and 89.0% in Derby and Derbyshire, respectively), although 2-dose performance remained significantly lower than 2018/19. Inability to offer school-based vaccination during the January to March 2021 lockdown, lower school attendance rates and disruption due to school-based COVID-19 outbreaks are likely to have contributed to this.

Figure 37 - A) HPV vaccination coverage for one dose in females aged 12-13 years and B) HPV vaccination coverage for two doses in females aged 13-14 years




*During 2015/16, the commitment to deliver the childhood flu vaccine programme (extended to school yrs 1 & 2), school leaver booster programme (diphtheria/tetanus/polio vaccine), and the MenACWY routine and catch-up programme was reported to have reduced the capacity of school immunisation providers to deliver the HPV vaccination programme in some areas, and this appears to have been the case in Derbyshire[6].

As the adolescent HPV vaccination programme was only expanded to include males in September 2019, data for the HPV coverage indicator in males is only available for 1-dose. During 2020/21, HPV coverage of the priming dose for year 8 males was 68.4% in Derby, 84.1% in Derbyshire and 71.0% in England, significantly below the goal of ≥90% (*Figure 38*). Dose 1 coverage was significantly higher in females than males, in all areas (*Figure 39*).

Figure 38 - HPV vaccination coverage for one dose in males aged 12-13 years

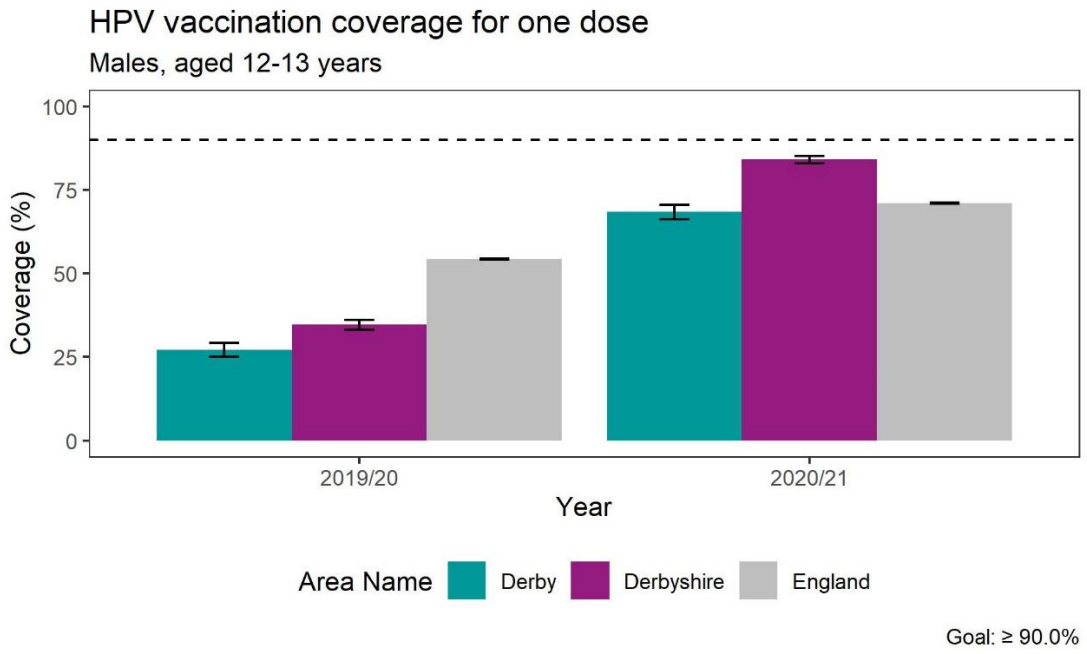
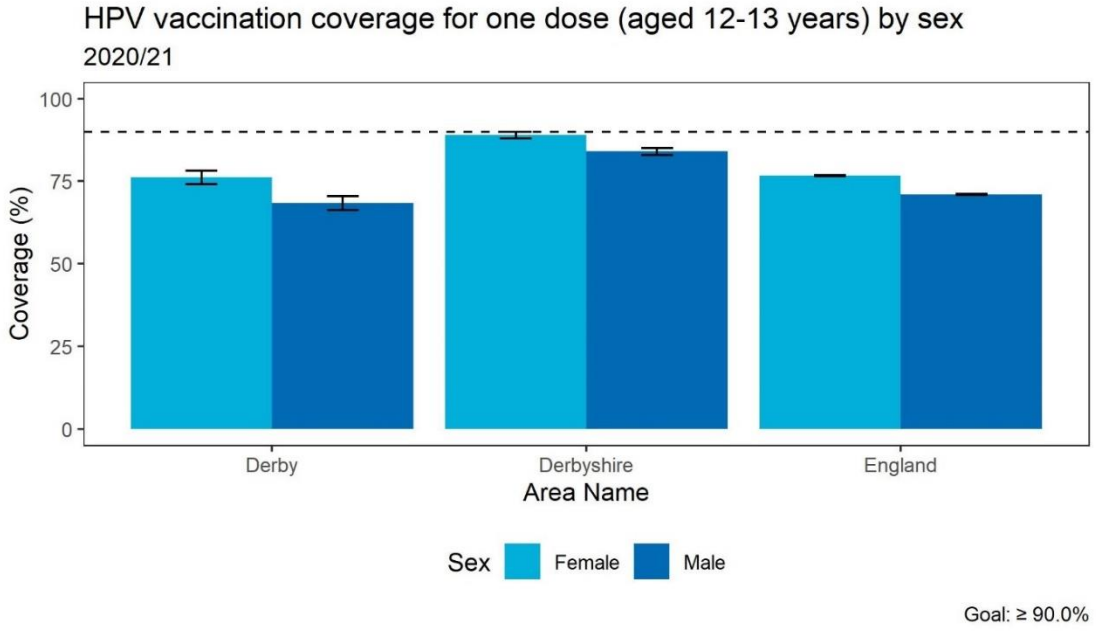



Figure 39 - HPV vaccination coverage for one dose in population aged 12-13 years by sex in 2020/21



## 5.2 Cervical cancer incidence

Cervical cancer is the 14th most common cancer in females in the UK[7]. More than 99% of cases are caused by HPV infection, with just two types (16 and 18) responsible for over 70% of cases[8]. When diagnosed at an early stage, cervical cancer is very treatable and improvements in survival mean that more than 60% of patients will now survive for 5 or more years after diagnosis. Around 3,200 women are diagnosed with cervical cancer every year, with the greatest burden of disease in women in their early 30s[9]. Since the introduction of the HPV vaccination programme, the incidence of cervical cancer has decreased by 87% in women in their 20s[10]. In combination with the effectiveness of screening, the World Health Organization has set the goal of eliminating cervical cancer as a public health problem within a generation[11].

Between 2015-19, the age-standardised incidence rate for cervical cancer was 11.1 cases per 100,000 population in NHS Derby and Derbyshire, significantly higher than the average rate of 9.6 cases per 100,000 for England[12]. There has been no change in incidence since 2010-14 (11.1 per 100,000 in Joined Up Care Derbyshire ICS and 9.5 per 100,000 in England).

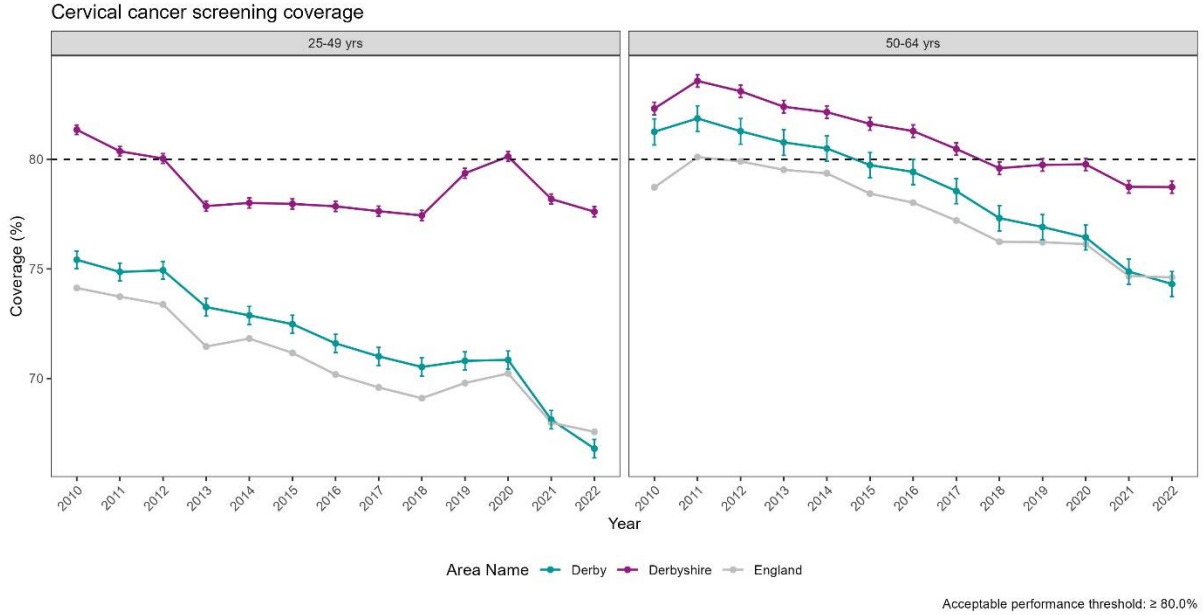
## 5.3 Cervical screening coverage

The HPV vaccine does not completely eliminate the risk of cervical cancer, therefore cervical screening, to check for HPV infections, is still an important aspect of reducing cervical cancer rates.

In England, the NHS Cervical Screening Programme is offered to all women aged 24.5-64 years with the aim of reducing the incidence and mortality of cervical cancer. Screening is designed to detect HPV which can cause the growth of abnormal, and potentially cancerous, cells on the cervix. If HPV is found, a cytology test is used to check for any abnormal cells before individuals are then referred for a colposcopy. Women aged 25-49 years are invited every 3 years, with women aged 50-64 years invited every 5 years.

Both local and national trends in cervical screening showed declining coverage until 2018, when the rate of decline appeared to slow, while in Derbyshire, coverage increased, particularly in the 25-49 years age-group (*Figure 40*). In recent years, screening coverage in Derby has remained slightly above the average for England, while Derbyshire has reported considerably higher coverage than both Derby and England in both age-groups. Coverage has consistently been greater in the 50-64 years age-group, compared to the 25-49 years age-group.

Figure 40 - The proportion of eligible women screened adequately for cervical screening within the previous 3.5 years by age-group




As cervical screening coverage is reported over 3.5 and 5.5 years, this data is less affected by the short-term disruption to services caused by the COVID-19 pandemic, however, there has still been a notable decrease in performance in all areas since 2020. In 2022, cervical screening coverage in the 25-49 years age-group decreased to 66.8% in Derby (14th highest amongst its CIPFA nearest neighbours), 77.6% in Derbyshire (1st highest compared to CIPFA nearest neighbours) and 67.6% in England. In the 50-64 years age-group, during the same period, coverage decreased to 74.3% in Derby (7th highest compared to CIPFA nearest neighbours), 78.7% in Derbyshire (3rd highest compared to CIPFA nearest neighbours) and 74.6% in England.

Individuals under the age of 25 are not routinely offered cervical screening because cervical cancer is extremely rare in under-25s, and modelling suggests that screening at a younger age would increase the amount of unnecessary treatment without reducing the number of cervical cancers[13].

Currently trans men, who may have a cervix, are eligible for cervical screening, however they do not receive invitations for screening by post if they are registered as male with their GP. In these circumstances the GP practice or the healthcare team managing gender reassignment should send screening invites[14]. Jo's Cervical Cancer Trust provides more advice for trans men and nonbinary people[15], people with a learning disability[16], people who have experienced sexual violence[17] and over 65s[18].

Improvements in coverage would mean more cervical cancer is prevented or detected at earlier, more treatable stages.

## 5.4 HPV and Cervical Cancer Recommendations

**HPV and Cervical Cancer Recommendations**

Continued support to promote the HPV vaccine for girls and boys is recommended locally towards alignment of the advised England coverage rate. Specific awareness of vaccine uptake for boys is recommended.

Understanding local need and patient demographics is vital to review the cervical screening offer. This includes having access to timely local data on uptake and an understanding of the eligible population demographic including age, ethnicity, language, gender identity and cultures of those attending and not-attending cervical screening. This is to enable improved planning of interventions where they are most needed and to monitor outcomes.

Local data suggests declining screening for both Derby and Derbyshire across both eligible age groups and specifically across the 25-49yrs group. For Derby more proactive intervention is recommended to increase screening uptake with specific focus on the 25-49yrs cohort.

Collaborative reviews should also include contribution from eligible groups who may find it challenging to access screening for example groups of diverse cultural backgrounds and individuals with different gender identity, such as trans men. Co-production of interventions, campaigns and staff training to improve local screening uptake is recommended.

NHS E commissioning, local ICBs and general practice should work together in sustained, multifaceted reviews to develop local planning to improve uptake. Inclusion of other opportunistic “screening” settings for example ISHSs and VCS partners to engage groups with specific vulnerability. Appropriate funding should be available to increase availability at other settings aligned to local population need. Provider engagement for example general practice in screening awareness weeks, targeting resources, targeting interventions and making reasonable adjustments for patients are advised to improve screening.

Staff involved in screening should have regular training on sample taking but training should also be extended to reception staff and others who might speak to patients. General awareness of patient demographic should also be trained.

### HPV and Cervical Cancer - Assets/services available

General practice provides cervical screening routinely to eligible women. Jo’s Cervical Cancer Trust, the UK’s leading cervical cancer charity, provides advice and information about HPV, the HPV vaccine, cervical screening and cancer. Website: https://www.jostrust.org.uk/

## 6. Contraception

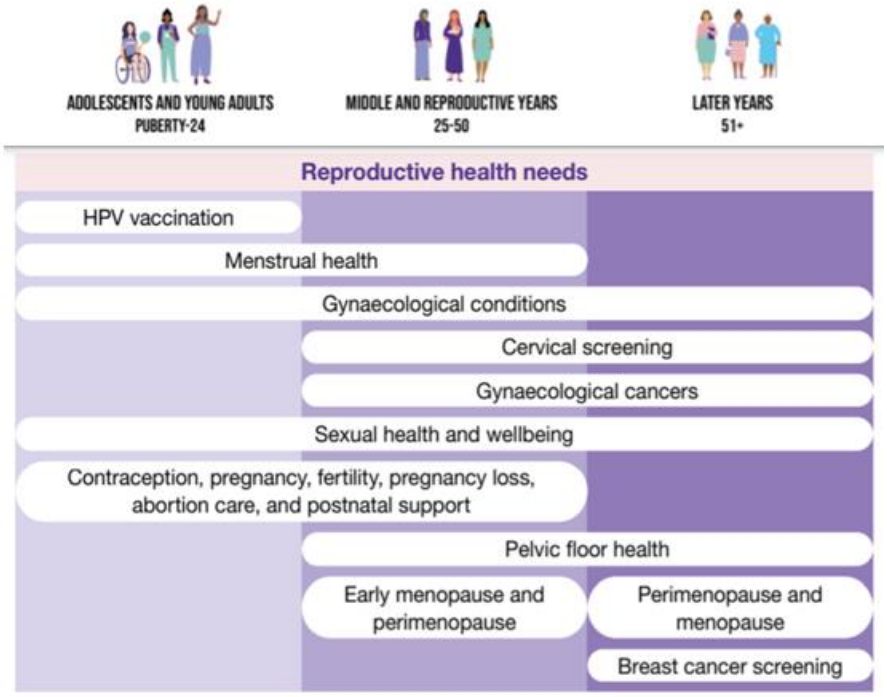
The ability to choose when and whether to become pregnant has a direct impact on a woman's mental and physical health and in 2012, the United Nations Population Fund declared access to voluntary family planning a universal human right[1].

In the UK, women are becoming sexually active earlier and having children later in comparison with previous generations[2]. Along with trends showing people are choosing to have fewer children, this means that the majority of women are now trying to prevent pregnancy for between 30 to 40 years of reproductive life.

The new Women's Health Strategy published August 2022[3] outlines women's health across the life course, noting that contraception is a key building block for women's health, potentially needed for up to 40 years of the life course.

"Most women will menstruate for nearly 40 years, and most women require reliable contraception (which is also a highly cost-effective intervention) for most of this time to prevent unplanned pregnancies."

Figure 41 – Women's reproductive health across the life course




Source: Adapted from Women's Health Strategy for England, 2022

The Strategy is supported by the Hatfield Vision, August 2022[4], giving specific focus on reproductive health inequalities and accessibility of contraception across 16 goals.

Health inequality in the area of contraception and this may be linked to:

- Competing priorities in life for some women

- Accessibility barriers disproportionately affecting women with chaotic and vulnerable lifestyles
- Challenges in knowing where and how to access contraception at GP services, ISHS or other provision
- Providers of contraception services not being fully able to meet a patient's contraceptive needs
- Time pressure on NHS appointments and competing clinical priorities that give limited time available to the patient
- Lack of knowledge, misperceptions or unfounded concerns about the safety of contraceptive methods
- Myths of when a woman can become pregnant, for example a belief that conception cannot happen if a woman is breastfeeding

Goal 6 of the Hatfield Vision recommends equity of long-acting reversible contraception (LARC):

**"Goal 6.** Access to Long-Acting Reversible Contraception (LARC) is made equitable across ICS geographies and demographics."

Under Goal 8, Hatfield reiterates the inclusion of contraception discussion across the Maternity pathway during pregnancy and postpartum contraception being provided before discharge from maternity services:

**"Goal 8.** ICS should ensure that all methods of contraception are discussed with women during pregnancy and, where possible, their method of choice should be initiated prior to discharge from maternity services. Rapid follow-up pathways for LARC should be in place when needed."

Both the Women's Health Strategy and the Hatfield Vision reiterate the need to reduce reproductive health disparities across maternal health outcomes.

**Goal 15** of the Hatfield Vision reiterates a reduction of poor maternal health outcomes by 2030 with specific focus on reducing disparity experienced by black women and women of colour as well as women and girls from Asian and minority ethnic groups.

Access to contraception for all women is a key factor to preventing unplanned pregnancies and a reduction in short inter-pregnancy intervals where baby can be at risk of low birthweight and/or complications and death during the pregnancy or childbirth. Access to contraception for women with vulnerability is evidenced to prevent risk of shorter interpregnancy intervals and this aspect is where contraception can contribute to the goals underpinned by Better Births and national work within Maternity Transformation.

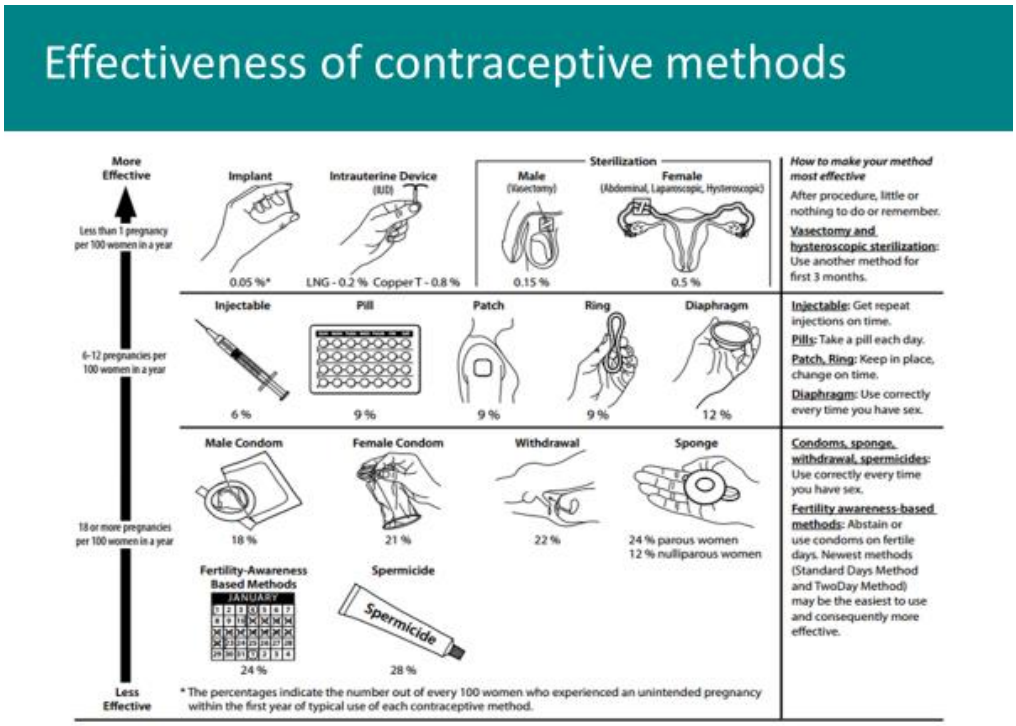
"Through the Long Term Plan, the NHS will accelerate action to achieve 50% reductions in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025.[5]"

Currently in the UK it is estimated that 45% of births are unplanned and 1 in 13 women presenting to maternity have been pregnant in the previous year and almost 25% of conceptions are terminated for women aged 25yrs or over. The cost of unwanted conceptions is significant to the health and social care system whether it results in NHS costs for an abortion or miscarriage; health costs associated with injury or health impact to baby or mother; socio-economic costs where a baby is taken into care or education and employment opportunities are limited for a mother.

There are a range of contraceptive methods, ranging from those that rely on the individual remembering to use them, to those that need administering less than once a month to permanent methods and these are classed as long-acting reversible contraception (LARC).

Methods that rely on an individual remembering to use/take them include the vaginal ring, patch, combined oral pill, progesterone-only pill, male condom, female condom, diaphragm/cap with spermicide and fertility awareness. LARC include the implant, injection, intrauterine system (IUS) and intrauterine device (IUD, also known as the coil). NICE advises the use of LARC as both clinically and cost-effectiveness. Clinically LARC is the best method due to greater effectiveness compared to user dependent methods[6].

Figure 42- Effectiveness of contraceptive methods




Provision of contraception is widely recognised as a highly cost-effective public health intervention:

"for every £1 invested in publicly funded contraception, the public sector will get a £9 return on investment (ROI)[7]. Providing contraception in maternity settings has an even greater estimated ROI, at £32 savings to the public sector for every £1 invested[8]."

As already stated, LARC contraceptive methods are evidenced to be the best to prevent unplanned conceptions and further evidence indicates this to be particularly strong for women with vulnerabilities[9].

Contraception should be delivered alongside promotion of safer sexual behaviour. Some contraceptive methods also protect against Sexually Transmitted Infections (STIs).

Condoms are considered the current best method to prevent STIs[10]. Condom distribution schemes exist across the UK, they provide free or cost-price condoms (often to young people) and can also be a good introduction to broader sexual and reproductive health services. Condom distribution schemes can be multicomponent, meaning they distribute condoms and lubricant together with training, information and other support, or single component, meaning they just deliver condoms and lubricant. The C-Card scheme is probably the most widespread across the UK and is offered in Derby. NICE notes that there is a lack of evidence on condom-distribution schemes in the UK, research on these schemes often does not cover key intervention details or cost-effectiveness[11].

In addition, emergency contraception can be used after unprotected sex or if regular contraception fails. Evidence suggests that the advance provision of emergency oral contraception does not encourage risky sexual behaviour among young people.

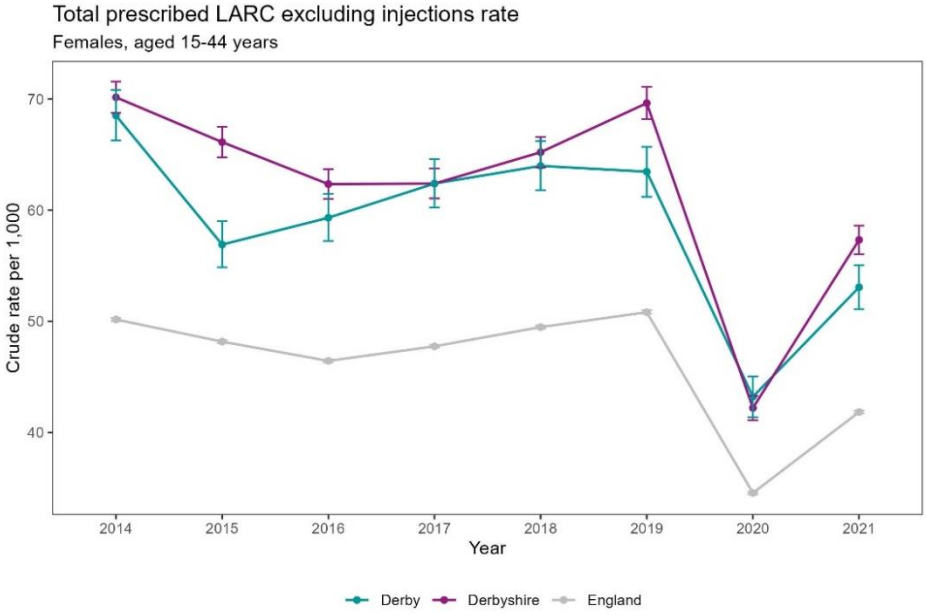
## 6.1 LARC Prescribing

Within this report, contraceptive injections are not categorised as LARC as they rely on timely repeat visits and have a higher failure rate than other LARC methods[12].

Since 2014, the prescribing rate of LARC (both in GP practices and SRH Services) has been significantly higher in Derby and Derbyshire compared to England (*Figure 43)*. Prior to the start of the COVID-19 pandemic in March 2020, the prescribing rate of LARC had been gradually rising, however there was a significant reduction in all areas in 2020, especially in the rate of SRH prescribed LARC where the rate of decline was significantly greater than that seen in England.

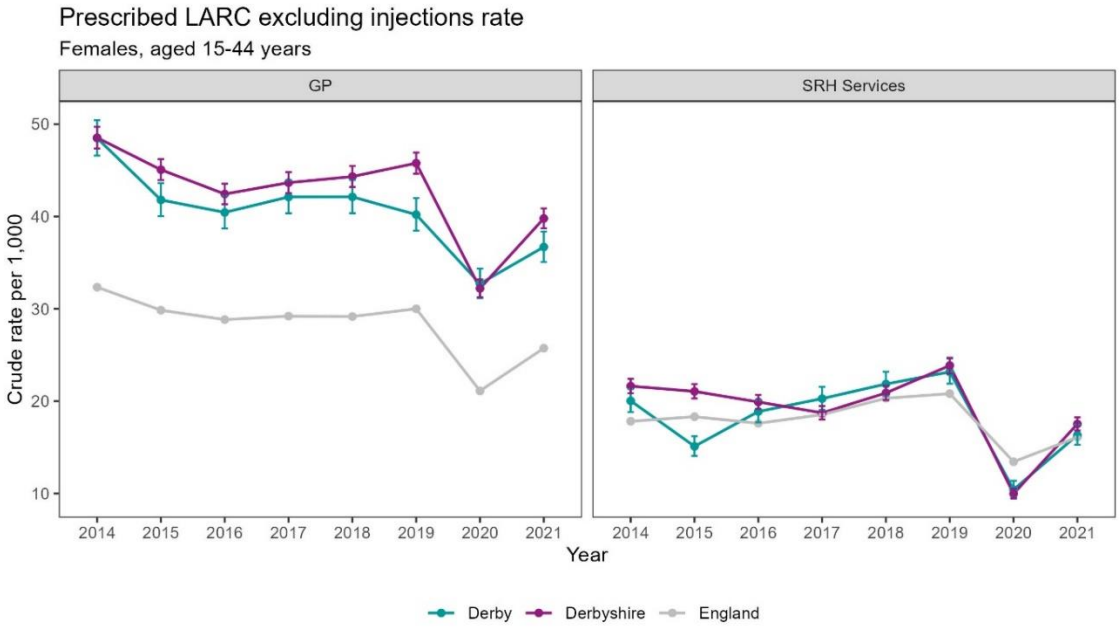
In 2021, the total prescribing rate of LARC increased, although it remains considerably below the rates seen in 2019. During this period, Derbyshire (57.3 per 1,000) and Derby (53.1 per 1,000) had the two highest total prescribing rates of LARC seen in the East Midlands, with both areas recording a prescribing rate higher than the England average (41.8 per 1,000). Derbyshire had the 6th highest rate compared to its CIPFA nearest neighbours, while Derby was 3rd highest.

Figure 43 - Crude rate of long-acting reversible contraception (LARC) excluding injections prescribed per 1,000 resident female population aged 15-44 years




Historically, a greater number of females have accessed LARC through their GP than via SRH services, with this pattern even more marked during the COVID-19 pandemic in 2020 (*Figure 44)*. In 2021, 69.2% of females in Derby and 69.4% in Derbyshire accessed LARC through their GP, compared to 61.5% in England. During this time period, the rate of GP prescribed LARC was significantly higher than the regional and national averages in Derby and Derbyshire. Derbyshire also had a higher rate of SRH-prescribed LARC than seen regionally and nationally, while Derby performed similarly to the regional and national figures.

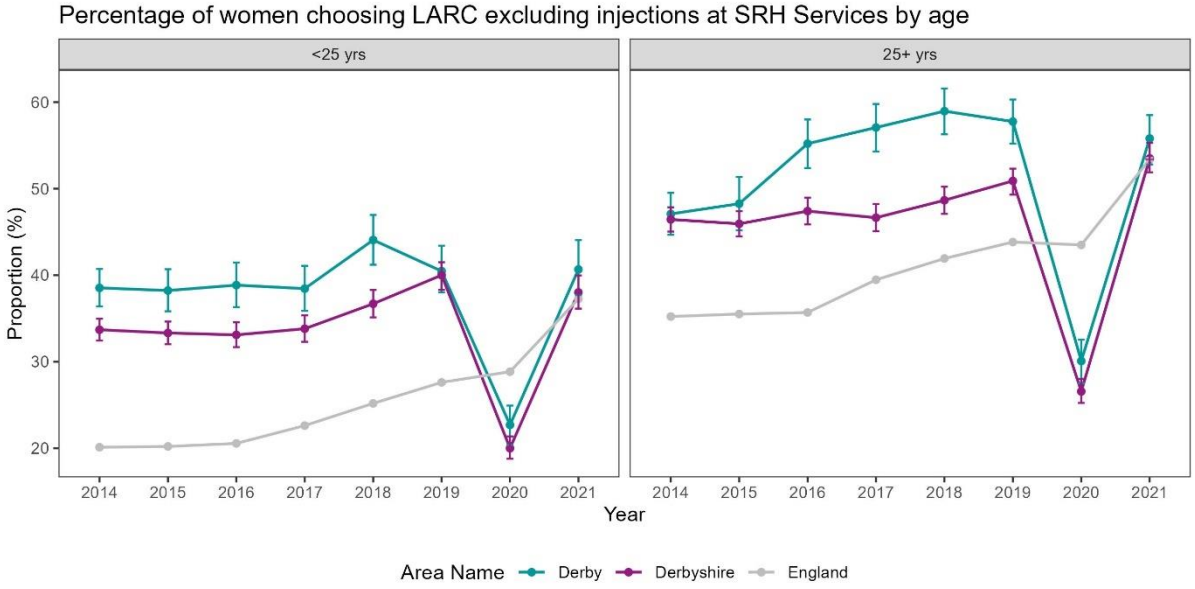
Figure 44 - Crude rate of long-acting reversible contraception (LARC) excluding injections prescribed by GP and SRH Services per 1,000 resident female population aged 15-44 years



Prior to the beginning of the COVID-19 pandemic in March 2020, the proportion of women in contact with SRH services choosing LARC (excluding injections) as their main method of contraception in Derby and Derbyshire had historically remained significantly higher than the England average (*Figure 45)*.

In 2020, there was a significant reduction in the percentage of women choosing LARC at SRH services and the rate of this decrease was significantly greater in Derby and Derbyshire than that seen nationally. Data for 2021 shows that the proportion of women choosing LARC at SRH services was similar to the levels seen pre-pandemic in 2019. Historically, a greater proportion of women aged 25 years and over have chosen LARC as their main method of contraception at SRH services than women aged under 25 years.

Figure 45 - Percentage of women in contact with Sexual and Reproductive Health Services who choose long-acting reversible contraceptives (LARC) excluding injections as their main method of contraception by age-group



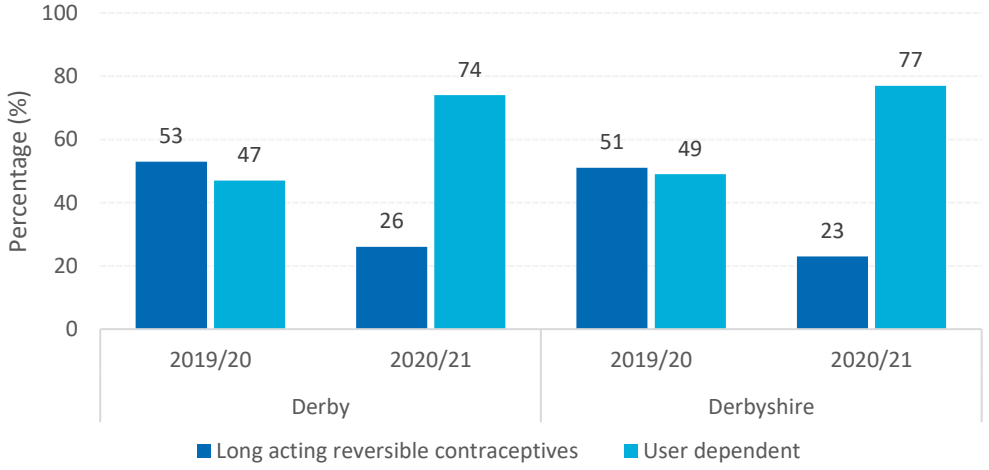

## 6.2 LARC - Sexual and Reproductive Health Services Activity

Nationally, despite the uptake of LARC increasing and uptake of user dependent methods decreasing in recent years, females attending SRH services have remained more likely to choose user dependent methods of contraception than LARC (54% choosing user dependent methods compared to 46% LARC). There was no change in these figures between 2019/20 and 2020/21.

Locally, the uptake of LARC in females attending SRH services for contraception has been greater than seen nationally. During 2019/20, females were slightly more likely to choose LARC as their main method of contraception than user dependent methods (53% vs 47% in Derby and 51% vs 49% in Derbyshire). However, the figures in 2020/21 show a significant change in the use of contraception locally, with a greater uptake of user dependent methods than LARC at SRH services (74% of females in Derby and 77% in Derbyshire).

Almost all contraception provided to males by SRH services is the male condom (99%), with spermicides and natural family planning representing the only other options available[13].

Figure 46 - Main method of contraception by females using Sexual and Reproductive Health Services in 2019/20 and 2020/21. Data sourced from SHRAD.



## 6.3 Women's Sexual and Reproductive Health Recommendations

**Women's Sexual and Reproductive Health (SRH) Recommendations**

- Ensure all women are aware of their contraception choices and have ease of access to services. Particular focus should ensure accessibility for younger women aged under 25 and women of vulnerability. The full menu of contraception choice should be available for women, with LARC encouraged based on its stronger evidence of most effectiveness
- Local LARC capacity should be regularly explored to ensure maintenance and continued offer across general practice, addressing future training needs and adequate numbers of LARC fitters
- Services delivering to women across the sexual health system should consider:
  - Promotion and offer of contraception especially for women with vulnerability across various service settings. Abortion and Maternity services are key in this to ensure prevention of repeat abortions, unwanted pregnancies and pregnancies within a shorter inter-pregnancy interval which is harmful to health of mother and baby
  - Discussion with women of all methods of contraception during pregnancy is advised, and provision of contraception including LARC should be initiated prior to discharge from maternity services
  - Contraception advice should be given alongside STI prevention through use of condoms, with condoms being provided where possible to service users
- Services should be inclusive, non-judgemental, empathetic, and culturally appropriate, staff and service users should be aware of confidentiality policies
- Consideration by system commissioners and providers of women's SRH about opportunities to offer women "seamless" access through greater integration across services in a "hub" approach to ensure women's multiple needs are met at one setting or one appointment. Services within a "hub" approach could include:
    - cervical screening
    - contraception for prevention of conception
    - contraception for treatment of gynaecological conditions
    - menstrual care
    - menopausal support and care
    - STI testing e.g. chlamydia prevention
- A hub approach should also ensure up-to-date awareness of patient pathways to and from other SRH services including abortion and abortion care, maternity, perinatal and postnatal support, care for pregnancy loss, fertility and associated women's health support including mental health, substance misuse and domestic and sexual violence.

## Women's Sexual and Reproductive Health - Assets/Services Available

**Derby Integrated Sexual Health Service (ISHS)** is provided by Derbyshire Community Health Service NHS Foundation Trust (DCHS) as the lead provider working with general practice, pharmacy, a digital provider and voluntary sector partners. A range of sexual health services are provided in clinics, online services, through outreach provision in communities, in general practice, pharmacy and through the support of voluntary organisations working with specific groups. Provision includes:

- STI testing, treatment, partner notification
- All contraception including LARC
- Psychosexual counselling (sexual health element)
- Sexual Health promotion and outreach with specific sexual health support for groups at risk

Visit the central booking line – for both the Derby and the Derbyshire service
Tel: 0800 3283383, Website: https://www.yoursexualhealthmatters.org.uk/

Emergency contraception is available in pharmacies across Derby and Derbyshire. LARC is provided by general practice and in ISHS clinic settings.

**Free Condoms Service**
Your Sexual Health Matters provides a free and confidential condom and lube by post service to people who live in Derby City and Derbyshire. The postal condom service is available to people aged 13 years and upwards. Follow the link to find out more or to place an order https://www.yoursexualhealthmatters.org.uk/contraception/condoms/postal-condoms

The Condom scheme or C-scheme is available at various community settings across Derby and Derbyshire. C-Wallets (small packets of free condoms and lube) are available for people to pick up from their local community settings. This may be from places like hairdressers or barbers, community/faith centres, leisure facilities and other local organisations.
https://www.yoursexualhealthmatters.org.uk/contraception/free-condoms

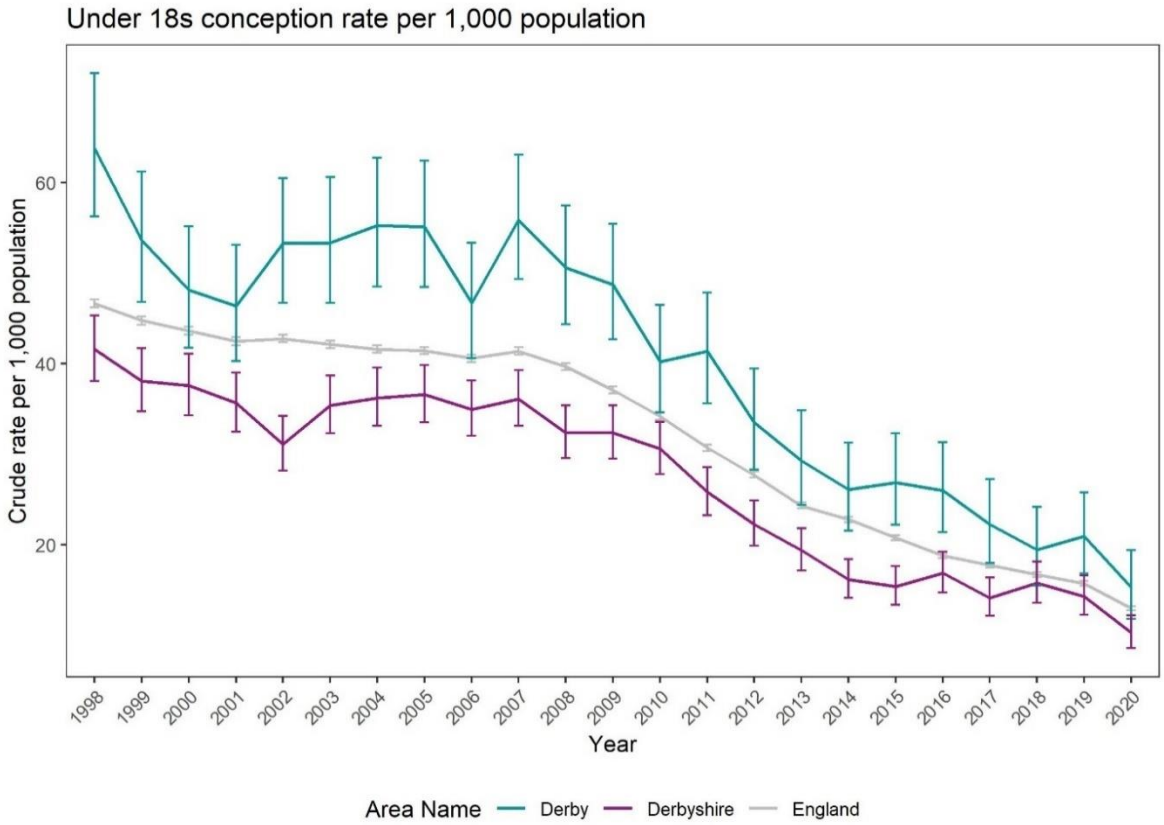
**Women's Work** is a charity working across Derby and Derbyshire offering support to vulnerable women and families, Sexual Health outreach services are offered.
Free, confidential support: 01332 242525, https://www.womens-work.org.uk/projects/sexual-health-outreach/

## 6.4 Teenage pregnancy rates

For some young people having a child can be a hugely positive event, however, the majority of teenage pregnancies are unplanned, with over 50% resulting in abortion[14]. Research has linked teenage pregnancies with poorer social and physical health outcomes for both the mother and child[15]. Teenage mothers are less likely to complete their education and more likely to experience poverty, social isolation and unemployment in later-life, while children born to teenage mothers are at a greater risk of low birth weight, neonatal mortality, developmental delays and child poverty[16]. Therefore, teenage pregnancy is included in the Public Health Outcomes Framework as a key priority for improving health outcomes and reducing inequalities.

Since 1998, the under 18s conception rate has fallen by over 60%, both locally and nationally, to the lowest levels ever recorded in 2020 (*Figure 47*). However, despite this, the teenage pregnancy rate in the UK remains amongst the highest in Western Europe and significant inequalities remain locally, which are almost entirely explained by patterns of deprivation[17].

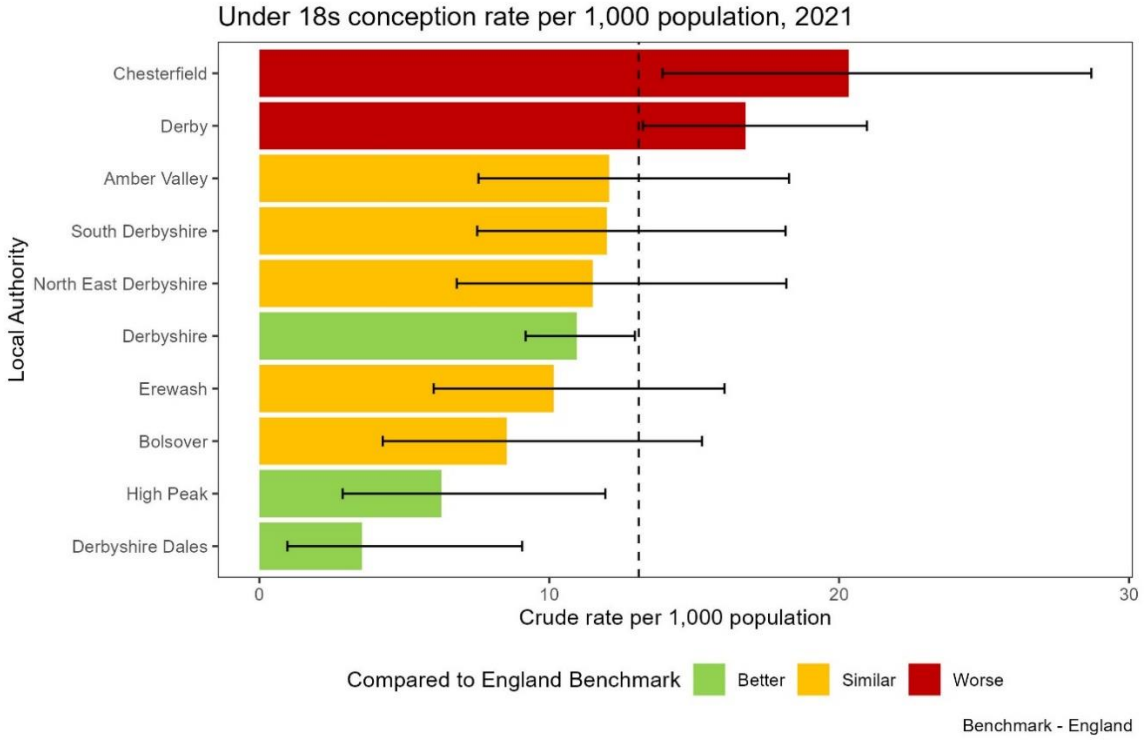
Figure 47 - Conception rate in women aged under 18 years per 1,000 females aged 15-17 years




Whilst the under 18s conception rate in Derby has remained consistently higher than England, the gap between these populations does appear to be getting smaller. In 2021, the rate of under 18s conceptions in Derby was 16.8 per 1,000 population, significantly worse

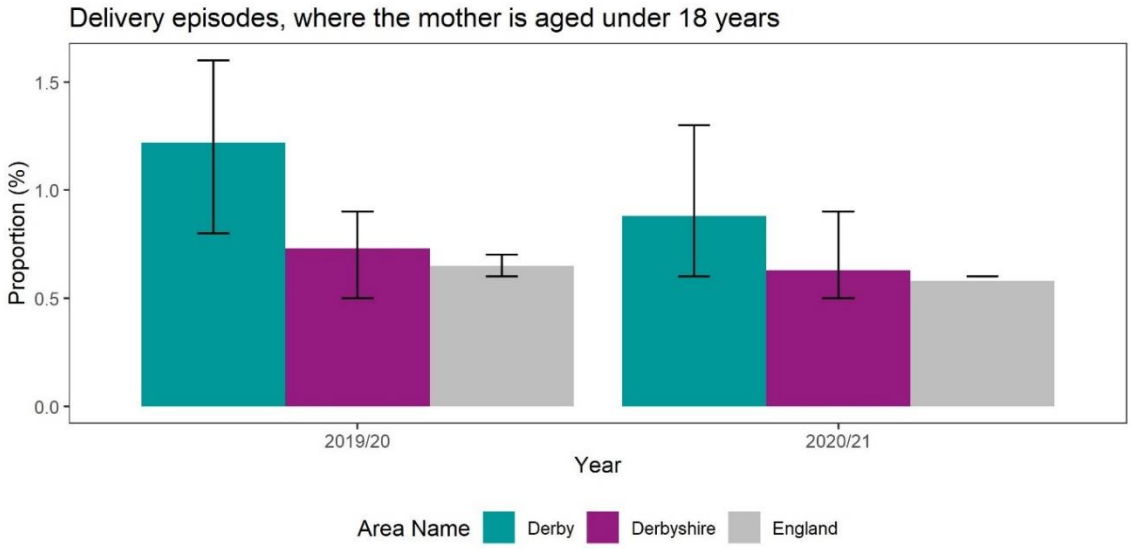
than the rate of 13.1 per 1,000 in England, 9th highest amongst its CIPFA nearest neighbours and 43rd highest of the 149 UTLAs in England (which had a value recorded) (*Figure 48*). Meanwhile, the rate of under 18s conceptions in Derbyshire has remained consistently lower than the national figure. In 2021, the rate of under 18s conceptions in Derbyshire was 10.9 per 1,000: ranking as 12th highest amongst its CIPFA nearest neighbours and 100th highest amongst the 149 UTLAs in England. Chesterfield had the highest rate of under 18s conceptions of the districts (20.3 per 1,000) with a rate which was significantly higher than the national average, while Derbyshire Dales (3.5 per 1,000) and High Peak (6.3 per 1,000) had the lowest rates; performing significantly better than England.

Figure 48 - Conception rate in women aged under 18 years per 1,000 females aged 15-17 years in 2021




In addition, the proportion of deliveries to teenage mothers also decreased between 2019/20 and 2020/21, both locally and nationally. However, Derby still has the highest proportion of teenage mothers in the East Midlands with a significantly higher proportion than England (0.9% compared to 0.6%) (*Figure 49*).

Figure 49 - Percentage of delivery episodes, where the mother is aged under 18 years




Variation exists between wards in Derby, which closely reflects the level of deprivation and educational attainment. In 2020/21, Arboretum and Normanton had the highest proportion of deliveries to teenage mothers (1.9%), followed by Mackworth (1.8%) and Derwent (1.7%) (Local Health). Derbyshire performs similarly to England, with 0.6% of deliveries to mothers aged under 18 years in 2020/21. Due to small numbers, no data is available at ward-level in Derbyshire, however, at Lower Tier Local Authority (LTLA) level, the proportion of deliveries to teenage mothers was highest in Amber Valley (1.0%) and Bolsover (0.8%)[18].

This highlights a need to ensure the continued delivery of Relationship and Sex Education (RSE) within schools, particularly those located in wards or districts with high teenage pregnancy rates.

## 6.5 Teenage Pregnancy Recommendations

**Prevention Teenage Pregnancy and Supporting Young People's Sexual Health**

- Embed and strengthen a system-wide "Teenage Pregnancy Partnership" to drive a new local strategy to support the sexual health of young people including prevention of under 18 conceptions
- Align local action to national evidence base, policy and guidance including the National Teenage Pregnancy Framework
- Ensure inclusion of the voice of young people in developing action, service change and development
- Local commissioners should ensure sustainable approaches for quality Relationship and Sex Education (RSE) to all children and young people in school settings and for those not attending school
- Service design and promotion should be equitable and fair to meet the diverse access needs of young people
- Development of Sexual Health services for young people should be across a system-wide approach with service and pathway knowledge. Organisations and services may include education, children's services, NHS services including school health and general practice and voluntary and community sector organisations
- The sexual health system should ensure inclusion of organisations and services that address need of specific groups of children and young people with vulnerability and risk, including community safety and youth justice provision, sexual violence and domestic violence, young people in care and care leavers, substance misuse, prevention of child sexual exploitation risk and harmful sexual behaviour. It is vital to work closely with voluntary organisations who may specifically work with children of vulnerability
- Targeted provision should be utilised to address barriers for some young people at risk who are unwilling to access sexual health and associated services
- Ensure training and awareness is available for all staff working with children and young people to support improved sexual health outcomes
- The sexual health system should support services addressing particular challenges such as the uptake of the HPV vaccine for boys; support to teenage mothers to prevent and mitigate risk of subsequent pregnancies; working collaboratively to help address emerging risks of harm, for example sexting, behaviours, attitudes and messaging through the use of social media

## 6.6 Termination of Pregnancy

An abortion, or termination of pregnancy, is the medical process of ending a pregnancy so that it does not result in the birth of a child. The pregnancy is ended either by taking medications or having a minor surgical procedure. Most abortions are carried out because the pregnancy was unintended and whilst not all unplanned pregnancies are unwanted,

each year in the UK about one in four pregnancies ends in an abortion, with this increasing to one in two in under 18s. Abortion rates can indicate low levels of sexual education amongst young people and also lack of access to good quality contraception and abortion services.

During the pandemic, temporary measures were introduced in England, Scotland and Wales to allow both tablets for early medical abortion to be taken at home[19]. Certain conditions were required including pregnancy having not exceeded nine weeks and six days, the woman being prescribed mifepristone and misoprostol, and after a remote consultation with a clinician. In 2021 this was the most common procedure, accounting for 52% of all abortions in 2021[20].

This temporary decision was made an ongoing and permanent option in England and Wales in March 2022, commencing 30 August 2022 to coincide with the end of the temporary approval on 29 August 2022.

The Health and Care Bill received Royal Assent on 28 April 2022. Section 178 of the 2022 Act amends the Abortion Act 1967 to make early medical abortion at home (where the pregnancy has not exceeded nine weeks and six days), via telemedicine, an ongoing option in England and Wales[21].

Evidence highlights inequalities across women in terms of abortion. Women living in the most deprived areas of England were more than twice as likely to have abortions than women living in the least deprived areas[22]. Rates of repeat abortions are higher in black and black British women[23].

The national specification for Abortion Care was published in November 2022[24] endorsed by The Royal College of Obstetricians and Gynaecologists (RCOG), the Faculty for Sexual and Reproductive Healthcare (FSRH) and the Faculty of Public Health (FPH). In England, abortion care is commissioned through Integrated Care Boards (ICB) as part of the Integrated Care System (ICS). The specification is underpinned by key principles outlined by NICE[25 26]. Principles reiterate placing the patient at the heart of the service and include that services offer evidence based, cost-effective care, following core aims of:

- Improving access
- Minimising waiting times with no unnecessary delay
- Giving choice of procedure and location
- Ensuring privacy and convenience
- Reducing stigma and judgement

The specification also reiterates the importance of patient pathways and recommends that core abortion services (early medical abortion and surgical abortion up to 14 weeks' gestation) are managed across the same population footprint that is served by the nearest

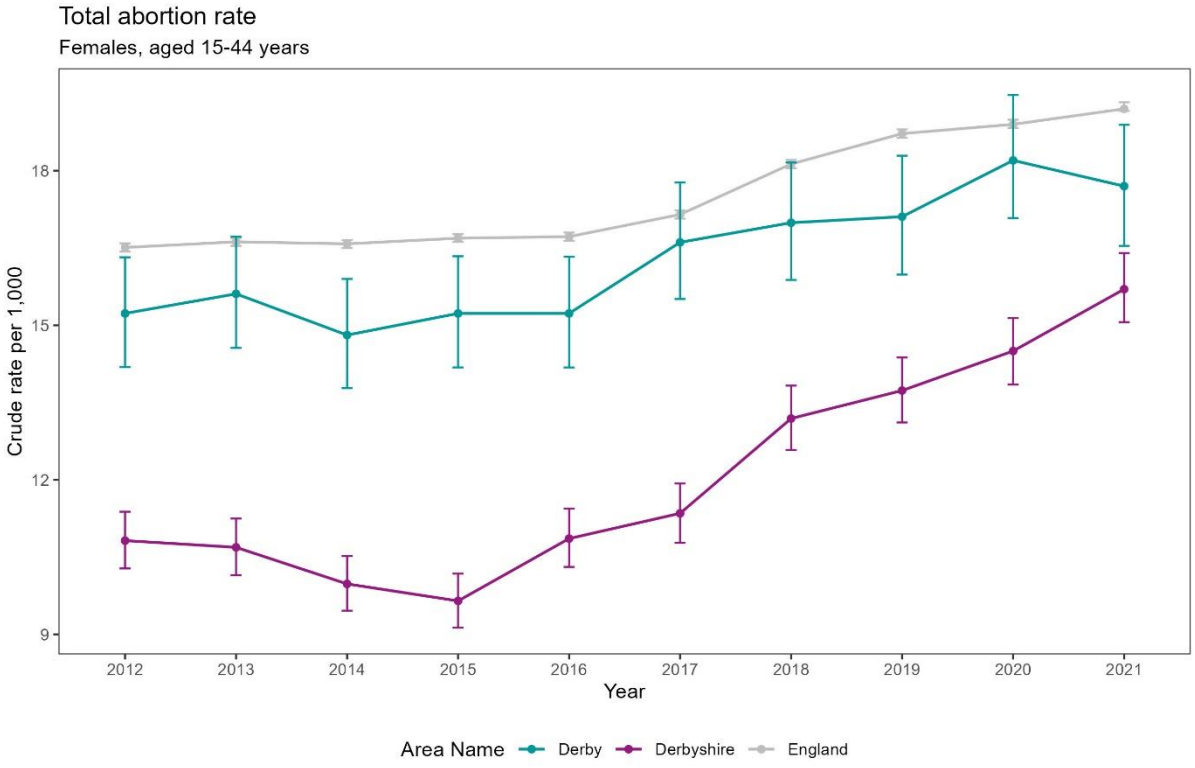
NHS Trust offering gynaecology care, with more complex care (e.g. later gestations or co-morbidities) being delivered by regional or, in the most complex cases, national centres. Historically differences in tariff for local abortion services has impacted on services provided, with some services unable to offer core parts of abortion care such as provision of oral contraceptives, availability of Chlamydia testing to high risk patients and availability of surgical services in the locality. The specification reiterates use of the National Tariff workbook with further advice where local variations are considered.

## 6.7 Abortion Rates

Research has suggested that problems accessing contraception amongst females during the COVID-19 pandemic may have led to an almost doubling in the proportion of unplanned pregnancies in the UK[27]. In addition, it is estimated that 36% of unintended pregnancies in the UK ended in abortion between 2015-19, thus any increase in the proportion of unplanned pregnancies is likely to have major implications on the demand for abortion services[28].

In 2021, the total abortion rate in Derby (17.7 per 1,000) and Derbyshire (15.7 per 1,000) was significantly lower than England (19.2 per 1,000) (*Figure 50*). There has been no significant change in this rate in Derby in recent years, while in Derbyshire, it has been increasing year on year since 2015.

Figure 50 - Crude rate of abortions per 1,000 female population aged 15-44 years

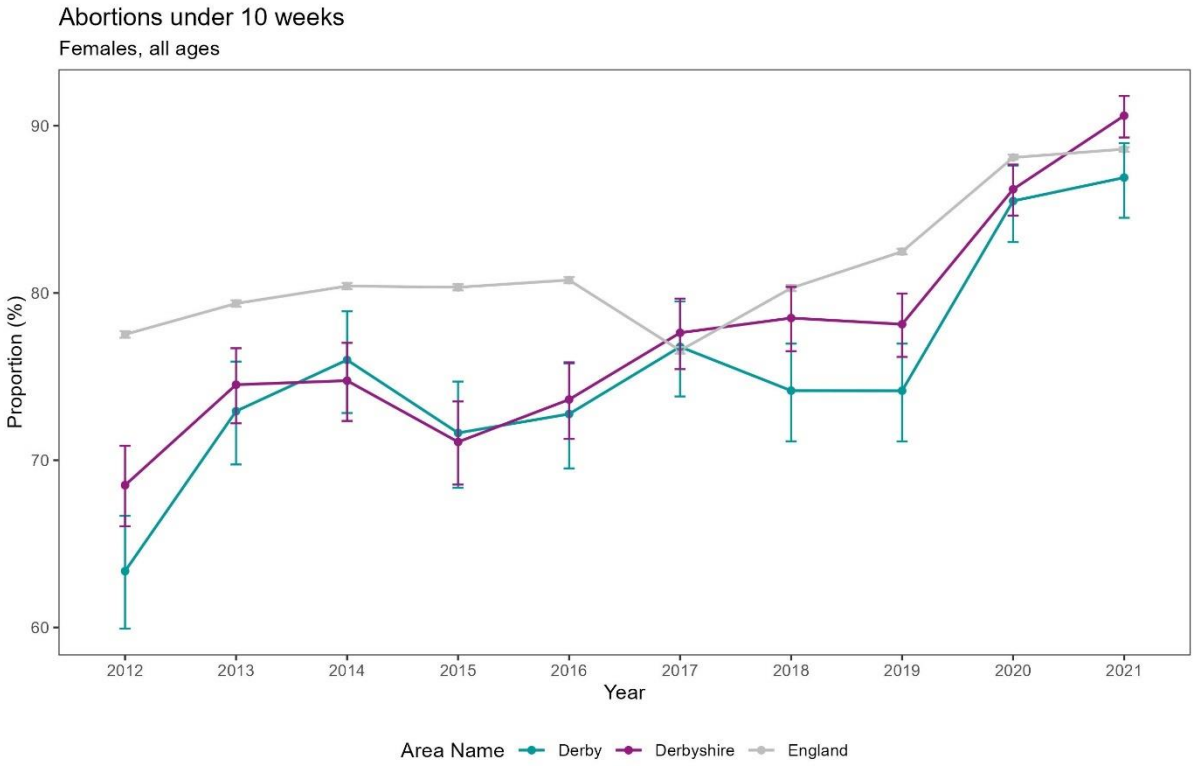


## 6.8 Late Abortions

The earlier abortions are performed the lower the risk of complications. Furthermore, any delays within the abortion pathway may limit the choice of termination method available and increase the cost of care.

Both locally and nationally, the proportion of NHS-funded abortions performed under 10 weeks gestation has been increasing and getting better in recent years. In 2021, performance for this indicator in Derby (86.9%) was similar to that seen nationally (88.6%), while Derbyshire (90.6%) performed significantly better than both Derby and England.

Figure 51 – NHS funded abortions under 10 weeks




## 6.9 Under 18s Conceptions Leading to Abortion

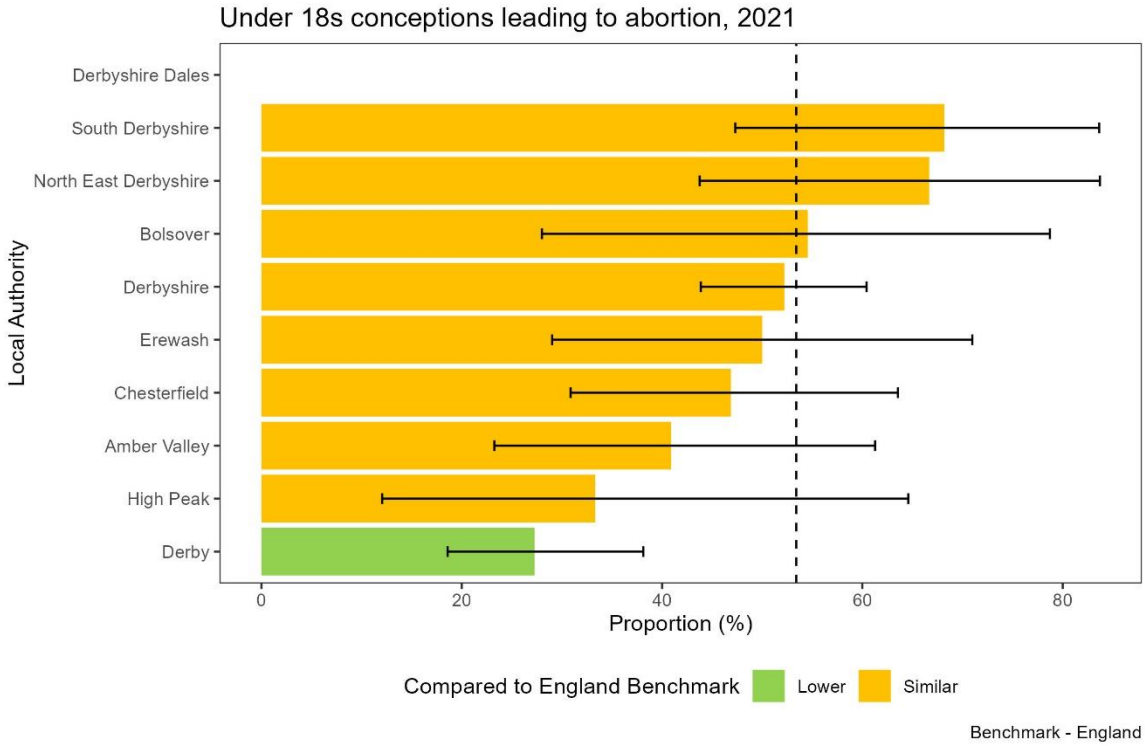
While the rate of teenage conceptions has been decreasing since 1998, the proportion ending in abortion has been steadily rising. Lower-than-average rates may indicate a higher proportion of young women choosing to continue their pregnancy to full term or may reflect barriers to accessing sexual health services.

In Derby, the proportion of under 18s conceptions leading to abortion has remained consistently lower than the national average, with the exception of 2020, where there was a large, but not statistically significant, increase from 34.8% (in 2019) to 55.2%. In 2021, 27.3% of under 18s conceptions resulted in an abortion in Derby, compared to 46.2% in the East Midlands region and 53.4% in England. This proportion in Derby was the lowest observed (out of 16) when compared against its CIPFA nearest neighbours. Abortion rates typically follow a strong social gradient, with the lowest levels in the most deprived areas, which may

partially explain the historically lower rate of under 18s terminations in Derby compared to Derbyshire and England[29].

In Derbyshire, despite an increase from 40.3% to 49.6% between 2015-20, the proportion of under 18s conceptions leading to abortion has remained similar to the national figure and its CIPFA comparator areas. In 2021, 52.2% of under 18s conceptions resulted in an abortion in Derbyshire, which ranked as the 6th lowest amongst its 16 CIPFA nearest neighbours. During this period, all districts performed similarly to the rate of 53.4% in England, with the exception of Derbyshire Dales, where there was no data available.

Figure 52 - Percentage of conceptions to those aged under 18 years that led to an abortion in 2021 by LTLA in Derby or Derbyshire




## 6.10 Under 25s Repeat 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 and previous studies have shown that service users often fail to attend family planning clinics following abortions[30]. Meanwhile, repeat abortions have also been associated with an increased risk of adverse perinatal outcomes in subsequent pregnancies[31].

High levels of repeat abortions in young people may indicate issues in access to good quality contraception services, sexual health advice or problems with individual use of contraceptive method and highlights the need to develop more effective “secondary prevention” interventions[32].

In 2021, the proportion of repeat abortions in women aged under 25 years in Derby (26.5%) was similar to that seen in England (29.7%), while performance in Derbyshire (24.9%) was significantly better. This proportion has been increasing and getting worse in recent years, although there has been no significant change observed locally.

## 6.11 Under 25s Abortion After a Birth

In 2021, the proportion of women aged under 25 years having an abortion who have previously had a birth in Derby (36.7%) and Derbyshire (33.0%) was higher than that in England (26.0%). There has been no significant change in this trend recently in Derby, while it has been increasing and getting worse in Derbyshire. This indicator was introduced to increase the awareness of postpartum contraception need locally and shows that currently around 1 in 3 females aged under 25 years having an abortion have previously had a birth, thus indicating a persistent need to provide rapid and accessible contraception.

## 6.12 Termination of Pregnancy Recommendations

**Termination of Pregnancy Recommendations**
Abortion care should include:

- Continued improvements to equitable access with minimal waiting times to prevent unnecessary delay
- Choice of procedure and location including early medical abortion
- Confidentiality, privacy and convenience
- Compliance with national standards and following evidence-based pathways to maximise delivery of safe and effective care including support post procedure
- The full range of contraception offer and provision to be available on the same day of the abortion procedure to mitigate risk of repeat abortion. Staff should provide collaborative, non-judgemental discussion with patients to support their contraception choice before they leave
- Staff and service awareness of patient's worries about attitudes to stigma around abortion
- Service providers should identify women who require more support when making an abortion decision and offer them counselling and/or promotion to local counselling support. Counselling should not delay access to an abortion

## Termination of Pregnancy - Assets/ Services Available

Local abortion services are accessible by referral through general practice and sexual health clinic and self-referral. Chesterfield Royal Hospital and University Hospital Derby and Burton are local providers.

The British Pregnancy Advisory Service (BPAS) host a Derby and Derbyshire network providing a choice of medical or surgical abortion from multiple locations and abortion pill treatment at home: https://www.bpas.org/abortion-care/abortion-treatments/the-abortion-pill/remote-treatment/

BPAS Derby and Derbyshire offering abortion care appointments on behalf of the NHS and private bookings: https://www.bpas.org/contact-us/bpas-derby-and-derbyshire/

Impartial information and support are available from an individual's GP or another in practice, the local sexual health clinic or from organisations as follows:

**Brook** offers sexual health and wellbeing support and advice for under 25s. https://www.brook.org.uk/

**British Pregnancy Advisory Service (BPAS)** abortion clinics, information, advice and treatment https://www.bpas.org/

**MSI Reproductive Choices UK** https://www.msichoices.org.uk/

**National Unplanned Pregnancy Advisory Service (NUPAS)** https://www.nupas.co.uk/

# 7. Psychosexual Health

Psychosexual Health Services generally treat the psychological aspects of sexual dysfunction. According to the World Health Organization (WHO) *"sexual dysfunction covers the various ways in which an individual is unable to participate in a sexual relationship as he or she would wish. Sexual response is a psychosomatic process and both psychological and somatic processes are usually involved in the causation of sexual dysfunction*[1]*."*

The Diagnostic and Statistical Manual of Mental Disorders, fifth addition (DSM-5) states that sexual dysfunction is "typically characterised by clinically significant disturbances in a person's ability to respond sexually or to experience sexual pleasure". The DSM-5 goes on to define sexual dysfunction disorders as having two morbidity criteria that make problems clinically significant. These are duration and symptom severity. Sexual dysfunction needs to last for a minimum of approximately 6 months, be experienced in almost all or all (75-100%) of sexual encounters and cause the individual clinically significant distress to be clinically significant. Like the WHO definition, the DSM-5 also states that sexual dysfunction is a "complex interaction among biological, sociocultural and psychological factors[2]."

Sexual dysfunction is generally conceptualised as primary, secondary, situational, or generalised[3]. However, in the UK there is no nationally agreed upon definition for sexual dysfunction or psychosexual health. Most of the literature in this area agrees that sexual dysfunction can include:

- Non-consummation (inability to permit vaginal penetration), painful sexual intercourse (dyspareunia/vaginismus), loss of sexual desire and difficulties with orgasm
- Chronic pelvic pain or genital pain, recurrent discharge with or without a physical cause
- Emotional and psychosexual aftereffects of STIs
- Erectile dysfunction, ejaculatory problems, other penile problems, and loss of sexual desire
- Contraceptive related problems which include the inability to find an acceptable method from any of those available
- Vasectomy and sterilisation requests with a hidden agenda of sexual problems
- Psychosexual problems associated with, and after, childbirth including those with dyspareunia/vaginismus requesting elective caesarean sections
- Psychosexual problems after regretted abortion, repeated requests for abortions, continuation of unplanned pregnancy, or following miscarriage
- Psychosexual problems related to infertility and ending of fertility
- Emotional and psychosexual effects of surgical interventions, chronic conditions, or terminal care
- Psychosexual after-effects of sexual abuse
- Effects of ageing, disability, or illness on sexuality

The Integrated Sexual Health Service (ISHS) commissioned by local authorities includes the provision of the sexual health aspects of psychosexual counselling.

The document 'Commissioning Sexual Health Services and Interventions' (2013) splits the commissioning of psychosexual health into sexual health and non-sexual health elements of psychosexual health, the distinction between these is not clearly defined[4].

The quality outcome listed for psychosexual health services within ISHS is that 100% of clients should be seen within 18 weeks of referral.

Physical contributors to sexual dysfunction include medical conditions, treatments for medical conditions and STIs[5]. Psychological contributors to sexual dysfunction include anxiety, depression, sexually adverse experiences and relationship problems. Social and cultural factors such as attitudes to sexual relationships and religion can also contribute[6].

There is a strong association between sexual dysfunction and risk-taking behaviours such as not using condoms[7, 8].

The prevalence of sexual dysfunction is difficult to estimate, there are limited sources of information, and this is a very sensitive topic therefore subject to bias in surveys[9]. The National Survey of Sexual Attitudes and Lifestyles conducted between 2010-2012 (known as Natsal-3) assessed sexual function. The survey found that for both men and women low sexual function was associated with increased age, and after adjustment for age, with depression and self-reported poor health status. Low sexual function was also associated with experiencing the end of a relationship, inability to talk easily about sex with a partner, and not being happy in the relationship. There were also associations with engaging in fewer than four sex acts in the past 4 weeks, having had the same sex partners, paying for sex (in men only) and higher numbers of lifetime sexual partners (in women only)[10].

According to Natsal-3, problems with sexual response are common, 41.6% of men and 51.2% of women reported one or more problems[11]. Although sexual function was associated with age, there was also a significant number of participants aged 16-21 who had one or more problems with sexual function. However, it is worth noting that not all of these individuals reported distress about their sex lives, so not all of this can necessarily be classed as 'sexual dysfunction' according to the DSM-5 definition. Taking the DSM-5 definition, approximately 4.2% of men and 3.6% of women surveyed in the Natsal-3 reported a sexual function problem that met all 3 of the morbidity criteria[12].

## 7.1 Psychosexual Health Recommendations

**Psychosexual Health Recommendations**
The South West Sexual Dysfunction Expert Advisory Group highlights that psychosexual services should be evidence based, provide access to specialist skills and treatment, and be holistic and integrated into other sexual health services.

Services should also show quantifiable outcomes, and provide co-ordinated assessment, advice and treatment.

Psychosexual services should be multidisciplinary in terms of sexual dysfunction and have clear referral pathways into other integrated sexual health services.

### Psychosexual Health - Assets/Services Available

**Relate** are subcontracted within the integrated sexual health service to provide sexual health aspects of counselling and support within the psychosexual service. Self-referrals are accepted, or you can be referred through general practice or by another health professional: https://www.yoursexualhealthmatters.org.uk/further-sexual-health-support/psychosexual-counselling

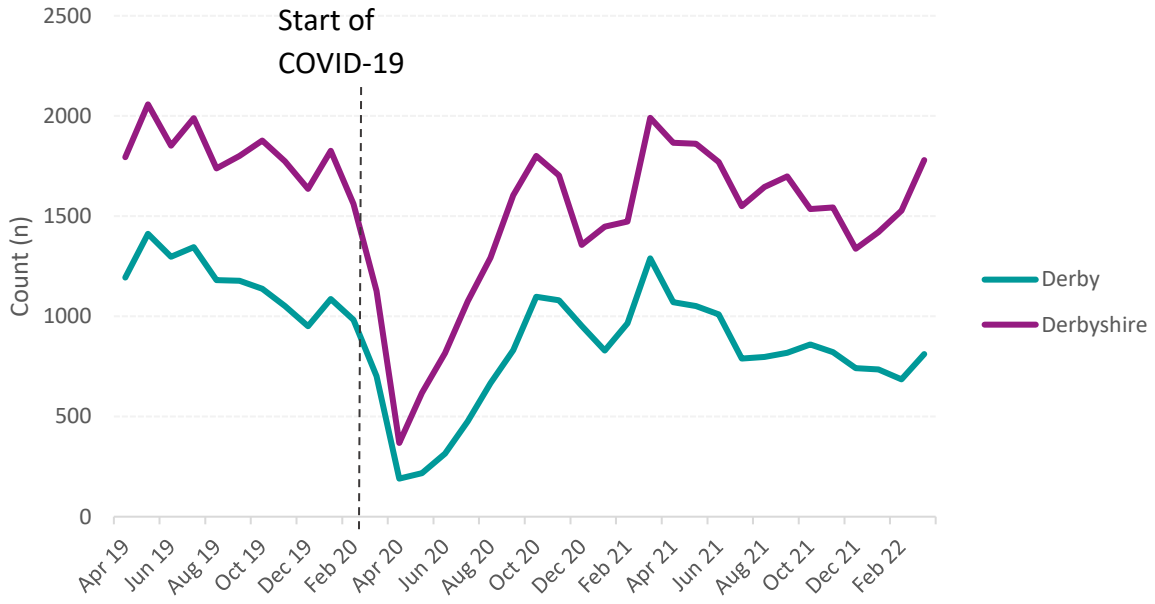
Free Relate psychosexual therapy can be accessed through **Talking Mental Health** http://www.derbyshirehealthcareft.nhs.uk/services/talking-mental-health-derbyshire

# 8. Integrated Sexual Health Service in Derby and Derbyshire

## 8.1 Service Usage

There was a large drop in the number of clinic attendances for contraception/STI-related care from March-2020 as a result of the COVID-19 pandemic (*Figure 53)*. However, the number of attendances has been trending upwards recently and is now similar to pre-pandemic levels.

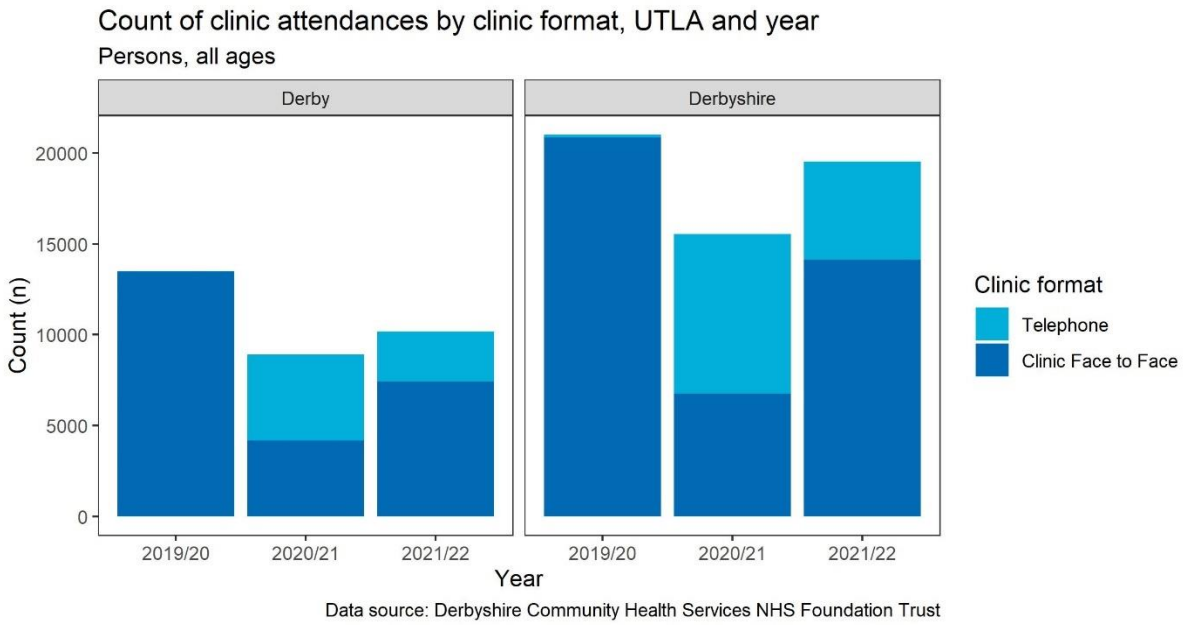
Figure 53 - Count of clinic attendances for contraception/STI-related care by attendance date




Data sourced from Derbyshire Community Health Services NHS Foundation Trust

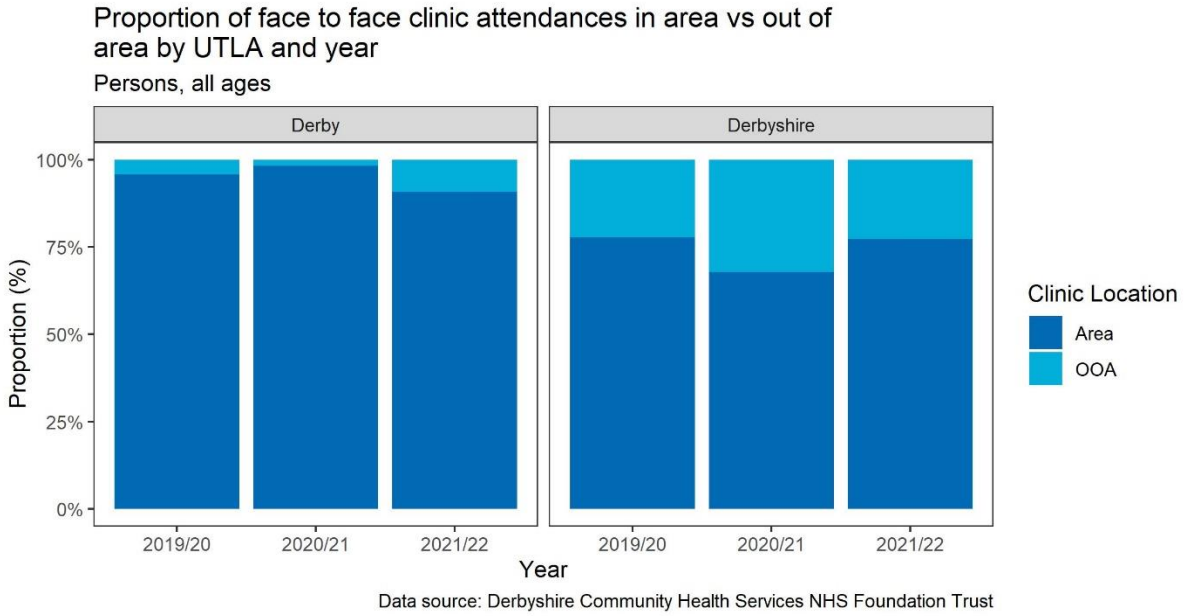
The decrease in clinic attendances observed during 2020/21 was largely driven by the reduction in the number of face-to-face appointments, despite a large increase in the number of telephone appointments (*Figure 54)*. However, data for 2021/22 shows that the increase in the number of clinic attendances is a result of an increased number of face-to-face appointments, while the proportion of telephone appointments has declined.

Figure 54 - Count of clinic attendances by clinic format, UTLA and year




There has also been a change in the proportion of contacts accessing out of area services (*Figure 55*). In Derby, the proportion of residents attending an out of area Integrated Sexual Health Service (ISHS) clinic for a face-to-face appointment for STI/contraception-related care increased from 4.2% to 9.2% between 2019/20 - 2021/22. Meanwhile, in Derbyshire, the proportion of out of area clinic attendances increased from 22.3% to 32.1% between 2019/20 – 2021/21 before decreasing to 22.8% in 2021/22.

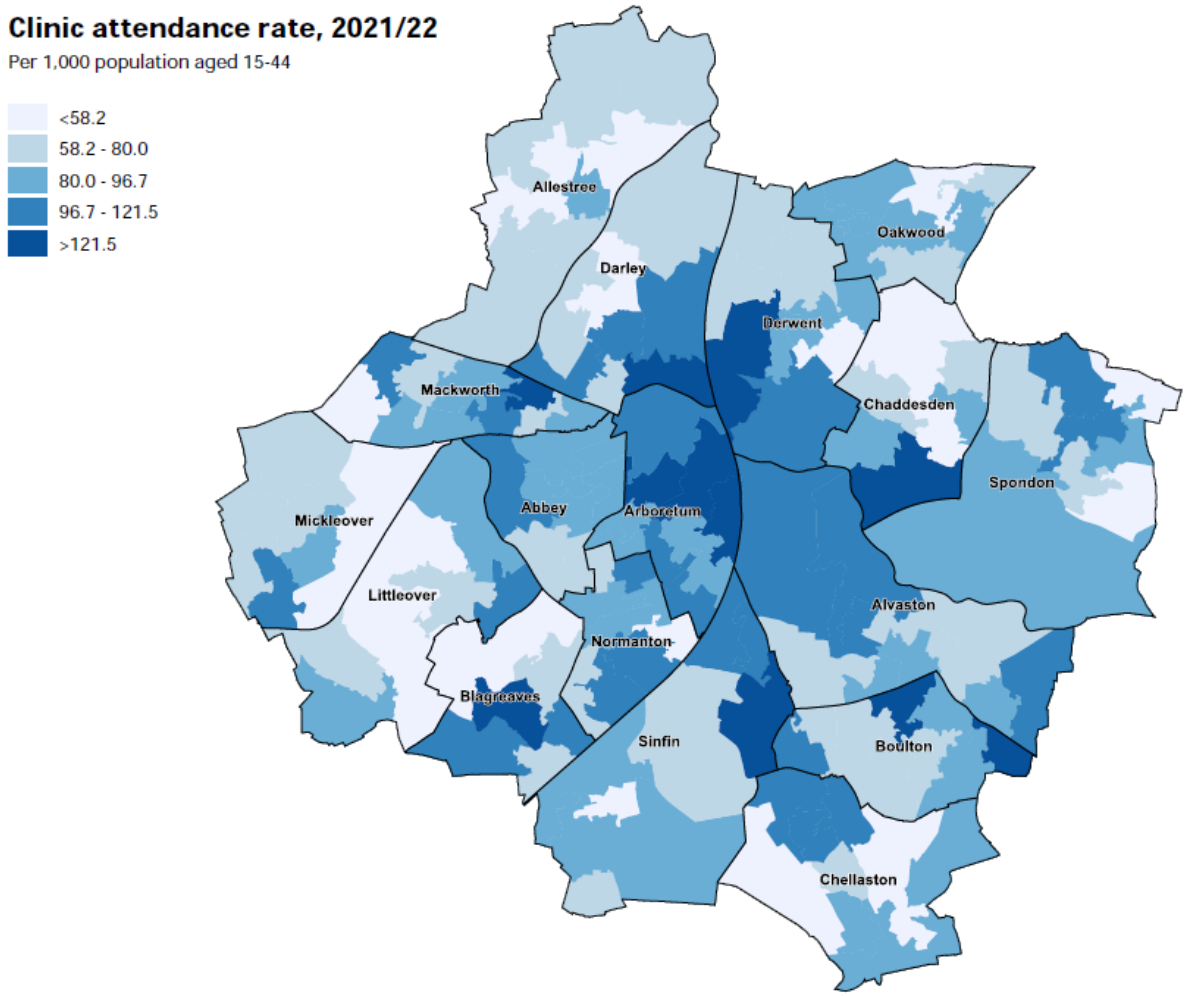
Figure 55 - Proportion of face-to-face attendances in area vs out of area at ISHS for contraception/STI-related care by Derby and Derbyshire residents (all ages) between 2019/20 – 2021/22



## 8.2 Population Attending Clinics

In Derby, the highest rates of clinic attendances during 2021/22 were observed in LSOAs located within Arboretum and Darley (*Figure 56*). These inner city wards are characterised by high-levels of deprivation, suggesting that the demand for contraception/STI-related services (amongst the population aged 15-44 years) is greatest in the most deprived areas.

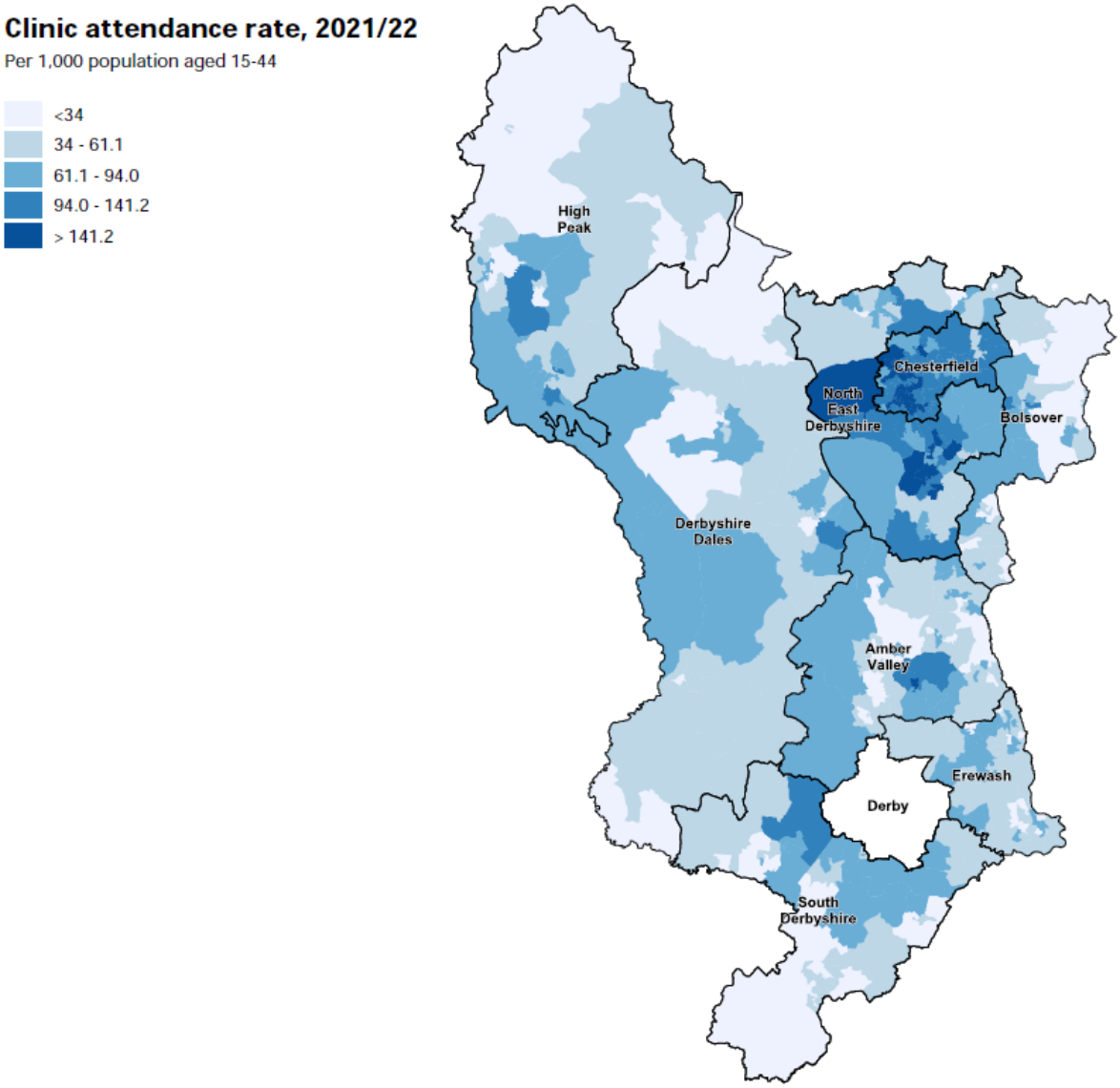
Figure 56 - Clinic attendance rate in Derby population aged 15-44 years by LSOA, 2021/22




Data sourced from Derbyshire Community Health Services NHS Foundation Trust

In Derbyshire, the greatest rate of clinic attendances during 2021/22 were seen in LSOAs located within Chesterfield and North East Derbyshire (*Figure 57)*. Similar to the observation in Derby, patterns of clinic use in Derbyshire appear to follow a social gradient, with the greatest rate of clinic attendances in the most deprived areas of the County.

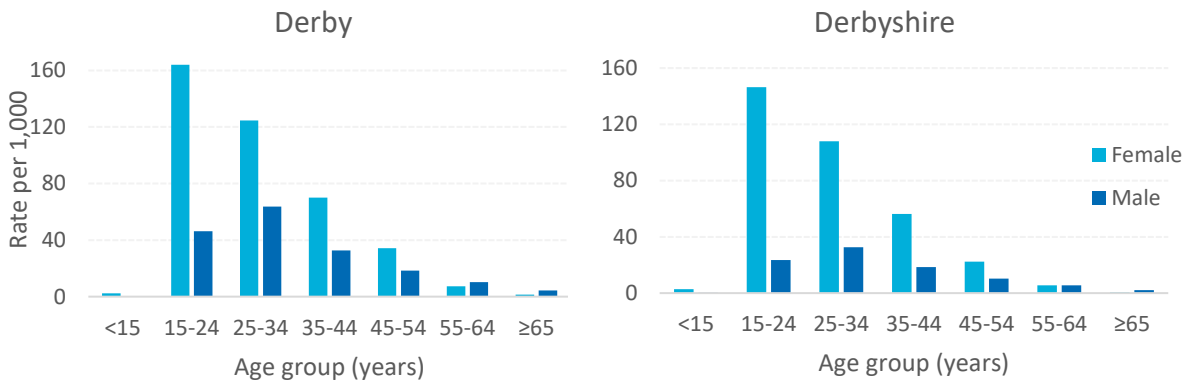
Figure 57 - Clinic attendance rate in Derbyshire population aged 15-44 years by LSOA, 2021/22




Data sourced from Derbyshire Community Health Services NHS Foundation Trust

In Derby and Derbyshire, the clinic attendance rate was greatest in females aged 15-24 years (164.0 and 146.4 attendances per 1,000), followed by the 25-34 years age-group (124.7 and 107.9 attendances per 1,000) (*Figure 58)*. Meanwhile, the greatest rate of clinic attendances in males during 2021/22 were observed in the 25-34 years age-group (63.6 and 32.7 per 1,000 in Derby and Derbyshire, respectively) followed by the 15-24 years age-group (46.2 and 23.5 per 1,000 in Derby and Derbyshire, respectively).

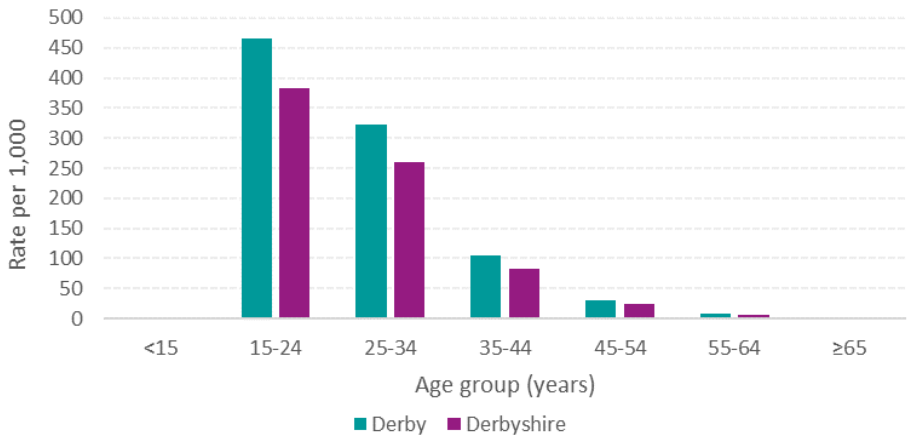
Figure 58 - Rate of population attending ISHS clinic for contraception/STI-related care by sex and age group during 2021/22




Data sourced from Derbyshire Community Health Services NHS Foundation Trust

Furthermore, the rate of requested/returned STI tests from the online service (SH24) between 2019/20 – 2021/22 was higher in Derby than Derbyshire, amongst all age-groups (*Figure 59*). The rate of requested/returned tests from SH24 appears to follow an age-related gradient, with the greatest rate of requested/returned tests in the 15-24 years age group followed by the 25-34 years age-group.

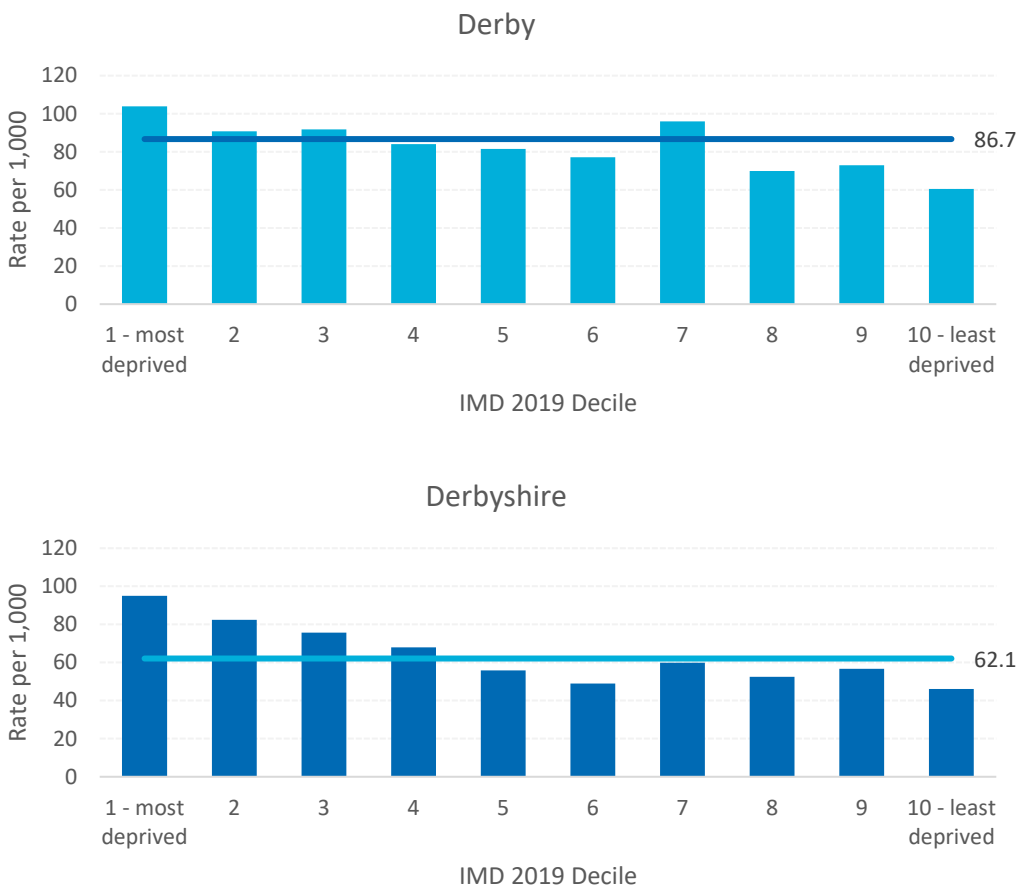
Figure 59 - Rate of SH24 requested/returned STI tests by age group and UTLA between 2019/20 - 2021/22




Data sourced from Derbyshire Community Health Services NHS Foundation Trust

In both Derby and Derbyshire, the clinic attendance rate was greatest in the population from the most deprived decile (103.9 per 1,000 in Derby and 95.1 per 1,000 in Derbyshire) and lowest in the least deprived group (60.4 per 1,000 in Derby and 46.1 per 1,000 in Derbyshire) (*Figure 60*).

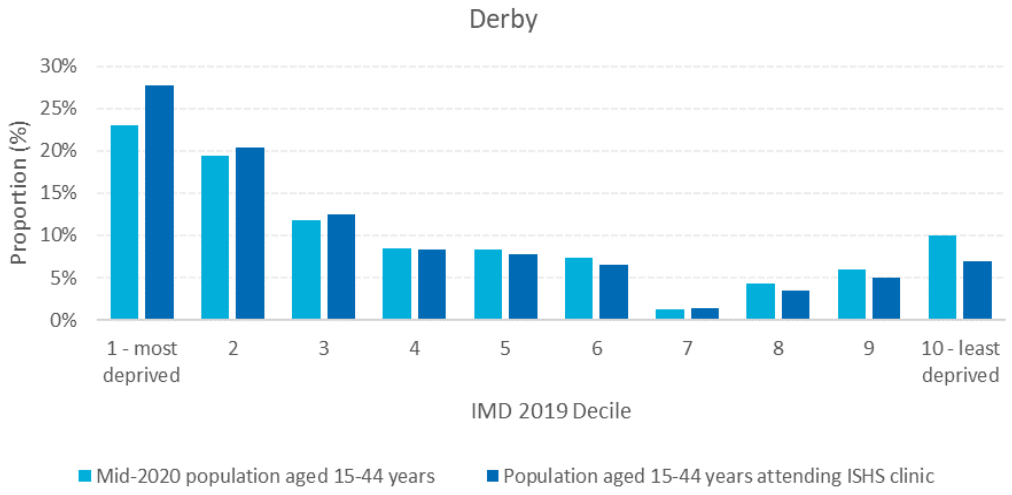
Figure 60 - Attendance rate at ISHS clinic for contraception/STI-related care in population aged 15-44 years by deprivation decile during 2021/22




Data sourced from Derbyshire Community Health Services NHS Foundation Trust

In Derby, 23.1% of the 15-44 years age-group live in IMD 1 however this population accounted for more than one quarter (27.7%; *n=2,455*) of clinic attendances during 2021/22 (*Figure 61*). In contrast, 9.9% of the population aged 15-44 years in Derby live in the least deprived decile, however this population accounted for only 6.9% *(n=615)* of clinic attendances during 2021/22. For all other deprivation deciles, the proportion of the population aged 15-44 years was similar to the proportion attending a clinic appointment.

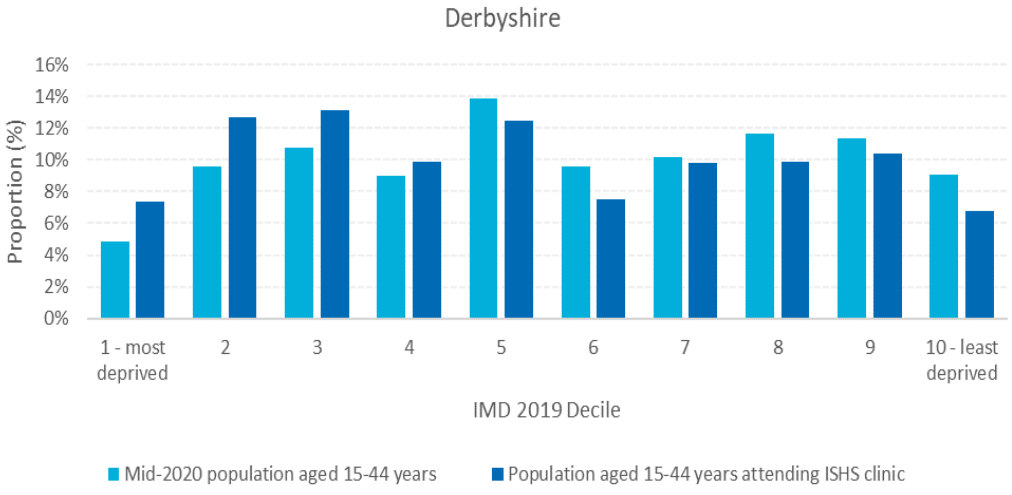
Figure 61 - Proportion of total population aged 15-44 years and population attending ISHS clinic for contraception/STI-related care aged 15-44 years by deprivation decile in Derby




Data sourced from Derbyshire Community Health Services NHS Foundation Trust

In Derbyshire, only 4.8% of the population aged 15-44 years live in the most deprived decile, however this population accounted for 7.4% *(n=1,229)* of clinic attendances during 2021/22 (*Figure 62)*. The population from the second and third most deprived deciles were similarly overrepresented in the clinic attendance data. Meanwhile, despite 9.1% of the Derbyshire population aged 15-44 years living in the least deprived decile, this population only accounted for 6.7% of clinic attendances during 2021/22.

Figure 62 - Proportion of total population aged 15-44 years and population attending ISHS clinic for contraception/STI-related care aged 15-44 years by deprivation decile in Derbyshire

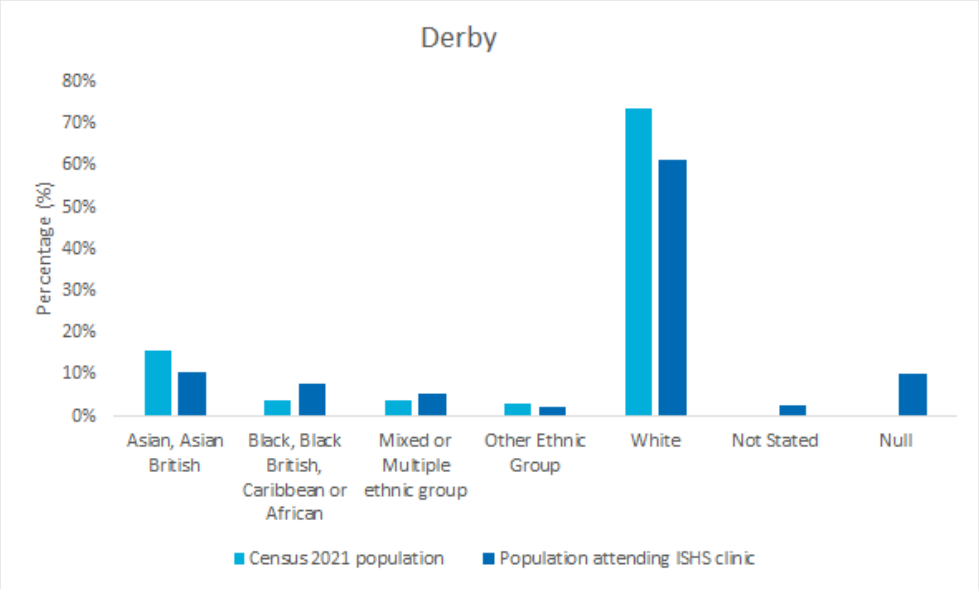



Data sourced from Derbyshire Community Health Services NHS Foundation Trust

Data on ISHS clinic attendances by ethnicity should be treated with a degree of caution, as not all records have an ethnic group assigned (either Not stated or Null), making any comparisons against underlying usual resident populations much less reliable. In Derby, 13.1% (n=1,334) of attendances in 2021/22 did not have an ethnic group assigned, and in Derbyshire County this was 4.4% (n=828). This means some ethnic groups will be under-represented as a proportion of the total.

In Derby, 73.8% of the population identified as "White" in the Census 2021, compared to 61.4% (n=6,270) of clinic attendances assigned to this ethnic group (*Figure 63*). The proportion of clinic attendances with a known high-level ethnic group of Black, Black British, Caribbean or African and Mixed or Multiple ethnic group were relatively higher.

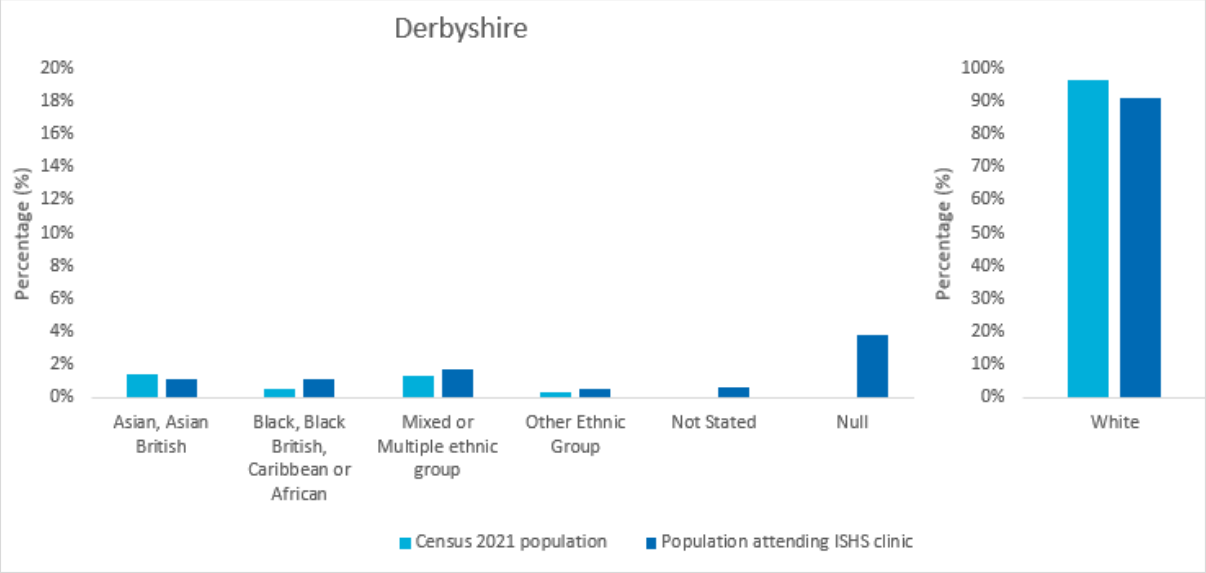
Figure 63 - Proportion of total population by high-level ethnic group Census 2021, and population attending ISHS clinic for contraception/STI-related care in Derby




Data sourced from Derbyshire Community Health Services NHS Foundation Trust

In Derbyshire, 96.3% of the population identified as "White" in the Census 2021, compared to 91.1% (n=17,689) of clinic attendances assigned to this ethnic group (*Figure 64*). The proportion of clinic attendances with a known high-level ethnic group of Black, Black British, Caribbean or African and Mixed or Multiple ethnic group were relatively higher.

Figure 64 – Proportion of total population by high-level ethnic group Census 2021, and population attending ISHS clinic for contraception/STI-related care in Derbyshire




Data sourced from Derbyshire Community Health Services NHS Foundation Trust

# 9. Felt Need: Analysis of the Outputs from the SHARP Report and the SHNA Report

This section highlights analysis from summarised findings in the SHARP and SHNA consultation projects with majority focus on the provision of the Integrated Sexual Health Service. It is recognised that throughout this work the sample size is small enough to not be statistically significant however the response rate was reasonable at 50% of those invited to participate.

The approach to completion of both the SHNA consultation and SHARP reports was based on qualitative approaches only to support and add value to the quantitative data shared in this full SHNA report. Analysis was undertaken across three main themes – Communication, Marketing and Service Delivery.

## 9.1 Communication

Participants raised various issues relative to communication about service provision. Stigma was raised but its experience differed between participants. Services need to distinguish between how stigma manifests across different audiences and consider how different communications and patient centred care can disrupt it e.g. normalising STI testing as part of regular self-care or undertaking regular inclusivity training. Consideration is advised as follows:

- Consider how staff communicate 'risk' to patients, with particular care over how HIV risk is discussed with African patients
- Give regular patient feedback to staff to acknowledge positive interactions and celebrate and reinforce what is important to patients
- Continue to engage and inform primary care leaders and staff about local services so that they can give accurate information to patients
- Revisit how information and updates from the team can help support up-to-date knowledge for GPs. Insight suggests that this is specifically needed for both trans sexual health and HIV updates
- Where appropriate, the service should highlight the use of self-sampling as a way of reducing embarrassment and a less stressful clinic experience
- Update future and current patients about waiting times. This should be on the information and booking telephone line, during clinics and on the website.
- On the YSHM website, add a single page with clinic timetable information (or drop-down filters) to improve search functionality to allow people to select by date and evening opening hours
- On the YSHM website, clarify the age eligibility information on the 'Condoms by post' page
- On the YSHM website, include testimony and video of people from communities of identity so that it is more representative of 'people like me'

## 9.2 Marketing

Findings proposed consideration of the following:

- Strengthen marketing and promotion of the condoms by post scheme to older adults
- Strengthen marketing and promotion of the SH:24 service, particularly the full range of services other than STI testing and time to test
- Strengthen marketing and promotion of PrEP using social marketing approaches that segment and target different audiences with messages and campaigns that resonate for them
- Communications teams should make sure that search optimisation is a top priority to ensure top placement of the YSHM website
- Sexual health promotion for older audiences should be considered, including how to talk to younger relatives
- Update future and current patients about waiting times. This should be on the information and booking telephone line, during clinics and on the website.
- On the YSHM website, add a single page with clinic timetable information (or drop-down filters) to improve search functionality to allow people to select by date and evening opening hours.
- On the YSHM website, clarify the age eligibility information on the 'Condoms by post' page.
- On the YSHM website, include testimony and video of people from communities of identity so that it is more representative of 'people like me'.

## 9.3 Service Delivery

Although there was no general preference for appointment-based services, there were some communities who preferred them. Recognising that effective appointment systems and staff resource are also significant considerations, it is recommended that services 'check-in' with those communities who have expressed a need for walk-in options on a regular basis.

- Outreach is valued and this should continue to be part of a service model
- Use of peer-to-peer approaches should be considered, particularly with trans and non-binary communities
- Where staffing capacity and rostering allows, staff should be encouraged to build up a longer-term presence within the same clinic
- Explore how confidentiality can be strengthened in clinic spaces by promoting them as 'confidential spaces' where patients also have a role to play
- Explore other types of blood testing within home kits
- Revisit the appointment priority for 'positive' contacts
- There are pressures around LARC (Coil) appointments across primary care and within service. Consider how primary care can be supported and remunerated

- Make sure that staff take advantage of 'teachable moments' to raise the topic of monkeypox within appointments
- Opportunities to integrate sexual health services within other organisations should be explored as they are a valued service approach by some target communities. Young people and users of drug and alcohol misuse services are particularly positive about this
- Explore the option of a trans and non-binary clinic at one of the clinic hubs
- Equip staff with information about fertility issues for trans and non-binary patients
- Explore extending the supply of PrEP to 6-months for patients with an appropriate system of postal testing at 3-months
- Pilot use of QR codes to access patient information in clinical spaces
- Review the approaches to targeting older MSM and gay and bisexual men including use of online dating apps
- Use social marketing approaches to target PrEP
- Especially with patients who belong to communities of identity, engage and involve them in service planning

## 9.4 Felt Need Recommendations

Recommendations are presented in seven categories:

1. In-person Delivery
2. Online and Digital Offer
3. Staffing
4. Vulnerable and At-risk Groups
5. Young People
6. Promotion of Services
7. Communication and Partnership Working

These too can be themed in the same way as the responses from patients and residents.

### Communication

- Raise awareness of SH:24 service across all stakeholders, including what is available, for whom and how it is accessed. This means that they can provide information about this to more people who could benefit from accessing this service offer. This could be in the form of a video, PDFs and/or emails to stakeholders. The resources provided should be suitable for staff training and may be uploaded on to staff intranet/online portals
- More promotion of SH:24 to the general public, with a particular focus on more vulnerable and access groups. This could include at venues such as cafes, pubs and night clubs, colleges and universities, gyms and leisure centres, plus through social media. Set a KPI on awareness levels of SH:24 as a measure of success
- Encourage stakeholders to promote SH:24 as part of conversations with patients/service users. This could include all conversations with young people and anyone with an appointment connected to sexual health. Provide leaflets that could be given out and a QR code that could be shared during appointments

- Review which services are currently invited to be part of the Sexual Health Alliance and who is missing from these conversations, identifying potential gaps in stakeholders who would benefit from attending, for example primary care and pharmacies
- Improved communication across all partners involved in the delivery and promotion of sexual health services. Carry out further research into the best format for this, such as a monthly e-newsletter, and what information to include
- Use a third party to facilitate a small number of Sexual Health Alliance meetings on key topics, in order to provide greater focus on key topics, structure to meetings and encourage greater commitment to actions. These could be in addition to the current schedule and involve inviting more partners to be part of the conversation

### Marketing

- Further promotion of SH:24, including raising awareness of all parts of the service
- Consider redistribution of funding for testing and contraception from other services towards greater investment in SH:24
- Research with users of sexual health services about how they would prefer to access them - whether face to face or online or by telephone. This will enable more informed decision making about the most appropriate way of providing services. This includes the most effective way of using digital and telephone for triage
- Review service specification for community pharmacy to explore adding digital and telephone services to the offer

### Service Delivery

- Provision of sexual health clinics at a wider range of times, including weekday evenings and at weekends
- Improve access to appointments for people in smaller towns or rural areas of Derbyshire, accessing existing community assets for regular clinics
- Re-instatement of regular drop-in sexual health clinics and at appropriate times for people who need to attend without prior appointment
- Review the feasibility of providing access to more services through community pharmacy, including STI testing and treatment, contraceptives and vaccinations
- Targeted work to improve access to long-acting reversible contraceptives, in particular coil fittings, through primary care and/or other services
- Review policies around parents of young children being able to bring them to appointments, addressing challenges people have finding childcare in order to attend
- Review how people can access appointments at sexual health clinics, both in person and telephone or online, including the feasibility of making appointments online and/or requests for appointments online
- Targeted recruitment of more sexual health nurses to address the current shortage of these professionals, with consideration for succession planning
- Closer partnership working to find solutions to address gaps in service provision at primary care caused by staffing issues

### Supplementary Activities

Some of the comments lend themselves to additional supplementary activity across the patch and these are summarised here by specific group.

### Vulnerable and At-risk Groups

- Increased outreach work within communities, including more partnership working with the voluntary sector, who may already reach targeted vulnerable and at-risk risk groups and be more trusted. Provide training and support for voluntary organisation to raise awareness of issues related to sexual health and how people can access services, including both SH:24 and in-person services
- More research into where inequalities of access to services by vulnerable and at-risk groups are, to inform strategies for better reaching people in greatest need of support in managing their sexual health
- Provision of resources in more languages and review availability of interpreters for in-person appointments
- At existing sexual health clinics, re-introduce drop-in services that people can access without appointments, on days/at times when people are most likely to need help. This includes days/times suitable for young people in education
- Explore how barriers to accessing digital and remote services for under 16s can be removed, addressing the issue of under 16s being ineligible to use SH:24

### Young People

- Explore how digital and remote services could be accessed by under 16s, who are currently ineligible to use SH:24
- Within schools, raise the agenda of education around sexual health so young people are better able to make informed choices. Increase the number of schools where the C-Card Scheme is promoted and provided
- Explore how to improve access to in person sexual health appointments, including raising awareness of what is available and making it easier for young people to book appointments
- Review the services provided by school nurses and explore expanding what can be offered, such as emergency contraception
- Strategy for how to reach young people who are not in mainstream education, including who are home schooled or do not attend school

### Promotion of SH:24 Service

- Raise awareness of SH:24 service across all stakeholders, including what is available, for whom and how it is accessed. This means that they can provide information about this to more people who could benefit from accessing this service offer. This could be in the form of a video, PDFs and/or emails to stakeholders. The resources provided should be suitable for staff training and may be uploaded on to staff intranet/online portals

- More promotion of SH:24 to the general public, with a particular focus on more vulnerable and difficult to access groups. This could include at venues such as cafes, community venues, pubs and night clubs, colleges and universities, gyms and leisure centres, plus through social media. Set a KPI on awareness levels of SH:24 as a measure of success
- Encourage stakeholders to promote SH:24 as part of conversations with patients/service users. This could include all conversations with young people and anyone with an appointment connected to sexual health. Provide leaflets that could be given out and a QR code that could be shared during appointments

### Themes for a Further Stakeholder Survey

It is advised that further consultation across some of the themes identified would be useful including:

- Exploration of ISHS clinic days and times to expand the service offer
- Impact of measuring performance of sexual health services using KPIs around maximising capacity. Findings of this research suggest that services are not offering drop-ins because this reduces capacity, which is at the expense of having a service that is accessible by vulnerable people who may require the availability of drop-in appointments
- A key issue identified is a lack of availability of services geographically across the whole of Derbyshire. This could potentially be at least partially addressed by provision of more services through community pharmacy. Recommend exploring this as a means of providing services in more locations. This could include STI testing and treatment, contraceptives and vaccinations
- Explore how people value and rate the Sexual Health Alliance meetings. Including:
  - Are the right people in attendance? Who may be missing who should be there?
  - How useful are the meetings in creating action and driving change?
  - What else would people like to see as outcomes from the meetings?
  - What particular themes should be addressed at the meetings?
  - Setting annual goals for what the Sexual Health Alliance achieves year to year. What should they be and how could they be measured?
- How would partners like receive information about what other stakeholders are doing and what would be most useful for them to know to improve the services they offer?
- Would additional shared training be welcome across City and County; GP and SH staff and, VCSE organisations and Statutory services? Evidence shows that where carefully crafted non-threatening training is offered and supported by leaders it encourages future partnership working

# 10. Impact of External Factors

## 10.1 Wider Determinants of Sexual Health

The Sexual and Reproductive Health Profile in the Public Health Outcomes Framework also includes several indicators which are suggested to act as 'wider determinants' of sexual health outcomes, particularly in relation to teenage conceptions. Data for these wider determinants are shown in *Figure 65.*

Figure 65 - Wider determinants of sexual health

| Indicator Name | Derby | | Derbyshire | | England |
|---|---|---|---|---|---|
| IMD Score (2019) | 26.3 | | 18.4 | | 21.7 |
| Admission episodes for alcohol-specific conditions in under 18s (rate / 100,000) (2018/19 - 20/21) | 13.9 | Better | 35.7 | Worse | 29.3 |
| Average Attainment 8 score (2020/21) | 46.1 | Worse | 49.9 | Worse | 50.9 |
| Children under 16 years in relative low income families (%) (2020/21) | 22.2 | Worse | 13.4 | Better | 18.5 |
| First time entrants to the youth justice system (rate / 100,000) (2021) | 248.9 | Worse | 95.3 | Better | 146.9 |
| Pupil absence (%) (2020/21) | 4.8 | Similar | 4.2 | Better | 4.6 |
| Violent crime - sexual offences (rate / 1,000 population) (2021/22) | 4.6 | Worse | 2.5 | Better | 3.0 |

Compared to England: Better Similar Worse

Source: Office for Health Improvement & Disparities. Public Health Profiles. Crown copyright 2022

Derby is characterised by higher levels of deprivation than both Derbyshire and England, and in 2020/21, it was estimated that 22.2% of children aged under 16 years were living in relative low-income families, compared to 13.4% in Derbyshire and 18.5% nationally. Children in Derby also have lower educational attainment and higher rates of first-time entrants to the youth justice system than England, while pupil absence rates are similar to the national figure. Derbyshire also has lower levels of educational attainment compared to England, while the rate of first-time entrants to the youth justice system and rates of pupil absence are better than nationally.

In 2021/22, the crude rate of 4.6 sexual offences per 1,000 population in Derby was significantly higher than the rates of 2.5 and 3.0 in Derbyshire and England, respectively. Although, it is worth noting that the majority of sexual offences are hidden crimes, with only around 16% of offences estimated to be reported to the police[1]. Therefore, these figures are likely to significantly underestimate the prevalence of sexual assault.

Previous research has linked alcohol misuse with condomless sex and an increased number of sexual partners, while alcohol-related hospital admissions have been associated with increased rates of teenage pregnancy and common STIs[2]. Alcohol-specific hospital admissions in under 18s were significantly higher in Derbyshire at a rate of 35.7 admissions per 100,000 compared to 13.9 in Derby and 29.3 per 100,000 in England.

## 10.2 COVID-19

A pandemic is generally defined as a widespread occurrence of an infectious disease over a wide geographical area, country, or the world at a particular time. COVID-19, a respiratory syndrome coronavirus 2 (SARS-CoV-2) was declared a worldwide pandemic on 11th March 2020. Two years on, the World Health Organization (WHO) continues to declare this ongoing pandemic as a 'Public Health Emergency of International Concern' (PHEIC).

The initial impact of the pandemic was profound, with the UK plunging in and out of national and regional 'lockdowns'; legal restrictions which limited people's movement through social and physical distancing measures, to reduce the transmission of the virus, where self-testing and mask wearing became the norm and sometime after mass vaccination was introduced. During these periods, many services limited face-to-face interaction resulting in disruptions in reproductive health services such as prenatal and postnatal care, childbirth and abortion services, contraception availability, and the management of sexually transmitted infections[3], which may suggest implication for unplanned pregnancies, later STI/HIV diagnosis and reduced support for sexual assault and domestic violence.

### Summary of Service Changes

The prioritisation of the COVID-19 response meant that some capacity in some sexual health services was diverted. However, it became evident that some services were able to continue to provide a full range of services, whilst others had to reduce theirs, prompting the Faculty of Sexual and Reproductive Healthcare (FRSH) to issue a range of guidance documents[4] to ensure equitable provision, which included highlighting those most at risk of unplanned pregnancy - most notably:

- To ensure a mix of modalities of consultations is available, including face-to face, to ensure they meet the needs of all patients: e.g. those with a language barrier, data, poverty, or internet illiteracy
- Telemedicine for abortion care should be maintained
- Remote/electronic prescribing for contraception and Hormone Replacement Therapy (HRT) should be maintained, as well as dispense/click and collect systems for medication or delivery of medication by post
- Online contraception provision should be maintained/developed
- Patients should be provided with links to online resources

In addition, during the height of the pandemic, the FRSH Clinical Effectiveness Unit, supported the extended use of LARC (beyond their relevant recommended expiry dates). The implementation of the mass vaccination programme has meant that this advice was later retracted in November 2021.

In the case of abortion services, in March 2020, the health secretary approved two temporary measures[5] to allow women to access early medical abortion (under 10 weeks).

These are two tablets to be taken at home, providing certain conditions were met. This provision has since been made permanent in England and Wales.

Many sexual health services 'scaled up' their online service offer during the pandemic, following the implementation of a national e-sexual and reproductive framework[6]. This facilitated a more comprehensive offer of online testing for sexually transmitted infections, HIV, and emergency contraception. Locally, we were already fortunate to have a comprehensive online offer in place, which was further boosted during this period to include condoms and oral contraception by post.

### Impact

Sexual activity at a population level appears largely unaffected by the COVID-19 restrictions, at least initially, a marked impact on chlamydia, gonorrhoea and syphilis tests and diagnoses, as seen in other high-income countries[7, 8, 9]. Diagnoses rates were highly related to testing rates in 2020, 'reflecting how most of the British population are in cohabiting relationships[10]'.

The UK National Survey of Sexual Attitude and Lifestyle (NATSAL) is one of the largest and most comprehensive surveys of sexual behaviour, providing much needed insight on which to build policy and practice. The Natsal-COVID study[11] (18-44 sexually active) sample found:

- Around 1 in 5 people reported using SRH services in the four months after lockdown: most common in young people and those with higher risk behaviour
- 1:10 men and 1:30 women reported a new sexual partner
- Of those in steady relationships 78% reported that their quality of sex life was worse
- 11% reported sexual difficulties
- 18% men and 6% women who had sex since lockdown reported needing, but being unable to access condoms
- In all age groups women reported a higher need for use of SRH services
- 1:10 men and 1:5 women required SHS services in the past year, 10% of which reported difficulty in accessing services, whilst 3% reported needing services, but had not tried to access them
- 10% women (including trans women) reported using services for cervical screening, compared to previous year of 18%
- 16% reported unplanned pregnancies, compared to 4% of NATSAL 3 survey
- 9% reported a termination of pregnancy, compared to 12% in NATSAL 3
- Substantial use of online and telephone STI-services, but video consultations were less common, however, there may still be an unmet need for those unable or unwilling to use online services

Statistics from the UK Health Security Agency[12], showed a reduction in STIs in the East Midlands between 2019 and 2020 which most likely is a result of the combination of reduced testing due to service disruption and changes in behaviour, however there was a

large number of diagnosis made in 2020, which is suggested as clear evidence of sustained STI transmission; further supported by evidence from community surveys such as NATSAL, that although fewer people reported meeting new sex partners during 2020 compared to previous years, a substantial proportion still had an ongoing risk for STIs (for example, condomless sex with new sex partners) during 2020, alternatively, this could be an artefact related to changes in testing practices, such that partners and symptomatic cases were more likely to be tested, during the COVID-19 pandemic[13]. STIs continue to show geographic and socioeconomic variation and disproportionately impact GBMSM, people of Black Caribbean ethnicity, and young people aged 15 to 24 years.

It is likely that some women may have experienced a delay or denial of abortion care to women with COVID-19 symptoms, or living with those who had them, and decreased availability of surgical abortion, during the lockdown period.

It should be noted that lockdown restrictions may have meant a delay to sexual debut for some young people. Coupled with lockdown limiting young people's access to relationship and sex education delivered through schools, community organisations and peer discussion, it is plausible that this cohort may be more vulnerable to adverse circumstances when they do experience sexual debut, with implications for their subsequent sexual well-being[14].

## 10.3 Monkeypox

Mpox is a zoonotic viral infection (a virus transmitted from animals to humans), similar in presentation to the Smallpox virus, occurring mostly in West and Central Africa, with some imported cases being seen periodically in the UK. Symptoms may start 5 to 21 days after exposure and can include:

- A blistering rash that usually starts 1 to 5 days after other symptoms – the rash may start on the face or in the genital area and may spread to other parts of the body
- Inflammation of the rectum (proctitis) – for example pain or bleeding from your back passage
- High temperature (fever)
- Headache
- Flu-like symptoms, including muscle and back aches, shivering and tiredness
- Swollen glands that feel like new lumps (in the neck, armpits, or groin)
- The skin lesions (pox) go through 4 phases:
    - Flat spots
    - Raised spots
    - Blisters
    - Healing by scabbing or crusting over

Mpox is considered a self-limiting infection, usually resolving itself in 2-4 weeks, however, some people can become seriously ill and in some cases it can be fatal. Whilst Mpox is not a

sexually transmitted infection in of itself, it is transmitted by close contact with an infected person, including sexual contact.

A vaccine became available for Mpox during 2022 with the nationwide Mpox outbreak vaccination programme due to come to a close on 31 July 2023. Vaccination was administered through ISHS and primary care to eligible populations such as GBMSM, to contacts of cases diagnosed with Mpox, and to health professionals who may come in close contact with people at risk.

Due to the low numbers diagnosed in the East Midlands region, and with both Derby and Derbyshire reflecting this, there has been limited impact on the delivery of local sexual health services.

The current position reported by the UK Health Security Agency (UKHSA), is a continued vaccine offer available in London based on risk, primarily in interconnected sexual networks of gay, bisexual, or other men who have sex with men and a small number of cases (<20) diagnosed in London in recent weeks (June 2023).[15]

# 11. Sexual Health Promotion

Sexual health promotion is a vital area of service provision towards improved health outcomes. It addresses aspects such as support to self-management of one's sexual health, support towards healthy and safer behaviours and lifestyle choices and enables targeted approaches working with individuals and groups at higher risk of poor sexual health outcomes. Sexual Health Promotion places a key focus on prevention, and this can enable a system-wide delivery working alongside multiple providers of sexual health services to ensure improved outcomes.

Interventions to change behaviour, such as the promotion of good sexual health practices, can take place on an individual level, household level, community level, or at population level. Individual level interventions might be discussing contraception, including Long-acting reversible contraception (LARC), with a woman requesting abortion services. Examples of population level interventions include national policies or campaigns that address underlying social, environmental, and economic conditions that affect sexual health, for example campaigns to destigmatise HIV and HIV testing. Interventions will include policy, education or communication, technology, and resources[1, 2].

Sexual health promotion focuses on key sexual health indicators, through the Public Health Outcomes Framework. However, there are a number of factors that can influence sexual health behaviour including personal beliefs, personal perception of risk, social norms, peer pressure, self-esteem and confidence, past behaviour, relationships within families, stigma and discrimination, behavioural willingness, informants and religion[3]. Therefore, sexual health promotion interventions need to cover individual behaviour alongside a wide range of social and environmental interventions.

Sexual health promotion activities should promote an open and honest culture, addressing and challenging stigma and discrimination, alongside signposting to clinical care and providing information[4]. There is evidence that preventative interventions that are based on behavioural change theories are effective in promoting sexual health. These interventions draw on a robust evidence base, promoting individual responsibility, with focus on motivating the individual to change and 'nudge' people into healthier choices.

As part of this wide-ranging approach, sexual health promotion should work closely with related areas like drug and alcohol use, children's and young people services, and mental health services. Key groups for sexual health interventions include women who suffer domestic abuse and sexual assault, children at risk of sexual exploitation and groups where drug and alcohol use are associated with sexual risk-taking behaviour. Working with partners across related services will allow a holistic approach with better access to at risk-groups[5]. Making Every Contact Count (MECC) and the Quality Conversations programme are examples of behaviour change strategy. Both behaviour change interventions can enable multiple organisations to support sexual health promotion outcomes.

There is evidence that alcohol-attributable hospital admissions is associated with teenage pregnancy, therefore advice on alcohol from sexual health services can help to lower the risk of sexual health harm associated with drinking[6].

Sexual health promotion focuses on groups at high risk including young people, men who have sex with men (MSM), black and minority ethnic populations and women of childbearing age, who all bear a large burden of poor reproductive and sexual health. Evidence suggests the need for inclusivity to support better outcomes through perhaps co-production with individuals and groups of high risk.

A life course approach for sexual health promotion intervention is also recommended in the national strategy[7]. For example, children and young people should receive good quality Relationship and Sex Education (RSE), evidenced as an important part of ensuring that children and young people gain knowledge, understanding and skills to manage healthy and safe relationships as they grow up[8]. RSE is now a mandatory element of the school curriculum as stated in The Relationships Education, Relationships and Sex Education and Health Education (England) Regulations 2019 under sections 34 and 35 of the Children and Social work Act 2017[9]. Further detail is found in Section 14.

Sexual health promotion is key in working age adults and including focus on at risk population groups. For older people, there should be an understanding of the sexual health risks that can affect individuals at any age; but also an understanding of issues that may be more likely to affect older people. Erectile dysfunction is associated with cardiovascular disease, diabetes and high blood pressure. Sexual health services and cardiovascular services should take this into account[10].

## 11.1 Sexual Health Promotion Recommendations

**Sexual Health Promotion Recommendations**
Sexual health promotion provision should be underpinned by evidence based behaviour change approaches e.g. MECC and Quality Conversations. With individuals and groups, this may include goals and planning; feedback and monitoring and using social support.

Training for staff in the use of brief interventions should be offered to maximise sexual health promotion support for individuals. This might include sexual health discussion within Drug and Alcohol services.

Sexual health promotion interventions should take into account the different social, cultural and economic context of the individual or group that is being targeted. The same intervention may have differing impacts on different individuals and groups due to their diversity of context. Utilising approaches such as co-production is recommended in the design and development of sexual health promotion interventions, communications and marketing and campaigns.

A life course model is recommended working through a system-wide approach to ensure opportunity to maximise sexual health promotion intervention is achieved.

Sexual health promotion should also be targeted in terms of reach to individuals and groups at higher risk.

### Sexual Health Promotion - Assets/Services Available

**Derby Integrated Sexual Health Service (ISHS)** is provided by Derbyshire Community Health Service NHS Foundation Trust (DCHS) as the lead provider working with general practice, pharmacy, a digital provider and voluntary sector partners. Sexual Health Promotion services are provided including communications and marketing of services; outreach services and including a mobile outreach bus, subcontracted services working with voluntary sector providers. Website: https://www.yoursexualhealthmatters.org.uk/

**Derbyshire LGBT+** is a voluntary organisation working with individuals and groups who identify as LGBT. Support is offered to adults and young people across general health and wellbeing as well as sexual health. https://www.derbyshirelgbt.org.uk/sexualhealth

**Well for Life Community Health Hub** is a charity based in Derby whose aims are to promote the physical, emotional and mental health of people living with or affected by HIV in Derby and Derbyshire. https://www.wflderby.org/

**Women's Work** is a charity working across Derby and Derbyshire offering support to vulnerable women and families, Sexual Health outreach services are offered.
Free, confidential support: 01332 242525, https://www.womens-work.org.uk/projects/sexual-health-outreach/

**Sexwise** is a national website with advice on sexual health and support to locate services near you: https://www.sexwise.org.uk/

**National Helpline for Sexual Health:** FREE on 0300 123 7123, Monday to Friday, 9am to 8pm, Saturday and Sunday, 11am to 4pm.

**THT (Terrence Higgins Trust)** offers advice and information about HIV, other sexually transmitted infections and how to maintain good sexual health. Resources for people living with HIV and those newly diagnosed.
Freephone telephone number: THT Direct on 0808 802 1221 for support, advice and information or email info@tht.org.uk Website: https://www.tht.org.uk/hiv-and-sexual-health

# 12. Priority Populations

## 12.1 Young People and Vulnerable Young People

### Young People

The term 'young people' is generally defined as people between 10-24 years of age. In England the age of consent to any form of sexual activity is 16 for both women and men, however, the age at which sexual activity begins varies between individuals, families, and cultures. Whilst there is a general decrease in the age at which sexual activity in young people begins, these relationships tend to be of a shorter duration, have a higher frequency of new sexual partners, and are more likely to include a wider variety of sexual practices[1]. Young people are also less likely to use contraception, particularly at first intercourse; be more at risk of non-consensual sex; have an immature perception of risk and communication skills and be at risk of engaging in at-risk sexual practices when using alcohol or illicit substances making young people the group at the greatest risk of experiencing poor sexual health[2].

This is evident as a disproportionate burden of STIs remains one of the highest in this group[3]. Research also shows that young people who are at risk of an STI tend to underestimate their risk and those who do perceive themselves to be at risk subsequently do not always access healthcare[4]. Several common perceived barriers to accessing sexual health services include confidentiality, stigma, embarrassment, and fear[5]. Young people from some groups face additional barriers to accessing services than others, with disparities in access based on gender, race and ethnicity, and sexual orientation, among other characteristics. Structural barriers, such as clinic location, transport costs and clinic opening times can also impact health seeking behaviour[6].

The reproductive and sexual health decisions young people make today affects the health and wellbeing of individuals and their communities for decades to come, so it is vital that they are armed with the skills and knowledge to build healthy positive relationships, this includes positive, pleasurable, and safe sexual relationships and knowing where and how to access services and/or support when needed.

The national Framework for Sexual Health Improvement in England (2013)[7] identifies a number of ambitions, to support building knowledge and resilience in young people, including evidence of what works. Fundamental to this is Relationship and Sex Education (RSE), which is now a mandatory part of the national curriculum. Research shows that young people receiving good quality RSE are[8]:

- more likely to seek help or speak out
- more likely to practice safe sex and have improved health outcomes
- more likely to have consented to first sex, and for first sex to happen at an older age
- more likely to understand digital safety in regard to relationships and sex

- more knowledgeable and aware of discrimination, gender equity and sexual rights; and less likely to be a victim or perpetrator of sexual violence

For further detail please see Section 14.

### Vulnerable Young People

The term "vulnerable young people" describes many different groups including, under 18s or teenagers, those in care, those with physical ill health, those with emotional health issues, those in poverty, those in the youth justice system and those not in mainstream education[9].

It is important to note that the sexual health needs of each vulnerable group will be diverse and therefore this section will explore some overarching themes and only explore the surface of this topic. For young people's health and wellbeing services to be effective, they need to acknowledge the different approaches needed for different ages and vulnerabilities.

Different approaches are needed for a young adolescent, an older adolescent and a young adult under 25 years. Each of their different needs must be considered when developing service design with the recognition that building good health behaviours at a young age can prevent risky behaviour[10].

Some young people may be particularly vulnerable to poor sexual health, these include those living with higher deprivation, those from a minority ethnic group (including gypsy and traveller communities), refugees, asylum seekers and people recently arrived in the UK, and additionally:

- Young people who are teenage parents or the children of teenage parents are at higher risk of poor sexual health outcomes[11]
- Young people who are looked after or leaving care, excluded from school or not attending regularly
- Young people with poor educational attainment, unemployed or not in education or training (NEET)
- Young people with learning disabilities often do not receive an appropriate sexual health education
- Young people who are homeless, experiencing poor mental and emotional health, living with physical or learning disabilities
- Young people displaying risk-taking behaviours such as substance and alcohol misuse and young people within the criminal justice system[12].

Challenges affecting vulnerable young people in terms of sexual health include, teenage pregnancy, increased risky behaviours, exploitation, abuse and access to services and support. Services should be tailored to meet the specific requirements of vulnerable groups.

Low levels of quality relationship and sex education is associated with poor sexual health outcomes and increased rates of sexual abuse in those with learning disabilities[13]. Those not

in Education and Employment (NEET) may not be able to access relationships and sex education which is key to supporting the reduction of risky sexual behaviour and teenage pregnancy[14].

Currently Derby shows an increasing trend and Derbyshire shows a static trend of 16–17-year-olds not in education, employment or training (NEET) based on data where activity reporting is known. The Derbyshire rate is statistically lower than the England average and the Derby rate is statistically higher (*Figure 66)*[15].

Nationally it is estimated that 12% of females who were NEET are also a teenage parent[16]. The Teenage Pregnancy Prevention Framework outlines the need to support teenage parents in terms of education and service accessibility to prevent subsequent repeat unplanned conceptions.

Figure 66 - 16–17-year-olds not in education, employment or training (NEET)

16 to 17 year olds not in education, employment or training (NEET) or whose activity is not known 2021 — Proportion - %

| Area | Recent Trend | Count | Value | 95% Lower CI | 95% Upper CI |
|---|---|---|---|---|---|
| **England** | ↓ | 57,090 | 4.7 | 4.7 | 4.8 |
| East Midlands region | → | 4,700 | 4.6 | 4.4 | 4.7 |
| Leicester | ↑ | 839 | 9.0 | 8.4 | 9.5 |
| Nottinghamshire | ↑ | 1,101 | 6.5 | 6.1 | 6.8 |
| Derby | ↓ | 341 | 5.6 | 5.0 | 6.2 |
| Lincolnshire | ↓ | 857 | 5.4 | 5.0 | 5.7 |
| Nottingham | ↓ | 309 | 4.7 | 4.2 | 5.2 |
| Leicestershire | ↓ | 463 | 3.2 | 3.0 | 3.5 |
| Derbyshire | → | 382 | 2.4 | 2.2 | 2.7 |
| North Northamptonshire | – | 195 | 2.4 | 2.1 | 2.8 |
| West Northamptonshire | – | 207 | 2.3 | 2.0 | 2.6 |
| Rutland | → | 9 | 1.4 | 0.7 | 2.6 |

Source: Office for Health Improvement & Disparities. Public Health Profiles. Crown copyright 2022

A factor associated with teenage pregnancy is being a looked after child or care leaver - with this group being 3 times more likely to be a teenage parent compared to another young person[17]. Young people in care may have a more limited access to RSE due to factors such as moving placements, increased school absence and having less opportunity to discuss their sexual health with carers[18]. It is recommended as part of the annual health check for children and young people in the care system, that it includes relationships and sexual health advice aligned to RSE guidance, need and age appropriateness. Assessment of the risks of child sexual exploitation, antisocial or youth offending behaviour, bullying, domestic abuse or sexually harmful behaviour should be included.

It is recommended that care staff should have the relevant skills and knowledge to be able to help young people understand, and where necessary work to support them to change negative behaviours in sexual relationships, promote good sexual health, and use contraception[19].

For young people in the youth justice system, it is recommended that targeted provision should be utilised in settings where young people frequent as there may be barriers to them accessing or an unwillingness to access mainstream support[20]. Those in poverty or in the youth justice system, are also likely to have more time off school.

Teenage pregnancy rates are declining globally. However, young people in England still experience higher teenage birth rates than their peers in Western European countries[21], teenagers remain at highest risk of unplanned pregnancy[22], inequalities in rates persist between and within local authorities, and outcomes for young parents and their children are still disproportionately poor, contributing to inter-generational inequalities. There is a need to sustain and accelerate this downward trend and consider those most vulnerable and local areas of high conception rates (see Section 6.4).

Derby and Derbyshire show a decreasing trend in 10–17-year-olds entering the youth justice system. The Derbyshire rate is statistically lower than the England average and the Derby rate is statistically higher (*Figure 67)*[23].

Figure 67 – Children entering the youth justice system

Children entering the youth justice system (10-17 yrs) 2020/21 — Crude rate - per 1,000

| Area | Recent Trend | Count | Value | 95% Lower CI | 95% Upper CI |
|---|---|---|---|---|---|
| **England** | ↓ | 14,970 | 2.8 | 2.8 | 2.9 |
| East Midlands region | ↓ | 1,173 | 2.6 | 2.5 | 2.8 |
| Nottingham | ↓ | 156 | 5.4 | 4.6 | 6.3 |
| Derby | ↓ | 135 | 5.1 | 4.3 | 6.0 |
| Leicester | ↓ | 112 | 3.2 | 2.6 | 3.8 |
| West Northamptonshire | – | 191 | 2.5* | 2.2 | 2.9 |
| North Northamptonshire | – | 191 | 2.5* | 2.2 | 2.9 |
| Nottinghamshire | ↓ | 174 | 2.3 | 2.0 | 2.7 |
| Derbyshire | → | 145 | 2.0 | 1.7 | 2.4 |
| Lincolnshire | ↓ | 130 | 2.0 | 1.7 | 2.4 |
| Rutland | ↓ | 130 | 1.9* | 1.6 | 2.2 |
| Leicestershire | ↓ | 130 | 1.9* | 1.6 | 2.2 |

Source: Office for Health Improvement & Disparities. Public Health Profiles. Crown copyright 2022

A local organisation, Safe and Sound, work with children at risk of sexual exploitation. They saw a 50% increase in individuals that sought their support from 2019 to 2020 and saw another significant increase in 2021[24].

Locally it is recommended that further work is needed with particular vulnerable young people and organisations working with them relative to ensuring strong service pathways are in place to relationship and sexual health services as need indicates. It is also particularly important to ensure close working with young people's groups themselves to ascertain their contribution to service design and development.

## 12.2 Young People Recommendations

**Young People Recommendations**

- Commissioners and providers should ensure opportunity to engage and co-produce services with young people, also working closely with services supporting children and young people with a focus to understand specific challenges for young people in their access of sexual health services. It is recommended that a multi-services provision is developed with young people within Derby city centre – to ensure accessibility and maximise use
- Local commissioners should consider collaborative approaches to ensure quality Relationship and Sex Education (RSE) is available to all children and young people in school settings and for those not attending school. Awareness and training to promote consistent information about RSE should be available to staff system-wide in and out of school settings
- Service design and promotion should be equitable and fair to meet the diverse access needs of young people
- Sexual Health services for young people should ensure they collaborate with associated organisations and services including education, council children's services, NHS services including school health and general practice
- The sexual health system should ensure inclusion of organisations and services that address need of specific groups of children and young people with vulnerability and risk, including community safety and youth justice provision, sexual violence and domestic violence, young people in care and care leavers, substance misuse, prevention of child sexual exploitation risk and harmful sexual behaviour. It is vital to work closely with voluntary organisations who may specifically work with children of vulnerability
- Targeted provision should be utilised to address barriers for some young people at risk who are unwilling to access sexual health and associated services
- Those who are disadvantaged socially need additional support from services to support them to access sexual health services and use them effectively. This could be in the form of adapting facilities, providing assistance for those with learning disabilities and ensuring professional interpreters are utilised where needed
- For looked after children, it is recommended that their annual health check includes relationships and sexual health advice aligned to RSE guidance, need and age appropriateness
- Ensure training and awareness is available for all staff working with children and young people to support improved sexual health outcomes
- The sexual health system should support services addressing particular challenges such as the uptake of the HPV vaccine for boys; support to teenage mothers to prevent and mitigate risk of subsequent pregnancies; working collaboratively to help address emerging risks of harm, for example sexting, behaviours, attitudes and messaging through the use of social media

## Young People - Assets/Services Available

**Derby Integrated Sexual Health Service (ISHS)** and **Derbyshire Integrated Sexual Health Service (ISHS)** are both provided by Derbyshire Community Health Service NHS Foundation Trust (DCHS) as the lead provider working with general practice, pharmacy, a digital provider and voluntary sector partners. A range of sexual health services are provided in clinics, online services, through outreach provision in communities, in general practice, pharmacy and through the support of voluntary organisations working with specific groups. Provision includes:

- STI testing, treatment, partner notification
- All contraception including LARC
- Psychosexual counselling (sexual health element)
- Sexual Health promotion and outreach with specific sexual health support for groups at risk

Visit the central booking line – for both the Derby and the Derbyshire service
Tel: 0800 3283383 Website: https://www.yoursexualhealthmatters.org.uk/
Emergency contraception is available in pharmacies across Derby and Derbyshire. LARC is provided by general practice and in ISHS clinic settings.

**Free Condoms Service** Your Sexual Health Matters provides a free and confidential condom and lube by post service to people who live in Derby City and Derbyshire. The postal condom service is available to people aged 13 years and upwards. Follow the link to find out more or to place an order
https://www.yoursexualhealthmatters.org.uk/contraception/condoms/postal-condoms

The Condom scheme or C-scheme is available at various community settings across Derby and Derbyshire. C-Wallets (small packets of free condoms and lube) are available for people to pick up from their local community settings. This may be from places like hairdressers or barbers, community/faith centres, leisure facilities and other local organisations.
https://www.yoursexualhealthmatters.org.uk/contraception/free-condoms

**Safe and Sound Group** work with young people and their families affected by sexual exploitation. Preventative work and support for all areas of vulnerability.
https://www.safeandsoundgroup.org.uk/

**Become** is a charity for children in care and young care leavers. They offer an advice line which can provide coaching, advice and opportunity to meet other care leavers.
Tel: 0800 023 2033, https://becomecharity.org.uk/

**Help at hand** offers advice and assistance for children in care, children with a social worker or are working with social services, children living away from home and care leavers.
Tel: 0800 528 0731, https://www.childrenscommissioner.gov.uk/help-at-hand/,

**Change Grow Live** is a young person's drug and alcohol service in Derbyshire, https://www.changegrowlive.org/young-peoples-service-derbyshire/info

**Derbyshire Police** Protecting people and promoting law across Derbyshire, https://www.derbyshire.police.uk/

**Derbyshire Police and Crime Commissioner** The commissioner is designed to bring communities and the police closer together. The commissioner works closely with community safety partners and the local authorities of Derby and Derbyshire, https://www.derbyshire-pcc.gov.uk/

## 12.3 Gay, Bisexual and Men Who Have Sex with Men (GBMSM)

Gay is a term commonly used to describe men who have a romantic and/or sexual orientation towards men; whilst bi-sexual (often referred to as Bi) is an umbrella term used to refer to romantic and/or sexual orientation towards more than one gender. Men who have sex with men (commonly referred to as MSM), refers to sexual activity between men, irrespective of how they identify. Stigma and discrimination as well as culture and ethnicity remain key factors in the sexual health inequalities that persists in GBMSM population[25].

Gay, bisexual and other MSM account for an estimated 5.5% of the male population in the United Kingdom (UK) representing an incredibly diverse community, however they are still one of the groups most at risk of Sexually Transmitted Infections (STIs) and HIV and this disproportionate, elevated risk persists across age groups reflecting biological and behavioural factors[26]. MSM report higher numbers of sexual partners and unprotected anal intercourse (UAI); Chemsex is evidenced to be common amongst GBMSM and whilst the research on this topic is in its infancy, current research concludes that chemsex is associated with risky sexual behaviour[27].

Evidence highlights the need for continued awareness raising amongst GBMSM[28] about how STIs are prevented (and individualised to different STIs), transmitted, diagnosed and treated and the importance of protecting themselves and also partners. The difference between STI prevention and HIV Pre-exposure Prophylaxis (PrEP) should also be reiterated.

There should be focus on support for individuals to improve their sexual wellbeing within services that are properly equipped to provide non-judgemental, confidential, professional and empathetic provision. Individuals should feel able to access services as safe places to discuss their needs to sexual health care to create a safe and comfortable environment for gay, bisexual and other men who have sex with men to discuss their needs.

The promotion of PrEP to prevent HIV must also include discussion on the use of condoms to prevent other STIs and prevent increased risk of individuals taking PrEP but not using condoms and therefore putting themselves at greater risk of STI transmission.

## 12.4 GBMSM Recommendations

**GBMSM Recommendations**

- Alternative and innovative ways of providing services and developing strategies to facilitate targeted, appropriate, accessible, culturally sensitive and inclusive access to sexual health services that meet the needs of GBMSM are recommended
- Regularly review the offer of PrEP through engagement with eligible populations at risk including gay, bisexual and men who have sex with men (GBMSM) to maximise messaging and reach appropriately
- Training and awareness for all staff to ensure understanding of diversities that may impact an individual's accessing services due to experiences or perceptions of stigma, judgement and discrimination
- Tailored messaging to address inequalities in GBMSM and including people of Black African and Black Caribbean descent
- Understanding of the needs of trans men, women and non-binary and greater collaborative working with associated organisations across the sexual health system to ensure service accessibility
- Engagement of higher risk groups in service co-production to address needs. Specific groups to include may be LGBT individuals, Black African communities, people living with HIV and young people

### GBMSM - Assets/Services Available

**The Integrated Sexual Health Services in Derby and Derbyshire** offer an open access service for testing, diagnosis, and treatment of STIs and HIV, onwards referral to HIV treatment services for those diagnosed with HIV and access to the full range of contraception including free condoms.
Visit the central booking line – for both the Derby and the Derbyshire service
Tel: 0800 3283383, Website: https://www.yoursexualhealthmatters.org.uk/

**Free Condoms service** Your Sexual Health Matters provides a free and confidential condom and lube by post service to people who live in Derby City and Derbyshire. The postal condom service is available to people aged 13 years and upwards. Follow the link to find out more or to place an order
https://www.yoursexualhealthmatters.org.uk/contraception/condoms/postal-condoms

The Condom scheme or C-scheme is available at various community settings across Derby and Derbyshire. C-Wallets (small packets of free condoms and lube) are available for people to pick up from their local community settings. This may be from places like hairdressers or barbers, community/faith centres, leisure facilities and other local organisations.
https://www.yoursexualhealthmatters.org.uk/contraception/free-condoms

**Derbyshire LGBT+** provide a range of support for GBMSM and people living with HIV including free condom distribution schemes (all ages). Click and Collect STI kits are also offered as part of outreach provision. Support is offered to adults and young people across general health and wellbeing as well as sexual health.
https://www.derbyshirelgbt.org.uk/sexualhealth

**Well for Life Community Health Hub** is a charity based in Derby whose aims are to promote the physical, emotional and mental health of people living with or affected by HIV in Derby and Derbyshire. https://www.wflderby.org/

**Sexwise** is a national website with advice on sexual health and support to locate services near you: https://www.sexwise.org.uk/

**National Helpline for Sexual Health:** FREE on 0300 123 7123, Monday to Friday, 9am to 8pm, Saturday and Sunday, 11am to 4pm.

**THT (Terrence Higgins Trust)** offers advice and information about HIV, other sexually transmitted infections and how to maintain good sexual health. Resources for people living with HIV and those newly diagnosed.
Freephone telephone number: THT Direct on 0808 802 1221 for support, advice and information or email info@tht.org.uk Website: https://www.tht.org.uk/hiv-and-sexual-health

## 12.5 People Living with Human Immunodeficiency Virus (HIV)

HIV remains a serious communicable disease for which there is no vaccine or cure. In general, more men than women are living with HIV. Of everyone accessing HIV care in the UK in 2021, 69% were men and 31% were women. Around 0.2% were transgender or gender diverse. Over the last few decades, the success of Anti-Retroviral Therapy (ART) in improving life expectancy has led to more and more people aging with HIV; more than two in five people accessing HIV care in 2019 were aged 50 or over and although people living with HIV now have the same or similar life expectancy to HIV-negative people, studies show that they may spend fewer of their years in good health. People living with HIV (PLWHIV) appear to have higher rates of illnesses typically associated with ageing, such as heart disease, diabetes, osteoporosis, and kidney disease[29].

The optimum goal is for those diagnosed with HIV to have an undetectable viral load, which means they cannot transmit this to another individual, but as much as HIV is a medical condition, it is a social one too; living with HIV impacts a person's physical, psychological, emotional, and social aspects of living. Considering the diversity of our population by sex, sexual orientation, ethnicity, cultural and religious background adds further layers of complexity in the type and nature of support that PLWHIV may require.

Four objectives underpin the UK's target of zero new transmissions of HIV by 2030[30] and the associated HIV England Action Plan[31] sets out these aims through ensuring that those who are newly diagnosed remain in treatment; deliver services and interventions that tackle stigma and discrimination; rapidly diagnose those that are unaware of their HIV status and ensure the availability of Pre-Exposure Prophylaxis (PrEP) both of which prevent onwards transmission.

## 12.6 People Living with HIV Recommendations

Compliance with Standards of Care produced by British HIV Association (BHIVA)[32] and other partners:

**People Living with HIV Recommendations**

- Promotion of testing strategies that aim to reduce the proportion of people living with HIV who are unaware of their diagnosis or who present with advanced infection
- Patient centred care in all aspects of service provision, design, and delivery, to include support to improve well-being and dealing with stigma
- Access and retention in HIV care
- Complex HIV care; supporting people with higher levels of need
- Supporting the management of their sexual and reproductive health
- Psychological care
- Management of HIV across the life course
- Development, training, and competencies needed across the workforce to maintain excellent care
- Collaborative cross-agency support to ensure prevention of access to treatment due to cost of living pressures overwhelming retention of appointments

## People Living with HIV - Assets/Services Available

**Derbyshire LGBT+** is a voluntary organisation working with individuals and groups who identify as LGBT. Support is offered to adults and young people across general health and wellbeing as well as sexual health. https://www.derbyshirelgbt.org.uk/sexualhealth

**Well for Life Community Health Hub** is a charity based in Derby whose aims are to promote the physical, emotional and mental health of people living with or affected by HIV in Derby and Derbyshire. https://www.wflderby.org/

**Sexwise** is a national website with advice on sexual health and support to locate services near you: https://www.sexwise.org.uk/

**National Helpline for Sexual Health:** FREE on 0300 123 7123, Monday to Friday, 9am to 8pm, Saturday and Sunday, 11am to 4pm.

**THT (Terrence Higgins Trust)** offers advice and information about HIV, other sexually transmitted infections and how to maintain good sexual health. Resources for people living with HIV and those newly diagnosed.
Freephone telephone number: THT Direct on 0808 802 1221 for support, advice and information or email info@tht.org.uk Website: https://www.tht.org.uk/hiv-and-sexual-health

## 12.7 People Living with a Long-Term Condition, Disability and Health Literacy

Long-term conditions, also known as chronic diseases, are conditions for which there is currently no cure, and which are managed with drugs and other treatment. Examples of long-term conditions include, diabetes, high blood pressure, arthritis and epilepsy – to name a few. The definition of a disabled individual is "having a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on their ability to do normal daily activities[33]." These can include neurodiversity, visual impairments and mobility disabilities.

This topic group is vast, with there being many different types of long-term condition and disability. Each condition or disability will affect an individual differently in regard to their sexual health needs and therefore this chapter only explores the surface of this topic.

Health Literacy is a person's ability to understand and use information to make decisions about their health. An individual with low health literacy may struggle with reading and understanding health information and what to do with it. This can lead to those with lower levels of health literacy leading unhealthier lifestyles, lower use of preventative services, higher use of emergency care and reduced life expectancy[34]. Some people with long-term conditions and or a disability are more at risk of having low levels of health literacy. To support these individuals to make good decisions around their sexual health, it is important that the information provided to them regarding their sexual health is easy to understand and services are accessible.

Individuals that are disabled and or have a long-term health condition can find their sex lives impacted by their long-term condition or their disability. This has often not been covered in young people's sex education and adult sexual health support. Resources previously used in sex education may not have been as accessible as they are now. For example, providing accessible resources for those who are deaf. These individuals are not represented equally in terms of sexual health services and may find it more challenging to seek support[35].

It is sometimes perceived that those with a certain disabilities and conditions are asexual. Therefore, individuals can be stigmatised for wanting a sexual relationship, denied a sexual relationship or perceived as being incapable of consenting to a sexual relationship[36].

The GP Patient Survey (2022) is an independent survey that is run on behalf of NHS England and sent out to 2 million people in England. Data from this survey shows that 55% of the

respondents in England said that they had a long-term illness or disability. In Derbyshire this was 60%[37].

Alongside this, data from sexual health related studies have shown:

- Low levels of sex education and a lack of accessible resources among people with learning disabilities leads to low awareness of safe sex practices, contraception, sexually transmitted diseases, sexual consent and abuse[38]. (Men and women with a learning disability are more likely to have unsafe sex (50% or more of the time)[39]
- A high proportion or women with a physical disability reported not attending cervical screening because of their disability[40]
- Barriers to accessing sexual health services can discourage engagement such as lack of wheelchair accessible routes into services and judgemental staff lacking knowledge of disabilities[41]

NICE guidance suggests that to meet the needs of groups with greater access needs to support sexual health services it is important to:

'Engage with groups with greater sexual health or access needs to understand how best to meet their sexual health and wellbeing needs. Take into account factors such as existing barriers to access (for example, for people with learning difficulties, or because of their gender or sexuality), language and other socioeconomic factors, including deprivation'[42].

The NHS Long Term plan includes a Personalised Care model which will be rolled out nationally to ensure individuals are given choice and control over aspects of their care. The model is not based on an individual's condition, yet on what matters to the individual[43] which would in some cases include sexual health. The model involves training for staff on identifying and supporting service users' wider health needs.

The NHS guide: Supporting people with a learning disability and autistic people to live happier, healthier, longer lives - recommends that commissioned services should consider the human rights of an individual including their right to a relationship[44].

Organisations have clear guidance and support for staff to provide accessible information and processes for booking additional support such as interpreters[45].

For children and young people, the mandatory RSE (and Health) Guidance for Education Settings reiterates that subjects must be accessible for all pupils – including disabled pupils and SEND[46].

## 12.8 People Living with a Long-Term Condition, Disability and Health Literacy Recommendations

**People Living with a Long-Term Condition, Disability and Health Literacy Recommendations**

- Commissioners and service providers should ensure engagement with individuals and groups living with learning disabilities and long-term conditions to inform service development and design
- Staff awareness and training specific to support individuals needs to access sexual health services should be maintained system-wide including participation of local training around Health Literacy
- Practical resources should be readily available across service provision to ensure access to meet the diversity of need
- Improved partnership arrangements locally should develop with services specifically working with people living with a learning disability, physical or mental disability and a long-term condition to ensure proper access to services and meeting the individual's human rights without risk of stigma or prejudice

### Assets/ Services Available

**Joined Up Care Derbyshire** offers a wealth of resources to support professionals to embed health literacy into their practice. This includes links to national training, videos, toolkits and applications to understand health literacy needs.https://joinedupcarederbyshire.co.uk/stay-well/quality-conversations-personalisation/health-literacy/resources/

**The Sex Education Forum** has released guidance for education settings regarding Relationship and Sex education with SEND pupils. https://www.sexeducationforum.org.uk/resources/advice-guidance/rse-pupils-send-short-guide

The **Health Literacy 'how to' guide** from health education provides relevant guidance for healthcare professionals and services to follow to ensure they can implement good practice to support individuals with low health literacy. https://library.nhs.uk/wp-content/uploads/sites/4/2020/08/Health-literacy-how-to-guide.pdf

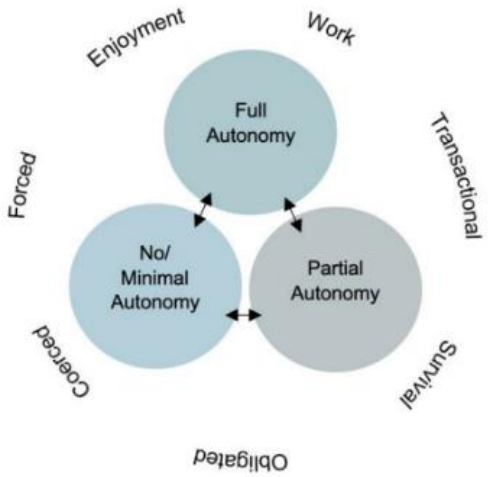
**Mencap** a national charitable organisation supporting adults with a learning disability. They offer advice and guidance around relationships and sex.
https://www.mencap.org.uk/advice-and-support/relationships-and-sex

**Deaf-initely Women** is a local charity managed and governed by deaf, deafblind and hard of hearing women. Deaf-initely Women serves all deaf and hard of hearing women in Derby, Derbyshire, Nottingham, Nottinghamshire and beyond.
https://www.deafinitelywomen.org.uk/

## 12.9 Individuals Involved in the Sex Industry

The term "sex industry" relates to all activities involving sexual services in exchange for money and/or gifts. The individuals working in the industry vary from those who see it as an enjoyable job to those who are forced into the industry or see it as a necessity to provide an income. These levels of autonomy are illustrated as follows[47]:

Figure 68 – Levels of sexual autonomy




Sexual autonomy describes the level of which an individual is able to make and maintain informed decision over their body, their sexuality and their sexual experience. Sex industry activities can include:

- Indoor and outdoor prostitution
- Escort services
- Lap dancing
- Stripping
- Virtual sex (via online or over the phone)

A broad range of people from all genders, age, nationality, ethnicity, sexual orientation, health and social circumstances, take part in these activities[48]. Although all genders are involved in the sex industry, those identifying as women make up the majority of those who work in the industry as opposed to other genders[49].

In England, the exchange of sexual services for money is legal if the individual providing the service is over the age of 18 and the individual in receipt of the service is over 16. However, there are certain activities which are illegal such as soliciting individuals in a public place, running a brothel, advertising sexual services, and forcing someone to work in the sex industry for financial gain[50].

We know those working in the sex industry have higher rates of poor health, including mental health, chronic disease, reproductive health need, respiratory problems and

substance misuse related problems[51]. In terms of sexual health, those working in the sex industry have a higher risk of STI's than those who do not engage in sex work[52].

There are many barriers to those involved in the sex industry to accessing "mainstream" healthcare including inaccessible appointment times due to chaotic lifestyles and fear of judgement. For example, individuals may fear being outed, arrested or deported and may not access a service where they feel their safety is compromised[53].

There can be stigma attached to those working in the sex industry in respect to accessing healthcare. It is often believed that individuals engaging in paid sex work do not value their health, do not want to engage with services, are unmotivated or only have specific health needs such as substance misuse and sexual health[54].

Due to the stigma felt by those in working in the sex industry it is difficult to ascertain the scale of how many individuals may need support from sexual health services. Due to the internet being more widely used generally by the population, this may have changed how services are provided in the sex industry as it can provide anonymity and promote peer networking . From the 2018 Beyond the Gaze report interviewing those working , using and supporting those in the sex industry, one of the conclusions found that:

*"The internet was seen by sex workers to be of considerable importance in developing services, enabling independent working and greater control over working circumstances, and improving safety strategies"*[55]

During 2022, less than 50 individuals identified themselves as a paid sex worker when they attended an appointment at a Derby or Derbyshire sexual health clinic (January to January)[56].

## 12.10 Working in the Sex Industry Recommendations

**Working in the Sex Industry Recommendations**

- Ensure those working in the sex industry can access services by offering a range of ways of engaging with them including outreach, a community presence, fast track access – with all of these offering a friendly, welcoming, trauma informed, gender sensitive service
- Provide a range of condom distribution schemes to meet the needs of different local populations, based on needs assessment, consultation and STI rates. Target those most at risk – of which include those working in the sex industry. Include multicomponent schemes, single component schemes (free condoms) and cost-price sales schemes
- Services should consider responsive and drop-in appointments and employ consistent staff with specialist knowledge of substance misuse, mental health, domestic violence and homelessness
- Health services should be made available, accessible and acceptable to sex workers based on the principles of avoidance of stigma, non-discrimination and the right to health
- Violence against sex workers is a risk factor for HIV and must be prevented and addressed in partnership with sex workers and sex worker led organisations
- Improved engagement of those working in the sex industry and/or organisations working specifically with this community in order to understand health need, enable their contribution to design services and to further enable greater co-production where possible

Further recommendations are provided as part of the BHIVA Standards:

- All those attending a sexual health screen should be asked if they have been involved in sex work, or if they have received money or goods in exchange for sex. This helps to ensure that there is no unconscious bias or judgmental assumptions about who could be involved in sex work
- Sexual health assessments should be the same as for non-sex workers, and further questions regarding work-life should be clearly separated from what occurs in their personal life. Specific work-related questions must be relevant to care and not unnecessarily intrusive
- Services should consider the following options which may improve adherence and reduce onwards transmission: Shorter courses or single-dose treatments, possible syndromic management and dispensing full courses on the day, oral alternatives where patients cannot attend services for injectable treatments, offering antiviral suppression treatment for individuals with herpes simplex virus

### Working in the Sex Industry - Assets/Services Available

**Restore – Derby** describe themselves as walking with women who are working in the sex industry. Their aim is to support women in a non-judgemental way and support them to access appropriate services. https://jacobswellderby.co.uk/

**Women's Work** is a local organisation that provides support for vulnerable women and families. They provide essential skills and help to instil confidence in women. Their service is personalised, holistic and person centred, that aims to boost mental and physical wellbeing as well as improving access to services and facilities. They provide a sexual health outreach service. https://www.womens-work.org.uk/

**National Ugly Mugs** is a national charity working with sex workers to do research, design and deliver safety tools and to provide support services to people in adult industries. https://nationaluglymugs.org

**Beyond the Streets** is a national charity working with women involved in the sex industry, who aim to see women safe from coercion, violence and abuse. https://beyondthestreets.org.uk

## 12.11 Prison Sexual Health

Prison as defined by the World Health Organization (WHO) refers to "as a minimum, the institutions that hold people who have been sentenced to a period of imprisonment by the courts for offences against the law[57]". Prisoners should have the same right to healthcare as the general population; the United Nations Basic Principles for the Treatment of Prisoners states that prisoners should have access to health services in the country irrespective of their legal situation[58].

Sexual health is important in prisons. Prison sexual health is a part of public health and prisoners move in and out of prison and within the community. Therefore, it is important to correctly address the wider determinants of health such as prevention of infection and disease[59]. It is important that prisons provide adequate healthcare, and the conditions should support the wellbeing of all prisoners and staff[60]. In the United Kingdom prison health is managed by the NHS within a primary care model[61]. It is important to treat prisoners with dignity and respect when it comes to sexual health, healthcare and reducing health inequalities[62].

The prevalence of severe mental illness and substance abuse is higher in the prison population compared to the general population[63]. In an independent review of unmet mental health needs in prison "a little too late" (2009), it was found that prisons are ill-equipped to deal with mental health and prisoners are being discharged back into the community without adequate support. Reducing the drivers of criminal behaviour like substance misuse disorders and mental health related conditions can reduce recidivism and thus save costs later[64].

### Prisoner Characteristics

The prison population are often hard to reach as they are more likely to be marginalised in society; particularly men who face higher levels of exclusion[65]. The prison population share similar characteristics due to their shared experiences and circumstances such as early childhood trauma, poor education and poverty. This, coupled with social deprivation and

loss of freedom can have detrimental consequences and influence how they make healthy choices[66]. Prisoners have high levels of mental illness linked to issues such as substance misuse and hepatitis B and C[67]. In a report by HM Inspectorate of Prisons, it was recorded that an estimated 71% of women and 47% of men self-reported experiencing poor mental health[68].

UK Drug Policy Commission (UKDPC) reported that 1 in 8 arrestees in England and Wales are thought to be problem heroin and crack cocaine users[69]. Prisoners are a high-risk group for STIs and risk-taking sexual behaviour. Furthermore, limited access to healthcare services within prisons make prisoners more vulnerable to acquiring and spreading STIs[70]. Whilst prison staff do not allow prisoners to have sex, there are no guidelines in prison that prohibit sex and it is difficult for prison staff to differentiate between consensual and coercive sex between prisoners. It is important for prisons to protect the vulnerable and to ensure that prisoners feel safe and have access to clear reporting channels[71].

### Sexual Violence in Prison

Sexual violence in prison is particularly prevalent. Vulnerable prisoners are open to sexual violence and coercive relationships. Sometimes prisoners form sexual relationships for protection or bribes but there can be an issue when one wants to withdraw the arrangement but are prevented from doing so[72]. The Ministry of Justice (MoJ) reported on sexual violence that it most frequently occurs within cells, and social settings such as wings and dining areas[73]. According to Statista, in 2019 the number of sexual assaults in England and Wales showed that prisoner on prisoner sexual assaults was the highest form[74].

### STIs

People who inject drugs (PWID) in prison are at higher risk of contracting STIs as their environment is more likely to be overcrowded and have unsafe needle injecting practices such as illegal drug use and tattooing, and unprotected sexual relations[75]. Prisoners are more likely to have multiple sexual partners, and poor sexual health education[76]. Blood born virus (BBVs) infections are also higher in the prison populations due to higher levels of injecting for drug use[77].

### Impact of COVID-19

The impact of COVID-19 on prison sexual health meant that there was reduced staffing capacity and funding[78]. Following the announcement of the first national lockdown, UK prisons went into “Command Mode” to restrict movement of prisoners and contain the virus. Prisoners were ever more isolated with face-to-face contact reduced, and had to spend more time in cells[79]. The Institute of Criminology reported that prisoners were spending up to 23 hours a day locked up, with prohibited access to social areas such as the gym, libraries and rehabilitation activities and sanitation levels were generally poor[80].

### Harm Reduction Measures

Barriers to accessing contraception should be removed and condoms should be readily available to prisoners to minimise the risk of STIs and unprotected sexual relations. Condom

provision and dental dams are the most effective harm reduction measures to prevent STIs being transmitted in prison[81]. Lack of condom provision and dental dams may be a result of poor infrastructural issues such as a limited financial and human resource or not enough political will from prison policymakers. Some researchers believe that Supervised Injection Sites and Needle Exchange Programmes can create mixed messages[82]. However, there is strong data to suggest that these harm reduction programmes can prevent the negative consequences of harmful substance misuse such as overdosing[83].

### Guidance/Policy

Prison healthcare should be the same standard as community healthcare. There are various factors which make it difficult to achieve this such as short-term sentences, overcrowding, and staffing issues etc[84]. Prisons should adhere to The National Institute for Health and Care Excellence (NICE) and other clinical guidelines such as the British Association of Sexual Health and HIV (BASSH).

The Equalities Act 2010 states that prisons have a duty to not discriminate against anyone because of their sexuality[85]. Policies to prevent sex in prisons can be seen as discriminatory against gay prisoners. It is critical that staff are trained on how to address sex between prisoners[86].

The Health and Justice Outcomes Framework aims to reduce the rate of HIV and STIs upon reception of prisoners. There are guidelines in place, including[87]:

- Vulnerable prisoners should be monitored closely, especially those who are at risk of sexual violence, coercion, and bribes
- STIs, BBVs and HIV should be detected early via asymptomatic infection testing to prevent the spread of infection, and partner notification should be standard practice
- BASHH standards, guidelines and services should be followed accordingly
- Access to timely treatment should be improved, and there should be the appropriate emphasis on mental health support and emotional wellbeing
- Increase health promotion activities such as better communication about the risks associated with HIV and hepatitis. Moreover, education about unsafe needle injecting
- There should be an integrated approach to healthcare in prison into national health policy

## 12.12 Prison Sexual Health Recommendations

NICE advises a series of recommendations to improve prison sexual health[88]:

**Prison Sexual Health Recommendations**

- Health assessments should include identifying patients with high-risk behaviours and refer them to the relevant drug treatment service such as the Offender Substance Abuse Programme (OSAP) and Addressing Substance Related Offending (ASRO)
- Upon reception, prisoners should be asked about their sexual history in a non-judgemental manner, if high-risk they should be prioritized for screening of STIs even if they are not displaying symptoms. They should also be asked about their drug history and a urine/blood sample be taken
- Care pathways for prisoners released into the community should be reviewed, and there should be continuity of care not just within prison but upon release and relapse to help prisoners transition
- Integrated Drug Treatment Systems (IDTS) should be improved and there should be improved supervision and monitoring
- Quality of service for prisoners should be prioritised, including staff training
- Services need to be improved, more funding and specifically tailored care packages
- Interventions should adopt a holistic approach based on best practice
- It is important for prisoners and their families to have a say in their healthcare
- There should be vaccine equity and accessibility for prisoners, for example HPV should be available in women's prison. Furthermore, all prisoners should be offered the Hepatitis B vaccination upon reception
- Health promotion interventions should take a participatory approach to enable prisoners to be involved in their own healthcare, and behavioural change techniques such as nudge should be adopted

A recommendation for sexual health care of women in Derbyshire Foston Hall prison encourages:

- The respective commissioning authorities to collaborate more closely to ensure commissioning responsibilities and accountability align and do not exacerbate risk of capacity to either the Integrated Sexual Health Service or the prison sexual health provider
- The prison sexual health provider to work closely with Derbyshire ISHS to ensure patient pathways are in place and accessible as required to meet the needs of prison leavers
- To develop closer working at a regional level to support strategies for sexual healthcare for prison leavers returning to areas outside of Derbyshire
- For ISHS to ensure patient pathways are in place with associated partners working with prison leavers including the Probation Service
- To ensure work is undertaken for services to be aware of the challenges women may face in their access to sexual health care on leaving prison and using this intelligence in appropriate service development including patient pathways

### Prison Sexual Health – Assets/Services Available

There are different local services available in Derby for prisoners once they are back in the community. For example, the **Derwent Centre, Derby** provides support and supervision for offenders who have been released back into the community and may require additional support. https://www.gov.uk/guidance/derby-derwent-centre

# 13. Associated Key Factors

## 13.1 Substance Misuse

Risks including initiation of sexual activity at an earlier age, having multiple sexual partners, using condoms less consistently and being at higher risk of STIs are linked to substance misuse. In young people, drugs and alcohol use is associated with riskier sexual behaviour.

Sexual health needs and substance use needs can be linked in the following ways:

- Drug use makes people intoxicated and lose their inhibitions, resulting in sexual activity (or a specific aspect of it, such as no condom use) that would not have happened unless the drug was consumed
- People dependant on substances may engage in activities that put their sexual health at risk, such as engaging in sex work or transactional sex in order to fund drug use
- People using psychoactive drugs immediately before or during sex to enhance pleasure
- Drugs are used to cope with the emotional distress associated with a sexual health problem such as a new diagnosis, ongoing debilitating symptoms or associated stigma[1]
- Substance use is strongly associated with sexual risk and adverse sexual health outcomes among young people[2]
- Young people, men who have sex with men, and people working within the sex industry appear to be at the highest risk of co-occurring harms relating to drug use and sexual activity[3]
- In young people, use of drugs and alcohol is associated with riskier sexual behaviour
- Young people with substance problems are more likely to engage in risky sexual behaviours during adolescence and to continue risky sexual behaviours to the extent that substance problems persist. Risk reduction education is a crucial component of substance abuse treatment for young people

Alcohol use can affect sexual health and wellbeing:

- Early alcohol use is associated with earlier sexual activity that is more likely to be regretted, and clusters with other risk behaviours, including smoking and drug use
- People who drink hazardously are more likely to have multiple sexual partners. Hazardous consumption of alcohol is more common in people attending genitourinary medicine departments than the general population
- Use of alcohol by both victim and perpetrator is common in cases of sexual assault[4]

Local intelligence from users of Drug and Alcohol services indicate a need for more proactive support from sexual health services and not just "*posters in reception, an occasional drop-in*

*by ISHS staff,* incorporating *sexual health within service interventions and the support offer.*" Similarly discussion including sexual health is not always apparent at first contact in Drug and Alcohol services. Service knowledge and patient pathways are crucial to mitigate risk and support patients who would benefit.

## 13.2 Substance Misuse Recommendations

**Substance Misuse Recommendations**

- Greater collaboration between Drug and Alcohol services and Sexual Health to ensure awareness of patient pathways, respective service provision and consistency in patient assessment and discussion relative to risk of either drug and alcohol consumption or sexual behaviour choices
- Sharing of relevant data and intelligence from sexual health services and substance misuse services to inform commissioning and provision
- Ensuring substance misuse service users are enabled to contribute their voice to service design in terms of sexual health as relevant
- It is important that sexual health services ensure they are up-to-date on local needs and barrier to service access for users of substances and users in recovery who may experience or perceive barriers to access services including sexual health services
- Sharing of data relevant to higher risk groups such as GBMSM due to some association with chemsex
- Working with voluntary sector providers such as Well for Life and Derbyshire LGBT+ charities to local services and LBGT charities to develop and improve data collection including ascertaining where there is low service use by MSM, either in substance misuse or sexual health services to inform local planning
- Combined approaches in communications and campaign development towards prevention of substance misuse and risky sexual health behaviours – adults and young people
- Collaborative approaches should be taken with commissioners of other services that impact on HIV prevention (for example with substance misuse services to ensure that investment in high-quality needle exchange services continue)
- Explore greater joint working and opportunities for co-commissioning to the benefit of some population groups. This might include the provision of LARC to women accessing substance misuse services, pregnancy testing, HIV prevention through continued investment in needle exchange services, rapid HIV testing and referring individuals to sexual health services including PrEP
- Joint training and awareness sessions for staff to ensure relevant knowledge is across both local services
- Strategic planning across substance misuse and sexual health should be collaborative in relation to groups of vulnerability such as GBMSM and in the context of chemsex

## Substance Misuse - Assets/Services Available

**Derbyshire Drug & Alcohol treatment services** The current providers for drug and alcohol treatment services in Derbyshire, commissioned by the County Council are outlined below:

**Adult Services – Derbyshire Recovery Partnership:** This partnership is made up of four organisations who work together to deliver a joined up, countywide treatment service for adults with both drug and alcohol issues.
https://www.derbyshirerecoverypartnership.co.uk/

**Derbyshire Healthcare NHS Foundation Trust** (Partnership Lead) - in addition to co-ordination of the pathway, the foundation trust provide: pharmacological interventions (titration, stabilisation, reduction etc), health improvement (vaccinations, GP liaison, blood borne virus testing and mental health assessment etc.

**Phoenix Futures, Derby Drug and Alcohol service,** working in partnership with Derbyshire Healthcare Foundation Trust and Aquarius, community support is provided for people with drug and alcohol problems. The service includes advice and guidance, one-to-ones and group sessions, harm reduction support, prescription services, needle exchange and onward referral to treatment for complex recovery. The service accepts self-referrals and organisation referrals. Tel: 0300 7900 265, https://www.phoenix-futures.org.uk/phoenix-futures-for/people-and-families-who-use-our-services/find-a-service/derby-drug-and-alcohol-service/

**Breakout** is the young persons' drug and alcohol service for Derby for under 18s**.** Services include treatment and support, one-to-one support, detox programs and work on coping mechanisms. https://www.derbyshirehealthcareft.nhs.uk/services/drugs-and-alcohol-support/drugs-and-alcohol-support-young-people-derby

**Change Grow Live Derbyshire** is a free and confidential service for young people, under the age of 19, who are using drugs or alcohol and want some support. Outreach services are offered for under 25s through 1625 Outreach.
Support offered includes:

- Specialist one-to-one support for those who wish to make changes to their drug or alcohol use
- Targeted one-to-one support for those who want support but do not wish to make changes to their drug or alcohol use
- Targeted group work for individuals identified as using or at risk of using drugs or alcohol
- Harm reduction services, including providing information to reduce harms associated with substances and how to stay safe, covering topics such as recognising and avoiding exploitation
- Motivation and encouragement
- Individual relapse prevention support

Contact: 01773 303646 or email derbyshire@cgl.org.uk
https://www.changegrowlive.org/young-peoples-service-derbyshire

**Substance Misuse Outreach Service 16-25 years** Change Grow Live deliver this service. The service objectives are for the provider to: work within communities with key stakeholders to deliver evidence-based interventions targeted at groups of individuals deemed to be at increased risk, target young people in their own settings to reduce substance misuse and related harms, respond quickly and flexibly to address emerging needs.
https://www.changegrowlive.org/1625-outreach/team

**Space4U - support service for children and young people affected by substance misuse** Space 4 U is delivered by Action for Children. The aim of the service is to provide high quality, age-appropriate and evidence-based interventions to strengthen protective and resilience factors, reduce harm and develop coping strategies for children and young people (aged 5-18 years) who are affected by another person's substance misuse (drugs or alcohol).
https://services.actionforchildren.org.uk/derbyshire/

**Recovery Grants** have been offered to smaller local organisations over a number of years. The projects delivered with these grants, and other recovery support (including local NA and AA fellowship meetings), can be found at the following website:
https://www.growingrecoveryinderbyshire.co.uk/

## 13.3 Chemsex

Although there is still no formal definition for chemsex, the regionally agreed working definition describes it as "the planned use of drugs as an integral part of sex (usually immediately prior to, or during sex)." Information from presenting patients offered from clinicians working in Derbyshire ISHS corroborates this definition of chemsex. The drugs most commonly involved according to clinicians are gamma-hydroxybutyrate (GHB) and gamma-butyrolactone (GBL) which is supported by a plethora of evidence from other organisations and academics. Other drugs which are also used include methamphetamine and mephedrone[5], [6].

The people taking part in chemsex most frequently are men who have sex with men (MSM) and this is identified by the sexual health service within Derbyshire which correlates with wider research and the picture known nationally[7]. However, it is worth noting that this is the group believed to be most prominent because they are the ones coming forward most and are therefore most known to services. As chemsex is often a very hidden activity and many people do not want it known that they are participating, there may be a large number of individuals who will simply not be identified. The reasons for this include the fear of being punished for drug use, the stigma attached to chemsex and the worry of being caught cheating - these are all points which have been shared to the sexual health service and wider stakeholders locally.

The COVID-19 pandemic had a big impact on sexual relationships with a forced restriction of contact between people and this may have mitigated risk of casual sex.

Reasons for people taking part in chemsex are varied, as with any sexual preferences. Much of the research and anecdotal information points towards chemsex for some people being used as a way to overcome intimacy issues, to want sex which feels better and lasts longer, to feel more confident, to cope with stigma (this is shown to be particularly common among the MSM community) and to overcome past sexual issues including sexual assault.

The issue of consent for individuals participating in chemsex may initially be given. However, when an individual is under the influence of drugs, consent may be at significant risk and deemed questionable.[8] This may then lead to greater risk of non-consensual behaviours. The risk of STIs is increased when partaking in chemsex, as well as blood borne viruses particularly for those injecting drugs and sharing needles. Furthermore, reports have risen in recent years of sexual assaults occurring during chemsex, often due to a misunderstanding of consent in this context[9].

The prevalence of chemsex in Derby and Derbyshire is largely unknown and both the city and county sexual health services acknowledge that they probably only see "the tip of the iceberg" and so it is difficult to measure accurately. It is clear that more needs to be done to engage those taking part and encourage them to access sexual health services. Dating apps such as Grindr are sometimes used to 'advertise' chemsex, and saunas and swingers clubs are still places where participants in chemsex are known to sometimes attend.

## 13.4 Chemsex Recommendations

**Chemsex Recommendations**

- Sexual Health commissioners and providers should ensure close working with Drug and Alcohol service commissioners in the context of chemsex to share up-to-date intelligence and awareness of pathways for support, outreach and joint communications
- Patient pathways between sexual health services and drug and alcohol services should continue to strengthen and embed with appropriate awareness for staff
- Safe messaging relative to chemsex and risk should be jointly delivered by providers of drug and alcohol and sexual health services to identified at risk populations including MSM but also to the broader population accessing sexual health services
- Questions relative to assessment of risk due to chemsex should be collaboratively developed and consistently offered across both drug and alcohol and sexual health services

### Chemsex - Assets/Services Available

Despite a range of national organisations offering support for people taking part in chemsex, there are no known specific services within Derby or Derbyshire.

## 13.5 Sexual Violence

The World Health Organization (WHO) defines sexual violence as:

"Sexual violence refers to any sexual act, attempt to obtain a sexual act, or other act directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting. It includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part or object[10]."

UK legislation defines rape as the penetration of the vagina, mouth, or anus without consent[11]. However, it is important to note that women can also be the perpetrators and can be convicted if they assist a male perpetrator in rape[12]. Rape and sexual violence disproportionately affect women and girls and can impact people differently[13]. Physical injuries may often include cuts, bruises, abrasions, and swelling to the site of injury. However, the absence of physical injuries due to rape is not evidence that the rape did not occur. Although known as sexual violence, rape is not always violent, and survivors and victims often report feelings of confusion and guilt if they did not say no or physically struggle.

Amongst the multiple harmful impacts of sexual violence, there is risk of STI transmission and for a woman unwanted pregnancy. Most victims and survivors of rape or sexual abuse feel a detrimental impact on their mental health including depression, suicidal thoughts, shame, and guilt[14]. This may result in unhealthy behaviours such as substance misuse and self-harm.

However, it is important to note that with the right support and timely intervention, victims of sexual violence can recover and can achieve positive outcomes and make meaningful changes to their life.

In March 2020, the Crime Survey for England and Wales (CSEW) reported that approximately 1.6 million people between the ages of 16-74 have experienced some form of sexual assault, with almost half having experienced this on more than one occasion. Statista reported that in 2021/2022, there was a reported 194,683 sexual offences recorded by the police in England Wales[15]. Given that sexual abuse crimes often go under reported, it can be challenging to understand the full scale of sexual violence.

2021/22 data show that Derby is in the highest quintile for sexual offences with 4.6 per 1000 population, compared to the England rate of 3.0 per 1000. This trend is an increasing one. Derbyshire is in the second lowest quintile for sexual offences with 2.5 per 1000 population, lower than the England rate but with an increasing trend.[16]

### Impact of COVID-19

The impact of COVID-19 has increased the occurrence of domestic and sexual violence particularly amongst the most marginalised groups in society. At the start of the pandemic,

March 2020 to the end of the year, crime reports in England and Wales showed a decrease of 0.7% to 162,936 of sexual violence recorded by the police compared to 2019, however this is likely due to underreporting[17].

## Risk Factors

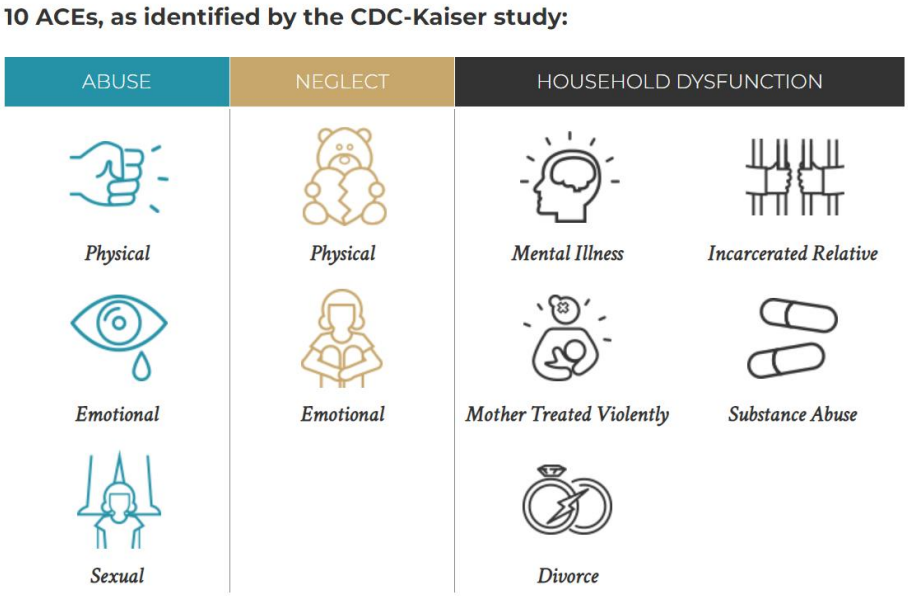
There are common factors that increase the risk of an individual being subjected to sexual violence, and an individual becoming a perpetrator. For example, the prevalence of sexual violence is higher in less socio-economically developed groups, with the Centre for Control and Disease (CDC) stating how substance misuse and a history of sexual violence elevates risk factors[18]. Evidence also suggests that having poor mental and physical health, as well as a learning disability, increases the risk of sexual violence, with women and girls with disabilities at an elevated risk of sexual and gender-based violence (GBV)[19].The Crime Survey for England and Wales (CSEW) reported that at the end of 2020, people with disabilities were twice as likely to become victims of domestic abuse which included stalking and rape than people without a disability[20].

It was also reported that transgender, transexual, and trans-variant people were more likely to experience sexual violence with the National Institute of Care Excellence (NICE) reporting that 80% of trans people had experienced some form of emotional, physical and sexual abuse by their partner or ex-partner. 38.4% of people who classify as gay, lesbian, and bisexual also reported experiencing domestic violence and abuse[21].

## Cost to Society

The Adverse Childhood Experiences (ACE) sets out a sequence of traumatic events and circumstances that occur before the age of 18[22]. It predicts through evidence-based research that the greater number of ACEs results in poorer adult outcomes such as victimisation and perpetration.

Figure 69 – What are ACEs? Source: Joining Forces for Children



The National Association for People Abused in Childhood (NAPAC) reports that child sexual abuse costs the UK £3.2bn per year[23]. In the year ending 2019, the cost of sexual violence for Child Sex Abuse (CSA) was estimated at £89,240[24]. This cost was associated with factors such as the impact on victims, survivors, and the wider economy. For example, preventative programmes relating to education, offenders, costs of physical and emotional harm and CSA training costs. In addition, added costs related to the Crown Prosecution Service and Criminal Justice System. The estimate is a prediction of the potential of those affected being revictimized in the future and a higher likelihood of being out of work. Prevention and early intervention are paramount to reducing the impact of CSA and costs.

### Men and Boys

Much of the literature excludes sexual violence against men and boys, despite men and boys also being victims of abuse. For example, in the year ending March 2020 there was an estimated 155,000 male victims of sexual assault[25]. In addition, it is estimated by the Centre of Expertise on Child Sexual Abuse that around 5% of boys and young men experience CSA by the age of 16[26].

The structures in place are not always culturally sensitive to men and boys which can create challenges and barriers to coming forward and reporting abuse. The Evidence from Male Survivors Partnership calls for the need to strengthen pathways to encourage help seeking among men and boys which should start by an "institutional awareness of male victimisation and of entitlement to belief and support[27]."

It is important when addressing sexual violence that a holistic approach is adopted.

### Policy and Strategy

Research from the Call for Evidence, National Public Survey has shown that not enough is being done to prevent women and girls from becoming victims and survivors of sexual violence[28]. Derbyshire and Derby aim to raise awareness and focus on prevention by helping women and girls to be safer and using national and evidence-based practice to achieve its priorities in prioritising prevention through the Violence against Women and Girls Strategy (VAWG) 2022-25[29].

The government's 2023-2030 domestic and sexual abuse strategy outlines four main pillars[30]:

- Partnership – collaborative/multi-agency working
- Prevention – maximising prevention sexual violence
- Support – improving access for support and sexual health services
- Justice – improving the criminal justice response/system

The pillars are centred around outcomes, priorities, and objectives and if applied correctly, they can help improve outcomes for victims and survivors of sexual violence in terms of

health and wellbeing. Furthermore, prevention can reduce overall costs to society, community, and family[31].

The Government also passed the Domestic Abuse Act 2021 which aims at improving the response to adults who have suffered domestic abuse at the height of lockdown in March 2020. The Act protects victims and survivors by implementing a stricter justice system and improving protections for victims and survivors. For example, laws are in place to dismiss "rough sex defence" in non-fatal injuries such as strangulation, or "revenge porn" including threats[32]. These measures will be applied to England and Wales and are estimated to cost between £247 to £300 million a year.

In the Violence Against Women and Girls (VAWG) Strategy (2021-2024); the consultation aims to engage with women and girls who have experienced sexual violence. Furthermore, it aims to help create a bottom-up approach to improving services and focuses on understanding the scale of sexual violence, identifying, and preventing these crimes[33].

### Local links between Sexual Health Services and Interventions and Support for Victims of Sexual Violence

Both Derby and Derbyshire ISHSs with the adult and child Sexual Assault Referral Centre (SARC) providers have jointly developed strong pathways, endeavouring to achieve seamless support in terms of sexual healthcare for individuals at this time of trauma.

A pilot to determine need of Harmful Sexual Behaviour perpetrated by young people is currently provided by Action for Children up to October 2024. This addition to a main contract across both city and county is solely for Derbyshire to analyse the level of need and to offer a consultative model of support to staff working with cases.

RSE is evidenced as a strong intervention to reduce harm including sexual and domestic violence. RSE is emphasised to address the recent rapid review by Ofsted in 2021 that concluded that in secondary schools, sexual harassment has become "commonplace.[34]"

RSE supports positive peer to peer relationships, acknowledges young people's agency and autonomy and balances protective and participatory rites. Quality RSE is also evidenced to increase the likelihood of young people to speak out or seek help where sexual abuse may be present[35]

## 13.6 Sexual Violence Recommendations

**Sexual Violence Recommendations**

- Sexual violence is an issue that should be addressed not on an individual, but a societal level
- Service providers are recommended to ensure the victims of sexual violence are enabled to contribute their voice to service development
- Education settings across Derby and Derbyshire should be supported to provide quality RSE in secondary settings and Relationships education in primary settings including provision in the special education sector. RSE education must be compliant with national mandatory guidance for schools. This is to ensure early prevention to support safe, healthy and respectful relationships amongst children and young people
- Collaborative development and co-production with young people in the area of communications and campaigns aimed to prevent harmful relationships, supporting resilience and coping mechanisms amongst young people
- Support should be given to education and other settings working with young people to ensure prevention of harm and maintaining knowledge of risks such as misogyny, grooming and exploitation and the use of social media that can seek to exacerbate harmful behaviours and attitudes across young people
- Maintenance and review of patient pathways between SARC and ISHS to ensure seamless care for individuals - with the emphasis on the individual at the heart of decision-making and development. Clear accountability for provision, the pathway and funding of post-exposure prophylaxis following sexual exposure (PEPSE or PEP) should be in place and reviewed as appropriate to focus on any changing patient need
- Closer working across strategic development in the sexual health system and community safety agenda to support prevention, maximise care relative to sexual and relationship health and awareness of ways to address sexual violence
- Explore need in terms of staff awareness and training to identify victims of domestic and sexual violence through a system-wide approach relative to the sexual health system such as within abortion services
- Learning from the external evaluation of the current Derbyshire Harmful Sexual Behaviour Pathway programme for young perpetrators (pilot phase) – it is recommended that system partners consider the recommendations from the evaluation due in October 2024

### Sexual Violence - Assets/Services Available

There are a range of local services in Derbyshire County that offer support for victims of sexual violence such as **Safer Derbyshire**. It is a multi-agency partnership that allows victims to receive counselling, advice, and support without the need for police intervention. Should an individual wish to receive support from the police or legal system there is assistance to do so[36].

Derbyshire also offers counselling and support via the **Supporting Victims of Sexual Violence (SV2)** to individuals over the age of 14 in various locations across the county. SV2 offer medical checks and the service is confidential[37].

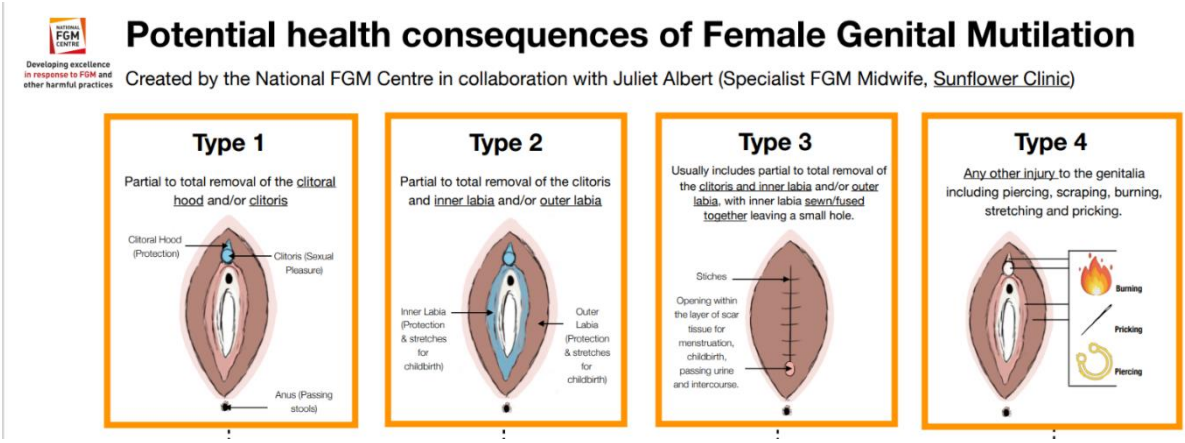
Anyone who has been affected by sexual violence in Derby and Derbyshire can visit **Millfield House** which is the local Sexual Assault Referral Centre (SARC). Millfield House is open to male and females, 24/7 and provides advice, forensic and medical examinations, counselling, and sexual health services[38].

## 13.7 Female Genital Mutilation

Female Genital Mutilation (FGM) is recently defined by the World Health Organization (WHO) as a procedure where the external female genitalia is removed either partially or fully; also known as female circumcision or cutting. The procedure can cause injury and complications such as issues urinating, repeated infections, cysts, and complications with childbirth[39].

WHO has classified FGM into 4 different types:

Figure 70 – Types of FGM. Source: WHO




FGM is a human rights violation and a serious public health concern. WHO estimates that approximately 200 million women and girls in 30 countries have been affected by FGM mainly across Africa, the Middle East and Asia. Women and girls who are most at risk are those from countries such as Somalia, Egypt, Sudan, Sierra Leone, Eritrea, Gambia and Ethiopia[40] https://www.unfpa.org/resources/female-genital-mutilation-fgm-frequently-asked-questions Furthermore, women and girls who have a family history of FGM or a culture which promotes this practice are more at risk[41].

According to the National FGM Centre, the practice is typically carried out by "traditional cutters" but also healthcare providers which is known as "medicalisation". It is usually carried out between infancy to 15 years old and is often for cultural and social pressure within the community, beliefs regarding female cleanliness, and proof of a female's virginity[42].

There is no medical benefit for FGM, and although it is illegal in the UK it is reported that each year around 170,000 females have undergone FGM; and a further 60,000 girls are at risk with most of that figure under the age of 13[43]. It is likely that this figure is underrepresented due to patients only presenting FGM when they become pregnant or develop health complications[44].

In the Derbyshire Violence Against Women and Girls Strategy 2022-2025 (VAWG), only one FGM crime was recorded by the police despite Derby recording 35 patients having undergone FGM, and Derbyshire less than 10[45].

FGM may have catastrophic consequences on its victims both in the long and short term. In terms of the physical and immediate impact, FGM can cause excessive pain, bleeding, shock and in some cases death. The longer impact of FGM can include urinary retention and sexual dysfunction. There is an increased risk of clotting and infections such as hepatitis and septicaemia; in addition, menstruation can be painful, and it can cause infertility and problems during childbirth[46]. Some women who have undergone FGM report difficulties conceiving[47]. The mental impact can also be devastating with much of the research discussing feelings of trauma, anxiety, shut down dissociation and PTSD[48]. The WHO's Sustainable Development Goals (SDGs) aims for the practice to be abandoned by 2030, with the need for support from the global community[49].

The COVID-19 pandemic has stifled efforts to abandon the practice of FGM. UNFPF (2020) estimated that two million additional cases of FGM would have likely been missed due to the impact of the pandemic[50].

It has been reported that due to law enforcement such as lockdown, quarantine, and the closure of schools, many women and girls were at risk of Gender Based Violence (GBV) and FGM. There was an increased risk of marginalisation and under reporting of the practice[51]. Furthermore, prioritising of COVID-19 cases meant that many victims of FGM were not able to get the treatment they needed. In 2021, NHS services reported dozens of female victims of FGM in Bedfordshire, Luton, and Milton Keynes[52].

Conversely, mandatory lockdown measures, meant that there was an increase in police presence which could have protected women and girls from against FGM. People were not allowed to travel, and anyone found doing so were more likely to be caught[53].

### Treatment

There are different treatment options for women and girls who have undergone FGM. For example, mental health services including counselling and psychiatric help. In addition uro-gynaecological services such as surgery reversal, and treatment for infertility[54].

Individuals who have undergone FGM can carry out a self-referral or go to a walk-in clinic which is known as the National FGM Support Clinics (NFGMSCs)[55].

Trauma-informed care takes a holistic patient-centred approach, by understanding and addressing all aspects of a patient's life and experiences and how they react together hence should be dealt with in parallel[56].

### Policy/Guidance

In the UK, FGM is illegal as specified by the Female Genital Mutilation Act 2003[57] which made it a serious criminal offence (In Scotland Prohibition of FGM Act 2005)[58]. It is also illegal to take girls out of the UK to countries where FGM is practised.

There are safeguarding measures in place to protect people at risk of FGM such as a protection order, where there are certain conditions to follow within this order such as surrendering a passport to prevent taking a girl abroad for FGM. Failure to comply to the FGM Order can result in a breach and imprisonment; and anyone who is found guilty in the UK of performing FGM or assisting a girl by taking her outside of the UK to get this done or failing to protect her is committing an offence. To directly perform FGM, an individual can face up to 14 years in prison, and up to 7 years for failing to protect[59].

The National Action Plan on FGM highlights the importance to recognise FGM as any other form of child abuse and a criminal offence. Healthcare and educational professionals should be trained to feel confident in having such conversations as a routine and priority of training should be in communities where FGM is more prevalent. The multi-agency statutory guidance on FGM's website provides resources and signposts support services for professionals[60].

If a regulated professional is concerned for the welfare of a child/under the age of 18 and suspects they have undergone FGM, they should report this to 101 as part of their mandatory reporting duties[61].

However, if the risk is immediate then 999 should be called as an emergency. Children at risk should be referred to the local services team, please see good referral guide for more information[62].

## 13.8 FGM Recommendations

**FGM Recommendations**

- Training and awareness across staff working with young girls as appropriate to cultural background – to identify potential signs of FGM or risk of FGM being perpetrated:
    - Changes in behaviour
    - Missing school, particularly after a trip to a country where FGM is common
    - Spending long periods of time out of the classroom
    - Spending longer than usual going to the toilet
    - Avoiding going to the toilet
    - Discomfort when sitting down
    - Avoiding physical exercise
    - Frequent menstrual or urinary infections
- Training with staff working with young girls and women who have undergone FGM – in terms of cultural sensitivity an all-medical staff to work within the appropriate guidelines and pathways
- Sexual health services should be up to date with training as appropriate, use of consistent assessments to determine FGM status and intentions and local procedures under Safeguarding

### FGM - Assets/Services Available

**Derby and Derbyshire have a Safeguarding Children's Partnership Manual** which provides the appropriate advice and pathway referrals on FGM[63]. It would be beneficial for schools to have information accessible for children on how to seek help should they have undergone FGM or are at risk such as Childline[64].

**Soroptimist International** is a women's volunteer organisation dedicated to supporting and empowering women and girls around the world and raising awareness about FGM. There is a specific service for Derby known as SI Derby[65].

Should there be concerns that a woman or girl is at risk of FGM, then the **National Society For the Prevention of Cruelty to Children (NSPCC)** helpline can be contacted[66].

Similarly, if under pressure to assist with FGM, Derby Medical Centre can be contacted about what services are available in the area[67]. Whilst there is no specific FGM clinic in Derbyshire, there are multiple FGM Support clinics in the Midlands[68].

## 14. Relationships and Sex Education (RSE)

Relationships and Sex Education (RSE) is defined as "learning about the emotional, social and physical aspects of human development, relationships, sexuality, wellbeing and sexual health[1]."

UNESCO using the term "comprehensive sexuality education" gives further helpful detail:

"a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality. It aims to equip children and young people with knowledge, skills, attitudes and values that will empower them to: realize their health, well-being and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others; and understand and ensure the protection of their rights throughout their lives[2]."

Relationship, Sex and Health Education (RSHE) is a mandatory element of the school curriculum as stated in The Relationships Education, Relationships and Sex Education and Health Education (England) Regulations 2019 under sections 34 and 35 of the Children and Social work Act 2017. Table 2 outlines to whom this guidance is applicable.

Table 2. RSHE Guidance in schools[3]

| Relationships Education | Relationships and Sex Education (RSE) | Health Education |
|---|---|---|
| All schools providing primary education, including all-through schools and middle schools | All schools providing secondary education, including all-through schools and middle schools | All maintained schools including schools with a sixth form, academies, free schools, non-maintained special schools and alternative provision, including pupil referral units |
| Exclusions<br>· The statutory requirements do not apply to sixth form colleges, 16-19 academies or Further Education (FE) colleges although it is encouraged that subjects are offered to support students and to support periods of transition into Further Education, employment.<br>· The statutory requirement to provide Health Education does not apply to independent schools. Personal, Social, Health and Economic (PSHE) is already compulsory, advised by the Independent School Standards as set out in the Education (Independent School Standards) Regulations 2014. However this Guidance on Health Education is encouraged in terms of being helpful to plan an age appropriate curriculum | | |

Right to be excused from some or all of sex education as part of statutory RSE

Parents have the right to request that their young person be withdrawn from some or all of sex education delivered as part of statutory RSE. Schools are advised to operate a Policy that outlines the process for right to withdrawal and this might include good practice as follows:

- head teacher discussion with parents/carers to confirm and clarify the nature and purpose of the curriculum; to understand the reasons for the request and to include if appropriate the young person to ensure all wishes are understood. Discussion should be documented by school.

The statutory guidance endeavours to improve the quality of RSE provision. The Sex Education Forum, based on a plethora of evidence outlines the following factors as vital to ensure good quality in RSE:

- Comprehensive, accurate and up-to-date information including not only physical or biological aspects of reproductive and sexual health and choices within, but broader themes of self-identity and sexuality, online harms, and consent. Life skills development including communication, listening and ethical decision-making skills are encouraged
- Ensuring a rights-based approach is taken – RSE should address rights, values and equality. Topics such as gender norms and inequality should be discussed in terms of their negative impact on sexual wellbeing
- Effective RSE must include inclusivity, being mindful of the diverse needs of young people and taking "active care" to acknowledge pupil diversity in a classroom. Pupil inclusion in curriculum design in content and teaching delivery is important alongside support for staff awareness on topics such as anti-racism, gender and sexuality, trauma-informed practice and personalised learning. RSE should strive to increase a pupil's sense of empowerment and inclusion
- Ensuring a confident, willing and competent staff with ongoing development of effective pedagogy in RSE delivery. This is further enhanced if it is within a setting of both a supportive management and wider school community and adopting a whole school approach to learning

A joint survey by the National Society of Prevention of Cruelty to Children (NSPCC) and the teaching union NASUWT found that half of secondary school teachers (46%) did not feel confident in teaching RSE[4].

The recent national RSE poll, 2022 concluded that 40% of respondents felt RSE to be good or very good.[5] A Derbyshire pilot commissioned by Derbyshire County Council Public Health and provided by the School Improvement Team offers support and training to schools, both primary, secondary and SEND towards quality RSE in line with mandatory guidance. The pilot adopts a whole school approach and works through a RSE Award programme called

Building Effective Relationship Together (BERT). External evaluation during the last 2 years indicates positive difference from staff engaged in BERT compared to staff not yet engaged directly. Emerging themes are indicated for example the important inclusion of the pupil voice in lesson design and delivery and the importance of harmful themes both nationally and locally such as misogyny – this being reflective of national surveys.

RSHE is currently under a review[6] since the mandate on schools in 2019. The Review Panel has a focus on RSHE content taught in schools and age appropriateness. The outcome of the Government Review is expected in September 2023.

There is overwhelming evidence of the benefits to children and young people in receipt of quality RSE provision, including physical health outcomes such as prevention of unintended pregnancy and sexually transmitted infections but also benefits for young people's behaviours and attitudes, respect for self and others and emotional wellbeing due to support around resilience and protective factors against risk of harm. Further evidence highlights benefit from RSE resulting in:

- Improved mental wellbeing and in particular generating positive impact for some groups including young people identifying as LGBTQ – where RSE resulted in higher rates of safety, lower rates of bullying and lower reports of adverse mental health in secondary schools. Additionally increased positive behaviours through developing attitudes that are gender-equitable are seen which is a key element of addressing social injustice such as racism, sexual violence and transphobia[7]
- Reducing harm including sexual and domestic violence. RSE is emphasised as a vehicle to address the recent rapid review by Ofsted in 2021 that concluded that in our secondary schools, sexual harassment has become "commonplace"[8]. RSE supports positive peer to peer relationships, acknowledges young people's agency and autonomy and balances protective and participatory rites
- Increasing the likelihood of young people to speak out or seek help where sexual abuse may be present[9]
- Increased likelihood to delay first sex until ready and more likely that the first time is consensual. This benefit is evidenced in the third National Survey of Sexual Attitudes (Natsal-3) where adults reporting that school lessons were the main information source about sex reported higher competence (safer practice such as condom use and including consent by both partners)[10]
- Growing evidence showing association between quality RSE and improving digital literacy[11]

## 14.1 RSE Recommendations

**RSE Recommendations**

- Quality RSHE should be within a whole school approach and develop with the inclusion and involvement of children and young people, staff, parents and carers
- Honest and transparent conversation is vital with parents, carers and relevant outside agencies as part of the provision of quality RSHE, working towards a shared understanding for the safety, health and wellbeing of children and young people
- Schools should deliver the RSHE curriculum within the recommended mandatory guidelines
- Targeted RSHE should be provided to ensure the diversity of need across young people is met alongside signposting or referral to agencies who can meet need
- RSHE should include regular monitoring and measure of impact on health and wellbeing of children and young people
- RSHE should be consistent within evidenced based information provision across the broader system of organisations working with children and young people and support training and awareness to meet local need across staff. Evidenced based criteria should also be developed and considered to support external agencies in schools participating in RSHE provision.
- Cultural sensitivities and diversity of learning needs should be considered in RSHE provision, with appropriate support given
- Establishment of a local RSE Forum is beneficial for the promotion of RSHE to support meeting local need and challenges
- Regular training and development should be available for staff in schools and in outside agencies
- RSHE should be included as a priority in local strategic development across the areas in which it is evidenced to impact and with the appropriate commitment to local provision

### RSE - Assets/Services Available

Local RSE resources:

- RSE twitter address available for all schools: RSE day Twitter @RSE_day
- Building Effective Relationships Together (BERT award) Twitter @BERT_RSE – available for Derbyshire county schools
- RSE Portal https://portal.insightnow.co.uk/ui/#_bertrse/page/home

This is a portal owned by Derbyshire county schools for **Derbyshire schools** but with a level of complimentary access to **Derby city schools**. Various resources, national updates are included which may be of use to schools relative to RSE.

Sex Education Forum provides much information and guidance relative to evidence, policy, resources, training and events. https://www.sexeducationforum.org.uk/

# 15. Emerging Factors

## 15.1 Gonorrhoea

Gonorrhoea continues to remain an emerging need due to the persistent high rate of diagnosis, both locally and nationally. Gonorrhoea is the second most diagnosed Sexually Transmitted Infection (STI) in the UK, which is considered an indication of unsafe sexual practices. If left untreated, gonorrhoea can lead to complications, such as chronic pelvic pain, Pelvic Inflammatory Disease (PID), ectopic pregnancy, and infertility. As indicated earlier in this report gonorrhoea remains concentrated among specific population groups; GBMSM and people of Black Caribbean ethnicity continue to experience disproportionately higher rates of gonorrhoea diagnoses[1].

The effectiveness of first-line treatments of gonorrhoea continues to be threatened by antimicrobial resistance. Reducing gonorrhoea transmission and ensuring treatment-resistant strains of gonorrhoea do not persist and spread remains a public health priority.

## 15.2 Gonorrhoea Recommendations

**Gonorrhoea Recommendations**

Consistent and correct use of condoms can significantly reduce the risk of gonorrhoea and other STIs. Regular testing for Human Immunodeficiency Virus (HIV) and STIs is also essential for good sexual health among the sexually active population. Similarly, open access to rapid treatment and partner notification at sexual health services is vital to reducing the risk of complications and onwards transmission.

Anyone having condomless sex with new or casual partner/s should have an STI screen annually, including an HIV test. In addition:

- Women and other people with a womb or ovaries under the age of 25, who are sexually active should have a chlamydia test annually and on change of sexual partner/s
- GBMSM should have an annual test for HIV and STIs or every 3 months if having condomless sex with new or casual partner/s

Engagement of higher risk groups in service review through co-production approaches and communications promoting the importance of STI testing. Specific groups to include may be LGBT individuals, black African communities, people living with HIV and young people, sex workers and individuals displaying risky sexual behaviours.

## Gonorrhoea - Assets/Services Available

**Derby Integrated Sexual Health Service (ISHS) and Derbyshire Integrated Sexual Health Service (ISHS)** are both provided by Derbyshire Community Health Service NHS Foundation

Trust (DCHS) as the lead provider working with general practice, pharmacy, a digital provider and voluntary sector partners. A range of sexual health services are provided in clinics, online services, through outreach provision in communities, in general practice, pharmacy and through the support of voluntary organisations working with specific groups. Provision includes:

- STI testing, treatment, partner notification
- All contraception including LARC
- Psychosexual counselling (sexual health element)
- Sexual Health promotion and outreach with specific sexual health support for groups at risk

Visit the central booking line – for both the Derby and the Derbyshire service
Tel: 0800 3283383, Website: https://www.yoursexualhealthmatters.org.uk/

**Free Condoms service** Your Sexual Health Matters provide a free and confidential condom and lube by post service to people who live in Derby City and Derbyshire. The postal condom service is available to people aged 13 years and upwards. Follow the link to find out more or to place an order. Young people under the age of 16 are required to speak to a clinician and register for this service to ensure safeguarding and understanding.
https://www.yoursexualhealthmatters.org.uk/contraception/condoms/postal-condoms

C-Wallets (small packets of free condoms and lube) are available for people (16yrs+) to pick up from their local community settings. This may be from places like hairdressers or barbers, community/faith centres, leisure facilities and other local organisations.
https://www.yoursexualhealthmatters.org.uk/contraception/free-condoms

**Derbyshire LGBT+** is a voluntary organisation working with individuals and groups who identify as LGBT. Support is offered to adults and young people across general health and wellbeing as well as sexual health. https://www.derbyshirelgbt.org.uk/sexualhealth

## 15.3 Modern Slavery

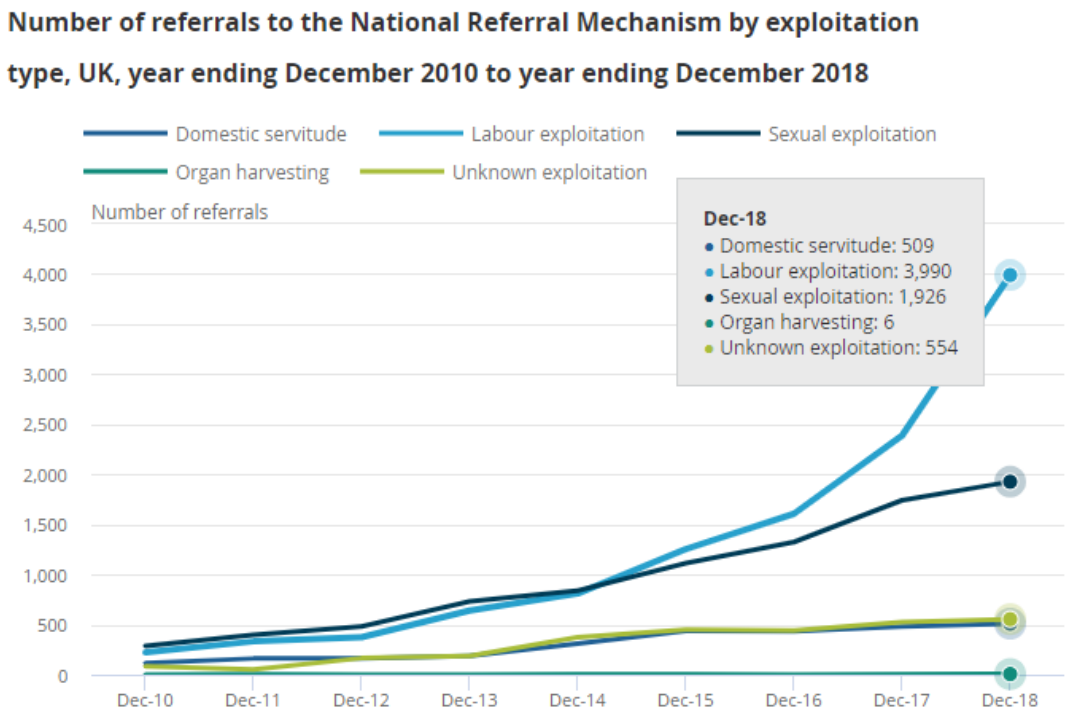
Modern Slavery is the moving around or bringing in of individuals into the country and forcing them to work or do other things against their will[2]. Of the activities that individuals are forced to do, sexual exploitation is one of the most common[3] which includes: working as prostitutes, in pornography, phone sex lines, internet chat rooms and escort agencies. Throughout the trafficking process, individuals are likely to experience many health risks mentally and physical which may impact them long term.

Evidence suggests that modern slavery affects all individuals, however women and children are more likely to be involved in sexual exploitation[4]. From studies conducted with individuals that have been sex trafficked, many of them reported having sexually transmitted infections[5] and experienced sexual violence[6]. Those trafficked often have poor overall health and have often been forced to take drugs and alcohol as a method of control[7].

Victims of trafficking, like victims of other forms of abuse, sustain injuries and illnesses that frequently fall to the health sector to address in a safe and confidential way. For a trafficked person, contact with someone in the health sector may be the first – or only – opportunity to explain what has happened or ask for help[8].

The number of referrals for modern slavery in the UK show an increasing trend since 2010 (*Figure 71*) which may not mean a rise in cases, but a rise in awareness of spotting signs and how to refer.

Figure 71 – Referrals for modern slavery. Source: ONS[9]




## 15.4 Modern Slavery Recommendations

**Modern Slavery Recommendations**

Training and awareness of staff across the local system to spot signs of modern slavery and respond effectively in accordance with local guidance through the Derby and Derbyshire modern slavery partnership. Awareness should be appropriate and up to date.

Sexual health outreach teams and other organisations working with populations of vulnerability including individuals working in the sex industry and migrant groups have opportunities to alert individuals to the risk of modern slavery; identify and refer people who are in exploitative circumstances; and provide care as part of a post-trafficking referral system. It is recommended that sexual health services ensure they are engaged with this agenda through the local partnership.

## Modern Slavery - Assets/Services Available

**Derby and Derbyshire Modern Slavery Partnership** The vision of the partnership is to protect the public by identifying and safeguarding potential victims of modern slavery and human trafficking and target those who commit this crime. Partnership work is rooted in having a visible impact on people's lives and making a difference for them and their long-term outcomes. The Partnership provides multiple guidance and advice to support identification of risks of modern slavery, how to respond, how to support victims, training and awareness and policy updates: https://www.saferderbyshire.gov.uk/what-we-do/modern-slavery-and-organised-crime/modern-slavery-and-organised-crime.aspx

**Process where an individual is suspected to be a potential victim of modern slavery or trafficking, please contact:**

- 999, if the person is at immediate risk
- Call Derbyshire on 01629 533190 (24 hours adults and children) Children triaged via Starting Point
- Derby City Council: 01332 640777 and refer to social care
- 101, if a non-emergency - quote Modern Slavery Human Trafficking Unit
- Modern Slavery Human Trafficking Unit for advice tel: 0300 122 8057 or email: AEIU@derbyshire.police.uk

**Kalayaan:** Providing advice advocacy and support services in the UK for migrant and domestic workers http://www.kalayaan.org.uk/

**Derbyshire Victims Services:** offering support to victims of different types of crime. They offer practical and emotional support for those who have been affected by crime. https://www.derbyshirevictimservices.co.uk/
**Refuge** is a charity supporting women and children against domestic violence. https://refuge.org.uk/

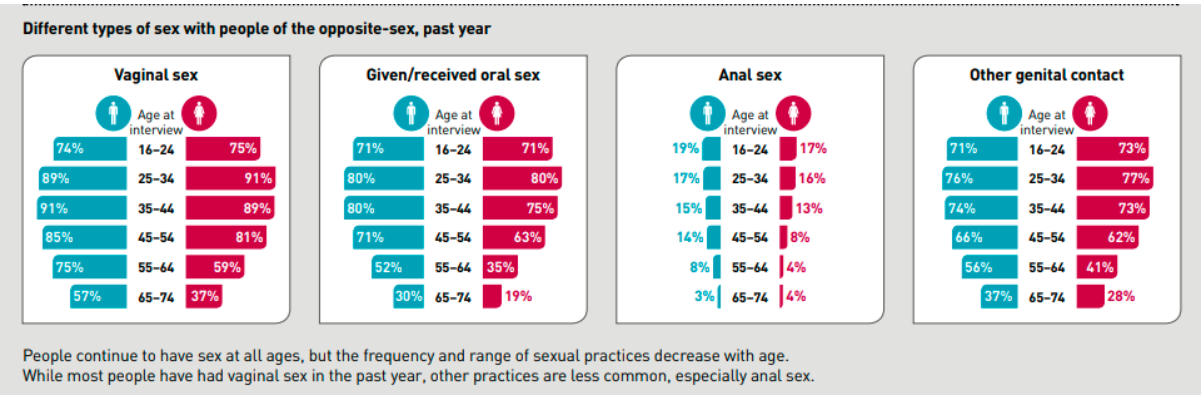
**Home Office** Training resources from different organisations to support basic awareness raising for local authorities, healthcare providers and charitable organisations[10].

## 15.5 Sexual Health of Older Adults

The World Health Organization states that sexual health is a need throughout a person's life course:
"People have sex as part of a healthy life and intimate relationships, and not solely for reproduction, and enthusiastic promotion of sexual health is essential to every person's fulfilment of their human rights related to sexuality and well-being"[11]. However, there is a stereotype that older adults lead a sexless life and ageing is often associated with decline and needing care[12].

There is often a greater stigma in terms of sexual health in older age groups because most sexual health interventions focus on younger age groups, and this may deter an individual from seeking support. Generally, sexual activity decreases with age, however, studies have shown that a high proportion of older individuals are still sexually active[13] as indicated in Figure 72.

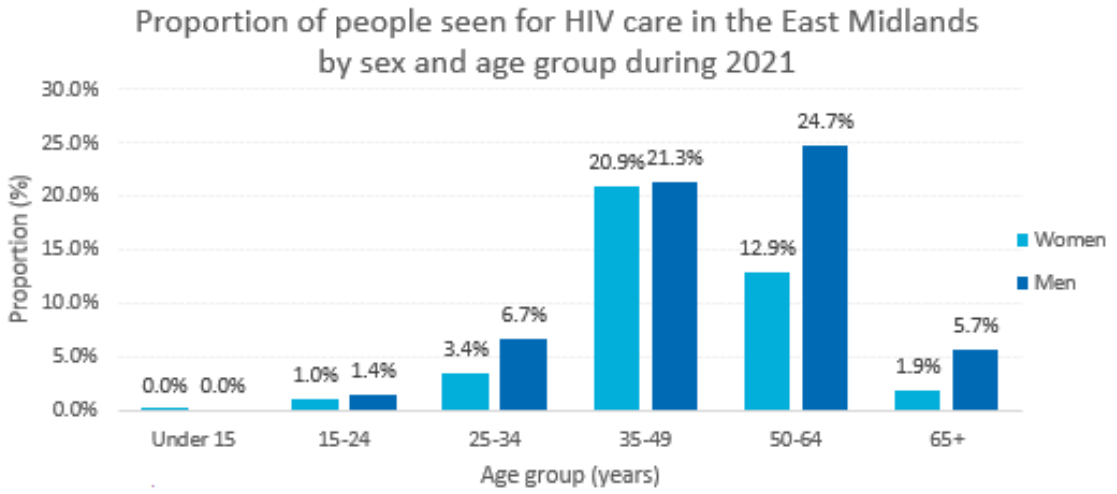
Figure 72 – Forms of sexual activity. Source: Natsal 2014[14]




This clearly shows that people of all ages continue to have sex, but the type of sex may change with age.

There are risks to not considering the sexual health needs of older adults. For example, there are vulnerable groups of older people that may need support such as those who are homeless, migrants, sex workers and non-native language speakers[15]. Older adults may be affected by circumstances relating to their age that may adversely affect their sexual health. These could include living in a care home, having a long-term condition, or having a carer[16]. In terms of HIV diagnosis, older adults are more at risk of being diagnosed late with subsequent risk to health as a result[17]. Locally, in the East Midlands, the highest proportion of people seen for HIV care are men aged 50-64 years.

Figure 73 – People seen for HIV care in the East Midlands by sex and age group



From the recent SHIFT research conducted with individuals aged 45+, many individuals did not perceive themselves to be at risk of poor sexual health due to being in monogamous relationships, having no risk of pregnancy, and sexual health not being a priority. LGBT groups that were more likely to have open conversations about sexual health, were more aware of sexual health risks[18]. However, from 2017 to 2019 there was a 20% increase in STI infections in England in those aged 65+[19], highlighting the need to engage with older adults around prompting good sexual health.

2021 data indicates that the largest increase in abortion rates by age are among women aged 30 to 34, increasing from 17.2 per 1,000 in 2011 to 22.1 per 1,000 in 2021[20]. The average age of mothers in England being higher than it has ever been, suggesting pregnancy and birth are being delayed until later in a woman's life and the desire for small families[21]. This emphasises the need for continuous promotion and engagement in contraception access for comparatively older women especially after pregnancy alongside comparatively younger women under 30 years.

Good sexual health is not just about the absence of STIs and unplanned pregnancy, it involves being confident to ask for sex that is pleasurable and respecting your sexual partner's needs[22]. There is evidence that positive sexual experiences benefit our health. Often individuals who enjoy being sexually active also have improved cardiovascular health and lower rates of depressive symptoms than those not sexually active[23].

Evidence suggests that, due to sexual health not being seen as a priority for the older age group by professionals, their sexual health needs are not being met adequately[24].

## 15.6 Older Adults Recommendations

**Older Adults Recommendations**
Sexual Health services should continue to be engaging and accessible to meet the needs of older people and in compliance with national standards for sexual healthcare.

Taking learning from developing programmes such as SHIFT, sexual health services should ensure consideration of:

- Sexual health to be included in general health check ups
- A non-judgemental approach from medical professionals when discussing their sexual health
- Messaging around accessing sexual health support to include voices of over 45s and images not just representing young people

For sexual health services to meet the needs of older people, it is recommended that further consultation takes place. This action should be included in general health and wellbeing service development work, for example through local over 50 forums and other voluntary sector organisations.

The Sexual Rights Charter for Older People recommends:

- Older adults are treated with dignity and respect when it comes to their sexuality
- Services create a culture of openness that is supportive of adults intimate and sexual relationships, respectful of privacy, and enables important conversations to be had
- Scientifically accurate and understandable information related to sexuality and ageing is available to older adults, younger adults, and the workforce through communications channels they are familiar with
- Older adults are fully informed about the potential impact of medicines and treatments for health conditions on sexual function, pleasure and desire
- Sexual rights remain important when adults are not sexually active and do not want to be

Training and awareness of sexual health service staff and other health practitioners of the importance of meeting the sexual health and relationship wellbeing needs of older people.

### Older Adults – Assets/Services available

**Sexual Rights Charter for Older Adults, 2022** is a resource for public health, social care professionals, community and voluntary workforce, researchers, educators and policymakers. The charter aims to tackle ageism and support older people's sexual choices. https://agesexandrights.com/

**Age UK** is a charity that provides advice and support for older people, including advice on sexual health and relationships. https://www.ageuk.org.uk/information-advice/health-wellbeing/relationships-family/sex-in-later-life/

**SHIFT** is an organisation supporting those aged 45+ and over to have good sexual health and focuses on topics that are more prevalent in older age such as erectile dysfunction and menopause. https://shift-sexual-health.eu/

## 15.7 Social Media

Social media is currently a key tool to share and promote information. The various platforms offer positive ways to promote sexual health services and deliver safe, healthy messages. Online platforms can be particularly supportive for groups including young people and LGBTQ groups.[25]

However, increasingly social media is also used for harmful influencing of adults and young people which may result in criminal activity. Myths about health behaviours including sexual health are promoted resulting in risk to poor sexual health outcomes such as unplanned pregnancy or STI transmission. The influence of social media makes it easier for individuals to access pornography, or to be victims of online sexual abuse and grooming; all of which can impact on sexual and reproductive health.

NICE[26] advises positive impact on the use of social media to mitigate risk of STI transmission but with caution in terms of effectiveness.

This area is ever-changing with new themes emerging and further in-depth research and analysis of this topic area is needed.

## 15.8 Social Media Recommendations

**Social Media Recommendations**

- Promote stronger links between the Sexual Health Alliance and Community Safety developments both city and county to explore collaborations around aspects of harm reduction due to social media use
- Promote online safety and be aware of risks. The Internet Watch Foundation has developed a checklist to help keep children safe online. All parents and carers need to be aware of the risks of online child sexual abuse and the scale of the issue affecting children today. Information and resources can help support parents to keep their children safe online
- Better signposting for where to report inappropriate behaviour online

## 15.9 Sexual Health Alliance

One of the biggest challenges for sexual and reproductive health (SRH) across Derby and Derbyshire is working collaboratively across commissioning and provider colleagues with responsibility for sexual and reproductive health care. Sexual and reproductive health is commissioned by 3 main organisations:

- Local Authority Public Health
- Integrated Care System
- NHS England

Nationally and locally the SRH commissioning system is diverse, fragmented and at times complex, raising a need to reduce further fragmentation and work towards greater "joining up" elements of the system. A space for the different sexual health commissioners and providers was needed locally to support this action.

A major new forum, **the Sexual Health Alliance** (SHA), was established in the summer 2022 bringing together a growing number of partners from commissioners, providers and associated organisations including the voluntary and community sector operating within the local SRH system aligned to the ICS footprint.

The evolving work of the Sexual Health Alliance mirrors the principles of Integrated Care Systems towards greater "collaborative approaches to planning and improving services [27]."

Like an ICS, the Sexual Health Alliance depends on system-wide collaboration with focus on communities and local populations to drive sexual health improvement. It acknowledges that the business of sexual healthcare has to be about trusted relationships within a safe, honest space to address patient need and engender seamless, efficient and caring pathways that support navigation across the services landscape.

### Future working

The Sexual Health Alliance reports directly into the ICS, through the Integrated Place Executive (IPE). This gives strong opportunity towards greater collaboration to maximise the sexual health and wellbeing of the Derby and Derbyshire population, ensuring patient healthcare is central.

For additional information about our work: please contact mary.hague@derbyshire.gov.uk

# 16. Conclusions

This needs assessment should be seen as part of a continuous and inclusive process for staff, volunteers, service users and non-users going forward.

Derby and Derbyshire have different and diverse needs relative to sexual health and within each local authority area there are further challenges experienced by some populations which are harmful to their sexual health and wellbeing. It is important to regularly monitor this different need.

Findings from this SHNA reiterate the importance to ensure continued engagement with at risk populations and organisations. Placing individuals at the heart of strategic development and service design is key to address inequalities - co-production, active listening and use of people's "stories" alongside health data can really inform service developments and address challenges.

Sexual Health is not an isolated agenda, it is an intrinsic part of life and therefore it is important to ensure our local sexual health system is visible and collaborative across multiple areas of local strategy and provision.

Priorities within this SHNA and from the discussion at a stakeholder event, 21 June 2023 – 4 top priorities were favoured:

- Inclusivity
- Joining up and collaboration
- Prevention
- Workforce including the community and voluntary sector

The Sexual Health Alliance will lead the strategic direction for sexual health improvement mindful of the SHNA findings, recommendations and priorities towards a new 3-year Strategy.

The Alliance will ensure it evolves at pace to be truly representative of all stakeholders and embed its presence in the developing relationship within the Integrated Care System.

**Recommendations offering a system-wide perspective**

- Greater collaboration across the sexual health system – building on the work of the Sexual Health Alliance to address current challenges and opportunities
- Continue to strengthen the current membership of the Alliance ensuring opportunity is offered to engage key partners such as general practice, pharmacy and groups working with populations living with inequality
- Build on the positive but "recent" profile of the Sexual Health Alliance within the Integrated Care Partnership - through support and approval on agreed key priorities and the development of a longer-term strategy
- Explore ways to simplify sexual health commissioning and streamline pathways for users
- Expand performance indicators and monitoring to include service user experience and views. To ensure regular inclusion of "data" from users and non-users alongside available health data; with proactive ways to engage vulnerable communities to support development of local service offers
- Explore a system-wide review through the Alliance and evolving partners with focus on
    - Key findings from the SHNA and the evolving priorities
    - Challenges in the system including budget allocation meeting changing demand
- Develop a 3-year strategy underpinned by agreed priorities:
    - Inclusivity
    - Joining up and collaboration
    - Prevention
    - Workforce including the community and voluntary sector
- Develop and implement a 3-year action plan, to fulfil the agreed strategic vision and priorities, exploring "enabler" options discussed across stakeholders to address priorities

# 17. Sexual Health Service Standards

The following service standards are taken from the Integrated sexual health service specification published 20 March 2023 and produced in partnership between the Office for Health Improvement and Disparities and the UK Health Security Agency[1].

- BASHH and Brook. Spotting the signs: a national proforma for identifying risk of CSE in sexual health services (2014): https://www.bashhguidelines.org/current-guidelines/urethritis-and-cervicitis/mycoplasma-genitalium-2018/
- BASHH guideline for the management of infection with mycoplasma genitalium (2018): https://www.bashhguidelines.org/media/1198/mg-2018.pdf
- BASHH standards for the management of STIs in outreach services (2016): https://www.bashh.org/about-bashh/publications/sti-outreach-standards/
- Link to all BASHH Guidelines: https://www.bashh.org/guidelines
- BHIVA and BASHH UK guideline for the use of HIV PrEP (2021): https://www.bhiva.org/pepse-guidelines
- BHIVA and BASHH guidelines on the use of HIV PrEP (2018): https://www.bhiva.org/PrEP-guidelines
- BHIVA standards of care for people living with HIV (2018): https://www.bhiva.org/standards-of-care-2018
- BHIVA UK national guidelines on safer sex advice (2012): http://www.bhiva.org/safer-sex-guidelines.aspx
- BHIVA standards for psychological support (2011): http://www.bhiva.org/StandardsForPsychologicalSupport.aspx
- Link to all BHIVA guidelines: http://www.bhiva.org/guidelines.aspx
- COSRT code of ethics (2022): https://www.cosrt.org.uk/professional-standards/code-of-ethics-and-practice/
- FSRH service standards for SRH care (2016): https://www.fsrh.org/standards-and-guidance/documents/fsrh-service-standards-for-sexual-and-reproductive-healthcare/
- FSRH standards for emergency contraception (2017 amended 2020): https://www.fsrh.org/documents/ceu-clinical-guidance-emergency-contraception-march-2017/
- FSRH service standards for confidentiality in SRH services (2020): https://www.fsrh.org/standards-and-guidance/documents/fsrh-service-standards-for-confidentiality-in-srh-services/
- FSRH service standards for consultations (2020): https://www.fsrh.org/standards-and-guidance/documents/fsrh-service-standards-for-consultations-june-2020/
- FSRH quality standard for contraceptive services (2014): https://www.fsrh.org/standards-and-guidance/documents/fsrhqualitystandardcontraceptiveservices/
- FSRH clinical standards medicine management in SRH services (2018): https://www.fsrh.org/standards-and-guidance/documents/fsrh-service-standards-for-medicines-management-in-sexual-and/
- FSRH service standards for workload in SRH services (2020): https://www.fsrh.org/news/updated-service-standards-for-workload-in-sexual-and/
- FSRH service standards for record keeping in SRH care services (2019): https://www.fsrh.org/standards-and-guidance/documents/fsrh-service-standards-for-record-keeping-july-2019/
- Link to all FSRH standards and guidelines: https://www.fsrh.org/standards-and-guidance/
- Female genital mutilation: safeguarding women and girls at risk of FGM (DHSC 2017): https://www.gov.uk/government/publications/safeguarding-women-and-girls-at-risk-of-fgm
- GMC projection children and young people (2012, amended April 2019): https://www.gmc-uk.org/guidance/ethical_guidance/13257.asp
- Hepatitis A, Green Book, chapter 17 (PHE 2013): https://www.gov.uk/government/publications/hepatitis-a-the-green-book-chapter-17
- Hepatitis B, Green Book, chapter 18. (PHE 2013 updated November 2019): https://www.gov.uk/government/publications/hepatitis-b-the-green-book-chapter-18
- Hepatitis B and C testing: people at risk of infection. NICE Public Health Guidance 43 (2012 updated 2013): https://www.nice.org.uk/guidance/ph43
- Link to Institute of Psychosexual Medicine: https://www.ipm.org.uk/
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- NICE NG60 HIV testing: increasing uptake among people who may have undiagnosed HIV (2016): https://www.nice.org.uk/guidance/ng60
- NICE PH49 behaviour change; individual approaches (2014): https://www.nice.org.uk/guidance/ph49
- NICE PH50 domestic violence and abuse: multi-agency working (2014): https://www.nice.org.uk/guidance/ph50
- NICE CG30 LARC (2005 updated July 2019): https://www.nice.org.uk/guidance/cg30
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**Associated Key Factors**

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