

Leicestershire and Rutland Sexual Health Needs Assessment

Executive Summary for Rutland

October 2015

Executive Summary

1. Introduction

The sexual health needs of the population are evolving. Over the past few decades there have been significant changes in relationships, and how people live their lives including personal attitudes and beliefs, social norms, peer pressure, confidence and self-esteem, misuse of drugs and alcohol, coercion and abuse.

Although sexual relationships are essentially private matters, good sexual health is important to individuals and to society. WHO, 2002 defines sexual health as;

‘... a state of physical, emotional, mental and social well-being in relation to sexuality.’ (Page 5, WHO, 2002)(1)

Sexual ill health can affect all parts of society – often when it is least expected. Investment in sexual health not only improves the overall health of the population, it is also cost effective. The consequences of poor sexual health cost the NHS an estimated £193m in unintended pregnancies in 2010 and approximately £630m in HIV treatment and care in 2012/13. Evidence also suggests that;

- For every one_pound invested in contraception saves £11.09 in averted negative outcomes
- An increase in long acting reversible contraception (LARC) usage could save £102 million and
- Increasing HIV testing among Men who have sex with Men (MSM) and black Africans in England would prevent 3,500 cases of HIV transmission within five years and save £18million in treatment costs per year(2),(3).

There have been unprecedented changes to the sexual health system since the implementation of the Health and Social Care Act 2012. This has created fragmentation across the sexual health system with three main commissioners (local authorities, Clinical Commissioning Groups (CCGs) and NHS England.) National guidance suggests the need to take a patient-centred, systematic approach to sexual health commissioning around patient pathways. With key commissioners facing financial pressures, there is a need to develop strong collaborative approaches across commissioning organisations to ‘pull the system back together’ and ensure seamless, high quality, evidence based services are available to the local population.

2. Methodology

This Leicestershire and Rutland sexual health needs assessment triangulates national and local policy with quantitative and qualitative data to understand the needs, demands and supply of sexual health services across Leicestershire and

Rutland. The needs assessment has been split into chapters to ease navigation through the document. These are

- Demography
- High risk groups
- Sexually transmitted infections (STIs)
- HIV, sexual and reproductive health
- Sexual violence
- Engagement
- Conclusion
- Recommendations

The results will be used to inform the future direction for sexual health commissioning across Leicestershire and Rutland. This summary identifies the key issues for Rutland.

3. Demography of Rutland

- Rutland has an older population than the England average. This population is expected to increase by 6.8% by 2028, with greatest increases seen in people aged over 75years.(4)
- The main ethnic group is White, being 97% of the Rutland population.(5)
- Nationally 1.6% of the population define themselves as gay, lesbian or bisexual, this equates to ~600 people in Rutland. Men are twice as likely as women to declare themselves gay or bisexual.(6)
- Overall Rutland is a very affluent county with over half of the population living in the least deprived 20% of areas in the country. However there are still pockets of deprivation.(7)

Implications for sexual health services

- Evidence shows that sexual health needs are greatest in young adults and often reduce with age. Rutland has an aging population, meaning there may be less need for contraception than the England average. However there have been significant increases in numbers of over 45's presenting with STIs across LCR (59% increase between 2010-2014(8)). With the advances in treatment, HIV has become more of a long term condition with many people living with HIV into older age. Therefore the sexual health needs across the life course must be considered including those of the older population which may entail increased demand in psychosexual, HIV treatment and HIV social care services. Services also need to be equitable to meet the needs of different vulnerable groups. For example evidence shows that black ethnic minority (BME) groups and men who have sex with men (MSM) are at higher risk of STIs and HIV. Although

proportions of these populations are not high in Rutland, they are groups with high levels of sexual health service need, meaning that culturally appropriate, targeted services are required.

- There is a social gradient indicating that those living in the most deprived areas of Rutland experience the poorest health (including sexual health) outcomes and are at greater risk of teenage pregnancy. Hence service location need to take into account deprivation and groups of high risk of poor sexual health. This includes support for teenage parents who are at significantly higher risk of not being in education, employment and training.

4. Groups at high risk of poor sexual health

- Rutland has lower estimated prevalence of opiate and/or crack cocaine users aged 15-64, alcohol hospital admission rates and deaths due to alcohol specific conditions than the England average.
- Sex workers are at greater risk of sexual violence and poor sexual health and outcomes. Evidence suggest that men paying for sex are the bridging population for STIs, hence further work is needed to ensure that sex workers and men who pay for sex have access to condoms and regular STI screening. There are currently no saunas/parlours or street work known to be operating in Rutland. However, this does not mean that there are no sex workers operating in the locality although those choosing to pay for sex may do so outside of the county.
- At least one in four people will experience a mental health problem at some point in their life. In 2013/14 0.7% of the Rutland population is diagnosed with a mental health condition. This is significantly lower percentage than the England average (0.9%).(9) Poor mental health can be both a cause and effect of poor sexual health in particular the impact of stigma and discrimination, and mental health support following sexual violence or termination of pregnancy.
- In 2012, an estimated 12.0% of 16-64 year olds in Rutland had a moderate to severe physical disability. This is a higher prevalence than the national (11.1%).(10) National data suggests that people with physical disabilities are more likely to experience forced vaginal and anal intercourse, report greater than 10 sexual partners over a lifetime and identify themselves as other than heterosexual than people without disabilities.(11) These activities contribute to people with disabilities experiencing increased rates of STIs, unintended pregnancies, and sexual violence than those without disabilities.(12)

- In 2013/14 0.4% (122) of the Rutland population aged 18 years and above were registered with a learning disability.(9)
- In 2013/14, 27 households in Rutland were categorised as statutory homeless. This is significantly lower than the national rate of homelessness acceptances.(13) Homeless people are at increased risk of STIs and unwanted pregnancies and can come under pressure to exchange sex for food, shelter, drugs and money.
- The 2013/14 rate of looked after children in Rutland was 45.1 per 10,000, which is similar to the national average of 59.8 per 10,000 population.(13) Young people who are looked after are recognised as being vulnerable to risk taking behaviour(14) including early and unprotected sexual activity, self-harming, misusing illegal and/or volatile substances and alcohol. This makes this group particularly at risk of teenage pregnancy.

Implications for sexual health services

There are a number of vulnerable groups (including those that misuse substances, sex workers, homeless, those with mental health, learning or physical disabilities, children with child protection plans or that are looked after) that are more likely to participate in risk taking sexual behaviour and consequently have poorer sexual health outcomes than the general population. Each group has diverse requirements and therefore sexual health services should regularly complete an equalities impact assessment to review how they are meeting the diverse needs of these populations. Interventions may include targeted services (for example to MSM) or tailored information (for people with learning disabilities or English as a second language). Pathways between services that address risk taking behaviours (sexual health, mental health and substance misuse) should also be further developed across service providers to address the root cause of risk taking behaviours.

5. Sexually Transmitted Infections (STIs)

- In 2014, there were 193 new STIs diagnosed in residents of Rutland (62% male and 38% female), a rate of 515.9 per 100,000 residents. These rates were significantly better than the national rate of 796.1 per 100,000 population and similar to comparator local authorities (Appendix 1).(15)
- The highest rate of STI diagnoses in Rutland were in the 20-24 age band. This was followed by the 25-34 year age band, differing from Leicestershire and England, where the 15-19 age band was next highest.(15)
- Rutland has a new diagnosis STI rate (excluding chlamydia under 25years and prisons) significantly lower than the national average. Chlamydia, followed by

genital warts, were the most prevalent STIs in 2014. From 2012 the rate of genital warts in Rutland was higher (although not significantly) than the national average.(16)

- Syphilis has the lowest rate of new STIs both nationally and locally. Rutland has a higher syphilis rate than comparator local authorities, but this is not significant due to the rate in Rutland fluctuating due to small numbers.(16)
- The rate of genital herpes nationally has increased year on year since 2009, although Rutland rates have remained continuously lower than the national rate. Rutland rates fluctuate due to small numbers involved.(16)
- Nationally, young people aged 15-24 years, MSM and black Caribbean ethnic groups have been shown to have higher rates of new STIs.
- There has been an increase in the proportion of new STIs among MSM from 5.5% (n=6) in 2010 to 7.6% (n=8) in 2013 for Rutland. Chlamydia, gonorrhoea and syphilis diagnosis is higher in MSM as compared to heterosexual men, where chlamydia and genital warts was the most dominant STI.(17)
- The majority of STI diagnosis across Rutland is found in the White population.

Chlamydia screening

- In 2014 Rutland screened a significantly worse percentage of 15-24 year olds for chlamydia (18.9%) than the national average (23.9%) and some comparator local authorities (East Riding of Yorkshire, Cheshire East, Wiltshire, Cambridgeshire, North Yorkshire and Oxfordshire, Appendix 1). The chlamydia diagnosis rate for 15-24 year olds in Rutland was 1,390 per 100,000 population, being significantly lower than the national average of 1,978 per 100,000 population. In terms of percentage positivity both Rutland had lower positivity than the national percentage of 8.3% at 7.8%. Rutland performs lower than some comparator local authorities for Chlamydia detection rates, but this is only significantly lower than East Riding of Yorkshire.(16)
- Nationally and across Rutland males age 20-24 years have the highest percentage of tests with a positive result, followed by females aged 15-19 years. Chlamydia detection rates are higher in females than males aged 15-24 years. This distinction is particularly marked in Rutland where the rate for males is 888 per 100,000 aged 15-24 years, whereas the female rate is 2,054 per 100,000 females aged 15-24 years. Interestingly positivity rates from the Integrated Sexual Health Service (ISHS) are higher in males than females across LCR.(13)
- In Rutland, the highest percentage of 15-24 year olds tested for chlamydia were in 'Other locations', GPs and GUM.(8)

- In Rutland, community sexual health services has the highest percentage positivity (17.0%) followed by GUM clinics (11.3%). It must be noted that these high positivity percentages are likely to fluctuate due to smaller numbers involved.(8)

GUM access overall

- In 2014, there were 684 first time attendees from Rutland attending any sexual health clinic in England, of these 63% were male. In 2014, the age group most frequently attending for a sexual health screen was 25-34 age band. This could indicate problems of access for younger people or reflect the Rutland population profile.(8)
- 14% of attendees were homosexual/bisexual males and less than 1% of women were homosexual or bisexual.(8)
- There was a decrease in women and an increase in men attending for a sexual health screen in 2014 in Rutland.(8) This could be a consequence of the new ISHS model.

Leicester, Leicestershire and Rutland (LLR) integrated sexual health service (ISHS)

- The new LLR integrated sexual health service model commenced from 1 January 2014 with two new hub site locations (St Peter's and Loughborough) and five additional spokes (4 in Leicestershire and 1 in Rutland). Hub opening hours have increased to 9am-8pm Monday to Friday and Saturday mornings, (spoke sites are sessional). The change of clinic sites and establishment of the new service may have impacted on activity levels in 2014 as the new service established new locations. However there was an overall increase in attendances for GUM purposes to LLR sexual health sites by 44 for Rutland.
- In 2014 there were 354 attendances to the LLR ISHS by Rutland residents for both GUM and contraceptive services. 83% of the patients attending the Leicestershire clinics were residents of Leicestershire, 1.9% were residents in Rutland and 7% lived in Leicester City. The new service has decreased the percentage use of GUM clinics outside of LLR by 10% in Rutland between 2013 and 2014. In Rutland in 2014, Loughborough Health Centre (hub and spokes) had the highest counts of patients attending a GUM, followed by Edith Cavell in Peterborough.(18)
- The highest user age band was in the 15-24 age group. The majority (73%) of attendances were female. This is likely to be reflective of attendances for contraceptive services.(18)

- The majority of attendees were of white ethnicity which is reflective of the local population.
- The percentage of male attendees identifying as homosexual or bisexual was 13.8% for Rutland and 14.2% for Leicestershire.(18)
- In Rutland 40% of the population live less than a 10 minute drive from an ISHS site and 19% have a drive of 20-30 minutes. However the Rutland clinic site is sessional and has limited capacity.(19) N.B. this assumes residents access the service via private transport as public transport were not reviewed in this document.

Implications for sexual health

- Overall Rutland experiences lower than rates of STI diagnosis than the England average. Chlamydia is the most common STI across Rutland, followed by genital warts. This is a similar trend to Leicestershire County. Young people aged 15-24 years, MSM and black Caribbean ethnic groups have been shown to have higher rates of new STIs across LCR, which is aligned with the national picture. Increases in have been seen in the proportion of STIs diagnosed in MSM across Rutland (and Leicestershire). This may be due to increased uptake of STI screening or higher STI prevalence. Either way targeted work must be maintained with MSM due to the high level of sexual health need.
- Rutland does not perform well against the national average and some comparator local authorities for Chlamydia screening in 15-24 year olds. This has been particularly apparent since changes have occurred in the national data collection from 2012. However all comparator local authorities perform similarly, which may indicate that the overall prevalence of chlamydia is lower than the national average. Either way chlamydia screening is a useful tool in normalising STI screening with young adults, therefore opportunistic screening should be increased in core sexual health services.
- There have been increases in GUM attendance locally and to clinics outside of LLR by Rutland residents. This may reflect increased access due to the new LLR ISHS, increased awareness of STI screening, but also reflects the increased STI need. Slightly older populations (25-29year olds) are most frequently accessing the ISHS from Rutland as compared to Leicestershire (20-24year olds) which may reflect reduced access or the demography of the population. In 2014 there was an increase in men and decrease in women accessing GUM sexual health services locally. This may be due to changes in the ISHS service model. Further work is needed to increase sexual health access to high risk groups (including MSM), female and younger populations in Rutland.
- Rural access is a particular difficulty for Rutland due to limited access to some

hub and spoke sites via public transport. The use of clinics outside of LLR by Rutland residents reflects access issues as some residents may choose to go to other open access sexual health services perhaps closer to workplaces and colleges. The new ISHS has reduced out of area GUM access by 10% in Rutland between 2013 and 2014. Increasing accessibility to local services and providing alternative local sexual health service provision such as general practice and pharmacy may continue to reduce use of out of area services.

6. Human Immunodeficiency Virus (HIV)

- In 2013 the HIV diagnosis prevalence in was 0.73 per 1,000 population aged 15-59 years for Rutland. This is significantly lower than England average of 2.1 per 1,000 population aged 15-59 years and lower than most comparator local authorities (Appendix 2).(16)
- HIV prevalence rates across Rutland (and Leicestershire) have increased over time. This is largely due to increased life expectancy as treatment has improved to make HIV a long term condition.
- In 2013 there were 15 adults received HIV related care in Rutland, 66% male and 33% female. 53% were white and 40% black African ethnicity. The likely route of infection was approximately 53% sex between men and 47% sex between men and women. There were no new diagnoses in 2013, which shows Rutland is performing better than all its local authority comparators.(20)
- In 2011-13 67% of HIV patients in Rutland were diagnosed at a later stage of infection, most of these being heterosexual. This is higher than the England overall percentage of 45%. However due to the small numbers, Rutland's overall rate of late HIV diagnosis is the best performance compared to local comparators (Appendix 1).(13)
- The uptake of HIV testing at GUM clinics was similar in Rutland (79.4%) than in England (80%). Uptake by men in Rutland was lower than the England average.(16)
- Community based testing is available for some groups in Leicestershire and Rutland. Home testing and home sampling HIV tests are now legally available and a home sampling pilot targeting MSM and black African communities is due to commence across Leicestershire and Rutland in late 2015.

Implications for sexual health

- There is significantly lower HIV diagnosis rates across Rutland compared to

the national rate and local authority comparators. However HIV prevalence overall is increasing locally and nationally largely due to increased life expectancy as treatment has improved to make HIV a long term condition. There are implications for health and social care providers as the HIV positive group increases in number and becomes an aging population with changing health needs.

- Early HIV diagnosis is important to improve health outcomes for the individual, reduce risk of onward transmission and lower treatment and care costs. Rutland has a higher late HIV diagnosis percentage than the England average. This is particularly apparent in heterosexual transmission. Therefore further work is needed to educate the heterosexual population about HIV and increase access and uptake of HIV testing, for example in Rutland males accessing GUM. Referral pathways between sexual health and HIV services must also be reviewed to ensure there are seamless pathways which prevent unnecessary delay between diagnosis and treatment. Commissioning of alternative HIV testing methods such as home testing and home sampling are important options to consider for increasing HIV testing to high risk groups including MSM and black African communities. The implications of the PROUD study on pre-exposure prophylaxis should also be considered to reduce HIV transmission to specific high risk groups.

7. Sexual Reproductive Health

Contraception

- It is estimated that on average, women have a 30 year time period in which they will need to avert an unintended pregnancy.
- Contraception is cost saving, with £11 saving for every £1 spent. NICE guidance identifies that LARC methods such as contraceptive injections, implants, the intrauterine system (IUS) or intrauterine device (IUD) are more effective at preventing pregnancy than user dependent methods(e.g. oral contraception, condom).
- Contraception is available from specialist open access sexual health services and from general practice. It is estimated that 80% of contraception is delivered through general practice (GP).
- In 2013, 193 Rutland residents attended specialist sexual health services for contraception.(17)
- In specialist contraceptive services across LCR, user dependent methods of contraception (UDM) were most frequently prescribed for all ages except for the

35-44 year age group, who were most frequently prescribed LARC methods. In 2013, similar or lower proportions of LARC were prescribed overall compared to the England average in all age groups except for the 18-19 and 25-34 year age groups in Rutland.(17)

- For Rutland residents, LARC represents 46% of contraceptive provision from specialist sexual health services and 15% from general practice.(17)
- LCR has a higher rate of LARC prescribing from primary care compared to the national average. The rates in 2013 were 76.1 per 1,000 women aged 15-44 years for Rutland as compared to 52.7 for England and compared to local comparator local authorities. There has been a small increase in the proportion of LARC delivered across Rutland in primary care between 2013 and 2014.(16)
- 4 practices provide contraceptive implant fitting and activity levels vary across practices. In 2014/15 there were 157 implant insertions and 104 implant removals.
- 4 practices provide inter uterine devices/ systems (IUD/S) fitting and activity levels vary across practices. 183 IUD/S fits were completed in 2014/15.
- Retention of LARC methods is an important factor. LARC methods are cost effective even at one year's use compared to user dependent methods such as the contraceptive pill. Retention rates are difficult to calculate as women may attend different services for fits and for removal.
- The IUS is also used for non-contraceptive purposes e.g. control of heavy menstrual bleeding. This is the commissioning responsibility of Clinical Commissioning Groups. The number of fits for this purpose is difficult to determine from available data sources.
- Approximately 60% of practitioners delivering LARC services across LCR currently hold national FRSB Letters of Competence. Ongoing training is required to maintain competencies of practitioners to provide IUD/S and SDI in primary care.

Emergency Contraception

- It is important to access emergency contraception (EC) as early as possible after unprotected sex or contraceptive failure so good access to local services is important.
- There are different types of EC available. There are two types of Emergency Hormonal Contraception (EHC), LNG and UPA (EHC) and also Cu IUD.
- All forms of EC are available from the ISHS and General Practice. EHC (LNG) is available from 5 pharmacies in Rutland, 84 pharmacies in Leicestershire and from some school nurse clinics.

- In 2014-15 there were 190 EHC consultations in Rutland Pharmacies. Rutland residents also use Pharmacy services outside of Rutland. Across LCR, the majority of users were in the 19-24 age group. The most frequently stated reasons for accessing EHC were split condom (almost 50%) and no contraception used (40%). The number of patients referred on to sexual health services for further sexual health/contraceptive advice increased between 2013-14 and 2014-15.(21).

Psychosexual services

- There have been no known referrals for psychosexual services for residents of Rutland.
- The Natsal-3 sexual attitudes and lifestyles in Britain survey (2010-12) indicated 51% of men and 42% of women surveyed experienced one of more sexual difficulties lasting more than three months in the past year, including lack of interest in having sex, feeling anxious during sex, pain during sex, vaginal dryness and problems getting or keeping an erection.(22)

Teenage Pregnancy

- In 2013, the under 18 conception rate per 1,000 female aged 15 to 17 years was 9.2 in Rutland, while in England the rate was 24.3. Between 1998 and 2013, Rutland achieved a 45.6% reduction in the under 18 conception rate. Nationally the rate reduced by 47.9% throughout this time. Rutland has the lowest under 18 conception rate when compared to comparator local authorities.(16)
- In Rutland, the rate of under 18 conceptions has remained consistently lower compared to all Leicestershire districts over time. Rutland saw an increase in their conception rate 11.7 per 1,000 15-17 aged females in 2010-12 to 12.3 per 1,000 in 2011-13.(23)
- Since 2008-10, Rutland has witnessed a year on year decrease in the percentage of under 18 conceptions leading to abortions from 50.0% in 2008-10 to 30.0% in 2011-13.(23)

Abortion

- Nationally an estimated one in six of pregnancies were unplanned, two in six were ambivalent and three in six were planned. This gives an annual prevalence estimate for unplanned pregnancy of 1.5%. Pregnancies in women aged 16–19 years were most commonly unplanned (45.2%) however, most greatest proportion of unplanned pregnancies were in women aged 20–34 years (62.4%).(24)
- There were 55 abortions for Rutland residents in 2014.(25)

- In 2014 the abortion rate for Rutland was 9.5 per 1,000 female population. This is significantly better than England average of 16.5 per 1,000 female.(25)
- The highest abortion rate was for the 20-24 year population. Note this is different to Leicester City where the highest abortion rate is in the 25-29year olds.(25)
- In 2014, 21.4% of women in Rutland had had a previous abortion, while in England the proportion was higher at 27.0%. This increases to 37% for Rutland in the over 25 age group, however this is aligned with the England proportion at 45.6%.(25)
- In 2014 85.2% of Leicestershire women accessing abortion were under 10 weeks gestation at time of procedure, which is higher than the England average of 80.4%. Rutland has the highest performance compared to comparator local authorities (Appendix 1).(25)
- In 2014 in Rutland, 8% women accessed an abortion procedure at 13 weeks or more gestation. This was similar to National average of 9%.(25)
- In 2014, approximately a third of all abortions in Rutland were surgical procedures compared to approximately half in England.(25)
- There are two providers of abortion services commissioned for LLR population. There is limited local availability of procedures over 12 weeks. Self-referral is not available for both providers.

Implications for sexual health

- Contraception is a cost effective intervention for the whole of society. LARC is shown to be the most cost effective method available. Across Rutland LARC prescribing rates are above the national average for primary care, however contribute to a lower proportion of total contraception use. Therefore additional work is needed to maintain the level of GP provision and increase the proportion of LARC procedures completed in the ISHS. This will include working with GPs to increase the proportion of LARC fitters accredited via the national Letter of Competence and to undertake an audit to gain a better understanding of how long LARC devices are being retained by women.
- It is important to maintain easy access to emergency contraception (EC) to allow women to access services as soon as possible after they have had unprotected sex. There is good access to EC across LCR provided by the ISHS, GP and local pharmacy. Consideration should be given to new forms of EHC such as UPA (which has a longer effective window) and ensuring women accessing EHC are referred into contraceptive services to establish a longer term contraceptive regime (in particular LARC).

- The Natsal-3 sexual attitudes and lifestyles in Britain survey (2010-12) indicated 51% of men and 42% of women surveyed experienced sexual difficulties lasting more than three months in the past year. **Error! Bookmark not defined.** Hence there is likely to be some unmet demand for psychosexual services across Rutland due to no current attendances within the ISHS. With an aging population, this demand is likely to increase. Therefore commissioners should consider increasing awareness of the existing service and increasing the activity levels in the future. Discussions are also needed with the local CCGs to identify services for patients with sex addiction.
- The under 18 year conception rate is significantly lower than national average and comparator local authorities. The proportion of under 18 conceptions leading to abortion, is reducing and is lower than the England average. However conceptions leading to abortion and numbers of young people accessing emergency contraception, suggests that there are still young people who continue to take risks and not use contraception despite not wanting to become pregnant. Therefore continued easy access to relationships and sex education, including provision in independent schools, and to community based sexual health services is important to maintain and improve current progress. Training around teenage pregnancy and related issues is important to ensure a high quality children's workforce who feel competent to discuss a range of issues and support young people's access of health services.
- Teenage parents experience barriers in accessing education, employment or training. This will impact on their lifelong opportunities, which will impact on the health and wellbeing of both themselves and their child. Therefore a co-ordinated response to the support of young parents is important to ensure a range of needs are addressed.
- Rutland has a lower abortion rate than the national average. However a fifth of women had previously had an abortion and some women are accessing services at a stage of later gestation, which reduces their choice of procedure and increases risk of complications and healthcare costs. There is also limited local availability for procedures over 12 weeks across Leicestershire and Rutland and self-referral is only available in one provider. Therefore additional work is needed to increase access to local abortion services and ensure that all abortion patients are supported to establish a long term contraceptive plan to avoid repeat abortions.

8. Sexual Abuse

- In 2013/14, there were 14 reported sexual offences in Rutland. In this year, the rate of sexual offences in Leicestershire was 0.38 per 1,000 population. This rate is lower than the national rate of 1.01 per 1,000 population. Since 2011/12, the rate for sexual offences in Rutland has decreased year on year.(13)

- Natsal-3 found that 1 in 10 women and 1 in 71 men said they had experienced non-volitional sex since age 13 (median age for males was 16 and for females was 18). People with poorer physical, mental and sexual health, including treatment for depression or another mental health condition in the past year, a long-term illness or disability, and a lower sexual function score were more likely to report non-volitional sex.(26)
- In 2014, the estimated numbers of people the adult population aged 18-64 who report having been sexually abused during their childhood was 735 females and 1,600 males in Rutland. These numbers are estimated to decrease slightly in Rutland over the next fifteen years.(27)
- Over the past three years referrals to the LLR Child Sexual Exploitation (CSE) team have increased from 54 in 2012/13 to 165 in 2014/15. Prevention, identification and support for victims of CSE remains a key priority for sexual health services.

Implications for sexual health services

- Domestic abuse is a widespread issue and can take place in a range of relationships. There is a lack of understanding around what constitutes domestic abuse. The national coverage on historic abuse and current approaches to raise awareness about CSE are likely to lead to increases in the number of victims coming forward and seeking help. It is therefore important that staff who work in sexual health services are aware of the prevalence of domestic abuse and CSE and are equipped to ask appropriate questions when seeing patients to allow disclosures to be made and appropriate referral onto specialist services.

9. Engagement

- As part of this SHNA a range of stakeholders and service users have been consulted. This includes 2 sexual health stakeholder events consulting over 100 stakeholders and 7 focus groups consulting with 94 people from May to September 2015. Specific Rutland groups that were engaged included the Oakham Youth Group, and Learning Difficulties and Disabilities (LDD) Partnership Group. Rutland specific feedback included the need to complete the needs assessment, develop the workforce, increase access to rural populations (including C-Card), school nurse EHC provision and to have parity of RSE support. LLR historical research findings on HIV prevention services, Relationships and Education, young people's knowledge, attitudes and experience of sexual health and access to LARC and have also been summarised.

- National data and local engagement work highlighted the critical exploration of relationships in both Relationships and Sex Education (RSE) and in the delivery sexual health services.
- There continues to be a lot of confusion over how contraceptive methods work and myths about their reliability and use.
- Services need to take account of the role the media plays in influencing decisions about sex and relationships and make attempts to counter negative or unhelpful overt messages with positive ones e.g. promotion of consent, how to access confidential services and what a healthy relationship looks like.
- Service users value the importance of having local, community based sexual health provision.
- Service providers and users both highlighted gaps in information about the sexual health services that are available, how they can be accessed and how complaints can be raised.
- Additional messages from local stakeholders and professional included the need to clarify the sexual prioritises and commissioning responsibilities across the system to develop a truly integrated LLR sexual health system. Particular feedback was gained on the need to provide equitable and timely access to services, develop the wider sexual health workforce (including primary care) and develop seamless pathways across organisations and services.

Implications for sexual health

- National data and local engagement work highlighted the critical exploration of relationships in both RSE and in the delivery sexual health services. With the impact of social media, evolving sexual practices and a reducing age of first sex, promotion of consensual, informed and respectful relationships is important to balance against other messages.
- Services need to take account of the role the media plays in influencing decisions about sex and relationships and make attempts to counter negative or unhelpful overt messages with positive ones e.g. promotion of consent, how to access confidential services and what a healthy relationship looks like.
- Service users value the importance of having local, community based sexual health provision. Service providers and users both highlighted gaps in information about the sexual health services that are available, how they can be accessed and how complaints can be raised. Clear and consistent information is required to ensure practitioners and service users know which services they can access and how they do this.

- Despite there being a wider choice of contraception available, there continues to be a lot of confusion over how contraceptive methods work and myths about their reliability and use. Messages about relationships and sex (in school and beyond) need to include clear and concise information about contraceptive methods. In order to promote the LARC methods it is important that the benefits and implications of these methods are understood and communicated to the women who choose to use them.
- From the perspective of Sexual Health Service Providers, key priorities to address are clarifying the priorities for sexual health delivery, commissioner and provider roles and responsibilities, integrating sexual health services across the system and further development of the wider sexual health workforce (including primary care and school nursing). Areas which both providers and service users highlighted including wanting more equitable and timely provision across LLR, wanting easier access in to services, seamless patient pathways, prioritising education on relationships and sex and ensuring clear information about local services.

10. Conclusion

Overall Rutland is meeting the majority of the sexual health needs of the local population. This is evidenced by continuing lower rates for all STIs (including HIV), under 18 conceptions and sexual abuse than the England average and many local authority comparators (see Appendix 1 and summary dashboard Appendix 2). Nevertheless absolute numbers of some STIs (including gonorrhoea) and patient led demand is increasing across Rutland. This is consistent with the national picture, where more people are accessing specialist sexual health services. However locally this increase is also likely to be linked to the improved access created by the new integrated sexual health service and community based contracts, which have increased numbers and proportions of residents accessing local services across Rutland. (Although there is still significant use of specialist sexual health services outside of LLR by residents of Rutland.) STI screening and contraception uptake are part of a prevention approach to enable people to maintain good sexual health. Further work is on-going to establish high quality relationships and sex education across all secondary schools; this supports young people to develop positive, healthy relationships.

Each section above (demography, high risk groups, STIs, HIV, sexual reproductive health, sexual violence and engagement) provides specific implications for sexual health services following the review of evidence of need. When triangulating these sections together key areas for improvement across Leicestershire and Rutland include bringing together the sexual health commissioning system, prioritising prevention and access to vulnerable groups (including young people, men who have sex followed by sex workers, black African communities and people with physical

disabilities) and developing the sexual health workforce (including non-specialist provision such as primary care, school nursing and substance misuse). The recommendations from this triangulation are set out below. These will be translated into a sexual health strategy for Leicestershire and Rutland and reported to local authority departmental management teams, Health and Wellbeing Boards, health scrutiny, Cabinet and other appropriate meetings for approval and implementation.

Key strengths of the needs assessment include the breadth and depth of validated quantitative national data sources that deliver reliable accurate data on service utilisation. This is a good reflection of need for contraception and STIs that have symptoms, however is less effective for symptomless or latent STIs such as chlamydia and HIV. Although recent media interest may increase presentation, there is also likely to be underreporting for psychosexual issues and sexual abuse including FGM and CSE. High quality information on specific vulnerable groups (e.g. sex workers, MSM, FGM etc.) was difficult to ascertain. Due to small numbers in many indicators (especially for Rutland) numbers can fluctuate widely across years, making trends more difficult to interpret. There were also different time lags in data sources which must be considered when comparing sections. Qualitative feedback with nearly 200 people was also completed as part of the needs assessment to add additional local detail and identify themes from the results, however fully validated thematic analysis using NVivo was not completed. The consultation with representatives from services was undertaken at a time of year that made it difficult for certain sectors to be involved e.g. teachers and representatives from education and the service user consultation was quite targeted being mainly with individuals under 25. Wider consultation with the general population would provide a broader perspective of views and this will be completed as part of the consultation on the needs assessment and strategy. Results from the needs assessment may be similar to that seen in other affluent counties across England, however is less generalisable to more urban cities.

The Rutland sexual health needs assessment provides commissioners with a clear evidence base on sexual health need, supply and demand. With increasing and aging populations, changing sexual health needs across Rutland and increasing pressure on public sector budgets. It is therefore necessary to evolve innovative integrated service models to meet this demand within constrained budgets across the local health and social care system.

11. Recommendations

The following section summarises the key recommendations for sexual health commissioners and service providers across Rutland; N.B. these have been categorised to develop the key themes in the draft Rutland Sexual Health Strategy 2016-19.

11.1 Sexual Health Commissioners

- 1. Development of a sexual health strategy for Leicestershire and Rutland.**
Ensure that this engages and integrates the whole sexual health system, has clearly defined priorities, roles and responsibilities and considers sexual health across the life course.
- 2. Explore co-commissioning opportunities to integrate sexual health patient pathways across commissioning organisations.** For example, with CCGs for primary care, menorrhagia, sex addiction, abortion services and NHS England for HIV services (including the implications of the PROUD study). Also consider how sexual health services can be further integrated into other local authority services such as substance misuse, school nursing, health visiting and social services (for HIV positive patients).
- 3. Monitor demand for psychosexual services** and potentially increase provision as awareness and need increases with an aging population.
- 4. Identify service provision to support people with sex addiction.** Work with CCG mental health commissioners to consider appropriate access to treatment for sex addiction across LCR.
- 5. Development of an LLR sexual health marketing and communications strategy** to promote consistent brands and messages about healthy relationships, reducing stigma and how to access services. Additional service promotion is needed to target groups and areas at higher risk of poor sexual health including young people, MSM, sex workers, black African communities. The implications of late HIV diagnosis should be raised with the heterosexual population. N.B. This should consider links to out of area services such as those accessed in Peterborough.
- 6. Assess the cost effectiveness of UPA emergency hormonal contraception** by completing a cost benefit analysis of increasing access to UPA locally. This should then inform future emergency contraception provision across LCR.
- 7. Undertake an audit of LARC retention rates in primary care and ISHS** to ascertain how well informed women are of the implications of these methods and how long women are retaining them for. This should focus particularly on younger women aged 15-34years.
8. Consider **locality priorities to address the differing trends in teenage pregnancy** across the 7 Districts in Leicestershire and in Rutland.
9. Additional work is needed with the police to **understand the causes of the increases in sexual offences** in Leicestershire and interventions to help reduce these offences.

10. **Rutland commissioners to consider agreeing a local tariff arrangement with Peterborough sexual health services** due to the number of GUM attendances within this area.
11. Consider the **sexual health needs of the military barrack populations in Rutland**. This should form part of a wider health needs assessment on these defined populations.

11.2 Sexual health services

12. **Equality impact assessment should be completed in all sexual health services** to ensure the services are meeting the needs of whole population including those with protected characteristics as determined in the 2010 Equality Act. Particular attentions should be placed on sexual orientation, BME (including Asian populations that have under representative STI diagnosis), English not as a first language and people with learning and physical disabilities.
13. **Investigate the current barriers to accessing sexual health services from General Practice**, in particular by young people, LGBT and Sex Workers.
14. **Increase chlamydia screening as part of the core ISHS** (i.e. GUM and CSHS) due to high positivity rates and prioritise opportunistic screening to sources of highest positivity such as preventex postal kits.
15. Explore more **innovative models of ISHS service delivery to improve access particularly in more rural areas** including Melton and Rutland .e.g. implementing virtual clinics, online testing etc. Priority should be given to increasing access to sexual health screening to men across Leicestershire and women and those aged 20-24years in Rutland.
16. **Improvements are needed to the appointment booking system for ISHS**. The service should continue to offer both appointments and drop-in appointment options.
17. **Develop effective and efficient pathways between sexual health services and domestic abuse, substance misuse and mental health services** to address the root causes of the risk taking behaviour.
18. **Ensure sex workers and men who pay for sex have access to condoms and regular STI screening** to reduce bridging of STIs into the wider population.
19. **Increase access to community and home based HIV testing for specific groups at higher risk of HIV** (MSM, sex workers, young people, African heritage.) This includes developing robust protocols and pathways for local HIV testing to ensure rapid access to support and treatment for people with reactive

test results. Attention should also be given to increasing HIV testing within ISHS for men in Rutland.

20. **Health and social care providers should consider future needs of HIV positive population.** This includes implications of an ageing HIV population and assurance for patients that confidentiality is maintained as the group of care providers extends beyond specialist HIV care providers.
21. **Maintain good access to emergency contraception,** particularly for young people and Asian women. Improve pathways between emergency contraception providers and other sexual health services to ensure longer term sexual health needs are met.
22. **Improve information and access to range of contraception methods to young women aged 15- 25years,** including LARC. This includes reviewing the current model of LARC delivery in primary care to reduce the proportion of women using user defined methods through GPs and ensuring community provision is available for young people.
23. **Increase access to abortion services by developing a single point of access for LLR** (including self-referral) to improve the proportion of women accessing services under 10 weeks gestation. Consideration is also needed to improve local access to abortion services over 12 weeks gestation.
24. **Review of the specialist teenage pregnancy and community midwifery service pathways** to identify opportunities for further integration with sexual health services and to determine the extent to which they are meeting current need.
25. **Review the support needs of teenage parents and mothers in particular those aged 19-21** to ensure that they can positively progress into education, employment and training at a point that is timely for them and their families.
26. **All sexual health services should support the LLR CSE strategy.** Consultation with the CSE Team and if possible, victims of CSE needs to explore to what extent the current SHS offer meets the needs of this vulnerable cohort

11.3 Training

27. **Complete a sexual health training assessment to develop a workforce plan** to improve all levels of sexual health competencies across LCR. LARC provision and primary care is a key priority for this plan.
28. **Ensure high quality RSE training/ provision is delivered across LCR** to ensure young people can make informed choices about their sexual health. Materials should give greater emphasis on healthy relationships, consent, domestic abuse, how to seek help, all contraceptive methods and the links

between alcohol and risk taking sexual behaviour. RSE materials to support parents should also be considered.

29. **CSE and domestic abuse training should be accessed by key staff from all sexual health providers** to ensure that practitioners can identify and understand local support pathways available.

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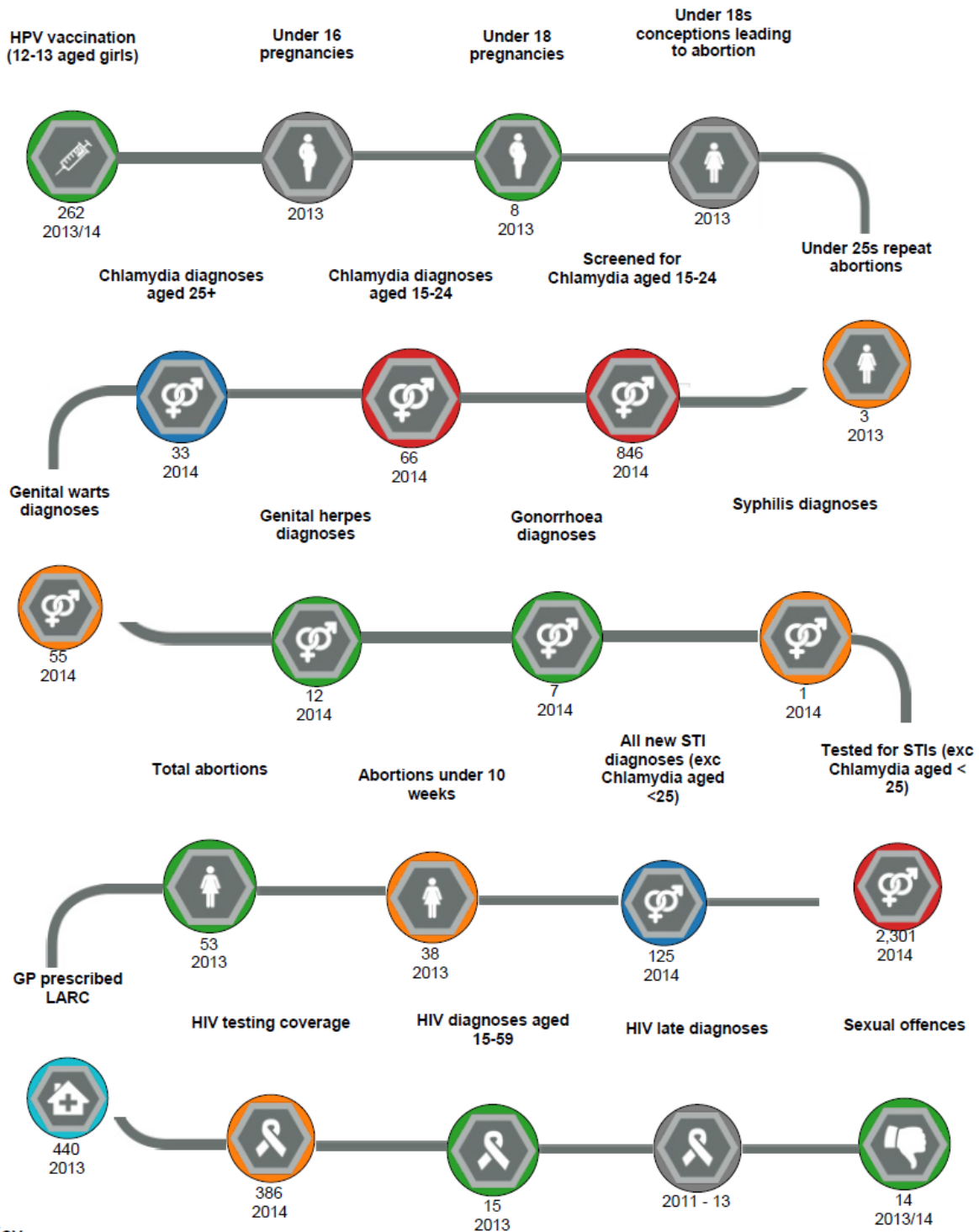
Appendix 1 Rutland Sexual and Reproductive Health performance compared to comparator local authorities. (Data PHE Sexual and Reproductive Health profiles, data as of November 2015. N.B HIV data has been updated from the full needs assessment).

Indicator	Buckinghamshire	Cambridgeshire	Central Bedfordshire	Cheshire East	East Riding of Yorkshire	North Yorkshire	Oxfordshire	Rutland	West Berkshire	Wiltshire	Worcestershire	Rutland rank (1 best)	Polarity (is L or H good)
Abortions under 10 weeks (%)		74.60	82.40	78.96	80.17		76.24	85.19	83.19	81.55	76.99	1	H
All new STI diagnoses (exc Chlamydia aged <25) / 100,000	575.77	481.32	508.41	551.21	448.07	397.57	776.91	538.93	512.18	473.10	567.83	7	L
Chlamydia detection rate / 100,000 aged 15-24 (PHOF indicator 3.02)	4237.51	4713.74	3944.60	5175.80	6003.10	5043.97	3530.27	4332.37	2844.18	5123.84	4774.39	7	H
Chlamydia proportion aged 15-24 screened	19.13	24.94	16.05	23.21	21.67	22.93	20.86	17.82	10.86	19.62	17.96	9	H
Gonorrhoea diagnosis rate / 100,000	25.00	17.24	21.55	19.85	14.88	12.28	50.74	18.61	17.38	19.39	21.85	5	L
GP prescribed LARC rate / 1,000	56.94	72.41	63.18	52.61	74.07	100.57	65.02	90.30	74.00	82.76	63.42	2	H
HIV diagnosed prevalence rate / 1,000 aged 15-59	1.39	1.09	1.32	0.91	0.41	0.59	1.13	0.48	0.75	0.70	0.76	2	L
HIV late diagnosis (%) (PHOF indicator 3.04)	53.73	52.81	45.71	43.90	47.83	55.00	44.44		0.00	40.63	67.50	1	L
HIV testing uptake, total (%)	79.60	83.60	76.40	61.80	63.00	75.70	81.90	77.90	80.50	78.20	70.10	6	H
New HIV diagnosis rate / 100,000 aged	5.67	5.85	5.00	6.08	1.40	2.96	3.43	0.00	2.37	2.26	5.41	1	L

15+													
Population vaccination coverage - HPV (%) (PHOF indicator 3.03xii)	88.37	91.84	91.25	93.12	89.31	83.77	92.51	93.57	85.07	87.98	86.39	1	H
Sexual offences rate / 1,000 (PHOF indicator 1.12iii)	1.18	1.17	0.81	0.92	1.19	1.16	1.33	0.98	1.20	1.23	1.54	3	L
Syphilis diagnosis rate / 100,000	1.55	2.37	2.65	5.37	2.08	3.82	3.00	2.66	2.57	1.46	2.62	8	L
Under 18s conception rate / 1,000 (PHOF indicator 2.04)	17.21	16.14	19.86	19.31	20.34	17.12	16.54	9.18	18.48	19.49	25.09	1	L
Under 18s conceptions leading to abortion (%)	55.09	47.40	58.70	61.11	49.59	53.55	48.37		61.40	46.89	50.40		L
Under 25s repeat abortions (%)		19.44	24.25	25.19	16.61			21.43	26.32	25.06	23.01	3	L

Appendix 2 Summary of sexual health indicators across Rutland (Data as of October 2015)

Sexual Health and Wellbeing in Rutland



Key

- Significantly better than the England average
- Similar to the England average
- Significantly worse than the England average
- Significantly higher than the England average
- Significantly lower than the England average
- Disclosure control applied



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