



Bristol Clinical Commissioning Group

Bristol JSNA Chapter 2016

Sexual Health

Summary of Needs Assessment

Chapter information

Chapter title	Sexual Health – Summary of Sexual Health Needs Assessment (SHNA) 2015-16
Chapter reference group	SHNA Steering Group
Chapter author(s)	Beth Bennett Britton, Annette Billing and David Thomas
Quality reviewed by who/date	Jo Copping, Consultant in Public Health and Barbara Coleman, Service Manager, Oct 2015
Chapter endorsed by	SHNA Steering Group, 2015
Chapter approved by	JSNA Steering Group, May 2017
Linked JSNA chapters	

This document summarises the findings from a comprehensive sexual health needs assessment and was written to inform the procurement of a new integrated sexual health service for Bristol, North Somerset and South Gloucestershire. The summary used the format of the JSNA Chapter Template and was originally published to inform the consultation about the new service which took place between 1 November 2015 and 31 January 2016. The document was available until a new provider had been selected towards the end of 2016.



Executive summary

Sexual health covers the provision of advice and services around contraception, relationships, sexually transmitted infections (STIs) including HIV and abortion.

According to the World Health Organisation (WHO), the definition of sexual health is:

“...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 and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.” (WHO, 2006)

Efforts to improve the sexual health of the population are a public health priority. Sexually transmitted infections (STIs) can have lasting long-term and costly complications if not treated and are entirely preventable. There are also health benefits from people with HIV being diagnosed and starting treatment earlier, minimising the use of health and social care services. Unplanned pregnancies have a major impact on individuals, families and the wider society. Prevention of unintended pregnancies and control over reproductive choices preserves good mental and psychosexual health. Poor relationships, coercion and sexual bullying can have a lasting effect on an individual’s mental wellbeing, self-esteem and confidence.

Sexual ill health is not equally distributed within the population. Strong links exist between deprivation and STIs, teenage conceptions and abortions, with the highest burden borne by women, men who have sex with men (MSM), teenagers, young adults and black and minority ethnic (BME) groups. Similarly HIV infection in the UK disproportionately affects MSM and black Africans. Some groups at higher risk of poor sexual health face stigma and discrimination, which can influence their ability to access services.

The importance of improving sexual health is acknowledged by the inclusion of three indicators in the Public Health Outcomes Framework (PHOF). The PHOF sets the national and local strategic direction for public health. These indicators have been prioritised, as each represents an important area of public health that needs sustained and focused effort in order to improve outcomes. The indicators are: under-18 conceptions; chlamydia diagnoses (15–24-year-olds); and people presenting with HIV at a late stage of infection.

This document provides the key messages from the full Sexual Health Needs Assessment for Bristol, 2015 which is available upon request. Please refer to the full version of the report for all references.

Key issues

Bristol hosts a comprehensive range of sexual health services either commissioned through Bristol City Council, NHS England or Bristol CCG, or provided in house by Bristol City Council Public Health team. However although progress has been made (for example in the reduction in teenage conceptions and increasing access to sexual health services), high levels of need still exist across the city.

In Bristol, the groups that continue to be at greater risk of poor sexual health are the same as those seen nationally. They include young people, MSM, certain BME groups, people involved in sex work, people with learning difficulties and homeless people. Young people in care and care leavers are also at increased risk.

Although emphasis should be put on improving sexual health amongst those groups with highest need, partnership formation continues throughout the life course and therefore this should not be at the expense of efforts across all sections of society.

Evidence suggests that both locally and nationally sexual health behaviours are becoming more risky. Nationally the age of first sex is decreasing, reports of anal sex are increasing indicating expanding sexual repertoires, and changing cultures have led to emerging needs such as the practice of chemsex (use of injecting drugs to increase sexual pleasure), sexual exploitation, forced marriage, female genital mutilation, sexual harassment, sexual bullying and sexism.

High diagnosis rates of syphilis, gonorrhoea and genital warts have been observed in Bristol. Whilst this is in part due to improved testing it is also likely to be due to increased infection rates in the population. Other infections, such as chlamydia, remain high. MSM make up the greatest proportion of HIV diagnoses in Bristol. Bristol also has higher late diagnosis of HIV rates than that seen nationally. Heterosexuals and black Africans are at higher risk of late diagnosis.

As previously stated, national evidence suggests that people's sexual repertoires are expanding and age of first sex is decreasing. This is coupled with high levels of unprotected sex, particularly amongst some BME groups. Despite the most effective forms of contraception being long acting reversible contraceptive (LARC) methods such as the implant, coil and injection, their use varies between 1-5% nationally and are more commonly used by older women.

There is evidence nationally that sexual dysfunction (such as feeling anxious during sex and problems getting or keeping an erection) is increasing. Sexual dysfunction may result from emotional or physical causes and is treated through psychosexual health services.

Recommendations for consideration by commissioners

Based on the findings from this sexual health needs assessment, the following recommendations have been drawn up. Commissioners will need to consider these recommendations and endeavour to incorporate into any future procurement / contractual arrangements, whilst recognising the need for ensuring best value for money and the reduction in available resources.

General

- Bristol's population is growing; therefore services need to be able to adapt to meet increasing demand.
- Bristol's population is also becoming more ethnically diverse, particularly in younger groups; therefore services need to be accessible to diverse population needs.
- There are some concerns regarding data quality and issues comparing data across different providers. This may be improved through a reduction in the number of contracts that currently exist for sexual health services.
- Research and evidence based practice should be an important element of sexual health services.

Prevention and health promotion

- Preventative education needs to be integrated with sexual health services to reduce repeat presentations, particularly in high risk groups.
- Sexual health services need to work together and ensure they make patients aware of other services available to them.
- Sexual health professionals need to be responsive to emerging sexual health needs such as domestic and sexual violence and abuse (including sexual harassment, bullying and sexism), sexual exploitation and drugs and alcohol misuse e.g. chemsex.
- Sexual health services need to strengthen collaboration between partner organisations working in the wider determinants of health such as drugs and alcohol services, DSWA support services, mental health services and adult and child social services. The additional time required for this in consultations needs to be acknowledged. This may require the development of systems and processes in order to share data and information.
- Programmes such as the 4YP Bristol initiative (public health's brand to promote young people's sexual health and improve access to services) have been welcomed by professionals. Further work is needed to ensure that this level of support is provided to other groups at greater risk of sexual ill health.
- Health promotion efforts need to take a 'sex-positive' approach, focusing on building confidence in making informed choices and consent.
- Health promotion efforts need to respond to changing cultures and take advantage of technological developments such as social media as well as responding to emerging needs such as social networking websites.
- Education around sexual health needs to be targeted at parents and the wider community and not just those who may benefit from accessing the service themselves. Interventions need to be community led using trained professionals whom the community trust. Messages need to take a sex-positive approach.

Services offered

- Many services are highly regarded by residents and professionals and it is important that areas of good practice are maintained and supported.
- Diagnoses of STIs continue to increase, reflecting both an increase in access to sexual health services but also increasing risky behaviour. Existing prevention efforts, such as greater STI screening coverage and easier access to sexual health services, need to be sustained to help reduce further transmission of infection.
- Teenage pregnancies in Bristol have shown a steep decline since 2007 and are now only slightly higher than the England average (25.7 per 1,000). The efforts to reduce these rates need to be sustained.
- LARC uptake remains low, particularly in young people. Conversely oral emergency contraception use is high amongst young people. As LARC methods are more effective forms of contraception, consideration should be given to increasing uptake.
- A local analysis of emergency IUD fitting recommended that a pathway for IUD access is developed, equitable access is available throughout the week, more IUD fitters should be trained and improve patient and staff awareness of IUD as a form of emergency contraception, amongst others. Consideration should be given to implementing these recommendations.
- Late diagnosis of HIV is high for Bristol. Encouraging regular testing amongst high risk groups such as MSM and black Africans is key. This may be achieved through innovative approaches to testing such as self-sampling kits.

- Psychosexual health services need to be able to cope with the reported increase in sexual dysfunction seen nationally.
- The condom distribution scheme has been praised by professionals as a way to engage with more people, especially young men. The number of condoms distributed has been decreasing so efforts are required to maintain the effectiveness of this service.
- Awareness of the option to be screened for cervical cancer in sexual health settings could be increased and may increase access amongst harder to reach groups.
- Sexual health services need to provide outreach services to engage with certain vulnerable groups such as people with learning difficulties and people that work in the sex industry.

Access to services

- Sexual health services are generally well positioned in the areas with highest deprivation. However some of the community and outreach clinics are reported to have low attendances and conversely, others report high waiting times. A review of the location, opening times and the appropriateness of the setting of these services is required.
- Sexual health services should work collaboratively to ensure easy access and transition between services.
- There is some evidence of low uptake of services for BME and LGBT groups. Services need to ensure they are accessible to all high risk and equalities groups and promote their services appropriately.
- Marketing of services should take advantage of technological developments such as social media, text and online booking and triage.
- Other technological innovations in order to increase uptake of services should be considered, such as ordering STI testing kits online.
- Specific support should be offered to the groups at particular risk of poor sexual health such as people involved in sex work, BME groups, people with physical and learning disabilities, LGBT and MSM, homeless people and young people.
- Some issues have been raised by professionals relating to eligibility for a service if a service can be provided from elsewhere (e.g. a GP practice). Issues have also been raised relating to referrals between services. The number of referrals required between services should be kept to a minimum. When referrals are required a clear pathway should be in place. This should include referrals to services related to the wider determinants of health (such as mental health and drugs and alcohol services).
- Services need to ensure they are accessible at times of the day and week that will have higher demand. This includes Saturdays and Sundays, particularly for young people. Flexible drop in sessions and short waiting times are also key. The clinic environment should be relaxed and informal. Different methods of booking appointments should be available (such as text message, telephone and online).
- Feedback from the general public indicated that confidentiality was central to feeling able to access a sexual health service. All services providing sexual health services should promote their confidentiality policy clearly to patients (both verbally and through patient information signs and leaflets).
- Staff should be trained in the needs of vulnerable groups and ensure they do not come across as judgemental or critical.
- A range of options for where a service can be accessed from should be available as preferences varied both across and within different groups.

Main report - Summary of Sexual Health Needs Assessment

1. Introduction: Why is this area important?

This Sexual Health Needs Assessment for Bristol provides a comprehensive overview of sexual health need and current service provision. It identifies key sub-groups of the population at greater risk of poor sexual health and draws out potential areas of unmet need and recommendations for commissioners. Sexual Assault Referral Centres have not been included in this report as they will be reviewed via a separate process.

This report builds on earlier sexual health profiles undertaken for Bristol. A sexual health report on high risk groups and access to services in Bristol was undertaken in 2009; a sexual health needs assessment for people with learning disabilities was undertaken in 2010; and a rapid appraisal of sexual health services provided by UHB and Brook was completed in early 2014.

Sexual health covers the provision of advice and services around contraception, relationships, sexually transmitted infections (STIs) (including HIV) and abortion. The Health and Social Care Act 2012 split responsibilities for the commissioning of sexual health services between Local Authorities, Clinical Commissioning Groups and NHS England. Since 2013, Local Authorities commission the vast majority of sexual health provision, which includes prevention, sexually transmitted infection testing and treatment, and long acting reversible contraception. Sexual health is one of five mandatory public health services that local authorities must provide. NHS England commissions HIV treatment and Sexual Assault Referral Centres, level 1 primary care sexual health services including symptomatic STI testing and oral contraception, and the Clinical Commissioning Groups (CCG) commission termination of pregnancy services and psychosexual counselling.

According to the World Health Organisation (WHO), the definition of sexual health is:

“...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 and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.” (WHO, 2006)

Efforts to improve the sexual health of the population are a public health priority. Sexually transmitted infections (STIs) can have lasting long term and costly complications if not treated and are entirely preventable. There are also health benefits from people with HIV being diagnosed and starting treatment earlier, minimising the use of health and social care services. Unplanned pregnancies have a major impact on individuals, families and the wider society. Prevention of unintended pregnancies and control over reproductive choices preserves good mental and psychosexual health. Poor relationships, coercion and sexual bullying can have a lasting effect on an individual’s mental wellbeing, self-esteem and confidence.

Sexual ill health is not equally distributed within the population. Strong links exist between deprivation and STIs, teenage conceptions and abortions, with the highest burden borne by women, men who have sex with men (MSM), teenagers, young adults and black and minority ethnic (BME) groups. Similarly HIV infection in the UK disproportionately affects MSM and black Africans. Some groups at higher risk of poor sexual health face stigma and discrimination, which can influence their ability to access services.

The importance of improving sexual health is acknowledged by the inclusion of three indicators in the Public Health Outcomes Framework (PHOF). The PHOF sets the national and local strategic direction for public health. These indicators have been prioritised, as each represents an important area of public health that needs sustained and focused effort in order to improve outcomes. The indicators are: under-18 conceptions; chlamydia diagnoses (15–24-year-olds); and people presenting with HIV at a late stage of infection.

The Department of Health published 'A Framework for Sexual Health Improvement in England' in March 2013 (DH, 2013). This outlines the national focus across the life-course for those working in and for sexual health, including Local Authorities. In summary their focus is to:

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

Bristol has a relatively young population compared to England as a whole and this is predicted to rise. The city is ethnically diverse and has areas of high deprivation. There is an active Lesbian, Gay, Bisexual and Transgender (LGBT) scene supported by an LGBT-friendly businesses and entertainments district. These factors mean sexual health is a priority for Bristol.

Table 1(i) shows Bristol's performance against key sexual health indicators compared to other Core Cities, the South West and England as a whole. Bristol performs worse than England as a whole on the following sexual health indicators; gonorrhoea diagnosis rate; chlamydia detection rate; new STI diagnoses; HIV testing coverage; HPV vaccination coverage; and rate of sexual offences. Whilst a high detection rate for sexually transmitted infections is an indication of poor sexual health, it may also reflect good access to current services and high detection rates.

Table 1(i) Key Sexual Health Indicators, Sexual & Reproductive Health Profiles, Public Health England

Indicator	Period	Bristol	Nottingham	Manchester	Liverpool	Sheffield	Newcastle	Birmingham	Leeds	South West	England
Syphilis diagnosis rate / 100,000	2014	4.6	6.8	17.5	6.2	5.2	11.5	6.2	4.6	2.8	7.8
Gonorrhoea diagnosis rate / 100,000	2014	80.7	140.6	139.0	54.2	56.8	93.1	101.9	91.3	28.9	63.3
Chlamydia detection rate / 100,000 aged 15-24 (PHOF indicator 3.02) [Red < 1900; Orange 1900 - 2300; Red > 2300]	2014	1,818	2,807	2,066	2,209	1,778	2,409	2,063	2,720	1,836	2,012
Chlamydia proportion aged 15-24 screened	2014	29.6	31.1	24.0	25.3	22.0	31.6	21.6	28.7	23.4	24.3
All new STI diagnoses (exc Chlamydia aged <25) / 100,000	2014	989	1,156	1,383	960	645	978	995	978	660	829
HIV testing coverage, total (%)	2014	59.1	77.4	80.6	64.1	80.3	61.8	71.4	80.2	68.5	68.9
HIV late diagnosis (%) (PHOF indicator 3.04) [Green <1; Orange 1 - 2; Red > 2]	2011 - 13	49.4	63.9	50.6	46.6	51.0	34.6	48.3	47.3	46.0	45.0
HIV diagnosed prevalence rate / 1,000 aged 15-59	2013	1.68	2.41	5.76	1.84	1.87	1.91	2.54	2.39	0.99	2.14
Population vaccination coverage - HPV (%) (PHOF indicator 3.03xii) [Red < previous year's England value Green >= previous year's England value]	2013/14	76.6	90.4	77.9	88.4	90.0	88.3	87.9	94.0	83.2	86.7
Abortions under 10 weeks (%)	2014	82.4	65.9	86.4	78.8	71.5	74.4	80.4	82.1	80.3	80.4
Under 25s repeat abortions (%)	2014	24.8	22.6	26.2	30.4	27.9	22.0	31.7	26.0	23.9	27.0
GP prescribed LARC rate / 1,000	2013	70.8	51.8	29.9	26.5	55.8	60.8	44.3	67.8	72.6	52.7
Under 18s conception rate / 1,000 (PHOF indicator 2.04)	2013	25.7	37.5	36.5	34.1	27.9	26.8	25.9	31.6	21.2	24.3
Under 18s conceptions leading to abortion (%)	2013	44.9	37.6	48.3	59.1	43.5	36.4	47.4	49.1	50.3	51.1
Sexual offences rate / 1,000 (PHOF indicator 1.12iii)	2013/14	1.67	1.31	1.59	1.18	0.83	1.15	1.11	1.19	1.02	1.01

Better than England
Similar to England
Worse than England

A re-procurement of sexual health services across Bristol, North Somerset and South Gloucestershire is currently underway in order to comply with EU procurement law. This provides an opportunity to address some of the gaps and inefficiencies in the current sexual health system. The aim will be to ensure a more joined up and effective system, which is more equitable in outcomes, and with an improved focus on the needs of vulnerable and high risk groups. Additionally, it will be an opportunity to increase the focus on prevention and address the wider determinants that impact on people's sexual health in Bristol.

2. Who is at risk and why?

The Framework for Sexual Health In England identifies those that have experienced sexual and/ or domestic violence and abuse; those at risk of or who have had female genital mutilation (FGM); people involved in sex work; those with learning disabilities; lesbian, gay, bisexual and transgender (LGBT) people; homeless people; young people; and some BME communities as groups at higher risk of sexual ill health. The list below summarises the findings from a review of sexual health amongst these groups nationally and in Bristol.

2.1 Those that have experienced sexual and/or domestic violence and abuse

According to the British Crime Survey data, nationally, at least 29.9% of women and 17.0% of men in England and Wales have, at some point, experienced domestic and sexual violence and abuse (Smith et al, 2011). It is likely that this figure is an underestimate due to the extent of underreporting. Women are disproportionately at risk of this crime (77% of national domestic violence crimes in 2011/12 involved a female victim) with women also at greater risk of repeat victimisation.

2.2 Those at risk of or who have had female genital mutilation

Female genital mutilation (also referred to as FGM, female circumcision or cutting) is defined as all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. It is estimated that more than 66,000 women and girls living in Britain have experienced FGM. The procedure can have long-lasting physical and psychological effects, such as chronic pain, sexual difficulties and complications in pregnancy and childbirth and can increase the risk of HIV and other STIs.

It is estimated that 170,000 women and girls are living with FGM (female genital mutilation) and 65,000 girls aged 13 and under are at risk of FGM in the UK. Sexual health services should be able to advise on FGM, however in most cases women will need to be referred to a specialist service. The government have announced new measures aimed at bringing an end to FGM in the UK including a reporting system and additional funding.

2.3 People involved in sex work

Sex workers are not all female but are a culturally diverse group that include women, men, and transgender people. Some sex workers are at higher risk of poor sexual health outcomes. Sex workers also experience vulnerabilities such as violence, rape and sexual assault, homelessness, and drug and alcohol problems that may impact on their sexual health needs (DH, 2013).

A literature review commissioned by the Department of Health found that many sex workers still engage in risky behaviour, such as having sex without a condom, however condom use amongst sex workers has increased over the last 30 years and incidents of HIV have decreased over the same period. The numbers of other STIs also remains low; however, the potential for transmission is high, and STIs are an inevitable risk.

In September 2011 the police estimated 280 women working in the sex market in Bristol, and an estimated 126 women working in 25 parlours in Bristol. This does not include women working from their own homes. Specialist services should be available to meet all relevant needs, including screening, vaccinations, support for violence and abuse, and ways to leave prostitution.

2.4 People with learning disabilities

It is estimated that there are more than one million people living in England with a learning disability, but research has found that young people with learning disabilities do not have good access to sex and relationship education or information (DH, 2013). The Framework for Sexual Health Improvement in England (DH, 2013) recommends that there be more accessible information and support for young people with learning disabilities and for their parents. This needs to include information about sexuality, abuse and consent and practical information about contraception and safer sex where appropriate.

2.5 Lesbian, Gay, Bisexual and Transgender people

Lesbian, gay, bisexual and transgender (LGBT) people experience a number of health inequalities that are often unrecognised in health and social care settings (DH, 2014). According to PHE (2014f) gay, bisexual and other MSM constitute an estimated 5.5% of the male population in the UK. This diverse population continues to experience inequalities in health and wellbeing and in other areas – such as the experience or fear of stigma and discrimination, despite significant improvements in social attitudes and laws that protect and uphold the rights of LGBT people.

Gay, bisexual men and other men who have sex with men (MSM) continue to be the group most affected by HIV infection (Public Health England, 2014d). In 2013, an estimated 43,500 (40,200-48,200) MSM were living with HIV in the UK; this is equivalent to 59 per 1,000 MSM aged 15-59 years. According to the latest data from Public Health England (2014a) large increases in STI diagnoses have been seen in MSM. Although only 2.6% of the male English population is estimated to be MSM, in 2013, about 81% of syphilis, 63% of gonorrhoea, and 17% of chlamydia diagnoses were reported within this group. Gonorrhoea diagnoses in Bristol rose 26% in this group, nearly double the national rate, which is of particular concern as harder to treat gonorrhoea strains emerge.

2.6 Homeless people

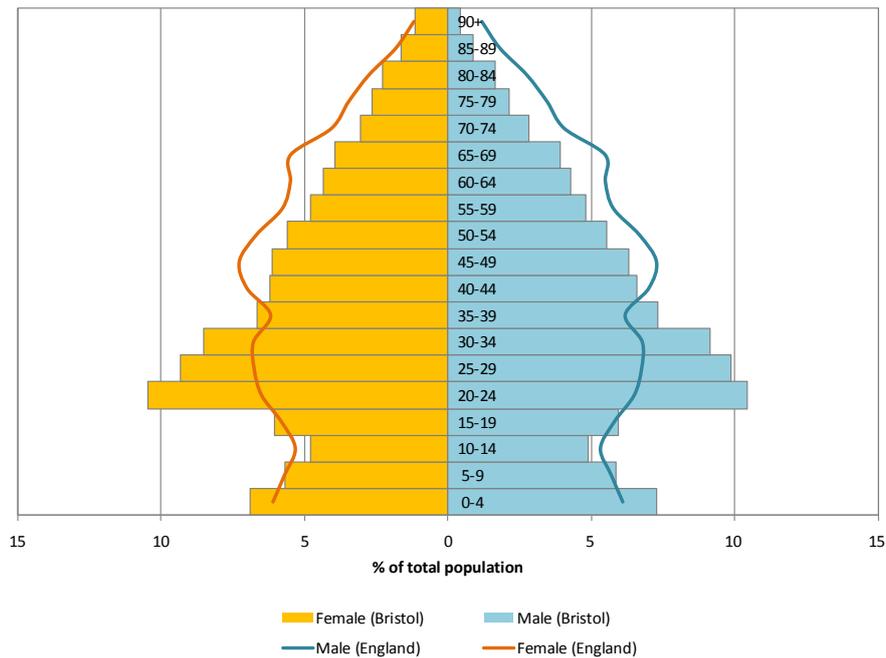
Homeless people are at increased risk of STIs and unwanted pregnancies and can come under pressure to exchange sex for food, shelter, drugs and money (DH, 2014). A recent systematic review of studies of homeless youth (Heerde et al, 2015) indicates that homeless youth commonly report being raped and sexually assaulted, being sexually victimized, and engaging in sex work and survival sex. Rates of victimisation and sexual risk behavior were generally higher for females.

2.7 Young People

Young people are at increased risk of poor sexual health due to sexual development at this age and societal changes such as sexualised imagery and social media. There are also particular sub-groups of young people that are vulnerable to poor sexual health. These include looked after children, care leavers and young offenders.

Bristol's population is currently estimated to be 437,500 and is growing rapidly. The most significant increase over the next two decades is expected to be in the 0-15 year old age group. The 16-24 year age group is the only group expected to reduce over the next decade, with a 0.9% reduction by 2022. This is due to migration out of the city for employment and education and a low birth rate around a decade ago. It is likely to start increasing beyond 2022. Bristol has a much larger proportion of its population in the 20 to 35 year old age group compared to England as a whole.

Figure 1: Population structure of Bristol and England average in quinary age-groups by gender.
 Source: ONS population estimates mid-2013

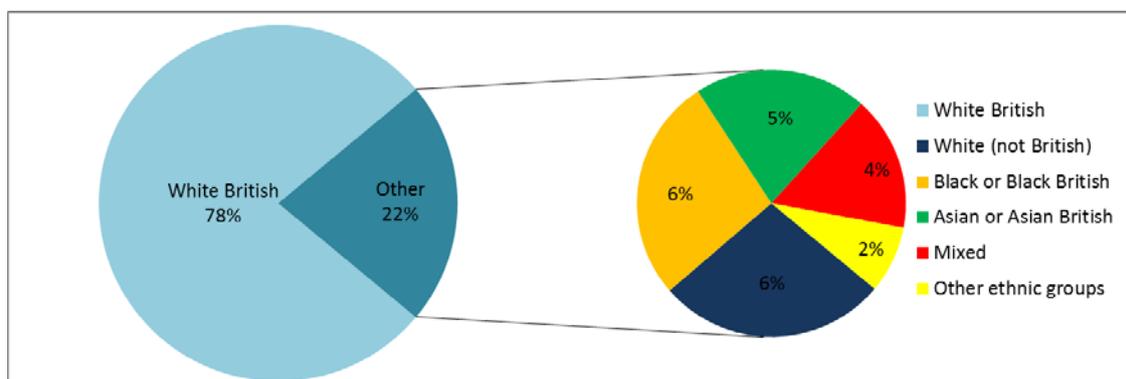


2.8 BME Communities

Some BME groups are at greater risk of poor sexual health, including higher rates of STIs, and female genital mutilation. There are also cultural barriers to BME communities accessing sexual health services and support. Black African communities collectively contain the largest number of people with undiagnosed HIV infection (13,000) in the UK (PHE, 2014d). The highest rates of STI diagnoses in Bristol have been found among people of black ethnicity. This high rate of STI diagnoses among black ethnic communities is most likely the consequence of a complex interplay of cultural, economic and behavioural factors. Additionally, risk behaviours and STI epidemiology vary between black African and Caribbean ethnic groups.

Bristol has a more ethnically diverse population than England as a whole. 16% of the population describe themselves as BME, and 22% describe themselves as not 'white British'. The younger population is much more ethnically diverse with 28% of 0-15 year olds described as BME.

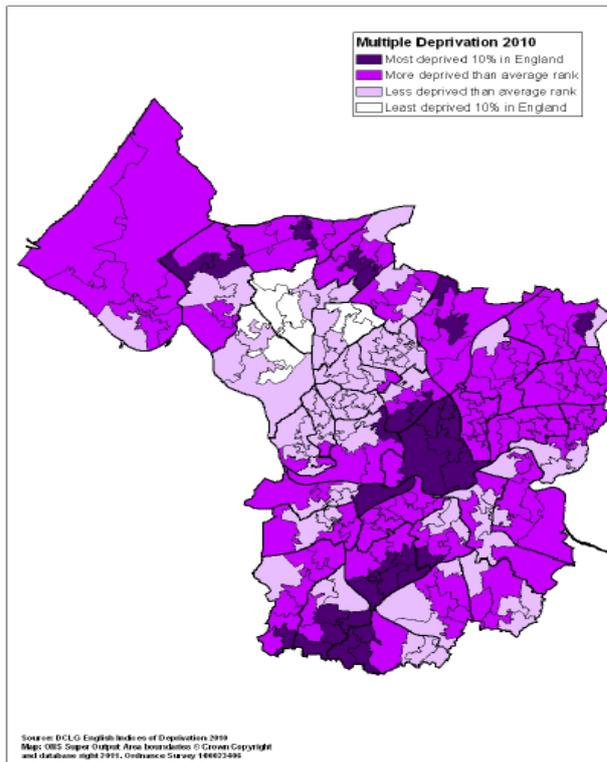
Figure 2: Ethnic groups in Bristol



2.9 Deprived Communities

There are pockets of high deprivation located in the Inner City, East, South and outer Northern areas of Bristol. Poor sexual health is closely correlated with high deprivation and urbanised areas.

Figure 3: Index of Multiple deprivation 2010 for LSOAs in Bristol compared to England Average



3. What is the level of need?

3.1 Relationships

Sexual health includes providing advice and services to promote positive relationships. Over the past few decades there have been significant changes to the way people live their lives and the relationships they form. The quality of these relationships is determined by a number of factors such as personal attitudes and beliefs; social norms; peer pressure; religious beliefs; culture; confidence and self-esteem; misuse of drugs and alcohol; and coercion and abuse (DH, 2013).

The Department of Health's Framework for Sexual Health in England (2013), describes the importance for people to have the confidence and emotional resilience to understand the benefits of loving, respectful, healthy relationships. In order to enable people to make informed choices about relationships, they stress the importance of services providing accurate and timely information and building an honest and open culture amongst society.

3.1.1 Characteristics of sexual relationships

The National Survey of Sexual Attitudes and Lifestyles (NATSAL) is a longitudinal cross sectional survey of sexual behaviours in Britain. Three surveys have been conducted covering the past 3 decades, all with a sample size of well over 10,000 participants. Mercer et al (2013) published the findings from NATSAL 1 to 3 relating to changes in sexual attitudes and lifestyles in Britain through the life course and over time. This data provides an overview of sexual behaviours in Britain and the key findings from the study include:

- According to British NATSAL data, median age at first heterosexual intercourse was 17 years in both sexes, however the proportion reporting first heterosexual intercourse before age 16 years increased in successive birth cohorts in both men and women.
- Same-sex sexual experiences were more common in those with higher educational attainment.
- Reporting of anal sex has increased over the 3 decades, indicating expanding sexual repertoires.
- The proportion of women reporting sexual experience with same-sex partners exceeds that of men (16% compared to 7.3%), this is particularly marked in younger age groups.
- Although reporting of new partners remains highest in those under the age of 25, partnership formation continues throughout the life course, especially for men, so sexual health advice should not exclusively target young people.
- Public health programmes should be appropriate to present relationships and sexual lifestyles by promoting informed, consensual, safe, respectful, and pleasurable relationships; and be consistent with a broader definition of sexual wellbeing.

Locally, the Avon Longitudinal Study of Parents and Children (ALSPAC) undertook a recent survey of the cohort which included questions around their sexual health. At the time of completing the survey children were aged 21 years old. 2,005 responses were received for Bristol residents. The proportion of respondents having their sexual debut under the age of 15 was highest for the south Bristol locality (40.30%), followed by the inner city and east (32.34%) and then north & west (23.30%). These differences are associated with indices of deprivation and also correlate with teenage pregnancy rates across the geographical localities of the city. Women were also more likely to have an earlier sexual debut than men. The study also found that young people from more deprived backgrounds were less likely to use contraception.

3.1.2 Domestic and Sexual Violence and Abuse

One aspect of promoting positive relationships, includes preventing sexual violence and abuse (DSVA). This includes forced marriage, so-called 'honour' crimes and female genital mutilation (FGM) are included in the definition. Feedback from professionals highlights the need for sexual health services to work in close partnership with those working on domestic and sexual violence and abuse. Nationally, at least 29.9% of women and 17.0% of men in England and Wales have, at some point, experienced domestic and sexual violence and abuse

According to the British Crime Survey data, nationally, at least 29.9% of women and 17.0% of men in England and Wales have, at some point, experienced domestic and sexual violence and abuse (Smith et al, 2011). It is likely that this figure is an underestimate due to the extent of underreporting. The British Crime Survey has consistently shown that victims of domestic violence were more likely to experience repeat victimisation than victims of other types of crime. Women are disproportionately at risk of this crime with women at greater risk of repeat victimisation.

Key findings were:

- Abuse within young people's relationships is also an area gaining national recognition, with children as young as 13 reported to have experienced DSVA. Being in a relationship with an older partner, and especially a 'much older' partner, is a significant risk factor for young women.
- A recent study in Bristol looked specifically at children and young people's experiences of sexual harassment, sexual bullying and sexism and found that these were every day experiences and heavily normalised, many experiences are as early as primary school
- Females are the victims in over 70% of cases and are more likely to experience ongoing abuse and more severe injuries.
- Substance misuse is often associated with DSVA. It can be a disinhibitor for perpetrators and a coping mechanism for victims.
- Domestic and sexual violence and abuse is the most common cause of depression and other mental health difficulties in women. This impact can be seen in various guises; post-traumatic stress, anxiety, depression, eating disorders, self-harm, and suicide.
- People with physical disabilities and learning difficulties and people who are LGBT, are more likely to experience DSVA than the general population.
- 30% of domestic violence and abuse starts during pregnancy. Up to 70% of teenage mothers have experienced adolescent domestic violence and abuse.
- Other risk factors for DSVA include recent separation, being isolated socially from family and friends, poverty, unemployment or poor living situations and insecure immigration status.
- In Bristol, male victims of DSVA reported the perpetrators as their son or daughter in 50% of cases and the remainder from a female partner or ex-partner. In contrast, virtually all perpetrators against women were male partners.
- In 2012/13 6,178 cases of DSVA were reported to the police, much lower than the Home Office prevalence estimate for Bristol of 14,273 women and girls aged 16-59.

3.2 Sexually Transmitted Infections

Sexually Transmitted Infections (STIs) is a term used to describe a variety of infections passed from person to person through unprotected sexual contact. Some STIs are symptomatic and may result in increased discharge, pain and ulcers, whilst others are asymptomatic and often remain undiagnosed. If STIs remain undiagnosed they can lead to serious complications and have long term health implications such as pelvic inflammatory disease and infertility. Risk of infection is reduced through consistently and correctly using condoms until all partners have had a sexual health screen, reducing

the number of sexual partners and avoiding overlapping sexual relationships, and having a sexual health screen either once per year or on changing partners.

3.2.1 Rates of STI diagnoses

Over the last decade the rates of all STIs diagnosed in genitourinary medicine GUM clinics have risen across England as a whole. This is partly explained by increased testing through the National Chlamydia Screening Programme (NCSP) and improvements in diagnostic tests, however also reflects ongoing unsafe sexual behaviours. The increases seen nationally are reflected in Bristol. Sharp rises have been observed for syphilis and gonorrhoea in particular. Concurrently, recent rates of genital warts have been rising in Bristol despite reductions nationally.

There is considerable variation in the distribution of the most commonly diagnosed STIs by age, gender, sexual orientation and ethnicity:

- Young people (15-24 year olds) continue to experience the greatest burden of STI diagnoses in England.
- There has been a considerable rise in STI diagnoses within the MSM population. There is some evidence that this is in part due to HIV sero-adaptive behaviours.
- Diagnoses of syphilis and gonorrhoea are more likely to be reported in men who have sex with men than other groups.
- There is wide variation in the rates of STIs diagnosed within different ethnic groups. The highest rates of STI diagnoses were found among persons of black ethnicity, and the majority of these cases were among persons living in areas of high deprivation, especially in urban areas.

3.2.2 Chlamydia

Chlamydia trachomatis is the most common STI in England. Infection is asymptomatic in 50% of men and 70-80% of women and as a result the majority of infections remain undiagnosed. Without treatment, chlamydia can spread to other parts of the body and lead to serious long term health problems such as pelvic inflammatory disease and infertility.

Locally the ALSPAC cohort study participants were invited for a chlamydia test at the age of 17 years. The researchers found an overall adjusted prevalence of 2.0% in those who were sexually active. Prevalence was strongly associated with measures of deprivation, with participants whose mothers had the lowest level of educational achievement being ten times more likely to test positive than participants whose mothers had the highest level of educational attainment.

Rates of chlamydia diagnosis in England have been increasing since 2004, and almost doubled with the introduction of the NCSP in 2008. Approximately a third of all Bristol residents aged between 15 and 24 years are screened for chlamydia each year. These are to a large extent a self-selecting proportion of the population, and may not be representative of the total population within this age-group, therefore, we cannot extrapolate a true population prevalence estimate from this group.

3.2.3 Gonorrhoea

Gonorrhoea is the second most common bacterial STI in the UK. The bacteria can infect the cervix, urethra, rectum and, less commonly, the throat or eyes. One in ten cases in men and half of all cases in women, are asymptomatic. Gonorrhoea is treated with antibiotics however it quickly develops resistance and therefore is becoming more difficult to treat. Studies have found that risk of gonorrhoea infection is highly associated with co-infection with chlamydia.

In 2013, 225 people in Bristol were diagnosed with gonorrhoea. This corresponds to a rate of diagnosis of 52.0 cases per 100,000 population. The number of diagnoses has been steadily increasing since 2010 which is likely to be due to more targeted testing through the NCSP (the Bristol programme has included gonorrhoea in its testing programme since its introduction). These rates are similar to those seen nationally. More men are diagnosed with gonorrhoea than women, reflecting high rates amongst the MSM population. Black and mixed ethnic groups are over-represented indicating a greater level of need amongst these groups.

3.2.4 Syphilis

Syphilis is a sexually transmitted infection and can also be spread through sharing needles and vertical transmission from mother to child. If diagnosed early, syphilis can be easily treated with antibiotics. Initial symptoms of primary syphilis are a painless but highly infectious sore in the genitals or mouth which lasts for 2-3 weeks. If untreated syphilis can develop into secondary and tertiary stages with complications including stroke, paralysis, blindness and can lead to death. It is estimated that people with syphilis are three to five times more likely to catch HIV.

Rates of syphilis are relatively low in the UK however outbreaks do sometimes occur. In 2013 there were 6.07 cases diagnosed in GUM clinics per 100,000 people in England. Rates are much higher in men than women. This is due to higher rates of infection amongst MSM. In 2013 there were 22 people diagnosed with syphilis in Bristol which corresponds to a rate of 5.1 per 100,000. Rates in Bristol are generally much lower than England as a whole, though have sharply risen over the last four years. High rates of syphilis and gonorrhoea in a population are strongly associated with risky sexual behaviour.

3.2.5 Genital Herpes

Genital herpes is caused by the Herpes Simplex Virus (HSV). There are two types of HSV, type 1 and type 2. They both affect mucous membranes such as the mouth and genitals. HSV is highly contagious and is commonly passed through sexual contact. Genital herpes is a chronic condition which can flare up, producing painful blisters on the genitals and surrounding areas. Flare ups tend to become less regular and less severe over time. Eight out of ten people with the virus will be unaware as there are often no initial symptoms.

Diagnoses of genital herpes have been increasing in England over the past decade. This is due to a combination of increased testing, improved diagnostic tests and ongoing unsafe sexual behaviour (PHE, 2014a) and also reflects the high infectivity of the virus. In 2013 there were 248 cases of genital herpes diagnosed in Bristol, this corresponds to a rate of 57.3 diagnoses per 100,000 population. Rates of genital herpes are similar to rates seen nationally. Diagnoses for genital herpes are similar for men and women. Women diagnosed tend to have an older age profile compared to men. The majority of diagnoses of genital herpes occur in the heterosexual community. Black and mixed ethnicities are over-represented compared to population size in Bristol for genital herpes diagnoses indicating a higher need amongst these groups.

3.2.6 Genital warts and HPV

Genital warts are a common sexually transmitted infection in the UK. They are caused by the Human Papillomavirus (HPV). There are many different strains of HPV and around 30 can cause genital warts, although 90% of cases are caused by type 6 and type 11. Genital warts are small fleshy growths, bumps or skin changes that appear on or around the genital or anal area. They are usually painless and do not pose a serious health risk, however they can be unpleasant to look at and may cause psychological distress.

Rates of genital warts diagnosis are common in England. Over the past decade overall rates of genital warts have increased, this is due to increased diagnoses in men and may reflect patterns of infection in men who have sex with men. In 2013 694 people were diagnosed with a first episode of genital warts in Bristol. This corresponds to a rate of 133.4 per 100,000 residents in Bristol. The rates of genital warts are higher in Bristol than for England as a whole and appear to be increasing locally despite a reduction nationally. More men are diagnosed with genital warts than women, and the majority of diagnoses for genital warts in Bristol occur amongst the heterosexual community. White ethnicities are over-represented amongst diagnoses of genital warts compared to the Bristol population, indicating higher need amongst this group.

3.2.7 HIV

HIV is associated with considerable morbidity and mortality and requires significant long-term care and treatment. Drug therapies have reduced the incidence of HIV-related deaths but it remains a life-threatening infection.

The overall UK prevalence of HIV in 2014 was 2.8 per 1,000 population aged 15-59 years (1.9 per 1,000 women and 3.7 per 1,000 men). The overall HIV prevalence rate for Bristol increased in 2014 to 2.07 per 1,000 residents aged 15-59 year which means Bristol is now considered to be over the threshold for expanded HIV testing.

Nationally, a quarter (24%, 26,100) of people estimated to be living with HIV were unaware of their infection and remain at risk of passing on their infection if having sex without condoms. Some groups in society are affected disproportionately by HIV, including MSM and the black African population.

Late diagnosis of HIV is defined as a CD4 count of less than 350 cells/mm³ at diagnosis. Bristol has a slightly higher rate of late diagnosis of HIV than that seen nationally (44.7% compared to 42.2%). This is a concern since late HIV diagnosis remains clearly linked to increased rates of illness, hospital admission and mortality, as well as reduced life expectancy, for the individual concerned, in addition to increased onward transmission. Heterosexuals and black Africans are at higher risk of late diagnosis.

3.2.8 *Trichomonas vaginalis*

Trichomonas vaginalis (TV) is a sexually transmitted infection (STI) caused by a tiny parasite. Symptoms usually develop within a month of infection, although up to half of all infected men and women have no symptoms. In women, trichomoniasis can cause soreness and itching around the vagina and a change in vaginal discharge. Infected men may experience pain during urination and a thin white discharge from the penis. Complications of trichomoniasis are rare, although some women with the infection may be at an increased risk of further problems.

A local study of *Trichomonas vaginalis* (TV) found more TV in primary care than previously thought, with hotspots in areas such as Hartcliffe with prevalence amongst white British population. Deprivation may be a risk factor for TV.

3.3 Pregnancy Prevention

For many, pregnancy is a joyous experience and often planned. However often pregnancies are unplanned and unintended. The Natsal-3 study found that nationally 16.2% of pregnancies among women in Britain aged 16-44 were unplanned and 29% were ambivalent (Wellings et al, 2013). Pregnancy can be prevented through the use of contraception. If a person has unprotected sex or there is a contraception failure, they have the option of emergency contraception. If a woman unintentionally becomes pregnant she is able to have a termination, otherwise known as abortion, or continue with the pregnancy.

- In 2013 there were 6,515 live births in Bristol. This corresponds to a General Fertility Rate (GFR) of 63.1 live births per 1,000 women aged 15-44. This is slightly higher than the England GFR of 62.2 live births per 1,000 women aged 15-44. Bristol has a higher birth rate in the under 18 and over 30s compared to England as a whole. The rates are similar for 18 to 19 year olds and lower for 20 to 29 year olds.
- Nationally evidence from the NATSAL-3 study suggests that the highest proportion of unplanned pregnancies occurs in the 16-19 year old age group. Factors associated with unplanned pregnancies are having first sex before the age of 16, lower educational levels, and not living with a partner. Recent experiences of smoking, having used drugs other than cannabis, and depression are also more common amongst women reporting unplanned pregnancies. The likelihood of unplanned pregnancies was found to be lower amongst those who reported receiving sex education mainly from school lessons compared to other sources.

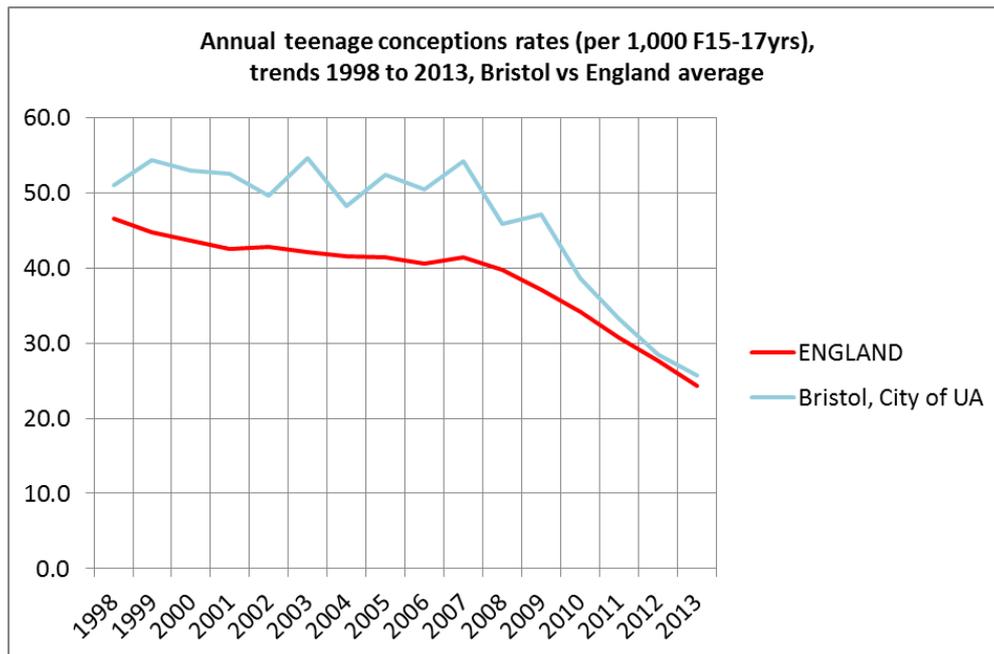
3.3.1 Teenage pregnancy

During the period from the start of monitoring for the Teenage Pregnancy Strategy in 1998, until 2007, Bristol had a high teenage conception rate around 50 per 1,000 with some fluctuation year to year, but no distinct rising or falling trend. This rate was considerably more than the England average for the period, which was slowly declining during that time to around 40 per 1,000. The number of teenage conceptions in Bristol each year was typically well in excess of 300. From around 2007 onwards the teenage conception rate began to fall, and with the exception of 2009, has fallen ever since until the latest year of data 2013, when the rate was 25.7 per 1,000.

The reasons for this decline are still open to conjecture, but it is likely to be a combination of socioeconomic and/or cultural factors acting at a national scale as evidenced by the presence of similar trends in many other cities in the UK over the same period, and a long term, multi-faceted strategy to address teenage conception at a local level.

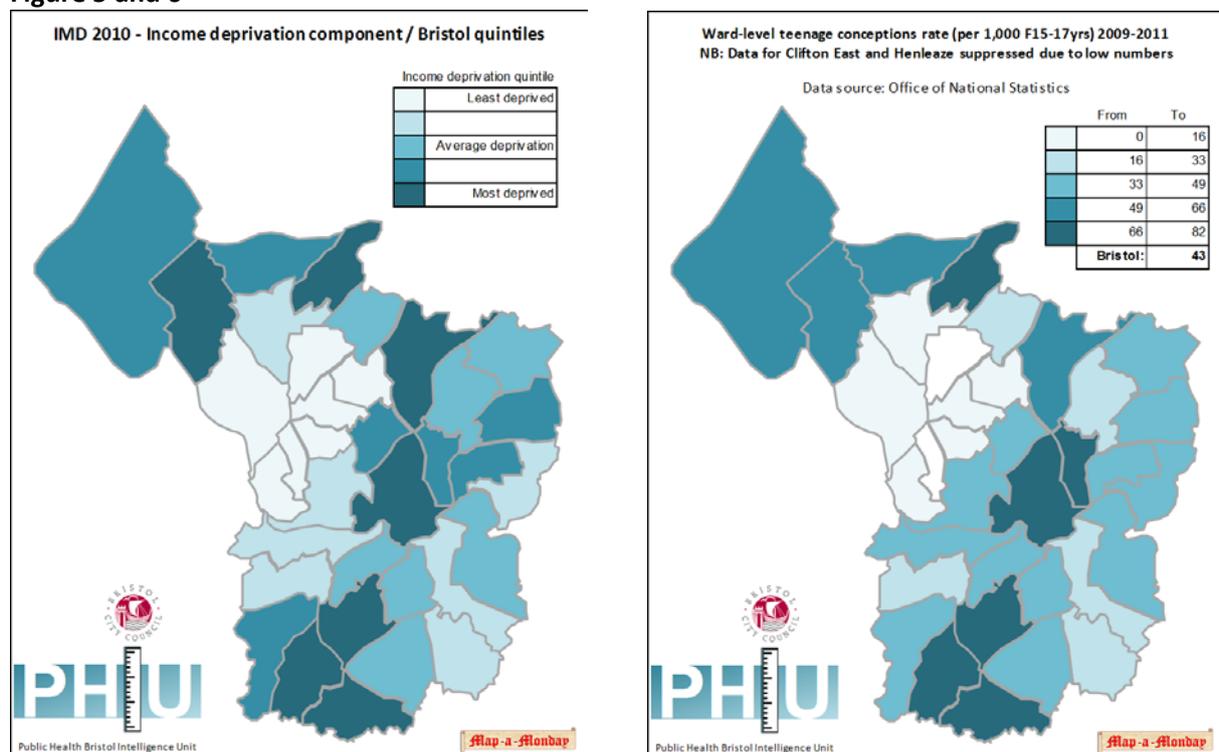
Bristol's teenage conception rate is now just a little higher than the national average, and is the lowest in the 'core city' group of comparator cities of which it is a member. Teenage conception remains much more common in Bristol than in the neighbouring LA areas, as would be expected of a more urbanised area with greater levels of deprivation and a more diverse population, but is akin to that found in other urban regional centres in the south west: Cardiff (30.4), Plymouth (28.9) and Swindon (24.4).

Figure 4



The proportion of the population affected by teenage conception is relatively small, in 2013 it was just over 1 in 40 women in the appropriate age-group in Bristol, but the risk varies widely across the city. In those wards where it is most frequent, around 1 in 12 women aged between 15 and 17 years of age conceived during an average year (2009 – 2011), while we can estimate that the risk was 10 times smaller in the wards with the lowest incidence. Figures 2 and 3 below illustrate both the range of difference in the incidence of teenage conception across the city, and the coincidence of high rates of teenage conception and higher levels of deprivation.

Figure 5 and 6



The long term trend over the last 15 years has been a slight decline in the likelihood of a teenage conception ending with a termination, with the latest data (2013) indicating that around 4 in 10 conceptions will result in a termination. In Clifton East, Cotham and several areas in the inner city and east of the city, it appears to be more common to seek the termination of a teenage conception than other parts of the city when considered alongside the teenage birth rate. Conversely, on the south west fringe of the city, and Henbury on the northern edge, it appears that terminations of teenage conceptions are a less likely outcome.

3.3.2 Contraception

There are 15 methods of contraception available in the UK. The effectiveness of each method is dependent on a number of factors; the method failure rate; the user failure rate; and the provider failure rate. Guidance from NICE (2014) states that, while all methods of contraception are effective, LARC methods such as contraceptive injections, implants, the intrauterine system (IUS) or the intrauterine device (IUD) are much more effective at preventing pregnancy than other hormonal methods, and are much more effective than condoms. This is because the effectiveness of barrier methods and oral contraceptive pills depends on their correct and consistent use. By contrast, the effectiveness of LARC methods does not depend on daily concordance.

Expert clinical opinion is that LARC methods are more cost effective at one year of use compared with the oral contraceptive pill and that increasing the uptake of LARC methods will reduce the numbers of unintended pregnancies. Although progress has been made the uptake of LARC is still low in the UK, at around 12% of women aged 16–49 in 2008–09, compared with 25% for the oral contraceptive pill and 25% for male condoms.

According to NICE (2014) contraceptive guidance with a focus on young people up to the age of 25, among those aged 16–19, 7% of men and 10% of women reported using no form of contraception at first intercourse. Unprotected first sex is more likely for the youngest age groups. Access to contraceptive services is most problematic for people in disadvantaged communities.

3.3.3 Emergency contraception

Emergency contraception is a safe and effective way of preventing unwanted pregnancy when regular methods have failed or have not been used. There are two different types of emergency contraception, the emergency hormonal contraceptive pill and the IUD. The IUD is considerably more effective than hormonal emergency contraception.

In 2013, 854 women resident in Bristol were prescribed emergency contraception at SRH Services. Of those, 9.1% were prescribed it more than once in 2013, compared to 10.3% in England (PHE, 2013). The rate of emergency pill and IUD prescriptions is highest for the 16 to 17 year age group. The rates of emergency pill prescription reduce with age, whereas IUD prescriptions proportionately increase for the older age groups. Younger age groups were more likely to be prescribed emergency contraception more than once in 2013 (PHE, 2013).

A local analysis recommended that a pathway for emergency IUD access is developed, equitable access is available throughout the week, that more IUD fitters should be trained and improved awareness is needed among both patients and staff of the IUD as a form of emergency contraception.

3.3.4 Abortion

In total there were 1545 abortions notified as taking place among Bristol residents in 2013 (DH, 2014). This represents an age standardised rate of 13.8 per 1000 Bristol resident women aged 15-44, which is lower than the England rate of 16.1. In Bristol, the crude abortion rate in 2013 was highest for women aged 20-24 (21 per 1,000), although the rates for 18-19 year olds and 25-29 year olds were similar (20 per 1000). There were 75 abortions to women aged under 18 (4.9% of the total).

Department of Health policy is that women who are legally entitled to an abortion should have access to the procedure as soon as possible. Evidence shows that the risk of complications increases the later the gestation (DH, 2014). The vast majority of abortions in Bristol are performed at under 13 weeks (90% in 2013), which is slightly below the England average of 92%. Nationally there has been a continuing increase in the proportion of abortions that are performed under 10 weeks since 2003. In 2013, 79% of abortions were performed at under 10 weeks, compared to 77% in 2012 .

Different methods may be used to terminate a pregnancy, depending on the duration of gestation, and other circumstances relating to the individual woman. There is one principal medical method, involving the use of the abortifacient drug Mifegyne (mifepristone, also known as RU486). The main surgical methods are vacuum aspiration, recommended at up to 15 weeks gestation, and dilatation and evacuation (D&E) recommended where gestation is greater than 15 weeks (DH, 2014).

In Bristol, medical abortions accounted for 42% of the total in 2013, compared to the England average of 48%. Anecdotally, professionals in Bristol felt that the lower rate in Bristol may be because all women are offered a choice of method at all stages of gestation, whereas in some other areas of the country women at early stages of gestation are only offered a medical termination. Bristol Sexual Health Service is currently conducting a small scale study to better understand the reasons for the choice of method in Bristol.

In 2013, 36% of women in Bristol undergoing abortions had one or more previous abortions. 26% of abortions to women aged under 25 were to women who had one or more abortions. This is similar to the England average.

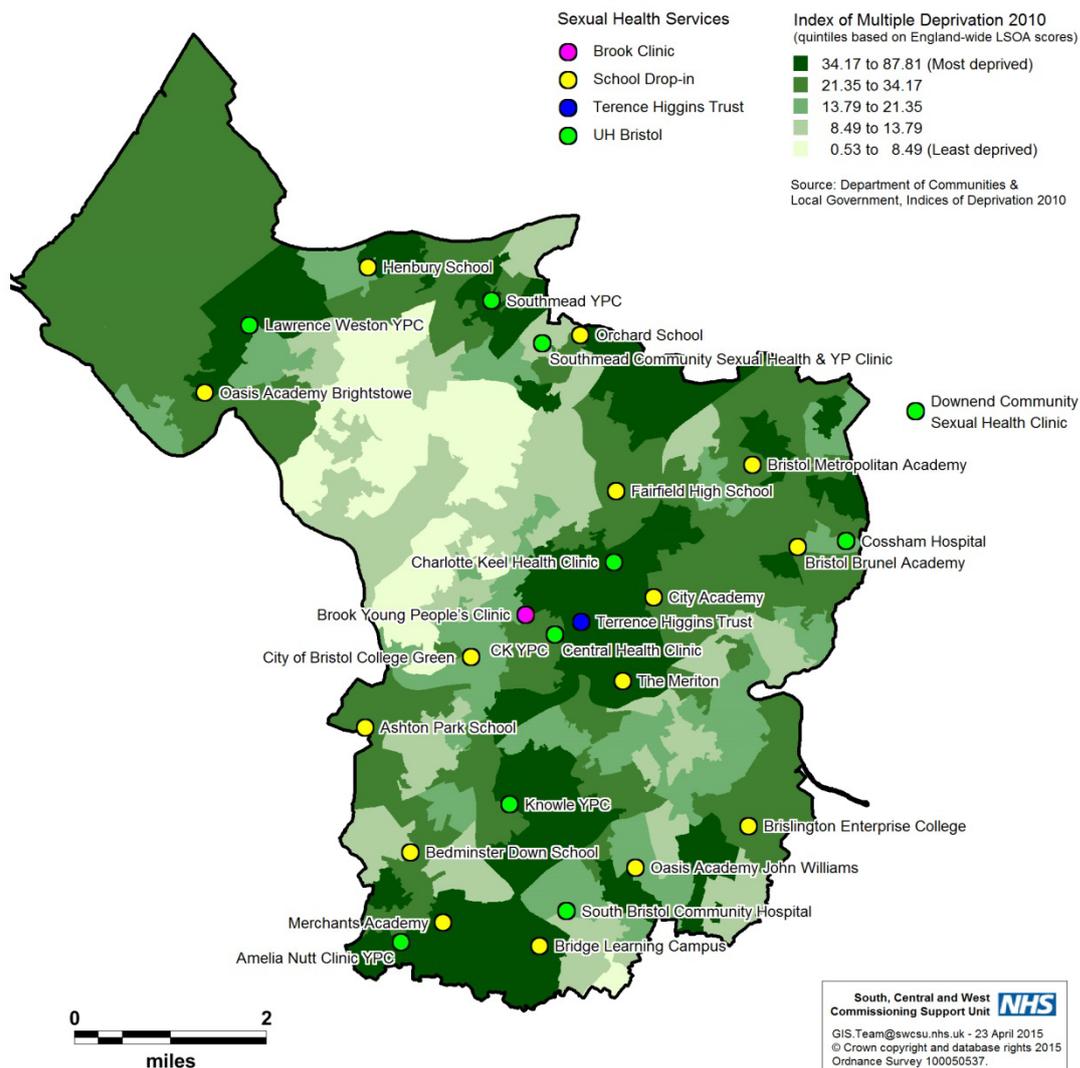
3.4 Psychosexual Health

- Psychosexual health refers to sexual dysfunction which may result from emotional or physical causes.
- There is no clear definition of what represents a problem, although it is thought that it is common within the general population.
- Data from the most recent NATSAL survey of Sexual Attitudes and Lifestyles in Britain suggests that sexual dysfunction is increasing and found that 42% of men and 51% of women interviewed, who had had sex in the past year, had experienced one or more sexual difficulties lasting a minimum of three months.

4. What services / assets do we have to meet and prevent this need?

Sexual health services are currently commissioned from a range of providers across the city. This helps to ensure that services are accessible to everyone who needs to use them and that, where appropriate, services are targeted to particularly vulnerable groups such as young people, men who have sex with men (MSM) and people from black and minority ethnic (BME) groups. The clinic locations have been geographically aligned to the areas of greater deprivation and correspondingly areas with a higher proportion of 15 to 24 year olds (Figure 7).

Figure 7: The locations of current services (excluding primary care) mapped against LSOA IMD



The Bristol City Council commissioned services which are in scope for the procurement are described in the following sections:

4.1 Brook

Brook is a national sexual health charity providing sexual health services, support and advice to young people. In Bristol, Brook is well established, and is commissioned by the local authority under a block contract agreement to provide a central clinical service and an outreach service to local secondary schools and further education colleges. The clinic is jointly commissioned with North Somerset and South Gloucestershire local authorities. South Gloucestershire also commission outreach services in a limited number of their secondary schools. Additional time limited work, such as a learning disabilities project and a participation project have also been commissioned in recent years.

The central clinic is located close to the main shopping district, Broadmead. The clinic occupies the top floor of The Station, a building which operates as a 'youth hub' offering young people from across the city a space for a variety of creative and physical activities, as well as access to advice and support. The Brook clinic provides Level 1 and 2 sexual health services, using a 'one stop shop' model, offering young people testing and treatment for sexually transmitted infections, a full range of contraceptive methods, emergency contraception, pregnancy testing, and confidential advice and signposting to other health services when necessary. The clinic is open 6 days a week for walk-in appointments with a sexual health nurse. There are also a limited number of booked doctor appointments. Young people may also be seen by a youth worker or a counsellor at the clinic.

The outreach service operates in the majority of the state maintained secondary schools and some colleges across Bristol. The drop-in clinics aim to provide pupils with easy access to health information, advice and support around issues that are relevant to them. The drop-ins provide a limited range of sexual health and contraception services, and signpost to other services when necessary. The outreach clinics usually operate during a lunch time once a week in each school, and are run by a Brook outreach nurse and youth worker, often supported by a local youth worker. The Brook youth worker registers young people onto the local C-card condom distribution scheme and runs small group discussions. The venues used vary in each school and are dependent on the availability of suitable spaces. The Brook team are also commissioned to support the delivery of Sex and Relationships Education (SRE) in the schools where they work, which allows them to meet young people, promote the service, and offer reassurance around confidentiality.

- In 2012/13 there were 15,342 visits made by young people at Brook (9,157 Brook clinic visits and 6,185 outreach services visits).
- Brook clinic will refer clients to the Level 3 specialist service for certain STI treatments, such as cryotherapy and gonorrhoea treatment.
- Since 2014, Brook has been commissioned to improve support for young people with learning disabilities and their families around issues related to puberty, relationships and sex. Brook currently employs a specialist worker to deliver this work.
- Local research has shown that there is wide variance in attendances at Brook school based outreach services. Although research showed the model was very effective at reaching groups that would otherwise not attend (such as young men), qualitative feedback identified barriers such as concern of being seen by peers, restrictive opening times and the position of the clinic in the school.
- There is some evidence that the number of Brook appointments is lower for those from a BME community than expected.
- 80% of Brook attendances are for young women.
- The most common age group for attending Brook outreach clinics was 15-16 years compared to 17-18 years for Brook's central service

- Young people living in central Bristol are more likely to access the central clinic whereas young people living further away from central Bristol are more likely to access the outreach services.

4.2 Bristol Sexual Health Service

University Hospitals Bristol are commissioned by Bristol, North Somerset and South Gloucestershire local authorities to provide specialist sexual health services. Known as Bristol Sexual Health Service (BSHS), it comprises of sexual health screening/testing, treatment, advice and provision for a wide range of contraceptive methods, including emergency contraception. The service consists of a main central 'hub' clinic where complex level 3 and level 2 services are mostly delivered, and 8 'spoke' community clinics (4 of which are in Bristol) which mostly deliver level 2 services, with the exception of a few that deliver more complex services. In addition the service runs 9 dedicated young people's clinics (5 of which are in Bristol). Outreach services are offered for some vulnerable populations, including sex workers and children who have been sexually exploited.

BSHS also run a number of regular specialist clinics, which include deep implants, difficult IUD/IUS fits, chronic pelvic pain, chronic herpes and an African Well Women's clinic. Health professionals may provide written referrals to these specialist clinics.

The main 'hub' clinic is based at Central Health Clinic, Tower Hill, Bristol, close to the main shopping district of Cabot Circus. The building is also used by related UHB services, with the same staff working across the different elements of the service. These are:

- Bristol Pregnancy Advisory Service (a termination of pregnancy service) commissioned by Bristol Clinical Commissioning Group (CCG)
- Second pregnancy prevention nurses (part of the Bristol Pregnancy Advisory Service but funded by Bristol City Council Public Health)
- Psychosexual services commissioned by Bristol CCG
- The Bridge, a Sexual Assault Referral Centre (SARC) commissioned by NHS England

A team of health advisors based at Central Health Clinic are available to see patients during clinic opening hours. The team give all positive STI results, including HIV, and provide further information and support, and initiate partner notification. This is a combination of telephone work and face to face consultations. Their role may also include some basic psychosexual work. The team are multidisciplinary, including advisers with a nursing background as well as others with a relevant degree.

- Attendances for GUM slightly increased over the last three fiscal years, from 22,637 visits in 2010/11 to 23,098 in 2011/12 and 23,968 in 2012/13 (representing a 5.9% increase over the three years). Conversely the number of attendances for CASH (contraception and sexual health) dropped during this time.
- The service is fully integrated, but current commissioning arrangements do not reflect this, with GUM and CASH commissioned separately.
- Services are provided by the main Central Health Clinic and a number of smaller satellite clinics across the city. The sites are geographically aligned to the areas of greater deprivation.
- Services are available in the morning (from 9am), afternoon and evening on Monday, Wednesday and Thursday. They are available in the morning and afternoon on Tuesdays and Fridays and in the morning on a Saturday. No service is available before 9am or on a Sunday.

- A rapid appraisal of sexual health services in 2014 identified issues around data quality, data availability and data management.
- There are slightly more male attendances than female attendances for GUM, whereas the majority of CASH attendances are female.
- The highest proportion of attendances at both GUM and CASH occurred in the 20-24 and 25-34 year old age groups, with attendances much lower in those aged under 20.
- The proportion of people from a BME background was the same as that expected based on the total BME population in Bristol (16%) for GUM appointments but only 12% for CASH appointments. As some BME groups are at higher risk of sexual ill health it might be expected that access to services from these groups should be higher.
- Patients responding to a survey in 2014 were very satisfied with the service, with 99% saying they would recommend the service to a friend and 97% saying they received the help they needed during their visit.

4.3 Terrence Higgins Trust

Terrence Higgins Trust (THT) are a national voluntary sector organisation specialising in supporting people with HIV; promoting better sexual health amongst high risk communities, and providing some clinical services such as the HIV Fastest (where results are available in 20 minutes) and non-complex STI testing. Currently Bristol City Council have two separate contracts with THT. The long term condition management work for people living with HIV is commissioned by Social Services. The health promotion and clinical work is commissioned by Bristol Public Health.

THT in Bristol offer services to people living with HIV/AIDS and those close to them (i.e. their families, partners, friends or carers) and other agencies providing services to these people. Health promotion work includes outreach sessions to specific communities at greatest risk of getting or passing on HIV in a range of settings and online; distribution of information, health promotion messages, campaign/ mass / social media; training and management of volunteers and peer educators to provide support to people living with HIV and also sexual health advice; and a condom distribution scheme. They also have a twice weekly drop in clinic, offering open access to finger prick rapid testing for HIV with follow up blood test if necessary as well as STI screening for chlamydia, gonorrhoea and syphilis.

- Between April 2013 and March 2015 THT supported 285 Bristol residents living with HIV, and a further 10 family members or partners who have also required support. THT supported 22 residents that are living with HIV and recently arrived in the UK and settled locally.
- During the two year period between April 2013 and March 2015, 430 individuals accessed THT clinical services. The number of people accessing THT services increased from 158 to 272 over the two year period.
- THT stress the growth of social networking sites which MSM use to meet sexual partners such as Grindr, Fitlads and Bareback Real Time. THT is working with these sites to develop a presence to continue and diversify this form of outreach and ensure that as many individuals as possible are receiving the information and support they need.
- THT are finding that HIV-positive service users are getting older and in need of specific information and support regarding the additional issues this may create.
- The majority of condoms distributed by THT are to MSM (77%) compared to only 13% received by people from a BME group. The numbers of condoms distributed increased from 13/14 to 14/15.
- The majority of people accessing THT clinical services were aged 25 to 34. This is a slightly older age profile than the general population of Bristol. This may reflect the demographics

of the communities they are targeting or may be due to Brook services meeting the needs of younger people.

4.4 C-Card Scheme

The 4YP C-card condom distribution scheme forms part of the work of the Young People's Public Health Team in Bristol City Council. The scheme aims to support young people (13 – 24 year olds) in making healthy sexual choices, by making it easier for them to access condoms when they need them and increasing opportunities for them to talk to trained workers. The C Card scheme also gives access to free condoms, signposts young people to other sexual health services and ensures young people get up-to-date information on sexual health services.

- The C-card scheme was used 2,851 times during 2013/14. Of these, 749 were young people registering on the scheme for the first time. During the last year 13,200 condoms were distributed through the scheme.
- Professionals view the C-card scheme as a successful way to have conversations with young people about sex and relationships and to spread information about correct condom use, as well as reducing barriers to condom use such as cost and embarrassment.
- 57% of the uptake of C-card was young men, demonstrating that the scheme is a useful way to engage young men.
- There has been a reduction in the number of condoms distributed through the scheme in recent years. This may be explained by less time being spent co-ordinating the scheme and supporting outlets, but also by the significant change in the landscape for young people's services many of which are c-card outlets.
- In a survey, almost half of the young people who used the scheme said they would have sex without condoms if the C-card scheme did not exist.

4.5 Avon Chlamydia Screening Programme

The Avon Chlamydia Screening Programme supports opportunistic chlamydia screening for young people aged 15-24, as part of the NCSP which aims to reduce chlamydia prevalence nationally. The team are based in the Young People's Public Health Team in Bristol City Council, but are commissioned to deliver the service for North Somerset, South Gloucestershire and Bath & North East Somerset populations. The team also supports practices, pharmacies, Brook and termination of pregnancy services to offer chlamydia testing to their patients. This includes supplying testing kits, training staff, results management and treatment, and partner notification.

- Bristol compares well to the England average and neighbouring local authorities in respect of the population coverage of chlamydia testing for 15-24 year olds, with coverage typically around 30% of the eligible population, compared to a national average of 25%.
- Bristol's testing programme has fallen short of the recommended diagnostic rate of 2,300 diagnoses per 100,000 people in the appropriate age-group
- The local chlamydia screening team have overseen around a half of all chlamydia tests for residents in the 15-24 year old age-group over the last three years.
- During the last four years, the positivity rates for chlamydia tests conducted by the screening team have been slightly higher than those carried out by other services. This may possibly indicate more effective targeting of tests.

4.6 Marie Stopes International and Bristol Pregnancy Advisory Service (termination of pregnancy service)

Bristol CCG commissions a termination of pregnancy (ToP) service through Marie Stopes International (MSI) and University Hospitals Bristol (UHB)

- There is an overall increasing trend in the number of terminations undertaken in Bristol, however 2014-15 is slightly lower than the previous year's data. A total of 1,483 terminations were undertaken in 2014-15.
- UHB receive almost three times more referrals compared to MSI (73.3%), however they undertake fewer abortions overall (41.5% of all abortions). MSI provide more surgical abortions and UHB provide more medical abortions.
- More medical abortions were undertaken in 2014-15 compared to surgical. This contradicts the nationally reported data from 2013 where Bristol undertook a lower proportion of medical abortions than the national average (42% compared to 48%).
- Almost half of MSI patients had a LARC fitted (49.2%) after their abortion. The most common method was the implant, followed by IUS, injection and IUD.
- 81% of all terminations undertaken by MSI were under 10 weeks gestation.
- 2% of all terminations performed by MSI were under 18 years of age and 40% were aged between 19 and 24 years old.

4.7 Second Pregnancy Prevention Service

The second pregnancy prevention service works with individual young women in Bristol who have had a pregnancy, in order to support them to access an ongoing method of contraception so that they may prevent any subsequent unplanned conceptions. The service was set up to work with all under 18s that have been pregnant. Approximately half of these young women will have had an abortion or miscarriage and half will have given birth. The service may also work with 18 year olds with vulnerabilities, such as those in care and care leavers, homeless young people and those with mental health issues.

- The number of users of the service peaked in 2010 at 210 patients, but numbers have reduced since as the numbers of conceptions have fallen in the city.
- Around 1 in 5 of the clients seen by the second pregnancy prevention nurses is currently in care, or is a care leaver.
- A higher proportion of clients are not in education or training compared to the general population.
- The proportion of clients planning to use LARC after contact with the service rose from 10% before to 60% after contact. Follow up data on whether the woman goes on to use and maintain use of a LARC method is rarely recorded.

4.8 Teenage Pregnancy Midwives

The teenage pregnancy midwives are commissioned to work with pregnant young women aged under 18 at the time of conception. They work as part of the hospital/community midwifery service at Southmead Hospital and St Michaels Hospital. The service aims to improve outcomes for pregnant teenagers, with a particular emphasis on physical and mental health and social isolation, and prevention of second unplanned conceptions. It is commissioned by Bristol CCG.

- The number of clients seen by the service has reduced in line with the fall in teenage conceptions.
- Intended contraception use in clients was much higher than prior to conception.

4.9 GP practices

All GP practices are required to provide a minimum level of sexual health services as part of their GMS/PMS contract with NHS England. This includes giving advice about the full range of contraceptive methods, and the prescribing of contraceptive pills and injections, but excludes some LARC methods. It also includes symptomatic testing for sexually transmitted infections. Through an additional contract with Bristol City Council, most practices will also fit intrauterine devices, and fit and remove contraceptive implants. Practices will also receive payment for any chlamydia screening of young people aged 15-24.

- Using GP prescribing data recorded on the ePACT system, during the financial year of 2013-14 there were 15,049 prescriptions made by Bristol GPs for the various forms of Long Acting Reversible Contraception (LARC).
- There has been a gradual increase in GP prescriptions for the implant and intrauterine contraception, but this has been countered by a gradual decrease in injection prescriptions. LARC prescribing overall has remained stable since 2011.
- The rate of LARC prescriptions varies widely between GP surgeries.
- Public Health Bristol is currently undertaking a LARC audit to ascertain the reasons for the wide variation in LARC prescribing between GPs. This will also look at whether there are inequities in access between population sub-groups.
- Young people reported the main reasons they were not accessing GPs for sexual health services was due to lack of knowledge of what is available and concerns around confidentiality.
- Results from a 'mystery shopping' exercise of 4YP in GP surgeries highlighted the following:
 - Receptionists talking quietly and discretely and the practitioner welcoming them into the consultation room were felt to give a positive experience.
 - Having clear posters regarding the practice's confidentiality policy, and having the policy explained verbally, were felt to be important and reassuring to young people.

4.10 Pharmacies

Over 50 of the pharmacies in Bristol are able to offer free sexual health services for young people under 25. This includes emergency hormonal contraception, chlamydia testing and treatment and free condoms with a C-card. The service is commissioned by Bristol City Council through a public health contract. The public health team provide support to pharmacists to deliver the service including regular training events on sexual health and safeguarding children.

- Pharmacies have proven to be popular with young people due to their high street locations or positions within supermarkets, long opening hours and ease of access.
- There has been an increase in activity in pharmacies in recent years, particularly in young women accessing the service for emergency contraception.
- Chlamydia screening tests accessed through pharmacies have a higher positivity rate than the average rate for Bristol.
- Mystery shoppers reported an overall positive experience of using pharmacy sexual health services, although some pharmacies scored higher than others.

4.11 Psychosexual health

In Bristol, psychosexual health services are provided by UHB across two sites. One service is based at Central Health Clinic alongside Bristol Sexual Health Service, and the other is based at St Michaels Hospital within Reproductive Medicine. The service is commissioned by Bristol CCG. The remit of the service is to provide help for patients presenting with problems of sexual dysfunction.

- Psychosexual health services in Bristol provide help to patients presenting with problems of sexual dysfunction.
- The service is provided by a multidisciplinary team which including clinicians, therapists and psychiatrists.
- The service is based at Central Health Clinic and St Michaels. The service is seen as an integral part of Bristol Sexual Health service, with staff working jointly across the contraception, genitourinary medicine and psychosexual elements of the service.

4.13 Cervical Cancer Screening and HPV vaccination

The NHS Cervical Screening Programme was introduced in the 1980s. The purpose of the programme is to screen all eligible women for cells which may develop into cervical cancer and ultimately reduce the number of women who develop cervical cancer and the number of women who die from the condition. The Cervical Screening and HPV vaccination programmes are commissioned by NHS England.

The Human Papilloma Virus (HPV) vaccine protects against two strains of HPV which are associated with 99% of cervical cancer cases. In England, the vaccine is currently offered to girls aged 12-13. The programme was established in 2008 and is commissioned by NHS England.

- The majority of women visit their GP for their cervical screen, however some women choose to attend a sexual health clinic instead.
- Women can also be opportunistically screened for cervical cancer during a full sexual health screen if they are overdue.
- Cervical cancer screening coverage is lower nationally than the recommended aim (78% compared to an objective of 80%) and is currently falling.
- Women aged under 40, certain ethnic groups and those from lower socio economic groups are less likely to attend screening.
- The coverage in younger women is of greatest concern since the 25 – 34 year old age group is where incidence of cervical cancer is rising.
- The routine HPV vaccination programme is delivered by the school nurse service, however the catch up programme for 16 to 18 year olds may be offered in sexual health clinics.
- The current HPV vaccine coverage in Bristol for 12-13 year olds is low (76.6%) compared to England as a whole (86.7%) and neighbouring local authorities.

4.14 Health Promotion and Prevention of Sexual Ill Health

The national strategy “A Framework for Sexual Health Improvement in England” (DH, 2013) defines sexual health promotion and prevention as work which “aims to help people to make informed and responsible choices, with an emphasis on making healthy decisions. Effective health promotion addresses the prejudice, stigma and discrimination that can be linked to sexual ill health.” (p22).

- Health promotion and prevention includes provision of information and education around positive sexual health; reducing the stigma associated with sexual health; opportunistic identification of people experiencing non-consensual sex and coercion, domestic and sexual abuse and violence; and ensuring ‘every contact counts’ through brief interventions on broader issues such as mental health, drugs and alcohol and smoking.
- Prevention and health promotion efforts should be targeted at populations who are most at risk. The key groups are young people, men who have sex with men and some black and ethnic minority communities.
- Bristol City Council Public Health team currently commissions health promotion services from THT and Brook. More information can be found in sections 4.4, 4.5 and 4.1.

- 4YP is a Bristol brand developed and promoted by Bristol City Council Public Health team. It provides sexual health information and advice to improve young people's sexual health outcomes in Bristol. There is a dedicated website, newsletter to professionals, resources, and support for sexual health services to gain Young People Friendly accreditation and provides multi-agency training.
- The 4YP programme was highly praised in the interviews undertaken for this needs assessment and interviewees commented that it would be good to extend the model to other vulnerable groups.
- Bristol City Council Public Health administers two schemes which contribute to promoting good sexual health in schools. The first is the Bristol Healthy Schools initiative which sets standards around health which schools can sign up to and receive support to meet. The standards include Relationship and Sex Education. The second is the Bristol Ideal, which is an award schools can gain to demonstrate that they are tackling domestic and sexual violence.

4.15 Other Specialist Services

In addition to the services detailed above, the following services also provide an element of sexual health care:

- Homeless Health Service: Compass Health
- Barnardos BASE Project
- Looked after children health services
- Sexual health and relationships services for teenage parents
- Refugee and asylum seeker health service: Haven
- Gypsy and traveller community health visitor service
- Youth Offending Team School Nurse
- The Rose Clinic
- School Nurses

5. Views of service users, key prevention groups and professionals

5.1 Service users

Where service user feedback was available (Brook at The Station and Bristol Sexual Health Service) they have been included in the summaries for this service above.

5.2 Key prevention groups

The main findings from the engagement with key prevention groups are summarised below. The information is derived from a combination of interviews, focus groups and local research.

Communication:

- Providing clear information about the services that are available was considered key. This should be accessible to everyone, regardless of disability, learning difficulties, mental health considerations, homeless, age, sexuality or culture. For example providing videos of what to expect when attending a clinic would benefit people with learning disabilities amongst others.
- Information needs to be provided in accessible ways to the target audience such as through websites and social media.

Sex and Relationships Education in schools and other settings:

- There's often a feeling that sex and relationships education is given a negative spin when discussing issues, rather than focusing on the positives of healthy relationships.
- People with LD felt a lack of support was available if they approached professionals about wanting a sexual relationship or starting a family and in general this was discouraged.
- Services available in schools need to be accessible, ensuring opening times reflect demand and students cannot be seen by peers when they attend.
- Raising awareness and educating parents of children from BME communities was a priority, as the main barrier to BME communities accessing services was being considered a taboo by the wider community. This is particularly relevant to first generation migrants.
- Awareness raising interventions need to be community led, using trained professionals that the local community trust. They need to be longer term as it will take a while for opinions and behaviours to change.
- The words 'sexual health' and 'relationships' may put people off. Better to use 'health' and 'safe'.

Access to Sexual health Services:

- Sexual health services need to provide outreach services to engage with certain vulnerable groups such as people with learning difficulties and people that work in the sex industry.
- The importance of confidentiality and anonymity in sexual health settings was a common theme.
- The importance of services offering flexible walk-in sessions, evening and weekend opening hours, short waiting times and in convenient, local facilities was raised in order for services to be accessible to groups that tend to have more chaotic lifestyles. Young people felt they would prefer drop-in clinics but wouldn't be willing to wait longer than 15 minutes. Weekend opening was particularly important to young people.

- Ensuring the clinic environment is relaxed and informal with entertainment available was felt important in order for people to feel relaxed and not feel as though they are being judged.
- Ensuring staff are trained in the needs of vulnerable groups and do not come across as judgemental or critical.
- Ensuring different methods of booking appointments are available such as via telephone, text message and online.
- A range of options for where a service can be accessed from should be available as preferences varied both across and within different groups.

5.3 Professionals working in sexual health services

As part of the needs assessment, a combination of face to face interviews and focus groups were held with professionals working for current sexual health services in Bristol, North Somerset and South Gloucestershire. The aim was to gain their perspective on the strengths and challenges of current service provision, any emerging sexual health needs in the local population and opportunities for the future. Some of the key themes arising were:

Access

Staff felt that the services based in the centre of Bristol (Brook Clinic and Central Health Clinic) are in good locations close to public transport links and central amenities. These services are very busy and there was acknowledgement from staff that waiting times and people being turned away are a challenge. There have been some efforts to help manage the flow of patients and waiting times, but there are ambitions for further service improvements, including introducing a system for online booking and registration in order to improve triage. Others suggested longer opening hours. Staff highlighted a particular pressure on the services on Fridays and Saturdays when central clinics have restricted opening hours but high demand.

Access to clinics in community settings was recognised to be more challenging, with attendance often patchy. This was particularly true for the clinics with shorter opening hours. Staff felt some of the clinic locations may need reviewing in relation to current and future need, as many are long established and have historical arrangements.

The school outreach work was seen as important in reaching out to young people who would otherwise not attend the main clinic. In terms of accessibility, this means a service is available to young people when they need it. However, accessibility within each school is very dependent on the individual school context, which determines factors such as the clinic opening times, whether young people can be seen outside of lunchtimes, the rooms that are made available for the clinics, and the opportunities for promoting and advertising the service e.g. during assemblies, tutorials or SRE lessons. The location within the school can pose challenges in terms of young people's confidentiality, since most young people do not want to be seen by their peers to be attending the clinic. A good partnership with school management was seen as critical, but this can be very variable depending on the school.

Services offered

The main sexual health service providers felt they were offering fully integrated services. Staff felt strongly that patients should be offered a choice about where they are seen for their sexual health, regardless of the level of service required. They argued that service users will choose specialist sexual health services because they are able to walk-in and because of the confidentiality that they

may not feel they would get elsewhere. However, a tension exists between wanting to offer a universal walk-in service for all and the acknowledgement that less complex cases could go elsewhere (e.g. repeat pills to GP). Staff pointed out that often what seems simple at triage will reveal complex issues underneath in consultation.

Generally staff felt that they were able to offer a wide range of services, which they felt was beneficial to service users. The offer of point of care testing and improved access to emergency IUDs were two examples of services that have been recently introduced. Those offering level one and two services clearly had an ambition to further expand the range of services on offer, particularly since there was a reluctance to make onward referrals for vulnerable people who may not attend, or those who may not attend fast enough.

Staff

Managers expressed concerns around the shortage of trained sexual health nurses and associated difficulties with recruitment. Services were looking at sustainable ways of retaining a nurse workforce and investing in sexual health nurse training, helped by strong links with the integrated sexual health nursing course at UWE. Lead nurses from the south west also meet together which is an opportunity to look at workforce issues.

Clinical Governance

Staff generally had confidence in their clinical governance arrangements and felt that robust systems were in place.

Marketing

There was recognition that some sexual health services are more successful in marketing their services than others. Some benefit from a strong national brand, whereas others acknowledged that branding could be better and needs developing, with more use made of social media to promote services.

Care pathways/referral processes/partnership arrangements

Many staff pointed to strong partnership arrangements with other providers. For example, it was felt that the referral process to the HIV treatment service at Southmead Hospital provided by NBT was straightforward and worked well, despite the services not being co-located as they are in many other places. However there was a feeling that transitions between sexual health services could often be problematic, and that more could be done to promote other providers services. It was also felt that the process for referring into other services could be made smoother.

Service user involvement

Generally staff felt positive that they had a number of different ways for ensuring service user involvement. Dedicated staff time was recognised as important for facilitating this work.

Ensuring vulnerable and high risk groups access services

Staff felt that the outreach work with high risk and vulnerable groups was important and worked well. It was recognised that it is important to take the service to where people are. Services have also established fast track systems for specific vulnerable groups, including very young people attending services.

Training and support

Training offered to staff was perceived as excellent, with time set aside each week for staff development, and recognition that this will contribute to strengthening service quality.

Research

Staff strongly argued for the value of having a research element as a provider, since this improves the evidence base and quality of provision. Staff from the NHS providers felt that they had a well-established research ethos and there was a strong desire to embed clinical research into routine clinical services. There were some example of research in voluntary sector providers but these were more limited.

Sexual health promotion and prevention

For staff in some services it was felt that health promotion and prevention was an integral part of their work, but for others the potential to do more of this work was recognised. Generally it was felt that there is an increasing need for work around prevention, especially psychosexual health and issues around consent.

Data collection, IT systems and reporting

There was widespread frustration from staff with regards to data collection and IT systems, with the feeling that much time is spent inputting data, but that this is not rewarded with useful information coming out of systems in return. Staff welcomed the introduction of electronic patient records, but paper based systems are still in use in community and outreach settings due to the complexities of using host IT systems.

Links to wider determinants of health

Staff felt that they are increasingly being asked to look at the wider determinants of health. This has included drug and alcohol use, domestic violence and sexual assault. Whilst there was an understanding that this work was important, it is inevitable that more time is needed to deal with the issues that this raises.

6. What works- what is the evidence base?

The following guidelines exist for sexual health services:

- Service Standards for Sexual and Reproductive Healthcare (FSRH 2013)
- British HIV Association Standards of Care for People Living with HIV (BHIVA 2013)
- Clinical Guidance – Emergency Contraception (FSRH 2012)
- UK National Guideline on Safer Sex Advice (BASHH & BHIVA 2012)
- National Chlamydia Screening Programme Standards (6th Edition 2012)
- BASHH Statement on Partner Notification for Sexually Transmissible Infections (2012)
- Hepatitis B and C: Ways to promote and offer testing to people at increased risk of infection. NICE Public Health Guidance 43 (NICE 2012)
- Standards for psychological support for adults living with HIV (British Psychological Society, BHIVA & MEDFASH 2011)
- UK Guideline for the use of Post-Exposure Prophylaxis for HIV following Sexual Exposure (BASHH 2011)
- PH34 Increasing the uptake of HIV testing among men who have sex with men (NICE 2011)
- PH33 Increasing the uptake of HIV testing among black Africans in England (NICE 2011)
- The Care of Women Requesting Induced Abortion, Evidence-based Clinical Guideline Number 7 (RCOG 2011)
- Standards for the Management of Sexually Transmitted Infections (BASHH & MEDFASH 2010)
- UK National Guidelines for HIV Testing (BHIVA 2008)
- Progress and Priorities - Working Together for High Quality Sexual Health (MEDFASH 2008)
- PH3 One to one interventions to reduce the transmission of sexually transmitted infections (STIs) including HIV, and to reduce the rate of under 18 conceptions, especially among vulnerable and at risk groups (NICE 2007)
- CG30 Long-acting reversible contraception (NICE 2005, updated 2014)
- Recommended Standards for Sexual Health Services (MEDFASH 2005)
- Research Governance Framework for Health and Social Care (Department of Health 2005)
- Male and Female Sterilisation , Evidence-based Clinical Guideline Number 4 (RCOG 2004)
- Contraceptive services with a focus on young people up to the age of 25 (NICE 2014)

7. What is the cost effectiveness/return on investment (where available)?

Although local cost effectiveness data was beyond the scope of the needs assessment, there is strong national evidence that investment in sexual health and HIV services will reduce future costs to the NHS and to local authority public health budgets.

- For every £1 spent on contraceptive services, the net gain to the NHS has been estimated to be £11.
- Prompt access to high quality sexual health clinical & health promotion services will reduce the onward transmission of sexually transmitted infections (STIs), preventing avoidable expenditure.
- All currently available LARC methods (intrauterine contraception, implants and injectable contraceptives) are more cost effective than the combined oral contraceptive pill even at one year of use. Increasing the uptake of LARC methods will reduce the numbers of unintended pregnancies and save an estimated £100m in health costs annually across the country.
- The health cost of providing lifetime treatment for people with HIV is increasing nationally by £1 billion each year. Each time a person is prevented from getting HIV the NHS saves over £350,000.
- People whose HIV is undiagnosed are at particular risk of passing on HIV, & those diagnosed late in the course of their infection are more costly to treat. Reducing the proportion of HIV infections diagnosed late therefore offers significant health economic benefits.

8. What are the projected needs for the future?

Trends over time have been included in the description of needs and current services sections.

A literature review of emerging needs around sexual health nationally identified the following concerns:

- Sexual exploitation of children
- Sexual exploitation and sexual violence in gangs and groups
- Issues of consent
- Abuse in teenage relationships
- Sexualisation of children
- The influence of pornography
- Sexting
- Poor sex education
- Increase in anal sex and its impacts
- Chemsex
- Female genital mutilation
- Forced marriage and honour violence

9. What are the key issues?

Bristol hosts a comprehensive range of sexual health services either commissioned through Bristol City Council, NHS England or Bristol CCG, or provided in house by Bristol City Council Public Health team. However although progress has been made (for example in the reduction in teenage conceptions and increasing access to sexual health services), high levels of need still exist across the city.

In Bristol, the groups that continue to be at greater risk of poor sexual health are the same as those seen nationally. They include young people, men who have sex with men, certain Black and Minority Ethnic Groups, people involved in sex work, people with learning difficulties and homeless people. Young people in care and care leavers are also at increased risk.

Although emphasis should be put on improving sexual health amongst those groups with highest need, partnership formation continues throughout the life course and therefore this should not be at the expense of efforts across all sections of society.

Evidence suggests that both locally and nationally sexual health behaviours are becoming more risky. Nationally the age of first sex is decreasing, reports of anal sex are increasing indicating expanding sexual repertoires, and changing cultures have led to emerging needs such as the practice of chemsex (use of injecting drugs to increase sexual pleasure), sexual exploitation, forced marriage, female genital mutilation, sexual harassment, sexual bullying and sexism.

High diagnosis rates of syphilis, gonorrhoea and genital warts have been observed in Bristol. Whilst this is in part due to improved testing it is also likely to be due to increased infection rates in the population. Other infections, such as chlamydia, remain high. Men who have sex with men (MSM) make up the greatest proportion of HIV diagnoses in Bristol. Bristol also has higher late diagnosis of HIV rates than that seen nationally. Heterosexuals and black-Africans are at higher risk of late diagnosis.

As previously stated, national evidence suggests that people's sexual repertoires are expanding and age of first sex is decreasing. This is coupled with high levels of unprotected sex, particularly amongst some BME groups. Despite the most effective forms of contraception being Long Acting Reversible Contraceptive methods (such as the implant, coil and injection), their use varies between 1-5% nationally and are more commonly used by older women.

There is evidence nationally that sexual dysfunction (such as feeling anxious during sex and problems getting or keeping an erection) is increasing. Sexual dysfunction may result from emotional or physical causes and is treated through psychosexual health services.

10. Recommendations for consideration by commissioners

Based on the findings from this sexual health needs assessment, the following recommendations have been drawn up. Commissioners will need to consider these recommendations and endeavour to incorporate into any future procurement / contractual arrangements, whilst recognising the need for ensuring best value for money and the reduction in available resources.

General

- Bristol's population is growing; therefore services need to be able to adapt to meet increasing demand.
- Bristol's population is also becoming more ethnically diverse, particularly in younger groups; therefore services need to be accessible to diverse population needs.
- There are some concerns regarding data quality and issues comparing data across different providers. This may be improved through a reduction in the number of contracts that currently exist for sexual health services.
- Research and evidence based practice should be an important element of sexual health services.

Services offered

- Many services are highly regarded by residents and professionals and it is important that areas of good practice are maintained and supported.
- Diagnoses of STIs continue to increase, reflecting both an increase in access to sexual health services but also increasing risky behaviour. Existing prevention efforts, such as greater STI screening coverage and easier access to sexual health services, need to be sustained to help reduce further transmission of infection.
- Teenage pregnancies in Bristol have shown a steep decline since 2007 and are now only slightly higher than the England average (25.7 per 1,000). The efforts to reduce these rates need to be sustained.
- LARC uptake remains low, particularly in young people. Conversely oral emergency contraception use is high amongst young people. As LARC methods are more effective forms of contraception, consideration should be given to increasing uptake.
- A local analysis of emergency IUD fitting recommended that a pathway for IUD access is developed, equitable access is available throughout the week, more IUD fitters should be trained and improve patient and staff awareness of IUD as a form of emergency contraception, amongst others. Consideration should be given to implementing these recommendations.
- Late diagnosis of HIV is high for Bristol. Encouraging regular testing amongst high risk groups such as MSM and black Africans is key. This may be achieved through innovative approaches to testing such as self-sampling kits.
- Psychosexual health services need to be able to cope with the reported increase in sexual dysfunction seen nationally.
- The condom distribution scheme has been praised by professionals as a way to engage with more people, especially young men. The number of condoms distributed has been decreasing so efforts are required to maintain the effectiveness of this service.
- Awareness of the option to be screened for cervical cancer in sexual health settings could be increased and may increase access amongst harder to reach groups.
- Sexual health services need to provide outreach services to engage with certain vulnerable groups such as people with learning difficulties and people that work in the sex industry.

Access to services

- Sexual health services are generally well positioned in the areas with highest deprivation. However some of the community and outreach clinics are reported to have low attendances and conversely, others report high waiting times. A review of the location, opening times and the appropriateness of the setting of these services is required.
- Sexual health services should work collaboratively to ensure easy access and transition between services.
- There is some evidence of low uptake of services for BME and LGBT groups. Services need to ensure they are accessible to all high risk and equalities groups and promote their services appropriately.
- Marketing of services should take advantage of technological developments such as social media, text and online booking and triage.
- Other technological innovations in order to increase uptake of services should be considered, such as ordering STI testing kits online.
- Specific support should be offered to the groups at particular risk of poor sexual health such as people involved in sex work, BME groups, people with physical and learning disabilities, LGBT and MSM, homeless people and young people.
- Some issues have been raised by professionals relating to eligibility for a service if a service can be provided from elsewhere (e.g. a GP practice). Issues have also been raised relating to referrals between services. The number of referrals required between services should be kept to a minimum. When referrals are required a clear pathway should be in place. This should include referrals to services related to the wider determinants of health (such as mental health and drugs and alcohol services).
- Services need to ensure they are accessible at times of the day and week that will have higher demand. This includes Saturdays and Sundays, particularly for young people. Flexible drop in sessions and short waiting times are also key. The clinic environment should be relaxed and informal. Different methods of booking appointments should be available (such as text message, telephone and online).
- Feedback from the general public indicated that confidentiality was central to feeling able to access a sexual health service. All services providing sexual health services should promote their confidentiality policy clearly to patients (both verbally and through patient information signs and leaflets).
- Staff should be trained in the needs of vulnerable groups and ensure they do not come across as judgemental or critical.
- A range of options for where a service can be accessed from should be available as preferences varied both across and within different groups.

Health promotion

- Preventative education needs to be integrated with sexual health services to reduce repeat presentations, particularly in high risk groups.
- Sexual health services need to work together and ensure they make patients aware of other services available to them.
- Sexual health professionals need to be responsive to emerging sexual health needs such as domestic and sexual violence and abuse (including sexual harassment, bullying and sexism), sexual exploitation and drugs and alcohol misuse e.g. chemsex.
- Sexual health services need to strengthen collaboration between partner organisations working in the wider determinants of health such as drugs and alcohol services, DSVA support services, mental health services and adult and child social services. The additional

time required for this in consultations needs to be acknowledged. This may require the development of systems and processes in order to share data and information.

- Programmes such as the 4YP Bristol initiative (public health's brand to promote young people's sexual health and improve access to services) have been welcomed by professionals. Further work is needed to ensure that this level of support is provided to other groups at greater risk of sexual ill health.
- Health promotion efforts need to take a 'sex-positive' approach, focusing on building confidence in making informed choices and consent.
- Health promotion efforts need to respond to changing cultures and take advantage of technical developments such as social media as well as responding to emerging needs such as social networking websites.

Education around sexual health needs to be targeted at parents and the wider community and not just those who may benefit from accessing the service themselves. Interventions need to be community led using trained professionals whom the community trust. Messages need to take a sex-positive approach.

11. Key contacts

Thara Raj, Consultant in Public Health, Bristol City Council Thara.Raj@bristol.gov.uk

Annette Billing, Public Health Principal, Bristol City Council Annette.Billing@bristol.gov.uk

Glossary

BME	Black and minority ethnic communities
CCG	Clinical Commissioning Group
FGM	Female genital mutilation
CASH	Contraception and Sexual Health
FSRH	Faculty of Sexual and Reproductive Healthcare
GMS	General Medical Services
GUM	Genitourinary Medicine
HIV	Human Immunodeficiency Virus
IUD	Intrauterine device
IUS	Intrauterine system
LARC	Long acting reversible contraception
LGBT	Lesbian, gay, bisexual, transgender
MSM	Men who have sex with men
NCSP	National Chlamydia Screening Programme
PHE	Public Health England
PMS	Personal medical services
SARC	Sexual assault referral centres
SRE	Sex and Relationships Education
STI	Sexually transmitted infections
ToP	Termination of Pregnancy
UHB	University Hospitals Bristol

References

Bristol City Council (2014) Public Health Commissioned sexual health services in Bristol, North Somerset and South Gloucestershire. A Rapid appraisal focussing on existing sexual health service provision.

Bristol City Council (2014b) The Health and Wellbeing of Bristol, <http://www.bristol.gov.uk/page/adult-care-and-health/joint-strategic-needs-assessment-jsna> (accessed 28.4.15)

Department of Health (2013) A Framework for Sexual Health Improvement in England, London, 61pp

Department of Health (2014) Report on Abortion Statistics for England and Wales. Accessed online 20 April 2015
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/319460/Abortion_Statistics_England_and_Wales_2013.pdf

Health Protection Agency (2013) Gonococcal Resistance to Antimicrobials Surveillance Programme (GRASP) Action Plan for England and Wales: Informing the Public Health Response, London, 17pp

Heerde, J., Scholes-Balog, K. and Hemphill, S. (2015) Associations Between Youth Homelessness, Sexual Offenses, Sexual Victimization, and Sexual Risk Behaviors: A Systematic Literature Review, *Archives of Sexual Behavior*, Volume 44, Issue 1, pp 181-212

The Lancet (2014) HIV and sex workers, <http://www.thelancet.com/series/HIV-and-sex-workers> (accessed 22.5.15)

Mercer, C., Tanton, C., Prah, P., Erens, B., Sonnenberg, P., Clifton, S., Macdowall, W., Lewis, R., Field, N., Datta, J., Copas, A., Phelps, A., Wellings, K. and Johnson, A. (2013), Changes in sexual attitudes and lifestyles in Britain through the life course and over time: findings from the National Surveys of Sexual Attitudes and Lifestyles (Natsal), *Lancet*, 382: 1781–94

NICE (2005) Long acting reversible contraception (CG30) <https://www.nice.org.uk/guidance/cg30>

NICE (2014) Contraceptive services with a focus on young people up to the age of 25, <https://www.nice.org.uk/guidance/ph51> (accessed 24.4.15)

Public Health England (2015) Annual Epidemiological Spotlight on HIV in Avon, Gloucestershire and Wiltshire produced by Public Health England, 21pp

Public Health England (2014a) Sexually transmitted infections and chlamydia screening in England, 2013, Health Protection Report: weekly report vol. 8 no. 24, 18pp

Public Health England (2014b) Sexual and reproductive health in England: A guide to local and national data (Revised December 2014), PHE, London, 17pp

Public Health England (2014c) Table1: STI diagnoses & rates in England by Gender, 2004-2013, London, <https://www.gov.uk/government/statistics/sexually-transmitted-infections-stis-annual-data-tables> (accessed 19.2.15)

Public Health England (2014d) HIV in the United Kingdom: 2014 Report, 51pp
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/401662/2014_PHE_HIV_annual_report_draft_Final_07-01-2015.pdf (accessed 22.5.15)

Public Health England (2014e) HIV and STIs in men who have sex with men in London, 51pp
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/357451/2014_09_17_STIs_HIV_in_MSM_in_London_v1_0.pdf (accessed 22.5.15)

Public Health England (2014f) Promoting the health and wellbeing of gay, bisexual and other men who have sex with men: Summary Document, PHE, London, 6pp

Public Health England (2014g) Annual HPV vaccine coverage in England : 2013-14,
<https://www.gov.uk/government/statistics/annual-hpv-vaccine-coverage-2013-to-2014-by-pct-local-authority-and-area-team> (accessed 15.8.15)

Public Health England (2013) *Bristol, City of Local Authority sexual health epidemiology report (LASER): 2013*, Public Health England, 31pp

Smith, K. Osborne, S., Lau, I., & Britton, A. (2011) Homicides, Firearm Offences and Intimate Violence 2009/10. Home Office Statistical Bulletin 01/11. London: Home Office.

Sonnenberg P, Clifton S, Beddows S, Field N, Soldan K, Tanton C, Mercer CH, Coelho da Silva F, Alexander S, Copas AJ, Phelps A, Erens B, Prah P, Macdowall W, Wellings K, Ison CA and Johnson AM (2013) Prevalence, risk factors and uptake of interventions for sexually transmitted infections:

Wellings, K., Jones, K., Mercer, C., Tanton, C., Clifton, S., Datta, J., Copas, A., Erens, B., Gibson, L., Macdowall, W., Sonnenberg, P., Phelps, A., Johnson A. (2013) The prevalence of unplanned pregnancy and associated factors in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3), *Lancet*, 382: 1807–16

WHO (2006) Defining Sexual Health. WHO: Geneva. Accessed at:
http://www.who.int/reproductivehealth/topics/sexual_health/sh_definitions/en/