

Warrington

Joint Strategic Needs Assessment (JSNA)

Sexual Health

2017-18

October 2017

Version control

Version	Description of amendments	Date of amendment
V1	Update of sexual health chapter since last version in 2012	Dec 2016
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The Joint Strategic Needs Assessment (JSNA) considers a wide range of factors that affect the health and wellbeing of the people of Warrington. The objective of the JSNA is to involve partner organisations, such as the local NHS, local authorities, Police, Fire and third sector organisations in order to provide a top level, holistic view of current and future need within the borough. The JSNA is used to agree key priorities to improve the health and wellbeing of all our communities at the same time as reducing health inequalities.

Executive Summary

Scope of the Chapter

This chapter examines the diagnosis rates of the top five sexually transmitted infections (STIs) in Warrington and compares Warrington's position to regional and national rates. Future projected trends in STI rates are also included. Analysis on human immunodeficiency virus (HIV), cervical screening and human papilloma virus (HPV) vaccination data has been conducted. Teenage conception is briefly discussed. Abortion, and contraception, particularly around emergency hormonal contraception (EHC) and long acting reversible contraception (LARC) have also been analysed.

Data has been sourced from Public Health England (PHE), which is readily available online via data profiles. Service data has also been used where possible, enabling analysis at a sub-Warrington level.

Introduction

Good sexual health is an important aspect of health and wellbeing and it is vital that people have the information, confidence and the means to make choices that are right for them. It helps people to develop positive relationships and enables them to protect themselves and their partners from infections and unintended pregnancy. Sexual health services can provide cost savings to the NHS and can significantly reduce physical and emotional ill health through prevention work and early intervention.

If left untreated, sexually transmitted infections can lead to long-term fertility problems, cervical cancer, long-term illness, HIV and can reduce life span and cause premature death. Teenage parenthood can lead to many health and social disadvantages for mother and baby, but an unplanned pregnancy can have a devastating effect both emotionally and economically for people of any age. Termination of pregnancy can have long term emotional consequences, and sexual dysfunction can lead to low self-esteem, relationship problems and possible marriage and family break-up. All of these aspects of poor sexual health can occur at any stage of life, and can have an enduring and severe impact upon people's overall quality of life.

Modern day sexual health challenges are significant. The numbers of new diagnoses of sexually transmitted infections (STIs) have risen since 2007. In 2016 there were approximately 420,000 diagnoses of STIs made in England, which represented a 4% reduction since 2015. Chlamydia is the most commonly diagnosed infection, making up 49% of all new diagnosed STI cases in 2016 (PHE, 2017a).

Young people aged between 15 and 24 experience the highest rates of new STIs. In 2016, those aged 15 to 24 had STI diagnosis rates twice as high in men and seven times as high in women than those aged 25-59 (PHE, 2017a).

Men who have sex with men (MSM) are also disproportionately affected, with just over 49,000 new diagnoses of STIs in this cohort in 2016. Gonorrhoea and chlamydia infections were the most commonly diagnosed, 36% and 26% respectively of all new STI diagnoses in MSM (PHE, 2017a).

Each new case of HIV infection is estimated to represent between £280,000 and £360,000 in lifetime treatment costs (LGA, 2016). People with HIV, if diagnosed and treated early, can now expect a near-normal life span and thus reducing late diagnosis rates is key to this (and whole system savings), as those diagnosed late have a ten-fold increased risk of death in the year following

diagnosis compared to those diagnosed promptly (PHE, 2016a). Working with those considered to be at higher risk of HIV such as MSM, and black African men and women, is an essential part in improving early diagnosis and preventing infection where possible.

Teenage conceptions have seen numbers fall over the years, both nationally and locally in Warrington. In Warrington, figures are at their lowest since first monitoring it in 1998. However, we cannot be complacent due to stark inequality issues, where teenage conception rates are significantly higher in the more deprived areas of the borough.

Some groups at higher risk of poor sexual health face stigma and discrimination, which can influence their ability to access services. Public Health transferred from the NHS to local government in April 2013, and is responsible for commissioning a number of sexual health services. Great strides have been made in sexual health provision. Rapid, open access to high quality integrated genitourinary medicine (GUM) and sexual health services, together with improved choices for people's reproductive health, have an enormous impact on individual and population health and wellbeing. Local authorities will need to liaise closely with fellow commissioners across the system in order to join up what is a complex agenda.

Key Issues and Gaps

The rate of new STI diagnoses in Warrington is currently less than England, however over half of new STIs in Warrington were in young people. High chlamydia rates for young people will be partly due to the National Chlamydia Screening Programme (NCSP) which aims to increase the rate of chlamydia detection. The Warrington NCSP rate is improving, but there is a need to ensure that local effort is recorded and submitted correctly to the national dataset (The Chlamydia Testing Activity Dataset - CTAD). Across all ages, the gonorrhoea diagnostic rate has remained steady in Warrington in recent years, and warts and herpes diagnoses have seen a reducing trend. There are a very low number of syphilis diagnoses in Warrington.

Late diagnosis of HIV in Warrington is currently 57.1% (over 3 years) compared to the national rate of 40.1%. There has been an increase in Warrington since the previous 3 year period in which it was 45.5%, although caution should be used when interpreting these figures as actual numbers are low.

Long term trends show an increase in prevalence of HIV in Warrington which is likely due to longer lives through early and better treatment, and Warrington has a significantly better prevalence rate than the national goal of less than 2 cases per 1,000 population. HIV testing uptake and coverage taking place in GUM in Warrington (reported by PHE) is significantly worse when compared to England.

Teenage conceptions continue to reduce in Warrington overall but we still have high rates in the most deprived areas of the borough. Warrington also has significantly higher abortion rates than England, with the highest rates seen in young people. Over half of under 18 conceptions in Warrington lead to abortion.

Recent data shows a reduction in pharmacy consultations for emergency hormonal contraception (EHC), but there has been a modest increase in patients, seen by GPs, who require EHC. Data suggest that young people in Warrington are more likely to access EHC from the integrated sexual health service rather than pharmacies and GPs.

Long acting reversible contraception (LARC) uptake has increased in sexual health services and reduced at GP practices. More recent local data suggests that GPs have had an increase in uptake of

intrauterine devices (IUDs), although implants have declined. Warrington sexual health services show implants and injections are the most popular forms of LARC, although this is surpassed by the pill which is the most popular contraception. Data from the British Pregnancy Advisory Service (BPAS) also shows an increase in the pill in Warrington. Data suggests that younger women prefer injection and implants, older age groups prefer IUD and intrauterine system (IUS).

Cervical cancer prevention in Warrington is at a similar level to that seen in England overall. The first dose of HPV immunisation for young girls currently stands at 88.1% in Warrington. Compared to other local authorities in the North West there is still room for improvement on this figure. Cervical screening coverage rates for women aged between 25 and 64 show a reducing trend in Warrington but does remain higher than the England average. National data highlights that those aged 25-29 have the lowest coverage rates than any other age group. Although it's not possible to obtain local data for the same age groups, it is known from what we have there is a lower coverage rate for those aged 25-49 in Warrington, compared to those aged 50-64 years.

There are currently some gaps in the data, which, if available, would contribute to improved analysis:

- There is a clear need to improve the coding of data in primary care for IUD/IUS fitted for menorrhagia, indeed for all purposes in order to allow improved analysis of pathways
- Furthermore, there is a need to develop the coding/datasets around reason for fitting IUD/IUS within the integrated sexual health service as this has not always been clear
- There is at present a lack of data (activity data) coming from primary care for the local authority long acting reversible contraception (LARC) Local Enhanced Service delivery. This presents a risk not only in terms of an inability to analyse various activity/uptake levels and understanding system flow, but also means that local authority commissioners cannot appropriately quality check data and pay accordingly against said activity (in essence, GPs will not receive payment).

Recommendations for Commissioning

Updates to Previous Recommendations from Last Chapter

- Review of current sexual health services including chlamydia screening with a view to adopting the regional integrated sexual health service specification including a thorough outcome based performance management framework. **Action completed. Reviewed all services and tendered for an integrated sexual health service consisting of Genitourinary Medicine (GUM) and Sexual Reproductive Health services, combined with chlamydia screening offer in one service specification based on all relevant guidance and standards and worked on collaboratively with regional colleagues/commissioners. Contract awarded to Bridgewater Community Healthcare NHS Foundation Trust and mobilised in April 2015.**
- Investigate the adoption of sexual health tariffs such as a “Payment by Results” approach (PBR) which ensures that all providers are fairly remunerated. **Various work has been undertaken to baseline and benchmark this, the cost of moving to tariff. Work has been undertaken at regional level, involving Warrington, to understand the impact of moving to PBR. Other areas have presented their findings and the impact upon them, across the North West. For now, the provider Bridgewater continues to input their activity into pathway analytics, which uses all tariffs and generates likely costs on tariff to baseline all of this so that we can fully understand impact on local budgets. Continued investigation of this is required, locally and regionally. Recommendation to be carried forward.**
- The development of a comprehensive contraception plan to incorporate prevention, contraception, barrier and Long Acting Reversible Contraception (LARC), referral for abortion and testing and treatments for STIs. **Plan completed – this is contained within both Bridgewater service planning (mobilisation and strategic approaches moving forward) and the recently refreshed Warrington Sexual Health Strategy, which is multi-faceted and includes a raft of work on prevention, contraceptive methods, promotion of LARC, improving access and availability of contraception (particularly LARC) and to key vulnerable groups/areas (deprivation based – teenage pregnancy hot spots). We also have a clear promotion and communication plan around this, to promote visibility and improve access.**
- Investigation into the late diagnosis of HIV and the feasibility of introducing near patient screening in appropriate targeted situations. This would have a financial implication. **Warrington’s late diagnosis rate in 2013-15 was 45.5%. Decision was taken that we could improve our promotion of early intervention, screening, testing and reduction of stigma around the issue (normalise testing in a range of settings as a result of assessing the situation). A HIV Prevention and Support service commissioned and mobilised from September 2014, with the intention to provide greater support to at risk/high risk populations (men who have sex with men (MSM), black and minority ethnic groups (BME)) within the town. The service provides Point of Care (POC) testing at various arranged clinics and outreach to encourage and improve testing uptake to reduce onward transmission of HIV and to also help reduce our late diagnosis rate.**
- Investigation into HIV positive clients who are not accessing support services; is this an unmet need or are they asymptomatic? **Currently within provider contract and with support from Bridgewater Trust to baseline this, with MSM outreach worker leading on a piece of work to understand numbers of positive patients not regularly engaging with services.**
- Ensure multi-agency commitment to tackling teenage conception including channelling investment and service re-design in a collaborative and joined up manner, in order to maximise limited resources. **Excellent progress made here. All elements of the newly revised Warrington Sexual Health Strategy (based on national priorities, Department of Health) contain vital elements, contraceptive plan, promotional work, commissioning priorities, targeting vulnerable groups, training of professionals to support the agenda, to tackle the teenage pregnancy agenda. Furthermore, the Strategic Sexual Health Implementation Group (SSHIG) and Better Prevention Groups pull together a wide array of partners across**

the system to appropriately target and utilise resources.

- Ensure that all young people's services need to meet 'You're Welcome' Quality Criteria. ***This is in all plans. It is being undertaken by major services and was refreshed and included in the latest Sexual Health Strategy – still being completed, but on the radar.***
- Review the recommendations from the rapid needs assessment 2009, with a view to integrating into service redesign and promotion. ***This has been superseded by numerous needs assessments and pieces of intelligence¹ that we will have acted on within commissioning and delivery locally.***
- Undertake a piece of social marketing scoping work, with a view to targeting known high risk groups. ***Known high risk and vulnerable groups are being targeted as per the guidance - MSM, BME for testing and screening in HIV/sexually transmitted infections, Lesbian Gay Bisexual Transgender community and other minority groups who do not speak English as a first language and where barriers to service exist. Specific projects to engage with and support sex workers active in the town are well underway to also fit this recommendation. Various consultations have taken place with young people around services and access, school based services etc, but no specific piece of social marketing work undertaken.***
- Identify and support vulnerable young people who may be at risk of teenage pregnancy and sexually transmitted infections (STIs). ***There is a lot taking place around the teenage pregnancy agenda, support to families, contraceptive awareness/uptake, Family Nurse Partnership (FNP), parenting sessions to avoid second unplanned pregnancies, commissioning of emergency hormonal contraception in pharmacy, improved choice and access to sexual health services locally, commissioning of a hub and spoke integrated***

sexual health service. A piece of work to identify and target the most vulnerable young people is possibly still required.

- Analyse skills available within the Primary Care Trust and local authority to promote sexual health and identify appropriate education and training to meet gaps, including delivery of the 'Every Contact Counts' training programme. ***This is being delivered. A full partner based training plan (upskill via Making Every Contact Count (MECC) model) is taking place with a whole range of sexual health courses available to raise awareness of issues and services available amongst staff when they meet with possible patients.***
- Develop interventions that manage broader 'risk-taking' behaviour including sexual health and alcohol. ***There is a range of communication plans and campaign based work to discourage risk taking, via the schools programme, Sex and Relationship Education (SRE) training, teacher support, Personal Social Health Economic Education (PSHE) model and community based campaigns. Stay Safe campaigns run annually around alcohol and risky sex. Various messages of this nature are embedded in everything partners do in relation to C-Card (condom distribution scheme) and other aspects.***
- Consider the findings of the Department for Education internal review regarding how schools might improve the quality of PSHE offered (Teenage Pregnancy Strategy Group to consider this as part of a revised plan). ***There is no longer a Teenage Pregnancy Strategy Group, the group was time limited. We now have the Strategic Sexual Health Implementation Group (SSHIG) and Better Prevention Groups that formulate and deliver the sexual health priorities and action points across the town. PSHE and SRE are included in current thinking and work within Priority 2: Building Knowledge & Awareness/Resilience amongst our Young People. This work is ongoing, teacher support, training packages, SRE delivery in schools via PSHE programme, and via the Public Health commissioned Risky Behaviour Programme***

¹ For example, Local Authority Sexual Health Epidemiology Reports (Public Health England), Sexual and Reproductive Health Services information (NHS Digital), national guidance, Faculty of Sexual & Reproductive Health (FSRH), and British Association of Sexual Health & HIV (BASHH) standards

Recommendations from Current Chapter

1. Investigate the adoption of sexual health tariffs such as a “Payment by Results” approach (PBR) which ensures that all providers are fairly remunerated. Continued investigation of this is required, locally and regionally.
2. To maintain a higher level strategic group to oversee the complex commissioning arrangements. This is vital in order to ensure that contraceptive and GUM provision come together and work effectively with HIV services and termination of pregnancy services in a whole systems approach. Indeed the whole system has been fragmented significantly and so retaining key commissioning and provider input into SSHIG to draw arrangements and pathways together is vital, understood to reduce any potential duplication in resource and effort (financially and staffing wise).
3. There is still a need for all services dealing with young people to implement ‘Your Welcome’ quality criteria in light of the number of young people accessing sexual health services.
4. With pending Sex & Relationships Education (SRE) policy change on the horizon, there is a need to develop a clear package of support and curriculum assistance for teachers around key/crucial messages in relation to sexual health and healthy relationships for delivery in the classroom.
5. Place continued emphasis and focus upon ensuring that the highest risk age group (15-24) are appropriately screened and tested for chlamydia in all available/relevant services.
6. Increase the numbers of males under 19 years old being tested for chlamydia as data suggests that services are not testing enough teenage males.
7. Investigate further the higher levels of chlamydia positivity in one MSOA (Middle Super Output Area) in Bewsey & Whitecross for both 15-24s and all age datasets.
8. Ensure we routinely screen at risk groups for HIV (most notably MSM, BME) and improve the testing offer across services to bring Warrington’s late diagnosis rate down further. We have seen a slight rise in latest 3-year datasets around percentage diagnosed late, hence a need to focus efforts (current rate stands at 57.1% diagnosed late).
9. Carry out extra analysis on Public Health England (PHE) testing uptake and coverage data for HIV. Recent figures (in this chapter) suggest uptake and coverage both significantly worse than England (query).
10. In light of the current rate of abortion in under 18s, 18-19 and 20-24 age groups, place continued emphasis on effective promotion of contraception, especially LARC.
11. Critically also related to abortion, ensure pathways from current providers (including BPAS) to contraception, counselling and support are clear and well-drawn out/communicated (offers outside BPAS model).
12. There is a need to tighten and develop pathways between pharmacies (EHC delivery/dispensation) and contraceptive offers within the local integrated sexual health service and primary care (GPs) – 54% women presented to pharmacy for EHC with ‘no method of contraception’ as reason for access.

13. In relation to recommendation 12, consider the development of an electronic referral system and/or central booking set up to more swiftly send women who consent to a consultation into their GP or Integrated Sexual Health Service.
14. Ensure we continue to promote LARC and set high percentage uptake targets within services as the most cost effective long-term method of contraception.
15. Specifically aim to improve LARC uptake in the under 18 age range.
16. Investigate the data around particular cohorts accessing Integrated Sexual Health Service (ISHS) for IUD/IUS and associated coding/reason for fitting to be added – investigate pathways/data for commissioning purposes.
17. Work to address falling/declining cervical screening coverage rates across all cohorts (25-49, 50-64). National figures suggest 25-29 age group seen most decline in screening rates/uptake (consider promotional work and access here).
18. Furthermore, in relation to the above issue, there is still work to be done to improve coverage rates for cervical screening in our most deprived areas (particularly Quintile 1 (20% most deprived areas)).

1) Who is At Risk and Why?

All people who are sexually active have the potential to contract an STI, HIV or have an unplanned pregnancy. Research highlights that sexual ill health is not equally distributed within the population, and there is a clear relationship between sexual ill health, poverty and social exclusion (Department of Health, 2001).

Groups who are most at risk of poor sexual health and may experience barriers to accessing services include women, young people; minority ethnic groups; single homeless people; gay and bisexual men; looked after young people; drug injecting misusers; people with learning difficulties; people in prisons and youth offending institutions; young people not in education, training or employment.

Sexually transmitted infections remain greatest in young heterosexuals under the age of 25, men who have sex with men (MSM), and some black and ethnic minority groups.

1.1) Young People

Young people (aged 15-24 years old) experience the highest STI diagnosis rates. In 2016, heterosexuals aged 15-24 accounted for 62% of chlamydia, 50% of gonorrhoea, 49% of genital warts, and 42% of genital herpes diagnosed in sexual health services across England (PHE, 2017a).

The most common sexually transmitted infection in young people is genital chlamydia. The National Chlamydia Screening Programme in England, which is aimed at 15-24 year olds, performed over 1.4 million screens in under 25 year olds in 2016. Of these, 8.3% of screens in women and 11.0% in men were positive for chlamydia (PHE, 2017b).

1.2) Men who have Sex with Men (MSM)

HIV is still an issue of major concern for MSM. Public Health England (Kirwan et al., 2016) reported that the number of new infections (or incidence) of HIV in MSM remains consistently high in England. In 2015, it was estimated that 2,800 MSM were diagnosed with HIV, and around 47,000 MSM are living with HIV with an estimated 12% (5,800) still undiagnosed. The overall prevalenceⁱⁱ of HIV in the UK was estimated to be 1.6 per 1000 population of all ages, however this was considerably higher in MSM, estimated to be 58.7 per 1000 population.

MSM are also affected by other STIs and in England in 2016, 49,445 new STIs were diagnosed in MSM (PHE, 2017a). In 2015, MSM accounted for 84% of syphilis diagnoses, 70% of gonorrhoea diagnoses, 21% of chlamydia diagnoses, 12% of genital herpes diagnoses and 9% of genital warts diagnoses of males attending sexual health clinics (PHE, 2016b). The authors also report an increased trend in recent years in the number of STI diagnoses in MSM which accounts for the majority of the increased diagnoses seen among men. Better detection through increased screening is thought to contribute to some of the increase, however high levels of condomless sex is likely to be the main reason.

1.3) People from Black Ethnic Communities

People of black ethnicity are disproportionately affected by STIs than other ethnic groups. In England in 2015, they had the highest rates of STI diagnoses at Sexual Health Clinics, and most of these cases were among people living in areas of high deprivation, particularly in urban areas (PHE, 2016b).

Although estimated prevalence of HIV in heterosexuals is low (1.0 per 1000 population in 2015), it is greater among black African adults. Black African heterosexual men are estimated to have a prevalence of 22.2 per 1000 population, and black African heterosexual women even higher at 42.6 per 1000 population (Kirwan et al., 2016).

2) The Level of Need in the Local Population

2.1) Sexually Transmitted Infections (STIs) Overview

In 2015, 1023 new STIs were diagnosed in Warrington residents, equivalent to a rate of 495.6 per 100,000 residents. In comparison, England had a rate of 767.6 (PHE, 2017c).

Over half of diagnoses of new STIs in Warrington (53%) were in young people aged 15-24, compared to 45% in England, and 16.1% of new STIs in Warrington were among men who have sex with men (MSM), where sexual orientation was known. This includes those tested in specialist sexual health clinics only (PHE, 2016a).

The following table illustrates the rates per 100,000 population of the top 5 STIs in 2015, comparing Warrington with the North West and England.

ⁱⁱ Prevalence = existing cases of disease

Table 1: Rate of diagnosis from the top 5 Sexually Transmitted Infections (STIs), 2015

Rate per 100,000	Warrington	North West	England
Chlamydia 15-24 yrs	1,587	2,328	1,887
Chlamydia 25+ yrs	108	176	179
Genital warts	113.8	120.0	118.9
Genital herpes	36.3	56.2	57.6
Gonorrhoea	29.1	42.6	70.7
Syphilis	3.4	6.2	9.3

Source: PHE - Sexual & Reproductive Health Profiles, 2017

Young adults (under 25s) are disproportionately affected by STIs, as illustrated in table 1, where the diagnosis rate of chlamydia in Warrington in the 15 to 24 year old population was nearly 15 times higher than in the 25 years and above population. However, it should be recognised that the high rates are also likely to be partly due to the National Chlamydia Screening Programme, which targets the 15 to 24 age group. The aim of the programme is that, by detecting and treating sufficient chlamydia infections that have no noticeable symptoms, it will result in a decrease in incidenceⁱⁱⁱ. Chlamydia diagnoses for those aged 15 to 24 are measured against a national target of 2,300 per 100,000 young people, and higher numbers are better.

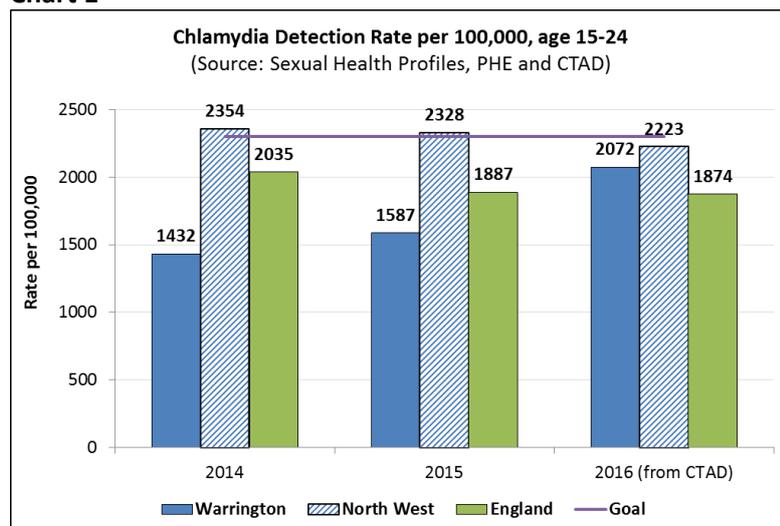
2.2) STI Trends

All data and comparisons in section 2.2 come from the Public Health England Sexual and Reproductive Health Profiles (PHE, 2017c) unless otherwise specified.

2.2.1) National Chlamydia Screening Programme: The Chlamydia Testing Activity Dataset (CTAD)(PHE, 2017d) shows that in 2016, Warrington had a detection rate of 2,072 per 100,000 15-24 year olds. Although this did not meet the goal of 2,300 it was higher than in 2015 in which the rate was 1,587. In 2016, England had a rate of 1,874 per 100,000, and the North West 2,223. Chart 1 contains further detail. The chlamydia detection rate reflects both screening coverage levels and the proportion of tests that are positive at all testing sites. In Warrington, 19.9% of 15-24 year olds were tested for chlamydia, and 492 tests came back positive out of 4,725 tests undertaken, giving a positivity rate of 10.4%. In England, 20.7% of 15-24 year olds were tested, with a 9.1% positivity rate.

ⁱⁱⁱ Incidence: rate of new/newly diagnosed cases of a disease, different to prevalence which relates to all cases

Chart 1



2.2.2) The gonorrhoea diagnostic rate has remained steady in Warrington over the past 3 years since 2013, and most recent data (2015) shows it to be 29.1 per 100,000 population. This is equivalent to 60 cases. Warrington has closely followed the same pattern as the North West since 2009 but has remained statistically better than the North West in all years but one (2011), in which the rate was similar. England has seen an increasing trend since 2009, and Warrington has had a statistically better rate than England in all years except for 2011 where it was similar. See chart 2.

2.2.3) Warts diagnoses in Warrington have experienced a downwards trend, more noticeably since 2012 (chart 3). The rate is currently 113.8 per 100,000 population (at 2015), and although lower than the North West (120.0) and England (118.9), it is not statistically lower. The rate of 113.8 is equivalent to 235 cases. England and the North West also show declining trends. Public Health England suggests that decreases seen in genital warts diagnoses may be due to a moderately protective effect of the HPV-16/18 vaccination (PHE, 2016a).

2.2.4) Herpes diagnoses show a downwards trend in Warrington since 2012 (chart 4), and at 2015 the rate was 36.3 per 100,000 population (or 75 diagnoses). In comparison, the North West rate was 56.2 and England 57.6. In the past 2 years the Warrington rate has been statistically better than regional and national rates. Whilst the Warrington rate has declined in recent years, England and the North West have remained fairly steady.

2.2.5) The numbers of syphilis diagnoses in Warrington are very low, an average of 6 diagnoses per year. At 2015, the rate per 100,000 was 3.4 which is equivalent to 7 cases. Warrington's rate was statistically better than the England rate of 9.3, but not statistically different to the North West (6.2). See chart 5.

Chart 2

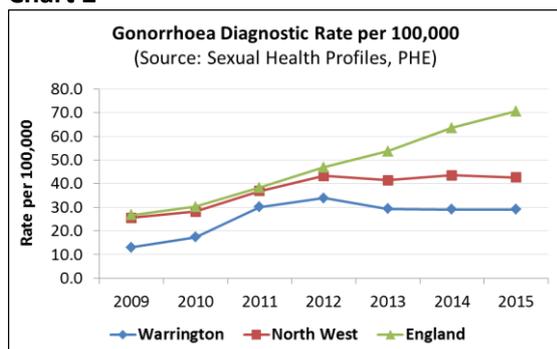


Chart 3

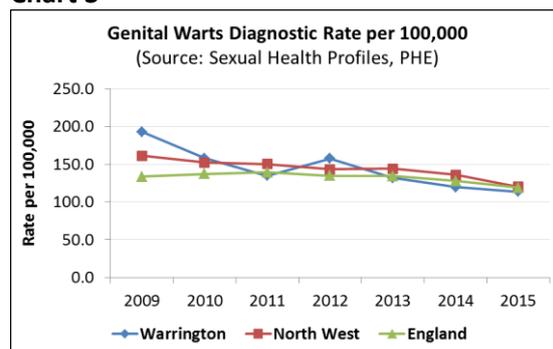


Chart 4

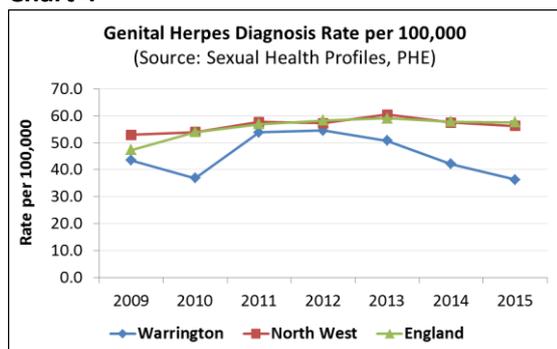
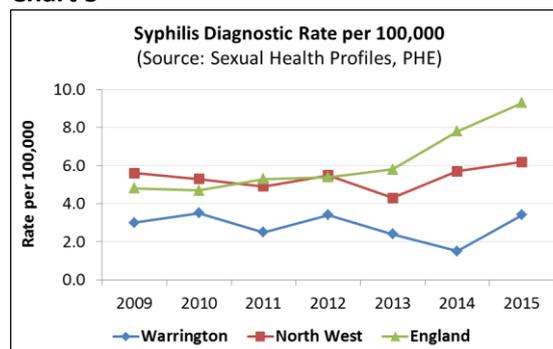


Chart 5



2.3) STIs by Age / At Risk Groups

The following charts show 3 years of diagnoses data from 2013 to 2015 for Warrington, aggregated together and turned into rates per 100,000 population and broken down by age group and gender.

2.3.1) Chart 6 highlights the higher rates seen in young adults for **chlamydia** diagnoses, particularly young females. However, the focussed work of the Chlamydia Screening Programme will partly explain the high rates in young adults. Males have the highest rates in those age groups aged 25 and over. However, males aged under 20 have a very low rate compared to females of the same age.

2.3.2) Younger people tend to be more at risk from **gonorrhoea**, particularly males aged 20 to 24 (chart 7). Males accounted for two thirds of diagnoses in Warrington (66%) over the 3 years.

2.3.3) Males aged 20 to 24 have the highest rate of **warts** diagnoses. As can be seen in chart 8, males have higher rates than females in all age groups apart from 15-19 year olds. Males accounted for over half of diagnoses in Warrington (54%) over the 3 years.

2.3.4) Chart 9 highlights that females have the highest rates for **herpes** in nearly all age groups. Females accounted for 59% of diagnoses in Warrington over the 3 years.

2.3.5) Due to the small numbers of **syphilis** cases diagnosed in Warrington, it is not possible to conduct robust analysis.

Chart 6

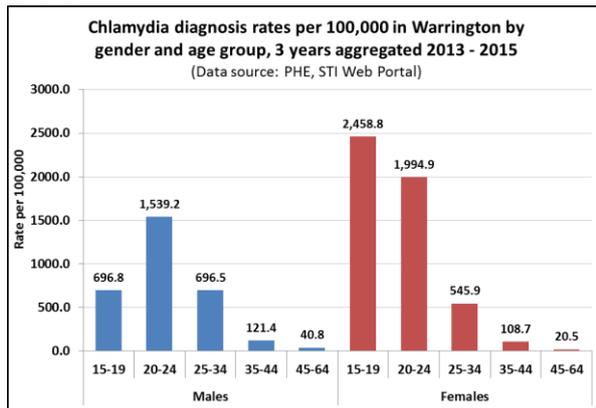


Chart 7

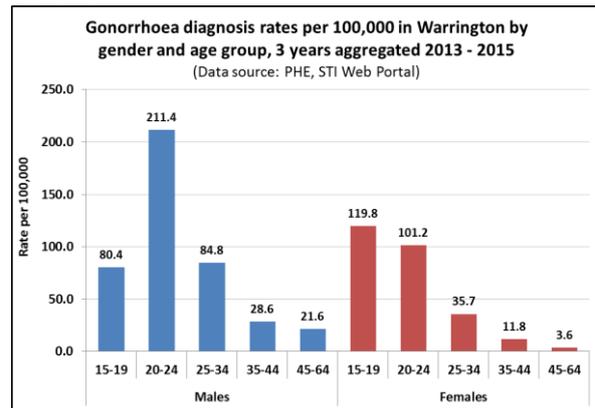


Chart 8

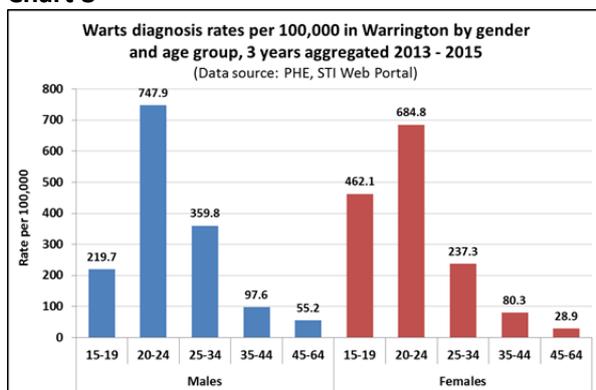
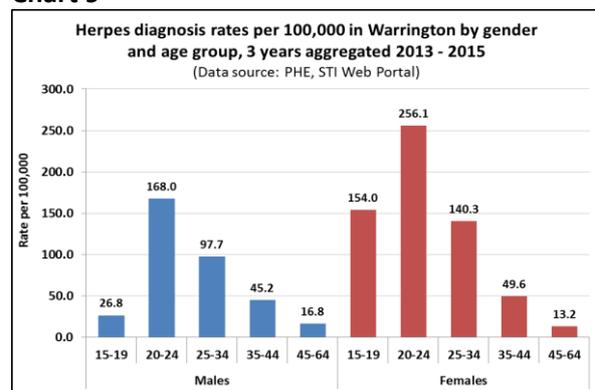


Chart 9



2.3.6) Sexual Health Services: The following charts are based on STI tests conducted by the current service provider of the Integrated Sexual Health Service, Bridgewater Community Healthcare NHS Foundation Trust. The time period is April 2015 to March 2016. High proportions of younger people were tested up until the age of 34, with a large drop seen in those aged 35+. This reflects the demographics of the clientele attending the sexual health centre.

Chlamydia and gonorrhoea testing are offered at the same time to clients of the service which is why the percentages are the same in charts 10 and 11.

A low proportion of males aged under 19 have been tested for chlamydia compared to females of the same age range. Coupled with the fact that the chlamydia diagnosis rates for males aged under 20 are very low compared to females, suggests that the service is not testing enough teenage males.

These figures do not represent all tests conducted in Warrington as people can go elsewhere such as GPs. However most STI testing in Warrington will be undertaken by the (Bridgewater) Sexual Health Service, and all chlamydia testing for 15 – 24 year olds is undertaken by Bridgewater.

Chart 10

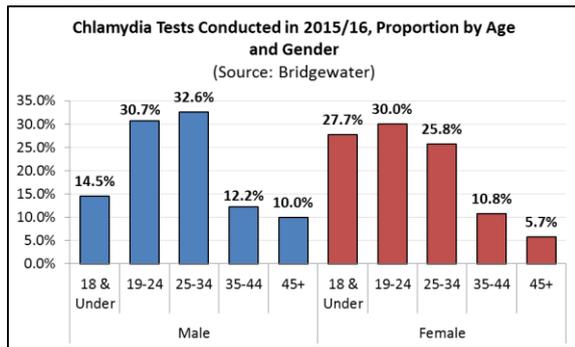


Chart 11

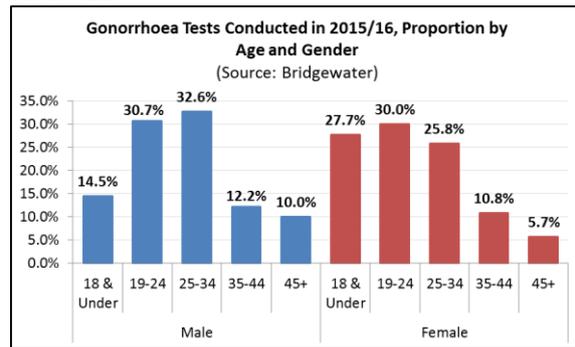
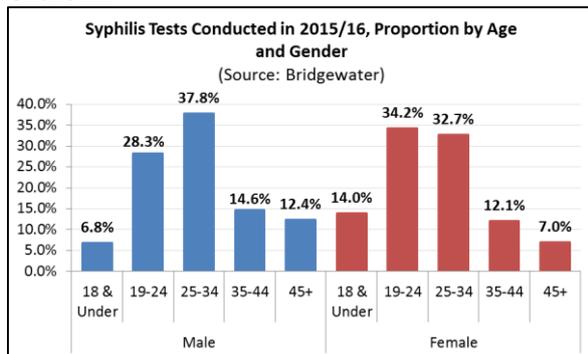


Chart 12



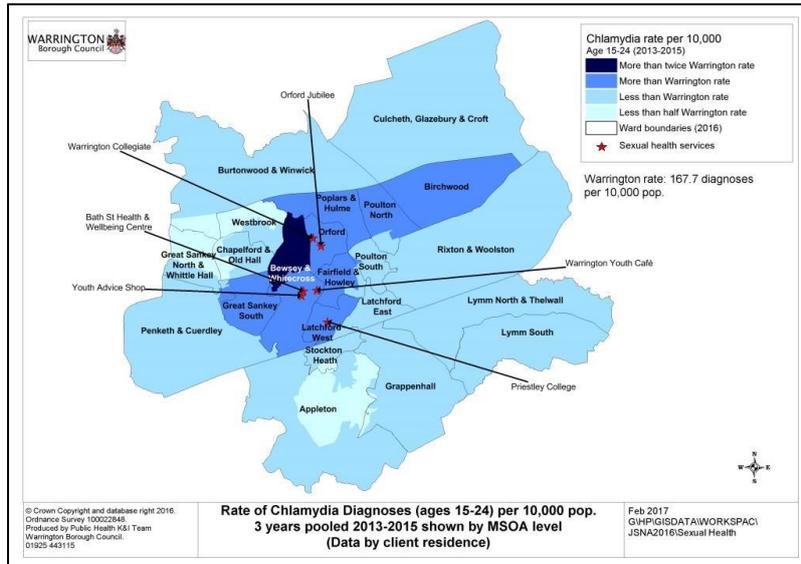
2.4) Location of STI Diagnoses

The following maps show STI diagnoses (based on patient residence) aggregated over 3 calendar years (2013-2015), and turned into rates per **10,000** population. The rates are shown by Middle Super Output Area (MSOA)^{iv}. Although the darkest coloured MSOAs in the map define higher rates of diagnoses, incidence is not necessarily spread evenly across the whole area, and may be clustered around specific locations within the MSOA. Locations of Warrington's Integrated Sexual Health Service are also shown.

2.4.1) Chlamydia Diagnoses: One area of Bewsey & Whitecross ward has a rate more than twice the Warrington average. The rate in this particular MSOA, for those aged 15-24, is 477.8 per 10,000 population (or 144 diagnoses) compared to the Warrington rate of 167.7 (as seen in map 1). For all ages, the same MSOA has a rate of 114.0 per 10,000 (or 262 diagnoses) compared to Warrington's rate of 30.0 (map 2). This MSOA falls within the 20% most deprived areas of Warrington, and we would expect to see a higher rate of diagnosis in the more deprived areas.

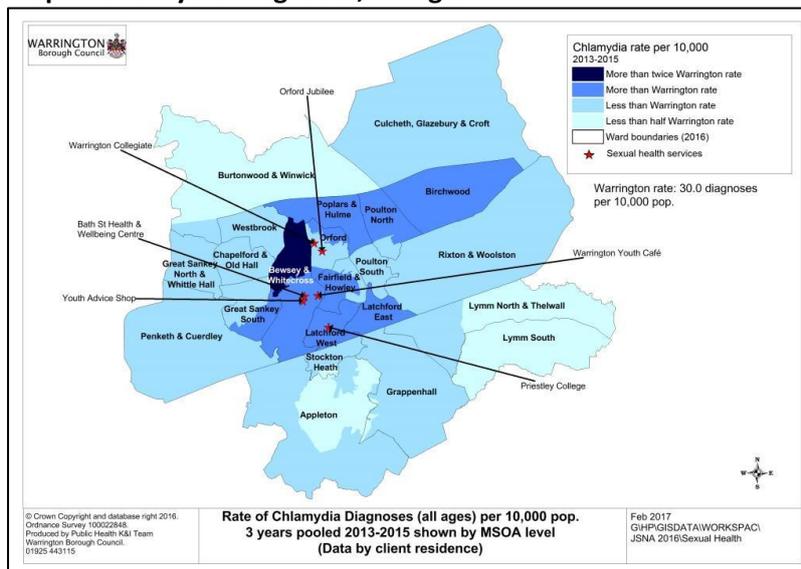
^{iv} MSOAs are geographic areas designed to improve the reporting of small area statistics. They have a minimum size of 5000 residents and 2000 households with an average population size of 7500.

Map 1: Chlamydia Diagnoses, Ages 15-24



Source of data: Public Health England

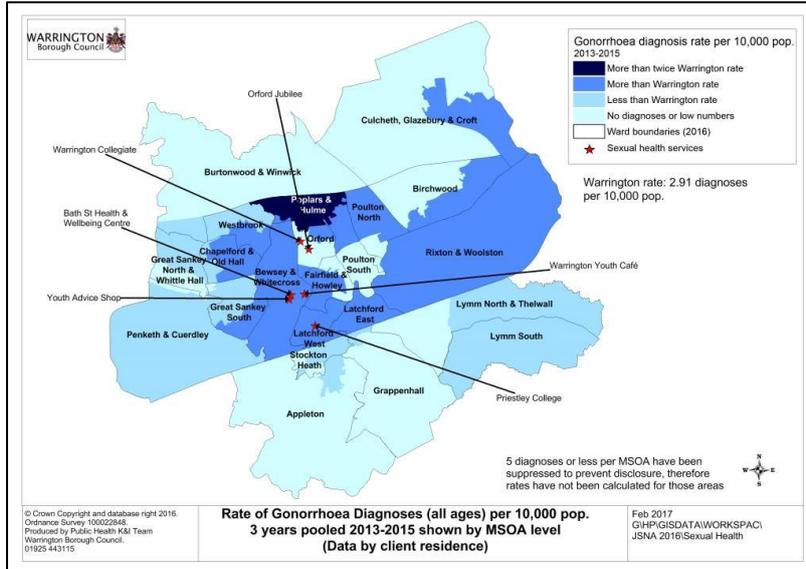
Map 2: Chlamydia Diagnoses, All Ages



Source of data: Public Health England

2.4.2) Gonorrhoea Diagnoses: The Warrington rate was 2.91 diagnoses per 10,000 population over the 3 year period. Actual numbers are small when broken down by MSOA, and overall there was a total of 180 diagnoses. Only one MSOA had a rate more than twice that of Warrington. This area is located in Poplars & Hulme ward, and had a rate of 7.03. The area sits within the 20% most deprived areas of Warrington. The outer areas of the borough had the lowest rates, or no diagnoses, and therefore rates have been suppressed to prevent disclosure.

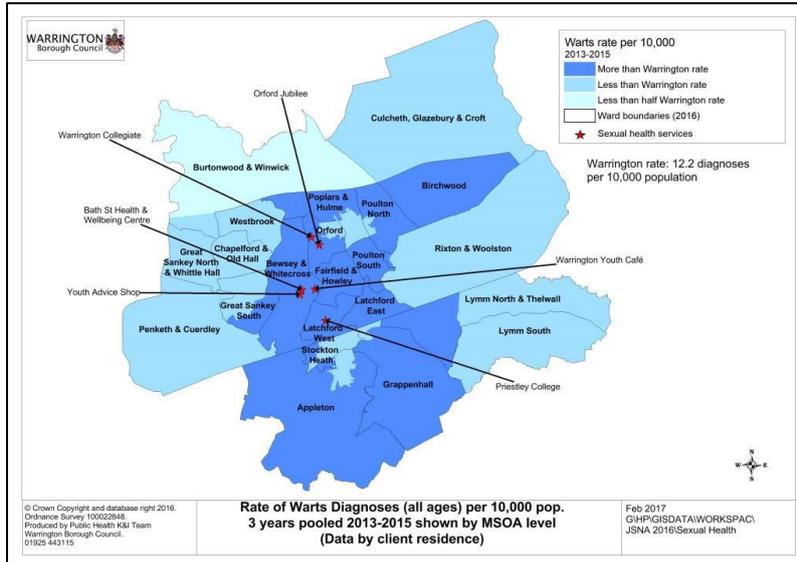
Map 3: Gonorrhoea Diagnoses, All Ages



Source of data: Public Health England

2.4.3) Warts Diagnoses: The Warrington rate for warts diagnoses over the 3 years shown in map 4 is 12.2 per 10,000 population. This is equivalent to 753 diagnoses. A number of MSOAs had rates higher than the Warrington rate, ranging from 12.4 to 17.5. The area with the highest rate is located within Grappenhall ward, and HMP Thorn Cross is situated here, and it is possible the prison contributes to the high diagnosis rate.

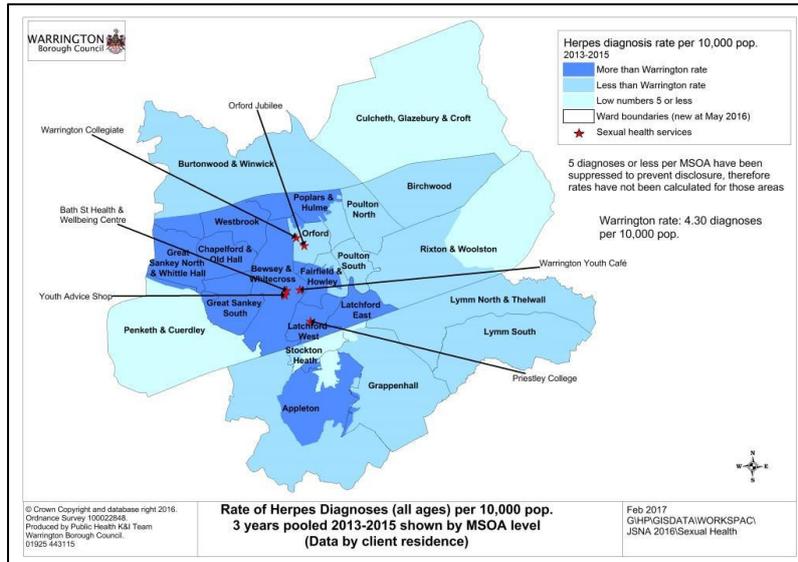
Map 4: Warts Diagnoses, All Ages



Source of data: Public Health England

2.4.4) Herpes Diagnoses: The Warrington rate was 4.30 diagnoses per 10,000 population over the 3 year period. Actual numbers are small when broken down by MSOA, and overall there was a total of 266 diagnoses. Several areas had a diagnosis rate higher than the Warrington rate, ranging from 4.43 to 8.27, this area found in the top half of Bewsey & Whitecross ward. Some areas, on the borough boundaries, had a small number of diagnoses, and have been suppressed to prevent disclosure.

Map 5: Herpes Diagnoses, All Ages



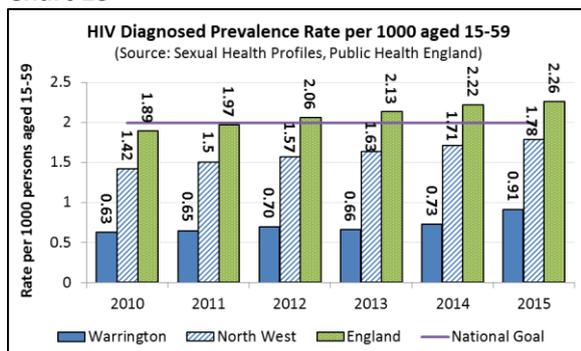
Source of data: Public Health England

2.5) HIV

Kirwan et al. (2016) estimated that, in 2015, 101,200 people were living with HIV in the UK. Of those estimated to have HIV, 13% (13,500) are unaware of their infection and risk passing it on if having unprotected sex. Most HIV transmission in the UK occurs through sexual contact. Those most at risk of infection are men who have sex with men (MSM) and black Africans.

In 2015, Warrington had a prevalence^v rate of 0.91 cases of HIV per 1,000 people which is significantly better than the national goal of less than 2 cases per 1,000 population (PHE, 2017c). Warrington also had a prevalence rate significantly better than the current England (2.26) and North West (1.78) averages. Since 2010, the Warrington trend shows an increase in prevalence which is most likely due to people living longer lives with HIV through early diagnosis and accessing effective treatment. Warrington's prevalence rate of 0.91 cases per 1,000 population is equivalent to 111 cases of HIV. See chart 13 for further information.

Chart 13



New diagnoses of HIV in Warrington are low, with less than 10 cases per year. In 2015 there were 6 new diagnoses of HIV which is a diagnosis rate of 3.5 per 100,000 population. Warrington's rate is

^v Prevalence refers to the proportion of individuals in a population who have a disease at a given time, often expressed as a percentage or as a rate.

lower than the North West rate of 6.8, and significantly lower than the England rate of 12.1 (PHE, 2017c).

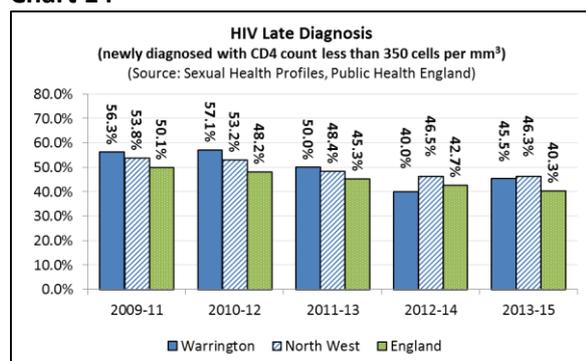
2.5.1) Late Diagnosis: The sooner somebody is diagnosed with HIV, the greater their life expectancy, and the less likelihood of transmitting the virus to their sexual partners. Late diagnosis is defined as a CD4 count of less than 350 cells per mm³ within 3 months of HIV diagnosis. In the period 2013-15, 45.5% of Warrington adults were diagnosed at late stage of infection; this is not significantly different to the England rate of 40.3% (PHE, 2017c).

In the UK, late diagnosis rates have been declining since 2003, with the steepest decline among MSM (Harris and Khatri, 2015). As observed in chart 14, which shows late diagnosis rates from 2009-11 onwards, both Warrington and England have seen a reducing trend.

Recently published data for 2014-16 (PHE, 2017c) highlights that Warrington has seen an increase in late diagnosis and now currently stands at 57.1% compared to England's 40.1%.

Actual numbers of people diagnosed late in Warrington are very small and therefore small changes in numbers can affect the proportions seen between reporting periods. Please use caution when interpreting the figures.

Chart 14



2.5.2) Testing: HIV testing can reduce undiagnosed infection and late diagnosis. Anyone can acquire HIV and it is important that stigma and other socio-cultural barriers are reduced that prevent people from testing and accessing the care that is needed. Tests are free and anonymous and within Warrington there are a variety of settings that people can be tested at.

- i) **Genitourinary Medicine (GUM) Clinic:** Public Health England monitors uptake (number of tests reported) and coverage (number of people tested) of HIV testing taking place in GUM clinics. In 2015 (PHE, 2017c), the HIV testing uptake in Warrington was 64.2% and testing coverage was reported as 47.8%, both significantly worse than the England averages (76.2% and 67.3% respectively).
- ii) **Warrington Integrated Sexual Health Service:** Provided by Bridgewater Community Healthcare NHS Foundation Trust, it carries out HIV testing, and all first time visitors get offered HIV tests as standard. Between April 2015 and March 2016, the Sexual Health Centre conducted 3592 HIV tests, 54.4% on females and 45.6% on males. Of these tests, less than 5 tests came back positive. All positives were male.

Chart 15 highlights that, over the 12 months, numbers of tests rose as the year progressed, to quarter 3, and then reduced in quarter 4. The largest age group tested for HIV was 25-34

year olds, accounting for 35% of tests conducted across all age ranges (chart 16). This will reflect that the clientele for visiting Warrington Centre for Sexual Health tends to be the younger age groups, with less numbers attending from those aged 35 and over.

Chart 15

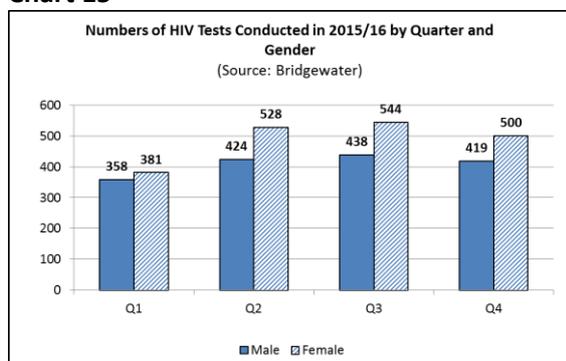
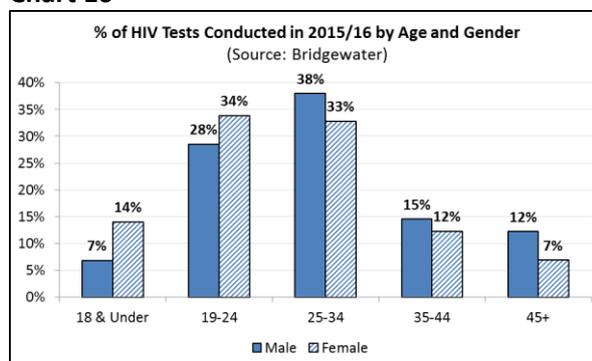


Chart 16



- iii) **Outreach HIV Testing:** Bridgewater now provide outreach HIV testing, and Point of Care^{vi} testing in community settings and venues across Warrington (formerly Terrence Higgins Trust (THT) until March 2017). They also target key at risk groups to encourage uptake of tests. In their first year of contract, running from October 2014 to September 2015, THT carried out 87 HIV tests. This increased to 97 in the 12 months ending September 2016, up by 11.5%.
- iv) **GP Practices:** 196 HIV tests were conducted through Warrington GP practices for the period October 2015 to November 2016.
- v) **Home sampling:** HIV home sampling kits can be ordered online and a small blood sample sent back to the laboratory.

It should be noted that due to the sensitivity of the topic, the low numbers involved and the need to prevent the risk of identity of people diagnosed with HIV, this section gives an overarching view of HIV in Warrington. More detailed information around age, gender, ethnicity, location of prevalence is known and acted on by the Public Health team and partners to manage the risk of HIV infection in Warrington and commission appropriate services.

2.6) Teenage Conceptions

Research conducted by Botting et al. (1998), using the Office for National Statistics Longitudinal study, showed that the risk of unintentionally becoming a teenage mother is ten times higher among girls in social class five (manual unskilled) than in social class one (professional). Teenage pregnancy is strongly associated with socio-economic deprivation. Botting et al. (1998) suggest local areas experiencing high levels of material deprivation generally have the highest rates of teenage conceptions. Other groups who are more vulnerable to becoming teenage mothers include children in care and children of teenage mothers (FPA, 2010).

In 2015, the under 18 conception rate in Warrington was 20.3 per 1000 females. This compares to the England rate of 20.8 and the North West rate of 24.7. Overall, the long term trend in Warrington

^{vi} Point of care testing is medical diagnostic testing at or near the location of the patient, enabling results to be obtained quicker and allows for immediate clinical management decisions to be made.

shows a reduction, and the reduction has continued into 2015. Actual numbers of teenage conceptions are at their lowest ever since monitoring this indicator, with 74 conceptions in 2015.

Although rates are reducing in Warrington, under 18 conception rates in the most deprived areas of the borough are significantly higher than the rest of Warrington. Latest data from the Office for National Statistics, covering the period 2012 to 2014, show that the 20% most deprived areas of Warrington have a rate of 47.9 per 1000 females compared to 14.8 in the remainder of the borough.

Of course, not all teenage conceptions will be unplanned. Further information can be found in the dedicated JSNA chapter on [teenage conceptions](#).

2.7) Abortions

In 2015, 661 abortions were performed on females from Warrington, equivalent to a rate of 17.2 per 1000 women aged 15-44. Warrington’s rate is significantly higher than England’s rate of 16.2 (DoH, 2016).

The majority of abortions in Warrington occurred at 3 to 9 weeks gestation (81.2%, slightly higher than England and similar to the North West). Warrington had a similar abortion rate when compared to England and the North West for the gestation period of 10 to 12 weeks, and a lower rate than England for 13+ weeks (but similar to North West). The differences between England and Warrington were not statistically significant. The table below illustrates the stage of gestation when abortions were performed (DoH, 2016).

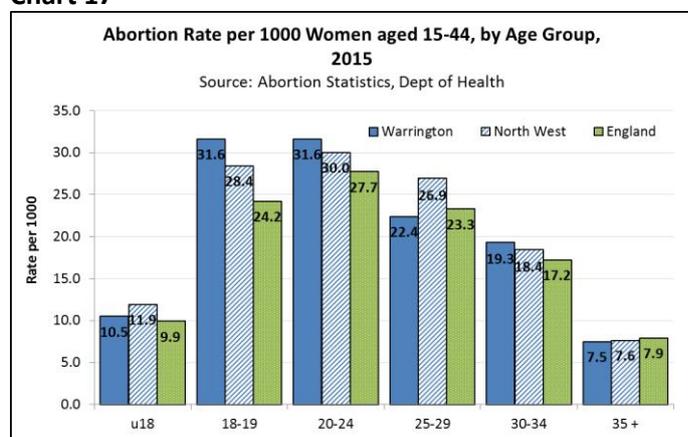
Table 2: Percentage of Abortions performed by Gestation Weeks, 2015

	3 - 9 weeks	10 - 12 weeks	13+ weeks
England	80.4%	11.2%	8.3%
North West	81.7%	11.0%	7.3%
Warrington	81.2%	11.3%	7.4%

Source: Department of Health

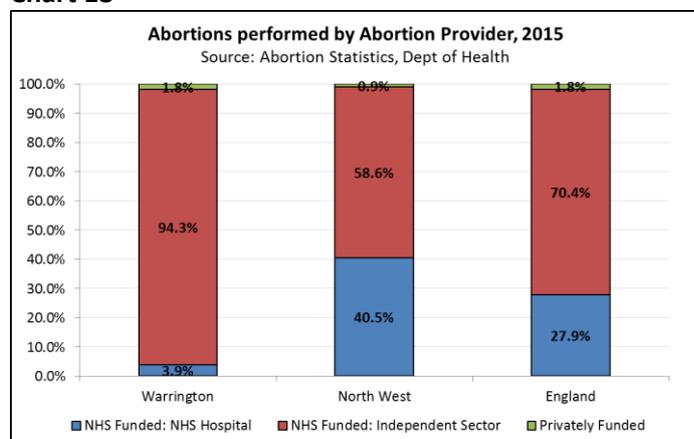
2.7.1) Abortions by Age Group: Warrington females aged 20 to 24 years had the highest number and one of the highest rates for abortion out of all age ranges. Those aged 18 to 19 also shared the same high rate as 20 to 24 year olds. Regionally and nationally, the highest rates were also observed in these 2 age groups, although not as high as in Warrington.

Chart 17



2.7.2) Abortions by Provider: Chart 18 shows the proportion of abortions performed by abortion provider in 2015. The chart shows that the vast majority of abortions performed for Warrington females were conducted by the independent sector, funded by the NHS.

Chart 18



In Warrington, the main abortion provider funded by the NHS is the British Pregnancy Advisory Service (BPAS). Local data provided by BPAS, for April 2015 to March 2016 shows that the abortion rates for women aged 19 and under, and for those aged 20 and over is higher in the most deprived areas of Warrington compared to the remainder of the borough.

Table 3: Abortion Rates per 1000 Females: April 2015 – March 2016, and Deprivation in Warrington (based on IMD 2015)

	<i>Rates in 20% most deprived areas</i>	<i>Rates in 80% least deprived areas</i>
Age 19 and under	20.5	15.2
Age 20 and over	18.0	10.6

Source: BPAS

2.7.3) Repeat Abortions: In 2015, there were 35% repeat abortions in women of all ages in Warrington. The rate was 21% for those aged under 25, and 45% for those aged 25 and higher. Rates had reduced since 2014. Warrington rates were also better than the North West and England as see in table 4. It means that over a third of abortions in Warrington are repeat abortions (Department of Health, 2016).

Table 4: Percentage of Repeat Abortions by Age Band, 2015

	<i>% repeat abortions under 25 yrs</i>	<i>% repeat abortions 25+ yrs</i>	<i>% repeat abortions all ages</i>
England	27%	46%	38%
North West	26%	47%	38%
Warrington	21%	45%	35%

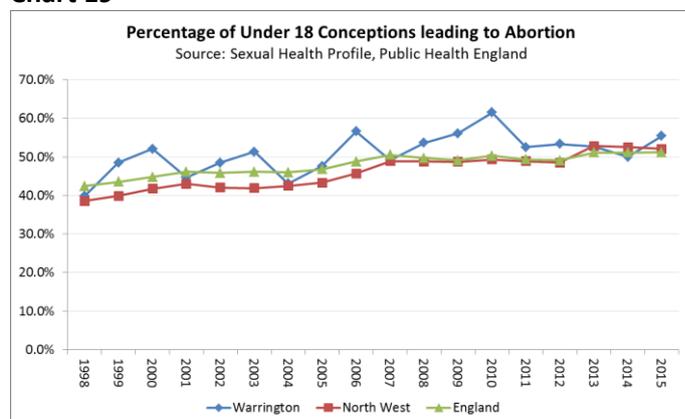
Source: Department of Health

Under 18 Conceptions leading to Abortion: In 2015, 55.4% of under 18 conceptions in Warrington led to abortion. The North West average was 52.1% and England 51.2% (PHE, 2017c).

The proportion of teenage conceptions leading to abortion has increased over the years, in Warrington and also regionally and nationally. In 1998 in Warrington, 39.8% of under 18 conceptions led to abortion. Actual numbers have dropped since 1998 in which there were 66, now currently 41 (2015). However, over this same time period, the number of under 18 conceptions

generally in Warrington has also reduced, meaning that the proportion of conceptions leading to abortion has not changed a great deal in the past 5 years, it's been between 50.5% and 55.4% (PHE, 2017c).

Chart 19



Abortions and repeat abortions can indicate a lack of access to good quality contraception services and advice, as well as problems with individual use of contraceptive method (PHE, 2017c). The following sections will examine current use of Emergency Hormonal Contraception and Long Acting Hormonal Contraception.

2.8) Emergency Hormonal Contraception

Emergency Hormonal Contraception (EHC) comes in the form of a pill or an intrauterine device (IUD) and is used following unprotected sex to prevent pregnancy. The following analysis will examine EHC obtained from Warrington pharmacies^{vii}, Warrington GPs, and the Warrington Integrated Sexual Health Service.

During April 2016 to March 2017:

- Warrington pharmacies held 1,456 EHC consultations which is a reduction of 21% since 2015/16 in which there were 1,839 consultations (from PharmOutcomes system). Nearly all consultations (99.0%) resulted in EHC medication being dispensed. The main reason given for needing EHC was that no contraception was used (approximately 54% of consultations), followed by contraception failure, around 42%. Of the 1456 consultations, in 283 or 19% of them the patient stated that alcohol had been involved.
- Warrington GPs prescribed EHC to 295 patients, an increase of 8% from 274 patients in 2015/16.

In April 2015 to March 2016, Warrington's Integrated Sexual Health Service prescribed EHC to 537 patients. The majority of females (97%) received the pill and a small proportion (3%) received an IUD.

2.8.1) EHC by Age Group: Between April 2015 and March 2016, 8 women per 1,000 in Warrington were provided emergency contraception. When broken down by age, 27 per 1,000 13–15 year olds compared to 7 per 1,000 aged 16-54 were provided with EHC (NHS Digital, 2016a). However, the

^{vii} As at April 2017, 26 out of 46 Warrington pharmacies are accredited to deliver EHC.

data shown is partly dependent on where services are located and how accessible they are for women. Women may also obtain EHC from other sources such as GPs or pharmacies.

Those aged between 13 and 15 are less likely to access EHC from Warrington GPs and pharmacies. Warrington GP data for 2015/16 showed that only a very small number of patients prescribed EHC were aged between 13 and 15, a rate of less than 1.5 per 1,000 females of this age range compared to a rate of 4.92 per 1,000 16-54 year olds. 2016/17 data showed a similar rate for young girls. Pharmacy data for 2015/16 gave a rate of 6.2 consultations per 1,000 13-15 year olds as opposed to 34.1 per 1,000 16-54 year olds. In 2016/17 the rate for 13-15 year olds saw a small increase to 7.0 per 1,000. Furthermore, only a small proportion of 13-15 year olds in Warrington access EHC, approximately 4% of this population. This suggests that the high rate seen in young girls accessing EHC in sexual health services is more to do with preferred service and/or location of services rather than a large number of them accessing EHC.

2.8.2) Deprivation: Between April 2016 and March 2017, 57.6% of pharmacy consultations for EHC took place in the 20% most deprived areas of Warrington^{viii} and 42.4% of consultations took place in the 80% less deprived areas. This is based on pharmacy location and which deprivation quintile they sit within. When looking at deprivation based on where clients reside, the proportion of consultations for those living in the 20% most deprived areas of Warrington dropped to 28.4%, with 71.6% of consultations attended by females living in the less deprived areas of Warrington. This suggests that some people travel further than their residential area to attend pharmacies; this could be due to a variety of reasons, for example they prefer to go to a different location for anonymity, attend pharmacies close to work or study locations, or maybe there are no EHC accredited pharmacies near where they live.

Table 5: Proportion of Warrington EHC Consultations by Deprivation Quintile (IMD2015): April 2016 – March 2017

	<i>Quintile 1 (most deprived)</i>	<i>Quintiles 2-5 (less deprived)</i>
Consultations (pharmacy location)	57.6%	42.4%
Consultations (clients residence)	28.4%	71.6%

Source: PharmOutcomes

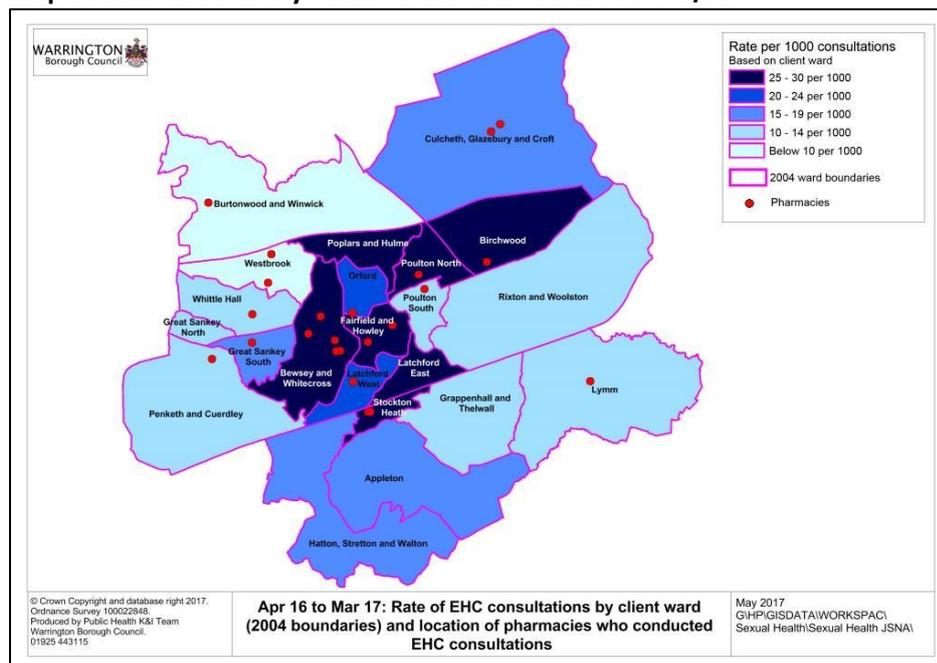
2.8.3) Location of EHC Consultations: Map 6 shows the ward location of where clients reside who attended pharmacies for EHC consultations between April 2016 and March 2017. It is based on numbers of consultations, not clients, and turned into rates per 1,000 population (females aged 13-54) to enable comparison between wards. Please note the data is only currently available by old ward boundaries^{ix}. The location of pharmacies that conducted EHC consultations over the year have been plotted on the map.

The map shows that seven wards had the highest rates, with Stockton Heath and Poulton North joint highest at 27.6 consultations per 1,000 population. These seven wards plus Orford and Latchford West accounted for nearly two thirds of consultations (63%) within Warrington over the 12 months.

^{viii} Based on Indices of Multiple Deprivation 2015

^{ix} Warrington ward boundaries were updated in 2016 and some ward boundaries changed

Map 6: Consultations by Client Ward of Residence: 2016/17



Source: PharmOutcomes

Table 6 presents a list of Warrington pharmacies that supply EHC. Pharmacies are accredited to deliver EHC and therefore from year to year the list of pharmacies may change. It can be seen in the table that, in all years, those pharmacies delivering the highest number of EHC consultations are located either in the town centre or in retail areas.

Table 6: List of Warrington Pharmacies supplying EHC Consultations

Pharmacy	Apr 13 - Mar 14	Apr 14 - Mar 15	Apr 15 - Mar 16	Apr 16 - Mar 17
Boots, Golden Square	309	320	462	404
Well Pharmacy, Bath St Health & Wellbeing Centre	103	193	173	122
Hub Pharmacy, Manchester Road	181	93	32	115
Lloyds, Sainsburys	295	278	294	115
Well Pharmacy, Birchwood	39	32	38	108
Boots, Gemini	241	130	283	93
Lloyds, Orford	71	95	85	91
Well Pharmacy, Warrington Hospital	67	91	76	90
Thomas Brown Pharmacy, Stockton Heath	60	55	90	86
Tims & Parker, Culcheth	31	42	42	38
Stockton Heath Pharmacy	0	0	18	37
Lloyds, Padgate	19	24	29	33
Well Pharmacy, Fearnhead	32	22	23	26
Boots, Stockton Heath	34	46	39	22
Hood Manor Pharmacy, Great Sankey	<10	13	<10	22
Green Cross Pharmacy, Allen Street	52	42	33	17
Boots, Lymm	0	0	15	14
Asda, Westbrook Centre	117	96	78	<10
Hub Pharmacy, Chapelford	0	0	0	<10

Lloyds, Penketh	36	27	22	<10
Rowlands Pharmacy, Folly Lane	0	0	0	<10
Rowlands Pharmacy, Wilderspool	0	0	0	<10
Rydale Chemists, Burtonwood	0	0	0	<10
Well Pharmacy, 276 Manchester Road	56	13	0	<10
Well Pharmacy, Culcheth	34	16	0	<10
Aston Pharmacy, Great Sankey	12	<10	<10	0
Lloyds, Lymm	10	<10	0	0
Lloyds, Stockton Heath	<10	73	0	0
Rowlands Pharmacy, Guardian Street	<10	<10	0	0
Rowlands Pharmacy, Tanners Lane	11	0	0	0
Superdrug, Cockhedge Centre	10	0	0	0
Tesco, Winwick Road	<10	0	0	0
Well Pharmacy, Appleton	<10	0	0	0
TOTAL	1848	1712	1839	1456

Source: Webstar and PharmOutcomes

2.9) Long Acting Reversible Contraception (LARC)

Long-acting reversible contraception or LARC are methods of contraception that don't depend on the user to take or use them to be effective and they can remain in place for several years. LARC include implants, intrauterine devices (IUDs), intrauterine systems (IUS), or injections.

In the Sexual and Reproductive Health Profiles published by Public Health England (PHE, 2017c), the use of LARC is measured. In 2015, Warrington had a rate of 48.1 total prescribed LARC (excluding injections^x) per 1,000 females aged 15-44. This is equivalent to 1,840 prescribed LARC. The Warrington rate was very similar to the England rate of 48.2 per 1,000 females, and is a reduction compared to 2014 in which it was 51.8. Total prescribed LARC includes LARC prescribed by GPs, and Sexual and Reproductive Health Services (SRH).

Table 7: Total Prescribed LARC excluding Injections Rate, per 1000 Females 15-44 yrs

	2014	2015
Warrington	51.8	48.1
England	50.2	48.2

Source: Sexual and Reproductive Health Profiles, PHE

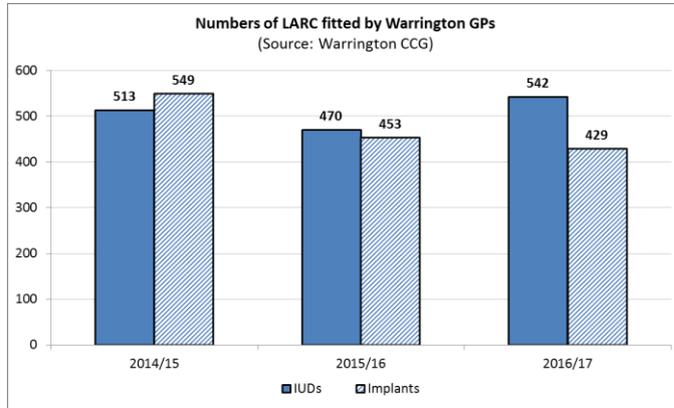
Examining GPs and SRH Services separately shows that Warrington had a rate of 21.3 for SRH Services prescribed LARC in Warrington in 2015, an increase since 2014, and also significantly higher than England (18.3). For GP prescribed LARC, in 2015 the rate was 26.9 per 1,000 females, a reduction compared to previous years, and significantly lower than the England average of 29.8 (PHE, 2017c).

Data obtained from Warrington Clinical Commissioning Group (CCG) gives a more up to date picture. Please note that the following is based on financial year, not calendar year like the rates highlighted above from PHE. Between April 2016 and March 2017, Warrington GPs fitted 542 IUDs which was a

^x Injections are excluded from the indicator because they rely on timely repeat visits/administration and therefore have a higher failure rate than other LARC; they are easily given in primary care and do not require same resources and training as other methods; injections are outside local authority contracts.

5.7% increase since 2014/15, and a 15.3% increase since 2015/16. Implants have seen a declining trend year on year over the past 3 years. In 2016/17, GPs fitted 429 implants, a reduction of 21.9% since 2014/15 (see chart 20).

Chart 20

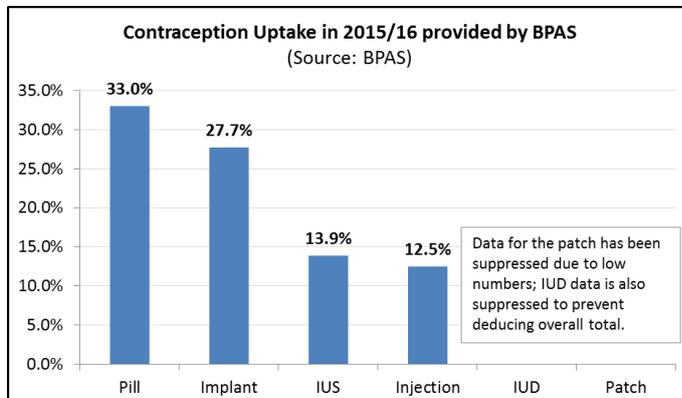


The British Pregnancy Advisory Service (BPAS) supplies contraception to clients who attend for abortions in Warrington. In April 2015 to March 2016, BPAS supplied/fitted 204 types of LARC, 191 of which were to Warrington residents. The remainder live outside Warrington but are registered with a Warrington GP. In 2014/15 the number of LARC supplied or fitted was 248 (to all women, not just Warrington residents).

2.9.1) Type of LARC: In the 12 months April 2015 to March 2016, 37% of Warrington women using SRH Services used LARC as their main method of contraception, of which implants (14%) and injectable contraception (10%) were the most popular. However the oral pill (which is not considered as LARC) was the main method of contraception with 45% of women choosing this (NHS Digital, 2016a). (Note: this source of data is not inclusive of all contraceptive access – it excludes settings such as GPs and contraceptives purchased over the counter at a pharmacy or in another retail setting).

Data from BPAS also shows a similar picture. In April 2015 to March 2016, the pill was the most popular method of contraception chosen (33.0%, 100 out of a total of 303), followed by the implant (27.7%, 84). Furthermore, the proportion of females choosing the pill in 2015/16 had increased from 17.3% in 2014/15, resulting in a reduction in females choosing IUD or IUS during 2015/16.

Chart 21



2.9.2) LARC by Age Group: BPAS provided or fitted 203 types of LARC in 2015/16, 82.8% to females aged 20 and over, 17.2% to under 20s. Implants were the preferred method in both age groups,

particularly in under 20s where it accounted for 65.7% of all LARC in this age group (36.3% for those aged 20+). Injections were next favoured method in under 20s (17.1% of all LARC) whereas those aged 20 and above chose IUS and IUD as the next preferred method with similar proportions for each (22.0% and 20.2% respectively).

Table 8: BPAS LARC for Under 20s, Preferred Methods – 2015/16

LARC	Proportion of all LARC used
Implants	65.7%
Injections	17.1%

Source: BPAS

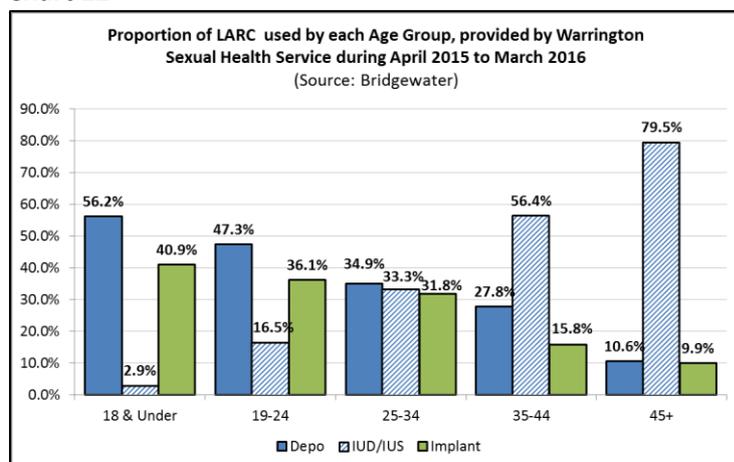
Table 9: BPAS LARC for 20+, Preferred Methods – 2015/16

LARC	Proportion of all LARC used
Implants	36.3%
IUS	22.0%
IUD	20.2%

Source: BPAS

Data received directly from Warrington’s Integrated Sexual Health Service is shown in chart 22. The age breakdown is slightly different in this set of data but it can be seen that Depo (injections) and implants are most popular in the youngest age group and usage reduces as the age groups get older. IUDs and IUS see the opposite pattern and usage increases with age. Note, IUDs and IUS cannot be split in this particular dataset.

Chart 22

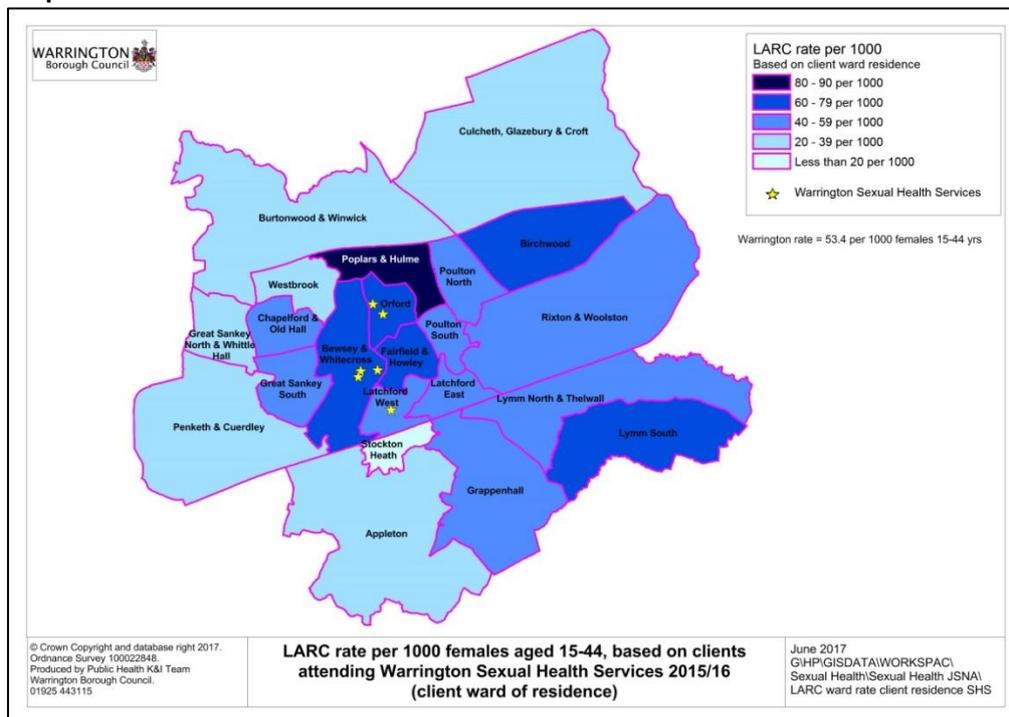


There is a low uptake in LARC in under 19s from those females visiting the Integrated Sexual Health Service, with data suggesting approximately 26% of all contraception consultations of this age group during 2015/16 resulted in LARC being taken as an option. Indications suggest that other local areas have a higher uptake than Warrington. Warrington has set a local target to improve uptake in LARC in young women, to ensure that they have all the necessary information to make an informed choice on the most suitable form of contraception.

2.9.3) Location of clients accessing LARC from Warrington Integrated Sexual Health Service: Map 7 illustrates the LARC rate by ward of residence of clients accessing LARC from Warrington’s Integrated Sexual Health Service. LARC data includes IUD, IUS, implant and injection. The map also highlights the locations of the Integrated Sexual Health Service.

Poplars and Hulme has the highest rate of all wards, 85.0 LARC per 1,000 females, approximately 1.5 times higher than the overall Warrington rate of 53.4, and equivalent to 229 LARC.

Map 7



2.10 Cervical Cancer Prevention

2.10.1) HPV Immunisation: In 2008, the national human papillomavirus (HPV) immunisation programme was introduced for 12-13 year old girls to protect them against the main causes of cervical cancer. Initially a three dose programme, it was changed to two doses from September 2014 following expert advice (PHE, 2016c).

The following information, reported by Public Health England in the Public Health Outcomes Framework (PHE, 2016c), highlights coverage of the HPV vaccination for the first dose for girls aged 12-13. Currently only first dose information is available.

In 2015/16 (latest data available), 88.1% of girls aged 12-13 in Warrington received the first dose. This proportion is similar to the England average of 87.0%, and the North West (88.2%). Warrington is positioned 15 out of the 23 local authorities in the North West (ie, 14 local authorities are better performing). The best performing local authority within the North West has a coverage rate of 95.3%.

2.10.2) Cervical Screening: The NHS Cervical Screening Programme is available for women between the ages of 25 and 64. Eligible women are invited for regular cervical screening which is intended to detect abnormalities within the cervix that could, if undetected and untreated, develop into cervical cancer. Women aged 25-49 are invited every three years for routine screening and those aged 50-64 are invited every five years (NHS Digital, 2016b).

Definition of cervical cancer screening coverage: the percentage of women in the resident population eligible for cervical screening who were screened adequately^{xi} within the previous 3.5 years or 5.5 years, according to age (3.5 years for women aged 25-49 and 5.5 years for women aged 50-64) on 31 March each year. This measure is also known as ‘age-appropriate coverage’.

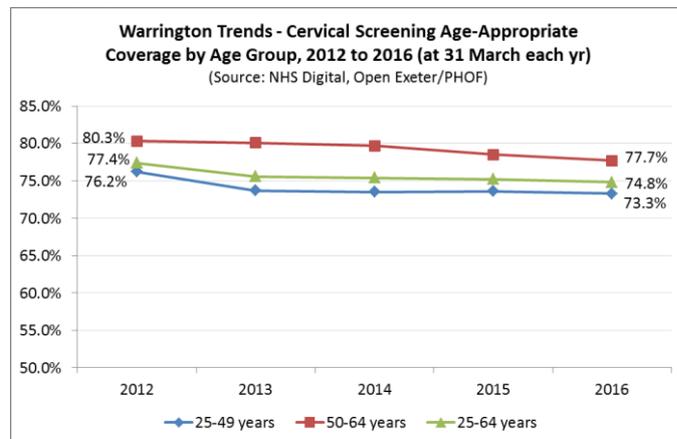
Most recent data, at March 2016, shows 74.8% of women in Warrington (aged 25-64) who were eligible for cervical screening were screened adequately (NHS Digital, 2016b). This was slightly lower than 2015 (75.2%). This reduction is seen not only in Warrington, a fall in coverage was also seen in England overall and in all regions, compared to 2015. Public Health England states that “screening coverage has fallen over the last 10 years and attendance is now at a 19-year low”^{xii}. The actual number of screens conducted in Warrington at March 2016 increased by 270 to 40,524 but because the eligible population had increased, the percentage of those screened reduced slightly.

Looking at a breakdown of 25-64 year olds by the two age groups 25-49 years and 50-64 years, shows that coverage at March 2016 is higher for those aged 50-64 (77.7%), and slightly lower for those aged 25-49 (73.3%). This pattern is also seen nationwide and regionally.

National figures (NHS Digital, 2016b) show that coverage amongst women aged 25-29 years was lower than any other age group, and at 31 March 2016 had reduced slightly to 63.3% (63.5% in 2015). Those aged 50-54 had the highest coverage at 80.2%. It is currently not possible to obtain the same age group breakdowns in local data.

Trends from 2012 to date show the coverage rate in Warrington has reduced slightly practically every year, as can be seen in chart 23.

Chart 23

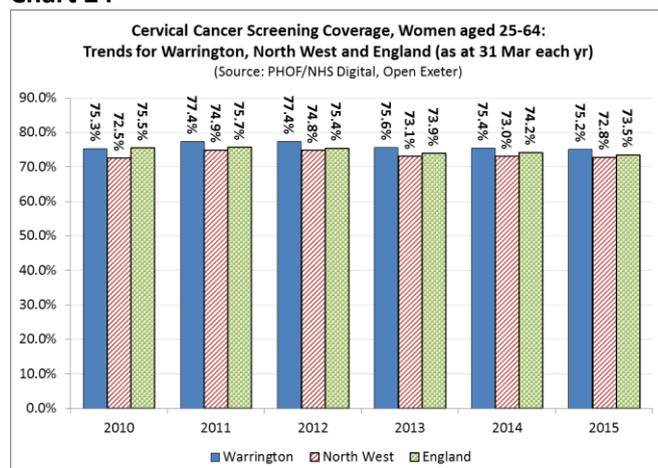


In 2016, Warrington has a larger proportion of women screened aged 25-64 (74.8%) than England (72.7%) and the North West (72.3%). Historically, this has also been the case as can be seen in chart 24. Between the years 2011 and 2015, Warrington had coverage rates significantly better than England, and from 2010 to 2015 significantly better than the North West.

^{xi} In a small proportion of cases the pathology laboratory is unable to assess the cells to give a result and the test is considered inadequate.

^{xii} <https://www.gov.uk/government/publications/health-matters-making-cervical-screening-more-accessible/health-matters-making-cervical-screening-more-accessible--2>

Chart 24



Receipt of Results: Time from screening to receipt of result is monitored, and cervical screening departments are expected to ensure that at least 98% of result letters are received by post within 2 weeks of the test. Latest published figures for 2015/16 (NHS Digital, 2016b) show that 99.2% of letters (11,386) sent to Warrington women who had been tested were reported to have an expected delivery date of within 2 weeks of the sample being taken. This compares with 89.1% for England, and 88.2% for the North West.

Deprivation and Coverage by GP Practice: At 31 March 2016 cervical cancer screening coverage in Warrington GP practices ranged from 63.3% to 81.5%. Analysing GP practices by deprivation^{xiii} shows a strong relationship with coverage rates. In quintile 1 (20% most deprived areas of Warrington) cervical cancer screening coverage was 69.7% compared to 76.3% in quintiles 2 - 5 (less deprived areas).

The 20% most deprived GP practices had seen a very slight reduction since the previous year in which the coverage rate was 70.1% (currently 69.7%). The actual number of screens performed during 2015/16 was higher (8419) when compared to the previous year (8315).

Coverage in the 80% less deprived areas was again slightly reduced when compared to the previous year (76.7% v. 76.3%). Overall, 166 more screens took place when compared to the previous year (32,105 screens at March 2016).

3) Current Services in Relation to Need

The National Framework for Sexual Health Improvement in England (DoH, 2013a) highlighted the Government's ambition to improve the sexual health and wellbeing of the whole population by reducing inequalities and improving sexual health outcomes; building an honest and open culture where everyone is able to make informed and responsible choices about relationships and sex, and recognising that sexual ill health can affect all parts of society.

In order to do this the Government highlighted the following key action points:

^{xiii} An average deprivation score was calculated for each GP practice based on all their patients' postcodes. Practices were then grouped into 1 of 5 deprivation quintiles based on their average deprivation score (quintile 1 being the most deprived and quintile 5 the least deprived).

- Continue to tackle the stigma discrimination and prejudice often associated with sexual health matters
- Continue to work to reduce the rate of sexually transmitted infections (STIs) using evidence-based preventative interventions and treatment initiatives
- Reduce unwanted pregnancies by ensuring that people have access to the full range of contraception, can obtain their chosen method quickly and easily, and can take control to plan the number of and spacing between their children
- Support women with unwanted pregnancies to make informed decisions about their options as early as possible
- Continue to tackle HIV through prevention and increased access to testing, to enable early diagnosis and treatment
- Promote integration, quality, value for money and innovation in the development of sexual health interventions and services.

Locally, the Warrington Public Health Team has developed a Sexual Health Strategy (WBC, 2016) for 2016 - 2019, in consultation with a wide range of stakeholders, working towards and delivering agreed strategic priorities for Warrington across the life-course. The actions and interventions outlined within it focus on the specific needs of young people, adults and older people in the population. Furthermore, the challenge is to meet the key Public Health Outcome Framework targets for this area (PHOF 2013 – 2016), which are:

- Reducing under 18 conceptions
- Increasing chlamydia diagnosis
- Reducing late diagnosis of HIV.

There is currently a Strategic Sexual Health Implementation Group (SSHIG) that acts as the strategic/overarching group for delivering against the priorities identified for sexual health. This group has an identified work plan and list of key priorities/actions that aims to provide quality needs-based integrated sexual health services for the population of Warrington. This is where locally we aim to bring together commissioners and services to truly join up what is a fragmented and challenging commissioning agenda (PHE, 2014a). Additionally, there is a Sexual Health Better Prevention Group that reports to the SSHIG around operational based tasks/actions and progress around targeted work and interventions (the delivery side). Both groups oversee a range of activities that help to deliver the PHOF outcome indicators (plus many more) and indeed vitally support the reduction in teenage pregnancy prevalence across Warrington (reporting to various Children's Boards).

3.1) Integrated Sexual Health Service

Provided by Bridgewater Community Healthcare NHS Foundation Trust, and commissioned by Warrington Borough Council, the service focuses on reducing demand in more specialist clinics. The Service offers a wide range of services across a number of locations in the town, including testing and treatment of all sexually transmitted infections, HIV testing and pathways to treatment, contraceptives, pregnancy testing, and confidential advice. It also provides chlamydia screening for young people, which is part of the National Chlamydia Screening Programme aimed at young people between the ages of 15 and 24.

Chlamydia is the most commonly diagnosed STI, with young people at highest risk. The aim of the service is to control chlamydia through early detection and treatment of infection, and to reduce onward transmission. As chlamydia often has no symptoms and can have serious health

consequences, the programme has an opportunistic screening approach aiming to reach young people under 25 without them having to visit a genito-urinary medicine (GUM) clinic.

3.2) HIV Prevention and Support Service

In April 2017, the formerly Terrence Higgins Trust (THT) delivered HIV Prevention and Support Service was integrated into the main sexual health services (Bridgewater) contract to more effectively link programmes together. Bridgewater are thus commissioned to work in a variety of ways to engage with communities at heightened risk of HIV transmissions in Warrington, specifically with high at risk groups such as men who have sex with men (MSM), and black and minority ethnic (BME) populations.

3.3) GPs and Pharmacies – Local Enhanced Service

GPs across Warrington provide Long Acting Reversible Contraception (LARC). Warrington Public Health commissions primary care to deliver intrauterine contraceptive device (IUCDs) and implants via a Local Enhanced Service (LES) to build our model and yet further improve and increase access to contraceptive methods town-wide. This is a vital service in impacting upon our unintended pregnancy (particularly teenage pregnancy) rates and abortion, and repeat abortion figures, as bringing women onto longer-term planned and most effective/cost effective methods is proven to impact here in a positive way.

Pharmacies are trained and paid to provide Emergency Hormonal Contraception (EHC) via Public Health LES agreements. Currently 26 pharmacies located in key areas across the town provide vital access to this provision in the event of a contraceptive method failure/lack of method to prevent an unplanned pregnancy.

Pharmacies have recently (April 2017) been commissioned to further provide Quick Start contraception, again via a Public Health LES agreement/contract. This allows pharmacies who dispense EHC currently to (in the correct circumstances via Patient Group Directives (PGD)) offer the Progestogen-Only Pill (POP) as a start-up method to contraception, bringing that woman onto a planned, effective contraception method there and then.

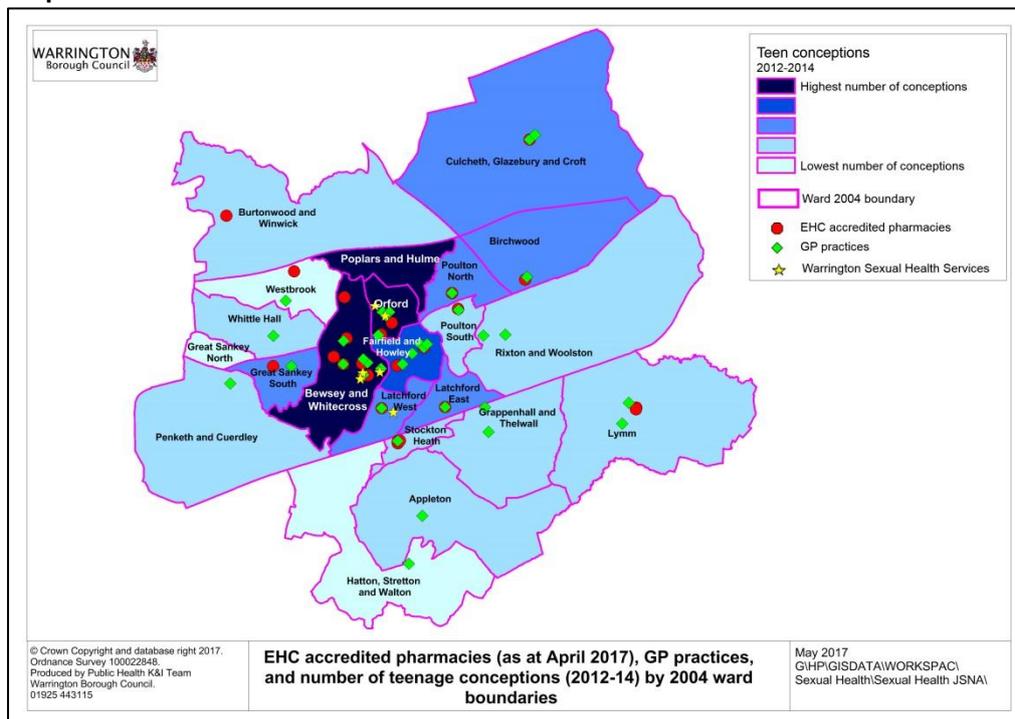
Additionally, pharmacies are providing chlamydia testing to local residents across the town, so the full suite being offered by pharmacies now across the town is enhanced and offers much more scope for patient access.

Map 8 shows EHC services in Warrington provided by accredited pharmacies, GP practices and Warrington Sexual Health Service. This is shown against a backdrop of teenage conceptions which are thematically mapped by ward. Please note that ward boundaries changed in April 2016, however conception data is still only currently available by the old ward boundaries.

There is a concentration of EHC services in the central areas of Warrington where teenage conceptions are highest. The central wards are also some of the most deprived wards in Warrington. The outer wards have a reasonable spread of services, although there are some exceptions. In South Warrington, aside from Stockton Health and Lymm, there are no other accredited pharmacies. There is patchy provision of accredited pharmacists in West Warrington. Although there are no Warrington GP practices located in Burtonwood and Winwick it is known that 65% of Warrington residents in this ward are registered in practices outside the area. One notable area lacking services is Poplars and Hulme which is one of the most deprived areas in Warrington.

The Warrington Integrated Sexual Health Service is working more with pharmacies and GPs during 2016/17 with a view to enhancing existing services rather than duplicating them.

Map 8: Location of EHC Services



Source: ONS (U18 conceptions), Bridgewater, Warrington PH Team

3.4) British Pregnancy Advisory Service (BPAS) – Termination of Pregnancy Service

BPAS provide a high quality, non-judgemental abortion service, consisting of evidence-based counselling and advice pre and post abortion. All abortion treatment options and appropriate aftercare are discussed with clients.

3.5) Sexual Assault Referral Centre (SARC)

The St Mary’s Sexual Assault Referral Centre (Manchester) provides services to the population of Cheshire to ensure timely access to appropriate care and treatment to support recovery, improve the chances of a conviction and ultimately reduce the amount of long term care needed and the strains on the NHS in the future.

3.6) HIV Treatment Service

NHS England commissions HIV treatment (specialised) services across the country. Locally the contract for the provision of this service sits with Warrington & Halton Hospitals NHS Foundation Trust (WHHT). The aim of these HIV services for adults (outpatient and inpatient services) is to provide specialist assessment and ongoing management of HIV and associated conditions in order to support patients to stay well (reduced mortality and morbidity) and to reduce the risk of onward transmission of HIV. The service aims to ensure that the outcomes, wellbeing and quality of life of adults with HIV are maximised.

The service ensures timely initiation and effective ongoing management of antiretroviral treatment that enables patients to achieve and maintain undetectable levels of virus. This is achieved through the provision of treatment, adherence and support for patients.

This service links in very closely with our Integrated Sexual Health service that (as detailed above) provides a GUM service (STI screening, treatment and management) and also makes vital links with the above listed HIV Prevention and Support Service. HIV prevention case workers link into the Multi-Disciplinary Team (MDT) model and offer appropriate support and advice around wider wellbeing (housing, employment) needs to ensure that the person recently diagnosed with HIV is fully supported with an all-round package of care.

3.7) CGL – Substance Misuse

CGL Pathways, the local drug and alcohol service, prioritise the groups of individuals who are prone to Blood Borne Virus and potentially HIV. Due to people's historic injecting use, and the possibility of them sharing needles, CGL will highlight this group and ensure that they are offered the range of screening and treatment available. CGL will link in with the sexual health services in Warrington and ensure service users are aware of the breadth of services available for them.

4) Projected Service Use and Outcomes in 3-5 years and 5-10 years

The following set of charts illustrate the predicted rate of incidence of certain sexually transmitted infections (STIs), and abortions, if the number of STIs and abortions observed during 2015 remain static over the next 6 years. Projected rates have been calculated using population projections and assume that no targeted interventions are put into place over the coming years.

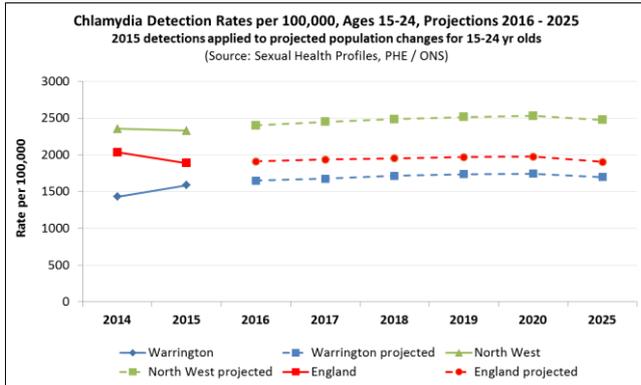
Population projections are based on mid-year 2014 estimated populations available from the Office for National Statistics.

4.1) Sexually Transmitted Infections

Local authorities aim to increase the rate of **chlamydia detections** in the 15-24 year age group. Projections suggest that chlamydia detection rates are likely to increase up until 2020 as the targeted population reduces, this is seen locally, regionally and nationally. Warrington is projected to see an estimated 10% increase in the chlamydia detection rate, from the current position in 2015 to the projected rate in 2020. This is higher than increases projected for England (5%), and slightly higher than the North West (9%).

Between 2020 and 2025, as estimated populations of 15-24 year olds are projected to increase, this will affect detection rates which will start to reduce. Again this is expected to affect Warrington, the North West and England.

Chart 25



Projections for rates of **gonorrhoea, herpes and warts** are based on projected estimated populations of all ages. In the following 3 charts, projected trends for Warrington, the North West and England, show that for all three STIs, a small decline in rates from 2016 through to 2025 is expected due to the population increases thought to be experienced over the next ten years.

Chart 26

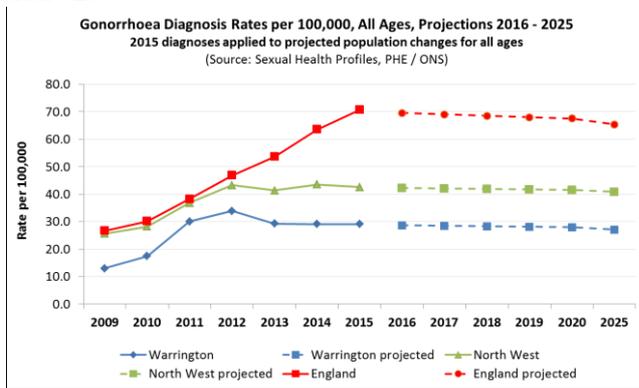


Chart 27

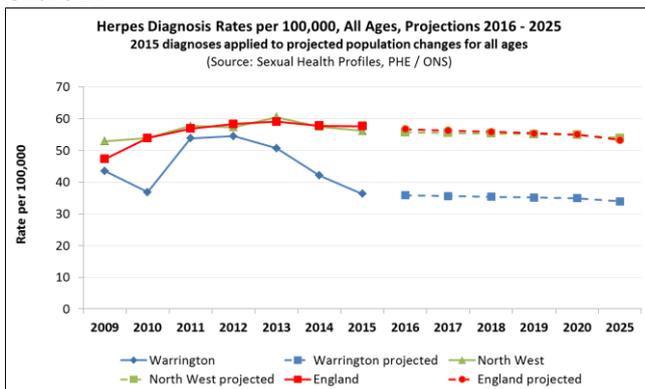
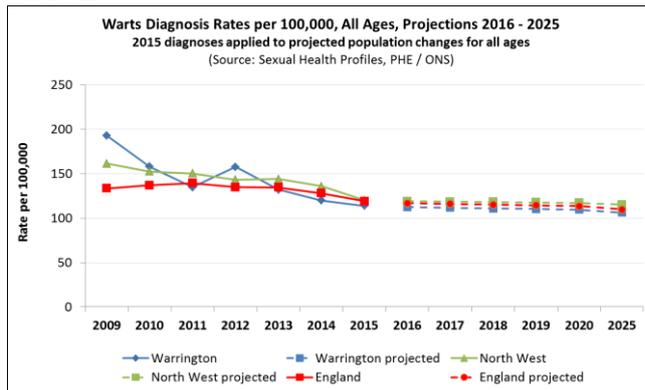


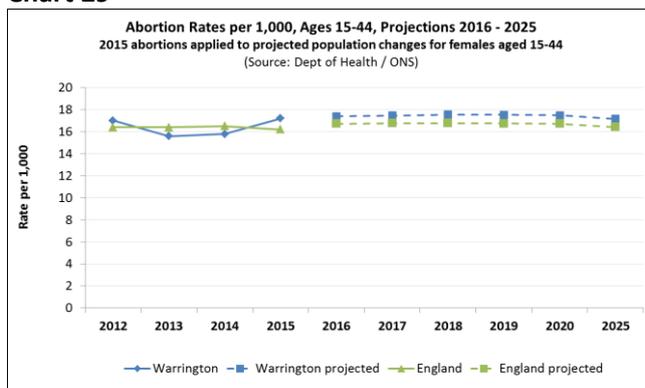
Chart 28



4.2) Abortion

Rates of abortion in Warrington have risen since 2013, and projections show a stable but higher rate of abortions than that projected for England as a whole. From 2020 to 2025 projections suggest rates will have declined for both Warrington and England.

Chart 29



5) Evidence of What Works

5.1) National Strategies and Reports

In England various reports and guidance have been published in recent years. Some of the key ones are listed below.

The King’s Fund has published its research findings: ***The future of HIV services in England: Shaping the response to changing needs*** (Baylis et al., 2017) in which it puts forward a number of recommendations for the planning and delivering of HIV services over the next 5-10 years. A number of recommendations are made for local services and national bodies; in particular: “Directors of public health and lead HIV clinicians should work together to ensure effective system leadership that will get all key stakeholders on board with a single, overarching plan for developing future HIV services across the HIV pathway” (p6).

The Specialist Pharmacy Service (2012) has developed the following: ***Toolkit for developing Contracts for pharmacy support to Community Health Services***, it has been updated in February 2017 and the aim is to support commissioners and organisations in developing contracts and to define the appropriate levels of pharmaceutical support.

Sexual health commissioning in local government: building strong relationships, meeting local needs (LGA, 2015) contains a number of case studies from different local authorities around the country and shows how public health in councils is approaching the commissioning of sexual health services.

Health promotion for sexual and reproductive health and HIV: strategic action plan, 2016 to 2019 (PHE, 2015) presents how Public Health England intend to improve sexual and reproductive health and reverse the HIV epidemic and focusses on 4 key areas to reduce: incidence of HIV, rates of STIs, unplanned pregnancies and rates of under 16 and under 18 conceptions.

Making it work: a guide to whole system commissioning for sexual health, reproductive health and HIV (PHE, 2014a) looks at how to pull the whole commissioning system together and provides very clear and practical examples of how to ensure commissioners improve pathways, the patient's journey and patient care.

Public Health England have published reports on chlamydia screening. ***Information to support the commissioning of chlamydia screening in general practice and community pharmacies*** (PHE, 2014) is aimed at commissioners and service providers to support them in providing high quality screening services. ***Opportunistic Chlamydia Screening of Young Adults in England*** (PHE 2014) provides an overview of current, published evidence in relation to screening of young adults.

Aimed at commissioners and providers of sexual health services, ***A Framework for Sexual Health Improvement in England*** (DoH, 2013a) sets out evidence, interventions and actions to improve sexual health outcomes.

The Department of Health also published ***Commissioning Sexual Health services and interventions*** (DoH, 2013b), guidance aimed at helping local authorities fulfil the legal requirements around ensuring the provision of certain services, and describes best practice and referral to a number of other sources.

5.2) Guidelines and Standards

The Faculty of Sexual & Reproductive Healthcare (<https://www.fsrh.org/home/>), a UK professional membership organisation, provides a range of standards and guidelines that outline evidence-based recommendations and good practice points. Some of the more recent ones around emergency hormonal contraception (EHC) and long acting reversible contraception (LARC) are listed below:

- [Emergency Contraception](#) - Clinical Guidance, FSRH (2017a)
- [Quick Starting Contraception](#) – Clinical Guidance, FSRH (2017b)
- [Intrauterine Contraception](#) – Clinical Guidance, FSRH (2015)
- [Progestogen-only Implants](#) - FSRH Clinical Guidance (2014)

The British Association for Sexual Health and HIV (<https://www.bashh.org/>), another professional organisation, also provides UK national evidence-based guidelines on sexual infection screening and management.

- [UK guideline for the use of HIV Post-Exposure Prophylaxis Following Sexual Exposure](#) - BASHH (2015a)
- [CEG 2015 summary guidance on tests for Sexually Transmitted Infections](#) – BASHH (2015b)
- [Standards for the management of sexually transmitted infections \(STIs\)](#) - BASHH (2014a)

- [Recommendations for Testing for Sexually Transmitted Infections in Men who have Sex with Men](#) – BASHH (2014b)
- [Safer Sex Advice](#) - BASHH (2012)

The National Institute for Health and Care Excellence (NICE) has published a number of guidelines, quality standards and pathways applicable to sexual health. The following lists some of the most recent publications since 2012.

- [HIV testing: increasing uptake among people who may have undiagnosed HIV](#) – NICE guideline NG60 (NICE, 2016a)
- [Contraception](#) – Quality standard QS129 (NICE, 2016b)
- [Contraceptive services for under 25s](#) – Public health guideline PH51 (NICE, 2014)
- [Long-acting reversible contraception](#) – Clinical guideline CG30, updated September 2014 (NICE, 2005)

Please see the earlier version of this chapter (2012) for clinical guidelines pre 2012. The report can be found by clicking on the following link:

https://www.warrington.gov.uk/downloads/download/2157/jsna_-_previous_years

Navajo Merseyside and Cheshire Lesbian, Gay, Bisexual and Transgender (LGBT) Charter Mark is an equality mark and signifies good practice, commitment and knowledge of the specific needs and barriers facing the LGBT community. The Charter Mark is based on 10 simple assessment criteria, and a number of organisations within the region have received the Charter Mark. Further information can be found here: <https://merseysideintrust.org/navajo-information/>

You're Welcome – quality criteria for youth-friendly health services (DoH, 2011) lays out principles to help health services, in the community and in hospitals, to become young people friendly. The quality criteria cover 10 topic areas such as accessibility, confidentiality and consent, health issues for young people, and the criteria are based on examples of effective local practice working with young people under the age of 20.

5.3) Research

A systematic review by Brunton et al. (2016) undertook economic evaluations of sexual health interventions within the responsibility of local authorities, focussing on contraception and on health promotion, between 2010 and 2015. Of the 29 studies that met the criteria, 9 were in the UK and the rest US based. Fifteen studies evaluated contraception and 14 evaluated health promotion.

Findings from contraception studies suggested cost-effectiveness in several interventions, although few met NICE thresholds:

- Oral ulipristal acetate (UPA) is considered more cost-effective than oral levonorgestrel (LNG) as a method of emergency contraception.
- Advance and on-demand emergency contraception offered in clinics or community pharmacies were found to be cost-saving compared to no access, for both high- and low-use groups.
- Long acting reversible contraception (LARC) could be more cost-effective to use than user-dependent contraceptive methods as a result of less pregnancies.
- Cost savings could be achieved by expanding contraceptive provision to low- and high-risk groups for instance sexually active young people, adolescent mothers and new immigrants,

with savings resulting from services and benefits linked to unintended pregnancies that are not needed.

Health promotion studies which evaluated HIV prevention interventions suggested cost-effectiveness or cost-savings for different interventions. However, only 2 nurse-led HIV testing and tailored counselling, and condom negotiations skills training for female sex workers were shown to be cost-effective within NICE thresholds. Findings for cost-effectiveness of health promotion studies relating to STI prevention were a bit more mixed.

Specifically relating to the 9 UK-based studies, the findings suggest:

- “interventions to promote STI screening indicated that point-of-care tests, and interventions offered to high-risk groups in more accessible locations such as clinics, pharmacy, by phone, or at schools, could potentially be more cost-effective than their relevant alternatives.
- interventions that targeted annual HIV testing to high-risk adults were found to be cost-effective by NICE standards, with (£17,500 per QALY^{xiv} gained) and without anti-retroviral treatment (ART) (£26,800 per QALY gained).
- Ulipristal acetate (UPA) could be more cost-effective than LARCs for emergency hormonal contraception.
- LARC methods could be more cost-effective to use than user-dependent contraceptive methods in terms of the pregnancies they would avert and the resultant costs potentially borne by health and social services.
- school contraceptive services such as condom distribution, hormonal contraceptive provision and advance contraceptive provision could be cost-effective”.

There are limitations to the study, and decision makers should carefully consider the context and the target population they wish to reach and those of individual studies.

6) (Target) Population/Service User Views

6.1) Integrated Sexual Health Service

As part of Warrington Public Health’s ongoing evaluation programme, users of Sexual Health Services, delivered by Bridgewater Community NHS Trust, were asked to complete a feedback survey. This process for gathering service user feedback will be repeated twice a year during the remaining contract period.

A total of 43 services users completed the survey, 21 of which were female and 13 male (9 people did not complete this question). Over half (52.9%, 18) were aged between 15 and 24.

Respondents were given a series of statements relating to their experience of the service and asked to select from strongly agree to strongly disagree. Generally answers and comments received were positive; there were a small number of respondents to each statement that either disagreed or were not sure. Some of the key points include:

^{xiv} Quality-adjusted life year: A measure of burden of disease in which both the quantity of life expectancy and quality of life are taken into account. A year of perfect health is worth 1 and death is equivalent to 0.

- 81% (34) of respondents strongly agreed/agreed they were able to access support, advice or treatment when needed
- 88.4% (38) of respondents strongly agreed/agreed that staff listen to them and treat them with respect with nearly two thirds strongly agreeing
- 86.1% (37) of respondents strongly agreed/agreed that they were given enough time to fully discuss their needs, with over half of them strongly agreeing
- 86.1% (37) of respondents strongly agreed/agreed that staff have the knowledge and skills necessary to meet their needs, with over half strongly agreeing
- 83.8% (36) of respondents strongly agreed/agreed that their physical health has benefited from the help/support received
- 47.5% (19) of respondents agreed that they had made changes to their lifestyle as a result of the help/support received, with another 10% strongly agreeing. A larger number than in previous questions disagreed or were unsure.

6.2) Terrence Higgins Trust (THT)

THT previously received feedback from MSM service users when it led the HIV Prevention & Support Service, either through small surveys they conduct, or on an ongoing basis through the work they do such as when attending public sex environment sites^{xv} where they will talk to MSM about sexual health and STI testing. The following is a snapshot of feedback received and concerns that some MSM have, although it must be stressed that there will be many who are happy with the services they receive.

Stigma about using local sexual health services is one concern:

- Worried about people seeing them in the waiting room and wondering why they are there
- Experiencing long waits to be seen
- Not feeling they can openly discuss the types of sex and issues they have with the nurses – having multiple partners, using public sex environment sites etc. – a few people have voiced they would like to see a gay male nurse they can discuss issues with, and some felt they would be judged by people who did not agree with their lifestyle.

Some men seem to have a lack of understanding and knowledge of STIs, and for some their only concern seemed to be with HIV.

A regular amount of MSM come to THT for tests, preferring the one-to-one appointments that are offered, and the low key environment where staff aren't in uniforms, private rooms used – it is felt to be more discrete. Some men have also said that they don't feel judged by THT as they have a good reputation and are well known for their work with MSM.

THT have spoken to a lot of people who were not aware of the free postal HIV testing service and had not seen any advertising.

Feedback from some transgender people suggested the need for some basic training for NHS staff in dealing with the transgender community, to allow them to feel more confident in accessing services. Poor experiences included staff not using the correct pronouns (for example still being referred to as 'he' rather than 'she'), and use of old names, even in waiting rooms.

^{xv} Areas where MSM go 'cruising' for sex or group sex with strangers in a public place. This can be woodland, parks, motorway junctions, or public toilets for example.

6.3) Pharmacies – Emergency Hormonal Contraception

Furthermore, commissioners receive feedback from service users around their satisfaction levels related to the provision of Emergency Hormonal Contraception (EHC) within pharmacy. As part of the contract a minimum 6 surveys are returned per pharmacy each year, as well as regular audits of provision being undertaken to assess delivery/quality.

7) Unmet Needs and Service Gaps

Pathways and services in relation to IUD/IUS fittings for non-contraceptive purposes (along gynaecology pathway) and where they are best placed, aligned to appropriate budgets.

Collaboration around commissioning, and intentions. The sexual health commissioning landscape is hugely fragmented, with potential pitfalls and gaps in pathways that could be appropriately addressed by commissioning leads collaborating not only on a Warrington footprint (joining up differing specifications/responsibilities) but also across patches into other local authority areas – to solve pathway and coding issues that currently arise on the patient journey. Work is well underway to address this issue.

There is a need to increase chlamydia testing for young (under 19) males as it appears there a low proportion of clients are being tested and the resulting diagnosis rate seems very low when compared to females of the same age.

There are very high chlamydia diagnosis rates in Bewsey and Whitecross and it would be useful to investigate further to determine if this is a true reflection of what is happening or an anomaly of the data. If the cause is not a data related issue, consideration should be given as to whether to introduce outreach services in this area.

Cervical screening uptake is reducing, this is also seen nationally, and in Warrington it is especially low in deprived GP practices. There is a need to increase the rates.

8) Recommendations for Commissioning

1. Investigate the adoption of sexual health tariffs such as a “Payment by Results” approach (PBR) which ensures that all providers are fairly remunerated. Continued investigation of this is required, locally and regionally.
2. To maintain a higher level strategic group to oversee the complex commissioning arrangements. This is vital in order to ensure that contraceptive and GU provision come together and work effectively with HIV services and termination of pregnancy services in a whole systems approach. Indeed the whole system has been fragmented significantly and so retaining key commissioning and provider input into SSHIG to draw arrangements and pathways together is vital, understood to reduce any potential duplication in resource and effort (financially and staffing wise).
3. There is still a need for all services dealing with young people to implement ‘Your Welcome’ quality criteria in light of the number of young people accessing sexual health services.

4. With pending Sex & Relationships Education (SRE) policy change on the horizon, there is a need to develop a clear package of support and curriculum assistance for teachers around key/crucial messages in relation to sexual health and healthy relationships for delivery in the classroom.
5. Place continued emphasis and focus upon ensuring that the highest risk age group (15-24) are appropriately screened and tested for chlamydia in all available/relevant services.
6. Increase the numbers of males under 19 years old being tested for chlamydia as data suggests that services are not testing enough teenage males.
7. Investigate further the higher levels of chlamydia positivity in one MSOA (Middle Super Output Area) in Bewsey & Whitecross for both 15-24s and all age datasets.
8. Ensure we routinely screen at risk groups for HIV (most notably MSM, BME) and improve the testing offer across services to bring Warrington's late diagnosis rate down further. We have seen a slight rise in latest 3-year datasets around percentage diagnosed late, hence a need to focus efforts (current rate stands at 57.1% diagnosed late).
9. Carry out extra analysis on Public Health England (PHE) testing uptake and coverage data for HIV. Recent figures (in this chapter) suggest uptake and coverage both significantly worse than England (query).
10. In light of the current rate of abortion in under 18s, 18-19 and 20-24 age groups, place continued emphasis on effective promotion of contraception, especially LARC.
11. Critically also related to abortion, ensure pathways from current providers (including BPAS) to contraception, counselling and support are clear and well-drawn out/communicated (offers outside BPAS model).
12. There is a need to tighten and develop pathways between pharmacies (EHC delivery/dispensation) and contraceptive offers within the local integrated sexual health service and primary care (GPs) – 54% women presented to pharmacy for EHC with 'no method of contraception' as reason for access.
13. In relation to recommendation 12, consider the development of an electronic referral system and/or central booking set up to more swiftly send women who consent to a consultation into their GP or Integrated Sexual Health Service.
14. Ensure we continue to promote LARC and set high percentage uptake targets within services as the most cost effective long-term method of contraception.
15. Specifically aim to improve LARC uptake in the under 18 age range.
16. Investigate the data around particular cohorts accessing Integrated Sexual Health Service (ISHS) for IUD/IUS and associated coding/reason for fitting to be added – investigate pathways/data for commissioning purposes.
17. Work to address falling/declining cervical screening coverage rates across all cohorts (25-49, 50-64). National figures suggest 25-29 age group seen most decline in screening rates/uptake (consider promotional work and access here).

18. Furthermore, in relation to the above issue, there is still work to be done to improve coverage rates for cervical screening in our most deprived areas (particularly Quintile 1 (20% most deprived areas)).

9) Recommendations for Needs Assessment Work

1. Investigate further the higher levels of chlamydia positivity in one MSOA (Middle Super Output Area) in Bewsey & Whitecross for both 15-24s and all age datasets.
2. Carry out extra analysis on Public Health England (PHE) testing uptake and coverage data for HIV. Recent figures (in this chapter) suggest uptake and coverage both significantly worse than England (query).
3. Investigate the data around particular cohorts accessing Integrated Sexual Health Services (ISHS) for IUD/IUS and associated coding/reason for fitting to be added – 79.5% women aged 45+ accessing ISHS did so for a coil, investigate pathways/data for commissioning purposes.

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