Sexual Health Needs Assessment

Surrey 2015

SURREY

Foreword

In 2013, local authorities took on the responsibility of commissioning sexual health services as part their new public health responsibilities. Good sexual health enables healthy relationships, planned pregnancies and prevention of disease as well as maintaining and improving population health.

In March 2013, a Framework for Sexual Health Improvement in England was published by the Department of Health[1]. This document highlighted the need for a continued focus on sexual health, across the life course and highlighted four priority areas for improvement:

- Sexually transmitted infections (STIs)
- HIV
- Contraception and unwanted pregnancy
- Preventing teenage pregnancy

The national Public Health Outcomes Framework (PHOF) contains three indicators specific to sexual health, highlighting the need to continue and sustain effort in the following areas:

- Chlamydia diagnostic rate in 15 – 24 year olds
- People presenting with HIV at a late stage of infection
- Under 18 conceptions

This needs assessment provides the latest data for Surrey for each of these priority areas and PHOF indicators, and also includes feedback from stakeholders on their assessment of current needs. This needs assessment will inform the commissioning of robust, fit for purpose sexual health services in Surrey.

Cllr Helyn Clack

Cabinet Member for Wellbeing and Health
Surrey County Council

[1] A Framework for Sexual Health Improvement in England (2013) Department of Health

Contents

1 Key messages

- Runnymede and Spelthorne have historically shown higher than the national average rates of teenage conceptions. Preston ward within Reigate and Banstead has the highest rate in Surrey.
- Over 60% of teenage conceptions result in termination.
- Woking has a higher than the national rate of HIV.
- Through engagement work it was identified that both adults and young people wanted better access to services, this included more flexible opening times such as evenings and weekends.
- Both adults and young people felt that sexual health services could be promoted more effectively.
- Services could be better promoted online i.e. through the Healthy Surrey website.
- Surrey County Council Public Health must look for opportunities and work with our commissioning colleagues in CCGs and NHS England to ensure pathways are joined up in order to improve patient experience and health outcomes.
- Variations in service provision across the county needs to be addressed during the through the recommissioning of services. This will ensure resources are more effectively targeted to meet needs.
- Integration of services would allow needs to be met holistically. Dual trained clinicians would mean GUM and CASH services could be delivered by the same clinicians, improving patient access and experience.

2 Introduction

Having good sexual health is an important aspect of overall physical and emotional health and well-being. It is central to the development of some of the most important relationships in our lives. Any person who is sexually active could be negatively affected by their sexual health decisions and may need to take precautions or access sexual health services to maintain a positive and healthy sexual life.

2.1 Aims

- To gather information from a comprehensive range of sources in order to build a picture of levels of need and current service provision with respect to the sexual health of the population of Surrey.
- To use the resulting needs assessment report to inform and guide future commissioning and service provision to promote and improve the sexual health of people in Surrey.

2.2 Objectives

- To ensure involvement and ownership of the process by key stakeholders.
- To gather information in order to provide an overview and increased understanding of current sexual health service provision in Surrey and its use.
- To gather information in order to provide an overview of the sexual health needs of the population of Surrey.
- To use the overview of needs to assess whether or not resources have been appropriately directed.
- To make recommendations with regard to service provision, location, capacity, expected performance, cost and effectiveness.
- To make recommendations regarding the spatial allocation of resources between and within different groups and geographical areas in relation to identified need.

3 Rationale

3.1 Sexual Health Commissioning in England

Following publication of the Healthy Lives, Healthy People white paper[1] and changes introduced in the Health & Social Care Act 2012[2], local authorities took on a new public health role from April 2013. The new arrangements for the commissioning of sexual health services are summarised below[3]:

Local authorities will commission comprehensive sexual health services. These include:

- contraception including LESs (implants) and NESs (intra-uterine contraception) and all prescribing costs, but excluding contraception provided as an additional service under the GP contract;
- sexually transmitted infection (STI) testing and treatment, Chlamydia screening as part of the National Chlamydia Screening Programme (NCSP) and HIV testing;
- sexual health aspects of psychosexual counselling;
- any sexual health specialist services, including young people's sexual health and teenage pregnancy services, outreach, HIV prevention and sexual health promotion services in schools, colleges and pharmacies.

Clinical Commissioning Groups (CCGs) will commission:

- most abortion services (but there will be a further consultation about the best commissioning arrangements in the longer term);
- vasectomy;
- non-sexual health elements of psychosexual health services;
- gynaecology, including any use of contraception for non-contraceptive purposes.

The NHS Commissioning Board will commission:

- contraception provided as an additional service under the GP contract;
- HIV treatment and care (including drug costs for post-exposure prophylaxis after sexual exposure);
- promotion of opportunistic testing and treatment for STIs, and patient-requested testing by GPs;
- sexual health elements of prison health services;
- Sexual Assault Referral Centres (SARCs);
- cervical screening;
- specialist foetal medicine services.

3.2 Public Health Outcomes Framework

To accompany these changes the Department of Health published the Public Health Outcomes Framework[4] which sets out desired outcomes for public health and how they will be achieved. These outcomes focus on length and quality of life as well as reducing health inequalities. The importance of improving sexual health is acknowledged in the Public Health Outcomes Framework with the inclusion of three sexual health indicators:

- under-18 conceptions;
- Chlamydia diagnoses in 15–24-year-olds;
- people presenting with HIV at a late stage of infection.

Related indicators

- Children in poverty (63% higher risk)
- Child development at 2-2.5 years
- Rates of adolescents not in education, employment or training (NEET)(11% of all female NEETs are pregnant or teenage mothers)
- Proportion of people in long term unemployment(22% higher rates of poverty for teenage mothers x2 rate of unemployment for young fathers
- Infant mortality rate
- Incidence of low birth weight of term babies (25% higher risk)
- Maternal smoking prevalence (including during pregnancy) (x3 smoking rate)
- Breastfeeding initiation and prevalence at 6-8 weeks (1/3 lower rate)
- Hospital admissions caused by unintentional and deliberate injuries to under 5s
- Sexual violence

3.3 A Framework for Sexual Health Improvement in England

Following publication of the Public Health Outcomes Framework, the Department of Health published: A Framework for Sexual Health Improvement in England[3], which lays out 4 key objectives with associated ambitions.

Key objectives:

- Improve the sexual health of the whole population
- Reduce inequalities and improve sexual health outcomes
- Build an open and honest culture where everyone is able to make informed and responsible choices about relationships and sex
- Recognise that sexual ill health can affect all parts of society, often when it is least expected.

Ambitions:

1) Build knowledge and resilience among young people:

- all children and young people receive good-quality sex and relationship education at home, at school and in the community;
- all children and young people know how to ask for help, and are able to access confidential advice and support about wellbeing, relationships and sexual health;
- all children and young people understand consent, sexual consent and issues around abusive relationships;
- young people have the confidence and emotional resilience to understand the benefits of loving, healthy relationships and delaying sex.

2) Improve sexual health outcomes for young adults:

- all young people are able to make informed and responsible decisions, understand issues around consent and the benefits of stable relationships, and are aware of the risks of unprotected sex;
- prevention is prioritised;
- all young people have rapid and easy access to appropriate sexual and reproductive health services;
- all young people's sexual-health needs – whatever their sexuality – are comprehensively met.

3) All adults have access to high quality services and information:

- individuals understand the range of choices of contraception and where to access them;

- individuals with children know where to access information and guidance on how to talk to their children about relationships and sex;
- individuals with additional needs are identified and supported;
- individuals and communities have information and support to access testing and earlier diagnosis and prevent the transmission of HIV and STIs.

4) People remain healthy as they age:

- people of all ages understand the risks they face and how to protect themselves;
- older people with diagnosed HIV can access any additional health and social care services they need;
- people with other physical health problems that affect their sexual health can get the support they need for sexual health problems.

5) Prioritise prevention:

- build a sexual health culture that prioritises prevention and supports behaviour change;
- ensure that people are motivated to practise safer sex, including using contraception and condoms;
- increased availability and uptake of testing to reduce transmission;
- increase awareness of sexual health among local healthcare professionals and relevant non-health practitioners, particularly those working with vulnerable groups.

6) Reduce rates of sexually transmitted infections (STIs) among people of all ages:

- individuals understand the different STIs and associated potential consequences;
- individuals understand how to reduce the risk of transmission;
- individuals understand where to get access to prompt, confidential STI testing and provision allows for prompt access to appropriate, high-quality services, including the notification of partners;
- individuals attending for STI testing are also offered testing for HIV.

7) Reduce onward transmission of and avoidable deaths from HIV:

- individuals understand what HIV is and how to reduce the risk of transmission;
- individuals understand how HIV is prevented;
- individuals understand where to get prompt access to confidential HIV testing;
- individuals diagnosed with HIV receive prompt referral into care, and high-quality care services are maintained;
- individuals diagnosed with HIV receive early diagnosis and treatment of STIs.

8) Reduce unwanted pregnancies among all women of fertile age:

- increase knowledge and awareness of all methods of contraception among all groups in the local population;

- increase access to all methods of contraception, including long-acting reversible contraception (LARC) methods and emergency hormonal contraception, for women of all ages and their partners.

9) Termination of Pregnancy Counselling:

- all women requesting an abortion should be offered the opportunity to discuss their options and choices with a trained counsellor.

10) Continue to reduce the rate of under-16 and under 18 conceptions:

- all young people receive appropriate information and education to enable them to make informed decisions;
- all young people have access to the full range of contraceptive methods and where to access them.

3.4 Integrated Sexual Health Services: National Service Specification

In 2013, the Department of Health published a suggested service specification for integrated sexual health services[5]. The proposed model aims to improve sexual health by providing easy access to services through open access 'one stop shops', where the majority of sexual health and contraceptive needs can be met at one site, usually by one health professional, in services with extended opening hours and accessible locations.

Services will support delivery against the three main sexual health Public Health Outcome Framework[4] measures and provide open access, cost-effective, high quality provision for contraception and prevention, diagnosis and management of sexually transmitted infections, according to evidence-based protocols and adapted to the needs of local populations. The proposed integrated service model is characterised by:

- being provided on an open access basis and available to anyone requiring care, irrespective of their age, place of residence or GP registration, without referral;
- having walk-in and appointment clinics, including evenings and Saturdays;
- using a hub and spoke model of care (working with local general practices and linking into local outreach work);
- multidisciplinary working;
- providing a full range of sexual health services;
- providing interpretation services for clients whose first language is not English and who require interpretation;
- providing services to women and men of any age;
- proving evidence based care centred on recognised national best practice guidance where this exists;
- delivery in broad accordance with the Level 1, 2 and 3 service model which is well established for sexual health service provision including the following elements: self managed care; basic and intermediate care; complex service provision.

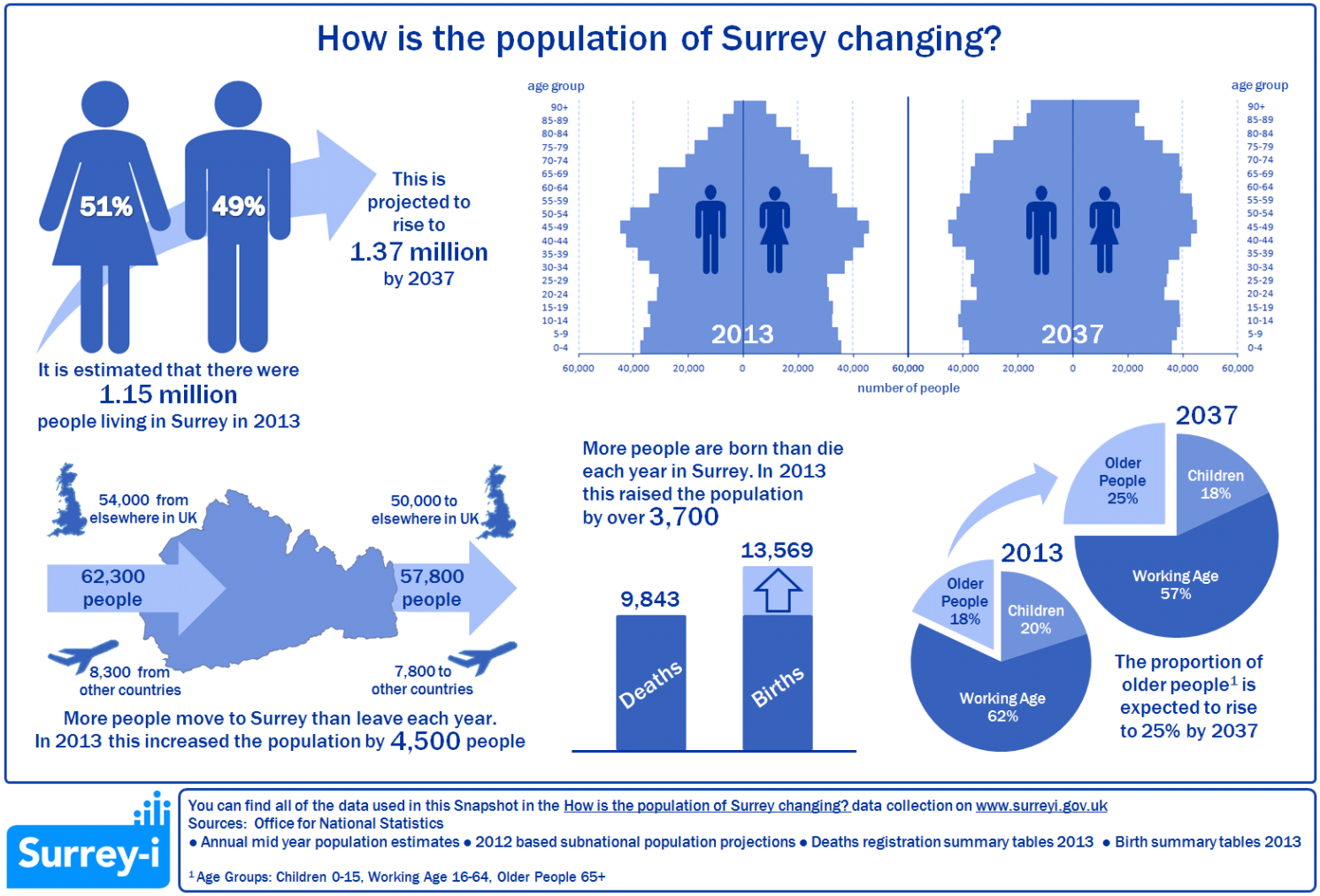
3.5 Surrey Health & Wellbeing Board

The Surrey Health & Wellbeing Board has five strategic priorities, sexual health improvement and access to sexual health services are considered as part of the prevention priority and the children and young people's priority.

4 Surrey: Local Context

This section of the Needs Assessment provides a basic overview of population characteristics across Surrey. More detailed over information about the demographic breakdown of Surrey's residents can be found on Surreyi; www.surreyi.gov.uk .

4.1 Population profile of Surrey



Source: ONS, Surrey Snapshots www.surreyi.gov.uk

4.2 Areas of Deprivation in Surrey

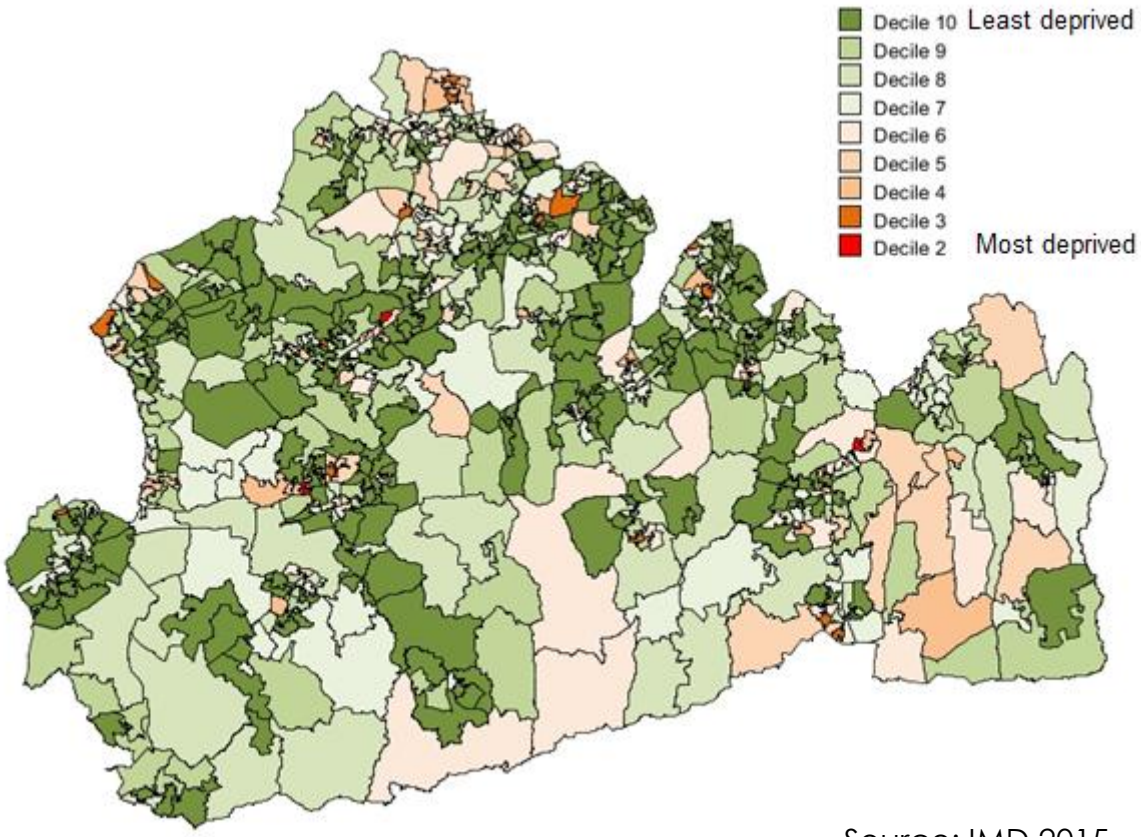
The county of Surrey has a diverse environment with a mix of rural and urban areas. While overall the population is affluent in comparison to the national average, there are masked pockets of deprivation and inequalities present across Surrey. The Index of Multiple Deprivation (IMD) is a national index that identifies the spread of relative deprivation by local authority, electoral ward and "super output areas". The 326 local authority boroughs across the whole of England have been ranked according to this index.

Table 1: Ranking of IMD average scores; Rankings of Surrey's Local Authorities out of 326 Lower Tier authorities

Local Authority	Rank (where 1 is most deprived)
Elmbridge	322
Epsom and Ewell	310
Guildford	302
Mole Valley	305
Reigate and Banstead	290
Runnymede	283
Spelthorne	236
Surrey Heath	318
Tandridge	286
Waverley	323
Woking	298

Source: IMD 2015

Figure 1: Index of multiple of deprivation 2015 by Surrey Lower Super Output Area (LSOA)



Source: IMD 2015

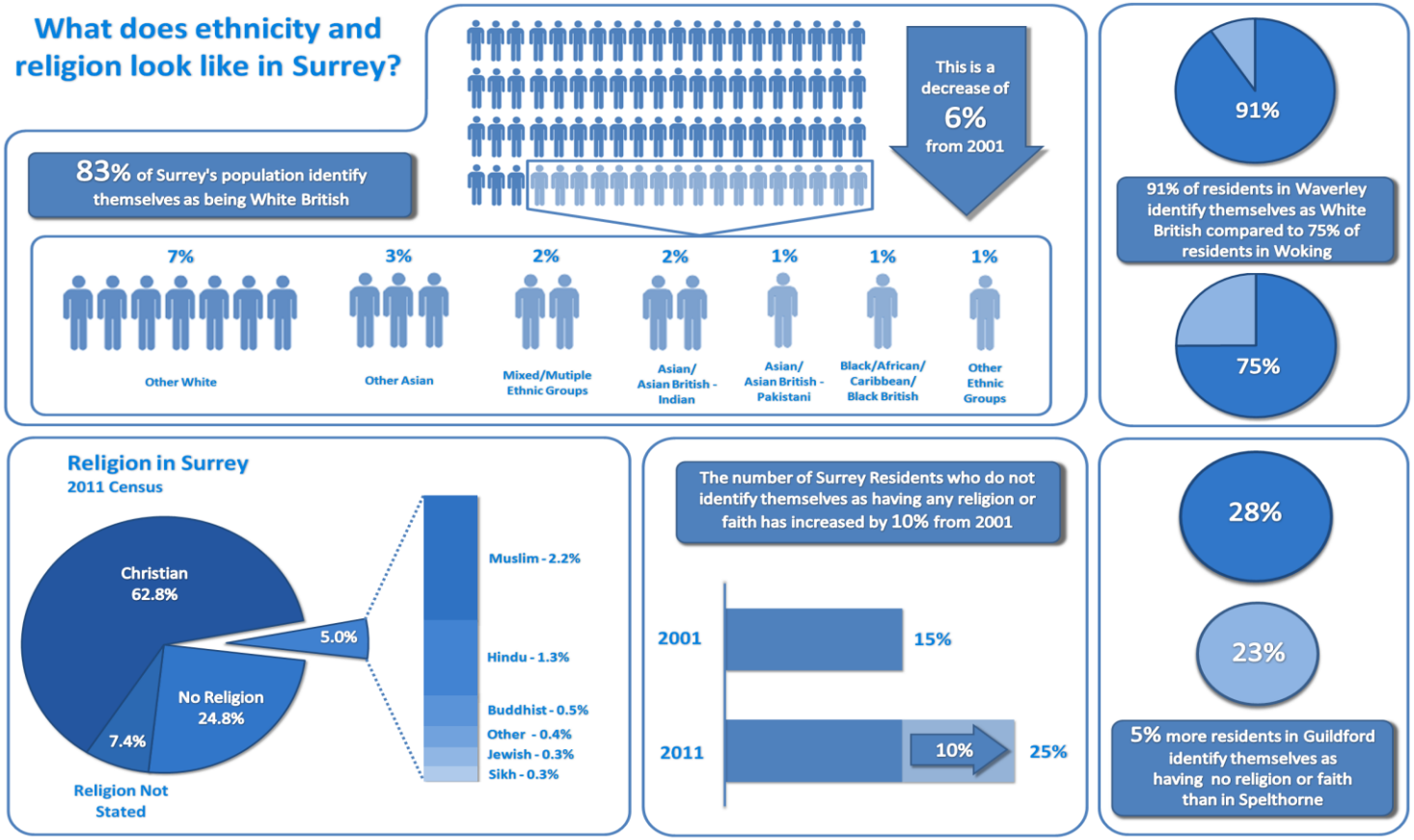
4.3 Protected Characteristics and Inequalities in Surrey

Under the terms of the Equality Act 2010[6] public bodies have to consider all individuals when carrying out their day-to-day work, in shaping policy, in delivering services and in relation to their own employees. Public bodies must also:

- have due regard to the need to eliminate discrimination
- advance equality of opportunity
- foster good relations between different people when carrying out their activities

The act introduces the following protected characteristics: age (including children and young people), disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation. (People who are considering, undergoing or have undergone gender reassignment are referred to in the Act as transsexual people.)

Figure 2: What does ethnicity and religion look like in Surrey?



Source: ONS, Surrey Snapshots www.surreyi.gov.uk

Figure 3: Surrey County Council, Equality, Fairness and Respect Strategy 2015-20

Confident in Surrey's Future: Equality, Fairness and Respect Strategy 2015-20

SURREY

PURPOSE

Ensure services support all Surrey residents and our staff are healthy, safe and confident about their future.

VISION

- Equality
- Fairness
- Respect

VALUES

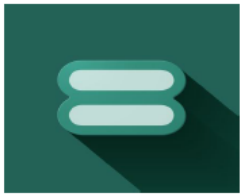
- Listen
- Responsibility
- Trust
- Respect

Context

The makeup of Surrey's 1.1 million residents is continuing to change, and over the next 25 years the population is projected to increase by over 20%. We will see an increase in the number of residents aged over 65 and an increase in the number of children and young people too. Residents are living longer with a range of different health and care needs, some have multiple and complex needs. Surrey is also a more ethnically diverse place to live than ever before.

This document sets out our priorities and demonstrates our commitment to deliver fair and inclusive services to meet the needs of all Surrey's communities. As one of the largest employers in Surrey this document also supports the Council's commitment to be a best practice employer for all our staff and reflect the diversity of Surrey's population.

This meets the Council's duty in the Equality Act 2010 to publish objectives that show how we will promote equality of opportunity and tackle discrimination.



- There are an estimated 110,000 unpaid carers of all ages in Surrey. The majority of carers are women and includes an estimated 14,000 young carers.
- We support around 30,000 people each year with a range of physical and learning disabilities as well as mental health issues. Over 20,000 people each year in Surrey access NHS mental health services.
- In Surrey's most deprived areas life expectancy is on average five years lower than areas of higher wealth.
- 17% of Surrey's population identify themselves as being from a minority ethnic group. Since 2001, the non-white British population has doubled to 9.8%.

Our strategic goals

1. Wellbeing

Everyone in Surrey has a great start to life and can live and age well

2. Economic prosperity

Surrey's economy remains strong and sustainable

3. Resident experience

Residents in Surrey experience public services that are easy to use, responsive and value for money

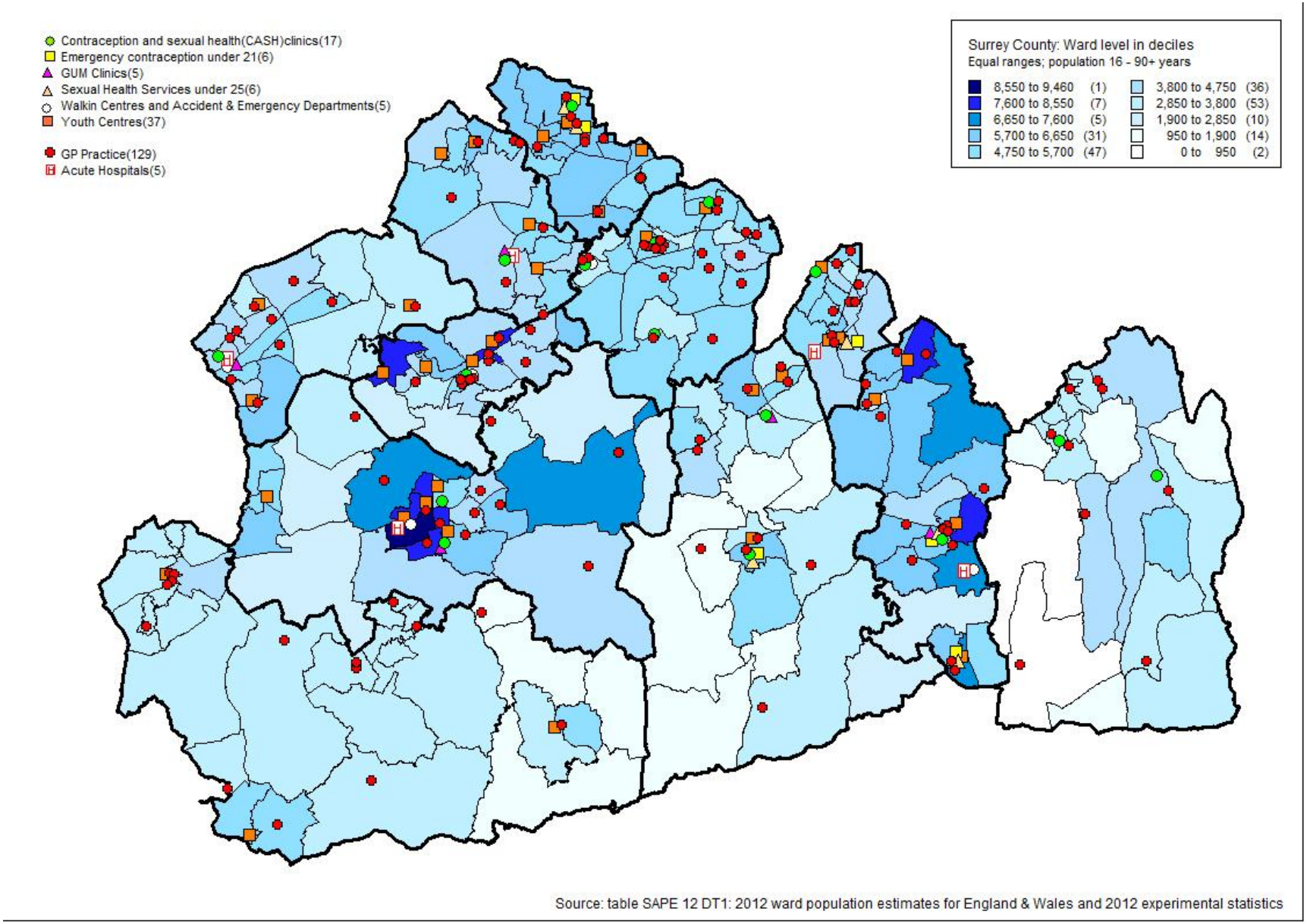
Our Equality, Fairness and Respect Priorities

Drawing on a robust evidence base from sources such as Surrey-i, and following engagement with internal and external stakeholders, we have set the following four priorities. These complement our Corporate Strategy, People Strategy and Customer Promise, and support the design and delivery of inclusive and accessible services that help meet the needs of our communities.

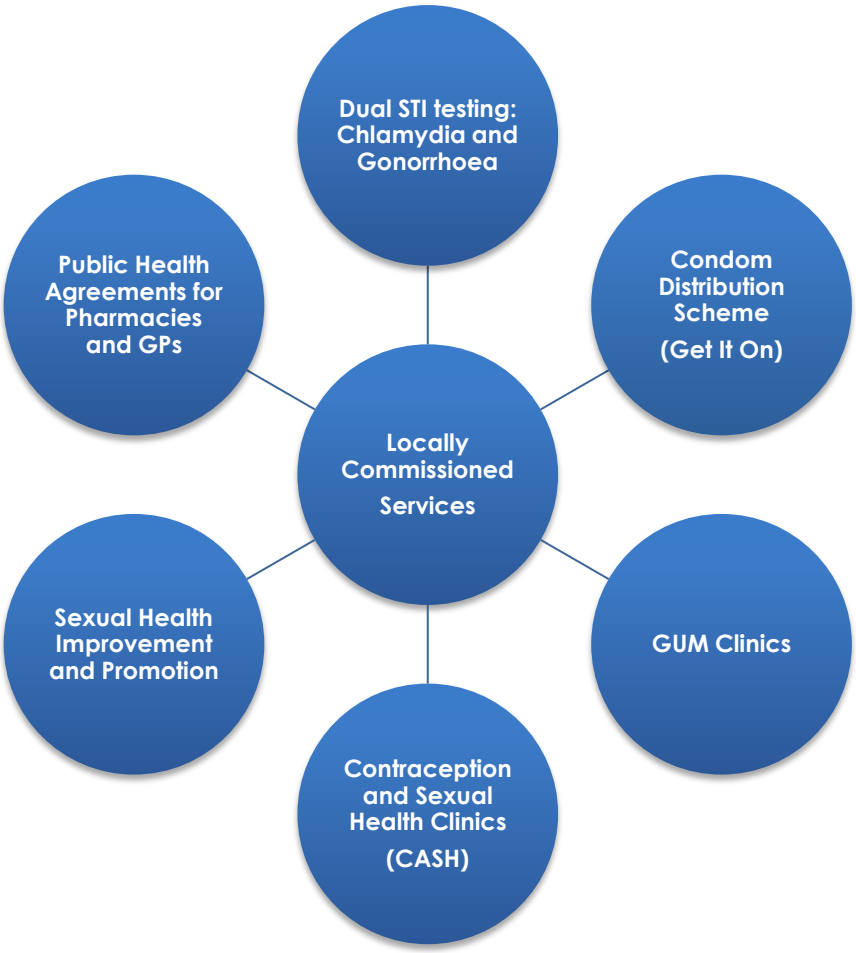
1. Ensure Surrey's children, adults and families are supported and helped to lead more independent lives.
2. Support all children and young people to participate and succeed in education, training and employment.
3. Support preventative actions to reduce health inequalities and increase wellbeing for our communities.
4. Be a local employer of first choice for people from all our diverse communities, particularly for disabled and younger people.

5 Sexual Health Services in Surrey

5.1 Map of Sexual Health Services available in Surrey



5.2 Public Health Commissioned Sexual Health Services in Surrey



Currently in Surrey there are three main Genitourinary Medicine (GUM) sexual health services providing first and follow up appointments. These are as follows;

1. Frimley Park Hospital, approximately 3,600 attendances per annum
2. Ashford and St Peter's Hospital, approximately 8,000 attendances per annum
3. Virgin Care; Leatherhead Hospital, Berryfields (Guildford), Earnsdale (Redhill) and Woking Community Hospital, collectively having approximately 17,500 attendances per annum.

Additionally Virgin Care provide contraceptive and sexual health services (CASH) with approximately 21,500 attendances per annum and sexual health improvement and promotion including outreach.

Through Public Health Agreements (PHAs) GPs provide the contraceptive implant and Intrauterine Contraceptive Device (coil), totalling over 10,000 procedures per annum and pharmacies provide emergency hormonal contraception (EHC), approximately 360 per annum to under 25 year olds.

Sexual health services are open access as such there are around 15,000 attendances by Surrey residents to out of area services. Around 50% of out of area attendances are made to bordering counties or London Boroughs.

This section looks at the sexual health needs, services and recommendations for young people in Surrey using a variety of data sources, published guidance and reports.

In the development of this sexual health needs assessment focus groups were held with three young people's groups;

- Young People 16 years+,
- Young Mother's and
- LGBT young people.

In total 22 young people took part in the focus groups which were led by a staff member from Service for Young People. Each group was asked the same questions about their experience of sex education, sexual health and services across Surrey. Their views will be shown throughout this section.

6 Under 16s

6.1 Schools

The 2013 Chief Medical Officer's Report[7] states that schools are a central factor for young people's health during childhood and adolescence. Promotion of health by schools helps schools achieve their 'core business' of increasing educational attainment and enhancing later life chances for pupils. PSHE at school is an important part of the way in which schools can contribute to improving resilience and health among children. The report goes on to suggest that children and young people appear to value PSHE and feel that it provides relevant and useful information, although older teenagers are less likely to be positive about the quality of PSHE that they receive. There is evidence that specialist teachers trained in PSHE deliver the most effective health-related teaching, especially in relation to the topics that children are reported to be most likely to want information about, including health exploratory behaviours and sexual health.

The Department of Health state the following in A Framework for Sexual Health Improvement in England[5]: "Both young people and parents want high-quality education about sex and relationships. The provision of sex education is a statutory requirement for maintained secondary schools."

A recent national Ofsted report[8] concluded that:

> "Sex and relationships education required improvement in over a third of schools. In primary schools this was because too much emphasis was placed on friendships

and relationships, leaving pupils ill-prepared for physical and emotional changes during puberty, which many begin to experience before they reach secondary school. In secondary schools it was because too much emphasis was placed on 'the mechanics' of reproduction and too little on relationships, sexuality, the influence of pornography on students' understanding of healthy sexual relationships, dealing with emotions and staying safe."

"Lack of high-quality, age-appropriate sex and relationships education in more than a third of schools is a concern as it may leave children and young people vulnerable to inappropriate sexual behaviours and sexual exploitation. This is because they have not been taught the appropriate language or developed the confidence to describe unwanted behaviours or know where to go to for help."

6.2 Personal, social and health education (PSHE) Review 2014

A full review of PSHE in all Surrey secondary schools (local authority funded and Academies) was completed in August 2014. The conclusion and recommendations are summarised below.

Surrey PSHE review conclusion

The evaluation of Secondary PSHE provision in Surrey highlights that there is good practice in place in many schools across the county. Overwhelmingly teachers strive to provide a high standard of provision of PSHE as they recognise the role it plays in supporting the mental health, wellbeing and the resilience of young people. There are, however, barriers to effective provision which can be overcome, either fully or partially, by effective pooling of expertise, the provision of high quality PSHE education consultancy, training and resources, the alignment of local priorities and strategies and an increased priority given to the subject area – in short – increasingly efficient and effective partnership working.

In many ways the evaluation is in line with OfSTED findings that teachers and schools recognise the importance of PSHE as a subject, however as PSHE is frequently not delivered by a specialist team – training and support for a variety of PSHE specialist areas is required.

FOCUS GROUP: What was your first experience of sex education?

"It's all giggly at that age"

Each focus group talked about the first experience of sex education being at school. All groups remembered a video with cartoon characters they watched at primary school that focused on reproduction.

Experiences of sex education at secondary school varied within each focus group. Several participants didn't remember having any lessons, another member said they missed the relationship and sex education (RSE) session because of poor attendance at school. Lesson time varied from 15 minute – 50 minute PSHE lessons, some had regular lessons- others one-off days. The LGBT group with the exception of one participant didn't feel their schools taught anything about sexuality, one participant remembered being told stories "to put you off being gay". Topics covered at some of the participants schools included STIs, preventing pregnancy- in reaction to girls in the year above becoming pregnant, and how to use a condom.

Surrey PSHE review recommendations:

1. A selection of mainstream, special and short stay schools that did not respond to the evaluation and do not readily engage with PSHE education consultancy and Healthy Schools are selected and visited in order to find out how their feedback compares to the evaluation findings.

2. Capacity building for Healthy Schools and partnership working.

3. The Healthy Schools Team to update and develop policies for PSHE, SRE and Drug Education, update the Surrey Secondary Scheme of Work for PSHE - in line with recent guidance and local strategies; and disseminate these resources and guidance documents through training and information events for PSHE teachers and related partnership workers.

4. The Healthy Schools Team to develop an SRE Toolkit for Secondary schools which supports the Surrey Secondary PSHE Scheme of Work, complementing the Tobacco Toolkit and the Drug and Alcohol Toolkit; and for this to be launched through a training event and given to schools attending the event, or through face to face communication.

5. To ensure that teachers at both special and short stay schools are provided with PSHE education consultancy and support appropriate to their requirements.

6. Greater alignment of support between education and health.

7. Effective and dedicated lines of communication.

8. Schools to be mapped and prioritised according to both education and health need, and Healthy Schools (including PSHE) support to be provided in order for them to deliver effective practice in promoting mental and physical health and wellbeing.

9. For identified teachers and staff (including school nurses and external contributors) to receive financial support towards taking part in the National PSHE CPD Programme

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6.3 Supporting Relationship and Sex Education (RSE) delivery in Surrey

"Sex and relationships education is learning about sex, sexuality, emotions, relationships, sexual health and ourselves."

Sex Education Forum

Following the PSHE review, 45% of respondents said relationship and sex education was an area within PSHE where they would like information and training. As a result an online survey was carried out in February and March 2015 with staff working with young people that aimed to find out what information, training and support staff would like to ensure young people in Surrey receive high quality RSE.

The survey was completed by 26 people including Specialist Practitioner / School/ Community Nurse (13); Teacher/ Headteacher/ PSHE Co-ordinator (7), Youth Worker/ Volunteer Youth Worker (4) who work across education and youth settings in Surrey.

When asked how they could be better supported to feel confident and equipped to deliver RSE, the areas staff identified were training/ workshops, access to resources, strengthening partnerships and access to data & information.

They felt existing provision could be improved in their setting through staffing, resources, suitable space and groups, training, consistency and time given for RSE

The ways in which they would like support to deliver RSE were (in order of most requested to least requested)

- Resources for RSE sessions (i.e. Contraception packs, activities)
- Classroom based learning
- Session plans
- External agency to deliver session
- E-learning/ Computer-based learning
- External agency to co-deliver session

FOCUS GROUP: What do you think young people need to know about sex, relationships and sexual health services?

- Contraception
- To get checked (for STIs)
- To be safe
- Type of service wanted
- Consequences/ risks; pregnancy/STIs
- Relationship Counsellors;
- Information about safe sex in same sex relationships
- Consent; no means no
- Attitudes to different sexual orientations
- Empathy to stop bullying / attacks

6.4 School Nursing Services

School nurses provide a variety of services such as providing health and sex education within schools, carrying out developmental screening, undertaking health interviews and administering immunisation programmes. School nurses can be employed by the local health authority, community NHS providers or by a school directly[9]. In Surrey School nurses are commissioned by SCC Public Health team from three health providers CSH Surrey, First Community Health Care and Virgin Care.

Review of school nursing in Surrey 2014

"School Nurses have a unique role in terms of coordinating between health and education, between communities and families. They are the Navigator – but they are not the 'catch all'. They 'see the need' but it is not their role to meet it all."

A review into School Nursing Services was carried out in late 2014 partly driven by new commissioning arrangements as part of the Health and Social Act (2012), and the transfer of responsibilities from NHS to local authority. The review found;

First Community Health and Care

- 2.89 Qualified School Nurses
- 3.72 Skill mix
- Ratio of 1 Qualified SCPHN to 14000 children and young people

VirginCare

- 9.06 Qualified School Nurses
- 12. 49 Skill mix
- Recruiting a lead School Nurse
- Ratio of 1 Qualified SCPHN to 8000 children and young people

CSH Surrey

- 8.9 Qualified School Nurses
- 9 Skill mix

- Ratio of 1 Qualified SCPHN to 4000 children and young people

33 schools from within the area responded to the questionnaire. All agreed the role of the School Nurse was either important or very important to the school. Most would like to see the School Nurse more and there was great variation, reported, in the amount of time School Nurses spent at schools. The School Nurse role varied and included;

- Input into PSHE lessons, Health education, promotion and support – healthy living, smoking, self harm, sex and relationships, preventing accidents
- Drop-in Clinic in a box.
- Parents information evenings
- Child protection and safe guarding
- Developing a school health profile and plan
- Advising on health needs of children with complex needs
- Coordination of immunisation programmes
- Liaison with GPs once a term to never seen

FOCUS GROUP: Where have you previously got information about relationships and sex education; sexual health (STIs/ Contraception/ LARC); or sexual health services?

- Internet
- Secondary school- local health centres visited school, talk in assembly
- Youth Worker/ Peer Education programme
- Session at youth club
- Family member
- Leaflet at a clinic
- Television programme
- Staff at sexual health clinics

6.5 Children & Young People Missing Out on Education

A recent Ofsted report[10] highlighted that many thousands of children and young people in England do not attend full-time education. Reasons for this include permanent exclusion, emotional & behavioural difficulties and pregnancy. There is evidence[11] to show that disengagement from school, including truancy and exclusion, is linked to drug and alcohol use and other risky health behaviours. Absence from school also damages educational achievement, and young people with few or no qualifications are at high risk of becoming NEET. It follows that children and young people not receiving full-time education will miss out on opportunities for relationships and sex education.

In Surrey the numbers of children with Fixed Term Exclusions had been reducing but is now beginning to increase again. The number of children excluded for persistent disruptive behaviour remains high although this category is broad and covers a range of behaviours and potential needs. The number of Fixed Term Exclusion at the primary age range is increasing as the needs of this cohort are becoming more complex. The highest number of fixed term exclusions is of children from Irish Traveller and Gypsy Roma Traveller communities.

6.6 Surrey CAMHS Needs Assessment

The particular groups of children and young people who may be vulnerable to increased risk of emotional wellbeing and mental health issues include: young parents; parent and young carers; lesbian, gay, bisexual and transgender young people; refugee and asylum seeking

children; children from the Gypsy Roma Traveller community; recently adopted young people; and children witnessing domestic abuse.

The Surrey CAMHS Needs Assessment[12] concludes that professionals need to continue to work collaboratively to ensure that their role in providing PSHE and Sex and Relationship Education counters negative influences and experiences outside of school such as poor role models, and takes account of the rapidly changing technological environment in which children and young people access social media and the internet. Professionals also need to aim for a to better understanding of the emotional wellbeing and mental health needs of young people in Surrey who are lesbian, gay, bisexual or transgender.

6.7 Lesbian, Gay, Bisexual & Trans* (LGBT) Young People

In 2013, 4,166 LGBTQ young people aged 11-16 years were identified in Surrey[13].A recent study involving over 7,000 young people aged 16-25[14] found the following with regard to lesbian, gay bisexual, trans* and questioning young people:

- in sex and relationships education, where more inclusion might be anticipated, young people report very limited acknowledgement of LGBTQ relationships and issues
- around two thirds of LGBTQ young people say they learn a lot about relationships and safer sex between a man and a woman, compared to less than 5% who say they learn a lot about same sex relationships and safer sex
- 89% of LGBTQ young people report learning nothing about bisexuality issues and 94% report learning nothing about transgender issues
- only 25% of LGBTQ young people report that they learned *anything* at school about safer sex for a male couple
- less than one in five LGBTQ young people (18%) report that school provided any useful preparation for happy and healthy sex and relationships.

The recently published supplementary advice[15] on teaching sex and relationships (SRE) in schools includes the following on LGBT young people:

> "Schools have a clear duty under the Equality Act 2010 to ensure that teaching is accessible to all children and young people, including those who are lesbian, gay, bisexual and transgender (LGBT). Inclusive SRE will foster good relations between pupils, tackle all types of prejudice – including homophobia – and promote understanding and respect, enabling schools to meet the requirements, and live the intended spirit, of the Equality Act 2010.
>
> Too often, groups of young people say they feel excluded in SRE lessons. For example, lesbian, gay and bisexual pupils (who make up approximately 10% of any school population) often report that their SRE is solely about heterosexual relationships, or that non heterosexual identities were addressed negatively and that it fails to address sexual health issues linked to the range of sexual behaviours and activities that people encounter whatever their sexual orientation.
> Teachers should never assume that all intimate relationships are between opposite sexes. All sexual health information should be inclusive and should include LGBT people in case studies, scenarios and role-plays. Boys and girls can

explore topics from a different gender's point of view, and a variety of activities – including practical tasks, discussions, group activities and competitions – can provide something for everyone."

Twister Youth Groups

Three Twister Youth Groups for lesbian, gay, bisexual and trans (LGBT) young people aged 13-19 (or up to 25 if the young person has disabilities) are currently available in Surrey. These youth groups are run by Surrey County Council Services for Young People and staffed by youth workers. The venues are not made public but the groups are based at youth centres in Guildford, Redhill and Spelthorne and meet one night a week in each venue for 46 weeks of the year.

Anti-homophobic Bullying Work in Schools

Much of the work that has been carried out with schools has been in response to incidents of homophobic bullying. All work has been in partnership with either Surrey Police or Outline Surrey. It is important to tackle homophobic bullying because as well as addressing the issues of acceptance and acceptable & unacceptable behaviour, it raises the issue of sexuality and allows young LGBT people to gain the information they need to stay safe physically, emotionally and sexually including sexual health services and sources of help & support.

7 16 – 24year olds

7.1 Young People 16-18 in Education

The Department for Education[16] has recently made changes to the 'school' leaving age. In England, young people must now stay in some form of education or training until the end of the academic year in which they turn 18. This can be: full-time education, e.g. at a school or college; an apprenticeship; part-time education or training (as well as being employed, self-employed or volunteering for 20 hours or more a week).

The Sex Education Forum[17, 18] suggest that further education (FE) is an important context in which young people learn, socialise and develop. The late teenage years (16–19) are significant as part of young people's transition from adolescence to adulthood, and the majority of young people first have sex when they are 16 years old or above. For health providers, including public health teams in the local authority and voluntary sector health providers, Apprenticeship & Foundation Learning programmes are a potentially untapped setting in which to engage with young people, some of whom are particularly vulnerable to poor sexual health outcomes. For learning providers, building in opportunities to provide SRE and to promote the sexual health needs of learners is a sound investment as it can improve both retention and attainment. Making links with local health providers can bring in new expertise and resources.

There are a number of sixth form colleges, further education colleges, training centres and school based 6th Forms in Surrey catering for the 16-18 age group in Surrey. This needs assessment has not been successful in accessing information about educational input or advice and information given to these students about sexual health issues. There are currently no known sexual health drop-ins, advice sessions or services based in these educational establishments.

7.2 Young People Not in Education, Employment or Training (NEET)

The definition of NEET is a young person who has not been in education, employment or training for at least 6 months out of the previous 12. Research has shown that these young people are disproportionately likely to have poorer outcomes on five indicators of disadvantage: low attainment, teenage parenthood (see section 10 above), emotional health concerns and criminal activity. The research also indicates that NEET young people are more likely to engage in multiple risk taking behaviours including alcohol and drug use, early sexual activity (under 16). There are currently 1,170 NEET young people aged 16-18 years in Surrey[19].

7.3 Surrey's 18+ Student Population

University students are predominantly aged between 18 and 25 years. There are 5 universities in Surrey: University of Surrey in Guildford, University of Creative Art (UCA) in Farnham and Epsom, Royal Holloway University of London in Egham, University of Law in Guildford. The university student population in Surrey is over 25,500.

There are currently no dedicated specialist sexual health services at any of the 4 universities in Surrey. Each of the universities has a website giving information to students on sexual health and local sexual health services. A recent search of the websites for each university revealed omissions and inaccuracies in the information contained on 4 out of the

4 websites about local sexual health services.

Studies in a number of UK universities have shown that increasing numbers of students (male and female) are turning to sex work to fund their studies and avoid large debts[20]. The Harm Reduction Outreach Team and Surrey Police report that this is also the case in universities in Surrey.

7.4 Surrey County Council Services for Young People

Through centre based youth work, Surrey County Council Services for Young People provides planned and opportunistic input for young people on sexual health and support to access services as appropriate. Surrey Services for Young People have recently updated their Relationships & Sex Education and Sexual Health Policy to support and guide this work.

7.5 Teenage Pregnancy

It is widely understood that teenage pregnancy and early motherhood can be associated with poor educational achievement, poor physical and mental health, social isolation, poverty and related factors. There is also a growing recognition that socio-economic disadvantage can be both a cause and a consequence of teenage motherhood. Teenage pregnancy rates are a well established and evidence based indicator of deprivation and inequality with 50% of all teenage conceptions occurring in the top 20% most deprived wards in England. Poor self-esteem, lack of aspiration and alcohol misuse increase the likelihood of a teenage girl falling pregnant.

The babies of teenage mothers can face more health problems such as premature birth or low birth weight and higher rates of infant mortality; than those of older mothers. Teenage mothers themselves may also have experience health problems. For example, post natal depression is three times more common in teenage mothers; smoking in pregnancy is also three times more common in teenage mothers than older mothers and teenage mothers are one third less likely to breast feed.

Teenage Pregnancy data for England and the South East

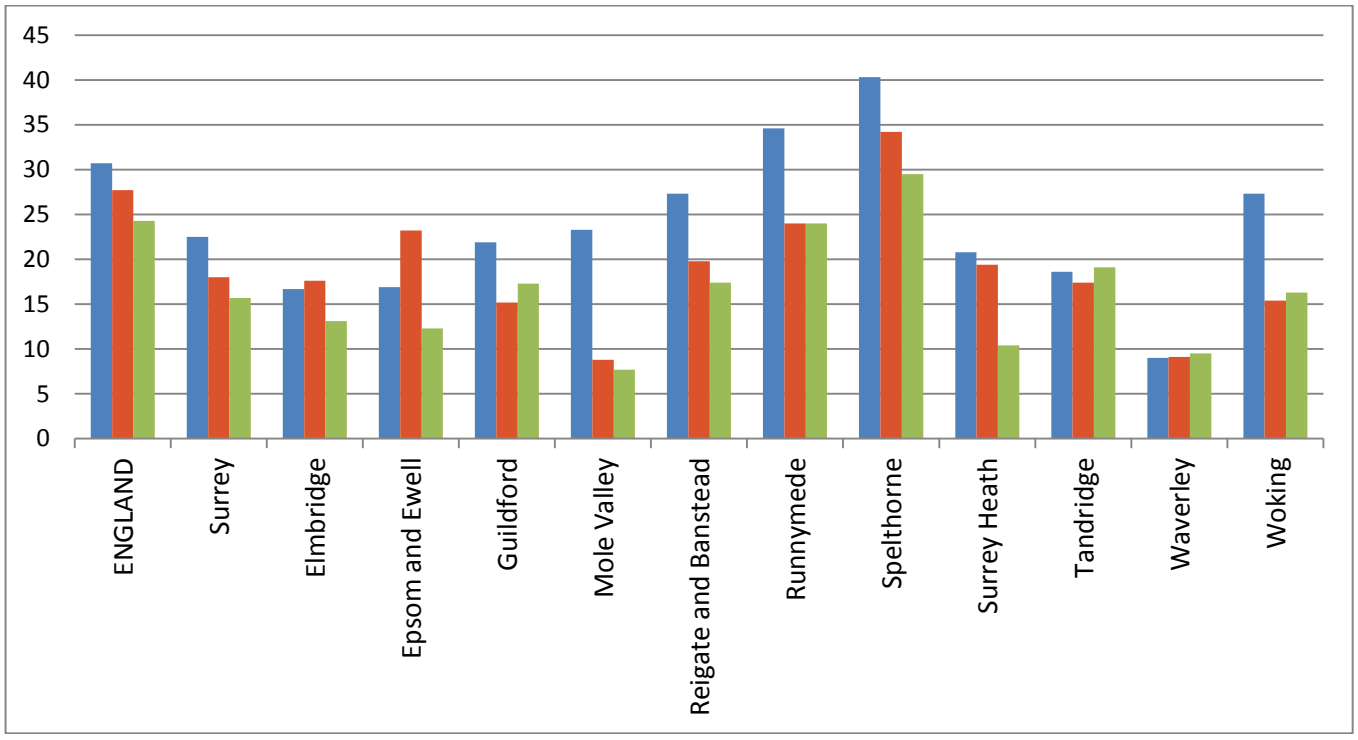
In 2013[21] there were 22,830 conceptions to women aged under 18 compared with 29,166 in 2011, a decrease of approximately 22%. This is the lowest number of conceptions in this age group since 1969.

The under 18 conception rate continues the overall decline recorded since 1998 when there were 47.1 conceptions per thousand women aged 15-17. Since 1998 the conception rate for women aged under 18 has decreased by 41%. There are a number of factors which could explain recent reductions in teenage conceptions including:

- Programmes such as relationships and sex education;
- improved access to contraceptives and contraceptive publicity;
- a shift in aspirations of young women towards education and

Teenage Pregnancy Data for Surrey

Figure 4: Rates per 1,000 females of under 18 conception by local authority 2011-13



Source: ONS

Table 2: Numbers of under 18 conceptions 2011-2013

	Number of Conceptions		
	2011	2012	2013
England	**29,166**	**26,157**	**22,830**
Surrey	**460**	**363**	**315**
Elmbridge	40	41	31
Epsom and Ewell	25	35	18
Guildford	50	34	39
Mole Valley	38	14	12
Reigate and Banstead	67	49	42
Runnymede	43	30	30
Spelthorne	65	54	46
Surrey Heath	34	31	16
Tandridge	31	29	32
Waverley	21	21	22
Woking	46	25	27

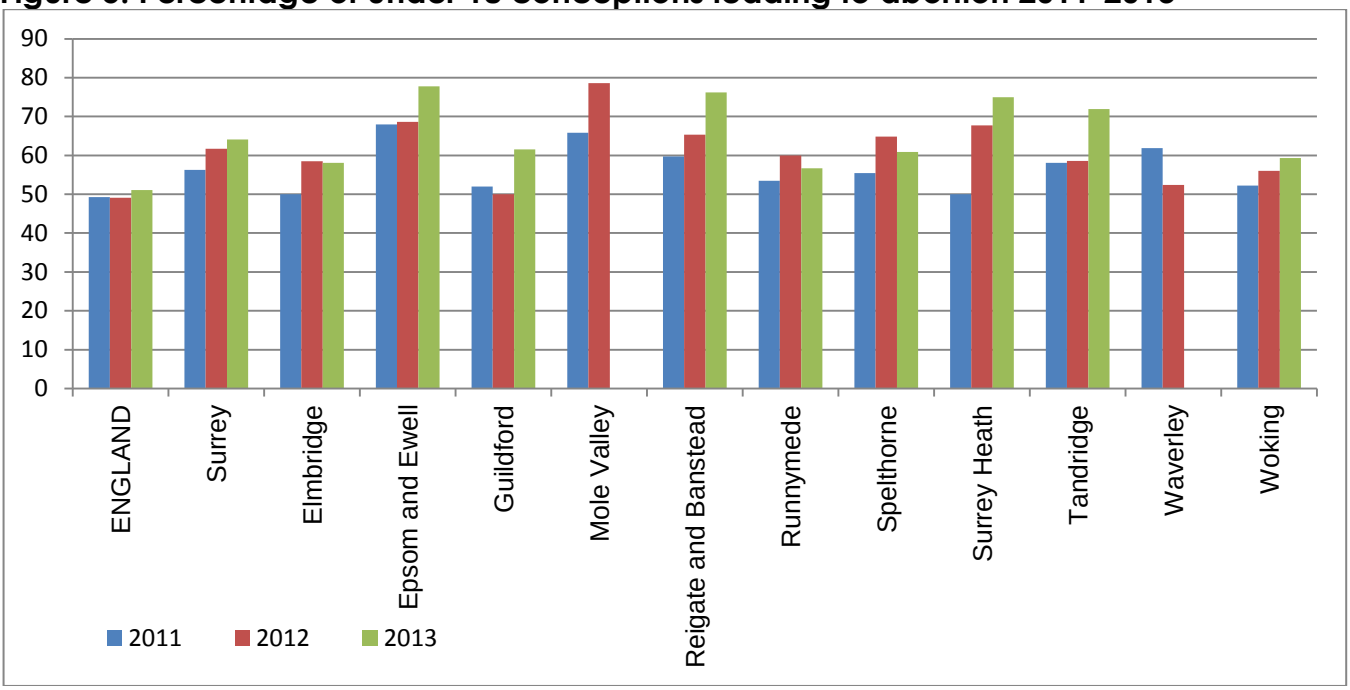
Source: ONS

Preston ward within the borough of Reigate and Banstead is the only ward significantly higher than the England average.

7.6 Termination of Pregnancy

Nearly half (49%) of all conceptions to women aged under 18 in 2012 led to an abortion, this proportion has remains relatively unchanged since 2006. Over the last two decades the percentage of conceptions leading to a legal abortion has generally increased for women aged under 20. In 2012, the percentage of conceptions leading to a legal abortion decreased slightly for under 18s but increased for the under 20s.

Figure 5: Percentage of under 18 conceptions leading to abortion 2011-2013



Source: ONS

Data is confidential for Mole Valley and Waverley in 2013 due to low numbers of conceptions.

Table 3: Repeat abortions by Clinical Commissioning Groups, 2014

Clinical Commissioning Groups/ Locality Office	Total	Repeat abortions all ages (%)	Repeat abortions in women aged under 25 (%)	Repeat abortions in women aged 25 and over (%)
England	**176,238**	**37.6**	**27.0**	**45.6**
Surrey and Sussex	7,270	36	25	45
NHS East Surrey	477	39	34	42
NHS Guildford and Waverley	434	32	24	38
NHS North West Surrey	1,000	38	28	45
NHS Surrey Downs	728	37	27	44
NHS Surrey Heath	239	38	21	49

Source: Department of Health

7.7 Young Parents

Becoming pregnant can make it extremely difficult for teenage mothers to continue their education with over one third of teenage mothers having no qualifications and 70% not in education, training or employment (NEET). 15 per cent of all NEETs are teenage mothers or pregnant teenagers[10].

Teenage mothers, young fathers and their children are more likely to be in poor health and to live in poor housing thus perpetuating on-going socioeconomic disadvantage and inequality.

Table 4: Total number of teenage mothers <19 and <20 years of age compared to England and the South East

	Total	Total <19	Total <20	% <19 mothers	% <20 mothers
England	6501	4145	6214	17	12
South East	743	464	710	15	11
Surrey	37	24	36	10	7

Source: Education funding agency

Post-natal contraception

20% of conceptions to under 18s are repeat pregnancies[22] highlighting the importance of post-natal contraception for teenage mothers. The Teenage Pregnancy Unit suggests that care pathways for post-natal contraception for teenage mothers should ensure that discussions about post-natal long-acting reversible contraception (LARC) methods should begin during pregnancy as part of antenatal care.

There is evidence from working with young in parents in Surrey, that young parents experience difficulties in accessing sexual health services. For example, as a result of feedback from young parents they have been working with, the Youth Support Service have provided support to access sexual health services to approximately 10 young parents over the last 2 years. The young parents indicated that they lacked information about what services were available and where. This issue was explored further in the focus groups conducted with young people.

Engaging teenage fathers

The Department of Health document, A Framework for Sexual Health Improvement in England[3], acknowledges that needs of boys and young men are different to that of girls and suggests that approaches tailored specifically for boys should be considered. The document stresses the importance of addressing issues such as relationships, consent, contraception and infections from a young man's perspective; and suggests links with sport as an approach.

There is very little data on teenage fathers but health, economic and employment outcomes for young fathers post-parenthood seem to be similar to those of young mothers. Although Teenage Parent's Groups are open to fathers as well as mothers, nationally they are predominantly used by teenage mothers. This picture seems to be true for Surrey Teenage Parent's Groups with very few fathers accessing them.

Teenage Parent's Groups

There are a number of Teenage Parent Groups operating in Surrey. The groups are run by either Surrey County Council Services for Young People, the Youth Support Service, health services (midwives or health visitors) or Children's Centres. In some cases they are run in partnership. The groups provide support with a wide range of issues affecting teenage parents in an appropriate informal setting including advice on sexual health, contraception and services available locally.

7.8 Sexual Health Outreach Workers

Two part-time nurses working in Spelthorne and in Elmbridge and Mole Valley are commissioned by Surrey County Council Public Health and provided by Virgin Care. The aim of these roles are to provide a flexible service for young people in a variety of settings including:

- a sexual health drop;
- a twice monthly sexual health promotion session for STEPS (Surrey Training & Education Programme);
- access to Chlamydia screening and the Get it On – C Card condom scheme;
- sexual health promotion sessions in secondary schools;
- collaborative working with Surrey County Council Youth Support Service including the Keep Safe Project.

The Family Nurse Partnership

The Family Nurse Partnership (FNP) is an evidence-based, preventive programme offered to young mothers having their first baby. It begins in early pregnancy and its focus is the future health and well-being of the child, as well as the future social benefits and economic self-sufficiency of the parents. It benefits those mothers with low psychological resources: low educational achievement, limited family support and poor mental health. However it is offered universally to all first-time teenage parents-to-be[23].

FNP is a nurse-led, intensive home visiting programme - intensive enough to make a difference, a targeted element of the Healthy Child Programme (HCP) and one of a range of established Early Intervention programmes (Cabinet Office 2006). FNP is a licensed programme with structured visits and interventions; and well-tested theories and methodologies. The help offered covers a wide range of issues, including parenting, child behaviour and practical problem solving[23].

7.9 Looked After Children & Young People

Surrey Looked After Children (LAC) Health Needs Assessment 2014

Children and young people who are looked after share many of the same health risks and problems as their peers, but often to a greater degree. They often enter care with a worse level of health than their peers due to the impact of poverty, abuse and neglect. About 60% of children and young people who are looked after in England are reported to have emotional and mental health problems and a high proportion experience poor health, educational and social outcomes after leaving care. Children in Surrey are, in general healthier than children living in other parts of the Country and this may make the health gap between Looked after children (LAC) and other children even greater.

LAC Sexual Health Needs

21 of the 27 (77.8%) KS4 LAC that responded to the questionnaire answered questions relating to sexual experience. 38% of these said that they were either currently in a sexual relationship or had been previously. The sample size does not allow us to say definitely that this is higher than we would expect to see in a sample living with their family. One KS3 pupil also reported having had sex in a previous relationship.

LAC are exposed to greater risk factors for teenage pregnancy than many other groups. Risk factors include socio-economic deprivation, low educational attainment, and lack of consistent positive adult support, having a teenage mother,

low self-esteem and experience of sexual abuse.

53% (n=129) of professional respondents on the online survey felt they could identify the risks and respond appropriately to children with sexual health issues either well or very well, whilst 12% did not feel they could respond well or very well.

7.10 Pornography

A survey for the Channel 4 programme Sex Education versus Pornography found 60% of 14 to 17 year olds agreed that "pornography might give boys or girls false ideas about sex", and three in 10 said they learn about sex from porn[24].

A BBC survey of 18-24 year old men found: 60% men (18-24) say porn has harmful effects; a quarter of all men in the survey said they were worried about the amount of porn they were looking at, while almost as many said they were concerned about the type of images they were viewing; 1 in 5 men worry that porn is influencing their behaviour[25].

A recent poll conducted by Young Minds[26] showed that of the young people who took part in the poll:

- one third aged between 11 and 14 years old and half aged between 15 and 17 years old had watched online pornography on a tablet or mobile phone
- three quarters of the 11-14 year olds described their reaction to watching pornography as disturbed, upset, worried or excited
- over half of 11-14 year olds and four out of ten of the 15-17 year olds, who had viewed pornography, said it had affected their relationships
- a quarter of 11-14 year olds said they had viewed pornography with a group of friends

Young Minds also concluded that for many children and young people exposure to online pornography is their sex education and what they see are often violent portrayals of sex that lack the love and respect that young people need in order to understand the key ingredients of healthy sexual relationships. Pornography makes girls feel they have to act like porn stars and boys feel they have to act like they are constantly ready for sex and want to dominate and control women. All this creates insecurity, self esteem issues, shame, anxiety, fear and increases stress and pressure for both boys and girls.

The recently published supplementary advice[71] on teaching sex and relationships (SRE) in schools includes the following on pornography:

> "It is helpful to address the issues surrounding pornography and there is widespread support from parents who recognise the need for this. Teaching should emphasise that pornography is not the best way to learn about sex because it does not reflect real life, and can therefore be worrying, confusing and frightening for young people. Some young people may be concerned that their use of pornography is becoming compulsive – teachers should recommend talking about this to a trusted, non-judgmental adult. Pupils must also learn that some pornography – child abuse images, for example – is illegal for any age.
> SRE should enable all young people to understand pornography's influence on gender expectations of sex. It should build on earlier learning about relationships, body image, consent and gender, which begins in primary school with discussions about the importance of loving and respectful relationships. Pupils should understand that

pornography shows a distorted image of sex and relationships, including 'perfect' bodies and exaggerated sexual prowess. SRE provides opportunities to discuss body image and understand how pornographic pictures and videos are routinely edited and 'photoshopped'. Pornographic images must never be shown to pupils, and there is no need for teachers to look at pornography to plan their teaching."

7.11 Sexting

'Sexting' is defined as the exchange of sexual messages, images or films and/or creating, sharing and forwarding sexually suggestive, nude or nearly nude images through mobile phones or the internet. A recent qualitative study conducted by the NSPCC[27], although small scale, served to highlight that the issue of 'sexting' amongst young people is more complex and varied than portrayed in the media. Statistics range between 15% and 40% of young people being involved in 'sexting' depending on age. The NSPCC study suggested that 'sexting' tends to be between peers and social media 'friends'. Young people who took part in the study thought that issues around 'sexting' and pornography should be discussed in school alongside other e safety issues.

It is also important to make young people aware that, essentially, 'sexting' is classed as a criminal offence as it constitutes sharing and/or possessing an indecent image of a child under 18. Although it is uncommon for a child to be prosecuted, a conviction would result in the person being put on the sex offenders register for life. The recently published supplementary advice[15] on teaching sex and relationships (SRE) in schools includes the following on 'sexting':

"'Sexting' and other self-made images and messages of a sexual nature, raise particular issues of safety, privacy, peer influence and personal responsibility. 'Sexting' is a term used by adults, referring to sexual content and images sent by mobile phone (though other digital communication raises similar concerns). Young people may use their own terms, including 'selfies', 'nudes' or 'fanpics'.

Research shows that sexting is of most concern to young people in their early teens. Schools should address privacy and boundaries from a very early age in the context of personal safety and abuse. Specific work about 'sexting' should be addressed in SRE as soon as it is identified as a potential issue. Teaching should cover communication skills, attitudes and values, the law, acceptable and unacceptable behaviour, and how to seek help.

Pupils should learn that it is illegal to produce, possess or distribute an indecent image of a person under the age of 18 – even if it's a picture of themselves. These laws have been created to protect children and young people. It is therefore unlikely that the police would prosecute a young person unless they were concerned that images were being used to harass or coerce, or shared with intent to harm."

7.12 Child Sexual Exploitation (CSE)

Child Sexual Exploitation is one of Surrey Safeguarding Children Board's top 4 priorities. A long-standing sub group of the Board is responsible for developing an action plan to implement the requirements of the Department for Education CSE Guidance document[28] at a local level.

As part of the action plan, a CSE awareness raising programme took place in Surrey during the first quarter of 2014. The programme included a drama workshop called Chelsea's Choice offered free of charge to secondary schools (LA funded, special, academies, PRUs and independent); plus information sessions and literature for parents/carers. A total of 43 schools hosted workshops with approximately 7,000 pupils from school years 9, 10 & 11 attending. Approximately one new disclosure of CSE was made following each workshop suggesting that the programme was successful in raising awareness of the issue and encouraging young people to come forward for help.

7.13 Young People's Involvement in Gangs & Associated Sexual Violence/Exploitation

A recent report[29] produced by the Office of the Children's Commissioner concludes that the issue of gang related sexual exploitation and sexual violence must be included in local action plans to implement the Department for Education CSE Guidance document. It also concludes that this issue should be included in Relationships and Sex Education programmes which must be provided by trained practitioners, in every educational setting, for all children as part of a holistic/whole-school approach to child protection that includes internet safety and all forms of bullying and harassment and the getting and giving of consent.

7.14 SCC Youth Support Service (YSS) Targeted Support Offer

The YSS have recently developed their offer to include young people from the age of 14 years (previously 16 years). Their thresholds for intervention include:

- Children, or young people who pose a risk to themselves; through significant self-harm, frequent and extended periods of absconding that puts them in danger, serious drug misuse, sexually harmful behaviour, persistently aggressive behaviour.
- Children at risk due to actual, or likely contact with persons who pose a risk to children and/or young people, i.e.: convicted of causing harm to children, on the sex offender's register.
- Unhealthy sexual / intimate partner relationships e.g. where IPV is known or suspected, unsafe sex with multiple partners, frequent use of morning after pill etc
- At risk of sexual exploitation / prostitution

8 Specialist Services for Young People

Surrey has a number of free to user services that are commissioned specifically for young people under 25 years old.

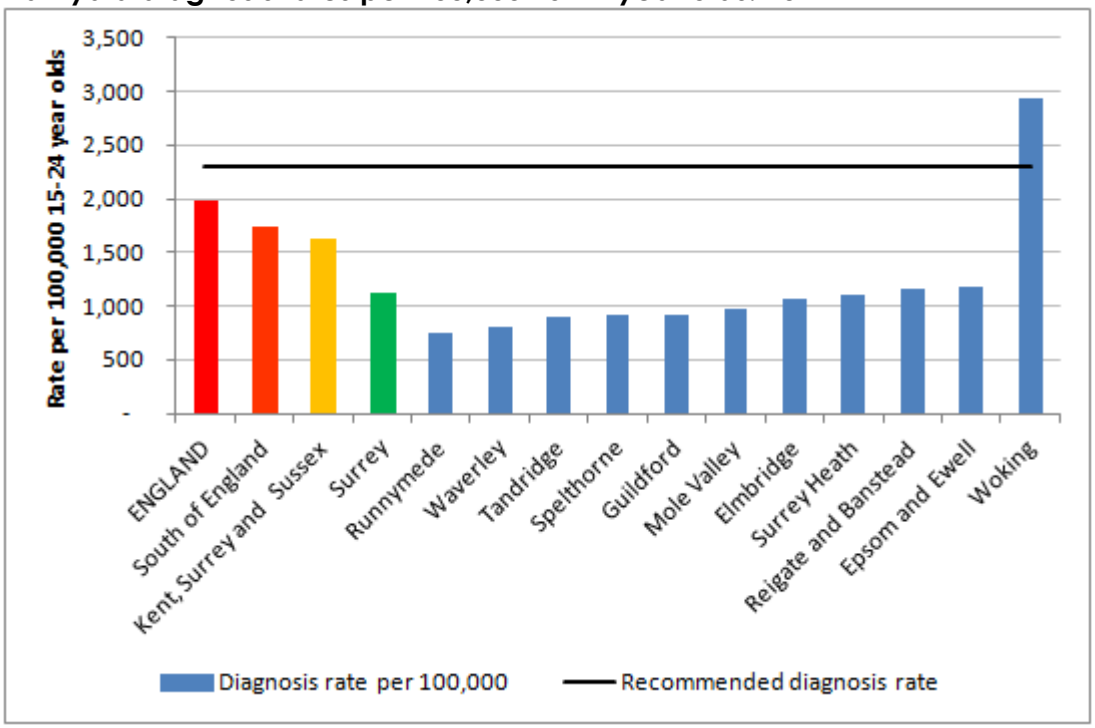
- Chlamydia and Gonorrhoea testing
- Condom distribution scheme
- Emergency contraception

These are delivered in a variety of settings from schools and colleges, outreach and youth centres, clinic and in pharmacies under Public Health Agreements.

8.1 Surrey Chlamydia Screening Programme

The National Chlamydia Screening Programme (NCSP) aims to test all sexually active people under the age of 25 annually or with each change of sexual partner as a routine part of primary care and sexual health consultations. In Surrey young people are dual tested for Chlamydia and Gonorrhoea.

Figure 6: Chlamydia diagnosis rates per 100,000 15-24 year olds: 2012



Source: National Chlamydia screening programme (NCSP)

FOCUS GROUP: What do you know about...

...Chlamydia Screening?

Groups had varied knowledge on Chlamydia Screening, those that knew had experience of it being offered in their school or college and were aware of the testing procedure of urine samples or swabs. A small number of participants across the three focus groups knew that test kits can be sent home.

8.2 Get it On – C Card condom distribution scheme

Get it On is the condom distribution scheme in Surrey providing free condoms to young people under 25 who have registered for a c-card. Outlets include school, colleges, youth centres and some pharmacies.

FOCUS GROUP: What do you know about...

...C-Card/ Get It On Scheme?

Focus groups knew about the c-card scheme but had limited information. Young people generally didn't recognise name or know what the scheme involved including what is asked at registration. One of the focus group venues also offered C-Card but participants were unaware of this.

8.3 Emergency Hormonal Contraception (EHC)

EHC in Surrey is primarily provided by community contraception and sexual health clinics (CaSH), Primary care, walk-in centres and pharmacies. EHC is free to young people under the age of 25. Additionally EHC in pharmacies contributes to the Teenage Pregnancy strategy. A review into EHC provision in pharmacy in 2014 showed that 81 pharmacies in Surrey have been commissioned to provide this service.

FOCUS GROUP: What do you know about...Emergency Contraception?

Several participants had accessed EHC for themselves or with a friend at a pharmacy and were unaware that it is available for free for under 25s in some pharmacies. General awareness was that it is available in pharmacies at a cost of £26. Young people did know that sexual health clinics provide EHC for free and said they would wait to access the free service on a Monday rather than pay at a pharmacy

8.4 HPV vaccination

The human papilloma virus (HPV) vaccination programme was introduced in 2008. This vaccine protects against the two virus types that cause over 70% of cervical cancer. The vaccine does not protect against all of the other cancer-causing types, so it's vital that women still go for routine cervical screening tests when they are older. All girls aged 12 to 13 years will now receive the HPV vaccine routinely in year 8 at school. Three injections are required over a period of around six months.

So far only one study has been conducted looking at the effectiveness of the programme[30]. The study concluded that first indications seemed to show that the national HPV immunisation programme is successfully preventing HPV16/18 infection in sexually active young women in England. However, continued surveillance is required.

Surrey operates a predominantly school based programme for delivery of the HPV vaccinations. Although no target has been set for coverage, uptake figures for 2012-2013[31] show that uptake of all 3 doses in Surrey (64.8%) is well below the average for England (86.1%).

HPV is now the major cause of oropharyngeal cancer in developed countries, detected in 90% of cases.

There is also a connection between HPV and oral cavity cancers[32]. A rise in incidence of oral cancers in younger people has been attributed to this link prompting the government advisory group, the Joint Committee on Vaccination and Immunisation, to consider extending the HPV vaccination programme to include boys as well as girls.

8.5 Choice

Sexual health services are open access meaning anyone can use a service in any area. Understanding how and why Surrey young people choose *to* access or choose *not to* access services is crucial to improving and providing high quality sexual health services:

FOCUS GROUP: How would you choose a service to go to? Where would you prefer to go for advice and information health sexual health services?

- Recommendation from friends; about service, friendliness of staff,
- Relationship with staff member; being able to seeing the same staff member- building a relationship and feeling comfortable talking the staff member was a factor across all three focus groups.
- Location; being close by, easy to access (walking/public transport) or the choice to go somewhere away from people you know;
- At youth centre/ offered by youth worker;
- Staff not knowing young person's family or being a friend of the family;
- Opening times; being open in an evening or at a weekend for people at college or work, being open most days of the week- one group said the centre near them is closed three days in a row which makes access difficult;
- Not being asked too many questions;
- Drop-in services; so you can go anytime especially if you have a baby
- Young people or LGBT only service;

FOCUS GROUP: Why do you think young people choose not to access services?

Reasons young people choose not to access services given across the focus groups were:

- need encouragement;
- laziness;
- confidentiality being broken;
- being recognised/ seeing someone they or their family knows;
- mum finding out;
- being judged;
- thinking young people won't be at a service, that it'll be older people.

FOCUS GROUP "I don't think complaining would change anything"

"Young people do complain but not to the right people"

When asked if they were happy or unhappy with a service would they feedback, young people said they would verbally tell friends, family (sister, cousin, mum), youth worker or 'rant on facebook'. If providing feedback at a service, they would during a consultation but not afterwards. Some had fed back using the smile face boxes and counter system but said 'putting a sad face doesn't tell you a lot".

9 Over 25 year olds

The National Framework for Sexual Health sites the following ambitions:

Improve sexual health outcomes for young adults:

- all young people are able to make informed and responsible decisions, understand issues around consent and the benefits of stable relationships, and are aware of the risks of unprotected sex;
- prevention is prioritised;
- all young people have rapid and easy access to appropriate sexual and reproductive health services;
- all young people's sexual-health needs – whatever their sexuality – are comprehensively met.

All adults have access to high quality services and information:

- individuals understand the range of choices of contraception and where to access them;
- individuals with children know where to access information and guidance on how to talk to their children about relationships and sex;
- individuals with additional needs are identified and supported;
- individuals and communities have information and support to access testing and earlier diagnosis and prevent the transmission of HIV and STIs.

People remain healthy as they age:

- people of all ages understand the risks they face and how to protect themselves;
- older people with diagnosed HIV can access any additional health and social care services they need;
- people with other physical health problems that affect their sexual health can get the support they need for sexual health problems.

Figure 7: Sexual & Reproductive Health Profile: South East Region

Figures 7 and 8 below compare Surrey with other areas in the South East region, it shows that Surrey has generally good sexual health but that areas of focus for the over 25 population are contraception, at risk groups and termination of pregnancy.

Compared with benchmark: Better | Similar | Worse | Lower | Similar | Higher | Not compared

Indicator	Period	England	South East region	Bracknell Forest	Brighton and Hove	Buckinghamshire	East Sussex	Hampshire	Isle of Wight	Kent	Medway	Milton Keynes	Oxfordshire	Portsmouth	Reading	Slough	Southampton	Surrey	West Berkshire	West Sussex	Windsor and Maidenhead	Wokingham
Syphilis diagnosis rate / 100,000	2014	7.8	5.2	1.7	60.8	1.6	4.1	2.2	0.7	2.8	3.3	2.3	3.0	3.9	6.9	2.1	7.4	3.6	2.6	5.8	4.8	3.2
Gonorrhoea diagnosis rate / 100,000	2014	63.3	36.2	25.7	202.8	25.0	27.9	15.3	8.7	24.2	28.0	52.8	50.7	64.6	79.8	44.0	42.1	29.6	17.4	37.3	27.3	29.1
Chlamydia detection rate / 100,000 aged 15-24 (PHOF indicator 3.02) <1,900 1,900 to 2,300 ≥2,300	2014	2012	1682	1719	2010	1409	1961	1285	1893	1738	2048	2298	1310	1883	2799	1912	2379	1296	945	2082	1575	985
Chlamydia proportion aged 15-24 screened	2014	24.3	22.1	21.4	36.9	19.1	22.0	17.5	28.2	22.5	26.9	30.6	20.9	24.6	33.8	23.0	29.1	16.5	10.9	22.9	20.9	13.1
All new STI diagnoses (exc Chlamydia aged <25) / 100,000	2014	829	649	536	1534	576	598	419	510	563	652	648	777	875	1094	732	899	614	512	702	581	538
HIV testing coverage, total (%)	2014	68.9	68.1	54.4	79.3	70.4	49.7	62.8	61.8	77.4	75.5	74.3	80.1	54.3	56.6	59.3	65.0	74.7	58.5	69.0	61.5	58.7
HIV late diagnosis (%) (PHOF indicator 3.04) <25% 25% to 50% ≥50%	2012 - 14	42.2	45.3	66.2	29.8	53.7	32.4	48.1	*	52.8	45.9	65.9	44.4	55.3	48.5	44.2	37.5	48.0	0.0	43.0	38.7	39.1
New HIV diagnosis rate / 100,000 aged 15+	2014	12.3	7.5	5.3	32.3	5.7	2.9	3.0	1.7	4.3	6.8	14.2	3.4	8.1	16.9	18.2	6.9	4.5	2.4	6.4	10.8	4.7
HIV diagnosed prevalence rate / 1,000 aged 15-59 <1 1 to 2 ≥2	2014	2.22	1.70	1.56	8.06	1.39	1.69	0.97	0.59	1.18	1.44	2.97	1.13	1.85	3.07	3.68	2.18	1.37	0.75	1.71	1.51	1.07
Population vaccination coverage - HPV (%) (PHOF indicator 3.03xii) <previous year's England value ≥previous year's England value	2013/14	86.7	84.6	88.3	84.0	88.4	51.1	90.1	92.0	85.0	84.9	84.5	92.5	92.1	85.6	85.1	89.2	84.6	85.1	87.1	84.0	87.5
Abortions under 10 weeks (%)	2014	80.4	80.6	81.0	81.9	*	79.6	78.4	73.7	81.9	83.1	83.5	76.2	82.5	84.3	82.3	75.8	82.4	83.2	*	82.8	84.3
Under 25s repeat abortions (%)	2014	27.0	25.4	26.2	23.5	*	24.6	23.4	14.3	25.8	30.6	26.9	*	25.5	33.0	24.5	28.4	27.1	26.3	21.6	26.3	26.0
GP prescribed LARC rate / 1,000	2014	55.2	59.6	62.2	56.0	56.9	62.1	66.0	89.1	60.9	48.4	65.3	65.0	35.3	70.8	26.6	54.7	51.2	74.0	67.7	49.4	56.1
Under 18s conception rate / 1,000 (PHOF indicator 2.04)	2013	24.3	20.5	14.6	25.0	17.2	22.3	19.5	32.1	22.9	33.4	24.1	16.5	24.8	23.1	19.0	36.2	15.7	18.5	18.9	13.5	12.0
Under 18s conceptions leading to abortion (%)	2013	51.1	52.9	78.8	66.7	55.1	51.0	55.1	42.9	47.8	40.4	55.5	48.4	37.8	53.6	46.0	45.0	64.1	61.4	58.8	72.2	50.0
Sexual offences rate / 1,000 (PHOF indicator 1.12iii)	2014/15	1.40	1.36	1.47	1.81	1.18	1.41	1.31	1.70	1.32	1.72	1.81	1.33	2.03	1.93	1.80	2.62	0.92	1.20	1.20	1.16	0.89

Source: Public Health England

Figure 8: Sexual & Reproductive Health Profile Surrey

Indicator	Period	Surrey		Region	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Syphilis diagnosis rate / 100,000	2014	42	3.6	5.2	7.8	132.1		0.7
Gonorrhoea diagnosis rate / 100,000	2014	341	29.6	36.2	63.3	633.9		8.7
Chlamydia detection rate / 100,000 aged 15-24 (PHOF indicator 3.02) <1,900 1,900 to 2,300 ≥2,300	2014	1,686	1,296	1,682	2,012	945		4,270
Chlamydia proportion aged 15-24 screened	2014	21,468	16.5%	22.1%	24.3%	10.9%		48.7%
All new STI diagnoses (exc Chlamydia aged <25) / 100,000	2014	4,499	614	649	829	3,190		383
HIV testing coverage, total (%)	2014	19,448	74.7%	68.1%	68.9%	20.8%		86.1%
HIV late diagnosis (%) (PHOF indicator 3.04) <25% 25% to 50% ≥50%	2012 - 14	73	48.0%	45.3%	42.2%	70.0%		0.0%
New HIV diagnosis rate / 100,000 aged 15+	2014	43	4.5	7.5	12.3	85.4		0.0
HIV diagnosed prevalence rate / 1,000 aged 15-59 <1 1 to 2 ≥2	2014	924	1.37	1.70	2.22	0.25		15.08
Population vaccination coverage - HPV (%) (PHOF indicator 3.03xii) <previous year's England value ≥previous year's England value	2013/14	5,363	84.6%	84.6%	86.7%	51.1%		96.6%
Abortions under 10 weeks (%)	2014	2,432	82.4%	80.6%	80.4%	62.0%		88.5%
Under 25s repeat abortions (%)	2014	343	27.1%	25.4%	27.0%	37.1%		14.3%
GP prescribed LARC rate / 1,000	2014	11,037	51.2	59.6	55.2	7.7		100.6
Under 18s conception rate / 1,000 (PHOF indicator 2.04)	2013	315	15.7	20.5	24.3	43.9		9.2
Under 18s conceptions leading to abortion (%)	2013	202	64.1%	52.9%	51.1%	35.2%		83.3%
Sexual offences rate / 1,000 (PHOF indicator 1.12iii)	2014/15	1,060	0.92	1.36	1.40	0.76		3.48

Source: Public Health England

9.1 Sexually transmitted infections

Sexually transmitted infections (STIs) represent an important public health problem in the South East. Out of all the Public Health England centres it has the ninth highest rate of new STIs in England.

Over 53,400 new STIs were diagnosed in South East residents in 2014, representing a rate of 626 diagnoses per 100,000 population. Rates by upper tier local authority ranged from 413 new STI diagnoses per 100,000 population in Hampshire to 1,454 new STI diagnoses per 100,000 population in Brighton and Hove.

The number of new STIs diagnosed in South East residents remained the same between 2013 and 2014. Numbers of three of the five major STIs rose: syphilis increased by 55%, gonorrhoea by 23% and chlamydia by 6%. Numbers of genital herpes decreased by 4% and genital warts by 9%.

PHE messages

- Prevention efforts should include ensuring open access to sexual health services and STI screening and should focus on groups at highest risk.

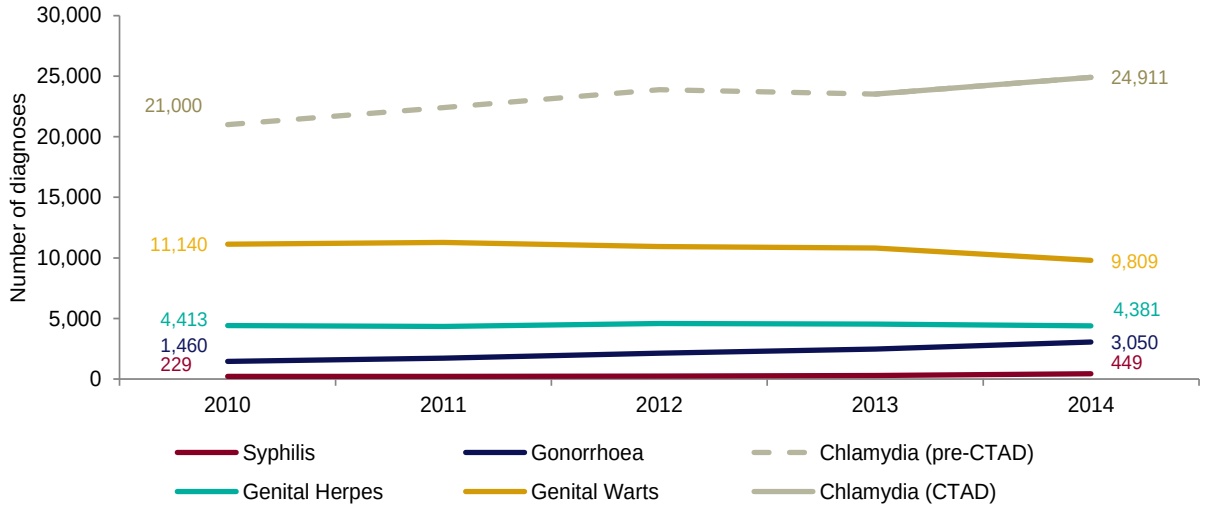
- MSM should have a full HIV and STI screen at least annually, or every three months if having condomless sex with new or casual partners.

- Black African men and women should have a regular full HIV and STI screen if having condomless sex with new or casual partners.

- Individuals can significantly reduce their risk of transmitting or being infected with an STI by:
    - Consistently and correctly using condoms until all partners have had a sexual health screen
    - If in a high-risk group, getting screened regularly to ensure early identification and treatment, as these infections are frequently asymptomatic

- Reducing the number of sexual partners and avoiding overlapping sexual relationships

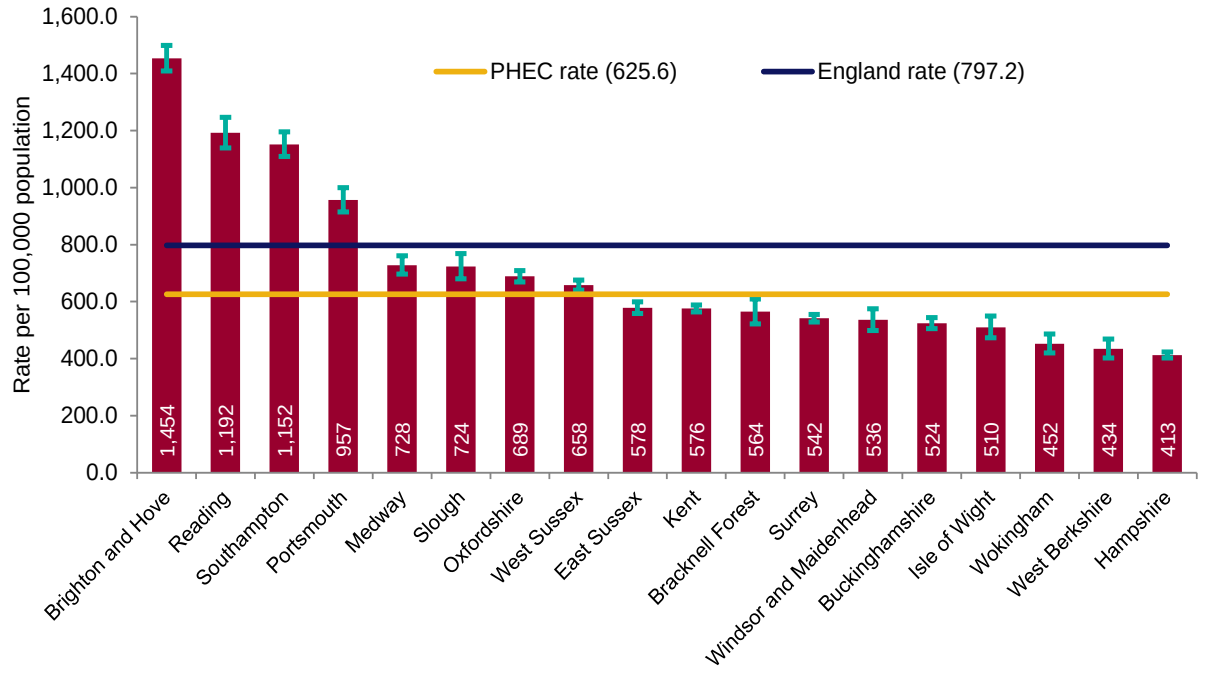
Figure 9: STI New Diagnoses 2010-2014



Source: PHE STI data tables for England

Incidence in Surrey

Figure 10: Rate of new STI diagnoses per 100,000 population among South East residents by local authority of residence: 2014



Source: PHE STI data tables for England

Antibiotic resistant strains of Gonorrhoea

Neisseria gonorrhoeae is the second most common bacterial STI in the United Kingdom. High gonorrhoea transmission rates are concerning as the global threat of antibiotic resistance grows[33]. Ensuring treatment resistant strains of gonorrhoea do not persist and spread remains a public health priority. In early 2013 the Gonorrhoea Resistance Action Plan[34] for England and Wales was launched by Public Health England to help tackle this threat.

9.2 Contraception

There is evidence that investment in sexual health prevention is cost effective and can actually generate cost savings in other areas of public spending. The Department of Health[3] state the following:
for every £1 spent on contraception, £11 is saved in other healthcare costs;
the provision of contraception saved the NHS £5.7 billion in healthcare costs that would have had to be paid if no contraception at all was provided;
National Institute for Health and Clinical Excellence (NICE) Clinical Guideline CG30 demonstrated that (LARC) is more cost effective than condoms and the pill, and if more women chose to use these methods there would be cost savings.
Improved awareness and access to all methods of contraception including long-acting reversible contraception (LARC) methods and emergency hormonal contraception are two of the ambitions set out in the Framework for Sexual Health Improvement in England[3].

Contraceptive use - data for England

During the period April 2013 to March 2014[35] there were 2.2 million attendances at NHS community contraceptive clinics made by 1.19 million women and 150,000 men. This represented a decrease of 2.2% (49,844) on the number of attendances in 2012/13 (2.3 million) and a decrease of 0.9% (12,703) on the number of individuals in 2012/13.

Among women who attended NHS community contraceptive clinics, the 18-19 year old age group had the highest number of attendances per population at 22%, followed by 16-17 year olds at 19% and 20-24 at 17%. An estimated 9% of women in aged 25-34 visited a clinic during the year while the equivalent proportion for those aged 35 and over was 7%.

Oral contraception was the most common method of contraception for those in almost every age group. It was the most common method for females aged 15 attending NHS community contraceptive clinics (46% chose oral contraception), for those aged 16-17 (50%), 18-19 (54%), 20-24 (54%), 25-34 (45%) and 35 and over (33%).

Eighteen per cent of the women attending NHS community contraceptive clinics in 2013/14 were recorded as using the male condom. In 2013/14, the male condom was used more widely amongst the youngest age group (36% of females aged under 15 who attended a clinic).

The use of Long Acting Reversible Contraceptives (LARCs) as a primary method of contraception amongst women has been slowly increasing and now accounts for 31% of primary methods of contraception among women who attended NHS community contraceptive clinics. This is an increase on 2011/12 when it was 28%. LARCs are comprised of Intra-Uterine Devices - IUD (4% of all primary methods of contraception), Intra- Uterine System - IUS (5%), Injectables (9%) and Implants (13%). The percentage of those choosing LARCs as a primary method of contraception increased with age, (19% of those aged under 15 compared to 43% of those 35 and over).

9.3 Emergency Contraception

In England, during the period April 2013 to March 2014 there were approximately 118,000 contacts in relation to Emergency Hormonal Contraception (EHC) at NHS community contraceptive clinics, a decrease of 10.6% (14,000) on 2012/13.

9.4 Key Issues; Contraception

Prescriptions for contraceptives (FP10) dispensed in the community as part of the GP contract

This provision is funded by NHS England as detailed in section 3.1 above. Data for England shows that prescriptions for Long Acting Reversible Contraceptives (LARCs) have increased from 0.7 million in 1997/98 to 1.3 million in 2012/13. During the same period prescriptions for user dependent methods, such as oral contraception, have remained stable varying between 7.5 and 7.8 million.

Ulipristal Acetate

A new emergency oral contraception method, Ulipristal Acetate (UA or ellaOne®) was introduced in 2009. It is licensed for use up to 5 days (120 hours) after unprotected sexual intercourse (UPSI). The Faculty of Sexual & Reproductive Healthcare Clinical Effectiveness Unit have undertaken a review of effectiveness[36] which broadly concludes that, whilst more expensive than progesterone only emergency contraceptive (POEC) methods (e.g. Levonelle ®), Ulipristal Acetate may be more cost effective due to the fact that it can be used up to 5 days after unprotected sexual intercourse. The review also included a comparison of efficacy rates: UA 98-99% within 120 hour of UPSI; POEC 84% within 72 hours of UPSI.

Ulipristal Acetate (ellaOne®) is not currently available free of charge to under 25s through pharmacies in Surrey but it is available at all CASH clinics in the county.

Long Acting Reversible Contraception provision post termination of pregnancy

The Royal College of Obstetrics and Gynaecology guidelines on termination of pregnancy[37] state that abortion services should be able to provide all methods of contraception (including long-acting methods) immediately after abortion; contraception should be discussed with all women before discharge; the advantages of LARC explained and supplies/a LARC method offered; the chosen method of contraception should be initiated immediately or information about local sexual health services given if the women chooses not to take up the offer of contraception at that time.

Feedback from sexual health services in Surrey indicate that this may not be happening at abortion providers commissioned for Surrey residents.

10 Key population groups

10.1 Sex Work

Sex work or prostitution carries a high risk of sexually transmitted infections for both the sex worker and their customers. The people involved in sex work often face challenges such as substance use, limited access to services, violence and exploitation. It is estimated that there are about 80,000 sex workers in the UK up to 20,000 of which could be migrants[38]. Street-based sex work accounts for about one third of this number with indoor activity such as brothels, escort work and 'parlours' accounting for the remainder.

There are thought to be over 120 men and women involved in sex work in Surrey. It is difficult to give an accurate figure for the number of sex workers due to the covert nature of sex work and its transient nature. In Surrey there is no street based sex work or 'red light district'. Sex work in Surrey is indoor and takes place in brothels, through escort agencies, in sex workers homes, at lorry parks, or ad hoc in a variety of places such as pub toilets, cars and wooded areas. There tend to be clusters of sex work in areas close to Heathrow and Gatwick airports and the larger towns in Surrey. One to one contact with sex workers takes place in a variety of settings: working flats or brothels; cafes or other public places; in a worker's car; escort agency base; clinic or other health service venue; sex worker's own home; hotels; at social events; lorry parks/truck stops and 'dogging' sites. Engaging those involved in sex work with services is not easy due to the legal issues associated with prostitution and their fears around disclosure. This can lead to sex workers being marginalised, leaving them vulnerable. Repeat contact with individual sex workers can be challenging as they are often transient, not resident in Surrey, under the control of another person or lead very chaotic lifestyles.

The profile of prostitution is currently being raised through government[39] and police strategy[40, 41]. The Department of Health strategy on sexual health, A Framework for Sexual Health Improvement in England[3], identifies those involved in prostitution as a specific target group in need of specialist sexual health services. The strategy recognised the particular risks inherent in this group, their vulnerability and their particular access requirements. It recommends that specific local services should be provided to address their sexual health needs; and that commissioners and service providers should work together to overcome the common barriers that those involved in prostitution face when accessing services, including stigma, discrimination and social exclusion.
In recent years the picture of prostitution in Surrey has changed due to a large number of brothel closures resulting in an increase in lone working, out-calls escort agency work and porn industry work. This has impacted on the work of the Harm Reduction Outreach Team in two main ways. Firstly, it has made contacting sex workers in Surrey much more difficult and time consuming. Second, it has increased the risks faced by sex workers as lone working, out-calls and escort agency work is much less safe for the sex workers than working in a brothel. In order to address these issues, the Surrey Harm Reduction Outreach Team have undertaken liaison work with Surrey police in order to develop a more positive relationship and partnership working to improve policing of sex work and enable sex workers to feel more supported by the police in Surrey.
Very recently two new ways of working have been observed amongst sex workers in Surrey: 'pop-up' brothels (brothels opening up and closing within a month or two) and 'tours' (sex workers advertise on

line that they will be in a particular town on a particular day, customers book an appointment to visit the sex worker at a hotel). Both working practices are fairly transient meaning that making contact with these sex workers and building a relationship with them can be challenging.

10.2 Sex Worker Services

The following services are available for sex workers living and/or working in Surrey:

Harm Reduction Development Worker for sex workers

A part-time (0.4 fte) worker commissioned by Surrey County Council Public Health and provided by Surrey Harm Reduction Outreach Team (SHROT) as part of the Virgin Care block contract. This post has a key role in liaising with other key services in and Surrey and the south east region to ensure access to appropriate services to promote the sexual health and physical & emotional safety of sex workers living and/or working in Surrey. The Harm Reduction Development Worker provides specialist advice and advocates for the needs of sex workers with local agencies such as Surrey Police, GUM services, Surrey Safeguarding Children Board, drug & alcohol services, female prisons in Surrey and the Surrey Sexual Assault Referral Centre (SARC); as well as undertaking direct face to face work with sex workers themselves.

The service is available to anyone involved in selling or exchanging sex including those working as prostitutes in the commercial sex industry, those forced into prostitution, those who use drugs and/or alcohol and sell sex in an ad-hoc fashion as well as people (children & adults) who are sexually exploited. The service is open to male, female and trans-gender sex workers. Face to face contact takes place in a variety of venues including: working flats or brothels; cafes or other public places; in a Worker's car; escort agency base; clinic or other health service venue; sex worker's own home; hotels; at social events; lorry parks/truck stops and 'dogging' sites. Sex workers are provided with specialist safer sex information & advice, safer sex supplies (e.g. condoms, dental dams etc), point of contact screening for chlamydia, HCV, HBV, pregnancy testing, literature, support to access the National Ugly Mugs Scheme, fast-track access to Surrey GUM/contraception clinics and referral to other appropriate services such as TOP, DA, drug & alcohol services the police and services for trafficked sex workers. Intensive support is given to individuals presenting with multiple risk factors. Proactive sexual health promotion work is undertaken in female prisons in Surrey and one to one support for prisoners being released to Surrey is given on request.

During the six month period from September 2013 – February 2014 the SHROT Development Worker for Sex Workers undertook 203 interventions with sex workers in Surrey, 150 of which were face to face.

'Delta' fast-track access to GUM clinics

Through on-going liaison and advocacy work between the SHROT Harm Reduction Development Worker for Sex Work and sexual health services in and around Surrey, a 'fast track' access to GUM clinics for sex workers has been developed using the code word 'Delta'. Provision of dedicated clinics for sex workers would not be appropriate in Surrey due to the large geographical area and transient nature of the sex worker population; development of the 'Delta' system is a more appropriate way of improving access to GUM services for sex workers in Surrey. Use of the word 'Delta' enables sex workers to disclose that they are sex

working in a discrete manner and alerts services to their screening and vaccination needs.

Surrey Police SPOC for sex workers

Through on-going liaison and advocacy work between the SHROT Harm Reduction Development Worker for Sex Work and Surrey Police, a female officer has been identified as a Single Point of Contact (SPOC) for Sex Workers to enable sex workers to report crime committed against them and help improve confidence in the police amongst sex workers in Surrey.

Ugly Mugs Scheme

Ugly Mug schemes have been operating at a local level for many years. The scheme was set up to improve the safety of sex workers by alerting them to dangerous individuals or groups who target and commit crimes such as rape, physical assault, robbery and murder against sex workers.

In 2012, a national Ugly Mugs scheme was launched as a pilot using e mail, text message and a mobile app to send and receive reports of incidents to sex workers who have opted in to the scheme. The Surrey Harm Reduction Outreach Team operate the scheme in Surrey with their sex worker clients.

10.3 People with Learning Disabilities

The sexual rights of people with learning disabilities are often overlooked and frequently only become an issue to be discussed when a problem arises[42]. Coping with puberty, sexual identity, and sexual feelings can be much more difficult for people with learning disabilities who might be struggling to understand their emotions and their bodies. Compared to their non-disabled peers, people with learning disabilities have a more limited and incomplete understanding of sexual health issues.

It is well documented[43] that people with learning disabilities want to know about sex, relationships and sexual health and want this as well as their need for friendship and relationships to be part of their care and health action plans. Most carers acknowledge that people with learning disabilities have the right to sexual expression but it is reported that staff feel under pressure to supervise the sexual expression of people with learning disabilities[44].

10.4 LGBT People with Learning Disabilities

The Lesbian, Gay, Bisexual and Trans Public Health Outcomes Framework Companion Document[45] stresses that Local government should ensure social workers and care providers have training to support LGB&T identified adults with learning disabilities and provide opportunities for them to safely express their sexual and gender identities.
The Harm Reduction Development Worker for Gay Men & MSM works on a one to one basis with gay men with learning disabilities. There has been an apparent increase in the number of referrals requesting support for men with learning disabilities who are gay or bisexual or who require information, advice and support to understand their sexuality. This seems to indicate that many service providers are recognising that the people they provide their services to are not all heterosexual. Men in this category are particularly at risk of being exploited as they want to learn about and have sex with men, but do not necessarily have the confidence or skills to communicate their wishes and negotiate the sexual activities they feel comfortable with. As a result, gay men with learning

disabilities can be easily coerced or forced to engage in activities dictated by the other person. Work with this client group is usually long term and involves working with their support networks as well as with the individual themselves. Appropriate social environments for these men are very few and far between and there are many organisational barriers that prevent men with learning disabilities from accessing the lifestyle that they feel would be right for them.

10.5 Physically Disabled People

Physical disability does not prevent sexual maturity, or remove sexual feelings, desires or curiosity. Some people wrongly regard disabled people as not developing sexually in the same way as non-disabled people. People with disabilities are sexual individuals with sexual desires and concerns that require the attention of health care providers. The largest myth about people with disabilities is that they are less sexual than people without disabilities. Some disabled people may have physical problems that can contribute to erectile dysfunction or to sexual arousal disorder. Their physical condition may involve the circulatory or nervous system or may be associated with anomalies in the spine that impact those systems. Pain, neurological damage or dysfunction or limitation of motion from injuries may depress interest in sex or sexual performance. The dysfunction also may be of psychological origin e.g. negative emotions may inhibit arousal; or low hormone levels might delay puberty or affect sexual performance or arousal[46]. Disability, however, does not prevent sexual maturity, or remove sexual feelings, desires or curiosity. Even if a disability does affect sexual function, the physical and emotional aspects of sexuality continue to be as important for disabled people as for non-disabled people. Opportunities for sexual relationships among disabled people, particularly the young, are very limited. Times of privacy might be rare, and disabled young people are much more likely to receive a negative reaction from adults if they are discovered. The need for privacy needs to be acknowledged and addressed, even if care needs make this inconvenient[47].

Disabled people have the right to accurate and complete information that will enable them to make choices about their sexual health and relationships. They require full and open education about sexuality, sexual development and safer sex; and support around issues of communication, self-image and self-esteem, relationships, and boundaries. Young disabled people need to prepare for adulthood and parents of young disabled people need to be ready to accept the upcoming adulthood of their child. The sexual and social development process should not be denied or inhibited, and where necessary, specialist information should be available for specific physical conditions[47].

There is anecdotal evidence from the SHROT Harm Reduction Development Worker that a number of their sex worker clients have customers with physical disabilities. The sex workers report that the men with disabilities who use their services do so as they feel unable to enter into sexual relationships because of their disabilities.

10.6 People with Sensory Impairment

Visual Impairment

Blindness or visual impairments do not have a direct effect on sexual development, or an individual's wish to pursue their sexual experiences. What may be necessary is additional support to access relevant and appropriate information, education and services.

Good quality, appropriate sexual health information and education should be available to all children, young people and adults. Nearly all forms of information around sexual health are visually based. Much information is gleaned by watching the behavior of others and building up an understanding of social norms and acceptability, as well as looking at pictures, reading magazines or watching television. Alternatives need to be provided for those who are visually impaired and the requirement to provide this, needs to be included in resource development, service development and education programmes for young people in schools and other environments[47].

Hearing Impairment

Although many of the sexual health issues faced by people who are deaf or have limited hearing are the same as for hearing people, it is the access to easily understandable information and support that may present the greatest difficulty. Service providers and their front-line staff really need to be aware of these issues and consider how they might modify their communication methods for example, the availability of interpreters, use of email, text message or on line booking systems[47].

10.7 People from Black & Minority Ethnic Communities

The United Kingdom's black and minority ethnic populations continue to be disproportionately affected by poor sexual health. The groups affected and their experiences of HIV and STIs vary greatly, reflecting the diversity present in the migratory patterns, socio-economic circumstances, and experiences of disadvantage and discrimination in these populations. Variation in the burden of STIs amongst BME groups is further influenced by a number of factors, including, diverse sexual attitudes and behaviours, patterns of sexual mixing, language barriers and access to sexual health services. For example, black Africans in the UK are particularly affected by HIV but, by comparison, black Caribbean populations in the UK experience a higher incidence of acute bacterial STIs, such as gonorrhoea, chlamydia and syphilis but lower HIV rates[48].

Table 5: Proportion of South East residents diagnosed with a new STI by ethnicity: 2014

Ethnic group	Number	Percentage (excluding unknown)
White	38,213	89%
Black Caribbean	561	1%
Black African	946	2%
Other BME	3,134	7%
Unknown	10,555	-

Table 6: Percentage of first time Surrey resident attendees by ethnic group compared to Surrey population BME community, 2012-13

Ethnic group	% 16-64 Surrey population (census 2011)	Number of first time attendees	% first attendees
White	89.7	28116	78.7
Black or Black British	1.3	1379	3.9
Asian or Asian British	6.4	762	2.1
British Mixed	1.6	609	1.7
Other ethnic groups	0.9	508	1.4
Not specified		552	1.5
Total		**35736**	**100**

Source: GUMCAD

10.8 People from Gypsy, Roma & Traveller Communities

It is estimated that there are between 200,000 and 300,000 Gypsies, Roma and Travellers in the UK, two thirds of whom are settled in homes rather than travelling[38]. The Traveller identity is often used as an umbrella definition for all populations coming from a nomadic cultural background, including Roma, Welsh, Irish, English and Scottish Gypsies, Roma, as well as fairground and boating communities.

There are striking inequalities in the health of Gypsies and Travellers, even when compared with people from other ethnic minorities or from socio-economically deprived white UK groups[49]. There are a range of contributory factors leading to poor health outcomes including low levels of literacy, stigma, poor access to health information and culturally held health beliefs. These communities experience difficulties accessing healthcare and are often reluctant to seek treatment because of their cultural beliefs about health or may underestimate the seriousness of a condition. When individuals do seek help from healthcare services; lack of cultural awareness, including racism, perceived judgemental behaviours, or inability to 'explain things properly' often contributes to the poor patient experience. The nomadic lifestyle complicates access to appropriate care: registration can be difficult, information is not being shared, and patients may have difficulty articulating their needs. Hence, they often travel long distances to see a professional they trust.

The Royal College of General Practitioners[38] recommends that commissioners of health services need to take the following into account in order to make healthcare accessible to members of the Gypsy, Roma and Traveller communities:

- **Information sharing** between different agencies is a key factor in improving access for Gypsies and Travellers, especially given their high mobility and complex needs

- **Community engagement** to establish a relationship and ensure that trust is gradually established, accessible services can be developed and a sense of ownership is created

- **Mainstream services:** feedback has indicated that these communities do not necessarily require dedicated services, unless in response to identified need, but would rather access the same good quality services as everyone else to reduce the issue of being 'different'.

Gypsy and Traveller societies are highly 'gendered'[50]. Significant taboos exist around sexual health, gynaecological matters and pregnancy related issues especially if women are being cared for by male staff. Low rates of cervical and breast screening have been found amongst these communities, with women expressing particular reluctance to attend clinics where no guarantee exists that female staff will be on duty. Most Gypsies, Roma and Travellers are opposed to sex education and dissemination of information about contraception. Inclusion of sex education in the school curriculum is often cited by parents as a reason for non-attendance at school or early school leaving.

10.9 Older People (50+)

There is evidence that there is an increase in STI rates in the UK amongst people over 50. HIV diagnoses in those over 50 are also rising[61] (see section 8 above). In response to this rise, Age UK conducted a study[51] of sexual health amongst older people in the

UK. 2,000 men and women aged 65 or older took part in the study which concluded that:

- most older people are keen to continue a fulfilling sex life
- many view sex as a taboo subject and find it difficult to discuss sex with their partner
- only 17% felt comfortable talking about sex to a health professional
- there was a lack of knowledge about sex with 76% of respondents not currently getting sexual health advice and only 14% having sought sexual health advice in the last 20 years
- many people were unsure where to go for help or advice.

10.10 Co-infection

Sexually transmitted infections (STIs) increase the risk of HIV infection by breaching protective mucosal barriers and recruiting susceptible immune cells to the site of infection. Ulcerative and non-ulcerative STI also create portals of entry for HIV to access susceptible cells. The association between ulcerative STI and HIV transmission is well established, with as many as half of newly HIV-infected people demonstrating herpes simplex virus infection. STIs can also cause genital bleeding, further increasing the risk of exposure to HIV during sexual activity.

HIV increases the risk of STI infection as the effect if HIV on immunity can increase susceptibility to other STI as individuals who are immune compromised are less able to mount a protective response against sexually transmitted pathogens.

10.11 People with Mental Health problems

The physical and sexual health needs of people using mental health services have been overlooked however there is an urgent need to understand and address the physical health needs of this population in order to improve life expectancy, quality of life and overall recovery[52]. People with ill mental health aspire to have positive and supportive intimate relationships however the reality is often more bleak. Research findings suggest that as a group, they are at greater risk of intimate partner violence and exploitation, as well as unplanned pregnancies and sexually transmitted infections. People with ill mental health may also require additional community or outreach support to access sexual health services.

10.12 LGBT people and mental health

Although attitudes towards gay people are improving, most lesbian, gay and bisexual people have experienced difficulties in their lives. Being gay does not, in and of itself, cause mental health problems. Instead, homophobic bullying, rejection from family, harassment at work and poor responses from healthcare professionals are still commonplace for many lesbian, gay and bisexual people. There is evidence[53] that lesbian, gay and bisexual people are more likely to have experienced depression or anxiety, attempted suicide or had suicidal thoughts, and self-harmed than men and women in general. For young lesbian, gay and bisexual people who have experienced homophobic bullying, levels of suicidal thoughts and depression are far higher than amongst those who have not been bullied.

10.13 Services for Gay Men and Men who have Sex with Men (MSM)

The following services for gay men & MSM are currently available in Surrey:

Harm Reduction Development Worker for Gay Men & MSM

A full time worker commissioned by Surrey County Council Public Health and provided by Surrey Harm Reduction Outreach Team (SHROT) as part of the Virgin Care block contract. This post has a key role in raising awareness of discrimination towards gay men & MSM and promoting and developing anti-discriminatory practise in order to address health inequalities experienced by gay men & MSM. The Harm Reduction Development Worker provides specialist training and consultancy to key agencies in Surrey such as Surrey Police, Surrey Domestic Abuse Forum, schools & colleges and Public Health; liaison and advocacy with sexual health and other services to ensure the needs of gay men & MSM are catered for; as well as undertaking direct face to face work with gay men and MSM in Surrey to reduce risk and promote safer behaviours and good sexual health. Face to face work takes place in a variety of settings on a one to one basis including those who require support around 'coming out', men with learning disabilities, transgender individuals, male sex workers, victims of homophobic hate crime, men recently released from prison and men accessing public sex environments (PSE) to have sex with other men. The majority of users of the service are aged mid 30s upwards, but can range from men in their early 20s up to those in their 70s.

During the six month period from September 2013 – February 2014 the SHROT Development Worker for Gay Men & MSM undertook 1129 interventions with gay men and MSM in Surrey, 962 of which were face to face.

Surrey Police Lesbian and Gay Liaison Officers (LAGLO)

As a result of work undertaken over many years by the SHROT Harm Reduction Development Worker for Gay Men & MSM, Surrey Police now have a well established programme of LGBT awareness raising & anti-discriminatory practice training for all its newly trained officers run by the SHROT worker. Many experienced staff have also undertaken this training. Also as a result of this work, Surrey Police have established Lesbian and Gay Liaison Officers (LAGLO) who work closely with the Harm Reduction Development Worker around the policing of PSEs, incidents of Hate Crime, same sex domestic abuse and other police issues relevant to the LGBT and MSM population in Surrey. Due to the close links and positive working relationship that has been developed, the LAGLO officers often refer individuals they come into contact with to the SHROT worker and also to other sexual health services.

Married Men's Groups

The SHROT Harm Reduction Development Worker for Gay Men & MSM runs a Married Men's Group periodically as the need arises. The purpose of this group is to allow men who have sex with other men and are also married or in a relationship with a woman to meet with others in the same situation. The group is facilitated and aims to help the men to gain support and understanding to help them to cope with the situation that they are in and also to gain a better understanding of safer sex and the risk they may be taking. They often forget that their sexual practices can have an impact back at home if they are still in a sexual relationship with their female partners. The group allows a safe space for these issues to be raised in

confidence. The SHROT Harm Reduction Development Worker receives approximately 3-4 calls per month on this issue. Although almost all of the men who call choose not to attend a group, groups are set up if the need and demand are evident.

Terrence Higgins Trust Surrey

The Terrence Higgins Trust (THT) are commissioned by Surrey County Council Public Health to provide sexual health information and support to public sex environment (PSE) users across 11 PSE sites in central and east Surrey including Wisley and south of the A3 corridor. This work includes monitoring and investigating new PSE sites as they become established and extending PSE Outreach to include them as appropriate. The THT aims to conduct at least 4 site visits per month to high attendance PSE sites and 1 site visit per month to low attendance PSE sites equating to a minimum of 35 site visits per month in Central and East Surrey. Within this, at least one joint visit to the Wisley site is carried out with Surrey Police each quarter. The purpose of the joint visit is to increase awareness of sexual health support, site safety, hate crime and acceptable activity on site. In addition the THT attend joint PSE strategy meetings with Surrey Police to discuss any difficulties with and improvements to PSE outreach service and update on issues jointly affecting outreach and police work. The THT also liaise with local authorities and land management organisations (Surrey Wildlife Trust, National Trust etc) to monitor and discuss any difficulties arising from PSE activity and implement improvements to the PSE outreach service and update on issues jointly affecting outreach, local authority and land management work.

The THT PSE Outreach Service makes use of a number of strategies to increase coverage of the service. For example: the Glow-box method of resource distribution at authorised sites to ensure condom provision when workers are not available; social media interventions (e.g. Squirt, Grindr and Gaydar) so PSE site users can contact the outreach team whilst on-site, as well as between outreach shifts; resources are sent out by post following requests received from users via mobile phone apps.

During the 3 month period from January 2013 – March 2013, the THT PSE Outreach Service conducted 154 visits to PSE sites in Surrey. 3547 resources were distributed during this period; 2269 of which were left on sites, 646 were taken from the Glow-box at Wisley, 360 were sent by post to users of the mobile apps and 272 were given out face to face. The service engaged directly with 100 PSE users and 55 users of the mobile apps providing sexual health advice and support in addition to resources. Of these direct contacts, 15 were given specific sexual health related information, 27 were given information about PSE safety & acceptable use, 10 users were provided with safer sex resources and 3 were referred on to local services.

Specialist Clinics for Gay Men

Currently there are no sexual health services or clinic sessions specifically for gay men or MSM operating in Surrey.

10.14 Outline Surrey

Outline Surrey is a website providing an online resource with information on a variety of issues including sexual health, mental health and social groups/events plus access to support via e mail or a telephone helpline staffed by trained volunteers.

A recent analysis of use of the Outline website found that between April 2013

and March 2014 a total of 1,776,500 different sexual health related Google searches were made from the Surrey area that lead to the Outline website appearing within search results.

Table 7: Searches including STI specific keywords:

STI	Search No.	STI	Search no.
Herpes	289,498	**Crabs [Pubic Lice]**	4,037
HIV	141,752	**Scabies**	3,661
Chlamydia	106,179	**Hepatitis**	7,427
Syphilis	44,175	**Gonorrhoea**	913
Non-specific urethritis	1,999	**General/non infection specific**	1,170,403
HPV	6,456		

Table 8: Searches including location specific keywords:

Location	Search no.	Location	Search no.
Horley	5,252	**Chertsey**	11,999
Guildford	50,605	**Redhill**	5,776
Frimley	4,802	**Leatherhead**	9,046
Home testing	3,183		

11 HIV

11.1 Data for England and the South East

An estimated 98,400 (93,500-104,300) people were living with HIV in the UK in 2012[54]. The overall prevalence was 1.5 per 1,000 population (1.0 in women and 2.1 in men). In 2012, 6,360 people (4,560 men and 1,800 women) were newly diagnosed with HIV in the UK, a slight increase on 6,220 diagnoses in 2011. Like the previous year, this is an estimated new HIV diagnosis rate of 1.0 per 10,000 population (1.5 per 10,000 men and 0.57 per 10,000 women). Figure 11 shows testing coverage and diagnostic rates for HIV in Surrey compared to the England and Regional average.

Figure 11: HIV Profile Surrey

Compared with benchmark: Better Similar Worse | Lower Similar Higher | Not Compared

Benchmark Value: Worst/Lowest | 25th Percentile | 75th Percentile | Best/Highest

Indicator	Period	Surrey		Region	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
HIV testing uptake, total (%)	2014	21,493	85.3%	76.6%	77.5%	22.0%		94.2%
HIV testing uptake, MSM (%)	2014	1,847	95.0%	92.9%	94.5%	81.6%		99.0%
HIV testing uptake, women (%)	2014	11,205	83.1%	70.8%	71.5%	15.5%		92.2%
HIV testing uptake, men (%)	2014	10,287	87.9%	84.0%	84.8%	48.3%		96.4%
HIV testing coverage, total (%)	2014	19,448	74.7%	68.1%	68.9%	20.8%		86.1%
HIV testing coverage, MSM (%)	2014	1,463	86.5%	85.9%	87.2%	65.1%		94.6%
HIV testing coverage, women (%)	2014	10,134	71.1%	61.3%	61.9%	15.1%		86.3%
HIV testing coverage, men (%)	2014	9,313	79.2%	77.5%	78.0%	41.1%		87.1%
HIV late diagnosis (%) (PHOF indicator 3.04) <25% 25% to 50% ≥50%	2012 - 14	73	48.0%	45.3%	42.2%	70.0%		0.0%
New HIV diagnosis rate / 100,000 aged 15+	2014	43	4.5	7.5	12.3	85.4		0.0
HIV diagnosed prevalence rate / 1,000 aged 15-59 <1 1 to 2 ≥2	2014	924	1.37	1.70	2.22	0.25		15.08

Source: Public Health England, Public Health Outcomes Framework

Table 9: Number of HIV diagnosed persons seen for care by Upper Tier LA of residence and survey year

Public Health England

Persons resident in South East PHE Centre
Data to the end of December 2014

	Survey year				
Upper Tier LA of residence	2010	2011	2012	2013	2014
Bracknell Forest	88	91	103	115	124
Brighton and Hove	1,438	1,535	1,588	1,666	1,735
Buckinghamshire	344	368	390	422	444
East Sussex	512	528	570	590	598
Hampshire	676	750	764	825	841
Isle of Wight	39	42	48	49	56
Kent	836	913	981	1,048	1,133
Medway	183	206	220	250	258
Oxfordshire	491	507	563	582	507
Portsmouth	226	226	236	253	267
Reading	305	314	347	368	353
Slough	308	330	327	366	364
Southampton	284	300	325	339	370
Surrey	840	949	966	1,034	1,030
West Berkshire	75	83	85	83	77
West Sussex	657	727	800	855	895
Windsor and Maidenhead	102	108	112	119	140
Wokingham	78	82	83	94	106
Z - Not known	35	9	45	2	0

Source: Survey of Prevalent HIV Infections Diagnosed (SOPHID), Public Health England, 2014

Table 10: Number of HIV diagnosed persons seen for care by Local Authority of residence and survey year

Public Health England

Persons resident in South East PHE Centre
Data to the end of December 2014

	Survey year				
LA of residence	2010	2011	2012	2013	2014
Elmbridge	102	109	118	120	127
Epsom and Ewell	44	56	52	54	58
Guildford	100	102	108	109	111
Mole Valley	38	47	51	54	57
Reigate and Banstead	101	113	116	127	135
Runnymede	67	80	76	84	81
Spelthorne	84	90	95	103	102
Surrey Heath	49	60	66	73	69
Tandridge	57	71	68	80	79
Waverley	80	88	91	94	96
Woking	118	133	125	136	115
Surrey	**840**	**949**	**966**	**1,034**	**1,030**

Source: Survey of Prevalent HIV Infections Diagnosed (SOPHID), Public Health England, 2014

11.2 Men who have Sex with Men (MSM)

MSM remain the group most affected by HIV with 47 per 1,000 living with the infection[54]. This is equivalent to an estimated 41,000 (37,300-46,000) MSM living with HIV in 2012, of whom 7,300 (18%; 3,700-12,300) were unaware of their infection (18%).

There has been a steady increase in the number of new HIV diagnoses among MSM. This number surpassed the number of new diagnoses among heterosexuals in 2011. Diagnoses among MSM accounted for 3,250 (51%) of new diagnoses in 2012, the highest number ever reported. This reflects both on-going high levels of HIV transmission and an increase in HIV testing. It is probable that the large majority of new infections stem from MSM unaware of their infection.

11.3 HIV acquired through heterosexual transmission

People who acquired their infection through heterosexual contact were the second largest group of people newly diagnosed with HIV in 2012[54]. They accounted for 2,880 (45%) of new HIV diagnoses. Over the last decade, the number of new diagnoses among heterosexuals declined in England. In 2012 a higher number of heterosexual women (1,530), than men (1,050), were newly diagnosed with HIV. The average age of

diagnosis was 39 years overall; 42 years among men and 37 years among women. Based on data from England and Wales, HIV prevalence in the UK was 26 per 1,000 among black African men and 51 per 1,000 among black-African women. Over the past five years, an estimated 1,000 black-African men and women probably acquired HIV in the UK annually. Approximately half (52%, 1,560/2,990 in 2011) of all infections among heterosexuals were probably acquired in the UK. This proportion has increased over recent years, up from 27%.

11.4 Older Adults (50 years +)

New diagnoses among older adults more than doubled between 2002 and 2011, rising from 442 in 2002 to 990 in 2012[54]. One in four adults living with diagnosed HIV were aged 50 years and over compared to only one in eight in 2003. Nearly two-thirds (63%) of older adults were diagnosed late* Adults diagnosed when aged 50 years and over were more likely to present late compared with adults aged under 50 (44%).

11.5 Late diagnosis

A late diagnosis is defined as having a CD4 count below 350 cells/mm³ within three months of diagnosis. Previously it meant having a CD4 count below 200 cells/mm³ within 91 days of diagnosis; this is now referred to as a very late HIV diagnosis.

People diagnosed late have a eleven-fold increased risk of death within 1 year of HIV diagnosis compared to those diagnosed promptly (3.8% vs. 0.35%)[55]. Over the last decade, 81% of the 2,000 AIDS-related deaths in England and Wales were attributable to late diagnosis. Late diagnosis also means that a person has remained unaware of their HIV status for many years, increasing the risk of onward transmission.

In 2012, just under half (47%) of adults newly diagnosed were diagnosed at a late stage of HIV infection*. Among MSM, the proportion of late diagnoses reduced from 42% to 34%, but the number of late diagnoses rose from 900 to 1,100. Among heterosexuals, the proportion diagnosed late reduced from 65% to 58% with the absolute number halving from 3,180 to 1,620.

11.6 HIV testing, coverage and uptake

An estimated 21,900 people living with HIV were unaware of their infection in 2012. HIV testing continued to increase in 2012, with 902,610 HIV tests performed in sexual health services in England[55]. Overall, 71% (902,610/1,263,980) of attendees were tested; a higher proportion of MSM (84%; 72,710/86,360) were tested compared to heterosexual men (76%; 355,460/469,450) and women (67%; 454,930/677,620). Among heterosexuals, the number of tests rose by 6%, from 815,450 in 2011 to 863,820 in 2012.

Not all sexual health clinic attendees were offered or accepted an HIV test at every visit; in 2012, of the 1,568,010 episodes of care among people not previously diagnosed with HIV, only 79% (1,238,340) included the offer of an HIV test. Nearly one in five people (19%, 234,510) declined a test. A higher proportion of heterosexual men (83%) compared to women (78%) were tested, with uptake highest among MSM (94%).
The number of MSM having an HIV test in the UK increased by 13%, from 64,270 in 2011, to 72,710 in 2012. In 2011, 58% (640/1,110) reported having had an HIV test in the last year, an increase from 48%

in 2006 (840/1,760). However, 8% of MSM reported never having tested and almost half of MSM newly diagnosed with HIV between 2010 and 2012 had their diagnosis made at their first HIV test at that sexual health clinic, an indicator that many MSM who require an HIV test have yet to seek one.

11.7 Co-infection

Due to suppressed immunity in people with HIV, co-infection, where people have more than one disease at the same is more prevalence. Co-infections most commonly seen with HIV are

- Hepatitis B virus (HBV)
- Hepatitis C virus (HCV)
- Tuberculosis (TB)

Data highlights the importance of the universal offer of an HIV test to all patients diagnosed with TB and screening for TB among people living with HIV[54].

People with HIV who have an STI are more likely to transmit HIV during sex. Data from sexual health services show that, of the 4,220 people newly diagnosed with HIV in a sexual health clinic in England in 2012, nearly one in five (19%, n=810) were diagnosed with a concurrent acute STI (chlamydia, gonorrhoea and syphilis). This was highest among MSM, with 29% (600/2,070) having a concurrent STI, compared to 11% (110/940) among heterosexual men and 9% (90/1,080) among heterosexual women.

12 Other Sexual Health Related Issues

12.1 Embarrassment & stigma

Stigma is still associated with poor sexual health[3]. Feelings of embarrassment or fear of being judged stop some people from getting information or from asking for early help. This can have a very real impact, for example:

- discrimination resulting from sexual health status can have an effect on quality of life and mental health
- stigma linked to HIV and STIs can deter people from getting tested and taking their treatment
- embarrassment about sexual health issues can deter people, especially young people, from seeking and obtaining contraception leading to unwanted pregnancies
- some healthcare professionals may feel embarrassed to offer an HIV (or STI) test, even if a patient is presenting with possible symptoms
- individuals find it very difficult to discuss sexual health matters with their sexual health partners and to discuss the use of protection such as condoms
- people who engage in risky behaviours such as sex work, use of PSE sites, multiple sexual partners may find it difficult to be honest about this behaviour to health professionals and thus may not get the most appropriate service for their needs.

12.2 Female Genital Mutilation

Female genital mutilation (also referred to as FGM, female circumcision or cutting) is defined as all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons[56]. The Government has issued multi-agency practice guidelines on FGM and it is a criminal offence under the Female Genital Mutilation Act 2003 to subject a girl or woman to FGM or to assist a non-UK person to carry out FGM overseas on a UK national or permanent resident. (The 2003 Act covers mutilation of the *labia majora*, *labia minora* or clitoris.) However, no offence is committed by a specified approved person who performs a surgical operation that is necessary on physical or mental health grounds or is for purposes connected with childbirth. The following additional sexual health problems may arise as a result of FGM:

Problems with gynecological health

Women who have had FGM sometimes have painful menstruation. They may not be able to pass all of their menstrual blood. They may also have infections over and over again. It can also be hard for a health care professional to examine a woman's reproductive organs if she has had a more severe form of FGM. Normal tools cannot be used to perform a smear test or an internal examination.

Increased risk of sexually transmitted infections (STIs), including HIV

Damage to the female sex organs during FGM can make the tissue more likely to tear during sex, which could also increase risk of infection with STIs or HIV.

Problems getting pregnant, during pregnancy and labour

Infertility may be a problem among women who have had FGM and is possibly related to difficulties in achieving

sexual intercourse due to scar tissue in the vaginal area.

12.3 Sexual Assault & Sexual Violence

Sexual Assault and Referral Centres (SARCs) aim to promote recovery and health following a rape or sexual assault, whether or not the victim wishes to report it to the police. A SARC typically provides specialist clinical care and follow-up to victims of acute sexual violence, including sexual health screening and emergency contraception, usually in one place, regardless of gender, age, ethnicity or disability. In addition, victims can choose to undergo a forensic medical examination if they wish. Surrey SARC is provided by Solace and located at Cobham Community Hospital.

The SARC concept is one of integrated, specialist clinical interventions and a range of assessment and support services through defined care pathways. This allows co-ordination with wider healthcare, social care and criminal justice processes to improve health and wellbeing, as well as criminal justice outcomes for victims of sexual assault as appropriate. Robust partnership working is therefore vital for the successful planning, commissioning and running of SARCs. From April 2013, NHS England will take over responsibility for commissioning the health aspects of SARC services as a public health service working with the police who commission forensic services, and local authorities who invest in specialist follow-up and other support.

12.4 Drug & Alcohol Use

Research[3] has shown that there is an association between alcohol use and teenage pregnancy; even after controlling for the overriding and strong effect of deprivation (the same was true of the more common STIs). There is evidence that alcohol consumption and/or drug use can result in lower inhibitions and poor judgements regarding sexual activity, vulnerability and risky sexual behaviour, such as not using contraception or condoms. Alcohol consumption by young people leads to an increased likelihood that they will have sex at a younger age. Alcohol and/or drug use (particularly in certain commonly used combinations such as alcohol and cocaine) is also linked to: a greater number of sexual partners; more regretted or coerced sex; increased risk of sexual aggression, sexual violence and sexual victimisation of women.

High Risk Substance Use

There are many complex interacting factors leading to poor sexual health amongst high risk substances users such as chaotic poly drug users and those who inject heroin and also use crack. These include: history of sexual abuse; low self esteem; domestic abuse; multiple often unstable sexual relationships; sex work (often opportunistic and without condom use); increased risk taking (due to coercion, domestic abuse or the need for money); sexual partners also high risk substance users; increased exposure to BBVs through injecting[57].

Women who are high risk substance users have additional sexual health issues such as: amenorrhoea leading to the assumption that they are infertile and contraception is not necessary; involvement in sex work; increased risk of some STIs (pelvic inflammatory disease, HPV, genital herpes); increased incidence of cervical intraepithelial neoplasia.
A recent study conducted by the Windmill Community Drug & Alcohol Team[58] (Surrey & Borders Mental Health Foundation Trust) involving 44 female injecting drug users, all of whom were sexually active, found that

41% used no method of contraception. Of those who did use contraception, the oral contraceptive pill was the most commonly used. Of the 44 women, 35 had been pregnant at some time and between these 44 women there had been 102 pregnancies and 58 live births (60 babies), one still birth and 44 pregnancies ended before 24 weeks (this includes abortions and miscarriages). Of the live births, 40% of the babies were not in the care of the mothers (23 children). When interviewed, many of the women stated that they had assumed they could not get pregnant as their periods had stopped.

The study concluded that pregnancy in unstable drug users leads to unfavourable outcomes for the pregnancy, the mother and the baby and requires significant resource deployment by health and social care services. Effective contraception is readily available at GPs and local sexual health services but this client group are poor at accessing it despite support and encouragement to do so. As a result of the study, the Windmill Drug & Alcohol Team undertook a pilot to provide initial contraception (depo-medroxyprogesterone acetate injection) to female injecting drug users accessing drug treatment. Unfortunately, uptake was low which has been attributed to the chaotic attendance of some clients, lack of time during consultations making it difficult for drug & alcohol specialists to discuss the issue with their clients, and possibly some lack of confidence on the part of some staff to broach the issue with clients. It was suggested that introducing a mandatory field on the standard assessment form may help to address this issue and ensure that the subject is raised during consultations.

New Psychoactive Substances (NPS) & Chemsex

Chemsex is a term commonly used to describe sex that occurs under the influence of drugs, which are taken immediately preceding and/or during the sexual session. The drugs most commonly associated with chemsex are crystal methamphetamine, GHB/GBL, mephedrone and, to a lesser extent, cocaine and ketamine. All, except ketamine, are stimulant drugs in that they typically increase heart rate and blood pressure and trigger feelings of euphoria. Crystal methamphetamine, GHB/GBL and mephedrone also have a common effect of facilitating feelings of sexual arousal. There is gathering evidence[3] of this as an emerging issue for sexual health services. It appears that gay men in particular are becoming involved in risky sexual activities involving these drugs (sometimes injected) usually in combination with alcohol. A survey found that 51% of gay men had taken illegal drugs in the previous year, compared with 12% of men in the wider population.

A recently published study undertaken in south London explored drug use in sexual contexts among gay men and bisexual men who lived in South London. The study concentrated on men who had used any of the three main chemsex drugs - crystal methamphetamine, GHB/GBL, and mephedrone either immediately before, or during sex with other men. The study explored perceived norms about drug use in the gay scene; men's' experiences of using drugs during sex (both good and bad); if or how they thought about HIV or STIs when they are having sex on drugs; and whether they had ever sought help to manage their drug use or sexual behaviour. The study found the following:

- More than a quarter of participants (all of whom were HIV positive) had made pre-determined decisions to engage in unprotected anal intercourse (UAI) with men they believed to be sero-concordant. Drugs may increase the volume of men they have sex with, and the

duration of sexual acts, but did not appear to be the main driver of sexual risk taking.

- Nearly a third of men found it difficult to control their behaviour while under the influence of drugs and engaged in HIV/STI transmission risk behaviour, which they subsequently regretted. These were often men who had pre-existing problems negotiating safer sex, which were exacerbated by the presence of drugs.
- A small sample of men sought out risky sex and felt that this was facilitated by the drugs they took. The drugs enabled them to push sexual boundaries and to play out sexual fantasies of danger and transgression.
- While drugs were able to facilitate a great deal of sexual pleasure, they were also associated with a range of physical, mental, social and relational harms. Overdosing was an issue of significant concern for a large number of men, particularly in relation to dosing of GHB/GBL. Several men had been hospitalised as a result of overdosing, while others had experienced panic attacks, convulsions and loss of consciousness.
- Three men reported being the victim of sexual assault under the influence of drugs, and several others reported hearing about the sexual assault of friends or acquaintances.
- Problems relating to paranoia, anxiety and aggression were reported by some men, while a few had experienced acute attacks of mania or psychotic episodes that required medical attention.

Services in Surrey report chemsex as an increasing issue, seeing cases every week.

BASHH published a statement on recreational drug use[59] the purpose of which is to raise awareness and assist clinicians in genitourinary medicine (GUM) services to identify and manage (primarily by signposting and referral) patients who may have problematic substance misuse, particularly when it is having a negative impact on their (or others') sexual health or HIV medication adherence.

12.5 Prisons

Addressing the sexual health of prisoners and children and young people in secure settings supports the strategy for the prevention of the spread of communicable diseases in prison[60]. The PHPQI Green Standard 2012-13 states that all people in prison and other places of prescribed detention are entitled to:

- be aware of means of accessing condoms in prisons
- have access to the social and life skills modules on relationship and sex education (RSE) or similar
- have access to a genitourinary medicine (GUM) service (either provided externally or in house)
- have access to a chlamydia screening programme
- have access to barrier protection and lubricants
- girls to have access to Human Papillomavirus (HPV) vaccine.

12.6 Reported Unmet Needs

Psychosexual Counselling

Sexual health services in Surrey report a lack of provision for psychosexual

counselling leading to reluctance on the part of sexual health professionals to refer on for psychosexual counselling as they are concerned about long waiting times at the few services that are available.

Menopause Services

Sexual health services in Surrey report that they frequently identify a need for specialist menopause services among women. These services can include LARC for non-contraceptive purposes.

Cervical Screening

Sexual health services report that a number of women are being referred to them for smear tests when the GP practice does not offer this service or does not have suitably trained female staff.

13 Recommendations

Schools and further education

- Ensure schools have access to appropriate resources for PSHE and RSE.
- Encourage schools to include work on homophobic bullying and positive relationships within their PSHE work.
- Ensure sexual health is included in school nurse remit in the recommission of community services.
- Provide Surrey Universities with links to accurate and current sexual health information and services via the Healthy Surrey website.
- Look at the opportunities for University-based, dedicated sexual health services as part of future service commissioning.

Key population groups

- Link with professionals who work with children and young people who may miss out on education, to ensure their needs are met.
- Link with professionals who work with looked after children and young people to ensure their needs are met.
- Ensure suitable pathway in place for young parents with engagement from relevant stakeholders.
- Continue to engage with at-risk groups such as MSM, Sex Workers and Black Africans.
- Increase access to STI testing and treatment for at-risk groups
- Increase early diagnosis of HIV for at-risk groups

Feedback from service users

- Ensure young people's views are sought in service design and that responses are considered in new service design.
- Work with Services for Young People to gain detailed feedback from young people and service users to identify what type of services they would like and how and where they would like them to be available.
- Work with all sexual health service providers to collect feedback on service and experience from service users.

Strengthening partnerships

- Extend the role of the existing Sexual Health Operational Group to provide a forum for professionals working in sexual health or related services.
- Establish an annual network meeting for representatives of organisations working in sexual health or related services i.e. substance misuse, colleagues in Borough and District Councils.
- Continue to link with Surrey Health Protection Forum to increase awareness and uptake of HPV vaccination.
- Contribute to and implement recommendations made by, related task groups such as FGM, CSE and the Young Parents Pathway.

Improving outcomes and choice

- Ensure sexual health services have been Equality Impact Assessed and appropriately meet the needs of people with protected characteristics.
- Increase awareness of sexually transmitted infection testing with young people.
- Increase number of young people screened and treated (for Chlamydia and Gonorrhoea) where necessary.
- Review the evidence on contraceptive choices in maternity services post-birth and implement accordingly.
- Improve the offer to young people from pharmacy, through the provision of a suite of services including EHC, condom distribution scheme and Chlamydia/ Gonorrhoea testing.
- Move towards an integrated GUM and CASH service, where clinicians are dual trained.
- Review available training and ensure that everyone who delivers sexual health services or sexual health promotion has access to appropriate training.
- Work with sexual health services to better understand and address the increase in chemsex related attendances at GUM services

Using technology and online

- Map location of EHC providers and identify any gaps.
- Promote young people's services including free EHC and availability through the Health Surrey website.
- Use Pharmoutcomes system to better understand uptake of EHC in pharmacy settings and inform future work on EHC.
- Look at opportunities to provide an online datasystem to support the condom distribution scheme, improving access for young people and reducing impact on staff.

Improving commissioning links

- Work with CCGs to ensure termination providers in Surrey provide consistent contraception information to reduce young women having repeat terminations.
- Work with colleagues in NHS England to join the HIV pathway for initial testing and treatment and care

Unmet Need

- Ensure consistent provision of contraception provided for non-contraceptive purposes across Surrey.
- Ensure psychosexual counselling relative to local need is included within the future of Public Health commissioning of sexual health services.
- Work with Surrey Health Protection Forum to maximise opportunistic cervical screening within sexual health services.

14 Next Steps

Through the development of this needs assessment including prevalence research, feedback from service users, professional's surveys and focus groups with young people the following key messages have been identified;

- Runnymede and Spelthorne have historically shown higher than the national average rates of teenage conceptions. Preston ward within Reigate and Banstead has the highest rate in Surrey.
- Over 60% of teenage conceptions result in termination.
- Woking has a higher than the national rate of HIV.
- Through engagement work it was identified that both adults and young people wanted better access to services, this included more flexible opening times such as evenings and weekends.
- Both adults and young people felt that sexual health services could be promoted more effectively.
- Services could be better promoted online i.e. through the Healthy Surrey website.
- Surrey County Council Public Health must look for opportunities and work with our commissioning colleagues in CCGs and NHS England to ensure pathways are joined up in order to improve patient experience and health outcomes.
- Variations in service provision across the county needs to be addressed during the through the recommissioning of services. This will ensure resources are more effectively targeted to meet needs.
- Integration of services would allow needs to be met holistically. Dual trained clinicians would mean GUM and CASH services could be delivered by the same clinicians, improving patient access and experience.

The Public Health Team at Surrey County Council is in the process of recommissioning their sexual health services with the new contact due to begin in April 2017. The findings, recommendations and key messages from this Sexual Health Needs Assessment will be used in the development of the new service.

Abbreviations/ Glossary

- **BME** Black and minority ethnic groups
- **CAMHS** Child and Adolescent Mental Health Services
- **CASH** Contraception and Sexual Health
- **CCG** Clinical Commissioning Group
- **CSE** Child Sexual Exploitation
- **EHC** Emergency hormonal contraception
- **FE** Further Education
- **FGM** Female Genital Mutilation
- **FNP** Family Nurse Partnership
- **GRT** Gypsy, Roma and Traveller
- **GUM** Genitourinary Medicine
- **HIV** human immunodeficiency virus
- **HPV** Human papilloma virus
- **IMD** Index of multiple deprivation
- **LA** Local Authority
- **LAC** Looked After Children
- **LARC** Long Acting Reversible Contraception
- **LGBT** Lesbian, Gay, Bisexual and Transgender
- **LSOAs** Lower super output areas
- **MSM** Men who have sex with men
- **NCSP** National Chlamydia Screening Programme
- **NEET** Not in Education, Employment, or Training
- **NICE** National Institute of Clinical Excellence
- **NPS** New Psychoactive Substances
- **ONS** Office of National Statistics
- **PSE** Public Sex Environments
- **PSHE** Personal, social, health and economic education
- **RSE/ SRE** Relationships and Sex Education
- **SARC** Sexual Assault Referral Centre
- **SCC** Surrey County Council
- **SHROT** Surrey Harm Reduction Outreach Team
- **STIs** Sexually Transmitted Infections
- **SYP** Services for Young People (Surrey County Council)
- **THT** Terrence Higgins Trust
- **TOP** Termination of Pregnancy
- **YSS** Youth Support Service

Acknowledgements

Authors: Public Health, Surrey County Council

Lisa Andrews, Hannah Bishop and Sue Whitfield

Analyst support: Jon Walker

In addition special thanks to the Sexual Health Expert Reference Group:

Anne-Marie Ellison	: Virgin Care
Dr Jillian Pritchard	: Ashford and St. Peter's Hospitals NHS Foundation Trust
Dr Ramalingam Nadzrajah	: Frimley Health NHS Foundation Trust
Dr Tina Peers	: Virgin Care
Frank Henderson	: Virgin Care
Gill McCarthy	: Kingston Hospital
Ian Cole	: Virgin Care
Julie Speed	: Services for Young People, Surrey County Council
Maria Edwards	: Surrey Police
Mary Lawn	: Virgin Care
Nicky Palmer	: Surrey and Borders Partnership NHS Foundation Trust
Nikki Parkhill	: Services for Young People, Surrey County Council
Patricia Battersby	: Care UK
Robyn Alford	: Services for Young People, Surrey County Council
Ros Louth	: Policy and Performance, Surrey County Council
Sarah Lyles	: Babcock International
Sue Peters	: Terrence Higgins Trust
Sue Strank	: Children, Schools and Families, Surrey County Council
Sue Zirps	: AGE UK Surrey

References

[1] Healthy Lives, Healthy People: our strategy for public health in England, November 2010, Department of Health

[2] Health & Social Care Act, 2012, HM Government

[3] A Framework for Sexual Health Improvement, March 2013, Department of Health

[4] Public Health Outcomes Framework, January 2012, Department of Health

[5] Integrated Sexual Health Services: National Service Specification, June 2013, Department of Health

[6] Equality Act, April 2010, Government Equalities Office

[7] Chief Medical Officer's annual report 2012: Our Children Deserve Better: Prevention Pays, October 2013, Department of Health

[8] Not yet good enough: personal, social, health and economic education in schools, May 2013, Ofsted

[9] Careers in School Nursing, NHS Careers

[10] Pupils Missing Out on Education, November 2013, Ofsted

[11] Thinking Prevention, Making a public health case for investing in prevention and early intervention initiatives to tackle substance misuse, January 2013, Mentor

[12] CAMHS HNA refresh Version 9,January 2014, Surrey County Council

[13] HES Standard Outputs: Miscellaneous - Self Harm Admissions, 2013, CHIMAT

[14] Youth Chances Summary of First Findings: the experiences of LGBTQ young people in England, 2014, Youth Chances

[15] Sex and Relationships Education (SRE) for the 21st Century, supplementary advice to the Sex and Relationships Education Guidance DFEE (0116/2000), February 2014, Brook, the PSHE Association & the Sex Education Forum

[16] School Leaving Age, January 2014, Department for Education

[17] Key Findings Sex & Relationships Education for young people in Further Education, A briefing paper, 2010, Sex Education Forum

[18] Meeting the SRE and sexual health needs of young people on Apprenticeship and Foundation Learning Programmes A Sex Education Forum practice briefing, 2010, Sex Education Forum

[19] Child Health Profile – Surrey, March 2014, Public Health England

[20] UK Medical Students Turning to Sex Work, February 2012, British Medical Journal

[21] Conceptions in England and Wales, February 2014, Office for National Statistics

[22] National Perspectives on Supporting Teenage Parents: Policy & Implementation, 2013 presentation by Alison Hadley, Teenage Pregnancy Unit

[23] FNP (Ref: Investing in children's mental health) FNP Report for information to Surrey Safeguarding Childrens Board

[24] Porn: the new sex education; http://www.guardian.co.uk/society/joepublic/2009/mar/30/teenagers-porn-sex-education

[25] http://www.bbc.co.uk/newsbeat/12918531

[26] Safer Internet Day: Porn affecting 11 year olds, February 2014, Young Minds Blog, ClareJerrom

[27] Children, Young People and 'Sexting' Summary of a qualitative study, 2012, NSPCC

[28] Safeguarding children and young people from sexual exploitation: supplementary guidance, August 2009, Department for Education

[29] "If only someone had listened" Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups, November 2013, Office of the Children's Commissioner

[30] Reduction in HPV16/18 prevalence in sexually active young women following the introduction of HPV immunisation in England, November 2013, D. Meshera et al, Vaccine 32 (2014) 26–32

[31] Annual HPV Vaccine Coverage in England: 2012 -2013, 2013, Public Health England

[32] HPV Vaccine for Boys, January 2014, British Dental Journal

[33] Sexually Transmitted Infections and Chlamydia Screening for England, June 2013, Public Health England

[34] Gonorrhoea Resistance Action Plan for England and Wales, February 2012, Public Health England

[35] NHS Contraceptive Services: England 2013/14 Community Contraceptive Clinics, October 2014, Health and Social Care Information Centre

[36] New Product Review, Ulipristal Acetate (ellaOne®), 2009, Faculty of Sexual & Reproductive Healthcare Clinical Effectiveness Unit

[37] The Care of Women Requesting Induced Abortion, Evidence-based Clinical Guideline Number 7, 2011, Royal College of Obstetrics and Gynaecology

[38] Improving Access to Health Care for Gypsies and Travellers, Homeless People and Sex Workers, 2013, RCGP Clinical Innovation & Research Centre

[39] A Coordinated Prostitution Strategy, 2006, The Home Office

[40] ACPO Strategy & Supporting Guidance for Policing Prostitution and Sexual Exploitation, 2011, ACPO

[41] Strategy on Policing Prostitution in Surrey, 2013, Surrey Police

[42] Good Sexual Health for People with Learning Disabilities, 2009, FPA

[43] Talking About Sex and Relationships, 2009, University of Leeds

[44] Sexual Health and People with Learning Disabilities, 2010, FPA

[45] The Lesbian, Gay, Bisexual and Trans Public Health Outcomes Framework Companion Document, 2013, Public Health England

[46] Sexuality & Disability, February 2013, Milton J Klein et al, Medscape

[47] Sexual Health & Wellbeing, 2014, NHS Lanarkshire

[48] Population sub-groups requiring targeted prevention interventions, 2009, HPA

[49] Social Exclusion of Gypsies & Travellers: health impact, July 2010, Journal of Research in Nursing

[50] Educational Equality for Gypsy, Roma and Traveller Children and Young People in the UK, 2012, Equal Rights Review, Volume Eight

[51] Health & Wellbeing: Sex in Later Life, February 2013, Age UK

[52] Mental Health & Addiction: Physical Wellbeing & Sexual Health, 2013, University of York

[53] Mental Health: Stonewall Health Briefing, 2011, Stonewall

[54] HIV in the United Kingdom: 2013 report, 2013, Public Health England

[55] Sexual Health Profiles, 2012, Public Health England

[56] Female genital mutilation, (2016) World Health Organisation http://www.who.int/mediacentre/factsheets/fs241/en/

[57] Drug Users & Sexual Health, 2010, NHS Lothian

[58] The Reproductive Health of Female Class A Drug Users, 2011, Windmill Drug & Alcohol Team

[59] BASHH statement on 'club' recreational drug use, February 2014, BASHH

[60] Service Specification Number 29: Public health services for people in prison or other places of detention, including those held in the Young People's Secure Estate, November 2012, NHS Commissioning Board