Nottinghamshire County Council

Report to Health and Wellbeing Board

6th March 2013

Agenda Item: 6

REPORT OF DIRECTOR OF PUBLIC HEALTH

SEXUAL HEALTH IN NOTTINGHAMSHIRE COUNTY

Purpose of the Report

1. This report provides an overview of Sexual Health and Wellbeing in Nottinghamshire County. It provides estimates of prevalence of sexual ill health across the county, information on national and local policy drivers and a summary of the services in place to meet assessed need and improve population sexual health. It also highlights future commissioning options in line with priorities and the new organisational roles and responsibilities.

Information and Advice

2. The World Health Organisation defines Sexual health as:

   "…a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled." (WHO, 2006a)

3. Sexual Health includes a number of key elements:

   - Prevention and treatment of Sexually Transmitted Infections (STIs)
   - Prevention of unintended pregnancy
   - Early access to Termination of Pregnancy services
   - Infertility help and advice
   - Sexual well-being services, including advice on and access to contraception services
   - Safeguarding of young people and vulnerable adults
   - Aspects of mental health related to sexual dysfunction
   - Addressing risk taking behaviour associated with substance misuse and insufficient resilience

4. Sexual health is an important issue for Nottinghamshire County for a number of reasons:

- Many STIs have long-term effects on health.
- Some Genital Wart infections and Chlamydia are associated with cervical cancer.
- Untreated, between 10 and 20% of Chlamydia cases result in infertility due to pelvic inflammatory disease (Land et al 2010). Chlamydia is the most commonly diagnosed bacterial sexually transmitted infection and over 186,000 new cases were diagnosed in England in 2011 (HPA website).
- Genital warts are caused by the Human Papilloma Virus (HPV) and these do not usually have any long term effects on health. However, other strains of HPV which are also sexually transmitted are associated with cervical cancer.
- Syphilis can mimic a range of conditions and the long term consequences, which may occur many years later, can affect the cardiovascular and neurological systems. Untreated it can lead to serious complications and even death. In pregnancy it can lead to miscarriage or stillbirth and can be passed on to the baby.
- The natural progression of the Human Immunodeficiency Virus (HIV) is to develop profound immunosuppression, which can lead on to the Acquired Immunodeficiency Syndrome (AIDS) and may possibly lead to death.
- In 2011, 6,280 people were newly diagnosed with HIV in the UK, compared with 7,914 in 2005, when the number was at its highest (BASHH 2011).
- The proportion of heterosexuals who acquired their infection in the UK continues to increase (BASHH 2011).
- There are at least 20,000 people unaware of their infection, around half of whom are heterosexual (BASHH 2011).
- There has been a slow but significant decline in the proportion of people diagnosed late (CD4<350 cells/mm^3) over the past decade. Nevertheless, the proportion of late diagnoses remained high in 2010 (50%). These individuals carry a tenfold increased risk of dying within a year of diagnosis, compared to those diagnosed promptly (HPA 2012).
- More than 2.1 million HIV tests were performed in England in 2010; most were within the STI clinic and antenatal settings. The coverage of HIV testing among all attendees in these settings was 69% and 96%, respectively (HPA 2012).
- If the 3,640 UK-acquired HIV diagnoses made in 2010 had been prevented, between £1.0 and £1.3 billion lifetime treatment and clinical care costs would have been saved (NICE 2011)

5. There is evidence of an increase in risky sexual behaviour, with continued lack of knowledge about the possible consequences:

    - The average (median) age which people start having sex is now 16; forty years ago it was 21.
    - Between a third and a half of teenagers do not use contraception at first intercourse. 43% of young people (age 15-24) had unprotected sex with a new partner in Great Britain in 2010. Of those surveyed 15%, compared to 36% in 2009 (Bayer 2010) gave the reason as getting drunk or forgetting contraception.
    - Young adults (15-24 years old) make up only 25% of the sexually active population, but represent almost 50% of all new acquired sexually transmitted diseases (Ros et al 2008).
    - 15% of young adults between the ages of 18 and 26 have had a sexually transmitted disease in the past year (Wildsmith 2010)
    - Nationally there were 32,552 under age 18 conceptions in 2010 compared to 40,336 in 2007. Across Nottinghamshire in 2010 there were 461 compared to 524 in 2007. 43% lead to abortion.
    - Half of all conceptions in those aged under 18 occur in the 20% most deprived wards. Teenage pregnancy can affect long-term health and social outcomes of both parents and children. Babies of teenage mothers have a 60% higher risk of dying in the first year of life and have a significantly increased risk of living in poverty, achieving less at school and being unemployed in later life.
    - The National Survey of Sexual Attitudes and Lifestyles (NATSAL) in 2000 identified that the East Midlands had the highest percentage of women aged 16-29 that had had 2 or more partners in the last year and did not use a condom.

Health inequalities

6. The highest burden of sexually related ill-health is borne by women, gay men, teenagers, young adults, black and minority ethnic groups and more deprived communities.

7. Children born to teenage parents are less likely to be breastfed, more likely to live in poverty and more likely to become teenage parents themselves (Botting et al. 1998 cited in NICE 2007).

8. Children born to teenage mothers are much more likely to experience a range of negative outcomes in later life, such as developmental disabilities, behavioural issues and poor academic performance (Hofferth et al 2002).

Resource Implications

9. Preventative services both promote well-being and positively impact upon financial costs. It has been estimated that that the prevention of unplanned pregnancy by the National Health Service (NHS) contraception services saves the NHS over £2.5 billion a year, and through activities such as Chlamydia screening there is the potential to dramatically reduce costs associated with preventable infertility and pelvic inflammatory disease.

10. Every £1 invested in contraception saves the UK NHS £11 plus additional welfare costs, which is a powerful economic argument for maintaining contraceptive services (Teenage Pregnancy Independent Advisory Group 2010).

11. Overall, the cost to the NHS alone of teenage pregnancy is estimated to be £69m annually (Teenage Pregnancy Independent Advisory Group 2008 http://publicpolicyexchange.co.uk/docs/8J02-PPE_4_Gill_Frances.pdf).

12. In October 2006 NICE guidelines on Long Acting Reversible Contraception (LARC) suggested that an 8% shift from oral contraceptive to LARC methods would result in a net saving to the NHS of over £102 million.

National and Local Drivers

National Drivers

13. The National Strategy for Sexual Health and HIV (DH 2001) highlighted significant inequalities in sexual health and set out a blue print for the development of sexual health services. Subsequently, improving sexual health was identified as one of the key national priorities in the White Paper, Choosing health (2004) The White Paper 'Our Health, Our Care, Our Say (Department of Health 2006)[3] and associated consultation paper 'Commissioning Framework for Health and Well Being' 2007 prioritises sexual health, adopting the themes and principles of person centred services, better understanding of the needs of populations and individuals, preventative services that emphasise healthy living and well-being and more effective joint planning and service delivery. It also builds on principles within the National Strategy for Sexual Health and HIV (Department of Health 2001) and Effective Commissioning of Sexual Health and HIV Services (DH 2003). These include improved health and social care for people with HIV and AIDS, reducing health inequalities within sexual health, reducing stigma and involving service users in plans and developments.

14. The following documents also shape the focus for Sexual Health service provision:

- Public Health Outcomes Framework for England (2012).
- Service Standards for Sexual Health and Reproductive Healthcare (2011).
- Teenage Pregnancy Independent Advisory Group Final Report (2010).
- Moving forward: Progress and priorities – working together for high-quality sexual health (2009) Department of Health.
- High Quality Care for All (Darzi) Review (2008).
- Evaluation of One-Stop Shop Models of Sexual Health Provision (2007).

- Home Office. Tackling sexual violence: Guidance for local partnerships (2006) The Government is committed to taking a partnership approach to improving both justice and health outcomes for victims of sexual violence. Sexual Assault Referral Centres (SARC) have a role to play in the delivery of several government agendas, including safeguarding, sexual health, mental health, public health, reducing crime and the fear of crime, increasing victim and witness satisfaction and bringing offenders to justice.
- National Institute for Health and Clinical Excellence guidance on Long Acting Reversible Contraception (LARC 2005).
- Prevention of sexually transmitted infections: a review of reviews into the effectiveness of non- clinical interventions. Health Development Agency (2004).
- HIV Prevention: a review of reviews assessing the effectiveness of interventions to reduce the risk of sexual transmission. Evidence briefing Health Development Agency (2003).
- The National Sexual Health and HIV Strategy (2001).

Local Drivers

15. The Joint Strategic Needs Assessment (JSNA) has identified Sexual Health (including Teenage Pregnancy) as important to the Health and Wellbeing of people living in Nottinghamshire County. It reinforced that poor sexual health is closely linked to social patterns and deprivation. The JSNA highlighted significant variation across the county in both the prevalence of STIs and the number of teenage conceptions. Addressing sexual ill health and promoting sexual wellbeing is a key step to reducing overall health inequalities.

16. In 2010/11 the NHS Operating Framework instructed Primary Care Trusts to divest themselves of provider services by April 2011 as part of the Transforming Community Services Programme. As a result responsibility for the delivery of Sexual Health services for Nottinghamshire County Southern Boroughs transferred to Nottingham University Hospital (NUH), Nottinghamshire Northern Districts to Sherwood Forest Hospital Trust and Bassetlaw to Bassetlaw Health Partnership (which is part of the Nottinghamshire Mental Health Trust).

Targets and Performance

17. **Targets and indicators** – currently key priority indicators for teenage pregnancy, Chlamydia screening, Genitourinary Medicine (GUM) and abortions include the following targets:

    - A 50% reduction in the under 18 conception rate by 2010 (from the 1998 baseline of 46.4 per 1,000). Nottinghamshire County has extended this to continue to achieve a downward trend.

    - A Chlamydia screening diagnostic target of 2,400 diagnoses per 100,000 15-24 year olds (until 2012 this was a coverage target which measured the proportion of 15-24 year olds screened for Chlamydia as a proxy for Chlamydia prevalence)

    - 100% of patients attending GUM services are offered an appointment to be seen within 48hrs

18. The Public Health Outcomes Framework, which comes into effect from April 2013, includes three sexual health specific outcomes in two of the four domains.

Targets from April 2013

Domain	Indicator
Domain 2 Health Improvement	Under 18 conceptions
Domain 3 Health Protection	Chlamydia diagnoses (15-24 year olds)
Domain 3 Health Protection	People presenting with HIV at a late stage of diagnosis

Epidemiology of Sexual Health in Nottinghamshire

19. Please see Appendix A for a comprehensive description of health needs, service analysis and gaps in service delivery.

Future Commissioning of Sexual Health Services Post April 2013

20. Local Authorities will be mandated to commission needs led sexual health services for its population from April 2013. The commissioning responsibilities will involve commissioning comprehensive sexual health services, the core functions which include: comprehensive needs assessment , strategy development linking in with the new national sexual health strategy (due imminently), sexual health promotion and education, particularly high risk groups who experience disproportionally poor sexual health outcomes: provision of partner notification: targeted services, including outreach for high risk groups: procuring high quality accessible integrated sexual health services and monitoring sexual health outcomes.

21. Responsibility for commissioning some aspects of sexual healthcare currently discharged by PCTs will not transfer to Local Authorities. Abortion services will be the responsibilities of Clinical Commissioning Groups. HIV treatment and care services, which are low volume / high cost services, will be commissioned by the NHS Commissioning Board.

22. Sexual Health Referral Centres which provide crisis response and coordinate forensic medical care for victims of sexual violence will be commissioned by the NHSCB, as a devolved Public Health function. As such Health and Wellbeing Boards will be required to maintain a line of sight in the commissioning of their local service.

Responsibilities for commissioning sexual health services from April 2013

Service	NHS Commissioning Board	Clinical Commissioning Groups	Local Authority
Comprehensive Sexual Health Services (including contraception, STI testing and treatment, HIV testing but not treatment, EHC in primary care settings)			✓
Termination of Pregnancy		✓	

HIV treatment (but not testing) and Care Outpatients/ Inpatients	✓		
Sexual Assault Referral Centres	✓		
Psychosexual services (Sexual Health aspects)			✓
Sex Relationship Education			✓

Further Actions Required

23. Reducing sexual ill health:

- Commission Sexual Health services that meet the need of the target population, are cost effective and easy to access.
- Ensure engagement of all key stakeholders at Sexual Health Strategic Commissioning Group to ensure seamless care pathways
- Strengthen sexual health prevention services and initiatives to prevent infection, re-infection and unintended pregnancies across key population groups and settings.
- Ensure high quality sex and relationship education is available and accessible in schools and other settings
- Ensure that Emergency Hormonal Contraception is easily available through Community Pharmacies
- Increase accessibility to long acting reversible contraception through training programmes to the relevant health professionals
- Develop a local programme to increase earlier diagnoses of HIV infections consistent with identified needs.
- Further integrate as standard practice opportunistic Chlamydia screening in core clinical services
- Explore with target at risk groups effective methods to communicate Sexual Health messages effectively and implement these.
- Strengthen links with targeted Youth support to increase exposure to sexual health promotion and more effectively address young people's sexual health needs

24. All these actions will be taken forward via a Health and Wellbeing Board workshop, which will focus on the actions required to develop the overall specification for sexual health services and commissioning action plan. The specifications will then form the basis of the contracts between the local authority and sexual health providers. This process will be

coordinated by the sexual health strategy group (chaired by the Director of Public Health) which will ensure a joined up approach between the local authority, NHS commissioning board and CCGs in their commissioning roles.

25. Agreement of the detailed action plan and progress made against the plan will be monitored through the Health & Wellbeing Implementation Group.

Summary and Key Points

26. The responsibility and resource for commissioning Comprehensive Sexual Health Services move to the Local Authority in April 2013.

27. The responsibilities for commissioning Termination services moves to the CCGs in April 2013

28. The responsibility for commissioning SARC, elements of contraception within the GP contracts and HIV treatment and care moves to the NCB form April 2013

29. Public Health will retain responsibility to provide public health advice to all commissioners of the Sexual Health Services

30. The Local Authority is well placed to have a significant impact on improving sexual health outcomes for its residents and to effectively address the wider determinants of health and wellbeing which influence sexual health.

31. The Health and Wellbeing Board in collaboration with its stakeholders will agree the key priorities for improving sexual health

Statutory and Policy Implications

32. This report has been compiled after consideration of implications in respect of finance, equal opportunities, human resources, crime and disorder, human rights, the safeguarding of children, sustainability and the environment and those using the service and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

RECOMMENDATION/S

The Health and Wellbeing Board is asked to:

1) Note and endorse the content of the report.

2) Note the roles and responsibilities for Local Authorities for commissioning to support comprehensive sexual health services from April 2013.

3) Support the list of further actions required as described in paragraph 23

4) Support the development of a detailed action plan using a forthcoming Health & Wellbeing Board workshop.

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Constitutional Comments (NAB 25.02.13)

33. The Health and Wellbeing Board has authority to consider and support the matters set out in this report by virtue of its terms and reference.

Financial Comments (CLK 25.02.13)

34. The financial implications are contained in paragraph 24 of the report.

Background Papers

References used in the development of the report

Electoral Division(s) and Member(s) Affected

All