Nottinghamshire County Council

Report to Public Health Committee

26 November 2014

Agenda Item: 4

REPORT OF DIRECTOR OF PUBLIC HEALTH

COMMISSIONING COMPREHENSIVE SEXUAL HEALTH SERVICES IN NOTTINGHAMSHIRE FROM APRIL 2016

Purpose of the Report

1. The purpose of this report is to:

   a. Advise the Committee of the health needs and contractual arrangements related to the Council's responsibility for commissioning mandatory comprehensive sexual health services, and the implications and consequential costs of potential reductions in funding.

   b. Secure approval to consult with stakeholders about how to address these sexual health needs in advance of a Committee decision in March 2015 about the budget to be allocated to sexual health.

Information and Advice

Public health significance of good sexual health

2. Good sexual health is an important part of physical, mental and social well-being, requiring a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences which are free of coercion, discrimination and violence[i].

3. The burden of poor sexual health falls most heavily on disadvantaged groups and there is a clear link between sexual ill health, poverty and social exclusion in Nottinghamshire County. The consequential costs of poor sexual health are borne by society at large as well as the individuals.

4. The public health significance of the overall sexual health agenda is underlined by the inclusion of several indicators in the Public Health Outcomes Framework:

   a. **Under 18 conceptions** (Domain 2, Health Improvement): 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.

   b. **Chlamydia diagnoses in people aged 15-24 years** (Domain 3, Health Protection): if untreated, between 10-20% of chlamydia cases result in infertility due to pelvic inflammatory disease.

c. **People presenting with HIV at a late stage of diagnosis** (Domain 3, Health Protection): the proportion of late diagnoses remained high in Nottinghamshire County in 2012 (63%) compared to England (50%)[ii]. These individuals carry a tenfold increased risk of dying within a year of diagnosis, compared to those diagnosed early. In addition to the significant, dismal and unnecessary health outcomes for the individuals concerned, late diagnosis also yields significant treatment, clinical and social care costs.

5. In recognition of the extent to which good sexual health contributes to health and wellbeing, the Nottinghamshire County Health and Wellbeing Strategy includes the priority to reduce the rates of STIs and unplanned pregnancy.

Commissioning responsibilities & interdependencies

6. Since April 2013 responsibilities for commissioning comprehensive sexual health, reproductive health and HIV services have been divided across local government, Clinical Commissioning Groups (CCGs) and NHS England (NHSE).

7. Local Authorities Regulations[iii] mandate that unitary and upper tier local authorities commission confidential, open access services for STIs and contraception, as well as reasonable access to all methods of contraception. Appendix 1 provides a summary of the system wide commissioning responsibilities for sexual health, reproductive health and HIV services.

8. The delegation of commissioning responsibilities for a single patient "pathway" to a number of organisations means that the delivery of an effective overall commissioning system depends on close collaboration between CCGs, NHSE, and other local authorities. This is important both in terms of ensuring satisfactory outcomes at each stage of the patient pathway and to mitigate the unintended consequential costs of changes made to services earlier in the same pathway.

9. The consequential costs of poor access to timely testing for STIs, prompt treatment and a full range of contraception are borne by CCGs, NHSE, Nottinghamshire County Council, neighbouring local authorities and other public service budgets. Some of these costs are considerable. For example, the cost of completing treatment and clinical care of the 30 people in Nottinghamshire County who were diagnosed with HIV in 2010-11 is estimated to be £8,400,000[iv].

10. Appendix 2 provides insight into three service users' sexual health "journey" and demonstrates the interdependencies and collaborative commissioning arrangements required to ensure seamless access across and between a range of services.

11. There are also close dependencies between sexual health and other local authority agendas. For example, the availability and accessibility of effective sexual health and reproductive health services makes a critical contribution to Nottinghamshire's ambition to continue to lower teenage conceptions across the whole of Nottinghamshire and to a greater degree in more deprived areas[v]. Similarly there are close dependencies with Sex and Relationships Education (SRE) and the Child Sexual Exploitation (CSE) agenda.

12. Nottinghamshire County's Joint Strategic Needs Assessment (JSNA) highlighted significant variation across the county in both the prevalence of STIs and the number of teenage conceptions and identified that addressing sexual ill health and promoting sexual wellbeing is a key step to reducing overall health inequalities.

13. Further needs assessment is under way. Amongst other things, this is likely to confirm the need to commission an integrated sexual health service, so that residents (as service users) are able to attend for STI testing and at the same appointment be able to access relevant contraceptive advice and provision.

14. We know that there is a gap in what is commissioned to deliver Sexual Health promotion, particularly targeting sexual health promotion to young people in teenage hot spot areas across the county and to people who have higher sexual health risks (MSM - Men who have sex with men and sex workers). Along with the need to address the late diagnosis of HIV across the county.

Current contracts and pressures

15. The Council's current sexual health contracts are summarised in Appendix 3.

16. The total annual cost of these sexual health contracts is in excess of £6.8 million.

17. In regard to management of contracts which cover the south of the County, it is critical to work in close collaboration with Nottingham City Council who are also associate commissioners of Nottingham University Hospitals for Genito-urinary Medicine (GUM) and Contraception and Sexual Health (CaSH) services. Dependencies in Bassetlaw are with Doncaster Council whose services are currently provided by Doncaster & Bassetlaw Hospital. Account needs to be taken of any implications for services in Bassetlaw of what Doncaster Council chooses to do with services provided by Doncaster & Bassetlaw Hospital in their neighbouring locality.

18. In common with other commissioners of acute healthcare services, the council is obliged to pay for its GUM services using a simple per-patient tariff which is determined nationally. Therefore there is little scope for reducing the unit price of each treatment. Indeed, looking ahead it is more likely that the tariff will be increased. Furthermore, since the Council must provide equity of access to an open universally available service there is limited scope in the short term for reducing the volume of activity.

19. Payment for Contraception and Sexual Health (CaSH) services are currently transacted through "block" contracts, in which a fixed overall amount is paid to the provider irrespective of the total number of treatments. Exceptions to this arise in respect of residents who are at liberty to access CaSH services in other areas, for which we are liable to make payment. Changes to the way pathology costs are recharged to providers may present as a cost pressure.

20. The Council also commissions Long Acting Reversible Contraception (LARC) from general practice, for which there is evidence of gaps in coverage. Treatments provided are paid according to a pricing schedule which varies across the County. Discussions with primary care to rationalise payment stalled last year due to limited freedom of movement on either side.

21. Service accessibility is important to increase outcomes, Emergency Hormonal Contraception (EHC) is commissioned from 144 Community Pharmacies; the service includes signposting to contraceptive and sexual health services and C-Card for young people.

22. Within our current and future commissioning arrangements, there is a need to be mindful that NHS providers (within specialist areas such as sexual health) are key contributors to medical and clinical workforce development and training, which is essential to support future Sexual Health Service sustainability and delivery.

23. The key implications arising from these considerations is that short term scope for reducing costs to the Council is limited and that financial pressures on the current budget are growing.

Future commissioning & prospects

24. All current CaSH and GUM contracts expire on 31/3/2016 and have no further permissible extension periods. This means that some form of procurement will have to be undertaken to commission services for the period from 01/04/2016. This will be a key opportunity to address the recommendations from the needs assessment (e.g. to implement an integrated service across the county) and the goals agreed by the Health and Wellbeing Board (to reduce rates of STIs and unplanned pregnancy).

25. In considering the reprocurement of these services, current and potential providers are unlikely to agree to new arrangements based on block contracts which expose them to risk of cost pressures if treatment activity increases. Work is under way to quantify the additional financial pressures for the Council of “unblocking” these contracts.

26. Introduction of a new national integrated tariff will provide a payment structure which enables a faster implementation of integrated working. The rate for the per-patient tariff has yet to be determined, but is likely to represent a net additional financial pressure compared to our current pricing arrangements.

Likely consequences of reductions in funding for sexual health services

27. The portion of the Public Health Grant to be allocated to sexual health will not be determined by the Public Health Committee until March 2015. Until that time, it is not possible to quantify the impact of changes to the budget. Nevertheless, there is some evidence which indicates that the nature of the impact would be adverse, significant and felt by a range of stakeholders (refer to Appendix 4). The reasons are as follows.

28. Firstly, it is likely that any reduction in budget is likely to result in some kind of restriction in access to mandatory open services and/or curtailment of discretionary services targeted to address underlying causes in areas with the worst sexual health outcomes. This is because there is limited scope within our mandated sexual health services for containing all of the existing cost pressures. Taken together with the requirement to move from block contracts to a per-patient tariff, it is unlikely that current levels of provision can be maintained within the existing budget. A reduction in budget would increase the likelihood and scale of the impact on services.

29. Secondly, reductions in access to mandatory open sexual health services and/or curtailment of discretionary services targeted to address underlying causes are likely to impact outcomes at individual and population levels. For example, reductions in the proximity of services or opening hours will impact on their accessibility to some people in need of contraceptive services or STI testing. Evidence for this rests on local intelligence from providers, feedback emerging from engagement with service users and is consistent with assumptions underlying modelling undertaken at a national level.

30. Thirdly, the scale of impact at an individual level is potentially very serious including, for example, unplanned pregnancies in teenagers and adults, onward transmission of untreated STIs, infertility arising from delay in or lack of treatment for Chlamydia infection, and additional complications or early death associated with delayed diagnosis of HIV. At a population level, these outcomes are likely to be reflected in terms of increased health and social inequalities with their long term implications (Refer to Appendix 5 emerging early themes from the SH JSNA refresh).

31. Fourthly, in addition to the potentially serious impact for individuals and their communities, these impacts also entail adverse financial consequences for public service budgets in Nottinghamshire County. For example, a recent study based on national-level modelling found that modest restrictions to sexual health services would negatively impact outcomes and that the consequential costs of this to public service budgets across the whole UK would be in the order of £100 billion over an 8 year period[vi]. Accurately quantifying what the scale or timing of these impacts would be in Nottinghamshire is problematic and sensitive to underlying assumptions and local conditions. Nevertheless, it indicates the general scale and adverse nature of the likely impact.

32. An earlier study provides crude support for the significant positive economic impact of investment in contraceptive services, which was found to deliver £11 of benefit to public service budgets for every £1 invested[vii]. NICE guidance relating to sexual health interventions also provides summaries demonstrating their cost effectiveness. None of these studies provides a refined basis for estimating the impact on outcomes from a reduction in sexual health services in Nottinghamshire, but it is clear that the impact would be negative for individuals, population outcomes, and for commissioners of public services responsible for managing the associated consequences.

33. The implication of this is that it is very likely that any net saving the Council finds it possible to realise from its sexual health budget will be paid for by CCGs who will have to divert funds to meet the costs associated with additional demand for termination of pregnancy, ante- and perinatal services, treatment for infertility and other complications arising from delayed diagnosis and treatment. NHS England and other parties will bear additional costs associated with failure to secure early diagnosis of HIV.

34. Fifthly, notional savings in the Council's sexual health budget will be offset by increased demand and consequential costs for other interventions. Some of these will represent additional pressures on other Council budgets (e.g. increased demand for Early Years interventions such as Sure Start). In other instances, the impact will be felt in Council commissioned services funded by some form of capitated grant (e.g. nursery provision), for which it is already very challenging to identify sufficient adequate capacity in the market.

35. Appendix 4 outlines the benefits of investment in effective SH services.

Immediate next steps

36. The immediate next steps are to complete the needs assessment, continue with work to develop a proposed future service model and a recommendation about the preferred procurement approach for securing this.

37. Work on the future service model will explore the value of delivering contraceptive and sexual health services in a more integrated way, and other recommendations which emerge from the needs assessment work which will be completed by December. Appendix 5 identifies early emerging themes identified so far.

38. Work on the future service model will be undertaken in collaboration with Nottingham City Council in particular, because of our shared interest in the availability of services which are accessible to people who live or work near to Nottingham.

39. Engagement with CCGs on this agenda is through their participation in the Sexual Health Procurement Group, and the Public Health directorate's CCG Engagement Group. It is proposed to bring a version of this paper to the Health and Wellbeing Board in January.

40. As our recommendations develop, Public Health will undertake consultation with relevant stakeholders. It is likely that this will take place in early 2015.

41. It is proposed that a paper is brought to the Public Health Committee in March to recommend a procurement approach and to secure approval for a budget to support this.

Reason for Recommendations

42. Contract expiry and the timescales involved in procurement mean that it is necessary to undertake preparatory work and stakeholder consultation about future sexual health services during the next few months, and prior to seeking Committee approval in March 2015 for a budget.

Statutory and Policy Implications

43. This report has been compiled after consideration of implications in respect of crime and disorder, finance, human resources, human rights, the NHS Constitution (Public Health only), the public sector equality duty, safeguarding of children and vulnerable adults, service users, sustainability and the environment and ways of working and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

44. None

RECOMMENDATIONS

1. The Committee is asked to note the information shared in the paper to inform future decision making
2. The Committee is asked to approve the consultation with stakeholders about the future model of sexual health services in advance of a Committee decision in March 2015 about the budget to be allocated to sexual health

Dr Chris Kenny
Director of Public Health

For any enquiries about this report please contact: Dr Jonathan Gribbin Consultant in Public Health (jonathan.gribbin@nottscc.gov.uk)

Constitutional Comments (LMC 31/10/14)

45. The Public Health Committee has delegated authority within the Constitution to approve the recommendations in the report.

Financial Comments (KAS 04/11/14)

46. There are no financial implications contained within the report.

Background Papers and Published Documents

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

- None

Electoral Divisions and Members Affected

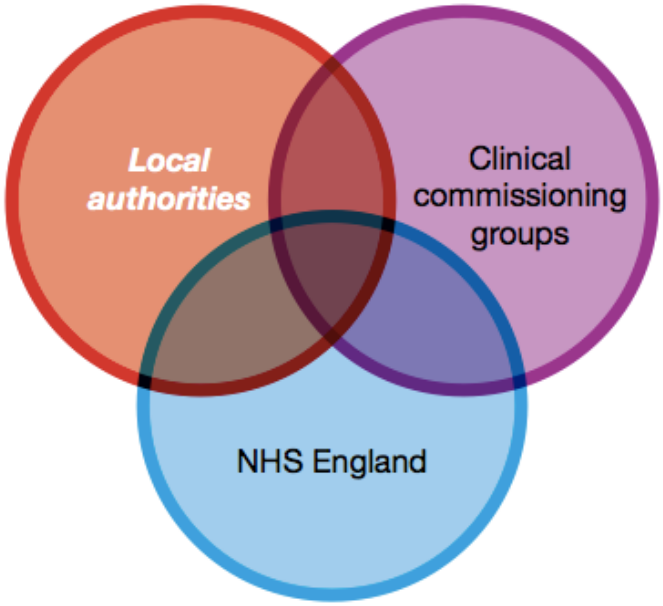
- All

Appendix 1

Commissioning Responsibility for sexual health, reproductive health and HIV [viiiix]

Local Authorities	CCGs	NHS England
• Contraception • STI testing and treatment • Chlamydia testing as part of the National Chlamydia Screening Programme • HIV testing • Sexual health aspects of psychosexual counselling • Sexual services including young people's sexual health, teenage pregnancy services, outreach, HIV prevention and sexual health promotion work, services in schools, colleges and pharmacies	• Abortion services • Vasectomy • Non sexual health elements of psychosexual health services • Gynaecology including use of contraception for non-contraception purposes	• Contraception provided as an additional service under the GP contract • HIV treatment and care including post-exposure prophylaxis after sexual exposure • Promotion of opportunistic testing and treatment for STIs • Sexual health elements of prison health services • Sexual Assault Referral Centres • Cervical screening • Specialist fetal medicine
Original Source: Department of Health Commissioning Sexual Health services and interventions: Best Practice guidance for local authorities, 2013		

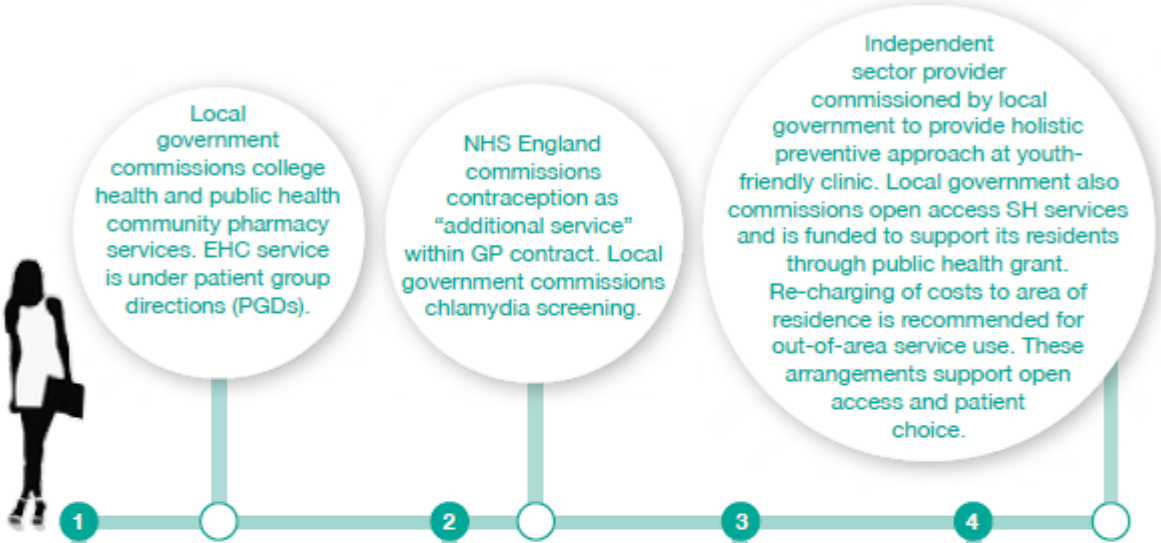
The Venn diagram illustrates the interface and co-dependency of commissioning sexual health, reproductive health and HIV services[x].



Appendix 2 Three people's sexual health journeys (DH 2014)

A young woman's journey

The first service user journey describes a young woman's use of open access sexual health services. It illustrates the need to provide information, advice and care that support her positive sexual health. To avoid unwanted pregnancy and treat an STI, she uses services commissioned by two local authorities and NHS England. Her story underlines the importance of open access and confidential, young person-friendly services.



Step one: Young woman (17) attends college health promotion session, given leaflet on contraceptive services. Saturday two weeks later, gets emergency hormonal contraception (EHC) from pharmacist, plus information about contraceptive options and local services. Pharmacist offers chlamydia screen which she accepts (negative result sent by text).

Step two: Makes and attends appointment at GP for contraceptive advice and provision, prescribed oral contraception. Declines chlamydia screen due to recent pharmacy screen.

Step three: Three months later has new sexual partner, attends local youth-friendly clinic for chlamydia test, diet, exercise and smoking advice. Registers with local condom card scheme and given first supply of condoms. Receives positive chlamydia screen result by phone, referred to integrated sexual health (SH) service for treatment, partner notification (PN) and full STI screen. The nearest service, in nearby town, is commissioned by a different authority from that in which she lives.

Step four: Attends early evening walk-in session at integrated SH clinic, screened for other STIs (negative), treated for chlamydia and PN discussed. Contraceptive choices also discussed. Opts to change to contraceptive implant.

A woman's journey

The third service user journey is that of an adult woman who has an unplanned pregnancy. The services she accesses are commissioned by a CCG and a local authority. She has wider health needs but these are poorly catered for as she is not able to access a range of other, disparate services. The opportunity to meet her needs in an integrated way is therefore lost.

Local government commissions open access integrated SH service.

CCG commissions abortion service.

Local authority and CCG should ensure service and contracting arrangements support an effective integrated pathway for service users.

1 2 3 4

Step one: Woman (37) attends integrated SH service for pregnancy test (positive result), has full STI screen including HIV test (all results negative), and receives advice on choice of contraception. After discussion, seeks referral to abortion service.

Step two: Attends abortion service, discussion with clinician identifies problems with alcohol use, opts for termination of pregnancy and given appointment.

Step three: Attends for day case abortion, requests condoms, sees counsellor within the service who encourages return to integrated SH service for further contraceptive advice. Also referred to women's alcohol advice service.

Step four: Does not return to SH service nor attend appointment at alcohol advice service. No mechanism exists for follow-up between different services and opportunities to support this woman are lost.

A gay man's journey

The second service user journey describes the sexual health needs of an HIV positive gay man. It underlines the importance of linkages and referral pathways between sexual health and HIV services. It also illustrates the wider needs of people living with HIV (PLWH) for treatment information and social support, which they may seek outside their local authority of residence to maintain confidentiality. Flexible funding mechanisms are required which match patterns of service usage.

Local government commissions integrated SH services including HIV testing.

NHS England commissions HIV treatment and care services. These are often provided at same site as local government-commissioned GUM or integrated SH services by same team of professionals.

Local government commissions social and peer support services, PN and STI screens for PLWH. NHS England commissions primary care for PLWH as part of "essential services" in GP contract.

1 2 3 4

Step one: Gay man (early 20s) attends integrated SH clinic. Gonorrhoea diagnosed, treated and managed, HIV test negative.

Step two: Returns to integrated SH clinic 18 months later with new gonorrhoea infection. Tests positive for HIV. Supported by GUM team, counselled by health adviser including issues of disclosure and PN. Urgent referral to specialist HIV outpatient clinic.

Step three: Seen at HIV outpatient clinic for assessment and evaluation, receives treatment information. Referred to voluntary organisation for peer and social support. Agrees HIV service can inform his GP of his HIV status and share details of his treatment and care.

Step four: Initial assessment, then ART initiated. With SH and HIV services delivered by same provider and co-located, PN undertaken, sexual history taken and full STI screen performed during same visit. Advised to return regularly for STI screening.

Appendix 3 Summary of current contracts for Sexual Health Services

Local Authority Commissioned Services – Sexual Health	
Type of Service	**Provider**
CaSH Service	
South County Community CaSH Clinics	Nottingham University Hospitals
Central Nottinghamshire Community CaSH	Sherwood Forest Hospitals Foundation Trust
Bassetlaw CaSH Clinics	Doncaster and Bassetlaw Hospital
GU Med	
City Hospital	Nottingham University Hospitals
KMH and Newark Hospital	Sherwood Forest Hospitals Foundation Trust
Retford Primary care Centre and Reyton Street	Doncaster and Bassetlaw Hospital
CaSH in the city accessed by county residents	
Health Shop Sexual Health Service - accessed by county Service Users, positive engagement with people increased sexual health needs/risks	Nottinghamshire Healthcare Trust (NHT)
LARC - Long Acting Reversible Contraception	
Intra Uterine Contraceptive Devices	LCPHS – GPs and in CaSH
Contraceptive Implants	
Emergency Contraception	
Emergency Hormonal Contraception	Community Pharmacies and in CaSH
HIV Prevention and Testing	
Outreach advice and Point of Care Testing (POCT)	Terence Higgins Trust
Health Promotion and advice Young People	
SEXions – *only commissioned in Central Nottinghamshire	Sherwood Forest Hospitals Foundation Trust
C Card Scheme	Available at various locations across the county and in the city
Out of Area GUM and Out of Area CaSH	Nottinghamshire County residents can access services out of area and the respective provider invoices the relevant LA
Nottinghamshire County residents can access services when out of area and the respective provider invoices the relevant LA	Any CaSH or GUM provider within England
KEY: **CaSH** – Contraceptive and Sexual health Service **GU Med** – Genito-urinary Medicine (sometimes referred GUM) **GPs** – General Practitioners **LCPHS** –Locally Commissioned Public Health Services **C –Card Scheme** access to condoms for young people and signposting to CaSH and GUM	

Appendix 4 Benefits of investment in effective SH services (DH 2014)

Key objectives in 'A Framework for Sexual Health Improvement in England'	Benefits at the individual level	Benefits at the public health/population level	Other benefits (economic, health and social outcomes) ✓=benefit for specified commissioner(s)
Objective: Continue to reduce the rate of under 16 and under 18 conceptions Commissioning intention: Ensure choice and timely access to young people-friendly reproductive health services and all methods of contraception	Control over fertility through increased use of contraception Greater ability to pursue educational and employment opportunities Improved self-esteem Improved economic status/reduction in family and child poverty	Fewer unwanted pregnancies Improved health outcomes for mothers and babies Better educational attainment Better employment and economic prospects	Improved infant mortality rates ✓CCGs Reduced A&E admissions/childhood accidents ✓CCGs Decrease in abortions ✓CCGs Reduced use of mental health services ✓CCGs Reduced use of social services ✓LAs Fewer young people not in education, employment or training ✓LAs Reduction in family and child poverty ✓LAs
Objective: Reduce rates of STIs among people of all ages Commissioning intention: Encourage uptake of chlamydia screening and testing for under 25 year olds	Treatment of STIs Reduced risk of other health consequences (eg pelvic inflammatory disease, tubal-factor infertility, ectopic pregnancy)	Reduction in prevalence and transmission of infection Opportunities to test for other STIs/HIV in those diagnosed with chlamydia Reaching young people with broader sexual health messages Increased uptake of condom use	Reduced use of gynaecology services (to manage other health consequences) ✓CCGs Increased uptake of sexual health services by young people ✓LAs Increase in chlamydia diagnoses enabling more treatment and consequent reduction in prevalence ✓Las
Objective: Reduce onward transmission of HIV and avoidable deaths from it Commissioning intention: Ensure access to high quality reproductive health se4rvices for all women of fertile age	Access to treatment Better treatment outcomes/prognosis Improved ability to protect partner from HIV	Fewer people acquiring HIV Greater contribution of people living with HIV to workforce and society Less illness and fewer avoidable deaths	Lower health and social care costs for HIV ✓NHS England, CCGs and LAs Lower healthcare costs for associated conditions and emergency admissions ✓CCGs Enhanced public

			health/prevention ✓Las
Key objectives in 'A Framework for Sexual Health Improvement in England'	Benefits at the individual level	Benefits at the public health/population level	Other benefits (economic, health and social outcomes) ✓=benefit for specified commissioner(s)
Objective: Reduce unintended pregnancies among all women of fertile age Commissioning intention: Ensure access to high quality reproductive health services for all women of fertile age	Better control over fertility for women at all life stages, through access to choice of full range of contraceptive methods Optimisation of health for women prior to becoming pregnant Fewer abortions and repeat abortions for individual women Improved quality of family life	Fewer unwanted pregnancies Improved pregnancy outcomes Improved maternal health and reduced maternal mortality	Investment in contraception is cost effective in reducing pregnancies and abortions ✓CCGs Lower healthcare costs through reduced antenatal, maternity and neonatal costs due to better management of pregnancy and improved outcomes ✓CCGs Reduced social care costs for infant and child care ✓LAs

Appendix 5

Early emerging themes form the refresh of the Sexual Health JSNA
A summary of the population groups identified as most at risk of poor sexual health

Early emerging themes from the refresh of the SH JSNA

The highest rates of poor sexual health outcomes across the population are seen in Mansfield and Ashfield districts. Patterns in diagnosis rates for acute STIs broadly follow local deprivation patterns, with the highest rates of poor sexual health outcomes in areas of greatest deprivation. Exceptions to this trend are seen in Bassetlaw, where the second highest rate of new STI diagnosis is seen in the least deprived quintile of the population and in Rushcliffe where there is no clear association between deprivation and rate of new STI diagnosis.

A health equity audit will be needed to fully assess whether we are reaching vulnerable groups, and those in greatest need of sexual health services. An initial assessment of available evidence suggests that there is fairly equitable service provision, with regard to diagnoses rates and access by age group, gender, BME groups and deprivation level. However, this analysis is limited by current availability of appropriately segmented provider activity data for some services.

Despite a low coverage rate of the target chlamydia screening population (ages 15 to 24) in Nottinghamshire, some areas, notably Mansfield Ashfield and Gedling, have high positivity rates in those tested for chlamydia from this age group, and amongst the highest chlamydia diagnosis rates in the East Midlands. Concurrently, Nottinghamshire County has had a crude rate of admissions for pelvic inflammatory disease (PID) over the past 5 years which is significantly higher than the England average, and in 2013 is in the highest 15% of upper tier and unitary authorities. The rates in Ashfield and Mansfield districts are amongst the worst 5 districts in England. There are a number of possible explanations for this pattern, including that there may be a high level of undiagnosed STI infection (primarily chlamydia and gonorrhoea) in these areas leading to poor long term sexual health outcomes. Further investigation and research is needed to understand the reasons underlying this high rate of poor sexual health outcomes.

Whilst rates of diagnosis for gonorrhoea remain significantly below the England average in Nottinghamshire County, the rate of increase in diagnosed gonorrhoea infection is greater than for any other county or unitary authority in the East Midlands, with the exception of Nottingham City. This trend may be due to small numbers and random chance variation, or may reflect a change in testing patterns locally, to use more sensitive tests or introduce dual testing for chlamydia and gonorrhoea. Alternatively there may be a significant increase in gonorrhoea diagnosed in Nottinghamshire County. High rates of gonorrhoea and syphilis in a population reflect high levels of risky sexual behaviour. The reasons underlying the observed increase in Nottinghamshire County need to be explored.

Reinfection rates are higher in some districts than the England average. The highest rates of reinfection are seen in those aged 15 to 19 years. Reinfection is a marker of persistently risky behaviour and potentially of unmet need. Further investigation is needed to understand what may be driving higher rates of reinfection and how behaviour change can be encouraged via sexual health services and health promotion routes.

More than 50% of HIV diagnoses in Nottinghamshire were classed as late diagnosis in 2013. This should be taken in context of a very low prevalence of HIV in Nottinghamshire (0.64 per 1,000 among persons aged 15 to 59 years). Effective strategies for early diagnosis in a low prevalence population need to be considered.

Summary of the population groups identified as most at risk of poor sexual health

- Young people aged under 25 years (in particular those living in the most disadvantaged areas of Nottinghamshire and those who do not routinely access core health services). Specific groups of vulnerable young people include:
    - Those at risk of offending or who are excluded from school
    - Homeless young people
    - Teenage parents
    - Lesbian, gay, bisexual and transgender (LGBT) young people
    - Those not in education, employment or training (NEET)
    - Those with low educational achievement

    - Those with learning disabilities or mental health problems
    - Children in the care of the local authority
    - Young people at risk or involved with CSE
- BME young people
- Black and ethnic minority groups
- Refugees and asylum seekers and people for whom English is a second language
- Sex workers (male and female)
- Women experiencing domestic violence
- Lesbians
- Bisexual, gay men and men who have sex with men
- Transgender

References

[i] WHO Health Topics Sexual Health. Accessed on line on 24.10.2014 at: http://www.who.int/topics/sexual_health/en/

[ii] PHE Laser Summary Report (2012)

[iii] The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013. Accessed on line on 24.10.2014 at: http://www.legislation.gov.uk/ukdsi/2012/9780111531679/contents

[iv] NICE (2011) Increasing the uptake of HIV testing among men who have sex with men. Accessed on line on 24.10.2014 at: http://www.nice.org.uk/guidance/ph34

[v] Nottinghamshire County JSNA (2014) Teenage Pregnancy Chapter (including health and wellbeing for young families) 2014

[vi] Development Economics (2013) Unprotected Nation. The Financial and Economic Impacts of Restricted Contraceptive and Sexual Health Services. A report by Development Economics

[vii] McGuire & Hughes (1995) The economics of family planning services

[viii] PHE (2014) Making it work. A guide to whole system commissioning for sexual health, reproductive health and HIV

[ix] DH (2013) Commissioning Sexual Health Services and Interventions – Best practice guidance for Local Authorities

[x] PHE (2014) Making it work. A guide to whole system commissioning for sexual health, reproductive health and HIV