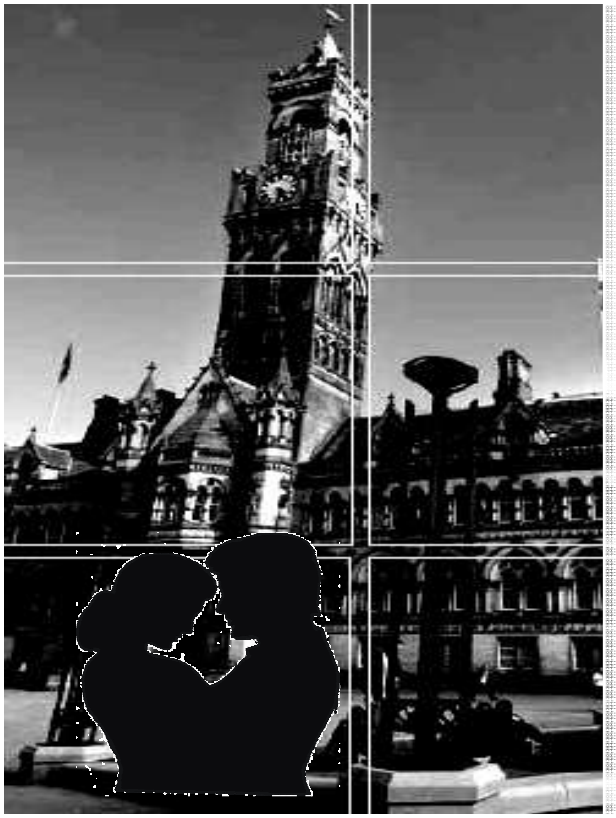

Sexual Health Needs Assessment

Bradford District

2011

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The Bradford district Sexual Health Needs Assessment was produced through the partnership working of the following organisations:

1. Executive summary

The Bradford District Sexual Health Needs Assessment is intended to direct and support the development and delivery of high quality, integrated, accessible sexual health provision for the population of Bradford district. It underpins the delivery of both the Sexual Health Strategy and the Young Person's Sexual Health and Teenage Pregnancy Strategy (YPSH&TP) providing a structure for the systematic review of the district's sexual health needs.

Sexual health features strongly in both the Public Health White Paper and the Public Health Outcomes Framework 2013-2016. It is proposed that the new Public Health Framework will be in operation from April 2012 and during 2011/12, work needs to focus on preparing for and implementing transition arrangements working towards this direction. All public health functions, including commissioning of comprehensive sexual health provision, will be transferred to the local authority by April 2013. However, at the time of writing, the Coalition Government have yet to release information regarding sexual health and this guidance is not now expected until mid 2012.

The needs assessment will be reviewed on a three yearly basis with annual updates to the performance appendices and any other relevant additional information. It will be overseen by the Sexual Health Network which enables the population of the health economy of Bradford district to access the full range of sexual health services in a range of settings and to ensure they receive fully integrated, coordinated care including prevention, education and treatment appropriate to their need. The chair of the group is the head of public health, with representation from a range of clinical and non-clinical providers and local authority and voluntary sector partners. Delivery of the recommendations of this needs assessment will be through the Sexual Health Strategy and action plan, which have the members of the Sexual Health Network as named leads for the work.

The YPSH&TP Board will oversee the YPSH&TP Strategy with responsibility to the chair of the group placed within the Children's Trust of the local authority. The board has representation from Children's Trust, health commissioners and providers and voluntary sector partners. The sub-groups of the network and board will ensure the different elements of the strategies and action plans are completed, with named leads for each area of work to be completed.

Sexual health encompasses a wide range of issues from education and promotion of positive sexual health to treatment and testing for Sexually Transmitted Infections (STIs) including Human immunodeficiency virus (HIV) and Acquired immune deficiency syndrome (AIDS). Bradford district takes a holistic approach to the promotion of positive sexual health and reduction of health inequalities and seeks to work in innovative partnerships to meet the varied sexual health needs of the population. We deliver services and programmes across a wide range of people, using a variety of service models and providers. Challenges and opportunities for the future include increasing STI rates including HIV and building capacity in services in the current financial climate, whilst sustaining our continued success in reducing unwanted teenage conceptions and building capacity in our workforce to increase the delivery of comprehensive sex and relationships education (SRE) both in educational and informal youth settings.

Data reporting and performance will have particular challenges for reporting on STIs including Chlamydia, as we transfer to updated systems across genitourinary medicine (GUM) and non-GUM settings. However, the changes will ensure we have better quality data, including patient level characteristics, to support effective analysis and service development and delivery. Alongside this change we will be undertaking impact evaluations of long-standing programmes as we realign direction of travel to support the delivery of sexual health following the Health and Social Care Bill 2011.

To support the development of effective service provision we will also increase consultations with our population to improve general sexual health,

accessing more specific providers and vulnerable groups at increased risk of adverse sexual health outcomes, again supporting our ultimate aim of reducing the gradient of health inequalities faced by our resident population.

In addition to this we intend to support the expansion of enhanced primary care services to be more responsive to patient need. By providing more enhanced sexual health services within the community we can enable our highly specialised secondary care providers to develop their own areas of expertise to target those at increased risk of poor sexual health outcomes.

Finally, this Sexual Health Needs Assessment could not have been produced without the support, assistance, expert knowledge and opinions of the members of the Bradford Sexual Health Network, for which the authors are extremely grateful. The membership of the network has recently been reviewed in line with the needs of the needs assessment and to reflect recent structural changes in both the NHS and local authority, but membership of the previous Sexual Health Network group has been included as a note of grateful thanks.

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2. Introduction

The World Health Organisation defines sexual health as *a state of physical, mental and social wellbeing in relation to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.*

The breadth and depth of this definition highlights the fact that

- Sexual health is a complex area of healthcare that extends beyond the provision of genitourinary medicine or contraception services operating in isolation
- Sexual health is a cross-cutting issue and liaison with colleagues across other sectors of healthcare and related services is therefore essential
- By strengthening self-esteem, confidence and personal responsibility we can positively promote healthy behaviours and lifestyles; and by adapting the environment we can support individuals to make healthy choices.

Since the introduction of the National Strategy for Sexual Health and HIV in 2001, NHS Airedale, Bradford and Leeds and its predecessors, NHS Bradford and Airedale, and Airedale, South & West, City and North Bradford PCTs, and partners have strived to develop a strategic plan to effectively prioritise sexual health activity across the district. The aim is to enable our population to be in good sexual health and be well educated in how to protect themselves against STIs and unplanned pregnancies. In addition to this we constantly seek ways in which we can provide improved services that meet their needs in a non-judgemental and supportive way.

This needs assessment, and subsequent strategy and action plan, will provide us with the framework in which to design, develop and deliver improved sexual health activity be that through education and health promoting activity or the more clinically based testing and treatment. It builds on the 5 key strategic areas as identified in *Progress and priorities- working together for*

high quality Sexual Health- Review of the National Strategy for Sexual Health and HIV (2008) by demonstrating that in the district:

- Sexual health is prioritised as a key public health issue, sustained by high level leadership at a local level
- Strong strategic partnerships drive the work forward
- We commission for improved sexual health
- We invest more in prevention
- We deliver a modern sexual health service

The sexual health National Support Team (NST) visited Bradford and Airedale teaching Primary Care Trust (BAtPCT) in 2007 and presented its report in November 2007. Its final report recommended 5 key actions (Appendix iii)

1. The tPCT needs to develop a new strategic plan that is informed by a Sexual Health Needs Assessment
2. There is a need to review the nursing and health advisor teams and roles, as outlined within the NST recommendations, to release existing capacity within the service
3. There is a need to further develop sexual health service capacity within the community, while developing links between GUM and contraception. The tPCT should consider the need for consultant input within the contraceptive service, including the appointment of a sexual health nurse consultant.
4. There is a need for a recovery plan for the Chlamydia Screening Programme (CSP) to be developed and implemented. The NST and Health Protection Agency (HPA) can offer assistance
5. The tPCT needs to capitalise on the new opportunities arising with the local authority to review partnership working arrangements. Particularly with Education Bradford in relation to teenage pregnancy

The Bradford and Airedale Sexual Health Network was established following the NST visit in November 2007. The principal purpose of the network is to enable the population of the health economy of Bradford district to access the full range of sexual health services in a range of settings and to ensure they receive fully integrated, coordinated care including prevention, education and treatment appropriate to their need. The network also leads on the implementation of the Sexual Health Strategy and action plan

In acknowledgement of the particular issues faced by young people, since 2001 Bradford district also has a fully integrated Young Persons Sexual Health and Teenage Pregnancy Strategy (YPSH&TP). This is owned by the local authority and delivered in partnership.

Sexual health features strongly in both the Public Health White Paper (DH, 2010) and the Public Health Outcomes Framework (DH, 2012). It is proposed that the new Public Health Framework will be in operation from April 2013 and during 2011/12, work will need to focus on preparing for and implementing transition arrangements working towards this direction. In addition to this some public health functions including commissioning of comprehensive sexual health provision will be transferred to the local authority by April 2013.

To ensure smooth transition to the new commissioning arrangements oversight of the Sexual Health Needs Assessment will be undertaken by the Sexual Health Network. While we await the further guidance on sexual health related to the Public Health White Paper and also the results of the Public Health Outcomes Framework consultation, it is our priority to support local sexual health providers with successful outcomes and on the quality of service provided for the population of Bradford district.

3. Methodology

Health needs assessment (HNA) is classically defined as:

'A systematic method of identifying unmet health and health care needs of a population and making changes to meet those unmet needs'

HNA was initially thrown into the spotlight in 1989 by the National Health Service Review which, by separating purchasers and providers, identified population health care purchasing, and therefore health care needs assessment, as a distinct task. Specific reasons for the introduction of HNA included:

- Increasing costs of health care
- Constraints on public sector finance
- Doubts about effectiveness
- Health inequalities
- More explicit resource allocation

Practical uses of HNA:

- Improve health and other service planning
- Priority setting
- Policy development

Three recognised HNA approaches are used in this HNA:

3.1 Epidemiologically based HNA

This approach combines epidemiological approaches with assessment of the effectiveness and possibly the cost-effectiveness of the potential interventions.

3.2 Comparative HNA

This approach compares levels of service receipt between different populations.

3.4 Corporate HNA

This approach involves canvassing the needs and demands of professionals, patients, politicians and other interested parties.

HNA may also be complemented by the Health Equity Audit (HEA) which specifically investigates issues around access to health care according to epidemiological and demographic group.

The latest development in this area of analysis is Joint Strategic Needs Assessment (JSNA), where the work is undertaken through HNA in partnership designed to provide strategic direction for the district based on high level analysis of need.

There is a need to begin viewing HNA as a cyclical process rather than as a document encompassing identification of the relevant population, identification of issues and challenges, prioritisation of needs, action planning for change and finally a process for reviewing the cycle. This is the cornerstone of JSNA and pragmatically addresses issues around data becoming out of date and the danger that the HNA is viewed as purely a document on a shelf.

This piece of work is designed to act as a live toolkit, and it is anticipated that data will be updated on an ongoing basis and reviewed as a bimonthly iteration of the toolkit at each meeting of the Sexual Health Network. Close co-operation between public health, performance and other key partners will be crucial.

Equally, evidence and policy updates can be incorporated into the HNA as they are published. Regularly published data, by its very nature, becomes out of date as soon as its next dataset is published. The toolkit approach will ensure, where possible, that data should never be more than a few months out of date.

Ultimately, the data and documents that constitute this piece of work will be lodged on the tPCT SharePoint system where they can be accessed by all

stakeholders. Ownership of this will be allocated to the chair of the Sexual Health Network.

Scope

The importance of sexual health and HIV was reflected in the 2001 National Strategy for Sexual Health & HIV. It defines sexual health as a key part of our identity as human beings, together with the human rights to privacy and a family life with freedom from discrimination. “essential elements of good sexual health are equitable relationships and sexual fulfilment, with access to information and services to avoid the risk of unintended pregnancy, illness or disease.’’

The key aims of the strategy include:

- Reducing the transmission of HIV and STIs
- Reducing the prevalence of undiagnosed HIV and STIs
- Reducing unintended pregnancy rates
- Improving health and social care for people living with HIV
- Reducing the stigma associated with HIV and STIs

This needs assessment aims to:

- Describe sexual health in Bradford district, looking at trends in STIs, HIV, teenage conceptions, and terminations.
- Describe current service provision with regards to prevention, treatment and support.
- Identify the type and level of need.
- Identify key prevention groups in greater need of services locally.
- Provide recommendations to address gaps in services and current unmet needs.

There is little point in providing services that are not provided in a time and place that matches the needs and lifestyles of patients. A key challenge is to identify the combination of ‘where’ and ‘when’ that will lead to the maximum number of patients accessing services.

Health needs assessments must consider the evidence relating to effectiveness, cost effectiveness and efficiency of services, in order to deliver maximal outcomes for unit input. To this end, we must review our current service provision in the light of existing and emerging evidence, and also other models of delivery. This is a key area of the HNA that will evolve over time.

Once this process is complete, we will have a clearer idea of what our strategic priorities will be over coming years, and how these can be translated into commissioning activity and intention.

4. Demographics and populations

Bradford district is a metropolitan district with a population of just over half a million people. It contains within it a large rural area and comprises a number of discrete towns, including Bingley, Ilkley, Keighley and Shipley, many villages each with their own character, needs and differences, as well as the large urban city of Bradford itself, with its high levels of poverty, deprivation and health and social needs. Bradford district has many positive attributes but also many areas of severe disadvantage and associated health inequalities.

Bradford district is within the most deprived 10% of local authorities nationally and is the most deprived authority in West Yorkshire. One in 25 residents (20,000 people) lives in the most deprived 1% of the country (Indices of Deprivation 2007), whilst parts of Ilkley are among the least deprived 1%. The gap between the most deprived and least deprived areas of the district is the largest in the country (BMDC, 2010)

Age

- Age is a significant factor in the epidemiology of STIs
- STI infection rates are of higher prevalence in the 15 – 24 age group
- Age profile is not equally spread through the district - the previous boundary area of City PCT has the largest % of younger people.
- STIs in older adults must not be forgotten – there is a need to develop appropriate service access informed by robust information and support.

Deprivation

- Deprivation is often given as a proxy overarching indicator of need and is closely correlated with many outcomes, including sexual health.
- Deprivation is concentrated in a relatively small number of areas of Bradford
- 43% of the Bradford district population live in the most deprived 20% of areas in England

- Bradford also has some of the most affluent wards in the country - inequalities exist *within* the district as well as compared with the country as a whole
- STIs and teenage conceptions are strongly associated with deprivation

Ethnicity

Bradford district has a diverse population with the majority of the ethnic minority population in the district residing in the inner city areas of Bradford and Keighley. Minority ethnic communities currently make up approximately 22% of the total current population. Of particular note in inner city areas of Bradford and Keighley:

- Significantly lower white population
- Significantly higher Asian /Asian British population

Asylum seekers and refugees

A significant number of international migrants have arrived in Bradford since 2001. Until recently most migrants originated from the New Commonwealth. Bradford has also been accommodating increasing numbers of asylum seekers during the past few years, although this trend has begun to reverse. There are now fewer than 900 asylum seekers in the district, largely single men from Middle Eastern and African countries. Particular health issues relating to this group of people centre on access to health care (provision is currently focused through Bevan House principally) and entitlement to treatment.

European Economic Area Migrants (EEA)

Since the enlargement of the European Union (EU) in 2004, accession country migrants have made a significant impact on population numbers as well as the composition of the district's population. Most EU migrants originate from Poland, Slovakia and Latvia, although since 2008 and the economic downturn in the UK numbers arriving in the district have fallen. There are programmes to aid migrants accessing NHS provision although for some younger people who have not qualified for entitlement through EU accession rules regarding employment, there may be a problem with having lack of

recourse to public funds which may impact upon the inequalities they face in relation to their sexual health.

5. Sexual health programmes

Sexual health is about more than avoiding unintended pregnancies and infections and having access to good Contraception and Sexual Health (CASH) services which whilst necessary are not sufficient if provided in isolation. An individual using contraception and free of infection could not be described as having good sexual health if, at the same time, they were in an abusive relationship or had sexual relations in order to please others with little or no concern for their own pleasure or enjoyment.

In 1986 WHO adopted the Ottawa Charter which promoted and supported developments in public health. These 5 principles support the basis of all public health promotion work and so form the underpinning of a public health approach to promoting positive sexual health and preventing the spread of HIV and STIs in Bradford and Airedale. These principles are:

- Building a healthy public policy
- Creating environments that are supportive of public health
- Developing personal and social skills related to sexual health and HIV
- Building on the evidence base and developing staff skills/ knowledge/attitudes
- Strengthening community action

In order to promote positive sexual health and reduce inequalities in sexual health for the whole population, a holistic approach to sexual health is integral to this strategy and is reflected in this Sexual Health Needs Assessment and also the Sexual Health Strategy and action plan. Political and social determinants of health are taken as seriously as individual choices, decisions and behaviours along with acknowledgement that individuals do not make choices related to their sexual health in a vacuum but are influenced by wider factors, sometimes beyond their control.

An holistic sexual health strategy and action plan will reflect the vital importance of work at organisational, institutional, social and community levels as well as work with individuals and groups if the conditions for positive sexual health are to be created, sustained and supported. It should also be informed by a positive and holistic model of sex itself, acknowledging the vital part this plays in human experience and in many people's lives.

Equal respect and status should be accorded to the social and educational models of health as to medical and clinical approaches, seeing them as complementary and supportive of one another. This acknowledges and recognises the complex interventions required to address growing inequalities in sexual health. By taking a holistic view rather than having a limited concept of sexual health and HIV prevention, issues such as self esteem and emotional development, of communication and negotiation, of power, stigma and discrimination are acknowledged to play as vital a role as identification, testing and treatment. Keeping both in balance and acknowledging the constant interplay between the two will result in the most effective action.

Recommended standards for sexual health services support the development of a range of sexual health services outside NHS settings, with integrated care pathways, to promote increased user choice and consistent quality of care. Health promotion interventions should provide information, support and opportunities to enhance personal and social skills, enabling people to exercise control over, and improve their sexual health. In addition to this the impact of other issues such as alcohol and drug use are acknowledged to impact upon sexual health. Healthy Lives, Healthy People states:

> *"We will work towards an integrated model of service delivery to allow easy access to confidential, non-judgemental sexual health services (including for sexually transmitted infections, contraception, abortion, health promotion and prevention). The Department of Health is piloting interventions on alcohol misuse linked to sexual health risks in order to manage broader risk-taking behaviour. We will also publish the results of an evidence review for sexual health which will help develop targeted*

interventions for particular groups, taking account of their specific needs and motivations. DH 2010

Essential to a successful integrated sexual health service is the empowering and involving of people who use sexual health services both at an individual level, to support individual assessment of personal risk and access service provision, and also at a collective level, in planning and organisation of sexual healthcare to help services become more responsive to individuals, groups and communities. This would assist commissioners and services to promote action to increase uptake of services, target high need communities and expand opportunities to identify needs in a range of settings.

Finally, in the standards not related to clinical provision, improving access to services is a key priority. Individuals, groups and communities should have prompt access to a full range of sexual health services and to comprehensive information on local sexual health provision. In order to know how, when and where to access full contraceptive, GUM, pregnancy testing and abortion services people need information and education; providing this alongside a medical model of sexual health will ensure we are promoting increased self-efficacy in our population to take control of their own sexual health.

There are a number of factors that must be addressed to achieve good sexual health and contribute to a broad and holistic sexual health strategy.
These factors, which can apply to all ages, include;

- developing skills, attitudes and understanding relating to sexual health
- raising self-esteem, confidence, respect, assertiveness
- taking a ‘sex positive’ approach and recognising the role of pleasure
- addressing the effect of media, sexualisation and pornography and of gender stereotyping on attitudes and behaviour
- developing strategies for recognising and reducing relationship abuse and increasing understanding of mutual consent

- examining the effect of alcohol and drugs on sexual behaviour and risk taking

By paying attention to the personal or ‘micro’ factors that may influence behaviour, issues of choices and decision making become more evidently important to supporting positive sexual health, for example having the self-esteem and communication skills to negotiate condom use or contraception, to resist coercion and abuse as well as withstanding the pressure to have sex. Rather than being seen as ‘prevention’ work it should be described as ‘promotion’, ‘development’ or ‘improvement’ work, thus clearly embracing positive elements of human and sexual relationships such as pleasure, trust, support, love and a sense of wellbeing and partnership.

Low self-esteem can be an expression of poor experiences and low expectations. For young people there may be no expectation of academic success or (sufficiently rewarding) employment which might otherwise be compromised by a pregnancy. Girls therefore may feel they have nothing *‘to lose’* from becoming pregnant. Sexual intercourse may *‘validate the adolescent as an attractive person’* (Crockenberg and Soby 1989) and pregnancy would validate capacity in a central biological role.

There would be a gain in self-esteem from a sexual relationship or even from pregnancy.

- Young people may see parenthood as a more prestigious status than the one they currently occupy.
- Pregnancy may signal a rite of passage, as a move to the status of adult and an escape from a childhood status, particularly in some communities where there is an established social norm.
- Sexual contact may be associated with being loved and valued.

Research shows that lower self-esteem:

- Is associated with an increased risk of pregnancy in adolescence

- In teenage girls leads to an increased risk of unprotected sex (up to 50%) than with peers.
- Leads people to being more easily influenced than those with high self-esteem (Janis and Field 1959 quoted in Emler 2001).

More evidence now exists with a meta-analysis finding adequate tests of the connection between influence and self-esteem in 57 separate pieces of research (Rhodes and Wood 1992). Consequently, we are able to see a causal connection and how strong it is.

Research shows that higher self-esteem leads to

- Increased likelihood of acquiring contraceptives
- Increased likelihood of contraceptives being used consistently
- Greater success in persuading sexual partners to take precautions
- Less vulnerability to pressure from a partner to have unprotected sex

Clearly self-esteem affects all but some groups or individuals may be particularly vulnerable to low self-esteem.

Health promotion and social marketing

There is a wide variety of approaches to sexual health that encompass health promotion and social marketing. Behaviour change would be perhaps the primary activity undertaken and would have the most impact on the under 25 population. This is acknowledged as an area for continued prioritisation in Healthy Lives, Healthy People: Our Strategy for Public Health in England 2010:

> "*This White Paper sets out …based on the evidence of what works… the Government's core values...by strengthening self-esteem, confidence and personal responsibility; positively promoting healthy behaviours and lifestyles; and adapting the environment to make healthy choices easier…Improving self-esteem and developing positive*

social norms throughout the school years should be the focus of local strategies and will be supported by information about effective behavioural interventions for self-esteem."

As part of the sexual health strategy and through delivery of the action plan we will endeavour to commission or provide capacity building interventions which include training and development for the broader workforce, direct delivery with young people through targeted and generic programmes and direct and indirect delivery to parents. This delivery will include a range of training opportunities leading to professional and personal development of skills, attitudes and understanding relating to contraception, STIs, access to services, delay, pleasure, self- esteem, sexualisation, gender stereotyping, pornography, consent, relationship abuse, grooming, media, alcohol and drug use, social marketing.

The action plan has been developed to encourage partnerships between a range of statutory and voluntary and community sector (VCS) organisations to ensure that the issues are addressed with particular groups at increased risk of poor sexual health outcomes and to maximise use of existing skills and experience e.g.)

- Young offenders
- Looked after young people
- Young people as a population group
- Lesbian, gay, bisexual and transgendered young people (LGB and T)
- Young parents
- Others identified as at increased risk of poor sexual health outcomes- black and minority ethnic (BME) groups, asylum seekers and refugees, European Economic Area (EEA) migrants, gypsies and travellers

Changing health behaviours is extremely challenging, often requiring not just individual motivation but sustained support from friends, family and society.

Social marketing borrows concepts and techniques from commercial sector marketing, such as insight generation and customer segmentation, and applies them to the problems facing our society. By utilising the concepts outlined and building on a new national programme targeting young people, which will seek to influence behaviours, such as smoking, binge drinking, experimenting with drugs and risky sexual behaviours, we will be able to better target resources and be confident of a high rate of achievement.

Sex and relationships education (SRE)

Action plans in both the sexual health strategy and the YPSH&TP Strategy promote a joined up approach to delivery both in formal and informal settings and across a wide span of age ranges. Coordinated delivery of informal SRE across the broader workforce is one of the recommendations of the recent audit into delivery of SRE across the district (Brook, 2010). The audit was commissioned to address the needs of the broader workforce in relation to the delivery of sexual health work with young people.

The strengthening of more formal approaches to the delivery of SRE in educational settings, building on positive self-esteem, is reflected in the Schools White Paper:

> *"Good schools will be active promoters of health……, because healthy children with high self-esteem learn and behave better at school. Schools will be able to draw on additional expertise from local health professionals and children's services, to best meet the needs of their pupils"* (DCSF, 2010).

Development and implementation of training and SRE programmes should comply with recommendations set out in National Institute for Health and Clinical Excellence (NICE) guidelines (NICE 2007) and The National Sexual Health Training Standards (Dept of Health 2005). Careful planning, local consultation and clear targeting demonstrated through strategic aims and objectives are examples of this. Paying significant regard to the research

evidence, programmes organised and delivered for young people should adopt the following principles:

- to promote the benefits of not engaging in sexual activity until ready
- the accepted premise that sex should be pleasurable, and not pressured or coerced.

Delay and the Pleasure Principle (Sheffield Centre for HIV & Sexual Health 2007) should inform work alongside evidence from national agencies on homophobia, the impact of pornography and teenage relationship abuse (Barter 2009) (Brook, 2009) (Warwick and Douglas 2006). Sexual health promotion should promote personal responsibility, use social norms approaches and address body image and self-esteem issues as previously highlighted in the Coalition Government White Paper; Healthy Lives, Healthy People (DH, 2010).

Information on sexual orientation, homophobia, hate crime and bullying should be integrated into training and SRE work with young people in order to challenge prejudice and promote inclusivity. Research suggests that this may increase the sense of wellbeing and safety felt by some LGB and T young people in school (Warwick and Douglas 2006). Training of workers and peer educators should explore personal values and attitudes and offer evidence of the value to young people of addressing LGB and T issues, homophobia and transphobia. This work contributes to positive mental health and wellbeing, as well as meeting sexual health needs.

Gender stereotyping work should be undertaken to address fundamental inequalities and assumptions that '*increase the risk of violence by men against women and inhibit the ability of those affected to seek protection'* (WHO 2009). This work should be in accordance with the Coalition Government's strategic vision outlined in 'Call to end violence against women and girls' and related action plan (Home Office 2011); '*prevent such violence from happening by challenging the attitudes and behaviours which foster it …'*

The issue of consent should be included in programmes exploring sexual relationships. Exploration of consent is advocated (DH 2003) and recommended (Coy, Lee, Kelly and Roach 2010) and SRE sessions should cover; *'emotions and feelings, managing risk, societal pressures and healthy lifestyles'* (Power and Proctor 2009; DCSF 2010). Objectives should include: increasing tolerance, respect and mutual understanding, enhancing knowledge of STIs and safer sex, establishing/strengthening positive social norms relating to healthy relationships and identifying elements of abusive or exploitative relationships, signposting to accessible sexual health and support services and increasing young people's confidence in accessing these.

Consultation has been undertaken, through a full evaluation of the schools based SRE programme Added Power And Understanding in Sex Education (APAUSE), to ensure that our work meets the needs of specific groups e.g. BME groups and LGB and T young people in schools. The production of the Ur Choice SRE programme reflects the diversity across the district and the commitment to have a comprehensive programme that addresses a variety of issues. Opportunities should be provided in programmes and training for people to contribute their own cultural perspectives. Clear information and messages should be given to young people about abuse – sexual, physical, emotional, and neglectful and also including abuse which occurs within intimate relationships. Signposting to support and protection services should accompany these messages in order that young people are able to access support.

Development and implementation of training and SRE programmes should comply with recommendations set out in NICE guidelines (NICE 2007) and The National Sexual Health Training Standards (Dept of Health 2005). Careful planning, local consultation and clear targeting, aims and objectives are examples of this. There is strong evidence of effectiveness for the following::

Youth development programmes focussing on:

- personal development (confidence, self-esteem, negotiation skills),
- vocational development (may increase contraceptive use and reduce pregnancy rates)
- School-based sex education, particularly linked to contraceptive services (measured against knowledge, attitudes, delaying sexual activity and/or reducing pregnancy rates) (HDA 2003)

There is strong evidence that comprehensive SRE:

- Delays the initiation of sex (Kirby 2007)
- Reduces the number of sexual partners (UNESCO 2009)
- Increases the use of condoms and contraception (NICE 2010)

Characteristics of effective SRE programmes:

- Both school and home contribute to SRE
- Trained educators are used
- A comprehensive range of topics is addressed
- Psychosocial factors which affect behaviour including values, norms and self efficacy are addressed
- Contraception education is linked to services
- Programmes begin before a young person has sex
- Participatory learning methods are used
  (Kirby 2007 and 2008)

Nationally and locally the role of learning mentors is seen as important in dealing with these issues within and without Personal Social Health Education (PSHE) classes.

Community outreach with vulnerable groups - a key outcome of sexual health programmes is for individuals, groups and communities to experience greater levels of self-efficacy in regard to taking greater responsibility for their own sexual health. This entails building capacity within communities and other settings with the aim of increasing people's self-esteem and their sense of

control over their own health and wellbeing, by acquiring practical skills such as negotiation or assertiveness.

Partnerships with VCS organisations would provide access to the most vulnerable and those individuals and groups at increased risk of poor sexual health outcomes. Those not accessing services in healthcare settings would be able to have their sexual health needs met in a supportive environment, building self-efficacious beliefs and promoting positive sexual health. This also includes support to parents and carers to discuss sex and relationship issues with their children.

The Speakeasy programme has run successfully in the Bradford district since 2005, building confidence, skills and knowledge in parents to support their children making positive, sexually healthy choices. It encompasses principles of good parenting and family dynamics which support the following:

- maintaining an open family communication style
- being open to discussing sex with children
- making sure children get sex education
- discussing media experiences with children
- using the internet and other media with children

Immediate Outcomes

By promoting positive sexual health through sex and relationships education, community and voluntary sector outreach, health promotion and social marketing immediate outcomes become evident. This will include increased uptake of condoms, increased self-efficacy to negotiate condom use, an increased uptake in other sexual health services including partner notification and treatment and testing alongside more effective use of contraception.

Longer-term Outcomes

Whilst immediate outcomes may provide measures to support delivery of sexual health programmes, longer-term outcomes will benefit wider health by promoting self-efficacy and trust in health services, particularly by those less willing to access traditional health settings. In addition to this specific sexual health outcome, benefitting from such approaches are a reduction in the transmission rates of HIV and other STIs, reduction in the prevalence of undiagnosed HIV and STIs, a reduction in unintended pregnancy rates (especially amongst those under 19 years) and a reduction in the stigma associated with HIV and other STIs.

Additional issues impacting upon Sexual Health

A report from Independent Advisory Group (IAG) on Sexual Health and HIV states:

> "*The increase in sexually transmitted infections (STIs) and high levels of teenage pregnancy in the UK are "disturbing" and there is "no doubt" alcohol and drugs enhance sexual activity.*
> *Young people are exposed to conflicting messages, with "explicit or subliminal" advertising and coverage of "celebrity" behaviour being prevalent, while other information such as advertising for condoms is restricted.*
> *"Young people engaging in risky sexual behaviour are at greater risk of contracting an STI, becoming young parents, failing at school, building up longer-term physical and mental health problems and becoming addicted to alcohol and drugs".* (IAG 2007)

Sexualisation can be described as where a person:

- Is valued mainly by their (perceived) sexual appeal or behaviour,
- Is held to a standard of physical attractiveness,
- Is sexually objectified for other's 'use' and
- Has sexuality inappropriately imposed upon them.

In an increasingly sexualised society, with immediate access to media (TV, internet, video, DVD, computer games and mobile phones) providing a vehicle for widespread dissemination of sexual images and information, there are implications for all, but with young people's access to and mastery of new technology, tendency to peer influence but inexperience for critical analysis there is an increased risk of significant impact upon them.

Sexualisation for children and young people *"is the imposition of adult sexuality before they are capable of dealing with it, mentally, emotionally or physically"* (Papadopolous, 2010). A survey revealed that 88% of parents think children are under pressure to grow up too quickly, that celebrity culture, adult style clothes and music videos are guilty of encouraging children to act older than they are and most are unhappy with images and content on television before the 9pm watershed. There is broad agreement among researchers and experts in health and welfare that sexualising children prematurely places them at risk of a variety of harms, ranging from body image disturbances to being victims of abuse and sexual violence (Papadopoulos, 2010).

Pornography contributes to sexualisation and gender stereotyping.
In a survey of over 400 young people (aged 13-17) for the Channel 4 programme 'Sex Education versus Pornography':

- 66% said they viewed pornography
- 60% said that pornography has an impact on their sex lives and
- 60% said that pornography affects their self esteem and body image
- Over 50% said that adults should raise the issue of pornography with them by talking, listening and discussing the issue with them

There is evidence that the consumption of pornography and related sexual media (including music videos):

- influences sexual violence, sexual attitudes, moral attitudes, and sexual activity of children and young people
- is related to the sexual activity and attitudes of adolescents
- has an adverse effect on older adolescent boys and young men already at high risk of aggressive behaviour

  (Malamuth, Addison & Koss 2000)
- leads to high expectations of a 'repertoire' of sexual activity including greater heterosexual anal sex – with satisfaction often being reported low for women
- distorted body image for young men and women
- girls being blamed for boys' sexual 'failure' of not being able to perform
- contribute to extreme gender roles with males as sexually dominant and ambiguities as to whether or not females are consenting

There is clear evidence from 5 Meta analyses and 161 studies that extreme pornographic material leads to negative psychological, attitudinal and behavioural effects, with some men:

- believing that rape is enjoyed or desired
- possessing lack of empathy with rape victims
- developing pro rape attitudes
- self reporting likelihood to use force or to rape
- displaying aggression after exposure
- self disclosing of actual rape and sexual aggression as a result

(Itzin, Taket & Kelly 2007)

It is important to encourage critical thinking in SRE about websites with pornographic content and need to challenge the impact of pornography on men and women .Young people's concerns over impact of pornography should be explored as part of comprehensive programmes as outlined in 'Young People and Pornography, A Briefing for Workers' (Brook, Centre for HIV and Sexual Health, FPA and The National Youth Agency, 2010).

As well as pornography's contribution to gender role stereotyping and sexualisation, it raises questions of (mutual) consent and how that is perceived. Consumption of pornography and sexualisation can result in unrealistic expectations, and power and dominance can lead to partner exploitation and violence in intimate relationships. This phenomenon has been the subject of a consultation by the Coalition Government leading to a strategy and action plan which specifically addresses the impact of Teenage Relationship Abuse. (Home Office 2011)

Teenage relationship abuse should be acknowledged as a reality for many young people and opportunities given to identify types of abuse, to discuss complexities and learn about strategies and sources of support. Workers should receive detailed information and training based upon findings such as those in 'Partner exploitation and violence in teenage intimate relationships' (Barter et al 2009). The use of violence by older male partners should be seen as a risk factor on its own merits, as well as those for whom grooming may be seen a risk.

The **Sexual Exploitation** of children and young people has been identified throughout the UK, in both rural and urban areas, and in all parts of the world. It affects boys and young men as well as girls and young women. It robs children of their childhood and can have a serious long-term impact on every aspect of their lives, health and education. It damages the lives of families and carers and can lead to family break-ups. Sexual exploitation can take many forms, from the seemingly 'consensual' relationship where sex is exchanged for attention/affection, accommodation or gifts, to serious organised crime and child trafficking. What marks out exploitation is an imbalance of power within the relationship. The perpetrator always holds some kind of power over the victim, increasing the dependence of the victim as the exploitative relationship develops.

It is important that all young people develop the knowledge and skills they need to make safe and healthy choices about relationships and sexual health.

This will help them to avoid situations that put them at risk of sexual exploitation or to know who to turn to if they need advice and support. Some professional groups or agencies may require specific training or awareness raising, especially if they are working with children and young people who are already vulnerable and who may be at particular risk of becoming involved in child sexual exploitation. This has been carried out in Bradford & Airedale by specialist Voluntary Sector organisations: MESMAC's BLAST Project working primarily with boys and young men residing within the Bradford and Leeds postcodes, Barnardos' Turnaround project addressing the needs of girls and young women in Bradford and the Children's Society's Hand-In-Hand project working in Airedale. Their work not only encompasses direct 1-1 work with young people but they also build capacity within the broader workforce by awareness raising, training professionals and working in schools and youth projects to challenge homophobia.

Homophobia

Exploration and appreciation of diversity and difference should be integral to sexual health training and programmes in order that marginalised groups are included and oppression challenged. This work should incorporate clear messages about the moral, social and legal implications of bullying, oppressive or abusive behaviour. Positive behaviours and relationships should be modelled and discussed by trainers and those delivering programmes and these linked to responsibility and our ability to make informed, positive choices.

Research of LGB and T adults shows that because they were lesbian or gay…..

- 6 in 10 young people were verbally abused
- 1 in 2 had problems at school
- 1 in 5 had been beaten up
- 1 in 7 had been sent to a psychiatrist
- 1 in 10 had been thrown out of home
- 1 in 5 had attempted suicide

…… and yet only 1 in 38 said that homosexuality was mentioned in sex education at school.

So sexual health training and programmes should not just address LGB and T issues in the context of homophobic bullying alone, but also ensure proper representation and acceptance at all levels including within policies, SRE, programmes, projects and pervading attitudes.

Factors influencing sexual behaviour

While people may aspire towards a healthier lifestyle, the initiation and maintenance of health behaviours result from an interaction of social, psychological, biological, and environmental factors. It is important to consider the wider impact of all factors in enabling people to make healthy choices. Sexual health is directly affected by a range of physical, psychological, cognitive, socio-cultural, religious, legal, political and economic factors, over some of which the individual has little or no control. An individual's capability to make a healthy choice will depend not only on their own free will, but also on the range of choices presented in a locality, affordability of different options, their mental wellbeing and personal drive to value their health. Research suggests that intentions to change behaviour, while often a prerequisite of change, can be insufficient to produce sustained change. Starting and maintaining behavioural change can be aided by psychological characteristics and processes. These include self-efficacy, the belief that one has the psychological resources to undertake the desired behaviour, and self-regulation, the individual's ability to use self-regulatory strategies and access a number of processes which aid implementation of the behaviour.

External influences on health are important and impact on health throughout an individual's life course. Positive and negative experiences accumulate over life to affect health outcomes, so it is important to understand the public health challenges at different stages in people's lives. The accumulation and interactions of wider social influences on health affect our social development,

our behaviours and, consequently, our health and wellbeing. These effects may be protective - increasing esteem, life skills, resilience and resistance to ill health and encouraging 'healthy behaviours'; or hazardous – damaging self-regard, undermining social skills and the ability to learn, and creating the conditions for mental and physical ill health.

The National Sexual Health Equality Impact Assessment (EqIA)

This has six domains which are identified to have an impact on individual's ability to enact behaviour change and must be considered when developing local policies or commissioning services. Significant regard has been paid to these domains throughout the development of the sexual health needs assessment, strategy and action plan.

Age There are clear inequalities in the sexual health of young people. It has been shown that they have relatively high rates of unintended pregnancies and STIs, with the exception of HIV. There is evidence to suggest that the incidence of STIs in older people is increasing and it would be beneficial to consider the sexual health needs of this group, with a particular focus on the prevention of STIs. In addition, there is an ageing cohort of people living with HIV, and their needs should be taken into account when developing future sexual health policy.

Disability There is limited data and research available on the needs of people with learning disabilities or physical disabilities. Consequently, people with disabilities have not to date been a focus for sexual health policy.

Gender The sexual health needs of both males and females are currently considered in sexual health policy, and there are particular initiatives to address any gender inequalities. There is a potential need to further examine the sexual health needs of trans-gendered people. While it is estimated that the number of trans-gendered people in the UK is relatively

low, it is a group that often has particular health needs and that can face discrimination. Available evidence highlights the negative impact of sexual violence and abuse on the sexual health of victims/survivors. Further consideration should be given to the sexual health needs of victims/survivors of sexual violence and abuse.

Race While the relatively high rates of HIV among black African communities is currently being addressed through the funding provided to the African HIV Policy Network, other inequalities (such as the high rate of STIs or the relatively high abortion rates among certain communities) are not currently being addressed separately at a national level. Instead, the emphasis on tackling these inequalities is at PCT level, where PCTs are expected to commission services to meet the needs of their local communities.

Religion or belief Sexual health policy should allow people to make informed decisions about their own sexual health, and these decisions may or may not be influenced by their religion or beliefs. If there is evidence to demonstrate links between religion or belief and inequalities in sexual health, then initiatives may be introduced.

Sexual orientation There is strong evidence to demonstrate that men who have sex with men (MSM) have relatively high rates of HIV, and work is already underway to address this inequality. However, surveys of women who have sex with women (WSW) highlight the fact that more needs to be done to address the sexual health needs of this group.

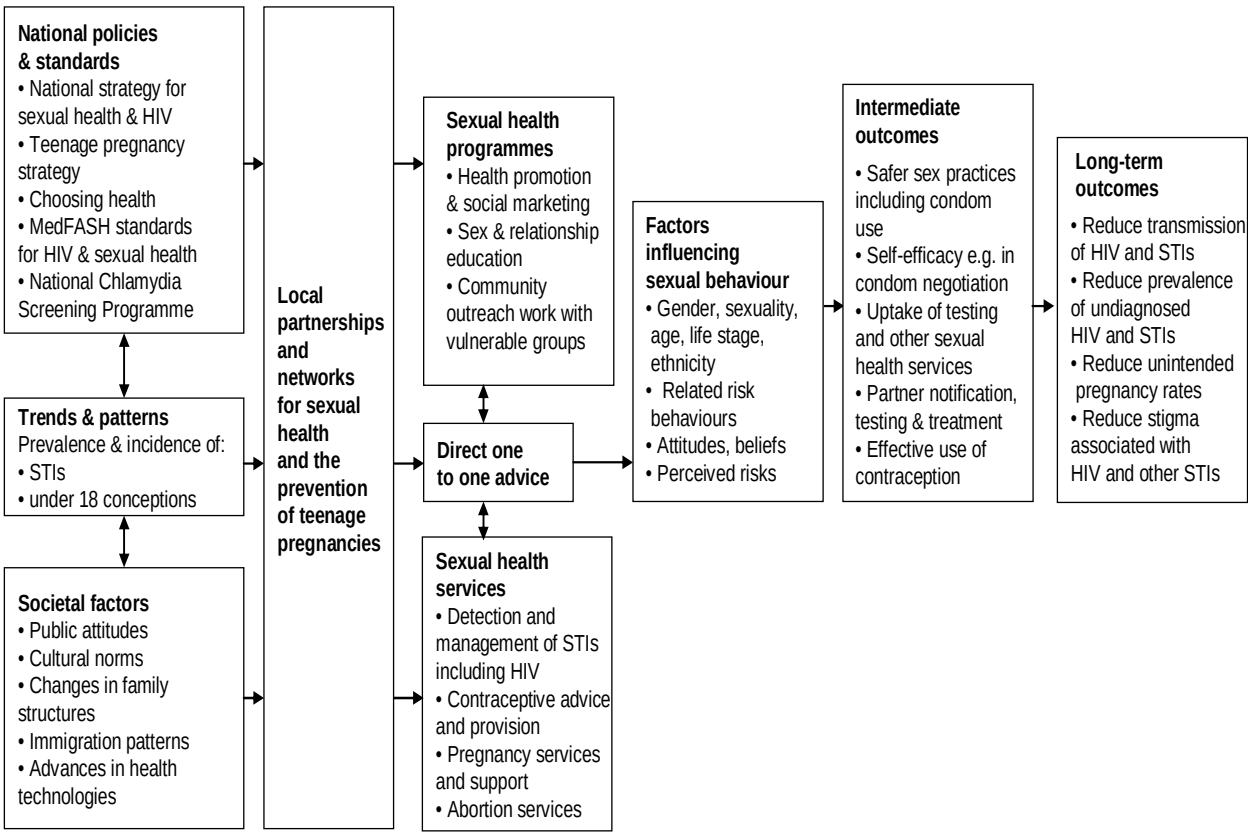
Recommendations

We are over reliant on national data. We should aim to collect more robust local data to inform future service development.

6. Service model

Bradford district takes a whole systems approach to the development of a sexually healthy population. This means education, health promotion and programmes take equal footing with service provision including contraception, testing and treatment. This is best illustrated using the model developed by NICE demonstrating the need to provide both areas of work, underpinned by local partnerships and networks.

Figure 1 **Sexual Health Interventions Framework**



NICE 2007

Prior to specific services there is a range of preventative services available described here as pre-level 1.
The current service model in Bradford district is based on three levels of service:

- **Level 1 / Core** – testing and contraception for patient population
- **Level 2 / Core +** - those services that provide treatments and partner notification and also initiate tests
- **Level 3 / Enhanced**- those services that provide Levels 1 and 2, but also provide testing, treatment and partner notification for those with more complex STI conditions and HIV

Pre-Level 1 Service

To accurately reflect the complexity of sexual health, it is essential to document the range of services, education and promotion of sexual health that exists within the district. Much work has been done locally to create a strong evidence base to support the implementation of work, particularly with young people, around building capacity in self-efficacious beliefs to support delivery of the above service provision. This includes informal education from youth services, direct delivery in schools, colleges and to community groups, emergency hormonal contraception (EHC) provision in community pharmacies, condom distribution including the C-Card scheme, direct delivery in children's social care to at risk vulnerable young people and delivery of the sexual health training programme to health, local authority and VCS organisations in partnership by specialist sexual health promotion team Bradford MDC employee development officer for sexual health and some voluntary sector providers.

Nationally the evidence base to support this type of activity is widely recognised and is expected to be continued in emerging policy. It is also reflected in the sexual health strategy, YPSH&TP strategy and subsequent action plans. This includes increasing joint working between statutory and voluntary sectors services, good quality SRE in schools and colleges, early intervention and prevention including aspiration building with identified at risk

groups, active and integrated youth provision and increased support for parents and carers to talk to their children about sex and relationships. Keeping the focus on building increased confidence and self-esteem to support accessing of services and associated behaviours, such as condom negotiation, will build the capacity in the population to actively engage with service provision at all levels. The NICE Sexual Health Interventions Framework (2007) outlines how sexual health services and programmes work alongside each other to promote positive sexual health outcomes.

Level 1 & 2 services/ Core & Core +

At Levels 1 and 2, Bradford Teaching Hospital Foundation Trust (BTHFT) Contraception and Sexual Health (CASH) service provides 32 sessions delivered across 12 venues over 6 days of the week during the daytime and evening. The venues are predominantly health centres but include local authority and youth service venues worked in partnership. More recently, a number of GP practices have signed up via a standardised practice based commissioning template to deliver enhanced services to their own patients and to patients registered with other practices, with a locally set tariff paid. In addition, drop-in clinics for young people are provided from eight GP practices offering a range of services from advice to fitting implants. Teenage Information and Advice Centres (Tic Tacs) are provided in 8 schools and community settings, offering signposting and condom distribution, with three more to be developed in other hotspot schools. EHC is available free in 26 pharmacies to young people under 25 years old.

Level 3 Enhanced

Level 3 sexual health services are historically described as those services led by a Genitourinary Medicine (GUM) consultant and involve specialised infections management, including co-ordination of partner notification. This level of service is delivered locally by BTHFT Department of Infectious Diseases and Sexual Health who undertake a comprehensive range of diagnostic and treatment services, HIV+ care and follow-up appointments. Level 3 services are provided at the Trinity Centre in the city area of Bradford. The Trinity Centre is open Monday – Friday with three evening clinics.

Level 3 clinician teams take responsibility for sexual health services needs assessment, for supporting provider quality, for clinical governance requirements at all levels, and for providing specialist services. Services can include:

- Outreach for sexually transmitted infection prevention
- Outreach for contraception services
- Specialised infections management, including co-ordination of partner notification
- Specialised HIV treatment and care

General Practice - Delivered as part of the existing PMS/nGMS contract

Services provided in primary care include:

- Sexual history and risk assessment
- STI testing for women
- HIV testing and counselling
- Pregnancy testing and referral
- Contraceptive information and services
- Assessment and referral of men with STI symptoms
- Cervical cytology screening and referral
- Hepatitis B immunisation

Voluntary and Community Sector (VCS)

Bradford District has a strong history of provision of public services through the voluntary and community sector. By engaging service users through a variety of networks, with the specialist skills to support the various needs and communities in the district, we can be confident that our services are adaptable and responsive to the changing dynamics of our population.

The Public Health White Paper calls for an increased use of VCS projects at an increasingly local level to not only deliver services but to also determine local need

"…*local communities will be at the heart of improving health and wellbeing for their populations and tackling inequalities…working collaboratively with business and the voluntary sector through the Public Health Responsibility Deal …working in partnership with the local NHS and across the public, private and voluntary sectors*"

(PHW Paper 2010)

VCS commissioning and public health work together with VCS organisations to develop appropriate programmes milestones for project delivery to meet the overall strategic aim of reducing health inequalities in the population of Bradford district and as such are reflected in the membership of the Sexual Health Network. Some examples of this include provision of community testing sites for the Chlamydia Screening Programme, condom distribution in youth provision, HIV training for health providers, counselling for survivors of sexual abuse and working with parents to deliver sex and relationships education to their children.

Bradford District Care Trust (BDCT)

In addition to formal Levels 1, 2 and 3 service provision and the work of the voluntary and community sectors, Bradford District Care Trust (BDCT) delivers specialist services within the health economy of Bradford district. These include

- School Nursing Service (SN)
- Bradford Working Women's Service (BWWS)
- Health of Men team (HoM)
- Health on the Streets (HOTS)
- Youth Offending Health Team (YOT)

These teams provide specialist services to some of the most vulnerable people in the district accessing sexual health service provision. These services have strong links into education, acute services and often deliver their services in non-traditional settings where the clients would be usually accessing other services and thus improving access.

School Nursing Service has long been involved in the provision of sexual health advice, information and support to young people of statutory school age. This has been through formal delivery of the Added Power and Understanding in Sex Education (APAUSE) and latterly the Ur Choice programmes delivered in the district. Also through the provision of a confidential health service in schools and delivering the Human Papilloma Virus (HPV) Immunisation programme.

Bevan Healthcare aims to provide access to high quality health and social care for the most socially excluded people of Bradford district, covering a wide range of issues affecting such individuals, including sexual health. In 2008 they became a rapid HIV testing centre and link closely with Trinity Centre to support delivery of this service to an incredibly vulnerable and high risk patient group. In addition to this they provide a holistic approach to healthcare often involving a range of statutory and voluntary sector providers covering maternity and child health, drug and alcohol services and organisations working with survivors of rape and sexual assault and / or abuse. They offer primary medical services tailored to the needs of people who struggle to engage with usual services and particularly those who are homeless, in temporary accommodation, refugees or asylum seekers.

Recommendation

To develop further responsive, community based provision, amongst a range of statutory and voluntary sector providers, to increase accessibility for vulnerable groups of people at increased risk of poor sexual health outcomes.

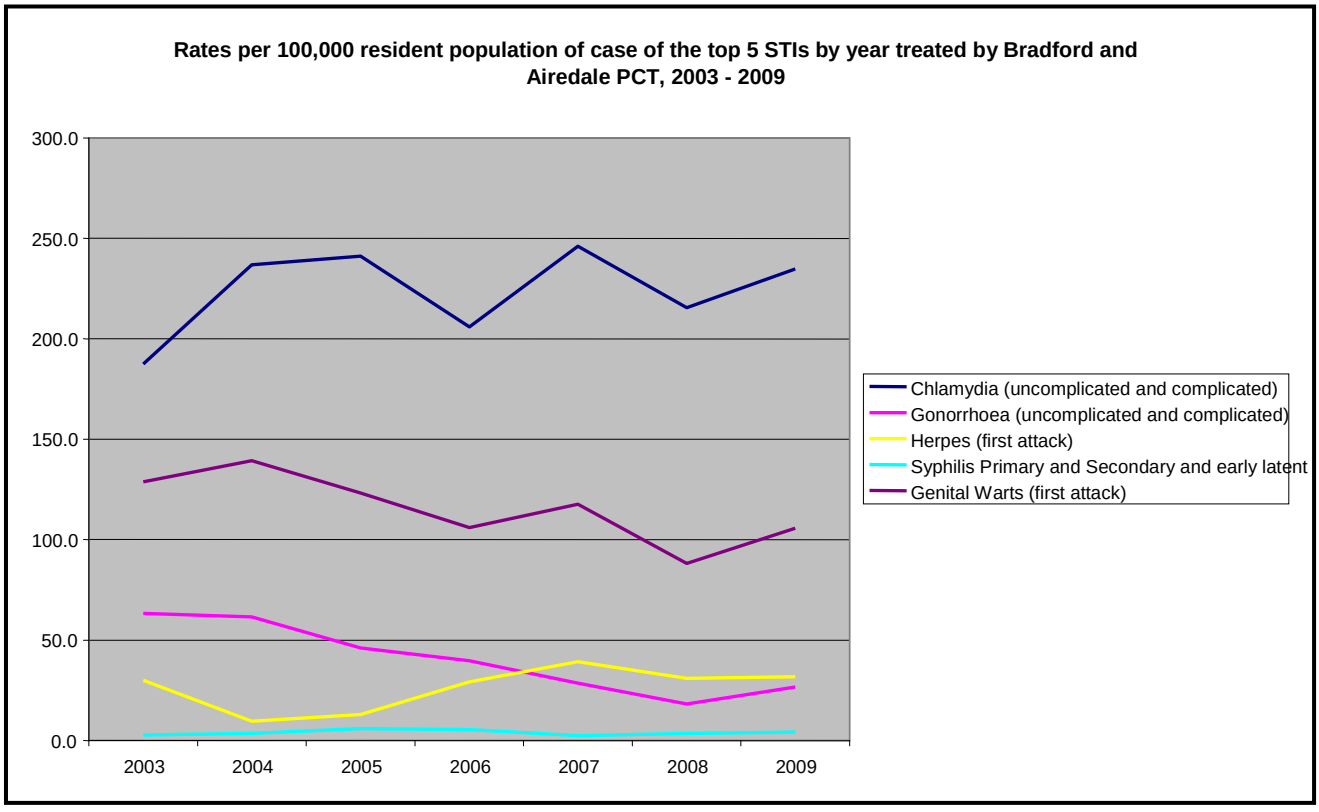
7. Top 5 Sexually Transmitted Infections (STIs)

Rates per population have been analysed over time for the top 5 STIs per 100,000 population:

- Chlamydia
- Gonorrhoea
- Herpes
- Genital warts
- Syphilis

In general whilst there is some variability over time, the general trend is that of rising rates of STIs which is in keeping with the national trend.

Figure 2



Source: HPA 2011

7.1 Chlamydia

Chlamydia remains the most commonly diagnosed STI in GUM clinics with a rise of 11% since 2004 in the Yorkshire and Humber region. In 2009 a total number of 22,498 new Chlamydia diagnoses of both complicated and uncomplicated infection in the region were reported.

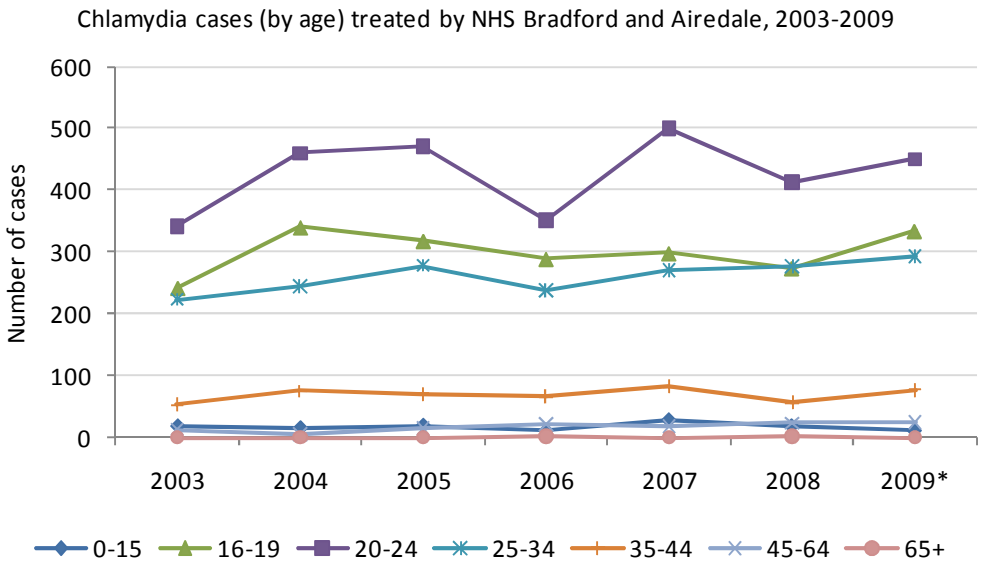
The incidence of diagnosis of uncomplicated infection in Bradford district has risen steadily since 1996 and data from 2003-2009 shows this trend to be continuing. There was a 3% rise in the diagnoses of Chlamydia between 2008 and 2009. This probably reflects the increase in screening programmes across PCTs, hospital GUM settings and the wider community but also the use of more sensitive diagnostic methods as well as possible changes in sexual behaviour.

The greatest number of new diagnoses is in the 16-24 age group which is consistent with regional and national trends. It is important to note that the 25-34 age group also shows a rise in the numbers of new diagnoses. This important indicator of sexual health has been retained in the Public Health Outcomes Framework (DH, 2012).

Women show a consistently higher number of infections than men although the difference is not particularly marked. The number of diagnoses in males varied in an unremarkable fashion between 2005 and 2007 remaining markedly below those for females, in contrast to the gender split in Bradford district. Rising rates of Chlamydia are of particular concern as the vast majority of people are asymptomatic. Untreated infection can be associated with significant morbidity, including infertility, and facilitate ongoing transmission of infections including HIV.

Figure 3

Chlamydia (treated cases) by age group 2003-2009



Source: HPA 2011

- includes complicated Chlamydia, Gonorrhoea and early latent Syphilis

The Chlamydia Screening Programme has been running in the Bradford district since September 2006 and has consistently been praised for the quality of the service it delivers. Whilst numbers of screens have not met the nationally set target, the programme has always performed well in partner notification, consistently over achieving against a target of 0.6 per index case, involvement of core services (GPs, CASH, TOP and pharmacies), again consistently over achieving against the 60% target and finally in screening the right cohort, our positivity levels have remained above the national average and position us well for achievement against the proposed diagnostic indicator.

The programme has worked extensively with providers of services for young people outside the traditional health setting. Working in partnership with the Health of Men team to deliver services and screening in educational, youth and workplace settings. The programme team has trained local youth workers from both the voluntary and statutory sectors to deliver screening to their young people in their own settings, thus making the screening more

accessible and ensuring we have a screening programme that reaches those young people who do access health services.

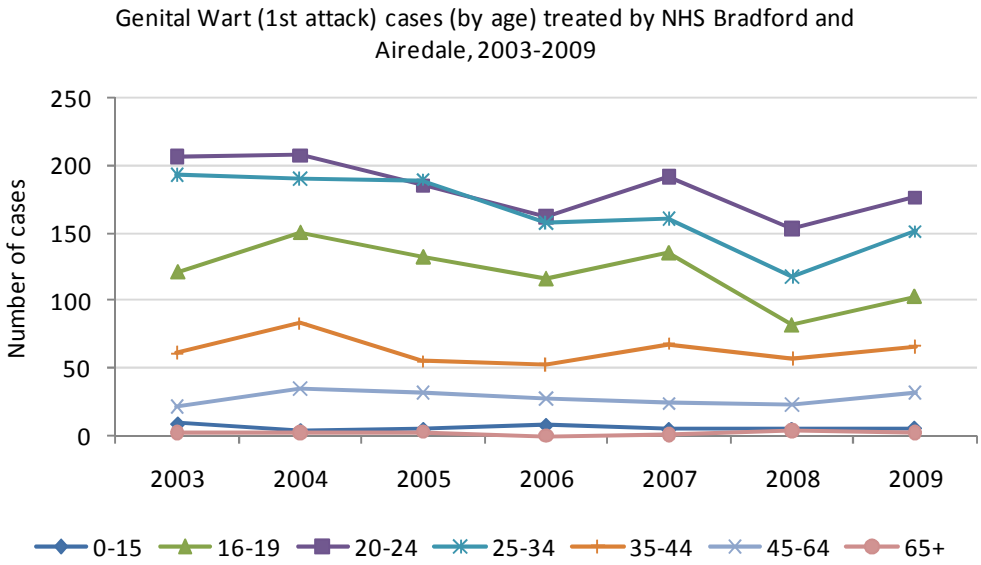
7.2 Genital Warts

Genital warts are the second most common STI in the UK and are caused by the human papillomavirus (HPV).The lifetime risk of infection is high amongst sexually active people. HPV types 16 and 18 are associated with cervical cancer. Types 6 and 11 are associated with genital warts.

Annual numbers of diagnoses of genital warts (first attack) in GUM clinics in Yorkshire and Humber have been increasing since 2005. Data on genital warts (treated cases 1st attack) for Bradford district show a variable trend. Overall rates for treated first time genital warts have decreased since 2003 but latest data for 2009 show an increase. Most cases occur in the younger age groups aged 16-34.

The **human papilloma virus** (**HPV**) **vaccine** prevents infection with certain species of human papillomavirus associated with the development of cervical cancer, genital warts, and some less common cancers. The HPV vaccine, Cervarix, used until 2012 protects against the two HPV types (HPV-16 and HPV-18) that cause 70% of cervical cancers, and cause most HPV-induced genital and head and neck cancers. From September 2012 there will be a change to use Gardasil which also protects against the two HPV types (HPV-6 and HPV-11) that cause 90% of genital warts (Jit, M. et al., 2011). At the end of the 2010/11 academic year concluding on 31/8/11, there was an 89.4% uptake of completed HPV courses in 12/13 years olds in the old NHS Bradford & Airedale boundary area.

Figure 4



Source: HPA 2011

7.3 Genital Herpes

Genital Herpes is caused by the herpes simplex virus (HSV). It is the most common ulcerative STI in the UK and is associated with physical and psychological morbidity.

In Yorkshire and the Humber GUM clinics there was a 70% increase in the number of herpes diagnoses (first attack) between 2003 and 2008.

In Bradford district:

- All ages show a decline in number of cases from 2003 to 2005.
- Between 2005 and 2008 cases increased across all ranges and then began to decline in 2007 and 2008.
- This trend is not evident in the data for the 25-34yr age bracket, which suggests treated cases have increased since 2005 and then sharply risen between 2008 and 2009.
- The number of treated cases in the 15 to 19 yr olds fell sharply between 2008 and 2009. Other age groups show a slight increase in numbers.

7.4 Syphilis

The number of cases of syphilis has been rising quite significantly in the UK over the last decade. The diagnoses of infectious syphilis declined in the late 1980s and early 1990s as a result of increased HIV awareness through campaigns that led to changes in sexual behaviour at that time. The majority of diagnoses have been made in MSM (men who have sex with men) since the late 1990s and the characteristics of these patients have changed little over the course of the years.

In Bradford district overall rates remain low and with no significant increase 2003-2009.

Data on syphilis (primary and secondary) shows a great deal of variability, but overall numbers of treated cases are small across all age groups. The majority of treated cases are in the 25-34 and 35-44yr age groups.

Treated case numbers peaked between 2004 and 2006 and then declined.

Cases in the 45 -64 age group have risen linearly since 2007, whilst all other age groups (except the over 65s) show an increase since 2008 but this increase may reflect the inclusion of latent and early syphilis in the 2009 data.

7.5 Gonorrhoea

Gonorrhoea is the second most common bacterial sexually transmitted infection in the UK. Untreated infections can be associated with significant morbidity. Gonorrhoea tends to be concentrated in core risk groups including young adults, black and minority ethnic populations and MSM. Following a steady rise in diagnoses in the mid 1990s and early 2000s there has been a steady decline in Gonorrhoea diagnoses since 2003.

In Yorkshire and the Humber GUM clinics the number of diagnoses of uncomplicated Gonorrhoea between 2003 and 2008 fell by 44%.This decline was not sustained in 2009.

In Bradford district the number of infections peaked in 2002-2004, but possibly due to effective treatment, screening and health promotion, numbers started to fall. The data provided is to clinic level, one clinic did not return data for

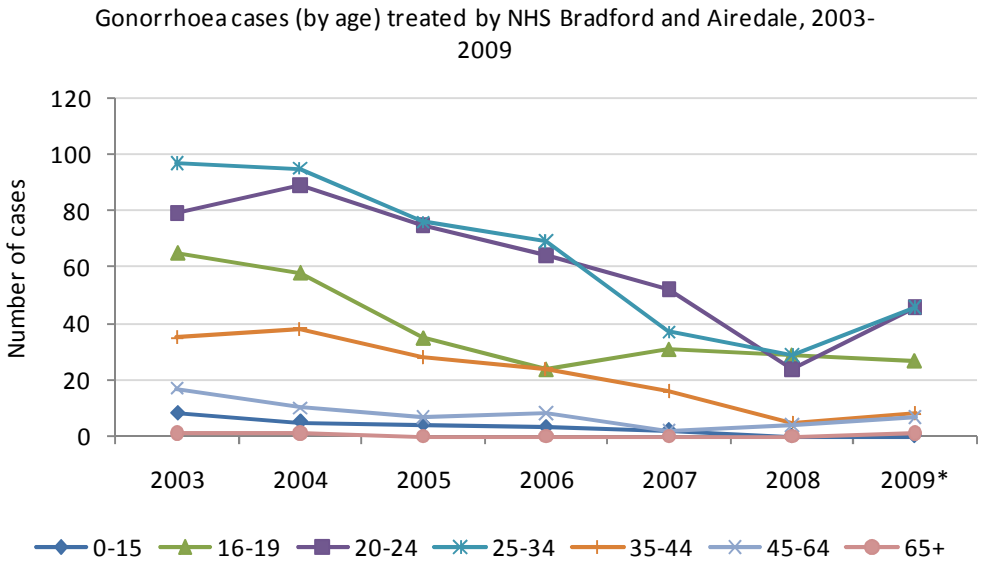
quarters 2 and 4 in 2006 and numbers of diagnoses were not adjusted for missing clinic data. The biggest decreases between 2003 and 2008 are evident in the 20-24 and 25-34 age groups.

However, from 2008, all age groups, with the exception of the 16-19 age group, have shown an increase. Bradford district has experienced a 48% increase in diagnoses, second to Leeds (58%), which is among one of the 4 PCTs outside London to have the highest rate of diagnoses of Gonorrhoea. The majority of new diagnoses of Gonorrhoea occur in those aged 16 to 34 with the highest numbers overall in the 25-34 age group. The majority of cases are in men; this is in keeping with regional trend.
However the gap between the two sexes has been closing in recent years.

Drug resistant Gonorrhoea nationally continues to be a problem. However, no isolates have been found with resistance to any cephalosporins over the last five years.

Figure 5

Trends in Bradford and Airedale



Source: HPA 2011

* includes complicated Chlamydia, Gonorrhoea and early latent Syphilis

The main source of epidemiological data on STIs was originally sourced from KC60 statistical return which collected data on the diagnoses of sexually transmitted infections and other services provided by all GUM clinics in England. This has now been replaced by GUMCAD (genitourinary medicine clinic activity dataset) which was phased in during 2008-2009.GUMCAD provides more useful information at a local area of residence level rather than by clinic attended. Information on age, sexual orientation, ethnic group and country of birth is collected; with this the robustness of data will change.

During 2012 data will also be collected from community based providers using GUMCAD2 returns. This will greatly improve the understanding of the epidemiology surrounding all STIs

Recommendations

There is currently work in progress to evaluate the full impact of the Chlamydia Screening Programme, which will lead to the realignment of the service.

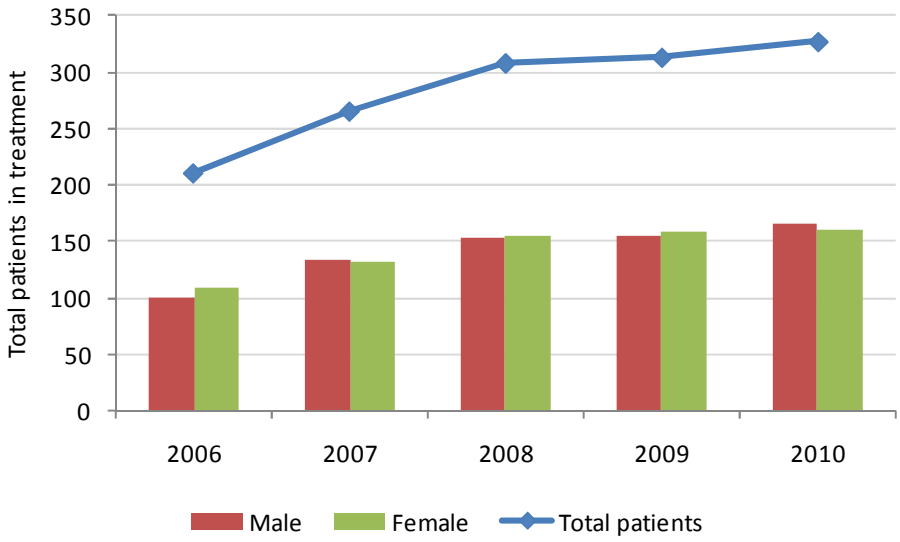
A systematic approach to data collection for epidemiological analysis needs to be established.

8. Human immunodeficiency virus (HIV)

The total number of patients accessing HIV treatment within Bradford district has increased each year for the last 5 years (2006 to 2010). In 2010, 327 patients accessed treatment for HIV. Although there has been an annual increase in total patients diagnosed, the total number of patients accessing treatment appears to be stabilising.

Figure 6.

Total patients accessing HIV treatment within Bradford and Airedale, 2006-2010



Source: HPA further analysis by NHS Airedale, Bradford and Leeds, Public Health Analysis team 2011

Approximately the same proportion of males and females access treatment each year. In 2010, 166 male patients and 161 female patients were in treatment for HIV across Bradford and Airedale. The majority of patients have a CD4 count of between 350 and 699 (68.2%). 4% have a CD4 count below 100. Of the estimated 86,000 people living with HIV in the UK, 1 in 4 are unaware of their diagnosis. In 2009, 32% of people identified as newly diagnosed, with a reported PCT of residence in Yorkshire and the Humber, were diagnosed very late (CD4< 200).

In Bradford district (2010) 99 people accessed care with a CD4 < 350 and 197 accessed care with a CD4< 499. Late diagnosis has a significant detrimental effect on outcome and survival. It can also facilitate ongoing transmission, an estimated 50-70% of transmissions originate from the undiagnosed. Improving early diagnosis/testing and access play important roles in reducing the transmission of HIV and also the mortality and morbidity associated with late or lack of diagnosis of the infection.

Table 1.

CD4 counts of all patients undergoing treatment for HIV, 2010

	2010	
CD4 counts	No.	%
<350	99	30.3%
350-499	98	30.0%
500-699	94	28.7%
700-899	28	8.6%
900+	8	2.4%

Source: HPA further analysis by NHS Airedale, Bradford and Leeds, Public Health Analysis team 2011

Data are primarily at Yorkshire and Humber level, supplemented by some local data and overarching national data and evidence including that sourced from the HPA. Yorkshire and the Humber reported the second highest proportional increase in new HIV diagnosis during 2000-2009 outside London. The number of existing cases of HIV rose at a faster rate in PCTs in the east and west compared to other parts of Yorkshire. In Bradford district the number of new cases has been rising steadily over the last 8 years.

There is recent data to show that infections acquired heterosexually within the UK are slowly on the rise. The number of black Africans infected abroad has been declining, contributing to the fourth consecutive year on year decline in new HIV diagnoses in the region. The number of heterosexual white Yorkshire and the Humber residents with diagnosed HIV has increased by about 60% between 2005 and 2009 (from 260 in 2005 to 414 in 2009).

In the years between 2005 and 2009, the prevalence of diagnosed HIV in adults in Bradford district increased by 83%. Bradford has one of the highest prevalence of diagnosed HIV in adults per 100,000 head of population in the region.

The picture in Bradford district is broadly similar to the regional and national picture, however these are showing some element of tail off which has yet to be observed in the area. This is possibly due to the fact that smoother trends can be observed in the much higher numbers regionally and nationally and that Bradford district figures are not large enough to demonstrate this.
The reason for this may be due to an increase in the number of residents being tested and diagnosed, migration in and out of the district and the decreased mortality due to the availability of effective treatment.

The large majority of cases are among the 20-50 age groups; in particular the 30-40s, with yearly increases seen in patients over 40.

Majority of cases, about two thirds, are seen in black Africans who usually acquire their infection abroad (reflecting a growth in the black African migrant population). However, the proportion of total patients who are black African is falling. The total number and proportion of total patients who are white is increasing year on year. In 2006, 19% of the patients seen were white; in 2010 this has risen to 31%.

The commonest route of infection is through heterosexual contact, outnumbering MSM by 3 to1. The main route for infection for male patients is through heterosexual sex, though this is decreasing. Infection through sex between men has increased year on year. The main route for nearly all female patients is via heterosexual sex. Infection through intravenous drug use has seen an increase over the last 5 years, particularly in men. However, the numbers are small. Mother to child transmission rates have been stable over the years and account for <2% of infections.

There has been a yearly increase in the number of patients accessing care, with a near equal split between men and women.

In 2006, the majority of male patients accessing care were black African/Caribbean (61%) with only 32% of the male patients being white. In 2010 this had changed; with the majority of male patients in treatment now of a white background (51%), with only 42% black African/Caribbean. The trend in female patients has remained relatively the same, with the majority of female patients in treatment being black African/Caribbean (over 80% per year). The proportion has decreased slightly however, with small increases seen in white female patients (up from 7.3% in 2006 to 9.9% in 2010).

Male patients with AIDS have increased between 2006 and 2008, but fallen between 2009 and 2010. The picture is a little different in females, where a year on year increase has occurred. For females, this increase has been seen the most in black African/Caribbean patients.

Total patients on antiretroviral therapy have increased for both male and female patients. For males, an increasing proportion of patients on antiretroviral medication are white. Uptake is slightly higher in females than males.

In Yorkshire and the Humber the number of black African heterosexual adults accessing HIV related care has increased significantly since 2005. Women are the majority, making up around two thirds of the total black African heterosexuals. MSM accessing care has also significantly increased in the region since 2005.

HIV testing strategies have largely focused on the STI and antenatal setting. Antenatal screening benefits both mother and child and provides a good opportunity for sexual health promotion. The Department of Health recommends that information about the HIV test is offered to all pregnant women and that testing is available in all antenatal clinics. Since the introduction of routine testing, mother to child transmission rates have significantly fallen. The uptake of antenatal testing in Bradford and Airedale hospitals has been high, at 98-99%, comparing favourably with other hospitals in the region. The indicator for antenatal HIV screening is retained in the recently published Public Health Outcomes Framework (DH, 2012).

Recommendations

A more developed analysis of incident cases, specifically by route of infection and epidemiological/demographic group, gives a potential steer to strategic approaches to tackling the rising incidence of HIV.

A bespoke approach to individual high risk groups should be considered, building on existing work to prevent infection, promote prevention and maximise therapeutic options.

Consultation should take place with existing asylum seeker and refugee services to explore issues around awareness, testing and interventions in this group of people.

9. Teenage pregnancy

Teenage conceptions are defined as conceptions in persons aged under 18 years. Bradford district has a strategy that focuses on young people's sexual health and teenage pregnancy. National and local targets are delivered through partnership working in the district. The strategy is a shared responsibility, led by Bradford Metropolitan District Council, requiring NHS Airedale, Bradford and Leeds engagement as one of the key partners in working towards achieving the districts targets.

We are currently the 26th best performing district nationally, having reduced under 18 teenage conception by 28% from a baseline of 57.2 per 1000 young women aged under 18 years in 1998 to 41.0 per 1000 in 2009.

The targets are:

- To halve the under 18 conception rate by 2010 from the 1998 baseline figure.
- To reduce health inequality, including sexual health inequality, across the wards in the district.

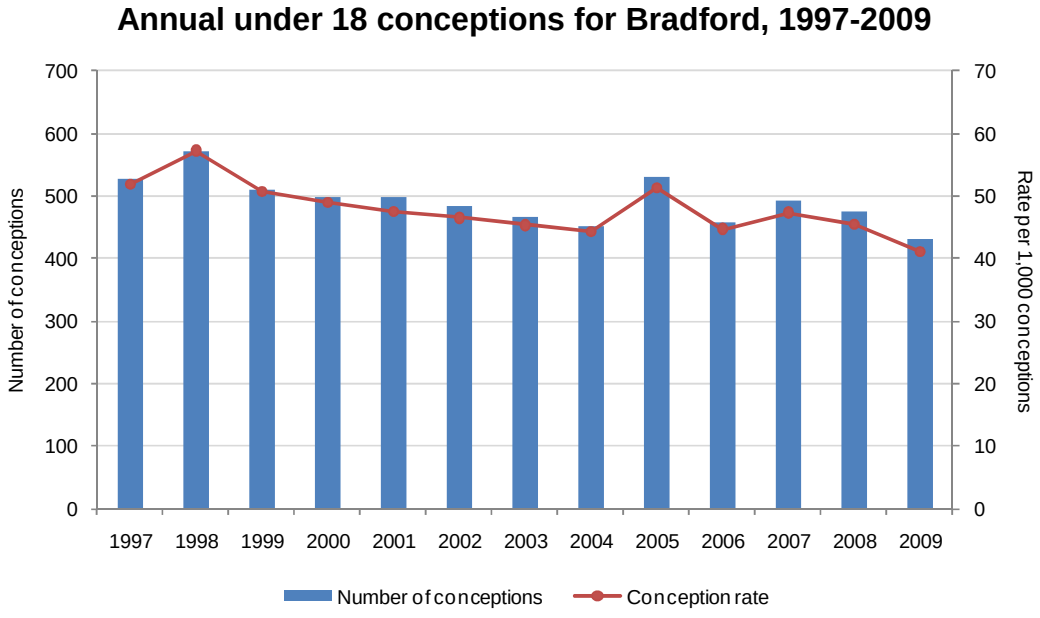
Maintaining the significant progress made over the previous 10 years strategic focus, the reduction in the under 18 conception rate remains an outcomes under the Public Health Outcomes Framework (DH, 2012). Maternity and termination data are the two main sources for teenage conceptions and pregnancy. NHS Airedale, Bradford and Leeds does not receive monthly Office of National Statistics (ONS) birth figures which provide mother's age and is therefore reliant on local providers to provide maternity data containing this information. The local picture is based on our two main providers,

Airedale NHS Trust (ANHST) and BTFTH. Work is ongoing to address this through contracting arrangements with other providers and PCTs. NHS Airedale, Bradford and Leeds does not currently have access to private termination figures from local providers, but this is being addressed as an issue through the Termination of Pregnancy subgroup of the Sexual Health Network and is reflected in the sexual health strategy and action plan.

Based on 2009 proxy data, conception rates continue to be highest in Tong ward, followed by Great Horton and Bowling & Barkerend, and represent 8.1%, 6.7% and 7.1% of the total under 18 conceptions across the district respectively. Rates are lowest in Wharfedale, Ilkley and Heaton. Proxy data relates to local data and is based on GP practice not resident postcode. Problems can occur as it does not fit exactly with the same definition used at national level but it is only used at a local level to give an indication as ONS data can often take up to two years to filter down.

The under 18 conception rate in Bradford district is at its lowest since 1998, with a rate of 41.0 per 1,000 conceptions (Figure 6). Total numbers are also at their lowest, with a total of 430 conceptions in 2009 compared to 572 in 1998.

Figure 7

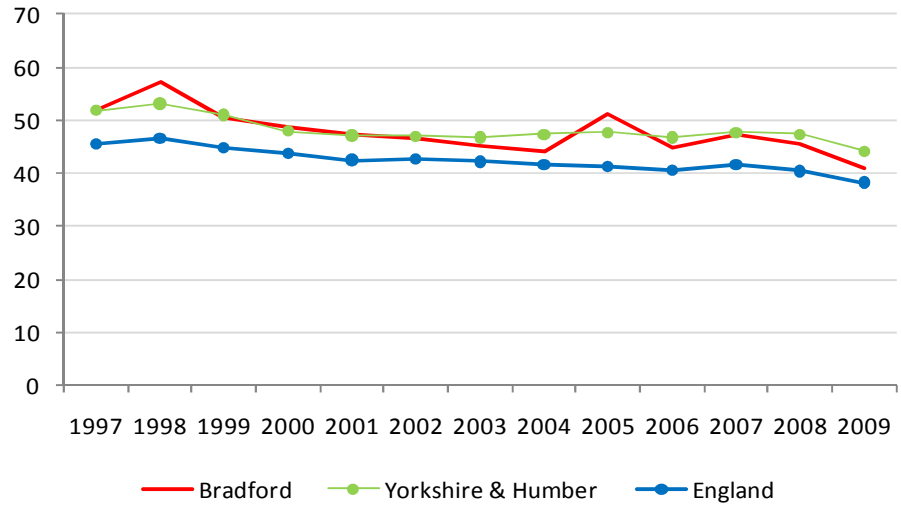


Source: Teenage pregnancy analysis spreadsheet, DfE Teenage Pregnancy Unit

Under 18 conception rates in Bradford district have remained above the national rate, though the gap is closing (Figure 7). However, Bradford district has seen a greater reduction in conception rate since 1998 when compared to England, with a fall of 28% compared to 18% nationally, making the district the 26th best performing district when measured against the 1998 baseline. Rates in Bradford district have remained consistently below the average for Yorkshire and the Humber since 2005.

Figure 8

National and regional under 18 conception rate comparisons, 1997-2009



Source: Teenage pregnancy analysis spreadsheet, DfE Teenage Pregnancy Unit

When compared to its statistical neighbours, Bradford district has seen the third highest reduction in rates since 1998, with a fall of 28% (**Table 2**). In terms of yearly rates, Bradford district has the second lowest rate of its statistical neighbours.

Table 2 – Under 18 conception trends by statistical neighbour

LA	Deprivation score (2007)	Under 18 conception rate				% change since 1998
		1998	2007	2008	2009	
Bradford	32.0	57.2	47.3	45.4	41.0	-28%
Rochdale	33.9	61.9	48.8	55.4	47.7	-23%
Oldham	30.8	66.1	46.8	40.9	42.3	-36%
Blackburn with Darwen	35.8	58.2	45.5	42.6	39.3	-32%
Kirlees	25.2	48.6	45.7	47.7	48.5	-0.2%

Source: Teenage pregnancy analysis spreadsheet, DfE Teenage Pregnancy Unit

Recommendations

To review teenage pregnancy hotspots

Full review of the teenage pregnancy action plans

10. Termination of pregnancy

There is a well established Termination of Pregnancy (TOPs) pathway and significant improvements in service and access have taken place. TOPs in Bradford district are lower than England & Wales, West Yorkshire and many other local authorities. However, rates have increased since the pathway work and improvement in access was undertaken. It was initially the case under the Public Health White Paper that termination of pregnancy would in future be commissioned with Sexual Health in the Local Authority. Further direction has now indicated that this will become a function of the Clinical Commissioning Groups (CCGs) rather than Public Health as was first anticipated.

TOPs service is delivered as part of the Women and Children's Directorate and is part of the acute contract to provide terminations for women across the Bradford district up to 12 weeks gestation. Two clinics are held per week on Thursday and Friday afternoons plus the first Wednesday of every month. This service is also provided to the population of ANHSFT with a weekly counselling and abortion clinic being held on Friday at Airedale General Hospital in Steeton.

British Pregnancy Advisory Service (BPAS), Marie Stopes, and Calderdale & Huddersfield NHS Foundation Trust are all commissioned to provide surgical and medical terminations under contract with NHS Airedale, Bradford and Leeds.

Early termination is essential as the risk of complications increases as the gestational age increases. The Department of Health policy is that women who are legally entitled to an abortion should have access to this service as soon as possible. The Chief Medical Officer recommends that 70% of abortions are carried out before 10 weeks.

Over the last 7 years (2002-2009), the proportion of abortions carried out before 10 weeks has increased from 39.9% to 65.8%. In 2010 73 % of TOPS

in Bradford district were carried out within 10 weeks, which is over the target level of 70% recommended by the Chief Medical Officer.

There were 1,615 terminations reported to NHS Bradford and Airedale in 2010. 2.2% of all locally reported TOPS were carried out within 6 weeks and 4.6 % of all local TOPS were delivered to those aged under 16 for our 4 main providers in 2010.

In 2010 29.8% of TOPS were medical procedures; these procedures are much safer than surgical interventions. By increasing provision of services to provide equity across the district, this can improve further.

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Until we can be assured that we have accurate and timely data to support local monitoring, the figures presented must be used with caution. This, along with other data analysis issues, is being addressed with the sexual health network.

Recommendations

Local monitoring still remains inconsistent. There is a need for clarity in relation to the number of terminations being carried out in the independent sector.

11. Service provision

What has been delivered in Bradford district?

To accurately reflect the complexity of sexual health we need to acknowledge the range of services, education and promotion of sexual health that exists within the district. Much work has been done locally to create a strong evidence base to support the implementation of work, particularly with young people, around building capacity in self-efficacious beliefs to support delivery of the above service provision.

Nationally the evidence base to support this type of activity is widely recognised and is expected to be continued in emerging policy. This includes increasing joint working between statutory and voluntary sector services, good quality SRE in schools and colleges, early intervention and prevention including aspiration building with identified at risk groups, active and integrated youth provision and increased support for parents and carers to talk to their children about sex and relationships. Keeping the focus on building increased confidence and self-esteem to support accessing of services and associated behaviours, such as condom negotiation, will build the capacity in the population to actively engage with service provision at all levels.

Service provision:

- The Bradford district CASH has been developed in partnership to bring together all the services commissioned by NHS Airedale, Bradford and Leeds in the Bradford district and more specialised services provided by BTHFT Genitourinary Medicine (GUM) service.
- During 2008/09 more enhanced services were introduced which allow patients to access fully integrated contraception and sexual health advice, treatment and care and sexual health promotion in the same primary care setting.
- In addition to these services some specialist GPs provision exists and also training to fit Long Acting Reversible Contraception (LARC) has

been delivered to build capacity in community based contraceptive services.

- Development of community based services to support access by those individuals who would not usually accesses health provision in a traditional setting.
- In November 2008, a single point of access for contraception and sexual health advice was introduced. This means that people in Bradford district can call 01274 200024 between 8am and 6pm, Monday to Friday, and get access to a wide range of sexual health services available across the district, including booking appointments.
- Development of the Bradford and Airedale Sexual Health (BASH) website
- Production of a local qualitative evidence base with a particular focus on HIV testing, treatment and associated support needs.
- Achieved the national TOPs target of 70% performed before 10 weeks, 2010 data at 73%.
- Development of a sexual assault pathway to support individuals who have experienced sexual assault to access safe and confidential support services, and strong strategic regional partnerships to deliver the statutory Sexual Assault Referral Centre (SARC).
- The Chlamydia Screening Programme has been running in the Bradford district since September 2006 and has consistently been praised for the quality of the service it delivers. Whilst numbers of screens have not met the nationally set target, the programme has always performed well in partner notification, consistently over-achieving against a target of 0.6 per index case. Involvement of core services (GPs, CASH, TOP and pharmacies), again consistently over achieving against the 60% target.
- Informal education from youth services, direct delivery in schools, colleges, to community groups and children's social care to young people at increased risk of vulnerability.
- Emergency Hormonal Contraception (EHC) provision in community pharmacies.

- Delivery of the sexual health training programme to health, local authority and voluntary and community sector in partnership by a range of providers including NHSBA specialist sexual health team (SHARe), Bradford MDC employee development officer for sexual health and the voluntary sector.

11.1 Contraceptive and Sexual Health (CASH) services

The Bradford district CASH has been developed by NHS Airedale, Bradford and Leeds' predecessor NHSBA in partnership with BTHFT. A significant amount of new funding was invested in developing the new service, which brings together all the services provided by NHS Airedale, Bradford and Leeds, including contraception, cervical smear tests, pregnancy testing and sexual health screening, young people's services and more specialised services provided by BTHFT GUM clinic. In addition to this it also provides education and training to support doctors and nurses and offers specialist contraceptive advice to primary care clinicians as appropriate. Under the new service, people have the guarantee of being offered an appointment with a health professional within 48 hours. The service is split across the district into Bradford and Airedale service provision and provides a mix of clinical and non-clinical services.

Clinical Services comprise 32 sessions delivered across 14 venues over 6 days per week, primarily using health venues but also working in partnership with Local Authority to provide some clinical services in youth service provision, The Information Shop for Young People. In addition to this CASH provide 7 hours of Level 2 Enhanced service to clients at Turnaround, Barnardos support service for young people experiencing sexual exploitation. Staffing the clinics is through a skill mix of doctors, nurses and health care assistants depending on the level of service being provided.

Non-Clinical Services include the Condom Distribution Scheme, C-Card (until July 2011), EHC distributed by Pharmacies, Young People's Services and the You're Welcome Initiative. An evaluation of the C-Card Scheme has been undertaken by Leeds Metropolitan University, the findings of which are

included in the appendices of this needs assessment and the recommendations made will inform future service development.

11.2 Contraception

KT31 is the main source of contraception data nationally; the coverage of KT31 includes individual patient activity in services provided by trusts in clinics and non-clinic venues. Not included are health promotion activities (e.g. school sessions) and services provided by consultants in outpatient clinics or those provided by general medical practitioners. It includes data for total contacts and first contacts by age, gender and main method of contraception.

It is anticipated that all sexual and reproductive health services will be able to submit Sexual and Reproductive Health Activity Dataset or SRHAD returns by 2012/13, at which point the KT31 will be retired. In 2008/2009 there were 13,000 first attendees at community contraceptive clinics. Looking at age of first contact with CASH clinics, majority of contacts fall within the 20- 34 age bracket. The most common methods of contraception requested at first contact are user dependent methods (oral contraceptives, condoms, patches etc).

Oral contraception is the most commonly used form of contraception in primary care throughout the district. Main source of information on contraception prescribed in these settings is prescribing data. Bradford district has the lowest rate of contraception prescriptions for all methods in the region (31 items per 1000).

There is under-use of the most effective contraception, Long-Acting Reversible Contraception (LARC). This constitutes roughly 10 or 25% of prescribing depending on area, appearing to be highest in the North of Bradford area. The rate of prescribing of the oral contraceptive and LARC from primary care appears relatively small in the inner city area of Bradford, however there is a notable clustering of high emergency contraception

prescribing rates in the same area. (Note: This information does not include over the counter emergency hormonal contraception)

A relationship between deprivation profile of practice and the rate of LARC prescription at practice level is observed in Bradford district, however the nature of this relationship is unclear and it should be treated with caution until further analysis has taken place.

In addition to these services some specialist GPs provision exists and also training to fit LARCs. There are now 95 implant fitters and 89 IUD fitters in primary care with 52 practitioners trained to deliver a Level 1+/ Core Plus service and 26 trained to provide a Level 2 / Enhanced service across the district. A specialist service is offered by one GP provider to remove deep implants.

The use of pharmacies to deliver free emergency hormonal contraception (EHC) for the under 25s, free pregnancy tests to the under 25s and test those aged between 16 and 25 years for Chlamydia has increased in recent years. Training for named pharmacists to dispense EHC and pregnancy tests to customers aged under 25 years and training for Chlamydia screening is delivered by the CASH and CSP teams which transferred to BTHFT in 2011, driven by the sexual health strategy, YPSH and TP Strategy and this remains a priority action for the district.

11.3 GUM Activity

GUM services at the Trinity Centre provide comprehensive sexual health services, including HIV services, to the population of Bradford district. These can be accessed directly in person at the centre, by referral from the Contact Centre, or core or enhanced primary care providers. The service is open to service users who walk-in on Monday to Friday 08.30-12.00, early morning appointments Tuesday and Thursday from 08.00, all other appointments Monday to Wednesday 13.15 – 18.15 and Thursday and Friday 13.15 -16.15.

The operating framework for the NHS in England identified 48hr access in GUM clinics as a priority in 2006/2007. In 2007/2008 a target was set to ensure that 100% of patients attending GUM services are offered an appointment to be seen within 48hrs of contacting a service. The Strategic Health Authorities (SHA) were also asked to plan for 95% of patients to be seen within 48hrs by 2008.

Work done in Bradford district has consistently achieved the 100% offered target but has been unable to reach the 95% target for those seen within 48hrs. A regional target of achievement above 85% has been met consistently with an average yearly performance of 92%. In 2010/11 more patients were seen within 48hours, offered appointments was maintained but DNA (did not attend) rates have risen.

11.4 Primary Care

Delivered as part of the existing contract Personal Medical Services/ new General Medical services, core primary care services provided to patients include:

- Sexual history and risk assessment
- STI testing for women
- HIV testing and counselling
- Pregnancy testing and referral
- Contraceptive information and services
- Assessment and referral of men with STI symptoms
- Cervical cytology screening and referral
- Hepatitis B immunisation

Supplementing this provision there are 14 enhanced GP providers across the district providing services including STI testing diagnosis and treatment and IUD/IUS fitting and removal. Concern has previously been expressed that appointments specifically reserved for sexual health appointments to be filled

by the Contact Centre (CC) have not been utilised as fully as was anticipated. The Sexual Health Strategy and Action Plans have been developed to include a review of the services provided by the Contact Centre and all Level 2 sexual health provision to lead further development of a community based approach to our non-specialist sexual health provision.

Markers have been added to the Sexual Health Dashboard to monitor the referral of service users to the level of service appropriate to their need by the CC. Since the withdrawal of the financial incentive for GPs delivering the Chlamydia Screening Programme we have seen a reduction in the number of GPs screens from low prevalence areas, but the levels screening in hotspot wards are being maintained.

11.5 Other Community Based providers

a) Pharmacies

Until April 2011 financial incentives were paid to pharmacists to deliver the Chlamydia Screening Programme alongside dispensing EHC and conducting pregnancy tests. This has now been withdrawn and the impact on the CSP has been a reduction in the number of pharmacists offering opportunistic Chlamydia tests to customers. There has been no impact on EHC and pregnancy testing as reimbursement of prescription costs is still available to pharmacies. There are currently 37 named pharmacists registered to deliver the above service working from 27 pharmacies across the district. They cover 6 days a week with one provider opening for limited hours on Sunday once every fortnight. Commissioning concerns about the service, now there is no incentive for the scheme, are around maintaining governance for the delivery of EHC and pregnancy tests to young people, and sustainable funding streams to support the delivery of free EHC to the under 25 population, following the dissolution of the Pharmacy Development Team at NHS Airedale, Bradford and Leeds predecessor NHS Bradford and Airedale.

b) Health of Men (HoM), Bradford Working Women's Project (BWWP) Health on the Streets (HOTS) and the Youth Offending Health Team (YOT

Health) Under the terms of transforming community services (TCS) much of the PCT provider arm was transferred to Bradford District Care Trust (BDCT). This included teams who had delivered sexual health work direct to target groups and young people's community based health services. They all provide essential delivery to vulnerable groups at increased risk of adverse health outcomes and are located in venues that are easily accessed by the target service users groups. The nature of the vulnerability of the service users accessing these services means that there are very strong interdependencies between these projects and other commissioned sexual health providers across the district.

c) The Looked After Children's Nursing team (LAC Nurses), Health Visitors (HV) and School Nursing (SN) provide health services to children across the district and as such deliver sexual health provision as part of their day to day work. The LAC Nursing team provide coordinated comprehensive health care, through named nurses, to the looked after children population of Bradford district. This includes sexual health requirements as well as general health and wellbeing and is delivered in close partnership with Social Care services

Health Visitors have previously given out Chlamydia screening information cards to all mothers below the age of 24 at the birth visit. This was an initiative to boost the PCT up take figures. Although not now a contractual requirement, it can still be discussed with mothers based on professional judgment. In addition to this, the HV service provides advice and support to families and children following the identification of sexual health issues.

School Nursing has a specific role in delivery of SRE, support for health drop-ins in both school and community settings and support to pregnant teenagers to access follow on services such as abortion counselling or midwifery care. They also oversee the delivery of the HPV immunisation programme and referral for Chlamydia screening as required. In addition to this, SNs regularly deliver support to the 8 Teenage Information Centre Teenage Advice Centres (Tic Tacs) based in community venues and secondary schools across the district in wards of high teenage conceptions.

d) Bevan Healthcare is the service for asylum seekers and refugees which has recently become a community interest company. They provide care that recognises the social, environmental and behavioural determinants of health, linking people in with services that address these factors and emphasising the promotion of health as well as the treatment of illness, seeking to empower clients, going beyond addressing their immediate needs to helping them integrate into mainstream services. Their work is based on the motto "Health, Hope, Humanity"; it is open 5 days a week to meet the sexual health needs of refugees and asylum seekers in the district on a drop-in basis.

e) Voluntary Community Sector (VCS) organisations provide more specialised sexual health provision to identified groups at increased risk of poor sexual health outcomes. Working closely with VCS commissioners, to set milestones in line with the refreshed strategy and action plans, and piloting a quality standards framework to support future development within VCS organisations this provision is essential to meet the needs of the most vulnerable at risk of the poorest sexual health outcomes. Examples of specialist provision to at risk vulnerable groups include HIV support from Yorkshire Mesmac; support for survivors of sexual abuse and rape from Bradford Rape Crisis and young people's sexual health from Hale and Step 2.

Recommendation

To review all level 2 service provision to inform the development of sexual health provision in a range of community based settings, to increase accessibility for vulnerable groups at increased risk of adverse sexual health outcomes. This will include consultation with service users in line with MedFash recommendations and NICE guidelines (Mann, S and Lowry R. 2008; NICE (2007).

12. Training

Bradford is using the British Association for Sexual Health and HIV (BASHH) STI Competencies as the Gold Standard for training and delivery across the district. This is primarily a clinical training package designed to deliver more specialised STI services in primary care. Training and professional development underpin the sexual health strategy and action plan which implement the recommendations of this needs assessment.

Core Services

These are delivered in primary care by all doctors and many nurses who have undergone extra training as well as by trained CASH staff.

Core Plus

Asymptomatic screening of men is currently seen as a Level 2 service but testing can now be done by a urine sample for Chlamydia and Gonorrhoea and a blood test for HIV and Syphilis. It could be done within a Level 1 service with patient's subsequently requiring treatment, and contact tracing being referred to health advisors based in The Trinity Centre and CASH service. This service is currently available and is offered to service users dependent on individual case outcome MSM or those with symptoms are recommended to attend a level 3 site as they will require microscopy.

Clinicians wishing to deliver a core plus service are required to have attended a STIF course and confirm that they are up to date with current BASHH guidance. They are then required to register with NHS Airedale, Bradford and Leeds.

Enhanced

There are a range of GP practices delivering enhanced services to asymptomatic men and women who are symptomatic or are asymptomatic but have been proven to have a STI when tested previously in the community across the district.

Future training has been agreed following the STIF intermediate competency requirements. Other practitioners may attend an agreed number of GUM sessions to gain experience to support an enhanced site but will not be the accredited provider of services.
Current capacity in Bradford district:

- all GP practices can provide core services
- 28 providers delivering Core Plus services
- 21 providers delivering Enhanced services
- 13 CASH clinics are providing enhanced services
- 1 provider delivering level 3 services at the Trinity Centre

In addition to the formal service level training delivered to clinicians there is a wide variety of delivery from NHSBA SHARe Team, Bradford MDC and the voluntary and community sector. This primarily supports delivery of the pre-level one agenda and is mostly accessed by practitioners working with children and young people. There are some crossover courses supporting more general population sexual health and these could be accessed by practitioners working in adult services. Rolling out the recommendations of the Brook Training Needs Audit will open up these courses to the broader workforce and so widen the impact of the training programme and is recognised in the action plans of both the sexual health strategy and the YPSH and TP strategy.

The use of peers to deliver training across the district is a specialised but highly effective approach to delivery. Currently peer educators are used to deliver the Ur Choice formal SRE programme in schools. Further peer education training will be undertaken by the more specialist services in the district, including those developing HIV community testing services.

Recommendation
To review capacity in primary care to deliver core + and enhanced provision in community settings, including IUD fitting and removal and STI testing and treatment as part of the wider review of level 2 sexual health service provision across a range of community based providers**.**

13. User involvement and Participation

Choice, Responsiveness and Equity in the NHS and social care states that: *'…people who are more involved in their treatment, who understand the options available to them and who have taken responsibility and control of their own healthcare have better long term health outcomes'*. One of the key messages from The Marmot Review 'Fair Society, Healthy Lives' (2010) is acknowledgement that *'Effective local delivery requires effective participatory decision-making at local level. This can only happen by empowering individuals and local communities'*

Current health policy emphasises the need to put people using services at the centre of NHS activity and to enable them to have greater input into their individual care as well as into helping to plan and monitor services. Service developments informed by coordinated user involvement programmes can contribute to quality improvement and increase both uptake and user satisfaction.

People can be supported to engage actively in the development of services and other activities to support their sexual health and wellbeing in a number of ways. At the individual level, people need information and support to assess their personal risk, and to access and use services effectively. Shared decision-making between professionals and service users can result in better health outcomes. At the collective level, the involvement of users and the public in the planning and organisation of sexual healthcare can help services become more responsive to individuals and communities.

Commissioned activity in Bradford district to support the development of service design and delivery includes service evaluations, qualitative research and 'mystery shopper' exercises. Full service evaluations have led to improvements in GUM accessibility and the development of provision outside traditional health settings along with qualitative research and service user feedback:

- The Sexual Health Needs of South Asian Young People
- The HIV Related Needs of Asylum Seekers and Refugees of Sub-Saharan African Origin
- Ur Choice(SRE)
- Mapping Bradford Tic Tacs: An evaluation of school linked health services for young people.
- Report into the Sexual Health Needs of young people with disabilities
- Being Positive in Bradford; An analysis of the Social Support Needs of people affected by HIV & AIDS in the Bradford District (Sept 2009)

All of the named documents above can be accessed through the appendices attached to this needs assessment.

Mystery shopper' activity was coordinated under the You're Welcome scheme and young people were supported to access a range of sexual health provider settings and feed back on the experiences they encountered. By providing individuals and communities with opportunities to widen their health knowledge through interventions or training programmes we know we can assist our population to take a more proactive approach to their sexual health.

Structured programmes of learning such as Pathways to Health and Seniors Show the Way have engaged a wide variety of the population in learning about their own and their community's health needs. By using members of different communities to deliver positive message about health behaviour change can impact not only directly on health but also improve self-efficacious beliefs in those imparting this health knowledge. Assurity can also be gained that the provision of services are acceptable to the population and as such will not result in the misdirection of scare resources.

Understanding the experience that our patients, families and carers have of services and what matters most to the population of Bradford district is crucial to this strategic approach. This wealth of information is now used systematically within the commissioning process, from supporting needs

analysis, testing out new plans, informing specifications for services and providing consumer evidence within performance management processes. This has been shaped around the invaluable insights gained from consulting with and involving patients and local people.

Recommendation

Increase use of consultations and user participation techniques to develop effective, accessible, service provision in geographical areas, and amongst groups at increased risk of experiencing sexual health inequalities.

14. Programme budgeting

Programme budgeting is the analysis of NHS expenditure on specific healthcare conditions, such as cancer and mental health problems. There are currently 23 programme budgeting categories, which are based on the World Health Organisation (WHO) International Classification of Disease (ICD10).

Using retrospective appraisal of resource allocation broken down into 'programmes' it is possible to influence and track future expenditure in those same programmes. Tracking expenditure enables benchmarking against statistical neighbours (those areas that share similar characteristics in terms of population and economic activity), both locally and nationally, with a view to directing healthcare expenditure in the most efficient, effective and equitable manner.

The role of commissioners is to achieve the best possible health outcomes for their population from every pound invested in healthcare. To do so it is necessary to have a good understanding of the activities and services that are being purchased. Programme budgeting provides a framework which supports analysis of expenditure and supports understanding how that expenditure relates to health outcomes.

Programme budgeting is a potentially powerful tool in identifying and characterising inequitable allocation of resources, thereby assisting in tackling health inequalities.

Programme budget Bradford district

The programme budget for sexual health for Bradford district is established by utilising data from a variety of different sources. Obtaining a complete picture of spend is challenging due to the ways in which contract funding, particularly in blocks to secondary care and GPs, is distributed. By using the family health services (FHS) expenditure for genital tract diagnosis as thousand pounds per 100,000 population as a proxy measure for overall sexual health spend, it is evident that since 2006/07 the Bradford district has spent

progressively more than the cluster average year on year, with the results reflected in the national ranking of 43 in 2009/10. The exception to this was during 2007/08 where the PCT reduced spend by £0.5 million or 0.1% as a proportion of total health expenditure. This was then reflected as a national ranking of 129, thus demonstrating the need for sustained and concerted efforts to be maintained in spend on this area of the population's health.

By analysing the comparisons between Bradford district and our statistical neighbours it is possible to track the trends in resource allocation and prevalence of HIV/AIDS, examine the distribution of resource to support maternity and fertility, health promotion activity, and spend on contraception prescribed by GPs to their resident population and emergency patients. Examination of NHS Bradford and Airedale's data for 2009/10 (NHS Airedale, Bradford and Leeds predecessor) demonstrates:

- FHS prescription expenditure for HIV/AIDS as thousand pounds per 100,000 HCHS weighted population was in line with our statistical neighbours -0.1% of total expenditure for a prevalence rate of 1.06 per 1,000 population
- FHS prescription expenditure on Genitourinary system as thousand pounds per 100,000 HCHS weighted population was significantly more than our statistical neighbours- 0.7% of total expenditure
- FHS prescription expenditure on maternity and fertility as thousand pounds per 100,000 HCHS weighted population is in the range of total expenditure comparable with our statistical neighbours
- Spending on health promotion activity does not just include sexual health promotion and prevention programmes. The spend in Bradford district is in the lower range of resource allocation for this activity compared to our statistical neighbours but this reflects to wide variation in spend on this across all our statistical neighbours
- Bradford district spent more than any of its statistical neighbours on FHS prescription expenditure: other areas of spend as thousand pounds per 100,000 HCHS weighted population. Although this does

not just include contraception for resident population or emergency patient referrals.

However, it is more difficult to determine levels of expenditure for both health promotion and prevention programmes and FHS prescription as these contain activity not just related to sexual and reproductive health or contraception.

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15. Data

To ensure effective planning of provision accurate data collection, sharing and reporting systems both within and without NHS Airedale, Bradford and Leeds are essential. Understanding what data is collected, by whom and for what purpose can support the development of a timely and responsive sexual health strategy and inform a dynamic strategic action planning process.

Changes are being made at a national level to collecting and reporting mechanisms that must be fully understood at a local level to ensure minimum disruption to public health analysis of the sexual health of the population of Bradford district.

Data is collected from a variety of partners that, when viewed as a total dataset, give a richer and more robust picture of the state of sexual health across the district. Increasing and strengthening partnerships can only add to this understanding of how integrated sexual health provision is across the patch and the region.

Contraception

Data collected from service providers includes the number of attendances, contraceptive method of choice, age and sex of attendee and is collected using KT31 returns. This is in addition to the information collected by NHS Contraceptive Services from GPs and Family Planning Clinics on what services are provided to patients and service users.

Terminations of Pregnancy (TOPs)

National data is collected on postcode of residence with local data collected on registration with an NHS Airedale, Bradford and Leeds GP. This enables performance management of providers to support delivery of a quality service.

Sexually Transmitted Infections (STIs)

Prior to 2009 this information was returned via KC60 and laboratory report data on Chlamydia, herpes and Gonorrhoea quarterly though the Health Protection Agency (HPA). This information is available to public health direct from the HPA and although there are no specific targets relating to STIs, or local thresholds to monitor, will support the development of more responsive service provision in areas of 'hotspot' STI activity. GUMCAD 2 will be rolled out during July 2011 and will collect data from services outside GUM that are commissioned to provide sexual health services and this will complement the data provided by GUM clinics through GUMCAD2 which again will support more detailed public health analysis.

Chlamydia

The specific target of 35% of the under 25 population to be screened is changing to reflect the positivity rate to supported targeted provision of testing and treatment services. It is currently reported via the sexual health dashboard.

The reporting for Chlamydia is also undergoing a change with the introduction of the Chlamydia Testing and Activity Dataset (CTAD) from April 2012. This will enable comprehensive collection of robust data from laboratories on all Chlamydia testing activity in England. It is hoped this will contribute towards an improved understanding of the epidemiology of the infection in England and will be collected across all settings.

HIV and AIDS

Data are collected by the national HPA at Colindale to inform commissioning at a local level. Efforts continue to be made to ensure that all data collected at a national level is sufficiently robust and the regional HPA continues to support GUM clinics to provide this data.

HIV/AIDS quarterly data collects by exposure category and age. The Survey of Prevalent Diagnosed HIV Infection (SOPHID) collects by sex, exposure, residence, therapy, clinical stage and ethnicity. Finally the HIV Prevalence Monitoring Programme estimates the prevalence amongst GUM attendees, pregnant women and those women accessing TOPs and IUDs.

Recommendation

Agreement must be made amongst all partners to share data in a confidential manner which enables effective public health analysis which will inform the delivery of the sexual health strategy and action plans for the whole district. This will be of even greater importance when public health moves from the NHS into Bradford Metropolitan District Council in April 2013.

16. Conclusions and recommendations

This Sexual Health Needs Assessment outlines the direction of travel for the district for the next three years. Delivery of the recommendations in this document will be achieved by the implementation of the sexual health strategy and comprehensive action plan, which are monitored by named leads from the multiagency Sexual Health Network. During this time public health and the commissioning of sexual health services will experience a significant shift by transferring all commissioning functions from the NHS to the local authority by April 2013.

Specific guidance, expected in the spring of 2012, from the Department of Health will inform the transition process but work has started with the Local Authority in an integrated approach to this work. By establishing priorities based on epidemiological analysis assurance can be gained that by continuing to target provision at those experiencing the poorest outcomes in sexual health we can start to reduce the gradient in sexual health inequalities.

The recommendations made in this document will assist in providing the best quality sexual health provision to a diverse population in the most equitable way possible. The recommendations primarily cover data sharing and reporting as changes to new systems and ways of commissioning take effect, but also collecting qualitative data on additional factors affecting sexual health, at a local level, will support better targeting of resources to groups at greatest risk.

Community testing and treatment is a priority area for the district to ensure accessibility for those at most risk and compliance with good practice. Building capacity in community based service provision, and increasing consultations and service user participation, will also reduce the issues with accessibility from groups at increased risk of poor sexual health outcomes. This includes providing a bespoke approach to HIV services for identified groups, especially men who have sex with men and asylum seekers and refugees.

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18. Appendices

(i) Figures and tables

Figure 1	Sexual Health Interventions Framework	NICE 2007
Figure 2	Rates per 100,000 resident population of cases of Top 5 STIs by year treated by Bradford & Airedale PCT, 2003-2009.	HPA
Figure 3	Chlamydia (treated cases) by age group treated by NHS Bradford and Airedale 2003-2009	HPA
Figure 4	Genital Wart (1st attack) cases (by age) treated by NHS Bradford & Airedale 2003-2009	HPA
Figure 5	Gonorrhoea cases (by age) treated by NHS Bradford & Airedale 2003-2009	HPA
Figure 6	Total patients accessing HIV treatment within Bradford and Airedale 2006-2010	HPA further analysis by NHS Airedale, Bradford and Leeds, Public Health Analysis team
Figure 7	Annual under 18 conceptions for Bradford 1997-2009	DfE TPU
Figure 8	National and regional under 18 conceptions rate comparisons 1997-2009	DfE TPU
Table 1	CD4 counts of all patients undergoing treatment for HIV, 2010	HPA further analysis by NHS Airedale, Bradford and Leeds, Public Health Analysis team
Table 2	Under 18 conception trends by statistical neighbour	DfE TPU

(ii) Glossary of terms

Acronym	Definition	Acronym	Definition	Acronym	Definition
STIs	Sexually Transmitted Infection	**EU**	European Union	**BASH**	Bradford and Airedale Sexual Health
NST	National Support Team	**WHO**	World Health Organisation	**HIV**	Human Immunodeficiency Virus
BAtPCT	Bradford & Airedale Teaching Primary Care Trust	**DH**	Department of Health	**AIDS**	Acquired Immune Deficiency Syndrome
PCT	Primary Care Trust	**VCS**	Voluntary and Community Sector	**TOPs**	Termination of Pregnancy
EHC	Emergency Hormonal Contraception	**BME**	Black and Minority Ethnic	**SARC**	Sexual Assault Referral Centre
SHARe	Sexual Health and Relationships team	**DCSF**	Department for Children, Schools and Families	**HNA**	Health Needs Assessment
Bradford MDC	Bradford Metropolitan District Council	**HCHS**	Hospital and Community Health Service	**JSNA**	Joint Strategic Needs Assessment
SRE	Sex and Relationships Education	**LGBTU**	Lesbian, Gay, Bisexual, Transgender and Undecided	**EEA**	European Economic Area
CASH	Contraception and Sexual Health Advice	**NICE**	National Institute for Health and Clinical Excellence	**HPV**	Human Papilloma Virus
NHSBA	National Health Service Bradford and Airedale	**HDA**	Health Development Agency	**HSV**	Herpes Simplex Virus
BTHFT	Bradford Teaching Hospitals Foundation	**UNESCO**	United Nations	**ONS**	Office of National Statistics

	Trust				
GUM	Genito-urinary Medicine	**PSHE**	Personal, Health and Social Education	**C-Card Scheme**	Condom-Card Scheme
LARC	Long Acting Reversible Contraception	**KC60**	Reporting and returns for STIs prior to April 2009	**SRHAD**	Sexual and Reproductive Health Activity Dataset
TCS	Transforming Community Services	**SN**	School Nursing	**IAG**	Independent Advisory Group
HoM	Health of Men	**STIF**	Sexually Transmitted Infection Foundation (Course)	**BDCT**	Bradford District Care Trust
HOTS	Health on the Streets	**FHS**	Family Health Services	**BWWP**	Bradford Working Women's Project
LAC Nurses	Looked After Children's Nurses	**CTAD**	Chlamydia Testing and Activity Dataset	**YOT Health**	Youth Offending Team Health Team
BASHH	British Association for Sexual Health and HIV	**ICD10**	International Classification of Disease	**GUMCAD**	Reporting and returns for STIs after April 2009 from GUM service providers
KC31	Reporting and returns for contraception prior to April 2012	**CCG**	Clinical Commissioning Groups	**GUMCAD 2**	Reporting and returns for STIs after December 2010 from community based services

(iii) Key actions and recommendations from sexual health National Support Team visit November 2007

"5 Key Actions" RECOMMENDED BY VISIT					
No.	Detail	Organisational Action Plan	Lead	Key Milestone	Review date
1.	The tPCT needs to develop a new Strategic Plan that is informed by a Sexual Health Needs Assessment	The tPCT's Public Health Directorate to commission production of a Rapid Needs Assessment to inform a revised Sexual Health Strategy. Sexual Health Network to revise the Strategy. Outline with business case to Clinical Executive	Consultant in Public Health Commissioner	Outline to Clinical Executive meeting April 2008	
2.	There is a need to review the nursing and health advisor teams and roles, as outlined within the NST recommendations, to release existing capacity within the service	NST Nurse Consultant review of GUM service NST Consultant review of CASH and tPCT Level 3 services	District Wide Clinical Lead GUM Consultant	January 2008 March 2008	
3.	There is a need to further develop sexual health service capacity within the community, while developing links between GUM and contraception. The tPCT should consider the need for consultant input within the contraceptive service, including the appointment of a sexual health nurse consultant.	Explore options for increasing training capacity in secondary care. Consider single provider for CASH/Level 3 services. Seek guidance on RCOG Consultant Community O&G/ Nurse Consultant clinical leadership	District Wide Clinical Lead GUM Consultant	January 2008	
4.	There is a need for a recovery plan for the Chlamydia Screening Programme to be developed and implemented. The NST and HPA can offer assistance	Utilise the National CSP resource/ intelligence to inform recovery plan Chlamydia Screening to be included in local QOF	tPCT Provider Service Lead Primary care Commissioning	January 2008 April 2008	
5.	The tPCT needs to capitalise on the new opportunities arising with the Local Authority to review partnership working arrangements. Particularly with Education Bradford in relation to Teenage Pregnancy	Await outcome of Joint Area Review of Children's Services Confirm future of Teenage Pregnancy service in Local Area Agreements arrangements	tPCT Teenage Pregnancy Champion	March 2008	

(iv) Performance report 2010-11

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Sexual Health Networ

(v) User involvement and participation reports

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