ISLE OF WIGHT

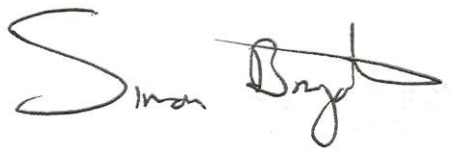
SEXUAL HEALTH NEEDS ASSESSMENT

2013

FOREWARD

Sexual health is an important aspect of health and wellbeing. This needs assessment brings together the information we need to understand sexual health issues for island residents and helps us plan for future service provision. Responsibilities for commissioning sexual health services are now with the Isle of Wight Council, Clinical Commissioning Groups and NHS England. We will use this needs assessment to ensure that we have comprehensive services for the whole population.

On the Island, people have good sexual health with low rates of sexually transmitted infections and excellent service delivery. We have comparable rates of teenage pregnancy to England. However we must not be complacent when considering sexual health, as our hard work in the past has ensured this positive picture. There is much more we can do with the need to improve our Sex and Relationships Education (SRE), increasing our chlamydia screening positivity rates and ensuring effective community delivery. This goes alongside ensuring the most vulnerable people are supported to achieve positive sexual health outcomes.



Simon Bryant FFPH
Acting Director of Public Health

Contents

Who we are

The Public Health team sit within the Isle of Wight Local Authority. As part of the reorganisation of the NHS following the Health and Social Care Act of 2011, local authorities have a statutory obligation to deliver open access sexual health services. The Island's Public Health team saw this as an opportunity to carry out an in-depth needs assessment to ascertain how best to take forward sexual health provision. The recommendations from this report will be used to design and commission these services.

Figures

Sexual Health Needs Assessment
Executive Summary

'Working together to improve sexual health'

Achieving good sexual health is complex, and there are variations in need for services and interventions for different individual groups. It is essential that there is collaboration and integration between a broad range of organisations including commissioning organisations, in order to achieve desired outcomes[1].

This Sexual Health Needs Assessment (SHNA) has been carried out by the Isle of Wight Council Public Health Department, in order to understand more fully the current state of Island resident's sexual health. This report provides a detailed picture of both sexual health needs and the current configuration of sexual health services, which can be used to support commissioning decisions and service improvement.

The reorganisation of health care delivery has meant that the responsibility for sexual health commissioning is now divided between Local Authority (Council), Clinical Commissioning Group (CCG), NHS England and Public Health England (Appendix 1). These new commissioning arrangements underline the pressing need to ensure that all commissioning organisations and providers are engaged in meaningful discussions to provide high quality treatment and care for Island residents that is not fragmented. Locally the Health and Well Being Board will be influential in enabling this to happen.

Sexual health is an issue that affects most people at some point during their life course, with different needs at different times of their lives[2] . In addition to this, evidence identifies that young people (under 25 years), men who have sex with men (MSM) and those living in higher areas of deprivation (figure 6) disproportionally suffer from poor sexual health outcomes. Therefore an overarching recommendation of this report is to ensure there are excellent comprehensive sexual health services available to all Island residents and visitors, while being mindful that particular attention is paid to meeting the needs of vulnerable and marginalised groups to reduce sexual health inequalities.

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

Key Facts and recommendations:

Compared to England and Wales, the Island has a higher proportion of older and lower propotion of younger population[3]. This should be considered when designing and commissioning services, to ensure that they are available at a range of settings and convenient opening times. This is illustrated through feedback from stakeholders, where older residents wanted sexual health services available at their GP Practice, with LGBT groups and young people preferring to attend a specialist integrated sexual health clinic.

High quality information is essential to measure sexual health morbidity, identify vulnerable and target groups, inform and influence service planning, monitor performance and evaluate outcomes. This needs assessment uses national, regional and local data to inform its recommendations. Continuing to have access to high quality data and information will be needed by both commissioners and providers in order to maintain the quality of service provision.

Teenage pregnancy rates on the Island have broadly followed the national downward trend, with a lower rate than England (figure 9). Teenage pregnancy (under 18 conceptions) is affected by a range of personal, social, economic and environmental factors. There is a strong correlation between teenage pregnancy, poverty and health inequalities for both mother and child.[4] Reducing teenage pregnancies along with all age unplanned pregnancies must remain a local priority.

There is a strong evidence base that links excessive alcohol use and poor sexual health outcomes. In addition having a learning disability and/or mental illness are associated with poor sexual health outcomes. It is essential that strong relationships, signposting and referral pathways are developed between sexual health providers and drugs and alcohol services; mental health services; and learning disability services.

The most commonly reported form of gaining sexual health information, regardless of age, is same age friends, television, and the internet. Locally, accurate, high quality, consistent information that allows individuals to make informed decisions about relationships, sex and sexual health[5] should be available in a number of formats that are acceptable to all residents.

Sex and Relationships Education (SRE) plays a central role in sexual health[6]. Nationally evidence suggests that young people, parents and carers want and value high quality sex and relationships education.[7] Locally all stakeholders and professional groups asked identified SRE as extremely important in tackling and improving poor sexual health outcomes, with a recommendation that all children and young people have access to evidence based SRE across all Island schools.

[3] Office for National Statistics (ONS) (2011) 2011 Census for England and Wales
[4] Carson C et al (2011) Effect of pregnancy planning and fertility treatment on cognitive outcomes in children at ages 3 and 5 : longitudinal cohort study', *BMJ*; 343:d4473
[5] Kirkby D (2007) *Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases*, National Campaign to Prevent Teen and Unplanned Pregnancy, Emerging Answers
[6] FPA (2011) Sex and Relationships education factsheet [online] Available at: http://www.fpa.org.uk/professionals/factsheets/sre [accessed 24th April 2013]
[7] Department of Health (2013) A Framework for Sexual Health Improvement in England

Safe, efficient, cost effective, high quality care is dependent on a broad, multi-skilled sexual health workforce that includes specialists, GPs, pharmacists, nurses, youth workers, teachers and carers. This needs assessment identifies that there will be a reduction in areas of this workforce over the next five years, particularly sexual health nurses working in Primary Care due to retirement. Succession planning along with continuing professional development will be needed to maintain and build on current provision. Alongside professional development, it is recommended that further training for non-specialists is available (universal training) to the wider sexual health workforce.

Introduction

The World Health Organisation defines 'sexual health' as:

"... a state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence."

In order to ensure that all residents and visitors on the Isle of Wight have the opportunity to achieve sexual fulfilment, it is important to have the right support in place to promote good sexual health[8].

This Sexual Health Needs Assessment (SHNA) has been carried out in order to understand more fully the current state of play regarding sexual health for Island residents, and enable high quality services to continue to be delivered in ways that are acceptable and accessible for all groups. This report has been developed with the prime objective of assisting commissioners in making strategic and operational decisions. As such, it provides a detailed picture of both sexual health needs and the current configuration of sexual health services.

Nationally sexual health has been given a high priority, with the inclusion of three indicators within the Public Health Outcomes Framework (PHOF):

1. Under 18 conceptions
2. Chlamydia diagnosis (15-24 year olds)
3. People presenting with HIV at a late stage of infection

Recent changes to the NHS have affected the commissioning of sexual health services (NHS White Paper[9]). Clinical Commissioning Groups, NHS England, Public Health England and local authorities are all responsible for ensuring all elements of sexual health needs are delivered and met. Local authorities are responsible for the delivery of local open access services as part of the move of public health from NHS to local authority.

[8] NB: From here on the description 'Island residents' refers to all individuals needing sexual health services whether resident, temporary resident or visiting the Island.

[9] NHS (2010) Equity and Excellence: Liberating the NHS

Currently the Island operates an integrated sexual health hub-and-spoke model of delivery (figure 1) with contraception and genitourinary medicine delivered through the same clinics.

This needs assessment has been divided in to the following sections:

1. Demographic and population groups
2. Reproduction and sexual health
3. Service mapping
4. Service user feedback

The information for this report has been gathered using mixed methodologies:

- Epidemiological data
- Questionnaires of both providers and users
- Small group discussion with both providers and users
- Expert panel
- Primary care group
- National and local data

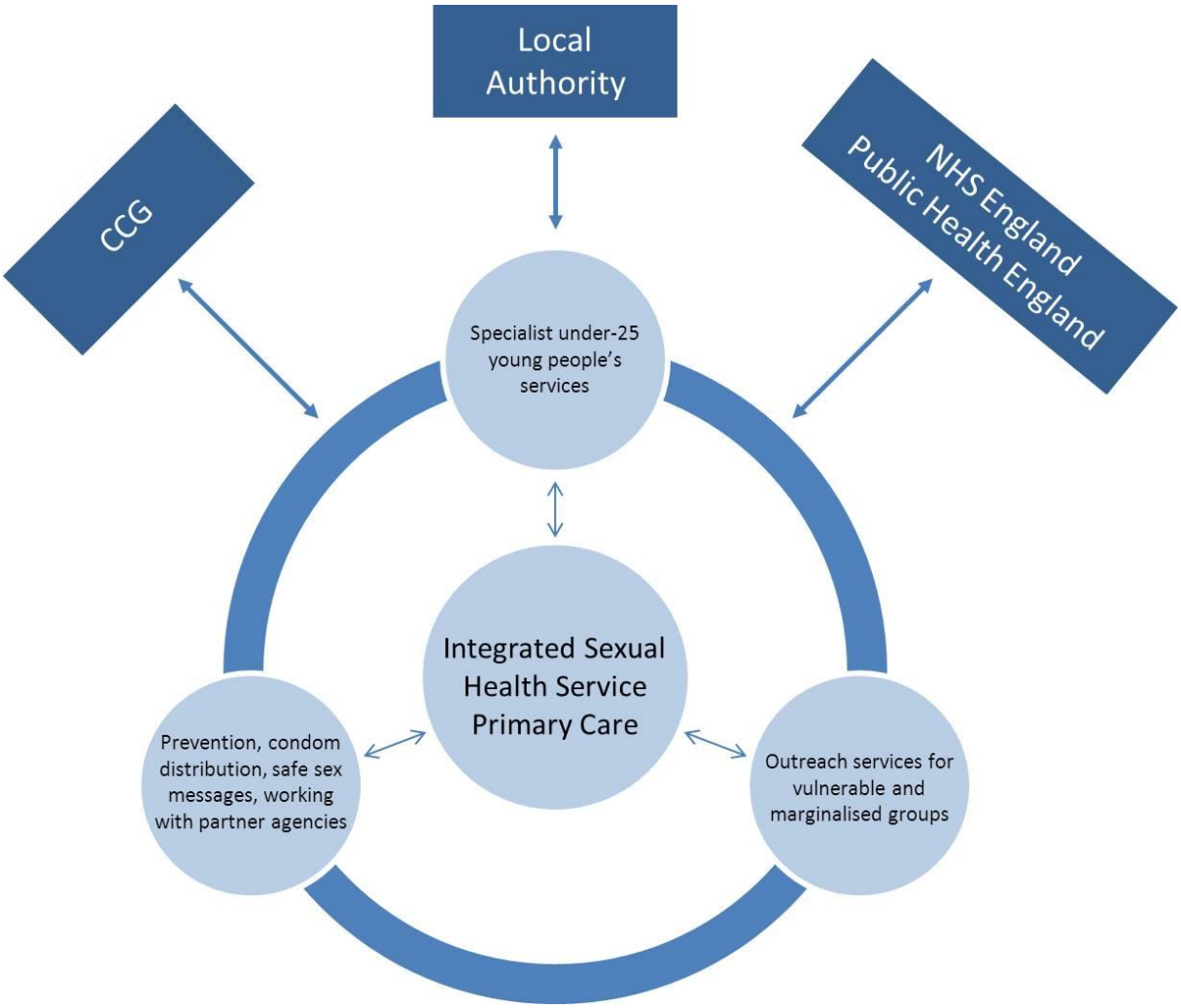


Figure 1: Hub-and-spoke model

1.0 Demographic and population groups

1.1 Population and demographic changes

The resident population of the Isle of Wight is 138,265[10]. The demographic structure of the Island population has slightly more females (51%) than males (49%), mirroring the national picture. The local resident population has grown by 4% since 2001, which has in part been due to the inward migration of residents aged 65 years and over, which has increased by 11%, and the number of live births on the Isle of Wight which has increased. The crude fertility rate per 1000 females aged 15-44 has increased from 48.2 in 2003 to 59.5 in 2011, although this remains significantly lower than the England average of 64.2[11]. It is expected that the Island population will grow by approximately 0.6% over the next four years – below the England average of 0.9%.

The Island population fluctuates throughout the year due to tourism. The Island has approximately 2.6 million visitors per year, which means there are 21 tourists to every Island resident, with an estimated 156,000 overseas visitors[12].

1.2 Life course

Sexual health is an issue that affects most people at some point during their life course, with different needs at different times of their lives. Data in the latest Department of Health Framework for Improvement of Sexual Health[13] cites that nationally:

- Most adults are sexually active, with 92% of men and 94% of women aged 16 to 69 years reporting that they had ever had sexual intercourse with someone of the opposite sex.
- Men reported 9.3 sexual partners in their lives, while women reported an average of 4.7 male sexual partners.
- The median age of first sex with someone of the opposite sex was 17 for both men and women.
- Of those aged 16-69, 1.6% of men and 1.8% of women reported that they had had sex with someone of the same sex in the past five years.
- Young people under the age of 25 are at higher risk of STIs due to increased sexual activity with a number of sexual partners
- Family planning is about preventing pregnancy as well as trying to conceive. Adults aged 25-49 are more likely to form long-term relationships and think about starting to plan families.

[10] Office for National Statistics (ONS) (2011) 2011 Census for England and Wales
[11] Isle of Wight Council (2011) Isle of Wight Joint Strategic Needs Assessment; births and health Start to life Factsheet
[12] Isle of Wight Council (2013) Health on the Isle of Wight 2012, Annual report of Director of Public Health
[13] Department of Health (2013) A Framework for Sexual Health Improvement in England

- While the 25-49 age group does not have the highest rates of STIs, they are still at risk; 46% of all STIs diagnosed in genitourinary medicine (GUM) clinics in 2011 were in this age group. This increased by 4% between 2009 and 2011.

- Abortion statistics show that rates for those aged over 25 have increased over the past 10 years.

- As people get older, their need for sexual health services and interventions will change. Women will enter the menopause and increasingly not be at risk of pregnancy.

- While STI rates in the 50 and over age group accounted for 3% of all STIs in 2011, they rose by 20% between 2009 and 2011.

- Older age groups are more likely to be living with long-term health conditions that may cause sexual health problems; for example, erectile dysfunction is linked with cardiovascular disease (CVD). Late diagnosis of HIV is also more common in older age groups.

1.3 Population

The 2011 population pyramid below (figure 2) shows the difference between the Island population and the rest of England. The Isle of Wight population clearly shows a 'narrow waist' and is very top heavy in contrast to the England pyramid which bulges out in the middle.

Population pyramid for the Isle of Wight (darker outline shows comparison to England)

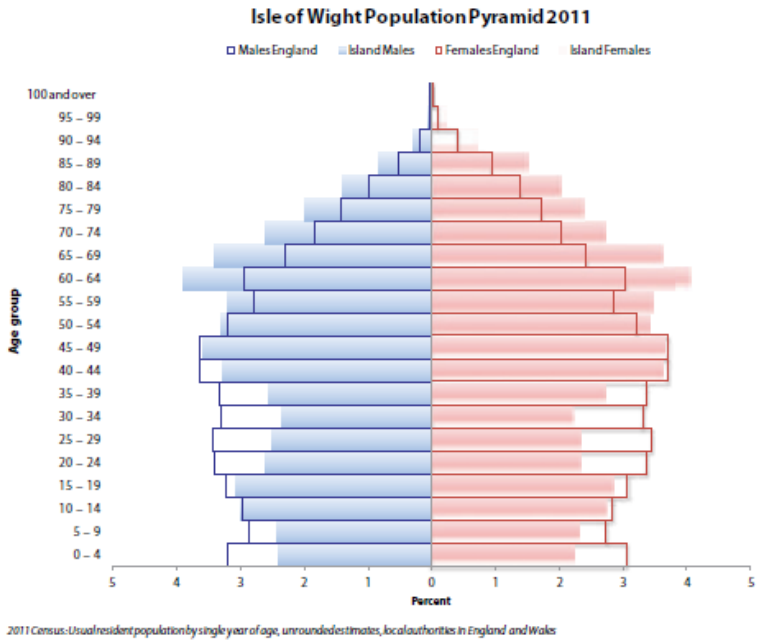


Figure 2: Isle of Wight Population Pyramid 2011

The Isle of Wight has a higher than average older population (aged 65 years and over) at 24.1%, compared to England and Wales of 16.6% and a lower than average younger population (from 0 to 15 years) of 16.2% compared to 18.7% nationally.

1.4 Recommendations

1. The local Health and Wellbeing Strategy prioritises good sexual health outcomes for all Island residents.
2. Use of evidence based health promotion to ensure messages and information around achieving good sexual health outcomes are widely available to residents in formats that are easily understandable and take account of differences in demographics, ethnicity and sexual orientation.

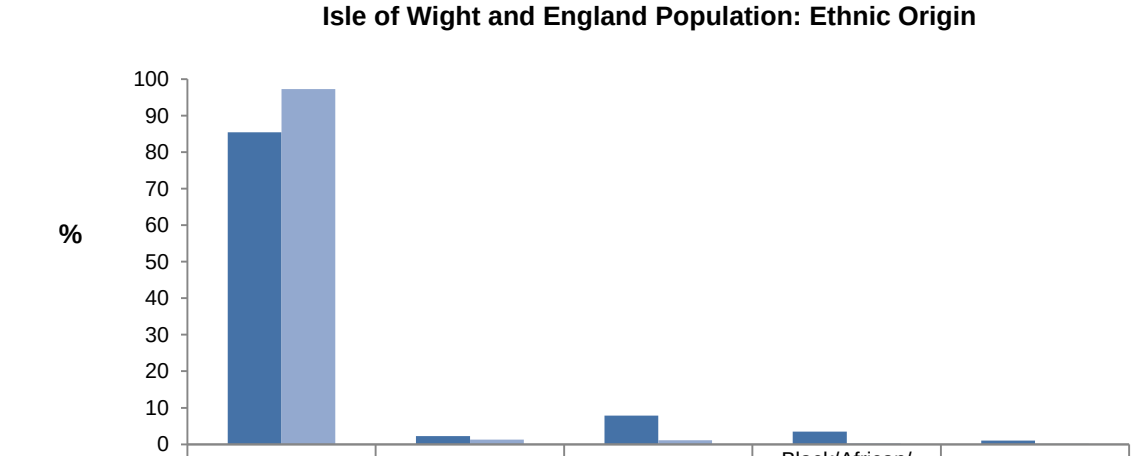
2.0 Target Groups

The following groups have been identified as likely to suffer from poorer sexual health outcomes.

2.1 Ethnicity

Nationally it is recognised that ethnicity plays an important role in sexual health. The UK's black and ethnic minority populations continue to be disproportionately affected by poor sexual health[14]. The groups affected and their experiences of HIV and STIs vary greatly, reflecting the diversity present in the migratory patterns, socio-economic circumstances and experiences of disadvantage and discrimination in these populations.

Locally, the white ethnic group makes up the largest proportion of the population of the Isle of Wight at 97.3% (figure 3). This highlights that the Island is less ethnically diverse than the England population as a whole. For mixed/multiple groups, Asian/Asian British (all), Black/African/Caribbean/Black British (all) and other ethnic groups the population is considerably lower than the England population.



	White (all white)	Mixed/Multiple groups (all)	Asian/Asian British (all)	Black/African/ Caribbean/Black British (all)	Other ethnic group
ENGLAND	85.4	2.3	7.8	3.5	1.0
Isle of Wight UA	97.3	1.2	1.1	0.2	0.1

Source: 2011 Census, Crown copyright applies (Office for National Statistics)

Figure 3: Isle of Wight and England Population: Ethnic Origin

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

The diagnosis of acute STIs[15] for the Isle of Wight in 2012 reflects this split. The proportion of acute STIs diagnosed in GUM clinics by ethnic group is shown (figure 4).

Ethnic Group	Number	%
Not specified	12	2.1
Asian or Asian British	0	0.0
Mixed	6	1.1
Other ethnic groups	0	0.0
Black or white British	5	0.9
White	542	95.9

Figure 4: *Number and proportion of acute STIs diagnosed in GUM clinics by ethnic group: 2012*[16]

While locally ethnic group numbers are low, these populations must be considered when designing services, in order to prevent exclusion and discrimination widening the health inequalities gap.

2.2 Deprivation

Sexual ill health is not equally distributed across the population. Socio-economic deprivation (SED) is a known determinant of poor sexual health outcomes[17].

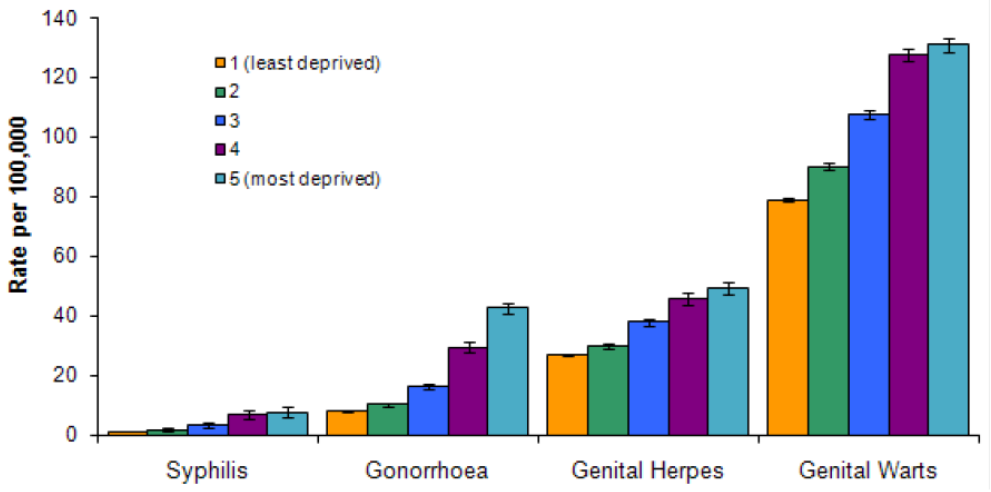


Figure 5: Rates of diagnosis of STIs by deprivation quintile using the Index of Multiple Deprivation England (2009)[18]

[15] HPA (2013) Isle of Wight Local Authority sexually transmitted infections epidemiology report: 2012
[16] PHE (2013) Isle of Wight Local Authority sexually transmitted infections and HIV epidemiology report (LASER): 2012
[17] Stafford M, Marmot M. (2003) Neighbourhood deprivation and health: does it affect us all equally?
[18] Genitourinary Medicine Clinic Activity Dataset (GUMCAD)

There is a strong positive correlation between rates of STIs and deprivation across England (see Figure 5). The relationship between STIs and SED is influenced by a range of factors in health related behaviours, knowledge and awareness of sexual health risk and access to sexual health services.

The Isle of Wight was among the 40% most deprived local authorities in England (126th out of 326 – lower numbers are worse as 1 = most deprived)[19].

The 20% most deprived areas on the Isle of Wight are found in urban areas (see map below) The Health Protection Agency (2010)[20] identified considerable geographic variation in the distribution of STIs, with the highest rates seen in urban areas.

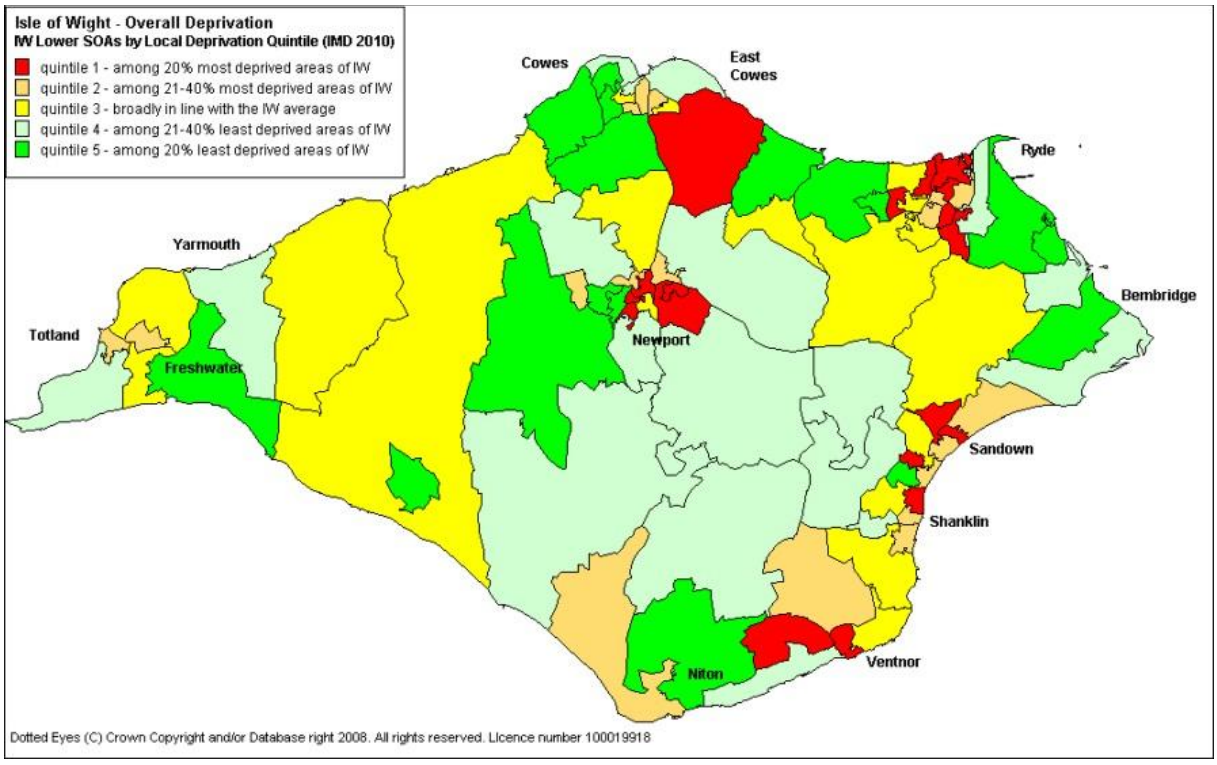


Figure 6: Isle of Wight overall deprivation: Isle of Wight Lower Super Output Areas (LSOAs) by Local Deprivation Quintile (IMD, 2010)

There is evidence to suggest the Island reflects the national link between sexual health and deprivation. In 2012 the rate per 100,000 of acute STIs by deprivation category was higher in areas more deprived, than those less deprived (figure 7).

[19] Source: indices of multiple deprivation.
[20] Health Protection Agency (2010) 'Health Protection Report – Weekly Report', Volume 4 Number 34 Published on: 27 August 2010 [Online] Available at: http://www.hpa.org.uk/hpr/archives/2010/hpr3410.pdf

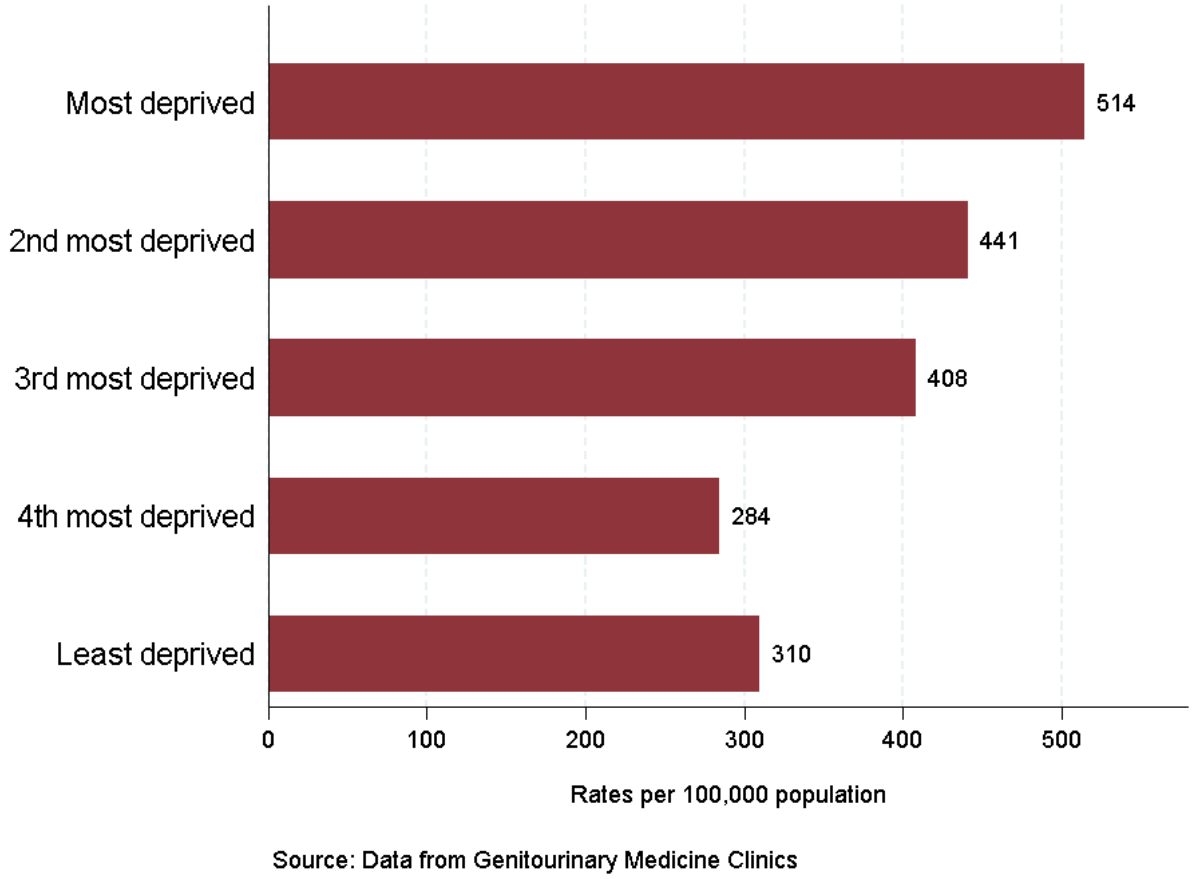


Figure 7: The rate per 100,000 of acute STIs by deprivation category on the Isle of Wight

2.3 People with learning disabilities

It is estimated that there are more than one million people living in England with a learning disability. On the Island it is estimated that approximately 2,700 Island residents (2%) of all ages have a learning disability (ranging from mild to severe)[21]. Approximately 80% of these people are likely to have a mild disability and approximately 20% (about 540 people) a moderate or severe disability. The number of people aged 18 to 64 predicted to have a learning disability on the Island[22] is expected to increase by 2.8% by 2020 (this is higher than our comparator authorities at 0.49%). For those with a moderate or severe learning disability this figure is higher at 3.9% by 2020 (1.7% in our comparator authorities).

Evidence has found that young people with learning disabilities do not have good access to sex and relationship education and find it difficult to access sexual health services[23]. Residents with learning disabilities have the right to experience fulfilling emotional and sexual relationships, including access to knowledge, information and appropriate services[24].

[21] Isle of Wight Council (2011) Joint Strategic Needs Assessment 2011/12
[22] PANSI
[23] Change (2010) Talking about sex and relationships: the views of young people with learning disabilities
[24] Department of Health (2013) A Framework for Sexual Health Improvement in England

The majority of staff within the specialist sexual health service have undergone training to support them to meet the needs of residents with learning disabilities accessing the service. Training in sexual health has previously been delivered across the Island in a number of settings, working with or caring for residents with learning disabilities; however, this is currently not being delivered.

2.4 Young people

Nationally, most people become sexually active and start forming relationships between the ages of 16 and 24. This is reflected across the Island.

Young people between 15 and 24 years old experience the highest rates of STIs. On the Isle of Wight, 66% of diagnoses of acute STIs were in 15 to 24 year old young adults. The age profile of acute STI diagnosis is shown in figure 8.

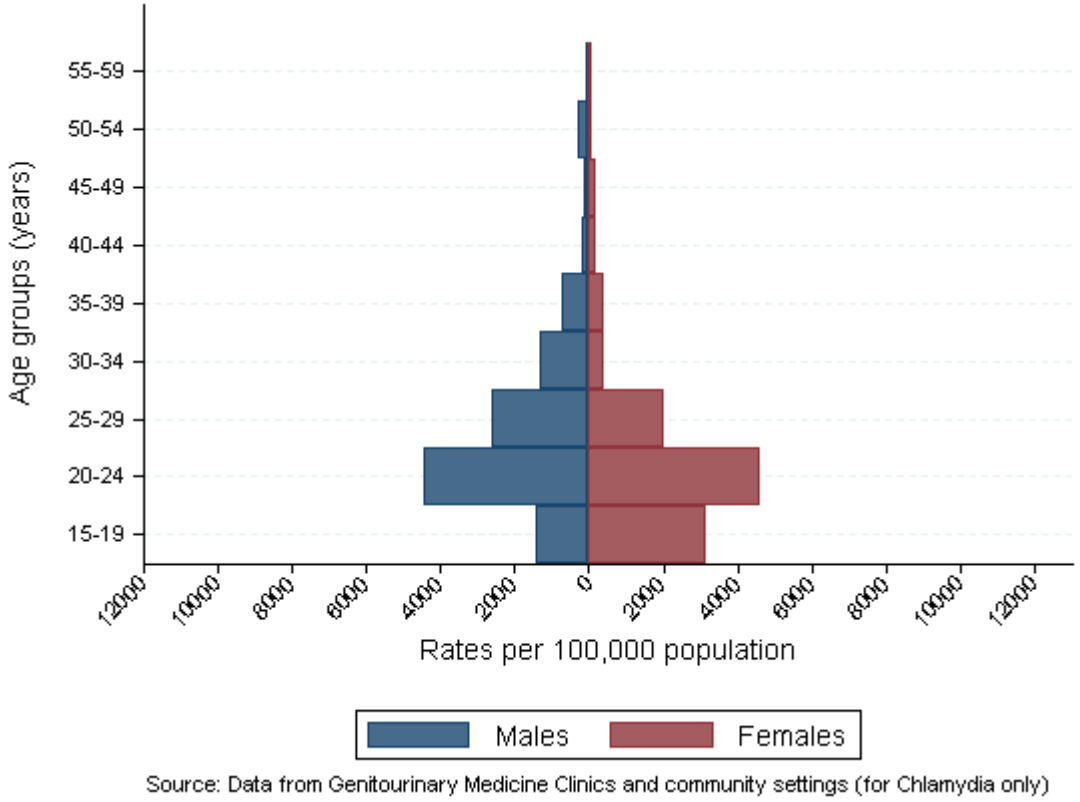


*Figure 8: Age group and gender of cases of acute STIs in Isle of Wight as a rate per 100,000: 2012 (*NB Data used in Fig 8 from community settings refers to chlamydia diagnosis only and not all acute STI diagnosis.)

Young people are also more likely to become re-infected with STIs, contributing to infection persistence and health service workload. On the Isle of Wight, an estimated 8.4% of 16 to 19 year old women and 8% of 16 to 19 year old men presenting with an acute STI at a GUM clinic during the three year period from 2009 to 2011 became re-infected with an STI within twelve months. Teenagers may be at risk of re-infection because they lack the skills and confidence to negotiate safer sex.

2.4.1 Teenage pregnancy (under-18 conception)

The UK has one of the highest rates of teenage pregnancy in Europe. Teenage pregnancy is a complex issue, affected by a range of personal, social economic and environmental factors. The reasons for tackling teenage pregnancy are well documented and include health and wider inequalities issues.

The national under 18 conception rate has fallen by 34% since 1998 to 31 per 1000 young women according to 2011 figures, it is at its lowest rate since 1969. However, this still equates to nearly 30,000 conceptions a year. Around three quarters of these are unplanned and about half end in abortion.

The Isle of Wight under 18 conception rate has fallen by 26.4% over the same period and in 2011 stood at 29.6 per 1000 young women (2011 data). Between 1998 and 2011, the Isle of Wight has had a comparable reduction in teenage pregnancy rates to England.

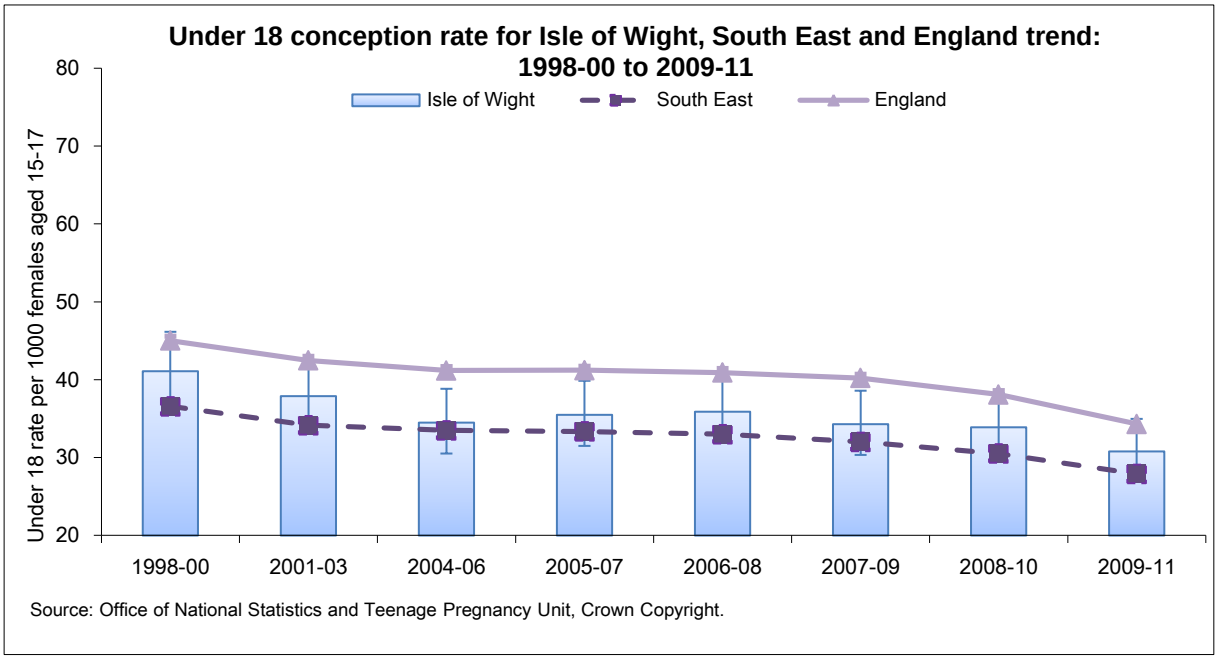


Figure 9: Under 18 conception rate for the Isle of Wight, South East and England trend: 1998-00 to 2009-11

There is a multi-agency Teenage Pregnancy Strategy group within the Isle of Wight Council with an overall action plan tackling all elements related to under 18 conception rates. This includes prevention, information and education, access to good sexual health services and support for young parents.

Locally and nationally there is a clear link between higher rates of teenage conception and deprivation (figure 10).

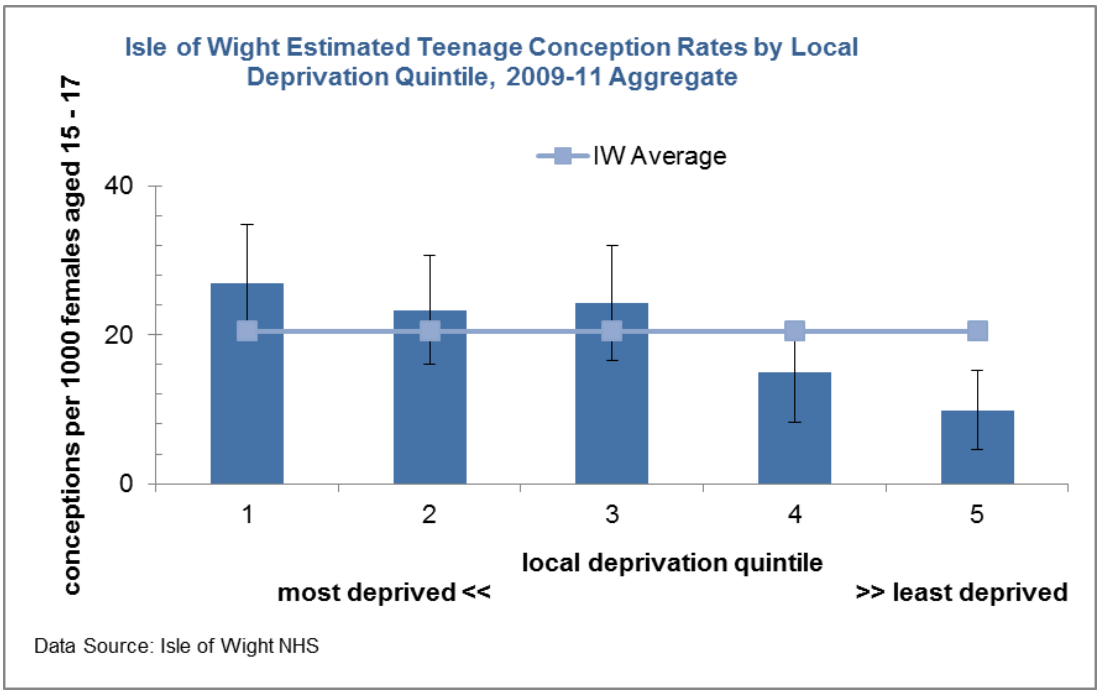


Figure 10: Isle of Wight estimates teenage conception rates

There are particular concerns for pregnancy in under-18 year olds. Teenage pregnancy is associated with poorer health and well-being for both mother and child as set out below.[25]

- Teenage parents are 20% more likely to have no qualifications at age 30.
- Teenage mothers are 22% more likely to be living in poverty at 30, and much less likely to be employed or living with a partner; and teenage mothers have three times the rate of postnatal depression and a higher risk of poor mental health for three years after the birth.
- Children of teenage mothers have a 63% increased risk of being born into poverty
- They more likely to have accidents and behavioural problems.
- The infant mortality rate for babies born to teenage mothers is 60% higher.
- Teenage mothers are three times more likely to smoke throughout their pregnancy
- They 50% less likely to breastfeed, with negative health consequences for the child.

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

2.4.2 Young peoples' attitudes to sexual health

2.4.2.1 Good Childhood Survey

As part of the Isle of Wight and Children's Society Good Childhood Survey of Children and Young People, children in Years 9 to 11 (13 to 16 year olds) were asked to state their views about acceptability of health-related behaviours including sex[26]. In total, young people felt that to have sex at their age was more acceptable than smoking and using drugs but less acceptable than drinking alcohol.

Do you think it is OK for someone who is you age	Not OK	Unsure	OK
…to have sex	47%	17%	35%

Figure 11: Good Childhood Survey: Views about acceptability of health-related behaviour

The level of acceptability of having sex by age group increases with age. Having sex was deemed by the majority to be more acceptable in Year 11 compared to smoking, alcohol and drugs. In Year 9 and 10, having sex was less acceptable than alcohol but was more acceptable than smoking and using drugs.

% thinking it is OK for someone who is their age	Year 9	Year 10	Year 11
…to have sex	11%	28%	64%

Figure 12: Good Childhood Survey: Views about acceptability of health-related behaviour

2.4.2.2 School Health Education Unit (SHEU) survey

Public Health commissioned Exeter University to conduct a health and well-being research study of over 860 pupils in 5 secondary schools across the Isle of Wight. Sexual health questions were asked only of pupils in Year 10 and above. Figure 13 illustrates the respondent profile.

Gender	Year 10	Year 12
Female	168	65
Male	189	36

Figure 13: Isle of Wight SHEU survey respondents

[26] The Children's Society (2012) Isle of Wight survey of children and young people, 2012 Final report http://www.childrenssociety.org.uk/sites/default/files/tcs/isle_of_wight_report_2012_final.pdf [accessed 9th April 2013]

School Health Education Unit (SHEU) key findings

Education and knowledge:

- 39% of pupils in Year 10 and above said that HIV/AIDS can be treated but not cured.
- 45% of pupils of pupils in Year 10 and above responded that there is a special contraception and advice service for young people available locally, while 47% said they 'don't know' if there is.
- 31% of pupils in Year 10 and above think their sex education programme at school covers everything they need (26% said no while 44% were not sure).
- 50% of pupils responded that they know where they can get condoms free of charge.
- 53% of pupils said that they think condoms are reliable to stop pregnancy; 54% think that condoms are reliable to stop infections.
- 12% of pupils think none of the contraceptive methods listed are reliable to stop infections like HIV/AIDS.

Sexual health risk-taking behaviour:

- 57% have not had sex, that is, 53% have not had a sexual relationship at all while 4% are 'currently in a relationship and thinking about having sex'. 20% have had sex, that is, 6% have 'had a sexual relationship in the past' while 12% are 'currently in a sexual relationship'. The remainder (23%) preferred not to say. [To avoid giving students the impression that everybody but them is having sex, this question was preceded by a statement: Nationally, we know that most young people under 16 have not had sex (only 25% of under 16s report having sex).]
- Of those pupils in Year 10 and above who have ever had sex, 82% said they always used a method of protection or contraception.

Current Service Use:

Percentages who had heard of any of the following programmes/services:

	Males	Females
Condom distribution scheme	20	24
Chlamydia screening	17	23
Under-25 Clinics	10	17
www.wish-net.co.uk	6	10

Figure 14: Percentage of Isle of Wight SHEU respondents by gender who had heard of any of the programmes/services

Percentages who think they can access confidential sexual health services on the Island at these places:

	Males	Females
Your local GP	21	27
Under-25 Clinics	16	20
St Mary's service	15	14
A pharmacy	14	14

Figure 15: Percentage of Isle of Wight SHEU respondents by gender who think they can access confidential sexual health services on the Island

Percentages who would be happy to talk to any of the following about sexual health:

	Males	Females
Local doctor/nurse	18	19
Specialist community nurse	14	18
Specialist at St Mary's	14	18
Your parent/carer	11	16
A pharmacist	8	7

Figure 16: Percentage of Isle of Wight SHEU respondents by gender who would be happy to talk to any of the following about sexual health

2.5 Lesbian, Gay, Bi-sexual and Transgender (LGBT)

Lesbian, gay, bisexual and transgender (LGBT) people experience a number of health inequalities. Specifically, men who have sex with men (MSM) remain at greatest risk of acquiring HIV infection in the UK, with no evidence of declining infections in this group. This group is a socially and culturally diverse group, some of whom may not self-identify as 'gay'.

According to the 2010 Integrated Household Survey the adult population (aged 16+) on the Isle of Wight found that 1.5% (1,736 people) identified themselves as lesbian, gay or bisexual (LGB) and 0.3% identified themselves as 'other' (not heterosexual/straight, not LGB)[27].

The 2011 census found 148 people - 65 households - live in a same sex civil partnership on the Island. This equates to approximately 0.1% of Island residents.

Recent high profile studies by Stonewall[28][29][30] found that the LGBT community are experiencing a number of health inequalities that are often unrecognised in health and care settings.

[27] Transgender was not listed as a sexual orientation.
[28] Stonewall is a charity working for equality and justice for lesbians, gay men and bisexuals
[29] Stonewall (2011) Gay and Bisexual Men's Health Survey [online] Available at: http://www.stonewall.org.uk/what_we_do/research_and_policy/health_and_healthcare/4922.asp [accessed 19th August 2013]
[30] Stonewall (2008) Prescription for change: Lesbian and Bisexual women's health check [online] Available at: http://www.stonewall.org.uk/what_we_do/research_and_policy/health_and_healthcare/3101.asp [accessed 19th August 2013]

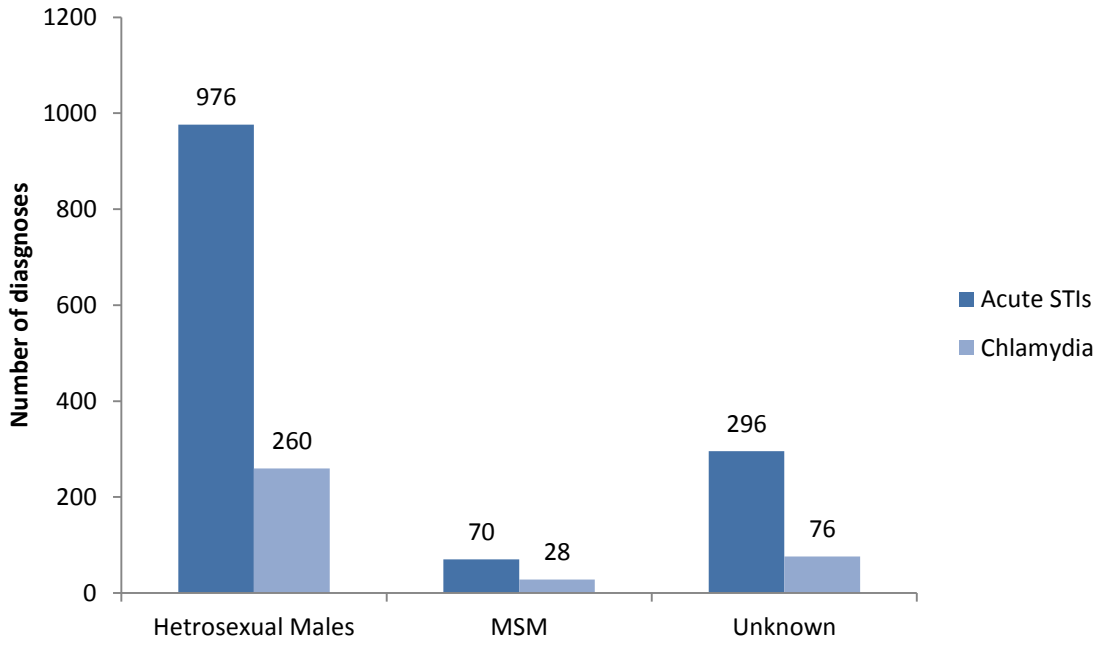
- Three in ten gay and bisexual men have never had an HIV test [31] Despite being at higher risk.

- One in four gay and bisexual men have never been tested for any sexually transmitted infection

- Less than half of lesbian and bisexual women have ever been screened for STIs[32]. Of those who have been screened, half had an STI and a quarter of those with STIs have only had sex with women in the last five years.

2.6 Men who have sex with men (MSM)

On the Isle of Wight in 2009 to 2012, for cases in men where sexual orientation was recorded, 6.7% of acute STIs were among MSM (figure 17). Sexual orientation in sexual health plays a pivotal role with MSM identified as being a high risk group for STIs[33]. Sexual orientation[34] refers to whether a person's sexual attraction is towards their own gender, the opposite gender or to both genders.



Source: Data from Genitourinary Medicine Clinics – excludes diagnoses outside GUM Clinics

*Figure 17: Number of acute STIs and chlamydia, in men by their sexual orientation in 2009 to 2012 *Breakdown by gonorrhoea, syphilis, genital warts and genital herpes removed due to small numbers*

[31] Stonewall (2011) Gay and Bisexual Men's Health Survey [online] Available at: http://www.stonewall.org.uk/what_we_do/research_and_policy/health_and_healthcare/4922.asp [accessed 19th August 2013]
[32] Stonewall (2008) Prescription for change: Lesbian and Bisexual women's health check [online] Available at: http://www.stonewall.org.uk/what_we_do/research_and_policy/health_and_healthcare/3101.asp [accessed 19th August 2013]
33 Department of Health (2013) A Framework for Sexual Health Improvement in England
34 Isle of Wight Council (2013) Diversity & Equality Factsheet IWC Business Information Team, April 2013

2.7 Mental wellbeing and sexual health

There is an asocatioan with sexual health risk behaviour is and poorer mental health and lower levels of wellbeing[35].

Local surveys[36] show that a higher than expected proportion of younger people living on the Island report that they experience low self-esteem and anxiety issues.

2.8 Alcohol and sexual health

The link between excessive alcohol use and poor sexual health outcomes has been recognised for some time[37]. A study[38] of 520 GUM clinic attenders found that 86% of GUM clinic attendees exceeded the UK government's safe drinking advice and 32% of subjects thought that alcohol played a role in their clinic attendance. 77% reported that they had been drinking before sex with a new partner.

Locally, the Good Childhood Survey (2012) identified the level of acceptability of drinking alcohol by age, with 40% of 13 to 15 year olds interviewed stating it was acceptable to drink alcohol. This increased to 63% at age 16. An estimated 17.3% of adults (16+) drink alcohol at 'increasing risk' levels regularly in excess of recommended limits or at levels of 'high risk' of alcohol-related health harms. The rate is comparable to the England rate.

2.9 Sexual assault

The health needs of sexual assault victims include the physical health consequences of sexual violence and for rape, a risk of pregnancy in 5% of cases, contraction of STIs and HIV, and for all victims, longer-term health issues such as increased rates of chronic illnesses, poor perceived health and increased use of medical services[39]. NHS England commission Sexual Assault Services which cater for the needs of victims of sexual assault. Close working between local authorities and NHS England is needed to integrate care pathways for such victims to receive improved care and support as they choose and to exploit synergies in co-location between SARCs and sexual health and GUM clinics.

Estimates from the Crime Survey for England and Wales indicate that there are around 400,000 female victims of sexual offences each year and, of these, around 85,000 are victims of the most serious offences of rape or sexual assault by penetration (2013)[40][41]. Many more women than men experienced some form of sexual assault (including attempts) in the last year: 3% of women compared with 0.3% of men. Nationally and locally victims are

35 Department of Health (2011) No Health without Mental Health, London
36 The Children's Society (2012) Isle of Wight Good Childhood survey [Online] Available at: http://www.childrenssociety.org.uk/sites/default/files/tcs/isle_of_wight_report_2012_final.pdf
37 Royal College of Physicians/BASHH (2011) Alcohol and sex: a cocktail for poor sexual health, A report of the Alcohol and Sexual Health Working Party
38 Standerwick K, Davies C, Tucker L, Sheron N. (2007) Binge drinking, sexual behaviour and sexually transmitted infection in the UK. *Int J STD AIDS*; 18:810–819
39 NHS (2013) Securing Excellence in commissioning sexual assault services for people who experience sexual violence
40 Based on a self-completion module of the Crime Survey for England and Wales using data from the 2009/10. 2010/11 and 2011/12 surveys combined
41 Department of Health (2013) A Framework for Sexual Health Improvement in England

predominately female, aged 14-21 (although the age ranges from 1-84 years) from vulnerable or marginalised groups living in socially deprived areas. Offenders are predominately male, aged 16-34 again, mostly coming from vulnerable or marginalised groups living in areas of deprivation.[42]

It is estimated that up to 3000 women aged between 16-59 living on the Isle of Wight, would have been victims of sexual assault in the past year (2012/13). This estimation is reflective of reported and unreported sexual assaults. Figures of sexual offences are heavily influenced by the willingness of the victims to report. It is reported that just 10% of victims of serious sexual assault will go to the police. In the latest Hampshire Constabulary report of serious sexual offences on the Island, covering February 2013 to July 2013, the highest number of offences recorded was rape of a female over 16 years of age. This is in line with findings from previous reporting periods and national statistics.

It also found that the majority of offences have occurred in a dwelling linked to the offender or victim, usually where the victim/offender relationship is primarily an acquaintance. There was evidence that some victims had experienced previous sexual assault and that some of the suspects had been reported as previous sexual assault suspects.

The consumption of alcohol remains a contributory factor to serious sexual offences on the Isle of Wight, with victim vulnerability remaining the key underlying issue in this reporting period.

The Isle of Wight currently has access to a Sexual Assault Referral Centre (SARC) locally (as part of St Mary's Hospital) and to SARC facilities in Southampton. Due to difficulties recruiting and maintaining appropriate forensic skills, the majority of victims attend the Southampton facilities.

[42] Hampshire Constabulary (2012)

2.10 Recommendations

1. The needs of specific groups, particularly young people, gay and bisexual men and some black and ethnic minority groups who are at risk of poorer sexual health outcomes, must be considered and planned for within joint Health and Wellbeing strategies and service provision.
2. Up to date information is available in formats that are appropriate for residents with learning disabilities, their families and carers
3. Staff working in sexual health services should have appropriate sexual health training that will meet the needs of residents with learning disabilities
4. Robust signposting and referral pathways are implemented between mental health services, drug and alcohol services and associated voluntary organisations across all sexual health providers

Teenage Pregnancy

5. Public Health to maintain a key influencing role within the teenage pregnancy strategy group ensuring that all commissioned services contribute to the outcome of reducing under 18 conceptions.

Sexual Assault

6. Improve and increase knowledge of the scale of sexual assault and under reporting across all agencies, voluntary and statutory sectors. Improving identification of vulnerability factors and encourage victims to report incidences.
7. Develop resources and information for victims, wider public, statutory and non-statutory organisations to raise awareness of what constitutes sexual assault and abuse, how to report cases and how to develop protective factors, particularly around alcohol and relationships.
8. Review current SARC, explore opportunities to bring forensic specialists to Island in order to take evidence from the victims locally, rather than making them travel to Southampton.
9. Continue to support advocate and support groups for victims and perpetrators of sexual assault.

3.0 Burden and trend of acute Sexual Transmitted Infections (STIs)

825 acute STIs were diagnosed in residents of Isle of Wight in 2012 (423 in males and 399 in females), a rate of 596.1 per 100,000 residents (males 627 and females 562.5) (gender was not specified or unknown for 3 episodes).

Diagnoses	Rate: 2011 (Isle of Wight)	Rate: 2012 (Isle of Wight)	% change 2011 to 2012*	Rank within England 2012**	Rate in England residents 2012
Acute STI †	499.3	596.1		175	803.7
Chlamydia	265.2	304.9		125	371.6
Genital Warts ‡	118.5	139.5	17.7	95	134.6
Genital Herpes ±	36.9	49.1	33.1	171	58.4

Figure 18: Rates per 100,000 population of all ages of STIs in Isle of Wight: 2011-2012[43]

* change not provided where rate per 100,000 population in 2011 was 0.0
**Out of 326 local authorities, 1st rank has the highest rates. Rank within England has been based on alphabetical order of local authority name where rate for local authority was 0.0 per 100,000 population
†Acute STI as of 2012 includes HIV new diagnosis - Acute infection
‡Any decrease in genital warts diagnoses may be due to a moderately protective effect of HPV-16/18 vaccination
±Any increase in genital herpes diagnoses may be due to the use of more sensitive NAATs
Data Source: The Genitourinary Medicine Clinic Activity Dataset (GUMCAD) and Chlamydia test and diagnosis data from community services are sourced from NCSP and 'Non-NCSP/Non-GUM' services for 2008-2011 and include only those aged 15-24 years. From 2012, chlamydia test and diagnosis data are sourced from CTAD and include all ages

The STI diagnostic rates show that on the whole the Isle of Wight has lower incidences of acute STIs, chlamydia, genital warts and genital herpes than the Wessex region (Dorset, Hampshire, Portsmouth, Southampton and the Isle of Wight) and England. The exception to this rule and where the Isle of Wight is seeing higher diagnostic rates than Wessex and England are for chlamydia in the age 15-24 year age group and genital warts which have seen an increase in diagnosis per 100,000 in 2012. It is important to note that with diagnostic rates that the level of diagnosis can be influenced by confounding factors such as awareness campaigns. Awareness campaigns can increase testing and potentially diagnosis. Therefore, the diagnostic rates need to be interpreted with caution as only those who are tested will be diagnosed and there will be a proportion of STIs in the population that will not be captured in this data.

The increase in genital warts is in contrast with the downward trend of Wessex and England, however rates remain in line with the rest of the region. Genital warts are caused by the human papilloma virus (HPV). It is reported that the moderate downward trend seen in

[43] Data Source: The Genitourinary Medicine Clinic Activity Dataset (GUMCAD) and community settings (National Chlamydia Screening Programme (NCSP) and non-GUM, non-NCSP returns)

genital warts in England may be due to the protective effect of the HPV vaccination. More insight into the breakdown of the diagnoses is required to understand how the levels can be driven down.

Further emphasis is required to ensure that the National Chlamydia Screening Programme (NCSP) presence continues to control chlamydia through early detection and treatment of asymptomatic infection, so reducing onward transmission and the consequences of untreated infection in 15 to 24 year olds.

Figures 18a to 18i show the rates per 100,000 resident population of all ages of diagnoses of acute STIs, chlamydia, gonorrhea, syphilis, genital warts and genital herpes by year in Isle of Wight compared to rates in the Wessex region and England. (Please note different scales of each graph).

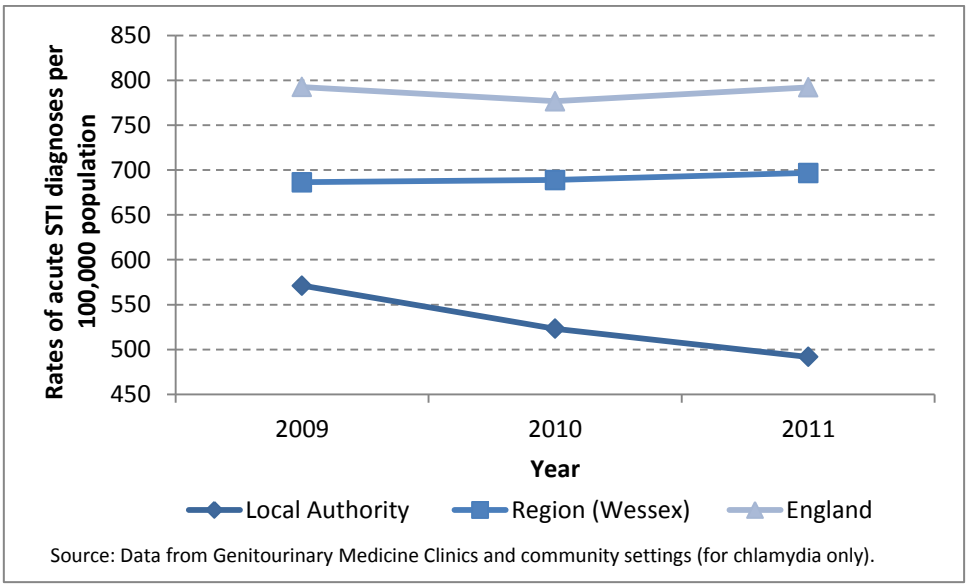


Figure 18a: Rates of acute STIs diagnoses per 100,000 population, 2009 to 2011, Isle of Wight Local Authority compared to Wessex Region and England

Figure 18b reflects Public Health England June 2012 figures for rates of acute STIs per 100,000 and includes the new chlamydia rate.

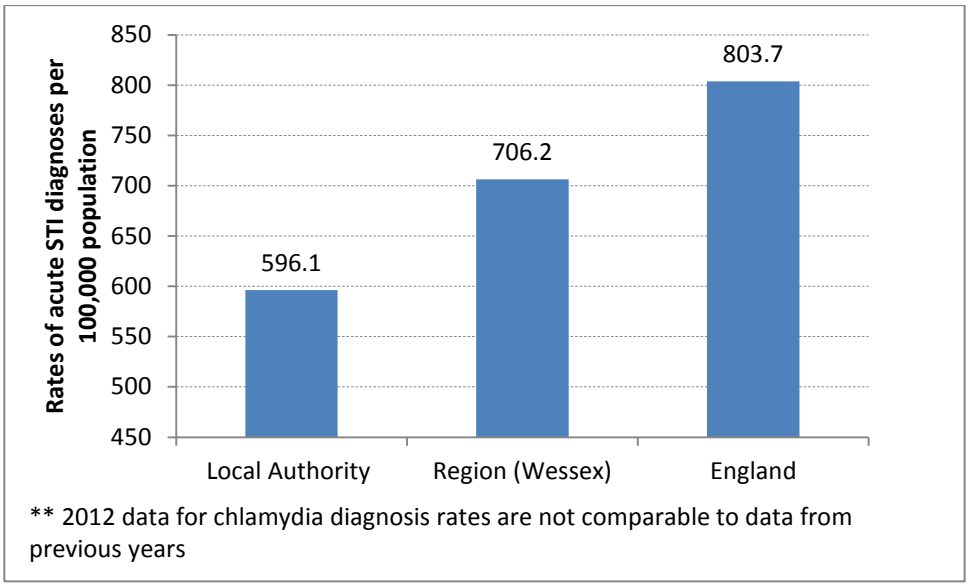


Figure 18b: Rates of acute STI diagnoses per 100,000 population, 2012: Isle of Wight Local Authority compared to Wessex Region and England

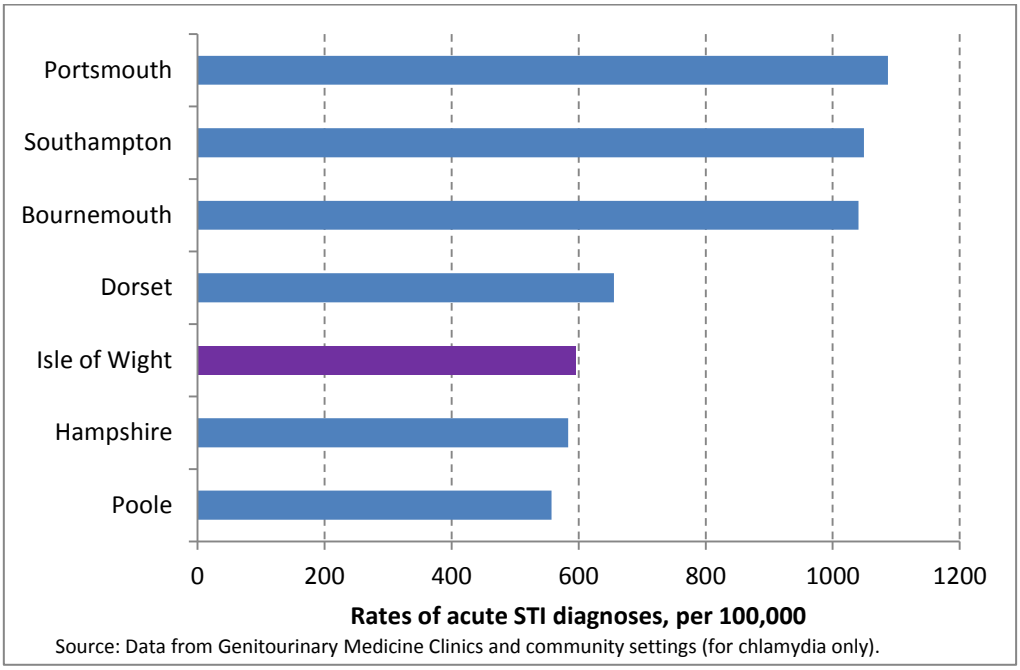


Figure 18c: Rates of acute STIs in each local authority in the Wessex region: 2012

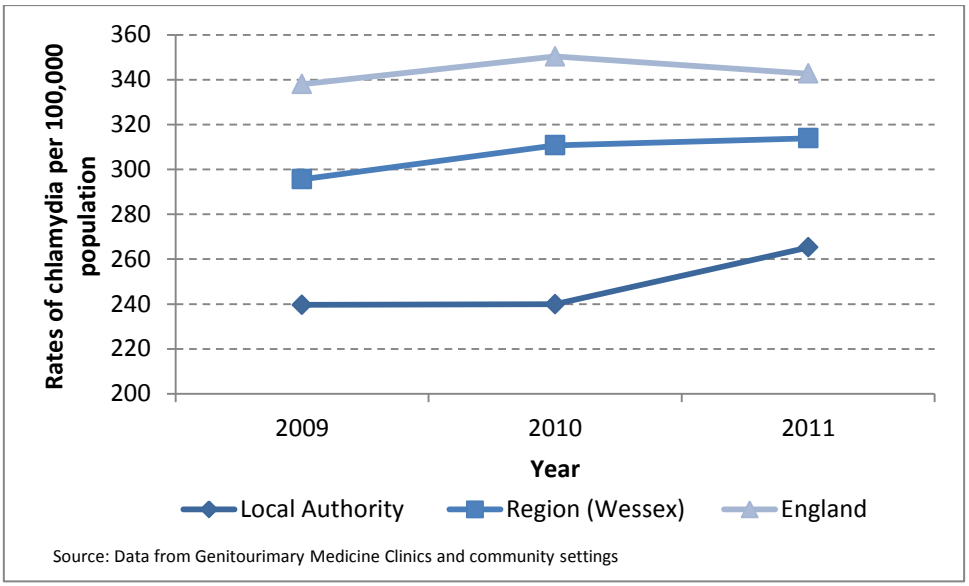


Figure 18d: Rates of chlamydia 2009-2011, per 100,000 population, Isle of Wight Local Authority compared to Wessex Region and England

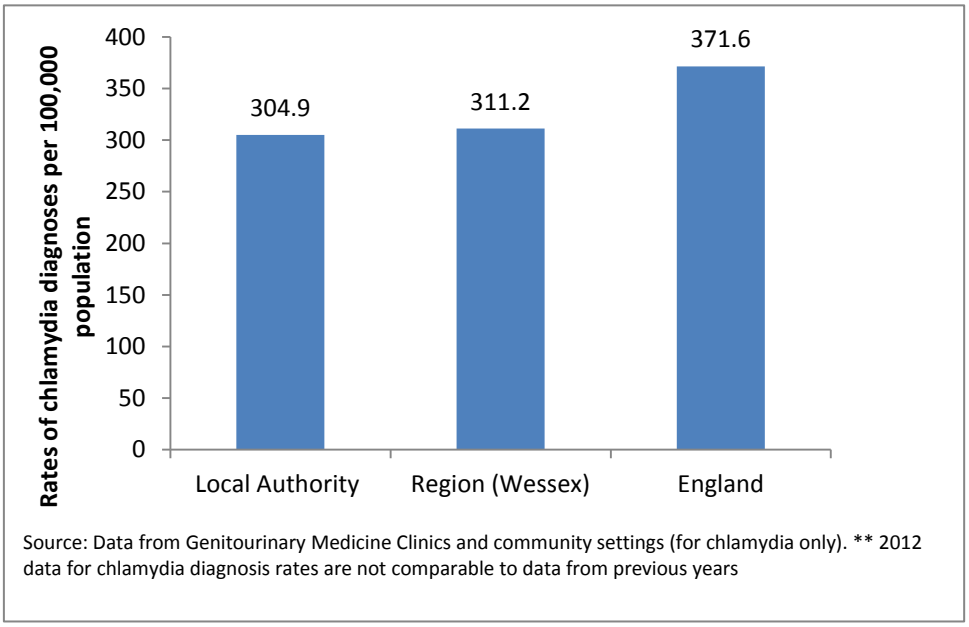
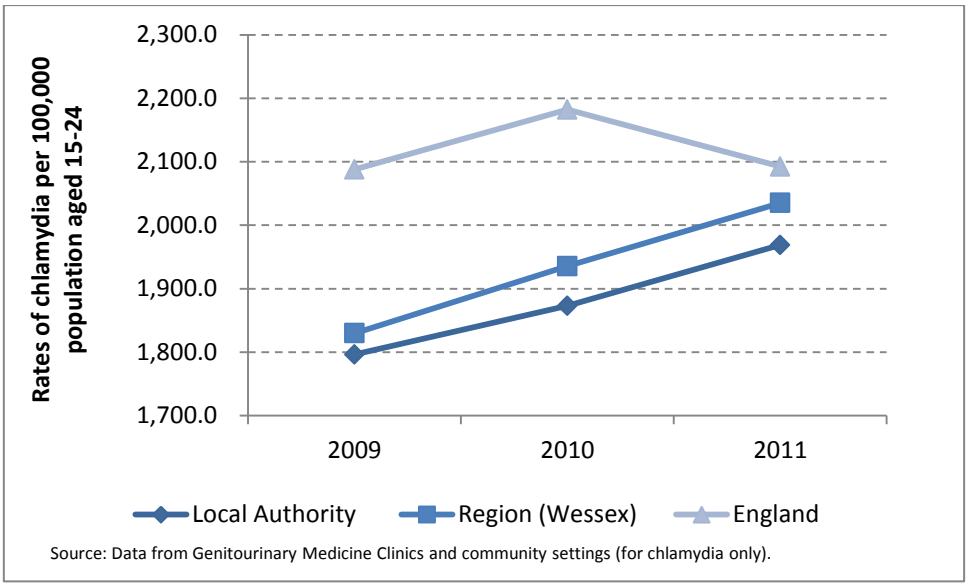
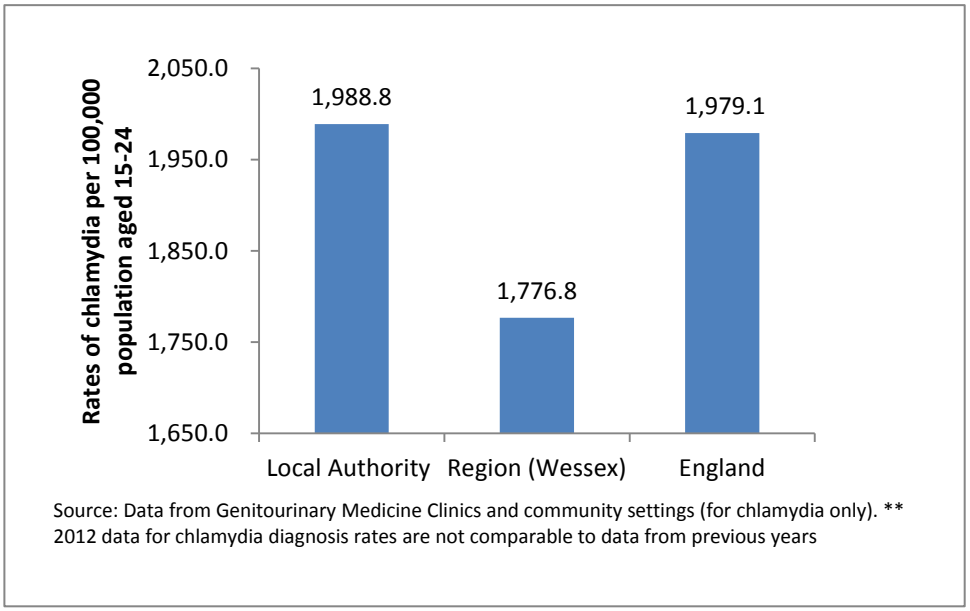


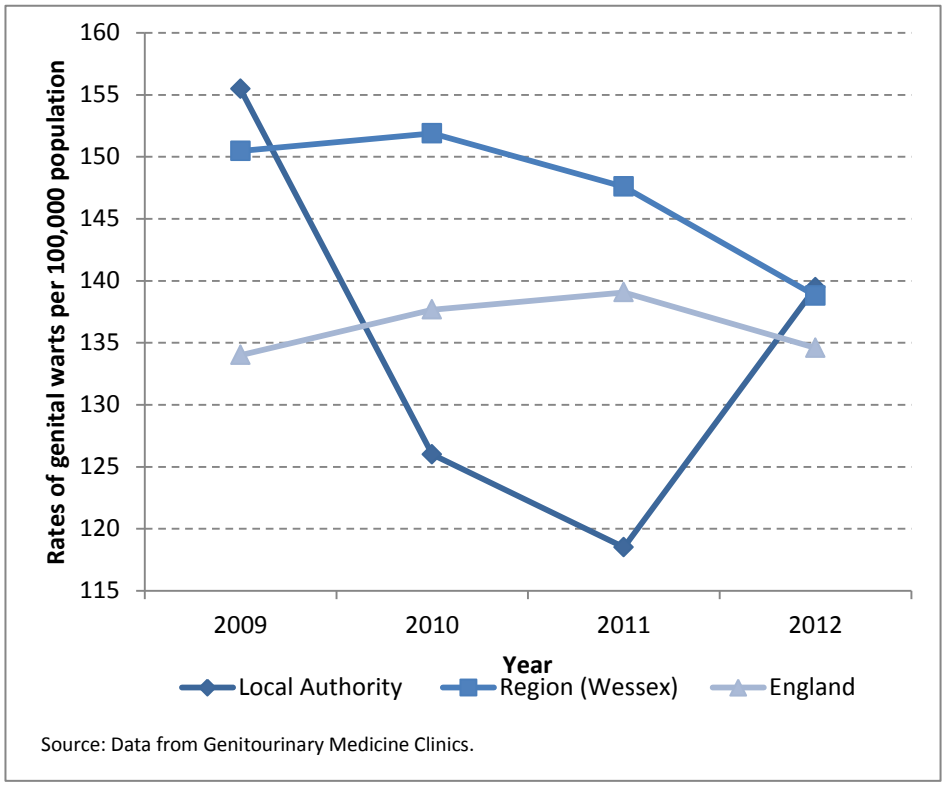
Figure 18e: Rates of chlamydia in 2012, per 100,000 population: Isle of Wight Local Authority compared to Wessex Region and England



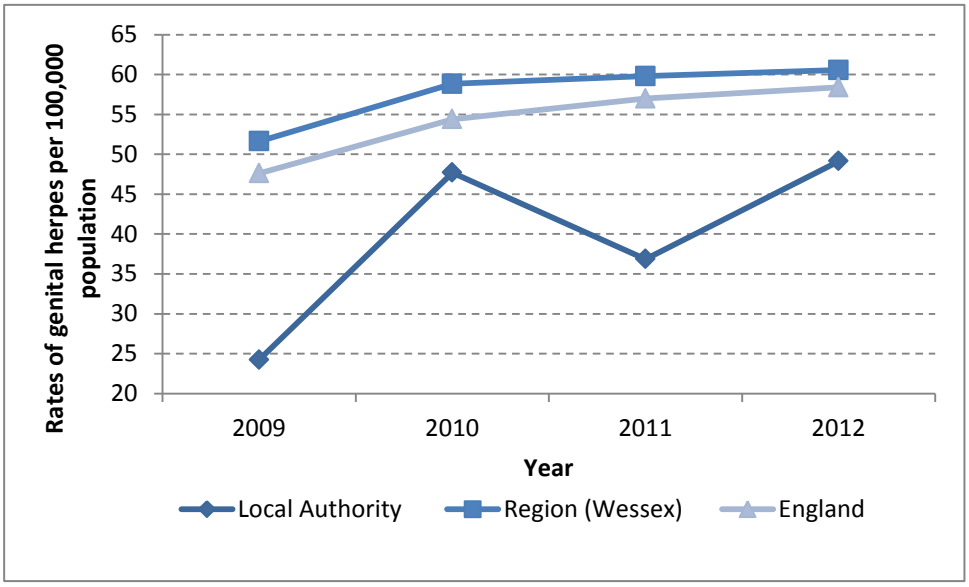
18f Rates of chlamydia in 15 to 24 year olds 2009 - 2011, per 100,000 population, Isle of Wight Local Authority compared to Wessex Region and England



18g Rates of chlamydia in 15 to 24 year olds 2012, per 100,000 population, Isle of Wight Local Authority compared to Wessex Region and England



18h Rates of genital warts in 2009 - 2012, per 100,000 population, Isle of Wight Local Authority compared to Wessex Region and England



18i Rates of genital herpes in 2009 - 2012, per 100,000 population, Isle of Wight Local Authority compared to Wessex Region and England

3.1 Human Immunodeficiency Virus (HIV)

According to the latest Department of Health Framework[44], late diagnosis of HIV is more common in older age groups (half of those aged over 50) compared with younger age groups (one-third of those aged 16 to 19).

Offer and uptake of HIV testing in GUM clinics

To gain an understanding of how the Isle of Wight HIV testing compares to regional and national areas data from the HPA[45] have been used specifically looking at how many patients at a GUM clinic are *offered* a HIV test as well as the resulting percentage *uptake*. The Isle of Wight offers fewer patients HIV tests compared to the England average although over the three year period there has been a slight increase.

Nationally in 2012, 80% of attendances at GUM clinics were offered a HIV test of which 92% go on to have a test. This compares to local data where 68% of all those attending the sexual health clinic are offered a test with a 79% of attendees taking up the test[46]. Therefore, locally less people are offered an HIV test and of those offered, less take up the test.

HIV diagnoses: how the Isle of Wight compares regionally and nationally

The Isle of Wight has a low rate of patients with HIV accessing care. Figure 19 illustrates the rate of people with HIV who are accessing care per 1,000 population aged 15-59 as a proxy measure of HIV prevalence. The Isle of Wight has the second lowest rate of 0.4 cases per 1,000 population compared to our statistical and geographical neighbours. The England HIV diagnosis average is 2 cases per 1,000.

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

[45] HPA (2012) Table 4: HIV test uptake in England, 2009 – 2011 [online] Available at: http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1215589013442

[46] HPA (2012) Table 4: HIV test uptake in England, 2009 – 2011 [online] Available at: http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1215589013442

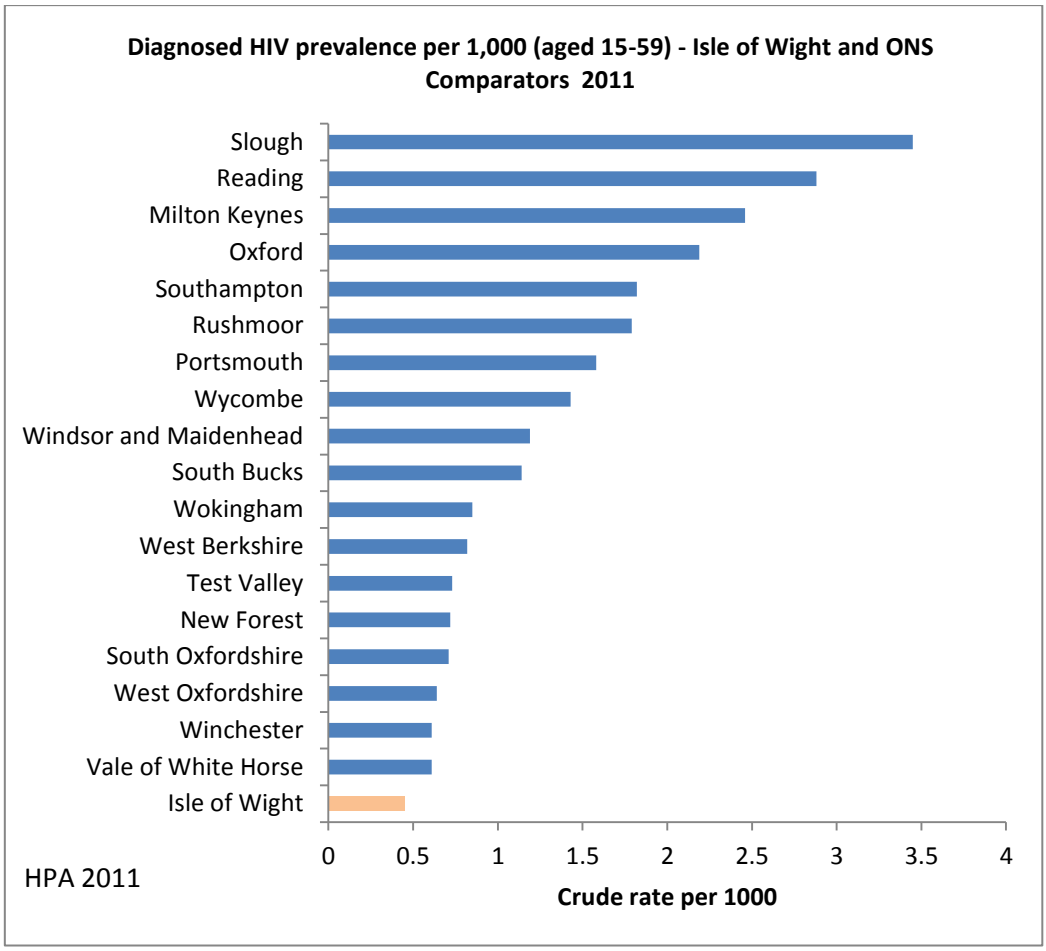


Figure 19: Number of cases of HIV infected individuals accessing care (aged 15-59) Isle of Wight compared to South Central: 2011[47]

National research has shown that health outcomes and cost of care are significantly improved with early diagnosis for HIV. This is monitored nationally as the percentage of HIV diagnoses that are late[48]. The England average for this measure is 52.3% and the Isle of Wight is slightly better at 50%.

3.2 National Chlamydia Screening Programme (NCSP)

The Public Health Outcomes Framework includes an indicator to assess progress in controlling chlamydia in sexually active young adults under 25 years old: the annual diagnostic rate amongst the resident 15-24 year old population. The diagnosis rate reflects both coverage and the proportion testing positive at all sites, including Genitourinary Medicine (GUM) diagnoses as well as those made outside of GUM.

Chlamydia is most often asymptomatic, a high diagnosis rate reflects success at identifying infections that, if left untreated, may lead to serious reproductive health consequence. Nationally it is recommended that local areas achieve a rate of at least 2,300 per 100,000

[47] HPA (2012) Diagnosed HIV prevalence in Local Authorities (LAs) in England, 2011 [Online] Available at: http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1228207184991 [accessed 26th July 2013]
[48] Late HIV diagnoses are defined as where the CO4 cell count <350mm3, and the measure is a combined for 3 years data. The data used here is for 2008-2010

resident 15-24 year olds, a level which is expected to produce a decrease in chlamydia prevalence. Such a level can only be achieved through the on-going commissioning of high-volume, good quality screening services across primary care and sexual health services.

A focus only on individuals who are perceived to be at high-risk of chlamydia infections is not recommended as this approach has a number of problems:

- The recommended diagnosis rate will only be achievable by widespread community testing as well as testing in GUM services
- Modelled reductions in population prevalence are based on the assumption of population-wide testing
- Chlamydia infection occurs quite commonly in individuals without well-characterised risk-factors who should not be excluded from screening opportunities, and approaching groups on the basis of their perceived sexual risk behaviours can increase stigma and discrimination
- A selective screening approach risks undoing the advances the programme has made in normalising discussions about sexual health with young people and making opportunities for sexual health promotion
- The most effective and sustainable way to achieve this is to embed chlamydia screening in primary care and sexual health services

The chlamydia positive diagnosis rate in 15-24 year olds on the Isle of Wight was 1988.8 per 100,000. 32% of 15-24 year olds were tested for chlamydia with a 6% positivity rate. Nationally, 26% of 15-24 year olds were tested for chlamydia with an 8% positivity rate. The number of tests, annual coverage and positivity for Isle of Wight are shown in figure 20 below. The diagnosis rate per 100,000 and its rank in Wessex PHEC and England are shown in figure 21.

Number of chlamydia tests in GUM	Number of chlamydia tests in other settings	Total number of tests	Number of positives (all settings)	Percentage of population tested*
905	3850	4755	299	32

Figure 20: Chlamydia testing data in 15-24 year olds on the Isle of Wight: 2012

*Repeat tests are not excluded
Source: Data from Genitourinary Medicine Clinics and community settings

Rates of diagnosis	Rank within PHE Centre †	Rank within England*
1988.8	5	94

Figure 21: Rates per 100,000 of chlamydia diagnosis in 15-24 year olds on the Isle of Wight: 2012

†Out of 22 local authorities in Wessex PHEC, 1st rank has the highest rates

*Out of 326 local authorities in England, 1st rank has the highest rates
Source: Data from Genitourinary Medicine Clinics and community settings

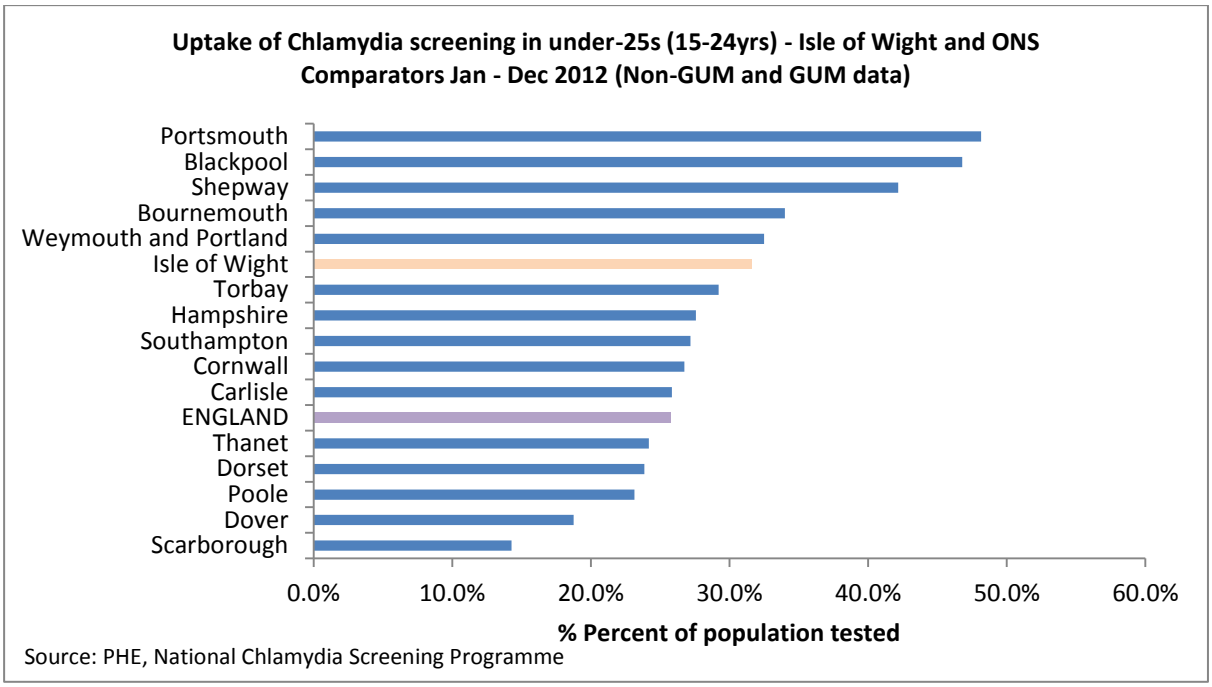


Figure 22: Uptake of Chlamydia Screening in Under-25 year olds on the Isle of Wight compared to ONS comparators: 2012

The majority (nearly 75%) of chlamydia tests were taken by females. This is consistent with national trends.

A significant number of chlamydia tests have been completed across the spectrum of deprivation quintiles on the Island. For all tests with a recorded postcode there is a clear trend of greater chlamydia testing in areas of greater deprivation.

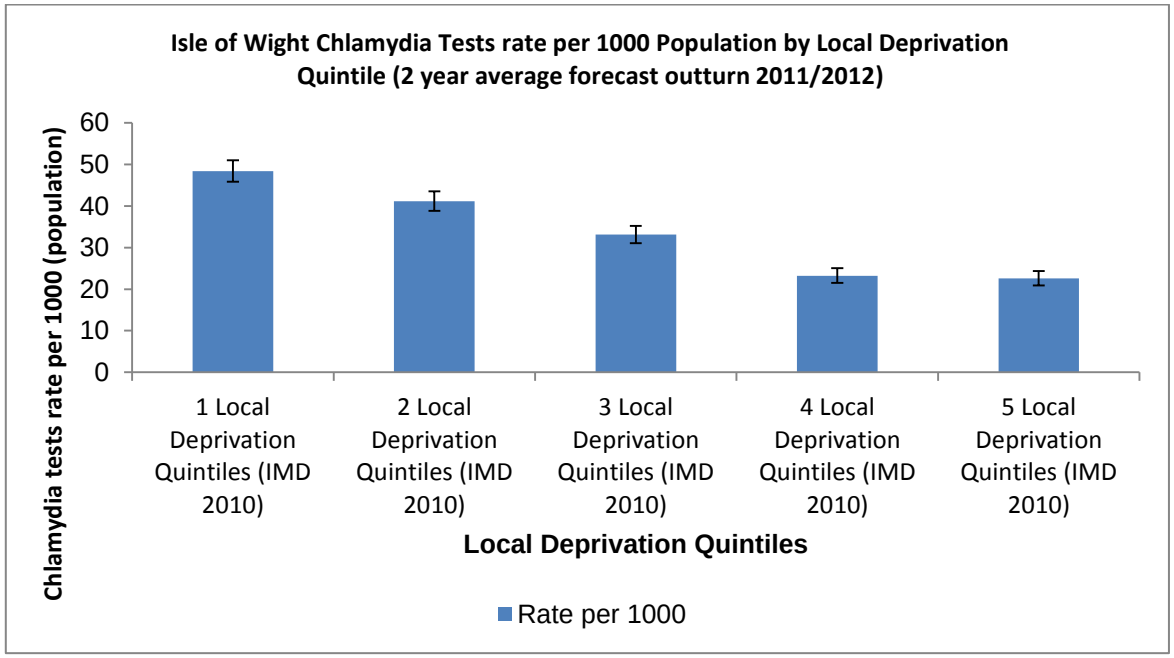


Figure 23: Isle of Wight chlamydia tests rate per 1000 population by Local Deprivation Quintile

Although only 26% of chlamydia tests were in males, it is interesting to note that 37% of the diagnoses were male.

This shows that whilst females are more likely to be tested for chlamydia, a higher proportion of male chlamydia tests are positive than female tests.

3.3 Reinfection of STIs

Reinfection with an STI is a marker of persistent risky behaviour. Nationally, during the four year period from 2009 to 2012 an estimated 9.6% of women and 12% of men presenting with an acute STI at a GUM clinic became reinfected with an acute STI within twelve months. The Island during the same time period has a comparatively lower rate with an estimated 7.7% of women and 6.8% of men presenting with an acute STI at a GUM clinic became reinfected with an acute STI within twelve months. Partner notification is an essential component of STI management and control, protecting patients from reinfection, partners from long term consequences from untreated infection and the wider community from onward transmission[49].

3.4 Recommendations

1. Continue to offer confidential, comprehensive, open access STI testing and treatment services in a range of settings across the Isle of Wight to ensure that infections are diagnosed rapidly and prevent onward infection. Increase HIV testing to reduce undiagnosed and late diagnosed HIV across health care settings, by:
   - Increasing knowledge and understanding of HIV and reducing associated stigma within the local population
   - Improving health care professionals knowledge of HIV and confidence to offer opportunistic testing
   - Supporting sustained condom use and other behaviours that prevent HIV.
2. Continue to commission the chlamydia screening programme working with providers to achieve agreed diagnosis rates through increasing targeted outreach and partner notification via a range of settings, including remote/on line, whilst maintaining universal access.
3. Continue to use national and local messages to promote safe sex including avoiding STI reinfection

[49] Bell G and Potterat J (2011) Partner notification for sexually transmitted infections in the modern world: a practitioner perspective on challenges and opportunities', Sexually Transmitted Infections; 87: ii34–ii36

4.0 Contraception (Including Emergency Hormonal Contraception)

Contraceptive choices made by men and women are part of lifestyle decisions and are likely to change as the circumstances of the individual or couple change. There is a scarcity of research in a primary care population that measures women's knowledge about commonly used contraceptive methods.

Access to the full range of contraceptive methods at a location and time that meets the needs of women, who have sex with men, is vital to minimise the risks and consequences of unintended pregnancy. Despite the availability of reliable contraceptive methods in this country many pregnancies are unintended with some ending in abortion. Women in England have a wide range of contraceptives available to them, but they may not be aware of all methods and the differences between them. Locally, this can be illustrated by the responses from young people on the Isle of Wight to the School Health Education Unit (SHEU) survey (refer to section 2.4.2.2). The survey found that only 53% of pupils surveyed in Year 10 and 12 thought condoms were a reliable way to stop pregnancy with 54% thinking that condoms were a reliable method to prevent infections. These responses demonstrate some important gaps in knowledge about commonly used contraceptive methods.

There are three main categories of contraception:

1. User-dependent methods are methods you have to think about regularly or each time you have sex; you must use them according to instructions, e.g. combined oral contraceptive pill (COCP); barrier methods (condoms);

2. Long-acting reversible contraception (LARC) methods, e.g. sub-dermal implant;

3. Sterilisation is a surgical procedure for men or women.

In addition, emergency contraception can be used after a person has had unprotected sex or their regular contraceptive method has failed.

4.1 Long-Acting Reversible Contraception (LARC)

Long-acting reversible contraception (LARC) methods have a lower failure rate than all other reversible methods and are the most cost effective ways for sexually active people to prevent unintended pregnancies. LARC methods include:[50]

- Contraceptive injections, which work for up to 12 weeks and can be repeated
- Intrauterine contraceptive devices (IUD) and intrauterine system (IUS) are devices fitted inside the womb and last for 5 or 10 years and can be replaced after this.
- Contraceptive implants which are placed under the skin in the upper inner arm and last for 3 years and can be replaced after this.

In 2011 the Isle of Wight was ranked 3rd highest for the rate of GP prescribed LARC out of 152 PCTs in England[51] which indicates that a high amount of LARC is prescribed in general

[50] NICE (2013) What is long-acting reversible contraception? [online] Available at: http://publications.nice.org.uk/long-acting-reversible-contraception-ifp30/what-is-long-acting-reversible-contraception

practice when compared to other areas. Figure 24 shows the Isle of Wight compared to statistical neighbours,[52] geographic neighbours and the England average for 2011/12 for the percentage rate of LARC prescribed by GP practices per 1000 GP registered female population aged 15-24. This high rate of LARC provision is seen across all main LARC types.

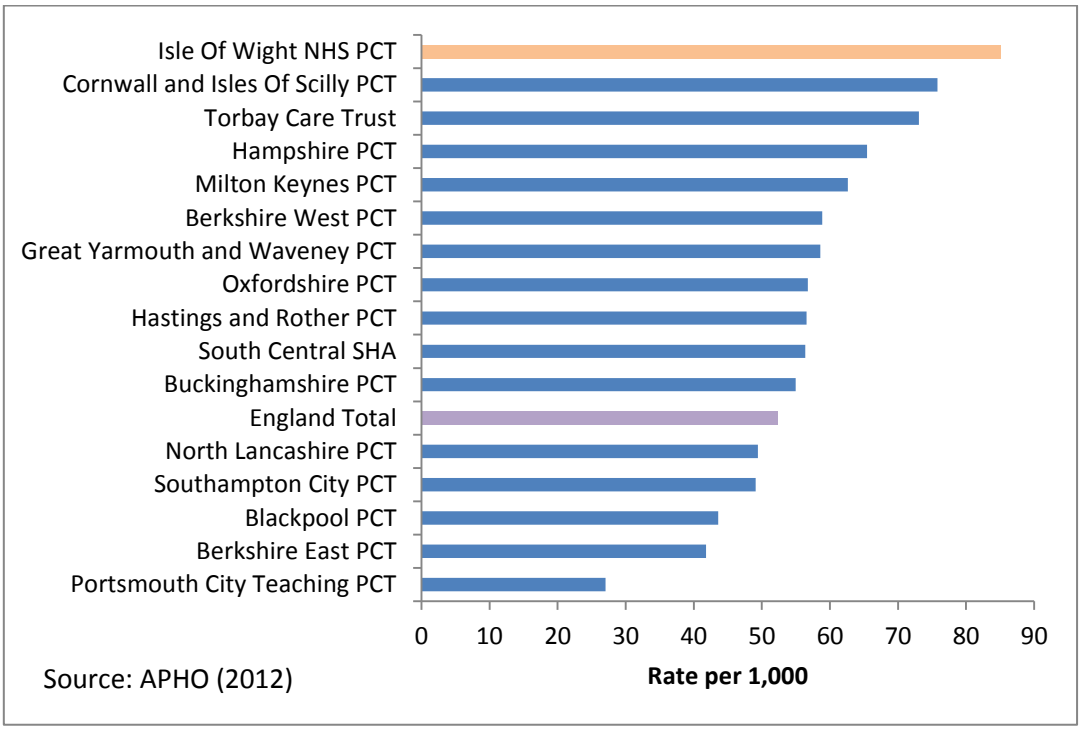


Figure 24: Rate of GP prescribed long-acting reversible contraception (LARC), 2011/12 Rate per 1,000 GP registered female population aged 15-44 – Isle of Wight and ONS PCT comparators[53]

IUD, IUS and implants are provided in all GP practices on the Isle of Wight with the exception of one surgery. This practice currently has a referral pathway in place for the patient to access these methods. All Practices provide contraceptive injections.

[51] APHO (2012) Sexual Health Balanced Scorecard [Online] Available at: http://www.apho.org.uk/default.aspx?QN=SBS_PAGE02
[52] A statistical neighbour has a similar population and demographic to the one it is being compared with
[53] APHO (2012) Rate of GP prescribed long-acting reversible contraception (LARC), 2011/12 [online] Available at: http://www.apho.org.uk/default.aspx?RID=74107&TYPE=FILES [accessed 26th July 2013]

4.2 Emergency Contraception

Emergency contraception aims to prevent pregnancy after unprotected sex or if the contraceptive method has failed. There are two methods of emergency contraception: the emergency hormonal contraceptive (EHC) pill ('the morning after pill') and the copper intra-uterine device (IUD or 'coil').

There are currently two types of oral hormonal emergency contraception:

- Levonorgestrel (Levonelle): this is licensed for up to 72 hours following unprotected sexual intercourse
- Ulipristal (Ella One): licensed for up to 5 days following unprotected sexual intercourse

The IUD is effective up to 5 days after unprotected sexual intercourse and in addition to being the most effective form of emergency contraception is able to remain in place for continuing contraception.

In 2006/07, 6% of women in Great Britain had used emergency contraception at least once during the last year[54]. The majority of these had used hormonal methods. Use of emergency contraception was highest in women in their twenties, 10% of whom had used it at least once in the previous year[55]. This links to higher sexual activity in this age group.

All types of emergency contraception are available from the sexual health clinic and some general practices. All general practices offer emergency hormonal contraception. Community pharmacists also provide an EHC (Levonelle) service, free at the point of delivery, to women over the age of 13 years through a Patient Group Direction (PGD)[56]. This PGD has been in place on the Isle of Wight since 1998.

[54] Family Planning Association (2007) Contraception: Patterns of use factsheet [online] Available at: http://www.fpa.org.uk/professionals/factsheets/contraceptionpatternsofuse#dPwMHZsJdLQ3FeuU.99

[55] Family Planning Association (2007) Contraception: Patterns of use factsheet [online] Available at: http://www.fpa.org.uk/professionals/factsheets/contraceptionpatternsofuse#dPwMHZsJdLQ3FeuU.99

[56] A PGD permits the supply of prescription-only medicines to patients without individual prescriptions

Activity in community pharmacies suggests that highest uptake of EHC is in the 20 to 30 year old age group, closely followed by 19 and under (figure 25), however, it should be noted, that this cannot be taken as a full representation of all types of emergency contraception provision from all providers.

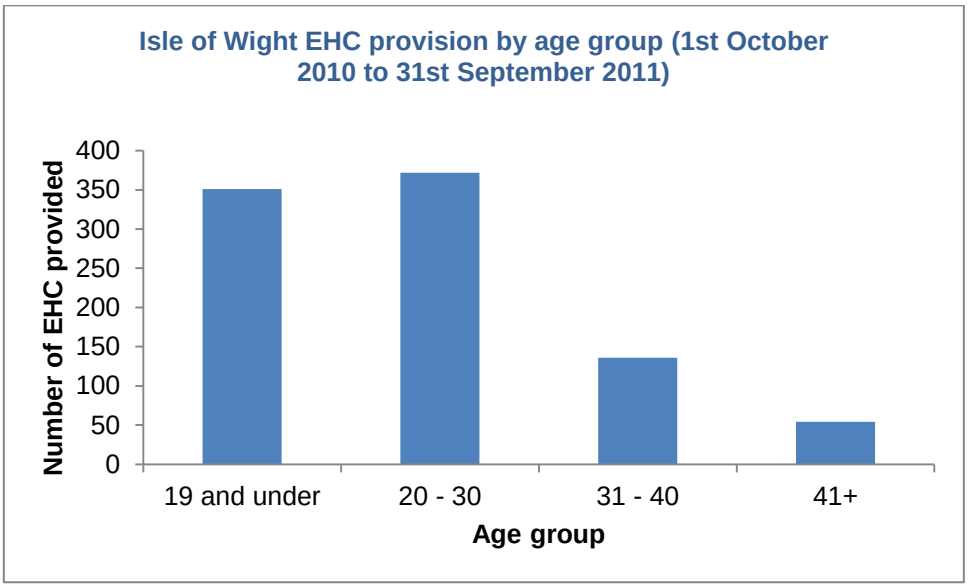


Figure 25: Isle of Wight Levonelle-1500 PGD Medication supplied (01/04/09 to 31/03/12)[57]

[57] Isle of Wight Community Pharmacies (2009-2011)

Reasons for service

EHC has been provided for different reasons (figure 26 below). The majority of patients reported that EHC was required due to no contraception being used. Burst condoms were the second most frequent reason, followed by having missed the contraceptive pill. However, this is not fully representative of all the causes for accessing all types of emergency contraceptive from all providers.

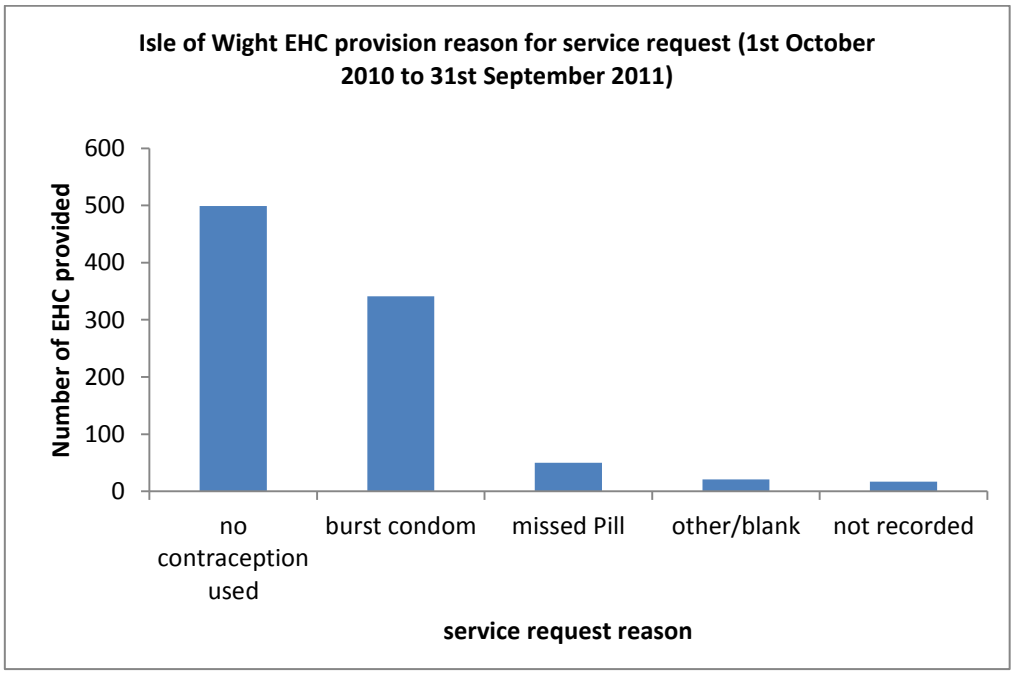


Figure 26: Isle of Wight EHC provision, reason for service request[58]

4.3 First Contraception

The First Contraception service provides pharmacists with the opportunity to refer patients who have attended for EHC to a mainstream contraceptive provider to ensure continued access to planned contraception. In addition to this pharmacists who have undergone the appropriate training are able to supply 28 days of Cerazette, a progestogen only contraceptive pill.

The aims of this service are

1. To reduce the numbers of unwanted pregnancies
2. To reduce the numbers of termination of pregnancies
3. To reduce the number of teenage pregnancies
4. To promote reliable contraception in line with NICE guidance to those who are sexually active in the target group (those accessing the EHC service aged under 25), specifically the use of Long Acting Reversible Contraception (LARC).
5. To ensure safeguarding of vulnerable individuals accessing the service through the adoption of a specific referral pathway.

[58] Isle of Wight Community Pharmacies (2009-2011)

6. To create an integrated care model of service delivery that links community pharmacists with mainstream contraception services as an integrated provider. This improves access and patient choice, all of which are key to improving uptake and outcomes and recognised as such in all three recent government white papers.

First contraception: variations across the Isle of Wight

Since service introduction in November 2010, 60 EHC patients have accessed the First Contraception service. The majority of patients accessing this service were aged 16-19, the rest were aged 20-25. The table below shows uptake activity for the service from start date.

Age	Number of patients
Under 16	8
16-19	39
20-25	13

Figure 27: Isle of Wight First Contraception by age group between 24th November 2010 and 19th March 2013

Of the 35 patients with a known contraceptive outcome, 49% ended up on contraception, which was split as shown below[59]:

Contraceptive type	% of total patients referred to sexual health service
Oral contraception	26%
Long acting reversible contraception	23%
No long term contraception	51%
Total patients referred	100%

Figure 28: Contraception outcomes from pharmacy first contraception service from24th November 2010 and 19th March 2013

[59] Contraceptive outcomes are only known for patients who attend the Sexual Health Service (as opposed to their GP practice).

5.0 Unintended Pregnancies

Up to 50% of pregnancies are unplanned and these have a major impact on the individual, families and wider society[60]. Some women with unintended and unplanned pregnancies will decide to proceed with their pregnancies. While many of these pregnancies will become wanted, the fact that the pregnancy was unplanned may cause financial, housing and relationship pressures, and have impacts on existing children[61]. This is why provision of high-quality, effective and accessible contraception for women of all ages is crucial to support people to plan and space their families. It also re-enforces the need for joint commissioning with the Clinical Commissioning Group (CCG), who is responsible for commissioning abortion services (appendix 1), to ensure that the contraceptive services available are meeting the need of the residents of the Isle of Wight.

Abortions: National and local comparison[62]

The majority of abortions were funded by the NHS in 2012 and medical abortions accounted for 48% of the total, the same as in 2011 and 14% in 2002.

In 2012, for women resident in England and Wales there were a total of 185,122 abortions which was 2.5% (189,931) less than in 2011 and 5.2% (175,932) more than in 2012. On the Isle of Wight there were a total of 233 abortions in 2012, 6% lower than in 2011 (248).

Nationally, the age-standardised abortion rate was 16.5 per 1,000 resident women aged 15-44 which is the lowest for 16 years. On the Isle of Wight it was 11.4 per 1,000 resident women aged 15-44 down from 12.2 in 2011 and 12.8 in 2010 (figure 29).

[60] Effect of pregnancy planning and fertility treatment on cognitive outcomes in children at ages 3 and 5: longitudinal cohort study', Carson C et al, BMJ 2011; 343: d4473

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

[62] Department of Health (2013) Abortion Statistics [Online] Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/211790/2012_Abortion_Statistics.pdf [accessed 31st October 2013]

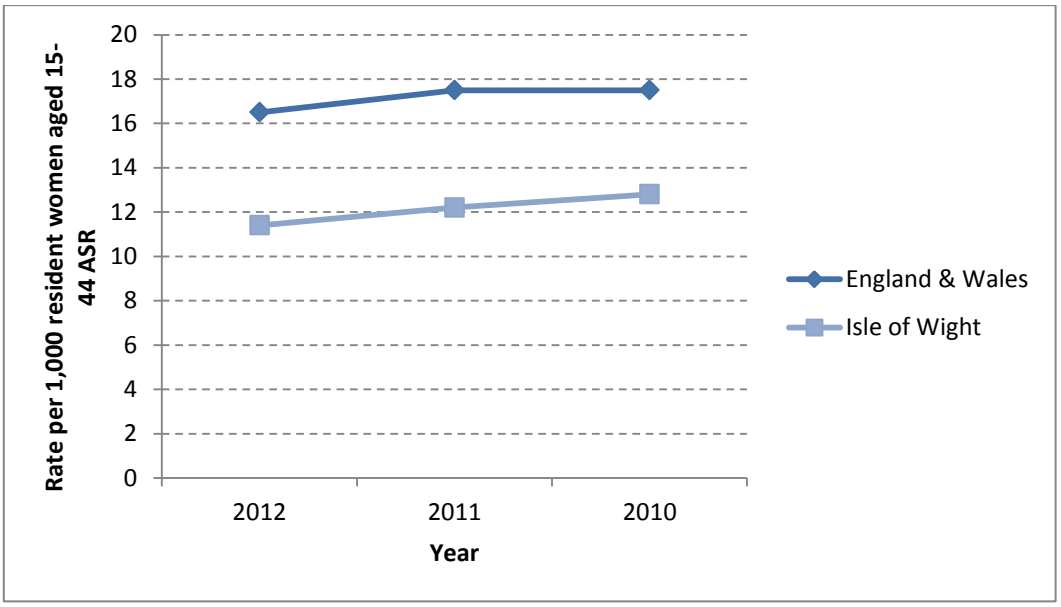


Figure 29: Age-standardised abortion rate per 1,000 resident women aged 15-44 England and Wales and Isle of Wight comparison by calendar year[63]

In England and Wales the abortion rate was highest in the 20-24 age group with a crude rate per 1,000 women of 29. On the Isle of Wight the abortion rate was highest in the 18-19 year olds with a crude rate per 1,000 women of 22 which is below the 26 per 1,000 national figure.

[63] Department of Health (2013) Abortion Statistics [Online] Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/211790/2012_Abortion_Statistics.pdf [accessed 31st October 2013]

6.0 Preventing poor sexual health outcomes

Preventing poor sexual health outcomes is a key element of reducing sexually transmitted infection, unplanned pregnancies.

Island residents have access to information through the WISHNET (sexual health website) as well as from services and partner organisations.

Results from the consultation with a number of groups including young people and LGBT residents (refer to section 11.3) identified areas where individuals looked for and gained their sexual health information.

Friends (same age)	28
TV Programmes	28
The internet	22
Magazines	21
Friends (older)	20
Films	18
Sex & relationship education	18
Leaflets	17
Books	14
Social Forums	12
Parents/carers	9
Brothers/sisters/cousins	8

Partner	6
OLGA	3
Radio	3
Aunts/ uncles	2
Grandparents	2
Festivals	1
Experience	1
Children	1
Support groups	1
Sexual health outside school	1
Youth workers	1

Figure 30: Isle of Wight Discussion Group response regarding the source of sexual health information

The most common forms of information across all demographics appear to be same age friends and television, closely followed by the internet.

7.0 Condoms

The most effective way for sexually active people of any age to prevent STIs is to use a condom when having sex[64]. Condoms, if used effectively, significantly reduce the chance of transmitting and contracting most STIs and can also reduce unintended pregnancies. There is no way of accurately measuring use of condoms as they are freely available for individuals to buy.

The Condom Distribution Scheme (CDS) provides free condoms to specific groups on the Isle of Wight including young people under 25 and MSM. Since the condom distribution scheme commenced in June 2007, 4464 users have signed up to the scheme. The majority, 86%, of registrations have been users aged 19 and under (figure 32). Users from the 20-24 age group contributed 12%.

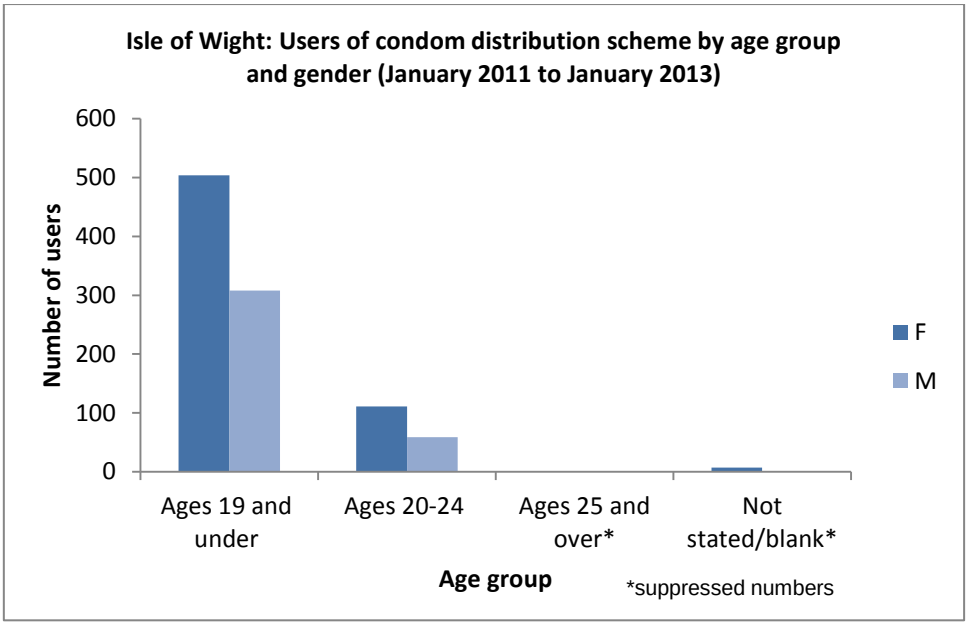


Figure 31: Isle of Wight: Users of Condom Distribution Scheme by age group and gender (June 2007 to January 2013)

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

8.0 Recommendations

Contraception

1. Increase knowledge and awareness of all methods of contraception among all groups in the Island population
2. Increase access to all methods of contraception including LARC methods and all emergency contraception, for women of all ages and their partners
3. All women requesting an abortion should be offered the opportunity to discuss their options and choices with a trained counsellor
4. Review and refresh current condom distribution protocol and policy
5. Ensure that both appropriate STI testing and choice of contraception with an emphasis on LARC are offered and provided to all residents accessing abortion services whether provided through local providers or off Island providers
6. Review first contraception service

Unintended Pregnancy

7. Continue to commission confidential, timely termination of pregnancy services for those women requesting them as part of an integrated sexual health service.

9.0 Service provision

9.1 Current service provision

The current model of sexual health service provision is based on the national strategy for sexual health set out by the Department of Health in 2001[65]. This strategy sets out a model of sexual health consisting of three levels of service provision to meet the needs of our local population. The elements of care at each level have been set out below and are guidelines for the different levels of provision. The levels are along a continuum from the provision of a basic service, level 1, to a comprehensive specialist service, level 3.

Level 1 consists of the following service provision:

- Sexual history and risk assessment
- STI testing for women and men
- 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

Level 2 consists of the following service provision:

- Incorporates level 1 plus:
- Intrauterine device insertion (IUD)
- Testing and treating sexually transmitted infections
- Vasectomy
- Contraceptive implant insertion
- Partner notification
- Invasive sexually transmitted infection testing for men (until non-invasive tests are available)

Level 3 consists of the following service provision:

- Incorporates levels 1 and 2 plus:
- Outreach for sexually transmitted infection prevention
- Outreach contraception services
- Specialised infections management, including co-ordination of partner notification
- Highly specialised HIV treatment and care

[65] Department of Health (2001) The national strategy for sexual health and HIV; Better prevention, Better Services, Better Sexual Health

Standards for the delivery of sexual health services

The Department of Health 2013 document 'A Framework for Sexual health Improvement for England'[66] recommends the following themes when planning sexual health services and interventions:

Services/Intervention	
- Rapid, easy access - Confidential - Non judgemental - Clear signposting to other services - Involve local partners including local authorities, NHS, business and voluntary sector - Offer age appropriate services e.g. HPV vaccination, chlamydia screening	- Good quality services - Full range of contraceptive methods available - Increase testing for HIV particularly in high prevalence areas - Available at times and places which are convenient

Figure 32: Services and Interventions Common Themes

Local service provision: how provision varies across the Island

Below is an overview of sexual health care across the Island (figure 34).

Service level	Service provider	Service provision
3	Integrated Sexual Health Service	A comprehensive sexual health service with integrated contraception, STI and pregnancy advisory service based at St Mary's Hospital, Newport.
2	Under 25 Community Sexual Health Clinics	Four walk-in sexual health clinics for young people aged under 25. The clinics are based in general practices.
1 & 2	General Practices	All general practices provide a minimal level of sexual health care, with most practices offering enhanced services.
1	Pharmacies	All pharmacies provide a minimal level of sexual health provision, with some variances through enhanced services.
1	Non-health settings	A number of non-health settings have received sexual health training to deliver a basic level of sexual health provision and signposting e.g. targeted youth services.

Figure 33: Isle of Wight sexual health service provision overview by service level

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

9.2 Integrated Sexual Health Service

The Integrated Sexual Health Service is a Consultant Nurse led, comprehensive service combining contraception and STI screening, treatment and care based at St Mary's Hospital in Newport, Isle of Wight.

The service is also commissioned to deliver the Pregnancy Advisory Service (commissioned by the CCG), psychosexual counselling, the National Chlamydia Screening Programme (NCSP), and young people and LGBT outreach.

The integrated sexual health service aims to ensure that Isle of Wight residents have a high quality, accessible service, provided locally and assuring individuals have prompt access to consistent, equitable and high quality sexual healthcare.

The majority of nursing staff working in the sexual health clinic are dual trained (sexual and reproductive health).

The clinic also has two GPs offering two sessions per week and one consultant offering two morning sessions per week. Access to specialist treatment and care is available through Southampton and Portsmouth for hepatitis C and HIV. Termination of pregnancy up to 13 weeks gestation is offered through gynaecology service at St Mary's Hospital. It should be noted that termination of pregnancy post 13 weeks gestation up to 24 weeks gestation is offered through off Island providers.

The service offers an open access clinic so that attendance can be through self-presentation, telephone or professional referral.

Days of Opening	Hours of Opening
Monday	08:30 - 19:00
Drop-in	08:30 - 11:00
Tuesday	08:30 - 19:00
U25 Drop – in	13:00 - 16:30
Wednesday	Closed, other specialist clinics being run
Thursday	08:30 - 18:00
Drop – in	08:30 - 11:00
Friday	09:00 - 14:00

Figure 34: Isle of Wight Integrated Sexual Health Service opening times

Patient Profile

Patient Profile of Integrated Sexual Health Clinic 1st April 2011 to 31st December 2012

Patient profile: The majority of attendees of the Integrated Sexual Health Clinic were females (68%).

Sexual Orientation: 94% of attendees to the Integrated Sexual Health Clinic were recorded as heterosexual. 2% of attendees were homosexual and 1% bisexual. For 2% of attendees no sexual orientation was recorded.

Of those attending the majority are in the 24 and under age group, with the least number attending being over 45 years. This is consistent with the national picture. The high level of under 24 year old clients may reflect the fact that the service holds a weekly targeted U25 clinic.

9.3 Psychosexual Counselling

Psychosexual counselling is delivered through the Integrated Sexual Health Service. Psychosexual counselling supports patients where a physical or psychological difficulty impacts on their ability to engage in and enjoy sexual activity. These can include lack of interest in sex, pain or difficulty in experiencing penetrative sex and being unable to get or keep an erection.

The commissioning responsibilities for psychosexual counselling is split between the local authority, who are responsible for the sexual health aspects of psychosexual counselling (Figure 34), and the Clinical Commissioning Groups (CCGs), who are responsible for non-sexual health elements of psychosexual health services.

Psychosexual Counselling Service for clients aged 16 and over who are referred by their GP for the management of the following psychosexual conditions:
- Low sexual desire/Lack or loss of libido - Non-consummation - Non-orgasmic problems - Vaginismus - Dyspareunia/Vulvadynia - Ejeculatory control – premature / retarded Erectile dysfunction may be considered, following medical treatment in primary care in line with clinical protocol

Figure 35: Psychosexual services Local Authority commissioning responsibility.

Health professionals should be alert to how sexual health conditions presented can be associated with other conditions such as erectile dysfunction which is associated to cardiovascular disease (CVD), diabetes, and high blood pressure. All physical, potentially contributory, effects should be explored prior to the referral for psychosexual counselling.

On the Isle of Wight for the calendar year of 2012 there were 63 patients who attended counselling. This equated to 157 sessions. Of the patients 51% were self-referrals and 49% were GP referrals. In 2011, 67 patients attended counselling which equated to 197 sessions. There were 14 patients which overlapped from 2011 into 2012. Of the patients 67% were referred by a GP, 28% were self-referred and 4% were not recorded.

9.4 General Practice

General practice plays a key role in ensuring the wider sexual health service provision in the community. General practice is the largest provider of sexual health services – particularly the provision of contraception - and is the most frequently chosen first point of contact for those with sexual health problems[67]. Increasing numbers of practices are providing a range of more specialist sexual health services such as sexual health community clinics.

Sexual health provision on the Isle of Wight varies from practice to practice. All general practices provide a minimal level of sexual health provision, with some practices offering enhanced services. The following two enhanced services are in place:

- Walk-in community sexual health clinics for under 25s
- Enhanced services to provide the intrauterine contraceptive device and implant fitting and removal (LARC)
- Chlamydia screening

Under 25 Clinics

There are currently four under-25 (U25) community sexual health clinics, which are level 2 services that operate in GP practices across the Isle of Wight open at various times during the week. The is a clinic in Dower House Surgery, Newport; at Sandown Health Centre, Sandown; at Tower House Surgery, Ryde; and a clinic at the Esplanade Surgery, Ryde. These are targeted to the areas of highest need. The clinics are available on an open-access basis, i.e. made available to any young person that attends, regardless of whether they are registered with the provider (GP practice) or not. A total of 3824 young people have attended these clinics between April 2010 and March 2013. Of those who attended 92% were female and 8% were male.

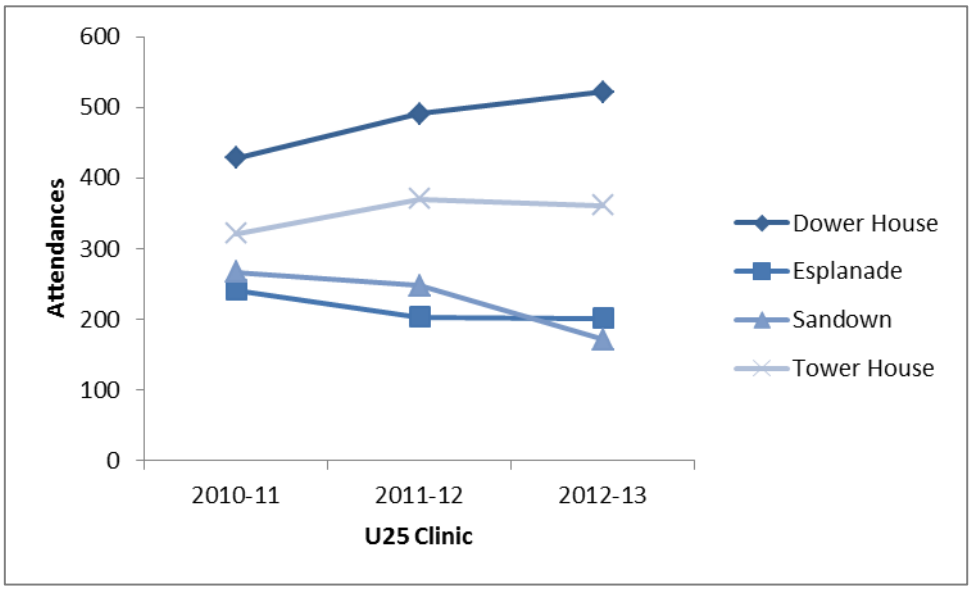


Figure 36: Isle of Wight U25 Community Sexual Health Attendances by Clinic by Financial Year (1/4/10 to 31/3/13)

[67] DOH (2013) A Framework for Sexual Health Improvement in England

The majority of patients, males and females, attending the U25 clinic were those aged in the 19 and under age group. For a small percentage of those attending (0.4%) no data was recorded.

The majority of young people attending the clinics were registered with the practice where the clinic is held, 77% (2952) registered and 23% (872) not. The Newport clinic attracted a significant number of non-registered attendees which might be due to the central location of the clinic allowing for ease of access to specialist provision.

More patients from the most deprived areas are attending the U25 clinics.

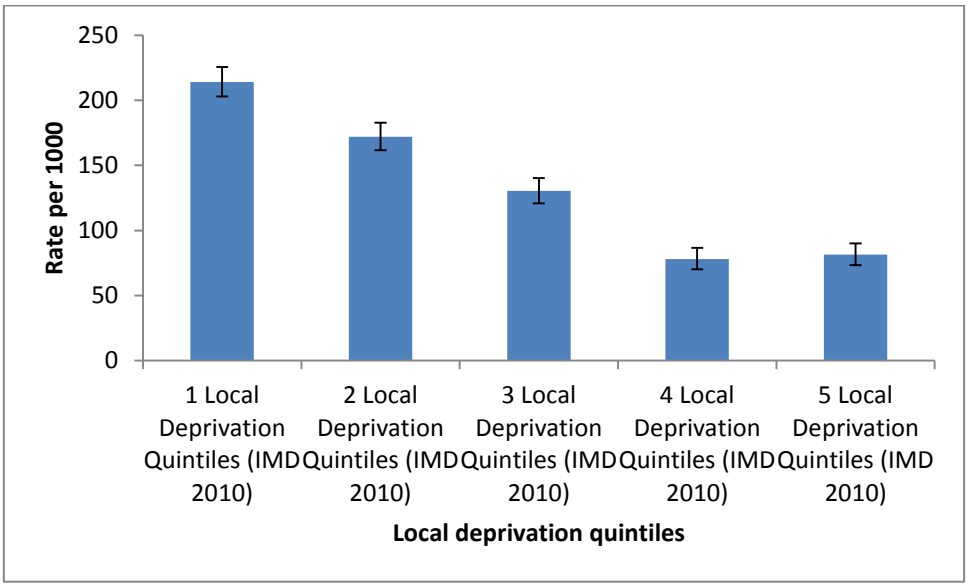


Figure 37: Isle of Wight U25 clinic patient attendance rate per 1000 by local deprivation quintile (Using 2010 population estimates - 15 to 24 year olds)

In total 3824 residents attended the U25 clinics. Of these some may have had multiple reasons for visiting the clinic. Reasons for visiting are set out in the chart below

Reason	%
Oral Contraception	21
Condoms	17
Chlamydia screen	15
Advice only	6
Pregnancy Tests	5
Implant Fitting/removal	4
STI Screen	4
Depo/Contraceptive Injection	3
HIV Test	1
EHC	1
Patch	<1
Contraceptive Fitting	<1
Other	22

Figure 38: Isle of Wight U25 Clinic reason for patient attendance (1st April 2010 to 31st March 2013)

General Practice: Service Mapping

All Island general practices were invited to take part in a service mapping online survey in February 2013 to which there was a 100% response rate. The findings have been captured below:

Workforce: All GPs currently fitting LARC methods of contraception have completed appropriate training.

There are 34 sexual and reproductive health trained nurses at 13 GP practices on the Isle of Wight. Four practices have no specialist sexual and reproductive health trained nurses.

Of the 34 sexual and reproductive health nurses, 26% (9) nurses are due to retire in the next five years.

Data was not available regarding retirement status of current sexual health trained GP workforce.

Contraception: Of those practices that completed the service mapping survey (16 out of the 17), all provided free condoms, combined and progesterone only oral contraception and LARC.

Emergency contraception: All GP practices on the Isle of Wight provide oral emergency hormonal contraception. However, only 13 practices provide IUD as an emergency contraception. All GP practices provide under-16s with emergency contraception. Ten GP

practices currently provide a 'special appointment system' for patients requesting emergency contraception.

Pregnancy testing: All practices completing the survey reported they offered same day, free of charge, pregnancy testing.

Assessment and Testing of Sexually Transmitted Infections (STIs): All GP practices responding to the survey reported that they provide assessment and testing for some or all STIs, including HIV. All practices reported having clear signposting and referral pathways in place with the sexual health service for STI screening, including HIV.

Treatment of Sexually Transmitted Infections (STIs): All GP practices offer treatment for bacterial vaginosis and chlamydia, yeast infections, pubic lice and trichomoniasis. Those GP practices who reported that they did not provide treatment for the following PEP (post exposure prophylaxis treatment after sexual exposure to HIV), HIV, hepatitis A, B, C, syphilis gonorrhoea and Human Papillomavirus (HPV) all have referral pathways to the integrated sexual health service in place.

9.5 Community Pharmacies

Pharmacies are increasingly playing a pivotal role in sexual health, offering a wider range of provision. The White Paper 'Healthy Lives, Healthy People' recognises the role of community pharmacy in improving public health and the part that it plays in preventing ill-health. It states specifically that *"community pharmacies are a valuable and trusted public health resource"*[68], identifying the potential to use pharmacy teams more effectively to improve health and giving specific mention to pharmacy's role in improving sexual health.

Locally, the Isle of Wight currently commission pharmacies to provide:

- EHC consultation and medication
- Chlamydia screening and treatment
- Condom distribution scheme

BBV and HIV testing is available to any resident who considers themselves at risk from any of these infections. The Isle of Wight was the first to offer this service through pharmacies. Introduced in 2009, the service involves dried blood spot testing and referral of anyone testing positive for Hep B or C and/or HIV to the sexual health service for appropriate testing, treatment and care.

Community Pharmacies: Service Mapping

33 Island community pharmacies were invited to take part in a service mapping online survey in February 2013 to which there was a 79% (26) response rate. The findings have been captured below:

[68] Cited in Chatterton, M., Kinsey, K. (2012) Current Thinking On…Delivering a pharmacy-based sexual health service, The Continuing Professional Development Programme [online] Available at: http://www.pm-modules.co.uk/pm_modules/sex_pm0712.pdf

Access: The majority of pharmacies on the Isle of Wight are open during business hours of 9.00am until 5.00pm, Monday to Saturday. Two Newport pharmacies - Boots and Sainsbury's - are open on Sundays, with Sainsbury's in Newport having the longest opening hours during the week (Monday to Friday) 7.00am until 11.00pm.

Confidentiality is an essential part of sexual health services and all pharmacies are required to offer a safe, confidential space to carry out any sexual health consultations. One pharmacy in Newport does not have a private consultancy room and other arrangements are made to ensure confidentiality during consultations.

Workforce: Pharmacist sexual health training is not consistent across the Island. However, of those responding to what had been completed in the last two years by the permanent pharmacist(s), the majority stated they had completed emergency hormonal contraception training (89%) closely followed by chlamydia testing and treatment and condom distribution. This would be in line with the services they provide.

Provision: There is some variation in provision of services by Island pharmacies. Of those responding to the survey regarding provision (26 out of 33), all offered a range of services, with the majority offering free condoms and chlamydia testing, closely followed by chlamydia treatment (see chart below). All pharmacies with the exception of a pharmacy in Freshwater have an enhanced service contract to provide EHC. It should be noted that First Contraception (provision of a 28 day course of progesterone hormonal contraception) can only be offered as part of the EHC pathway and onward referral to sexual health clinics or to the specialist young people's outreach nurse. In addition oral hormonal contraception is provided through the general dispensing contract on prescription (FP10) and not as an additional service.

Promotion: As well as offering service provision, of those pharmacies asked, the majority stated they gave out general health promotion messages around safe sex and signposted on to other services across the Island.

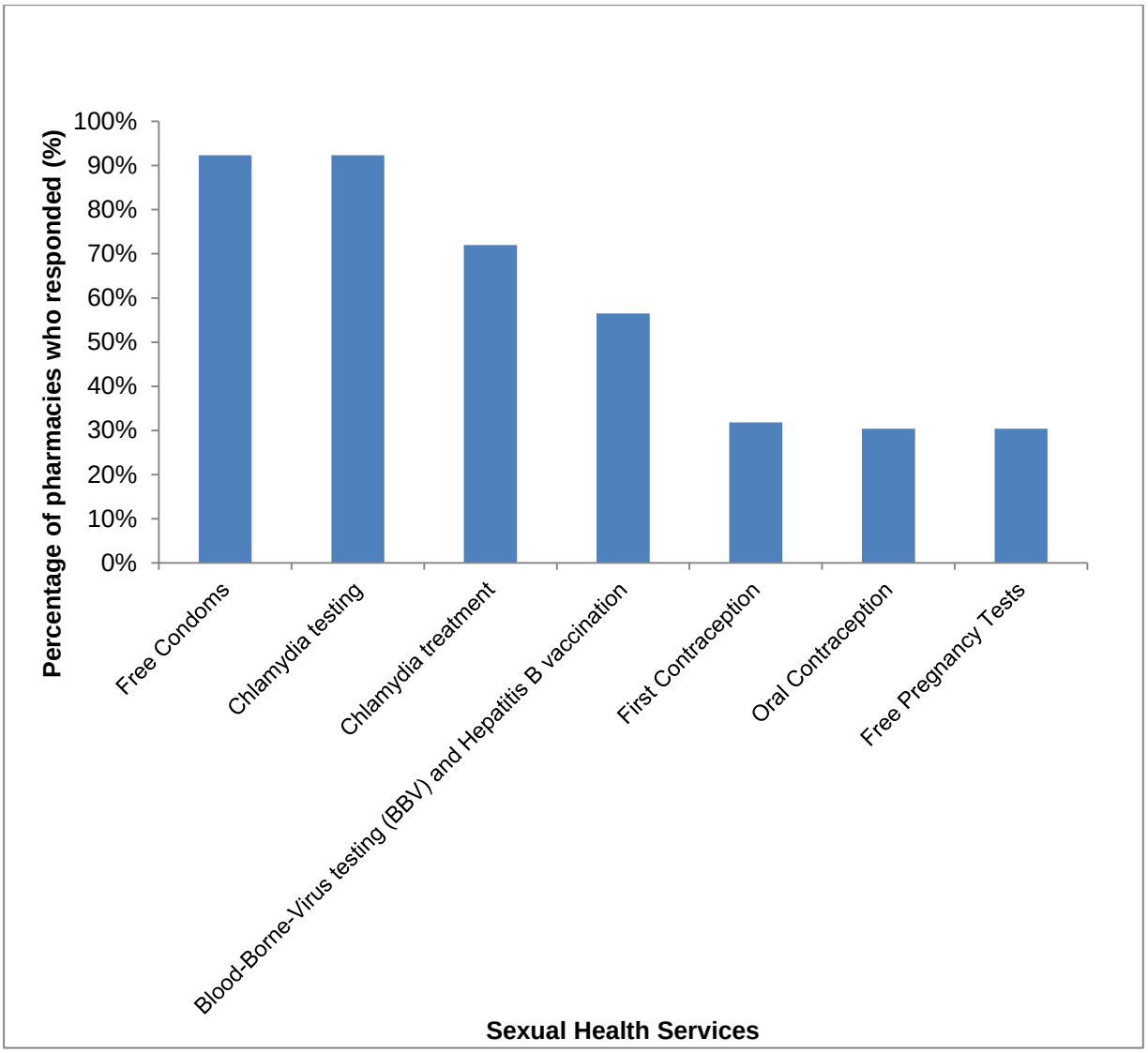


Figure 39: Isle of Wight Community Pharmacies: Percentage of pharmacies who currently provide the following sexual health services

9.6 Non-traditional health settings

Sexual health provision in settings where health care is not traditional provides an opportunity to improve access and target those that might not use traditional health settings. By utilising non-health settings this has nationally been reported as having helped vulnerable groups into contact with services that they would not otherwise have engaged with. Non-traditional health settings aid the engagement of harder to reach groups such as men and MSM[69]. This follows the national trends for increasing sexual health services in non-traditional locations such as schools, colleges and youth clubs[70].

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

The Isle of Wight currently commissions a universal sexual health training initiative which is targeted at individuals and organisations ranging from health professionals local authority employees, education, private and voluntary sector. The aim of the training is to provide high-quality, ethical and safe basic sexual health awareness and knowledge to:

- Gain a broad understanding of sexual health enabling participants to dispel myths and give clear unbiased information to residents in their care.
- Increase awareness of what good sexual health is.
- Have confidence and knowledge to support and signpost residents in their care to access sexual health services.
- Increase the number of venues offering chlamydia testing and the condom distribution scheme.

Over 237 individuals from a range of settings have accessed the training from 1st April 2012 up to the 31st March 2013 (Appendix 2). The profile of professionals has been outlined in figure 41.

Profile of professionals	No. trained
YP Support Worker	51
Family Support	24
Pharmacy Assistant	20
Mental Health Practitioner	17
Targeted Youth support	17
School nursing	15
Teacher	15
Tutor	15
Universal Youth Support	11
Practice Nurse	10
Social Care	8
Administration	7
Personal Advisor	5
Behaviour support	5
School Pastor	5
Health Visitor	3
Community Support Officer	3
Deputy Manager	2
Pharmacist	2
Doctor	1
Midwife	1
Grand Total	237

Figure 40: Sexual Health Tier 1 Training profile of professionals who have attended the course from 1st April 2012 to 31st March 2013

Non-traditional health settings service mapping

A total of nine children's centres and ten youth clubs were contacted in January 2013 and the survey received 100% response rate.

It should be noted that the co-ordinators of the youth clubs submitted one response per area. The Bays Children Centres submitted one survey for their Sandown and Shanklin establishment.

Service outcomes

Condom distribution: The majority of respondents take part in the condom distribution scheme (91%). Only one provider (West Newport Children's Centre) does not.

Chlamydia tests: The majority of respondents provide chlamydia tests. Only two providers (West Newport Children Centre and West Wight) do not.

Pregnancy tests: 33% of youth clubs and children centres provide pregnancy tests.

Termination of pregnancy: All providers that responded said that there was no referral pathway in place for termination of pregnancy.

Promotion of sexual health services: The majority of respondents promote the condom distribution scheme, STI testing, chlamydia screening, general safe sex advice, Wish-net (local sexual health website), sexual health clinics and U25 clinics.

9.7 Education Providers

Sex and Relationship Education (SRE) plays a central role in sexual health because it informs young people about the emotional, social and physical aspects of growing up, relationships, sex, human sexuality and sexual health[71].

According to the latest sexual health national paper '*both young people and parents want high-quality education about sex and relationships*'[72]. Surveys show that the majority of the general public,[7374], parents[7576], young people[7778],and education professionals[79] agree with this and think that SRE should cover emotional and relationship issues as well as biological aspects.

[71] Family Planning Association (FPA) (2011) Sex and relationships education factsheet [online] Available at: http://www.fpa.org.uk/professionals/factsheets/sre [accessed 24th April 2013]
[72] Department of Health (2013) A Framework for Sexual Health Improvement in England
[73] No Sex Please Until We're at Least 17 years Old, We're British [Observer Mori Poll 2006].
[74] Brook GFK NOP Survey 2006.
[75] Durex, National Association of Head Teachers, National Confederation of Parent Teacher Associations, and the National Governors Association, Sex and Relationship Education: Views from Teachers, Parents and Governors (London: Durex, 2010).
[76] Health Promotion Agency for Northern Ireland, Sex Education in Northern Ireland: Views From Parents and Schools (Belfast: Health Promotion Agency for Northern Ireland, 1996).
[77] UK Youth Parliament, Sex and Relationships Education: Are You Getting It? (London: UK Youth Parliament, 2007).
[78] Martinez A and Emmerson L, Key Findings: Young People's Survey on Sex and Relationships Education, Sex Education Forum Briefing (National Children's Bureau, 2008).
[79] Martinez A and Emmerson L, Key Findings: Teachers' Survey on Sex and Relationships Education, Sex Education Forum Briefing (National Children's Bureau, 2008).

In one UK survey[80] of over 20,000 young people aged under 18:

- 40% thought the SRE they had received was either poor or very poor;
- 61% of boys and 70% of girls reported not having any information about personal relationships at school;
- 73% felt that SRE should be taught before the age of 13.

In the recent 2013 School Health Education Unit (SHEU) survey on the Isle of Wight (refer to section 2.4.2.2), only 31% of pupils in Year 10 and above think their sex education programme at school covers everything they need (26% said no while 44% were not sure).

It is the responsibility of individual schools to determine their SRE curriculum. The provision of sex education is a statutory requirement for maintained secondary schools. What schools include in their sex-education programme is a matter for local determination; however, all schools must have regard to the Secretary of State for Education's Sex and Relationship Education Guidance [1]. Academies do not have to teach sex education, but are required through their funding agreements to provide a broad and balanced curriculum. They are also required to have regard to the Sex and Relationship Education Guidance when providing sex education. All schools delivering sex and relationship education are required to ensure that their pupils receive high-quality information on the importance of good sexual health.

Education Providers: Service Mapping

11 Island state and private schools with secondary education were invited to take part in a service mapping online survey in February 2013 to which there was a 91% (10) response rate. The findings have been captured below:

Hours spent on SRE vary from school to school.

There was mixed response from providers when asked whether they follow a prescribed SRE programme. Three providers do not follow a prescribed programme, some devise an in-house programme and others follow national programmes which include the Christopher Winter Project, APPAUSE and Equals.

Respondents were asked to select the sexual health service provision that they provide. Of the 9 who responded, 67% of respondents said that they do provide a mix of sexual health provision and information which includes condoms through the condom distribution scheme, chlamydia screening, sexual health promotion and signposting on to appropriate services. 33% said that they do not.

[80] UK Youth Parliament, Sex and Relationships Education: Are You Getting It? (London: UK Youth Parliament, 2007).

9.8 Recommendations

Service Provision

1. Continue to provide, all age, universal, open access service, of Emergency Hormonal Contraception (EHC) through primary care services including pharmacies.
2. Continue to ensure a range of emergency contraception is available through open access provision in a variety of settings based on best practice guidance, need and choice.
3. Fully review the impact and make recommendations on the first contraception pharmacy based service including what impact redesigning this service would have on local communities.
4. Monitor referral and sign posting activity of those residents accessing EHC services in primary care to appropriate sexual health services in order to access contraception and STI screening
5. Develop robust referral pathways for all young people aged 13-16 years accessing EHC in primary care settings to the Young People Sexual Health Outreach Service
6. Carry out GP workforce planning survey to understand current status and future needs in order to sustain quality and levels of provision.
7. Ensure that all pathways of care for abortion services and HIV treatment remain robust with clear pathways of care and referral to appropriate specialist services.
8. Continue to monitor population groups attending reproduction and sexual health services ensuring that all services offer appropriate provision to meet the specific needs of different groups.
9. While accepting the need for choice explore innovative ways to increase uptake of LARC across all services with a particular focus on community U25 clinics.
10. Work with current providers across all services to consider succession planning of appropriately trained and skilled members of staff
11. Work closely with General Practices to deliver timely access to residents requiring IUD fitting for emergency contraception.
12. To increase opportunistic testing for HIV in Primary Care settings for those residents either requesting a test or having identified risk factors.
13. To audit all pharmacies offering sexual health consultations to ensure the availability of private consultation areas for residents accessing their services.
14. Ensure all staff, regardless of level of delivery, are appropriately trained to deliver sexual health information and treatment to Island residents.
15. Maintain the WISHNET website to deliver timely information regarding good sexual health.
16. Develop a marketing plan to ensure that information is readily available in a variety of mediums to meet the needs of all Island residents.
17. Maintain current open access tier 3 (specialist) integrated reproductive and sexual health services that offer high quality specialist interventions and offer support to all service providers at all levels across the community

10.0 User and Stakeholder Consultation

User Consultation

10.1 Introduction

Service users were invited to participate in discussions to determine the sexual health needs, knowledge, attitudes and practices of Isle of Wight residents.

10.2 Methodology

A series of user engagement took place over the period of August 2012 and February 2013. A triangulation of research methodologies were chosen to improve validation of data.

Quantitative research consisted of:

- All age and gender exit surveys: Questionnaires to current users of the four Under 25 Sexual Health Community Clinics and the St Mary's Sexual Health Clinic in Newport.
- Lesbian, Gay, Bisexual and Transgender (LGBT) survey: Postal and online surveys were distributed to the LGBT community on the Isle of Wight.
- The Children's Society survey (refer to 2.4.2.1)
- School Health Education Unit (SHEU) survey (refer to 2.4.2.2)

Additional qualitative discussion groups took place:

- Youth Pride (LGBT youth group, under 25 years)
- Island Professionals (Adult friendship group)
- Older Lesbian, Gay and Bisexual (OLGA, older LGBT friendship group)

10.3 Background

It is crucial that commissioners consider the differing needs of men and women during their life course as well as different groups in society that need to be considered when planning sexual health services and interventions. The LGBT community are an example of a homogenous group consisting of individuals who identify across several demographic groups, of which their sexual orientation and gender identity are only two. The Department of Health[81], sets out a broad span of research that shows LGBT people experience significant health inequalities compared to the wider population. These inequalities range from emotional bullying, through to higher rates of suicide and self-harm, drug and alcohol use and smoking in adulthood through to social isolation and extreme vulnerability in old age. It is therefore important to find out the perspectives and opinions from users of the service and how this intelligence can be used in shaping the sexual health service in the future.

[81] The Lesbian, Gay, Bisexual and Trans Public Health Outcomes Framework Companion Document. Department of Health 2012

11.0 User Engagement

11.1 User Consultation Key themes

Satisfaction with current provision: Overall users are satisfied with the current sexual health clinic and U25 clinics.

Expectations of service

Access: The ideal service would be confidential, offer all sexual health and contraceptive services and open in evenings and at weekends. On the whole respondents were impartial for services designated for specific age groups or sexuality. Staff should be qualified sexual health specialists, listen to concerns, and be approachable and non-judgemental.

Location: All sexual health services need to be in convenient locations which are accessible through public and private transport. Walk-in and appointment only appointments are a must. There were mixed responses regarding the value of targeted outreach provision, particularly for the LGBT community.

Preferred venue: Different groups have different preferences. The Sexual Health Clinic remained the most popular venue for all sexual health services, followed by general practices. The Sexual Health Clinic was preferred for all services including more invasive procedures such as STI testing; this was particularly prominent in older and LGBT groups. Delivering sexual health services through non-traditional settings, such as children's centres, youth centres and schools met with mixed response. Pharmacies were preferred for services such as free condoms and pregnancy testing.

Barriers: Barriers to accessing services were consistent regardless of age, gender or sexuality. Concerns around confidentiality and privacy were identified, along with lack of information, whether electronic or written. Generally it was felt that there needed to be higher profile awareness-raising around opening times of all services, where services were and what they offered.

Attitudes and behaviour: The acceptance of friends of the same age having sex in 13 to 16 year olds increased with age. The majority (82%) of sexually active pupils in Year 10 and Year 12 always used a method of protection or contraception. Of those who were sexually active that participated through the Exit Survey and LGBT Survey there was mixed response regarding condom and dam use.

Knowledge and information: Those respondents age 25 years and below reported that they had a good knowledge of sexual health, including pregnancy and STI prevention, however the SHEU survey did identify some gaps in knowledge particularly around the efficacy of condoms to prevent STI transmission (including HIV) and prevent pregnancy. In the same survey, of those reporting that they were sexually active or considering becoming sexually active, knowledge of STI prevention and contraception was higher.

There is a mixture of preferred sources of sexual health information. Same age friends, specialist sexual health workers, written information and the internet were popular sources for all groups. Younger respondents reported they were able to talk to parents and carers in direct contrast to older respondents who felt they still could not.

Sex and Relationship Education (SRE): Education plays an integral role in sexual health. All user engagement highlighted the importance of education. SRE was identified as potentially a key source of knowledge and information. However there was a general feeling from all ages groups that SRE often felt short of expectation with only 31% of pupils in Year 10 and above, who answered the question, stating their sex education programme at school covers everything they need ,26% said no while 44% were not sure (SHEU survey 2013).

Older participants regardless of gender or sexuality identified the lack of education during their school years and the need to improve sexual health knowledge.

Marketing and publicity: Marketing is essential to ensure that all communities know what services are available when and where. Lack of awareness was identified as a barrier for accessing services.

Discussion groups identified the need to normalise sexual health services and use a variety of mediums to communicate to different communities. This would help to reduce the barrier of embarrassment when accessing services.

11.2 Recommendations

1. Ensure that open access, confidential, specialist led, cost effective, sexual health services that offer both booked and walk in appointments at venues across the Island.
2. Review the role of outreach within sexual health provision.
3. Develop a robust marketing plan and brand awareness.
4. Investigate quality of the Sex and Relationship Education (SRE) provision in Isle of Wight schools to develop sustainable SRE for the future.
5. Use expert stakeholders to mystery shop all sexual health providers to check quality and consistency of provision as part of continual improvement of services.

11.3 Exit Surveys

97 service users of the Sexual Health Clinic and the Under 25 (U25) sexual health community clinics participated in an anonymous questionnaire in August 2012. The demographic make-up of respondents reflected the users of sexual health services on the Island in that:

- 80% were female, 20% male
- 93% were heterosexual, 7% other (LGBT and preferred not to state)
- 96% of participants were from a British or English background.
- 95% described themselves as “white British”.

11.3.1 Key themes

Reason for attendance: 37% of participants said that the main reason for attending the sexual health clinics and U25 sexual health clinics were for routine/planned contraception.

Referral: 6% were referred to sexual health services. Although only 6% were referred, 34% were recommended to use the service. Friends were the most popular source of recommendation, followed by GP Practice staff.

Access: 60% of participants booked an appointment whereas 40% just walked in. The majority of patients with appointments either made their appointments at their previous appointment or waited less than 7 days for an appointment. 87% of service users indicated they were happy with the time they waited for an appointment. 75% indicated they were happy with the length of time they waited to be seen. 46% of respondents travelled to the clinic by private car, 30% walked and 18% used public transport.

Service quality: 60% were either very happy or happy with the overall service they received, 20% said they were neither happy nor unhappy, and 20% said they were unhappy or not at all happy.

Fewer people strongly agreed to the statement about reception staff being welcoming on arrival in community settings which could be reflecting surgery reception’s multipurpose functions.

Venue preference for Sexual Health Services:
Pharmacies: Participants were happy to visit pharmacies for free condoms, information and advice, routine/planned contraception, emergency contraception, pregnancy tests (figure 42). Participants were not happy to visit pharmacies for chlamydia screening and testing for sexually transmitted infections.

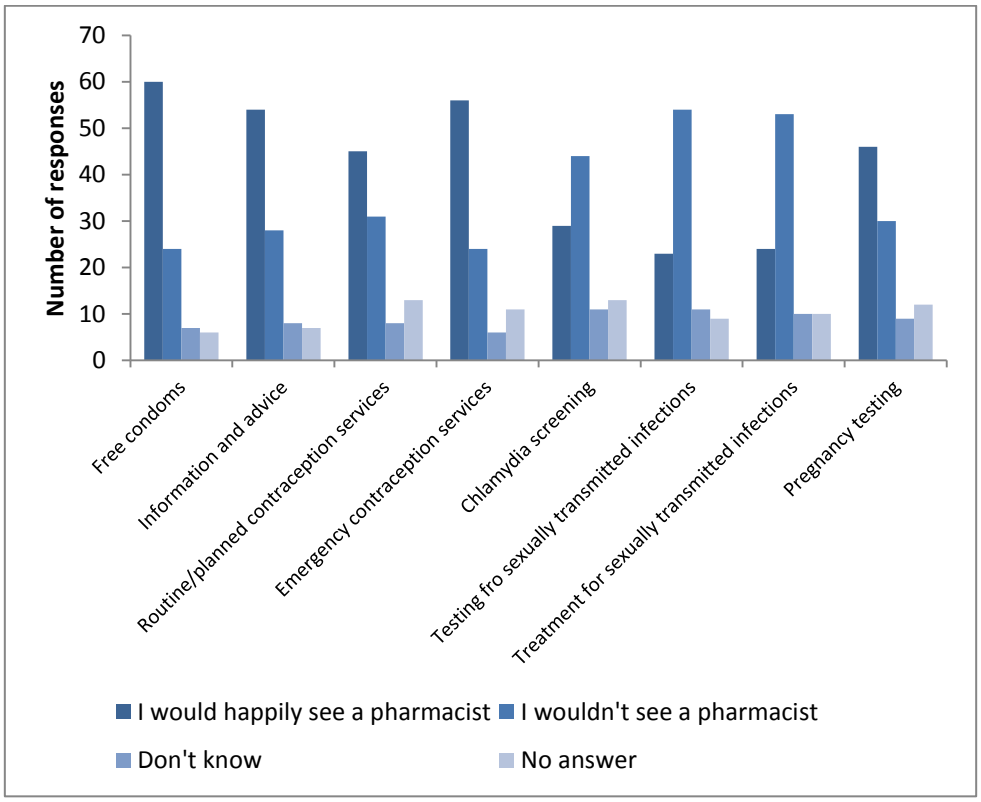


Figure 41: Exit Survey: Would you see your pharmacy for these sexual health services?

General Practice: Far more participants said they would happily use their GP for free condoms, information and advice, routine/planned contraception, emergency contraception services, chlamydia screening, testing for STIs, pregnancy testing (figure 43). However, a higher proportion said they wouldn't see their doctor for STI testing.

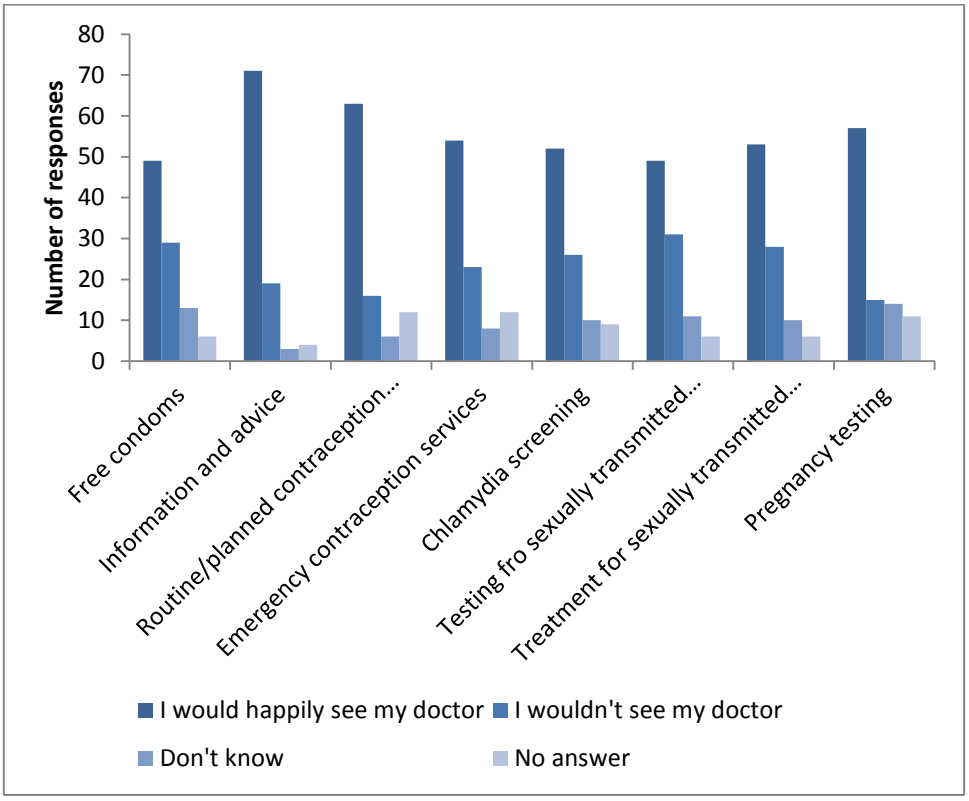


Figure 42: Exit Survey: Would you see your Doctor for these sexual health services?

Expectations of Sexual Health Services

Services should be confidential, discreet, in one-place, easy to get to; staff should be qualified sexual health specialists, approachable and non-judgemental, have the time to listen to your concerns; and you should be able to get an appointment at short notice. A more mixed response was identified when participants were asked about attending a service without an appointment and if services should open in the evening and weekends.

The majority of respondents said the service should not be specifically designed for, and only open to, your age group. The level of agreement, however, varies with age.

Respondents under 25: knowledge and Information

There were a total of 68 responses. Of those, 95% of 63 who responded were or had been sexually active in the past. 74% of respondents felt that they have good or very good knowledge of STI prevention and 81% felt they were very knowledgeable about prevention of pregnancy. Of those who had poor knowledge of prevention of STIs and pregnancy were in their late teens/early twenties.

The most popular source of knowledge and information about sexual health were from leaflets, followed by parents and SRE (figure 44). When asked who they feel most comfortable talking about sex respondents identified same age friends (34%) and sexual health workers (23%) as the most popular.

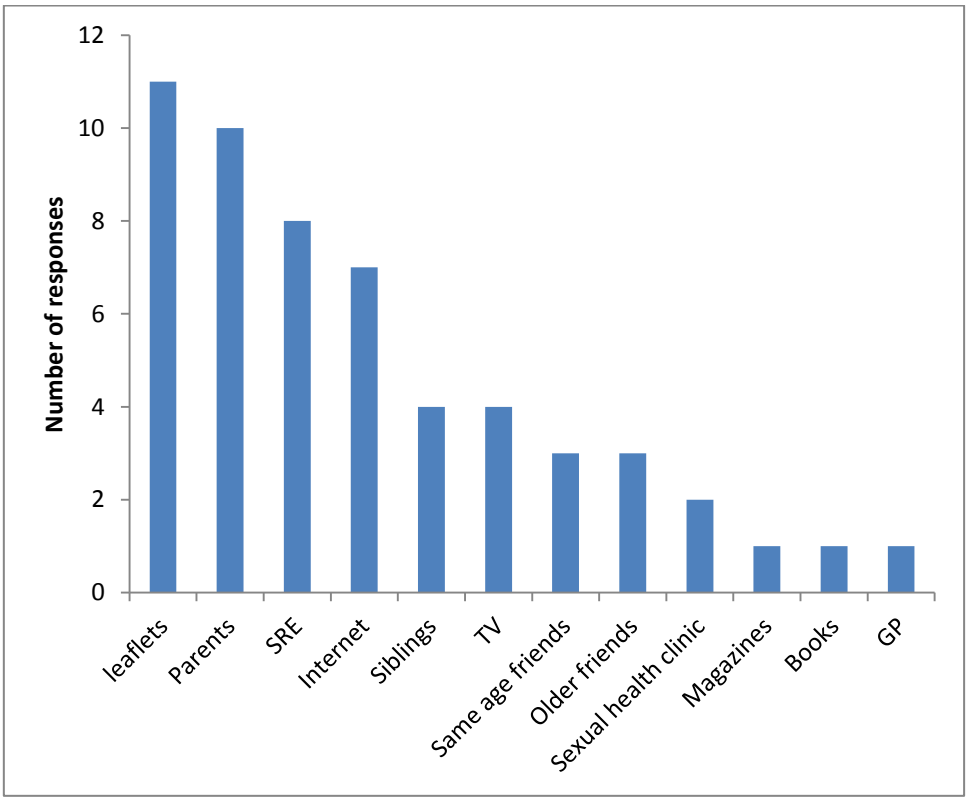


Figure 43: Exit Survey: Most useful source of knowledge and information about sexual health

11.4 Lesbian, Gay, Bisexual and Transgender (LGBT) Survey

In November 2012 the distribution list of the 'Out and About' LGBT newsletters were invited to participate in an anonymous postal survey with a freepost envelope enclosed. 33 responded were aged between 25 and 71 and 82% were male and 18% were female. 68% identified themselves as gay, 17% lesbian, 9% bisexual and 6% transgender. 67% of the participants were in relationship, 30% were single and 3% preferred not to state. 67% were sexually active, 18% were not, 12% were not sexually active but in the past have been, 3% no answer.

In January 2013 an online anonymous questionnaire was cascaded through a snowball sample. The majority of questions were the same; however, some additional questions were added to the online survey. The additional questions have been separated out below. There were 28 responses aged between 18 and 65 of which 82% were male and 18% female. 73% were gay, 15% lesbian, 8% bi-sexual and 4% preferred not to say. 31% single, 58% in a relationship, 11% civil partner/married. 80% were sexually active, 15% were not but in the past have been, 5% were not.

The postal and online survey results have been combined. The online survey additional questions have been analysed separately.

11.4.1 Key themes

Current service use

The sexual health clinic was the most used service, followed by off Island services.

For those who haven't used sexual health services on the Isle of Wight, 49% of responses said that they hadn't needed to use them, 17% did not know about them, 14% preferred to access services on the mainland, 10% stated that the service did not cater to their needs, 7% said they would prefer to take their needs privately and 3% said that they were not bother by their sexual needs.

Respondents who regularly use sexual health services on the Isle of Wight identified their preferred venue as the Sexual Health Clinic, followed by off Island services, and GPs.

Venue preference for sexual health services

Each respondent was asked if they would attend the Sexual Health Clinic, GP, pharmacy and LGBT Outreach Worker for the following services:

- Free condoms/dams and lube
- For information and advice
- Chlamydia screening
- Testing for sexually transmitted infection (STI) including H.I.V, Hep B
- Treatment and care for sexually transmitted infection (STI) including H.I.V. Hep B
- PEPSE (antiretroviral treatment following possible HIV) (antiretroviral treatment following possible HIV exposure)
- Pregnancy testing
- Routine or planned contraception services (e.g. pill, coil, implant, injection, patch)
- Emergency contraception services (morning after pill or coil)

Asked to indicate which services they would access from different venues, the Sexual Health Clinic was the most popular, followed by the LGBT Outreach Worker, general practice, pharmacies and the least were mainland services. For those who completed the snowball survey, respondents indicated that they would not use the Outreach Worker.

79% of responses said they would use the Sexual Health Clinic for at least one service, whilst 16% said they would not and 5% said they did not know. The most popular options to be accessed from the sexual health clinic, all with 34 (70 %) selections were 'Testing for STI inc. HIV, Treatment for STI inc. HIV' and 'Information and advice'. Only 1 (2%) selected receiving 'condoms via post'.

50% of responses said they would use their GP for at least one SH service, while 46% said that they would not. 4% said that they did not know if they would. The most popular service

to be accessed from the GP is 'Information and advice' with 28 (56%) selections. The least popular services to be accessed from the GP are 'routine contraception, emergency contraception' and 'pregnancy testing' all with 6 (12%) selections.

42% of responses said that they would use a pharmacist for at least one SH service, while 58% said they would not. The most popular service accessed from a pharmacist is 'Information and advice' with 24 (48%) participants selecting this. The least popular services are 'Emergency contraception' and 'pregnancy testing' both with 6 (12%).

57% of the responses received said that they would see an LGBT Outreach Worker to access these services. 40% said they would not, while 3% said they did not know is they would. The most popular service accessed from a LGBT Outreach Worker are 'free condoms, dams and lube' and 'information and advice with 35 (71%) of participants selecting these.

64% of the responses received said that they would not access the specified services on the mainland, while 35% said they would. Just 1% said they did not know. Participants were most reluctant to access 'free condoms, dams and lube' and 'information and advice' with only 25 (57%) choosing these. The service which was the most popular for accessing on the mainland was 'information and advice', with 17 (39%) selections.

Expectations of Sexual Health Services

Services should be confidential, offer all sexual health and contraceptive services and open in evenings and at weekends. Respondents were impartial for services designated for specific age groups and stated that services should not be specific to the LGBT community. Staff should be qualified sexual health specialists, listen to concerns, and be approachable and non-judgemental.

Services should be easy to access on public transport, open at weekends and evenings and should provide walk-in appointments any week day and if appointments are required you should be able to get an appointment short notice.

Sexual health risk-taking behaviour

Of the 46 who responded, 17% stated they never use a condom, 39% said they sometimes use one, 30% stated they always use one and 13% selected not applicable.

Only 2% of respondents always use a dam and 28% stated they never use one. No-one said they sometimes used one and the remaining 70% said that not applicable.

Knowledge and information

The most popular method for obtaining information, proved to be 'the internet' with 41 (76%) selections. The least popular method was the 'LGBT outreach worker' with only 2 (4%) votes. This outcome is in contrast to participants response to the preferred venue for services. The most helpful source was 'the internet' with 21% of responses. Books and Personal, Health, Social and Economics Education (PHSEe) were both the least with 2% of

responses. Respondents feel most comfortable talking to a specialised sexual health worker (36%), while the least chosen options were 'siblings or cousins, self-help groups, parents/ carers' and 'the internet' with only 1 (2%) selection each.

Additional questions for online survey

LGBT Outreach worker

43% of 28 who responded had heard of the LGBT Outreach Worker and of those 30% had been in contact with the Outreach Worker, 40% had not and 30% said they were unsure. Asked how effective the Outreach Worker 75% responded and of those who responded 52% said that the service was effective whilst 24% said it wasn't and 24% were unsure.

"I am aware there is a LGBT outreach worker, but I have no idea how or where to find them, or what they do. As there is no real active or sense of LGBT community on the island, you never see any general information or sign posting."

"It's good way of outreach but the current worker is inappropriate for young people, does not engage and is not approachable and wouldn't confide in him."

Out & About Newsletter

52% of 28 who responded had heard of the newsletter, of which 42% had received a copy. Feedback regarding the newsletter was mixed.

"It is a good newsletter full of good information about up and coming events and news about the LGBT community which is interesting to read."

"Receive through a third party despite asking to receive it myself a few times "

"I am surprised that it is not available on the web."

"Total crap and a waste of taxpayers' money. Pure plagiarism. Unless its changed in the last 6-months anyway."

11.5 Discussion Groups

The Expert Panel (appendix 4) agreed on targeting three 'hard to reach' groups of the community to undertake some exploratory discussion and group work.

The groups which were chosen were:

- Youth Pride are a lesbian, gay, bisexual, transgender youth group on the Isle of Wight for young people aged up to 25. There were 22 participants.
- Older, Lesbian, Gay and Transgender (OLGA) group is a support group for anyone over 50 who is either lesbian, gay, bisexual or transgendered (LGBT). There were 5 participants.

- Island Professionals is an Isle of Wight singles social group with over 180 members. The average age is 50 to 65 year olds. There were 18 participants.

11.5.1 Youth Pride: Key Findings

Barriers: Embarrassment was the biggest barrier to accessing sexual health services followed equally by feeling uncomfortable; because they know and trust their doctor; they are not fully aware of the services available; not being able to talk to their parents.

"People don't care"

Publicity and Marketing: There were a variety of communication mediums to raise awareness of sexual health services. Incentives were their preferred marketing/publicity tool. Marketing in schools and colleges were also important as was Google.

"I'd phone 111.",
"Wikipedia",
"If it's serious I would just ignore it."

Venue preference for sexual health services: The sexual health service was the most popular location for sexual health services. Participants would use the Sexual Health Clinic for chlamydia screening, free condoms, information and advice, PEP, routine contraception, testing for HIV and testing for STIs; GPs for treatment for STIs, treatment for prostate problems; use pharmacies for emergency contraception and pregnancy testing. The Pharmacy was the least popular location when asked what provider they wouldn't use. Participants wouldn't use pharmacies for chlamydia screening, information and advice, PEP, psychosexual counselling, testing for HIV, testing for STIs, treatment and care of HIV, treatment of STIs; GPs for free condoms, dams and lube; and the sexual health clinic for pregnancy testing.

Education and knowledge: Participants felt that friends of the same age, the internet, TV programmes and SRE were the top four sources of knowledge and information regarding sexual health. Participants feel most comfortable speaking with their friends of the same age, youth workers, friends who are older or partners about sexual health.

Expectations of Sexual Health Services: Services should be walk-in (without an appointment) and wait to be seen; available through general practice and sexual health clinics; in a convenient location – close to schools, work, within walking distance of home; an age and LGBT specific service.

"*I definitely would want an age-specific service."*

11.5.2 Older, Lesbian, Gay & Transgender (OLGA) Discussion Group: Key findings

Barriers: Embarrassment in the case of being outed by loud counter-staff; likelihood of bumping into someone they knew; and lack of information were the barriers identified by OLGA to accessing sexual health services. The physical geography of the Isle of Wight and close-knit community also contributed to barriers accessing services.

"Being an island is a stigma"
"I definitely felt differently about this when I lived in London"

Publicity and marketing: The LGBT newsletter was identified as the predominant communication channel of raising awareness of sexual health services as well as internet blogs such as 'On the Wight' and 'Ventnor Blog'. Participants were despondent about social media being used as a communication channel.

"Speaking as a gay person I'd like there to be an LGBT newsletter to inform me about gay sexual health issues"
"Don't use social networks. Stay clear of them."
"Twitter and Facebook for younger people but we don't access it so it's not important for it."

Venue preference for sexual health services: The Sexual Health Clinic came out as the most popular location for sexual health services – although this trend was not as prominent as other discussion groups. Participants would use the clinic for free condoms, information and advice, PEP, psychosexual counselling, testing for HIV, testing for STI, treatment and care for HIV and treatment for STIs; GPs for psychosexual counselling and treatment and care of HIV; and pharmacies for free condoms, information and advice, PEP.

Education and knowledge: Magazines, partners/lovers and books were the main sources of sexual health information. Family were the least likely point of contact for participants. Participants stated that there was little or no education at school about sexual health.

"My parents told me nothing"
"The perception was your mother of father would teach you these things but he didn't tell me anything"
"Absolutely zilch has been useful. No education whatsoever. Something particularly to our demographic. It's made accessing information later in life harder. Cross reference to gay being illegal and even though it's been made legal it's still very difficult"

Participants also highlighted the issue of loneliness and the importance of using different mediums to communicate to different groups.

"...issue of loneliness. Far more important than the issue of contraception. This is how it was and how it still is. This difference for different demographics should be reflected in the services. "

Participants felt that they were most comfortable talking with friends (of the same age) and specialist sexual health workers. When the participants were asked who was their most important point of contact to talk too this was split between their partner and their doctor – albeit concerns were raised if doctors change.

"Can't pick a favourite one. It depends on who is there at the time."
"Difficulty if a doctor changes."

Expectations of Sexual Health Services: Services should be available at general practice, by appointment only (and within 48 hours) and have good parking close by. A small number of participants also said they would like to have age specific sexual health services. OLGA said that services should not be run by a non-specialist nurse or set in children centres.

"If it was a toss-up between a GP and a pharmacist I'd rather talk to a GP."
'It's different if there's a sexual health nurse – so it's about them being a specialist. I wouldn't want to see a non-sexual health nurse."
"Feel far more uneasy about going to pharmacy"
"Didn't want to go to a specific sexual health clinic so go to a pharmacy instead"

11.5.3 Island Professionals: Key Findings

Barriers: Lack of awareness of the services available on the Island and limited privacy were the main barriers identified for attending sexual health services on the Isle of Wight.

"As a teacher, attending the sexual health clinic is out of the question because of the risk of seeing one of my pupils. "

Publicity and marketing: There was an array of suggestions to improve the awareness of services on the Island including newspaper adverts, posters/billboards (in public toilets, bus shelters, etc.).

"Crutches for sex. Don't see much literature on how to keep having sex when you're getting older. Need leaflets on cruise ships."

Education and knowledge: Same age friends, TV programmes, magazines and leaflets were the most popular source of information relating to sexual health. Island Professionals were least likely to contact family members such as children, parents, aunts and uncles, etc. for sexual health education and knowledge. The focus of sexual health education when the participants were at school was limited.

"All that happened at school they only talked about biology and anatomy. Nothing about diseases. We did rabbits at school. "
"It's not such a taboo subject anymore. "
"Story about a woman whose mum didn't want to talk about sexual health so just bought a book and gave it to them."

Most Island Professionals feel most comfortable speaking with their partner, or parent/carer or a nurse in a doctor's surgery about sexual health related issues. Discussions also took place around how different family members approach them for advice such as grandchildren.

"My grand-daughters talk to me but I wouldn't have talked to my grandparents. I think they find it easier to talk to us."
"Longer with a nurse. Don't want to time waste so I could feel more comfortable seeing a nurse because I want to talk about things at length"

Expectations of Sexual Health Services: Sexual health services should be available at general practice, at the Sexual Health Clinic, have appointment only (within 48 hours) and walk-in (without an appointment) options. Participants said their ideal sexual health service would not include services in schools, youth centres and children centres. Discussions also took place around contraception services which some participants felt was not applicable to their age group.

"Contraception perhaps isn't relevant. But our age group are not so knowledgeable about STIs."
"We don't need contraception. That is a good door which is now missed. WHAT ABOUT MEN! Especially when they get older."

12.0 Stakeholder Engagement

Feedback from wider stakeholders, including clinicians and service providers were sought to understand their needs in dealing with the demands of sexual health of Isle of Wight residents.

12.1 Introduction

A series of GP engagement took place over the period of July 2012 and February 2013. A triangulation of research methodologies were chosen to improve validation of data.

Quantitative:
- Voting survey: General Practitioners (GPs) and General Practice Nurses
- Online surveys: General Practice, U25 Clinics, Pharmacies, Non-traditional health settings

Qualitative:
- General Practitioner focus group

12.2 Key Themes

Access to Sexual Health Services: Services should be open access, and open at different times to suit the differing needs of residents. The St Mary's Hospital based sexual health clinic is a highly valued service. U25 community clinics are seen as very important to meet the local sexual health need.

General practice is not the best place to provide *all* routine sexual health services. However, improvement in training and provision of equipment could enhance services offered.

Barriers to accessing Sexual Health Services: Confidentiality, embarrassment, fear of being judged, lack of time to discuss their issues, difficulty in getting an appointment are perceived barriers by medical professionals of patients accessing sexual health services.

Training: There is not sufficient general sexual health training for practice nurses and there is room for improvement for GPs. Other professional groups e.g. mental health nurses or midwives should have a broad understanding of sexual health and champion this in their specialist areas.

Service provision: In general, participants across all groups were happy with current provision. Issues were raised around times of openings, particularly evenings and weekends for specialist sexual health services. It was identified that there were variations in provision and quality of provision across general practice and pharmacies but there were real opportunities to review and improve consistency. Non-traditional settings (e.g. youth clubs) were keen to take opportunities to extend the range of services and signposting they could offer. Further discussions and comments from professionals taking part identified that it would be useful to roll out chlamydia testing and condoms to professionals in mental health, maternity services and drugs and alcohol services as it was felt their client groups were often part of the high risk and vulnerable individuals needing to be targeted.

The referral procedure within general practice differs. GPs are more likely to refer patients who are at risk of an STI to the sexual health service whereas practice nurses are more likely to test for an STI. Practice nurses are more likely to provide proactive condom distribution to under-25s, GPs are less likely.

Opportunistic HIV testing and identifying those individuals who would benefit from PEP was extremely inconsistent. The majority of general practices did not offer these services.

Comprehensive partner notification is not widely undertaken in general practice.

Marketing and publicity: Identified that there is an inconsistency of marketing sexual health services across service providers and settings. This is particularly apparent across HIV and Post Exposure Prophylaxis (PEP) treatment information.

There is a general consensus that sexual health locally requires re-branding in order to reflect the different needs of people across their life-course.

Support for the continuation 'Claptrap' sexual health services and clinical update Newsletter

12.3 Recommendations

1. Promote sexual health services across partner organisations, developing opportunities for the delivery of some sexual health services and or/signposting within them e.g. condom provision, chlamydia testing.
2. Sexual Health training of clinicians should be reviewed with the intention of improving sexual health provision and opportunistic testing in General Practice.
3. Improve STI testing in General Practice for example through the introduction of dual testing for chlamydia and gonorrhoea.
4. Review current attitudes in general practice regarding improving opportunistic HIV testing and identifying individuals who would benefit from PEP
5. Review services offered in Island pharmacies in light of the variation in service provision, including the extension of EHC provision to include Ella One.
6. Review the feasibility and impact of re-branding sexual health services.
7. Review Sex and Relationship Education is school as part of the overall Children and Young Peoples plan.
8. Continue with the 'Claptrap' clinician newsletter, using this to inform general practice not only around clinical issues but update information around partner organisations in regard to sexual health provision e.g. Get Sorted.

12.4 Voting survey

As part of the General Practice Health Conference 27 practice nurses and 51 GPs took part in two separate electronic voting surveys. The method was used to identify trends, highlight areas requiring further investigation and to acquire immediate responses to give a snap shot of sexual health services in general practices.

Key findings

Access to Sexual Health Services:

- The majority of GPs (73%) would refer a patient at risk of STIs to the sexual health service, whereas the majority of nurses (81%) would offer STI tests within the practice.

- Both GPs and nurses do not promote opportunistic HIV testing and do not carry out comprehensive partner notification.

- On the whole, when feedback was combined, both practice nurses and GPs do proactively offer under-25s free condoms. 63% of nurses said they offer under-25s free condoms, however, only 46% of GPs said that they did.

- The majority of GPs (95%) and practice nurses (96%) felt that the sexual health clinic at St Mary's was an important setting for sexual health services.

- The majority of GPs (80%) and practice nurses (92%) said that it was very important to have under-25 sexual health community clinics.

- When asked whether standard clinics in General Practice are best placed to provide all routine sexual health services the majority of GPs (91%) and practice nurses (92%) said that there weren't.

Training: When asked whether they have had adequate sexual health training, the majority of nurses felt they have not had sufficient training (81%), which contrasts the majority of GPs (63%) who felt they have had sufficient training.

Barriers: GPs and practice nurses were asked for their perceptions of the barriers young people face accessing sexual health services from General Practice.

Of the 93% of nurses who responded 60% identified the following; concerns about confidentiality, embarrassment, fear of being judged lack of time to discuss their issues and difficulty in getting an appointment.

GP findings concurred, identifying concerns about confidentiality, embarrassment, fear of being judged, lack of time to discuss their issues and difficulty in getting an appointment as the main barriers.

12.5 Online surveys

The purpose of the online survey was to explore the current service provision of sexual health services, understand marketing and publicity and future service provision in General Practice, Under-25 (U25) Clinics, Pharmacies and non-traditional health settings.

General Practice

All 17 Isle of Wight GP practices responded.

Marketing and publicity: General practices undertake some form of promotion – either through posters, leaflets or other printed materials or verbally for most sexual health services. Post Exposure Prophylaxis (PEP) is not promoted through general practice.

Sexual Health Services in General Practices in the future: GP Practices were asked whether there were any sexual health services that aren't currently provided but would like to in the future:

"[We] would like to develop further testing of other sexually transmitted diseases"
"Could provide more comprehensive GUM services if given more training and appropriate equipment"
"One of our GPs has recently completed her family planning training so we will be able to offer IUD/IUS in the near future"
"We frequently refer patients to St Marys Sexual Health clinic which provides an excellent service"

U25 Community Sexual Health Clinics

All four U25 community sexual health clinics that operate in GP practices responded to the survey.

Marketing and publicity: All U25 clinics reported they promote U25 specific services including oral contraception, LARC, pregnancy testing, STI testing and chlamydia screening through either leaflet/printed information, poster or verbally with the exception of HIV testing, PEP and partner notification.

*Sexual Health Services in U25 Clinics in the future: U*25 Clinics were asked if there are any sexual health services that you currently don't provide, that you would like to…

"Presently unable to test for gonorrhoea."

Community Pharmacies

33 community pharmacies were invited to take part in the online survey. 27 responded to the survey and 26 completed the survey; one pharmacy partially completed the survey.

Marketing and publicity: Promotion through leaflet/printed materials and posters across the community pharmacies is consistent with provision i.e. more pharmacies promote chlamydia screening and condoms.

Most pharmacies reported they promoted other Island-wide sexual health services. Termination of pregnancy was the least promoted service and the majority of respondents stated that they do not wish to promote. One pharmacy did remark in an open-ended question that there is a *"…need to be mindful of how many posters are issued - sometimes we get too many especially from sexual health"*.

Sexual Health Services in Pharmacies in the future: When the pharmacies were asked what sexual health services that they aren't currently providing but would like to – there was a 70% response rate.

Nearly half of pharmacies who responded would like to provide the First Contraception service and free pregnancy tests.

Pharmacies were also invited in an open question about future services. Feedback included:

"Patient group direction allowing the supply of the 5-day window oral emergency contraception (Ella-One)"

"First contraception service is variable as one Pharmacist needs to accredit"

Non-traditional health settings

All nine children's centres and ten youth clubs contacted to take part in the online survey responded.

Marketing and Publicity: The majority of respondents promote the condom distribution, STI testing, chlamydia screening, general safe sex advice, wish-net, sexual health clinics and U25 clinics.

If providers did not promote a service - most of them said that they would like to with the exception of termination of pregnancy - where the majority 63% of those who did respond said that they would not want to promote this.

Sexual Health Services in non-traditional health settings in the future: Respondents were asked about services that they currently do not provide but would like to in the future. Pregnancy testing, specialist U25 clinics, chlamydia testing, advice and signposting for contraception and termination of pregnancy full STI screening were all identified as possible options.

12.6 General Practitioner Focus Group

In February 2013 seven GPs attended a focus group.

Key findings

Access to Sexual Health Services: GPs questioned the open access characteristic of sexual health. The overall consensus was that there is a need for various opening times to meet the needs different people in the community.

"…working people might prefer later opening times"

Opening times of sexual health services were explored. The mental health service was used as an example to demonstrate that need is 24 hours but support services are often designed to run parallel to GP opening times.

"It doesn't make sense… Clinics that run at the same time suit the provider but not the service users".

Saturday morning walk-in clinics were discussed – highlighting the importance of appointment only options out-of- hour services.

"If you ran Saturday mornings as a business no-one would go to sexual health clinic – everyone would sleep in."

GPs recognised the importance of the time the Sexual Health Clinic can provide to patients in comparison to the General Practice.

"…the SHS have more time to speak with patients whereas GPs do not and will say to phone sexual health Monday morning"

There were mixed views regarding the location of the level 3 Sexual Health Clinic.

"Good place"
"Benefits from being private"
"…should be in the middle of Newport"
"It's a specialist service – if we need further clinics these should be through satellite services"

Improvements to the provision of testing and treatment of STIs, other than chlamydia, were identified in General Practice. Overall consensus was that tests have improved and the laboratory service works well. The growth of antibiotic resistance was also raised as an issue.

GPs emphasised the need for continued focus on sexual health service at pharmacies.

"Enhance pharmacy service and make sure it doesn't fizzle out "Encourage pharmacists to engage in dialogue"

Access to emergency hormonal contraception (EHC) was highlighted as vital in pharmacy settings. Albeit, GPs thought that there was room for improvement at some pharmacies.

"You get patients who have been signposted from pharmacists to GPs. "
"…there are good pharmacists who recommend the coil"
"…should be universally available"
"Access is the most important aspect – however, still should be good quality signposting",
"Confidentiality can be a problem in pharmacies. One minute a pharmacy assistant is working in the pharmacy and the next day they're down the bakery. "

Training GPs and non-specialists and outreach

Discussions took place around sexual health champions and peripheral health workers. One participant raised an example in ante-natal.

"Why don't midwives take an active role in chlamydia screening?"
"Tests should be part of the booking in process [for pregnant women]"
"Increase training for non-specialists e.g. healthcare assistants, midwives, and health visitors"

Alcohol and drugs was another example of how other health agendas could link up with sexual health services.

"Sexual Health should be tied up with IDAs [Island Drugs and Alcohol Service]. There are cross-overs – should be all under one roof"
"… there is someone in Sevenacres who is championing sexual health as there are a lot of patients coming across from Sevenacres to the sexual health. "

Suggestions for sexual health champions included: mental health, children centres, health visitors, maternity, children's ward, learning disability services, social services – "looked after children", youth workers and having someone who is a 'link' into these groups.

GPs felt that the sexual health conference was great and it had *'good national speakers'* but it was *'slightly over done – having it every year for the past 7/8 years'*, it was also described as *'too broad – covering too many different audiences'*.

The need for continued training was also identified for GPs.

"I am in danger of losing my 'trainer' qualification through lack of training opportunities/paid time out of general practice"

Marketing and publicity

Initial discussions focused on marketing of sexual health services to different target groups. Examples included the use of animation on adverts in cinemas.

GPs recognised that the term 'sexual health' is multi-faceted and discussions took place around what Public Health could do to make it more encompassing – although feedback was mixed.

"The term family planning is outdated."
"The name can make a huge amount of difference"
"Consider change of clinic name – "Family planning and sexual health services"
"Rebranding of clinic – Sexual Health, Family Planning, GU Medicine. Important to spread the message about what sexual health is and make it seem open to all groups."

'Claptrap', the clinician newsletter written by the Sexual Health GP Link Dr Patrick Wills, was well received amongst attendees.

Education: Education was identified as extremely important.

"Though it can be difficult….education regarding sexual health would be main aim."
"The key is to normalise sexual health"

GPs stressed the need for increased support for education and LARC services for GPs and other places to reduce the termination of pregnancy figures.

Discussions took place around a set of 'approved' sexual health workshops at all schools across the island, which target specific year groups within the PHSE curriculum. One participant suggested the use of independent workshops delivered on a day over a fixed period where students can drop-in to attend a workshop or ask questions/be given sexual health advice/be given the option of picking up condoms; akin to the role carried out by Connexions. They also suggested that the workshops should have the same format to give them additional credence.

School governors were identified as playing a crucial role in shaping Sex and Relationship Education (SRE) in schools. GPs suggested the Sexual Health Lead in general practices along with local statistics would be vital in getting the message across.

Another suggestion was to include a 'Teacher' page on wish-net which could provide a consistent and accurate message for teachers as one participant remarked…*'the internet is full of lots of useful information but it is knowing what is credible'*.

Glossary

Acute STIs[82]: Acute STIs include the following: Chancroid/LGV/Donovanosis, Chlamydia, Gonorrhoea, Anogenital Herpes (first episode), new HIV diagnosis (acute infection), Molluscum contagiosum, Non-Specific Genital Infection, Pelvic Inflammatory Disease & Epididymitis, Scabies/Pediculosis pubis, Syphilis (primary, secondary & early latent), Trichomoniasis, and Anogenital Warts (first episode).

STI	WHAT ARE THE RISKS?
SOURCE: **NHS CHOICES**[83]	
Chlamydia: A bacterial infection that is found in sexual fluids	Most people who have chlamydia don't notice any symptoms and won't know they have the infection. However, if left untreated women can develop **pelvic inflammatory disease**, which can lead to pelvic pain, infertility or an ectopic pregnancy. It can also lead to an infection of the womb, ovaries or fallopian tubes, which can cause infertility. It has been linked to fertility problems in men. It can be successfully treated with antibiotics
Genital herpes: An infection caused by the herpes simplex virus	Causes painful blisters on the genitals. It is a long-term condition because the virus can lie dormant in the body and then become active again. It recurs an average four or five times in the first two years after infection. Flare-ups reduce over time. Symptoms can be controlled with anti-virals
Genital warts: A skin infection caused by types of the human papilloma virus (HPV)	Causes fleshy growths that appear around the genitals from three months after infection. The growths are usually painless but can be unsightly. The types of HPV that cause warts do not usually cause cell changes that develop into cancer. Warts can be successfully treated at a **GUM clinic**
Gonorrhoea: A bacterial infection that is found in sexual fluids	Like chlamydia, gonorrhoea can cause pelvic inflammatory disease in women if left untreated. In men it can lead to a painful infection in the testicles and prostate gland, increasing the risk of reduced fertility. It can be treated with antibiotics though some strains are becoming resistant
HIV/AIDS: A viral infection that attacks the immune system. The final stage is AIDS	The human immunodeficiency virus attacks the immune system, and weakens the body's ability to fight infections and disease. The final stage, when the body can no longer fight life-threatening infections, is AIDS. There's currently no cure for HIV but there are treatments that enable most people with the virus to live a long and healthy life
Pubic lice: Tiny parasitic insects that live in body hair and are passed on by close contact	The 2mm-long blood-sucking lice cause itching and inflammation in affected areas. It can take weeks for symptoms to develop. They are not the same as head lice and aren't linked to poor personal hygiene. Can be successfully treated with medicated ointments

[82] PHE (2013)
[83] NHS Choices (2013) [Online] Available at: http://www.nhs.uk/Pages/HomePage.aspx

STI	WHAT ARE THE RISKS?
Syphilis: A bacterial infection passed on via infected sores	Syphilis causes painless infectious sore that lasts up to six weeks. Skin rash and sore throat then develop. If left to progress, syphilis can cause serious conditions such as stroke, paralysis, blindness or death. It can be successfully treated with antibiotics if caught early

Appendix 1

Figure 2: From April 2013		
Local authorities will commission	**Clinical Commissioning Groups (CCGs) will commission**	**The NHS Commissioning Board will commission**
• Comprehensive sexual health services. These include: • contraception, including LESs (implants) and NESs (intra-uterine contraception) and all prescribing costs, but excluding contraception provided as an additional service under the GP contract; • sexually transmitted infection (STI) testing and treatment, chlamydia screening as part of the National Chlamydia Screening Programme (NCSP) and HIV testing; • sexual health aspects of psychosexual counselling; and • any sexual health specialist services, including young people's sexual health and teenage pregnancy services, outreach, HIV prevention and sexual health promotion, services in schools, colleges and pharmacies.	Most abortion services (but there will be a further consultation about the best commissioning arrangements in the longer term) Sterilisation Vasectomy Non-sexual health elements of psychosexual health services Gynaecology, including any use of contraception for non-contraceptive purposes.	Contraception provided as an additional service under the GP contract HIV treatment and care (including drug costs for post-exposure prophylaxis after sexual exposure) Promotion of opportunistic testing and treatment for STIs, and patient-requested testing by GPs Sexual health elements of prison health services Sexual Assault Referral Centres Cervical screening Specialist fetal medicine services

Figure 44: Department of Health commissioning arrangements for Sexual Health from the 1 April 2013

Appendix 2: Tier 1 Training

Over 234 individuals from a range of settings have accessed tier 1 training from 1st April 2012 up to the 31st March 2013.

Organisation	
Alliance Boots, Sandown	Lloyds Pharmacy
APT	Medina Healthcare
Atkinson Drive	Mencap
Bays Children Centre	NHS
BBH	Niton Pharmacy
Boots Newport	NYAS
Boots Tower house, Rink Road	Oak house
Boots Ventnor	Oakfield Primary School
Boots, Ryde	People Matter
Brookside Health Centre	Pharmacy Boots Ryde
CAMHS	Polygon School
Carisbrooke College	PRU Thompson House
Children's Centre	Regent Pharmacy
Children's Society	Ryde Children Centre
Clatterford Centre	Ryde School
Community Learning	Sainsbury Pharmacy
Cowes Children Centre	Sandown Bay Academy
Cowes Primary	School Nursing
Dower House	School Pastor
East Newport Children Centre	Seaview Pharmacy
East Cowes Pharmacy	Smart training
Fostering - IWCC	Social Care
Fostering (carer)	South Wight Medical Practice
Grove House, Ventnor	Southern Housing
Island Choices	St. Catherine's School
IW College	St. George's School
IW NHS	The Bays Children Centre
IWCC	Boots, Tower House Pharmacy
IWCC Youth Service	Ventnor Children Centre
Job Centre Plus	West Newport Children Centre
John's Club	West Wight Children Centre
Kitbridge Farm	Wightchyps

Figure 45: Organisations who have attended the sexual health Tier 1 training

Appendix 3

Expert panels are vitally important for community services – they bring together people who are able to represent different perspectives and understanding of the needs of the local area. They provide critical knowledge and local intelligence about non-statutory provision and opportunities for additional provision. They can help to identify at risk groups not currently being sufficiently catered for and awareness of local idiosyncrasies with key groups as well as barriers and preferences.

Isle of Wight Sexual Health Needs Assessment Expert Panel attendees are listed in the table below:

Service Delivery Manager	NHS – Sexual Health Clinic, St. Mary's Hospital
Consultant Nurse	NHS – Sexual Health Clinic, St. Mary's Hospital
Sexual Health GP Lead	Carisbrooke Medical Centre, Carisbrooke
GP	Esplanade Surgery, Ryde
Family Planning Nurse	Tower House Medical Centre, Ryde
Trainee GP	Carisbrooke Medical Centre, Carisbrooke
Pharmacist	Lloyds Pharmacy
Public Health Consultant	Isle of Wight Council
Public Health Commissioning Manager	Isle of Wight Council
Sexual Health Commissioning Manager	Isle of Wight Council
Children Centre Commissioning Manager	Isle of Wight Council
Drugs and Alcohol Commissioning Manager	Isle of Wight Council

Figure 46: The Isle of Wight Sexual Health Needs Assessment Expert Panel

Appendix 4

The discussion groups involved several activities which have been summarised below:

a. **Ice Breaker Sexual Health Clinic Quiz**: Various contraceptive methods were displayed and participants were asked to identify what each contraceptive method was and what it does e.g. prevent STIs or pregnancy or both.

b. **Introductions and presentation –** the facilitators introduced the purpose of the discussion groups, the context to the sexual health needs assessment and the agenda of the groups.

c. **Activity 1**: Barrier Wall - looked at what put people off from attending services. Following the discussion participants were asked to write what may actually put them off using sexual health services on to bricks (paper). Respondents were asked to collect them and create a barrier wall.

d. **Activity 2**: Publicity and Marketing - looked at how people find out about the sexual health services offered. After a facilitated discussion - the group were asked to put up any suggestions on a flip chart and given voting stickers - green for good idea and gold for the best idea.

e. **Activity 3**: What service where? Looked at understanding where people would be comfortable accessing the service. Participants were given cards with services on and were asked to place them in a box depending on whether they would use, wouldn't, use , don't know, or not relevant per setting e.g. Pharmacy, GP and Sexual Health Clinic.

f. **Activity 4**: Education and Knowledge - this activity was designed to help understand what sources of information and knowledge people have found useful when making informed decisions about their sexual health.

g. **Activity 5**: Who can you talk to? This activity was designed to help us understand who participants feel they can talk with openly and honestly about sex.

h. **Activity 6**: Your ideal service: Participants discussed and selected what would make the perfect service from a range of options presented and their own ideas. Participants also discussed what they felt would be their nightmare service.