Surrey Sexual Health Needs Assessment 2021

SURREY
COUNTY COUNCIL

Surrey Sexual Health Needs Assessment 2021

This sexual health needs assessment aims to cover all aspects of sexual health, and reviews provision both in individual settings (specialist clinics, pharmacies, GP practices) and as an integrated whole.

Please note that this report encompasses the wide engagement that took place and not everyone will want to read all parts.

If you only have ten minutes:

Please read:

1) ‘Ten Minute Read’ (the executive summary)
2) Summary Recommendations
3) Key messages from our engagement

If you want to read the summaries and any relevant chapters:

It is easy to navigate through specific chapter headings by clicking the ‘Bookmarks’ icon in the left hand menu.

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About this Sexual Health Needs Assessment

Assessing the sexual health needs of Surrey residents is a continuous process for the public health team at Surrey County Council. This includes reviewing population level data and service usage, and comparing this with the views of patients, the public and other key partners across the system. There is a relatively heavy focus on clinical services linked to sexual health in this needs assessment. This is partly because the assessment is timed to inform the commissioning of the specialist service as the current contract ends on 31st March 2022, and partly because clinical services also featured heavily throughout our engagement. However, sexual health is dependent on a wide range of factors and this assessment identifies both local and system-wide actions to ensure key indicators continue to improve. Services for people living with HIV are commissioned by NHS England and NHS Improvement and are covered in a separate needs assessment which was published in June 2021. A copy of this separate needs assessment entitled 'Surrey health needs assessment for people living with HIV 2021' can be accessed by emailing england.speccom-se-contracts@nhs.net and requesting a copy.

Over the last 12 months, most engagement has been online due to COVID-19. This represents both challenges and opportunities. There were a number of key groups we hoped to engage with, including:

- people from specific ethnic groups
- people who do not identify as heterosexual/straight
- people from specific areas such as Spelthorne (where teenage conceptions are highest in Surrey)
- People with a disability

We have talked to and/or received survey responses from a range of individuals and organisations including members of each of these groups. Details of the groups we engaged with can be found in Appendix D. However, some groups were better represented in our engagement than others. Where a group was less well represented, we looked at findings from engagement and/or research with similar groups carried out elsewhere in the U.K. and adapted relevant recommendations. Engagement is a continuous process and Surrey County Council would like to hear from anyone who can help us continue to engage with key priority groups.

Engagement should not be separated from the numerical (quantitative) picture and we have employed a 'mixed methods' approach. We have therefore combined the results of our engagement with key information on the sexual health of Surrey residents and the use of sexual health services by Surrey residents. We have produced an engagement log with full details of all the engagement that was undertaken.

Acknowledgements

We are incredibly grateful to everyone who gave up their time to engage with us on this. As part of our continuous engagement we would like to ask for any comments on this needs assessment to be sent to our Sexual Health Needs Assessment e-mail address: **shna@surreycc.gov.uk.** Many thanks for taking the time to read this.

Surrey County Council Public Health Team

Ten minute read

This section can be read in conjunction with the 'Summary Recommendations' and the 'Key messages from our engagement' to give an overview of the whole report. Key areas of interest can also be easily found in the main report by selecting the 'Bookmarks' icon in the left hand menu.

Engagement during this needs assessment

We continuously engage on our sexual health services with residents and partners. This engagement helped shape our questions for surveys and topics for discussion. Our engagement during this needs assessment is outlined as a separate section in the main report and our communication plan is provided as Appendix D – Communications plan. We have included the results of our stakeholder engagement throughout the report where relevant and used to it to give context to some of the quantitative (numerical) date given.

Overview and national picture

Many factors contribute to sexual health, including the culture and place we grow up in, our education, and the individual decisions we make about sex and sexual relationships. Sexual health services can be accessed through:

- Specialist services (currently provided by CNWL in Surrey)
- Online/telephone access (also provided by CNWL in Surrey)
- Primary care (mainly through GP practices)
- Pharmacies

This needs assessment covers all services plus the wider aspects of sexual health such as education and the effects of deprivation & other indicators on sexual health.

The national picture highlights concerns that services do not always feel joined up for patients as services are organised and funded ('commissioned') by different organisations. A common example of this are the challenges faced by a woman who attends a specialist sexual health clinic but is unable to undergo screening for cervical cancer (a 'smear test') at the same time. Commissioners and providers are currently working together on this and other examples of where closer working by commissioners and providers is needed are given throughout.

Specialist sexual health services within Surrey

The use of sexual health services in Surrey has changed enormously recently. Surrey was the first area in the South East to offer online/telephone services for both contraception and testing of Sexually Transmitted Infections (STIs). This was in response to concerns about access to services for people living further away from clinics. However, it enabled the specialist service to quickly respond to the restrictions put in place to respond to the COVID-19 pandemic. Remote services are not the best for everyone and commissioners and providers continue to work together to ensure face to face appointments are available to those who need them.

Appointment types and availability

In our engagement with primary care colleagues we heard that Sexually Transmitted Infection (STIs=) diagnosis and treatment and access to emergency coil fitting appointments, were particularly important as these were generally beyond the scope of a GP. In our primary care survey, appointment availability for STI diagnosis and treatment was the biggest concern for GPs and practice staff; 64 out of 81 respondents selected this as a 'main concern'. We also heard that referrals to the specialist service for more complex long acting contraception (LARC) appointments have remained an issue for some time.

The requirements, needs and demands for urgent sexual health care (for example, for symptoms of STIs) are very different from those for routine care (for example, for a routine appointment for oral contraceptives). Situations in which urgent, walk-in care at a specialist sexual health clinic are needed include:

- Treatment of acute symptoms of Sexually Transmitted Infections
- Urgent contraception such as emergency coil fitting when Emergency Hormonal Contraception (EHC – also known as the 'morning after pill') was not accessed or available
- Urgent issues with routine, long-acting contraception such as coils

It would be unusual for individual patients to require repeated, urgent face-to-face appointments. Where there are repeated Sexually Transmitted Infections, more intense prevention work would be needed to encourage safer sex. Health advisors have previously been used for this.

Routine care such as simple contraception often requires repeat prescriptions and this is available face to face in the specialist service, through the online/telephone service, and in primary care. Long-acting contraception is provided in some GP practices, but some patients require care from a specialist due to complex anatomy or medical histories.

The overall picture suggests that more could be done to encourage patients with less complex, routine requirements to access services by telephone/online, or through routine face to face appointments. An increase in online services for routine contraception also helps reduce pressures on primary care colleague who also provide this. These measures would help ensure that more face to face appointments with specialist clinicians are available for urgent and complex care

Service model

Quarterly contract meetings show generally good performance on key indicators (such as STI test results within one week and an increase in Long-Acting Reversible Contraception in under 25s). The proportion of 15-24 year olds screened for chlamydia could be improved. The specialist service has remained highly adaptive to change. Our engagement suggests that patients are happy with the clinical care provided, and there was high praise for a committed workforce who are sensitive to patients' needs. Our engagement also identified a number of areas which could be improved, and this will be particularly important in developing the service specification for the re-procurement of the specialist service.

- Having a booking office in central London is universally unpopular and any future service should have a booking office based in Surrey (see also 'Key messages from our engagement' below)
- It was felt that communications to patients and the public need to be more Surrey specific (both health promotion and service communications) and any future service should include an element of the communications team dedicated to Surrey
- The success of the outreach model is difficult to quantify and this also needs to be clarified in the future service specification
- Regular updates about key service changes are sent out by the specialist service but GPs in practice often don't receive these – the communication cascade from the specialist service to GPs in individual surgeries needs to be reviewed (this could be done within the current contract)

'Online' (remote) services and changes to services due to COVID-19.

The term 'online' suggests no interaction with clinical staff. In reality, patients request services online and in many cases are contacted by a clinician for a telephone consultation and are offered a face to face appointment if clinically appropriate.

Surrey residents benefited from the first service in the South East region to have both online contraception and Sexually Transmitted Infection (STI) testing. Both of these were established before the advent of COVID-19. Online contraception prescriptions increased from 91 in February to 258 in March of 2020. Telephone consultations became the most common form of consultations in 2020 although face to face and walk in appointments were always available if clinically required.

The huge increase in online/remote (telephone) consultations offers some benefits in terms of reducing the need to travel to clinics, maximising clinical time and ensuring face to face appointments are available to those who need them most. National guidance is followed to ensure services remain clinically appropriate and acceptable to patients. As restrictions are lifted, commissioners and providers of all sexual health services will continue to review the use of remote consultations and online service use.

Our engagement suggested concerns for vulnerable groups in the move to more remote consultations since March 2020. Clinicians and other professionals working with vulnerable groups have had to work in a very different way to ensure safeguarding concerns are identified and acted upon and again, national guidance on this is followed.

Specialist sexual health services outside of Surrey

We now have more detail on the use of specialist services outside of Surrey by Surrey residents, and of the number of people from outside of Surrey who chose to use Surrey based services. Specialist sexual health services are 'open access' which means Surrey residents are able to choose any specialist sexual health clinic. If this is outside Surrey borders, then Surrey County Council pays the relevant provider for that visit (and does not pay the cost of a visit to the Surrey based service). Commissioners have worked closely with providers in neighbouring areas to ensure reduced tariffs for cross-border use. As an example, over 50%

of Elmbridge residents chose to use attend the sexual health clinic in nearby Kingston. Surrey County Council and the Kingston service work closely to ensure the needs of Surrey residents are addressed but additional cost is minimised. Clinics located closer to county borders are more likely to be used by 'out of county' patients and this reduces appointment availability to 'in county' residents. This is an important consideration for clinic locations.

Our engagement with primary care colleagues suggested large variation in how acceptable they felt it was to suggest specialist services outside of Surrey to their patients. Our engagement also revealed that primary care colleagues often felt that using clinics outside of Surrey was inappropriate due to patient acceptability or increased costs. Both our data analysis and our engagement has highlighted that many Surrey residents see services outside of Surrey as the obvious choice, especially those who live on or near county borders. There is also wide variation in what is meant by 'local' services. For example, focus groups with young people in Spelthorne suggested that Feltham, Hounslow and Stanwell were all seen as 'local' to them, but professionals were more likely to use the term 'local' for clinics within Surrey boundaries.

Patient choice remains key and specialist clinics need to be viewed from the context of all specialist services accessed by Surrey residents and funded by Surrey County Council. This includes services outside of Surrey boundaries. Understandably, our engagement suggests people in areas who have traditionally had a specialist clinic very close were more likely to raise issues about clinic locations. The northern/north western parts of Surrey have seen the biggest changes to services in recent years; particularly to services within Surrey boundaries. Looking at proximity to a specialist clinic, however, the southern aspects of Surrey are less well served but there have been no significant changes in this in recent years. Appendix A gives more detail on service provision in and around the 5 main healthcare geographies in Surrey. Our engagement also suggests that people feel the location of Surrey-based sexual health clinics are key factors in specific outcomes such as teenage pregnancies. There is a main specialist hub in Guilford and teenage pregnancies have been increasing in Guilford but decreasing in Spelthorne in recent years.

Primary care

Sexual health services provided in primary care includes:

1) General sexual health services including:
    - advice and provision of routine and emergency (oral) contraception
    - initial appointments for genito-urinary symptoms which may identify potential sexually transmitted infections (which are referred to specialist services)
2) 'Long Acting Reversible Contraception' (LARC) including coils and implants which are optional for a practice to sign up for and require additional training (often by specialist nurses)

Most practices continued to provide Long-Acting Reversible Contraception throughout 2020 and this was highly valued by patients and commissioners.
GPs and other primary care colleagues responded to our engagement more than any other group. We received 81 responses to our primary are survey, attended at meetings such as Integrated Care Partnership and spoke to individual GPs by telephone. This highlights the importance of sexual health to Surrey GPs and the comments feature throughout the main report and within this summary.

Pharmacy

Pharmacy provision is an important element of the overall sexual health offer to residents. In addition to providing general advice and signposting to specialist services were necessary, pharmacists also provide:

- Emergency Hormonal Contraception Service (also known as the 'morning after pill' although can be taken up to five days following sex)
- Chlamydia screening and treatment

Prevention of unwanted pregnancies (particularly in teenagers) and increasing the chlamydia detection rate in under 25s are key priorities in Surrey. The pharmacy offer ensures young people do not need to travel to specialist clinics or attend GP practices to access these services. Our engagement with pharmacists suggests they would be keen to increase their sexual health offer and would like more information on changes to sexual health services. Commissioners and pharmacy colleagues now plan to increase services in pharmacy and promotion of pharmacy services.

The sexual health of Surrey residents

The population data suggests that sexual health outcomes in Surrey compare well to other local authority areas. Surrey now has the lowest proportion of under 18 conceptions since current data collection methods started in 2011. Gonorrhoea infection rates have been rising sharply across England in recent years, but the same sharp rise has not been observed in Surrey. HIV testing rates in Surrey are some of the best in the South East. However chlamydia detection rates and early detection of HIV (particularly in heterosexual people) require improvement in Surrey.

Health inequalities and priority groups

Healthcare services account for a relatively small proportion of differences in health outcomes. Other differences, such as levels of income, education and cultural aspects are much bigger factors. Being able to be open about sex and sexual health is important in reducing inequalities and views and practices can differ from our own without being 'worse'.

People in less deprived areas tend to first have sex at a later age and are more likely to have children later than people in more deprived areas. People in less deprived areas are more likely to access abortion services than people in more deprived areas. Both of these factors combine to mean that people in the most deprived areas are far more likely to become parents as teenagers than people in less deprived areas. There are also links between higher rates of sexually transmitted infections and higher deprivation. The main report outlines some of these links and gives recommendations for more targeted work.

The sexual health of young people in Surrey was seen as really important throughout our engagement. Relationship and sexual education is now compulsory and system-wide actions are needed to ensure young people in Surrey are able to make informed choices about sex. Our engagement with school nurses suggests they would value more information on sexual health promotion and services. Surrey covers a large geographical area and some young Surrey residents would find it difficult to access sexual health services yet may be reluctant to access services closer to home (in pharmacies and GP practices for example). Online/remote

services and information go some way in addressing this. However, through our focus groups with young people we heard that many of them preferred a conversation to online services. They also said they were unsure of which online information was reliable and they felt more reassured by information from someone they trust such as their GP. The main report includes resources for improving the sexual health of young people. More of the recommendations in this needs assessment relate to young people than any other group.

There are fewer people who do not identify as heterosexual/straight in Surrey than in neighbouring areas such a London and Brighton. People from this group do not tend to live in a specific area in Surrey. Our engagement with people who identify as Lesbian, Gay, Bisexual or Transgender suggests did not suggest significant differences in satisfaction/dissatisfaction with sexual health services in Surrey to people who identify as heterosexual/straight. There is a specific outreach programme for men who have sex with men.

People from minority ethnic groups tend to have worse outcomes for sexual health. This is partly due to perceived stigma which makes it uncomfortable to talk about sex and sexual health in certain cultures. We worked with a number of groups in Surrey to hear from people from minority ethnic groups and translated our questionnaires in several languages and formats. Unfortunately we had relatively little engagement from this broad group and would welcome any suggestions or contacts for our continued engagement in this area.

Engaging with people with learning disabilities around sexual health has always been challenging. There is a perception that people with learning disabilities don't have sex, or don't want to have sex. Our engagement with clinicians in the specialist service helped us understand how we can ensure all services are more inclusive in this respect.

We heard about the challenges of accessing sexual health services from people with a physical disability and the report outlines some ways to address this. There are also suggestions on how to make services easier for deaf people to use.

Finally we are keen to hear people's views on this sexual health needs assessment as part of our continuous engagement.

Please e-mail any comments to: shna@surreycc.gov.uk

Summary Recommendations

- More detailed recommendations are embedded within the main report and are related to the specific context within the main report
- These detailed recommendations have been summarised here so they can be understood outside of the context of the main report.
- The detailed recommendations will inform an action plan to be agreed with key stakeholders

For commissioners and the provider of the current specialist service

- Urgent appointments in specialist clinics, particularly for Sexually Transmitted Infections (STIs) and long-acting reversible contraception, remain in high demand and need to be prioritised
- Further consideration should be given to ensuring patients are able to access less urgent care (such as STI screening and simple contraception) through telephone/online services
- Improve communications (to residents and other partners) to highlight the different options for less complex care such as online contraception
- Continue to review availability of LARC appointments in conjunction with other appointments to maximise specialist clinical care
- Sexual health promotion should be Surrey specific, particularly for young people
- Commissioners and providers to identify areas/methods for improvement of chlamydia screening (particularly in under 25s) and diagnostic rates
- Undertake a review of the condom distribution scheme in Surrey
- Review and undertake recommendations from the PHE Guided Evaluation on Surrey online contraceptive service
- Ensure priority groups for outreach are appropriate
- Training for people who work with young people was highlighted as really important during engagement
- Consultants in Sexual Health/Genito-Urinary Medicine suggested more teaching for primary care colleagues and primary care colleagues would welcome this
- A clear communications plan should be available on how priority groups are to be targeted and updated regularly
- Explore acceptability of different methods of service delivery with older people specifically as the perception that younger people prefer online advice and services compared to older people has been challenged
- Communication methods for young people should have input on design from young people and be tested with young people – our engagement taught us that people are more likely to trust communications from healthcare professionals than online resources
- Ensure healthcare services follow NICE recommendations around inclusive healthcare provision for minority ethnic groups
- Follow BASHH guidance on provision of inclusive services for LGBTQ+ people; ensure all communications and websites are inclusive
- A dedicated outreach worker for men who have sex with men remains appropriate and continued engagement with the LGBTQ+ community is important
- Ensure services are aligned to the needs of sex workers including outreach, and fast-track attendance/alternatives to home testing where appropriate

- A Learning Disability Champion should be located at each specialist service hub site to ensure services are delivered appropriately
- All staff in patient contact roles should receive Learning Disabilities awareness training.

For commissioners of the specialist service to consider for inclusion in the re-procurement of the specialist service

- The Surrey Integrated Sexual Health and HIV Service requires a booking office to be Surrey specific, ideally located within one of the Surrey services
- Commissioners to consider the inclusion of Health Advisors in the specification for the specialist sexual health service - these could work remotely by telephone to maximise clinical space
- Specialist providers should have a communications lead, with specific communications experience, dedicated to Surrey for at least part of their role
- Commissioners to include a Surrey wide Independent Domestic and Sexual Violence Advocate (IDSVA) as part of the specialist service staff profile.
- Robust and evidenced referral pathways both from and into the specialist service must be formalised with relevant partner organisations especially in respect of services for young people under the age of 13.

For the Public Health Sexual Health team at Surrey County Council

- Continue to strengthen links with providers outside of Surrey boundaries particularly in areas where these services are more accessible to Surrey residents living close to bordering local authority areas
- Improve communications for Surrey residents and health professionals around out of area services
- Focus on pharmacy location and prioritise coverage by Primary Care Network footprint and according to distance from specialist clinics/spokes
- Increase promotion of pharmacy services, particularly for young people
- The Sexual Health Outreach Group should review challenges and opportunities raised by online service provision
- Commissioners should review the 2014 guidance: ‘Towards achieving the chlamydia detection rate Considerations for commissioning’
- Continue to engage with people and representatives from multi-ethnic groups and promote translated surveys as face to face contact – maintain links with the Surrey Minority Ethnic Forum in particular
- Where direct engagement is not acceptable to specific groups, other available sources should be used to identify key areas for prevention and for reducing barriers to accessing sexual health services
- Review provider policies to ensure they are as inclusive as possible for people who are deaf
- Support the further development of a range of easy read leaflets and information sheets on a range of sexual health issues including STI’s, contraception, what will happen at a sexual health service appointment

For the Public Health Sexual Health team in conjunction with commissioners/providers across the health and care system (CCGs, NHSE/I etc)

- Commissioners of all healthcare services to explore opportunities for further integration (e.g. cervical cancer screening being commissioned in sexual health services)
- Pathways between maternity services and the specialist sexual health service should be improved
- Clinical imaging information (chest x-rays/ultrasounds) is not currently accessible electronically to doctors in the specialist sexual health service and this would benefit patients and clinicians
- Ensuring key information sent by the specialist service reaches GPs and nurses in practice remains a challenge and a task and finish group is recommended to address this (including CCGs and GPs)
- A system-wide shared clinical record system should be the aspiration and Integrated Care Systems may help achieve this
- Support primary care and Primary Care Networks, in further developing the Public Health Agreement buddy scheme and using shared clinical services with cross organisational appointments

For the Public Health Sexual Health team in conjunction with wider Surrey County Council colleagues

- SCC Public Health Team to work with education colleagues to ensure Personal, social, health and economic (PSHE) education is linked to commissioned sexual health services
- Sexual health training should be available for PSHE Leaders, PSHE teachers, pastoral leaders, Home school link workers and Designated Safeguarding Leads (DSL's)
- There should be a particular focus on training for school nurses and improving communications about sexual health services to this group
- Consider establishing a network of school nurses who can link with clinicians in the specialist service
- Ensure that SCC (Surrey County Council) Community Teams working with residents with learning disabilities can access up to date information and training on sexual health.

Key messages from our engagement

Through our engagement we heard about a number of key issues that should be addressed.

These are summarised here:

1. Addressing sexual health issues for young people specifically is really important to people in Surrey

This included questions around teenage pregnancies, access to services, the use of online services (including managing safeguarding concerns), communication about sexual health and sexual health services, and about relationship and sex education.

2. Having a Central Booking Office located outside of Surrey for the specialist sexual health service is universally unpopular with patients, specialist service staff and GPs/other healthcare professionals

Currently, the booking office is based in London. Staff at the booking office do not know Surrey geography and do not know the clinical staff or the needs of Surrey patients. At times it has led to patients being sent to inappropriate clinics.

3. The use of sexual health services outside of Surrey draws a wide range of opinions

Some GPs/healthcare professionals feel comfortable suggesting patients use sexual health services outside of Surrey. Others thought that this was not appropriate or meant hugely increased costs. Services are commissioned so that residents can chose the sexual health clinic most convenient to them, and commissioners work with providers outside of Surrey to reduce costs. There was also variation in what people define as 'local services', with professionals more likely to view 'local' services as those within Surrey and residents being less likely to focus on county boundaries. Understandably, this was particularly apparent in areas where there have been large sexual health clinics historically.

4. Teenage pregnancies remain a high area of concern, particularly in North West Surrey

Teenage Pregnancies are now lower than ever in Surrey, but inequalities remain, and Spelthorne still has the highest rates of teenage pregnancy in Surrey. The PHE Teenage Pregnancy Framework will be useful in identifying key areas for improvement on this. There is a perception that teenage pregnancy is linked to specialist clinic locations, but this view is not supported by research or local evidence. For example, teenage pregnancies have reduced in Spelthorne in recent years but have increased in Guildford.

5. GPs and other professionals are not always getting the information they need

Commissioners and providers regularly provide updates on sexual health services. But many GPs and other patient facing professionals do not always receive them. There are a number of potential 'blockages' in getting this information to the people who need it and there are recommendations for resolving this.

6. Some people require emergency contraception and urgent treatment for symptoms of Sexually Transmitted Infection on a repeated basis and there is a need to offer more support to these people in terms of prevention

Repeated need for urgent or emergency treatment for infections or contraception suggests that more health promotion, and preventative options and pathways may be needed. We heard that some key groups in Surrey, including sex workers and people who enjoy group sex, are currently not being reached fully by outreach/health promotion efforts.

7. There is felt to be a particularly high level of stigma attached to people living with HIV in Surrey.

People living with HIV prefer to make a distinction between HIV treatment services and sexual health services. Stigma affecting people living with HIV is therefore covered in more detail in the HIV needs assessment being completed by PHE and NHSE/I. It is noted here as this was a repeated theme in our engagement as well and warrants addressing as a concern.

Main Report

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How we carried out this needs assessment:

- This section explains how we carried out the needs assessment
- It outlines our engagement with residents and professionals

The following processes are carried out in assessing sexual health needs.[1] The first three processes are carried out continuously as part of the commissioning cycle. This report represents the results of the fourth and fifth processes below.

Process

1: **Current service provision review** - what services are available to Surrey residents and how do they use them?

2: '**Epidemiological' needs assessment** - what does the sexual health of people in Surrey look like? Which specific groups live in Surrey and what can be done to improve their sexual health?

3: **Stakeholder and public engagement** – what do people in Surrey think about sexual health in general, and about sexual health services?
(See below for more details)

4: **Synthesis and gap analysis** – based on 1-3 above, what is the overall picture of sexual health in Surrey and where are the gaps? This relates to commissioned services (including the specialist sexual health service) and wider system gaps.

5: **Recommendations** – recommendations fall into three categories:

1) Recommendations for commissioners/providers of the integrated sexual health service, including those to inform the specialist service specification
2) Recommendations for commissioners/providers of sexual health services outside of the integrated service
3) Recommendations for the whole of Surrey County Council and the wider system on how we can all work together to improve the sexual health of Surrey residents

[1] Methods are based on Sexual Health Needs Assessments (SHNA) A 'How to Guide' (2007), commissioned by the National Support Teams for Sexual Health and Teenage Pregnancy, under the Department of Health (DH).

Stakeholder and public engagement

We continuously engage with residents and system partners on our sexual health services. This engagement helped shape our questions for surveys and topics for discussion, in the engagement outlined below. Our communication plan is provided as Appendix D – Communications plan.

The resident and professional engagement for the needs assessment had several strands to it. A mixed methods approach was taken with quantitative surveys, and more in-depth follow ups (interviews/focus groups/discussion at key meetings) using qualitative methodology. The four broad groups engaged with were:

- Surrey residents
- Primary care colleagues
- Pharmacists
- Other professionals whose work has an impact on sexual health (e.g. school nurses).

The main method of engaging with these four groups was via an online survey using the Surrey Says platform. The surveys were open for four weeks (25th November to 23rd December 2020).

Resident engagement

Resident engagement was primarily online, including a survey hosted on the Surrey Says platform, due to the restrictions on face to face contact in place due to the COVID-19 pandemic. As well as being in English the survey was translated into three other languages commonly spoken in Surrey (Bengali, Urdu, and Polish). An easy read version (with simplified language and illustrations) and a plain text version were also created. These surveys were available as printed paper versions that could be posted out to residents upon request with a pre-paid envelope included so they could return the survey free of charge. The surveys were piloted with representatives from these communities. Where this was not possible, the professional opinion of colleagues working with the target community were sought. We also engaged with council members who provided us with useful local context and comments.

The survey was also distributed to target groups with the support of key partners (see full communications plan in Appendix D – Communications plan for more details). They were able to advise on the best way of engaging with a particular group and further promote the survey via their social media channels and other resident communications.

The resident engagement was conducted as part of an ongoing engagement process. Surrey County Council consistently seeks feedback from residents in various forms. The ongoing pandemic has meant that it was not possible to engage with some groups face to face, but we welcome any opportunity for this whenever this is possible.

Professional engagement

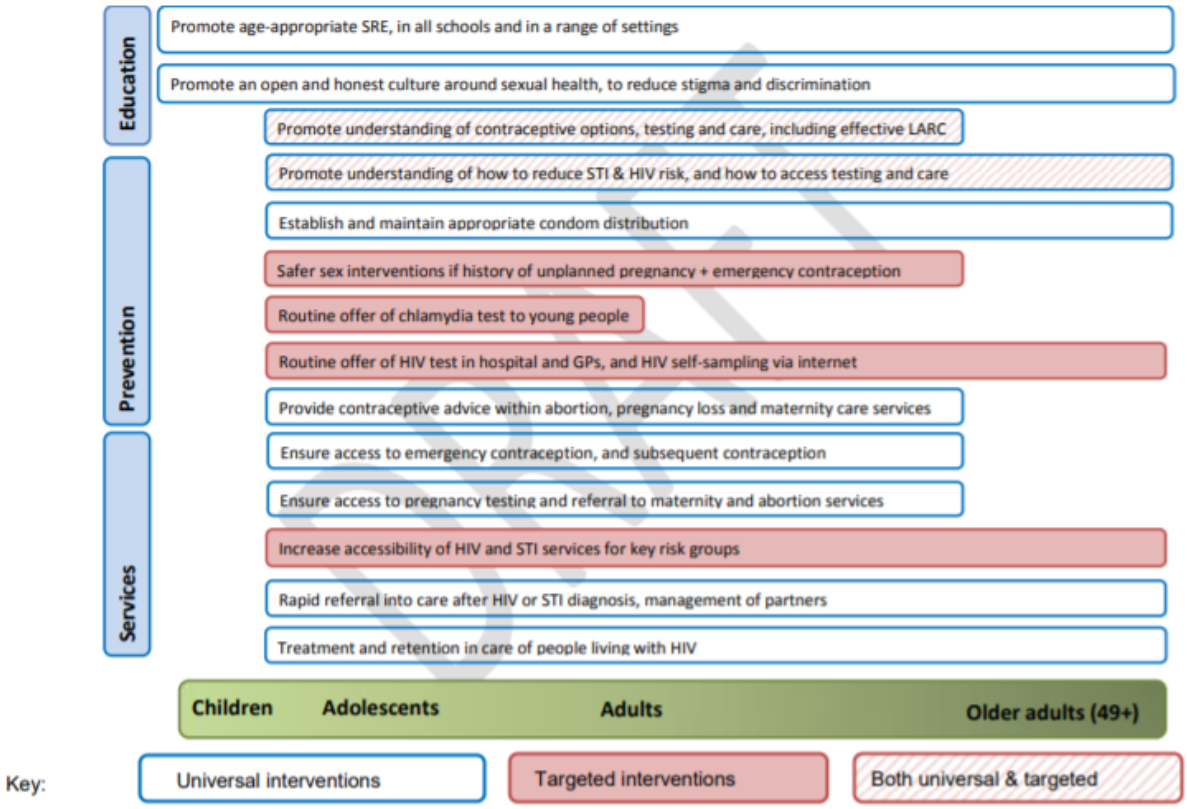
In addition to the surveys, we attended meetings with Clinical Commissioning Groups (CCGs) and Integrated Care Partnerships (ICPs), the Local Medical Committee and Local Pharmaceutical Committee. We held one to one interviews with clinical staff working in the specialist service and in primary care. We also heard from partners working in hospitals/secondary care (mainly by e-mail).

National drivers and context

- National guidance outlines that sexual health is dependent on a wide range of factors including education, prevention, and sexual health services
- Recommends more integrated commissioning, for example, around cervical cancer screening
- Outlines the national policies that led to the current service model

The most recent nationwide strategy/framework for sexual health was the Department of Health's Framework for Sexual Health in England (2013). In 2015 PHE published Health promotion for sexual and reproductive health and HIV: Strategic action plan, 2016 to 2019 which outlined the following key targeted and universal approaches to sexual health, as shown in Figure 1 below:

Figure 1 Targeted and universal approaches to promoting sexual health, source: PHE (Note that this remains 'Draft' in the PHE document)



The national 2013 framework and the 2015 PHE Strategic action plan both highlight that sexual health in a population is dependent on a variety of factors, requiring joint work by a number of organisations.

A national Service Specification for Integrated Sexual Health Services was published in 2018 by The Department of Health and Social Care (DHSC) and PHE. As shown in Figure 1, specialist sexual health services have an important role in the sexual health of the population, but they are intricately linked to wider structures and services. Local authorities currently hold commissioning responsibility for specialist sexual health services, with links to many of the agencies and settings which contribute to sexual health. This needs assessment aims to address many of the wider issues around sexual health. The results will inform the

commissioning of specialist sexual health services and will also form the basis of a Surrey-wide action plan to support and improve the sexual health of our population.

In June 2019, the Government published the results of a national Parliamentary Inquiry into Sexual Health Services in England. Its first recommendation to Parliament was to increase national funding to sexual health services following previous cuts to spending. This was echoed in much of our engagement, particularly with Surrey GPs:

> *Due to funding cuts- sexual health services have been reduced in too many areas, and general practice is struggling to cope with all the areas we cover. The population deserves to have better sexual health services, which are funded appropriately and easily accessible.* (Surrey GP)

It also recommended that commissioning arrangements were simplified as sexual health services are currently commissioned by, and provided in, multiple organisations and settings. It highlighted the complex commissioning arrangements of sexual health services in England, as described in Figure 2 below.

Figure 2 Commissioning arrangements for sexual health services in England[2], source: PHE

As an example of these complexities, a care pathway may require that a woman may need to:

- visit her GP to discuss contraception (covered under the General Medical Services contract commissioned by NHSE/I and CCGs)
- agree to a coil being fitted by a primary care practice nurse (commissioned by Surrey County Council)

[2] https://publichealthmatters.blog.gov.uk/2019/08/21/health-matters-preventing-stis/

- attend a more complex LARC appointment at the specialist sexual health service (also commissioned by Surrey County Council)
- have a cervical cancer screen or 'smear test' (commissioned by NHSE/I)

All of these services are simply 'NHS services' to most patients and it is important to work together to offer as seamless a service as possible. Our engagement highlighted an example where this is affecting patients:

> *I am told that women having a Mirena coil change at sexual health clinics in Surrey are not allowed to have a smear at the same time. That is shameful. Again, no doubt down to costs… but many women will just not want to undergo a further speculum examination and internal procedure and take their chances. Are women leaders making these decisions? If so, they should appreciate the sensitivities of this.* (Surrey GP)

Work is now under way between CNWL, NHSE/I and Surrey County Council to ensure women can have a cervical cancer screen in the specialist sexual health service.

We also heard through our engagement with Consultants in Genito-Urinary Medicine about other areas where care could be more integrated, such as improving pathways from maternity services to sexual health services to prevent babies being born with STI's such as syphilis.

The current Integrated Sexual Health and HIV Service in Surrey is an example of integrated commissioning between Surrey County Council and NHSE/I. In a recent White Paper on a new health and care bill there was no indication that commissioning of sexual health services would be moved from local authority public health teams. However, integrated commissioning is recommended throughout. To address some of the issues identified for residents, the first recommendation from this needs assessment is therefore:

Recommendation

- In addition to the integration of HIV and sexual health services, commissioners of all services should use every opportunity in the current integration agenda to improve pathways for patients. An example of this is current work between Surrey County Council and NHSE/I to provide cervical cancer screening in specialist sexual health clinics.

Attempts to improve access to sexual health services was a key policy driver in the 2001 national strategy for sexual health and HIV. This policy was largely responsible for the implementation of the following model of sexual health service provision in England:

Level 1 - care to be delivered by all primary care teams

Level 2 - the development within primary care trusts (PCTs) of primary care teams with a special interest in sexual health

Level 3 - specialist services such as Genito-Urinary Medicine and contraception in specialist/community clinics, plus abortion services[3]

This model remains largely in place in 2021. General (universal) contraception services are now included in the General Medical Services contract. LARC (coils and implants) are offered by primary care healthcare teams with the required additional skills (commissioned by local authorities). Universal sexual health services are also delivered by specialist services, along with services requiring consultant-led teams of specialist doctors and nurses. This leads to a complex interaction between ever increasing demands on primary care and the need for a

[3] https://sti.bmj.com/content/78/2/83

more specialist workforce able to offer more complex services for sexual health and HIV as well as emergency or ‘walk in’ appointments. Through our engagement we heard that both residents and professionals still missed the previous model, particularly having numerous, less specialised sexual health or ‘family planning’ clinics more geographically spread.

Service review

This includes the following services:

- Specialist sexual health clinics (face to face/telephone services)
- Online contraception and STI testing services
- Sexual health services provided in primary care
- Sexual health services provided in pharmacy
- Sexual health outreach activity (including the condom distribution scheme)

Sexual health services are not the only 'services' which influence sexual health and other areas, such as education, are included later in the assessment.

There are also a number of organisations not formally commissioned who are important in improving sexual health. These include charity or 'third sector' organisations who provide support for people who have specific issues related to sexual health. This type of support has changed enormously during the COVID-19 pandemic.

Engagement in this section includes:

- Engagement with the public (mainly through the 'Have Your Say' Survey)
- Patient feedback collected by CNWL on their services
- Engagement with wider partners (through the professional surveys/meetings)
- Engagement with CNWL staff – mainly through interviews due to small numbers – included clinical staff of all levels and non-clinical staff

Specialist Sexual Health Clinics

- This section outlines provision by the specialist Integrated Sexual Health and HIV Service in Surrey, currently provided by Central and North West London NHS Foundation Trust (CNWL).
- This describes the overall model used, including key changes since the service started

In April 2017, CNWL began delivering sexual health and HIV treatment and care services in Surrey following award of the contract in 2016. The integrated sexual health three-year contract awarded had the option to extend for up to two years without the need for a new procurement process. The service contract was extended for two years in April 2020.

The commissioned service is an Integrated Sexual Health and HIV service with a lead provider using a 'hub, spoke and outreach' model. The hubs are centrally located and offer a full range of services with complex level 3 service provision in addition to levels 1 and 2 at two sites and a level 1 and 2 service at a third hub. Spoke clinics offer contraception including implant fitting and removal, chlamydia/gonorrhoea screening and condom distribution.

The Outreach team distributes chlamydia/gonorrhoea testing kits to under 25 year olds but is not able to offer full STI testing kits in the same way due to the necessary information links to the laboratory, however they signpost other individuals to the appropriate clinics and on-line services instead. The outreach service delivers health promotion, the Surrey Chlamydia and Gonorrhoea screening programme for under-25s and the C-Card (condom distribution) Scheme. The service operates in partnership with other commissioned community sexual health support in Pharmacies, General Practice and the Third Sector and complements clinic-based work. It also offers training and awareness raising for young people and professionals.

A key aim of the service model is to ensure that appointments for those needing specialist, complex sexual health services are available from the specialist provider. Services not requiring a specialist doctor are provided by other professionals in the specialist service or elsewhere (such as primary care or pharmacy), or online where appropriate.

The specialist service provides:

- Urgent and routine contraception, long acting reversable contraception (LARC), STI and HIV appointments bookable via a Central Booking Office
- Fixed hours walk-in clinics for urgent and routine contraception and STI testing and treatment
- Online STI testing and contraception services

Note that urgent walk-in services are available any time during opening hours at Earnsdale (Redhill) and Buryfields (Guildford) for emergency contraception, Post-Exposure Prophylaxis (PEP) for HIV (which prevents people becoming infected if taken soon after unprotected sex), those who have experienced sexual assault, those who are under-18 and people in pain. Some urgent services are also available in Woking, but these are dependent on which clinicians are currently in the clinic (not all clinicians are able to prescribe PEP for example).

Urgent Care versus Routine Care

The requirements, needs and demands for urgent sexual health care (for example, for symptoms of STIs) are very different than those for routine care (for example, for a routine appointment for oral contraceptives).

In the main hubs, the specialist service offers walk-in appointments for *all* services including for routine contraception. Through our engagement we heard different views on how services should be organised.

In our attendance at Primary Care ICP meetings we heard that STI diagnosis and treatment and access to emergency coil appointments, were particularly important as these were generally beyond the scope of a GP.

In our primary care survey, appointment availability for STI diagnosis and treatment was the biggest concern for GPs and practice staff; 64 out of 81 respondents selected this as a ‘main concern’. This was not limited to issues with access to appointments but also to requests for more support:

> *Access to timely advice and support for STI. Access to rapid emergency contraception (copper coil).* (Surrey GP)

The below Table 1 highlights the type of situations where urgent care in a walk-in clinic may be *required:*

Table 1 – Situations where urgent care walk-in may be required

Urgent testing and treatment for potential sexually transmitted infection People with symptoms after having sex without a condom with someone with an infection
People who have had sex with someone known to have a Sexually Transmitted Infection (STI) e.g. someone who was contacted through the service's partner notification service
People requiring Emergency Post Exposure Prophylaxis (PEP) This is emergency treatment for people who are likely to have been exposed to HIV (this can have severe side effects and should not be used routinely)
Urgent contraception People who have had sex without effective contraception and who have not taken emergency contraception orally (the 'morning after pill') and require a coil to be fitted within 5 days to prevent pregnancy
Urgent issues with routine contraception Someone requiring a specialist clinician for urgent issues with an Inter-uterine Device or 'coil'

It would be unusual for individual patients to require repeated urgent face-to-face appointments. Where there are repeated Sexually Transmitted Infections, more intense prevention work would be needed to encourage safer sex. Through our engagement we heard that Health Advisors were previously available in some clinics:

> *In the past Health Advisers fulfilled that role and I understand they have mostly been made redundant so I wonder if there is good evidence of appropriate support and continuing care for the most vulnerable.* (Secondary care clinician, by e-mail)

Health Advisors were able to give advice and support on safer sex practices for vulnerable patients who frequently required urgent treatment. Previously health advisors occupied valuable clinical space in the hubs which could have been used for patients with more complex clinical needs but recent changes to working practices has shown that health advisors could work remotely by telephone and video conferencing to maximise clinical space.

Staff in the specialist service explained that sometimes people using the walk-in service for more simple requests (such as routine contraception) meant that these clinics became full very quickly. This can lead to specialist clinical staff seeing people who could use the online service or obtain simple contraception prescriptions in the spoke clinics or in primary care.

Our engagement with school nurses suggests there is an expectation that out-of-hours, walk in services should be available across Surrey for all appointments:

> *The lack of easy access walk-in sexual health clinics after school is negatively impacting YP ability to access high quality and timely sexual health advice and treatment. (School nurse, General Professional Survey)*

Again, there is a need to separate 'treatment' (usually of STIs using antimicrobials) and 'advice'. It is acknowledged that Surrey-wide provision of walk-in, out of hours clinics for all services would be viewed as the ideal situation with unlimited resources. Whilst financial constraints place limits on this, there are also limits to this in terms of specialist clinicians (and in some cases clinical space). There is a need to work with both residents and professionals in clarifying this request. There was wide variation in opinions on availability of sexual health services in Surrey. For example, there was feedback from residents, primary care colleagues and other professionals who were satisfied with the provision in Surrey:

*I think there are amazing services out there it is just making young people aware of them (*Youth Offending Nurse, Surrey)

I usually signpost my patients to the Earnsdale clinic in Surrey and found it very accessible. (Surrey GP)

Satisfaction with location of clinics is naturally dependent on how close people are to the nearest clinic. The qualitative feedback received from primary care and other professionals was more weighted towards negative comments when discussing accessibility of appointments (both in terms of location and appointment availability). However, a proportion of these highlighted issues with communication around clinic availability. This is outlined in more detail below in a separate section on communications.

Recommendations

- Commissioners to consider the inclusion of Health Advisors in the specification for the specialist sexual health service – these could work remotely by telephone to maximise clinical space
- Communications with patients and professionals should be improved to highlight the different options for obtaining less complex care, such as the online contraception service.

Hub Clinical Services

CNWL deliver services from three Clinical Hubs:

- Buryfields Clinic (Guildford): GUM, contraception and HIV services (Walk-in available)
- Earnsdale Clinic (Redhill): GUM, contraception and HIV services (Walk-in available)
- Woking Community Hospital: GUM and contraception (appointment only)

Spoke Clinical Services

- Leatherhead Hospital (appointment only)
- Epsom Clinic (appointment only)
- North West Surrey (Runnymede and Staines) service (see below)

Spoke clinics offer contraception including implant fitting and removal, chlamydia/gonorrhoea screening and condom distribution (see Table 2).

At time of writing, a new spoke clinic location in North West Surrey for young people is being located. As shown below, attendance at Epsom and Leatherhead is generally good and has remained stable. Specific issues with spoke clinics in North West Surrey are explored in more detail in the 'North West Surrey ICP' section in Appendix A – provision by ICP/CCG area.

Table 2 – Number of appointments by clinic location

Location	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Total (n)
Epsom	39	38	9	45	26	32	49	34	26	38	37	30	403
Leatherhead	45	23	29	49	25	36	19	22	39	31	28	20	366
Runnymede	2	5	3	4	2	3	4	2	4	0	0	0	29
Staines	1	4	7	4	9	5	2	5	0	0	0	0	37

Services for Young People

The specialist service run clinics specifically for young people. A young person's session at Earnsdale clinic was being piloted and was starting to show success but closed due to the COVID-19 pandemic. Young people can go to any sexual health service and either book an appointment or walk-in depending on what the service offers and what they need. Under 18-year-olds can walk into any service during opening hours. As well as emergency contraception, specific services for under 25s include chlamydia and gonorrhoea screening, chlamydia treatment and condom distribution (c-card) scheme. Chlamydia treatment is a service for all patients requiring chlamydia treatment, it is not restricted to those under 25.

Specialist Service Outreach Team

'Outreach' is the term used to describe the delivery of sexual health services and health promotion which takes place in community settings and delivered by CNWL. This includes chlamydia and gonorrhoea screening for people under-25 and the C-Card (condom distribution) scheme for young people. The Outreach service is designed to target those most in need, either because they are at high-risk of sexual ill health or unintended pregnancy or less likely to use mainstream sexual health services. Reducing health inequalities and improving sexual health outcomes is a key aim of outreach services. CNWL are currently commissioned to work with the following priority populations who are disproportionately affected by sexual ill health or unintended pregnancies:

- Young people under 25
- Black and Minority Ethnic communities
- Sex Workers
- Men who have sex with men (MSM)
- People with disabilities
- Those engaged in ChemSex (sexual activity engaged in while under the influence of stimulant drugs such as methamphetamine or mephedrone, typically involving several participants)
- Transgender communities.

There are three members of staff in the Outreach Team which includes a targeted worker for men who have sex with men and a targeted worker for female sex workers.

The Outreach Team also provide training sessions for staff working with young people in Surrey. The sessions promote the sexual health and wellbeing of Surrey young people and equip those working with them with the knowledge, skills and tools to develop resilience & respect and to promote consensual healthy and safe sexual relationships.

Our engagement with residents has shown that there are a number of groups, in particular under 18s, who are unaware of the range of sexual health services available. Responses to our survey from school nurses showed that in general they are aware of services but raised the issue of access to services.

> *Clear guidelines to follow from our service. I know where to direct/signpost students to so that they can access the services that they need. The problems are in them being able to get to these services because they are limited. (School Nurse, General Professional Survey)*

There are also key vulnerable groups which may not be covered by the outreach team currently:

> *I work with young asylum seekers and refugees. They often arrive in the UK without having any previous sex education. They often come from backgrounds with diverse cultural norms and this can impact on their understanding of healthy relationships. Sex and sexual health can be a difficult topic for them to speak openly about. (Youth Worker, General Professional Survey)*

Outreach is a standing agenda item at contract meetings and in operational meetings. Monitoring outreach activity is complex as simple numbers of contacts gives little indication of outcomes, and outcomes themselves are more difficult to quantify. However, the commissioning of the specialist service should include clearer measures for the outreach service, to be brought to the quarterly contract meetings.

Recommendations

- Ensure priority groups for specialist outreach are appropriate and regularly reviewed
- Include clear performance measures for the outreach team and include the review of these in contract meetings
- Clear outreach plan on targeting priority groups and a way of demonstrating progress
- Regular sexual health training for staff who work with young people is valued and should be included in outcome measures
- There should be a particular focus for school nurses on improving communications about sexual health services and sexual health promotion materials

Safeguarding/Prioritisation of Vulnerable Groups

The sexual health service has an identified senior clinician who leads on issues regarding safeguarding for both young people and adults. The work of the safeguarding lead and the team she has supporting her across CNWL has grown due to the level of support being offered and also the level of referrals being made. Patients are routinely asked about domestic abuse, sexual abuse and other harmful behaviours they may be facing as a way of enabling patients to disclose issues of concern to their clinician in a trusting and safe environment. Staff within the specialist service currently receive between 7-10 direct disclosure per month in addition to the referrals they receive from other organisations in respect of sexual assault/violence. Patients have reported confidence in the service being offered and that they feel it is a 'safe space' should they need to discuss or disclose safeguarding issues.

Recommendations

- All staff to receive regular awareness training and support to ensure they are confident in the identification and reporting of safeguarding concerns
- Develop a proposal to include a Surrey specific Independent Domestic and Sexual Violence Advocate (IDSVA) as part of the support being offered to victims.

'Get it On' Condom Distribution (C-Card)

The 'Get it On' Condom Distribution (C-Card) Scheme is a free and confidential condom distribution network for young people aged 13–24 years old. The scheme provides regular, easy and confidential access to condoms, contraceptive & sexual health information, and signposting to sexual health services in places young people already access such as youth centres or colleges.

The Outreach Team provides safeguarding training to staff who distribute condoms. Distribution points return monitoring data to the Outreach Team (see Table 3).

Table 3 – Condom distribution by year

YEAR	TOTAL DISTRIBUTIONS	TOTAL CONDOMS DISTRIBUTED
2017/18	**345**	**2907**
2018/19	**387**	**3597**
2019/20	**228**	**2271**

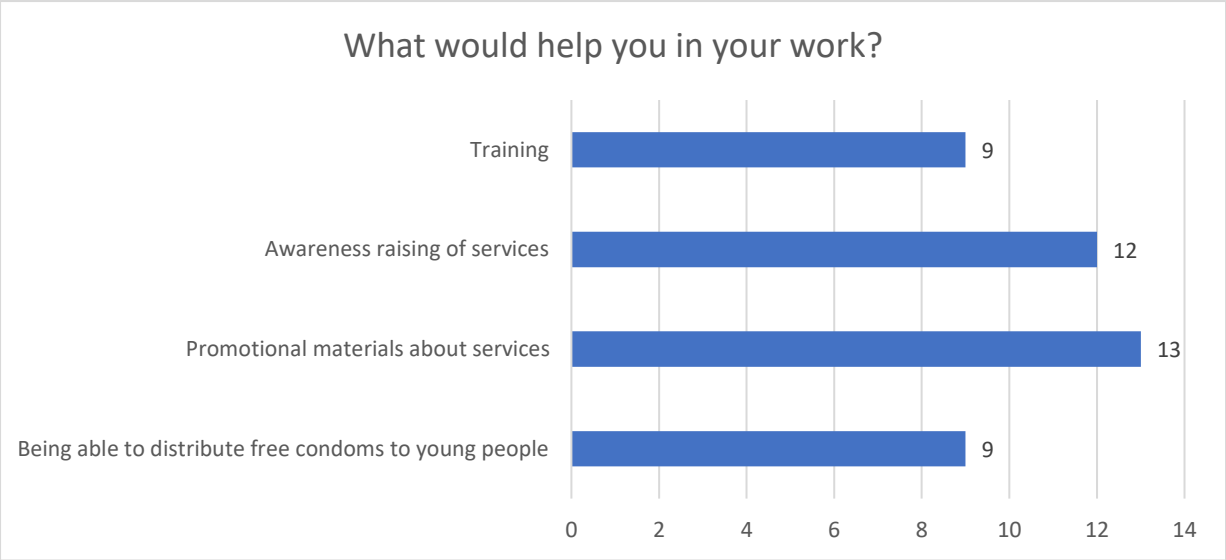
The data above shows the total amount of distributions made to young people. This data is reliant on services providing the scheme to return their activity records to the Outreach Team. Many services who were providing the scheme in the community have gone through re-organisation and this has caused issues with data collection. Covid-19 has also created gaps in data being returned.

Monitoring of the condom distribution schemes is currently challenging for commissioners. Condoms are the best way to prevent STIs for anyone having sex outside of monogamous relationships. They are also a crucial factor in preventing unwanted pregnancy and easily

distributed to young people without the need for clinical appointments. A review of monitoring and distribution of condoms in Surrey is recommended.

Our survey of General Professionals (including school nurses and youth workers) also highlighted the need to improve condom availability. When asked about what would help in their work, nine respondents said they would like to be able to distribute free condoms to young people, as shown in Figure 3 below.

Figure 3 – Responses from professionals on support needed in their work



COVID-19 has affected the ability to distribute condoms but has also reduced sexual contact in general due to social distancing. The easing of restrictions means that sexual contact is likely to increase. Commissioners have funded an extensive purchase of condoms and educational materials in expectance of this and are working with the specialist provider to ensure education and distribution is co-ordinated with the easing of restrictions.

Recommendations:

- Undertake a review of condom distribution scheme in Surrey. This should include:
  - Consideration of an online scheme which could reduce paperwork and improve data returns
  - Consideration of venues and locations of c-card distribution points

Sexual Health Outreach Group (SHOG)

The Sexual Health Outreach Group (SHOG) enables representatives from our target groups and those working with people who use sexual health services to meet quarterly. This provides the opportunity for updates on sexual health services (Specialist service provision, Pharmacies and GPs) to be discussed. It is also an opportunity for those representatives to feedback on the needs of the priority groups they work with and share good practice. Through the SHOG, we strengthen the partnerships between our sexual health providers and our local community providers to ensure that we are giving out consistent sexual health information across Surrey. Membership is regularly reviewed to ensure priority groups are represented.

COVID-19 has changed the way many of the groups attending the SHOG meet. With little face to face contact, many groups may have lost contact with some members, or gained more through virtual meetings. These challenges and opportunities should be reviewed once face to face contact resumes. SHOG meetings may continue online to maximise attendance.

Recommendation:

- The SHOG should review challenges and opportunities since online communications have become more common

Communications and Sexual Health Promotion

Communications about changes to specialist service provision, and health promotion materials (particularly for younger people) were a common theme in our engagement. Surrey County Council works closely with the specialist provider to ensure that the Healthy Surrey website is up to date, and that key changes are sent out in briefings to primary care and other key partners. However, our engagement has shown us that GPs and nurses in primary care do not always receive the information sent or find that they receive so many communications about changes (across all services) that identifying key information can be challenging. This may require a more targeted approach for specific locations. CNWL has a dedicated comms team which aims to cover London, Milton Keynes and Surrey but there is a perception that comms tend to be London-focussed. The responsibility for communications in the specialist service in Surrey should not fall to service managers/service leads in Surrey as these roles require a different and important skill set. Importantly, Surrey and London have very different geographies, demographics and service provision and Surrey communications should reflect that.

Key feedback on communications from our engagement:

Public engagement:

- There were several comments requesting more information on services available - the Healthy Surrey website is kept up to date, but it is evident that not all residents are aware of this:

It would be helpful to be given a list of places people can go or just make people aware of the possible places people can go to get help (Under 18 Resident)

From GP/ICP feedback

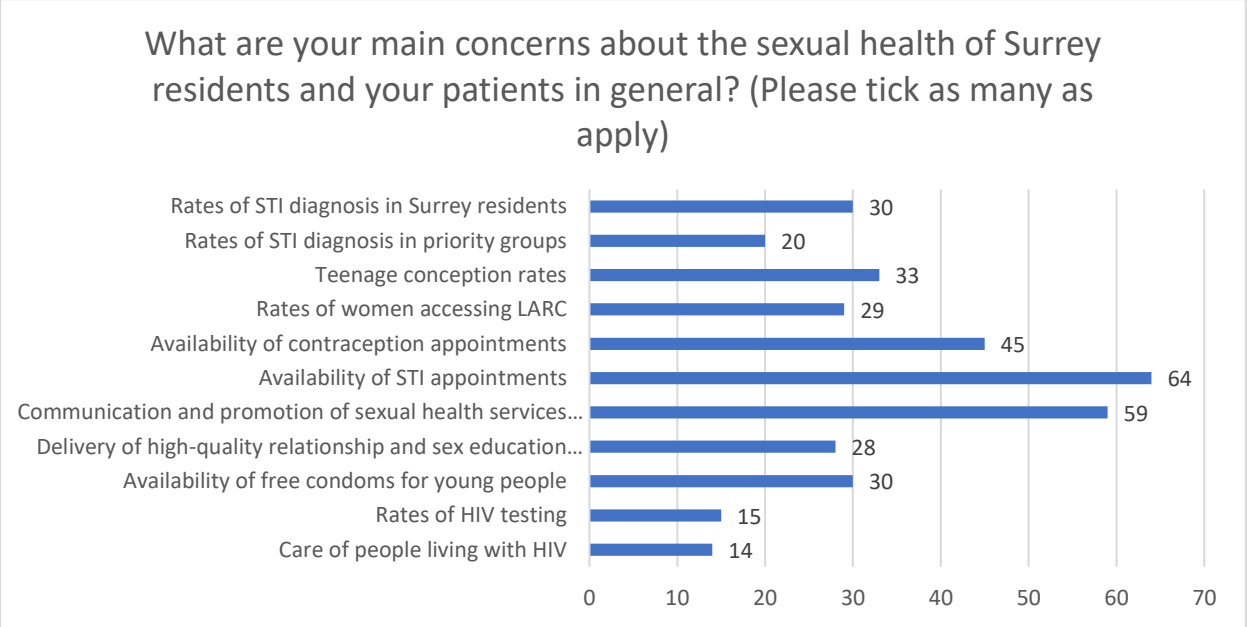
- Explore best ways of helping health professionals be aware of what services are available and how residents should use services
- Promote the range of services available in Surrey more widely
- Work with specialist sexual health provider to ensure provider website is clear, up to date and user friendly
- Working with ICPs (Integrated Care Partnerships) to ensure sexual health service information is available on GP practice websites (e.g. ‘Footfall’)
- Ensure all young people promotional materials are tested with young people
- Specialist sexual health service communications need to be delivered locally

We should be using 'Footfall' [GP website system] for promoting sexual health service so patients can be directed to service rather than going to GP (Surrey Downs ICP meeting)

Whilst Sexual Health Clinic info is available online - updates on service provision by CNWL direct to GPs is often lacking, or lost amongst the myriad of other correspondence that GPs receive… I recently found out from a colleague that there is a separate referral pathway/form for complex coil issues. (GP Survey)

When primary care colleagues were asked about their main concerns about the sexual health for Surrey residents, communication and promotion of sexual health services was the second most common concern, as shown in Table 4.

Table 4 – Primary care concerns about sexual health services



Recommendations:

- Sexual health commissioners should work with partners in CCGs/ICPs to identify the most effective way of delivering information on service changes - this may involve short, key messages specific to each ICP and the use of 'Footfall'
- Ensuring key information sent by the specialist service reaches GPs and nurses in practice remains a challenge and a task and finish group is recommended to address this (including CCGs and GPs)
- Sexual health promotion should be Surrey specific, particularly for young people (see also later in this report)
- Specialist providers should have a communications lead, with specific communications experience, dedicated to Surrey for at least part of their role

Contract Management

Joint quarterly contract meetings are held between SCC, NHS England and CNWL. More frequent operational meetings are held between commissioners and the specialist service provider.

Performance of the contract is monitored through a series of key performance indicators (KPIs) as detailed in the service specifications and reviewed at the quarterly meetings. Several KPIs are set nationally by the Department of Health, and these are in line with the public health outcome framework whilst others are set locally to reflect local priorities. Since

the current service specification was developed a new national service specification for Integrated Sexual Health Services has been published. This will specify many of the performance indicators for the procurement of the specialist sexual health service in Surrey. This needs assessment will add key local context and locally developed recommendations for the service specification.

In addition, sexual health services are monitored by two national datasets 'GUMCAD' (Genitourinary medicine activity dataset) is the dataset for STI testing and treatment, and 'SHRAD' (Sexual health and reproductive activity dataset) is the dataset for contraception. The contract meetings provide a formal opportunity to raise any key issues, provide updates and interrogate the data.

Commissioners in Surrey use local sexual health data, national recommendations and our continuous engagement processes to identify important indicators during contract meetings. Examples of three key indicators are outlined below:

STI test results within 7 days

Why? Our engagement tells us that receiving test results within 7 days is important to service users.

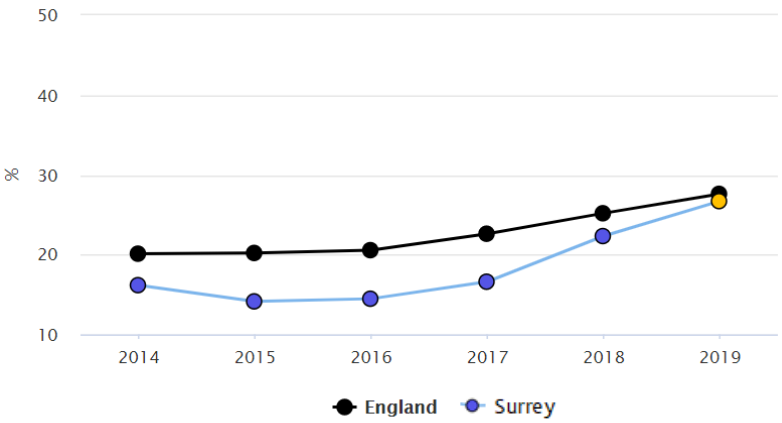
Performance - Consistently at 99-100%

Long Acting Reversible Contraception in under 25s

Why? Important in preventing unwanted pregnancies – see box below

Performance – steady improvement since 2016. A monthly figure is reported at the quarterly contract meetings but due to monthly variation the annual figure is more reliable as shown in Figure 4 below:

Figure 4 - Under 25s choosing LARC (excluding injections) at Sexual Health Services (%), Source: PHE Fingertips



Long Acting Reversible Contraception ('LARC')

In 2019, Surrey County Council reviewed its LARC provision. A summary is provided here:

LARC is provided by CNWL at their three clinical hubs: Buryfields Clinic (Guildford), Earnsdale Clinic (Redhill) and Woking Clinic, and patients can book appointments online or by phone.

Intra-uterine contraception and contraceptive implants are inserted and removed at CNWL clinics by specialist nurses, whereas complex LARC needs to be carried out by a Consultant/Specialist Doctor in Sexual and Reproductive Health. Surrey County Council also funds any Surrey resident's visit to their closest/preferred specialist sexual health services outside of Surrey.

'Complex' LARC

- Removal of a deep or impalpable implant
- Removal of implants not licensed in the UK
- IUD/IUS removal where there are missing threads or a previous attempt at removal has failed
- IUD/IUS insertion in the presence of anatomical abnormality or in the presence of complicating medical conditions

LARC is also provided in primary care, under 'Public Health Agreements'. This is carried out by clinicians (usually specialist nurses) with additional training to provide this (excluding more complex procedures as above). During engagement for the 2019 LARC review, primary care colleagues were asked about LARC provision in Surrey via both a survey and by attending primary care group meetings in each of the 5 Surrey CCGs (Clinical Commissioning Groups) at the time. Key results:

- The most frequently cited reason for difficulties with access was the long waiting time at CNWL sexual health clinics (54%)
- 45% thought that the travel time to a CNWL clinic was contributing to access difficulties.
- 43% of respondents thought that the waiting time for an appointment in primary care was contributing to lower than expected uptake.
- 9% thought that the travel time to a buddy clinic was problematic.

Work has continued on these issues since the review and the number of under 25s choosing LARC at the specialist clinic is improving. However, this is a separate issue to the perceived availability of LARC appointments at specialist clinics.

GP Survey Results

Access to appointments for LARC remains an issue. This is linked to other sections (such as the availability of walk-in appointments for all services, and the increased use of online services for less complex appointments). Learning from improved triage procedures during COVID-19 could be explored to increase access to more complex/specialist services.

Recommendation:

- Continue to review availability of LARC appointments in conjunction with other appointments, particularly considering increased use of telephone triage/online services for less complex appointments in the specialist service.

Proportion of 15-24 year olds screened for chlamydia infection

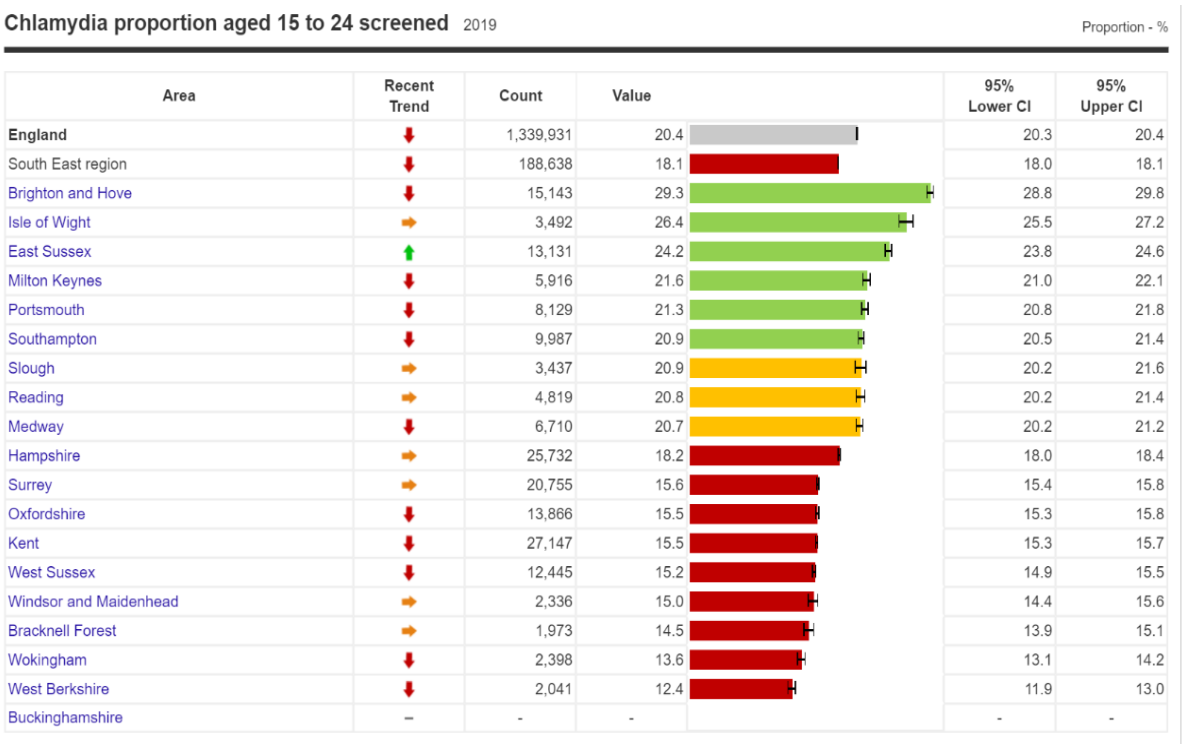
Why: Important to identify for prompt treatment and to prevent spread as chlamydia usually causes no symptoms

Performance: This tends to be higher in more deprived areas (as more people attend sexual health services for infections causing symptoms). Surrey compares well to other less deprived areas in the South East but is below the South East average. Numbers of people offered, tested and diagnosing positive for Chlamydia are provided monthly, broken down into under 25s and all ages in Table 5. As with attendance for contraception appointments, screening varies across the year so an annual average is taken.

Table 5 - Chlamydia testing in under 25s in Surrey

CT	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Offered <25	1004	951	877	1174	932	871	964	840	777	1031	677	517
Tested <25	604	604	587	725	581	551	631	512	455	644	384	296
Diagnosed <25	49	42	48	61	46	39	53	48	40	49	41	24

Figure 5 - Proportion of population aged 15 to 24 screened for chlamydia, source PHE



Chlamydia proportion aged 15 to 24 screened 2019 — Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	1,339,931	20.4	20.3	20.4
South East region	↓	188,638	18.1	18.0	18.1
Brighton and Hove	↓	15,143	29.3	28.8	29.8
Isle of Wight	→	3,492	26.4	25.5	27.2
East Sussex	↑	13,131	24.2	23.8	24.6
Milton Keynes	↓	5,916	21.6	21.0	22.1
Portsmouth	↓	8,129	21.3	20.8	21.8
Southampton	↓	9,987	20.9	20.5	21.4
Slough	→	3,437	20.9	20.2	21.6
Reading	→	4,819	20.8	20.2	21.4
Medway	↓	6,710	20.7	20.2	21.2
Hampshire	→	25,732	18.2	18.0	18.4
Surrey	→	20,755	15.6	15.4	15.8
Oxfordshire	↓	13,866	15.5	15.3	15.8
Kent	↓	27,147	15.5	15.3	15.7
West Sussex	↓	12,445	15.2	14.9	15.5
Windsor and Maidenhead	→	2,336	15.0	14.4	15.6
Bracknell Forest	→	1,973	14.5	13.9	15.1
Wokingham	↓	2,398	13.6	13.1	14.2
West Berkshire	↓	2,041	12.4	11.9	13.0
Buckinghamshire	–	-	-	-	-

Increasing the availability and uptake of chlamydia screening and diagnosis across system partners remains a key priority in Surrey as long term complications can be caused if the infection is left untreated, particularly in women.

Recommendation:

- Commissioners and providers to identify areas/methods for improvement of chlamydia screening (particularly in under 25s)

Overview and scrutiny of service

During engagement following mobilisation of the current service, a number of improvements were suggested. Commissioners and providers were invited to update the Adult and Health Select Committee in July 2017, September 2017, April 2018 and January 2020. In response to feedback, a Continuous Improvement Plan was developed. Progress on this was reported at the Surrey Adult and Health Select Committee January 2020 meeting where commissioners and providers were happy to respond to questions from council members, Healthwatch and other members of the committee. The only recommendation from this meeting was "*For the Director of Public Health to circulate pathways and flow charts provided to GPs as guidance on sexual health protocol*" which was carried out.

Patient feedback for the specialist service

The specialist sexual health provider routinely collects patient feedback on the services they provide and is one of the quality indicators within the service specification. The service values patient feedback and uses it to inform and improve services. Feedback in the form of compliments and complaints from Surrey patients is shared with CNWL sexual health managers for consideration and action. A summary is also shared with commissioners. The service actively collects feedback regularly from patients attending the service and those accessing online services. Themes are discussed, learning shared at the internal CNWL Quality and Assurance Group, and changes implemented where appropriate.

Mechanisms for collecting patient feedback include:

- Comments cards in clinics
- Quarterly patient survey, incorporating the NHS Friends and Family Test
- CNWL Patient Support Service – formal and informal concerns, complaints and compliments
- Patient engagement events
- Feedback via the 'Healthy Surrey' website (by Surrey County Council)
- Mystery shopping
- Feedback from partners and stakeholders
- Use of social media
- Feedback from www.nhs.uk reviews and ratings
- Feedback from Care Opinion www.careopinion.org.uk/

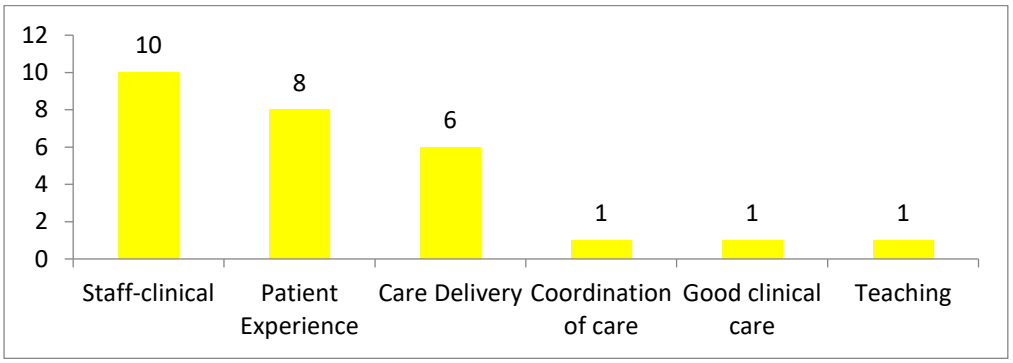
During the COVID-19 pandemic, collection of service user feedback was affected by the reduction of face to face clinics, however, the specialist service explored alternative methods of collecting service user feedback to ensure this important focus was not lost.

Example of specialist service feedback:

In the period of 1 September 2019 to 1 September 2020, 69 patient feedback submissions were received. This comprised of patient compliments (64%), comments (21%), concerns (10%), complaints (5%) and general enquiries (1%) (figures have been rounded up to the nearest whole number).

Most of the compliments received were prior to March 2020 before the COVID – 19 pandemic. 37% (26) of the compliments detailed good experience with clinical staff. These are further broken down in figure 6 below:

Figure 6 - Breakdown of compliments received as part of patient feedback



Patients raised a number of different concerns. 21 of the 26 concerns raised were prior to the COVID-19 pandemic. These related to a variety of issues, such as communication with patients (n=4), patient expectations not being met (n=3), unable to make an appointment (n=3) and delay in making an appointment (long waiting lists) (n=2). Those concerns raised during the pandemic period related to service expectations and comments about staff.

Some of these concerns were echoed in the feedback obtained in the resident survey:

Hard to book an appointment at sexual health centres to see someone specific if needed.

Walk in times too early in the day/limited in the evenings.

Sexual health clinic was overcrowded and lacked privacy. I left after waiting over an hour.

Patients also provided feedback on their experiences (see Figure 7 below). The feedback showed that patients viewed staff in the clinic (from reception staff to clinical staff at all levels) in very high regard and were very pleased with the service they received. They were made to feel welcome and comfortable and the service delivered was non-judgemental.

Figure 7 - a selection of patient feedback

The staff were amazing support and help today. After coming in for an Implant Removal after weeks of discomfort they not only helped me get a coil fitted but also ensured my Implant removal happened so that I left with the right solution and much happier. Thanks Ladies - February 2020

Dr is a wonderful doctor. She is calm, professional, friendly, polite and attentive. I felt at ease and calm in her presence, she is also informative - February 2020

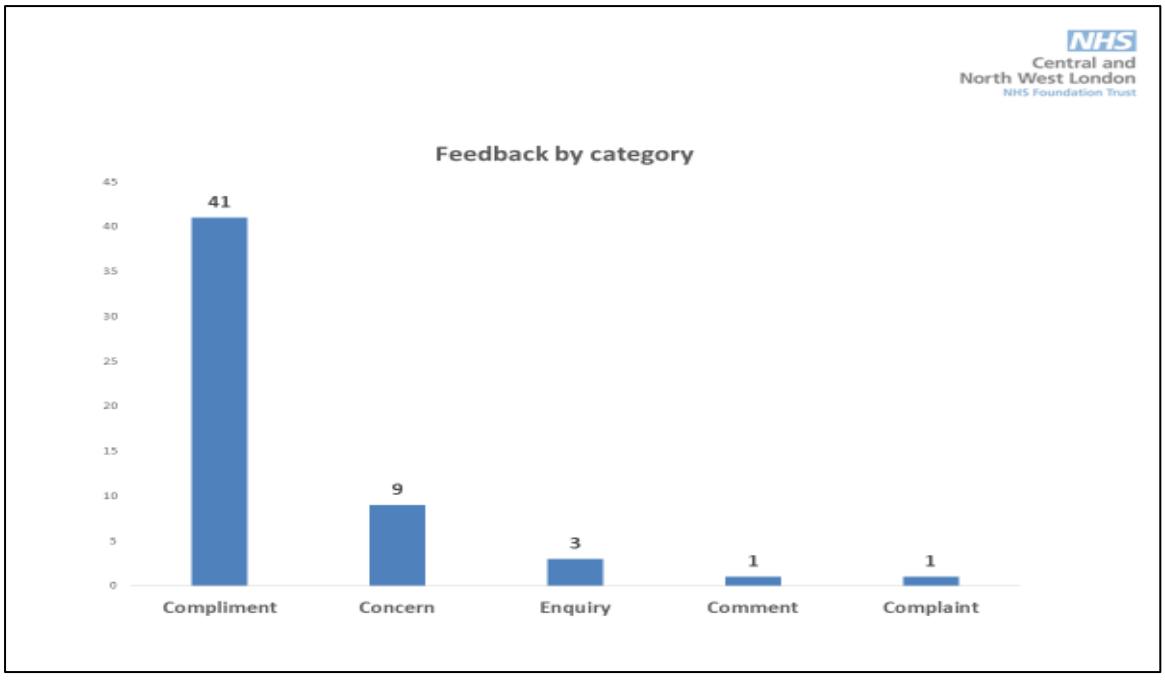
The online contraception has been a god send during COVID. I just wanted to say a BIG THANK YOU to you both for your hard work in keeping this working so well - Sept 2020

The team at Buryfields are amazing! Such a friendly, happy and professional team of people, and it is obvious they are a team! Appointments for me have always been on time. They make you feel like an individual not a number and I have never felt judged.

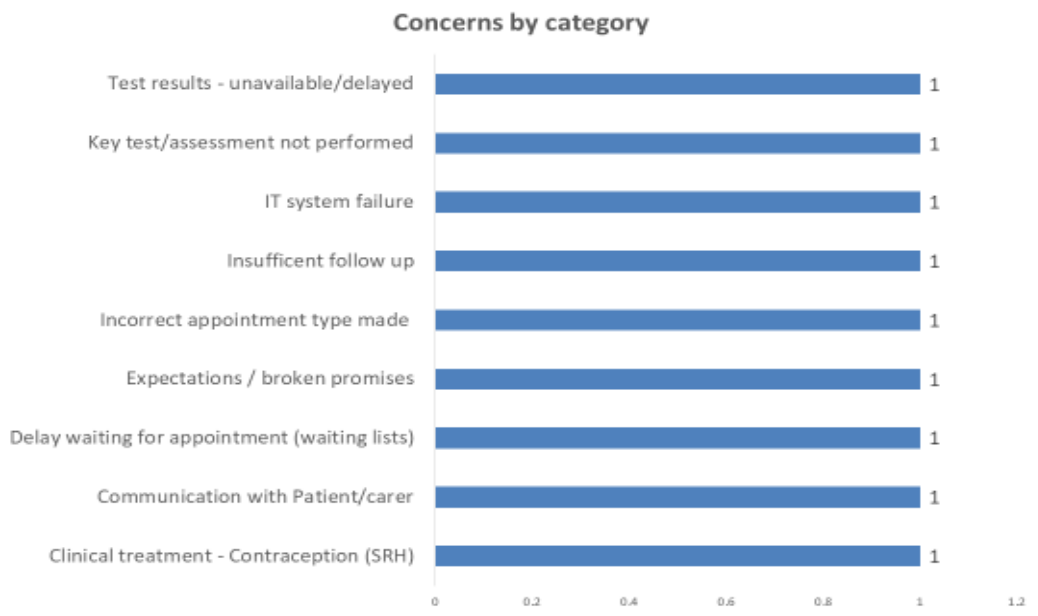
Patient feedback is also reviewed quarterly, as part of the quarterly contracts meetings. Below in

Figure 8 are examples of how patient feedback was reviewed in the contract meeting covering 1st October 2020 to 1st January 2021:

Figure 8 - Quarterly patient feedback



NHS
Central and
North West London
NHS Foundation Trust



Examples of compliments

thank you for looking after me so well and making an unpleasant experience as painless as possible.

You really are an important part of my care, medication and testing on their own is nothing without the human touch you provide.

Receptionist were lovely. Nurse was welcoming and gentle, made me feel very comfortable and safe. Procedure was very quick and genuinely painless. HCSW kept me smiling, and was great support - Thank you ;)

Buryfields clinic, Thank you for being so compassionate, accommodating & 100% non-judgemental.

I saw the band 6 nurse today and she was so lovely and helpful, really calmed me down and was so informative.

Really lovely staff - Band 6 nurse really put me at ease and was very helpful and informative.

Efficient and friendly service. I cannot fault anything and thank the duty staff from the Welcome to consultation and aftercare. Senior Nurse and HCSW are a credit to your team.

NHS
Central and
North West London
NHS Foundation Trust

1 x Complaint
Patient complained about content of text message sent from Surrey Sexual Health service, on behalf of Surrey County Council who were seeking views from HIV patients.

Our response: One of the key lessons learned is that should the views of patients be sought in future by external organisations we will not text patient and instead we will put up posters up in clinics, add messages on our website and invite patients to give feedback when they visit the clinic or have a telephone consultation.

1 x Comment
Patient submitted a comment detailing difficulty in making an appointment via the central booking line.

Action: Admin staff from Surrey contacted the patient and booked a face to face appointment, this issue was highlighted to the central booking line supervisor to share the patient experience with staff.

Online services

As part of the new service model CNWL introduced online STI testing for those aged 18 and over in April 2018 and in May 2019 an online contraception service was also launched. When the specialist service was re-procured, the tender asked for modernisation of the service using emerging technologies. The aim of the online services is to make it more convenient for the user and to increase accessibility across Surrey. In the 2015 local sexual health needs assessment (SHNA), residents identified the need for an online offer as a mode of delivery for sexual health[4].

Surrey residents benefited from being the first service in the South East region to have both online contraception and Sexually Transmitted Infection (STI) testing established before the advent of COVID-19. But online services, and online engagement, are not the best for everyone. Clinicians and other professionals working with vulnerable groups have had to work in a very different way to ensure safeguarding concerns are identified and acted upon.

What is an 'online' service?
Online provision includes:

- Online home screening (for over 18 year olds); including self-tests for HIV, syphilis, gonorrhoea and chlamydia.
- Online Contraception; including the progestogen-only pill (POP) and repeat contraceptive pills for existing patients
- Chlamydia and gonorrhoea self-test kits for under 25s

Online services provided from Surrey are only available to Surrey residents due to postcode restrictions being in place during the ordering process.

How do online services work?

- Online STI screening
    - A Surrey resident orders an online STI screening test from www.sexualhealth.cnwl.nhs.uk
    - The test kit is sent via the post to the address stated on the order.
    - Patient undertakes the tests at home and sends the samples back via the post directly to the lab
    - The patient is informed by the laboratory via text that the kit has been received or if the kit is not returned within 14 days of despatch, a text message reminder is sent.
    - A negative test result is sent to the patient via text message
    - If results are positive, the patient will be called by the CNWL results team and treatment and partner notification will be arranged. Medication may be posted to the patient or an appointment will be made (often within 24 hours).
    - Patient will be contacted if partial results are found or if there is an issue with the sample

[4] https://www.surreyi.gov.uk/dataset/emy3p/sexual-health-needs-assessment-surrey-2015

- Online oral contraception
    - Surrey resident completes online questions for either Progestogen only pill (mini-pill, POP) or the Combined oral contraceptive pill (COC). COC is available if the patient is a current user of this method and has already received this from the specialist service within the last 12months.
    - A number of health-related questions to assess suitability are asked, just as it would happen in a clinic appointment. Patient will need to provide a blood pressure reading.
    - Answers are reviewed by a doctor. The doctor will call the patient within 3 days of request if clarification is required.
    - Patient will be informed via text message if a prescription is being issued or not. If not, the patient will be advised how to book an appointment.
    - Medication or a prescription will be sent to the patient by tracked delivery, usually requiring a signature.

Online Oral Contraception service survey – 2020

Between March 2020 and October 2020, the specialist service ran an online survey for online oral contraception service users. This period also covered the lockdown period due to the COVID-19 pandemic. In the seven months that the survey was open, there were 270 responses. Summary of results:

- 91% of respondents had used oral contraception previously
- Of those who had used oral contraception previously, 74% was through the specialist sexual health service; 13% was from a GP; and 5% was from an online service
- 38% of respondents said they chose the online service rather than a clinic appointment because it was more convenient than a GP or clinic appointment; 19% said they used the online service due to COVID-19 restrictions; 36% said there was no appointments available at the local sexual health service and 7% said there was no appointments available at their GP.
- 72% of respondents rated the service as excellent; 15% of respondents rated the service as very good; 5% of respondents rated the service as good; 4% of respondents rated the service as fair; 4% of respondents rated the service as poor.

Engagement with professionals about online services

The overall picture from our engagement with professionals on online services is that whilst these are popular and convenient for many, there are also limitations to online services, and some priority groups may be less likely to use online services:

> *Ease of access is important - young people want to do things online/ mobile phone rather than face to face.* (Surrey pharmacist)

This is a common perception, but other engagement/research suggests that older people, particularly working adults, are often the most likely to prefer online services. Engagement with young people suggests that they do not always trust online information and sometimes prefer to speak to a trusted professional instead.

> *[My main concern is] accessing the higher risk/ vulnerable groups of patients that need time and expertise, who need outreach and services designed for them, rather than online care that they will not access.* (Surrey GP)

This concern was commonly raised in interviews with clinical staff in the specialist service and is outlined further below in the section on Telemedicine.

Online oral contraceptive service: Public Health England Guided Evaluation

Online services were expanded to wider population groups due to COVID-19 – extension of this should be considered, in line with guidelines around safeguarding and digital inclusion. Public Health England led a guided evaluation session in November 2020 between Surrey County Council Commissioners and specialist sexual health service provider Central North West London Healthcare NHS Foundation Trust (CNWL). The purpose of the session was to assist the evaluation of Surrey's online contraception service. PHE were keen to undertake the evaluation because Surrey were the first service in the South East to have an online oral contraceptive service. During the meeting participants were taken through a structured approach to elicit knowledge and understanding as part of the evaluation of the service. The guided evaluation was essentially a qualitative process (through guided discussion/consensus) but using quantitative data (numbers of patients using the service/patient satisfaction data etc). Key positive findings included:

- Patients reported improved access to contraception
- High user satisfaction – recent survey 80% to 90% rated service as good to excellent
- Concluded it is feasible to do a medical history remotely and not all contraceptive appointments need to be face-to-face
- It is acceptable to send out prescriptions and or medication
- No untoward incidents

Following the evaluation, the commissioner and provider will consider:

- Reviewing indicators to help evaluate and demonstrate that objectives of the online service have been met
- Review feasibility of adding other methods of contraception
- Continue to promote the online services so more people can access it

The evaluation was shared with regional and national groups as an example of how to evaluate online contraception services.

Recommendations:

- Review and undertake recommendations from the PHE Guided Evaluation Discussion on Surrey online contraceptive service
- Online services were expanded to wider population groups due to COVID-19 – extension of this should be considered, in line with guidelines around safeguarding and digital inclusion for the long term

Impact of the COVID-19 Pandemic on the Specialist Sexual Health Service

During the initial phase of the COVID-19 pandemic from the end of March 2020, demand decreased due to the first national lockdown (see Table 6). The service adapted to ensure basic provision was available, whilst dealing with staffing reductions due to isolation and redeployment and included:

- Vital services being delivered using telephone consultations and online provision. Minimal face to face urgent appointments were offered.
- Some face to face services such as Long Acting Reversable Contraception (LARC) were paused in line with guidance from relevant clinical faculties and royal colleges
- Patients living with HIV were contacted and prioritised
- Venues, particularly those that are maintained by other organisations, were unavailable for sexual health services due to the pandemic. The spoke clinics were closed due to this reason.
- Following telephone consultation, medications were posted to service users' homes where clinically safe to do so
- Walk-in services for under 18s, emergency contraception and Post-Exposure Prophylaxis for HIV (which prevents people becoming infected if taken soon after unprotected sex) have remained available throughout the pandemic.
- Service user feedback and service user engagement that was collected in clinics was stopped

The Patient Group Direction (PGD) for emergency contraception and chlamydia treatment was also amended so those needing to self-isolate could have telephone consultations and send someone to pick up the medication on their behalf.

As the first national lockdown began to ease during the summer 2020, face to face services were stepped up whilst ensuring staff and patient safety concerns were fully addressed and following social distancing guidelines.

Table 6 – Clinic attendance by month

Month	Apr-2020	May-2020	Jun-2020	Jul-2020	Aug-2020	Sep-2020	Oct-2020	Nov-2020	Dec-2020
Clinical Attendances	83	166	345	534	604	726	781	793	749

By the end of the summer 2020, the service was providing a combination of face to face appointments, telephone consultations and online services. This model has continued to be used flexibly in response to restrictions and clinical need.

Telephone triage during the COVID-19 Pandemic

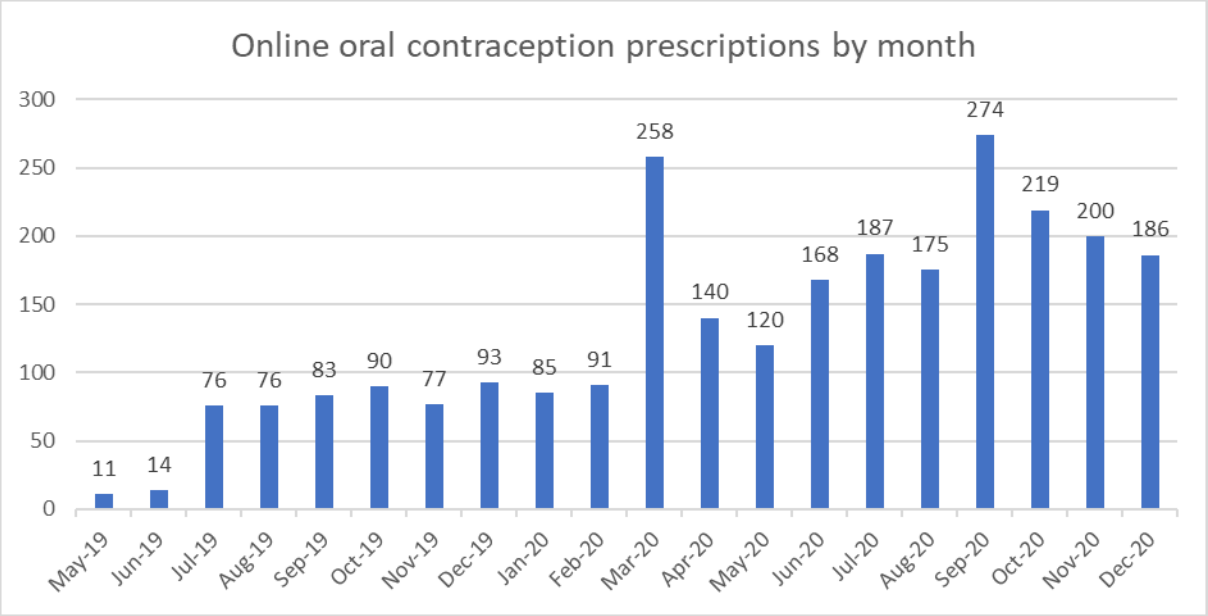
Lockdown resulted in increased use of telephone consultations. Service users were encouraged to contact the service first to determine whether a telephone appointment was appropriate, to reduce walk-ins, waiting times and to help ensure clinic settings were kept COVID secure. Restrictions represented significant challenges for some aspects of delivery of clinical care, particularly around issues such as safeguarding of young people and other vulnerable groups. Clinicians adapted to the challenge of identifying vulnerable people raising concerns during consultations in their own homes. This continues to be an area of focus both in Surrey and in services nationwide.

Online services during the COVID-19 Pandemic

Contraception:

Figure 9 below shows the sharp rise in online contraception use from March 2020. The peak in September is an annual trend thought to be related to a combination of Surrey resident students ensuring they have their contraception before going away to university, and students from outside Surrey starting university locally. Having an already established online service offered a huge advantage in being able to respond to the pandemic more efficiently.

Figure 9 - Online oral contraception prescriptions by month



Online (postal) STI Screening

Steady increases in online STI screens were observed, particularly from June 2020 (see Table 7).

Table 7 – Online screening test requests by month

Testing	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Tests rec'd	617	765	658	709	724	878	827	790	714	932	733	702
Testing	**Apr-20**	**May-20**	**Jun-20**	**Jul-20**	**Aug-20**	**Sep-20**	**Oct 20**	**Nov-20**	**Dec-20**	**Jan-21**	**Feb-21**	**Mar-21**
Tests rec'd	888	898	1186	1238	1335	1531	1459	1333	1066	1286	917	1368

During the pandemic, the shift in use of online services has allowed the specialist service to prioritise more complex and specialist patients. Asymptomatic patients were encouraged to take up the online offer. Symptomatic patients were also directed to the on-line STI service and under 18s identified by a clinician to be at risk were also able to use the on-line service. Residents of other areas without an existing online service had to wait for online services to match those in Surrey.

Telemedicine considerations for safe working and protecting vulnerable groups

Engagement with the specialist service, council members, Healthwatch, and the regional sexual health network has identified the importance of identifying and addressing safeguarding concerns when moving to online / telephone models of care. This includes holding patient consultations over the telephone or patients using an online modality. The pandemic has forced the expansion of telehealth services, with many novel practices being implemented at a rapid pace. In general the changes have been met positively by the healthcare professionals delivering them and the patients receiving them with many of these changes likely to be adopted for long term delivery. Whilst there are several benefits to online services, services also need to be inclusive of the needs of the whole population, especially members of the community who may not have access to digital/telephone services.

The following resources may be helpful for those in primary care and specialist services in moving to an online model of care. They cover best practice guidelines for a number of considerations in delivering care remotely, including safeguarding concerns. The resources were developed by Mary Kyle, Senior Sexual Health Advisor at PHE National Sexual Health Helpline, in collaboration with the Faculty of Sexual and Reproductive Healthcare, the British Association for Sexual Health and HIV, Public Health England and Brook.

1. Triage integration considerations to prioritise vulnerable groups - https://www.fsrh.org/documents/teletriage-for-sexual-and-reproductive-healthcare-services-1/
2. Homeworking considerations: protecting governance, stability and staff wellbeing - https://www.fsrh.org/documents/teletriage-for-sexual-and-reproductive-healthcare-services-2/
3. Resource directory for telehealth services - https://www.fsrh.org/documents/teletriage-for-sexual-and-reproductive-healthcare-services-3/
4. Designing triage to prioritise vulnerable groups - https://www.fsrh.org/documents/teletriage-for-sexual-and-reproductive-healthcare-services-4/
5. Call handling tips for maximising risk identification - https://www.fsrh.org/documents/teletriage-for-sexual-and-reproductive-healthcare-services-5/

Workforce availability and deployment

Trained healthcare staff are an increasingly valuable and limited resource; this is particularly the case for sexual health. In 2017 the British Medical Association identified Genito-Urinary Medicine (GUM) as being one of the lowest three medical specialties in terms of filled posts. Against this backdrop, through additional efforts to retain and recruit staff, CNWL currently have all their consultant and speciality doctor posts filled but still have vacancies for some nursing posts. Appointment availability is being addressed through dual-training of all staff and recruitment to specialist nurse posts. All four consultants in the specialist service are now trained in Sexual and Reproductive Health, Genito-Urinary Medicine and HIV treatment. This enables specialist consultant-led clinics to be run more flexibly. However, this flexibility also requires consultants to be spread across multiple sites:

> *Clinically, it is great to be trained in different areas and being able to work in different sites is generally good, but being spread across 3 big sites can be challenging as a consultant* (Consultant, Specialist Service)

A key aim of the service model is to ensure that, where possible, the specialist workforce is able to prioritise patients with more complex service needs, whilst services not requiring a specialist are provided by other professionals in the service/system or online where appropriate. With limits on specialist trained clinical staff there is essentially a balance needed between availability of consultant-led appointments for complex issues and clinics spread across a wider geographical area.

Engagement with specialist clinicians

Staff in the specialist service were invited to give input to the needs assessment via e-mail. Staff were asked what they felt was going well in the service and what were the challenges they faced. Responses came from a range of staff, both clinical and non-clinical.

Overall the engagement with staff in the specialist service closely mirrored our public engagement and engagement with wider partners.

Individual interviews were held with Consultants and the Service Manager. This enabled us to hear their views and also enabled us to address issues raised during our wider engagement. Most of the comments and responses from the wider engagement are covered at the relevant point in the main report but key comments from staff in the specialist service not reported elsewhere are below.

Clinicians were frustrated that patients have to go through the central booking office in London to make an appointment or contact their doctor. This is also reported by patients and a dedicated booking office for Surrey, located within Surrey, is recommended.

> *Patients have to call a booking office in London, and the people there don't know Surrey. At times this has resulted in patients going to the wrong clinic.* (Consultant in Sexual Health/HIV)

Care pathways between maternity services and sexual health services could be improved. This is important to make access to contraception easier to reduce unwanted pregnancies. It is also important to prevent babies being born with STI's such as syphilis.

Doctors in the specialist service felt that clinical records are shared between primary and acute care but not with the sexual health service:

[Primary and acute care] can see each other's but. CNLW still has paper forms. Is there an opportunity for greater integration through the ICS [Integrated Care System]? Electronic reporting is good to have as an aspiration! (Consultant in Sexual Health/HIV)

Another doctor raised the issue of difficulties making urgent referrals into acute trusts under the 'two- week rule' (the urgent referral pathway for suspected cancer)

There is a different referral system for urgent referrals under the two-week rule. We can't do this electronically, and the e-mail from [name of hospital] says it is no longer in use (Consultant in Sexual Health/HIV)

IT systems also mean that clinical imaging information (chest x-rays/ultrasounds) is not currently accessible electronically with doctors in the specialist sexual health service. This is important for treating patients with complex medical conditions (such as Tuberculosis and HIV combined) and access would benefit both patients and clinicians.

Issues around recruiting specialist doctors and nurses were also raised. Where recruitment to doctors of a particular grade is challenging the service can recruit to a higher grade. Specialist nurses able to fit Long-Acting Reversible Contraception are also highly sought-after.

The effect of the COVID-19 pandemic on vulnerable young people was a concern:

Since COVID it's been harder to see some younger people face to face. Some young people used to come with support workers but now we have real concerns about school work being prioritised over appointments. If there is a clinician available we will fit an emergency coil out of hours but this needs to be looked at in future for non-urgent appointments too. (Consultant in Sexual Health/HIV)

Coils can be fitted up to five days after unprotected sex to prevent unwanted pregnancy. Specialist clinicians are required for this procedure and it is important that young people requiring this service are able to attend at a time when there is a specialist able to carry out this procedure.

Many of the clinicians had worked previously in acute trusts (hospitals) before coming to the integrated specialist service. The challenges of bringing several services together into one integrated service were raised. Working for an integrated service as part of a large specialist sexual health and HIV service was seen to be an advantage:

It feels much better in terms of training opportunities, and they are really keen on Quality Improvements for patients and have the specialist expertise to back this up (Consultant in Sexual Health/HIV)

Finally, the advantages to patients of a joined-up service during a global pandemic were highlighted. It was felt that having a single, larger specialist team meant that resources could be pooled to provide a consistent service for the whole county:

We were able to be really responsive with a cross-Surrey service - we all pulled together. This would have been really difficult with several different providers in terms of a standard process and messaging for opening hours etc. (Consultant in Sexual Health/HIV)

Recommendations:

- Pathways between maternity services and the specialist sexual health service should be improved
- Clinical imaging information (chest x-rays/ultrasounds) is not currently accessible electronically with the specialist sexual health service and this would benefit patients and clinicians
- A system-wide shared clinical record system should be the aspiration and Integrated Care Systems may help achieve this

Out of Area specialist clinics

As with all specialist sexual health and HIV services, patients are able to choose where they attend. Patients often chose to access specialist services closest to home or work (which often lie across local authority borders). For example, in the young people focus group, when asked specifically about accessing sexual health services for themselves or a friend, they said they would look up information on the NHS website or go direct to the clinic in Feltham or Ashford, which they felt was the most accessible for them even though they were not in Surrey.

Many commissioners of healthcare choose to commission services within their boundaries by paying a fixed sum each year to the provider. All care is expected to be delivered within that sum (this is known as a 'block contract'). Many local authorities in the South East take this approach for their specialist sexual health services. If residents in these local authorities use sexual health clinics outside of their borders, then the local authority pays for the out of area use and also continues to pay the 'block' fee for the service within their local authority. This is sometimes described as being 'charged twice'. Surrey County Council chose not to take this approach and instead pays Surrey residents' clinical attendances 'per visit'. We are charged on a negotiated 'integrated tariff' when Surrey residents choose to use services across Surrey borders, to reduce costs while maintaining patient choice.

Analysis of this 'Out of Area' service use shows that, for example, in 2018 (most recent data) 61% of Elmbridge residents who had a consultation for sexual health with a specialist provider chose to access services in Kingston upon Thames which borders Elmbridge. Surrey County Council Public Health team work closely with providers and commissioners in Kingston (and other areas) to ensure more effective pathways for Surrey residents.

Our recent engagement suggests that whilst GPs are aware of and do refer into other services (see Figure 10 and Figure 11 below, respectively), there is still variation in understanding and acceptability of suggesting Surrey residents use services out of area. This was particularly apparent during engagement at meetings and individual discussions with GPs:

" I often have to send my patients to Kingston now, I know that means that you're paying twice but I don't know where else to send them and Kingston is so convenient for patients" (Surrey GP, by telephone)

Figure 10 – GP responses to question on informing patients about services outside of Surrey

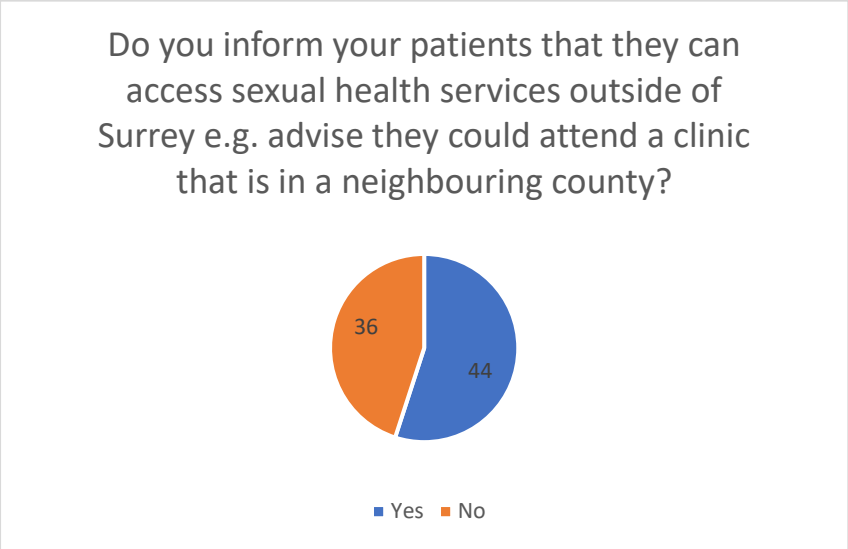
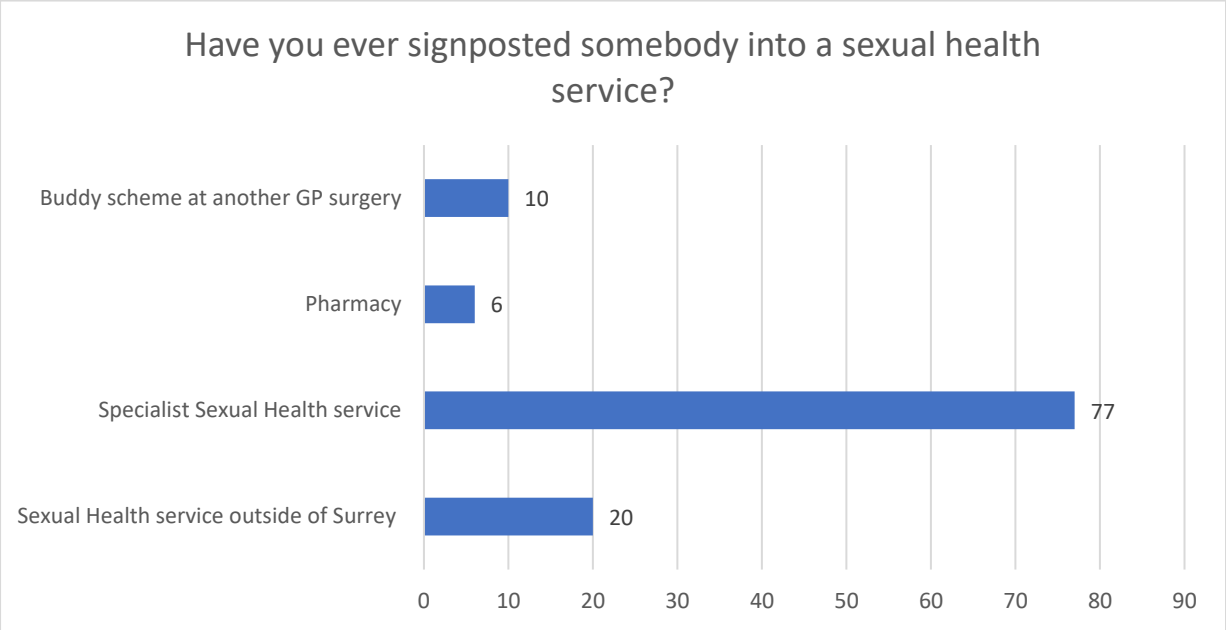


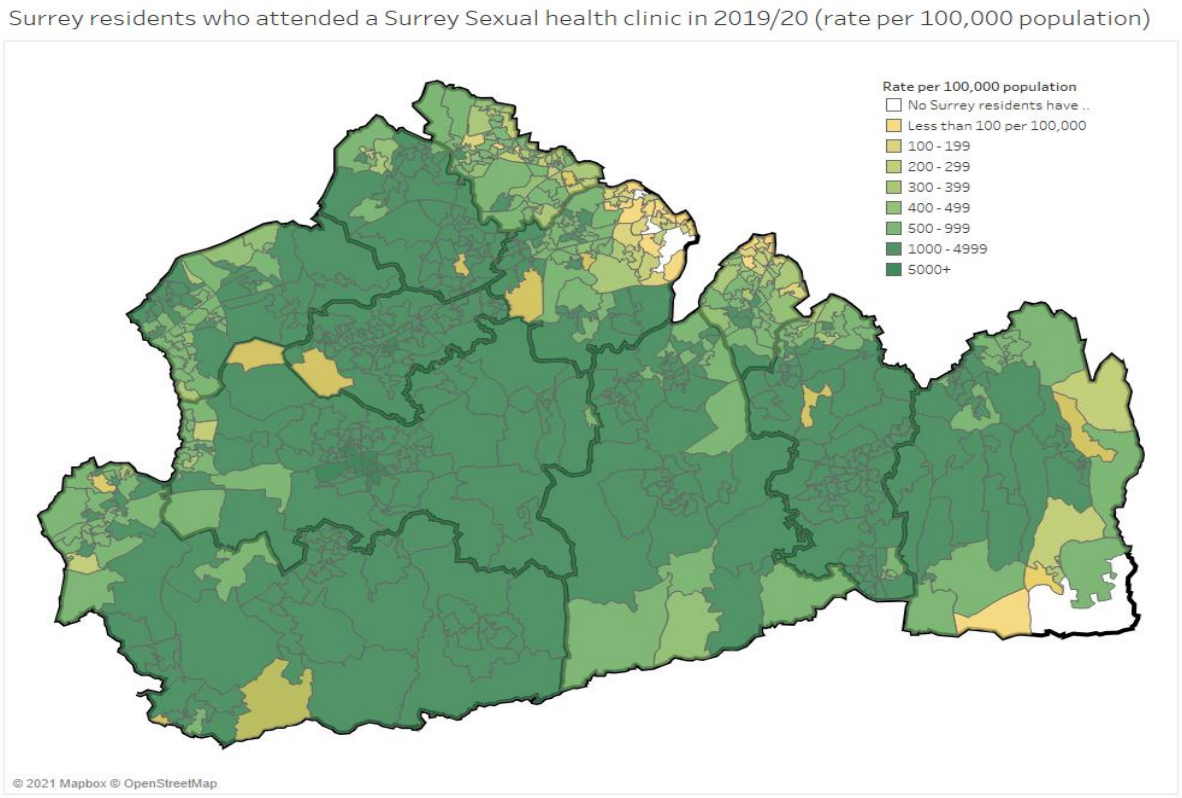
Figure 11 – Number of GPs who have signposted patients into a sexual health service inside and outside of Surrey



This helped identify that we need to do more to ensure GPs are aware that current commissioning arrangements have reduced the cost of patients choosing services closest to them which may be out of county providers.

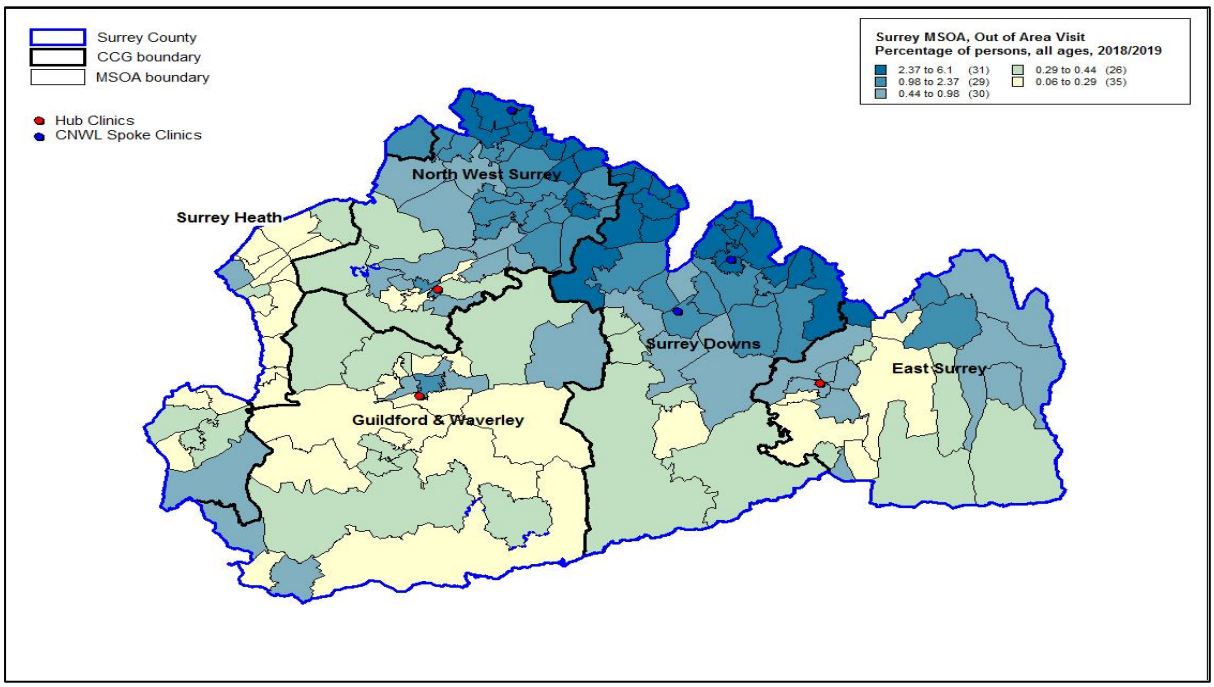
During our continued engagement (particularly when we attended the Adult and Health Select Committee in January 2020) we heard that partners felt concerned that Surrey residents were not choosing to access services in Surrey, and that this meant they were unable to access any services. We analysed our data on the use of specialist sexual health services in Surrey, by Surrey residents (Figure 12 below):

Figure 12 – Surrey residents attending Surrey sexual health clinics, Source: CNWL contract data



This suggested large areas, particularly in the North of Surrey, in which Surrey residents were not accessing specialist sexual health services in Surrey. This was in agreement with our engagement with partners. We therefore also analysed the use of specialist sexual health clinics outside of Surrey, by Surrey residents (as we receive monthly invoices for this activity from providers across the U.K.). This is shown below in Figure 13):

Figure 13 - Use of clinics outside of Surrey by Surrey residents



The general trend is that, when comparing the two maps, the areas where attendance at Surrey clinics by Surrey residents are lower corresponds to higher use of services outside of Surrey.

As sexual health services are open access, residents from other local authorities are also able to use services within Surrey. Capacity in sexual health clinics is a challenge across England for many of the issues discussed previously. Table 8 below shows that 12.4% of patients using specialist sexual health clinics in Surrey are residents outside of the county. The top 5 areas that out of county patients came from were Rushmoor, Croydon, East Hampshire, Hart and Chichester.

Table 8 – Attendance at Surrey sexual health clinics 2019/20

Attendance at Surrey Sexual health clinics, 2019/20

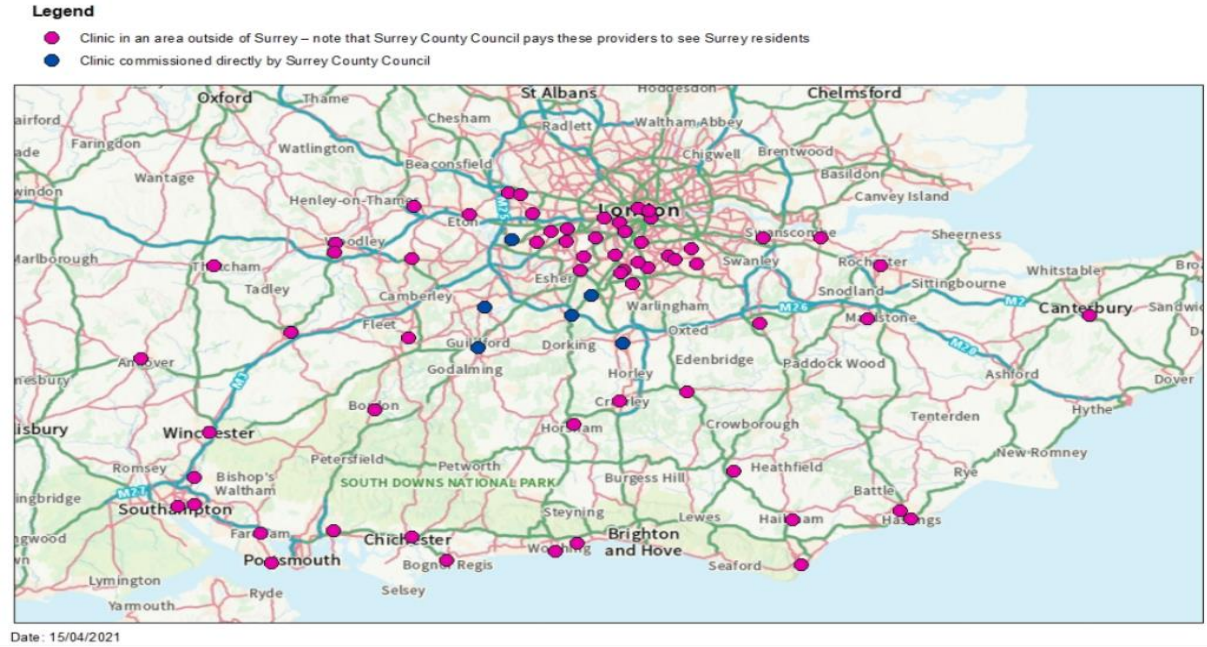
Commissioner	Number of patients	Percentage of patients	Number of visits	Percentage of visits
Surrey local authorities	16,670	87.2%	24,291	87.6%
Other local authorities	2,449	12.8%	3,444	12.4%
Grand Total	19,119	100.0%	27,735	100.0%

Comparing this figure (12.4%) to other areas neighbouring Surrey, there is a relatively small number of people using Surrey clinics from outside of the county. Surrey's main sexual health clinics are generally located further away from borders with other local authorities. Surrey residents are also more likely to travel out of Surrey to work (in London for example) than for people from London boroughs to travel to work in Surrey.

This is a crucial point when considering location of specialist sexual health clinics in Surrey; the closer clinics are to Surrey borders then the more likely it is that people from neighbouring boroughs will use these services. The net effect of this will be to reduce clinic availability for Surrey residents.

Figure 14 below shows all clinics in neighbouring counties. Many of these clinics are popular with Surrey residents. This is outlined in more detail in Appendix A – provision by ICP/CCG area. Geographically, the South West areas of Surrey are least well served by specialist clinics. It was interesting to note that this issue was not commonly raised in our engagement, including with GPs in the area. This could be because historically there have been no specialist clinics here for some time.

Figure 14 - Map of Specialist Sexual Health clinics in neighbouring counties



Recommendations:

- Continue to monitor use of services outside of Surrey borders
- Continue to strengthen links with providers outside of Surrey borders particularly in areas where these services are more accessible to Surrey residents living close to bordering local authority areas
- Improve communications for Surrey residents and health professionals around out of area services

Primary care

There are two main elements to sexual health provision in primary care (see Figure 1).

1) General sexual health services commissioned by NHSE/I under the General Medical Services Contract and these include:
    - advice and provision of routine contraception (excluding the fitting and removal of intrauterine contraceptive devices and implants)
    - advice and provision of emergency hormonal (oral) contraception
    - initial advice about Sexually Transmitted Infections and referral to a specialist sexual health clinic if tests are required

2) 'Long Acting Reversible Contraception' which are optional for a practice to sign up for and which Surrey County Council pay additional fees under a separate Public Health Agreement or 'PHA'. These require additional training (often for specialist nurses) and include:

    - Intra-uterine contraceptive device and Intra-uterine systems - IUCDs (also known as 'coils')
    - Contraceptive Implants
    - The PHA covers fitting, monitoring and removal of IUCDs and implants

The PHA enables practices to work with buddy practices to offer a choice of provider for contraceptive implants and IUCD. Further opportunities for this should be explored through Primary Care Networks, recognising the pressures on primary care currently.

Table 9 - GP surgery sign up and activity 2019/20 (this is not a full count of practices as some have chosen not to sign the PHA for LARC) - Note that a 'practice' is often a practice group which may include several practices.

Table 9 - GP surgery sign up and activity 2019/20

	Surrey	East Surrey ICP	Guildford and Waverley ICP	North West Surrey ICP	Surrey Downs ICP	Surrey Heath CCG
Signed for PHA 2019/20	107	16	19	35	26	7
Practices providing coil insertions and removals	100	16	19	31	23	7
	87.0%	94.1%	90.5%	79.5%	74.2%	100.0%
Practices providing coil removals only	7	0	0	4	3	0
	6.1%			9.8%	12.5%	
Practices providing implant insertions and removals	90	13	18	30	22	7
	75.4%	76.5%	85.7%	76.9%	71.0%	100.0%
Practices providing buddy scheme services	57	6	8	20	18	5
	48.3%	35.3%	38.1%	51.3%	58.1%	71.4%

Engagement with primary care

Surrey County Council receive comments/issues/concerns from primary care about sexual health services through e-mail, through our attendance at ICP and CCG meetings, and through issues raised with the specialist service. This continuous engagement has been fundamental in this needs assessment. Many of the questions in the survey were based on this continuous engagement. We also engaged with primary care specifically for this needs assessment and we heard from 81 colleagues in primary care through our survey. We attended meetings and had other communications with ICP/CCG colleagues. The needs assessment engagement was carried out in the last quarter of 2020 when primary care was facing enormous challenges due to COVID-19. We contacted each ICP in Surrey and arranged to attend locality meetings. Understandably, due to COIVD-19, many of these meetings were either cancelled or there were more urgent issues that meant our item was taken off the agenda. However, we heard from individual primary care colleagues from across Surrey in our survey and through other engagement and are very grateful to everyone who gave their time to complete the survey or feedback in other ways.

Many of the comments we hear are specific to the area where primary care colleagues work. We have therefore included a separate section as Appendix A – provision by ICP/CCG area, which aims to tie together the services available to residents in each area, along with comments from healthcare colleagues and other comments specific to that locality.

A key message from our engagement with primary care was the need for greater integration between primary care and the specialist service:

> *There needs to be greater partnership between local commissioned specialist services and primary care. Service delivery, patient safeguarding, clinician training, and many other aspects of care would be of higher quality and reach a greater proportion of the patient population if done in this way.* (GP Survey)

This was echoed in our engagement with clinicians working in the specialist service who are happy to provide update/training sessions for GPs:

> *I think we are better linked in with pharmacy than we are with GPs – I have done some teaching with pharmacists but less with GPs. I would be happy to link up with GPs around some teaching sessions* (Consultant, Specialist Service)

We also heard about issues in primary care around knowledge and understanding of screening (among both patients and professionals):

> *Patients struggle to access screening. Awareness of postal services poor and overall testing rates in my practice are very low. There is a deficit of awareness amongst GPs about when and what they should be testing for. We as a cohort need to take on more responsibility for opportunistic screening when we are already drawing bloods or investigating relevant problems (LUTS). Support and education from sexual health services about what we should be doing and when would be useful (GP Survey)*

Again, clinicians in the specialist services would be keen to link with GPs more and commissioners should facilitate this.

An issue was raised about private online testing:

> *We are having to deal with patients who have had a private online STI test, but then need treatment. Is the sexual health service dealing with this issue too?* (GP, Surrey Downs ICP meeting)

Our engagement with consultants in the specialist service suggest that this is also an issue for them:

> *Online companies are private and offer testing that they should not be and do not tell them about local services, they suggest that commissioners have not commissioned this and offer 12 tests that should not be offered at all! We need to be engaged with patients on this - BASHH [British Association for Sexual Health and HIV] are producing something.* (Consultant, Specialist Service)

Commissioners will work with the specialist service on this issue.

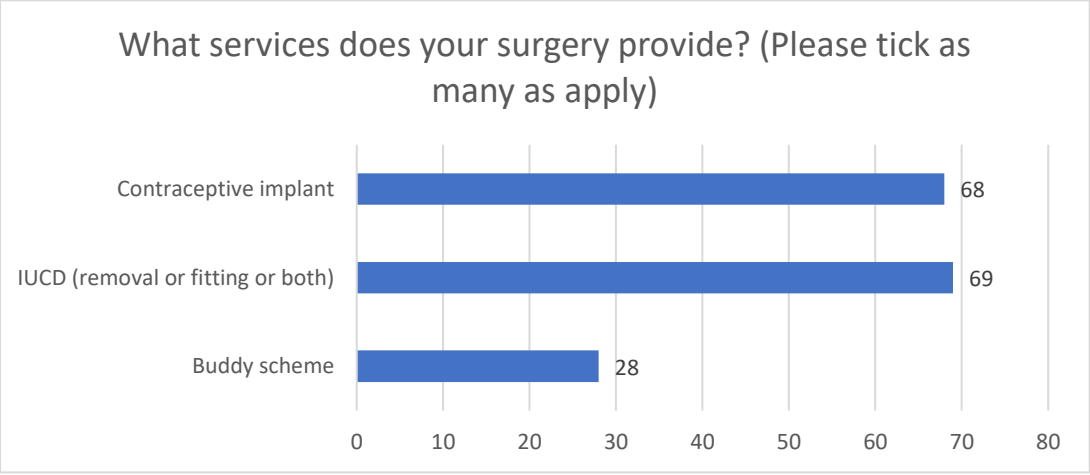
Recommendations

- Commissioners (of both specialist sexual health services and primary care) should work together to improve communications between the specialist service and primary care
- This should include teaching sessions by Consultants in Sexual Health/Genito-Urinary Medicine for primary care
- Commissioners to work with the specialist service on communications around private STI testing services which may be offering inappropriate tests

Provision in primary care during COVID-19

Primary care colleagues were hugely instrumental in the response to COVID-19. In addition to providing quality care in incredibly challenging circumstances, many also continued to provide Long-Acting Reversible Contraception or 'LARC' (commissioned by Surrey County Council) plus other sexual health services (under the General Medical Services contract), as shown in Figure 15.

Figure 15 – Services provided by GP surgeries at time of survey



Our engagement with primary care highlighted a commitment to continuing to address issues around access to LARC but again, that STI services, and communications around these, remains a concern:

> *We are able to offer a good service normally but because of the time we stopped doing LARC we have accumulated a waiting list, but we will work through this.*

My main concern is the lack of STI services and the fact that young people do not seem to know where to go since the Blanche Herriot Clinic closed (Surrey GP)

Again, ensuring appropriate use of specialist clinician's clinical time, and dedicated Surrey communications expertise, are recommended to address these issues.

Sexual health provision by healthcare area (ICP/CCG)

A recurrent theme through our engagement with primary care were around the increasing centralisation of services. This fell broadly into two categories:

a) Comments related to the move away from numerous smaller, less specialised clinics (often referred to as 'family planning clinics')
b) Comments related to changes to the location and number of larger, more specialised clinics located within Surrey boundaries.

Due to the considerable number of responses from primary care colleagues raising this issue we have outlined the services available to residents in each of the ICP/CCGs areas in Surrey. This is included as Appendix A – provision by ICP/CCG area. The summary and recommendations from this Appendix are included below.

Summary

Residents can access standard, long-acting and emergency contraception in specialist sexual health services and primary care (and pharmacy for emergency contraception). However, for testing and treatment of Sexually Transmitted Infections, only specialist sexual health services are available. It was not surprising, therefore, to hear through our engagement with primary care in particular that access to testing and treatment of Sexually Transmitted Infections was a high priority. As outlined in 'Urgent Care' above, the need for urgent care should be uncommon for any one individual and where this is not the case, more intensive health advice/promotion is needed and can be provided.

There remains a difficult balance between ensuring there is the required 'critical mass' of specialist clinicians to provide a full, walk-in service and ensuring access to services across an area as large of Surrey. Telephone/online services have offered some opportunities in this but these will not be the solution to all issues. Spoke services continue to be explored but as outlined in the North West Surrey ICP section these are not always attended by the target population. Testing and treatment of Sexually Transmitted Infections generally needs to be consultant led and this makes walk-in access to these services particularly challenging outside of the main hubs.

Provision of sexual health services should be viewed as a whole (including specialist services in and out of Surrey, primary care, pharmacy, and the online service) and communicated to residents, particularly to younger people unable to travel for face to face appointments.

Recommendations:

- Urgent appointments in specialist clinics (particularly for Sexually Transmitted Infections and urgent long-acting contraception appointments) remain in high demand and need to be prioritised

- Further consideration should be given to ensuring patients are able to access less urgent care (such as STI screening and simple contraception) through telephone/online services
- Support primary care, and primary care networks, in further developing the Public Health Agreement buddy scheme, and using shared clinical services and remote consultation systems
- Improve communications to ensure primary care colleagues are aware of patient choice in accessing specialist services outside of Surrey boundaries
- Continue to work closely with specialist providers in areas bordering Surrey
- Where there are particular concerns about a geographical area in terms of service coverage, targeted work is needed, including education around online services and increasing pharmacy provision

Pharmacy

Public Health Agreements provided by pharmacy currently include:

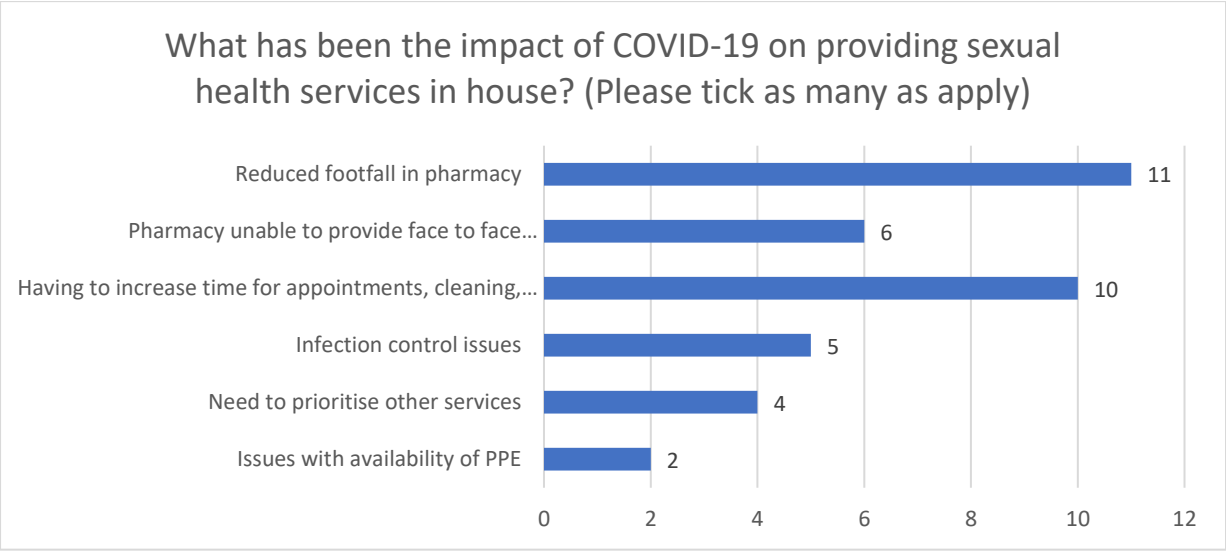
- Chlamydia screening and treatment for the target population of under 25 year-olds, as defined by the National Chlamydia Screening Programme (NCSP)
- Emergency Hormonal Contraception Service (also known as the 'morning after pill' although can be taken up to five days following sex) (see Table 10 below)

Table 10 - Pharmacy sign up and activity

	Surrey	East Surrey ICP	Guildford and Waverley ICP	North West Surrey ICP	Surrey Downs ICP	Surrey Heath CCG
Number of pharmacies	203	31	39	67	50	16
Signed for PHA for Chlamydia treatment 2019/20	70	11	13	22	18	6
	34%	35%	33%	33%	36%	38%
Dispensed Chlamydia treatment 2019/20	19	4	4	4	5	2
	27%	36%	31%	18%	28%	33%
Signed up to PHA for EHC 2019/20	103	18	20	29	29	7
	51%	58%	51%	43%	58%	44%
Dispensed EHC 2019/20	59	14	11	14	16	4
	57%	78%	55%	48%	55%	57%

Pharmacy services also continued to provide sexual health services in addition to their key response to COVID-19, in spite of the impact of the pandemic on services (see Figure 16 below).

Figure 16 – Impact of COVID-19 on pharmacy



Our engagement with pharmacy was mainly through an online survey, and through our ongoing engagement with the Local Pharmaceutical Committee. Issues around privacy and safeguarding concerns specific to COVID-19 were raised. More general issues were similar to engagement with other groups – particularly around making people more aware of services:

Lack of awareness that [sexual health services] are available in pharmacy - variability in service offered by different pharmacies - different regs across borders - so much info on web - not always up to date or reliable (Surrey pharmacist)

In the focus group that was conducted with young people, they were specifically asked about their views on accessing sexual health services at a pharmacy. They all said they would not go to a pharmacy unless '*it was an emergency'* and they could not get support elsewhere. They felt that pharmacies were '*judgemental'* about what they might be collecting. They all mentioned that if needed, they would prefer to go to a clinic or pharmacy nearer to where they lived because it was most convenient to travel there and cheaper than paying for transport further afield. They felt it was not deemed socially acceptable for young people to access sexual health services and so they would ask their friend or mum to accompany them if they needed to access healthcare. However, they went on to say that if they did not want to tell their parents of a particular issue, they would go to the pharmacy first to seek advice and then make an appointment with their GP.

Summary

Pharmacy provision is particularly important for young people requiring Emergency Hormonal Contraception and chlamydia screening and treatment. As outlined in the section on young people below, keeping teenage pregnancy rates low and increasing chlamydia screening are key priorities for Surrey. Pharmacies play a vital role in increasing access for residents in areas further away from the specialist sexual health hub or spoke clinics. Both provision and communication of sexual health services should be increased where possible.

Recommendations:

- Focus on pharmacy location and prioritise coverage by PCN footprint
- From 2022/23, pharmacies delivering sexual health services will be required to deliver both emergency hormonal contraception (EHC) and chlamydia treatment Public Health Agreements. (Currently, pharmacies can choose to deliver just one of the sexual health PHAs).
- Increase promotion of pharmacy services, including in store communications
- Increase awareness of pharmacy services through wider comms including community centres and schools
- Explore use of 'branding' pharmacies as sexual health service friendly for young people

The sexual health of Surrey residents

Health inequalities

Healthcare and health services account for a relatively small proportion of differences in health outcomes. This is summarised below in Figure 17:

Figure 17 - Influences on health Source: Healthy People

The Marmot Review – Health Lives, Healthy People highlights this in detail. It states:

- People living in the poorest neighbourhoods in England will on average die seven years earlier than people living in the richest neighbourhoods
- Health inequalities arise from a complex interaction of many factors - housing, income, education, social isolation, disability - all of which are strongly affected by one's economic and social status
- Action on health inequalities requires action across all the social determinants of health, including education, occupation, income, home and community

Reducing social/wage inequalities is more important in reducing health inequalities than healthcare services, but the gap between the richest and poorest neighbourhoods is not getting smaller.

The effects of this on sexual health is outlined in more detail in the next section.

Deprivation

- Sexual health and deprivation are intricately linked
- This section outlines some of those links
- Surrey is less deprived than most other local authorities in England, although there is variation within Surrey

Sexual health is intricately linked to deprivation (people in more deprived areas tend to have poorer sexual health than people in less deprived areas). This is outlined here to explain some of the variation in sexual health outcomes between districts and boroughs in Surrey.

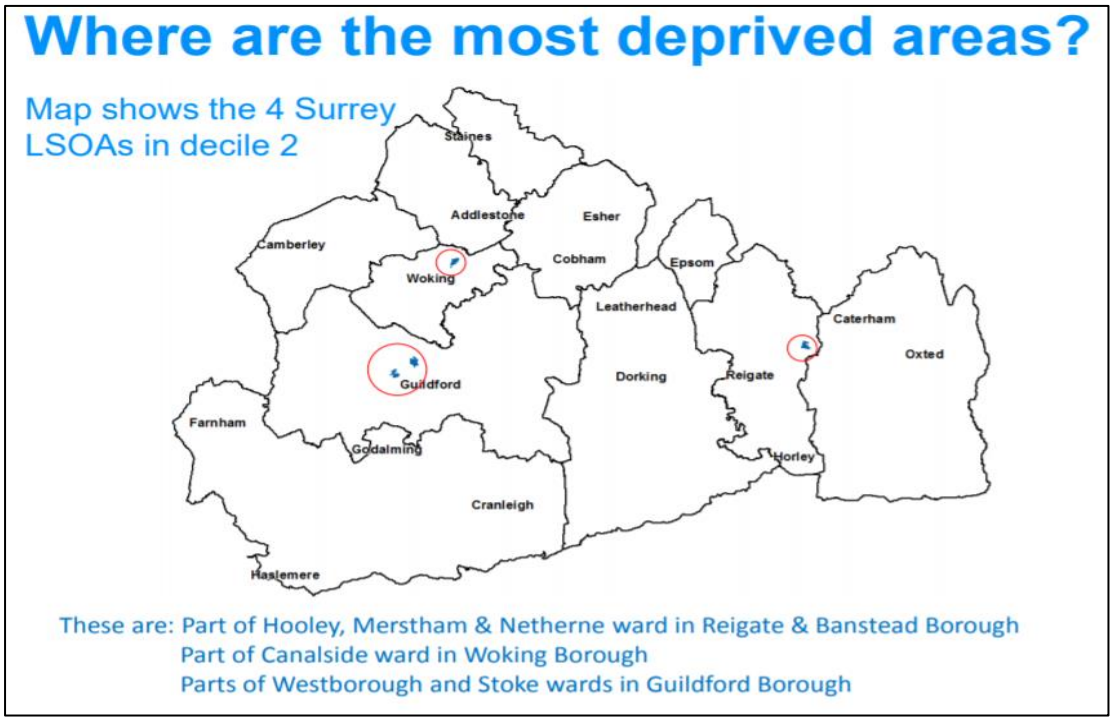
What does deprivation mean?

Deprivation is measured by comparing small geographies with each other in terms of factors such as education, employment, income and the living environment. It is not the direct opposite of 'affluent' but sometimes it is used that way. It is a *relative* measure; a comparison between areas. If an area moves up in the index this could mean it had become more deprived, or that other areas had become less deprived. It is measured by the Index of Multiple Deprivation (IMD). There is a useful summary available called the IMD 2019 What it is and What it tells us about Surrey.

Deprivation in Surrey

The most deprived areas in Surrey are the four small areas ('LSOAs') shown below in Figure 18. These are the only areas in the top 20% most deprived areas in England (in 'decile 2'). Nowhere in Surrey is in the top 10% most deprived in England (decile 1).

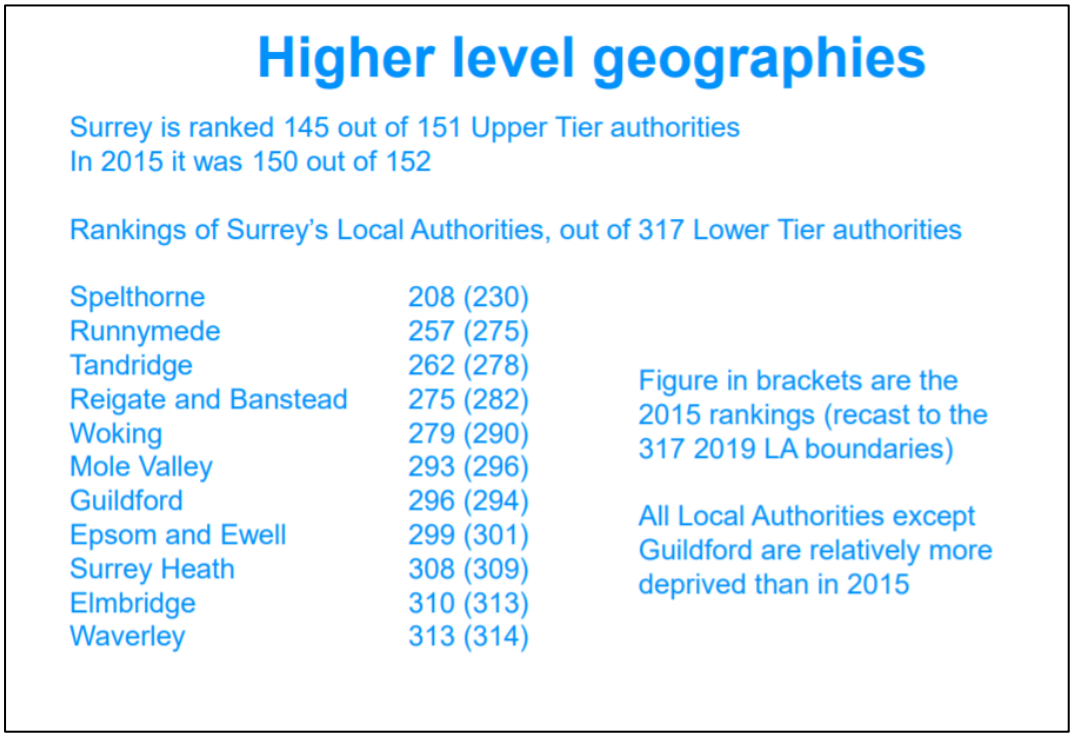
Figure 18 – Areas of deprivation in Surrey



From the above we can see that the only Surrey LSOAs to be in the top two deciles for deprivation are very close to a specialist sexual health clinic.

We can group all the small areas together to get an average relative deprivation score, as shown in Figure 19 below:

Figure 19 – Higher level geographies



This shows that when averaged together, the deprivation scores of all the small areas in Spelthorne are higher than any other district or borough (also called 'lower tier Local Authority'). Therefore, we can say 'Spelthorne is the most deprived local authority area in Surrey'. However, there are lots of areas in Spelthorne which are not classed as deprived, and there are areas of Waverley (the least deprived area) with higher deprivation. There are 207 lower tier Local Authorities in England which are more deprived (on average) than Spelthorne.

The table in figure 19 also shows that several Upper Tier local authorities became less deprived than Surrey between 2015 and 2019 (because Surrey is now ranked 145 out of 150).

Why does deprivation matter to sexual health?

Sexual health and deprivation are intricately linked.

Conceptions in England and Wales shows that in 2018 there were 23.6 conceptions per 1,000 women aged 15 to 17 years usually resident in the most deprived areas of England. Yet there were only 9.5 conceptions per 1,000 women aged 15 to 17 years in the least deprived areas of England. In contrast, the percentage of conceptions leading to abortion for women under 18 years was higher in the least deprived areas of England than in the most deprived areas. According to a 2012 study on teenage parenthood the risk of becoming a teenage mother in the UK is nearly 10 times higher for girls in the lowest social class than those in the highest social class. They are more likely to get pregnant but less likely to access abortion services.

Sexually Transmitted Infections (STI's) are also generally more common amongst people in areas of higher deprivation but as above this was not observed with Gonorrhoea rates in Surrey. A 2016 study on deprivation and ethnicity suggests that this is more complicated than the link between deprivation and teenage pregnancy as it is also linked to cultural differences.

Sexual health outcomes for Surrey residents

- Teenage pregnancy is now lower than ever in Surrey but a framework is suggested to continue to improve this
- Many STI rates are increasing sharply in England but the same sharp rise has not been observed in Surrey to date.
- Chlamydia screening rates in Surrey could be improved

Public Health England (PHE) collate data on a range of sexual health and HIV treatment outcomes and compare us with other local authorities.

The numbers of people using sexual health services is relatively low as a proportion of the population. This means that at the district and borough level the numbers are often broad estimates from which it is difficult to draw firm conclusions.

These comparisons are a useful and objective guide to how sexual health provision in Surrey compares to other areas. Key indicators are outlined below. For large numbers of indicators Surrey compares well to the South East and England averages.

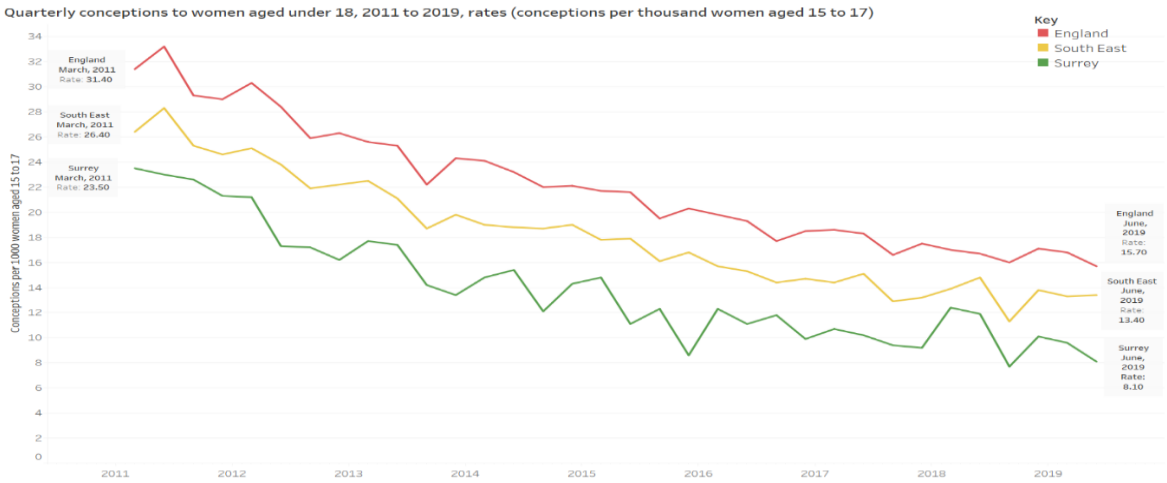
The sexual health data presented below was last updated in 2018. This is generally published by Public Health England (PHE). Currently this information is not being updated in the usual timeframes due to COVID-19. Comparing numbers from before March 2020 with numbers after March 2020 will not be particularly useful due to changes in who people have sex with and what services have been available recently.

Teenage pregnancy

Under 18 conception rates

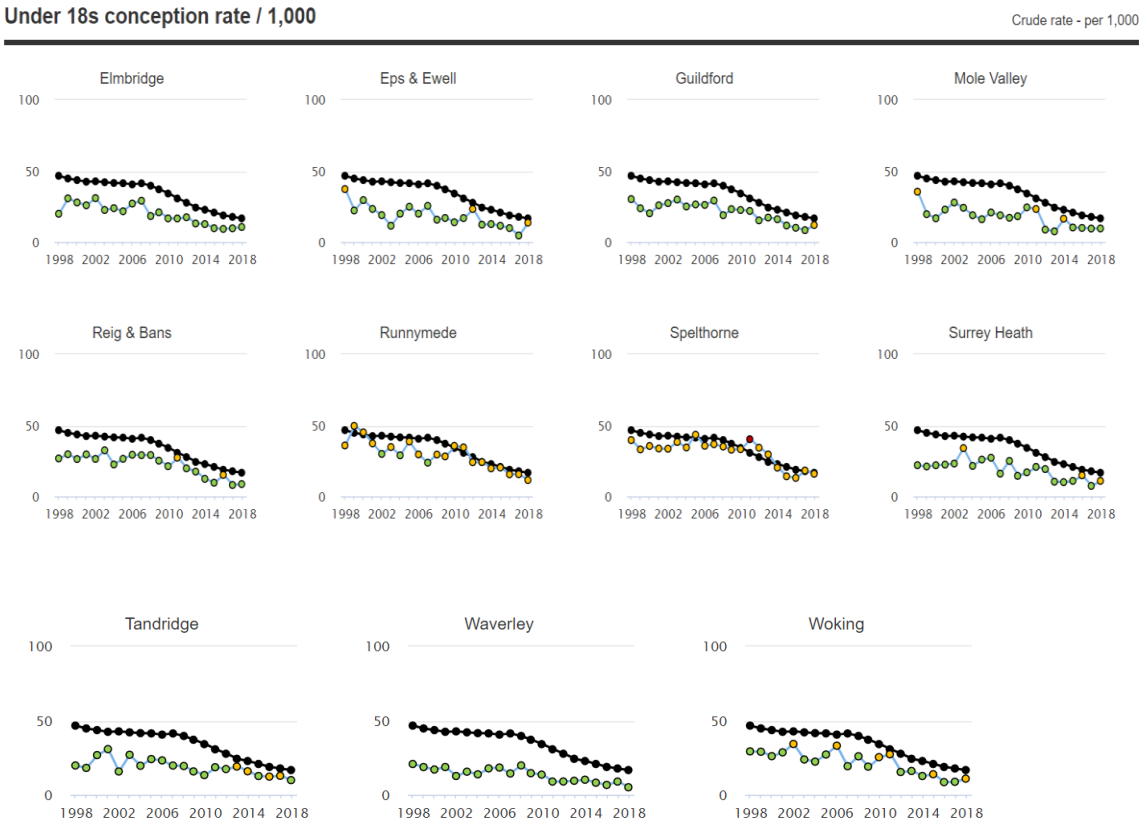
These are now the lowest they have been in Surrey since current data began being collected in 2011. In 2011 there were 22.5 conceptions per 1,000 under 18-year-olds decreasing to 10.5 conceptions per 1,000 in 2018. The numbers are small but the overall trend is definitely much improved. Figure 20 below shows the rate per 1,000 women aged 15-17 in Surrey. The numbers are decreasing and are lower than the South East region averages.

Figure 20 – Quarterly conceptions 2011 to 2019 to women aged under 18



Under 18 conceptions can be viewed by district and borough, with a comparison with England (shown in black in Figure 21 below). The general trend for an overall reduction is seen for each district and borough, Runnymede and Spelthorne have remained closer to the England average than other areas. Note that data for 2019 would usually be available by this time in 2021 but PHE data reporting is currently delayed due to COVID-19. Note also that small numbers mean that small fluctuations can appear as larger trends, which is why looking at the longer-term trend is important.

Figure 21 – Under 18s conception rate per 1,000



As teenage pregnancies are highest in Spelthorne, we used this as a case study including focus groups with young people in the area. Key points are below with the full case report given as Appendix C - Case study - Young people in Spelthorne

Case Study – Young People in Spelthorne – see Appendix C - Case study - Young people in Spelthorne for full details

Actual numbers of under 18 conceptions/births (see Table 11Table 16 – under 18s conceptions in Spelthorne) continue to reduce but this remains a key priority area.

Table 11 – Under 18 conceptions in Spelthorne

Year	Total under 18 conceptions in Spelthorne	Total births to under 18s in Spelthorne
2008	58	N/A
2009	54	6
2010	53	7
2011	65	17
2012	54	15
2013	46	8
2014	31	10
2015	22	6
2016	20	4
2017	27	4
2018	24	5

In order to obtain more detailed feedback from young people in Surrey, qualitative methodology (in the form of focus groups) were used to gain further insight into the groups experiences of accessing services – full results are given as Appendix C - Case study - Young people in Spelthorne**.**

Key points:

1. Knowledge of sexual health services was poor in young people
2. The younger group reported finding pharmacy services far more accessible than the older group
3. The concept of the 'local area' for this group differs from that of professionals we have engaged with (who are more likely to see services in Surrey boundaries as 'local')
4. The young people in this group seemed less concerned about people knowing they were accessing sexual health services than was expected

Whilst it is important to ensure equal access to services, it is important to point out that sexual health, particularly in young people, is dependent on a wide range of factors.

The diagram in Figure 22 comes from the PHE Teenage Pregnancy Framework but is largely relevant to other areas such as STI prevention and testing.

Figure 22 – Effective local strategies Source: PHE

Clinical services important in reducing teenage pregnancy are outlined in Table 12 below:

Table 12 – Clinical services for reducing teenage pregnancy

Clinical service	Online or phone	In a GP practice	From a pharmacy	Specialist service in Surrey	Specialist service outside Surrey	A&E
Oral contraception – non emergency	Yes (may need face to face)	Yes All GPs	Yes selected pharmacies	Yes	Yes	No
LARC (coils and implants)	No	Yes Selected practices	No	Yes	Yes	No
Emergency oral contraception	No	Yes	Yes selected pharmacies	Yes	Yes	Yes In emergency
Commissioned by	Surrey CC	CCGs (Except LARC - SCC)	Surrey CC	Surrey CC	Relevant Local Authority (SCC funded)	CCG

Table 12 highlights the range of clinical settings which can help reduce teenage pregnancy. Our focus group with young people showed the variety of preferences in accessing contraception for young people and it is important to maintain as many options as possible.

As outlined above, the ideal way to prevent teenage pregnancy is through education and planned contraception if required. COVID-19 has led to innovative ways of ensuring under 18s can receive standard contraception by post. Continuation of this increased access should be considered once restrictions are lifted, provided this is clinically appropriate. Prevention (including planned contraception) should also reduce the reliance on emergency contraception. However, emergency contraception is available across at least four different settings as above.

A recent study by Glasgow university looked in depth at the views of young people around condom use and contraception. This highlights some key points which are likely to be valid in any location:

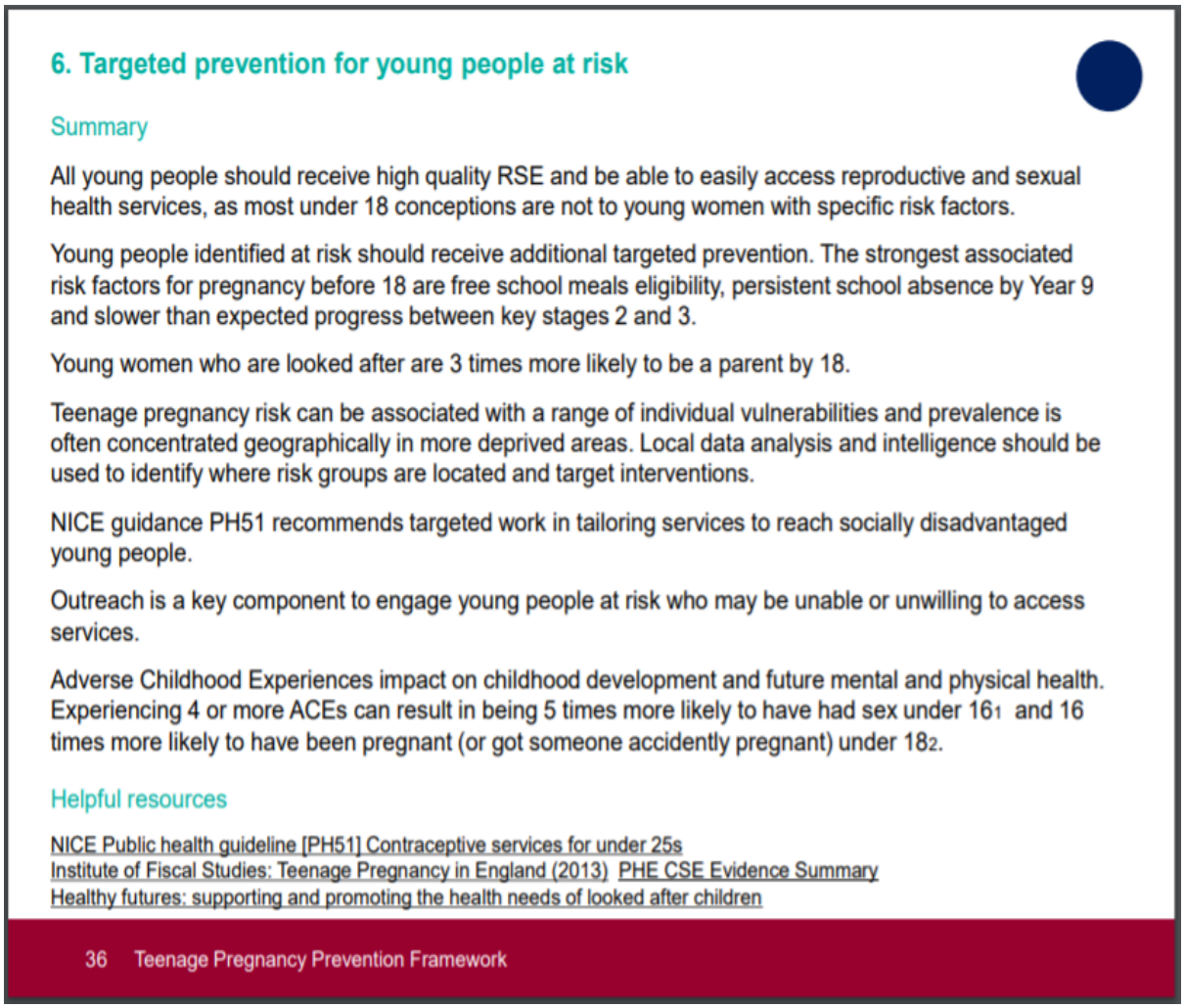
- While many young people reportedly turn to official healthcare sources (e.g. NHS websites, GPs, nurses) for accurate information on condoms and contraception, they do not always trust that they will receive the most honest input (e.g. on side effects) from these sources
- Improving young people's trust in information produced by 'official sources' (e.g. Scottish Government, NHS) would require more sophisticated use of social media platforms (e.g. Instagram) and digital formats (e.g. video blogs of contraceptive consultations) by these organisations
- Young people are embarrassed to use free condom services and expressed concerns about anonymity, a perceived lack of understanding about condom sizes and fit, and perceived lower quality of free products
- The majority of intercourse-experienced survey respondents had never tried to access STI testing at a GP surgery or sexual health clinic
- Approximately one third of survey respondents who had used contraception (including condoms) had never spoken about the method(s) with a health professional.

In addition to the universal offer, the data for Surrey suggests that there are areas where more targeted work is needed.

Targeted prevention for young people at risk

The following summary in Figure 23 is from PHE.

Figure 23 – Targeted prevention for people at risk



6. Targeted prevention for young people at risk

Summary

All young people should receive high quality RSE and be able to easily access reproductive and sexual health services, as most under 18 conceptions are not to young women with specific risk factors.

Young people identified at risk should receive additional targeted prevention. The strongest associated risk factors for pregnancy before 18 are free school meals eligibility, persistent school absence by Year 9 and slower than expected progress between key stages 2 and 3.

Young women who are looked after are 3 times more likely to be a parent by 18.

Teenage pregnancy risk can be associated with a range of individual vulnerabilities and prevalence is often concentrated geographically in more deprived areas. Local data analysis and intelligence should be used to identify where risk groups are located and target interventions.

NICE guidance PH51 recommends targeted work in tailoring services to reach socially disadvantaged young people.

Outreach is a key component to engage young people at risk who may be unable or unwilling to access services.

Adverse Childhood Experiences impact on childhood development and future mental and physical health. Experiencing 4 or more ACEs can result in being 5 times more likely to have had sex under 16[1] and 16 times more likely to have been pregnant (or got someone accidently pregnant) under 18[2].

Helpful resources

NICE Public health guideline [PH51] Contraceptive services for under 25s
Institute of Fiscal Studies: Teenage Pregnancy in England (2013) PHE CSE Evidence Summary
Healthy futures: supporting and promoting the health needs of looked after children

36 Teenage Pregnancy Prevention Framework

Recommendations:

- Increased pharmacy provision in areas most distant from any specialist clinics (see also pharmacy provision section)
- Where clinically appropriate, maintain access to contraception by post for under 18s (pre-COVID this was provided for 18+ only but other services do provide this for 16+) – this is a clinical decision based on national guidance

Abortion rates

Abortion services are commissioned by Clinical Commissioning Groups. The most recent (2019) abortion statistics are given below in Table 13 for local authorities in the South East. These are not provided by lower tier local authority (such as districts and boroughs).

Table 13 - Abortion rates by upper tier local authority in the South East Source: Abortion Statistics for England and Wales 2019

	Rate per 1000 women aged 15-44	**Age**					
		Under 18	18-19	20-24	25-29	30-34	35 +
England	***18.1***	***8.0***	***24.0***	***30.2***	***26.3***	***21.0***	***9.8***
South East	***16.9***	***6.9***	***22.1***	***27.8***	***25.0***	***20.2***	***9.3***
Bracknell Forest	*16.5*	*7.0*	*30.7*	*26.6*	*22.6*	*18.5*	*9.6*
Brighton And Hove	*14.2*	*8.2*	*21.0*	*22.6*	*16.8*	*16.0*	*8.6*
Buckinghamshire	*17.4*	*4.7*	*17.7*	*29.8*	*25.6*	*21.6*	*10.0*
East Sussex	*16.8*	*5.5*	*21.8*	*28.4*	*26.8*	*20.1*	*8.3*
Hampshire	*16.1*	*5.9*	*23.5*	*28.6*	*23.3*	*18.6*	*7.9*
Isle Of Wight	*14.4*	*10.0*	*24.4*	*27.6*	*19.3*	*17.8*	*4.9*
Kent	*18.3*	*8.5*	*23.0*	*30.8*	*27.3*	*21.3*	*9.7*
Medway	*21.2*	*11.4*	*27.8*	*37.3*	*31.9*	*23.5*	*10.6*
Milton Keynes	*24.0*	*8.1*	*34.5*	*49.9*	*33.5*	*22.3*	*13.4*
Oxfordshire	*14.0*	*4.8*	*17.7*	*19.0*	*22.6*	*17.2*	*8.7*
Portsmouth	*19.8*	*11.1*	*28.3*	*28.8*	*25.8*	*22.7*	*12.2*
Reading	*19.7*	*8.0*	*24.3*	*23.8*	*29.1*	*27.8*	*12.3*
Slough	*25.7*	*4.9*	*30.3*	*44.5*	*34.3*	*34.3*	*15.6*
Southampton	*16.9*	*7.6*	*13.9*	*20.3*	*22.9*	*26.8*	*11.4*
Surrey	*15.7*	*6.1*	*19.8*	*25.4*	*22.6*	*19.4*	*8.7*
West Berkshire	*15.7*	*4.7*	*19.6*	*27.9*	*26.5*	*17.3*	*7.3*
West Sussex	*16.2*	*7.5*	*24.2*	*29.8*	*24.2*	*17.1*	*7.7*
Windsor And Maidenhead	*16.6*	*7.0*	*24.0*	*28.4*	*27.7*	*15.1*	*9.5*
Wokingham	*15.1*	*5.6*	*16.5*	*27.9*	*22.2*	*14.9*	*8.8*

Table 13 above shows that Surrey has one of the lowest abortion rates in the South East. Young people in more deprived areas are *less* likely to access abortion services. However, Surrey has lower abortion rates for under 18s even though it is less deprived than most local authorities in the South East. This reflects the lower overall rates of under 18 pregnancies in Surrey.

People may choose to have an abortion for lots of different reasons and many people talk about the stigma attached to choosing an abortion. The term 'abortion' is used here because abortion statistics are described in that way but there is evidence that some clinicians feel the phrase 'termination of pregnancy' can be less emphatic and/or distressing.

Guidance from the Faculty of Sexual & Reproductive Healthcare of the Royal College of Obstetricians and Gynaecologists recommends strong links between abortion services and sexual health services. This is to ensure contraception is provided as part of the abortion care

pathway. Repeat abortions can be an indication that contraception advice could be improved during the abortion care pathway.

Table 14 – Repeat abortions data

	Repeat abortions all ages	Repeat abortions in women aged under 25	Repeat abortions in women aged 25 and over
England	40.4	27.7	48.0
South East	40.6	27.2	48.4
Surrey	38.8	26.7	45.7

Surrey has lower numbers of repeat abortions for both under and over 25s compared to England and the South East (see Table 14) but work to improve this should be ongoing.

Recommendation:

- Sexual health providers and abortion providers should continue to work together to ensure contraception is available as part of the abortion pathway; commissioners should support this

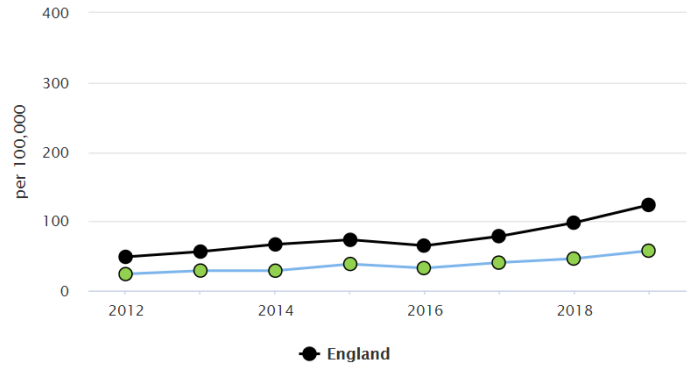
Sexually Transmitted Infections (STIs)

Gonorrhoea

Gonorrhoea is passed on through unprotected sex and often causes symptoms. It can be prevented by increasing condom use and reducing the number of different sexual partners. If people do contract gonorrhoea, then it is important, they are tested, treated and, importantly, that any recent sexual partners are notified of their infection. Testing, treatment and partner notification is carried out by specialist sexual health services.

There has been a sharp rise in gonorrhoea rates in England in recent years. Surrey has seen a slight increase in line with the national trend but not as sharp as the England average, as shown in Figure 24 below.

Figure 24 – Gonorrhoea rates in England and Surrey, 2012 - 2018



According to the BMJ, cases of gonorrhoea in England increased by 26% last year to the highest level since records began in 1918. Most gonorrhoea diagnoses were reported in gay, bisexual, and other men who have sex with men (up 26% to 33,853), but diagnoses also increased in heterosexual women (up 26% to 17,826) and heterosexual men (up 17% to 15,253). Public Health England have reported that the rise in diagnoses was partly due to people not using condoms correctly and consistently but also due to an increase in testing.

Gonorrhoea rates for districts and boroughs are given below in Figure 25.

Figure 25 - Diagnostic rates per 100,000 population for 2019

Area	Recent Trend	Count	Value
England	↑	69,499	123
Surrey	↑	688	58
Guildford	↑	112	75
Spelthorne	→	75	75
Epsom and Ewell	↑	57	71
Reigate and Banstead	↑	97	65
Elmbridge	→	82	60
Mole Valley	↑	52	60
Tandridge	→	41	47
Surrey Heath	→	41	46
Runnymede	→	40	45
Woking	→	44	44
Waverley	→	47	37

Source: Public Health England

All districts and boroughs in Surrey have lower gonorrhoea diagnostic rates than the England average (they are all in green in the figure above). Some areas have higher rates than others. For teenage pregnancy we saw that more deprived areas usually have higher rates of teenage pregnancy. This pattern is not seen with gonorrhoea rates and there are no specific recommendations for particular areas based on the rates above. General prevention (including condom distribution and education) remain important. As outlined in the section on 'Urgent Care' above, repeated infections with gonorrhoea (and other STIs) in the same person suggests more health promotion is needed.

Chlamydia

Chlamydia is the most commonly diagnosed bacterial sexually transmitted infection in England, with rates substantially higher in young adults than any other age group. The National Chlamydia Screening Programme (NCSP) recommends screening for all sexually active young people under 25 annually or on change of partner (whichever is more frequent). Chlamydia differs from gonorrhoea as it often does not cause symptoms initially but can cause complications in pregnancy and pelvic inflammatory disease if untreated.

The section on Contract Management above outlined the number of under 25s receiving a test for chlamydia. In this section we look at the number of people in Surrey who are detected as having chlamydia in the population.

Note that the rates in Surrey for chlamydia and gonorrhoea are both lower than the England average. Because there is a screening programme for chlamydia, lower detection rates are seen as negative and shown in red (the opposite situation to gonorrhoea in which lower rates are shown in green). This is complicated as higher numbers of people being infected with chlamydia will give a higher detection rate but that is not a desired outcome. If more people in an area have chlamydia, this could be because more people are being tested, or it could be that more people are infected with chlamydia, but both would be reported as an 'improvement'. Overall the aim of this indicator is to ensure that more people are screened (i.e. tested without having symptoms) in the community - through pharmacies for example. This is outlined in more detail in the PHE Fingertips data.

Figure 26 - Chlamydia detection rate per 100,000 people aged 15 to 24

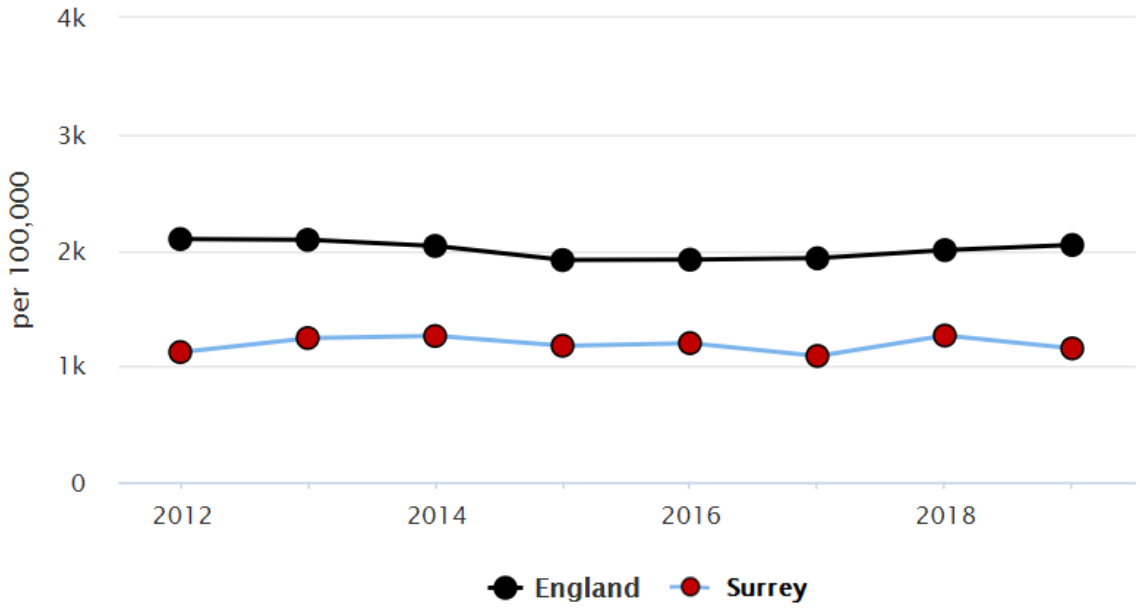


Figure 26 above shows that the Chlamydia detection rate in Surrey (red) is considerably lower than the rate for England. Again, this is in part due to fewer people in Surrey being infected with chlamydia. However, we also know that more could be done to improve the number of people tested for chlamydia. Screening is a 'universal offer' in that it is not targeted in specific locations (although this screening programme is for under 25s specifically). The most recent guidance on this is from 2014: Towards achieving the chlamydia detection rate Considerations for commissioning. This outlines the following services which can increase the chlamydia detection rate:

- General practice
- Specialist sexual health services
- Community pharmacies
- 'Internet-based testing' (online services)

Commissioners should review the 2014 guidance but should be mindful of the increased pressures on general practice and community pharmacies currently (and on health services in general).

Recommendation:

- Commissioners should review the 2014 guidance 'Towards achieving the chlamydia detection rate'

Syphilis

Syphilis is an important public health issue in men who have sex with men (MSM) among whom incidence has increased over the past decade. If it is not diagnosed and treated early then it can cause severe complications and can lead to death (although this is now very rare in the U.K.). Rates of syphilis have increased sharply in some areas of the U.K. Figure 27 below shows that rates of syphilis are very low in Surrey. The highest rates are seen in areas where there are higher proportions of men who have sex with men.

Figure 27 – Syphilis diagnostic rate per 100,000, source PHE

Syphilis diagnostic rate / 100,000 2019

Area	Recent Trend	Count	Value
England	↑	7,793	13.8
South East region	↑	847	9.2
Brighton and Hove	→	147	50.5
Portsmouth	→	30	14.0
Southampton	→	33	13.1
Medway	→	33	11.8
Bracknell Forest	→	14	11.4
West Sussex	→	84	9.7
Isle of Wight	→	12	8.5
Kent	↑	128	8.1
Slough	→	12	8.0
Surrey	→	87	7.3
Windsor and Maidenhead	→	11	7.3
Oxfordshire	↑	50	7.2
Hampshire	↑	99	7.2
Reading	→	11	6.8
Wokingham	→	11	6.4
East Sussex	→	34	6.1
West Berkshire	→	9	5.7
Milton Keynes	→	12	4.5
Buckinghamshire	–	-	-

Rates of syphilis continue to be monitored but currently the only recommendations are those based on general prevention, particularly for men who have sex with men.

HIV

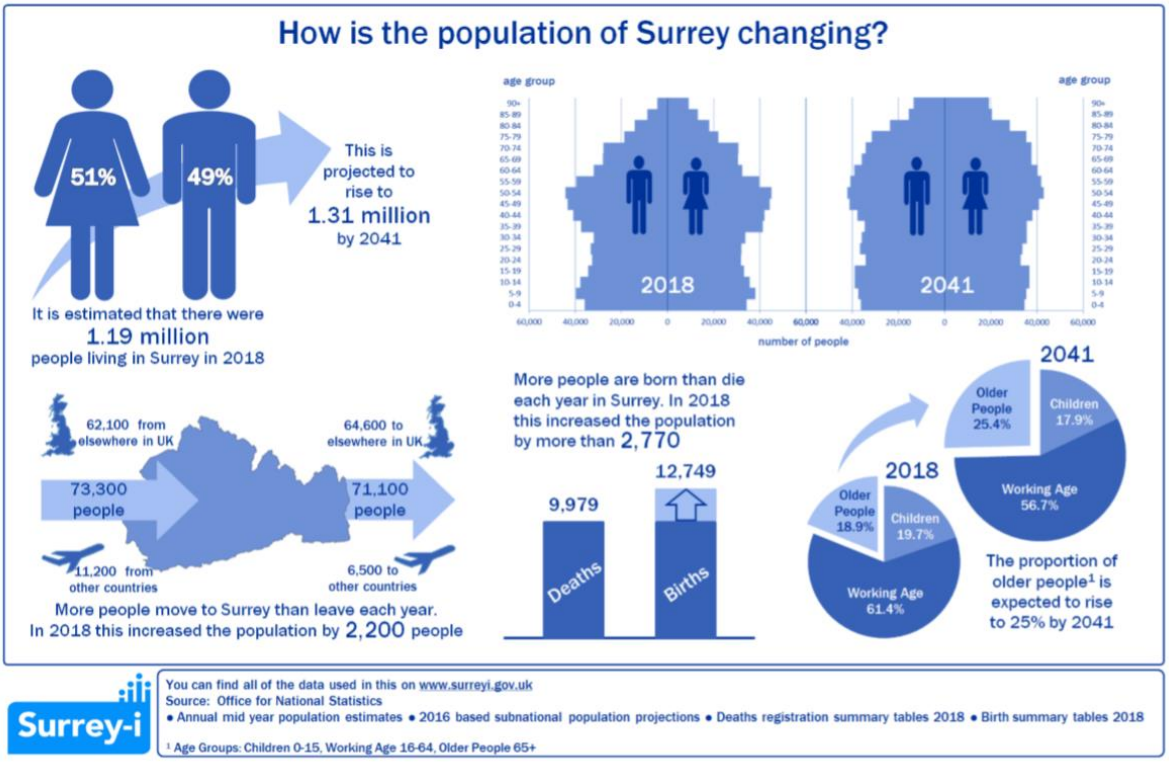
Information related to HIV and services for people living with HIV are commissioned by NHS England and NHS Improvement and are covered in a separate needs assessment which was published in June 2021. A copy of this separate needs assessment entitled ‘Surrey health needs assessment for people living with HIV 2021’ can be accessed by emailing england.speccom-se-contracts@nhs.net and requesting a copy.

Specific groups in Surrey

- Outlines specific groups who may need a more targeted approach for sexual health
- Young people are a particular focus
- Some local authority areas have particularly high proportions of certain demographic groups (for example people from minority ethnic groups or who do not identify as heterosexual/straight) but this is not the case for Surrey
- Lower proportions of people can make it more difficult to target certain groups and working with people who represent these groups is particularly important

This section of the Needs Assessment provides a basic overview of population characteristics across Surrey. It then relates this to specific aspects of sexual health related to those characteristics (see Figure 28). More detailed information about the demographic breakdown of Surrey's residents can be found on Surreyi; www.surreyi.gov.uk

Figure 28 – How population of Surrey is changing, source: ONS, Surrey Snapshots www.surreyi.gov.uk



Age

Older people

In the UK, sexual practices have changed vastly over the last 50 years. This is especially apparent amongst females. People are sexually active well into their later life and so a 'life course approach' to the promotion of good sexual health is needed[5]. More recent data

[5] Mercer C. H. Et al (2013) Changes in sexual attitudes and lifestyles in Britain through the life course and over time: findings from the National Surveys of Sexual Attitudes and Lifestyles (Natsal) The Lancet 382(9907); 1781 – 1794

suggests that older people may now be in more need of sexual health services than previously. STI rates are increasing amongst people aged 50 and over[6].

Data shows that more older people are becoming newly single through separation, divorce or the death of their partners. People in this age group may have less knowledge regarding how to maintain optimal sexual health and may not always take protective measures e.g. using condoms to protect against STIs in a new relationship[7]. Age UK[8] conducted a survey with 2,000 males and females aged 65 and above and found that:

- most older people were keen to continue a fulfilling sex life
- sex was viewed as a taboo subject for many and they found it difficult to discuss with their partner
- only 17% said they felt comfortable talking to a health professional about sex
- there was a lack of knowledge about sex overall - 76% of those asked were not getting any sexual health advice at present and less than 15% said they had actively sought any sexual health advice in the last 20 years. Many people also said they did not know where to access guidance or advice

A recent review[9] identified four key barriers that older people have identified that stops them from accessing sexual health advice and treatment:

1. Cultural and societal views and beliefs toward sexual health
2. Stigma, embarrassment and discrimination
3. Lack of education and training of healthcare professionals
4. Quality of relationship between patients and health professionals

There is a perception that younger people prefer online services and information more than older people but through our engagement this has been challenged. Older people are now a lot more confident and comfortable to access support online and this should be encouraged to ensure a diverse availability of service provision.

Recommendations:

- Explore acceptability of different methods of service delivery with older people specifically (online vs face to face for example) as the perception that younger people prefer online advice and services compared to older people has been challenged
- Consider targeted communications for older people around sexual health promotion

[6] Terrence Higgins Trust (2018), Insight Briefing, Still Got It – Sexual Health of the Over 50s, accessed from https://www.tht.org.uk/sites/default/files/2018-04/Still%20Got%20It%20-%20Over%2050s%20Insight%20Briefing.pdf

[7] Age UK (2019), As STIs in older people continue to rise Age UK calls to end the stigma about sex and intimacy in later life, accessed from https://www.ageuk.org.uk/latest-press/articles/2019/october/as-stis-in-older-people-continue-to-rise-age-uk-calls-to-end-the-stigma-about-sex-and-intimacy-in-later-life/

[8] Age UK (2013), Health & Wellbeing: Sex in Later Life

[9] Ezhova, I., Savidge, L., Bonnett, C., Cassidy, J., Okwuokei, A., & Dickinson, T. (2020). Barriers to older adults seeking sexual health advice and treatment: A scoping review. International journal of nursing studies, 107, 103566.

Young People

People start having sex at different ages. In England the age of consent to any form of sexual activity is 16 for both men and women. The acceptable age to start having sex varies hugely between different individuals, families and cultures. It is important that young people feel able to talk openly about sex and ask about which services they might need in a non-judgemental way. The sexual health of young people was the most common concern raised during our engagement as well as 'young people' as a group and this has been addressed in sections on sexual health services and teenage pregnancy above. This section outlines wider opportunities for improving the sexual health of young people.

Schools

Relationships and sex education (RSE) and health education

Relationships and Sex Education (RSE) should form an integral part of Personal Social and Health Education (PSHE) and be embedded as a whole school approach. In September 2020 relationships education in primary schools, RSE in secondary schools, and health education in both primary and secondary became statutory in all schools. This includes academies, free schools, faith schools and the independent sector. Statutory guidance was published in 2019.[10]

School is cited by young people as the preferred source of RSE, followed by parents and health professionals. Media and internet are not the most preferred sources. [10]

What did young people in Surrey tell us?

Young people who took part in a focus group spoke at length about sexual health education at school. They felt that what they were taught at secondary school was useful but it was not enough. They identified a gap in that the education did not cover anything about sexual health services; what they were, what they offered and how they could be accessed if needed. They also felt that they could not speak to teachers in school because they were limited in what they could say and rather than provide advice, they were more likely to signpost them onwards. They would prefer an external speaker or specialist to come in and tell them about the services where they could openly ask questions.

RSE should be an age appropriate entitlement for all children and young people, including young people with additional needs, disabilities or learning difficulties, through comprehensive delivery in schools, special schools, colleges and alternative provision.

RSE contributes to health, emotional wellbeing and safeguarding. Providing information, skills and values to have safe, fulfilling and enjoyable relationships; alongside resilience and protective benefits concerning issues such as Child Sexual Exploitation (CSE), Child Sexual Abuse (CSA) and mental health

10 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/836597/Teenage_Pregnancy_Prevention_Framework.pdf

What does the evidence say?

National and international research shows that good quality RSE has a protective function as young people who have had good RSE are more likely to choose to have sex for the first time later. There is no evidence that RSE hastens the first experience of sex[11]. Teaching young people about contraception does not contradict messages about delaying the first experience of sex[2]. There are also longer term benefits to health and wellbeing associated with receiving comprehensive RSE[2]

The Surrey Approach

The Surrey Healthy Schools Self-Evaluation Tool provides Surrey schools with the opportunity to reflect upon, capture and develop practice which actively promotes physical, emotional and mental health and wellbeing. It provides an evidence-based framework for schools to co-ordinate, develop and improve their provision which supports personal development, behaviour, teaching and learning, and leadership and management. Surrey Healthy Schools is not aimed merely at pupils' health or school curriculum development but centres around the whole school environment and all aspects of school life.

Engaging with the Surrey Healthy Schools Self-Evaluation Tool enables schools to capture qualitative and quantitative data which will assist in the identification of areas of strength and areas which require development. It also provides opportunities for both internal and external reporting and in the development of action planning by automatically populating actions where standards are not met.

All Maintained, Academy, Foundation, Voluntary-Aided, Trust, Independent and Free schools can access the Surrey Healthy Schools Self-Evaluation Tool.

To engage in the Surrey Healthy Schools Approach, schools must use the online Surrey Healthy Schools Self-Evaluation Tool available here: www.healthysurrey.org.uk/professionals/healthy-schools

RSE needs to integrate with a whole school approach promoting healthy and respectful relationships with clear links to relevant policies on anti-bullying, alcohol and drugs, emotional health, CSE and safeguarding.

Looked after Children and Young People

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

Children who are looked after are exposed to greater risk factors for teenage pregnancy than many other groups. Risk factors include socioeconomic deprivation, low educational

[11] https://www.sexeducationforum.org.uk/sites/default/files/field/attachment/SRE%20-%20the%20evidence%20-%20March%202015.pdf

attainment, lack of consistent positive adult support, being the child of a teenage mother, low self-esteem and experience of sexual abuse.

Representatives from the Looked After Children's Health Team are part of the Surrey Sexual Health Outreach Group.

School Nursing Services

School nurses provide a variety of services such as providing health and sex education within schools, carrying out developmental screening, undertaking health interviews and administering immunisation programmes. In Surrey, school nurses are commissioned by SCC Public Health team and come under Children and Family Health Surrey services. The school nursing teams are made up of school nurses, registered nurses, nursery nurses and clinical health assistants.

The school nursing team are part of the Surrey Sexual Health Outreach Group. School nurses were the largest group to respond to our 'General Professionals' Survey (see box on engagement below)

Family Nurse Partnership

Surrey's Family Nurse Partnership (FNP) service supports young women aged 19 or under who are expecting their first baby from early in pregnancy until their child is two years old. The service is delivered by a team of specialist nurses who are based at Leatherhead Clinic but who work across the whole of Surrey.

The voluntary programme provides on-going intensive, structured support from specialist nurses. They work closely with the young women to ensure they receive practical health and emotional support and advice for themselves and their babies. The future outcomes for both children and adults are strongly influenced by factors in pregnancy and first years of life, so this programme offers some of the most vulnerable babies and young parents a better chance in life.

The Family Nurse Partnership are part of the Surrey Sexual Health Outreach Group.

Surrey County Council Services for Young People

Through centre based youth work, Surrey County Council Services for young people provides planned and opportunistic input for young people on sexual health and support to access services as appropriate. Many of the centres in Surrey provide the 'Get It On' condom distribution scheme and youth service staff receive training from the Specialist Sexual Health Service Outreach Team.

Representatives from the youth service are part of the Surrey Sexual Health Outreach Group.

What did health professionals tell us about young people?

When asked what the main issue was for the people they work with in the general health professional survey, a key concern was access to services. Many commented they felt there was a lack of services that young people could access on their own, given that they were often reliant on an adult for transport. They also highlighted a concern that young people often do not know where or how to get access to information on sexual health related topics and the relevant services:

> *'[There are] not enough clinics or advice locally to them, not knowing where to get advice from, too embarrassed to ask at school etc.*' (School Nurse, by survey)

This, and other similar comments, suggest that some healthcare professionals view specialist sexual health clinics as the only or main service available to young people. In our engagement with younger people, however, many of them said that a specialist clinic would not be their first choice for sexual health advice and services. Whilst the pressure on healthcare services, particularly primary care, is acknowledged, it is also important to respond to the preferences of young people.

One professional commented on the impact of the individual's cultural background, as this influenced their understanding of sexual health issues and their willingness to discuss the topic:

> *I work with young asylum seekers and refugees. They often arrive in the UK without having any previous sex education. The often come from backgrounds with distinct cultural norms and this can impact on their understanding of healthy relationships. Sex and sexual health can be a difficult topic for them to speak openly about.* (Youth Worker, by survey)

When asked about knowing how to respond when people asked for their support, the vast majority answering the general health professionals survey said they were confident in providing advice due to previous trainings attended. One individual highlighted they were not always clear on 'availability of local sexual health services and how YP [young people] access these'.

We heard from one respondent about concern for young people accessing pregnancy testing. Pregnancy testing is available for young people at the specialist sexual health service and GP surgeries if required. This reflects the confusion and misunderstanding amongst health professionals about what provision is available, and the need to highlight and promote services available.

It was suggested that the condom distribution scheme could be improved, and this is addressed in the specific section on this above.

Clinicians in the specialist service agreed that links with school nurses could be improved:

> *It would be great to link in more with school nurses…to have a network of school nurses we could link in with? (*Consultant in Sexual Health and GU Medicine)

Surrey County Council commission school nurses and the specialist sexual health service so could facilitate this.

Recommendations for education:

- Information sessions for primary and secondary school staff and specialist teachers for inclusive practice to support subject knowledge. These should be framed by prevention and address RSE and wider health topic areas
- Sexual health training for PSHE leaders, PSHE teachers, pastoral leaders, Home School link workers and Designated Safeguarding Leads
- Information session available to school governors each year
- Specialist PSHE/RSE training for secondary schools, SEND schools and PRUs, also primary schools.

Recommendations for communications:

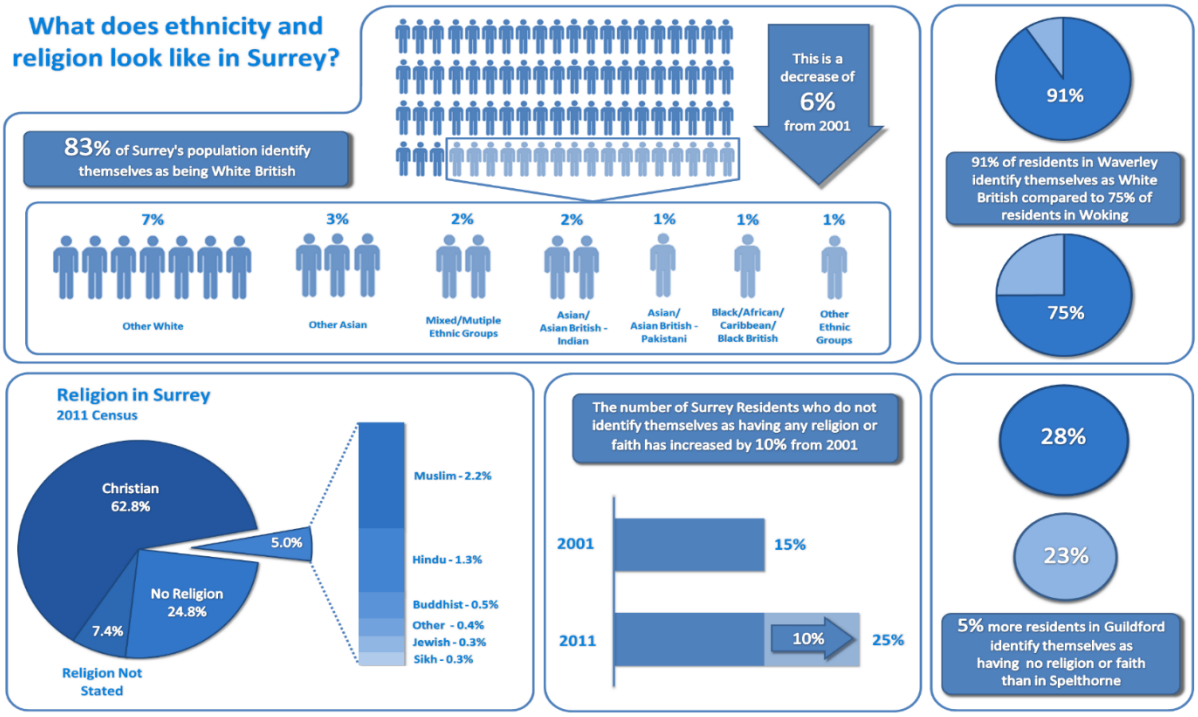
- A clear communications plan should be available on how priority groups are to be targeted and updated regularly
- A range of communication methods, including digital, need to be used to target young people
- Communication methods should have input on design from young people and be tested on young people
- Communications on the variety of ways young people can access services should be clear
- Health Professionals should have clear pathways and understanding of services available for young people

Priority groups

This section looks at specific groups in Surrey who may require more targeted sexual health promotion, targeted outreach work and/or specific services to reduce inequalities in sexual health outcomes.

People from a minority ethnic background

Figure 29 – Ethnicity and religion breakdown in Surrey



According to the 2011 Census data, 17% of Surrey's population are from a minority ethnic background (see Figure 29). There is an aim to record ethnicity in all healthcare data. However, this is mainly 'self-reported' (by the patient) and this is a notoriously poor method of recording. Qualitative research such as this BMC Public Health paper report that uncertainty on how ethnicity data would be used is a key reason people from minority ethnic backgrounds choose not to report their ethnicity.

It is important to note that comparing patient reported ethnicity data with Census data is not appropriate. Reporting of ethnicity in medical records is generally far lower than that in the census and this comparison will suggest far lower proportional use of services by people from minority ethnic groups.

Nevertheless, ethnicity is an essential consideration in sexual health prevention and service provision. Within the UK, residents from a minority ethnic background are disproportionately affected by having poorer sexual health outcomes. There is wide variation in the levels of STIs amongst ethnic minority communities which is influenced by several factors, such as varying sexual attitudes and behaviours, patterns of sexual mixing, language barriers and access to sexual health services. The data shows that people from black African ethnic minority groups

are at a higher risk of contracting sexually transmitted infections (including HIV). For example, people from black African backgrounds in the UK are particularly affected by HIV but in comparison, black Caribbean residents tend to have higher prevalence of STIs (such as syphilis, chlamydia and gonorrhoea) but have lower HIV rates[12]. Data collected in 2016 in London shows that the highest number of new STIs diagnosed are within the white ethnic group, with only 9% of new STIs diagnosed in people from a black Caribbean ethnic background. However, they have the highest rates in relation to the population; 2,815 per 100,000 people. This is twice as high as seen in the white ethnic group, as reported by Public Health England Spotlight on sexually transmitted infections in London.

Engagement

In 2019, the Surrey County Council public health team began a project aimed at identifying the views of people from minority ethnic backgrounds on using sexual health services. A number of organisations were approached to try and engage with target groups and one, the University of Surrey, agreed to support the work. Ethical approval was obtained and the project began with an initial interview in March 2020. Unfortunately, the COVID-19 pandemic then impacted universities, this project was paused and subsequent communications suggest this is not currently feasible. As only one participant was interviewed then any views given would be identifiable so no results can be published.

As part of the needs assessment, the team sought online engagement with key groups on this. Early discussion with Healthwatch on this helped us identify the need to translate the survey into the following languages:

- Urdu
- Bengali
- Polish
- An easy read version

In depth engagement was sought by promoting the survey and seeking interviews and focus groups with members of these ethnic groups through established organisations working with these groups in the community such as the Surrey Multi-Ethnic Forum or ‘SMEF’.

We received a small proportion of survey responses from people from non-white backgrounds. None of our translated surveys were requested. Engagement does not take place in a single time frame and we will continue to use these as more face to face contact is allowed.

Reflections on engaging with key groups on sexual health

Part way through the engagement process the team reflected on our low returns/engagement with people from black, Asian and other minority ethnic groups. Dr Suhana Begum led on engagement and has a professional doctorate using qualitative research to explore challenging topics. Dr Begum has previous experience of engagement with Bengali women on screening for cervical cancer (‘smear tests’). Dr Begum described that even though cervical screening is not seen as specifically ‘sexual’, it was still incredibly challenging for women from Bengali backgrounds to discuss with other people. The reasons people from certain ethnic

[12] London Councils (2013), HIV Prevention Needs Assessment for London, Future Commissioning of London HIV Prevention Services Project Steering Group, accessed from file:///C:/Users/sbegum/Desktop/FCLHPSHIVNeedsAssessmentForLondon.pdf

backgrounds do not access sexual health services (embarrassment, shame etc) are often the very reasons that people from these backgrounds may find it difficult to talk about their sexual health needs to non-clinicians. The team discussed this further with Healthwatch. It was agreed that, in the absence of direct engagement with certain groups, it was still important to consider the needs of these groups. Relevant research was reviewed and summarised as below.

The evidence base suggests a number of barriers to accessing sexual health services for these groups. In many cultures there is still great stigma attached to health issues related to sex. People from some communities may experience feelings of 'shame' or embarrassment in needing to access sexual health services. They may also feel reluctant to access services due to not wanting to bring 'dishonour' or damage the family reputation. This is especially common in South Asian families[13]. Other research looking at 'one stop shop' models of sexual health care found that people from African backgrounds were distrustful of confidentiality within general practice. People from South Asian background often associated stigma with accessing GUM services and expressed a preference for a general practice one-stop shop where they could access services in a more discrete manner[14]. Research also indicates that people who are at risk of an STI tend to underestimate their risk and those who do perceive themselves to be at risk subsequently do not always access healthcare[15]. With regards to accessing services, existing research and our own engagement has shown that embarrassment is a key factor; people are afraid of being seen or identified when accessing services[16]. Another barrier was conflicting values and norms when it came to sex and sexual behaviour, especially amongst young people. If the behaviour that had resulted in them needing sexual health services was disliked or frowned upon within their cultural context (e.g. sex outside of marriage), they were less likely to access services[17].

Surrey also has a large Gypsy, Roma and Traveller population (GRT). This is a very specific group, with specific needs, and this is covered separately in

[13] Weston, H. J. (2003). Public honour, private shame and HIV: issues affecting sexual health service delivery in London's South Asian communities. Health & place, 9(2), 109-117.
[14] Griffiths C, Gerressu M, French RS, et al. Are one-stop shops acceptable? Community perspectives on one-stop shop models of sexual health service provision in the UK, Sexually Transmitted Infections 2008;84:395-399.
[15] Clifton, Soazig et al. STI Risk Perception in the British Population and How It Relates to Sexual Behaviour and STI Healthcare Use: Findings From a Cross-sectional Survey (Natsal-3)
EClinicalMedicine, Volume 2, 29 - 36
[16] Samangaya, M. (2007). ACCESS TO SEXUAL HEALTH SERVICES FOR YOUNG BME MEN: Nursing Times, 104(43), 32-33.
[17] Naz ProjectLondon(2006) Sexual Health Knowledge, Attitudes and Behaviours among Black and Minority Ethnic Youth in London. A summary of findings. Trust for the Study of Adolescence (TSA) and Naz Project London (NPL)

Appendix B – Gypsy, Roma and Traveller community (GRT).

Recommendations on engagement:

- Continue to engage with people and representatives from multi-ethnic groups and promote translated surveys as face to face contact
- Where direct engagement is not acceptable to specific groups, other available sources should be used to identify key areas for prevention and for reducing barriers to accessing sexual health services

Recommendations for services:

- The National Institute for Clinical Excellence (NICE) have published numerous guidance documents outlining best practice in delivering sexual health services[1]. A key recommendation is for organisations to try to reduce the barriers for access through service delivery. For example:
    - Services should emphasise confidentiality and make people aware they can access services anonymously.
    - Staff should also try to understand and be sensitive to the cultural issues or stigma that diverse groups may face in accessing treatment or having a particular diagnosis e.g., HIV[1].
    - All services need to ensure that they operate in a way that is as inclusive as possible.

Sex / sexuality

The 2011 Census did not collect information on sexual orientation so there is little reliable data on the number of people in these groups in Surrey. The most recent (2018) data from the Office of National Statistics only goes down to regional level. This is challenging as people who do not identify as heterosexual tend to live in urban metropolitan areas. The data provides information on people who identify as heterosexual/lesbian or gay/bisexual/do not know/refuse. The percentage of people who do not identify as heterosexual or straight is likely to be the best indicator of the proportions of people who have sex with people of the same sex as themselves. This is partly to due to cultural differences across regions in identifying as 'gay' or 'bisexual (ethnicity has a strong influence on this). This group also includes people who do not have sex at all. Within these limitations, the following key figures are relevant:

- In England 94.4% of people identified as heterosexual/straight (with 2.2% identifying as gay, lesbian or bisexual)
- In the South East, 94.9% of people identified as heterosexual/straight (with 2.5% identifying as gay, lesbian or bisexual)
- In London just 91.5% of people identified as heterosexual/straight (with 2.8% identifying as gay, lesbian or bisexual)

Men who have sex with men

Gay, bisexual and other men who have sex with men (MSM) are disproportionately affected by having poorer sexual health outcomes. In England, of the 64,831 new STI diagnoses in MSM in 2018, gonorrhoea and chlamydia were most common at 41% and 29%, respectively. Among MSM, although the majority of syphilis, gonorrhoea and chlamydia diagnoses are in those who are HIV-negative or of unknown HIV status, the population diagnosis rates are 3-6 times higher in those diagnosed with HIV[18].

The rise in syphilis, gonorrhoea and chlamydia diagnoses among MSM is likely to be primarily associated with behavioural changes such as an increase in partner numbers and condomless anal intercourse with new or casual partners. For some MSM, chemsex and group sex facilitated by geosocial networking applications may have also contributed[1]. MSM also tend to report higher rates of partner change than heterosexual populations and are more likely to belong to complex, densely connected sexual networks that facilitate rapid STI transmission[1].

Currently the specialist service has a specific outreach team member working exclusively with men who have sex with men. Surrey is limited in terms of entertainment venues specifically for LGBTQ+ people as seen in London, Brighton and other cities and there is no natural geographical focus for LGBTQ+ people. Some services in London and other areas with a higher concentration of LGBTQ+ people have dedicated LGBTQ+ clinics. The demographics of LGBTQ+ people in Surrey, along with our engagement, suggested that specific clinics for young people were a better use of clinical resources than dedicated LGBTQ+ clinics.

Women who have sex with women

Lesbian, bisexual and other women who have sex with women (LBWSW) have not experienced the single catastrophic disease scenario that was HIV for gay and bisexual men and their needs within women's health issues have often been marginalised or invisible[19]. This has perpetuated a lack of evidence and visibility within research and policy which creates a continual loop of exclusion.

A 2018 PHE report on 'Improving the health and wellbeing of lesbian and bisexual and other women who have sex with women[2] reports higher rates of some specific types of sexually transmitted infections, primarily bacterial vaginosis in women who have sex with women. However unlike for men who have sex with men, there is no routine publication of the prevalence of different sexually transmitted infections (STIs) in UK sexual minority women. Evidence from grey literature suggests that LBWSW are less likely to have undertaken STI testing than heterosexual women, suggesting a potentially unmet need[2].

Research into LBWSW's use of reproductive health services is limited, but multiple small-scale studies in the UK highlight consistent barriers, especially around heteronormative assumptions in access across sexual health, maternity and infertility treatment services. This suggests opportunities to improve access for this population[2].

Transgender, non-binary and gender diverse people

[18] https://www.gov.uk/government/publications/health-matters-preventing-stis/health-matters-preventing-stis

[19] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/723557/improving_health_and_wellbeing_LBWSW.pdf

At present, there is no official estimate of the trans population. GIRES, in their Home Office funded study estimate the number of trans people in the UK to be between 300,000 – 500,000, defined as 'a large reservoir of transgender people who experience some degree of gender variance'[18].

The 2020 State of the Nation report states that globally, transgender people face higher rates of HIV with risk of transmission up to 12 times greater than the general population[20]. We do not know about STI rates in trans and non-binary, including gender diverse, people in England as this data is not available.

Transgender, non-binary and gender diverse people often experience inequalities and discrimination when accessing healthcare services. Internalised self-stigma may also contribute to health inequalities experienced[3]. The sexual health needs of trans people remain understudied in the UK and internationally. Previous research into trans sexual health and HIV has focused mostly on trans women and little is known about trans men and non-binary people, who may be at risk of HIV if having condomless sex with cisgender men.[21].

The UK National LGBT Survey 2018 undertaken by the Government Equalities Office found that 17% of trans people had attended a sexual health clinic, compared to 29% of cisgender people. Among those that had attended a sexual health clinic, trans people were more likely to report a negative experience when accessing the service[22]. Trans respondents were also more likely to say that they had not found their GP supportive (4%) than cisgender respondents and were also more likely to say that their GP had not known where to refer them than cisgender respondents. In particular, trans men were more likely to have been worried, anxious or embarrassed about going (20%) than trans women (11%) and non-binary respondents (12%)[4].

BASHH provide guidelines on the provision of trans, non-binary and gender-diverse inclusive services and these guidelines highlight the need for waiting rooms and forms to be gender neutral, as well as ensuring forms and tests are inclusive of trans and non-binary, including gender diverse, identities[3].

What did our engagement tell us about people who identify as trans or non-binary?

In our engagement we heard from a small number of people who identify as non-binary. The issues raised were not specific to gender identity but included comments on advertising of services and travel time to the nearest clinic.

Through Healthwatch we also heard that the male/female question on the specialist service website was 'not trans-friendly'. This is a complex issue due to the need to identify the specific service required. For example, a person who identifies as male but was assigned as female at birth may require contraception based on progesterone rather than a condom. We are particularly keen to hear from people who identify as transgender to ensure that language and services are seen and felt to be inclusive.

Consultants in the specialist service told us that they used to see several people working in the entertainment and adult sex industry with higher STI rates but contact with these

[20] https://www.tht.org.uk/sites/default/files/2020-02/State%20of%20the%20nation%20report%20v2.pdf
[21] https://blogs.bmj.com/bmjsrh/2019/11/13/low-uptake-shc-trans/
[22] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721704/LGBT-survey-research-report.pdf

groups has reduced. This is an important group as trans people are more likely to report that they experience stigma when attending healthcare appointments.

Recommendations:

- Provide training for staff providing sexual health services, including provision in primary care and pharmacy to highlight barriers, discrimination and stigma experienced by the LGBTQ+ community
- Follow BASHH guidance on provision of inclusive services; ensure all communications and websites are inclusive
- Continue to engage and provide outreach with the LGBTQ+ community

Chemsex

Although not exclusively an issue of concern for MSM there is an increasing number of individuals who are using illegal chemical substances to enhance the sex they are having by reducing their inhibitions & increasing their confidence and enabling them to participate for much longer time periods potentially leading to multiple sexual partners in the same session. Chemsex as it has become known usually involves one of three main drugs being consumed Crystal Meth(amphetamine), Mephedrone or GHB/GBL, with all three having the potential to cause serious physical and mental ill health and potentially death if overdosed. GHB and GBL is a liquid which when drunk makes the user feel less inhibited and euphoric whilst Crystal Meth and Mephedrone are mainly smoked, snorted or injected and makes the user feel alert, confident and euphoric. If a person is under the influence of drugs, they are less likely to consider using condoms during sex and be less aware of other risks they may be taking which will increase the risk of STI or HIV transmission. This requires targeted work and the clinicians in the specialist service, and relevant outreach workers, ensure that services and prevention is targeted for this specific group.

Sex workers

The evidence suggests that the numbers of people selling sex has increased in Surrey in recent times. Streetlight is an organisation in Surrey which supports women selling sex in a variety of ways. In January 2020 on one day, a Streetlight UK support worker found over 2,000 adverts for women selling sex across Surrey (a 9% increase from 2018). From the period of March to August 2020, they reached out to 765 women selling sex across Surrey via the online outreach service. This led to 134 referrals into the service for either practical, emotional, exit or post-exit support. They have also accompanied police on six operations across Guildford and Epsom and have planned to do this on a regular basis to support women in suspected brothels or addresses where modern day slavery may be taking place. There are a number of factors associated with sex work (i.e. having multiple partners, substance misuse and violence) that mean the health of the sex worker is at risk. The prevalence of HIV and sexually transmitted infections (STIs) are higher amongst female sex workers in comparison to the general female population. Within this group, there are some subpopulations (e.g. migrant female sex workers) who show increasingly worse sexual health outcomes. Other evidence

shows that in England, female sex workers experience a number of barriers to accessing prevention and treatment services[23].

With regards to male sex workers, the male sex work industry in Surrey is very disparate and the workers tend to work independently. When they access sexual health services they rarely declare that they are sex workers. They will often describe themselves as gay men because they will get all the screening that they need without making a sex worker declaration. Most men will also advertise their services via the internet as there is not any street based male sex work. Therefore, searching for men who would fit this criterion would be very difficult, even if they subsequently engaged and gave their feedback.

Engagement with clinicians in the specialist service suggests that far fewer sex workers have been presenting to the specialist service recently. COVID-19 will have had a major effect on the sex industry but it is unlikely to have stalled completely.

Recommendations:

- Ensure that sexual health service outreach team continue to work closely with Streetlight UK in Surrey and provide targeted interventions
- Consider a scheme for sex workers which will enable fast track attendance at sexual health services
- Explore whether home testing options are used by sex workers and explore alternatives if needed

Physical disability

Data from the 2011 Census shows that 13.5% of Surrey's population said their day to day activities were limited by a long-term health problem or disability[24].

There is a prevalent belief that people with a disability do not want sex, which can lead to barriers to sex education, especially for young people with a disability[25]. This can make it difficult to have discussions with parents / caregivers and others about what good sexual health looks like and where they can access sexual health services if needed. All services are required to make 'reasonable adjustments' for people with a disability. This includes ramps, adjustable beds or suitable facilities e.g. disabled toilets.

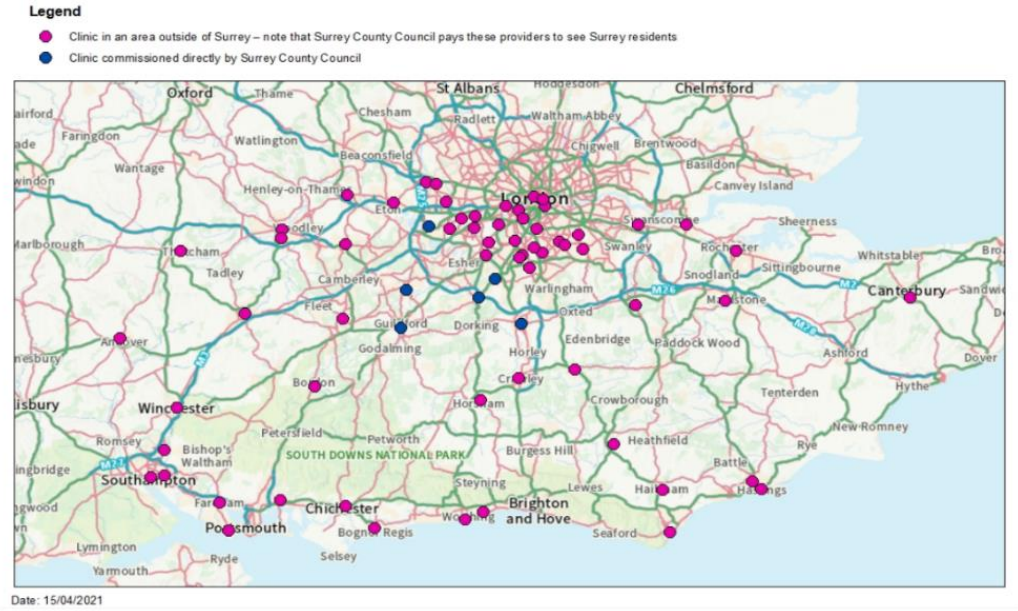
In our continued engagement we are extremely grateful to the Surrey Coalition of Disabled People for representing the needs of people in Surrey living with disabilities. They have raised that a further barrier to access is often travel to services as transport may be unsuitable for those with disabilities e.g. no step free access. These issues can be even more difficult in a large county such as Surrey.

[23] Mc Grath-Lone L, Marsh K, Hughes G, Ward H. The sexual health of female sex workers compared with other women in England: analysis of cross-sectional data from genitourinary medicine clinics. Sex Transm Infect. 2014 Jun;90(4):344-50. doi: 10.1136/sextrans-2013-051381. Epub 2014 Feb 3. PMID: 24493858; PMCID: PMC4033115.
[24] https://www.surreyi.gov.uk/2011-census/disability-health-and-carers/
[25] Shah, S. (2017, September). "Disabled People Are sexual citizens too": supporting sexual identity, Well-being, and safety for Disabled Young People. In Frontiers in Education (Vol. 2, p. 46). Frontiers.

I use a wheelchair and sometimes when I need to go to a [sexual health] clinic, the lifts in the train station are not working. I cannot ask my mum for a lift, and sometimes I had to go to A&E for treatment, which wastes everyone's time (Surrey resident)

As outlined above in the section on 'Out of Area' specialist clinics, there remain large geographical areas in Surrey that are a considerable distance from specialist sexual health clinics. Our engagement often focused on the areas where there have historically been specialist sexual health clinics in acute trusts. However, Figure 14 (repeated below) shows that disabled people in the South West of Surrey would face considerable challenges accessing specialist sexual health services.

Figure 14 - Map of Specialist Sexual Health clinics in neighbouring counties



Even if resources (clinical staff, clinical space, budgets etc) were vastly increased, there would still be people living considerable distances from specialist sexual health clinics. For some people, online services offer solutions for non-urgent care such as routine STI testing. However, our engagement also identified barriers to this:

> *I have tried to use the online service, but I need to take a small blood sample, and because of my disability I cannot get enough blood into the pot. I asked my GP if they could help but they said they do not do sexual health testing* (Surrey resident)

Further investigation with primary care colleagues suggested this can be down to misunderstandings with reception staff on the type of appointment/care needed. Residents may be able to request testing kits online and to return them, but assistance may be needed in using the test kits. Engagement with primary care suggested that a Healthcare Assistant may be able to assist with this, but that it would need to be explained to reception staff that the testing, results and any treatment would still be carried out by the specialist service.

Urgent appointments also represent a considerable challenge for people with a disability. As outlined above in the section on 'Urgent versus routine care', the need for repeated urgent appointments suggests that either different contraception methods are needed, or more targeted health promotion is required. Again, consideration should be given to the use of Health Advisors for targeted prevention work.

Deaf people

Our engagement highlighted particular challenges for deaf people, particularly around using telephone services:

> *Text service would help for deaf people* (Have your Say survey)

> *I have not seen any format in BSL (British sign language) for deaf users. I also do not seem to see any information on social platforms?* (Have your Say survey)

Communication with charities suggested that people who are deaf are particularly struggling to access health services in the pandemic due to difficulties with telephone appointments and triaging processes. The actions below are steps that can be taken by organisations to ensure that their service is accessible for all:

1. The Accessible Information Standard ensures people's communication needs are routinely collected and shared throughout the healthcare system, ensuring that people only need to state their preferences once (e.g. requiring an interpreter, requiring communication in a written format etc) and this should be applied to all settings

2. The British Sign Language association recommends that health care settings should also ensure patients are offered access to video relay services to enable them to communicate with people whose first language is sign language and cannot use a regular telephone. Further information can be found here

Recommendations:

- Ensure all services are conforming to relevant regulations for people who are deaf
- Review provider policies to ensure they are as inclusive as possible for people who are deaf

Learning disability

Many people with a learning disability can and want to participate in a healthy, safe and happy sexual and personal relationship[26] but their sexual health needs will vary considerably and be very individualistic in nature. This can make providing a standardised service offer difficult to achieve. This should not however, prevent or impact on residents receiving the information and support they need to have a full and satisfying sex life which is also safe and consensual.

It is difficult to identify exactly how many people are living with a learning disability in Surrey as the latest health needs assessment published in 2011 estimated that there were between 3,000 and 16,000 individuals but that this figure was likely to have increased by a further 14% by 2021 to a total of over 18,000 who currently or in the future may have difficulties accessing sexual health services in Surrey[27]

To reduce these issues, we need to consider how individuals are provided with information about their sexual health and whether educational establishments and/or caregivers can support and reinforce the messages of what good sexual health is and how to access services in an appropriate way. Relationship and sex education should not be limited to those local residents who are young people but should be made available to anyone with a learning disability who would benefit from it as often it is currently provided in an unplanned and inappropriate way and consequently places individuals at risk of contracting an STI or having a negative sexual experience.

[26] Sinclair, J., Unruh, D., Lindstrom, L. and Scanlon, D. (2015) 'Barriers to sexuality for individuals with intellectual and developmental disabilities: a review,' Education and Training in Autism and Developmental Disabilities, 50(1): 3-16.
[27] https://www.surreyi.gov.uk/dataset/vdkq5/learning-disability-in-surrey-health-needs-assessment-2011

Consideration also needs to be given to how a resident with a learning disability accesses local services in ways which reduce their anxiety and ensures that their needs are met. Examples of good practice found in the Surrey sexual health service include the provision of easy read information sheets about the service and how to access it, longer appointment times to ensure that information has been understood, maintaining continuity of care with the same clinicians supporting the patient to increase the feelings of trust, minimising waiting times in public areas which may add to the feelings of unease by using a separate space for the patient to wait in, but there are also other elements which could still be introduced. For example, awareness training for all staff in contact with patients, the identification of a Learning Disability Champion within each sexual health team who could liaise directly with the Safeguarding Lead as a single point of contact for questions or concerns as this area of work is a key focus for them.

When considering the sexual health needs of residents with a learning disability we also need to understand and consider the issue of 'Consent'. Under the Sexual Offences Act 2003 somebody with a learning disability may not have the capacity to refuse involvement in a sexual activity and therefore the person they are intimate with is breaking the law; which will also raise safeguarding issues around exploitation. There also needs to be consideration around consent when discussing contraception or termination of pregnancy services with women living with a learning disability and staff should receive additional training and support to ensure they are able to recognise and respond appropriately to any patient who presents to them. People with a learning disability are a key focus in clinical safeguarding and in the specialist sexual health service there is a safeguarding lead and a consultant who leads on safeguarding.

Mencap produces really helpful information on relationship and sexual health of people with a learning disability, including:

Challenges

Many people with a learning disability would like to pursue intimate or sexual relationships, but they face multiple barriers to developing such relationships, including the following:

- Meeting people is more difficult and social isolation is common.
- People are not receiving adequate relationships and sex education to give them the skills and knowledge to have healthy and fulfilling friendships and relationships, and to understand and explore their own sexuality.
- There is often a lack of privacy which restricts opportunities to explore and understand sexuality.
- The balance between risk and rights for people with a learning disability engaging in intimate or sexual relationships is often biased towards restricting their choices, both within family settings and other living arrangements.

We know that some of these barriers also prevent people with learning disability from accessing sexual health advice and services. In the specialist sexual health service there is a safeguarding lead and a consultant who leads on safeguarding.

The public health team worked with the engagement and participant officer for learning disability at Surrey County Council to establish the best ways to contact people with learning disability and the people who care for or represent them. We produced an 'easy read' version of or survey and contacted recommended organisations for distribution. However, people with learning disabilities were unfortunately not represented in our engagement. We therefore looked for other ways of representing the views on this group. The Mencap page provides easy read information for people with learning disability on sex and relationships. However, it does not give information on sexual health services specifically. We identified resources on how to make general healthcare settings more accessible to people with learning disability but nothing about sexual health services specifically.

Recommendations:

- Ensure that SCC Community Teams working with residents with learning disabilities are able to access up to date information and training on sexual health and know how to access appropriate services in either primary or secondary care.
- Support the further development of easy read leaflets and information sheets on a range of sexual health issues
- Identify a Learning Disabilities Champion at each specialist service Hub site to ensure
- Continue to work with partners on identifying ways to improve support and accessibility for people with learning disability

Other key areas

This final section addresses key areas of sexual health promotion and service provision that are not covered in previous sections.

Antimicrobial resistance in STIs

Increasing resistance and decreasing susceptibility to antimicrobials used to treat STIs has reduced treatment options and are therefore emerging concerns[28].

In the case of treating gonorrhoea, there are no classes of antimicrobials to which gonorrhoea has not developed resistance. As a result, in the UK, first-line gonorrhoea treatment was recently changed from dual therapy of ceftriaxone with azithromycin, to monotherapy with ceftriaxone at a higher dose[28]. Fortunately, ceftriaxone resistance remains rare in the UK[28]. With patterns of antimicrobial resistance (AMR) having the potential to change rapidly, ongoing monitoring of AMR is vital to ensure that first-line treatment remains effective

Cervical cancer screening

Most cervical screening is carried out in GP practices. It is one of eleven NHS national population screening programmes available in England which are commissioned by NHSE/I. The House of Commons Health Select Committee (chaired by former MP and General Practitioner Dr Sarah Wollaston) was highly critical of these effects of the fragmented commissioning arrangements introduced by Andrew Lansley's 2012 Health and Social Care Act:

It is unacceptable for women to have to undergo entirely unnecessary separate intimate examinations for smear tests that could have been carried out at the same time as an STI screen or contraceptive fitting at a single visit.[29]

NHSE/I are now in the process of developing a programme to roll out cervical screening in sexual health venues. Surrey commissioners and the specialist service provider have taken every opportunity to co-operate with NHSE/I as they introduce this in Surrey. The programme will enable cervical screening samples to be taken by a Sexual Health Service Provider (this covers Sexual Health, Contraceptive and Genitourinary Medicine). This is an additional option to the well-established General Practice (GP) service. GPs will remain the main point of access for cervical screening sample taking. Access through Sexual Health Services is expected to be of benefit to those people who would not access or are not registered with a GP Practice. This will have a positive impact on cervical cancer incidence and mortality rates and a reduction in inequalities. It will also reduce the need for cancer treatment such as chemotherapy and surgery.

[28] https://publichealthmatters.blog.gov.uk/2019/08/21/health-matters-preventing-stis/
[29] https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/1419/1419.pdf

Mycoplasma genitalium

Mycoplasma genitalium (also known as Mgen, M. genitalium or MG) is a sexually transmitted infection caused by a germ (bacterium). MG transmission can occur if someone has sex with a person who already has the infection[30].

MG has similar symptoms to Chlamydia but can also cause few or no symptoms. It is more resistant to treatment and if left untreated, can lead to pelvic inflammatory disease (PID) in women, an infection of the reproductive organs that can cause infertility31. It is often described as a 'new' STI but was discovered in 1981 and at the time, it was unclear that it was an STI. A reliable test has only been available since 2017 30.

Although awareness of MG is low, it is in fact more prevalent than Gonorrhoea. 72% of sexual health experts said that if current practices do not change, MG infections will become a superbug, resistant to 1st and 2nd line antibiotics, within a decade[31]. In 2018, The British Association of Sexual Health and HIV (BASHH) launched new NICE accredited treatment guidelines to help prevent MG 31.

Pre-exposure prophylaxis (PrEP)

PrEP is a pill taken to greatly reduce the risk of becoming HIV positive. It is taken before sex, so it is pre-exposure. Prophylaxis means to prevent infection. If people are HIV negative, at high risk and do not always use condoms, then PrEP can stop the risk of HIV.

Initially, PrEP was made available to 10,000 people in England as part of the IMPACT trial, which ended in July 2020. After the trial finished and results analysed, the PrEP drug was funded by the NHS in England and became available for free from sexual health clinics.

The specialist sexual health service in Surrey began their first PrEP clinic in October 2020 making PrEP available to service users. Service users that had received PrEP from the service in the past as part of the IMPACT Trial continued to get their supply in the usual way.

The first PrEP clinic opened in Buryfields with a second clinic opening at Earnsdale in December 2020. The service has plans to offer PrEP follow up via online services and are working to provide this in the future.

Psychosexual Counselling

The remit of psychosexual counselling is to provide help for residents presenting with problems of sexual dysfunction.

Local authorities are responsible for commissioning the sexual health aspects of psychosexual counselling. CCGs are responsible for commissioning the non-sexual health elements of psychosexual counselling[32].

In Surrey, the specialist sexual health service provides a specialist sexual medicine service, led by a Consultant qualified in sexual medicine and psychosexual therapy. Patients with

[30] https://patient.info/sexual-health/sexually-transmitted-infections-leaflet/mycoplasma-genitalium-mgen
[31] https://www.bashh.org/news/news/bashh-launches-new-nice-accredited-guidelines-to-help-prevent-mycoplasma-genitalium-becoming-the-next-superbug-but-funding-cuts-may-hinder-implementation/
[32] Making_it_work_revised_March_2015.pdf (publishing.service.gov.uk)

sexual problems are assessed by the consultant in a weekly clinic and an appropriate management plan is instituted. This may include:

- Further investigations and tests within Sexual Health Clinic, with GP or specialist referral (for example, Urology, Gynaecology) as appropriate
- Psychosexual therapy: referred internally to clinical psychologist for one to one or group therapy, or in some cases referred to specialist psychotherapy or psychiatric services (for example, Substance Misuse, Trauma care)
- Joint management by consultant and GP or specialist

For issues not covered by the specialist sexual health service, a referral would be made to the appropriate service, either directly or through the GP.

Blood Borne Viruses

In addition to the risks of STI and HIV transmission during sex there are also risks around becoming infected with other blood borne viruses such as Hepatitis B (HBV) and Hepatitis C (HCV). These risks are further increased through the use and sharing of equipment such as sex toys or drug paraphernalia.

Hepatitis is more infectious than HIV with the virus remaining infectious outside of the body for much longer and in the case of the HCV virus it can still be infectious in blood after 4 days.

Unlike HIV or HCV there is an effective vaccine to prevent HBV and all MSM especially those with multiple partners or who share drug taking equipment are encouraged to access the free vaccine through a sexual health clinic. There are no effective treatments for anyone who does become infected with Hepatitis B, although there is for residents if they become infected with Hepatitis C. The treatment for HCV infection has changed dramatically over recent years with a much higher success rate for curing the infection. The main difference between the HBV and HCV virus is that there is vaccine to prevent infection taking place from an infected individual. 70% of people who inject drugs and have a hepatitis C infection are unaware of their infection and if they share any drug taking equipment are potentially transmitting the infection[15]

Female Genital Mutilation

Female Genital Mutilation (FGM) is known by many names including female circumcision or cutting and is a non-medical procedure to change the female genitals by injuring or cutting them. It's practice in the UK is ILLEGAL and can lead to a lengthy prison sentence for anyone performing FGM, as well as for anyone found guilty of failing to protect a girl from having FGM carried out on them.

It is usually carried out on girls before the age of 15 and most commonly before puberty starts without her consent. It is carried out for various religious, cultural or social reasons predominantly from parts of Africa, the Middle East or Asia.

There are no health benefits to FGM but can lead to serious physical harm through initial blood loss or infection, ongoing pain and incontinence, pain during sexual intercourse, infertility issues and problems during childbirth. The process of FGM can leave the woman with extreme mental trauma leading to depression, anxiety, post traumatic stress disorder, sleep disorders, etc.

Anyone concerned about the potential for FGM to take place or becoming aware of it having happened has a responsibility to report their concerns. Regulated health & social care professions and teachers in England Wales must report 'known' cases of FGM in those under age 18 to the police as failure to do so constitutes a criminal offence.

Appendices

Appendix A – provision by ICP/CCG area

A recurrent theme through our engagement with primary care were around the increasing centralisation of services. This fell broadly into two categories:

a) Comments related to the move away from numerous smaller, less specialised clinics (often referred to as 'family planning clinics')
b) Comments related to changes to the location and number of larger, more specialised clinics located within Surrey boundaries.

Both of these changes affect how people access specialist services. Specialist clinics offer walk-in and/or booked appointments for all sexual health services and this naturally increases access to those who live closest. As outlined in 'Urgent Care' above, treatment of infections requiring urgent care would ideally not be a common occurrence. Similarly, complications with LARC (coils and implants) requiring a specialist would not generally be a common occurrence for the same individual as these are not replaced frequently and complications with one form of contraception may suggest other options are more suitable. Due to the considerable number of responses from primary care colleagues raising this issue this section outlines services available to residents in each of the ICP/CCGs areas in Surrey. However, it should be noted that ICP/CCG boundaries differ greatly in terms of population and area so the distinction can be somewhat arbitrary/artificial.

Note that the below represents what is commissioned in the area either through a contract or Public Health Agreements. Individual clinics, practices and pharmacies may not be offering sexual health services currently and anyone wishing to access services should check relevant websites and call in advance before attending

East Surrey ICP

For face-to-face specialist sexual health services, residents living in East Surrey are likely to be closest to the Earnsdale clinic in Redhill. There are currently no spoke clinics in this area. Approximately 20% of Tandridge residents use the sexual health service in Crawley. Residents in Reigate and Banstead also use the clinic in Crawley (9%) and the clinic in Epsom (8%). The costs of these are covered by Surrey County Council under cross-charging agreements.

16/17 GP practices or practice groups provide LARC (coils and implants) under Public Health Agreements.

Our engagement suggested variation in what would be considered a 'local' service:

> *Access to GUM clinics locally. Working in [practice in North of East Surrey area] it is quite a trek to encourage teenagers to make to get to a GUM clinic* (GP Survey) [note that this GP, was aware that they could send patients to Croydon, 6 miles away, or Redhill]

> *Lack of local service, nearest service 12 miles away, poor access to sexual health clinics, reduced service in last few years in community* (GP Survey)

It is acknowledged by commissioners that current commissioning arrangements would not support sexual health clinics closer than 6-12 miles for all Surrey residents. Ensuring all groups, particularly those less able to travel, are aware of the different options available is a key recommendation of this needs assessment.

Guildford and Waverly ICP

Buryfields specialist sexual health clinic in Guildford is located in the far north of the Guildford and Waverley ICP area. Up to 39% of Waverley residents accessing sexual health services go to the clinic in Aldershot (Hampshire). Guildford residents generally access Buryfields but around 9% access the Aldershot clinic.

19/21 of GP practices or practice groups in this area provide LARC (coils and implants) under Public Health Agreements.

Engagement at an ICP meeting suggested that specialist services were popular with GPs in the area:

We think the GUM service is fantastic! (Guildford & Waverley GP)

The main concern was around access to urgent appointments for Sexually Transmitted Infections and/or Long Acting Reversible Contraception. There were also questions around engaging with specific vulnerable groups.

The main comments from this area for the GP survey also focussed on availability of appointments, particularly for Sexually Transmitted Infections:

Availability of appointments [is my main concern, particularly for STIs (GP Survey)

The survey suggested that some GPs suggest patients go to Aldershot, but there was no mention of clinics south of Surrey borders (in Sussex for example).

Having a main specialist hub in Guildford naturally increases access for residents close to Guildford. However, it should be noted that more southern areas of this ICP represent some of the most remote parts of Surrey in terms of access to specialist services. Haslemere, for example, is 15 miles from Guildford by car. For many years, the nearest specialist sexual health services in Surrey have been in Guildford or further north. This, along with good transport links to Guildford, could explain why there was little comment about provision in this area throughout our engagement.

North West Surrey ICP

Epidemiological data and our continued engagement with residents, healthcare colleagues and elected members has continued to identify this area, particularly Spelthorne, as one where teenage conceptions, and other issues, are a particular concern. Clinics in nearby Hounslow and Feltham (provided by Chelsea and Westminster Hospital Foundation Trust) are very popular with residents of Spelthorne and Runnymede. Attendances at these clinics represent 30% of all visits to specialist services outside of Surrey.

31/39 of the GP practices or practice groups in this area provide LARC (coils and implants) under Public Health Agreements.

The specialist clinic in Woking is commissioned to provide urgent and routine contraception, STI and HIV blood appointments.

Weekly spoke clinics are also commissioned further north in the area to provide implant fitting and removal, chlamydia/gonorrhoea screening and condom distribution. This is to address transport issues, particularly for younger patients who may be unable to travel to the nearest clinics in Surrey or in neighbouring areas. Compared to clinics in Epsom and Leatherhead, clinics in North West Surrey have not been well used by patients. Clinical staff have been available but the premises for these clinics have frequently become unsuitable due to changes within the premises themselves. Clinics have been housed in community centres, general practice and a youth centre. None of these premises has been available/suitable in the long term. Clinics have alternated weekly between two areas.

Our engagement with CNWL staff has shown that the limited patients who do attend are often not from North West Surrey (the group who the spokes are commissioned to help):

> *It would be younger people, but usually in cars. Some people would drive from Guildford because they could not get an appointment there.* (Specialist Nurse, NW Surrey Spoke Clinic)

This highlights the importance of maximising the time clinical staff see patients for. Having clinical staff dispersed through different clinics intuitively feels like people would be able to access services closer to home. But this is balanced by the fact that larger clinics can offer all day/later appointments and walk-in services. However, access for young people in this area who may be unable to use online/telephone services remains a key priority. Through our engagement we heard:

> *The Stanwell clinic in a GP practice was quite well attended, but then the practice hired their own contraception nurses. Maybe a school or college would be better?* (Specialist Nurse, NW Surrey Spoke Clinic)

Options for spoke clinics in a college are recommended for future commissioning considerations. Based on analysis of attendance and our engagement it is also recommended that a weekly spoke clinic in the same area is preferred to alternating weeks in different locations. Although this reduces the geographical coverage it is important to have consistency so that young people who hear about the clinic are clear as to when the clinic runs.

NW Surrey GPs were particularly keen to give their views on services, highlighting the importance of this issue to GPs in the area:

> *Access for our patients in NW Surrey has been challenging. In fact, we feel that we need to avoid this service and use another one due to the provision for our patients. This is disappointing that residents of Surrey feel they do not have accessible sexual health care, in particular relating to STIs.* (GP Survey)

This feedback highlights the different perceptions of using services that are local to residents but outside of Surrey local authority boundaries (when compared to the views of GPs in Elmbridge for example). *Appendix C - Case study - Young people in Spelthorne* gives details of focus groups in Spelthorne in which young people were asked where their 'local' health services where and they included Feltham/Hounslow in their responses.

We heard reports of nearby services not accepting patients from outside of their area:

Good centre in Feltham but cannot use as do not accept patients out of area i.e., Hounslow vs Surrey. Very little in North West Surrey - buddy service we used sent patient to Woking Practice as no one else available. (GP Survey)

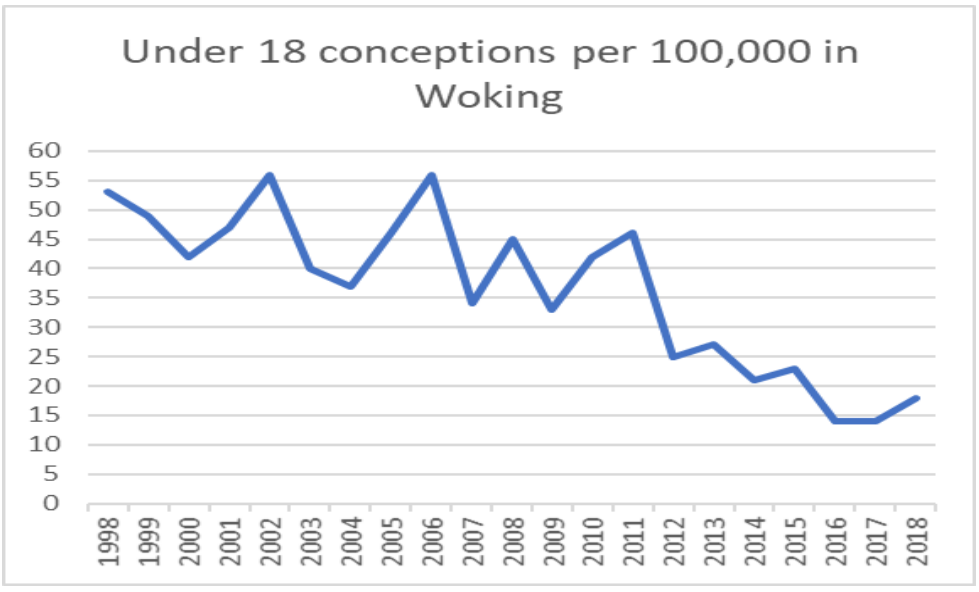
We heard similar reports from residents via council members. This was a serious concern and we investigated these claims as a matter of urgency. This was related to a misunderstanding on behalf of the trust providing these services in terms of payments for the use of services. Surrey County Council have always paid for Surrey residents to use services outside of Surrey and the issue has now been resolved. This has strengthened our relationship with the provider, and we will continue to build on this to ensure better communication between commissioners, specialist providers and primary care providers.

*The sexual health services in North West Surrey, Woking specifically are poor. There is no obvious clinic to attend and the rates of teenage Pregnancy has gone up immensely. (*GP Survey*)*

This highlights a number of issues. This feedback was given in December 2020 when elements of the Woking clinic were not available due to COVID which could explain the sense of there being no clinic to attend. The specialist provider sends regular communications to primary care via CCGs/ICPs. However, we heard from GPs that they receive so many communications about so many services that it is difficult to find and note key changes. Websites should be kept fully up to date as patients do not generally need referrals into specialists services so can see which services are currently available. Commissioners need to work with colleagues in the specialist service and in primary care to ensure key changes are highlighted.

Under 18 conception rates for Woking are given below in Figure 30:

Figure 30 – Under 18 conceptions per 100,000 in Woking



Currently (Apr 2021), 2018 is the most recent data available. Under 18 conception rates have generally been declining in Woking. In 2018, out of every 100,000 conceptions in Woking, 18 were in people aged under 18, compared with 14 in 2016 and 2017. With such small numbers this is very much within the bounds of 'normal variation' and is not evidence of an immense rise. However, GPs in some practises are likely to see local variation in this. In these

instances, where there are particular local concerns, it would be useful for the outreach team to be aware of these as local interventions may be appropriate.

Surrey Downs ICP

The Surrey Downs ICP area covers 3.5 districts and boroughs and has the largest variation in specialist clinic usage. In terms of Surrey based specialist clinics, Earnsdale clinic is close to the Surrey Downs border, but in the area covered by East Surrey ICP. There are spoke clinics in Epsom and in Leatherhead and these are well used.

The Wolverton clinic at Kingston hospital is close to many residents in the Surrey Downs ICP area. Surrey County Council's public health team work closely with commissioners and providers in Kingston to ensure that the clinical and financial pressures of providing care for residents in the Surrey Downs ICP area are minimised. Kingston hospital sees 66% of attendances by Elmbridge residents and 48% of attendances by Epsom and Ewell residents. Epsom and Ewell residents also visit Epsom hospital (25%) and Woking clinic (6%).

Reigate and Bansted covers parts of Surrey Downs ICP. Clinic attendances from this borough are Earnsdale (60%), Crawley (12%) and St Helier, Sutton (7%).

Specialist clinic use by Mole Valley residents is particularly variable with 8 clinics representing over 5% each of attendances by Mole Valley residents as shown in Table 15 below (Surrey County Council funds all attendances at non-Surrey clinics from the overall sexual health budget).

Table 15 – Specialist clinic use by Mole Valley residents

Clinic	**% of all attendances by Mole Valley residents***
Earnsdale (Redhill)	19
Kingston	16
Dorking	10
Leatherhead	9
Epsom	8
Crawley	8
Woking	7
Buryfields (Guildford)	5

* From restricted SHRAD data – most recent (2017) figures

28/31 of the GP practices or practice groups in this area provide LARC (coils and implants) under Public Health Agreements.

Engagement with primary care in this area generally raised similar issues to other areas which are relatively well-served by specialist sexual health clinics (whether in the ICP area or close by), namely availability of appointments for more urgent care or for more complex appointments such as for long-acting contraception:

Patients say it is hard to get appointments for LARC at the sexual health service (Surrey downs GP)

There were suggestions that the buddy system and links to pharmacy could be improved:

> *Explore the PCN (Primary Care Network) model to support the Buddy system - this could also link to pharmacies who are providing chlamydia and EHC (Emergency Hormonal Contraception) as well - working across PCNs* (Surrey Downs GP)

In our engagement at a locality meeting we also heard about the lack of a specialist hub in the Surrey Downs ICP area:

> *The hub and spoke model needs looking at - there is no hub in Surrey Downs* (Surrey Downs ICP meeting)

Although this is acknowledged, when looking at access as above it appears that patients in the Surrey Downs ICP area are aware of how to access their nearest service, even if these are outside of the Surrey Downs ICP area, or outside of Surrey boundaries.

Surrey Heath

There are no main hub clinics in Surrey Heath and no spoke clinics. Attendances by Surrey Heath residents are mainly to the Woking clinic (30%) and at Aldershot in Hampshire (25%).

7/7 of the GP practices or practice groups in this area provide LARC (coils and implants) under Public Health Agreements.

Engagement with primary care in Surrey Heath raised the issues following the closure of the sexual health clinic at Frimley Park Hospital after there were no bids to provide services there in the 2015 procurement:

> *Since closure of Frimley hospital service large distances for patients to travel (GP Survey)*

At the Surrey Heath Place Based Committee meeting there was a useful discussion around the fact that public transport links are not as well developed as other parts of Surrey. Surrey Heath is relatively rural, and less deprived with higher car use. This means that although teenage pregnancies are lower, there will still be a cohort of young people who find it difficult to access sexual health services if they cannot use public transport or ask their parents.

For some clinical specialties, specialist transport is provided, however, due to the sensitive nature of using sexual health services, specific transport would be unlikely to be used. Planned oral contraception is becoming more available by post but this is not suitable for all young people.

The issue of local clinics was raised at the place-based committee meeting:

> *Shame there is not anything local [specialist service]. Surrey Heath is problematic because it is in between several other areas* (Surrey Heath GP)

When viewed in isolation, Surrey Heath does represent a challenge as there is no specialist clinic within Surrey Heath boundaries. This needs to be balanced with the need to ensure specialist clinicians are based in the most accessible locations for Surrey residents in general and considering specialist clinic locations outside of Surrey boundaries. Further outreach work on ensuring young people in this area are aware of the different services available to them is recommended as a minimum.

Summary

Residents can access standard, long acting and emergency contraception in specialist sexual health services and primary care (and pharmacy for emergency only). However, for testing and treatment of Sexually Transmitted Infections, only specialist sexual health services are available. It was not surprising, therefore, to hear through our engagement with primary care that availability of and access to testing and treatment of Sexually Transmitted Infections was a high priority. As outlined in 'Urgent Care' above, the need for urgent care should be very uncommon for any one individual and where this is not the case, more intensive health advice/promotion is needed.

There remains a difficult balance between ensuring there is the required 'critical mass' of specialist clinicians to provide a full, walk-in service and ensuring access to services across an area as large of Surrey. Telephone/online services have offered some opportunities in this but these will not be the solution to all issues. Spoke services continue to be explored but as outlined in the North West Surrey ICP section these are not always attended by the target population. Testing and treatment of Sexually Transmitted Infections generally needs to be consultant led and this makes walk-in access to these services particularly challenging outside of the main hubs.

Provision of sexual health services should be viewed as a whole (including specialist services in and out of Surrey, primary care, pharmacy, and the online service) and communicated to residents, particularly to younger people unable to travel for face to face appointments.

Recommendations:

- Urgent appointments in specialist clinics (particularly for Sexually Transmitted Infections and urgent long-acting contraception appointments) remain in high demand and need to be prioritised
- Further consideration should be given to ensuring patients are able to access less urgent care (such as STI screening and simple contraception) through telephone/online services
- Support primary care, and primary care networks, in further developing the Public Health Agreement buddy scheme, using shared clinical services and remote consultations
- Improve communications to ensure primary care colleagues are aware of patient choice in accessing specialist services outside of Surrey boundaries
- Continue to work closely with specialist providers in areas bordering Surrey
- Where there are particular concerns about a geographical area in terms of service coverage, targeted work is needed, including education around online services and increasing pharmacy provision

Appendix B – Gypsy, Roma and Traveller community (GRT)

At the last survey (July 2019), there were 901 registered caravans stationed in Surrey[33]. The term Traveller is often used as an umbrella term for all populations from a nomadic cultural background, including Roma, Welsh, Irish, English and Scottish Gypsies, Roma and boating and fairground communities. Within this community in particular, there are stark health inequalities in comparison to other ethnic minority and/or other deprived groups[34].This is due to a range of factors which compound together to lead to poorer health outcomes, such as poor access to health information, low literacy levels and specific cultural beliefs, amongst others. These communities can often be reluctant to seek advice and treatment for health concerns due to culturally held beliefs about health. If they do seek help, they may often find that health professionals may lack awareness of their cultural beliefs and fail to account for any adjustments that may increase the likelihood of them accessing health care (e.g. gendered care where females are seen by female healthcare professionals)[34]. As part of this needs assessment, the team sought guidance from the Clinical Service Manager for Gypsy, Roma Traveller & Inclusion Health in engaging with this community to explore their health needs.

The Gypsy Roma Traveller community (GRT) is a term used to describe a wide range of traveller communities. It often overs a mixture of several communities, who may also resent being grouped together with others who they feel are different to them. There are common themes, but they are distinct communities. Within Surrey, the largest group is of a Romany Gypsy background, followed by Irish Travellers. They often have strong family values and religious beliefs, with the latter group in particular having a tendency to follow the Catholic church. However, they are not always accepted within the Church. They also hold strong gender identities. As a group, the GRT community often face discrimination and exclusion. They have particular attitudes towards sex and health and often do not want for their children to have mainstream sexual health education for fear of 'contamination' of ideas that are against their beliefs e.g. LGBT relationships. Overall, they tend to see health as something that an individual does not have control over. They often struggle to access mainstream service dues to a number of barriers e.g. knowledge of navigating the system, illiteracy or basic literacy and not being able to complete forms etc. For females in particular, they are not willing to discuss their health with male health professionals. They may also be reluctant to discuss issues with unfamiliar female practitioners, so sensitivity and relationship building is key, even for short interventions. Being able to trust health professionals is a key factor in them accessing services and discussing their health. As a population, they are highly mobile. If they require healthcare, the further away the appointment is, the less likely they are to attend. This mobility also often means a lack of reliable postal address and so appointments, clinic letters and vital information may never reach them having been sent to a temporary address. Better practice would be to agree a particular permanent address (such as a GP surgery) where post can be collected and someone takes ownership of ensuring the clients receive the information, appointments and follow up letters. With regards to sexual health services, they may be reluctant to attend due to embarrassment of discussing sex with someone else and they may not routinely use contraception and so may not feel there is a

[33] iSurrey (2020). Gypsy and traveller caravan count, accessed from https://www.surreyi.gov.uk/dataset/v816m/gypsy-and-traveller-caravan-count
[34] Van Cleemput, P. (2010). Social exclusion of Gypsies and Travellers: health impact. Journal of Research in Nursing, 15(4), 315–327. https://doi.org/10.1177/1744987110363235

need to attend services. They often marry at an early age and are likely to have a monogamous relationship, which may mean they are at a decreased risk of contracting an STI. While the women are more likely to have monogamous relationships and even now, suffer abuse and be cast out of family groups if they do not, the men are often not assumed to be monogamous, putting the women at risk of STIs. Their reluctance to take up STI testing is largely concerned with the perception of other people and what the fact of an individual having STI testing says about their behaviour. However, more young people are asking for access to sexual health services and open to accessing them, due to having better access to the internet, as opposed to older women (30 and above).

Appendix C - Case study - Young people in Spelthorne

Spelthorne has in the past seen under 18 conception rates that are significantly higher than other districts and boroughs in Surrey (see Table 16). Actual numbers of under 18 conceptions are shown below for the most recently available ten years. This shows a large peak at 65 in 2011 with rates dropping to around one third of this from 2015 onwards.

Table 16 – under 18s conceptions in Spelthorne

Year	Total under 18 conceptions in Spelthorne	Total births to under 18s in Spelthorne
2008	58	N/A
2009	54	6
2010	53	7
2011	65	17
2012	54	15
2013	46	8
2014	31	10
2015	22	6
2016	20	4
2017	27	4
2018	24	5

In order to obtain more detailed feedback from young people in Surrey, qualitative methodology (in the form of focus groups) were used to gain further insight into the young people's experiences of accessing services. Two focus groups were held in January 2021, one with young people aged 17 to 18 and one with young people aged 14 to 16 from a youth centre in Spelthorne:

The 17 to 18 year olds were asked about their preference for accessing different services. They mentioned that Kingston, Staines, Addlestone and Feltham were all what they would consider their 'local area'. These locations were all easily accessible by one train or one bus or even within walking distance for some of the young people. They felt confident they could access these areas by themselves, either using public transport or taking a taxi if needed.

If they needed to access sexual health services, the group said they would speak to their friends or older siblings and ask their opinions of any services they may have accessed, and then access those services themselves first. For most, their first point of call would be the doctor because:

> *The doctor could 'guide you to the right service if you have no clue* (17- to 18-year-old focus group participant)

They felt comfortable going there by themselves:

> *…if you go to the doctor, it could be for anything* (17- to 18-year-old focus group participant)

They said there was no reason anyone would assume it was for a sexual health related issue so it could be confidential. Others said they would prefer to go to a clinic because they thought going to the doctors' was 'scary'.

When asked about accessing sexual health services at a pharmacy, they all said they would not go to a pharmacy unless *'it was an emergency'* and they could not get support elsewhere.

They felt that pharmacies were '*judgemental'* about what they might be collecting. Although the young people expressed a preference for services closer to home, having services available quickly was more important. So if what they needed could be accessed faster from a further away location, then they would be willing to travel.

The young people in the 17 to 18 year old focus group were not worried about being seen by anyone they knew in terms of accessing services closer to home. However, they did say they felt it was not deemed socially acceptable for young people to access sexual health services and so they would ask their friend or mum to accompany them if they needed to access healthcare.

The second group of young people aged 14 to 16 were asked the same questions. When asked about general services they also felt that Staines and Feltham was their local area. It was accessible by bus but they would usually ask their parents to drop them off. This is probably reflective of their younger age and being less independent than the older group.

They would also speak to their friends or GP about the issue. When asked specifically about sexual health services, they said they would speak to their GP or parents to seek support. They mentioned they do not know where the specialist clinics are and would always go to the GP as their first point of call for further advice or information (again, this is reflective of their younger age with no experience of accessing healthcare alone). They said they were not aware of any specialist sexual health services in their area. In contrast to the older group, the 14 to 16 year olds said that if they did not want to tell their parents of a particular issue, they would go to the pharmacy first to seek advice and then make an appointment with their GP. This group also said they would prefer to access support from somewhere closer to home because:

> *If I had to travel, then my parents would have to take me, and I would have to explain where I am going* (14 to 16 year old focus group participant)

In terms of which service they would prefer, there were no strong preferences apart from one person who said:

> *I would prefer to go to a specialist clinic because then you know you are getting that specialist care* (14 to 16 year old focus group participant)

However, they said it would be dependent on how easily accessible the clinic would be for them to access by themselves.

Key points:

1. Knowledge of sexual health services was poor
2. The younger group reported finding pharmacy services far more accessible than the older group
3. The concept of the 'local area' for this group differs from that of professionals we have engaged with (who are more likely to see services in Surrey boundaries as 'local')
4. The young people in this group seemed less concerned about people knowing they were accessing sexual health services than was expected

Appendix D – Communications plan

Sexual Health Needs Assessment 2020/21

Engagement and Communications Plan

Background

Surrey County Council are carrying out a Sexual Health and HIV Needs Assessment. This is timed to precede the commissioning of the specialist Integrated Sexual Health and HIV Service as the current contract ends on 31st March 2022. However, sexual health is influenced by a large number of factors outside of specially commissioned services and the needs assessment reflects that.

Key points:

- This engagement plan represents the initial engagement for the sexual health needs assessment specifically; continued engagement will be an ongoing part of the whole procurement
- The assessment is both of the sexual health needs of Surrey residents and a review of all sexual health services available to Surrey residents:
    - The 'Integrated Sexual Health and HIV Service - Specialist face to face/phone services in Surrey (CWNL)
    - Online contraception and STI testing (CNWL)
    - Specialist face to face/phone services outside of Surrey (known as 'Out of Area')
    - Primary care
    - Pharmacy
- The current phase is *assessment* of current need/services rather than proposals for change

Due to the current COVID-19 Pandemic, engagement for a needs assessment when face to face contact is restricted raises some challenges. It also gives opportunities considering the huge increase in the use of digital/online communications. Before compiling this plan, we met with Healthwatch Surrey to learn from their experiences of engaging with Surrey residents during the pandemic. It is important that people who are unable to engage through online services are also represented.

Objectives

- Establish key opportunities to improve the sexual health Surrey residents
- Establish what Surrey residents know about sexual health in general
- Undertake engagement with the public using online survey and focus groups to gain feedback and views on:
    - sexual health and HIV services in Surrey
    - experiences of using sexual health and HIV services
- Undertake engagement with stakeholders using online survey and gaining feedback via meetings on:
    - sexual health and HIV services in Surrey
    - their views on the sexual health of Surrey residents

- Engage with as many groups and communities as possible, ensuring they have access to the survey in different accessible formats

Timescales

Planning of the engagement:	October 2020
Engagement:	November 2020 – January 2021
Needs Assessment write up:	Early 2021

Target audiences

Stakeholder engagement

- What groups would we ideally like to hear from?
    - Priority groups:
        - All residents
        - Young people under 25 (including Looked After Children and care leavers)
        - Black and Asian Minority Ethnic communities (including Gypsy, Roma, and Traveller community)
        - Sex Workers
        - Men who have sex with men (MSM)
        - Those engaged in ChemSex
        - Trans communities
        - People with disabilities
        - People living with HIV
    - GPs and staff
    - Pharmacists and staff
    - Professionals working in Surrey supporting others with sexual health related issues e.g. School nurses
    - Surrey Heartlands CCG and Surrey Heath CCG – board level

Resident engagement - target group	Stakeholder	What type of engagement? How will we promote?
All Surrey residents	Surrey County Council Engagement Team	Meet regarding engagement
	Surrey County Council Comms Team	Meet regarding comms and engagement
	Cllr Mooney and other interested Councillors	• Community engagement and young people in Spelthorne area • Inform of engagement plan • Ask for support to promote survey

		• Gather any feedback
	Surrey County Council Public Health Team	• Ask to forward survey to partners and promote as wide as possible • Ask for contacts
	Engagement & Participation Team, SCC Adult Social Care	• Consult on engagement plan • Contacts and ideas on making surveys accessible • Share any contacts
Young People	Surrey County Council Youth Service	• Ask staff to complete survey • Ask to promote survey to service users
	Surrey Youth Focus	• Ask staff to complete survey • Ask to promote survey to service users
	Surrey Users Voice and Participation	• Ask staff to complete survey • Ask to promote survey to service users • Check survey with staff and service users to ensure young people friendly • Conduct two focus groups with local youth organisation
BAME communities	Surrey Minority Ethnic Forum	• Ask staff to complete survey • Ask to promote survey to service users • Check on language translations needed
GRT community **Homeless families**	Health Visiting – Inclusion Health Project, including Gypsy, Romany, Traveller (GRT) project	• Ask staff to complete survey • Ask to promote survey to service users • Meet with GRT Health Visitor re targeted engagement with GRT community
Sex workers	Streetlight – Sex worker organisation	• Ask staff to complete survey • Ask to promote survey to service users • Check if alternative formats are needed for service users
LGBTQ+ community **MSM**	CNWL Outreach team – MSM worker	• Check terms are correct • Ask staff to complete survey • Ask to promote survey to service users • Check on other organisations

	Outline Surrey	• Ask staff to complete survey • Ask to promote survey to service users
	Pride in Surrey	• Ask staff to complete survey • Ask to promote survey to service users
People living with disabilities	Surrey Disability Coalition	• Ask staff to complete survey • Ask to promote survey to service users
	Surrey Sensory Services	• Ask staff to complete survey • Ask to promote survey to service users
	Sight for Surrey	• Inform of engagement plan • Ask for support to promote survey • Gather any feedback • Check on accessible version of survey
People living with HIV	Metro	• Inform of engagement plan • Ask for support to promote survey • Gather any feedback
All priority groups	Surrey Sexual Health Outreach Group	• Inform of engagement plan • Ask for support to promote survey • Gather any feedback

Professional engagement - target group	**Stakeholder**	**What type of engagement?** **How will we promote?**
Pharmacists	Local Pharmacy committee	• Inform LPC of engagement plan • Ask for support to promote survey to pharmacists • Gather any feedback
GPs and staff	Local Medical Committee	• Inform LMC of engagement plan • Ask for support to promote survey to GPs and staff • Gather any feedback
GPs and ICP/CCG board level	ICP / CCG Engagement: • Surrey Heartlands CCG • North West Surrey ICP • Guildford & Waverley ICP	• Inform of engagement plan • Ask for support to promote survey • Gather any feedback

	• Surrey Downs ICP • East Surrey CCG • Surrey Heath CCG	
Staff **Service users**	Healthwatch	• Inform of engagement plan • Ask for support to promote survey • Gather any feedback

See appendix 1 for additional lists of groups and community organisations.

Risks and mitigation

What are the communications and engagement risks for the project?

- Difficulties engaging due to COVID – it may be difficult to engage with the public due to COVID
- Regardless of COVID, experience shows that engagement with certain groups represents a significant challenge for any services. This is particularly the case when discussing sex and sexual health needs. We will make every effort to be as accessible as possible during engagement. In some cases we may need to use existing literature or professional opinion to represent the voices of certain groups.
- Conflicting priorities due to COVID – stakeholders and partners are extremely busy due to COVID which may mean reduced capacity
- Difficulties supporting engagement – stakeholders may not be able to support engagement
- Conflicting priorities due to time of the year – engagement will be happening near to Christmas time
- Timescales – we will start arranging key meetings in October planned for November but can postpone these to December if needed

Actions

Engagement design

- Mix of qualitative and quantitative methodology - Online surveys via Surrey Says – accessibility options must be considered
- Open for 4 weeks
- Piloting of survey with user groups
- Invitations to key groups to offer focus groups etc.

Communication / Promotion Materials

- Accessibility – consider the following:
  - Language translation – most spoken languages in Surrey (Bengali, Polish and Urdu)
  - Alternative to online survey completion – paper version of survey available
  - Easy read version – explore developing an Easy Read version of the survey – contact SCC's preferred supplier: https://easy-read-online.co.uk/

        - Plain text version of survey – contact Sight for Surrey
        - Users of British Sign Language – contact Sight for Surrey
    - Set up of account with council Docmail system to post out surveys with pre-paid envelopes for return.
    - Sexual health is a sensitive topic – will people ask for help in completing survey?
    - Set up email address for the needs assessment communication with residents
    - Ensure text message contact available on all communications for people from the deaf community

Media

- Sexual Health briefing – internal briefing
- Write a briefing on sexual health providing an update on services and local data which includes promotion of needs assessment engagement

Social media and digital

Communication channels that will be used for promotion:

CHANNEL	LEAD
Facebook	Shannon Mulkerrins (Public Health), Georgie Lloyd (Community team)
Twitter	Shannon Mulkerrins (Public Health), Georgie Lloyd (Community team)
Surrey Health & Wellbeing Comms group	Shannon Mulkerrins (Public Health)
Public Health Bulletin	Shannon Mulkerrins (Public Health)

Appendices:

Appendix 1 - additional lists of groups and community organisations

Group, Network or Organisation name	Membership	Type of group/ network	Geographical area covered	Theme / area of work
Autism Partnership Board	Professionals & people who use services and carers	Disability	Surrey	Implementation of the national autism strategy in Surrey
Chinese Association of Woking	Professionals and people who use services	BAME	Around Woking area, Guildford, Walton-on-Thames, Weybridge, etc	Ethnic and education
Disability Empowerment Network (x4 groups) East, North, South	People who use services	Disability	Surrey	Engage and empower the local disabled community

West and Mid				
Elmbridge Equalities Group	Professionals	Equalities	Elmbridge	Equality
Elmbridge Multi Faith Forum	Professionals	Faith	Elmbridge	Faith
Epsom and Ewell Interfaith Forum	Professionals and partners	Faith	Epsom and Ewell	Faith
Family Voice Surrey	Carers	Disability (Children)	Surrey	Family Voice Surrey champions the needs and rights of SEND families in Surrey: families with children or young adults up to the age of 25 who have special educational needs, chronic illnesses, including mental health conditions, or disabilities
First Community network	Professionals and providers	Health	East Surrey (and parts of West Sussex)	Professionals
FoCUS – Forum of Carers and people who use Surrey and Borders Partnership NHS Foundation Trust's (SABP) services. There are 4 FoCUS Area Group Meetings – East & Mid Surrey, South West Surrey, North Surrey and West Surrey & North East Hampshire	People who use services and carers	Disability	Surrey and North East Hampshire	All SABP's services including: mental health, learning disability, drug and alcohol, and older people's services
Guildford & Godalming Interfaith Forum	Professionals and partners	Faith		Faith
Guildford and Waverley Social Prescribing Partners	Professionals	Social Prescribing	Guildford and Waverley	Social Prescribing
Guildford Mental Health Forum	Professionals	Disability	Guildford	Mental health awareness
Gypsy, Roma, and Traveller	Professionals and people who use services	BAME	Surrey	Gypsy, Roma, and Traveller
Independent Mental Health Network	People who use services and carers	Disability	Surrey and NE Hants	Mental health awareness

Let's Hear Surrey	People who use services	Disability	Surrey	Hearing loss
Long Term Neurological Conditions Group	People who use services	Disability	Surrey	Long term neurological conditions
MS Society	People who use services	Disability	Surrey	
Outline (LGBT+ support)	Professionals	LGBT+	Surrey	LGBT+ Sexuality and Gender Identity]
Parkinsons UK (x 4 groups) across Surrey	People who use services	Disability	4 branches serving surrey, each has at least one group	PSD
Preston Partner Network	Professionals	Community	Preston area (Epsom)	To provide opportunities to network and joint working
Redhill West Partnership	Professionals and Providers	Community	Redhill	To provide an opportunity to network/ Encourage joint working and to avoid duplication of work
SMEF (Surrey Minority Ethnic Forum)	Professionals and providers	BAME	Surrey	Charitable company, we seek to unify ethnic minority communities from across Surrey
Surrey Carers Commissioning Group	Professionals and Providers	Carers	Surrey	Carers
Surrey Children and Young People's Partnership	Professionals	Children	Surrey	To better coordinate working with all children, young people, and families in Surrey.
Surrey Communications Group	Professionals	Comms	Surrey	
Surrey Diversity Equality Network	Professionals	Equalities	Surrey	
Surrey Faith Links	Professionals and partners	Faith	Surrey	Faith
Surrey Forum For People Who Are Hard Of Hearing or Deafened	People who use services	Disability	Surrey	Increase awareness of hearing loss
Surrey Heath Faith Forum	People who use services	Faith	Surrey Heath	Faith
Surrey Learning Disability Partnership Board	Professionals & providers, people who use services and carers	Disability	Surrey	Learning Disability services in Surrey

Surrey Local Valuing People Groups (x4)	Professionals & providers, people who use services and carers	Disability	Surrey	Learning Disability services in Surrey
Surrey Muslim Association	People who use services	Faith	Surrey	Faith
Surrey Positive Behaviour Network	Professionals & providers, people who use services and carers	Disability	Surrey	Challenging behaviour
Surrey Safeguarding Adults Board	Professionals		Surrey	
Surrey Vision Action Group	People who use services	Disability	Surrey	Feeds into and disseminates issues relating to sight loss and dual sensory loss
United Communities	Professionals and people who use services	Disability	NE Hants and Farnham	Mental health awareness
Voluntary Actions South West Surrey - Older People's Forum x 3	Professionals and people who use services	Older people	South West Surrey	Older People
Waverley Faith Forum	Professionals and people who use services	Faith	Waverley	Faith
Woking People of Faith	People who use services	Faith	Woking	Faith

Glossary and abbreviations

Adapted from BASHH Recommendations for Integrated Sexual Health Services for Trans, including Non-binary, People, NHS Dumfries and Galloway Glossary (sexualhealthdg.co.uk) and Oxfordshire County Council Sexual Health Needs Assessment 2018

ABORTION: Ending a pregnancy through medical intervention

AGE OF CONSENT: The age when the law says it is legal to have sex. In the UK the legal age is 16 except in Northern Ireland where it is 17.

BISEXUAL: A person who is sexually attracted to both men and women. Can also be known as 'bi'

CCG: Clinical Commissioning Group

CHLAMYDIA: A sexually transmitted infection (STI) which is very common among men and women under 25. If untreated, Chlamydia can lead to infertility in women. Pregnant women can also pass it onto their babies. It is easily treated with antibiotics. Partners must be treated as well.

CISGENDER/CIS: A cis person's gender identity is generally congruent with the sex they were assigned at birth.

COIL: A contraceptive device usually made of plastic or copper, also known as an IUD or IUCD. It is inserted into the womb and stops fertilised eggs from settling and growing.

COMBINED PILL: A contraceptive pill that is taken every day and prevents pregnancy by stopping a woman from producing eggs. It contains 2 hormones - oestrogen and progestogen.

CONDOM: A thin, rubber sheath (cover) worn over the penis or placed inside the vagina to protect against unplanned pregnancies and sexually transmitted infections (STIs).

CONFIDENTIALITY: If something is confidential then it is secret and private. Even if you are under 16 you have the same right to confidentiality as adults.

CONSENT: Another word for permission. It is against the law for anyone to have sex with another person without their consent. It is also against the law to have sex with a young person under 16 (17 in Northern Ireland) This is known as the age of consent.

CONTRACEPTION: The word used to describe the prevention of conception (pregnancy) by artificial means. There are many different contraceptive methods and different methods suit people at different times of their lives.

CONTRACEPTIVE INJECTIONS: An injection which protects against pregnancy for 12 weeks.

CSA: Child Sexual Abuse

CSE: Child Sexual Exploitation

EHC: Emergency Hormonal Contraception

EMERGENCY CONTRACEPTION: Pills that can be taken up to 120 hours after unprotected sex to prevent pregnancy. The earlier it is taken the more effective it is. Also known as Emergency Hormonal Contraception (EHC) and the morning after pill.

FEMALE GENITAL MUTILATION (FGM): A non-medical procedure to change a females genitals by injuring or cutting. Also known as female circumcision or cutting.

FERTILITY: When a woman or man has a healthy reproductive system and they are able to get pregnant or to produce healthy sperm, they are known as fertile, if not they are said to have FERTILITY PROBLEMS

FNP: Family Nurse Partnership

GAY: A word meaning homosexual or lesbian. Someone who fancies people of the same sex; a men who is sexually attracted to men and women who are sexually attracted to women.

GENDER: Identifying a person as male or female.

GENITAL EXAMINATION: When a doctor or nurse examines the vulva, vagina, penis or testicles.

GENITAL WARTS: Small growths on or around the genitals caused by a virus.

GENITALS: The sex organs that you find between your legs. In a woman these are the vagina and vulva and in a man these are the penis and testicles. Also called genitalia.

GP: General Practitioner or Doctor.

GUM CLINIC: (Genito-Urinary Medicine) A common name for a clinic that can help both men and women with free confidential sexual health advice and treatment. Also known as STI clinics.

GUMCAD: Genitourinary Medicine Clinic Activity Dataset

HETEROSEXUAL: feelings involving sexual attraction to people of the opposite sex. Also known as straight.

HIV: Human Immunodeficiency Virus, - the virus that causes AIDS. HIV can be transmitted during unprotected sex as well as through blood and blood products. When the virus enters the blood stream it begins to destroy the body’s defence system against infection. There is no cure but it can be treated. HOMOSEXUAL: Someone who is sexually attracted to people of the same sex.

HORMONES: Naturally occurring chemicals that guide the changes that take place in the body. As well as causing physical changes, hormones cause emotional changes too. Hormones cause sexual developments such as puberty to start in men and puberty and periods in women.

IMD: Indices of Multiple Deprivation

IMPLANTS: A very reliable type of contraception where the hormone is in a small, plastic rod, which a specially trained doctor, or nurse inserts under the skin on a woman's arm. The implant works for 3 years and is over 99% effective at stopping pregnancy.

INFECTION: An illness caused by a bacteria or virus.

INTERCOURSE: When the penis is put inside / penetrates the vagina or anus during sex

INTIMACY: Being close with someone.

IUD: (Intrauterine Device) A very reliable type of contraception. The IUD is another name for the coil. It is a small device made of plastic and copper which is inserted into the womb to inactivate the sperm and stop fertilised eggs from settling and growing. Lasts up to ten years and is over 99% effective at stopping pregnancy. It can be used up to 5 days following unprotected sex to stop unwanted pregnancy.

IUS: (intrauterine system) A very reliable type of contraception similar to IUD. It is a small, plastic T-shaped device containing hormones. It sits in the womb and works for five years. It is more than 99% effective at stopping pregnancy.

LESBIAN: A woman who is sexually attracted to another woman.

LGBTQ+ Lesbian, Gay, Bisexual, Trans, Queer plus is a generic term for individuals who do not identify as heterosexual

LONG ACTING CONTRACEPTION (LARC): Contraceptive methods that require administration less than once per cycle or month, including copper intrauterine devices, progestogen-only intrauterine systems, progestogen-only injectable contraceptives and progestogen-only subdermal implants

LSOA: Lower Super Output Area

MINI PILL: Also known as the progestogen-only pill. It prevents pregnancy by changing a woman's mucus making it difficult for sperm to reach the egg. This pill has to be taken at same time every day and there is a break every 3 weeks.

MORNING AFTER PILL: Proper name is emergency hormonal contraceptive pills. It can be taken up to 120 hours after unprotected sex to prevent pregnancy. However, the sooner it is taken the more effective it is.

MSM: Men who have Sex with Men

NATSAL National Survey of Sexual Attitudes and Lifestyles

NCSP: National Chlamydia Screening Programme

NICE: National Institute for Health and Care Excellence

NON-BINARY: This is a term for individuals whose gender identity does not align with either of the binary categories of ‘man’, ‘woman’ or ‘male’, ‘female’. Non-binary identities may be static, or fluid. Some non-binary people may include some aspects of male and female into their identities, others may reject them entirely. For some, ‘non-binary’ is an identity in itself, for others it is a way of describing or categorising their gender (or lack of) or distinguishing between binary and non-binary genders.

ORAL CONTRACEPTION: A hormonal form of contraception which is taken by the mouth in tablet form.

PERIOD: Once a woman reaches puberty she will have a menstrual bleed, or period, each month. The bleeding happens when an egg is not fertilised and comes out of the vagina. Periods can start from 8-16 years old but it is usually between 12 -13 years old.

PHARMACIST: A person who works in a chemist and is qualified to prepare medicines and drugs and give some medical advice.

PHE: Public Health England

PHOF: Public Health Outcomes Framework

POP: Progesterone Only Pill

PROGESTERONE: One of the female hormones that controls reproduction.

SAFE SEX: Ways of having sex that lowers the risk of pregnancy and catching an STI e.g. kissing, mutual masturbation and using condoms

SEXUAL INTERCOURSE: The insertion of an erect penis into the vagina or anus. Also known as penetration

SEXUAL ORIENTATION: Whether we prefer sexual relationships with opposite sex or same sex.

SEXUALITY: How we feel about ourselves as a sexual being and how others see us. Emotions, feelings, behaviour and culture can shape our sexuality and it develops throughout our lives.

SHN: School Health Nurse

SMEAR: A medical test to detect any changes in a woman's cervix

SHRAD: Sexual and Reproductive Health Activity Dataset

STI: Short for sexually transmitted infection. The best way to protect yourself from an STI if you are having sex is to always use a condom

STRAIGHT: Common word for heterosexual.

SYPHILIS: A sexually transmitted infection which causes a painless sore. It may go unnoticed and can spread without either partner knowing. It is passed during sex or sexual activity and can be serious if left untreated.

TERMINATION: Another word for abortion. Operation or procedure to end a pregnancy.

TESTICLES: Two balls under a man's penis where sperm is produced.

TRANS: An umbrella term to describe people whose gender identity differs from the sex they were assigned at birth. There is a spectrum of trans identities, including but not limited to: trans woman, trans man, transgender, genderqueer, non-binary, agender.

TRANSGENDER: Someone who views themselves as one gender but is seen by others to be another. Transgender people do not always have surgery to change their bodies.

TRANSEXUAL: A person who views themselves as the opposite sex and wants to become the opposite sex.

UNPROTECTED SEX: Sex without a condom or contraception - carries the risk of pregnancy and catching an STI

URINE SAMPLE: When you pee in a bottle and give it to a nurse or doctor to examine for infection. Now a common test for Chlamydia.

WHO: World Health Organisation

WOMB: Another name for the uterus.