

Sexual Health Needs Assessment Cheshire West and Chester

• Jane Harris • Suzy C Hargreaves • Hannah CE Madden

Simon Henning • Ann Lincoln • Gayle Whelan

Rachel Lavin • Hannah Timpson



ACKNOWLEDGEMENTS

We would like to thank many people for their help with the project, including all staff who distributed questionnaires, helped organise interviews and focus groups and sent in data. We are especially grateful to those who took part in the research.

We would particularly like to thank: Katie Whitehead, Jayne Fortune, the project steering group, Patricia Bowcock, Sharon Cotton-Smith, Heather Cantrill, Christopher Tomkinson, Debby Magee and Sheila Lister.

CONTENTS

1. INTRODUCTION	4
National and regional perspective of sexual health	4
Profile of Cheshire West and Chester	7
2. METHODOLOGY	11
Aims and objectives	11
Quantitative methods	13
Qualitative methods	15
3. EXISTING INFORMATION ON SEXUAL HEALTH IN CHESHIRE WEST AND CHESTER	17
Sexually Transmitted Infections (STIs) including HIV	18
Teenage Pregnancy	23
Termination of pregnancy	25
Fertility/infertility	25
Sexual Assault	26
Genitourinary Medicine (GUM) attendances	26
Integrated contraception and sexual health services (iCASH)	29
General Practitioner Sexual Health Services	33
Contraception prescribing in Cheshire West and Chester	40
Chlamydia screening	42
4. SEXUAL HEALTH SERVICE USER SURVEY	44
Demographics	45
Making an appointment	45
Before making an appointment	47
Reason for visit	49
Getting to the service	50
Views on sexual health and sexual health services	51
5. GENERAL POPULATION SEXUAL HEALTH SURVEY	55
Demographics	56
Knowledge of Sexual Health Services	57

Service Use	59
Privacy and confidentiality	61
Staff Issues	62
Service issues	62
General Health and Lifestyle.....	64
Relationships, contraception, sexually transmitted infections (STIs) and HIV	68
6. INSIGHTS INTO ‘SELDOM-HEARD’ GROUPS: MEN WHO HAVE SEX WITH MEN/LGBT.....	73
Background.....	73
Findings.....	79
7. INSIGHTS INTO ‘SELDOM HEARD’ GROUPS: ADULTS WITH LEARNING DISABILITIES	93
Background.....	93
Findings.....	98
8. INSIGHTS INTO ‘SELDOM-HEARD’ GROUPS: CARE LEAVERS	101
Background.....	102
Findings.....	103
9. INSIGHTS INTO ‘SELDOM-HEARD’ GROUPS: GYPSY AND TRAVELLER POPULATION.....	113
Background.....	113
Findings.....	115
10. SERVICE AUDIT	119
11. RECOMMENDATIONS	125
General recommendations.....	131
Recommendations following consultation with ‘seldom heard’ groups	133
Key themes arising from the Sexual Health Needs Assessment.....	137
References	143
Appendices	149

1. INTRODUCTION

National and regional perspective of sexual health

The sexual health of England has been a major concern to successive governments for over a decade, with escalating levels of sexually transmitted infections (STIs) including HIV, unplanned pregnancies leading to abortion and the highest teenage pregnancy rates in Europe. Additionally, excessive waiting times for genito-urinary medicine (GUM) services were a barrier to seeking care which also added to the spread of sexually transmitted infections. In response, a number of key documents were produced (see box 1.1) in order to improve access to services and reduce the burden of poor sexual health.

Box 1.1 Summary of key sexual health documents

- In 2000, the *Teenage Pregnancy Strategy* was launched – a 10 year action plan to reduce teenage conceptions by 50% (DCFS, 2010);
- In 2001 the *National Strategy for Sexual Health and HIV* was published (DH, 2001a), the first national strategy to highlight the issues around the rising levels of STIs and HIV and poor access to services and how these issues could be reversed;
- In 2004, the *Choosing Health: Making Healthier Choices Easier* white paper (DH, 2004) was published, and centred on the risk taking behaviours in relation to sexual health that were fuelling the problems. In particular, mandatory targets were introduced such as:
 - A reduction of 50% in the rate (from 1998) of under 18 conceptions by 2010;
 - All patients attending a GUM clinic to be offered an appointment within 48 hours by 2008;
 - A decrease in the rate of new gonorrhoea diagnoses by 2008;
 - An increase in the uptake of chlamydia screening for people between 15 and 24 years by 2008.
- In 2008 the Medical Foundation for AIDS and Sexual Health (MedFASH) was commissioned by the Independent Advisory Group on Sexual Health and HIV to review the National Strategy for Sexual Health and HIV and published *Progress and Priorities – Working Together for High Quality Sexual Health* (MedFASH, 2008). The review built on the Lord Darzi review *High Quality Care for All, NHS Next Stage Review Final Report*, 2008 (DH, 2008) and saw the inclusion of the 48 hour GUM access target within the recommended top six priority commissioning goals for the NHS. *Progress and Priorities* placed a far higher emphasis on prevention and highlighted service developments including the move towards more integrated provision between GUM and contraception services, the development of nurse consultants and nurse-led clinics as well as the widening scope of provision in primary and community care.

As a result of the strategies, guidance and service improvement above, significant progress has been made in improving sexual health in England, in particular:

- Teenage pregnancy rates have fallen to their lowest levels since records began in 1969, with an overall reduction of 34% nationally since 1998 to 31 per 1,000 women (ONS, 2011a);
- Access to specialist GUM services within 48 hours has improved across England and has been sustained;
- The use of more effective long-acting methods of reversible contraception (LARC) increased from 18% of community contraception services users in 2003, to 28% in 2011/12 (NHS Information Centre for Health and Social Care, 2012);
- Access to services has been improved through the expansion and integration of service delivery outside of specialist services, particularly in the community and general practice settings (Church and Mayhew, 2009).

Commissioning of sexual health services post-April 2013

Changes within the structures and functions of the NHS as a result of the Health and Social Care Act 2012 has resulted in significant changes to the commissioning of sexual health services; with local government taking the lead role in the commissioning of the bulk of sexual health services, including sexual health promotion and open access contraception and sexual health services (CaSH) and GUM. Other sexual health services provided through general practice or pharmacy are to be commissioned through local government teams and include the provision of LARC, chlamydia screening and the sexual health elements of psychosexual therapies through locally enhanced services (LES).

NHS England is responsible for the commissioning of HIV treatment and care services and sexual assault services. Local clinical commissioning groups (CCGs) will be responsible for commissioning local abortion provision.

The sexual health needs assessment plays a vital role in underpinning the development of the Joint Strategic Needs Assessment (JSNA). The JSNA is used by the local Health and Wellbeing Boards to inform their commissioning plans to improve the health and wellbeing of their local population and reduce health inequalities.

Each local authority has its own Health and Wellbeing Board. Board members will collaborate to understand the needs of their local community, agree priorities and encourage commissioners to work in a more joined-up way. As a result, patients and the public should experience more joined-up services from the NHS and local councils in the future.

As local authorities are now responsible for commissioning GUM, CaSH and sexual health promotion services; the Local Government Association has produced guidance for local authorities on the commissioning of open access sexual health services *Sexual Health Commissioning, Frequently Asked Questions*, February 2013. http://www.local.gov.uk/web/guest/publications/-/journal_content/56/10171/3880628/PUBLICATION-TEMPLATE. The issue around testing and treatment for sexually transmitted infection (STI) and contraception services remaining open access means that they have to be accessible to residents who may be from other local authority areas.

Outcomes

Earlier targets for sexual health which included the 48 hour access target for GUM services and screening young people between the ages of 15 and 24 have been replaced, although GUM access in

48 hours is still being monitored. The targets have been replaced by Public Health Outcome Indicators for Sexual Health and are included in the Public Health Outcomes Framework. For sexual health specifically the indicators are:

- Reduction in under 18 conceptions;
- Chlamydia diagnoses in young people (15 to 24 year olds);
- Reduction in numbers of people with HIV diagnosed at a late stage.

All three of the above outcome indicators require a targeted approach to the design and implementation in order to achieve sustainable changes in improved sexual health. All three outcome indicators also require a change in commissioning and provision in order to be successful, with a far greater emphasis on “upstream” preventative working and tackling of risk-taking behaviours on an individual and community basis.

Policy

In light of the changes in the commissioning of sexual health services, the Department of Health (DH) produced *A Framework for Sexual Health Improvement in England* (DH, 2013), a summary of the aims are to:

1. Reduce inequalities and improve sexual health outcomes;
2. Build an honest and open culture where everyone is able to make informed and responsible choices about relationships and sex;
3. Recognise that sexual ill health can affect all parts of society.

To do this, the DH has chosen to focus the current sexual health guidance on the following areas (box 1.2):

Box 1.2 Department of Health focus on current sexual health guidance

- Tackling the stigma, discrimination and prejudice often associated with sexual health matters;
- Reducing the rate of sexually transmitted infections using evidence-based preventive interventions and treatment initiatives;
- Reducing unwanted pregnancies by ensuring that people: have access to the full range of contraception; can obtain their chosen method quickly and easily; and, can take control to plan the number of, and spacing between their children;
- Supporting women with unwanted pregnancies to make informed decisions about their options as early as possible;
- Tackling HIV through prevention and increased access to testing to enable early diagnosis and treatment;
- Promoting integration, quality, value for money and innovation in the development of sexual health interventions and services.

DH (2013) A Framework for Sexual Health Improvement

Profile of Cheshire West and Chester

Cheshire West and Chester Unitary Authority was formed in 2009 and includes the city of Chester and the towns of Ellesmere Port, Frodsham, Helsby, Malpas, Neston, Northwich and Winsford. The age proportions of Cheshire West and Chester are generally representative of the North West as a whole. Figures 1.1 and 1.2 show male and female age categories as a proportion of the total population. The charts show a similar proportion of males and females in the age groups between 15 and 64. There are small but noticeable differences between male and female proportions in age groups 0-15 years and above 65 years. Further breakdown of age is available in table 1.1 showing estimated numbers and gender proportions of people in each age group.

Figure 1.1: Age profile of the male population of Cheshire West and Chester

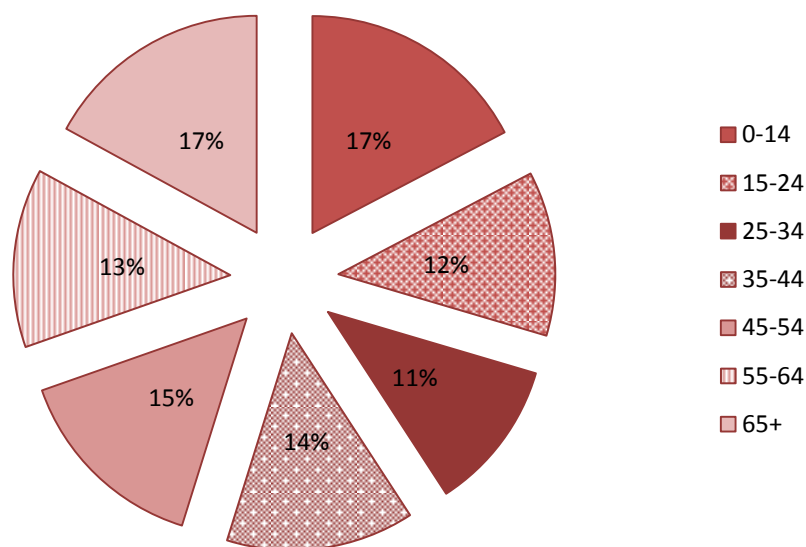
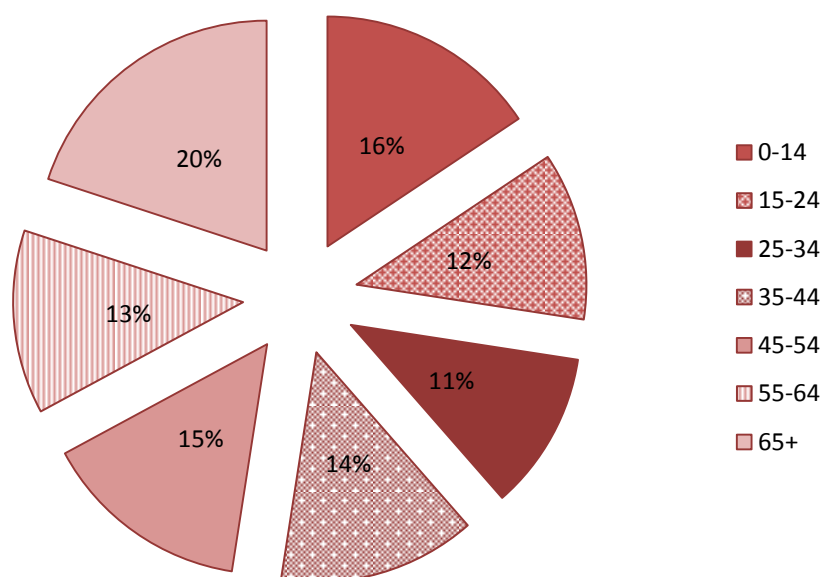


Figure 1.2: Age profile of the female population of Cheshire West and Chester



Source: ONS, 2011b

Table 1.1: Age Group by Sex in Cheshire West and Chester

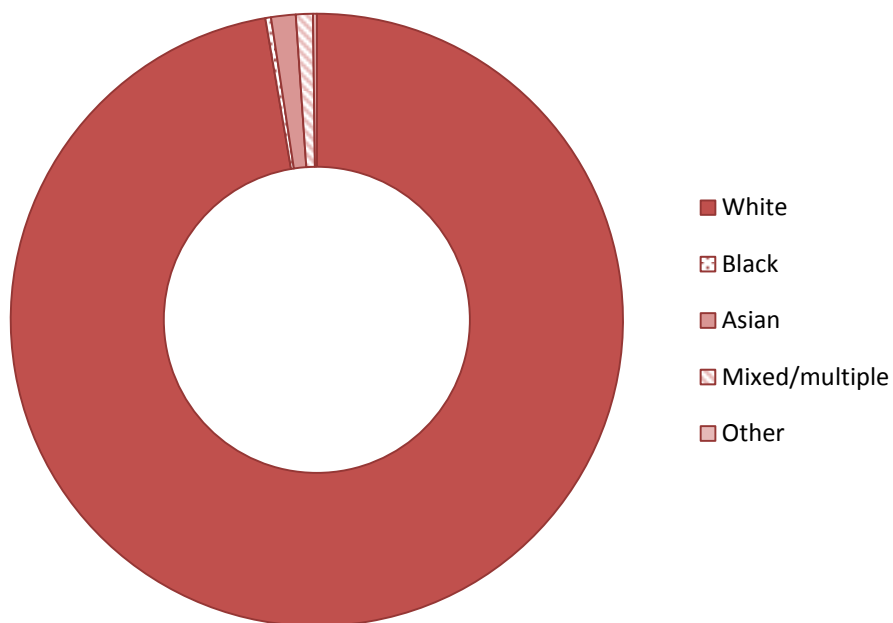
Age group	Sex				Total
	Males		Females		
0-14	27813	17%	26417	16%	54230
15-24	19675	12%	19941	12%	39616
25-34	18064	11%	18817	11%	36881
35-44	22483	14%	23490	14%	45973
45-54	23767	15%	24782	15%	48549
55-54	21416	13%	21843	13%	43259
65+	27368	17%	33732	20%	61100
Total	160586	49%	169022	51%	329608

Source: ONS, 2011b

Ethnicity

Figure 1.3 shows the proportional breakdown by ethnicity of the total population of Cheshire West and Chester. The vast majority of residents are of white (including British, Irish, and Other) ethnicity; constituting 98% of the total population. Cheshire West and Chester has a small black and minority ethnic (BME) population, with approximately 2% of the resident population belonging to a BME group. Within this group, residents of Asian / British Asian ethnicity (including Indian, Pakistani, Bangladeshi, Chinese and Other) are the largest contributors with 1%; and residents defined as black (including Caribbean, African, and Other) constitute 0.3%.

Figure 1.3: Total population of Cheshire West and Chester presented by ethnic group



Source: ONS, 2011c

Religion

The majority of Cheshire West and Chester residents define their religion as Christian (70%), followed by 22% who described themselves as of “No Religion”. Followers of Buddhism, Hinduism, Judaism, Islam, and Sikhism accounted for very small percentages of the overall population (<0.5%) (ONS, 2011d).

Health and Wellbeing Indicators

The health profile of Cheshire West and Chester UA is mixed. Levels of deprivation are lower than the national average; however, childhood poverty is higher than the national average with approximately 98,000 children living in poverty across the Unitary Authority. Life expectancy in Cheshire West and Chester for females (82.7 years) is similar to the national average and life expectancy for males (79.3 years) is significantly better than the national average (ONS, 2011e).

Health Indicators in Cheshire West and Chester are also mixed. Levels of adult obesity, new cases of Tuberculosis, violent crime, long term unemployment, sexually transmitted infections and early deaths from heart disease and stroke are all significantly better than the national average. Conversely, rates of road injuries and deaths, breast feeding initiation, hospital stays for alcohol related harm and alcohol specific hospital stays in under 18s are all significantly worse than the national average (DH, 2012).

Sexual health indicators for Cheshire West and Chester also show a mixed picture. Rates of acute sexually transmitted infection diagnoses are significantly better than the national average including Gonorrhoea and Syphilis diagnoses in Genitourinary Medicine (GUM). Conversely the uptake of HIV tests in GUM settings is significantly worse than the national average. Performance against the Chlamydia testing Public Health Outcomes Framework target is mixed; rates of testing for 15-24 year olds outside of GUM settings are significantly better than the national average, however rates of Chlamydia diagnoses in all settings are significantly worse than the national average. The change in rate of conceptions in under 18 year olds is also significantly worse than the national average with a 5% change from 220 births per 1,000 in 1998 to 207 per 1,000 in 2010 compared to a decline of 24% nationally (PHE, 2013).

Cheshire West and Chester Unitary Authority is made up of two Clinical Commissioning Groups (CCG); Western Cheshire CCG which is made up of 37 GP practices and Vale Royal CCG with 12 GP practices. The overall GP registered population for these two CCGs in 2012 was 330,200. Data from the NHS Information centre show that in 2011, the number of life years lost from causes amenable to healthcare among adults and children was 4,154 years per 100,000 female population and 4,108 per 100,000 male population. Rates of under 75 mortality per 100,000 population from heart disease (121), respiratory conditions (61) and liver disease (38) were all considerably lower than national figures. Between 2011-2012 there were a total of 62 emergency admissions for alcohol related liver disease across the two CCGs, a rate of 41 admissions per 100,000 population compared with a national level of 5,418 per 100,000 population (HSCIS, 2012).

Health of Young People

There were 58,135 children and young people aged 0 to 15 years living in Cheshire West and Chester Unitary Authority in 2011 (ONS, 2011b). Children's health indicators show that the health and wellbeing of children in Cheshire West and Chester is generally similar to the national average. Levels of childhood obesity are average with 20.1% of Year 6 children classified as obese and participation in sport among children is higher than the national average with 60.1% of children participating in at least 3 hours of sport per week. A lower percentage of mothers initiate breastfeeding (68.2%) compared with the national average (ChiMat, 2013). Cheshire West and Chester also reports a higher level of uptake of MMR vaccine with 94.5% of children having received their first dose of immunisation by age two and 87.6% of children receiving the second dose by age five.

The rate of young people (under 18 years) admitted to hospital for a wholly alcohol related condition (such as an overdose) has declined since 2004, however the level of alcohol related admissions in under 18s remains higher than the national average. Levels of hospital admission for self-harm have remained broadly similar over the past 7 years and the overall rates of admission for self-harm are similar to the national average (ChiMat, 2013).

Deprivation

Levels of deprivation in Cheshire West and Chester Unitary Authority are lower than the national average. Areas around Ellesmere Port, central Chester, Winsford and Northwich show the highest scores. Life expectancy for men living in the most deprived quintiles of Cheshire West and Chester is ten times lower than those living in the least deprived quintiles and just under eight years less for women.

2. METHODOLOGY

Sexual health needs assessments are commissioned to provide local services with evidence to support them in meeting the needs of their local population. This, in turn, will ultimately help to reduce health inequalities in the locality. Through this work new services may be developed or existing services enhanced or realigned.

Aims and objectives

To gain a full understanding of the needs, demand and gaps in sexual health services in Cheshire West and Chester by collating the most recent existing data, and historical data if available. We will gather insight from local experts, service users and the public to provide a comprehensive assessment with recommendations for planning and monitoring. The needs assessment will encompass:

- Mapping need;
- Examining demand;
- Mapping service provision;
- Assessing any gaps between these factors;
- Making recommendations as to how sexual health services could better meet the needs of the population.

Outcomes and impacts

The results of the study will inform and guide Cheshire West and Chester Council to develop effective partnerships, services and support to ensure that the population in Cheshire West and Chester receive information and services that meet their sexual health needs. This will include:

- Awareness of what the population of Cheshire West and Chester perceive as priorities and risks in relation to their sexual health;
- Knowledge of the awareness of sexual health services available to them locally;
- Identification of services that can better support residents to achieve healthier lifestyles and remove health-related barriers;
- Identification of new and innovative sexual health approaches and services that can deliver healthcare savings through prevention and reduction measures;
- Support commissioners to enable them to prioritise and allocate resources effectively and efficiently to best meet the needs of residents;
- Provide information to work towards reducing health inequalities;
- Information on services with regard to accessibility (transport and opening times), systems and procedures, awareness/promotional materials used and how they address diversity and equal opportunity;
- Involvement of service staff, practitioners, service users and community stakeholders.

Scope of study

The sexual health needs assessment was conducted within Cheshire West and Chester Local Authority. A separate Sexual Health Needs Assessment has recently been completed for Vale Royal residents and so the Vale Royal population were not included in the scope of this study. Reference is made to the Vale Royal Sexual Health Needs Assessment throughout this report as appropriate. Individuals who could give adequate consent, who were aged between 16 and 60 years and who lived, worked or socialised within the Cheshire West and Chester council area, were included in the study.

Depth and type of work

- Engage service users, potential service users, and current non-service users in the needs assessment;
- Engage relevant professionals and stakeholders in the continual development of the needs assessment process;
- Gather and analyse quantitative and qualitative data.

Population under study

The commissioners requested this study focus on the following service users, potential service users and non- service users:

- People aged 16-60 years who are resident in Cheshire West and Chester and are currently using the sexual health services;
- People aged 16-60 from the general population of Cheshire West and Chester (defined as those who live, work or socialise in Cheshire West and Chester) who may or may not have used sexual health services;

In addition, a recent Sexual Health Needs Assessment conducted in Vale Royal had gathered insights from seldom heard groups across Cheshire West and Chester. The findings from this work are also included in this report and involved:

- Adults (aged 16-60) from a range of seldom-heard groups from a range of backgrounds including:
 - Men who have sex with men (MSM);
 - Young people (aged 16 and over) who are leaving or have left local authority care;
 - Adults with learning disabilities;
 - Adults from the Gypsy and Traveller community.

Protocol development

Researchers and commissioners from Cheshire West and Chester LA met to discuss the scope and population for the study and to identify key stakeholders for involvement in the project steering

board. Initial meetings confirmed that the study should extend recent work completed in Vale Royal and include primary research gathered from NHS service users (thus requiring ethical approval from the National Research Ethics Committee (NREC)), and the general population of Cheshire West and Chester.

A project steering group was convened and comprised the research team from the Centre for Public Health, Liverpool John Moores University, commissioners from Cheshire West and Chester LA and interested stakeholders from Vale Royal CCG, sexual health service providers and other interested parties. The group initially met to discuss the potential for extending an existing sexual health needs assessment being undertaken in Vale Royal to cover Cheshire West and Chester. The project steering group continued to meet on a bi-monthly basis for the duration of the sexual health needs assessment.

Ethical and NHS Research and Development (R&D) approval

The general sexual health survey was approved by the Liverpool John Moores University Research Ethics Committee (LJMU REC). Approval was granted by the LJMU REC in July 2013. Ethical approval for the NHS section of the needs assessment was sought through the NHS Research Ethics Committee (NREC) at the North West meeting in Preston and approval was granted in June 2013. R&D clearance from Countess of Chester NHS trust was given in November 2013.

Quantitative methods

Service Users

Design: A cross-sectional survey with service users at six sexual health services across Cheshire West and Chester; the Countess of Chester Department of Sexual Health, St Martin's Sexual Health Clinic, Stanney Lane Sexual Health Clinic, Neston Sexual Health Clinic, Blacon Sexual Health Clinic and West Cheshire College Healthzone.

Tools: A service user questionnaire was developed to gather the opinions of service users, including their experiences of the service, why they were attending and their awareness of the services available. A copy of the service user questionnaire is included as an appendix to this report.

Sampling and Recruitment: Questionnaires were distributed to the six sexual health services listed above. Reception staff asked participants if they would like to take part in the questionnaire as they arrived at the service.

Participants: Adults aged 16-60 years, of any sexuality, ethnicity or gender who attended a sexual health service in Cheshire West and Chester. Data collection was conducted during December and January 2013.

Procedure: Visitors were asked by reception staff if they would like to participate. Individuals showing interest were given a pack containing a participant information sheet, questionnaire,

postcode slip and envelopes. Individuals who decided to complete the questionnaire completed the first section of the form before their appointment and the second section following their appointment. They then sealed it in the envelope provided and returned it to reception. To preserve service user anonymity, postcode information was written on a separate slip which was again sealed into an envelope and stored separately from the completed questionnaires.

General population

Design: A cross-sectional online questionnaire, hosted on the Survey Monkey website, with the adult (aged 16-60 years) population of Cheshire West and Chester.

Tools: A general population questionnaire was developed to gather information from the general population of Cheshire West and Chester (aged 16-60 years) on their knowledge and attitudes towards sexual health and opinions and experiences of sexual health services. A copy of the general population questionnaire is included as an appendix to this report.

Sampling and recruitment: Participants were recruited through the Cheshire West and Chester Council Citizens Panel. The survey was also promoted through email, newsletters, websites and social media including Facebook and Twitter by a range of local organisations including the Centre for Public Health at Liverpool John Moores University, Cheshire West and Chester LA, Body Positive Cheshire and North Wales (BPCNW), local councillors and members of parliament. A paper version of the questionnaire was also made available for those who requested them. The online survey used filter questions to ensure that those completing the survey were living, working or socialising in Cheshire West and Chester and aged between 16 and 60 years.

Participants: Adults aged between 16 and 60 years who were living, working or socialising in Cheshire West and Chester at the time of the survey. Data collection ran between September and December 2013.

Procedure: Participants were sent a link to access the online survey. Those being contacted directly by the Citizen's Panel were sent a copy of the participant information sheet in advance. All individuals accessing the online survey had to answer a series of filter questions and then were asked to read the participant information before beginning the survey. The participant information made clear that participants did not have to respond to any questions that they did not feel comfortable answering.

Analysis: The data was downloaded and coded in the statistical analysis package SPSS 20. SPSS programme command syntax language was developed to analyse the data. Analysis consisted of frequency distributions, cross-tabulations and statistical tests of data. These tables were then exported to Microsoft Excel, where the data were graphically displayed. Chi squared tests were used to determine whether there was a statistically significant association between two non-constant categorical variables. Statistical associations were significant at the 95% level (e.g. $p = 0.05$ or less).

Qualitative methods

As part of a Sexual Health Needs Assessment for Vale Royal, information was gathered from seldom-heard groups across Cheshire West and Chester and has also been used to inform this Sexual Health Needs Assessment. Data was generated from a series of focus group and semi-structured interview discussions conducted as follows:

Design: Qualitative methods using focus groups (care leavers), or one-to-one semi structured interviews (care leavers, adults with learning disabilities, MSM/LGBT, and the Gypsy and Traveller community).

Tools: The focus group and interview topic guides were developed for each seldom-heard group and was used as the basis for the group/ interviews. Guides were based on previous studies and advice was sought from professionals working in each gatekeeper organisation. The guide provided a list of topic headings and prompts. The key topics selected for use within all groups were: knowledge of sexual health, most important and frequently used resources, awareness of services, service improvement, barriers to accessing services and risk behaviour and knowledge, attitudes, beliefs and practices. Copies of the focus group/interview guides are available as an appendix to this report.

Sampling and recruitment: Focus groups and interviews were arranged through a variety of organisations. Key gatekeepers were identified within each organisation and these key gatekeepers approached existing service users within their organisation on behalf of the research team. Initially, semi-structured interviews were intended only to take place with the Gypsy and Traveller community, but practical and recruitment challenges meant that semi-structured interviews were also arranged for some individuals from the care leavers, learning disabilities and MSM/LGBT groups.

Procedure: All participants were informed about the focus group/interview by key gatekeepers prior to final arrangements. They were provided with information sheets and asked if they wanted to participate. Before the focus group or interview started, the project was explained again and any questions answered by the researcher. Consent forms were signed by all participants. Before the focus group started participants were asked to set some ground rules for the group and the researcher discussed the importance of respecting the views of others, not interrupting and confidentiality. Participants were also reminded that researchers did not want to know about personal sexual experience but rather those views of their peers in general. Before interviews began participants were reminded that they did not have to answer any question with which they felt uncomfortable and that they were free to end the interview at any point without giving a reason. Sessions were recorded on a digital voice recorder with participant consent. Participants were informed that no names or personally identifiable information would be included in the transcripts and all quotes given would be checked to ensure anonymity. Following the session the recordings were transcribed verbatim.

Analysis: Transcripts were analysed using content analysis. Each transcript was reread to gain a sense of the main issues emerging from the data, irrespective of the topic guide. Notes were made before returning to the individual transcripts. Key themes were noted for each transcript, and within these, sub themes were identified. This process was adopted for all the groups. A list of the key and

sub themes was drawn up as a master list. The list was then used alongside each of the transcripts in order to code the data. Once coded, the analysis was written up within a thematic framework, with quotes used to illustrate the text. Transcripts were used as a consistency check. This involved checking for any new themes, which were added to the framework, again with illustrative quotes. They were then considered in light of the overall framework. Where they corresponded to the findings thus far, they were seen as corroborating the data. Where they contradicted the findings the raw data were revisited to check the initial interpretation. If not, this was re-analysed and written up in light of the new findings. If the analysis showed inconsistencies with the raw data presented previously, this was taken to be a reflection of the view of that specific group, and incorporated as a new finding. As a final check, the initial notes were reviewed and any contradictions with the narrative explored further.

Table 2.1 Details of interviews/focus groups

Participant Group	Interview/ Focus Group	Date held	Gender of participants	Location/ partner organisation
Gypsy/ traveller community	Interviews	18/06/13		Cheshire Gypsy and Travellers Voice, Winsford
Care Leavers	Interviews	04/07/13	Female	Cheshire West and Chester Social Services Care Leaving Team, The HQ, Chester
	Focus Group	23/07/13	Mixed	Cheshire West and Chester Social Services Care Leaving Team, The HQ, Chester
Learning Disabilities	Interviews	03/09/13	Female	Chester West and Chester Adult Social Care
	Interviews	03/09/13	Female	Chester West and Chester Adult Social Care
	Interviews	03/09/13	Female	Chester West and Chester Adult Social Care
MSM/LGBT	Interviews	04/10/13 and 21/10/13		Body Positive Cheshire and North Wales, Crewe

3. EXISTING INFORMATION ON SEXUAL HEALTH IN CHESHIRE WEST AND CHESTER

Key findings

- Cheshire West and Chester has the lowest local authority prevalence of sexually transmitted infections (STIs) in Cheshire and Merseyside with an overall acute STI prevalence of 583.9 per 100,000 population;
- The 20 to 24 years age band has the highest overall prevalence of acute STIs (3,800 per 100,000 population) with the 15 to 19 years having the second highest prevalence (2,272 per 100,000 population);
- Amongst young people aged 15 to 19 years, STI prevalence among females is over three times the prevalence among males. However, this is reversed for those aged 25 and over where the prevalence for males is higher for all age bands;
- HIV prevalence in Cheshire West and Chester in 2012 was 80 per 100,000 adult population (15-59 years) compared to the North West as a whole (156 per 100,000 adult population) The majority of those living with HIV in Cheshire West and Chester were infected through sex between men (55%);
- In 2012, 90% of eligible GUM attendees resident in Cheshire West and Chester were offered a HIV test (higher than the national average; 79%) and 63% of eligible attendees accepted a test (lower than the national average; 81%);
- Between 2009 and 2011, 74% of new HIV diagnoses in Cheshire West and Chester were diagnosed late; significantly higher than the national average (50%);
- In 2011 the rate of conceptions to 15-17 year olds in Cheshire West and Chester was 25.8 per 1,000 young women, significantly lower than the national average (30.7 per 1,00 women). In 2012, there were 163 conceptions to teenage mothers under the age of 18 years a 12% decline on the previous year.
- There were 255 abortions in Vale Royal CCG and 633 abortions in West Cheshire CCG in 2012. The rate of abortion in both CCGs was slightly lower than the national average.
- According to Public Health England, there were 8,618 attendances at GUM in Cheshire West and Chester in 2012, of which 67% (5,776 attendances) were Cheshire West and Chester residents.
- A total of 4,486 clients at the Countess of Chester GUM received a sexual health screen in 2012, representing 80% of all new attendees.
- There were 17,071 attendances at community contraception and sexual health (CaSH) services between April 2012 and March 2013 of which 13,817 were at iCASH services in Cheshire West and Chester and a further 3,254 attendances were at CaSH services in Vale Royal. The majority of attendances were made by young people aged under 25 years (n = 9,993; 59%).
- The majority of attendances at contraception and sexual health services were female (80%) and 84% of women attended for contraception. The predominant reason for accessing services was to access the pill followed by implants and injectable contraceptives.

Key findings continued...

- The majority of requests for post-coital contraception at CaSH services were among the 15-19 years age group (50%).
- There were 1,808 Long Acting Reversible Contraception (LARC) fittings and 1,094 LARC removals in CaSH services between April 2012 and March 2013. In Cheshire West and Chester iCaSH services only 75 of 897 LARC removals were patients who had a LARC fitting over the same 12 month period.
- GP practices across Cheshire West and Chester currently operate under two different service specifications and practices across both CCGs may offer different levels of services;
- In total, 2,945 Chlamydia tests were completed in General Practice across Cheshire West and Chester between April 2012 and March 2013, an average of 245 tests per month. In general, levels of testing were higher in urban than in rural practices;
- There were 992 implants fitted in General Practice in 2012/13, an average of 83 fittings per month and 854 removals; an average of 71 removals per month. There were approximately four removals for every five implants fitted;
- In 2012/13, 995 intrauterine contraceptive devices were fitted in General Practice, an average of 83 fittings per month.
- There were 11,264 contraceptives prescribed in General Practice across Cheshire West and Chester from July to December 2012. The majority of prescriptions were for oral contraceptives (West Cheshire CCG; 71% and Vale Royal CCG; 85%). LARC accounted for around one quarter of all contraceptives prescribed. Emergency contraception accounted for between one and five percent of contraceptive prescriptions per month.
- A total of 10,580 Chlamydia tests were reported to the National Chlamydia Screening Programme (NCSP) in Cheshire West and Chester in 2012 of which 809 (7.6%) were positive.

Sexually Transmitted Infections (STIs) including HIV

Nationally, there has been a sustained increase in diagnoses of Sexually Transmitted Infections over the past decade. The level of sexually transmitted infections (including HIV) diagnosed in the United Kingdom increased by 2% from 2010-2011 with the number of infections diagnosed in GUM and community based settings rising from 419,773 in 2010 to 426,867 in 2011. This increase has included increased diagnosis of gonorrhoea (25%), infectious syphilis (10%), genital herpes (5%) and genital warts (1%). However, diagnoses of genital chlamydia in the same period fell by two percent. It is likely that high levels of unsafe sexual behaviour have contributed to this overall increase in diagnoses. However, other factors such as higher levels of chlamydia and sexual health screens performed under the National Chlamydia Screening Programme and in GUM clinics, combined with the use of more sensitive tests for the diagnosis of gonorrhoea and genital herpes will also have contributed to this overall rise.

Poor sexual health remains greatest among men who have sex with men and young heterosexual adults. Overall, 67% of infections diagnosed in 2011 were in young adults aged 15-24 and 88% of these were among young heterosexual men and women representing 173,705 infections diagnosed. Among men who have sex with men, the number of STI diagnosis continues to rise with diagnoses of gonorrhoea, syphilis, chlamydia, genital warts and genital herpes all rising by at least 20% from 2010-2011. Furthermore, men who have sex with men accounted for 75% of syphilis diagnoses and 50% of gonorrhoea diagnosis amongst men diagnosed in 2011. Whilst improved testing methods for gonorrhoea, syphilis and chlamydia combined with improved reporting of sexual orientation will be in part responsible for this rise among men who have sex with men, it is likely that high levels of unsafe sex will have made an important contribution to the rise in diagnoses. Men who have sex with men remain a key priority for targeted STI and HIV prevention work (DH,2013).

Rising concerns about these increasing rates of sexually transmitted infections, along with other issues has been identified as a key priority by the Department of Health. Reducing the number of Chlamydia diagnoses in young people aged 15-24 and reducing the number of people presenting with HIV at a late stage of infection have both been identified as indicators in the Department of Health's Public Health Outcomes Framework for England 2013-2016. The recently published Framework for Sexual Health Improvement in England emphasises the need to continue work to reduce the rate of sexually transmitted infections using preventative interventions and treatment initiatives. It also emphasises the need for early, effective and accurate diagnosis of sexually transmitted infections (including HIV) combined with partner notification for those who may be at risk.

Sexually Transmitted Infection Data

Data presented in this section is taken from the Genitourinary Medicine Clinical Activity Dataset (GUMCAD) produced by Public Health England. GUMCAD data are published at Local Authority and clinic level.

Table 3.1 shows the prevalence rates of the five key sexually transmitted infections for Cheshire West and Chester (namely Chlamydia, Genital Warts, Genital Herpes, Gonorrhoea and Syphilis) by sex. The most prevalent sexual infections are chlamydia (333.2 per 100,000 population) and genital warts (108.3 per 100,000 population). Females have a higher rate of chlamydia and genital herpes whilst the rate of genital warts, gonorrhoea and syphilis is higher amongst males. The overall prevalence of acute STIs (583.9 per 100,000 population) is substantially lower than the average prevalence across the whole of Cheshire and Merseyside (767.8 per 100,000 population) and Cheshire West and Chester has the lowest prevalence of sexually transmitted infections of any LA across Cheshire and Merseyside. Table 3.2 presents the prevalence of five key sexually transmitted infections for Cheshire West and Chester by age band. The 20-24 age band have the highest overall prevalence of acute sexually transmitted infections (3,800 per 100,000 population) with the 15-19 age band having the second highest prevalence (2,272 per 100,000 population). Chlamydia prevalence is highest among the 20-24 age band (2,441 per 100,000 population). The over 65 age band has the lowest prevalence across all infections with an overall prevalence of 6.5 per 100,000. These patterns of prevalence by age band are in line with trends across the north west of England.

Table 3.1: Prevalence (per 100,000 population) of key sexually transmitted infections in GUM clinics by sex for all residents of Cheshire West and Chester, 2012

Infection	Prevalence by sex		Total
	Male	Female	
Chlamydia	262.1	396.0	333.2
Gonorrhoea	34.2	22.5	28.2
Syphilis	1.9	0	0.9
Genital Herpes	31.8	62.8	47.6
Genital Warts	123.9	93.5	108.3
All acute STIs*	569.7	593.2	583.9

Data source: Genitourinary Medicine Clinic Activity Dataset (GUMCAD), Public Health England, Accessed November 2013.

*Total includes all acute sexually transmitted infections

Table 3.2: Prevalence (per 100,000 population) of key sexually transmitted infections by age for all residents of Cheshire West and Chester, 2012.

Infection	Prevalence by age group								Total
	<15	15	16-19	20-24	25-34	35-44	45-64	65+	
Chlamydia	101.9	1659.3	2441	581.1	94.4	26.1	0	333.2	
Gonorrhoea	12.7	25.6	105.2	164.1	59.7	19.8	10.9	1.6	28.2
Syphilis	0	0	0	5.1	2.7	0	1.1	0	0.9
Genital Herpes	0	25.6	123.7	261.5	122.2	37.3	23.9	1.6	47.6
Genital Warts	0	51.2	371.2	702.6	255.3	90.1	23.9	1.6	108.3
All acute STIs*	63.7	2272.2	3800.0	1213.9	329.5	131.7	6.5	583.9	

Data source: Genitourinary Medicine Clinic Activity Dataset (GUMCAD), Public Health England, Accessed November 2013.

*Total includes all acute sexually transmitted infections

Tables 3.4 and 3.5 show the prevalence of the five key sexually transmitted infections in Cheshire West and Chester by male and female age bands respectively. The tables show that for both males and females prevalence of acute sexually transmitted infections is highest among those aged 20-24 years (3,384 per 100,000 population and 4,618 per 100,000 population respectively). Amongst males those aged 25-34 have the second highest prevalence (1,175 per 100,000 population) whilst amongst females the second highest prevalence is among those aged 15-19 (3,754 per 100,000 population). There is a clear difference between the age of males and females greatest affected; amongst young people aged 15-19 prevalence among females is over three times the prevalence amongst males. However, this is reversed for those aged 25 and older, with the prevalence for males is higher than females for all age bands over 25.

Table 3.4: Prevalence (per 100,000 population) of key sexually transmitted infections by age for male residents of Cheshire West and Chester, 2012.

	Prevalence by age group (male)								Total
	<15	15	16-19	20-24	25-34	35-44	45-64	65+	
Chlamydia	24.6	789.1	1970.2	614.9	107.6	42.1	0	262.1	
Gonorrhoea	0	0	84.6	181.0	83.1	31.4	17.7	34.2	
Syphilis	0	0	0	10.6	5.5	0	2.2	1.9	
Genital Herpes	0	0	24.2	149.1	105.3	26.9	19.9	31.8	
Warts	0	0	229.6	809.4	349.0	116.6	31.0	123.9	
All acute STIs*	0	1256.7	3461.1	1501.3	457.5	185.9	14.5	569.7	

Data source: Genitourinary Medicine Clinic Activity Dataset (GUMCAD), Public Health England, Accessed November 2013.

*Total includes all acute sexually transmitted infections

Table 3.5: Prevalence (per 100,000 population) of key sexually transmitted infections by age for female residents of Cheshire West and Chester, 2012.

	Prevalence by age group (female)								Total
	<15	15	16-19	20-24	25-34	35-44	45-64	65+	
Chlamydia	184.7	2560.2	2838.8	538.0	77.5	10.7	0	396.0	
Gonorrhoea	26.4	52.2	126.8	148.4	37.3	8.6	4.3	22.5	
Syphilis	0	0	0	0	0	0	0	0	
Genital Herpes	0	52.2	228.2	366.0	138.5	47.4	27.8	62.8	
Warts	0	104.3	519.8	603.4	165.1	64.6	17.1	93.5	
All acute STIs	131.9	3315.0	4095.0	926.9	202.3	79.2	0	593.2	

Data source: Genitourinary Medicine Clinic Activity Dataset (GUMCAD), Public Health England, Accessed November 2013.

*Total includes all acute sexually transmitted infections

HIV background and national figures

In their recently published Sexual Health Improvement Framework for England, the Department of Health identified reducing onwards transmission of HIV and avoidable HIV related deaths as a key objective for improving sexual health across the whole population. The importance of HIV testing in improving sexual health nationally has been acknowledged by its inclusion as an indicator in the Public Health Outcomes Framework for 2013-2016; specifically through reducing the number of people presenting with HIV at a late stage of infection (DH, 2013b). Furthermore, men who have sex with men and those of black African ethnicity tend to be disproportionately affected by HIV and the National Institute for Clinical Excellence has identified these populations as key target groups for HIV prevention (NICE 2011a and 2011b).

Nationally, an estimated 96,000 people were living with HIV in the United Kingdom at the end of 2011 and it is estimated that almost a quarter (24%) of those living with HIV in the UK are unaware

of their infection. Overall HIV prevalence nationally is 1.5 per 1,000 population with prevalence highest among men who have sex with men (47 per 1,000 population) and black Africans (37 per 1,000 population). The number of new cases of HIV in the United Kingdom is declining, with a 21% decline since their peak in 2005, and a total of 6,280 people were diagnosed with HIV in 2011. This decline in new diagnoses is mostly due to a decline in those acquiring their HIV infection abroad and over half of the 2,990 heterosexual men and women diagnosed with HIV in 2011 were infected in the UK, compared to 27% in 2002. Conversely, new diagnoses among men who have sex with men (MSM) have been increasing since 2007, and new cases amongst MSM reached an all-time high in 2011 with 3,010 men newly diagnosed. Around 70% of STI clinic attendees received at HIV test in 2011 and uptake was highest amongst men who have sex with men (83%).

HIV in the north west of England

Since data collection began in 1996, the number of individuals reported to the North West HIV and AIDS monitoring unit as accessing HIV services has increased year on year, and has risen by 590% (from 1,014 individuals in 1996 to 6,993 individuals in 2011). The rate of increase year on year has been slowing with an increase of 6% between 2010-2011 compared to a 23% increase at its peak between 2002 and 2003. In 2011, 6,993 individuals accessed treatment and care for HIV in the north west of England and prevalence was 1.49 per 1,000 population. There were 789 new cases reported in 2011; overall the number of new cases has been decreasing since 2005 but this has been a fluctuating trend and between 2010 and 2011 there was a 7% increase in new cases.

Sex between men continues to be the predominant mode of exposure (51%) amongst individuals accessing treatment and care in the North West. This varies across the counties with 61% of those resident in Lancashire and 57% of those resident in Cheshire infected through sex between men compared with just 39% of those resident in Merseyside. Amongst new cases, 44% were infected through sex between men and 42% through heterosexual sex. There has been a 53% increase in the number of new cases in Cheshire between 2002 and 2011, with 53 new cases in 2011. This includes a 117% increase in those infected through heterosexual sex and a 75% increase in those infected through sex with men (Harris et al, 2012).

HIV in Cheshire West and Chester

Cheshire West and Chester has a low prevalence when compared with the rest of the region, adult (age 15 to 59 years) HIV prevalence in Cheshire West and Chester in 2012 was 80 per 100,000 population compared to the North West as a whole (156 per 100,000 population). Table 3.6 presents a breakdown of HIV cases by route of infection, the majority of those living with HIV in Cheshire West and Chester were infected through sex between men (55%) and this is higher than the region as a whole. A further 39% of those living with HIV in Vale Royal were infected heterosexually.

Table 3.6: Number of HIV cases by route of infection, Cheshire West and Chester, 2012

		New cases				All cases			
		MSM	Heterosexual	Other/ unknown	Total	MSM	Heterosexual	Other/ unknown	Total
Cheshire West and Chester	Number	10	11	2	23	98	70	10	178
	%	43	48	9		55	39	6	
North West	Number	386	318	68	772	3811	3070	448	7329
	%	50	41	9		52	42	6	

Source: HIV & AIDS Monitoring Unit, Centre for Public Health, Liverpool John Moores University, 2012

In 2012, 90% of eligible GUM attendees living in Cheshire West and Chester were offered a HIV test (4,673 of 5,221 eligible individuals) which is a substantially higher offer rate than the national average (79%). In total, 3,289 Cheshire West and Chester residents were tested for HIV in a GUM clinic in 2012; representing 63% of all attendees eligible for a test. Rates of testing in Cheshire West and Chester were higher than the average for Cheshire and Merseyside (59%) but substantially lower than the national average of 81% (PHE, 2013).

Public Health Outcomes Framework Indicator 3.04: *People presenting with HIV at a late stage of infection*

Between 2009 and 2011, 74% of new diagnoses in Cheshire West and Chester were diagnosed late (with a CD4 cell count of <350). This is **significantly higher** than the North West (53%) and national average (50%)

Source: Public Health Outcomes Framework data tool, PHE, 2013

Teenage Pregnancy

Teenage pregnancy rates in England and Wales are continuing to fall; in 2012 the Office for National Statistics reported the lowest teenage pregnancy rate since records began in 1969. In 2012, there were 27,834 conceptions to women aged under 18 years and the conception rate was 27.9 conceptions per 1,000 women aged 15-17 compared with a rate of 47.1 per 1,000 women in 1969. However, reducing levels of teenage pregnancy still remains a key national priority, the United Kingdom continues to have one of the highest rates of births to mothers aged 15-17 years in the European Union and teenage mothers and their children continue to have poorer health and wellbeing outcomes when compared to the population as a whole. Teenage pregnancy was highlighted in the recently published Framework for Sexual Health Improvement in England as a key ambition. The framework ambition is to reduce the numbers of conceptions under 16 and 18 years

through access to appropriate advice and education and full range of contraceptive methods for all young people (ONS 2012a, DH, 2013a).

Public Health Outcomes Framework Indicator 2.04: Under 18 conceptions

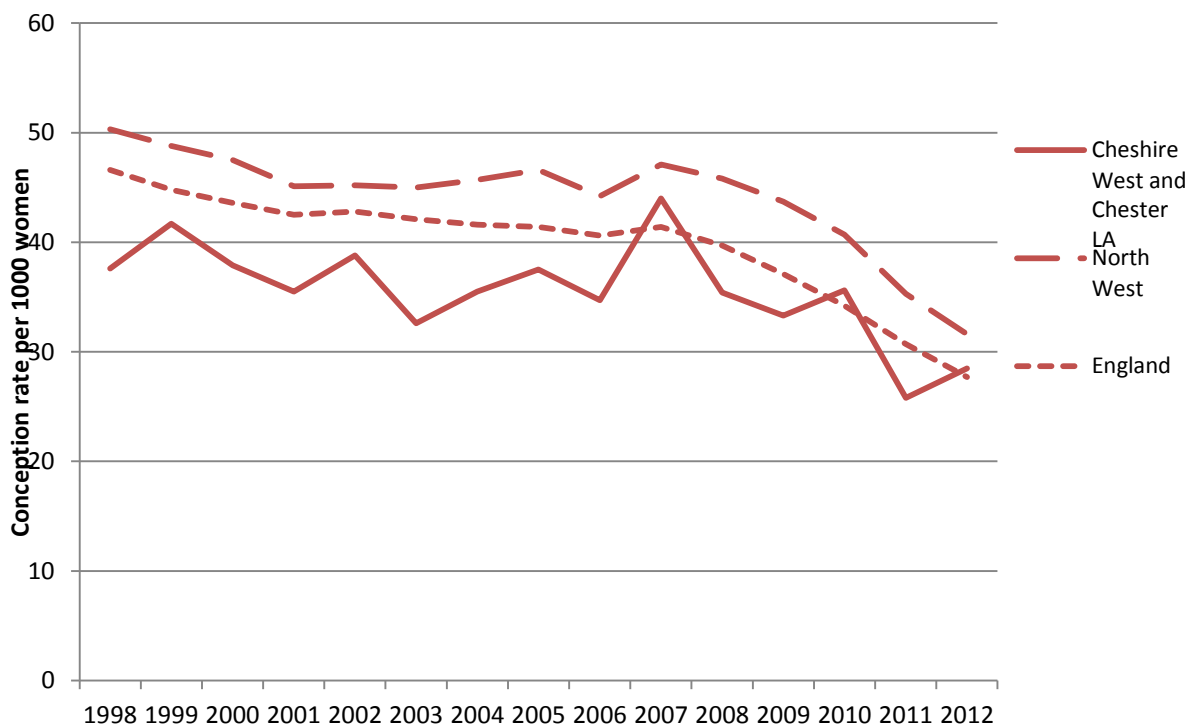
In 2011, the rate of conceptions to 15-17 year olds in Cheshire West and Chester was 25.8 per 1,000 young women; this is **significantly lower** than the national average (30.7 per 1,000 young women).

Source: Public Health Outcomes Framework data tool, PHE, 2013

In 2012, there were 163 conceptions to mothers under the age of 18 years in Cheshire West and Chester, representing a rate of 28.5 per 1,000 young women and a 12% increase on the previous year (146 conceptions). Overall, the rate of teenage conceptions has declined by 26% since 1998; however this decline is lower than the national average (36%) (figure 3.1). The maternity rate for Cheshire West and Chester in 2011 was 13.5 births per 1,000 young women (compared to 14.1 per 1,000 women nationally) and 53% of teenage pregnancies resulted in abortion; a rate of 15.1 abortions per 1,000 young women. As of December 2011, 28% of mothers aged 16-18 known to Cheshire West and Chester Local Authority were in education, training or employment.

Eight wards in Cheshire West and Chester (Westminster, Stanlow and Wolverham and Central wards in Ellesmere Port, Northwich Witton, Winsford Wharton and Over, and Blacon Hall and Blacon Lodge in Chester) have a rate of under 18 conceptions that is significantly higher than the national average.

Figure 3.1: Rate of conceptions to mothers aged under 18, Cheshire West and Chester, 1998-2012



Source: ONS, 2013

Termination of pregnancy

Abortion is identified in the Department of Health's Framework for Sexual Health Improvement in England as a priority area (DH, 2013). One of the key ambitions of the strategy is that all women requesting an abortion should be offered abortion counselling; giving them the opportunity to discuss their options with a trained individual (DH, 2012).

In 2012, the age-standardised rate of abortion per 1,000 resident women of England and Wales was 16.5. The abortion rate was highest for women aged 20-24 years (30.1 per 1,000 women). Over a third of women (37%) who had an abortion in 2012, had previously had an abortion. This rate has increased from 31% in 2001. Over a quarter (27%) of abortions to women aged under 25 were repeat abortions (DH, 2013).

In the north west of England, the crude rate of abortions in 2012 was 17.5 per 1,000 women. There were 255 abortions in Vale Royal CCG in 2012 and 633 abortions in West Cheshire CCG in 2012. The rate of abortion in both CCGs was slightly lower than the national average. The highest abortion rate was among women aged 20-24 years, in line with national trends.

Table 3.7: Rate of legal abortions in Cheshire West and Chester, England and Wales residents, 2012

	Under 18	18-19	20-24	25-29	30-34	35+	All ages
Vale Royal CCG	13	20	29	18	14	5	14.8
West Cheshire CCG	13	29	27	18	16	5	15.1
Cheshire West and Chester UA	13	26	28	18	15	5	14.9
North West	15	29	32	24	17	6	17.5
England	13	26	29	22	17	7	16.6

Source: National Statistics (2013) Abortion Statistics, England and Wales: 2012, Department of Health

In Vale Royal CCG, over half of abortions (55%) took place in the independent sector. Conversely in West Cheshire CCG, the majority of abortions (58%) took place in an NHS hospital. This is lower than the England average; nationally 64% of abortions in 2012 were in the private sector.

The majority of abortions were conducted between three and nine weeks gestation; 69% in Vale Royal CCG and 80% in West Cheshire, compared with the national average of 78%. Only a small proportion of abortions were conducted at 13 weeks or more (12% in Vale Royal, 9% in West Cheshire). The number of abortions occurring at 13 weeks or more in Vale Royal CCG is slightly higher than the national average (9%). Twenty percent of abortions that took place in 2012 in Vale Royal CCG and 19% in West Cheshire CCG were repeat abortions in women aged under 25, lower than the England and Wales proportion of just over a quarter (27%) (ONS, 2012).

Fertility/infertility

In Vitro Fertilisation treatment in the north west of England is provided by infertility treatment specialist service North West Fertility, which combines NHS and private infertility services in Liverpool, Chester, Nantwich and Manchester. In north west England, there were four clinics

providing in vitro fertilisation (IVF) in 2011. There were 6,116 cycles of IVF provided for 4,816 patients (HFEA, 2013).

Sexual Assault

In the North West of England, there are four sexual assault referral centres (SARC). In Cheshire, the SARC commissions services from Greater Manchester with aftercare based in Cheshire. In 2011/12 there were 214 sexual offences recorded, a crude rate of 0.65 per 1,000 population, this is significantly better than the North West average of 1 sexual offence per 1,000 population (Home Office, 2012a).

The rate of police recorded rape in women in the former Western Cheshire PCT area is significantly lower than the national average. In 2010/11 there were 35 recorded instances of rape in Western Cheshire PCT, a rate of 29 per 100,000 women compared with the North West average of 50 per 100,000 women and national average of 53 per 100,000 women (Home Office, 2012b).

Sexual Health Service Delivery utilising some surveillance sources

Genitourinary Medicine (GUM) attendances

Local Authority level data provided by Public Health England show that there were 8,618 attendances at GUM in Cheshire West and Chester in 2012, of which 67% (5,776 attendances) were Cheshire West and Chester residents. Figure 3.2 shows a breakdown of Local Authority of residence for all attendances at GUM clinics in Cheshire West and Chester Unitary Authority in 2011. Similarly, there were 9,096 GUM clinic attendances by Cheshire West and Cheshire residents in 2012 of which 64% (5,776 attendances) were at a clinic in Cheshire West and Chester. Figure 3.3 gives a full breakdown of GUM attendances by clinic location for all Cheshire West and Chester residents. Of those attending a clinic outside of Cheshire West and Chester, the majority attended Leighton Centre for Sexual Health (23%, 2117 attendances) followed by Arrowse Park Hospital (4%, 394 attendances) and Halton General Hospital (2%, 201 attendances) (PHE, 2013).

A total of 4,864 Cheshire West and Chester residents received a sexual health screen at first attendance in 2012, representing 74% of all new attendees. The majority of sexual health screens were in the 20 to 34 years age group, representing 66% of all screens in 2012. Levels of sexual health screening at first attendance were higher among men (79% of new attendees) than women (70% of new attendees). Among men, there was a higher proportion of men identifying as heterosexual screened (81%) compared to those identifying as homosexual (78%). In total 66% of Cheshire West and Chester residents screened attended the Countess of Chester hospital GUM clinic (3,207 screens).

Data from the Genitourinary Medicine Access Monthly Monitoring (GUMAMM) for 2011 (the last year for which data was collected) shows that 100% of GUM attendees in the former Western Cheshire PCT area were offered an appointment within 2 days. The percentage of GUM clients seen within two days of contacting the service was 86.1% which is significantly worse than the regional average (90.6%) and the national average (88.4%). The proportion of GUM clinic clients missing their first appointment in 2011 was 8.3%, a level significantly worse than the north west of England average (6%) and national average (5.8%) (DH, 2011).

Figure 3.2: Cheshire West and Chester GUM clinic attendees by Local Authority of Residence, 2012

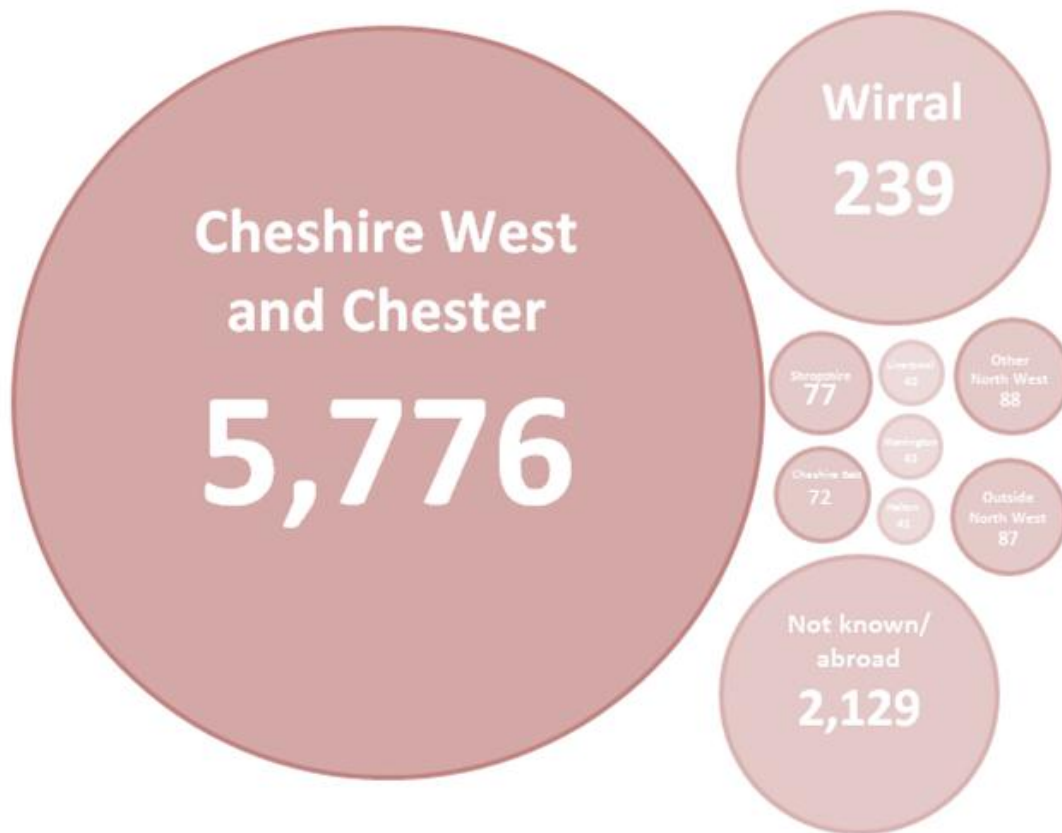


Figure 3.3: Cheshire West and Chester residents GUM clinic attendances by Local Authority of Clinic, 2012



Source: Genitourinary Medicine Activity Dataset (GUMCAD), Public Health England, 2013

Countess of Chester Hospital, Department of GUM

The Department of GUM, at the Countess of Chester hospital is the only GUM clinic based within Cheshire West and Chester Unitary Authority. The Countess of Chester GUM had 8,618 attendances in 2012 by 5,365 patients. Table 3.8 shows the number of key sexually transmitted infections diagnosed in at the Centre for Sexual Health in 2012 by gender. There were a total of 1,236 new STI diagnoses made at the Countess of Chester Hospital in 2012. The proportion of infections are similar to Cheshire West and Chester as a whole (see table 3) with Chlamydia being the most prevalent STI (PHE, 2013).

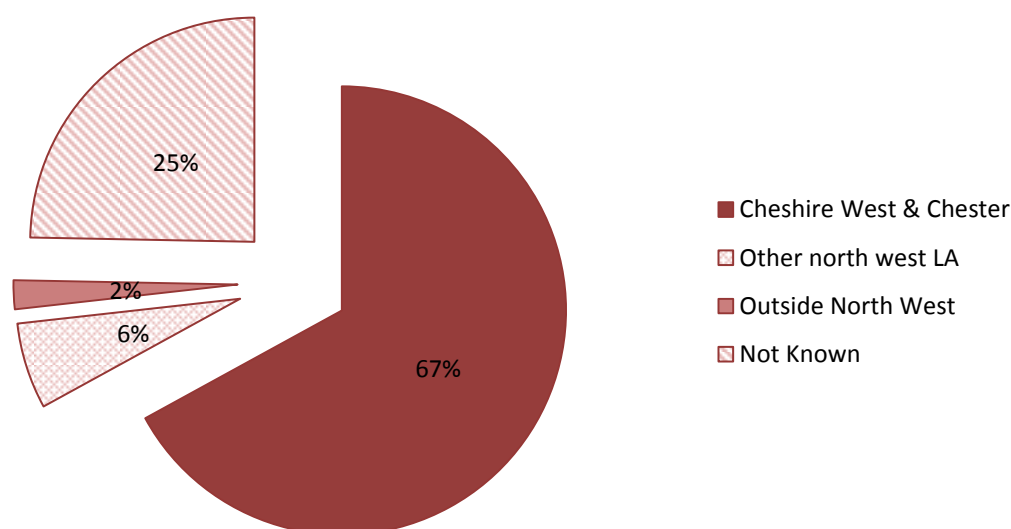
Table 3.8: Numbers of key sexually transmitted infection diagnoses, Countess of Chester Hospital, 2012

	Male	Female	Total
Chlamydia	189	146	335
Gonorrhoea	57	19	76
Syphilis	5	0	5
Genital Herpes	62	104	166
Genital Warts	204	139	343
All STIs	760	476	1236

Source: Genitourinary Medicine Activity Dataset (GUMCAD), Public Health England, 2013

A total of 4,486 clients received a sexual health screen in 2012, representing 80% of all new attendees. Levels of sexual health screening were similar to the Local Authority level, with 84% of male new attendees being screening compared with 75% of females. Figure 3.4 shows that the majority of attendances the Countess of Chester GUM were residents of Cheshire West and Chester (67%) with a further 6% resident in another local authority within the north west of England (for a more comprehensive breakdown refer to figure 3.2).

Figure 3.4: Attendances at Countess of Chester GUM by Local Authority of residence, 2012.

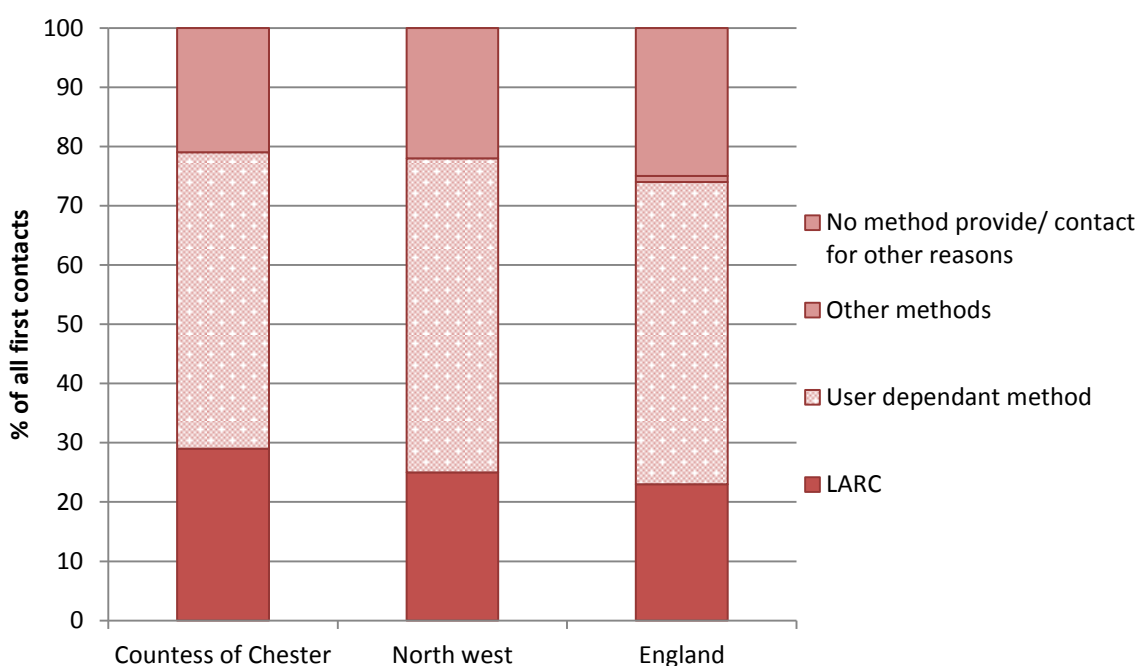


Source: Genitourinary Medicine Activity Dataset (GUMCAD), Public Health England, 2013

Integrated contraception and sexual health services (iCASH)

According to the Department of Health, Community Contraception clinics provided by Countess of Chester NHS Trust had 13,800 clinic attendances in 2012/13 of which 6,900 were first contacts with females and 2,400 were first contacts with males. The majority of female first contacts (54%) were aged between 20 and 24 years, and 87% of all first contacts among females were for contraception reasons (5,500 contacts). Figure 8 shows the reason for attendance at clinics for females as a proportion of all first contacts. The level of Long Acting Reversible Contraception fittings at first contact is slightly higher than the England average (29% compared with 23%).

Figure 3.5: First contacts at Countess of Chester NHS Trust provided contraception clinics for females, 2012



Source: NHS Information Centre, 2013.

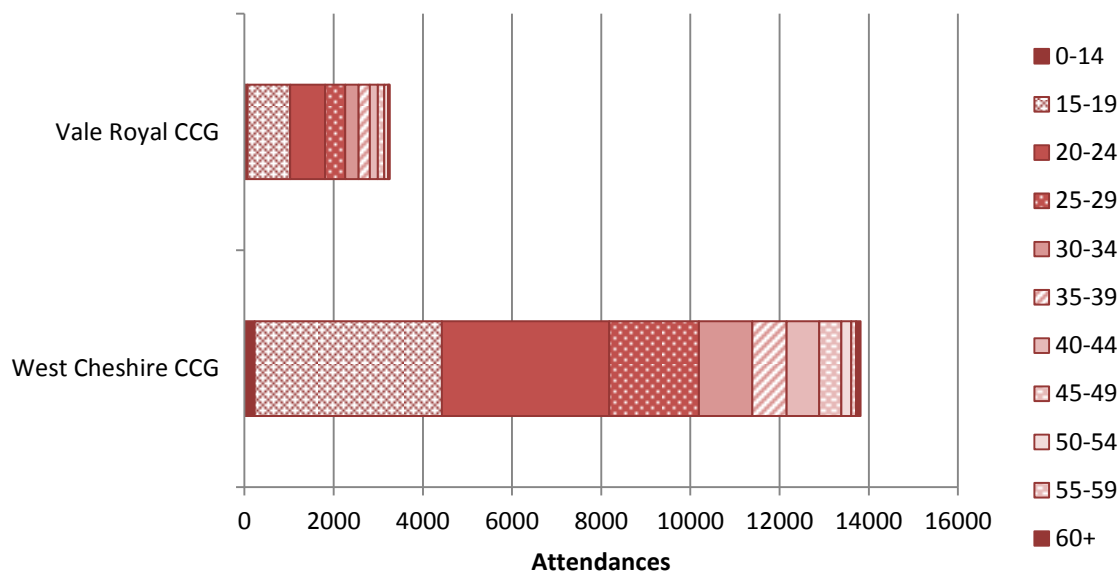
The Countess of Chester Hospital NHS Trust Integrated Contraception and Sexual Health service (iCASH) began operating in its current form in 2011. Doctors and dual trained specialist nurses can provide both sexual health and contraception services at all sites. Services are a mixture of walk in and appointment sessions and include clinics for all ages and dedicated young person's sessions. The Department of Sexual Health within the Countess of Chester Hospital, St Martins Clinic Chester, and Stanney Lane Clinic, Ellesmere Port provide sessions throughout the week. A weekly session is also provided at Neston Clinic and Blacon Clinic.

A nurse led holistic Health Zone session is provided throughout the year from West Cheshire College, Ellesmere Port and is open to all young people under 25's, including young people who are not students at the college. Nurse led Health zone sessions are also provided in term time at Blacon High School, Chester Queens Park High School, Chester, University of Chester C of E Academy, Ellesmere Port and Bishop Heber High School, Malpas. Support is given to the school health zones from School Health Advisors. A lunchtime drop in service is also provided at Chester University. In

addition a growing outreach support service is provided to young people under 19 years and vulnerable adults under 25 years by a Young Person's Sexual Health Outreach Nurse who takes referrals both from within the service and other professionals and outside agencies and links closely with Safeguarding and social services.

Data from the Sexual and Reproductive Health Activity Dataset (SRHAD) show that between April 2012 and March 2013 there were 17,071 attendances at community contraception and sexual health services of which 13,817 were at iCASH services in Cheshire West and Chester and a further 3,254 attendances were at CaSH services in Vale Royal. The majority of attendances (n=9,993, 59%) were by young people aged under 25 years. Figure 1.9 provides a breakdown of CaSH attendances in Western Cheshire and Vale Royal by age band.

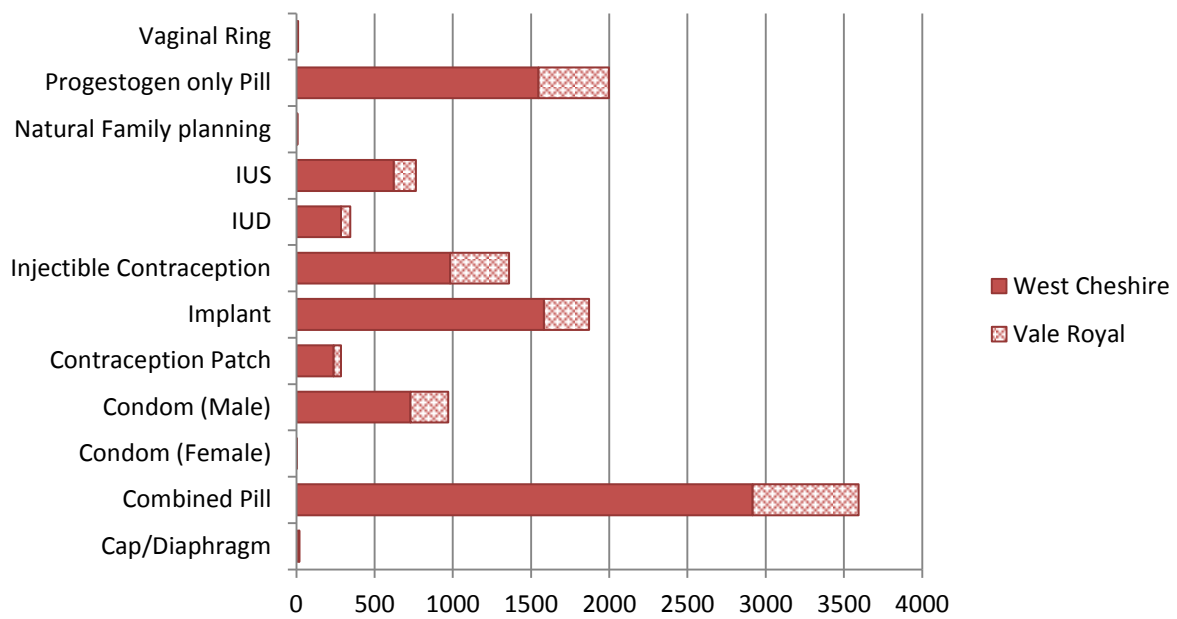
Figure 3.6: Attendance at CaSH services by age group



Source: SRHAD, 2012/13

The majority of attendees were female (80%, n=13,637) and among male attendees 99% of attendances in Vale Royal were for male condoms. At the iCASH service in Cheshire West and Chester 39% of attendances among males were for male condoms (n=1,223) and the remaining 61% of male attendances were for reasons other than contraception. Figure 3.7 shows the reason of attendance at all clinics in Cheshire West and Chester for women by contraception type accessed. Among women at the iCASH services in Cheshire West and Chester, 84% attended for contraception. Overall in Cheshire West and Chester, the predominant reason for accessing services was to access the pill (either combined of progestogen only) followed by implants and injectable contraceptives.

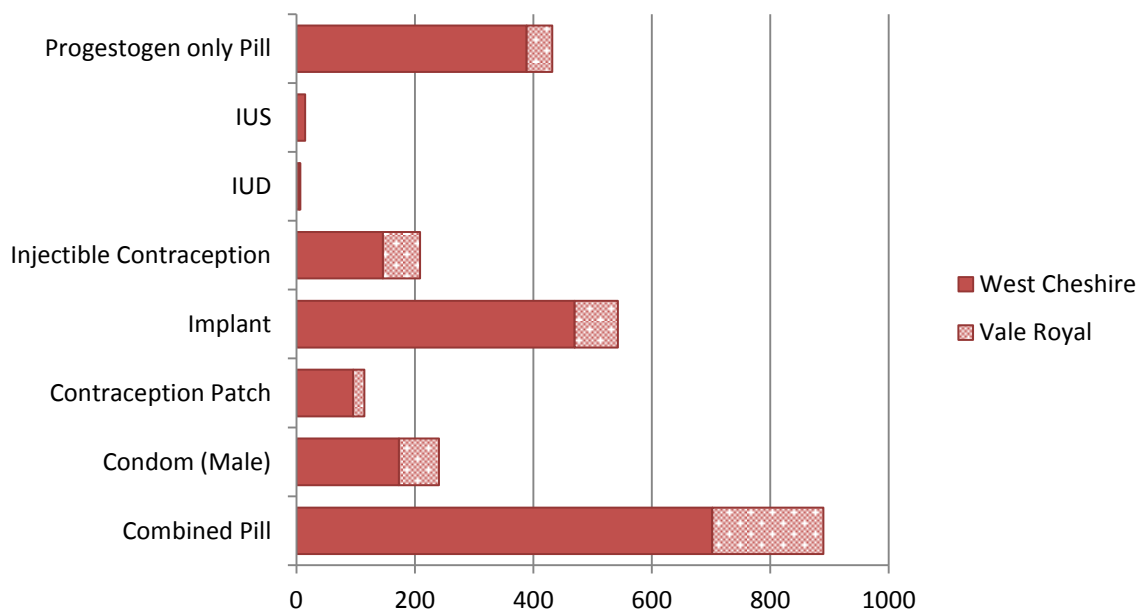
Figure 3.7: Contraception services accessed by females, Cheshire West and Chester 2012/13



Source: SRHAD, 2012/13

Figure 3.8 shows the primary reason for visiting community contraceptive services among females aged under 18 years. Proportionately the number of females under 18 years accessing the contraceptive pill (both combined 34% and progestogen 16%), the implant (21%) and the contraceptive patch (4%) was higher than those aged over 18 years (20% and 12%, 10% and 1% respectively).

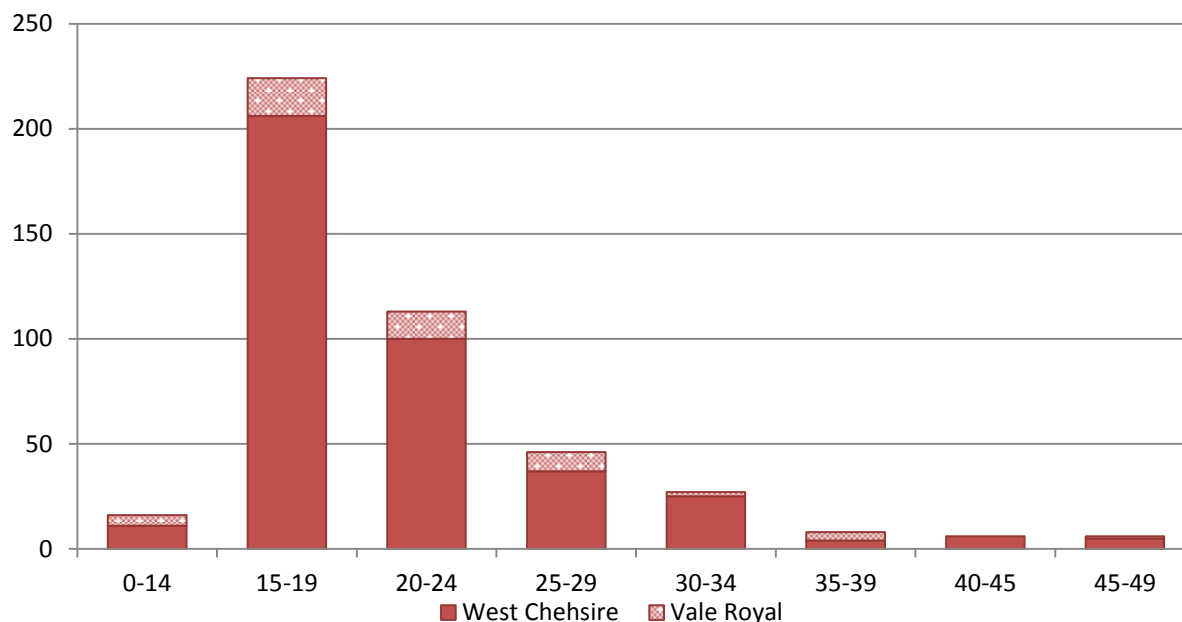
Figure 3.8: Contraception services accessed by females aged under 18 years



Source: SRHAD, 2012/13

Figure 3.9 shows the number of women who requested post-coital contraception by age. The majority of requests for post-coital contraception were among the 15-19 years age group (50%) with over three quarters (76%) aged between 15 and 24 years. This is in line with national trends.

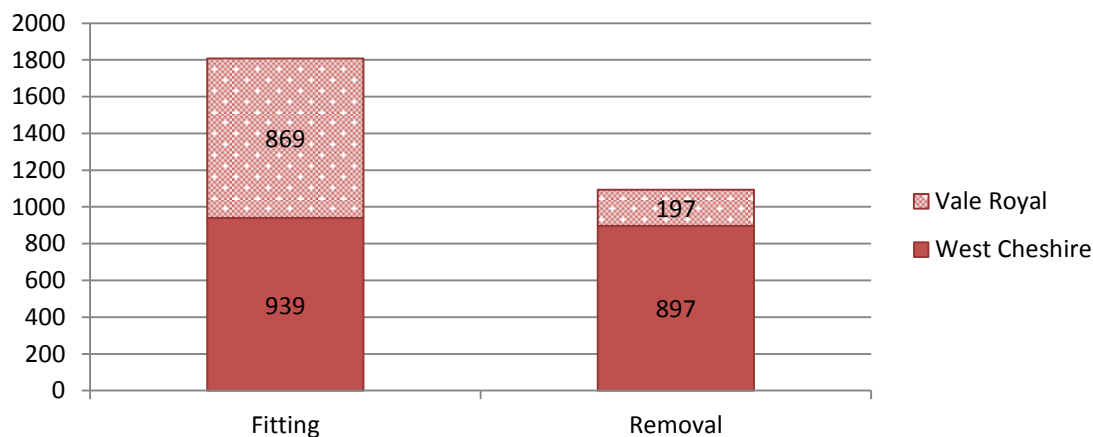
Figure 3.9: Post-coital contraception, Cheshire West and Chester, 2012/13



Source: SRHAD, 2012/13

Figure 3.10 shows the number of LARC fittings and removals at sexual health clinics from April 2012 to March 2013. Overall there were 1,808 LARC fittings and 1,094 LARC removals in Cheshire West and Chester in this period. It is important to note that the below figures represent LARC removals for all reasons including reaching the clinically recommended device duration and pregnancy intentions and do not necessarily represent premature removal. In Cheshire West and Chester iCASH services in 2012/13 only 75 of 897 removals were patients who had a LARC fitting over the same period.

Figure 3.10: LARC fittings, Cheshire West and Chester, 2012/13



Source: SRHAD, 2012/13

General Practitioner Sexual Health Services

There are two CCGs serving the population of Cheshire West and Chester; West Cheshire CC and Vale Royal CCG. West Cheshire CCG is made up of 37 GP practices sitting across three localities Chester City, Ellesmere Port and Neston and Rural Cheshire. Vale Royal CCG is made up of twelve member practices across Northwich, Winsford and surrounding rural areas. Population estimates for mid-2012 show that West Cheshire and Vale Royal CCG serve a combined population of 330,200 people. Data from 2011/2012 Practice Profiles show that 86% of patients in West Cheshire CCG and 80% of patients in Vale Royal CCG would recommend their GP practice and the majority (82% and 71 % respectively) report a good overall experience of making an appointment (Practice Profiles, 2012).

General Practitioners (GPs) across Cheshire West and Chester currently operate under two different service specifications and practices across both CCGs may offer different levels of sexual health services. Vale Royal CCG currently operate locally enhanced services specified by the former Central and Eastern Cheshire PCT whilst West Cheshire CCG operate services specified by the former Western Cheshire PCT. In West Cheshire CCG only practices offering Level 1 services (Chlamydia screening) can offer Level 2 services. Locally enhanced sexual health services in Cheshire West and Chester cover the following areas:

GP surgeries which offer enhanced services aim to:

Level 1: Chlamydia Screening Programme

The Objectives of screening in General Practice are to screen men and women between the ages of 15 to 24 years for Chlamydia infection and thus decrease the burden on secondary care services by diagnosing and treating infections in the community. In so doing this will increase the early detection/ treatment of Chlamydia and thereby reduce the transmission and complications associated with STIs; increase acceptability of Chlamydia testing through non-invasive testing, increase screening of asymptomatic patients consulting for other reasons and increase involvement of general practice in relevant initiatives. Practices are required to:

Vale Royal CCG

- Nominate an appropriate practice lead for Chlamydia screening
- Ensure that at least one GP and practice nurse attend an hour of training from Team Chlamydia on Chlamydia screening
- Develop a practice brief detailing the ways in which the practice will implement the screening programme
- Adhere to screening guidelines outlined by Team Chlamydia.

West Cheshire CCG

- Chlamydia testing for young people aged under 25 years using Western Cheshire Chlamydia office protocols
- Provision of condoms to prevent infection, information on safer sex practices and participation in Condom Distribution scheme
- Sexual History Taking to ensure that Chlamydia screening is appropriate

Level 2a: Local Enhanced Service for Implanon (Hormonal Contraceptive Implant)

Practices are required to:

- Fit, monitor, check and remove contraceptive implants as appropriate
- Produce a register of all patients fitted with a contraceptive implant including type of device and where fitted
- Possess the appropriate equipment including resuscitation equipment
- Use an appropriate patient consent form which should be included in the patient's notes
- Comply with annual review and audit
- Undertake appropriate sterilisation and infection control procedures with a move towards the use of CSSD or disposable instruments
- Provide patient with appropriate information about all contraceptive options, on follow up and symptoms which require urgent assessment during counselling and after fitting.
- Maintain an appropriate GP record of patient history, counselling processes, and problems with insertion and follow up.
- Gain and maintain appropriate clinical competencies.

West Cheshire CCG are **also** required to

- Take medical/sexual history to ensure most appropriate method of contraception undertaken by appropriately trained physician
- Carry out a risk assessment to assess the patient for STI or HIV testing prior to recommending the implant

Level 2b: National Enhanced Service for IUCD fittings

The aims of the enhanced service are to

- i) Ensure that the full range of contraceptive options is provided by practices to patients
- ii) Ensure that the availability of post-coital IUCD fitting for emergency contraception are more adequately provided as another means of reducing unwanted pregnancies
- iii) Increase the availability of LNG-IUS in the management of menorrhagia within primary care

Practices are required to:

- Fit, monitor, check and remove IUCDs as appropriate
- Keep a register of patients with an IUCD
- Provide an appropriately trained nurse to support the patient and assist the practitioner during fitting
- Possess the appropriate equipment including resuscitation equipment
- Use an appropriate patient consent form which should be included in the patient's notes
- Comply with annual review and audit
- Undertake appropriate sterilisation and infection control procedures with a move towards the use of CSSD or disposable instruments
- Provide patient with information on about all contraceptive options, follow up and symptoms which require urgent assessment during counselling and after fitting.
- Maintain an appropriate GP record of patient history, counselling processes, the pelvic examination and problems with insertion and follow up.
- Gain and maintain appropriate clinical competencies.

West Cheshire CCG are **also** required to:

- Take medical/sexual history to ensure most appropriate method of contraception undertaken by appropriately trained physician
- Carry out a risk assessment to assess the patient for STI or HIV testing prior to recommending the implant

Vale Royal CCG are **also** required to:

- Offer Chlamydia screening to the patient before insertion of an IUCD and refer for other STI screening if positive

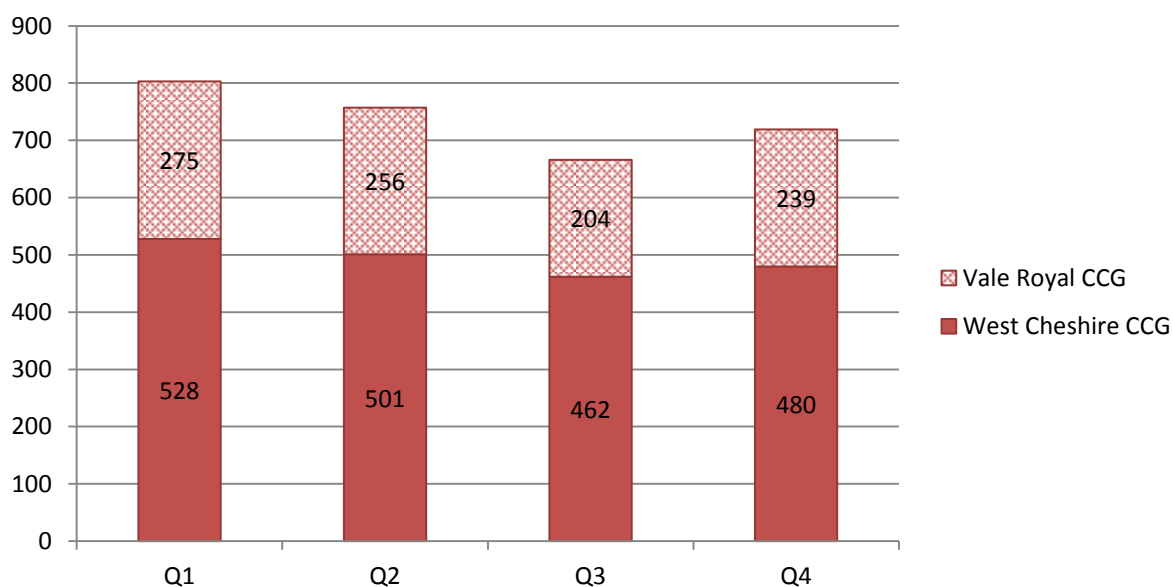
GP Sexual Health Enhanced Service Data

Chlamydia testing

The locally enhanced services offered by GPs in West Cheshire and Vale Royal CCGs provide an opportunity to examine local uptake of sexual health services in a GP setting. Data is provided which shows the number of Chlamydia tests given to 15-24 year olds, the amount of contraceptive implants fitted and removed and the amount of intrauterine contraceptive devices fitted.

Figure 3.11 shows the number of Chlamydia tests performed in general practices within Cheshire West and Chester in 2012. In total 2,945 Chlamydia tests were completed in General Practice in 2012, an average of 245 tests per month. As figure 3.11 shows, the majority (66%) of tests were completed in West Cheshire CCG and testing activity was slightly higher in the first quarter of 2012 and slightly lower in the third quarter.

Figure 3.11: Number of Chlamydia tests completed in GP practices, 2012/13




Source: Local Enhanced Service Data, 2013

There were substantial variations in testing activity across GP practices; in general there was a higher level of testing in urban practices and lower levels of testing in rural practices. The overall crude rate of chlamydia testing was 75 tests per 1,000 population aged 15 to 24 years, with a slightly higher crude testing rate in Vale Royal CCG (86 per 1,000) compared with West Cheshire CCG (85 per 1,000).

HIGHEST TESTING ACTIVITY:
 West Cheshire CCG City Walls Practice (235 tests)
 Vale Royal CCG Danebridge/Kingsmeade Practice (196 tests)

AVERAGE LEVEL OF TESTING ACTIVITY:
 60 tests per year

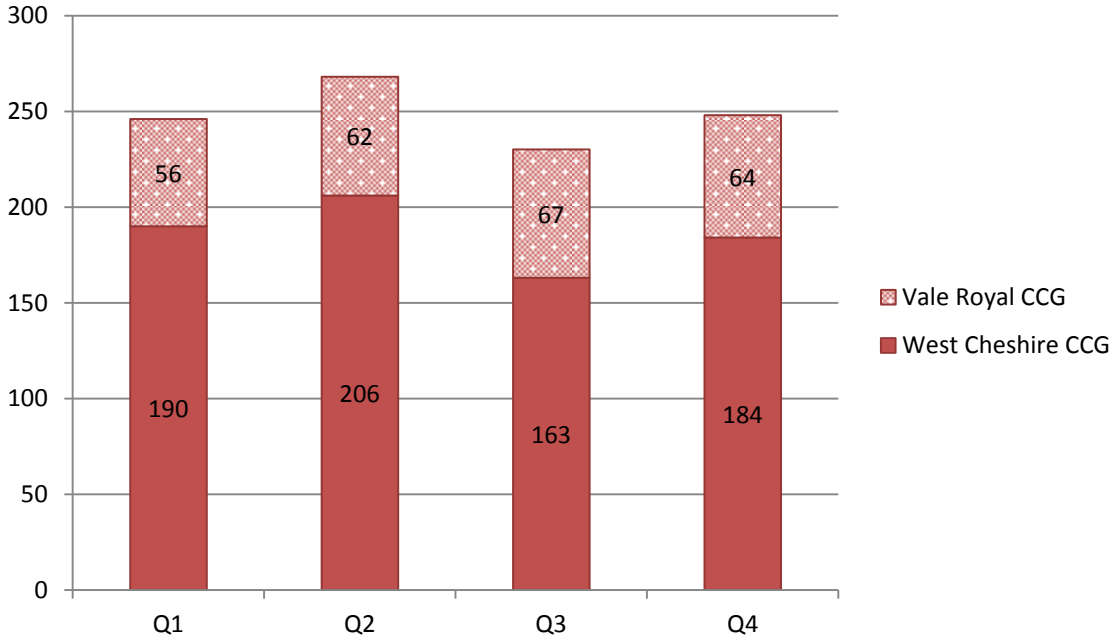
LOWEST TESTING ACTIVITY:
 West Cheshire CCG St Werburgh's Practice for the Homeless (0 tests)
 West Cheshire CCG Rookery Surgery (5 tests)
 Vale Royal CCG Launceston (not signed up to LES) (22 tests)



Implant fittings

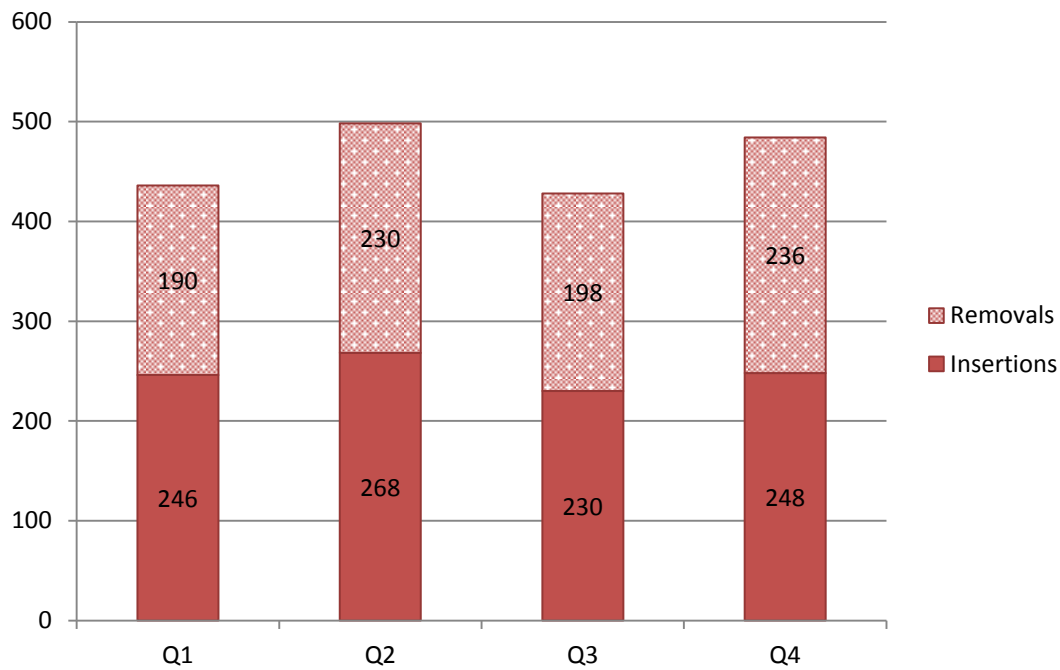
Figure 3.12 shows the number of implants fitted in GP practices across Cheshire West and Chester in 2012. There were 992 implants fitted in GP practice, an average of 83 per month. As with Chlamydia testing, a slightly lower level of activity was seen in quarter 3 (October to December). Figure 3.13 shows the number of implant fittings and removals for Cheshire West and Chester. There were 854 implant removals between April 2012 and March 2013; an average of 71 removals per month. Overall there were approximately four removals for every five implants fitted (0.8).

Figure 3.12: The number of implants fitted in GP practices, Cheshire West and Chester, 2012/13



Source: Local Enhanced Service Data, 2013

Figure 3.13: The number of implants fitted and removed in GP practices, Cheshire West and Chester, 2012/13



Source: Local Enhanced Service Data, 2013

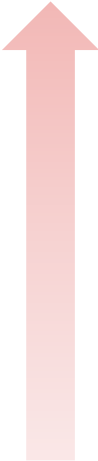
There was considerable variation in fitting rates across GP practices with eight practices reporting zero fitting activity for 2012. The crude rate of implant fittings was 7 per 1,000 women of reproductive age (aged 15-49 years) and the rates were slightly lower in Vale Royal CCG when compared to West Cheshire CCG (5.5 and 7.3 per 1,000 respectively).

HIGHEST FITTING ACTIVITY:
 West Cheshire CCG Garden Lane Medical Centre (80 fittings)
 Vale Royal CCG Danebridge Practice (54 fittings)

AVERAGE LEVEL OF FITTINGS:
 21 fittings per year

LOWEST TESTING ACTIVITY:
 West Cheshire CCG Farndon Health Centre (1 fitting)
 West Cheshire CCG Launceston Close (2 fittings)

PRACTICES WITH NO FITTING ACTIVITY:
 Rookery Surgery, St Werburgh's Practice for the Homeless,
 Westminster Surgery, Whitby Group Practice (Dr Wall - Green)
 Willaston Surgery, Watling Street, High Street, Launceston Close

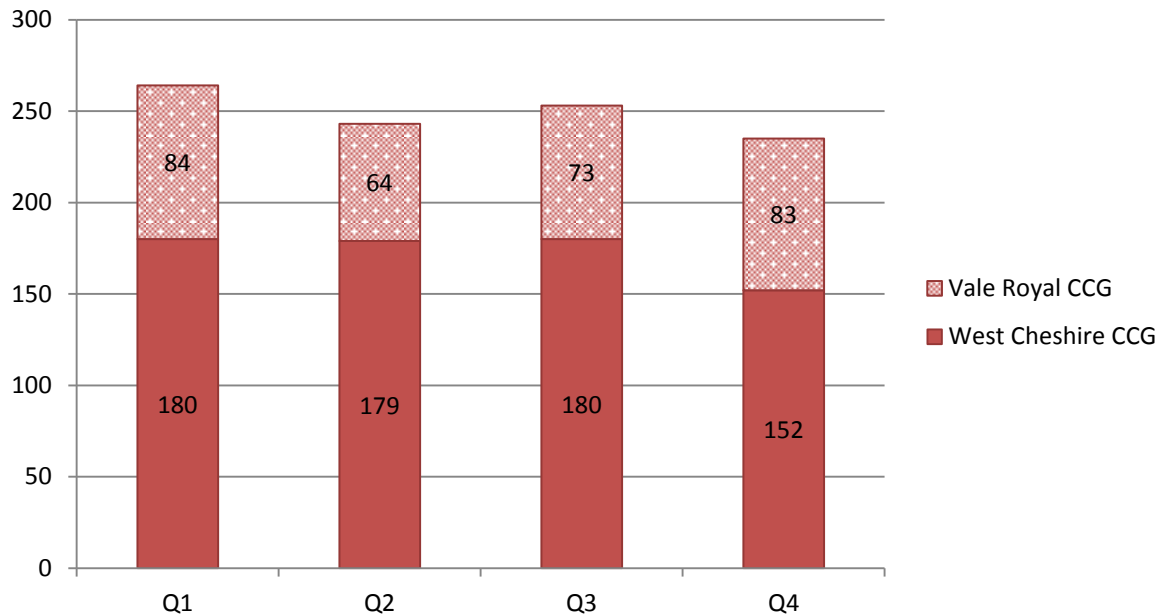


IUD fittings

Figure 3.14 displays the number of intrauterine contraceptive devices fitted in Cheshire West and Chester GPs from April 2012 to March 2013. In total 995 devices were fitted, an average rate of 83

fittings per month. There was little variation in the number of fittings across the year, with a roughly equal number of fittings in each quarter.

Figure 3.14: IUD fittings in GP practices, Cheshire West and Chester, 2012/13



Source: Local Enhanced Service Data, 2013

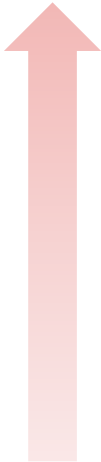
The rate of IUD fittings varied by practice, with 11 practices reporting no activity between April 2012 and March 2013. The overall crude rate of IUD fitting per 1,000 women of reproductive age (15-49 years) was 7 and the rates across Vale Royal CCG and West Cheshire CCG were similar (6.7 and 6.8 respectively).

HIGHEST FITTING ACTIVITY:
 West Cheshire City Walls Medical Centre (62 fittings)
 Vale Royal CCG Danebridge Practice (59 fittings)

AVERAGE LEVEL OF FITTINGS:
 21 fittings per year

LOWEST TESTING ACTIVITY:
 West Cheshire CCG Westminster Surgery (1 fitting)
 West Cheshire CCG Launceston Close (2 fittings)

PRACTICES WITH NO FITTING ACTIVITY:
 Neston Medical Centre, Northgate Village Surgery, Rookery Surgery,
 St Werburgh's Practice for the Homeless, Upton Village Surgery,
 Whitby Group Practice (Dr Wall-Green), Willaston Surgery.

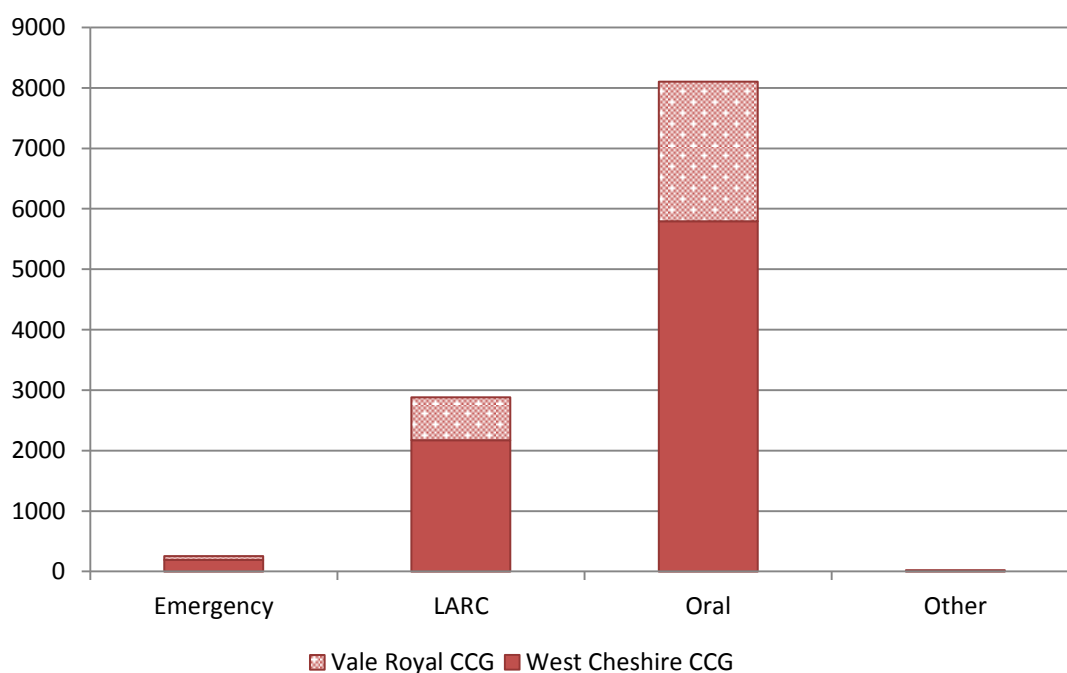


Contraception prescribing in Cheshire West and Chester

Since the introduction of the Community Pharmacy Contractual Framework in 2005, importance has been placed on the role of community pharmacies (DH, 2005) not only as a dispenser of medicines but as a generic healthcare advisor, advising patients on their use of prescribed medicines and offering innovative services and lifestyle advice. In the 2010 *Healthy lives, Healthy People* White Paper (DH, 2010) emphasis was placed on the role community pharmacies can play in reducing health inequalities and improving health and wellbeing through the provision of public health services such as alcohol guidance, cessation of smoking and weight management. Sexual health services include chlamydia screening, and access to contraception including emergency hormonal contraception (EHC).

In Western Cheshire PCT there were 36,890 contraceptives and 112 contraceptive devices prescribed between April 2012 and March 2013. The data below show the provision of prescriptions for sexual health related services in general practices in West Cheshire and Vale Royal CCG for July to December 2012. In total there were 11,264 contraceptives prescribed across West Cheshire and Vale Royal CCG from July to December 2012.

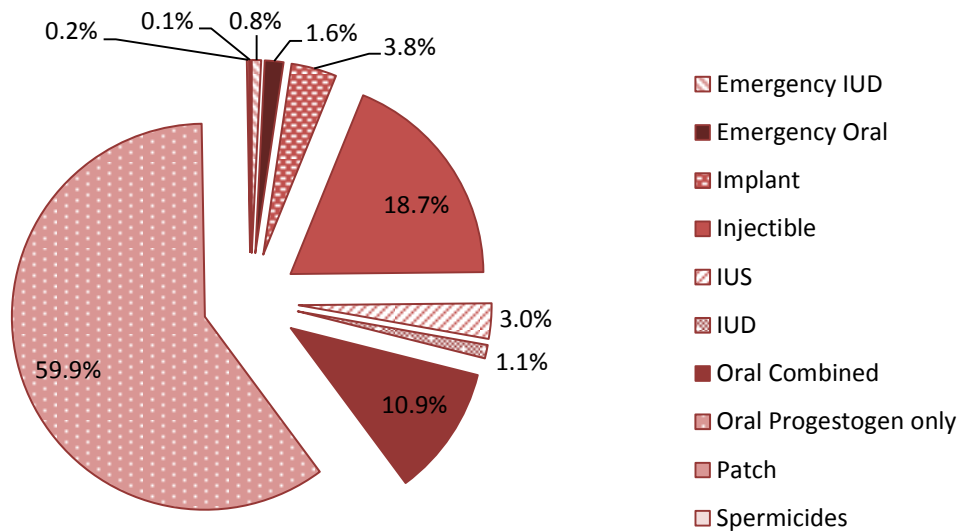
Figure 3.15: Contraception prescribed by type by CCG, July to December 2012



Source: HSCIC, 2013

Figure 3.16 shows the proportion of prescriptions for the different types of emergency and non-emergency contraceptives made in West Cheshire CCG general practices between July and December 2012. The majority of prescriptions (71%) were for oral contraceptives. Injectable contraceptives accounted for a further 19% of contraceptives prescribed. Long acting reversible contraception (LARC) accounted for 27% of contraception and emergency contraception accounted for a further 2%.

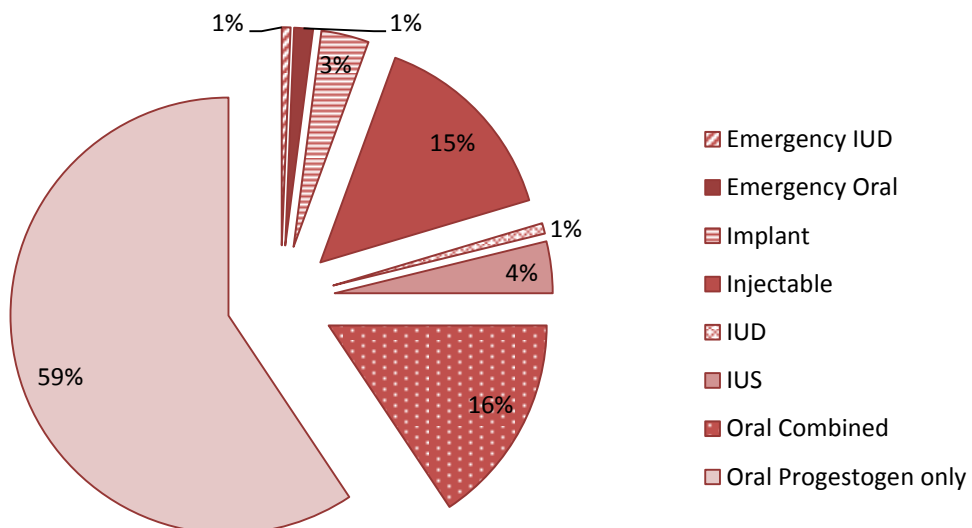
Figure 3.16: GP contraception prescribing data for West Cheshire CCG, July to December 2012



Source: HSCIC, 2013

In Vale Royal CCG (figure 3.17), over three quarters (85%) of prescriptions were for oral contraceptives, with injectable contraceptives accounting for a further 15%. Long acting reversible contraception (LARC) prescriptions represented 23% of total contraceptive prescriptions. Emergency contraception accounted for 2% of all contraceptive prescriptions.

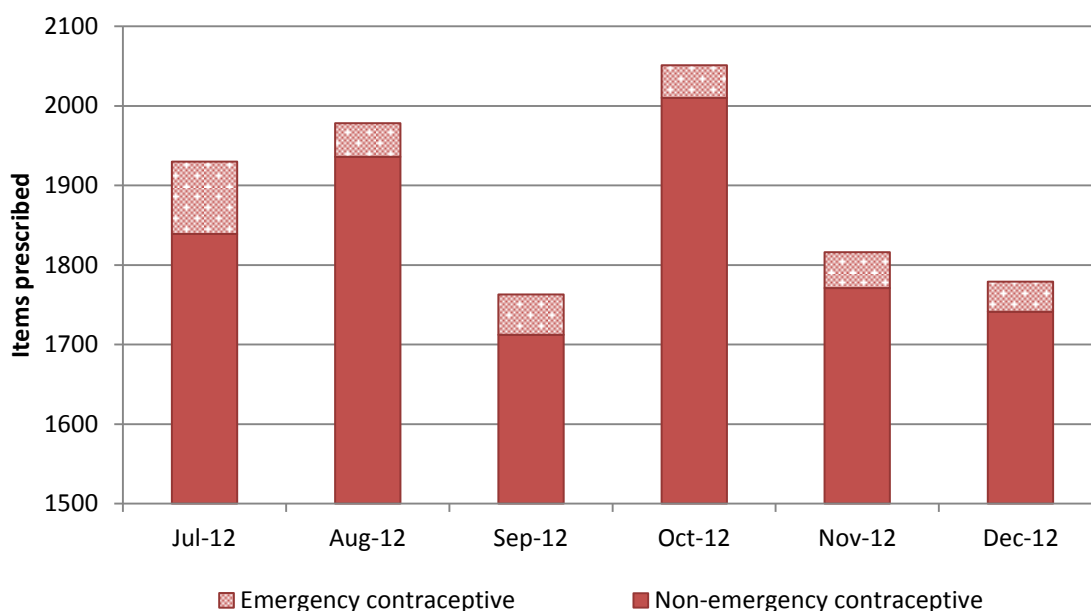
Figure 3.17: GP contraception prescribing data for Vale Royal CCG, July to December 2012



Source: HSCIC, 2013

Figure 3.18 shows data on the prescription of emergency and non-emergency contraception in general practice by month. Emergency contraception accounted for between one and five percent of contraceptive prescriptions per month. The mean monthly rate of prescribing for contraceptives was 1,351 oral contraceptives and 480 LARCs per month.

Figure 3.18: Emergency and non-emergency contraception prescribed in General Practice, Cheshire West and Chester, July – December 2012



Source: HSCIC, 2013

Chlamydia screening

Chlamydia remains the most prevalent sexually transmitted infection (STI) nationally and is often symptomless. To address rising chlamydia prevalence the National Chlamydia Screening Programme (NCSP) was created in 2003 with the aim of testing all sexually active young people aged 25 years and under either annually or at each change of sexual partner as part of routine sexual health screens and primary care. The continuing importance of reducing the rates of chlamydia in young people is evident from its inclusion as an indicator in the Department of Health's Public Health Outcomes (PHO) Framework for 2013-2016. Public Health England recommends that local areas should be achieving a rate of 2,300 diagnoses per 100,000 15-24 year old resident population annually. In 2010/11 the chlamydia positivity rate for young people in Cheshire West and Chester was 5.8% significantly higher than the national average of 5.2% but lower than the north west England average (6.6%).

A total of 10,580 chlamydia tests were reported to the NCSP in Cheshire West and Chester in 2012, of which 809 (7.6%) were positive. This represents a diagnosis rate of 2,042 per 100,000 15-24 year old resident population, slightly below the Public Health England recommended outcome. The majority of tests (74%; 7,809 tests) were taken by females with 41% of all tests taken by females aged 20 to 24 years. Levels of positivity were higher among males with 10% of tests among males

resulting in a chlamydia diagnosis compared with 7% of tests among females (table 3.9). Young adults of white ethnicity represented 97% of tests taken where ethnicity was recorded.

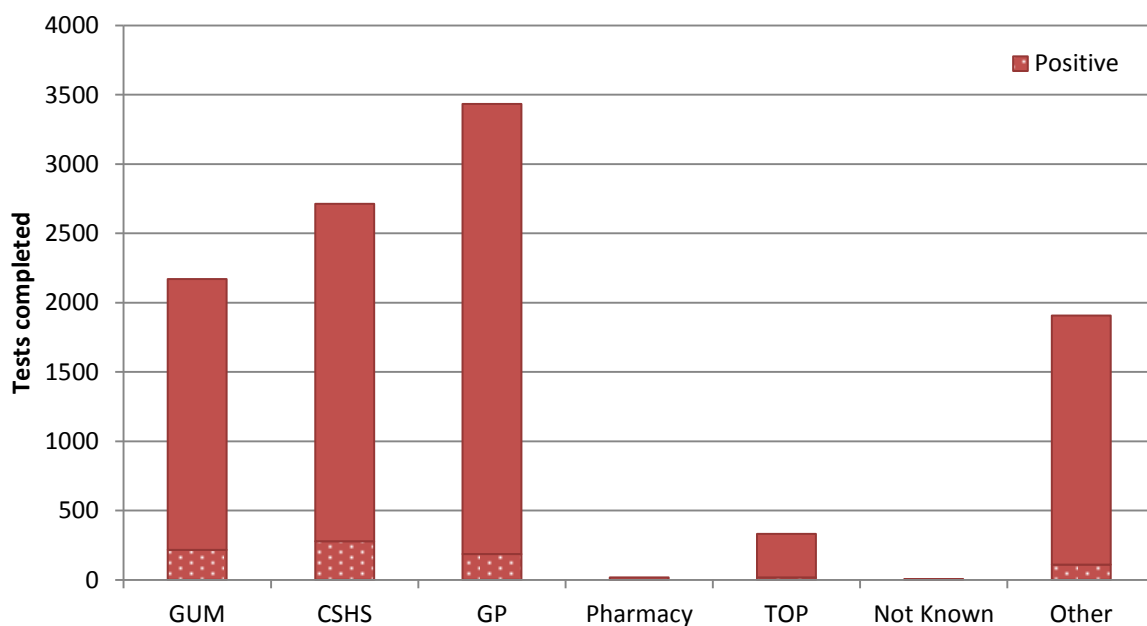
Table 3.9 Chlamydia tests reported to the NCSP by gender and age group, Cheshire West and Chester, 2012

	Male			Female			Total by age		
	15-19	20-24	Total	15-19	20-24	Total	15-19	20-24	Total
Tests	1,043	1,635	2,678	3,486	4,323	7,809	4,575	6,005	10,580
Positive	81	185	266	251	287	538	333	476	809

Source: NCSP, 2013

The highest proportion of tests were taken in General Practice (31%; 3,246 tests), followed by community sexual health services (23%; 2,435 tests) and GUM (18%; 1954). The highest number of chlamydia diagnoses was made in community sexual health services (279 diagnoses) representing 10% of tests taken. GUM saw the highest rate of diagnoses per test at 11% (figure 3.19).

Figure 3.19 Number of chlamydia tests reported to the NCSP by centre, 2012



Source: NCSP, 2013

Public Health Outcomes Framework Indicator 3.02: Chlamydia diagnoses (15-24 year olds)

The crude rate of Chlamydia diagnoses in Cheshire West and Chester was 2,045 per 100,000 young adults aged 15-24 years, a similar rate to the England average of 1,979 per 100,000 young adults.

Source: Public Health Outcomes Framework data tool, PHE, 2013

4. SEXUAL HEALTH SERVICE USER SURVEY: ATTITUDES, OPINIONS, NEEDS AND PRACTICES OF SERVICE USERS IN CHESHIRE WEST AND CHESTER

Box 4.1 Key findings from sexual health service user survey

Sample

- A total of 260 individuals completed the service user survey. Questionnaires were completed at the Countess of Chester Department of Sexual Health, St Martin's Sexual Health Clinic, Stanney Lane Sexual Health Clinic, Neston Sexual Health Clinic, Blacon Sexual Health Clinic and West Cheshire College Health Zone

Making an appointment

- All respondents attending the Countess of Chester Department of Sexual Health had booked an appointment. At the remaining five clinics, the majority of respondents were attending a drop-in clinic (69%).
- For respondents attending a booked appointment (n=130), 45% had waited less than a day for their appointment and 29% had waited "a few days". The majority of respondents (90%) reported that the time they had to wait for an appointment was acceptable to them.

Before making an appointment

- Overall, 34% of respondents had sought advice from at least one other source before their visit to the sexual health clinic. The most common source of advice was GPs (42%), followed by another sexual health clinic (33%) and friends (23%).
- Most respondents heard about the service they were attending through a friend (30%), an NHS website (23%) or their GP (17%). Most individuals had used a mobile phone browser (n=48) or a laptop/tablet (n=32) to access online information

Reason for visit

- The most common reason for visiting the service was testing or treatment for the symptoms of a sexually transmitted infection (not including HIV, n=58), followed by Chlamydia screening (n=54) and "getting the pill" (n=54).

Getting to the service

- The majority of respondents drove to the service (43%) with a further 32% walking.
- Over a third of respondents (37%) travelled between one and three miles to visit the service. In contrast, 20% of respondents travelled over 6 miles.

Views on sexual health and sexual health services

- The most important elements of sexual health services were; the service being confidential (74%), feeling treated with respect (67%) and staff being non-judgemental (61%).
- The main issues that would discourage respondents from using a sexual health service were feeling judged, embarrassment, a lack of privacy and confidentiality in the clinic environment and negative staff attitudes.

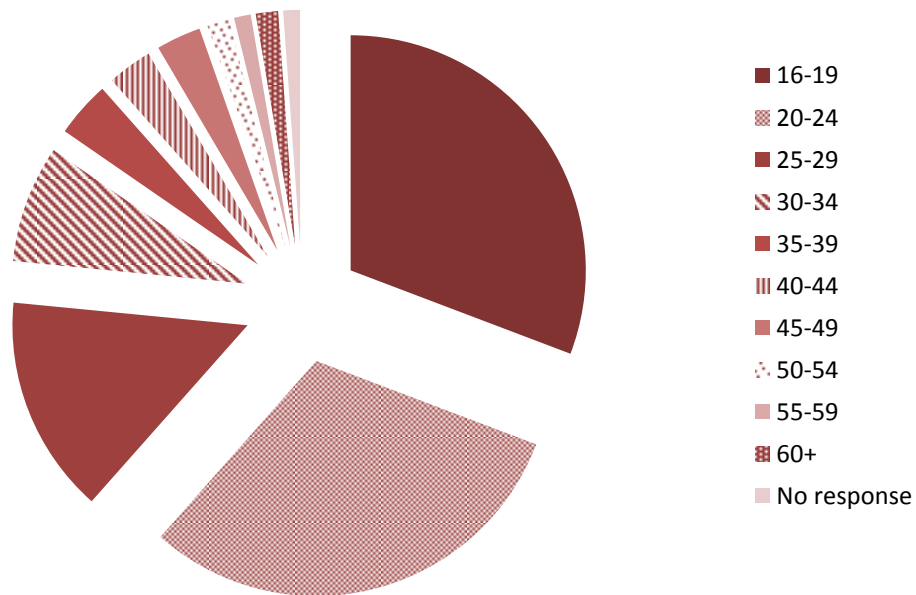
Key findings continued...

- A large proportion of respondents stated they found sexual health matters easy to talk about with friends (59%), doctors at the iCASH service (40%) and nurses at both iCASH (47%) and family planning (33%). Opinions on GPs and family members were mixed.
- The most frequently heard of and used services were Countess of Chester Department of Sexual Health, St Martin's and Stanney Lane.
- The majority of respondents reported a positive experience during their visit. Overall, 88% of respondents said they would recommend the service to a friend.
- The most commonly mentioned area for improvement was reducing the time spent in the waiting room before an appointment.

Demographics

A total of 260 individuals completed the service user survey. Questionnaires were completed at the Countess of Chester Department of Sexual Health, St Martin's Sexual Health Clinic, Stanney Lane Sexual Health Clinic, Neston Sexual Health Clinic, Blacon Sexual Health Clinic and West Cheshire College Health Zone. For a full description of the survey methods, refer to chapter two of this report.

Figure 4.1: Age group of questionnaire participants



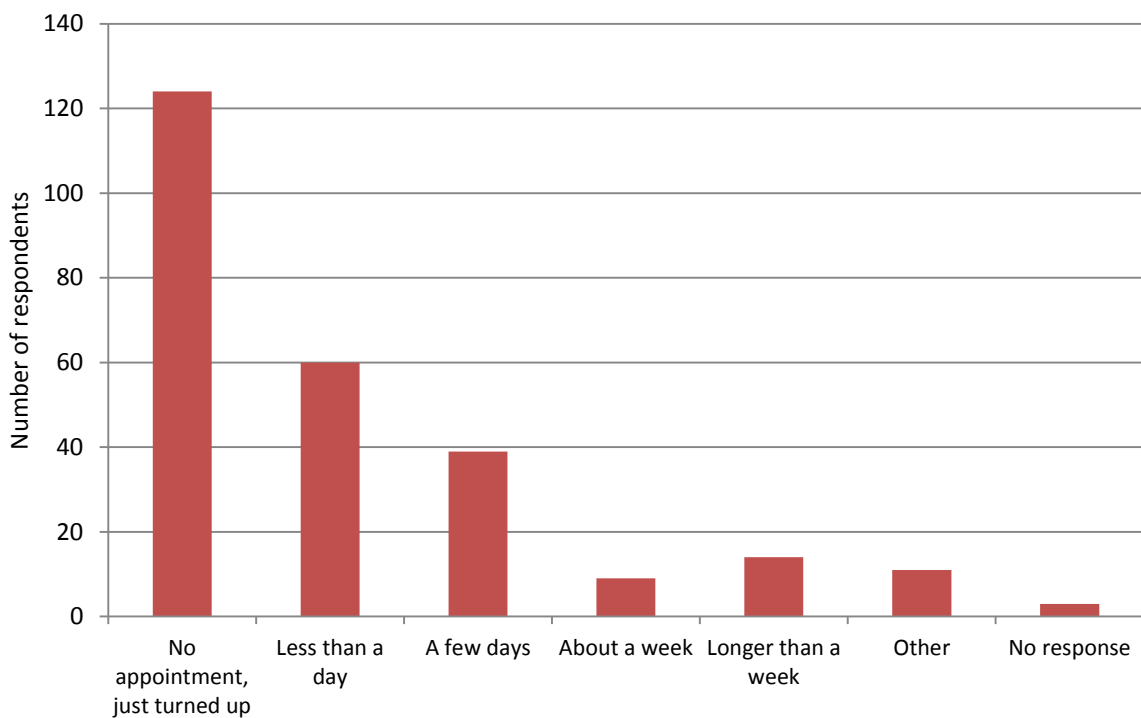
The majority of questionnaire respondents (65%) were aged between 16 and 24 years with just 10% aged 40 years or over (figure 4.1). Nearly three quarters (74%) of respondents were female. The majority of respondents (92%) identified as white British. The majority of respondents reported their sexuality as heterosexual (91%), 5% as gay/lesbian and 3% as bisexual. One percent of participants stated that their current gender identity was not the same as their gender (biological sex) at birth.

Making an appointment

All respondents attending the Countess of Chester Department of Sexual Health had a booked appointment (n=98). The majority of respondents from the remaining five clinics were attending a drop-in clinic (69%, n=129) with a further 17% having a booked appointment (n=32).

For respondents attending a booked appointment (n=130), 45% had waited “less than a day” for their appointment and 29% had waited “a few days”. A further 7% had waited “about a week” for their appointment and 10% “more than a week” (figure 4.2). Among the 11 individuals who stated they had waited an “other” amount of time, 5 waited between 2 and 3 weeks and 6 had a pre-booked follow up appointment. The majority of respondents (90%) reported that the time they had to wait was acceptable to them.

Figure 4.2: Waiting time for an appointment, all clinics



All respondents were asked to state why their wait was or was not acceptable. The most common reasons for the wait being acceptable included; the flexibility of a drop-in system, being offered an appointment on the same day, being able to arrange an appointment for follow up or for a time that suited them and not spending too long in the waiting room. Other reasons included visiting for a non-urgent issue, being given time to prepare and the wait being shorter than could be expected in General Practice

"It's a drop in clinic it's expected that you'll have to wait"

"I find it hard to get an appointment at the main surgery, so this drop-in suits me well. I always arrive early so am seen quickly"

"Always offered to be seen same day, great flexibility"

"I was offered a sooner appointment but I chose to wait to get a better time to suit my work"

"Decent time wait considering the amount of patients waiting"

However, 7% of respondents felt that the wait for their visit was unacceptable. The majority of respondents stated this was because of a long wait in the waiting room. Other reasons included opening times not suiting their work/daily routine and a preference for an appointment or drop in clinic over the service offered:

"30 minutes until first seen. More staff would be good. Waited 1hr 30mins in total. Unacceptable waiting time & not even a drinks machine in waiting area. All customers appeared frustrated"

"I was on time, always am when I come here (with a booked appointment) yet I still end up waiting"

"There should be a service provided every day for this as trying to arrange a visit with times you work are hard if you work full time. It would also decrease times if this service was offered 5 or 6 times a week after work hours"

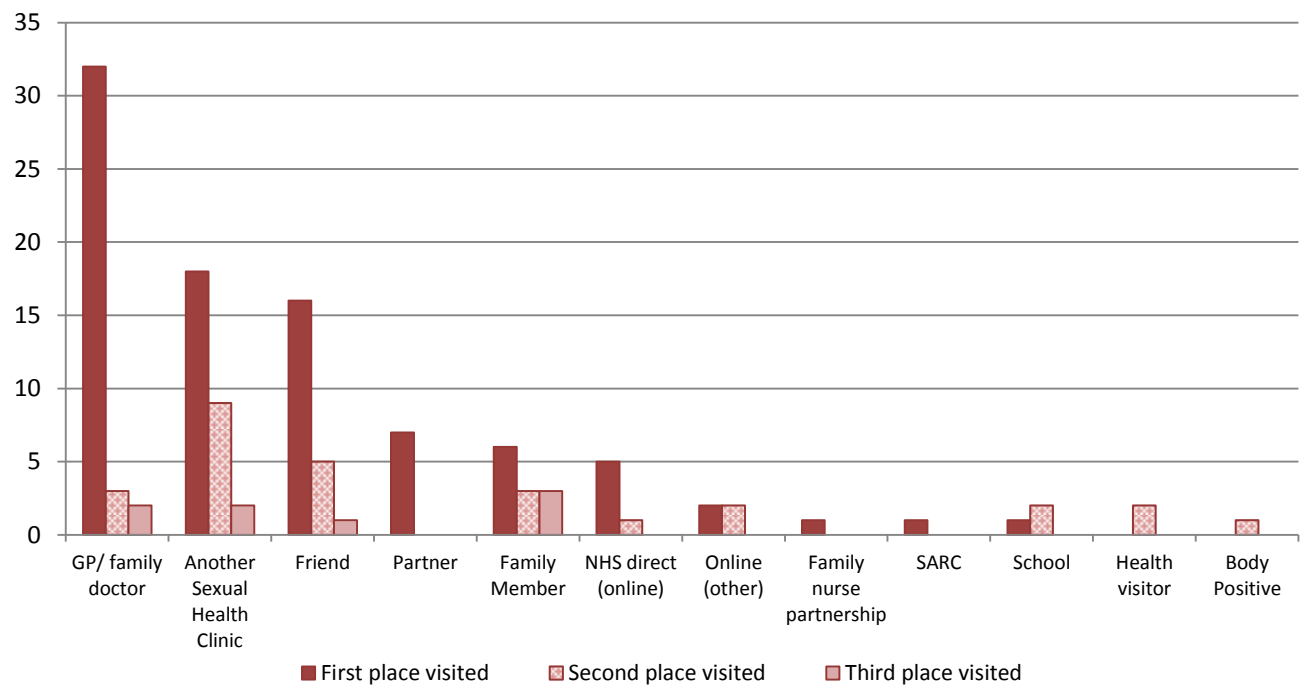
"Even though it was only the next day for an appointment I'd much prefer a drop in system where I could just turn up when I like"

"I would have preferred an appointment as sometimes the drop ins have a really long wait and I only come to get a repeat prescription of patch that doesn't take long"

Before making an appointment

Survey participants were asked if they had seen anyone else for advice prior to this particular visit to the clinic and if so where they had sought advice first, second and third. Sixty six percent of participants had not sought advice from another source prior to their visit. Amongst those who had sought advice elsewhere, 23% of participants had sought advice from one other source before their visit, 8% from two other sources and 3% from three sources. The most common source of advice was GPs, with 42% of those seeking advice elsewhere contacting their GP, followed by another sexual health clinic (33%) and friends (23%, figure 4.3).

Figure 4.3: Sources of advice before visiting sexual health clinic



Most respondents had heard about the service they were attending through a friend (30%), through an NHS website (23%) or through their family doctor/GP (17%, figure 4.5). Other responses included having visited the clinic before, through watching a television documentary and through other service providers including Sexual Assault Referral Centre, Body Positive Cheshire and North Wales, health visitors and family nurse. In total 31% of respondents had heard about the service via the internet, through either NHS or other websites. Most individuals had used a mobile phone browser (n=48) or a laptop/tablet (n=32) to access online information (figure 4.6).

Figure 4.5: How survey respondents found out about the service

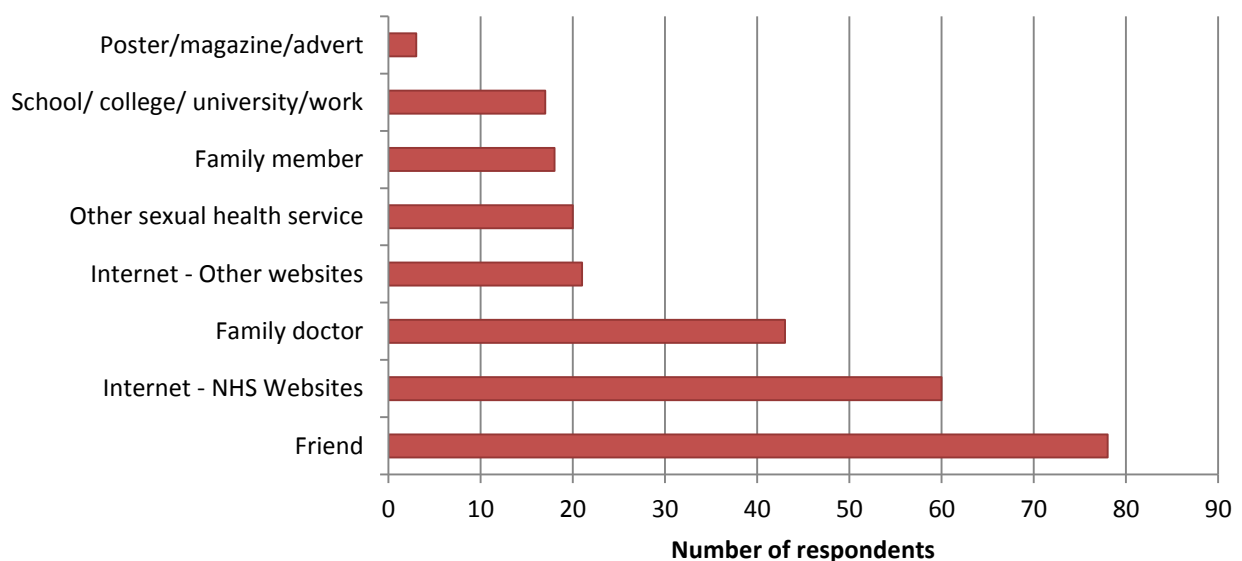
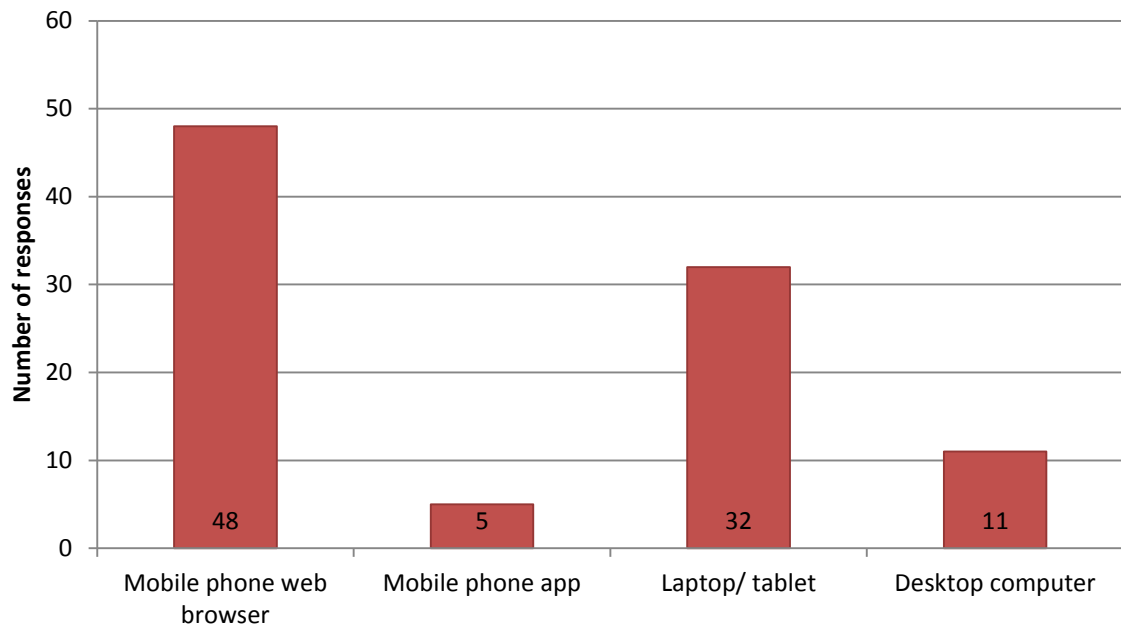


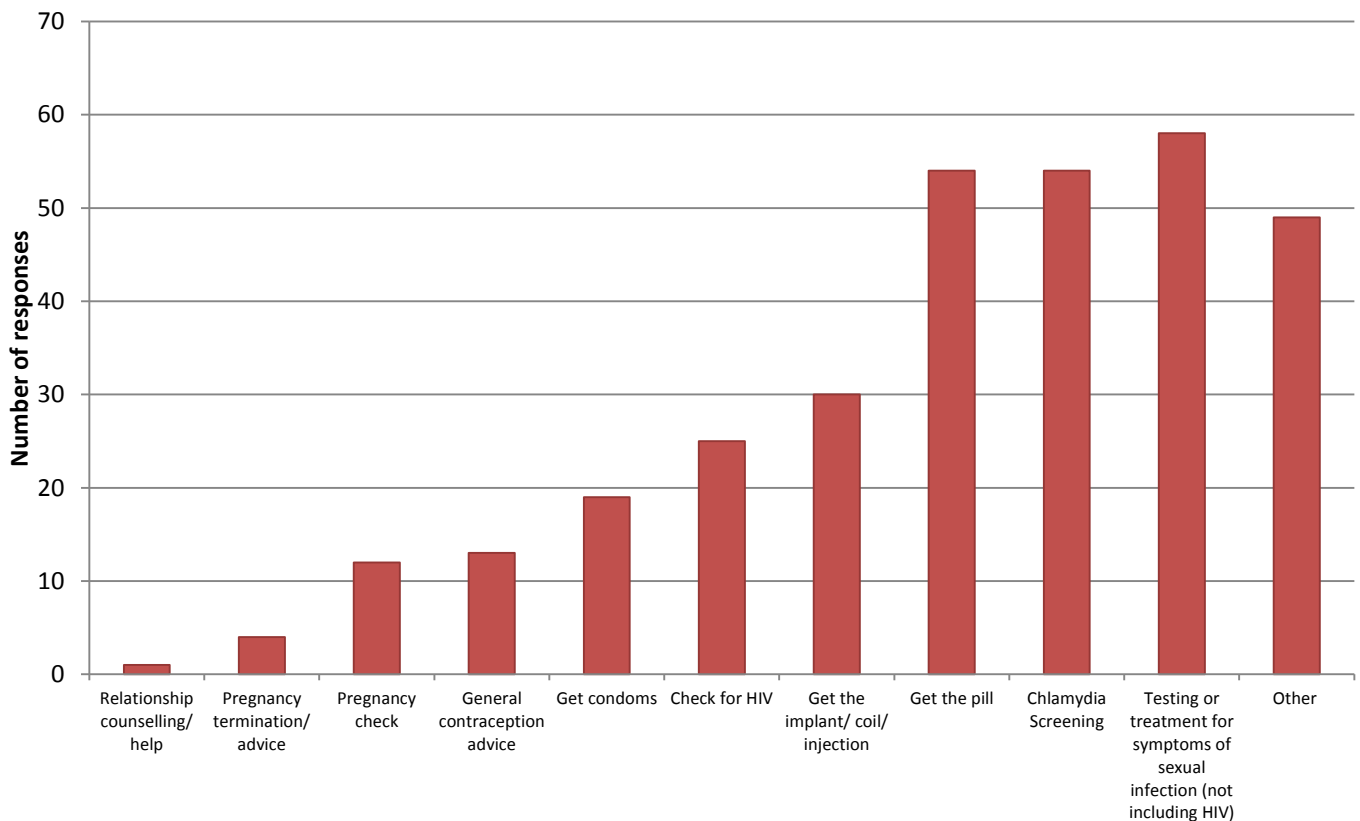
Figure 4.6: How survey respondents accessed online information



Reason for visit

The most common reason for visiting the service (n=58) was testing or treatment for the symptoms of a sexually transmitted infection (not including HIV), followed by Chlamydia screening (n=54) and “getting the pill” (n=54). Forty nine individuals stated they had attended for other reasons including 14 individuals who were having an implant or IUD removed and four individuals attending for a cervical smear (figure 4.7).

Figure 4.7: Reason for visiting the service



Travelling to the service

The majority of the respondents drove to the service (43%) with a further 32% walking and 13% given a lift. Numbers accessing the service via public transport or cycling were lower (Figure 4.8). Over a third of respondents (37%) travelled between one and three miles to access the service and a further 26% travelled less than one mile. In contrast, 20% of respondents had travelled over six miles to visit the service (Figure 4.9).

Figure 4.8: Method of travel to the service

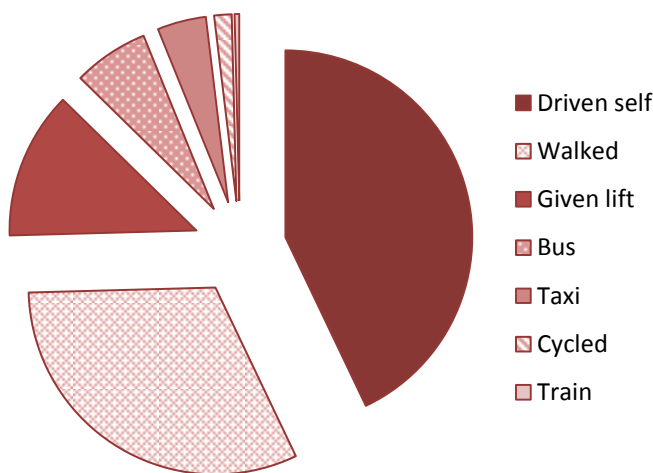
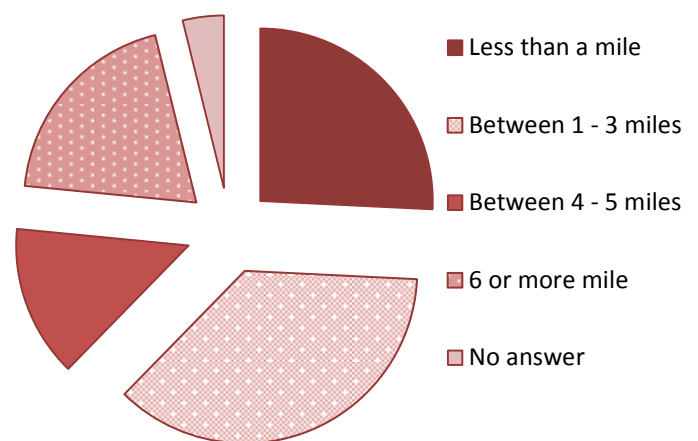


Figure 4.9: Distance travelled to the service



Only 13% of respondents reported missing school/work/university or college to attend the service (figure 4.10) and only 2% reported that they had any problems accessing the service (figure 4.11). Those who reported problems with the service mainly reported transport issues including difficulties finding parking and frequency of buses.

Figure 4.10: Missed school/work/university/college to attend

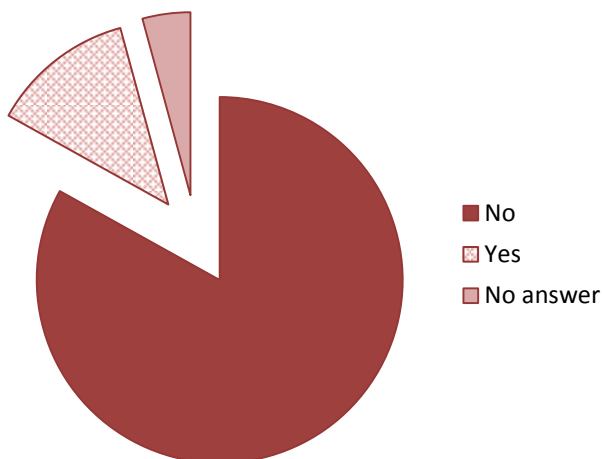
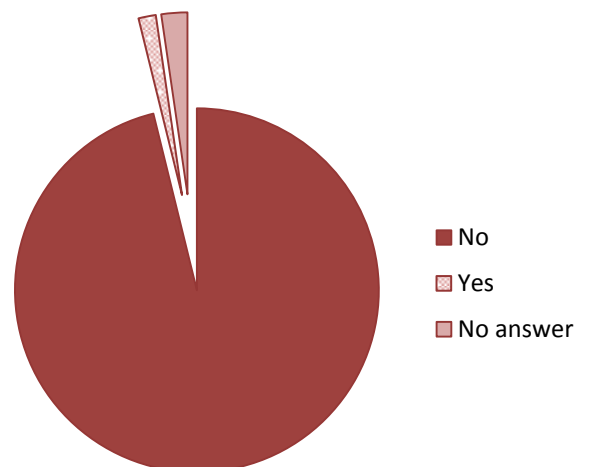


Figure 4.11: Problems getting to the service

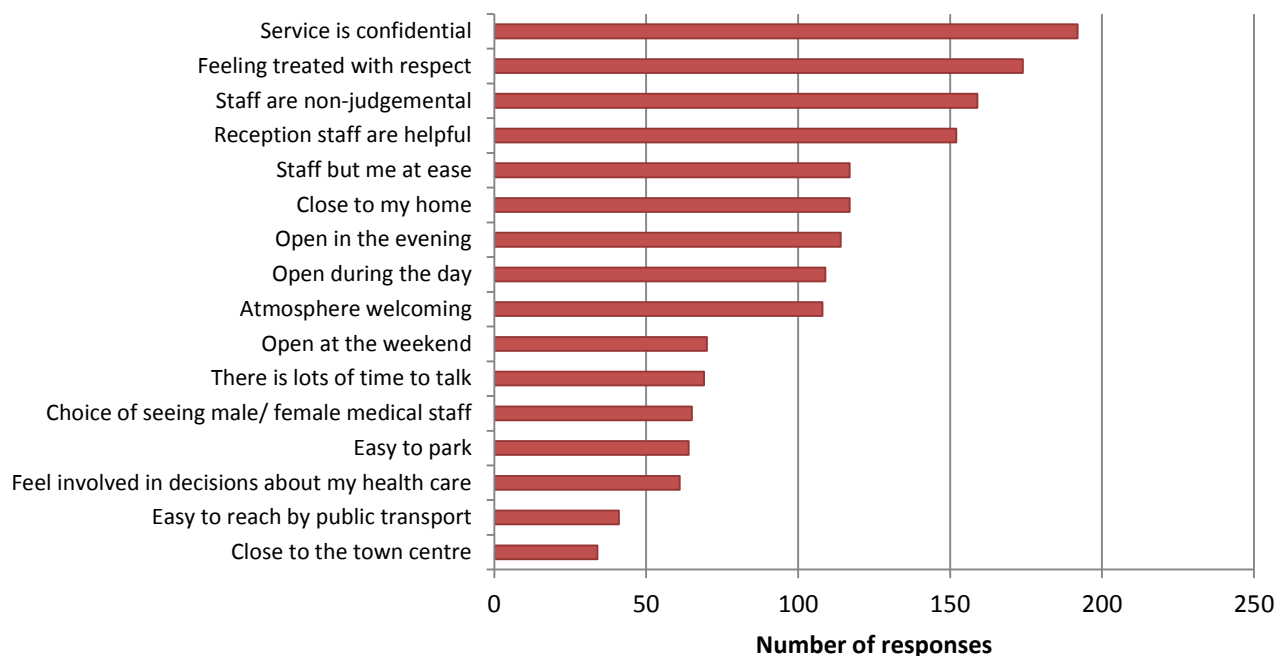


Views on sexual health and sexual health services

Participants were asked to identify which aspects of sexual health services were important to them. The most frequently selected options were the service being confidential (74%), feeling treated with respect (67%) and staff being non-judgemental (61%). The least frequently selected options were being close to the town centre (13%) and easy to reach by public transport (16%; figure 4.12).

Participants were also asked if there was anything that would put them off accessing a sexual health service. The main reasons mentioned were being judged by others for attending, embarrassment, a lack of confidentiality and privacy in the clinic environment and staff attitudes; including staff rudeness and being judged by staff. Other less commonly cited reasons were the cleanliness of the clinic environment, long waiting times and not having time to consider all the available options.

Figure 4.12: Important elements of sexual health service



“If I felt like I was putting people out and wasn't treated as I would treat others looking for advice and help”

“If the staffs seem judgemental”

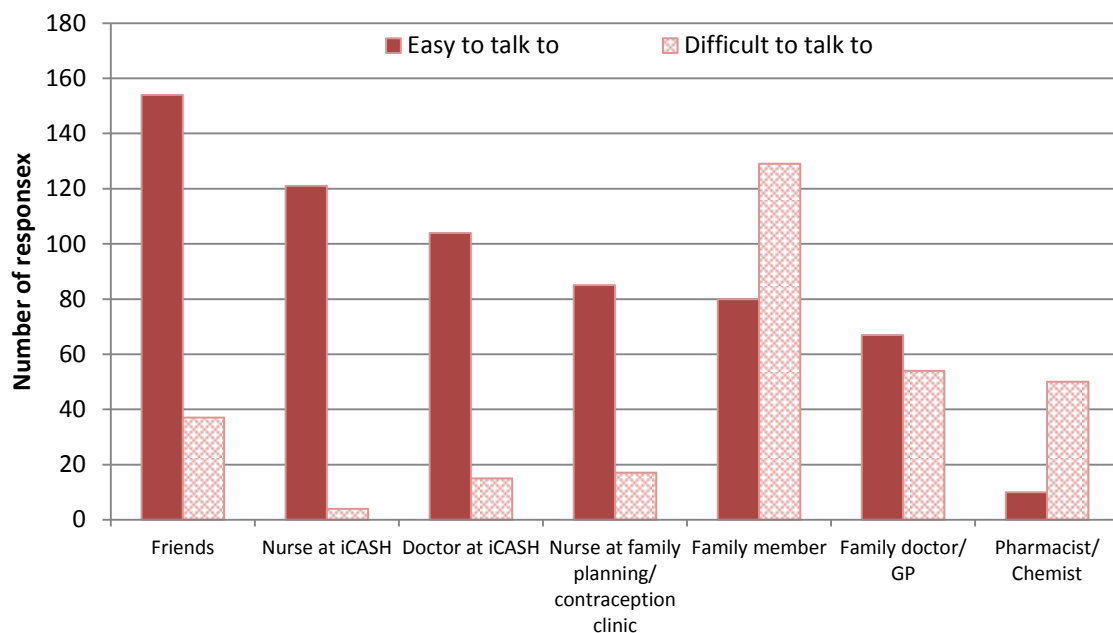
“Yes at the moment coming to this hospital is nice and anonymous. In my own town (Wrexham) the clinic is in a separate unit near the old entrance (still in use) and other services. There is NO anonymity, if anyone sees you entering the "special unit" they know immediately what you are going there for!”

“People from school finding out my sexuality by knowing I've come here”

“It is an embarrassing place to visit. Staff need to be understanding of that”

Participants were asked to identify who they would find easy and difficult to talk to about sexual health matters. A large proportion (59%) stated they found friends easy to talk to about sexual health matters, with only 14% finding friends difficult to talk to. In general, doctors at the integrated sexual health service (40%) and nurses at both integrated sexual health (47%) and family planning (33%) were considered easy to talk to about sexual health matters, with only a small number of respondents reporting them difficult to talk to (7%, 6% and 2% respectively). In addition, 20% of respondents felt their pharmacist would be difficult to talk to about sexual health matters. Opinions of family members and family doctors/GPs were mixed; 31% of respondents felt it was easy to talk to family members about sexual health matters compared with 50% who reported it was difficult to talk to family members. Similarly, 26% felt it was easy to talk about sexual health with their family doctor/GP compared with 21% who felt it was difficult.

Figure 4.13: Easy/ difficult to talk to about sexual health matters



Survey respondents were asked to identify which sexual health services in Cheshire West and Chester they had heard of and which they had used in the past year. More individuals had heard of a service than had used them. The most frequently heard of service was the Department of Sexual Health at the Countess of Chester (n=192), followed by St Martins (n=113) and Stanney Lane (n=69). Similarly, the most commonly attended services in the past year were the Department of Sexual Health at the Countess of Chester (n=78), St Martins (42) and Stanney Lane (n=40; figure 4.14).

Figure 4.14: Knowledge and use of Cheshire West and Chester sexual health services

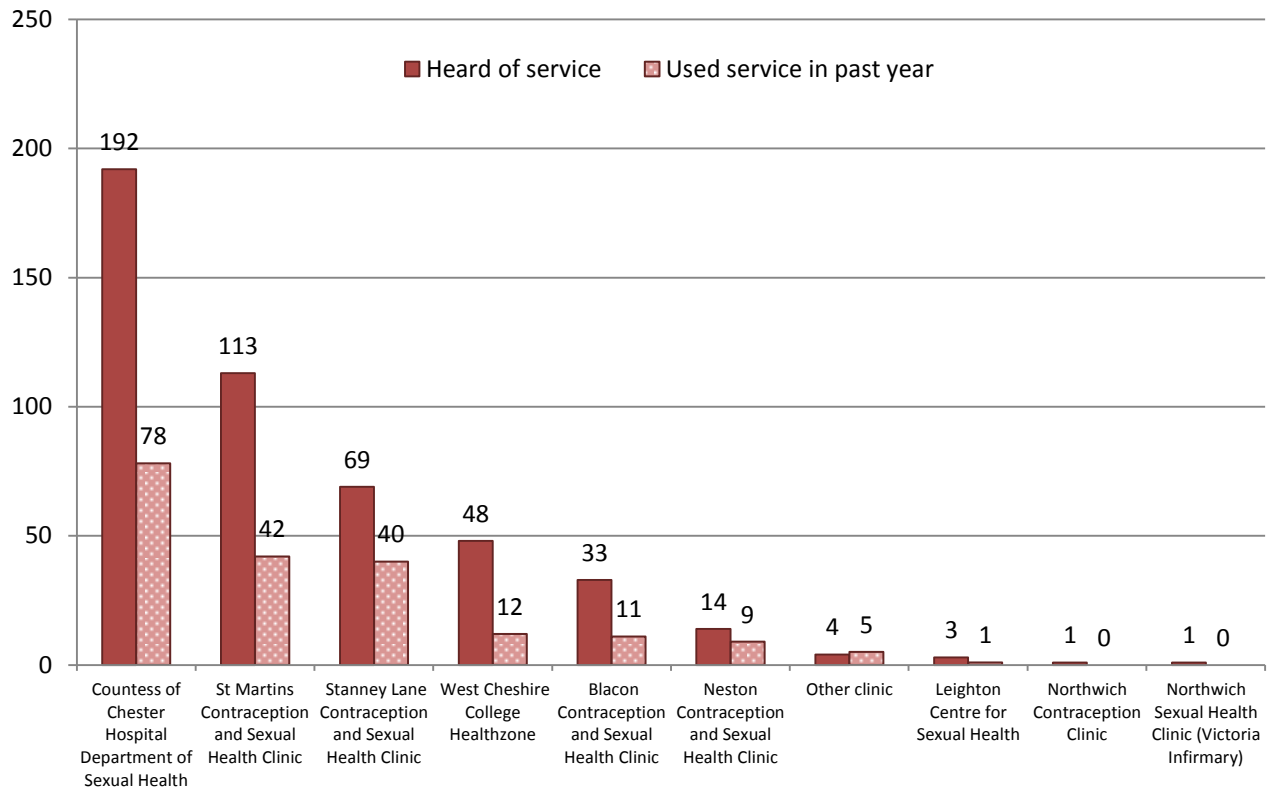
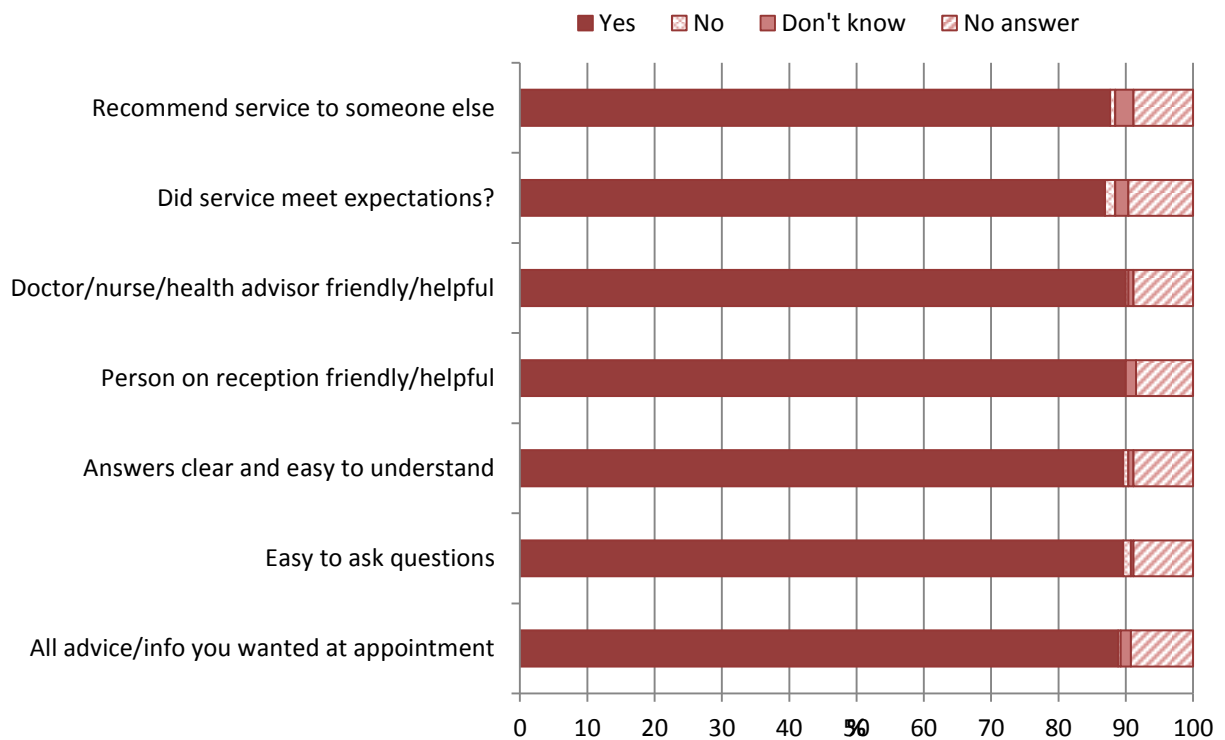


Figure 4.15: Experience of visit to service



The majority of respondents reported a positive experience during their visit to the sexual health services. Ninety per cent of respondents reported that they had found it easy to ask questions, that the answers received were clear and easy to understand and that the doctor/nurse/health advisor and person on reception had been friendly and helpful. In addition, 89% received all the advice/information they wanted at their appointment and 87% felt their experience met their expectations (figure 4.15). Overall, 88% of respondents said they would recommend the service to a friend. Reasons for recommending the service to a friend included the friendly, knowledgeable and confidential manner of staff, the flexibility of drop-in/appointment systems and local services close to their home.

Respondents were also asked how the service could have been improved. A substantial number of respondents felt the waiting time could be reduced. Other suggestions included a faster turnaround time for results, improved parking, a water/drinks machine available in the waiting room, an online booking system and making changes to opening times (for example over the Christmas period) clear on websites. One participant also reported a negative experience, where they felt they had been judged during their appointment.

“More staff - i.e. nurses and doctors. Shorter waiting hours. Offered repeat prescription maybe?!”

“As in all visits waiting times are far too long, even taking into account walk-in service. More staff are required, or more drop in sessions per week to reduce waiting times”

“waiting time could be reduced, 4 patient seen in 1hr - considering size of clinic and amount of staff this is poor. Provide water in reception”

“Get results quicker, rather than worrying for so long i.e. same day results”

“Drinks machine in reception may help if waiting and not able to get any refreshment”

“List of opening times over Xmas on website, online appointment (i.e. without calling)”

“free parking or longer than the 30 free mins.”

5. GENERAL POPULATION SEXUAL HEALTH SURVEY: ATTITUDES, OPINIONS, NEEDS AND PRACTICES OF THE VALE ROYAL GENERAL POPULATION

Box 5.1: Key findings from the general population sexual health survey

Sample

- In total 112 respondents who lived, worked or socialised in Cheshire West and Chester were eligible for inclusion in the survey analysis.

Knowledge, use of and attitudes towards sexual health and sexual health services

- The Countess of Chester Department of Sexual Health was the most frequently recognised service (n=47), followed by St Martin's (n=23) and Leighton Centre for Sexual Health (n=21).
- The majority of respondents (88%) felt they knew where to access contraception and 79% felt they knew where to access emergency contraception, 75% of participants said they knew where to access testing for sexually transmitted infections and 72% knew where to access testing for HIV.
- Nineteen of the respondents had attended one or more sexual health services in the past year, representing 17% of the participants. The most commonly attended clinics were the Countess of Chester Centre for Sexual Health (n=8), St Martins (n=7), Leighton Centre for Sexual Health (n=4) and Stanney Lane (n=2).
- Most participants found a 10 to 30 minute journey by car or motorbike (n=53) or a 10 to 30 minute walk (n=35) an acceptable distance to travel to a sexual health service.
- The vast majority of participants (n=90) felt confidentiality, feeling treated with respect (n=80), non-judgemental staff (n=75) and being put at ease by staff (n=70) were important aspects of sexual health services (figure 4.8).
- Some individuals would not be put off using a sexual health service at all. However, reasons that people would be put off using the services included: issues of privacy and confidentiality, staff attitudes including feeling judged and service issues such as waiting times.
- NHS websites (n= 61), family doctors (n=58) and other websites (n=47) were the most commonly sources of information about sexual health.

Relationships, contraception and sexually transmitted infections

- Thirteen individuals had had more than one sexual partner in the past twelve months, of which three had between four and ten sexual partners and two had more than ten sexual partners. Amongst those with two or more sexual partners, six had never used a condom in the past six months.
- The most commonly used methods of contraception in the past twelve months was the contraceptive pill (n=24, different types combined) followed by condoms (n=19).
- In general, knowledge of sexually transmitted infections (STIs) and HIV was good. However, when compared with knowledge of STIs, questions on HIV had more "don't know" responses.
- The majority of respondents (79%) had not tested for a sexually transmitted infection in the past twelve months.

Two hundred and seven people started the online questionnaire. Forty two were not eligible for inclusion in the survey since they lived, worked or socialised outside the Cheshire West and Chester area and had not accessed any sexual health services in the area within the past year. A further fifty three individuals did not give answers to any of the questions beyond basic demographics. Therefore, the analysis is based on the remaining 112 people who were both eligible for inclusion and who answered some or all of the questions in the survey.

Demographics

Figure 5.1: Age distribution of questionnaire respondents (n=112)

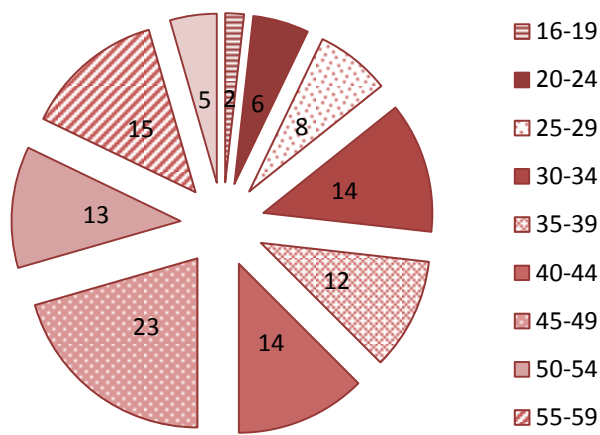
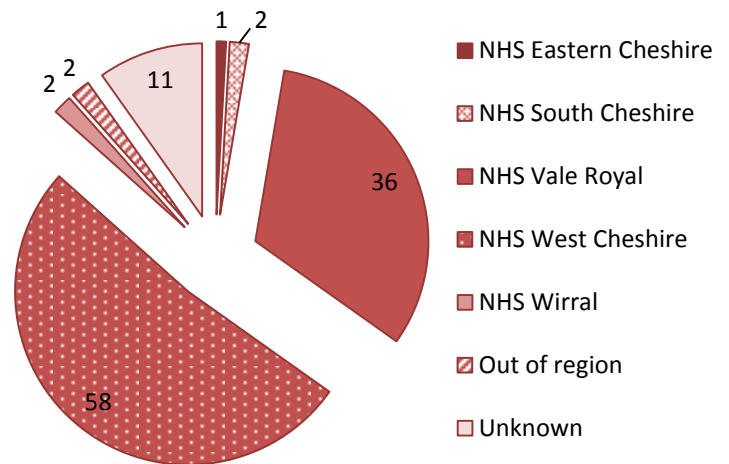


Figure 5.2: Residency of respondents by Clinical Commissioning Group (CCG) (n=112)

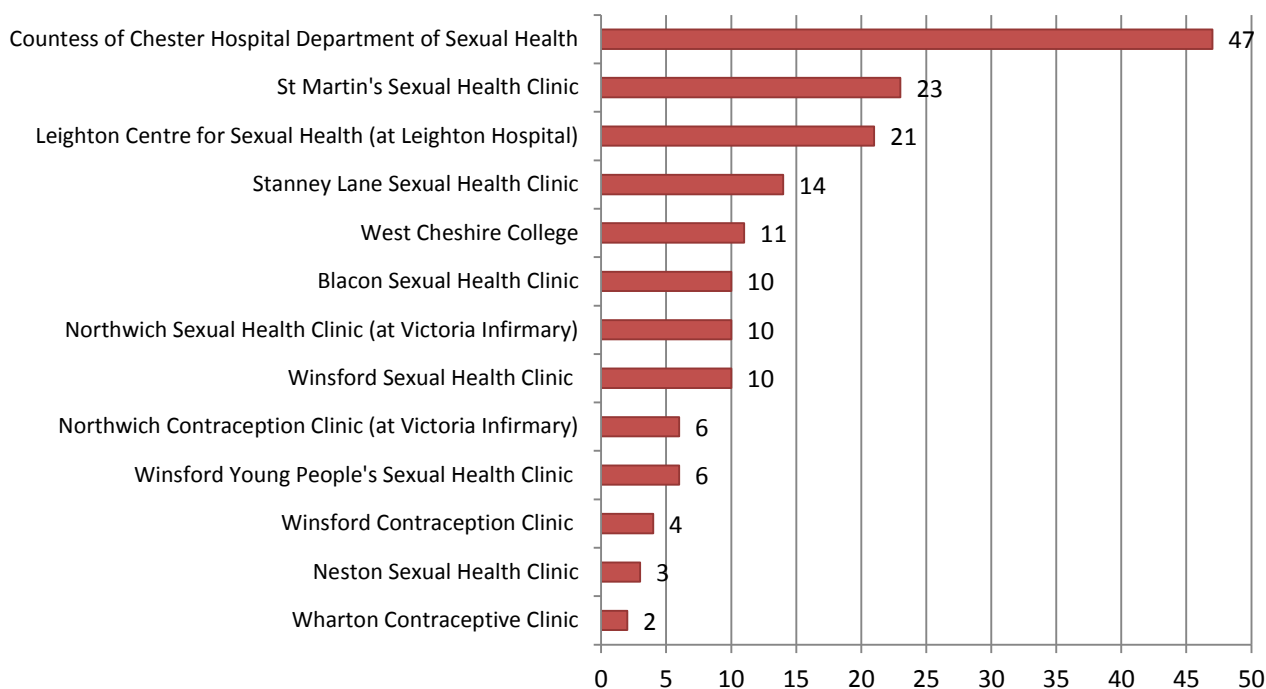


The age of respondents was fairly evenly spread, with all age groups represented. The 45 to 49 years age group represented the largest proportion of respondents (23 individuals, 21%) and over half of the respondents (56%) were aged between 30 and 49 years. The majority of respondents were resident in Cheshire West and Chester Unitary Authority (84%) with 58 individuals resident within the boundaries of NHS West Cheshire Clinical Commissioning Group and a further 36 in NHS Vale Royal Clinical Commissioning Group. The remaining 18 respondents were either resident outside of Cheshire West and Chester or their exact area of residency was unknown but stated that they worked or socialised within Cheshire West and Chester.

The majority of respondents (96%) identified themselves as being of white British ethnicity. Over half of respondents were female (59%) and all respondents described their current gender as the same as their biological sex at birth. The majority (90%) described themselves as heterosexual, a further five individuals described themselves as homosexual (one female and four males), three individuals as bisexual and one individual as asexual.

Knowledge of Sexual Health Services

Figure 5.3: Prior knowledge of sexual health services



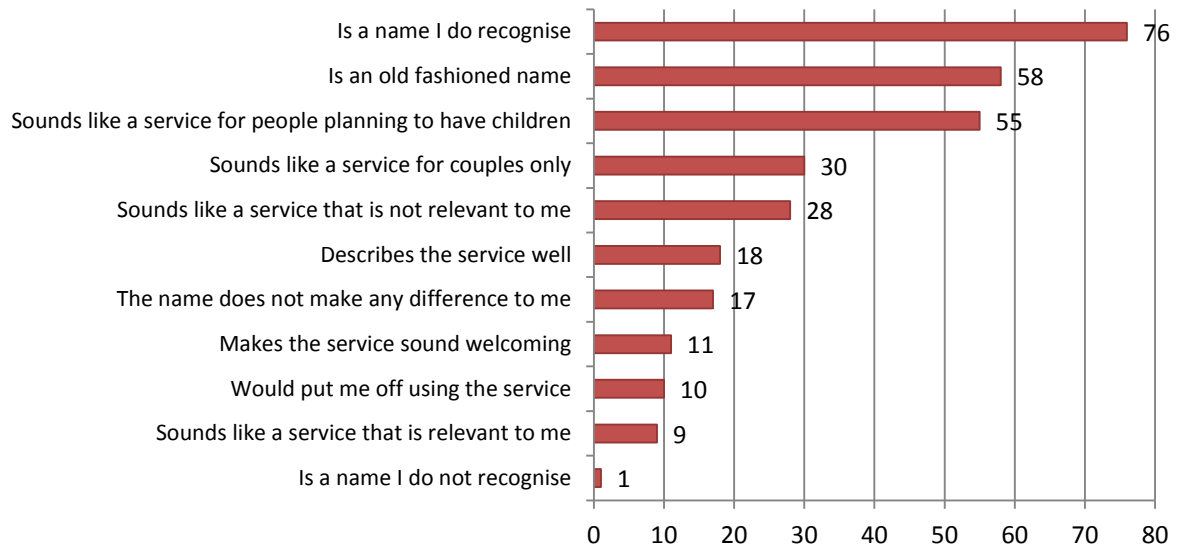
Respondents were asked the question “Before doing this questionnaire, had you heard of any of the following sexual health services”. The Countess of Chester Department of Sexual Health was the most frequently recognised service (n=47), followed by St Martin’s (n=23) and Leighton Centre for Sexual Health (n=21). Awareness of smaller local clinics was lower.

Many of the sexual health clinics in the Vale Royal area are known as “family planning” clinics. Figure 5.4 shows perceptions of the name “family planning” to describe sexual health services. The majority of participants had heard of the term “family planning” (n=76) with only one respondent stating it was a name they did not recognise, 58 participants felt it was an old fashioned name, 55 thought it sounded like a service for those planning to have children and 30 thought it sounded like a service for couples only. Two individuals provided additional commentary on the term, with both individuals feeling that the term “family planning” was a misleading one:

“Horrible outdated inaccurate euphemistic term. Let's drop it!!”

“It suggests for pregnancy purposes which is not the case. Some young vulnerable children may not associate it with sexual diseases”

Figure 5.4: Views of the term “family planning clinic”



Participants were asked if they knew where to access a number of sexual health services namely contraception, emergency contraception, HIV testing, STI testing and abortion.

Figure 5.5 Would you know where to go if you needed contraception (e.g. condom, the pill, coil etc.)?

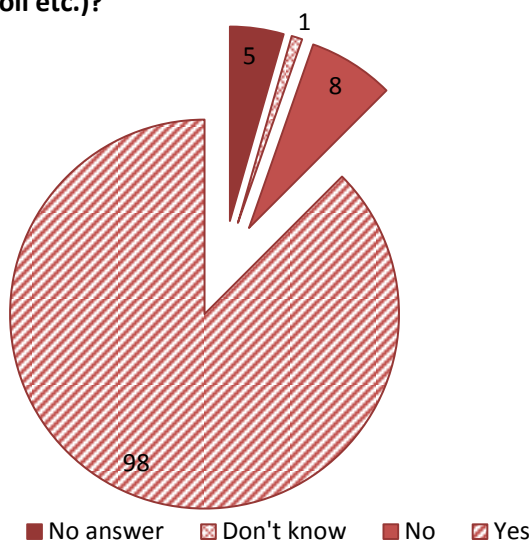
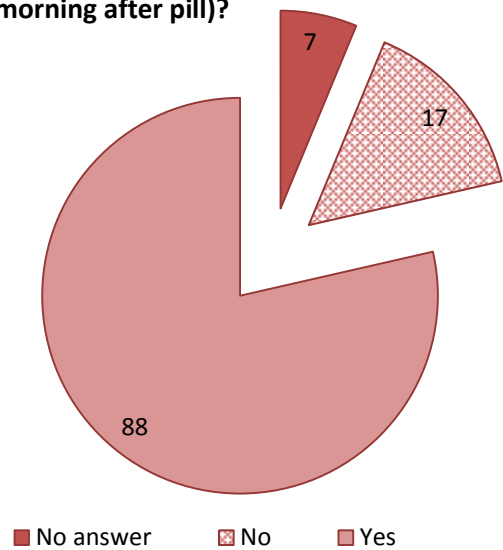


Figure 5.6: Would you know where to go if you needed emergency contraception (e.g. the morning after pill)?



The majority of respondents (88%) felt they knew where to access contraception such as condoms, the pill or LARC and 79% felt they knew where to access emergency contraception. Eight participants responded that they would not know where to access contraception and 17 that they would not know where to access emergency contraception. When asked to name where they would access contraception, 38 respondents mentioned their GP/ practice nurse, 23 said the pharmacy/chemist, 15 family planning, contraception or GUM services. A further ten said they would purchase contraception in supermarkets or shops and two mentioned vending machines in pubs. Twenty six respondents stated they would access emergency contraception from their pharmacy/chemist, 24

from their GP/practice nurse and 12 from Contraception and Sexual Health, GUM or family planning clinic.

Figure 5.7 Would you know where to go if you needed to get tested for HIV?

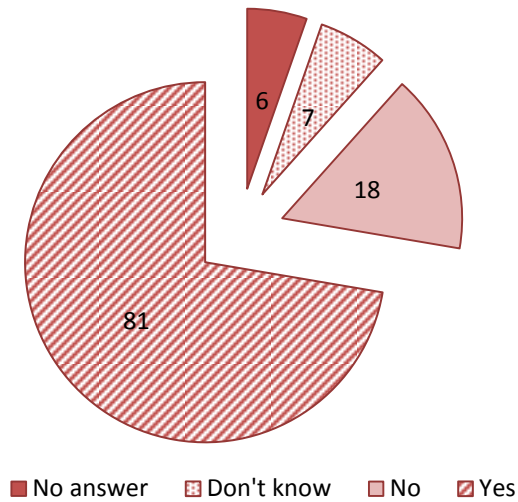
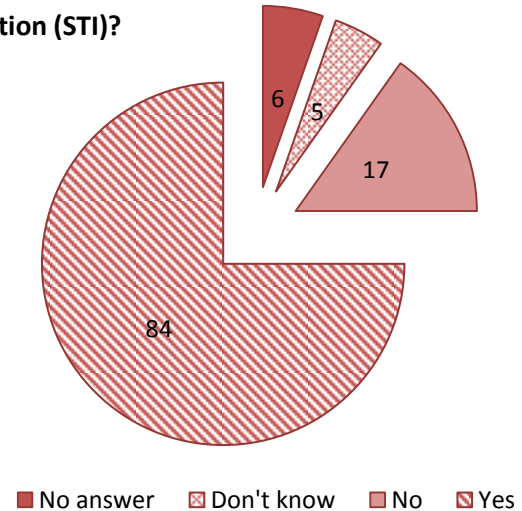


Figure 5.8 Would you know where to go if you needed to get tested for a sexually transmitted infection (STI)?



Respondents were asked about awareness of testing services, 75% of participants said they knew where to access testing for sexually transmitted infections and 72% knew where to access testing for HIV. Eighteen individuals stated that they did not know where to access testing for HIV and 17 that they did not know where to access STI testing. When asked to name where they would access testing 27 said they would access STI testing at their GP, 18 at a GUM clinic and 18 at a sexual health or family planning clinic. Similarly 23 would access HIV testing through their GP, 17 through GUM and 15 at a sexual health or family planning clinic.

Service Use

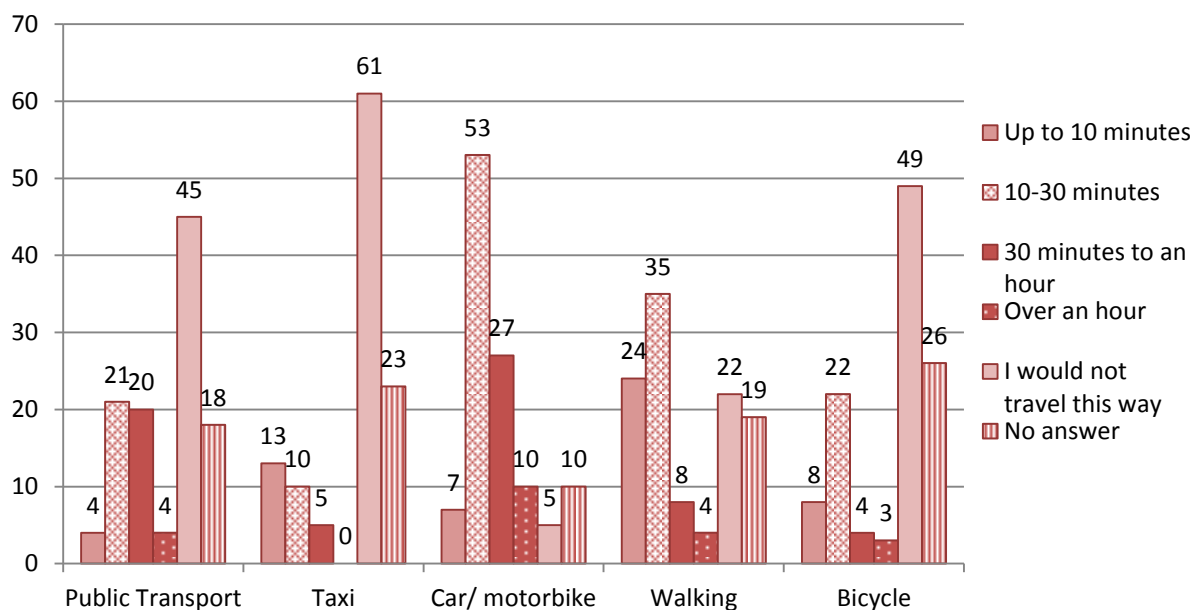
Participants were asked to indicate which sexual health services in Cheshire West and Chester they had attended in the past year. Nineteen of the respondents had attended one or more sexual health services in the past year, representing 17% of the participants. The most commonly attended clinics were the Countess of Chester Centre for Sexual Health (n=8), St Martins (n=7), Leighton Centre for Sexual Health (n=4) and Stanney Lane (n=2). Winsford Sexual Health Clinic, Northwich Contraception Clinic, Blacon Sexual Health Clinic and West Cheshire College Health zone all had one individual reporting attendance in the past year. Another participant indicated they had attended St Catherine’s Sexual Health Clinic in Birkenhead. Participants were also given the opportunity to comment on why they had chosen to attend a service other than the clinics listed; these selected comments below highlight some of the issues which will be addressed in later questions.

"Doctors - convenience (early morning appointments (from 8.30am) so can go on the way to work)"

"I had a Chlamydia test done at a festival."

"The Lesbian & Gay foundation in Manchester, I've never received same sex sexual health advice from mainstream services, I am out to GUM clinic at the Countess but they didn't provide me with any information at all that was relevant to my sexual health when I had a female partner."

Figure 5.9: The distance survey participants would be willing to travel to a sexual health service by different forms of transport



When asked how long they would be willing to travel by various forms of public transport, the most commonly chosen option was a 10 to 30 minute journey by car or motorbike (n=53) and a further 27 individuals would be willing to travel between 30 minutes and an hour. Opinions on public transport and taxi travel were mixed with some individuals finding a 10 to 30 minute (n=21) and a 30 minute to an hour (n=20) journey acceptable journey on public transport. Conversely, 45 individuals said they would never travel to sexual health service by public transport and the majority (n=61) said they would not travel by taxi. A 10 to 30 minute walk was an acceptable distance for 35 of the participants, a further 24 would walk up to ten minutes and 22 said they would not walk to a sexual health clinic.

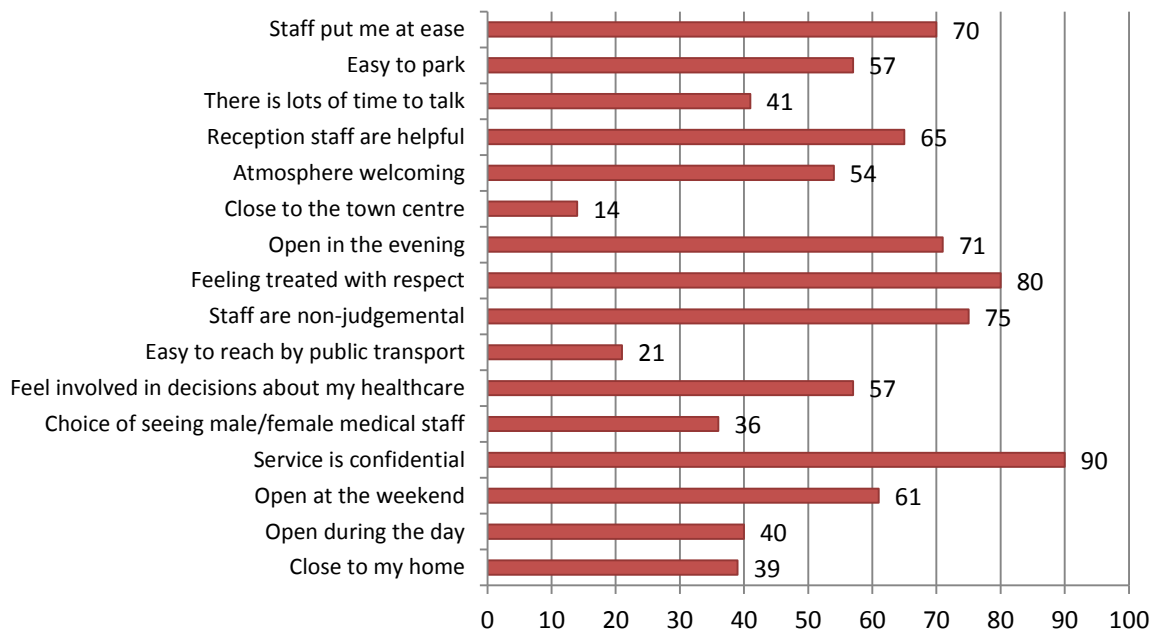
The vast majority of participants (n=90) felt confidentiality, feeling treated with respect (n=80), non-judgemental staff (n=75) and being put at ease by staff (n=70) were important aspects of sexual health services (figure 5.10). A large number also prioritised feeling involved in decisions about their healthcare (n=57) and a welcoming atmosphere (n=54). In terms of the accessibility of clinics, being open in the evening (n=71), being open at the weekend (n=61) and easy parking (n=57) were the

most commonly chosen responses. Two respondents provided further information on the issues above which are included below:

“No interruptions - I don’t go to St Martins anymore because a nurse would always walk in when I was with the doctor without knocking.”

“Open of an evening or from 8am so appointments can fit around working day.”

Figure 5.10: What things are (or would be) most important for you in a sexual health service?



Participants were given the opportunity to comment on what might put them off using a sexual health service. Thirty six respondents answered this question, of which six individuals felt there was nothing that would put them off using a service, with one participant specifying that they would not be put off attending *“if I was worried enough to go in the first place”*. The remaining thirty comments can be summarised into several broad themes; privacy and confidentiality issues, staff attitudes and service issues which are summarised below

Privacy and confidentiality

Privacy and confidentiality concerns were mainly centred around being easily identified as attending a sexual health service user through the clinic environment or location, however there were mixed opinions in this area with one participant disliking a shared waiting room and reception area and another wanting a private and discreet entrance whilst two other participants felt that a separate clinic drew too much attention and would preferred the anonymity of a shared environment. Other concerns

“Shared clinics with other services with open or shared reception desks are not private enough.”

“Being easily identified as attending service if it is a stand alone building. Better if within other health premises so if seen going into building it is not obvious where you are attending.”

included embarrassment or the feeling that they were being judged by other service users and concerns about contact details being shared with private providers.

Staff Issues

Concerns about staff fitted into two areas; concerns about the gender of staff and the impact of negative staff attitudes. Negative staff attitudes identified by participants included feeling patronised and a lack of professional and confidential manner. One participant highlighted that it was not only their own experiences, but that negative experiences by families and friends could also put them off using a service. Gender was also an important issue for female respondents, with one participant stating a desire to see a female healthcare professional. A second respondent stated that although seeing a male healthcare professional would not put them off using a sexual health service they would prefer to see a female healthcare professional.

Service issues

A number of other issues relating to the service were identified and these covered three main categories; waiting time and clinic opening hours, clinic location and appropriateness of the service for all potential service users. Some concerns were expressed about a busy waiting room environment, long waiting times and the impact this had on appointment length. Others mentioned that clinic opening hours needed to fit in with working and parental commitments. The appropriateness of clinics and advice was also raised with two individuals emphasising the importance of being able to be open about their sexuality and receiving the correct advice for them. Another individual felt they would be put off using the service if they were alongside very young people, emphasising the importance of young people's clinics.

"If it were provided by a for-profit organisation or shared my details outside the NHS."

"embarrassment of bumping into someone you know."

"As a female, I would personally prefer to see female practitioners. I would not be put off using a sexual health service if there were male practitioners but would like the option of expressing a preference."

"Being judged by staff and not being dealt with in a professional, caring and confidential manner."

"Not if I really needed it but on a day to day basis the staff need to treat people with respect and with confidentiality - I have felt often just a number or a silly girl, rather patronised."

"Feeling rushed/not enough time, waiting for a long time in the waiting room."

"Long waiting times - mix of pre-booked and drop-in appointment is best."

"Hours that don't fit in with my lifestyle e.g. work, children"

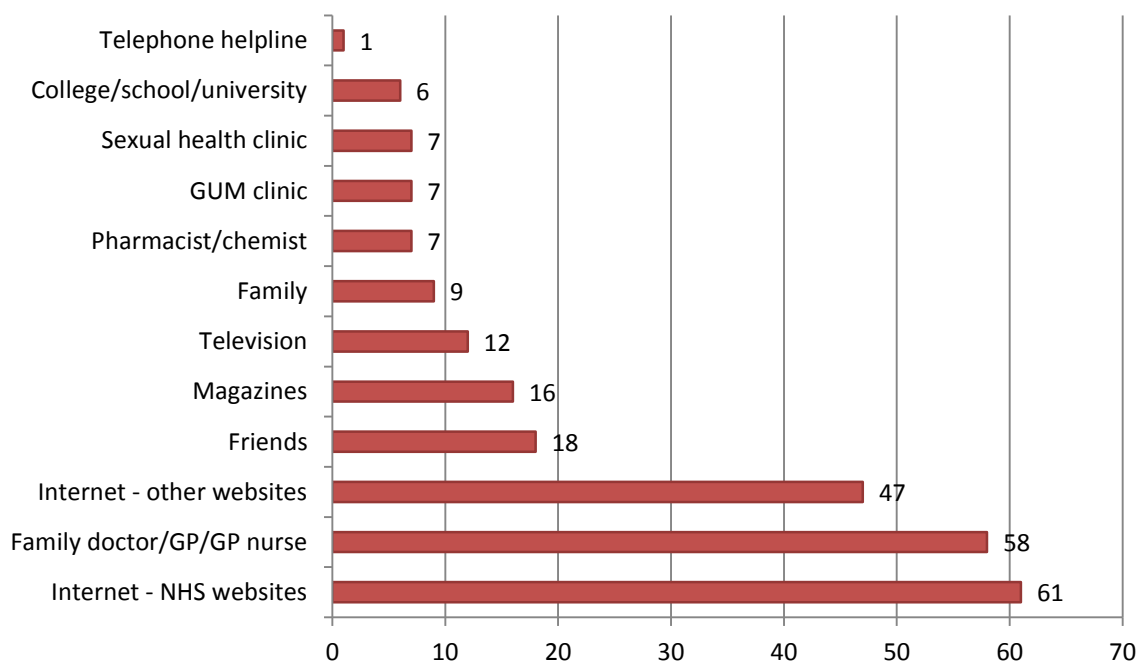
"If it was based in a bad area of a town"

"Really young people using it"

"Feeling that I won't receive any information that is relevant to me about same sex partners. I know friends who have received good sexual health advice who are gay men from the GUM clinic but not for gay women. It does put me off access a second time when clinicians presume I am heterosexual, or when I say I am bisexual not really acknowledging it, or thinking it doesn't matter. It does I need different information."

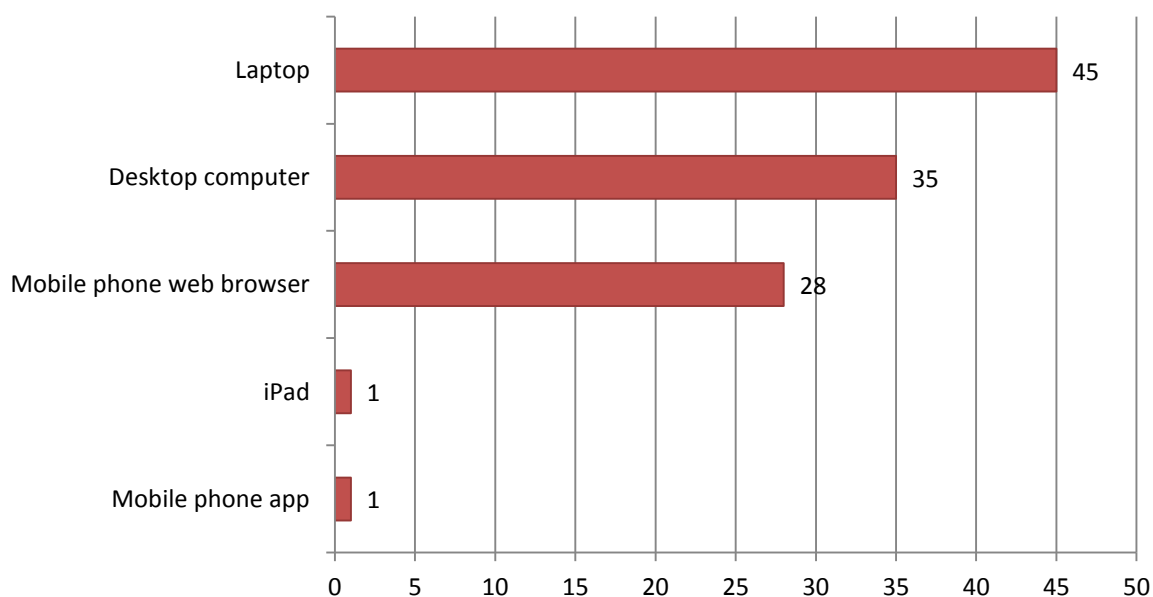
Information on sexual health

Figure 5.11: Sources of sexual health information



NHS websites (n=61), family doctors (n=58) and other websites (n=47) were the most commonly selected sources of information about sexual health. Of those who stated they accessed information via the internet, the majority of respondents accessed this information using a laptop (n=45) or a desktop computer (n=35). A further 28 individuals accessed information using a mobile phone web browser. Use of mobile phone apps and iPad was low.

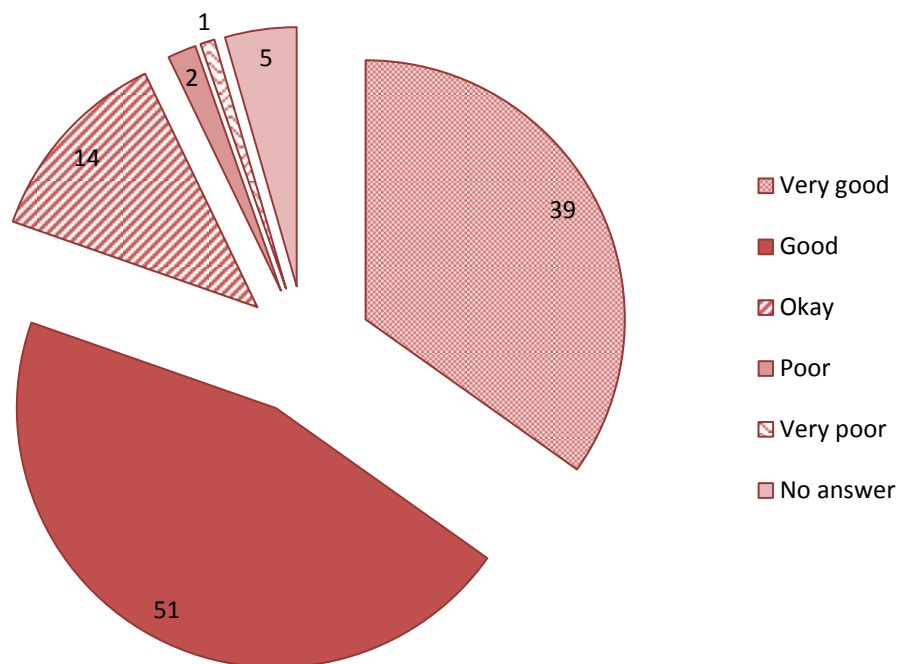
Figure 5.12: Access to information via the internet



General Health and Lifestyle

Participants were asked a number of questions about their general health and lifestyle to see if any of these factors were related to knowledge and use of sexual health services and sexual health behaviours.

Figure 5.13: How would you describe your general health?



Just under half of questionnaire respondents (46%) reported their health to be “good” and a further 35% described their health as “very good” (figure 5.13). When asked about their drinking habits (figure 5.14), 35% of respondents said they drank eight units (men) or six units (women) on a single occasion less than monthly and a further 30% never drank this much. However, 18% said they drank this amount on a monthly basis, 6% on a weekly basis and 3% on a daily or almost daily basis (figure 5.14). When asked about the consequences of alcohol consumption, the majority of individuals (79%) had never experienced the negative situations proposed in the past twelve months. However, a small number of individuals (16%) stated they had failed to remember what had happened the night before due to alcohol, although all stated this happened on a less than monthly basis. In total 21% had failed to do what was normally expected of them due to alcohol and 9% had experienced concern or a request to cut down their alcohol consumption from a friend, relative or healthcare professional on at least one occasion.

Figure 5.14: How often do you drink more than eight (men) or six (women) alcoholic drinks on one occasion?

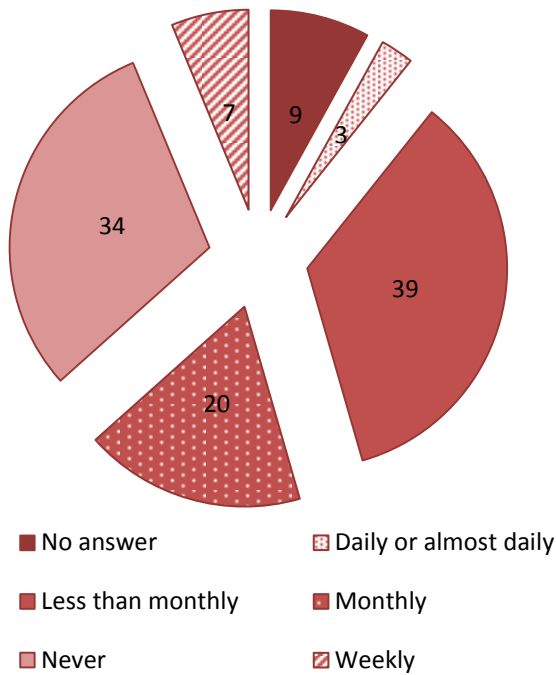


Figure 5.15: How often in the past year have you been unable to remember what happened the night before because of drinking?

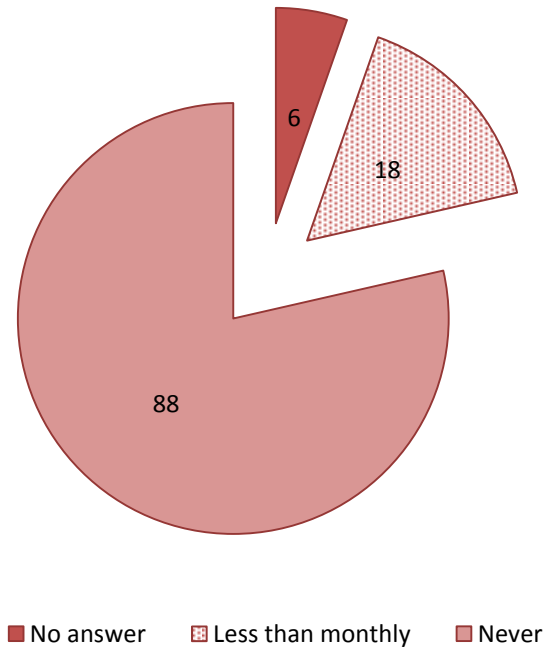


Figure 5.16: How often during the last year have you failed to do what was normally expected of you because of alcohol?

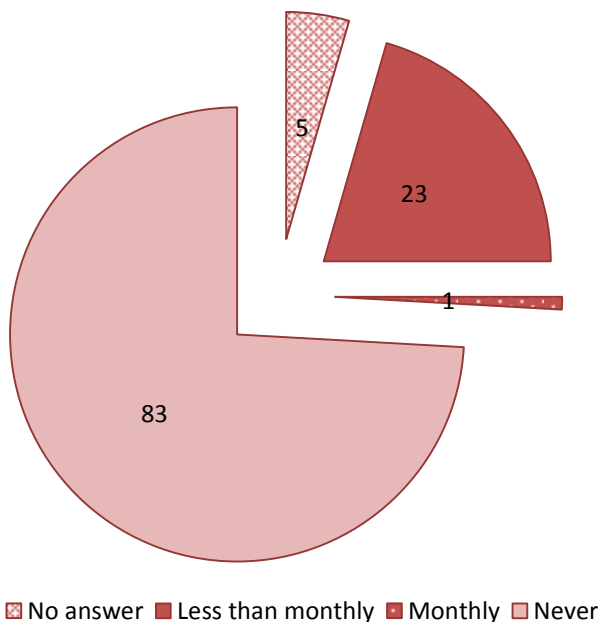


Figure 5.17: In the last year has a relative, friend, doctor or other health worker been concerned about your drinking or suggested you cut down?

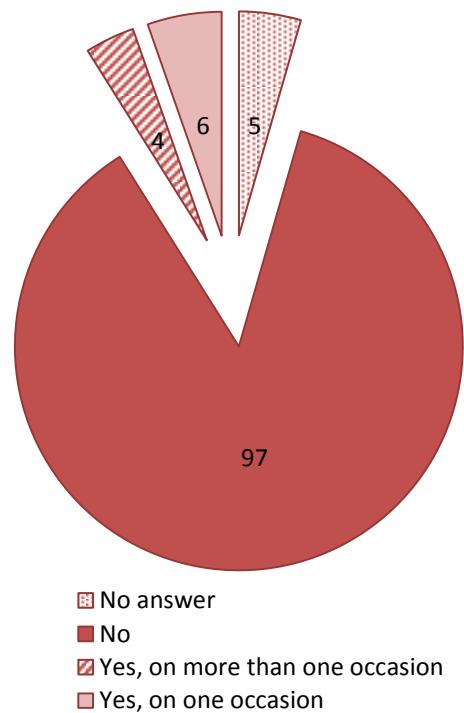
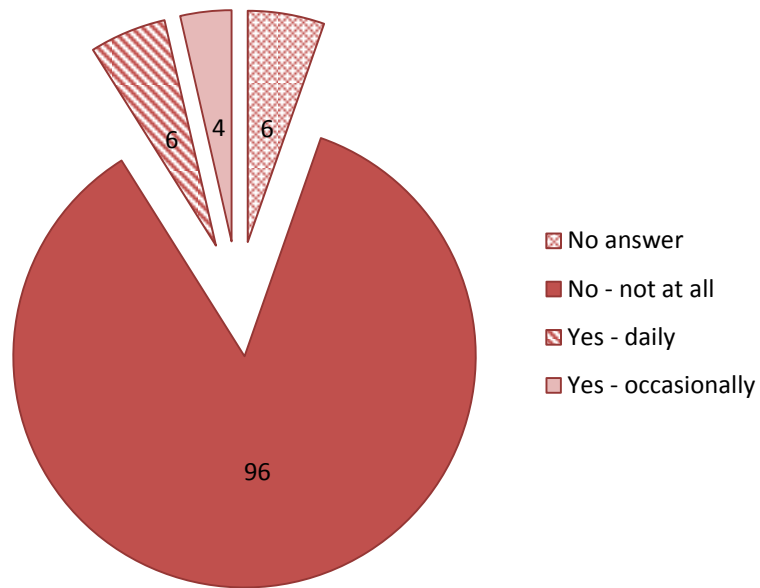


Figure 5.18: Do you currently smoke tobacco (e.g. in a cigarette, cigar, roll-up, pipe etc.)?



The majority of respondents (86%) did not smoke tobacco, 5% of respondents smoked on a daily basis (figure 5.18).

The responses from the five alcohol and smoking related questions (see figures 5.14 to 5.18 above) were collated to create a health risk behaviour score. These scores were then categorised into three groups; low health risk behaviour, moderate health risk behaviour and high health risk behaviour.

Figure 5.19: Health risk behaviour score

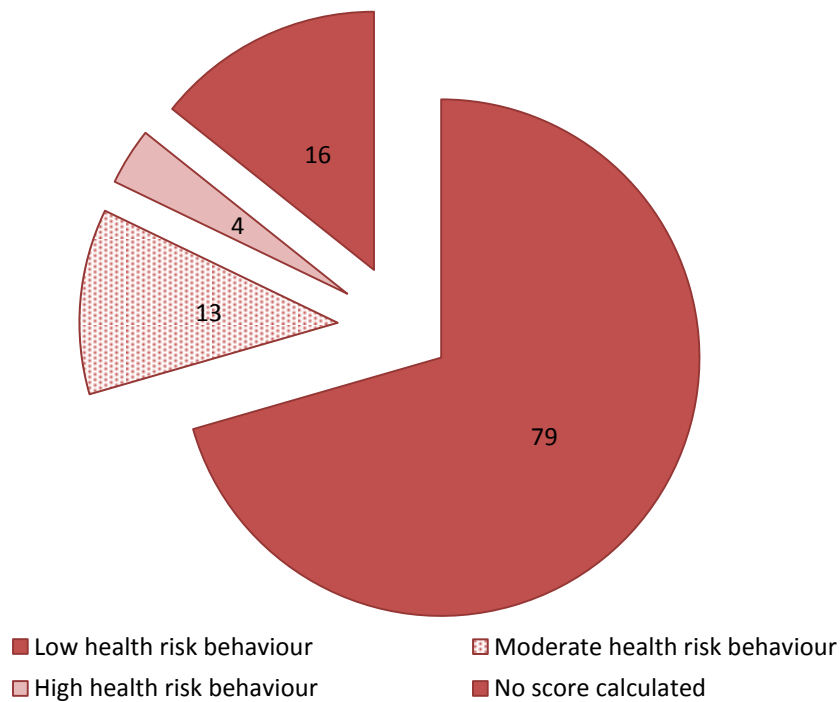
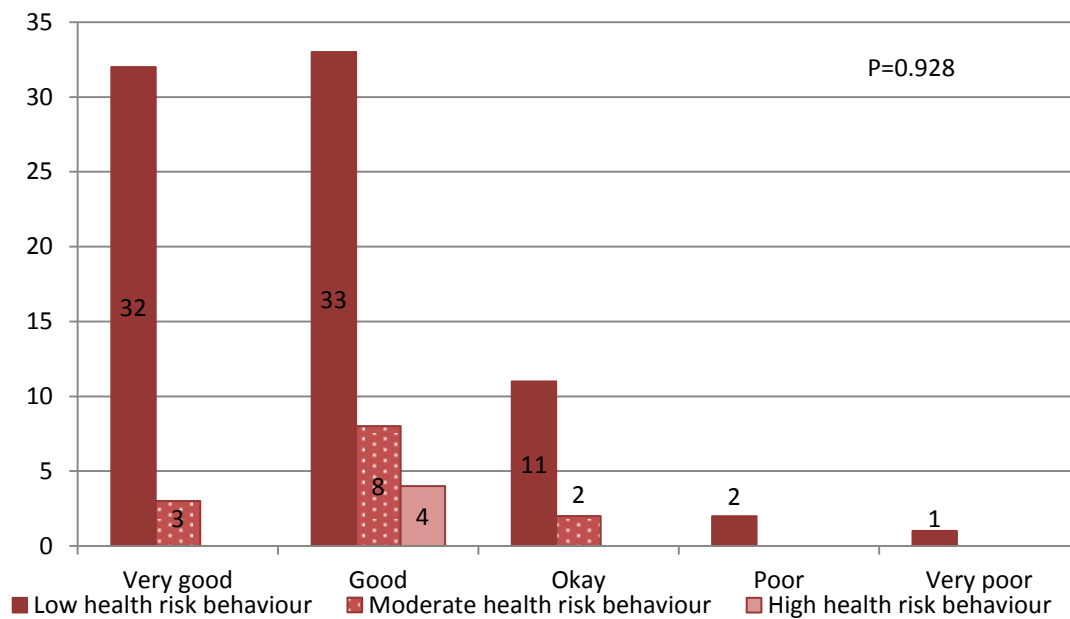


Figure 5.20: Self assessed health by health risk behaviour score



The majority of respondents (71%) had a low health risk behaviour score, 12% had a moderate risk behaviour score and 4% had a high risk score. Figure 5.20 above compares health risk behaviour to self-assessed health score. The majority of respondents with low risk health behaviour (82%) described their overall health as either good or very good. Interestingly all 4 individuals with a high health risk behaviour score described their overall health as “good”. There was no statistically significant difference between self-assessed health behaviour and health risk behaviour.

Figure 5.21: In the past twelve months have you had protected sex (sex with a condom) with all your sexual partners?

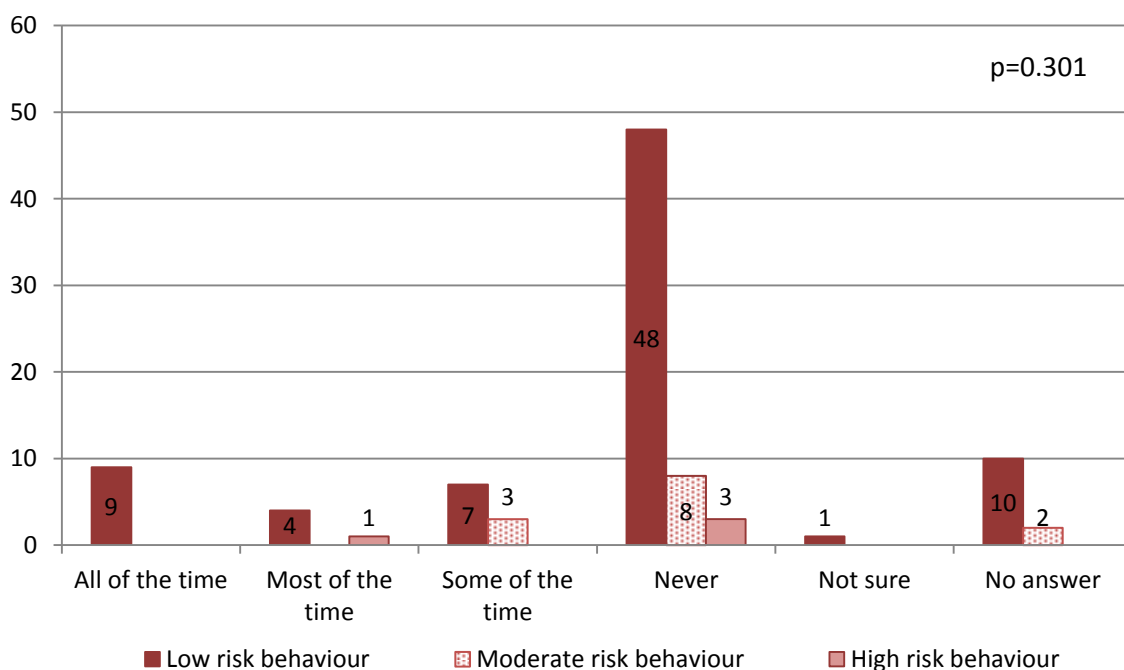
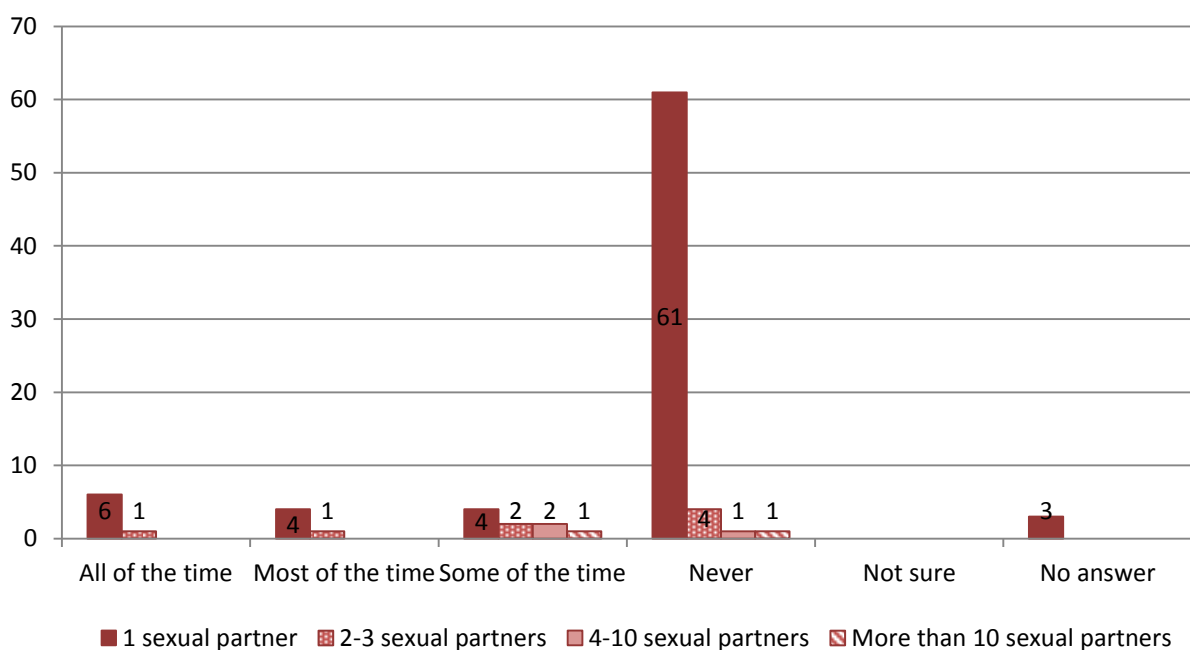


Figure 5.21 shows the health risk behaviour score against whether participants had used a condom with all of their sexual partners in the past 12 months. Three of the four individuals with a high risk health behaviour score reported never using a condom in the past 12 months. However, 48 individuals with a lower health risk behaviour score had also never used a condom in the past twelve months. The relationship between health score and condom use was not statistically significant and so these results should be interpreted with caution.

Relationships, contraception, sexually transmitted infections (STIs) and HIV

Respondents were asked about the number of sexual partners they had had in the past 12 months and this has been compared with condom use with all sexual partners in the past twelve months. Thirteen individuals had had more than one sexual partner in the past twelve months, of which three had between four and ten sexual partners and two had more than ten sexual partners. Amongst those with two or more sexual partners, six had never used a condom in the past six months.

Figure 5.22: Condom use in the past twelve months by number of sexual partners



Participants were asked what factors would influence their condom use. Condom use was particularly influenced by the nature and length of their current relationship and other types of contraception being used. Pregnancy intentions, the type of sex participants were having and how they felt at that particular moment were also cited as influences on condom use.

The most common reason for not using condoms was using other types of contraception and nature/length of current relationship as illustrated in the quotes below:

“Both my partner and I have been tested for STI’s and are clear, so would not use a condom to prevent infection (also on the pill so no need to use as contraceptive).”

“Don’t need them in stable relationship for past 25yrs and have been sterilised.”

“At my time of life I think it unlikely I'd use one because I don't have casual sex. If I were to get a new partner I'd only have sex with them once I knew them well and so would be confident their lifestyle before they met me was such that they were highly unlikely to have a sexually transmitted disease i.e. had virtually no sexual partners/same sexual partner for many years.”

“Don't-as married for number of years so (hopefully unless husband has some explaining to do!!) don't need for STI prevention and have other forms of contraception in place.”

Another reason participants for not using condoms related to their intentions around pregnancy:

“Don't need them as unable to conceive, but it used to be to stop pregnancy.”

“I needed to for the first seven days if taking the pill until I was covered.”

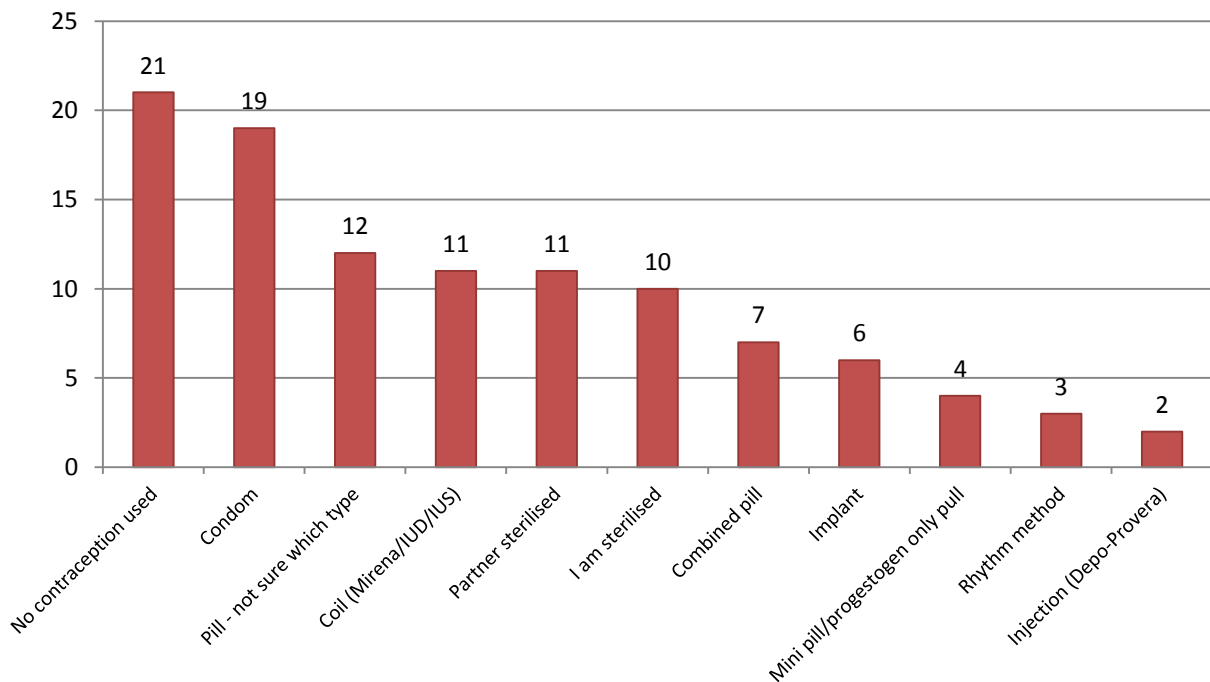
“Not ready for any more kids yet.”

Other reasons included the type of sex participants were having and how they felt at the time:

“Never do for vaginal sex as only ever had my one sexual partner and she only has had me. Only wear condom for anal sex.”

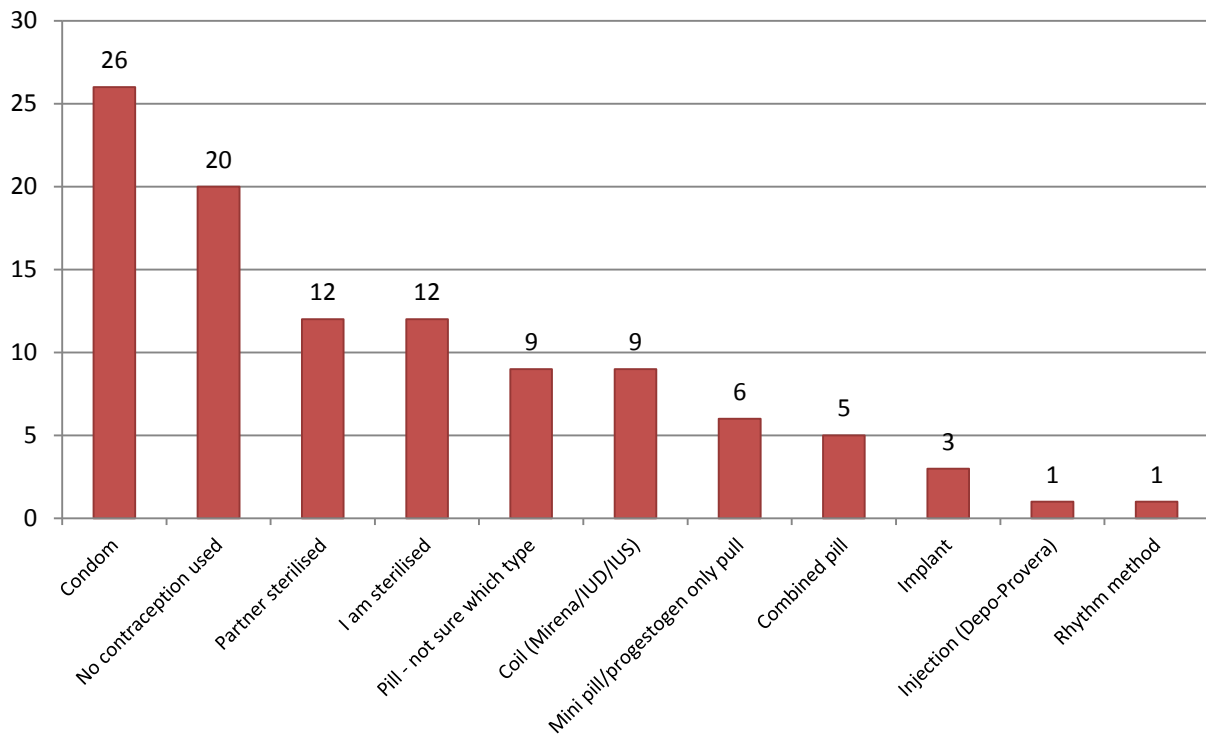
“the moment.”

Figure 5.23: Which types of contraception have you and your partners used in the past 12 months.



The most commonly used methods of contraception in the past twelve months were the pill (n=24, different types combined), followed by condoms (n=19). A further 21 respondents stated that either they or their partner were sterilised and a further 19 were using a LARC method.

Figure 5.24: Current usual method of contraception (participants could select up to three options)



The most commonly used form of contraception was condoms (n=26; figure 5.24). Twenty individuals stated they were no currently using any form of contraception. Amongst those who have used condoms in the past twelve months the main reason given for condom use was to prevent pregnancy (n=15, figure 5.25).

Figure 5.25: Reason for condom use in the past twelve months

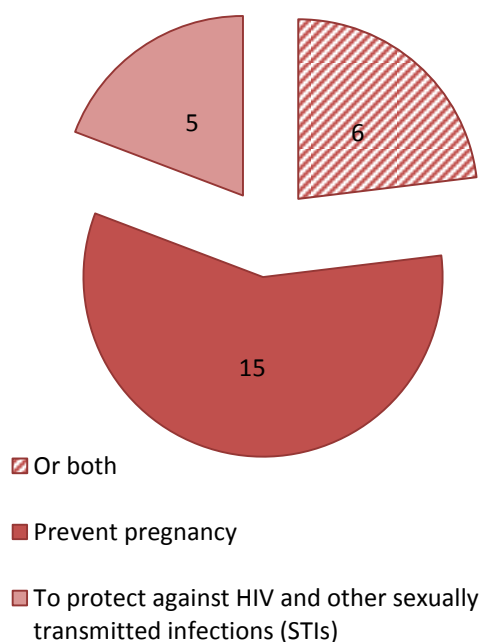
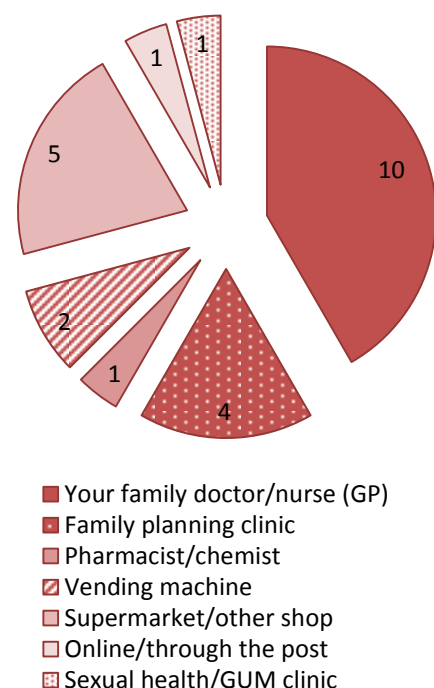


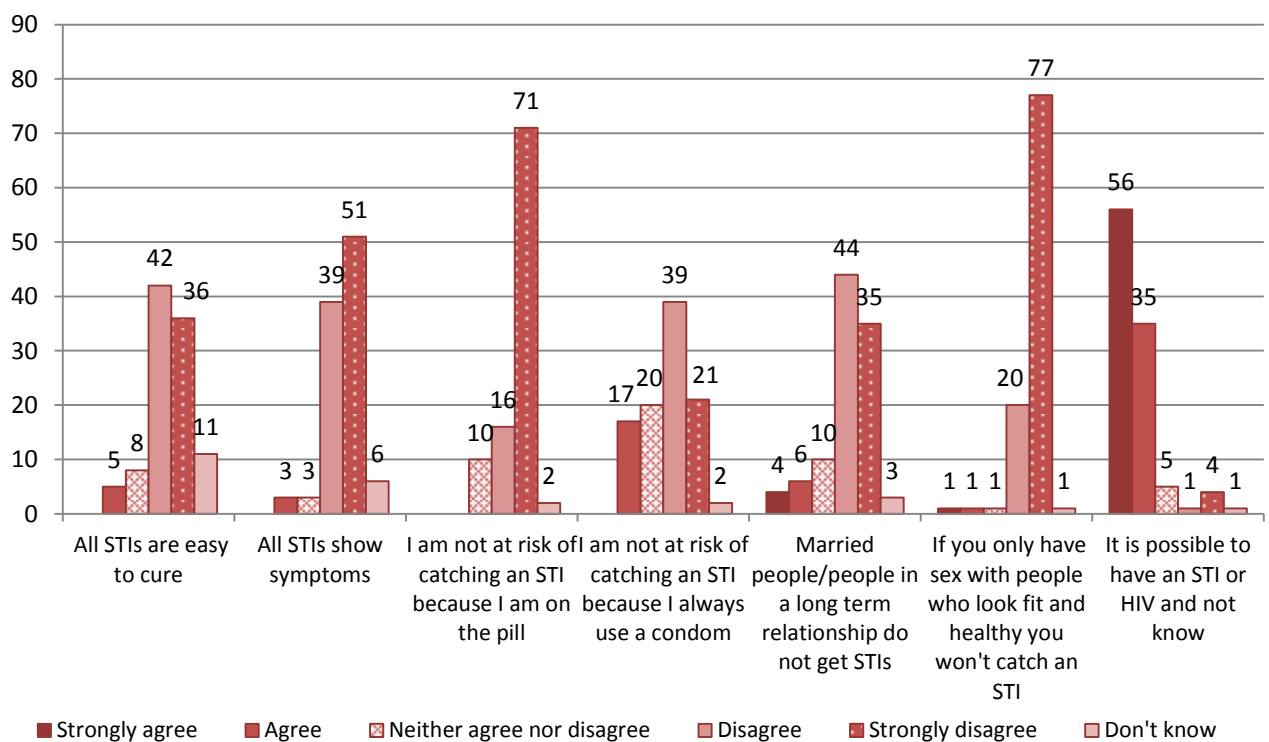
Figure 5.26: Sought advice or obtained contraception in the past twelve months



The majority of respondents stated that they had not sought advice or obtained contraception in the past twelve months (n=75, 67%). Of those that had accessed contraception or advice the majority (n=10) obtained advice from the GP practice and a further five individuals from a supermarket or other shop and four from their family planning clinic (figure 5.26).

Questionnaire participants were given a number of statements about STIs and HIV and were asked to strongly agree, agree, neither agree nor disagree, disagree or strongly disagree. In general, knowledge of sexually transmitted infections was good. The majority (n=90) of participants disagreed or strongly disagreed with the statement “All STIs show symptoms” and the majority (n=91) agreed or strongly agreed that “it is possible to have an STI/HIV and not know” (figure 5.27). The majority of respondents also disagreed or strongly disagreed with “all STIs are easy to cure” (n=78), “I am not at risk of catching an STI because I am on the pill” (n=87), “married people/people in a long term relationship do not get STIs” (n=79) and “if you only have sex with people who look fit and healthy you won't catch an STI” (n=97).

Figure 5.27: Knowledge of sexually transmitted infections (STIs)



Four statements on HIV were answered by survey participants. Compared with the questions on STIs, there were more responses of “don't know”. The majority (n=52) of participants agreed with the statement “HIV drugs make HIV easier to live with” whilst 16 disagreed or strongly disagreed (figure 5.28). Seventy four participants disagreed with the statement “HIV drugs make people less infectious” whilst 11 agreed. Forty nine participants agreed or strongly agreed with the statement “I don't think I am at risk of catching HIV” whilst 22 agreed or strongly agreed. Seventy eight participants disagreed or strongly disagreed with the statement “All HIV positive people die from HIV before they get old”.

Figure 5.28: Knowledge of HIV

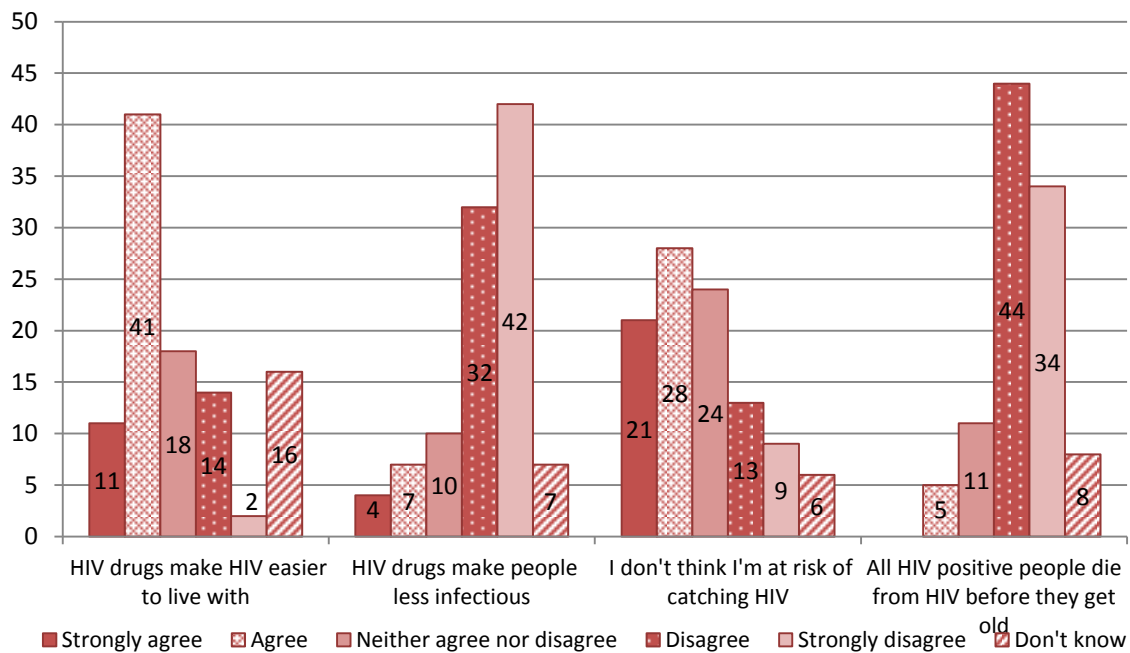
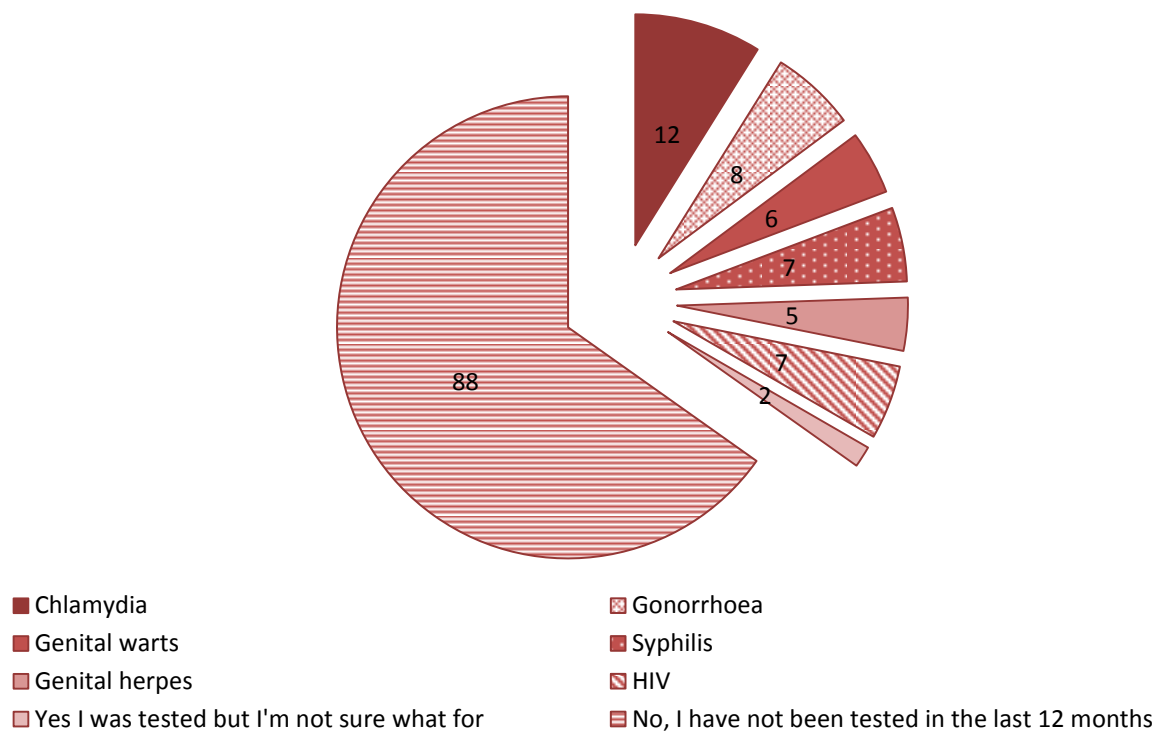


Figure 5.29: Tested for sexually transmitted infection in the past 12 months.



The majority of respondents (79%) had not tested for a sexually transmitted infection in the past twelve months (figure 5.29). The sexually transmitted infection most commonly tested for was Chlamydia (n=12) followed by Gonorrhoea (n=8), HIV (n=7) and syphilis (n=7). Only one participant had been diagnosed with a STI in the past 12 months.

6. FURTHER INSIGHTS INTO ‘SELDOM-HEARD’ GROUPS: MEN WHO HAVE SEX WITH MEN/LGBT

Box 6.1 Key findings – men who have sex with men/LGBT

- Men who identify as gay or bisexual are more likely to use condoms and access sexual health screening services;
- Men who identify as heterosexual but also have sex with men, including married men, are the least likely to use condoms, have more sexual partners and are less likely to access sexual health services for STI screening;
- Trans people are particularly at risk as they are less likely to use condoms and have more sexual partners. Support for trans people could reduce the need to seek acceptance in risky sexual encounters;
- The cost of fuel and parking and the time consuming nature of journeys by public transport are barriers to access to Leighton and Chester hospitals;
- Out of hours clinics are needed to encourage access, especially for MSM who identify as heterosexual;
- More work is needed to promote condom use and STI screening to men who identify as heterosexual but have sex with men, this may be outreach at the sauna or through websites that facilitate ‘hook ups’;
- STIs and HIV can often have no symptoms. Wider publicity of GUM services is needed to encourage men to attend for regular STI screening when they are asymptomatic not just when they are showing symptoms;
- STI and HIV screening in the Northwich Sauna facilitate access to older men and men who do not identify as gay or bisexual. These are two groups who are less likely to attend GUM services.

Background

Men who have sex with men (MSM) have been identified by commissioners as a target group for this needs assessment as they are at higher risk of sexual ill-health. Therefore this needs assessment aims to engage further with MSM in Cheshire West and Chester to better understand their sexual health needs, unmet needs, barriers to access and experiences. Rather than using the term ‘gay/bisexual men’, the term ‘MSM’ will be used. ‘MSM’ refers to men who engage in sexual activity with other men and may include those who identify as homosexual, bisexual or heterosexual. The term refers to sexual behaviour rather than self-defined sexual orientation or identity.

A brief literature review was conducted to identify national and local epidemiology, as well as examples of successful working and best practice. Some research discussed below relates to the general lesbian, gay, bisexual and trans (LGBT) community and some focuses specifically on MSM. Although there are differences in experiences and epidemiology it is worth including both areas of evidence to provide a fuller picture. The LGBT population will be referred to as LGBT or LGB, depending on which groups are being discussed.

Epidemiology of sexually transmitted infections (STIs) and HIV

MSM are disproportionately affected by STIs and HIV. The Public Health England Health Protection Report (June 2013) included the latest figures on STI diagnoses. The key findings that relate to MSM are:

- In England in 2012, among male GUM clinic attendees, 79% (2,142/2,713) of syphilis diagnoses, 58% (10,754/18,537) of gonorrhoea diagnoses, 17% (8,509/51,454) of chlamydia diagnoses, 11% (1,360/12,159) of genital herpes diagnoses and 9% (3,492/40,392) of genital warts diagnoses were among MSM;
- The number of diagnoses of STIs reported in MSM continues to rise, although to a lesser extent than reported the previous year;
- Gonorrhoea diagnoses increased by 37% in the past year (7,851 to 10,754 diagnoses), chlamydia diagnoses by 8% (7,851 to 8,509), genital warts diagnoses by 8% (3,238 to 3,492), and syphilis diagnoses by 5% (2,043 to 2,142). Gonorrhoea was the most commonly diagnosed STI among MSM in 2012;
- Some of the increases in diagnoses may be due to changes in the tests used. However, the large increase in the number of gonorrhoea diagnoses in MSM over the last year, the ongoing *lymphogranuloma venereum* (LGV) epidemic in older, HIV-positive MSM, outbreaks of other STIs in this group such as *shigella flexneri* and *shigella sonnei* and the continued increase in new diagnoses of HIV strongly suggest that ongoing high levels of unsafe sex is leading to more STI transmission in this population (PHE, 2013).

The latest national HIV figures were released in 2012 and present data collected in 2011. New HIV diagnoses among MSM have been increasing since 2007 with 3,010 reports in 2011, representing an all-time high. HIV rates are higher in MSM than their heterosexual counterparts (HPA, 2012a). New HIV diagnoses among MSM have surpassed the number of diagnoses made among heterosexuals for the first time since 1999, accounting for 48% of all new diagnoses made in 2011, after adjusting for missing information.

Late diagnosis is the most important predictor of morbidity and short-term mortality among those with HIV infection. In 2011, 47% (2,950) of HIV diagnoses were made at a late stage of infection (with a CD4 cell count <350 cells/mm³ within three months of diagnosis). Late diagnoses were lowest among MSM (35%; 1,050; HPA, 2012).

HIV disproportionately affects two populations in England; black Africans and MSM. HIV prevalence is approximately 30 times higher in these groups than in the general population of England. In 2012 there were 31,830 people accessing HIV care who acquired the infection through sex between men, of whom 87% (27,700) were white.

For information on HIV in Cheshire West and Chester, see chapter three of this report.

STI and HIV Testing

HIV testing within STI clinics is higher in MSM (84% of attendees) than in heterosexual men (74%) and women (66%; HPA 2012). However, 63% (1,160/1,840) of MSM newly diagnosed with HIV at an

STI clinic had not attended that clinic for testing in the previous three years, which suggests there is much room for improvement in the frequency of testing of those at highest risk.

In 2011, Stonewall and Sigma Research conducted the largest ever survey of gay and bisexual men's health needs (Stonewall, 2012a). The survey was completed by 6,861 men in England, Scotland and Wales and one section of the survey focused on sexual health. They found that over a quarter (26%) of gay and bisexual men have never been tested for STIs. Eighty three percent of these gave the reason 'I don't think I'm at risk', 13% were 'scared' to have a test and nine percent said they are 'too busy'. Stonewall provide a breakdown by local authority and this shows that a similar proportion of men who completed the survey and live in Cheshire West and Chester have never been tested for an STI (27%), this figure is slightly higher for Cheshire East (33%; Stonewall 2012b).

In the national survey, all participants were asked 'have you ever had an HIV test?' and 30% of respondents had never had an HIV test. The most common reason for this was "I don't think I have put myself at risk (69%), 'I have never had symptoms of an HIV infection' (33%) and 'I have never been offered a test' (26%). Fear of a positive result (17%) and finding clinics intimidating (14%) were also common. Fourteen percent of respondents said they did not know where to get a test and more than half (54%) have never discussed HIV with a healthcare professional. The report concludes *"These figures do raise grave concerns about the effectiveness with which hundreds of millions of pounds of public money have been spent on HIV awareness and prevention in recent years."* (Stonewall 2012a). Information from the local authority data shows that local respondents have slightly lower levels of HIV testing; amongst respondents from Cheshire West and Chester 35% had never had an HIV test and in Cheshire East 33% had never had an HIV test (compared with the national figure of 30%; Stonewall 2012b).

Holistic Sexual Health

The World Health Organisation definition of sexual health takes a holistic approach that includes physical, mental and social wellbeing and acknowledges the importance of pleasurable and safe sexual experiences (Glasier et al 2006). Therefore, it must be remembered that sexual health for all people, including men who have sex with men, is not just the absence of STIs and HIV. Inability to express emotional intimacy in public due to fears of homophobic abuse has been found to be a common obstacle in sexual health for LGB people (Sigma 2000). It needs to be remembered that it is sexual behaviour, not purely sexual identity that is associated with increased risk of sexual ill-health. Other findings about sexual activities need to be addressed; twenty-seven percent of MSM have regretted the sex they have had and 27% have agreed to sex they did not want. Eleven percent of MSM have been forced to have sex when they did not want to in the last year (Sigma, 2000). This high figure suggests a great need for support and psychological services for those men who have been assaulted.

Accessing Sexual Health Services

In general, LGB people face many barriers to accessing sexual health services. A fifth of MSM have had a bad experience in sexual health services because of their sexual orientation, 17% of MSM feel they have less access to sexual health services and 29% of MSM do not feel safe enough to discuss sexuality with their GP/family doctor (Sigma, 2000). These barriers, or perceived barriers, to care could lead to undiagnosed STIs and other sexual health problems. Other barriers to good quality sexual health services can come from the health professionals themselves. One study in Sheffield found that GPs were not confident to discuss sexual health issues with non-heterosexual patients due to embarrassment about lack of understanding of sexual practices, not knowing the appropriate language and, in a minority of cases, personal prejudices. The GPs interviewed in this study suggested more training needed to be given about how they could improve these types of consultations (Hinchliff et al., 2005).

Best practice - Improving access to healthcare for the LGBT population

In 2007, the Department of Health produced a series of briefing documents called 'Reducing health inequalities for lesbian, gay, bisexual and trans people' (DH, 2007). They aimed to provide guidance to service planners, commissioners and frontline staff by raising awareness of the issues, informing them of the evidence and helping to inform the delivery of appropriate services, with the overall aim of helping reduce health inequalities for LGBT people.

Dodds et al (2005) suggest that improved openness and honesty, where men are assured of a non-prejudicial response in advance of disclosure, will increase professional capacity to understand the whole patient and make a correct diagnosis when one is required. They suggest the most obvious means of addressing this issue is to improve the quality of diversity training for health care workers. They recommend that training focuses on the dignity and human rights of LGBT clients and should be supported by non-discrimination and confidentiality policies that explicitly include sexual orientation. The Centre for HIV and Sexual Health in Sheffield also suggest ten tips for providing inclusive healthcare to all LGB people. These are presented in box 6.2 below.

The language that practitioners use can exclude many LGBT people. Terms such as 'husband', 'wife' or 'marriage' assumes opposite sex relationships only and can often force LGBT people to 'come out' when they may not have felt comfortable to. Using terms such as 'partner' and 'they/them' will avoid this problem and is also inclusive of heterosexual couples, regardless of their marital status (NHS Inclusion Project 2005).

Box 6.2 Top ten tips for providing inclusive healthcare

1. **Respect** the individuality of lesbian, gay and bisexual (LGB) people - LGB people are as unique and diverse as everyone else.
2. **Don't make assumptions** about a patient's sexual orientation.
3. **Be aware of the language** you are using when talking to patients. Does it presume heterosexuality? Try to use gender neutral language (e.g. partner). Listen to how people describe their identity and reflect this.
4. **Behaviour will not always match labels.** Someone may present as heterosexual but may have same sex partners or visa versa. Be open to this possibility.
5. **Create a welcoming atmosphere** where lesbian, gay and bisexual people feel comfortable discussing their health concerns. For example, display a statement in your waiting room explicitly demonstrating a commitment to fair treatment for all, irrespective of sexual orientation. And check that the practice environment is representative of all your patients.
6. **Promote respect of diversity** amongst all staff and encourage an environment where homophobia and heterosexism is unacceptable and can be challenged.
7. **Be aware of specific health issues** for different groups.
8. **Don't forget that families and friends of LGB people** can be affected by the sexual orientation of others and that specific support is available to them.
9. **Think about confidentiality** – consider discussing with the patient what you record in their notes about their sexual orientation. This information is potentially very sensitive.

Local initiatives to increase access to health services

Some work is being done in the north west of England to reduce barriers to healthcare for LGB people. In Lancashire and Merseyside an organisation called Navajo awards a Charter Mark to *“private and public sector organisations that take positive steps to welcome and encompass LGBT issues within their organisation or service provision”* Organisations which apply are evaluated by Navajo and if they meet the criteria are awarded the Charter Mark at an annual ceremony. So far 150 organisations across Lancashire and Merseyside have been awarded the Charter Mark (www.navajoonline.org.uk).

The Lesbian and Gay Foundation (LGF) runs a similar scheme called Pride in Practice; *“a benchmarking tool that identifies GP surgeries that are fully committed to assuring that their lesbian, gay and bisexual patients are treated fairly and able to discuss their issues openly with their GP or healthcare provider...This means that LGB people will be more likely to provide health care professionals with accurate information earlier on. As a result, they will be able to address health problems and unhealthy lifestyles without fear that divulging certain information, which could be needed by the health professional (such as sexual history, or specific issues relating to mental health,*

for example), will result in prejudice or discriminatory treatment.” However this scheme is specifically aimed at primary care (www.lgf.org.uk/for-professionals/pride-in-practice/)

Monitoring sexual orientation

Monitoring of the protected characteristics of age, gender and race is common across public bodies and health services. Monitoring sexual orientation is important because by law all public bodies must also think about how they treat people of different sexual orientations fairly and equally. The Equality Act 2010 requires all public sector organisations to take account of the needs of people with protected characteristics when designing services. The Public Health Outcomes Framework includes sexual orientation as one of the equalities strands against which the public health indicators are compared.

When health services monitor for sexual orientation they can safeguard against discrimination and ensure equal access to their services. Monitoring sexual orientation provides information to enable service providers to better understand their service users and deliver the appropriate services for their different needs.

The Lesbian and Gay Foundation have produced a useful and important guide to sexual orientation monitoring called *Everything you always wanted to know about sexual orientation monitoring... but were afraid to ask* (LGF 2011). The benefits to organisations of monitoring for sexual orientation include:

- Identifies inequalities between different groups;
- Enhances ability to identify issues that affect LGB people;
- Improves understanding of the potential barriers to services;
- Supports the ability to provide appropriate and tailored services, and to improve existing services;
- Supports the ability to monitor incidents of discrimination and prevent them from happening;
- Helps to measure performance, improvement and change;
- Improve processes to tackle problems;
- Lack of accessibility for LGB people may not be obvious without investigation;
- Sometimes people do not have a choice about where they access services, for a multitude of reasons (LGF, 2011).

Findings

Initially we had planned to conduct a focus group with men who have sex with men from Cheshire West and Chester and Body Positive Cheshire and North Wales (BPCNW) distributed information inviting their service users to take part. However, due to the very low response rate it was decided interviews would be a more appropriate method to collect data from local MSM. The focus group discussion guide, similar to the guides for the other target groups, was amended slightly to make it applicable for one-to-one interviews.

Two interviews were conducted in October 2013. Before the interview each participant was given an information sheet, any questions were answered and written consent was obtained. Each interview lasted approximately one hour and, with consent, both were recorded. Both interviews were conducted in private rooms, one in the Body Positive office in Crewe and the other in a council building in Northwich. Detailed notes were made from the recordings and thematic analysis conducted, quotes are included in the results and some elements have been anonymised to ensure confidentiality for the participants.

Throughout the interviews both participants referred to men who identify as heterosexual but also have sex with men as 'MSM'. This language could be confusing because in epidemiology and health literature the term 'MSM' refers to all men who have sex with men, no matter how they define their sexual orientation. These two participants used 'MSM' to *only* refer to men who would not identify as gay or bisexual. They did not include openly gay and bisexual men in the 'MSM' category. The researcher asked the participants for clarification on this and where necessary clarification has been included in the analysis below.

Participant one (P1) was a male in his 30s who lived in the Crewe area. Although the participant lives outside of the Vale Royal area he was one of only two individuals who volunteered to take part so was included in the data collection. Although he lives in Crewe, he talked about the experience of living in Cheshire generally not just about Crewe. He identified as gay and had lived around the north west of England, in a number of different cities, before settling in the Crewe area.

Participant two (P2) was also in his 30s and identified as bisexual. He lives in the Vale Royal area and is HIV positive. He also identified as being trans and described his gender as:

"I class myself in the gender fluid spectrum, in the middle. I flow between masculine and feminine, there are times when I am extremely feminine in the way I dress, my actions my mannerisms and behaviours. Then there are other times when I am extremely masculine" (P2)

He talked about how he was not able to express his feminine side in public as often as he would like to, when asked why this was he responded:

“That is down to the situation of where I live and opportunities where I am. Village communities are not the easiest. It is a commuter slash farming village. I couldn’t walk down to the local pub dressed as a female, it just wouldn’t happen. At the moment...I don’t have very much money, getting money to go to other places where I can be me is very difficult.” (P2)

Not being able to express this side of his personality caused depression and was not easy to deal with. Participant two was also living with HIV and some of the conversation focused on the support and treatment he received for his HIV. However, as HIV is not within the remit of this needs assessment we will focus on the discussion around sexual health in general.

Awareness of Services

Both participants were aware of the GUM clinics in Leighton and both had used the services at BPCNW. Participant one was not aware of other services within the Cheshire area but had used GUM and community services for gay men in other areas of the north west of England before he moved to Crewe. During the discussions participant one often compared local services to experiences at services in other parts of the region. Participant two was also aware of services in Chester and mentioned the Warrington GUM but did not know much about it, and had not used it. He also talked about using a GUM clinic in Staffordshire.

Neither participant thought the sexual health services were very well publicised and not many people necessarily knew about them unless they had a problem. Participant one discussed how he had taken a number of friends to Leighton Hospital for STI testing and they would not have known anything about the service without his guidance. He had never seen posters or information about the GUM and thought that people only found about it when they had symptoms and searched online for what services were available locally. Participant two, who lived in Vale Royal, was not aware of any of the local sexual health services in Winsford or at Victoria Infirmary in Northwich.

Experience of The Centre for Sexual Health at Leighton Hospital

Both participants had accessed sexual health services in Leighton Hospital. Participant one talked about it in detail and compared it to other GUM clinics he had attended in other areas of the North West. He was very positive about the staff, care and organisation of the Leighton clinic. He thought the staff had a caring and non-judgemental attitude and appreciated that they took the time to talk things through with you.

“In Leighton [GUM] they are really really good. They are really friendly. [The GUM in another big city in North West] was a bit impersonal. You go up to a glass window, give them your name, sit down and hand a form back in and then wait for hours. It is big and impersonal. But that it is how it is at a big GUM. But here [Leighton] it is quite...it’s a big building but it is smaller. The staff are really friendly and really professional. They remember you, which is good. You can go in and chat a bit and it is a much more relaxed environment to get tested. They don’t talk down to you either.” (P1)

Participant one compared it to the busy and impersonal service at GUMs in bigger cities, staff in these bigger clinics were thought to be more judgemental.

“When they talk down to you over and over and over... you see the same person you remember them but they don’t remember a thing about you. It gets quite...you’re given the same lecture.” (P1)

He thought the waiting time at the drop in clinic was acceptable and again better than in GUMs in other areas. He had taken friends who do not live in Cheshire to the GUM at Leighton Hospital and they agreed it is better than their local service so return to Leighton.

“They come back over [to Leighton] cos it is a nice relaxed atmosphere and they are not lectured. They explain things to you, if they are at risk it is talked about. But it isn’t explained in a way where you are talked down to. I think that is important....people aren’t treated like kids.” (P1)

He thought the GUM provide all the services one needed including HIV and STI testing, vaccinations and appreciated how they took the time to go over results in detail. He felt the service at Leighton GUM was very personalised.

“Rather than you just go in and they do things and you go out. They talk to you a bit, see what you have been up to, test you for what you have been doing, the right risks...they are more reassuring. They are really really nice...I recommend everybody goes [laughs]. The nurses are really really nice, very friendly and they can always find the vein [laughs]. They pick up things not directly related to sexual health, referrals to other hospital departments if they notice something and make you an appointment.” (P1)

He thought the location was easy to get to by car and the bus service was reasonable but not very frequent. The only problem with access was parking:

“Parking is a nightmare, they charge a fortune. £2.50 an hour, if you are there over a certain period it jumps up and they think you are there all day £15 or something.” (P1)

Participant two did not discuss Leighton Centre for Sexual Health in much detail as he usually attended The Countess of Chester Hospital (COCH). He knew people who used Leighton GUM and said they found it very good. He thought that Leighton was easy to get to by car but not by bus as from Vale Royal you had to get either a train and then a bus or two buses. Being out of town means it is not possible to walk from the train station or bus station. He also thought the parking fees at Leighton Hospital were too expensive. However, he also saw high parking fees as a drawback to the COCH.

Experience of the Centre for Sexual Health at the Countess of Chester Hospital (COCH)

Participant two attended COCH regularly for HIV care and STI screening. He had received his positive HIV test at another hospital outside the north west of England but now attended Chester for HIV care. He spoke positively about the service and staff at Chester. Again parking and public transport was a problem for accessing the service. As COCH is out of town it made public transport from Vale Royal very time consuming and the fuel and parking fees were expensive, especially if he was having to make frequent trips for HIV care. However, he did talk about having been lucky to find somewhere free to park near COCH which made attending regularly easier.

“The main issue is parking, there isn’t free parking anywhere...[if you have to go regularly] and pay the parking fees it is a lot of money.” (P2)

He thought the name of the clinic (Centre for Sexual Health) would discourage some people from attending, and thought it should return to ‘genito-urinary medicine clinic’. He thought calling it the GUM makes it more general and does not give the impression that everyone is attending because of STIs. He did appreciate some people do not understand the term and acknowledged he has more of an understanding of medical terms because of his family background:

“Chester is called ‘the sexual health clinic’ which I don’t think does it any favours...they should be called the GUM Clinic, what it used to be called. Cos the GUM Clinic isn’t just sexual health it is all gynae issues [sic]. For blokes it could be a problem with his prostate. There are many other reasons you could be going into a GUM clinic rather than sexual infection.”(P2)

He talked favourably about the availability of counselling at Chester which he thought was important for people who had received a positive diagnosis. Although he had not used the counselling he thought it was important that it is available.

Barriers to accessing services

As well as parking fees and the distance to the services, other general barriers to accessing sexual health services were discussed by both participants.

Opening times were discussed by both participants. If clinics are only available during weekdays this will discourage a lot of people from attending because people will not take a day off work for a routine check-up, participant two acknowledged that people would probably take time off work if they had symptoms but not for routine screening.

"You try and find anywhere open on a weekend. If you work, what chance have you got. You have no chance of accessing any GUM or sexual health service. It is putting them off cos they can't get there, they aren't going to take a day off work just to get an STI check. Taking day off to go for an MOT is ridiculous. Whereas if you had weekend access..." (P2)

Participant one also thought that the opening times might put people off attending, especially the MSM who identify as heterosexual.

If you are working and for the straight MSM, people probably wouldn't go because of the hours maybe. Finding the time to go...it isn't a quick process you are usually there for 45 mins to an hour...finding the time for them. (P1)

Participant one also thought there was a lot of stigma and fear associated with sexual health that discouraged people from attending services. People, especially the men who identify as heterosexual, would be scared that they would be seen by people they know and of being judged.

"The implication is if you are going to get tested you think you have got something....if someone sees you...they run several clinics at once so you could see your neighbour. Chances are very slim. But people worry. Especially with the MSM [men who identify as heterosexual but have sex with men] Gay, out men are aware and get tested quite regularly." (P1)

"A lot of married men, how do they explain to their wife that they are going to go for an STI check 'when I have only slept with you my dear'"(P2)

Participant one also thought people were scared to attend sexual health services because they did not know what to expect and had heard many myths and scare stories.

"Once you are in there they guide you through and hold your hand. But if it is your first time going and you don't know what to expect, hearing stories about when they used to do penile swabs. People love to try to scare you off...mention some horrible gruesome test they haven't done since the 80s... I think if you have never been it is quite intimidating cos you just don't know."(P1)

He thought this fear could be reduced by outreach work where nurses talk people through the process, answer questions and alleviate any fears. He also thought social media could be used to demystify the process.

"[Reduce fear by] nurses coming out and having a chat at a Body Positive group – if they are willing to just to answer questions or something. If they wanted to get all high-tech they could do some social media or something. Do a YouTube video 'come to Leighton and get your bits tested'" (P1)

Improving local sexual health services

Participant one thought the sexual health department at the Countess of Chester Hospital needed to improve the way they communicate results. He discussed the processes at other GUMs where they send separate text messages as soon as the results come through. He understood that Chester informs patients that if they haven't heard anything in two weeks the results are all negative. He felt having a text to say they are negative is much more reassuring as you worry for two weeks. He especially liked the idea of getting results for each test as soon as possible because he could be worrying about one specific infection. He thought the current system of waiting for two weeks made patients panic, especially if they received a call in that time. If there was a way to employ technology to communicate results it would reduce anxiety for patients. However, following a pilot study in 2010, the GUM at Chester successfully implemented the use of a computer-facilitated telephone system where negative results are automatically uploaded within 10 days of the patient's clinic attendance (Evans-Jones et al., 2011). It is possible that participant one's recalled experience was prior to the implementation of the telephone system, or that he was unaware of it at the time.

"If they call in that two week period, even if it is just [to repeat a test] I had a missed call...I thought 'oh my god' whereas if they'd just texted you...that would have been better. I asked them why and they said it was to do with data protection, you are calling my phone, it is my information please tell me. Any call from a doctor when you're not expecting one, that is it"(P1)

Participant two wanted GUMs to have more facilities and staff time to discuss and support patients especially those who had received positive results. This emotional support was especially important for those who had lifelong conditions such as HIV or herpes.

"You do need a soft room and couple of soft chairs. Just to sit down and have a cup of tea and a biscuit. When you've had bad news, even if it is something that can be dealt with, the chlamydia and gonorrhoeas, it is still not a nice thing." (P2)

Improving support for MSM in the area

The two participants did not know of any non-clinical or support services other than Body Positive Cheshire and North Wales (BPCNW). They both used the BPCNW services and spoke positively of their experience. One participant used the gay men's groups and commented that it felt like the funding had been cut to the organisation because the staff seemed to spend more time working in the office and less time facilitating the support groups. This was seen as a negative change as the groups were better when BPCNW were leading the discussion. The other participant accessed the counselling service available at BPCNW.

Participant one talked about what it was like to be a gay man in Cheshire. He compared it to the other areas he had lived in and thought it felt more closed-minded and that people were less likely to be open about their sexual orientation:

P1: "Yeah. I think the further you go from cities then more, definitely yeah. I sort of semi went back in the closet when I moved here. I moved to the suburbs and go down the street everyone has union jacks everywhere and being stereotypically 'Daily Mail', sounds horrible, but then you start chatting and getting to know people and they are really nice people. When you first look at it it is intimidating. We will hide being gay for now 'no we are just sharing a house' rather than a couple. Got to know neighbours told one and then everyone knows [laughs]"

He felt isolated socially and there were not as many services or places to meet other MSM. This meant that MSM from the area have to travel to access services or meet people.

"Isolated. There doesn't feel like there is much for a gay or bi man in the area in terms of....it is somewhere you go and you live and you go somewhere else to meet people. You go out to meet friends in Manchester, or Birmingham or Liverpool. From here to Chester it is just very far...Body Positive was the first thing socially that I found when I first moved here. There is a group in Macclesfield and Stoke." (P1)

He thought this lack of community meant men were less likely to identify as gay or bisexual and that there were more men who identify as heterosexual but have sex with men (discussed in the section below). He thought that the geographically spread out population meant people used websites more to meet potential sexual partners, and a lot of the discussion related to meeting men on websites and mobile phone apps. He thought MSM in Cheshire used websites more often than phone apps; this was especially important to ensure privacy.

"People use them [apps and websites] cos it is easy and convenient to meet up with people. A lot of it is just about sex. A few are about chatting and making friends, but most are about sex" (P1)

"In [big North West City] it seemed to be more app based, not the websites. In small areas it is websites cos you can delete your history. Whereas if someone sees your phone you have an app on your phone and that raises questions. Whereas if you can just delete browse history." (P1)

Participant one thought that these websites would be a good way to promote sexual health and target messages at local MSM, especially the men who identify as heterosexual. Promoting services, condom use and regular screening through these sites would provide access to all men, irrespective of how they defined their sexuality.

"If you could go through the websites and apps they use to meet men...if they were to agree to it...'if you have sex regularly you should get tested' don't say who you have sex with. I don't know if they could do it but targeted emails depending on how they identify as straight." (P1)

Participant one also described how isolating it could feel, especially at the weekend when there is no support or contact available, especially support for people living with HIV. He suggested an internet chat room for local men that is facilitated by an organisation like BPCNW and could be linked to names or hospital numbers. He thought it needed to be kept local so that it was personal and there would be some continuity.

When asked if there were any other ways for the NHS or local authority to improve the sexual health of local MSM, participant one didn't think the council had anything to do with sexual health and was surprised that they would be involved:

"When it comes to sexual health I don't think the council do anything at all...the council I think of those annoying people who keep messing up my road...and don't get me started on bins [laughs]" (P1)

With further prompting and after the changes in public health commissioning had been explained he suggested that having members of the gay community doing outreach work could be a way to improve the sexual health of local LGBT people. He discussed some projects he had been involved with in other areas and how these had raised awareness:

"If they could get the active members of the [gay] community involved, either as voluntary or pay expenses, to go out places and promote it...when I first came out I was involved with [gay youth and student groups] part of that they asked people to go with them to different places...we did presentations in school and businesses, maybe council, but they were very active in promoting the service. If you take that and you shift it onto sexual health maybe. Have people who can answer questions, people who have had the training...and people who aren't going to talk down and lecture. Talk about different STIs and testing. 'Community hero' isn't the right name for it but that sort of thing - outreach and volunteers" (P1)

Sexual health of men who identify as gay or bisexual

Both participants thought that men who identify as gay or bisexual were generally responsible about their sexual health, were more likely to use condoms and regularly accessed STI screening services. Participant two thought this was due to the health promotion aimed at gay men in the 1980s and he thought this had changed the mind-set of gay men, for gay men there wasn't as much stigma around STI testing as this has become the norm.

"A lot of the gay men that I know... tend to go for 6 monthly MOTs...quick check, make sure everything is running ok, make sure they haven't picked anything up. Especially the gay men, the bisexuals not so much, but the gay men have joined on with the bandwagon of 'we need to make sure we're healthy'. A lot of it to do with the tombstone advert in the 80s...HIV is the motivation. HIV is the one a lot of gay men are specifically being tested for. The health promotion has evolved from that point but has always been a higher priority than it has been for any other group. [For gay men] it isn't uncool to go for a sex check. It is the cool thing to do. It is the norm." (P2)

MSM who identify as heterosexual

During both interviews a lot of the conversation focused on the risk taking behaviour of men who identify as heterosexual but have sex with other men. Both participants referred to these men as 'MSM' and thought they engaged in more risky behaviour than men who actively identify as gay or bisexual.

They talked about groups of men who do not want to identify as gay because of prejudices or fear.

"You have the MSM group [who identify as heterosexual], they will sleep with a man 'but I am not bisexual' they are very difficult to get through to...Married men who sleep with men don't want to be classified within gay or bisexual group, because of the prejudices they had been brought up with" (P2)

From his experience, participant two thought these MSM who identify as heterosexual are less likely to want to use condoms and more likely to have multiple partners.

"They are also the highest risk group....sexual infection...because they tend to be more promiscuous with multiple partners rather than the same partner. They don't want to be seen with one person too often so they use cruising grounds, the saunas and they tend to be not wanting to use condoms, the whole thrill of bareback. There is a lot more risk involved." (P2)

"The MSM you chat to [online], they think condoms are optional" (P1)

Participant one thought this might be a practical issue for some men as they do not want to keep condoms in their house where they might be found by their families.

"If you've got a stack of condoms just for when you meet men... if you hide them in the house they could get found. There is issues around it...you can't." (P1)

The MSM who identify as heterosexual are also less likely to attend sexual health services and have STI screening. Often they feel like they can't access sexual health services because someone may find out and ask questions, or because they do not think they are at risk and just don't think about it.

"All the straight MSM I know are either in a relationship [with a woman] or so far in the closet they don't actually...there are a few people near me married with children. The situations a lot of them are in it is hard for them to go and get tested cos if they disappear off out or someone asks 'why you getting tested? What have you been doing to need it?'" (P1)

"[MSM who identify as heterosexual] they don't think about things like 'I don't want to catch anything', they think 'well I haven't got anything'. But I don't know, they have 30 verifications on

their website 'you've met these people recently, I am sure you have something...when were you last tested?' And they don't really know. They give excuses and things." (P1)

Both participants were asked about possible ways that MSM who identify as heterosexual could be encouraged to use condoms, access services and test regularly. Both thought it was a very difficult challenge and struggled to think of ways to target these men, mainly because these men do not identify as gay or bisexual even though they have sex with other men.

"I am not sure it is actually possible. They would need to engage with and identify with [being gay], I think part of gay and bi men being so on top of their own sexual health is partly because they identify as belonging to a group whereas these straight men, they don't, they see themselves as straight and occasionally have a play on the side." (P1)

"Enormous question [laughs], cos you can't advertise through the typical LGBT routes. How do you get it through your general everyday straight life...if you just happen to sleep with a man' it is not going to work." (P2)

Three possible ways were suggested of targeting these men; outreach work and health promotion in cruising areas and the sauna, changing society's attitude to homosexuality and ensuring that heterosexual people are as responsible about sexual health as gay men.

Both participants discussed that local MSM who identify as heterosexual use cruising grounds. They both suggested these spaces provided opportunities for health promotion, especially at the men who identify as heterosexual. Distributing condoms and promoting regular screening in these cruising areas could also capture the men who do not identify as gay or bisexual but engage in risky activity. However both participants acknowledged that health promotion in public areas is a difficult problem because the spaces are used by other people during the day.

"I heard they are putting condom dispensers around cruising areas. ...there are a few around here, parks and toilets. But it is the next day when people are walking their dogs and they see condoms....people will do it anywhere, so here is a machine buy a condom do it properly." (P1)

"There is a cruising ground on the [road]. It is quite well known, the police know about it and go down there quite often. But it is getting information through to places like that. It is a layby. But it is a layby that during the day has a café that families use. So you can't put a big billboard up saying 'stick a condom on it'." (P2)

Participant two discussed how the GUM outreach work in the Northwich sauna will be targeting some of these MSM who identify as heterosexual by bringing STI testing to them. He acknowledged there were some problems with the reliability of postal HIV tests but thought for the people who

would never attend an STI clinic these tests were better than nothing. He thought this was probably the only effective method of testing the MSM who identify as heterosexual.

“They have nurses [in the sauna] once a week doing STI testing. They are doing take home STI kits. But they don’t do HIV kits, which is something I would like to see. Chester isn’t overly keen on them, the HIV tests. They can give false positives they can give false negatives. But if you are dealing with a secretive community that won’t go to an STI clinic you need to take it to them. Even if it isn’t 100% reliable, it is still going to catch a lot.” (P2)

Participant one suggested that the wider issue of homophobia and the prejudices of the wider society need to be addressed. If more men could be encouraged to accept their sexual orientation, be open about it and identify that they were bisexual then health promotion messages might be more accepted and men would feel less need to hide their identity.

“But even just removing that strange mental block of ‘I’m not gay because I put my penis in a man. ..I think slowly introducing the idea that if you are straight and occasionally have sex with men it isn’t a big deal. It doesn’t mean you’re gay. Kind of getting that idea of ‘so what it doesn’t matter. You are what you say you are there is no shame in it’. Then they would probably be a bit more open about it and be more inclined to get tested and behave sensibly.” (P1)

Both participants suggested that to encourage MSM who identify as heterosexual to take fewer risks and access sexual health services you need to change the mind-set of the heterosexual population. They both thought that heterosexual people, especially heterosexual males, are less likely to access sexual health services than men who identify as gay. If you cannot specifically target the MSM who identify as heterosexual then you need to target all heterosexuals and encourage all sexually active people to use condoms, access sexual health services and regularly screen.

“I think if you target the straight community and bring them up to the same standard they [the MSM who identify as heterosexual] would be dragged up with it.” (P1)

“It is the norm [for gay and bisexual men to go for STI screening]. Whereas I don’t think it has got that way in the heterosexual community yet. It is starting to become more of a thing that people do, that young people do. But it needs a lot more work to bring it to the same point that it is within the gay community, that people will openly say ‘I am going to the sexual health clinic for a quick MOT’. Once you get it to the accepted stage within mainstream heterosexual community then you’re going to get the MSM [who identify as heterosexual] coming along. I think that is the only way you are going to target the MSM group to join in and start getting checked more regularly.” (P2)

Support for the local trans community

Although this section mainly focuses on the target group of MSM there was a lot of discussion with participant two about the local trans community. MSM and trans people should not necessarily be seen as two distinct groups with different needs as there is a lot of cross over.

Participant two believed trans people were more at risk of sexual ill-health because of two main factors; they are more likely to be promiscuous and they are less likely to insist on condoms. He thought that both of these were because trans people want to feel accepted and through sexual encounters they can find some acceptance they don't get in other areas of their life. This is all encapsulated in the quote below:

"The trans community...tends to be very promiscuous. But that is on a different scale because they do it to feel accepted. To be accepted as a woman. Even if it is for that three minutes, half an hour of a man treating them as a woman...it is the acceptance. And once they have had it once they tend to go back for it more and more just for that...cos trans is such an unaccepted thing, by general communities, one of the biggest things trans people have is just walking down the road and the abuse that gets hurled. So to all of a sudden have 20mins where someone accepts them and makes them feel nice... they will do anything, like not use condoms." (P2)

Participant two discussed how secretive trans people are about their gender identity and how this leads to feelings of isolation and mental health problems.

"With trans you're dealing with such a bunch of people...HIV is secretive, I have friends and their close family don't know the diagnosis, because of prejudice...but the trans community is even more secretive...they hide. ...they can hide it for 20, 30, 40 years. There are trans people who have never met another trans person...and wouldn't even know where to look. But they have been trans all their life and they die trans." (P2)

He thought that trans people use the sauna and engage in risky sexual activities because it gives them some level of acceptance.

"[Trans people use the sauna] just to be who they are. They then get the gratification of acceptance because men are coming onto them, which then alleviates some of the mental problems of non-acceptance of who they are" (P2)

Participant two discussed that there is often sexual activity between MSM who identify as heterosexual and trans women, this then means that two groups who are less likely to use a condom are taking even more risks.

“And quite often the MSM [who identify at heterosexual] group goes with trans women, because it’s not sleeping with a man. So they rationalise it ‘I’m not sleeping with a man it is a trans woman’...the MSM are less likely to use protection and trans people will do anything to get that acceptance for 20 mins, so they accept not using protection. And it snowballs.” (P2)

Participant two believed there was a strong need in the Vale Royal area for a support group for trans individuals. The only support groups for trans people are very difficult to access from Vale Royal, due to cost and distance, there are groups in Rhyl, Manchester and Stoke. He referred to some research that Body Positive had done in the Northwich Sauna that had showed that all 16 of the trans respondents had said they needed a support group in the local area. The problem is with funding and finding an appropriate space. He suggested that Northwich is ideally placed to host this service.

“If you do geographic map Northwich is the centre of the hole...it is the centre of Rhyl, Stoke, Manchester, Shrewsbury...it is the middle of the hole. It is an ideal location.” (P2)

The problem was finding an appropriate venue as the group would need somewhere with multiple rooms as the members need somewhere to get changed.

“But finding the location is difficult...somewhere that is suitable. Need a minimum of two rooms and somewhere to make drinks, because you need a changing room cos 95% of trans people are not out to anybody....so need to get changed there.”(P2)

He also suggested the meeting would need to last 2-3 hours as it takes a long time for trans people to get ready as there is a lot of makeup and a lot of preparation, and then you need time at the end to take all of the makeup off.

“If it is only an hour meeting...the majority need to be 2-3 hours to allow people enough time to relax to be who they are” (P2)

Although the Northwich sauna has a trans day on a Wednesday this is not appropriate for some trans people because the sauna is mainly a venue to meet sexual partners and being trans is about more than sex.

“There is nothing in this area that supports anyone who is trans. The gay sauna in Northwich has a trans day on a Wednesday, but when I am in a female persona I don’t want it all to be about sex. So that doesn’t fulfil the role. You got to the sauna and all you get is pickup lines permanently. It’s not me, it is not who I am”(P2)

However, participant two also discussed some people he knew who would not necessarily identify as trans but dress as trans to facilitate sexual encounters.

“There are trans people I know who get dressed up and go cruising cos they know they can get sex. Cos that is another aspect of trans, people who dress as trans cos they can get more sex doing it. They can get the MSM and bisexual people who just fancy trans women. They are targeting a group they know they can get what they want.”(P2)

The Northwich sauna

Both the participants discussed how the sauna attracts MSM from out of the area as people are worried about being seen and people knowing they are visiting the sauna.

*“People travel out of area to go to saunas, so nobody recognises their car in the sauna...in case grandma is driving down the road and says ‘that is my Johnny’s car, what is he doing there?’ So they will travel. There isn’t the social tie to an area so they can be more open and leave their car outside.”
(P2)*

Participant one discussed how people from all over the country visit the areas for business, including overseas business men who are visiting local businesses, and how they arrange to meet in the sauna for sex.

“People travel to Crewe to work, they are here for a couple of days then they go away again. They will go over there [the sauna]. You see it in the [online] boards, people from outside the areas use it as a place to go and meet. This happens in most saunas but it is convenient in Northwich, it is cheaper than a hotel and there are more men there.” (P1)

Participant two thought the Body Positive and GUM outreach at the sauna was good and participant one had some comments about the sexual health information provided in the sauna. He described the information board and information in the entrance of the sauna as being important but not very visible. He acknowledged it was the only place they could put it but thought it wasn’t very obvious and people just ignored it. He suggested by drawing more attention to it with light this might mean people take on board the messages:

“Just putting a spotlight on the table, cos it is quite dark. It is one of those boards with stuff on it...if they just had a spotlight above it so you could see it. There are no windows and it isn’t a very brightly lit area. Just making it a bit more prominent would probably be enough”. (P1)

7. FURTHER INSIGHTS INTO ‘SELDOM-HEARD’ GROUPS: ADULTS WITH LEARNING DISABILITIES

Box 7.1 Key findings – adults with learning disabilities

- Three adult women with a learning disability were interviewed face-to-face, with their carers present. Interviews explored: the understanding of sexual health and relationships, awareness of services, experience of services and potential barriers to accessing services;
- The understanding of the term “sexual health” amongst the interviewees was generally low;
- There was some understanding of the word “sex” and what this entailed, some understanding of contraception, personal anatomy and preventing pregnancy. However, not all participants understood what sex was or what sexual health entailed;
- Doctors (GPs) were trusted individuals with whom the participants felt able to discuss sex and contraception;
- Participants were unaware of other places they could access sexual health information, although two were able to speak to their parents;
- All interviewees were in relationships, two of which were sexual and both these women used contraception and knew why they were using contraception. One of the women did have an understanding of sexual health and some knowledge of STIs.

Background

Services for adults with learning disabilities in Cheshire West and Chester including support groups where advice could be sought on personal and sexual relationships, were once jointly provided by health and social care (by occupational therapists, community nurses, day service staff). This also included in-house training to provide staff with skills and ensure they understood and felt comfortable with the subject of sexual health. As adults with learning disabilities have moved into supported accommodation, these support groups have ceased to operate and their role has been fulfilled by support staff from the housing providers. Service providers estimate that about a third of the people with a learning disability in the former Vale Royal LA area would benefit from some information/education delivered specifically to help them understand about caring relationships and staying safe and healthy (personal communication, Deborah Magee, Cheshire West and Chester LA).

Box 7.2: Department of Health definition of learning disability

The Department of Health defines learning disability as a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence) along with a reduced ability to cope independently (impaired social functioning) which started before adulthood with a lasting effect on development (DH, Valuing People White Paper, 2001b).

Sexual health of people with learning disabilities

Studies have found that young people with learning disabilities are more likely to engage in risky behaviours, including marijuana use, smoking, alcohol consumption, suicide attempts and acts of

violence and minor delinquency, when compared with their peers (Blum et al, 2001, Hollar D, 2005, McNamara et al 2008). However, there is dichotomised evidence when addressing the relationship between learning disabilities and high risk sexual activity. A study by Blum et al (2001) found that adolescents with learning disabilities were more likely to have an early sexual debut. Conversely, in a study by McNamara et al (2008) no significant difference was found for high risk sexual activity in adolescents with learning disabilities compared to their peers, suggesting that adolescents with learning disabilities and with no learning disabilities were comparable in their sexual behaviour. Importantly, however, these studies concur that adolescents with learning disabilities are at equal if not higher risk of unsafe sexual activity when compared with their peers.

Young people with learning disabilities often experience low self-esteem, poor language and communication skills and poor negotiating skills and these factors have been found to increase the likelihood of these young people being in unsafe situations, having unprotected sex and being more susceptible to abuse and exploitation (Doyle, 2008).

Mandell et al (2008) examined the relative risk of sexually transmitted infections (STIs) amongst adolescents with learning disabilities as identified by the US special education system. They estimate that around 3% of males and 5% of females were treated for an STI in a 12 month period. Studies have also found that lower cognitive ability is significantly linked to early pregnancy (before age 18) and on average women with lower cognitive ability initiate sexual activity 1.4 years earlier than those with higher cognitive scores (Shearer et al, 2002). Adolescent males and females with lower cognitive ability have been found to have three times the odds of contracting a sexually transmitted infection and females three times the odds of becoming pregnant when compared with their peers and this remains at two times odds when taking into account different economic circumstances (Cheng and Udry, 2005). This higher prevalence, particularly in females, could in part be accounted for by higher levels of diagnosis in this group due to increased and regular contact with health and social care organisations. However, even if true prevalence in this group is similar to overall adolescent prevalence, it represents important implications for policy and the development of services and interventions.

Evidence from a UK study in South East London suggests that gay men with learning disabilities are disproportionately involved in higher risk sexual behaviours including cottaging and cruising. Men in this group were also found to be at a disproportionate risk of exploitation due to an imbalance of power and at higher risk of STI transmission due to a lack of knowledge or understanding of safer sex and condom use (Cambridge, 1996).

Between 2007 and 2010, CHANGE (a national organisation campaigning for equal rights of people with learning disabilities) undertook research in collaboration with the University of Leeds using Big Lottery Funding. Using drama role play, interviewing parents of young people with learning disabilities and talking to groups of teachers, the following recommendations were drawn up to inform areas where change is needed: there needs to be more accessible information about sexual health available; there should be more support for young people with learning disabilities about sex and relationships and similar support for the parents of young people with learning disabilities; families from black and minority ethnic communities should get the right support; young people with learning disabilities need more chances to meet with friends and be independent; people should see sex education for people with learning disabilities as important; there needs to be better

training for professionals about sex education; and, young people with learning disabilities have a right to sex education (CHANGE, 2009).

ChaMPs Public Health Network (Cheshire and Merseyside) outlined a number of ways in which it is important to consider the needs of young people with a physical and/or learning disability in sexual health promotion. They suggest a number of tips, some of which can be applied to adults with a learning disability where appropriate. See box 7.3 below.

Box 7.3 Top tips for sexual health promotion with young people with a physical and/or learning disability

- Ensure that sex and relationship education (SRE) is part of the overall curriculum for people with disabilities. Provide tailored sexual health promotion, education and individualised sex education plans for people with disabilities, to meet their specific needs;
- Encourage health care professionals and carers to initiate discussions on sexuality, dealing with issues relating specifically to the disability itself;
- Consider the fact that children with developmental disabilities are more likely to experience early pubertal changes, and so have to cope with puberty earlier than their able bodied peers;
- Provide deliberate training to promote independence in self-care activities. Ensure young people are afforded sensitive and confidential discussions with health professionals with dignity and privacy;
- Support parents and carers in recognising the potential of children and adolescents with disabilities to enjoy intimacy and sexuality in their relationships;
- Encourage positive attitudes to disability and sexuality, including challenging negative stereotypes and misconceptions.

ChaMPs (2009) Top Tips for Sexual Health Promotion. ChaMPs Public Health Network.

relationships and this group are rarely seen at sexual health services, with a lack of specialist clinics for adults with learning disabilities offered in a GUM setting (Clark et al, 2007). The barriers which prevent adults with learning disabilities from accessing sexual health services are varied and complex but the main body of literature on this topic can be divided into four main areas; societal attitudes; issues of knowledge and communication of health information; attitudes of parents and carers, and; awareness and attitudes among healthcare professionals (including issues of consent).

Societal attitudes

Despite supportive government strategies, the sexual health of adults with learning disabilities often remains a taboo topic, with adults with learning difficulties often being side-lined or excluded from sexual advice. Much of this is linked with historical views of adults with learning disabilities as either non-sexual beings or as sexual deviants. Whilst many of these views have been dissipated as adults with learning disabilities have moved on from institutional care and become more established in society, the need for adults with learning disabilities to have relationships is frequently overlooked (Futcher, 2009).

In 2009, the Department of Health produced a three year strategy in response to the Joint Committee of Human rights addressing this issue (DH, 2009). The key recommendations from the

strategy were that commissioners and local leads should work together to develop systems which help people with learning disabilities build and sustain relationships, encourage registered care services to help adults with learning disabilities develop relationships and develop relevant toolkits for professionals. It is thought that often adults with learning disabilities do not seek sexual health advice because they do not know that such services exist (Ly, 2009).

Adults with learning disabilities also lack opportunities to explore their sexuality and significant barriers exist in enabling adults with learning disabilities to consent to same sex relationships. Adults with learning disabilities often encounter negative attitudes from family and care staff when exploring their sexuality and can experience discrimination, bullying and harassment. Research has also identified that negative attitudes towards adults with learning disabilities often exist in the LGBT community and a lack of support from care staff to enable adults with learning disabilities to meet people from the LGBT community (Foundation for People with Learning Disabilities, 2010, Norah Fry Institute, 2005).

Lack of knowledge and information

Adults with learning disabilities tend to be neglected in national sexual health policy with information tending to focus on those groups considered at highest risk particularly young people, men who have sex with men and those from black and minority ethnic groups. Several studies have found that adults with learning disabilities lacked knowledge in several key areas including pregnancy, contraception, STIs and legal consent (Murphy 2003, Galea et al 2004). Research comparing sexual health knowledge among adults with mild learning disabilities compared to non-disabled 16 year olds found that knowledge of sex and understanding of sexual abuse was much lower among adults with learning disabilities. For example 60% of the adults surveyed had not heard of AIDS and only 18% could identify condoms as a way of reducing HIV infection. Only 55% of adults with learning disabilities stated they had received sex and relationship education (SRE) at school compared with 98% of 16 year olds, and those adults who could recall SRE scored significantly higher on sex education and vulnerability assessments (Murphy, 2003). Studies looking at contraception use among women with learning disabilities found that there is often insufficient information and attention given to confidentiality and consent with few women feeling that they had control over their choice of contraception (McCarthy, 2009).

A review by NHS Scotland found that the following barriers to accessing healthcare services to be commonly identified: short appointment times, a reliance on the ability to read and the reactive delivery of healthcare which is reliant on people coming forward to ask for help, poor coordination of information between services, physical access barriers as those with learning disabilities will experience higher levels of physical disability and institutional discrimination (2007).

Attitudes of parents and carers

Research suggests that conflicting and negative views from family members or carers can often have a negative impact on the self-confidence of adults with learning disabilities and this in turn can impact upon them forming relationships and accessing sexual health services (Futcher, 2011, Greive, 2008). Adults with learning disabilities will have to adjust to differing attitudes from family and carers and that this is not only across the different services they use but also individual staff within teams and services. For example, nationally around 8% of women with learning disabilities will

attend for a cervical smear test compared with 79% of all women nationally. The related literature suggests that this low uptake is associated with the assumption that most women with learning disabilities will not be sexually active combined with the notion that women with learning disabilities will be more difficult to screen and concerns among GPs that consent would not be given (Broughton and Thompson, 2000).

Research suggests that attitudes are linked to numerous characteristics; with older people tending to hold less liberal views than younger people, and families tending to have less liberal views than care staff who have had training around sexuality (Futcher, 2011, Cuskelly 2004, Krellou 2003). Parents generally feel they lack the knowledge and confidence to discuss sexual health issues, especially as talking about such issues often does not occur easily in their relationships. Parents also tend to have protective attitudes linked to the fear that increased sexual knowledge may increase the risk of sexual abuse (NHS Scotland, 2007). Research suggests that staff in support agencies are often influenced by personal views rather than policy; a study found that 95% of support staff felt women with learning disabilities should have the freedom to express their sexuality but only 45% felt that support organisations viewed women with learning disabilities as sexual beings (Christian et al 2001). Parent and carer involvement has been shown to improve the effectiveness of sexual health services (NHS Scotland, 2007).

Awareness among healthcare professionals

A recent literature review completed by NHS Scotland (2007) found that many NHS staff lacked confidence and felt unequipped to provide sexual health services and SRE to people with learning disabilities. It also found that there were tensions between protection and empowerment for people with learning disabilities and that staff expressed concerns about negative parental reactions to sexual health services.

Issues of consent to treatment for those with learning disabilities are often an unclear area for healthcare staff. While legally, adults with learning disabilities have the same age of consent as the general population; this often conflicts with policy and guidelines for treatment for vulnerable adults and the risks of exploitation. Evidence suggests that staff involved in STI screening feel under-informed on where consent must be gained from the patient and where “best interest” (i.e. the healthcare professional assuming responsibility for acting in the patient’s interest) comes into force (Clark and O’Toole, 2007). This highlights the need for specific training for staff on issues of learning disabilities as well as reworking of the Royal College of Nursing Guidelines on consent which solely focus on young people.

Murphy (2003) suggests that a minimum level of understanding should be a requirement for consent based on the knowledge that sex is different from personal care, penetrative vaginal sex can lead to pregnancy, penetrative anal sex is associated with an increased risk of HIV infection and that people have a choice about whether to engage in a sexual relationship.

Adults with learning disabilities in Cheshire West and Chester

- There were 1,085 adults with learning disabilities known to GPs in Cheshire West and Chester in 2012, of whom 925 were known to Cheshire West and Chester Local Authority;

- The rate of learning disabilities among the adult population was 3.87 per 100,000 population, significantly lower than the North West and national average;
- In 2011/12, 64% of adults with a learning disability attended their GP for a health check and in 2008-2009 (the most recent year for which data are available), 41% of adults with learning disabilities had an emergency hospital admission. Both of these rates are better than the national average;
- Identification of adults with learning disabilities in general hospital admissions was worse than the national average, with only 23% of adults with learning disabilities being identified in hospital statistics;
- 79% of adults with learning disabilities were living in settled accommodation in 2011/12. Access to specialist services was higher than the national average with 43% of adults aged 18-64 using day services and 84% accessing community services;
- 5% of adults with learning disabilities were in paid employment in 2011/12;
- Rates of referral for abuse of a vulnerable person among adults with learning disabilities in Cheshire West and Chester in 2011/12 were 38 per 1,000 population.

Source: Learning Disability Profiles, 2012

Findings

Semi-structured interviews were conducted with adult women with learning disabilities, with varying forms and severity of disability. Interviews were facilitated by the researcher and took place face-to-face with each of the individuals and their carers. The carer would help to facilitate communication between the researcher and the individual, by clarifying what the individual had said and helping the individual understand questions. In total, three adult women were interviewed face-to-face (with their carers present). Interviews explored: understanding of sexual health and relationships, awareness of services, experience of services, and potential barriers to accessing services. Findings from each interview are described below. Audio recording of these interviews was not possible, therefore, notes were made by the researcher and used to describe the content of the discussions which are presented in the case studies below.

Participant one (P1), aged 60 years

P1 explained how she had a long term sexual relationship with her boyfriend of 15 years. When asked what she felt 'sexual health' meant, P1 explained how she understood the term sex but was less familiar with the term 'sexual health.' P1 explained how this to her meant 'looking after lady bits' and making reference to not being pregnant. P1 was asked about relationships, and was aware of different sexual relationships and orientations of other people, discussing lesbian and gay relationships. P1 was asked about where she accessed information on sexual health, and who she would talk to about sex. P1 explained how her parents had given her some sex information, and that her parents would take her to a doctor to talk further about sex and pregnancy. P1 explained how she would ask her doctor questions about sex, and also talk about her boyfriend to her doctor. When asked who should people ask if they wanted to find out more information about sexual health, P1 said that she would 'tell them to see a doctor', and also explained how she would ask her support worker or key worker if she wanted more information. P1 explained how she would not talk about her experiences with anyone else, and there was no-one else she knew of that she could talk to

about sex. P1 explained how she trusted her doctor, and knew that their conversations about sex were private. P1 also explained how she would visit the doctor with her friend, who was a service provider. P1 explained how she felt slightly embarrassed, but that 'it doesn't bother' her much.

Participant two (P2), aged 46 years

P2 explained how she had a younger boyfriend who she speaks to every day over the phone. When initially asked about sexual health, P2 did not understand the term, and did not understand what was meant by the word sex. P2 was asked what her understanding of a relationship was, and she spoke of a relationship involving a man and a woman, speaking of two people 'with only one for a boyfriend'. P2 explained how sex involves a man and a lady, and drew a picture of a penis. P2 was asked about where she accessed information on sexual health, and who she would talk to about sex. P2 explained how she did not speak to her parents about sex, or her keyworker, but explained how she spoke to her doctor about sex. P2 discussed how she was not embarrassed to talk to her social worker or her mum. P2 spoke of talking to her boyfriend about sex, and explained how she liked speaking to her doctor about sex as it was private and she could trust her doctor. P2 spoke of how her boyfriend 'had problems and put a cream on it.' P2 spoke of getting married to her boyfriend in a few months, and then made reference to having another boyfriend. P2 was asked if she and her boyfriend have sex, P2 replied 'yes' spoke of being 'stuck together', and explained that her boyfriend had bought condoms. P2 explained how condoms prevented a baby, and explained how she wanted a baby when she was married, but 'not yet.' When asked who she would ask if she wanted to find out more about sex or sexual health, P2 explained how her mum may take her to the doctor, or how her and her boyfriend could go to her doctor together with her carer. P2 explained how she 'doesn't worry about pregnancy' as she uses condoms as contraception.

Participant three (P3), age unknown

P3 explained how she was in a relationship. When asked what she felt 'sexual health' meant, P3 explained how the term 'sexual health' meant 'the bits women have' and made reference to smear tests. P3 also spoke about STIs such as chlamydia and thrush, and explained how these infections can pass between people. P3 was asked about where she accessed information on sexual health, and who she would talk to about sex. P3 described how she would see her doctors, and would not speak to her parents about sex or sexual health. P3 explained how she trusted and knew her doctor well, and would speak to nurses. P3 also explained how she 'doesn't know about other services' where she could access further information. P3 explained how she took two buses to see her doctor, and needed help to attend her appointment. P3 explained how she would 'read leaflets' and take some home to read after her appointment. P3 described that she was not worried about pregnancy, because she was 'protecting' herself 'using the pill', and mentioned how she had regular 'check-ups'.

Overview

All the women stated they would access their GP for more information on sexual health, with one saying they would talk to their support worker/key worker or social worker. All the women explained how they were unaware of other places they could access for further sexual health information. Two of the women spoke of gaining information about sex from their parents.

All interviewees were in relationships with boyfriends, two of which were sexual. Both of these women used contraceptives (the pill and condoms), which were obtained from their GP and their boyfriend, and they were able to explain why they used contraception. One woman was able to explain sex and sexual health and gave examples of STIs and described how they could be transmitted between sexual partners. One woman was uncertain of what sex was or what sexual health entailed. Not all questions outlined within the focus group discussion guide were able to be asked, as two out of the three participants did not understand the words and terms used.

8. FURTHER INSIGHTS INTO 'SELDOM-HEARD' GROUPS: CARE LEAVERS

Box 8.1 Key findings – care leavers

- In 2011/12 there were 365 looked after children in Cheshire West and Chester, a rate of 55 per 100,000 children aged under 18. In 2012, 145 children ceased to be looked after, of whom 34% were over 16 years of age and 14% moved into supportive accommodation. Among 19 year olds who were looked after at age 16 years, 76% are in education, training or employment and 86% are in suitable accommodation.
- Research shows that young adults who have been looked after are more likely to have:
 - an earlier sexual debut (Crocker and Carlin 2002);
 - a higher median number of sexual partners (Carpenter et al, 2001);
 - higher levels sexual risk taking (Barn and Mantovani, 2007; Risley-Curtiss, 1997);
 - increased risk of sexually transmitted infections during young adulthood (Ahrens, 2010);
 - younger age at first conception (Carpenter et al ,2001);
 - received less or no SRE in school (Knight et al, 2006; Hudson, 2012).

Knowledge of sexual health and sexual health services

- Participants viewed sexual health as one aspect over their overall health and wellbeing;
- There was generally a good awareness of sexual health and sexual health related issues;
- There was good awareness of sexual health services with all participants able to name their nearest service and understanding the different services offered in general practice, CaSH and GUM;
- General consensus was that information on sexual health services came via word of mouth and that friends had an important influence on choice. All participants first visit to a sexual health clinic was with a friend.

Care leavers / Looked after children and sexual health

- There was a consensus that young people who had been looked after took risks with their sexual;
- Risky behaviour was associated with a number of factors including experience of childhood abuse and the need for attachment;
- It was felt that not all care leavers would feel confident accessing services.

Experiences of sexual health services

- Experiences of sexual health services were mixed; some negative and some positive;
- Participants identified several elements of the service were identified which impacted upon their experiences namely issues of privacy, opening and waiting times, staff attitudes and paperwork;
- The majority of participants reported positive attitudes towards their GPs and stated this would be their preferred option for sexual health services.

Key findings continued...

Improvements to sexual health services

Participants wanted:

- A sensitive service; open and understanding of the complex emotional and mental health needs of those who had been looked after;
- Visible links between NHS and Social services with clear and visible signposting and active involvement from NHS staff;
- “Loud and proud” public health promotion that had active public promotion outside of NHS settings.

Background

Looked after children have complex and diverse individual needs and addressing the health outcomes of this group is vital as they have some of the worst outcomes of any group of young people nationally. Guidance on improving the health and wellbeing of looked after children, published in 2009, stated that all local authorities and health agencies should “*make sure that all looked after children and young people are physically, mentally, emotionally and sexually healthy, that they will not take illegal drugs and that they will enjoy healthy lifestyles*” (DSCF and DH, 2009, pg.5). This duty of care continues past childhood to ensure that looked after children continue to have improved health outcomes during early adulthood. The *Children Leaving Care Act 2000* has been in operation since 2001 and requires local authorities to provide continuity of care and support for young people leaving care up to the age of 21 years. The act was created to ensure that young people did not leave care until they were ready to do so. Through the development of a pathway plan by a young person’s sixteenth birthday, local authorities ensure that effective support is in place to meet the young person’s needs as they transition to independent living.

Children and young people in care will experience many of the same health issues as their peers but often to a greater extent and factors including poverty, experience of abuse or neglect, poor parenting and chaotic lifestyles mean that young people often enter the care system with worse health outcomes than their peers. Young people leaving care are particularly vulnerable and they are likely to have worse health and wellbeing than those who have never been in care and these health outcomes generally worsen within a year of leaving the care system (DSCF and DH, 2009). These poor outcomes include increased drug and alcohol problems, higher levels of mental health problems and poorer sexual health outcomes. Research has shown that young people who have experienced the care system are more likely to have an earlier sexual debut (Crocker and Carlin, 2002), have higher levels of sexual risk taking (Barn and Mantovani, 2007, Risley-Curtis, 1997), have increased risk of sexual infections during young adulthood (Ahrens, 2010), a younger age at first conception (Carpenter et al, 2001) and have received little or no sex and relationship education (SRE) in school (Knight et al 2006, Hudson, 2012).

Looked after children and young people in Cheshire West and Chester

- In 2011/12 there were 365 looked after children in Cheshire West and Chester, a rate of 55 per 100,000 children aged under 18;
- 160 children and young people started to be looked after in 2012, 34% of whom were taken into care. The majority of children and young people starting to be looked after in 2012 were due to abuse or neglect (57%) with a further 26% due to family dysfunction;
- The majority (49%) were under full care orders, with 22% under interim care orders. In Cheshire West and Chester, 79% of looked after children were in foster placements with a further 9% in secure units, children's homes or hostels;
- In 2011/12 52% of looked after children were male and the highest proportion (40%) were aged 10-15 years with 13% aged 16 years and over. The majority (96%) of looked after children were of white ethnicity;
- In 2012, 145 children ceased to be looked after, of whom 34% were over 16 years of age. Of those who left local authority care, 14% moved into supportive accommodation for independent living, 17% were placed under special guardianship orders including 10% where the order was made to former foster carers and 3% were moved to residential care funded by adult social services;
- Among 19 year olds who were looked after at age 16 years, 76% are in education, training or employment and 86% are in suitable accommodation.

Source: ONS, 2012

Participants who had left local authority care and were aged 16 years and over were recruited by Leaving Care Social Workers at Cheshire West and Chester Council. One focus group of three participants and one significant other and one semi structured interview were completed. They were designed to cover a range of topics including knowledge of sexual health, experiences of sexual health services including barriers to accessing services, improvement of services and risk behaviour and knowledge, beliefs and attitudes towards sexual health.

Findings

Knowledge of sexual health and sexual health services

Participants demonstrated a holistic view to their health and wellbeing and perceived sexual health as being linked to wider health issues.

Researcher: ...what kind of things make up your sexual health?

P1: Like your physical health...Like how you you're looking after yourself and stuff like that.

Sexual health services were viewed as being of the same importance as other primary care services, such as GPs and dentists. One participant said it was routine for those leaving care to be given support in registering with a general practice and a dentist when they moved to a new area and suggested that local sexual health services should be signposted to care leavers as part of the same process. Similarly, they felt sexual health should be represented at health promotion events, and the focus group discussed a recent healthy living event which had taught some cookery skills and budgeting and the potential for a similar event focusing on sexual health.

P2: *And I think young people because when they're moving places, moving around you'll get, they'll help you get your doctor and a dentist. They should also point out your local sexual health clinic as well which is what they don't do. I've never had that, so I think for young people if they just had it pointed out to them it would be beneficial.*

P1: *I think if the NHS work alongside of with them so like they have people come in, like and do like we did the healthy living, we went to the council place and they said so this is how you cook meals this is how you do your budgeting. I think it would be good if they had an NHS worker come and they do like open days and they do like activity days this is sexual health, this is where your local things are based for each area.*

General awareness of sexual health was good across the group. Participants identified contraception, sexually transmitted infections, HIV, pregnancy and termination of pregnancy as key elements of their sexual health. Some participants also demonstrated a higher understanding of contraception, quoting key messages about effectiveness and the potential side effects of different contraceptive methods. The group also had a good awareness of sexual health services, all the participants were able to name a sexual health clinic near to where they lived and most were able to identify other clinics within their local area. There was also a clear understanding of the different levels of services offered in general practice, community sexual health and genito-urinary medicine.

There was a general consensus that information about sexual health and sexual health services was mainly communicated through informal channels. The experiences and opinions of friends and peers were considered particularly important and had a strong impact on decision-making around sexual health and service choice.

P1: *Young people know a lot of people, and they're the word that gets spread. Go there it's really good or; do you know what I mean.*

P2: *Word of mouth.*

P1: *Whereas if you don't like it your friends like go to the Stanney Lane Clinic and I'm like I wouldn't go there.*

The role of friends was noted as particularly important during their teenage years. All of the participants had attended a sexual health clinic for the first time with a friend and they said this was due to a lack of confidence and knowledge about sexual health services. Opinions and information passed on by friends also played an important role, and one participant spoke of information about the implant that she now recognised as being incorrect having an important impact on contraceptive choice.

P3: *I went with a friend me, the first time*

P2: *Same*

P3: *I didn't have a clue what to do*

P1: *Most people do because they talk down to you, so you take someone with you.*

P4: *Yes, I remember when I got my implant when I was 17 and then over the next couple of weeks everyone was getting them. Cos apparently one girl said they glow in the dark and that and I was just like do they, everyone was really fascinated going it's like a little stick oh I wanna get one. So next minute everybody's down there getting them then. Which was a good thing, that it was like a sort of trend.*

Care leavers/looked after children and sexual health

The participants were asked to consider the statement “Do you think people who are in care or who have been in care take risks with their sexual health?” and there was a universal consensus that young people who had been in care did take greater risks with their sexual health than their peers. The participants stated that a young person’s background and history before and during their time in care would impact upon their attitudes to sex and their risk-taking behaviour. Risky sexual behaviour including having multiple sexual partners and an early sexual debut was linked to the need for attention and a feeling of emotional attachment, which those in care had often lacked when growing up.

P4: *Obviously instability and attachment issues you generally find they crave attention from people so they’re more likely to have quite a few different people you know in a week and stuff that they’re just craving that attention and obviously they won’t use anything and stuff cos obviously generally there’s higher pregnancy rates and that in people in care and obviously I think most probably they generally have higher STI rates as well. I think just that attachment and obviously sex in general you hope it’s quite an intimate thing and stuff and I think that’s what they generally crave, so they’ll look for that even if it’s just a one night stand, it’s a few moments of being together which someone so no matter what the cost, even if they feel horrible when they wake up the next morning, they go to the clinic and a couple of weeks later they’ve got chlamydia you know at least they’ve had that close feeling.*

P1: *Yeah, because a lot of them, I know as a female, a lot of them look up to men as in, not personally myself, I mean other people, that I used to hang around with in care, they look for that type of like father figure but they do it in a sexual way because they think that love, that men, look at them because they love them but men sometimes only want one thing, to take advantage of them and I think with young people in care, because of what’s happened, because of their mental state, they are quite vulnerable.*

P3: *There’s a certain person that lives there who’s like had quite a bad childhood and been abused and stuff like that when they were kids and she, she’s now only sixteen and she’s slept with over 72 people and now she’s been mithering the hell off the NHS about how to get away from doing that sort of stuff and only now four years later, she’s getting the help she needs.*

It was also felt that some young people who were in care or had left care would not necessarily access sexual health services when they needed them. This was linked to a lack of understanding among healthcare professionals of the background and experiences of those in care and it was felt that some young people would not seek advice or care without additional guidance and support.

P1: *They think cos we’re young oh they’re all out doing this they’re all out sleeping with everyone it’s like seriously not all of us are like that, some of them have gone that way because of the childhood they’ve been brought you in. You know it’s like being in an environment with parents who take drugs, you either do the same or you do the opposite d’you know what I mean. Every kid has a choice people need a lot more support and I mean you know we have support off our care leavers or services but...*

P2: *Some of them don’t get that.*

P1: *Some of them don’t get that, and they’re the people we’re speaking for like that that need help.*

Experiences of sexual health services

The participants reported mixed experiences of sexual health services. Some reported that attending a sexual health clinic had been a positive experience; they described an efficient service which met their expectations and described a structure and routine to their appointments which they found positive.

P2: *I mean, I've, I went to sexual health clinic once, I was in and out in twenty five minutes which I thought was alright, so that was in Birkenhead GUM clinic, in Birkenhead somewhere. Yeah, no problems with that, filled in a quick form to say what I'd come in for, I didn't even have to give them me name or anything, so it was all confidential, they were quite polite in seeing me, so I didn't have any problems.*

P4: *They're asking you questions that they need to know because if any things wrong obviously you know it can have an effect on your body and stuff... and obviously you know check your weight and then they'll ask you, you know have you had any new sexual partners or you know are you still with the same person and you know obviously ask you if you're happy with your contraception you're on, you know do a review of you know cos they've done a review with me you know you've been on your injection this long and things like that so then obviously they'll give me my injection stuff, you know my next appointment and just say you know would you like any free condoms sort of thing and then.*

P2: *They gave me the option of whether I want a letter or it sent to me mobile phone results. They gave me the option of taking some contraception if need be and they were open to answer any questions. So it was fine, it was a good experience.*

However, others reported more negative experiences of sexual health services, both personally and amongst their peers. These negative experiences had a lasting impact on those involved. In both cases, the result of these negative experiences was that the participant wouldn't return to the service in question.

P3: *I did once work with a young man who's got childish behaviour and I arranged for him to go to one cos he's been saying for a while he wants to go but he won't actually make the effort to go so in the end I arranged for some staff to take him and erm they started to go quite often and one of the staff was really rude to him on one of the visits and in front of everyone in the waiting room she turned round and said to him oh you're here again....and he was a bit like, well you're providing the service and I'm coming to you and he was a bit like if I don't come here you haven't got a job and I'm coming here as well for myself.*

Researcher: *And what affect do you think that had on him later?*

P3: *Oh he didn't go back.*

The participants were concerned about privacy and confidentiality in the clinic environment. They mentioned the shared waiting room areas at some of the clinics which they found embarrassing and not always as confidential as they would like. Similarly, some participants felt uncomfortable disclosing the reason for their visit to general practice reception staff.

P1: *Cos like the one in Ellesmere Port the one in the Stanney Lane Clinic it's got like the chiropody there, you've got like the dentist and then they've got on the door sexual health clinic, so you're all sat in a waiting room and everyone knows that you're going to the sexual health clinic and everyone thinks the worst.*

P2: They automatically think you've got something don't they.

P1: And everyone whispers about you and that, oh they're going to the sexual health clinic and I don't think it's right for young people because and then they start getting intimidated and feeling overwhelmed and they don't go and it deters them from going to get contraception.

P1: I think in a closed area, like somewhere private, not just where everyone goes for having babies and chiropody and dentists, speech therapy.

P2: You can go in and just see your doctor about it.

P1: Yeah but then it's not private either because you have to tell them over the phone what you're going to see your doctor for and if you say it's private they say well we can't give you an appointment until two weeks' time.

P3: I refuse to, every time the reception asks me what's wrong with you I say you're a receptionist not a doctor.

P1: They don't really pay much attention to confidentiality, I mean they walk out the door and they're like "oh your test for blah, blah, blah has come back clear" and it's like, loads of people sat there and you think, hang on a minute.

Participants wanted staff to be open, friendly, approachable and non-judgemental and for some their experiences of sexual health services were not living up to these expectations. Almost all of the participants wanted the choice of whether they saw a male or female member of staff, one participant raised the issue of staff age stating that they would prefer a younger member of staff but there was no consensus amongst the participants about whether age of staff mattered. Some participants felt that the questions asked by staff were intimidating and intrusive. However, opinions were split on this issue; some participants did not understand why it was necessary to disclose all of the information required whilst others felt comfortable answering what they described as routine questions.

P3: I think they question you as well it's so bad as well.

P1: It's like going into an interrogation isn't it.

P3: They're like, when was the last time you had sex, who was it with, were you drunk, in what scenario did it happen.

P2: How.

P3: Yeah how. Have you cheated on that person, are you in a relationship, could they be pregnant, can I have the name, they ask you for the name and everything.

P1: Are they under age.

P3: I think that doesn't, it shouldn't matter, it shouldn't.

P3: All you need to do is basically you should go in there with that professional and say right you're here to have a chlamydia test or whatever it is you're there for, they should just give you the test and they don't need to know why.

P4: Cos I know I know some people do but at the end of the day, you know they're asking you questions that they need to know because if any thing's wrong.

In general, participants were aware of the opening times of various clinics and had an understanding of where appointments and drop-in clinics were available. They felt that waiting times were often long but staff were open and realistic about what waiting times could be expected. However, several participants felt the opening times were a barrier to accessing services because they didn't fit in with

their daily lives either due to work or childcare. One participant suggested that the clinic run at a local college should be opened up as these times were suitable for parents. Some participants were also unhappy about the appointment times, they felt that ten to twenty minutes was often insufficient and found rigid appointment times impersonal. Participants also mentioned the paperwork they had to fill in on arrival at a new clinic; they found this a lengthy experience and suggested the paperwork required could be shortened. One participant had a learning condition which made it difficult for them to read black text on white paper and this participant described the volume of paperwork and the lack of an alternative option as overwhelming.

All of the participants demonstrated positive attitudes towards their GPs with three out of four participants saying this would be their preferred option for sexual health services. These participants talked of a personal and friendly relationship with their GP which was built on trust. This relationship meant they were happy to speak openly with their GP and some participants compared their experience with their GP with what they felt was an intrusive experience at sexual health clinics. They also spoke positively about the clinic environment which they felt was comfortable and calming.

***P2:** Well at the moment I've got quite a good doctor, I explain the problem, I ask what sort of, I tell her what sort of things I think would help me and she does it, she's quite good. So I would go to the doctor cos it's one-to-one, no one knows what you're going in to see the doctor for so it's easier that way.*

***P1:** Yeah my GP is very friendly. And also in my GP surgery they have like things that like calm you down they have like fish in there, the wall paper's not very cold or like white it's like very relaxed the lights are dead low it's the whole way the surgery presents itself.*

***P1:** He's, he doesn't push me. He's like, well what are you here for today, do you wanna tell me, if you don't that's fine you know but I just need a brief description to put it on my computer and half the time I just sit there and tell him everything because I feel so comfortable with him, he's so lovely.*

***P3:** My GP. I can tell him anything I want. You're like, he always shakes your hand when he goes in, he gives you a cup of tea, he tells you to relax, and he does seem, he does the same with me, he says just tell me, you don't have to tell me everything just a few words, how you want me to help.*

There was low awareness of information and promotional materials about sexual health. Most of the participants did not know where they would look up clinic opening times. Several participants stated that they would ask their GP for this information. One participant said they would look up information on the internet but others did not trust information from the internet as they felt it was frequently out-of-date. Opinions on the leaflets available in clinics were also mixed; some said they read leaflets when they were given them but others stated that they were simply thrown in the bin. Some felt that the way leaflets were presented was unappealing and wanted bright and colourful promotional material. There was also confusion about the information displayed in clinics; participants mentioned flu campaigns and the National Bowel Screening Programme, both of which they felt were inappropriate for the sexual health clinic environment.

***P2:** Just more information about it to be handed out. I mean there is a few things, like they've got a few posters and things like that. Sometimes your GP will tell ya, but generally they need to be getting the information out there so more people know and understand what it's about and how they can get in contact with them.*

***P1:** It's the typical spiny leaflet things, you spin them round and you think; boring, black and white.*

P1: *If it looks good people will pick it up. It's about in your face, big, bold, bright, "hello, I'm the sexual health clinic" and I'm here. Instead of being the typical NHS, blue...*

P2: *Tucked away somewhere.*

P1: *They're very like sterile, although it's good sterile, but it's a bit too... I think it should be colours.*

Improvements to sexual health services

Participants wanted a sensitive service which was conscious of, and adapted to the needs of looked after children and those who had left care. They felt the service should have an awareness and understanding of the complex emotional and mental health needs of those who had been looked after. They felt staff should have open and non-judgemental attitudes and they particularly stated that staff should be prepared for recurrent or extreme behaviour and understand how to respond to this. Without this level of understanding, many young people would disengage from the services.

P1: *This is where abuse to any staff comes in, the way people speak to them, the way people look at them. Some young people in the services have mental health problems, some people have learning difficulties some people have behavioural difficulties which means they'll lash out. So it just means catering, because they think they're NHS they think they can speak to you in a way you know that they do but really if they offered that little bit extra then half of them either wouldn't be abused or wouldn't be spoke to like rubbish d'you know what I mean?*

P1: *And they need to be very sensitive cos some young people come from a very difficult background.*

P2: *It's about the young person or the young adult than the person who's interviewing you or the doctors, they're getting all their views across but it's not about their views it what's right for them so they've got to listen to them not put their views across cos that's wrong.*

P1: *Because if say to a kid oh you're in the wrong you're either likely to get a thump, you're likely to get a gob full because most young people snap because they haven't got family, you know the family's abandoned them and I don't think to be quite honest with you it's fair that they get looked down on cos at the end of the day everyone's a human being, everyone could be in that situation, everyone could lose their parents, everyone could lose their job and everyone could be on the dole in the situation or their kids could be in care cos they can't look after them.*

It was also suggested that health promotion should be targeted in areas where it would reach those who had left care; supported accommodation, care homes, young offenders units and prisons were all suggested as areas where specific health promotion was needed. This issue was linked not only to sexual health but to wider public health promotion. Participants described strong social groups among supported housing residents and those who had been looked after, and these groups were often formed due to common experiences such as a history of abuse during childhood or repeated self-harm. It was suggested that these groups were seen as a support network by those involved and as a consequence these individuals would not necessarily be accessing services for health and wellbeing support.

P1: *I think that's another place they should aim for, is vulnerable people in housing, like supported housing because also they're in a situation where they're all kind of in the same boat and they link sexually in that way, they think because they've had a bad past together they can somehow make it work. But, it's like self-harmers tend to go with self-harmers, it's that whole using your vulnerability to your advantage and that should be*

targeted in places like that because, not saying it's rife in there but that's where some of it starts as well.

Children's homes, prisons, young offenders, places like that.

P3: *People have their own groups,*

P1: *Yeah, self-harmers will stick to self-harmers, because they know*

P3: *Because some of the girls that are living where I live they've all been abused so they will stay in their own group and when someone says an inappropriate comment or whatever, they'll say no 'cos actually this has happened to more than one of us and they all have their own groups.*

The participants also wanted to see a visible link between social services and sexual health services with a more proactive role taken by NHS staff. All the participants agreed that they could get the information they needed from their social worker but some felt that their social workers had too many other priorities and that the responsibility should fall upon NHS staff in general practices and sexual health services to actively direct them to the correct services. Some participants mentioned a recent drop in service that had been started at Cheshire West and Chester Council but they spoke of a lack of NHS engagement with the service which was interpreted as disinterest.

P1: *I know social workers, I know my leaving care worker, [name], she's brilliant she goes above and beyond, like [name]. They do go above and beyond and [name] who'll drive me around town and say this is where the local hospital is this is where the doctors is and they'll do it, but really they shouldn't have to take that role on, it should be the NHS's part where they say you know all the doctors say that to you but they don't they don't offer that service and for someone that's quite intimidated for quite shy or isn't outspoken or quite vulnerable they are in a like danger zone really because they don't know the area they don't know the local sexual health they don't know the doctors to speak to they don't know any other services.*

P2: *A social worker would be the easiest way of going around it, wouldn't it, your social worker would be able to point out the doctors, sexual health.*

P1: *It's about putting more on their plate though, I mean social services they already do job centre, they book into the job centre for you, they do housing, which housing are quite abrupt in the way they work with social services, cos I've had it many a times, like the doctors cos they do that, dentist they do that, money they sort that out, d'you know what I mean they sort quite a lot and to just chuck something on the work load I think 's quite unfair. Cos they already do above and beyond their job, well I know from my leaving care worker she does.*

P3: *Yeah, the NHS don't make an effort, because the council have recently started drop-ins and at the beginning the NHS staff said they would attend the drop-ins with advice for young people...*

P1: *And then they kind of clear away.*

P3: *They have not even turned up once, not one member of the NHS have turned up.*

Researcher: *And to you that gives a negative, what does that make you feel?*

P1: *It's like well they can't even be bothered to turn up why should I?*

The clear consensus from the focus group participants was that they wanted to see involvement from both sexual health staff and from senior level council staff in the delivery of the services they received; and a lack of an open and visible level of involvement was interpreted negatively by the participants. They spoke of often being "let down" in their home and family life and a perceived lack of interest and involvement from service providers was linked by one participant to this notion of someone letting them down.

***P1:** And I if all the above people come down to our level they'd actually gain a great insight because it's alright them sitting behind a desk saying this money's going out to that and this money's going out to there, well if they actually got involved they'd feel a better profit because it would be like now I'm paying for this, this is what it's going on I've seen what it's going on, I've seen where it's helping young people, whereas just sitting behind a desk, if someone asks them in 20 years' time where did that money go and what was it on, oh sexual health. Whereas if you gain an insight and you know and you go to a workshop and that and they'd say oh yea we went to this work shop and you know the kids really enjoyed it or the young adults really enjoyed it, you'd gain a lot more. Than just sitting behind a desk saying that's where the money's going to.*

***P1:** We are like essentially a social services class, children in care family. You know and we all sit together, we all go to the meetings together d'you know what I mean. We are one big Cheshire family, people in care because we've been either let down by our families or stuff like that. So I think from a very young age there needs to be a service that is sensitive, that applies for all children and young adults.*

Some of the participants also expressed quite a strong lack of faith in the NHS as a whole and, although these sentiments were not universal, they had quite a significant impact on the outlook of some of the participants. In general, these attitudes were linked to particularly negative experiences both of sexual health services and other NHS services. Interestingly, these attitudes were not necessarily associated with general practice, and those participants who expressed a lack of faith in the NHS still held positive attitudes towards their GP. There was a good general understanding of the commissioning of services and role of cost-effectiveness in NHS decision making, but the participants were particularly critical of what one participant described as a "text book attitude" which was linked to previous interpretations of the service as being impersonal.

***P3:** Honestly I've got no trust in the NHS anymore.*

***P1:** That's where the whole like, I'm gonna sue the NHS comes from. Whereas if the NHS went in a totally different way, mannerism about the way they approach things and the way they change their mannerisms and that I think it would be a lot better. I think it would save the NHS quite a lot of money.*

***P1:** Yeah, I think qualifications and PhDs and doctors and all this, doesn't matter about what paper work you've got, it's about not following text book and taking a risk. Because by doing that it saves the NHS a lot of money in the long run because if they actually send them for proper tests and look into things further it solves the problem a lot quicker and it stops money going out, being wasted.*

The focus group participants discussed what they thought should be a "Loud and Proud" approach to sexual health promotion. They wanted promotion of sexual health services to be public with information available in a range of public venues such as shops, libraries, job centres, schools and colleges. The participants were particularly influenced by the Channel 4 television programme "Embarrassing Bodies" and proposed the idea of mobile units which provided sexual health services and promotion in town and city centres and likened these to similar units they had seen for blood donation and cancer screening.

***P2:** Even in the local shop windows just a little poster, something to say there's a clinic nearby, opening times are such and such, could make a big difference.*

***P1:** The local schools, the local libraries, the colleges...The places where people go on a day to day basis, council offices, supermarkets... schools, colleges, the lot.*

P1: *I think that instead of being quite quiet, I think they should be proud and loud about it. I honestly do think, because I'm the type of young person that would go out billboards, tops on saying sexual health clinic that way...*

P1: *Yeah, like Embarrassing Bodies. They just park the vans up and they go and stream round the whole town and people are like, you know they offer them coffee, they offer them teas, they're dead relaxed, do you know what I mean?*

P3: *They do it in local Tesco down the road, a mobile cancer Clatterbridge unit; it sits right in the middle of town so it's like*

P1: *Like Give Blood, like those kind of things*

P1: *Yeah and they have those big trucks and just slap bang them in the middle of the civic halls and I think that's a good idea, yeah.*

Participants suggested that promotional materials needed to be bright and bold, and likened sexual health promotion to the advertising of sales in local shops and the sale of goods like chocolate and cereal. One participant also proposed the use of a mobile phone application as a quick and easy way to access clinic opening times.

P1: *Bright, in your face, stands out 'cos then you think "ooh", like kids with cornflake packets or cereal...If it looks good people will pick it up. It's about in your face, big, bold, bright, "Hello, I'm the sexual health clinic" and I'm here. Instead of being the typical NHS, blue...*

P4: *Cos you can just get it up on your phone cos like quite a lot of people have got smart phones now and that so you know you can just go on the internet and er you know just get the information off there. Maybe an app or something..., just like you know your really basic app of you know you put in your postcode or your town and it comes up with you know ...it tells you where your closest clinic is and obviously the times and days that it's open obviously for the different ages and you know obviously on some days they'll go well you know Fridays appointments are only for you know implants and you know removals of them you know just like you know just letting them know.*

9. FURTHER INSIGHTS INTO ‘SELDOM-HEARD’ GROUPS: GYPSY AND TRAVELLER POPULATION

Box 9.1 Key findings – Gypsy and Traveller population

- Amongst Gypsy and Travellers, GPs are often seen as trusted individuals and would be the first contact for many health problems. Midwives and health visitors are also generally well-regarded amongst women in the community;
- Great emphasis was placed on seeing a doctor of the same gender as the patient, particularly for women, and some women do not have the confidence to insist. Building up of trust with a GP and consistency of care is also important;
- Some women from the Traveller community feel uncomfortable when reception staff ask the reason for their visit. This is also the case when pharmacists use names and addresses in the pharmacy when dispensing medication;
- Women in the Gypsy and Traveller community generally tend not to have sex before they are married and some do not know about contraception until they are married. This knowledge and the knowledge of sexual health services tends to vary with age. Sexual health clinics are often seen as “dirty”, as sex and sexual health are very private;
- There is often a basic lack of knowledge and understanding about sex as well as sexual health. A lack of knowledge about the basics can cause problems when explaining a medical condition to a health professional;
- Sexual health is often viewed as less of a priority to some than other health or wellbeing concerns for members of the Gypsy and Traveller community.

Background

There is little wide-scale research on the health of the Gypsy and Traveller community in the UK, although there are some small-scale, local, descriptive studies. Studies that have been conducted suggest that health problems within the Gypsy and Traveller community are worse than in the rest of the population. An epidemiological survey based in the UK compared the health of the Gypsy and Traveller community with that of the settled community, matching individuals to a non-Traveller sample drawn from across different socioeconomic and ethnic backgrounds. It confirmed that individuals from the Gypsy and Traveller community have poorer health than comparable non-Traveller populations, particularly relating to long-term limiting health conditions (Parry et al., 2007). Qualitative research revealed that cultural beliefs and attitudes, such as stoicism, fatalism, lack of knowledge, fear and perceiving illness as “normal”, effect health related behaviours (Van Cleemput et al., 2007).

Some subjects are considered taboo to discuss amongst the Gypsy and Traveller population. A study investigating cultural influences on health by interviewing Traveller women found that the subject of personal health and hygiene was embarrassing, dirty and shameful and the study went on to suggest

that this may have an impact on breastfeeding rates within the community (Dion, 2008). Sexual health can be an embarrassing area for discussion in the general population (Scoular, 2001), and this appears to be amplified in the Gypsy and Traveller population.

For the first time in 2011, Gypsy and Traveller was included in the census question on ethnicity. In England, 54,895 individuals self-identified as Gypsy and Traveller, with 4,147 in the north west of England, 213 in Cheshire West and Chester and 36 in Weaver Vale electoral ward (ONS, 2011).

Twice a year, Cheshire West and Chester conduct a count of Gypsy and Traveller caravans. The count records the number of caravans on socially rented sites, privately owned sites, unauthorised developments of land and unauthorised roadside encampments (DORIC online, 2013).

Table 9.1 Gypsy and Traveller caravan count, January 2013

	Authorised sites (with planning permission)			Unauthorised sites (without planning permission)		
	Socially rented caravans	Private caravans	"Tolerated" caravans on land owned by Gypsies	"Not Tolerated" caravans on land owned by Gypsies	"Tolerated" caravans on land not owned by Gypsies	"Not Tolerated" caravans on land not owned by Gypsies
Cheshire West and Chester		105		4	6	
Cheshire East	17	88		5		2
England	6934	9102	938	897	424	434

Source: Communities and Local Government, Gypsy and Traveller Caravans Count, DORIC online, Cheshire West and Chester Council

The caravan count recorded 105 private caravans and ten on unauthorised sites in Cheshire West and Chester (table 9.1).

However, the census ethnicity data is likely to underestimate the numbers of Gypsy and Travellers in the population due to lowered levels of completion. In addition, caravan count data do not take account of Gypsy and Travellers living in regular housing rather than caravans, and specifically counts both traditional Gypsies and Travellers and members of non-traditional New Traveller groups (DORIC online, 2013).

Local engagement with the Gypsy and Traveller population

In 2008, Western Cheshire PCT, partly in collaboration with Central and Eastern PCT, conducted health promotion work within the Gypsy and Traveller community in preparation for the introduction of the HPV vaccination programme. The culmination of the work was the delivery of an agreed presentation to key individuals in the Gypsy and Traveller community. In preparation for this, meetings were held with key stakeholders and local community organisations, to ensure and agree that its content was appropriate. The aim of the session was to dispel myths regarding the vaccine and HPV itself. A key male from the community agreed to act as a peer educator to other men and engaged them in understanding the dangers of the disease and the benefits of the vaccine. Unfortunately, the number of women coming forward for the vaccine was low. However, the project

was deemed a successful method for engaging male Travellers in health promotion (personal communication, Nicola Matthias, formerly of Western Cheshire PCT).

A partnership was established in 2012 and is continuing to develop between public agencies and voluntary agencies in Cheshire, to engage with the Gypsy and Traveller population on the subject of health. In March 2013, a health event for Traveller women was organised and held in Ellesmere Port. The event was well attended by 12 Traveller women from across Cheshire on a day when weather conditions were poor. On the day, there were representatives from: Family Learning, maternity services, sexual health, iVan (a mobile cancer awareness service), MacMillan, Wirral Immunisation, the Fire Service, Police, Equality and Diversity representatives from various organisations, Irish Community Care Merseyside and Cheshire West and Chester Gypsy and Traveller liaison. Although in general, the Traveller women rated the day well, sexual health was rated fairly negatively. However, this is the first time this type of event has been run and sexual health can be a taboo subject for women to discuss (Cheshire and Wirral Partnership NHS Trust, 2013).

Findings

Contact was made with *Cheshire Gypsy and Travellers Voice*, a support organisation based in mid-Cheshire, offering advocacy and advisory services to Gypsies and Travellers across Cheshire including Halton and Warrington. A meeting was arranged with representatives from the Gypsy and Traveller community to discuss sexual health issues. Following advice from *Cheshire Gypsy and Travellers Voice*, the interview guide was “toned down” in terms of direct references to sex and sexual health and made more general as opposed to specific questions about individuals’ experiences. The interview guide aimed to give a general impression of how sexual health is viewed in the Gypsy and Traveller community.

The interviews were semi-structured and endeavoured to gain insight into knowledge of sexual health services, barriers in accessing services, awareness of sexual health issues, improving sexual health services, looking after health and pregnancy/fertility issues amongst the Gypsy and Traveller community. The interview guides were designed as semi-structured to allow for flexibility in discussing any other issues which were brought up.

The discussion generated a number of themes on analysis of the data and these were:

- The role of the general practitioner;
- Barriers to accessing sexual health services;
- Lack of knowledge of sexual health and sex;
- Gender and age differences within the community;
- Sex before marriage;
- Privacy and trust;
- Health professionals/training opportunities;
- Other issues, including: concerns about hate crime, other diseases, maternity and fertility.

These themes have been synthesised in the results section below.

Data caveat: Previous research and engagement work has found that members of the Gypsy and Traveller community can often be very private and reserved about sex and sexual health. As such, we did not get a large sample of people to talk to about their knowledge of services and sexual health. Caution needs to be taken when interpreting the information gathered in these interviews and note that although these are useful findings, they cannot necessarily be extrapolated to all individuals from the Gypsy and Traveller community within or outside the Cheshire region.

Amongst Gypsy and Travellers, general practitioners (GPs) are seen as trusted individuals and would be the first contact for many health problems. Additionally, midwives and health visitors are also generally well-regarded amongst women in the Gypsy and Traveller community.

"I think they're just seen as the be all and end all to everything..."

For women, it is often important that the doctor they see is a female doctor. It was identified that some women from the Gypsy and Traveller community feel uncomfortable when reception staff ask the reason for their visit:

"The receptionist to be honest with you because the receptionist wants to discuss your business in front of the whole complete place and when you ask to go and see a woman doctor for example, 'why do you need to see her, what's your symptoms, what's your problem?' and you're like, well I just want to see a doctor I don't want to tell you..."

Additionally, there were concerns regarding privacy within pharmacies when collecting prescriptions; specifically that revealing names and addresses in public (such as in a pharmacy when picking up medication) may lead to hate crime that is already directed at other communities:

"So to be honest with you with what's going on at the present moment with hate crime...it's only a matter of time, I feel, before it hits the Gypsy Traveller community and if you've got people saying "oh [name] from the caravan park" and then when I go out on the street, they go oh yeah, she's the one from the caravan park, do you know what I mean?"

"Pharmacies, cos pharmacies is another one 'is it a prescription for whatever, lives at caravan park?' Well I don't want to know, I don't want everybody to know I live on a caravan park, do you know what I mean? Or whatever their address is, so they shout the address out when there's a big queue."

As found in previous health research amongst this population, it was reported that women generally tend not to have sex before they are married. A lack of knowledge about contraception prior to marriage was sometimes apparent:

"...cos a lot of the girls don't have sex before they get married so when you talk about the pill and things like that, they don't even know about them till they get married some of them."

Age was thought to impact on the attitudes and experiences of women in the community. It was thought that older generations may not necessarily be aware that there are specific clinics for sexual health that they can visit, whereas some younger women may have an awareness of sex/contraception from the television or other media sources, or from their friends. The younger women may not use sexual health specific services even if they are aware of them. One possible reason for not accessing services is that they are seen by some as "dirty".

"I think the younger people wouldn't go [to a specialist clinic] because one, 99.9% of them don't have sex before marriage, girls we're talking about, don't have sex before marriage anyway but they're more aware that there's things out there because they see it on the television, speak to friends, they get a lot more information than the ones that was probably maybe in their 40s to 50s."

For some members of the Gypsy and Traveller community, there is a basic lack of knowledge and understanding about sex as well as sexual health. A lack of knowledge of the basics could cause problems when explaining a medical condition to a health professional. If a patient does not have the basic knowledge about contraception or sexually transmitted diseases and is unable to communicate the symptoms, either through lack of knowledge or through embarrassment in some cases, it can be a significant barrier to accessing services:

"How do you tell somebody what's wrong with you, if you don't know what's wrong with you?"

There was an acknowledgement in the interviews that building up trust with a health professional, such as a GP, does occur and is very important, as is consistency of care; seeing the same GP each time. There is a great importance in seeing a doctor of the same gender as the patient, particularly for women, and having the confidence to insist on seeing a female doctor if needed.

"Erm maybe how to start the conversation, people might not, you know, there's something wrong with me but I don't know what it is or there's something, doesn't feel right but I don't know what it is. Some doctors are quite good and if they know the patient they're fine with it."

"...other people tend to shy away from it and go well if you haven't got a woman it's okay and they end up going seeing somebody about a headache for example, or you know, some other random thing..."

One of the main themes to come out of the interviews was that there were age and gender differences in attitudes towards health. As mentioned previously, amongst women from the Gypsy and Traveller community, there is often a preference for a female doctor. There was an acknowledgement that women over 40 were less likely to discuss issues such as sexual health or other women's health related matters with family and friends. However, younger women were seen as more likely to ask their mothers or friends for advice about embarrassing subjects.

"Now you've got a lot of, the younger ones are quite happy to go mother look, I've got a spot here or I've got this here or here...I think the time's changing to be honest with you and the younger ones are asking more questions or saying can you have a look at this, can you have a, what do you think of this."

As is discussed in the wider literature, the interviews discussed a reluctance of men from the Gypsy and Traveller community to use medical services unless very seriously ill, particularly younger men. Possible reasons for this are a fear of uncovering an incurable illness or taking the time off work to attend, as many men tend to be self-employed. This extends to sexual health services as well in the experience of the interviewees. There appears to be a lack of understanding about sexual health amongst men as well as women in some members of the community. However, older men tended to be more likely to seek help for medical conditions than younger ones, particularly if they have experienced a life-threatening event, such as a heart attack.

"Yeah, they would talk more to family or friends. But if it's a girl that's got the problem they would talk to the girl, if it was a boy they would talk to a boy. But I think there's a lack of understanding with boys not realising they can catch all these..."

“...there’s a lack of understanding in the men as well as the women.”

Sexual health can be seen as less of a priority to some people within the Gypsy and Traveller community than other health or wellbeing concerns. Caring for more life-threatening conditions or for elderly family can be viewed as more important. Sexually transmitted infections are not necessarily causing problems or showing symptoms and are, therefore, less of a priority than issues that need more immediate attention. Additionally, younger women in particular may not see sexual health as an issue for them, with so many not having sex before they are married.

“There’s other things that are more important to be honest because on the other hand, if my parents were dying they wouldn’t go into a nursing home or a care home or wherever, they’d be brought home...it’s like even when someone’s dying from cancer or such a wasting disease like that, they come home and you see them going through every stage of it and you go through it with them. So I think health as a if you’re fit and healthy then that’s all that matters cos people have had chlamydia for years and nobody’s known they’ve had it no matter who you are or where you’re from but they’ve managed to live a healthy life according to them, do you know what I mean?”

It was suggested that when approaching young men from the Gypsy and Traveller community health professionals need to be careful not to be judgemental when dealing with matters of sexual health. As with the preference for seeing female doctors for women, it was suggested that encouraging young men to use sexual health services would be more successful if done by another male:

“...how you would approach it I really, really don’t know because I think if you as a woman went to speak to them I think it would be a bit, they’d fob you off and give you a load of wives tale stories if you like but I think if your colleague went who was the same age as you or, do you know what I mean? I think he would get more joy, but it’s how you approach people because if you say come on we’re taking you for a test because we think you’ve got some form of sexually transmitted disease they’d be like who do you think you’re talking to, what’s your problem? But then if you got through the point of explaining how you get it, why you get it, it doesn’t have to be in-depth, it can just be a quick overview and then we’re doing free testing.”

Possibly one of the most important things to acknowledge about the Gypsy and Traveller community is that they are not a homogeneous group; everyone is different in what they will discuss and what they know regarding health in general and sexual health in particular and it is important not to over-generalise.

“...Some people will talk about it quite openly and you know as long as it’s a group of women it’s fine, others are like not telling her my dirty washing kind of thing and then you’ve got some that they have to be ill before they say look what do you think of this or what’s your opinion of it. I think that just depends on the person to tell you the truth what the person is, I can’t answer that one...”

Finally, there were misunderstandings with regards to health/STIs, which also need to be addressed:

“Yeah because I’m [age] and I only learned that I could catch hepatitis C by sharing a razor; I always thought you caught that by sex, do you know what I mean?”

10. SERVICE AUDIT

Box 11.1 Key findings of the Sexual Health Service Audit

- Community sexual health services in Cheshire West and Chester have been operating as an integrated service since 2011
- All sexual health services offer free condoms, emergency and non-emergency contraception, testing and treatment for sexually transmitted infections and HIV testing
- As well as dedicated young people's clinic sessions, nurse led sessions for young people are offered at West Cheshire College, at Chester University and term time at four high schools
- Two clinics (St Martins, Chester and Stanney Lane, Ellesmere Port) reported that they held sessions that were fully booked or booked to capacity.
- There is no community walk-in service provision on a Friday morning and only two hours of clinics over the weekend
- The majority of pharmacists who completed the audit provided emergency contraception and free condoms. Other sexual health service provision was low, with four pharmacies providing non-emergency contraception, two offering chlamydia testing and one offering LARC;
- Over 80% of the pharmacies reported that staff had received some form of sexual health or contraception training.

The Countess of Chester Hospital NHS Trust Integrated Contraception and Sexual Health service (iCASH) commenced in 2011. Doctors and dual trained specialist nurses can provide both sexual health and contraception services at all sites. The services are a mixture of walk in and appointment sessions and include clinics for all ages and dedicated young person's sessions. A nurse led holistic Health zone session is provided from West Cheshire College, Ellesmere Port and is open to all young people aged under 25, including young people who are not students at the college. Nurse led Health zone sessions are also provided in term time at Blacon High School, Chester Queens Park High School, Chester, University of Chester C of E Academy, Ellesmere Port and Bishops Heber High School, Malpas. A lunchtime drop in service is also provided at Chester University.

In addition a growing outreach support service is provided to young people under 19 years and vulnerable adults under 25 years by a Young Person's Sexual Health Outreach Nurse who takes referrals both from within the service and other professionals and outside agencies and links closely with Safeguarding and social services.

Sexual health services in Vale Royal do not operate under the iCASH service and so have been included in a separate section below.

Cheshire West and Chester Integrated Service

All clinics across the iCASH service offer emergency and non-emergency contraceptive services (including free condoms and Long Acting Reversible Contraception (LARC)), testing and treatment for sexually transmitted infections and testing for HIV. In addition, the service also provides a pre-assessment clinic for clients who are referred or self refer to the abortion service provided at the Countess of Chester Hospital and a community based vasectomy service providing vasectomy under

local anaesthetic. Consultant led HIV treatment and care is provided by the Department of Sexual Health at Cheshire West and Chester hospital.

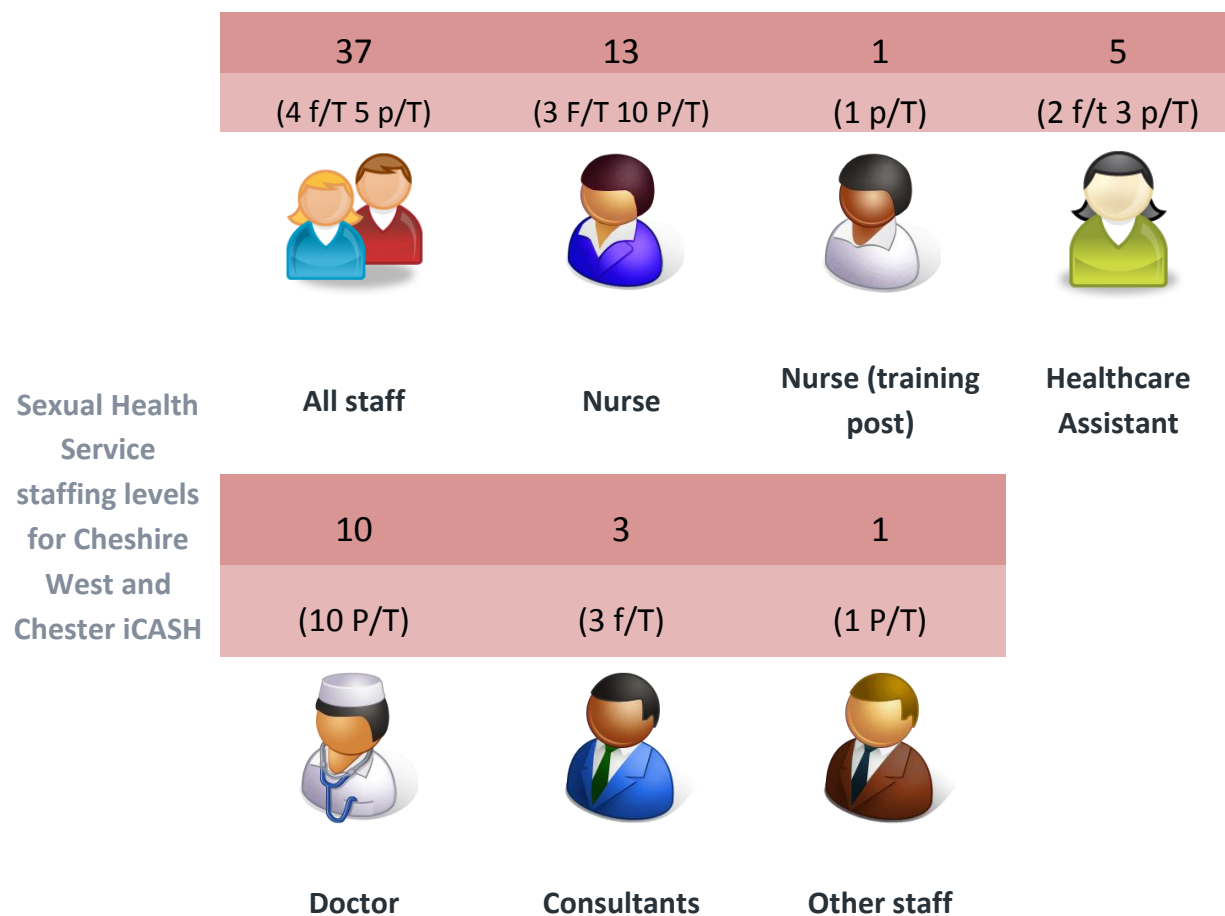
All Community clinic walk in sessions at St Martins Clinic, Chester and Stanney Lane Clinic, Ellesmere Port are often oversubscribed leading to increased waiting times and clinics running beyond their finish time. This issue is currently being addressed by the service with work in progress for increased appointments and online booking facility.

Table 10.1 shows a breakdown of service opening times across the Cheshire West and Chester iCASH service. There are six main services operating within Cheshire West and Chester, with two services (St Martins and West Cheshire College) running young people’s clinics. Services run between the hours of 9am and 7.30pm. Young people’s clinics are available four days a week with clinics running for a total of 15.5 hours. There is no walk in service provision on a Friday morning. St Martin’s clinic is the only service which provides a weekend service. Evening services (after 5pm) are available four evenings per week.

Staffing levels for Cheshire West and Chester iCASH service

In total there are 37 NHS professionals involved in the provision of sexual health services across Cheshire West and Chester iCASH. A breakdown is available in Figure 10.1 below:

Figure 10.1: Integrated Contraception and Sexual Health (iCASH) Service Staffing Levels



Community Pharmacies

There are 34 community pharmacies across Cheshire West and Chester (excluding Vale Royal). Thirty three pharmacies provided data for the audit and all pharmacies offered some level of sexual health service provision. Figure 10.2 shows the breakdown of sexual health provision for responding pharmacies. All 33 pharmacies provided emergency hormonal contraception and 22 provided free condoms. Provision of other sexual health services was low with four providing non-emergency contraception, two selling Chlamydia testing kits and one providing Long Acting Reversible contraception. For a full breakdown of community pharmacy provision see table 10.2.

Twenty six pharmacies reported that staff had received some form of sexual health or contraception training. Twenty four of the 33 pharmacies offering emergency hormonal contraception reported receiving specific training for EHC. All pharmacies reporting EHC training had received the training within the last four years with six pharmacies reporting that they renewed their training every twelve months.

Figure 10.2: Sexual Health Provision at Community Pharmacies, Cheshire West and Chester

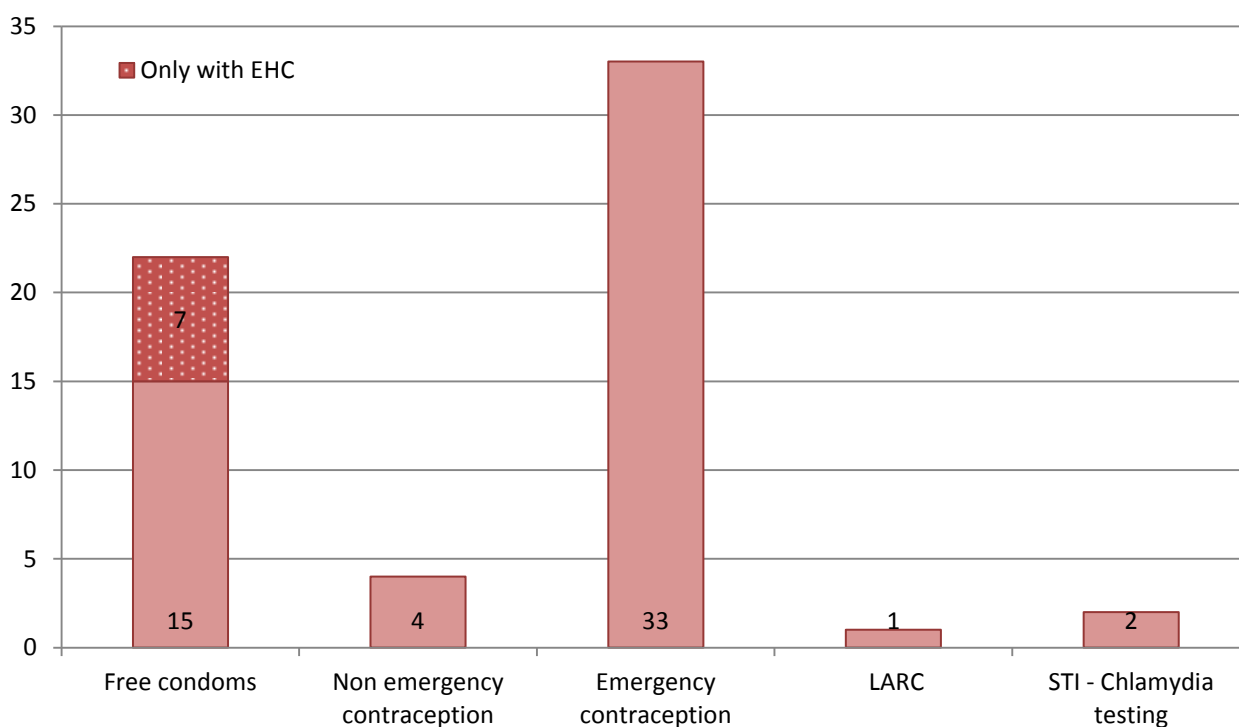


Table 10.1: Integrated Sexual Health Service Opening Times, Cheshire West and Chester

	9am	10am	11am	12pm	1pm	2pm	3pm	4pm	5pm	6pm	7pm	8pm
Monday				St Martin's Clinic				Neston Clinic		Countess of Chester		
Tuesday				St Martin's Clinic			Countess of Chester		Neston Clinic		Countess of Chester	
Wednesday			St Martin's Clinic				Blacon Clinic	Neston Clinic		West Cheshire College Health Zone		
Thursday	Neston Clinic			St Martin's Clinic		Neston Clinic			Countess of Chester		Countess of Chester	
Friday					*	Neston Clinic			Countess of Chester			
Saturday				Neston Clinic								
Sunday												
St Martin's Clinic	Neston Clinic	Stanney Lane Clinic	Countess of Chester	Blacon Clinic	West Cheshire College Health Zone							

Table 10.2: Community Pharmacy Sexual Health Service Provision

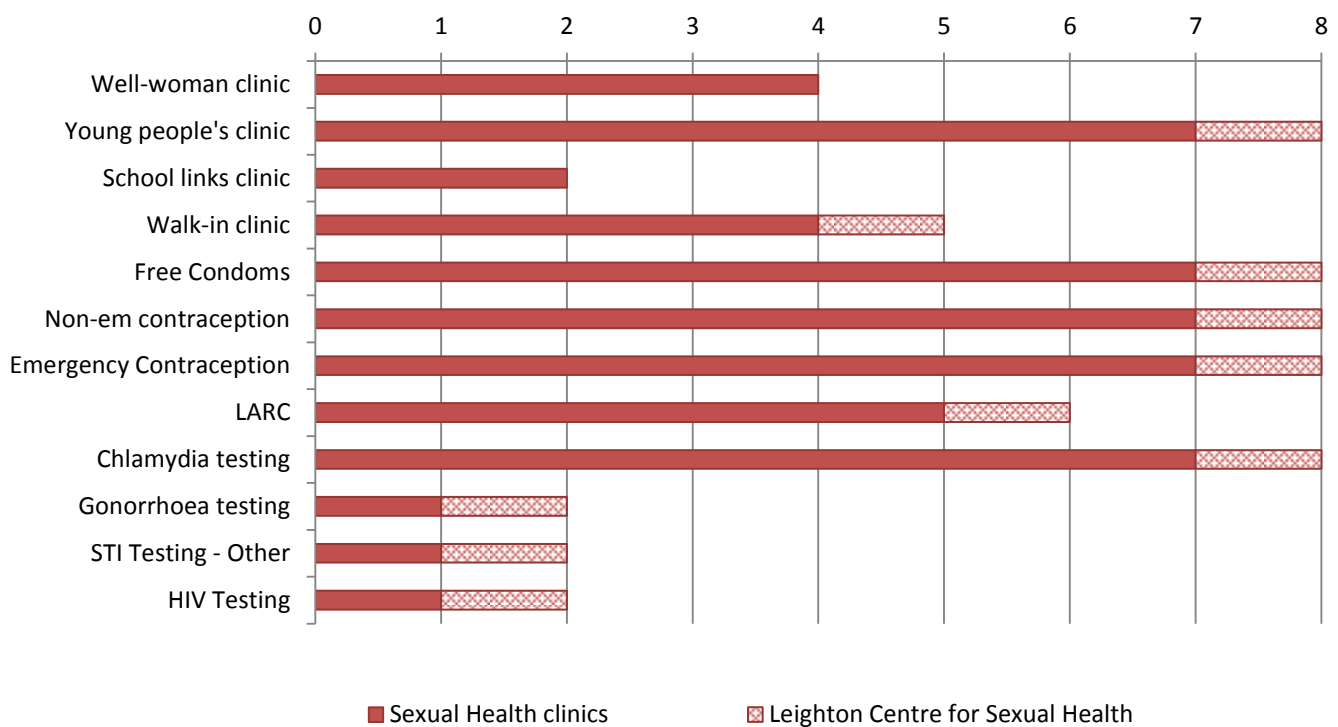
Pharmacy		Free condoms	Non-emergency contraception	Emergency contraception	LARC	STI – Chlamydia testing
Deeside Pharmacy	Neston					Sell the testing kit
Galen Pharmacy	Neston					
Boots UK	Neston					
Asda Pharmacy	Ellesmere Port					
Boots UK	Ellesmere Port					
Boots UK	Ellesmere Port					
Hope Farm Pharmacy	Ellesmere Port					
Little Sutton Pharmacy	Ellesmere Port					
Lloyds Pharmacy	Ellesmere Port					
Lloyds Pharmacy	Ellesmere Port					
Stanney Lane Chemist	Ellesmere Port					
Sainsbury Pharmacy	Ellesmere Port					
Superdrug Pharmacy	Ellesmere Port	Only with EC				
The Co-operative Pharmacy	Ellesmere Port	No data				
Boots UK	Chester					
Boots UK	Chester					

Boots UK	Chester					
Garrett Pharmacy	Chester	Only with EC				
Handbridge Pharmacy	Chester					
Morrison's Pharmacy	Chester					
Sainsbury's Pharmacy	Chester					
Saughall Pharmacy	Chester	Only with EC				
Superdrug Pharmacy	Chester					
Swettenham Chemists	Chester					
Swettenham Chemists	Chester					
The Co-operative Pharmacy	Chester					
W S Young Pharmacy	Chester					
Westminster Park Pharmacy	Chester					
Elton Pharmacy	Cheshire					
Fearns Pharmacy	Cheshire	Only with EC				Branded kit offered
Holland Pharmacy	Cheshire					
Ian Littler Pharmacy	Cheshire					
Rowlands Pharmacy	Cheshire					
The Co-operative Pharmacy	Cheshire	Only with EC				

Vale Royal Sexual Health Services

Figure 10.3 shows the provision of sexual health services in Vale Royal (a full breakdown is available in table 10.4 below). All sexual health services in Vale Royal offer free condoms, emergency and non-emergency contraception and chlamydia testing. All clinics operate a specific clinic for young people. Availability of testing for sexually transmitted infections other than chlamydia is fair, with testing offered at three sites; the Leighton Centre for Sexual Health, the sexual health clinic at Victoria Infirmary Northwich, and Winsford Sexual Health Clinic. HIV testing is offered at the same two clinics, with the Leighton Centre for Sexual Health providing specialist HIV treatment and care.

Figure 10.3 Sexual Health Service Provision, Vale Royal



All clinics reported that they held sessions that were fully booked or full to capacity and both Winsford Sexual Health Clinic and the Leighton Centre for Sexual Health reported that all weekly sessions were full to capacity. The universal consensus across clinics was that they would never turn a client away, but would always find an alternative time or offer an appointment.

Staffing levels for Vale Royal sexual health clinics

Figures 10.4 – 10.5 show a breakdown of staffing levels for sexual health services in Vale Royal. In total there are 37 NHS professionals involved in the provision of sexual health services in Vale Royal. Excluding services provided by Leighton Centre for Sexual Health, there are ten sexual health nurses providing sexual healthcare in the community, a rate of 0.17 per 1,000 GP registered adult population (aged 15-59) and 6 doctors, a rate of 0.1 per 1,000 GP registered adult population.

Figure 10.4 Sexual health service staffing levels for Vale Royal (wte)

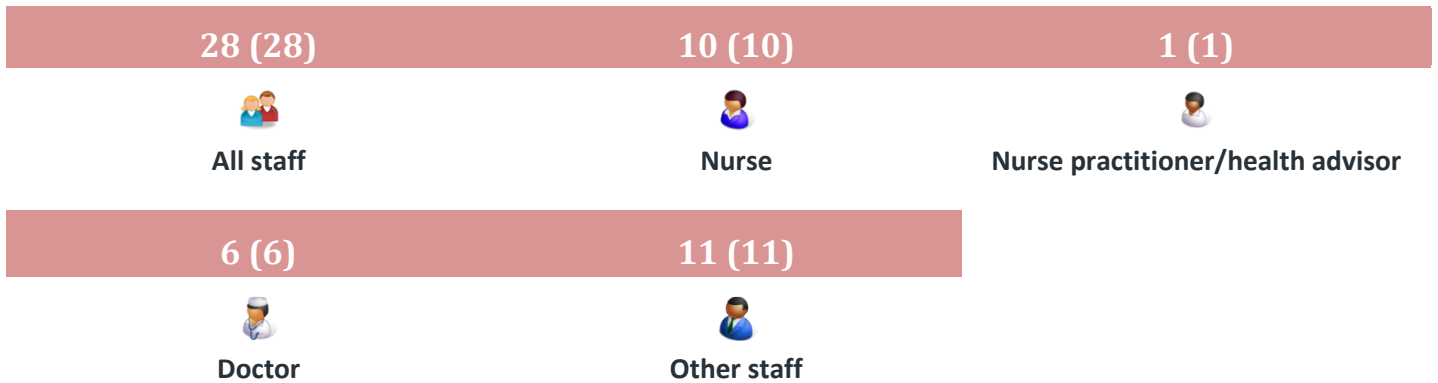
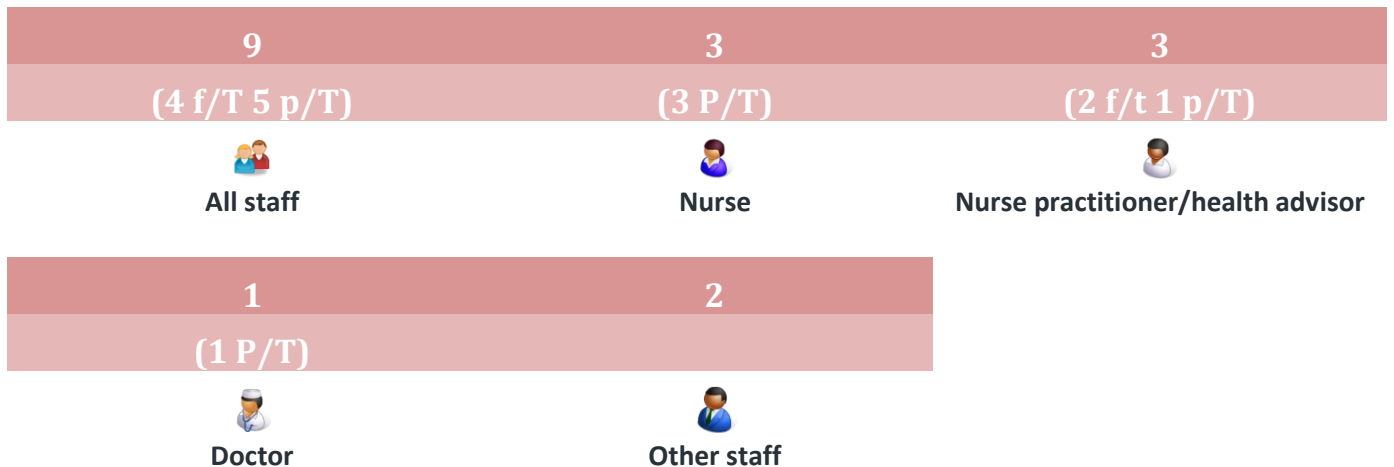


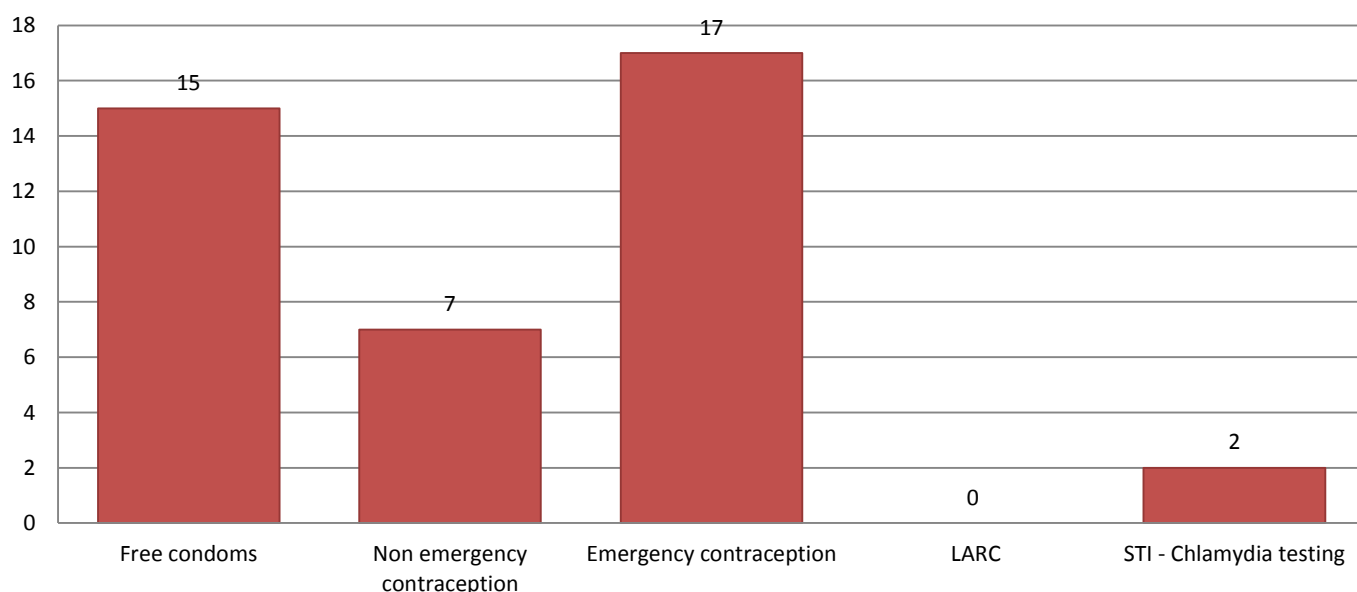
Figure 10.5 Sexual health service staffing levels for Leighton Centre for Sexual Health



Community Pharmacies

There are 24 community pharmacies in Vale Royal. Twenty one pharmacies provided data for the audit, of which twenty recorded some level of sexual health provision. Figure 10.6 shows the breakdown of sexual health provision for responding pharmacies. The majority (17/21) provided emergency contraception and fifteen provided free condoms. Provision of other sexual health services was low with seven pharmacies providing non-emergency contraception and two offering chlamydia testing. There was no community pharmacy provision of long acting reversible contraception (LARC) in Vale Royal. For a full breakdown of community pharmacy sexual health service provision see table 10.5.

Figure 10.6 Sexual health service provision at community pharmacies, Vale Royal



Fourteen pharmacies reported that staff had received some form of specific sexual health or contraception training. Twelve out of the seventeen pharmacies providing emergency contraception reported specific EHC training, a further two pharmacies had staff trained in EHC but were not currently providing it and one pharmacy recorded that EHC provision had stopped in March 2013 as existing staff were not yet trained.

Table 10.3 (below) shows the opening times of community sexual health services within Vale Royal, this includes GUM services provision at the Centre for Sexual Health and Leighton Hospital which sits outside of the Vale Royal boundaries. Excluding Leighton Centre for Sexual Health there are six services operating within Vale Royal CCG including two young people's clinics. All services are based within the Northwich and Winsford areas. There is no community sexual health service provision on in Vale Royal on a Friday afternoon or over the weekends. The Centre for Sexual Health at Leighton Hospital is the only service which provides morning clinics. Young people's clinics are open for three and a half hours per week. Evening services (after 5pm) are available three nights per week

Table 10.3 Community sexual health and GUM service opening times, Vale Royal

	9am	10am	11am	12pm	1pm	2pm	3pm	4pm	5pm	6pm	7pm	8pm	
Monday	Winsford General Clinic					Northwich Young People's Contraception Clinic				Winsford Sexual Health Clinic		Northwich General Contraception Clinic	
Tuesday													
Wednesday	Winsford General Clinic					Wharton Primary Health Care		Northwich Young People's Contraception Clinic		Winsford Sexual Health Clinic		Northwich General Contraception Clinic	
Thursday													
Friday	Winsford General Clinic												
Saturday													
Sunday													

Winsford General Clinic	Orange	Northwich Young People's Contraception Clinic	Pink
Winsford Sexual Health Clinic	Blue	Northwich General Contraception Clinic	Magenta
Winsford Young People's Clinic	Light Purple	Northwich Sexual Health Clinic	Light Purple
Wharton Primary Health Care	Green	Leighton Centre for Sexual Health	Light Orange

Table 10.4 Community Sexual Health and GUM service provision, Vale Royal

	Winsford Sexual Health Clinic			Wharton Contraception Clinic	Northwich Contraception Clinic			Leighton Centre for Sexual Health
	Winsford General Clinic	Winsford Sexual Health Clinic	Winsford Young People's Clinic		Young People's Contraception Clinic	General Contraception Clinic	General Contraception Clinic	
Well-woman clinic								
Young people's clinic								
School links clinic								
Walk-in clinic								
Free Condoms								
Non-em contraception								
Emergency Contraception								
LARC								
STI testing - Chlamydia								
STI Testing - Gonorrhoea								
STI Testing - Other								
HIV Testing								

Table 10.5: Community Pharmacy Sexual Health Service Provisio

Pharmacy		Free condoms	Non-emergency contraception	Emergency contraception	LARC	STI - Chlamydia testing
The Co-operative Pharmacy	Davenham					
Leftwich Pharmacy	Northwich					
The Co-operative Pharmacy	Kingsmead					
Lloyds Pharmacy	Rudheath					
The Co-Operative Pharmacy	Northwich					
Rowlands Pharmacy	Hartford					
Tesco Instore Pharmacy	Northwich					
Hoggs Chemist	Northwich	No data				
Boots the Chemist	Northwich					
Sainsbury's Instore Pharmacy	Northwich					
Eastfield Pharmacy	Lostock Gralam					
L Rowland & Co	Sandiway					
Lloyds Pharmacy	Weaverham					
Lloyds Pharmacy	Weaverham					
The Co-operative Pharmacy	Barnton	No data				
The Co-operative Pharmacy	Northwich					
Barnton Pharmacy	Barnton					
ASDA	Winsford					
Boots the Chemist	Winsford					
Ponda's Chemists Ltd	Winsford					
The Co-operative Pharmacy	Winsford					
Ponda's Chemists Ltd	Winsford					
The Co-operative Pharmacy	Wharton					
David Stearne Pharmacy	Winsford	No data				

11. RECOMMENDATIONS

General recommendations

- 11.1 Sexual service provision in Cheshire West and Chester currently operates on several different footprints with Vale Royal CaSH service clinics operating separately. Sexual Health services in General Practice do not currently have the same contract across Cheshire West and Chester Unitary Authority as a whole and services in Vale Royal are still operating on a Locally Enhanced Service (LES) Specification agreed by the former Central and Eastern Cheshire Primary Care Trust. Current models should be reviewed to ensure equitable service provision across Cheshire West and Chester including bringing together General Practices under a single LES agreement and linking CaSH clinics in Vale Royal with the existing integrated sexual health service operating across Cheshire West and Chester.
- 11.2 The development of an Integrated Sexual Health Service across the whole of Cheshire West and Chester must take into account the value of local services. Sexual health services in Vale Royal are well used by the local population and some service users attending Blacon and Neston clinics emphasised the importance of accessing a local service. In addition, questions on distance travelled and willingness to travel in the general and service user surveys suggested most residents would travel between one and three miles to access a sexual health service; it is therefore important that services continue to be offered where local people can access them at times that are convenient.
- 11.3 Where people are accessing sexual health services, communication between patient, health care professional and reception staff needs to be clear. It must be made clear to patients exactly why a sexual health history is being taken, why personal questions need to be asked and why reception staff may be asking the reason for attending (to allocate an appointment to the right health care professional). In turn, reception staff need to be understanding when patients do not want to share that information or when they request a particular gender of doctor. Training in this area must be reviewed regularly, especially when members of staff change.
- 11.4 Whilst the term “family planning” is one that is recognised, there is some level of assumption as to what the service offers that may put people off using it for other sexual health needs. In contrast, there is also concern that naming a service “sexual health” may also put people off using the service as it draws attention to why they are attending. Discuss and consider the naming of the services and what works best locally.
- 11.5 Whilst overall knowledge of STIs was good in the general population survey, there were a lot of “don’t know” responses in the HIV knowledge section. Some “myth busting” HIV promotion would be useful to increase knowledge of HIV, HIV transmission and HIV treatment and care.

- 11.5 There were clear variations in levels of contraception use and demand reported in the general and service user surveys. Secondary and survey data suggests that condoms are a commonly used method of contraception particularly among young males. A condom distribution scheme would be beneficial in widening access to contraception across Cheshire West and Chester.
- 11.6 A large number people found out about the sexual health service they were visiting through the internet. It is important that all information on websites is mobile phone browser friendly, attractive, accurate and up-to-date. It would be useful for potential new service users to have an explanation of what to expect when they visit for a sexual health check-up to help alleviate any anxiety about attending. In addition, local information about each clinic's processes would help to dispel myths and prepare the service user. Social media such as Facebook, Twitter and YouTube could be used to promote and supplement this information.
- 11.7 General practice plays an important role in accessing and providing sexual health advice. Among sexual health service users who had sought advice elsewhere, 42% visited their GP before accessing sexual health services. General practice was also a key source of sexual health advice for seldom heard groups (see specific recommendations below). Communication links between sexual health services and general practice should be maintained and strengthened. Training for GPs should aim to increase GP confidence in talking about sexual health matters.
- 11.8 Questionnaire participants identified that it was difficult to talk to pharmacists about sexual health matters. Research has shown that pharmacists are seen as drug experts and not experts in health, but recognises that there is a role for community pharmacists in delivering public health services (Saramunee K, et al., in press). Improved communication of pharmacy based sexual health services and regular accredited training updates for pharmacists could increase the role of community pharmacies in Cheshire West and Chester.
- 11.9 More females access sexual health services than males and it was mostly females who completed the service user and the general sexual health surveys. It would be useful to focus on trying to elicit the views of men in the area particularly heterosexual men and men over the age of 25. Strong links with other clinics who have a higher volume of men using sexual health services, would be highly beneficial to share good practice, concerns and evidence. Methods of engaging with men on sexual health matters will need to be considered, for example, men attending contraception services to obtain condoms would be a good opportunity to promote safer sex messages.
- 11.10 As this sexual health needs assessment was focussed on the population aged 16 to 60 years, it is important to conduct a similar piece of work specifically for young people which builds upon the interventions already taking place in the Cheshire West and Chester area.

Recommendations following consultation with MSM/trans population

- 11.11 Consider increasing the number of GUM outreach clinic hours at Northwich Sauna from monthly to weekly clinics and introduce point of care HIV testing to help reduce the number of late HIV diagnoses and the risk of onward transmission.
- 11.12 Facilitate the development of a support group in Vale Royal / Cheshire West and Chester, specifically for trans people to reduce isolation and improve mental health. Although the focus would not be on sex, a support group would provide opportunities for sexual health promotion and discussion. The space for the meeting should include private changing rooms and extra time for changing to enable group members to feel comfortable.
- 11.13 Continue health promotion and sexual health outreach at the sauna in order to reach people who would not otherwise seek testing and treatment services (for example MSM who identify as heterosexual). Improve health promotion boards at the sauna and place health promotion materials more prominently.
- 11.14 Increase health promotion and targeted outreach work amongst MSM who identify as heterosexual, and amongst trans people by collaborating further with BPCNW who already engage with service users at Northwich sauna and other locations. Investigate where other organisations in other regions are already successfully engaging with these two “higher risk” groups.
- 11.15 Further promotion of the use of condoms to prevent HIV and STI transmission at Northwich Sauna, to reach harder-to-reach MSM (such as those who identify as heterosexual) and more generally, for instance at LGBT groups in colleges.
- 11.16 Ensure there is linked partnership working across Cheshire West and Chester Council and the NHS. Isolation and mental ill-health can impact on sexual health and sexual risk taking. Wider support for the sexual health of LGBT people should lead to improvement in sexual health
- 11.17 Ensure sexual orientation is included on all equality monitoring forms alongside questions about other protected characteristics. Analyse data to assess whether services are attracting members of LGBT communities and to identify gaps and trends. Ensure staff understand the importance of these questions and how this data can improve patient outcomes. Refer to the guidance produced by NHS North West and The Lesbian & Gay Foundation: www.lgf.org.uk/som

Recommendations following consultation with adults with learning disabilities

- 11.18 Commission good quality, person-centered relationships and sexual health training with members of staff who work with adults who have learning disabilities.
- 11.19 Recognise that parents/carers may have a lack of knowledge and confidence to discuss sexual health. Appropriate relationship and sex education needs to encompass not only organisations offering sexual health services, but also generalised services (e.g. GP, social services, and accommodation/support workers), the service user and the service user's parents/carers. Sex and relationship education should be universal but individualised to take into account varying understanding and meaning of sexual health and sex from person to person. SRE should cover knowledge of sex, dealing with relationships, sexuality, contraception, sexually transmitted infections, pregnancy, personal safety and recognising abuse.
- 11.20 Specific training is needed for sexual health service staff on consent to screening, treatment and contraception for adults with learning disabilities.
- 11.21 General practitioners are seen as a key source of advice on sexual health matters for adults with learning disabilities. GPs need to continue to ensure that they recognise individual sexual health needs and allow for this in the time given in appointments.
- 11.22 Clear pathways between the patient and GP services, sexual health services and support workers/social workers need to be established in order to deliver sexual health education, training and services in a joined up way to individuals with a learning disability in Cheshire West and Chester.
- 11.23 Consider the opportunities for sexual health promotion where adults and young people with a learning disability will be able to access it and in a format in which it can easily be understood, such as in day services, community services and with the GP.

Recommendations following consultation with care leavers

- 11.24 Develop sexual health staff awareness of the complex emotional and behavioural needs of those young people who have been looked after to develop an open and sensitive sexual health service. Increase awareness of how to respond to recurrent or extreme behaviour from young people.
- 11.25 Create visible and structured links between social services and sexual health clinics including appropriate signposting to services for looked after young people who are new to the area, tailored awareness raising events as part of leaving care programme, and regular presence at council drop-in sessions.
- 11.26 Increase availability of information about sexual health services in locations which ensure maximum visibility for young people leaving care including supported accommodation, care homes and council offices.
- 11.27 Develop “loud and proud” promotion through bold, colourful and public promotion materials and activities which dispel embarrassment about sexual health issues.
- 11.28 Consider adaptations to the clinic environment to create a calming and positive experience. Suggestions include reducing levels of paperwork and developing alternatives for those with learning difficulties and creating a waiting room environment that is similar to primary care. Participants described the primary care waiting room environment as less clinical and more calming and mentioned practical changes such as avoiding white and blue paint colours, having lower lighting and calming focal points such as fish tanks.
- 11.29 Address the negative attitudes of some young people leaving care towards the NHS by personalising routine aspects of the consultation process. Build upon care leaver’s positive attitudes towards their GPs by developing links between community, GUM and primary care that are easy for patients to navigate.
- 11.30 It was beyond the scope of this study to consider the sexual health needs of looked after children particularly those aged between 13 and 16 years. The sexual health needs of looked after children in Cheshire West and Chester are unexplored and this group are at particular risk of sexual ill health and unplanned pregnancy. Consultation work with young looked after children by an organisation with links and specialised training to talk with potentially vulnerable young people would be ideal.

Recommendations following consultation with the Gypsy and Traveller population

11.31 Although cultural awareness exists in places, training opportunities and refreshers for health professionals and reception staff in primary care and pharmacy will be highly beneficial. Training needs to include the following:

- Awareness of likely lack of knowledge about sexual health (patient may not know the words to communicate what is wrong), and possible lack of willingness to discuss sexual health through embarrassment, requiring extra patience and awareness at first contact and at appointments.
- Making it clear to patients why reception staff are asking for medical details. Training in re-wording how these questions are asked, would benefit all patients but in particular individuals from the Gypsy and Traveller community.
- Making reception staff aware that patients may lack the confidence to ask for or insist on seeing a female doctor/nurse and to make sure that patients are aware of when a female doctor or nurse is available.
- Increased sensitivity to privacy needs to reduce concerns about hate crime or prejudice; staff in primary care and in pharmacy need to be able to verify identity without revealing names and addresses in public.

11.32 Men in the community do not necessarily prioritise their health and basic health promotion is needed that is both brief and non-judgemental. Promotion should include visiting doctors and dentists, sexual health, spotting signs of cancer, heart disease, breathing problems and mental health and wellbeing.

11.33 Health promotion with women needs to be conducted within the context of other health concerns. Basic information on contraception, maternity, fertility, breast care could be delivered together. Further information could be given at this point on how to start a conversation with their doctor about sensitive subjects.

11.34 To gain a greater understanding of the needs of the local Gypsy and Traveller community, further work needs to be conducted looking at sexual health in the wider context of health. This should take the form of discussions or one-to-one interviews rather than group work. This future work should take place over an extended time in order to gain the trust of the community and for the researcher to get an accurate view of health needs within the context of particular social and cultural constructs.

Key themes arising from the Sexual Health Needs Assessment

Boxes 11.6 – 11.9 show summaries of the key themes that arose across the course of the needs assessment process. The summaries relate to key groups where further actions require consideration. Recommendations and opportunities for further research/health promotion activity reflect the recommendations laid out in more detail earlier in chapter 11 and are designed to be a quick reference point. The opportunities for future research are based on findings in the primary and secondary research conducted as part of the needs assessment where further in-depth and more long-term research (which was outside the scope of this needs assessment) is considered beneficial to supplement this document.

Box 11.6 Key themes arising from the Cheshire West and Chester Needs Assessment – actions and targets relating to the general population

Key theme		Opportunities for health promotion/intervention	Other recommendations	Opportunities for research
General population	Young people aged 16 years and under			Sexual health needs assessment focussing specifically on these groups to assess service use and needs (known and unexplored).
	All population of Cheshire West and Chester	<p>Communication in sexual health services;</p> <p>Communication in general practice.</p>	<p>Communication between patient, health care professional and reception staff needs to be adapted. It must be made clear why sexual history is being requested;</p> <p>Where people are accessing sexual health services through their GP, it needs to be made clear to patients why reception staff may be asking the reason for attendance. Reception staff need to be understanding and discreet when patients do not want to share that information or when they request a particular gender of doctor.</p>	
		<p>HIV knowledge;</p> <p>Knowledge of local services and STI screening process</p>	<p>Make sure all information on websites is, or continues to be mobile phone browser friendly, attractive, useful and up to date;</p> <p>On websites and other literature, it would be useful for potential new service users to have an explanation of what to expect when they visit for sexual health or contraception to help alleviate any anxiety about attending.</p> <p>Make use of social media, such as Twitter, Facebook and You Tube to demystify STI screening and share information on local sexual health services;</p> <p>Some general “myth-busting” HIV health promotion would be useful to increase general levels of knowledge of HIV, HIV transmission and HIV treatment and care</p>	

Box 11.7 Key themes arising from the Cheshire West and Chester Sexual Health Needs Assessment – actions and targets relating specifically to men

Key theme			Opportunities for health promotion/intervention	Other recommendations	Opportunities for research
Men	MSM/Trans	MSM who identify as heterosexual; Trans people	<p>Improve prominence of health promotion boards at Northwich Sauna;</p> <p>Introduce point of care testing for HIV at Northwich Sauna;</p> <p>Continue outreach work at Northwich Sauna between local voluntary services and Sexual Health services;</p> <p>Continue to promote the use of condoms to prevent transmission of HIV and STIs both at Northwich Sauna and in outreach groups, and making use of social media where possible.</p>	Consider increasing the number of outreach clinic hours at Northwich Sauna from monthly to weekly.	Further exploratory research into the sexual health needs of MSM who identify as heterosexual including research or finding examples of good practice in communication with these two groups.
	Men in seldom-heard groups	Gypsy and Traveller community			Further exploratory research into the unexplored/unknown sexual health needs of men in the Gypsy and Traveller population
	Heterosexual men		Promote sexual health and contraception services to men – e.g. accessing men through men’s parenting groups at Children’s Centres/sports groups/events		

Box 11.8 Key themes arising from the Cheshire West and Chester Sexual Health Needs Assessment – actions and targets relating specifically to young people

Key theme			Opportunities for health promotion/intervention	Other recommendations	Opportunities for research
Young people	Teenage pregnancy/teenage parents			Work being done locally supporting young people must continue to establish reasons why levels of STIs are high and why rates of under 18 conceptions are falling at a slower rate than nationally	Focus groups conducted with females in local colleges on teenage pregnancy and sex and relationships education was helpful. Consider extending this to help continue to create an evidence base and understand sexual health and attitudes to contraception and teenage pregnancy at a local level
	Young people in the seldom-heard groups	Gypsy and Traveller community	Health promotion already in existence in Cheshire West and Chester with young people in the Gypsy and Traveller community needs to be continued. This is particularly important for young males. Health promotion needs to be basic, brief, non-judgemental and within wider health promotion programmes		Some exploratory work across services (voluntary services, council liaison officers, health visitors/midwives, schools, youth groups) would be useful to look further into the possibility of rolling out health promotion and encouraging use of sexual health services
		Care leavers/looked after children			See section in box 11.9 (below) seldom-heard groups
	Young people- general population		Make use of social media, such as Twitter, Facebook and You Tube to demystify STI screening and share information on local sexual health services	Consider working with colleges to improve the experience of young people with regards to sex and relationship education and knowledge of local contraception and sexual health issues	

Box 11.9 Key themes arising from the Cheshire West and Chester Sexual Health Needs Assessment – actions and targets relating specifically to seldom-heard groups

Key theme		Opportunities for health promotion/intervention	Other recommendations	Opportunities for research	
Seldom-heard groups	MSM and Trans	Trans For recommendations specifically for MSM see table 11.7 (above)		Support the development of a support group in Vale Royal for trans people where the focus is away from sex but where opportunities for sexual health discussion and promotion can be conducted	Further exploratory research into the sexual health needs of trans people.
	Adults with learning disabilities		Appropriate individualised sex education.	Ensure that within the sexual health service provision there are members of staff with the skills to work with patients who have learning disabilities.	Further exploratory research into the unexplored/unknown sexual health needs of adults with learning disabilities (men and women) with both organisations, parents/carers and potential service users.
			Defined pathways for adults with learning disabilities to access sexual health information and services. Must also be well publicised to carers/parents/social services	Form filling and paper work for adults with a learning disability should be kept to a minimum where possible and staff must be aware and understanding that there may be literacy problems.	
Care leavers/looked after children		Develop “loud and proud” promotion through bold, colourful and public promotion materials and activities which dispel embarrassment about sexual health services; Increased availability of information on local sexual health services in prominent locations, such as supported accommodation, care homes and council buildings	Create visible and structured links between social services and sexual health clinics, including signposting to services for looked after young people who are new to the area and tailored awareness raising events as part of leaving care programme. Form filling and paper work for looked after children and care leavers should be kept to a minimum where possible and staff must be aware and understanding that there may be literacy problems; Build upon care leavers’ positive attitudes towards their GPs by developing links between community, GUM and primary care that are easy for patients to navigate.	Further, in depth research on the sexual health needs of looked after children needs to be conducted, particularly those aged 13 years plus. Consultation work with looked after children by an organisation with links and specialise training to talk with potentially vulnerable young people would be idea. Consultation with stakeholders should also be elicited to ensure that the sexual health needs of looked after children and care leavers are covered in sexual health service planning	

Continued...	Gypsy and traveller population	See also table 11.8, young Gypsy and Traveller population	<p>Health promotion already in existence in Cheshire West and Chester with young people in the Gypsy and Traveller community needs to be continued. This is particularly important for males. Health promotion needs to be basic, brief, non-judgemental and within wider health promotion programmes. Any health promotion should be accessible to those individuals who may have low levels of literacy and who may be put off using services by form filling, letters and other written material</p>	<p>Build on positive attitudes towards GPs and health visitors/midwives and relationships and links with local Gypsy and Traveller community services to develop links between the community and local community sexual health services and GUM services.</p> <p>Training opportunities and refreshers for cultural awareness should be continued and knowledge kept up to date. Be continually aware in all aspects of care of Gypsy and Travellers, that traditional health information, including opening times and procedures for referral and communication (such as form filling, health promotional material, letters) may be putting people off using services</p> <p>Develop awareness in both medical and non-medical staff, and at community pharmacies, that privacy concerns may put people from the Gypsy and Traveller community from using services and that discretion and open explanation will enable service users to navigate health services more easily</p> <p>Continue local health events with Traveller women including a variety of health promotion activity, including sexual health</p>	<p>Some exploratory work across services (voluntary services, council liaison officers, health visitors/midwives) would be useful to look further into the possibility of rolling out health promotion and encouraging use of sexual health services</p> <p>Further research needs to be conducted looking at sexual health in the wider context of health to gain a greater understanding of the needs of the local Gypsy and Traveller community, in the form of in-depth, one-to-one interviews. This should be done over an extended time, in order to gain trust and to get an accurate view of health needs</p>
--------------	--------------------------------	---	---	---	---

REFERENCES

- Abbott, D et al (2005) *Secret Loves, hidden lives? A summary of what people with learning difficulties said about being gay, lesbian or bisexual* Bristol: Norah Fry Research Centre, University of Bristol
- Ahrens, K R et al (2010) *Laboratory-diagnosed Sexually Transmitted Infections in Former Foster Youth Compared with Peers* *Paediatrics* 136(1): e97-103
- Barn, R and Mantovani, N (2007) *Young Mothers and the Care System: Contextualizing Risk and Vulnerability* *British Journal of Social Work* 37: 225-243
- Blum, RW et al (2001) *Health-Risk Behaviors and Protective Factors among Adolescents with Mobility Impairments and Learning and Emotional Disabilities* *Journal of Adolescent Health* 28:481-490
- Broughton, S and Thompson, K (2000) *Women with learning disabilities: risk behaviours and experiences of the cervical smear test* *Journal of advanced nursing*: 32(4):905-912
- Cambridge, P (1996) *Men with learning disabilities who have sex with men in public places: mapping the needs of services and users in South East London* *Journal of Intellectual Disability Research* 40(3): 241-251
- Carpenter, S C et al (2001) *The Association of Foster Care with Adolescent Sexual Behaviour and First Pregnancy* *Paediatrics* 108(3):1-6
- Centre for HIV and Sexual Health (2009) *Sheffield in the Pink: Providing Excellent Care for Lesbian, Gay and Bisexual People A Practical Guide for GPs and Other Health Practitioners*
- ChaMPs (2009) *Top Tips for Sexual Health Promotion* ChaMPs Public Health Network
- CHANGE (2009) *Talking about sex and relationships: the views of young people with learning disabilities* University of Leeds
- Cheng, MM and Udry, J R (2005) *Sexual Experiences of adults with low cognitive abilities in the US* *Journal of developmental and Physical Disabilities* 17(2): 155-172
- ChiMat (2013) *Child and Maternal Health Indicators*, <http://www.chimat.org.uk/profiles>, Child and Maternal Health Intelligence Network
- Christian, L et al (2001) *Staff values regarding sexual expressions of women with developmental disabilities* *Sexuality and disability* 19(4): 283-291
- Church K & Mayhew SH (2009) *Integration of STI and HIV prevention, care and treatment into family planning services: a review of the literature* *Studies in Family Planning* 40 (3) : 171-86
- Clark, LL and O'Toole, M S (2007) *Intellectual Impairment and Sexual Health: information needs* *British Journal of Nursing* 16(3): 154-156
- Crocker, A R and Carlin, E M (2002) *Coitarche and care: does experience of the 'looked after' system affect timing of a woman's sexual debut?* *Int J STD AIDS* 13(12):812-4

Cuskelly, M and Bryde, R (2004) Attitudes towards the sexuality of adults with intellectual disability: parents, support staff and a community sample *Journal of intellectual and development disability* 29 (3): 255-264

Data Observatory Research and Intelligence Collaborative (DORIC) Births by age of mother Cheshire West and Chester 2010 Available at: <http://www.doriconline.org.uk/>

DCSF & DH (2009) Statutory Guidance of Promoting the Health and Wellbeing of Looked After Children London: TSO

DCSF (2010) Teenage Pregnancy Strategy: Beyond 2012 DCSF and DH

DH (2001a) The National Strategy for Sexual Health and HIV Department of Health

DH (2001b) Valuing People: A New Strategy for Learning Disability for the 21st Century Department of Health

DH (2004) Choosing Health: Making Healthy Choices Easier Department of Health, HM Government, NHS

DH (2005) The Community Pharmacy Contractual Framework London: TSO

DH (2007) Reducing health inequalities for lesbian, gay, bisexual and trans people Crown Copyright

DH (2008) High Quality Care for All, NHS Next Stage Review Final Report Department of Health

DH (2009) Further Government Response to the Joint Committee on Human Rights Report: A Life Like Any Other? Department of Health

DH (2010) White Paper: Healthy Lives, Healthy People: our strategy for public health in England London: TSO

DH (2012) Health Profile, Cheshire West and Chester Department of Health

DH (2012) Genitourinary Medicine Access Monthly Monitoring (GUMAMM) Department of Health

DH (2013a) A Framework for Sexual Health Improvement in England Department of Health

DH (2013b) Improving outcomes and supporting transparency Part 1A: A public health outcomes framework for England, 2013-2016 London: TSO

Dion X Gypsies and Travellers: cultural influences on health *Community Practitioner* 2008; 81 (6): 31-4

Dodds C, Keogh P and Hickson F (2005) It makes me sick Heterosexism, homophobia and the health of gay men and bisexual men Briefing paper Sigma Research/CHAPS

Doyle, J (2008) Improving sexual health for young people with learning disabilities *Paediatric Nursing* 20 (4): 26-28

Evans-Jones J, Steedman N, Newman M, Jones R, Milburn A & O'Mahony C (2011) Use of Telephonetics® RESULTS™ computer-facilitated telephone system with automatic results upload International Journal of STD & AIDS 2011; 22: 525-526

Futcher, S (2011) Attitudes to sexuality of patients with learning disabilities: a review British Journal of Nursing 20(1): 8-14

Foundation for People with Learning Disabilities (2010) Equalities scoping study London: FPLD

Galea, J et al (2004) The assessment of sexual knowledge in people with intellectual disability Journal of intellectual development and disability 29 (4) 350-365

Glazier A et al (2006) Sexual and reproductive health: a matter of life and death The Lancet, 368 (9547); 1595-1607

Grieve, A et al (2008) Staff attitudes towards the sexuality of adults with learning disabilities: a comparison of different professional groups and residential facilities British Journal of Learning Disabilities 37:76-84

Hinchcliff S, Gott, M & Galena E (2005) 'I daresay I might find it embarrassing': general practitioners' perspectives on discussing sexual health issues with lesbian and gay patients Health & Social Care in the Community 13 (4); 345-353

Harris J, Hargreaves SC, Lincoln A, McVeigh J, Syed Q, Bellis MA (2013) HIV & AIDS in the North West of England 2012 Centre for Public Health, Liverpool John Moores University

Health Scotland (2008) Sexual Health and Relationships: A review for people with learning disabilities Edinburgh: Health Scotland

HFEA (2011) Fertility Treatment in 2011, Trends and Figures Human Fertilisation and Embryology Authority

HM Government (2000) Children (Leaving Care) Act 2000 London: TSO

Home Office (2011a) Percentage of adults aged 16-59 in England and Wales who were victims of a sexual assault in the last year <http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/crime-research/hosb0111/hosb0111-tabs?view=Binary>

Home Office (2011b) Rate police recorded rape in women, by Strategic Health Authority and Primary Care Trust, England, 2010/11, www.sexualhealthscorecard.org.uk

Hollar, D (2005) Risk behaviours for varying categories of disability in NELS: 88 J Sch health 75(9): 350-358

HPA (2012a) HIV in the United Kingdom: 2012 Report Health Protection Agency

HPA (2012b) STI diagnoses in the United Kingdom Table 3: Number of selected STI diagnoses Health Protection Agency

Hudson, A L (2012) Where do youth in foster care receive information about preventing unplanned pregnancy and sexually transmitted infections? Journal of Paediatric Nursing 27:443-

Karellou, J (2004) Laypeople's attitudes towards the sexuality of people with learning disabilities in Greece *Sexuality and Disability* 21(1): 65-84

Knight, A et al (2006) Teenage Pregnancy among Young People in and Leaving Care: Messages and Implications for Foster Care Adoption and Fostering 30(1): 58-69

LGF (2011) Everything you always wanted to know about sexual orientation monitoring but were afraid to ask Lesbian and Gay Foundation Available from www.lgf.org.uk/policy-research/SOM/

Li, K (2009) Learning disabilities: able to love (news feature) *Community Practitioner* 82(7):12-13

Mandell, DS et al (2008) Sexually transmitted infection among adolescents receiving special education services *Journal of School Health* 78(7): 382-388

McCarthy, M (2009) Contraception and women with intellectual disabilities *Journal of applied research in intellectual disabilities* 22: 363-369

McNamara, J et al (2008) Learning disabilities and risk taking behaviours in adolescents A comparison of those with and without comorbid Attention-Deficit/Hyperactivity disorder *J Learn Disabil* 41: 561-574

MedFASH (2008) Progress and Priorities – Working Together for High Quality Sexual Health Medical Foundation for AIDS and Sexual Health (MedFASH)

Murphy, G H (2003) Capacity to consent to sexual relationships in adults with learning disabilities *Journal of family planning and reproductive health care* 29(3) 148-149

NHS Inclusion Project (2005) Fair for All - The wider challenge - Good LGBT practice in the NHS Stonewall Scotland/NHS Scotland

NHS Information Centre for Health and Social Care (2012) NHS Contraceptive Services – England 2011 – 12 NHS

NICE (2011a) Increasing the uptake of HIV testing among Men who Have Sex with Men National Institute for Health and Care Excellence

NICE (2011b) Increasing the Uptake of HIV testing among Black Africans in England National Institute for Health and Care Excellence

Northwich and Rural North Area Partnership Board (2011) Teenage Pregnancy Websearch Report Cheshire West and Chester Council

Northwich and Rural North Area Partnership Board (2012) Teenage Pregnancy Focus Groups, Hartford College Cheshire West and Chester Council

ONS (2010) Births by Age of Mother, Cheshire West and Chester Subanalysis Dataset

ONS (2011a) Conception Statistics, England and Wales London: ONS

ONS (2011b) 2011 Census KS102EW – Age Structure Neighbourhood Statistics and Census Output

ONS (2011c) 2011 Census – QS211EW – Ethnic group (detailed) Data downloaded from DORIC Online, <http://www.doriconline.org.uk/> on 21/11/2013

ONS (2011d) 2011 Census QS201: Religion (detailed), Lower Super Output Area Neighbourhood Statistics and Census Output

ONS (2011e) Life Expectancy at Birth and at Age 65, England and Wales Dataset

ONS (2012) Abortion Statistics, England and Wales: 2011, Department of Health

Parry G, Van Cleemput P, Peters J, Walters S, Thomas K, Cooper C Health status of Gypsies and Travellers in England J Epidemiol Community Health 2007; 61:198-204

Personal communication (2013) Local provision of sexual health education for people with a learning disability Deborah Magee, Cheshire West and Chester Council

Personal communication (2013) HPV health promotion work with Gypsy and Traveller population in Western Cheshire PCT Nicola Mattias, formerly of Western Cheshire PCT

PHE (2012) Sexual Health Balanced Scorecard Available at <http://www.apho.org.uk/sexualhealthbalancedscorecard>

PHE (2013) Health Profile, Cheshire West and Chester Public Health England

PHE (2013) Public Health England Weekly Health Protection Report June 2013 Volume 7 Number 23

PHE (2013) HIV test and Uptake Coverage by residence Available at: www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1215589013156

PHE (2013) Genitourinary Medicine Clinical Activity Dataset (GUMCAD) Public Health England

Risley-Curtis, C (1997) Sexual Activity and Contraception Use among Children entering out-of-home Care Child Welfare LXXVI (4): 475-499

Saramunee K, Krska J, Mackridge A, Richards J, Suttajit S & Philips-Howard P (In Press) How to enhance public health service utilization in community pharmacy?: General public and health providers' perspectives Research in Social and Administrative Pharmacy Epub 2012

Scoular A, Duncan B, Hart G “That sort of place...where filthy men go...”: a qualitative study of women’s perceptions of genitourinary medicine services Sex Transm Inf 2001; 77:340-343

Shearer, DL et al (2002) Associations of Early Childbearing and low cognitive ability Perspectives on sexual and reproductive health 34(5):236-24

Sigma (2000) Sexual Health for All 2000: Identifying key obstacles to sexual health for lesbians, gay and bisexual people Sigma Research, Lesbian & Gay Foundation and National AIDS Trust

Stonewall (2012a) Gay and Bisexual Men’s Health Survey <http://www.healthylives.stonewall.org.uk/lgb-health/gay-and-bisexual-men/default.aspx>

Stonewall (2012b) Stonewall Gay & Bisexual Men's Health Survey 2012: North West data report by Local authority area of residence <http://www.healthyives.stonewall.org.uk/lgb-health/local-data/default.aspx>

Van Cleemput P, Parry G, Thomas K, Peters J, Cooper C Health-related beliefs and experiences of Gypsies and Travellers: a qualitative study J Epidemiol Community Health 2007; 61:205-210

APPENDICES

For appendices, please see separate document at: www.cph.org.uk.



Sexual Health Needs Assessment – Cheshire West and Chester

Centre for Public Health

Faculty of Health, Education and Community

Liverpool John Moores University

15-21 Webster Street, Liverpool, L3 2ET

+44 (0)151 231 4506

www.cph.org.uk

March 2013

