Sexual Health Needs Assessment NHS Western Cheshire

Leighton Jones, Penelope A. Phillips-Howard, Hannah C.E. Madden, Suzy C. Hargreaves, Linda Mason, Linford B. Briant, Timothy Bird, and Penny A. Cook.

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liverpool JMU
Centre for Public Health

Executive summary

Sexual Health needs assessments are commissioned to provide evidence which supports local services to meet the needs of their population which, in turn, will help reduce health inequalities. Assessing needs, using input from those with professional experience of delivering care as well as from patients and the public, is central to commissioning efficient and effective services. The aim was to establish the sexual health-related needs of the population of Western Cheshire and to establish how the current supply of services can be modified to best meet these.

Overall summary

This needs assessment made use of available data, as well as the views of service staff, practitioners, end-users and community stakeholders. Young people were identified as the key target of this needs assessment, since, as well as being a national priority, Western Cheshire has a higher rate of teenage pregnancy than expected considering its deprivation profile and in comparison to its statistical neighbours. Moreover, the highest rates of sexually transmitted infections are in the age groups spanning 15 to 24 years. Local data show that by the age of 13 to 14 years, over 5% of children have had sex, and this rises to more than 70% of young people aged 16 to 19 years. The age at which children were most vulnerable to unwanted and regretted sex was identified as 14 years, reinforcing the need for effective sex and relationships education to be in place early in the school career. Awareness of sexually transmitted infections was raised by particular popular television shows, which were considered by young people to be ideal for use in schools. The majority of young people knew where to get family planning services, but there was less awareness of where to get help on wider sexual health issues. Young people wanted services located discretely, preferably in a non-medical setting, with friendly non-judgemental staff. Although professionals considered that more should be done to train parents to talk to their children about sex, few young people considered they could talk to their parents about such issues. Professionals and young people agreed that the greatest requirement from services was privacy and confidentiality. Condoms were reported to be easily available, yet barriers remain to their use, particularly when instigated by young women. Young people considered that alcohol was far too easily available and was responsible for increased risk behaviour.

Key actions for Western Cheshire

- Ensure consistent, early Sex and Relationships Education in schools from well trained teachers or third party providers.
- Lobby for increased controls on availability and price of alcohol.
- Ensure that education and signposting covers sexually transmitted infection services as well as contraception, and target college students with information on the whole range services available in community and sexual health services.
- Improve advertising of services available in the community. This applies to health professionals as well as public, so that general practitioners no longer advise attendance at a genito-urinary medicine clinic when community clinic could provide the same service.
- Address the areas where there are gaps in service provision. For example there is currently no community and sexual health service or young person services on a Monday in Neston, Frodsham, Malpas and Audlem.
- Plan services for young people that are discretely located in non-medical settings, with staff that are trained to deal with young people in a friendly and non-judgemental manner.
- Investigate the variable long-acting reversible contraception removal rate. For those with high removal rates, ensure that professionals are providing adequate information on the advantages and disadvantages of each method of contraception.
- Investigate needs of populations not covered in detail in this assessment, such as the aging HIV positive population.
- Address the lack of engagement between schools, colleges and other gatekeepers for young people and the needs assessment process, since lack of participation by these young people has significantly weakened these conclusions

Summary of chapters

Key Findings on sexually transmitted infections and HIV

- Western Cheshire has the third highest prevalence of key sexually transmitted infections in the Cheshire and Merseyside sub-region with 662 infections per 100,000 population. The highest diagnosed prevalence of sexually transmitted infections (over 1131 per 100,000) was in populations living in the city centre, and to the north east of the city centre in villages such as Dunham-on-the-Hill.
- Uncomplicated chlamydia (267 per 100,000), followed by genital warts (247 per 100,000) were the most prevalent infections. Males had higher rates of chlamydia, gonorrhoea and syphilis, and females higher rates of herpes and warts.
- The highest sexually transmitted infections prevalence by age was among the 20-24 years (3,029 per 100,000), with 15-19 year olds representing the next highest (2,084 per 100,000). 20-24 year olds reveal the highest prevalence of chlamydia (1,356 per 100,000) and also genital warts (1,130 per 100,000).
- There was an age/sex cross over with young females having a higher rate of infections than males, crossing over to older males having a higher rate than females. A low prevalence of all key diagnosed sexually transmitted infections were reported in those aged over 50 years.
- Western Cheshire had 126 individuals in HIV treatment and care in 2008 and a prevalence of 54.2 per 100,000, compared with 79 per 100,000 for the north west, ranging from 378 per 100,000 in Manchester to 19 per 100,000 in Allerdale.
- A low proportion (15%) of individuals in treatment and care for HIV had an AIDS defining illness, which is lower than the average proportion (22%) in the North West.

Key Findings on sexual health delivery from surveillance data

- Examination of the treatment locations of persons living with HIV in Western Cheshire shows 75% seek treatment and care from the department of Genito-Urinary Medicine at the Countess of Chester Hospital. There were a total of 732 outpatient episodes recorded at statutory centres giving an average of ~six visits per individual a year, lower than the 7.45 average visits for the North West.
- Between April 2008 and March 2009 there were 10,255 attendances at community contraceptive services, one third of clients were aged under 25 years.
- 207 under-25 Young People Clinics were held over the data collection period and each session was attended by an average of 16 young people.
- The main reason females attended the clinics was to obtain the contraceptive pill; a higher proportion (57%) of females under 18 requested the pill compared with 40% over 18s.
- About 12% of attendees request condoms.
- 610 chlamydia tests were performed by GPs per quarter, with variation by location.
- 188 implants were administered by GPs per quarter.
- Very few young females in Western Cheshire utilise community contraceptive services for post-coital treatment (hormonal or intrauterine contraceptive device) or advice.
- No requests were documented for intrauterine contraceptive device, patch, female condom, or fertility issues.
- 39 general practitioners offer tier 1 enhanced services; general practice tier 2 level services appear patchy.
- General practitioners removed one implant for every two new implants given, there was a wide difference in the number of implants given and removed by location, and by quarter. It is unclear whether this is by chance or if other service factors have come into play. The overall rate of general practitioner prescribed long-acting reversible contraception is higher (52 per 1,000 females ages 15-44) than the England average (41 per 1,000 females ages 15-44).
- Of emergency and non-emergency contraceptives issued in 2009, 75% were for combined oral contraception, 20% for injectable contraception, and 3% for emergency contraception.
- 3,000 and 350 clients are prescribed oral and injectable contraception respectively each month. Contraceptive patch and intrauterine contraceptive device prescriptions range between 12 and 55 per month.

Key Findings from Stakeholder engagement Meeting

Stakeholders with an insight into patient/client needs were invited to contribute to a group discussion (28 Jul 2009), since not all population groups could be invited for primary research. Participants' suggestions are included if there was general consensus.

- **Participants' assessment of progress**

Partnership: There is strong linkage with other organisations including hospitals, schools and communities. A number of sexual health services have been developed and are available in communities (e.g. health zone, Connexions). However this collaborative work is on a micro-scale, not widely generalised to cover the whole area and should be expanded, e.g. to young workers and volunteers, Chlamydia screening service.

Services are wide ranging and largely work well (e.g. chlamydia screening, Genito Urinary Medicine, Utopia for Lesbian, Gay, Bisexual, and Transgender, Contraceptive and Sexual Health, antenatal care delivered by the midwifery team). Target groups (e.g. teenage mothers and university students) are aware of the services and do make use of them. However, there is some concerns that the approachability of General Practitioners might limit accessibility of sexual health services.

Policy needs to achieve a balance between national and local priorities. Prevention strategy should be further developed and linked into other public health areas (e.g. alcohol, drugs).

- **Needs**

General public's greatest need from services is privacy and confidentiality. Services should be extended into the community (e.g. more centres) and be established in other places (e.g. Aqua House). Services should focus on health and well-being and target children and families.

Men: There are many issues around men's engagement, with male only sessions not well attended. The use of sports clubs, army camp and engagement with 16-18 year-olds in Further Education colleges was suggested.

Vulnerable groups: Some vulnerable groups are small and dispersed (e.g. Eastern European immigrants) and difficult to access (e.g. sex workers, travellers, drug users). It was reported that their needs were not well understood and poorly catered for.

- **Barriers**

Knowledge and education of sexual health issues was raised as an important barrier, with low levels of sexual health education in young people (particularly around long-acting reversible contraception). Parents should be encouraged to educate their children about sexual health. Some of the health care providers (e.g. General Practitioner, pharmacists, nurses) lack skills in delivering sexual health services. Further training courses should be considered and supported.

Services insufficient for need: Participants identified a variety of services that should be provided (e.g. C-card, genitourinary medicine, long-acting reversible contraception, and Chlamydia screening etc.)

Accessibility: Revise the location and opening hours of services (e.g. there are no evening services for Ellesmere Port), increase the number of services and focus on high risk areas. Services should be more widely available, perhaps through other health organisations to improve accessibility. Engage with the other potential community groups (e.g. young people groups, schools, substance misuse services). A call centre for sexual health should be established to give consultations to potential clients and direct them to appropriate services.

Service providers with good frontline access (e.g. General Practitioners, pharmacists, health nurses) need training. Some lack communication skills for dealing with young people. Even if this can be supplied, it is not possible with transient locum pharmacist population.

Funding was known to be limited, but it was felt the PCT was not trying innovative techniques.

Transport was identified as a major barrier. The issues included: rural nature of Western Cheshire; difficultly in travelling from east to west; and expense.

Other barriers included culture (alcohol use is a barrier to good sexual health and the conservative nature of the community prevents approach to sexual health services), lack of ability/willingness to approach target groups (rather than wait for people to visit), lack of data sharing, lack of use of technology to engage with the public (e.g. websites, online communities).

- **Priorities**

Service: Strengthen commissioning strategies to ensure change; train more staff to administer long-acting reversible contraception and put long-acting reversible contraception into the contracts; increase accreditation levels for pharmacy to offer emergency hormonal contraception; find better ways to distribute condoms; provide holistic care, build up call centre system.
Policy: ensure prevention is integrated; improve communication to ensure knowledge is shared.
Partnership: expand collaborative work to others (e.g. police, local authority, schools/colleges) and formalise joint work (clear commissioning with integrated approaches to prevention).
Communication: promote services using clear marketing strategy and improve communication at every level.

Key Findings from Study of Service Users

- 184 service users (99 from genitourinary medicine and 85 from community and sexual health services) contributed towards a survey on their attitudes, opinions, needs and practices related to sexual health services in Western Cheshire; a higher proportion of respondents were female (71.2%).
- ~70% of genitourinary medicine respondents attended for a sexually transmitted infection check, and 30% of respondents required chlamydia screening. Double the proportion of females stated they sought chlamydia screening. A third visiting community and sexual health services sought oral contraception, with a further third attending for other reasons (cervical smear, pregnancy advice, removal of implants/coils). 14% of males and 6% of females utilised their visit to get condoms. Few sought emergency contraception, support for a termination, sex advice or counselling.
- The majority heard about sexual health services from a friend or from a general practitioner. Genitourinary medicine services were also identified via the internet, while community and sexual health services were signposted through colleges and/or schools. Adverts were a poor source of information.
- The majority of respondents attending genitourinary medicine made an appointment; half waited less than a day, a further third waited a few days. A small proportion (~10%) recorded they waited a week or longer.
- Genitourinary medicine users travelled longer distances to get to the service; data show some clients travelled over 6 miles to genitourinary medicine for services that could be obtained locally, e.g. condoms.
- One in seven clients missed work, college or school to attend a sexual health service. A higher proportion (19%) missed work when visiting genitourinary medicine versus community services (7%). All persons seeking termination, pregnancy test, or emergency contraception had missed work, college or school.
- A warm and friendly welcome was considered the most important attribute of a sexual health service, followed by having private rooms and time to talk. More females than males requested free condoms, and younger people wanted services closer to their home, and to see the same person on each visit.
- The majority of males (75%) and half of females (48%) wanted services to be located in a hospital and a higher proportion of females wanted them located in the doctors clinic. Few wanted them located close to school, college or work, in town centres, in youth centres, or through a mobile bus service.
- Males preferred to talk to a sexual health doctor, while females opted for friends before the sexual health doctor. A quarter thought talking to the family doctor was difficult.
- Two thirds of males and half of the females would prefer to be referred to a hospital, and an equal proportion considered a special clinic for all ages, the family general practitioner, and a general practitioner close to school or work.

Key Findings from the Further Education College survey among young people

- A survey of 223 students 16-19 years of age, from Mid Cheshire College, was conducted to identify local young people's attitudes and practices to sexual health.
- Two thirds of males (68%) and three quarters (76%) of females reported having sexual intercourse; two thirds experienced oral sex; both males (32%) and females (28%) went further sexually than wanted or planned, and nearly a quarter claimed they were pressured against their will to have sex.
- 14 years of age is a vulnerable age for young people, as it was the most common age to have first sex, oral sex, and to be pressured to have sex against their will.
- Of those having sex, 16% of females and 7% of males discussed with a parent about having first sex prior to the event; the majority indicated parents never knew, or if parents found out they were mostly supportive, however 10% of females stated parents were very angry.
- 59% of females had first sex in their partners (boyfriends) house, double that of males (29%), while more males (43%) than females (22%) had first sex in their own homes. 10% or less had first had sex in a public place, party or elsewhere.
- Of those reporting having ever had sex, 58% reported using a condom during first sex. A quarter (24%) were on the contraceptive pill; no protection was used by 10%; and 7% of females reported using emergency contraception (morning after pill) following their first sexual encounter.
- Condom use decreased between first and recent sex; among males from 46% to 44%, and among females from 61% to 40%. Condoms are rarely used during oral sex.
- 11% of females had been or were pregnant, the majority at age 16; 1 in 10 of these pregnancies were planned. Half of the pregnancies went to full term.
- 40% of females reported having a pregnancy check and half sought emergency contraception.
- More females (43%) than males (32%) agreed girls sometimes say no to sex when they mean yes.
- Most young people thought 20-29 was the ideal age to become a parent. If they became a parent before 20, half thought they would cope well and a quarter thought it would be a nightmare; only 4% said it would be worth having a baby to get extra benefits.
- The students indicated their local general practitioner as the predominant place to get help or advice on sexual health. This included visiting the general practitioner first for a pregnancy check, relationship health/advice, oral contraception, termination of pregnancy information, and long-acting reversible contraception.
- Significantly more females than males attended sexual health services in the past three months.
- 72% of females and 45% of males stated they did not know a specific local location to get a test for a sexually transmitted infection; however 76% knew where to attend for 'family planning' information.
- Over 90% reported they received sex and relationships education at school. Most young people sought sexual information from a variety of sources such as magazines, television and the internet, including pornography, and only 3% wanted information but had not sought it.

Key Findings of the Connexions Service Survey

- 466 young people 12 to 20 years old were surveyed through Connexions in a variety of settings throughout the area, in March 2010; the majority were 14-17 years of age.
- A high proportion of young people stated that they knew where sexual health services were but where to get information generated from a broad range of answers. Young people gave different answers to who they wanted to talk to about sexual health and who to get information from; thus, they prefer to talk to family (25%) and friends (19%), but only ~5% said they get information from 'Home/Friends and Family'.
- Young people would also access information from their doctor, or a hospital. Chemists or pharmacies were thought of as good locations to access sexual health services.

- When asked 'where do you get information about contraception and sexual health?' the most popular location was 'Sexual Health/Family Planning Clinic, followed by Health Centre/ Community Centre' (30%), the 'Hub/Youth Club' (19%) and 'NHS/General Practitioner Surgery' (16%).
- Young people recognise they can get contraception and have conversations about safe sex at sexual health services, but few recognise sexual health services provide someone to talk to or develop young people's understanding and awareness.
- Barriers to using services related to fear of parents knowing, not knowing where services were, embarrassment, and opening times, suggesting a one stop shop may be useful as it does not define reason for visit as specific to sexual health.
- Young people considered religion has an influence on their sexual health seeking behaviour but not necessarily how much they access services.
- Over half (56%) wanted to access sexual health services during the weekday, with mostly older people stating weekends. Different times were mentioned, with the highest proportion (33%) suggesting 6-9pm.
- 30% of young people surveyed had accessed services; rising from a quarter of 13-15 year olds to half of 18-19 year olds.
- Experience of sexual health services was generally positive in each area, with high proportions rating the service they accessed as 'very good' or 'good'. Preferences for services differed by geographical area, but not by gender.
- Comments on improvements included better opening times, more autonomy, better advertising, and privacy and confidentiality. However, only 9% had heard of 'You're Welcome'. Findings suggest a need to broaden the information on what services are available and from where, to further expand the You're Welcome Standard.

Key Findings from Focus Groups

- Young people were aware that risk taking occurred amongst their peers. Whilst there was a core of young people who did not use condoms for protection, many young people would use them if they had access to them at the time. If not available, this would not deter them from having unprotected sex as immediate gratification far outweighed any fear of sexually transmitted infections or pregnancy.
- While young people can easily obtain condoms, problems occurred at night time if sex was unanticipated, or if they were drunk. Another barrier to access was cost. However, free availability of condoms in vending machines etc. would be wasted.
- Young people vehemently agreed that alcohol increases sexual behaviour, casual relationships and unprotected sex; makes girls more confident and lowers their inhibitions. They consider alcohol too easily available, and more control is needed.
- Drug taking also results in sexual risk taking but young people felt drugs were more harmful; Viagra is taken to counter the negative sexual effects of alcohol.
- Brook educational activities provided skills on condom use even when drunk.
- There was evidence of negative attitudes towards girls who carry condoms (classed as sluts/slags).This had the compounding effect of preventing girls from carrying them. Two suggestions were to include girls in condom adverts (always feature men), and make condoms more like fashion accessories with good packaging and colours.
- Young people thought an overemphasis on pregnancy and contraception in sex and relationships education has created a greater concern about pregnancy and less concern about sexually transmitted infections.
- Despite this, during sex young people rarely think about pregnancy; most are accidents; generally girls did not get pregnant for benefits/housing, but may if they have no ambition, want independence, or mimic their own upbringing. Teen mums were worried their own children would also become teen parents.
- Some positive comments were made about young parenting, including it offered some girls structure and stopped some from drinking or taking drugs.

- Participants were aware of chlamydia and gonorrhoea; they felt chlamydia campaigns and adverts meant young people only knew of this, and nothing about other sexually transmitted infections. Young people have a casual attitude towards contracting chlamydia and think it easily treatable, but having any other sexually transmitted infection is stigmatising and is a barrier to screening.
- Participants were ignorant about HIV and Aids, only aware through the teen TV soap Hollyoaks, and believed they were not at risk. It was too scary to risk being tested.
- A lot of knowledge about sexually transmitted infections has come from *The Sex Education Show* and *Embarrassing Bodies,* two TV shows that young people praised and wanted copied in schools.
- Within the focus groups, many did not know the names or whereabouts of the sexual health clinics; they were unsure if they could go to their general practitioner; many would be too embarrassed to attend for an STI and feared their parents would find out.
- Young people felt they were talked down to, and confidentiality was breached by calling out their names in waiting rooms.
- Limited opening times, needing an appointment or drop in, and access greatly confused young people and was a barrier to use; advertising must improve.
- Friendly, approachable and non-judgemental staff were required, with staff that enable young people to talk about their problems.
- Young people considered sex education should have a broader curricula including sexually transmitted infections and relationships, not just about pregnancy. It should be started at a younger age before sexual debut, and be taught by professionals, with good materials.
- Being scared to talk to parents prevents some young people from getting advice and seeking help early, poor parental communication increases young people's risk.

Key Findings from pupils receiving Sex and Relationships Education lessons in a school in Western Cheshire

- 390 young people aged 11-14 years attending a school participating in the North West sex and relationships education evaluation project completed a pre-intervention baseline survey questionnaire during school time.
- Trust, love, able to be yourself, and good friendship were identified as the most important features of a 'relationship'. 7% ranked safe sex as important.
- Young people get information from school, parents and youth workers; few stated friends, siblings, or their doctor. Older children (year 9) went to youth workers and less to parents. Young people would like to get more information predominantly from parents, girl/boyfriends, school, and magazines.
- Young people talk to parents about body changes and puberty, stress, relationships, and bullying. Girls report talking to parents more than boys but <5% talk about conception and twice as many boys as girls talk to parents about sexual activity A threefold higher proportion of girls talk to parents about pregnancy, suggesting talk about sex and contraception misses any discussion about sexually transmitted infection risks.
- At school young people learn about relationships, their body and puberty, sexual activity (particularly older children), sexual infections, and a number of self-esteem, and practical aspects about sexual relationships. 11-12 year olds had no education on sexual activity.
- In each year group young people wanted to know more about how to say no, older age groups wanted more information on condom use and how to prevent sexually transmitted infections, and about sexuality.
- 32% of females and 43% of males agreed they would be able to buy condoms, however nearly half of girls stated they would be able to ask a partner to use a condom.
- Over three quarters of girls and just over half of the boys thought they would be able to say no to sex or sexual actions that they did not want. Over 50% of boys and 43% of girls were not sure if they could access emergency contraception.

- Double the proportion of girls (7.1%) recorded having intercourse compared with boys (3.7%), and 8.9% of girls and 5.6% of boys had had oral sex. Reasons for having a sexual relationship were predominantly being 'In love' for girls and to try it out for boys. 17% of girls, but no boys stated it was because they were drunk.
- Boys reasons for not yet having a sexual relationship were because they are too young and did not want to, but the main reason for girls was fear of pregnancy, followed by too young, followed by not wanting to/not having met the right person/not being ready. Girls cited parental disapproval and fearing pregnancy, but not fear of a sexual disease.

Key Findings within Teenage Pregnancy Rates

- The under 18 conception rate remained relatively stable until 2007 when, in line with a national trend, the rate sharply increased (39.3 per 1,000 females aged 15-17). This figure is higher than that of the 1998 baseline and represents a considerable challenge to reduce and ultimately meet the 2010 target.
- 2008 data showed a reduction compared to 2007 and the rate now stands at 6.1% lower than 1998 baseline.
- Compared to Cheshire West and Chester's statistical neighbours (Stockport Warwickshire, Warrington, and Cheshire East), Cheshire West and Chester has had lower progress in reducing its under 18 conceptions target.
- Although Cheshire West and Chester has a low level of deprivation, the under 18 conception rate is slightly higher than nationally predicted or expected. It is noted that the majority of Cheshire West and Chester's statistical neighbours have rates below the predicted rates.
- In the first half of 2008 Western Cheshire reduced the rate of abortion to well below the North West average.
- Compared to national and regional rates, Cheshire has a lower rate of conceptions to 16-17 year olds, and also a lower rate of conceptions to under 16s.

Key findings of Service Mapping

- Services are generally located in the most populous areas.
- In the Neston area, community and sexual health services are available for two and a half hours a week. Emergency contraception is available on six days. There is no young persons' service.
- In the Ellesmere Port area, emergency contraception is available seven days. Young people centres are available on Monday, Tuesday, and Wednesday. However they are only open during school/college hours during Mondays and Wednesdays.
- In the Frodsham area, emergency contraception is available six days. There are no community and sexual health services or young people services.
- In Chester, a wide variety of services are available over seven days. This includes the PCT's only genitourinary medicine department and termination of pregnancy service.
- In the area of Malpas, a service for young people operates for two hours a week. There are no pharmacies offering free emergency contraception in this area.
- In the area around Audlem, there are no services specifically for young people. Emergency contraception is available six days a week.

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Contents

1. Introduction

National and regional perspective

The decline of sexual health in the United Kingdom population is cause for concern. The rates of newly diagnosed sexually transmitted infections (STIs) and human immunodeficiency virus (HIV) continue to increase nationally. The total number of new HIV diagnoses in the United Kingdom in 2008 was 7,298 compared with 1,415 in 2001, a percentage increase of 415%. The rate of chlamydia diagnoses has more than doubled, from 447 per 100,000 in 1998 to 1,102 per 100,000 in 2007. Although rates of gonorrhoea have declined in recent years from the peak in 2002 (186 per 100,000), to 130 per 100,000 in 2007; rates are still a third higher than in 1998 (96 per 100,000). More locally, in 2007 the North West recorded higher than national average rates of diagnoses for the five key sexually transmitted infections (gonorrhoea, syphilis, chlamydia, genital warts, and genital herpes)[1]. Sexually transmitted infections affect all age groups, ethnicities, and sexual orientations; however data show that young people under the age of 25 in the United Kingdom continue to be disproportionately affected by sexually transmitted infections.

The health of adolescents is a growing concern in developed countries, particularly the United Kingdom. The death rate of 15-19 year olds in the United Kingdom is now higher than in the under 5's[2]. Health risks are associated with alcohol/drug abuse, social disruption, depression and stress. A fifth of adolescents have mental health problems with serious problems in one in eight boys and one in five girls aged 11-15[2]. UNICEF placed the United Kingdom last in a league table on child wellbeing in the 21 richest countries, based on data gathered on 40 indicators including poverty, family relationships, and health[3]. A YouGov poll, reported by the Prince's Trust in January 2009, found half of 2000 teens questioned regularly felt stressed, a quarter were often down or depressed and one in ten felt life was meaningless[4]. Bullying, including sexual bullying, is now endemic in the United Kingdom[5]. The national Tellus3 survey found nearly half of children reported bullying at school and over 40% felt it was not dealt with well[6]. Engaging in two or more health-risk behaviours such as smoking, alcohol, drugs, and risky sexual behaviour predicts psychological distress and depressive symptoms[7]. Adolescent binge drinking causes significant current and long term harm, and correlates with violence, sexual risk-taking, and sexual victimization[8,9,10,11].

Adolescent sexual health is of particular concern. Earlier onset of puberty results in uninformed risk-seeking behaviour and increased vulnerability at ever younger ages[12]. Nationally a quarter of young people reported sexual debut before the age of 16 with the median debut age of 16 years[13]. The risk of sexually transmitted infections doubles with early sexual debut[14], with a higher risk if first infection occurs before 16 years[15], Use of a condom at first intercourse is lower the earlier the sexual debut. United Kingdom teen pregnancy rates are the highest in Europe and relate to poor parental supervision, deprivation, city living, low educational expectations, and poor access to services. Girls having sex aged under-16 are three times more likely to become pregnant than those beginning after 16, and is highest in early school leavers with no qualifications[16]. In 2006, 7.8 and 40.9 per 1,000 13-15 and 15-19 year olds, respectively, became pregnant in England and Wales[17]. In the past decade conceptions rose 9% in 15-19 years olds (from 94,900 to 103,100) while dropping 12% in 13-15 year olds (8,900 to 7,800) and 4% in 15-17 year olds (43,500 to 41,800)[18]. Under 18 (15-17 year olds) pregnancy rates per 1000 in England & Wales, and NW England were 40.9 and 44.2 respectively. In the most vulnerable, one in three girls become a teen mother by age 20[19]. Pregnancy prevention, including abortion, is crucial because of the poor health and wellbeing outcomes (including a 60% higher infant mortality rate) associated with teen pregnancies[19]. The choice to abort decreases by age (65% at 14, 49% at 16, and 39% at 18)[17]. The proportion of under-18's who undergo abortions is the same nationally, regionally and locally (48%)[17].

Rates of sexually transmitted infections have risen dramatically in the United Kingdom since 1997, with a high burden in young people 16 to 24 years old[20,21 22]. Young people account for half of all sexually transmitted infections diagnosed in genitourinary medical (GUM) clinics, while representing only 12% of the population[20,22]. Data from national and North West England GUM clinics indicate diagnosis is proportionately higher in young females compared with males[22,23]. In the North West, a local study found nearly half of males 16 years and older would not go to a GUM because of embarrassment, 43% because they did not know where it was, and a quarter because they feared someone would find out they had been[24]. When questioned specifically, only 13% knew where their local genitourinary medicine clinic was.

In the United Kingdom, risky behaviour tends to refer to drug, alcohol and tobacco use, as well as underage sex and any unprotected sexual activity. Risks additionally also involve behaviours such as criminal activity, carrying weapons, gang membership, bullying, running away, obsessive study leading to stress, contact sports, sedentary lifestyles, excessive 'screen watching', over- and under-eating. Alcohol use and pervasive bingeing (5 or more per session) have become entrenched within youth culture, creating one of the greatest challenges to United Kingdom public health in recent years[25,26,27]. Adolescents in the United Kingdom outrank their international peers with 15-16 year olds ranked in the top 5 of 30 countries for most measures of alcohol abuse[28]. A national study reported 52% of 11-15 year olds have drunk alcohol, including 16% of 11 year olds[29]. While this is a drop from 61% in 2003, between 2007 and 2008 consumption in those drinking rose 15% to 14.6 units with the greatest rise in 11-13 year old girls (63%). North West England represents an area of the United Kingdom with heavy drinking and high levels of alcohol-related harm[30]. Surveys report a third of 15-16 year olds binge drink weekly[31,32], and alcohol-related hospital admissions are the highest in the country[30]. Evidence is accumulating, particularly from American studies, of a strong association between alcohol abuse in young people and poor sexual behaviour[33]. These studies suggest early regular consumption is associated with early onset of sexual activity, and any drinking is associated with being sexually active[33,34]. Few peer reviewed studies are available from the United Kingdom, and most reports are anecdotal, or based on local area data[35]. A NW regional survey did find, however, a 2-fold higher risk of regretted sex in 15-16 year olds who had been binge drinking[10]. Exploration of associations between alcohol abuse and sexual behaviour in adolescents in the United Kingdom is thus required to inform integrated strategies at local regional and national level.

Sexual health services for young people

A bold whole-system approach, with a broad set of integrated policies to enhance wellbeing, is required to counteract risks to health and wellbeing in young people in the United Kingdom. Good quality sex and relationships education (SRE) is required to ensure young people acquire the knowledge and skills to stay healthy and achieve sexual health[36,37,38,39]. Five key factors needed for sexual health are compulsory SRE in schools, access to local services, meeting women's needs in relation to abortion, building contraceptive services, and prevention of sexually transmitted infections[40]. The reshaping of children and young people's services, through Every Child Matters and Youth Matters programmes (Box 1), aims to prevent poor outcomes, target the underlying risk factors linked to teenage pregnancy, and give young people the chance to make positive choices and achieve their potential[41]. Stigma and barriers to health seeking by young people are being tackled, by locating services in places where children and young people go[42,43].

Box 1 Choosing Health[44]and Every Child Matters[41] guidance

The Choosing Health White Paper contained a specific focus upon young people, in line with the Every Child Matters recommendations, and recognises that 'emotional well-being underpins good physical health and reduces the likelihood that children and young people will take inappropriate risks'. To this end the White Paper states that:

- extended schools can also provide, for example, One Stop Shops and multi-agency health centres located on a school site, which will enable health professionals to work alongside education and social care professionals;
- personal health guides (PHG) will encourage young people to build health into the way they live their lives;
- general information, advice and support about health issues, as well as emotional wellbeing, puberty, sexual health and access to further help and advice will be provided, for example, through a confidential email service;
- learning about health choices and managing risk will be supported, for example, through incentive schemes using reward points.

Department of Health (2004) Choosing Health: making healthy choices easier
DfES (2003) Every Child Matters

Local authorities (LA) and primary care trusts (PCT) are required to take young people's needs into account, applying criteria to services to become young people friendly. The Department of Health provides 'You're Welcome' quality criteria (2007)[45] to aid in the promotion of young people (under 20) friendly services. The criteria covered many areas including accessibility, publicity, confidentiality, environment, staff training, joined up working, monitoring and evaluation, health issues, sexual and reproductive health, and mental health services.

The Department of Health has prioritised sexual health as a key public health issue in the United Kingdom. It defines the need to reduce the prevalence of sexually transmitted infections, reduce unintended pregnancies (particularly in teenagers), and to improve the range, access to and quality of service provision. Their National Strategy for Sexual Health and HIV, developed in 2001, has several specific aims (Box 2).

Box 2 The National Strategy for Sexual Health and HIV[46]

In 2001, the Government published the national sexual health strategy, which aimed to:

- reduce the transmission of HIV and sexually transmitted infections;
- reduce the prevalence of undiagnosed HIV and sexually transmitted infections;
- reduce the rates of unintended pregnancies;
- improve health and social care for people living with HIV;
- reduce the stigma associated with HIV and sexually transmitted infections.

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

The Government hoped to achieve their aims through, for example, the provision of clear information; ensuring there is a sound evidence base for effective local HIV/STI prevention; setting a target to reduce the number of newly acquired HIV infections; developing managed networks for HIV and sexual health services; evaluating the benefits of more integrated sexual health services[47], including pilots of one-stop clinics; beginning a programme of chlamydia screening; stressing the importance of open access to genito-urinary medicine (GUM) clinics and ensuring that a comprehensive range of contraceptive services are available to those who need them[48]. Specific government targets were defined in the White Paper Choosing Health: making healthier choices easier (Box 3).

Box 3 Choosing Health[37] guidance

In 2004 the public health White Paper, Choosing Health: making healthier choices easier, called for action to improve sexual health in the United Kingdom, through a £300 million investment over three years. The subsequent action plan reinforced earlier public service agreements. Clear targets were set in the paper and incorporated:

- 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.

Department of Health (2004) Choosing Health: making healthy choices easier.

Through government investment genitourinary medicine clinics across the United Kingdom have worked towards improving patient waiting times. The 48-hour waiting time audit was established and has been in place since 2004 recording the progress of clinic waiting times. With the increased emphasis on sexual health from the Department of Health there are high-profile targets to be achieved, including the 48 hour appointment target[37]. The improvement of sexual health was one of the top six priorities for the NHS in 2006/2007 and continued to be the case for 2007/2008. To help ensure these targets are met it is essential that comprehensive monitoring of services and service users is in place to further focus resources where they are needed most.

Government investment also produced a national campaign to promote the use of condoms. 'Condom Essential Wear' was launched and has been running since December 2006 along with the sexual health campaign for young people, RU Thinking. Both campaigns also have websites providing additional information and advice. Additional community services have been set up to provide sexual health screening for chlamydia and to provide more local and specific sexual health services for young people, for example, with one stop shops and C-card distribution schemes. More specifically, targets were set to address acute needs. For example, the National Chlamydia Screening Programme's aim to control genital chlamydia among people aged under-25 through early detection and treatment with a target to screen 15% of the eligible population (15-24 years) in 2007/2008[49]. Recent guidance outlined in 'vital signs' reassesses the target for 2009/10 and suggested PCTs plan to screen 17% of the eligible population in 2009/2010 as part of tier two national priorities[50].

One of the key targets from the White Paper (see Box 3) is to reduce the under 18 conception rate in line with the 1999 Teenage Pregnancy Strategy[37]. However, there continues to be a high number of teenage conceptions in the United Kingdom, a high proportion of which lead to abortion[51]. In addition, the United Kingdom has the highest rates of teenage births in Europe. UNICEF have rated the United Kingdom as bottom of 21 'rich' countries with regard to general child health, and also report that more United Kingdom children have had sex by the age of 15 than any other country in the survey[52]. This gives rise to public health concerns because of the links between teenage pregnancy and low socioeconomic status. Research suggests that not only can teenage pregnancy have a negative impact on a young woman's academic achievement, employment, earning potential, mental health and living conditions, it can also have a negative impact on the child. The child of a teenage mother is more likely to belong to a one-parent family, be a low academic achiever, experience abuse, be involved in crime, misuse drugs and alcohol and become a teenage parent, thereby perpetuating the cycle[53].

The Teenage Pregnancy Strategy: Beyond 2010 updated policy to address the changing situation. The under 18 conception rate is now 13.3 per cent lower than in 1998 (Ref: Teenage Pregnancy Strategy: Beyond 2010). Local progress on reducing teenage pregnancy rates shows a great deal

of variation. While 28 percent of areas have reduced rates by over 20 per cent, around 14 per cent show an overall increase since 1998. Although this is behind the trajectory needed to achieve the target to halve the teenage pregnancy rate by 2010, conceptions and births are at their lowest level for over 20 years.

Since the 1998 strategy there has been a shift in society's views about how best to tackle problems like high teenage pregnancy rates and poor sexual health amongst young people. There is now a clear consensus among the majority of parents and young people on the key issues; young people and parents both expect that most young people will have their first sexual experience between 16-17 years of age; young people (96 per cent) and parents (86 per cent) support SRE being a statutory part of the national curriculum; 86 per cent of parents believe there would be fewer teenage pregnancies if parents talked more to their children about sex and relationships; and over 80 per cent of parents agree young people should have access to confidential contraceptive services, even if they are under 16.

There has also been a significant change in the services provided for young people, to help them make safe and healthy choices about sex and relationships and to avoid unplanned pregnancies and sexually transmitted infections. In 1998, there were a relatively small number of discrete young people's sexual health services, but for the majority of young people access to contraceptive and sexual health advice was limited to their local GP or an all-age sexual health clinic. By 2007, around 30 per cent of secondary schools and three quarters of Further Education colleges had an on-site health service, providing advice on relationships and a range of services.

While there is still a long way to go, the level and quality of information, advice and support for young people has improved. Personal, Social, Health & Economic (PSHE) Education (which includes sex and relationship education [SRE]) is judged by OfSTED to be improving overall and good in many schools. Over 10,000 teachers have taken part in the national PSHE training programme. SRE is increasingly included within tutorial and enrichment programmes in Further Education. Clear and consistent messages have been promoted to young people through media campaigns, and more parents feel confident to talk to their children about sex and relationships.

The future focus will be on improving young people's knowledge, skills and confidence – through strong, consistent delivery of SRE in schools and other settings; support for parents to talk to their children about sex and relationships; and clear and consistent media messages – alongside improving access to and use of effective contraception. Universally provided to all young people, with more intensive support for those most at risk.

The Government has set contraceptive services as a high priority within sexual health. It is recognised that access to sexual health services varies across the country. The Government stated in the *National Strategy for Sexual Health and HIV* that they would ensure a range of contraceptive services are provided for those who need them and promised an audit of contraceptive service provision in its White Paper, *Choosing Health*[46,37]. Contraceptive services are cost effective and are estimated to save £11 for every £1 spent; and the prevention of unplanned pregnancies by NHS contraceptive services saves the NHS over £2.5 billion per annum[54]. The average spend on community contraceptive services (which include primary care prescriptions and emergency contraception) is £11.67 per female aged 15-49 per annum. Good quality contraceptive services are important in the achievement of the public service agreement of reducing under 18 conceptions by 50% by 2010 and also, more broadly, the improvement of sexual health[54]. It is important that patient choice in terms of choosing a method of contraception is a priority and that men and women requesting contraception should be given the advantages, disadvantages and failure rates of each method. As recommended by NICE, this should also include information on long-acting reversible contraception (LARC) methods[54,55]. It is estimated that 30% of pregnancies are unplanned and, in order to reduce the rate of unplanned and unwanted pregnancies, the National Institute for Health and Clinical Excellence (NICE) has produced guidelines to promote long acting contraception to women[55]. The guidance promotes the

use of long acting reversible contraceptives such as the contraceptive injection, contraceptive implant and intra-uterine methods, which do not need to be remembered daily and are less susceptible to incorrect usage. The most popular methods of contraception for women in 2006-07 were the pill and condoms (46% and 28% respectively), with 21% of women, using long-acting reversible contraception[56].

NICE also aims to improve the deficit in guidance and training available to healthcare workers in order to enable women to make informed contraceptive choices[55]. An issue with the promotion of long-acting reversible contraception, or any method of hormonal contraception, is that it could potentially reduce the number of women using barrier method contraceptives and could contribute to the risk of sexually transmitted infections. However, long-acting reversible contraception has the potential to effectively reduce the rate of contraceptive failure, the average cost of which is approximately £1500 which includes ectopic pregnancy, maternity (live births), abortion, and miscarriage. Further, it is estimated that for every £1 spent on contraceptive services, £11 is saved[57].

Sexual ill health costs the NHS more than £700 million a year[58]. Appropriate investment in sexual health services can deliver healthcare savings through preventing unplanned pregnancies and reducing the transmission of sexually transmitted infections including HIV. The direct cost of treating sexually transmitted infections (not including HIV) is approximately £165 million a year, which would increase if the cost of treating sequelae were included[57]. There is a strong correlation between sexually transmitted infections, sexual behaviour, and substance abuse (including alcohol). The implications for young people engaging in risky sexual behaviour are that they are at greater risk of contracting a sexually transmitted infection; becoming young parents; failing at school; building up longer-term physical and mental health problems; and becoming addicted to alcohol and drugs. The most at risk young people are those[*]

- suffering deprivation and being in lower socio-economic groups;
- who are homeless;
- whose parents have no aspirations or expectation of educational attainment for them;
- not attending school regularly;
- who have no self-worth;
- who were a child of a teenage mother;
- classified as looked-after children;
- who have no-one to discuss intimate issues with.

Recent guidance on 'one to one interventions'[59] published by NICE determines good practice for preventing sexually transmitted infections and reducing under-18 conceptions. Recommendations include health professionals in general practice, community health, voluntary sector and genito-urinary medicine services should identify individuals at high risk of sexually transmitted infections, using the client's sexual history. Further, GPs, nurses and other clinicians should, where appropriate, provide vulnerable young people aged 18 years and under with one-to-one sexual health advice.

Improving the sexual health of school−aged children, their ability to negotiate safe sex, and opportunities to access services is recognised to be a significant public health challenge. In July 2008, the advisory group defined five key things we need in place in order to improve sexual health in United Kingdom: compulsory sex and relationships education in schools, access to local services, meeting women's needs in relation to abortion, building contraceptive services, and prevention of sexually transmitted infection including HIV. The 'You're Welcome' criteria should be

[*] This most at risk list is taken from 'Sex, Drugs, Alcohol and Young People'. Published June 2007 by the Independent Advisory Group on Sexual Health and HIV.

viewed as essential requirements for all Primary Care/NHS Trusts, regarding sexual health services, due to the pressing need to improve the sexual health of young people.

Box 4 Sexual Health Services for Young People

Local areas need to ensure:

- All Contraception and sexual health services for young people are commissioned and provided against the 'You're Welcome' Quality Criteria 2.
- The full range of Contraception methods, including long acting reversible contraception, are available to all young people at convenient times and in convenient places.
- Young people's services are widely publicised through universal services (eg schools, colleges and Integrated Youth Support Services) and through targeted services (eg Targeted Youth Support, Positive Activities, CAMHS workers and social workers/foster carers).
- Contraception and sexual health services for all young people are located in accessible settings, (eg schools, colleges, outreach services and other youth settings).
- Testing and treatment for sexually transmitted infections is provided where possible with contraception as this is an effective way for local areas to meet both chlamydia screening and teenage pregnancy targets. There should be strong links and sign-posting between all sexual health services (including condom distribution schemes, pregnancy testing and NHS pharmacy emergency hormonal contraception schemes).
- Abortion providers are funded to supply the full range of contraception methods in line with new NHS contract requirements to ensure that young women receive immediate and continuing contraception post-abortion. This is an essential part of reducing repeat abortions in young people, which are as high as 20% in some areas.
- Contraception is accompanied by well planned and effective sex and relationships education (SRE) in schools and colleges and other relevant settings and support for parents in talking to their children about relationships, contraception and sexual health.

Evidence suggests that young people with disabilities (learning and physical) or chronic conditions are a sexually active group[60,61], and have similar expressions of sexuality, and if not similar levels of sexual experience in comparison to able bodied peers, then at least a substantial prevalence of sexual activity[62,63,64]. However it must be acknowledged that there are variations between these groups of young people, for example Wiegerrink and colleagues (2008)[65] reported that young people with cerebral palsy had less sexual experience than their able bodied peers, whilst other studies have reported either that sexual activity begins earlier[66], or there is a higher rate of sexual activity in comparison with the typical adolescent[67]. It is likely these differences are a function of the degree of incapacity of the groups studied.

There are however, areas relating to sexual health that show some consistent differences between young people with or without a disability. One issue noted in several studies relates to the difficulty that young people with a learning or physical disability or chronic condition report in developing intimate relationships[65,68]. Other studies point to the lack of adequate sex education, specifically contraception and sexually transmitted diseases[62,68,69]. It is widely believed that this is in order to 'protect' the young person. Thus, young people with disabilities participate in sexual relationships without knowledge and skills to keep them healthy, safe, and satisfied, and are at greater risk of abuse[70]. A number of studies have also found that they are more at risk of sexual abuse than their peers[63,66,71].

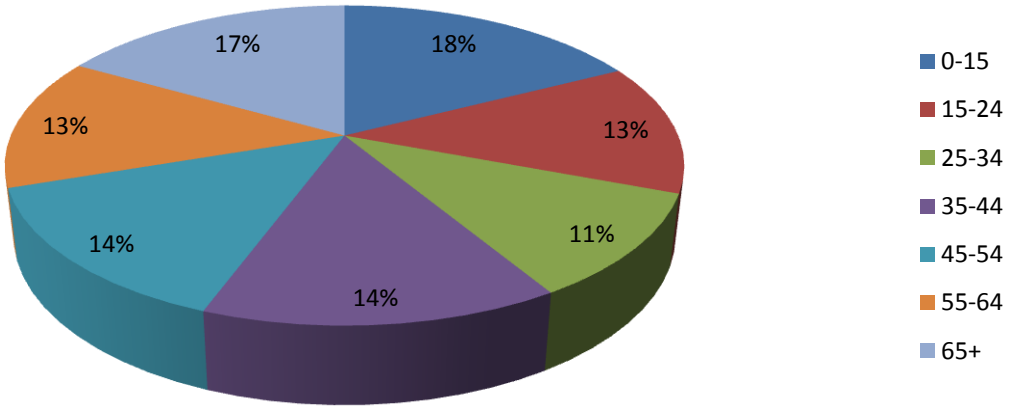
Western Cheshire

Sexual Health is a priority for Cheshire West and Cheshire. The joint strategic needs assessment stated a priority would be to 'Increase the amount of advice and support young people and their parents get on relationships and sexual health'[72]. The needs assessment also stated that local young people wanted sexual health services in local communities but with appropriate branding

and publicity to not cause embarrassment. There was acknowledgement that services should be accessible and friendly; an acknowledgement which should aim to bring services in line with the 'You're Welcome' criteria[45].

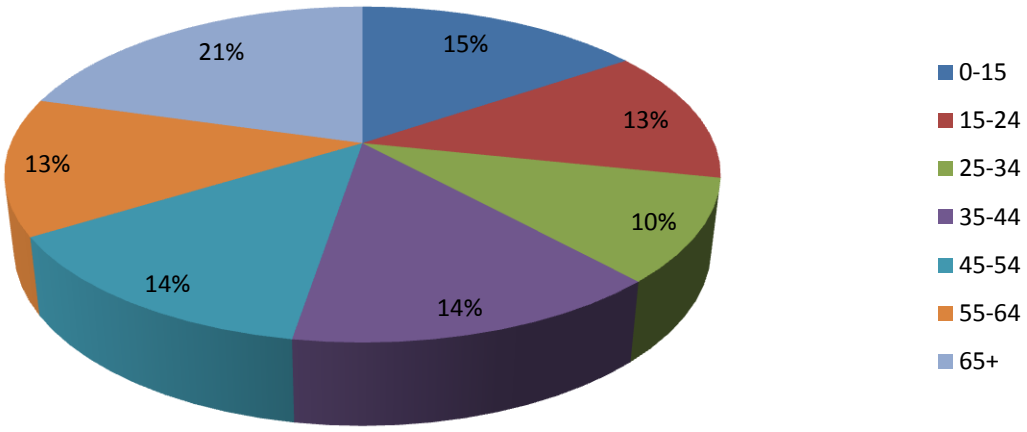
The majority of NHS Western Cheshire sits within the Cheshire West and Chester Unitary Authority boundary with an additional four wards in Cheshire East Unitary Authority (Audlem, Bunbury, Wrenbury and Peckforton). Where possible in this report, data are given for the PCT boundaries of NHS North West. Where data are given only at a unitary authority level, figures for Cheshire West and Chester Unitary Authority are given. The age proportions of NHS Western Cheshire are generally representative of the North West as a whole. Figures 1 and 2 show age categories as a proportion of the total population. The charts show a similar proportion of age groups between 15 and 64 for both males and females. There are 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 showing estimated numbers and gender proportions of people in each age group.

Figure 1 Age profile of male population in NHS Western Cheshire



Source of data: Office for National Statistics 2008 population estimates. © Crown Copyright.

Figure 2 Age profile of female population in NHS Western Cheshire



Source of data: Office for National Statistics 2008 population estimates. © Crown Copyright.

Table 1 Age group by sex in NHS Western Cheshire

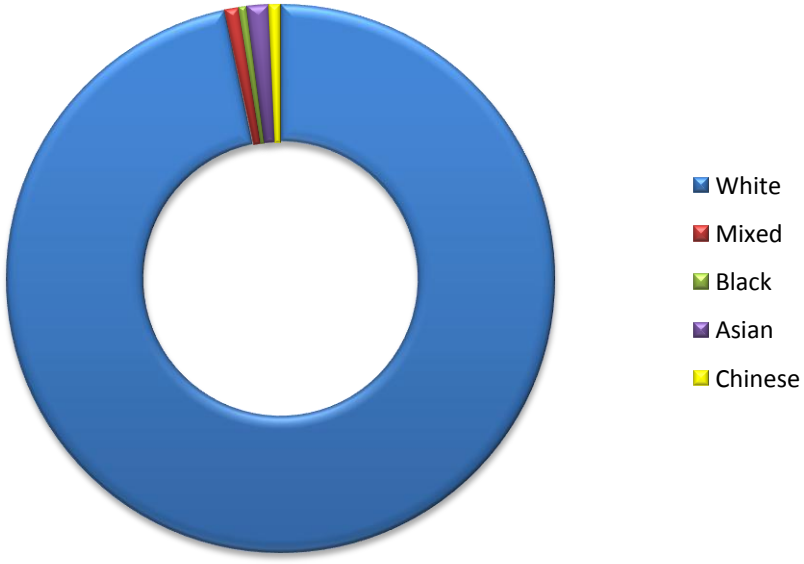
Age Group	Sex				
	Males		Females		Total
0-15	19,798	*52%*	18,538	*48%*	38,337
15-24	14,950	*49%*	15,295	*51%*	30,245
25-34	11,974	*50%*	11,824	*50%*	23,798
35-44	16,247	*49%*	17,245	*51%*	33,492
45-54	16,001	*50%*	16,267	*50%*	32,268
55-64	15,134	*49%*	15,783	*51%*	30,917
65+	19,004	*44%*	24,609	*56%*	43,613
Total	**113,109**	***49%***	**119,561**	***51%***	**232,670**

Source of data: Office for National Statistics 2008 population estimates. © Crown Copyright

Ethnicity

Figure 3 shows the proportional breakdown of ethnicities within the total population of NHS Western Cheshire. The vast majority of residents are of white (including British, Irish, and Other) ethnicity; constituting 97% of the total population. It is clearly evident that Western Cheshire has a small black and minority ethnic (BME) community of approximately 3% of the total population. Within this group, residents of Asian (including Indian, Pakistani, Bangladeshi, and Other) ethnicity are the largest contributors with 1.25%; with residents defined at Black (including Caribbean, African, and Other) constituting 0.46%.

Figure 3 Total population of NHS Western Cheshire presented by ethnicity.



Religion

Across the areas of Chester, Ellesmere Port and Neston, Crewe and Nantwich, and Vale Royal the majority of residents define their religion as Christian; 78.2% in Chester; 82.5% in Ellesmere Port and Neston; 80.3% in Crewe and Nantwich; 82.1% in Vale Royal. Percentages of people who described themselves as 'No Religion' ranged from 13% in Chester to 10.2% in Ellesmere Port and Neston. Followers of the religions of Buddhism, Hinduism, Judaism, Islam, and Sikhism contributed very small percentages (≤ 0.5%) to the total population in each local authority. (NB data from previous local authority boundaries).

Health indicators

There are several indicators in Cheshire West and Chester Unitary Authority's 2010 health profile that show that the population health is above national and regional levels. However, there is disparity within the local authority which can be seen when considering 2008 health profiles which

included the four smaller local authorities. The previous local authority of Chester reported excellent health in many indicators, whereas Ellesmere Port and Neston reported poor health in many indicators. The health indicators for the newly formed larger local authority are not fully representative of health differences throughout the entire area. There are inequalities in the local authority, for example, men in the least deprived areas can expect to live eight years longer than men in the most deprived area. This difference is six years for women.

Life expectancy in Cheshire West and Chester for both males (78.1 years) and females (81.9 years) is similar to the national average (77.9 years for males, and 82 years for females). Of the health indicators showing significantly worse than national averages, the amount of hospital stays for alcohol related harm is of most concern to public health. Although the level is better than North West average, hospital stays for alcohol related harm remain significantly higher than the national average. There are several positive health indicators for the area, particularly the significantly higher than regional and national average levels of physically active adults. Significantly better levels than the national average were also achieved in the following public health concerns: adults who smoke, obese adults, obese children, physically active children, children in poverty, and people diagnosed with diabetes.

Sexual and reproductive health indicators for the four local authorities that previously existed within NHS Western Cheshire show a mixed picture. Three of the four LAs had worse than regional average levels for breast cancer. Two of the LAs reported higher than regional average rates of pelvic inflammatory disease. Within Ellesmere Port and Neston there are high incidence of HIV, corpus uteri cancer, and elective caesareans. There is lower than regional average incidence of syphilis, and cervical cancer. Further, Ellesmere Port and Neston has a lower than average rate of combined hormonal contraceptive use, and higher than average rate of teenage conceptions ending in abortion and rate of emergency contraception. Chester LA reported lower than regional incidence for several indicators including: cervical cancer, ovarian cancer, corpus uteri cancer, and rate of teenage conception.

Health of young people

Children and young people's health indicators for the North West region show that the former Chester LA had better average scores for many indicators than the three other LAs that were formerly covered by NHS Western Cheshire. Nonetheless, all four areas have significantly worse than regional averages for special education needs statements in both primary and secondary schools. Three of the four LAs also had significantly lower uptake of the MMR vaccination by 5th birthday. Ellesmere Port has high levels of obesity in both males and females at school reception age and Year 6. Three of the four LAs show overall levels of good health and income deprivation affecting children appears to be low.

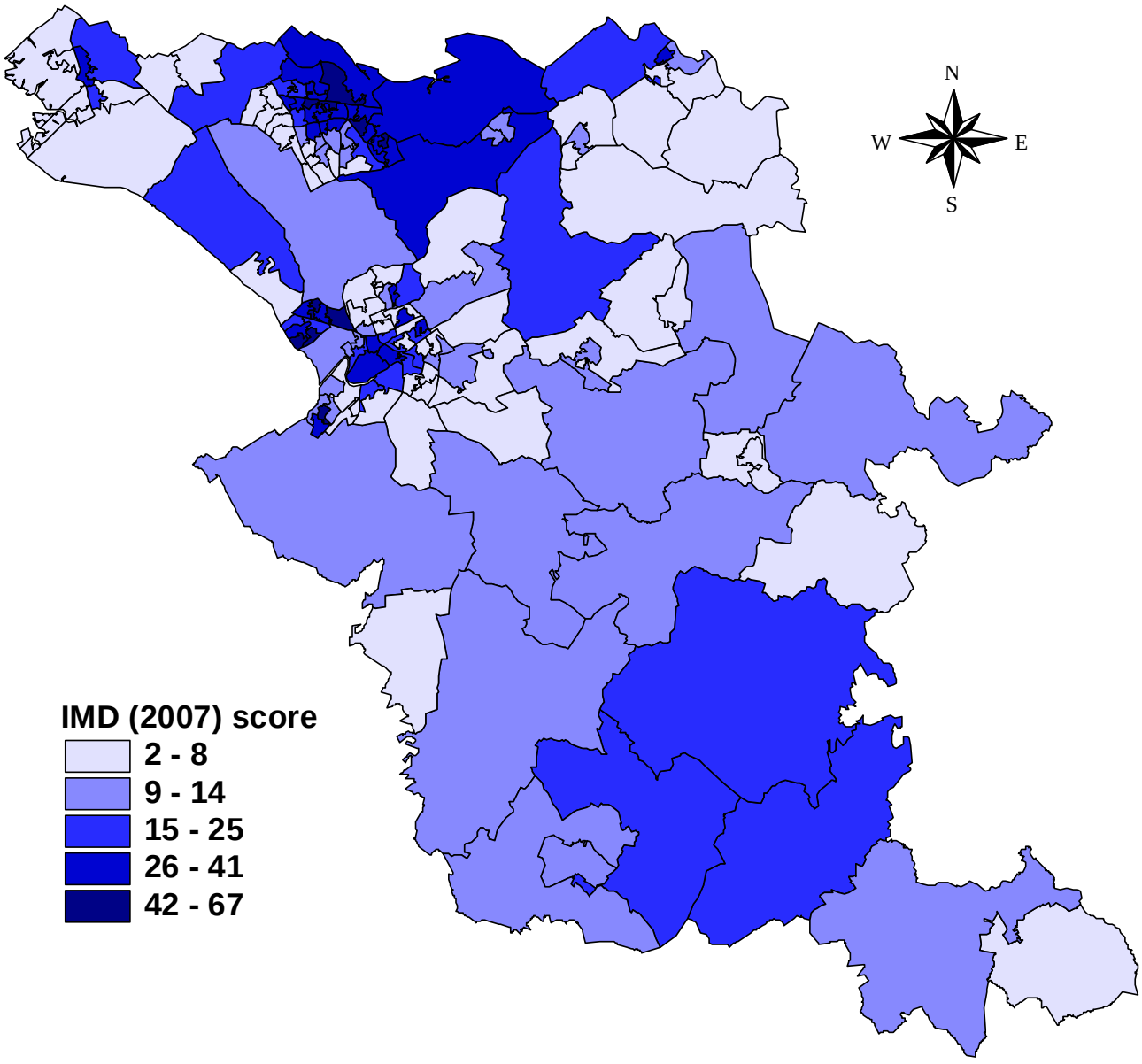
Deprivation

Map 1 shows the deprivation score of each lower super output area in Western Cheshire. Areas around Ellesmere Port and part of Chester show the highest scores.

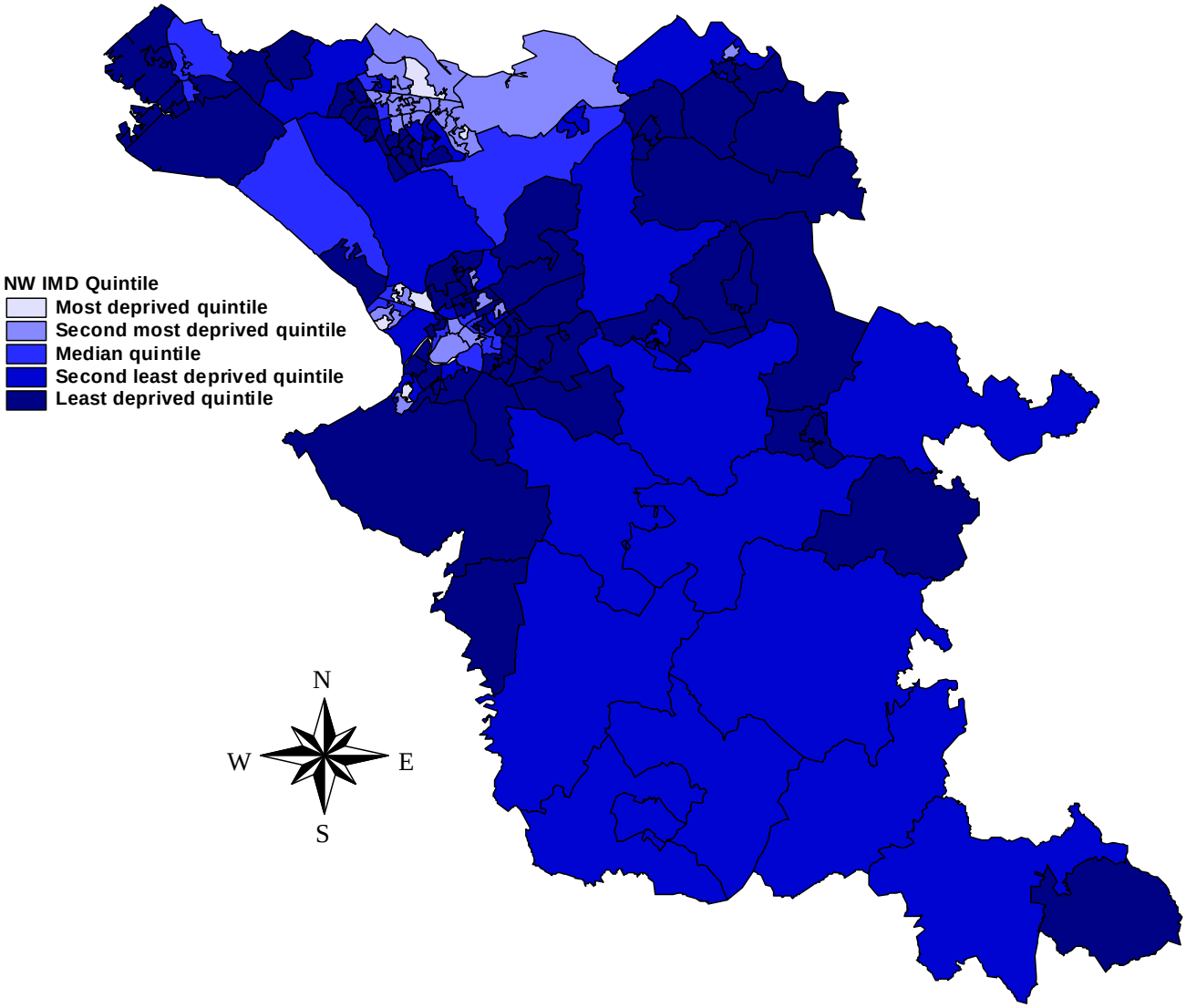
Map 2 shows deprivation in Western Cheshire according to the rest of the north west region. Large areas of Western Cheshire are in the least deprived quintile, demonstrating relative wealth compared to many areas of the North West. There are some areas of Ellesmere Port and Chester that are amongst the most deprived in the north west.

Map 3 shows deprivation quintile within Western Cheshire. Areas around Frodsham, Audlem and Neston are relatively the least deprived.

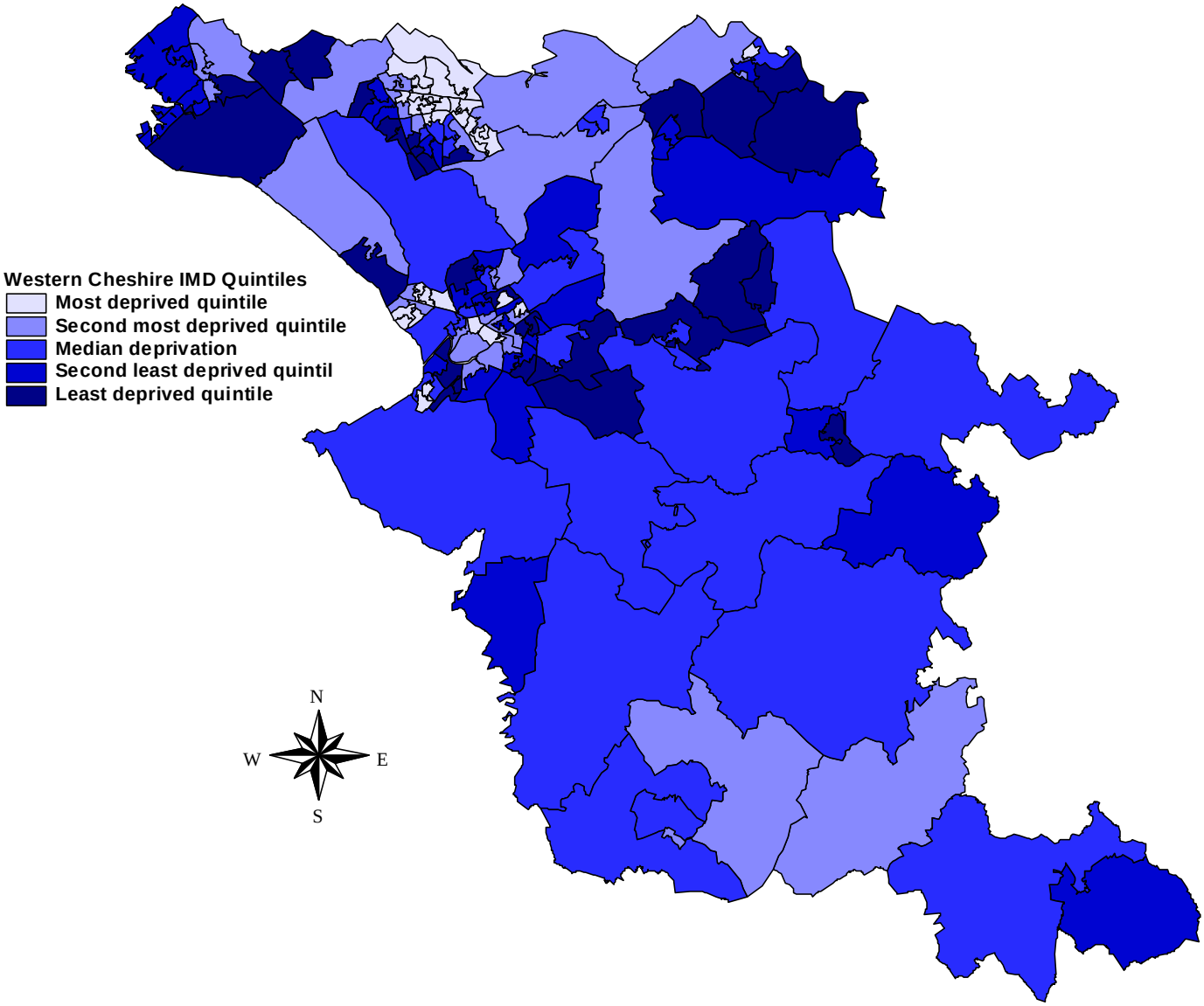
Map 1 IMD score for NHS Western Cheshire by LSOA



Map 2 North West IMD quintile for NHS Western Cheshire by LSOA



Map 3 IMD quintile within NHS Western Cheshire by LSOA



2. Methodology

Sexual Health needs assessments are commissioned to provide evidence which supports local services to meet the needs of their population which, in turn, will ultimately help reduce health inequalities. Through this work, new services may be developed and existing ones may be redesigned or further enhanced.

Aim
Complete a needs assessment to help understand the sexual health needs of Western Cheshire and to establish how the current supply of services can be modified to best meet their needs. Assessing needs, using input from those with professional experience of delivering care as well as from patients and the public, is central to efficient and effective commissioning[73]. The needs assessment process ideally also energises local stakeholders as their full engagement is vital to the successful implementation of any changes to sexual health services.

Objectives
- Develop and propose a validated needs assessment process using reliable tools which will produce comprehensive credible outputs, outcomes, conclusions and recommendations.
- Conduct reviews of relevant national, regional and local research studies and statistical analysis data to use as baseline information.
- Consult with young people and relevant professionals from a range of organisations to identify existing and possible gaps in sexual services for young people in Western Cheshire.
- Provide an insight into young people's attitudes, opinions, real-life challenges, experiences and opportunities in dealing with their own sexual health, health and well being needs.
- To collect contextual data on specific sub-populations.
- Work closely with the established and appropriate Expert Panel in Western Cheshire.
- Carry out and complete the Needs Assessment
- Present the report to highly relevant stakeholders.

1. To provide an insight into people's attitudes, experiences, and behaviours; as well as their real-life challenges, opportunities and perceived barriers in dealing with their own sexual health needs.

2. Within this context, to explore met and unmet needs not only in young people in general but also in particular subgroups who may be sexually more vulnerable: e.g. homeless, those not engaged in education employment or training, young teen parents, young gay lesbian bisexual transgender people.

3. To utilise the data to describe health seeking and barriers to sexual health services, and identify changes that could be made to encourage uptake and use leading to improved health and wellbeing Western Cheshire.

Outcomes/Impact
The results of the study will inform and guide the PCT to develop effective partnerships, services and support to ensure that the population in Western Cheshire receive information and services that meet their sexual health needs. This will include:
- Awareness of what young people perceived as risks to their sexual health, health and wellbeing.
- Knowledge of the awareness of sexual health services available to them locally.
- An understanding of the perceived and actual sexual health needs as confirmed by young people and professionals.
- Identification of services that can better support residents to achieve healthier lifestyles and remove health-related barriers.

- Identification of new and innovative SH 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), safety, systems and procedures, awareness/promotional materials used and how they address diversity and equal opportunity.
- Involvement of service staff, practitioners, end-users and community stakeholders.

Scope
The project will be conducted within the geographical boundary of NHS Western Cheshire only.

Depth and type of work
- Engage end users, potential end users, and current non-users in the needs assessment.
- Engage relevant professionals and specialists in the needs assessment.
- Identify 'gatekeepers' for the specific groups of 'high risk' populations (see below) and involve them in the needs assessment.
- Gather and analyse quantitative and qualitative data.

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

- People who have used and / or using the sexual health services;
- Young people (under 25 years) from a range of backgrounds including:
  - Young offenders
  - Homeless young people
  - Not in Employment, Education, or Training (NEET)
  - Young teenage parents
  - Young Lesbian, Gay, Bisexual and Transgender people

Analysis
Where appropriate a statistical software package (SPSS) is used to analyse data. This is of particular use in the SRE data, service user questionnaires, and data collected from FE colleges. Focus group transcripts were to be analysed using content analysis. All other data is appropriately analysed to ensure the data is presented clearly and accurately.

Protocol development
Meeting at NHS Western Cheshire confirmed (i) intelligence from this project should include primary research gathered through NHS providers and users, necessitating an ethics submission to the National Research Ethics Committee (NREC); (ii) generation of information on vulnerable groups of young people within the community is essential.

The research protocol underwent a number of changes before final approval was granted. The project initially proposed to distribute a core questionnaire to 2000 young people during their PSHE lessons in secondary schools and colleges in Western Cheshire. Data generated would have provided intelligence on young and older teenagers' met and unmet sexual health, health, and wellbeing needs (including knowledge and behaviours). However, prospective gathering of information with young people in state schools, or from local colleges was not possible to orchestrate at a local level.

To ensure the voices of young and mid-aged teenagers was included in this study we sought potential data generated from allied LJMU and partner projects, to bridge this gap. Two projects were available (i) a recent (autumn term 2008) evaluation of Sex and Relationships Education (SRE) conducted throughout North West England in collaboration with Government Office North

West, which included one Western Cheshire school; (ii) an ongoing NW Teen Study exploring alcohol use, wellbeing, and sexual health of mid-aged teenagers (16-19 years) in FE colleges. For the latter, while colleges in the immediate western Cheshire location were unable to participate, another college from an adjacent area (with a wide catchment area), was able to do so. Findings from this study are presented in this report to furnish evidence about this age groups general knowledge, attitudes and practices towards their sexual health needs.

Ethical approval

Ethical clearance for the NHS component of the project was sought and from the NHS Liverpool Research Ethics Committee; provision of information to them verified that the project could be classified as an audit. Approval was granted in September 2009. Ethical approval from Liverpool John Moores University was also granted on September 2009. Ethical approval from NHS Western Cheshire Research and Development department was granted in October 2009.

Ethical approval was independently sought for allied (supplementary) projects which collected primary research data on the knowledge, attitudes, and behaviours of young people. This included:

- The evaluation of Sex and Relationships Education package delivered by Government Office North West in North West England (Ethical approval by Liverpool John Moores Ethical Committee August 2008).
- North West Teen Study: Collaborative study throughout North West England (Ethical approval by Liverpool John Moores Ethical Committee July 2009).

Qualitative methodologies

Information from young people was generated from a series of Focus Group Discussions, conducted as follows:

Design: Qualitative methods using focus groups of between four and ten participants

Tools: The focus group guide developed by Ingham & Stone[74] was used as the basis for the group interviews. The guide provided a list of topic headings and prompts for use within these. The key topics initially selected for use with all groups were: Awareness of services, Use of services, and Risk behaviour and Condom use. Key topics for each specific group were identified for further exploration. Some topics emerged through local knowledge e.g. one local Brook in Cheshire and Merseyside identified a high occurrence of partner swapping and subsequent sexually transmitted infection among those living in hostels, whilst other topics emerged from the literature e.g. the lack of sex education generally provided for young people with special educational needs (SEN). These key topics were added to the list for use with the appropriate group.

Sampling and recruitment: Focus group sessions were arranged through a variety of organisations in West Cheshire and the focus group was set up as a one off session at a group that meet regularly. The majority of focus group sessions were organised through groups allied to Connexions. A number of other vulnerable groups were identified through statutory services and agreement (in principle) was reached for us to conduct focus groups with them. Logistical difficulties and limitations on opportunities to sample widely reduced this studies ability to reach all groups originally targeted.

Procedure: Young people were informed about the focus group prior to final arrangements, they were also provided with information sheets and asked if they wanted to participate. Before the focus group started, the project was explained again and any questions answered by the researchers. Consent forms were signed then handed to the research team and any young people who did not wish to take part were allowed to go to a different area. Before the focus group started participants were asked to set some ground rules for the group and were prompted to include respecting others views, not interrupting and confidentiality. Participants were also reminded that researchers did not want to know about their own sexual experience but rather those and the views of their peers in general. Sessions were recorded on a digital dictaphone with participant consent. No names or locations were included in the transcripts and all quotes given were checked to

ensure anonymity. Participants were informed of this. Following the session the recordings were transcribed verbatim and checked by a researcher who was present at the session whilst simultaneously listening to the recording.

Table 2 Focus Group Details

Participant Group	Date held	Gender of participants	Location, partners
1 Teenage Mothers	17/11/09	Female	Connexions, Ellesmere Port
2 Teenage Mothers	24/11/09	Female	Stanlaw Abbey, Ellesmere Port
3 Youth Parliament	12/02/10	Mixed	NHS Western Cheshire
4 Sheltered Accommodation	11/03/10	Mixed	Arena Housing
5 NEET (1)	11/03/10	Mixed	Princes Trust, Winsford
6 NEET (2)	11/03/10	Mixed	Princes Trust, Winsford

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 back to the individual transcripts. The 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 subthemes 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.

Stakeholder meeting

A stakeholder meeting, held on July 8th 2009, formed a qualitative phase of intelligence gathering. Invitations of attendance were sent out following suggestions from the PCT. People were also invited if their job roles were deemed relevant. The meeting included a presentation of data and a series of short workshops. The workshops aimed to establish the current state of sexual health services in the area and possible ideas for improvement. The contents of this meeting were analysed using a thematic technique, as above, following the collection of notes and recordings made during each of the workshops, and table discussions.

Quantitative data collection

1. Service users

Design: Cross-sectional survey of service users of sexual health services in Western Cheshire.

Tools: A service-users specific questionnaire was developed to glean service users' opinions on the services they were visiting, why they were attending and waiting times. The questionnaire was to be completed over the course of their visit.

Sampling and recruitment: Questionnaires were distributed at the main sexual health services in Western Cheshire – The Department of genitourinary medicine at the Countess of Chester

Hospital and at community CASH (Contraceptive and Sexual Health) services. This intended to capture as large a sample as possible. A poster was displayed in the waiting room and the receptionists asked people if they would like to fill in the questionnaire.

Participants: People of any age, gender, sexuality and ethnicity who attended sexual health services in Western Cheshire. Data collection at the locations covered two periods – October to November 2009 and January 2010 to March 2010.

Procedure: Visitors were asked by reception staff if they would like to complete a questionnaire. Any people showing interest were given a questionnaire pack containing a participant information sheet, consent form and prepaid addressed envelope. The person then completed the form, sealing it in the envelope and then handed it back to reception.

Analysis: The data was entered manually into the statistical analysis package SPSS 17. SPSS programme command syntax language was developed to analyse the data. Analysis consisted of frequency distributions, cross-tabulations and statistical tests of data. Using syntax resulted in ease of reproducibility of analytic outputs and the correct treatment of missing values, the latter of which is essential when determining the correct denominator for multiple response questions. These tables where then exported to Microsoft Excel, where the data were graphically displayed. Chi-squared tests where 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).

GONW Sex and Relationship Education pilot study

Background: In December 2007 Government Office North West (GONW) contacted Directors of Children's Services in 11 areas of the North West and invited them to participate in developing a benchmark for Key Stage 3 for schools across the region. Prior to this, GONW had consulted with young people, the North West regional network of Teenage Pregnancy co-ordinators, and Healthy Schools co-ordinators. The Sex and Relationship Education (SRE) study aimed to develop a curriculum resource that built on existing good practice and to establish a regional benchmark for the minimum quality of SRE. As part of this, the SRE intervention was piloted in 22 schools across 11 authorities in the North West in order to understand and document the barriers and facilitators affecting the implementation of effective SRE in schools, and respond to the recommendations. Ethical approval was obtained from Liverpool John Moores Ethics Committee, and GONW obtained agreement and support from the Regional Safeguarding Office.

Aim of SRE evaluation study: The primary goal of the research conducted by LJMU was to determine whether standardised SRE lessons in schools lead to higher and more consistent knowledge about sexual health, along with more healthy attitudes and behaviours. The project also sought to gather evidence on factors affecting the delivery and effectiveness of SRE in schools such as the effect of school ethos and whether schools differ by deprivation in the level of increase in knowledge/change in attitudes.

Study population: Of 22 original schools participating, 15 completed the pre-intervention questionnaires, among these one school was located in Western Cheshire. The target population for the survey was students 11 to 14 years of age in year groups 7 to 9. Students outside the age range, not resident in North West England, terminally ill or severely incapacitated, did not speak English, had a signed withdrawal from consent by a parent or carer, or who personally did not consent were excluded from the survey.

Methodology: Prior to survey, letters informing about the study and parental withdrawal forms (non-consent) were sent to the homes of children in classes selected to be part of the SRE pilot. On the day of the survey, teachers informed school children about the survey, provided an information sheet about the project, and distributed consent forms. After signed consent, an anonymous self-completed questionnaire was administered to students estimated to take 15 minutes to complete. Both students and teachers were informed that the questionnaires were confidential, that

completion was voluntary, and students were free to stop answering the questionnaire at any time. Teachers were told not to vet, monitor, or validate answers given freely by the students. Completed questionnaires were folded so that teachers could not review answers given by a specific student.

Tools: The questionnaire sought information on students' knowledge, behaviour and attitudes towards sex and relationships. Specific questions on SRE related to the exact content of the SRE programme. Other questions (by request of GONW) were involved with broader themes of school and general wellbeing; for the purpose of this sexual health needs assessment, few of these analyses are presented here. Questions were age appropriate (by year group), and structured around the proposed intervention content for each year. Knowledge questions varied in complexity, allowing students of different ages and abilities to express their knowledge. Behaviour and attitude questions were also tailored appropriately. For example, questions about behavioural intention were more appropriate among younger age groups, while sexual behaviour questions were possible for older students. As noted above, sexual debut before 16 years of age occurs in a third to a quarter of the population, thus it was essential to categorise adolescents by level of sexual experience.

Analysis: The data was entered manually into the statistical analysis package SPSS 17. SPSS programme command syntax language was developed to analyse the data. Using syntax resulted in ease of reproducibility of analytic outputs and the correct treatment of missing values, the latter of which is essentially when determining the correct denominator for multiple response questions. These tables where then exported to Microsoft Excel, where the data could be graphically displayed. Data generated from the baseline survey was abstracted for the Western Cheshire school and reanalyzed separately. Analysis consisted of frequency distribution and cross-tabulations by gender and age, or by year group. Year 9 students were also asked detailed questions about sexual activities, and if they can talk to their parents about sex. Where feasible, chi-squared tests were used to determine whether there was a statistically significant association between categorical variables. Statistical associations were significant at the 95% level (e.g. $p = 0.05$ or less).

NW teen project: Sexual attitudes and behaviours of young people, alcohol and teenage conceptions

This study has been conducted by local authorities in North West England who require data on teenage sexual health needs, attitudes and practices, and the influence other risk behaviours, such as alcohol, have on these needs. Generation of information from the study will provide data to inform policy within the education institutions, at PCT level, and to a wider audience. The main study was a large-scale cross-sectional quantitative survey of young people aged 16-19 years in colleges in North West England.

A standard survey methodology was prepared for all participating local authorities, developed and agreed through joint meetings and workshops. Local authority level activities were conducted by the Teenage Pregnancy (or Sexual Health /Alcohol) Leads, in consultation with LJMU study team. College Principals were approached and informed about the study by letter, by direct contact from the Lead, and then followed up for further discussion by researchers at LJMU. Following agreement, materials were sent to the tutors, including a tutor/teachers script describing the study. This enabled them to discuss the survey with their students. On the day of survey, each student was provided with a questionnaire and a consent form, and an information sheet again describing the study along with contact information if further advice, help or counselling was required following completion of the questionnaire.

Students were reminded their participation was voluntary and confidential, and that they could stop participating at any time, and that they did not need to complete any questions if they did not wish to do so. The questionnaire was timed to take approximately 20 minutes but a one hour lesson was requested to allow plenty of time to answer questions, to prevent rushing or errors. Completed questionnaires were sealed in blank envelopes and forwarded to LJMU. Signed consents were

stored separately to the anonymous questionnaires to prevent disclosure. Questionnaires were reviewed, coded, then forwarded to the scanning company (DCC, Wembley, London).

Data from a FE college in Cheshire was abstracted and analysed separately. Analysis consisted of frequency distributions and cross-tabulations by gender and age. Student characteristics of interest were predominantly about their sexual experiences, knowledge of sexual health services, exposure to pregnancy and abortion, and other sexual health risks. Where feasible, chi-squared tests were used to determine whether there was a statistically significant association between categorical variables. Statistical associations were significant at the 95% level (e.g. $p = 0.05$ or less). Due to the small sample size more complicated analytic investigations were not feasible.

Constraints

The North West teen project was initially designed to incorporate young people from the age of 13 to 19 years. However, no secondary education schools in Western Cheshire were prepared to participate in the study. As such, the study was re-orientated to solely include students in Further Education. The principal college in Western Cheshire also declined to participate in the study. A college located in Cheshire East Local Authority did agree to participate and was deemed appropriate for this needs assessment as many of the students who attend the college reside in Western Cheshire and Chester Local Authority. The preceding section relates to the redesigned methodology following the non-participation of all secondary education establishments and the principal college in Western Cheshire. This non-participation clearly has implications for the applicability of findings and every effort should be made to include these educational establishments in future similar work.

3. Findings

3.1 Epidemiological data on Sexually Transmitted Infections (STIs) including HIV

Box 4 Key Findings on STIs and HIV

- Western Cheshire has the third highest prevalence of key sexually transmitted infections in the Cheshire and Merseyside sub-region with 662 infections per 100,000 population. The highest diagnosed prevalence of sexually transmitted infections (over 1131 per 100,000) was in populations living in the city centre, and to the north east of the city centre in villages such as Dunham-on-the-Hill.
- Uncomplicated chlamydia (267 per 100,000), followed by genital warts (247 per 100,000) were the most prevalent infections. Males had higher rates of chlamydia, gonorrhoea and syphilis, and females higher rates of herpes and warts.
- The highest sexually transmitted infection prevalence by age was among the 20-24 years (3,029 per 100,000), with 15-19 year olds representing the next highest (2,084 per 100,000). 20-24 year olds reveal the highest prevalence of chlamydia (1,356 per 100,000) and also genital warts (1,130 per 100,000).
- There was an age/sex cross over with young females having a higher rate of infections than males, crossing over to older males having a higher rate than females. A low prevalence of all key diagnosed sexually transmitted infections were reported in those aged over 50 years.
- Western Cheshire had 126 individuals in HIVtreatment and care in 2008 and a prevalence of 54.2 per 100,000, compared with 79 per 100,000 for the north west, ranging with a range from 378 per 100,000 in Manchester to 19 per 100,000 in Allerdale.
- A low proportion (15%) of individuals in treatment and care for HIV had an AIDS defining illness, which is lower than the average proportion (22%) in the North West.

In the United Kingdom, between 1999 and 2008, diagnoses of primary and secondary syphilis, uncomplicated gonorrhoea, uncomplicated chlamydia, genital herpes and genital warts all increased; the most significant of which was the 1032% increase in diagnoses of syphilis, although absolute numbers were low. However, between 2007 and 2008, diagnoses of syphilis and gonorrhoea both decreased (by 4% and 11% respectively). All services provided by genitourinary medicine clinics increased by 405% over the nine year period and increased by 10% on 2007 figures. The group most at risk of being diagnosed with an sexually transmitted infection is the 16 - 24 year age group and it is recommended that there should be easy access for young people to sexual health services that can provide advice, screening and treatment for sexually transmitted infections (including HIV)[2] and this is also important for reducing the number of unintended pregnancies. Black African and black Caribbean communities are disproportionately affected by sexually transmitted infections, particularly bacterial infections, such as gonorrhoea.

Rising concern about these increasing rates of sexually transmitted infections, amongst other issues, have led sexual health to be defined a priority area by the Department of Health. There are a series of targets relating to sexual health for primary care trusts (PCTs) and strategic health authorities (SHAs). For example, public sector agreement (PSA) target area PSA11C1 relates to the number of new diagnoses of gonorrhoea in a calendar year in each PCT10 and *Every Child Matters* requires knowledge of sexually transmitted infection rates by local authority area for those aged under 16 years. Measurements of these targets require good quality data. The payment by results scheme has needed patient-level data in order to be implemented and this level of data collection is now supported by the recent development of the national tariff. Until recently, data of the required resolution did not exist, and the funding and planning of sexual health services was based on quarterly aggregated data returns known as KC60. KC60 data also lacked denominator data to calculate infections as a proportion of total attendances and there were calls for better data on sexual health.

In 2005, a pilot scheme established the feasibility and efficacy of setting up an enhanced system of routine data collection for sexually transmitted infections in the North West of England. As a result, this scheme was expanded and continued for the Cheshire and Merseyside region. Nationally, there began a change from KC60 reporting to the Genitourinary Clinic Activity Dataset (GUMCAD) system. The Cheshire and Merseyside enhanced surveillance, and the new GUMCAD dataset are disaggregated, patient-level data, enabling more detailed epidemiological analysis. The Cheshire and Merseyside enhanced surveillance system has collected and collated local disaggregated data for the region whilst GUMCAD has been rolled out nationally. Roll out of GUMCAD has been slow, but now 91% of genitourinary medicine clinics are submitting data and half have submitted historical data covering the period January 2008 to September 2009. Compliance with GUMCAD requires data to be submitted within strict timescales, with those clinics failing to submit excluded from the dataset. Data for this Cheshire and Merseyside report are comprehensive, achieved by ongoing negotiation with each clinic.

Sexually Transmitted Infection Data

The data presented in this section were collected by the sexual health team at the Centre for Public Health as part of an enhanced surveillance system across Cheshire and Merseyside. As the data collected is more comprehensive than the current KC60 data, it is not possible to make comparisons beyond the Cheshire and Merseyside area. Map 4 shows prevalence of the five key sexually transmitted infections (primary and secondary syphilis, uncomplicated gonorrhoea, uncomplicated chlamydia, genital herpes and genital warts) diagnosed in genito-urinary medicine clinics in Cheshire and Merseyside for 2008. The data are residence based and do not include any data from community testing sites. Findings from Western Cheshire show the highest sexually transmitted infection prevalence (over 1131 per 100,000 population) in the city centre, and to the north east of the city centre in villages such as Dunham-on-the-Hill.

Table 3 shows the prevalence rates of the key five sexually transmitted infections in NHS Western Cheshire by sex. The overall prevalence figures are heavily driven by the chlamydia figures for both males and females, which is a trend seen across Cheshire and Merseyside. Uncomplicated chlamydia (267 per 100,000), followed by genital warts (247 per 100,000) were the most prevalent infections. Males had a higher rate of chlamydia, gonorrhoea and syphilis, and females had higher rates of herpes and warts. Overall, Western Cheshire has the third highest prevalence of key sexually transmitted infections in the Cheshire and Merseyside region. Table 4 presents the prevalence of the key five infections by age group for NHS Western Cheshire. Data show that those aged 20-24 years have the highest prevalence (3,029 per 100,000 population), with 15-19 year olds representing the next highest (2,084 per 100,000). This age grouping is similar to all other PCTs in the region. The 20-24 year olds reveal the highest prevalence of chlamydia (1,356 per 100,000) and also genital warts (1,130 per 100,000). A low prevalence of all key sexually transmitted infections were reported in the over 50s.

Table 3 Prevalence (per 100,000 population)* of key infections diagnosed in GUM clinics by sex for Cheshire and Merseyside PCT of residence, Western Cheshire, 2008

Infection	Prevalence by sex		Total
	Male	Female	
Western Cheshire			
Primary and secondary syphilis	30.7	1.2	15.7
Uncomplicated gonorrhoea	67.5	26.3	46.6
Uncomplicated chlamydia	295.6	239.4	267.1
Genital herpes	52.7	118.5	86.0
Genital warts	242.8	251.3	247.1
Total**	**689.2**	**636.7**	**662.6**

*Prevalence calculated on population aged 10-64 years, although some cases fall outside this range.
**Total prevalence calculation includes double counting of individuals with more than one infection.
Population data source: Office for National Statistics, © Crown Copyright 2007.

Map 4 Prevalence of the five key STIs (primary and secondary syphilis, uncomplicated gonorrhoea, uncomplicated chlamydia, genital herpes and genital warts) diagnosed in genito-urinary medicine clinics in Cheshire and Merseyside for 2008.

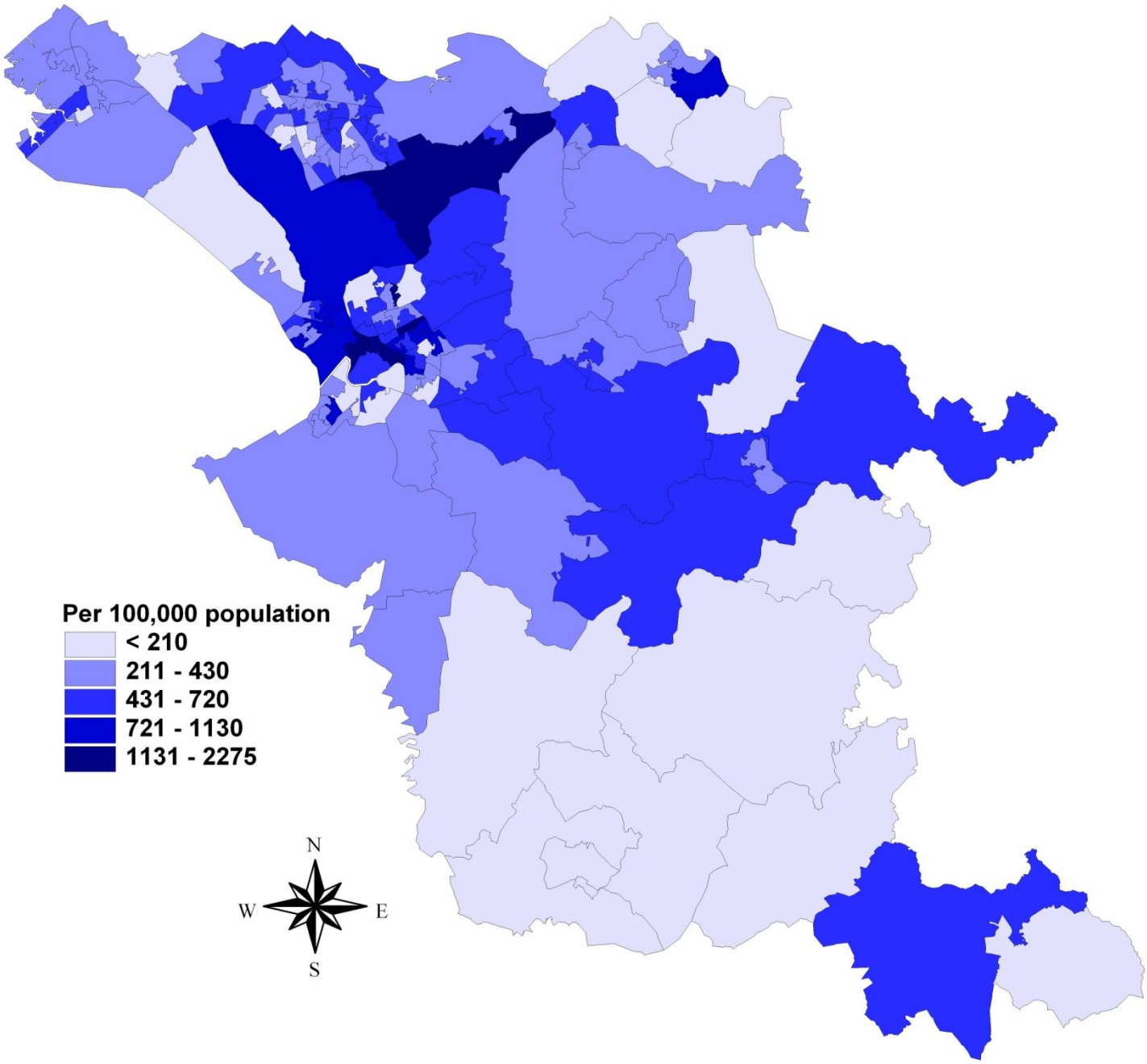


Table 4 Prevalence (per 100,000 population)* of key infections diagnosed in GUM clinics by age group (all persons) for Cheshire and Merseyside PCT of residence, Western Cheshire, 2008

	Prevalence by age group											Total †
	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	
Western Cheshire												
Primary and secondary syphilis			37.7	17.3		52.9	11.0	49.9				15.7
Uncomplicated gonorrhoea		100.8	173.3	60.5	56.3	47.0	5.5	93.6				46.6
Uncomplicated chlamydia	13.7	954.7	1356.4	536.2	197.1	70.5	27.6	37.4	6.6	12.0	7.3	267.1
Genital herpes	41.0	201.7	331.6	190.3	91.5	47.0	49.7	18.7	19.8	6.0	22.0	86.0
Genital warts	75.1	826.9	1130.4	458.4	147.8	76.4	66.3	56.2	46.3	36.1	14.6	246.5
Total**	**129.7**	**2084.2**	**3029.4**	**1262.8**	**492.8**	**293.8**	**160.1**	**255.9**	**72.7**	**54.2**	**43.9**	**662.0**

*Total population aged 10-64 years.
**Total prevalence calculation includes double counting of individuals with more than one infection. Totals may not add up due to rounding.
†The total prevalence for age groups does not include diagnoses made amongst those outside the 10-64 age range and so do not match the total prevalence on Table 5. Population data source: Office for National Statistics, © Crown Copyright 2007.

Table 5 displays the prevalence of the key five infections by age group for males only. Data show that males aged 20-24 years have the highest prevalence (3,164 per 100,000), with 25-29 year olds representing the next highest (1,609 per 100,000). Table 6 shows the prevalence of the key five infections by age group for females only. Females aged 20-24 years have the highest prevalence (2,902 per 100,000) followed by 15-19 year olds (2,651 per 100,000). Tables 3 and 4 clearly show a gender difference in the age bands most greatly affected by sexually transmitted infections. In all age bands over 15-19, males have higher diagnosed infection rates compared with females; for example, among 45-49 year olds it was ten-fold higher compared with females (478 versus 37 per 100,000). An age/sex cross over occurs with a higher proportion of males compared with females diagnosed with sexually transmitted infections above the age of 20.

Table 5 Prevalence (per 100,000 population)* of key infections diagnosed in GUM clinics by age group (males) for Cheshire and Merseyside PCT of residence, Western Cheshire, 2008

	Prevalence by age group - males											Total male†
	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	
Western Cheshire												
Primary and secondary syphilis			77.5	35.4		109.7	11.3	100.8				30.7
Uncomplicated gonorrhoea		105.9	170.6	123.8	102.1	97.5		176.4				67.5
Uncomplicated chlamydia		807.3	1488.8	760.4	248.1	121.8	45.1	75.6	13.5	24.3	14.9	295.6
Genital herpes		66.2	263.6	141.5	58.4	36.6	22.5	25.2		12.2	14.9	52.7
Genital warts		555.8	1163.2	548.2	233.5	109.7	90.2	100.8	53.9	36.5	14.9	241.6
Total		**1535.2**	**3163.8**	**1609.2**	**642.1**	**475.2**	**169.1**	**478.8**	**67.3**	**73.0**	**44.8**	**688.0**

*Total male population aged 10-64 years.
**Total prevalence calculation includes double counting of individuals with more than one infection. Totals may not add up due to rounding.
†The total prevalence for age groups does not include diagnoses made amongst those outside the 10-64 age range.
Population data source: Office for National Statistics, © Crown Copyright 2007.

Table 6 Prevalence (per 100,000 population)* of key infections diagnosed in GUM clinics by age group (females) for Cheshire and Merseyside PCT of residence, Western Cheshire, 2008

	Prevalence by age group - females											Total female†
	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	
Western Cheshire												
Primary and secondary syphilis							10.8					1.2
Uncomplicated gonorrhoea		95.7	175.9		13.6		10.8	12.4				26.3
Uncomplicated chlamydia	28.7	1106.9	1231.3	321.7	149.6	22.7	10.8					239.4
Genital herpes	86.0	341.6	395.8	237.0	122.4	56.8	75.8	12.4	39.0		28.7	118.5
Genital warts	157.7	1106.9	1099.4	372.4	68.0	45.4	43.3	12.4	39.0	35.8	14.3	251.3
Total	**272.4**	**2651.0**	**2902.4**	**931.1**	**353.7**	**124.9**	**151.5**	**37.1**	**78.0**	**35.8**	**43.0**	**636.7**

*Total male population aged 10-64 years.
**Total prevalence calculation includes double counting of individuals with more than one infection. Totals may not add up due to rounding.
†The total prevalence for age groups does not include diagnoses made amongst those outside the 10-64 age range.
Population data source: Office for National Statistics, © Crown Copyright 2007.

HIV background and national figures

As with other sexually transmitted infections, the HPA have identified specific groups to target for HIV prevention. These include men who have sex with men (MSM), as they are disproportionately affected by HIV, and those of black African ethnicity are at higher risk of HIV. In the North West of England, in 2008, there were 5,767 HIV positive people in treatment and care[75]. There are an estimated 27% of the 83,000 HIV positive people in the United Kingdom who are unaware of their infection[76]. There is no further local breakdown available on undiagnosed people as this data is derived from the unlinked anonymous survey, in which all identifiers are stripped from the sample. In the North West the predominant mode of exposure to HIV for all individuals who accessed treatment in the North West was men who have sex with men (52%) of all cases in 2008, followed by 41% who were exposed through heterosexual sex. Over a third (36%) of all HIV positive individuals accessing treatment and care in the region were reported to have been infected outside the United Kingdom, the vast majority (82%) were infected in sub-Saharan Africa. Of these cases heterosexual sex was the most common route of infection (80%), a much higher proportion than amongst those known to be infected in the United Kingdom (15%). Two-thirds of the people in treatment and care for HIV in the North West region whose ethnicity is known are of white ethnicity with black and minority ethnic (BME) communities making up the other third. Individuals of black African ethnicity make up the largest proportion of the BME population with HIV[75]. Individuals with HIV have varying and often complicated social needs in conjunction with their medical care. Support is needed with respect to welfare, benefits, housing, advocacy issues and financial issues. Support services are also necessary for those affected by HIV, such as families, partners, children, and friends.

HIV in the North West

The North West HIV and AIDS Monitoring Unit has been collecting and collating data on the treatment and care of HIV positive individuals since 1996. The number of people accessing HIV services in the North West has increased year on year since recording began, and has risen by 469% since 1996 (from 1,014 individuals in 1996 to 5,767 individuals in 2008). There has been a continued increase (11%) in the size of the HIV positive population from 2007 to 2008, although the increase has slowed down in recent years (2003 to 2004: 20%; 2004 to 2005: 17%; 2005 to 2006: 13%; 2006 to 2007: 9%). The number of new cases (defined as individuals seen in the data collection period and includes new cases that died during the period) in the North West rose annually between 2000 and 2005 with the most dramatic increase 2001 to 2002 (a rise of 37%). Between 2005 and 2006 cases fell by 2%, and 10% between 2006 and 2007. New cases (925) in 2008 showed an increase of 13% on the 2007 figure.

Although heterosexual cases dominate the statistics, the annual number of new infections transmitted through men who have sex with men has increased steadily since 1997. This stresses the need to maintain and develop prevention strategies amongst this group. The number of cases acquired through injecting drug use has declined over the years; this may partly be due to the early implementation of syringe exchange programmes across the North West. The number of cases due to mother to child transmission has begun to increase with a 200% increase seen in 2007 compared to 1996, and a further increase between 2007 and 2008. The increase in mother to child transmission is linked to the increase in the number of heterosexually infected HIV positive women, which in turn is linked to migration from high prevalence countries. Were it not for large improvements in diagnosis during pregnancy and effective prevention of HIV transmission to the infant, the increase in the number of infected children would be much higher. The majority of cases of mother to child transmission in the North West have occurred overseas prior to arrival in the United Kingdom.

Across counties, Cumbria has seen the largest increase in new cases since 2003 (130%), followed by Cheshire which has seen an 82% increase over the same period. Cumbria saw the greatest increase between 2007 and 2008 (35%), compared with little change in Merseyside (7%). The overall number of new heterosexual and men who have sex with men cases has risen since 2000 (401% and 103% respectively). Four counties reported an increase in the number of new

heterosexual infections since 2007 (Cumbria, Greater Manchester, Merseyside, and Cheshire), while only Lancashire, Greater Manchester, and Cheshire reported a percentage increase in the number of new men who have sex with men cases compared to 2007. The highest overall number of men who have sex with men cases remains in Greater Manchester. This is consistent with the fact that the Manchester area has a large gay community and evidence of high levels of sexual risk behaviour (as revealed in investigations of the syphilis outbreak). There was a 9% increase in new men who have sex with men cases between 2007 and 2008.

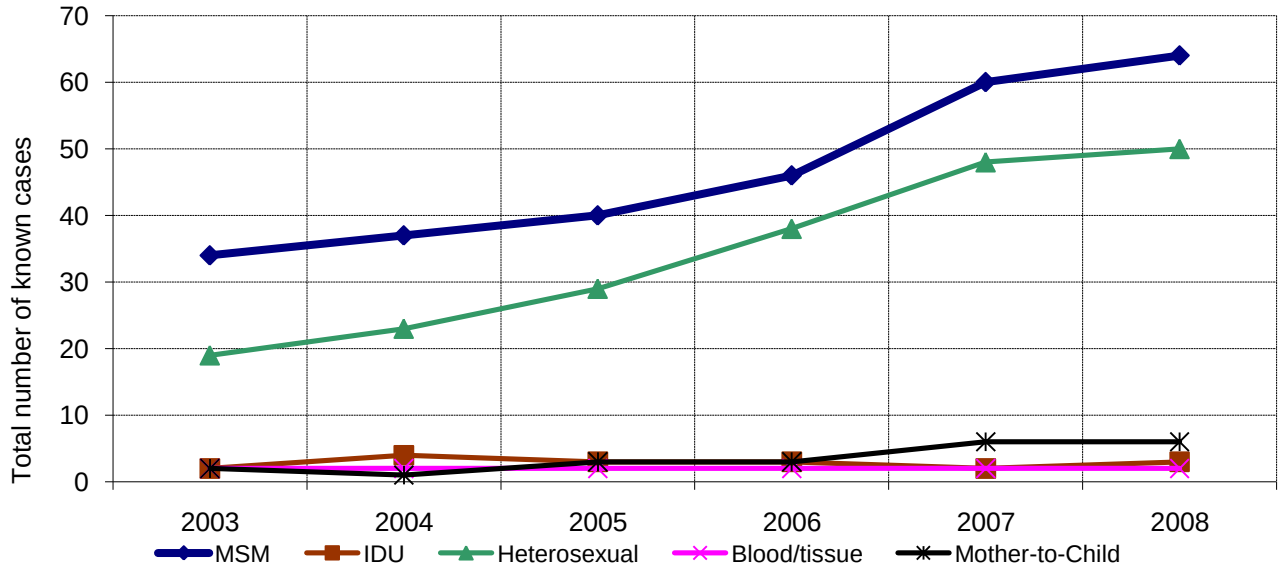
Western Cheshire

Western Cheshire has a low HIV prevalence compared to other parts of the North West (figure 4). There were 126 individuals in treatment and care for HIV residing in NHS Western Cheshire in 2008 and the HIV prevalence in the PCT was 54.2 per 100,000 population. This compares with 79 per 100,000 population for the region, ranging from 378 per 100,000 in Manchester to 19 per 100,000 in Allerdale. Of the individuals in Western Cheshire, 46% were in the age range of 35-49, the majority of which are among male residents (75%). The predominant mode of exposure to HIV in NHS Western Cheshire is via men who have sex with men (MSM; 51%), with 40% infected heterosexually. The majority of people in treatment and care for HIV in Western Cheshire were of white ethnicity (79%), with 59% of infections acquired in the United Kingdom. A low proportion (15%) in treatment and care for HIV had an AIDS defining illness, which is lower than the average proportion (22%) in the North West.

Examination of the treatment locations for the 126 HIV positive individuals resident in Western Cheshire, shows that the majority of residents (75%) seek treatment and care from the department of genitourinary medicine at the Countess of Chester Hospital. Overall there were a total of 732 outpatient episodes recorded at statutory centres in 2008 from HIV positive residents in Western Cheshire. This gives an average of ~six visits per individual over the year, lower than the 7.45 average visits for the North West. Western Cheshire's HIV positive residents required a similar number of inpatient stays in hospital to the North West average. No data were available on the total number of HIV tests taken as only positive results are recorded, precluding comment on the levels of HIV testing.

Antenatal screening data from 2007 and 2008 show an increase in uptake from 87% to 97%. The rate of patients declining an HIV screen increased from 1.9% to 2.6% during the same period. As a result of the increased uptake there has been a slight increase in rates of positive results from 0.03% to 0.06%.

Figure 4 Diagnosed HIV cases for NHS Western Cheshire from 2003-2008



3.2 Sexual health service delivery utilising some surveillance sources

Box 5 Key Findings sexual health delivery from surveillance data

- Examination of the treatment locations of persons living with HIV in Western Cheshire shows 75% seek treatment and care from the department of Genito-Urinary Medicine at the Countess of Chester Hospital. There were a total of 732 outpatient episodes recorded at statutory centres giving an average of ~six visits per individual a year, lower than the 7.45 average visits for the North West.
- Between April 2008 and March 2009 there were 10,255 attendances at community contraceptive services, one third of clients were aged under 25 years.
- 207 under-25 Young People Clinics were held over the data collection period and each session was attended by an average of 16 young people.
- The main reason females attended the clinics was to obtain the contraceptive pill; a higher proportion (57%) of females under 18 requested the pill compared with 40% over 18s.
- About 12% of attendees request condoms.
- 610 chlamydia tests were performed by GPs per quarter, with variation by location.
- 188 implants were administered by GPs per quarter.
- Very few young females in Western Cheshire utilise community contraceptive services for post-coital treatment (hormonal or intrauterine contraceptive device) or advice.
- No requests were documented for intrauterine contraceptive device, patch, female condom, or fertility issues.
- 39 General Practitioners offer tier 1 enhanced services; GP tier 2 level services appear patchy.
- General Practitioners removed one implant for every two new implants given, there was a wide difference in the number of implants given and removed by location, and by quarter. It is unclear whether this is by chance or if other service factors have come into play. The overall rate of General Practitioner prescribed long-acting reversible contraception is higher (52 per 1,000 females ages 15-44) than the England average (41 per 1,000 females ages 15-44).
- Of emergency and non-emergency contraceptives issued in 2009, 75% were for combined oral contraception, 20% for injectable contraception, and 3% for emergency contraception.
- 3,000 and 350 clients are prescribed oral and injectable contraception respectively each month. Contraceptive patch and intrauterine contraceptive device prescriptions range between 12 and 55 per month.

KT31 Community Contraception Collection 2008-2009 in Western Cheshire: between April 2008 and March 2009 there were 10,255 attendances at community contraceptive services, a third of these (3,271) were by people aged less than 25 years. A total of 207 Under-25 Young People Clinics were held over the data collection period and each session was attended by an average of 16 young people. Figure 5 shows the reasons for attendance at the clinics for females of all ages. The predominant reason was to obtain the contraceptive pill (combined or progesterone only). No requests were documented for intrauterine contraceptive device (IUD), patch, female condom, or fertility issues.

Figure 5 Contraceptive services accessed by females

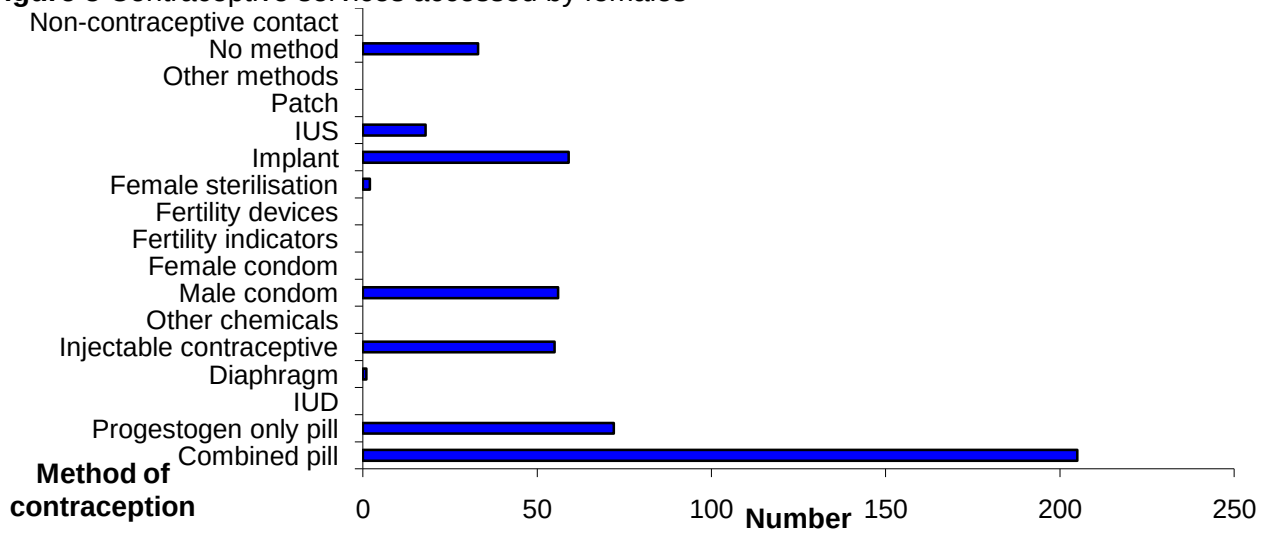


Figure 6 shows the primary reasons females aged under 18 visit community contraceptive services. As with all ages females, the predominant reason was to obtain the contraceptive pill (combined or progesterone only). Proportionately, the reason for attendance between all ages and females under 18 was very similar when requesting male condoms (13% under 18s, 11% over 18s). However, proportionally, there was a difference between requests for the contraceptive pill (57% under 18s for contraceptive pill compared to 40% of females over 18 years).

Figure 6 Contraceptive services accessed by females under 18 years

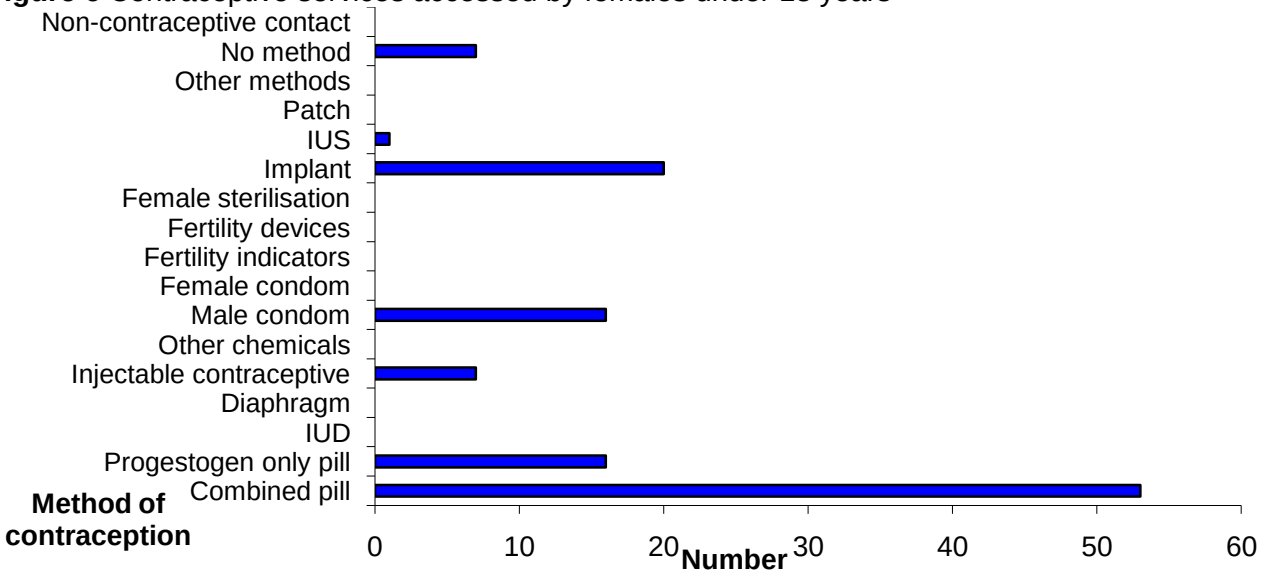


Figure 7 shows the number of people who requested post coital contraception, by age, and the type given. The oral hormonal method was predominantly given with intrauterine contraceptive device contributing a smaller proportion. The majority of requests were from females aged over 35 years; this is consistent with other PCTs in the Cheshire and Merseyside area.

Figure 7 Post coital contraception

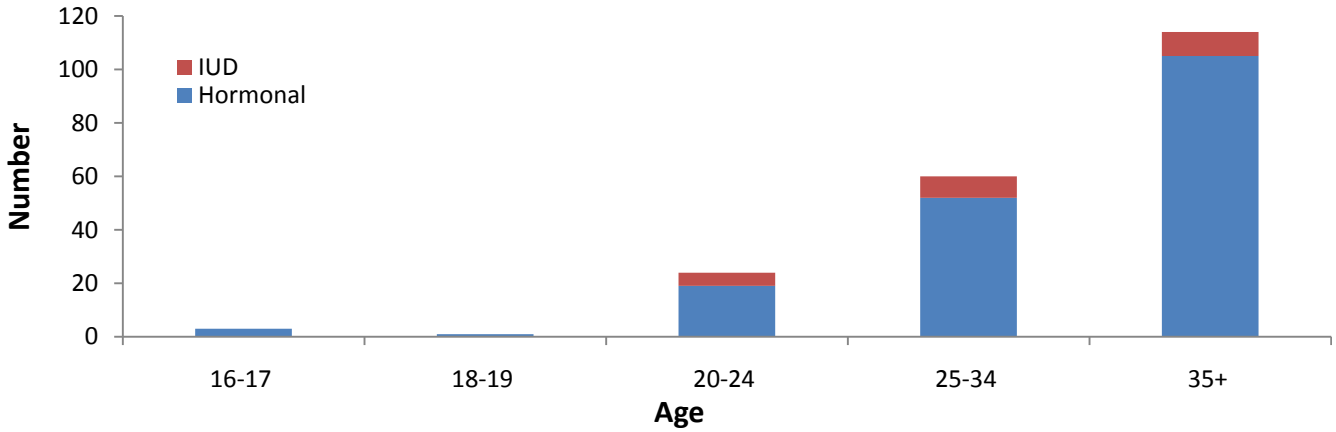
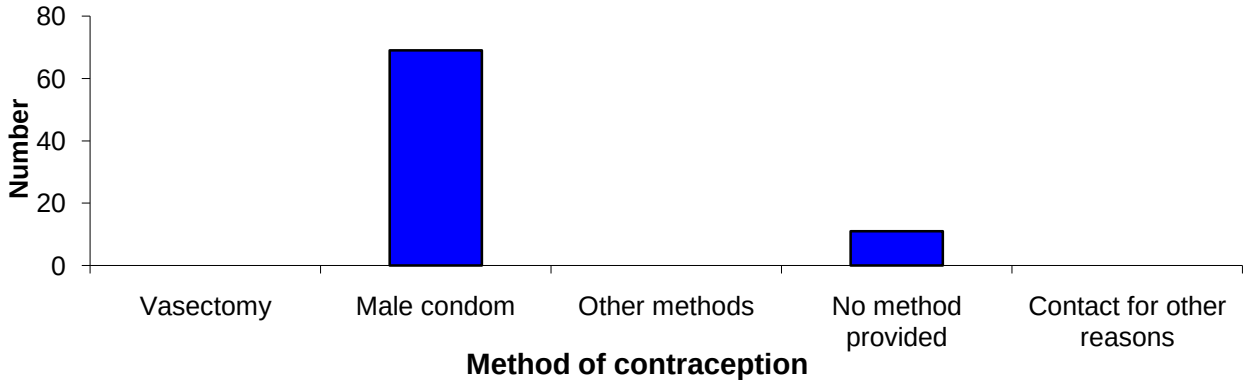


Figure 8 shows the reasons males attend community contraceptive services. The predominant reason is to access free condoms and the only other reason was for advice (without provision of any contraceptive).

Figure 8 Contraceptive services accessed by males



General Practitioner Sexual Health services

Locally Enhanced Services

General Practitioners (GPs) throughout Western Cheshire may offer different levels of sexual health services, as Tier 1 and Tier 2 (see enhanced sexual health services Tier 1 and 2, below). GP surgeries which offer enhanced services aim to:

(i) ensure the full range of contraceptive options are provided by practices to patients.

(ii) ensure the availability of post-coital intrauterine contraceptive device fitting for emergency contraception should be more adequately provided as another means of reducing unintended pregnancies.

(iii) increase availability of LNG-IUS in the management of menorrhagia within primary care.

(iv) increase the availability of the Chlamydia Screening Programme, contraceptive implants and intrauterine contraceptive devices through primary care.

Tier 1: Chlamydia Screening Programme

(i) Chlamydia testing for young people aged under 25 years using the Western Cheshire Chlamydia Screening Office protocols.
(ii) The provision of condoms to prevent infection and public health information on safer sex practices, and participation in Condom Distribution scheme.
(iii) Sexual history taking to ensure Chlamydia screening is appropriate (www.bashh.org).

The local enhanced service will be provided by GP practices. All resources such as laboratory request forms, testing kits, stationery, training etc will be provided by the Western Cheshire Chlamydia Screening Office. The Chlamydia Screening Office will be responsible for patient and partner management (of positive results) and treatment, and data collection and reporting to the Health Protection Agency.

Tier 2: Enhanced Sexual Health Services (only practices willing to provide tier 1 can offer tier 2 services)

The practice is required to ensure patients are aware of the various contraceptive options through the use of posters and/or leaflets, to more generally promote the availability and advantages of Long Acting Reversible Contraceptives (LARC). These materials should be displayed in a manner that is visible to patients. The full range of Family Planning Association leaflets can be obtained from Health Promotion. The Western Cheshire Chlamydia Screening Office can also supply posters.

(i) Practitioners to undertake regular continual professional development in accordance with the Faculty of Sexual and Reproductive Healthcare guidance
(ii) Provision of adequate equipment.
(iii) Medical/Sexual history taking.
(iv) Risk assessment.
(v) Assessment and follow up.
(vi) Provision of information.
(vii) Production of an appropriate clinical record.
(viii) Patient consent.
(ix) Periodic reviews of the service at least annually

Contraceptive Implants

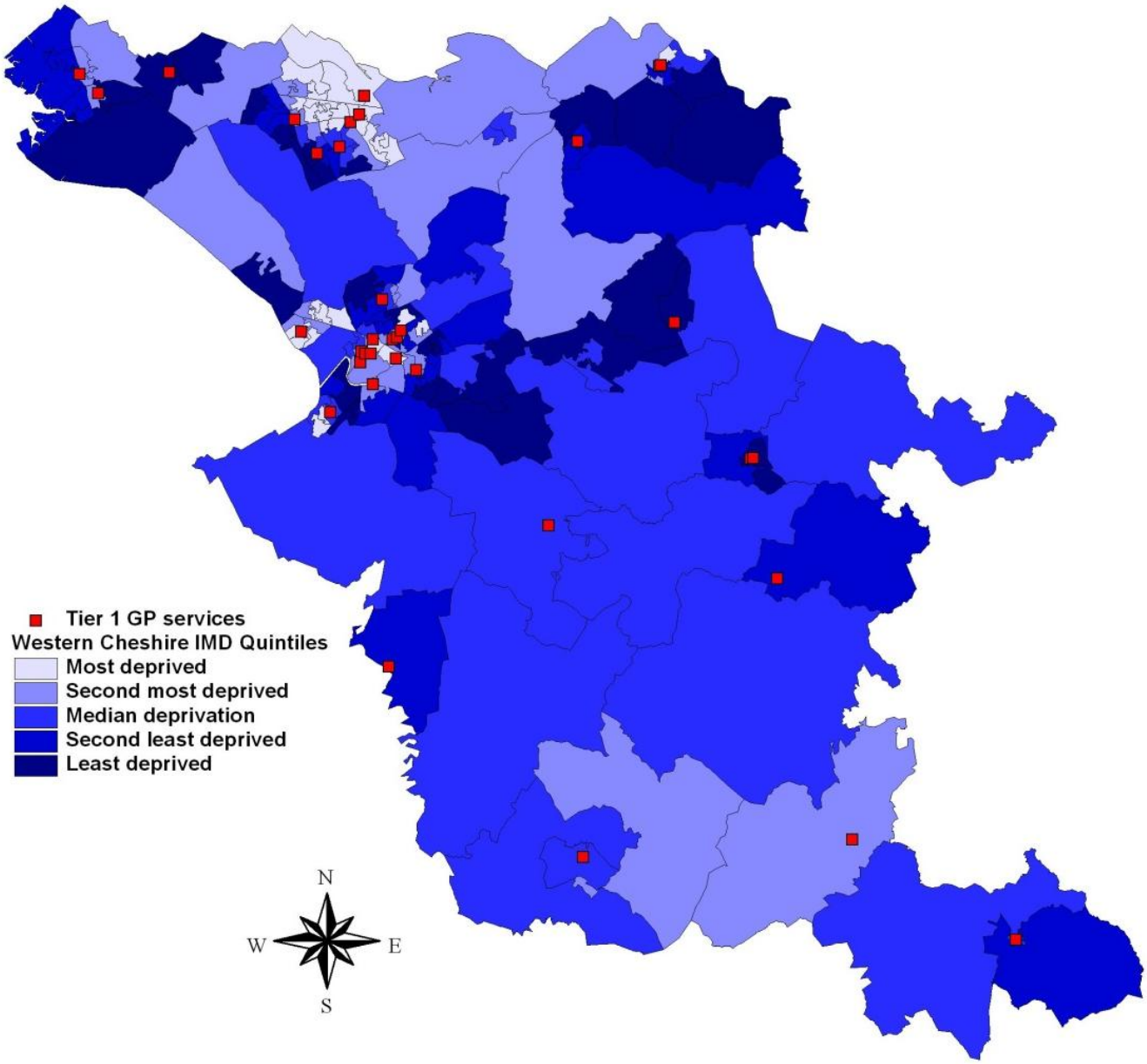
(i) Fitting, monitoring, checking and removal of contraceptive implants licensed for use in the UK, as appropriate
(ii) Production of an up-to-date register of patients fitted with a contraceptive implant

Intrauterine Devices (IUDs)

(i) Fitting, monitoring, checking and removal of IUDs as appropriate
(ii) Production of an up-to-date register of patients fitted with an IUD.

Map 5 below shows GP services in the PCT who offer Tier 1 enhanced services, mapped against IMD scores. There are a total of 39 GPs that offer this level of service. Services are more readily available for more highly populated areas such as Chester city centre and Ellesmere Port. Five of the GPs are located in most deprived area and a further six border the most deprived areas. Seven were in the least or second least deprived areas.

Map 5 IMD score with GP surgeries offering Tier 1 services



Map 6 below shows GP services that offer Tier 2 enhanced services mapped with IMD score. There are 30 GPs offering this level of service, nine less than those offering tier 1 service. The map shows that many of the GPs in the more populated areas of Chester city centre and Ellesmere Port do offer tier 2 services but there are some other areas where coverage is poor. Only one GP in the Neston area offers tier 2 services, but three GPs are currently offering tier 1 service. Also there are no GP tier 2 services around Tattenhall and Wrenbury, although tier 1 is offered. This links with focus group discussions with young people and Service Users accessing their GPs.

GP sexual health enhanced service data

The locally enhanced services offered by the GPs provide an opportunity to examine local uptake of sexual health services in a GP setting. Data is provided which show the amount of Chlamydia tests given to 15-24 year olds, the amount of contraceptive implants fitted and removed, and also the amount of intrauterine contraceptive devices fitted. Table 7 shows the number of chlamydia tests performed in general practice in a specific area of the PCT, approximating 600 per quarter. These geographical areas are concomitant with the maps presented in section 3.10 and are designed to represent a small area which would be easily accessible to any residents of that area.

GP surgeries in Chester city centre performed an average of 73 Chlamydia tests. This is substantially higher than other areas where the average number of tests per GP surgery offering tier 1 enhanced services is much lower: Ellesmere Port (41), East Western Cheshire (25), Frodsham (38), Malpas (12), and Neston (46).

Map 6 IMD score with GP surgeries offering Tier 2 services

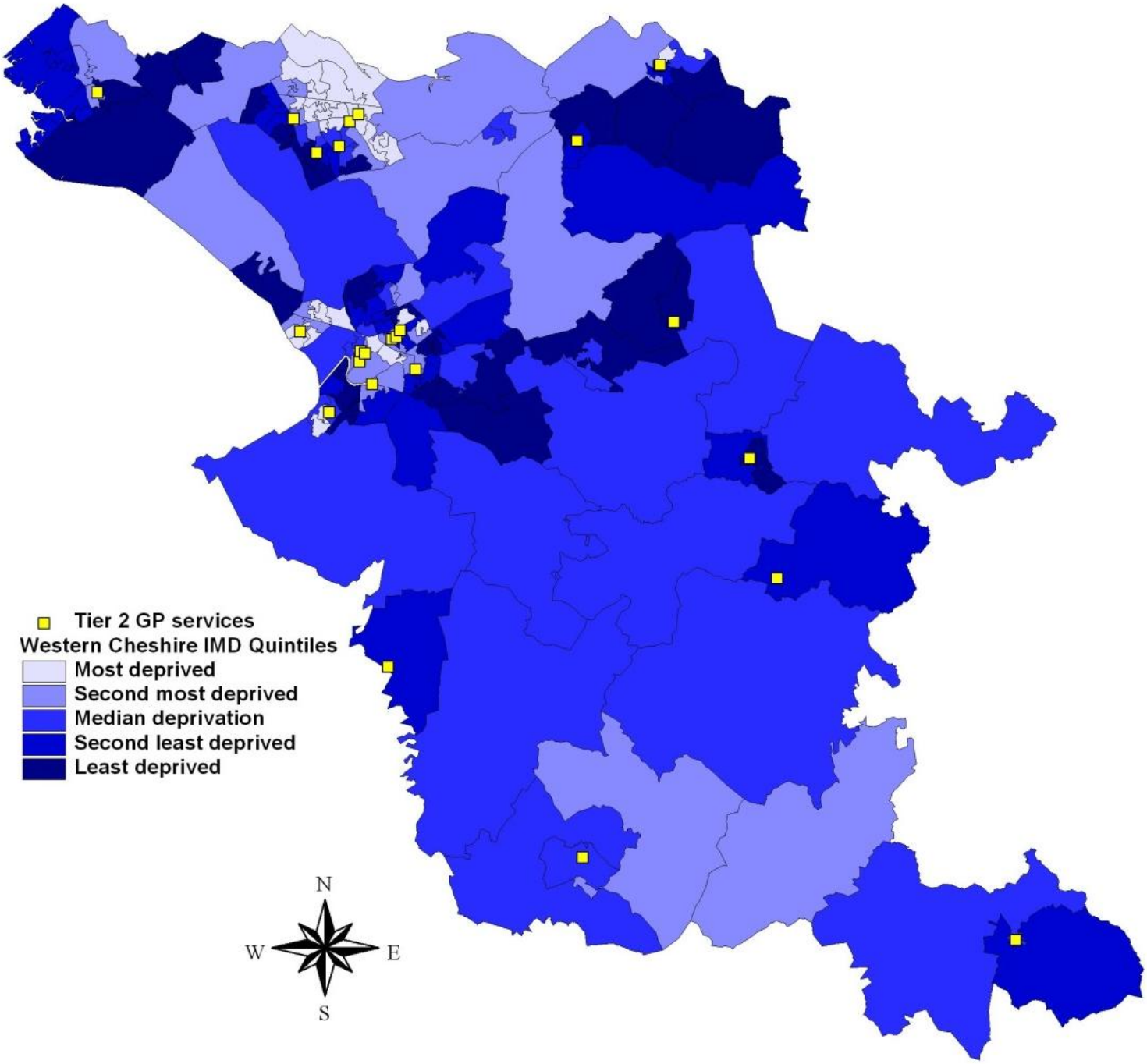


Table 7 Number of Chlamydia tests given to patients under 25 by area and quarter

	April – June 2009	July – Sept 2009	Oct – Dec 2009	Total
Audlem	5	0	0	**5**
Chester	319	332	375	**1026**
Ellesmere Port	119	146	147	**412**
East	41	43	15	**99**
Frodsham	58	30	27	**115**
Malpas	13	23	0	**36**
Neston	31	63	43	**137**
Total	**586**	**637**	**607**	**1830**

Table 8 Number of implants fitted by area and quarter

	April – June 2009	July – Sept 2009	Oct – Dec 2009	Total
Audlem	3	1	0	**4**
Chester	80	87	89	**256**
Ellesmere Port	52	58	71	**181**
East	7	7	7	**21**
Frodsham	23	25	21	**69**
Malpas	5	16	2	**23**
Neston	1	5	4	**10**
Total	**171**	**199**	**194**	**564**

Table 8 displays the number of contraceptive implants fitted at GP surgeries during the final three quarters of 2009. GP surgeries in Chester and Ellesmere Port fitted the highest absolute numbers of implants. Further, on average GPs in these areas fitted a higher number compared to some other localities. However, GPs in Frodsham fitted the highest number of implants per GP surgery.
Table 9 shows the number of implants removed at GP surgeries by area. Activity was greatest in the most populated areas of the PCT. The overall figure for GPs across the PCT approximated one removal for every 2 implants (0.44), but this varied from 1:10 to 1:1 across the area, as follows:

- In the Frodsham area there were two removals for every three implants fitted (0.64).
- Audlem had one removal for every fitment (but numbers involved are very small).
- In Chester there was almost one removal for every 2 implants (0.44).
- In Ellesmere Port and the east of Western Cheshire there was one removal per three implants (0.38).
- In Malpas there was one removal for every three implants (0.35).
- In Neston there was one removal per ten implants (0.10) (but numbers involved are very small).

Table 9 Number of implants removed

	April – June 2009	July – Sept 2009	Oct – Dec 2009	Total
Audlem	4	0	0	**4**
Chester	32	54	27	**113**
Ellesmere Port	25	19	25	**69**
East	2	1	5	**8**
Frodsham	17	15	12	**44**
Malpas	2	6	0	**8**
Neston	0	0	1	**1**
Total	**82**	**95**	**70**	**247**

Table 10 displays the number of intrauterine contraceptive devices fitted at GP surgeries in the different areas. Chester, Ellesmere Port, and Frodsham had the highest number of devices fitted, consistent with amount of implant fitments/removals. The spread of fittings at different times of the

year are not constant, it is unclear whether this is by chance or if other service factors have come into play.

Table 10 Number of intrauterine contraceptive devices fitted

	April – June 2009	July – Sept 2009	Oct – Dec 2009	Total
Audlem	2	11	0	**13**
Chester	89	86	118	**293**
Ellesmere Port	57	42	55	**154**
East	13	16	25	**54**
Frodsham	25	21	37	**83**
Malpas	15	14	2	**31**
Neston	0	8	8	**16**
Total	**201**	**198**	**245**	**644**

Prescribing data

The importance of community pharmacies has been highlighted in a 2008 White Paper, *Pharmacy in England*[77]. The paper seeks to develop alternative modes of health care delivery by developing the public health role of community pharmacies. The guidelines set out the future for community pharmacies by ensuring they take on a more visible and active role through provision of many services such as alcohol guidance, cessation of smoking, and weight management. For sexual health services include chlamydia screening, and access to contraception including emergency hormonal contraception (EHC). The data below show the current provision of prescriptions for sexual health related services in NHS Western Cheshire.

Figure 9 shows the proportion of prescriptions for each of the different types of emergency and non-emergency contraceptives made between January 2009 to December 2009. Three quarters were for combined oral contraception, with the next greatest, injectable contraception, constituting a further 20% of contraceptives prescribed within the PCT. Emergency contraception made up 3% of all contraceptive prescriptions. These proportions are similar to that of neighbouring PCTs.

Figure 10 shows data on prescriptions of emergency and non-emergency contraception by month. Emergency contraception constituted 2% and 3% of all prescriptions per month. Prescriptions for emergency oral contraception were greatest in the first three months, dropped in July, and steadied in the final quarter. January and July had two oral contraception prescribing peaks.

Figure 9 Prescribing data for NHS Western Cheshire from January 2009 – December 2009

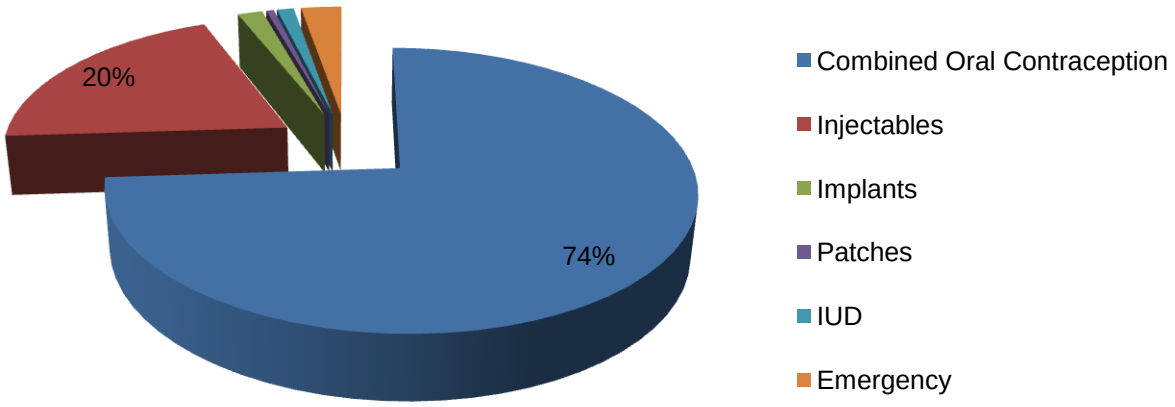


Figure 10 Emergency and non-emergency contraception prescribed in NHS Western Cheshire, January 2009 – December 2009

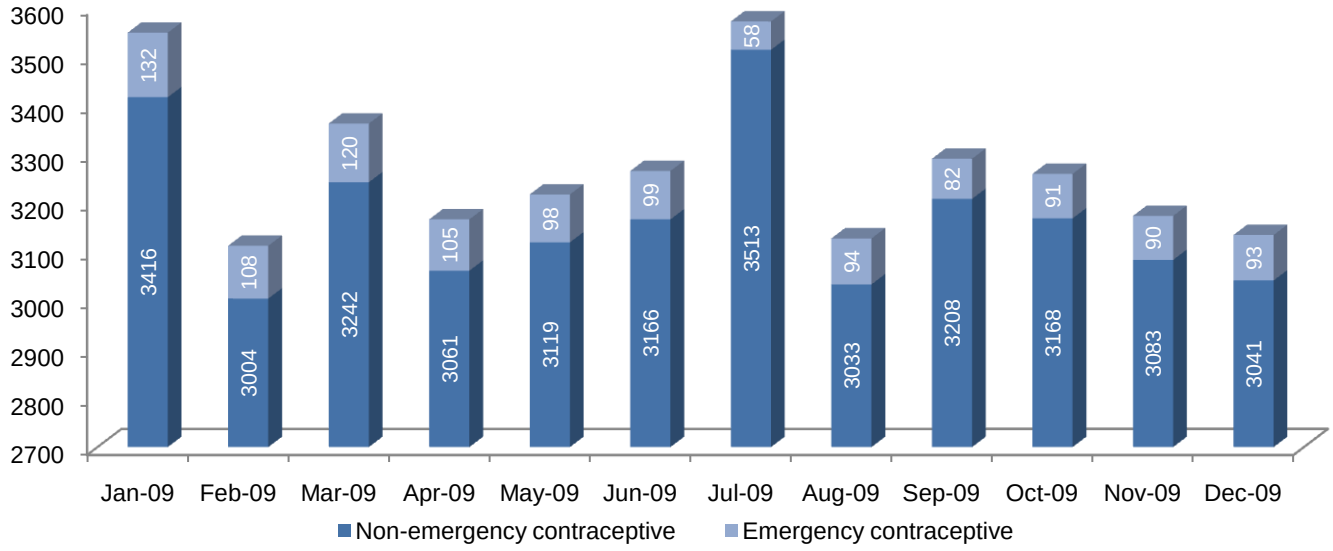
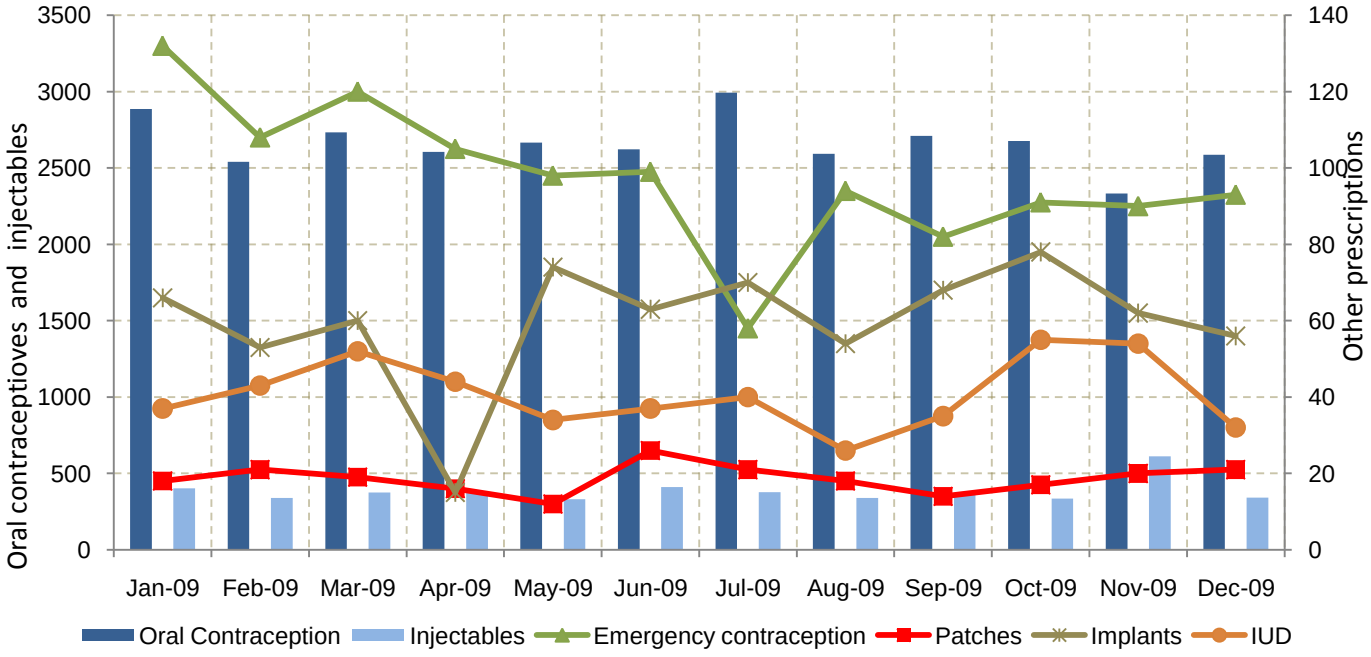


Figure 11 shows monthly prescriptions for emergency and non-emergency contraception over the same time period, broken down by type. The left axis shows the number of prescriptions of the oral contraceptive pill and injectable contraceptives (represented by the bars) and the right axis shows all other contraceptive services (represented by the lines). Oral contraceptive pills were the most prescribed in the period (just below 3000 each month). Prescriptions for injectable contraception were steady throughout the period, around 350/month, except in November when there was a prescribing surge to 611. Contraceptive patch and intrauterine contraceptive device prescriptions were low, ranging between 12 and 55 per month. Prescriptions for emergency contraception reduced during July having peaked during January.

Figure 11 Monthly sexual health-related prescribing data, NHS Western Cheshire in 2009



3.3 Meeting of Stakeholders to Advise on Sexual Health Needs and Policy

This section is the summary of the group discussion of the working team involved with sexual health in Western Cheshire. Stakeholders participating in this session included those with daily contact with patients/public/clients, and are considered to offer insight into sexual health needs. Participants' suggestions are included if there was general consensus among the subgroup members. The group discussion was undertaken at NHS Western Cheshire on Wednesday 8th July 2009.

Box 6 Key Findings from Stakeholder engagement Meeting

Stakeholders with an insight into patient/client needs were invited to contribute to a group discussion (28 Jul 2009), since not all population groups could be invited for primary research. Participants' suggestions are included if there was general consensus.

- **Participants' assessment of progress**

Partnership: There is strong linkage with other organisations including hospitals, schools and communities. A number of sexual health services have been developed and are available in communities (e.g. health zone, Connexions). However this collaborative work is on a micro-scale, not widely generalised to cover the whole area and should be expanded, e.g. to young workers and volunteers, Chlamydia screening service.
Services are wide ranging and largely work well (e.g. chlamydia screening, Genito Urinary Medicine, Utopia for Lesbian, Gay, Bisexual, and Transgender, Contraceptive and Sexual Health, antenatal care delivered by the midwifery team). Target groups (e.g. teenage mothers and university students) are aware of the services and do make use of them. However, there is some concerns that the approachability of General Practitioners might limit accessibility of sexual health services.
Policy needs to achieve a balance between national and local priorities. Prevention strategy should be further developed and linked into other public health areas (e.g. alcohol, drugs).

- **Needs**

General public's greatest need from services is privacy and confidentiality. Services should be extended into the community (e.g. more centres) and be established in other places (e.g. Aqua House). Services should focus on health and well-being and target children and families.
Men: There are many issues around men's engagement, with male only sessions not well attended. The use of sports clubs, army camp and engagement with 16-18 year-olds in Further Education colleges was suggested.
Vulnerable groups: Some vulnerable groups are small and dispersed (e.g. Eastern European immigrants) and difficult to access (e.g. sex workers, travellers, drug users). It was reported that their needs were not well understood and poorly catered for.

- **Barriers**

Knowledge and education of sexual health issues was raised as an important barrier, with low levels of sexual health education in young people (particularly around long-acting reversible contraception). Parents should be encouraged to educate their children about sexual health. Some of the health care providers (e.g. General Practitioner, pharmacists, nurses) lack skills in delivering sexual health services. Further training courses should be considered and supported.
Services insufficient for need: Participants identified a variety of services that should be provided (e.g. C-card, genitourinary medicine, long-acting reversible contraception, and Chlamydia screening etc.)
Accessibility: Revise the location and opening hours of services (e.g. there are no evening services for Ellesmere Port), increase the number of services and focus on high risk areas. Services should be more widely available, perhaps through other health organisations to improve accessibility. Engage with the other potential community groups (e.g. young people groups, schools, substance misuse services). A call centre for sexual health should be

established to give consultations to potential clients and direct them to appropriate services.
Service providers with good frontline access (e.g. General Practitioners, pharmacists, health nurses) need training.
Some lack communication skills for dealing with young people. Even if this can be supplied, it is not possible with transient locum pharmacist population.
Funding was known to be limited, but it was felt the PCT was not trying innovative techniques.
Transport was identified as a major barrier. The issues included: rural nature of Western Cheshire; difficultly in travelling from east to west; and expense.
Other barriers included culture (alcohol use is a barrier to good sexual health and the conservative nature of the community prevents approach to sexual health services), lack of ability/willingness to approach target groups (rather than wait for people to visit), lack of data sharing, lack of use of technology to engage with the public (e.g. websites, online communities).

- **Priorities**

Service: Strengthen commissioning strategies to ensure change; train more staff to administer long-acting reversible contraception and put long-acting reversible contraception into the contracts; increase accreditation levels for pharmacy to offer emergency hormonal contraception; find better ways to distribute condoms; provide holistic care, build up call centre system.
Policy: ensure prevention is integrated; improve communication to ensure knowledge is shared.
Partnership: expand collaborative work to others (e.g. police, local authority, schools/colleges) and formalise joint work (clear commissioning with integrated approaches to prevention).
Communication: promote services using clear marketing strategy and improve communication at every level.

Section 1: Effectiveness of current services

The strengths and weaknesses of sexual health services/interventions have been identified in five main categories; partnership, services, knowledge, policy context, and data systems.

Partnership working
Participants identified that sexual health services have strong links with other organisations including hospitals, schools and communities. A number of effective sexual health services have been developed in communities, for example; health zones, Connexions, Emergency Hormonal Contraception in pharmacies and others. However this collaboration work seemed to be localised, not widely generalised to cover the whole area. Therefore, it would beneficial to expand the collaboration with youth workers and volunteers, the chlamydia screening service and other sexual health related working groups.

Successes:
- Sexual health working team generated a huge amount of goodwill.
- Good links between the sexual health working group and midwifes, hospitals, schools and communities.
- There is a general willingness to roll out work in schools and it seems that schools are becoming receptive to this.

Areas needing improvement
- The collaborative work has been small in scale and not linked with teenage pregnancy, so that a drop of using services has been identified.
- Connexions work well in supporting young people but do not emphasise prevention strategies.
- Need to identify the benefits of and then extend work with youth workers, voluntary agencies and children services and continue to engage clinicians.
- It was suggested the PCT should launch a sexual health road show through the local fair.
- Low staffing levels and financial restrictions limit services.

Sexual health services

Improving the delivery of sexual health services was highlighted as the major strategy to tackle this health issue. A wide range of sexual health services were mentioned and were thought of as working well; including health zone, CT screening, Connexions, Genito-urinary Medicine, Utopia for Lesbian, Gay, Bisexual, and Transgender (LGBT), Contraceptive and Sexual Health (CASH) services and emergency hormonal contraception, as well as the antenatal care which is delivered by the midwifery team. Target groups, such as teenage mothers and university students, were perceived to accept the services and tended to use them more. Unfortunately, some problems were perceived in the accessibility and approachability of some services such as GPs. However, the contraceptive pill seems to be well known among target groups but there is a lack of awareness on how to use it. Regarding the support from the local community groups, it seemed Body Positive Cheshire and North Wales (BPCNW) has been funded to deliver social services only, but not prevention services. To improve sexual health services, participants suggested long-acting reversible contraception needed to be put into the contract, and improvements needed to be made in providing holistic care, building up the call centre system and promoting the services appropriately.

Successes

- More teenage mothers are known to services – although figures are rising there is earlier identification of teenage mums and awareness of them.
- University students are attending services.
- BPCNW, in Cheshire East, are working well in Social Care.
- The midwifery team offers good ante-natal support which lasts for 4-6 weeks after birth.
- The emergency hormonal contraception scheme is thriving. Ninety pharmacists are trained each year and there is a system in place to target newly qualified pharmacists.

Areas needing improvement

- Youth Offending Service (YOS) does not meet the needs of young people.
- The availability of free condoms is limited.
- The flexibility of services is limited.
- People find it difficult to arrange a sexual health appointment at GPs.
- Sexual health services have too few staff or man hours to meet demand
- No funding for BPCNW to work on prevention with high risk groups and general population.
- Sexual health services need to be extended into the community to improve access.
- Long-acting reversible contraception is important and should be added to the contract.
- The quality of sexual health services could be improved by focusing on more holistic care.
- Health advisors are key professionals who can engage with people – they need to be able to contribute more time particularly to the high risk groups.
- A sexual health call centre system is needed to direct people to the right services.
- Provide information about PEP (Post-Exposure Prophylaxis) by using effective media/communication e.g. news letter launched by the County.

Sexual health knowledge

Lack of knowledge and education of sexual health was raised as an important barrier. Participants thought sexual health provision for young people was inadequate. Therefore the educational system in particular should be revised and simplified. Some of the general health care providers (for example GP, pharmacists and nurses) can lack skills in delivering sexual health services confidently. As such, further training courses should be considered and supported. Additionally, it is viewed as important to encourage parents to educate their children and is worthwhile of promotion.

Areas needing improvement

- The quality of sexual health education among young people still seems low, in particular the understanding of the body.

- One problem is trying to educate people to recognise whether they have or haven't a sexual health problem and being honest.
- Parents need to be encouraged to educate their children about sexual health.
- Do community psychiatric nurses have sexual health training – this needs to be investigated and rolled out if they don't.
- Training in sexual health for other health and youth work staff is needed, especially midwives and GPs.

Policy context

A balance needs to be struck between national priorities and the needs of the local population. Additionally, prevention strategies should be further developed and also linked with other related public health issues like substance misuse (drugs and alcohol) to enhance the outcomes. The sexual health services need to be promoted more widely and some participants suggested free condoms could be distributed in taxis and police cars.

Successes

- Perhaps use behaviours to identify high risk groups as opposed to pre-determined markers.
- Formulate a prevention agenda.
- Alcohol and drugs are important links to sexual health problems, these agendas need to be addressed together and sexual health services promoted in DAAT services.
- Need to promote other contraception methods. There is a distinct gap in knowledge, for young people and professionals, of contraception methods such as long-acting reversible contraception.
- Communication through peer groups is useful. For example if a friend has had a positive experience of a service they are more likely to share it with others. Many new service users find out about the services through word of mouth.
- At Chester University there has been some success with posters on the back of toilet doors.
- The community logo "Your body, your health" has been successful.

Sexual health data systems

Sexual health data should be available centrally for the health providers to access it easily from the local setting. Sexual health providers (GPs, nurses, midwifery) still need more training in data collection and provision. A suggestion was made that it would be helpful if data related to postcode could be supplied and all partnership agencies can access it.

Section 2: Understanding needs of existing and potential users

Target group

Participants had a discussion to identify current and potential users and their sexual health needs. Many potential users were specified into categories including many vulnerable groups: young offenders, men, sex workers, students, the Polish and Eastern European population, travellers and drug users). Participants suggested some issues with regard to specific groups:

Young people

- The sexual behaviour of younger teenagers differs from that of the general population, insomuch that it is 'normal' to have sex in open areas.
- Vulnerable children may suffer from attachment disorders.
- Vulnerable young people (under 18) need more accurate targeting as there is not enough contact with workers.

Teen parents

- Anecdotally, there is an increased incidence of teenage mothers with learning difficulties.
- There is a higher risk of teenage pregnancy in people with learning difficulties and heavy drinkers.

- Young parents do seem to attend youth centres
- It is a myth that there are high numbers of care leavers getting pregnant. Perhaps there is an issue with the definition of 'care leaver'.

Men

- There are many issues concerning the lack of engagement of men with services.
- Chlamydia screening targets could more easily be met if specific work was focused on sports clubs.
- Male only sessions are not very well attended. Resources need to be targeted at the age group 20-24.
- The Army Camp offers an opportunity for health improvement but is suffering from a decline in numbers.
- 16-18 year old males in further education represent a target group.
- Some GPs are reporting more men seeking advice and treatment for sexual health related issues.
- The challenge is to go to where men are, for example pubs, army camps, football clubs.

Sex workers

- Very little is known about this group. There are different levels of contact with this group throughout the area.

School and university students

- University students are made up of those who remain living with their parents and those living away from home in halls or rented accommodation.
- Schools do not offer good education and support regarding homosexuality. Connexions are better at offering this education and support, and also other outside agencies are key to support.
- What Lesbian, Gay, Bisexual, and Transgender work there is in schools and colleges seems to focus on sex and not relationships.

Immigrants and asylum seekers.

- There is an asylum seeker population in Crewe and Nantwich. There is a Polish community in Crewe and Ellesmere Port.
- The Polish and Eastern European populations are small and vulnerable but do not access services. If there is engagement with services it is generally for antenatal care.
- There are often language barriers with immigrants and travellers that make it difficult for them to access services.

Other vulnerable groups

- Connexions does have access to young offenders.
- There are very small numbers of black and minority people compared with other vulnerable groups.
- There are many issues concerning 'Looked after children'. Often they may be 'Couch surfing' (young people who move from couch to couch) and authorities don't know where they are. Once these children turn 18 they go under the radar and may only reappear if pregnant.
- Many vulnerable groups have small and disparate populations
- Travellers receive 'Hit and miss' support. Sexual health services are not good at linking with the people who could access them - e.g. traveller council.

Public need

Participants felt the most important thing that the public needed in a sexual health service is privacy and confidentiality and NHS West Cheshire should strive to reassure users, and especially potential users, of this. There is some need for specific services targeting particular groups (like for men only). Extending services into community (e.g. more centres) and also establishing the services in other services like Aqua House (Drug and Alcohol) would be beneficial. Services should focus on health and wellbeing and also target children and family. There is a need to combine condom distribution with chlamydia testing in order to prevent sexual health problems.

Section 3: Identifying barriers

Range of services

It was thought by some participants that many sexual health services are not sufficient for the public need. Additionally, the services should be available through other health organisations to improve the accessibility. Collaborative working should be engaged with the other potential community groups like young people groups, schools, and substance misuse services. The call centre for sexual health should be established to give consultations to potential clients. Further specific issues included:

- There is no C-card scheme because lack of financial support.
- Services need to be more user friendly and signpost effectively to other services because they are fragmented without a central booking system for Sexual Health (telephone). There is not one unique telephone number for sexual health services in Western Cheshire.
- Implementation of long-acting reversible contraception and wider distribution of condoms in pharmacies is needed
- A One Stop Shop (e.g. Pill and Chlamydia at same time) could work well. Current service delivery is very traditional.
- Some Catholic schools in the area wanted BPCNW to help with general services but not Lesbian, Gay, Bisexual, and Transgender.
- No service review has been undertaken and it may help to build this into routine practice.
- Substance misuse service is tiered and perhaps this may offer an example of how sexual health could be structured.
- There is a need for abortion services to be linked to other sexual health services.
- Full screening in clinics is not currently widely offered.
- Factors such as building aesthetics need to be addressed and services need to appear to be more confidential.
- A barrier common in many clinics is where there is a shared reception e.g. hospitals. People may not feel comfortable talking with staff who are also dealing with other admissions e.g. orthopaedics or dermatologist (non-sexual health related). This is a difficult barrier to target as it depends on the design of each clinic or service.
- Contraception and family planning services are very female focused with no focus on men (particularly gay men).

Accessibility

The accessibility of services was identified as another barrier. Many factors which should be considered include opening hours of services, increasing the number of service centres and focus on high risk areas. Specific topics that were raised included:

- No clarity of opening times.
- School aged people in Helsby have a long way to travel for services as there is no local service on a Saturday and it is a long way to Chester.
- There needs to be more sexual health services offered in non clinical settings, for example in Children's centres.
- Some clinics are in the wrong place and open at the wrong times, it is obvious why young people are going to certain places at certain times.
- There needs to be a hub in Ellesmere Port AND Chester.
- There needs to be a balance between accessibility and discreetness e.g. Brook Liverpool, Birkenhead and Manchester in central positions but off the main routes.
- Ellesmere Port is a teenage pregnancy hotspot and there are issues with residents not stepping out of boundaries.
- Ideally, Ellesmere Port would have a Connexions style service with clinical rooms to fit long-acting reversible contraception etc.
- Some clinics have been closed because of vandalism.

- There are no evening services for Ellesmere Port.
- There are long queues at youth services in Blacon at lunch times.

Services providers

GPs, pharmacists and health nurses are potentially on the front line to deliver sexual health services and training courses should be provided to improve their skills.

- It is not possible to get all pharmacists accredited as the locum population is very unpredictable and transient.
- 'Young people' are seen as a specialist area and all health professionals need to be encouraged to embrace this, not leave it to specialists.
- GPs do not take much interest in sexual health, they need to be encouraged to do this particularly in teenage pregnancy hotspot areas.

Financial support

Participants reported that sexual health still suffers a lack of funding and the PCT has not tried more innovative techniques. In the past sexual health services have been set up and run on a small amount of money and there is no money or time given to staff training.

Culture

In the local area drinking behaviour is the major barrier to tackling sexual health. Cheshire is also perceived to be a conservative community which some participants felt was a barrier to approaching sexual health issues.

- Alcohol is a massive contributing factor to all sexual ill health
- The perceived conservative culture is seen by some as a barrier for more vulnerable groups to seek support and advice.
- It was felt that many service users would not divulge if they were in a 'risk group' due to the isolation of services.
- Cheshire has quite 'out-of-date' approaches to the Lesbian, Gay, Bisexual, and Transgender community.
- There are some cultural issues with teenage mums who in-turn have daughters who follow the same pattern.
- Many cultural issues do not seem to be with young people, but with their parents. This should be something that is challenged.
- NHS Western Cheshire do not know much about teenage pregnancy. There should be an audit to try and collect information like: Why did you get pregnant? Did you try contraception? Why not?

Communication

The communication skills of service providers are a barrier with regard to language and also how to communicate with young people. Further, service providers lack confidence to address these issues.

Approaching target groups

The services should proactively approach target groups and not just wait for them to seek services.

Policy makers

The policy makers could seek the opinions of others on issues such as extending health zones and CASH, the plan of extended schools and the data storing systems.

- Services such as Health Zones and CASH (which cover multiple health needs) may appeal to governors as it fits their remit.
- Blacon High School is getting a new head teacher at the start of academic year 2009/2010 and it may be appropriate to contact them with suggestions.

- Transfer of data is identified as a barrier. Specifically around patient identifiable data. The local authority would like to access to individual patient data and personal information.

Knowledge
Sexual health education in school is still poor and there is little awareness of long-acting reversible contraception and/or what to do if you have an unplanned pregnancy.

- Front line staff are not trained on on sexual health issues and YP issues.
- Some people who have unplanned pregnancies do not know where to go.
- Some don't know they are at risk and where the services are to advise.

Transportation
Cheshire is located in a rural area; therefore, the transportation system is not convenient enough for the users.

- Public transport is limited from east to west and is very expensive.
- Transport is a massive barrier to accessing services. E.g. it is impossible to get out of Congleton after early evening.
- Overall tackling the problems of transport may be key to ensuring attendance and return to services.

Technology
West Cheshire need to develop the technology to help users access sexual health information in modern ways from their own homes using web sites and the online community (e.g. Facebook, Twitter):

- Currently not using the technology well.
- Continue to develop websites that are under construction.
- There is a good computer program working in colleges in Western Cheshire called 'Youth Bites' which all students have easy access to.
- Could organise sexual health information on websites such as Stufftodo.
- Facebook and Twitter could be used to give information about local services.

Section 4: Improvement – priorities for change

Service
Sexual health services could be improved in number of ways. long-acting reversible contraception is the key service which works effectively, however, there is a need to increase the number of trained staff. Regarding the emergency hormonal contraception service, more accredited pharmacists are needed. Other suggestions included:

- Try to encourage the discussion of long-acting reversible contraception in SRE lessons.
- Find out how many girls would be interested in using long-acting reversible contraception.
- Clearer service level agreements.
- Emergency hormonal contraceptive: Identify pharmacy locations that must offer EHC, continue to increase accreditation levels and increase access on special days (e.g. Christmas, bank holidays etc).
- It is important to find an easier way to distribute condoms - BPCNW offer a condom through the post scheme which is very popular.
- Not enough locations offering sexual health services, especially that offer genitourinary medicine level service.
- Sexual health workers are currently working at maximum capacity which makes it hard to be responsive.

Policy context
The policy makers should ensure prevention strategies are integral to their strategies and changes in policies could help, such as:

- The council does not have a sexual health member, whereas some councils such as Sheffield do. This may help to raise the profile.
- There needs to be improved routes of communication to find out what is happening in different areas.
- More focus on prevention and not just treating symptoms further down the line.
- People will often work for different targets and their own agendas instead of wider aims.
- Need to have collective response to sexual health scares.

Partnership

Collaborative work should be expanded with other organisations; including police, fire service, local authority, youth groups, schools, colleges, university and others. Other partnership working could include:

- There is scope to work with 'Second relationship' and 'mother and daughter' groups.
- Increase co-ordination of young people's groups, including time, money and barriers.
- Schools, colleges and university need to be helped to tackle sexual health problems.

Promotion/Communication

Sexual health services should be promoted and advertised appropriately:

- Many other services (e.g. dentist) are reluctant to put up SH posters.
- There should be a clear marketing strategy for advertising services (e.g. long-acting reversible contraception).
- Regular communication with service users should be encouraged.
- More ongoing and routine data collection.
- It is important to challenge the fear stories about sexual health testing devices.

3.4 The Attitudes, Opinions, Needs, and Practices of Service Users in Western Cheshire

Box 7 Key Findings in Study of Service Users

- 184 service users (99 from genitourinary medicine and 85 from community and sexual health services) contributed towards a survey on their attitudes, opinions, needs and practices related to sexual health services in Western Cheshire; a higher proportion of respondents were female (71.2%).
- ~70% of genitourinary medicine respondents attended for an sexually transmitted infection check, and 30% of respondents required chlamydia screening. Double the proportion of females stated they sought chlamydia screening. A third visiting community and sexual health services sought oral contraception, with a further third attending for other reasons (cervical smear, pregnancy advice, removal of implants/coils). 14% of males and 6% of females utilised their visit to get condoms. Few sought emergency contraception, support for a termination, sex advice or counselling.
- The majority heard about sexual health services from a friend or from a General Practitioner. Genitourinary medicine services were also identified via the internet, while community and sexual health services were signposted through colleges and/or schools. Adverts were a poor source of information.
- The majority of respondents attending genitourinary medicine made an appointment; half waited less than a day, a further third waited a few days. A small proportion (~10%) recorded they waited a week or longer.
- Genitourinary medicine users travelled longer distances to get to the service; data show some clients travelled over 6 miles to genitourinary medicine for services that could be obtained locally, e.g. condoms.
- One in seven clients missed work, college or school to attend a sexual health service. A higher proportion (19%) missed work when visiting genitourinary medicine versus community services (7%). All persons seeking termination, pregnancy test, or emergency contraception had missed work, college or school.
- A warm and friendly welcome was considered the most important attribute of a sexual health service, followed by having private rooms and time to talk. More females than males requested free condoms, and younger people wanted services closer to their home, and to see the same person on each visit.
- The majority of males (75%) and half of females (48%) wanted services to be located in a hospital and a higher proportion of females wanted them located in the doctors clinic. Few wanted them located close to school, college or work, in town centres, in youth centres, or through a mobile bus service.
- Males preferred to talk to a sexual health doctor, while females opted for friends before the sexual health doctor. A quarter thought talking to the family doctor was difficult.
- Two thirds of males and half of the females would prefer to be referred to a hospital, and an equal proportion considered a special clinic for all ages, the family general practitioner, and a general practitioner close to school or work.

Information was generated from 184 questionnaires, 99 from genitourinary medicine (The Countess of Chester Hospital) and 85 from community services in 2009. More females (131; 71.2%) participated; while ~half (45%) of genitourinary medicine respondents were male, few (9%) males responded at community services.

Figure 12 Survey respondents by age and gender in GUM services

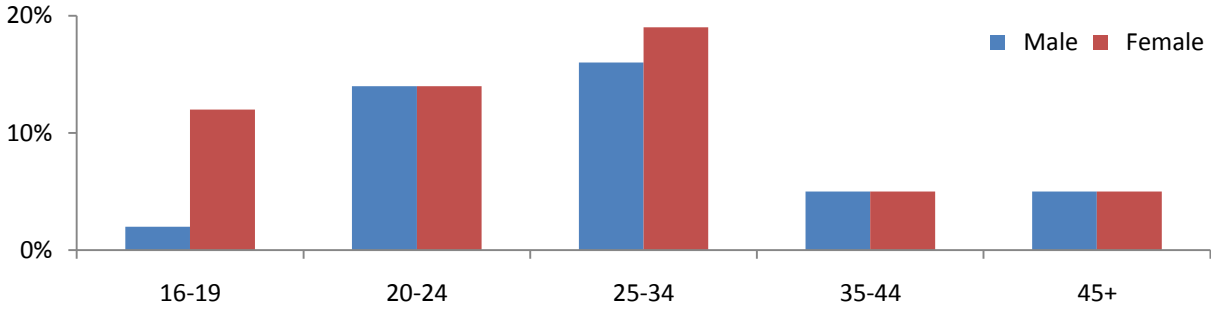
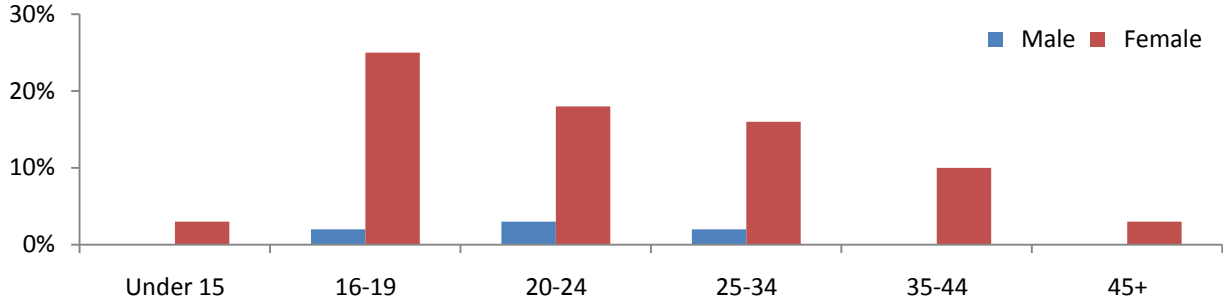
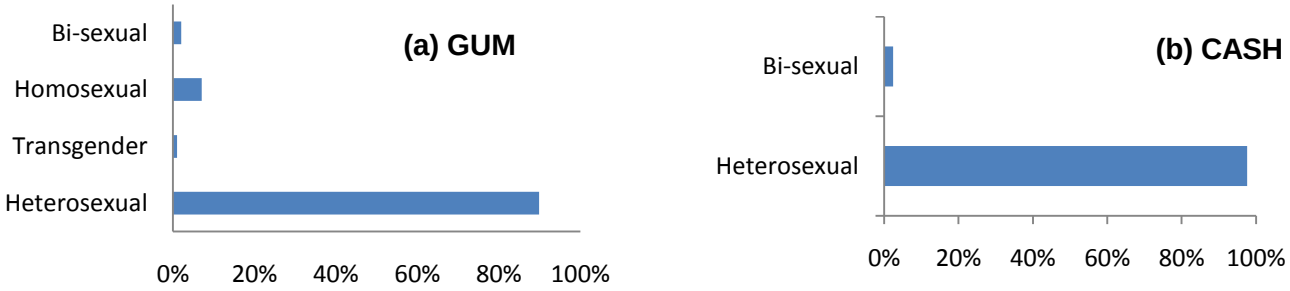


Figure 13 Survey respondents by age and gender in CASH services



Differences in respondents age and gender are evident between genitourinary medicine and CASH users. The average age of respondents from community services was younger than that of genitourinary medicine patients. Few males under the age of 20 responded. Ethnicity among services users responding to the survey was similar to the general population; with 93% and 95% recorded as White British in genitourinary medicine and CASH respectively. A higher proportion of 'black British' (3%) responded from genitourinary medicine.

Figure 14 Reported sexuality of respondents in (a) GUM and (b) CASH



Reasons respondents visited sexual health services

Use of sexual health services among respondents was restricted to a few requirements. Females went mostly for sexually transmitted infection checks, chlamydia screening, and oral contraception; males went for sexually transmitted infection and chlamydia checks, and a diverse 'other'. Double the proportion of females stated they sought chlamydia screening. A higher proportion of females responded yes to most of the options to attend, suggesting when they attend they seek advice on a range of needs, whereas males attend for one reason only (Figure 15). Few females or males sought emergency contraception, support for a termination, sex advice or counselling.

Figure 15 Reason for attending services today by gender

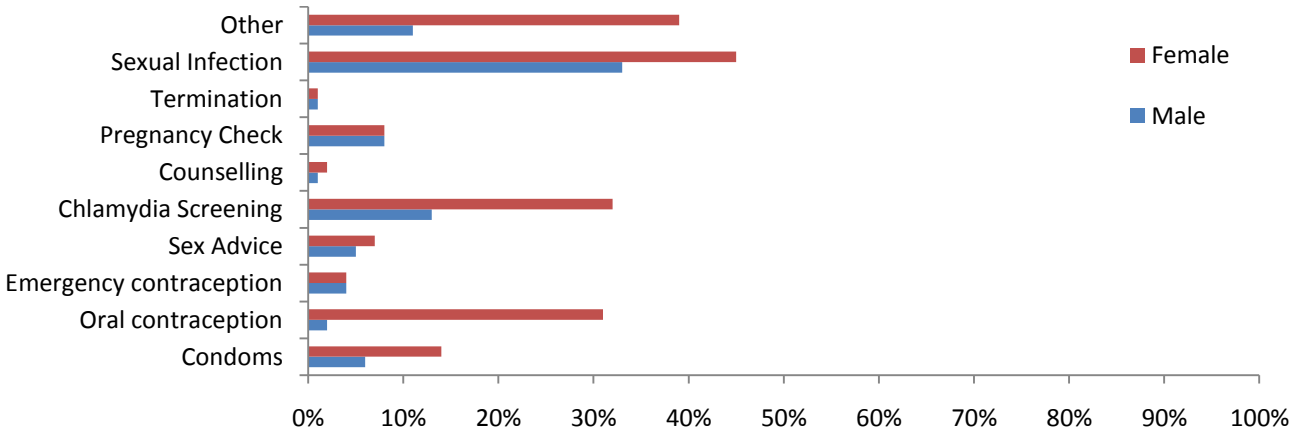
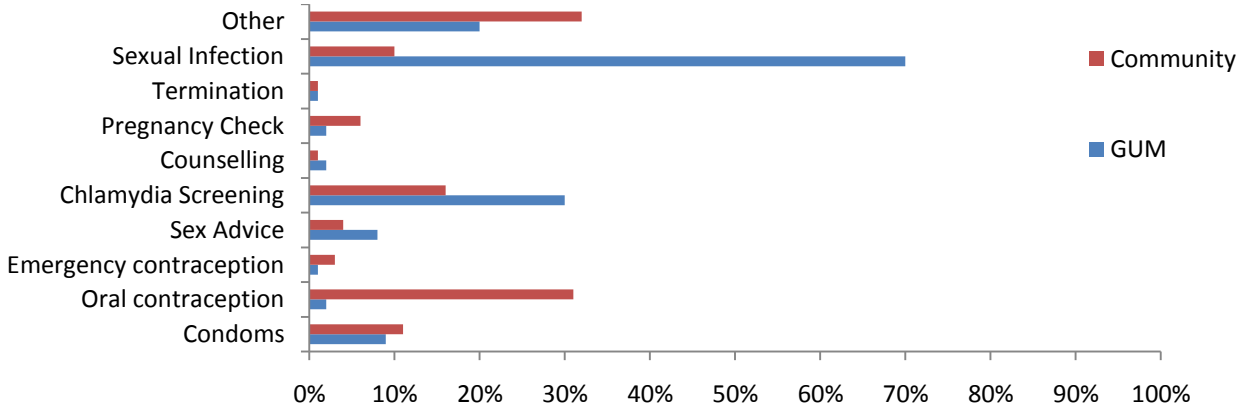


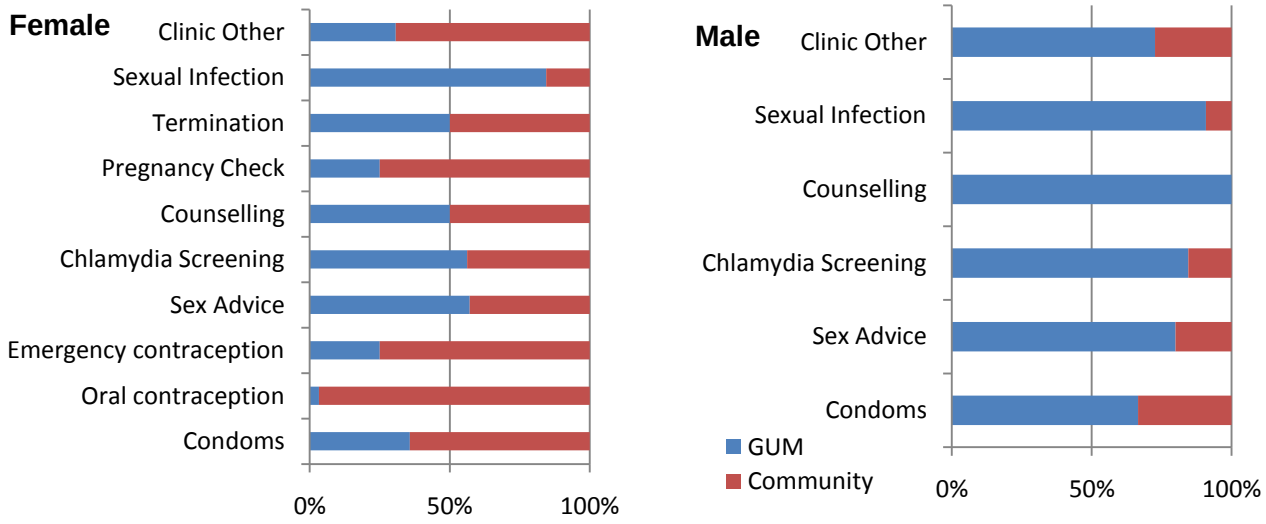
Figure 16 Reason for attending services today by service



Over 70% of respondents visited genitourinary medicine for a sexually transmitted infection check, and 30% sought chlamydia screening (figure 16). A third visiting CASH community service sought oral contraception, and a further third for other reasons including cervical smear test, advice on pregnancy, and removal of implants or coils. Reasons for attending community services were more varied, with the highest proportion seeking oral contraception. 14% of males and 6% of females utilised their visit to get condoms.

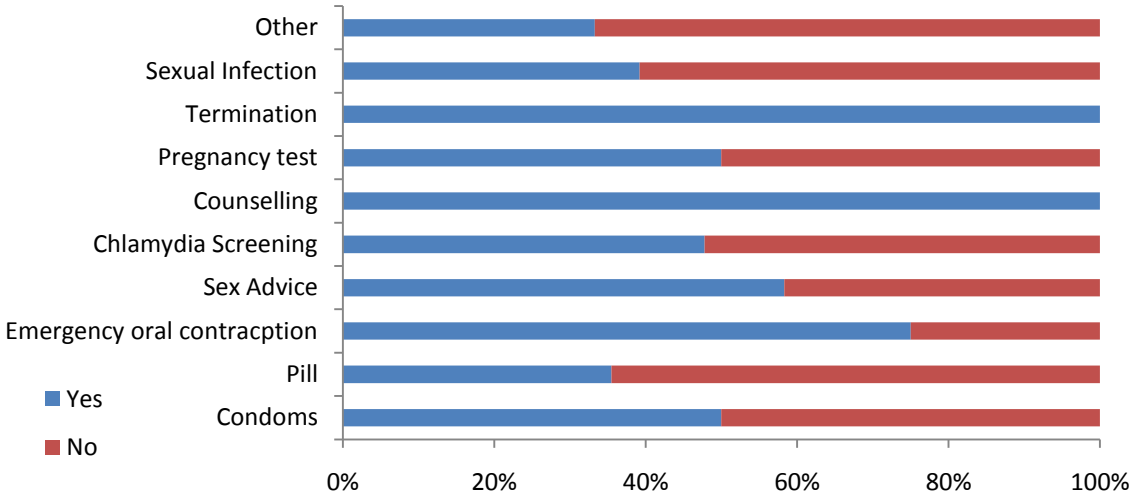
Males and females use the genitourinary medicine department more than community services for sexually transmitted infection testing (figure 17). Males used the genitourinary medicine for all their sexual health needs, with less clear evidence of interaction with CASH, while females used CASH community services for oral contraceptives.

Figure 17 Utilisation of service by reason for attendence by gender



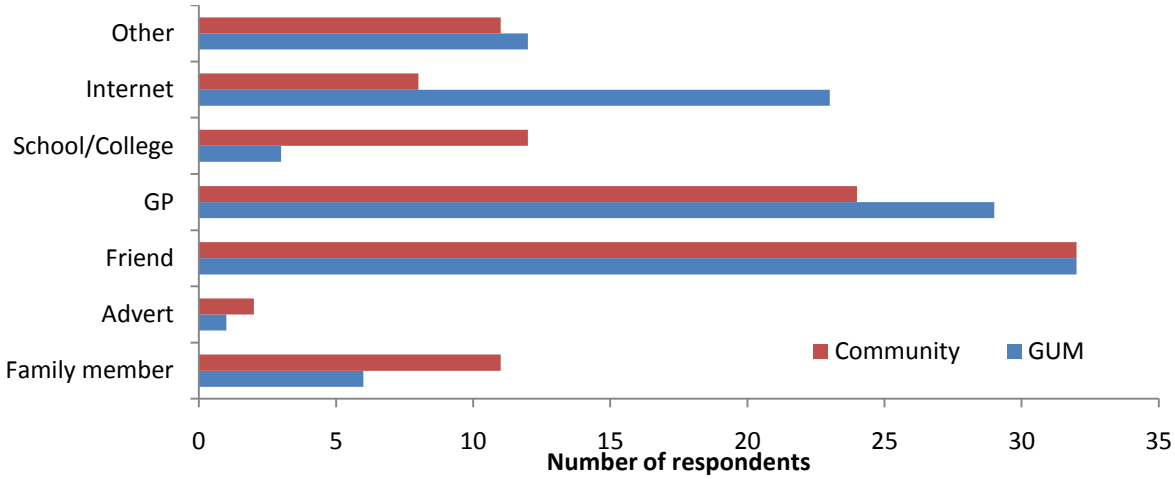
Respondents were asked if it was their first visit to this service, their response was plotted against the reason for the visit 'today' (figure 18). All terminations and counselling requests were first visits, three quarters of emergency contraception requests were also first visits. About 50% of pregnancy tests, chlamydia screens, and sex advice were first visits.

Figure 18 First visit and reason for attendance?



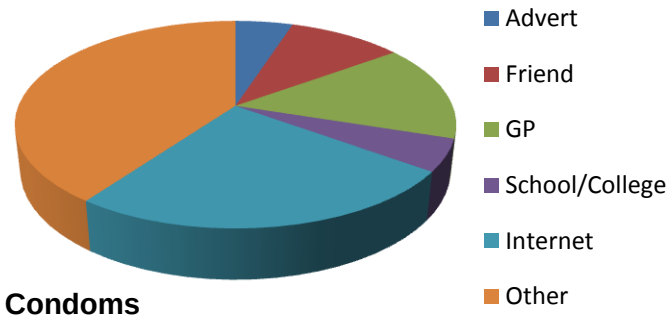
We were interested to know how respondents heard about the genitourinary medicine and CASH community service (figure 19). Responses showed that the majority heard through a friend, with the second entry route through signposting or referral from their GP, particularly for genitourinary medicine. Genitourinary medicine services were also identified through internet searches, while CASH community services were also signposted through colleges and/or schools. Adverts were not a good source of information for these services. Analyses were also subdivided by service and reason for visit, portrayed below (figures 20, 21).

Figure 19 How did respondents find out about the sexual health services?

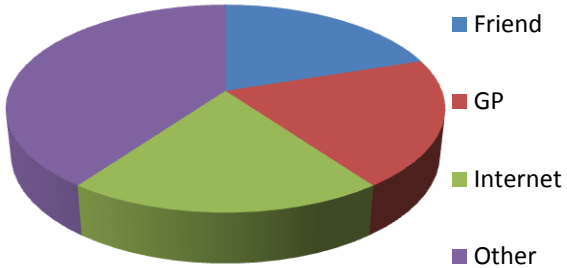


Friends recommended for pregnancy test, chlamydia test, emergency contraception, and sexually transmitted infection tests (figure 20). GPs signposted respondents to genitourinary medicine for sex advice, pregnancy tests, sexually transmitted infection checks, emergency contraception, chlamydia screening, and for oral contraception. Adverts were mentioned (very small proportion) for signposting of condoms, chlamydia testing, and sexually transmitted infection testing. Friends recommended community and sexual health services for chlamydia testing, sexually transmitted infection testing, pregnancy testing, oral contraception, and sex advice (figure 21). GPs signposted few services (as reported by respondents). Colleges and schools signposted for emergency oral contraception, chlamydia testing, pregnancy testing, and other sexually transmitted infection screening. The internet was reported to be the source for signposting some critical services.

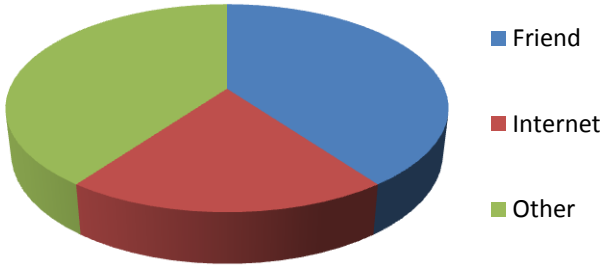
Figure 20 How respondents found out about service by their reason for attending: GUM



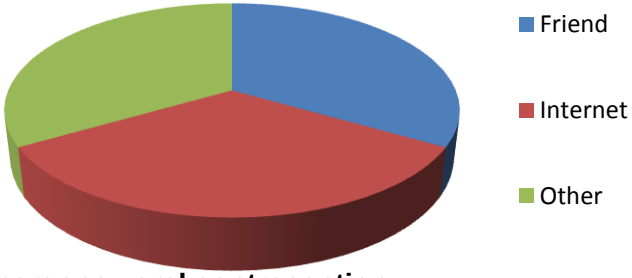
Condoms



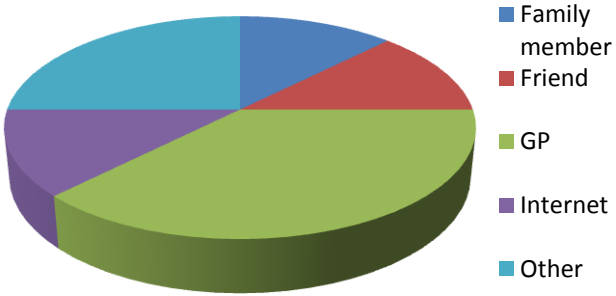
Oral contraception



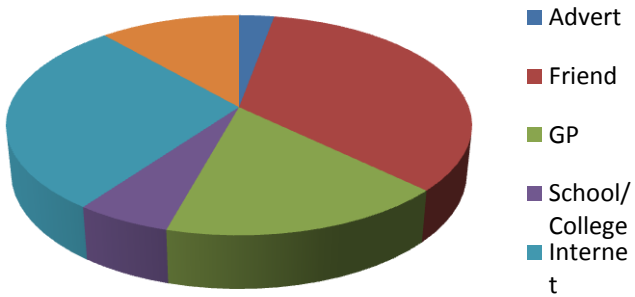
Pregnancy test



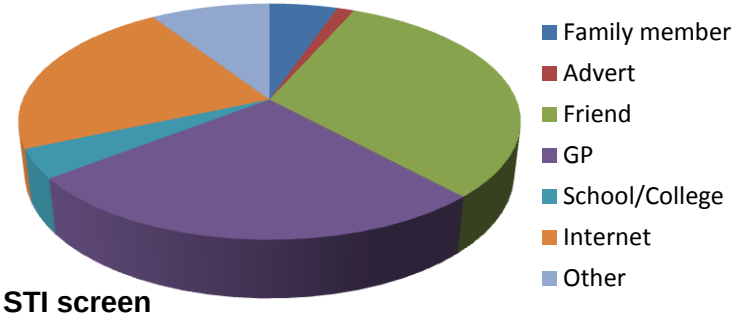
Emergency oral contraception



Sex advice

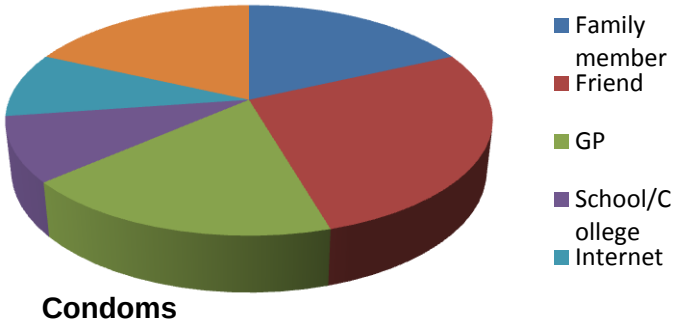


Chlamydia testing

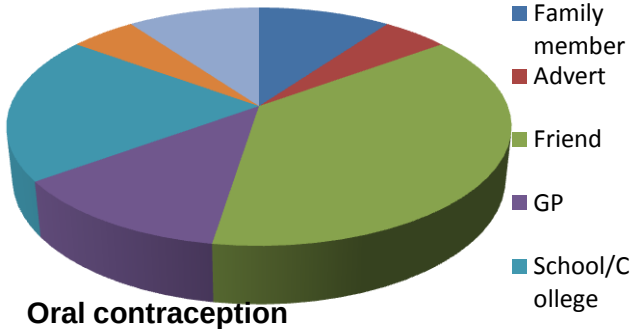


STI screen

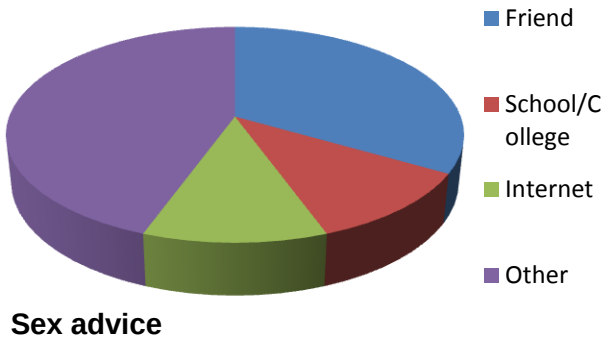
Figure 21 How respondents found out about service by their reason for attending: CASH Community SERVICES



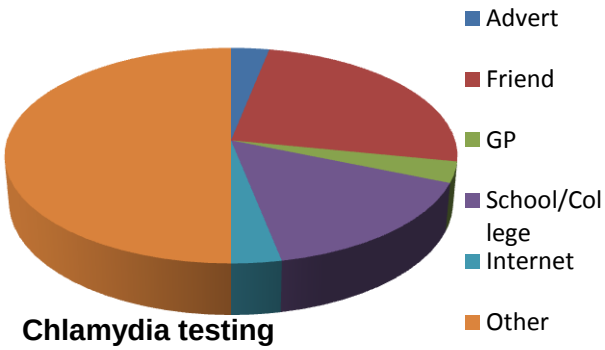
Condoms



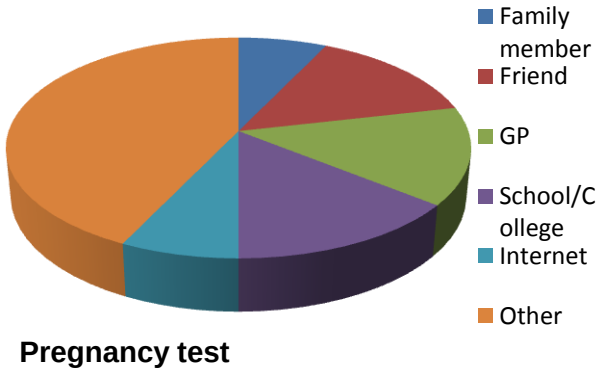
Oral contraception



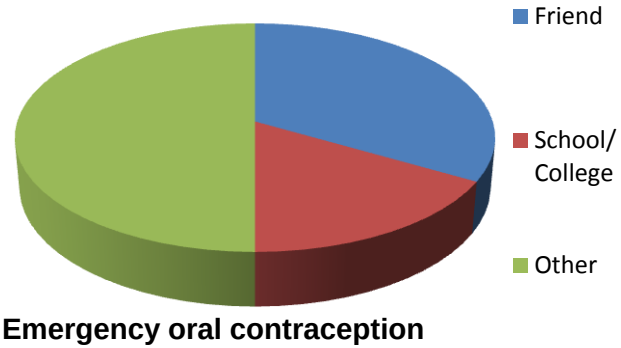
Sex advice



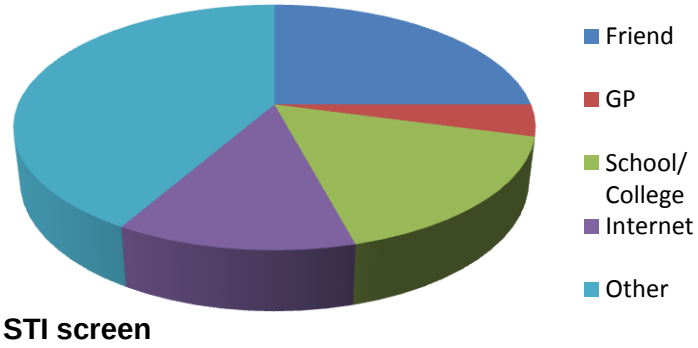
Chlamydia testing



Pregnancy test



Emergency oral contraception

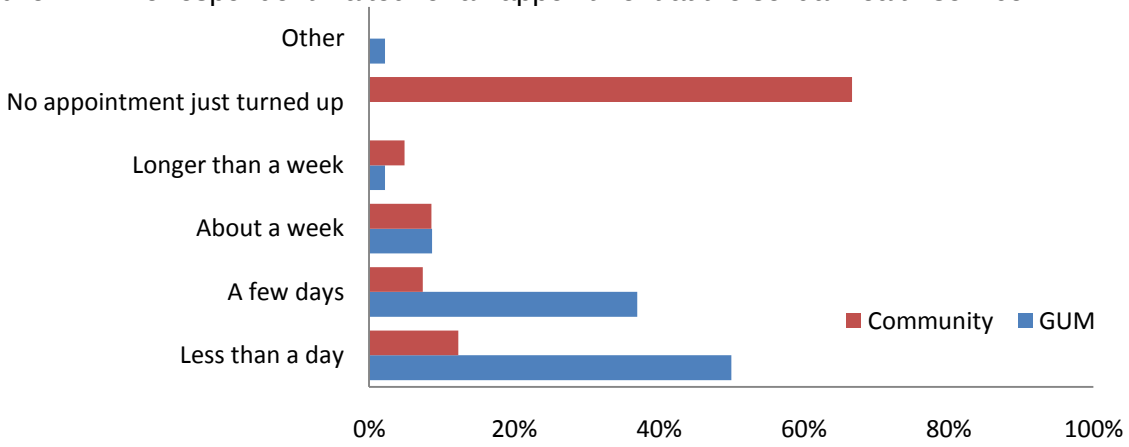


STI screen

Information from respondents during their visit on accessibility of service

A few questions were asked to respondents about how easily accessible the service was for their visit. This included how far people travelled, how long they waited for their appointment on the day, and whether they had to miss work, college or school to attend. The majority of respondents attending genitourinary medicine made an appointment; half waited less than a day to be seen, a further third waited a few days. Only a small proportion (~10%) recorded they had to wait a week or longer. For clients attending a community service, two-thirds of made no appointment and just turned up at the service.

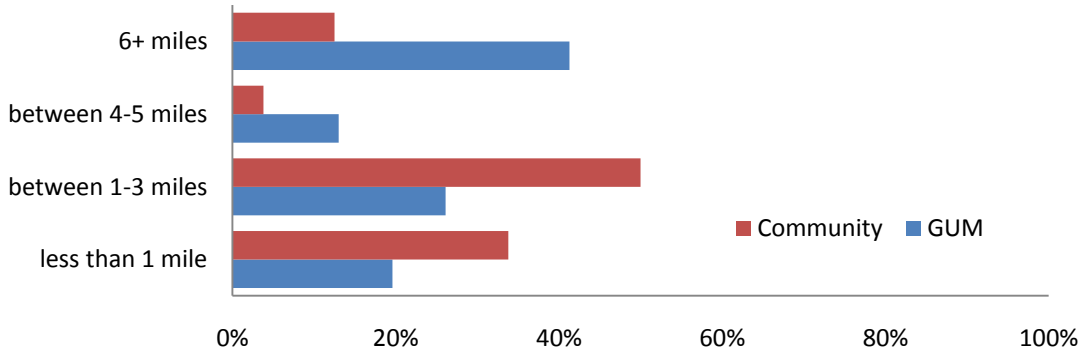
Figure 22 Time respondent waited for an appointment at the sexual health service



Distance travelled

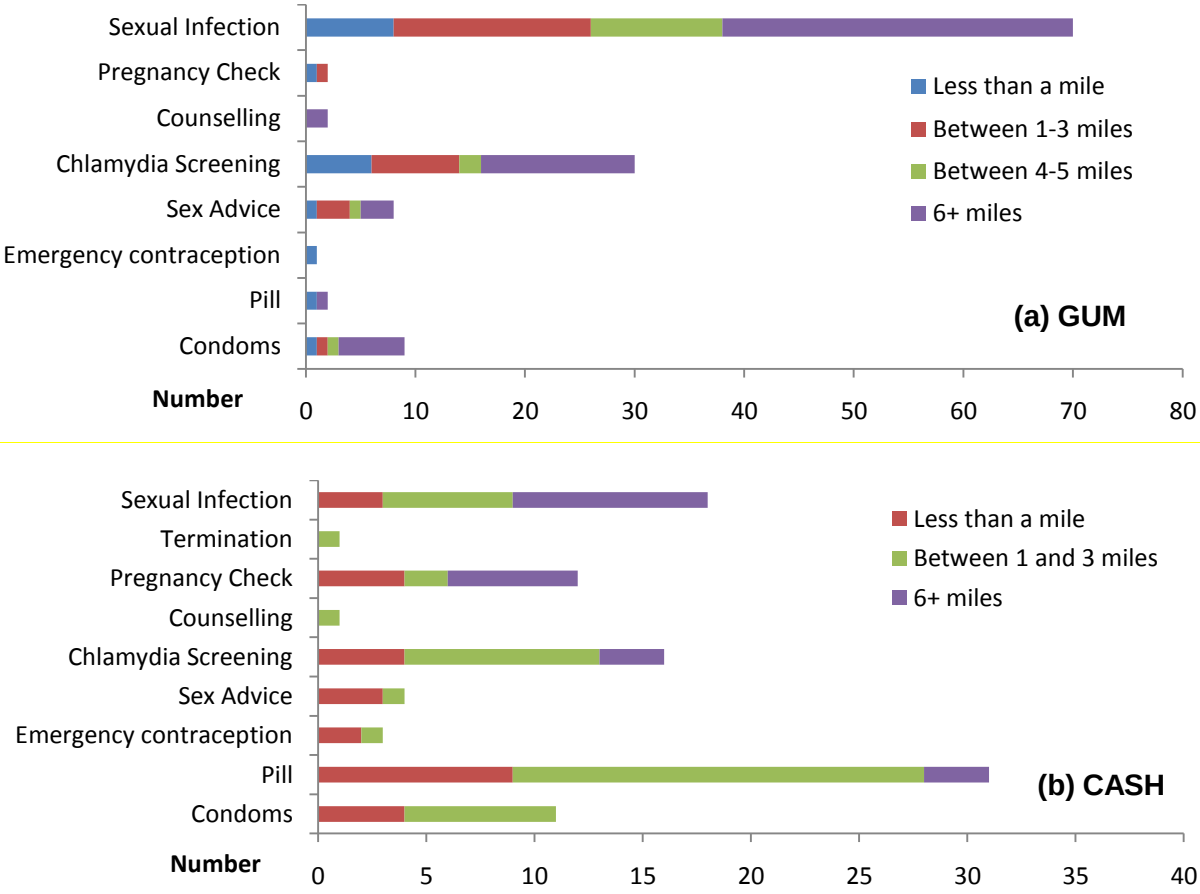
The average distance travelled by respondents to attend the genitourinary medicine clinic at the Countess of Chester hospital is considerably further than the average distance travelled to attend a community and sexual health services community service. This suggests those visiting community sexual health services attend more local services.

Figure 23 Distance travelled to get to sexual health service appointment



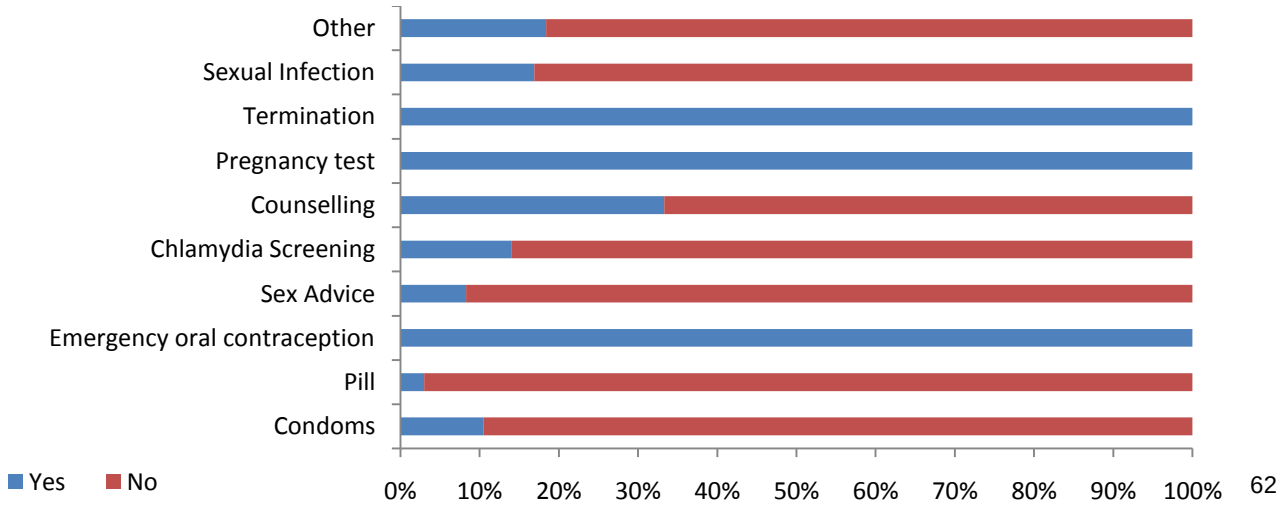
Data show that some clients travelled over 6 miles to the genitourinary medicine department for some services that could have been obtained locally, e.g. condoms. Approximately half of respondents seeking sexually transmitted infection checks at both the genitourinary medicine and at community and sexual health services travelled the greatest distances. Very few people were accessing the genitourinary medicine for the contraceptive pill whereas a high proportion of the community and sexual health services clients were attending for this service, the majority of whom were relatively local (3 miles or less).

Figure 24 Distance travelled by reason for visit to (a) GUM and (b) CASH



Missing school, college, or work to attend sexual health services.
Participants were asked if they missed work, college or school to attend a sexual health service. Responses indicate about one in seven clients had done so. A higher proportion of respondents missed work when visiting genitourinary medicine (19%), compared with community and sexual health services (7%). When plotted against reason for attendance at the sexual health service, there is a differentiation by 'seriousness' with 100% of persons seeking pregnancy tests, emergency contraception, and terminations missing work; while few did so for the contraceptive pill, sex advice, or condoms.

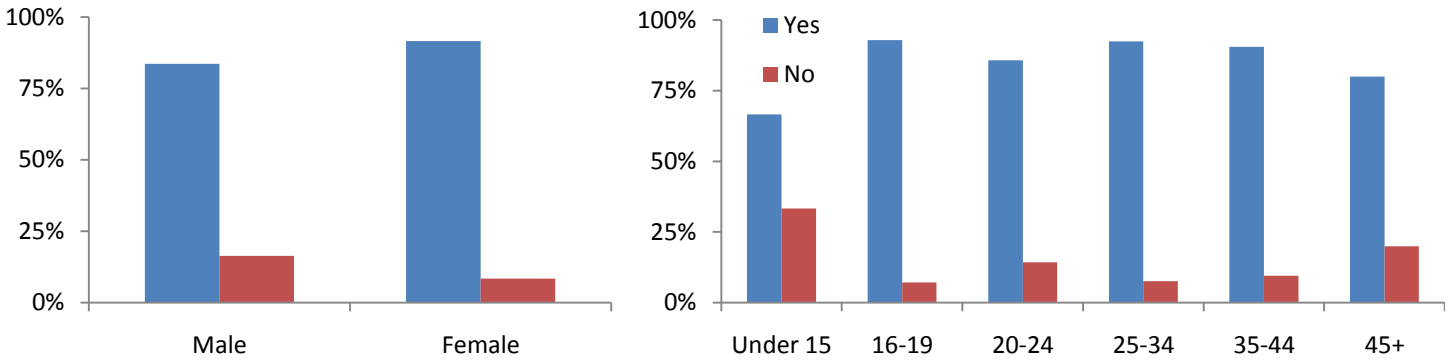
Figure 25 Proportion missing work, college or school by reason for visit to service



General opinion on sexual health services

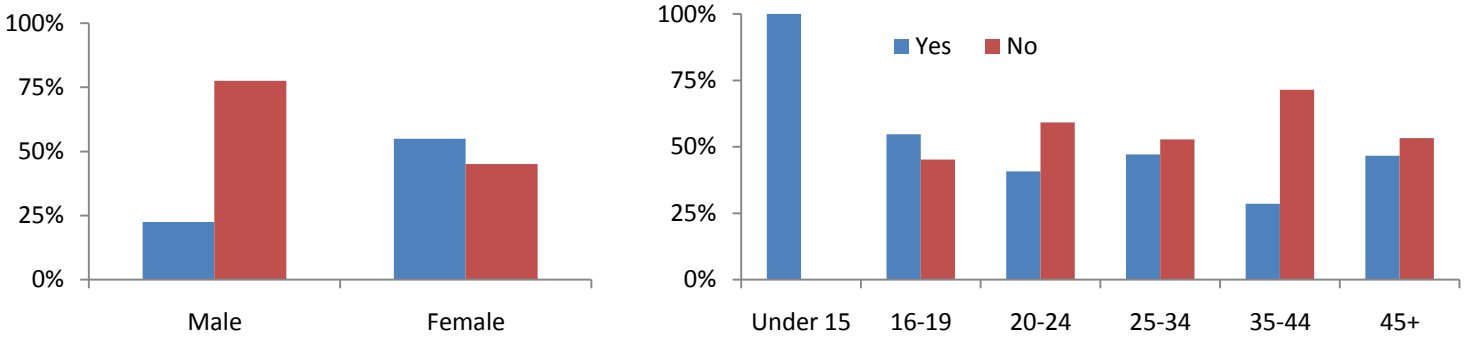
Respondents were asked what was important for a sexual health service, if it should be warm and friendly, open all the time, close to home, distribute free condoms, have time to talk, have rooms available for talking, always see the same person, visit with friends together. A warm and friendly service was the most important factor wanted by both males and females (figure 26). The proportion in each age group was also high, although young males were less keen.

Figure 26 Service is warm and friendly (a) gender and (b) age



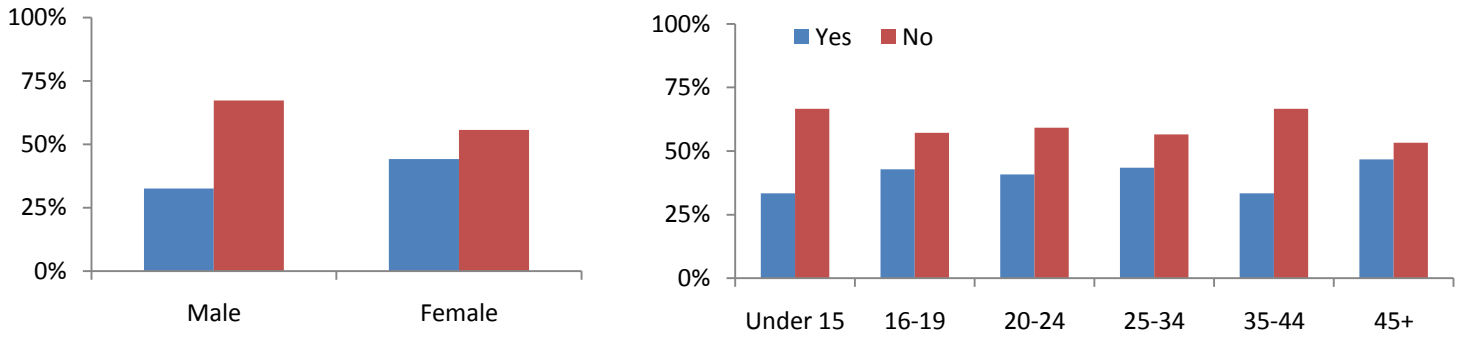
Significantly more females considered having the sexual health service open all the time was important compared with males (55% and 22% respectively; figure 27). This was notably important for the youngest age group.

Figure 27 Sexual health service is open all the time by (a) gender and (b) age



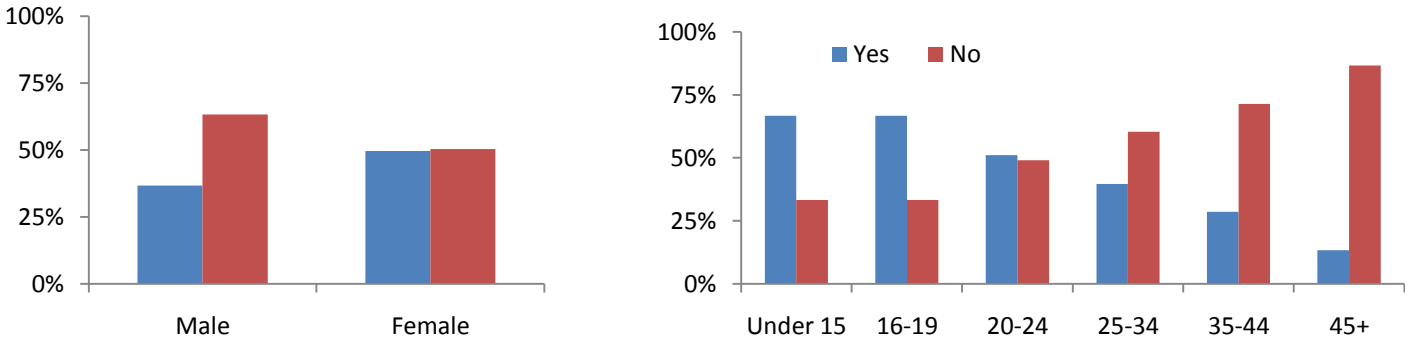
Around half of the sample indicated that it was important to have the sexual health service located close to their home. This was slightly less important in younger age groups, but generally was equal across the age range.

Figure 28 Sexual health service is close to home by (a) gender and (b) age



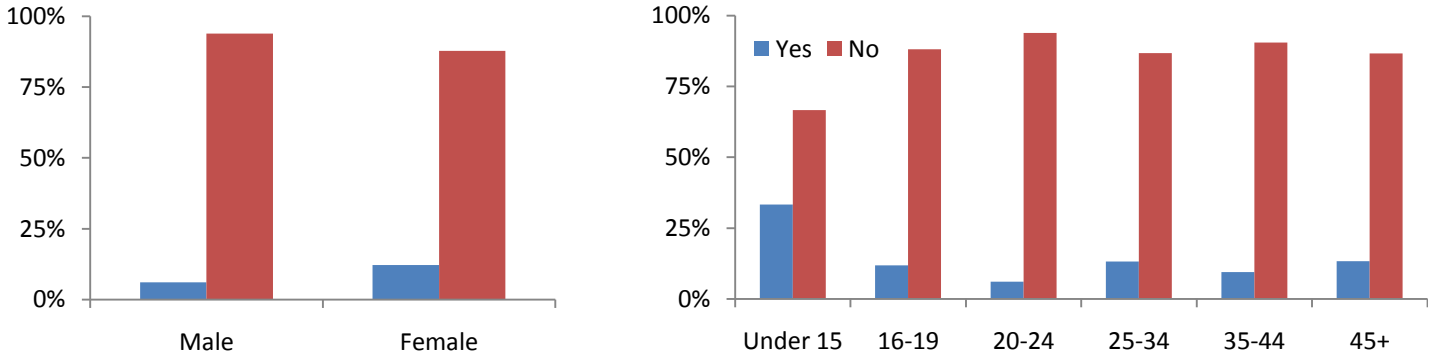
More females (50%) than males (38%) wanted to free condoms from sexual health services (figure 29). Younger aged service users also requested this more than older age groups.

Figure 29 Distribution of free condoms by (a) gender and (b) age



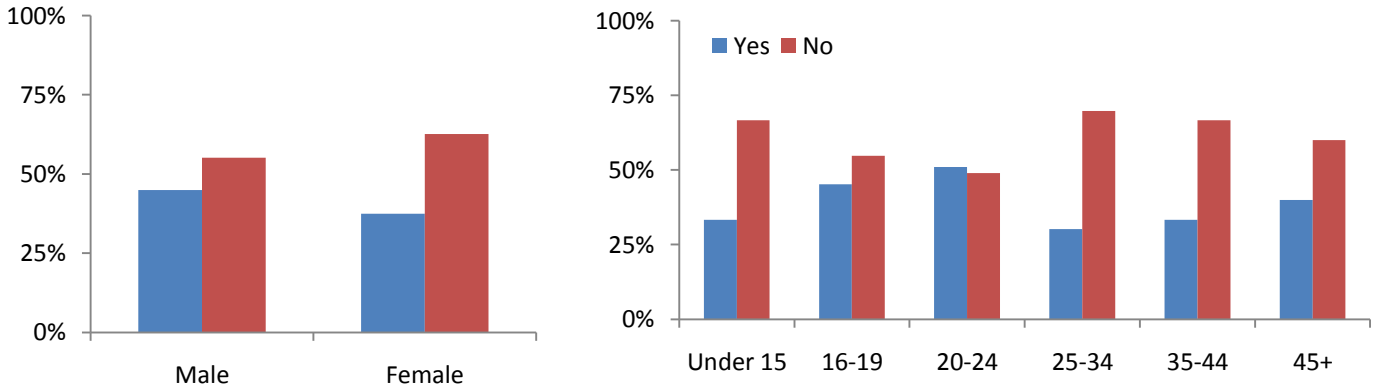
The majority of both males and females and those of all age groups did not see the availability of a variety of languages as important for a sexual health service (figure 30). This may be due to the sample consisting mainly of those of White British ethnicity whose first and only language is likely to be English.

Figure 30 Variety of languages available by (a) gender and (b) age



Interestingly more males than females in this sample recorded they would like time to talk when attending a sexual health service (figure 31). Those service users aged between 20-24 years had the highest proportion who thought having time to talk was important.

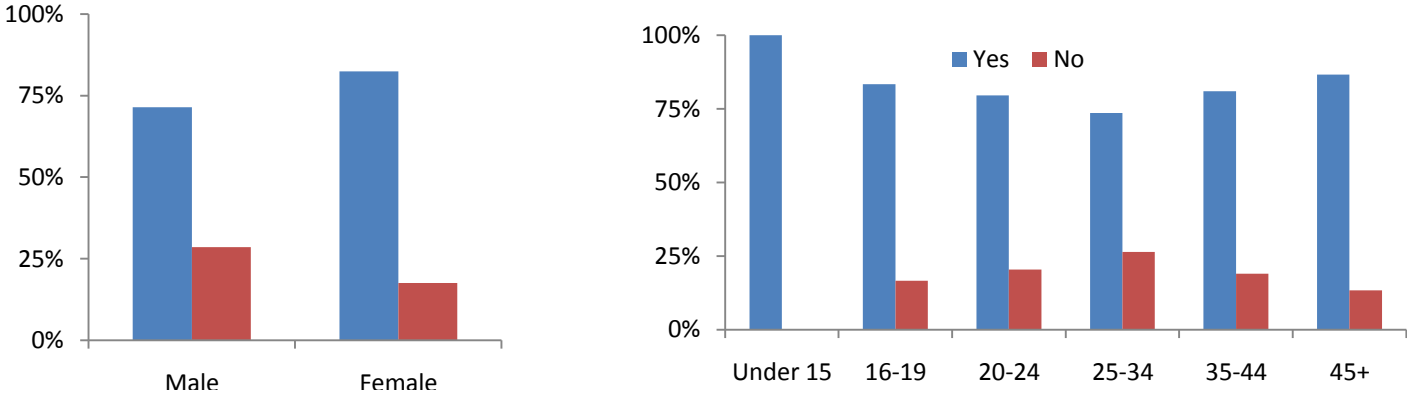
Figure 31 Time to talk by (a) gender and (b) age



A high proportion of both males (71%) and females (82%) would like to have rooms to be able to talk privately about their sexual health concerns (figure 32), making this the second most important

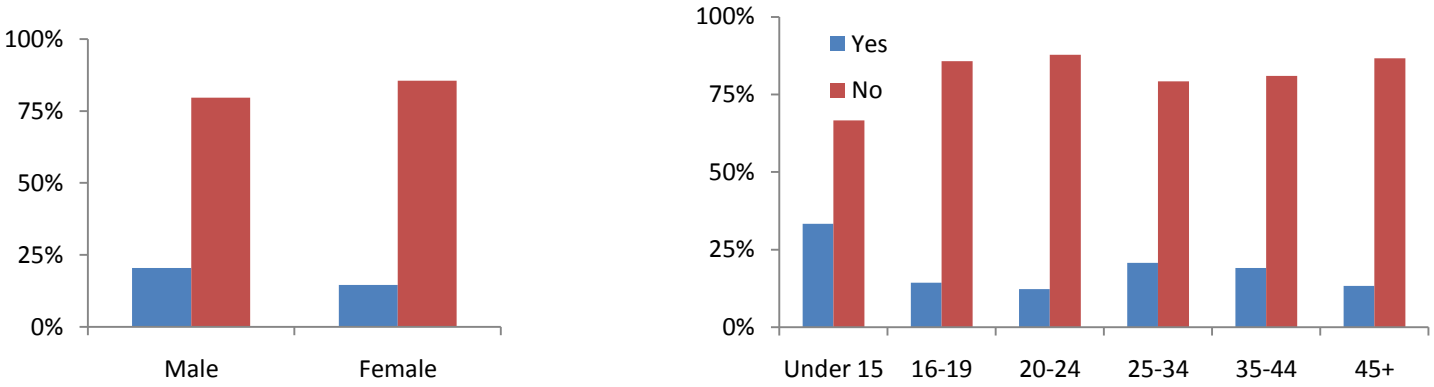
feature of the sexual health service. It was important for all age groups particularly the youngest and oldest age groups.

Figure 32 Rooms available to talk in private by (a) gender and (b) age



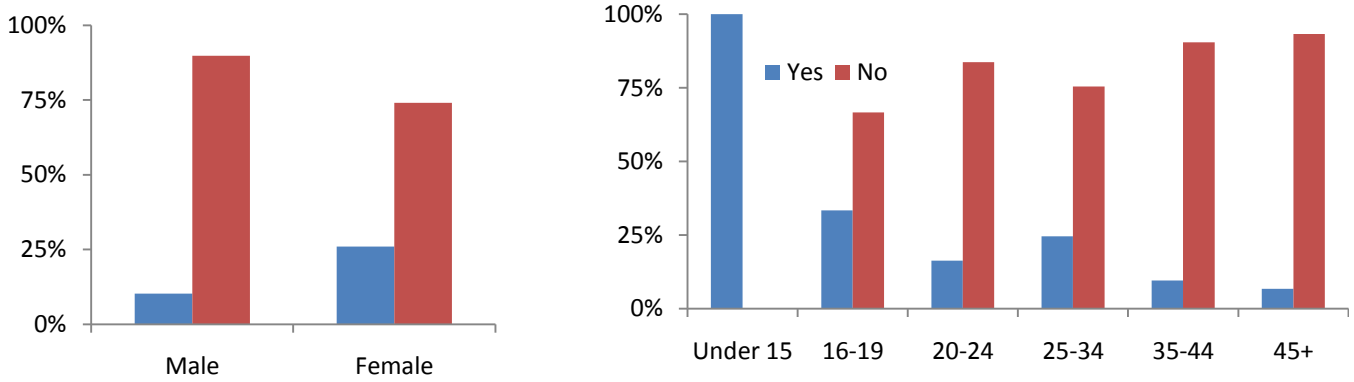
The highest proportion of respondents who indicated they would like to see same people in the sexual health service were the youngest clients (figure 33), while the majority of other persons sampled did not consider this to be important.

Figure 33 Always able to see the same person by (a) gender and (b) age



Young people aged under 15 were the only group who largely wanted to visit a service with their friends (figure 34). More females than males indicated going with friends would be important.

Figure 34 Visit a service with friends by (a) gender and (b) age



Where do you want a sexual health service to be?

Respondents were questioned on where they would like sexual health services to be placed. A number of options were available including in youth centres, in a hospital, in town centres close to the shops, at doctors or their GP clinic, at school/college, or in a mobile bus visiting the same place

every week (figures 35-40). Youth centres were not seen as a popular location for either males or females, nor for any specific age groups. A hospital was the preferred location for males (75%) whereas significantly less females agreed (48%). This was also suggested as a preferred location for those aged between 20-34 and those aged 45 and above. A very small proportion of the population thought having a sexual health clinic in town close to shops would be good; surprisingly the younger age groups did not record this as important, instead opting to locate services in a doctors/GP clinic. A small proportion (in youngest age group) wanted a clinic in a school or college. A mobile bus providing sexual health services was not popular among any age group or by gender.

Figure 35 Locate sexual health services in youth centres by (a) gender and (b) age

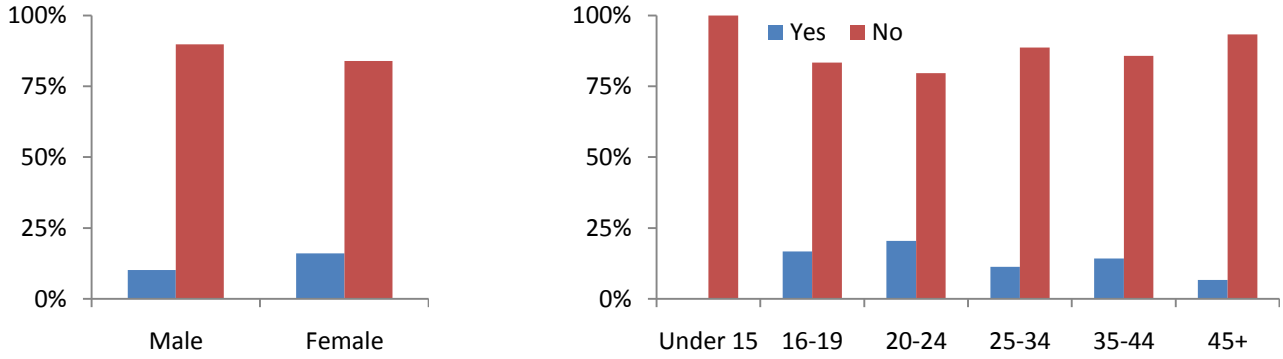


Figure 36 Locate sexual health services in hospital by (a) gender and (b) age

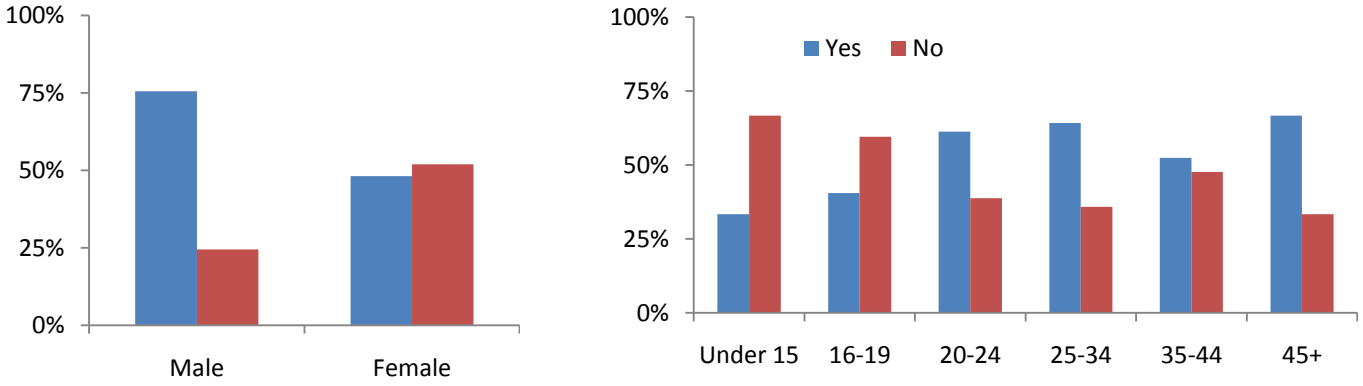


Figure 37 Locate sexual health services in doctor/GP surgeries by (a) gender and age

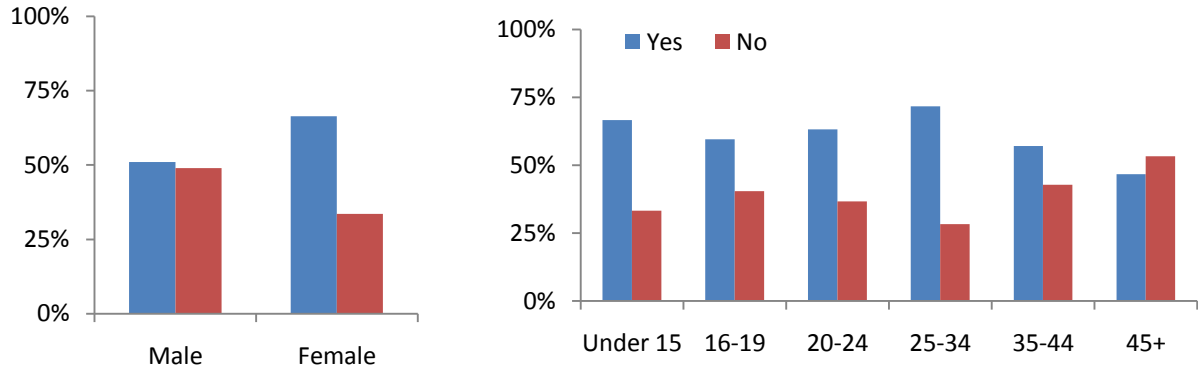


Figure 38 Locate sexual health services in town by shops by (a) gender and (b) age

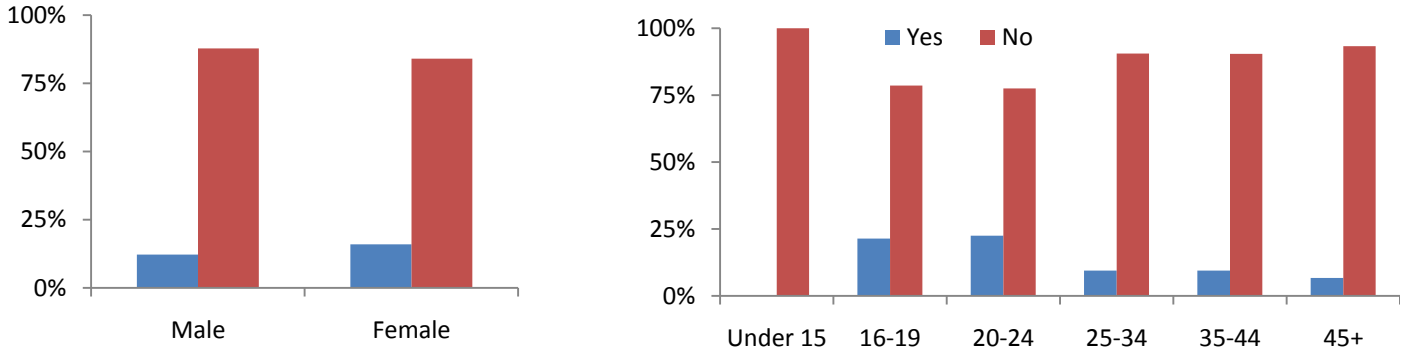


Figure 39 Locate sexual health services in schools or colleges by (a) gender and age

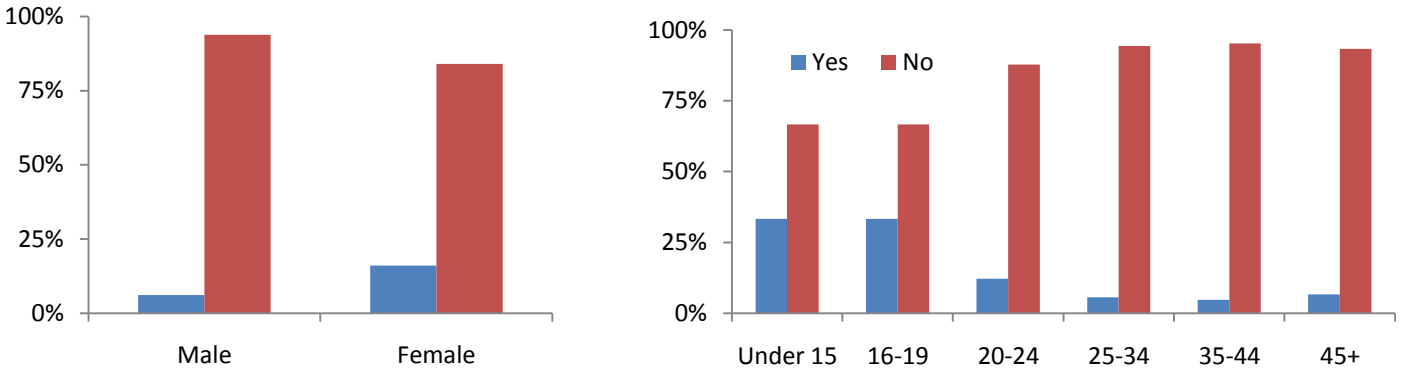
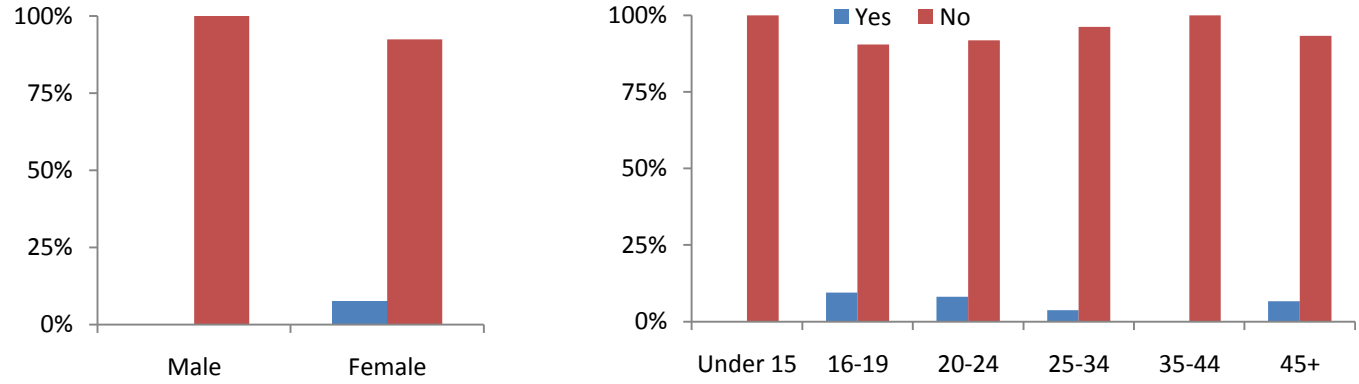


Figure 40 Provide sexual health services through a mobile bus by (a) gender and age



Who do you find it easy or difficult to talk to about sexual health issues?

We asked respondents who they found it easy and difficult to talk to about sexual health issues (two questions, listing a wide variety of providers and social contacts). More males indicated a sexual health doctor at a hospital was the easiest person to talk to whereas females mostly recorded friends followed then by a sexual health doctor at the hospital (figure 41). Significantly more females thought it would be easy to talk to a nurse at a GP practice whereas more males thought a sexual health nurse at a hospital would be easier. A third of respondents thought it was easy to talk to a family doctor. A very small proportion thought school/college/youth related persons would be easy, reflecting the older age of the majority of respondents. Over half of respondents indicated they find it difficult to talk to family members about sexual health. Around a quarter suggested it is difficult speaking to a family doctor (figure 42). When compared to the previous findings (who is it easy to talk to about sexual health issues) it suggests a distinct divide about talking comfortably to their GP. A significantly higher proportion of males than females find it difficult talking to friends about sexual health issues. A quarter of respondents find it difficult talking to a pharmacist. A small proportion cited other persons.

Figure 41 Who do you find it easy to talk to about sexual health issues

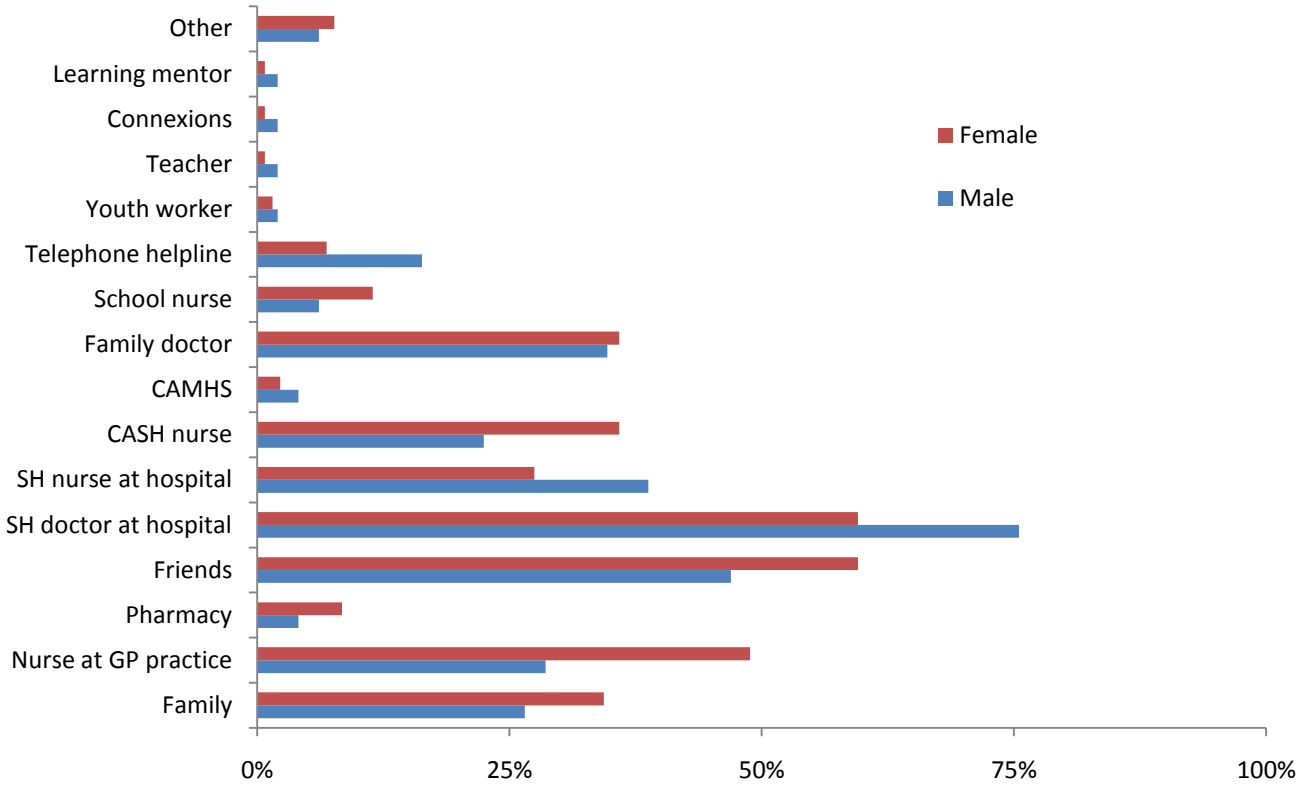
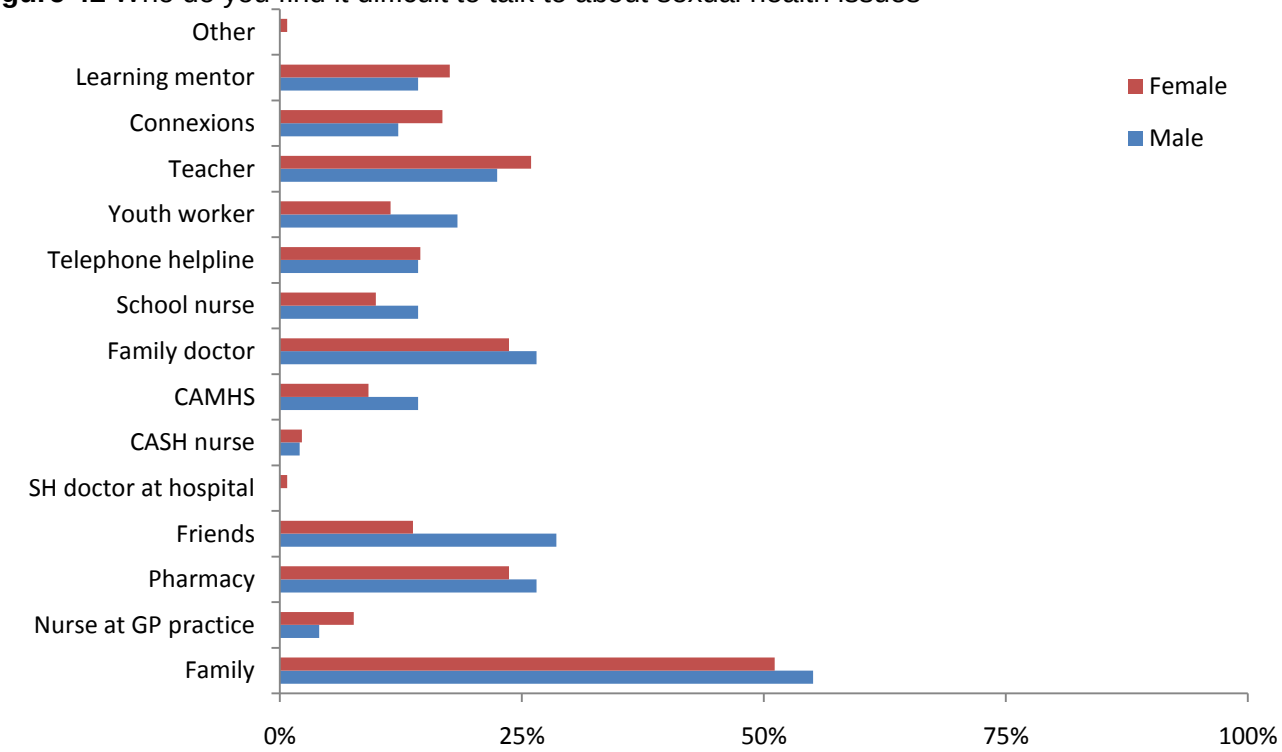


Figure 42 Who do you find it difficult to talk to about sexual health issues

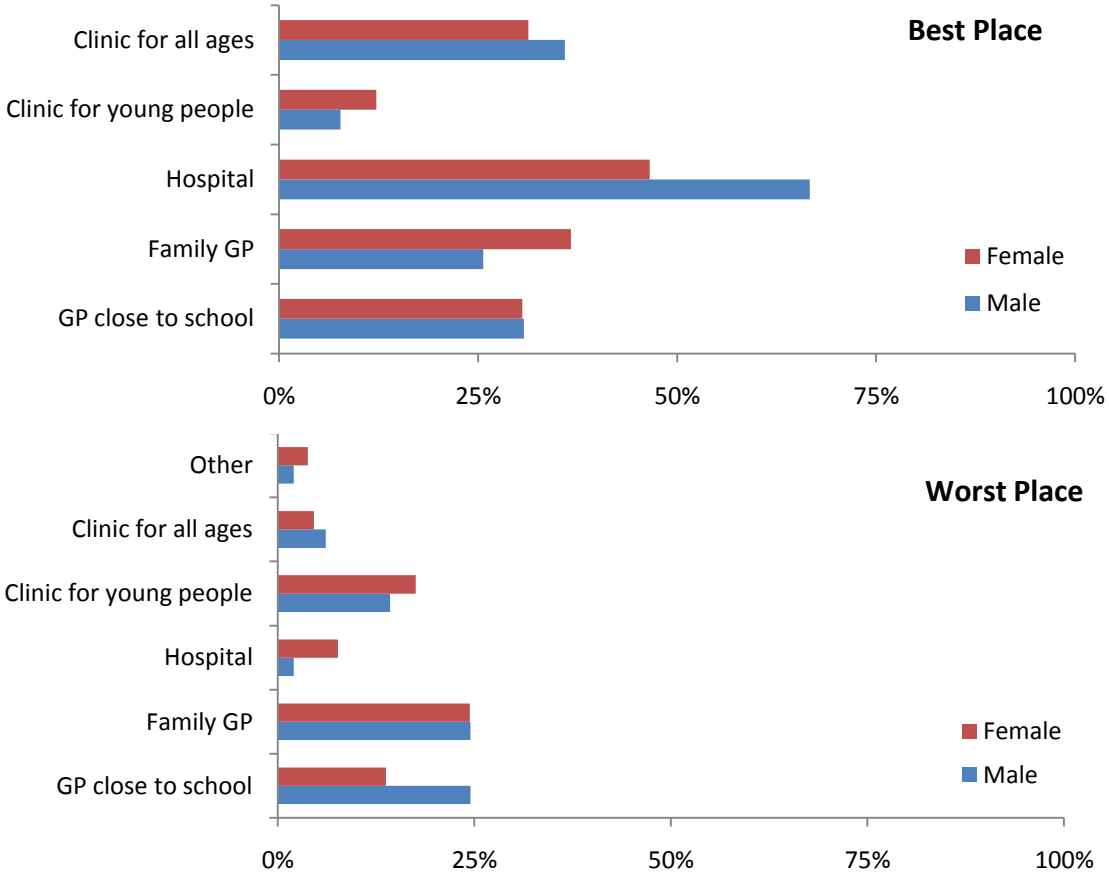


Where would be the best or worst place to be sent for extra help

Service users were asked if a health clinic advised them to get extra help regarding their sexual health where were the best and worst places to be sent. Two thirds of males and half of the females sampled recorded being sent to a hospital with all facilities would be the best option, an

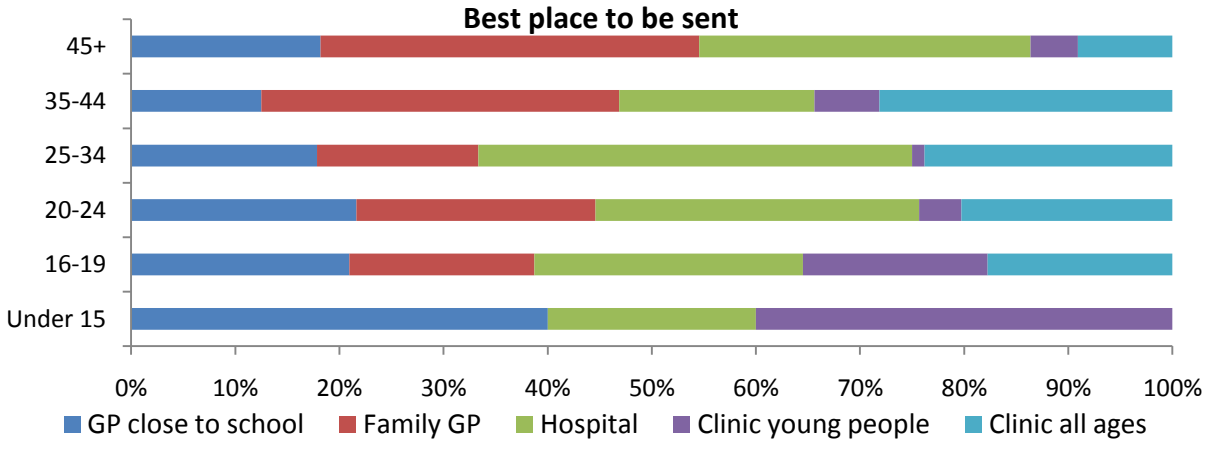
equal proportion considered the options such as a special clinic for all ages, the family GP, and a GP close to school or work (figure 43). Around 25% of males and females recorded being sent to their family doctor would be the worst option. A higher proportion of males considered a clinic close to school or work was the worst option.

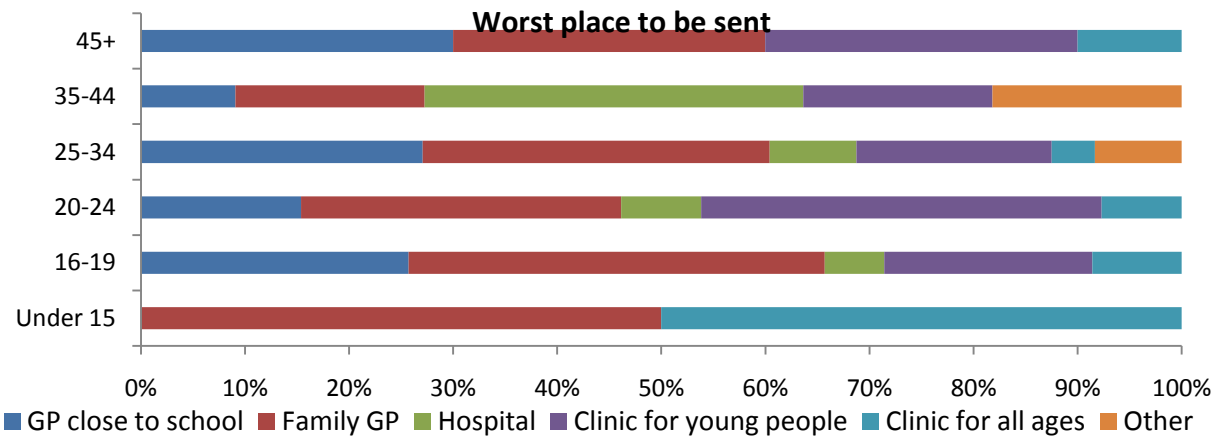
Figure 43 Where would the best and worst places be to get referred to by gender



Younger age groups did not want to attend clinics for all age groups, while older ages were happy to do so (figure 44). Young people also did not want to go to their family GP. In older age groups being referred to the family GP was mixed, some saying it was the best place, others that it was the worst. Other than one subgroup in the 35-44 year old age group, most considered hospital a good option. Older age groups did not want to go to a young clinic. A clinic near school or work had a mixed reception, liked more by the youngest age group, and least by the oldest age group.

Figure 44 Where would the best and worst places be to get referred to by age





Box 8 University Student Population

Limited data is available on the student population in Western Cheshire. The sexual health clinic at the Students Union, University of Chester, provides a service for students, including:

- Chlamydia and Gonorrhoea Testing and Treatment
- Pregnancy Testing
- Emergency oral contraception
- Contraception Advice
- Information on STI's
- Free Condoms
- Chlamydia Postal Kits

Although no empirical data is available, anecdotally the primary reason for attendance is screening for Chlamydia and Gonorrhoea. Attendance figures for the service have been provided for three academic years 2007/08 through to 2009/Feb 2010. This indicates 164 students attended in 2007 – 2008, 273 attended in 2008 – 2009 and 220 attended in 2009 – February 2010. These figures may be low because non-home based students are advised to register with one of a number of GP Practices within close proximity to the University campus.

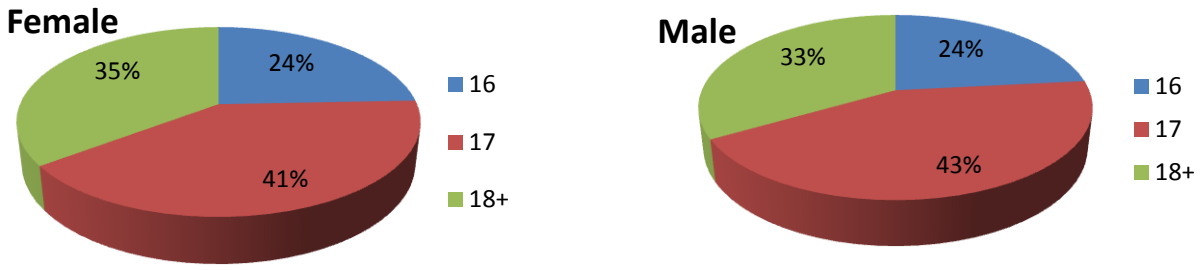
3.5 Quantitative Survey of Young People's attitudes and practices to sexual health, and other risk factors, who attend Further Education Colleges

Box 9 Key Findings from a Further Education College survey among young people

- A survey of 223 students 16-19 years of age, from Mid Cheshire College, was conducted to identify local young people's attitudes and practices to sexual health.
- Two thirds of males (68%) and three quarters (76%) of females reported having sexual intercourse; two thirds experienced oral sex; both males (32%) and females (28%) went further sexually than wanted or planned, and nearly a quarter claimed they were pressured against their will to have sex.
- 14 years of age is a vulnerable age for young people, as it was the most common age to have first sex, oral sex, and to be pressured to have sex against their will.
- Of those having sex, 16% of females and 7% of males discussed with a parent about having first sex prior to the event; the majority indicated parents never knew, or if parents found out they were mostly supportive, however 10% of females stated parents were very angry.
- 59% of females had first sex in their partners (boyfriends) house, double that of males (29%), while more males (43%) than females (22%) had first sex in their own homes. 10% or less had first had sex in a public place, party or elsewhere.
- Of those reporting having ever had sex, 58% reported using a condom during first sex. A quarter (24%) were on the contraceptive pill; no protection was used by 10%; and 7% of females reported using emergency contraception (morning after pill) following their first sexual encounter.
- Condom use decreased between first and recent sex; among males from 46% to 44%, and among females from 61% to 40%. Condoms are rarely used during oral sex.
- 11% of females had been or were pregnant, the majority at age 16; 1 in 10 of these pregnancies were planned. Half of the pregnancies went to full term.
- 40% of females reported having a pregnancy check and half sought emergency contraception.
- More females (43%) than males (32%) agreed girls sometimes say no to sex when they mean yes.
- Most young people thought 20-29 was the ideal age to become a parent. If they became a parent before 20, half thought they would cope well and a quarter thought it would be a nightmare; only 4% said it would be worth having a baby to get extra benefits.
- The students indicated their local General Practitioner as the predominant place to get help or advice on sexual health. This included visiting the General Practitioner first for a pregnancy check, relationship health/advice, oral contraception, termination of pregnancy information, and long-acting reversible contraception.
- Significantly more females than males attended sexual health services in the past three months.
- 72% of females and 45% of males stated they did not know a specific local location to get a test for a sexually transmitted infection; however 76% knew where to attend for 'family planning' information.
- Over 90% reported they received sex and relationships education at school. Most young people sought sexual information from a variety of sources such as magazines, television and the internet, including pornography, and only 3% wanted information but had not sought it.

A survey was conducted at Mid Cheshire College over two weeks in January 2010. In total, 223 students completed the questionnaire. It was predominantly answered by females (80%). The age distribution was 16 to 19 years of age; 45 (20%) were aged 16, 77(35%) were 17, 51(23%) were 18, 15 (7%) were 19 year olds, and 35% gave no age or gender. The proportion did not differ by gender (figure 45). Most respondents (97%) were white British.

Figure 45 Age of respondents by gender



The survey questioned young people in college on many aspects of their health and wellbeing. For the purpose of this sexual health needs assessment, we have abstracted information specifically on the sexual health aspects of their lives, which is rarely available through routine surveys.

Young peoples' attitudes towards sex and relationships

Young people at college were asked a series of questions about sex and relationships (figures 46-53). Responses were recorded on a Likert Scale (strongly agree, agree, disagree, and strongly disagree). Young people do not want parental involvement in any decision on when to start having a sexual relationship. Just under half of females and a third of males agreed that their first sex should be planned. 41% of males and 37% of females agreed that condoms spoilt sex. There was a significant gender difference about whether men should take the lead in relationships, with 38% of males agreeing compared with 17% of females; a quarter of females strongly disagreed. This sequence was seen in each age group suggesting males and females of all ages differ in their opinion about relationship dynamics. Most young people disagreed that their friends were more sexually experienced than themselves, with a slightly higher proportion of males agreeing compared to females. There was a strong split by age, with the majority of those agreeing aged 16 year old, and the majority strongly disagreeing aged 18+. Surprisingly, more females (43%) than males (32%) agreed that girls sometimes say no to sex when they mean yes. There were no significant differences in opinion by age. The majority of young people agreed it is easy to talk to their partner about sex. Younger teenagers were as confident as older teenagers in their ability to talk about sex. A little over half the population disagreed that girls found it easier to talk about sex than boys, with a marginal gender difference. Over half of males, and ~60% of females agreed they learned more about sex from friends than from anyone else; however, one in five males strongly disagreed.

Figure 46 Parents should help decide when you start having sex

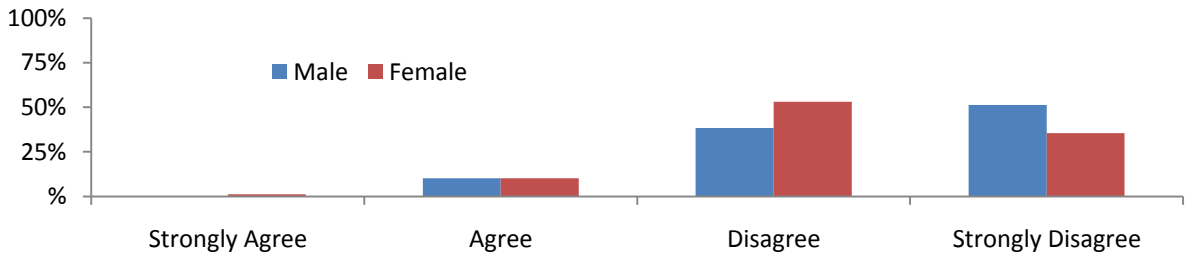


Figure 47 Your first sex should be planned

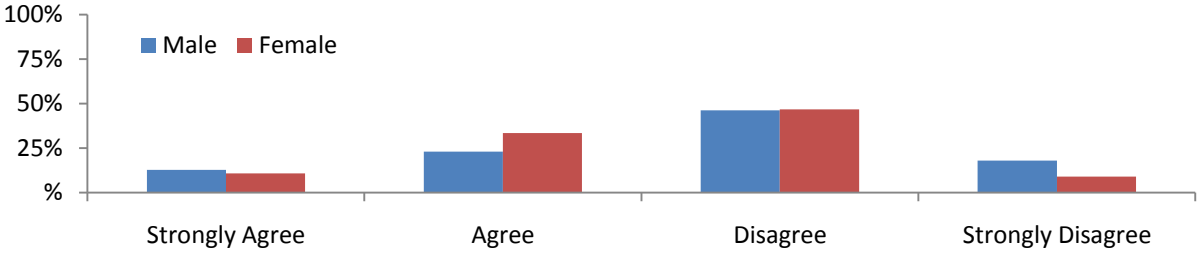


Figure 48 Condoms spoil sex

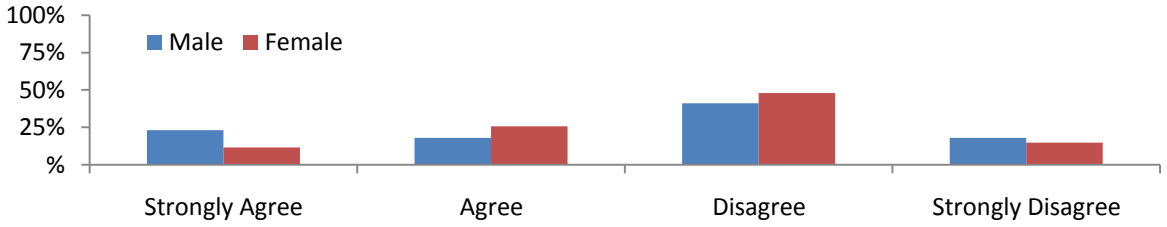


Figure 49 Men should take the lead in relationships

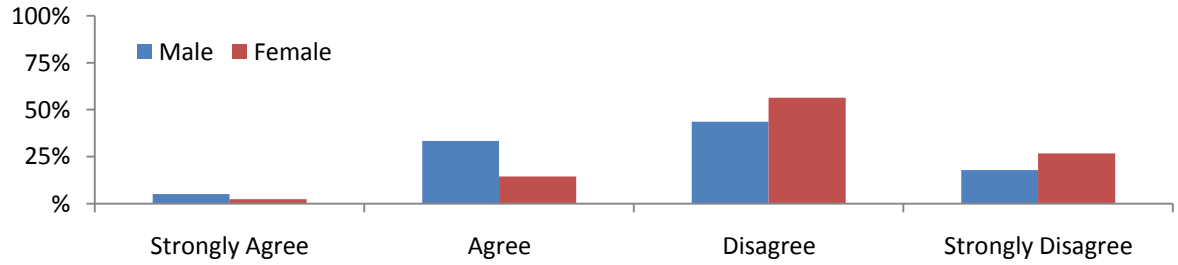


Figure 50 My friends are more sexually experienced than me

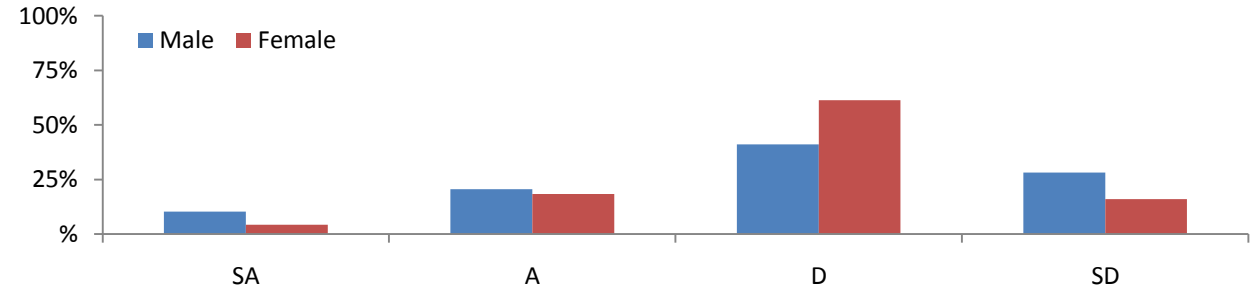


Figure 51 Girls sometimes say no to sex when they mean yes

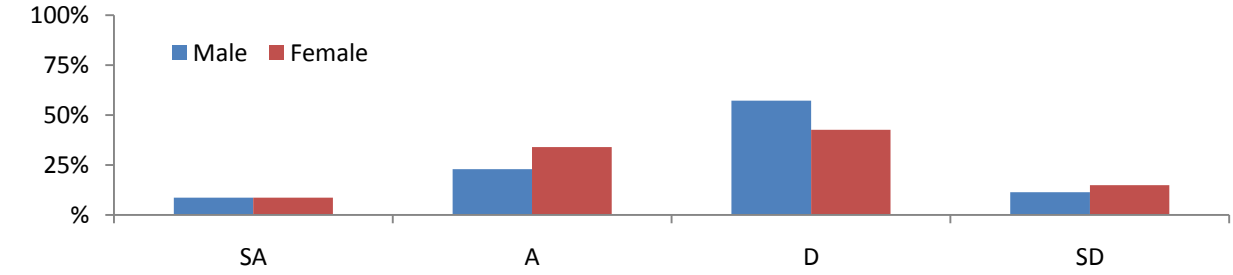


Figure 52 Talking to my partner about sex is or would be easy

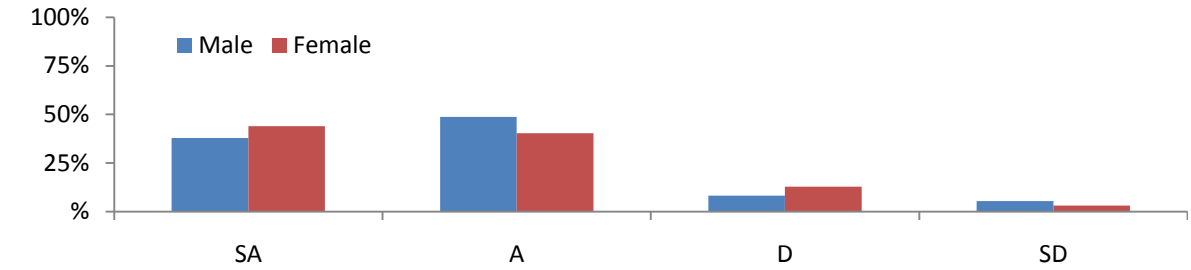


Figure 53 Girls find it easier to talk about sex than boys do

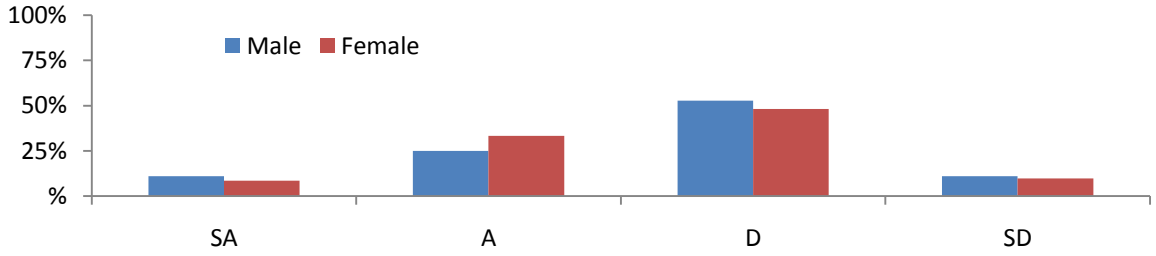
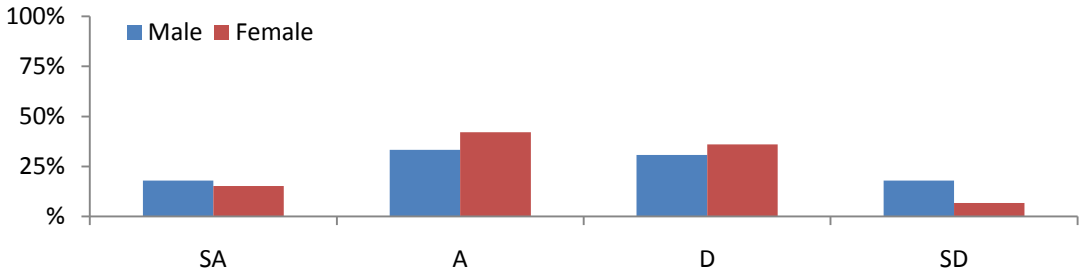


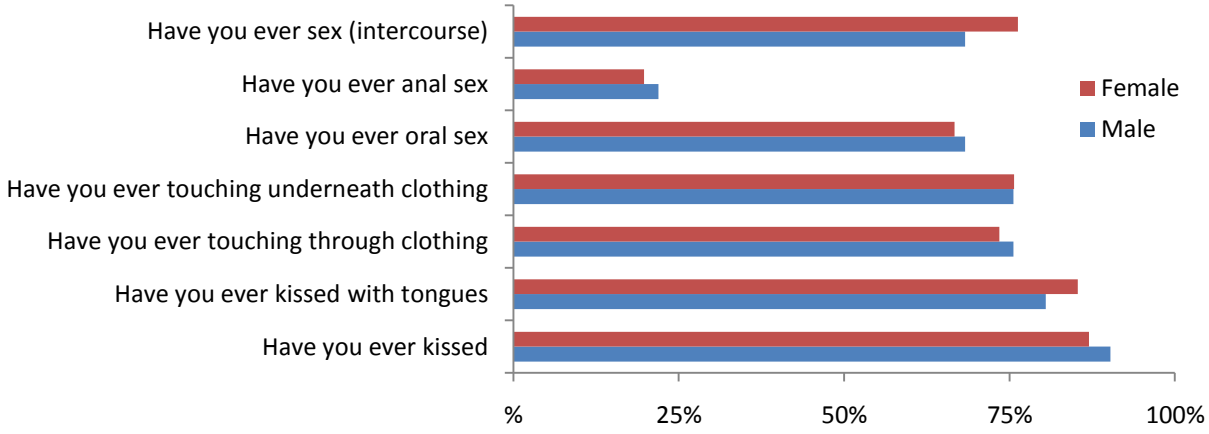
Figure 54 I learnt more about sex from my friends than anyone else



Sexual experiences

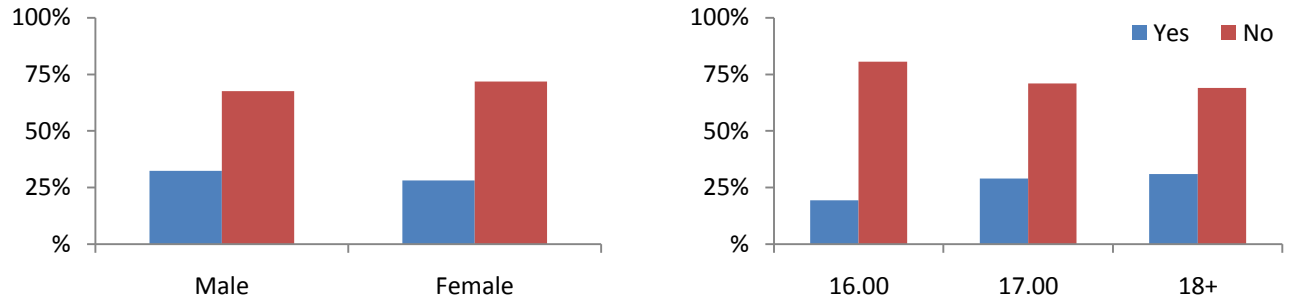
Young people were asked to record what sexual experiences they had had. Kissing and 'kissing with tongues' was experienced by 88% and 85%, respectively (figure 55). Three quarters had either touched through clothing or touched underneath clothing. Two thirds (68% males, 67% females) had had oral sex, and two thirds of males (68%) and three quarters (76%) of females had had sexual intercourse (sex). Approximately one in five had had anal sex. A higher proportion of males had kissed, had oral sex and had anal sex than females. The proportion of those having oral sex increased significantly with age (p<0.001). There was a higher proportion of 18 year olds who experienced anal sex than any other age. The vast majority of males and females stated they were heterosexual; 5% of males declared themselves homosexual, and ~2% of males and females stated they were bi-sexual. There was a small proportion who did not know or did not wish to state their sexuality. A small proportion (5.1%) of young people had previously been given gifts/favours in exchange for sex; Nearly a quarter of young people (22.7%) said they had been pressured to have sex against their will, among these, 20% was anal sex, 53% was intercourse, and 42% was oral sex. A wide age range was given, with 14 years the average age for being pressured into a sexual experience.

Figure 55 What sexual experiences students recorded they had had



A slightly higher proportion of males (32%) than females (28%) reported they went further sexually than they wanted or planned (figure 56). The highest proportion reporting they had gone further sexually than wanted or planned were young people currently aged 17 years.

Figure 56 Have you ever gone further sexually than you wanted or planned to?



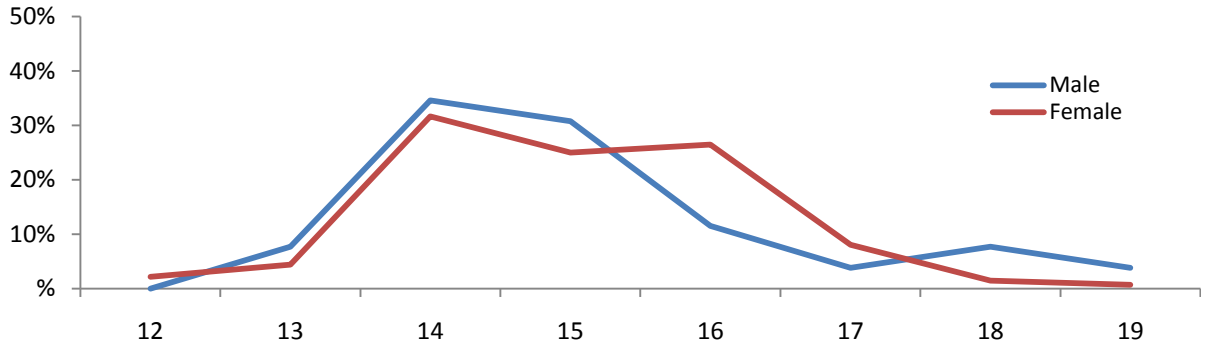
Oral sex

Two thirds (68% males, 67% females) had had oral sex, with an average of two partners. Condoms during oral sex were rarely used. No males recorded condom use during their most recent experience and only 15% of females reported use.

Sexual intercourse

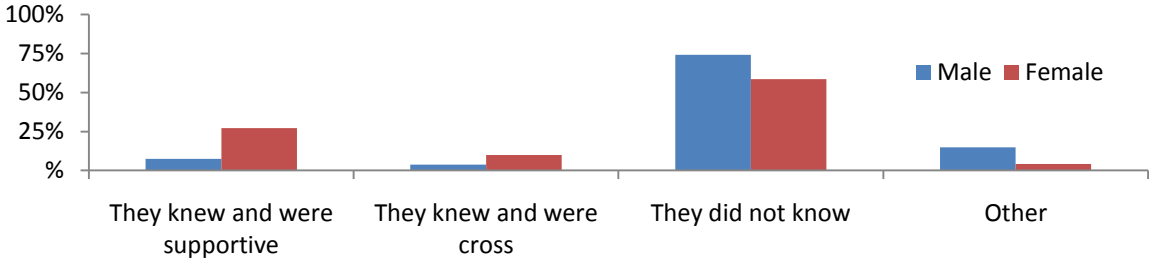
Of the two thirds of males and three quarters of females who have had sexual intercourse, 32% of females and 35% of males had sex for the first time at 14 years of age, and 25% of females and 31% of males were 15 years of age. A small proportion indicated an earlier age (figure 57). The graph illustrates earlier sexual debut among males compared with females. The majority of students experienced sex by the time they were 18 years old.

Figure 57 Students reported age when they first had sexual intercourse



Few discussed their intention to have intercourse prior to the first event with their parents, with twice the proportion of females (16%) compared with males (7%) doing this. The majority did not tell their parents at all (figure 58). Of those whose parents 'found out' about it, parents were mostly supportive, however 10% of female stated their parents were angry.

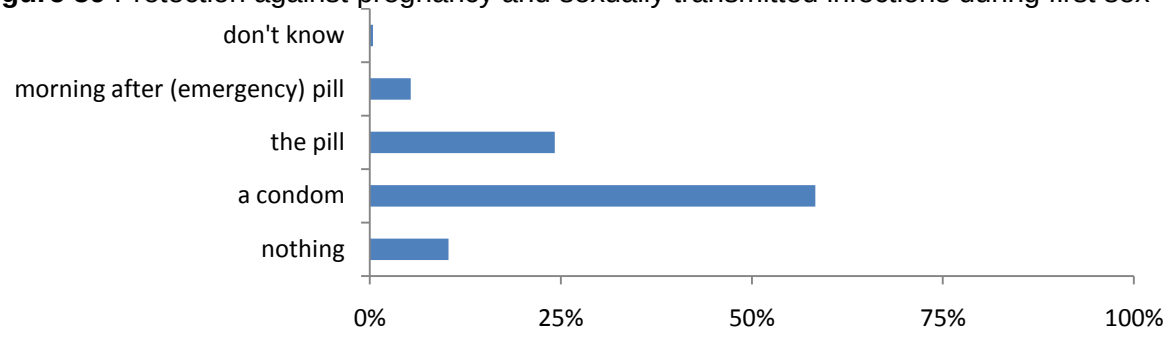
Figure 58 Response of parents to students having had first sex



When questioned on where they first had sex, nearly two thirds of females (59%) stated it was in their partners (boyfriends) house; nearly double that of males (29%). Similarly, double the proportion of males (43%) compared with females (22%) stated it was in their home. A small

proportion (10% or less) had first had sex in a public place, at a party or elsewhere. Three quarters of females (70%) and 57% of males stated they did not consume alcohol the first time they had sex. A third of males and 22% of females consumed some alcohol but stated they were fully aware of everything. A minority of both males (7%) and females (8%) reported being really drunk when having sex for the first time.

Figure 59 Protection against pregnancy and sexually transmitted infections during first sex

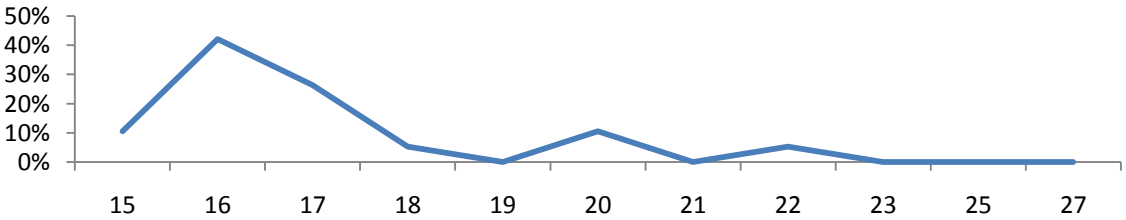


Fifty eight percent of young people reported using a condom during first sex (figure 59). Almost a quarter (24%) stated they (or partner) were on the contraceptive pill; no protection was used by 10%; and 7% of females reported using emergency contraception (morning after pill) following their first sexual encounter. A separate question asked young people about their protection during their most recent sex. There was an increase in non-contraceptive use for females (from 11% to 15% between first and recent sex), and males (from 10% to 24%). Condom use decreased among males from 46% to 44%, and among females from 61% to 40%. Use of the morning after pill decreased from 7% to 3%.

Pregnancy

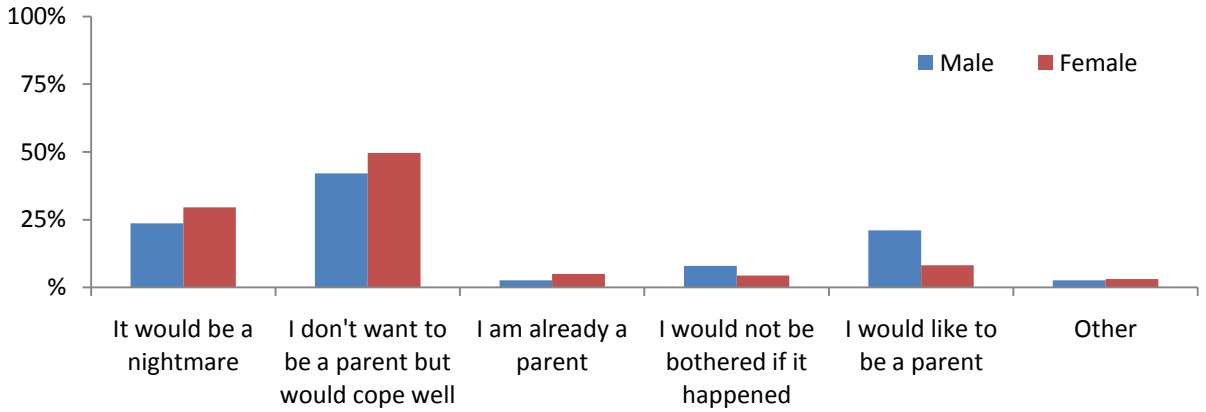
Eleven percent of the females who participated in the study have been or were currently pregnant at the time of survey; 84% had never been pregnant and 5% were waiting for their period. Of these females the majority became pregnant at 16 years of age (figure 60). When asked if they had drunk alcohol at the time of conception; 77% stated no, 10% drank a little, and 13% had drunk a lot.Ten percent of those who had become pregnant indicated the pregnancy was planned. Half of the pregnancies went to full term. We noted 42% of females recorded a 'miscarriage' and 26% had a termination, resulting in a proportion greater than 100%, suggesting more than 11% of females were or suspected they had been pregnant. Among all young people responding, we asked if they knew anyone who was pregnant. The majority knew someone who had been pregnant, with 21% knowing two. More than half of the young people questioned had known one person who had gone on to have a baby full term.

Figure 60 Age when became pregnant



We asked all young people what the ideal age to become a parent was. The majority thought 20-29 years was ideal. When asked their response if they became a parent before the age of 20 years, almost half thought they would cope well despite not wanting to become a parent, and a quarter thought it would be a nightmare (figure 61). A minority of young people (4.4%; mostly female) said it would be worth having a baby to get extra benefits.

Figure 61 If you become the mother/father of a child before you were 20, which of these best describes how you would feel about it



Where would young people go for sex and relationships help/advice?

Young people were given a list of issues relating to sex and relationships and asked where it was possible to go for help or advice (table 11). Doctors were the predominant place to go for every issue. Respondents predominantly identified the doctors as the place to visit for long-acting reversible contraception (59%), oral contraception (58%), TOP information (43%), pregnancy check (42%) and relationship advice (27%). Young people suggested they would predominantly go to a sexual health clinic/family planning clinic for a sexually transmitted infection check (45%), to a chemist/pharmacy for the morning after pill (39%), and to the shops for condoms (35%). They would obtain condoms primarily from a shop, the next most likely places would be a local community and sexual health services or pharmacy but with approximately half the amount of responses. About a quarter would visit local community and sexual health services for oral contraception, long-acting reversible contraception, and a third would visit a hospital for TOP information. Seventy two percent of females and 45% of males stated they knew a specific local location to get a sexually transmitted infection test. Similarly, 76% knew where to attend for 'family planning' information, with younger students again not knowing where to attend locally for these services.

Young people's actual sexual health seeking behaviour

Among 223 young people, three quarters completed answers on where they actually go to get advice or help. Significantly more females (59%) than males (30%) attended any service in the previous 3 months ($p<0.001$). Almost two thirds of females recorded ever getting condoms, compared to 55% of males (table 12). Although double the proportion of females (52%) reported getting sexually transmitted infection check compared with males (23%), the latter indicates 1 in 4 young males are starting to utilise such services. A third of females recorded they sought advice on long term contraception. It is notable that males have accompanied girlfriends on a number of occasions to get the pill, for terminations, or getting emergency hormonal contraception.

Where else do they source information or advice about sex?

Over 90% of young people received sex and relationship education at school, with a slightly higher proportion (20%) of 18+ year olds stating they did not. The majority of young people sought information from a variety of sources with magazines being the most popular source of information. Television and the internet were popular sources of information. Pornography was relied upon as a source of information with internet sites, movies, and magazines all featuring heavily in the locations where respondents looked for information. Fewer sourced information from the official websites such as RU Thinking. Only 3% of the young people questioned indicated they had wanted advice on sex and relationships but had not sought any.

Hypothetical questions on some sexual health seeking behaviours

Lastly, in the questionnaire we challenged these young people if they would (hypothetically) do various things to maximise their sexual health (figures 63-67). Females were more likely than males to talk to their mother/female carer about sex, say no to sexual action they did not want, and

use or ask for the use of condoms. Young people were more likely to obtain emergency contraception the older they got. Males were more likely than females to go out and buy condoms.

Figure 62 Where do you look for information or advice about sex?

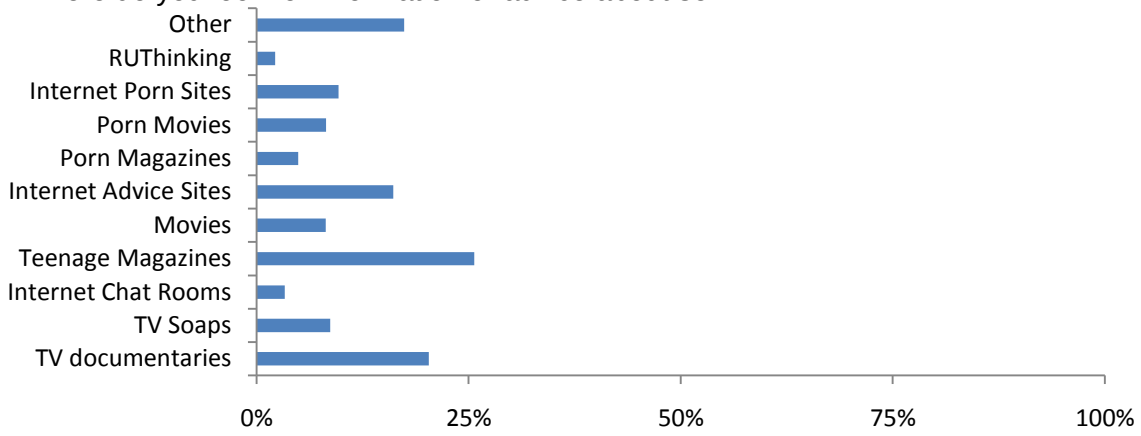


Table 11 Where would young people go to for sex and relationships help/advice?

	Doctors	Hospital	CASH	Shop	Chemist/ pharmacy	Home	School/ college	Counsellor/ advisor	Connexions	Other
STI check	40.0%	8.0%	44.8%	-	-	-	3.2%	-	-	4.0%
Pregnancy check	42.4%	12.2%	14.4%	5.8%	16.5%	3.6%	-	-	-	5%
TOP information	42.9%	33.3%	11.4%	-	6.7%	-	-	-	-	5.7%
Relationship advice	26.9%	5.1%	10.3%	-	-	-	9.0%	11.5%	16.7%	20.5%
Condoms	9.3%	12.4%	18.0%	34.8%	16.1%		4.3%	-	-	5.0%
Oral contraception	58.2%	6.9%	19.4%	-	9.7%	-	-	-	-	5.6%
LARC	58.9%	4.7%	27.1%	-	1.9%	-	-	-	-	7.5%
‘morning after pill’	30.6%	-	23.1%	-	38.9%	-	-	-	-	7.4%

Table 12 Have you ever been to get help or advice on sex or relationships issues?

	Male	Female	Total
Have been for a pregnancy check	14.7%	39.9%	35.3%
Have been for advice on pregnancy termination	6.3%	6.2%	6.2%
Have been for relationship advice	3.2%	13.2%	11.4%
Have been to get condoms	54.8%	64.6%	62.9%
Have been to get the pill	18.8%	74.0%	64.3%
Have been to get the morning after pill (EHC)	14.3%	49.6%	44.2%
Have been to get long acting contraception (LARC)	9.7%	33.6%	29.2%
Have been for a sexually transmitted infection check	23.3%	52.1%	47.1%

Figure 63 Talk to your mother about sex by gender and age

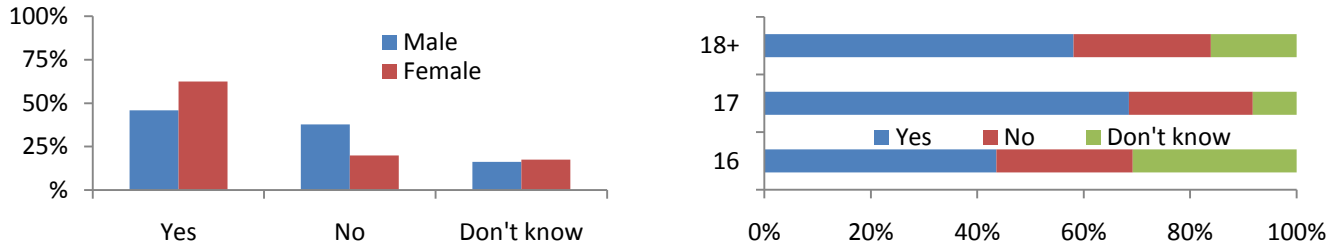


Figure 64 Say no to sex/sexual action you do not want

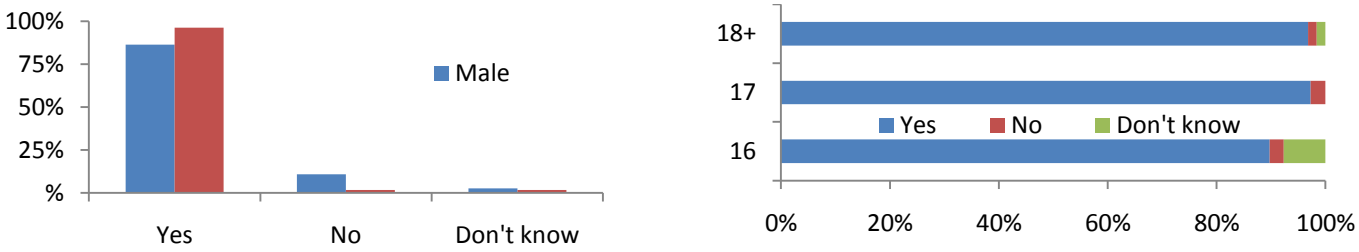


Figure 65 Go out and buy condoms

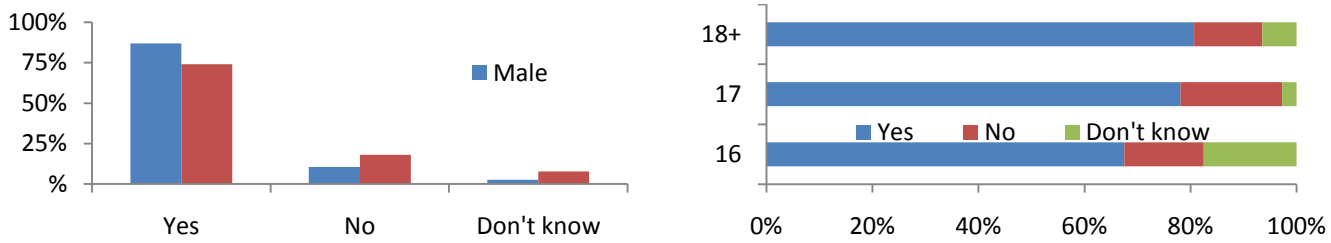


Figure 66 You use or ask your partner to use condoms

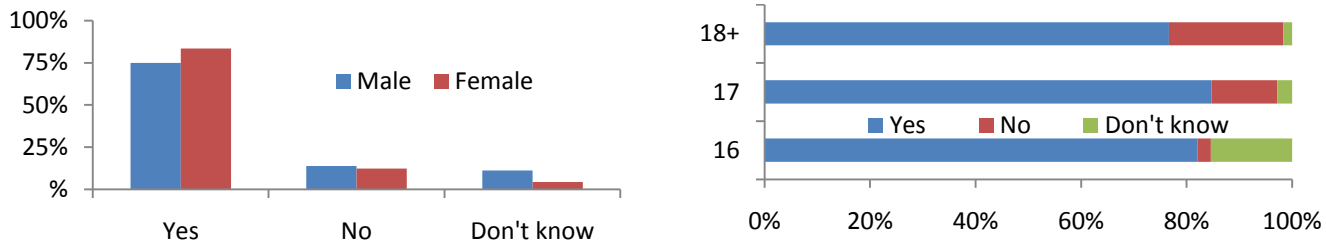
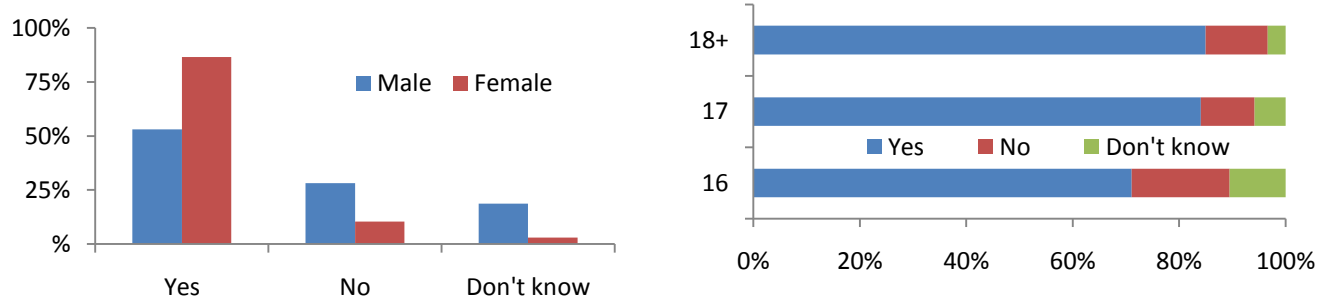


Figure 67 Get morning after pill (emergency contraception)



3.6 Survey among young people about sexual health services by Connexions

Box 10 Key Findings of the Connexions Service Survey

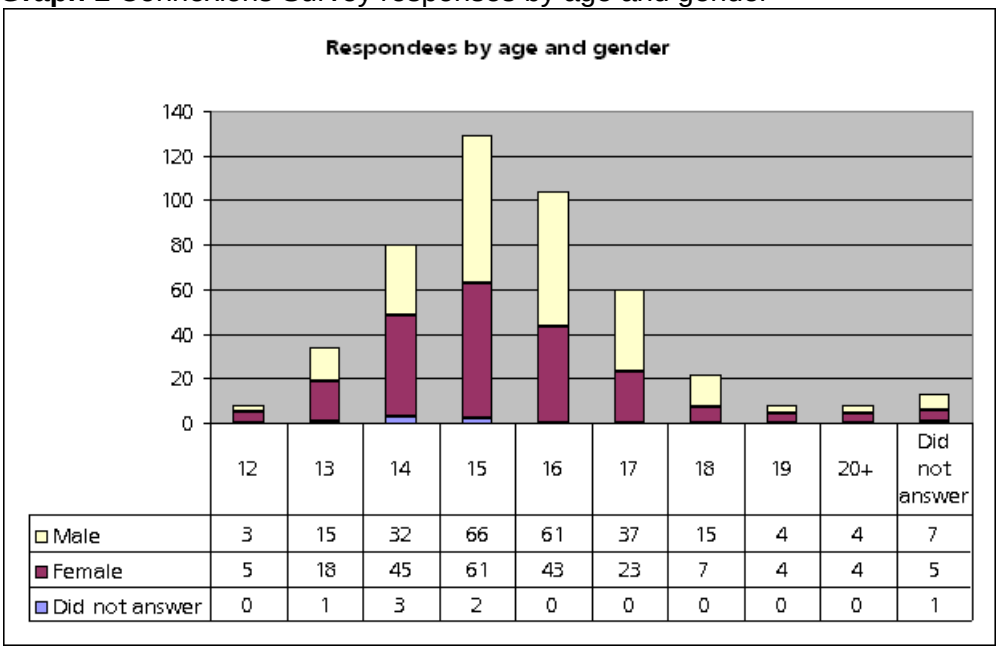
- 466 young people 12 to 20 years old were surveyed through Connexions in a variety of settings throughout the area, in March 2010; the majority were 14-17 years of age.
- A high proportion of young people stated that they knew where sexual health services were but where to get information generated from a broad range of answers. Young people gave different answers to who they wanted to talk to about sexual health and who to get information from; thus, they prefer to talk to family (25%) and friends (19%), but only ~5% said they get information from 'Home/Friends and Family'.
- Young people would also access information from their doctor, or a hospital. Chemists or pharmacies were thought of as good locations to access sexual health services,
- When asked 'where do you get information about contraception and sexual health?' the most popular location was 'Sexual Health/Family Planning Clinic, followed by Health Centre/ Community Centre' (30%), the 'Hub/Youth Club' (19%) and 'NHS/General Practitioner Surgery' (16%).
- Young people recognise they can get contraception and have conversations about safe sex at sexual health services, but few recognise sexual health services provide someone to talk to or develop young people's understanding and awareness.
- Barriers to using services related to fear of parents knowing, not knowing where services were, embarrassment, and opening times, suggesting a one stop shop may be useful as it does not define reason for visit as specific to sexual health.
- Young people considered religion has an influence on their sexual health seeking behaviour but not necessarily how much they access services.
- Over half (56%) wanted to access sexual health services during the weekday, with mostly older people stating weekends. Different times were mentioned, with the highest proportion (33%) suggesting 6-9pm.
- 30% of young people surveyed had accessed services; rising from a quarter of 13-15 year olds to half of 18-19 year olds.
- Experience of sexual health services was generally positive in each area, with high proportions rating the service they accessed as 'very good' or 'good'. Preferences for services differed by geographical area, but not by gender.
- Comments on improvements included better opening times, more autonomy, better advertising, and privacy and confidentiality. However, only 9% had heard of 'You're Welcome'. Findings suggest a need to broaden the information on what services are available and from where, to further expand the You're Welcome Standard.

The following survey information was abstracted from a report of a survey conducted by Connexions 'Your Views on Sex and Relationship Information and Advice in Cheshire West & Chester 2010'. Persons interested in the full report can contact Natalie Russell, Data Research Coordinator who is based within the Information & Marketing Team of Connexions Cheshire & Warrington Limited (Natalie.Russell@connexions-cw.co.uk). The Connexions staff carried out the survey in March 2010 among young people in Cheshire West & Chester. To ensure a range of responses, questionnaires were filled out by young people living in or near Chester, Ellesmere Port, Frodsham/Helsby, Malpas, Neston, Northwich, Weaverham and Winsford. Questionnaires were completed in schools, youth centres, Hubs and Connexions centres, ensuring responses from young people in the age range 13-19. Both males and females were encouraged to complete the questionnaire.

Section 1: About You

466 responses were gathered from 13-19 year olds. Eight 12 year olds and eight 20+ year olds also completed the survey. The majority of responses were from young people in the age range 14-17 (graph 1). There was an equal distribution by gender (52% were male).

Graph 1 Connexions Survey responses by age and gender

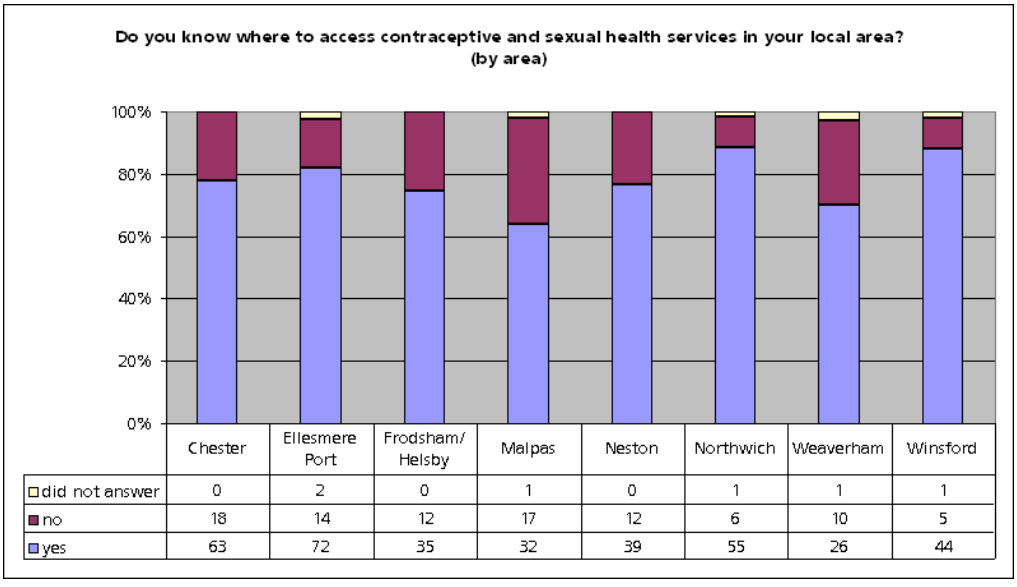


	12	13	14	15	16	17	18	19	20+	Did not answer
Male	3	15	32	66	61	37	15	4	4	7
Female	5	18	45	61	43	23	7	4	4	5
Did not answer	0	1	3	2	0	0	0	0	0	1

Access of young people to services

Do you know where to access contraception and sexual health services in your local area? 78.5% (366) of young people recorded that they did know where to access contraception and sexual health services in their local area (graph 2). Yes responses were highest among young people in Northwich (89%) and Winsford (88%) and was lowest in Malpas (64%).

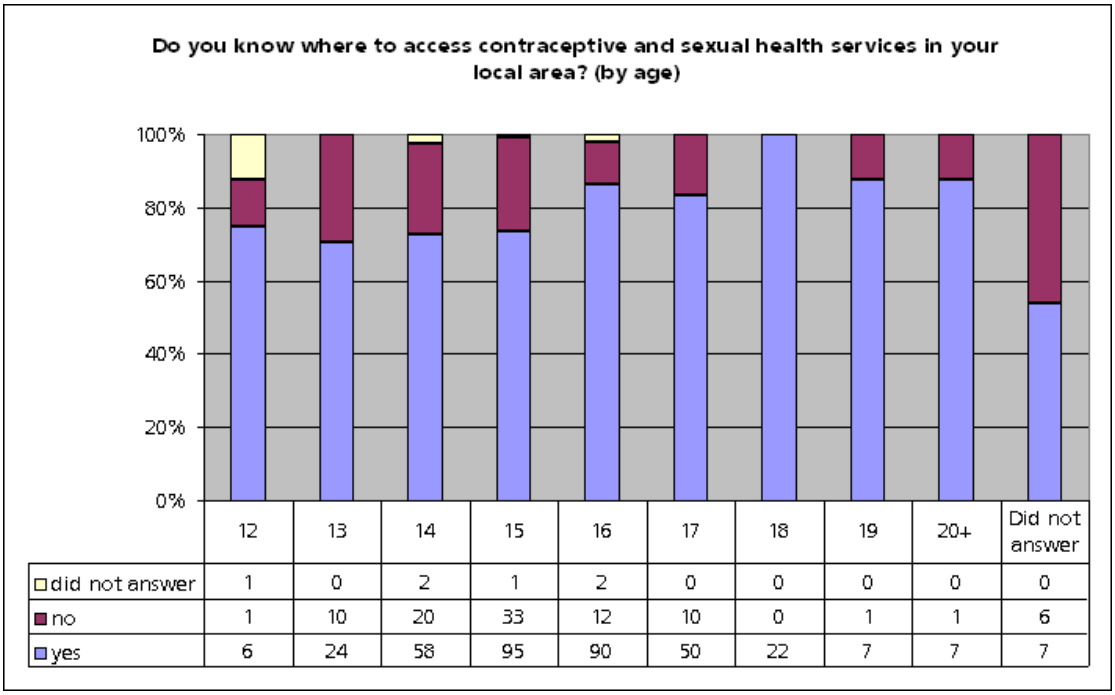
Graph 2 Do you know where to access contraceptive and health services in your local area?, by area



	Chester	Ellesmere Port	Frodsham/ Helsby	Malpas	Neston	Northwich	Weaverham	Winsford
did not answer	0	2	0	1	0	1	1	1
no	18	14	12	17	12	6	10	5
yes	63	72	35	32	39	55	26	44

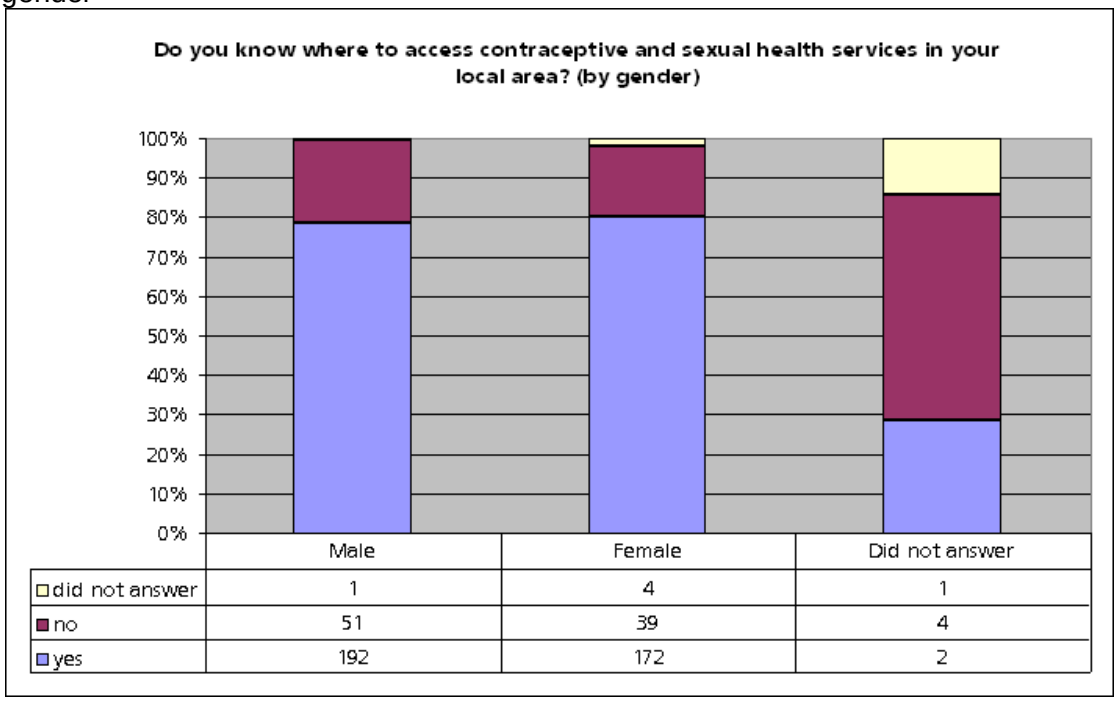
When this question was broken down by age group, nearly each age stated yes for each area (graph 3), with up to 70% of 12-13 year olds stating yes. When broken down by gender, 80% of both males and females had stated yes (graph 4).

Graph 3 Do you know where to access contraceptive and health services in your local area?, by age in years



	12	13	14	15	16	17	18	19	20+	Did not answer
did not answer	1	0	2	1	2	0	0	0	0	0
no	1	10	20	33	12	10	0	1	1	6
yes	6	24	58	95	90	50	22	7	7	7

Graph 4 Do you know where to access contraceptive and health services in your local area?, by gender

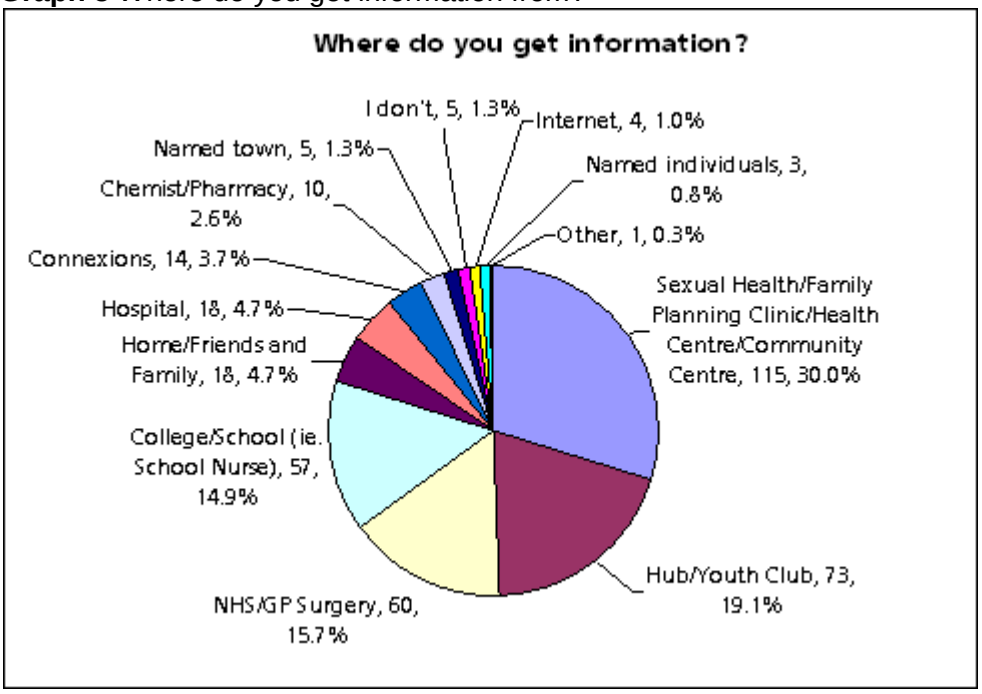


	Male	Female	Did not answer
did not answer	1	4	1
no	51	39	4
yes	192	172	2

Where do you get information about contraception and sexual health?

341 (73%) out of the 466 young people surveyed answered the question 'Where do you get information about contraception and sexual health?' Many young people stated more than one source so the total number of sources stated was 383. Some young people named actual locations (e.g. 'New Images'). In these cases, it has been necessary to record this information under the type of location (e.g. Youth Club). The most popular location type was 'Sexual Health/Family Planning Clinic, Health Centre/Community Centre' (30.0%), followed by 'Hub/Youth Club' (19.1%) and 'NHS/GP Surgery' (15.7%) (graph 5). There was differentiation between sexual health and non-sexual health service, thus a proportion of the 30% may overlap with the local health centre. There was no documentation of information from internet, TV, or magazine sources.

Graph 5 Where do you get information from?



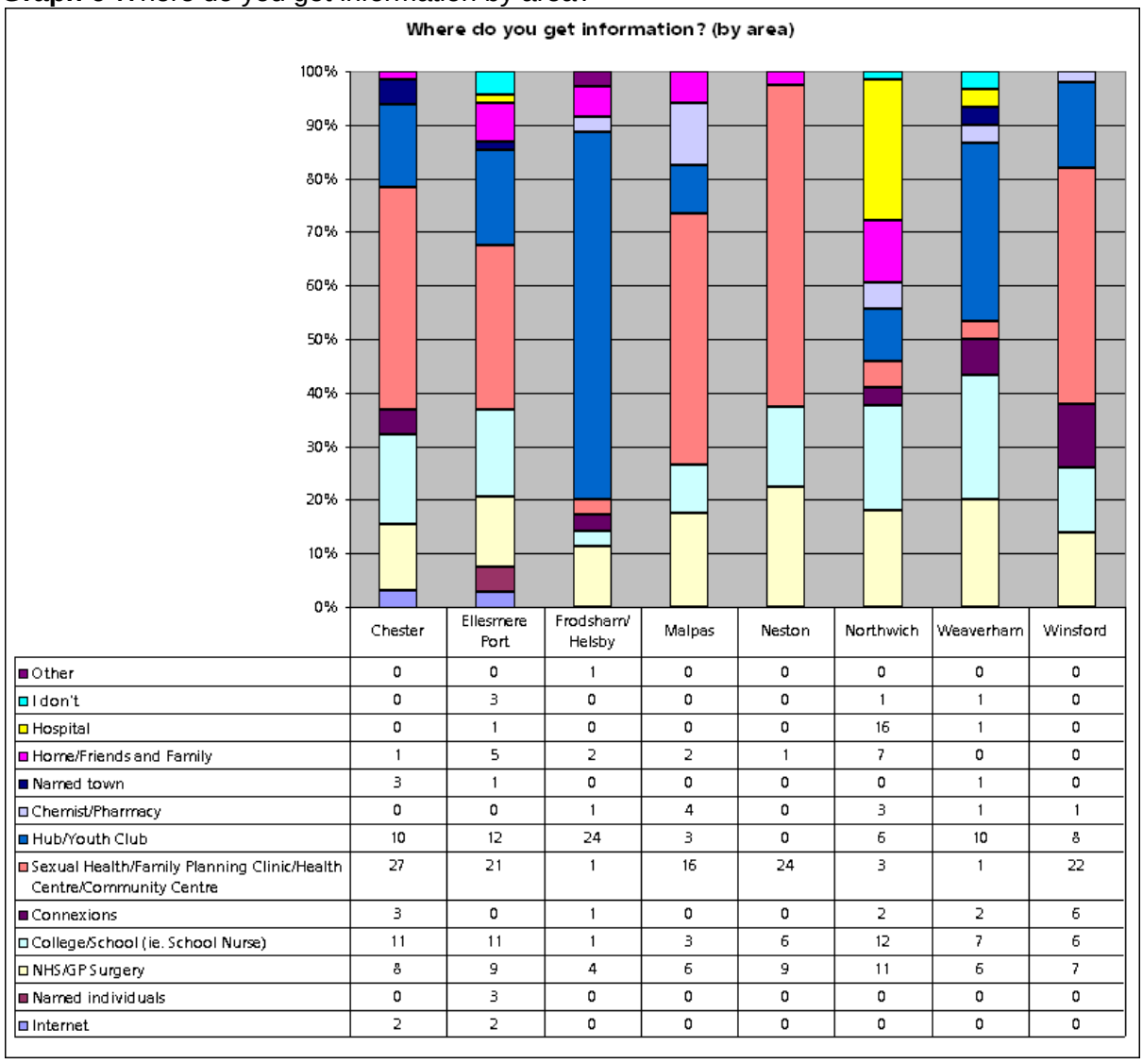
Specific places that were named by young people include:

- Chester - Blacon Community Centre, Delta Centre, Lache Centre, St Martin's Clinic
- Ellesmere Port - Home Farm Clinic, Stanney Lane Clinic
- Frodsham/Helsby – The Red Room
- Malpas – Young Person's Clinic
- Neston – The 'Brook'
- Northwich – The Infirmary
- Weaverham – none
- Winsford – The Junction

When results were assessed by area significant differences in where young people said they get information (graph 6) were identified, for example,

- In Northwich many young people mentioned Northwich Infirmary ('Hospital') as this is where the sexual health service is provided.
- In Frodsham many young people mentioned the Hub or Youth Club.
- In Frodsham and Weaverham few mentioned 'Sexual Health/Family Planning Clinic/Health Centre/Community Centre'.

Graph 6 Where do you get information by area?



	Chester	Ellesmere Port	Frodsham/ Helsby	Malpas	Neston	Northwich	Weaverham	Winsford
Other	0	0	1	0	0	0	0	0
I don't	0	3	0	0	0	1	1	0
Hospital	0	1	0	0	0	16	1	0
Home/Friends and Family	1	5	2	2	1	7	0	0
Named town	3	1	0	0	0	0	1	0
Chemist/Pharmacy	0	0	1	4	0	3	1	1
Hub/Youth Club	10	12	24	3	0	6	10	8
Sexual Health/Family Planning Clinic/Health Centre/Community Centre	27	21	1	16	24	3	1	22
Connexions	3	0	1	0	0	2	2	6
College/School (ie. School Nurse)	11	11	1	3	6	12	7	6
NHS/GP Surgery	8	9	4	6	9	11	6	7
Named individuals	0	3	0	0	0	0	0	0
Internet	2	2	0	0	0	0	0	0

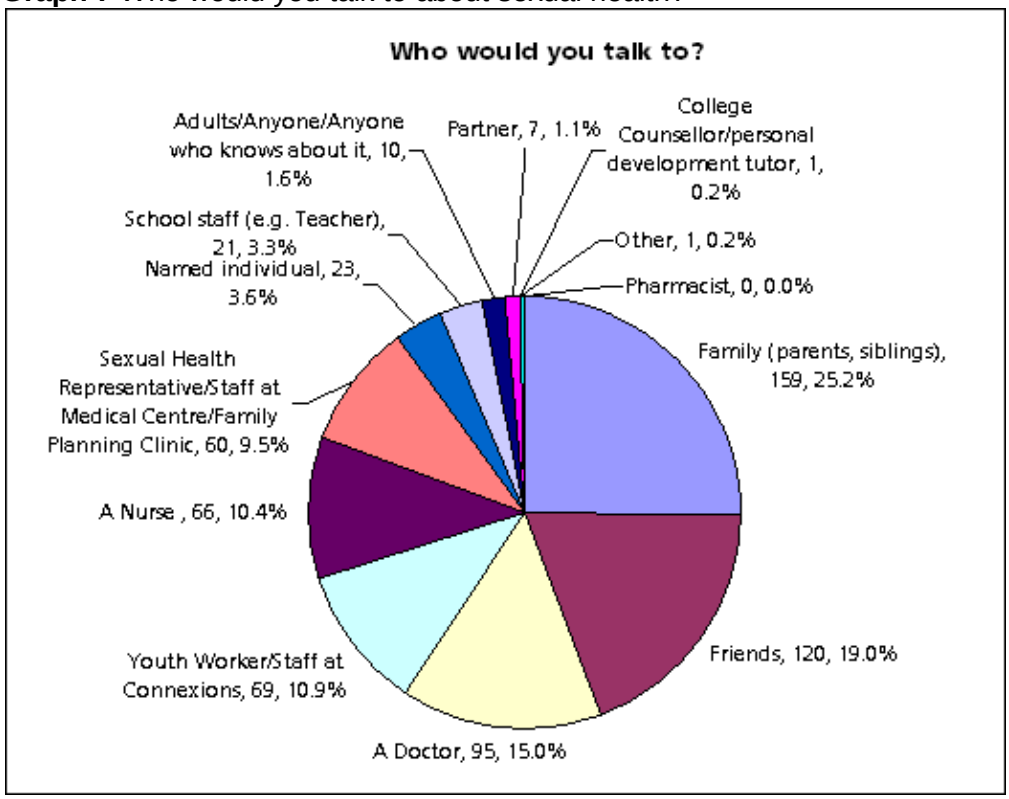
Who would you talk to about contraception and sexual health?

364 (78%) of the young people recorded who they would talk to about contraception and sexual health. Again, many young people stated more than one person (graph 7). The total number of people stated was 412. It was unclear what proportion of young people would have stated 'no one' as this was not recorded, although it could be assumed this was 22% (e.g. non-responders). Where they have named individuals, the information was recorded under job type where possible (e.g. 'Youth Worker'). There was no one specific source that young people stated they would talk to; the largest was family (25%), and second was friends (19%), and the third was a doctor (15%). In this Connexions survey, 10% stated they would talk to a Connexions/youth worker. No one said that they would talk to a pharmacist. There was a difference between recording who they would talk to and where they get information; for example, 25% said they would talk to family and 19% would talk to friends, but only ~5% said that they get information from Home/Friends and Family.

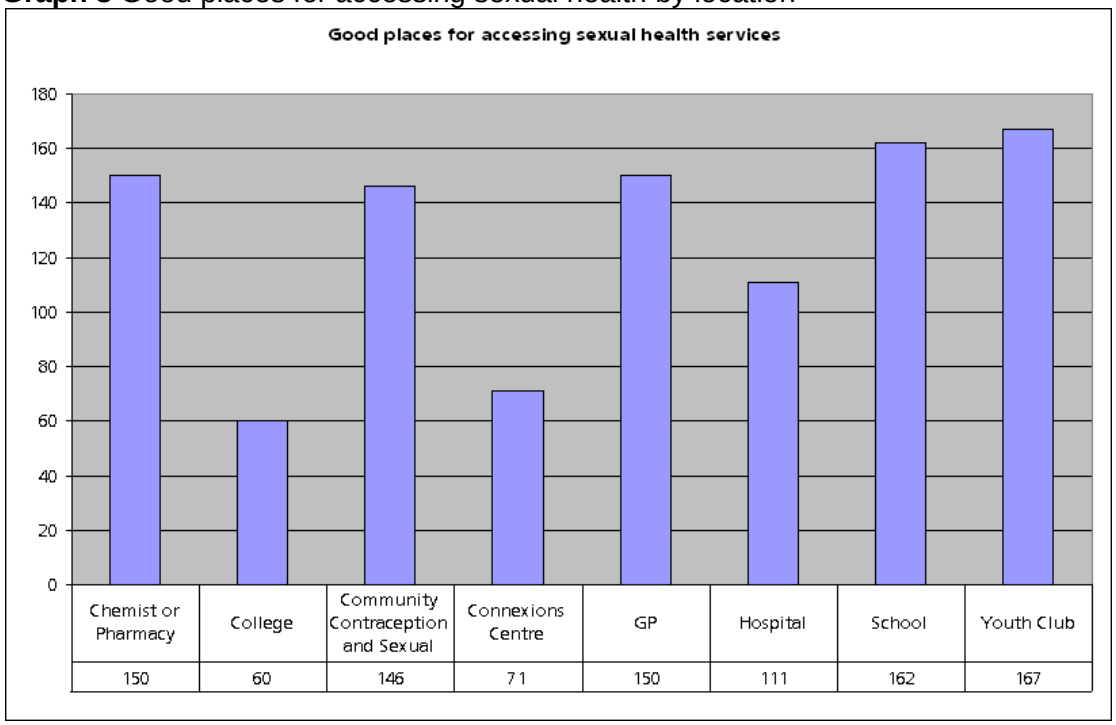
Good places to access services

Respondents ticked boxes for locations they thought were good places to access sexual health services. Many ticked more than one location (graph 8). The most popular were Youth Club' (16% of ticks), 'School' (16% of ticks), GP' and 'Chemist or Pharmacy' (both with 15% of ticks), Community Contraception and Sexual Health Clinic' (14% of ticks).

Graph 7 Who would you talk to about sexual health?



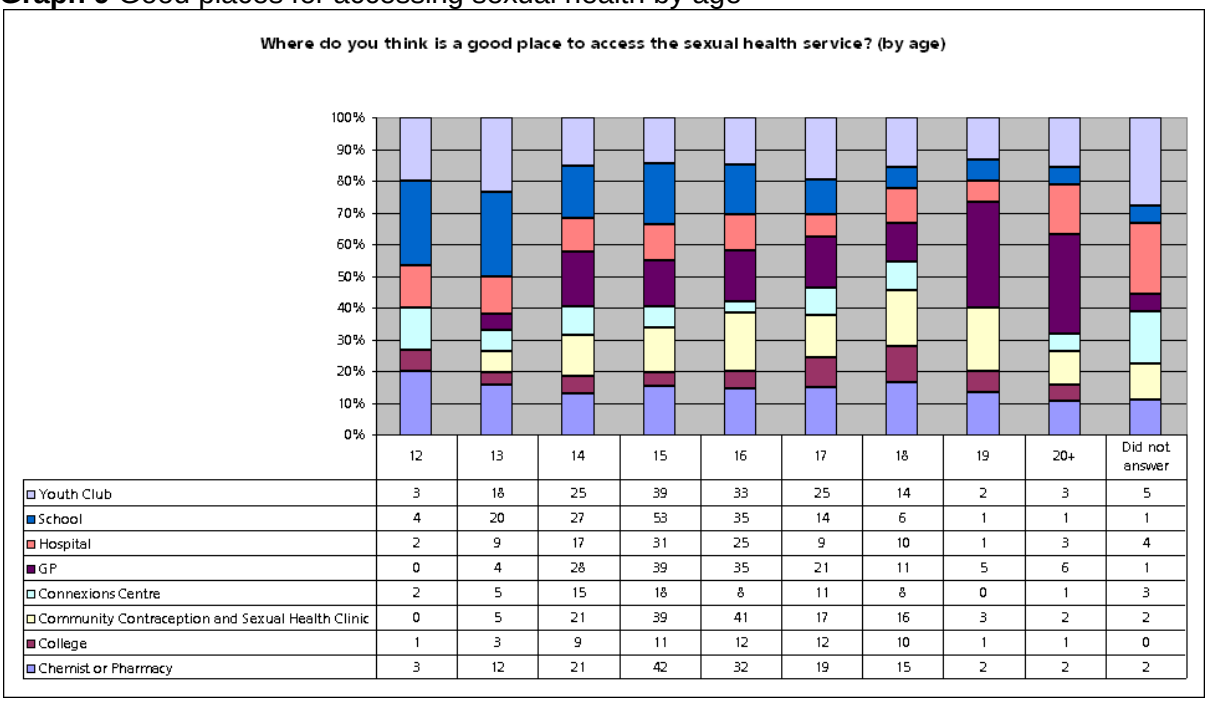
Graph 8 Good places for accessing sexual health by location



This contrasts with the question on who do you talk to about sexual health, where school (3%) and chemist/pharmacy (0%) were not mentioned, suggesting different interpretation of the question. Young people also stated 'somewhere else', including park/streets, private room/anywhere quiet, at home/with parents, supermarkets. An age breakdown (graph 9) showed school or college to be popular locations for all ages. The GP' was popular for young people aged 14 upwards, particularly among the oldest age group (19+). Youth Club' was popular among 12, 13 and 17 year olds. A

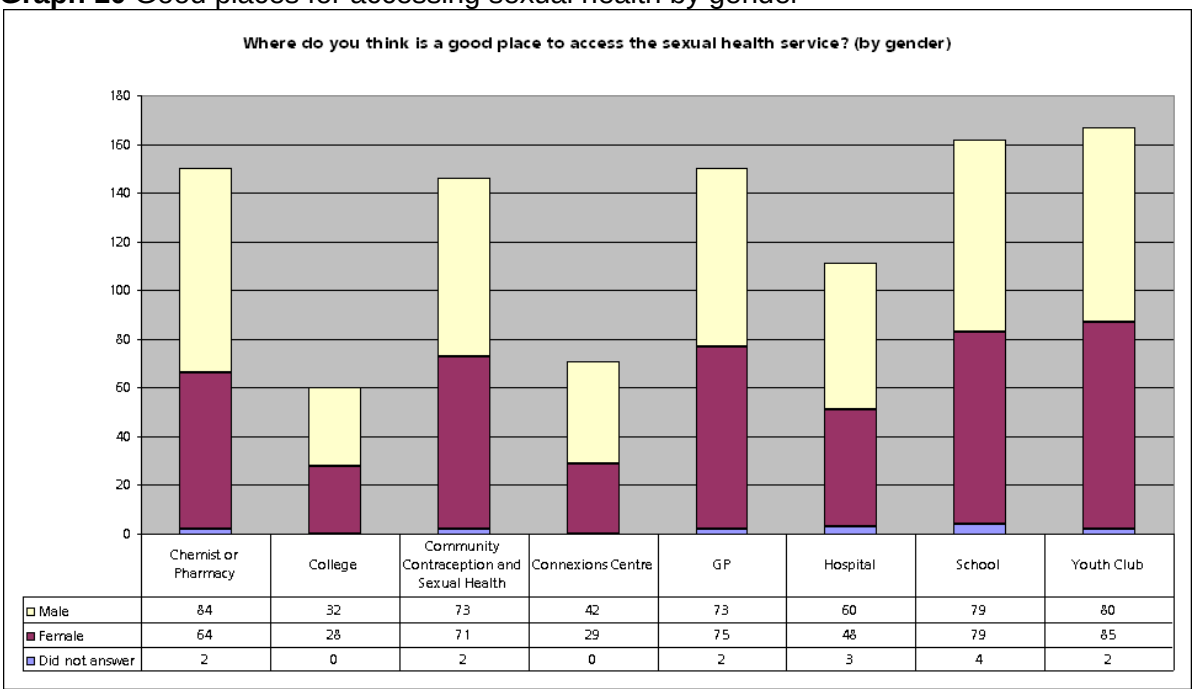
variety of locations were cited by the older age groups. There was no difference by gender, although more males than females stated that they wanted to access services at a 'Chemist or Pharmacy' (graph 10).

Graph 9 Good places for accessing sexual health by age



	12	13	14	15	16	17	18	19	20+	Did not answer
Youth Club	3	18	25	39	33	25	14	2	3	5
School	4	20	27	53	35	14	6	1	1	1
Hospital	2	9	17	31	25	9	10	1	3	4
GP	0	4	28	39	35	21	11	5	6	1
Connexions Centre	2	5	15	18	8	11	8	0	1	3
Community Contraception and Sexual Health Clinic	0	5	21	39	41	17	16	3	2	2
College	1	3	9	11	12	12	10	1	1	0
Chemist or Pharmacy	3	12	21	42	32	19	15	2	2	2

Graph 10 Good places for accessing sexual health by gender

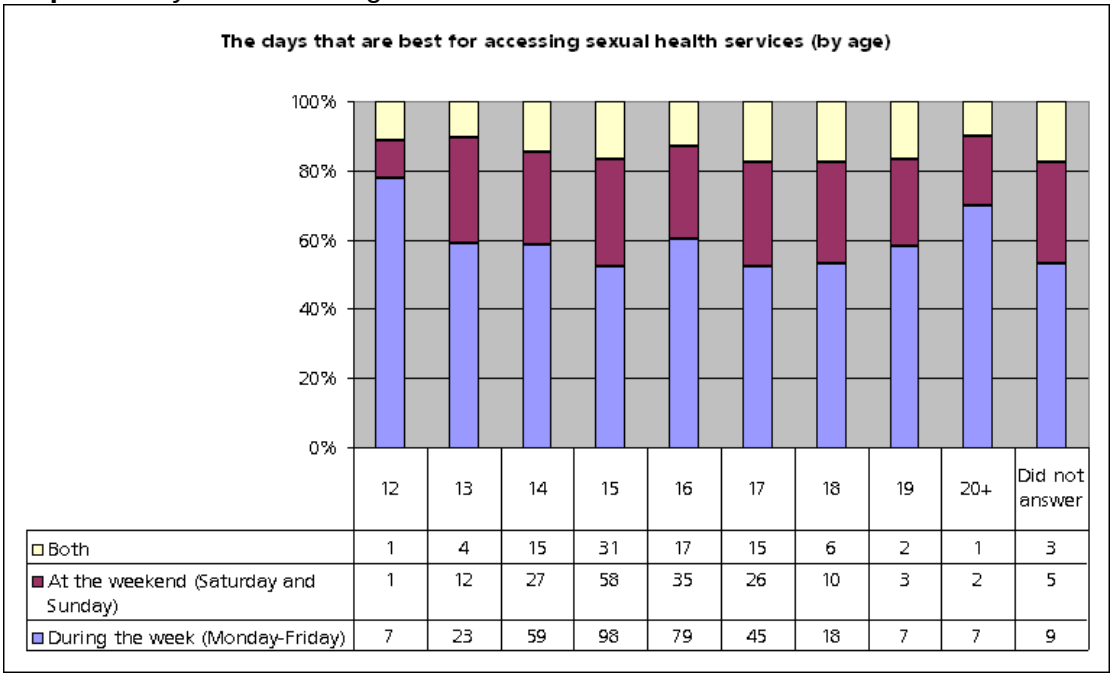


	Chemist or Pharmacy	College	Community Contraception and Sexual Health	Connexions Centre	GP	Hospital	School	Youth Club
Male	84	32	73	42	73	60	79	80
Female	64	28	71	29	75	48	79	85
Did not answer	2	0	2	0	2	3	4	2

Best days to access services

The young people were encouraged to tick which days they thought were best to access sexual health services. Many ticked more than one location. Monday-Friday received 56% of ticks, the weekend 29%, and both 15%. By age (graph 11) shows no differences in the suggested needs of young people aged 13-19 except 12 year olds did not want weekends.

Graph 11 Days for accessing sexual health services

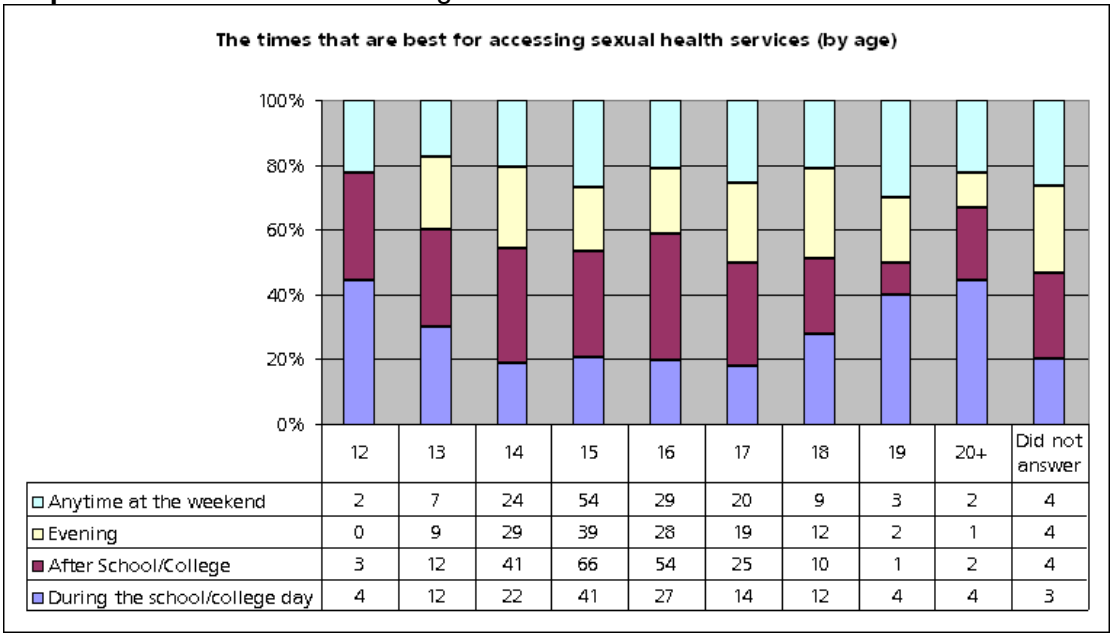


	12	13	14	15	16	17	18	19	20+	Did not answer
Both	1	4	15	31	17	15	6	2	1	3
At the weekend (Saturday and Sunday)	1	12	27	58	35	26	10	3	2	5
During the week (Monday-Friday)	7	23	59	98	79	45	18	7	7	9

Best times to access services

The young people were encouraged to tick all the times that they thought were good to access sexual health services. Results were spread across the time; during the school/college day (lunchtime, breaks) (22% of ticks), after school/college (4pm-6pm) 33%, evening (6pm-9.30pm) 22%, and anytime at the weekend 23%. By age (graph 12) indicates no set pattern or need expressed by age group, except the youngest did not want evenings.

Graph 12 Best times for accessing sexual health services

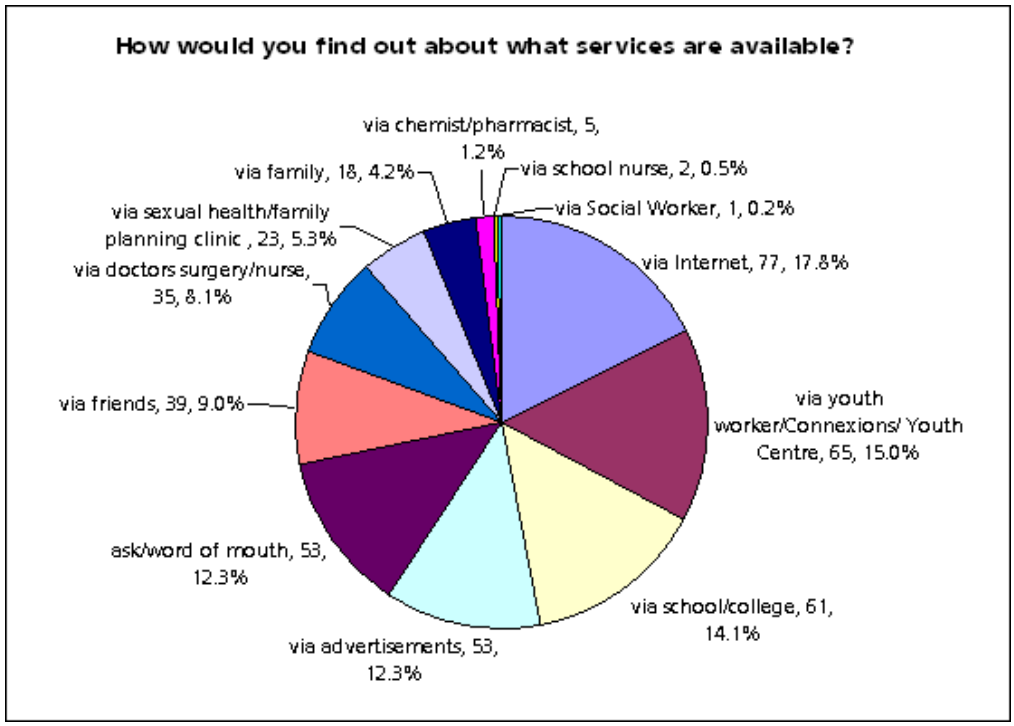


	12	13	14	15	16	17	18	19	20+	Did not answer
Anytime at the weekend	2	7	24	54	29	20	9	3	2	4
Evening	0	9	29	39	28	19	12	2	1	4
After School/College	3	12	41	66	54	25	10	1	2	4
During the school/college day	4	12	22	41	27	14	12	4	4	3

How would you find out about what services are available?

Of 353 (76%) young people who answered the question, 432 responses were given. Specific information given was categorised by source-types (graph 13). The most popular responses were Internet (17.8%), a youth worker/Connexions/Youth Centre (15.0%), and school/college (14.1%). In this survey friends and family were rated less, although word of moth was mentioned by 12.3%.

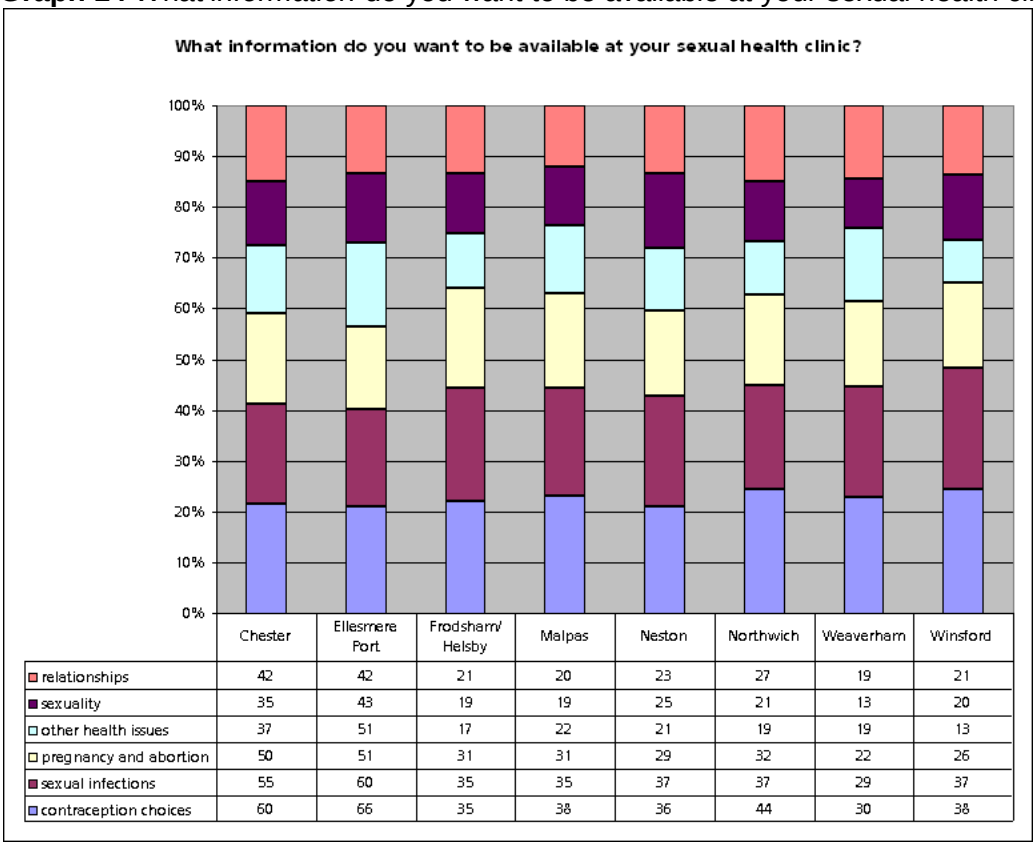
Graph 13 How would you find out about what services are available?



What information do you want to be available at your sexual health clinic?
The young people were encouraged to tick as many boxes as were applicable in answer to this question. The responses were contraception choices (22% of ticks), sexual infections (21% of ticks), pregnancy and abortion (18% of ticks), relationships (14% of ticks), other health issues (13% of ticks), sexuality (13% of ticks). Young people in the different areas had similar views on what information they want available (graph 14). The young people had the opportunity to suggest other *information* that they want. This included about being a dad, on how to please your partner, on abusive relationships, on the religious aspects of sex, just someone to talk to.

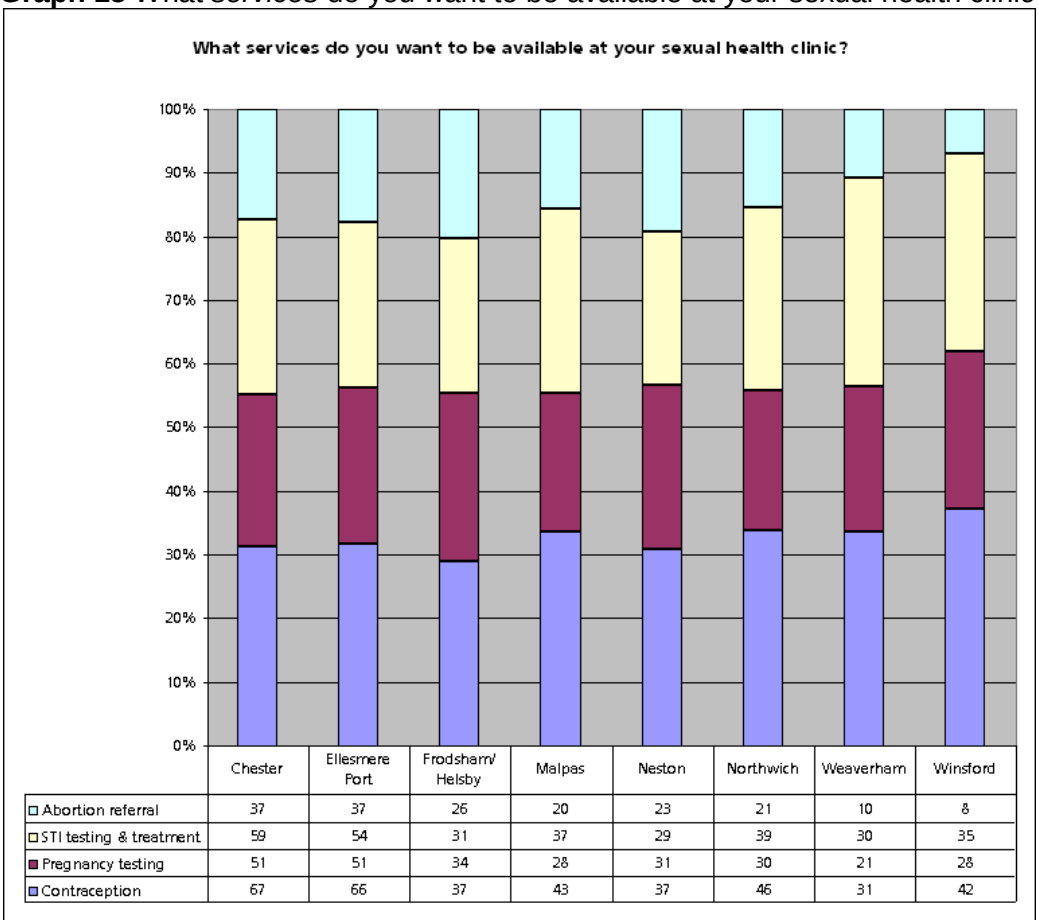
What services do you want to be available at your sexual health clinic?
The young people were encouraged to tick as many boxes as were applicable in answer to this question (graph 15). Responses included contraception (32% of ticks), sexually transmitted infection testing & treatment (28%), pregnancy testing (24%), abortion referral (16%). Young people in the areas generally have similar views on what services they want available but a lower proportion of young people in Weaverham and Winsford ticked 'Abortion referral'. The young people had the opportunity to suggest other services they want. A suggestion was 'someone to talk to about boyfriend problems'.

Graph 14 What *information* do you want to be available at your sexual health clinic?



	Chester	Ellesmere Port	Frodsham/ Helsby	Malpas	Neston	Northwich	Weaverham	Winsford
relationships	42	42	21	20	23	27	19	21
sexuality	35	43	19	19	25	21	13	20
other health issues	37	51	17	22	21	19	19	13
pregnancy and abortion	50	51	31	31	29	32	22	26
sexual infections	55	60	35	35	37	37	29	37
contraception choices	60	66	35	38	36	44	30	38

Graph 15 What *services* do you want to be available at your sexual health clinic?

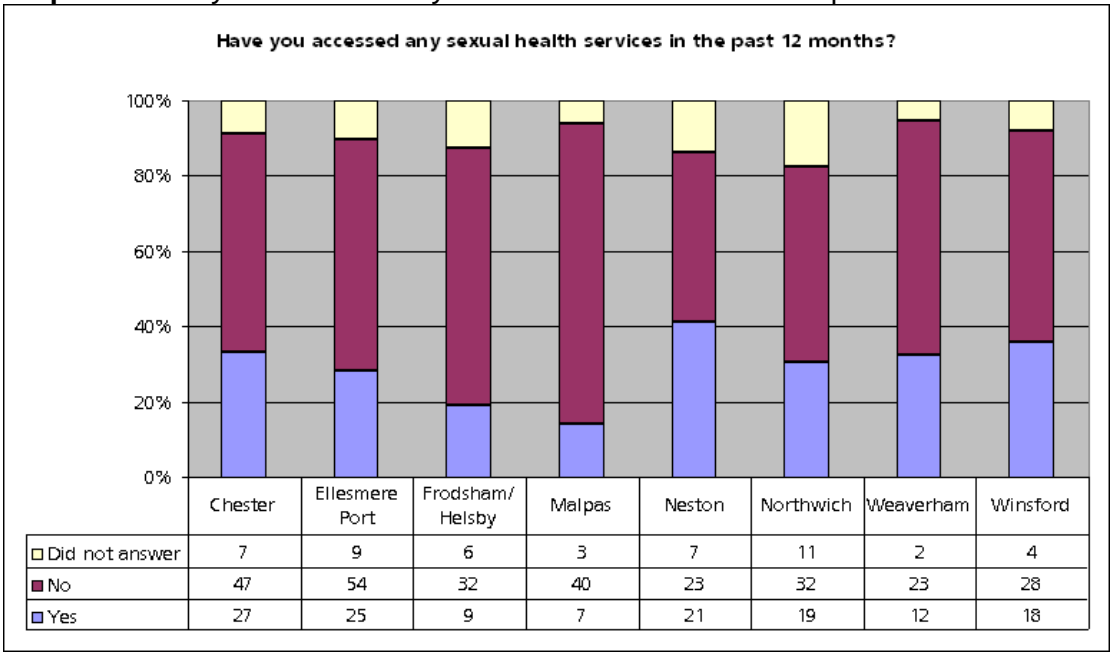


	Chester	Ellesmere Port	Frodsham/ Helsby	Malpas	Neston	Northwich	Weaverham	Winsford
Abortion referral	37	37	26	20	23	21	10	8
STI testing & treatment	59	54	31	37	29	39	30	35
Pregnancy testing	51	51	34	28	31	30	21	28
Contraception	67	66	37	43	37	46	31	42

Section 4: Your experience

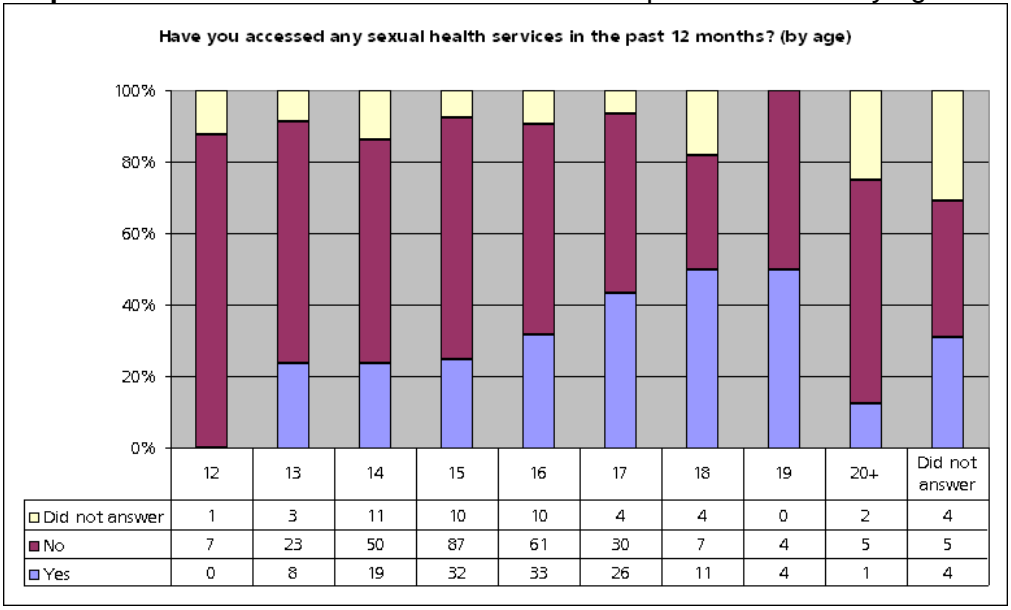
Have you accessed any sexual health services in the past 12 months?
138 (30%) young people said that they had accessed sexual health services in the past 12 months (graph 16). In Malpas only 7 (14%) out of the 50 young people surveyed said that they had accessed services. In contrast, 21 (42%) out of the 51 surveyed in Neston said the same. When broken down by age (graph 17), service utilisation is clearly seen to be in the older age groups rising from a quarter of 13-15 year olds, to half of 18-19 year olds.

Graph 16 Have you accessed any sexual health services in the past 12 months?



	Chester	Ellesmere Port	Frodsham/ Helsby	Malpas	Neston	Northwich	Weaverham	Winsford
Did not answer	7	9	6	3	7	11	2	4
No	47	54	32	40	23	32	23	28
Yes	27	25	9	7	21	19	12	18

Graph 17 Accessed sexual health services in the past 12 months by age



	12	13	14	15	16	17	18	19	20+	Did not answer
Did not answer	1	3	11	10	10	4	4	0	2	4
No	7	23	50	87	61	30	7	4	5	5
Yes	0	8	19	32	33	26	11	4	1	4

Issues stopping young people accessing services
The main reasons young people did not use services was fear of parents knowing (43) and they don't know where the services are (30), opening times.(14), and a further 14 said they were 'embarrassed' (table 13). The denominator is unknown preventing calculation of percentages.

Table 13 Number of young people giving reasons for not accessing services

	Chester	Ellesmere Port	Frodsham/ Helsby	Malpas	Neston	Northwich	Weaverham	Winsford	Total
Don't know where they are	5	1	4	7	1	3	6	3	30
Disability	0	0	0	0	0	0	0	2	2
Can't get an appointment at the doctors because the lines are always busy	0	0	0	0	0	1	0	0	1
Embarrassed	1	0	2	5	4	1	0	1	14
Fear/Scared	1	2	0	1	1	0	0	1	6
Fear of friends finding out	1	0	0	0	0	0	0	0	1
Fear of parents knowing	4	4	4	11	9	3	2	6	43
Fear of rumours going around	0	0	1	0	0	0	1	0	2
Fear of somebody I know being in there	0	1	0	0	0	0	0	0	1
Fear of them writing information down but not being confidential	0	0	0	0	0	0	0	1	1
In case I see someone I know in the doctors	1	0	0	0	0	0	0	0	1
I'm not old enough	1	0	1	0	0	0	0	0	1
I'm gay	0	0	0	1	0	0	0	0	1
Looking stupid	1	0	0	0	0	0	0	0	1
Location - not one near	0	0	2	1	0	0	0	0	3
My mum would want to know	0	1	0	0	0	0	0	0	1
Not being able to visit without parents knowing because of the opening times	1	0	0	0	0	0	0	0	1
Not knowing what to say	0	0	0	0	0	1	0	0	1
Not trusting or knowing someone at the clinic	0	0	1	0	0	0	0	0	1
Opening times (the weekends not being available)	3	2	1	1	3	2	2	0	14
Parents at same doctors	1	0	0	0	0	0	0	0	1
People seeing you going into the clinic	0	4	0	0	0	0	0	0	4
People finding out	0	0	2	0	0	0	0	0	2
Religion	0	0	0	0	0	0	1	0	1
Transport	0	0	1	0	0	0	0	0	1

How could sexual health services be improved?

The young people were encouraged to comment on how sexual health services could be improved (table 14). Some young people feel they want more information while others feel they don't get the right information, which supports the trend identified that services should be more individually-targeted. Comments suggest some are ignorant of what is available (e.g. on the need for free

contraception). Few had heard of the You're Welcome, but mentioned the need for privacy and confidentiality.

Table 14 Comments on how could sexual health services be improved?

A centre set up for young people that offers advice, free contraception and pregnancy advice
A drop in clinic at youth clubs
A proper clinic like 'the brook' in more areas. Give out better quality products not second best.
Abortion without parents consent
Advertising them better
Available more times
Be more available through school
Being very confidential
Free condoms
Friendly staff
Give you more information and time
Maybe having talk groups where teenagers can talk and not be embarrassed
More and maybe street stands
More confidentiality. They're quite good but are quite slow - need to be quicker to miss less of school.
More information
More privacy
More programmes to discourage underage sex and not be just a safety net/abortion clinic for mistakes - ensure people are aware that yes you will help them but understand real life effects
More publicity available and make known the services that they offer, show people that it is confidential
Not writing personal information down when you go to get contraception
Nurse in school more
One in Neston
Open 24 hours or helpline
Talk more about how to cope if you get pregnant
They could always give us condoms without us asking
They should be anytime through the week not one day a week.
Thicker condoms

3.7 Qualitative study among young people using Focus Groups

Box 11 Key Findings from Focus Groups

- Young people were aware that risk taking occurred amongst their peers. Whilst there was a core of young people who did not use condoms for protection, many young people would use them if they had access to them at the time. If not available, this would not deter them from having unprotected sex as immediate gratification far outweighed any fear of sexually transmitted infections or pregnancy.
- While young people can easily obtain condoms, problems occurred at night time if sex was unanticipated, or if they were drunk. Another barrier to access was cost. However, free availability of condoms in vending machines etc. would be wasted.
- Young people vehemently agreed that alcohol increases sexual behaviour, casual relationships and unprotected sex; makes girls more confident and lowers their inhibitions. They consider alcohol too easily available, and more control is needed.
- Drug taking also results in sexual risk taking but young people felt drugs were more harmful; Viagra is taken to counter the negative sexual effects of alcohol.
- Brook educational activities provided skills on condom use even when drunk.
- There was evidence of negative attitudes towards girls who carry condoms (classed as sluts/slags).This had the compounding effect of preventing girls from carrying them. Two suggestions were to include girls in condom adverts (always feature men), and make condoms more like fashion accessories with good packaging and colours.
- Young people thought an overemphasis on pregnancy and contraception in sex and relationships education has created a greater concern about pregnancy and less concern about sexually transmitted infections.
- Despite this, during sex young people rarely think about pregnancy; most are accidents; generally girls did not get pregnant for benefits/housing, but may if they have no ambition, want independence, or mimic their own upbringing. Teen mums were worried their own children would also become teen parents.
- Some positive comments were made about young parenting, including it offered some girls structure and stopped some from drinking or taking drugs.
- Participants were aware of chlamydia and gonorrhoea; they felt chlamydia campaigns and adverts meant young people only knew of this, and nothing about other sexually transmitted infections. Young people have a casual attitude towards contracting chlamydia and think it easily treatable, but having any other sexually transmitted infection is stigmatising and is a barrier to screening.
- Participants were ignorant about HIV and Aids, only aware through the teen TV soap Hollyoaks, and believed they were not at risk of infection. It was too scary to risk being tested for.
- A lot of knowledge about STIs has come from *The Sex Education Show* and *Embarrassing Bodies,* two TV shows that young people praised and wanted copied in schools.
- Within the focus groups, many did not know the names or whereabouts of the sexual health clinics; they were unsure if they could go to their General Practitioner; many would be too embarrassed to attend for an STI and feared their parents would find out.
- Young people felt they were talked down to, and confidentiality was breached by calling out their names in waiting rooms.
- Limited opening times, needing an appointment or drop in, and access greatly confused young people and was a barrier to use; advertising must improve.
- Friendly, approachable and non-judgemental staff were required, with staff that enable young people to talk about their problems.
- Young people considered sex education should have a broader curricula including sexually transmitted infections and relationships, not just about pregnancy. It should be started at a younger age before sexual debut, and be taught by professionals, with good materials.
- Being scared to talk to parents prevents some young people from getting advice and seeking help early, poor parental communication increases young people's risk.

The focus groups were conducted among different groups of young people aged 15 to 19 years old. They were designed to cover a range of topics including sex and relationship education in school, use of contraception, thoughts on pregnancy and sexually transmitted infections, and provision of sexual health services.

Condoms

Much of the discussion about condoms centred around opportunistic sex or one night stands rather than within more stable relationships. Whilst it is likely this is a result of the topics being introduced into the discussion, it was evident that the former were a familiar concept to these young people, whether part of their own lifestyle or those of their peers. In stable, monogamous relationships most young people thought couples only use, and only need to use, the contraceptive pill and not condoms. But it was also acknowledged that even in casual encounters if the girl is taking the pill then they won't necessarily use condoms.

[if] they don't have a condom then they're going to do it anyway cause … it's just gone too far they just end up doing it.
(Youth Representatives. P5. male)

…as soon as the girl's on the pill and the lad knows about it they don't use condoms. (NEETS 1, P1, male.)

Participants clearly identified risks taken through the non use of contraception. Some felt this practice was very common among their peers, others less so, but all seemed to know of friends or peers who engaged regularly in unprotected sex. The majority of young people said they would use a condom if one was available at the time. If they didn't have one it would not prevent them from having sex, as immediate gratification far outweighed any fear of sexually transmitted infections or pregnancy.

They really should be cheap in pubs like the toilet, pay about two quid and you get one condom (laughter) (NEETS 1, P1, male)

I don't think its ever going to stop [taking risks] because when you're that age I think you know what's right oh I'm indestructible I'm not going to get pregnant I'm not going to catch anything and I just think no matter how much you tell somebody, you'll obviously end up with the girls and boys [thinking] 'oh it will be alright' (Teenage Mothers 1, P1, female)

Young people clearly knew where to get free condoms listing sources such as the family planning clinics, pharmacies, The Junction in Winsford, school and colleges. They also acknowledged places you can buy condoms such as shops, pubs and toilets. Participants acknowledged that they could access condoms without difficulty – provided they planned ahead. If sex was unplanned or spontaneous this led to difficulty obtaining condoms, particularly at night. Whilst they could be bought in pub vending machines, a clear barrier was cost and young people would rather spend their money on another drink rather than on condoms. This was evident in many focus groups and is clearly an issue for young people.

…sometimes just if you're completely smashed, you know, you haven't got the coordination to put the thing on anyway.
(Youth Representatives, P4, Male)

Excessive alcohol consumption was acknowledged as a barrier to condom use. A couple was either less likely to use one or more likely to use it incorrectly. One participant praised a session Brook ran where they put a condom on a plastic model in the dark with hazy 'beer goggles' as it recreated a realistic situation and taught useful skills to young people.

If you go to a party you take [a condom] with you just in case…if you're drunk you forget all about it, I do. (NEETS 2, P2, male)

Providing the condom was almost universally stated to be the responsibility of both members of a couple, especially in casual sexual encounters. But when asked about girls carrying condoms the majority of girls and boys stated they, or their friends, think the girl is 'easy'. Girls who carried condoms on a night out to be used in a casual sexual encounter were thought of as 'sluts' or 'slags' who were looking for sex.

I think it depends on social class again because if you're in a [school] class of people who in quite like of a higher class I'd say my school is quite middle class…and you look around and you think not many of them have had sex really but then you can look at another school and think have a completely different view…But people in higher classes might think it can't be me. (Youth Representatives, P3, female)

The only girls who were confident to carry condoms were those in the two teenage mothers groups and they acknowledged this was

because they were experienced and knew, first hand, the risks of unprotected sex. Most of them stated they would never have carried condoms round when they were younger though. When asked how young girls could be encouraged to carry condoms two ideas were suggested:- include girls in condom adverts because they always feature men, and make condoms more like fashion accessories with good packaging and colours.

I'd say some girls carry it around if they were looking for it, if they had the intention by the end of the night to have sex.
(Youth Representatives, P5, male)

It was generally thought that younger girls did not have the confidence to carry condoms or to insist on their use. One teenage mother suggested nothing could be done to change this as young girls did not understand that they were at risk.

Females and males both have the responsibility to use protection so its not just up to the lads. (NEETS 2, P5, Male)

Some of the young participants believed free condoms encouraged younger sex and more partners. This was only mentioned by one group most of whom hinted they were not participating in sexual activity and they seemed to have stereotypes of the type of young people who engage sexual activity, risky or not (perhaps based on class and education).

"God I haven't used anything oh God I haven't got the morning after pill I could be pregnant" that's the first thing…they're not arsed about sexually transmitted thing.
(Sheltered Accommodation, P1,female)

Pregnancy

Young people thought most of the focus of sex education in school was about contraception and preventing pregnancy and very little about sexually transmitted infections. This may contribute to the feeling that the main thing young people were concerned about is pregnancy. Although young people indicated becoming infected with a sexually transmitted infection would be extremely stressful this was not the primary concern for the majority of people. This was the case for boys and girls. Despite this concern about unwanted pregnancies most young people suggested that during sexual encounters this is not something they thought about.

The only thing that comes into a lad's brain is if they're with a girlfriend "oh no she says she's missed a period" (Sheltered Accommodation, P1 female)

its normally the girls going round 'oh I don't want to do it cause I don't want to get pregnant' that's all you hear them saying.(NEETS 1, P2, male)

Young people generally thought that most teenage pregnancies came about because of accidents and were rarely intentionally planned. Not agreeing with abortion was also given as a reason for unintended pregnancies. For those that did become pregnant intentionally a number of young people suggested this was to achieve independence, because they had no other ambitions and because this was what their parents had done.

[teenage pregnancy] always appears to happen to the teenagers which have less control, less like restrictions in life and therefore they not looking to go far in education, they haven't got many in later life so therefore they resort to settling down at a stupid age and not, when they're like a child, and not real life (Youth Representatives, P3, female)

It was generally thought a misconception that young people got pregnant to get a house – this thought was held in both the groups of teenage parents and the more middle class group. It was suggested this was an idea held by older, parental generations but not by young people themselves. It was acknowledged by two groups that sometimes having a baby at a young age can be a positive thing for some young women. It was thought to give structure, control and can stop young people taking drugs and drinking (see alcohol/drugs, below).

For some people though having a baby as a teenager is a good thing if you had no kind of anchor…no point to your life, you weren't going to get good results in your exams and if you had a baby you could start building a family and then you would have sort of thing to do ...Taking their mind of things like drugs or alcohol cause if you've got to look after a baby then you can't really do that
(Youth Representatives, P2, female)

The role of parents was mentioned by some groups. It was thought that telling parents they were pregnant was a very scary concept that most young people dreaded having to do. Some participants in the

teenage mothers group said they were worried their children would have babies young as they knew how hard it was.

Sexually Transmitted Infections and Screening

Awareness of sexually transmitted infections was generally low with most groups only mentioning chlamydia and gonorrhoea. Participants had heard of the chlamydia screening campaign and were aware it is common in young people. Young people were aware of it through the 'Condom: Essential Wear' adverts and from pop up adverts on college computers but many felt the focus on chlamydia was at the detriment of other sexually transmitted infections as most thought people don't know anything about other sexually transmitted infections.

They're not concerned about anything…Because they're a teenager. (Teenage Mothers 1, P3, female)

Chlamydia the one that you get drilled into your head about isn't it? I think it is. (Teenage Mothers 2, P5, female)

Most young people in the focus groups understood the symptoms, consequences and dominance of chlamydia but reported many misconceptions about it amongst their peers. Young people in the focus groups had a casual attitude to chlamydia and all sexually transmitted infections, and thought it was something easily treated and not a major health concern if they did test positive.

like you say Chlamydia isn't the only infection you can catch so why are they only putting it on there about Chlamydia because it only ever comes up with Chlamydia…
(Teenage Mothers 2, P4, female)

They also believed it was not something they were at high risk of contracting even when the facilitator pointed out the prevalence of Chlamydia in young people. The participants thought young people always think it won't happen to them and they don't have realistic expectations of the consequences of unprotected sex. Despite this casual attitude they thought there was still a lot of stigma surrounding chlamydia and other sexually transmitted infections that they thought discouraged people from getting tested.

Facilitator: But do you think knowing one in ten young people have chlamydia brings it home a bit more or ...?
Male: You would like to think so but I don't think it would really make a difference.
Female: Cause people don't think it would really happen to me with the odds and everything.
(Youth Representatives)

Young people had heard of HIV but did not know much about how it was transmitted, the symptoms or how prevalent it is. Most felt the limited knowledge they had about HIV came from the media, and especially Hollyoaks. Two groups discussed being very scared of HIV and suggested this would discourage them from getting tested as they would not want to know they were infected. Despite being aware of it and knowing how serious it is none of the young people thought it is something they are at particular risk of catching and it was not considered a worry for young people where they lived.

P3: …this sounds bad but you don't hear of many people round here that's got [HIV] do you?
P2: I don't think of anyone round here that's got that.
P1: No the first I've heard is on Hollyoaks (laughs).
(Teenage Mothers 2, all female)

Young people were aware of and praised Channel 4 shows like *The Sex Education Show* and *Embarrassing Bodies*. A lot of the knowledge they did have about sexually transmitted infections came from these shows and they thought they gave accurate information in an entertaining way that young people absorbed.

You get bullied as well for that. Its like walk past them (makes clapping sound) so I wouldn't like to be that.
(NEETS 2, P4, female)

A lot of people have said to me you can die from Chlamydia. You can't. (Sheltered Accommodation, P1 female)

Alcohol and drugs

There was universal agreement in all groups that young people consuming alcohol increased the likelihood of sexual behaviour and particularly increased the chance of unprotected sex. Participants felt young people were less likely to think about the consequences of unprotected sex, to be more willing to engage in sex and more likely to have casual relationships when drunk. There was overwhelming acknowledgement that being drunk led to unprotected sex. All groups were questioned about this and were both explicit and vehement in their response.

Cause they can't muck about up town but they'll still get hold of ale and drugs and they'll sit in the park and they'll just get absolutely trashed and they'll be a group of girls and a group of boys and that's it then. Oh there's the woods there lets go behind the woods let's have a little fumble
(Sheltered Accommodation, P1, Female)

Young people, especially girls, thought alcohol made them more confident and lowered their inhibitions. Some participants felt people took this too far and could not control their behaviour. It was mentioned by a number of people that young women often behave in a provocative and sometimes dangerous way when they are very drunk.

P2: You get more confident don't you?
P1: some girls when they're drunk just don't even know what they're doing
P2: And they're asking for it when they're pulling their skirts up and tops down.
(Sheltered Accommodation, both female)

All young people thought it was easy to acquire alcohol and most suggested if young people wait outside an off licence someone will eventually buy it for them. Or some young people said alcohol could always be stolen from home. Young people said they drink in parks, on the street and in back alleys. It was suggested that the shrewder young people do it in quieter areas as police will often confiscate the alcohol and move the young people on.

But some people are stupid enough to go and drink out straight in the middle of public…and if they get caught they'll have the beer took off…and a little bit of a slap on the wrist. More needs doing.
(Sheltered Accommodation, P1, Female)

It was suggested by some young people that more needs to be done to address the problem of excessive drinking that can cause risky sex. One participant suggested that lack of entertainment or activity for young people and sheer boredom meant they drank in parks. Some participants did not believe there was anything that could be done to solve the problem and that it was futile to try.

Yeah cause they've got nothing better to do and there's stuff going on in the day time but its nothing to do in night time so pretty much turn to drink.
(Teenage Mothers 1, P2, Female)

When asked if drugs were as big a problem as alcohol around their area, opinion was divided. Some participants thought it was easier to acquire alcohol but some thought drugs were easier to get. Generally both were accepted as being universally available. Drugs were thought to be easily available at any time though expensive compared to alcohol.

If you don't know what you're doing. If you're off your head you're just not arsed. Just won't care at all…And actually some drugs make you feel 'wooo!' all lovey dovey (Sheltered Accommodation, P1, female)

The effect of drugs was acknowledged as varying depending on drug type but they were generally thought to have a similar effect to alcohol and encourage risky sex. Young people were aware that drugs were more dangerous than alcohol in other ways and that buying and using drugs could have other negative consequences, both from side effects and violence from dealers.

You can't get them to change you can't..its just not going to happen basically cause there's going to be always drink around, they're just going to have to make the mistake and learn from it or just think "oh my God I'm not being like this anymore".
(Sheltered Accommodation, P1, female)

One group mentioned that Viagra was easily available to young people and counteracted the side-effects of other alcohol and other drugs.

It's probably both everywhere. Really, cause the drugs are everywhere and the booze is everywhere innit?
(Sheltered Accommodation, P3, male)

Most of today's teenagers are just getting drunk and having sex unprotected cause they don't know what they're doing.
(Teenage Mothers 1, P1, female)

Sexual Health Services

Awareness of services varied between the groups and this may be due to geographical location of the group, age and sexual behaviour. Names of clinics mentioned by groups included the genitourinary medicine clinic at The Countess of Chester, Stanley Lane Clinic, Hope Farm, The Junction in Winsford, Connexions, St Martins and Blacken. Generally these names were new to most participants who then asked where they were and what they offered. Awareness of these services was highest in the groups of teenage mothers, although it was unclear whether this knowledge was gained since or before their pregnancy. Some participants stated the clinics were all far away in places like Warrington, Runcorn or Chester. Most participants were unsure if they could access their GP for sexual health advice and support and opinions about attending the GP was divided – some young people were confident to do this but a lot stated they would be too embarrassed or that they were worried their parents would find out.

I don't like the doctors…cause I'm 17 but when my mum used to come in the room with us and sometimes like I've been in the room and they've said something what I haven't told me mum and like me mum didn't know. So that's why I prefer clinic. (Teenage Mothers 2, P1, female)

P4: You have to see [your GP] on a regular basis with a snotty nose and then you go there 'oh my God I'm pregnant' (laughter).
P2: Exactly that's someone you know innit. (Teenage Mothers 1, both female)

Of those that knew about services, opinions of them varied as well. Some reported positive experience and some had had bad experiences. Some young people felt that staff had looked down their noses at the young people, especially because of their age. One issue raised by two groups was the worry that their full names were read out in the waiting room. This caused extreme embarrassment to young people and they felt it breached confidentiality. It was suggested that a numbering system like that used in the supermarket would be an appropriate.

I had a really bad experience at the clinic. They just look down their noses at you, because I look a lot younger than what I am they always think I'm a lot younger…and then they're dead snotty…I choose not to go there if I can. (Teenage Mothers 2, P2, female)

[they shout] 'is Sarah Smith[ll] in this room?' and wave the file around…she's going to think oh my God going through a pregnancy, like shit….[They should say] 'number 1' cause it's not confidential 'Sarah Smith' and say if like there was person that you knew with their back to you…but they shout out 'Sarah Smith'. (Teenage Mothers 1, P4, female)

The overall consensus was that the opening hours of sexual health services were unsuitable. They were thought to be too restricted with not enough services available in evenings or weekend which made it difficult for young people who worked. Young people were aware that various clinics were open at different times on different days but knowledge of actual opening times was very limited. There was also confusion about which clinics were drop-in or appointment, although almost all groups wanted clinics to be drop in as young people don't like appointment systems. There were concerns about long waiting times at drop in clinics though. One group of teenage mothers believed it was impossible to obtain free emergency contraception (EHC) in their area at the weekend – whether or not this is accurate this does still stop young people from accessing it quickly and thus increasing the chance of pregnancy. One of the members of this group attributed her unintended pregnancy to being unable to access free emergency hormonal contraception over the weekend.

[opening times] are very annoying especially when you've got work till 6 o'clock and they only open 4 till 6 at the latest (Teenage Mothers 1, P5, female)

People can't be bothered with the hassle of appointments stuff like that that's what it is. It would be easier if you could just go and walk in. (Sheltered Accommodation, P1, female)

Almost all participants wanted a choice of whether they were seen by a male or a female member of staff but there was no consensus about whether the age of the staff mattered. It was stated by many participants that the staff need to be friendly, approachable and non-judgmental as going to a clinic is a very stressful experience and they need to be made to feel as comfortable as possible. Opinion was divided over whether clinics should be split into male and female as some young people worried this would deter couples from going together. They wanted services to offer free condoms, full sexually transmitted infection testing (including blood tests) easy

When I've been to doctors in the past I don't even like male doctors touching me there, urgh, you know it knocks me sick, I don't like it. So I think it should be stick to your own ....
(Sheltered Accommodation, P1, female)

chlamydia testing, emergency hormonal contraception, pregnancy testing, counselling and general support.

Participants suggested many barriers that stopped them accessing sexual health services. Opening times, or uncertainty about opening times, was one of the most commonly cited barriers and the distance to clinics was also said to make attendance difficult; especially as a full range of tests (including HIV, hepatitis C etc) are only available at The Countess of Chester. Having to book appointments was also seen as a deterrent for young people. The attitudes and behaviour, expected or real, of staff made a lot of young people feel like they were being judged; especially if they were attended regularly. School clinics were mentioned by two groups but general consensus was that few people use these as the embarrassment at being seen and at talking to the school nurse was too high. General lack of knowledge of where to attend for advice or support was a barrier to access. Young people suggested the place they would look for this information was the yellow pages or for search online. The problem with the later is they would be worried someone would see the internet history and realise they were sexually active. It was suggested that services needed to be more approachable generally and that they don't just provide contraception but also encourage young people to talk about problems and get support not just free condoms for example.

I'd probably not Google [for sexual health clinics] because I'd be worried that somebody found the history of it. If you did it in school or something and the people check up on it…you'd probably get blocked (Youth Representatives, P1, female)

Get up the next morning think 'oh my God what did I do last night?'… but the thing is though if it's a weekend how are you supposed to go for morning after pill? That's my problem I got fell pregnant on a weekend when I was drunk but it was definitely a weekend, you can't till Monday. And then you've got 72 hours.
(Teenage Mothers 1, P3, female)

Many participants suggested ways that current services could be improved. These included more chlamydia screening packages in toilets so these could be taken without having to see a nurse, a numbering system for calling patients in clinics, more drop in and longer opening hours and friendly attentive staff. Young people wanted the choice of being seen by a male or a female doctor/nurse and were mixed on opinions of whether waiting room and clinics should be single sex. The ideal location for a sexual health service was somewhere central but not in the middle of the high street as it was thought to be important that you weren't seen coming and going. Embarrassment at being seen attending a sexual health clinic was a very important issue for all the young people and they felt everything should be done to limit the chance of people seeing you attending. The clinic at Blacken was criticised because it is open and in full view of a pub and bookmakers. It was also stated it should not be next to a school. Young people wanted clinics to offer more of a broad selection of services including 'chats' as well as the full range of blood tests.

I had to go to the hospital to have a blood test done when the GUM clinic was open, hepatitis, HIV, syphilis, I was dragging myself all the way up well I got a lift like in the end but go all the way to the Countess. But I think they should have it at local clinics definitely. (Sheltered Accommodation, P1, female)

P1: [a sexual health clinic] would be a bit embarrassing in the school lots of people would be able to see you they'd be 'oh what's she going ..'
P2: Its in pastoral care as well but can you honestly imagine going to somebody and telling them all your inner secrets and then passing them in the corridor again. (Teenage Mothers 2, both female)

Advertising could be done through internet sites such as Facebook (though they were unsure if they would join a group about sexual health), on bus stops (though it was acknowledged these were often graffitied), on actual buses and by leaflets through the door. One group felt their GPs surgery was a good place to advertise though they had never seen any there. Posters and leaflets in schools and colleges and pop up messages on the college intranet would reach more young people. Local radio stations and newspapers like The Standard were also suggested. One group thought advertising would be more effective if it was designed by young people and suggested a competition to design a poster would work well as young people

yeah and the back of the shops as well that's where everyone hangs about, and near the park so all the lads that hang about are 'yeah what are you going in there for?' and then like then you just get rumours going around 'oh I seen blah blah going into the clinic the other day.' (Sheltered Accommodation, P1, female)

I prefer to find out on the internet then you don't have to speak to someone; no one knows you're doing it do they? (Teenage Mothers 2, P3, female)

'love prizes' and that all posters should be big, bright and colourful to get attention.

It was suggested adverts needed to explicitly state the service was free as there is often confusion about this and expected price can discourage young people, especially from accessing emergency hormonal contraception. Some participants believed if it was easier to find out where to get free emergency hormonal contraception, especially at weekend, more young people would use it. Participants thought it was important adverts stated services were confidential and that opening hours needed to be long.

… we all knew everything if not through people telling you through school, and, you know, people talk about these things don't they? And so as you go through High school you pick up different bits of knowledge about these things
(Youth Representatives, P1, male)

They don't encourage you there for a chat, they just say 'this is basically who we are, this is what we do, bye.'…'You shouldn't do this
(Teenage Mothers 1, P5, female)

Sex education

Generally the young people who took part in the focus groups had a very low opinion of the sex education they had received in school. It was very brief, only focused on pregnancy and condoms, was done too late, was boring and was delivered badly by teachers. Most young people had learnt about puberty and development in year six and seven and about sex in years eight and above. Most had found the classes very embarrassing, brief and had not learnt much more than they had picked up from their peers and the media.

[sex education in school is] too late when you're 16, most people are already pregnant by then. Or already caught Chlamydia.
(Teenage Mothers 1, P2, female)

The young people involved in the focus groups had very definite ideas about how to improve the sex education in schools. They believed education should be started earlier and there was a universal conclusion that it should be delivered in single sex groups as people are more embarrassed in mixed sex groups and often the boys are not mature enough to handle it. It was also suggested by all participants that education should be provided by an external educator as they thought teachers did not have the confidence, skills or knowledge to teach young people about sex and this meant the pupils were less likely to ask questions. An external educator was thought to be good as young people wouldn't be as embarrassed as they would not see them again, they were likely to be younger, there was no history and above all the teacher would be confident and comfortable answering questions. Young people wanted a broader range of topics covered, especially more about all methods of contraception as current lessons had concentrated too much on condoms and pregnancy not Long Acting Reversible Contraception (LARC) or sexually transmitted infections. They wanted more information on sexually transmitted infections and thought using graphic images of symptomatic sexually transmitted infections would be a good way to inform young people of the dangers of unprotected sex. One group suggested schools should show the Channel 4 show *The Sex Education Show* as it was very informative, entertaining and interesting. They also liked that there was a website accompanying the show as it answered any additional questions they would be too embarrassed to ask at school. They also wanted more up to date materials as videos they had seen were often very old fashioned, 'cheesey' and not relevant to their lives.

That's why I'm here [at a teenage mothers group] we didn't really have sex education…All we had was condoms we didn't get told about the pill or anything like that. Obviously we knew but like they didn't explain it.
(Teenage Mothers 2, P1, female)

[Sex education should be done by] someone you don't know because its less embarrassing and then you know they can really give you some advice but from a distance. Then you won't have to come back and look them in the eye the next day.
(Youth Representatives, P2, female)

When you're at a young age you're in this group circle of friends and you're the only one who hasn't lost their virginity and you're like 'what's it like?' and all your mates are like 'oh it hurts but its alright yeah' they're going to want to go out and do it.
(Sheltered Accommodation, P2, female)

A minority of young people thought sex education encouraged promiscuity but when this was suggested the majority of the rest of the groups argued that young people are going to have sex anyway so it is best if they are aware of the risks and knew how to protect themselves. Peer pressure was thought to be a stronger factor in encouraging young people to have sex earlier.

Another thing is the parents' involvement in a child's life. I think it's vital, I mean young people hate it when their parents talk that kind of stuff…But I think it definitely needs to happen cause if it's coming from your parents it has to be taken seriously … cause you trust your parents and you normally agree with what they think. (Youth Representatives, P5, male)

Parental involvement

Four of the six groups mentioned the importance of parental attitudes and involvement and how this impacted upon the behaviour of young people. Many of the participants mentioned they had received no information or support from their parents when they were growing up and they believed this had caused them to take more risks. On the other hand, some participants had very close relationships with their parents and were confident to talk to them about sexual health issues. They felt this encouraged them to be more safe. The participants who regretted they were not able to talk to their parents, especially their mums, wished that their parents had been more open and supportive. It was suggested that educating parents and encouraging them to talk to their children about such issues would help reduce sexual ill-health amongst their children and young people suggested an advertising campaign aimed at parents would help. A number of participants in both teenage mothers groups had been very scared to tell their parents, and grandparents, and some put off doing this till late into the pregnancy. Even in the groups that were not made up of teenage mothers general consensus was that having to tell your parents you were pregnant or had got someone pregnant was an extremely terrifying scenario.

Channel 4 goes really in depth with diseases men can get and diseases women can get and how like different shapes and sizes…I think that's what they should use inside this school. They should use the channel 4 sex education show. (Teenage Mothers 1, P4, female)

I think that was my mum's worst mistake…I think that's how it happened to me [became pregnant] because my mum would never, I didn't feel like open and free to speak to my mum. (Teenage Mothers 111, P5, female)

My mum used to say to me she used to let me have boyfriends in the house when I was younger from like the age of 15 16. She used to say to me 'if you're going to do it you'll do it wherever you're going to do it. There's an outside you'll do it there' (Teenage Mothers 1, P1, female)

when I lost my V it was like my mum just come at me like a bomb 'you're going to have an implant put in your arm' and I was like 'what's that?' 'you're this you're that, you're this you're that', naming me all the names under the sun. She never had the decency or time to sit me down and tell me about anything like that, nor in school. (Sheltered Accommodation, P1, female)

3.8 Findings from a sex and relationships education pilot in a Western Cheshire school

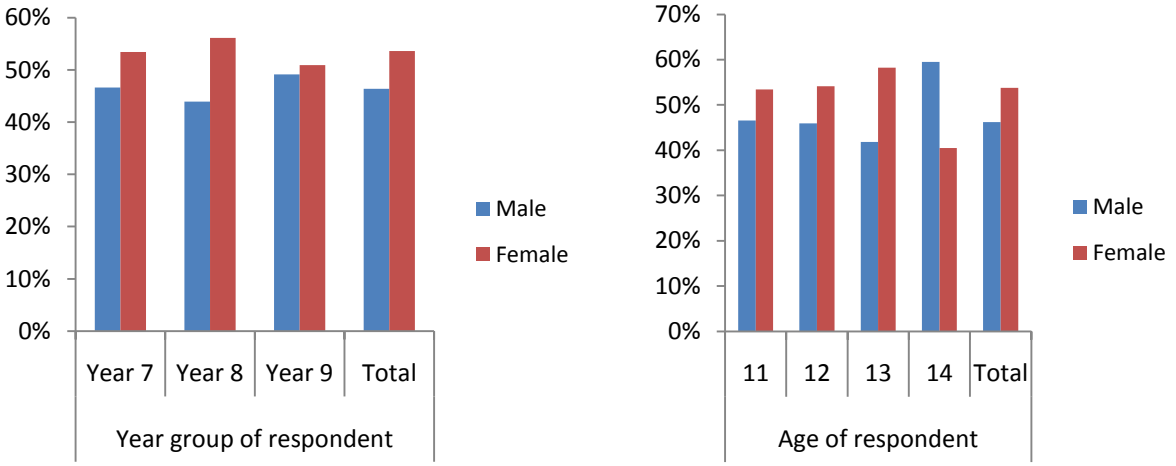
Evaluation of the Government Office North West piloting of a Sex and Relationships Education (SRE) took place in one school in Western Cheshire. Prior to SRE implementation, school children were surveyed to better understand their wellbeing, school life ethos, their relationships and attitudes and behaviours towards alcohol and sex.

Box 12 Key Findings from SRE in a school in Western Cheshire

- 390 young people aged 11-14 years attending a school participating in the North West sex and relationships education evaluation project completed a pre-intervention baseline survey questionnaire during school time.
- Trust, love, able to be yourself, and good friendship were identified as the most important features of a 'relationship'. 7% ranked safe sex as important.
- Young people get information from school, parents and youth workers; few stated friends, siblings, or their doctor. Older children (year 9) went to youth workers and less to parents. Young people would like to get more information predominantly from parents, girl/boyfriends, school, and magazines.
- Young people talk to parents about body changes and puberty, stress, relationships, and bullying. Girls report talking to parents more than boys but <5% talk about conception and twice as many boys as girls talk to parents about sexual activity A threefold higher proportion of girls talk to parents about pregnancy, suggesting talk about sex and contraception misses any discussion about sexually transmitted infection risks.
- At school young people learn about relationships, their body and puberty, sexual activity (particularly older children), sexual infections, and a number of self-esteem, and practical aspects about sexual relationships. 11-12 year olds had no education on sexual activity.
- In each year group young people wanted to know more about how to say no, older age groups wanted more information on condom use and how to prevent sexually transmitted infections, and about sexuality.
- 32% of females and 43% of males agreed they would be able to buy condoms, however nearly half of girls stated they would be able to ask a partner to use a condom.
- Over three quarters of girls and just over half of the boys thought they would be able to say no to sex or sexual actions that they did not want. Over 50% of boys and 43% of girls were not sure if they could access emergency contraception
- Double the proportion of girls (7.1%) recorded having intercourse compared with boys (3.7%), and 8.9% of girls and 5.6% of boys had had oral sex. Reasons for having a sexual relationship were predominantly being 'In love' for girls and to try it out for boys. 17% of girls, but no boys stated it was because they were drunk.
- Boys reasons for not yet having a sexual relationship were because they are too young and did not want to, but the main reason for girls was fear of pregnancy, followed by too young, followed by not wanting to/not having met the right person/not being ready. Girls cited parental disapproval and fearing pregnancy, but not fear of a sexual disease.

A total of 390 young people attending the SRE pilot school completed a pre-intervention baseline questionnaire during school time. The respondents came from years 7, 8 and 9 aged between 11-14 years with a mean age of 13.36 years (*SD* 9.81). The population was predominantly made up of females (54%), and those in year 8 aged 12 years (figure 68).

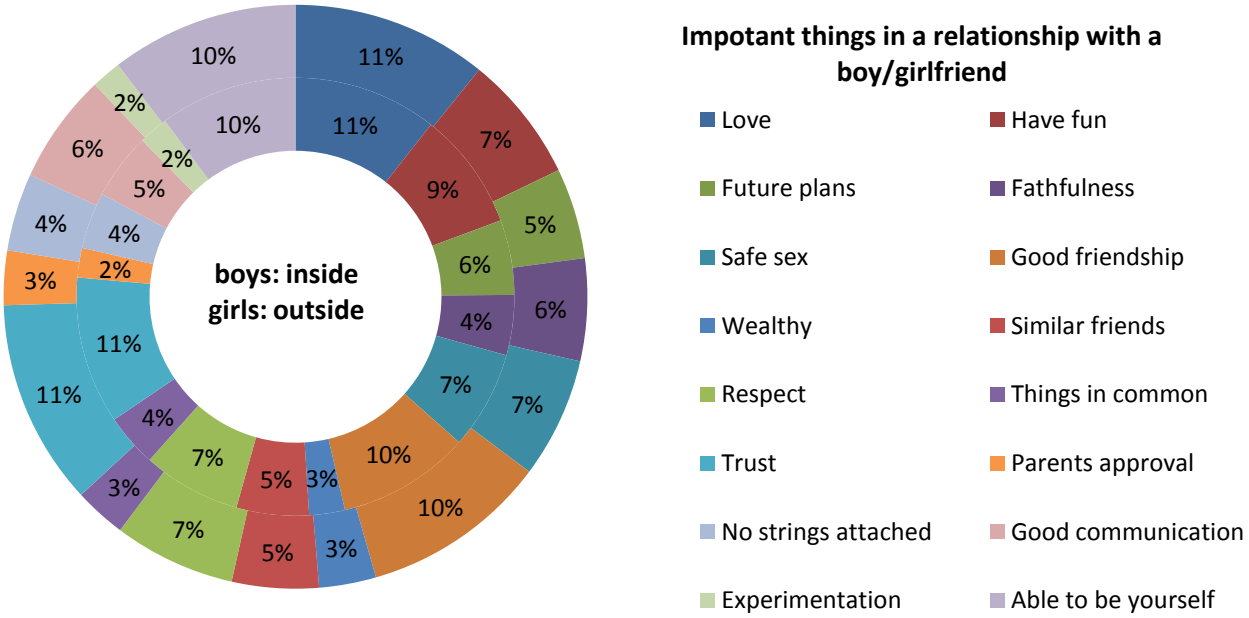
Figure 68 Demographics of the SRE population by gender, age and school year



Wellbeing and confidence

The majority of young people (80%) stated they have a happy home life. A significantly higher proportion of females (44%) wanted to change the way they look compared with males (23%; p<.001). Three-quarters have confidence in themselves with only 8% strongly disagreeing. The findings also suggest that the majority (~70%) of young people have someone at home they can talk openly to about problems. More young people (70%) could assert their views with friends, than with a boy/girlfriend (35%). Young people were asked what were the most important things about a relationship with a boy or girlfriend (figure 69).

Figure 69 What young people think about relationships?



Where do young teenagers get their information on sex and relationships from?

A number of questions were asked to identify where young people get their information from, and whether parents, school, as well as the media play a role in this. Young people predominantly get information from school, parents and youth workers; few stated they got information from friends, siblings, and local doctors. Older children (year 9) went to youth workers and less to parents (figure 70). They would like to get more information predominantly from parents, girl/boyfriends, school, and magazines (figure 71).

Figure 70 Where do you get your information from?

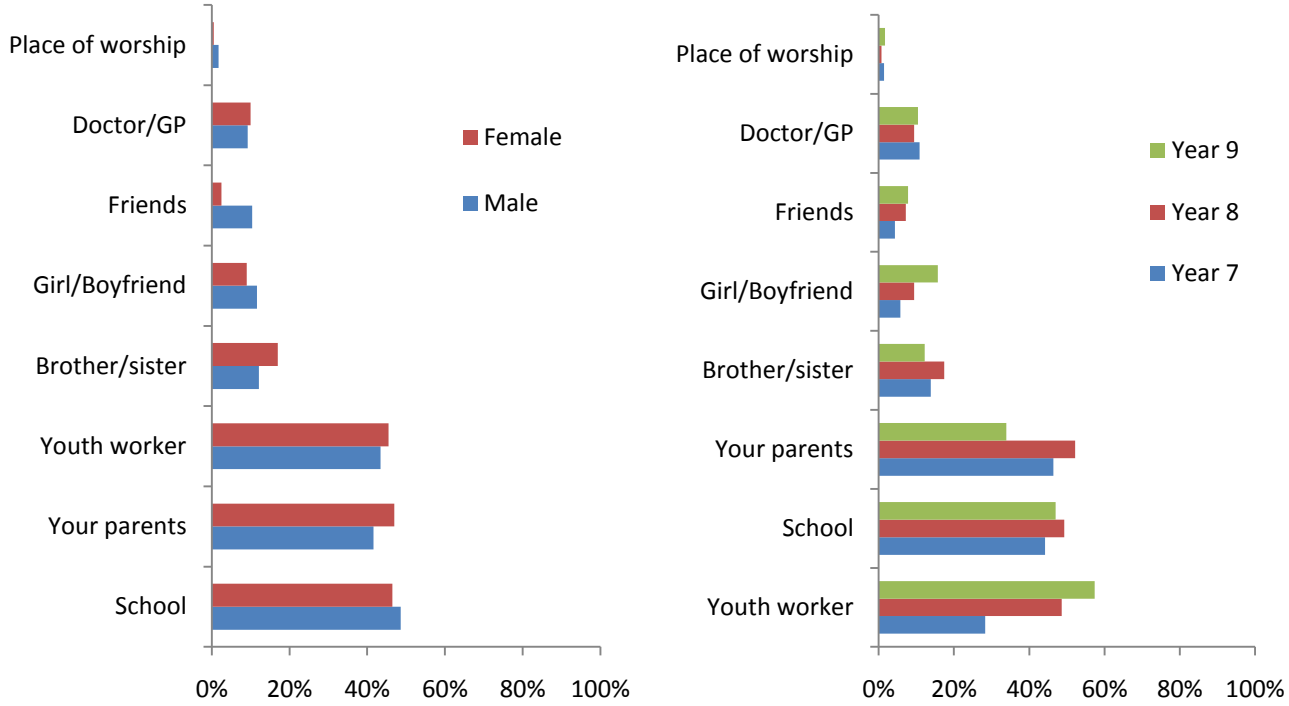


Figure 71 Where would you like to get more information from?

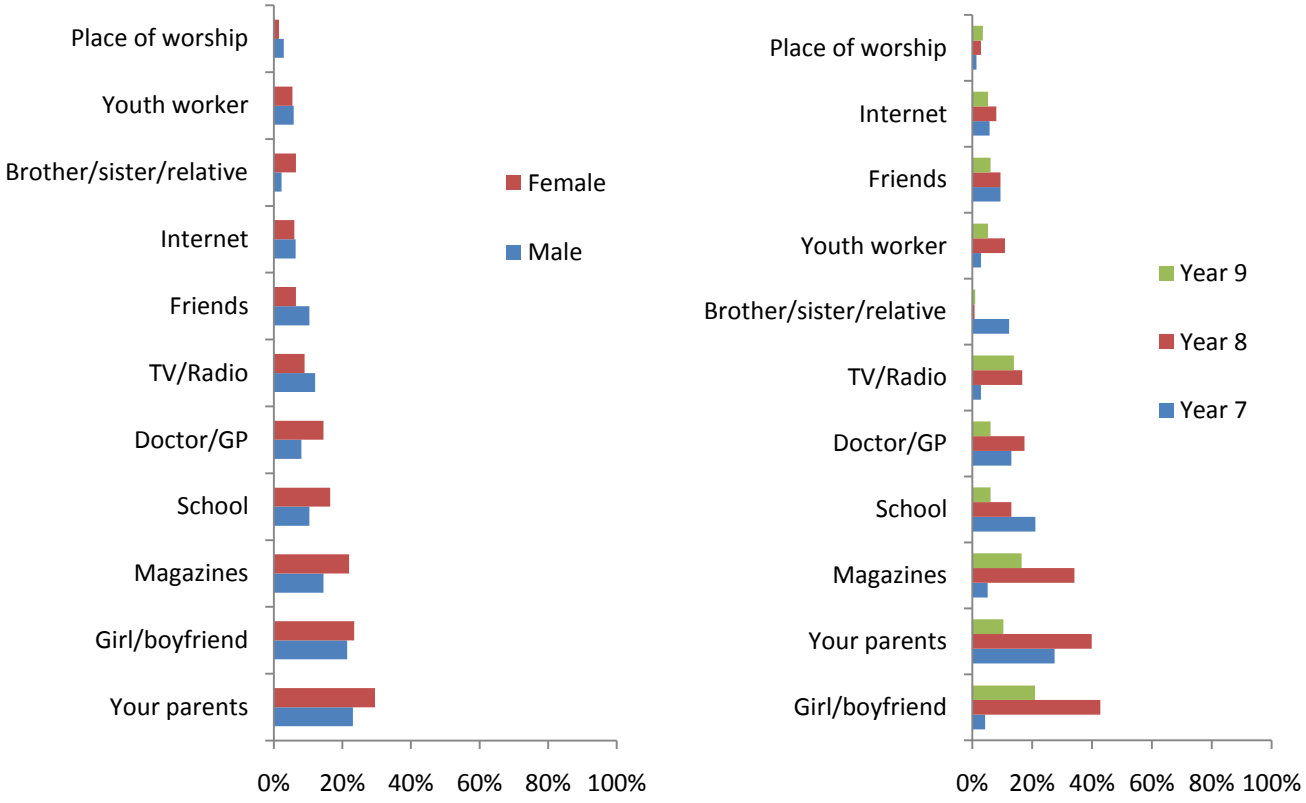
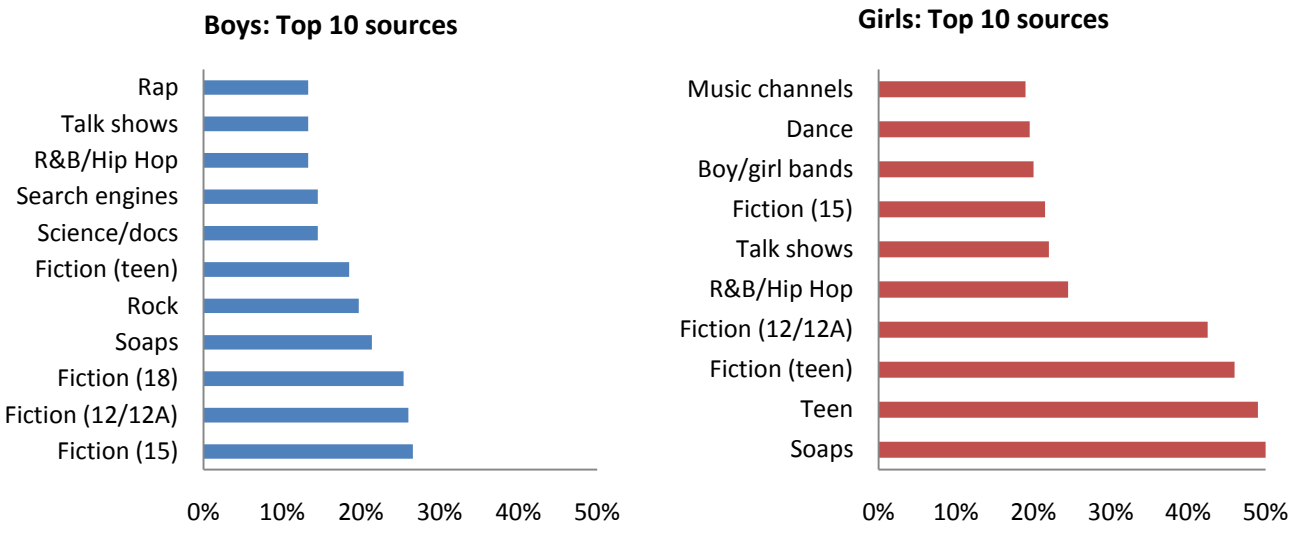


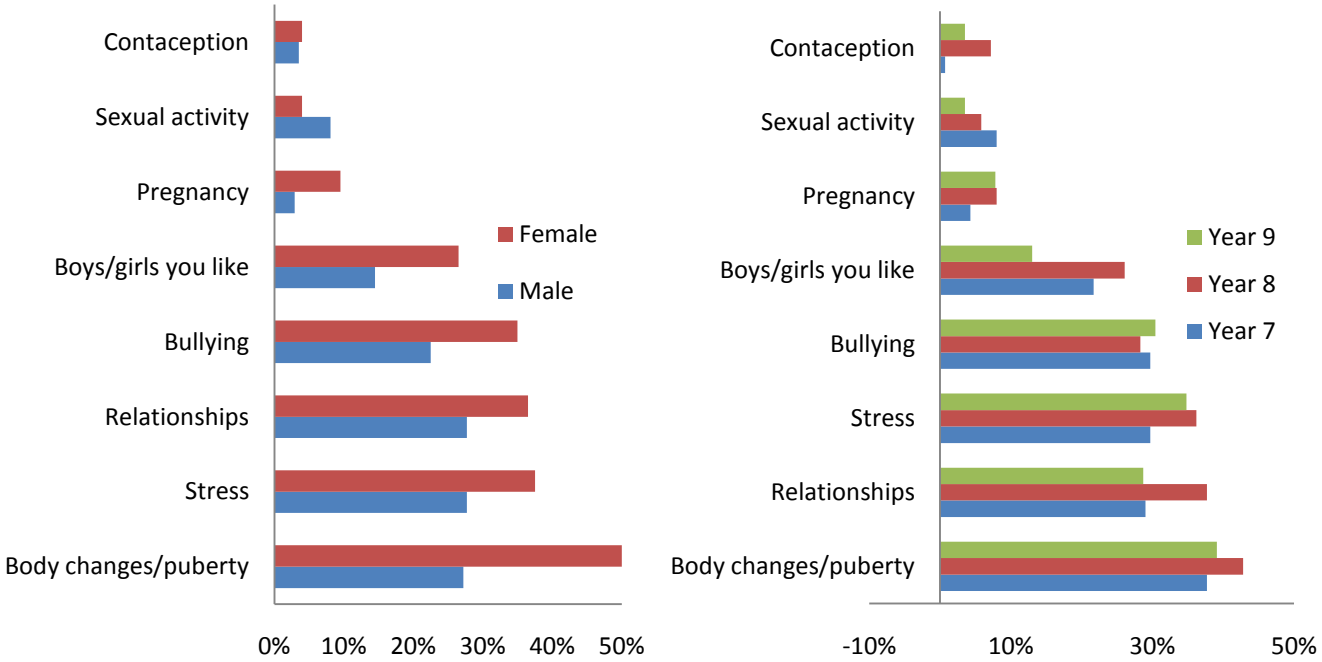
Figure 72 Sourcing information on sex and relationships from the media



Sourcing information on sex and relationships from parents and school

Young people talk to parents about body changes and puberty, stress and relationships, and bullying. Girls overall report talking to parents more than boys. A minority (<5%) talk about conception. The proportion who talk to parents about sexual activity is very low, however, proportionately twice as many boys as girls do this. A threefold higher proportion of girls talk to their parents about pregnancy, suggesting any talk about sex and contraception misses any discussion about sexually transmitted infection risks. Small differences occur by age (figure 73).

Figure 73 What issues do you talk about with your parents by age and gender?



At school young people learn about relationships, their body and puberty, sexual activity (particularly older children), sexual infections, and a number of self-esteem, and practical elements relating to sexual relationships (figure 74). Eleven and twelve year olds had no school-based education on sexual activity.

Figure 74 What have young people learnt about sex and relationships at school?

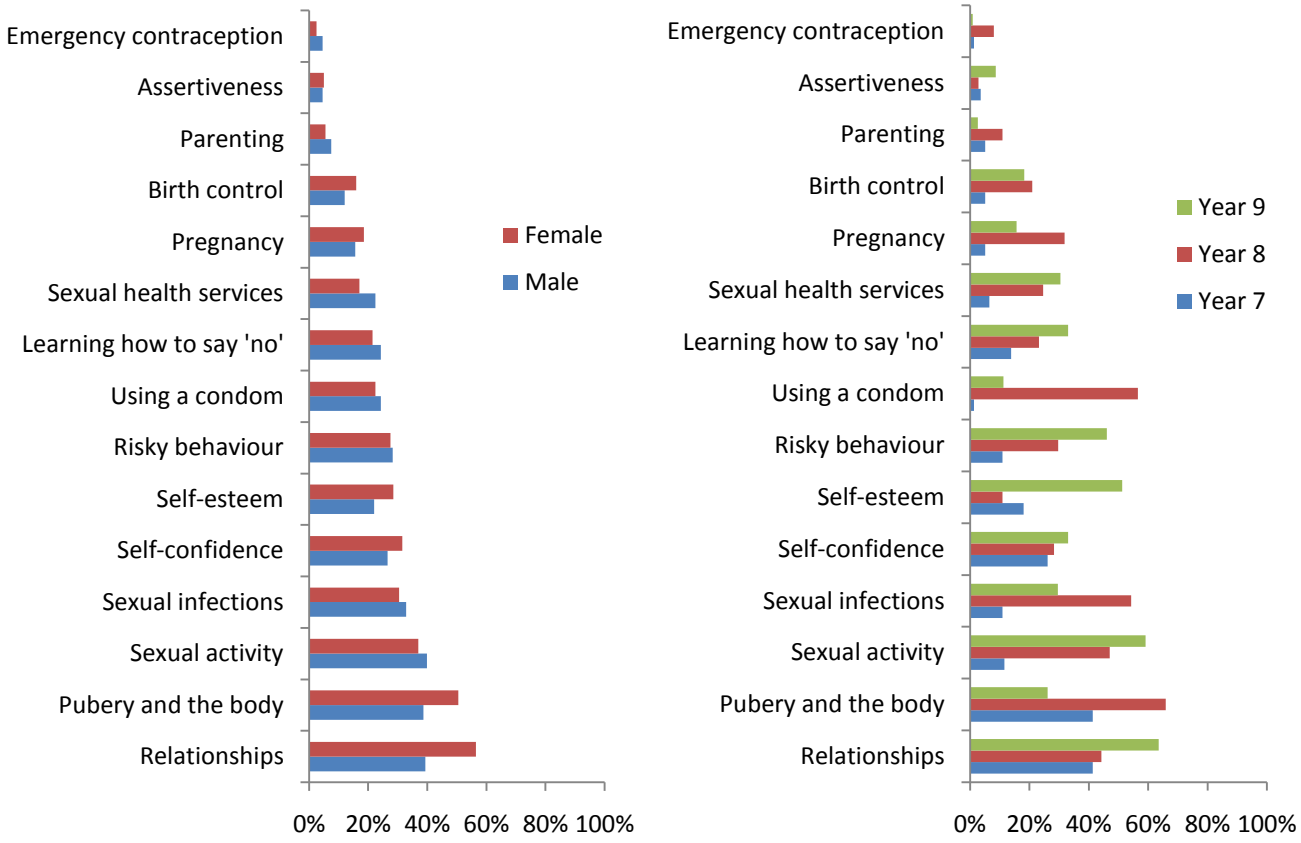
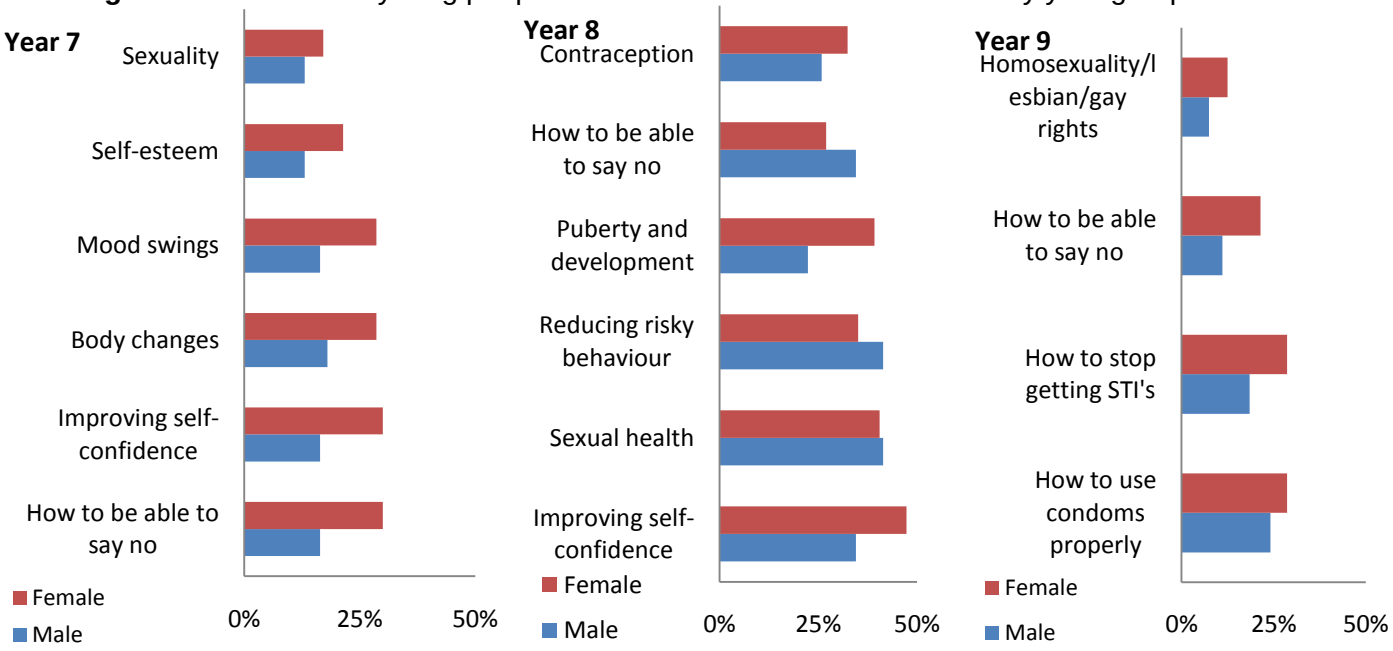


Figure 75 What would young people at school like to know more about by year group?



In each year group young people wanted to know more about how to say no, older age groups wanted more information on condom use and how to prevent sexually transmitted infections, and about sexuality. We asked young teenagers in Year 9 (13-14 year olds) questions about their sexual confidence (figure 75). A third of females and 43% of males agreed they would be able to buy condoms, but half of girls stated they would be able to ask a partner to use a condom (figure 76). Three quarters of girls and half of the boys thought they could say no to sex or sexual actions

that they did not want. Over 50% of boys and 43% of girls were not sure if they could access emergency contraception (figure 77).

Figure 76 Young people's attitudes about condoms

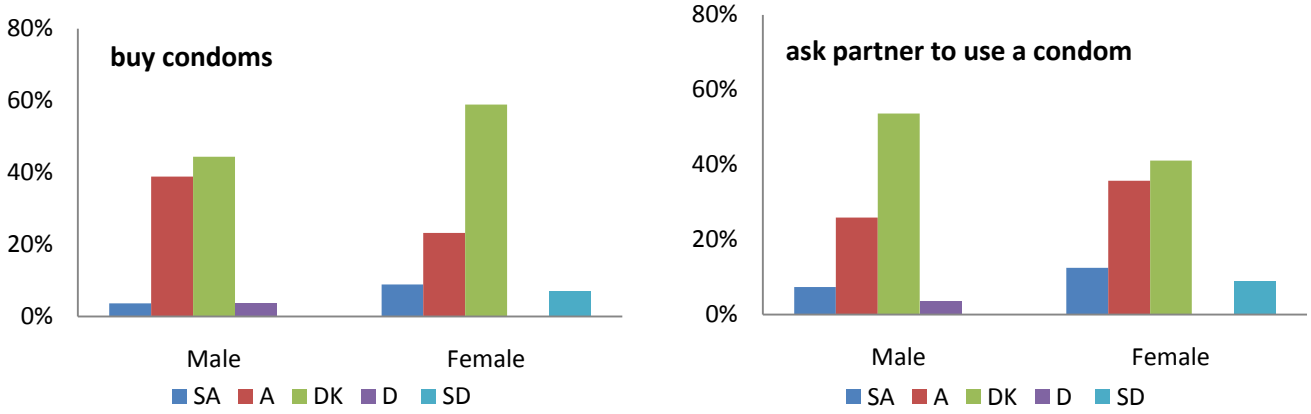
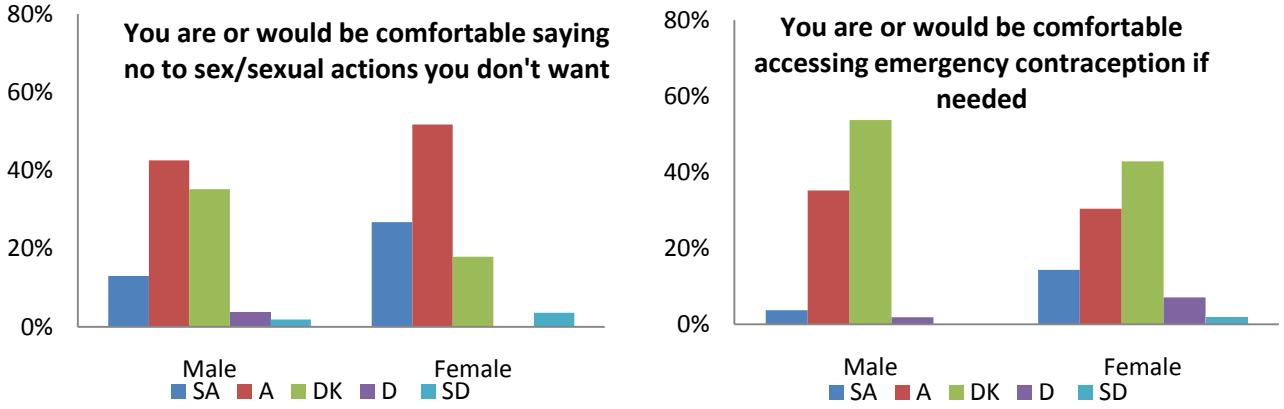


Figure 77 Young people's attitudes about saying no to sex and about emergency contraception



Sexual relationships in Year 9 students

Year 9 students were asked if they had already had a sexual relationship; and if so what type. Figure 78 illustrates that double the proportion of girls (7.1%) recorded having sexual intercourse compared with boys (3.7%). Further, more girls than boys also recorded having had oral sex (8.9%, compared with 5.6%). A much higher proportion of girls also reported being engaged with deep kissing, while a slightly higher proportion of boys reported petting.

Figure 78 Year 9 students sexual relationships

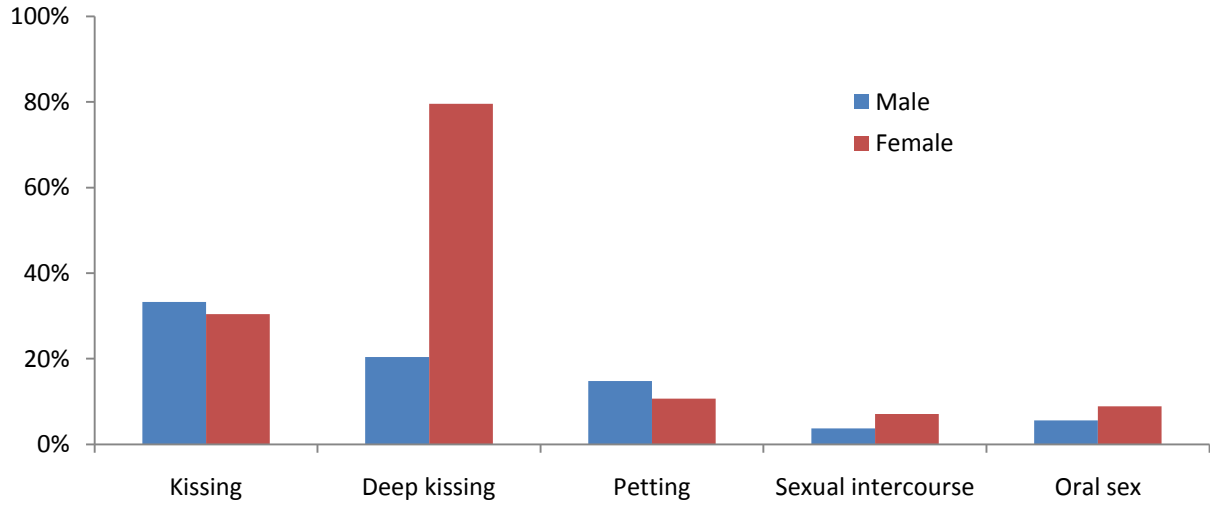
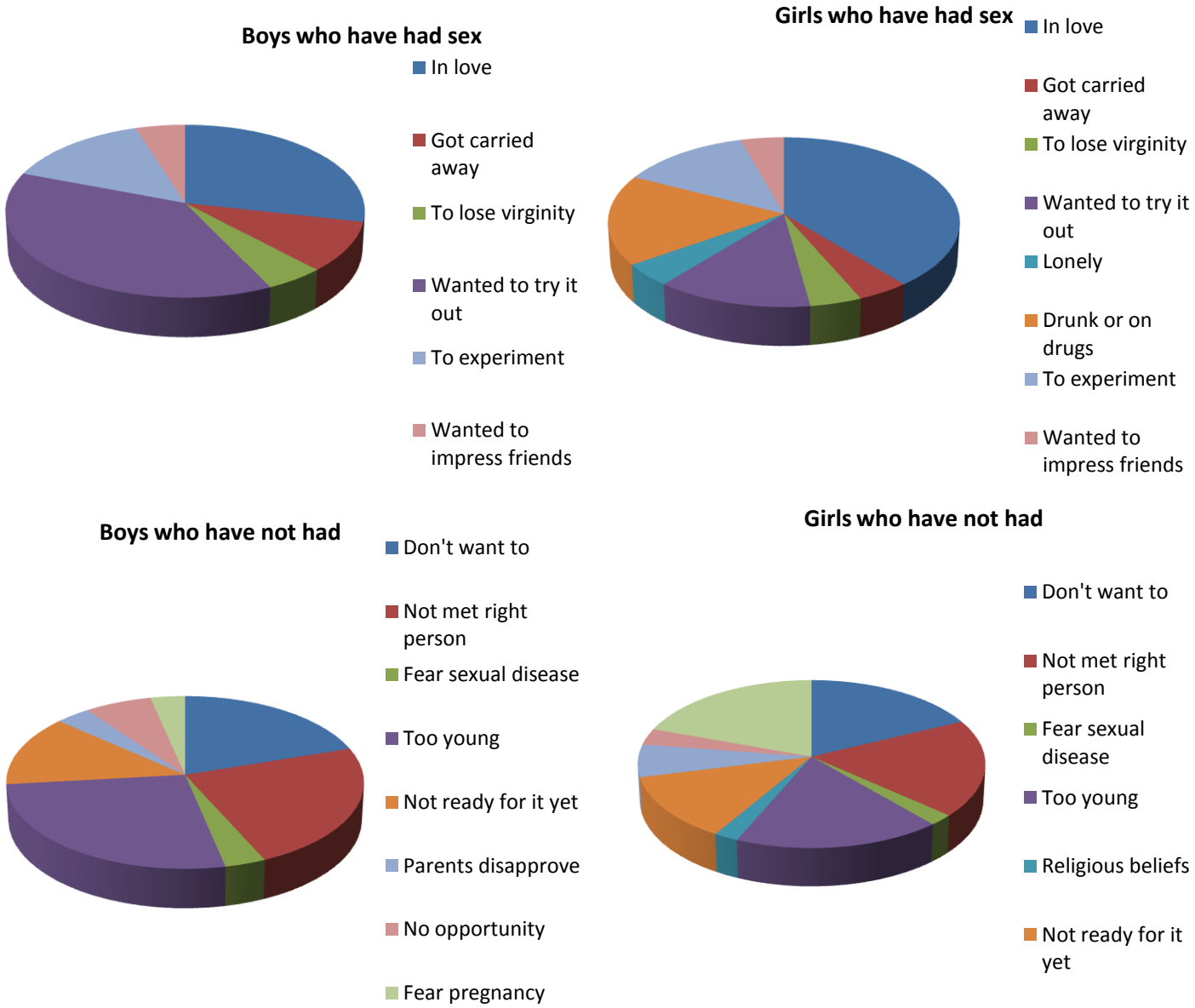


Figure 79 Year 9 students sexual relationships by gender



The main reason boys had sex among 13-14 year olds (year 9 group only) was to try it out (38%), and because they were in love (28%). For girls, 39% were in love, and 13% wanted to try it out. Importantly, 17% of girls, and no reported boys indicated they were drunk/on drugs at the time. In both groups 1:8 wanted to experiment. Reasons given for not having sex among girls and boys differed. For girls the main reason they gave was fear of pregnancy, with other considerations such as too young, not ready, not met the right person, and less frequently recorded. For boys, the main reason mentioned for not having sex was too young, with fear of pregnancy very rare (3%), (figure 79).

3.9 Comparative Teenage Pregnancy rates in western Cheshire and neighbours

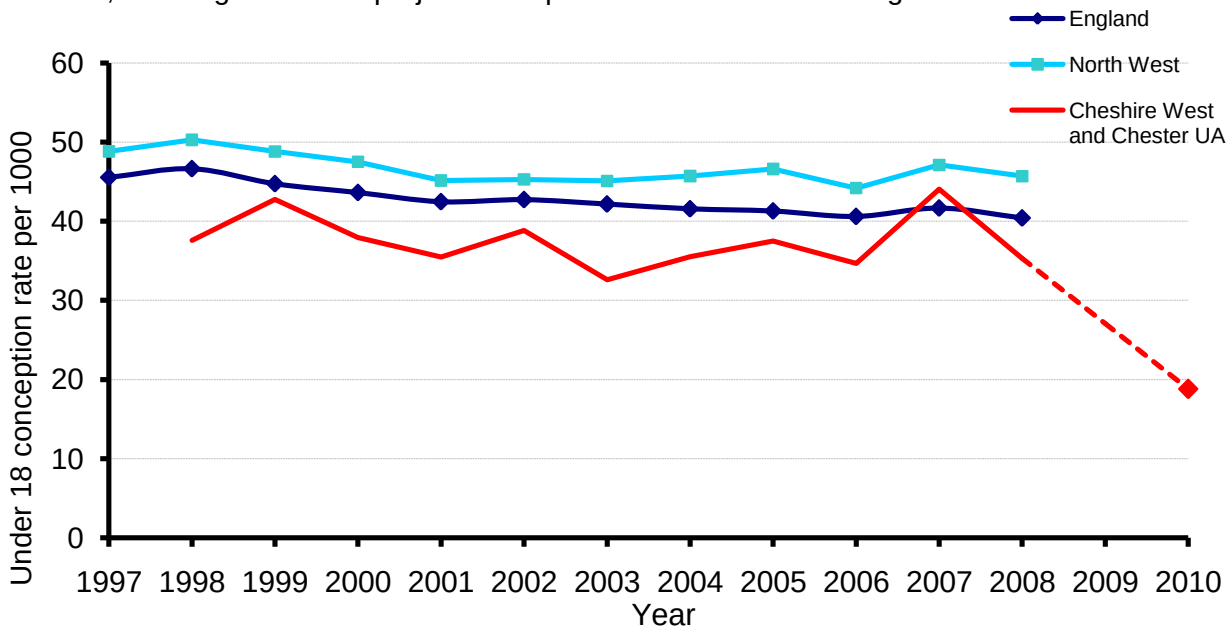
Box 13 Key Findings within Teenage Pregnancy Rates

- The under 18 conception rate remained relatively stable until 2007 when, in line with a national trend, the rate sharply increased (39.3 per 1,000 females aged 15-17). This figure is higher than that of the baseline and represents a considerable challenge to reduce and ultimately meet the 2010 target.
- 2008 data showed a reduction compared to 2007 and the rate now stands at 6.1% lower than 1998 baseline.
- Compared to Cheshire West and Chester's statistical neighbours (Stockport Warwickshire, Warrington, and Cheshire East), Cheshire West and Chester has had lower progress in reducing its under 18 conceptions target.
- Although Cheshire West and Chester has a low level of deprivation, the under 18 conception rate is slightly higher than nationally predicted or expected. It is noted that the majority of Cheshire West and Chester's statistical neighbours have rates below the predicted rates.
- In the first half of 2008 Western Cheshire reduced the rate of abortion to well below the North West average.
- Compared to national and regional rates, Cheshire has a lower rate of conceptions to 16-17 year olds, and also a lower rate of conceptions to under 16s.

In the United Kingdom, the likelihood of teenage pregnancy is related to a number of factors: teenage pregnancy is more likely to occur in deprived neighbourhoods, it is higher amongst those with lower educational attainment (even after accounting for deprivation) and in those who are or have been looked after. Teenage pregnancy is more common in young girls who have experienced mental health problems, sexual abuse in childhood, sex before the age of 16, violence and bullying at school, poor parental support, involvement in crime, use of alcohol and substance misuse and in those who have low aspirations and a lack of things to do[78]. The likelihood of teenage motherhood is higher among young women who are daughters of a teenage mother or who are of White British, mixed white and Black Caribbean, other black, and black Caribbean ethnicity[78]. Young fathers are more likely to live in deprived areas, be unemployed and in receipt of benefits and have similar characteristics as teenage mothers[78].

There has been a national target to reduce teenage conceptions by 50% amongst girls aged under 18 by 2010. Figure 80 shows the trend of teenage pregnancy rates from 1997 to 2008 for Cheshire West and Chester. The teenage pregnancy rate (37.8 per 1,000 females aged 15-17) in 1998 was reduced over the next three years, but there was a slight increase in 2002 (33.5 per 1,000 females aged 15-17). The rate remained relatively stable until 2007 when, in line with a national trend, the rate sharply increased (39.3 per 1,000 females aged 15-17). Data from 2008 shows a reduction from 2007 and brings the rate in line with rates from previous years. The 2008 rate is 6.1% lower than the baseline and is some way short of the 50% reduction target.

Figure 80 Teenage pregnancy trends in Western Cheshire, England, and the North West, 1997-2008, showing the line of projection required to meet the 2010 target



Statistical neighbours analysis provides a tool to benchmark progress of the *Every Child Matters* aims. For each local authority, the statistical neighbours model designates a number of other local authorities deemed to have similar characteristics, taking into account a large number of variables from sources including the 2001 census, the Driver and Vehicle Licensing Agency, Department for Education and Skills and the Annual Survey of Hours and Earnings. These include variables concerning the proportion of children living in a variety of different households (for example, overcrowded households, households where there is one adult and households where the main earner is in different types of occupation) and the proportion eligible for free school meals. Mean weekly pay is taken into account as well as the percentage of people in the household from different black and minority ethnic backgrounds, variables on qualifications, health, housing tenure, and whether the household is in a rural area[79]. For Cheshire West and Chester's statistical neighbours[Ω] (Stockport, Warwickshire, Warrington, and Cheshire East), Cheshire West and Chester has made less progress in reducing its under 18 conceptions target with a 6.1% decrease (see Table 15). Figure 81 shows Cheshire West and Chester's progress towards the target since 1998 when compared to its statistical neighbours.

[Ω] To produce statistical neighbours it is necessary to calculate an overall measure of difference between each pair of local authorities. To ensure consistency with previous statistical neighbour models (for example, those devised by Ofsted or the Institute of Public Finance comparator councils) a weighted Euclidean distance measure was used. The weighted Euclidean distance between two LAs is the square root of weighted average squared difference between the local authorities across all variables. Variables are weighted to emphasise the extent to which increased differences between local authorities (in terms of these background variables) is associated with increased differences in performance. This means that background variables that have a close association with performance measures are given more importance in the statistical neighbour model than variables that are more weakly associated with outcomes.

Table 15 Under 18 conception rates by Department for Education and Skills statistical neighbours

LA	Deprivation score	Under-18 conception rate 1998	Under-18 conception rate 2008	% difference 1998-2008
Cheshire West and Chester	14.9	37.8	35.3	**-6.1%**
Warwickshire	14.6	41.4	36.9	**-10.8%**
Warrington	17.9	48.8	32.9	**-32.5%**
Stockport	18.1	43.2	36.1	**-16.5%**
Cheshire East	14.9	37.9	34.5	**-9.1%**

Figure 81 Under 18 conception rates by Department for Education and Skills statistical neighbours, 1997-2008

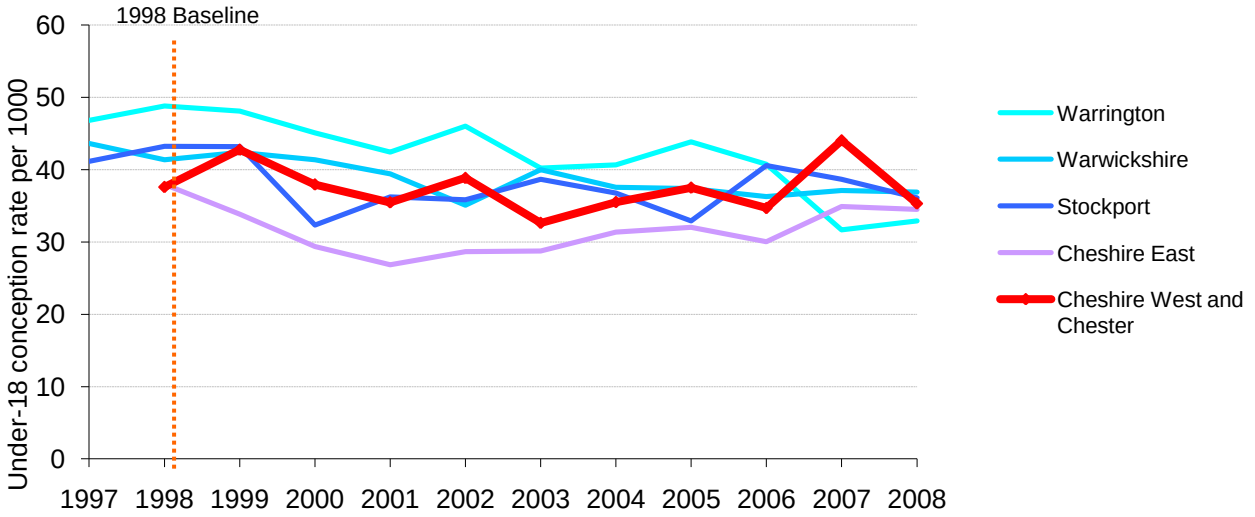


Figure 82 depicts the strong association between level of deprivation and conception rates in under 18s. The figure shows all local authorities across England, with Cheshire West and Chester highlighted (red diamond data point). It shows that although Cheshire has a low level of deprivation (IMD = 14.9) the under 18 conception rate is slightly higher than nationally predicted or expected. It is noted that the majority of Cheshire West and Chester's statistical neighbours (pink diamonds) have rates below the predicted rates.

Figure 82 Deprivation score and under 18 conception rate for 2006-2008 by local authority

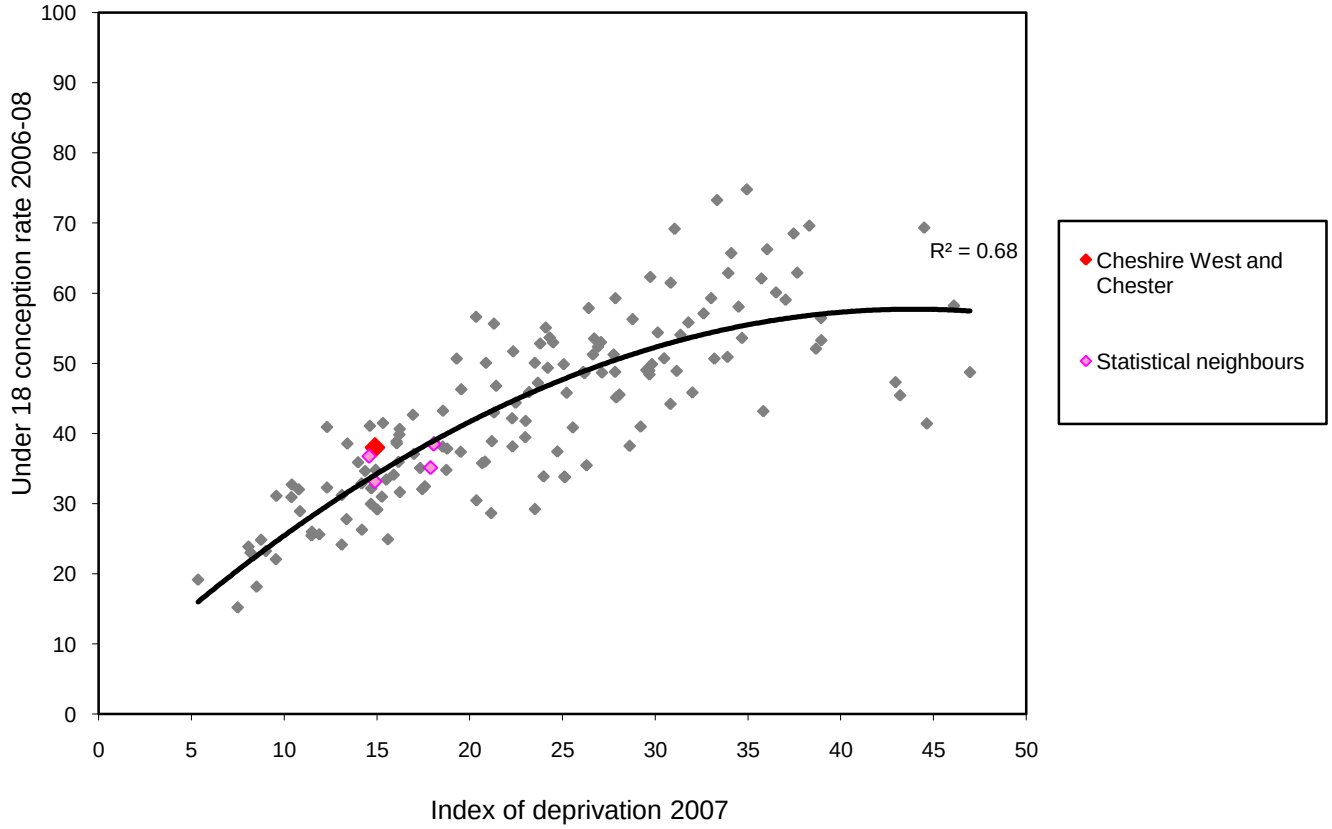


Figure 83 Outcome of under 18 conceptions 1997-1999 and 2006-2008

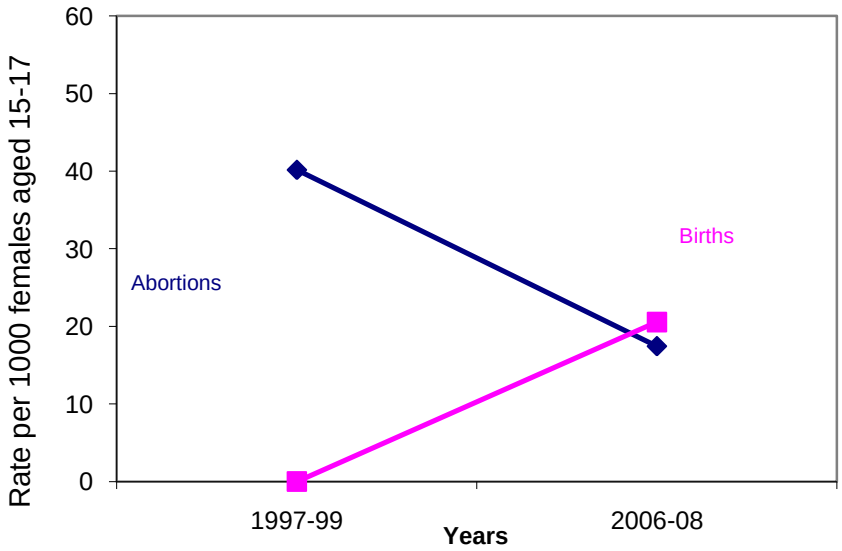


Figure 83 shows the change in outcomes of under 18 conceptions from 1997-99 until 2006-08 in Cheshire West and Chester. Interpretation of this data is difficult as no data is available for birth rates from 1997-99. The significant reduction in rates of abortion is different from that seen in other PCT in the North West region and is different from the national trend.

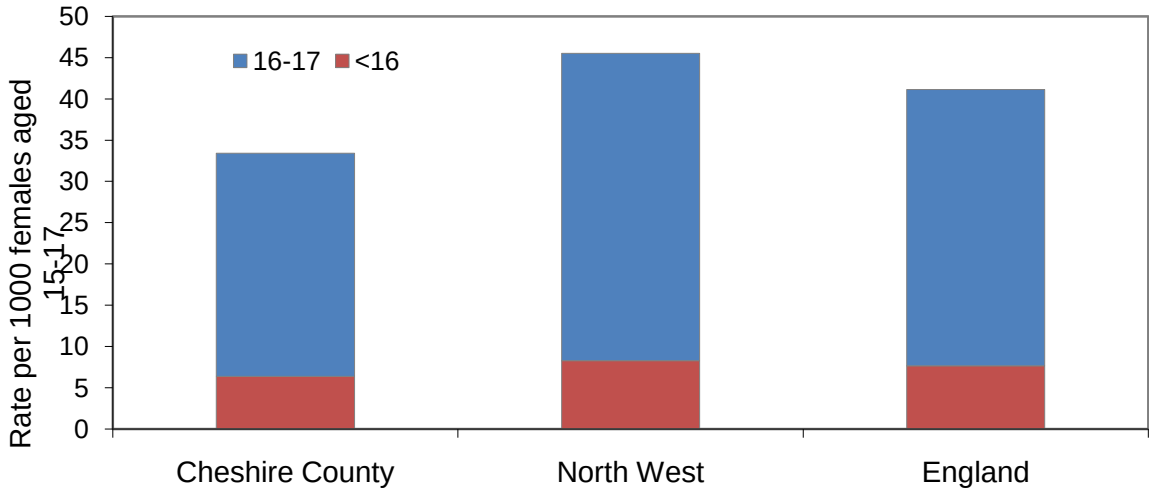
Table 16 Abortion rates by quarter for women under 18, 2007 and January - June 2008

	Q1 2007	Q2 2007	Q3 2007	Q4 2007	Q1 2008	Q2 2008
NHS Western Cheshire	4.16	6.47	6.47	5.78	4.61	4.84
North West SHA	5.98	5.24	5.55	5.16	5.65	5.39

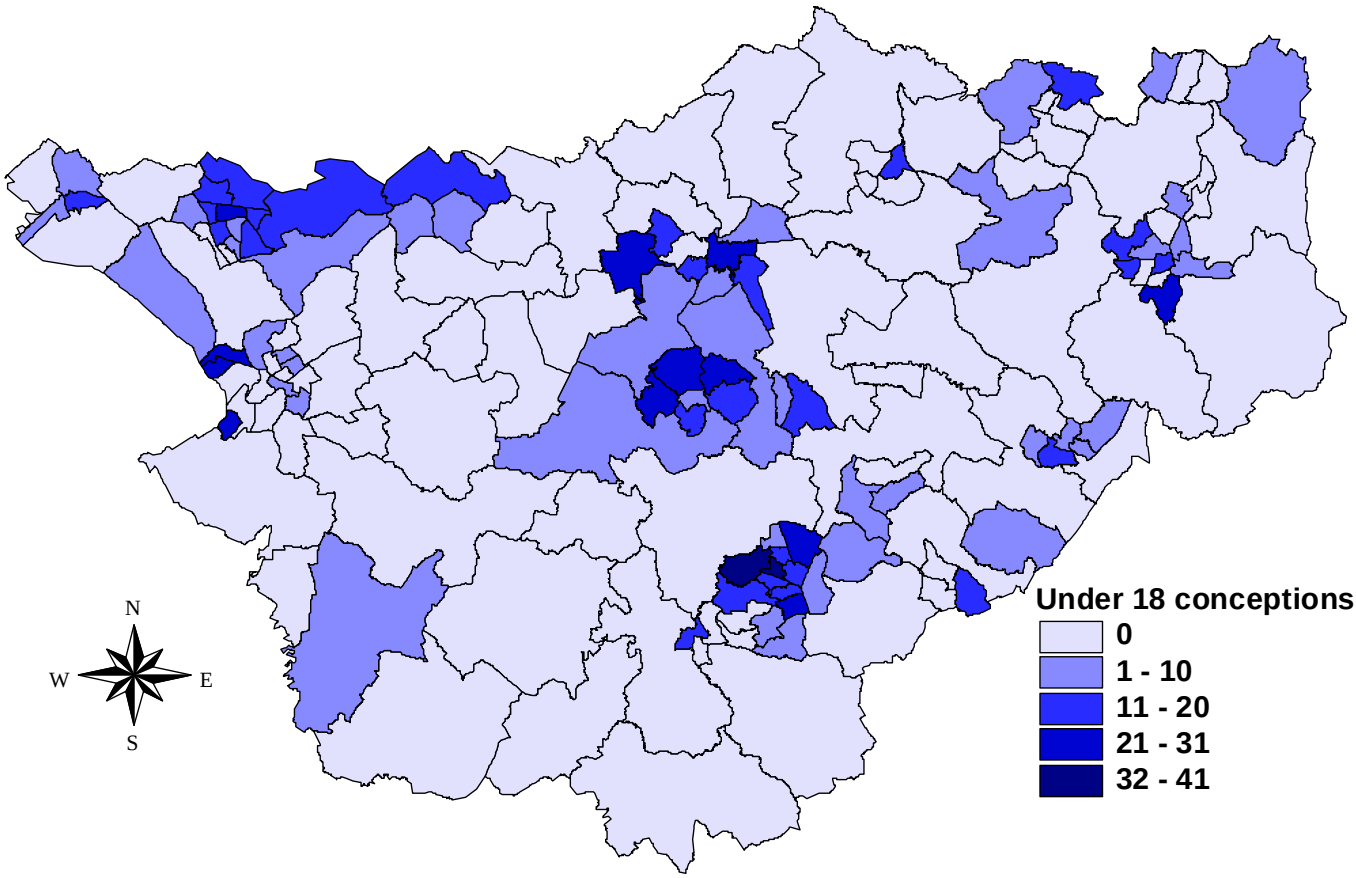
Table 16 shows the rate of abortions for females aged under 18. The data show that in the first half of 2008 Western Cheshire reduced the rate to well below the North West average. This signifies a sharp reduction from the final three quarters of 2007 where the rate was well above the North West average.

Figure 84 shows the under 18 conception rate when split by age group. The figure also allows for comparison of Cheshire with the wider North West region and at a national level. Compared to national and regional rates, Cheshire has a lower rate of conceptions to 16-17 year olds, and also a lower rate of conceptions to under 16s.

Figure 84 Under 18 conceptions by age group, comparison between Cheshire, the North West, and England



Map 7 Number of Under 18 conceptions by ward for Cheshire County



Waiting Times

Figure 85 Percentage of patients offered appointment within 48 hours of contacting GUM

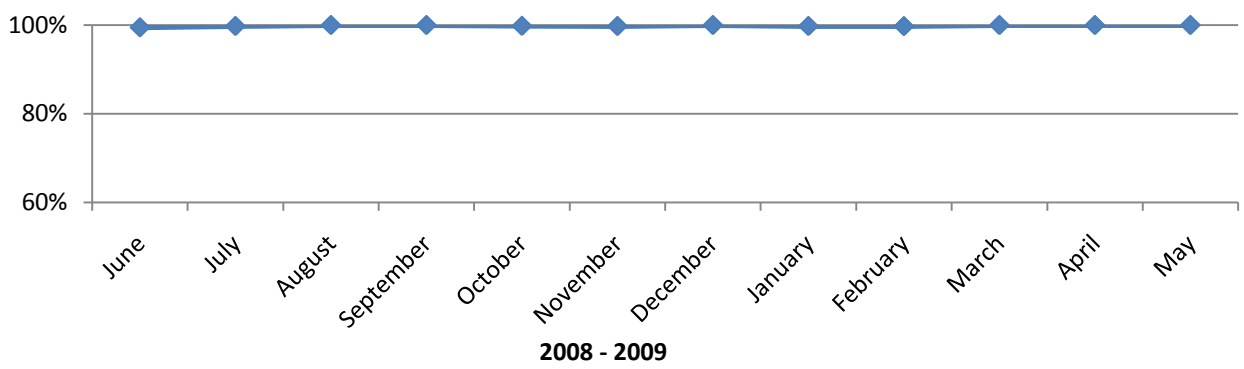
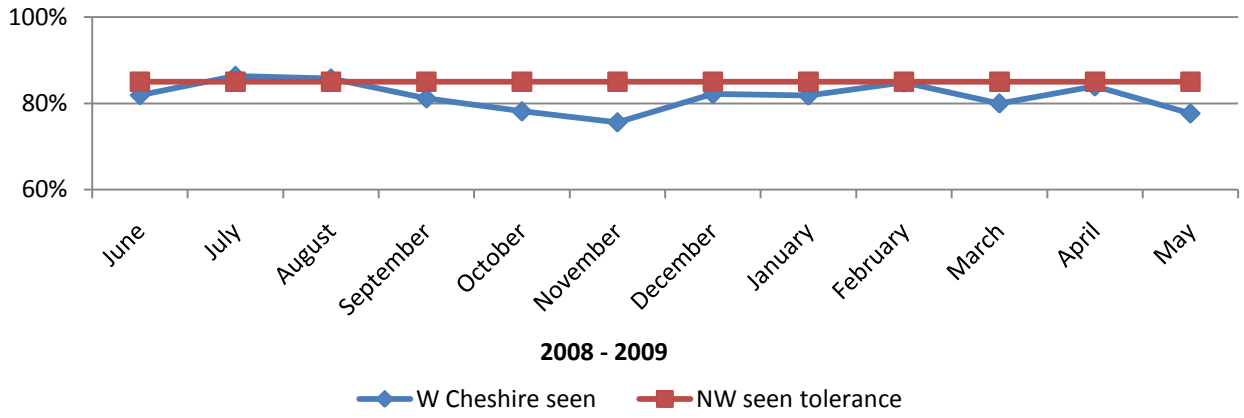


Figure 86 Percentage of patients seen within 2 working days of contacting GUM (of first attendances)



The above figures, 85 and 86, showing the results of the waiting time audit reveal mixed results. Services are currently meeting the target of offering an appointment to all patients within 48 hours. However, services are falling below the North West tolerance level of 85% of patients who are actually seen within 2 working days. This figure does fluctuate but regularly fails to reach the acceptable 85% level.

3.10 Service Mapping

Box 14 Key findings of Service Mapping

- Services are generally located in the most populous areas.
- In the Neston area, community and sexual health services are available for two and a half hours a week. Emergency contraception is available on six days. There is no young persons' service.
- In the Ellesmere Port area, emergency contraception is available seven days. Young people centres are available on Monday, Tuesday, and Wednesday. However they are only open during school/college hours during Mondays and Wednesdays.
- In the Frodsham area, emergency contraception is available six days. There are no community and sexual health services or young people services.
- In Chester, a wide variety of services are available over seven days. This includes the PCT's only genitourinary medicine department and termination of pregnancy service.
- In the area of Malpas, a service for young people operates for two hours a week. There are no pharmacies offering free emergency contraception in this area.
- In the area around Audlem, there are no services specifically for young people. Emergency contraception is available six days a week.

The following figures (maps 8-11) show different services mapped with the Index of Multiple Deprivation (IMD) score for Western Cheshire. Map 8 shows all sexual health service (not including GPs) locations throughout the PCT. Most services are located in the heavily populated areas of Chester and Ellesmere Port. Map 9 shows the location of community and sexual health services mapped with IMD score. These services are all in the north of the PCT, specifically in Chester, Ellesmere Port, and Neston. There are other areas of high deprivation which do not currently have any community and sexual health services locally. Map 10 shows pharmacies that offer free emergency hormonal contraception mapped with IMD score. These are distributed throughout the PCT region and, as expected, are more numerous in the populous areas. Map 11 shows the services for young people mapped with IMD. These services are generally located in the north of the PCT, but with a service in Malpas being the exception.
The following section focuses further on each area. The services available in that specific area can be seen in relation to transport links and other services.

The following maps focus on small areas of the PCT and show each sexual health service in the area.

Map 12 - gives an overview of all services in Western Cheshire

Map 13 – Neston

Map 14 – Ellesmere Port

Map 15 – Frodsham and Helsby

Map 16 – Chester

Map 17 – Villages in the east of the PCT

Map 18 – Malpas

Map 19 – Audlem

Maps 12-19 show each sexual health service across NHS Western Cheshire in detail. Map 12 gives an overview of the PCT area. The black boxes indicate the areas which have been examined in greater detail (in Maps 13-19) to provide a more in depth view of the services.
The maps of a smaller geographic area allow for viewing the services in relation to populous areas and transport links. All major roads and train lines are indicated on the map. The reason for the breakdown is that it is imperative that a variety of services are available in the local areas of all the most heavily populated areas. The areas have been chosen to indicate what we deemed as a reasonable distance to travel to services, with particular regard to young people.

Map 12 shows the different types of sexual health services mapped onto ordnance survey maps. The subsequent maps focus on smaller geographical areas within the PCT.

Map 13 shows the three services available in Neston. There is one GP service that offers an enhanced service, a community and sexual health services, and one pharmacy that offers free emergency contraception. The community and sexual health services is currently open for two and a half hours on a Wednesday evening, but there is no other provision for local residents outside this time. The pharmacy is open six days a week (not Sunday) and offers reasonable access to emergency contraception. All three services are central within Neston.

Map 14 shows services available in Ellesmere Port, which is the second most densely populated area within the PCT. A variety of sexual health services are available in this area including: five GPs offering enhanced services, two community and sexual health services, and four young people's centres and nine pharmacies offering emergency contraception. There is seven day availability of emergency contraception as the pharmacies offer comprehensive opening hours. Young people centres are available on Monday, Tuesday, and Wednesday. However they are only open during school/college hours during Mondays and Wednesdays. There is availability after school/college on a Tuesday between 4pm – 6pm. CASH are available for four hours over two days during the week. The services are distributed throughout the area and many are accessible from train stations.

Map 15 includes sexual health services in Frodsham. There are only two types of sexual health services available in this area, pharmacies offering free emergency contraception and GPs offering enhanced services. Pharmacy services are available six days a week (excluding Sunday) until 6.30pm but not available between 1-2pm.

Map 16 shows all sexual health services available in Chester and the immediate surrounding area. As Chester is the most populous area in the PCT it is to be expected that a large number of services can be found here. A wide variety of sexual health services are located in the city, including: GPs offering enhanced services, pharmacies offering free emergency contraception, genitourinary medicine department at the Countess of Chester hospital, termination of pregnancy, community and sexual health services, and young people centres.

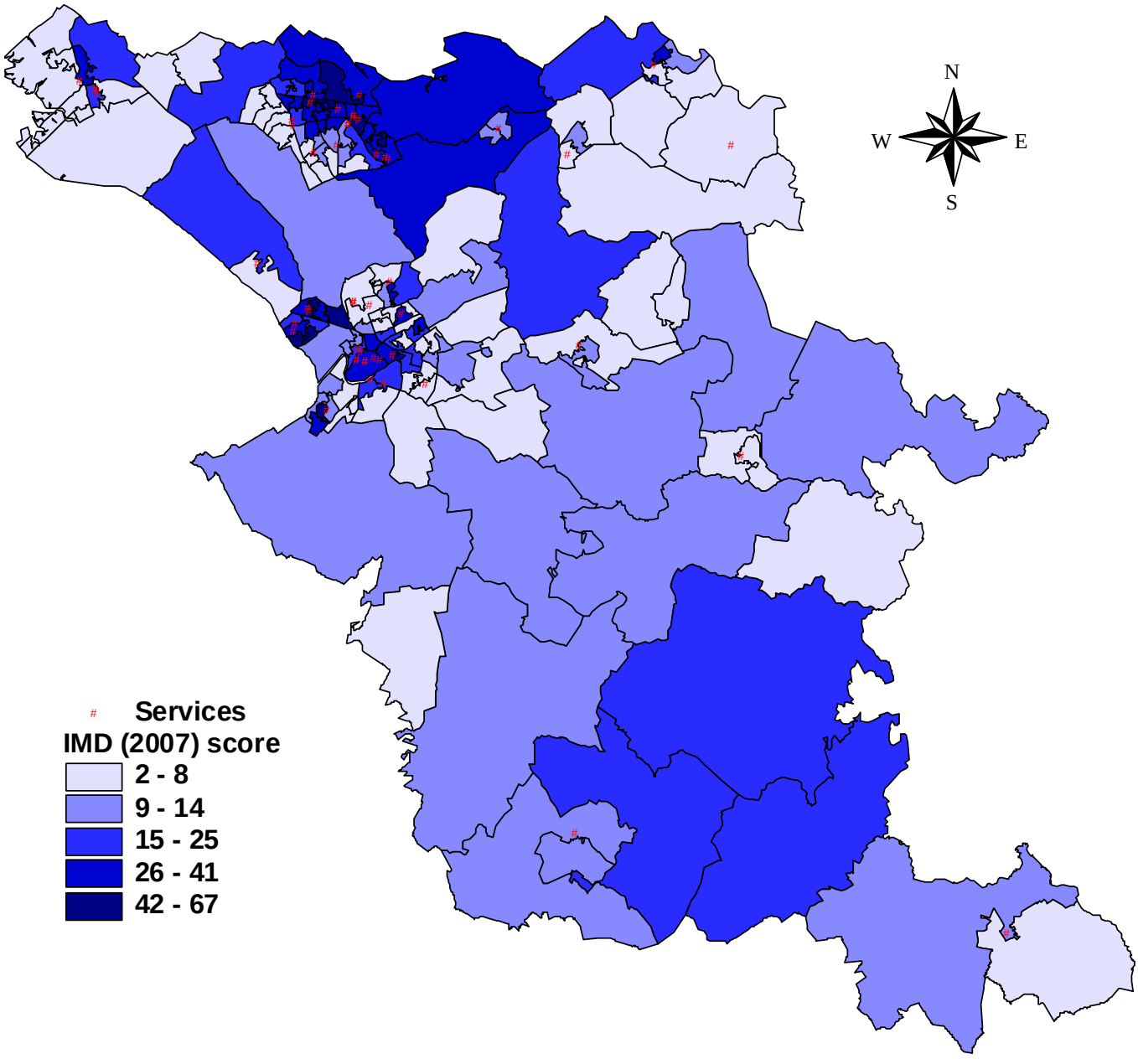
Map 17 shows the services available in the villages located in the east of the PCT. There are only two sexual health service types in this area, GPs offering enhanced services and pharmacies offering free emergency contraception. The pharmacy is open six days a week (excluding Sunday). The public transport links in the part of the PCT are limited as the area is relatively rural. This does the population of this area lacking on specific sexual health services.

Map 18 shows the services in the south western part of the PCT, including Malpas. There are two services in this area, a GP offering enhanced services and a service for young people. The service for young people opens on a Thursday between the hours of 12pm-2pm. No other sexual health provision is available in the area, including no pharmacies offering free emergency contraception.

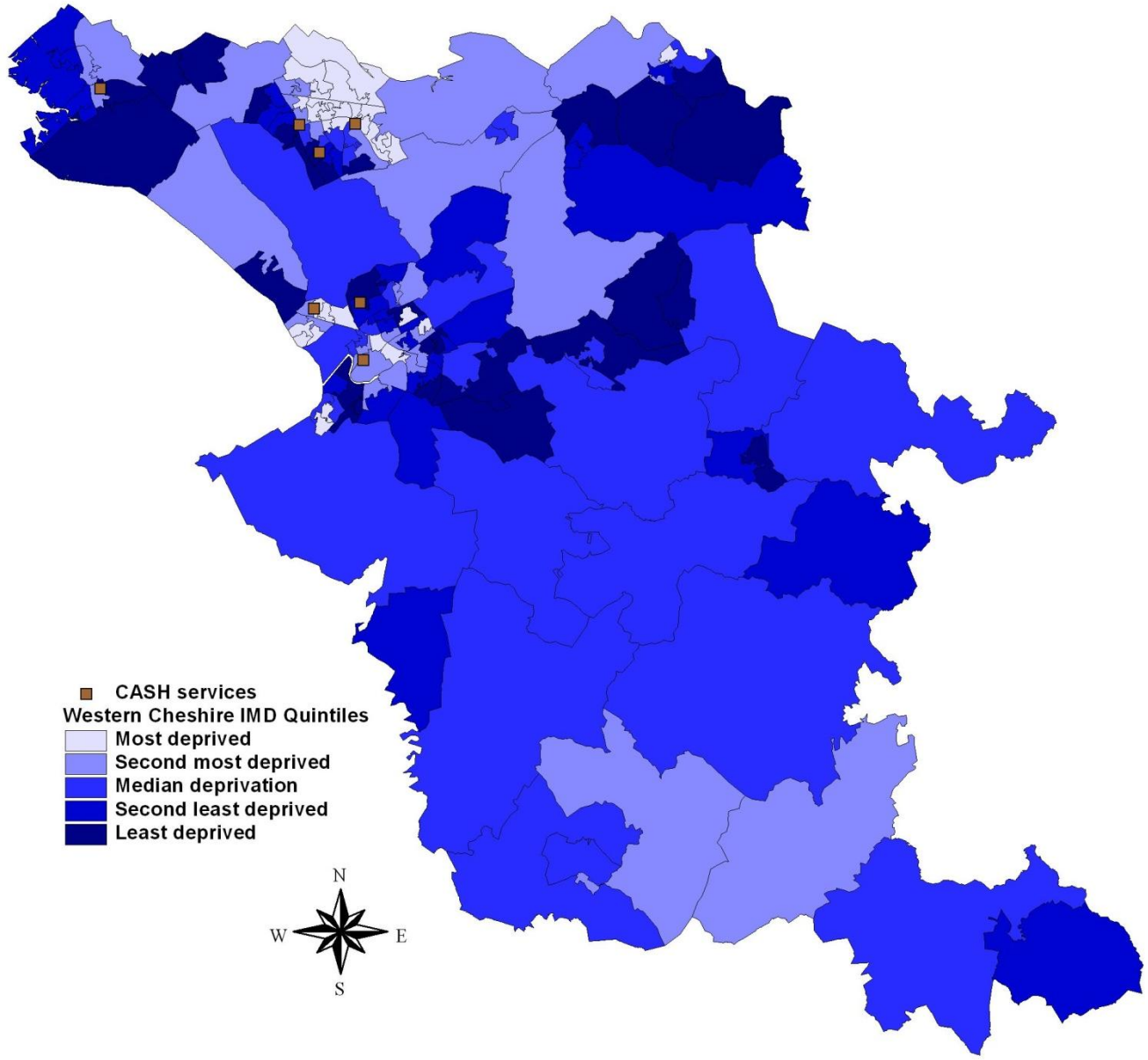
Map 19 shows the services in the south eastern area of the PCT, including Audlem. There are two sexual health services in this area; a GP offering enhanced services and a pharmacy offering free

emergency contraception. The pharmacy is open six days a week (excluding Sunday) from 9am-6pm. There are no services specifically for young people in this area.

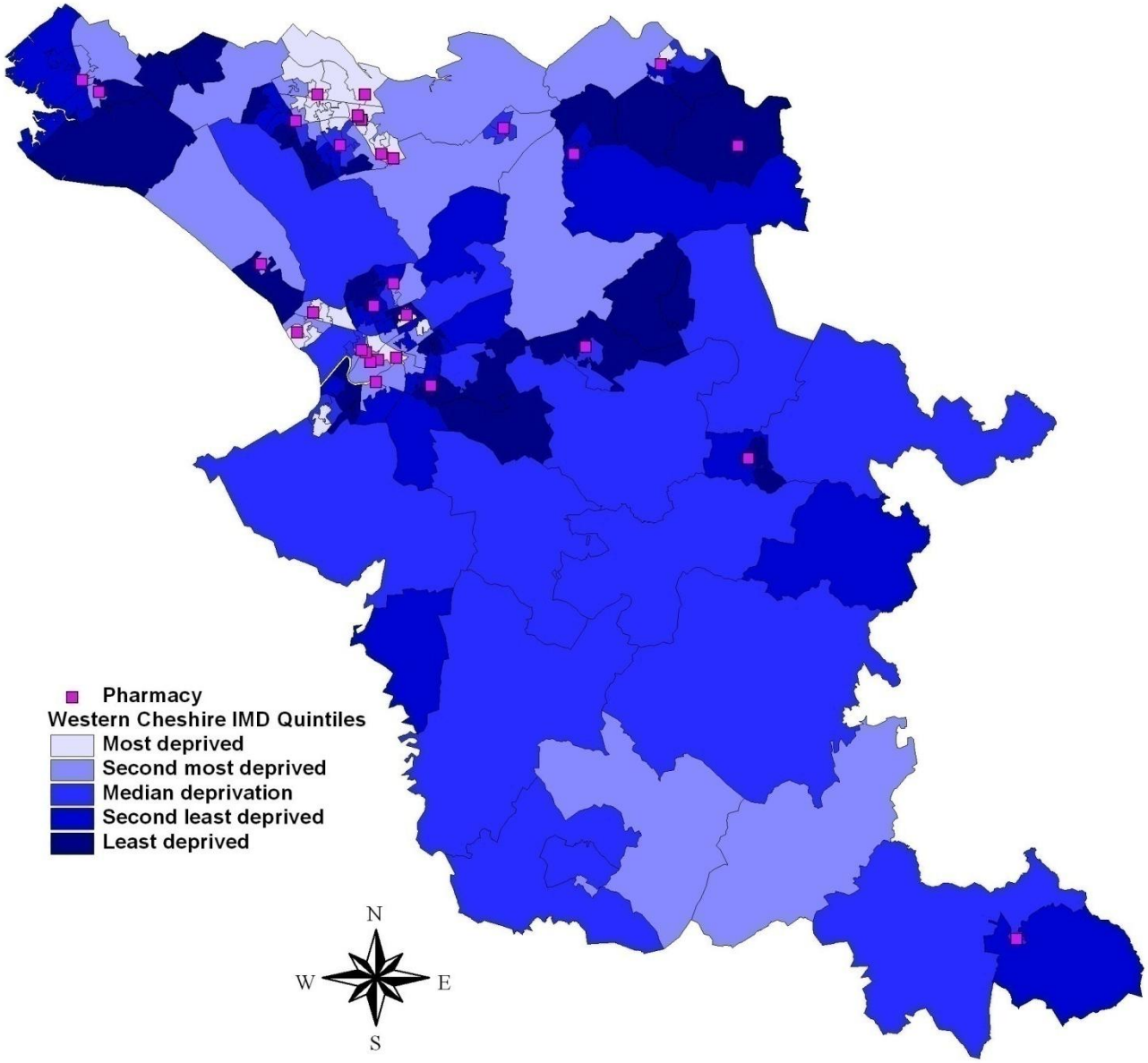
Map 8 IMD score with service locations



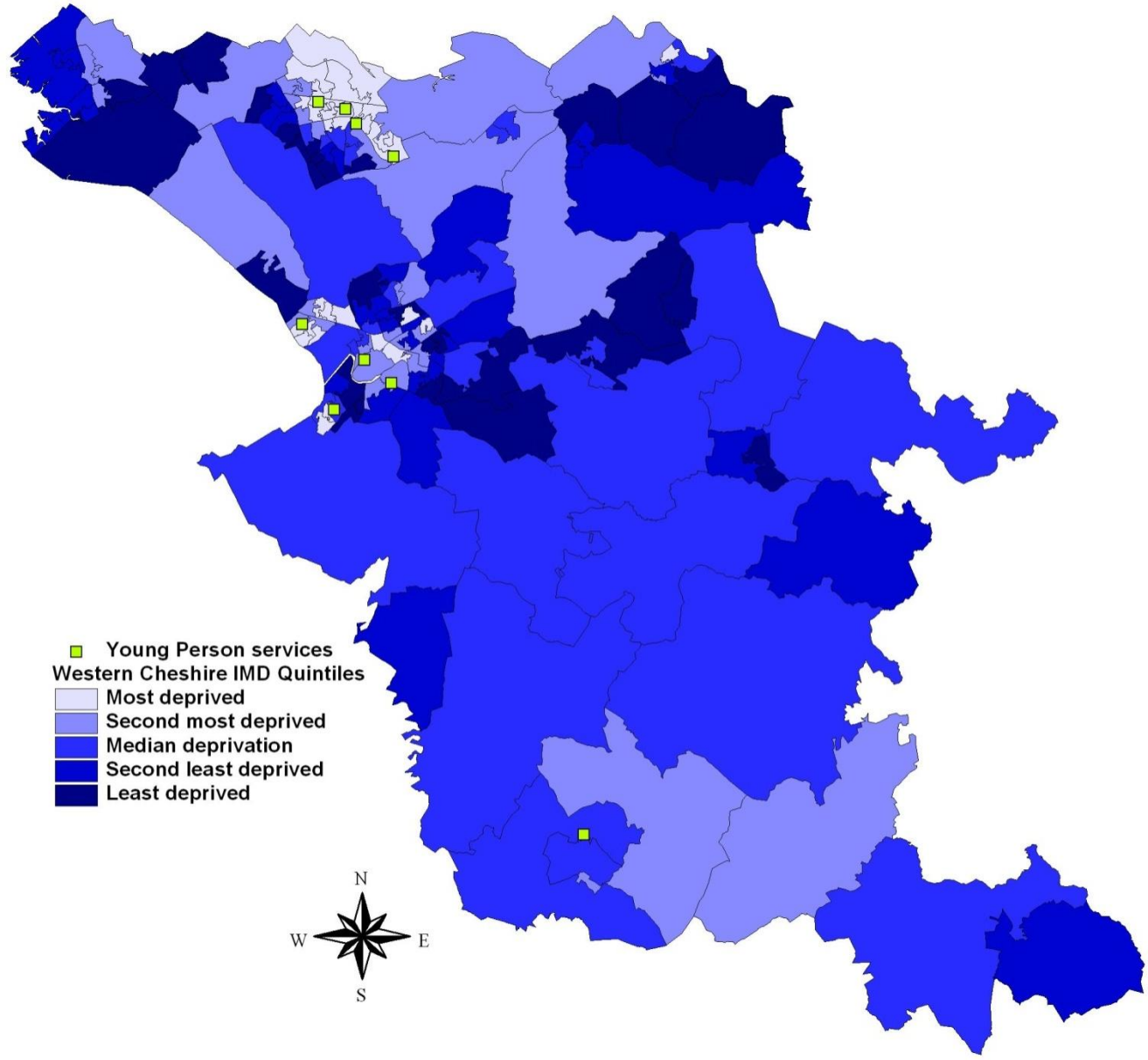
Map 9 IMD score with CASH service locations

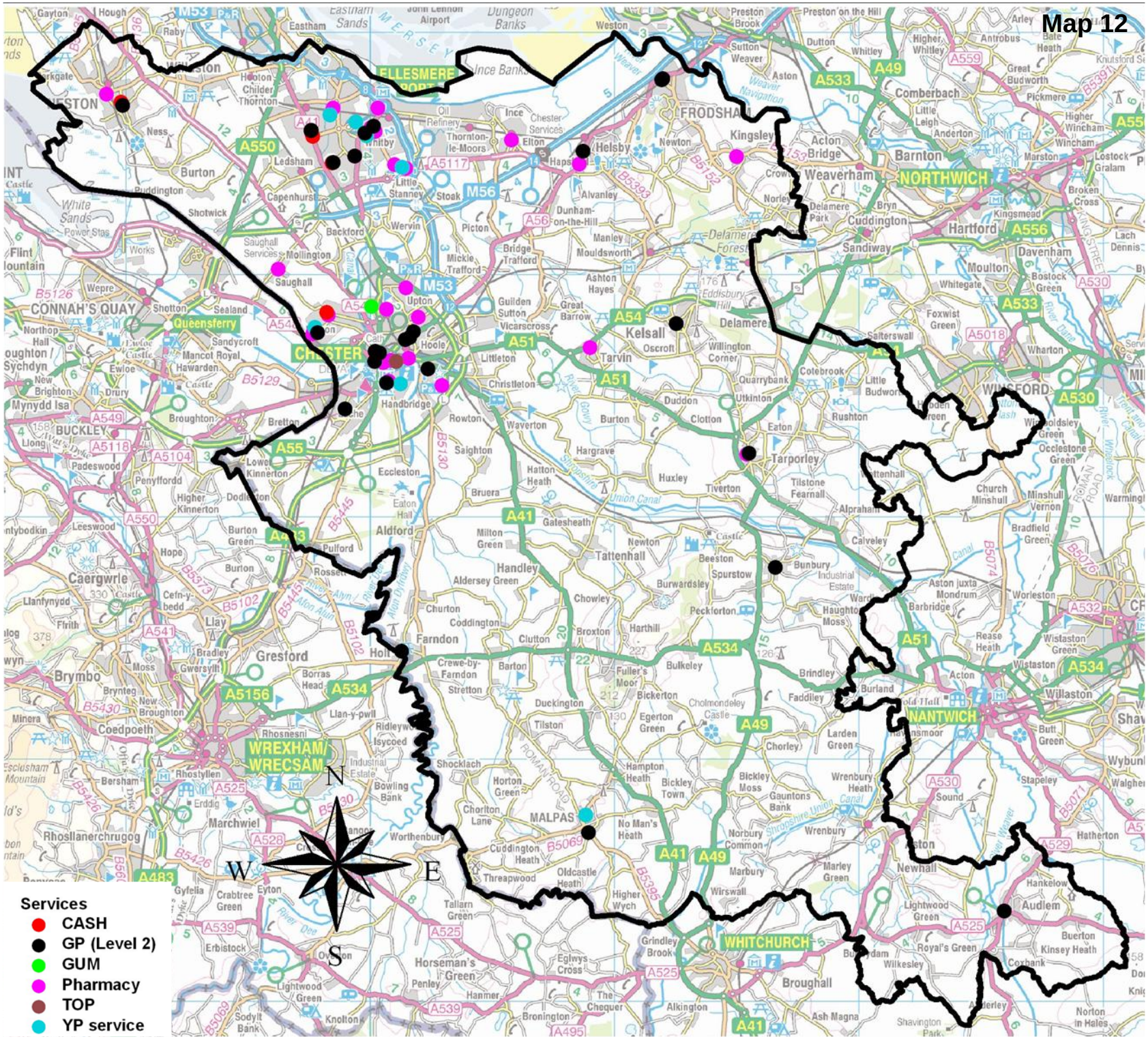


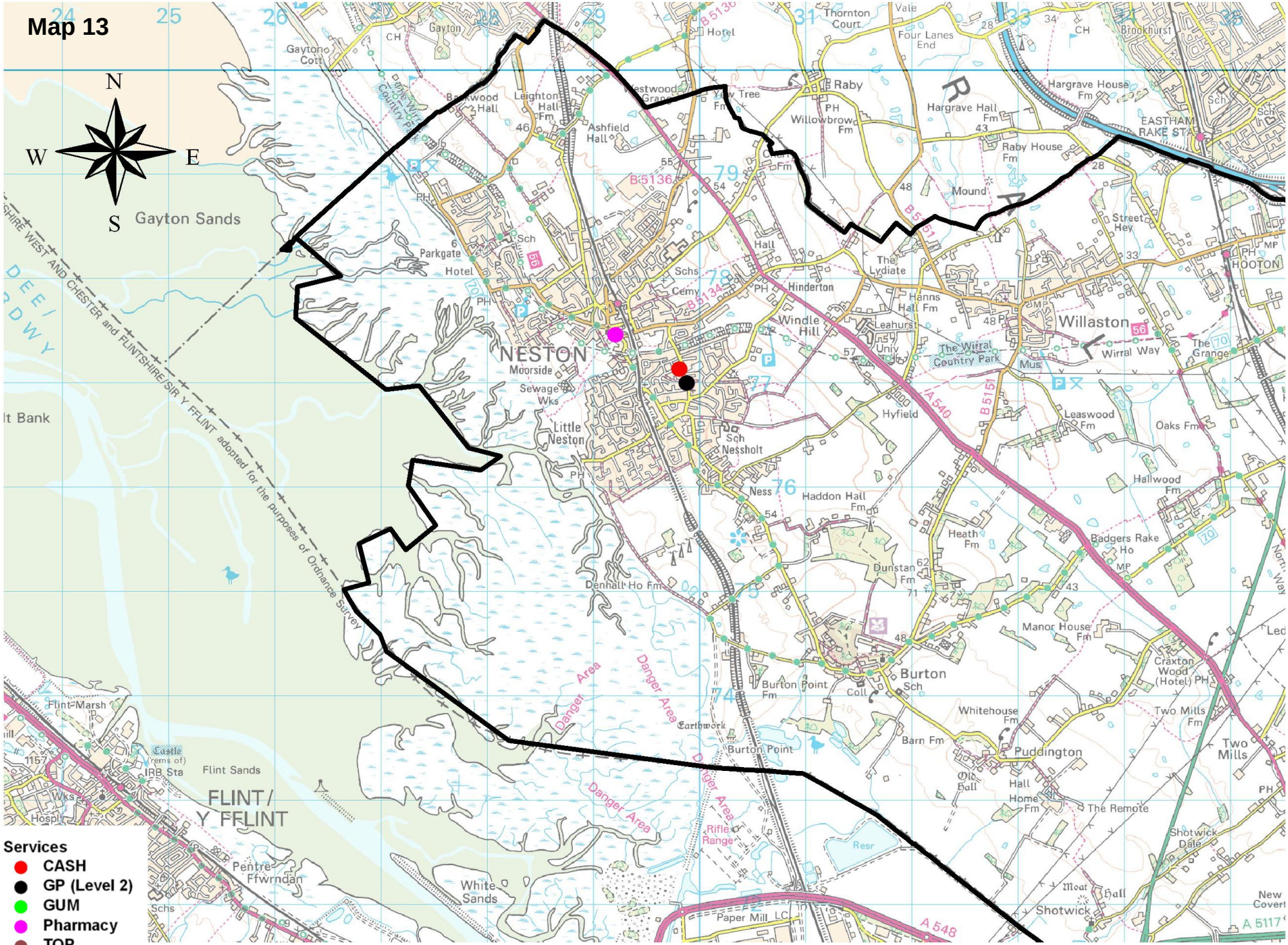
Map 10 IMD score with pharmacies offering free emergency hormonal contraception



Map 11 IMD score with young person's service locations




Map 12
Services
CASH
GP (Level 2)
GUM
Pharmacy
TOP
YP service
N
S
E
W
CHESTER
WREXHAM/
WRECSAM
NORTHWICH
NANTWICH
WHITCHURCH
FRODSHAM
ELLESMERE
CONNAH'S QUAY
Queensferry
BUCKLEY
MALPAS


Map 13
N
W
E
S
Services
CASH
GP (Level 2)
GUM
Pharmacy
TOP
YP service
NESTON
Willaston
FLINT/
Y FFLINT
Burton
Gayton Sands
Flint Sands
White Sands
Burton Point
Puddington
Shotwick
Hooton
Eastham Rake Sta
Raby
Thornton Court
Four Lanes End
Hinderton
Windle Hill
Little Neston
Ness
Haddon Hall Fm
Denhall Ho Fm
Hyfield
Leaswood Fm
Oaks Fm
Hallwood Fm
Badgers Rake Ho
Manor House Fm
Craxton Wood (Hotel) PH
Two Mills
Two Mills Fm
Whitehouse Fm
Barn Fm
Old Hall
Home Fm
The Remote
Shotwick Dale
Moat Hall
Dunstan Fm
Heath Fm
Burton Point Fm
Earthwork
Danger Area
Rifle Range
Resr
Paper Mill LC
Flint Marsh
Castle (rems of)
IRB Sta
Pentre Ffwrndan
Hospl
Wks
Schs
Cemy
Sewage Wks
Moorside
Parkgate
Hotel
Gaytono Cott
Gayton
Brookhurst
Hargrave House Fm
Hargrave Hall Fm
Raby House Fm
Willowbrow Fm
Ashfield Hall
Leighton Hall Fm
Bridgwood Hall
Mound
Street Hey
The Lydiate
Hanns Hall Fm
Leahurst
Univ
The Wirral Country Park
Wirral Way
The Grange
Mus
Sch
Nessholt
Coll
Hall
Fm
PH
MP
A 540
B 5151
B 5136
B 5134
B 5151
A 548
A 5117
DEE/DWY
It Bank
CHESHIRE WEST AND CHESTER and FLINTSHIRE/SIR Y FFLINT adopted for the purposes of Ordnance Survey

Opening times – Map 13

Neston (Black shading indicates opening hours)

YP clinics	Opening times												
	7-8am	8-9am	9-10am	10-11am	11-12am	12-1pm	1-2pm	2-3pm	3-4pm	4-5pm	5-6pm	6-7pm	7-8pm	8-9pm
Monday														
Tuesday														
Wednesday														
Thursday														
Friday														
Saturday														
Sunday														

CASH clinics	Opening times												
	7-8am	8-9am	9-10a	10-11am	11-12am	12-1pm	1-2pm	2-3pm	3-4pm	4-5pm	5-6pm	6-7pm	7-8pm	8-9pm
Monday														
Tuesday														
Wednesday														
Thursday														
Friday														
Saturday														
Sunday														

GUM	Opening times												
	7-8am	8-9am	9-10am	10-11am	11-12am	12-1pm	1-2pm	2-3pm	3-4pm	4-5pm	5-6pm	6-7pm	7-8pm	8-9pm
Monday														
Tuesday														
Wednesday														
Thursday														
Friday														
Saturday														
Sunday														

Pharmacy	Opening times												
	7-8am	8-9am	9-10am	10-11am	11-12am	12-1pm	1-2pm	2-3pm	3-4pm	4-5pm	5-6pm	6-7pm	7-8pm	8-9pm
Monday			[redacted]											
Tuesday														
Wednesday														
Thursday														
Friday														
Saturday														
Sunday														

TOP	Opening times												
	7-8am	8-9am	9-10am	10-11am	11-12am	12-1pm	1-2pm	2-3pm	3-4pm	4-5pm	5-6pm	6-7pm	7-8pm	8-9pm
Monday														
Tuesday														
Wednesday														
Thursday														
Friday														
Saturday														
Sunday														

Opening times Map 14

Ellesmere Port Map (Black shading indicates opening hours)

YP clinics	Opening times													
	7-8am	8-9am	9-10am	10-11am	11-12am	12-1pm	1-2pm	2-3pm	3-4pm	4-5pm	5-6pm	6-7pm	7-8pm	8-9pm
Monday						■	■	■						
Tuesday										■	■			
Wednesday						■	■							
Thursday														
Friday														
Saturday														
Sunday														

CASH clinics	Opening times													
	7-8am	8-9am	9-10a	10-11am	11-12am	12-1pm	1-2pm	2-3pm	3-4pm	4-5pm	5-6pm	6-7pm	7-8pm	8-9pm
Monday														
Tuesday							■	■						
Wednesday														
Thursday												■	■	
Friday														
Saturday														
Sunday														

GUM	Opening times													
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Pharmacy	Opening times												
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Opening time Map 15

Frodsham Map (Black shading indicates opening hours)

YP clinics	Opening times												
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CASH clinics	Opening times												
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Opening time Map 16

Chester Map (Black shading indicates opening hours)

YP clinics	Opening times													
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Opening time Map 17

East Western Cheshire Map (Black shading indicates opening hours)

YP clinics	Opening times												
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Opening times map 18

Malpas Map (Black shading indicates opening hours)

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Opening times Map 19

Audlem Map (Black shading indicates opening hours)

YP clinics	Opening times												
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CASH clinics	Opening times												
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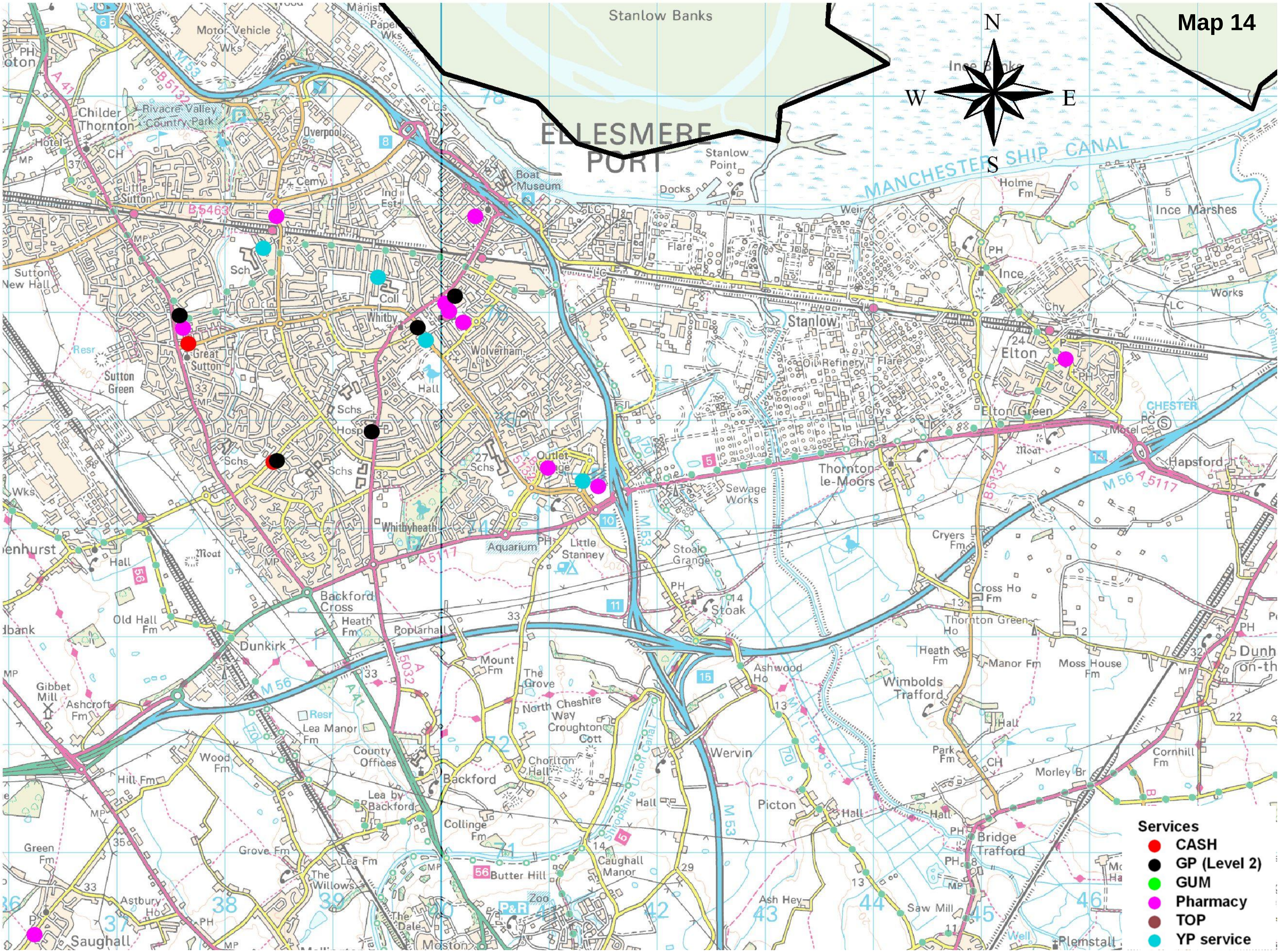
Map 14
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Stanlow Banks
ELLESMERE PORT
MANCHESTER SHIP CANAL
Stanlow
Oil Refinery
Ince
Elton
Thornton le-Moors
Great Sutton
Little Sutton
Childer Thornton
Overpool
Whitby
Wolverham
Whitbyheath
Little Stanney
Stoak
Backford
Backford Cross
Dunkirk
Wervin
Picton
Bridge Trafford
Wimbolds Trafford
Hapsford
Ince Marshes
Caughall Manor
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Boat Museum
Rivacre Valley Country Park
Services
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GP (Level 2)
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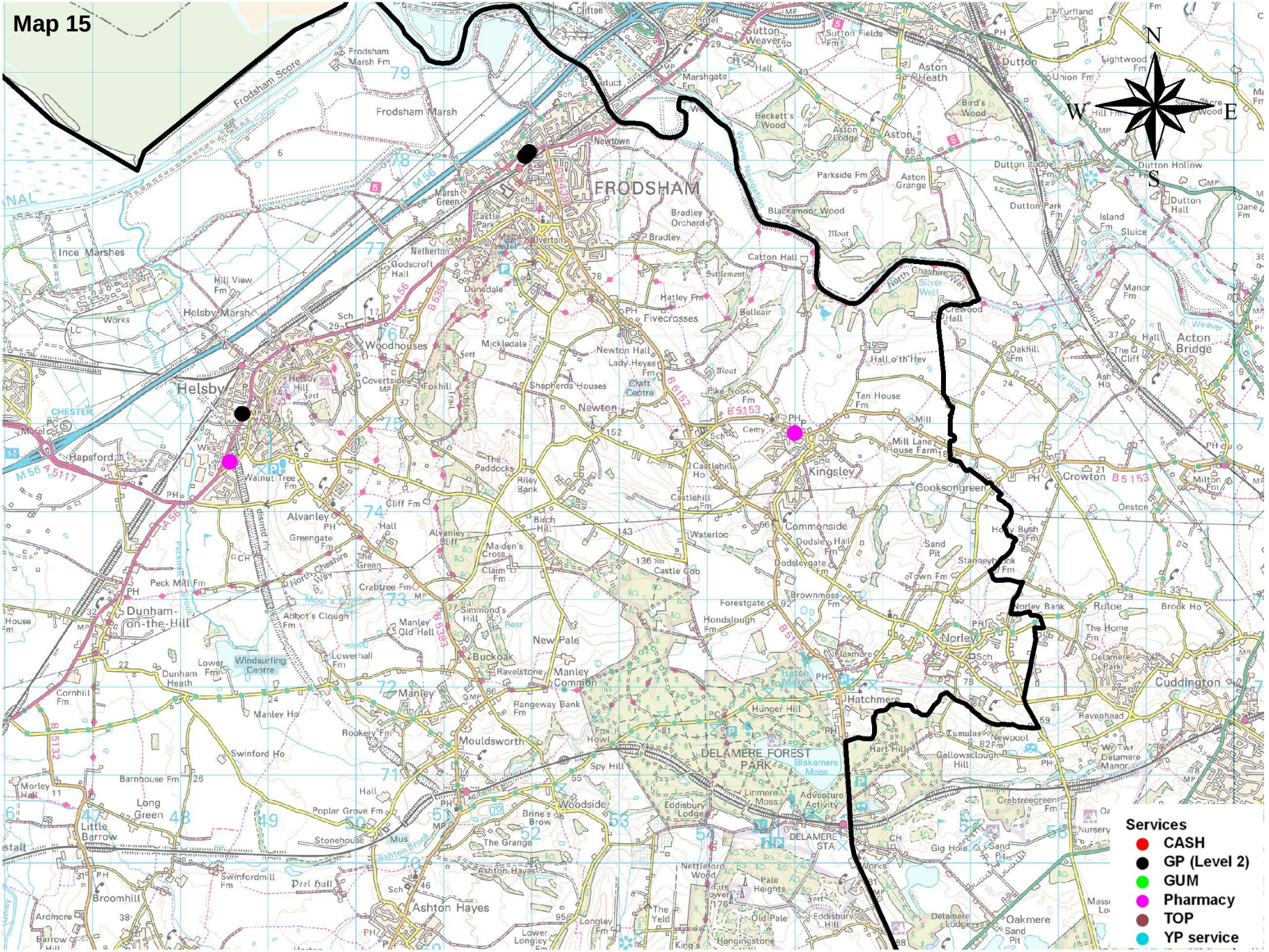
Pharmacy
TOP
YP service


Map 15
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Services
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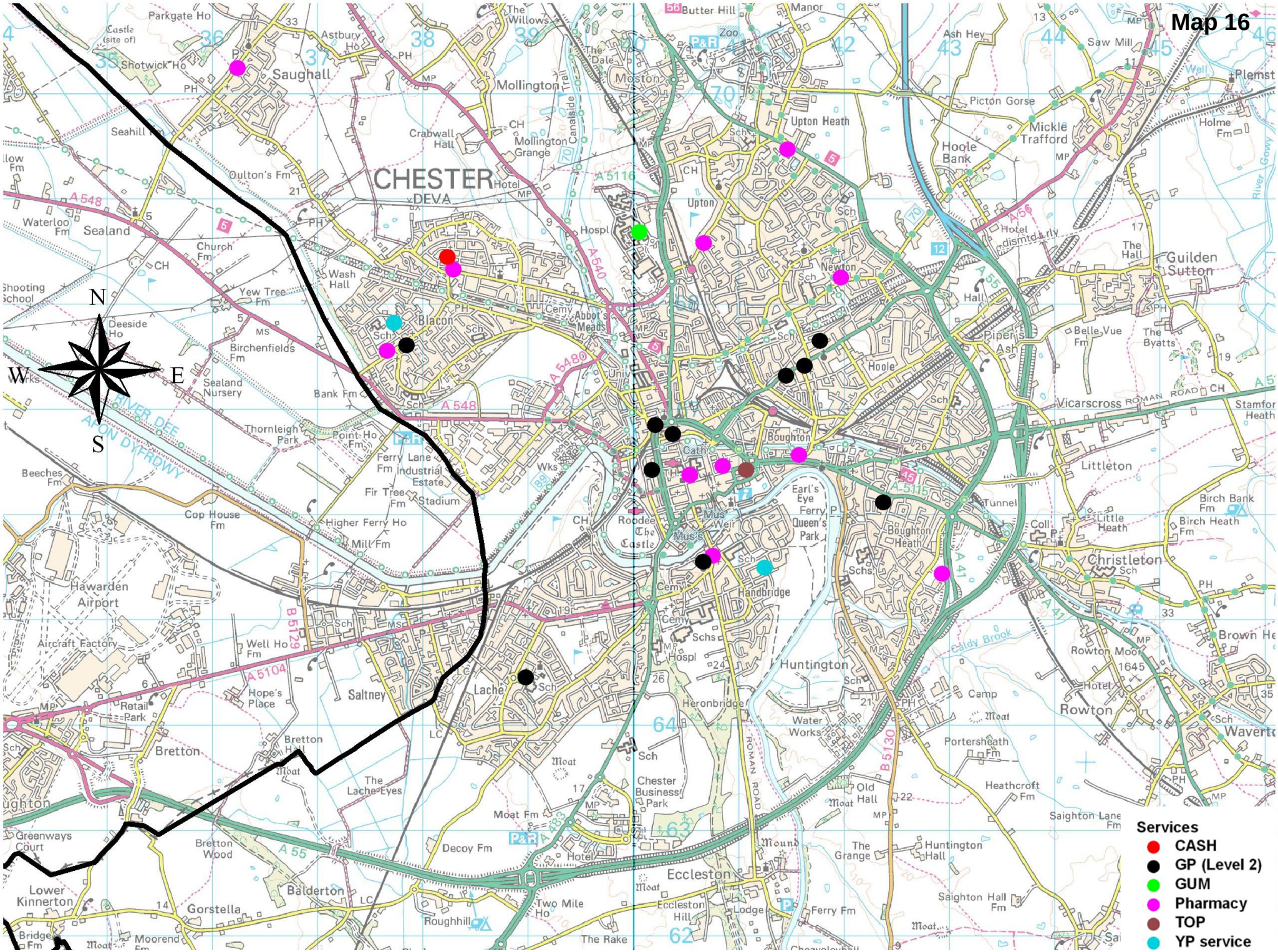
Map 16
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Pharmacy
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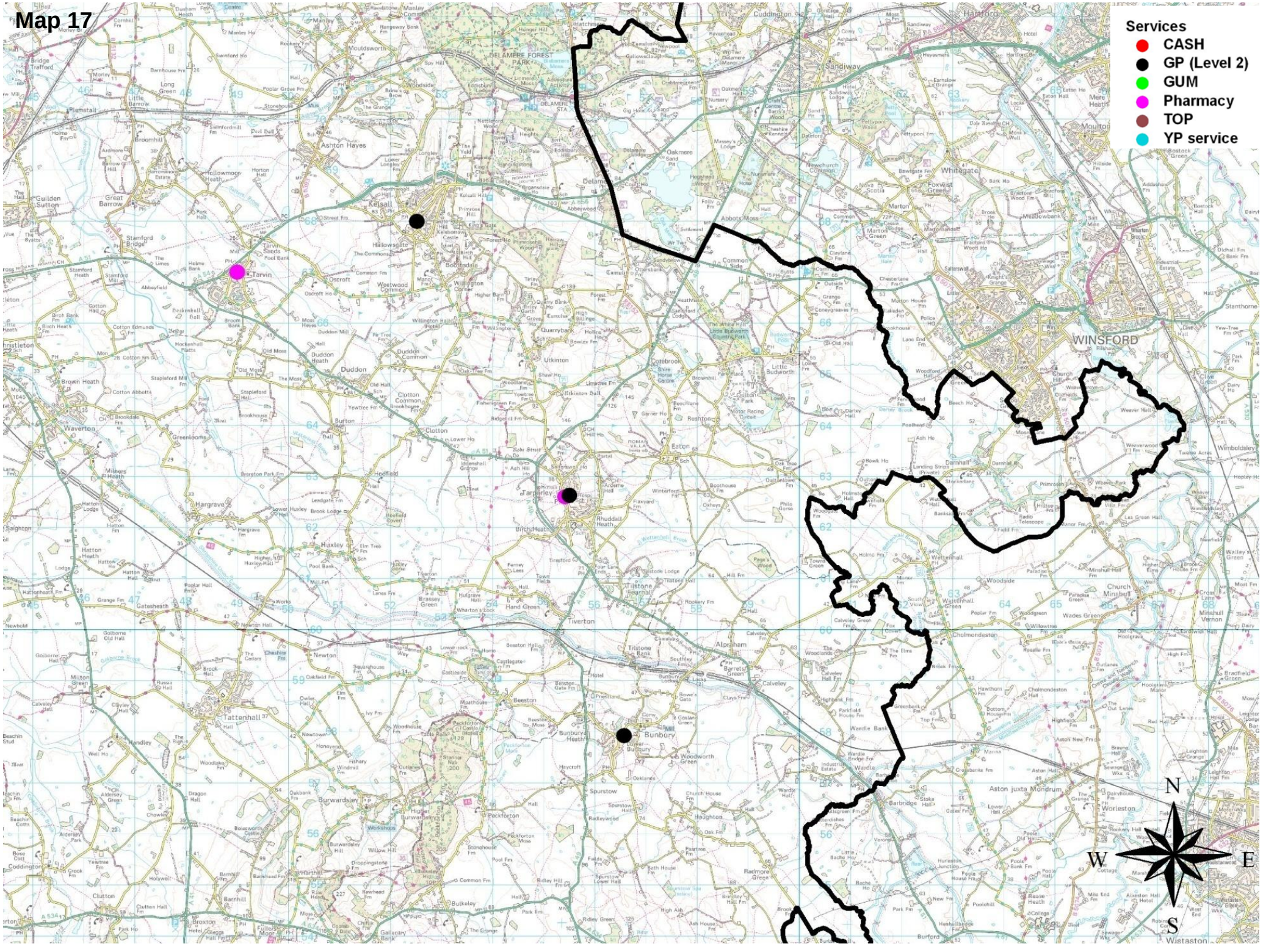
Map 17
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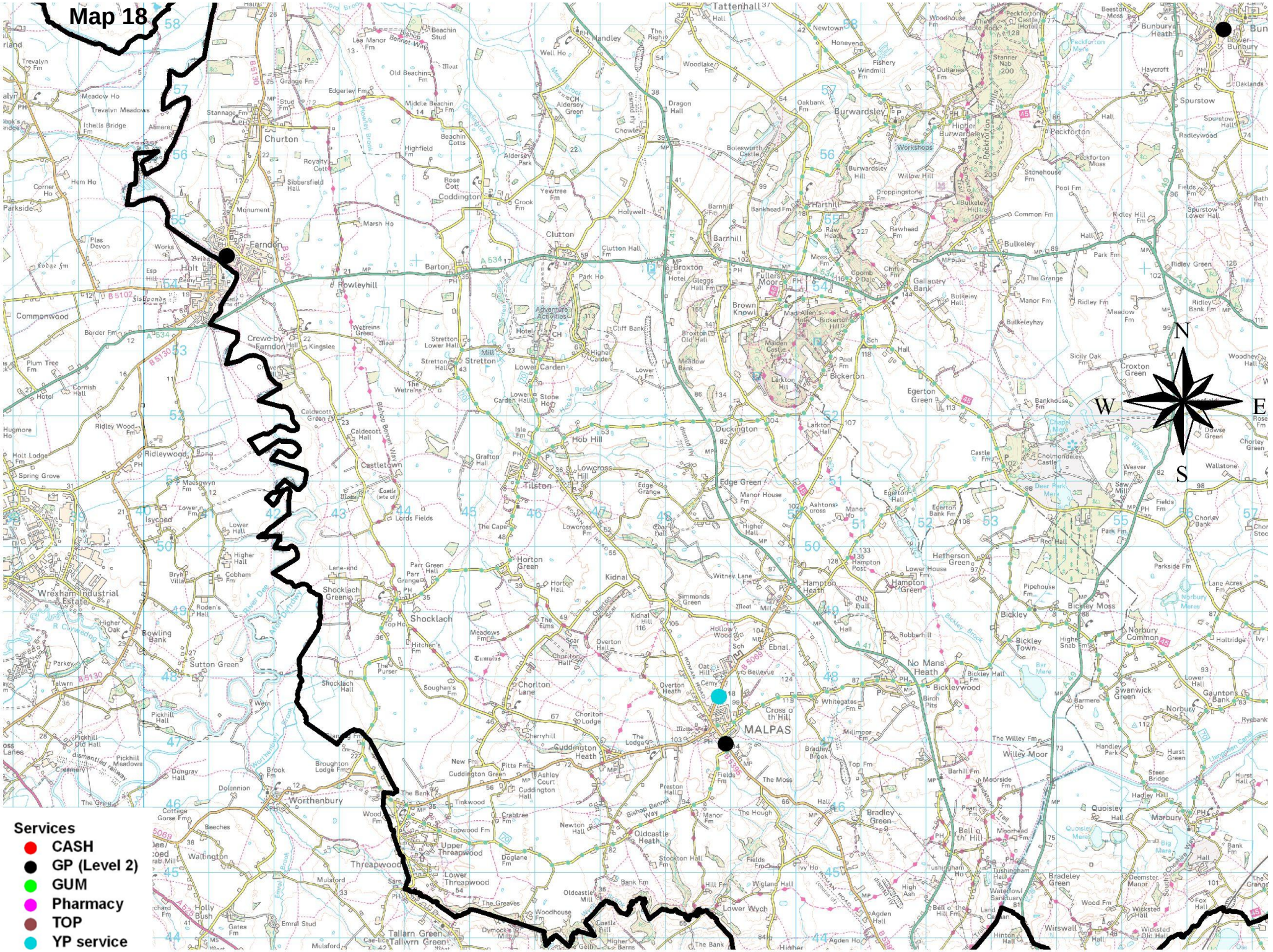
Map 18
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Pharmacy
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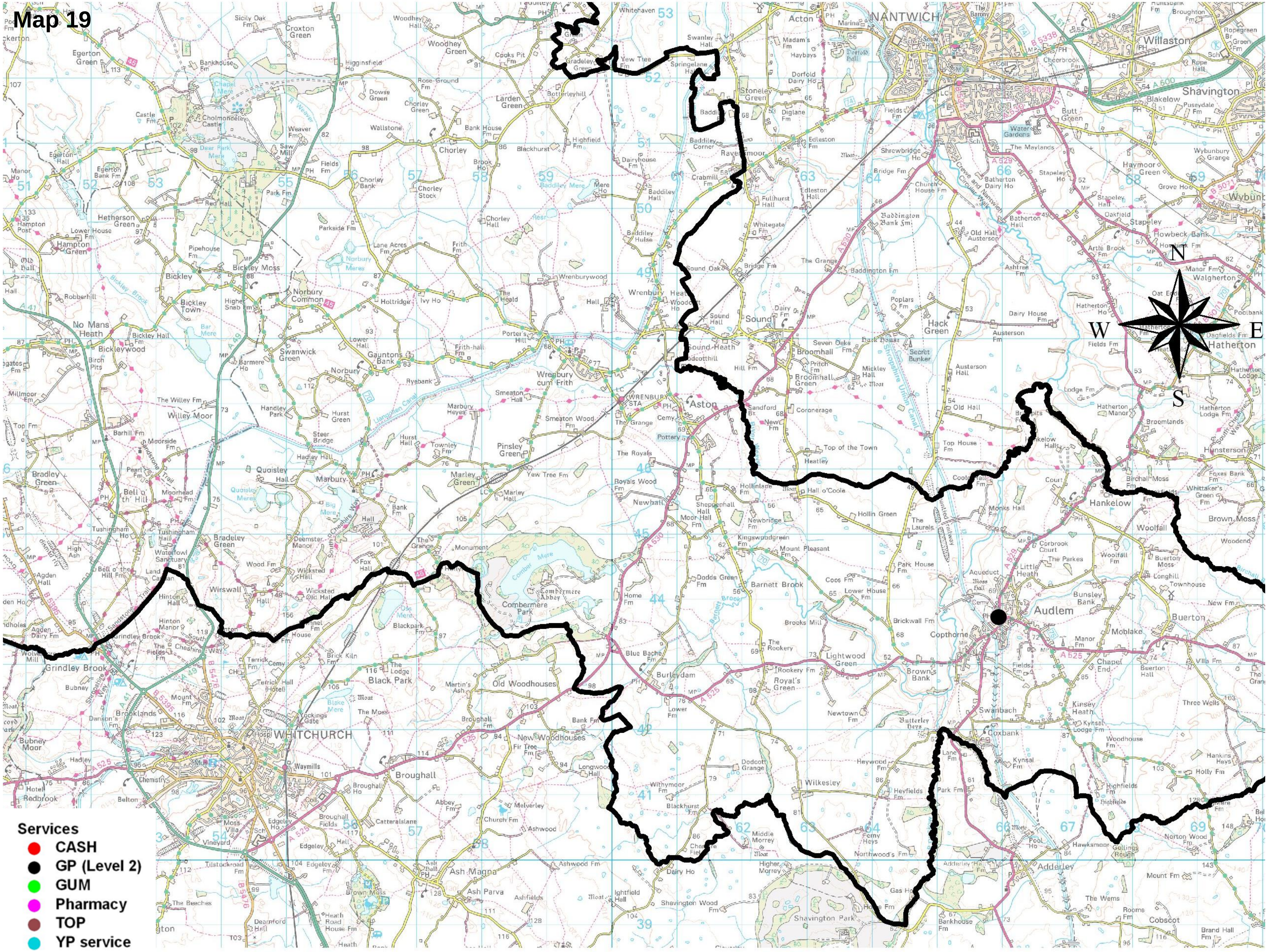
YP service

Map 19



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Buerton
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Aston
Sound
Broomhall
Hatherton
Adderley
Grindley Brook
Combermere Park

4. Glossary and List of Abbreviations

AIDS - Acquired immune deficiency syndrome

CASH – Community and sexual health services

Corpus Uteri Cancer – Cancer of the corpus uteri, or endometrium, is a common invasive cancer among women.

DfES – Department for Education and Skills

DH – Department of Health

DVLA – Driver and Vehicle Licensing Agency

EHC – Emergency Hormonal Contraceptive

FE – Further Education

GUM – Genito Uninary Medicine

HIV – Human immunodeficiency virus

Implants – A small (40mm), flexible tube containing progestogen. The implant is inserted under the skin of the upper arm by a trained professional, and it lasts for three years. In the UK, the implant is called Implanon.

IUD – Intrauterine contraceptive device

LARC – Long Acting Reversible Contraceptive

LGBT – Lesbian Gay Bisexual and Transgender

LNG-IUS – A levonorgestrel (LNG) releasing intra-uterine contraceptive device

MSM – Men who have sex with men

PHSE – Personal Health and Social Education

SRE – Sex and Relationships Education

STI – Sexually transmitted infection

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