Sexual Health Needs Assessment Teesside 2020

Tees Sexual Health Commissioners 2020

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Executive Summary

Since 1 April 2013, Local authorities have had a responsibility to improve the health of the population through the provision and commissioning of effective and efficient sexual health services. A sexual health needs assessment offers a strategic review of sexual health needs, current service provision and delivery in order to improve the sexual health of the population. The results of the health needs assessment inform commissioning decisions and influence future service configuration and development for the population as a whole but with a particular focus on access to services by young people and those most at risk.

In April and May of 2020, a refresh of the 2013 Sexual Health Needs Assessment for Teesside was carried out. The HNA focused on services delivered or commissioned by local authorities, the information used for the refresh includes routinely available epidemiological information from a wide variety of sources and service information. Due to the COVID-19 pandemic stakeholder and public views were not sought as part of the HNA refresh. A supporting document will be developed at a later stage to incorporate stakeholder and public views into the SHNA.

The main results of the needs assessment were:

1. Since the previous SHNA for Teesside, there have been changes in the type of acute STI infections diagnosed across the area, with reductions in infections such as gonorrhea and genital warts and increases in infections such as syphilis. Although the rate of acute STI infections has reduced slightly overall across the Tees, this is unlikely to indicate a reduction in demand for sexual health services overall.

2. Recent outbreaks such as the increase in syphilis across Tees indicate changing behaviours in groups not considered to be at risk of acquiring STI infections (i.e. transmission during pregnancy) and the response to the increase in these infections requires close working between sexual health and antenatal services.

3. Although the rate of under 18 conceptions continues to decrease for the Tees area, the rate remains significantly higher than the national average, and the reduction not continuing at the same pace as the national average. Abortions rates for the under 18 age group highlight some significant differences between areas of Tees, with Hartlepool, Middlesbrough and Redcar and Cleveland has been lower than the national average, while in Stockton the proportion of teenage pregnancy leading to abortion is similar to the national average.

4. The local system has changed significantly since the previous SHNA in 2014, with a significant reduction in the amount of providers of young people's services across the local area, and the development of local primary care networks. Although interventions have been put in place to increase the reach of sexual health provision to young people, such as prevention programmes (C Card) across community settings, some of these programmes have not been accessed by high numbers of young people.

5. Similar to the previous SHNA, it is apparent that key groups have the highest burden of disease from poor sexual health in the Tees area including young people, MSM and those living in deprived areas.

6. Pathways and system work to engage at risk groups (e.g. women undertaking abortion, adults with LD) is at different stages across different areas of the Tees footprint.

7. The national context and response to sexual health has undergone some significant changes since the previous SHNA, with the planned introduction of routine PREP treatment for HIV, HPV vaccinations for MSM aged 45 and under, proposed changes to chlamydia testing and the introduction of mandatory relationship and sexual health education across primary and secondary schools.

8. Levels of use of emergency contraception have remained consistent across the Tees since 2014, however there is no indication that this is having an effect on unintended pregnancies. However, the abortion rate across all Tees areas has increased since 2014 and across south Tees remains one of the highest in the North East.

Based on these results the following recommendations have been made:

1. To improve the uptake of Long Acting Reversible Contraception (LARC) given the increases in abortions.

2. To review prevention approaches across each Tees area to ensure that the sexual health prevention offer reflects and supports the changing system (e.g. mandatory RSHE, emerging Healthy Schools Frameworks).

3. To refresh approach to young people's treatment and testing to improve key outcomes including chlamydia detection rates, and the access of young people to service provision.

4. Maintain a focus on narrowing the inequalities associated with poor sexual health outcomes for local populations.

5. Establish mechanisms to involve local populations in the design and development of sexual health provision, although satisfaction rates for sexual health services are high when they are utilised, there is no established processed to understand the barriers facing groups who do not access services.

COVID-19.

During the writing of this SHNA, the COVID-19 pandemic meant that sexual health services had to undergo significant change to continue to deliver services safely, while this presented challenges due to the necessity to stand down certain procedures and limit face to face access at clinics, services adapted their methods of delivery and digital innovation to limit the impact of COVID-19 on the sexual health outcomes of local populations. Future provision should be developed which builds on and mainstream the elements of innovation applied during this period which have supported access to services. Services and activity will be reviewed in the near future to understand the impact of the pandemic on Sexual Health Outcomes?

1. Introduction

Sexual Health is a key Local Authority and Public Health priority area as it can have a significant impact on the population, the communities and individuals across Tees. Poor sexual health can be a consequence of and associated with other vulnerabilities (e.g. drug and alcohol use), coercion, exploitation and abuse, leading to poor short and long term outcomes. Deprivation and social exclusion also impact on sexual health, with a higher burden of disease in populations who live in more deprived areas.

Poor sexual health holds costs for both individuals and society; sexually transmitted infections are the main cause of preventable infertility, teenage pregnancy is associated with poverty, low aspirations, and not being in education, employment or training (Department of Health 2013). Unintended pregnancy can affect woman across all areas of society of fertile age, and it has been estimated that the annual cost to the NHS in England of unintended pregnancy stands at £817 million (2020health 2013).

Evidence demonstrates that spending on sexual health interventions and services is cost effective, for example:

- For every £1 spent on contraception, £11 is saved in other healthcare costs.
- National Institute for Health and Clinical Excellence (NICE) Clinical Guideline CG30 demonstrated that (LARC) is more cost effective than condoms and the pill, and if more women chose to use these methods there would be cost savings.
- Early testing and diagnosis of HIV reduces treatment costs – £12,600 per annum per patient, compared with £23,442 with a later diagnosis.

Cases of sexually transmitted infections (STIs) are increasing in England. In 2018, there were 447,694 new diagnoses of STIs, a 5% increase on the 422,147 in 2017.

Gonorrhoea increased the most - by 26% on 2017 to 56,259 cases; this is of concern given the three cases of extensively drug resistant Neisseria gonorrhoea identified in England in 2018. There were 7,541 cases of syphilis - a 5% increase on 2017. The impact of STIs remains greatest in young heterosexuals 15 to 24 years; black ethnic minorities; and gay, bisexual and other men who have sex with men (MSM). The most commonly diagnosed STIs in England in 2018 were:

- chlamydia (218,095 cases, 49% of all new STI diagnoses)
- genital warts (57,318 cases, 13%)
- gonorrhoea (56,259 cases, 13%)
- genital herpes (33,867 cases, 8%)

The number of gonorrhoea cases has been increasing year on year also among both men and women. Some people have no symptoms but can pass it on to their sexual partner. It can be treated with antibiotics, although there have been reports of some cases of hard-to-treat "super-gonorrhoea" that is resistant to the usual choice of drugs. Screening for chlamydia continued to decline in 2018, with just over 1.3 million young people tested and new cases of genital warts also continued to decline. [1]

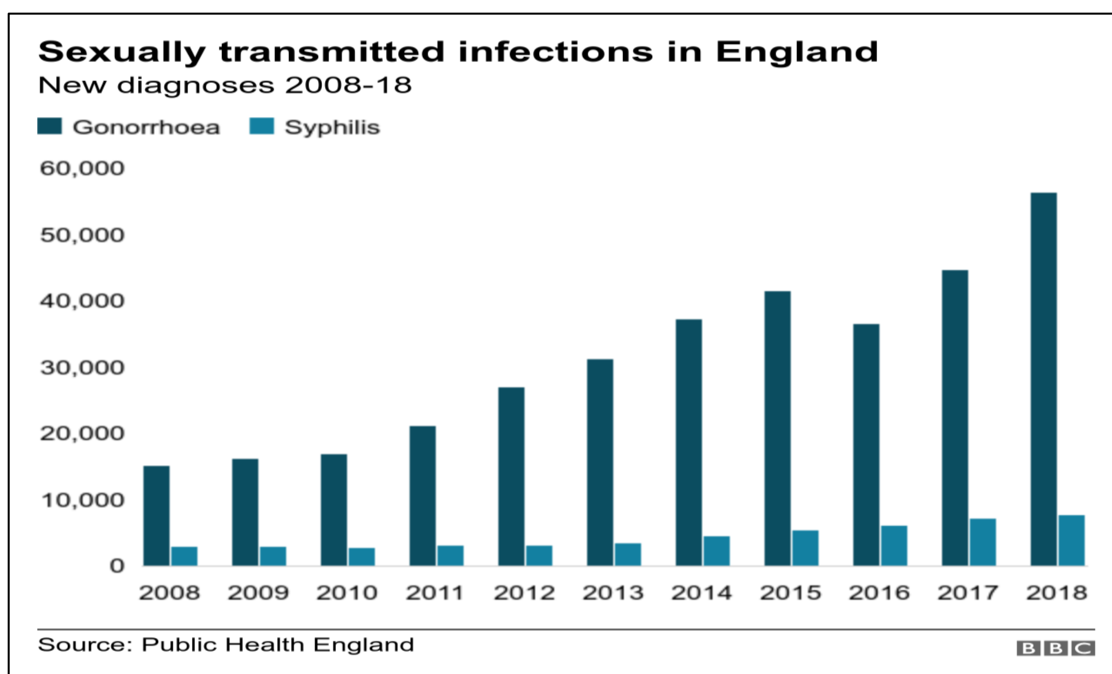


Table 1: Sexually transmitted infections in England 2008-2018

The total number of consultations at Sexual Health Services (SHSs) in England (attendances at physical clinics or consultations via e-SHSs) increased 7% between 2017 and 2018 (from 3,337,677 to 3,561,548). This continued the increasing trend over the five years between 2014 and 2018, in which there was a 15% increase in the number of consultations (from 3,101,960 to 3,561,548). [2]

In Teesside the main concerns are comparatively high rates of some STIs such as chlamydia as well as rising rates of syphilis and gonorrhoea together with rates of unintended pregnancies in under 18 conceptions.

Aims

This sexual health needs assessment aims to offer a strategic review of sexual health need, an overview of current services and delivery in Teesside in order to improve the sexual health and wellbeing of the population in Teesside and to inform commissioning decisions ensuring high quality, comprehensive and equitable sexual health services. The results of this health needs assessment will be used to inform future service configuration and development for the population as a whole but with a particular focus on access to services by young people and those most at risk.

Objectives

The objectives of this health needs assessment are to:

- describe the sexual health of the population in Teesside by looking at key indicators and trends in order to understand the local burden of disease;
- describe current provision of sexual health promotion, prevention and treatment services in Teesside;
- assess the capacity to meet current and future demand and to identify gaps between sexual health needs and service provision;
- provide recommendations to address gaps in services and current unmet needs and to help inform any future system and service redesign through the commissioning process.

2. Background

Sexual Health

Sexual health covers the provision of advice and services around contraception, relationships, sexually transmitted infections (STIs) (including HIV) and abortion.

Sexual health is influenced by the knowledge, attitudes and behaviours of individuals. Social norms, peer pressure, stigma, discrimination, cultural and religion influence both attitudes and decisions of individuals.

The World Health Organisation (WHO) defines sexual health as:

> *'...health is a state of physical, emotional, mental and social well-being related sexuality; it is not merely the absence of disease dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled'* [3]

The WHO acknowledges that for sexual health to be attained and maintained, the sexual rights of all people must be respected, protected and fulfilled and has developed a working definition of sexual rights.

Most adults are sexually active and good sexual health matters to individuals and communities. Sexual health needs vary according to factors such as age, gender, sexual orientation and ethnicity. However, there are certain core needs common to everyone, including high-quality information and education enabling people to make informed responsible decisions, and access to high-quality services, treatment and interventions. The consequences of poor sexual health include:

- unplanned pregnancies and abortions
- psychological consequences, including from sexual coercion and abuse
- poor educational, social and economic opportunities for teenage mothers, young fathers and their
- children
- HIV transmission
- cervical and other genital cancers
- hepatitis, chronic liver disease and liver cancer
- recurrent genital herpes
- recurrent genital warts
- pelvic inflammatory disease, which can cause ectopic pregnancies and infertility
- poorer maternity outcomes for mother and baby [3]

Sexual Health Promotion and Prevention

Sexual health promotion and prevention aims to support informed and healthy decisions and behaviour change through the provision of high quality, accessible information with clear messages, targeted interventions and programmes and through face to face advice and testing. Sexual health promotion aims to prevent unwanted pregnancies, prevent and reduce the spread of STIs and to take autonomous, non-regretted decisions about sexual activity. As part of a holistic approach to ensure the health of their patients, all health care professionals are encouraged to take the opportunity to raise sexual health issues in routine healthcare. [4]

Stigma and embarrassment about sexual health are widespread in particular in relation to HIV but also other STIs and contraception. This can result in patients not asking for information or seeking testing and treatment but also in healthcare professionals preferring not to offer advice and testing.

Knowledge and access to information on sexual health and sexual health services e.g. how to prevent or get tested for STIs and unwanted pregnancies, methods of contraception including LARC and how to get and use emergency contraception are crucial. This could be face to face advice through health professionals as recommended by NICE or other sources of information such as campaigns, sex and relationship education, leaflets, posters, websites and social media.

Health promotion aims to influence the risk taking behaviours which impact on their decisions on relationships, contraception and unprotected sex but also on alcohol and drug consumption and other behaviours. International evidence is clear that comprehensive relationships and sex education (RSE) protects young people from STIs and unplanned pregnancy, as well as some of the behaviours that make them more at risk, including non-consensual sex. Sex and relationship education (SRE) in primary and secondary schools aims to provide children with age appropriate information, to explore and develop their attitudes and values and to empower them to make positive decisions about their sexual health related behaviour. Consequently, from September 2020, The Department for Education is making Relationships Education compulsory in all primary schools in England and Relationships and Sex Education compulsory in all secondary schools, as well as making Health Education compulsory in all state-funded schools. [5]

Sexual health prevention and promotion must recognise the increasing role of the internet and social media in the life of most people and in particular for young people. Young people have wide access to websites and social media and use it to find information, advice and also to find local services.

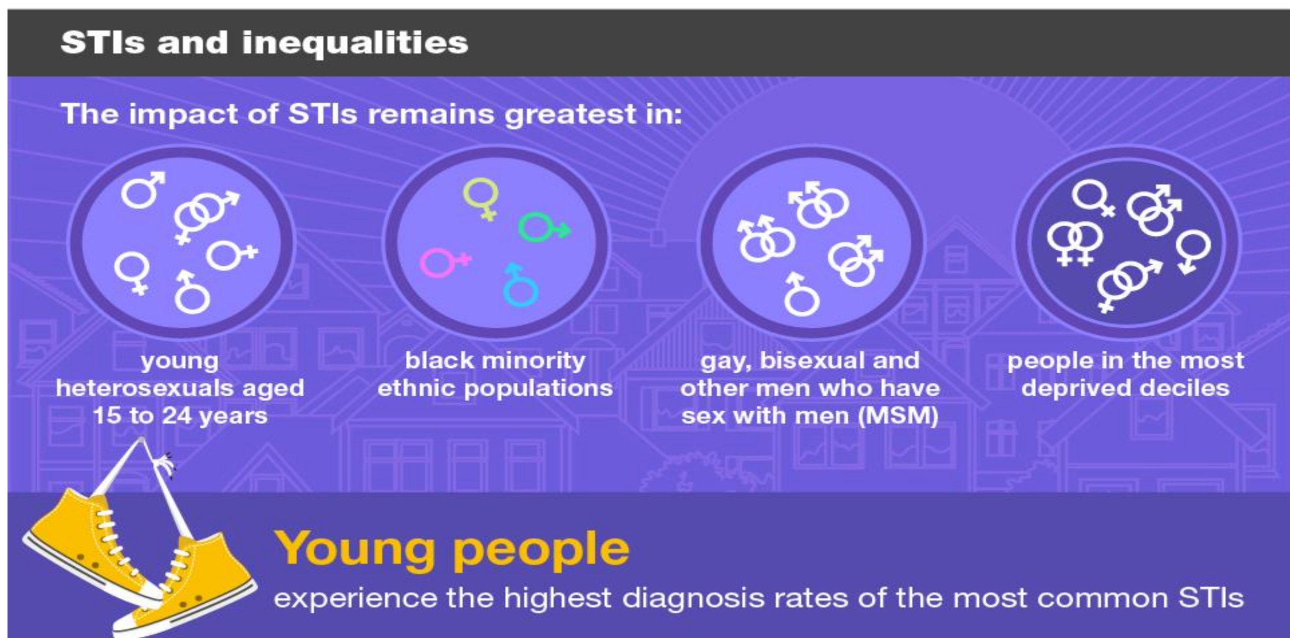


Figure 1: STIs and Inequalities PHE, 2019, Health Matters: Preventing STIs

Young people aged 15 to 24 years old experience the highest diagnosis rates of the most common STIs in England, likely due to higher rates of partner change. 61% (132,324 out of 218,095 cases of chlamydia

and 36% (20,453 out of 56,259 cases) of gonorrhoea diagnoses are among young people. Young women are more likely to be diagnosed with an STI than young men, partly due to greater uptake of chlamydia screening through the NCSP, as well as sexual mixing between younger women and older male partners. [6]

A lack of knowledge about risks and prevention as well as risk taking behaviours including drug and alcohol misuse contribute to the higher risk of contracting STIs.

People from **BME groups** have, depending on the prevalence in their country of origin, a higher risk of HIV. Women with African background are more likely to be a victim of female genital mutilation and suffering from the associated consequences and complications.

Lesbian, gay, bisexual and transgender people (LGBT). Men having sex with men (MSM) and bisexual men are at higher risk of contracting STIs, and therefore have a significantly higher incidence and prevalence of most STIs including HIV.

Of the 64,831 new STI diagnoses in MSM in 2018 in England, gonorrhoea and chlamydia were most common at 41% and 29%, respectively. Among MSM, although the majority of syphilis, gonorrhoea and chlamydia diagnoses are in those who are HIV-negative or of unknown HIV status, the population diagnosis rates are 3-6 times higher in those diagnosed with HIV.

Since the start of the **PrEP** Impact Trial (HIV Pre-exposure Prophylaxis) in October 2017 which offers a new way for people to reduce their risk of acquiring HIV for those who are at a high risk of HIV across England such as MSM; there has been an increase in the number of syphilis and gonorrhoea cases in this population. The trial is due to end in September 2020.

From April 2018, the government introduced a nationwide HPV vaccination programme for men who have sex with men (MSM) aged 45 or younger attending level 3 specialist sexual health services. This recognised the burden from genital warts MSM who do not benefit from indirect protection from the girls programme (11-13 years vaccination programme for all girls since 2008).

The rise in syphilis, gonorrhoea and chlamydia diagnoses among MSM is probably primarily associated with behavioural changes such as an increase in partner numbers and condomless anal intercourse with new or casual partners. For some MSM, Chemsex and group sex facilitated by geosocial networking applications may have also contributed. [6]

Deprivation is highly associated with sexual ill health. Poorer and more deprived areas are experiencing higher rates of STIs and teenage pregnancies.

Vulnerable, at risk and hard to reach groups within the population are more vulnerable in relation to particular aspects of their sexual health. Some are more exposed to the risk of unwanted pregnancies or sexual exploitation; others engage in risk taking behaviours such as unprotected sex, multiple partners and injecting drugs and therefore have a higher risk of STIs. Many also experience difficulties in accessing sexual health services or finding appropriate sexual health services.

Young people who are in or leaving care, who have low educational attainment and who are from disadvantaged backgrounds are particularly vulnerable to poor sexual health including STIs, sexual exploitation and teenage pregnancies.

People with learning difficulties often do not have appropriate access to sex and relationship education and information and consequently are more vulnerable to sexual exploitation, unwanted pregnancies and STIs.

Homeless people as well as **sex workers** are at a higher risk of poor sexual health and sexual exploitation.

The **prison population** with a high proportion of people with alcohol and drug misuse problems, people with poor educational attainment and from deprived backgrounds, care leavers and those from BME groups have a higher risk and prevalence of STIs.

Risk taking behaviours such as **alcohol and substance misuse** is strongly associated with poor sexual health. Alcohol consumption influences judgements and risk taking behaviours and is associated with an increased likelihood of sex at a younger age, a greater number of partners, more regretted or coerced sex, risk of sexual aggression and violence and teenage pregnancy.

Sexually Transmitted Diseases

Sexually transmitted infections are preventable and disproportionately affect vulnerable groups of the population. However rapid and early diagnosis and management of STIs minimises associated complications and can break the chain of transmission and spread of the disease. Late diagnoses and treatment of STIs however can lead to significant illness and complications such as ectopic pregnancies, infertility, systemic infections, long term illness and cancer.

A number of risk taking behaviours and other factors that increase the risk of contracting STIs have been identified. These include alcohol and drug misuse, early onset of sexual activity, unprotected sex, condomless sex with casual or multiple partners and poor contraceptive use. Other risk factors include, low self-esteem and lack of practical and negotiation skills as well as poor knowledge about the risk of different sexual behaviours. Young people are at increased risk of STIs if they have poor access to sexual health services, resources such as condoms and poor sex and relationship education. Peer pressure and attitudes of society also impact on poor access to services are other contributing factors.

Conception, Contraception and Abortion

In 2018, the birth rate in the UK was 11 births per 1,000 population, the lowest birth rate in the country since 2002. The average age at which a mother gives birth in the UK has also increased alongside the drop in birth rate. In 2000, the average age of a mother giving birth in the UK was 28.5, by 2018 it was 30.6. [7]

Over the last 18 years the under-18 conception rate has fallen by over 60% with all councils achieving reductions, but inequalities remain. There is a seven-fold difference in the rate between local authorities and 60% of councils have at least one ward with a rate significantly higher than England. Sustaining and accelerating progress is integral to improving wider outcomes for children and young people, particularly the most vulnerable, and reducing long term demand on services.[8]

Under 18 conceptions are strongly associated with deprivation, in 2018 the conception rate for women under 18 was higher in the 50% most deprived areas of England (ONS Conceptions in England and Wales: 2018)

While the number of teenage conceptions has dropped in England and Wales, the share of pregnant teenagers under 20 years getting abortions has increased. The number of teenage conceptions under 20 years ending in abortion has increased from 42 percent to 47 percent in the same period, 2008 to 2017. Teenagers are the most likely age group in England and Wales to go through an abortion after a pregnancy.[7]

Teenage parenthood is associated with considerable health and social risks. Teenage mothers are more likely to smoke during pregnancy and less likely to breastfeed which results in poorer health for their babies. Stillbirth rates are 30% higher for children born to women under 20. The Incidence of low birth weight of term babies is 30% higher for babies born to women under 20 and the infant mortality rate is 60% higher rate for babies born to women under 20. [8]
Young people in England still experience higher teenage birth rates than their peers in Western European countries, teenagers remain at highest risk of unplanned pregnancy, inequalities in rates persist between and within local authorities, and outcomes for young parents and their children are still disproportionately poor.[9]

Figure 2: Teenage Pregnancy whole systems approach, Teenage Pregnancy Prevention Framework, PHE May 2018

Sexual Violence

Sexual and domestic violence, sexual exploitation and abuse affect women, children and men. More than a third of rapes reported to police are against children under 16 years of age. Sexual violence is defined as any unwanted behaviour perceived to be of a sexual nature or sexual contact that takes place without consent or mutual understanding. The Sexual Violence Research Initiative defines sexual violence as:

> *"Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality*

using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work".

They go on to divide sexual violence into four types and five classification categories as follows:

- *Completed sex act without the victim's consent, or involving a victim who is unable to consent or refuse;*
- *An attempted (non-completed) sex act without the victim's consent, or involving a victim who is unable to consent or refuse;*
- *Abusive sexual contact;*
- *Non-contact sexual abuse;*
- *Sexual violence, type unspecified – Inadequate information available to categorize into one of the other 4 categories.* [10]

Serious sexual crime including rapes, sexual assaults, and sexual activity with children; other sexual offences including soliciting, exploitation of prostitution, and other unlawful sexual activity between consenting adults.

According to the Crime Survey for England and Wales (CSEW), 2018-19, there was an increase of 7% in the number of sexual offences recorded by the police in the year ending March 2019 compared with the previous year (up to 162,030). This is a smaller increase than in recent years (24% in the year ending March 2018). Within the overall increase:

- police recorded rape, accounting for 36% of all sexual offences, increased by 9% (to 58,657 offences), compared with 30% in the year ending March 2018
- other sexual offences (64% of all those recorded), increased by 6% (to 103,373 offences), compared with 20% in the year ending March 2018

The increase in sexual offences against children contributed to around one-fifth (20%) of the total increase in the number of sexual offences recorded by the police. [11]

In addition it is estimated that the year ending March 2017 12.1% of adults aged 16 to 59 have experienced sexual assault (including attempts) since the age of 16, equivalent to an estimated 4 million victims. This equates to 3.4 million female victims and 631,000 male victims.

Since the age of 16, an estimated 3.6% of adults have experienced domestic sexual assault (including attempts), that is sexual assault perpetrated by a partner or family member. Around three times as many adults experienced sexual assault (including attempts) by a partner (3.1%) than by a family member (0.9%).[11]

These offences range from the most serious crimes such as rape and sexual assault to indecent exposure and unwanted touching. An estimated 3.1% of women and 0.8% of men report that knowing their perpetrator.

Females aged 10 to 24 were disproportionately more likely to be victims of sexual offences recorded by the police, particularly those aged 10 to 14 and 15 to 19. For example, while 5% of the female population were aged 10 to 14, this age group accounted for 23% of police recorded sexual offences where the victim was female (Figure xxx below). Males aged 5 to 19 were also disproportionately more likely to be victims of sexual offences (Figure 4 below). For example, while 6% of the male population were aged 10 to 14, this age group accounted for 30% of police recorded sexual offences where the victim was male. [11]

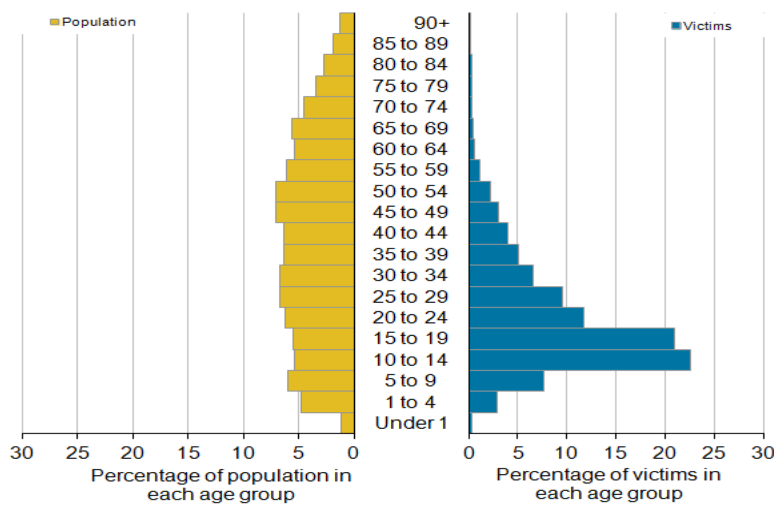


Figure 3: Distribution of female population and female victims of police recorded sexual offences, by age, Home Office Data Hub (28 forces), year ending March 2017

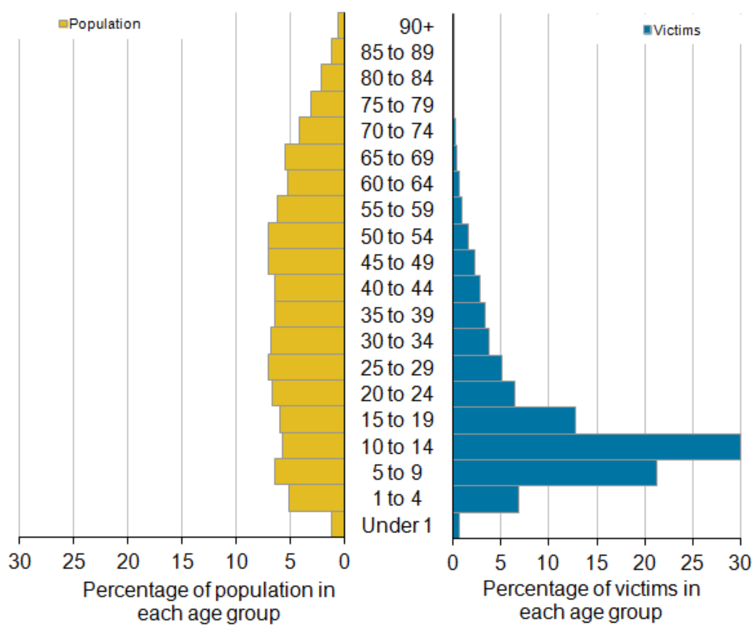


Figure 4: Distribution of male population and male victims of police recorded sexual offences, by age, Home Office Data Hub (28 forces), year ending March 2017

The effects of sexual violence on victims can include depression, anxiety, post-traumatic stress disorder, drug and substance misuse, self-harm and suicide. However, when victims receive appropriate and timely support they are more likely to take positive steps to recovery. Good access to effective support services is therefore crucial.

Adverse Childhood Experiences (ACE) and Sexual Health

ACEs are a set of traumatic events or circumstances occurring before the age of 18 that have been shown through research to increase the risk of adult mental health problems and debilitating diseases.

The 10 original ACEs are:

Physical abuse	Sexual abuse	Psychological abuse	Physical neglect	Psychological neglect
Witnessing domestic abuse	Having a close family member who misused drugs or alcohol	Having a close family member with mental health problems	Having a close family member who served time in prison	Parental separation or divorce on account of relationship breakdown

ACE studies consistently confirm that the greater the number of ACEs experienced before the age of 18, the greater the chance of poor adult outcomes. Findings from a recent systematic review of all ACE studies completed since 1998, for instance, observed that experiencing four or more ACEs, in comparison to experiencing no ACEs, typically:

- doubles the risk of obesity, physical inactivity and diabetes
- triples the risk of smoking, cancer, heart disease or respiratory disease
- quadruples the risk of sexual risk-taking, mental health problems and problematic alcohol use
- increases the risk of problematic drug use and interpersonal and self-directed violence by seven-fold.

There is evidence that they not only affect the person's physical and mental health, but also those experiencing more ACEs in childhood are more likely to have poorer outcomes in school, and more likely to be involved in anti-social or aggressive behaviour.

However it is important to note that not all children exposed to ACEs necessarily develop poor outcomes; resilience and other factors that can mitigate developmental harms can have better outcomes.

Summary

- Young people aged 15 to 24 years old experience the highest diagnosis rates of the most common STIs in England, 61% of chlamydia cases and 36% of gonorrhoea diagnoses (August 2017) with young women are more likely to be diagnosed with an STI than young men.
- Of the 64,831 new STI diagnoses in MSM in 2018 in England, gonorrhoea and chlamydia were most common at 41% and 29%, respectively.
- In 2000, the average age of a mother giving birth in the UK was 28.5, by 2018 it was 30.6.
- Under 18 conceptions are strongly associated with deprivation. In 2018, the conception rate for women under 18 was higher in the 50% most deprived areas of England (ONS Conceptions in England and Wales: 2018)
- The number of teenage conceptions under 20 years ending in abortion has increased from 42% to 47% in the same period, 2008 to 2017. Teenagers are the most likely age group in England and Wales to go through an abortion after a pregnancy.

- Stillbirth rates are 30% higher for children born to women under 20. The Incidence of low birth weight of term babies is 30% higher for babies born to women under 20 and the infant mortality rate is 60% higher rate for babies born to women under 20.
- In England and Wales (2019) police recorded rape, accounting for 36% of all sexual offences, increased by 9% (to 58,657 offences), compared with 30% in the year ending March 2018
- Females aged 10 to 24 are disproportionately more likely to be victims of sexual offences recorded by the police. While 5% of the female population were aged 10 to 14, this age group accounted for 23% of police recorded sexual offences where the victim was female (2017)
- Males aged 5 to 19 were also disproportionately more likely to be victims of sexual offences.
- While 6% of the male population were aged 10 to 14, this age group accounted for 30% of police recorded sexual offences where the victim was male. (2017)
- The greater the number of ACEs experienced before the age of 18, the greater the chance of poor adult outcomes

3. National, Regional and Local Policy Context

National Policy

Improving sexual health is one of the national public health priorities outlined in the national public health strategy **Healthy Lives, Health People**, [12] which pledged to work towards integrated sexual health services. Improving sexual health and reducing the burden of disease is also noted as a priority by Public Health England for 2013/14. [13]

The national sexual health strategy **A Framework for Sexual Health Improvement in England** aims to improve the sexual health of the whole population, to reduce inequalities and to improve sexual health outcomes.[14] The policy calls to build an open and honest culture where everyone is able to make informed and responsible choices about relationships and sex and to recognise that sexual ill health can affect all parts of society. The building stones to achieve this are the development of knowledge and resilience among young people, prevention and rapid access to high quality services for all leading to reduced rates and transmission of STIs, unwanted pregnancies and teenage pregnancies and people remaining healthy as they age. [15]

Public Health Outcomes Framework provides a key set of indicators against which progress is made [16].
In December 2015 Public Health England (PHE) published a strategic action plan for Health promotion for sexual and reproductive health and HIV. This plan identified the following as health
PHE has developed **sexual and reproductive health profiles** to support local authorities and others to monitor the health of their populations and the contribution of local public health related systems. [17]

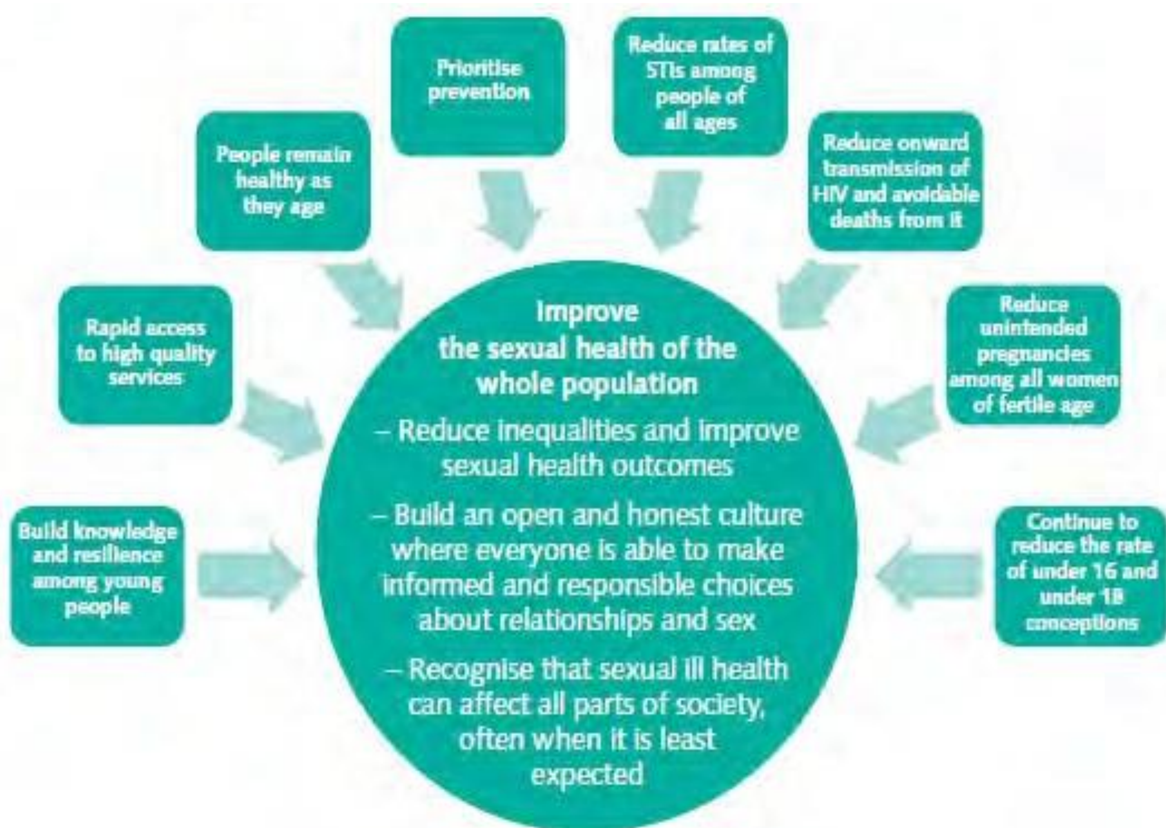


Figure 5: Framework for Sexual Health Improvement in England. 2013 [14]

PHE's **Teenage Pregnancy Prevention Framework** states that:

> *"Building the knowledge, skills, resilience and aspirations of young people, and providing easy access to welcoming services, helps them to delay sex until they are ready to enjoy healthy, consensual relationships and to use contraception to prevent unplanned pregnancy. Central to success is translating the evidence into a multi-agency whole system approach."* [8]

The Framework is designed to help local areas assess their local programmes to see what's working well, identify any gaps, and maximise the assets of all services to strengthen the prevention pathway for all young people. It is being used in a variety of ways: to review actions across a whole area, to focus on high rate wards or to strengthen a specific aspect of prevention, for example relationships and sex education in advance of statutory status in all schools from September 2020. A self-assessment checklist is provided for councils to collate a summary of the current local situation and identify gaps and actions.

Young people should be supported to take informed decisions about their sexual health leading to a reduction in teenage pregnancies, STIs and better outcomes for teenage parents. To achieve this the policy calls for strong and accountable leadership, high quality sex and relationship education in schools and colleges, youth friendly services, targeted programmes, education and advise for at risk groups as well as support and education for parents and practitioners working with young people at risk. The policy makes explicit reference to the '**You're Welcome**' initiative which sets out quality standards for sexual health services to improve services for young people. [18]

Local Policy

The Health and Wellbeing Strategies of the four local authorities across Teesside are informed by the Joint Strategic Needs Assessment which regularly updates key information and analysis on sexual health and victims of domestic and sexual violence. Health and Wellbeing strategies are closely linked to other local health and local authority strategies. Currently there are no sexual health strategies or teenage pregnancy strategies in place.

National Standards, Guidance and Plans

The national policy on **Commissioning Sexual Health Services and Interventions** supports local authorities in commissioning high quality services according to local need and national requirements. [19]

The national guidance **Making it work: A guide to whole system commissioning for sexual health, reproductive health and HIV** supports a whole system approach to commissioning sexual health services and focuses on the impact of commissioning in terms of outcomes defined in the Public Health and NHS Outcomes Frameworks and the benefits to service users as well as the wider population. Collaboration is essential to developing local commissioning strategies, assessing the implications of decisions across the whole system and agreeing shared pathways that ensures secure seamless SH, RH and HIV Services. It states:

> *'Sexual health, reproductive health and HIV services make an important contribution to the health of the individuals and communities they serve. Their success depends on the whole system - commissioners, providers and wider stakeholders - working together to make these services as responsive, relevant and as easy to use as possible and ultimately to improve the public's health'*

Figure 6 below shows the range of services commissioned by local authorities, clinical commissioning groups (CCGs) and NHS England. [20]

Commissioning responsibilities for sexual health services		
Local authorities	**CCGs**	**NHS England**
Comprehensive sexual health services. These include: • Contraception, including LESs (implants) and NESs (intro-uterine contraception and all Prescribing costs, but excluding contraception provided as an additional service under the GP contract • Sexually transmitted infections (STI) testing and treatment, chlamydia screening as part of the National Chlamydia Screening Programme(NCSP) and HIV testing • Sexual health aspects of psychosexual counselling • Sexual health specialist services including: young people's sexual health and teenage pregnancy services, outreach, HIV prevention in school, colleges and pharmacies.	• Most abortion services • Sterilisation • Vasectomy • Non-sexual health elements of psychosexual health services • Gynaecology, including any use of contraception of non-contraceptive purposes	• Contraception provided as an additional service under the GP contract • HIV treatment and care including drug costs for PEPSE • Promotion of opportunistic testing and treatment for STIs and patient-requested testing by GPs • Sexual health elements of prison health services • Sexual Assault Referral Centres • Cervical screening • Specialist fetal medicine services

Figure 6: Commissioning responsibilities for sexual health services. (DH Commissioning for sexual health services and interventions 2013)

The **Public Health Outcomes Framework for England 2013-1016** outlines targets for Chlamydia diagnostic rates, under 18 conceptions and people presenting with HIV at a late stage of infection.[21]

Standards and guidance for sexual health services have been developed by a number of organisations. The British Association for Sexual Health and HIV (BASHH) has published **Standards for the Management of Sexually Transmitted Infections**.[22] The Medical Foundation for HIV and Sexual Health (MEDFASH) developed **Recommended Standards for Sexual Health Services** and **Recommended Standards for NHS HIV Services.**[23,24] New **Service Standards for Sexual and Reproductive Healthcare** have been published Faculty of Sexual and Reproductive Healthcare.[25] The British HIV Association (BHIVA) issued **UK Guidelines for the Management of Sexual and Reproductive Health of People Living with HIV Infection**.[26]

The **Sexual and reproductive health: Spend and Outcome Tool (SPOT)** can be a useful tool for LAs who are interested in comparing spend data on sexual and reproductive health with sexual and reproductive health outcomes. [27]

NICE clinical guidance on **Long Acting Reversible Contraception** (LARC) from 2005, updated in 2019, offers best practice advice on the provision of information and care for women who consider using LARC. [28]

The report **Progress towards ending the HIV epidemic in the United Kingdom** [29] and the NICE standard **HIV Testing: encouraging uptake** [30] recommends actions to improve the availability and accessibility of HIV testing through community engagement, outreach and targeted services especially to gay, bisexual, other men who have sex with men, black African men and women.

NICE public health guidance on **Hepatitis B and C** specifically recommends the development of local care pathways including testing of high risk individuals in sexual health settings.[31]

The NHS Long Tem Plan has a focus on prevention to help people stay healthy and also moderate demand on the NHS. Within the Plan the NHS and the government will consider whether the NHS should have a 'stronger role' in commissioning sexual health services, health visitors and school nurses (currently commissioned by local government). [32]

4. Methodology

Health needs assessments (HNA) are best described as:

> *"A systematic process used by NHS organisations and local authorities to assess the health problems facing a population. This includes determining whether certain groups appear more prone to illness than others and pinpointing any inequalities in terms of service provision. It results in an agreed list of priorities to improve healthcare in a particular area."* [33]

A health needs assessment reviews needs and maps current service provision to identify any gaps in service provision as well as barriers to access services. The results of the health needs assessment will help to priorities the allocation of finite resources to best meet local needs.

The chosen approach for this HNA is a rapid HNA and due to both time constraints and capacity will be based on routinely available epidemiological information, service provision and performance data. Stakeholder, service user and public consultation will also take place alongside this HNA.

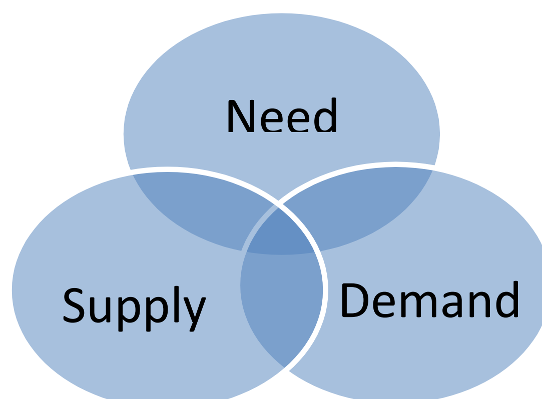


Figure 7: Health Needs Assessment. (HDA 2004) [34]

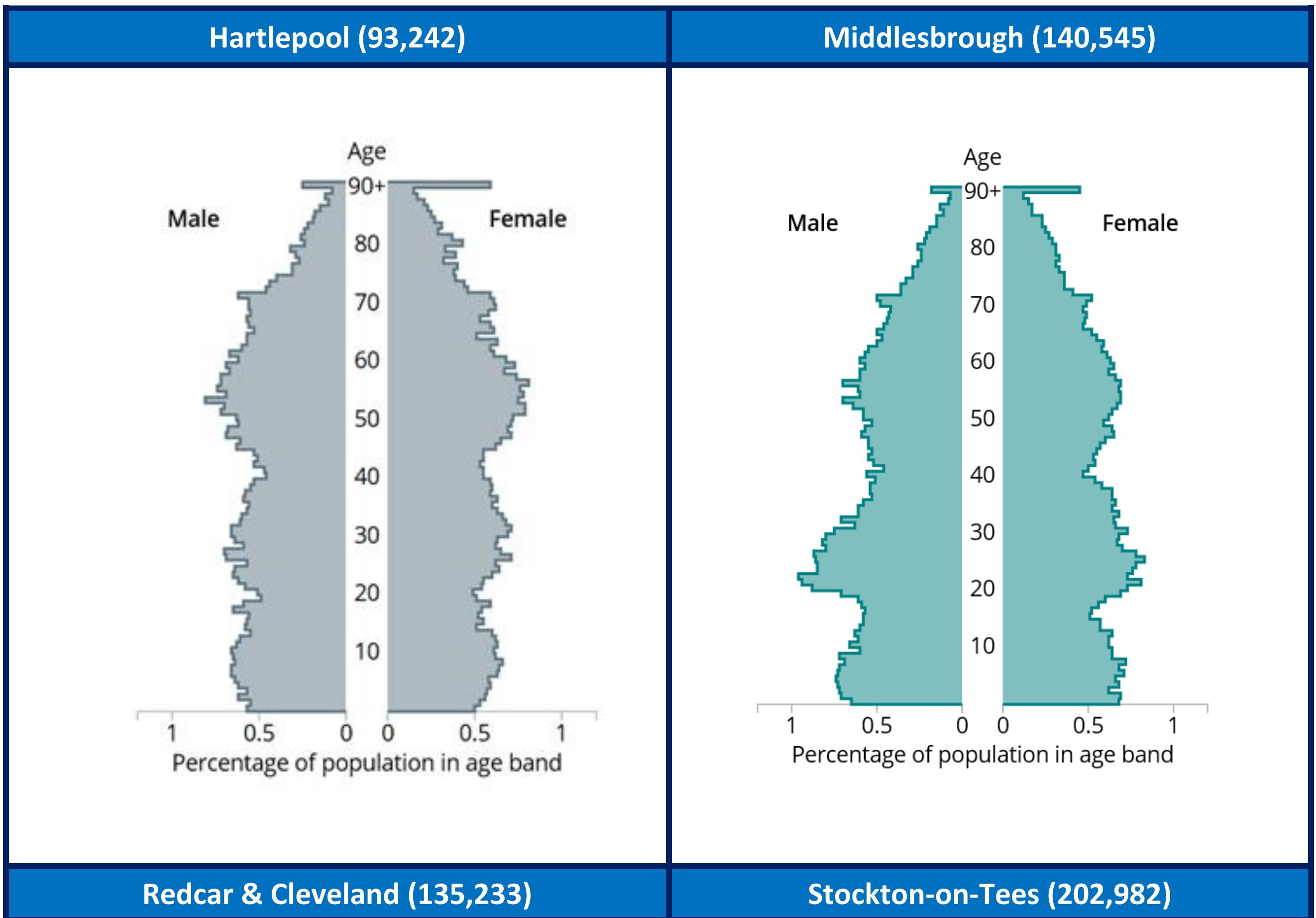
Data on demographic information was obtained from the Office of National Statistics and local authority Intelligence officers. Information on the incidence and prevalence of sexually transmitted infections was mainly provided through national publications of PHE, the Department of Health and Social Care and other national bodies such as FSRH. Statistics on conceptions and contraception were obtained from the Office of National Statistics. Sexual Health Teesside and local authorities have provided local service information for service mapping. There are a number of limitations associated with this health needs assessment:

- routinely available data, information and reports are frequently updated and newer data sets might be available by the time the report has been published. The authors have always endeavoured to use the most recent information available at the time of conducting the needs assessment;
- a full stakeholder involvement for a comprehensive health needs assessment has not been undertaken due to time and resource constraints;
- a review of expenditure is not part of the remit of this assessment;
- the report focuses on sexual health services provided and commissioned by local authorities and provides only limited information on sexual health services commissioned by CCGs and NHS England.

5. Demography and Socioeconomic Status

Population

The four local authorities in Teesside have a total population of 567,718. Stockton-on-Tees has the largest population with 197,213 followed by Middlesbrough with 140,545, Redcar & Cleveland with 136,718 and Hartlepool with 93,242. Middlesbrough has the youngest population with 16.2% of children aged 12 years and younger, alongside a higher proportion of people aged 15-44 years at 39.7%, compared to Stockton-on-Tees at 36.4%, Hartlepool at 35.3% and Redcar & Cleveland at 32.9%.



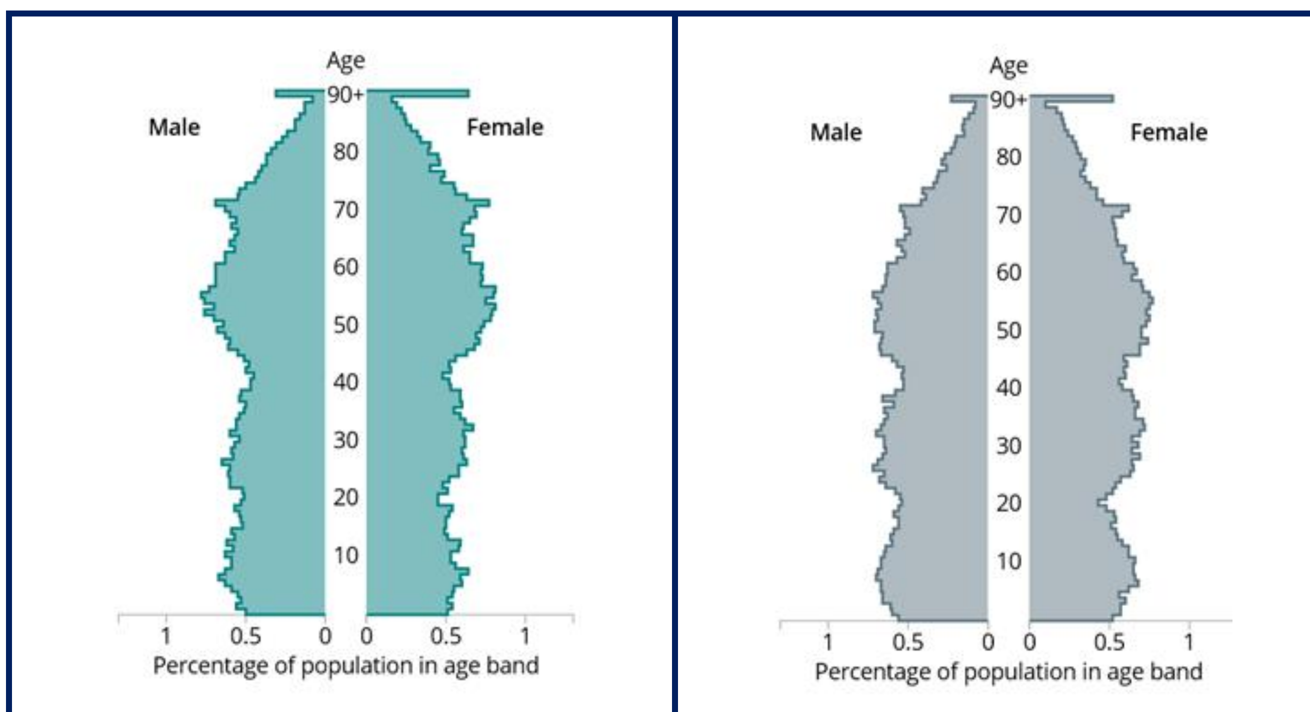


Figure 8: Population pyramids, ONS mid-2018 estimates

Population estimates for 2028 project a modest population growth for all areas with a population of 202,982 in Stockton-on-Tees, 141,608 in Middlesbrough, 135,233 in Redcar & Cleveland and 93,392 in Hartlepool. The number of young people aged 15-24 in 2018 in Teesside was 66,789. The projection for 2028 predicts an increase of around 5,000 young people to total of 71,559 aged 15-24.

Gender

The proportion of male and female residents in Teesside is similar to the national and regional distribution with slightly more women (50.9%) than men (49.1%).

Gender distribution of population in local authorities in Teesside										
	Hartlepool		Middlesbrough		Redcar & Cleveland		Stockton		Teesside	
N (%)	N	%	N	%	N	%	N	%	N	%
Female	47,718	51.2%	71,109	50.6%	70,301	51.4%	99,891	50.7%	289,019	50.9%
Male	45,524	48.8%	69,436	49.4%	66,417	48.6%	97,322	49.3%	278,699	49.1%

Table 2: Gender distribution of population in local authorities in Teesside. ONS 2018 mid-year population estimates.

Ethnicity

Teesside is less diverse than England on average, as 5.25% of the population is of non-white ethnicity compared to 14%. There is considerable variation between the local authorities however, with Hartlepool and Redcar & Cleveland the least diverse with very low BME populations of 2.3% and 1.5% respectively, whereas Middlesbrough is the most diverse due to 11.8% of the population deriving from non-white ethnicity.

Ethnicity of population in local authorities in Teesside										
	Hartlepool		Middlesbrough		Redcar & Cleveland		Stockton		Teesside	
N (%)	N	%	N	%	N	%	N	%	N	%
White	89,911	97.70%	122,079	88.20%	133,149	98.50%	181,263	94.60%	527,973	94.75%
Asian	1,104	1.20%	9,827	7.10%	676	0.50%	5,748	3.00%	16,438	2.95%
Black	92	0.10%	1,799	1.30%	135	0.10%	1,150	0.60%	2,925	0.53%
Mixed	644	0.70%	2,353	1.70%	811	0.60%	1,916	1.00%	5,572	1.00%
other	368	0.40%	2,491	1.80%	270	0.20%	1,533	0.80%	4,458	0.80%

Table 3: Ethnicity of population in local authorities in Teesside. ONS Census 2011.

Socio-economic Status

Local authorities in Teesside generally have high levels of deprivation. Middlesbrough has the highest proportion of Lower Super Output Areas (LSOAs) within the top 10% most deprived in England, as nearly half of all LSOAs fall in this category, with Hartlepool ranked 10th, Redcar & Cleveland ranked 29th, and Stockton-on-Tees ranked 39th.

Deprivation on Teesside 2019		
Area	**Proportion of LSOAs in 10% most deprived**	**Rank of proportion of 10% most deprived** (out of 317 LAs)
Hartlepool	36%	10
Middlesbrough	49%	1
Redcar & Cleveland	24%	29
Stockton-on-Tees	21%	39

Table 4: Deprivation in local authorities in Teesside. ONS census 2011

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Summary

- Teesside has a total population of 567,718 with 66,789 young people aged 15-24. Estimates for 2028 predict a modest population growth overall, including an increase of around 5,000 for this age group.
- The BME population in Teesside (5.25%) is small compared to the national average of 14%. Middlesbrough has the highest proportion of BME population with 11.8%. The majority of the BME population in Teesside is of Asian ethnicity.
- Deprivation is comparably high in Teesside, particularly in Middlesbrough and Hartlepool which are among the 10 local authorities in England with the highest proportion of most deprived LSOAs.

6. Sexually Transmitted Infections (STIs)

This chapter summarises the main findings of data from the Spotlight on STI's in the North East Annual Report, the Local Authority LASER Reports and PHE Fingertips data for 2018, for new diagnoses of STIs and trends in STIs.

Regional data indicates that the numbers of new cases of STIs have decreased since 2014. This was primarily associated with a reduction in chlamydia and genital warts infections, although there was a significant increase in syphilis infections as well as gonorrhoea and genital herpes.

Acute STIs include chlamydia, gonorrhoea, syphilis, genital warts and herpes and HIV infections. In Teesside 3300 acute STIs have been diagnosed in 2018, a reduction from 3794 cases in 2017.

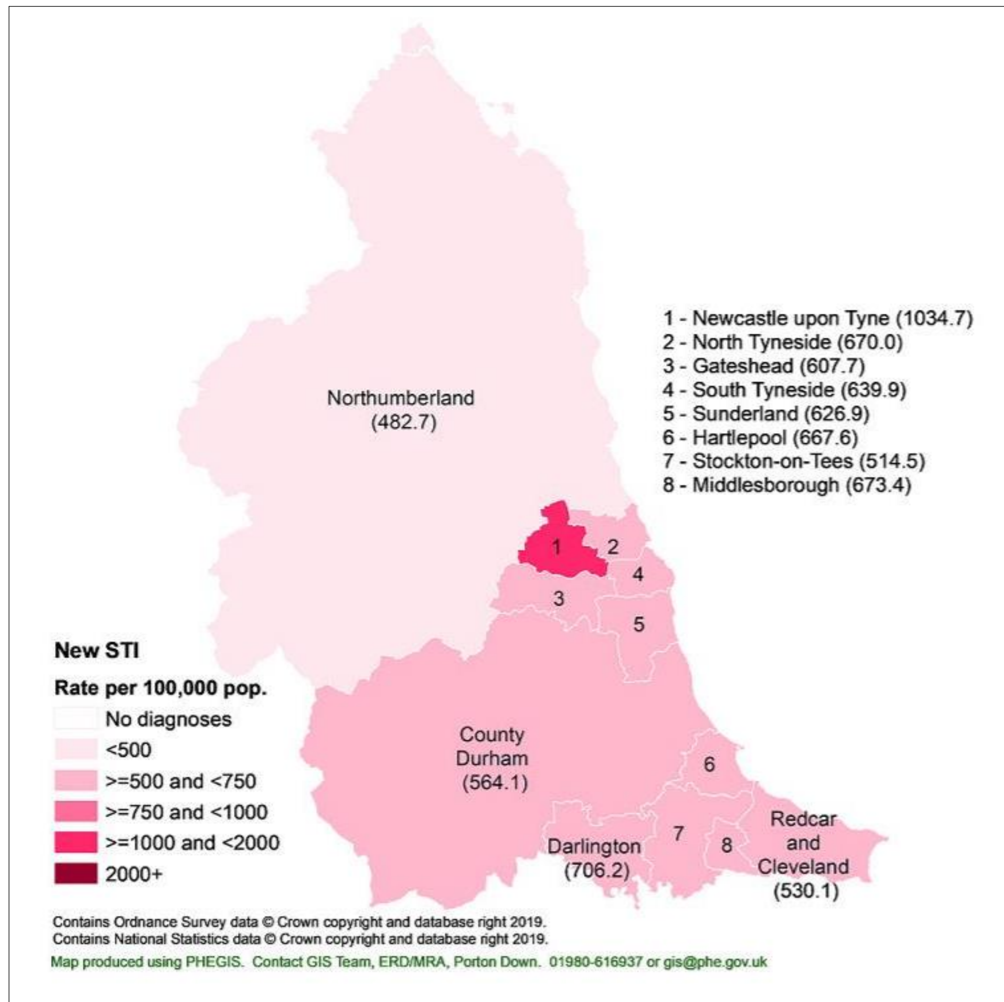


Figure 9: Map of new STI rates per 100,000 residents by upper-tier local authority in the North East, 2018

Rates of acute STIs 2018		
Area	**Acute STI rate 2018**	**Rank within England***
	n/100 000	Rank of 317 LAs
Hartlepool	668	102
Middlesbrough	673	99
Redcar & Cleveland	530	185
Stockton-on-Tees	515	199

Table 5: Rates of acute STIs per 100 000 population of all ages of STIs in population in 2018. PHE laser report for local authorities 2018
*1st rank has highest rates

Reinfection rates of STIs indicate persistent risky behaviour. At national level 7% of all women and 9.7% of all men presenting with an acute STI at a sexual health clinic became re-infected within 12 months. Reinfection rates across Tees are similar to the national average with only women in Hartlepool having a higher rate at 9.5%, whereas the rate was 6.8% for men. Reinfection rates were 5.3% for women and 4.8% for men in Middlesbrough, 4.8% for women and 4.6% for men in Redcar & Cleveland and 5.3% for women and 5.6% for men in Stockton-on-Tees.

Gonorrhoea

Gonorrhoea infections increased by 23% between 2014 and 2018 in the North East, with a slight reduction of 1% between 2017 and 2018. Rates have fallen in recent years across Teesside, particularly in Redcar & Cleveland. Middlesbrough has the highest rate of gonorrhoea in Teesside, however the rate is slightly lower than the North East average and considerably below national average.

Annual number and rate of gonorrhoea cases 2016-2018						
Area	**2016**		**2017**		**2018**	
	N	Rate*	N	Rate*	N	Rate*
Stockton-on-Tees	112	57.2	118	60.1	105	53.4
Middlesbrough	119	84.8	95	67.5	92	65.4
Hartlepool	54	58.2	52	55.9	48	51.6
Redcar & Cleveland	100	73.8	65	47.8	51	37.5
Tees	385	N/A	330	N/A	296	N/A
North East	N/A	65.2	N/A	67.2	1,760	66.5
England	N/A	64.8	N/A	78.5	54,798	98.5

Table 6: Annual number and rate of gonorrhoea cases 2016-2018. PHE, North East Annual STI Report 2018
*n/100 000 population

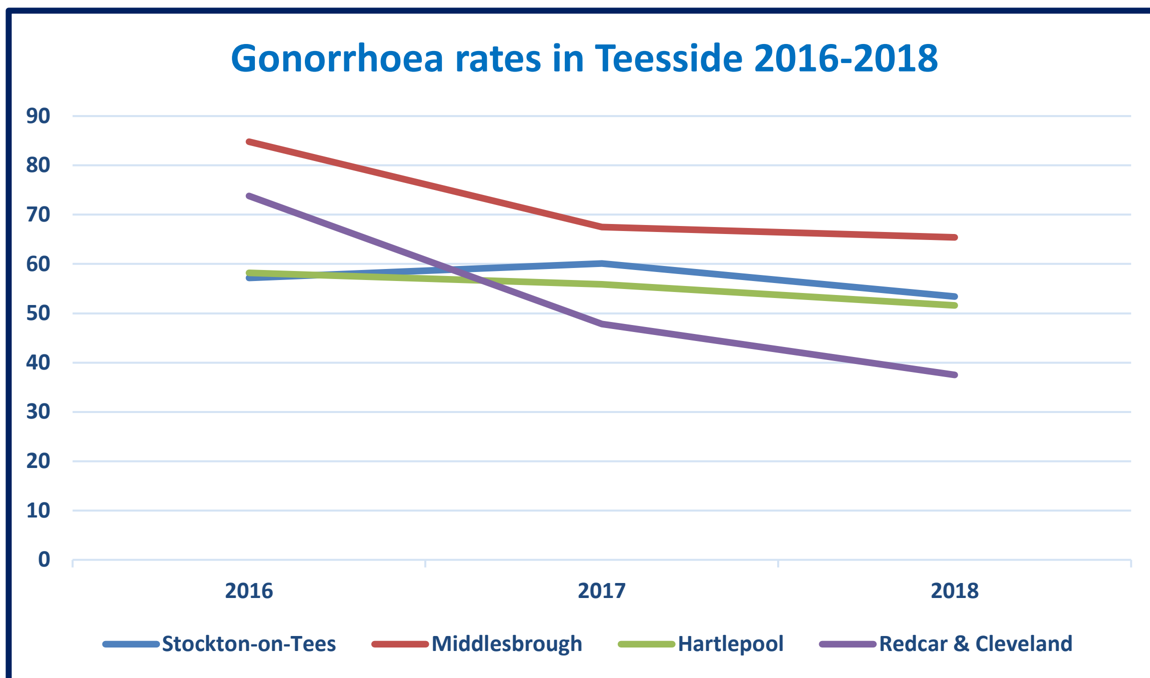


Figure 10: Trend in gonorrhoea rates in Teesside 2016-2018

Gonorrhoea infection rates were highest in young people aged 20-24, followed by those aged 15-19 and 25-34. The ratio between male and female patients has been stable over the past few years, with 1.4 male patients to female patients for gonorrhoea in the North East.

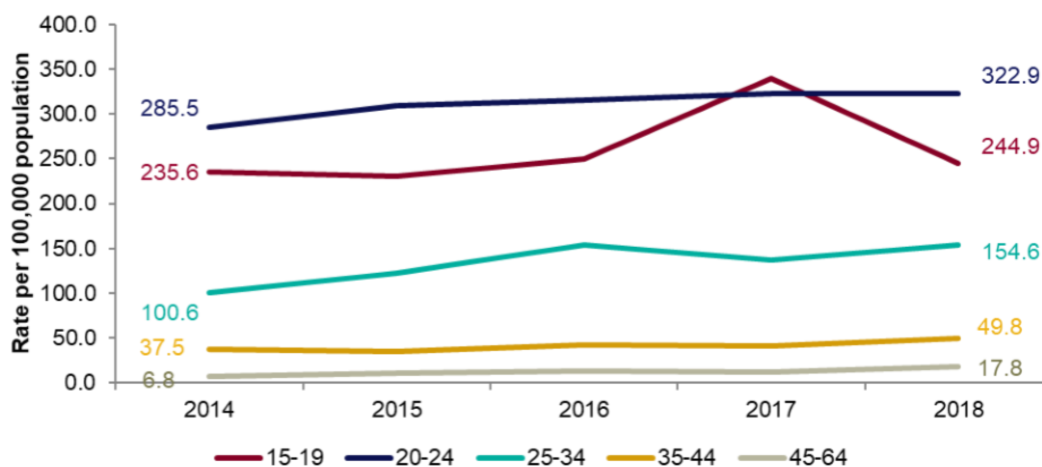


Figure 11: Trends in North East gonorrhoea rates (per 100,000) by age group 2014-2018. Spotlight, 2018.

Chlamydia

Chlamydia diagnoses in the North East decreased slightly between 2016 and 2018 but at the same time increased in Teesside from 1597 to 1946 cases, with a peak of 2481 cases in 2017. The increase seen in Teesside was caused by significantly more cases in Stockton-on-Tees, Hartlepool and Redcar & Cleveland, whereas there was a far smaller increase in Middlesbrough. The rate of newly diagnosed chlamydia infections in 2018 for Hartlepool and Middlesbrough was higher than the average rate in the North East and in England, with Stockton-on-Tees and Redcar & Cleveland's rates lower.

There are more female chlamydia infections than male infections in the North East, with a ratio of 0.7 male cases per female case.

Annual number and rate of chlamydia cases 2016 - 2018						
Area	2016		2017		2018	
	N	Rate*	N	Rate*	N	Rate*
Stockton-on-Tees	432	220	842	429	588	299
Middlesbrough	528	376	687	488	546	388
Hartlepool	276	297	392	421	370	398
Redcar & Cleveland	370	273	560	412	442	325
Tees	1,606	N/A	2,481	N/A	1,946	N/A
North East	8,844	N/A	N/A	N/A	8,735	330
England	N/A	365	N/A	363	213,785	384

Table 7: Annual number and rate of chlamydia cases 2016-2018. Fingertips, LASER Reports, Spotlight.
*n/100,000 population

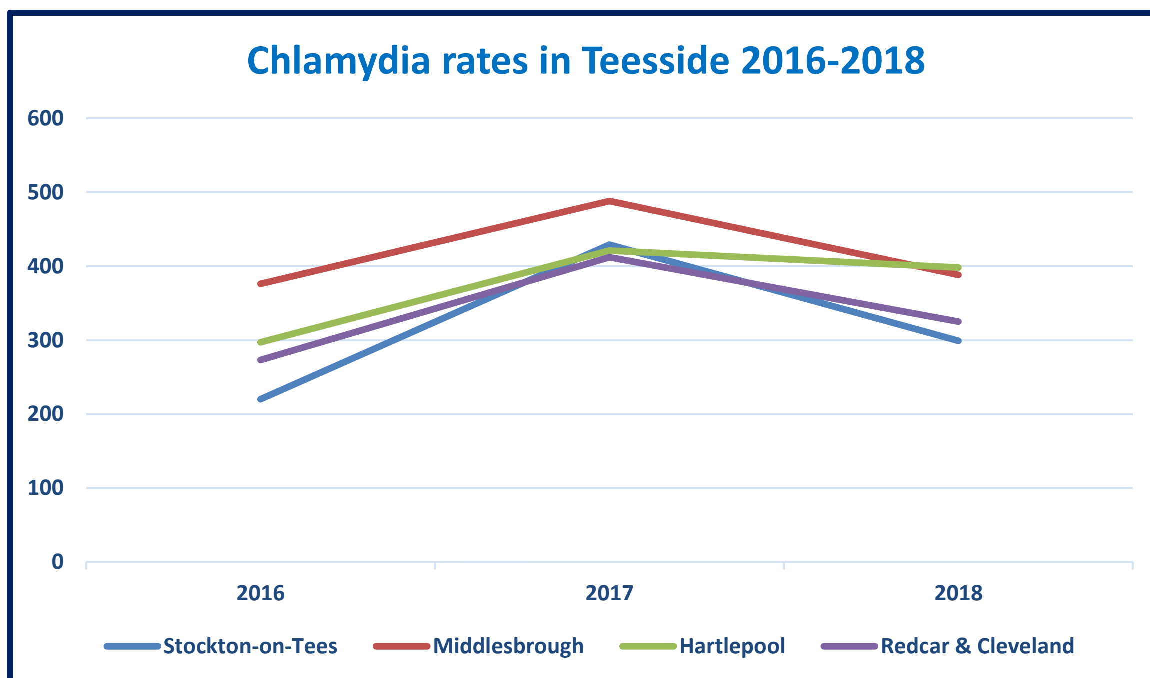


Figure 12: Trend in chlamydia rates in Teesside 2016-2018

Chlamydia tests, diagnoses and diagnostic rate in 2018 in young people aged 15-24					
	Total Tests	**Percent of population tested**	**Total Positive**	**Percent of tests positive**	**Diagnosis rate per 100,000**
Hartlepool	2,175	20.1%	281	12.9%	2,597
Middlesbrough	2,797	13.5%	375	13.4%	1,816
Redcar & Cleveland	2,443	16.5%	301	12.3%	2,034
Stockton-on-Tees	3,494	15.4%	401	11.5%	1,763
North East	60,263	18.3%	5,974	9.9%	1,815
England	1,304,113	19.1%	131,269	9.7%	1,975

Table 8: Chlamydia tests, diagnoses and diagnosis rate in 2018 in young people aged 15-24. PHE Fingertips 2018

Chlamydia testing is measured by the diagnosis rate, which considers both the number of tests and cases found. In Teesside in 2018, only Hartlepool achieved and exceeded the national target of 2,300 chlamydia diagnoses per 100,000 population aged 15-24, with 20.1% of the eligible population tested – the highest in Teesside, whereas Middlesbrough tested the lowest percentage of the population at 13.5%. Positivity rates were highest in Middlesbrough however, and lowest in Stockton-on-Tees.

The number of chlamydia tests performed in Teesside has dropped considerably between 2012 and 2018, with all but Hartlepool testing a lower percentage of the eligible population in 2018. The majority of chlamydia tests in 15-24 year olds in 2018 in all local authorities in Teesside, apart from Hartlepool took place in community settings as opposed to Genito-Urinary Medicine (GUM) clinics. Positivity rates were higher in tests from GUM clinics however, for all Teesside local authorities.

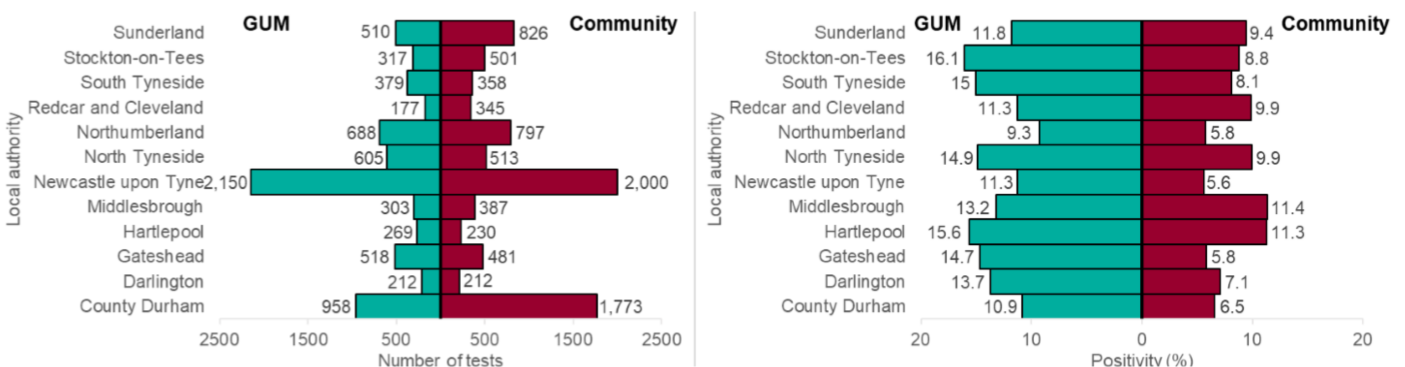


Figure 13: Number of tests and positivity (%) of chlamydia testing by North East local authority and GUM/community. Spotlight, 2018.

Syphilis

The number of syphilis cases in the North East increased by 63% between 2014 and 2018, including a substantial increase in the number of new cases in Teesside from 35 in 2014 to 115 in 2018. The North East male to female ratio increased from 5.5 male cases per female case in 2014, to 6.9 in 2018, with national and regional data demonstrating a strong correlation between deprivation and syphilis infections. Men having sex with men (MSM) are particularly at risk, accounting for 82% of male cases in England, 70% of male cases in the North East and 65% of cases in Teesside.

Annual number and rate of syphilis cases 2016 - 2018				
Area	2016	2017	2018	
	Rate*	Rate*	N	Rate *
Stockton-on-Tees	6.6	7.1	36	18.3
Middlesbrough	3.6	4.3	34	24.2
Hartlepool	11.8	8.6	12	12.9
Redcar & Cleveland	1.5	4.4	22	16.2
Tees	N/A	N/A	104	N/A
North East	N/A	N/A	245	9.3
England	10.5	12.4	7,287	13.1

Table 9: Annual number and rate of syphilis cases 2016-2018. PHE Fingertips.
*n/100,000 population

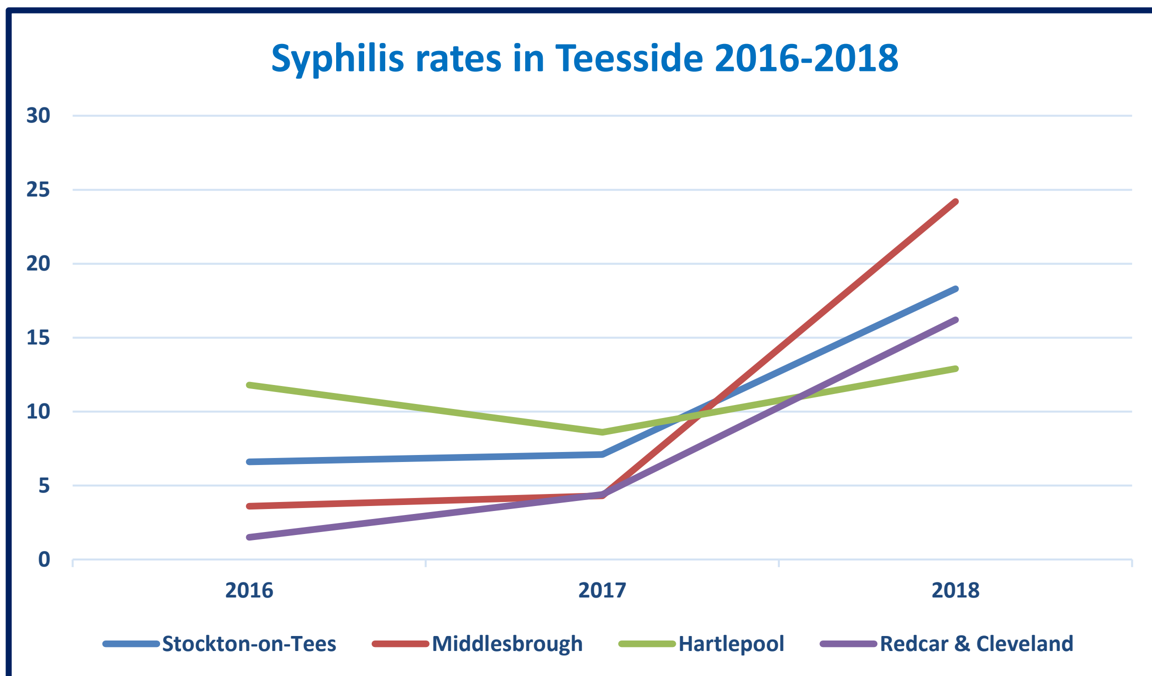


Figure 14: Trend in syphilis rates in Teesside 2016-2018

Genital Warts and Herpes

Genital wart infections decreased between 2016 and 2018 in England, the North East and in Teesside, with the rate in all Teesside local authorities lower than the North East and England averages. The highest rate in Teesside was found in Hartlepool, whereas Stockton-on-Tees had the lowest rate. Males are more affected in the North East, with a ratio of 1.4 male cases per female case.

Annual number and rate of genital warts and herpes 2016-2018												
	Number and rate of genital wart cases						Number and rate of herpes cases					
Area	2016		2017		2018		2016		2017		2018	
	No	Rate*	No	Rate*	No	Rate*	No	Rate*	No	Rate*	No	Rate*
Stockton-on-Tees	154	78.6	137	69.7	115	58.5	96	49	112	57	115	58.5
Middlesbrough	148	105.5	123	87.5	98	69.7	53	37.8	69	49.1	87	61.9
Hartlepool	98	105.6	92	98.9	81	87.1	54	58.2	60	64.5	55	59.1
Redcar & Cleveland	108	79.7	100	73.5	94	69.1	44	32.5	52	38.2	67	49.3
Tees	508	N/A	452	N/A	388	N/A	247	N/A	293	N/A	324	N/A
North East	N/A	113.3	N/A	104	2,464	93.2	N/A	55.9	N/A	58.2	1,600	60.5
England	N/A	112.4	N/A	103.3	55,683	100.1	N/A	58.1	N/A	56.4	32,790	59

Table 10: Annual number and rate of genital warts and herpes cases 2016-2018. PHE Fingertips.
*n/100,000 population

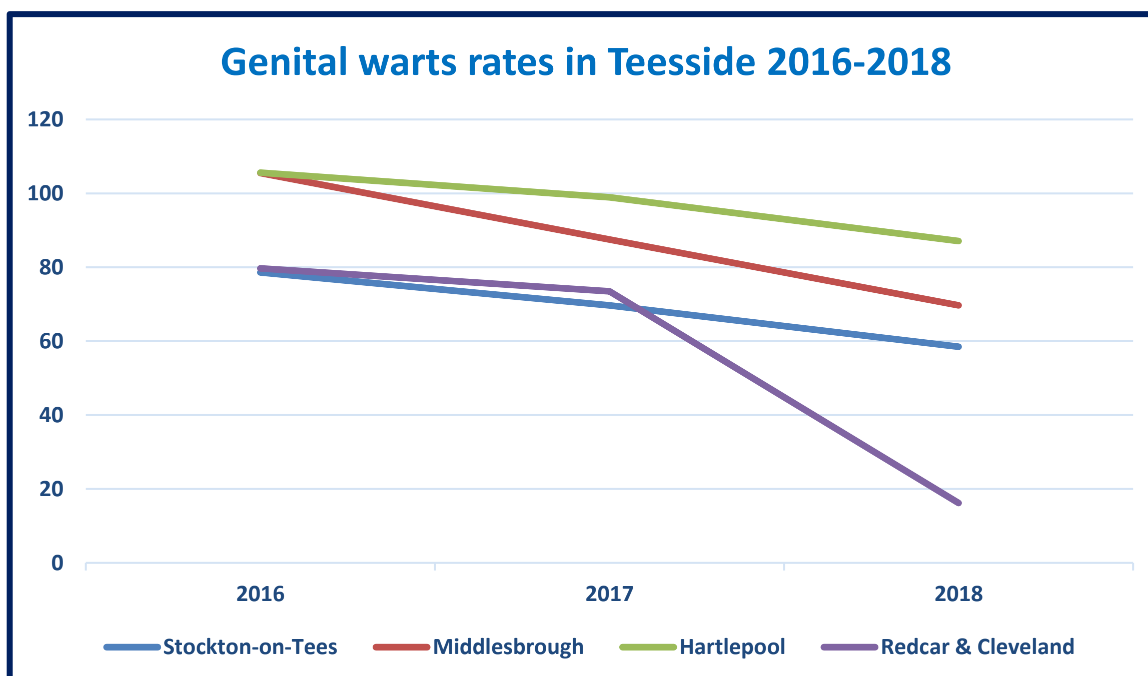


Figure 15: Trend in genital warts rates in Teesside 2016-2018

Genital herpes infections increased between 2016 and 2018 in England, the North East, and Teesside, with the highest rate in Teesside found in Hartlepool, whereas Redcar & Cleveland had the lowest rate. Females are more affected in the North East, with a ratio of 0.5 male cases per female case.

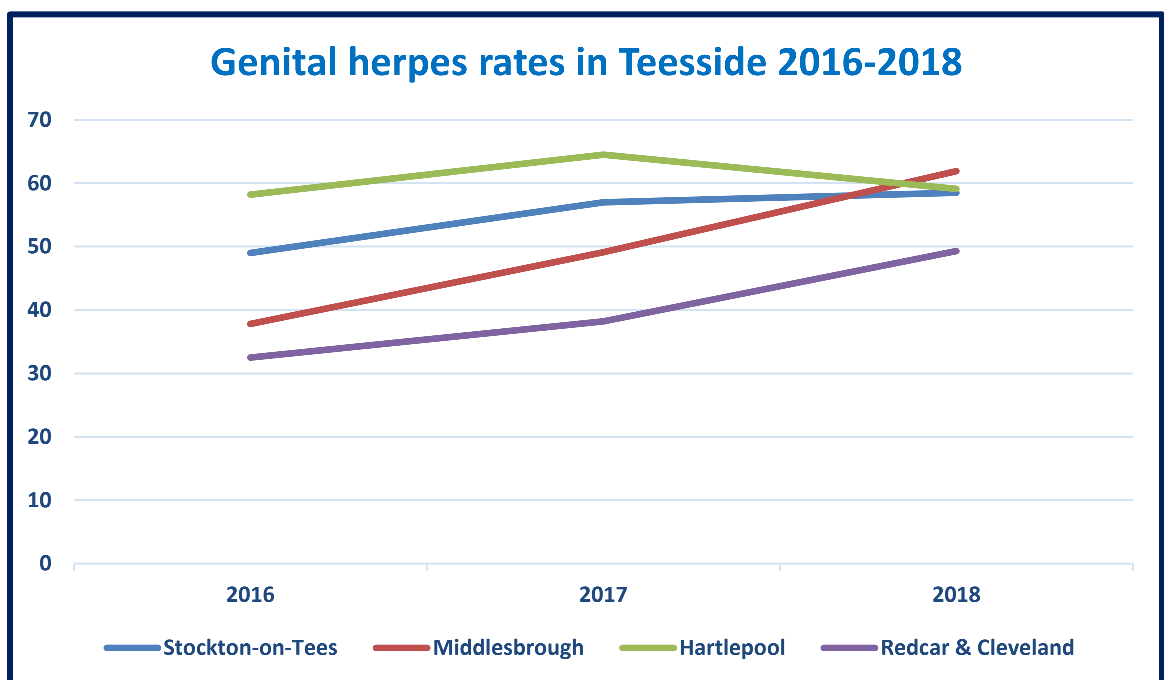


Figure 16: Trend in syphilis rates in Teesside 2016-2018

HIV

New HIV infections in England have decreased steadily since 2015, however simultaneously the number of people living with HIV in the UK has increased from 98,400 in 2012 to 103,800 in 2018, as less people are living with and dying from AIDS. Incidence and prevalence is significantly higher in London than any other area in the UK. 43% of all new HIV diagnoses in England are in MSM and although the proportion of late diagnoses of HIV has fallen over the past decade, it remains high.

Number and prevalence of diagnosed HIV-infected patients by local authority 2018		
Area	**Number**	**Prevalence (n/1000)**
Hartlepool	43	0.81
Middlesbrough	126	1.54
Redcar & Cleveland	38	0.51
Stockton	145	1.29
Tees	352	
North East	1,658	1.09
England	77,305	2.37

Table 11: Number and prevalence of diagnosed HIV-infected patients by Teesside local authority. PHE Fingertips.

The total number of people living with HIV has also increased in the North East and Teesside, however as the prevalence of HIV in Teesside is below 2/1000 population, it is considered a low prevalence area. HIV

prevalence in Teesside in 2018 was highest in Middlesbrough and lowest in Redcar & Cleveland, and out of 105 new HIV cases diagnosed in the North East in 2018, 30 were in Teesside.

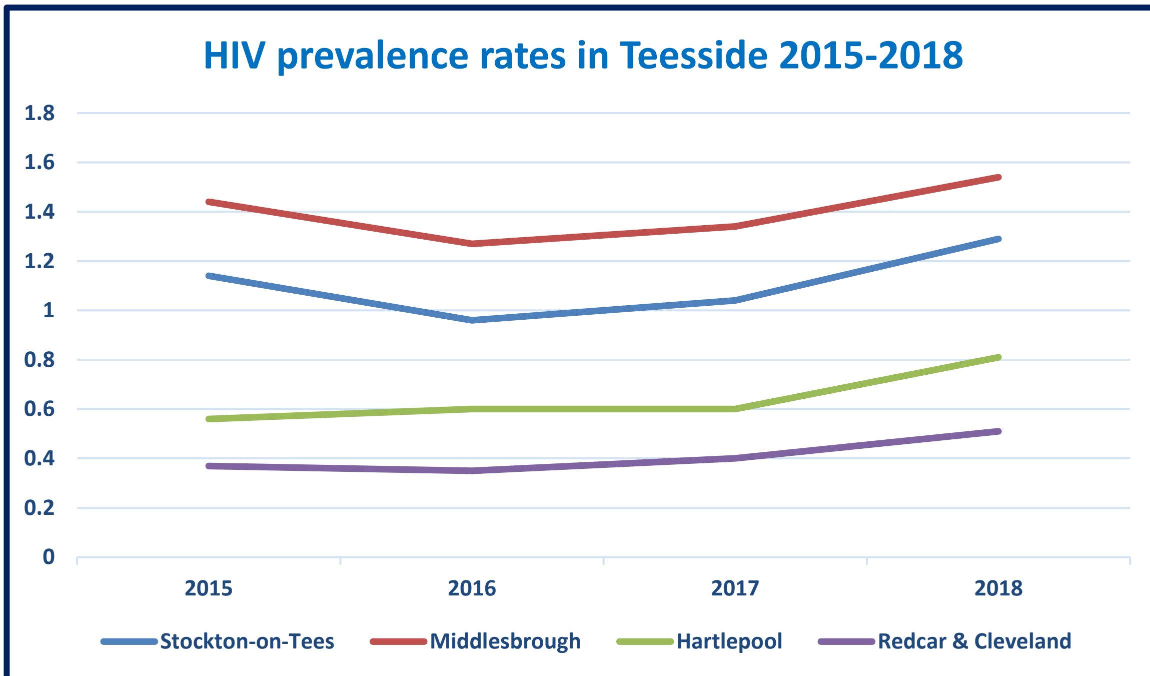


Figure 17: Trend in HIV prevalence rates in Teesside 2015-2018. Fingertips.

A late diagnosis is defined as having a CD4 count <350 cells/mm3 within three months of diagnosis and is the most important predictor of morbidity and one-year mortality among people with HIV infection. Between2016-2018 42.5% of all diagnoses in England were late, with a higher prevalence among heterosexuals, older people and black Africans.

Over a quarter of people living with HIV in Teesside were of black African or black Caribbean ethnicity. The 2018 HIV trends report outlines that the national decline in new HIV diagnoses since 2015 is driven by a decrease in the number of diagnoses reported among MSM.

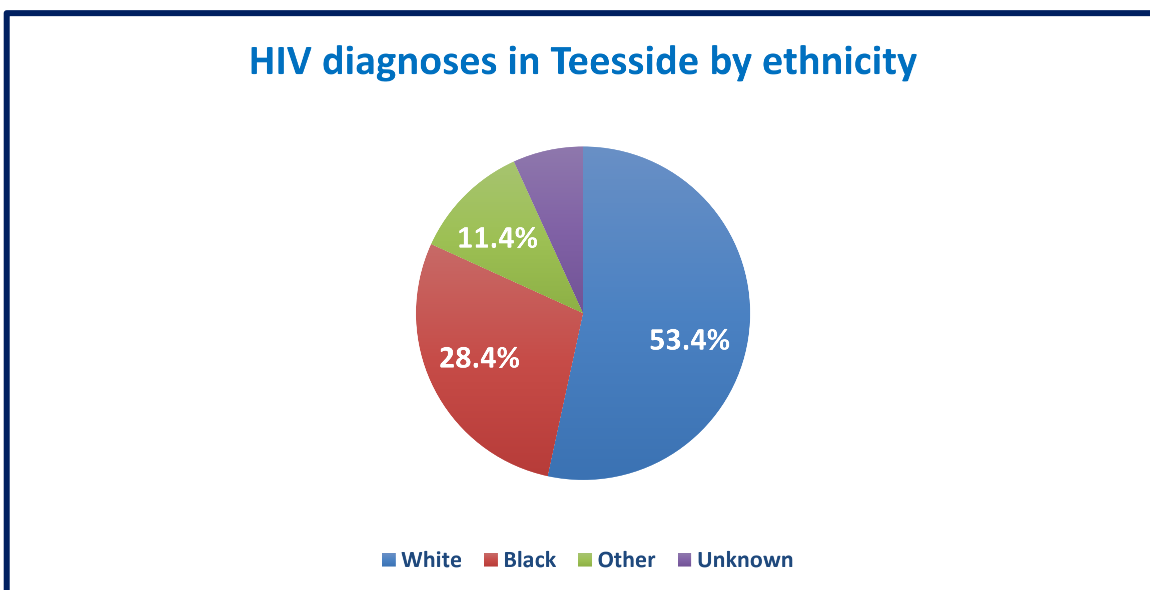


Figure 18: Proportion of those living with HIV in Teesside by ethnicity. LASER Reports 2018.

Vulnerable, at Risk and Hard to Reach Groups

Age Groups

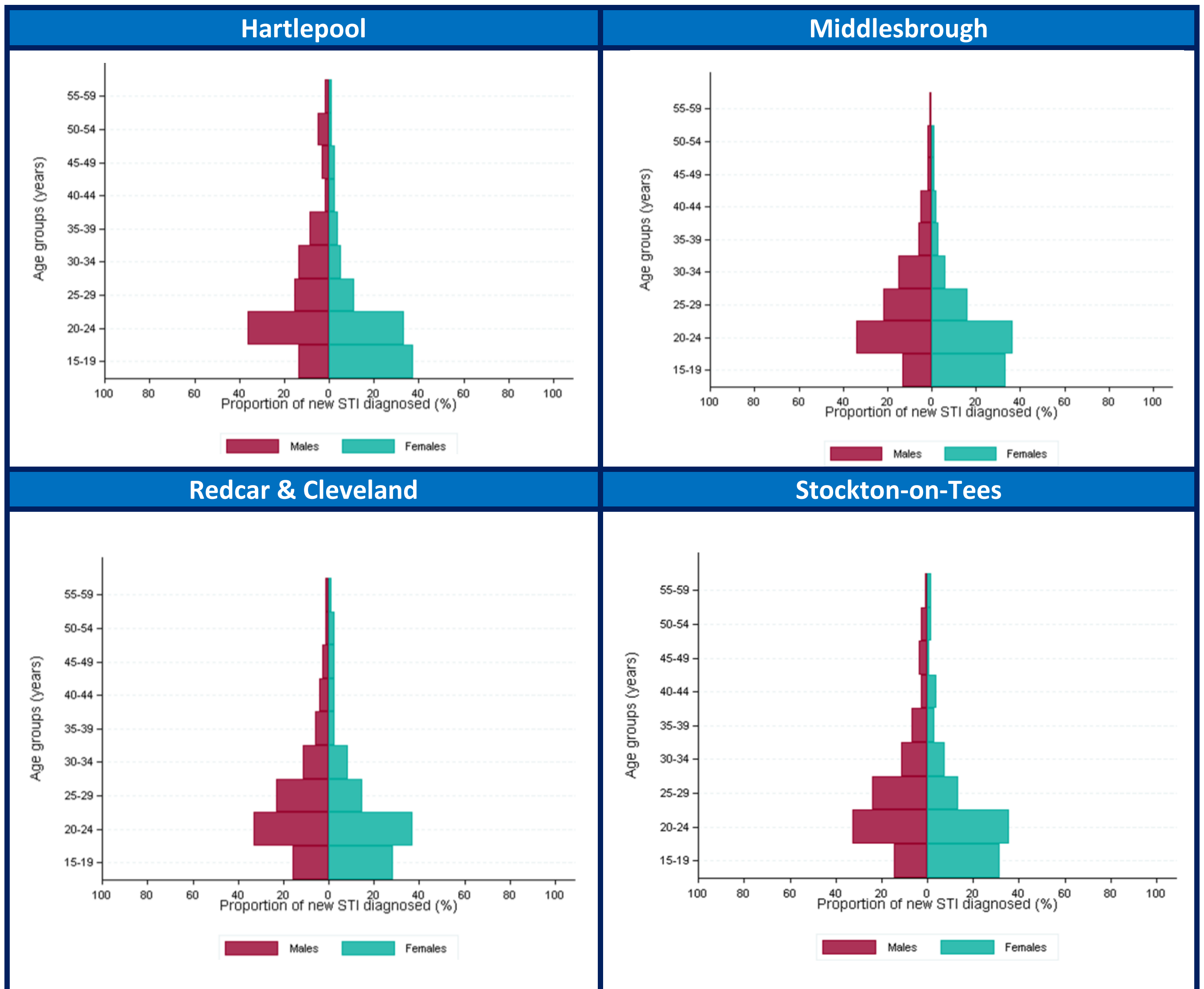


Figure 19: Age group and gender cases of new STIs. LASER Reports 2018.

Young people carry the burden of STIs and are also more likely to become re-infected with STIs, contributing to infection persistence and health service workload. Younger females 15-19 years carry more burden than males of the same age. Males who are 25years and above have more STI diagnoses than females 25 years and above.

Deprivation

Deprivation is strongly associated with a higher level of STIs. Almost half of all STIs diagnosed in Teesside in 2018 were for people from the most deprived 20% areas.

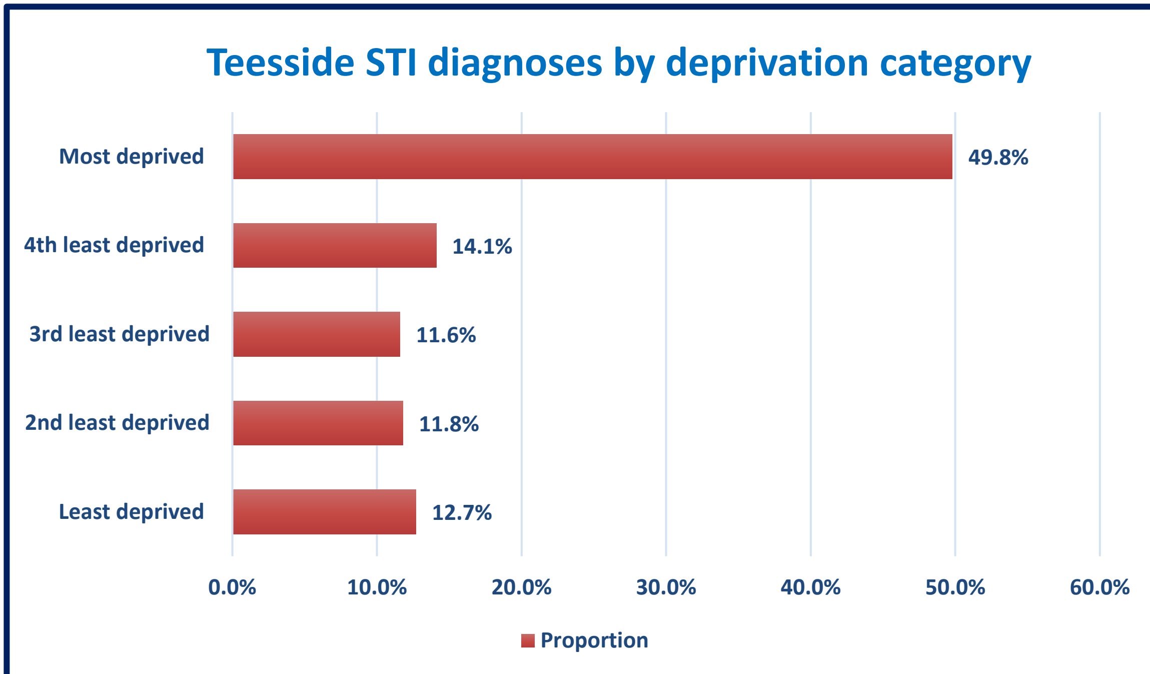
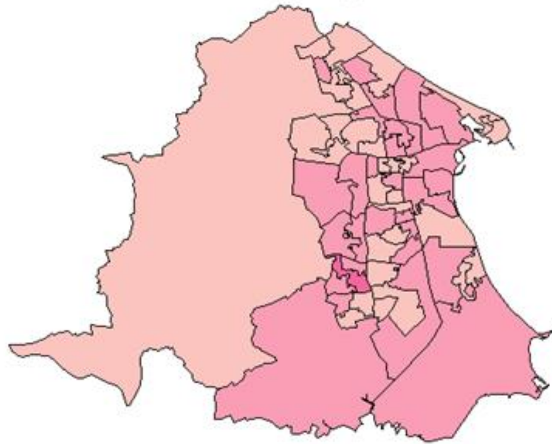
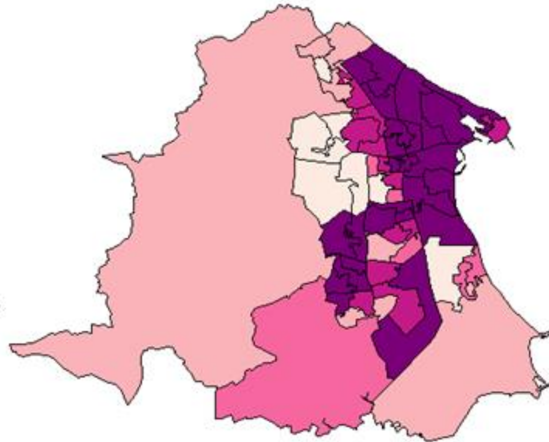


Figure 20: Proportion of 2018 STI diagnoses in Teesside by deprivation category. LASER Reports 2018.

Hartlepool





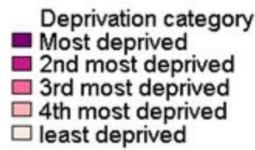
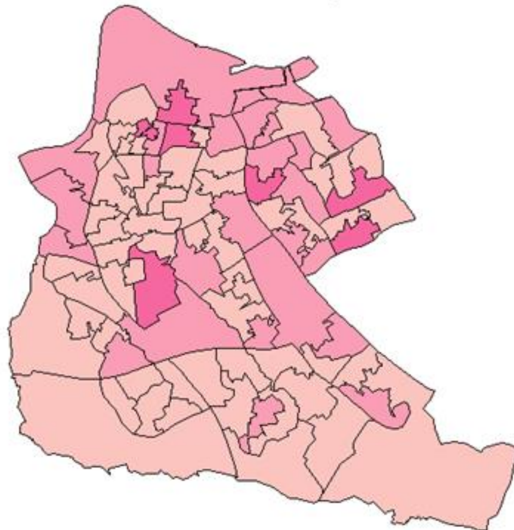
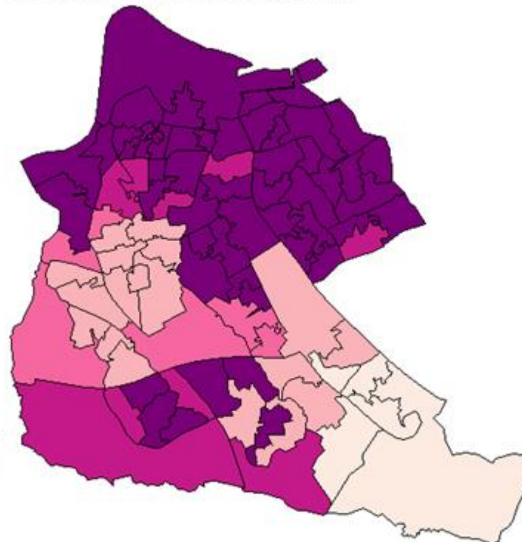


Figure 21 Rates per 100,000 population of new STIs and deprivation by LSOA in Hartlepool in 2018. LASER Report, 2018.

Middlesbrough





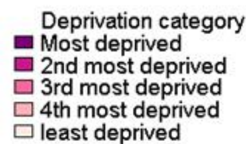
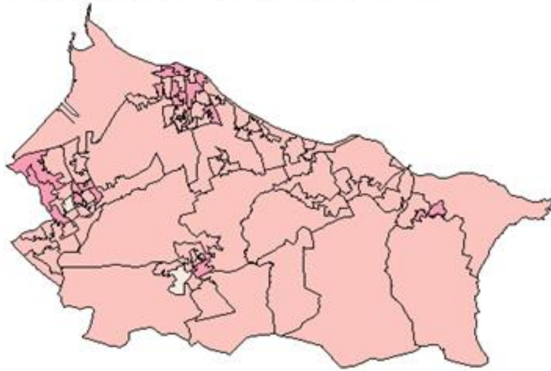
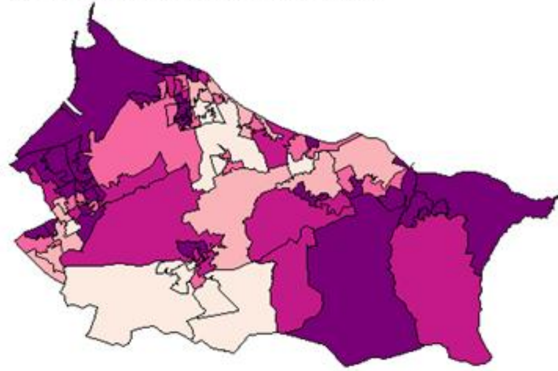


Figure 22: Rates per 100,000 population of new STIs and deprivation by LSOA in Middlesbrough in 2018. LASER Report, 2018.

Redcar & Cleveland





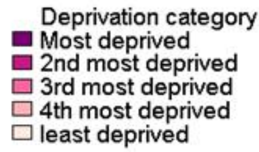
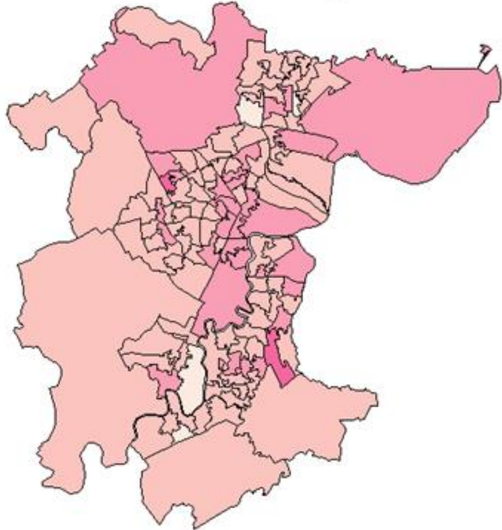
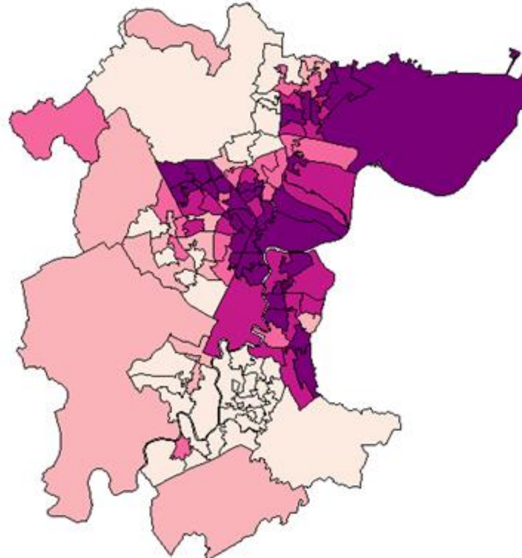


Figure 23: Rates per 100,000 population of new STIs and deprivation by LSOA in Redcar & Cleveland in 2018. LASER Report, 2018.

Stockton-on-Tees





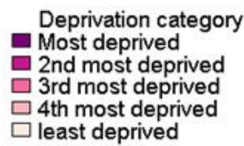


Figure 24: Rates per 100,000 population of new STIs and deprivation by LSOA in Stockton-on-Tees in 2018. LASER Report, 2018.

MSM

MSM have a higher risk of and prevalence of STIs compared to the general population. Where sexual orientation had been recorded, the proportion of acute STIs diagnosed in men in Teesside in 2018 attributed to MSM ranged from 15.4% in Hartlepool to 23.3% in Stockton-on-Tees.

In the North East 31% of all gonorrhoea and 70% of all syphilis infections were diagnosed in MSM. The figures for gonorrhoea and syphilis may vary considerably between local authorities from year to year because of the small number of infections.

Proportion of acute STIs and chlamydia infections in MSM		
	Acute STI	Chlamydia
	%	%
Hartlepool	15.4	12.5
Middlesbrough	20.7	18.2
Redcar & Cleveland	19.6	17.4
Stockton-on-Tees	23.3	16.2

Table 12: Rates per 100,000 population of new STIs and deprivation by LSOA in Stockton-on-Tees in 2018. LASER Report, 2018.

BME Groups

Some BME groups have a higher risk and prevalence of STIs. GUM data shows that the proportion of acute STIs in BME groups in Teesside is low with 3% in Hartlepool, 13.1% in Middlesbrough, 3% in Redcar & Cleveland and 7% in Stockton. These results however are based on records where ethnicity has been recorded and might not reflect the true proportion of acute STIs in BME groups, although unspecified ethnicity was low with all Teesside local authorities 1% and below.

Other Groups

Homeless people, sex workers and the prison population are known to have an increased risk of STIs. There is however no routinely available local sexual health data for these groups.

Summary

- National and regional increase in STI rates have been described. In Tees 3,300 acute STIs were diagnosed in 2018 compared to 3,794 in 2017.
- Reinfection rates as an indicator for risk taking behaviour were generally lower in Teesside, compared to national data, particularly for men.
- Gonorrhoea infection rates in Teesside have declined in recent years, and lie below the regional and national averages of 66.5 and 98.5. In Teesside, Middlesbrough has the highest rate with 65.4.
- Gonorrhoea infection rates correlate with deprivation. People living in most deprived areas are more than four times as likely to get gonorrhoea as those living in the least deprived areas.
- Gonorrhoea infection rates are highest in the 20-24 age group.
- Chlamydia infections have increased from 1,597 in 2016 to 1,946 cases in 2018 with higher than national and regional infection rates in Middlesbrough and Hartlepool.
- Chlamydia infection rates correlate with deprivation and are 70% higher in the population living in the most deprived areas.

- Chlamydia infection rates are highest in the 20-24 age group.
- Most chlamydia tests take place in community settings as opposed to GUM clinics (hubs). The highest positivity rates are found in GUM clinics compared to community settings however.
- Syphilis infections in Teesside increased substantially from 34 in 2014 to 115 cases in 2018, following the national and regional trend.
- Syphilis infections are associated with deprivation and the highest infection rates are found in the 25-34 age group.
- Genital wart infection rates generally decreased in Teesside and were lower than the North East and national averages.
- Herpes infection rates have increased in recent years. The highest infection rates for genital warts were seen in Hartlepool and highest rates for herpes were seen in Middlesbrough.
- New HIV infections decreased since 2015. The number of people living with HIV is increasing because there are less people living with and dying from AIDS.
- 30 new HIV infections were diagnosed in Teesside in 2018. Teesside has an overall low prevalence of HIV with altogether 352 people living with HIV. HIV rates are higher in Middlesbrough and Stockton-on-Tees compared to Hartlepool and Redcar & Cleveland.
- The burden of STIs was highest in young people aged 15-24. Between 58% and 63% of all STIs in Teesside occurred in this age group.
- Deprivation was strongly and positively associated with higher levels of STIs.
- MSM have a higher risk and prevalence of STIs. 15.4-23.3% of all STI diagnoses in Tees are in MSM, particularly gonorrhoea and syphilis where MSM account for 31% and 70% of diagnoses regionally.
- BME groups in general have a similar level of STIs as the local population, although black Caribbean's have higher infection rates of HIV.
- A higher risk and prevalence of STIs in other vulnerable groups such as homeless people, sex workers and the prison population is well known, although there is no routinely available data at national or local level.

7. Conceptions, Contraception and Abortion

Conceptions

The number and rate of conceptions in England and Wales has varied considerably between 1969 and 2017. The lowest rates were seen in 1976 and 2000 and the highest rates in 1971, 1989 and 2011. The number and rate of conceptions has increased steadily since 2000.

However, from 2012 the numbers and rate of conceptions has started to decline. The age at which women are most likely to conceive has also changed over time. Conceptions in women over 30 have increased considerably since 1990, while teenage pregnancies have decreased.

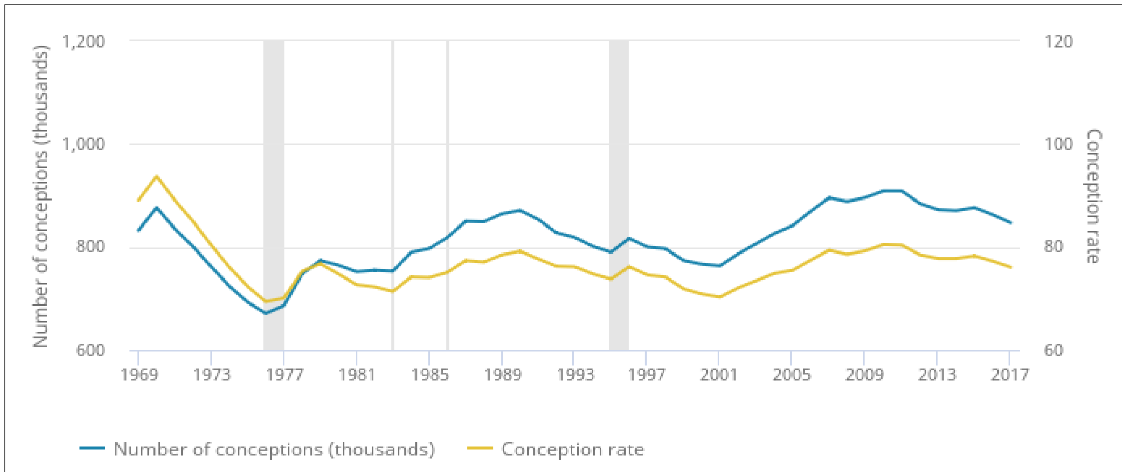


Figure 25: Number and rate of conceptions in England and Wales 1969 - 2017

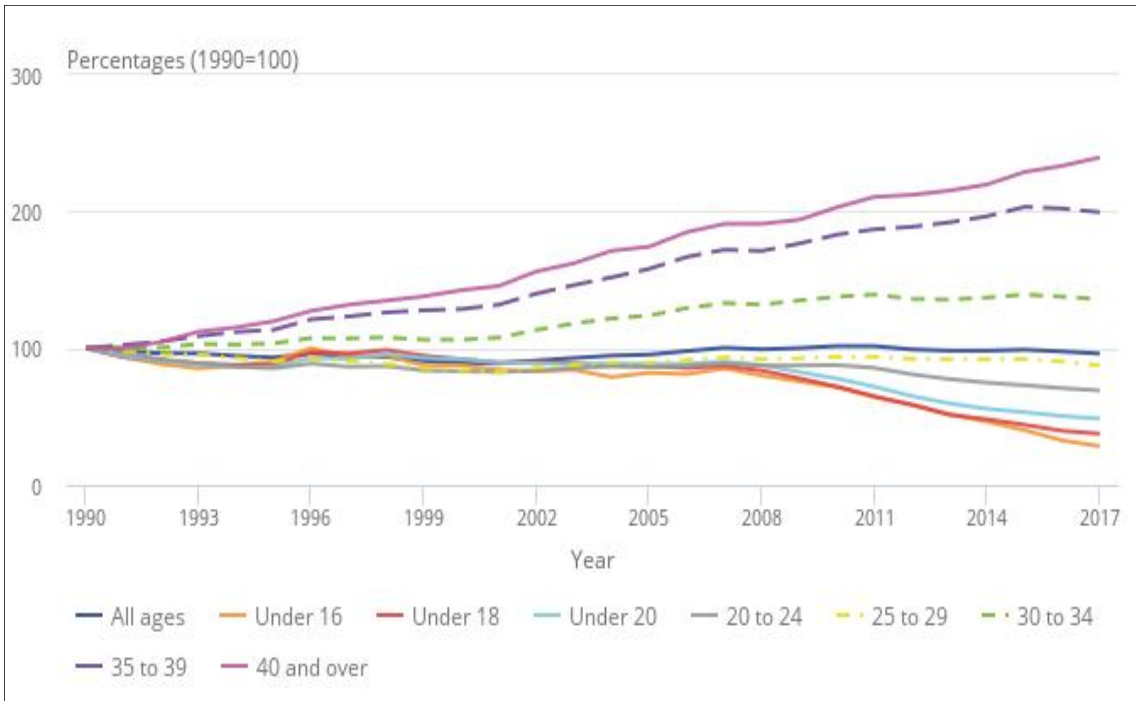


Figure 26: Percentage of conceptions per age group. ONS conception Statistics, England and Wales 2018

In 2018, the conception rates in Teesside were all above the national average of 75.7 with Middlesbrough having the highest rate at 89.6, followed by Hartlepool at 80.0, Stockton at 77.4 and Redcar and Cleveland at 76.1.

Number and rate of conceptions and proportion leading to abortion by local authority and year									
	2016			2017			2018		
	Number	rate per 1,000 women	% leading to abortion	Number	rate per 1,000 women	% leading to abortion	Number	rate per 1,000 women	% leading to abortion
Hartlepool	1,259	74.5	22.2	1,327	79.4	24.6	1,333	80.0	24.8
Middlesbrough	2,497	90.4	22.5	2,441	88.8	24.2	2,441	89.6	27.3
Redcar & Cleveland	1,776	76.7	18.5	1,738	75.9	22.9	1,734	76.1	24.6
Stockton	2,714	74.8	20.9	2,671	74.5	22.2	2,755	77.4	23.6
North East	34,358	70.5	20.5	33,861	69.9	21.5	34,156	70.5	23.6
England	822,745	77.6	21.8	807,245	76.4	22.7	800,196	75.7	24.0

Table 13: Number and rate of conceptions and proportion leading to abortion by local authority and year. ONS Conception Statistics, England and Wales, 2018

Teenage Pregnancy - < 18 conceptions

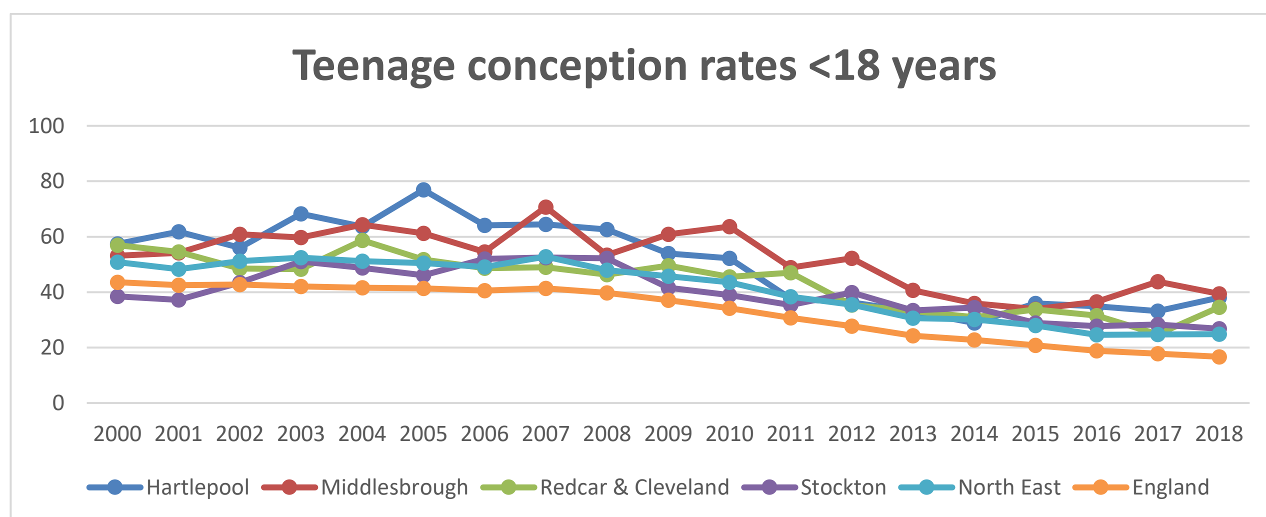


Figure 27: Trends of under 18 teenage conception rates 2000 - 2018 (based on ONS Conception Statistics, England and Wales, 2018)

The teenage pregnancy rate in England has decreased slowly between 2009 and 2011 and more sharply since 2011 from 30.7 to 16.7 in 2018. The teenage pregnancy rate in the North East is still higher than the national average but has shown a similar reduction from 38.4 to 24.9 in 2018.

During the same period, 2011-2018, teenage pregnancy rates in local authorities in Teesside have decreased in Middlesbrough (from 48.9 to 39.4), Stockton (from 35.4 to 26.8) and Redcar & Cleveland (from 47.0 to 34.6), while rates have remained practically the same in Hartlepool (from 37.7 to 38.0).

Middlesbrough has consistently high teenage pregnancy rates. The teenage pregnancy rate in Stockton which was below national (43.6) and regional (50.8) average in 2000 at 38.5 is now higher than national average (16.7) and similar to the regional average (24.9) in 2018 at 26.8.

Number and rate of conceptions for young women <18 by local authority and year								
Year	**2015**		**2016**		**2017**		**2018**	
	n of Concep-tions	rate per 1,000 Women <18	n of Concep tions	rate per 1,000 Women <18	n of Concep-tions	rate per 1,000 Women <18	n of Concep tions	rate per 1,000 Women <18
Hartlepool	62	35.9	58	34.9	52	33.2	57	38.0
Middlesbrough	84	33.9	90	36.5	103	43.8	88	39.4
R&C	77	33.7	70	31.6	53	24.8	72	34.6
Stockton	94	28.9	90	27.7	89	28.3	84	26.8
North East	1,199	28.0	1,023	24.6	994	24.7	986	24.9
England	19,080	20.8	17,024	18.8	15,748	17.8	14,736	16.7

Table 14: Number and rate of conceptions for young women <18 by local authority and year. ONS Conception Statistics, England and Wales, 2018

Table 14 above shows that teenage pregnancy numbers and rates have fallen in Hartlepool, Stockton and Redcar and Cleveland between 2015 and 2017. This trend has continued in 2018 in Stockton and Middlesbrough but not in Hartlepool and Redcar & Cleveland.

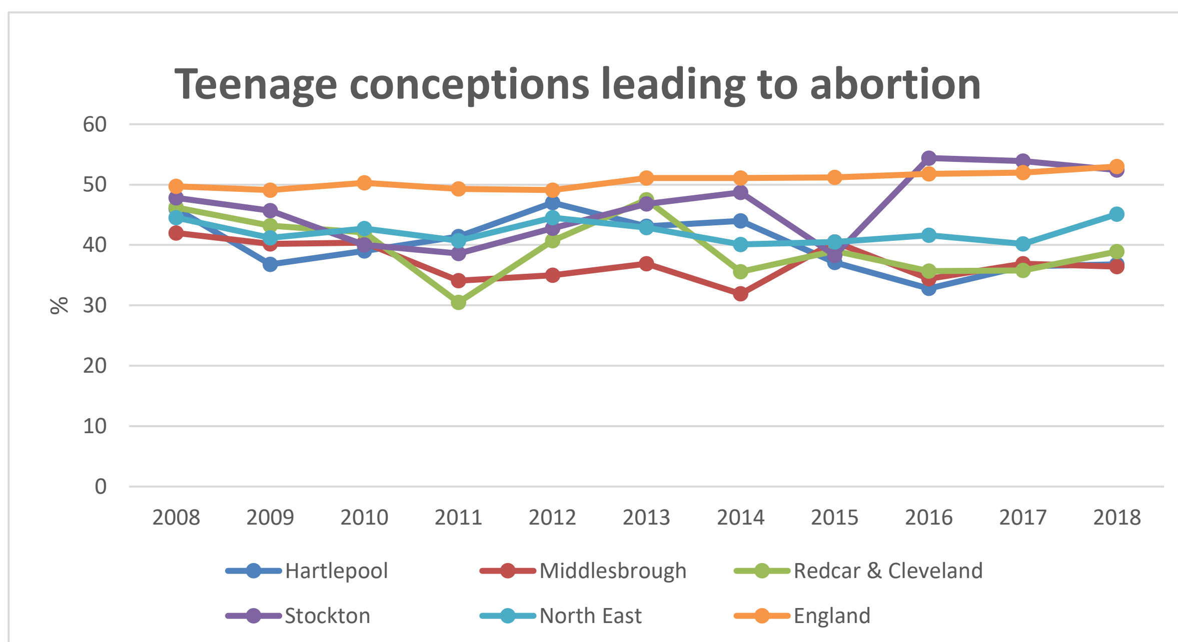


Figure 28: Proportion of conceptions leading to abortion 2008-2018 (ONS Conception Statistics, England and Wales, 2018)

The proportion of teenage pregnancies leading to abortions in 2018 was 53.0 nationally and 45.1 in the North East. In the same year, the proportion of teenage pregnancies leading to abortion in Hartlepool was 36.8%, Middlesbrough 36.4% and Redcar and Cleveland 38.9% were all lower than the national and

regional average. However, in Stockton 52.4% of the proportion of teenage pregnancy leading to abortion was higher than regional average and almost the same as the national average.

<16 Conceptions

There were 52 teenage conceptions in girls under 16 years in Teesside in 2018. Rates varied from 4.1 in Hartlepool to 7.7 in Middlesbrough compared to a North East average of 4.9 and a national average of 3.

An average of 61.9% of teenage pregnancies <16 in England led to termination of pregnancy in 2018. Termination of pregnancy rates in Teesside were lower between 35.3% in Middlesbrough and 53.3% in Stockton.

Number and rate of conceptions and proportion leading to abortion in young women <16									
	2016			2017			2018		
	n of Conceptions	rate per 1,000 women <16	% leading to abortion	n of Conceptions	rate per 1,000 women <16	% leading to abortion	n of Conceptions	rate per 1,000 women <16	% leading to abortion
Hartlepool	6	4.1	*	6	4.1	*	6	4.1	*
Middlesbrough	17	7.7	35.3	24	10.6	37.5	17	7.7	35.3
Redcar & Cleveland	14	6.9	42.9	7	3.5	57.1	14	6.9	42.9
Stockton	15	4.8	53.3	13	4.1	61.5	15	4.8	53.3
North East	191	4.9	48.7	167	4.2	53.9	191	4.9	48.7
England	2,646	3.0	61.9	2,373	2.7	60.5	2,646	3.0	61.9

Table 15: Number and rate of conceptions and proportion leading to abortion in young women <16. ONS Conception Statistics, England and Wales, 2018
*numbers <=5 are not shown

<18 conceptions and socio-economic status

The under-18 conception rate is closely related to the level of deprivation across England (r=0.74) but even more so in the North East (r=0.81). In depth analysis by the Office of National Statistics found that the level of deprivation accounted for 75% of the variation in teenage pregnancies across England and was even higher in local authorities in Teesside.

Conception rates, 2017 and IMD rank, 2019 by local authority		
	IMD Rank	Under 18 conception rate
Hartlepool	9	33.2
Middlesbrough	5	43.8
Redcar & Cleveland	31	24.8
Stockton	56	28.3

Table 16: Conception rates, 2017 and IMD rank, 2019 by local authority. Office for National Statistics, Department for Communities and Local Government

Teenage pregnancy rates across Teesside are among the highest in England. Hartlepool has a higher teenage pregnancy rate compared to most local authorities with a similar level of deprivation while the teenage pregnancy rate in Stockton is above the average rate for the level of deprivation.

Middlesbrough has a higher teenage pregnancy rate compared to most local authorities with a similar level of deprivation while the teenage pregnancy rate in Redcar & Cleveland is at the average rate for the level of deprivation.

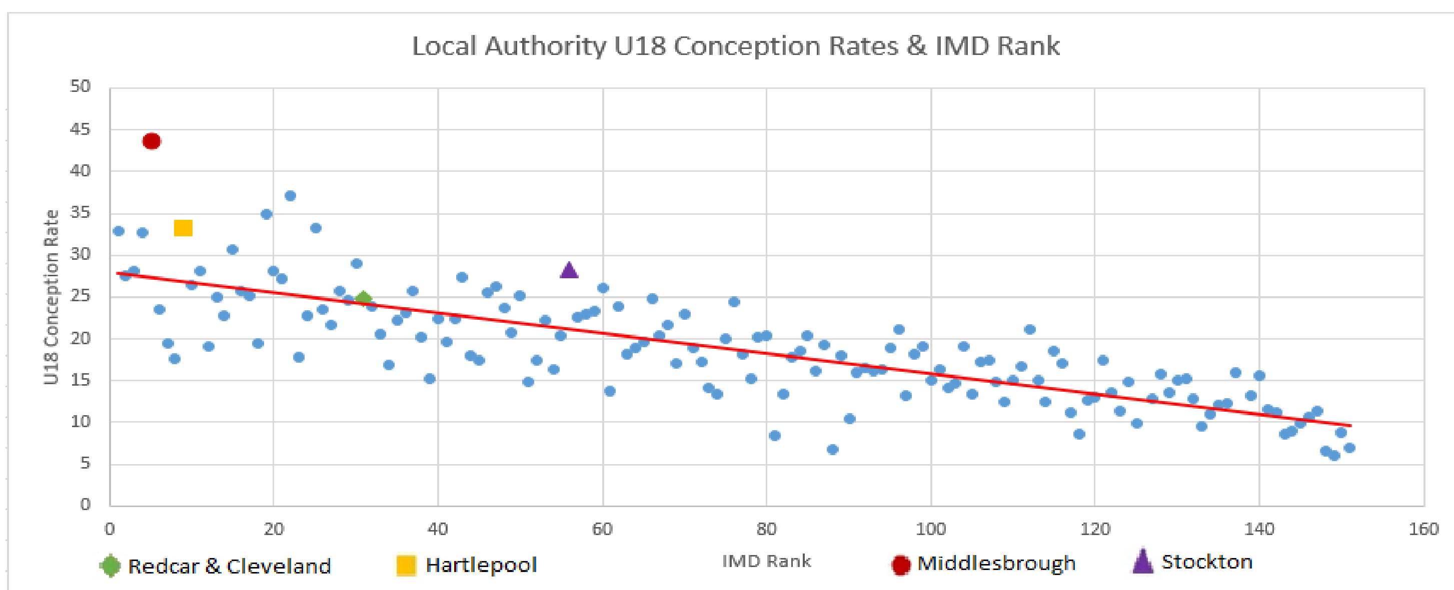


Figure 29: <18 conception rates in Middlesbrough and Redcar & Cleveland, 2017 and IMD rank, 2019 by local authority, England. Office for National Statistics, Department for Communities and Local Government

Contraception

Summary statistics on contraception 2007/08 to 2017/18 in England											
England											
	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
NHS Community Contraceptive Clinic data (thousands)											
attendances	2478	2542	2572	2569	2468	2258	2208	2126	2019	1859	1834
women attenders	1148	1220	1228	1158	1263	1203	1193	1158	1116	1057	1023
women attenders using contraceptive pill	785	842	885	831	907	893	910	941	906	871	817
NHS Community Contraceptive Clinic data (thousands)											
women attenders aged <16	81	78	75	71	71	59	50	43	34	27	25
male attenders	129	148	171	171	168	149	146	149	145	131	158
Oral contraceptive prescription items dispensed in the community (thousands)											
Prescriptions	8782	8865	8847	8835	8907	8859	8838	8751	8701	8620	8450
Emergency contraception (millions)											
dispensed in the community	277	265	253	253	245	230	215	204	186	168	154
dispensed at clinics	0.14	0.14	0.14							0.14	0.13
Sterilisation and vasectomy (thousands)											
female sterilisations	19.9	17.6	16	15.2	15	14.8	14.9	13.9	14	14.5	**13.7**
reversals of sterilisation	0.1	0.1	0.1	0.124	0.1	0.1	0.2	0.2	0.2	0.2	0.2
vasectomies - total	24.2	22.2	20.7	19.5	17.1	14.1	13.3	11.1	10.9	12	12
hospital in-patients	0.6	0.5	0.5	0.4	0.4	0.3	0.9	0.9	0.4	0.6	1
hospital day cases	15.8	13.9	13.4	12.4	10	9.6	8.8	7.9	8.2	9.1	9.2
outpatients and community clinics	7.8	7.8	6.9	6.7	6.8	4.2	..	..	..	..	..
reversals of vasectomy	0.2	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0

Table 17: Summary statistics on contraception 2007/08 to 2017/18 in England. HSCIC, NHS Contraceptive Services: England, 2017/18 Community Contraceptive Clinics, 2018

Contraception statistics in England show some interesting trends. The number of attendances at contraception clinics has seen a gradual reduction over the years with between 2.5 and 1.8 million attendances 2008 - 2018. Since 2012 the number of under 16 year old female attendees had steadily fallen, while the number of male attenders in the age group has increased until 2010 and fallen for the first time in many years between 2010 and 2011. Between 2011 and 2017 this reduction continued to steadily fall but 2018 has seen an increase in the number of male attenders.

In 2018/19 there were 1.93 million contacts with dedicated SRH services made by 1.22 million individuals; representing an increase of 4% on the number of contacts in 2017/18 (1.85 million), though 24% less than in 2008/09 (2.54 million).

In 2018-19 there were 1.40 million contacts with SRH services for reasons of contraception, down 3% compared to 2017-18 (1.45 million), and down 25% compared to 2014-15 (1.87 million).

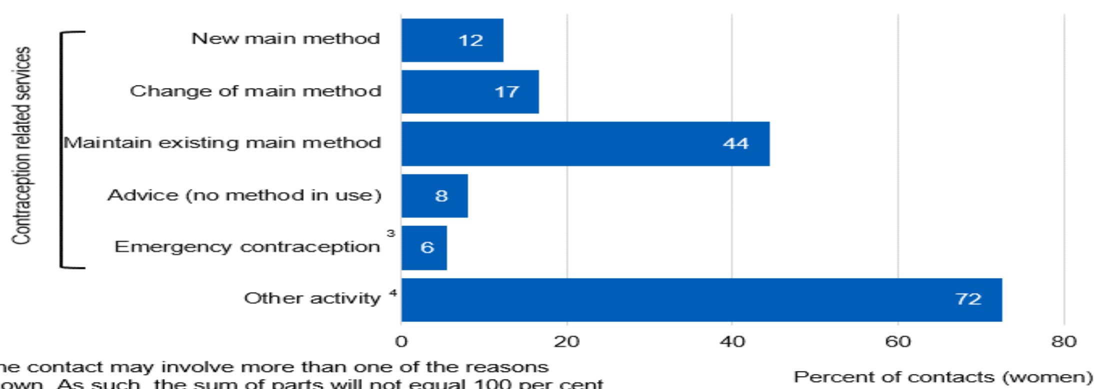


Table 18: Reasons for contacts with SRH service; 2018-19. Health and Social Care Information Centre, 2019.

In Tees, in 2018 -19 70% of attendees at sexual health services were female and 30% male.

Data from the Health and Social Care Information Centre, 2019 shows that in 2018-19, 85% of all contacts with SRH services were by females. The table above shows that of those 85% females 12% of contacts involved the provision of a new main method of contraception, 17% a change of main method and 44% the maintenance of an existing main method. This is a total of 73% of contacts where a main method was supplied or maintained.

In the same year, 2018-19, 15% of all contacts with SRH services were by males and of those 15% of contacts involved the supply/maintenance of a main method, and 5% pre-contraception advice. 93% involved other activities (whether with or without a contraception related service).

Contraception Method under 20 years of age

LA	Depo	Implant	IUD	IUS	Patch	COC	POP	Condom (Male)	Totals
H'pool	205	117	12	9	20	196	284	56	**899**
M'bro	85	127	11	6	9	92	135	22	**487**
R&C	97	129	7	3	8	78	92	22	**436**
S'ton	92	177	11	11	8	101	174	53	**627**
Totals	**479**	**550**	**41**	**29**	**45**	**467**	**685**	**153**	**2449**

Contraception Method 20 years and over

LA	Depo	Implant	IUD	IUS	Vaginal Ring	Patch	COC	POP	Cap/ D'phragm	Natural FP*	Condom (Male)	Totals
H'pool	763	316	118	141	1	49	420	669	2	7	158	**2644**
M'bro	435	539	240	232	1	23	265	407	1	7	226	**2376**
R&C	346	429	197	226	0	20	163	295	1	3	190	**1870**
S'ton	402	701	213	426	0	41	322	749	0	18	249	**3121**
Totals	**1946**	**1985**	**768**	**1025**	**2**	**133**	**1170**	**2120**	**4**	**35**	**823**	**10011**

Table 19: Contraception method by Local Authority 2018-19. Source Sexual Health Service 2020
*FP = Family Planning

For the under 20 year olds the most popular contraception method is the progesterone only pill (685) followed by the subdermal implant (550) and then the depo method (479). It is noted that this age group do not use spermicides, natural family planning, the female condom, the vaginal ring or the cap/diaphragm methods of contraception.

Similarly, for the 20 year olds and over the most popular contraception method is the progesterone only pill (2120), the implant (1985) and then closely followed by the depo method (1946). It is noted that this age group do not use spermicides or the female condom.

For both age groups, male condoms are also used as main method of contraception.

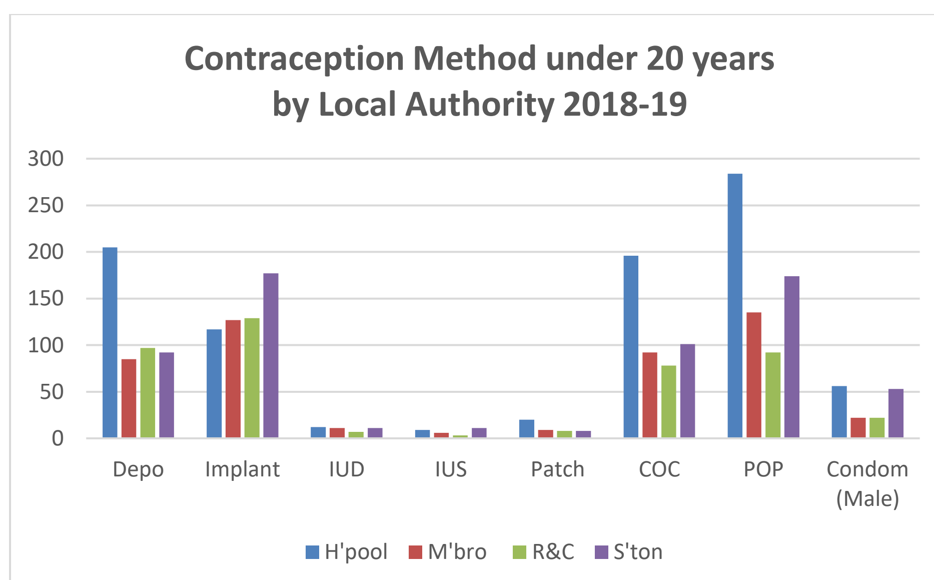


Figure 30: Contraception method under 20 years by Local Authority 2018-19. Source Sexual Health Service 2020

Within the under 20 year old population, Hartlepool has a much higher take up of the injectable contraception method (23% of all methods) than the other three local authorities. This is repeated for both the combined and progesterone only pills. Stockton residents have the highest take up of the implant contraception method

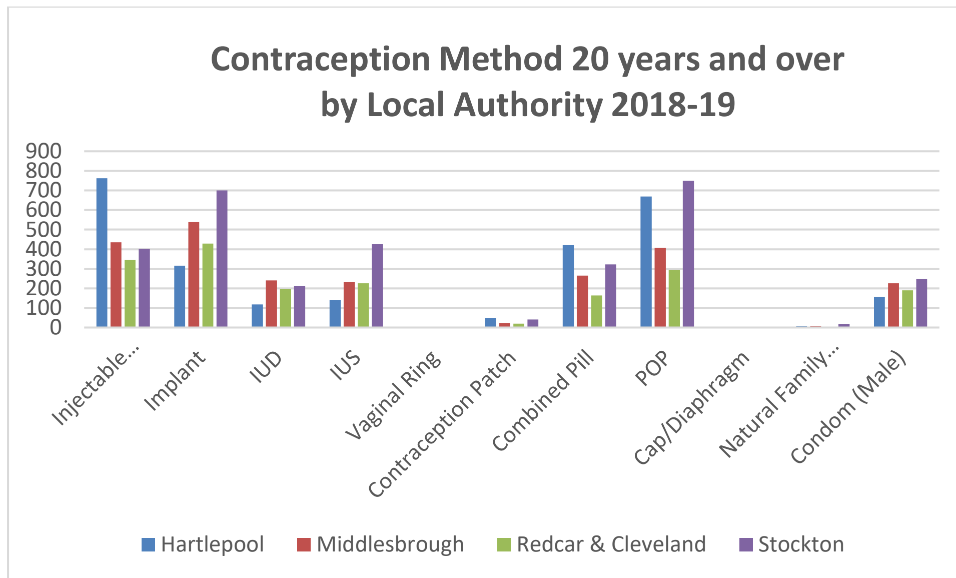


Figure 31: Contraception method for 20 years and over by Local Authority 2018-19.
Source Sexual Health Service 2018-19

Within the 20 year old and over population, Hartlepool again has a much higher take up of the injectable contraception method than the other three local authorities. Stockton residents have a higher take up of the implant, the progesterone only pill and the IUS methods of contraception than the other three local authorities.

Long Acting Reversible Contraceptives (LARC)

LARC were the first choice 45% of women attending contraception clinics in Hartlepool in 2018/19. In Middlesbrough 59%, in Redcar & Cleveland 61% and in Stockton 55% of women at contraception clinics of women choose LARC.

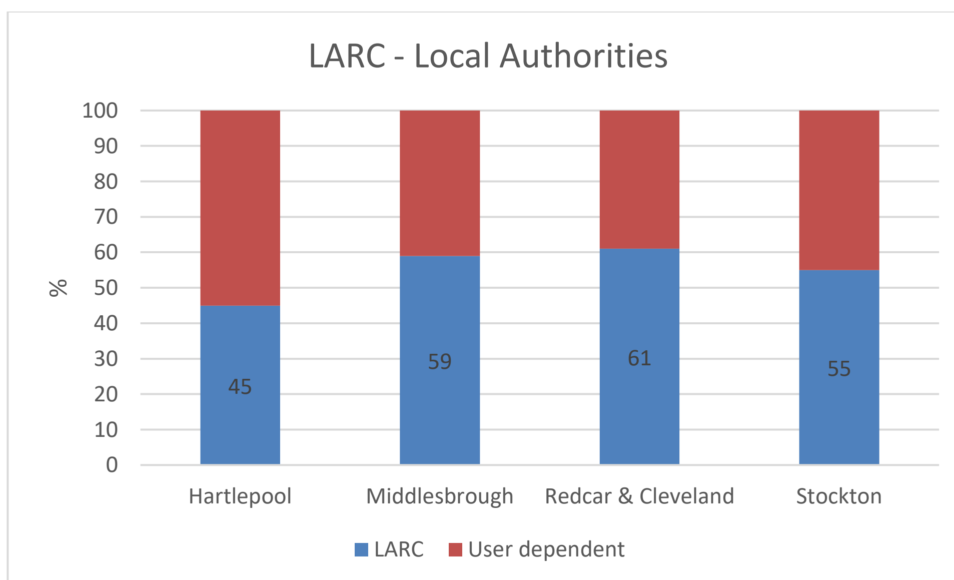


Figure 32: Total LARC in Teesside Local Authorities. TVPHSS/ Sexual Health Teesside 2018/19

LARC Contraception Method all Ages 2018-19

LA	Depo	Implant	IUD	IUS	Totals
Hartlepool	968	433	130	150	1681
Middlesbrough	520	666	251	238	1675
Redcar and Cleveland	443	558	204	229	1434
Stockton	494	878	224	437	2033
Totals	**2425 (36%)**	**2535 (37%**	**809 (12%)**	**1054 (15%)**	**6823**

Table 20: LARC Contraception Method all Ages 2018-19. Source Sexual Health Service 2018-19

Across Tees, in 2018-19, implants were the most popular method of LARC contraception at 37%, closely followed by the depo injection at 36%, then the IUS coil at 15% and then the copper coil (IUD) at 12%.

However, there are wide differences per local authority area. For example depo is the most popular LARC in Hartlepool whereas the implant is more popular in the other three local authorities. The IUD is only slightly less popular than the IUS LARC method in Hartlepool whereas in Stockton, the IUS is nearly twice as popular as the IUD. In Middlesbrough the IUS is only slightly more popular than the IUD.

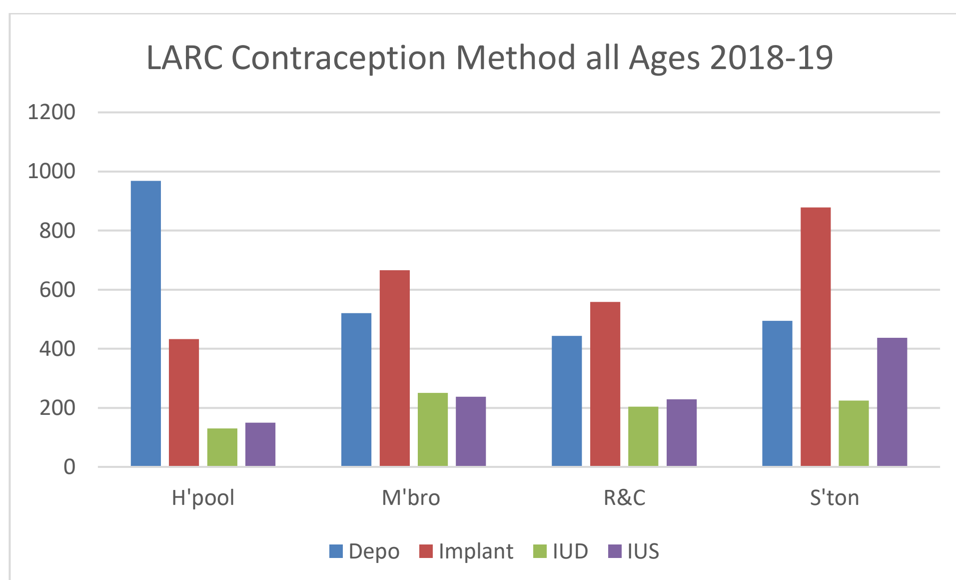


Figure 33: LARC Contraception Method all Ages 2018-19. Source Sexual Health Service 2018-19

Emergency Contraception

Emergency hormonal contraception (EHC) is provided free of charge from all sexual health clinics and subcontracted community pharmacies across Tees from the age of 13 years.

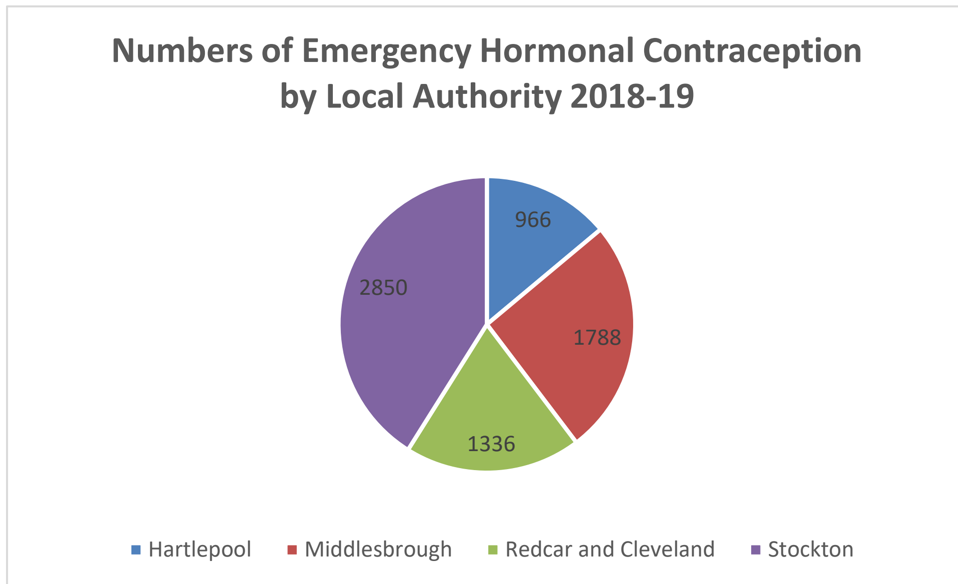


Figure 34: EHC dispenses across Tees in 2018-19. Source Sexual Health Teesside 2018-19

During 2018-19 there were 6,940 dispenses of EHC to women across Tees from the sexual health service and subcontracted pharmacies; 2850 to the residents of Stockton, 1788 to Middlesbrough residents, 1336 to Redcar and Cleveland residents and 966 to Hartlepool residents.

The amount of EHC distributed in each month varied over the year with very low dispenses in March and the highest dispenses in April (272), July (268), and December (260).

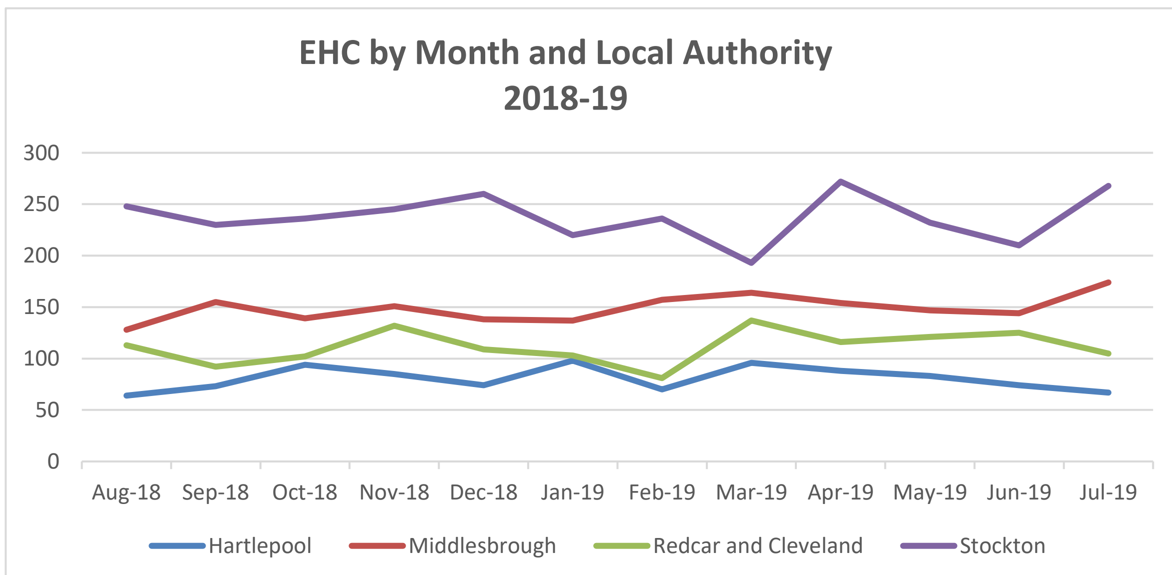


Figure 35: Number of EHC provided by SHT and Pharmacies by local authority and month. Source Sexual Health Teesside 2018-19

Subcontracted pharmacies dispensed 90% of all EHC provided by sexual health services in Teesside in 2018-19. Pharmacies located in busy high streets and shopping or retail centres dispensed the majority of EHC.

In 2018-19 6,175 EHC dispenses were carried out by subcontracted pharmacies across Tees to women aged 13 to 58 years. Just over half of those dispenses (3,092) were to females 13-24 years of age equating to 50.1%. The remainder (3,083) were dispensed to women 25 to 58 years of age equating to 49.1%.

The percentage of EHD given out was the highest in the 18-24 age group (37.4%), followed by the 24-34 age group (35.3%).

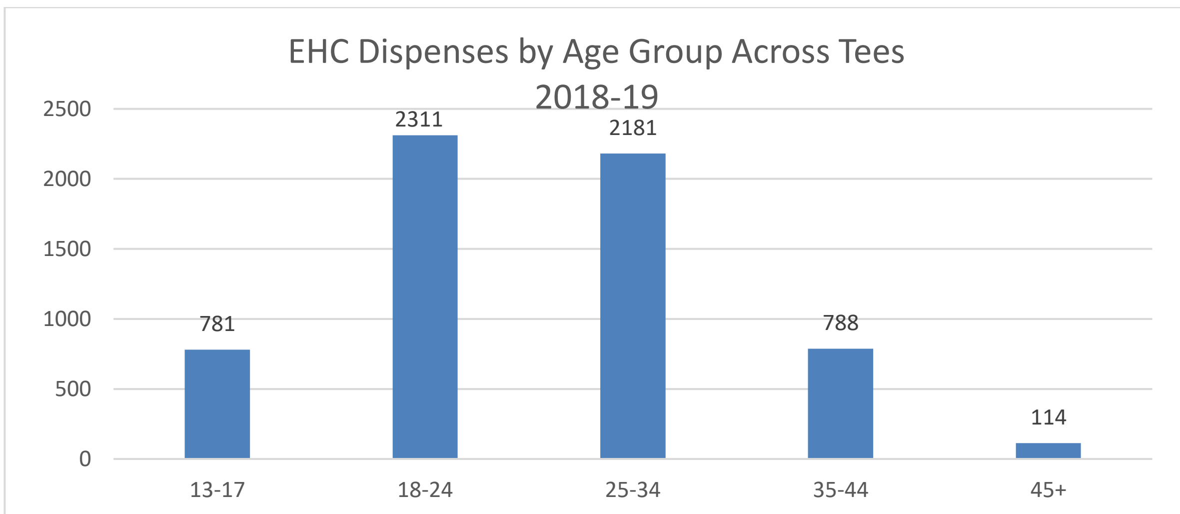


Figure 36: Number of EHC dispenses by community pharmacies across Tees by age group.
Source Sexual Health Teesside 2018-19

10 pharmacies provided 3,143 dispenses of EHC ranging between 150 and 656 and a further 7 pharmacies dispensed 849 ranging between 100 and 149. There were 14 pharmacies dispensing between 50 and 99 and finally, there were 46 contracted community pharmacies dispensing less than 50 EHCs each ranging from 49 down to 1 dispense.

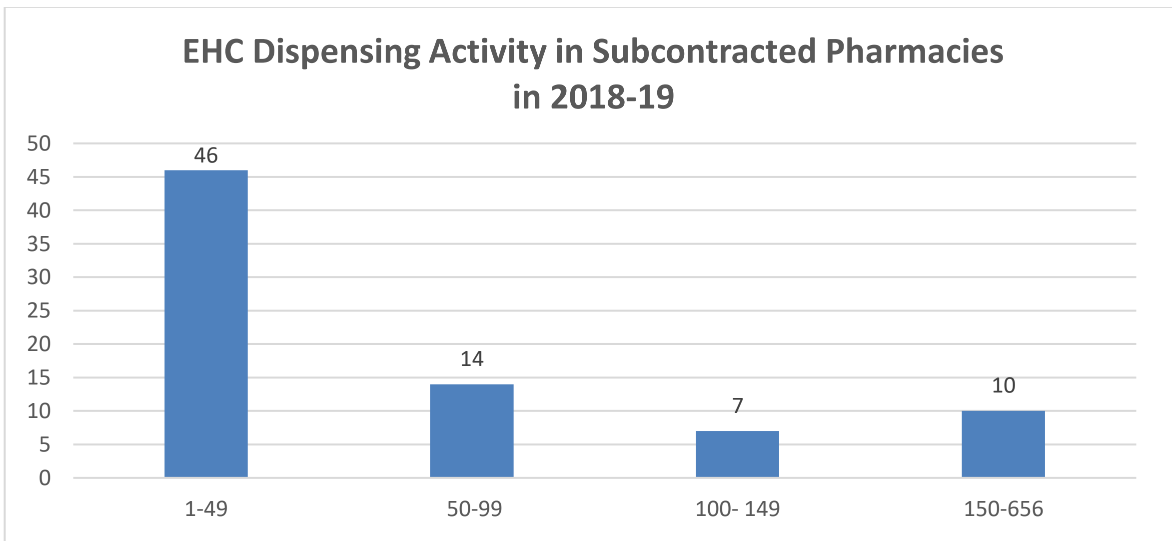


Figure 37: Number of subcontracted pharmacies dispensing EHC across Tees by age group.
Source: Sexual Health Teesside 2018-19

In 2018-19 subcontracted pharmacies dispensed both types of EHC, Levonelle (2,805) and EllaOne (2,587). There was slightly more Levonelle dispensed at 52% than EllaOne at 48%.

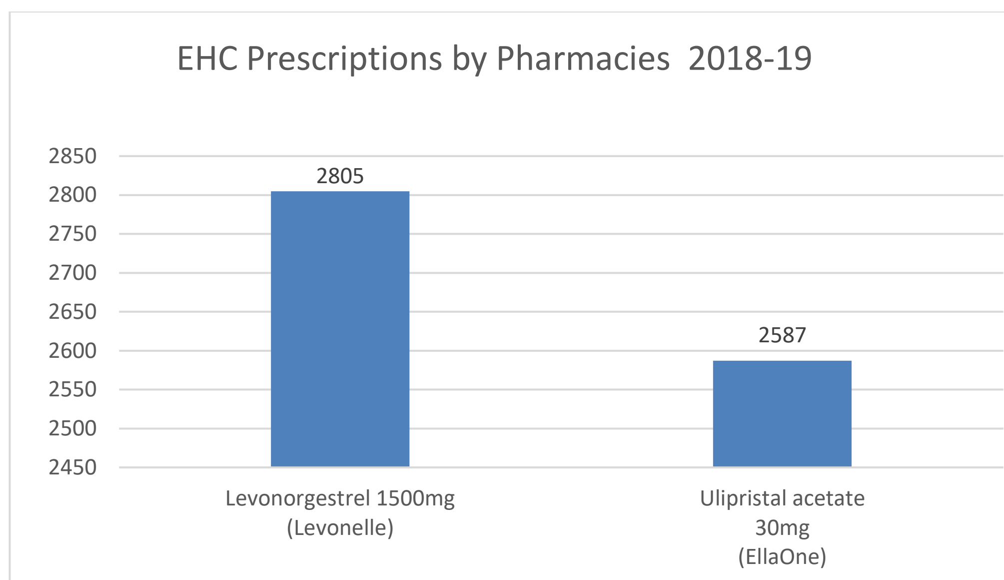


Figure 38: Number of prescriptions of EHC in subcontracted pharmacies in 2018-19.
Source: Sexual Health Teesside 2018-19

Abortions

Most abortions could be avoided if young women had better knowledge of and access to contraception thus resulting in better health outcomes for women. The level of abortions in an area can therefore indicate the effective use of contraception and access to contraceptive services. Nationally the abortion rate was highest at 30.2 per 1000 women for women in the 20-24 age group. The highest abortion rates in Teesside were also in the 20-24 age group; with Hartlepool (29.4), Stockton (29.6) and Redcar and Cleveland (33.3) all above the North East rate (25.6). Middlesbrough has the highest abortion rate (39.3) in the 25-29 age group which is above both the North East (22.5) and national (26.3) rates.

Abortion rate per 1000 women by local authority							
	All	<18	18-19	20-24	25-29	30-34	35+
Hartlepool	18.5	12.7	29.3	29.4	25.9	24.5	8.2
Middlesbrough	24.3	15.7	33.1	36.9	39.3	26.9	12.6
Redcar & Cleveland	17.8	13.9	26.0	33.3	22.6	19.1	8.8
Stockton	17.0	9.6	21.9	29.6	26.8	19.3	7.8
North East	15.3	9.7	21.6	25.6	22.5	18.0	7.2
England	18.1	8.0	24.0	30.2	26.3	21.0	9.8

Table 21: Abortion rate per 1000 women by local authority. DH Abortion Statistics, England and Wales: 2019

The risk of complications increases the later an abortion is carried out. Women should therefore have access to the procedure as early as possible following a decision to terminate the pregnancy. The percentage of abortions carried out under 10 weeks continued to increase steadily between 2014 and 2019.
In England, 82.5% of abortions were carried out under 10 weeks in 2019 and 91.7% under 13 weeks. In the North East of England 78.5% of abortions took place under 10 weeks gestation. In Middlesbrough (84.8%), Stockton (83.4%), Redcar and Cleveland (82.4%) and Hartlepool, (80.0%) of abortions were carried out under 10 weeks which is higher than the regional average and just higher than the national average (82.5%) for Middlesbrough and Stockton.

Proportion of abortions by time of gestation (%)			
	under 10 weeks	10-12 weeks	over 13 weeks
Hartlepool	80.0	14.5	5.5
Middlesbrough	84.8	7.1	8.2
Redcar & Cleveland	82.4	7.1	10.5
Stockton	83.4	9.0	7.6
North East	78.5	12.0	9.4
England	82.5	9.2	8.4

Table 22: Proportion of abortions by time of gestation. DH Abortion Statistics, England and Wales: 2019

Early medical abortion is less invasive than a surgical procedure and does not involve the use of anaesthetics. In England medical abortions accounted for 70.3% of the total. The proportion of medical abortions in the North East region of England was 86.1%. The proportion of medical abortions in Teesside exceeds both the regional and the national (72.8%) percentages with 97.5% in Hartlepool, 91.6% in Middlesbrough, 88.1% in Redcar and Cleveland and 94.0% in Stockton. Nationally, just over 40% of all women and just under 28% of women under 25 years undergoing an abortion have had a previous abortion. In the North East of England (38.6%) and Redcar and Cleveland (36.6%) the proportion of women undergoing a repeat abortion was slightly lower compared to the national average (40.4%). However in Middlesbrough, Stockton and Hartlepool the proportion of repeat abortion were higher. Women 25 years of age and older have the most repeat abortions with Hartlepool (53.3%), Middlesbrough (50.0%) and Stockton (52.3%) all above the national (48.0%) and regional (48.2%) figures and Hartlepool (46.9%) below both national and regional figures.

Proportion of method of abortion and repeat abortions (%)					
	Method of abortion		Repeat abortion		
	Medical	Surgical	All ages	<25	25+
Hartlepool	97.5	2.5	43.4	24.6	55.3
Middlesbrough	91.6	8.4	42.9	32.4	50.0
Redcar & Cleveland	88.1	11.9	36.6	22.8	46.9
Stockton	94.0	6.0	43.5	27.9	52.3
North East	86.1	13.9	38.6	25.1	48.2
England	72.8	27.2	40.4	27.7	48.0

Table 23: Proportion of method of abortion and repeat abortions. DH Abortion Statistics, England and Wales: 2019

Summary

- Conceptions in women over 30 have increased while teenage pregnancies have decreased.
- Tees has higher conception rates per 1000 population of women than the national (75.7) and regional (70.5) rates with Middlesbrough having the highest (89.6), followed by Hartlepool (80.0), Stockton (77.4) then Redcar and Cleveland (76.1).
- Between 2011 and 2018, Middlesbrough, Stockton and Redcar and Cleveland local authorities have seen a reduction in under 18 year old conception rates following the regional trend. Hartlepool however has remained static. However, across Tees, the under 18 year old conception rates are well above the England rate of 16.7 with Middlesbrough (39.4) having the highest rates in the country.
- In 2018, Stockton (52.4%) has the highest proportion of teenage conceptions leading to abortion. In Hartlepool (36.8%), Middlesbrough (36.4%) and Redcar and Cleveland (38.9%) the proportion of teenage conceptions leading to abortion were all very much lower than the national figure of 53%.
- The rates of teenage conceptions in girls under 16 have been variable across Teesside with the exception of Hartlepool who have remained static.
- In 2018, conceptions in girls under 16 years in Teesside varied from 4.1 in Hartlepool to 7.7 in Middlesbrough compared to a North East average of 4.9 and a national average of 3.
- In 2018, the percentages of teenage pregnancies <16 leading to an abortion varied across Tees from 35.3% in Middlesbrough to 53.3% in Stockton against the national figure of 61.9%.
- Middlesbrough has a higher teenage pregnancy rate compared to local authorities in England with a similar level of deprivation while the teenage pregnancy rate in Redcar & Cleveland is at the average rate for the level of deprivation.
- In Tees, in 2018 -19 70% of attendees at sexual health services were female and 30% male.
- For the under 20 year olds the most popular contraception method is the progesterone only pill (28%), followed by the subdermal implant (22%) and then the depo method (20%). It is noted that this age group do not use spermicides, natural family planning, the female condom, the vaginal ring or the cap/diaphragm methods of contraception.
- Similarly, for the 20 year olds and over the most popular contraception method is the progesterone only pill (21%), the implant (20%) and then closely followed by the depo method (19%). It is noted that this age group do not use spermicides or the female condom.
- Across Tees in 2018-19, implants are the most popular method of LARC contraception at 37%, the depo injection at 36%, the IUS coil at 15% and then the IUD at 12%.
- However, depo is the most popular LARC in Hartlepool and the implant is more popular in the other three local authorities.
- In Stockton, the IUS is nearly twice as popular as the IUD. In Middlesbrough the IUS is only slightly more popular than the IUD.
- During 2018-19 there were 6,940 dispenses of EHC to women across Tees from the SH service and subcontracted pharmacies.
- Subcontracted pharmacies dispense 90% (6,175) of all EHC provided by sexual health services in Teesside.
- In 2018-19 just over half of EHC dispenses (3,092) were to females 13-24 years of age equating to 50.1%. The remainder (3,083) were dispensed to women 25 to 58 years of age equating to 49.1%.
- The percentage of EHD given out was the highest in the 18-24 age group (37.4%), followed by the 24-34 age group (35.3%).
- 10 pharmacies provided 3,143 dispenses of EHC (53%).
- Levonelle and EllaOne are almost equally dispensed by pharmacy, 52% and 48% respectively.
- The highest abortion rate in England in 2019 is in the 20-24 age group at 30.2 per 1,000 women.

- The highest abortion rate in Tees is mostly in the 20-24 age group with Redcar and Cleveland (33.3) followed by Stockton (29.6) then Hartlepool (29.4). Middlesbrough has the highest rate (39.3) in the 25-29 age group.
- In England, 82.5% of abortions were carried out under 10 weeks in 2019 and 91.7% under 13 weeks.
- In Middlesbrough (84.8% and Stockton (83.4%) of abortions were carried out under 10 weeks which is higher than the national (82.5%) and regional average (78.5%).
- In Hartlepool (80.0%) and in Redcar and Cleveland (82.4%) of abortions were carried out under 10 weeks were above the regional average and only just below the national average.
- In England medical abortions accounted for 72.8% of the total.

8. Sexual Violence

The Crime Survey for England and Wales 2018/19 has published representative information on the number of sexual assaults that people have experienced in the previous 12 months to the survey. It is estimated that 1.2% of men, and 4.5% of women aged between 16-59yrs have been victims of sexual assault in the past year. This equates to approximately 7,168 women and 1,875 men in Teesside who are estimated to have been victims of sexual assault, including attempted sexual assault in the past year.

Estimated number of victims of any sexual assault (including attempted) by local authority						
	Population aged 16-59			Estimated number of victims of any sexual assault in previous 12 months		
	women	men	all	Female victims	Male victims	all
Hartlepool	26338	25418	51756	1185	305	1490
Middlesbrough	40132	40352	80484	1806	484	2290
Redcar & Cleveland	37283	35472	72710	1678	426	2104
Stockton-on-Tees	55540	55006	110546	2499	660	3159
Tees	159,293	156248	315496	7168	1875	9043

Table 24: Estimated number of victims of any sexual assault (including attempted) by local authority. ONS CSEW 2018/19.

More females than males are victims of sexual assault across Teesside. Stockton has both the highest number of female (2,499) and male (660) victims, followed by Middlesbrough (1,806 & 484), then Redcar and Cleveland (1,678 & 426) and finally Hartlepool (1,185 & 305). This ranking mirrors the population sizes of 16 – 59 year olds. However, Hartlepool (51,756) has less than half the number of 16 – 59 year olds as Stockton (110, 546).

Violent crime - sexual offences by local authority 2018/19		
	Number	*Rate per 1000 population (persons all ages)*
Hartlepool	*249*	*2.7*
Middlesbrough	*580*	*4.1*
Redcar & Cleveland	*336*	*2.5*
Stockton-on-Tees	*543*	*2.8*
North East	*8,246*	*3.1*
England	*137,040*	*2.5*

Table 25: Violent crime, sexual offences by local authority 2018/19. Fingertips, 2019.

Middlesbrough has the highest rate of violent crime - sexual offences (4.1) in Tees, higher than both the North East (3.1) and England (2.5) rates. Stockton has the next highest rate (2.8), followed by Hartlepool (2.7) and Redcar & Cleveland (2.5); all three local authorities are below the North East rate and equal to or just above the national rate.

Since the start of the SH contract in August 2016 data has been collected on referrals from the sexual assault referral centre (**SARC Teesside**) based at Helen Britton House, North Ormesby Health Village, Middlesbrough.

The three tables below show the data that has been collected for the last three years.

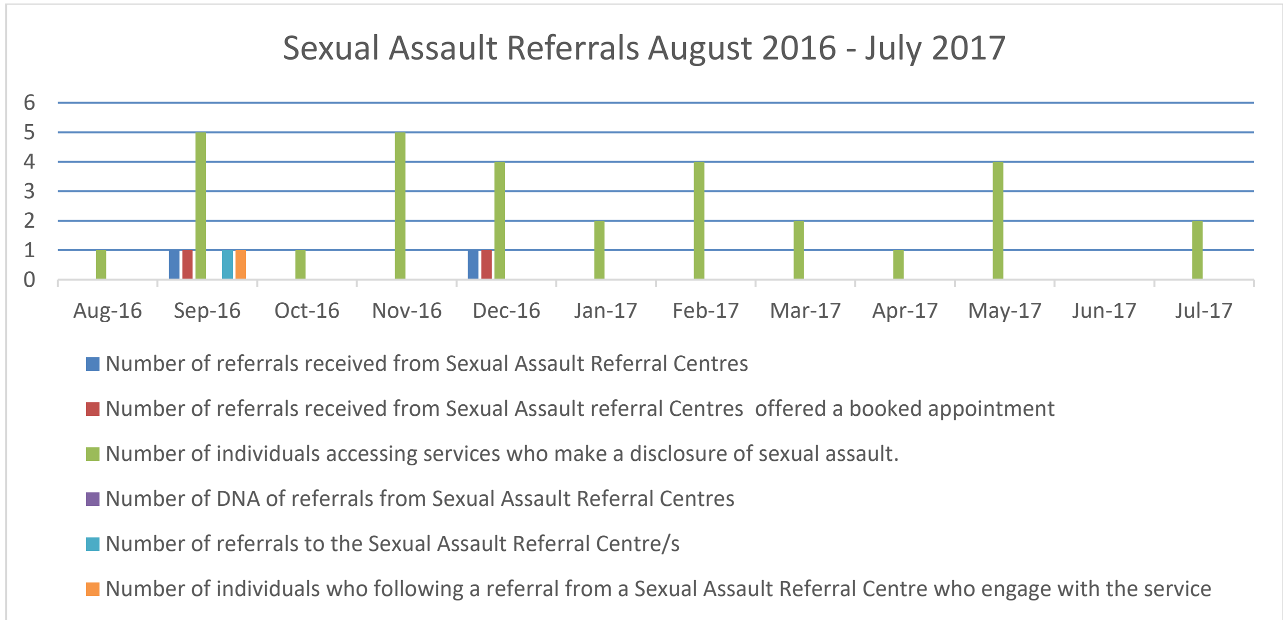


Figure 39: Sexual Assault Referrals to the Sexual Health Service from SARC 2016-17. Source Sexual Health Teesside 2020

Figure 40: Sexual Assault Referrals to the Sexual Health Service from SARC 2017-18. Source Sexual Health Teesside 2020

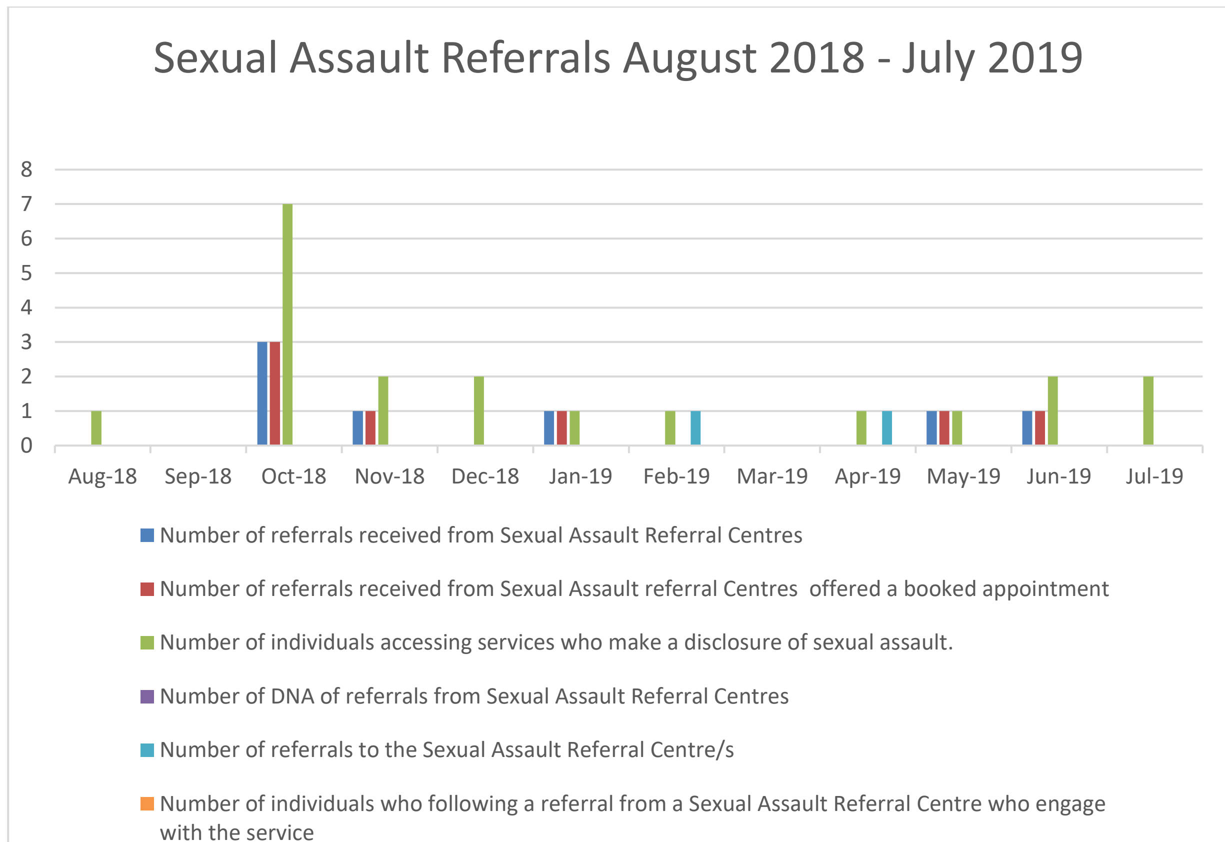


Figure 41: Sexual Assault Referrals to the Sexual Health Service from SARC 2018-19. Source Sexual Health Teesside 2020

Although numbers are very low, over the last three years the number of referrals from SARC have increased from 2 to 3 to 7. There are no DNAs for individuals referred to the sexual health service from SARC. The sexual health service will refer patients, with their permission to the SARC, after disclosures of sexual assault but numbers remain extremely low.

Summary
• Stockton has the highest number of female (2,499) and male (660) victims of sexual assault across Tees. • Hartlepool has the lowest number of female (1,185) and male (305) victims of sexual assault across Tees • Stockton (110,546) has the highest number of 16-59 year olds. • Hartlepool (51,756) has the lowest number of 16-59 year olds. • Middlesbrough has the highest rate of violent crime - sexual offences (4.1) in Tees, higher than both the North East (3.1) and England (2.5) rates. • Redcar & Cleveland has the lowest rate of violent crime - sexual offences (2.5). • The number of referrals from SARC to the sexual health service, although very small, are slowly increasing year on year.

9. Sexual Health Service and Service Utilisation

Sexual Health Service in Teesside

Sexual Health Teesside has provided a fully integrated community based sexual health service since 2010. Previous to this services were delivered in hospital based GUM services and community based CASH clinics. The current service is commissioned from Virgin Care Services Ltd. by local authorities, CCGs and NHS England and Improvement structured into four hubs, spoke clinics, outreach and subcontracted services based in the four local authorities in Teesside.

Sexual Health Teesside provides full contraception services including LARC, STI testing and treatment, chlamydia screening, HIV testing, PEPSE, PrEP, terminations of pregnancy, sterilisation, vasectomy, cervical screening and psychosexual counselling. The service also offers outreach services in schools, colleges and other settings to provide low threshold access to sexual health services for young people and other at risk groups. The following service description and utilisation analysis focuses on local authority commissioned services only.

Service Hubs

The service hubs are located in One Life Health Centre in Hartlepool, Lawson Street Health Centre in Stockton, The Live Well Centre in Middlesbrough and Redcar and Cleveland Leisure and Community Heart. All hubs offer extended opening times on most days of the week. Service hubs offer the full range of community contraceptive and GUM services, provided by nursing and medical staff.

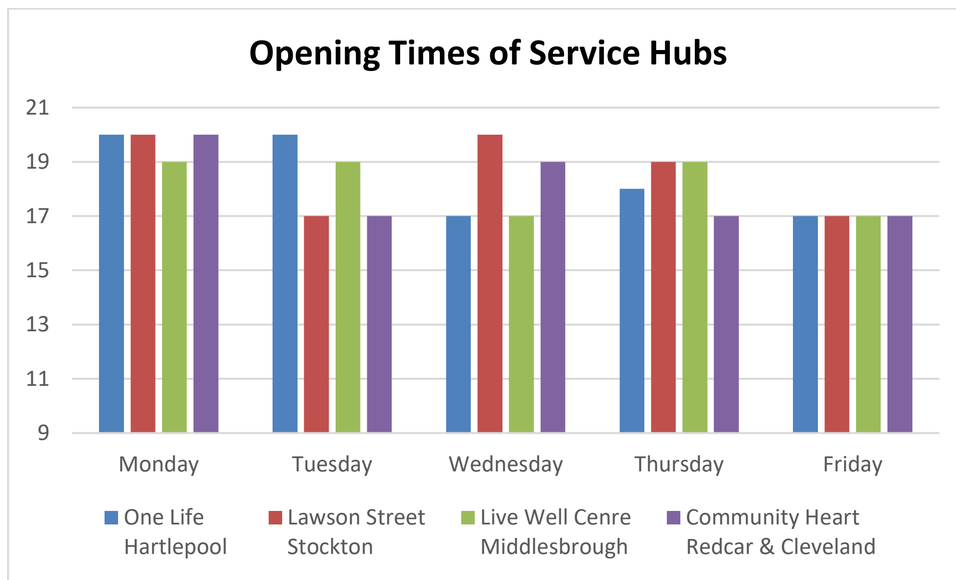


Figure 42: Service hubs opening times in 2020. Source Sexual Health Teesside 2020

Service Spokes

Spoke or satellite clinics are located in Middlesbrough, Redcar & Cleveland and Stockton. There are no spoke clinics in Hartlepool. The spoke clinic in Middlesbrough is co-located in the Live Well Centre in the centre of the town in the Dundas shopping centre and offers offer 4.5hours clinic time per week. Redcar & Cleveland spoke clinics are located in Eston, Guisborough and Brotton and altogether offer 13 hours of clinic time per week. Spoke clinics in Stockton are located in Billingham and Thornaby health centres and offer a total of 6 hours of clinic time per week.

Opening Times of Service Spokes							
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Middlesbrough							
The Live Well Centre						9-1:30	
Redcar & Cleveland							
East Cleveland PCH	12-6						
Guisborough PCH				5-8			
Low Grange Clinic			1-5				
Stockton							
Billingham Health Centre		5-8					
Thornaby Health Centre			5-8				

Table 26: Opening times of service spokes in 2020. Source Sexual Health Teesside 2020

Outreach

Outreach work is an essential part of Tees Sexual Health services and the current provider subcontract **Brook,** a national children's charity, to work specifically with young people's sexual health and wellbeing. Brook offer training programmes and assembly provision to schools and colleges across Teesside in addition to 1:1 support, advice and guidance to children and young people which will include advice on contraception options. Annually, Brook will offer 1: 1 support, advice and guidance to nearly 7,000 young people and over 16,000 receive information at assembly / group discussions. Brook continue to distribute and promote C-Card provision in all of their drop-in sessions, RSE events, 1:1s and school assemblies.

Brook are currently working with 15 of the 34 secondary schools across Teesside (not including SEND/Alt Curriculum schools):

Hartlepool 1/5
Stockton: 8/14
Middlesbrough 3/7
Redcar 3/8

The current provider subcontract **Terence Higgins Trust (THT)**, a national charity to support people living with HIV to achieve good sexual health. In addition THT provide services including raising awareness, advice, support, testing, screening and referral into the main services for vulnerable groups such as men who have sex with men (MSM), Black African/Caribbean and Black, Asian and Minority Ethnic (BAME) communities. Rapid Point of Care Testing (POCT) testing currently takes place in the following venues across Tees:

- All four main clinical hubs - Hartlepool, Stockton, Middlesbrough and Redcar (approximately 15-20 clinic a month across Tees)

- Liberty Project (Stockton)
- A Way Out (Stockton)
- Bridge House Hostel (Stockton)
- Hart Gables (Hartlepool / Middlesbrough)
- Teesside University (Middlesbrough)
- BME Refugee Groups at John Paul Centre (Middlesbrough)
- Reach Out Ministry (Hartlepool)

Note the limited THT provision in Redcar and Cleveland reflects the demographic mix and lower (HIV) prevalence rate in R&C.

Primary Care

GP Practices

General practices are providing general sexual health advice and contraception to their patients and STI testing where indicated. In addition, in 2018-19 there were 38 GP practices across Tees subcontracted by Sexual Health Teesside to provide more specialised sexual health services such as Long Acting Reversible Contraception (LARC) as well as chlamydia screening (15 – 24 year olds).

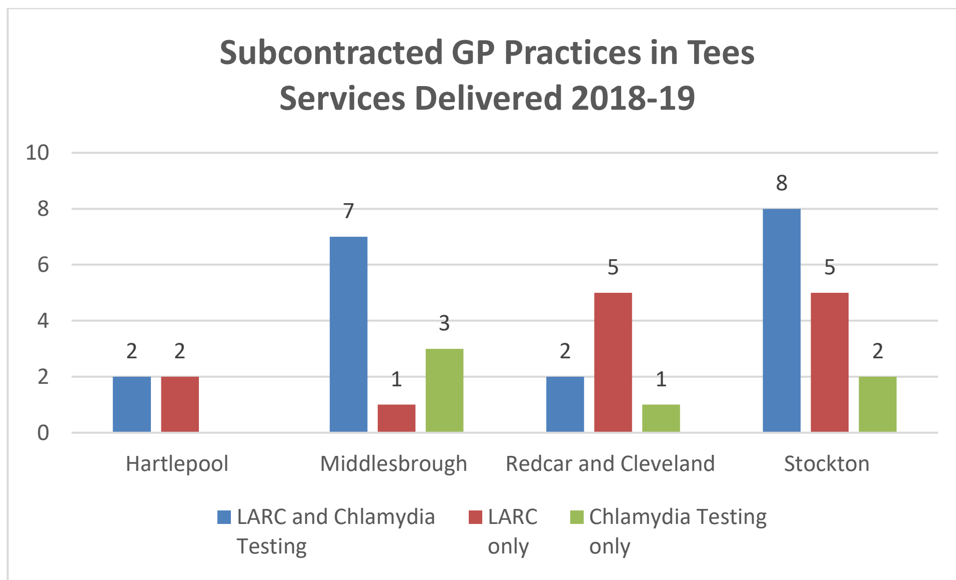


Figure 43: Subcontracted GP Practices in Tees and services delivered 2018-19. Source: Sexual Health Teesside 2018-19

The number of subcontracted practices across Tees delivering services varies from 4 in Hartlepool to 15 in Stockton-on-Tees.

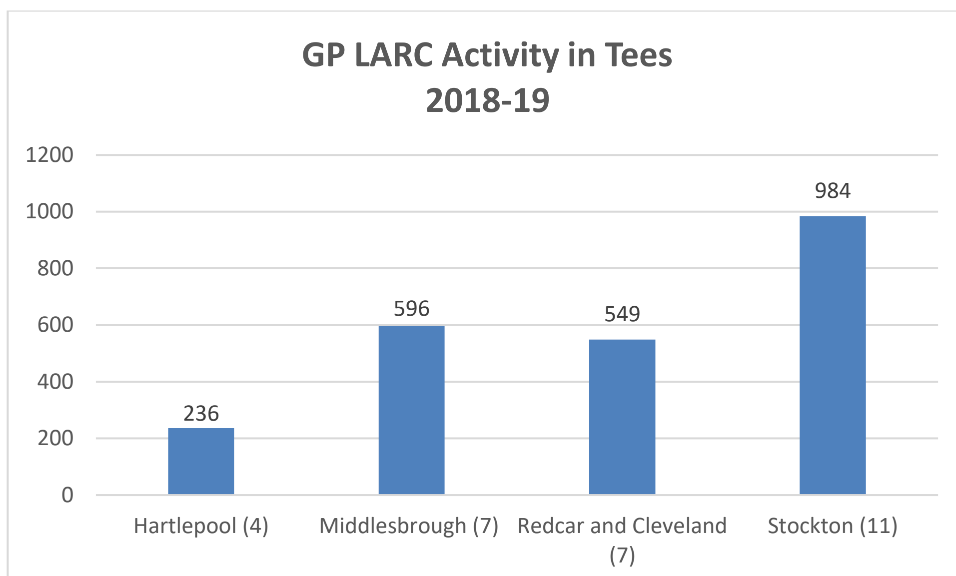


Figure 44: GP LARC activity in Tees 2018-19. Source: Sexual Health Teesside 2018-19

Activity includes the total numbers for fitting, removing and reinserting and removing. Stockton-on-Tees delivers the most LARC activity (42%), followed by Middlesbrough (25%), Redcar and Cleveland (23%) and finally Hartlepool (10%).

There were two subcontracted GP practices in Stockton-on-Tees and one in Middlesbrough not delivering any LARC activity in 2018-19.

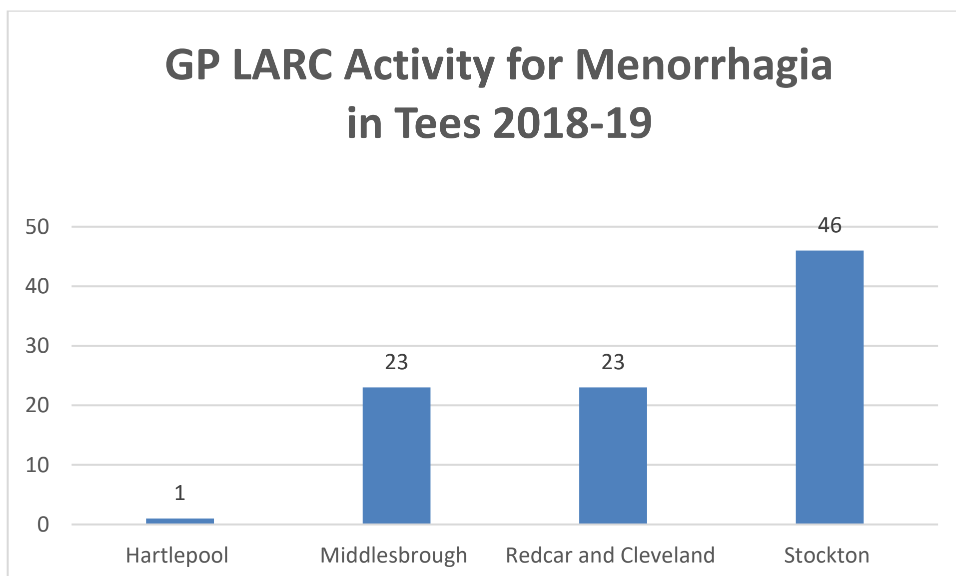


Figure 45: GP LARC activity in Tees for menorrhagia 2018-19. Source: Sexual Health Teesside 2018-19

Subcontracted GP practices across Tees also fit coils (IUS) for heavy menstrual bleeding. The table above shows again that in 2018-19, Stockton-on-Tees provision fitted the most (49%) followed by Middlesbrough and Redcar and Cleveland (25%) then Hartlepool (1%).

Community Pharmacy

Community pharmacies also play a key role in the delivery of sexual health services and are subcontracted to offer a free range of sexual health services. In 2018-19, 95 pharmacies were contracted to deliver a

range of services including Emergency Hormonal Contraception (see section Emergency Contraception for more pharmacy information), chlamydia screening (15 – 24 year olds), and C-Card (condom) scheme.

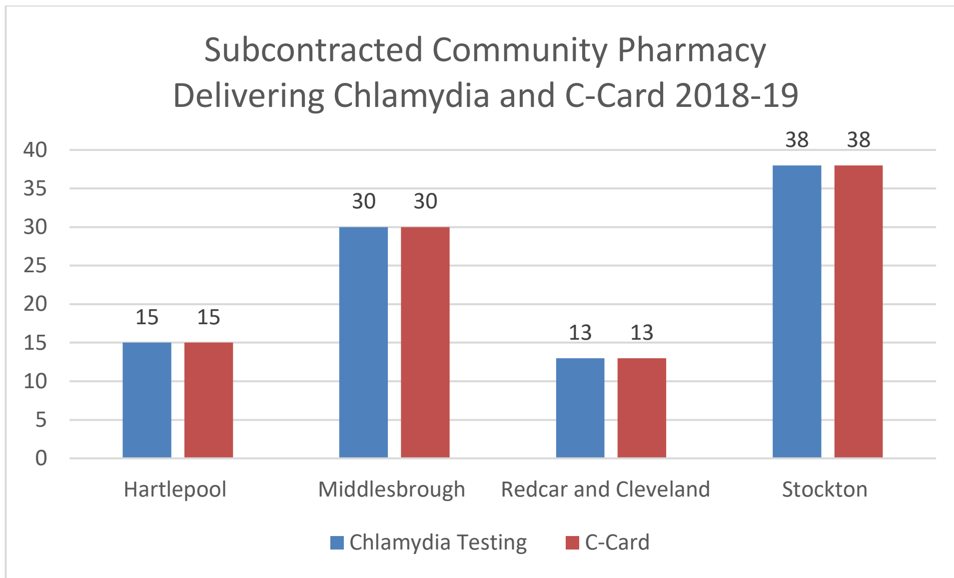


Figure 46: Subcontracted community pharmacy and delivering chlamydia and C-Card 2018-19.
Source: Sexual Health Teesside 2018-19

Stockton-on-Tees has the most subcontracted community pharmacies signed up to deliver both chlamydia and C-Card (38). Followed by Middlesbrough (30), Hartlepool (15) then Redcar and Cleveland (13).

Community Pharmacy C-Card Scheme

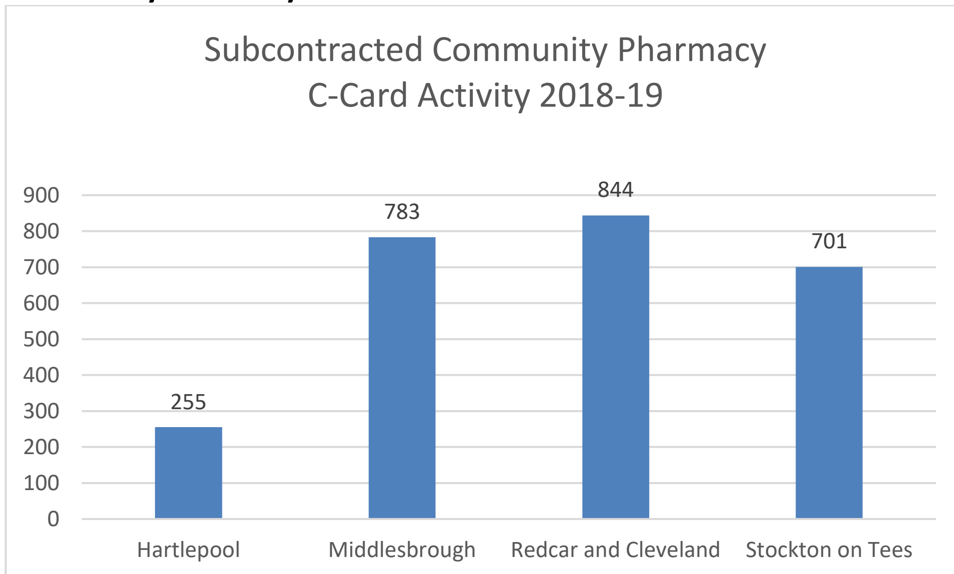


Figure 47: Subcontracted community pharmacy and C-Card activity 2018-19.
Source: Sexual Health Teesside 2018-19

In 2018-19, Redcar and Cleveland subcontracted community pharmacies dispensed the most C-Card activity (33%), followed by Middlesbrough (30%) Stockton-on-Tees (27%) then Hartlepool (10%).

Pathology

Acculabs Diagnostics UK Ltd, based locally at Wynyard, Billingham is subcontracted to carry out all pathology and testing for the service.

Marie Stopes International

Sexual Health Teesside subcontract Marie Stopes International to carry out vasectomy services across Teesside on behalf of Tees Valley Clinical Commissioning Group commission. At the end of contract year 3 (31st July 2019) the total number of vasectomies carried out for South Tees CCG was 232, below the contracted number of 350 annually. Vasectomies carried out for Hartlepool and Stockton-on-Tees CCG was 443, above the contracted number of 350 annually

Cervical Screening

Sexual Health Teesside are commissioned by NHS England and NHS Improvement (NHSE/I) to carry out cervical screening as part of the National Cervical Screening Programme At the end of contract year 3 (31st July 2019) the total number of cervical screens carried out across Tees was 887, below the contract number of 1,150 annually.

Terminations

North Tees and Hartlepool Foundation Trust (NT&HFT) and the British Pregnancy Advisory Service (bpas) are delivering terminations of pregnancies across Teesside. NT&HFT together with South Tees NHSFT perform sterilisation services for women across Tees.

C-Card Scheme

A free condom registration and distribution scheme exists across Tees for young people aged 13-24 years and delivered in a number of venues including the SH service, pharmacies, GP practices and young organisations. C-Card training is carried out by the sexual health service.

In 2018/19 the service trained over 200 individuals across a number of Tees' agencies supporting young people to deliver Universal C-Card; however, subsequent registrations and distributions have been low.

Local Authority	Organisation
Stockton-on-Tees	VCSE provision
Stockton-on-Tees	Corner house
Stockton-on-Tees	Children's Services (e.g. Targeted Youth)
Middlesbrough	Middlesbrough College
Middlesbrough	School Nursing
Redcar	NEET
Redcar	Careers Advisors
Hartlepool	Youth Direction
Hartlepool	College of FE
Hartlepool	School Nursing
Hartlepool	LAC
Hartlepool	Early Help team
Hartlepool	Sanctuary Housing

Table 27: C-Card audit on newly trained organisations 2020. Source Sexual Health Teesside 2020

In early 2019-20, a young people and vulnerable person's pathway was developed by the service that improves access into the service. The pathway includes:

- Direct reference points (lead nurse, direct line telephone number, email address) for partner agencies to directly contact the service to refer, request advice, book a call back, any other form of intervention.

- Any YP referred into service via a partner agency contact will be given priority support including clinic appointments.

In January 2020, a range or organisations in South Tees (with 58 participants) underwent sexual health training to refer young people vulnerable adolescents into the service using the new pathway including:

- Youth Offender Services
- LAC Nurses
- Early Help Teams
- C&F Social Work Teams
- Child Protection Teams
- VEMT partners
- Youth Services
- Leisure Services
- College pastoral and welfare support staff.

Training sessions have been delivered across young people's workforce in Tees to provide good sexual health education and support including:

- Sexual health and awareness
- Healthy relationship training
- Consent, Sex and the Law
- How to teach SRE

Sexual Health Promotion and Prevention offered through a number of programmes, organisations and services across the Tees area as part of their health and wellbeing offer, from signposting to advice and information. For example, drug and alcohol services are specifically required to advice and signpost their clients to sexual health services.

Training sessions by Terrance Higgins Trust have been delivered to over 270 people in 2018/19 in 21 training events, covering a range of topics to a variety of audiences to increase awareness and knowledge including;

- HIV & Sexual Health (BAME, LGBT, CSW)
- Understanding Community Based Testing (POCT)
- MSM update understanding Chemsex
- Risks in the digital age

Local authority communication and marketing teams also offer a range of social media platforms to get messages out to the general public. Sexual health promotion and prevention to young people is offered through the sexual health service. Brook and a range of organisations trained by the sexual health service working with young people.

Information and Campaigns

Both the sexual health service and local authorities promote events and campaigns via social media platforms such as Twitter, Facebook and websites. Teesside University and college Fresher' Week have sexual health promotion targeted at young people. Support is also provided through national resources from Public health England and other dedicated organisations. For example, following a rise in the number of syphilis cases seen in Teesside, during 'Sexual Health Week' 16th – 22nd September 2019, the commissioners of the sexual health service, working alongside Public Health England promoted

prevention, early detection and treatment of syphilis across Teesside with a series of daily tweets on a range of social media platforms.

Service Utilisation

Attendances

	Hartlepool	Middlesbrough	R&C	Stockton
Appointments	3,039 (33%)	3,621 (31%)	4,000 (41%)	5,204 (37%)
CSP	194 2%)	381 (3%)	333 (4%)	413 (3%)
Outreach	1,075 (12%)	2,522 (22%)	2,207 (23%)	2,952 (21%)
Virtual Hub	625 (7%)	1,319 (12%)	1,249 (13%)	1,500 (11%)
Walk-in	4,228 (46%)	3,707 (32%)	1,868 (19%)	3,940 (28%)
Total Attendances	**9,161 (100%)**	**11,550 (100%)**	**9,657 (100%)**	**14,009 (100%)**

Table 28: Local authority attendances split by type: Source Sexual Health Teesside 2020

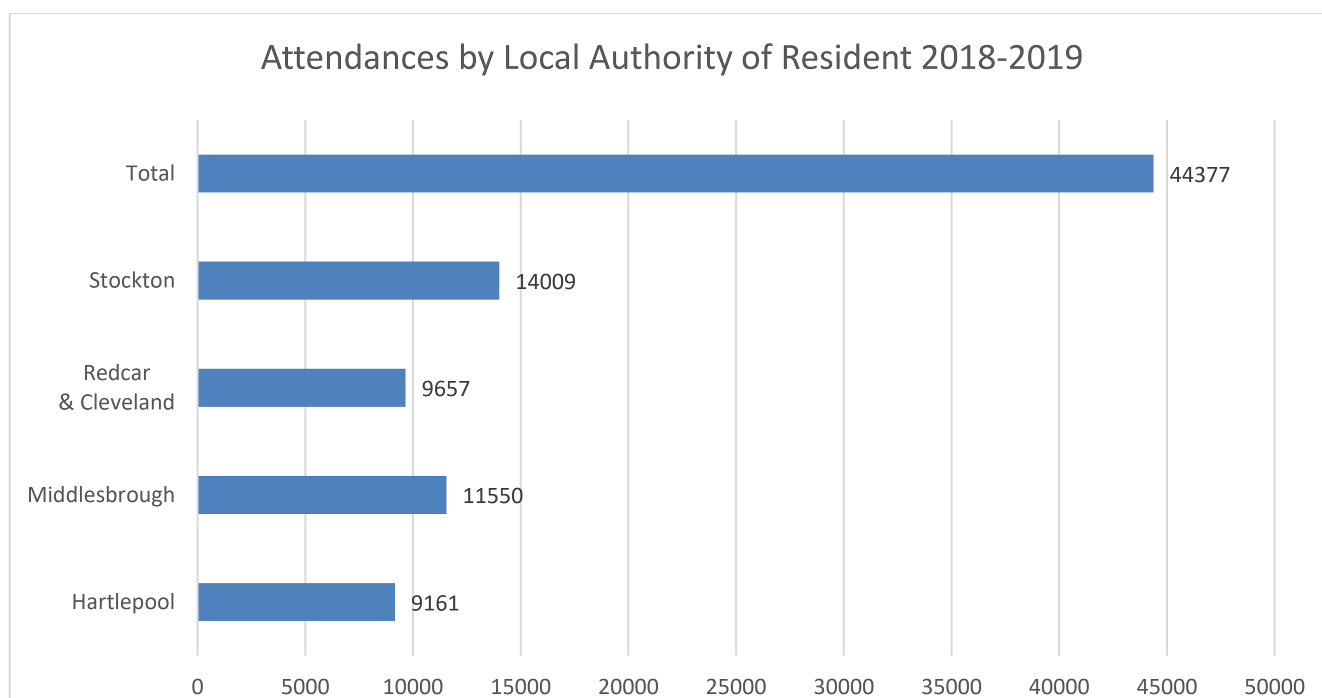


Figure 48: Attendances by LA of resident 2018-19: Source Sexual Health Teesside 2020

In 2018-19 there were 44,377 ‘attendances’ at the sexual health service across Tees. The largest number attending were Stockton (14,009) residents, followed by Middlesbrough (11,550), then Redcar and Cleveland (9,657) and finally Hartlepool (9,161). This follows the population sizes of the towns. See section 5 for population sizes and demographics.

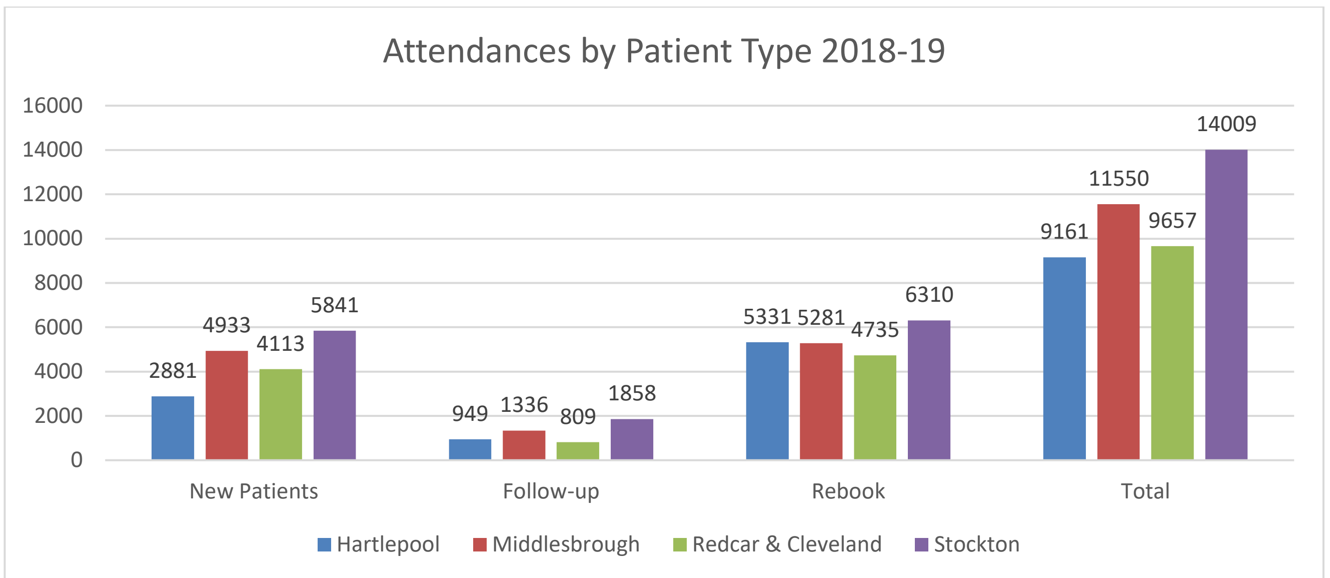


Figure 49: Attendances by patient type 2018-19: Source Sexual Health Teesside 2020

Rebooked patients (existing patients attending for a new appointment) account for the largest patient type attending sexual health services followed by new patients then follow-up patients.

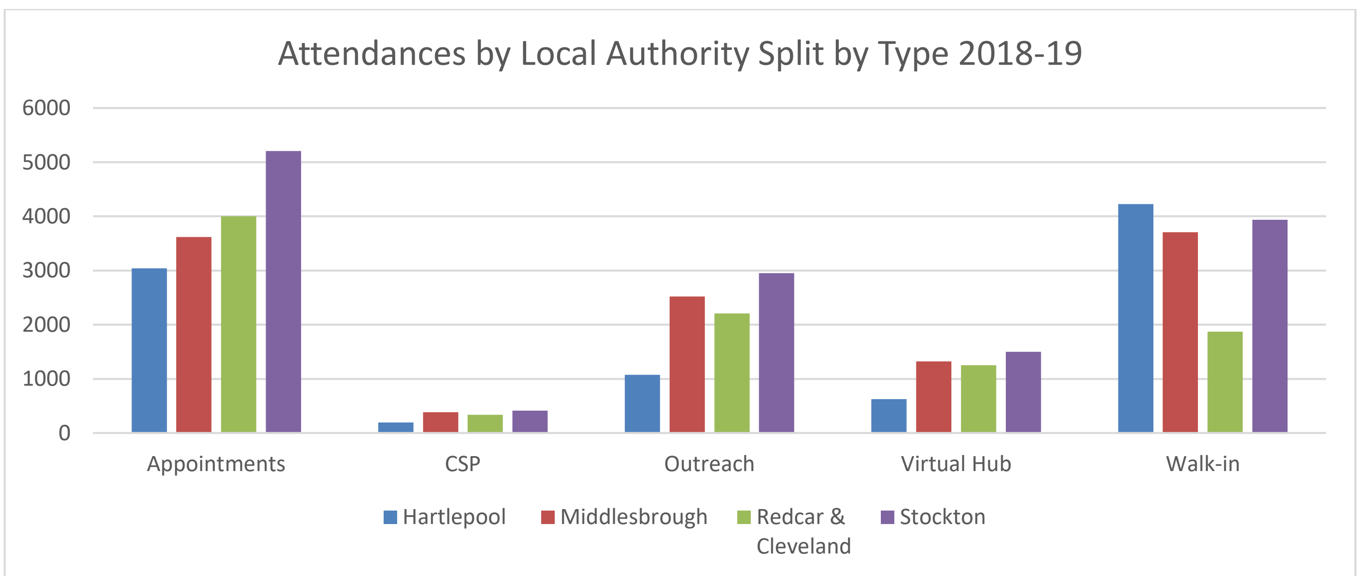


Figure 50: Attendances by LA of resident split by attendance type 2018-19: Source Sexual Health Teesside 2020

During 2018-19, for Hartlepool and Middlesbrough residents, the largest percentage of total attendances was via walk-in clinics at 46% and 32% respectively. Both local authorities shared similar percentages for attendances for booked 'appointments' at 33% and 31%, respectively. However, for Redcar and Cleveland and Stockton residents, the largest percentage of attendances was from booked appointments at 41% and 37% respectively. The next largest percentage of attendances for Redcar and Cleveland was for outreach (23%) unlike Stockton which was for walk-in attendances (28%). The three local authorities of Stockton, Middlesbrough and Redcar and Cleveland share similar percentages for testing kits given out via the virtual hub at 11%, 12% and 13% respectively. Similarly, the same three local authorities share similar percentages for outreach at 21% (Stockton), 22% (Middlesbrough) and 23% (Redcar and Cleveland). Hartlepool has both the lowest uptake of postal testing kits (7%) and outreach (12%).

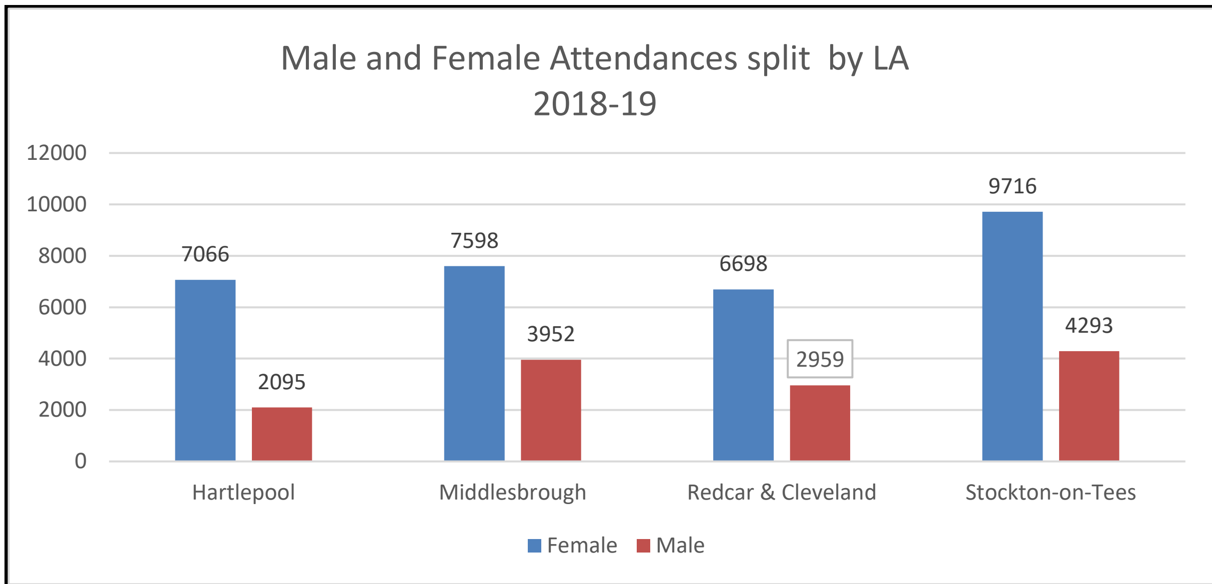


Figure 51: Male and Female attendances split by LA of resident 2018-19: Source Sexual Health Teesside 2020

During 2018-19, 44,377 attendance at the sexual health service were split 31,078 (70%) female and 13,299 (30%) male. Females clearly make up the largest number of patients attending sexual health services.

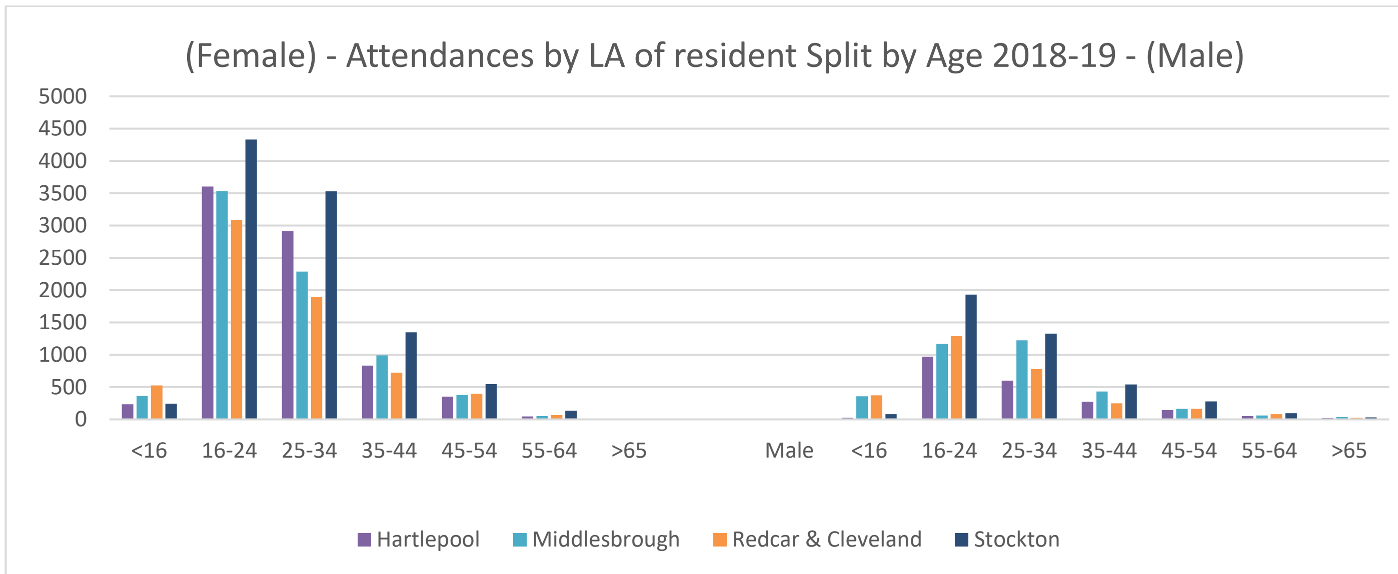


Figure 52: Attendances by LA of resident split by gender and age groups 2018-19: Source Sexual Health Teesside 2020

The largest age group attending the service is the 16-24 year olds for both males and female followed by the 35-44 year olds for both males and females.

Clinic Utilisation

The table below shows the different Tees hubs and spoke clinics' appointments available and their utilisation across 2018-19.

	Number of appointments available	Number of appointments booked	Number of appointments used	DNA numbers	DNA %
North Ormesby Health Village	4540	3962	3127	835	21%
Live Well Centre	614	596	453	143	24%
Redcar Community Heart	5504	4433	3779	654	15%
Low Grange	0	0	0	0	0%
East Cleveland Hospital	263	98	74	24	24%
Guisborough Primary Care Hospital	116	219	204	15	7%
Lawson Street Health Centre	6374	5904	4926	978	17%
Thornaby Health Centre	110	101	79	**22**	22%
Billingham Health Centre	349	330	291	39	12%
One Life Hartlepool	4537	4133	3363	770	19%

Table 29: Hub and spoke appointment utilisation, DNA numbers and percentages for 2018-10: Source Sexual Health Teesside 2020

Note:

- At the end of February 2019, the spoke clinic in Eston closed and although a spoke clinic was set up in Low Grange from March 2019 no patients were booked for the following five months.
- Guisborough Primary Care Hospital re-opened as a spoke site in March 2019.
- Thornaby health Centre re-opened as a spoke clinics in March 2019.
- Middlesbrough's hub relocated from NOHV to The Live Well Centre in July 2019.

The hub with the highest Did Not Attend (DNA) rates is The Live Well Centre Middlesbrough (24%), closely followed by NOHV Middlesbrough (21%), then One Life Hartlepool (19%), Lawson Street Stockton (17%) and finally Redcar Community Heart in Redcar and Cleveland (15%).

The spoke clinic with the highest rate of DNAs is East Cleveland Hospital in Redcar (24%), followed by Thornaby Health Centre Stockton (22%), then Billingham Health Centre Stockton (12%) and finally Guisborough Primary Care Hospital Redcar and Cleveland (7%).

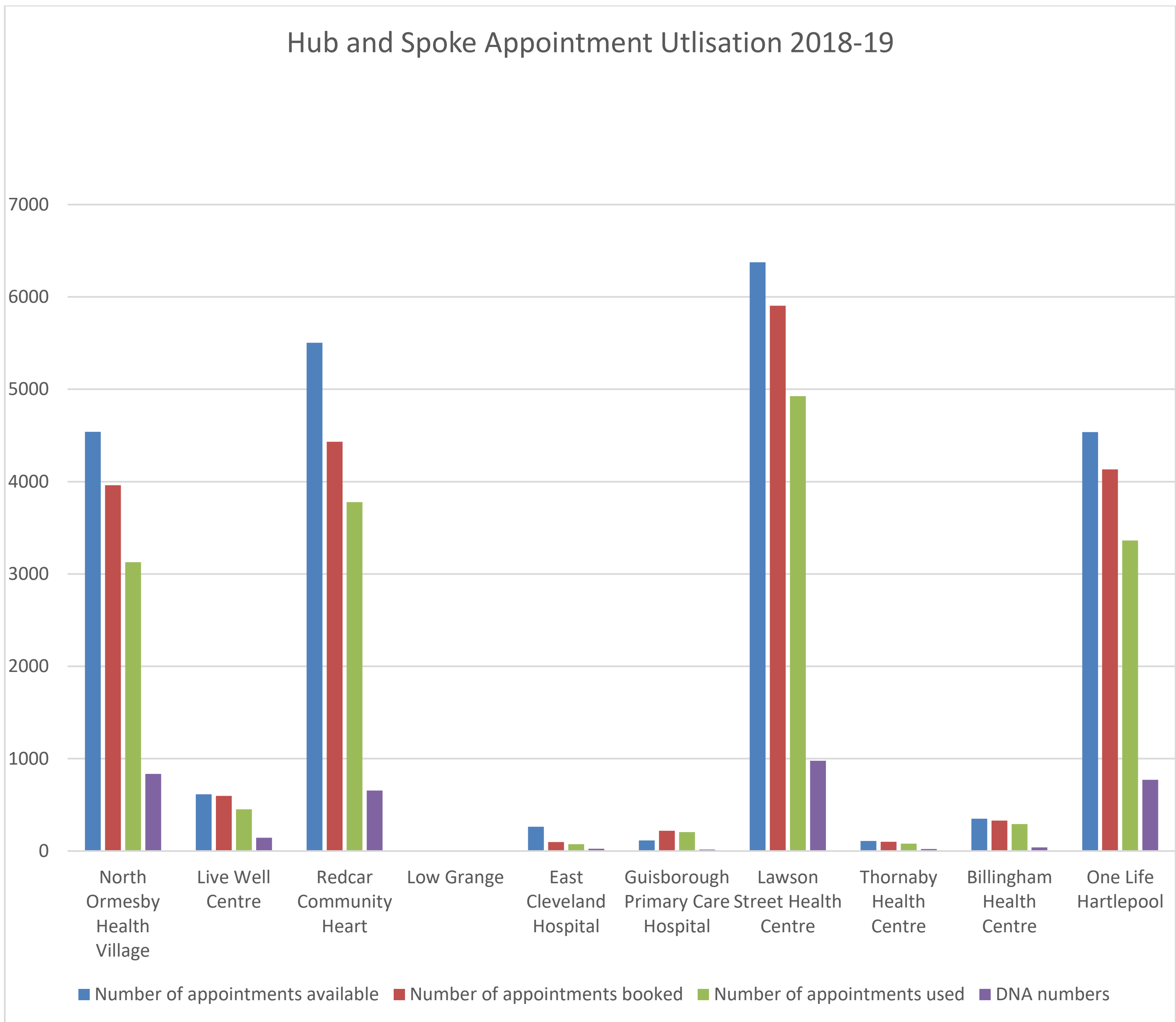


Figure 53: Hub and spoke appointment utilisation and DNA numbers for 2018-10: Source Sexual Health Teesside 2020

More appointments are available across Tees than are booked or used.

Stockton local authority has the most appointments available in 2018-19 (68333), followed by Redcar and Cleveland (5883), then Middlesbrough (5154) then Hartlepool (4537).

Vasectomy Procedures

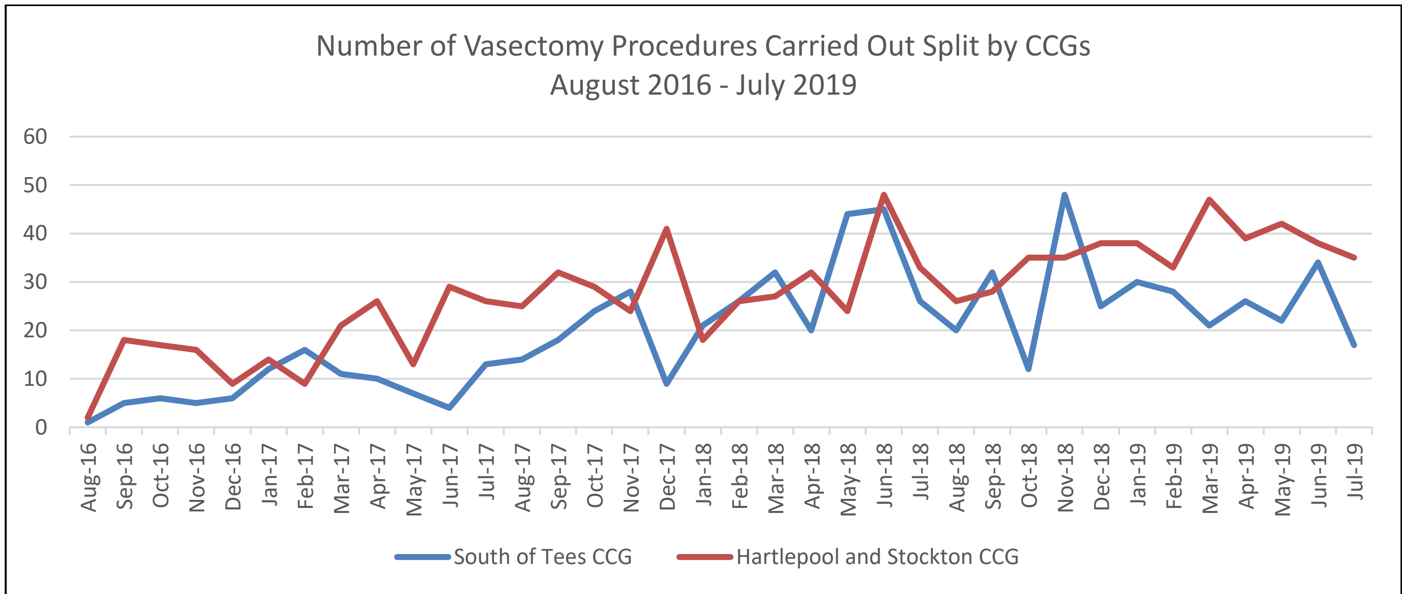


Figure 54: Number of vasectomy procedures carried out split by CCG August 2016 – July 2029: Source Sexual Health Teesside 2020

Overall, since the start of the contract in August 2016 there has been a steady increase in the number of vasectomy procedures carried out by Marie Stopes (subcontracted by the sexual health service). All referrals to the service are via GP referral and there are more referrals from GPs for their male residents in north Tees than for residents living in south Tees.

Cervical Screens

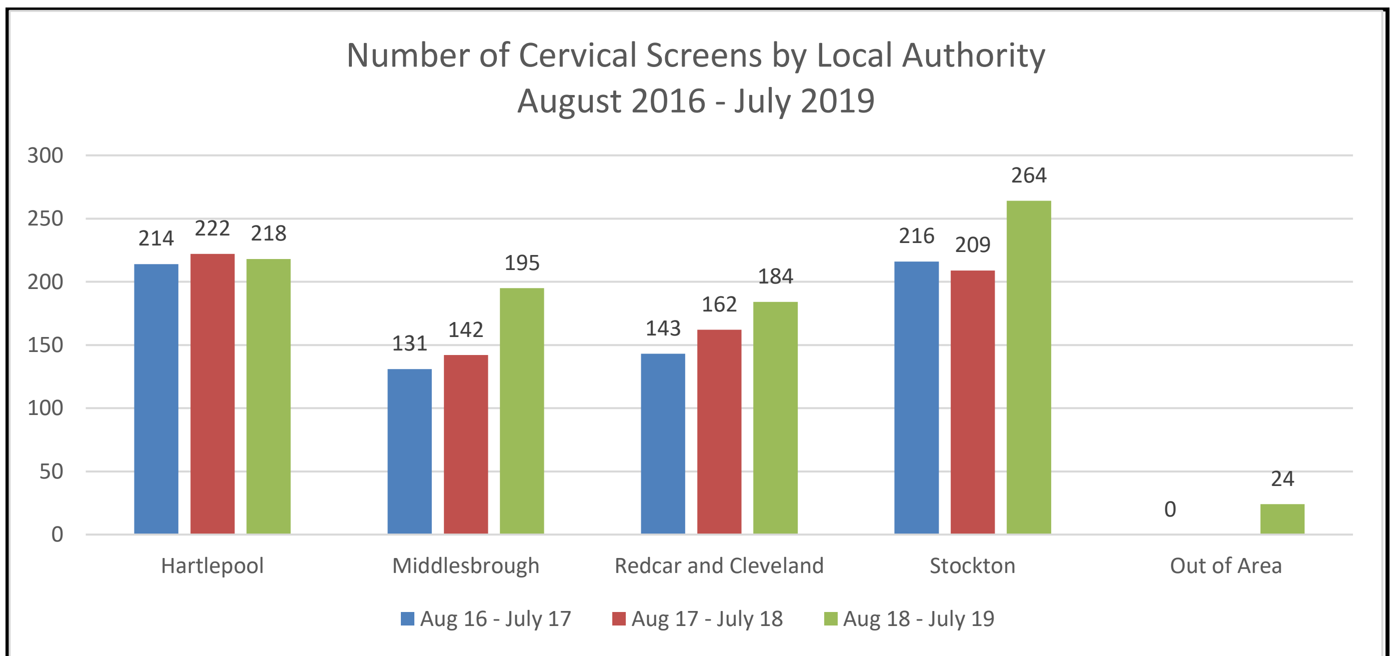


Figure 55: Number of cervical screens by local authority August 2016 – July 2029: Source Sexual Health Teesside 2020

Overall the last three years the number of cervical screens carried out booth booked appointments and opportunistic screens has increased in all four local authorities. In 2018/19 more cervical screens were carried out on women who reside in Stockton (30%) followed by Hartlepool (25%), then Middlesbrough

(22%) and then Redcar and Cleveland (21%). Out of area (attendees at SH services not living in Tees) screens were only reported from 2018/19 and make up only 3% of all screens carried out that year.

Psychosexual Attendances

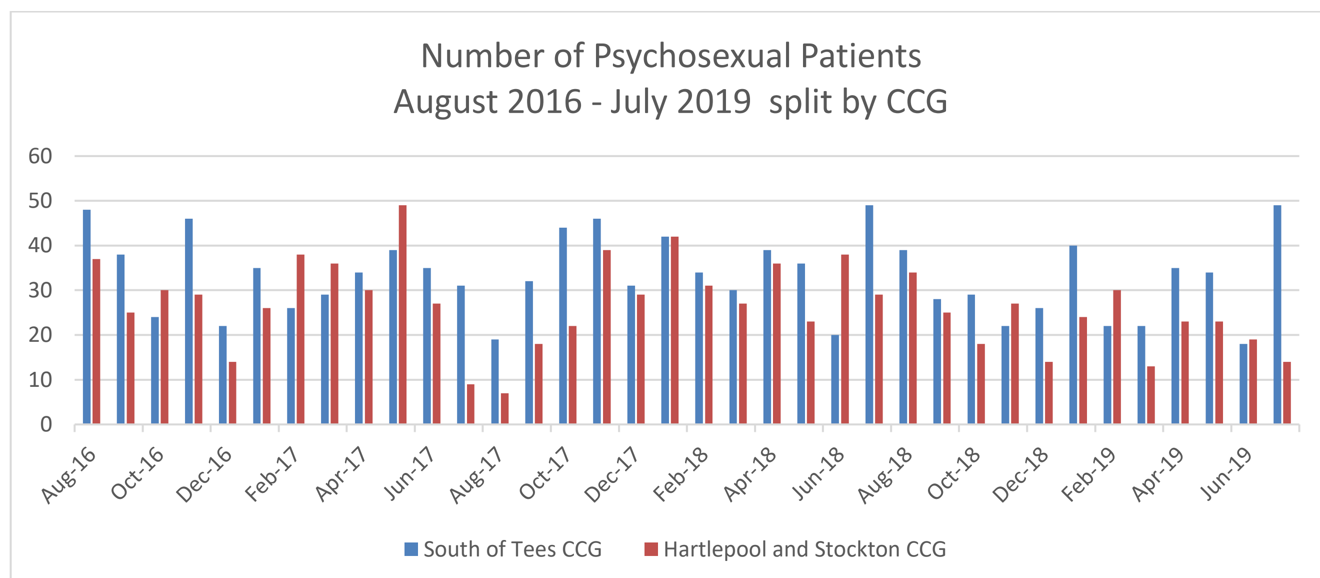


Figure 56: Number of psychosexual patients seen in the SH service August 2016 – July 2019: Source Sexual Health Teesside 2020

The number of patients attending the sexual health service for a psychosexual appointment has dropped over the last three years for both residents of north Tees and south Tees. The percentage drop is greater for north Tees's residents (24.5%) than for south Tees's residents (10.5%). The largest drop can be seen in 2018/19.

Interpreting Services

Local Authority	Aug 16 - July 17	Aug 17 - July 18	Aug 18 - July 19
Hartlepool	13	18	24
Middlesbrough	60	94	98
Redcar and Cleveland	7	7	16
Stockton-on-Tees	63	45	71
Total	143	164	209

Table 30: Uptake of Interpreting Services by Local Authority August 2016 – July 2019: Source Sexual Health Teesside 2020

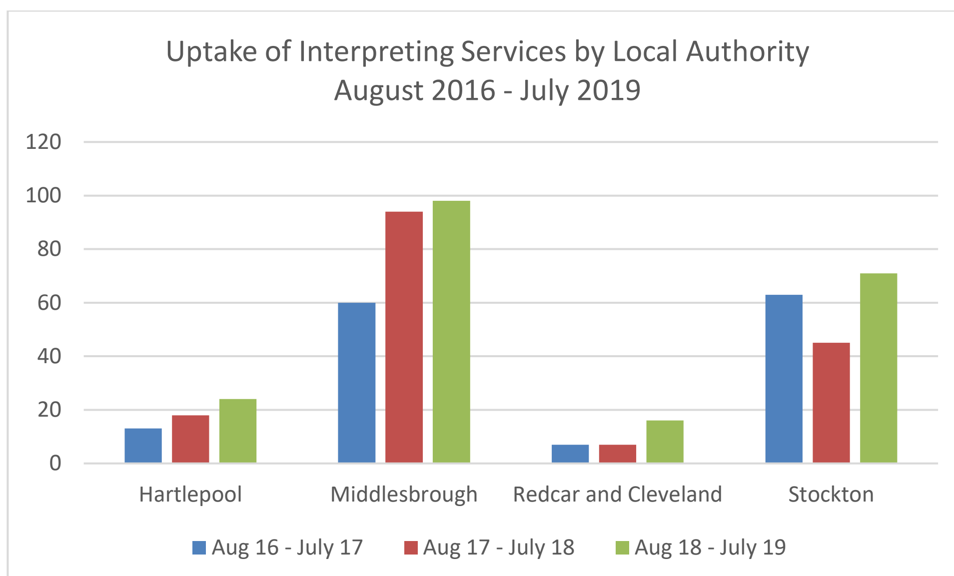


Figure 57: Uptake of Interpreting Services by Local Authority August 2016 – July 2019: Source Sexual Health Teesside 2020

The use of interpreting services within the sexual health service varies greatly across Tees. Patients living in Middlesbrough have the greatest need of this service compared to residents living in Redcar and Cleveland. Over the last three years the need for interpreting services has increased in all localities: by 85% in Hartlepool, 63% in Middlesbrough, 129% in Redcar and Cleveland and 13% in Stockton-on-Tees.

Summary

Sexual Health Service in Teesside

- The Tees sexual health service provides fully integrated, community based sexual health services for the population of Tees via one prime provider.
- Sexual health services are delivered through four hubs, spoke clinics, and subcontracted providers to deliver supporting services and outreach work; GPs, Pharmacies, Acculabs, Marie Stopes, THT and Brook.
- The service hubs offer extended opening hours on most but not all days of the week.
- Opening hours in spoke clinics in Middlesbrough are 4.5h, in Stockton 6h and in Redcar and Cleveland 9h (this excludes the clinic at Low Grange). There are no spoke clinics in Hartlepool.
- Outreach work targeting young people is provided by brook offering training programmes, assembly provision, 1:1 and advice and guidance to nearly 7,000 young people across tees annually.
- Outreach work to vulnerable groups including MSM and POCT is provided by THT.
- xxx subcontracted GP practices are subcontracted to provide LARC and chlamydia screening.
- xxx subcontracted community pharmacies provide chlamydia screening, EHC and C-Card.
- C-Card schemes are delivered through a variety of providers ranging from the youth service to outreach clinics and pharmacies.
- In 2028-19 over 200 individuals from agencies across Tees supporting young people were trained to deliver universal C-Card.

Sexual health promotion and prevention

- Sexual health promotion and prevention to young people is offered through the sexual health service, Brook and a range of organisations trained by the sexual health service working with young people.
- THT undertake prevention and promotion to vulnerable groups especially BAME and MSM.
- In January 2020, 58 participants from south tees underwent sexual health training including how to refer using the newly developed young person and vulnerable person’s pathway.

- Both the sexual health service and local authorities use social media platforms to promote sexual health campaigns and distribute information.
- Over 200 professional in 2018-19 underwent the new c-card training programme developed and delivered by sexual health staff.
- Work progresses with midwifery and maternity services to develop a post-partum contraception offer although this is more advanced in south of tees that north of tees.
- In 2018-19, Brook delivered four bespoke training sessions in Stockton linked into the local authority's strategy for community capacity building.
- In 2018-19, THT delivered training to over 270 in 21 training events, covering a range of topics to a variety of audiences to increase awareness and knowledge.

Service Utilisation in Teesside

- More residents from Stockton-on-Tees (14,009) use sexual health services.
- Rebooked patients (existing patients attending for a new appointment) account for the largest patient type attending sexual health services.
- Walk-in clinics are used the most by Hartlepool residents – 46% of all attendances.
- Booked appointments are used the most by Redcar and Cleveland residents – 41% of all attendances.
- Hartlepool residents (11%) access the virtual hub the least of all Tees residents.
- During 2018-19 70% of all attendances were female compare to 30% males.
- The 16-24 age group makes up the largest proportion of those attending the service for both males and females followed by the 35-44 year old age group.
- In 2018-19, Middlesbrough hub has the highest DNA rates (24%), Redcar and Cleveland hub the lowest (15%).
- In 2018-19, the spoke clinic with the highest DNA rates was East Cleveland Hospital (24%) , the spoke with the lowest DNA rates was Guisborough Primary Care Hospital (7%).
- In 2018-19 the Stockton hub and spoke clinics offered the most appointments in Tees (6833).
- GPs in north Tees refer more men for vasectomies than GPs in south Tees.
- In 2018-19 more women living in Stockton (30%) had a cervical screen.
- Appointments for psychosexual counselling have fallen over the last 3 years (August 2016 – July 2019) by 24.5% for residents living in north Tees and 10.5% for residents living in south Tees.
- The need for interpreting services has increased over the last 3 years with the largest increase seen in Redcar and Cleveland.

10. Service User and Stakeholder Views

During July 2020 young people, members of the public and key stakeholders across Tees were invited to take part in an engagement exercise designed to gather views about priorities for sexual health and relationships. The engagement included:

- Online Surveys (stakeholder, young people and service user)
- In depth interviews

Emerging themes from engagement

- **Flexibility** of access is important to both adults and young people i.e. services delivered from a variety of settings
- A need for sexual health services to be **proactive** in engaging with young people and different community groups.
- A need for **targeted approaches** to working with vulnerable groups of young people and adults
- A request for **more online and telephone services**, from booking appointments, telephone triage, to home testing and contraception.
- **Communication and promotion** needs to be clear, consistent and visible.
- Collaboration – a request for further **collaboration** with partner organisations and services such as the VCSE and Social Care workforce.

Total number of online surveys completed by members of the public, stakeholders and young people between 1st July and 29th July.

Public survey responses	Young people's survey responses	Stakeholder survey responses
133	**43**	**33**

The Public survey

What would make it easy to access sexual health services?

Feedback from the public survey in Stockton-on-Tees suggest that the two most popular options selected were 'services available online' at 55% and 'choice of appointments on evenings and weekends' at 52%. When comparing the responses to the same question from the other local authority areas the most popular choices selected in Redcar and Cleveland were 'choice of appointments on an evening and weekend', 'services available online', and more services for specific groups such as young people and women. In Hartlepool, 37% opted for services available online as opposed to 43% who selected more walk-in clinics. In Middlesbrough two options stood out as the most popular choices, these were, 'choice of appointments, evening and weekend' at 61% and 'services available online at 52%.

What services would you like to access online?

Across Tees local authorities, on average up to 70% of respondents requested appointment bookings and online consultations. The third most frequent answer was 'ordering contraception'.

Where would you like to access appointments?

In Stockton-on-Tees, 57% of respondents stated they would prefer to go someone close to home, with on average 50% of respondents in other Tees local authorities choosing this option. On average, 48% of respondents also requested that services were not identifiable as sexual health clinics. Despite the high proportion of respondents requesting online provision, across all four local authority areas still put t GP's and Specialist SH Clinics were the most frequently chosen option before online provision.

<u>Young people's survey and interview feedback</u>

At the end of July 27 young people from Stockton-on-Tees completed the online survey, compared to 8 from Hartlepool, 7 from Redcar and Cleveland and 1 from Middlesbrough.

How would you like to get information and advice about healthy relationships?':

85% of respondents stated they would like to receive information from websites.

70% from online chat.

59% in schools (PSHE).

'What would make it easier to use Sexual Health Services in the future?'

The majority of respondents selected online and telephone service options. The significance of this response is contextualized when **80%** of participants responded that embarrassment is the single biggest barrier to accessing services for young people.

Additional highlights from the survey include:

75% response rate for services being available online

75% response rate for services such as home testing kits/condoms to be available online

The majority of young people (65%) stated that they would prefer to attend somewhere that was not clearly identifiable as a sexual health clinic.

<u>Stakeholder survey and interviews</u>

The following stakeholders completed an online survey and / or an in-depth interview

- Secondary Care
- VCSE children's organisations
- VCSE adult organisations
- 0-19 Services
- Public Health commissioned services
- Adult and Children's Social Care
- Tees Local Pharmaceutical Committee
- Schools

Feedback from stakeholder surveys and interviews includes:

- Partner workforces are an untapped and underused asset in regard to tackling sexual health issues.
- Sexual Health provision needs to be promoted more widely.
- the use of technology could help tackle some of the barriers to access young people
- collaboration between sexual health services and stakeholders could be developed further to improve outcomes for all.

Healthwatch were a key partner in supporting the promotion of the engagement programme across July, Healthwatch also facilitated a limited number of public interviews, feedback included:

What barriers do you think stop people attending sexual health services?

That the main barrier was not knowing where to go.

What do you think would make it easy for people to use sexual health services?
There should be more walk in clinics, whilst the other felt that more services should be available online

Where do you think people would prefer to go for sexual health services?
Respondents felt that services should be close to home but expressed a preference for them also to be away from people who knew them.

Where do you think most people would like sexual health services to be delivered from?
Both people would like to see sexual health services being delivered from community centres.

Completed Surveys by Local Authority Area

Local Authority	Public survey responses	Young people's survey responses	Stakeholder survey responses
Stockton-on-Tees Borough Council	**68**	**27**	**21**
Hartlepool Council	**15**	**8**	**12**
Middlesbrough Council	**21**	**1**	**0**
Redcar and Cleveland Borough Council	**29**	**7**	**0**

11. Conclusions

The main results of the needs assessment were:

1. Since the previous SHNA for Teesside, there have been changes in the type of acute STI infections diagnosed across the area, with reductions in infections such as gonorrhea and genital warts and increases in infections such as syphilis. Although the rate of acute STI infections has reduced slightly overall across the Tees, this is unlikely to indicate a reduction in demand for sexual health services overall.

2. Recent outbreaks such as the increase in syphilis across Tees indicate changing behaviours in groups not considered to be at risk of acquiring STI infections (i.e. transmission during pregnancy) and the response to the increase in these infections requires close working between sexual health and antenatal services.

3. Although the rate of under 18 conceptions continues to decrease for the Tees area, the rate remains significantly higher than the national average, and the reduction not continuing at the same pace as the national average. Abortions rates for the under 18 age group highlight some significant differences between areas of Tees, with Hartlepool, Middlesbrough and Redcar and Cleveland has been lower than the national average, while in Stockton the proportion of teenage pregnancy leading to abortion is higher than the national average.

4. The local system has changed significantly since the previous SHNA in 2014, with a significant reduction in the amount of providers of young people's services across the local area, and the development of local primary care networks.

5. Similar to the previous SHNA, it is apparent that key groups have the highest burden of disease from poor sexual health in the Tees area including young people, MSM and those living in deprived areas.

6. The national context and response to sexual health has undergone some significant changes since the previous SHNA, with the planned introduction of routine PREP treatment for HIV, HPV vaccinations for MSM aged 45 and under attending level 3 services and proposed changes to chlamydia testing and the introduction of mandatory relationship and sexual health education across primary and secondary schools.

7. Levels of use of emergency contraception have remained consistent across the Tees since 2014, while the abortion rate across all Tees areas increasing since 2014.

12. Recommendations

Based on the conclusions the following recommendations have been made:

1. To review prevention approaches across each Tees area to ensure that the sexual health prevention offer reflects and supports the changing system (e.g. mandatory RSHE, emerging Healthy Schools Frameworks).

2. Sexual health provision to maintain focus on narrowing the inequalities associated with poor sexual health outcomes for local populations.

3. PReP and chlamydia

4. COVID-19 and online provision

5. Establish mechanisms to involve local populations in the design and development of sexual health provision, although satisfaction rates for sexual health services are high when they are utilised, there is no established processed to understand the barriers facing groups who do not access services.

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