PLYMOUTH SEXUAL HEALTH NEEDS ASSESSMENT 2015

Author: Public Health, Office of the Director of Public Health, Plymouth City Council
Date: March 2016 (v1.0)

This document is produced as part of Plymouth’s Joint Strategic Needs Assessment.
Document information

<table>
<thead>
<tr>
<th>Document status</th>
<th>Draft / Final-draft / Final</th>
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<tr>
<td>Author</td>
<td>Public Health</td>
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<tr>
<td>Document version</td>
<td>v1.0</td>
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<tr>
<td>Original document date</td>
<td>08 March 2016</td>
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Amendment record

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Reason(s) for change</th>
<th>Pages affected</th>
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1. Introduction

Sexual health is an important public health priority. Good sexual and reproductive health is an essential component of positive health and wellbeing. The World Health Organisation’s working definition of sexual health is;

“…a state of physical, emotional, mental and social well-being in relation to 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.”

The consequences of poor sexual health, including sexually transmitted infections (STIs) and unplanned pregnancies can have a lasting impact on people’s lives. STIs are communicable diseases and as such require effective clinical services and public health interventions to prevent onward transmission.

The most recent figures suggest that new diagnoses of STIs in England might be beginning to slow. There was an overall 0.3% decrease in new diagnoses from 2013 to 2014. The most commonly diagnosed STI was chlamydia with 206,774 diagnoses in England in 2014. Cases of gonorrhoea rose 19%, from 29,419 in 2013 to 34,958 in 2013.

It is estimated that there are 103,700 people living with HIV in the UK and that an estimated 17% of these are undiagnosed and not unaware of their infection. The overall HIV prevalence in the UK in 2014 was 1.9 per 1,000 people aged 15 years and over.

In 2013 the under-18 conception rate in England and Wales was the lowest since records began in 1969. There were an estimated 24,306 conceptions in this age-group. In 2013 there were an estimated 872,849 conceptions to women of all ages, compared with 884,748 in 2012, a decrease of 1.3%.

In 2014 there were 184,571 abortions for women resident in England and Wales, a 0.4% decrease (185,311) on 2013 and a 0.6% decrease (185,713) from 2004. The abortion rate was highest at 28 per 1,000 for women aged 22. The under-16 abortion rate was 2.5 per 1,000 women and the under-18 rate was 11.1 per 1,000 women. In 2014 37% of all abortions were repeat procedures.

There is a clear relationship between sexual ill health, poverty and social exclusion.

Evidence indicates that some groups are at more risk of poorer sexual health. These include young people, men who have sex with men, people from African communities and sex workers. Teenage mothers and their children are more likely to experience poor health and

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6 Contraceptive services with a focus on young people up to the age of 25. NICE public health guidance 51, March 2014.
social outcomes. As well as experiencing the greater burden of sexual ill health many of these groups may also experience difficulties in accessing services.

Sexual ill-health has been estimated to cost the NHS more than £700 million a year. In 2005 the Health Protection Agency estimated the cost of treatment and care in those diagnosed with HIV/AIDS at £400 million per year. Whilst the calculated cost of treating STIs in England, Wales, and Northern Ireland was approximately £165 million per year. Investing in sexual health services can deliver significant cost savings for the NHS and local authorities. Quality services and interventions that focus on prevention, screening and prompt treatment and partner notification can control disease, prevent unwanted pregnancies and avoid costly health complications and treatments.

The National Institute for Health and Care Excellence identifies that the costs of increased provision of long acting reversible contraception (LARC) are more than offset by the costs of unplanned pregnancies. It estimates that the NHS in England could save £100 million each year by increasing the use of long-acting reversible contraception.

Every case of HIV that is prevented saves the NHS over £350,000. The cost of HIV care in the first year after diagnosis is twice as much for someone with a late diagnosis. Increased HIV testing and early diagnosis saves money by both reducing hospital admissions and reducing the costs of caring for someone with HIV in the community.

1.1 Purpose of the Sexual Health Needs Assessment

This needs assessment has been carried out to provide an up to date analysis of the sexual health needs of the population of Plymouth. It also seeks to understand current service provision and determine if this is the most effective and efficient way of meeting sexual health needs. In this way the needs assessment informs future commissioning decisions and service configuration and delivery.

1.2 Methodology

This needs assessment is informed by a methodology recommended by the Department of Health. The assessment considers levels of need, current service provision (supply), service demand and evidence of gaps in provision (unmet need). In this way the assessment includes:

- A description of sexual health needs through consideration of overall demographics and sexual health profile for the Plymouth population
- Mapping and description of current service provision

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10 The case for including sexual & reproductive health and HIV as a central part of the Public Health White Paper. British Association for HIV & Sexual Health et al, 2010.
Definition of demand by analysing service activity
Clarification of any gaps between needs, current service provision and demand

This assessment has been undertaken in consultation with local authority and health service commissioners and a wide range of service providers and clinical experts. The views of service users have been drawn from various service user satisfaction surveys undertaken by current service providers and are presented in Section 9.

A number of additional reports provide supplementary information in support of this needs assessment:

- A needs assessment of those affected by or involved in street sex work in Plymouth (February 2014)
- A review of chlamydia screening and treatment in Plymouth (March 2015)
- An audit of the provision and accreditation re long acting reversible contraception in general practice (July 2014 – on-going)
- A snapshot audit of LARC training arrangements (June 2015)
- Performance and Impact Assessment of the Eddystone service (June 2015)

2. Background

2.1 Policy framework

The 2001 national strategy for sexual health and HIV\textsuperscript{13} provided the first framework for addressing a range of sexual health issues. It set out a 10 year plan to reduce transmission of HIV and STIs, enhance HIV/AIDS care services, modernise sexual health services and dramatically reduce teenage pregnancy rates.

The Choosing Health White Paper\textsuperscript{14} re-emphasised the direction of modernising services and focused on prompt access to Genito Urinary Medicine (GUM) clinics, provision of a full range of contraceptive services and delivery of a chlamydia screening programme. The 2006 White Paper\textsuperscript{15} set the agenda for sexual health services to be delivered in community settings, through engagement with primary care.

The Government’s 2010 strategy for public health\textsuperscript{16} defines an ambitious approach to addressing key public health concerns and to reducing health inequalities. It adopts a life course approach and directs local areas to ‘innovate and develop their own ways of improving public health in their area’. The strategy stresses the need for an accessible integrated model of sexual health service delivery at a local level.

The strategy is supported by a public health outcomes framework\textsuperscript{17} that defines the ambitions for a reformed public health care system. The top level ambitions are for increased healthy life expectancy and reduced differences in healthy life expectancy between

\begin{itemize}
  \item Our Health Our Care Our Say. Department of Health, 2006.
  \item Healthy Lives Healthy People – Our Strategy for public health in England, Department of Health. 2010.
  \item Improving outcomes and supporting transparency, Department of Health, 2012.
\end{itemize}
communities. The framework details a range of indicators including those concerned with under 18 conceptions, access to non-cancer screening programmes, chlamydia diagnosis, late presentation of HIV and mortality from conditions considered preventable.

The Lesbian, Gay, Bisexual and Trans (LGBT) Public Health Outcomes Framework Companion\(^{18}\) makes a series of recommendations to local areas for actions to address inequalities in LGBT communities. It stresses that the needs of LGBT people should be explicitly considered when designing and delivering local sexual health services.

A Framework for Sexual Health Improvement in England, 2013\(^{19}\) sets out a series of national ambitions. In line with broader public health policy it takes a life course approach emphasising that people have different needs at different times in their life. The Framework defines the following objectives, to:

- Build knowledge and resilience among young people
- Improve sexual health outcomes for young adults
- Provide access to high quality services and information
- Ensure people remain healthy as they age
- Prioritise prevention
- Reduce rates of STIs among people of all ages
- Reduce onward transmission of, and avoidable deaths from, HIV
- Reduce unwanted pregnancies among all women
- Continue to reduce the rate of under 16 and under 18 conceptions

Public Health England emphasise that education and early prevention should achieve the greatest improvements in sexual health and reductions in health inequalities\(^{20}\). They also stress the benefit of both universal health promotion and specific approaches for key populations with high risk of poor sexual health outcomes.

Guidance from the Department of Health\(^{21}\) stresses the legal requirements of local authorities to provide open access services to control sexually transmitted infection, prevent outbreaks and reduce unplanned pregnancies.

### 2.2 Clinical and best practice guidance

There is a wealth of clinical and best practice guidance offering evidence based approaches to the commissioning and provision of sexual health services. This guidance supports the policy direction towards an integrated local sexual health system with tiered levels of service provision.

The British Association for Sexual Health and HIV (BASHH) standards for the management of sexually transmitted infections\(^{22}\) represent best practice and suggest that local services are

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\(^{22}\)Standards for the management of sexually transmitted infections (STIs). Medical Foundation for AIDS & Sexual
accessible through self-referral and delivered by appropriately trained staff. They also stress the importance of clear local clinical pathways between services.

The Faculty of Sexual and Reproductive Healthcare Service Standards for Sexual and Reproductive Healthcare\(^{23}\) give further support to the standards above and stress the importance of leadership to ensure quality of service provision, development, training and clinical governance. They specifically provide a Quality Standard for Contraceptive Services\(^{24}\) that stresses the importance of open-access services in giving women and men choice and control over reproduction.

The National AIDS Trust toolkit\(^{25}\) provides guidance on commissioning HIV testing services and focuses on developing testing services and reducing the prevalence of undiagnosed HIV. The British HIV Association Standards of care for People Living with HIV\(^{26}\) sets out the type of treatment and care that people living with HIV should expect to receive. The Standards cover twelve areas of care and include HIV testing, clinical HIV care and the involvement of people living with HIV in the design and delivery of care.

Public Health England has published standards to support the early detection and management of chlamydia.\(^{27}\) These standards provide an evidence based and cost effective approach to the local delivery of chlamydia screening. The standards stress the benefits of integrating screening within local primary care, sexual and reproductive healthcare services and providing targeted outreach screening where there is evidence of unmet need.

Relevant guidance is also available from the National Institute for Health and Care Excellence (NICE). This covers a range of issues including the prevention of sexually transmitted infections and under-18 conceptions and the provision of long acting reversible contraception (LARC).

### 2.3 Integrated sexual health services

The aim of an integrated model is to deliver a range of accessible high quality sexual health services that are clinically sound and cost effective. Integrated provision aims to provide convenient and timely access to services. It seeks to ensure that where possible those using services are able to address all their sexual health needs in one place and minimises the need for repeat visits.

An integrated sexual health service can be delivered through a range of models provided by a single or multiple provider(s). It is characterised by robust clinical pathways across all levels of provision, a centralised booking system, a single IT system with dual trained staff leading on delivery of STI screening and contraception provision.

A tiered model of provision is described below.

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\(^{23}\)Service Standards for Sexual and Reproductive Healthcare. Faculty of Sexual and Reproductive Healthcare of the Royal College of Obstetricians and Gynaecologists, 2013.

\(^{24}\) A Quality Standard for Contraceptive Services. Faculty of Sexual and Reproductive Healthcare, 2014.


\(^{26}\)Standards of Care for People Living with HIV. The British HIV Association, 2013.

**Self-managed care**

People of all ages should be able to access some sexual health services and resources without the need to see a healthcare practitioner. Where people are under the age of 16 they must be seen by a professional trained to assess competence and to ensure that any safeguarding issues are identified and appropriately responded to. These services and resources include:

- Sexual health information – including that related to contraception and pregnancy, safe sex advice and sexually transmitted infections
- Primary prevention initiatives to improve population sexual health
- Condoms
- Chlamydia screening for sexually active under 25s
- Pregnancy testing kits

**Level 1 and 2 - basic and intermediate care**

Contraception and sexual health services can be offered in primary care and specialist community settings. These services are provided by doctors, nurses, community pharmacists and other staff with appropriate training. Components of these services include:

- Full sexual history taking and risk assessment
- Pregnancy testing
- Supply of male and female condoms and lubricant
- All methods of oral emergency contraception and the intrauterine device for emergency contraception
- All methods of contraception
- Cervical cytology
- Direct referral to other services including ante-natal care and abortion services
- Assessment and referral for psychosexual issues
- STI testing and treatment of symptomatic but uncomplicated infections in men (except men who have sex with men) and women
- Chlamydia screening for sexually active under 25 year olds
- Case management of uncomplicated chlamydia
- Initiation of Post HIV Exposure Prophylaxis
- Promotion and delivery of Hepatitis A and B vaccination
- Hepatitis C testing
- Uncomplicated contact tracing/partner notification
- Assessment and referral of sexual assault cases
- Holistic sexual health care for young people including child protection / safeguarding assessment
- Outreach services for STI prevention and contraception

**Level 3 – complex service provision**

These interventions are delivered from specialist services and include the following elements of provision:

- Management of complex contraceptive problems
- Management of complicated/recurrent STIs
- Management of STIs in pregnant women
- Management of HIV partner notification
• Management of sexual health aspects of psychosexual dysfunction
• Management of organic sexual dysfunction
• Provision and follow up of post-exposure prophylaxis after sexual exposure to HIV
• Leadership and coordination of pathways across clinical services, clinical governance and training

2.4 Local policy framework

Plymouth Co-operative Council Corporate Plan 2013-2017 defines a number of objectives in support of the city’s strategic vision to become ‘One of Europe’s most vibrant waterfront cities where an outstanding quality of life is enjoyed by everyone’. These include designing and delivering efficient and effective services and reducing health and social inequality.

Plymouth’s Health and Wellbeing Boards vision is to have ‘Happy, Healthy, Aspiring Communities’. It acknowledges that this vision will only be achieved by greater integration of health and wellbeing services and a greater focus on health promotion and prevention.

Plymouth City Council is currently leading a Transformation Programme to address ongoing financial pressures and change the way that local services are commissioned and delivered. On 1st April 2015 the council together with NHS Northern Eastern and Western Devon Clinical Commissioning Group (NEW Devon CCG) formed an integrated commissioning function. This brings together budgets to commission an integrated system for population health and wellbeing.

Plymouth’s Children and Young People’s Partnership Plan 2014 - 2017 sets out the key outcomes to deliver to give children and young people the best start to life. This is supported by a draft Integrated Children and Young People’s Commissioning Strategy that is focused on raising aspirations and delivering early intervention and prevention services. As part of this approach reducing teenage conceptions and improving young people’s sexual health are key priorities.

2.5 Commissioning arrangements

Since April 2013 responsibilities for commissioning sexual health services have undergone significant change.

Local authorities have a statutory responsibility\(^{28}\) to provide:

• Contraception services including those commissioned from general practice and community pharmacies as ‘local enhanced services’. This includes meeting the costs of devices and prescriptions and condoms
• Sexually transmitted infection (STI) testing and treatment including chlamydia screening and HIV testing
• Sexual health aspects of psychosexual counselling
• Other specialist services such as young people’s sexual health services, outreach, HIV prevention and sexual health promotion

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These services must be commissioned from the ring fenced public health grant and must be available to all people in the area, whether resident or not. This approach ensures rapid access to contraception, and testing and treatment for sexually transmitted infections thus preventing unwanted pregnancies and the onward transmission of disease. The local authority is also responsible for the cost of these services where its residents access them outside of the local area.

NHS England is responsible for commissioning:

- Contraception services as part of General and Personal Medical service contracts in primary care
- Testing and treatment for STIs, including HIV testing in general practice when clinically indicated as part of essential services under the GP contract
- HIV testing when clinically indicated in other NHS commissioned services
- HIV treatment and care for adults and children, including costs of antiretroviral treatments and post-exposure prophylaxis
- Sexual health services for people in secure and detained settings
- Sexual Assault Referral Centres
- Cervical screening
- HPV immunisation programme
- Specialist fetal medicine services, including late surgical termination of pregnancy for fetal anomaly between 13 and 24 gestational weeks
- NHS Infectious Diseases in Pregnancy Screening Programme including antenatal screening for HIV, syphilis and hepatitis B

Clinical Commissioning Groups are responsible for commissioning:

- Vasectomy and sterilisation services
- Abortion services – including STI and HIV testing and contraception provided as part of the abortion pathway
- Contraception primarily for gynaecological (non-contraceptive) purposes
- Non sexual element of psycho-sexual health services
- HIV testing when clinically indicated in commissioned services such as hospital Emergency Departments and haematology departments

These organisations are also responsible for commissioning a number of additional services that interface with those detailed above. Local authorities are responsible for commissioning HIV related social care, broader support to teenage parents and school nursing while NHS England and Clinical Commissioning Groups are responsible for general practice and gynaecology services.

There is an acknowledgement that these commissioning arrangements have the potential to fragment treatment pathways and destabilise integrated approaches to HIV and sexual and reproductive healthcare services. In response to this Public Health England has published guidance on delivering a local integrated system. Making it Work stresses that ‘whole

system commissioning' based on collaboration and cooperation across the system is necessary to deliver best outcomes for individuals and populations. More recently the All Party Parliamentary Group on Sexual and Reproductive Health in the UK\textsuperscript{32} highlighted the complexity of commissioning arrangements and the need for local services to be designed around population need rather than commissioning structures.

3. Demography and population

3.1 Population

The usual resident population of Plymouth, according to the 2013 mid-year estimate (ONS), was 259,200 people. However, other data sources suggest that the population of the city is higher. The GP registered population compiled by the NHS for example, recorded a 2013 figure of 268,000. The city has a population that changes during the course of the year; during the summer the city is supplemented by visitors, whilst in September many thousands of students arrive to undertake studies with the University of Plymouth and other higher education establishments. It is likely that at times the population swells in excess of 300,000.

The estimated usual resident population of the city has grown from 243,400 in 2003 to 259,200 in 2013, an increase of around 6.5%. The Office for National Statistics (ONS) projects that the population is likely to grow by a further 7% over the next 20 years reaching 277,100 by 2033.

The city population consists of similar numbers of males (50%) and females (50%) and reflects the national (49% vs. 51%) picture. The structure also follows the archetypal ‘beehive’ pattern characterised by a larger youthful population and a smaller, but growing, elderly population. Figure 1 shows the city’s age-groups for males and females as bars, and the equivalent for England as a black line.

Figure 1: Plymouth and England population pyramid by gender specific age-group, 2013

Source: 2013 mid-year estimates of usual resident population (ONS)
Overall the demographic structure of the city is similar to that seen nationally. However, there is marked difference in the 20-24 year age group compared with England. The latest 2013 mid-year population estimates suggest around 25,800 young people aged 20-24 years live in Plymouth, making up 9.9% of the city’s population. In contrast, this age group makes up only 6.8% of the total population of England. This may, in part, be linked to expansion of the university campus since 2000 or to a surge in births around 1985 to 1989. This is of significance given that the burden of sexual infection is borne by younger people.

The mid-2013 population estimate of 0-17 year olds in Plymouth in 2013 was 51,300. It is noteworthy that nearly 46.8% of these young people live in the North West and South West localities. It is recognised that children and young people in these two localities are significantly disadvantaged. Figure 2 shows the distribution of children and young people aged under-18 years across the city whilst Figure 3 displays those aged 18-24 years.

Figure 2: Population aged under-18 years by neighbourhood and locality (2013)

The city has experienced a baby boom since 2001. According to the GP population register the under-1 age group has shown a nearly year-on-year increase from 2,241 in 2001 to 2,903 in 2013, representing a 30% rise. Analysis of the 2013 annual birth extract from ONS highlights the uneven pattern of births across the city. There is an overall increasing trend from fewer births in those neighbourhoods which are less deprived to higher numbers in those more deprived. The least number of births (468) was seen in the middle deprivation group, the highest number (875) was seen in the most deprived group.
Life expectancy at birth (for males and females combined) has increased by 2.1 years since 2001-03 to 80.5 years in 2011-13. In the least deprived neighbourhood group life expectancy generally mirrors the pattern found across the city as a whole, albeit higher. In the most deprived neighbourhood group life expectancy generally mirrors the pattern found across the city as a whole, albeit lower. The gap between the most and least deprived neighbourhood groups has decreased from 4.7 years in 2001-03 to 3.9 years in 2011-13. There have, however, been considerable fluctuations in the gap over this period.

Since 2001 rates of all-age all-cause mortality in Plymouth have decreased from 124.2 per 10,000 population in 2001 to 103.5 per 10,000 in 2013. In the least deprived neighbourhood group the rates generally mirror the pattern found across the city as a whole, albeit they are lower. In the most deprived neighbourhood group the rates generally mirror the pattern found across the city as a whole, albeit they are higher. As well as the overall decrease, the gap between the most and least deprived groups has also reduced over the same time period. The gap is now 23.9 per 10,000 compared to 30.7 per 10,000 in 2001.

Thus, as a reflection of the increases in births and life expectancy, and the overall decrease in mortality, the local population has grown since 2001.

### 3.2 Ethnicity

There is relatively little ethnic diversity in Plymouth. According to the 2011 census 92.9% of Plymouth’s population was White British, 13% higher than the national average. Of the 7.1% Black and Minority Ethnic (BME) population White Other (2.7%), Chinese (0.5%) and Other
Asian (0.5%) were the most common ethnicities stated. Despite the low proportion the city’s BME population has actually doubled since the 2001 census.

Plymouth’s population is therefore predominantly white with a small but growing BME population. A challenge for front-line service staff is the number and variety of other languages spoken in the city. 2011 Census data suggests there are at least 40 main languages spoken in the city, with Polish, Chinese and Kurdish the most common. Based on data for 2012/13, the Translate Plymouth service recorded that the most requested languages were Polish, British Sign Language (BSL) and Chinese Mandarin.\(^33\)

### 3.3 Deprivation

Material deprivation and poverty have been features of life in Plymouth in recent years and there is a strong causal link between health inequalities and economic inequities that is long established in national research.\(^34\), \(^35\) Poverty is also a key risk factor in teenage pregnancy and poor sexual health.

The Indices of Multiple Deprivation (IMD) devised by the government and updated most recently in 2010, measures deprivation against 38 indicators. Plymouth’s ranking in the IMD 2010 is 72\(^\text{nd}\) out of 326.

Before the onset of the economic recession (2008-09), the city overall was becoming less deprived, but pockets of deep deprivation remain. The five neighbourhoods exhibiting the highest levels of deprivation are Devonport, Stonehouse, North Prospect and Weston Mill, East End, and Whitleigh.

Figure 4 displays the variation in deprivation across the city. The more deprived areas are found in the North West, South West, and South East localities.

Between October 2013 and September 2014 there were 39,100 adults of working age in Plymouth who were economically inactive.\(^36\) The number of residents claiming Job Seekers Allowance has decreased overall over the last five years, from 6,647 (Jan 2010) to 3,480 (Jan 2015).\(^36\) There were also 13,630 Employment and Support Allowance and Incapacity benefit claimants in Plymouth, equating to about 8.1% of the workforce in May 2014.\(^36\)

\(^{33}\) Knowing Your Communities. Social Inclusion Unit, Plymouth City Council. November 2014
\(^{34}\) Working Group on Inequalities and Health (1980): The Black Report
\(^{36}\) nomis Official Labour Market Statistics, ONS
3.4 Plymouth comparators

In 2001 the ONS identified health area clusters, also called comparison groups, which are most similar in terms of 42 selected census variables including demographics and deprivation. These comparators are routinely used as benchmarking groups, against which to make meaningful comparisons of services and performance.

Plymouth’s sub-group (Regional Centres - A) consists of the English local authorities (previously PCTs) of Bournemouth, Bristol, Brighton and Hove, Leeds, Liverpool, Newcastle-upon-Tyne, Portsmouth, Salford, Sheffield, and Southampton. Within this needs assessment these comparators have been used in addition to, or in place of, South West regional comparisons.

3.5 At risk groups

**Young people**

Evidence suggests that the greatest burden of sexual ill health and infection is borne by young people. Most recent reporting indicates that heterosexuals aged under 25 years’ experience the highest rates of chlamydia, gonorrhoea and genital warts in England.\(^{37}\)

The UK has one of the highest rates of teenage pregnancy in Europe. Teenage pregnancy is a complex issue, affected by a range of personal, social, economic, and environmental factors.

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The reasons for tackling teenage pregnancy are well documented and include both health and wider inequality issues. For example:

- Teenage mothers experience three times the rate of post-natal depression and have a higher risk of poor mental health for three years after the birth.
- Teenage mothers are three times more likely to smoke throughout their pregnancy and 50% less likely to breastfeed, with negative health consequences for the child.
- Children of teenage mothers have a 63% increased risk of being born into poverty and are more likely to have accidents and behavioural problems.
- The infant mortality rate for babies born to teenage mothers is 60% higher.
- The majority of teenage pregnancies are unplanned and nearly half end in abortion.
- Teenage mothers are 20% more likely to have no qualifications at age 30.
- Teenage parents and their children are at an increased risk of living in poverty.

The risk of teenage parenthood is greatest for young people who have grown up in poverty and disadvantage, or those with poor educational attainment. Children of teenage mothers have a much higher chance of becoming teenage parents themselves.

**Men who have sex with men (MSM)**

Men who have sex with men refers to the sexual behaviour aspect of sexual orientation rather than a specific sexual identification.

The National Sexual Attitudes and Lifestyle Survey (NATSAL)\(^{38}\) interviewed more than 15,000 people aged 16-74 years during 2010-12. They found that 8% of men had ever had a sexual experience or contact with another man. The estimated prevalence of men who have sex with men in areas outside of London is 2.8% of the male population over 15 years of age; this equates to 2,932 men in Plymouth.\(^ {39} \)

MSM experience high rates of STIs.\(^ {40} \) In England in 2014 the number of diagnoses of STIs reported in this group shows increases from the previous year in gonorrhoea, syphilis, chlamydia and genital herpes. Gonorrhoea was the most commonly diagnosed STI among men who have sex with men in 2014. There are several factors that are likely to have contributed to the continued increase in STIs in this population. These include condomless sex associated with seroadaptive behaviours and improved detection methods.

MSM are the group most affected by HIV in the UK. New diagnoses of HIV among this group continue to rise: in 2014 3,360 MSM were diagnosed with HIV in the UK.\(^ {41} \) There was a decline in the proportion of men diagnosed late from 43% in 2004 to 29% in 2014. It is estimated that 14% of MSM living with HIV are unaware of their status.

**Sex workers**

Evidence in this area suggests that those involved in sex work experience poor sexual health and general health.\(^ {42} \) Due to its covert nature it is not possible to accurately report the

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\(^{38}\) The National Sexual Attitudes and Lifestyle Survey. Mercer, 2013


\(^{42}\) A health needs assessment of street-based prostitutes: cross sectional survey, Jeal, N. and Salisbury, C.
number of people involved in sex work. A needs assessment of street sex workers in a small area of Plymouth reported that during the 12 month period from August 2012 to August 2013, 43 women involved in street sex work engaged with an outreach service. Additionally during a separate four month period in 2013 26 women involved in street sex work accessed a sexual health outreach service. The women often presented with multiple vulnerabilities and reported poor health, drug and alcohol misuse, violence within relationships and a lack of support networks. The needs assessment further identified that the chaotic nature of many of the women’s lives mean that it is difficult to initiate and sustain treatment with ‘services’ including sexual health services.

**Black and Minority Ethnic (BME) groups**

Nationally the highest rates of STIs diagnosis are found among persons of black ethnicity. In England in 2014 the highest rates of sexually STI diagnoses were found among people of black ethnicity living in urban areas characterised by high levels of deprivation.\(^43\) The high rate of STIs among black ethnic communities is most likely the consequence of a complex interplay of cultural, economic and behaviour factors.

**Refugees, asylum seekers and migrants**

Plymouth has a small population of 224 supported asylum seekers including 77 children, some of whom are unaccompanied, making up less than 0.1% of the city’s overall population.\(^44\) There is also a small but established migrant population in the city. The 2011 Census recorded 7,770 individuals from the European Union, the largest majority (2,332; 30%) from Poland.\(^45\)

There is currently no local intelligence available about the specific sexual health needs of these groups. However, it is known that these groups experience difficulties in accessing health services.

**People using drugs and alcohol**

Drug and alcohol use can have a significant impact on sexual behaviours and sexual health outcomes. It can lead to dis-inhibition and can influence poor decision making and can affect the ability to negotiate safe sexual contacts and relationships.

Alcohol use among young people is associated with early onset of sexual activity, sexually transmitted infections and teenage pregnancy. It is an indicator of sexual risk taking in other age groups. There is a strong correlation between sexual assault and alcohol use both in terms of the victims and the perpetrators.\(^46\)

The transmission of HIV through sharing of drug injecting equipment is relatively low in the UK when compared to other countries and accounts for 5% of all diagnoses ever reported. In 2014 150 people contracted the infection in this way in the UK, accounting for just over 2% of the total cases of diagnosed.\(^47\)

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\(^44\) Knowing your communities. Social Inclusion Unit, Plymouth City Council. November 2014

\(^45\) 2011 Census Table: QS203EW - Country of birth (detailed)


Chemsex describes sex that occurs under the influence of drugs which are taken immediately preceding and/or during a sexual session. Research\textsuperscript{48} to date suggests that it is most common among gay or bisexual men where the main drugs of choice appear to be crystal methamphetamine, GHB/GHL and mephedrone. These drugs can facilitate extended sexual sessions with multiple partners where risk taking behaviours can lead to STI transmission and drug related casualties. There is some evidence of chemsex in Plymouth reported by people attending sexual health services however there is currently no detailed intelligence about the nature or extent of these behaviours and their outcomes.

**Learning disabilities**

Population estimates suggest that in 2010 there were 932 adults aged 18-64 years with a moderate or severe learning disability in Plymouth. This is estimated to rise to 956 in 2015. Additionally it is estimated that by 2015 there will be 1,721 adults aged 18-65 years with autistic spectrum disorders.\textsuperscript{49}

There is a paucity of evidence and information about the sexual health status and needs of people with learning disabilities. Due to societal attitudes towards disability and sexuality people with learning disabilities are likely to have less access to information about sexual health and sexual health services.

There are additional groups where there is a lack of specific information about their sexual health needs. These groups may also be vulnerable to exploitation and sexual ill health and have difficulty in accessing services. These include people with physical disabilities, victims of sexual assault and domestic violence and abuse.

**Summary: demography and population**

- Plymouth has an estimated population of 259,200. It is estimated that the population will grow by 7% in the next 20 years.
- The population structure is similar to that seen elsewhere in England except that the 20-24 year old age group is significantly higher in Plymouth. This is important as the greatest burden of sexual ill health is borne by younger age groups.
- Between 2001 and 2013 there was a 30% rise in the number of babies being born every year. More babies are born in the more deprived areas of the city.
- There are areas of significant deprivation in the city with the highest levels seen in Devonport, Stonehouse, North Prospect and Weston Mill, East End, and Whitleigh.
- There is a strong association between deprivation and poorer health outcomes. The risk of teenage parenthood is greatest for young people who have grown up in areas of deprivation.
- Plymouth’s Black and Minority Ethnic population is small but growing. Nationally these groups experience high levels of sexually transmitted infections.

\textsuperscript{48} The Chemsex Study. Adam Bourne et al, March 2014.
\textsuperscript{49} Projecting adult needs and service information [www.pansi.org.uk](http://www.pansi.org.uk)
• Based on national prevalence estimates there are approximately 3,000 men who have sex with men in Plymouth. Nationally this group experience high rates of sexually transmitted infections and are the group most affected by HIV.

• There is a small and defined population of female street sex workers in Plymouth. These women experience multiple and complex needs and may find it difficult to initiate engagement with sexual health services.

• There is a small but significant population of people with learning disabilities in Plymouth. These groups are likely to have poor access to information about sexual health including sexual health services.
4. Plymouth’s sexual health profile

Sexually transmitted infections represent a significant burden of infectious disease on the population and have a substantial impact on health services. Prompt diagnosis and treatment of STIs is essential to preventing long term health consequences and complications, and reducing onward transmission and further cases of infection.

In comparison to other local authorities in the South West, a higher percentage of 15-64 year olds are tested for STIs in Plymouth (Figure 5). Of those tested in 2014 5.7% had a positive diagnosis, this is the third highest percentage in the South West and compares to the England average of 5.4% (Figure 6).

Figure 5: STI testing rate (excluding chlamydia in the under-25 population), in people aged 15-64 years by South West GUM clinic, 2014.

Upper and lower 95% CIs are also displayed
Source: Sexual and Reproductive Health Profiles, PHE
STIs: Herpes, syphilis, gonorrhoea15-64 years and chlamydia in those aged over 25 years only
Nationally, between 2005 and 2014, rates of herpes diagnoses have been increasing annually; the latest 2014 value however has shown a slight decrease. Over the same time period the syphilis diagnosis rate has shown an overall increase whilst warts diagnosis rates are decreasing from a peak in 2008. From 2005 to 2008 there was a decline in rates of gonorrhoea but since then diagnoses have risen year on year; the latest 2014 figure (64.9 per 100,000) is the highest in 10 years. The 2014 national chlamydia data shows a rate of 383.9 per 100,000 population corresponding to 206,774 cases. This is a 0.5% decrease on 2013 numbers.

The Plymouth picture from 2009 to 2014 is reflected in Figure 7. After a decrease in local GUM department chlamydia diagnoses, as would be expected following the introduction of the National Chlamydia Screening Programme in Plymouth in 2007/08, numbers are on the increase. Syphilis diagnoses are low; after a peak in 2013 the number has again dropped. Cases of genital warts were decreasing until 2013 when a peak of cases was seen; numbers dropped slightly in 2014. Gonorrhoea diagnoses remained largely stable between 2009 and 2012; the latest 2014 value is the highest seen over the last five years and over five times the number seen in 2011. The numbers of herpes cases in 2014 were the second highest seen since 2009.

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**STI annual data table 2014**: Table 1 STI diagnoses and rates in England, PHE

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50 STI annual data table 2014: Table 1 STI diagnoses and rates in England, PHE
Figure 7: Diagnoses of the top five STIs in Plymouth residents at Derriford GUM clinic, 2009 to 2014

The distribution of sexually transmitted infections varies by age and other demographic factors. The burden of sexually transmitted infections is greatest in young people.

The rate of total STI diagnoses for people aged under-25 in GUM departments is currently an indicator used by Sexual Health South West to indicate the burden of infection in local populations. In 2014 Plymouth had the second highest rate in the South West region (284.6 per 10,000 15-24 year olds) and the rate is over twice the rate for Bristol, the other large urban city in the region (Figure 8). The rate in Plymouth reflects the national picture where rates of diagnosis are higher in urban areas, reflecting the distribution of core groups of the population who are greatest risk but also access to diagnosis and treatment services.
Figure 8: Rate of acute STI diagnoses in people aged 15-24 years by South West GUM clinic, 2014

Upper and lower 95% CIs are also displayed
Source: GUMCADv2 surveillance data (PHE; HIV & STI web portal)) and ONS
Acute STIs: Herpes, syphilis, gonorrhoea, warts, and chlamydia
Data are sourced from GUM clinics only i.e. chlamydia numbers do not include data from community services (NCSP, ’Non-NCSP/Non-GUM services and CTAD)

Plymouth’s rank in the South West is likely to reflect the differences in the demographic make-up of the population, the socio-economic conditions, and the presence of high risk groups as well as the accessibility of services.

Looking at STI diagnosis rates in Plymouth’s local authority comparator group (Table 1) Plymouth is broadly equivalent to other similar areas. Plymouth has the second lowest rate of syphilis (4.2 per 100,000 population) across the group, just over 14 times lower than the highest rate seen in Brighton and Hove, and nearly half the England average. In contrast, the rate of herpes (99.5 per 100,000) is the highest value across the 11 authorities and 1.7 times higher than the England average of 57.8 per 100,000.
Table 1: Rates per 100,000 population (all-ages unless specified otherwise) of selected STIs and all acute STI diagnoses made at GUM clinics in England by Plymouth’s local authority comparator group, 2014

<table>
<thead>
<tr>
<th>Local authority/area</th>
<th>Chlamydia 15-24 years</th>
<th>Chlamydia ≥25 years</th>
<th>Gonorrhoea</th>
<th>Syphilis</th>
<th>Herpes</th>
<th>Warts</th>
<th>All new STIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bournemouth</td>
<td>2,610</td>
<td>208</td>
<td>41.3</td>
<td>10.6</td>
<td>91.1</td>
<td>214.6</td>
<td>1,102</td>
</tr>
<tr>
<td>Brighton &amp; Hove</td>
<td>2,010</td>
<td>360</td>
<td>202.8</td>
<td>60.8</td>
<td>72.6</td>
<td>202.4</td>
<td>1,454</td>
</tr>
<tr>
<td>Bristol</td>
<td>1,818</td>
<td>254</td>
<td>80.7</td>
<td>4.6</td>
<td>57.4</td>
<td>155.2</td>
<td>990</td>
</tr>
<tr>
<td>Leeds</td>
<td>2,720</td>
<td>229</td>
<td>91.3</td>
<td>4.6</td>
<td>73.0</td>
<td>169.5</td>
<td>1,114</td>
</tr>
<tr>
<td>Liverpool</td>
<td>2,209</td>
<td>203</td>
<td>54.2</td>
<td>6.2</td>
<td>59.5</td>
<td>183.5</td>
<td>1,068</td>
</tr>
<tr>
<td>Newcastle upon Tyne</td>
<td>2,409</td>
<td>208</td>
<td>93.1</td>
<td>11.5</td>
<td>84.0</td>
<td>239.9</td>
<td>1,191</td>
</tr>
<tr>
<td>Plymouth</td>
<td>2,718</td>
<td>179</td>
<td>74.5</td>
<td>4.2</td>
<td>99.5</td>
<td>221.5</td>
<td>1,168</td>
</tr>
<tr>
<td>Portsmouth</td>
<td>1,883</td>
<td>165</td>
<td>64.6</td>
<td>3.9</td>
<td>83.4</td>
<td>186.1</td>
<td>957</td>
</tr>
<tr>
<td>Salford</td>
<td>2,368</td>
<td>244</td>
<td>85.4</td>
<td>16.3</td>
<td>56.1</td>
<td>172.0</td>
<td>1,016</td>
</tr>
<tr>
<td>Sheffield</td>
<td>1,778</td>
<td>162</td>
<td>56.8</td>
<td>5.2</td>
<td>39.1</td>
<td>128.9</td>
<td>752</td>
</tr>
<tr>
<td>Southampton</td>
<td>2,379</td>
<td>255</td>
<td>42.1</td>
<td>7.4</td>
<td>69.8</td>
<td>137.5</td>
<td>1,152</td>
</tr>
<tr>
<td><strong>England</strong></td>
<td><strong>2,012</strong></td>
<td><strong>173</strong></td>
<td><strong>63.3</strong></td>
<td><strong>7.8</strong></td>
<td><strong>57.8</strong></td>
<td><strong>128.4</strong></td>
<td><strong>797</strong></td>
</tr>
</tbody>
</table>

Source: Sexual and Reproductive Health Profiles, PHE

The reporting of acute STI rates by neighbourhood has enabled mapping for both the under-25s (Figure 9 and Figure 10) and 25 years and over age-groups (Figure 11).

The neighbourhoods with the highest rates in 2014 are not those with the highest proportions of under-25s (Figure 9). With the exception of the City Centre, neither do these neighbourhoods correspond with those with the highest rates of teenage pregnancy (Figure 10).
Figure 9: Rate of acute STIs diagnosed in the under-25 population by neighbourhood in relation to the 15-24 year old population, 2014

Source: GUMCADv2 surveillance data provided by PHE Field Epidemiology Service Bristol, 2015 and ONS

Figure 10: Rate of acute STIs diagnosed in the under-25 population by neighbourhood in relation to under-18 conception rates, 2014

Source: GUMCADv2 surveillance data provided by PHE Field Epidemiology Service Bristol, 2015 and ONS
Figure 11: Rate of acute STIs diagnosed in the over-25 population by neighbourhood, 2014

Source: GUMCADv2 surveillance data provided by PHE Field Epidemiology Service Bristol, 2015 and ONS

Local GUM clinicians report that alcohol consumption is a common contributory factor in STI transmission among young people. Alcohol consumption is often reported to have led to increased risk taking behaviours. A further trend in the distribution of STIs which has been witnessed nationally and regionally is the increase in diagnoses of disease in people over the age of 35.\(^{51}\) Many of these infections might be occurring in people who have recently come out of long-term relationships and who may be unpractised in condom use and negotiating safe sexual practices.

\(^{51}\) STI annual data tables 2013: Table 8 selected STI numbers and rate by gender and age group, Public Health England.
4.1 Chlamydia

Genital chlamydia trachomatis is the most common STI diagnosed and treated in the UK. Highest rates are seen mainly in young men and women aged under-25. It is an important reproductive health problem which left untreated can have serious long-term consequences, particularly in women, where it can lead to pelvic inflammatory disease (PID). A significant proportion of chlamydia cases (around 75% of women and 50% of men) are asymptomatic and so are liable to remain undetected, putting both men and women at greater risk of developing complications.52

The National Chlamydia Screening Programme (NCSP) in England was established in 2003, with the objective of controlling the disease in 15-24 year olds through the early detection and treatment of asymptomatic infection, thus reducing onward transmission and the development of complications.

The Public Health Outcomes Framework53 includes an indicator focussed on the rate of chlamydia diagnoses in all settings. This reflects testing coverage and positivity across all sites with the aim of reducing prevalence. Local authorities have been advised to proactively review and monitor their rates and aim to achieve (or maintain) rates of at least 2,300 diagnoses per 100,000.

Table 2: Chlamydia screening and positivity in 15-24 year olds in Plymouth and England, January 2014 – December 2014

<table>
<thead>
<tr>
<th></th>
<th>Non-GUM (NCSP) tests</th>
<th>GUM tests</th>
<th>Total tests</th>
<th>Non-GUM (NCSP) +ve</th>
<th>GUM +ve</th>
<th>Total +ve</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plymouth</td>
<td>6,317</td>
<td>4,662</td>
<td>10,979</td>
<td>524</td>
<td>642</td>
<td>1,166</td>
</tr>
<tr>
<td>England*</td>
<td>1,087,202</td>
<td>576,808</td>
<td>1,664,010</td>
<td>76,485</td>
<td>61,508</td>
<td>137,993</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Percentage population (15-24 years) tested</th>
<th>Percentage of tests +ve</th>
<th>Detection rate per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plymouth</td>
<td>25.6%</td>
<td>10.6%</td>
<td>2,718</td>
</tr>
<tr>
<td>England*</td>
<td>24.3%</td>
<td>8.3%</td>
<td>2,012</td>
</tr>
</tbody>
</table>

Source: Chlamydia Testing Activity Database (CTAD), PHE (via HIV & STI web portal)

* Including tests with unknown local authority

Table 2 highlights that the percentage of young people tested in Plymouth is above that tested nationally the positivity rate is above the England percentage and is the highest in the region (data not presented). This could reflect effective targeting of resources, directing the programme at those likely to be more at risk of infection.

Alongside the NCSP, testing for chlamydia takes place within the GUM department at Derriford Hospital. There are considerable numbers of diagnoses and therefore treatments taking place in this service.

Diagnosis of chlamydia in Plymouth residents has risen over the last six years to the current 2014 level of 886 cases.

Of this number females accounted for 55% of the diagnoses. The majority of diagnoses (37.1%) were in the 20-24 year age-group and 96.5% of cases identified themselves as heterosexual.

Figure 13: Rate of chlamydia diagnoses in the under-25 population by Plymouth neighbourhood, 2014

Source: GUMCADv2 surveillance data provided by PHE Field Epidemiology Service, Bristol
Chlamydia diagnoses rates per 10,000 under-25s by Plymouth neighbourhood range from 100-199 per 10,000 in five neighbourhoods including Widewell and Manadon & Widey to ≥500 per 10,000 in City Centre, Morice Town, and Leigham and Mainstone (Figure 13).

Chlamydia testing and treatment will only have a limited impact on the burden of disease if sexual contacts and partners are not also tested and treated. Partner notification is regarded as an integral part of the management and control of STIs.

Between April and June 2015 in Plymouth 0.78 partners per chlamydia index case (diagnosed in GUM) attended a chlamydia related appointment in GUM.\textsuperscript{54} The performance standard for verified chlamydial partner notification is at least 0.4 contacts per index case.

\textsuperscript{54} South West sexual health quarterly outcome indicator report Q2 2015/16, Public Health England.
4.2 Gonorrhoea

Gonorrhoea is the second most common bacterial STI in the UK. Young people are most commonly infected, with current national 2014 rates highest (246.5 per 100,000) in those aged 20-24 years.\(^{55}\) If left untreated gonorrhoea can lead to serious health problems, particularly amongst young women, who can develop pelvic inflammatory disease (PID). This in turn can lead to infertility or ectopic pregnancy.\(^{56}\)

Figure 14: Diagnoses of gonorrhoea in Plymouth residents (all ages) at GUM clinics, 2009 to 2014

![Graph showing diagnoses of gonorrhoea over time](image)

Source: GUMCADv2 surveillance data, PHE (HIV & STI web portal)

Between 2009 and 2012 annual cases of gonorrhoea remained low (<52). From 2009 to 2011 cases of gonorrhoea in Plymouth residents decreased each year. Over the last three years there have been annual increases. The latest 2014 value (193 cases) is a 127% increase on that seen in 2013.

Of the 193 diagnoses in 2014, males accounted for 130 cases (67.4%). The majority of diagnoses (34.1%) were in the 20-24 year age-groups and in men there was an equal split by those identifying themselves as heterosexual and homosexual (47.7% and 46.9% respectively).

Overall, crude rates have increased from 2.1 per 10,000 all-age population in 2009 to 7.4 per 10,000 in 2014.

\(^{55}\) STI annual data tables 2014: Table 3 STI diagnoses by gender, sexual risk, and age group 2010-2014, Public Health England.

4.3 Syphilis

Syphilis infection is relatively uncommon in the UK. However over the decade 2003 to 2012 diagnoses made at GUM clinics have increased by 61% in men. In contrast diagnoses in women have decreased by 16% over the same time period. National enhanced surveillance of the current epidemic has shown that most of the cases diagnosed (76% in 2012) were amongst men who have sex with men whilst co-infection with HIV is also common.\textsuperscript{57}

Figure 15: Diagnoses of syphilis in Plymouth residents (all ages) at GUM clinics, 2009 to 2014

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{syphilis_graph.png}
\caption{Diagnoses of syphilis in Plymouth residents (all ages) at GUM clinics, 2009 to 2014}
\end{figure}

Source: GUMCADv2 surveillance data, PHE (HIV & STI web portal)

There have been very few cases of syphilis diagnosed in Plymouth residents in the last six years. After a decrease to only one case in 2011, 2012 and 2013 saw year on year increases to a peak of 24. The latest 2014 value of 11 cases is a 54% decrease on the previous year.

All 11 cases were diagnosed in men. Those aged 35-44 and 45-64 had the highest incidence and most cases were in men identifying themselves as homosexual.

Overall, crude rates have remained similar; 0.36 per 10,000 all-age population in 2009 to 0.42 per 10,000 in 2014.

\textsuperscript{57} Infectious syphilis and congenital syphilis: recent epidemiology, Health Protection Report 7 (44), Public Health England.
4.4 Herpes

Herpes simplex virus (HSV) infection is the most common ulcerative sexually transmitted disease in the UK and causes considerable physical and psychological morbidity. It is a life-long infection with some people suffering recurrent episodes.58

Figure 16: Diagnosis of herpes in Plymouth residents (all ages) at GUM clinics, 2009 to 2014

![Graph showing diagnosis of herpes in Plymouth residents from 2009 to 2014.]

Source: GUMCADv2 surveillance data, PHE (HIV & STI web portal)

The number of cases of herpes has been variable over the last six years. The highest numbers were seen in 2010 (257 cases) and 2014 (258 cases). The latest figure is a 27.1% increase on that seen in 2013.

In 2014 around 1.5 times more women (156) were diagnosed compared to men (102). Those in the 25-34 year age-bracket had the highest incidence and nearly all cases (96.9%) were in those identifying themselves as heterosexual.

Overall, crude rates have increased from 8.9 per 10,000 all-age population in 2009 to 9.9 per 10,000 in 2014.

4.5 Ano-genital warts

Warts are the most common viral STI diagnosed in the UK and are largely caused by the human papillomavirus. Some of these viruses are also associated with human cancers, most notably cervical cancer. Highest rates of new cases are seen in males and females in the 20-24 year old age group.\textsuperscript{59}

Figure 17: Diagnosis of ano-genital warts in Plymouth residents (all ages) at GUM clinics, 2009 to 2014

![Graph showing diagnosis of ano-genital warts](source)

Source: GUMCADv2 surveillance data, PHE (HIV & STI web portal)

Diagnosis of genital warts in Plymouth residents were on the decrease until 2013. A peak of 599 cases was seen in 2013. The latest 2014 figure (574 diagnoses) is a 4% decrease on the value from the previous year.

Numbers of male and female diagnoses were similar; 291 and 283 respectively. By far the age-group most affected were the 20-24 year olds (39.5%) whilst 96.3% of all cases were in those identifying themselves as heterosexual.

Overall, crude rates have remained the same; 22.0 per 10,000 all-age population in 2009 to 21.9 per 10,000 in 2014.

\textsuperscript{59} STI annual data tables 2014: Table 3 STI diagnoses by gender, sexual risk, and age group 2010-2014, Public Health England.
4.6 HIV

The human immunodeficiency virus or HIV is a virus that attacks the immune system. The virus can cause acquired immunodeficiency syndrome, AIDS. HIV is most commonly transmitted through sexual contact and can also be transmitted through infected blood products, sharing injecting equipment and from mother to child in utero or through breast milk. Many people who are infected with HIV do not have any symptoms. Pharmacological treatments can slow or prevent progression of the virus. The introduction of HIV antiretroviral therapy (ART) in 1995 has changed HIV into a chronic, controllable life-long condition rather than a fatal infection. The number of people living with HIV in the UK has risen annually due to both an ageing cohort and a continued number of new infections.

In 2014 there were an estimated 103,700 people living with HIV, of which an estimated 17% were unaware of their infection. This corresponds to an estimated overall prevalence of 1.9 per 1,000 population aged 15 years and over.

Prevalence of HIV is published at local authority level by year. This is calculated from the number of people accessing HIV services, extracted from the SOPHID dataset (Survey of Prevalent HIV Infections Diagnosed), and the population aged 15-59 years. The estimated diagnosed prevalence of HIV in Plymouth in 2013 was 1.23 per 1,000 15-59 year old population.

Nationally a total of 6,000 individuals were diagnosed with HIV in 2013, a slight decrease on the 6,250 diagnoses in the previous year. Although this number remains high it represents a 24% decline on the peak of new diagnoses seen in 2005. The decline is largely due to fewer reports of diagnoses amongst heterosexuals born in countries with a high HIV prevalence.

Additional key national statistics:

- Men who have sex with men (MSM) are the group most affected by HIV with 59 per 1,000 MSMs aged 15-59 years living with the infection (equivalent to an estimated 43,500 individuals).
- The black-African community are the second largest group affected by HIV with 56 per 1,000 population aged 15-59 years living with the infection.
- Of the estimated 59,500 heterosexual men and women living with the disease 65% are black-African born men and women.
- Over the last decade new diagnoses among MSM have been on the increase, reflecting high transmission and increased testing. An all-time high of 3,250 new cases were recorded in 2013.
- An estimated 45% of those diagnosed in 2013 (2,490 individuals) acquired their infection heterosexually whilst MSM accounted for 54% of new diagnoses.

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61 South West sexual health quarterly outcome indicator report Q2 2015/16, PHE
HIV testing is integral to the treatment and management of HIV. Knowledge of HIV status increases survival rates, improves quality of life, and reduces the risk of onward transmission. The 2008 Review of the Sexual Health and HIV Strategy identified an increase in HIV testing in a range of existing and new settings as a key measure of improvement in this area.

In Plymouth in 2014 the percentage of eligible GUM episodes where a HIV test was accepted, as a proportion of those offered, was significantly higher than the England average in total, for men, for women, and for MSM (Table 3). In terms of comparisons with other South West local authorities Plymouth ranks in the top five for all population group categories.

Table 3: HIV testing uptake (%), 2014

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Men</th>
<th>Women</th>
<th>MSM</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>77.5</td>
<td>84.8</td>
<td>71.5</td>
<td>94.5</td>
</tr>
<tr>
<td>Plymouth</td>
<td>85.4</td>
<td>89.7</td>
<td>82.2</td>
<td>96.5</td>
</tr>
<tr>
<td>South West rank (1 best, 16 worst)</td>
<td>4</td>
<td>3</td>
<td>5</td>
<td>2</td>
</tr>
</tbody>
</table>

Source: Sexual and Reproductive Health Profiles, Public Health England

Eligible new GUM episode defined as a visit to a GUM clinic including all subsequent GUM attendances in the following six weeks (i.e. eligibility for testing occurs only once every six weeks). Multiple episodes of HIV test offer and uptake are included per individual within a year.

HIV test coverage data represent the number of persons tested for HIV and not the number of tests reported. In 2014 the percentage of eligible new GUM attendees in whom a HIV test was accepted, as a proportion of eligible new attendees, was significantly higher than the England average in total, for men, for women, and for MSM (Table 4). In terms of comparisons with other South West local authorities Plymouth ranks in the top five for all population group categories and ranks the highest for coverage in MSM.

Table 4: HIV testing coverage (%)

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Men</th>
<th>Women</th>
<th>MSM</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>68.9</td>
<td>78.0</td>
<td>61.9</td>
<td>87.2</td>
</tr>
<tr>
<td>Plymouth</td>
<td>77.3</td>
<td>83.7</td>
<td>72.7</td>
<td>91.8</td>
</tr>
<tr>
<td>South West rank (1 best, 16 worst)</td>
<td>5</td>
<td>4</td>
<td>5</td>
<td>1</td>
</tr>
</tbody>
</table>

Source: Sexual and Reproductive Health Profiles, PHE

Eligible new GUM attendee is defined as a patient attending a GUM clinic at least once during a calendar year. Individuals will only be counted once within the year.

New diagnoses are not published at a local level for use in the public domain. Such data can be made available on request from Public Health England (PHE) for restricted local use only. The lowest available breakdown of published numbers of new diagnoses is at PHE Centre level.

Local statistics for Devon, Cornwall and Somerset (DCS) residents in 2013:

- There were 79 Devon, Cornwall and Somerset (DCS) residents newly diagnosed with HIV.

---

63 Annual epidemiological spotlight on HIV in Devon, Cornwall and Somerset: 2013 data, PHE
• The new diagnosis rate for residents aged 15-59 years (6 per 100,000) was below that of England (13 per 100,000) and is the fourth lowest centre figure across England.

• 69% new diagnoses were in men who have sex with men compared to 68% in 2012 and 35% in 2004.

• Of the newly diagnosed MSM 94% were white and 86% were born in the UK.

• Heterosexual contact was the second largest infection route for new diagnoses in DCS residents in 2013 (26%).

• Infections in UK born individuals accounted for 65% of all heterosexually acquired cases.

• Infections in African born individuals accounted for 20% of all heterosexually acquired cases in 2013 (n=<5), compared to 71% in 2004.

• Injecting drug use accounted for 1% of new diagnoses.

• Black Africans represented 8% of all new diagnoses compared to 9% in 2012 and 46% in 2004.

• The number of new diagnoses was highest in the 25-34 year age-group in males and the 35-44 years age-group in females.

Figure 18: Number of new HIV diagnoses by (a) age group and gender and (b) probable route of infection in males, Devon, Cornwall and Somerset residents, 2013

(a)  
(b)  

Source: HIV and AIDS new diagnosis database (HANDD), PHE
Reproduced from ‘Annual epidemiological spotlight on HIV in Devon, Cornwall and Somerset: 2013 data’, PHE

4.6.1 HIV late diagnosis

People living with HIV can expect a near normal life span and better clinical outcomes if diagnosed promptly. Late diagnosis can mean that a person remains unaware of their HIV status thus increasing the risk of deterioration in their condition and onward transmission or the virus.
A high proportion of new diagnoses of HIV (42%) nationally are ‘late’ diagnoses. A late diagnosis is defined as a CD4 cell count below 350/ml³ within 3 months of diagnosis. The importance of late diagnosis has been recognised by its inclusion in the Public Health Outcomes Framework. Monitoring and understanding this data is important for service provision, to evaluate the accessibility of HIV testing, and to assess progress in HIV testing and reductions in undiagnosed infection. In 2013, CD4 counts at HIV diagnosis were available for 78% of new HIV diagnoses.

The number of AIDS diagnoses nationally has declined over the past decade, from 1,020 in 2004 to 320 in 2013. The majority of these diagnoses were among people with a late HIV diagnosis. People diagnosed late have a ten-fold increased risk of death within one year of HIV diagnosis compared to those diagnosed promptly.⁶⁴

There has been a slow but significant decline in the overall proportion of people diagnosed late over the past decade, from 57% in 2004 to 42% in 2013. Nationally late diagnosis was highest among heterosexual men (62%). In addition, just over half of heterosexual women (51%) and 50% of those who inject drugs were diagnosed late in 2013.⁶⁵

In Devon, Cornwall, and Somerset 68.2% of heterosexuals and 37.3% of men who have sex with men between 2011 and 2013 had a new HIV diagnosis with a CD4 count <350/ml³.⁶⁶

Figure 19: Percentage late HIV diagnoses (CD4 count of <350/ml³) 2011-2013

Source: Sexual Health Quarterly Outcome Indicator Report Plymouth Q1 2014/15

Figure 19 shows that 31% of new HIV diagnoses in Plymouth between 2011 and 2013 were late diagnoses. This was lower than both the South West (46.7%) and England (45.0%) averages. Plymouth’s value was the lowest in the region and 34.5 percentage points below the highest value seen in South Gloucestershire. It is also a reduction in comparison to the value for 2010-12 (39.1%) ⁶⁶

---

Summary: sexual health profile

- In comparison to other local authorities in the South West, a higher percentage of 15-64 year olds are tested for STIs in Plymouth. Of those tested in 2014 5.7% had a positive diagnosis compared to the England average of 5.4%.

- In 2014 rates of STI diagnoses in Plymouth were broadly equivalent to the city’s local authority comparator group. Plymouth had the second lowest rate of syphilis in this group and nearly half the rate of the England average. However the rate of herpes in Plymouth was the highest in this group and was 1.7 times higher than the England average.

- In 2014 25.6% of 15-24 year olds in Plymouth were tested for chlamydia compared to 24.3% of 15-24 year olds in England. However 10.6% of those tested in Plymouth were positive compared to 8.3% in England. There are significant geographical differences in diagnosis rates across the city with the highest rates recorded in Leigam and Mainstone.

- The number of diagnosis of chlamydia at GUM clinics in all age groups is rising. In 2014 there were 886 cases in Plymouth with the majority of cases (37.1%) being in the 20-24 age group and 96.5% in people who identified themselves as heterosexual.

- The number of cases of gonorrhoea has increased in the last two years. In 2014 there were 193 cases in Plymouth a 127% increase on the number of cases seen in 2013. 67.4% of these were in men, the majority were in the 20-24 age group and an equal split in those identifying as heterosexual and homosexual.

- Syphilis is relatively uncommon in the UK but where diagnosed co-infection with HIV is common. There was an increase in diagnosed cases in Plymouth between 2011-2013 with 24 cases diagnosed in 2013. The latest 2014 value of 11 cases is a 54% decrease on the previous year. In 2014 all 11 cases were diagnosed in men with most of those identifying themselves as homosexual. The highest incidence was among those aged 34-44 and 45-64.

- The number of cases of herpes has been variable in Plymouth in recent years. In 2014 there were 258 cases, a 27.1% increase on the number of cases in 2013. In 2014 around 1.5 times more women were diagnosed than men and the highest incidence was seen in the 25-34 year age groups. 96.9% of cases were in those identifying themselves as heterosexual.

- In 2014 there were 574 cases of ano-genital warts diagnosed in Plymouth. This is a 4% decrease on the value from the previous year. Number of diagnosis in men and women were similar and 20-24 year olds were the most affected age group. 96.3% of all cases were in those identifying themselves as heterosexual.

- In 2014 there was an 85.4 % uptake of HIV testing among eligible GUM clients. This compares to the England average of 77.5%. HIV testing coverage was 77.3% compared to the England average of 68.9%.

- The estimated diagnosed prevalence of HIV in Plymouth in 2013 was 1.23 per 1,000 15-59 year old population. In 2013 the number of new diagnoses in the Devon, Cornwall and Somerset PHE Centre region was 79. The number of new diagnoses was highest in the 25-34 year age-group in males and the 35-44 years age-group in females. 69% were in men who have sex with men and heterosexual contact was the second largest infection route for new diagnoses in DCS residents in 2013 (26%).
Numbers of late diagnosis of HIV have declined in Plymouth over recent years and are significantly below the national average. However over 31% of diagnoses between 2011-2013 in Plymouth were classified as late. This has significant implications for onward transmission, treatment initiation, health outcomes and treatment costs.
5. Conceptions, contraception and abortions

Definitions

National conception data – Conception Statistics, produced by the Office for National Statistics (ONS) are compiled by combining information from birth registrations and abortion notifications. Conception Statistics include pregnancies that result in:

- One or more live or still births (miscarriages are not included); or
- A legal abortion under the Abortion Act of 1967 (illegal abortions are not included)

Local proxy conception data – gathered from Derriford Hospital by the Office of the Director of Public Health also includes pregnancies that result in miscarriage. It is timelier than the nationally compiled figures, and can be analysed by neighbourhood.

The ‘conception date’ is estimated using recorded gestation periods for abortions and stillbirths, and assuming 38 weeks gestation for live births. A woman’s ‘age at conception’ is calculated as the number of complete years between her date of birth and the date she conceived.

5.1 All-age conceptions

In 2013 there were an estimated 831,282 conceptions to women of all ages (15-44 years) in England compared with 842,202 in 2012, a decrease of 1.3%. In Plymouth the number has fallen from 3,928 in 2012 to 3,833 in 2013, a decrease of 2.4%.

In terms of rates per 1,000 women aged 15-44 years both areas have also seen a decrease; Plymouth from 73.2 to 71.8 and England from 78.8 to 78.0 between 2012 and 2013.

Nationally conception rates in 2013 increased for women aged 35 years and over, and decreased for those aged under 35 years compared to 2012.

5.2 Teenage pregnancy (under-18 conceptions)

Reducing teenage conceptions has been a defined national strategic priority for the last fifteen years. Reducing teenage conceptions and improving outcomes for teenage parents can reduce health inequalities and child poverty.

Quarterly under-18 conception rates for Plymouth, displayed in

Figure 20, show an approximate annual cyclical pattern. Additionally, after an overall decline in conceptions from December 1998 to March 2004 the rolling average increased to a peak of 53.3 per 1,000 in June 2007. Since then there has been an overall decrease to the current September 2014 value of 29.2 per 1,000.

As can be seen in Figure 21 Plymouth’s value has been much more variable than both the regional and national rates and has consistently been higher than both. The latest September 2014 data shows a gap between Plymouth and England of 5.8 conceptions per 1,000 and between Plymouth and the South West of 9.8 conceptions per 1,000.
Figure 20: Quarterly under-18 conception rates for Plymouth, March 1998 to September 2014

Source: Quarterly conceptions to women aged under-18, Q3 July to September 2014, ONS
Provisional data for March, June and September 2014

The latest official annual data (2013) from ONS for England was 24.3 conceptions per 1,000 females aged 15-17 years, a decrease of 3.4 conceptions per 1,000 from the same period in 2012. Since the 1998 baseline figure of 46.6 per 1,000 the England rate has fallen by 47.9%.67

67 Conception Statistics England and Wales 2013, ONS
The 2013 rate for Plymouth was 28.9 conceptions per 1,000, a decrease of 10.6 conceptions per 1,000 from the previous year. Since the 1998 baseline figure of 54.7 per 1,000 the Plymouth rate has reduced by 47.2% (Figure 21). Thus the rate of under-18 conceptions in Plymouth remains above the England average whilst the rate of decrease achieved locally since 1998 is now only slightly lower than that achieved nationally.

Table 5 details a comparison with Plymouth’s local authority cluster group regarding percentage changes in under-18 conception rates. It shows that Plymouth has achieved less of a reduction than some other areas in this group and that the rate remains higher than that seen in six of the eleven comparator areas and higher that the England average.

Table 5: Percentage change in under-18 conception rate per 1,000 females aged 15-17 years, 1998 to 2013

<table>
<thead>
<tr>
<th>Local authority/area</th>
<th>1998 rate</th>
<th>2013 rate</th>
<th>Percentage change in rate</th>
<th>Lower 95% CI</th>
<th>Upper 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bournemouth</td>
<td>51.6</td>
<td>21.7</td>
<td>-57.9</td>
<td>-69.3</td>
<td>-42.3</td>
</tr>
<tr>
<td>Brighton and Hove</td>
<td>48.1</td>
<td>25.0</td>
<td>-48.0</td>
<td>-59.3</td>
<td>-33.7</td>
</tr>
<tr>
<td>Bristol</td>
<td>51.0</td>
<td>25.7</td>
<td>-49.6</td>
<td>-58.1</td>
<td>-39.3</td>
</tr>
<tr>
<td>Leeds</td>
<td>50.4</td>
<td>31.6</td>
<td>-37.3</td>
<td>-44.7</td>
<td>-28.9</td>
</tr>
<tr>
<td>Liverpool</td>
<td>57.9</td>
<td>34.1</td>
<td>-41.1</td>
<td>-49.3</td>
<td>-31.5</td>
</tr>
<tr>
<td>Newcastle upon Tyne</td>
<td>52.8</td>
<td>26.8</td>
<td>-49.2</td>
<td>-59.2</td>
<td>-36.9</td>
</tr>
<tr>
<td><strong>Plymouth</strong></td>
<td><strong>54.7</strong></td>
<td><strong>28.9</strong></td>
<td><strong>-47.2</strong></td>
<td><strong>-57.5</strong></td>
<td><strong>-34.3</strong></td>
</tr>
<tr>
<td>Portsmouth</td>
<td>57.0</td>
<td>24.8</td>
<td>-56.5</td>
<td>-66.5</td>
<td>-43.4</td>
</tr>
<tr>
<td>Salford</td>
<td>61.5</td>
<td>30.4</td>
<td>-50.6</td>
<td>-60.2</td>
<td>-38.7</td>
</tr>
<tr>
<td>Sheffield</td>
<td>50.5</td>
<td>27.9</td>
<td>-44.8</td>
<td>-52.7</td>
<td>-35.5</td>
</tr>
<tr>
<td>Southampton</td>
<td>60.9</td>
<td>36.2</td>
<td>-40.6</td>
<td>-52.2</td>
<td>-26.1</td>
</tr>
<tr>
<td><strong>South West</strong></td>
<td><strong>39.4</strong></td>
<td><strong>21.2</strong></td>
<td><strong>-46.2</strong></td>
<td><strong>-49.1</strong></td>
<td><strong>-43.1</strong></td>
</tr>
<tr>
<td>England</td>
<td>46.6</td>
<td>24.3</td>
<td>-47.9</td>
<td>-48.7</td>
<td>-47.0</td>
</tr>
</tbody>
</table>

Calculated by the Public Health, Plymouth City Council
Source: ONS Conception Statistics England and Wales 2013

2014 proxy data from Derriford Hospital allows conception data to be split by neighbourhood. Amongst other information it highlights that:

- Nine neighbourhoods (out of the 39) account for 50.3% of all conceptions in the city.
- Conception rates range from 0.0 per 1,000 15-17 year old females in the three neighbourhoods of Colebrook, Newnham & Ridgeway, Derriford West & Crownhill, and Mutley to 285.7 per 1,000 in the City Centre.
- There is over a two-fold difference in conception rate when comparing the least deprived to the most deprived group of neighbourhoods.

The local data identifies that the highest conception rates occur in the South West locality (Figure 22).
The highest conception rates in females aged 15-17 years occur in the City Centre, East End, Devonport, Stonehouse, and Leigham & Mainstone neighbourhoods. With the exception of the City Centre and Leigham & Mainstone these are all in the most deprived group of neighbourhoods. Some of these neighbourhoods have relatively high numbers of females aged 15-17 years, but others have higher numbers and lower conception rates (pale green/yellow map shading; Figure 23). This suggests that the concentrations of under-18 conceptions are not explained by the age structure of the neighbourhood alone, and that other factors such as deprivation are also influencing the rate.
Public Health England’s Sexual and Reproductive Health Profiles provides data on some of the wider factors associated with teenage pregnancy such as academic attainment and the prevalence of risk-taking behaviours. As is expected of an urban area with pockets of significant deprivation, Plymouth scores relatively poorly for these factors. For academic attainment the measure used is the percentage of young people achieving five GCSE A*-C grades including Maths and English. Plymouth’s 2013/14 value of 53.1% is significantly lower than the England figure of 56.8%. The rate of alcohol-specific admissions to hospital in under-18s is the fourth highest in the region (57.5 per 100,000) and significantly worse than the England average of 40.1 per 100,000. In addition the percentage of 16-18 year olds not in education, employment, or training in Plymouth in 2014 was 6.2%; the second highest value in the region and significantly worse than the national average of 4.7%.

5.3 Contraception

Contraception is key to good sexual and reproductive health. It is a cost-effective intervention that is essential to family planning and avoiding unwanted pregnancy. Contraception does not, with the exception of condoms, provide protection against sexually transmitted infections. Women are the main users of contraceptive services. In England between 70-80% of women use their GP practice as the preferred provider of contraception services.

The reproductive female population is generally considered to be those aged between 15 and 44 years. According to the 2013 mid-year population estimate (ONS) there were 53,388 women of this age in Plymouth, representing 20.6% of the total city population. This is slightly higher than the national average of 20.0%.

Nationally, oral contraception is the primary method used by 47% of women at first contact with NHS contraceptive clinics in 2013/14 (Table 6). However, use of long acting reversible contraception, in particular contraceptive implants is continuing to rise now representing the primary method for 31% of women.

Analysis of the patient record database (Table 7) at Plymouth NHS community contraception clinic (Plymouth Community Healthcare Community Contraception and Sexual Health Service) indicates that oral contraception is the primary method used by 44.3% of women at first contact. Long acting reversible contraception is the method of choice at first contact for 34.5% of women in Plymouth.

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68 Sexual and Reproductive Health Profiles, PHE
69 NHS Contraceptive Services; England, 2013-14 Community Contraceptive Clinics, HSCIC
Table 6: First contacts with women at NHS community contraceptive clinics, by primary method of contraception, 2003/04 to 2013/14 (England) (%)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LARCs total</strong></td>
<td>22.1</td>
<td>23.6</td>
<td>25.3</td>
<td>27.7</td>
<td>28.2</td>
<td>30.0</td>
<td>31.0</td>
</tr>
<tr>
<td>IU Devices</td>
<td>5.7</td>
<td>5.0</td>
<td>4.7</td>
<td>4.9</td>
<td>4.3</td>
<td>4.1</td>
<td>4.2</td>
</tr>
<tr>
<td>IU System</td>
<td>3.1</td>
<td>3.9</td>
<td>4.1</td>
<td>4.3</td>
<td>4.3</td>
<td>4.6</td>
<td>4.9</td>
</tr>
<tr>
<td>Injectable</td>
<td>7.6</td>
<td>7.4</td>
<td>7.4</td>
<td>7.8</td>
<td>9.1</td>
<td>9.3</td>
<td>8.9</td>
</tr>
<tr>
<td>Implant</td>
<td>5.8</td>
<td>7.2</td>
<td>9.1</td>
<td>10.6</td>
<td>10.5</td>
<td>12.1</td>
<td>12.9</td>
</tr>
<tr>
<td><strong>User dependent total</strong></td>
<td>72.6</td>
<td>70.8</td>
<td>70.2</td>
<td>68.9</td>
<td>68.3</td>
<td>67.5</td>
<td>66.6</td>
</tr>
<tr>
<td>Oral contraceptives</td>
<td>46.2</td>
<td>44.1</td>
<td>44.4</td>
<td>42.6</td>
<td>44.7</td>
<td>46.4</td>
<td>47.0</td>
</tr>
<tr>
<td>Male condom</td>
<td>25.9</td>
<td>26.0</td>
<td>25.0</td>
<td>25.2</td>
<td>22.3</td>
<td>19.8</td>
<td>18.2</td>
</tr>
<tr>
<td>Female condom</td>
<td>0.2</td>
<td>0.2</td>
<td>0.2</td>
<td>0.1</td>
<td>0.2</td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>Contraceptive patch</td>
<td>0.4</td>
<td>0.6</td>
<td>0.6</td>
<td>0.9</td>
<td>1.1</td>
<td>1.2</td>
<td>1.3</td>
</tr>
<tr>
<td><strong>Natural family planning</strong></td>
<td>0.1</td>
<td>0.4</td>
<td>0.2</td>
<td>0.1</td>
<td>0.3</td>
<td>0.5</td>
<td>0.7</td>
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<tr>
<td>Sterilisation*</td>
<td>0.2</td>
<td>0.3</td>
<td>0.1</td>
<td>0.1</td>
<td>..</td>
<td>..</td>
<td>..</td>
</tr>
<tr>
<td><strong>Other methods</strong>**</td>
<td>5.0</td>
<td>4.8</td>
<td>4.3</td>
<td>3.3</td>
<td>0.7</td>
<td>0.4</td>
<td>0.4</td>
</tr>
<tr>
<td>Emergency contraception only</td>
<td>..</td>
<td>..</td>
<td>..</td>
<td>2.6</td>
<td>1.6</td>
<td>1.2</td>
<td></td>
</tr>
</tbody>
</table>

Source: NHS Contraceptive Services; England, 2013-14
* Figures prior to 2011/12 include female sterilisations and male vasectomies, but these are no longer considered as a primary method of contraception and so since then are excluded entirely from this data.
** Figures prior to 2011/12 include emergency contraception only, since when they have been reported separately.

Table 7: Method of contraception at first contact (females) 2012/13 and 2013/14 (%)

<table>
<thead>
<tr>
<th></th>
<th>2012/13</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plymouth*</td>
<td>South West</td>
</tr>
<tr>
<td><strong>LARCs total</strong></td>
<td>n/a</td>
<td>42.2</td>
</tr>
<tr>
<td>IU Devices</td>
<td>n/a</td>
<td>7.3</td>
</tr>
<tr>
<td>IU System</td>
<td>n/a</td>
<td>8.8</td>
</tr>
<tr>
<td>Injectable</td>
<td>n/a</td>
<td>7.6</td>
</tr>
<tr>
<td>Implant</td>
<td>n/a</td>
<td>18.5</td>
</tr>
<tr>
<td><strong>User dependent total</strong></td>
<td>n/a</td>
<td>56.4</td>
</tr>
<tr>
<td>Oral contraceptives</td>
<td>n/a</td>
<td>42.0</td>
</tr>
<tr>
<td>Male condom</td>
<td>n/a</td>
<td>13.6</td>
</tr>
<tr>
<td>Female condom</td>
<td>n/a</td>
<td>0.1</td>
</tr>
<tr>
<td>Contraceptive patch</td>
<td>n/a</td>
<td>0.8</td>
</tr>
</tbody>
</table>

* data not available locally due to a change in reporting systems
National and regional percentages will not add to 100% as methods other than LARC or user dependent are not included.
5.4 Long acting reversible contraception

NICE clinical guidelines on LARC advise that these methods of contraception are more reliable than the oral contraceptive pill, where user error can result in unplanned pregnancy. The additional costs of providing LARC methods are more than compensated by the cost savings related to abortion and births.

GPs, as the preferred suppliers of contraception for a majority of women are encouraged to promote LARC methods of contraception. The percentage of GP practices in Plymouth able to offer all methods of LARC (implant, intra-uterine device, intra-uterine system and injection) as of December 2014 was 37.5%. This was lower than the regional average of 69.9% and was the lowest percentage across the South West. However, there are some differences in interpretation regarding this reporting and recording so this data should be interpreted with caution. Local analysis shows that 69% of GP practices in Plymouth are currently providing at least one method of LARC.

Nationally collated data recorded that between 2011-13 GPs in Plymouth prescribed LARC at a rate of 74.3 per 1,000 registered female population aged 15-44 years. This was higher than the regional rate (72.6 per 1,000) and higher than the England rate (52.7 per 1,000).

5.5 Emergency contraception

Emergency contraception is important when there has been a failure of, or failure to use contraception appropriately, which in turn could lead to unwanted pregnancy. There are two main forms of emergency contraception; the emergency hormonal pill and emergency fitting of IUDs.

Table 8: Number of contacts (thousands) for emergency contraception at NHS community contraception clinics in England by type and age, 2013/14.

<table>
<thead>
<tr>
<th>Ages (years)</th>
<th>Hormonal</th>
<th>IUD</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 15</td>
<td>3.4</td>
<td>0.0</td>
<td>3.5</td>
</tr>
<tr>
<td>15</td>
<td>7.2</td>
<td>0.1</td>
<td>7.2</td>
</tr>
<tr>
<td>16-17</td>
<td>20.6</td>
<td>0.3</td>
<td>20.9</td>
</tr>
<tr>
<td>18-19</td>
<td>19.8</td>
<td>0.5</td>
<td>20.3</td>
</tr>
<tr>
<td>20-24</td>
<td>31.7</td>
<td>1.3</td>
<td>33.0</td>
</tr>
<tr>
<td>25-34</td>
<td>22.3</td>
<td>2.2</td>
<td>24.5</td>
</tr>
<tr>
<td>35 and over</td>
<td>7.5</td>
<td>1.1</td>
<td>8.6</td>
</tr>
<tr>
<td>All ages *</td>
<td>112.5</td>
<td>5.5</td>
<td>118.0</td>
</tr>
</tbody>
</table>

Source: KT31 and SRHAD returns * includes a small number of records where age was not recorded

The national figures in Table 8 show that women aged 16 to 24 tend to be the main users of emergency contraception prescribed through NHS community contraception clinics in England.

72 Sexual Health Quarterly Outcome Indicator report Plymouth Q1 2014/15; LARC prescription rate per 1,000 women, Public Health England.
73 NHS Contraceptive Services; England, 2013-14 Community Contraceptive Clinics, HSCIC.
5.6 Abortion

Abortions represent unplanned and unwanted conceptions. The level of abortion can be seen as an indicator of the degree of failure of contraceptive services in terms of access or availability of the most appropriate method for individual women at the time, the failure to use contraception effectively, or the failure of the contraception itself. As teenage parenthood and unwanted pregnancy can seriously impact on health and social outcomes, access to abortion is particularly important for young women. However, access to pregnancy testing and abortion services is crucial for women of all ages to enable informed decisions about family planning to be taken. The earlier in pregnancy an abortion is performed the lower the risks of complications.

Plymouth’s under-18 abortion rate in 2014 was 14.9 per 1,000 15-17 year old females. This was higher than the national average of 11.1 per 1,000 and the South West average of 13.6 per 1,000.

The local 2014 rate for all-age abortions (per 1,000 women aged 15-44 years) was 14.9 compared to 16.5 in England and 13.6 in the South West.

The percentage of abortions (all ages) that were repeat abortions in 2014 in Plymouth was 36.8%. This was lower than the England value of 37.6%.

Reducing the delay in obtaining an abortion saves the NHS between £645,000 and £30 million per year. The earlier an abortion is performed the lower the risk of complications and the more cost effective it will be.

Early abortions, under 10 weeks gestation, accounted for 78.7% of all abortions in Plymouth in 2014. This was lower than the national average of 80.5%.

The age distribution of all abortions carried out at Plymouth and reported nationally is given in Table 9. For each year the highest numbers of abortions were carried out in the 20-24 year age-group.

Table 9: Numbers of abortions in Plymouth local authority by age, 2012-2014

<table>
<thead>
<tr>
<th>Age band (years)</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;18</td>
<td>70</td>
<td>52</td>
<td>65</td>
</tr>
<tr>
<td>18-19</td>
<td>100</td>
<td>85</td>
<td>79</td>
</tr>
<tr>
<td>20-24</td>
<td>255</td>
<td>244</td>
<td>256</td>
</tr>
<tr>
<td>25-29</td>
<td>147</td>
<td>172</td>
<td>184</td>
</tr>
<tr>
<td>30-34</td>
<td>101</td>
<td>113</td>
<td>120</td>
</tr>
<tr>
<td>35 and over</td>
<td>99</td>
<td>83</td>
<td>90</td>
</tr>
<tr>
<td>Total</td>
<td>772</td>
<td>749</td>
<td>794</td>
</tr>
</tbody>
</table>

Source: Abortion statistics 2012, 2013, and 2014, Department of Health

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74 Abortion Statistics 2013: England and Wales, Department of Health

75 Health Economics of Sexual Health (2005): a guide for commissioning and planning, Department of Health.
Summary: conceptions, contraception and abortions

- In 2013 there were an estimated 3,833 conceptions to women of all ages (15-44 years) in Plymouth compared with 3,928 in 2012, a decrease of 2.4%. The conception rate per 1,000 women aged 15-44 years in Plymouth decreased from 73.2 to 71.8 between 2012 and 2013.

- The under 18 conception rate in December 2013 was 28.9 per 1,000 females aged 15-17 years. This is a decrease of 10.6 conceptions per 1,000 from the previous year and a 47.2% reduction from the rate in 1998.

- There is a strong correlation between deprivation and teenage conceptions. The highest conception rates in females aged 15-17 years occur in the City Centre, Devonport, East End, Barne Barton, and Stonehouse neighbourhoods of the city.

- Nationally, oral contraception is the primary method used by 47% of women at first contact with NHS contraceptive clinics in 2013/14. However, use of long acting reversible, in particular contraceptive implants, is rising and is now the primary method for 31% of women. In Plymouth LARC accounts for 34.5% of contraception prescribed to women at first contact with NHS contraception clinics.

- 69% of GP practices in Plymouth are currently providing at least one method of long acting reversible contraception. The rate of GP prescribing of LARC in Plymouth between 2011-13 GPs was 74.3 per 1,000 registered female population aged 15-44 years. This is significantly higher that the England rate of 52.7 per 1,000.

- In 2014 the rate of under-18 abortions in Plymouth’s was 14.9 per 1,000 15-17 year olds. This was higher than the national average of 11.1 per 1,000 15-17 year olds.

- In 2014 the rate for all-age abortions per 1,000 women aged 15-44 years was 14.9. This is lower than the England average of 16.5 per 1,000 women aged 15-44 years.

- In 2014 78.7% of abortions in Plymouth were classified as early. This is lower than the national average of 80.5%.

- In 2012, 2013, and 2014 the highest numbers of abortions were carried out in the 20-24 year age-group.
6. Sexual violence

Sexual violence is any unwanted behaviour perceived to be of a sexual nature or sexual contact that takes place without consent or mutual understanding. The World Health Organisation defines sexual violence as:

‘Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, directed against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including the home’. 76

The importance of sexual violence and the adverse effects on health has been highlighted through the inclusion of a violent crime (including sexual offence) indicator in the Public Health Outcomes Framework. Rape is not a gender-specific issue but evidence suggests that this crime disproportionately affects females. Historically, higher levels of recorded sexual offences have been seen to evidence victim confidence in reporting crimes committed against them. It is difficult to obtain reliable information on the extent of sexual offences as there is a degree of under-reporting of these incidents therefore it is likely that any figures quoted are an under-representation of the real levels.

Home Office open access data is available on the number of recorded sexual offences by Community Safety Partnership (CSP) area. Data for the last five years from the Devon and Cornwall Police Force is shown in Table 10 and Figure 24.

Table 10: Numbers of sexual offences (of all kinds) in Devon and Cornwall Police Force, 2009/10 to 2013/14

<table>
<thead>
<tr>
<th>CSP area</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cornwall &amp; Isles of Scilly</td>
<td>457</td>
<td>456</td>
<td>550</td>
<td>540</td>
<td>640</td>
</tr>
<tr>
<td>Devon</td>
<td>584</td>
<td>608</td>
<td>760</td>
<td>738</td>
<td>849</td>
</tr>
<tr>
<td>Plymouth</td>
<td>403</td>
<td>437</td>
<td>413</td>
<td>427</td>
<td>469</td>
</tr>
<tr>
<td>Torbay</td>
<td>146</td>
<td>186</td>
<td>176</td>
<td>222</td>
<td>219</td>
</tr>
<tr>
<td>Police Force total</td>
<td>1,590</td>
<td>1,687</td>
<td>1,899</td>
<td>1,927</td>
<td>2,177</td>
</tr>
</tbody>
</table>

Source: Home Office Police Recorded Crime Open Data tables.

The number of sexual offences across the whole of the force has increased year-on-year. A breakdown of the sexual offences in 2013/14 showed that 42% of the offences were sexual assault, 34% were rape, and 24% were other sexual crimes. The 469 sexual offences recorded in Plymouth in 2013/14 represented 21.5% of the total sexual offences within Devon and Cornwall.

The monetary costs of such crimes are considerable. Analysis undertaken by Devon and Cornwall Constabulary identified the cost associated with various crimes and incidents. The cost associated with a rape or serious sexual offence was calculated to be £31,458 based on 2010/11 data. 77 Based on the number of rape offences (157) recorded in 2013/14 the total cost for Plymouth for this type of offence alone would be in the region of £4,939,000.

The 2012/13 Crime Survey for England and Wales identified that 3.0% of the female

76 Strategic Assessment (Crime and Disorder) 2011/12; Community Safety Partnership, Plymouth City Council
population and 0.3% of the male population aged 16-59 years in England and Wales were victims of sexual assault (including attempts) in the previous 12 months.\textsuperscript{78} If these proportions are applied to the relevant 2013 Plymouth mid-year female and male population estimates (76,869 and 78,672 respectively) it could be expected that 2,306 women and 236 men aged 16-59 years suffer a sexual assault/attempt in any one year. The total actual recorded numbers are much lower than this though, as illustrated by the data in Table 10.

Since 2009/10 Devon has consistently had the lowest rate of sexual offences. Plymouth consistently had the highest rate until 2012/13 when the rate seen in Torbay surpassed that seen in Plymouth (Figure 24). The latest data shows that once again Plymouth has the highest rate at 1.8 per 1000 population

Figure 24: Crude rate of sexual offences (of all kinds) in Devon and Cornwall Police Force (per 1,000 all-age population) 2009/10 to 2013/2014

The rate of sexual offences (excluding exposure and voyeurism) recorded by the police in Plymouth for 2013/14 was higher than the South West regional average (1.0 per 1,000) and the second highest in the region behind Bristol.\textsuperscript{79}

As seen in Table 10 there were 469 sexual offences committed in Plymouth in 2013/14. This is an increase of 9.8\% (42 incidents) from 2012/13. Sexual assault on a female and rape of a female aged over 16 accounted for 50.1\% of the sexual violence recorded (Figure 25).\textsuperscript{80}

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{78} An overview of sexual offending in England and Wales, Home Office and Ministry of Justice
\item \textsuperscript{79} Sexual and reproductive health profiles, PHE
\item \textsuperscript{80} Police recorded crime open data tables, Home Office
\end{itemize}
\end{footnotesize}
Using 2012 ONS mid-year population estimates and publically available crime data the rate of recorded rape in females can be calculated. Figure 26 shows that in 2013/14 Plymouth had the second highest rate of recorded rape in the region. Plymouth’s value, 109.5 per 100,000 female population, is over 1.6 times that of both the regional and national values.

Source: Police recorded open data tables, Home Office

Source: Police recorded crime open data tables and ONS
Compared to its ONS comparator group Plymouth again ranks second highest behind Bristol for the same indicator. The areas with the next two highest rates, of 104.8 and 97.9 per 100,000, are Southampton and Brighton and Hove respectively (Figure 27).

Over the last five years there has been an increase in reported rapes nationally from 52.3 per 100,000 females in 2009/10 to 67.8 per 100,000 in 2013/14. Over the same time period Plymouth’s value has risen from 70.7 per 100,000 to 109.5 per 100,000.\(^8\) This corresponds to the number of recorded rapes in Plymouth increasing by 57.1\% (52 incidents) between 2009/10 and 2013/14.

**Summary: sexual violence**

- The number of sexual offences has increased year-on-year from 2009/10 – 2013/14. In 2013/14 there were 469 sexual offences recorded in Plymouth. This is an increase of 9.8\% from 2012/13.
- The rate of sexual offences recorded by the police in Plymouth for 2013/14 was 1.8 per 1,000. This is higher than the South West regional average (1.0 per 1,000) and the second highest in the South West behind Bristol.
- Sexual assault on a female and rape of a female aged over 16 accounted for 50.1\% of the sexual violence recorded in Plymouth in 2013/14.
- In 2013/14 the rate of recorded rape in Plymouth was 109.5 per 100,000 population. This is significantly higher than the rates recorded for most comparator areas and for England.
- The number of recorded rapes in Plymouth increased by 57\% between 2009/10 and 2013/14.

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\(^8\) Calculated by Public Health, Plymouth City Council
7. Sexual health service mapping (supply)

This section provides a description of the current sexual health service provision in Plymouth. All services are currently commissioned to provide an integrated sexual health system where the objectives are to:

- Reduce the number of under 18 conceptions
- Increase the uptake of long acting reversible contraception (LARC)
- Delay early onset sexual behaviour in young people and reduce risk taking behaviours among young people
- Reduce the rate of all unintended conceptions and repeat abortions
- Increase the proportion of medical abortions and the percentage of abortions carried out under nine weeks gestation
- Reduce the transmission of sexually transmitted infections including HIV
- Improve chlamydia diagnosis and partner notification rates
- Reduce late diagnosis of HIV and other STIs

Sexual health services are provided by a number of organisations in Plymouth. Referral and treatment pathways are in place to ensure the ‘system’ responds promptly to need and maximises treatment outcomes. Referral pathways to and from related services are also in place to promote co-ordinated care – examples of related services are social care services, maternity services and general medicine.

7.1 Contraception services

It is essential that women of all ages are able to access the full range of contraception methods in order to prevent unwanted pregnancies. The effectiveness of barrier methods and oral contraception depends on individual routine compliance. Expert clinical guidance suggests that LARC methods are the most clinically and cost effective approaches to reducing unintended pregnancy.

Plymouth Community Healthcare’s Community Contraception and Sexual Health Service (CCaSH) are commissioned by the local authority to provide a comprehensive contraception and sexual health advice service. Core elements of the service include:

- Provision of emergency hormonal contraception
- First prescription and continuing supply of combined hormonal contraception (combined and progesterone only)
- Long acting reversible contraception insertion and removal
- Deep implant removal service for Devon and Cornwall
- Targeted outreach service for vulnerable women
- Condom distribution
- Chlamydia screening and treatment
- Pregnancy testing and counselling
- Information around STI prevention and STI testing as part of contraception needs

The service is structured to ensure maximum accessibility and is delivered through open

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access drop in and booked appointments and includes access in the evenings and on Saturdays. The service is organised across the week to provide at least:

- 30 hours provision at the Zone young people’s service
- 38.5 hours at the Cumberland Centre and
- 16 hours outreach for vulnerable women

General practice has an important role in reducing unplanned pregnancy and it is estimated that up to 80% of contraception is provided in primary care. Contraception services are provided within general practice across Plymouth. The local authority commissions 10 surgeries to fit and remove Intrauterine Contraceptive Devices IUCDs and 28 to fit and remove contraceptive implants.

Under the management of NHS England a further 20 general practice surgeries have Personal Medical Service (PMS) contracts that include funding for IUCD fitting and removal in their financial baseline.

IUCDs are also provided for non-contraception purposes. NEW Devon Clinical Commissioning Group commissions both GMS and PMS practices to deliver this service. From July 2014 the commissioning of all of this provision has been rationalised into one system led by the local authority. In this way the provision of IUCDs (for contraception and non-contraception purposes) and contraceptive implants in general practice are delivered to a single service specification and remunerated according to activity.

Emergency Hormonal Contraception (EHC) is available in Plymouth from GPs and is also available from CCASH and GUM services. The local authority commissions 21 community pharmacies across the city to provide (EHC) free to 13-24 year olds. EHC can also be purchased from pharmacies and online providers without a prescription by those aged 16 years and over.
Figure 28: Public health commissioned GP LARC and pharmacy EHC contraceptive services, 2014/15

Note:
In three instances a mapped pharmacy location obscures a GP practice due to a shared postcode.
In two instances a mapped pharmacy location represents two pharmacies due to a shared postcode.
7.2 Genitourinary medicine (GUM) services

These services provide Level 1 to 3 sexual and reproductive healthcare services. This includes sexually transmitted infection screening, treatment and partner notification, HIV testing and counselling and the provision of complex contraception services. They also provide advice, information and health promotion in relation to all aspects of sexual and reproductive health.

The Plymouth Hospitals NHS Trust at Derriford Hospital is currently commissioned by the local authority to provide a comprehensive GUM service. Core elements of this service are:

- Assessment, testing and treatment of Sexually Transmitted Infections (STI)
- Specialist STI management e.g. syphilis, lymphogranuloma venereum, primary or complex herpes simplex virus, ano-genital warts
- Contact tracing and partner notification
- HIV testing
- Chlamydia screening and treatment
- Provision of emergency hormonal contraception
- Complex contraception (e.g. co-existing medical conditions making routine contraceptive prescription challenging or where specialist expertise is required)
- Psychosexual services

The service is provided through open access drop-in and booked appointments and includes early morning access, access in the evenings and on Saturdays. A weekly GUM Clinic is also delivered from the CCaSH service at the Cumberland Centre in Devonport. Additionally the local authority commissions the University Medical Practice to provide two GUM clinic sessions (one nurse, one doctor led) weekly. The services include:

- Information around STI prevention and prevention of unplanned pregnancy
- Provision of contraception – including emergency hormonal and referral for long acting reversible contraception
- STI screening and near patient testing for some infections
- HIV testing
- Assessment and management of some infections including chlamydia, gonorrhoea and genital herpes
- Partner notification
- Vaccination for hepatitis B in recognised at risk groups

7.3 Psychosexual services

Sexual dysfunction is common in the general population. A recent national survey\(^\text{83}\) of 15,000 people found that 42% of men and 51% of women aged 16-74 years interviewed, who had had sex in the past year, had experienced one or more sexual difficulties lasting a minimum of three months.

Guidance details that local authorities are responsible for commissioning sexual health aspects of psychosexual counselling and Clinical Commissioning Groups have responsibility for the non-sexual health elements of psychosexual health services. However there are no recognised definitions of ‘sexual health aspects’, non-sexual health elements’, psychosexual counselling, or psychosexual health services.

In Plymouth the GUM service currently provides interventions to address both physical and psychological issues affecting sexual functioning. A Clinical Psychologist led service works with people to address post-traumatic stress disorder, anxiety and depression and relationship issues caused by events which are sexual in nature. The service also provides specific clinical services to address physical conditions such as infections, dermatoses, vulvodynia and vaginismus that may adversely affect sexual functioning.

Plymouth Community Healthcare Plymouth Options Service (Improving Access to Psychological Services) provides a relationship and psychosexual counselling service that is accessed through self-referral, referrals from primary care and referrals from specialist sexual health services.

### 7.4 Specialist HIV services

HIV is one of the most important communicable diseases in the (UK). It has a significant impact on morbidity, mortality, lifestyle, relationships, work, health, wellbeing and life expectancy.

The Framework for Sexual Health Improvement in England 2013 highlights the need to reduce onward transmission of and avoidable death from HIV. It stresses the need for local areas to prioritise HIV prevention through increased provision of HIV testing, especially to those in high risk groups, and the need for people to have access to free condoms.

The effectiveness of clinical HIV treatment means that people with the infection will often live into old age. In some cases this will necessitate the need for integrated health and care support.

Plymouth NHS Hospital Trust is commissioned by NHS England to provide specialised HIV inpatient and outpatient services. These services provide specialist assessment and on-going management of HIV and associated conditions and focus on improving patient outcomes, reducing mortality and morbidity and reducing the onward transmissions of the virus. These services take a multi-disciplinary approach to treatment and care. Specific components of care include:

- Supporting individuals to minimise the risk of onward transmission
- Management of pregnant women to prevent mother to child transmission
- Timely initiation and on-going management of antiretroviral (ARV) treatment to achieve and maintain undetectable levels of the virus
- Management of opportunistic infections, malignancies and severe complications related to HIV

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HIV Post Exposure Prophylaxis
Post-exposure prophylaxis (PEP) is short-term antiretroviral treatment to reduce the likelihood of HIV infection after potential exposure. For optimal efficacy PEP should be commenced as soon as possible after exposure therefore it is recommended that the treatment is available in GUM services and hospital Emergency Departments.

NHS England is responsible for commissioning the antiretroviral treatments while the local authority pays for attendance at the GUM service under agreed contract arrangements and Clinical Commissioning Groups for attendance at the Emergency Department. In Plymouth PEP is available at the GUM service and Emergency Department at Derriford Hospital.

Pre-Exposure Prophylaxis for HIV
Pre-exposure prophylaxis (PrEP) is a course of HIV drugs taken before sex to reduce the risk of contracting HIV. PrEP is intended for people who are at high risk of contracting HIV including those in a relationship with an HIV positive partner or people who have multiple sexual partners and do not use condoms.

Recent research\(^{86}\) indicates that pre-exposure prophylaxis (PrEP) is highly protective against HIV for gay and other men who have sex with men, reducing the risk of infection by up to 86%. NHS England is currently evaluating the use of PrEP. PrEP is not currently available in Plymouth.

HIV home sampling and testing
HIV home sampling kits can be purchased from a number of commercial outlets. In home sampling a blood or saliva sample is taken and posted to a laboratory for analysis and results are then provided via phone or text. Legally approved HIV home testing kits have been available since April 2015 and can be purchased online. The blood prick test provides results within 15 minutes and does not require laboratory checking. An HIV home testing service using a mouth swab is available online from Derriford Hospital GUM service

https://www.yourship.uk/about.php

This is the first free home testing service available in England and is part of a research project funded by NHS England Research and Innovation Fund.

The Eddystone Trust
The Eddystone Trust is an independent organisation providing information, advice and support for people affected by HIV. They also provide advice and information about broader sexual health issues and a specialist workforce training and development programme. In Plymouth the Eddystone Trust is commissioned by the local authority to provide HIV prevention services, HIV Point of Care testing, advocacy, care and support services, and young people’s sexual health services.

Prevention - the prevention aspect of the service provides universal and targeted information, free condoms and other safer sex resources and HIV Point of Care testing. The service also delivers targeted outreach services in public sex environments and to street sex workers and other vulnerable women – this includes supporting referral to and engagement with relevant health and social care services.

Advocacy, care and support - this aspect of the service provides an advocacy and support

\(^{86}\) http://www.ctu.mrc.ac.uk/
service to individuals affected by HIV/AIDS and focuses on helping people to remain independent in the community. It also provides support and advocacy to families and affected others.

Young people’s services – this focuses on supporting the sexual health of young people and preventing teenage pregnancy through a C-Card condom distribution scheme, sexual health training to professionals working with young people, and administering a young people’s service quality assurance scheme – SAFE badge. These schemes are described in more detail in the Young People’s Sexual Health section below.

7.5 Abortion services

Abortion services are an important part of healthcare provision that ensures reproductive choice for women.

Guidance on the provision of abortion services directs that access to local services should be available for all women requesting induced abortions at all gestations. The guidance recommends that women should be able to access abortion as early as possible and as late as necessary. Clinical indications are that the earlier an abortion takes place the lower the risk of complications and the more cost effective it is. Abortion services should be able to provide sexually transmitted infection testing, including chlamydia screening for 15-24 year olds and all forms of contraception post abortion.

The NEW Devon Clinical Commissioning Group – Western Locality currently commissions Plymouth Hospitals NHS Trust to provide the Pregnancy Advisory Service. The service at Derriford Hospital provides a confidential counselling service, medical abortions up to eight weeks and six days gestation, surgical procedures up to 13 weeks and six days gestation and post abortion counselling. Chlamydia Screening and contraception services are also provided. Consultations and early medical abortions (under nine weeks) are also commissioned from BPAS (British Pregnancy Advisory Service) at the Mount Gould Local Care Centre.

Women requiring an abortion at a later gestation are referred to specialist facilities in Bristol, Bournemouth or London according to clinical need.

7.6 Chlamydia screening service

The National Chlamydia Screening Programme (NCSP) was established in 2003 and required local areas to provide free and confidential services providing testing, prevention, treatment and partner notification services to sexually active under-25 year olds.

Until April 2015 Plymouth Chlamydia Screening Programme was commissioned as a centralised service providing both administrative and clinical functions and provided by Plymouth Community Healthcare. From April 2015 the service has been integrated into the Plymouth Community Healthcare Community Contraception and Sexual Health Service. This integrated model co-ordinates the provision of free screening and treatment through a number of sites across the city and via the internet. The Programme includes:

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- Opportunistic screening for sexually active young people between 15 and 24 years olds
- Training and support to sites participating in the screening programme
- Treatment for those testing positive
- Partner notification
- Promotion and marketing of the programme

Across Plymouth 39 GP practices are commissioned to deliver chlamydia screening and 27 to provide treatment for chlamydia (Azithromycin). Additionally 21 community pharmacies are commissioned to provide chlamydia screening and six to provide treatment. Grab-bins providing chlamydia screening packs are available in three community pharmacies.

Figure 29: GPs and pharmacies commissioned to deliver chlamydia screening, as at October 2014

Note: in one instance a mapped GP practice obscures a pharmacy location due to a shared postcode.
7.7 Sexual Assault Referral Centre (SARC)

Sexual Assault Referral Centres (SARC) provide specialist medical and forensic services for people who have been raped or sexually assaulted. They are set up to provide rapid response services under one roof and are available to anyone including those who do not want to report their assault to the police or who want to report it at a later stage.

Twelve’s Company delivers the SARC for over-16 year olds in Plymouth and is commissioned with investment from NHS England Specialist Services, the Police and Crime Commissioner and the Home Office. This service provides 24 hour crisis support, access to Forensic Medical Examination, sexual health advice including emergency contraception and pregnancy testing and on-going support including liaison with criminal justice agencies and community services. Services for those under-16 years are provided from the Exeter SARC suite.

Twelve’s Company also receives funding from charitable sources to provide counselling and art therapy services to adults and young people.

7.8 Young people’s sexual health services

Many of the services defined above are commissioned to provide sexual and reproductive health services to young people in Plymouth. The services below provide additional sexual health promotion and interventions to support positive sexual health outcomes for young people.

The Zone

The Zone is Plymouth’s largest non-statutory provider of youth services to young people aged 13-25 and works with an average of 7,500 young people a year. The Zone provides a designated sexual health service. This is delivered in partnership with clinical staff co-located from Plymouth Community Healthcare’s Community Contraception and Sexual Health Service (CCaSH) and is provided via open access ‘drop-in’ six days a week. As part of this integrated service model the Zone delivers components of Level 1 and 2 basic and intermediate care.

Young people attending the service receive full sexual history taking and risk assessment, with access to pregnancy testing, most methods of contraception, chlamydia screening and treatment, condoms and lubricants, and direct referral to other services where indicated. The Zone estimates that the service sees approximately 12% of the sexually active population aged 13-25 in Plymouth, with 60% of users coming from the city’s most deprived neighbourhoods, and 8.5% identifying as non-white or BME.

The Zone provides information and guidance on relationships and decision making with regard to sexual health and informed choice, as well as alcohol screening and brief intervention. Young people accessing the service are assessed against criteria linked to vulnerability and potential risk of sexploitation or abuse. Aligned to the service is access to specialist counselling for those young people who report being the victim of a sexual crime.

C-Card

Access to free condoms is an essential part of sexual health promotion. The Eddystone Trust is commissioned to co-ordinate the C-Card condom distribution scheme that aims to
provide free condoms to under-25s. Under the scheme young people register and receive advice about how to use condoms and about sexual health more broadly. Once registered free condoms can be accessed from 47 sites across the city, these include community pharmacies, colleges and various young people’s services.

**Safe Badge**

The Safe Badge scheme is a quality assurance approach that registers services that have demonstrated that they are ‘young people friendly’. The Eddystone Trust is commissioned to co-ordinate the scheme that is based on the Department of Health You’re Welcome quality criteria. To achieve accreditation services must complete a comprehensive self-assessment process to demonstrate that they meet standards around nine criteria including staff training attitudes and values, confidentiality and consent and sexual and reproductive health. There are currently 29 sites across Plymouth that have achieved full SAFE accreditation.

**The Healthy Child Quality Mark**

Schools and colleges have an important role in supporting the health and wellbeing of their students. Plymouth City Council’s Healthy Child Quality Mark programme builds on the national Healthy Schools Programme and the South West Healthy Schools Plus Programme and focuses on the role that schools and colleges play in helping young people adopt healthy lifestyles. The award scheme provides a framework to plan, deliver and assess healthier behaviour change. It is a three tier scheme where bronze, silver and gold awards are achieved by successfully demonstrating that health and wellbeing targets have been met. The scheme covers the full range of health and wellbeing issues including healthy eating and physical activity, substance misuse, emotional health, mental health and wellbeing and relationships and sex education. To date 28 schools have achieved bronze award, five the silver award, and three the gold award.

**School nursing**

Plymouth’s School Nursing Team is commissioned by Plymouth City Council (Office for the Director of Public Health) and is delivered by Plymouth Community Healthcare. The team provides universal and targeted services to children and young people of school age and their families based on the Healthy Child Programme. The service includes a weekly confidential drop in at each secondary school/academy and input to schools Personal Health and Social Education Programmes and signposting to sexual health services within Plymouth. They deliver the HPV (human papilloma virus) vaccination programme as commissioned by NHS England Local Area Team.

**Sex and relationship education**

National and international research shows that good sex and relationship education (SRE) has a protective function for young people.

Sex and relationship education is a statutory requirement for maintained secondary schools and must meet the requirements of National Curriculum Science. Academies and Free Schools do not have to teach sex education, but are required to provide a ‘broad and balanced curriculum’. Governing bodies and head teachers of grant maintained primary schools determine the individual schools approach to sex and relationship education beyond

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89 SRE the evidence. Sex Education Forum. March 2015
that set out in the National Curriculum Science. All schools are required to have regard to
the Sex and Relationship Guidance90 that stresses the benefits of loving, healthy relationships
and delaying sex and human growth and reproduction.

In 2013, Ofsted reported that the quality of personal, social, health and economic education
(PHSE) and SRE in schools in England was ‘not yet good enough’91

7.9 Sexual health communication and information

All specialist services provide sexual health information as part of their core service delivery
and contribute to a number of health promotion events across the year including University
Fresher’s Events, Gay Pride events and Sexual Awareness Week. The Eddystone Trust co-
ordinates local events, information, and publicity for World AIDS Day in December. There
is currently no coordinated approach to sexual health communications across sexual health
services in the city.

<table>
<thead>
<tr>
<th>Summary: sexual health service mapping</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Sexual health services are provided by a number of different organisations in Plymouth. Services provide a full range of interventions from self-managed care to level 3 complex interventions. Sexual health promotion and prevention is a key element part of all sexual health services. GUM and contraception services are not fully integrated.</td>
</tr>
<tr>
<td>• Services are delivered from a number of locations with booked appointments and drop in facilities available across the week, in the evenings and on Saturday’s. Specific clinics for 13-25 year olds are held across the week.</td>
</tr>
<tr>
<td>• HIV testing is available through GUM services. A free online home testing service is also available. Point of care testing is provided as part of outreach delivered by the Eddystone Trust</td>
</tr>
<tr>
<td>• Contraception services are provided within General Practice across Plymouth. 77% of practices fit and remove IUCDs and 72% to fit and remove contraceptive implants. All practices are also commissioned to provide chlamydia screening and 66% provide chlamydia treatment.</td>
</tr>
<tr>
<td>• 41% of community pharmacies are commissioned to deliver free EHC to 13-24 year olds. 51% of pharmacies are also commissioned to provide chlamydia screening and 15% to provide treatment for chlamydia.</td>
</tr>
<tr>
<td>• Free condoms are available to under 25s from 50 sites across the city as part of the C-Card scheme.</td>
</tr>
<tr>
<td>• Delivery of the Sex and Relationship Education (SRE) programmes in schools and academies varies depending on the schools’ approach. There is currently no strategic overview of provision.</td>
</tr>
</tbody>
</table>

90 Sex and Relationship Education Guidance, Department of Education and Employment, 2000
Abortion services are provided locally for medical abortions up to eight weeks and six days gestation and surgical procedures up to 13 weeks and six days gestation. Later abortions are not available locally; women must travel to Bristol, Bournemouth or London.

The SARC provides specialist medical and forensic services to over 16 year olds. Services for those under-16 years are provided from the Exeter SARC suite.
8. Sexual health service activity and uptake (demand)

8.1 Contraception

As described in Section 5 contraception services are commissioned from a number of providers in Plymouth. Services are organised to ensure capacity and accessibility across the city. Over recent years the Community Contraception and Sexual Health Service provided by Plymouth Community Healthcare has been reconfigured to deliver a number of open access clinics and booked appointments across the week. Specifically the service delivers a number of clinics from the Zone to improve access for young people.

Table 11: CCaSH service utilisation by Plymouth residents, 2013/14 and 2014/15

<table>
<thead>
<tr>
<th></th>
<th>2013/14</th>
<th></th>
<th>2014/15</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
</tr>
<tr>
<td>Total contraception attendances</td>
<td>10,625</td>
<td>-</td>
<td>10,944</td>
<td>-</td>
</tr>
<tr>
<td>Females</td>
<td>10,413</td>
<td>98.0</td>
<td>10,813</td>
<td>98.8</td>
</tr>
<tr>
<td>Black and Minority Ethnic groups</td>
<td>854</td>
<td>8.0</td>
<td>1,063</td>
<td>9.7</td>
</tr>
<tr>
<td>Under-18</td>
<td>1,863</td>
<td>17.5</td>
<td>1,926</td>
<td>17.6</td>
</tr>
<tr>
<td>35 years and over</td>
<td>1,569</td>
<td>14.8</td>
<td>1,483</td>
<td>13.6</td>
</tr>
<tr>
<td>First contraception attendances</td>
<td>4,249</td>
<td>40.0</td>
<td>3,363</td>
<td>30.7</td>
</tr>
<tr>
<td>Contraceptive implant insertions</td>
<td>1,096</td>
<td>10.3</td>
<td>998</td>
<td>9.1</td>
</tr>
<tr>
<td>IUD/IUC insertions</td>
<td>578</td>
<td>5.4</td>
<td>583</td>
<td>5.3</td>
</tr>
<tr>
<td>Contraceptive injections</td>
<td>547</td>
<td>5.1</td>
<td>597</td>
<td>5.5</td>
</tr>
</tbody>
</table>

Source: CCaSH activity monitoring data, supplied 2015

Between 2013/14 and 2014/15 the number of people attending the CCaSH service has increased by 3%. The number of IUCD devices fitted at CCASH during that time remained fairly static at 578 in 2013/14 and 583 in 2014/15. The number of contraceptive implants fitted in during those years decreased by 10% from 1,098 in 2013/14 to 998 in 2014/15.

Contraception services are provided in general practice surgeries across the city. The total number of prescriptions dispensed by GPs in Plymouth April 2013 – March 2015 was 91,676.

Figure 30: GP contraception prescriptions (%), 2013/14 and 2014/15
In both 2013/14 and 2014/15 the majority of prescriptions were for combined oral contraceptives. An increase of 1.0 percentage point was seen for this category of prescriptions from 2013/14 to 2014/15.

Practices are specifically commissioned by Plymouth City Council (ODPH) to provide enhanced services to fit and remove IUCDs and contraceptive implants.

Table 12: Reported GP contraception activity

<table>
<thead>
<tr>
<th>Service</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>IUCD insertion</td>
<td>882</td>
<td>512</td>
</tr>
<tr>
<td>IUCD removal</td>
<td>Full reporting not available</td>
<td>90</td>
</tr>
<tr>
<td>Contraceptive implant fitting</td>
<td>1,119</td>
<td>1,082</td>
</tr>
<tr>
<td>Contraceptive implant removal</td>
<td>640</td>
<td>729</td>
</tr>
</tbody>
</table>

Intrauterine devices are also used for non-contraceptive purposes i.e., for the treatment of some gynaecological disorders. During 2014/15 there were 167 IUDs fitted and 33 removed in general practice for non-contraceptive purposes.

Reported activity levels show a significant drop in the number of IUCD devices fitted in general practice for contraceptive purposes between 2013/14 and 2014/2015. This may reflect changes in commissioning arrangements including revised service specifications detailing specific training and accreditation requirements. It may also be a result of overall capacity pressures within general practice making it difficult to prioritise these services which can take longer than consultations for many other health issues.

8.1.1 Emergency contraception

There are two types of emergency contraception, Emergency Hormonal Contraception (sometimes called the morning after pill) and IUDs fitted within certain timeframes after unprotected sex. The numbers of IUDs fitted for emergency purpose are included in the overall CCASH figures shown above. The GUM service at Derriford Hospital also fits a small number of devices where clinically indicated. During 2014/15 they fitted 12 devices for emergency contraception purposes.

Community pharmacies are commissioned to provide free Emergency Hormonal Contraception (EHC) to 13-24 year olds in Plymouth. During 2013/14 there were 742 consultations for EHC resulting in 696 dispensations of Levongestrel for this group. During 2014/15 there were 897 consultations resulting in 838 dispensations; a 20% increase in number of dispensations from the previous year. During 2014/15 the GUM service at Derriford Hospital also provided EHC on 138 occasions.

8.2 GUM services

The overall demand for GUM services in Plymouth have increased overall between 2010/11 and 2014/15. The GUM service at Derriford Hospital has seen an increase in new and follow up appointment attendances across this timeframe. Re-bookings, people who have previously used the service, have also increased.
Table 13: GUM attendances at Derriford by gender and appointment type (numbers), 2010/11 to 2014/15

<table>
<thead>
<tr>
<th>Appointment</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New</td>
<td>1,596</td>
<td>1,604</td>
<td>1,709</td>
<td>1,760</td>
<td>1,695</td>
</tr>
<tr>
<td>Re-book</td>
<td>1,803</td>
<td>1,972</td>
<td>2,148</td>
<td>2,474</td>
<td>2,539</td>
</tr>
<tr>
<td>Follow-up</td>
<td>1,424</td>
<td>1,431</td>
<td>1,475</td>
<td>1,700</td>
<td>1,824</td>
</tr>
<tr>
<td>Females</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New</td>
<td>2,145</td>
<td>2,285</td>
<td>2,096</td>
<td>2,208</td>
<td>2,194</td>
</tr>
<tr>
<td>Re-book</td>
<td>3,266</td>
<td>3,812</td>
<td>3,709</td>
<td>4,015</td>
<td>3,829</td>
</tr>
<tr>
<td>Follow-up</td>
<td>2,452</td>
<td>2,765</td>
<td>2,420</td>
<td>2,716</td>
<td>2,831</td>
</tr>
<tr>
<td>Persons</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New</td>
<td>3,741</td>
<td>3,889</td>
<td>3,805</td>
<td>3,968</td>
<td>3,889</td>
</tr>
<tr>
<td>Re-book</td>
<td>5,069</td>
<td>5,784</td>
<td>5,857</td>
<td>6,489</td>
<td>6,368</td>
</tr>
<tr>
<td>Follow-up</td>
<td>3,876</td>
<td>4,196</td>
<td>3,895</td>
<td>4,416</td>
<td>4,655</td>
</tr>
</tbody>
</table>

Source: Plymouth Hospitals NHS Trust GUM activity data, supplied 2015
New: the first appointment of someone who has never attended the GUM clinic before.
Re-book: a returning patient either with a new problem requiring tests or they have not been seen by the clinic within the last six months.
Follow up: an appointment relating to the patient’s last visit.

Of the demographic data recorded the majority of those attending the GUM service in 2014/15 were White British, from the postcode sector PL4, and between the ages of 20-22 years.

At the University Medical Practice GUM service between April 2014 and March 2015 there were 353 new appointments attendances and 42 follow up appointment attendances. As would be expected the majority of those attending were between 18-24 years old and most attendances are during the academic term time. Due to changes in commissioning arrangements and systems for activity monitoring it is not possible to provide comparable activity monitoring for previous years for this service.

There is a known continuing increase in the rates of STIs, particularly in the under-25s and so demand for services is anticipated to continue and increase. It should also be considered that more accessible services can lead to better ascertainment of illness and so increasing demand can also be a function of more accessible services.

8.3 Out of area service provision

Local authorities are legally required to provide open access sexual health services for everyone present in their area irrespective of age, gender or sexual orientation. This includes the provision of free STI testing and treatment, notification of sexual partners of infected people and free and reasonable access to all methods of contraception. These services cannot be restricted to residents of the area, those registered with a local GP or on other grounds such as visiting the local area. A system of cross charging is recommended to ensure that providers of services are appropriately remunerated for services provided to other local authority’s residents.

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People will choose to access sexual health services in other areas for a number of reasons including concerns regarding confidentiality and anonymity. A number of Plymouth residents access services in other areas across the country. During 2014/15 Plymouth City Council paid a total of £45,236 for out of area sexual health service activity provided by services across the country. The majority of out of area services used by Plymouth residents were in Devon and London.

8.4 Abortion

Service activity data provided by Derriford Hospital covers different time periods to that reported nationally. As such the totals in the tables below will not match those from Table 9. Early abortions, between 3-9 weeks of gestation, accounted for 80% of all abortions in Plymouth in 2013. This was slightly higher than the national average of 79%.94 Local data in Table 14 demonstrates the increase in the percentage of all-age abortions performed at <10 weeks gestation. The increase in abortions at <10 weeks is in line with national trends.

Table 14: Abortions at <10 weeks gestation at Derriford Hospital 2010/11 to 2014/15

<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
<th>% of total abortions</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010/11</td>
<td>396</td>
<td>52</td>
</tr>
<tr>
<td>2011/12</td>
<td>632</td>
<td>81</td>
</tr>
<tr>
<td>2012/13</td>
<td>571</td>
<td>83</td>
</tr>
<tr>
<td>2013/14</td>
<td>496</td>
<td>81</td>
</tr>
<tr>
<td>2014/15</td>
<td>431</td>
<td>80</td>
</tr>
</tbody>
</table>

Source: Plymouth Hospitals NHS Trust Pregnancy Advisory Service activity data, supplied 2015

Nationally, another clearly visible trend is for an increasing proportion of abortions to be medical rather than surgical. There has been a continuing upward trend in medical abortions since 1991 when the medicine Mifegyne was licensed for use in the UK. The proportion of medical abortions has nearly trebled in the last ten years, from 17% in 2003 to 49% of those performed in 2013.94

There has been a significant increase in medical abortions locally, shown in Table 15, with an increase since 2010/11 from 17.1% to 31.2% in 2014/15.

Table 15: Numbers and percentages of medical and surgical abortions in Derriford Hospital, 2010/11 to 2014/15

<table>
<thead>
<tr>
<th>Year</th>
<th>Surgical Number</th>
<th>%</th>
<th>Medical Number</th>
<th>%</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010/11</td>
<td>632</td>
<td>82.9</td>
<td>130</td>
<td>17.1</td>
<td>762</td>
</tr>
<tr>
<td>2011/12</td>
<td>499</td>
<td>63.9</td>
<td>282</td>
<td>36.1</td>
<td>781</td>
</tr>
<tr>
<td>2012/13</td>
<td>427</td>
<td>62.1</td>
<td>261</td>
<td>37.9</td>
<td>688</td>
</tr>
<tr>
<td>2013/14</td>
<td>404</td>
<td>66.0</td>
<td>208</td>
<td>34.0</td>
<td>612</td>
</tr>
<tr>
<td>2014/15</td>
<td>371</td>
<td>68.8</td>
<td>168</td>
<td>31.2</td>
<td>539</td>
</tr>
</tbody>
</table>

Source: Plymouth Hospitals NHS Trust Pregnancy Advisory Service activity data, supplied 2015

94 Abortion Statistics 2013: England and Wales, Department of Health 2013
The Pregnancy Advisory Service at Derriford carries out terminations up to 13 weeks and six days of gestation. During 2014/15 four women were referred to the British Pregnancy Advisory Service (BPAS) clinic based at Mount Gould Hospital. A further 25 referrals were made to the Marie Stopes International clinic in Bristol that offers procedures for gestations of 14 weeks and above.

### 8.5 The Zone

There were 9,720 visits by young people to the sexual health services of the Zone in 2014/15, from a total of 4,206 individuals.

#### Table 16: Demographics of Plymouth residents accessing the Zone, 2013/14 and 2014/15

<table>
<thead>
<tr>
<th></th>
<th>2013/14</th>
<th></th>
<th>2014/15</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
</tr>
<tr>
<td>Total individuals</td>
<td>4,634</td>
<td></td>
<td>4,206</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1,100</td>
<td>23.7</td>
<td>933</td>
<td>22.2</td>
</tr>
<tr>
<td>Female</td>
<td>3,521</td>
<td>76.0</td>
<td>3,263</td>
<td>77.6</td>
</tr>
<tr>
<td>Other</td>
<td>11</td>
<td>0.24</td>
<td>10</td>
<td>0.24</td>
</tr>
<tr>
<td>Missing gender</td>
<td>2</td>
<td>0.04</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Ethnicity non-White British</td>
<td>394</td>
<td>8.5</td>
<td>376</td>
<td>8.9</td>
</tr>
<tr>
<td>Ethnicity not recorded</td>
<td>25</td>
<td>0.5</td>
<td>15</td>
<td>0.4</td>
</tr>
<tr>
<td>13-16 year olds</td>
<td>886</td>
<td>19.1</td>
<td>784</td>
<td>18.6</td>
</tr>
<tr>
<td>17-19 year olds</td>
<td>1,782</td>
<td>38.5</td>
<td>1,486</td>
<td>35.3</td>
</tr>
<tr>
<td>20-24 year olds</td>
<td>1,819</td>
<td>39.3</td>
<td>1,778</td>
<td>42.2</td>
</tr>
<tr>
<td>25 years</td>
<td>147</td>
<td>3.2</td>
<td>156</td>
<td>3.7</td>
</tr>
<tr>
<td>Missing age</td>
<td>0</td>
<td>0.0</td>
<td>2</td>
<td>0.05</td>
</tr>
<tr>
<td>Number of visits</td>
<td>8,785</td>
<td></td>
<td>9,720</td>
<td></td>
</tr>
</tbody>
</table>

Percentages may not add to 100.0 due to rounding
Source: The Zone yearly compare data, provided 2015

Despite the number of individuals decreasing from 2013/14 to 2014/15 the actual number of visits has increased by 10.6% (935 more visits) over the same time period.

Most clients came from the PL4 and PL1 postcode districts of the city (Figure 29; note varying proportions of the PL5 to PL9 districts lay outside of the Plymouth city boundary). There were also 489 individuals from Devon, Cornwall, and further afield accessing the service.
In 2014/15 the primary reason for accessing the services on 2,423 occasions was to receive free condoms. Advice (1,567 appointments), chlamydia testing, (1,442 tests) and supply of the combined oral contraceptive pill (1,025 occasions) were also common reasons for visits.

Over the last two years the age profile of young people accessing services at the Zone has been similar. The biggest change has been the decrease in the proportion of 16-19 year olds and the increase in those aged 20 years (Figure 32). The percentage of 16-18 year olds accessing the service has decreased from 48.6% in 2013/14 to the latest 2014/15 value of 45.0% whilst those aged 20 have increased from 11.5% to 13.5%.
Figure 32: Age profile of those accessing The Zone, 2013/14 and 2014/15 (%)

Source: The Zone yearly compare data, provided 2015

8.6 Chlamydia Screening Programme

Table 17: National Chlamydia Screening Programme total screens in Plymouth, 2011/12 to 2014/15

<table>
<thead>
<tr>
<th>Service/location</th>
<th>2011/12 Number</th>
<th>%</th>
<th>2012/13 Number</th>
<th>%</th>
<th>2013/14 Number</th>
<th>%</th>
<th>2014/15 Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCaSH Cumberland Centre</td>
<td>127</td>
<td>2.3</td>
<td>80</td>
<td>1.5</td>
<td>87</td>
<td>1.6</td>
<td>81</td>
<td>1.6</td>
</tr>
<tr>
<td>CCaSH The Zone</td>
<td>1,524</td>
<td>27.6</td>
<td>1,676</td>
<td>30.5</td>
<td>1,870</td>
<td>33.7</td>
<td>1,623</td>
<td>31.5</td>
</tr>
<tr>
<td>Chlamydia Screening Office</td>
<td>75</td>
<td>1.4</td>
<td>38</td>
<td>0.7</td>
<td>67</td>
<td>1.2</td>
<td>34</td>
<td>0.7</td>
</tr>
<tr>
<td>GP surgeries (incl. University MC)</td>
<td>1,132</td>
<td>20.5</td>
<td>1,184</td>
<td>21.5</td>
<td>1,170</td>
<td>21.1</td>
<td>850</td>
<td>16.5</td>
</tr>
<tr>
<td>Military services</td>
<td>142</td>
<td>2.6</td>
<td>117</td>
<td>2.1</td>
<td>99</td>
<td>1.8</td>
<td>31</td>
<td>0.6</td>
</tr>
<tr>
<td>Other (including CCaSH other)</td>
<td>50</td>
<td>0.9</td>
<td>13</td>
<td>0.2</td>
<td>34</td>
<td>0.6</td>
<td>52</td>
<td>1.0</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>662</td>
<td>12.0</td>
<td>528</td>
<td>9.6</td>
<td>504</td>
<td>9.1</td>
<td>405</td>
<td>7.9</td>
</tr>
<tr>
<td>Universities/colleges</td>
<td>657</td>
<td>11.9</td>
<td>483</td>
<td>8.8</td>
<td>206</td>
<td>3.7</td>
<td>379</td>
<td>7.4</td>
</tr>
<tr>
<td>Web-based</td>
<td>986</td>
<td>17.9</td>
<td>1,302</td>
<td>23.7</td>
<td>1,414</td>
<td>25.5</td>
<td>1,682</td>
<td>32.6</td>
</tr>
<tr>
<td>Youth centre clinics</td>
<td>166</td>
<td>3.0</td>
<td>83</td>
<td>1.5</td>
<td>94</td>
<td>1.7</td>
<td>16</td>
<td>0.3</td>
</tr>
<tr>
<td>Total</td>
<td>5,521</td>
<td>-</td>
<td>5,504</td>
<td>-</td>
<td>5,545</td>
<td>-</td>
<td>5,153</td>
<td>-</td>
</tr>
</tbody>
</table>

Percentages may not add to 100.0 due to rounding; assumption of no repeat screens. This locally recorded
data does not correlate with CTAD data shown in Table 2 due to different time periods recorded and different approaches to reporting that have now been resolved
Includes individuals with missing/unknown postcodes and with postcodes outside of Plymouth
Source: NHS Plymouth Chlamydia Screening Office

Table 17 demonstrates that testing is available across a variety of locations and services within Plymouth, providing a good range of choice for young people. CCaSH clinics at The Zone, web-based services, and testing at GP surgeries have accounted for the majority of the screens each year. Web-based testing has seen the largest percentage point increase since 2011/12, from 17.9% to 32.6% in 2014/15. The largest decrease, from 11.9% to 7.4%, is evident in testing undertaken at universities/colleges.

Table 18: NCSP screen profile for Plymouth, 2011/12 to 2014/15

<table>
<thead>
<tr>
<th></th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
</tr>
<tr>
<td>Total screens</td>
<td>5,521</td>
<td>-</td>
<td>5,504</td>
<td>-</td>
</tr>
<tr>
<td>Non-Plymouth residents</td>
<td>300</td>
<td>5.4</td>
<td>166</td>
<td>3.0</td>
</tr>
<tr>
<td>Missing/invalid postcodes</td>
<td>356</td>
<td>6.5</td>
<td>382</td>
<td>6.9</td>
</tr>
<tr>
<td>Plymouth residents</td>
<td>4,865</td>
<td>88.1</td>
<td>4,956</td>
<td>90.0</td>
</tr>
<tr>
<td>15-16 years *</td>
<td>589</td>
<td>12.1</td>
<td>540</td>
<td>10.9</td>
</tr>
<tr>
<td>17-18 years *</td>
<td>1,057</td>
<td>21.7</td>
<td>1,122</td>
<td>22.6</td>
</tr>
<tr>
<td>19-20 years *</td>
<td>1,489</td>
<td>30.6</td>
<td>1,632</td>
<td>32.9</td>
</tr>
<tr>
<td>21-22 years *</td>
<td>1,075</td>
<td>22.1</td>
<td>980</td>
<td>19.8</td>
</tr>
<tr>
<td>23-24 years *</td>
<td>650</td>
<td>13.4</td>
<td>673</td>
<td>13.6</td>
</tr>
<tr>
<td>25 years and over *</td>
<td>4</td>
<td>0.08</td>
<td>5</td>
<td>0.1</td>
</tr>
<tr>
<td>Missing/invalid age *</td>
<td>1</td>
<td>0.02</td>
<td>1</td>
<td>0.02</td>
</tr>
<tr>
<td>Positive *</td>
<td>395</td>
<td>8.1</td>
<td>441</td>
<td>8.9</td>
</tr>
<tr>
<td>Negative *</td>
<td>4,470</td>
<td>91.9</td>
<td>4,515</td>
<td>91.1</td>
</tr>
</tbody>
</table>

Percentages may not add to 100.0 due to rounding; assumption of no repeat screens
* Plymouth residents only
Source: NHS Plymouth Chlamydia Screening Office

There have been over 5,000 NCSP screens in Plymouth each year since 2011/12 (Table 18). The percentage of these which have a valid postcode and are Plymouth residents has remained around 90%, whilst those with a valid but non-Plymouth postcode has decreased from 5.4% to 4.9%.
In 2014/15 the group most often screened by the NCSP were the 19 and 20 year olds. This group has had the most screens over the last four years.

The percentage of Plymouth residents testing positive for chlamydia has risen each year between 2011/12 and 2013/14. The latest 2014/15 value (8.6%) is a 1.4 percentage point decrease since the previous year. This decrease however could well be, in part, an artefact of the increase in missing/incorrect postcodes and non-Plymouth residents being tested.

Table 19 details the profile of those NCSP screens which tested positive. The percentage of 15 and 16 year olds testing positive has increased by 3.9 percentage points between 2011/12 and 2014/15 whilst the percentage of 21 and 22 year olds decreased by 4.8 percentage points.

Table 19: Profile of NCSP chlamydia positive screens, numbers and percentages, 2011/12 to 2014/15

<table>
<thead>
<tr>
<th></th>
<th>2011/12</th>
<th></th>
<th>2012/13</th>
<th></th>
<th>2013/14</th>
<th></th>
<th>2014/15</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
</tr>
<tr>
<td>Total positive screens</td>
<td>424</td>
<td>-</td>
<td>479</td>
<td>-</td>
<td>560</td>
<td>-</td>
<td>447</td>
<td>-</td>
</tr>
<tr>
<td>Non-Plymouth residents</td>
<td>19</td>
<td>4.5</td>
<td>10</td>
<td>2.1</td>
<td>19</td>
<td>3.4</td>
<td>26</td>
<td>5.8</td>
</tr>
<tr>
<td>Missing/invalid postcodes</td>
<td>10</td>
<td>2.4</td>
<td>28</td>
<td>5.8</td>
<td>40</td>
<td>7.1</td>
<td>22</td>
<td>4.9</td>
</tr>
<tr>
<td>Plymouth residents</td>
<td>395</td>
<td>93.2</td>
<td>441</td>
<td>92.1</td>
<td>501</td>
<td>89.5</td>
<td>399</td>
<td>89.3</td>
</tr>
<tr>
<td>15-16 years *</td>
<td>26</td>
<td>6.6</td>
<td>45</td>
<td>10.2</td>
<td>52</td>
<td>10.4</td>
<td>42</td>
<td>10.5</td>
</tr>
<tr>
<td>17-18 years *</td>
<td>85</td>
<td>21.5</td>
<td>108</td>
<td>24.5</td>
<td>108</td>
<td>21.6</td>
<td>81</td>
<td>20.3</td>
</tr>
<tr>
<td>19-20 years *</td>
<td>133</td>
<td>33.7</td>
<td>147</td>
<td>33.3</td>
<td>180</td>
<td>35.9</td>
<td>139</td>
<td>34.8</td>
</tr>
<tr>
<td>21-22 years *</td>
<td>95</td>
<td>24.1</td>
<td>93</td>
<td>21.1</td>
<td>99</td>
<td>19.8</td>
<td>77</td>
<td>19.3</td>
</tr>
<tr>
<td>23-24 years *</td>
<td>54</td>
<td>12.9</td>
<td>48</td>
<td>10.9</td>
<td>61</td>
<td>12.2</td>
<td>60</td>
<td>15.0</td>
</tr>
<tr>
<td>25 years and over *</td>
<td>1</td>
<td>0.3</td>
<td>0</td>
<td>0.0</td>
<td>1</td>
<td>0.2</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Missing/invalid age *</td>
<td>1</td>
<td>0.3</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Percentages may not add to 100.0 due to rounding; assumption of no repeat screens
* Plymouth residents only
Source: NHS Plymouth Chlamydia Screening Office
In 2014/15 the highest percentages of 15-24 year olds tested were in the neighbourhoods of City Centre (19.1%), Stonehouse (15.6%), and Greenbank and University (14.6%).

The highest percentages of those screened that subsequently tested positive for chlamydia were seen in the neighbourhoods of Leigham and Mainstone (19.2%); Colebrook, Newnham & Ridgeway (13.0%); and Plympton St Maurice & Yealmpton (12.9%).
8.7 HIV-related care

The rate of persons accessing HIV related care provides the best estimate of HIV prevalence available. The number of persons receiving HIV-related treatment or care is collected by the Survey of Prevalent HIV Infections Diagnosed (SOPHID). SOPHID is a cross-sectional survey of all persons who attend for HIV-related care at an NHS site in England, Wales and Northern Ireland within a calendar year. Scottish data collected by Health Protection Scotland and paediatric data (children aged under-15) are included in the final UK totals.

In 2014 there were 85,489 people diagnosed with a HIV infection who received care in the UK. This represents a 5% increase from the previous year and is over double the number of people receiving care a decade ago (41,160 in 2004). An increase in the number of new diagnoses in those aged 50 and over (590 in 2003 compared to 970 in 2014) and an ageing cohort due to effective antiretroviral therapies has led to a disproportionate rise in the number of people accessing care aged 50 years and over. Almost half (48%, 40,834) of all people seen for HIV care in 2014 were aged 45 and over, up from 25% over the past decade, whilst those aged 55 or over and 65 or over now account for 15% and 4% respectively.

As seen in Figure 34 the overall number of persons accessing HIV-related care in Plymouth is has increased steadily since 2009.

Figure 34: Numbers of persons accessing HIV-related care in Plymouth (all ages), 2008 to 2013

Source: SOPHID data, Public Health England Colindale

Of the 210 people accessing care for HIV-related illness across Plymouth in 2013 the highest numbers were seen in the PL1 postcode district. In terms of deprivation the biggest proportion was seen in the most deprived quintile (for reasons of confidentially data are not shown).\textsuperscript{96}

\textsuperscript{95} HIV New Diagnoses, Treatment and Care in the UK 2015 report, PHE. November 2015.
\textsuperscript{96} SOPHID data PHE Colindale, June 2015
Males accounted for the majority (73%; 154 individuals) of those accessing care in Plymouth in 2013. The highest proportion of those receiving care were in the 35-49 year old age-group (45.2%; 95 individuals) and individuals were mainly of a white ethnic background (74.3%; 156 individuals).°°

The overall increase in diagnoses means the numbers accessing care has increased over the last five years. Of those seeking care in 2013 the majority were men who have sex with men.°° Since 2009 the proportion of MSM in Plymouth accessing HIV-related care has increased from 44.8% to 54.3% in 2013.°°

Exposure via the heterosexual route accounted for 37.6% of those seeking care in 2013. Each year, for the last five, there have been approximately twice the numbers of heterosexual women seen for care compared to heterosexual men. When looking at the proportions by age-group the biggest increase, of 4.5 percentage points; from 20.7% in 2009 to 25.2% in 2013, has been seen in those aged 50 years and over.

Of the 210 individuals accessing care in 2013, 89.0% were receiving anti-retroviral therapy at the time seen.°°

This local data suggest that demand for HIV care services will continue to rise.

8.8 The Eddystone Trust

The Eddystone Trust provides HIV prevention services, HIV Point of Care testing, advocacy, care and support services. They also co-ordinate a citywide C-Card free condom distribution scheme and a young people quality assurance scheme called SAFE.

From April 2013 to March 2015 the number of people receiving support services, including those with a structured support plan has risen significantly. A review of caseloads and the categorisation of client need show that there are an increasing number of clients with lower levels of need.

Table 20: Support services for people living with HIV, 2013/14 to 2014/15

<table>
<thead>
<tr>
<th>Numbers/percentage</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
</tr>
<tr>
<td>Total number of clients receiving a service</td>
<td>54</td>
<td>55</td>
</tr>
<tr>
<td>Number of clients with structured support plan</td>
<td>36</td>
<td>37</td>
</tr>
<tr>
<td>Service users with a high level of need (%)</td>
<td>77</td>
<td>80</td>
</tr>
<tr>
<td>Service users with a medium level of need (%)</td>
<td>17</td>
<td>20</td>
</tr>
<tr>
<td>Service users with a low level of need (%)</td>
<td>6</td>
<td>0</td>
</tr>
</tbody>
</table>

°° SOPHID data, PHE Colindale, provided June 2015
In 2014/15 between 31% and 48% of those receiving structured support services were assessed as having a high level of need. More than twice as many men than women were receiving support services. Overall the most common presenting needs were health and medical issues. In addition the number of clients presenting with needs relating to finances, welfare benefits, and housing issues during 2014/15 increased significantly.

Table 21: Age and gender profile of HIV support service users, 2014/15

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
</tr>
<tr>
<td>Total clients receiving a service</td>
<td>77</td>
<td>80</td>
<td>80</td>
<td>83</td>
</tr>
<tr>
<td>Under 25</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>25-34 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>13</td>
<td>13</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>35-44 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>17</td>
<td>17</td>
<td>18</td>
</tr>
<tr>
<td>45-54 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>18</td>
<td>19</td>
<td>19</td>
<td>21</td>
</tr>
<tr>
<td>55 years and over</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>12</td>
<td>12</td>
<td>14</td>
</tr>
<tr>
<td>Not declared</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>9</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>Males</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>54</td>
<td>56</td>
<td>56</td>
<td>59</td>
</tr>
<tr>
<td>Females</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>22</td>
<td>21</td>
<td>21</td>
<td>21</td>
</tr>
<tr>
<td>Transgender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

The Eddystone Trust also provides sexual health and HIV prevention advice and information through telephone contact and contact at a range of community events. During 2014/15 there were a total of 2,123 contacts via telephone and community events. During 2013/14 the service distributed a total of 24,017 condoms. This rose 6.5% to 25,615 in 2014/15.

From 2013 the service has been delivering the Sexual Health Outreach Project for people involved in street sex work in the Stonehouse area of the city. From April 2013 to March 2015 this service provided support to between 17 and 38 individuals every quarter.

Table 22: Sexual Health Outreach Project, 2013/14 to 2014/15

<table>
<thead>
<tr>
<th>Numbers of...</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach sessions</td>
<td>85</td>
<td>85</td>
</tr>
<tr>
<td>Individuals seen (average per quarter)</td>
<td>24</td>
<td>37</td>
</tr>
<tr>
<td>Advice and information interventions</td>
<td>68</td>
<td>414</td>
</tr>
</tbody>
</table>

The C-CARD scheme provides free condoms and sexual health advice from 47 sites across the city to people under-25 years that are registered with the scheme. During 2014/15 over 5,000 under 25s were registered with the scheme and almost 40,000 condoms were distributed. This is a significant increase on the 30,834 condoms distributed through the scheme in 2013/14.

The SAFE badge is a quality assurance standard based on the ‘You’re Welcome’ quality framework initiated by the Department of Health in 2007 that ensures services are ‘young people friendly’. The badge is awarded to services that are able to demonstrate that they meet a range of criteria including accessibility, confidentiality and consent, and accessibility.
There are currently 29 services that have been accredited with the SAFE badge in Plymouth.

The training programme delivered by the Eddystone Trust is directed towards staff working within the health, social care, youth, and education workforce. It provides a structured modular programme covering issues such as teenage pregnancy, contraception choices and hepatitis awareness. In 2013/14 158 people from services across Plymouth participated in the training programme. In 2014/15 this increased to 264 people (an increase of 67%).

8.9 Sexual Assault Referral Centre (SARC)

The SARC in Plymouth is commissioned to provide the following services:

- Plymouth SARC acute Forensic Medical Suite (for aged 16 years and above).
- Crisis intervention to support victims through Forensic Medical Examination.
- Independent Sexual Violence Advisor (ISVA) providing information, guidance and support through the criminal justice process and at court.

The service also receives funding to provide:

- Solution focused counselling for adults aged 18 years and over and pre-trial therapy.
- Art psychotherapy for children and young people aged 18 years and under.

Figure 35: Plymouth SARC referrals, 2012/13 to 2014/15

Figure 35 shows the number of referrals to the different components of the service. Between 2012/13 and 2014/15 there has been a 26% reduction in referrals to the SARC forensic suite. Analysis of this reduction found that there was a lack of clarity regarding service eligibility criteria from referring agencies. The service has also been closed to self-referrals since October 2014 due to issues concerned with the Human Tissue Act and the storage of evidence.

Between 2012/13 and 2013/14 there was a 28% increase in the number of referrals to the ISVA service. The service also reports that the level of complexity in referred cases has increased over time. The counselling service has seen a year-on-year increase in number of referrals with a 10% increase from 2013/14 to 2014/15. There was a 100% increase in the
number of referrals to the Art Therapy Service between 2013/14 and 2014/15. These increases can, in part, be explained by a number of high profile sexual abuse cases and the establishment of the Independent Inquiry into Child Sexual Abuse in 2014.

Figure 36: Age profile of those accessing Plymouth SARC (all services), 2012/13 to 2014/15

![Age profile chart](image)

Figure 36 shows the age breakdown of those accessing all components of the SARC service over the last three years. Overall the numbers in each age group, and hence the totals, have increased. Those aged 25 years, the largest group of each year, has seen the biggest increase in numbers; from 225 in 2012/13 to 269 in 2014/15, a 20% increase.

**Summary: sexual health service activity and uptake**

- Between 2013/14 and 2014/15 the number of people attending the CCaSH service increased by 3%. The number of IUCD devices fitted at CCaSH during that time remained fairly static. The number of contraceptive implants fitted across those years decreased by 10%.

- Between 2013-14 and 2014-15 there was a significant decrease in the number of IUS/IUDs fitted in General Practice.

- The number of dispensations from community pharmacies for free EHC for 13-24 year olds increased by 20% from 2013/14 to 2014/15.

- The overall demand for GUM services have increased between 2010/11 and 2014/15. Almost 30% more women than men attended Derriford GUM service in 2014/15. 18-24 year olds are the most frequent users of GUM services. A significant number of Plymouth residents use out of area sexual health services.

- The overall number of abortions carried out at Derriford Hospital has decreased year on year since 2011/12. The percentage of terminations carried out at less than 10 weeks gestation has increased from 52% in 2010/11 to 80% in 2014/15. 31% of the abortions carried out in 2014/15 were medical a slight decrease in the previous year but an overall 14% increase from 2010/11.
• During 2014/15 there were a total of 9,720 visits by young people to the Zone for sexual health services, from 4,206 people. Almost 80% of those using the service were female. The primary reason for accessing the services on 2,423 occasions was to receive free condoms. Advice (1,567 appointments), chlamydia testing, (1,442 tests) and supply of the combined oral contraceptive pill (1,025 occasions) were also common reasons for visits. The age profile of those accessing services at the Zone has changed in recent years. The percentage of 16-18 year olds accessing the service has decreased from 48.6% in 2013/14 to the latest 2014/15 value of 45.0% whilst those aged 20 have increased from 11.5% to 13.5%.

• Chlamydia screening for sexually active under-25 year olds is available in a number of locations. Web based testing, testing at the Zone, and through GPs account for the majority of screens. There was an overall 7% decrease in the number of screens between 2012/13 – 2013/14.

• The number of people accessing treatment and care for HIV has steadily increased year on year from 2009. In 2013 210 people were receiving care from Derriford Hospital; 73% were men and the highest proportion was in the 35-49 age group and 89% were receiving anti-retroviral therapy. From 2009 to 2013 the largest increase in those accessing care was seen amongst those aged 50 years and over.

• From March 2013 to March 2015 the number of people living with HIV receiving support services from the Eddystone Trust increased from 54 to 83. In 2014/15 between 31% and 48% of those receiving structured support services were assessed as having a high level of need. More than twice as many men as women received structured support services. The most common presenting needs were in relation to health and medical needs and there was a significant increase in the number of people presenting with needs relating to finances and welfare benefits.

• During 2014/15 there were a total of 2,123 sexual health and HIV prevention, advice and information contacts delivered through telephone contact and community events by the Eddystone Trust.

• In 2013/14 the Eddystone Trust distributed 24,017 condoms. This rose by 6.5% in 2014/15 to 25,615. Additionally 40,000 condoms were distributed to under 25’s through the C-CARD scheme in 2014/15, a 30% increase on the number distributed through the scheme in 2013/14.

• Between 2012/13 and 2013/14 the overall number of referrals to the SARC services increased. Over that time there was a 28% increase in referrals to the Independent Sexual Violence Advisor service. However there was a 26% reduction in referrals to the SARC forensic suite.
9. Service user and stakeholder views

Specific service user consultation has not been undertaken as part of the development of this sexual health needs assessment. This section draws on views gathered from routine service patient satisfaction surveys, other relevant local surveys, and consultation with key service providers.

9.1 Service users

A survey of people using 12 GUM services in the South West region is undertaken annually. Responses (a total of 50) from the survey undertaken in January 2015 at the GUM service at Derriford reported high levels of satisfaction. 100% of respondents rated the care they received as ‘excellent’ or ‘very good’ and would recommend the service to others. 95% felt the booking processes were easy to follow and 97% were seen within 30 minutes of their appointment time. However, only 50% of first time users reported that the clinic was easy to find.

A HIV patient satisfaction survey is undertaken every two years with people receiving specialist treatment and support at Derriford Hospital. The most recent survey in 2013 took a random sample of 42 patients. High levels of satisfaction were reported with 98% of people rating their care as excellent. 81% of respondents reported that they could ‘always’ get in touch with the clinic when they needed to and 17% responded that they could ‘sometimes’ get in touch.

CCASH undertakes an annual patient satisfaction survey that asks respondents a number of questions about the quality of the service they have received. The most recent survey in March 2015 received responses from 53 service users and indicated high levels of satisfaction (90% or above) with all aspects of the service. Over 98% of respondents felt that the treatment location was convenient and that the treatment they received was explained well and that they were treated with respect and dignity. Nearly 95% felt that the time they waited for an appointment was acceptable. 100% of respondents would recommend that the service to others.

The Zone carried out a service user satisfaction survey in May 2015 and received 64 responses. These indicated high levels of satisfaction with 98.5% of respondents reporting that the way their enquiry was dealt with was excellent. 95% reported that the way the worker explained the information, confidentiality, and consent was excellent and 92.5% would recommended the Zone to others as an excellent service. Over 90% felt the reception they received was excellent but 24% of respondents felt that the reception area itself was ‘average’.

9.2 Service providers

During the drafting of this needs assessment there have been a number of structured discussions with service providers focussing on various aspects of need, current service provision and opportunities for service development. The key themes of those discussions are described below.
• Strategic direction and commissioning arrangements could be strengthened to ensure that the system is responding to local intelligence and evidence.
• A defined communications plan for the system would support co-ordination of messages, service provision and sexual health promotion activity.
• Services and pathways could be developed to ensure that wherever possible sexual health and contraception needs are met at one site within one consultation.
• The system would benefit from a more structured approach to workforce development to support the right skill mix for integrated working.
• Care pathways need to be clearly defined and accessible, particularly to the most vulnerable and in need populations.
• Governance arrangements, particularly for inter-agency working could be further developed to ensure minimum standards are employed and risk is appropriately managed.
• The system could develop an improved response to working with more complex clients, including young people with risk taking behaviours, who are frequent users of sexual health services.

Other more specific service development opportunities were also identified and include:

• An enhanced offer re HIV testing in community settings.
• Improved access to elective and emergency LARC fitting.
• Provision of education and information for young people could be improved – including oversight and assurance around sex and relationship education.
• The role of school nursing could be improved in relation to young people’s sexual health and well-being.
• The SARC could be more integrated into the broader sexual health system.
• Local provision of abortions for later gestations.

9.3 Schools Health Related Behaviour Survey 2014

The Schools Health Related Behaviour Survey was carried out during the spring and summer terms of 2014 with a total of 3,749 pupils in Year 8 (ages 12-13) and Year 10 (ages 14-15). The survey asked young people questions on a number of health related topics including sexual health. Responses to questions about sexually transmitted infections showed that 44% of pupils correctly identified that HIV/AIDS can be treated but not cured and only 16% correctly identified that herpes can also be treated but not cured.

47% of year 10 pupils responded that they have not had sex, but have thought about what form of contraception they would use in the future and 64% of year 10’s responded they know where to get information about contraception locally. Of the year 10 pupils who have had sex 53% responded that they always used contraception.
10. Commissioning framework

Plymouth City Council and NHS Northern Eastern and Western Devon Clinical Commissioning Group are working together to commission an integrated system for population health and wellbeing. One system, one budget aims to deliver the right care, at the right time in the right place. The aims of this approach are:

- To improve health and wellbeing outcomes for the local population
- To reduce inequalities in health and wellbeing of the local population
- To improve people’s experience of care
- To improve the sustainability of the health and wellbeing system

The approach has individuals at the centre and acknowledges the various priorities that are important to people who access services in Plymouth.

System wide transformational drivers
There are a number of cross cutting themes that run through the whole system and are essential in developing and delivering whole system success, illustrated below as system wide transformational drivers.

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98 Commissioning an integrated system for population health and wellbeing. Plymouth City Council and NEW Devon Clinical Commissioning Group. 2015.
A future model of sexual and reproductive health provision in Plymouth needs to provide an integrated service that supports people to be and stay healthy through an enhanced focus on primary prevention, early intervention and planned care including medicines and new technology optimisation.

Plymouth City Council and NEW Devon Clinical Commissioning Group will commission from providers who have a clear and proactive approach to health improvement, prevention of ill-health and whole person wellbeing and working with the wider community in which they operate.

An integrated model of sexual and reproductive health services in Plymouth needs to be outcome focussed giving clear priority to

Reducing the rate of sexually transmitted infections and re-infections
- Providing timely access for testing and treatment
- Ensuring robust contact tracing and partner notification

Improving the detection rate in chlamydia diagnosis in 15-24 year olds
- Providing testing in a number of settings
- Increasing testing in high risk populations and geographies with low detection
• Ensuring robust contact tracing and partner notification

*Reducing the late diagnosis of HIV*
• Improving the offer and uptake of HIV testing in relevant settings
• Enhancing prevention and outreach initiatives for high risk groups and communities

*Reducing the number of teenage conceptions*
• Increasing the accessibility of all forms of contraception for young people
• Increasing prevention and outreach initiatives for individuals and groups at high risk of teenage conceptions

*Reducing the rate of terminations, particularly repeat terminations in all age groups*
• Increasing the offer and uptake of all forms of contraception especially Long Acting Reversible Contraception
• Ensuring termination services provide comprehensive contraception services
• Delivering bespoke services to vulnerable and high risk individuals

*Reducing inequalities in sexual health outcomes*
• Targeting prevention work to high risk individuals and communities including those experiencing sexual exploitation, coercion and domestic abuse
• Ensuring that services are equipped to respond to multiple risk behaviours
• Using intelligence and evidence to direct approaches and responses
### 11. Existing service provision

Table 23: Plymouth City Council commissioned services

<table>
<thead>
<tr>
<th>Provider</th>
<th>Service</th>
<th>Commissioner</th>
<th>Annual contract value</th>
<th>Contract expiry date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plymouth Hospitals NHS Trust</td>
<td>Genito Urinary Medicine</td>
<td>ODPH</td>
<td>£1,820,895.94</td>
<td>March 2016</td>
</tr>
<tr>
<td>Plymouth Community Healthcare</td>
<td>Community Contraception and Sexual Health Service (CCASH)</td>
<td>ODPH</td>
<td>£901,240</td>
<td>March 2016</td>
</tr>
<tr>
<td>The Eddystone Trust</td>
<td>Community HIV and sexual health services</td>
<td>ODPH &amp; Adult Social Care</td>
<td>£218,089</td>
<td>March 2016</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>This includes:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>£156,589 – ODPH</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>£61,500 – Plymouth City Council Cooperative Commissioning</td>
<td></td>
</tr>
<tr>
<td>The Zone</td>
<td>Young people’s sexual health services</td>
<td>ODPH</td>
<td>£62,480</td>
<td>March 2016</td>
</tr>
<tr>
<td>Primary Care - General Practice</td>
<td>Enhanced sexual health services – including contraception, chlamydia screening and treatment</td>
<td>ODPH</td>
<td>£100,642.94 (total spend 2014/15)</td>
<td>March 2016</td>
</tr>
<tr>
<td>Community Pharmacies</td>
<td>Enhanced sexual health services for EHC and chlamydia screening and treatment</td>
<td>ODPH</td>
<td>£17,508 (total spend 2014/15)</td>
<td>March 2016</td>
</tr>
<tr>
<td>Peverell Park Surgery</td>
<td>GP with special interest</td>
<td>ODPH</td>
<td>£27,000</td>
<td>March 2016</td>
</tr>
<tr>
<td>Various including North Devon Healthcare Trust (cross charging)</td>
<td>Out of area access to SH services</td>
<td>ODPH</td>
<td>£53,000</td>
<td>On-going</td>
</tr>
<tr>
<td><strong>Total Plymouth City Council investment</strong></td>
<td></td>
<td></td>
<td><strong>£3,200,855.88</strong></td>
<td></td>
</tr>
</tbody>
</table>

*ODPH = Office of the Director of Public Health*
### Table 24: Other commissioned services

<table>
<thead>
<tr>
<th>Provider</th>
<th>Service</th>
<th>Commissioner</th>
<th>Annual Contract Value</th>
<th>Contract Expiry Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plymouth Hospitals NHS Trust</td>
<td>HIV treatment and care</td>
<td>NHS England – specialised commissioning</td>
<td>£207,448</td>
<td>Not defined</td>
</tr>
<tr>
<td>Plymouth Hospitals NHS Trust</td>
<td>Pregnancy Advisory Service - abortion services</td>
<td>NEW Devon Clinical Commissioning Group</td>
<td>£439,401</td>
<td>Not defined</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>£24,756 (BPAS)</td>
<td></td>
</tr>
<tr>
<td>Primary Care - General Practice</td>
<td>IUCD for non-contraception services</td>
<td>NEW Devon Clinical Commissioning Group</td>
<td>£16,989.33</td>
<td>Not defined</td>
</tr>
<tr>
<td>Primary Care - General Practice –</td>
<td>Contraception</td>
<td>NHS England (as part of financial baseline of PMS</td>
<td>£25,294.39</td>
<td>Not defined</td>
</tr>
<tr>
<td>PMS Practices</td>
<td></td>
<td>practices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Twelve’s Company</td>
<td>Sexual Assault Referral Centre</td>
<td>NHS England – specialised commissioning and Police</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>and Crime Commissioner</td>
<td>£162,000</td>
<td>Not defined</td>
</tr>
</tbody>
</table>
**Glossary**

**AIDS** – Acquired Immunodeficiency Syndrome is a spectrum of conditions caused by the HIV infection

**ART** – Anti-Retroviral Therapy is a combination of drugs that suppress the HIV virus and stop the progression of HIV disease.

**BASHH** - The British Association for Sexual Health and HIV is the UK’s leading professional organisation dealing with all aspects of sexual health care.

**BME** - Black Minority Ethnic is the terminology normally used in the UK to describe people of non-white descent.

**CCaSH** – Community Contraception and Sexual Health Services provide a full range of contraceptive services, pregnancy testing and some STI testing.

**GUM** – Genito Urinary Medicine is concerned with sexual health and HIV medicine and involves the diagnosis and care of sexually transmitted infections.

**HIV** – Human Immunodeficiency Virus is a virus that attacks the immune system weakening the person’s ability to fight infections and disease. It is most commonly transmitted through unprotected sex.

**LARC** – Long Acting Reversible Contraception is the most reliable forms of contraception and includes contraceptive implants, injections and intrauterine devices and systems.

**LGBT** – Lesbian, Gay, Bisexual and Transgender and describes sexual orientation or gender identity.

**MSM** – Men who have Sex with Men includes, but is not limited to, gay men. The term acknowledges that some men who have sex with men do not identify themselves as gay.

**NCSP** – National Chlamydia Screening Programme in England was set up in 2003 to prevent and control chlamydia infection in sexually active under 25 year olds.

**NICE** – National Institute for Health and Care Excellence provides guidance, advice, quality standards and information for health, public health and social care services.

**ONS** – Office for National Statistics is an independent producer of official statistics related to the economy, population and society. It is the recognised national statistical institute for the UK.

**SARC** – Sexual Assault Referral Centres are specialist medical and forensic services for people who have been raped or sexually assaulted. Most also provide psychological and emotional support.

**SOPHID** – The Survey of Prevalent HIV Infections Diagnosed is a cross sectional survey of all persons with diagnosed HIV infection

**STI** – Sexually Transmitted Infections are infections spread primarily through person to person sexual contact. Some infections can also be transmitted from mother to child during pregnancy and childbirth and through blood products.