Five steps to Healthy Sex in Dudley

Director of Public Health Annual Report 2008

Dudley Metropolitan Borough Council

Dudley Public Health

NHS Dudley

Acknowledgements

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Introduction

My Annual Report for 2008 is devoted wholly to a strategic assessment of sexual health and services in Dudley.

Our sexual health affects both our physical and mental health and can be described as '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' (World Health Organization, 2008).

Essential elements of good sexual health are equitable relationships and sexual fulfilment with access to information and services to avoid the risk of illness, diseases and unintended pregnancy.

However, we know that sexual ill health affects certain groups of society more than others. Factors such as young age, gender, sexual orientation, and deprivation affect self-esteem and the susceptibility for risk taking behaviour. For instance, a higher number of people diagnosed with HIV are from deprived and socially excluded populations (Gilson and Mindel, 2001; British Medical Association. Board of Science and Education, 2002).

In this needs assessment I look at the epidemiology of sexually transmitted diseases, induced abortion and teenage pregnancy in Dudley (step 1); a gap analysis of services available (step 2); sexual health knowledge and behaviour, as described by different groups of people, themselves, in Dudley (step 3); the effectiveness of different interventions to improve sexual health (step 4); and what should be done to match services to need (step 5).

On the basis of this I have set out in Chapter 6 a series of detailed recommendations for action in Dudley, but the overriding key message is that sexual health services need to change. It is no longer acceptable for Dudley to have no full provision of Level 3 contraception and sexual health services. The current configuration of the CASH (Contraceptive and Sexual Health) service commissioned from Dudley Community Health Services does not meet the needs of Dudley's population and is not fully in line with national and local standards and guidance.

Primary care provisions (in General Practice and Community Pharmacies) is under developed and too few practices have staff with the requisite competencies and training. Overall, the service is fragmented and best value may not be being obtained for the taxpayer. Services are not always targeted at areas or populations of greatest need.

My overall key strategic recommendation is that sexual health services in Dudley should be recommissioned as a functionally integrated service able to provide integrated care pathways.

Valerie A. Little

Director of Public Health for Dudley

Background

Sexually Transmitted Diseases

Sexually active adolescents are the group at greatest risk of acquiring sexually transmitted diseases. Approximately 10% of men and 6% of women under 44 years report having had more than one sexual partner concurrently in the previous year. This was more likely for younger people

Sexually transmitted infections STI) are a major public health problem due to their potential serious physical and mental health outcomes. The consequences of acquiring a STI can range from mild discomfort to pelvic inflammatory disease and infertility, cervical cancer and increased risk of death as a result of HIV/AIDS.

Chlamydia trachomatis is the commonest STI in the UK. The number of infections diagnosed through genito-urinary medicine (GUM) clinics has increased in the past 10 years.

Gonorrhoea is the second most common bacterial STI in the UK. The infection causes painful urination or discharge in men but may be asymptomatic in women. The treatment is curative in 95% of cases although there has been an increase in resistance to certain antibiotics.

Since the 1990s early infectious syphilis has re-emerged in Western Europe, including the United Kingdom. Syphilis is caused by *Treponeum pallidum* bacteria. Infection during pregnancy can lead to miscarriage, stillbirth, and congenital syphilis infection. Syphilis screening is an important part of antenatal screening.

Although syphilis is less common than other sexually transmitted diseases, it remains an important public health problem because it can cause outbreaks in vulnerable populations and facilitates the transmission of HIV infection as well as causing serious ill health and death if left untreated.

The clinical presentation of syphilis is diverse with patients presenting to a wide range of practitioners and services. A high index of suspicion of syphilis and a low threshold for testing are essential (French, 2007).

Important sequelae of STIs include pelvic inflammatory disease and infertility, cervical cancer and increased susceptibility to HIV infection (Gilson and Mindel, 2001; British Medical Association. Board of Science and Education, 2002; Grant and De Cock, 2001). Undiagnosed and untreated HIV infection is a significant risk both for the health of the individual and the risk of further transmission of the disease. About one third of the estimated people living with HIV are thought to be unaware of their infection. This figure is lowest among heterosexual women due to antenatal HIV screening and highest amongst heterosexual men and injecting drug users. Many cases are diagnosed late in the course of infection resulting in potentially avoidable mortality. Significant numbers of HIV positive people are faced with problems of unemployment, poverty, social exclusion, and mental-ill health (French, 2007).

The sustained rise in diagnoses of acute STIs over the last decade is attributable to increased transmission mainly due to unsafe sexual behaviour among young heterosexual adults and men who have sex with men, greater public and professional awareness of STIs, improved access to GUM services and improvement in diagnostic sensitivity and detection practices (Gilson and Mindel, 2001).

The control of STIs has two main aims: to interrupt the transmission of infection and to prevent the development of complications and consequences of sexually transmitted diseases (Catchpole, 1996).

Induced Abortion

Induced abortion is one of the most commonly performed gynaecological procedures in the UK, with around 186,000 performed annually in England and Wales and 11,500 in Scotland.

Over 98% of induced abortions in Britain are undertaken because of the risk to physical or mental health of the woman or her child. Gestation at abortion is a reliable indicator for the responsiveness and accessibility of abortion services. The ear-

lier in pregnancy the abortion is performed, the lower the risk of complications. Surgical termination is not recommended below 7-week gestation because medical termination is more effective at this gestation. Medical termination continues to be an appropriate method for women in the 7-9 week gestation band.

The Royal College of Obstetricians and Gynaecologists (2004) recommends the following organisational elements for abortion services:

- Abortion services should have local strategies in place for providing information to women and health care professionals on the choices available within the service and on routes of access.
- Access to services should be ensured for women with special needs.
- Women considering abortion should have access to clinical assessment. Also they should be able to be assessed by a second doctor within the abortion service.
- Ideally, all women should be offered an assessment appointment within 5 days and as a minimum standard, within 2 weeks.
- As a minimum standard all women should undergo the abortion within two weeks of agreeing the decision.

Unintended Teenage Pregnancy

The United Kingdom has the highest teenage pregnancy rate in Western Europe (World Health Organization Regional Office for Europe, 2003). In England, the rate has changed very little during the last 10 years, fluctuating around 42.0 per 1000 women aged 15-17 (Office for National Statistics, 2010).

Teenage pregnancy is associated with increased risk of poor social, economic and health outcomes for both mother and child. There is substantial evidence that deprivation and social exclusion are the greatest risk factors for unintended teenage conception. Rates of teenage births in social class V (Unskilled) can be up to 10 times greater than social class I (Professional) (Dickson *et al*., 1997).

Programmes that promote access to antenatal care, targeted support by health visitors, social workers or lay mothers and provision of social support, educational opportunities and pre-school education have shown to benefit teenage mothers and their children (Dickson *et al*., 1997).

School-based sex education can be effective in reducing teenage pregnancy, especially when linked to access to contraceptive services. The most reliable evidence shows that it does not increase sexual activity or pregnancy rates. Increasing the availability of contraceptive clinics for young people is also associated with reduced pregnancy rates (Dickson *et al*., 1997).

Policy Context:

National Strategy for Sexual Health

In 2001, the Department of Health published the National Strategy for Sexual Health and HIV (Great Britain. Department of Health, 2001). The strategy aims to modernise sexual health and HIV services in England. It also addresses the rising prevalence of sexually transmitted diseases and HIV.

The specific aims of the strategy are (Great Britain. Department of Health, 2001):

- To reduce the transmission of HIV and other sexually transmitted diseases.
- To reduce the prevalence of undiagnosed cases of HIV and STIs
- To reduce the number of unintended pregnancies by 20%.
- To improve health and social care for people living with HIV/AIDS.
- To reduce the stigma associated with HIV and STIs.

The strategy emphasises the importance of involving service users in planning and provision of sexual health services.

In July 2008, the Independent Advisory Group on Sexual Health and HIV and the Medical Foundation for AIDS & Sexual Health (MedFASH) published a review of the National Strategy for Sexual Health (Medical Foundation for AIDS & Sexual Health, 2008). The review assessed the impact of the strategy to date, identified key barriers to more effective implementation and strategic areas where priority actions are needed.

The National Public Service Agreement Target

In 2000, the Government set out Public Service Agreement (PSA) on targets for sexual health. New arrangements to reduce inequalities in health were introduced in 2004 (Communities and Local Government, 2008).

Choosing Health

The Government White Paper, Choosing Health and its 2005 action plan, Delivering Choosing Health, reinforced the PSA. Choosing Health sets out the following priorities for PCTs (Great Britain. Department of Health, 2004):

- Sexual health services to be delivered in a range of community settings targeting hard to reach and vulnerable communities.
- A 50% reduction in the rate of conception by those under 18 by 2010 (compared to the 1998 baseline year) as part of a broader strategy to improve sexual health.
- 100% of patients attending GUM clinics to be offered an appointment within 48 hours by 2008.
- A decrease in the rate of newly diagnosed gonorrhoea by 2008.
- An increase in the percentage of people aged between 15 and 24 accepting screening for Chlamydia.

The Medical Foundation of Sexual Health (MedFASH)

The Department of Health has endorsed the recommended standards for HIV services and the recommended standards for sexual health services from the Medical Foundation of Sexual Health (MedFASH). However, these recommendations do not have the official mandatory status of a national service framework (Medical Foundation for AIDS & Sexual Health, 2005):

Recommended Standard 1: the development of sexual health service networks across primary care, specialist services and other NHS and non-NHS services to facilitate equitable and prompt access; coordinate between services; development of integrated care pathways; increased users choice and consistent quality of care.

Recommended Standard 2: the development of a comprehensive programme of sexual health promotion by a local multi-agency group is needed to improve sexual health knowledge and attitudes especially of hard to reach groups; address local needs and reduce inequalities

Recommended Standard 3: empowerment and involvement of service users at individual care level as well as at service planning and monitoring levels.

Recommended Standard 4: identification and monitoring of sexual health needs at regular intervals to ensure equity and expand opportunities to identify needs in a range of health care settings.

Recommended Standard 5: people should have prompt access to a full range of sexual health services and to comprehensive information on local sexual health service provision.

Recommended Standard 6: access is needed without delay to effective diagnostic services for sexually transmitted diseases. This standard is relevant for the range of services where STIs may be diagnosed and treated, including GUM, primary care and other community services.

Recommended Standard 7: people should have prompt access to accurate information about, and free provision of all

contraceptive methods, either from their chosen provider or through an integrated care pathway.

Recommended Standard 8: women should have rapid access to free and confidential pregnancy testing and act upon informed choices

Recommended Standard 9: women seeking an abortion and who meet the current legal requirement should be able to access an NHS funded service within two weeks of their first contact with a service.

Recommended Standard 10: there is a need to develop an information framework to support local planning, audit process and surveillance. The information framework needs to ensure patient confidentiality and a consistent approach to data collection.

Other Key Policy Documents

- Effective commissioning of Sexual Health and HIV Services: a Sexual Health and HIV commissioning toolkit for Primary Care Trusts and Local Authorities (Great Britain. Department of Health, 2003a)
- Recommended quality standards for sexual health training (Great Britain. Department of Health, 2005)
- Social Exclusion Unit Teenage Pregnancy Report (Great Britain. Social Exclusion Unit, 1999)

Aims and Objectives

The main aim of the needs assessment is to assess the magnitude of sexual ill health and the inequality gap, map current service provision to identify any gaps and look into the best ways of delivering effective and cost effective readily accessible Sexual Health Services (Stevens, Raftery and Mant, 2004).

The specific objectives of the needs assessment are to:

- Describe the size of sexual ill health in Dudley Borough, including sexual health inequality.
- Describe existing services available and identify the service gaps
- Collate views of service users, especially hard to reach groups on current service provision, barriers for accessing sexual health services and opportunities for future changes in service provision
- Identify effective evidence-based interventions from the literature and examples of best practice to inform sexual health service redesign and service developments in the Borough.
- Identify potential health gain.

To be able to achieve the above aims and objectives, the needs assessment is divided into the following steps (Department of Health, 2008):

Step 1: Description of Dudley population and their sexual health problems (Need)

Step 2: What health services are currently available in Dudley and what are the gaps?

Step 3: Description of sexual health knowledge and behaviour of target population in Dudley (Need through corporate needs assessment)

Step 4: What health care (and other) interventions are worth doing? (Effectiveness and cost effectiveness of sexual health services and interventions)

Step 5: What services and procedures are required to ensure sexual health care needs are met (Matching Need to Supply)

Step 1: Description of the Dudley population and their sexual health problems:

Socio-demography of Dudley PCT population

Dudley PCT is located approximately 6 miles to the west of Birmingham. Its boundary is virtually identical to that of Dudley Metropolitan Borough Council. The borough includes 3 main towns – Dudley town towards the north, and Stourbridge and Halesowen in the south. It is surrounded by 5 other PCT's – Wolverhampton to the north, Sandwell and South Birmingham to the east, Worcestershire to the south and Shropshire County to the west.

Distribution by age and sex

The population of Dudley Borough is around 305,000, split between 5 main localities. These are Dudley & Netherton, Stourbridge, Halesowen, Sedgley, and Brierley Hill.

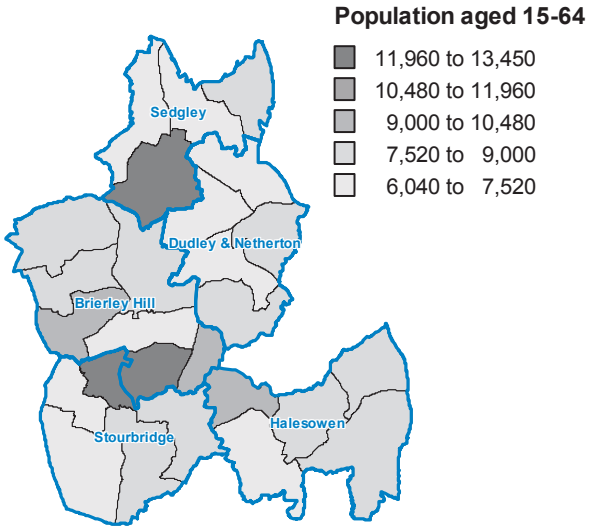
In Dudley Borough, 65% of the population are in the sexually active age band (15-64 years). Of these, over a quarter (27%) are in the Brierley Hill locality. The second highest number of sexually active people is in Dudley and Netherton. (Appendix 1, Table 1)

Figure 1 shows the distribution of the sexually active population across the borough by ward and locality. The number of sexually active people is concentrated in two main wards – Amblecote, between Stourbridge and Brierley Hill, and Gornal Wood

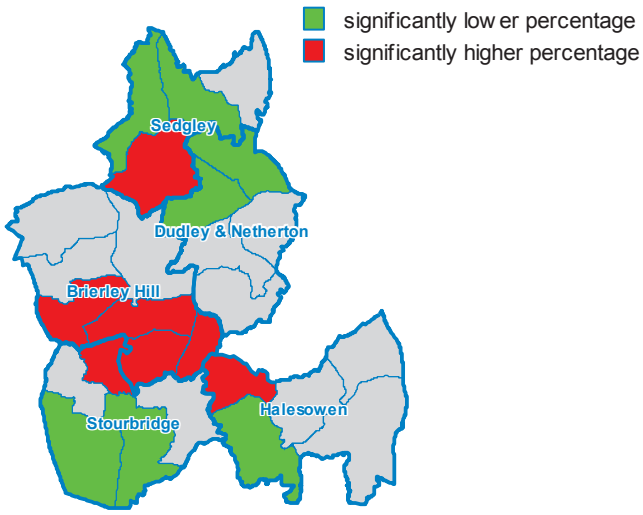
Sexual ill health is much higher among young people, aged 15-24. This group comprises 12% of the borough population. The highest percentage of these young people is in Dudley and Netherton (13.4%) and the lowest percentage is found in Sedgley (11.4%). Sedgley appears to have very high numbers aged 35-44 (Appendix 1, Table 1).

Figure 1: Sexually Active Population (Aged 15-64 years) by 200l Census Ward and Locality 2006

(a) Number of Sexually Active People



(b) Percentage of Population that is Sexually Active

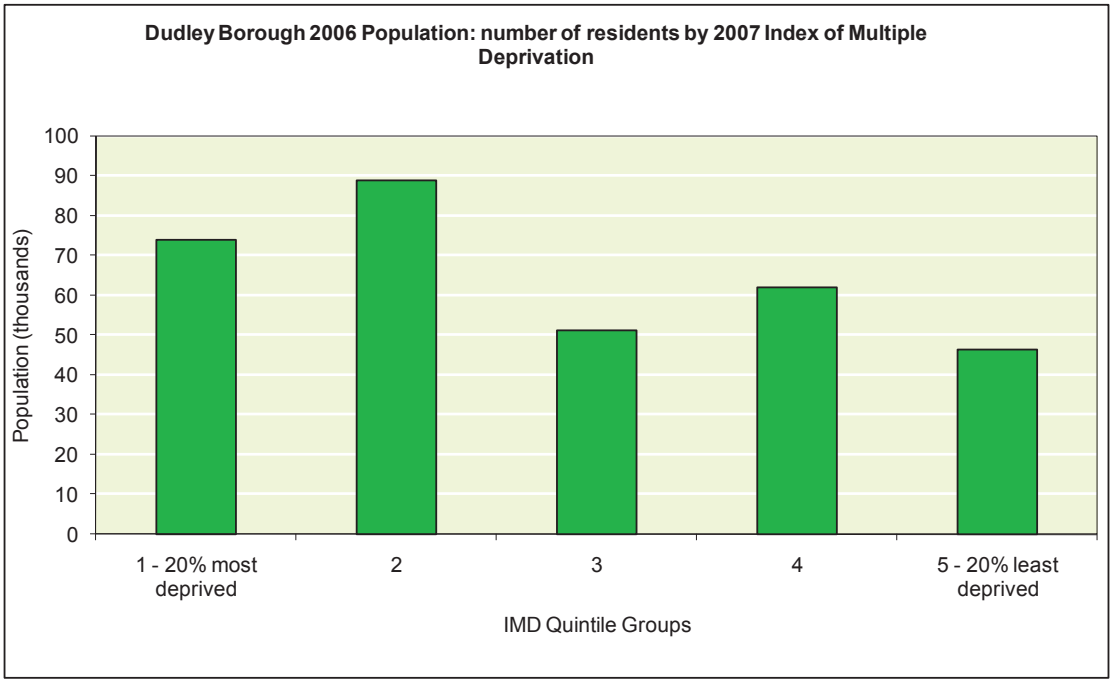


Source: ONS mid-year population estimate 2006

Distribution by Index of Multiple Deprivation

The more deprived areas tend to have a higher concentration of younger sexually active people (aged 15-24 years) (Figure 3). In the most deprived parts of the borough (IMD quintile group 1) 14% of the population are aged 15-24, compared with 10% in the least deprived areas. This difference is seen clearly in the population pyramids in Appendix 1, Figure 3 – in the most deprived areas (quintile group 1) the population is weighted towards young people, while at the other end of the spectrum in the least deprived areas most people are aged 35-64.

Figure 2



Source: ONS mid-year population estimate 2006, IMD 2007

Ethnicity

In Dudley as a whole, ethnic minority groups make up 6.4% of the Borough population (Figure 4) compared to 9% in England as a whole (Census 2001). This varies by locality, from 3% in Sedgley to nearly 15% in Dudley and Netherton.

The largest ethnic minority group is Asian, at 4% of the population. Again, this is highest in Dudley and Netherton where 9% of the population are Asian.

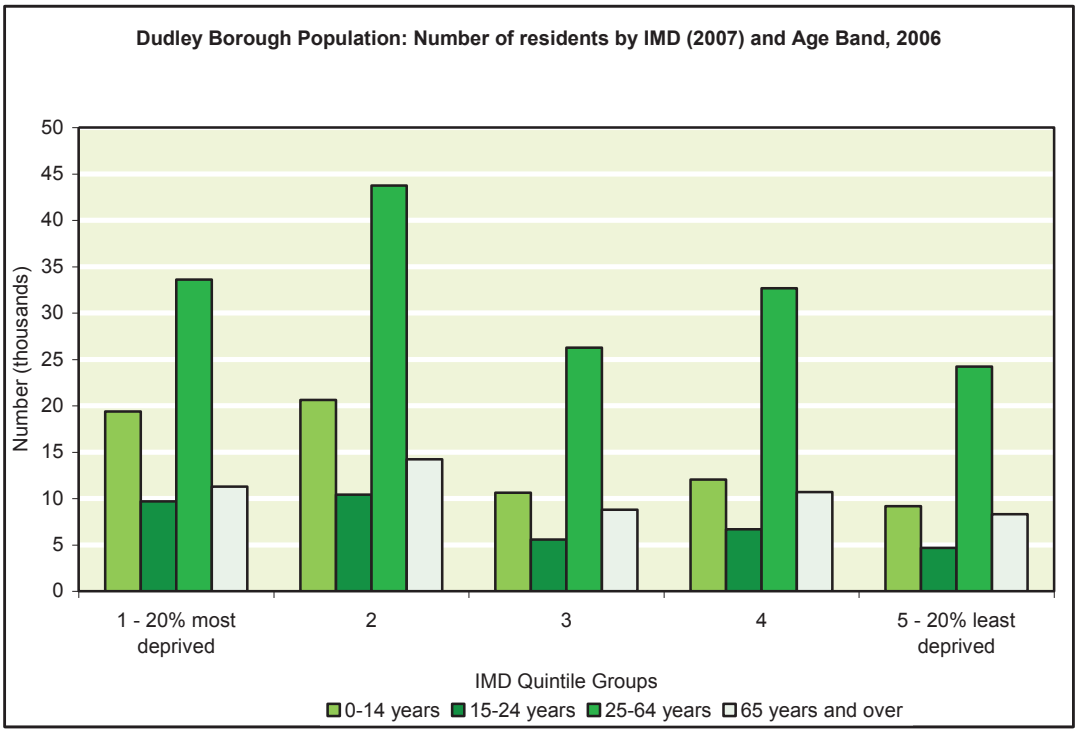
It should be noted that this data is based on the 2001 census, and does not reflect any changes in the ethnic composition of the borough over the last seven years.

Full-time Students

32% of 16-24 year olds in Dudley Borough are in full time education. Most localities have around 30% in full time education; however Halesowen and Stourbridge are higher at 34% and 36% respectively.

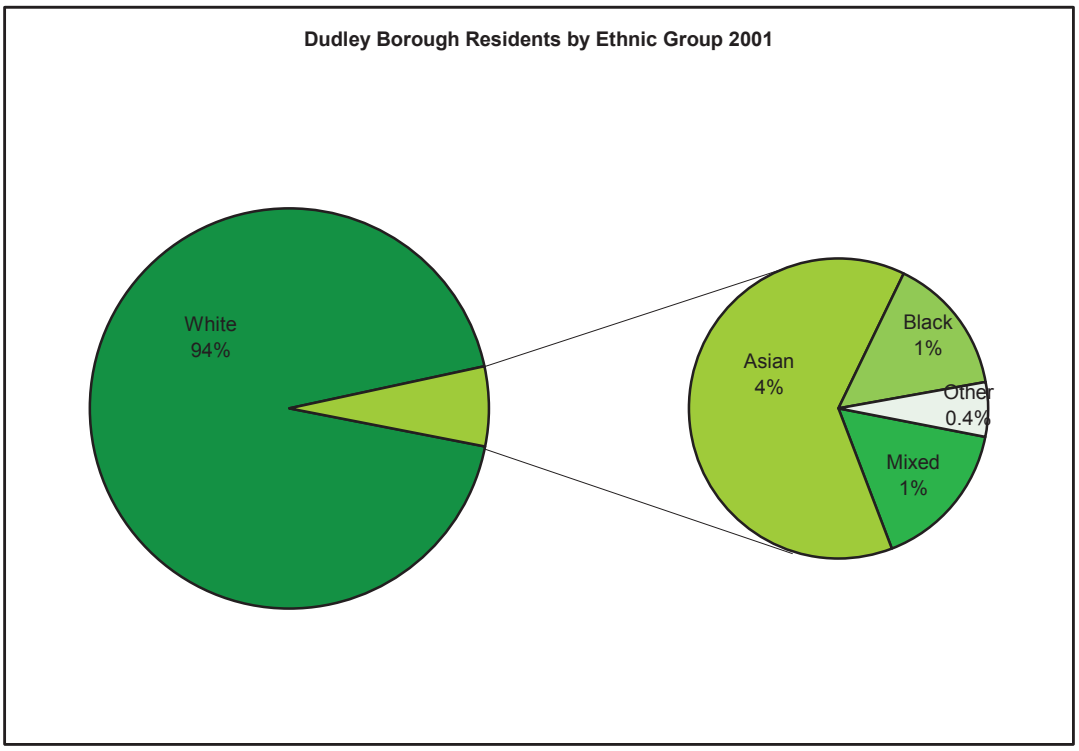
In terms of numbers, the highest number of full-time students is in Brierley Hill (Figure 5)

Figure 3



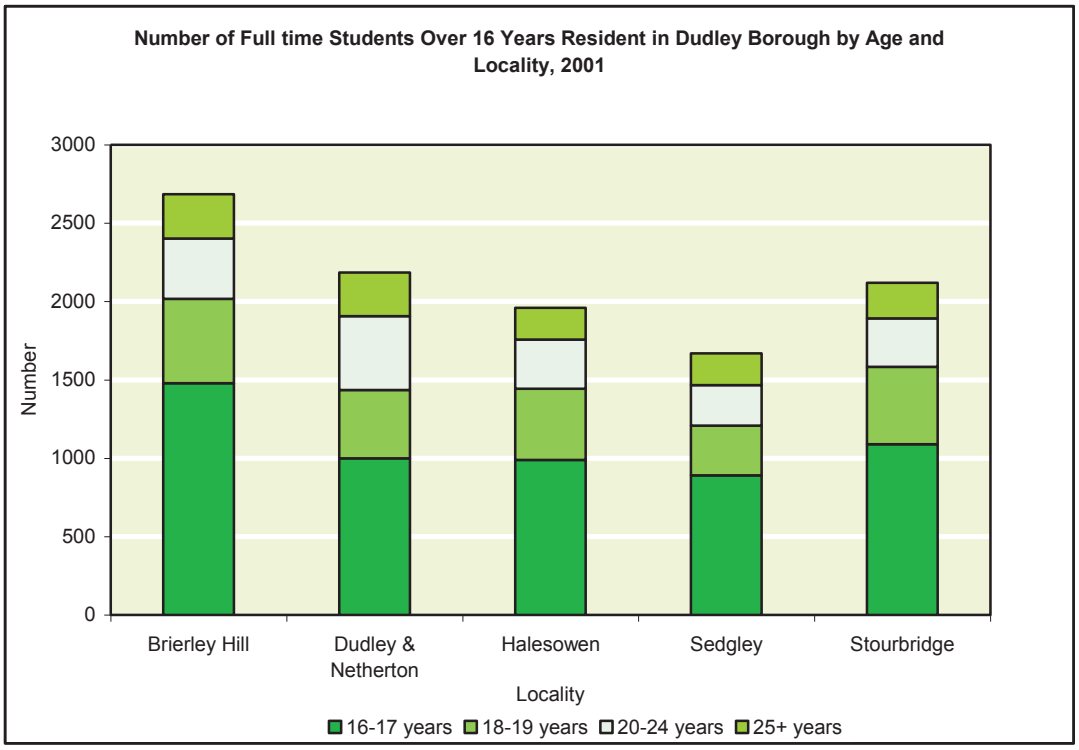
Source: ONS mid-year population estimate 2006, IMD 2007

Figure 4



Source: Census 2001

Figure 5



Source: Census 2001

Key points:

- 65% of the Dudley Borough population are in the sexually active age band (i.e. Aged 15-64)
- Over a quarter of 15-64 year olds live in Brierley Hill
- Young people (aged 15-24) comprise 12% of the Borough population. The highest proportion is in Dudley and Netherton locality
- Amblecote and Gornal Wood are the two wards with the highest number of residents aged 15-64 years.
- A larger proportion of 15-64 year olds in Dudley Borough live in the most deprived areas than in the least deprived
- The proportion of ethnic minority groups varies from 15% in Dudley and Netherton locality to 3% in Sedgley locality.
- The largest ethnic minority group in the Borough is Asian.
- In 2001, 32% of 16-24 year olds in the Borough were in full-time education. With the highest proportion in Stourbridge, and the highest number in Brierley Hill.

Sexually Transmitted Infections

Time Trend

The trend of sexually transmitted infections (STIs) in Dudley is mixed. Chlamydia is the most common STI. Between 2001 and 2007, the rate of Chlamydia infection ranged between 136 and 168 per 100,000 population.

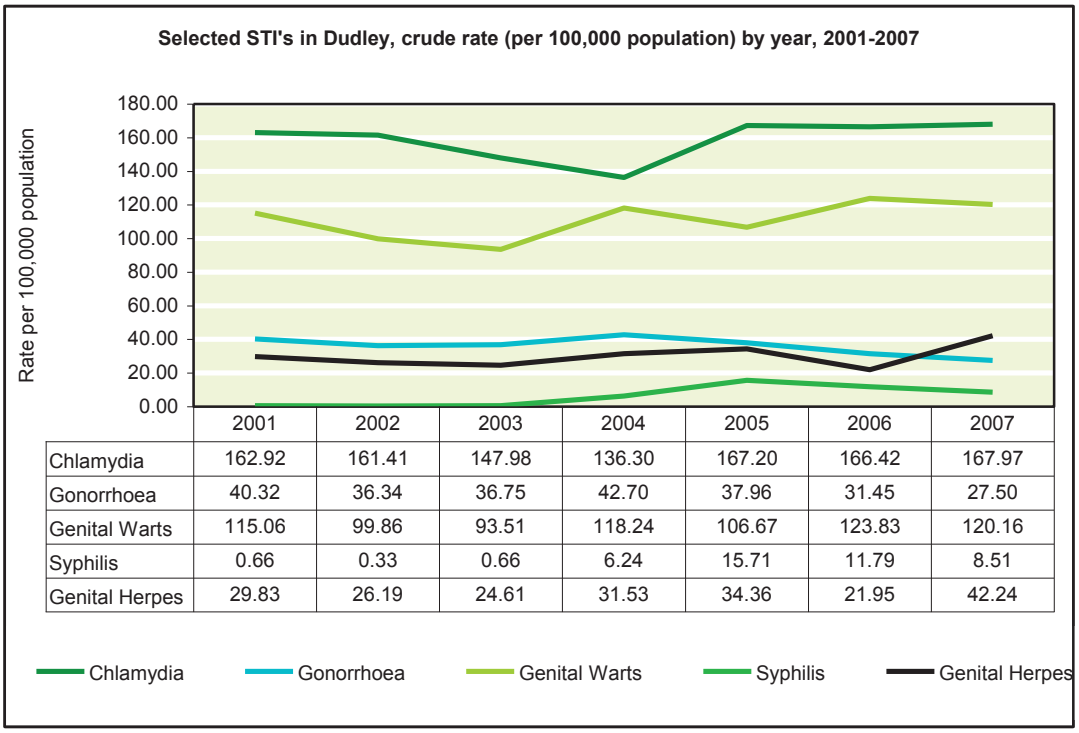
Overall, the rate for chlamydia has increased by 3% between 2001 and 2007 (Figure 6). Furthermore, Chlamydia rate is expected to increase temporarily as a result of the introduction of the Chlamydia screening programme in Dudley in September 2007, as previously undetected cases are diagnosed.

Genital Warts is the second most common STI in Dudley. Its rate has increased slightly over the last 6 years, from 115 per 100,000 in 2001 to 120 in 2007, and this represents a 4.4% increase (Figure 6).

The rate of Gonorrhoea has fallen by 32% overall since 2001 (Figure 6).

The rate of Syphilis, which was negligible until 2003, rose in 2004 and 2005 (to 48 cases in 2005) but has fallen by almost a half (46%) between 2005 and 2007.

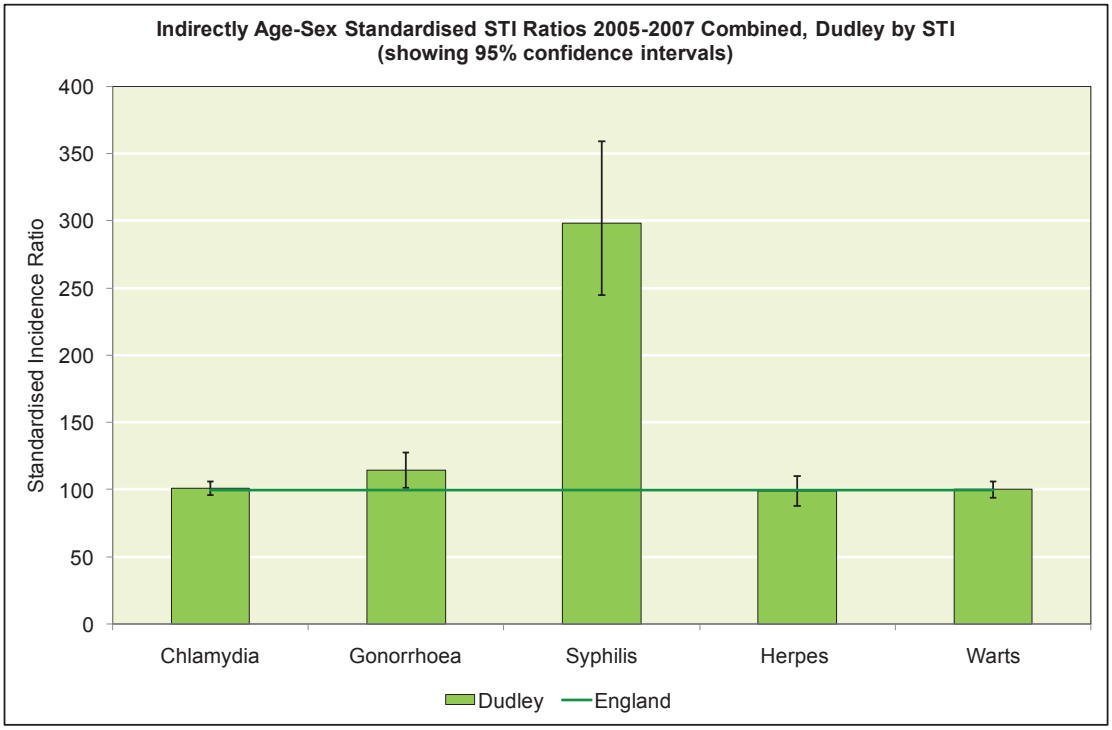
Figure 6



	2001	2002	2003	2004	2005	2006	2007
Chlamydia	162.92	161.41	147.98	136.30	167.20	166.42	167.97
Gonorrhoea	40.32	36.34	36.75	42.70	37.96	31.45	27.50
Genital Warts	115.06	99.86	93.51	118.24	106.67	123.83	120.16
Syphilis	0.66	0.33	0.66	6.24	15.71	11.79	8.51
Genital Herpes	29.83	26.19	24.61	31.53	34.36	21.95	42.24

Source: Health Protection Agency

Figure 7



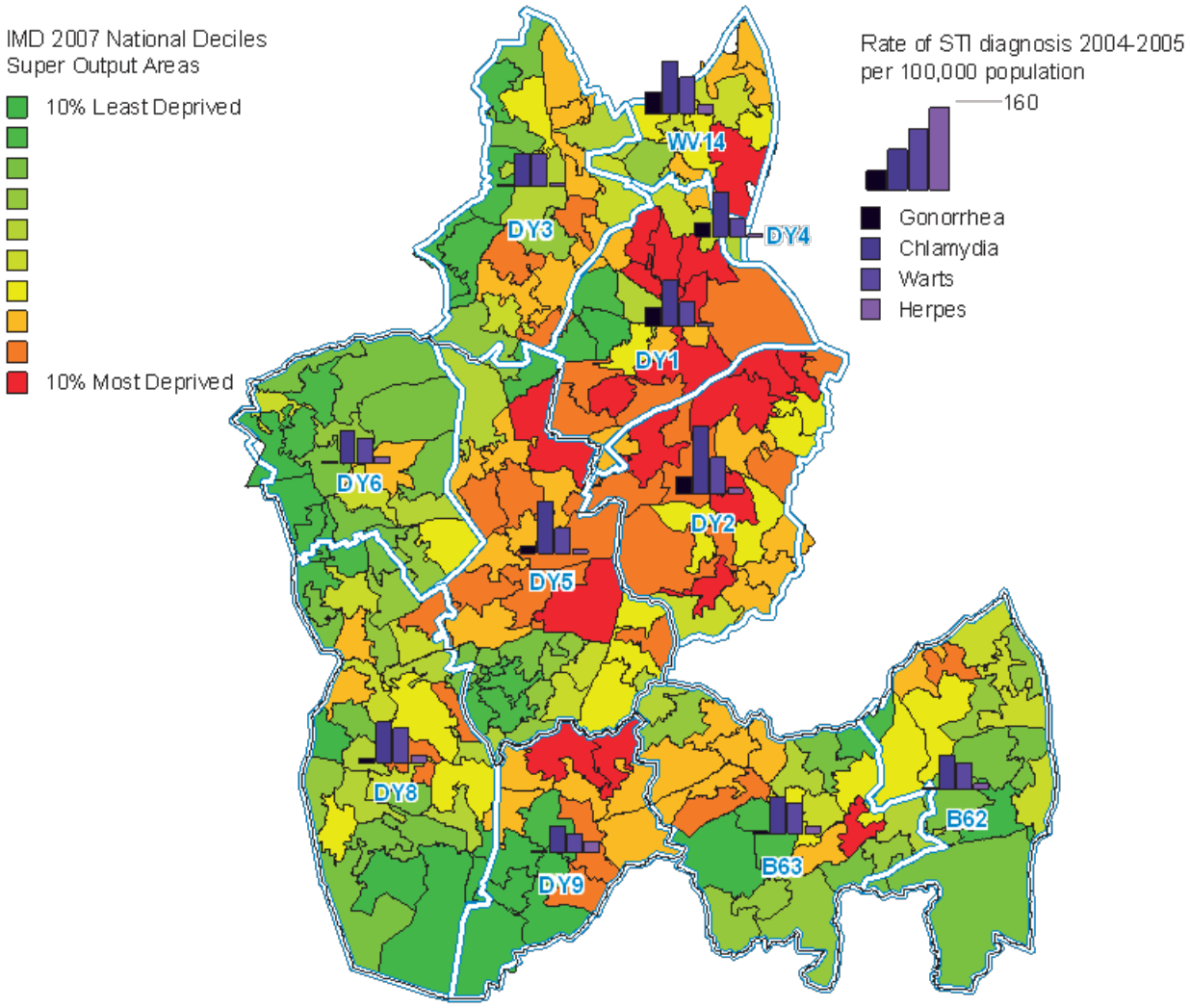
Source: Health Protection Agency

Figure 7 shows indirectly standardised STI ratios in Dudley (compared to an England rate of 100) for 2005-2007 combined. Standardised Incidence Ratio's (SIRs) above 100 indicate a standardised rate higher than that in England, whereas SIRs below 100 show a lower standardised rate. The chart shows that the Dudley's standardised incidence ratio (SIR) for Gonorrhoea is significantly higher than England, at 114 (95% confidence intervals (CI) 102,128). The SIR for Syphilis is 298 (95% CI 245, 360) which is also significantly higher, at nearly 3 times the England rate.

The standardised rates for Chlamydia, Genital Herpes and Genital Warts are not significantly different from England (100), at 101 (95% CI 96, 107), 99 (95% CI 88,110) and 100 (95% CI 94,106) respectively.

Analysis of STI rates in Dudley by postal sector (Figure 8) shows that the highest rates for gonorrhoea, chlamydia and genital warts are in DY2, which lies within the Dudley and Netherton locality. This is also an area of high deprivation. It should be noted that the postcode sectors do not fit exactly to borough boundaries and in particular for WV14 and DY4 a majority of the area lies outside the borough and this will influence the average rates in those sectors. Postcode sector data was only available for 2004-2005. There was insufficient data to do analysis by postal sector for syphilis due to the low number of cases.

Figure 8: 2004-2005 STI rates in Dudley by postal sector and IMD 2007



Sources: IMD 2007, HPA

Chlamydia

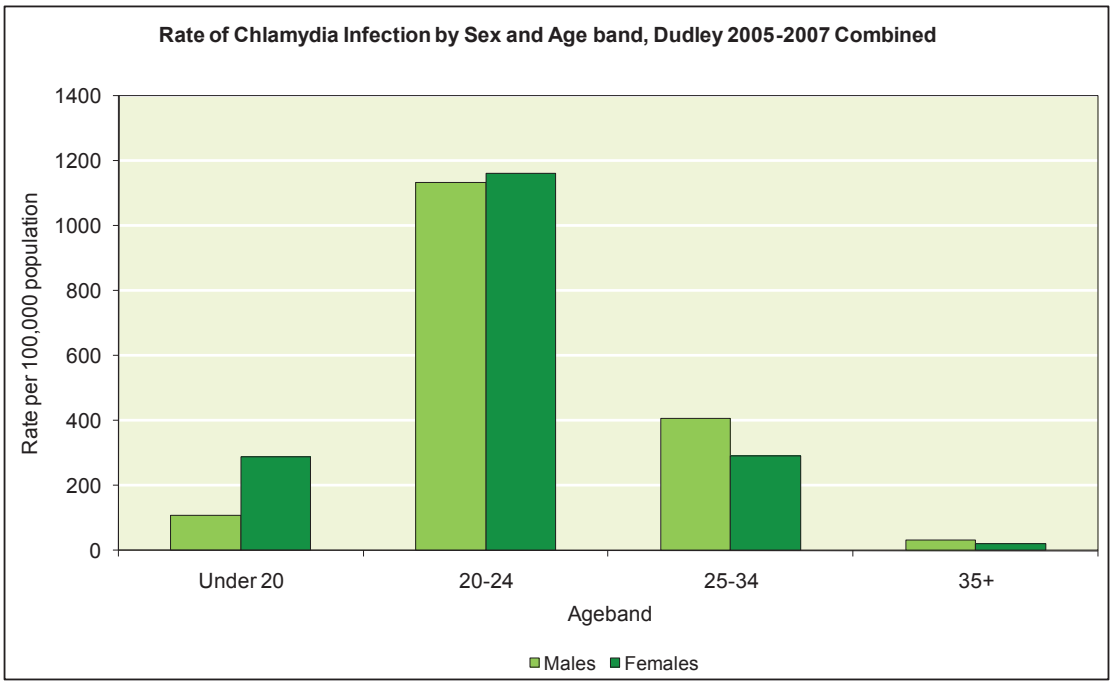
Overall, the rate of Chlamydia was slightly higher in females than males in 2005-07 (a 12% difference). However, this is not consistent over time – in the last 7 years the rate has been higher in males on 2 occasions. (Appendix 2, table 1).

In 2005-07 38% of cases of Chlamydia were diagnosed in the 20-24 year age group (Figure 9). In the under 20 year age group the rate of diagnosis in females is more than twice that in males, an increase of 170% (while at the other end of the scale, the rate of diagnosis in over 35 year old males is 53% higher than the rate in over 35 year old females).

The rate of Chlamydia diagnoses through GUM clinics was significantly higher in DY2 (91 per 100,000) than the combined average (the Dudley average) for these postal sectors* and significantly lower in DY9. There were no other areas with a significantly low rate. (Figures 10(a) and (b) respectively.)

* note that this rate is lower than the rates quoted in Figure 6 as it is based on the populations in the given postal sectors, which covers a larger population than Dudley borough.

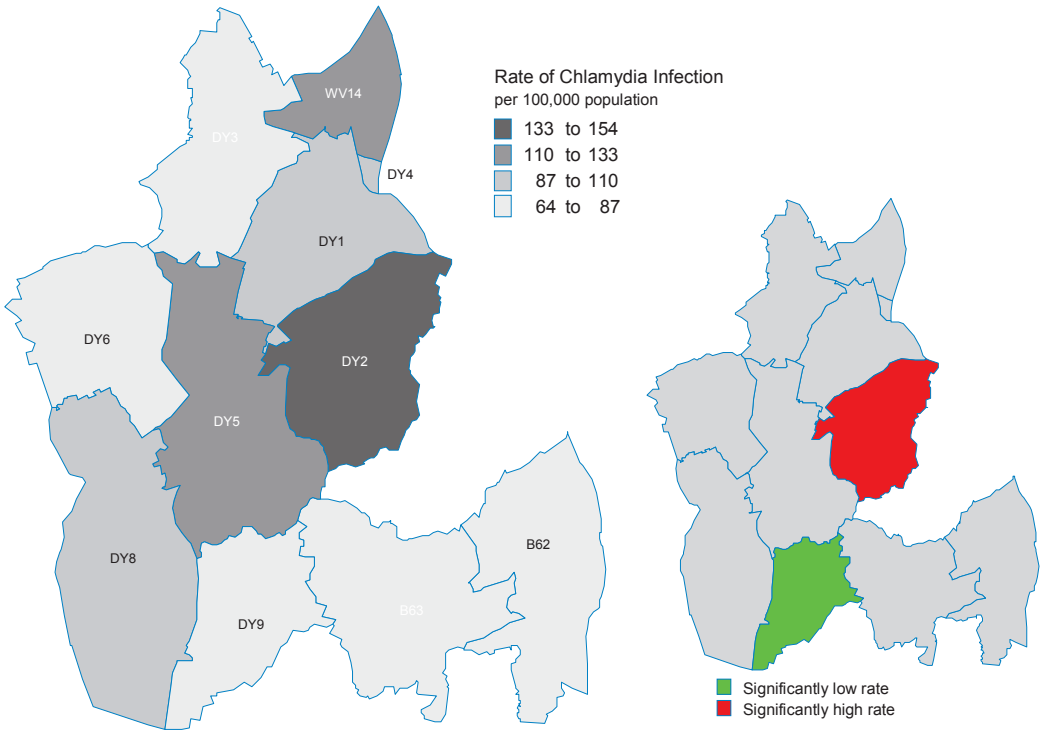
Figure 9



Source: Health Protection Agency

Figure 10: Rate of Chlamydia Infection by Postal Sector 2004-2005 combined

(a) **(b)**



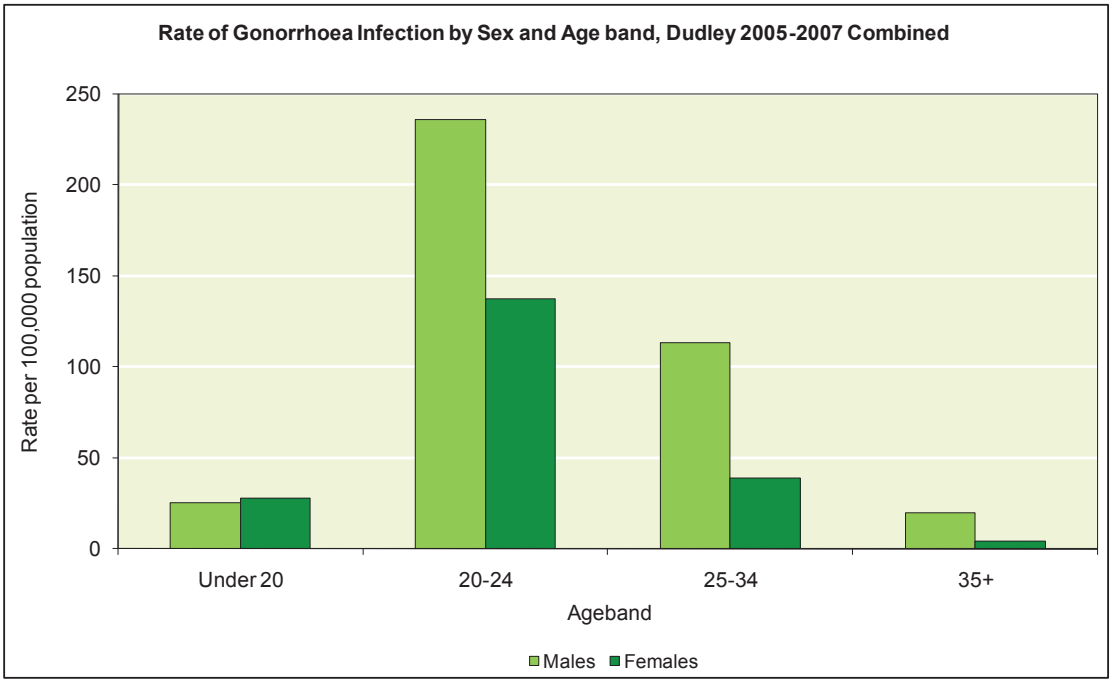
Source: Health Protection Agency

Gonorrhoea

In 2005-07 more cases of gonorrhoea were diagnosed in males than females in most age groups. However, in the under 20s the rate of diagnosis was 11% higher in females than males (Appendix 2, table 4). As with Chlamydia, the most common age group is 20-24 years (Figure 11).

The geographical distribution of Gonorrhoea (Figure 12(a)) shows a concentration around the Dudley town area, with DY2, DY1 and WV14 having a significantly high rate. No areas have a significantly lower rate of gonorrhoea infection (Figure 12(b)).

Figure 11



Source: Health Protection Agency

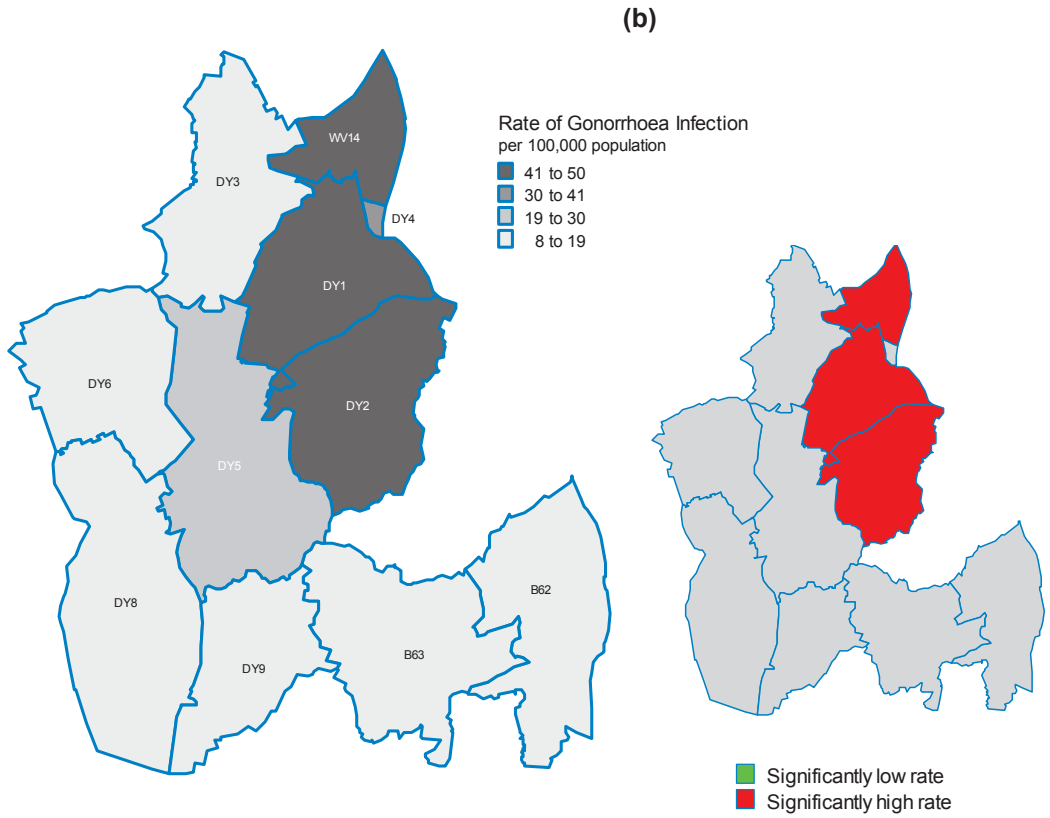
Genital Warts

The rate of genital warts diagnoses was 19% higher in males than females in 2005- 2007. The most frequent age band is 20-24 years, representing nearly a third (32%) of all diagnoses. Amongst the under 20s the rate is more than twice as high in females as in males (107% higher) (Appendix 2, table 6).

In 2007 the rate was the same in both males and female, although previous to then the rate had been consistently higher in males for at least 6 years (Figure 13).

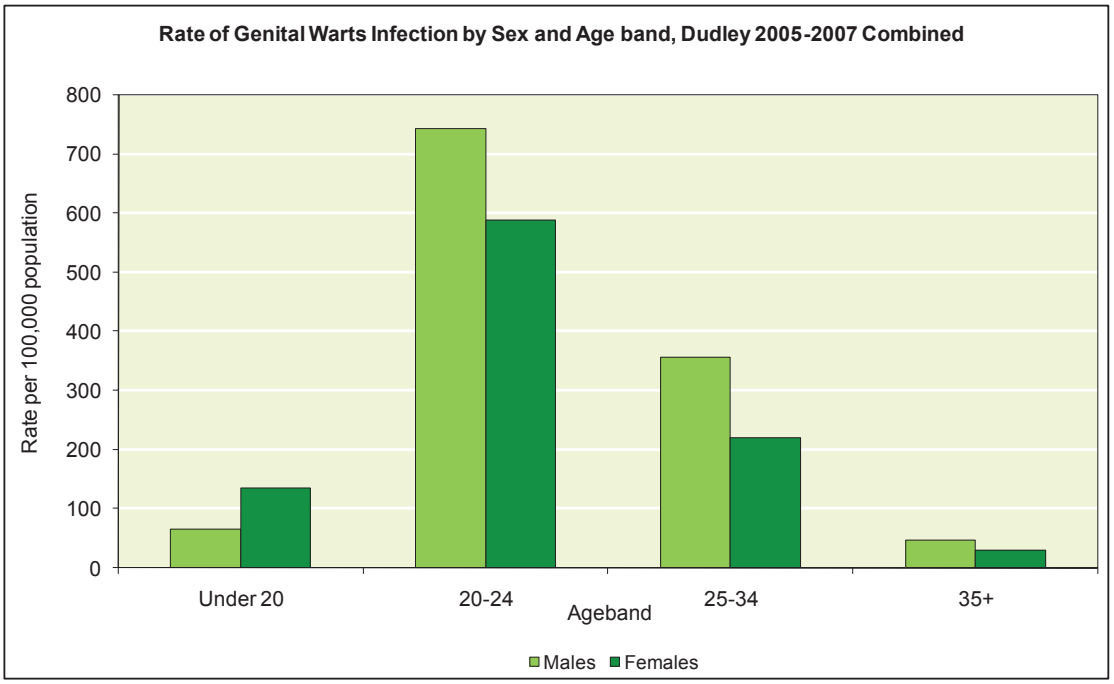
Figure 14(a) shows that there is no clear pattern of geographical spread. DY4 has a significantly low rate of Genital Warts infection, but there are no areas with a significantly high rate (figure 14(b)).

Figure 12: Rate of Gonorrhoea Infection by Postal Sector, 2004-2005 Combined



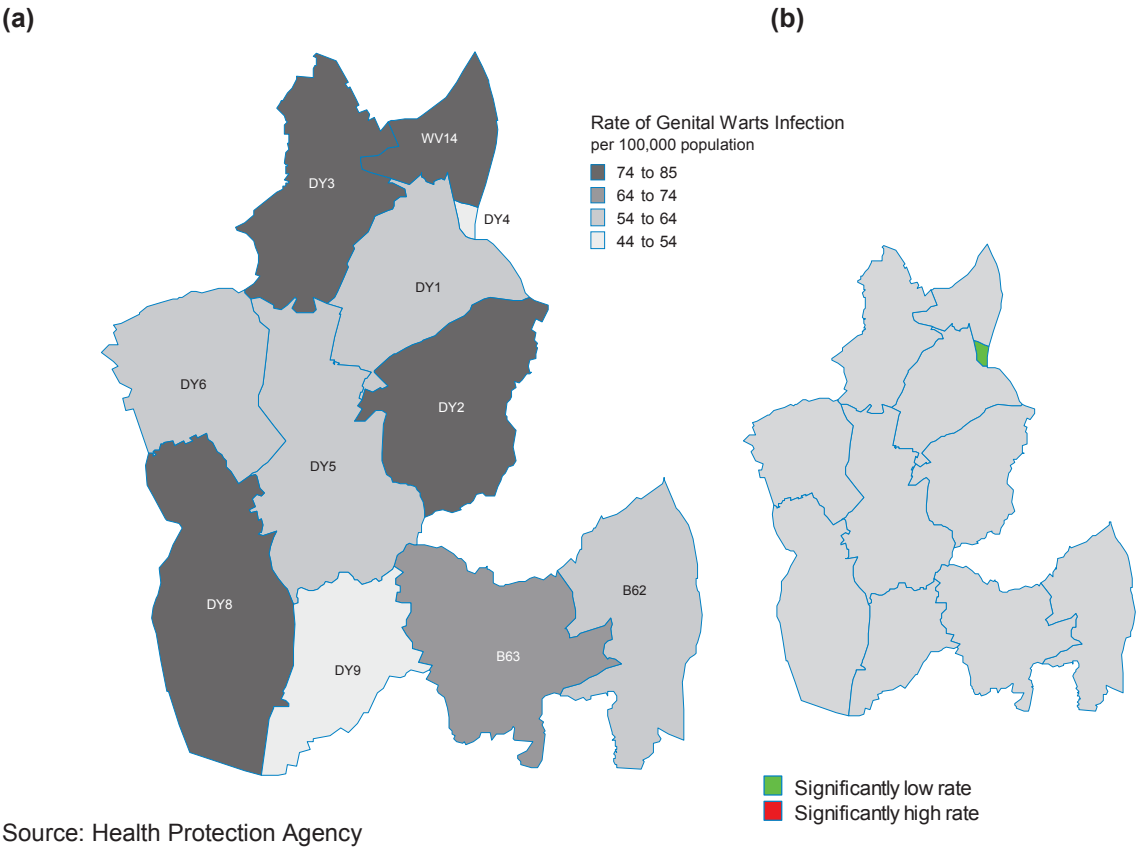
Source: Health Protection Agency

Figure 13



Source: Health Protection Agency

Figure 14: Rate of Genital Warts infection by Postal Sector 2004-2005 combined



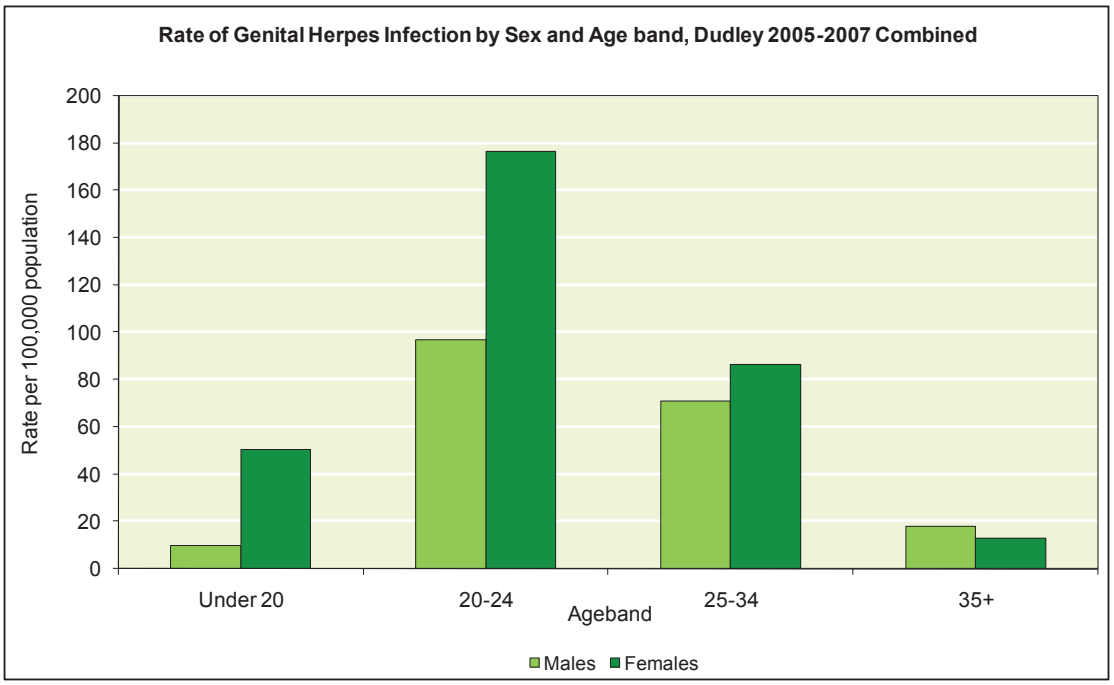
Source: Health Protection Agency

Genital Herpes

In 2004-07 the rate of Genital Herpes diagnoses was 46% higher in females than males (Appendix 2, Table 7). In both sexes the highest rate of diagnosis was seen in 20-24 year olds, in line with other STIs (Figure 15).

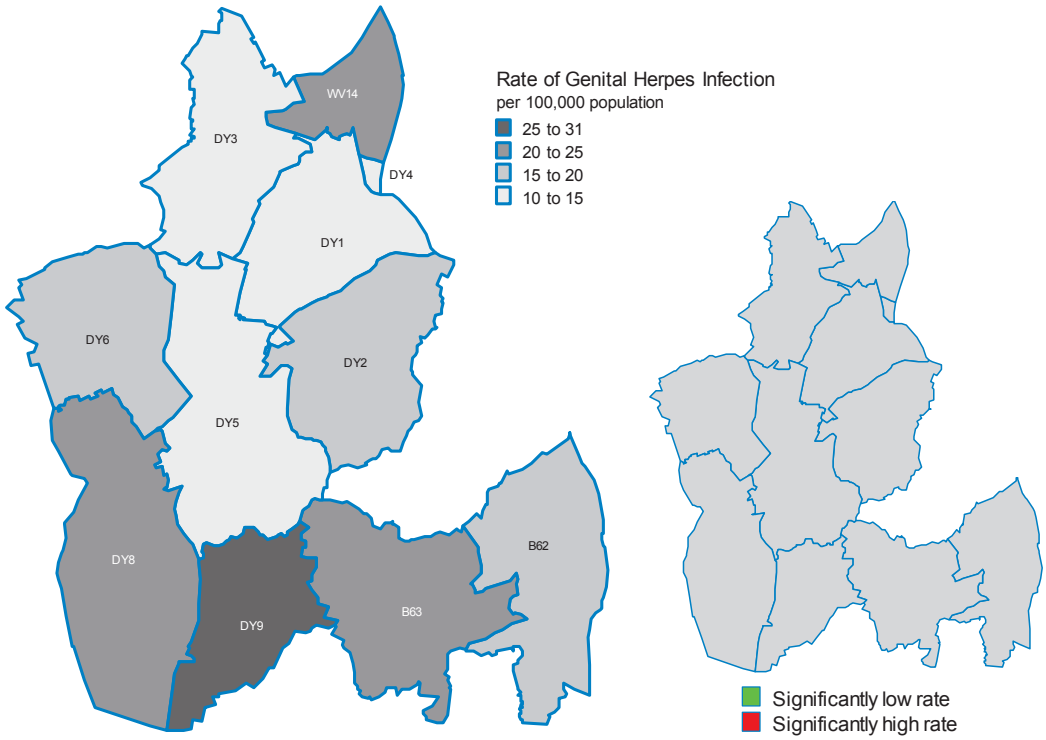
The number of males diagnosed has been inconsistent, falling by 71% in 2006 to 14 cases, but then rising to a 6-year high of 57 cases in 2007 (an increase of 300% since 2006). The geographical distribution of genital herpes is relatively even across the Borough (Figure 16).

Figure 15



Source: Health Protection Agency

Figure 16: Rate of Genital Herpes Infection by Postal Sector 2004-2005 combined

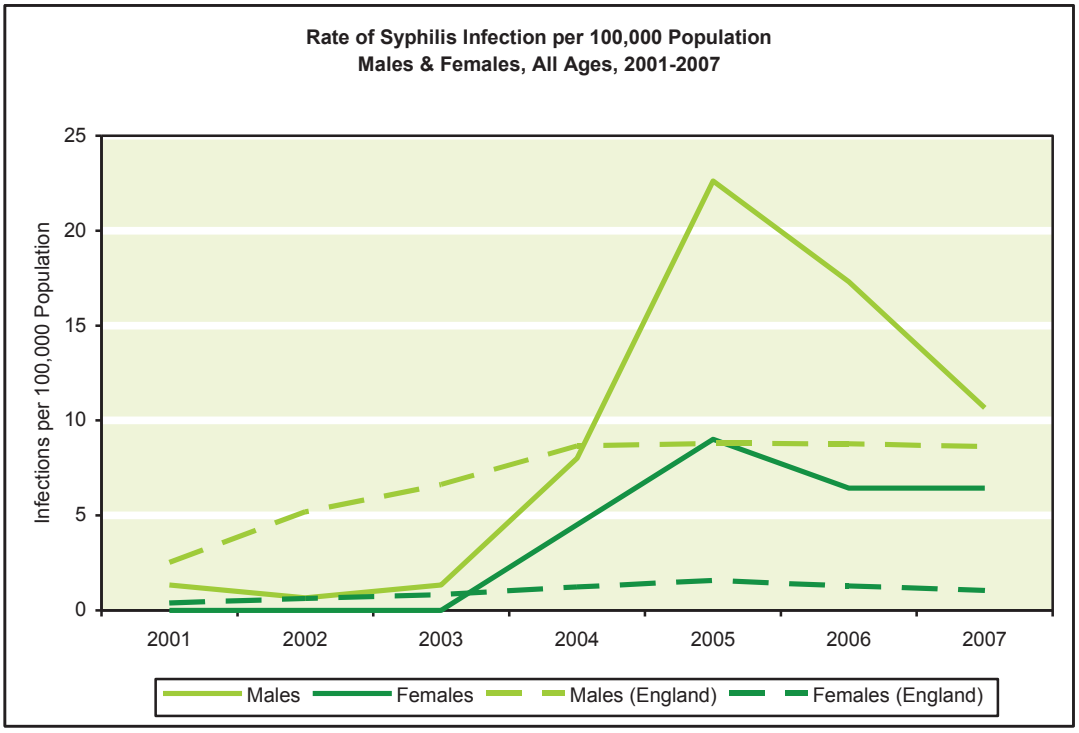


Source: Health Protection Agency

Syphilis

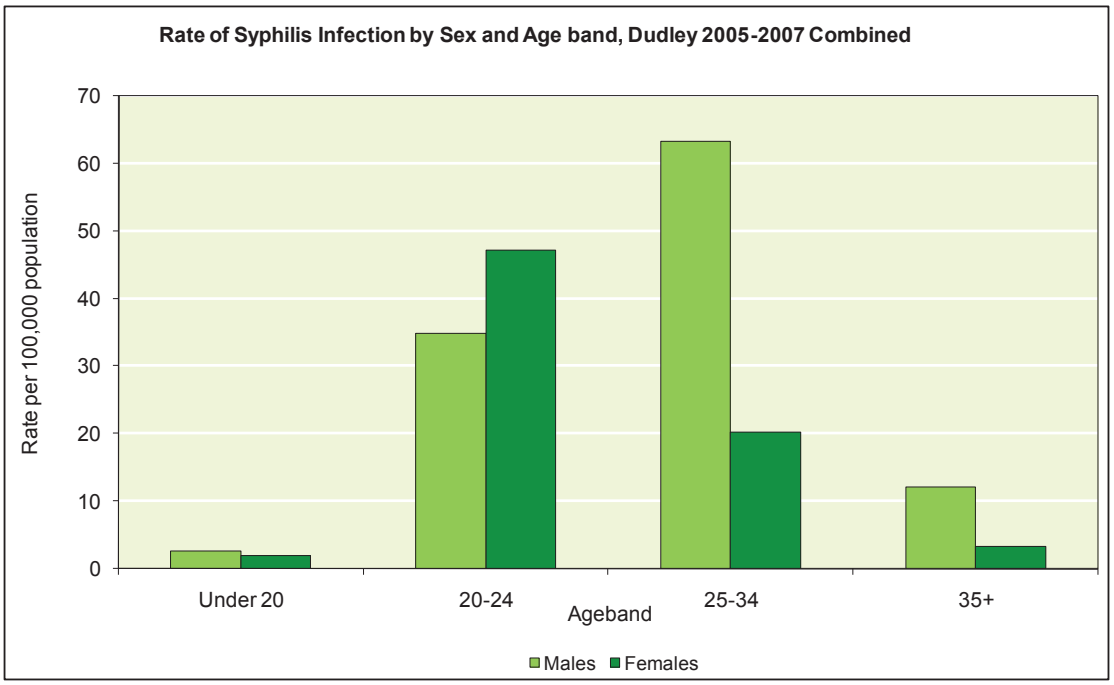
Although the standardised incidence ratio of syphilis in Dudley is much higher than 100, the actual rate in Dudley remains very low (Appendix 2, Table 9) in comparison with other STI's and it is falling. It is higher in males than females (Figure 17). There were 26 cases in total in Dudley in 2007, 129 cases in 2004-07 combined. The rate in 2004-07 was twice as high in males (88 cases) as in females (41 cases), and once again the highest rate of diagnosis for females was in 20-24 year olds, but for males the highest rate of diagnosis was in the 25 -34 year olds (Figure 18).

Figure 17



Source: Health Protection Agency

Figure 18



Source: Health Protection Agency

HIV and AIDs

The number of new HIV cases in Dudley rose sharply (by 128%) in 2002, to 16 cases. It continued to rise to 20 new cases in 2004, before dropping back to 17 cases in 2005 (Figure 19).

Data is based on the number of cases seen for treatment. Figure 20 shows the distribution of HIV cases seen for treatment in 2006. Similar to other sexually transmitted infections, the highest number of HIV infection was in DY2 – this was significantly higher than in other postcode sectors.

The majority of Dudley residents seen for HIV treatment in 2006 were over 35 years old. More than two thirds of HIV cases were in males (Table 1).

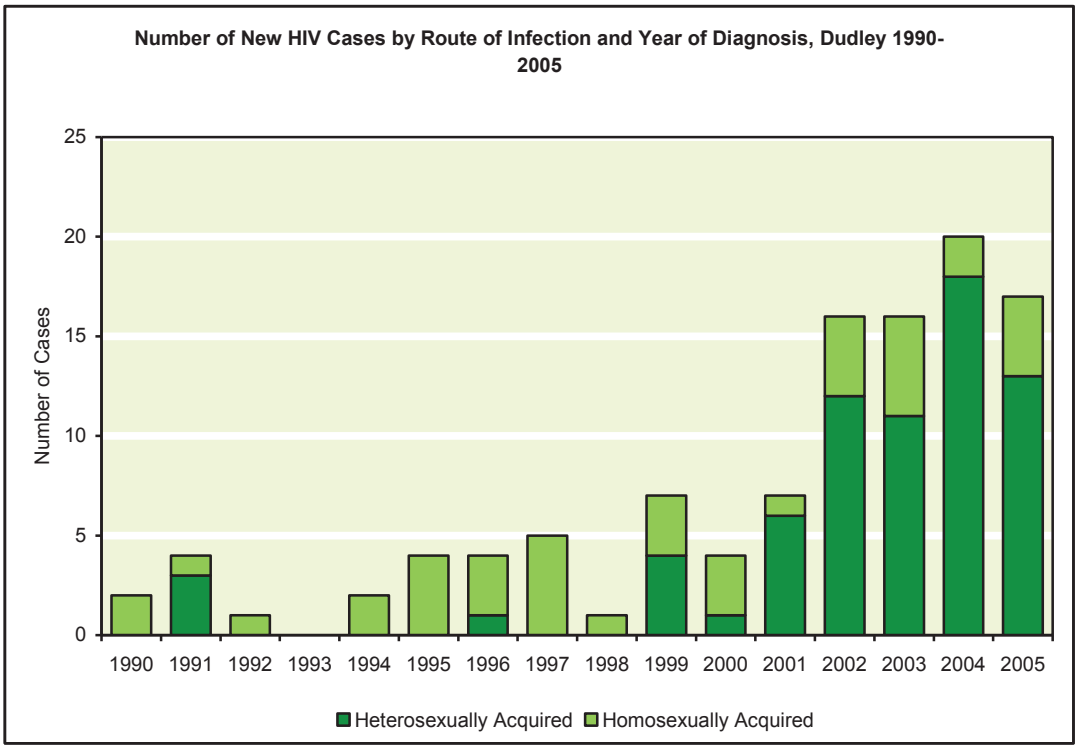
Table 1: Dudley Residents seen for HIV treatment in 2006 by Age and Sex

Age band	Sex	
	Male	Female
Under 25	*	*
25-34	*	12
35-44	29	16
45 and over	28	*
All Ages	68	32

Source: Health Protection Agency, SOPHID 2006

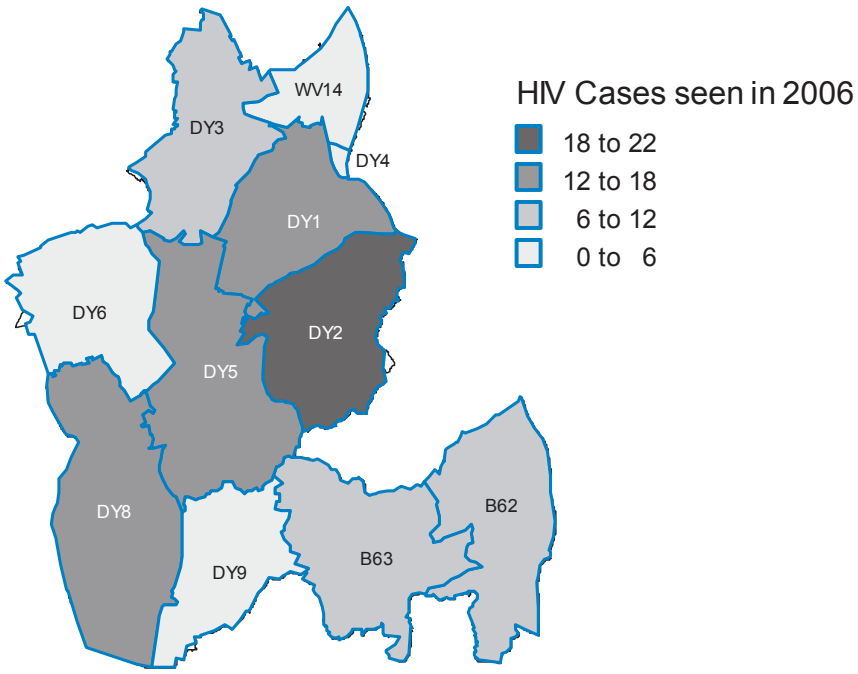
* Values smaller than 5 have been suppressed

Figure 19



Source: HPA West Midlands HIV Report 2005

Figure 20: Number of HIV Cases seen in 2006 by Postal Sector



Source: Health Protection Agency, SOPHID 2006

The vast majority of HIV cases seen in 2006 were of White (60%) or Black African (36%) origin. Amongst Whites the majority of cases were male, whereas in Black Africans there were slightly more females than males (Table 2).

Table 2: Dudley Residents seen for HIV treatment in 2006 by Ethnic Group and Sex

Ethnic group	Sex	
	Male	Female
White	52	8
Black-African	14	22
Other	*	*

Source: Health Protection Agency, SOPHID 2006

* Values smaller than 5 have been suppressed

The number of new cases of HIV diagnosed through antenatal screening in Dudley is negligible. There have been only 2 cases newly diagnosed since January 2004. So far in 2008, there have been 8 HIV positive cases where the diagnosis was already known prior to pregnancy.

Hepatitis B

The number of cases of Hepatitis B has increased by over 70% between 2004 and 2007 (Table 3).

Table 3: Acute and Chronic Hepatitis B notifications Dudley, 2004 – 2007

Year	No. cases
2004	17
2005	5
2006	21
2007	29

Source: Health Protection Agency CoSurv system

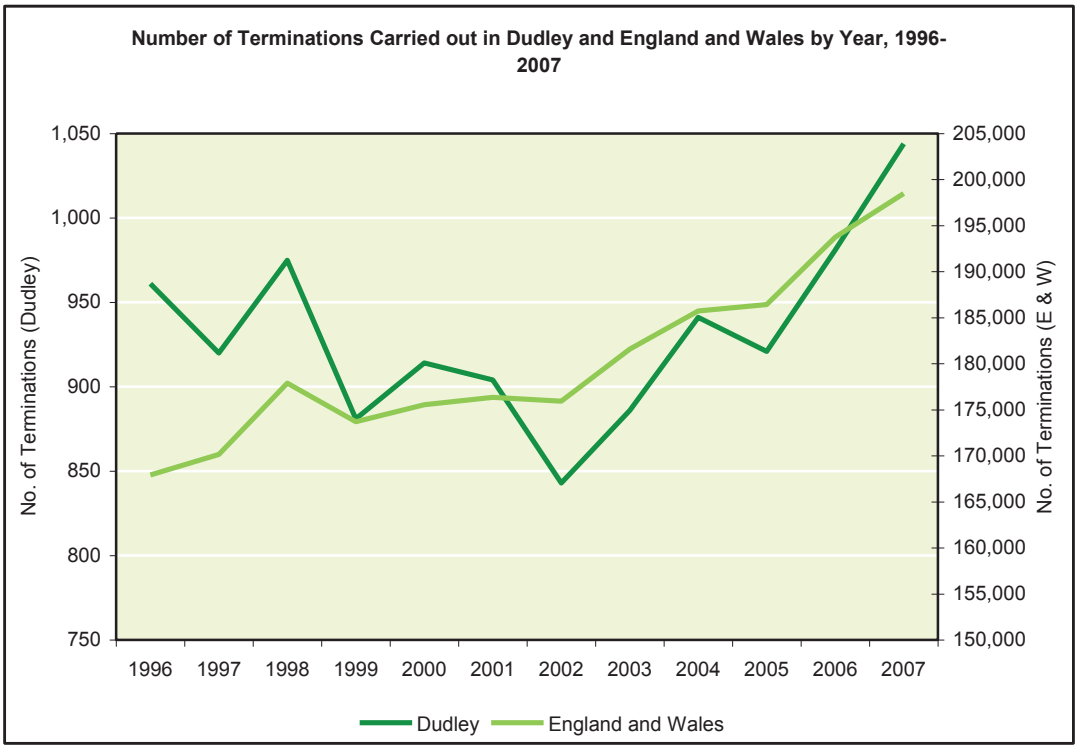
Key points:

- Chlamydia infection is the most common STI in Dudley Borough. Its rate has increased by 3% from 2001-2007.
- The rate of Gonorrhoea has fallen by 32% since 2001 while the rate for other STIs has increased.
- The indirectly standardised rates for Gonorrhoea and Syphilis in Dudley are significantly higher, while the rate for Chlamydia is significantly lower than the rates in England
- The number of cases of Hepatitis B has increased by over 70% between 2004 and 2007.
- Sexually transmitted diseases are most common among the 20-24 years old age group, except HIV which is most common among 35-44 years old age group.
- There is a strong correlation between deprivation and higher rates of sexually transmitted diseases, including HIV.
- DY2 showed significantly higher rates of almost all sexually transmitted diseases compared to other postal sectors in the Borough.

Termination of Pregnancy

Figure 21 shows the time trend of the number of terminations carried out on Dudley residents compared to England and Wales. In Dudley, overall, since 1996, the number of terminations have risen by 8%. In contrast, in England and Wales, termination numbers have risen by 18% since 1996. This includes all legal terminations, including those carried out privately.

Figure 21



Source: Office for National Statistics (ONS) Abortion Statistics

Table 4: Dudley residents undertaking NHS funded Terminations 2003/04 – 2007/08

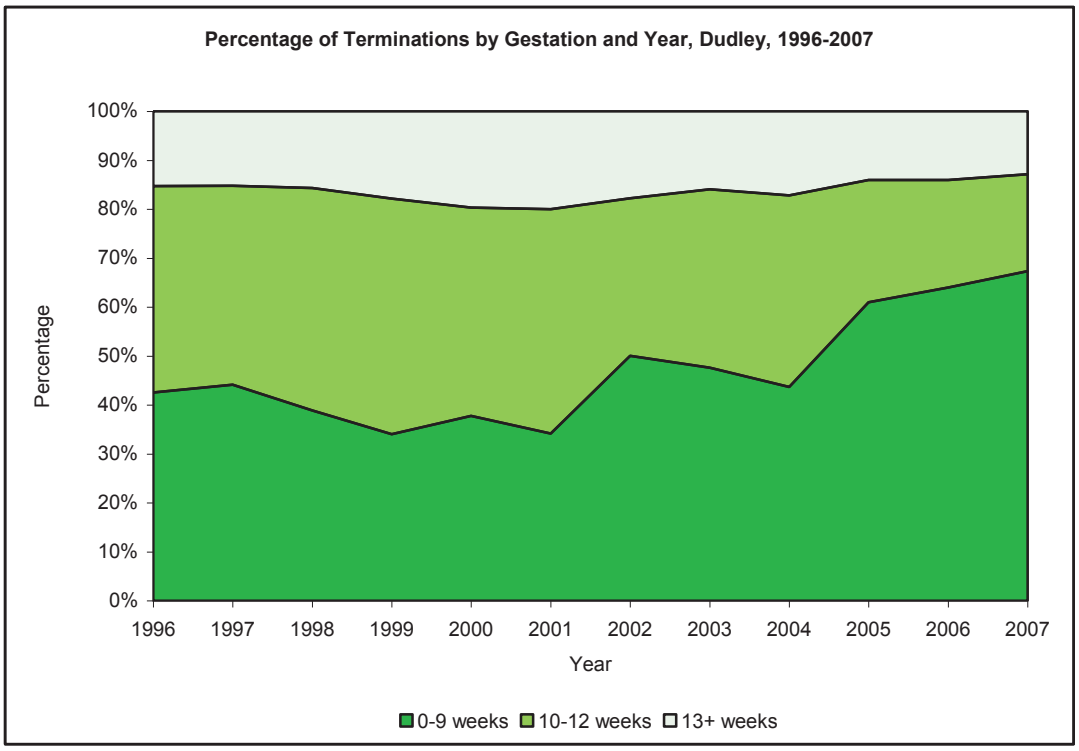
Year	Number
2003/04	709
2004/05	815
2005/06	806
2006/07	890
2007/08	995

Source: British Pregnancy Advisory Service, Calthorpe Clinic

Primary Care Trusts' performance on the percentage of NHS funded abortions performed up to and including nine weeks gestation is assessed by the Healthcare Commission (now Care Quality Commission) as part of their performance rating system. A performance measure of 80% of terminations performed at or before nine weeks is considered a good indicator of access to services. As Figure 22 shows the percentage of terminations at or before nine weeks has increased since 1996, to 66%. This is still well short of the 80% target.

The proportion of terminations taking place under 13 weeks has changed very little since 1996.

Figure 22

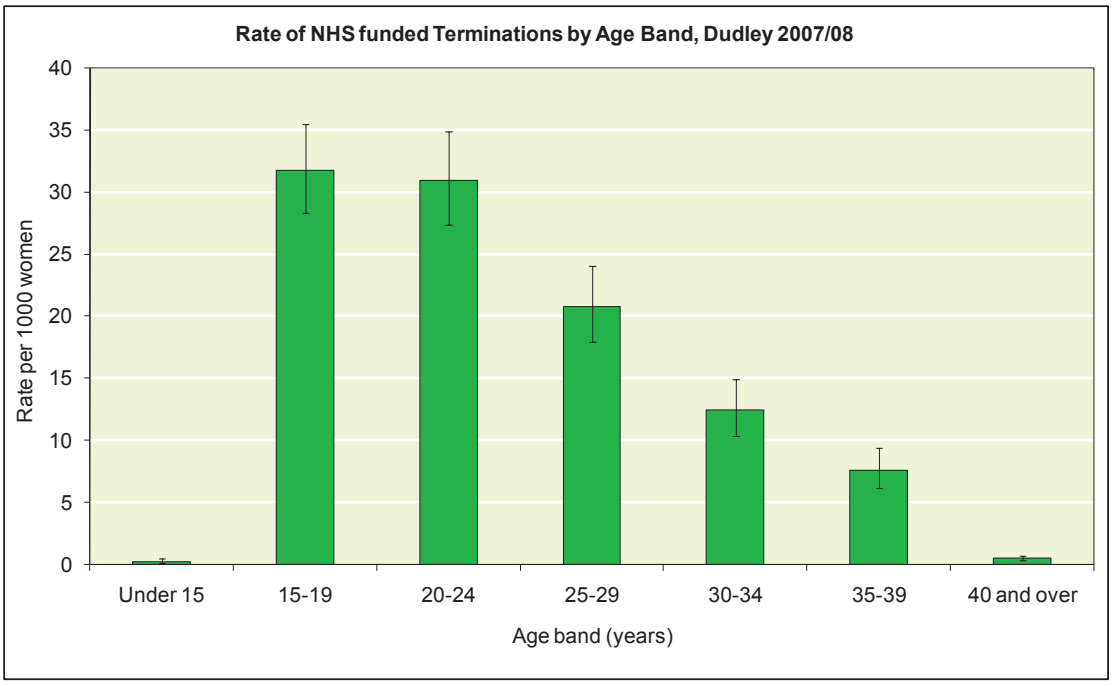


Source: Office for National Statistics (ONS) Abortion Statistics

Figure 23 shows that the age at which women had NHS funded terminations peaked at 15-19 years and decreased with age. The number of terminations are also highest amongst women living in those parts of Dudley that are among the 20% most deprived areas nationally (Figure 24) and lowest in whose women in the least deprived areas .

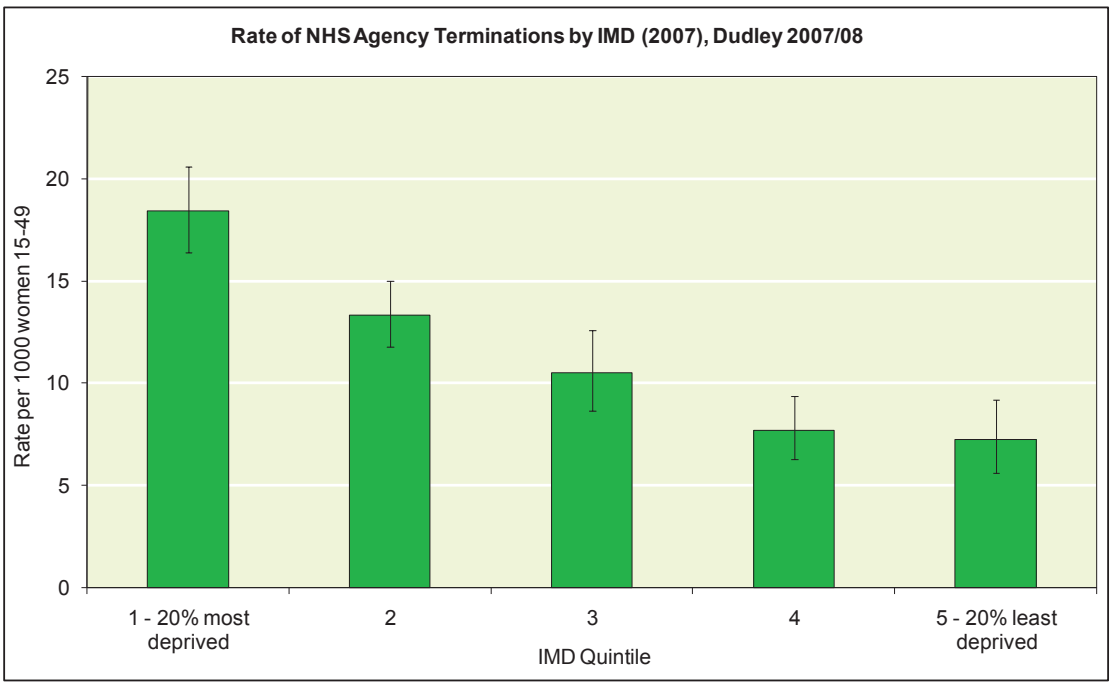
The geographical distribution of terminations shows the rate of terminations is significantly higher in Dudley and Netherton locality (Figure 25).

Figure 23



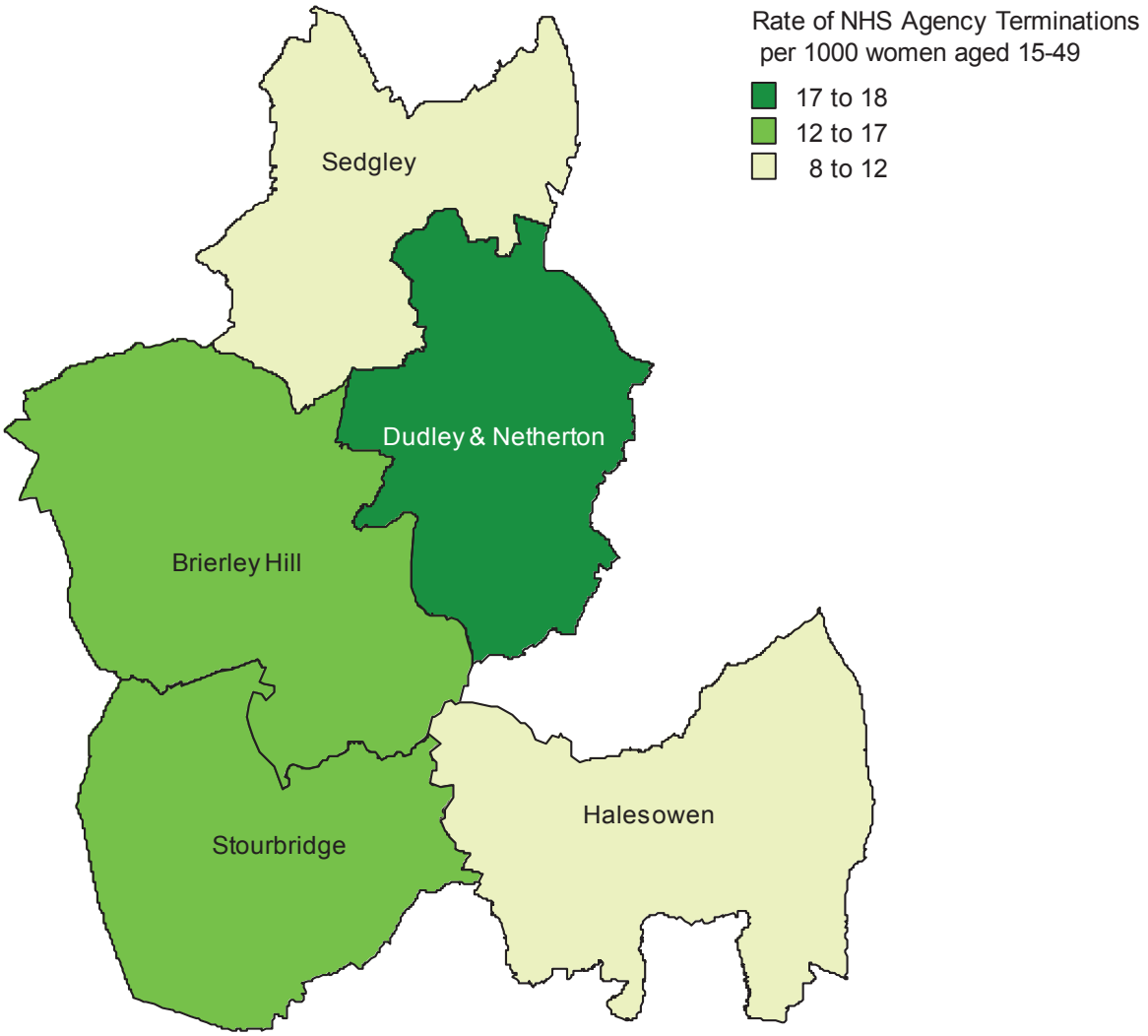
Source: British Pregnancy Advisory Service, Calthorpe Clinic

Figure 24



Source: British Pregnancy Advisory Service, Calthorpe Clinic, IMD 2007

Figure 25: Rate of NHS Agency Terminations by Locality 2007/08



Source: British Pregnancy Advisory Service, Calthorpe Clinic

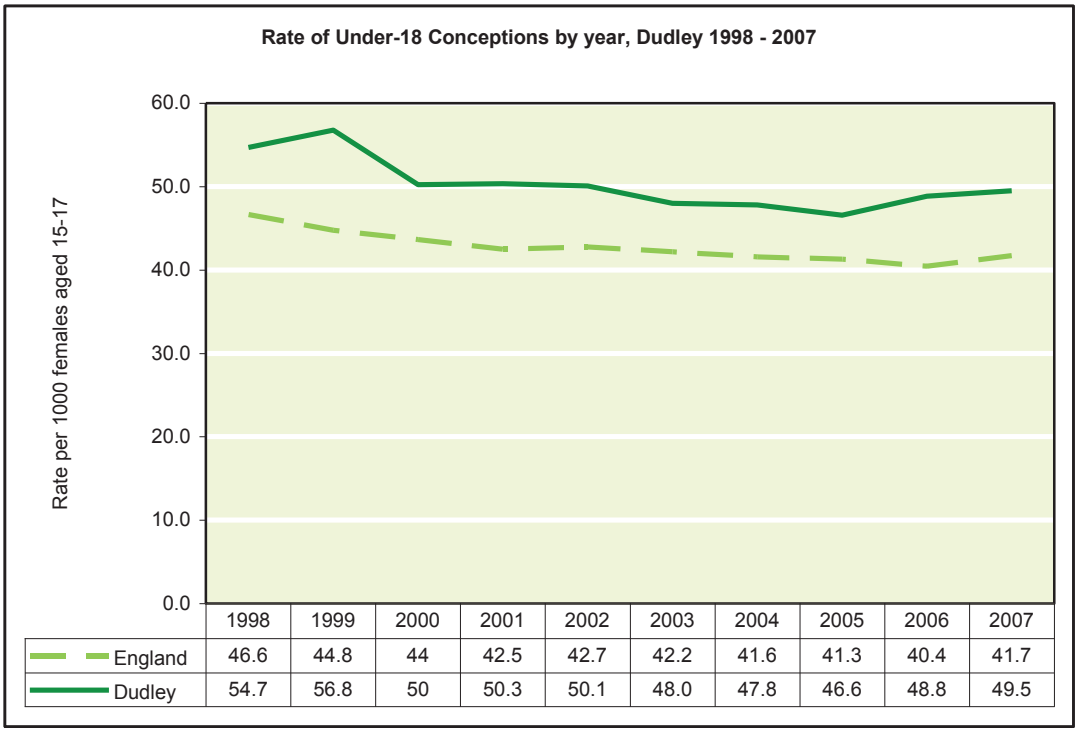
Key points:

- In Dudley, over the period 1996 to 2007 the number of terminations has increased by 8%. In contrast to an 18% increase in England and Wales in the same period.
- The percentage of terminations carried out on Dudley residents at or before 9 weeks gestation is lower than the minimum good standard (66% vs. 80%).
- There is a strong correlation between deprivation and higher rates of terminations.
- The highest rate of terminations is in the Dudley and Netherton locality.
- Termination rates are higher among the 15-19 age group.

Teenage Pregnancy

Figure 26 shows the trend in under 18 conceptions in Dudley compared to England. The rate in Dudley has been consistently higher than in England. The rate in England fell by 13% between 1998 and 2005, and in Dudley fell by 11% over the same period. The England rate continued to fall in 2006, while Dudley's rate increased by 5% to 48.8 per 1000 females aged 15-17. In 2007 both rates increased, England by 3% and Dudley by 1.5%.

Figure 26

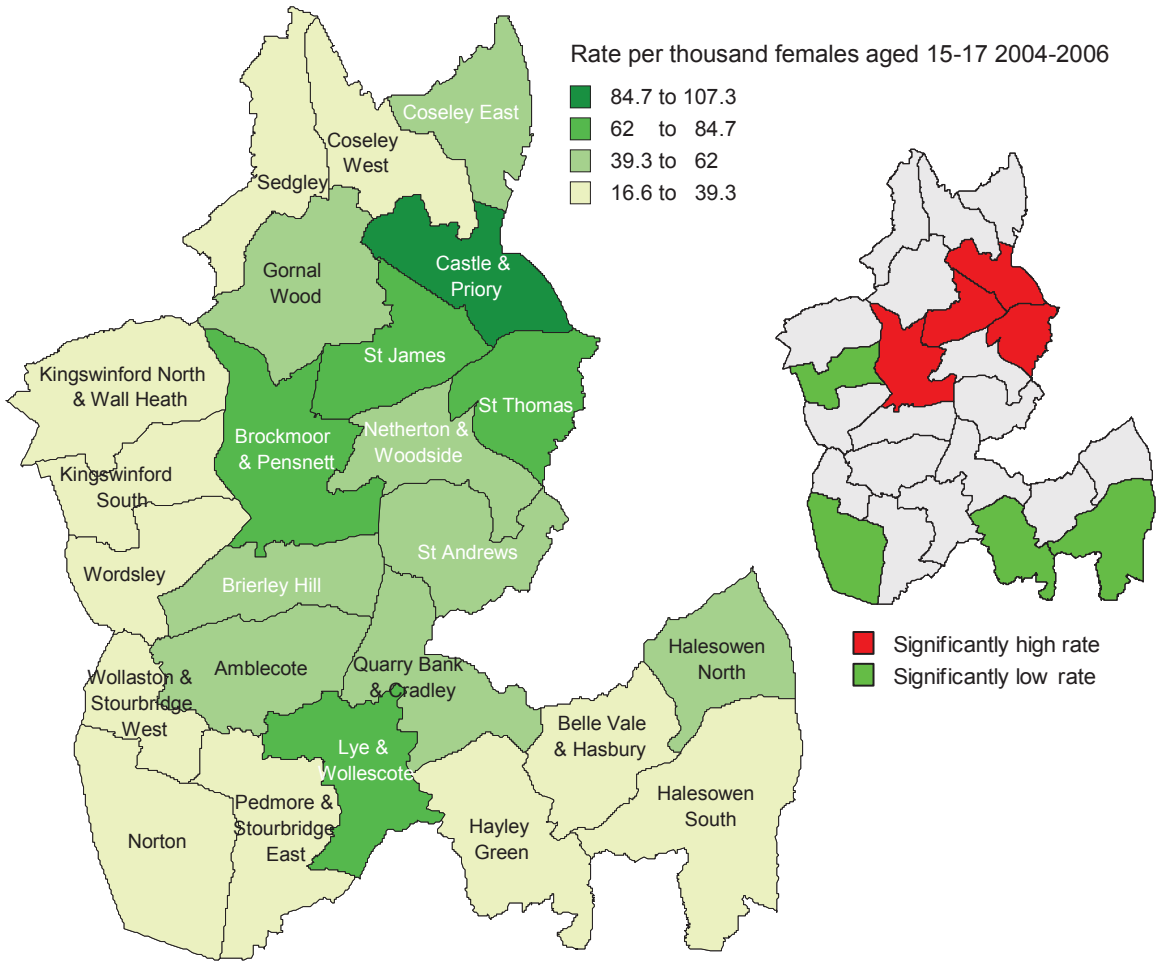


	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
England	46.6	44.8	44	42.5	42.7	42.2	41.6	41.3	40.4	41.7
Dudley	54.7	56.8	50	50.3	50.1	48.0	47.8	46.6	48.8	49.5

Source: Office for National Statistics and Teenage Pregnancy Unit

Official data by ward for 2004-06 shows that the highest rates of teenage pregnancy are in Castle and Priory ward. In fact, the four wards with significantly high rates form a cluster around central Dudley and Pensnett locality. The wards with the lower rates are towards the south and west of the borough, in areas which are generally less deprived (Figure 27).

Figure 27: Rate of Under-18 Conceptions by Ward 2004-06



Source: ONS conception statistics

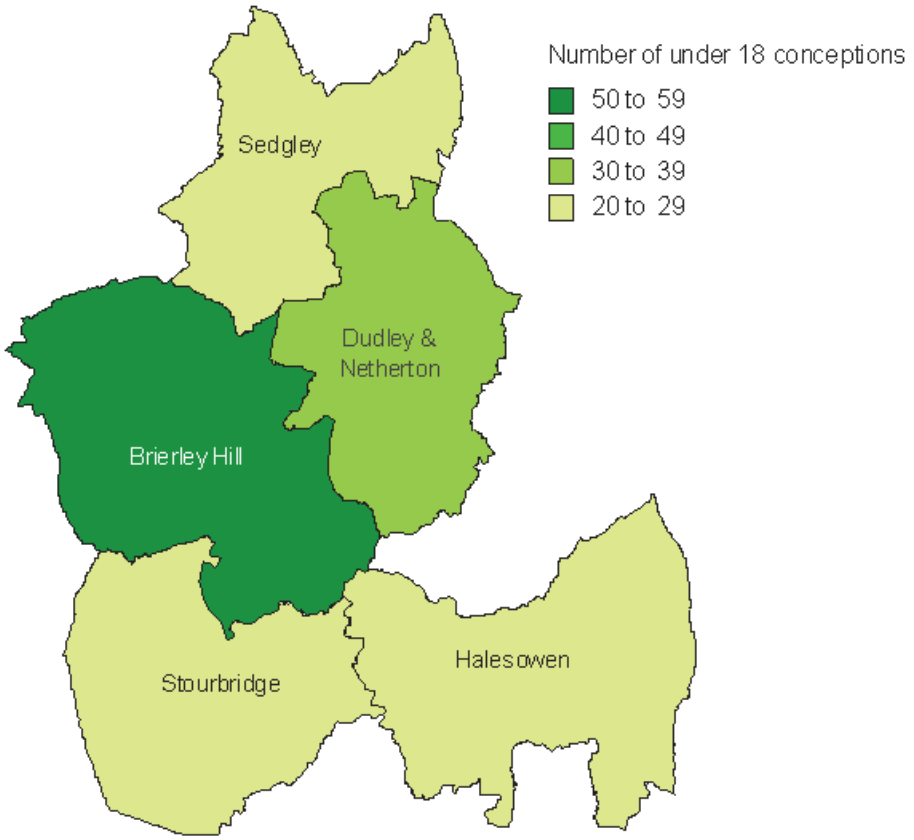
Table 5: Number of Under-18 Conceptions 2006 by IMD (2007) Quintile Group and Locality

IMD Quintile Group	Number
Unknown	31
1 - 20% most deprived	51
2	50
3	17
4	24
5 - 20% least deprived	18
Total	**191**

Locality	number
unknown	31
Brierley Hill	55
Dudley & Netherton	34
Halesowen	26
Sedgley	22
Stourbridge	23
Total	**191**

Source: Teenage Pregnancy Team, Dudley MBC

Figure 28: Number of under18 conceptions in Dudley by locality, 2006



Source: Teenage Pregnancy Team, Dudley MBC

Data available nationally on teenage pregnancy has the disadvantage that it is already at least 18 months out of date by the time it is published.

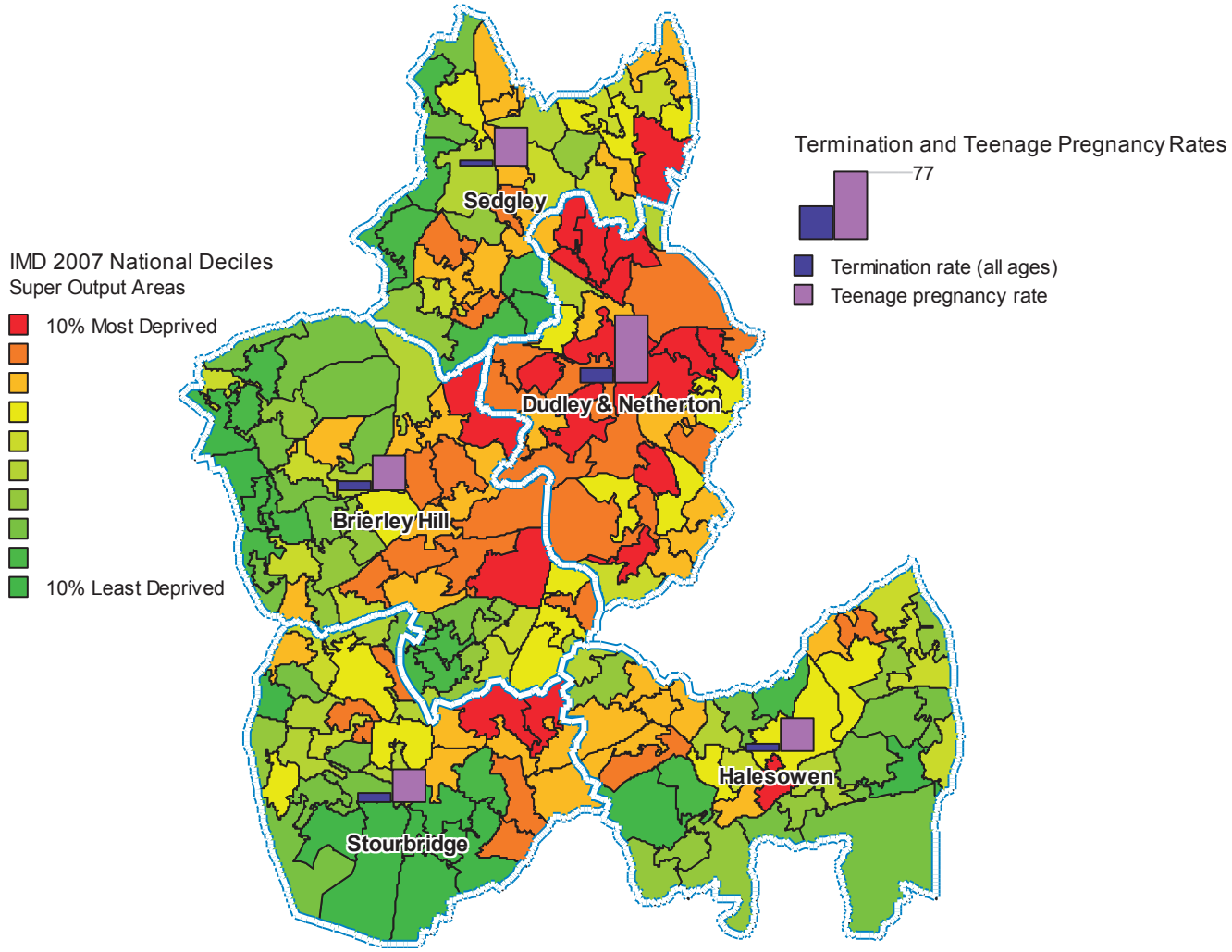
The information presented in Table 5 is based on local teenage pregnancy and termination data for 2006. This data has limitations in that it does not include information on all local teenage conceptions, with around 70% data coverage, as many were not reported to the Teenage Pregnancy team. This information has been included nonetheless as it is more up to date than that available nationally.

Of those under-18 conceptions where the IMD quintile group is known, 63% of them were in the 40% most deprived areas nationally. In comparison, 26% were from the 40% least deprived areas. This difference is significant at the 95% confidence interval.

Figure 28 shows that the largest number of under-18 conceptions is in Brierley Hill, and the second highest number in Dudley and Netherton locality.

Figure 29 shows the rates of termination (2006) and teenage pregnancy (2003-05) by locality, against a backdrop of deprivation. It shows that Dudley and Netherton locality is the hotspot area for teenage pregnancy and termination, and furthermore, that it is also the most deprived part of the borough.

Figure 29: Termination and Teenage Pregnancy Rates in Dudley



Sources: IMD (2007), ONS Conception statistics, Calthorpe Clinic, BPAS

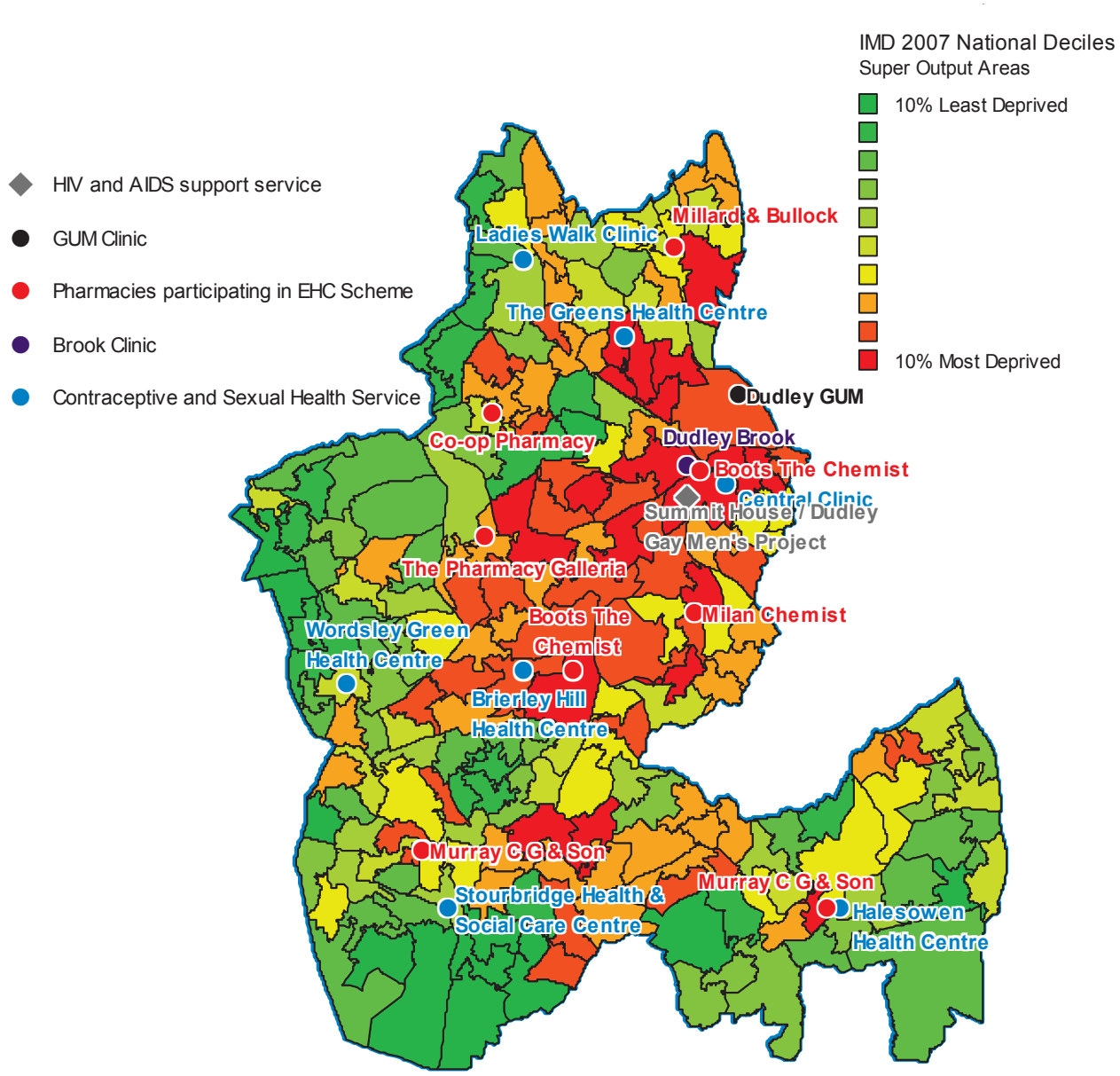
Key points:

- Since 1998 Dudley's teenage pregnancy rates have been consistently higher than England's rates , 47- 57 for Dudley versus 40-47 per 1000 females aged 15-17 for England
- The rate in England fell by 13% between 1998 and 2005 and Dudley fell by 11% over the same period
- The England rate continued to fall in 2006 while Dudley's rate increased by 5% to 48.8 per 1000 in 2006.
- In 2007 both rates increased, England by 3% and Dudley by 1.5%.
- The largest number of under-18 conceptions is in Brierley Hill locality and the second highest number in Dudley and Netherton locality.
- Both under 18 conceptions and termination rates show a strong correlation with deprivation.
- Dudley and Netherton locality is the hotspot area for under 18 conception and termination.

Step 2: What health services are currently available in Dudley and what are the gaps?

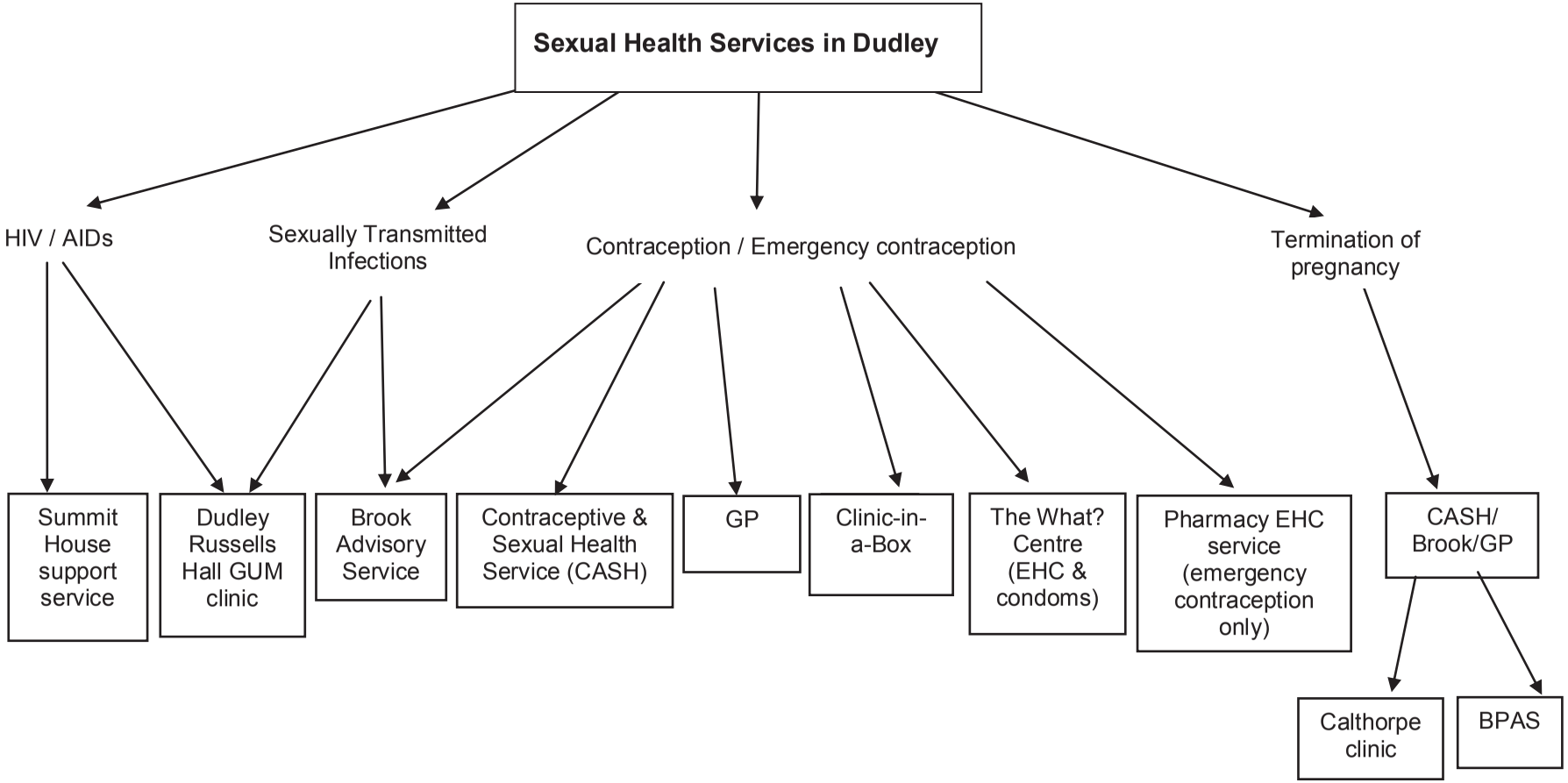
Sexual Health Service Mapping

Figure 1: Location of Specialist Sexual Health Services within Dudley Borough



Source: Dudley PCT, IMD 2007

Figure 2: The flow chart below summarises the available services



Source: Dudley PCT

Brook Advisory Centre, Dudley

Service configuration

Sandwell and Dudley Brook run clinical sessions in the Sandwell and Dudley areas, providing a wide range of free and confidential contraception services and sexual health advice for young people up to the age of 25. The service offers a walk in facility as well as an appointments schedule.

The services offered are:

- Free contraception
- Pregnancy testing with immediate results
- Emergency contraception
- Help, advice and referral for unplanned pregnancy
- Sexual Health advice and information
- Chlamydia testing and treatment
- STI testing and treatment (Saturdays only)

In Dudley, Brook offers clinic sessions on Mondays, Tuesdays, Fridays, and Saturdays at its clinic in Dudley town centre. It also offers a young people's GU service on Fridays and Saturdays.

In addition, it offers a clinic-in-a-box service once a week at the Priory Children's Centre and the What? Centre (commissioned by the PCT on behalf of the Teenage Pregnancy team).

Further clinics are held at various locations in Sandwell borough, which are also accessed by young people from Dudley.

Brook is commissioned by Dudley PCT. Services in Sandwell are funded by Sandwell PCT.

Information

Brook collects demographic and activity data at each visit for all clients using their service, which is then transferred to computer. They provide the PCT with an anonymised dataset from their Dudley clinic, and from Dudley residents using the Sandwell clinic on a quarterly basis. They submit an annual KT31 return to the Department of Health.

Equitable access and workload

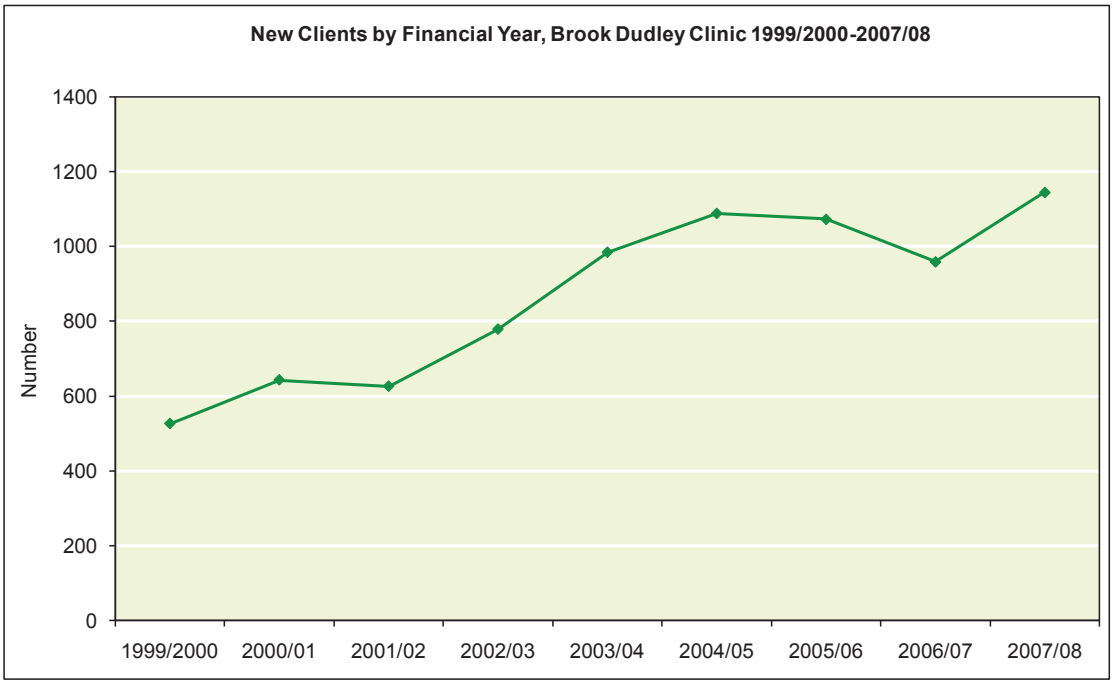
Since 1999 the number of clients using the clinic has increased steadily (Table 1). By 2005/06 both the number of clients and the total number of visits had tripled, to 3588 clinic attendances from 1945 clients. The number dropped back slightly in 2006/07, but rose again in 2007-08 (Figure 3).

Table 1: All visits by financial year Brook Dudley Clinic 1999/2000 – 2007/2008

Year	New clients	First visit in year	Repeat visits	All visits
1999/2000	526	95	439	1060
2000/01	643	225	643	1511
2001/02	626	330	723	1679
2002/03	779	430	920	2129
2003/04	985	530	1218	2733
2004/05	1089	668	1462	3219
2005/06	1073	872	1643	3588
2006/07	959	896	1398	3253
2007/08	1145	936	1667	3748

Source: Dudley PCT Public Health Intelligence Team, Brook Sandwell and Dudley

Figure 3



Source: Dudley PCT Public Health Intelligence Team, Brook Sandwell and Dudley

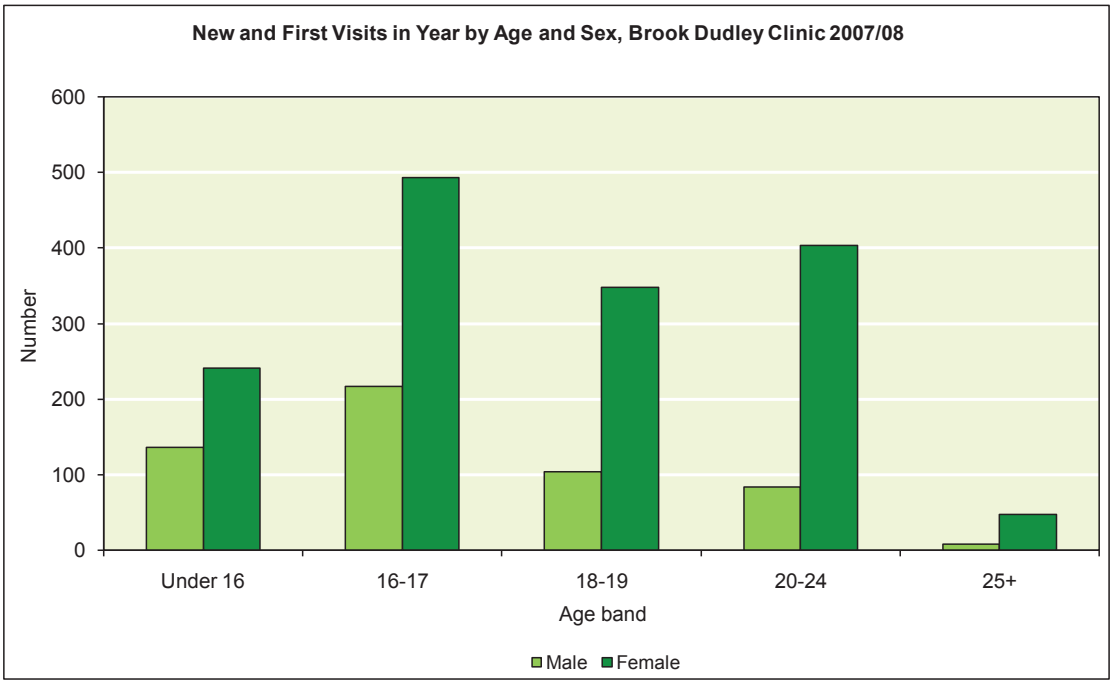
Age

Brook's service is aimed at young people aged under 25, although 3% of all females using the service in 2007/08 were aged 25 and over. Nearly half of female clients are aged under 18 (48%). In comparison, 1.5% of males were aged over 25 and 65% were aged under 18 (Figure 4).

Gender

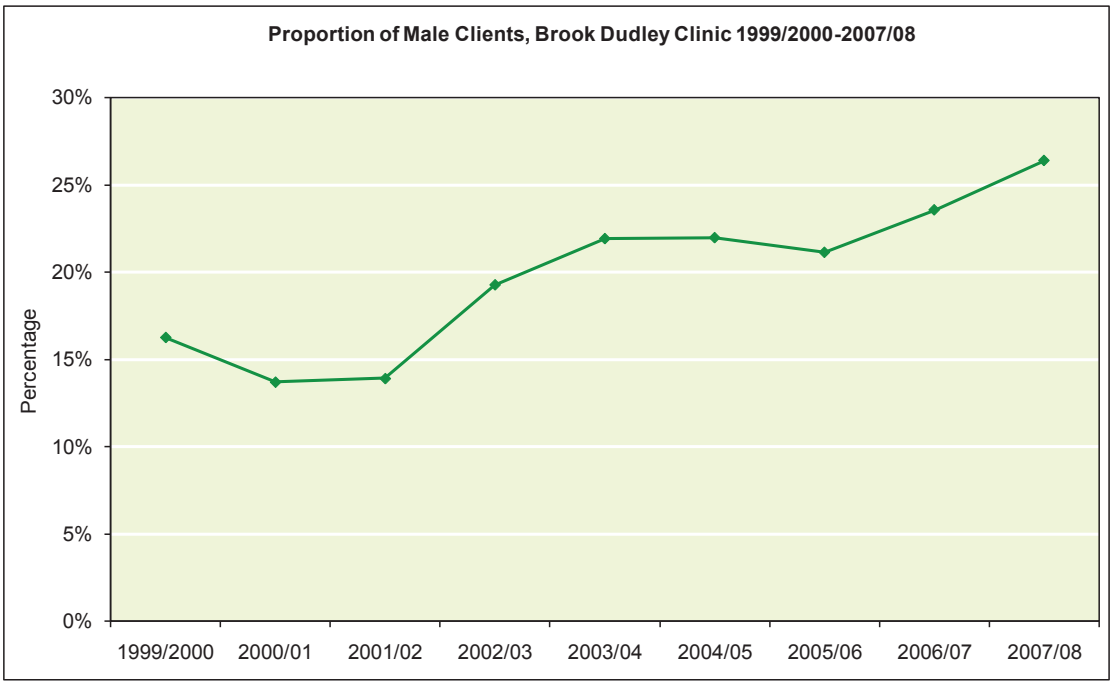
The proportion of male clients rose from 16% in 1999/2000 to 26% in 2007/08 (Figure 5).

Figure 4



Source: Dudley PCT Public Health Intelligence Team, Brook Sandwell and Dudley

Figure 5

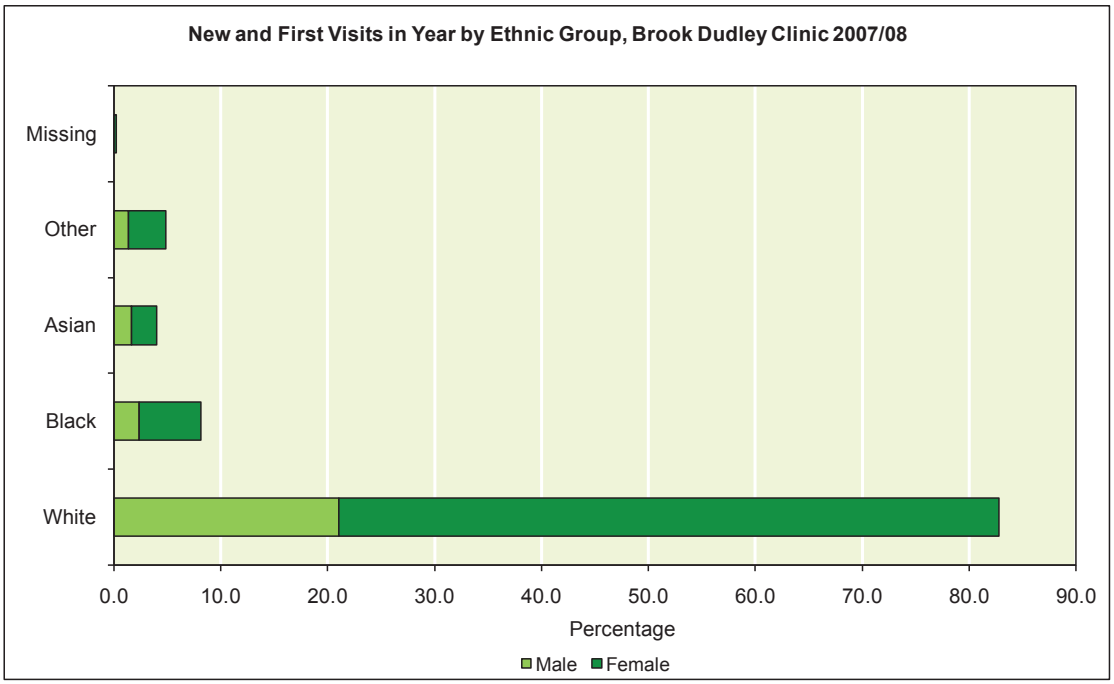


Source: Dudley PCT Public Health Intelligence Team, Brook Sandwell and Dudley

Ethnicity

83% of all clients attending the clinic in 2007/08 gave their ethnic group as White. The second highest group was Black, representing 8% of clients. The data collected by Brook does not contain information on the numbers classifying themselves as mixed race; this is divided amongst the other categories (Figure 6).

Figure 6



Source: Dudley PCT Public Health Intelligence Team, Brook Sandwell and Dudley

Index of Multiple Deprivation

It is not possible to analyse the Brook data by deprivation, as the dataset provided does not include the full postcode.

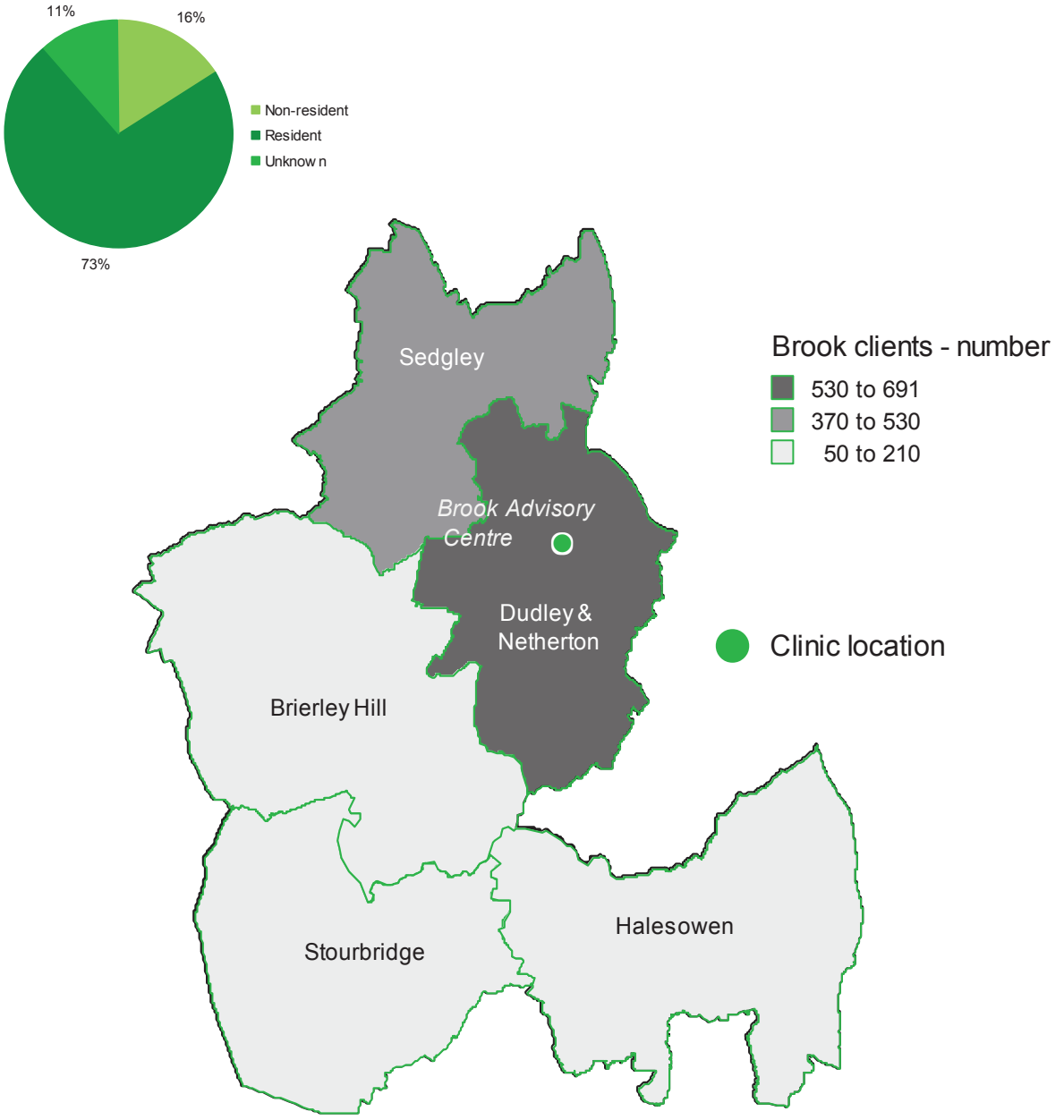
Distribution

The distribution of clients by locality shows that the vast majority of Dudley residents using the service come from Dudley and Netherton locality, the hotspot area for STIs, teenage pregnancy, and abortion, followed by Sedgley locality. Around a quarter of residents come from other localities within Dudley borough (Figure 7).

Contraceptive provision

As is shown in Table 2, the main form of contraception for young women using the service is the condom. Most others use the contraceptive pill, and very few women use long acting contraception.

Figure 7: Distribution of Brook Dudley clients in 2007/08 by Locality



Source: Dudley PCT Public Health Intelligence Team, Brook Sandwell and Dudley

Table 2: Main method of contraception for females using Brook Dudley, 2007/08 (first visits only)

Age band	Hormonal contraception (Numbers)		Long-acting reversible contraception (Numbers)			Condoms (Numbers)
	Combined oral contraceptive	Progestogen-only pill	Implant	Injection	IUD	
Under 15	10			*		57
15-19	256	32		21	*	467
20 and over	102	17	*	21	*	136

Source: Brook Advisory Centre, Sandwell & Dudley

Chlamydia screening

In Q1 08/09, Brook screened 40% of the total Chlamydia screening done in the Borough (90 tests). However, as Brook sees 12% of the target age group for Chlamydia screening per year (>3000), the service is in a good position to make a measurable contribution towards the Chlamydia target (17% of 15-<25 years old).

Skill mix

All staff at Brook are offered opportunities for training. This includes medical update training and specific training in new developments. Brook also undertakes training for other bodies on request, such as training school health advisors in the issuing of EHC.

Quality of service provision

Brook works to agreed National standards and governance with the support of the National Brook organisation and with reference to MEDFASH and BASHH standards. Internal quality systems are operated via the PQASSO quality standards package.

Client satisfaction surveys are undertaken at least once a year. The service was visited by mystery shoppers from Sandwell PCT, and was rated positive overall.

Gaps and future development

Over the past 5 years Brook has more than doubled the number of service users as well as increasing the scope of their work (for example by offering Chlamydia screening and STI testing). This has resulted in a major strain on the organisation's infrastructure. There is also a lack of suitably qualified Family Planning doctors and nurses available, which means that services may be adversely affected in times of sickness or annual leave.

In terms of future development, at a national level there are plans underway to examine the feasibility of Brook offering early medical termination as part of its service. There is an Education Outreach Worker due to be appointed shortly. The movement nationally is towards a national set of minimum service provision so that any young person anywhere in the country will be able to visit a Brook clinic and receive the same standard and quality of service. Brook is hoping to continue to escalate services in line with demand and subject to resources.

Key points:

- A large proportion of clients who access Dudley Brook Service are from the hotspot area for teenage pregnancy, STIs and abortion.
- There is a need for further family planning training so that the service can increase its contraception capacity especially LARC provision.
- Brook screened 40% of the total number screened for Chlamydia in Q1 08/09 in Dudley.
- As Brook sees 12% of the target age group for Chlamydia screening (15-<25) per year, the service is in a good position to make a measurable contribution towards achieving the Chlamydia target.

Brook Advisory Centre, Birmingham

Service configuration

The Brook service has one centre in Birmingham City centre, offering the same range of services as Dudley. It is open from Monday to Saturday, with STI testing available on Mondays and Wednesdays.

Information

Monitoring and review meetings are held every six months and a minimum data set of information is provided at these meetings.

Equitable access and workload

In 2003/04-2007/08, there was a 9% reduction in the number of Dudley population accessing Brook Birmingham services. The decline was most pronounced in people aged 16-19, which was 16%. In those aged under 16 there was an increase of 28%. In Table 3 the age ranges '20-24' and '25 and over' have been combined due to the very small numbers of over 25s using the service (less than 20 in total over the 5 years shown).

Table 3: All visits to Brook Birmingham by Dudley residents 2003/04 – 2005/06

	Year					% change
Age Band	2003/04	2004/05	2005/06	2006/07	2007/08	2003/04 to 2007/08
Under 16	103	118	69	128	132	28.2
16-19	524	442	399	428	442	-15.6
20 and over	241	208	200	206	215	-10.8
Total	868	768	668	762	789	-9.1

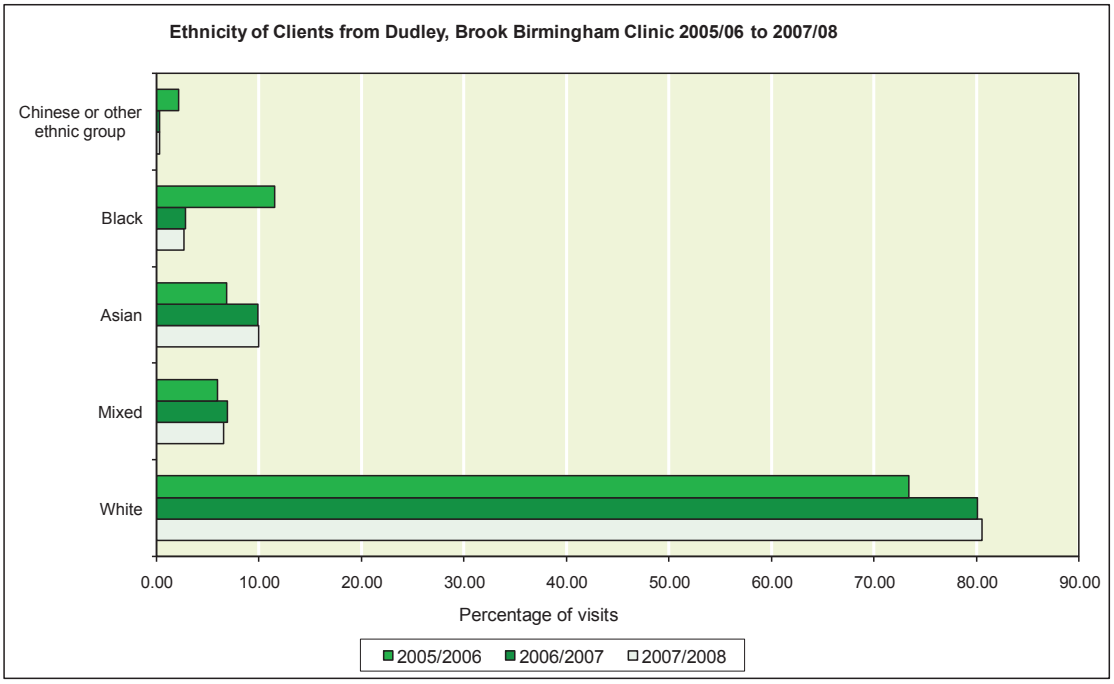
Source: Brook Advisory Service, Birmingham

Ethnicity

73% of Dudley clients who stated their ethnicity during 2005/06 were white, this increased to 81% during 2007/08. Of the other ethnic groups represented, the second largest was black, at 12% for 2005/06. The second largest for 2007/08 was Asian at 10%. 4% of clients in 2005/06 did not state their ethnicity, and this has remained at 4% for 2007/08 (Figure 8).

The proportion of BME clients is higher than at Dudley Brook.

Figure 8



Source: Brook Advisory Service, Birmingham

Services

The most frequently used service is supply of condoms, which accounts for over 40% of all activity at the clinic. This data is not currently available for 2007/08.

Table 4: Five most commonly used services at Brook Birmingham 2005/06

Service	No.	%
Condom Supplies	370	43.5
Contraceptive Supplies	84	18.3
Infection Testing	66	9.9
Pregnancy Testing	52	7.7
Emergency Contraception	35	6.1

Source: Brook Advisory Service, Birmingham

- In 2003/04-2007/08, there was a 9% reduction in the number of Dudley population accessing Brook Birmingham services. There was an increase of 28% in those aged under 16

Key points:

Contraceptive and Sexual Health Service (CASH) (Dudley PCT Community Services)

Service configuration

Clinics

The contraceptive and sexual health service runs the following clinics from its base in Central Clinic, Dudley:

4 general clinics on Monday, Tuesday and Wednesday evenings and Thursday afternoon

1 young persons clinic (alternate Thursdays)

2 pregnancy counselling clinics

2 vasectomy counselling clinics

1 long acting reversible contraception (LARCs) training clinic (which runs alongside a general clinic).

The service also runs 8 outreach clinics across the borough:

2 at Stourbridge Health and Social Care centre (Monday evening, Wednesday lunchtime)

2 at Halesowen Health Centre.

1 at Ladies Walk clinic, Sedgley.

1 at the Greens Health Centre, Dudley

1 at Brierley Hill Health Centre

1 young person's clinic at Wordsley Green

Clients can use a drop-in facility at all clinics or make appointments. Domiciliary visits, vasectomy and pregnancy counselling and smears are by appointment only. Clients will be seen for termination counselling within 10 working days of referral and vasectomy clients within 3 months of referral.

Services

Services available are:

- Pregnancy testing
- Emergency contraception. Emergency Intrauterine Device (IUD) is currently not offered at young persons clinics
- Free condoms
- A choice of methods of hormonal contraception
- Fitting of LARCs: Implant, IUD (coil), Intrauterine System (IUS) (Mirena)
- Domiciliary service is available to those unable or unwilling to attend clinics
- Unplanned pregnancy counselling and referral
- Vasectomy counselling and referral
- Cervical screening through the national screening programme
- Chlamydia screening through the national screening programme

- Advice and information on all aspects of sexual health and well being

Information

Demographic data are collected on all new patients accessing the service. In addition, activity data are collected at each visit for all patients. Information is coded by clerical officers from patient notes before inputting into a computer. Information for general and vasectomy clinics is stored on the 'Total Care' system and termination data are stored on 'PEAK' system. Further information on terminations is collected and stored manually, although a new computer system for pregnancy counselling is being introduced which will replace the manual data collection.

Information is used in compiling KT31 annual returns, although problems have been identified in producing accurate returns, as the system does not recognise more than one activity in the same care episode, which might result in the underestimation of clinical activities such as LARC. Other output from the system is possible but complicated and time consuming.

Equitable access and workload

Trend and Gender

Since 2002/03 the total number of clients has fallen by 13%. The number of males has fallen slightly faster than females, showing a 17% fall since 2002/03 (Table 5).

Table 5: Contraceptive and Sexual Health Service, Dudley. Number of clients by financial year 2002/03 to 2006/07

Year	Female	Male	Total
2002/03	5904	880	6784
2003/04	5692	913	6605
2004/05	5625	799	6424
2005/06	5370	762	6132
2006/07	5179	730	5909

Source: Dudley PCT Information Management Team

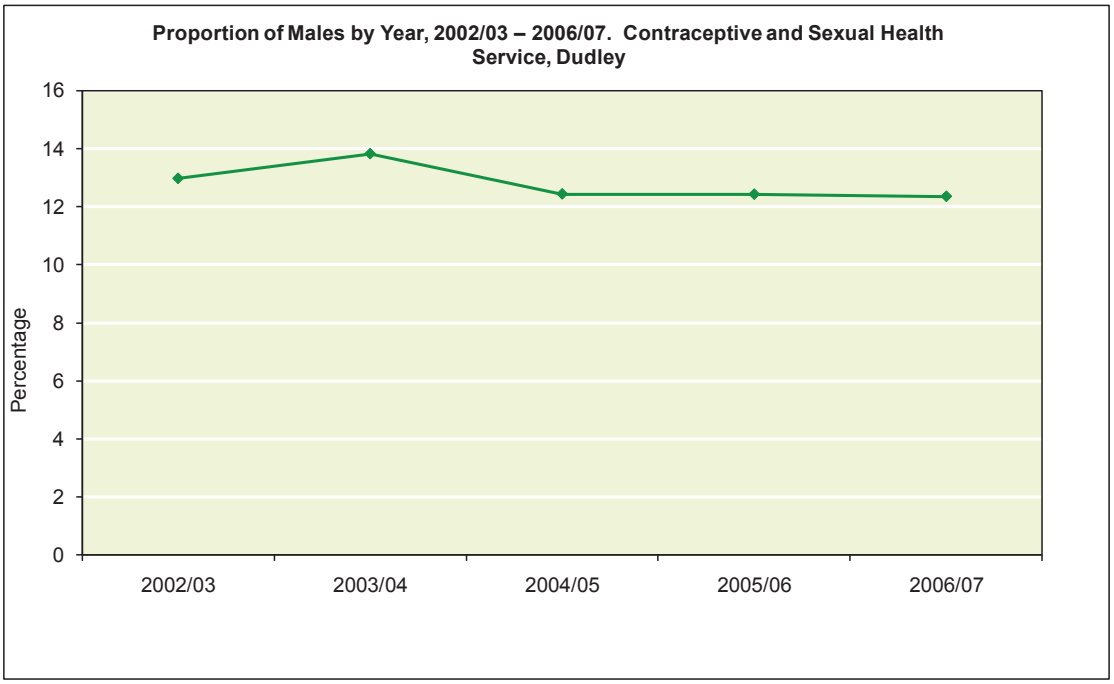
Age and Gender

During 2006/2007, 88% of CASH clients were females (Figure 9). 44% of all CASH clients were under 25 years old. 46% of all female clients were aged under 25 and 29% of all males were under 25 (Table 6, Figures 10 and 11).

During the same period, the peak age group of females using the service was 20-24 years old and for males it was 35-39. However, amongst males the proportion for this age band was 47%, higher than for females. There was also a second, smaller peak amongst males at 16-17 years.

However, it should be noted that the age bands for the under 20 age groups are less than 5 years. If considered on the same 5 year basis as older age bands, the under 20 age band is the highest proportion of clients accessing CASH.

Figure 9



Source: Dudley PCT Information Management Team

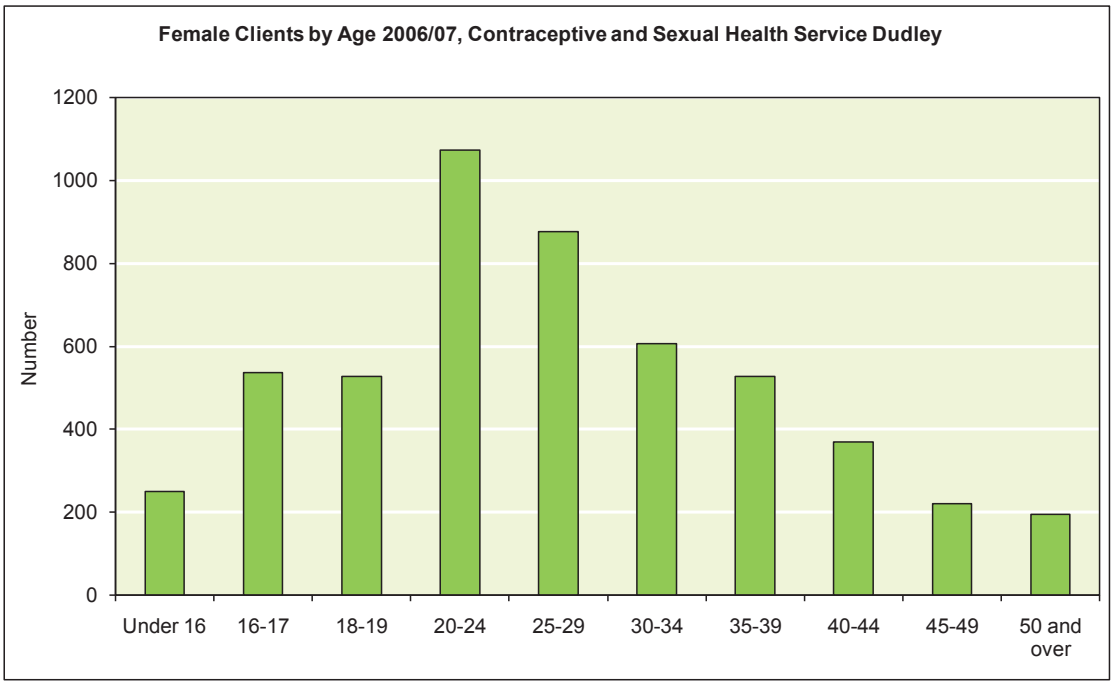
Table 6: Contraceptive and Sexual Health Service, Dudley. Clients by Age Band and Sex

Age Band	Females		Males		All Clients	
	Number	Percent-age	Number	Percent-age	Number	Percent-age
Under 16	250	4.8	46	6.3	296	5.0
16-17	536	10.3	80	11.0	616	10.4
18-19	527	10.2	36	4.9	563	9.5
20-24	1073	20.7	51	7.0	1124	19.0
25-29	876	16.9	63	8.6	939	15.9
30-34	606	11.7	109	14.9	715	12.1
35-39	527	10.2	152	20.8	679	11.5
40-44	369	7.1	111	15.2	480	8.1
45-49	221	4.3	54	7.4	275	4.7
50 and over	194	3.7	28	3.8	222	3.8
Total	5179	100	730	100	5909	100

2006/07

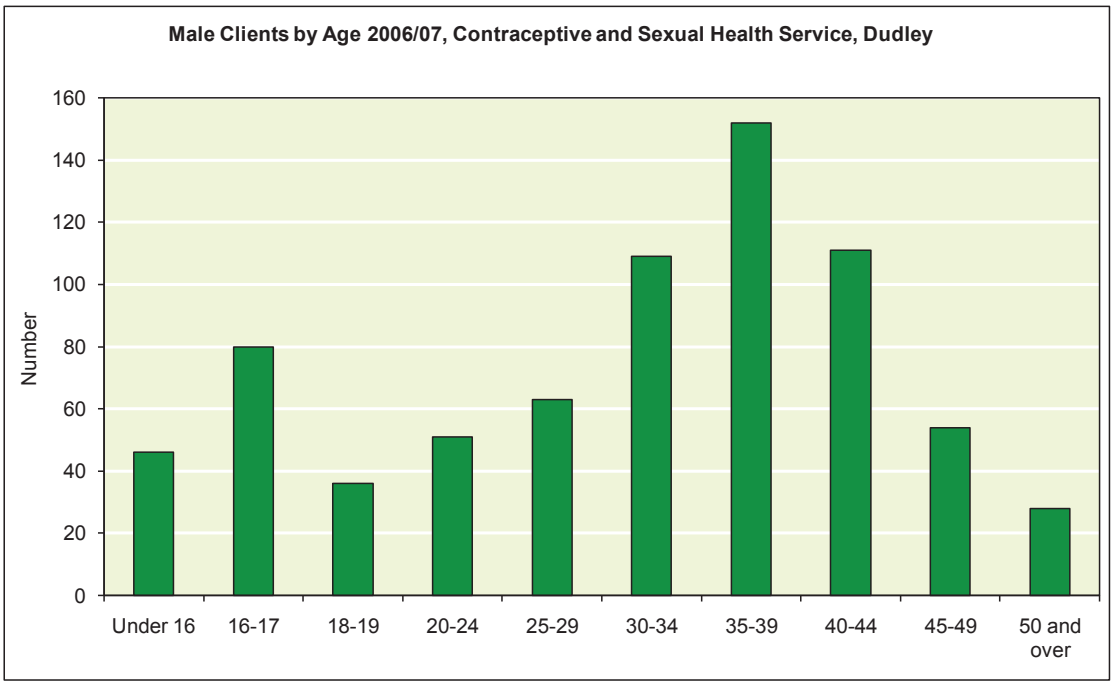
Source: Dudley PCT Information Management Team

Figure 10



Source: Dudley PCT Information Management Team

Figure 11

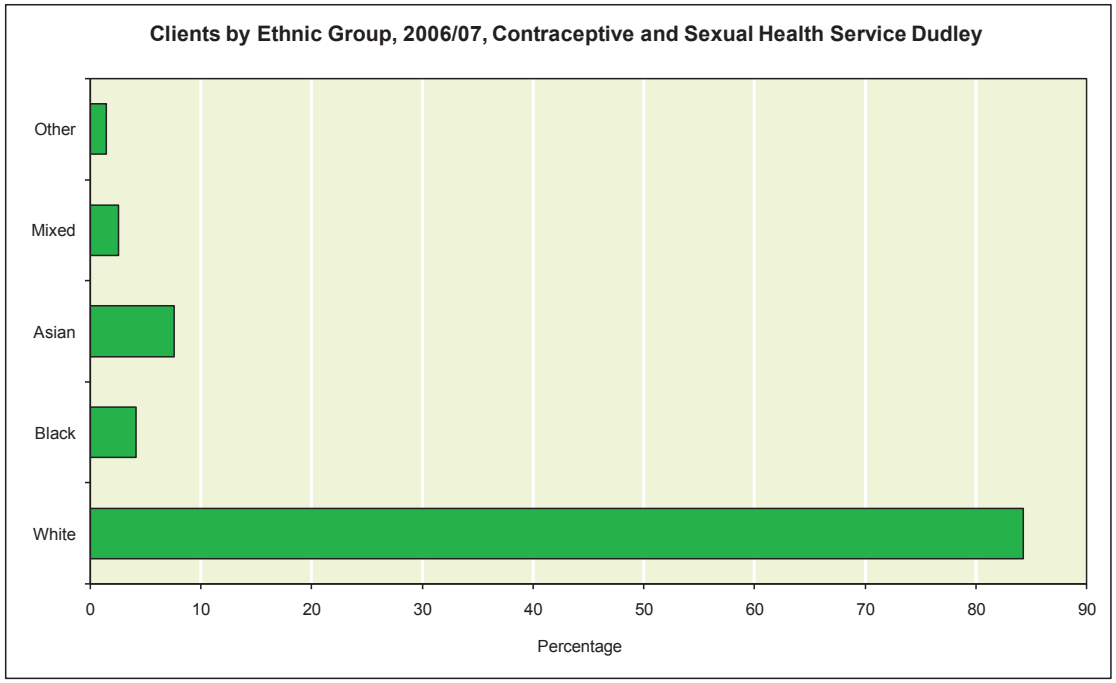


Source: Dudley PCT Information Management Team

Ethnicity

61% of clients did not state their ethnicity. Of those who did, 84% were White. The second largest ethnic group was Asian, at 8% (Figure 12).

Figure 12

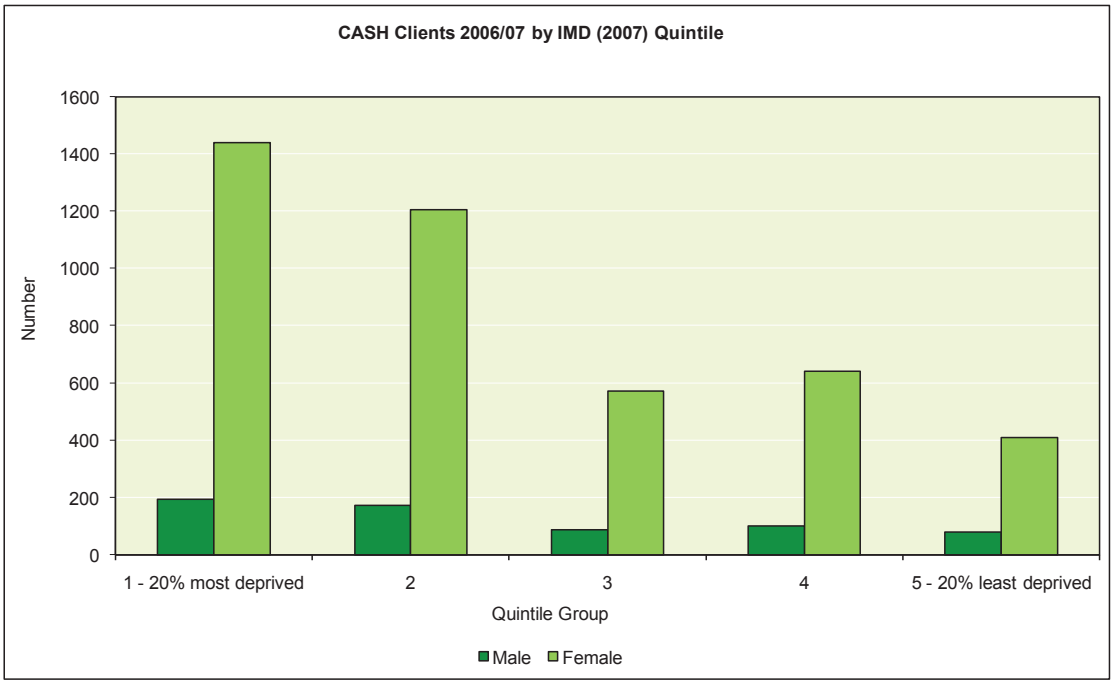


Source: Dudley PCT Information Management Team

Distribution by Index of Multiple Deprivation (2007)

The level of deprivation is unknown for 17% of clients, either because the postcode was missing or invalid or because they came from outside the borough. Of those where the deprivation level is known, a third came form the 20% most deprived areas nationally (Figure 13).

Figure 13



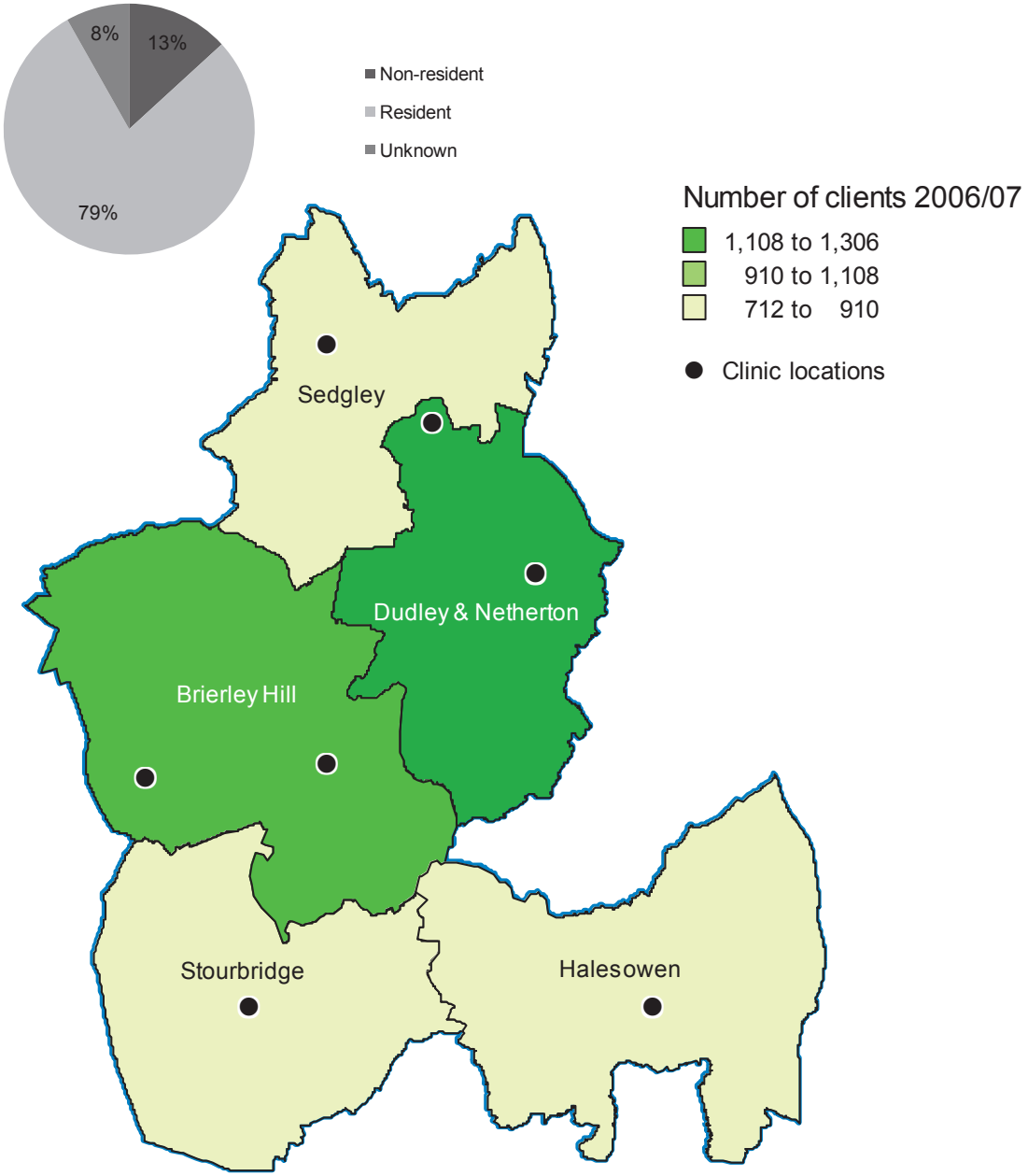
Source: Dudley PCT Information Management Team

Distribution by locality

The locality with the highest number of clients is Dudley & Netherton. Brierley Hill has the second highest number.

At least 13% of clients live outside the borough (Figure 14).

Figure 14: Contraceptive and Sexual Health Service Clients by Locality 2006/07



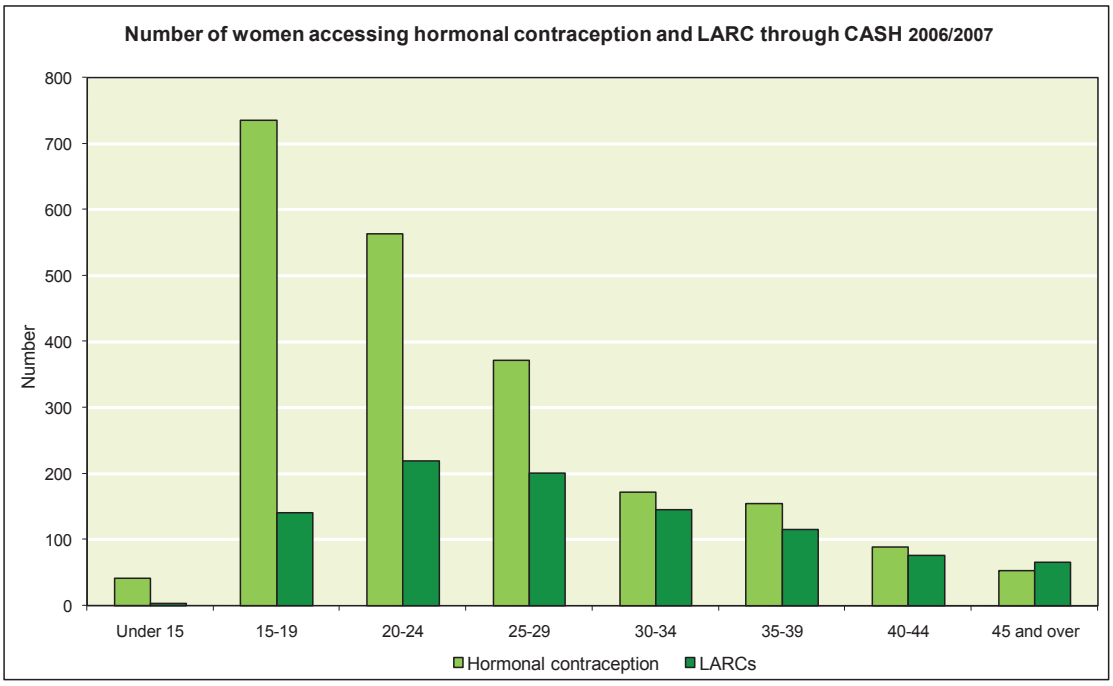
Source: Dudley PCT Information Management Team

Contraceptive use through CASH

Looking at the uptake of different contraceptive methods by age group for 2006/07, oral hormonal contraception was higher among all age groups except >45 years old, where LARC uptake was higher in the age group. The largest age group accessing oral hormonal contraceptives through the CASH service was 15-19 year olds. In this age group the proportion of oral hormonal contraception is much higher than LARC (87% vs. 13%).

LARCs usage in terms of numbers peaks at age 20-24. The ratio of LARCs to oral contraceptives increases with increasing age – above age 30 the numbers using LARCs and oral contraceptives are similar, with 30% of contraceptive usage being LARCs and 35% oral contraceptives. (The remainder being mostly condoms) (Figure 15).

Figure 15



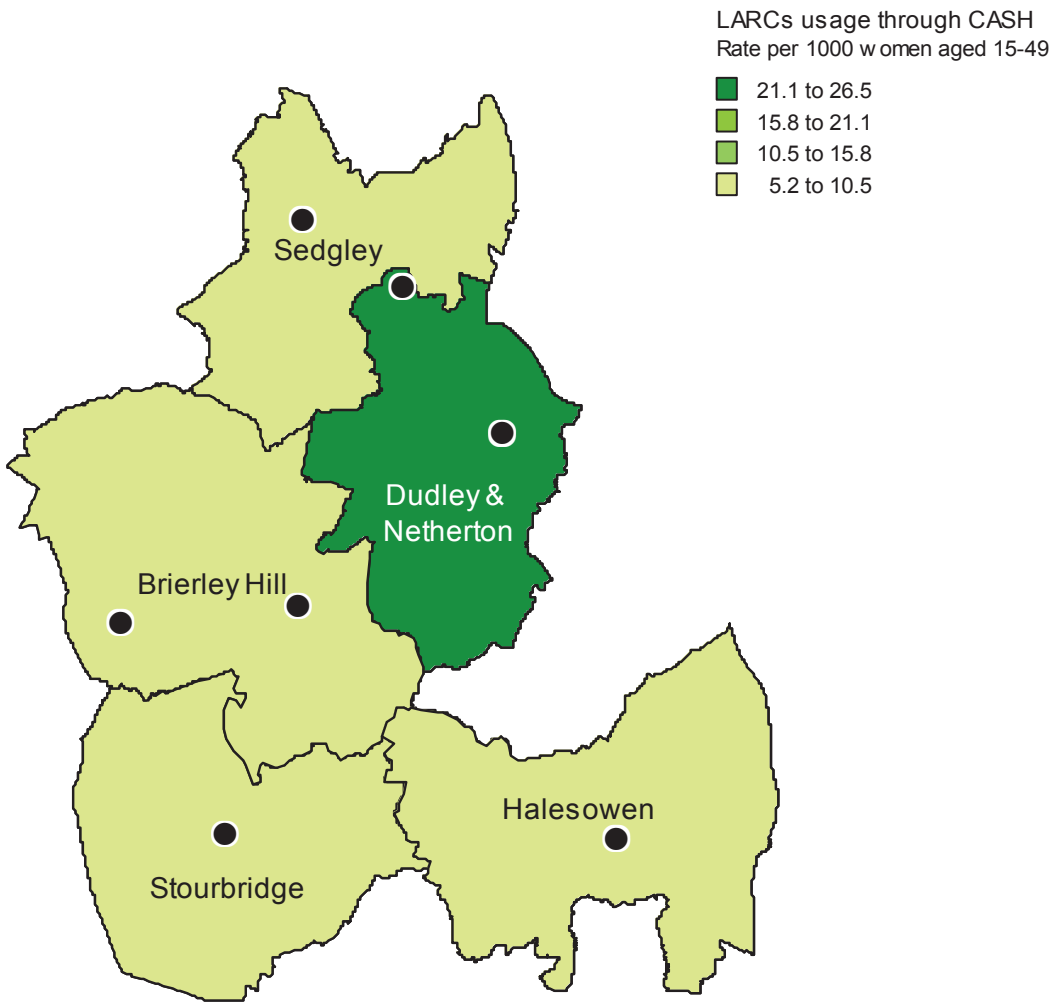
Source: Dudley Contraceptive and Sexual Health Service

Figure 16 shows the distribution of women receiving LARCs through the CASH service, and the location of CASH clinics. The highest concentration of women receiving LARCs is in Dudley and Netherton locality, which is where the main CASH clinic is based. The rate in Dudley and Netherton locality is significantly higher than in any other locality, but this may be due to the availability of services rather than increased need.

Chlamydia screening

Although CASH sees 8% of the Chlamydia screening target age group per year (15-<25 years), the service screened 18 persons only during quarter 1, 08/09(April-June 2008).

Figure 16: Rate of LARCs usage through CASH service 2006/07 by Locality (per 1000 women aged 15-49)



Source: Dudley Contraceptive and Sexual Health Service

Skill Mix

Medical staff

The service employs four part time Medical Associate Specialists posts, providing 1.04 whole-time equivalents (WTE) in total:

- 2 general clinic posts (0.31 WTE and 0.1 WTE)
- 1 pregnancy counselling post(0.21 WTE)
- 1 vasectomy counselling post (0.21 WTE)

In addition, there are six part-time Staff Grade Practitioners, with a combined total of 1.05 WTE (individual posts vary from 0.1 to 0.35 WTE).

Two members of the medical staff are trained to provide GU services – one has a diploma in GU medicine.

Three of the doctors employed are able to train others. Training sessions are offered on Monday evenings and Wed mornings at Central Clinic and Thursday evenings in Brierley Hill. A LARCs training clinic is also run, with the emphasis currently on training the service's own staff.

Nursing staff

In addition to doctors, the service employs one lead nurse (band 8a), at 0.8 WTE. There are 13 part-time nurses employed – 11 at band 6, totalling 1.51 WTE, and two at band 5 (0.2 WTE). Three part-time nursing assistants are also employed (band 2), at 0.37 WTE.

The nursing staff employed work in a variety of areas outside CASH – six work in general practice, one district nurse, one health visitor, one school nurse and one works for the Youth Offending Service. All are trained to give Depo-Provera injections, but none are currently trained to fit LARCs.

The service also employs 2.46 WTE Admin & Clerical band 2 and 0.88 WTE Admin & Clerical band 5.

The CASH service runs 2 courses – "Contraception and Sexual Health - the basics" and "Update on Contraception" – twice a year through the PCT training department. They also have input on the Wolverhampton University Family Planning Course.

They provide clinical placements to postgraduate medical and nursing staff undertaking family planning training.

Quality of service provision

As part of the PCT the CASH service is managed as a specialist community service and shares many policies and guidelines with the PCT, such as child protection and pregnancy testing. However, they do have their own service protocols which are in the process of being updated. An informal referral protocol exists for gynaecology, and there is an agreed protocol for psychosexual services with the GUM clinic.

The clinic has a general satisfaction questionnaire and satisfaction questionnaires specifically for pregnancy counselling and vasectomy counselling.

The latest satisfaction survey for general clinics was carried out in September and October 2008. This showed that 89% of respondents were satisfied with the service, and only 1% were dissatisfied (10% of respondents did not answer the questions). 95% thought that the environment was good and suited to their age group. The most frequent comments made on how the service could be improved were to open longer hours and offer more sessions.

Gaps and future development

The current system of data flow is not adequate for modern commissioning or provision. Work needs to be done to improve the quality of KT31 reporting and to establish a regular flow of data into Public Health to assist in development of the service. The service needs to be ready to respond when the new KT31 reporting is introduced in summer 2009.

There are currently no GUM sessions offered, and the possibility of offering such services is currently being explored with the GUM clinic at Russell's Hall hospital.

There are currently no nurses trained to fit LARCs. Work is ongoing to train nurses in this area, and the first four are due to be trained in 2009.

The service are due to employ a consultant, and there is a general lack of full time members of staff which may have implications on clinical governance, more specifically, continuity of care and the staff's continuing professional development.

The service is based at Central Clinic in Dudley, which is shared with various other services. CASH has no consulting rooms of its own, which limits its ability to expand and develop services further.

Key points:

- 44% of CASH clients are under 25 years old.
- CASH conducts a young person's clinic every fortnight and there is no young person's service over the weekend.
- Although CASH provides most methods of contraception, intrauterine device insertion for emergency contraception is not offered during young person clinics.
- CASH does not provide a genitourinary service at Central Clinic or any outreach clinics.
- CASH current information system does not provide accurate information on client's demographic characteristics and contraception use. As a result, it does not meet the need to track progress in service provision or to commission effectively on behalf of its population.
- Almost all CASH staff works on a part-time basis. This has implications on clinical governance, more specifically, on continuity of care and staff continuing professional developments.
- There is a lack of leadership at the consultant level.
- Although patient satisfaction surveys were positive, the need for extended opening hours and more sessions weer highlighted.
- The uptake of Chlamydia screening through CASH services is extremely low.

Emergency Hormonal Contraception Distribution Scheme

Service configuration

From March 2006 Dudley PCT introduced a Local Enhanced Service under the Community Pharmacy contract for selected Community Pharmacies within Dudley Borough to supply Emergency Hormonal Contraception (EHC) in the form of Levonelle 1500® free of charge to females aged 13 and over in accordance with licensed indications and the PCT approved Patient Group Direction. This service was introduced in a phased manner following a pilot that commenced in four sites. In 2007/08 the scheme included 7 pharmacies (11% of pharmacies in the Borough) (Figure 20). There are currently 13 pharmacies in the scheme which is 21% of the pharmacies in Dudley Borough.

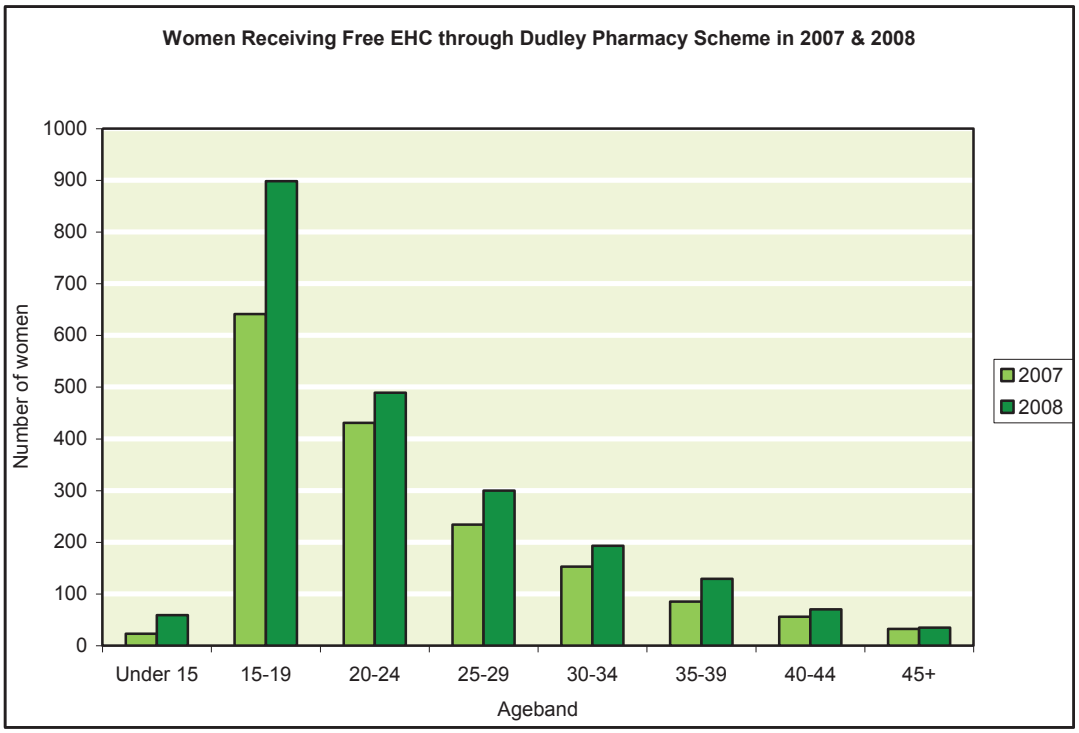
Information

Pharmacies in the scheme collect demographic data on women using the scheme, which is sent to the PCT monthly.

Equitable access and workload

In 2007/08 seven pharmacies issued free emergency contraception through the scheme (1655 packs were issued in total). 39% of EHC was used by teenagers aged 15-19. There was a significant increase in supplies issued in 2008/09 (2173 packs in total); this increase was most pronounced in the 15-19 age band (Figure 17).

Figure 17



Source: Dudley PCT

69% of all EHC issued through the scheme was through Boots pharmacy at Merry Hill shopping centre. The second largest issuer was Boots pharmacy in Dudley Market Place, at 15% (Figure 18).

An analysis of cost shows that the total cost for 2007/08 was £41,195 (Table 7).

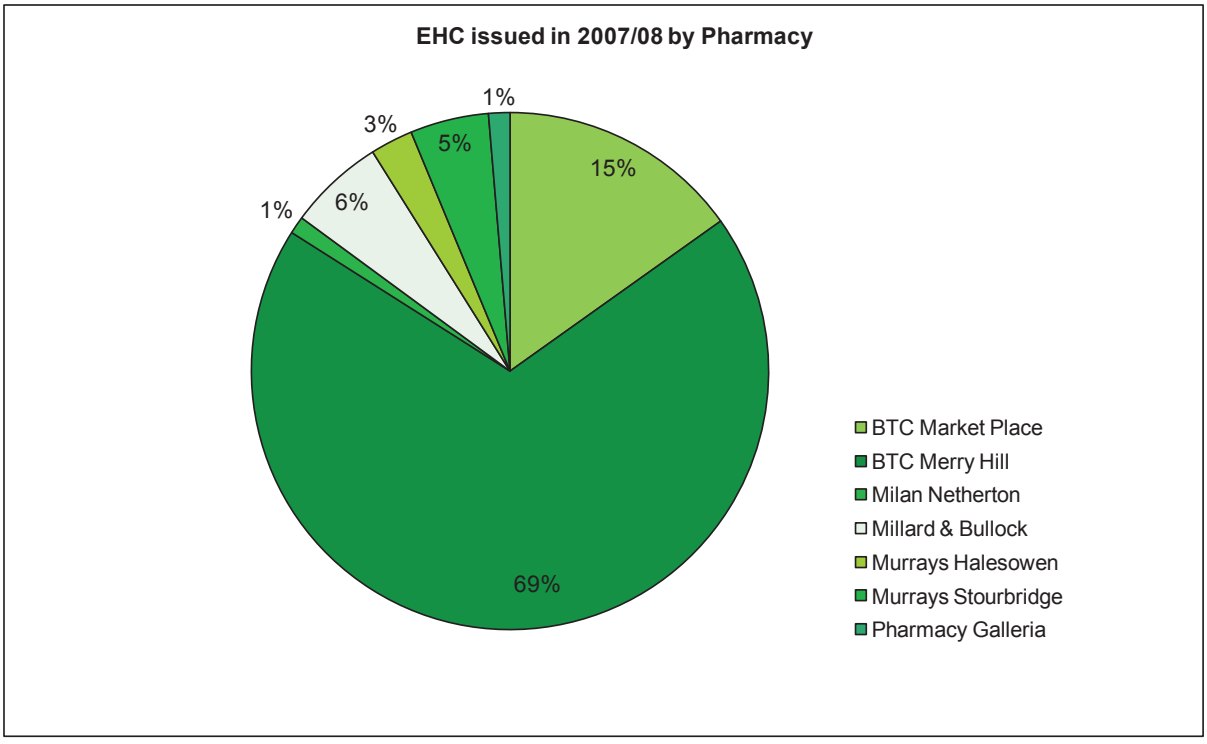
The highest rate of free EHC use was in Brierley Hill locality – this may be because of the easy availability of EHC at Boots in Merry Hill.

Table 7: Annual Spend on EHC Pharmacy Scheme, 2007/08

Pharmacy	Annual Total Cost 07/08
BTC Market Place	£6,375
BTC Merry Hill	£27,475
Milan Netherton	£555
Millard & Bullock	£2,850
Murrays Halesowen	£1,115
Murrays Stourbridge	£2,145
Pharmacy Galleria	£655
Swinford Pharmacy	£25
Total	£41,195

Source: Dudley PCT Information Management Team

Figure 18

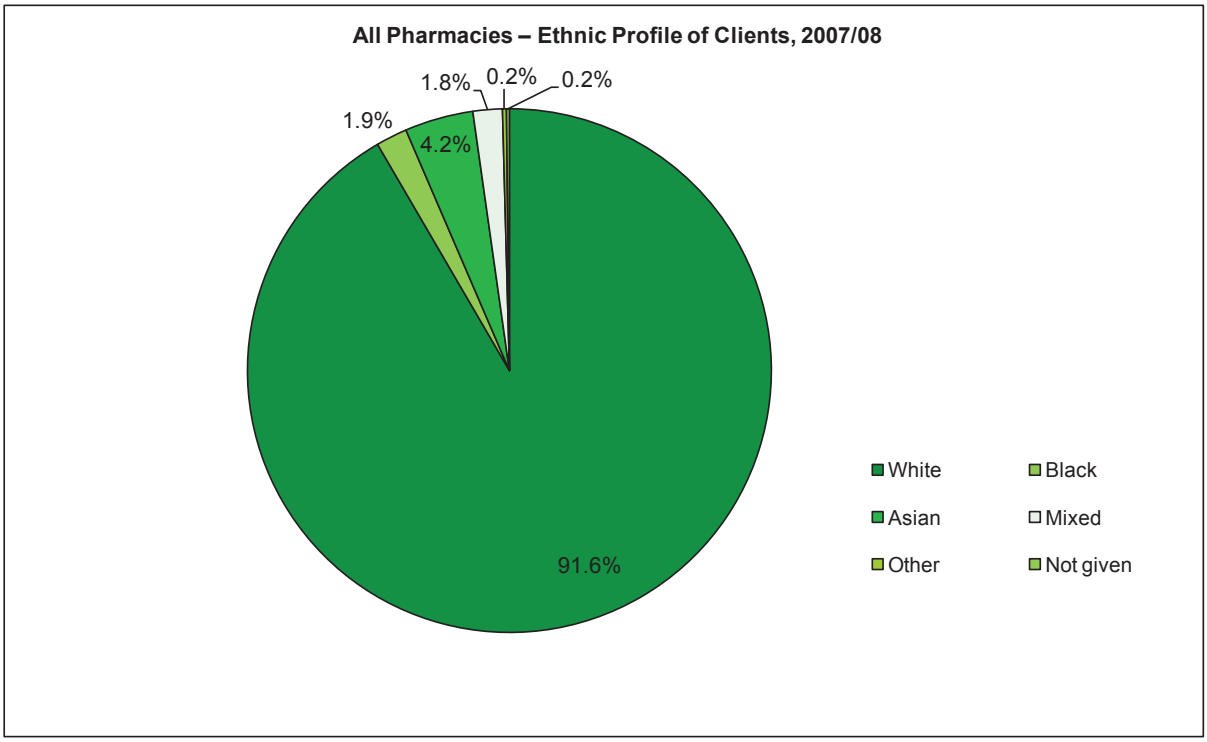


Source: Dudley PCT

Ethnicity

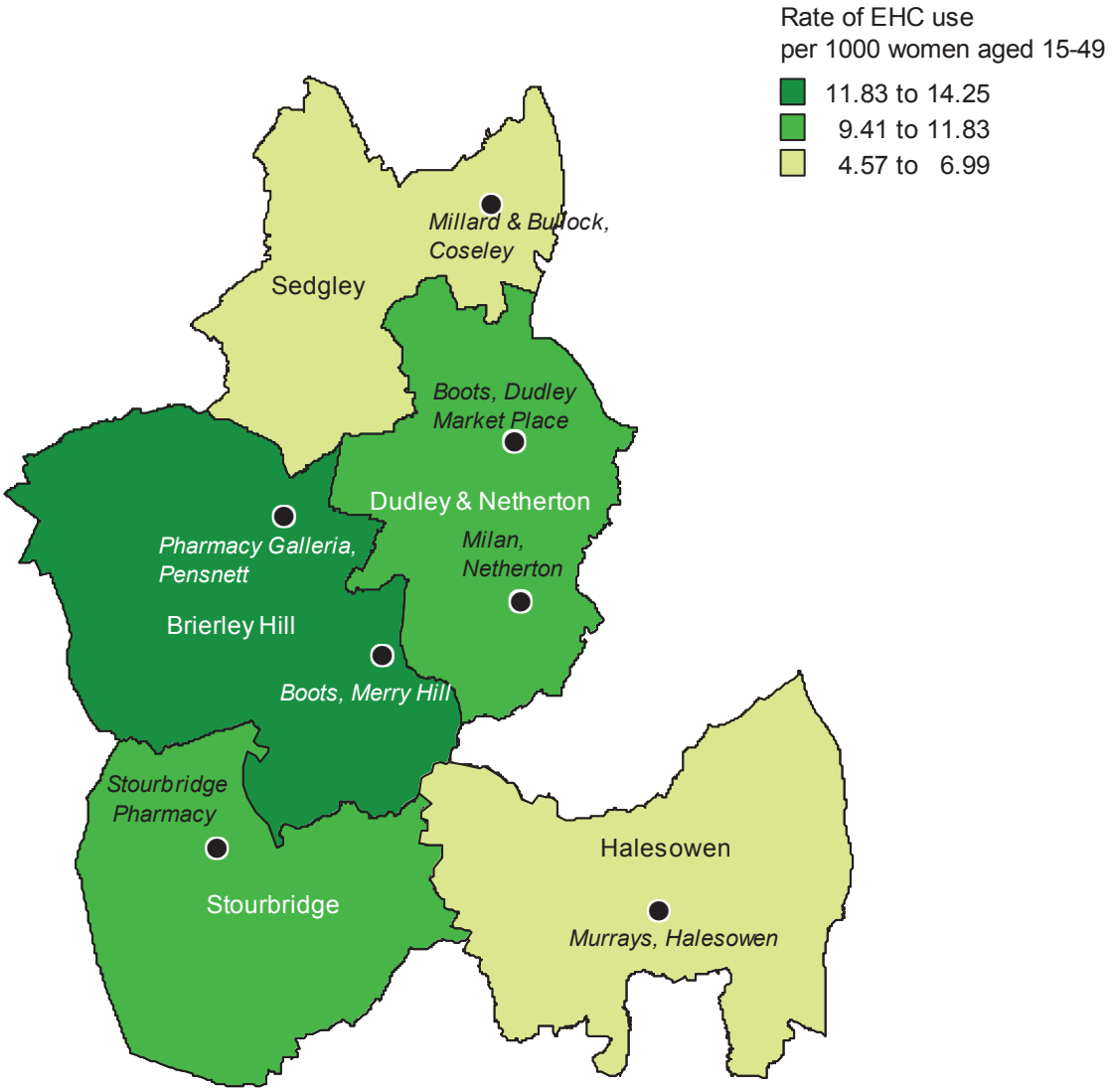
In 2007/08 91.6% of all clients gave their ethnicity as White. The second highest group was Asian, at 4.2%. Ethnicity was not stated by 0.2% of clients.

Figure 19



Source: Dudley PCT Information Management Team

Figure 20: Rate of EHC uptake through the Pharmacy distribution scheme 2007/08



Source: Dudley PCT

As the table below shows, approximately 40% of women using the service came from outside the borough. However, a third of the records collected did not include full postcode so were excluded from the analysis. Among the Dudley borough localities, the highest rate of EHC uptake was in Brierley Hill, at 16.7 per thousand women aged 15-45. The lowest rate was in Sedgley. As Sedgley is close to the border with Wolverhampton, many women may be accessing EHC there instead.

Table 8: EHC Uptake through the Pharmacy Scheme by Locality, 2007

Locality	Number	Rate per 1000 women aged 15 -49
Dudley Borough	672	9.7
Brierley Hill	272	14.2
Dudley & Netherton	136	11.0
Halesowen	78	5.7
Sedgley	57	4.6
Stourbridge	129	10.7
Outside borough	423	-
Unknown	1095	-

Source: Dudley PCT Information Management Team

Key points:

- EHC scheme covers 11% of Dudley's pharmacies
- In 2007/08, 39% of EHC was used by teenagers aged 15-19
- The highest uptake rates of EHC are in Brierley Hill locality. The second largest uptake was in the hot spot areas for Teenage pregnancy and abortion (Dudley and Netherton) and Stourbridge.
- Demographic data collected through the scheme is not complete (full postcode).
- 69% of all EHC issued through the scheme in 2007/08 was through Boots pharmacy at Merry Hill shopping centre. The second largest issuer was Boots pharmacy in Dudley Market Place, at 15%.

Condom Distribution Scheme

Service configuration

The condom distribution scheme is run by the PCT with the aim to make free condoms available to young people through a variety of settings such as youth centres and Colleges. The scheme has been running since December 2006.

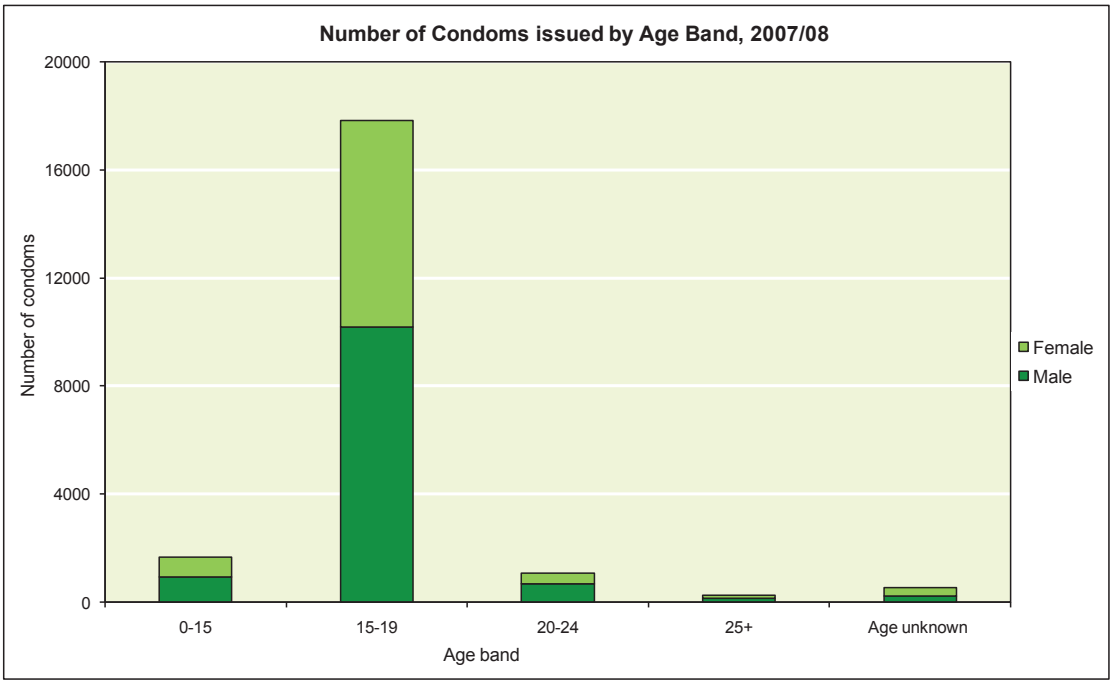
Information

There have been some teething problems with monitoring and data collection, so that the information presented here does not represent a complete picture of the scheme. The current system is due to be replaced with a 'C-card' monitoring system, which should eliminate these problems.

Equitable access and workload

The majority of condoms issued in 2007/08 (80%) were through the What Centre in Stourbridge (Appendix B, Table B14). Slightly over half were issued to males (57%) and the most common age band for both sexes was age 15-19.

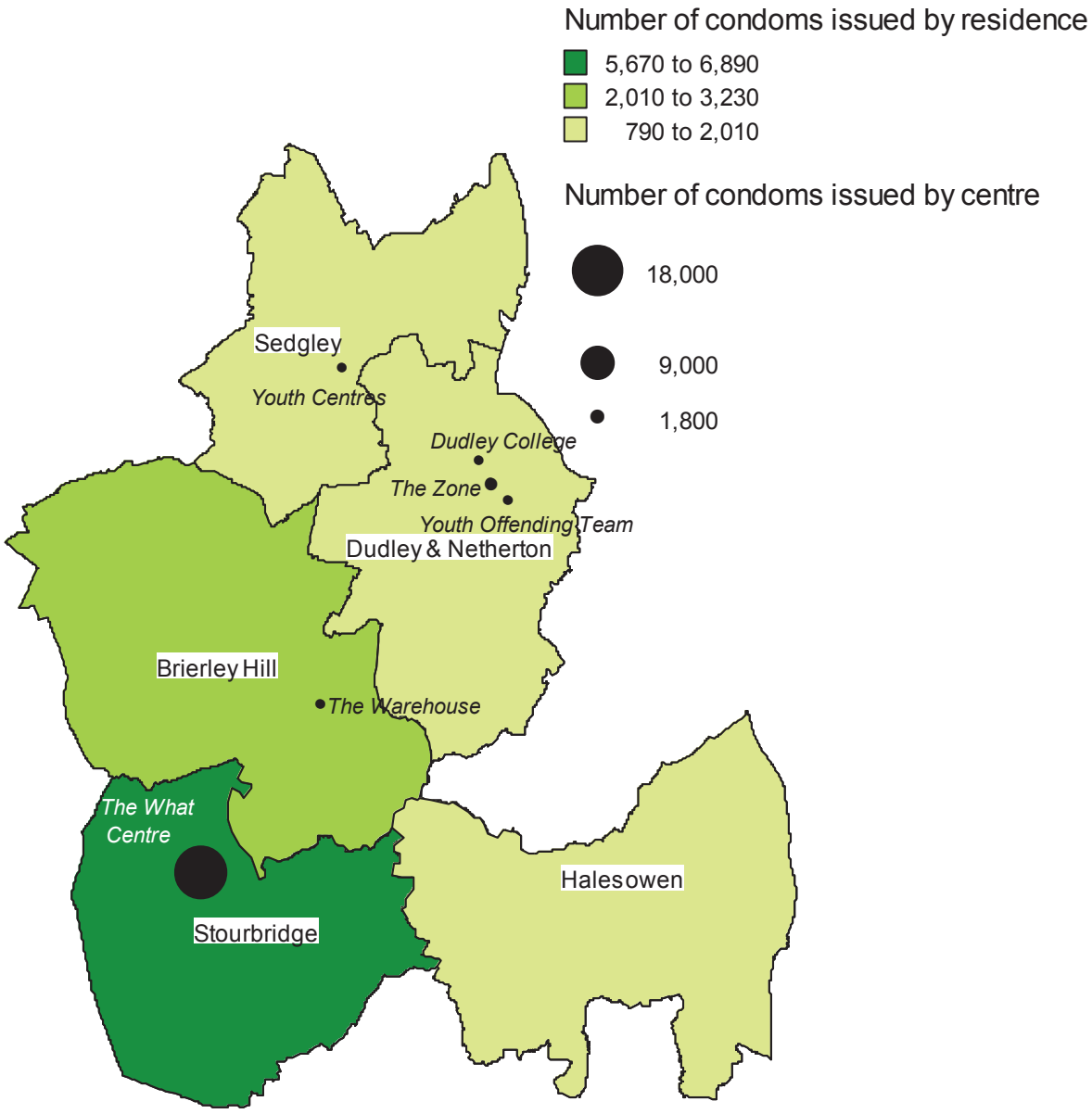
Figure 21



Source: Dudley PCT

The map (Figure 22) shows that most of the condoms issued were to residents in the Stourbridge locality. The low uptake in other areas (Table 9) is likely to be because other centres have been slower to introduce the scheme, combined with some under-reporting. At least 15% of users of the scheme were from outside the borough.

Figure 22: Condoms issued by Residence and Centre 2007/08



Source: Dudley PCT

Gaps and future development

The PCT is currently looking into replacing the existing scheme with a 'C-card' scheme, in which all young people receiving condoms through the scheme are issued with a card which they present on future visits. The scheme will improve the timeliness and accuracy of data collected while reducing the overall burden of data collection.

Distribution staff are now being trained to offer chlamydia testing and pregnancy testing. This expansion to the condom distribution service is to be reflected in a change of name to 'sexual health drop-in service'.

Table 9: Condoms Issued

Locality	**Number issued 2007**
Dudley Borough	13374
Brierley Hill	3202
Dudley & Netherton	1123
Halesowen	1366
Sedgley	799
Stourbridge	6884
Outside borough	3132
Unknown	4912

Source: Dudley PCT

GUM Service

Service Configuration

The GUM service in Dudley is based at Russell's Hall Hospital.

It is open 5 days a week, Mon-Fri. It offers both a walk-in and appointments service, although Wednesdays are reserved for appointments only.

It employs the following staff:

2 Consultants in GU Medicine

1 Associate Specialist in GU Medicine

1 Nurse in Charge/Clinic Manager

1 Health Advisor

1 Health Advisor/Nurse

The following services are offered:

- Tests for sexually transmitted infections and free treatment (no prescription charges).
- Investigation and treatment of other conditions (thrush and vaginal discharge).
- Counseling and testing for HIV infection, results may be available on the same day by appointment.
- Contraception (including emergency contraception).
- Free condoms.
- Free pregnancy testing.
- Cervical screening for women
- Information about sexual health.
- Erectile dysfunction (GP referral).

- Specialist treatment for people with HIV/AIDS
- Sexual health services for under 16's.

Other specialist services offered by the clinic include:

- Referral-only erectile dysfunction service
- 3 same-day HIV testing sessions

The GUM service is commissioned by Dudley PCT through an NHS contract with Payment by Results (PbR). Specialist services are commissioned separately.

Quality of Service Provision

The department manages STIs according to national protocols and guidelines: every client is offered full sexual health screen; hepatitis B vaccination is offered to all at risk clients; the department has good clinical governance arrangements; the option of seeing a female doctor is available at almost every clinic.

The department conducts the following audits annually:

- Annual British Assosciation for Sexual Health and HIV (BASHH) audits
- Patient satisfaction survey
- Patients with HIV satisfaction survey
- Waiting times, did not attend (DNA), and 48 hours access

The department also participates in the following research:

- National collaborative study of HIV and STIs
- Multicentre clinical trial for HIV

Information

Activity information is collected on all patients using the GU service. From this, data on STIs are submitted quarterly to the Health Protection Agency and summarised annually in the KC60 return. The department is in the process of implementing GUMCAD.

An agreement was reached with Russell's Hall to provide the PCT with quarterly activity data.

Data is also collected on waiting times to first appointment to support the 48 hour waiting time target. This is submitted to the Department of Health monthly via the online Unify system, and information on Dudley residents is available to the PCT through this system.

Equitable access and workload

Skill mix

The majority of medical staff are trained in contraception. Two of the doctors are members of the Faculty of Sexual and Reproductive Healthcare.

Audits and Guidelines

Clinical guidelines and protocols used in the department are based on national guidelines. The department has shared protocols for managing STIs with primary care, CASH, A&E and maternity. The department has developed a post exposure prophylaxis protocol in conjunction with microbiology and infection control departments. It also has a shared protocol for sexual assault with the clinical lead for Safeguarding children.

Gaps and future development

- There is a need to improve GUM nurse-led services
- Lack of provision of outreach services
- Lack of dedicated young people services
- There is no availability of an electronic link between GUM clinic and microbiology and virology laboratories to receive results promptly.
- There is a need to develop dedicated young people's clinics

Key points:

- GUM provides level 1, 2, & 3 GUM services and level 1 & 2 contraception services.
- Contraception services are offered as part of the GUM consultation.
- GUM clinic doesn't conduct outreach services or dedicated young people's sessions.
- The system of receiving laboratory results is laborious and results in delays in processing results.
- To be able to maintain the 48hour access to GUM target, 60% of the clinics are walk in clinics.

The What? Centre

Service Configuration

The What? Centre is an advice, information and counselling service for young people aged 13-25 based in Stourbridge.

The sexual health services it provides include:

- Advice and information on STIs, contraception, emergency contraception and pregnancy
- Free condoms through the PCT condom scheme
- Chlamydia self-testing (in partnership with Walsall PCT)
- Signposting to GUM, CASH, Brook and other primary care services
- Weekly clinic-in-a-box

The service is open weekdays on a drop-in basis. A nurse is available through clinic-in-a-box on Tuesday mornings. Any person presenting to the service who is outside the target age group will be referred to other services as appropriate.

Future Plans

Plans include monitoring the clinic-in-a-box to ensure it best meets the needs of clients.

Clinic-In-A-Box

Service configuration

The clinic-in-a-box scheme offers a community-based open access sexual health service for young people aged under 25. It is provided through Brook in Dudley, and commissioned by the PCT on behalf of the Respect Yourself campaign team. It has run in two locations across the borough – the What? Centre in Stourbridge and, Priory Children's Centre.

The clinics offer a range of services including:

- Contraceptive advice and provision, including condoms, contraceptive pill and injections
- Referrals to Brook for fitting of LARCs
- EHC
- Pregnancy testing and advice
- Termination counselling and referral
- Chlamydia screening
- Advice on STIs
- Referral to Brook young persons GUM clinic for STI testing
- Signposting to other services

Each clinic runs for 2 hours per week, and is open access.

Clinics are run by trained Family Planning nurses.

Gaps and future development

Two new clinics are now in operation at Dudley College, with the ultimate plan to have 8 clinics based in teenage pregnancy hotspots. A school-based EHC pilot is due to start soon, and discussions are ongoing with The Zone (a service for young people with drug and alcohol problems) to provide a service there.

Summit House Support

Summit House is a charity in Dudley providing support for people living with HIV and AIDS in Dudley and Sandwell. It's services are jointly commissioned by Dudley PCT and Dudley MBC.

Service configuration

Summit House offers appointments and outreach services on Mondays, Wednesdays, and Fridays. Drop-in sessions are offered on Tuesdays and Thursdays. A gay men's group meets once a month. Services are available to anyone affected by or infected with HIV of any age.

Sexual health services provided are:

- Provision of condoms, femidoms, and lubricants,
- Information/signposting on safer sex, STIs and blood-borne viruses (BBVs)
- HIV-related pregnancy information, referral to IVF/fertility services.
- The gay men's group provides condoms and lubricants and information on safer sex, STIs and BBVs

- A weekly HIV community outreach testing service is due to begin in 2009 in a local Public Sex Venue (PSV). This service will also provide condoms and lubricant to men using the venue plus advice on HIV, STIs and safer sex.

Information

The PCT are currently in the process of negotiating access to monthly summary data on clients using the service.

Future developments

Summit House are working with Barnardo's to provide a teen support group to young people affected by or infected with HIV. They are recruiting a training officer to work with statutory and voluntary groups concerning HIV/STI/BBV awareness (mainly in Sandwell).

School Health Service

Service configuration

The school health team work within schools to provide health education on STIs, sexual health and contraception.

A weekly drop-in service is provided in each secondary school.

Services provided are:

- Advice on contraception, STIs and sexual health
- Pregnancy testing
- Signposting to other services

Gaps and future development

The school health team have been trained to issue emergency contraception and are in the process of extending one of their drop-ins into clinic-in-a-box, where young people can access emergency contraception. Young people will also be able to access the school health service for emergency contraception through Health Centres when the CASH service is not available.

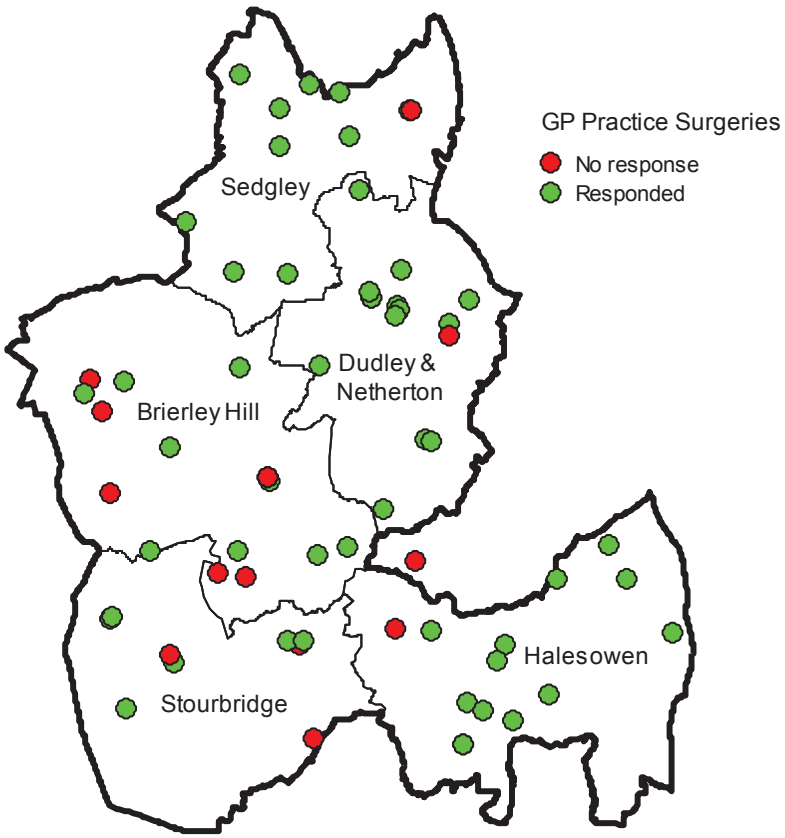
Although all school nurses are trained to offer Chlamydia testing, screening is offered on a reactive basis rather than proactive fashion.

Sexual Health Service Provision in Primary Care

To map sexual health service provision in primary care, a questionnaire was sent to all GP practices in Dudley in 2008 – a total of 52 practices. The questionnaire covered trained work force, contraception and genito-urinary medicine services provision (see appendix 4)

43 practices responded out of 52, an 83% response rate. The map below (Figure 23) shows the geographical spread of surgeries responding to the survey. Note that where a practice covers more than one surgery it will appear more than once on the map. Brierley Hill locality has a higher proportion of surgeries not responding than other localities.

Figure 23: Distribution of GP practices participating in the Primary Care Survey



Source: Dudley PCT

Training

Doctors with the Diploma of the Faculty of Sexual and Reproductive Healthcare

- 35 practices answered this question. Of these, 22 practices had at least one doctor with the Diploma (63%).
- A total of 35 doctors have the Diploma out of a total of 164 GPs in practices completing the survey (22%)

Doctors willing to obtain the Diploma of the Faculty of Sexual and Reproductive Health

- There are 10 doctors willing to obtain the Diploma, from 9 practices.
- 8 of these doctors are from practices where at least one doctor already holds a Diploma, and only 2 from practices where nobody has a Diploma

Nurses with a Family Planning Certificate

- 35 practices answered this question. Of these, 21 had at least one nurse with a Family Planning Certificate (63%)
- A total of 26 nurses have a family planning certificate out of a total of 91 nurses in practices completing the survey (29%)

Doctors with Letters of Competency

- 25 practices had at least one doctor with a Letter of Competency for IUDs (70% of the practices answering this question) - 39 doctors in total.
- 14 practices had at least one doctor with a Letter of Competency for implants (45% of the practices answering this question) - 17 doctors in total.
- 3 practices had at least one doctor with a Letter of Competency for sexual health medical education (an Instructors Doctors certificate) - 4 doctors in total.
- Two practices had doctors with Letters of Competency in all three - IUDs, implants and medical education.

Doctors and nurses who have attended the Sexually Transmitted Infection Foundation (STIF) course in last 2 years

- 12 doctors from 11 practices have attended the STIF course (31% of the 36 practices who answered the question).
- 10 nurses have attended the STIF course, from 5 practices. (15% of the 33 practices who answered the question)
- 12 practices have either a doctor or a nurse who has attended the STIF course (28% of practices taking part in the survey)

Doctors and nurses willing to attend the STIF course (Table 10)

- A total of 46 doctors from 27 practices are willing to attend the STIF course (79% of the 34 practices who answered the question).
- A total of 42 nurses from 31 practices are willing to attend the STIF course (86% of the 36 practices who answered the question).
- Of the 88 doctors and nurses willing to attend STIF, 64 are from practices that currently have no staff who have previously attended. One of these practices has 10 staff willing to attend. (7 doctors and 3 nurses)
- 1 practice has no staff willing to attend the STIF course and no staff who have already attended. This practice is in one of the teenage pregnancy and STI hotspot areas, and has no staff currently trained (although it has one doctor willing to take the Diploma, and one nurse requiring further contraceptive training)

Nurses who require further training in contraception

- 38 practices answered this question. Of those, 28 have nurses who require training (74%). In total, 46 nurses require training.

Contraception (Tables 11 & 12)

The questionnaire asked whether practices provided level 1, 2 and 3 contraception services. Level one is information and hormonal contraception services. Level two is IUD and implant insertion and level 3 is outreach and highly specialised contraception services.

- Level one provision: All practices who responded to the survey provide both injectable contraceptives and contraceptive pills.
- Only 5 practices provide male condoms (12% of all practices completing the survey)
- There are no practices that provide levels 1, 2, and 3 collectively.
- 3 practices provide 9 of the 10 services. These are Eve Hill (Dudley), Worcester Street (Stourbridge), and The Ridgeway (Sedgley). Eve Hill is in one of the hotspot areas for teenage pregnancy. The only service not provided by these practices is provision of condoms.

Table 10: Primary Care Staff willing to attend STIF course

Doctors or nurses willing to attend	No. practices	Total no willing to attend
No staff yet attended		
unknown	2	unknown
0	1	0
1	9	9
2	12	24
3	1	3
4	2	8
5	2	10
10	1	10
Total	30	64
Some staff already attended		
unknown	1	unknown
1	4	4
2	6	12
3	1	3
5	1	5
Total	13	24

Source: Dudley PCT

Table 11: GP Practices providing Contraceptive Services

Contraceptive Service	Provide service	Don't provide service	% who provide service
Pill	43	0	100.0
Injectable	43	0	100.0
IUCD	26	17	60.5
Mirena coil	24	19	55.8
Implant	12	31	27.9
Male Condom	5	38	11.6
Natural contraception	18	25	41.9
On site pregnancy testing	18	25	41.9
IUCD for emergency contraception	22	21	51.2
Referral for sterilisation/vasectomy	40	3	93.0

Source: Dudley PCT

- All 43 practices provide Emergency Hormonal Contraception
- 72% of practices refer patients to CASH for services they don't provide themselves, and 63% provide referrals to GUM.
- One practice refers patients to a chemist for contraceptive provision.
- From the questionnaires returned, it appears that many GPs are unaware that the acronym CASH refers to the family planning service. No less than 15 GPs had incorrectly recorded Family Planning under 'Other referrals'.

Table 12: Referrals to other contraceptive providers

	Refer	Don't refer	% who refer
CASH	31	12	72.1
Brook	20	23	46.5
Other practice	1	42	2.3
A&E	2	41	4.7
GUM	27	16	62.8
Others	2	41	4.7

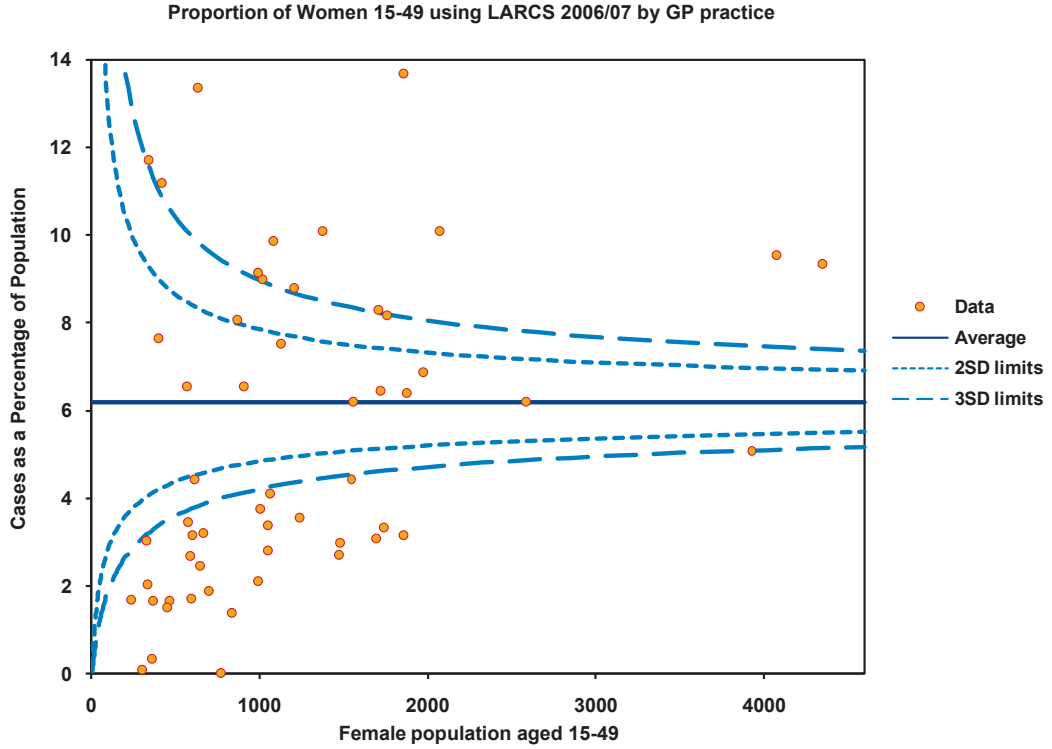
Source: Dudley PCT

Primary Care Contraceptive Prescribing

Analysis of prescriptions issued for contraception in 2006/07 shows that the proportion of women using long acting reversible contraception (LARCs) is highest in Stourbridge locality at 6.7% of females aged 15-49 (based on practice populations) and lowest in Sedgley locality at 5.5%. (See Appendix 3, Table 2 for actual figures, and Appendix 3 gives details of the methodology used in calculations). Interestingly, the same pattern is seen with prescriptions for emergency hormonal contraception (EHC) – the highest number is in Stourbridge and the lowest number in Sedgley locality.

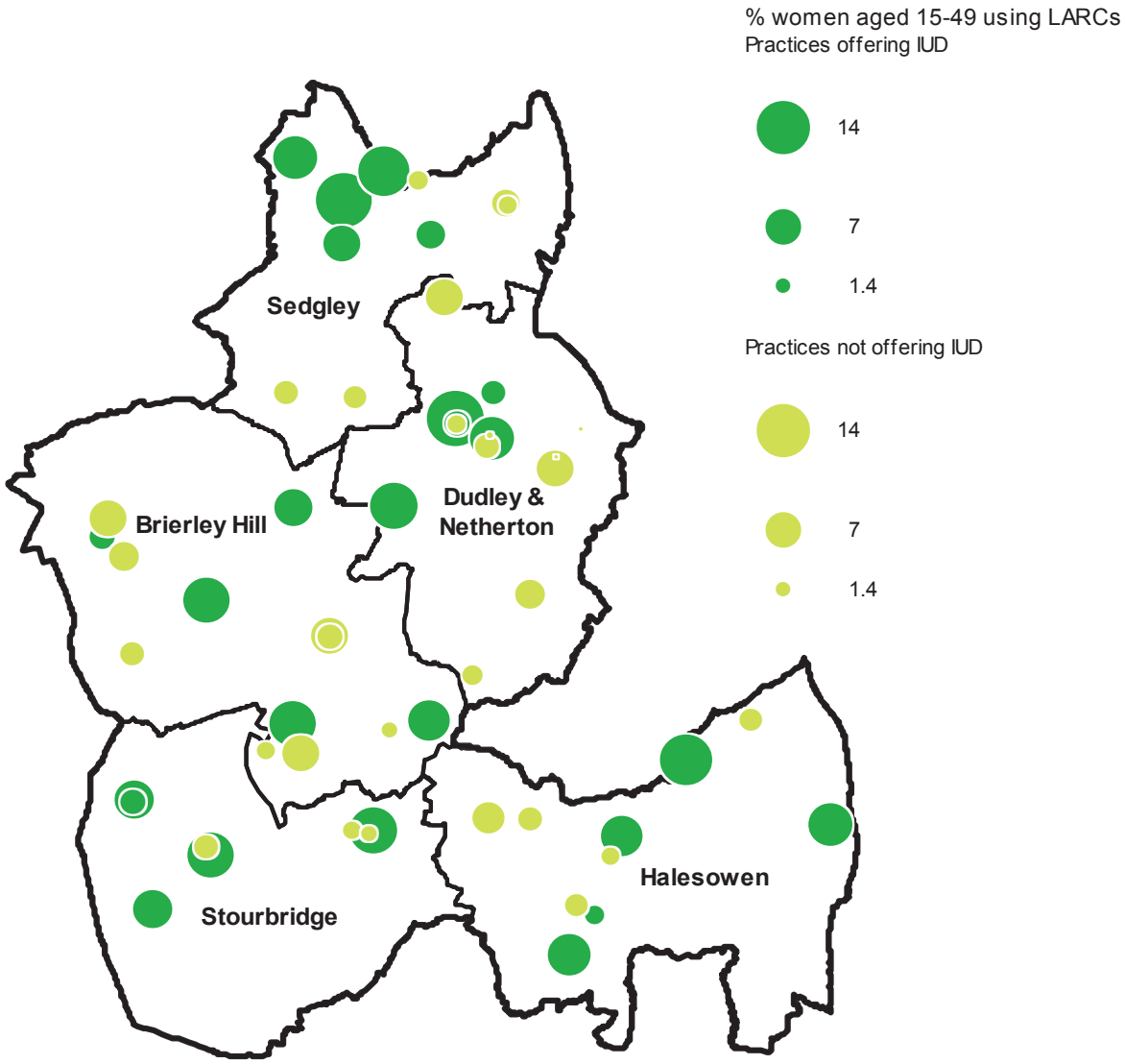
On average across the borough 20% of 15-49 year old women are using the combined oral contraceptive. The rate is highest in Sedgley locality, at 24% and lowest in Dudley and Netherton locality, at 16%.

The map (Figure 24) overleaf shows the proportion of 15-49 year old women in each GP practice using LARCs. It shows a great deal of variation between practices, with no clear geographical pattern in LARCs prescribing. The proportion varied from 0% (no LARCs prescribing) to 14%. The large degree of variation is obvious in the funnel plot below, where the majority of practice rates fall outside 3 standard deviations from the mean.



Source: ePACT prescribing database

Figure 24: Proportion of women using LARCs by GP practice



Source: Prescription Pricing Authority (PPA), ePACT prescribing database

Chlamydia Screening

- 33 practices are willing to take part in the Chlamydia Screening programme. Comments were made by some that resources and training would be needed.
- 7 practices are not willing to take part in the programme. One of these commented 'not at the moment'.
- 3 practices did not answer – one of these commented that they may be interested, another that they would need more information.

Genito-Urinary Medicine

STI testing (Table 13)

- More practices offer STI testing to females than to males
- 10 practices offer tests for all four STIs listed to both sexes

- 5 practices offer no STI testing to either sex
- Chlamydia testing is the most common test offered – 86% of practices offer this to women and 53% to men.
- Syphilis testing is the least common test offered – 44% of practices offer this to women and 37% to men.

Table 13: Practices offering STI tests by gender

STI	Male only	Female only	Both	None	*Overall % offering testing to males*	*Overall% offering testing to females*
Chlamydia	0	14	23	6	*53.5*	*86.0*
HIV	0	1	21	21	*48.8*	*51.2*
Gonorrhoea	0	8	17	18	*39.5*	*58.1*
Syphilis	1	4	15	23	*37.2*	*44.2*

Source: Dudley PCT

- 74% of practices offer pre-test counselling to females, and 61% to males (Table 14).
- The proportion of practices offering STI treatment is lower, at 62% for females and 49% for males.
- Only 1 practice offers contact tracing (Dr Sahni in Brierley Hill)

Table 14: Practices offering STI counselling and treatment

Service	Male only	Female only	Both	None	*% offering service to males*	*% offering service to females*
pre-test counselling	1	7	25	10	*60.5*	*74.4*
Treatment	0	5	21	17	*48.8*	*60.5*
contact tracing	0	0	1	42	*2.3*	*2.3*

Source: Dudley PCT

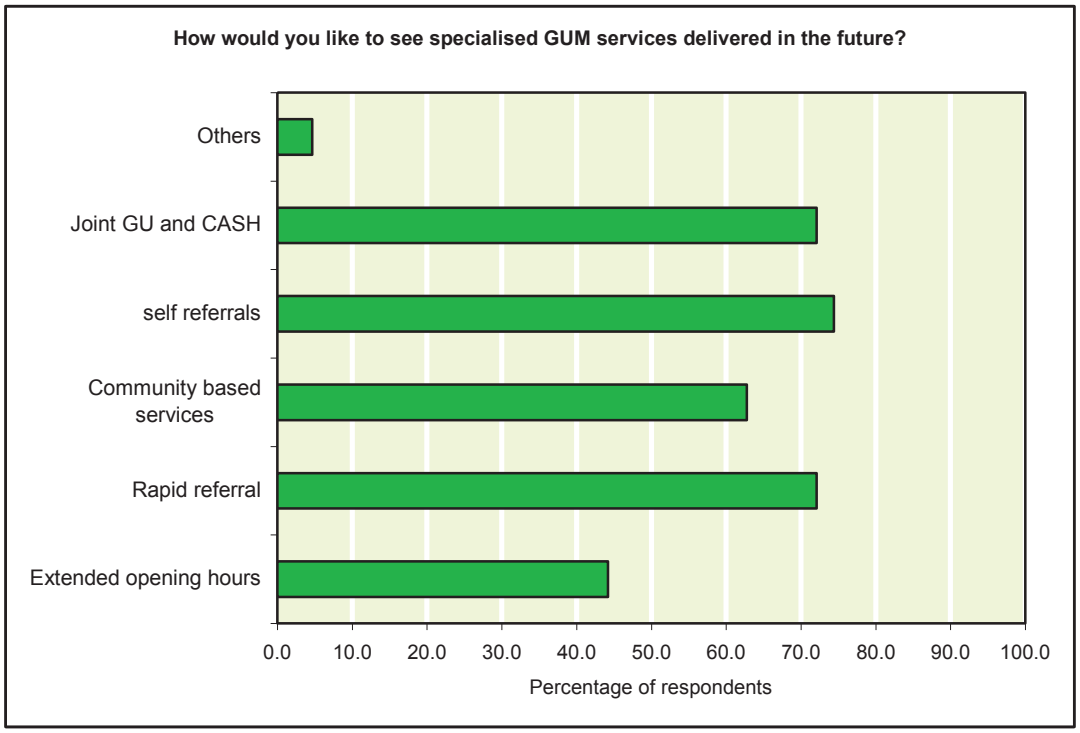
- All 43 practices refer to Russells Hall GUM clinic for STI services (Table 15).
- A small number refer to other GUM clinics, the most common being Wolverhampton and Birmingham.

Table 15: Referrals for STI services

Referral to:	Number	*% all practices*
Russells Hall GUM	43	*100.0*
Other GUM clinics:		
Birmingham	3	*7.0*
Wolverhampton	4	*9.3*
Sandwell	2	*4.7*
Worcester	1	*2.3*
Not specified	7	*16.3*
CASH	3	*7.0*

Source: Dudley PCT

Figure 25



Source: Dudley PCT

Future Delivery of STI services

Respondents were asked to indicate from a range of options which they would like to see in the future (Figure 25).

- The most popular options were a joint GUM and CASH service, self-referrals and a rapid referral system, with over 70% of respondents in favour of each.
- The least popular option was extended opening hours, with less than half (44%) in favour.
- Two practices came up with alternate suggestions of their own. These were:
  - "more communication from GUM to GP"
  - "one-stop shop at first point of contact"

Future Service Developments in Primary Care

This section of the questionnaire looked at whether practices were prepared to offer sexual health services to their own and other practices (Tables 16 & 17).

- 100% of practices were willing to offer oral contraceptives to their own patients. This is unsurprising given that previous questions have shown that these services are already offered by all practices.
- Around a third of all practices were willing to offer oral contraceptives and emergency contraceptives to patients from other GP practices.
- Less than a quarter of practices were willing to offer Chlamydia contract tracing, partner notification, invasive STI testing for men and specialised HIV treatment.

Table 16

Service	Own practice patients	Patients from other practices	None/not answered	*% willing to offer service to own patients**	*% willing to offer service to any patient**
Oral contraceptive pills	42	13	1	*100.0*	*31.0*
Emergency contraception	42	14	1	*100.0*	*33.3*
Chlamydia testing	35	10	8	*83.3*	*23.8*
Female sterilisation and counselling	34	11	9	*81.0*	*26.2*
Vasectomy counselling/ referral	34	9	9	*81.0*	*21.4*
Condom supply	32	9	11	*76.2*	*21.4*
IUCDs/Mirena	29	11	14	*69.0*	*26.2*
TOP counselling/referral	29	8	14	*69.0*	*19.0*
Diaphragm	24	9	19	*57.1*	*21.4*
Implants	23	12	20	*54.8*	*28.6*
Dedicated Young People's clinics	23	8	20	*54.8*	*19.0*
Other STI testing & treating	17	5	26	*40.5*	*11.9*
HIV counselling	14	5	29	*33.3*	*11.9*
Vasectomy	12	2	31	*28.6*	*4.8*
Chlamydia contact tracing	9	6	34	*21.4*	*14.3*
Partner notification/ contact tracing	8	5	35	*19.0*	*11.9*
Invasive STIs testing for men	6	3	37	*14.3*	*7.1*
Specialised HIV treatment	3	1	40	*7.1*	*2.4*

- The percentage is based on the 42 practices that completed this section of the questionnaire

Table 17

Service	No. willing to offer service	Willing to offer to:			
		Both sexes	women only	men only	unknown
Specialised HIV	3	3	0	0	0
Invasive STIs	6	4	0	1	1
partner notification	8	7	0	0	1
Chlamydia contact tracing	9	7	0	0	2
HIV counselling	14	9	0	0	5
other STI testing & treating	17	10	1	0	6
dedicated Young People's clinics	23	10	0	0	13
condom supply	32	12	2	2	16
Chlamydia testing	35	15	4	0	16

Practices willing to offer services were asked if they would offer them to women only, men only or both. This section was poorly completed, with many practices failing to specify

- Of those practices who did specify, the majority were willing to offer services to both sexes.
- A few practices were only willing to offer Chlamydia testing to women
- Two practices would only offer condoms to women and two practices would only offer them to men. The majority would offer to both sexes.

Sexual Health Services in Primary Care Key points:

- 35 general practitioners in Dudley have the Diploma of the Faculty of Sexual and Reproductive Health Care (Previously called DFFP), out of a total of 164 GPs in practices completing the survey (22%)
- A total of 26 nurses have a family planning certificate out of a total of 91 nurses in practices completing the survey (29%)
- 39 doctors have the letter of competence to fit intra-uterine devices and 17 doctors to fit implants. There are 4 instructing doctors i.e. doctors who are qualified to train other doctors and nurses
- 10 doctors are willing to obtain the Diploma of the Faculty of Sexual and Reproductive Health Care and 46 nurses are willing to obtain further training in contraception.
- LARC prescribing is variable across the Borough with no clear geographical pattern.
- 46 doctors and 42 nurses are willing to attend the Sexually Transmitted Infection Foundation course (STIF).
- All practices who responded provide oral hormonal contraception and Depo-Provera injection (level 1).
- Level 2 provision is variable across the Borough. 28% of practices provide implants, 60% provide the Cupper coil and 55% provide the Mirena coil.
- 33 practices are willing to take part in the National Chlamydia Screening programme.
- 5 practices (12%) offer no STIs testing to either sex. More practices offer STI testing to females than to males
- 62% of practices offer treatment for females and 49% for males. Only one practice offers contact tracing.
- The most popular option for future development in sexual and reproductive health care services in the Borough was a joint GU and CASH service, self-referrals and a rapid referral system, with over 70% of respondents in favour of each.
- Less than a quarter of practices were willing to offer Chlamydia contract tracing, partner notification, invasive STI testing for men and specialised HIV treatment

Comments

Additional comments made by practices on the questionnaires are:

"If funding was available to perform other sexual health and contraceptive services on site, we would be prepared to provide additional clinic hours"

"We are not licensed for minor surgery and unfortunately do not have the facilities to make available an appropriate space. We are keen and willing to support strategies where appropriate in our situation"

Sexual health service provision in community pharmacies

Inclusion of Community Pharmacy in Sexual Health Services Strategy

A recent review of the evidence showed that people would like more access to sexual health advice through pharmacies (Pharmacy HealthLink and RPSGB forthcoming). If advice is targeted at young people and hard-to-reach groups in the population, it can help to reduce inequalities in health.

The development of appropriate sexual health services for this group in pharmacies could significantly increase their access to confidential professional advice and testing; leading to higher rates of detection of sexually transmitted infections and improved self care.

A report commissioned by the charity Brook Advisory Centres, March 1998, *"Someone with a smile would be your best bet" What young people want from sex advice services* suggested that many young people are dissuaded from asking for sexual health advice in pharmacies, primarily because of concerns about confidentiality. The report suggests that pharmacists need training to meet the needs of the under-25s.

The advanced services component of the new contractual framework for community pharmacy requires the provision of a consultation area so that conversations are not heard by others using the pharmacy. As more pharmacies provide these services, the availability of consultation areas will increase.

The community pharmacy contract, April 2005 requires that promotion of healthy lifestyle is to be provided as an essential service. This is to be done through two main activates: participation in national campaigns and signposting services.

Campaign based service is as follows:

- Pharmacists and their staff will pro-actively take part in and contribute to national/local campaigns for patients and general pharmacy visitors during the campaign period, including giving advice to people on the campaign issues. This advice may be supplemented by provision of written information and in-store displays.
- The pharmacy will provide this service to its PCT for up to 6 campaigns per year. The pharmacy will record the number of people who receive advice if requested to do so by the PCT.
- The PCT will determine the topics of the campaigns and will provide any appropriate support, e.g. Briefing packs and patient literature to support campaign messages.

The Signposting service:

The provision of information to people visiting the pharmacy, who require further support, advice or treatment which cannot be provided by the pharmacy, or other health and social

care providers or support organisations who may be able to assist the person, this may include referral to local services .

Suggested Tiers of Pharmacy involvement

Level 0

- Pharmacy undertakes to display a set of PCT approved leaflets re sexual health and signposts to appropriate services as per NHS Contract.
- Basic training offered to all staff on a rolling programme.
- Basic leaflet stock supplied by PCT

Level 1

- As above plus Pharmacy Service Level Agreements (SLAs) for EHC provision and Chlamydia Screening
- Harmonisation of Accreditation Group (HAG) accredited training for all pharmacists involved.

Level 2

- As above plus Chlamydia treatment under Patient Group Directions (PGD)

Level 3

- Full sexual health SLAs to include all of above plus provision of contraceptive pill

Could be possible to have just Chlamydia screening provision with no EHC but would require training as per level 1

National Policy Drivers

Choosing Health (Great Britain. Department of Health, 2004) – Public Health White Paper Nov 2004

A Health promoting NHS.

Mapping sexual health service provision through community pharmacies was done through the routine clinical governance visits by the PCT. Pharmacies were asked to fill a questionnaire. 41 pharmacies in Dudley have completed the questionnaire from a total of 59 (69%).

The following questions were asked:

1. *Does the pharmacy provide written information on the following sexually transmitted diseases? (Chlamydia, gonorrhoea, HIV, syphilis and genital warts?)*

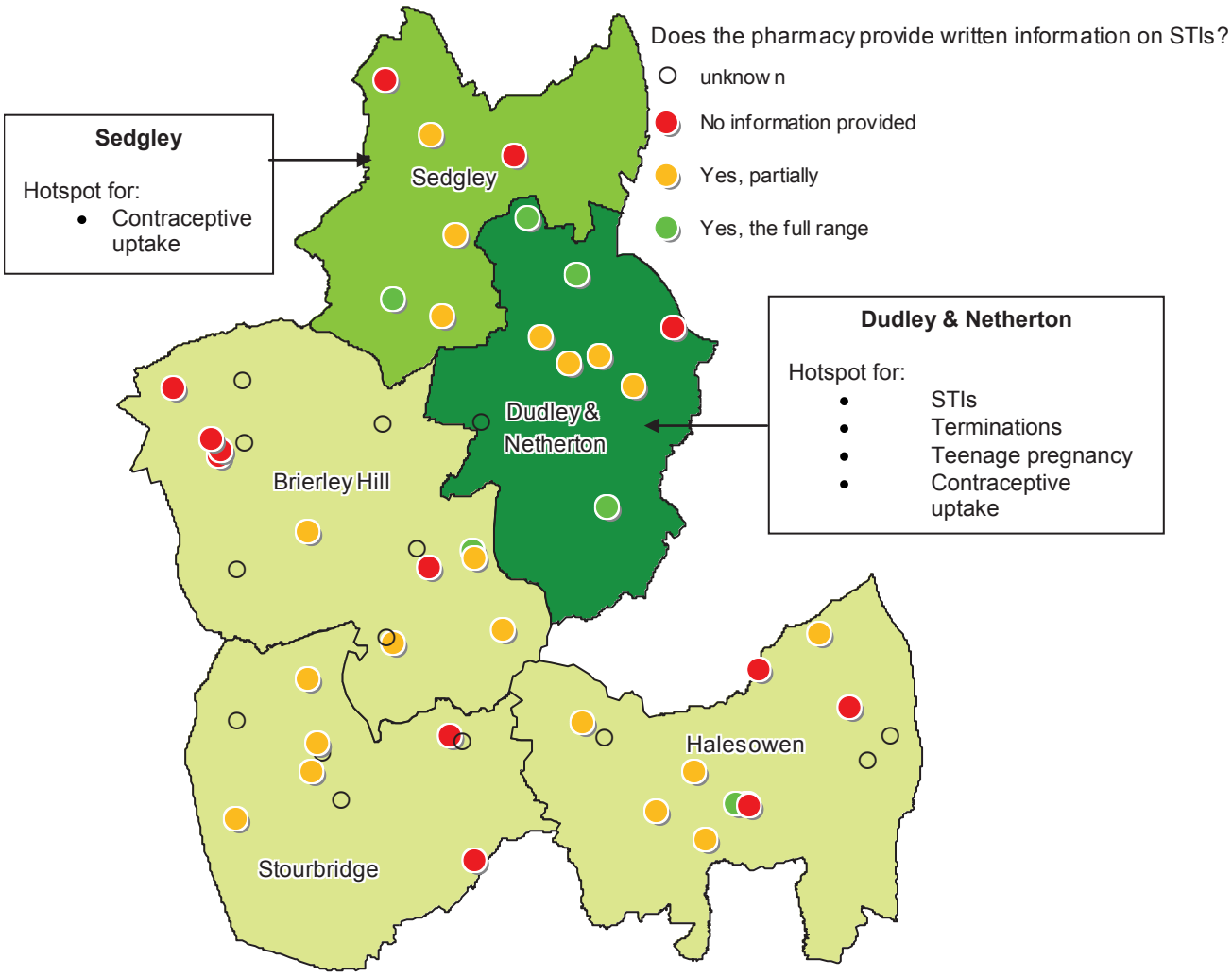
6 pharmacies (15%) provide a full range of written information on STIs.

22 pharmacies (54%) provide a partial range.

13 pharmacies (32%) provide no written information on STIs.

The map below (Figure 26) shows the geographical position of pharmacies and whether they provide information on STIs. It shows that Dudley and Netherton locality, the primary hotspot for STIs, has more pharmacies providing a full range of STI information than other parts of the borough. There is a cluster of pharmacies in Brierley Hill (around the Kingswinford area) that provide no information.

Figure 26: Pharmacies Providing Written Information on STIs



2. *Does the pharmacy provide written information on the following contraception methods? (combined pill, mini pill, coils, implants, EHC, male and female sterilisation and terminations of pregnancy)*

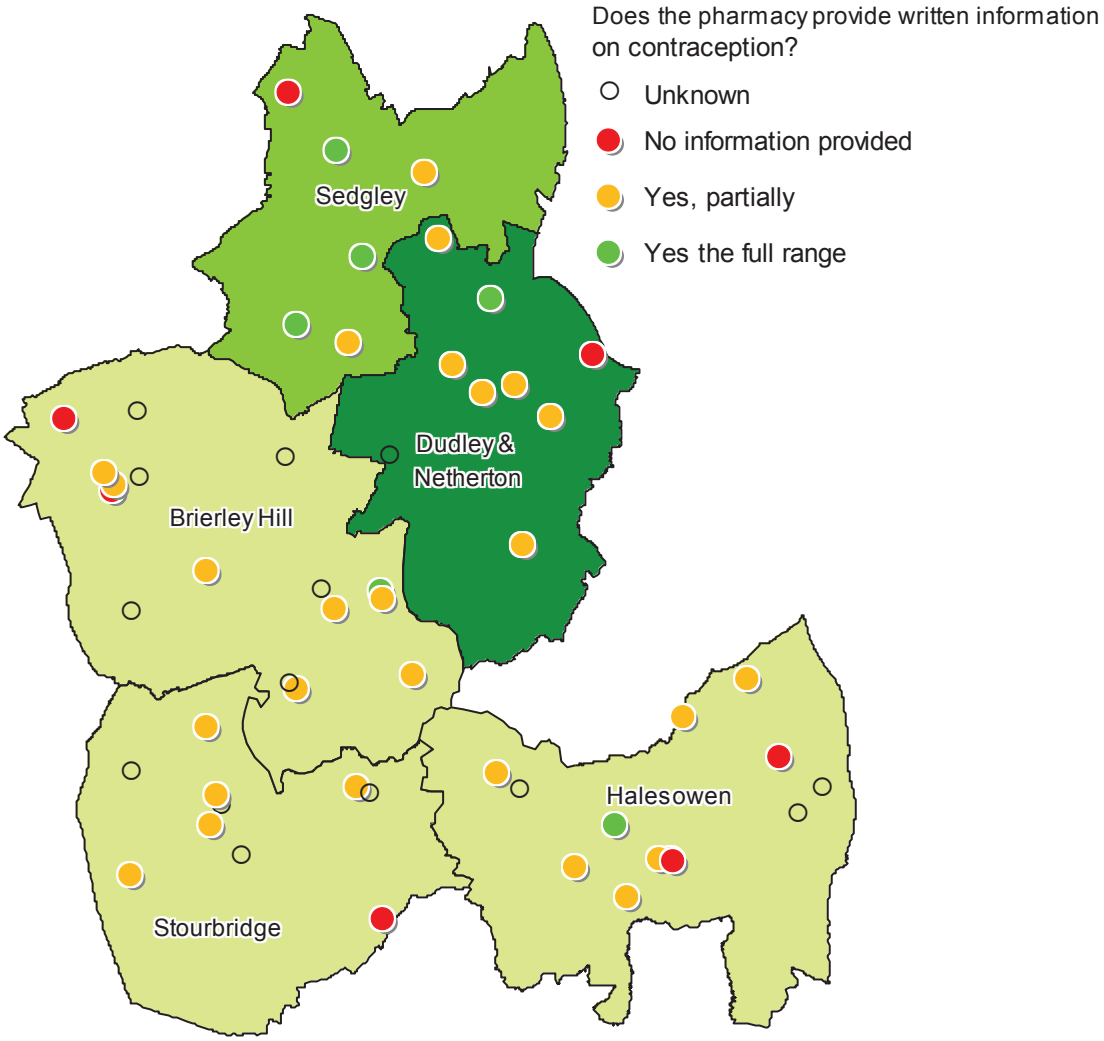
6 pharmacies (15%) provide a full range of written information on contraception.

27 pharmacies (66%) provide a partial range.

8 pharmacies (20%) provide no written information on contraception.

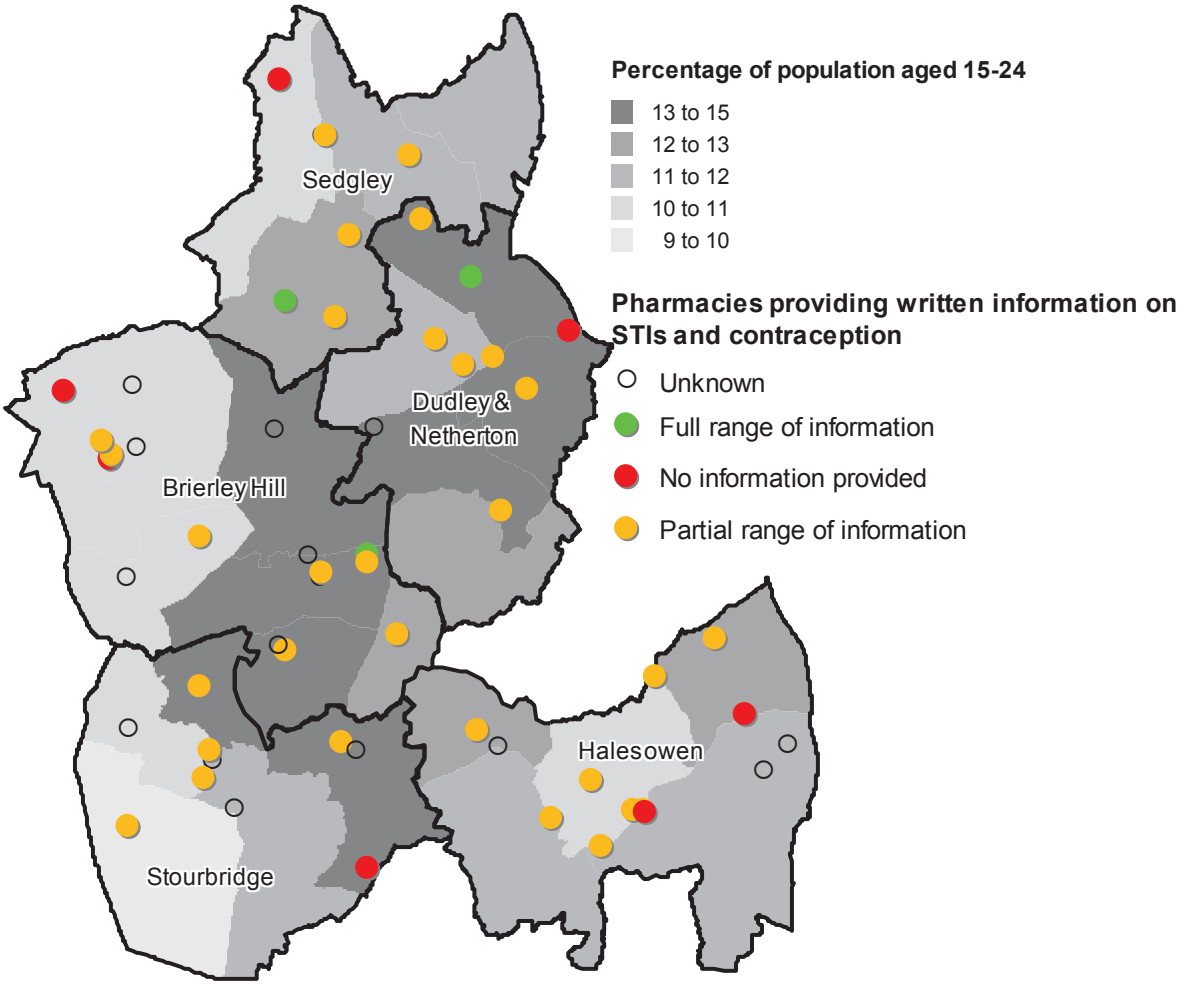
The following map (Figure 27) shows the pharmacies that provide contraceptive information by location. The pharmacies that provide a full range of information are largely in Sedgley locality, which has been identified as a hotspot for the uptake of long-acting contraceptives. One pharmacy in Dudley and Netherton locality also provides the full range of information. This is the Priory Pharmacy, in a known hotspot area.

Figure 27: Pharmacies Providing Written Information on Contraception



The following map (Figure 28) shows the combined picture of provision of STI and contraceptive information against the proportion of young people aged 15-24. Two of the three pharmacies that provide a complete range of information on both STIs and contraception are in areas with a high percentage of young people (13-15%). However, there are also two pharmacies in these areas that provide no information.

Figure 28: Pharmacies Providing Written Information on STIs and Contraception



3. How readily is the information available to the public?

1 pharmacy did not answer this question, as it did not provide written information

19 pharmacies (46%) have information available on display.

21 pharmacies (51%) have information available on request.

Four pharmacies commented that some of their information is on display, but more is available on request, and four pharmacies commented that information is available on request from online sources such as NHS Direct.

4. Do you have at least one pharmacist trained to identify sexual health high-risk clients?

10 pharmacies (24%) had a pharmacist trained to identify sexual health high-risk clients.

31 pharmacies (76%) had no pharmacists trained to identify sexual health high-risk clients.

5. *Has anyone in the pharmacy studied the CCPE Course "Sexual Health – Testing and treating"?*

8 pharmacies (20%) had a member of staff who had studied the course.

33 pharmacies (80%) had nobody who had studied the course.

Comments

Lloyds Pharmacy in Halesowen commented that they are willing to take part in Chlamydia screening.

Key points:

- Only 15% of pharmacies provide the full range of sexual health information
- 54% of community pharmacies do not provide a full range of written information on STIs, and only 15% provide the full range of STIs information.
- Dudley and Netherton locality, the primary hotspot for STIs, has more pharmacies providing a full range of STI information than other parts of the borough. There is a cluster of pharmacies around the Kingswinford area that provide no information
- 20% of community pharmacies provide no written information on contraception, 66% provide partial range and 15% provide a full range of contraception information
- The majority of pharmacies which provide the full range of contraception information are located in Sedgley locality, a hot spot area for low uptake of LARC.
- The geographical distribution of the provision of a full range of STIs and contraception through community pharmacies does not match the geographical distribution of young people in Borough or the hotspot areas for teenage pregnancy and STIs.
- 24% of pharmacies have a pharmacist trained to identify sexual health high risk clients while 76% do not.
- 20% of pharmacies have one member of staff who had studied the course of Sexual Health Testing and Treating.

Summary of sexual health inequality across Dudley Borough

Dudley & Netherton locality is the most deprived area in the Borough. It has a high rate of young people. In addition the area showed higher rates of teenage pregnancy, sexually transmitted diseases, termination of pregnancy and low access to hormonal contraception.

The uptake of LARC among women aged 15-49 years was lower than average across Sedgley locality (Figure 29).

Figure 29: Summary of Sexual Health Across Dudley Borough

	Locality				
	Brierley Hill	**Dudley & Netherton**	**Halesowen**	**Sedgley**	**Stourbridge**
STIs/HIV					
Gonorrhoea rate					
Chlamydia rate					
Genital Warts rate					
Genital Herpes rate					
HIV rate					
Pregnancy					
Termination rate					
teen pregnancy rate					
Contraceptive use					
% women 15-49 using LARCs					
% Combined oral contraceptive					
EHC scheme uptake (rate)					
Deprivation					
Average IMD(2007) score					
Population					
% young people 15-24					
% sexually active 15-64					
	Key:				
		Significantly high rate (significantly low for contraception)			
		Rate not significant			
		Significantly low rate (Significantly high for contraception)			

Step 3: Sexual health knowledge and behaviour in Dudley (What communities said).

The public health department in Dudley PCT conducted a series of consultations with various community groups to explore their knowledge and experience of sexual health, their views on current sexual health service provision, and their views on future sexual health needs and service development. The exercise provided a snap shot to illustrate some of the experiences of a range of people living in Dudley Borough.

Participants involved in the consultation included:

- People from Black and Minority Ethnic (BME) Communities (28)
- People who are HIV positive (12)
- People with a learning / physical disability (14 and 20 respectively)
- Adults (59)
- Young people (90)

Profile

Overall 223 people participated in the consultation from 21 different groups and organisations. Demographic information was collected from 203 of the participants and this profile is summarised in the table below. Overall the community groups identified were well represented in terms of gender, age, ethnicity and disability.

	BME Communities	HIV Positive Community	Learning/ Physical Disability	Adult Community	Young People	Total Number (%)
Participants	28	12	34	59	90	223
Male	3	8	20	19	43	93 (45%)
Female	25	4	14	40	27	110 (55%)
<20	0	0	0	4	73	77 (37%)
21-40	2	6	11	21	1	41 (19%)
41-60	10	6	16	7	0	39 (19%)
60+	16	0	7	27	0	50 (24%)
White	1	7	33	54	61	156 (75%)
BME	27	5	1	5	13	51 (25%)
Disability	11	6	34	12	9	72 (35%)
Community groups consulted	3	1	3	6	8	21

Format of data collection

The format for the data collection was tailored to the needs of the community groups and comprised participatory workshops, one to one interviews and self-completed questionnaires. The methodology was adapted dependent on the needs of the groups. For exam-

ple questionnaires were not used as some of the participants did not speak English and interpreters were required. The workshops were adapted further for the young people and those with disabilities to include more interactive exercises.

Key Findings

Sexual Health Information

The main source of sexual health information for the BME groups and adults were their GP, family, friends or a nurse/clinic. These were also largely their preferred sources of information, though the adult group also indicated they would prefer to get their sexual health information from magazines/newspaper and the television. For the group with HIV the main source of sexual health information was again their GP, but they also were dependent on information from magazines and newspapers, the internet, their friends and to a lesser extent nurse/clinics. These were also largely their preferred sources of information. For both the BME and HIV consultee's there was a desire for nurses to be a preferred source of sexual health information. Young people and those with a disability indicated their main source of sexual health information was their place of study, family and friends, and with a greater dependence on the internet for this information. People with a disability would prefer to get their sexual health information from a community group as well as their place of study.

Some participants had a fairly good knowledge of sexual health issues, but a lot of people also had quite poor knowledge, and this appeared to be dependent upon factors such as their previous experiences, cultural issues, and language barriers. For example, the women from the Asian women's group had very poor knowledge compared to the general adult population.

GPs, family and friends, nurses / clinics and magazines / newspapers were the most commonly reported sources of sexual health information. In addition to these, participants would like services to all be based in one place. Individual circumstances also dictated how and where people would like to access information, for example, people with a physical disability who find it difficult to travel, would like information to be available at their day centre, and would like to access services at a one stop shop or through home visits.

Knowledge of Sexual Health Services

The BME and HIV groups had poor knowledge of the range of sexual health services available locally. Most participants would go to their GP or health clinic / centre to access sexual health services, and most participants were not able to distinguish between the different types of service provision, other than to identify that condoms could be obtained from the supermarket. In the HIV group it appears that many of the participants were unable to distinguish between the different services and what they provide, often accessing their GP as a first point of contact, or having access to a wide range of sexual health services at the hospital, when they go for their appointments at the GUM Clinic. All the groups despite their level of knowledge of local sexual health services would go to their GP or health clinic as their first point of contact for sexual health services.

Many participants demonstrated a clear lack of knowledge about the range of sexual health services available locally, and were unable to distinguish between the different types of service provision. The GP was more often than not identified as the first point of contact and some participants, particularly those over the age of 60, prefer to access services through their GP as they see them as a 'trusted professional / expert.' Participants who did demonstrate knowledge of the different sexual health services were mainly those who had had personal experience of using them.

It was evident that many groups do not have equal access to sexual health information or sexual health services at present and it was felt that people don't talk openly enough about

sex. Sometimes this can be due to people's beliefs that certain others should not be, or do not have sex, for example those with a disability. Many of the older Asian women are reliant on male family members to pass on information or to translate for them. As a result they are often not able to / are too embarrassed to access information of this nature.

Many of the participants agreed that the best way of passing on information of this nature would be through talking and informal interactions, rather than through more clinical appointments / consultations.

Preferred Location of Sexual Health Services

Most participants would like sexual health services to be provided through GPs, a nurse at the GPs surgery, a clinic in town, or with all services in one place.

Knowledge of STI's

Knowledge of STIs varied considerably amongst individual participants, with the knowledge often greater in men than women particularly within the BME and HIV groups. However, in general most of the participants had a very limited knowledge of STIs and some participants, particularly those with a disability were not able to name any STIs or any methods of transmission. Knowledge of STIs was varied amongst young people, generally increasing with age. Overall knowledge of STIs in the adult group was comprehensive.

What are the different ways you can catch HIV?

Although several participants were able to identify ways in which people could catch HIV, again several of the Asian women and Afro-Caribbean elders did not know, and some responses suggested they were misinformed i.e. Catching HIV from toilet seats.

In addition to the physical symptoms, how could an STI affect your life?

Participants from BME communities and those with a disability had very limited knowledge of how an STI could affect their life. The other groups were able to think of a range of ways in which a STI could affect their life.

Which of the following sexual health services have you used?

The services most frequently accessed by participants were the GP and the Family Planning/CASH Service. Some individual participants had accessed other services such as the GUM clinic, BPAS, and the Pharmacy EHC service. Most participants reported a positive experience of accessing their GP, but this single point of access meant that where the GP was male, for the Asian women in particular, this would make it impossible for them to access sexual health information or services.

General suggestions for improving sexual health services in Dudley

Access to information through better advertising and in appropriate formats, and better access to services, i.e. through longer opening hours, more venues and culturally sensitive services, were considered key to improving sexual health services. Asian women face many barriers to accessing information about sexual health, refugees face many barriers in relation to accessing services, and within each of the groups there were many participants who had a very poor underlying knowledge of sexual health and sexual health services. Those that demonstrated a greater degree of knowledge appeared to have gained this through their own experiences of needing to access services in the past.

A number of common issues emerged from across the groups to inform the recommendations. These have been categorised under a number of themes: access to information /

education; service provision (in relation to location of services, access, confidentiality, buildings and inclusive services); and staff.

Key Themes and Recommendations:

Access to information / education

Access to information about sexual health issues and sexual health services was a major issue identified by most people. There was an overall consensus of opinion that sexual health services need to advertise themselves more widely and more effectively.

It is therefore recommended that a communications and marketing strategy/plan, and an information care pathway should be put into place and should respond to the following points:

- All information on sexual health service provision should include details of the location and how to get there, what services are on offer, opening times and details of how to access the services.
- Targeted information on sexual health service provision should also include information on important access issues such as staff with specialist knowledge, a fully accessible building, availability of specialist equipment such as hoists, and whether the service is young people friendly / inclusive.
- Sexual health information, including information on service provision, should be clear, accurate, up to date, presented in an unofficial and non-clinical way, and be available in a range of formats, including Braille, talking books and relevant languages.
- Information should be provided in attractive and accessible formats, with input from the target group wherever possible. More use should be made of magazines, newspapers, advertising on the back of toilet doors, buses and bus tickets, posters and fliers.
- The media should be used to help challenge stereotypes around sexual health e.g. the sexual health rights and needs of people with a disability, views on HIV etc. and to encourage people to talk more openly about sexual health issues.
- Information should be readily accessible at a range of venues, such as GPs, nurses / clinics and also through trusted professionals and community venues used frequently by particular client groups.
- Service providers should make sure that materials distributed to youth centres and other venues are up to date, and are reviewed and refreshed on a regular basis.
- Web pages containing information on sexual health services should be reviewed and updated and consideration should be given to the development of one website for all sexual health information, particularly for young people.
- Consideration should be given to the scope of a 24 hour emergency help line / confidential telephone help line service to assist people in accessing services or key information.
- Printed and electronic information should be supported by awareness raising / education sessions delivered to groups in their local community through outreach work. Sessions should be interactive and delivered by outside professionals / service providers. Where required they should be supported by inter-

preting and translation services to ensure that people who are unable to speak English or read in any community language, are still able to access information.

- Activities / projects which train and support members of the community to deliver basic awareness-raising information / education to other members within their community, should be considered and resourced appropriately.
- Each GP practice should include a female GP, so that women have the opportunity to speak to a GP about sexual health issues. This is of particular importance given that for many women their GP can be their only point of contact, and GPs play a pivotal role in referring on to other services.

> "*I've got a lady doctor – it's important as I wouldn't like to talk to a male doctor about this."*

- More information on sexual health issues should be available in schools, colleges, and alternative educational provision, through a range of formats, e.g. sexual health fairs, workshops, visits from service providers and mobile provision. This should also be available to young people at an earlier age i.e. before they become sexually active.

Service provision - location of services

- The majority of participants were of the view that sexual health services should be located centrally, within a discreet location, but should also offer additional service provision through satellite centres and outreach services throughout the borough.
- Satellite / outreach services should be provided in a range of different venues to ensure they are local and connected to the community, for example, through drop-in sessions at Children's Centres, mini health clinics within youth centres, mobile clinics, / vans and clinics in day centres.
- Wherever possible, a range of services should be provided in one place, such as at the GPs or at one-stop health centres.

> "*All sexual health services should be available as a 'one stop shop' at the GP's as it is particularly difficult for people with disabilities to travel to / access other locations."*

- More opportunities should be made available to access services through schools, colleges, and alternative education providers.

> *"It would be better to have all services in one place, such as at a youth club, where the purpose of your visit could be anything so that other people wouldn't know what you are there for."*

Service provision - access

- Sexual health services should be open for longer, particularly in the evenings and on weekends.

> "*I work full time and have to take a day's annual leave each time I have an appointment*."

- Appointment booking systems should be as accessible as possible and waiting times for appointments should be kept to a minimum.

- Appointments should be streamlined wherever possible to minimise the need for return / multiple visits and patients should be able to see the same doctor, to ensure consistency.

Service provision - confidentiality

- Sexual health services should take all possible measures to ensure the confidentiality and privacy of service users, by for example providing specific clinics for young people, and by openly communicating their policy on confidentiality, what this means in different situations and what rights people have to confidentiality.

Service provision - buildings

- Buildings should be DDA compliant, and services throughout the borough should have accessible consultation rooms which are suitably equipped to support the requirements of people with disabilities.
- Reception areas and waiting rooms should be designed / arranged to ensure privacy and to be more comfortable and inviting.
- Internally, buildings / facilities should have a welcoming waiting room with music / TV and be decorated in bright colours. Clear signage, plenty of space and a free car park should also be provided.

Service provision – inclusive services

- In addition to accessible mainstream services, specialist sexual health services for people with disabilities should also be available. For example, a sexual health clinical nurse specialist who is trained specifically in meeting the sexual health needs of people with disabilities, and who can run clinics / provide outreach clinics or even home visits, would help to address many of the access issues identified.
- Services should take practical steps towards reducing the stigma and discrimination associated with HIV and STI's.
- Service provision should be fully accessible and inclusive to meet the needs of all young people, including those with disabilities and LGBT young people.
- Primary care and sexual health services should consider undertaking the 'You're Welcome' self-assessment audit. Having established a baseline for their service, providers will then be able to identify areas for improvement and work towards becoming a young person friendly service. Young assessors will award the 'You're Welcome' kite mark when they believe the service has met the required standards.

Staff

- Staff working in sexual health services should be trained, skilled, and confident to provide services in a non-judgemental, respectful, and sensitive way. They should also actively counter and challenge discrimination, stigma and prejudice. Confidentiality should be maintained at all times.
- Given that GPs are the most preferred point of access for sexual health services for some people, service provision should be culturally sensitive and all staff should be trained, skilled, and confident to work in a culturally competent way.

- All staff should be friendly and welcoming, and should take the time to explain things clearly to service users, and encourage them to talk about sexual health issues.
- More sexual health service providers should receive specialist training on the sexual health needs of disabled people so that better support can be provided at a local point of delivery.
- GPs that have specialist knowledge of HIV / are HIV aware should be more accessible so that better HIV support can be provided at a local point of delivery.
- Staff should respect an individual's right to make an informed choice about accessing services and receiving treatment.
- Service users should be given the choice of seeing a male or female professional when accessing sexual health services.
- Young people should be able to see the same doctor each time if they wish, but also have the option of which doctor or nurse they would like to see.
- Young people should have the option of receiving support from peer educators.

Step 4: What health care (and other) interventions are worth doing? (Effectiveness and cost effectiveness of sexual health services and interventions)

To determine the effectiveness and cost effectiveness of sexual health interventions, the literature was searched under the following subheadings:

- The economics of sexual health.
- Delivery of sexual health services.
- Family planning, Genito-Urinary Medicine and Primary Care.
- Knowledge and education of sexual health in young people and other age groups.
- Prevention of unintended teenage pregnancy and its adverse health and social outcomes.

The Economics of Sexual Health

Investment in sexual health services can result in health care saving through preventing unplanned pregnancies and reducing the transmission of sexually transmitted infections including HIV.

Contraception services may save the NHS over £2.5 billion a year. The average cost of contraceptive failure was estimated in 2005/2006 as £ 1500 per case. This includes the cost of ectopic pregnancy, abortion, maternity live birth, and miscarriage.

HIV is associated with serious morbidity, significant mortality and a high number of potential years of life lost. HIV care costs the NHS around £580 million per year. Preventing further transmission of one case of HIV infection could save around £ 0.5 million in health care costs and increase individual health gain (Department of Health, 2008).

The direct cost of treating other STI's is around £165 million per year. This cost includes treating pelvic inflammatory disease, ectopic pregnancy, and infertility following Chlamydia infection.

Other cost effective sexual health interventions include:

- Sexual health promotion and disease prevention for high-risk groups such as wide spread condom provision, outreach safe sex training for high risk groups, school education programmes, and needle exchange services.
- HIV screening during pregnancy and Chlamydia screening for the under 25 years old.
- High quality and rapid access to sexually transmitted infections services. This leads to prompt treatment of STI's and effective partner notification.
- Wide choices of contraceptive and abortion services provided with minimal delay. For every £1 spent on contraception services, £11 is saved. The NHS could save money through improving contraception services by ensuring access to the full range of methods, which reflect women's preference including the more cost effective long acting reversible contraception (Department of Health, 2008).

Delivery of Sexual Health Services:

Sexual health services are provided by a range of providers including general practice, community sexual and reproductive health care services, genito-urinary medicine, gynaecology and the voluntary sector.

Most evidence on effective delivery of sexual health services points to the fact that integration of services is more likely to be successful in providing appropriate sexual health prevention, care and treatment.

Multi-faceted integrated services with close links to STI prevention services, contraception, and young people services are likely to be successful (Dehne, Snow and O'Reilly, 2000).

There is also evidence demonstrating the link between increased contraceptive use and dedicated young people services (Glasier, 2002).

The MedFash recommended standards for sexual health suggests that commissioners and service providers should ensure that sexual health services are organised within a service network to reflect pattern of service use and needs. Also, consistent standards of care are agreed and implemented across the service network to optimise clinical outcomes and service user experience. MedFash also recommends that care pathways within and across organisations are explicitly defined, clinical, and corporate governance arrangements are agreed and implemented.

The National Strategy for Sexual Health and HIV (Great Britain. Department of Health, 2001) suggested a need to strengthen the role of primary care in delivering sexual health services and to develop and evaluate the role of GPs and primary care teams with a special interest in sexual health. It enforced MedFash recommendations of developing managed service networks and improves access to services.

The Strategy recommends a three level approach to sexual health service delivery:

Level 1: includes the following:

- Sexual history and risk assessment
- STI testing for women
- HIV testing and counselling
- Pregnancy testing and referrals
- Contraception information and services
- Assessment and referrals of men with STI symptoms
- Cervical cytology screening and referrals
- Hepatitis B immunisation

Level 2:

- Intrauterine device and contraceptive implant insertion
- Testing and treating sexually transmitted diseases and partner notification
- Vasectomy
- Invasive sexually transmitted infection testing for men

Level 3:

This includes the responsibility for sexual health needs assessment, supporting provider quality and clinical governance requirements at all levels.

Level 3 services include:

- Outreach for sexually transmitted infection prevention
- Outreach contraception services
- Specialised infection management , including co-ordination of partner notification
- Highly specialised contraception
- Specialised HIV treatment and care

Family Planning, Genito-Urinary Medicine (GUM) and Primary Care:

It has been shown that contraceptive services are financially and socially beneficial to an extent, which far outweighs its cost. It is cheaper to provide contraceptive services than induced abortion services and the maintenance of children resulting from unwanted pregnancy. The cost benefit ratio of contraception versus no method is estimated to be 1:14 (McGuire and Hughes, 1995)

Good GUM services remain the cornerstone of any strategy aiming to treat and prevent STI's. These services are based on three principles:

1. Open access
2. Responsive to local needs
3. Confidential

Existing evidence for the effectiveness of STI intervention relates primarily to the efficacy of drug treatment. Very little information is available on the effectiveness of other key activities involved in the control of STI's such as contact tracing and health education. Hepatitis B vaccination is an exception, where there is good evidence of its effectiveness if offered to those at greatest risk.

Key elements of primary prevention within GUM clinics include: health education and promotion of healthy sexual lifestyle; provision of condoms; contact tracing; and the provision of hepatitis B vaccination.

Key elements of clinical provision include: on-site diagnostic facilities, facilities and drugs for treatment, contact tracing and follow up services and provision for referral to other services.

Sexual health services in General Practice:

Primary care is well placed to provide a wide range of family planning and sexual health services, with 75-80% of contraception currently provided by GPs. Over one third of women found to have Chlamydia are diagnosed in primary care (Wellings *et* al., 1999).

In the Royal College of General Practitioners (RCGP) Handbook of Sexual Health in Primary Care, it stated that these services are "an integral part of primary care." It went on to suggest that GPs should "offer care and advice on a wide range of sexual matters and promote safer sex to all patients." Primary care is highly accessible to all people, including young women, and those at risk of HIV.

The importance of contraception and sexual health in General Practice is recognised in the new GP contract, which came into effect on 1st April 2004.

Knowledge and education of sexual health among young people and other age groups

National and international evidence suggests that unintended teenage pregnancy and sexually transmitted diseases can be reduced through the following interventions:

- Good general education or vocational programmes that aim to increase aspiration, expectations, and motivation to avoid risk-taking behaviour.
- Sex education, which provides skills and information on contraception, sexually transmitted diseases, access to services and information that can help young people protect themselves against unwanted pregnancy and sexually transmitted diseases. It needs to be tailored to the needs of its specific target group.
- Provision of contraceptive services and counselling which aim to increase contraceptive use; user choice; compliance; and increase the use of post coital contraception.

Evidence also suggests that behavioural and /or social modifications are more likely to be effective in reducing HIV transmission among homosexual men compared to interventions aimed at reducing morbidity.

Prevention of unintended teenage pregnancy:

Much of the evidence on effective interventions in this area is focused on young people. School based sex education; linked to contraceptive services, youth development services, community based education and the inclusion of parents in information and preventative programmes have been shown to help in reducing teenage pregnancy.

Effective services and interventions need to have the following characteristics:

- Focus on improving contraception use and at least one other behaviour that is likely to prevent pregnancy and or STI transmission.
- Focus on high-risk groups and working through opinion leaders and peer educators.
- Services which are accessible in terms of location, opening hours, staff attitude and confidentiality.
- Encouraging an open and non-judgemental discussion about sex, sexuality, and contraception.
- Inclusion of personal skills development such as negotiation and refusal skills.
- Having a multi agency approach and working with communities.

Evidence also suggests that good antenatal care as well as parental, psychological, social, and educational support may help health and educational outcomes of young mothers and their children (Dickson *et* al., 1997; Zabin *et al*., 1986; Kirby, 2001).

Key points:

- Investment in sexual health services is cost effective and can result in financial saving and health gain.
- Integration of sexual health services is more likely to be successful in providing appropriate sexual health prevention, care and treatment.
- A three level model of service delivery is recommended: level 1 which is the provision of basic information, basic contraption testing and treatment, level 2, more specialised contraception and STI testing and treatment and level 3, which includes strategic planning of services according to local needs and outreach preventative and treatment services.
- Successful sexual health service is based on three principles: open access, responsiveness to local needs and confidentiality.
- Good general education or vocational programmes that aim to increase aspiration, expectations and motivation are effective in reducing risk-taking behaviour
- School based sex education; linked to contraceptive services, youth development services, community based education and the inclusion of parents in information and preventative programmes have been shown to help in reducing unwanted teenage pregnancy.

Step 5: What services and procedures are required to ensure sexual health care needs are met? (Matching need to supply)

To answer this question, the current sexual health service provision in the Dudley Borough was matched to effective interventions identified from national and local targets and guidance, the literature, policy documents and professional body's recommendations.

The following gaps were identified:

Sexual health service provision:

Brook

- Brook capacity to provide LARC is restricted by the lack of LARC trained workforce.
- Brook sees 12% of the target age group receiving Chlamydia screening (15-24 years olds) per year, the service is in a good position to make a measurable contribution towards achieving the Chlamydia target.

CASH

- Although CASH provides most methods of contraception, intrauterine device insertion for emergency contraception is not offered during young person clinics.
- CASH does not offer the new combined oral hormonal contraception Yasmin.
- CASH does not provide Genito-urinary Service at Central clinic or any outreach clinics.
- CASH current information system does not meet requirements to monitor quality and other aspects of clinical governance or to provide data for commissioning.
- Almost all CASH staff work on a part time basis. This has implications on clinical governance, more specifically, on continuity of care and staff continuing professional development.
- There is lack of leadership at a consultant level.
- Although patient satisfaction surveys were positive, the need for extended opening hours and more sessions were highlighted.
- The uptake of Chlamydia screening through CASH services is extremely low.

GUM services

- Contraception services are offered as part of the GUM consultation
- GUM clinic doesn't conduct outreach services or dedicated young people's sessions.
- The system of receiving laboratory results is laborious and results in delays in processing results.

Primary Care

- LARC prescribing is variable across the Borough with no clear geographical pattern: 28% of practices provide implants, 60% provide the Copper coil, and 55% provide the Mirena coil.
- 5 practices (12%) offer no STIs testing to either sex. More practices offer STI testing to females than to males
- 62% of practices offer treatment for females and 49% for males. Only one practice offers contact tracing.

Community pharmacies

- 54% of community pharmacies do not provide a full range of written information on STIs.
- There is a cluster of pharmacies around the Kingswinford area that provide no information on STIs.
- 20% of community pharmacies provide no written information on contraception, 66% provide partial range and 15% provide a full range of contraception information
- The geographical distribution of the provision of the full range of STIs and contraception through community pharmacies does not match the geographical distribution of young people in the Borough or the hotspot areas for teenage pregnancy and STIs.
- The EHC scheme covers 10% community pharmacies in Dudley. The uptake of EHC does not match teenage pregnancy hotspot areas for teenage pregnancy.
- Demographic data collected through the EHC scheme lacks the full postcode.

Other services:

- Chlamydia testing in schools is not offered proactively by school health
- The knowledge of Black and Minority Ethnic Communities (BMEC) regarding the range of sexual health services available locally is poor. Furthermore, their knowledge of sexually transmitted diseases, including its impact on life was found to be limited

Recommendations:

The Sexual Health Planning and Implementation Group (SHPIG) needs to ensure the following:

- SHPIG is to develop a local performance framework for sexual health, which takes into account national and local targets and priorities.
- All sexual health services for young people across the Borough follow the DH "You're Welcome" quality standards for young people. Moreover, the standards are monitored on a regular basis.
- Hotspot areas for teenage pregnancy and sexually transmitted diseases have readily accessible sexual health services, which provide contraception, TOP referral, EHC, and LARC prescribing.
- Increase Chlamydia screening uptake through the main stream sexual health services (CASH, Brook, primary care, and community pharmacies) through ensuring that all SLA/ contracts specify a target of Chlamydia screening uptake.
- Develop and implement LARC strategy which includes advertisement and raising awareness of the effectiveness of LARC among the general public and sexual health care providers, increase LARC trained workforce and improve access to LARC across primary care and mainstream sexual health services.
- Improve the information system for CASH, Brook Birmingham and the EHC scheme.
- The development of integrated care pathways for teenage pregnancy, sexually transmitted diseases, abortion and sexual health promotion to ensure functional integration of sexual health across the Borough

Dudley PCT commissioning is to ensure the following:

- Expand EHC scheme through community pharmacy, from its current 10% coverage.
- Include a clear care pathway for women requesting TOP to improve access to TOP before 9 weeks. This should cut across primary care, CASH and other family planning services and TOPs providers. It should enable patients self referral.
- Opportunistic screening for Chlamydia is delivered effectively through main stream sexual health services (CASH, Brook, and primary care) to ensure high volume uptake.
- An opt-out policy across all services, including FE and school settings if possible.
- Agree and implement targets for early diagnosis of sexually transmitted diseases, including HIV and syphilis as part of the integrated care pathway for STIs. The care pathway should cut across primary care, TOPS services, CASH, Brook, Summit House, and secondary care GUM services.

Public health in conjunction with commissioning and Primary Care is to ensure the following with regard to meeting the needs of minority groups in the Borough:

- Improve provision of information and training of pharmacists and pharmacy staff on sexual health effective communication and sexual health risk assessment
- Awareness raising / educational sessions need to be delivered to minority groups in their local community, with the support of interpreting and translation services to ensure that people that are unable to speak English or read in any community language, are still able to access information.
- Activities / projects which train and support members of the community to deliver basic awareness-raising information / education to other members within their community, should be considered and resourced appropriately.
- Each GP practice should include (or enable referral to) a female GP, so that women have the opportunity to speak to a GP about sexual health issues.
- Given that GPs are the most preferred point of access to sexual health services for some people, service provision should be culturally sensitive and all staff should be trained, skilled, and confident to work in a culturally competent way.
- GP practices should aim to make the appointment booking system as accessible as possible and keep waiting times for appointments to a minimum.
- As per the national strategy (Great Britain. Department of Health, 2003b) sexual health information should be clear, accurate, and up to date, provided in attractive and accessible forms and languages. This information should be readily available from GPs, nurses/clinics and also through other trusted professionals and community groups.
- More use should be made of magazines, newspapers, the internet, and other advertising mediums (e.g. Buses) to raise awareness of sexual health issues, and advertise the full range of services available, and what they provide.
- More education / preventative work should take place through schools to raise young people's awareness of the dangers of HIV and the possible consequences of particular lifestyle choices, whilst also ensuring that common stereotypes which may fuel stereotyping and discrimination are challenged.
- Services should review their opening hours to ensure they are as accessible as possible to service users, and that waiting times for appointments are kept to a minimum.
- Appointments should be streamlined wherever possible to minimise the need for return / multiple visits and patients should be able to see the same doctor, to ensure consistency, wherever possible.
- In line with the aims of the national strategy (Great Britain. Department of Health, 2003b), services should take practical steps towards reducing the stigma and discrimination associated with HIV and STIs.
- GPs and clinics should endorse the standards taken from Effective Sexual Health Promotion (French, 2007) and should use these as a framework to underpin their work, in order to be effective, sensitive, and appropriate.
- GPs that have special interest in HIV / are HIV aware should be more accessible so that better HIV support can be provided at a local point of delivery.

- All staff should provide services in a non-judgemental, respectful, and sensitive way, and should be trained, skilled, and confident to work in ways which exemplify this. They should also actively counter and challenge discrimination, stigma and prejudice, (Kinniburgh *et* al., 2001). Confidentiality should be maintained at all times.

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Table 1: 2006 Mid-Year Population Estimate by Sex, Age, and Locality

Females

LOCALITY	AGE (females)																							
	Under 15		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50-54		55-59		60-64		65+		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
DUDLEY TOTAL	**26453**	***17.1***	**9389**	***6.1***	**8500**	***5.5***	**8605**	***5.5***	**9542**	***6.2***	**11818**	***7.6***	**11614**	***7.5***	**10084**	***6.5***	**9413**	***6.1***	**10259**	***6.6***	**9202**	***5.9***	**30211**	***19.5***	**155090**	***100***
Brierley Hill	7108	*17.1*	2563	*6.1*	2341	*5.6*	2346	*5.6*	2637	*6.3*	3322	*8.0*	3126	*7.5*	2756	*6.6*	2668	*6.4*	2898	*7.0*	2563	*6.1*	7354	*17.6*	41682	*100*
Halesowen	4511	*16.0*	1675	*5.9*	1460	*5.2*	1504	*5.3*	1562	*5.5*	2051	*7.3*	2106	*7.4*	1985	*7.0*	1812	*6.4*	2022	*7.1*	1666	*5.9*	5923	*20.9*	28278	*100*
Dudley & Netherton	5685	*19.4*	1909	*6.5*	1881	*6.4*	1848	*6.3*	1934	*6.6*	2220	*7.6*	2049	*7.0*	1794	*6.1*	1515	*5.2*	1547	*5.3*	1507	*5.1*	5453	*18.6*	29340	*100*
Sedgley	4777	*17.0*	1599	*5.7*	1437	*5.1*	1572	*5.6*	1761	*6.3*	2233	*8.0*	2203	*7.9*	1669	*6.0*	1575	*5.6*	1763	*6.3*	1744	*6.2*	5712	*20.4*	28043	*100*
Stourbridge	4372	*15.8*	1643	*5.9*	1381	*5.0*	1336	*4.8*	1648	*5.9*	1993	*7.2*	2130	*7.7*	1880	*6.8*	1843	*6.6*	2030	*7.3*	1722	*6.2*	5770	*20.8*	27747	*100*

Males

LOCALITY	AGE (males)																							
	Under 15		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50-54		55-59		60-64		65+		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
DUDLEY TOTAL	**27944**	***18.6***	**10573**	***7.0***	**8575**	***5.7***	**8231**	***5.5***	**9189**	***6.1***	**11831**	***7.9***	**11481**	***7.6***	**10151**	***6.8***	**9622**	***6.4***	**10339**	***6.9***	**9124**	***6.1***	**23103**	***15.4***	**150163**	***100***
Brierley Hill	7350	*18.1*	2785	*6.9*	2379	*5.9*	2305	*5.7*	2592	*6.4*	3293	*8.1*	3140	*7.7*	2781	*6.9*	2602	*6.4*	2944	*7.3*	2536	*6.2*	5862	*14.4*	40570	*100*
Halesowen	4775	*17.6*	1832	*6.8*	1495	*5.5*	1470	*5.4*	1506	*5.6*	2028	*7.5*	2074	*7.7*	1917	*7.1*	1833	*6.8*	2046	*7.5*	1748	*6.4*	4381	*16.2*	27103	*100*
Dudley & Netherton	5981	*21.0*	2210	*7.8*	1763	*6.2*	1684	*5.9*	1836	*6.5*	2257	*7.9*	2095	*7.4*	1766	*6.2*	1723	*6.1*	1544	*5.4*	1541	*5.4*	4060	*14.3*	28460	*100*
Sedgley	4970	*18.4*	1753	*6.5*	1464	*5.4*	1400	*5.2*	1735	*6.4*	2229	*8.3*	2178	*8.1*	1753	*6.5*	1624	*6.0*	1787	*6.6*	1598	*5.9*	4484	*16.6*	26973	*100*
Stourbridge	4868	*18.0*	1993	*7.4*	1475	*5.5*	1372	*5.1*	1519	*5.6*	2024	*7.5*	1995	*7.4*	1934	*7.1*	1841	*6.8*	2019	*7.5*	1702	*6.3*	4316	*16.0*	27057	*100*

Source: ONS Mid-year population estimate

Table 2: Proportion of Population that are Sexually Active, or Sexually Active Young People, by Locality

LOCALITY	Females				Males				Total			
	15-24		15-64		15-24		15-64		15-24		15-64	
	No.	% of total	No.	% of total	No.	% of total	No.	% of total	No.	% of total	No.	% of total
DUDLEY TOTAL	**17889**	**11.5**	**98426**	**63.5**	**19148**	**12.8**	**99116**	**66.0**	**37037**	**12.1**	**197542**	**64.7**
Brierley Hill	4904	11.8	27221	65.3	5164	12.7	27358	67.4	10068	12.2	54578	66.4
Halesowen	3136	11.1	17843	63.1	3327	12.3	17947	66.2	6462	11.7	35791	64.6
Dudley & Netherton	3790	12.9	18203	62.0	3973	14.0	18419	64.7	7763	13.4	36621	63.4
Sedgley	3035	10.8	17554	62.6	3216	11.9	17519	64.9	6252	11.4	35073	63.8
Stourbridge	3024	10.9	17605	63.4	3467	12.8	17873	66.1	6492	11.8	35478	64.7

Source: ONS Mid-year population estimate 2006

Figure 1 Population Pyramid for Dudley Borough

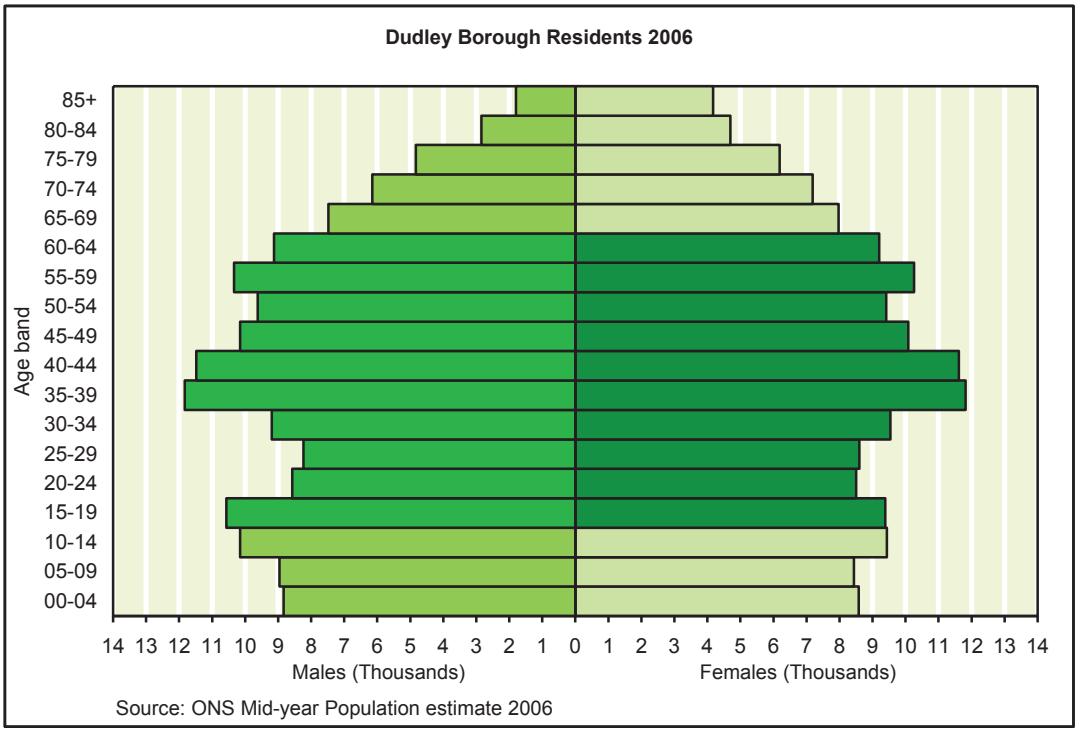
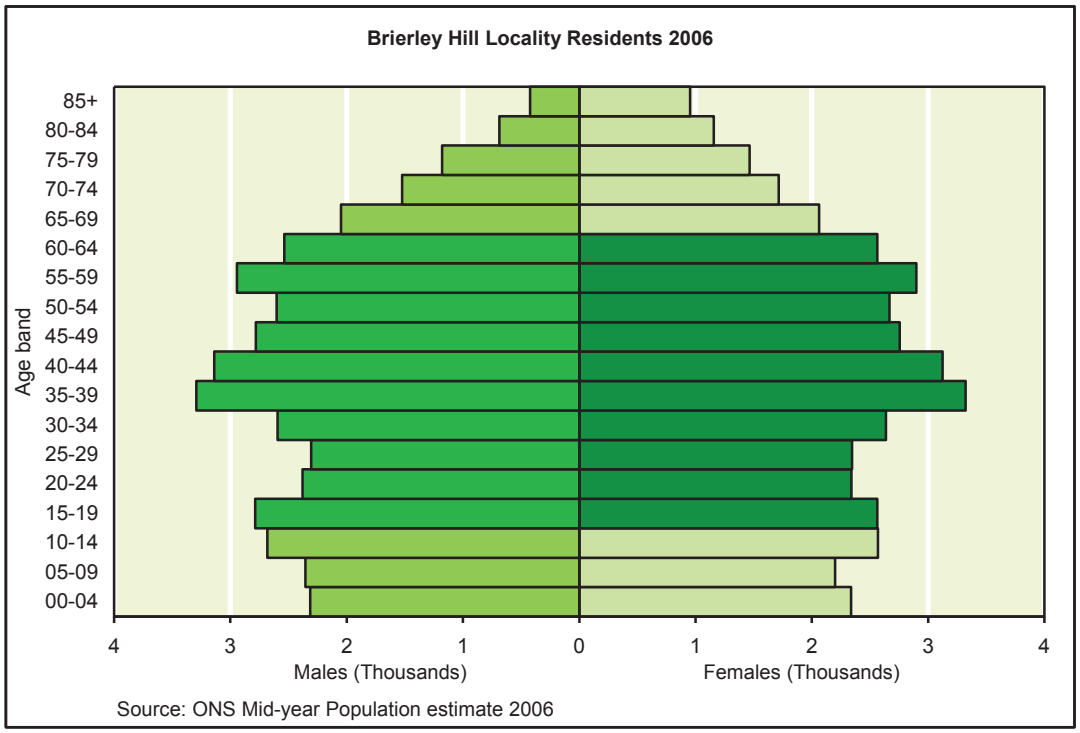
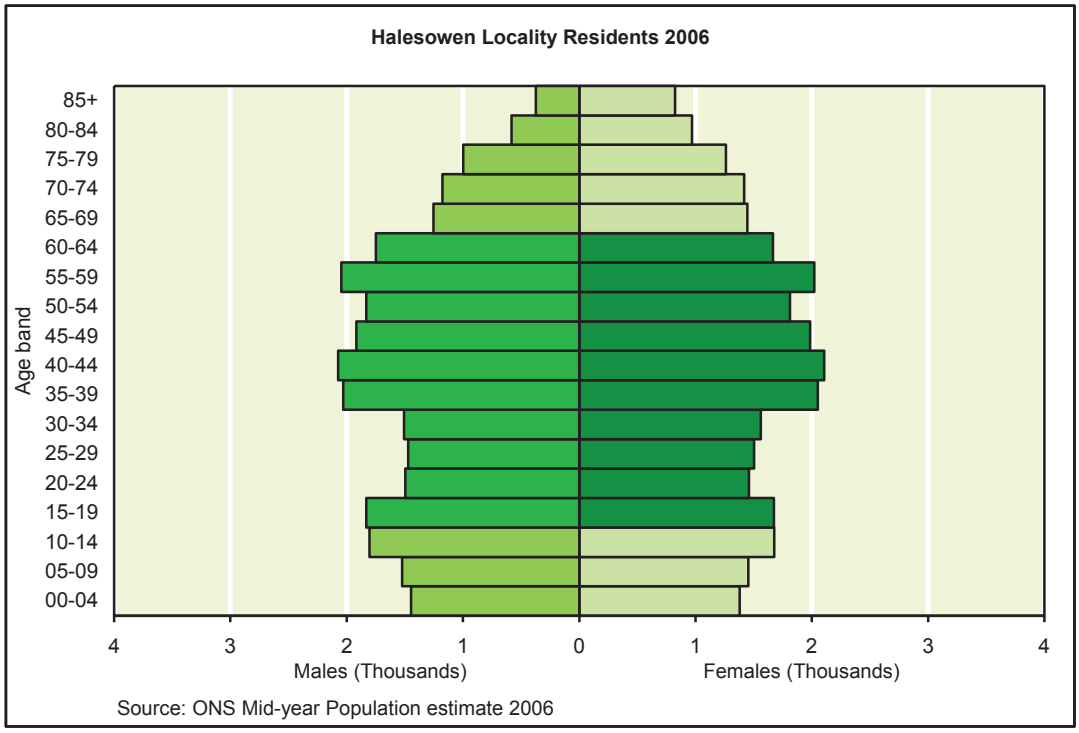
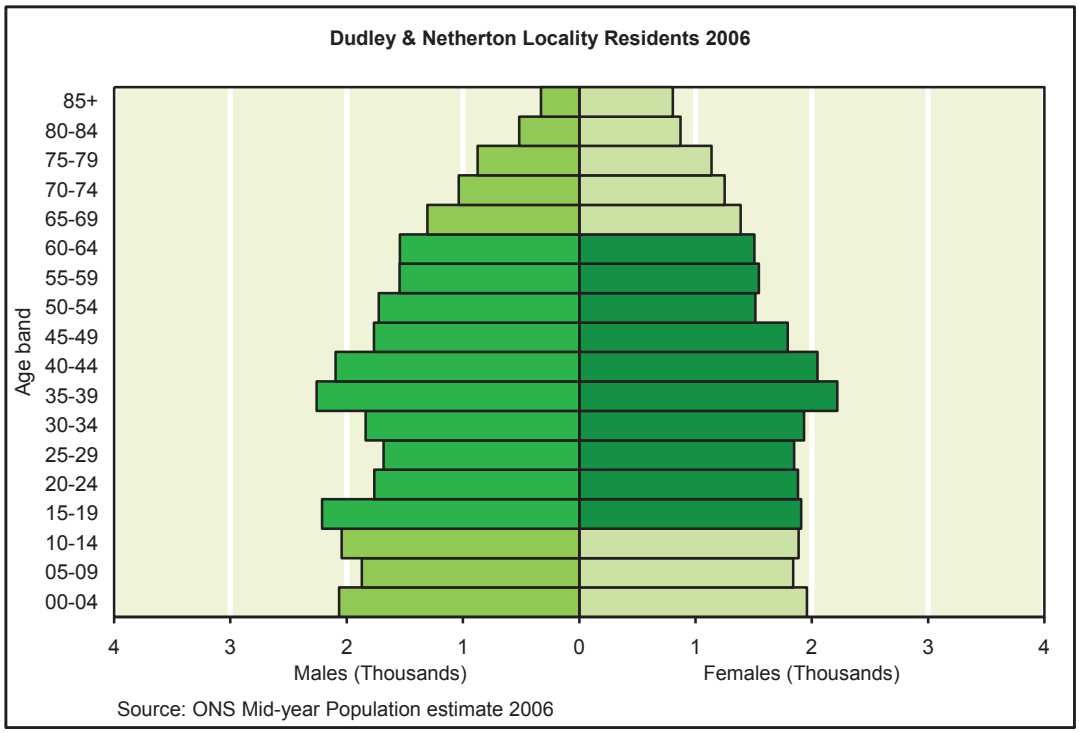


Figure 2 Population Pyramids by Locality

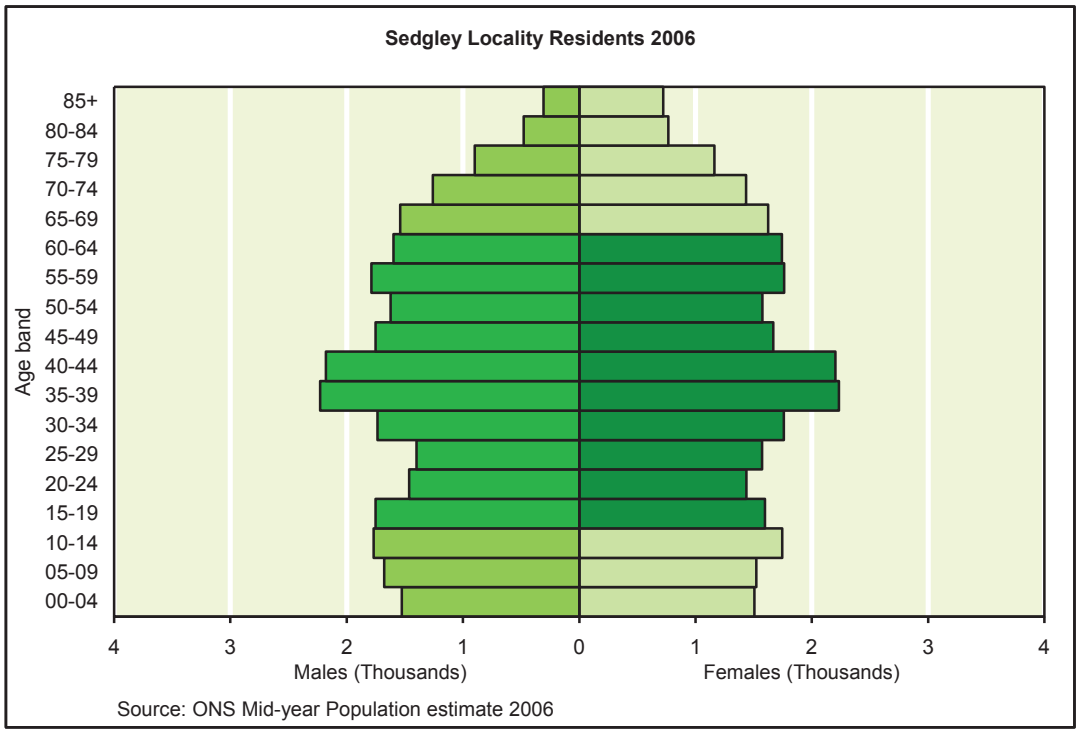




Source: ONS Mid-year Population estimate 2006



Source: ONS Mid-year Population estimate 2006


Sedgley Locality Residents 2006
Age band
85+
80-84
75-79
70-74
65-69
60-64
55-59
50-54
45-49
40-44
35-39
30-34
25-29
20-24
15-19
10-14
05-09
00-04
4
3
2
1
0
1
2
3
4
Males (Thousands)
Females (Thousands)
Source: ONS Mid-year Population estimate 2006

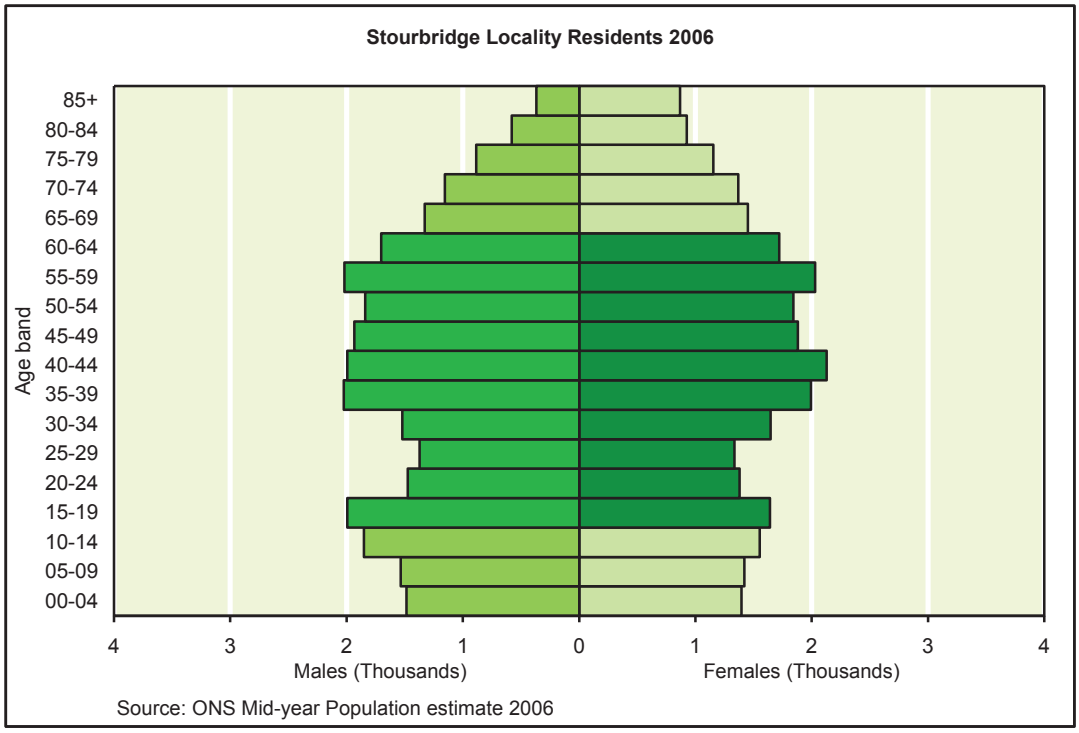

Stourbridge Locality Residents 2006
Age band
85+
80-84
75-79
70-74
65-69
60-64
55-59
50-54
45-49
40-44
35-39
30-34
25-29
20-24
15-19
10-14
05-09
00-04
4
3
2
1
0
1
2
3
4
Males (Thousands)
Females (Thousands)
Source: ONS Mid-year Population estimate 2006

Table 3: 2006 Mid-Year Population Estimate by Sex, Age and Index of Multiple Deprivation

Females	AGE (females)												
IMD quintile	Under 15	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+	Total
DUDLEY TOTAL	**26453**	**9389**	**8500**	**8605**	**9542**	**11818**	**11614**	**10084**	**9413**	**10259**	**9202**	**30211**	**155090**
1 - 20% most deprived	7078	2444	2411	2334	2301	2565	2405	1943	1715	1746	1697	6546	35186
2	7670	2679	2454	2649	2895	3331	3142	2734	2401	2513	2359	8099	42927
3	3826	1326	1242	1335	1550	1903	1923	1590	1515	1818	1490	5074	24592
4	4511	1732	1406	1413	1696	2284	2341	2130	2141	2404	2020	6049	30127
5 - 20% least deprived	3368	1208	988	874	1100	1735	1802	1687	1641	1778	1635	4443	22258

Males	AGE (males)												
IMD quintile	Under 15	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+	Total
DUDLEY TOTAL	**27944**	**10573**	**8575**	**8231**	**9189**	**11831**	**11481**	**10151**	**9622**	**10339**	**9124**	**23103**	**150163**
1 - 20% most deprived	7286	2612	2226	2260	2192	2554	2418	2091	1927	1757	1707	4734	33766
2	7941	2853	2433	2419	2686	3305	3044	2803	2540	2590	2338	6134	41084
3	4330	1733	1264	1232	1544	1949	1954	1560	1546	1811	1538	3729	24189
4	4748	1928	1610	1373	1722	2318	2315	2086	2056	2385	1988	4657	29185
5 - 20% least deprived	3639	1447	1043	948	1045	1705	1750	1611	1554	1796	1552	3848	21938

Source: ONS Mid-year population estimate /Index of Multiple Deprivation 2007

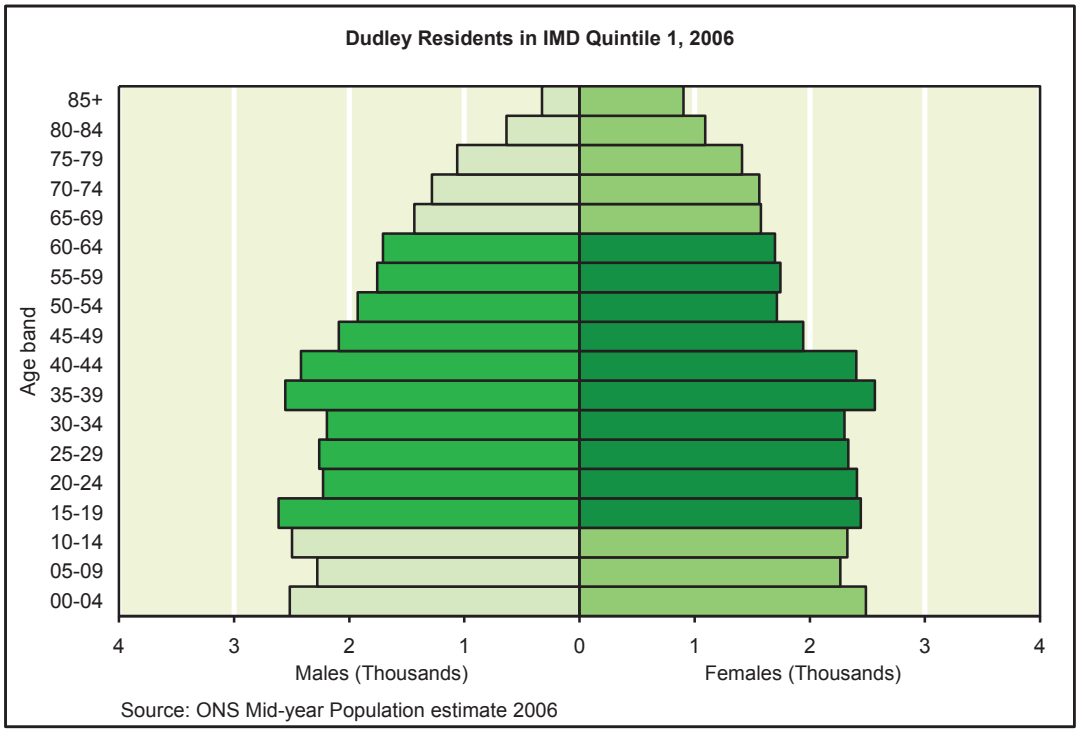
Table 4

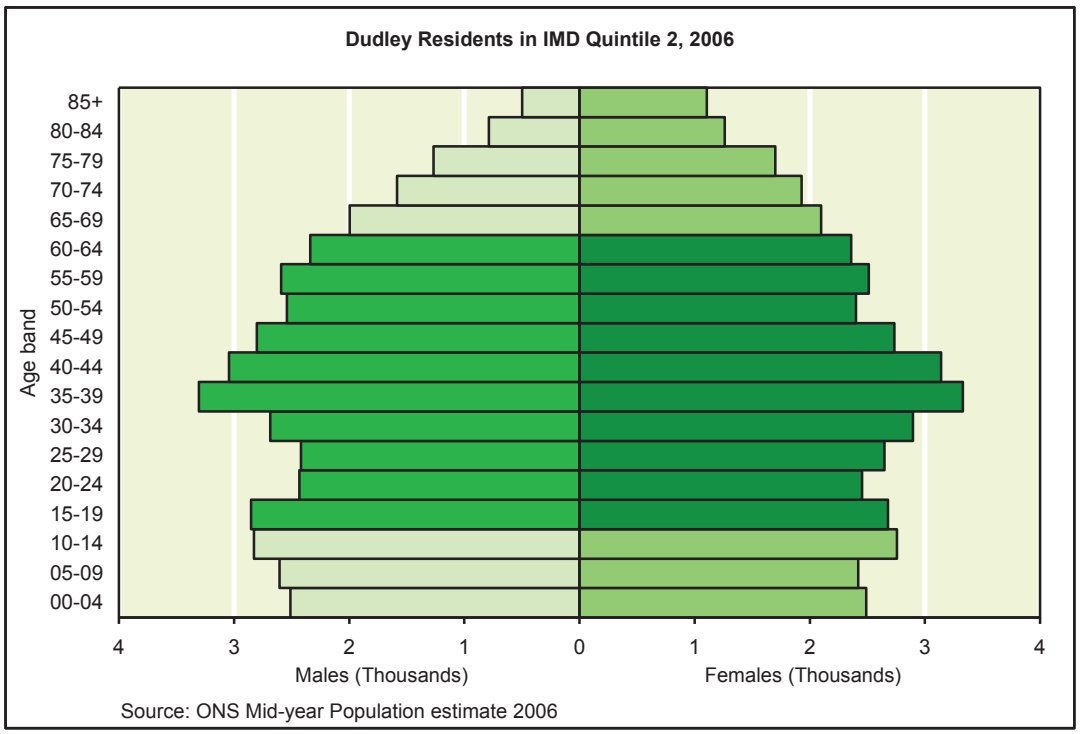
Proportion of Population that are Sexually Active, or Sexually Active Young People, by Index of Multiple Deprivation

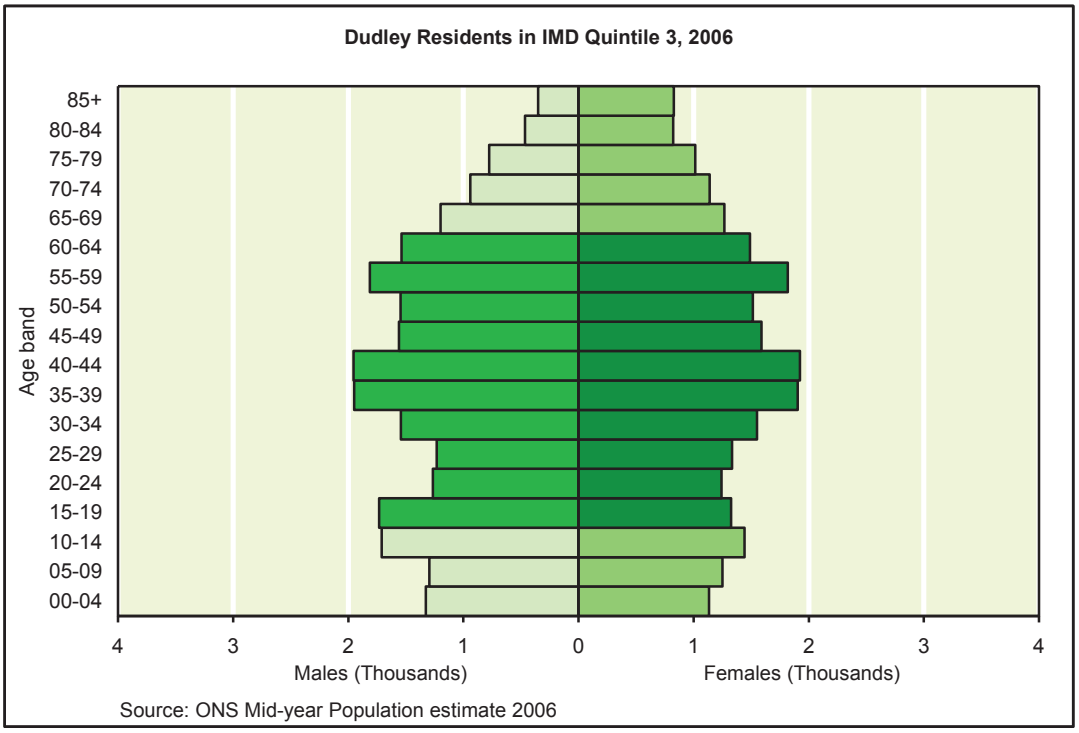
Females				Males				Total			
15-24		15-64		15-24		15-64		15-24		15-64	
No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
17889	**11.5**	**98426**	**63.5**	**19148**	**12.8**	**99116**	**66.0**	**37037**	**12.1**	**197542**	**64.7**
4855	13.8	21561	61.3	4838	14.3	21745	64.4	9693	14.1	43307	62.8
5133	12.0	27158	63.3	5286	12.9	27009	65.7	10419	12.4	54167	64.5
2568	10.4	15692	63.8	2997	12.4	16130	66.7	5564	11.4	31822	65.2
3138	10.4	19567	64.9	3539	12.1	19781	67.8	6676	11.3	39348	66.3
2195	9.9	14447	64.9	2489	11.3	14451	65.9	4685	10.6	28898	65.4

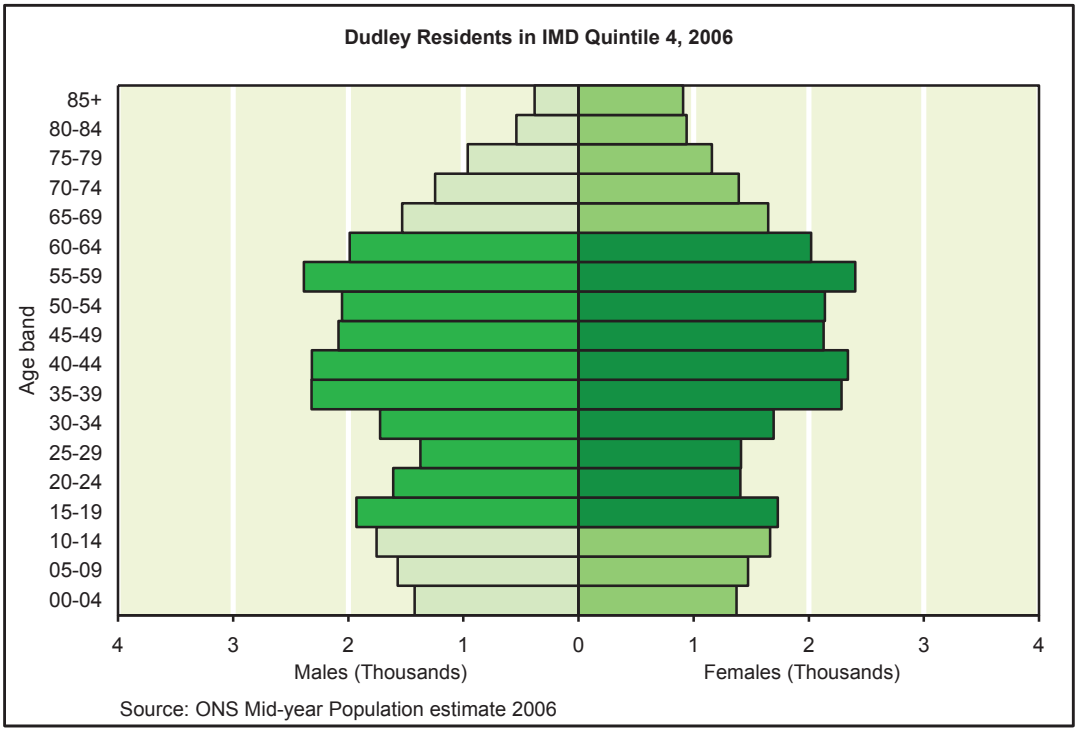
Source: ONS Mid-year population estimate /Index of Multiple Deprivation 2007

Figure 3: Population Pyramids by IMD Quintile






Dudley Residents in IMD Quintile 3, 2006
Age band
85+
80-84
75-79
70-74
65-69
60-64
55-59
50-54
45-49
40-44
35-39
30-34
25-29
20-24
15-19
10-14
05-09
00-04
4
3
2
1
0
1
2
3
4
Males (Thousands)
Females (Thousands)
Source: ONS Mid-year Population estimate 2006


Dudley Residents in IMD Quintile 4, 2006
Age band
85+
80-84
75-79
70-74
65-69
60-64
55-59
50-54
45-49
40-44
35-39
30-34
25-29
20-24
15-19
10-14
05-09
00-04
4
3
2
1
0
1
2
3
4
Males (Thousands)
Females (Thousands)
Source: ONS Mid-year Population estimate 2006

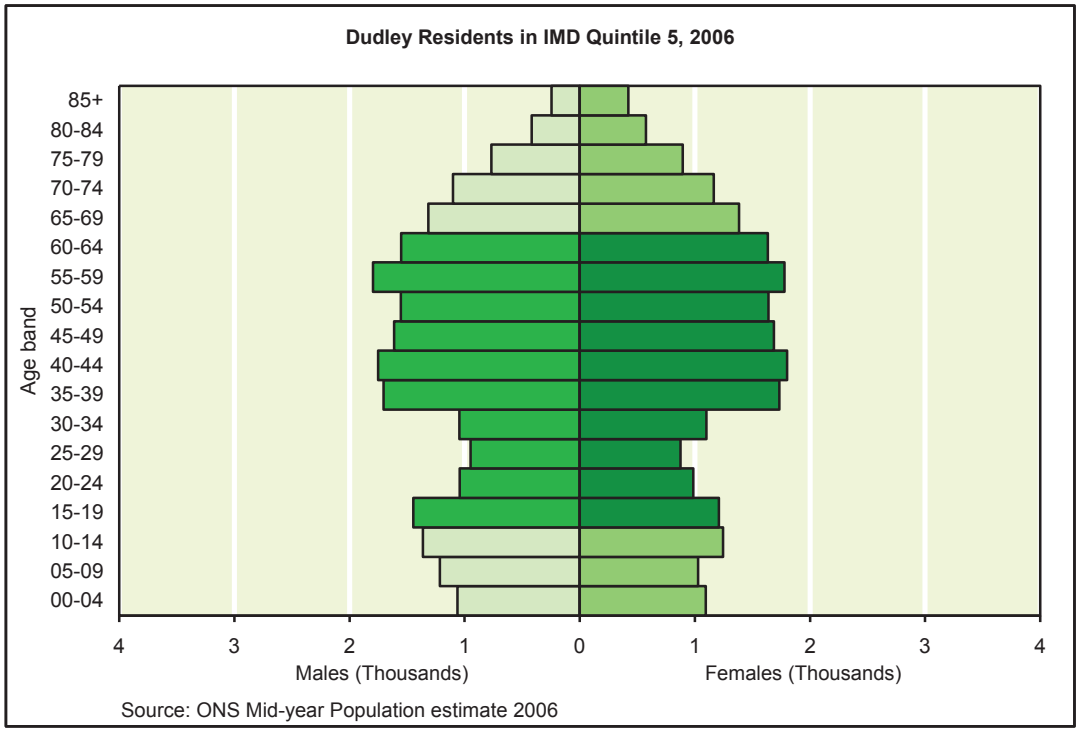

Dudley Residents in IMD Quintile 5, 2006
Age band
85+
80-84
75-79
70-74
65-69
60-64
55-59
50-54
45-49
40-44
35-39
30-34
25-29
20-24
15-19
10-14
05-09
00-04
4
3
2
1
0
1
2
3
4
Males (Thousands)
Females (Thousands)
Source: ONS Mid-year Population estimate 2006

Table 5: All Residents by Ethnic Group and Locality, 2001

Ethnic Group		Locality											
		Brierley Hill		Dudley & Netherton		Halesowen		Sedgley		Stourbridge		ALL LOCALITIES	
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
TOTAL		**80956**	***100***	**57289**	***100***	**55352**	***100***	**54538**	***100***	**55066**	***100***	**303200**	***100***
White	British	77391		48202		51328		52455		50960		280336	
	Irish	285		292		393		209		346		1525	
	Other	458		368		446		279		483		2034	
	White Total	**78134**	***96.5***	**48862**	***85.3***	**52166**	***94.2***	**52943**	***97.1***	**51790**	***94.1***	**283895**	***93.6***
Mixed	White and Black Caribbean	405		790		283		295		163		1936	
	White and Black African	18		27		26		12		25		108	
	White and Asian	152		179		156		75		141		703	
	Other	68		98		103		30		56		355	
	Mixed Total	**643**	***0.8***	**1094**	***1.9***	**568**	***1.0***	**412**	***0.8***	**385**	***0.7***	**3102**	***1.0***
Asian	Indian	613		2275		856		655		415		4814	
	Pakistani	771		2762		607		84		1971		6195	
	Bangladeshi	12		91		158		15		9		285	
	Other	170		214		355		45		121		905	
	Asian Total	**1566**	***1.9***	**5342**	***9.3***	**1976**	***3.6***	**799**	***1.5***	**2516**	***4.6***	**12199**	***4.0***
Black	Caribbean	234		1509		257		223		101		2324	
	African	47		103		66		15		38		269	
	Other	24		168		12		36		60		300	
	Black Total	**304**	***0.4***	**1780**	***3.1***	**336**	***0.6***	**274**	***0.5***	**199**	***0.4***	**2893**	***1.0***
Other	Chinese	196		124		127		89		120		656	
	Other ethnic group	112		87		178		21		56		455	
	Other Total	**308**	***0.4***	**211**	***0.4***	**305**	***0.6***	**110**	***0.2***	**176**	***0.3***	**1111**	***0.4***

Table 6: All Residents by Country of Birth and Locality, 2001

Country of Birth	Locality											
	Brierley Hill		Dudley & Netherton		Halesowen		Sedgley		Stourbridge		ALL LOCALITIES	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
ALL COUNTRIES	**82707**	***100***	**57341**	***100***	**55338**	***100***	**54630**	***100***	**55136**	***100***	**305152**	***100***
Europe total	81334	*98.3*	53807	*93.8*	53777	*97.2*	53940	*98.7*	53447	*96.9*	296305	*97.1*
UK total	80703	*97.6*	53281	*92.9*	53167	*96.1*	53598	*98.1*	52781	*95.7*	293530	*96.2*
England	*79440*	*96.1*	*52515*	*91.6*	*52154*	*94.2*	*52914*	*96.9*	*51529*	*93.5*	*288552*	*94.6*
Scotland	*415*	*0.5*	*255*	*0.4*	*319*	*0.6*	*211*	*0.4*	*410*	*0.7*	*1610*	*0.5*
Wales	*705*	*0.9*	*419*	*0.7*	*575*	*1.0*	*388*	*0.7*	*692*	*1.3*	*2779*	*0.9*
Northern Ireland	*139*	*0.2*	*92*	*0.2*	*117*	*0.2*	*85*	*0.2*	*142*	*0.3*	*575*	*0.2*
Channel Isles & Isle of Man	*3*	*0.0*	*0*	*0.0*	*2*	*0.0*	*0*	*0.0*	*9*	*0.0*	*14*	*0.0*
UK not specified	*8*	*0.0*	*6*	*0.0*	*9*	*0.0*	*11*	*0.0*	*13*	*0.0*	*47*	*0.0*
Republic of Ireland	233	*0.3*	211	*0.4*	312	*0.6*	146	*0.3*	260	*0.5*	1162	*0.4*
Ireland not specified	0	*0.0*	0	*0.0*	0	*0.0*	0	*0.0*	0	*0.0*	0	*0.0*
Other Western Europe	313	*0.4*	244	*0.4*	229	*0.4*	148	*0.3*	296	*0.5*	1230	*0.4*
Eastern Europe	77	*0.1*	65	*0.1*	61	*0.1*	37	*0.1*	97	*0.2*	336	*0.1*
Africa	184	*0.2*	278	*0.5*	171	*0.3*	105	*0.2*	130	*0.2*	868	*0.3*
Asia	971	*1.2*	2470	*4.3*	1170	*2.1*	421	*0.8*	1352	*2.5*	6384	*2.1*
North America	151	*0.2*	705	*1.2*	161	*0.3*	129	*0.2*	108	*0.2*	1254	*0.4*
South America	8	*0.0*	14	*0.0*	8	*0.0*	6	*0.0*	38	*0.1*	74	*0.0*
Oceania	41	*0.0*	32	*0.1*	33	*0.1*	20	*0.0*	51	*0.1*	177	*0.1*
Other	18	*0.0*	35	*0.1*	18	*0.0*	9	*0.0*	10	*0.0*	90	*0.0*

Table 7: All Residents by Age and Locality, 2001

Locality	Total		Age								Population 16-24	% of 16-24 year olds that are students
			16-17		18-19		20-24		25+			
	No.	%	No.	%	No.	%	No.	%	No.	%		
Brierley Hill	2685	*100*	1478	*55.1*	540	*20.1*	383	*14.3*	284	*10.6*	8110	*29.6*
Dudley & Netherton	2185	*100*	999	*45.7*	436	*20.0*	471	*21.6*	279	*12.8*	6319	*30.2*
Halesowen	1961	*100*	988	*50.4*	456	*23.3*	312	*15.9*	204	*10.4*	5229	*33.6*
Sedgley	1669	*100*	890	*53.3*	319	*19.1*	257	*15.4*	203	*12.2*	4912	*29.8*
Stourbridge	2120	*100*	1089	*51.4*	493	*23.3*	311	*14.7*	226	*10.7*	5210	*36.3*
Dudley Borough	**10619**	***100***	**5445**	***51.3***	**2244**	***21.1***	**1734**	***16.3***	**1196**	***11.3***	**29780**	***31.6***

Table 1: Rate of Chlamydia Infection by Year

Chlamydia	Males				Females				Total				% change in rate since 2001
	Number	Rate/ 100,000	*95% CI*		Number	Rate/ 100,000	*95% CI*		Number	Rate/ 100,000	*95% CI*		
2001	264	176.42	*155.8*	*199.0*	233	149.93	*131.3*	*170.4*	497	162.92	*148.9*	*177.9*	
2002	225	149.97	*131.3*	*171.2*	268	172.45	*152.5*	*194.4*	493	161.41	*147.7*	*176.5*	-0.9
2003	202	134.91	*117.1*	*155.1*	249	160.60	*141.3*	*181.8*	451	147.98	*134.7*	*162.4*	-9.2
2004	207	138.25	*120.3*	*158.7*	208	134.16	*116.8*	*154.0*	415	136.30	*123.6*	*150.2*	-16.3
2005	227	151.02	*132.3*	*172.4*	284	182.87	*162.6*	*205.8*	511	167.20	*153.4*	*182.7*	2.6
2006	236	157.16	*137.8*	*178.5*	272	175.38	*155.2*	*197.5*	508	166.42	*152.3*	*181.5*	2.1
2007	247	164.62	*144.7*	*186.5*	266	171.20	*151.3*	*193.0*	513	167.97	*153.8*	*183.1*	3.1

Source: Health Protection Agency

Table 2: Rate of Chlamydia Infection by Age and Sex, 2005-07 combined

Chlamydia	Males				Females				Total			
	Number	Rate/	*95% CI*		Number	Rate/	*95% CI*		Number	Rate/	*95% CI*	
Under 20	123	106.5	*88.6*	*127.1*	310	288.1	*256.9*	*321.9*	433	231.4	*210.2*	*254.3*
20-24	293	1133.2	*1007.8*	*1269.8*	296	1161.6	*1033.7*	*1300.8*	589	1366.9	*1259.4*	*1481.0*
25-34	212	405.8	*353.1*	*464.1*	158	289.9	*246.5*	*338.7*	370	420.2	*378.6*	*465.2*
35+	82	32.0	*25.4*	*39.7*	58	20.9	*15.9*	*27.0*	140	31.6	*26.6*	*37.3*
Total	710	157.7	*146.3*	*169.8*	822	176.6	*164.7*	*189.1*	1532	201.4	*191.5*	*211.7*

Source: Health Protection Agency

Table 3: Rate of Gonorrhoea Infection by Year

Gonorrhoea	Males				Females				Total				% change in rate since 2001
	Number	Rate/ 100,000	*95% CI*		Number	Rate/ 100,000	*95% CI*		Number	Rate/ 100,000	*95% CI*		
2001	86	57.47	*46.0*	*71.0*	37	23.81	*16.8*	*32.8*	123	40.32	*33.5*	*48.1*	
2002	59	39.33	*30.0*	*50.8*	52	33.46	*25.0*	*43.9*	111	36.34	*29.9*	*43.8*	-9.9
2003	77	51.43	*40.6*	*64.4*	35	22.57	*15.7*	*31.4*	112	36.75	*30.3*	*44.2*	-8.9
2004	93	62.11	*50.2*	*76.2*	37	23.86	*16.8*	*33.0*	130	42.70	*35.7*	*50.7*	5.9
2005	74	49.23	*38.8*	*61.9*	42	27.04	*19.5*	*36.6*	116	37.96	*31.4*	*45.6*	-5.9
2006	68	45.28	*35.2*	*57.4*	28	18.05	*12.0*	*26.1*	96	31.45	*25.5*	*38.4*	-22.0
2007	57	37.99	*28.8*	*49.2*	27	17.38	*11.5*	*25.3*	84	27.50	*21.9*	*34.0*	-31.8

Source: Health Protection Agency

Table 4: Rate of Gonorrhoea Infection by Age and Sex, 2005-07 combined

Gonorrhoea	Males				Females				Total			
	Number	Rate/ 100,000	*95% CI*		Number	Rate/ 100,000	*95% CI*		Number	Rate/ 100,000	*95% CI*	
Under 20	29	25.1	*16.8*	*36.1*	30	27.9	*18.8*	*39.8*	59	31.5	*24.0*	*40.7*
20-24	61	235.9	*180.5*	*303.0*	35	137.4	*95.7*	*191.0*	96	222.8	*180.5*	*272.0*
25-34	59	112.9	*86.0*	*145.6*	21	38.5	*23.8*	*58.9*	80	90.9	*72.1*	*113.1*
35+	50	19.5	*14.5*	*25.7*	11	4.0	*2.0*	*7.1*	61	13.8	*10.5*	*17.7*
Total	199	44.2	*38.3*	*50.8*	97	20.8	*16.9*	*25.4*	296	38.9	*34.6*	*43.6*

Source: Health Protection Agency

Table 5: Rate of Genital Warts Infection by Year

Genital Warts	Males				Females				Total				% change in rate since 2001
	Number	Rate/ 100,000	*95% CI*		Number	Rate/ 100,000	*95% CI*		Number	Rate/ 100,000	*95% CI*		
2001	174	116.28	*99.7*	*134.9*	177	113.89	*97.7*	*131.9*	351	115.06	*103.3*	*127.7*	
2002	170	113.31	*97.1*	*131.9*	135	86.87	*72.9*	*102.9*	305	99.86	*89.1*	*111.8*	-13.2
2003	148	98.84	*83.7*	*116.3*	137	88.36	*74.2*	*104.4*	285	93.51	*83.0*	*105.1*	-18.7
2004	196	130.9	*113.5*	*150.8*	164	105.78	*90.4*	*123.5*	360	118.24	*106.4*	*131.2*	2.8
2005	179	119.08	*102.5*	*138.2*	147	94.65	*80.1*	*111.5*	326	106.67	*95.6*	*119.2*	-7.3
2006	215	143.18	*124.7*	*163.6*	163	105.10	*89.6*	*122.5*	378	123.83	*111.7*	*137.0*	7.6
2007	180	119.97	*103.1*	*138.8*	187	120.35	*103.7*	*138.9*	367	120.16	*108.2*	*133.1*	4.4

Source: Health Protection Agency

Table 6: Rate of Genital Warts Infection by Age and Sex, 2005-07 combined

Genital Warts	Males				Females				Total			
	Number	Rate/	*95% CI*		Number	Rate/	*95% CI*		Number	Rate/	*95% CI*	
Under 20	75	65.0	*51.1*	*81.4*	145	134.7	*113.7*	*158.5*	220	117.6	*102.6*	*134.2*
20-24	192	742.6	*641.6*	*854.9*	150	588.7	*498.4*	*690.4*	342	793.7	*712.1*	*882.0*
25-34	186	356.0	*306.8*	*410.9*	120	220.1	*182.6*	*263.2*	306	347.6	*309.8*	*388.7*
35+	121	47.2	*39.1*	*56.3*	82	29.5	*23.5*	*36.6*	203	45.9	*39.8*	*52.6*
Total	574	127.5	*117.3*	*138.4*	497	106.8	*97.6*	*116.6*	1071	140.8	*132.5*	*149.5*

Source: Health Protection Agency

Table 7: Rate of Genital Herpes Infection by Year

Genital Herpes	Males				Females				Total				% change in rate since 2001
	Number	Rate/ 100,000	*95% CI*		Number	Rate/ 100,000	*95% CI*		Number	Rate/ 100,000	*95% CI*		
2001	38	25.39	*18.0*	*34.9*	53	34.10	*25.5*	*44.6*	91	29.83	*24.0*	*36.6*	
2002	32	21.33	*14.6*	*30.2*	48	30.89	*22.8*	*41.0*	80	26.19	*20.8*	*32.6*	-12.2
2003	26	17.36	*11.4*	*25.5*	49	31.60	*23.4*	*41.8*	75	24.61	*19.4*	*30.9*	-17.5
2004	39	26.05	*18.6*	*35.7*	57	36.76	*27.9*	*47.7*	96	31.53	*25.6*	*38.5*	5.7
2005	48	31.93	*23.6*	*42.4*	57	36.70	*27.9*	*47.6*	105	34.36	*28.2*	*41.7*	15.2
2006	14	9.32	*5.1*	*15.6*	53	34.17	*25.6*	*44.7*	67	21.95	*17.0*	*27.9*	-26.4
2007	57	37.99	*28.8*	*49.2*	72	46.34	*36.3*	*58.4*	129	42.24	*35.3*	*50.2*	41.6

Source: Health Protection Agency

Table 8: Rate of Genital Herpes Infection by Age and Sex, 2005-07 combined

Genital Herpes	Males				Females				Total			
	Number	Rate/ 100,000	*95% CI*		Number	Rate/ 100,000	*95% CI*		Number	Rate/ 100,000	*95% CI*	
Under 20	11	9.5	*4.8*	*17.0*	54	50.2	*37.7*	*65.5*	65	34.7	*26.8*	*44.3*
20-24	25	96.7	*62.6*	*142.7*	45	176.6	*128.8*	*236.2*	70	162.5	*126.7*	*205.2*
25-34	37	70.8	*49.9*	*97.6*	47	86.2	*63.4*	*114.6*	84	95.4	*76.1*	*118.1*
35+	46	17.9	*13.1*	*23.9*	36	13.0	*9.1*	*17.9*	82	18.5	*14.7*	*23.0*
Total	119	26.4	*21.9*	*31.6*	182	39.1	*33.6*	*45.2*	301	39.6	*35.2*	*44.3*

Source: Health Protection Agency

Table 9: Rate of Syphilis Infection by Year

Syphilis	Males				Females				Total				% change in rate since 2001
	Number	Rate/ 100,000	*95% CI*		Number	Rate/ 100,000	*95% CI*		Number	Rate/ 100,000	*95% CI*		
2001	*	1.34	*0.2*	*4.8*	0	0.00	*0.0*	*2.4*	*	0.66	*0.1*	*2.4*	
2002	*	0.67	*0.0*	*3.7*	0	0.00	*0.0*	*2.4*	*	0.33	*0.0*	*1.8*	-50.1
2003	*	1.34	*0.2*	*4.8*	0	0.00	*0.0*	*2.4*	*	0.66	*0.1*	*2.4*	0.1
2004	12	8.01	*4.1*	*14.0*	7	4.51	*1.8*	*9.3*	19	6.24	*3.8*	*9.8*	851.8
2005	34	22.62	*15.7*	*31.7*	14	9.01	*4.9*	*15.2*	48	15.71	*11.6*	*20.9*	2295.5
2006	26	17.31	*11.3*	*25.4*	10	6.45	*3.1*	*11.9*	36	11.79	*8.3*	*16.3*	1698.8
2007	16	10.66	*6.1*	*17.3*	10	6.44	*3.1*	*11.8*	26	8.51	*5.6*	*12.5*	1198.4

Source: Health Protection Agency

Table 10: Rate of Syphilis Infection by Age and Sex 2005-07 combined

Syphilis	Males				Females				Total			
	Number	Rate/ 100,000	*95% CI*		Number	Rate/ 100,000	*95% CI*		Number	Rate/ 100,000	*95% CI*	
Under 20	*	2.6	*0.5*	*7.6*	*	1.9	*0.2*	*6.7*	*	2.7	*0.9*	*6.2*
20-24	*	34.8	*15.9*	*66.1*	*	47.1	*24.3*	*82.2*	*	48.7	*30.2*	*74.5*
25-34	33	63.2	*43.5*	*88.7*	11	20.2	*10.1*	*36.1*	44	50.0	*36.3*	*67.1*
35+	31	12.1	*8.2*	*17.1*	9	3.2	*1.5*	*6.1*	40	9.0	*6.5*	*12.3*
Total	76	16.9	*13.3*	*21.1*	34	7.3	*5.1*	*10.2*	110	14.5	*11.9*	*17.4*

Source: Health Protection Agency

Appendix 3: LARCS Baseline Analysis – Dudley PCT

As part of the implementation of the NICE LARCs guidance we needed to establish a baseline of current contraceptive use in Dudley. This report outlines the methods used.

Primary Care baseline

The LARCs primary care analysis is based on prescribing data, which has some limitations. It doesn't allow individuals to be identified, so it is not possible to identify the number of women using contraception. Comparison between forms of contraception is difficult as the number of prescriptions issued will vary according to contraceptive type. For instance, a woman using contraceptive injections will typically have 4 injections in a year, while a woman using IUD may only need it replacing once every 5 years.

I have therefore developed a standard indicator of "women-years" which allows comparison between types of contraception and provides a proxy for the number of women using contraception. Its use as a proxy has limitations – various assumptions have been made about how long a woman will use various forms of contraception, and that one year of contraception is equivalent to one woman.

Data on the number of prescriptions for the combined oral contraceptive (COC), implants, injections, IUD and IUS was downloaded from the ePACT prescribing database.

From this, I derived the number of "women-years" as follows:

- Combined oral contraceptive

  I used the quantity of tablets issued per prescription to calculate the number of months, and hence years, worth of contraceptive issued.

- Injections

  Injections are typically given once every 3 months. I have therefore assumed that 4 prescriptions is equivalent to one year of contraception.

- Implants/ IUD / IUS

  I used the average number of years duration for each, as given in the NICE National cost-impact Report on implementing the LARCs guidance. (This is based on discontinuation rates).

The averages used are:

- Implant: 2.24 years
- IUD: 3.36 years
- IUS: 3.32 years

I combined the numbers for injections, implants, IUS and IUD to give a proxy figure for the number of women using LARCs in each GP practice.

The number of women aged 15-49 in each practice was used as a denominator to calculate the percentage of women using LARCs.

The Office for National Statistics Omnibus survey contains a set of questions for Contraception and Sexual Health. The survey results for 2006-07 show that 56% of female respondents aged 16-49 were using a non-surgical form of contraception. The remaining 44% were either not using contraception because they or a partner were sterilised or they were not using a method.

The maximum proportion of women who would possibly wish to use LARCs is therefore 56%.

I have therefore calculated a second figure, which shows the proportion of these women who are currently using LARCs.

Community baseline

The community analysis was carried out on individual-level data from the Contraceptive and Sexual Health Service (CASH) and Dudley Brook. Both databases allow information to be broken down into age band.

For the CASH service I have looked at all methods of contraception used by an individual woman over the course of a year, and a woman is counted once for each method that she uses. There will therefore be some double-counting of individuals. This is unavoidable, as there is no method of identifying the main method of contraception.

For the Brook service it was not possible to identify individuals. I have therefore produced 2 separate sets of figures. The first looks at first contacts in the year only. This ensures that each woman is counted only once, but may not pick up the main method of contraception – if a woman changes from the oral pill to IUD during the year for instance then this will not be picked up. The second set of figures looks at all contacts during the year – this will count some women more than once, but ensures that all methods of contraception are counted.

The true number of women receiving contraception from Brook will lie somewhere between the 2 sets of figures.

Contraceptive and Sexual Health Service

Table 1: Contraceptive use through CASH by age and contraceptive type 2006-07

All women 2006-07

Age band	Hormonal contraception		Long-acting reversible contraception				total no. using LARCS	Total women using any con-traception
	Combined oral contraceptive	Progestogen-only pill	Injection	IUS	Implant	IUD		
Under 20	660	117	129	*	8	13	145	1114
20-24	422	141	178	*	17	38	219	850
25-29	265	107	128	13	12	59	201	663
30-34	113	59	80	15	10	50	145	439
35-39	81	74	58	25	*	35	116	390
40-44	24	65	43	14	*	20	76	268
45 and over	13	40	38	17	*	15	66	261
Total	**1531**	**582**	**627**	**93**	**55**	**237**	**940**	**3857**

Note: a woman will be counted once for each method of contraception that she uses during the year.
Individual age bands do not add up to the total - where a woman changed age band during the year, she will be counted twice

Source: Dudley Contraceptive and Sexual Health Service

Table 2: Prescriptions for Contraception by Contraceptive type and Locality of GP Surgery, 2006-07

2006-07	LOCALITY					Dudley Borough TOTAL
	Brierley Hill	Dudley and Netherton	Halesowen	Sedgley	Stourbridge	
Number of prescriptions						
Combined oral contraceptive	9280	5409	5509	5806	7749	33754
Progestogen-only pill	1773	1278	1101	946	1990	7088
Implant	44	61	*	10	14	130
Injection	2082	1663	937	1192	1457	7337
IUD	80	57	*	20	71	270
IUS	71	34	67	42	126	340
All LARCs	**2277**	**1815**	**1047**	**1264**	**1668**	**8071**
EHC	47	17	37	14	107	222
Women-years						
Combined oral contraceptive	*3779*	*2201*	*2063*	*2193*	*3240*	*13476*
Progestogen-only pill	*639*	*452*	*386*	*318*	*726*	*2521*
Implant	*99*	*137*	*	*22*	*31*	*291*
Injection	*483*	*392*	*218*	*274*	*337*	*1705*
IUD	*284*	*198*	*	*70*	*242*	*947*
IUS	*236*	*113*	*222*	*139*	*418*	*1129*
All LARCs	*1101*	*839*	*595*	*507*	*1028*	*4071*
% women 15-49 using LARCS (based on practice populations)	**6.4**	**6.0**	**6.1**	**5.5**	**6.7**	**6.2**
% women 15-49 using Combined Oral Contraceptive (based on practice populations)	**21.8**	**15.6**	**21.0**	**23.7**	**21.0**	**20.4**

Note: Locality is based on the locality of the GP surgery where the prescription was issued, not on residence.
Source: Prescription Pricing Authority

Dudley Pharmacy Emergency Hormonal Contraception Scheme

Table 3: Women accessing Pharmacy EHC scheme in 2007 by Age and Pharmacy

Age band	PHARMACY					
	Dudley TOTAL	Boots, Dudley Market Place	Boots, Merry Hill	Millard & Bullock, Coseley	Murrays, Halesowen	Stourbridge Pharmacy
Under 15	**22**	*	10	*	*	*
15-19	**640**	93	426	32	24	51
20-24	**431**	63	326	29	*	6
25-29	**233**	39	158	19	7	6
30+	**324**	51	216	15	15	10
ALL AGES	**1650**	250	1136	99	44	81

Source: Dudley PCT

Dudley Condom Distribution Scheme

Table 4: Condoms Issued through the Condom Distribution Scheme by Age band and Organisation 2007

Age band	Organisation						
	Dudley College	The Warehouse	The What Centre	The Zone	Youth Centres	Youth Offending Team	DUDLEY TOTAL
0-15	**0**	0	1222	62	277	96	1657
15-19	**616**	144	14850	1132	537	588	17867
20-24	**56**	288	738	0	0	0	1082
25+	**32**	132	120	0	0	0	284
Missing/ invalid	**0**	144	180	144	0	60	528
TOTAL	**704**	**708**	**17110**	**1338**	**814**	**744**	**21418**

Source: Dudley PCT

Dudley NHS
Primary Care Trust

Mapping Sexual Health Service provision in Primary Care

Practice name: ---------- PBC Cluster name----------

Practice postcode:----------

Section One: Training

Q1. How many doctors in your practice have the Diploma of the Faculty of Sexual and Reproductive Health Care?

Q2. How many nurses in your practice have a Family Planning Certificate?

Q3. How many doctors in your practice have Letters of Competencies For?

Intrauterine devices

Sub-dermal implants

Instructors doctors certificates

Q4. How many doctors/ nurses in your practice have attended the Sexually Transmitted Infections Foundation (STIF) Course in the past 2 years?

Doctors Nurses

Q5. How many doctors/nurses in your practice are willing to attend the STIF Course?

Doctors Nurses

Q6. How many Doctors in your practice are willing to obtain the Diploma of the Faculty of Sexual and Reproductive Health Care?

Q7. How many nurses in your practice need further training in contraception?

Section Two: Contraception

Q8. What contraceptive services does your practice provide? Please tick all

☐ Pills ☐ Injectable IUCD ☐ Mirena ☐

☐ Implant ☐ Male condom Natural contraception ☐

☐ On site pregnancy testing

☐ Copper IUCD for emergency contraception

☐ Referral for female sterilisation /vasectomy

Q9. Does your practice provide emergency hormonal contraception?

Yes ☐ No ☐

Q10. What provision is made for patients, if your practice is unable to provide a full range of contraception? Please tick all that apply

Referral to CASH ☐ Referral to Brook ☐ Referral to other practice ☐

Referral to A&E ☐ Referral to GUM ☐

Others ☐ please specify ☐

Q11. Is your practice willing to participate in the National Chlamydia Screening Programme?

Yes ☐

No ☐

Section Three: Genitourinary Medicine (GUM)

Q12. Does your practice offer testing for the following Sexually Transmitted Infections for both men and women: please tick all that apply?

Chlamydia Men ☐ Women ☐

HIV Men ☐ Women ☐

Gonorrhoea Men ☐ Women ☐

Syphilis Men ☐ Women ☐

Q13. If you answered yes to any of the above, does your practice offer the following: (please tick all that apply):

Pre-test counselling Men ☐ Women ☐

Treatment Men ☐ Women ☐

Contact Tracing Men ☐ Women ☐

Q14. What provision is made for patients if your practice is unable to provide a full range of STIs services?

Referral to GUM at Russels Hall Hospital ☐

Referral to other GUM Clinics ☐ please specify ☐

Referral to Others services ☐ please specify ☐

Q15. How would you like specialist GUM services delivered in the future, in Dudley PCT?

Extended opening hours ☐ Rapid referral ☐

Community based services ☐ Self referrals ☐

Joint GUM and Contraception services ☐

Others ☐ please specify ☐

Section 4: Future Developments

16. if funded appropriately and staff were appropriately trained, who would you be willing to see / provide sexual health services for, and for what?

Please tick all that apply

	Own Practice patients	Patients from other Practices	Women only	Men only	Both women and men
Oral Contraceptive Pills					
Diaphragm fitting / supply					
Condom supply					
Emergency Contraception					
IUCDs / Mirena					
Contraceptive implants					
Counselling for Female Sterilisation					
vasectomy counselling / referral					
Vasectomy					
Dedicated Young People's clinics					
TOP counselling / referral					
Chlamydia testing					
Chlamydia contact tracing					
Other STI testing and treating					
Partner notification and contact tracing					
HIV counselling and testing					
Specialised HIV treatment and care					
Invasive STIs testing for men (until non-invasive testing is available)					

Please use this space for any comments or suggestion

Thanks you very much for your help.
Once you have completed the questionnaire, please send it back to ---------

Director of Public Health Annual Report 2008

ISBN No. 978-0-9556225-3-3

Dudley PCT
St John's House
Union Street
Dudley
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Printed on environmentally friendly paper

From trees from sustainable forests