

# Derby City and Derbyshire County Sexual Health Needs Assessment 2013

This assessment includes information from a range of sources, including some that are unavailable to the public. In order to protect sensitive information, this document summarises the key findings. The full analysis is available to inform and support commissioning and service development.

## Introduction

In 2002 the World Health Organisation defined sexual health as:<sup>1</sup>

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

Sexual health is an important part of both physical and mental health and is essential to general well-being. Good sexual health is aided by access to information and services that help avoid the risks of unintended pregnancy, sexually transmitted infections (STIs) and of harmful relationships. The consequences of poor sexual health can be serious and costly for the individual, for health and social services and for society as a whole. Developing services to prevent sexual ill health therefore makes good economic sense. Unintended pregnancy and STIs have preventable short term and long term effects on health and well-being, which can include:

- Pelvic inflammatory disease (PID), pregnancy outside of the womb (ectopic pregnancy) and difficulty getting pregnant (infertility);
- Cervical and other genital cancers;
- Inflammation of the liver (hepatitis), chronic liver disease and liver cancer;
- Chronic infection, such as human immunodeficiency virus (HIV), or recurrent infection, such as genital herpes;
- Distress over unintended pregnancy;
- Psychological consequences of sexual coercion and abuse;
- Limited educational, social and economic opportunities now and in the future for teenage parents and their children.

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<sup>1</sup> WHO (2006). Defining sexual health. Report of a technical consultation on sexual health, 28-31 January 2002. World Health Organisation: Geneva.  
[http://www.who.int/reproductivehealth/publications/sexual\\_health/defining\\_sexual\\_health.pdf](http://www.who.int/reproductivehealth/publications/sexual_health/defining_sexual_health.pdf)

We know that certain groups in society are at greater risk of poor sexual health and these include men who have sex with men (MSM), teenagers and young adults (especially those in care), certain minority ethnic groups (especially those of Black African origin), injecting drug users, sex workers and those within the criminal justice system.<sup>2</sup> It is a public health duty to reduce inequalities in sexual health.

At a national level, the strategic direction for improving sexual health and reducing sexual health inequalities is set out in the Department of Health's sexual health framework (2013).<sup>3</sup> This document emphasises that local authorities must provide comprehensive and open access STI testing and treatment services and contraception advice and services. This needs assessment is helping us develop a local sexual health strategy to align the national vision with priorities in the City and County, taking account of the resources available locally.

The new sexual health priorities recognise recent changes in the way services are commissioned (broadly, the process of identifying needs, allocating funding, buying and monitoring services). Responsibility for commissioning various aspects of sexual health is now shared between local authorities, clinical commissioning groups (CCGs) and NHS England. These key players have joint responsibility to provide sexual health services that are effective (based on good evidence of benefit) and efficient (providing value-for-money), which will often require working together. Such partnership working also extends to others with a stake in improving sexual health, including Public Health England (PHE) and Health and Well-being Boards, as well as service providers and current or potential service users.

In this report Public Health Outcomes Framework (PHOF) and Sexual Health Balanced Scorecard (SHBS) indicators have been used where relevant to compare local performance against the national norm; these will be used to monitor the new commissioning arrangements. A summary table of our position is provided at the end of this report.

## **Aim and objectives**

Our aim was to assess the sexual health needs of the population in the City and County, identify how well current services meet those needs, and to make recommendations to commissioners for improving services and reducing sexual health inequalities, within available resources. This involved:

- Collating the best available evidence on sexual health needs among the City and County populations;

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<sup>2</sup> NICE (2007). One to one interventions to reduce the transmission of sexually transmitted infections (STIs) including HIV, and to reduce the rate of under 18 conceptions, especially among vulnerable and at risk groups (PHI003). National Institute for Health and Care Excellence: London. <http://www.nice.org.uk/nicemedia/pdf/PHI003guidance.pdf>

<sup>3</sup> DH (2013). A framework for sexual health improvement in England (Gateway ref.18420). Department of Health; London. <http://www.dh.gov.uk/health/2013/03/sex-health-framework/>

- Describing current sexual health services in the City and County;
- Interpreting information about patterns of sexual ill health and use of local services, to identify where changes could have the biggest impact;
- Writing a report based on local evidence that describes how well services in the City and County meet the sexual health needs of our population, and where further development is required.

## Needs assessment methods

We built up a picture of sexual health in the City and County by combining a number of recognised approaches to assessing needs. Statistics provide information about how common sexual ill health is locally and, importantly, whether people in different parts of the City and County had the same chances of having good sexual health. This involved looking at how we are doing compared to the country as a whole (or to similar parts of the UK); here statistics can tell us not only about levels of illness, but also about how well the services we provide are performing to meet sexual health needs. We did a 'stocktake' of the assets we have to meet those needs (including everything that organisations from the health, voluntary and private sectors provide, such as buildings, staff, training, etc.). Finally, those who provide sexual health services or who use (or might use) those services were asked about their experiences and where they see opportunities to change things for the better.

Through combining these approaches we can get a clearer perspective on how well current services are meeting local needs. Having reviewed the numbers, listened to what people tell us, and taken account of new policy developments and best practice guidelines, we can identify what should drive changes (if any are indicated) to the way we commission services in future. This enables us to make recommendations to commissioners that are informed by the best available evidence.

## Sexually transmitted infections

STIs are passed from one person to another through unprotected sexual intercourse, other genital contact or via the exchange of bodily fluids (including blood). There is a wide range of STIs, which include chlamydia (there is a national screening programme for people aged under 25 years), gonorrhoea, HIV and syphilis. Certain groups within the general population are at higher risk of acquiring an STI.

### Key findings for Derby City

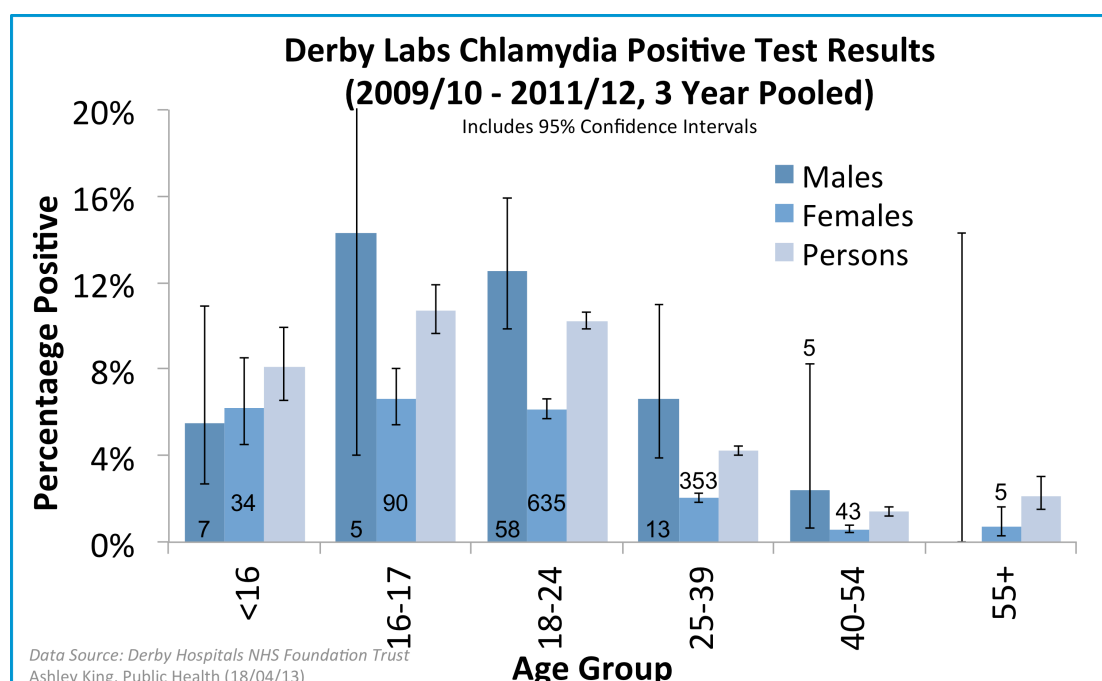
- Derby City has high rates of diagnosis for all STIs, with a high proportion of reinfection in females.
- Syphilis in MSM and gonorrhoea appear to be particular issues for the City.
- Derby City is significantly lower than the England average for the proportion of the target population tested for chlamydia outside of genitourinary medicine (GUM) clinics, although above the England average for diagnosis rate in all settings (29.5% of the target population tested; 8.1% of tests were positive during 2011–12).

- The prevalence of HIV in Derby City is 1.7 per 1,000 people; this is approaching the threshold of 2 per 1,000 people at which routine HIV testing is recommended.

### Key findings for Derbyshire County

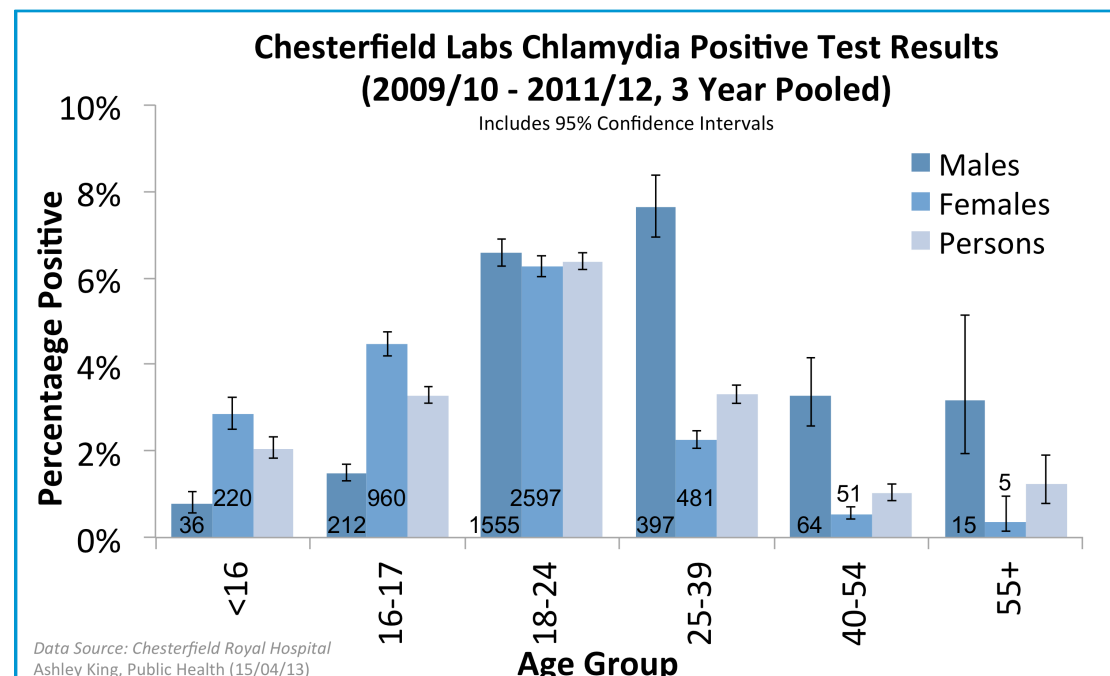
- All districts and boroughs across Derbyshire have lower rates of STIs than the national average.
- The proportion of the target population tested for chlamydia in the County is well above the England average (39.6%), yet the diagnosis rates in all settings are lower (5.8% of tests were positive during 2011–12).
- This may imply that chlamydia testing in the County is not well focussed on young people at the greatest risk of infection.
- The need for correctly targeted testing, effective partner notification (which offers testing and treatment to sexual partners of those diagnosed with an STI) and education to reduce reinfection is underlined by high local rates of admission for PID; this also applies to the City.

In the chart below, the proportion of positive chlamydia test results handled by the Derby laboratory is based on 37,329 tests in females and 907 in males (in whom a positive or negative result was reported and age and sex was known). Age and sex was not recorded in many more cases, and the overall proportion of positive chlamydia tests for all persons of all ages was 6.2%:



The number of positive tests is shown for males and females, rounded to a minimum count of 5; these figures relate to all lab activity and thus may include tests for non-residents (the same applies to Chesterfield figures, below). Note that the greater number of tests done in the 16–24 year brackets relates to targeted testing of this age group as part of the National Chlamydia Screening Programme.

In the chart below, the proportion of positive chlamydia test results handled by the Chesterfield (County) laboratory is based on 102,343 tests in females and 50,019 in males (in whom a positive or negative result was reported and age and sex was known). Age and sex was not recorded in many more cases, and the overall proportion of positive chlamydia tests for all persons of all ages was 4.3%:



Uptake of HIV testing in GUM settings within the City and County is favourable compared to the national average, but this is no justification for complacency. Increased testing outside of GUM settings could help improve rates of early diagnosis and thus lead to better outcomes for people living with HIV and their partners. PHE suggest that local authorities and NHS bodies with an HIV prevalence of more than 2 per 1,000 population aged 15–59 years could routinely undertake HIV testing for all general medical admissions as well as for people registering with GPs. Derby City is approaching this threshold (at 1.7 per 1,000 population) therefore action is needed now to improve early HIV detection and to prevent onward transmission.

Walk-in capacity within GUM in both City and County is limited, especially out of hours and at weekends where there is no service. Accessing specialist GUM services in the County may require significant travel. Both these limitations could conflict with the new sexual health framework vision of highly accessible services, although the development of community-based sexual health clinics has increased access to STI testing and treatment.

Figures from Chesterfield GUM show high rates of STIs among young people and also among 40–49 year olds (particularly for males) indicating that health messages need to address risk taking in this latter age group; these may need to be delivered differently from sexual health promotion to the younger population.

Despite a much greater number of chlamydia tests and wider population coverage in the County, the rate of diagnosis is lower. This may indicate a lower prevalence of chlamydia in the County, which underlines the importance of targeting testing to those at higher risk of disease: untargeted testing will not necessarily increase the rate of detection.

## Contraception

In the UK almost everyone uses contraception at some point in his or her life; there are a variety of different methods available, all of which are extremely safe compared with the risks associated with pregnancy and childbirth. Unplanned pregnancy may result from failure to use any contraceptive method at all, or the inconsistent or incorrect use of a method.

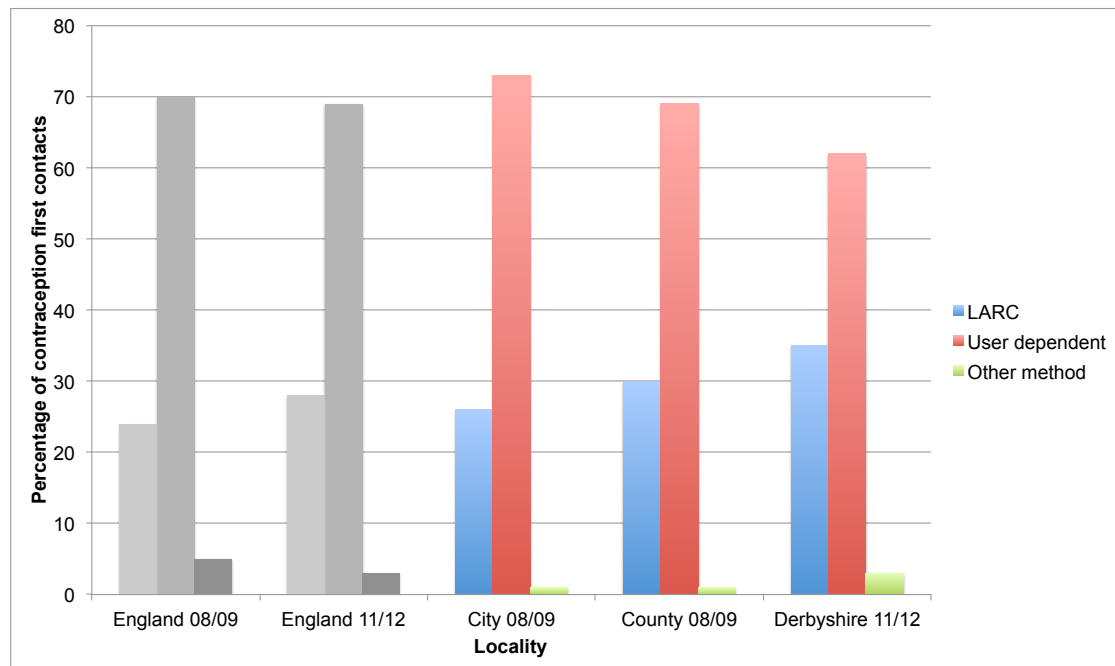
### Key findings for Derby City

- GP practices prescribe long-acting reversible contraception (LARC) at a rate (69.5) that is significantly better than the England average (52.4 per 1,000 females aged 15–44 years, during 2011–12).
- Community pharmacy consultations for oral emergency contraception (OEC), intended mainly to prevent unplanned teenage conceptions, occurred only 11% of the time with clients under 18 years (during 2011–12).
- The specialist contraception and sexual health (C&SH) service provides a higher proportion of LARC than the national average, including among those aged under 18 years.

### Key findings for Derbyshire County

- GP practices prescribe LARC at a rate (79.0) that is significantly better than the England average (52.4 per 1,000 females aged 15–44 years, during 2011–12).
- Community pharmacy consultations for OEC, intended mainly to prevent unplanned teenage conceptions, occurred only 18% of the time with clients under 18 years (during 2011–12).
- As in Derby, the rate of LARC provision by C&SH services is higher than the national average.

Sexual and Reproductive Health Activity Dataset (SRHAD) figures show that community clinics use LARC in line with the national trend and that the uptake of LARC in the Derbyshire-wide C&SH service is higher than nationally:



Locally we use more LARC in primary care and in the community than is average for England, which may reflect good practice in offering choice to women of all age groups. Despite the increased cost of LARC, this is both clinically effective and cost-effective and is in keeping with National Institute for Health and Care Excellence (NICE) guidelines and the national trend. NICE guidance suggests that an 8% shift from oral contraception to LARC would result in savings to the NHS of £102 million.

Local clinics might lack visibility and the joining up of services could be better; commissioners should seek to work with C&SH providers improve information and signposting. It may be appropriate to develop non-traditional tools to help people find and make use of sexual health services (e.g. smartphone apps and social media). The sexual health framework (2013) stresses the need for highly visible, accessible contraception services.

Relatively little emergency contraception is now supplied via C&SH services, with the majority of OEC being provided by community pharmacies. Access to OEC is a key opportunity to initiate on-going contraception, which is not currently available through community pharmacists. A clear pathway should be developed to ensure women accessing OEC are supported to consider and address their on-going contraception needs.

## Termination of pregnancy

Termination of pregnancy (TOP) or abortion is the term used to describe the use of a medical intervention to end a pregnancy before it has run its natural course. Although not all unintended pregnancies are unwanted, in the UK each year about one in five pregnancies end in an abortion. In teenagers approximately half of all conceptions end in an abortion.

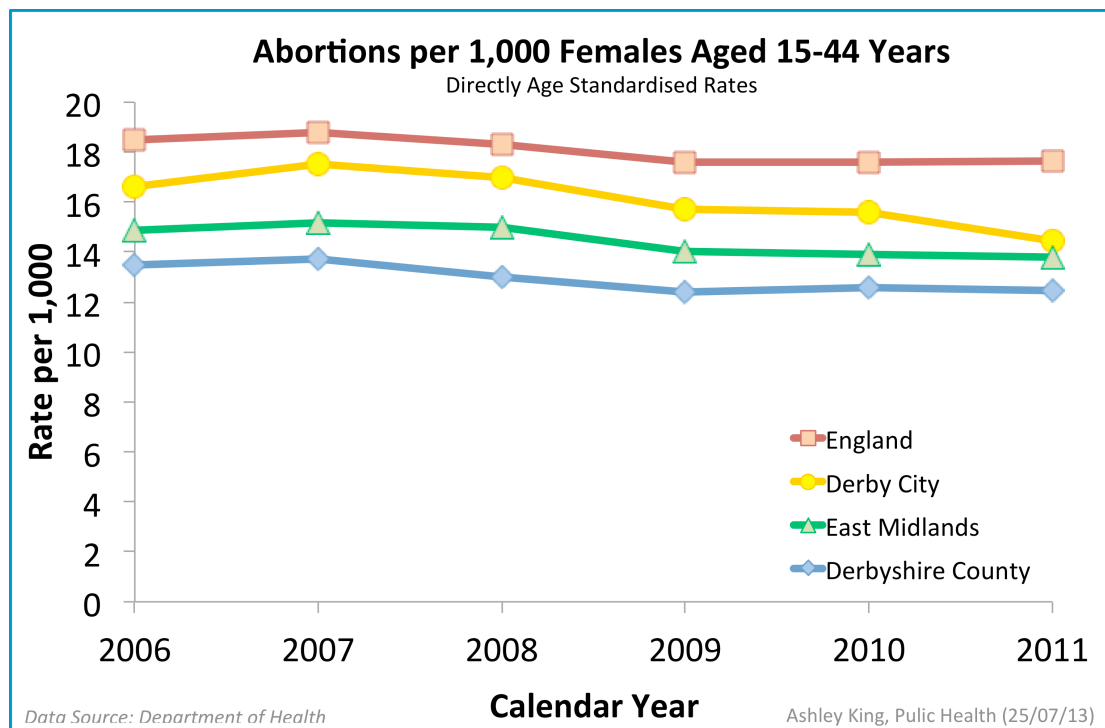
### Key findings for Derby City

- The abortion rate for the City is higher (14.9 per 1,000) than the regional rate (13.5 per 1,000), but significantly lower than the national rate (16.9 abortions per 1,000 women aged 15–44 years, 2011).
- For all NHS-funded abortions in the City the proportion undertaken at <10 weeks in 2011 was 68.5%; this is significantly worse than the England average proportion of 77.9%, falling short of the target of a 70% proportion.
- The proportion of repeat abortions in the City matches that of England.

### Key findings for Derbyshire County

- The abortion rate for the County is lower (11.1 per 1,000) than both the national rate (16.9 abortions per 1,000 women aged 15–44 years, 2011) and the regional rate (13.5 per 1,000).
- For all NHS-funded abortions in the County the proportion undertaken at <10 weeks in 2011 was 70.6%; this is significantly worse than the England average proportion of 77.9%, but just achieves the target of a 70% proportion.
- The proportion of repeat abortions in the County is significantly lower than the England proportion.

Department of Health figures indicate a slight downward trend in national rates of abortion per 1,000 females aged 15–44 years. The time trend in general fertility rate (GFR; live births per 1,000 females aged 15–45 years) similarly shows a regional and national decline. Although the County appears to follow national trends in both GFR and abortion rate, the City is experiencing a rise in fertility at the same time as a reduction in abortion:





Locally the main issue identified in this needs assessment is the relatively low proportion of NHS-funded abortions carried out below 10 weeks gestation. This may be due to delay between the diagnosis of pregnancy and arrival in TOP services, meaning comparatively more pregnancies are terminated in the 10–12 week range. Such delay may limit choice of termination method and increase the cost of care. Better access to community-based early medical and surgical termination would increase the proportion of abortions undertaken before 10 weeks.

Differences in service configuration suggest poorer access to TOP for Derby residents after 13 weeks of pregnancy, who are asked to travel to Chesterfield (or further afield if beyond 17 weeks and 5 days at the time of the procedure).

## **Sexual health promotion**

Sexual health promotion seeks to enhance sexual and emotional well-being and to reduce the risk of HIV, STIs and unintended pregnancies through providing information and education to service providers, individuals and communities. Evidence suggests that approaches encouraging abstinence or simply telling people not to engage in risky behaviours are ineffective.

### **Key findings for Derby City**

- A high proportion of the population in the City (27.6%) are living in the most deprived areas, compared to the national average of 19.8%. Deprivation is generally associated with poorer access to health care.

### **Key findings for Derbyshire County**

- A high proportion of the population in the Bolsover (27.3%) and Chesterfield (25.2%) districts are living in the most deprived areas, compared to the national average of 19.8%; other County districts and boroughs are significantly less deprived, indicating marked local inequalities.

The new sexual health framework emphasises the importance of prevention, but does not outline evidence-based actions for local commissioners to adopt. For example, there is low educational attainment in Bolsover and, along with Derby City and Chesterfield, a significant proportion of the population are in the most deprived segment of the UK population. These observations indicate the need to address inequalities in the wider determinants of health at population level—and not merely targeting health promotion ‘downstream’ at individuals.

The prevention agenda for children and young people must include universal and targeted focus on risky behaviours. Taking risks is fairly common in adolescence. Yet risky behaviours can be associated with serious, long-term and—in some cases—life-threatening consequences. To date prevention efforts have tended to focus on a single risky behaviour. A more powerful and cost-effective approach may be to employ strategies designed to address factors associated with multiple risky

behaviours. Alcohol and drug use has been found to heighten the likelihood of engaging in risky sexual behaviour, anti-social behaviour, youth offending, and self-harm, as well as to increase the risk of injury and death resulting from motor vehicle crashes. The integration of public health teams within local authorities should provide the opportunity to develop a strategic organisational approach.

The global recommendations in the new sexual health framework (2013) recognise the important role of sexual health promotion in reducing prejudice relating to sexual orientation and stigma and discrimination in all its forms. Effort needs to be expended on improving self-efficacy (belief in one's own abilities) and empowering people to make healthy choices in their relationships—again a clear national steer is required to facilitate the required cultural change locally.

Further work on effective ways to measure sexual health promotion interventions is required, as activity data does not necessarily reflect the impact of interventions on individuals and targeted groups. Without key performance indicators or other outcome measures for services commissioned from voluntary sector partners, it is difficult to judge how well such services are doing against their stated objectives. Engagement with all organisations that support the sexual health agenda is vital to improving sexual health outcomes.

## **Sexual health needs of vulnerable groups**

### **People living with HIV (PLHIV)**

- Local services appear to be meeting relevant targets and providing services that are generally well received.
- Although numbers of PLHIV are relatively small—particularly in the County—the impact or potential impact of each new diagnosis on individuals and services available to support them should not be underestimated.
- Trend data show increasing numbers of PLHIV and there are no current indications that the rise will abate.
- Local treatment services can anticipate the need to expand capacity in response to increasing demand; preventing the spread of infection ('onward transmission') must remain a priority.

### **Young people**

- The new sexual health framework (2013) recognises that for effective prevention work, young people need a comprehensive programme of sex and relationships education, and access to young people-centred contraceptive and sexual health services.
- Rates of chlamydia diagnosis in young people are above the PHE-recommended level of 2,400 per 100,000 in Derby City, Chesterfield, North East Derbyshire and South Derbyshire.

- The proportion of reinfections with STIs varies between localities and by gender; the reasons for this are unclear.
- Despite signs of improvement, the City continues to have significantly higher rates of teenage conception; this needs to be addressed.

### **Vulnerable young people**

- We did not identify any routine sources of information on vulnerable young people; integration of public health into local authorities may represent an opportunity to tap sources not traditionally available to NHS providers.

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

- Inclusive, tailored services can support behaviour change in MSM, who remain at increased risk of poor sexual health (especially HIV, syphilis and gonorrhoea).

### **Sex workers**

- More robust local information on sex workers and the prevalence of ill health in this group is needed.
- There is uncertainty as to the effectiveness and cost-effectiveness of specific health improvement interventions that might be targeted at sex workers.
- Although no commissioning arrangements are in place currently, there is a fast track referral pathway to C&SH and there may be further opportunities to prevent both primary infection and onward transmission of STIs and HIV.

### **People with drug and alcohol problems**

- The new sexual health framework clearly states that sexual health services can identify service users with potential alcohol problems and that basic advice can lower the risk of harm for most users; referral pathways need to be in place for those needing specialist support.
- Local areas should work in partnership to develop integrated pathways that maximise opportunities to intervene early and avoid longer-term problems.

## **Other areas of need**

### **Sterilisation**

- There is a national trend indicating a reduction in sterilisation operations, but the local picture is unclear as some sterilisation data were unavailable.

## **Psychosexual services**

- There is wide variation in available psychosexual interventions and the overall strength of evidence for their effectiveness and/or cost-effectiveness is weak.
- The level of need in the City and County is currently unknown.

## **Sexual violence**

- Derby City was worse than the England average for recorded rape in females, whereas County districts were similar to or better than the England average (2011–12).
- The figures do not provide a comprehensive picture, as they do not reflect crimes that may be unreported (up to 40%).

## **Related sexual health provision**

- Some services commissioned outside of sexual health have an important component related to sexual health and well-being; these include pre-menstrual syndrome (PMS) and menopause services, vaccination to protect against human papilloma virus, gynaecology, maternity services, cancer services, services for people with disabilities, accident and emergency services, school nursing services and children's services.

## **Training and workforce issues**

- Appropriately trained staff are essential to ensure effective and efficient sexual health services that result in a positive patient experience.

## **The bigger picture**

Best practice in sexual health commissioning requires that prevention is given priority; there is clear leadership and joined-up working; monitoring outcomes rather than processes; the wider determinants of sexual health are addressed; that services are of a high quality and that the needs of vulnerable groups are met.

Commissioning for the future entails meeting challenges posed by projected changes in the make-up of the City and County populations; strengthening insights into the best ways to facilitate healthy behaviours; being responsive to changing patterns of disease and disability; active development of the sexual health workforce; being mindful of public attitudes and expectations; a shared commitment to reducing inequalities in and improving the wider determinants of health; making effective use of medical advances and information technologies; ensuring our services are sustainable, and making wise choices in response to economic pressures.

## **Commissioning recommendations**

### **Core recommendations**

- Work with providers to increase the visibility and accessibility of services.
- Enable choice by offering different service configurations in each locality.
- Support a culture of collaboration rather than competition between service providers (e.g. via signposting, joint protocols, shared training, etc.).
- Ensure that neither multiparty provision nor commissioning results in fragmentation of services.
- Ensure commissioning decisions are evidenced-based and consistent with Public Health England recommendations.
- Ensure commissioned services are monitored against meaningful outcomes (i.e. services are effective).
- Ensure commissioned services deliver value for money (i.e. services are cost-effective).

### **Sexually transmitted infection**

- Address high rates of STI diagnoses in Derby through innovative approaches to sexual health promotion and improving access to testing, treatment and partner notification.
- Ensure that testing for chlamydia is better targeted to those at higher risk of infection.
- Increase the availability of free condoms to defined high-risk groups to help prevent STIs, reinfections, and to mitigate the longer-term health and social consequences.
- Work with partners to increase uptake of HIV testing in high-risk groups.

### **Contraception**

- Continue to expand the availability of LARC as a clinically- and cost-effective longer-term investment.
- Maintain access to emergency contraception for at-risk groups, and ensure that supply of OEC is linked to consideration of longer-term contraceptive needs.

### **Termination of pregnancy**

- Consider contractual incentives or penalties that result in women receiving their chosen intervention as early as possible and in compliance with Royal College guidelines.
- Address the need in Derby for improved access to medical TOP and explore the option of a local provider for more advanced pregnancies (14+ weeks).
- Ensure TOP providers supply LARC and other contraception as appropriate.

## Sexual health promotion

- Develop better ways to measure the impact of sexual health promotion interventions.
- Work with schools to support them to deliver high quality school-based sex and relationships education.
- Support the development of health and social care staff in all roles to promote sexual health and well-being, challenge risk-taking behaviours and signpost or refer to relevant services.

## Sexual health needs of vulnerable groups

- Ensure services are tailored to meet the needs of vulnerable groups and communities.
- Work in partnership with the public, private and voluntary sectors to identify and support persons at risk.
- Work with NHS England to ensure sexual health commissioning plans do not destabilise HIV treatment and support services.

## The bigger picture

- Follow the Department of Health 'best practice' guidance for local contracting.
- Ensure sexual health commissioning enables development of integrated care pathways.
- Ensure development and maintenance of core competencies in sexual health within the sexual health and wider workforce.
- Commit to sustained investment in training a skilled and enthusiastic workforce that will deliver a quality service, help retain staff and enhance patient experience.
- Ensure commissioning plans mandate services that reflect changing sexual health needs over the life course, whilst maintaining targeted provision for those groups at higher risk.
- Support initiatives to improve access to services in areas of deprivation through strengthening partnerships with diverse community-based providers.
- Seek to integrate services where feasible to benefit from economies of scale, being mindful that apparent 'duplication' may be desirable in reaching different target groups.
- Streamline routine data collected from all providers under contract to include all relevant information required for performance monitoring and needs assessment.
- Work with service providers to improve capture of service user perspectives.
- Work with academic partners to address capacity issues and skill deficits, aiming to independently evaluate the cost-effectiveness of local services and sexual health interventions.
- Consider commissioning a professional quality resource for signposting local sexual health services (locations, opening times, types of service, etc.) to address concerns about visibility, such as a dynamic website and/or

smartphone app; this should provide tailored portals for high risk groups (e.g. MSM, sex workers) and provide a single point of access to current information for service providers wishing to make onward referrals.

- Support a sexual health forum/ network involving all stakeholders to realise the vision of joined-up local services, making best use of available assets and pooling resources such as training.
- Require local providers to demonstrate adherence to a sustainability policy and aid them in appreciating the tangible benefits of doing so.

## Summary of local performance against national indicators

Please refer to the colour-coded 'quilt' table on the following pages, using this key:

Worse than England average	Similar to England average	Better than England average	Not statistically compared	No data at this locality level	This is a PHOF indicator
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## Briefings for non-experts

We recognise that those not working directly in sexual health may be unfamiliar with some of the terms and technical issues, and thus provide a concise background guide for non-experts covering important issues for the four principle topics of this needs assessment. These are available on the Derbyshire County Council website as optional reading.

# Authorship and acknowledgements

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Indicator	Period	England	Derby City PCT/ (UA)	Derbyshire County	Amber Valley	Bolsover	Chesterfield	Derbyshire Dales	Erewash	High Peak	North East Derbyshire	South Derbyshire
Teenage conceptions (source: SHBS; PHOF*)												
% change in rate of under 18 conceptions	1998–2010	-24.0	-32.1	-24.5	-27.2	-1.4	-7.2	-55.2	-18	-17.4	-36.8	-8.0
Age under 18 conceptions (2.04*) crude rate/ 1000	2010	35.4	43.3	31.4	31.8	43.4	37.3	16.8	33.0	38.0	26.8	23.1
Age under 18 conceptions rate/ 1000	2008–10 (3 yrs pooled)	38.1	48.6	32.1								
Age under 16 conceptions rate/ 1000	2010	7.0	8.5	7.4								
Age under 16 conceptions rate/ 1000	2008–10 (3 yrs pooled)	7.4	(10.1)		7.4	6.3	7.5	2.9	6.6	7.3	6.1	6.4
Abortions (source: SHBS)												
Age under 18 abortions rate/ 1000	2011	15.1	15	10.3								
Age under 16 abortions rate/ 1000	2009–11 (3 yrs pooled)	3.8	3.5	3.3								
Total abortions rate/ 1000	2011	17.6	14.4	12.5								
% of all NHS-funded abortions <10 weeks	2011	77.9	68.5	70.6								
Age under 16 abortions <10 weeks (%)	2009–11 (3 yrs pooled)	66.7	53.5	60.5								
Age under 18 conceptions leading to abortion (%)	2010	50.3	(36.2)		42.3	45.8	37.7	suppressed	42.3	54.1	60.9	suppressed
Age under 18 abortions <10 weeks (%)	2011	70.8	62.5	73.4								
Age under 19 repeat abortions (%)	2011	10.9	suppressed	5.8								
Age under 25 repeat abortions (%)	2011	26.4	23.8	21.1								
Contraception (source: SHBS)												
GP prescribed LARC rate/ 1000 females aged 15–44	2011–12	52.4	69.5	79								
Cost of GP prescribed LARC rate/ 1000 females aged 15–44	2011–12	2825.6	3848.9	4221.1								
Sexually transmitted infections and HIV (source: SHBS; PHOF*)												
% GUM clinic clients offered appointment within 2 working days	Jan–Nov 2011	99.8	100	100								
% GUM clinic clients seen within 2 working days	Jan–Nov 2011	88.4	97.6	88.6								
% GUM clinic clients did not attend 1 <sup>st</sup> appointment	Jan–Nov 2011	5.8	2.2	2.4								

% GUM clinic clients seen after 10 working days	Jan–Nov 2011	1.5	0.2	1.0								
Acute STI diagnoses rate/ 100,000 population	2011	792.1	(982.0)		574.1	606.1	673.0	342.4	577.7	409.2	549.3	659.1
Age 15–24 tested for chlamydia outside GUM clinics (%)	2011–12	20.5	(20.1)		27.4	30.0	69.3	31.6	23.6	23.4	37.5	23.3
Age 15–24 test positive for chlamydia outside GUM clinics (%)	2011–12	5.9	(4.7)		4.2	3.6	4.1	4.3	4.5	5.0	5.0	4.5
Age 15–24 chlamydia diagnoses (3.02*) crude rate/ 100,000	2010	2020	(2358)	(2251)								
Age 15–24 chlamydia diagnoses in all settings rate/ 100,000 popn	2011	2124.6	(2527.6)		2096.1	2151.8	3279.4	2057.4	1983.5	1795.9	2819.4	2493.2
Age 15–44 PID-related admissions rate/ 100,000 females	2010–11	247.9	(316.7)		368.2	282.3	292.5	350.9	308.3	369.1	211.7	343.1
Gonorrhoea diagnoses in GUM clinics rate/ 100,000 population	2011	39.1	(74.9)		26.3	25.5	15.8	5.7	16.2	19.4	13.2	24.5
Syphilis diagnoses in GUM clinics rate/ 100,000 population	2011	5.4	(5.7)		3.3	2.7	5.9	2.8	5.4	1.1	2.0	3.2
Uptake of HIV tests in GUM clinics (%)	2011	80.3	(87.9)		85.8	78.6	84.3	84.0	84.5	83.1	81.7	90.3
Late HIV diagnoses: CD4 count <350mm (%)	2008–10 (3 years pooled)	52.3	(55.6)		66.7	14.3	63.6	33.3	55.6	suppressed	suppressed	50.0
People presenting with HIV at a late stage of infection (3.04*) as %	2009–11 (3 yrs pooled)	50	(51.9)	(59.4)								
Prevalence of diagnosed HIV in age 15–59 rate/ 1000 popn	2010	1.9	(1.7)		0.4	0.5	0.8	0.4	0.4	0.5	0.2	0.4
Sexual violence (source: SHBS)												
Police recorded rape in females rate/ 100,000 females	2011–12	52.1	(77.2)		53.1	28.6	54.8	27.8	52.4	45.6	33.7	25.2
Factors relevant to sexual health promotion activity (source: SHBS)												
Age 12–13 uptake HPV vaccine first dose (%)	Sep 2010–Aug 2011	88.9	93.6	89.2								
Age 12–15 say sex & relationship education helpful (%)	2009–10	53	57	53								
Age 10–15 frequent substance misuse (%)	2009–10	9.8	11.7	12.5								
Age 16–18 mothers in EET where known to LA (%)	Dec 2011	30.0	(50.6)	29.1								
GCSE achievement 5 grades A–C incl English & maths (%)	2010–11	58.4	(56.9)		56.5	51.0	57.3	68.4	56.0	56.8	67.1	58.4
Average deprivation score	2010	21.5	24.6	18.5	17.9	27.2	24.3	12.6	19.2	15.8	16.9	13.6
% of population in most deprived quintile	2010	19.8	(27.6)		8.9	27.3	25.2	2.2	15.8	4.4	9.8	1.7