



Rapid Needs Assessment for Solihull Sexual Health Services

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Alan Keen, our Equality and Diversity Officer for data on LGBT population estimates.

Introduction

Solihull is negotiating a jointly commissioned sexual health service with Birmingham local authority. The last comprehensive sexual health needs assessment was in 2007 and this rapid needs assessment is designed as a foundation for a fuller needs assessment in the future and to provide a current overall picture of local data and needs to inform the imminent structuring of the sexual health service.

Solihull Profile

Data sources

The profile data summarised below is sourced from information provided by Solihull Observatory based at Solihull Metropolitan Borough Council. The data (including maps) originates from the Observatory's April 2013 published document *Solihull People and Place* and from the local census information available via the council's online census information pages and *Instant Atlas* mapping tool. Any supporting data used in this section outside of the above mentioned sources is referenced by footnote.

Links:

1. www.solihull.gov.uk/Attachments/Solihull_People_and_Place.pdf
2. http://www.solihull.gov.uk/about/Census_2011.htm
3. <http://www.solihull.gov.uk/IAS/>

Total Growth

The total population of Solihull is 206,700 (Census 2011) with 100,300 males and 106,300 females. The total figure has increased by 3.6% (7,100 persons) since the 2001 Census. This compares with population increases of 7.2% in England and 6.1% in the West Midlands over the same period.

Age

Aging

Solihull has a relatively high proportion of older residents, with 19.1% of over 65s compared to a West Midlands average of 16.9% and an England average of 16.3%. Between 2001 and 2011 the number of over 65s in Solihull increased by 17.2% (from 33,700 to 39,500), compared to an increase of 12.3% in England.

There are a proportionately lower percentage of adults under 50 years in Solihull compared to the England average, suggesting that the at risk population in Solihull for sexual health services forms a slightly lower proportion of its total than in other parts of the country:

Solihull 15-29 year olds: 15.8% total (18.7% for England)

Solihull 30-49 year olds: 26.6% total (28.0% for England)

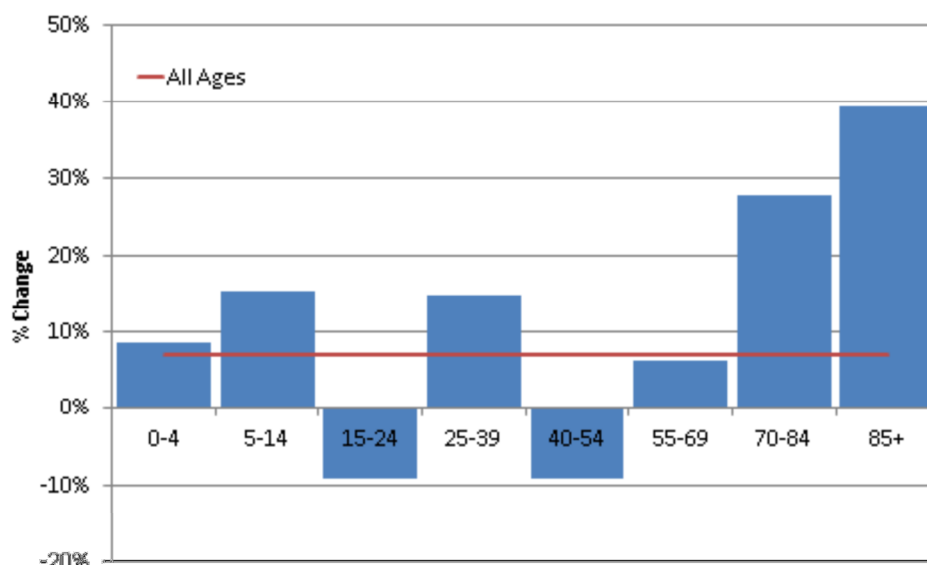
North/South Difference

The age profile of the north Solihull is significantly younger than the rest of Solihull. 29% of residents in north Solihull are aged under 19 years and 20% are aged 20-34 years, compared to 23% and 15% respectively in the rest of Solihull. This has significant implications for public health commissioning, especially in terms of sexual health services.

Future predictions and scope for review of a Sexual Health Needs Assessment

The report *Solihull People and Place*, Published April 2013 by Solihull Observatory suggests that current trends and population profiles may suggest a decrease in the number of 15-24 year olds by 2021 but an increase in the number of 25-39 year olds (see chart below from report). This reflects the dynamic nature of Solihull's population and establishes the need for regular review and restructure of public health services to match the needs of an ever evolving society. While those in age brackets 25 years and over tend not to have the highest rates of STI diagnoses, the trend nationally is that STI rates in those aged 25-49 is increasing (rise of 4% to 46% of all GUM STI diagnoses between 2009 and 2011)¹, possibly as a result of breakdown in marriage and divorce.

Projected Change in Population in Solihull by Age Band 2011-2021



Source: DNS

Figure taken from Solihull People and Place, Apr 2013

¹Department of Health; Feb 2010. Link: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/142592/9287-2900714-TSO-SexualHealthPolicyNW_ACCESSIBLE.pdf

Ethnicity

Although significantly less diverse than Birmingham, Solihull is rapidly becoming a more ethnically diverse place to live.

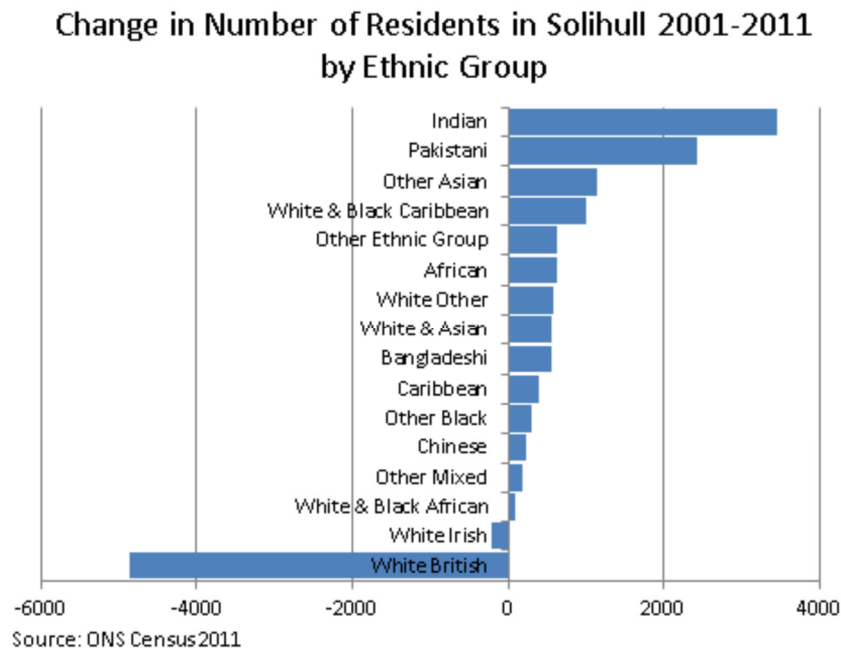


Figure taken from Solihull People and Place, Apr 2013

There has been a 108% rise in the number of Black or Asian Minority Ethnic (BAME) Groups between 2001-2011 (latest figure 10.9% of total population), and a 2% fall in the White British population in the same period. The Indian subgroup has seen the largest rise.

While Solihull is becoming more ethnically diverse however, the overall White British population is 85.8%, higher than the England average of 79.8%. Comparatively, Birmingham has a BAME Group population of 42%.

It should also be noted that the highest level of ethnic diversity is seen in Solihull's children, with 15.5% of 0-15 year olds from a BAME Group, compared to 11.7% of the working age population and 2.9% of the retirement age population. Current and future sexual health services will have to ensure that there is no inequality in the access to services by ethnicity given this trend in the young.

Religion

In terms of religion Christianity is followed by 65.6%, and no religion reported by 21.4%. However, the numbers of Muslims have more than trebled since the 2001 census (2.5%), and Hindu (1.8%) and Sikh (1.7%) populations have roughly doubled; most individuals identifying with these three religious groups live in the urban west of the borough. Given the implications of religious beliefs on sexual attitudes and lifestyle choices, the sexual health service should have an approach that respects and caters for the diverse needs of these varying groups.

Index of Multiple Deprivation

The Index of Multiple Deprivation (IMD) combines economic, health, social and housing indicators in a particular area to calculate an overall comparative score for that area in relation to the national average.

Solihull itself is as a borough in the 64th IMD percentile when compared nationally. Birmingham is in the 4th percentile and shows a much higher overall picture of deprivation.

However within Solihull's 133 LSOAs (Lower Super Output Areas) there is considerable variation in deprivation with the northern wards showing high levels of inequality along with some areas of the west of Solihull (see map below).

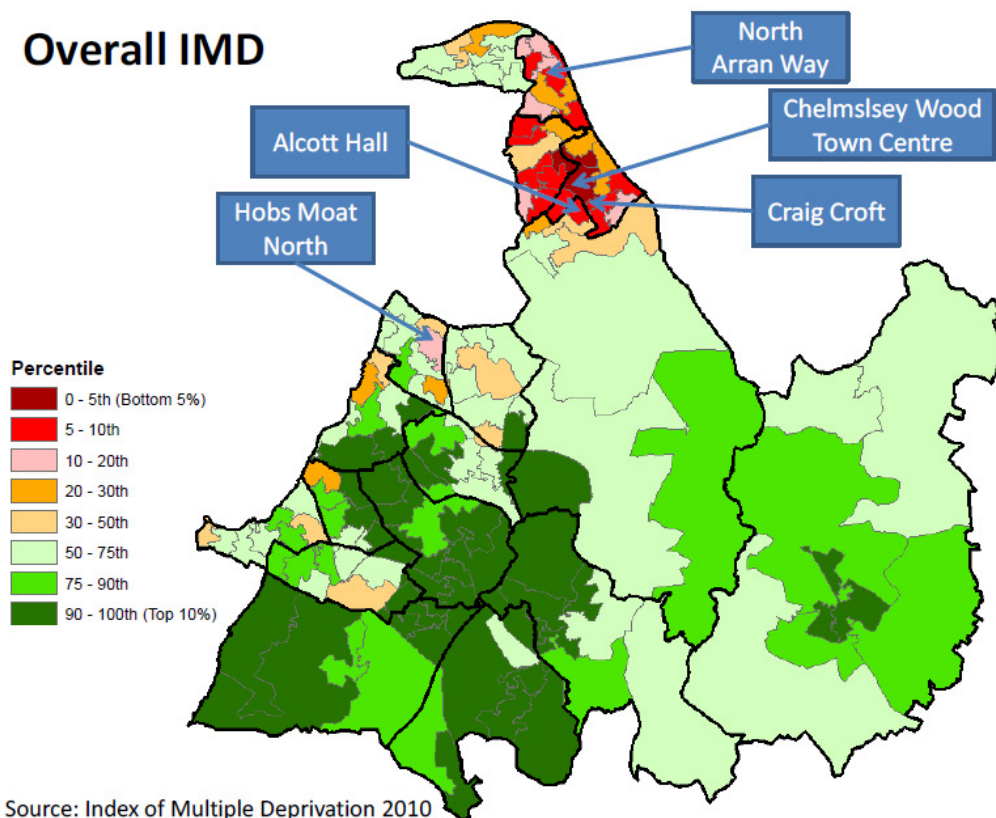
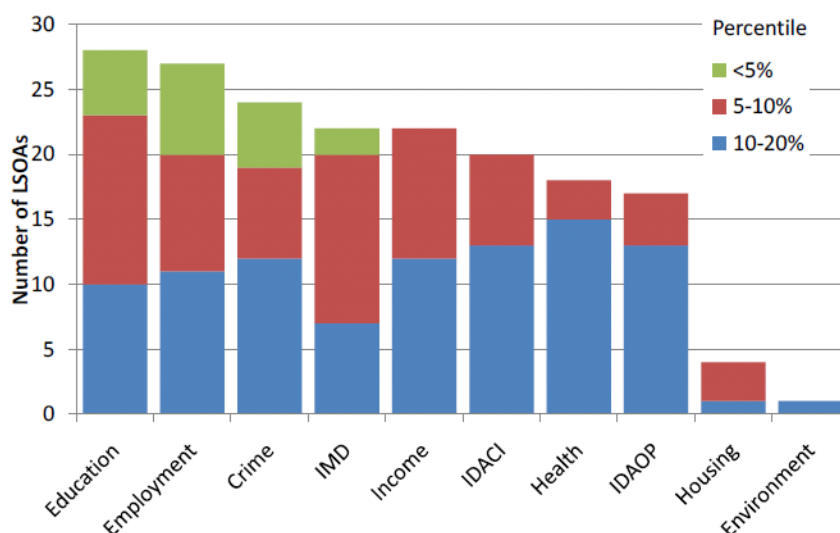


Figure taken from Solihull People and Place, Apr 2013

IMD indicators

Education, employment and crime fare worst of all when the IMD is broken down:

Deprivation in Solihull by IMD Domain



Source: Index of Multiple Deprivation 2010

Figure taken from Solihull People and Place, Apr 2013

Compared with 2007 there are 5 more LSOAs in the bottom 10% in 2010. All of the LSOAs currently in the bottom 10% are in the north Solihull regeneration area, the most deprived being Cole Valley and Chelmsley Wood Town Centre which are both in the bottom 5% nationally.

One measure of deprivation amongst ethnic groups is free school meal eligibility. Based on 2008 data, the highest rates of eligibility are in Mixed (21.8%) and Black (14.7%) children and lower rates are seen in White (10.6%), Asian (8.7%) and Chinese (4.3%) children, implying that there is much diversity in deprivation amongst minority ethnic groups and that they should not be seen as a cluster of comparable need².

² Health Profile 2009, Solihull. Produced by the Association of Public Health Observatories.
Link to Doc: www.apho.org.uk/resource/view.aspx?RID=71293

Homelessness

As can be seen from the table below, Solihull has maintained higher rates of statutory homelessness than the England average. Outside of those registered as statutory homeless, there will also be a significant number that are house sharing or boarding without rent or ownership that are not included (vulnerably housed). This is a challenging group for all service providers as there is limited data on these individuals. We know however from a significant body of evidence that this group of individuals are at increased risk sexually transmitted infections and unwanted pregnancies, and are often under pressure to exchange sex for money, food, drugs and shelter³.

Homelessness Rates Per 1,000 Households

Year	Solihull	West Midlands	England
2011/12	3.8	3.8	2.3
2010/11	3.7	3.8	2.0
2009/10	3.1	3.2	1.9
2008/09	3.1	3.9	2.5
2007/08	3.5	4.0	3.1

Table Source: <http://www.solihull.gov.uk/housing/homelessnesstrends.htm>

³ Source: *A Framework for Sexual Health Improvement in England*, March 2013; Department of Health Publications. Link: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/142592/9287-2900714-TSO-SexualHealthPolicyNW_ACCESSIBLE.pdf

Transport

Car Ownership

Car ownership and access to services (especially health) are important considerations when designing and restructuring services, as services need to be accessible as well as simply available. Again the northern regions of Solihull show the lowest levels of car ownership as can be seen from the figure below. While public transport links are better in the more urban northern areas of Solihull, each individual service will need to consider its accessibility to residents throughout the Solihull region.

Households with no access to a car or a van

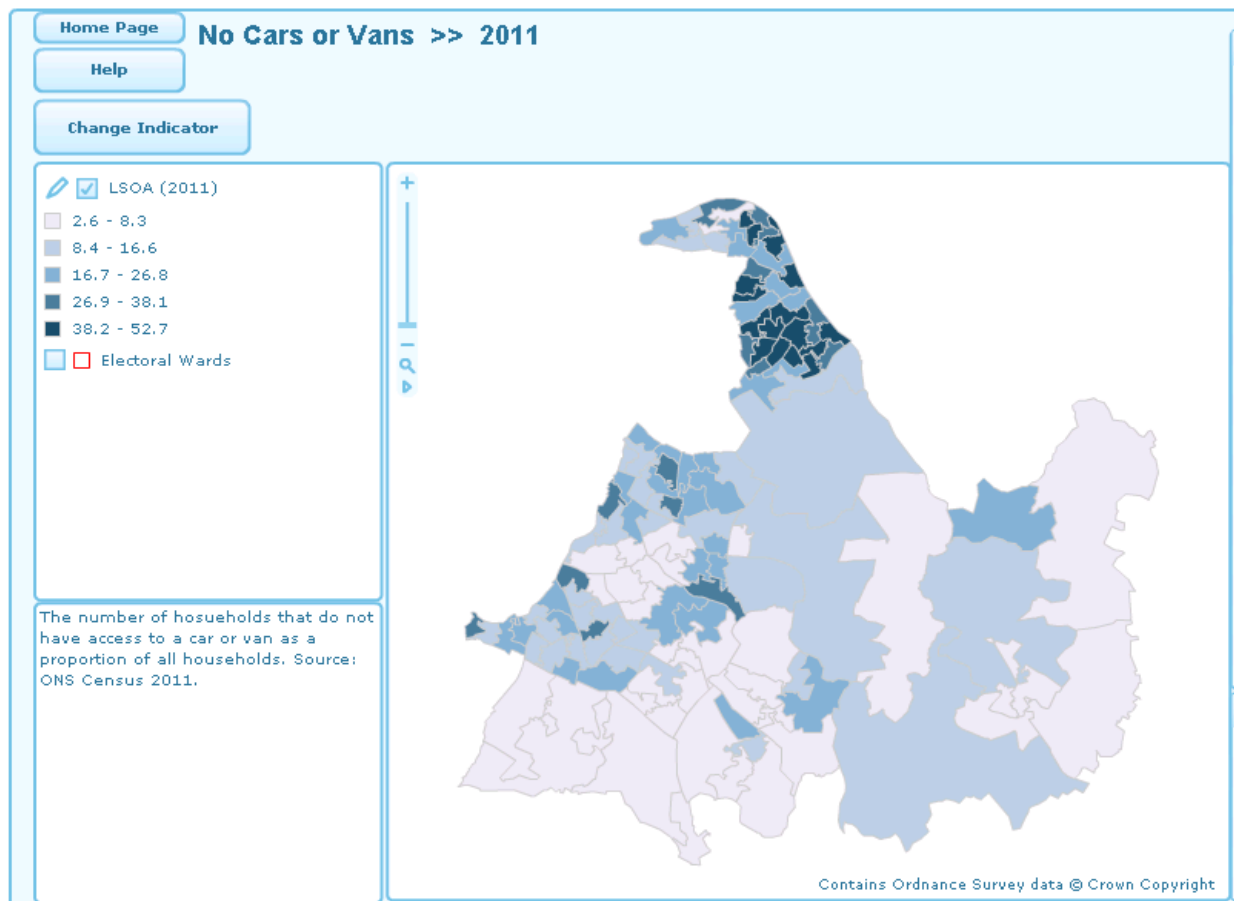


Figure taken from Instant Atlas mapping tool for Solihull, provided by Solihull Observatory.

Access to Primary Care

Access to primary care services is also another important indicator as a large proportional of sexual healthcare is delivered by GPs.

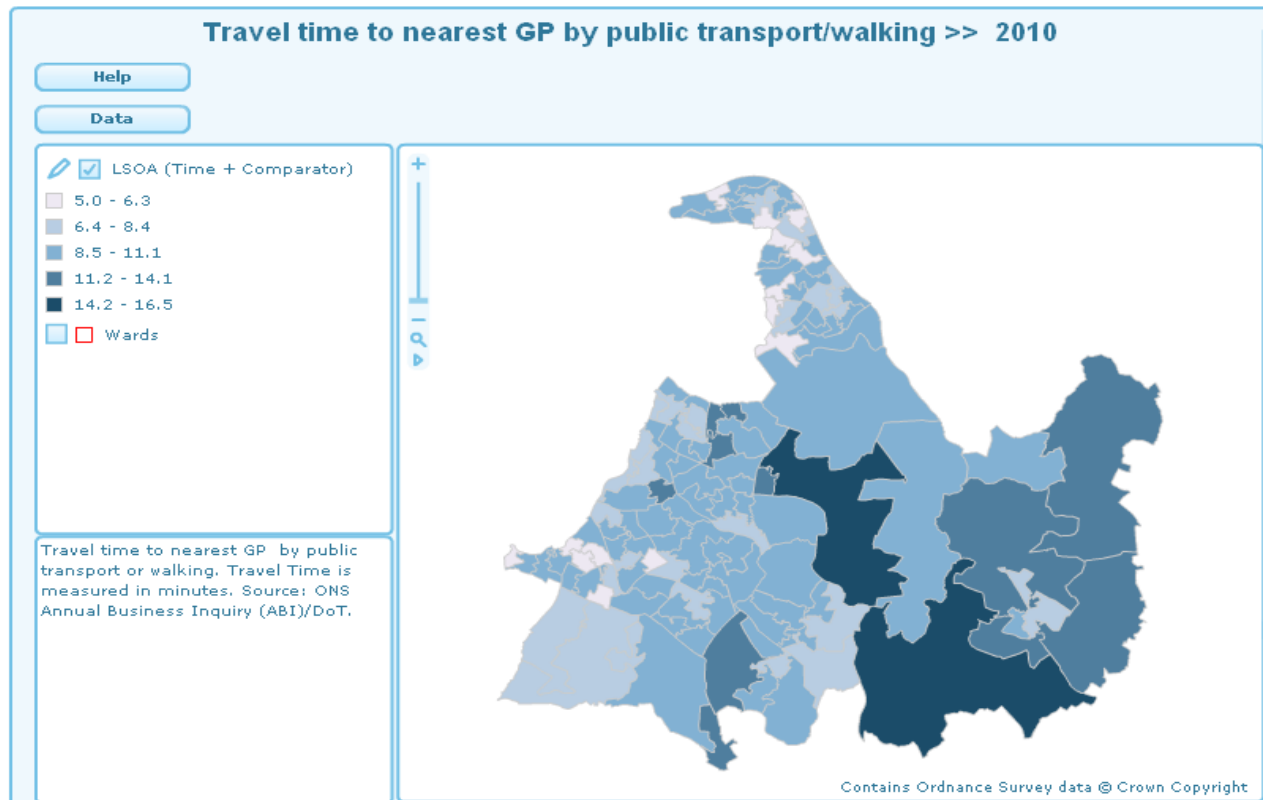


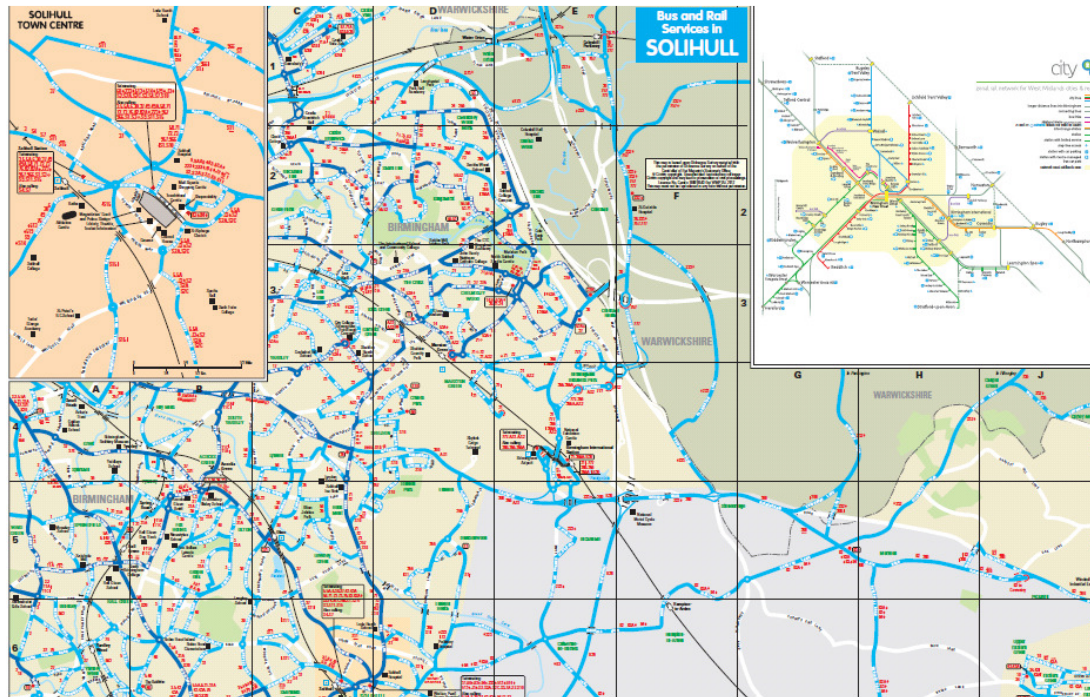
Figure taken from Instant Atlas mapping tool for Solihull, provided by Solihull Observatory.

Access to services is one of the only indicators in which the semi-rural south and east of Solihull show signs of deprivation. However while public transport links are poorer and distances to services are greater in these areas, we can see from car ownership data that generally these areas have the highest rates of car ownership which to some extent balances the inequality. It must be noted however that many young people in the rural south and east parts of Solihull may be either below the legal driving age or not yet eligible to drive and unable to ask for a lift from parents due to the heightened sensitivity of sexual health issues - the younger sexually active population in these areas are at a higher risk of poor sexual health due to reduced access to services.

Bus Availability

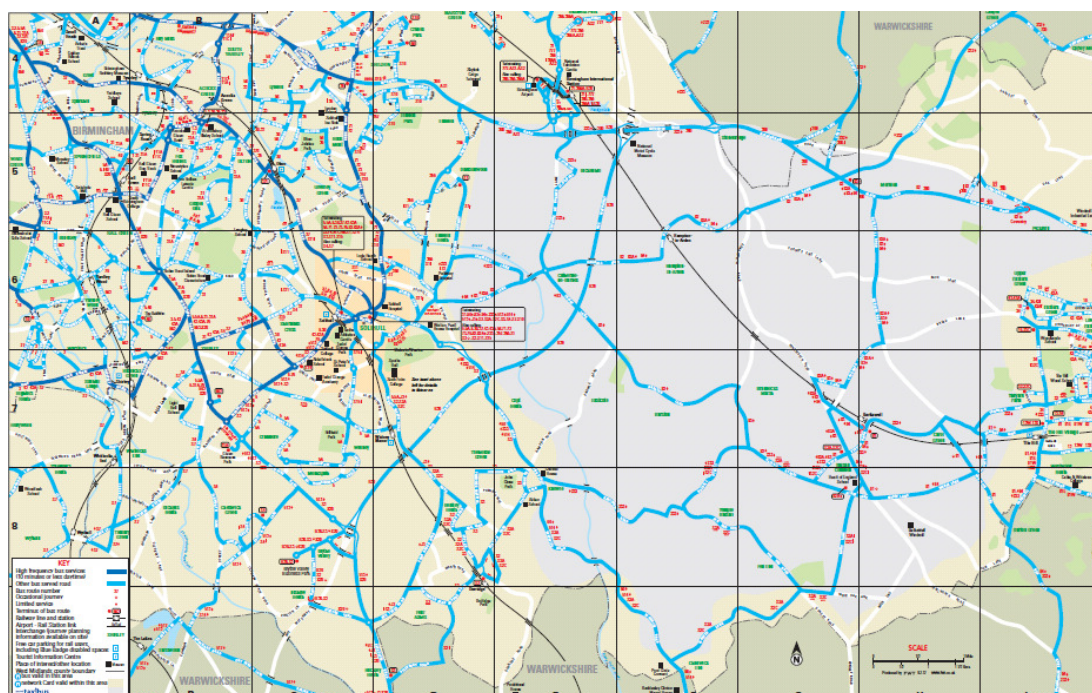
The maps below demonstrate local bus services: there are a higher proportion of frequent bus service roads (dark blue) and a greater density of bus stops (red markers) in the northern zone.

North Solihull⁴:



⁴ Source: Network West Midlands Bus Maps [cited 13/09/2013] http://www.networkwestmidlands.com/web/FILES/Solihull_WEB.pdf

South/East Solihull:



Looked After Children⁵

Looked after children are at particular risk of poor sexual health⁶. At the end of 2013 there were 324 looked after children in Solihull, a decrease from the previous year value of 366. This number consists of both local children (285) and unaccompanied asylum seeking children (total 39). The number of unaccompanied asylum seeking children has nearly halved in the last year. Over 25% of looked after children are aged 16-17 currently. 92.4% of looked after children that were in care for 12 months continuously or more had up to date medical and dental check ups by the end of March 2011, which is higher than the England average of 84.3%.

LGBT

There is very limited data on the local lesbian, gay, bisexual and transgender community. It is estimated that the LGB community is roughly 10,000 in Solihull and there is clear estimate for the transgender community⁷.

⁵ SDA903 Data Collection for Looked After Children, 2012-13 Report. Locally available data collected by Solihull Metropolitan Borough Council.

⁶ Family Planning Association webpage; Link: <http://www.fpa.org.uk/course/talking-about-sexual-health-relationships-and-rights-looked-after-children-and-young-people>

⁷ Cohesion Strategy for Solihull V1, 14 April 2010

Smoking in Pregnancy and Breastfeeding Initiation

Although outside the scope of this rapid needs assessment, other services such as drug and alcohol and maternity services are a natural partner to the sexual health service, and indeed the current national Public Health Outcomes Framework puts indicators such as breastfeeding initiation and smoking in pregnancy side by side with sexual health indicators such as under 18 conceptions as part of the wider health improvement agenda⁸.

To improve the overall health of the population, services need to interact and work in partnership to create a network of communication and support for all the wider determinants of health. In particular, maternity services need to work together with sexual health services to promote healthy lifestyles in women *before* and *after* conception. Overall, Solihull is a relatively healthy area compared to the rest of England, however smoking in pregnancy and breastfeeding initiation are still worse than the national average⁹. Every opportunity within the sexual health service should be used to promote and support women of childbearing age to access services that address these inequalities, giving both mother and baby a better chance to lead a healthy life.

Performance Indicators and Data

Under 18 Conceptions

Rationale¹⁰

As part of the Health Improvement domain of the national Public Health Outcomes Framework (2013 – 2016), there is a requirement for public health services to aim to drive down under 18 conceptions. Data shows that teenage pregnancies are more likely to be unplanned, end in abortion and to lead to poorer outcomes for both mother and baby.

3 year aggregate data

As part of the Service Level Agreement, the Office for National Statistics (ONS) release the number of under 18 conceptions at ward level to local practitioners in aggregate three year bands. Ward level conception rates are calculated by the Teenage Pregnancy Unit.

North Solihull has shown a persistent trend of higher under 18 conception rates than south Solihull since 2008, as can be visualised from the maps below. The distribution of rates of under 18 conceptions has remained relatively stable over time:

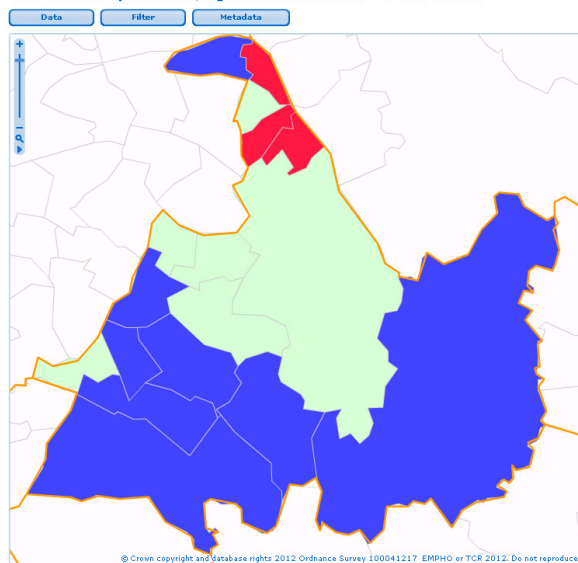
⁸ National Public Health Outcomes Framework [cited Sept 2013] Link: <http://www.phoutcomes.info/>

⁹ APHO District Level Interactive Atlas; 2010/11 data. Link: http://www.apho.org.uk/addons/_116627/atlas.html?HPT=R&config

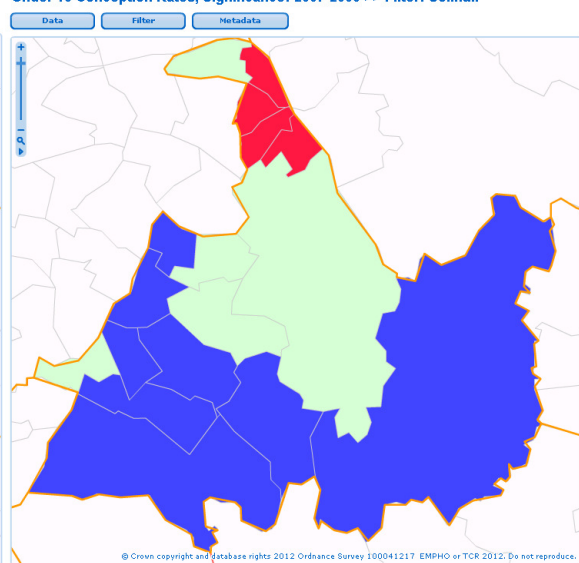
¹⁰ Association of Public Health Observatories; Sexual Health Balanced Scorecard: Indicator Metadata.

Link: http://www.apho.org.uk/default.aspx?QN=SBS_PAGE02

EMPHO Ward-level Teenage Pregnancy Mapping Tool - West Midlands Region
Under 18 Conception Rates, Significance: 2008-2010 >> Filter: Solihull



EMPHO Ward-level Teenage Pregnancy Mapping Tool - West Midlands Region
Under 18 Conception Rates, Significance: 2007-2009 >> Filter: Solihull



Differences between ward and national rates are displayed in terms of significance at 95% Confidence Intervals.

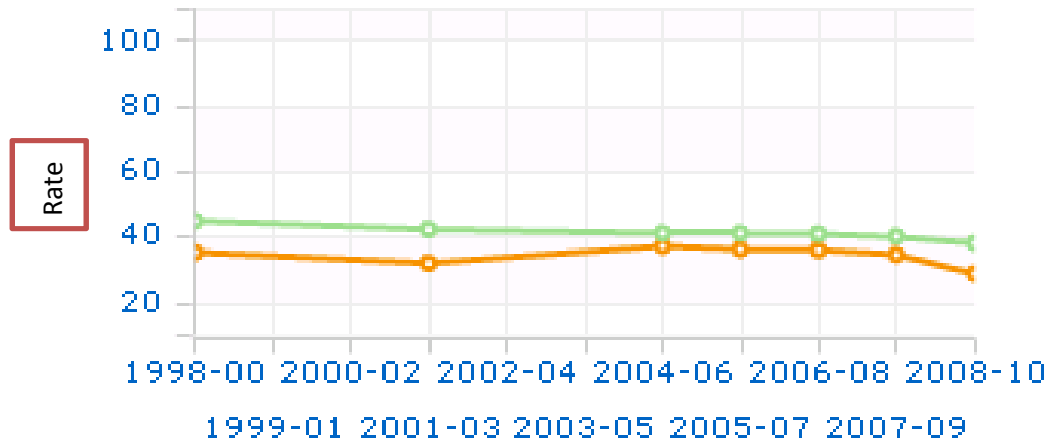
Source of maps: Association of Public Health Observatories [data sourced from Teenage Pregnancy Unit].
<http://www.apho.org.uk/resource/view.aspx?RID=116357>

Link:

Latest 2011 data

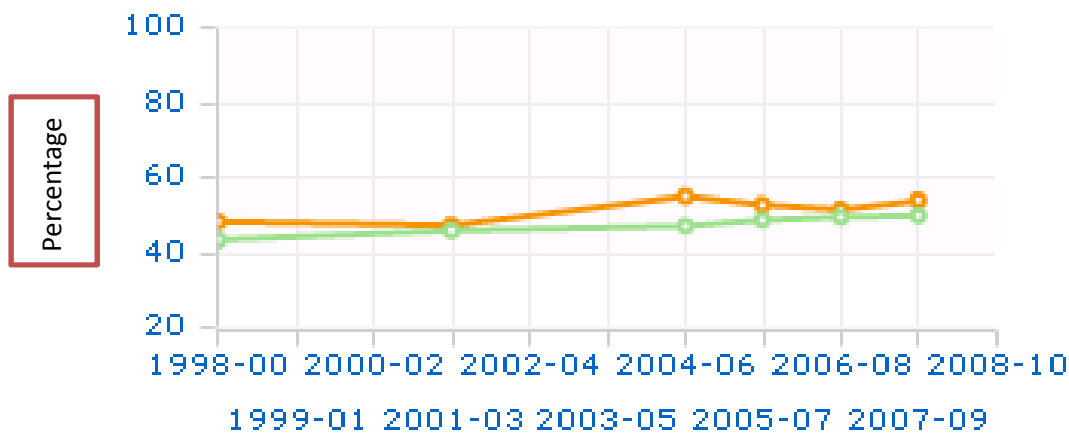
ONS usually release conception statistics around 14 months after the period to which they relate. Since 2004, there is a generally decreasing trend in under 18 conception rates in Solihull until very recently. Latest figures released to our local authority reveal that the 2011 under 18 conception rate is 26.2 per 1,000 females, compared to a low of 22.5 per 1,000 in 2010. However the 3 year aggregate trend is a reducing one and the current value is still relatively low given the significantly higher rates 5-10 years ago.

Under 18 conception rates per 1,000 females: Solihull (orange) vs England (green) trend by 3 yearly aggregates



There is a generally increasing trend in the percentage of under 18 conceptions leading to abortion in Solihull. Locally received data shows that this trend continues into 2011 to add to the data above with a Solihull percentage of 62.5% compared to an England average of 49.3%.

Percentage of under 18 conceptions leading to abortion: Solihull (orange) vs England (green) trend by 3 yearly aggregates



Graphical data on this page taken from EMPHO Teenage Pregnancy Interactive Mapping Tool

The percentage of under 18 conceptions leading to abortion gives insight into the extent of unplanned pregnancy in this vulnerable age group, although access to services and social class are potential confounders given that higher abortion rates are generally seen in teenagers from more affluent backgrounds nationally¹¹. This sub- indicator has been included here for context within the *Under 18 Conceptions* dataset, but can be read in conjunction with the *Abortions* section below.

¹¹ Association of Public Health Observatories; Sexual Health Balanced Scorecard: Indicator Metadata.
Link: http://www.apho.org.uk/default.aspx?QN=SBS_PAGE02

Abortions

Rationale¹¹

Abortion statistics are produced by the Department of Health to help commissioners monitor the rates of unwanted pregnancy, and therefore the relative success of their contraceptive services. Unwanted pregnancy and abortion carry obvious health risks to the mother and are a source of considerable cost to the NHS. A higher proportion of abortions performed under 10 weeks gestation reflects a good service as delayed abortion increases health risks to the mother and costs to the NHS. Repeat abortions are an indicator of the adequacy of contraceptive services and support for women with previous abortions, with young women being at increased risk nationally.

Abortion Rates by age group¹²

The overall age standardised abortion rate (per 1000 females aged 15-44) in Solihull for 2011 was 19.7, which is significantly higher than the England average of 17.6.

The abortion rate for 15-17 year olds was 17.7 (per 1000 females aged 15-17), higher than the England average of 15.1.

The only age group in which abortion rates were better than the England average was the under 16 age group, although this is a very small component of all abortions. The abortion rate per 1000 females in this group (collated over 3 years 2009-2011) was significantly lower at 2.5 compared to an England average over the same period of 3.8.

The abortion rate had dropped to 17.2 in 2009 from 19 in 2008; since 2009 however the rate has increased yearly to the 2011 value of 19.7 stated above. In England, the abortion rate has been showing a gradually decreasing trend since 2009.

Proportions of abortions < 10 weeks gestation¹²

The Chief Medical Officer in 2005 set a target of 70% of all abortions to be performed under 10 weeks gestational age. During 2012, 86% of all NHS funded abortions in Solihull were below 10 weeks gestational age which is significantly better than the England average of 77.5%. There is a slowly improving trend in Solihull for this figure which was 79% in 2008.

¹² Department of Health Abortion Statistics 2012.

Link: <https://www.gov.uk/government/statistical-data-sets/statistics-on-abortions-carried-out-in-england-and-wales-in-2012>

Repeat Abortion rates¹²

In 2012, 39% of all abortions in Solihull were repeat abortions, similar to the Birmingham and Black Country average of 40% but worse than the England average of 36.9%.

In 2012, 28% of abortions in the under 25s in Solihull were repeat abortions, better than the Birmingham and Black Country average of 31% but slightly worse than the England average of 27.1%. In 2011 however 23.5% of abortions in the under 25s in Solihull were repeat abortions, better than the 2011 England average of 26.4%¹³.

In 2012, 52% of all abortions in those aged over 25 in Solihull were repeat abortions, worse than the Birmingham and Black Country average of 49% and the England average of 45.4%.

In 2011, 5.5% of all age under 19 abortions in Solihull were repeat abortions, better than the England value of 10.9% for the same year¹³.

Please note Simon that 2011 comparison data has limited availability in DoH publications at LA level

National trends¹⁴

- a. 81% of abortions were carried out in single women.
- b. The highest abortion rates were in the 15-24 age group.
- c. Black or Black British and Mixed ethnic groups had the highest proportions of repeat abortions (49% and 46% respectively).

¹³ Sexual Health Balanced Scorecard, APHO. Link: http://www.apho.org.uk/addons/_116634/atlas.html

¹⁴ Abortion Statistics, England and Wales: 2012. Department of Health Report.

Link to Doc: <https://www.gov.uk/government/publications/report-on-abortion-statistics-in-england-and-wales-for-2012>

Sexually Transmitted Infections including HIV

Rationale

STI diagnoses rose nationally by 5% in 2012, although this is largely considered due to improved methods of data collection¹⁵. However, rates in England still remain high and STIs are a considerable burden to public health and the NHS. It is vital to understand local and national trends to help inform targeted services to those at most risk.

National trends by infection:

Chlamydia remains the most commonly diagnosed STI nationally (and is a focus area in the 15-24 age group on the national Public Health Outcomes Framework 2013-2016¹⁶), followed by genital warts and genital herpes¹⁵. Gonorrhoea cases are significantly lower but rising¹⁵ and syphilis diagnoses are rising in men¹⁵. HIV remains a high priority concern and is another focus of the national Public Health Outcomes Framework 2013-2016 with regards to late diagnoses¹⁶, given the transmission risk and chronic health implications when treated late. While other unmentioned STIs are also diagnosed and treated by sexual health services, they are outside the scope of this rapid needs assessment, and we will be concentrating specifically on the key infections mentioned in this text.

Data Sources

The local STI statistics presented are from the latest dataset released to us from the West Midlands Regional Epidemiology Service (part of Public Health England).

National and regional comparisons are made from data published by the Health Protection Agency (now part of Public Health England) and the National Chlamydia Screening Programme.

Links:

1. HPA STI Annual Data: <http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/STIs/>
2. Latest NCSP data can be found at: <http://www.chlamydia-screening.nhs.uk/ps/data.asp>

¹⁵Health Protection Report, weekly report; Volume 7 Number 23 Published on: 7 June 2013.

Link: <http://www.hpa.org.uk/hpr/archives/2013/hpr2313.pdf>

¹⁶National Public Health Outcomes Framework [cited Sept 2013] Link: <http://www.phoutcomes.info/>

Chlamydia

1. Screening and diagnosis rate in 15-24 year olds:

The *Public Health Outcome Framework 2013-2016* recommends an annual chlamydia diagnosis rate of over 2,300 per 100,000 15-24 year olds nationally to achieve a significant impact on chlamydia activity based on modelling studies¹⁷.

These studies also suggest that screening rates between 26-43% are needed, along with high rates of partner notification and management, to bring about a significant reduction in the prevalence of chlamydia¹⁸.

In 2012, screening for Chlamydia (GUM and non GUM testing) in Solihull reached 24.8% of 15-24 year olds, with a diagnosis rate of 1876 per 100,000. Both respective values were below the England average of 25.8% and 1979 per 100,000 and below the NCSP suggested targets.

In 2010 in Solihull, screening rates in 15-24 year olds had reached 27.8% and the diagnosis rate had reached 2219 per 100,000 (the actual figure for screening rates would likely have been even higher as GUM services were not included in the dataset that year), and so there has been an appreciable drop in coverage of chlamydia screening and diagnosis rate since 2010.

The first quarter of 2013 has had a screening coverage percentage of 2.5% compared to a West Midlands average of 5.4% and an England average of 6.4%, and a diagnostic rate of 1060 per 100,000 compared to a West Midlands average of 1807 and an England average of 2016. Last year, in the first quarter of 2012 the Solihull coverage was 7.1% by comparison. The projection here is that screening uptake rates may still be decreasing into this year.

2. Proportion screened by core services:

In 2012, the proportion of screening tests done by core services (defined by the NCSP as SRH services, primary care and GUM services) was 42.7%, below the West Midlands value of 48.4% and the England value of 56.4% and the new national NCSP target of 70%.

¹⁷NCSP Summer 2013 newsletter.

Link: http://www.chlamydia-screening.nhs.uk/ps/resources/newsletters/Chlamydia%20Connects_NCSP%20E-News_Summer%20Issue_FINAL.pdf

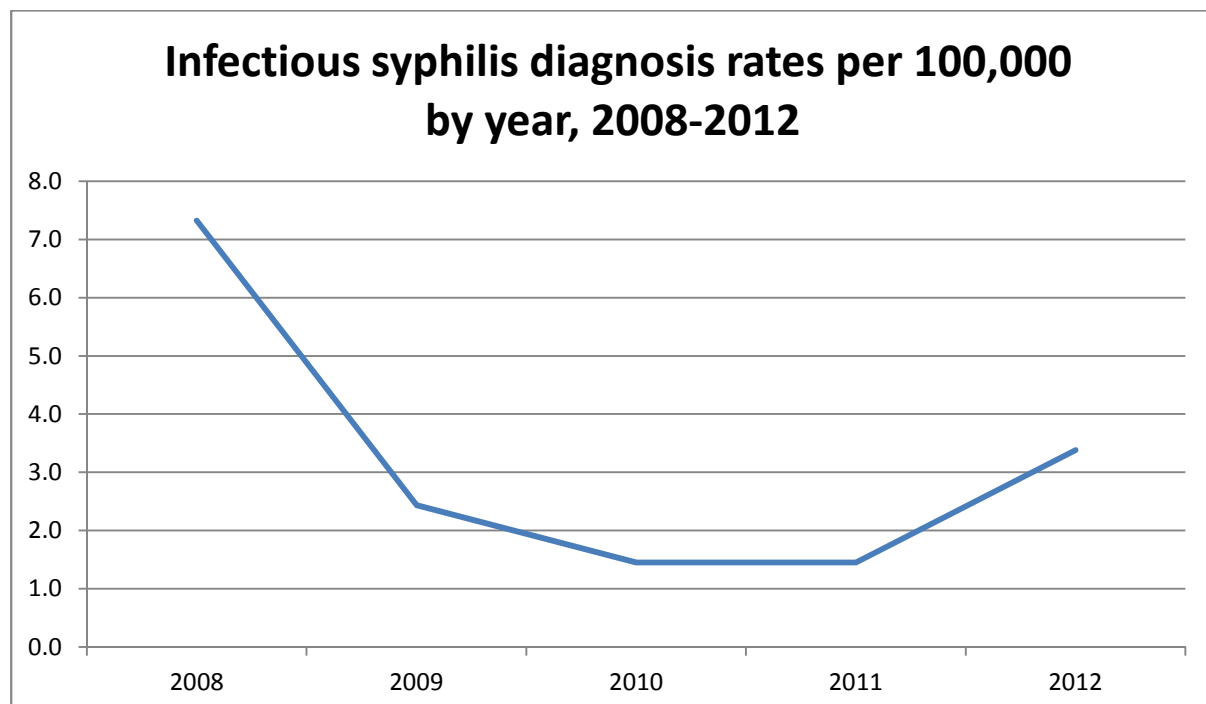
¹⁸NCSP 2008 Publication: *Quick wins and sustainable services: Hitting the target without missing the point.*

Link: http://www.chlamydia-screening.nhs.uk/ps/resources/guidelines/Commissioning_chlamydia_screening_06Oct08.pdf

Syphilis

In 2012 the rate of syphilis diagnoses made in GUM clinics in Solihull was 3.4 per 100,000; in 2011 the rate was 1.5 per 100,000 population, which was below both the regional and national average rates of 3.0 and 5.4 per 100,000 respectively at the time. The trend was stable over the previous 2 years with a rate of 1.5 per 100,000 in 2010 and 2.4 per 100,000 in 2009.

While it seems there has been a significant rise in the rate of diagnoses since 2011, the change in value represents a small number of extra cases given the numbers involved. Men who have sex with men (MSM) are likely to be at risk in line with national trends¹⁵.



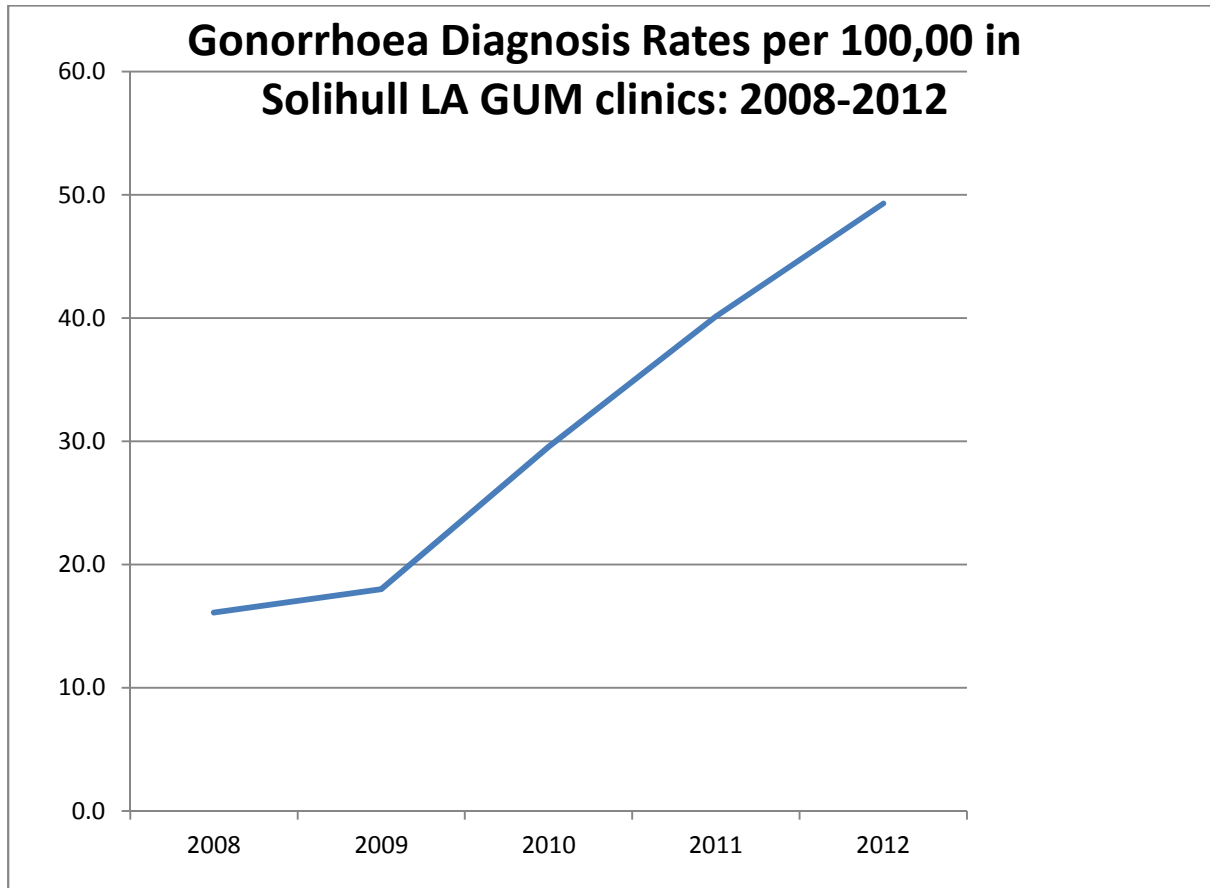
Gonorrhoea

The rate of gonorrhoea diagnoses made in GUM clinics in Solihull has been rising for the past 5 years, from 16.1 per 100,000 in 2008 to 49.3 per 100,000 in 2012.

Over the last 3 years around 60% of new diagnoses each year are in men, with men who have sex with men (MSM) being a particular risk group in Solihull. Ethnicity data has been largely suppressed due to small numbers and is therefore difficult to interpret, though cases are largely in white subjects, which reflects the ethnicity data for Solihull as a whole.

**There is a data discrepancy here between data provided to us by the West Midlands Regional Epidemiology Service for Solihull and available data from the *Sexual Health Performance Radar* (HPA) and *Sexual Health Balanced Scorecard* data (APHO), which may be a result of de-duplication processes performed by the health protection agency, although the exact reason is not clear at the

time of this report. The exact values for Solihull's diagnosis rate for gonorrhoea does not vary considerably between sources and a general comment can be made from all sources that gonorrhoea diagnosis rates in Solihull have risen in line with national trends and are similar to national levels.



Genital Herpes and Genital Warts

The new diagnosis rate of anogenital warts in Solihull was 130.7 per 100,000 in 2012, an increase of 36% on the 2011 rate and similar to the rate seen in 2008, but still lower than the West Midlands regional rate.

The new diagnosis rate of anogenital herpes simplex in Solihull was 44.5 per 100,000 in 2012, an increase of 32% on the 2011 rate but lower than the 2009 and 2010 rates of 49.6 and 48.9 respectively. The rate also falls below the regional West Midlands rate.

Again there are discrepancies between the local and national data available which may be related to coding or de-duplication issues but the differences in values are small or nil between those available locally and those available from the HPA. It can be generally stated that the anogenital warts diagnosis rate is roughly equivocal to the national average and that the anogenital herpes diagnosis rate is considerably lower than the national average.

HIV

1. New Diagnoses

Numbers of patients accessing HIV services by area give an indicator of prevalence, although we know that a significant proportion of cases may remain undiagnosed.

By the end of 2011, there were 91 people aged 15-59 accessing HIV related care in Solihull an increase of 15% when compared to 2010. In 2011 in Birmingham there were 1637 people accessing HIV related services, having increased by 8% since 2010¹⁹. Birmingham has over 3 times the prevalence of HIV in the 15-59 age group.

The number of new diagnoses of HIV in Solihull residents has remained stable since 2006, with annual numbers greater than 5 and less than 10 and no clear increasing or decreasing trend. Before 2006, the numbers of new diagnoses were generally less than 5 yearly.

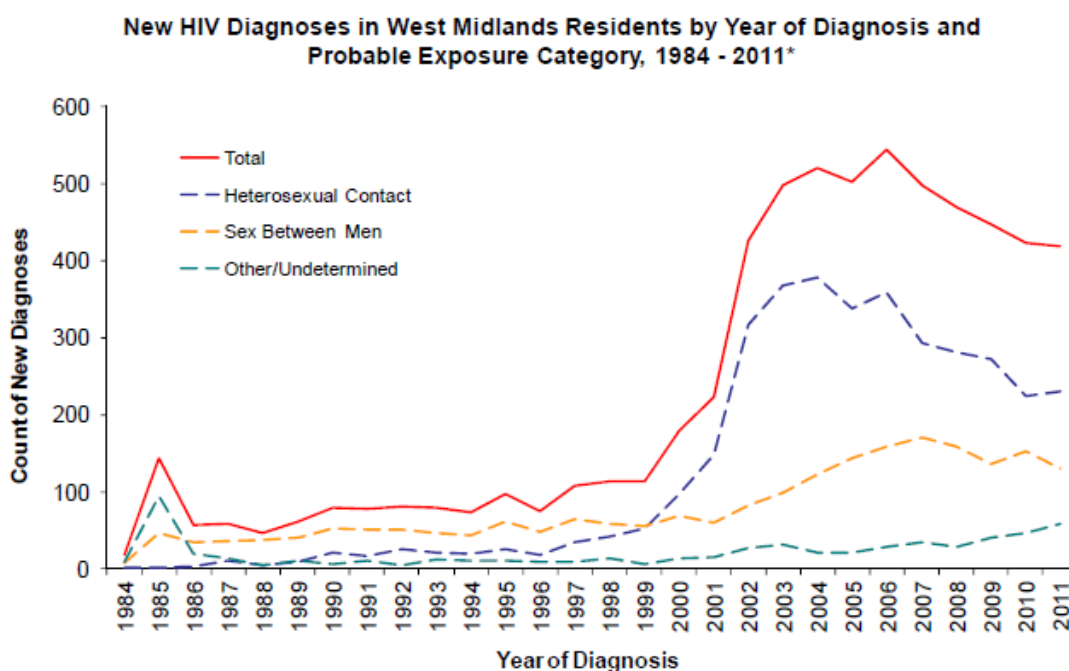


Figure taken from West Midlands Annual HIV Report for 2011 produced by West Midlands Regional Epidemiology Unit for local use

The figure above demonstrates that regionally there have been a decreasing number of new diagnoses of HIV yearly since 2006. However, the rates are still high by historical standards and we are now seeing proportionately more HIV in men who have sex with men (MSM).

¹⁹ West Midlands Annual HIV Report 2011. Data to 31 December 2011, HPA West Midlands. Link: http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1228207184991

National Trends:

- a. 71% of diagnoses of HIV were in males in 2011.
- b. The mean age of diagnosis was 37.5 years.
- c. Black Africans are 80 times more likely and Black Caribbean 6 times more likely to be affected by HIV than the white population.
- d. MSM remains a target group for HIV related services

2. The Offer and Uptake of HIV testing

Uptake of HIV testing in GUM Clinics, 2010-2011 - West Midlands Residents

2.30 Uptake of HIV Testing in GUM Clinics by Local Authority of Residence, 2010-2011

NHS CB Local Area Team	Upper-tier Local Authority	2010			2011		
		Offered	Tested	Uptake (%)	Offered	Tested	Uptake (%)
Arden, Herefordshire and Worcestershire	Coventry	7,916	6,830	86	9,021	7,930	88
	Herefordshire	3,407	2,218	65	3,422	2,577	75
	Warwickshire	9,954	7,355	74	10,380	8,295	80
	Worcestershire	8,088	5,584	69	8,260	6,099	74
	Subtotal	29,365	21,987	75	31,083	24,901	80
Birmingham, Solihull and the Black Country	Birmingham	26,482	23,626	89	28,950	26,834	93
	Dudley	4,793	3,670	77	4,990	4,112	82
	Sandwell	6,332	5,296	84	6,455	5,934	92
	Solihull	2,955	2,693	91	2,532	2,351	93
	Walsall	5,057	3,720	74	4,951	3,644	74
	Wolverhampton	5,897	4,183	71	6,075	4,513	74
Subtotal	51,516	43,188	84	53,953	47,388	88	
Shropshire and Staffordshire	Shropshire	2,989	2,247	75	3,007	2,296	76
	Staffordshire	13,181	11,414	87	13,570	11,694	86
	Stoke-on-Trent	4,565	4,133	91	4,360	3,652	84
	Telford and Wrekin	2,471	1,738	70	2,638	1,877	71
Subtotal	23,206	19,532	84	23,575	19,519	83	
Total		104,087	84,707	81	108,611	91,808	85

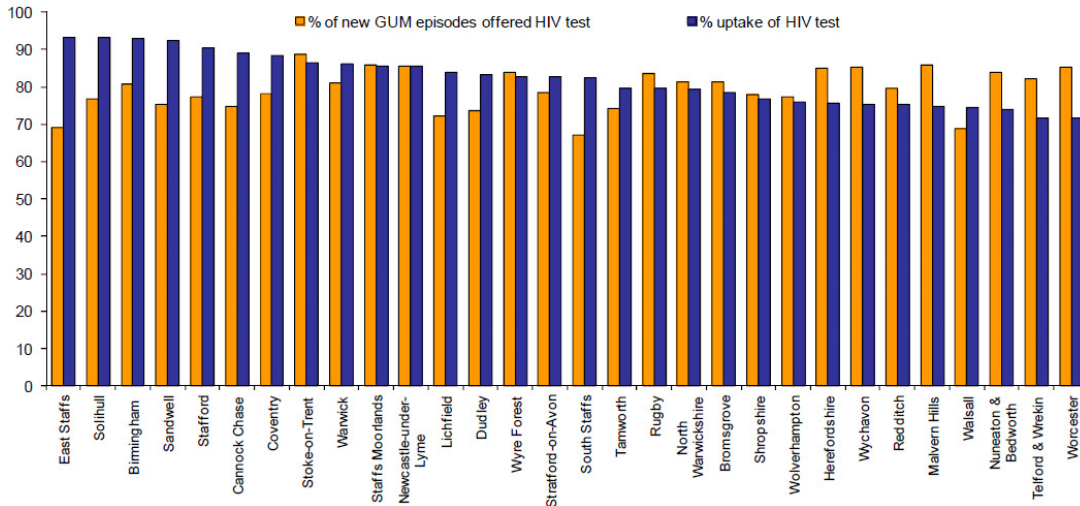
Please note that data above includes patients who attended clinics outside of the West Midlands

Data taken from West Midlands Annual HIV Report for 2011 produced by West Midlands Regional Epidemiology Unit for local use

Across the West Midlands region as a whole, 79% of residents attending GUM clinics in 2011 were offered a HIV test, ranging from 89% of residents in Stoke-on-Trent to 67% of South Staffordshire residents (Fig. 6). Uptake of HIV testing among West Midlands residents attending GUM clinics in 2011 was 86%, ranging from 93% for residents of East Staffordshire to 72% for residents of Worcester.

Figure 6: Offer and uptake of HIV testing in GUM clinics by PCT of residence, January to December 2011

Data source: HPA – Genitourinary Medicine Clinic Activity Dataset (GUMCAD)



Data taken from West Midlands Annual HIV Report for 2011 produced by West Midlands Regional Epidemiology Unit for local use

Solihull residents tend to agree to HIV tests in GUM clinics as they have the second highest uptake rates in the West Midlands amongst those offered HIV testing at GUM clinics. However, the proportion of Solihull residents presenting to GUM clinic being offered a HIV test was marginally below the West Midlands average of 79%.

3. Late diagnoses²⁰

The proportion of late diagnoses can be measured as the number of diagnoses occurring in a given time frame where the cell CD4 count was less than 350 at presentation as a proportion of all diagnoses made. The lower the CD4 count, the later the diagnosis is considered. In 2008-10, the proportion of late diagnoses was 45.5% in Solihull and showed a reducing trend when followed into 2009-11, dropping to 36.4% - this is significantly better than the Birmingham average of 50.1% and the England average of 50% for 2009-11.

²⁰ Sexual Health Profiles Performance Map, HPA.

Link: <http://profiles.hpa.org.uk/IAS/dataviews/report/fullpage?viewId=42&reportId=40&indicator=i426&date=2009-2011>

STI Summary

In 2012 there has been an overall 39% rise in acute STI diagnoses compared to 2011 for Solihull. In the West Midlands the overall number of STI diagnoses fell by 4% in 2012 compared to 2011. However, the overall rate of acute STI diagnoses in Solihull for 2012 was 460 per 100,000, which was lower than the regional rate of 551 per 100,000.

The individual number of diagnosed cases of chlamydia, gonorrhoea, syphilis, anogenital warts and anogenital herpes simplex all were higher in 2012 compared to 2011 in Solihull, with the greatest percentage increase in syphilis (133%), although this only represents a very small increase in the actual number of cases given the small numbers involved. Chlamydia diagnosis rate is dropping recently though (Q1 of 2013), along with reduced chlamydia screening rates which may be largely implicated.

Solihull STI activity in 2012:

The new diagnosis rates for **chlamydia** and **anogenital herpes simplex** were **significantly lower** than the regional rates.

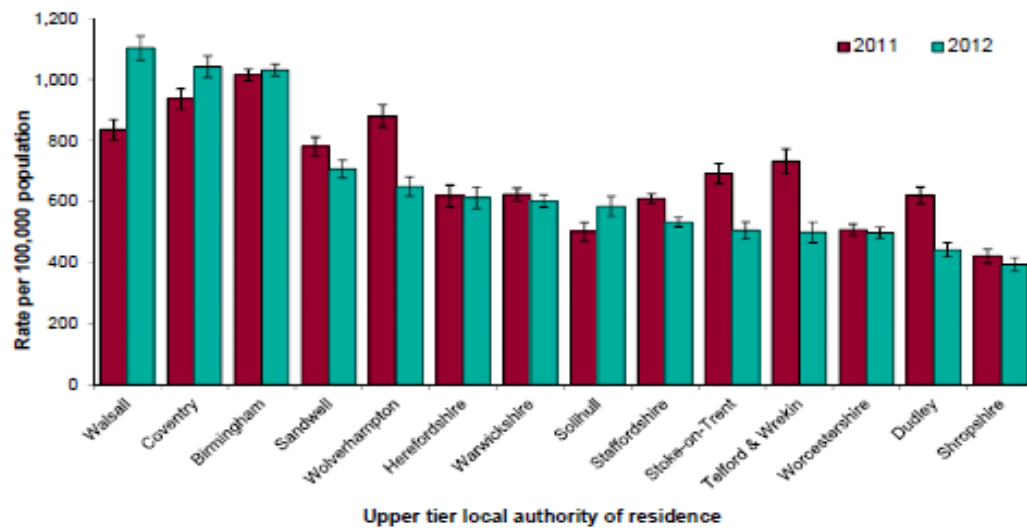
The new diagnosis rate for **anogenital warts** was also **lower** than the regional rate, although not significantly.

The new diagnosis rate for **gonorrhoea** and **syphilis** was **higher** than the regional rate, although neither was significantly higher.

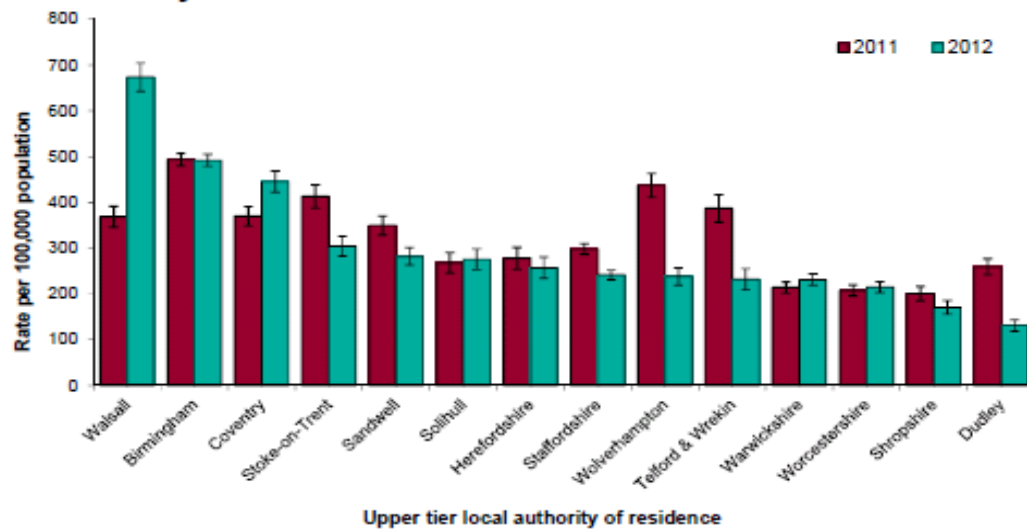
The new diagnosis rate for **HIV** is relatively **stable** for the last 6 years in Solihull, with a **lower** estimated HIV prevalence in the 15-59 age group compared to Birmingham. Late diagnosis rates are relatively **low** and residents have a **high acceptance of HIV testing** when offered at GUM services.

The charts below show a breakdown of local STI activity in comparison to Solihull taken from the report *Spotlight on Sexually Transmitted Infections in the West Midlands, 2012* prepared by the West Midlands Regional Epidemiology service:

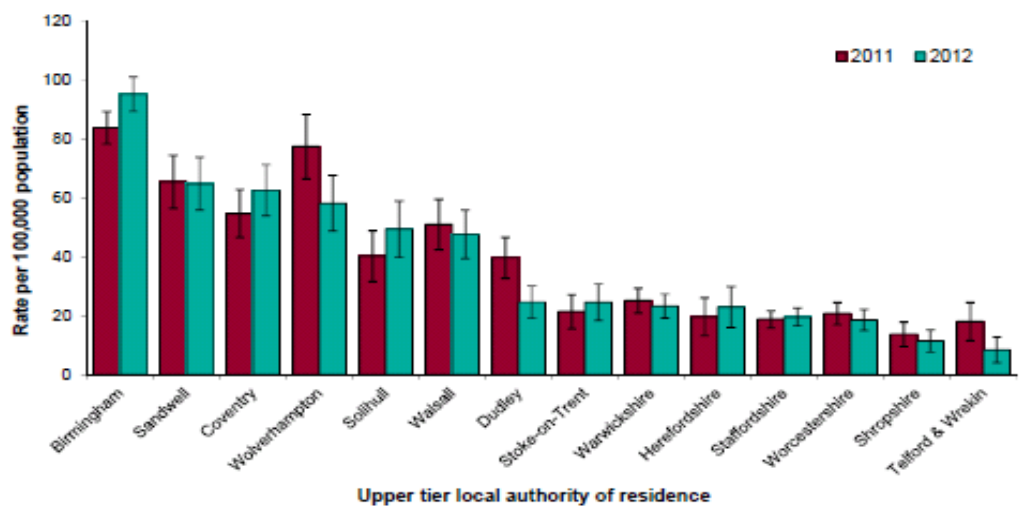
A. All new STIs¹



B. Chlamydia¹

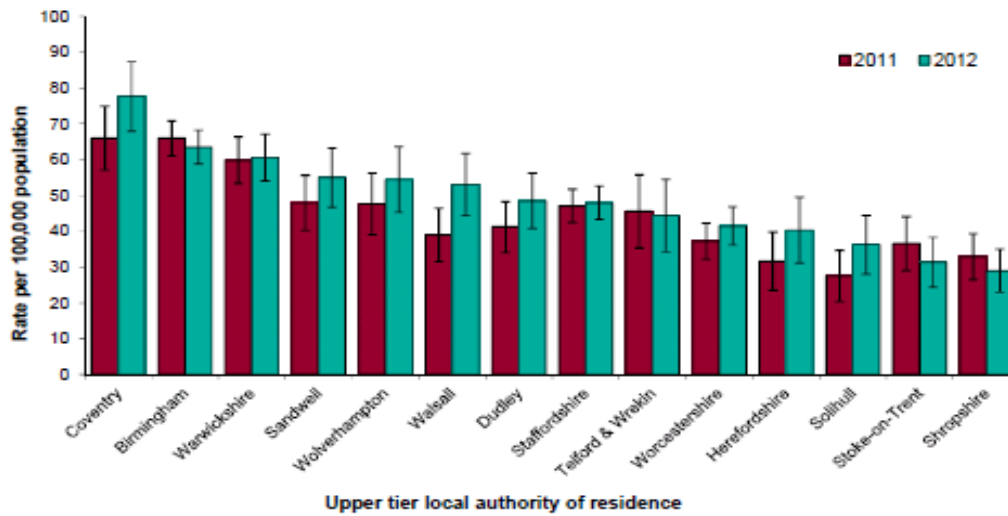


C. Gonorrhoea

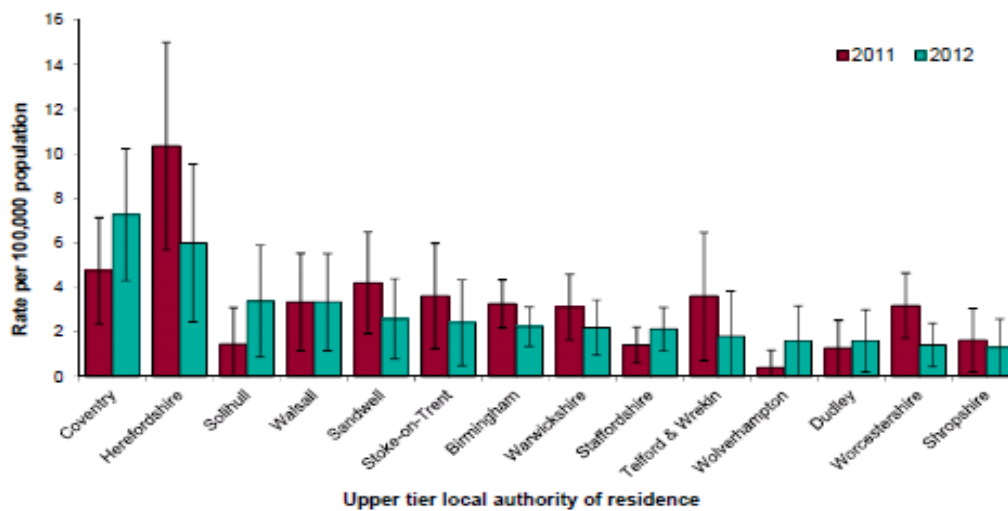


¹ Includes GUM diagnoses for all age groups and community chlamydia diagnoses for 15-24 year olds. Where residence data is limited, diagnoses may be attributed to local authorities where patients are diagnosed, rather than where they live.

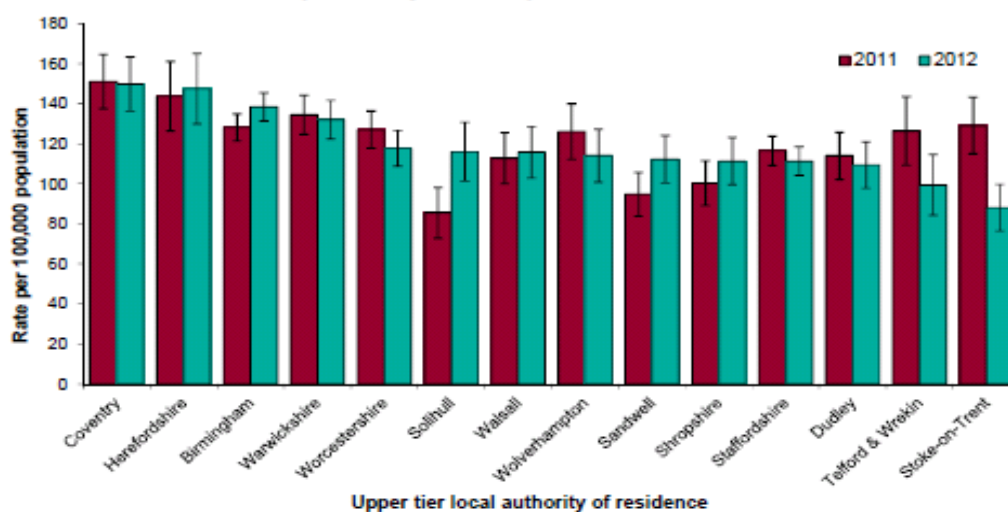
D. Herpes: anogenital (first episode)



E. Syphilis (primary, secondary and early latent)



F. Genital warts (first episode)



We can see from the above graphical data that apart from syphilis where small numbers can skew activity rates, Solihull falls roughly in the median range for STI activity both overall and by specific condition, whereas neighbouring Birmingham faces generally higher rates compared to the West Midlands as a whole.

The report also adds some useful regional information on disease activity with respect to ethnicity, gender, age and sexual orientation, with the following main findings:

1. In 2012 60% of new STI diagnoses in the West Midlands were in the under 25s. Overall 20-24 year olds had the highest rates of STI diagnoses for both men and women.
2. Significantly more chlamydia and anogenital herpes simplex is diagnosed in women and significantly more gonorrhoea and syphilis is diagnosed in men. This trend is not applicable to the black ethnic group where men tend to have higher rates of diagnoses across the board, except for anogenital herpes simplex where there is no significant difference by gender.
3. The highest numbers of all STI diagnoses made in 2012 were in the white ethnic group (73%). However to account for differences in population, when the disease activity is expressed as a rate, the black ethnic group have significantly higher rates for all STIs except for syphilis where significance is not reached. The next highest rates are seen in the mixed population and similar lower rates are seen generally within the white and Asian ethnic groups.
4. For new STI diagnoses amongst Solihull men in 2012, sexual orientation was reported for only 35% of cases, compared to a West Midlands average of 85%. Where sexual orientation was reported, 22% of all new STI diagnoses in Solihull men were accounted for by men who have sex with men (MSM), with a particularly higher risk for gonorrhoea diagnoses (55% male diagnoses coded as MSM).

Contraception

“Approximately 4 million people use contraception services each year. Roughly three-quarters see a GP and the remainder attend specialist community contraception services”²¹.

²¹ Department of Health webpages. Last modified Feb 2010.

Link: http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publichealth/Healthimprovement/Sexualhealth/Sexualhealthgeneralinformation/DH_4001998

Rationale

Contraceptive services aim to reduce the rates of unwanted pregnancy and transmission of STIs, both of which are a considerable public health burden and source of avoidable expense for the NHS. It is estimated that for every £1 spent on contraceptive services, the NHS saves £11 due to the reduction in adverse sexual health outcomes²².

Long Acting Reversible Contraception (LARC) is considered the most effective form of contraception to reduce the rates of unwanted pregnancies and is recommended by NICE guidance²³.

Emergency Hormonal Contraception (EHC) is another important part of contraceptive services, which when delivered effectively, has obvious health benefits when compared to delayed abortion or unwanted pregnancy.

Patterns of Contraception use including LARC – GP and CSRH data

Rates of GP prescribed LARC in Solihull in the financial year 2011-12 were 48.2 per 1,000 females aged 15-44, compared to an England average of 52.4 per 1,000²⁴.

Amongst Solihull users of the Community Sexual and Reproductive Health services (CSRH), 12.6% of under 18s chose LARC as their preferred means of contraception in 2009/10 compared to a regional average of 7.5% and a national average of 11.3%²⁵. This is much improved from the Solihull 2007/08 value of 6.7%²¹.

The commonest methods of contraception selected by CSRH first contact female users in 2011/12 in the West Midlands were **user dependent methods**²⁶:

1. Oral contraceptive (38%)
2. Male condom (35%)

The next commonest method was LARC at 21% of all methods selected in the regional service, which was lower than the England average of 28% for 2011/12²². The value in 2009/10 for the region was also 21%²². Further information by local authority is unavailable at this stage.

Amongst male users, there is a decreasing trend nationally of the use of vasectomy (2% in 2011/12), and the male condom remains the most popular method²³.

Can we get more local SRHAD data from local providers? – SIMON will check at workshop

²² McGuire A and Hughes D, *The Economics of Family Planning Services* (London: FPA, 1995)

²³ NICE guidance on the effective and appropriate use of LARC, Oct 2005. Link: <http://www.nice.org.uk/CG030>

²⁴ Sexual Health Balanced Scorecard, APHO. Link: http://www.apho.org.uk/addons/_116634/atlas.html

²⁵ APHO dataset resources online [SRHAD data]. Link: <http://www.apho.org.uk/resource/item.aspx?RID=74108>

²⁶ NHS Contraceptive Services: England, Tables, HSCIC webpages [SRHAD data]. Link: [http://www.hscic.gov.uk/article/1165/Search-catalogue?q=title:"NHS+Contraception+Services"&area=&size=10&sort=RelevanceDesc](http://www.hscic.gov.uk/article/1165/Search-catalogue?q=title:)

Emergency Hormonal Contraception

There is limited data available from local pharmacies this financial year in Solihull on Emergency Hormonal Contraception (EHC). We know that for the 1073 requests for EHC that we have data for to date, 49% were for unprotected sex and 42% were for a failed condom. 69.4% of requests were made within 24 hours, 21.9% between 24-48 hours and 8.7% between 48-72 hours after sexual intercourse. Alcohol was implicated in 12.4% of requests. 59.6% of requests were from previous users of EHC. 95.6% of requests were approved. 74.4% were counselled about STIs. 22.7% were supplied with condoms and only 0.3% were supplied with a chlamydia test. There has been an increasing monthly usage of the service with August 2013 (most recent complete data month) having the highest request numbers. Monday is the busiest day followed by Saturday. Morrisons Pharmacy (George Road) and Boots Pharmacies (Mell Square and Greenwood Way) receive the highest numbers of requests for the service.

GUM Clinic Appointment Indicators

Rationale

The national targets set out by the *Operating Framework for the NHS in England* (2006/7 and 2007/8) for GUM clinic appointments were for 100% of clients to be offered an appointment within 2 working days and for 95% of those offered an appointment to actually be seen within 2 working days²⁷. Although the current framework does not specify performance targets in the same way, the aim of earlier assessment times in GUM services is to reduce the health burden from STIs and to hinder their transmission.

Offer and uptake of 48 hour appointments at GUM clinics²⁸:

99.8% of GUM clinic clients based in Solihull were offered an appointment within 2 working days as per national guidance, which is similar to the national average of 98.2%. Of those offered an appointment 85.9% were actually seen within 2 working days, which is below neighbouring Birmingham East and North value of 87.8% and the national average of 88.4%. 8% of those living in Solihull missed their first appointment compared to a regional average of 11.2% and a national average of 5.2%. Only 0.2% of Solihull clients were seen after 10 working days, better than the regional average of 0.8% and the national average of 1.5%.

Sexual Violence and Coercion

²⁷ Department of Health Archives.

Link: http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_4130756

²⁸ Sexual Health Balanced Scorecard, APHO. Link: <http://www.apho.org.uk/addons/116634/atlas.html>

Rationale

The health related costs of rape have been approximated to almost £73,500²⁹. Sexual assault leads to a wide range of sexual and mental health complications in victims, and sexual health services must be able to empower victims to report sexual assault as well as provide the necessary support and treatment needed.

Police recorded rape

Police reported rape in women in Solihull 2010-11 year was 38.8 per 100,000 compared to a Birmingham East and North value of 64.8 per 100,000 and an England average of 53.1 per 100,000²⁴.

Sex workers and Child Sexual Exploitation

There is very limited formal data on the sex worker population working from Solihull. It is likely the numbers are small.

Child sexual exploitation is a significant national issue. It is estimated that a large proportion of children that are sexually exploited may never report their concerns to the healthcare system due to various barriers related to their age, resources and vulnerability. It is important therefore that sexual health service providers are well informed and trained in the recognition and management of child sexual exploitation concerns and aware of the local pathways established to manage such issues.

Main Data Limitations

Please note the following key limitations to data sources for the needs assessment indicators used in this review:

- The National Chlamydia Screening Programme has emphasised that data from 2012 should be interpreted with caution due to changes in the way in which data is now reported. CTAD data from NCSP and non GUM/non NCSP sources and GUMCAD data are now combined with a de-duplication method to give overall diagnoses rates.
- GUMCAD reporting has also been affected. Now there are much higher rates of LGBT reporting and complete sets of data overall due to changes in the system. This could affect results especially where interpretations are being made of particular at risk groups such as MSM.
- Also data presented on STI prevalence before and after 2011 will be affected by population estimate changes based on the 2011 census, though given the relatively smaller increase in

²⁹ *Progress and Priorities – Working Together for High Quality Sexual Health – Review of the National Strategy for Sexual Health and HIV.* Produced for the Independent Advisory Group on Sexual Health and HIV by the Medical Foundation for AIDS & Sexual Health (MedFASH), July 2008. Link: <http://www.apho.org.uk/resource/item.aspx?RID=74998>

population in Solihull when compared to Birmingham and nationally, this is unlikely to skew data as significantly as elsewhere.

- STI diagnoses are attributed to area of diagnosis when residence data is not available which is likely to affect results to a small extent.
- Contraception data is inherently difficult to interpret due to the vast sources of contraception including supermarkets, pharmacies, GPs, CSRH services and voluntary organisations. However as LARC is only available at selected services (GPs, CSRH), the trends in LARC use are still of particular value.
- Sexual Violence and Coercion data is very limited due to national trends in underreporting, and in order to learn more about this group, increasing effort needs to be placed in empowering victims to engage with services.

Unknown Needs

Sexual Health is a sensitive subject for many people and we know that significant numbers of people who suffer from poor sexual health may not seek the support of sexual health services due to a wealth of personal reasons. Confidentiality is a particular priority to encourage trust and engagement with the population, however at times this can lead to reduced levels of data recording by sexual health services regarding the location and risk factors associated with those presenting. This will limit the completeness of data and therefore the overall reliability of the inferences we make, and to some extent will contribute to an unknown and unmet need.

We also know that for certain risk groups there is little local data available often due to difficulties in recording data (e.g. unregistered homeless, asylum seekers) or due to limited reporting (LGBT populations, victims of sexual assault, sexual exploitation in vulnerable groups such as Learning Difficulty and Looked After Children). Here it is our responsibility to recognise and cater for these unknown needs based on national trends and guidance (e.g. NICE, Department of Health).

Current Services

Simon's section

Proposed Services

Simon's Section

Conclusions and Recommendations

Conclusions

Solihull has a dynamic and changing population. While aging as a whole, there are projected increases in 25-39 year olds by 2021, a high risk group for sexually transmitted infection. The north is considerably younger than the south and has a higher burden of inequalities and associated risk factors for poor sexual health. Ethnicity too is becoming increasingly diverse, especially in the younger population and this may well pose challenges to the sexual health service currently and in the future. Changes in the religious structure of the population will also have some impact on sexual attitudes and practices.

In many respects, Birmingham already faces and has faced some of the challenges that Solihull is now beginning to see with its changing population, given that the sexual health service in Birmingham has been focused on a more ethnically and religiously diverse population. Also while aging as a whole, the at-risk age group in Solihull will also be similar to Birmingham.

Within Solihull there is a clear divide between the risk status of the north and south regions, with higher rates of under 18 conceptions in the north and greater levels of deprivation which are poor prognostic indicators of sexual health. Again particular focus must be applied to the northern boroughs where the significant burden of sexual ill-health is likely to lie.

However, it must be noted that the rural south and east of Solihull is particularly deprived in terms of access to services by public transport including primary care services, and is further from Birmingham clinics than the northern wards. When read in context with the likelihood that young adolescents/adults often will not have access to a car given the driving age, there should be some clarity on how these groups of young people that live in the south/eastern wards are expected to access sexual health services. ? Simon to add concern: Gary says that Heartlands is difficult to get to from Solihull– is this where the main clinic is?

Simon to add concern re: ?Birmingham commissioning of community sexual health services planned for 15-24s and GP referral for >25 - but given the changing age profile prediction by 2021 (increasing over 25s projected – will the community services neglect our older population?) – cannot quite recall what exactly you had implied here Simon

Before 2011 there had been a decreasing trend in under 18 conceptions in Solihull, with lower than national values. There has been a moderate increase in under 18 conceptions in 2011, and this figure will need close observation.

Abortion rates and repeat abortion rates are higher for Solihull than the England averages, and while there has been an overall decreasing trend in abortion rates nationally over recent years, the opposite is true for Solihull. There is data that more affluent populations have higher abortion rates due to better access to services which limits the inference of this data, especially given the generally lower levels of deprivation in Solihull than elsewhere. What is somewhat concerning however is that the rates of repeat abortions remain higher than regional and national averages, and more should be done to reduce the risks of future abortions on first presentations. What is encouraging however is

that abortions are performed much earlier (<10weeks) in general than neighbouring regions and nationally, which has significant health and cost benefits.

STI diagnoses in Solihull increased by 39% overall compared to just a 5% rise in STI diagnoses nationally in the same time frame. While this rise must be taken seriously, it must be noted that due to changes in the way data is now collected in sexual health services, much of this may not reflect a true rise in incidence. In any case, despite the recorded rise in incidence in Solihull, STI diagnoses rates are still lower than the regional average.

Chlamydia is a key area of concern as there appears to be significant reductions in the screening of 15-24 year olds, a national PHOF target area. Incidence of chlamydia is lower for the first quarter of 2013 than recent years (against the previously increasing incidence trend), although much of this may be reflected by a very significant reduction in screening in the 15-24 age group.

Anogenital herpes and anogenital warts have higher local incidence rates (over 30%) in 2012 compared to 2011, although rates are still lower than regional values, especially anogenital herpes.

Syphilis and Gonorrhoea have seen rises locally, although gonorrhoea incidence follows the national trend closely and syphilis trends are of limited value due to the very small numbers involved. MSM may be at particular risk and should be a focus group.

HIV prevalence is increasing in Solihull at a faster rate than Birmingham although the actual value of prevalence is still less than a third of that of Birmingham. HIV testing is generally well accepted by Solihull residents attending GUM clinics which may have played a role in the prevalence statistic, but offer of testing at GUM clinics should improve above regional averages to make the most of this. There are significantly less late diagnoses of HIV in Solihull compared to regionally and nationally as a proportion of all diagnoses. MSM remain a key area of focus regionally for new diagnoses of HIV.

Interestingly, under 18s from Solihull are more likely to use LARC than their regional and national cohorts, but as a whole LARC is used less across Solihull's GP attenders than regional and national levels of use in *all ages*. More should be done to make LARC a more attractive option at local GP practices and across all ages.

Emergency Hormonal Contraception services are being used more throughout this financial year with the majority of requests from previous users of EHC, implying that more should be done at initial presentations to avoid future risks. This trend will need careful monitoring, and work should be done with local pharmacies to support them in delivering the right advice and resources to those at risk. Chlamydia testing uptake rates at EHC presentation are low and this could be an area of development, especially as we face a reducing trend in chlamydia screening in Solihull across the whole sexual health service.

Unknown needs of risk groups especially Looked After Children (LAC), sex workers, victims of sexual violence and coercion, registered and unregistered homeless and vulnerably housed, those with Learning Difficulty and the LGBT community must be addressed where possible.

Key Recommendations:

1. Work with Birmingham to adapt services to an evolving population.
2. Focus on the at-risk north but do not neglect the relative lack of access to services in the south.
3. Monitor under 18 conception rates which have recently risen, concentrating on the at-risk groups in the northern boroughs especially.
4. Monitor trends in the abortion rates, aiming to reduce repeat abortions and maintain and improve the relatively high rates of early abortion.
5. Significantly improve screening for chlamydia across all services, especially in the target 15-24 group.
6. Monitor the rising STI picture in Solihull, aiming to reduce incidence but improve testing. This area is complex: more testing can mean a 'rising' incidence; given the low rates of screening recently seen for chlamydia, we should aim for higher screening rates, and likely higher incidence initially, before we can start making conclusions on the true nature of chlamydia activity locally, with the eventual goal to bring the incidence down alongside consistent high screening rates. National guidance should be consulted here.
7. Encourage LARC in general practice specifically, but also across all services and across all ages.
8. Encourage offering of HIV testing in GUM clinics, especially given the high acceptability amongst Solihull residents.
9. Help local pharmacies to develop initiatives to reduce repeat presentations for EHC and consider using EHC services to improve chlamydia screening rates.
10. Target MSM groups and those of unknown need based on national recommendations. Design services to encourage these groups to make themselves recognised, and consent for and record their risk status in sexual health records so that we may learn more about these groups and inform future strategy.

In essence, we should aim to deliver services that are suited to meet the current needs of those at greatest risk and have the durability to adapt and respond to a changing population.

Drafted September 2013 by

Simon add your name

Dr Ankush Mittal

Speciality Registrar in Public Health

Solihull Metropolitan Borough Council