Rapid Sexual Health Needs Assessment

Knowsley Primary Care Trust

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Executive Summary

Introduction
A rapid sexual health needs assessment for Knowsley Primary Care Trust (PCT) was commissioned to provide an understanding of the sexual health needs of the population and establish whether the current supply of services is adequate enough to meet them. Data from the rapid needs assessment will be used for local monitoring, planning, intervention, and control purposes. Analysis from the needs assessment will also inform commissioning and service design.

Methodology
This rapid needs assessment involved convening an expert panel to support and inform the process. Existing service use data and relevant reports, service evaluations and needs assessments were gathered to provide a background to services in Knowsley. Additionally, a sexual health service audit was carried out to confirm the location and provision of services throughout Knowsley PCT. Demographic and health profile data were collated and all data were mapped wherever appropriate. A stakeholder meeting formed a qualitative phase of intelligence gathering. The contents of this meeting were analysed using a thematic technique following the collection of notes and recordings made at the session.

Findings
Unmet needs

- Overall fewer men are accessing sexual health services than women.
- The major need in the HIV positive population is in males aged 35-39 years. Consistent with the ethnic profile of Knowsley, there are low numbers of HIV positive people from BME groups.
- Men aged over 18 years do not appear to engage with contraceptive or community based sexual health services.
- The teenage pregnancy rate in Knowsley is declining and now stands at 40.3 per 1,000 females aged 15-17 years (2006 data).
- Women aged 20-24 years are the main group accessing contraceptive services in the community. However, they also have the highest rate of terminations in Knowsley (165 in 2006).
- There are high levels of chlamydia throughout the PCT, and specifically in women between 15-29 years.
- There are particularly low levels of male chlamydia diagnoses in community settings.
- There are high prevalence levels of the key five STIs in the areas of Prescot, Page Moss, Kirkby, and Halewood.
- STI prevalence is highest amongst ‘Disadvantaged Households’ and ‘Urban Challenge’ areas (see appendix 3 for all classification definitions).
- 62% of youth service users are male which represents a reversal in service use trend when compared to the KT31 data.

Insufficient Services

- There is insufficient availability of chlamydia testing kits freely available throughout the PCT.
- The areas of Halewood, Prescot, Southdene, and Tower Hill do not have the STI testing and treatment services required to cope with the localised high prevalence of STIs.
- There is insufficient emergency contraception provision available throughout Kirkby, with the exception of a service in the town centre.

Mismatched services

- There do not appear to be any mismatches of services within the PCT. Services are generally located in appropriate areas in terms of deprivation, under 18 conceptions, population density of young people, births to lone mothers, and barriers to housing.

Duplicated Services

- There is some evidence of contraceptive and youth services operating at similar times in close proximity to each other in Knowsley (e.g. Hilton Grace youth service and Abacus service on Wednesday evenings in Halewood). It may be beneficial to the local community to change the times that these services are available.

Service Reconfiguration

- Some pharmacies in Knowsley PCT highlighted issues with the accreditation process regarding free emergency contraception.

- There are pharmacies throughout Knowsley that do not currently offer the services they were previously thought to (e.g. free emergency contraception).
- There are issues regarding the marketing of the services to the relevant populations.
- There is scope to increase the amount and quality of routine feedback from service users.

General Findings

- The stakeholder meeting was a useful exercise and identified a need to establish a network or event for service providers to share information and best practice.

This rapid needs assessment encompassed the needs, demands and gaps in sexual health services across Knowsley PCT. The data presented in the report were made available by service providers. There are some services where data were unavailable or is currently not collected (e.g. infection route of STIs).

Recommendations

- Implement routine collection of data on service users, specifically to gather knowledge of MSM, asylum seekers, sex workers, and other high risk groups. Further research is needed to establish their needs and service use.
- There is a need for service providers to identify the needs and demands of their service users. It is important that the views of service users are collected by services to inform the services of changing demands and trends in service use. It is recommended that this is done on a regular basis and can be done through the administering of questionnaires.
- Develop a system to monitor and liaise with pharmacies to enable them to re-order stock quickly, and also to address any concerns or barriers they may face when providing the free services.
- This rapid needs assessment has identified gaps in local level data as well as inconsistency of data and data fields. It is important that an integrated IT system is rolled out to ensure that data are stored and shared appropriately. Information sharing between services would make evaluating service use more straightforward. It is essential that if an integrated system is established, comprehensive training is given to service providers that include how to enter access and analyse the data.
- Currently, local HIV surveillance is detailed and comprehensive, providing information for PCTs in the North West region over and above what is available nationally. The recently established enhanced STI surveillance system in Cheshire and Merseyside collected and used disaggregated data. These data provided the opportunity for analysts at PCTs to analyse data at a small area level to identify hotspots of infection and inform services. It is recommended that this level of data collection for both HIV and STIs continues at a local level as the presentation of the data provides a useful local resource for commissioners, clinicians and HIV and STI specialists.
- Expand upon the youth service provision. This will help to address the unmet needs of young men.
- Further promotion and funding of Long Acting Reversible Contraception ought to take place.
- Provide a network or annual event for workers within sexual health to allow sexual health professionals to exchange of ideas and initiatives.

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1. Introduction and Background

1.1 National Overview

Sexual health is an integral part of physical and mental health[1]. The World Health Organisation (WHO) defines good sexual health as "A state of physical, emotional, mental and social well-being related to sexuality; 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 protected, respected and fulfilled"[2].

The decline of sexual health in the UK population is cause for concern. The rates of newly diagnosed sexually transmitted infections (STIs) and HIV continue to increase nationally. The total number of new HIV diagnoses in the United Kingdom in 2006 was 7,800 compared with 1,415 in 2001, a percentage increase of 450%. STI data show that from 2002 to 2006 there was a 12% increase in the number of new STIs diagnosed at GUM clinics across the UK. Between 2002 and 2006 there was a 30% increase in new diagnosis of chlamydia, a 26% increase in new gonorrhoea diagnosis, and a 120% increase in new diagnosis of syphilis. More locally, in 2006 the North West recorded higher than national average rates of diagnoses for the five key STIs (gonorrhoea, syphilis, chlamydia, genital warts, and genital herpes)[3]. STIs affect all age groups, ethnicities, and sexual orientations; however data show that young people under the age of 25 in the UK continue to be disproportionately affected by STIs[3]. Box 1 shows the aims from the National Strategy for Sexual Health and HIV.

Box 1 The National Strategy for Sexual Health and HIV[1]

In 2001, the Government published the national sexual health strategy, which aimed to:
- reduce the transmission of HIV and STIs
- reduce the prevalence of undiagnosed HIV and STIs
- reduce the rates of unintended pregnancies
- improve health and social care for people living with HIV; and
- reduce the stigma associated with HIV and STIs

DH (2001) The National Strategy for Sexual Health and HIV

The Government hoped to achieve their aims through, for example, the provision of clear information; ensuring there is a sound evidence base for effective local HIV/STI prevention; setting a target to reduce the number of newly acquired HIV infections; developing managed networks for HIV and sexual health services; evaluating the benefits of more integrated sexual health services[4], including pilots of one-stop clinics; beginning a programme of chlamydia screening; stressing the importance of open access to Genito-urinary Medicine (GUM) clinics and ensuring that a comprehensive range of contraceptive services are available to those who need them[1]. Specific government targets were defined in the White Paper Choosing Health: making healthier choices easier (Box 2).

Box 2 Choosing Health[5] guidance

In 2004 the public health White Paper, Choosing Health: making healthier choices easier, called for action to improve sexual health in the UK, through a £300 million investment over three years. The subsequent action plan reinforced earlier public service agreements. Clear targets were set in the paper and incorporated:

- A reduction of 50% in the rate (from 1998) of under 18 conceptions by 2010.
- All patients attending a GUM clinic to be offered an appointment within 48 hours by 2008.
- A decrease in the rate of new gonorrhoea diagnoses by 2008.
- An increase in the uptake of chlamydia screening for people between 15 and 24 years by 2008.

DH (2004) Choosing Health: making healthy choices easier.

Through government investment GUM clinics across the UK have worked towards improving patient waiting times. The 48-hour waiting time audit was established and has been in place since 2004 recording the progress of clinic waiting times. Findings from the audit reveal an improvement in waiting times between 2005 and 2008 (see section 5 for data on Knowsley). With the increased emphasis on sexual health from the Department of Health there are high-profile targets to be achieved, including the 48 hour appointment target[5]. The improvement of sexual health was one of the top six priorities for the NHS in 2006/2007 and continued

to be the case for 2007/2008. To help ensure these targets are met it is essential that comprehensive monitoring of services and service users is in place to further focus resources where they are needed most.

Government investment also produced a national campaign to promote the use of condoms. 'Condom Essential Wear' was launched and has been running since December 2006 along with the sexual health campaign for young people, RU Thinking. Both campaigns also have websites providing additional information and advice. Additional community services have been set up to provide sexual health screening for chlamydia and to provide more local and specific sexual health services for young people, for example, with one stop shops and C-card distribution schemes. More specifically, targets were set to address acute needs. For example, the National Chlamydia Screening Programme's aim to control genital chlamydia among people aged under 25 through early detection and treatment with a target to screen 15% of the eligible population (15-24 years) in 2007/2008[6]. Recent guidance outlined in 'vital signs' reassess the target for 2009/10 and suggested PCTs plan to screen 17% of the eligible population in 2009/2010 as part of tier two national priorities[7].

One of the key targets from the White Paper (see Box 3) is to reduce the under 18 conception rate in line with the 1999 Teenage Pregnancy Strategy[5]. However, there continues to be a high number of teenage conceptions in the UK, a high proportion of which lead to abortion[8]. In addition, the UK has the highest rates of teenage births in Europe. UNICEF have rated the UK as bottom of 21 'rich' countries with regard to general child health, and also report that more UK children have had sex by the age of 15 than any other country in the survey[9]. This gives rise to public health concerns because of the links between teenage pregnancy and low socioeconomic status. Research suggests that not only can teenage pregnancy have a negative impact on a young woman's academic achievement, employment, earning potential, mental health and living conditions, it can also have a negative impact on the child. The child of a teenage mother is more likely to belong to a one-parent family, be a low academic achiever, experience abuse, be involved in crime, misuse drugs and alcohol and become a teenage parent, thereby perpetuating the cycle[10].

Box 3 Choosing Health[5] and Every Child Matters[11] guidance

The Choosing Health White Paper contained a specific focus upon young people, in line with the Every Child Matters recommendations, and recognises that 'emotional well-being underpins good physical health and reduces the likelihood that children and young people will take inappropriate risks'. To this end the White Paper states that:

- extended schools can also provide, for example, One Stop Shops and multi-agency health centres located on a school site, which will enable health professionals to work alongside education and social care professionals;
- personal health guides (PHG) will encourage young people to build health into the way they live their lives;
- general information, advice and support about health issues, as well as emotional wellbeing, puberty, sexual health and access to further help and advice will be provided, for example, through a confidential email service;
- learning about health choices and managing risk will be supported, for example, through incentive schemes using reward points.

DH (2004) Choosing Health: making healthy choices easier
DfES (2003) Every Child Matters

To help achieve these aims, additional support is being given to schools in areas with the worst health and deprivation indicators. Healthy schools initiatives are beginning to have a positive effect upon health and well-being, especially in disadvantaged areas[12]. Therefore, schools are encouraged to become healthy schools with a focus upon childhood obesity and teenage pregnancy[5]. In addition to this the White Paper supports the implementation of comprehensive personal, social, and health education (PSHE). The Secretary of State for Education and Employment has also issued guidance on sex and relationship education (SRE) in schools to support schools and teachers. It is linked to the Personal, Social and Health Education Framework and the National Healthy School Standard. However, parents have the right to withdraw their child from all or part of the SRE. Furthermore comprehensive SRE is not a compulsory part of the curriculum: it remains for each individual school to decide whether to provide more than the statutory SRE; one of these non-statutory elements includes units on sexual relationships, contraception and STIs.

Further information on young people's sexual health services, through a national audit of contraceptive services[13], revealed that clinic sessions for young people have doubled from 19,000 in 1996/1997 to 40,000 in 2006/2007. In conjunction with the clinics being held, there has been an increase in attendances from

234,000 in 1996/1997 to 474,000 in 2006/2007 which indicates the demand for the services when they are provided. In total there were an estimated 4 million users of NHS contraceptive services, three quarters of whom were seen through a GP. User dependent methods of contraception (e.g. contraceptive pill) were the most common with younger age groups with 89% of women under 16. Condoms were the most popular contraceptive method in under 16s, and oral contraception was the most popular with women between 16-34 years. However, information presented in the seminar findings from the Independent Advisory Group on Sexual Health and HIV stated that young people in the UK are least likely to use contraceptives or access sexual health advice[14].

It is estimated that 30% of pregnancies are unplanned and, in order to reduce the rate of unplanned and unwanted pregnancies, the National Institute for Health and Clinical Excellence (NICE) has produced guidelines to promote long acting contraception to women[15]. The guidance promotes the use of long acting reversible contraceptives (LARC) such as the contraceptive injection, contraceptive implant and intra-uterine methods, which do not need to be remembered daily and are less susceptible to incorrect usage. The most popular methods of contraception for women in 2006-07 were the pill and condoms (46% and 28% respectively), with 21% of women, using LARC[13].

NICE also aims to improve the deficit in guidance and training available to healthcare workers in order to enable women to make informed contraceptive choices[15]. An issue with the promotion of LARC, or any method of hormonal contraception, is that it could potentially reduce the number of women using barrier method contraceptives and could contribute to the risk of STIs. However, LARC has the potential to effectively reduce the rate of contraceptive failure, the average cost of which is approximately £1500 which includes ectopic pregnancy, maternity (live births), abortion, and miscarriage. Further, it is estimated that for every £1 spent on contraceptive services, £11 is saved[16].

Sexual ill health costs the NHS more than £700 million a year[17]. Appropriate investment in sexual health services can deliver healthcare savings through preventing unplanned pregnancies and reducing the transmission of STIs including HIV. The direct cost of treating STIs (not including HIV) is approximately £165 million a year, which would increase if the cost of treating sequelae were included[16].

There is a strong correlation between sexually transmitted infections (STIs), sexual behaviour, and drug use. The implications for young people engaging in risky sexual behaviour are that they are at greater risk of contracting an STI; becoming young parents; failing at school; building up longer-term physical and mental health problems; and becoming addicted to alcohol and drugs. The most at risk young people are those:[*]

- suffering deprivation and being in lower socio-economic groups
- who are homeless
- whose parents have no aspirations or expectation of educational attainment for them
- not attending school regularly
- who have no self-worth
- who were a child of a teenage mother
- classified as looked-after children
- who have no-one to discuss intimate issues with

Recent guidance on 'one to one interventions'[18] published by NICE determines good practice for preventing STIs and reducing under 18 conceptions. Recommendations include health professionals in general practice, community health, voluntary sector and genito-urinary medicine (GUM) services should identify individuals at high risk of STIs, using the client's sexual history. Further, GPs, nurses and other clinicians should, where appropriate, provide vulnerable young people aged 18 years and under with one-to-one sexual health advice.

The Department of Health provides guidelines to help achieve targets. The 'You're Welcome' quality criteria (2007)[19] were specifically developed to aid in the promotion of young people (under 20) friendly services. The criteria covered many areas including:

- Accessibility
- Publicity
- Confidentiality
- Environment
- Staff training
- Joined up working
- Monitoring and evaluation

[*] This most at risk list is taken from 'Sex, Drugs, Alcohol and Young People'. Published June 2007 by the Independent Advisory Group on Sexual Health and HIV.

- Health issues
- Sexual and reproductive health
- Mental health services.

These criteria should be viewed as essential requirements for all PCTs, as regard to sexual health services, due to the pressing need to improve the sexual health of young people.

1.2 Knowsley

Knowsley is one of the 70 local authorities across the country that comprises the Spearhead group. Spearhead Local Authority Districts (LADs) are classed as the fifth worst LADs for health and deprivation indicators in England in 1995-97. Spearhead local authorities aim to improve geographical inequalities in life expectancy, cancer, heart disease, stroke and related diseases, faster than the national average.

Knowsley PCT, which is co-terminus with the local authority, has sought to implement local strategies with the aim of improving the poor sexual health of the population. Overarching the interventions across Knowsley is 'Raising Aspirations' which could be seen as integral to all other interventions and programmes of action. Raising aspirations encompasses work with young people and specifically vulnerable young people in secondary and special schools. The campaign fundamentally seeks to improve self-esteem amongst young people in Knowsley. Sexual health and sexual health services are high on the agenda for the PCT, with the introduction of 'Abacus' services from Liverpool, a key factor in the improvement process (provided by The Liverpool Consortium consisting of Liverpool PCT, Royal and Broadgreen University Hospitals NHS Trust and the Women's Hospital).

Department of Health guidance suggests that a needs assessment will identify the current and future health and wellbeing needs of a local population, informing the priorities and targets set by Local Area Agreements and leading to agreed commissioning priorities that will improve outcomes and reduce health inequalities[20]. A sexual health needs assessment is crucial to understand the sexual health needs of the population and establish whether the current supply of services adequately meet the needs.

Aims

The present needs assessment was jointly commissioned by Knowsley PCT and Liverpool PCT and implemented by the Centre for Public Health at Liverpool John Moores University. Knowsley and Liverpool PCTs have acknowledged that whilst services must be responsive to local need there are some commonalities across the health economy and for this reason, wherever possible, it makes sense to work together in order to prevent duplication of effort and resource.

The aims of the assessment were to gain a full understanding of the needs, demands, and gaps in services by collating already existing data, including insight from local experts, into an assessment with recommendations for planning and monitoring. These data were collected and the assessment carried out by:

• Mapping need
• Examining demand
• Mapping service provision
• Assess gaps between these factors
• Making recommendations as to how sexual health services could better meet the needs of the population.

2. Methodology

The rapid needs assessment was jointly commissioned by Knowsley PCT and Liverpool PCT. The project was undertaken over a period of two months, from 1st February to 31st March 2008.

A standard methodology for a rapid needs assessment has recently been developed[21]. This guidance was adopted to inform the present work. Rapid needs assessments aim to review the needs of risk groups within a population using existing reports, surveys, demographic and service data to build up an understanding of need and demand. Key informants provide additional information especially in relation to specific risk groups where existing data provide limited or no information. A thorough analysis of all data is carried out to identify gaps or duplicated effort in relation to service provision; to determine where services can be reconfigured and to highlight limitations of existing information on specific risk groups. This rapid needs assessment also included a sexual health service audit of opening times and service provision. Further data were obtained through an intelligence gathering exercise with stakeholders and key informants, which helped to provide context to the service use data.

In the initial phase of the needs assessment an expert panel was convened to contribute to and support the needs assessment process. The expert panel consisted of public health and sexual health commissioners, sexual health service managers, a teenage pregnancy co-ordinator, children's services representatives, adult social care representatives, a local chlamydia screening coordinator, and public health analysts. The panel met once and acted as a virtual group thereafter. The expert panel fulfilled one of the initial stages of intelligence gathering by providing up to date information on relevant sexual health services in Knowsley PCT and by providing details of previous service evaluations, needs assessments and additional service and population data that would help inform the rapid needs assessment.

A list of sexual health services was collated and circulated to the expert panel. This list served as the basis for mapping the services and the subsequent audit of opening times and service provision. The audit of sexual health services provided across Knowsley was completed through telephone questionnaires, email requests, and also internet searches. Each service was contacted to ensure the most up to date information for all areas. Please see appendix 1 for a copy of the questionnaire used when contacting the services to confirm or establish opening times, staffing levels and types of services offered. This audit also provided qualitative data regarding barriers to services and service provision (see section 5 and appendix 2).

An outside consultant, Andrew Bennett, coordinated, facilitated and presented findings from the stakeholder meeting which formed a qualitative phase of intelligence gathering. Invitations were sent out to 49 people working in sexual health throughout the Knowsley PCT and Liverpool PCT, including all members of the original expert panel. The list of key contacts was constructed by members of the expert panel. The meeting was attended by 32 people from both Liverpool PCT and Knowsley PCT, however there was higher representation from Liverpool PCT. Participants included a range of service providers including sexual health nurses and voluntary service workers amongst others. The content of this meeting was analysed following the collection of notes and recordings made at the session.

All data that were able to be broken down by a geographical area and where it was deemed appropriate were mapped by Geographic Information Systems (GIS). Where possible, mapping was done by Lower Super Output Area (LSOA) which is an area with an average population of 1,500 people, or by Middle Super Output Area (MSOA) which is an area with an average population of 7,000 people. Selected services are displayed on maps along with other data (e.g. Teenage pregnancy rates). Maps that are relevant to each other are shown side by side. Services were also displayed on Ordnance Survey maps to show where they are in location to schools and transport links.

3. PCT Profile

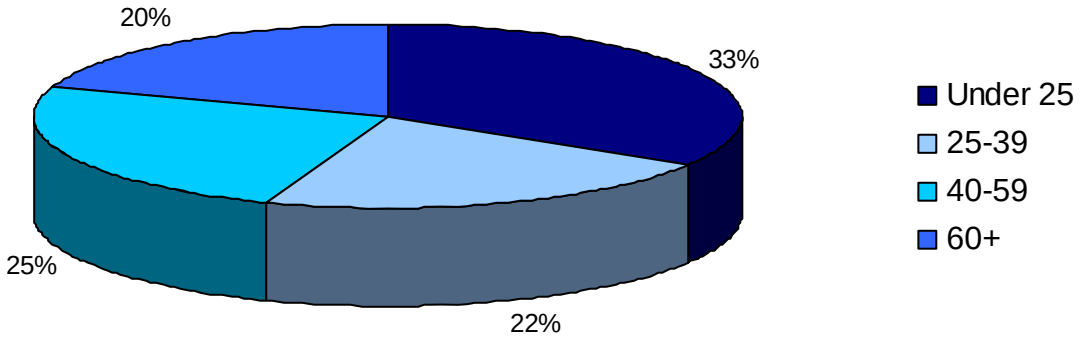
Knowsley Primary Care Trust (PCT), an area co-terminus with Knowsley Local Authority (LA), came into existence in October 2006. It replaced the previous PCT structure in which Knowsley was joined with the St Helens area to form 'Knowsley and St Helens PCT'.

Knowsley LA is one of 70 local authority areas identified as a Spearhead Area. The Spearhead Group was established based on local authority areas in the bottom fifth nationally for three or more health indicators and to target these inequalities[22]. As Knowsley is classed as a Spearhead Local Authority District (LADs), the Public Service Agreement (PSA) targets require Spearhead local authorities to reduce the gap in life expectancy between themselves and England by 10% by 2010 from the baseline of 1995-97. Currently, Knowsley is on target to achieve the life expectancy improvement for males but not for females[23].

3.1 Demographic Profile

The age proportions of Knowsley are generally representative of the North West as a whole. **Figure 3A** shows the largest proportion of the population are aged under 25 and over 60 years representing 33% and 25% respectively. Further breakdown of age is available in **table 3A** showing estimated numbers and gender proportions of people in each age group. Overall there are a slightly higher proportion of female (53%) residents in Knowsley than of male (47%).

Figure 3A Age profile of population in Knowsley



Source of data: 2001 Census, Office for National Statistics © Crown Copyright

Table 3A Age group by sex in Knowsley

Age Group	Sex				
	Males		Females		Total
0-14	14,942	*51%*	14,532	*49%*	29,474
15-19	5,817	*50%*	5,707	*50%*	11,524
20-24	4,929	*51%*	4,824	*49%*	9,753
25-29	3,620	*47%*	4,089	*53%*	7,709
30-34	4,327	*47%*	4,946	*53%*	9,273
35-39	5,480	*47%*	6,227	*53%*	11,707
40-44	5,534	*46%*	6,513	*54%*	12,047
45-49	5,036	*47%*	5,675	*53%*	10,711
50-54	4,335	*48%*	4,714	*52%*	9,049
55-59	4,075	*48%*	4,414	*52%*	8,489
60+	12,805	*43%*	16,852	*57%*	29,657
Total	**70,900**	***47%***	**78,493**	***53%***	**149,393**

Source of data: 2001 Census, Office for National Statistics © Crown Copyright

Figures 3B and 3C demonstrate the dispersion of younger people (under 25) in Knowsley. The figures illustrate the areas where there are high concentrations of young males and females. This information could be valuable when considering where to place youth orientated services. Figure 3B shows the percentage of the male population who are under 25 by LSOA, and shows that there are high concentrations around

Huyton, Prescot, and Kirkby. These are also the most densely populated areas in the PCT. In these areas the young males contribute between 42-49% of the general population. Figure 3C illustrates the percentage of the female population who are under 25 by LSOA. The young female population mirrors that of the young males with the highest concentrations in Huyton, Prescot, and Kirkby. Female youths contribute between 36-42% of the general population in these areas. Conversely, the areas around the south of Whiston and Knowsley Village have the lowest percentages of males and females under the age of 25.

Figure 3D shows the non-white population of Knowsley as a percentage of the total population by Lower Super Output Area (LSOA). The map shows that residents of white ethnicity comprise 98% of the PCT residents. The map shows a limited amount of ethnic diversity, with the non-white population of eastern Prescot, Halewood and Knowsley Village representing 2.87%-15.8% of the total population.

3.2 Health and deprivation

The link between ill-health and deprivation has also been highlighted as an issue within the North West region[24]. Reducing health inequalities in general and in sexual health continues to be a high priority[25,26,27,28,29]. *The National Strategy for Sexual Health and HIV* acknowledged the relationship between sexual ill-health, poverty, social exclusion, and the disproportionate burden of HIV infection on men who have sex with men and certain ethnic minority groups. With regard to teenage pregnancy, it recognised that there are links between deprivation, termination of pregnancy and teenage conception and that unintended pregnancy increases the risk of poor social, economic and health prospects for mother and child[27.] It is also acknowledged that children born to teenage mothers are much more likely to become teenage parents themselves[30]. Deprivation and health, including sexual health, are inextricably linked. Examining health indicators helps us to understand at a local level the general and sexual health of the population, in particular the population at risk of sexual ill-health.

3.2.1 Health Indicators

There are several indicators in Knowsley's 2007 health profile[31] which show that the populations health is below national and regional levels. Life expectancy in Knowsley PCT for both males (73.9 years) and females (78.2 years) is below the national average (76.9 years for males, and 81.1 years for females) and represents one of the lowest in the UK (total range from 72.5 years to 86.2 years). The percentage of adults who eat healthily is the lowest in the country. Furthermore, findings show that Knowsley residents perceive their own health to be significantly worse than both the national and regional average perceptions. This trend is mirrored in terms of mental health, stays in hospital due to alcohol, child tooth decay and people with diabetes. Health indicators also reveal that Knowsley has significantly higher rates of adults who smoke and binge drink. These factors subsequently impact upon the mortality rate relating to smoking, heart disease, strokes and cancer; all of which are significantly higher in Knowsley than the national average.

There are several negative sexual and reproductive health indicators which are worse than the national average; specifically, the high rates of ectopic pregnancy, cervical carcinoma, cervical cancer, and coverage of breast and cervical screening. There are lower than average rates for abortions performed under 10 week gestation, however this is overshadowed by the fact that Knowsley has a higher than average rate of abortion. The picture for male inhabitants of Knowsley is slightly more mixed, with very high levels of erectile dysfunction drugs used, however there are lower than average levels for testicular cancer. Knowsley LA also has a lower than average rate of general fertility, total fertility and emergency contraceptive use. Further, the rate of combined hormonal contraceptive use is lower to that of the rest of the North West region[32].

3.2.2 Health of young people

Children and young people's health indicators for the North West region show that Knowsley LA has significantly higher levels of absences and permanent exclusion from school. Further, Knowsley has a significantly lower than national average GCSE achievements. There are also a very high proportion of children subject to the Child Protection Plan. However, Knowsley has a significantly lower than national average rate for female hospital admissions due to alcohol[33].

3.3 Deprivation

The strong relationship between deprivation and ill-health in industrialised countries has been well documented since the publication of the 1980 Black report[34]. In the UK, groups of people with low socio-economic status have been characterised by higher-risk sexual behaviour, and are therefore at greater risk of contracting STIs including HIV. A study on men who were part of the "gay scene" in the West Midlands found that social class and employment were related to the adoption of safer sex practices, with manual workers or unemployed people inconsistent with safer sex practices[35]. The link between deprivation and early age (13-15 years) sexual activity was reinforced in a study which found that deprivation significantly increased the likelihood of early sexual activity, particularly among young women. In addition both area and

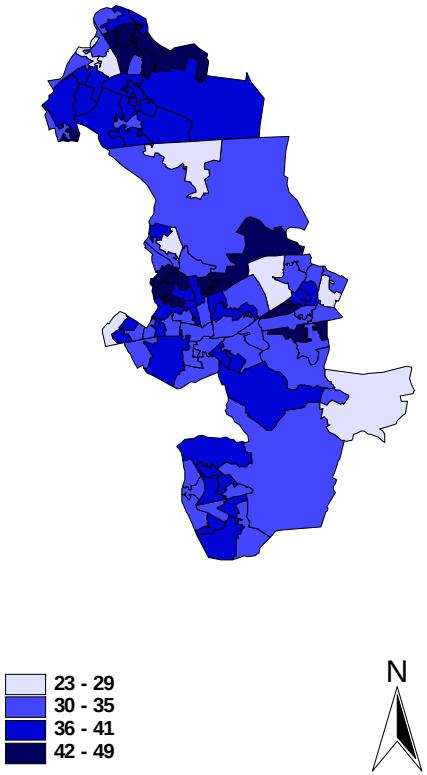
family deprivation significantly reduced life expectations. Living in a deprived area increased early sexual activity much more markedly among girls in deprived families[36].

Figure 3E shows the index of multiple deprivation (IMD, 2007) national quintiles by lower super output area (LSOA). Much of Knowsley falls within the poorest fifth of the country, with no areas falling into the least deprived national quintile. **Figure 3F** shows Knowsley LSOAs split into quintiles locally so that comparisons can be made across the area. Areas of north Knowsley (including Kirkby), and Huyton fall into the most deprived local quintile. If we consider that Knowsley, in comparison to the rest of England and Wales, is deprived we see that these areas are especially deprived.

Figure 3G shows barriers to housing and services by middle super output area (MSOA) for Knowsley. Barriers to housing and services are split into two sections: 1) Wider barriers, which include levels of household overcrowding, percentage of households who have had a decision on their application for assistance regarding homeless provisions made and difficulty in access to owner occupation. 2) Geographical barriers, which include road distance to GP surgery, road distance to general stores or supermarket, road distance to primary school and road distance to post office or sub post office[37]. The map shows that Kirkby and Halewood have the highest rate. However, as the map is only to MSOA it is difficult to highlight specific locations within these areas due to the score being averaged over a large geographical area with low population density.

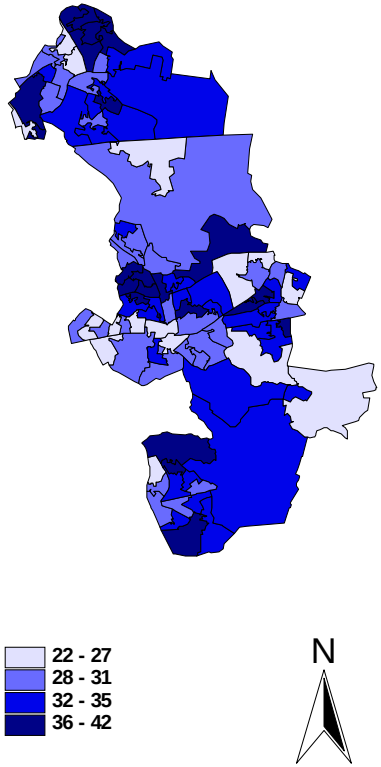
The income support claimant rate is a measure of income deprivation and **Figure 3H** shows income claimant rate as a ratio compared to the North West average of 100. The map shows that Huyton and Prescot are areas with high levels of claimants. This, higher than national average, level continues north through Knowsley and peaks again around the areas of Southdene and Northwood within Kirkby. Below the middle geographical band of Huyton and Prescot there is a reduction in the level of claimants which drops below the national average. This encouraging trend is punctured by a high level of claimants in the south Halewood area.

Figure 3B Percentage of the male population who are aged under 25 in each LSOA, Knowsley



Source of data: Mid-2005 population estimates. Office for National Statistics © Crown Copyright 2007
Source of map boundaries: 2001 Census, Output Area Boundaries. © Crown copyright 2003

Figure 3C Percentage of the female population who are aged under 25 in each LSOA, Knowsley



Source of data: Mid-2005 population estimates. Office for National Statistics © Crown Copyright 2007
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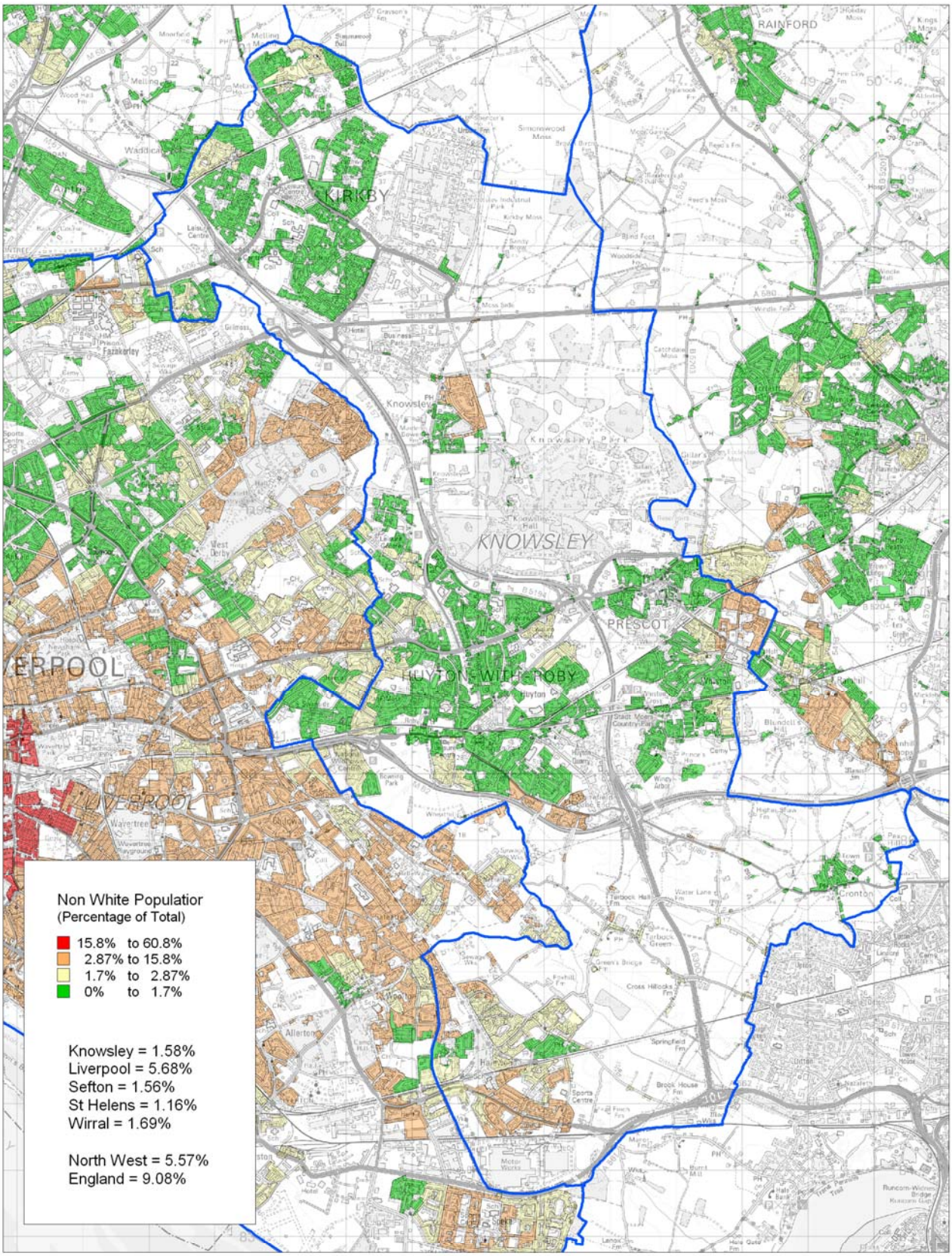
Figure 3D Non-white populations as a percentage of the total population for the residential areas of Knowsley

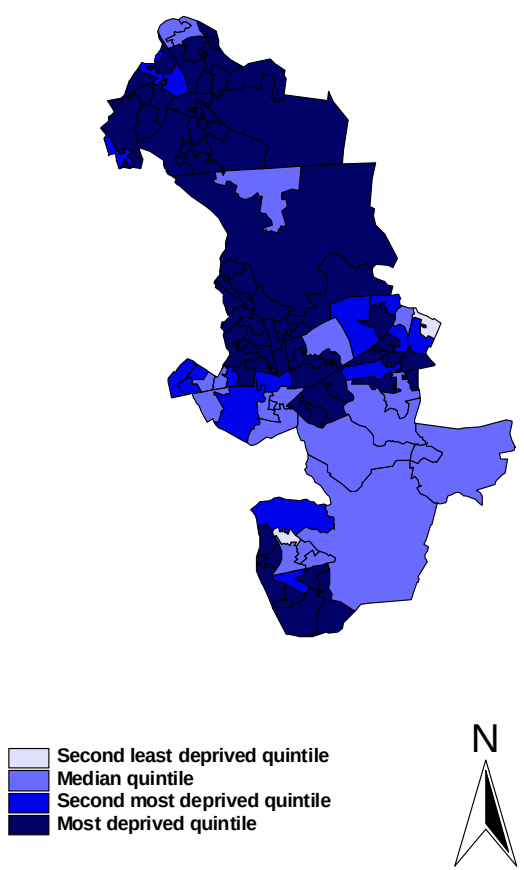


'Non White' population as a percentage of the total population for the residential areas of Merseyside.

Knowsl@y Council

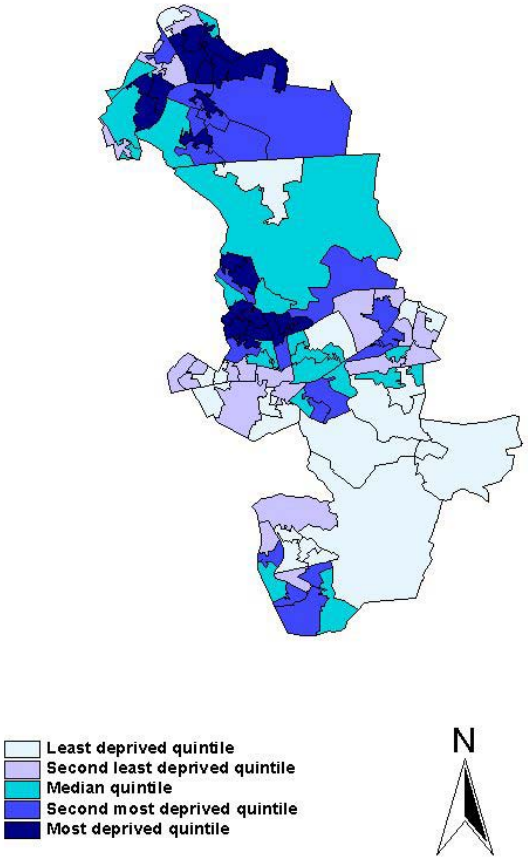
Knowsley NHS Primary Care Trust

Figure 3E Index of Multiple Deprivation (IMD 2007) national quintiles by LSOA, Knowsley



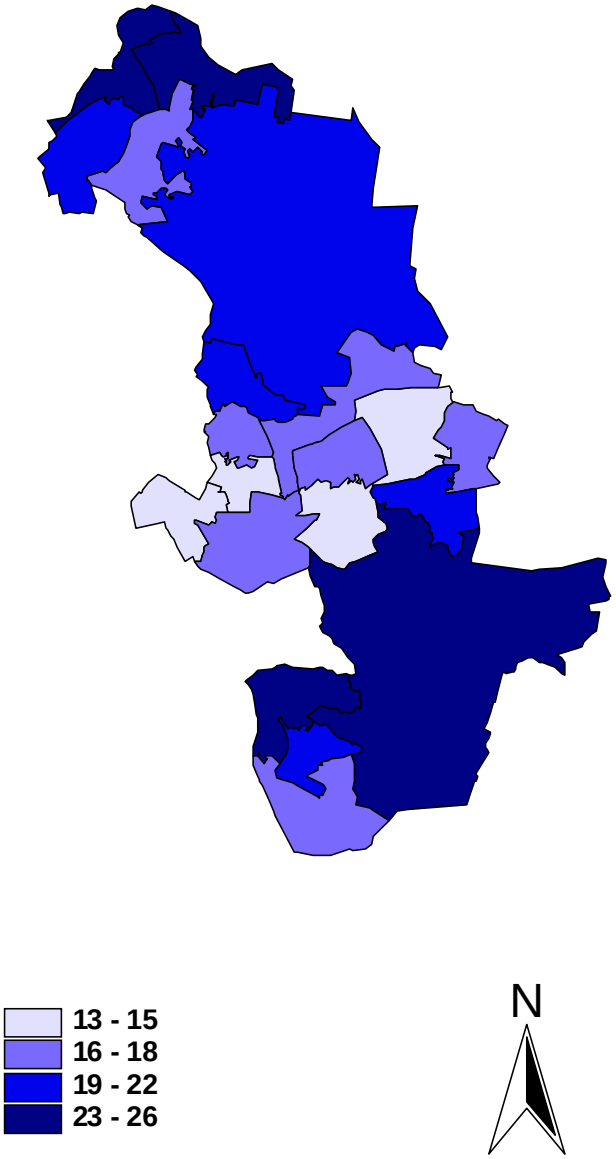
Source of data: Department of Communities and Local Government, Indices of Deprivation 2007
Source of map boundaries: 2001 Census, Output Area Boundaries. © Crown copyright 2003

Figure 3F Index of Multiple Deprivation (IMD 2007) local quintiles by LSOA, Knowsley



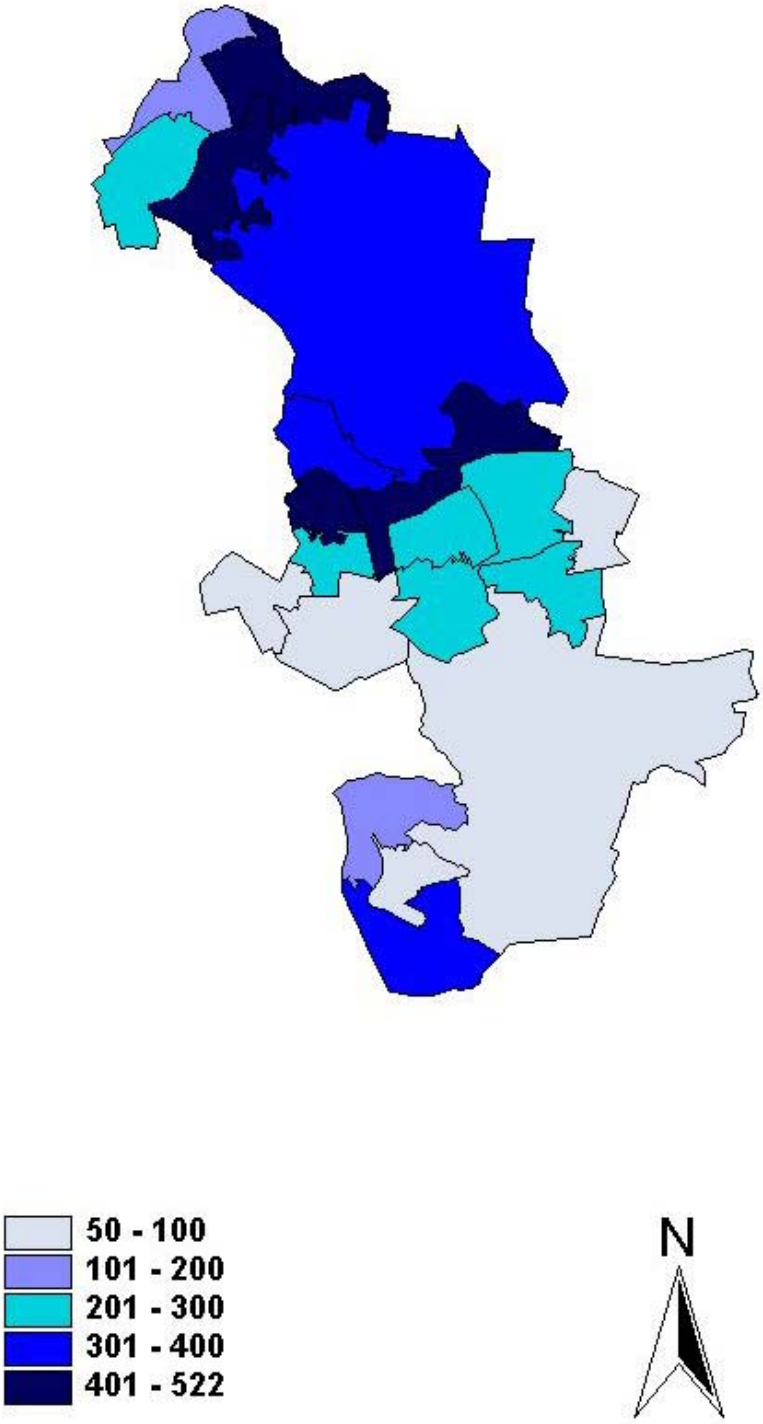
Source of data: Department of Communities and Local Government, Indices of Deprivation 2007
Source of map boundaries: 2001 Census, Output Area Boundaries. © Crown copyright 2003

Figure 3G Index of Multiple Deprivation: barriers to housing and services by MSOA, Knowsley



Source of data: North West Public Health Observatory.
Source of map boundaries: 2001 Census, Output Area Boundaries. © Crown copyright 2003

Figure 3H Income support claimant rate by MSOA, Knowsley
Data provided here is a ratio against a North West Regional Average of 100.



Source of data: North West Public Health Observatory.
Source of map boundaries: 2001 Census, Output Area Boundaries. © Crown copyright 2003

4. Need

The rationale behind this section is that service user needs must be examined in order to understand the sexual health needs of the PCT and to establish whether or not these needs are being appropriately met.

4.1 Overview of needs

Nationally, sexual behaviour is changing over time. The *National Survey of Sexual Attitudes and Lifestyles (NATSAL)* reported a number of ways sexual behaviour has changed between their two surveys in 1990 and 2000. There are higher rates of new partner acquisition in under 25s and amongst those who are not cohabiting or married. There has been an increase in total numbers of heterosexual and homosexual partners, concurrent partners, heterosexual anal sex and payment for sex. Also, the proportion of people who reported two or more partners in the past year and did not use a condom consistently increased over the ten year period[38]. There were also a higher proportion of young women in the UK who had heterosexual sex before the age of 16 in the 1990s than in the previous decade, and the median age at first intercourse for males and females has fallen[39]. More recently, the *Contraception and Sexual Health 2006/07* survey showed that of men under the age of 70 and women under 50, 12% and 10% respectively had had more than one sexual partner in the last year[40].

Those most at risk of sexual health problems include men who have sex with men (MSM), black and minority ethnic (BME) groups and young people. However, sexual health problems are more prevalent in certain individuals or groups who find it most difficult to access services and these include: asylum seekers and refugees, sex workers and their clients, those who are homeless and young people in or leaving care[18].

Information on the general and sexual health needs of travellers and gypsies in the UK is sparse and this group are relatively hidden in terms of their needs. It is known however, that travellers have significantly poorer health status than other (English-speaking, UK resident) ethnic minority groups and deprived white UK residents. As well as increased levels of ill health, access and use of services is also poor. In terms of sexual health specifically, embarrassment about discussing health concerns relating to sexual health has been found to be a common reason for avoiding accessing health care[41].

This section will look at the sexual health needs of Knowsley PCT by illustrating prevalence of STIs and their relationship with deprivation, local chlamydia screening, HIV, and teenage pregnancy.

4.2 People with Sexually Transmitted Infections (STIs) and HIV

Nationally, the HPA have identified specific groups to target for HIV and STI prevention. It is known that young adults (aged under 25 years) are disproportionately affected by STIs, young women are disproportionately affected by gonorrhoea and genital warts and that increases in all STIs between 1997 and 2006 have been more pronounced in young men than young women, in particular those aged between 16 and 19. In addition, MSM are disproportionately affected by HIV, and those of black African ethnicity are at higher risk of HIV. Furthermore, young people from black Caribbean backgrounds have a higher incidence of chlamydia and gonorrhoea compared with any other ethnic group[3]. However, in Cheshire and Merseyside in 2006, for the majority of infections (STIs) diagnosed, the individuals were of white ethnicity[42].

In the North West of England, in 2006, there were 4,761 HIV positive people in treatment and care. The predominant mode of exposure to HIV is MSM (53%), followed by 40% who were exposed through heterosexual sex. Over a third of people in treatment and care were infected outside of the UK and most (81%) of these were infected through heterosexual sex. Two-thirds of the people in treatment and care for HIV in the North West region whose ethnicity is known are of white ethnicity with black and minority ethnic (BME) communities making up the other third. Individuals of black African ethnicity make up the largest proportion of the BME population with HIV[43]. Individuals with HIV have varying and often complicated social needs in conjunction with their medical care. Support is needed with respect to welfare, benefits, housing, advocacy issues and financial issues. Support services are also necessary for those affected by HIV, such as families, partners, children, and friends.

4.2.1 Vulnerable groups with HIV and STIs

MSM

Sigma research presents a yearly report on gay men which is broken down by strategic health authorities. The results for the North West in 2006[44] were compiled from 974 gay men from all over the region. Although some sampling was attempted in Knowsley, there were no respondents. There were respondents from the neighbouring PCTs of Liverpool, and Halton and St Helens. In these areas, there was a less than average willingness to self-define sexual identity as gay. Also, both areas reported a higher than average rate for living with others who are not their male partner.

Over a third of men involved in the Gay Men's Sex Survey (GMSS) (2005) had used a GUM clinic in the last year and there was a positive association between higher numbers of male sexual partners and GUM clinic attendance. However, 40% of men with more than 30 male partners in the last year had not been to a clinic in the same time period[45]. In the North West, 37% of respondents to the GMSS had never been tested for HIV and a higher percentage (46%) had never been tested for hepatitis C. Most men had between two and four male sexual partners in the previous 12 months and 11% had 30 or more male sexual partners. Almost half of the respondents in the North West (48%) have had unprotected anal intercourse in the last year whilst 36% have had anal intercourse but always protected[46]. Although these data on sexual behaviour reflect that of other regions in the UK, it is clear that risk-taking behaviour is still an issue within the region. There were results to suggest that men would like more ways of meeting other gay men that did not revolve around sex. These findings could serve as a platform to build on for services in the local community who could offer an opportunity for gay men to meet that did not revolve around sex, an opportunity that could provide an outlet for sexual health information for this high risk group. There was also a positive feeling regarding the promotion of health among gay and bisexual men, which again represents a platform to build upon when trying to improve the sexual health of the population.

Data also show that MSM populations are more likely to have more general health needs through smoking, alcohol and drug use. As a population, they are also more likely to have suffered abuse or attacks[45]. There are also specific sexual health needs such as information on safer sex, HIV and STI testing, and support for MSM with HIV such as counselling services and social support.

Asylum seekers
Asylum seekers have a range of issues, from coping with the transition from one country and culture to another, uncertainty over immigration status, financial status, deprivation, marginalisation, stigmatisation and potentially, mental health issues[47]. Asylum seekers with HIV are a particularly vulnerable group of immigrants. In the North West of England, in 2006, 917 individuals accessing HIV treatment and care were classed as non-UK nationals, and over half of these (54%) were asylum seekers. Of the asylum seekers in treatment and care for HIV, the majority (69%) were female[43].

Refused asylum seekers
In the UK, healthcare for asylum seekers is free of charge[48,49], however until recently, refused asylum seekers (with the exception of emergencies) were no longer entitled to free healthcare in a hospital, including HIV treatment. It can take weeks or months before refused asylum seekers can be returned to their countries making this group one of the most vulnerable[47,50]. A ruling in the High Court in April 2008 has now changed the situation, enabling HIV positive refused asylum seekers to remain in treatment and care for HIV for as long as they remain in the UK, although it is possible that this decision may be challenged by the Department of Health[51]. However, asylum seekers generally face barriers to screening and GP services which may increase their feeling of stigmatisation and reluctance to seek help. It has been noted that refused asylum seekers with HIV are becoming destitute leading to the possibility of trading sex in order to survive[52]; which may consequently increase the onward transmission of both HIV and other STIs.

4.2.2 Sexually Transmitted Infection data
The data presented in this section were collected by the sexual health team at the Centre for Public Health as part of an enhanced surveillance system across Cheshire and Merseyside. As the data collected is more comprehensive than the current KC60 data, it is not possible to make comparisons beyond the Cheshire and Merseyside area. The enhanced system picked up an additional 110 diagnoses across Cheshire and Merseyside compared to the current KC60 method.

Figure 4A shows prevalence of the five key STIs (primary and secondary syphilis, uncomplicated gonorrhoea, uncomplicated chlamydia, genital herpes and genital warts) diagnosed in genito-urinary medicine clinics in Cheshire and Merseyside throughout 2006. The data are residence based and do not include any data from community testing sites. Findings from Knowsley show the highest STI prevalence (between 572 and 1,093 per 100,000 population) in parts of Prescot, Page Moss, Kirkby, and Halewood.

Table 4A shows the prevalence (per 100,000 population) of the key five STIs in Knowsley PCT. The overall prevalence figures are heavily driven by the chlamydia figures for both males and females, which is a trend seen across Cheshire and Merseyside. Uncomplicated chlamydia was the most prevalent infection (189 per 100,000 population) and was greater amongst males than females residing in Knowsley PCT. However, when community data are included in the calculations (see **Table 4C**), prevalence is higher amongst females than males, reflecting the higher number of females screened in the community, as is the case nationally[3].

Table 4B presents the prevalence of the key five infections by age group for Knowsley PCT. Data show that those aged 20-24 years have the highest prevalence (2,040 per 100,000 population), with 15-19 year olds

representing the next highest (1,718 per 100,000) revealing a high prevalence of chlamydia (833 per 100,000) and highest prevalence of gonorrhoea overall (251 per 100,000 population). The only STIs reported in the over 50s are genital herpes and genital warts. However, data show a low prevalence for both infections. This differs from other areas in the region (e.g. Liverpool PCT and Sefton PCT) where there is also prevalence for gonorrhoea and chlamydia in those aged over 50 years.

Table 4C displays the prevalence of chlamydia using both GUM and community data from the National Chlamydia Screening Programme (NCSP) testing sites. In Knowsley PCT, the total numbers of community diagnoses were 236 compared to the 265 diagnosed in GUM clinics. Combining the data gives total prevalence estimates of 335 per 100,000 population. A greater number of females were diagnosed in the community than in GUM providing a prevalence of 405 per 100,000 females in Knowsley. Conversely more males were diagnosed in a GUM setting than a community setting providing a prevalence of 258 per 100,000 males in Knowsley. This may be due to availability and practicality of testing for male chlamydia in a community setting. Knowsley has the second highest prevalence of chlamydia in comparison with the rest of Cheshire and Merseyside. Although males constitute a lower proportion of the figures than females, it is encouraging that males seek testing in both community and GUM settings. It is likely that the GUM and community settings appeal to different populations of men, with the MSM population seeking testing in a GUM setting and the heterosexual population seeking testing in a community setting.

In terms of ethnicity, in Cheshire and Merseyside in 2006, for the majority (88%) of the key five infections where ethnicity was known, individuals were classified as white and the percentage was greater for those infections diagnosed at the Royal Liverpool University Hospital (94%). There were 119 cases of chlamydia where the individuals were from black or minority ethnic backgrounds. The greatest number of diagnoses attributed to people of white ethnicity were genital warts (1,440 cases), followed by chlamydia (1,383 cases)[42].

Table 4A Prevalence (per 100,000 population) of key infections diagnosed in GUM clinics by sex for Knowsley PCT, 2006

Infection	Prevalence		
	Male	Female	Total
Knowsley PCT			
Primary and secondary syphilis	7.1		3.3
Uncomplicated gonorrhoea	40.9	26.8	33.5
Uncomplicated chlamydia	189.0	166.9	177.4
Genital herpes	22.6	35.7	29.5
Genital warts	159.4	119.8	138.6
Total†	**418.9**	**349.1**	**382.2**

† Total prevalence calculation includes double counting of individuals with more than one infection.
Source of data: Enhanced Surveillance of Sexually Transmitted Infections in Cheshire and Merseyside, 2006.

Table 4B Prevalence (per 100,000 population) of key infections diagnosed in GUM clinics by age group for selected PCT of residence, 2006

	Prevalence by age group											Total
	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	
Knowsley PCT												
Primary and secondary syphilis		8.7		25.9		8.5		9.3				3.3
Uncomplicated gonorrhoea		251.6	92.3	64.9	32.4	17.1	8.3	9.3				33.5
Uncomplicated chlamydia		833.0	1025.3	518.9	172.5	59.8	33.2	18.7				177.4
Genital herpes		104.1	143.5	51.9	32.4	42.7	24.9	18.7			14.9	29.5
Genital warts		520.7	779.2	415.1	129.4	94.0	58.1	28.0	33.2	35.3		138.6
Total†		**1718.2**	**2040.4**	**1076.7**	**366.7**	**222.1**	**124.5**	**84.0**	**33.2**	**35.3**	**14.9**	**382.2**

† Total prevalence calculation includes double counting of individuals with more than one infection. Totals may not add up due to rounding.
Source of data: Enhanced Surveillance of Sexually Transmitted Infections in Cheshire and Merseyside, 2006.

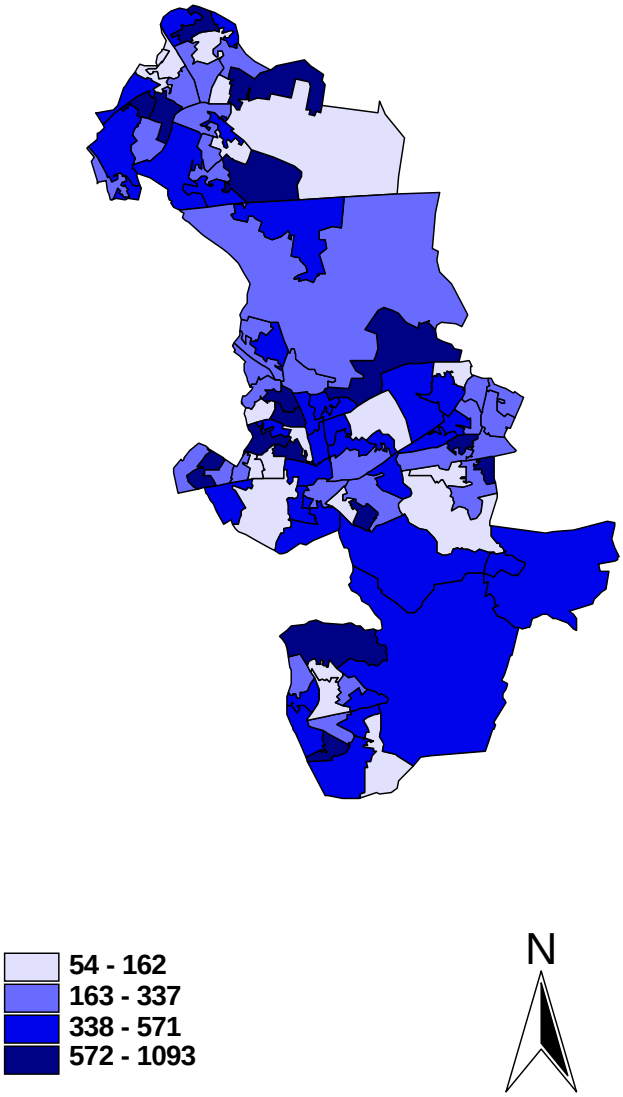
Table 4C Number and total prevalence (per 100,000 population) of chlamydia diagnosed in GUM and community settings* for selected PCT of residence, 2006

	Setting	Male	Female	Total
Knowsley PCT	GUM (number)	134	131	265
	Community (number)	49	187	236
	Total number	**183**	**318**	**501**
	Prevalence	**258.1**	**405.1**	**335.4**

*The total chlamydia prevalence is indicative only.
Note: Caution is needed when interpreting the results as it is possible that an individual has been tested both in the community and in a GUM setting for the same episode of chlamydia infection.
Source of data: Enhanced Surveillance of Sexually Transmitted Infections in Cheshire and Merseyside, 2006.

Figure 4A Prevalence (per 100,000 population) of key five sexually transmitted infections* diagnosed in GUM, Knowsley

* Key five infections: primary and secondary syphilis, uncomplicated gonorrhoea, uncomplicated chlamydia, genital herpes and genital warts



Source of data: STI data - Sexual Health Team, Centre for Public Health. Population data - Mid-2005 population estimates. Office for National Statistics © Crown Copyright 2007

Source of map boundaries: 2001 Census, Output Area Boundaries. © Crown copyright 2003

4.2.3 Sexually Transmitted Infections and Deprivation

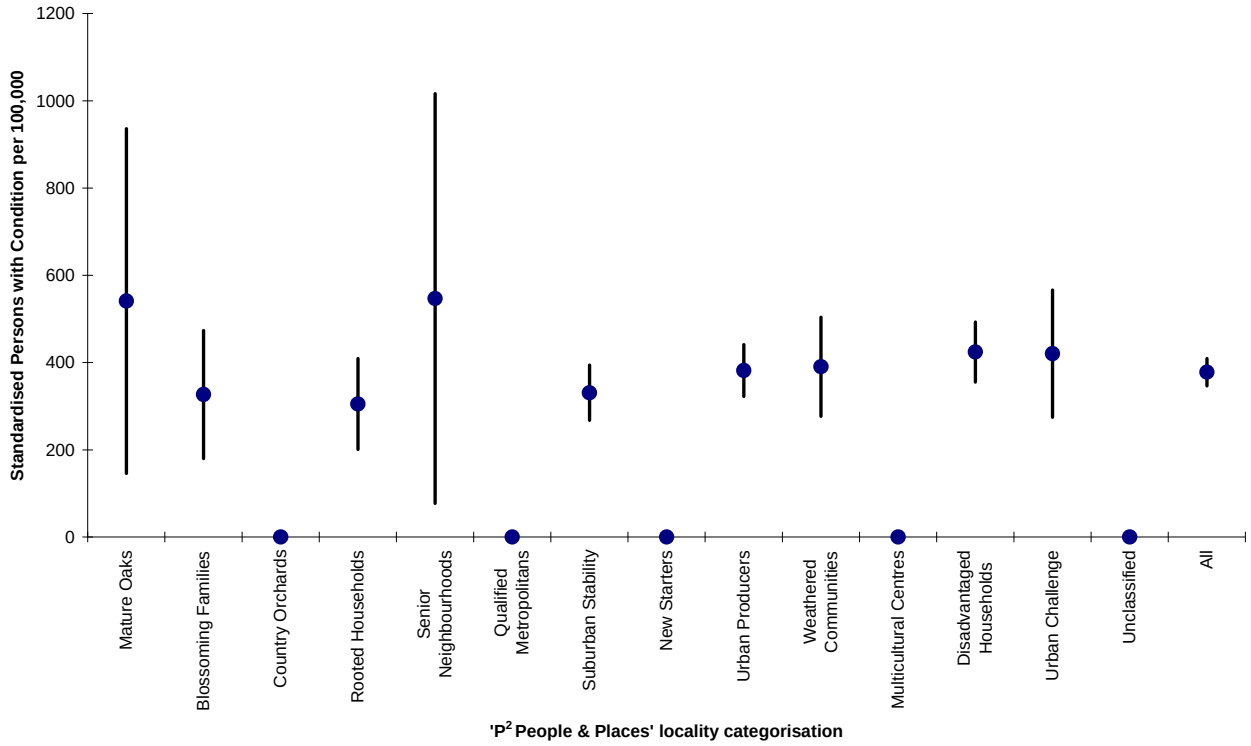
Figure 4B illustrates the prevalence of the key five infections diagnosed in GUM. The figure uses 'P^2 People and Places' which is a population segmentation tool based on 2001 Census data, Target Group Index data (TGI, which provides descriptive information), and geography to classify people by where they live. Classifications increase in level of deprivation from left to right with 'Mature Oaks' representing the least deprived and 'Urban Challenge' representing the most deprived group (please see appendix 3 for a definition of all classifications). Figure 4B shows that there are no areas in four classifications within Knowsley. The four classifications are: Country Orchards, Qualified Metropolitans, New Starters, and Multicultural Centres. Although initial indications from figure 4B suggest large STI prevalence in both 'Mature Oaks' and 'Senior Neighbourhoods', the confidence intervals are too large to state prevalence reliably due to small numbers of people residing in these areas. The group with the highest STI prevalence is 'Disadvantaged Households', which has a slightly higher prevalence than 'Urban Challenge' and 'Weathered Communities'. These groups tend to contain single parent families who are unlikely to own a car, are unlikely to be interested in politics, and read tabloid newspapers. The classification with the lowest STI prevalence is the 'Rooted Households' which is slightly lower than 'Blossoming Families'. These groups tend to include younger and older families, who will generally have two or more cars and read black top newspapers. When compared to the results for the neighbouring PCT of Liverpool (figure 4C) the differences in the groups of people affected by STIs can be seen. The highest prevalence in Liverpool is among the 'New Starters' and the 'Multicultural Centres'; which reflects the different demography especially in terms of ethnic diversity.

Table 4D shows the proportion of the population of Knowsley PCT and Liverpool PCT falling within each category. As previously mentioned there is no population in four categories for Knowsley PCT. Further, there is no population in the 'Country Orchard' category for Liverpool PCT, which is a similarity between the two PCTs. Over a quarter (26.5%) falls in the more deprived categories of Urban Challenge, and Disadvantaged Households.

Figure 4C, for Liverpool PCT, also shows there is no 'Country Orchard' population. However, there is much higher STI prevalence in classifications in Liverpool where Knowsley has none (e.g. 'Qualified Metropolitans', and 'New Starters'). Further, Liverpool shows a clearer relationship between rates of STIs and increasing deprivation. This may be because there is a more diverse population in Liverpool PCT, compared to Knowsley PCT, and higher populations in the less deprived areas in Liverpool. This would suggest that it is imperative to have individual local programs as the populations and needs are clearly different between the two areas. Although the PCTs share a border and there is undoubtedly some client cross-over, there are some clear differences in the needs of the individual populations.

Figure 4B Prevalence of an STI* diagnosed in GUM by people and places categorisation, Knowsley

*Primary and secondary syphilis, uncomplicated gonorrhoea, uncomplicated chlamydia, genital herpes and genital warts



Source: Sexual Health Team, Centre for Public Health, 2008.

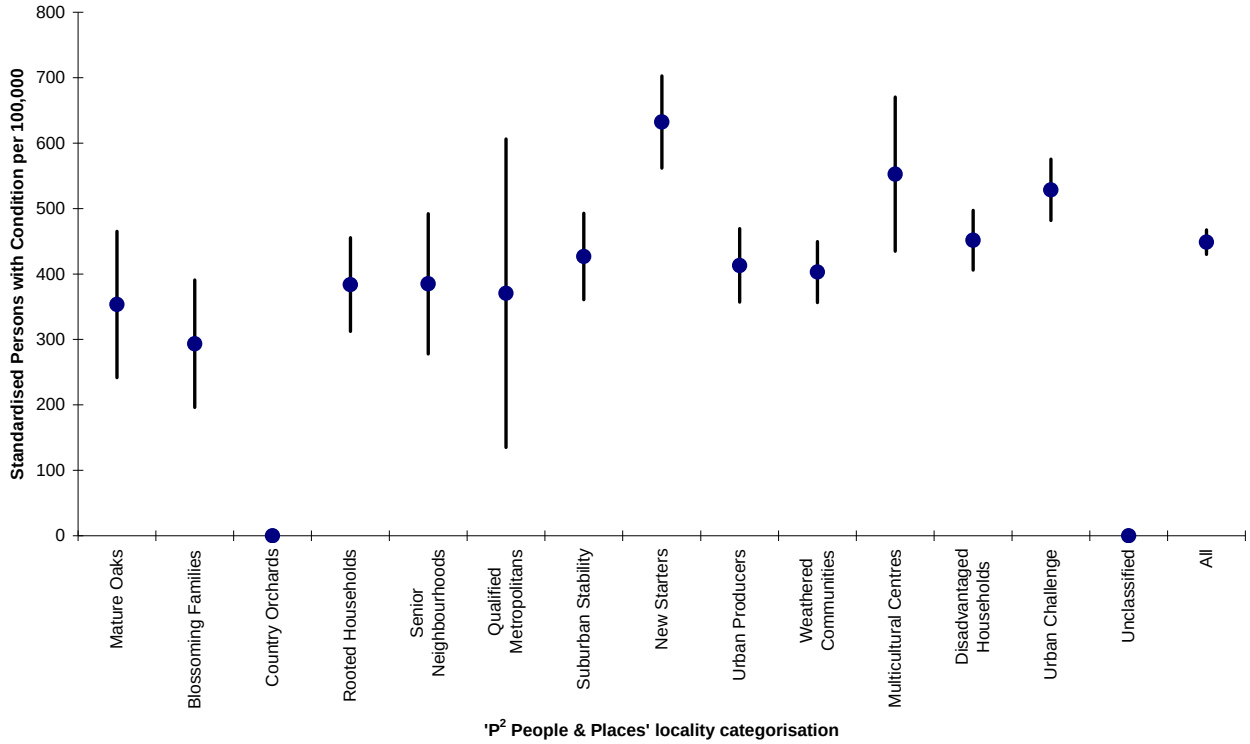
Table 4D Proportion of the populations of Knowsley and Liverpool falling into the P^2 People and Places categories

P^2 People & Places	Knowsley population	% of Knowsley LA population	Liverpool population	% of Liverpool LA population
Mature Oaks	1,750	1.2	12,313	2.8
Blossoming Families	6,806	4.5	12,221	2.8
Country Orchards	0	0.0	0	0.0
Rooted Households	12,619	8.3	32,728	7.5
Senior Neighbourhoods	1,199	0.8	12,905	3.0
Qualified Metropolitans	0	0.0	1,492	0.3
Suburban Stability	33,510	22.2	38,852	8.9
New Starters	0	0.0	40,154	9.2
Urban Producers	42,396	28.0	49,564	11.3
Weathered Communities	12,816	8.5	67,485	15.4
Multicultural Centres	0	0.0	11,255	2.6
Disadvantaged Households	31,646	20.9	77,111	17.6
Urban Challenge	8,421	5.6	80,972	18.5
Unclassified	0	0.0	0	0.0
Total	151,163	100.0	437,052	100.0

Source of data: Office for National Statistics Mid-2005 population estimates. Crown copyright 2007

Figure 4C Prevalence of an STI* diagnosed in GUM by P^2 People and Places categorisation, Liverpool

*Primary and secondary syphilis, uncomplicated gonorrhoea, uncomplicated chlamydia, genital herpes and genital warts



Source: Sexual Health Team, Centre for Public Health, 2008.

4.2.4 HIV

Knowsley has a low HIV prevalence compared to other parts of the North West. The were 26 individuals in treatment and care for HIV residing in Knowsley PCT in 2006 and the HIV prevalence in the PCT was 17 per 100,000 population. The prevalence for the North West is 70 per 100,000 population, but there are large variations within the regions; Manchester LA being 325 per 100,000, and Liverpool being 75 per 100,000 population. Of the individuals in Knowsley, 46% were in the age range of 35-44. Moreover, the majority of the cases are amongst male residents (81%). The predominant mode of exposure to HIV in Knowsley PCT is via men who have sex with men (54%), with 27% infected heterosexually. The majority of people in treatment and care for HIV in Knowsley were of white ethnicity (85%), with 69% of infections acquired in this country. High proportions (38%) of cases are AIDS defined which differs from the North West proportion of 24%. Higher levels of care are required as the infection progresses, which will mean a larger requirement on services due to the cohort generally being more severely ill.

4.3 Pregnant teenagers and teenage parents

In the UK, the likelihood of teenage pregnancy is related to a number of factors: teenage pregnancy is more likely to occur in deprived neighbourhoods, it is higher amongst those with lower educational attainment (even after accounting for deprivation) and in those who are or have been looked after. Teenage pregnancy is more common in young girls who have experienced mental health problems, sexual abuse in childhood, sex before the age of 16, violence and bullying at school, poor parental support, involvement in crime, use of alcohol and substance misuse and in those who have low aspirations and a lack of things to do[30]. The likelihood of teenage motherhood is higher among young women who are daughters of a teenage mother or who are of white British, mixed white and black Caribbean, other black, and black Caribbean ethnicity[53]. Young fathers are more likely to live in deprived areas, to be unemployed and to be in receipt of benefits and have similar characteristics as teenage mothers[53].

Local authority district (LAD2) data (1997-2005) show that the vast majority of teenage mothers in Knowsley are white (98%) with the only other ethnic group represented being white and black African mixed race (2%), which broadly corresponds to the general population of Knowsley (see figure 3D). Of the teenage mothers, most were lone parents (79%), with 19% co-habiting and 2% part of a married couple.

Figure 4D shows the trend of teenage pregnancy rates from 1997 to 2006. The teenage pregnancy rate (50 per 1,000 females aged 15-17) in 2004 was marginally higher than the target (47.45 per 1,000 females aged 15-17) set by Knowsley LA for 2004 to work towards the teenage pregnancy strategy target which aims to reduce under 18 teenage pregnancy rates by 50% from 1997 to 2010. The data since has shown an improvement in the rate which stands at 40.3 per 1000 females aged 15-17 for 2006. This represents a marked decrease in the rate since 2004. The current trend of improvement in under 18 teenage pregnancy rates will be required to continue if Knowsley is to reach a 50% reduction in the rate of teenage pregnancy in 2010 compared to that from 1997. There has been a reduction of 26% between 1998 rates and 2006 figures which represents good progress. In terms of Knowsley's statistical neighbours[†] (Salford, Liverpool, South Tyneside and Middlesbrough), Knowsley has had the third largest percentage decrease (-26%) in under 18 conceptions between 1998 and 2006, despite having the second highest deprivation score of the five (see **Table 4E**). Statistical neighbours analysis provides a tool against which to benchmark progress of the *Every Child Matters* aims. For each local authority, the statistical neighbours model designates a number of other local authorities deemed to have similar characteristics, taking into account a large number of variables from sources including the 2001 census, the DVLA, DfES and the Annual Survey of Hours and Earnings. These include variables concerning the proportion of children living in a variety of different households (for example, overcrowded households, households where there is one adult and households where the main earner is in different types of occupation) and the proportion eligible for free school meals. In addition, mean weekly pay is taken into account as well as the percentage of people in the household from different black and minority ethnic backgrounds, variables on qualifications, health, housing tenure, and whether the household is in a rural area[54].

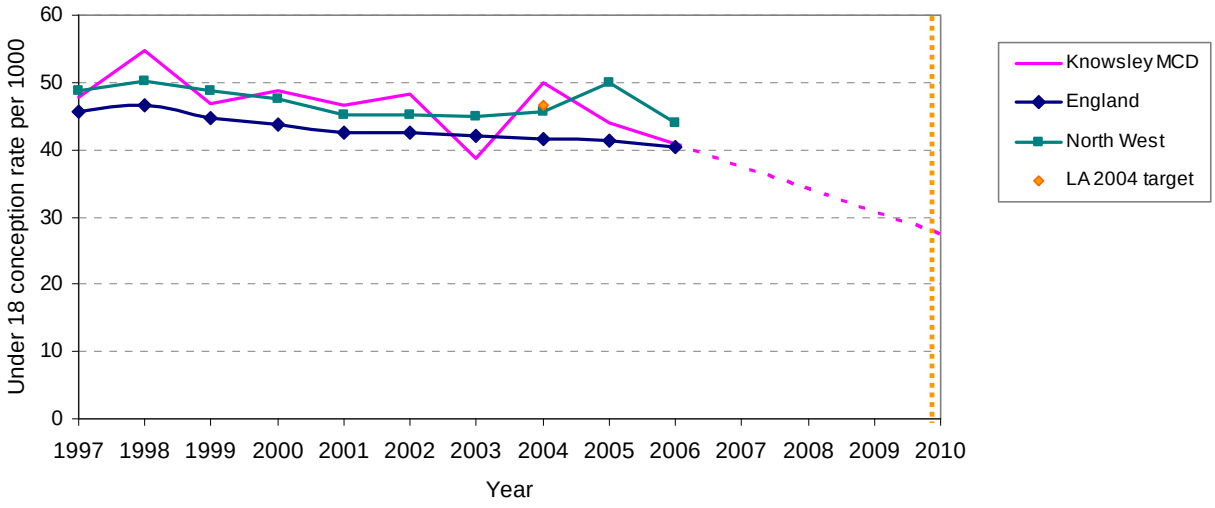
Figure 4E shows the change in outcomes of under 18 conceptions from 1997/99 until 2004/06. There is now a more similar rate of births and abortions in the outcomes of under 18 conceptions. This has shifted from the previous figures which showed the rate of birth much higher than that of abortion. There has been a 10% reduction in under 18 conceptions, a 14% increase in abortions, and a 26% reduction in births. This is indicative of the national trend which also shows higher rates of abortion in women across England[55].

Figure 4F highlights a link between level of deprivation and number of conceptions attributable to under 18s. There is a strong relationship between the two variables. The figure is of all local authorities across England, and Knowsley can be seen with the larger diamond shaped data point. Knowsley has very similar figures to that of Liverpool which is the data point to the right of Knowsley. These results suggest that although Knowsley has a high level of deprivation the level of conceptions attributable to under 18 are lower than nationally predicted or expected. These data show that Knowsley LA has a lower than expected under 18 conception rate considering it has a deprivation score of 46.6. This achievement is even more apparent when compared with Knowsley's statistical neighbours, three (Salford, Middlesbrough, and South Tyneside) of which have higher under 18 conception rates and stronger correlations with their deprivation scores.

Figure 4G shows the number of under 18 conceptions between 2002 and 2004 by electoral ward (2003 boundaries) for Knowsley; Under 18 conceptions only include females between 15 and 17 years of age. Numbers of under 18 conceptions tend to be higher in the north of Knowsley and across the central area; the lowest rates are across the south of Knowsley. When compared to the proportion of females aged 15-17 across Knowsley, **figure 4H,** it is possible to examine the link between a high proportion of young females in the area and high rates of under 18 conceptions. Figure 4H shows that some areas of Knowsley have between 6-7% of the total LSOA population as females aged between 15-17 years. There are some areas where a high rate of under 18 conceptions matches a high young female population (e.g. Page Moss) but equally there are others which do not (e.g. eastern Halewood). The two maps suggest that a high proportion of 15-17 year old females in the locality do not explicitly link to having a high proportion of under 18 conceptions. When comparing figure 4I to 5A it can be seen that there is some overlap of high rates of under 18 conceptions and high levels of deprivation; specifically around Woolfall Heath and Stockbridge Village in the central area of Knowsley. The trend can also be seen in the north of the PCT around Tower Hill, and in the south around southern Halewood.

[†] To produce statistical neighbours using this information it is necessary to calculate an overall measure of difference between each pair of local authorities. To ensure consistency with previous statistical neighbour models (for example, those devised by Ofsted or the Institute of Public Finance comparator councils) a weighted Euclidean distance measure was used. The weighted Euclidean distance between two LAs is the square root of weighted average squared difference between the local authorities across all variables. Variables are weighted to emphasise the extent to which increased differences between local authorities (in terms of these background variables) is associated with increased differences in performance. In essence this means that background variables that have a close association with performance measures are given more importance in the statistical neighbour model than variables that are more weakly associated with outcomes.

Figure 4D Teenage pregnancy trends in Knowsley, England and the North West, 1997-2006 (provisional) showing the line of projection required to meet Knowsley's 2010 target.



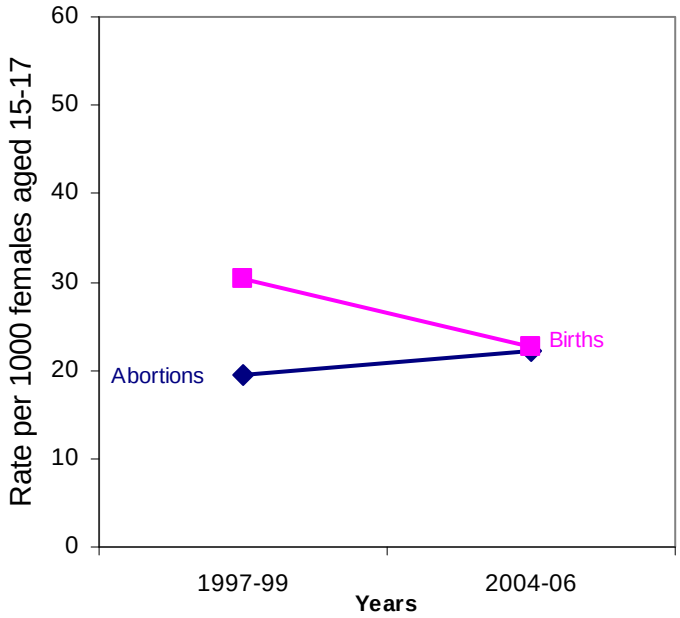
Source: Teenage Pregnancy Unit, DfES, 2008

Table 4E Under 18 conception rates by DfES statistical neighbours

Local Authority	Deprivation score	Under-18 conception rate		% difference 1998-2006
		1998	2006	
Knowsley	46.6	54.8	40.3	-26.5
Salford	38.2	61.5	58.8	-4.4
Middlesbrough	40.7	66.5	50.1	-24.7
Liverpool	49.8	57.9	41.6	-28.2
South Tyneside	33.1	64.9	40.5	-37.6

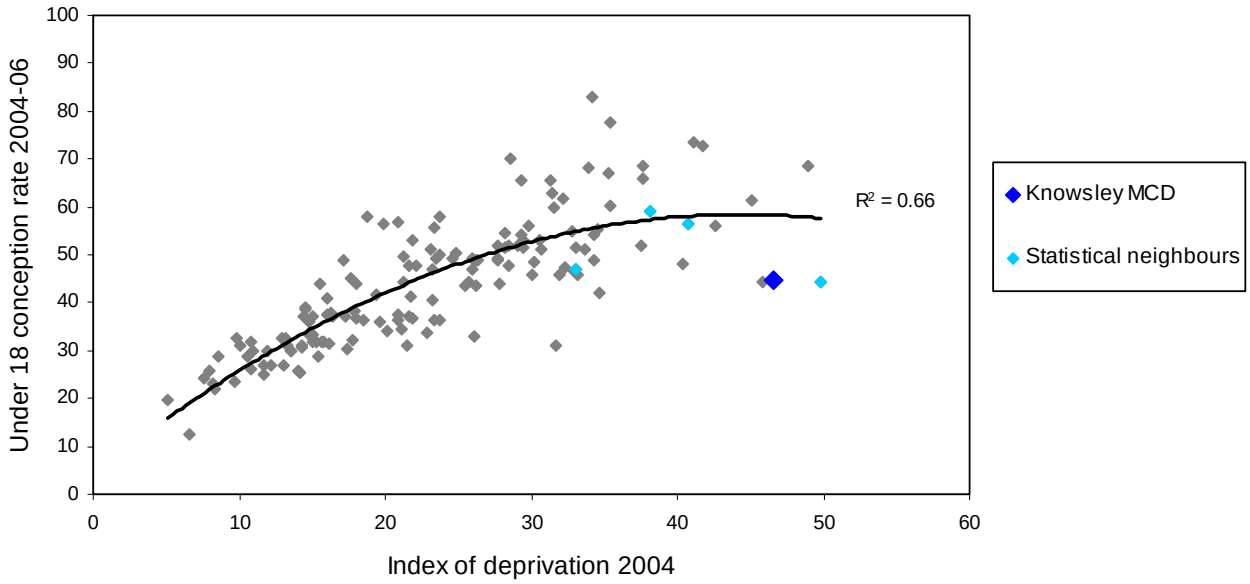
Source: Teenage Pregnancy Unit, DfES, 2008

Figure 4E Outcome of under-18 conception 1997-99 and 2004-06, Knowsley



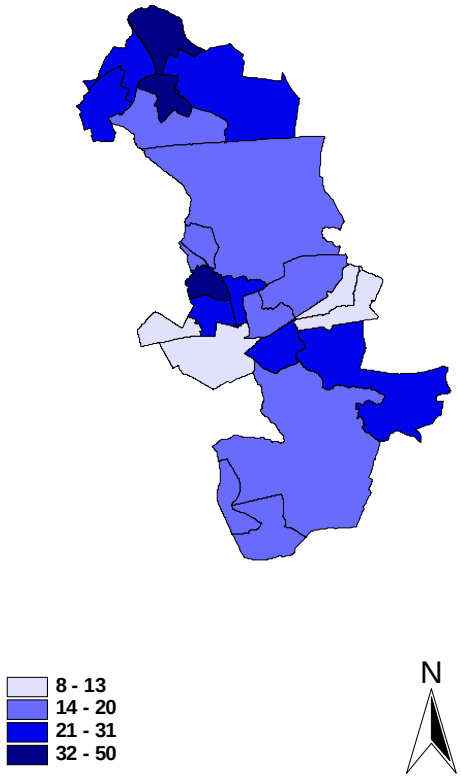
Source: Teenage Pregnancy Unit, DfES, 2008

Figure 4F Deprivation score and under-18 conception rate for 2004-06 by local authority



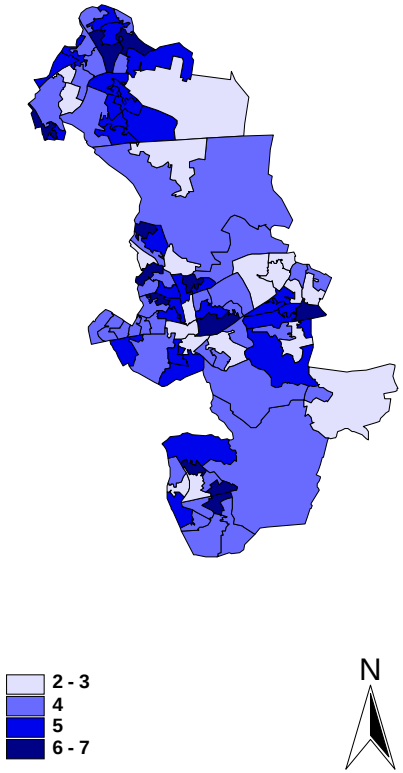
Source: Teenage Pregnancy Unit, DfES, 2008

Figure 4G Under 18 conceptions 2002-2004 by electoral ward, Knowsley



Source of data: North West Public Health Observatory.
Source of map boundaries: 2001 Census, Output Area Boundaries. © Crown copyright 2003

Figure 4H Percentage of the female population who are aged 15-17 years in each LSOA, Knowsley



Source of data: Mid-2005 population estimates. Office for National Statistics © Crown Copyright 2007
Source of map boundaries: 2001 Census, Output Area Boundaries. © Crown copyright 2003

4.4 Sexually active population

4.4.1 Contraception

The Government has set contraceptive services as a high priority within sexual health. It is recognised that access to sexual health services varies across the country. The Government made a promise in the *National Strategy for Sexual Health and HIV* to ensure a range of contraceptive services are provided for those who need them and promised an audit of contraceptive service provision in its White Paper, *Choosing Health*[1,5]. Contraceptive services are cost effective and are estimated to save £11 for every £1 spent; and the prevention of unplanned pregnancies by NHS contraceptive services saves the NHS over £2.5 billion per annum[56]. The average spend on community contraceptive services (which include primary care prescriptions and emergency contraception) is £11.67 per female aged 15-49 per annum. Good quality contraceptive services are important in the achievement of the public service agreement of reducing under 18 conceptions by 50% by 2010 and also, more broadly, the improvement of sexual health[56]. It is important that patient choice in terms of choosing a method of contraception is a priority and that men and women requesting contraception should be given the advantages, disadvantages and failure rates of each method. As recommended by NICE, this should also include information on long-acting reversible contraception (LARC) methods[15,56]. Nationally, approximately four million people are using contraceptive services per year. The majority of these are women and three quarters use general practitioner service and the remainder use community services such as family planning clinics[40,56]. Younger women were more likely than older women to be using the contraceptive pill or the male condom and women with no qualifications were less likely to be using at least one form of contraception and more likely to not be using contraception than others (compared with people with GCSE A-C grades)[40].

4.4.2 Emergency contraception

Seventy percent of PCTs reporting to the *Baseline Review of Contraceptive Services* reported some out of hours emergency contraception provision, although some of this is limited to evenings and Saturdays[56]. Generally, the knowledge of emergency hormonal contraception amongst women is high, with fewer aware of the IUD as a method of emergency contraception. However, knowledge amongst women about how and when it can be used is poor[56]. There is evidence to suggest that knowledge on how emergency contraception is used, how long after unprotected sex it can be taken and how regularly it can be used is poor amongst young people and attitudes can be negative towards emergency contraception but that it was felt that having it available was useful[57].

4.4.3 Long-acting reversible contraception (LARC)

NICE guidance on LARC clarified that IUDs, IUS, injectable contraceptives and implants were more cost effective than the combined oral contraceptive pill. Further, that IUD, IUS and implants are more cost effective than injectable contraceptives and that unintended pregnancies can be reduced with increased use of LARC methods[15].The North West region has a higher than national average uptake of LARC methods prescribed as the primary method of contraception in the community. Conversely, Knowsley PCT has a low prescription rate for LARC compared to national averages[56].

4.4.4 Termination of pregnancy

It is recognised that there are variations in access to abortion services and methods of termination and commissioners are advised to ensure that women who meet the legal requirements for abortion have access to the service within three weeks of seeing a general practitioner or other doctor and ensure that information about local pregnancy counselling and termination services are available and widely publicised[1,25]. In terms of economics, reducing the delay in obtaining abortions can save the NHS between £645,000 to £30 million per year (depending on the method used) and it is considered cost saving to provide these services with minimal delay[58]. In total there were 201,173 abortions in England and Wales in 2006. The majority (193,737 abortions, 96%) were to residents of England and Wales. The rate of abortions was 18.3 per 1,000 resident females aged 15-44 years (age standardised rate). Just under a third (32%) of females undergoing abortions in 2006 had one or more previous abortions compared with around 28% in 1996. Amongst those aged under 25 having abortions, nearly a quarter (23%) had had a previous abortion. Nearly three quarters (73%) of those aged under 25 having an abortion were offered chlamydia screening, which is the same as the proportion of all women screened in 2006[59]. Women who have already had one abortion are at risk of having future abortions and are, therefore, a group with contraceptive needs that may not be being met[56]. NICE guidance advises that LARC are suitable for women who have had an abortion (either at the time of abortion or later)[15] and the promotion of emergency contraception in addition to the promotion of condoms to help prevent STIs, may be appropriate for this group. In the North West region, there is also evidence of a relationship between crude rate of abortion (per 1,000 females aged 15-17 years) and deprivation showing an increasing rate of abortion with increasing deprivation[32].

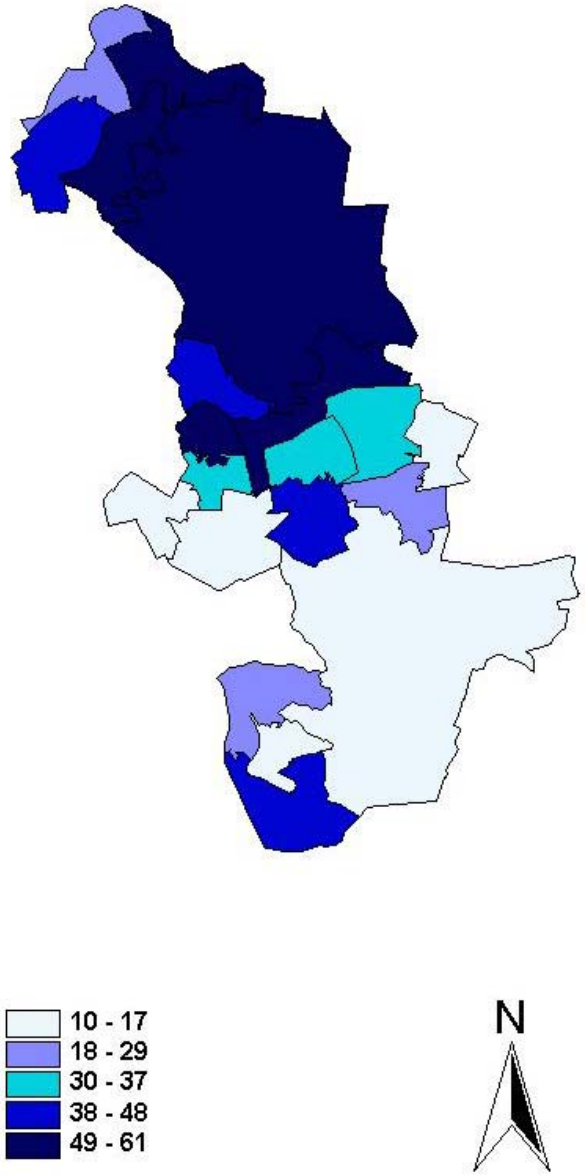
4.4.5 Lone Mothers

It is acknowledged that in the UK, lone mothers with pre-school children are a materially disadvantaged group when compared to mothers with partners. It has also been found that lone motherhood is associated with poorer mental health; although not consistently with poorer physical health[60]. Lone motherhood has health and behaviour impacts on the children of lone parents. Young people from lone parent families or having mothers who were teenagers when they were born are more likely to report early sexual debut (aged 15/16)[61].

Figure 4I illustrates the percentage of all births attributable to mothers living alone; showing Huyton and Prescot are identified as areas with particularly high percentages of births to lone mothers. This level of high percentage continues to northwards to include all areas up to Southdene and Northwood within Kirkby.

Figure 4I Percentage of live births to mothers living alone by MSOA, Knowsley

1999 to 2003 - Percentage of births registered to unmarried couples with no father identified on the birth certificate, or where the mother and father are living at different addresses.



Source of data: North West Public Health Observatory
Source of map boundaries: 2001 Census, Output Area Boundaries. © Crown copyright 2003

4.5 Sex Workers

Selling sex is not illegal, although related activities such as soliciting, advertising using cards in telephone boxes, and kerb crawling are offences which effectively render sex work illegal[62]. There are an estimated 80,000 people involved in sex work in the UK. Many of them have been subject to childhood abuse, have spent time in care, had poor school attendance, are or have been homeless and the vast majority involved in street sex work have problematic drug use issues[62]. There are also other vulnerable groups involved in sex work. Although most associated with women and young girls, there is also a significant market for men and young boys[62]. Children involved in sex work are particularly vulnerable[63].

Sex trade workers often operate within city centres and Liverpool city centre is the nearest to Knowsley and has a long history with sex work. Health care for sex workers has been a priority in Liverpool with health promotion, sexual health, drug advice and outreach work being invested in, in order to improve the health and well-being of sex workers to offer them routes out of sex work and protect them from assault[64]. In 2004, a consultation was conducted in Liverpool on the possibility of establishing a managed zone where sex workers can work within certain regulations and have access to health care. As part of the process, 50 female street sex workers were involved in questionnaires. Of these women, most (58%) were aged between 26 and 35 years and the vast majority (92%) were aged over 16 when they first became involved in sex work. In the four weeks preceding the questionnaire, of those who had used drugs, 86% had used heroin and 76% had used crack cocaine. Almost half (49%) had been arrested for prostitution or a related offence in the past and over two thirds (67%) had been physically or sexually assaulted whilst working in the past. Sex workers were asked what services they would access if a managed zone were established and the vast majority (98%) said they would use sexual health services and all would register with a health clinic within the zone. Ninety percent of the sex workers would use drug health care services and the majority would use services that would help them to exit prostitution (88%) and services which would offer employment opportunities (78%)[64].

4.6 Prison Population and Young Offenders

By the end of February 2008, the population in custody in England and Wales was 82,602, 3% more than a year earlier; both male and female prison populations increased by 3% to 77,425 for males and 4,454 for females[65]. Prisoners are recognised as a socially excluded group. They are more likely to have grown up in care, poverty or disadvantaged family, less likely to be in a stable relationship, more likely to be teenage or single parents, have much poorer mental health than the general population. Also, most prisoners have had disruptive experiences of school and leave with few qualifications or skills and most have never experienced regular or high quality employment. People from black and minority ethnic backgrounds are over-represented in a lot of dimensions of social exclusion and are therefore over-represented in the prison population. It is recognised that there is a high prevalence of blood borne viruses among the prison population and it is estimated that 17% of Knowsley offenders currently have a blood borne virus[66]. It has been recognised by sexual health and primary care service commissioners and providers that condom distribution and sexual health service development in general in prisons has been identified as an important gap in provision which needs addressing[67]. Near the Knowsley PCT area, there are two prisons, HMP Liverpool in Walton and HMP Altcourse (a privately run prison in Fazakerley). HMP Liverpool is a prison for male offenders covering the whole Merseyside area and its operational capacity is 1,393 (as of November 2006) and HMP Altcourse holds young offenders and adult male prisoners with an operational capacity of 1,024 (as of January 2006). The only female prison near Knowsley is HMP Styal in Cheshire which accepts female prisoners and some young offenders. HMP Styal has facilities for mothers with babies aged up to 18 months and the prison has an operational capacity of 459 (as of March 2007)[68].

Young prisoners are recognised to often be out of control when they arrive in custody and many have already had experience of institutions, with a disproportionate number of young prisoners having been in care[69]. It is also acknowledged that a large proportion of young people in prisons need help with health care and many young people's behaviour is harmful to health (e.g. unhealthy eating, lack of exercise, drinking alcohol to excess, smoking and using illegal drugs). In addition, many are taking risks with their sexual health with underage sex, multiple partners and unprotected sex[69].

Female prisoners face distinctive issues (such as maternity and gynaecological issues and also greater incidences of past abuse) and inequalities in terms of their health. A fifth of women in prison request a consultation with a doctor or nurse each day which is almost twice as many as male prisoners. In addition, female prisoners report higher incidences of health problems than in the general female population. Sexual health, along with maternity care, substance misuse, self-harm, mental health and smoking are priority areas for the health of female prisoners[70].

It is acknowledged that many prisoners, both male and female, need some targeted sexual health promotion and HIV prevention interventions as they are more vulnerable or at a particular risk. HMP Preston developed

a sexual health group which produces a magazine covering sexual health issues which aims to promote awareness and responsibility[70].

There are a number of risk factors for youth offending, including aggressive behaviour, low achievement in school, family history or problem behaviour, social alienation, peer pressure, parents condoning behaviour, family conflict, truancy and availability of drugs[71]. Youth offending in some cases leads to young people becoming young prisoners. Young prisoners are likely to be involved in risky sexual behaviour[69] and a large proportion of young people in custody aged 15-21 are parents. A quarter of young offenders in custody are estimated to be fathers and 39% of female young offenders in custody are estimated to be mothers[69,72].

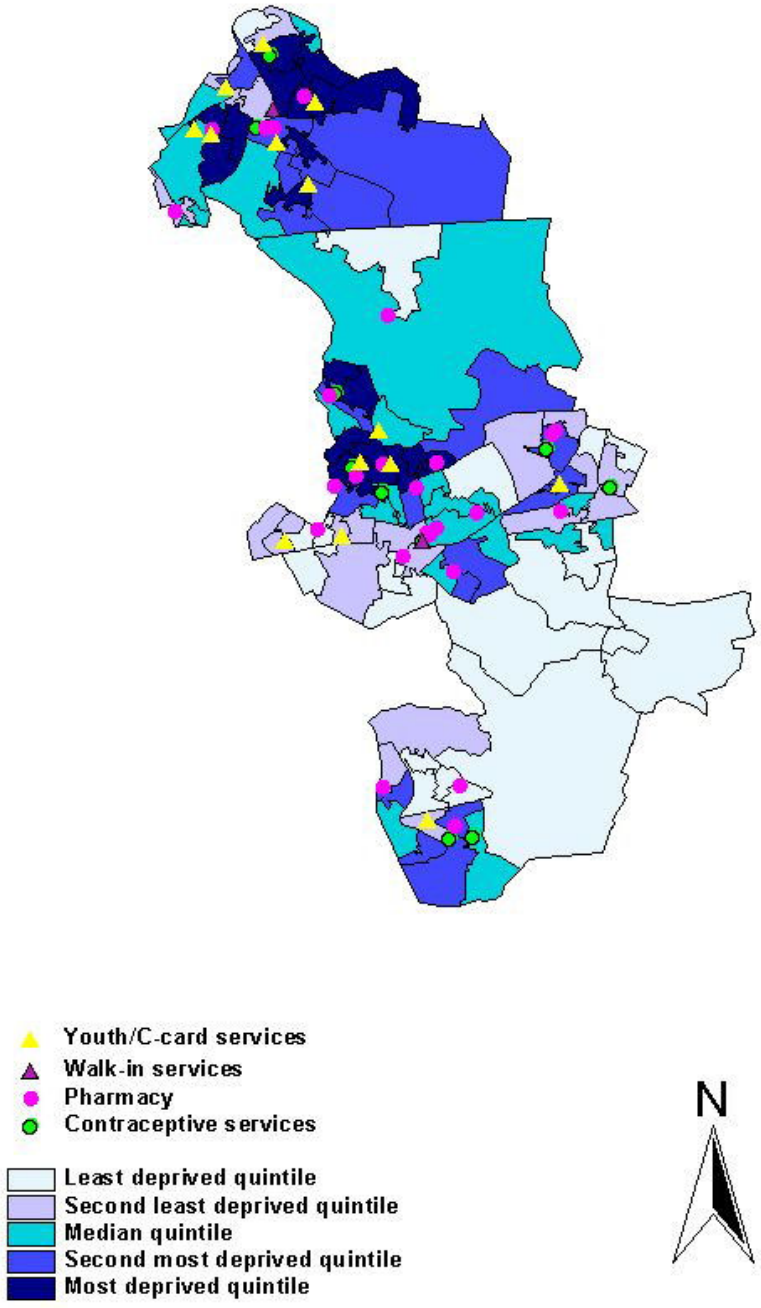
5. Demand and mapping services

Demand relates to those people who are willing to use services. This section of the report identifies demand by describing service uptake in contraceptive services, GUM services, Connexions and sexual health services in prisons. This section also looks at service locations in relation to deprivation and under 18 conceptions and also covers the results of an audit of sexual health service opening times and service provision.

5.1 Service Locations

Figure 5A overlays selected sexual health services available in Knowsley with Index of multiple Deprivation (IMD) local quintiles presented by LSOA. The map illustrates where sexual health services are located in the most deprived areas. Previously (see section 3.3) we have shown the high level of deprivation in Knowsley when compared to national levels. There is a very mixed picture of deprivation across the middle band of Knowsley running through Huyton and Prescot. This map shows that the majority of services provided throughout Knowsley are pharmacy services and youth services/C-card (community condom scheme) services. General contraceptive services are also provided throughout the PCT, although they are far fewer in number. There are two walk-in centres in Knowsley, one based centrally in Huyton and the other in Kirkby. The majority of services are located in the most deprived areas. However, there are some areas of median and second level deprivation that have no sexual heath services e.g. the area around Knowsley Industrial Park. This map needs to be considered in conjunction with service opening hours and service provision. Services are appropriately located in the areas of high deprivation; however these services need to be considered in conjunction with the services they provide and their opening times which are examined more closely in section 5.13.

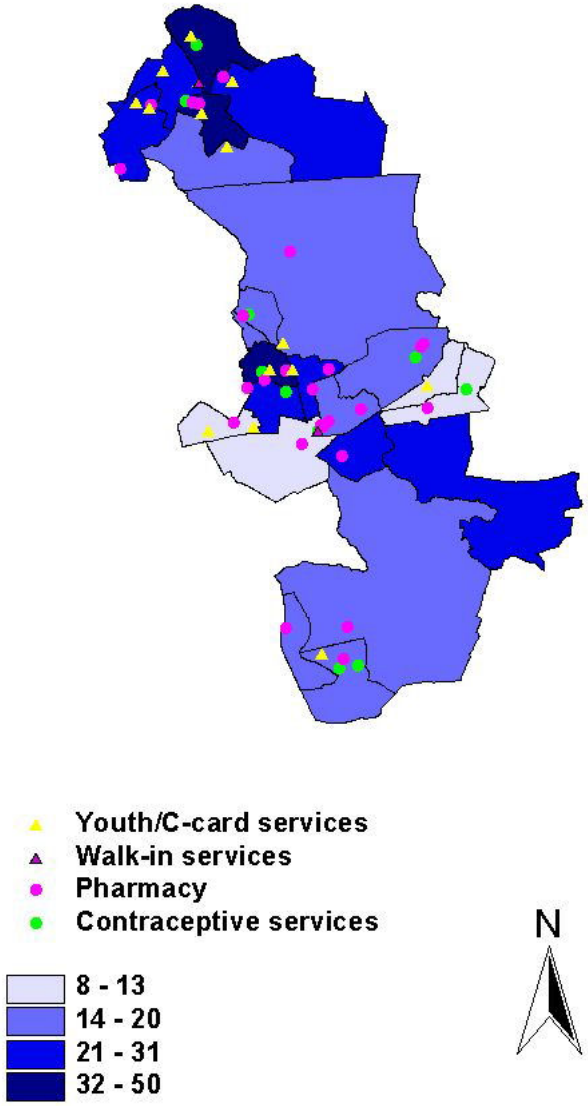
Figure 5A Index of multiple deprivation (IMD 2007) local quintiles showing sexual health services by LSOA, Knowsley



Source of data: Department of Communities and Local Government, Indices of Deprivation 2007
Source of map boundaries: 2001 Census, Output Area Boundaries. © Crown copyright 2003

Figure 5B overlays selected sexual health services, specifically relevant to young people, with under 18 conception data 2002-2004 by electoral ward. The mapped services are youth (including Community condom scheme), walk-in, pharmacy, and contraceptive. The highest rates of under 18 conception are in the areas of north Huyton, Northwood, and Tower Hill (rate 32-50 per year). The areas with the lowest rates are Whiston and the south east of Prescot, Swanside and the south of Huyton. The south of Knowsley around the Halewood area also has relatively low rates of under 18 conception. It can be seen that sexual health services are located in the areas with high conception rates. However there is a high conception rate in Cronton (21-31 per year) but no sexual health services are available. Therefore clusters of services exist in some areas whilst other areas have no sexual health services. However, service provision needs to be carefully examined alongside service opening times.

Figure 5B Under 18 conceptions 2002-2004 by electoral ward showing selected sexual health services, Knowsley



Source of data: North West Public Health Observatory.
Source of map boundaries: 2001 Census, Output Area Boundaries. © Crown copyright 2003

5.2 Chlamydia screening data

Figure 5C shows the distribution of chlamydia screening sites throughout Knowsley. As expected the sites are located around the most populated areas of Kirkby, Huyton and Halewood. Some testing sites are in areas with high percentage of under 25s, but there is a small exception to this in the Knowsley Park area, and the Knowsley Industrial Park area. The sites are overlaid on the IMD (2007) local quintiles to enable comparison between service location and areas of high deprivation; showing that the majority of services are located in or near areas of high deprivation.

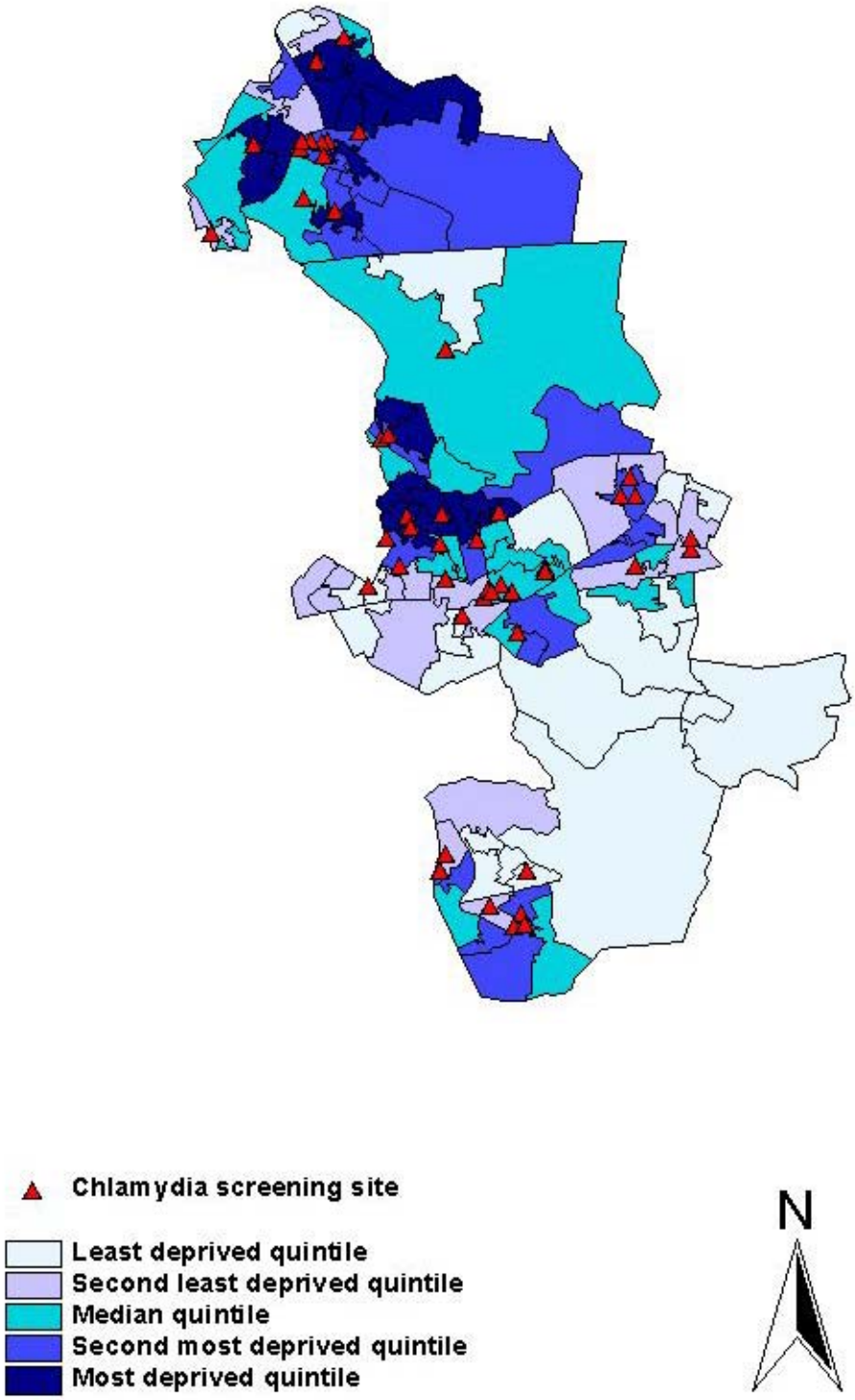
Table 5A shows the chlamydia and gonorrhoea screening data for Knowsley from 2004-05 to 2006-07. The data shows a consistently higher number of positive females than males, and also showing that the majority of those testing positive were treated. There is clearly a larger diagnosis of chlamydia compared to gonorrhoea across Knowsley. Most individuals were treated at a family planning/contraception clinic (*n* = 87), with 23 individuals treated at the chlamydia screening office. These trends are representative of the wider region including Liverpool PCT and Sefton PCT.

Table 5A Chlamydia screening data covering Knowsley PCT: Opportunistic screening of under 25 year olds outside GUM settings, 2006/2007

Knowsley PCT	2004-05	2005-06	2006-07
Chlamydia Positive patients <25 years opportunistically screened (outside GUM settings) through the NCSP			
Total Number of Positives	59	74	165
Total Number of Positive Women	53	66	133
Total Number of Positive Men	6	8	32
Gonorrhoea positive patients <25 years opportunistically screened (outside GUM settings) through the NCSP			
Total Number of Positives	3	8	14
Total Number of Positive Women	2	7	11
Total Number of Positive Men	1	1	3
Positive patients <25 years with clinician confirmed treatment			
Total Number of Positives Treated	59	74	153
Total Number of Positive Women Treated	53	66	122
Total Number of Positive Men Treated	6	8	31
Treatment location for all positives			
Total Number of Positives Treated at GUM	4	4	10
Total Number of Positives Treated at CSO	14	17	23
Total Number of Positives Treated at Family Planning Clinic	34	41	87
Total Number of Positives Treated at General Practice (G.P.)	1	2	4
Total Number of Positives Treated at Other Location	4	10	29

Source of data: Liverpool Chlamydia Screening Office

Figure 5C Location of chlamydia screening sites in Knowsley by IMD (2007) local quintiles, LSOA.



Source of map boundaries: North West Public Health Observatory. Reference number 100020290.

5.3 Summary of family planning activities (KT31 data) Knowsley PCT

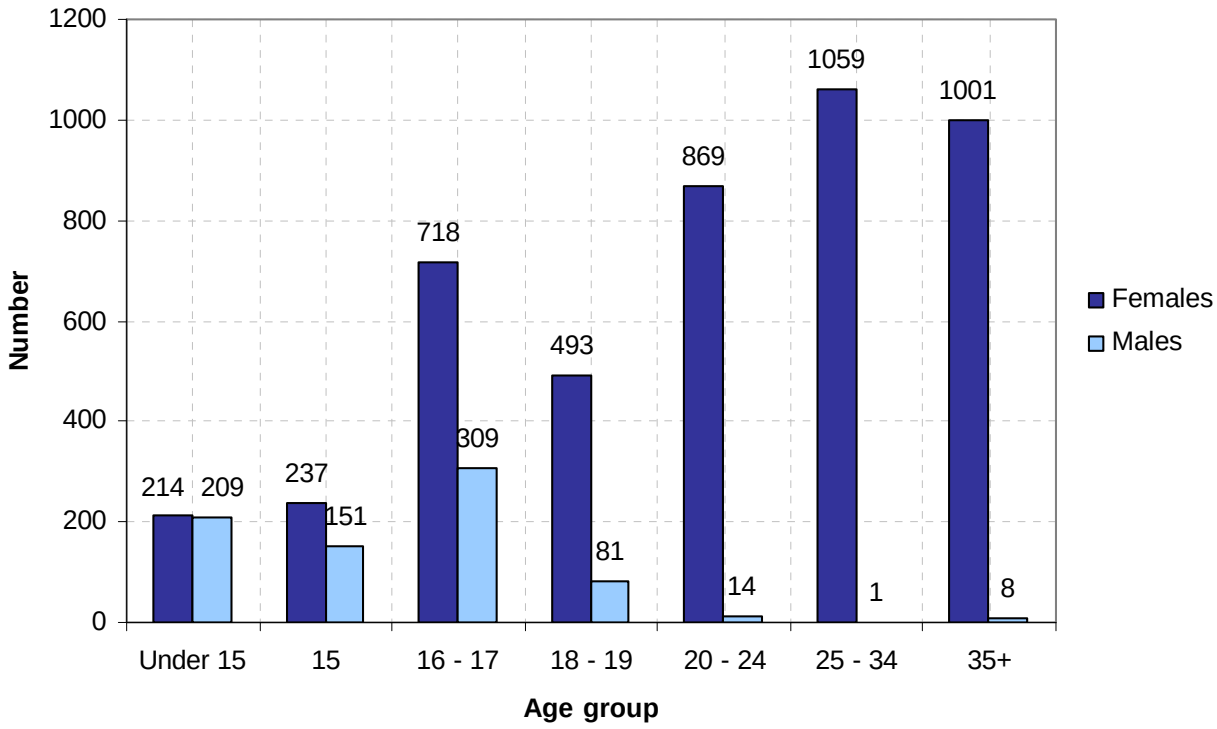
These data are based on first contacts in the financial year, running from May 2007 through to December 2007. These data represent the vast majority of service use by Knowsley residents however it does not contain Brook KT31 data.

Figure 5D shows use of contraceptive services by sex and age group. There is an equal split of males and females accessing services under 15 years of age. However, the vast majority of service users are female, and this trend becomes evident as the age of the service users increases. Females over 20 years (55%) are the main users of contraceptive services, with 25-34 year olds representing the main user group (20%). The data presented in **figure 5E** shows use of contraceptive services by males only. Of the visits to the contraceptive services, 95% of them were for male condoms, and no visits were made for vasectomies or other methods of contraception.

These data presented in **figure 5F** shows the female use of contraceptive services. Eighty seven percent of visits were for contraceptive products or consultation. The most common contraceptive used by females is the combined pill (33%), with 20% of women using the contraceptive injection (e.g. Depro Provera). However, the pattern of contraceptive choice differs when looking at females under 18 years (**Figure 5G**). Females under 18 years make up 25% of the total female population accessing contraceptive services (as recorded by the PCT). Nine percent of females under 18 accessed services for non-contraceptive purposes, which is a smaller proportion than that of the total female population (15%). The combined pill and the male condom represented 72% of the total contraceptive requests at first contact with services for young women aged under 18 years. This shows a large difference to the contraceptive requests of females over 18 where the combined pill and the male condom represented 42% of the total contraceptive requests at first contact with services. A total of 70% of all requests from all ages of females were for the combined pill, the injectable contraceptive and the male condom.

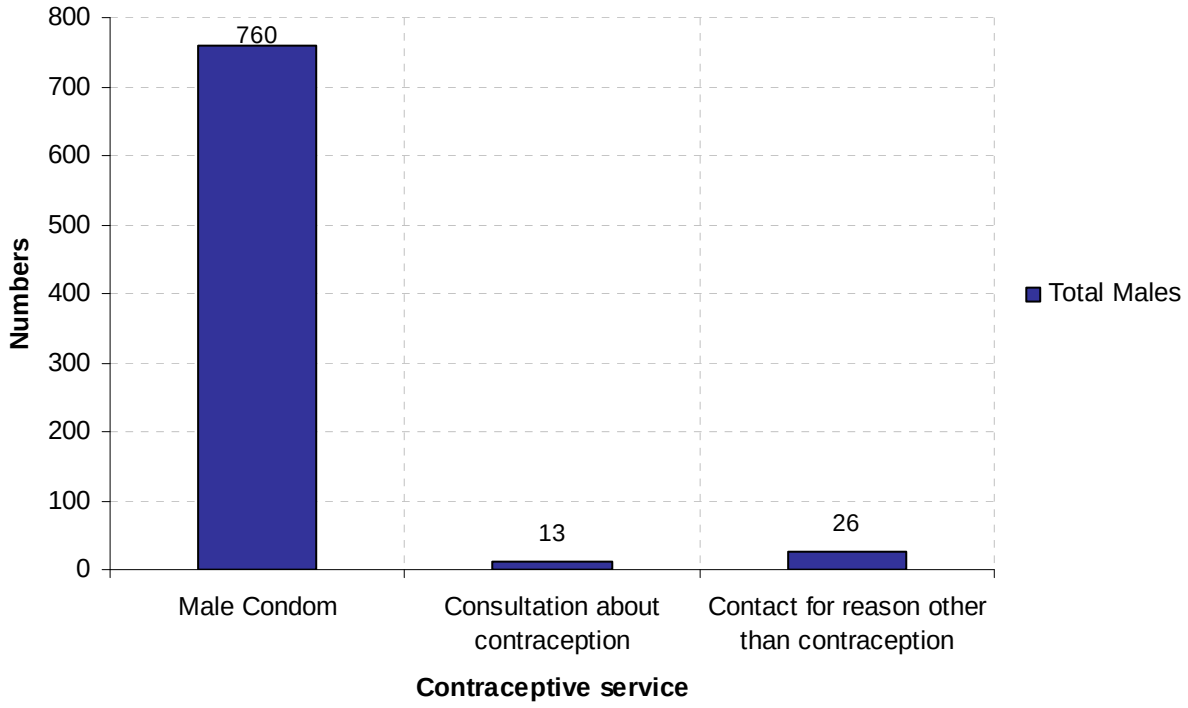
Figure 5H demonstrates the use of hormonal emergency contraceptive as the primary choice for women when compared to IUD. The use of IUD is small in all age groups; however the largest proportion of usage is in females aged over 35.

Figure 5D KT31 data by sex and age group, May 2007 – December 2007, Knowsley PCT



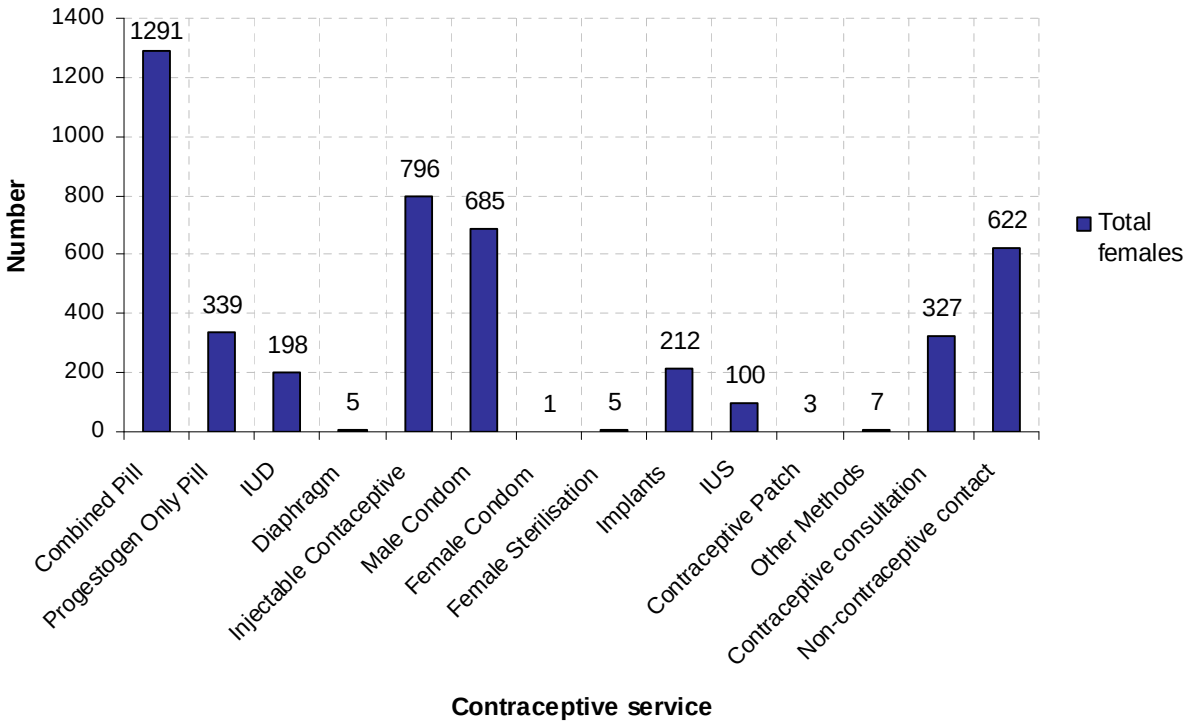
Source of data: Knowsley PCT

Figure 5E Contraceptive services accessed by males, May 2007 – December 2007, Knowsley PCT



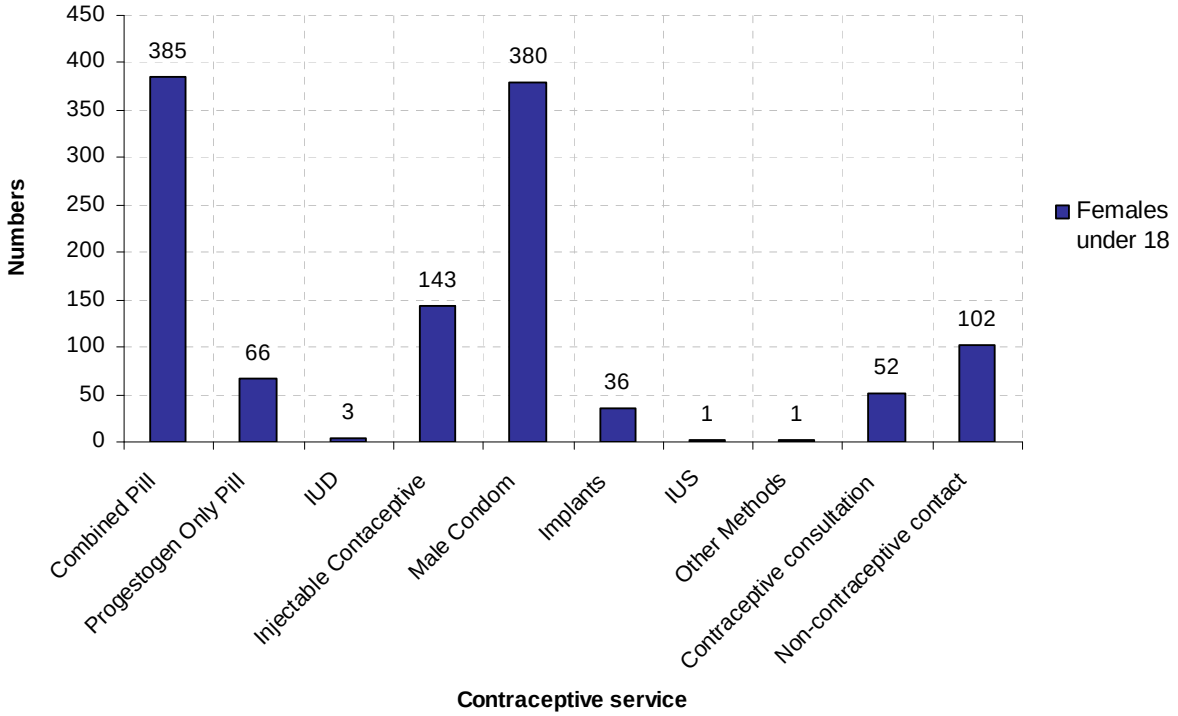
Source of data: Knowsley PCT

Figure 5F Contraceptive services accessed by females, May 2007 – December 2007, Knowsley PCT



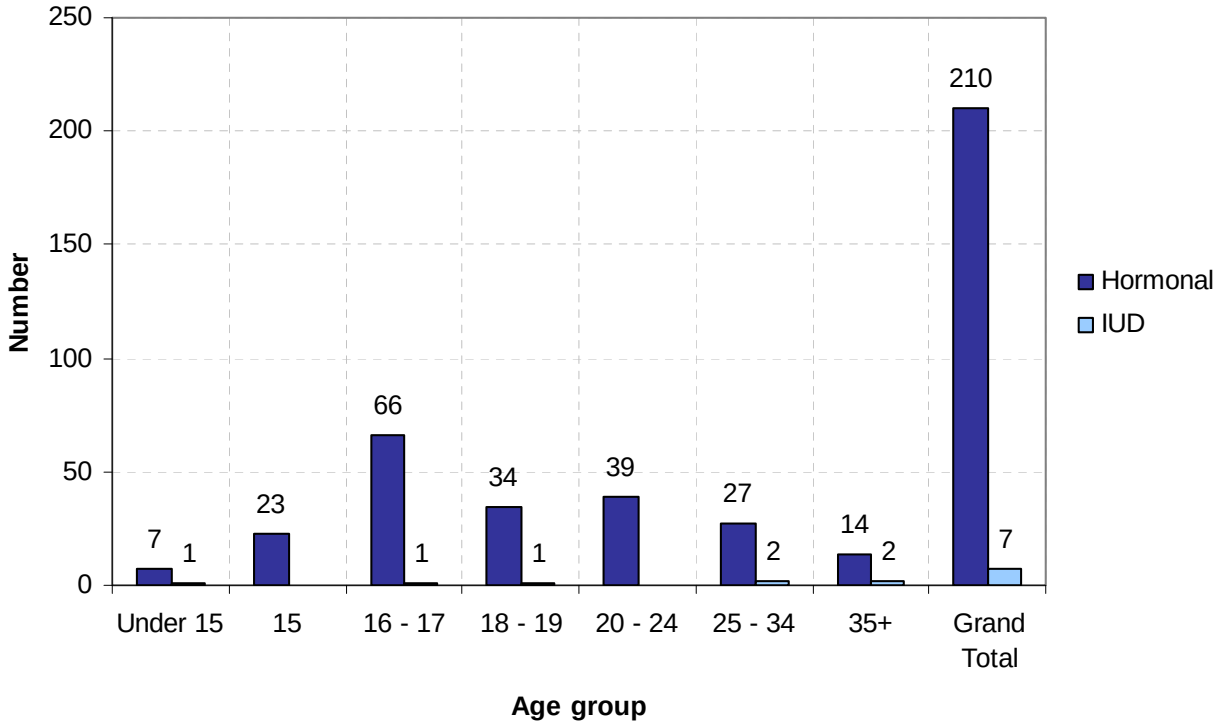
Source of data: Knowsley PCT

Figure 5G Contraceptive services accessed by females under 18 years, May 2007 – December 2007, Knowsley PCT



Source of data: Knowsley PCT

Figure 5H KT31 data by age group and type of emergency contraception, May 2007 – December 2007, Knowsley PCT



Source of data: Knowsley PCT

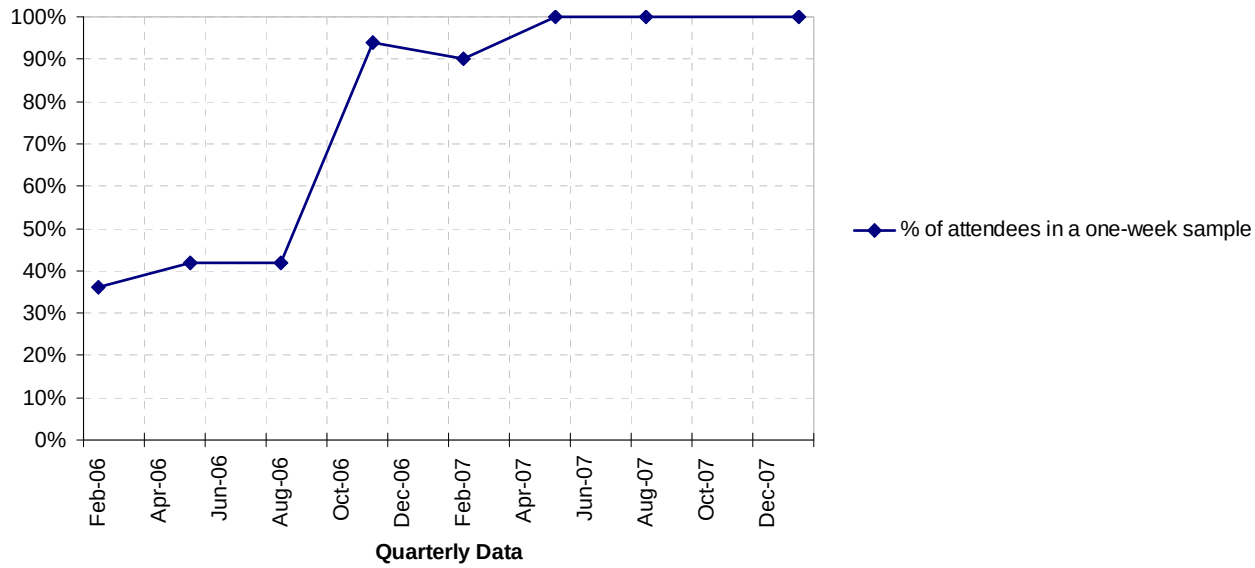
5.4 GUM data

STI data previously presented in section 4.2.2 showed the level of people in Knowsley diagnosed with infections. This information showed that the STI prevalence figures are largely driven by the prevalence of chlamydia, which has a higher prevalence in females than males. This local trend of chlamydia infection is reflected on a national level. The overall prevalence of the key five STIs in Knowsley is 382 per 100,00 people. Attendances at the Royal Liverpool University Hospital GUM department are high compared to other clinics in Cheshire and Merseyside. The enhanced STI surveillance shows that (excluding follow ups) the clinic had 18,315 attendances (defined as one individual with one date of diagnosis) in 2006. Twenty-one percent of all male attendances resulted in one of the key five infections (primary and secondary syphilis, uncomplicated gonorrhoea, uncomplicated chlamydia, genital herpes and genital warts) and the proportion was similar for females (20%)[42].

5.4.1 Waiting times audit at GUM clinics

Following the publication of the *Choosing Health* White Paper[5], the Health Protection Agency (HPA) and the British Association for Sexual Health and HIV (BASHH) developed the waiting times audit, a periodic cross-sectional one week survey of patients attending GUM for the first time with a new episode[73]. **Figure 5l** shows the percentage of patients resident in Knowsley seen at a GUM clinic within 48 hours. The percentage of people offered an appointment within 48 hours has improved from below 40% in February 2006 to 100% in January 2008. The majority (73%) of diagnoses for the five key STIs were made at the Royal Liverpool University Hospital, and 21% of diagnoses were made at St Helens Hospital.

Figure 5l Percentage of patients in quarterly one week samples seen at GUM within 48 hours, Knowsley



Adapted from: HPA/BASHH Waiting times audit at GUM clinics data

5.5 HIV data

Overall there were a total of 233 outpatient episodes recorded at statutory centres in 2006 from HIV positive residents in Knowsley. This is an average of just under 9 visits per individual over the year, which is higher than the North West average of 7.3. Knowsley's HIV positive residents also required a higher than average amount of inpatient stays in hospital and home visits. There are also a slightly higher proportion of HIV positive people on antiretroviral therapy in Knowsley than the North West average. This information suggests that the HIV population in Knowsley require high levels of service which is normally indicative of later stage HIV/AIDS. There are no data available on the total number of HIV tests taken, as only positive results are recorded, therefore it is not possible to say whether levels of HIV testing are high in the region.

Seven people with HIV residing in Knowsley were seen by the voluntary sector services in 2006, all of whom had also been seen in the statutory sector in 2006. Overall, 86% of those seen by the voluntary services were male, and infected through sex with men (57%). Four people with HIV were supported by Knowsley social services department, of these three were also accessing voluntary services. This suggests that only eight out of the 26 individuals in treatment and care for HIV across Knowsley accessed services other than that provided by the statutory sector. All of the people accessing support through social services were male, aged between 35 and 49, and were of white ethnicity. National undiagnosed prevalence estimates suggest

that up to a third of HIV infections are undiagnosed, which implies there is a higher HIV prevalence in Knowsley than recorded here.

5.6 Pharmacy data

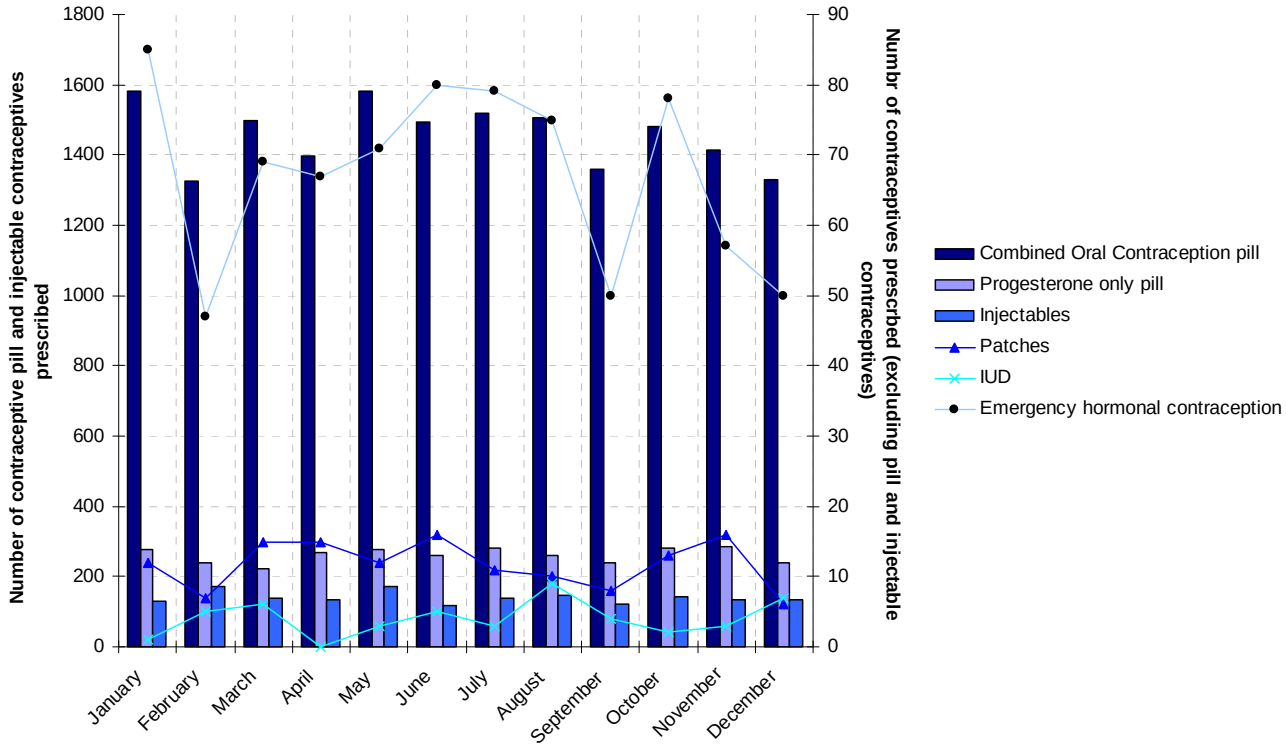
Figure 5J shows data on prescriptions of emergency and non-emergency contraception by month for 2007. The left axis shows the number of prescriptions of the oral contraceptive pill and injectable contraceptives (represented by the bars) and the right axis shows all other contraceptive services (represented by the lines). The oral contraceptive pills were the most prescribed in 2007 (between 1,300 and 1,600 each month). The numbers of prescriptions of the injectable contraception are the next most prescribed (between 117 prescriptions in June and 174 prescriptions in May). Prescriptions of the contraceptive patch were generally steady with a slight peak in June and November (16 prescriptions). Prescriptions of IUD were generally extremely low with the largest number (9 prescriptions) in August. Prescriptions for the cap/diaphragm were omitted from figure 5I as there were only two prescribed throughout 2007.

Figure 5K shows the proportion of each method of contraception used. Each GP in Knowsley was assigned to North, Central, or South Knowsley and the prescription proportions were compared between regions to see any differences within Knowsley. However, the proportions of contraception used across the region remained consistent. There is a less than 1% proportion of Cap/Diaphragm and IUCD use in total across the PCT.

Figure 5L shows data on prescriptions of emergency and non-emergency contraception by month for 2007. The figure illustrates there were some variations in prescriptions throughout the year for combined and progesterone only oral contraception. Emergency contraception made up between 3% and 6% of all the prescriptions per month.

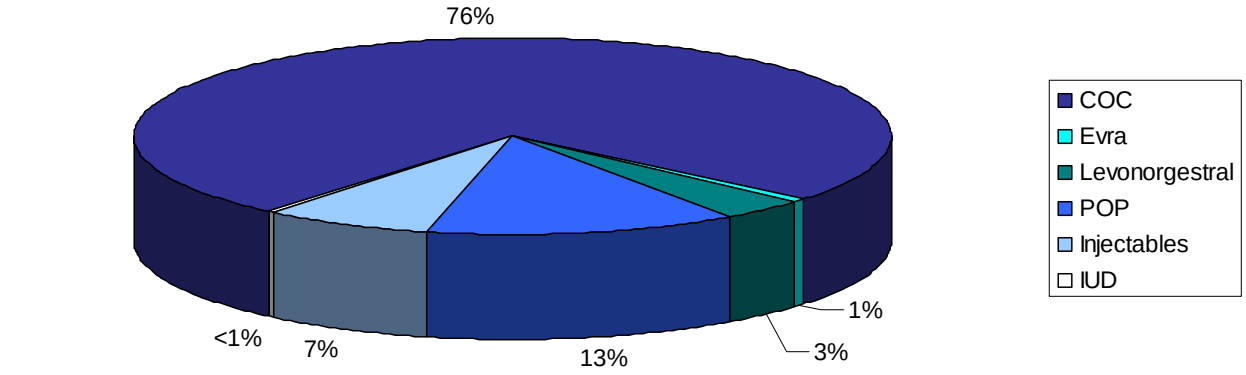
Figure 5J Prescription data for Knowsley PCT throughout 2007.*

* Cap/Diaphragm figures are not shown due to small numbers.



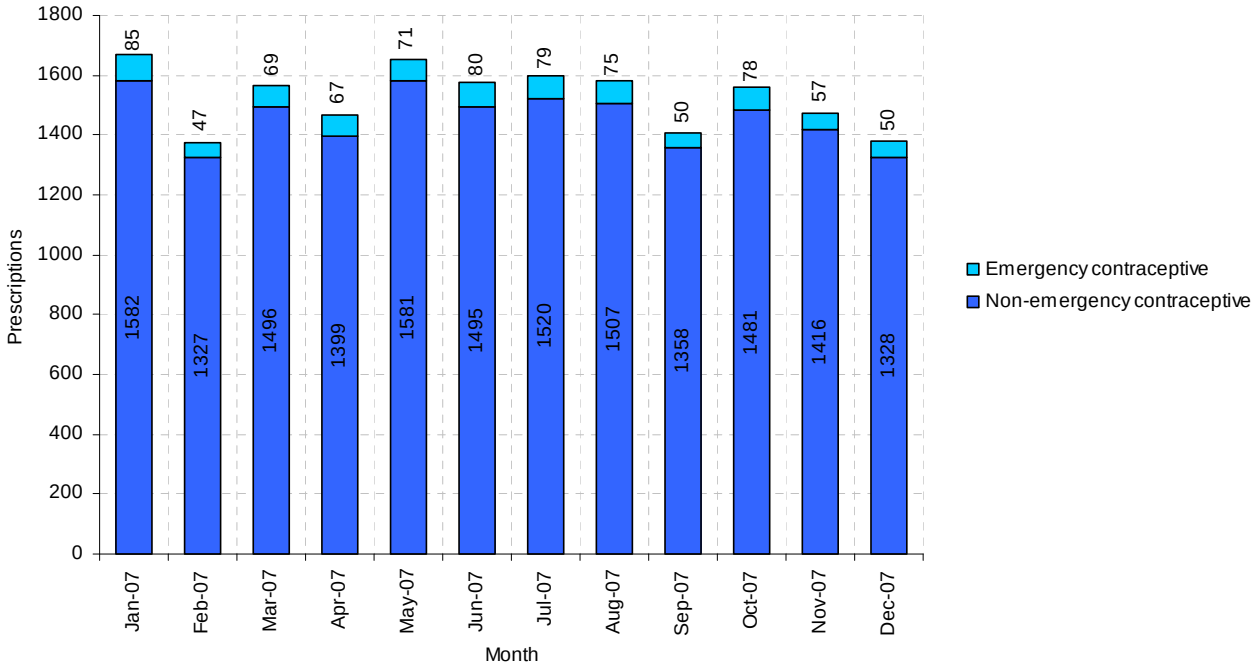
Source: Medicines Management, Knowsley PCT

Figure 5K Prescription data for Knowsley throughout 2007.*
* The figure does not include proportion of Cap/Diaphragm prescription due to small numbers.



Source: Medicines Management, Knowsley PCT

Figure 5L Emergency and non-emergency contraception prescribed by pharmacies in Knowsley, 2007



Source: Medicines Management, Knowsley PCT

5.7 Youth Services data

Specific youth services run throughout Knowsley (see section 5.13) allowing young people to access services in localised areas. Principally these services offer advice, condoms, emergency contraception, pregnancy tests, and chlamydia tests. The New Deal in the Communities (NDC) detached service operates in conjunction with these services which includes a 'touring' health bus. Sexual health/youth workers from Knowsley occasionally work with this team and accompany them around different sites across Knowsley.

A total of 439 people were seen at youth centres, including the health bus, across Knowsley in the second half of 2007, 62% of which were male. This represents an interesting finding when compared to the KT31 data which suggests that females are outnumbering males in service use. The attraction of these services for young males should be seen as an indicator for further promotion and availability. Almost half (49%) of youth service users are under 16, which demonstrates an equal use of the services by older and younger

teenagers. Every person that attended the youth service sessions was given advice (*n* = 439), and a total of 2,119 condoms were distributed. Only 2% of the total attendees were given a pregnancy test, and there was no emergency contraception given. Further, a quarter of attendees were dual tested for gonorrhoea and chlamydia.

5.8 Connexions data

Connexions is a national service with local partnerships. It offers information, confidential advice and support to young people aged 13-19 years old and for people aged up to 25 who have learning difficulties/disabilities. The services offered are wide ranging and includes information and advice on: careers, learning, health, housing, free-time, work, money, relationships, rights, and travel.

Table 5B shows the sex, age and ethnicity of teenage parents accessing Connexions services up to February 2008. There were many more females accessing the service than males (148 compared to 7) and the vast majority were of white ethnicity (97%).

Table 5B Teenage parents accessing connexions as of February 2008, Knowsley

Ethnic Origin	Age and Sex										Total
	Male					Female					
	16	17	18	19	Total	16	17	18	19	Total	
White British/Other		1	3	3	7	5	22	49	69	145	152
BME/Unknown								2	1	3	3
Total		**1**	**3**	**3**	**7**	**5**	**22**	**51**	**70**	**148**	**155**

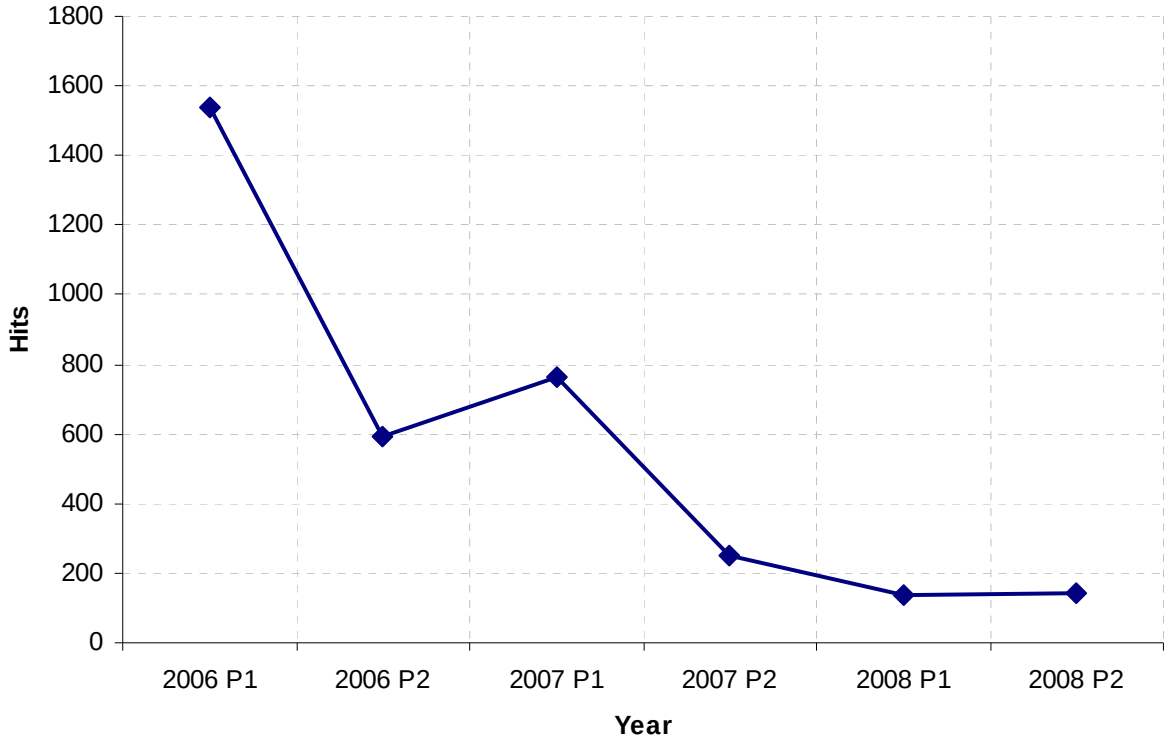
Source of data: Connexions Knowsley

5.9 Websites for young people

There are two specific websites aimed at young people in Knowsley that provide information on local services and general advice. Knowsleyspace.com was launched in July 2007 and has yet to be given a full launch and marketing campaign; as such there are no site statistics available for this website. The website links to a HIV/AIDS information page, and a more general sexual health page. The HIV/AIDS information includes a telephone number on which to contact the Knowsley THINK team. The sexual health page lists services that provide emergency contraception and STI testing. The website has a wide variety of links that can be easily accessed from many pages.

The knowsleythink.com website has been 'live' for longer than knowsleyspace.com and as such has more established monitoring of visitors in place. **Figure 5M** shows that visitors to the website have been gradually decreasing since 2006. This website offers general information on STIs and contraception as well as local clinics and a contact telephone number. These figures suggest that an effective website will receive visitors if it is marketed well and contains current and updated information.

Figure 5M Hits on the knowsleythink.com website, 2006-2008



Source: Knowsley Council, 2008

5.10 Prison Population data

Although Knowsley does not have a prison within its boundary, there are three prisons in the local region which could house Knowsley residents. Knowsley has developed an on site health check service for offenders going through probation service. The *Health Check Plus* service includes a sexual health assessment for men and women linked to advice and referral where required. In December 2007, a nurse-led sexual health clinic was set up at HMP Liverpool. It consists of one clinic per week with nine appointment slots and is held on a Friday morning. HMP Liverpool is a male prison with an operational capacity of 1,393 (operational capacity as of November 2006). Data from December 2007 to February 2008 shows that there were 39 new/re-registered clinic attendances. The new/re-registered attendances averaged 4.3 per clinic and the 'did not attend' (DNA) rate was 32.8%. Over two-thirds of the patients did not have an STI (KC60 code of D3). Of those who tested positive: 15.4% were diagnosed with genital warts (KC60 code C11A/B), 5.1% were diagnosed with uncomplicated chlamydia, and a further 5.1% were diagnosed with uncomplicated gonorrhoea.

5.11 Sex Worker data

There is a small provision of service available for male and female sex workers in Liverpool city centre, close to where sex workers operate. This is a commissioned service by The Armistead Centre in Liverpool which serves as an outreach centre for street sex workers and saunas in the city centre. The service, provided at Brownlow Medical, offers contraceptive services and testing for STIs and signposts to GUM services. The service also offers the opportunity to contact the sex workers with a variety of information. There is no evidence of any outreach work in Knowsley targeting brothels or saunas. Unfortunately there are no data available on service use. The only local data for sex workers as service users are from the National Drug Treatment Monitoring System (NDTMS). In the financial year 2007/2008, of clients accessing drug treatment, there were five in Knowsley PCT who were also street sex workers.

5.12 Termination of Pregnancy

In Knowsley PCT in 2006, there were 513 legal abortions carried out with the largest proportion (32%) aged between 20 and 24 years with the next largest proportion (16%) between 18 and 19 years. This differs from the North West as a whole which has the largest proportion (31%) aged between 20 and 24 years with the next largest proportion (19%) between 25 and 29 years. The majority (95%) of abortions in Knowsley were funded by the NHS or an NHS agency, which is higher than the national average of 86%. Almost a third (29%) of all abortions in Knowsley were in women aged under 25 who had had a previous abortion, which is a higher percentage than the national average (24%).

5.13 Information on sexual health services in Knowsley PCT

The following maps show each service in the different areas across Knowsley PCT.

Map A gives an overview of all services in Knowsley. The black boxes indicate the areas that are broken down further to provide a more detailed view of the services available in that specific area.
Knowsley is further broken down into four specific areas:

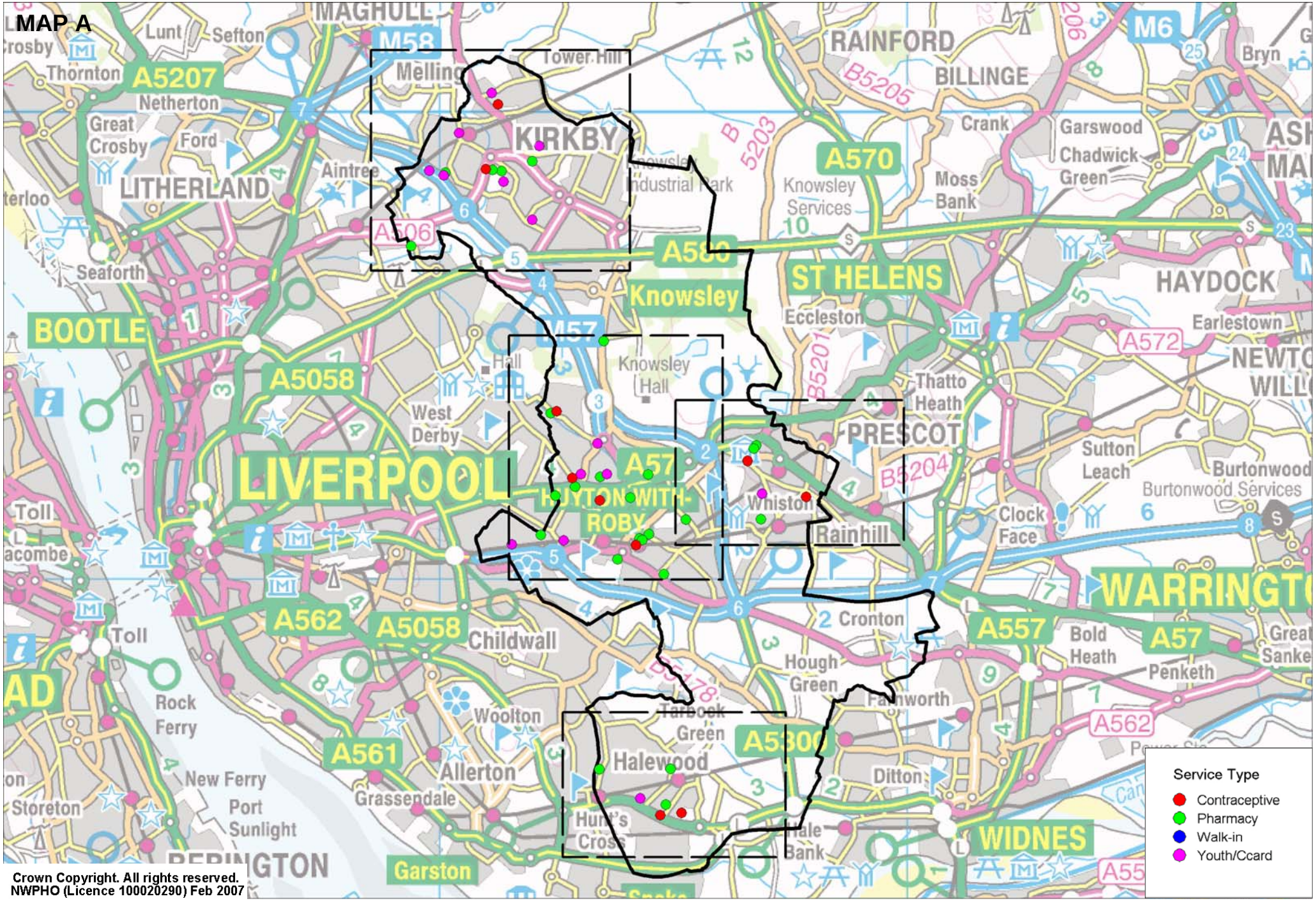
Map B – Kirkby area (Scale 1cm = 0.2km)
Map C – Huyton with Roby area (Scale 1cm = 0.2km)
Map D – Prescot area (Scale 1cm = 0.17km)
Map E – Halewood area (Scale 1cm = 0.17km)

The maps of a smaller geographic area allow for viewing the services in relation to populous areas and transport links. All major roads and train lines are indicated on the map. The reason for the breakdown is that it is imperative that a variety of services are available in the local areas of all the most heavily populated areas. The areas have been chosen to indicate what we deemed as a reasonable distance to travel to services, with particular regard to young people. All services have been numbered to allow for easy reference of service name and opening hours. Please see appendix 2 for a complete list of individual services and opening times corresponding to the service type and number.

A common theme with the pharmacies in all mapped areas was the disparity in the sexual health services thought to be provided (e.g. as included on the NHS website) and what is actually provided. A list of services was compiled using the NHS website which is how a potential service user may gain the information. This list was then presented to the expert panel for verification and additional information. Finally, a telephone based questionnaire was used when contacting all the services directly to establish what services they offered. The information presented here are the results of the telephone audit completed for the present needs assessment, unless otherwise stated.

All sexual health services identified at the expert panel meeting were contacted as part of this rapid sexual health needs assessment. Opening times and services offered and other comments were audited. All details regarding the services were correct at the time of the audit. The service information sheet used during the audit is included in appendix 1.

MAP A



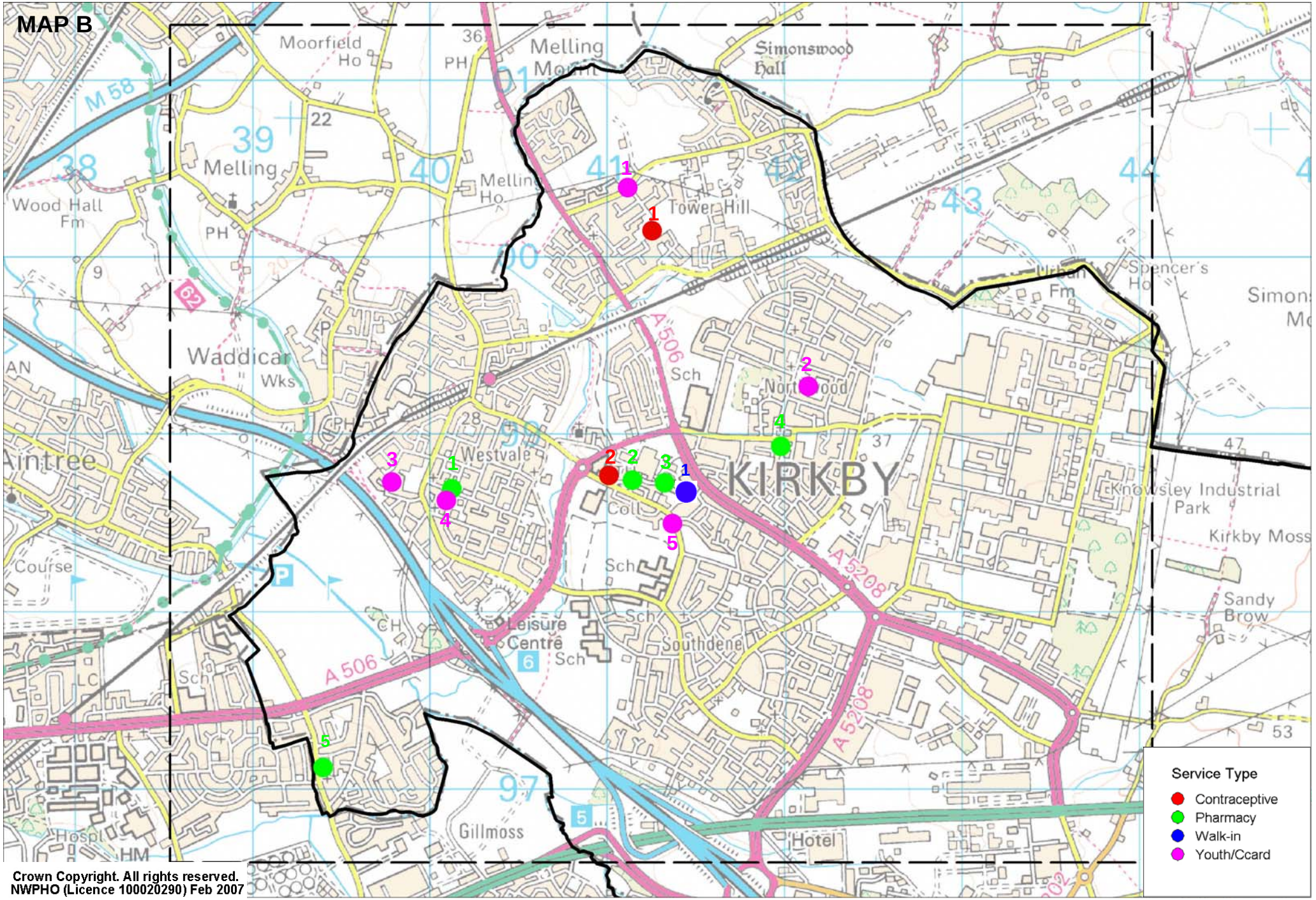
Map B covers the Kirkby area, and specifically Tower Hill, Northwood, Westvale and Southdene.
There are contraceptive, youth, pharmacy, and walk-in services available in the north of Knowsley.

Pharmacy
The five pharmacies give good coverage across the localised area and are available on every day of the week. There is a pharmacy available from 8.30am until 6.30pm on weekdays, and on Saturday and Sunday mornings. Regardless of the good coverage provided by the pharmacies, there seems to be some incongruence between what they are expected to provide and what they provide in reality. All of the pharmacies are listed as offering free chlamydia screening kits, however only one currently does. There were several reasons why the others were not offering the kits including waiting for stock. Of the five pharmacies expected to provide free male condoms only four currently offer them. One of the pharmacies is no longer offering any of the services previously expected of them due to opposition to the re-accreditation process. The accreditation process does not affect pharmacists in neighbouring PCTs, but Knowsley PCT has brought in an accreditation process that pharmacists must take in order for them to be able to prescribe free emergency contraception in the PCT. It is expected that the five pharmacies provide emergency contraception free of charge; however it is currently not on offer at any of the pharmacies. Reasons for this include completing the training but not finalising the application process, and not offering the service as they have recently been taken over by new owners. This limits the amount of access local residents have to emergency contraception, and shows a mismatch in service provision and expectations of services, as it was previously understood that emergency contraception was on offer at these five locations.

Contraceptive Services
With regard to contraceptive services available in the Kirkby area, there are two centres available for the local residents. The services offer a good variety of options including emergency contraception, advice on pregnancy, and chlamydia screening. One service is located in the Tower Hill area, however, this service is only available during very limited hours (4 hours per week), on two days of the week. The second service is centrally located in Kirkby and again opens for 6 hours per week. Between the two services they cover Monday through to Thursday but there is no availability at weekends or on any mornings.

Youth Service
Youth services, including THINK in a box services, are located throughout north Kirkby covering the majority of the area. The five youth services across the local area are available on a total of four days out of the week, which does not cover Friday or Saturday nights. The youth services are available from 6.30pm to 8.30pm on Monday and Tuesday; 6.30pm to 9pm on Wednesday; 5pm to 8.30pm on Thursday; and 5.30pm to 9.30pm on a Friday. The scheduling of these services does enable the majority of young people in education and paid work to access the services.

Walk-In Service
The walk-in centre is centrally located by the main shopping centre in Kirkby. The service has long opening hours on every day of the week and currently offers emergency contraception. The location of the service and opening times allow for all people to access the service when they are likely to need emergency contraception. There could be scope for increasing the amount of sexual health services offered considering the long opening hours and centralised location, which could be of benefit to the local area.



Map B

Pharmacy	Opening times													
	7-8	8-9	9-10	10-11	11-12	12-1	1-2	2-3	3-4	4-5	5-6	6-7	7-8	8-9
Monday														
Tuesday														
Wednesday														
Thursday														
Friday														
Saturday														
Sunday														

Contraceptive	Opening times													
	7-8	8-9	9-10	10-11	11-12	12-1	1-2	2-3	3-4	4-5	5-6	6-7	7-8	8-9
Monday														
Tuesday														
Wednesday														
Thursday														
Friday														
Saturday														
Sunday														

Youth/Ccard	Opening times													
	7-8	8-9	9-10	10-11	11-12	12-1	1-2	2-3	3-4	4-5	5-6	6-7	7-8	8-9
Monday														
Tuesday														
Wednesday														
Thursday														
Friday														
Saturday														
Sunday														

Walk-In	Opening times													
	7-8	8-9	9-10	10-11	11-12	12-1	1-2	2-3	3-4	4-5	5-6	6-7	7-8	8-9
Monday														
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Thursday														
Friday														
Saturday														
Sunday														

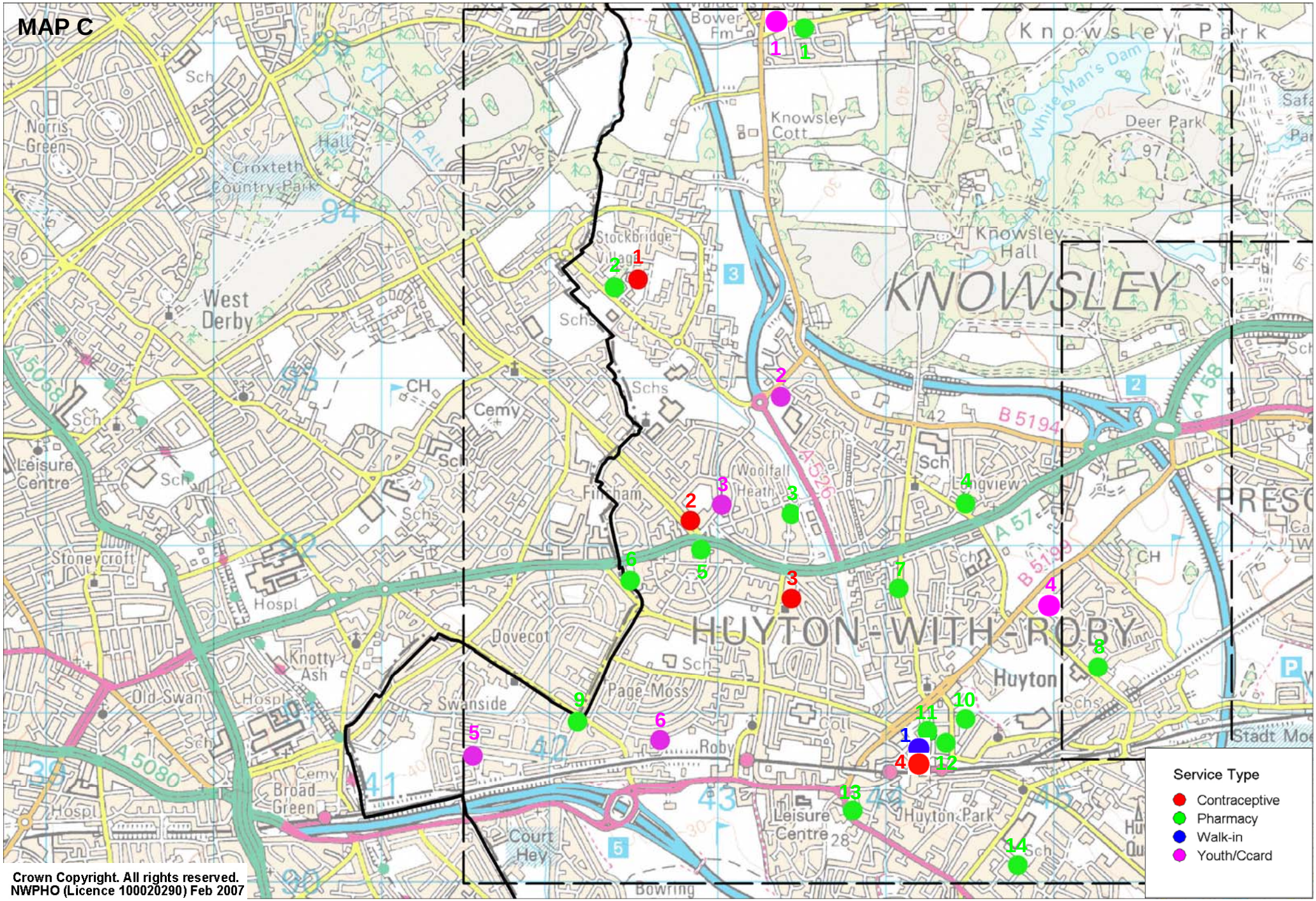
Map C focuses on the Huyton with Roby area, including Swanside, Page Moss, and Stockbridge Village.
This area has pharmacy services, contraceptive services, youth services, and a walk-in centre available to the residents. The Nutgrove Villa site offers a range of services which dominates much of the service provision in the area.

Pharmacy
There are 14 pharmacies in the area that are expected to offer a combination of contraceptive services and chlamydia testing. The availability of a pharmacy in the area is heavily dominated by one service available for 100 hours a week. This service offers free condoms but is currently not dispensing free emergency contraception; the pharmacy also participates in the chlamydia screening programme. This one branch offers good options to the residents of the area, particularly in central Huyton. Of the 14 pharmacies, all were expected to supply free male condoms, and 13 did so. The reason for the outstanding pharmacy not currently supplying the condoms is due to an unaccredited pharmacist.
Twelve pharmacies are expected to offer free chlamydia screening; and currently all but one is offering the free tests. There are currently seven pharmacies offering free emergency contraception in the area, and a further one who is seeking to be qualified for Knowsley in the near future. There is a good level of service provision offered by the pharmacists in the area, and this is reinforced by the accessibility to services due to long opening hours.

Contraceptive Service
With regard to specific contraceptive services offered throughout Huyton and Roby, there are four individual services available on four days of the week. Swanside is the only area within this locality which does not have a contraceptive service in its proximity.

Youth Services
There are six youth services available in the area which represents good coverage across the entire area. There is at least one youth service available on each week day evening which users can access for condoms, advice, emergency contraception, pregnancy testing, and chlamydia testing. One difference to the youth service in this area when compared to those of Kirkby is the availability on a Friday evening.

Walk-In
The walk-in centre at Nutgrove Villa located in the centre of Huyton offers access to many services on every day of the week from morning until night. The walk-in option for chlamydia and gonorrhoea screening allows for excellent access to free screening. There are specific clinics provided by Abacus on Monday evenings and Saturday mornings. This service is ideally located close to public transport links.



Map C

Pharmacy	Opening times													
	7-8	8-9	9-10	10-11	11-12	12-1	1-2	2-3	3-4	4-5	5-6	6-7	7-8	8-9
Monday														
Tuesday														
Wednesday														
Thursday														
Friday														
Saturday														
Sunday														

Contraceptive	Opening times													
	7-8	8-9	9-10	10-11	11-12	12-1	1-2	2-3	3-4	4-5	5-6	6-7	7-8	8-9
Monday														
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Sunday														

Youth/Ccard	Opening times													
	7-8	8-9	9-10	10-11	11-12	12-1	1-2	2-3	3-4	4-5	5-6	6-7	7-8	8-9
Monday														
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Saturday														
Sunday														

Walk-In Centre	Opening times													
	7-8	8-9	9-10	10-11	11-12	12-1	1-2	2-3	3-4	4-5	5-6	6-7	7-8	8-9
Monday														
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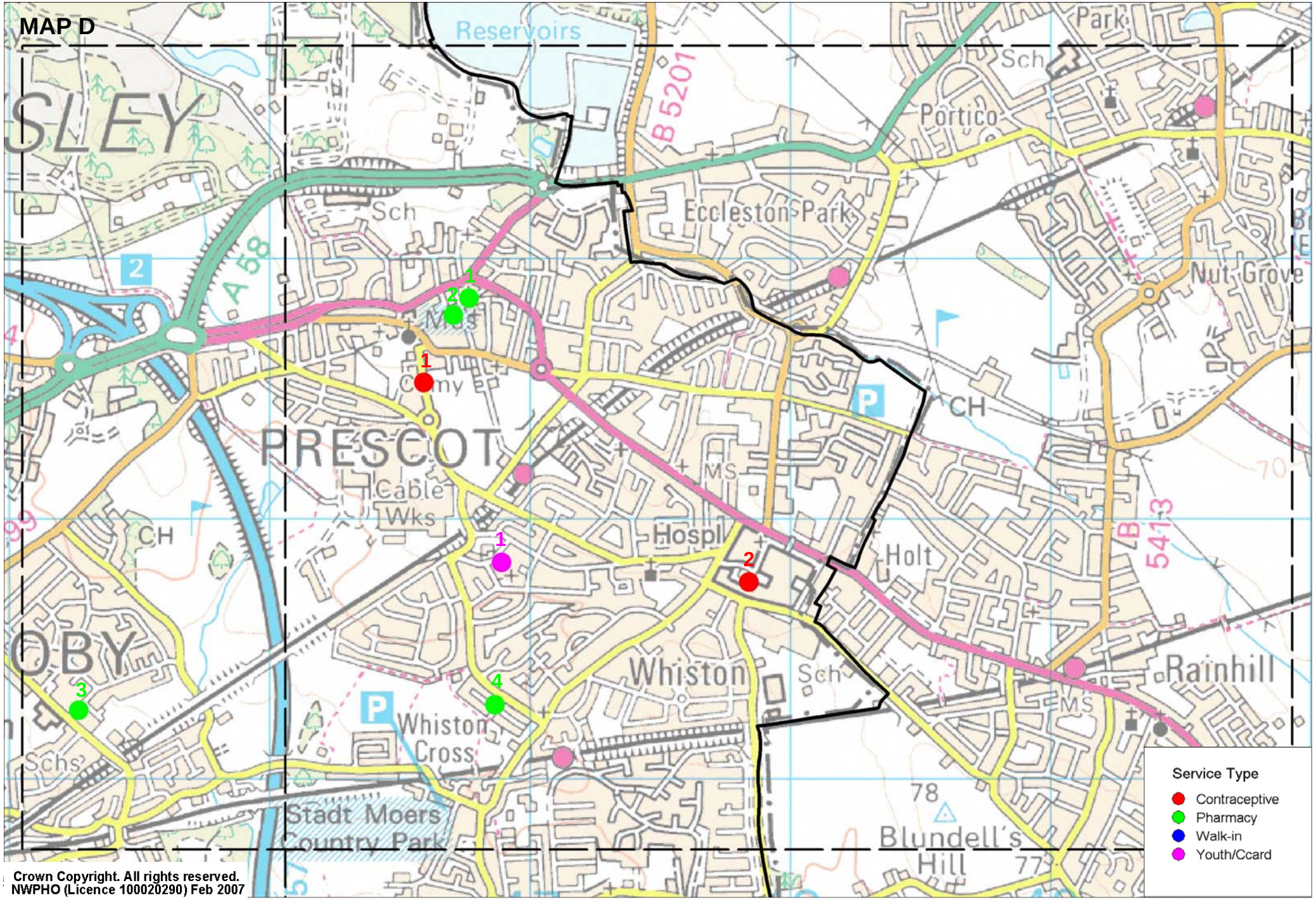
Map D focuses on the area to the east of Huyton around Prescot and Whiston. The amount of service available in this area is less than the other two areas previously discussed.

Pharmacy
There are four pharmacies in the surrounding area but no pharmacy available at the eastern edge of the PCT boundary. As expected two pharmacies provide free condoms, however these two pharmacies are in the south of the area which leaves limited access in the north of the area. There are two pharmacies, one in the north of the area and the other in the south, that were expected to offer free chlamydia screening tests. However, neither of them currently offer this service. One reason for this is due to the previous pharmacist leaving the area. All of the four pharmacies were expected to provide free emergency contraception, however only two currently offer it free of charge. One reason for the pharmacies not offering the free service, as expected, is due to them not being accredited in this PCT. However one of the pharmacists is eligible in a neighbouring PCT.

Contraceptive Service
Two specific contraceptive services are available in the vicinity, one in Prescot and one in Whiston. Subsequently there is limited access to these specific services in the area, which operate two evenings a week (Tuesday and Thursday).

Youth Service
The only youth service in the area is centrally located and offers services on two evenings a week, one of which clashes with the contraceptive service. The youth and contraceptive services are also located relatively near each other.



Map D

Pharmacy	Opening times													
	7-8	8-9	9-10	10-11	11-12	12-1	1-2	2-3	3-4	4-5	5-6	6-7	7-8	8-9
Monday														
Tuesday														
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Saturday														
Sunday														

Contraceptive	Opening times													
	7-8	8-9	9-10	10-11	11-12	12-1	1-2	2-3	3-4	4-5	5-6	6-7	7-8	8-9
Monday														
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Sunday														

Youth/Ccard	Opening times													
	7-8	8-9	9-10	10-11	11-12	12-1	1-2	2-3	3-4	4-5	5-6	6-7	7-8	8-9
Monday														
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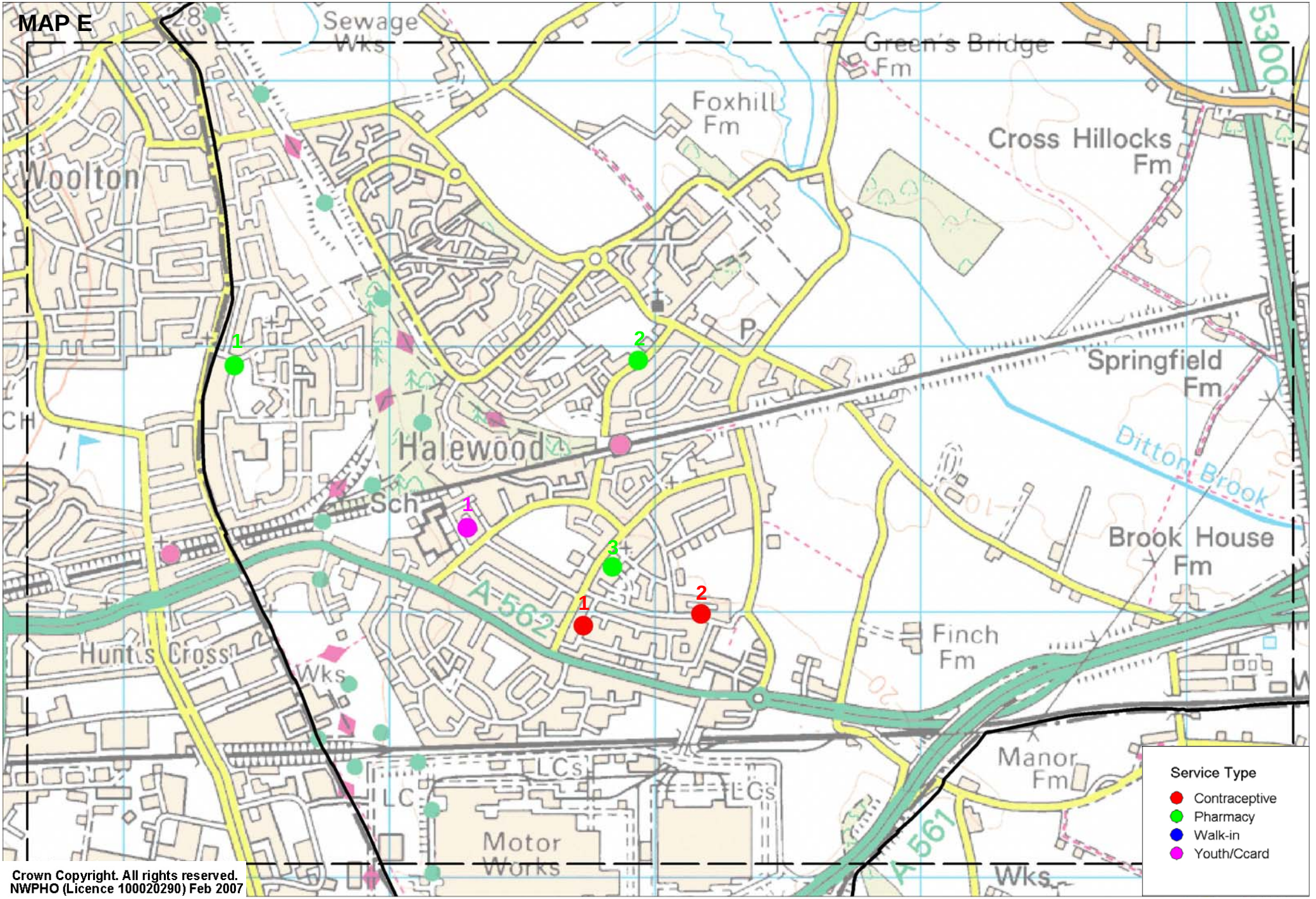
Saturday														
Sunday														

Map E focuses on the south of Knowsley and specifically around the Halewood area. Halewood is the most populous area of south Knowsley and as such the services are localised there. However, the amount of service offered is lower than other areas across Knowsley.

Pharmacy
As expected, there are three pharmacies in Halewood who offer free condoms. Both of the expected pharmacies participate in the chlamydia screening program. All three pharmacies offer emergency contraception as expected. Halewood appears to be the only area in Knowsley where the complete expected level of service is provided. Atleast one pharmacist is available until 6.30pm on weekday nights, and there is availability on Saturday mornings. This means that pharmacy services are available throughout the week and that service users can procure a range of the products and services.

Contraceptive Services
With regard to contraceptive services in the area, there is a THINK clinic and an Abacus service available on the same day of the week at the same centre. Essentially, a contraceptive service only runs on Wednesday afternoon and early evening. There is no other specific contraceptive service available at any other time during the week.

Youth Service
There is one youth service located in central Halewood which is available on Tuesday and Wednesday evenings. Similar to the Prescot area, there seems to be some overlap with the contraceptive services.



Map E

Pharmacy	Opening times													
	7-8	8-9	9-10	10-11	11-12	12-1	1-2	2-3	3-4	4-5	5-6	6-7	7-8	8-9
Monday														
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Wednesday														
Thursday														
Friday														
Saturday														
Sunday														

Contraceptive	Opening times													
	7-8	8-9	9-10	10-11	11-12	12-1	1-2	2-3	3-4	4-5	5-6	6-7	7-8	8-9
Monday														
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Sunday														

Youth/Ccard	Opening times													
	7-8	8-9	9-10	10-11	11-12	12-1	1-2	2-3	3-4	4-5	5-6	6-7	7-8	8-9
Monday														
Tuesday														
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6. Findings from the stakeholder meeting- Knowsley

6.1 Participants
Relatively small number of participant who worked exclusively in Knowsley (*n*=4). Groups also included participants who have a cross-PCT role. Hence some comments may not be attributable to Knowsley.

6.2 Commissioning
"If you have support from the leads it makes it work better. There is no sense of that is yours and this is ours - you can't see the threads it just merges into one."

All participants agreed that Knowsley works well because the leads work together. It was stated that joint posts across the Local Authority and PCT make a huge difference. It ensures that they have a full understanding of both systems.

National policy can be a barrier - funding needs to be longer term and more sustainable.

A priority is to focus on unmet needs. In the words of one participant, *"we know the needs of those accessing services but not those we don't know about."*

6.3 Capacity
Participants identified a number of positive aspects of current capacity including good clinical services; innovation-taking forward new ideas; excellent access to abortion services; and a large increase in the numbers of people accessing GUM for contraceptive services.

Participants also stated that there is never enough capacity - demand eats up capacity as soon as it is created. This can partly be verified by the concerns about waiting times in evening clinics, and on occasion, reports that people are not seen by a clinician despite presenting within a clinic's time slot. However it was also reported that some daytime clinics are underused. This issue clearly may be as much about service configuration as well as overall capacity.

Some argued that there is a need to be working further upstream, helping people make informed choices and preventing problems occurring in the first place.

A participant stated that some people are not always willing to go to a department of GUM if they are symptomatic. They prefer to be tested in the community and then, when positive go to the GUM. Therefore they are being tested once in the community and once in GUM.

6.4 Integration
"If you have a foot in one camp and a foot in another then it can work – rather than in two separate camps. If the leads at the top are joint posts, this filters down. For example - The drugs worker for healthy schools works with the drugs worker with the specialist nurse. They go into projects together and work out things together so they know what's happening and this is mirrored across Knowsley."

Participants agreed that an interdisciplinary approach works much better since it helps to link services to each other; establishes relationships between providers and helps to signpost patients appropriately.

Some participants argued that improvements could be made to ensure services are fully integrated. This could extend to including sexual health services in leisure centres, which would provide a holistic health approach.

GPs provide level one service to a point but the spill over is still seen at community clinics as the appointment system is not user friendly. It was argued that a compromise between appointment and walk-in is needed.

Participants agreed that sexual health services need to be managed as one integrated service, which would include teenage pregnancy, termination of pregnancy, contraception, STIs, screening and youth work.

The computerisation of client records is needed in order to ensure the continuity of care for young people who access various different sites for help. This would help clinicians to know a client's history and prevent the duplication of tests.

Participants identified the need to improve communication amongst service providers. Regular meetings and establishing networks will ensure that services work well and seamlessly together. Although this involves time out of work, it will help in the long run. One person recommended that there needs to be a general sexual health networking forum, which could send out email bulletins and coordinate the dissemination of information.

6.5 Accessibility

Are services accessible to all potential users?

Participants agreed that not enough information exists about people not accessing the services. It was recommended that it would be useful to conduct further research to find out more about potential service users.

Participants identified the following risk groups:

- Young people, especially non-school attendees, care leavers and young offenders. It was reported that chlamydia screening has links with youth offenders.
- An older population of 35-45 year olds – It was stated that women in this age group are seeking termination of pregnancy. It is thought that lifestyle freedom is the cause of unprotected sex amongst people who are recently divorced or recently separated.
- Recreational drug users and alcohol users
- People in areas of high deprivation areas
- Travellers
- Asylum seekers often have a lot of other issues and so don't always prioritise their sexual health. It was reported that asylum seeker assessment centres needs to strengthen the links with sexual health services. Language can be a major barrier
- Migrants from Eastern European - language and cultural barriers to overcome.
- Prison populations
- MSM – are poorly represented in the mainstream sexual health services. This may be because the services are still perceived as being 'family planning' orientated. The GUM is relatively more acceptable to MSM – partly because of the 50/50 male female split among clients. The Armistead project is successful in contacting MSM and establishing pathways into the GUM.

Participants spoke of their concerns that despite an increase in men attending sexual health services across Merseyside, the perception still exists that services are female orientated. Participants did report signs that things are changing with men seeking contraception and chlamydia screening.

Are services in the right places and available at the right time?

Discussion took place about the need to have accessible sexual health services nearby in the community but not necessarily on the doorstep. Services in the community are sometimes too close to residential areas. This could mean that they are too close to families and not anonymous enough.

The relocation of the Kirkby service from the town centre to Tower Hill was considered a problem by some and an opportunity by others at the meeting. It was reported that the numbers of people attending clinic sessions has fallen since the relocation. The service has looked at expanding the times but there are problems with planning issues. ***"****It is supposed to be for the whole community – so how can 1-3pm in the afternoon (session) be for the entire community?"*

Participants said that GU services need to be in neutral places. They need to be close to public transport routes and provide a central anonymous service. Town is popular because it is easy for people to access. People will travel to access services depending upon where they live. E.g. Kirkby people won't go to St Helens but will go to town (Liverpool) because of public transport routes are easier.

However, it was identified that there are problems with travel especially for young people whom may not be as mobile as people think they are. Some participants spoke about a cultural or territorial element concerning young people not wanting to go into other areas. On occasion's buses and bus routes have resulted in clashes among young people. Travel problems can be made worse for young people because of relatively expensive bus fares. It was reported that bus fares could be refunded to any pregnant under 18s.

Service location is not the only determinant of whether a service is accessible. Flexible opening times will be an important determinant of service use. It was stated that weekend and out-of-hours services are more accessible - especially for young people who understandably may find it difficult to attend services during school-times. Patients questioned at the GUM said that opening times before work, during lunch breaks and after work are convenient.

It was stated that daytime contraceptive clinics are under used, whilst the evening clinics are overused.

Participants mentioned the problems associated with trialling different opening times. They need to be trialled over a long period in order to determine whether the new times are beneficial. If the trial proves that the proposed shift in opening hours was not successful, there are problems associated with reverting to other times.

Discussion also took place about availability and accessibility of telephone helplines and websites. Participants mentioned the *RU Thinking* website, which can provide local information, and the *Sexwise* phone line. It is thought that knowledge of these sources of help will be variable across Knowsley.

Are services providing what people need? Are they appropriate, friendly, confidential, flexible, and effective?
It was reported that satisfaction was high among drop-in patients in GUM settings. The biggest cause of complaint was waiting time. It is common for a relatively large number of people to arrive at the beginning of a session or even prior to its start. It was stated that occasionally the session may close early and everyone may not be seen. Some participants considered that consistent delivery of some services is also affected by staff variability.

Brook GU only runs twice per week and it should be available at least five times per week. Since it has been in operation the proportion of men accessing Brook has gone up from 5% to 35%. It was reported that Brook GU clinic causes the waiting room to fill up as it is so popular. However, this has a knock-on effect causing people to think that the clinic is really busy when it is in fact people for the GUM clinic.

Participants stated that some services are turning people away and are sometimes forced to close their doors when their waiting rooms are full. Although they reopen the doors later when demand has lessened, it is inevitable that some people will have chosen not to attend the service in the mean time.

It was reported that a waiting room survey recently conducted showed that people weren't in favour of mixed waiting rooms. THINK (Teenage Health in Knowsley) consists of sexual health workers and substance and alcohol misuse workers who work across the borough through centres, detached projects, clinics and other youth provision. It was reported that youth workers manage these waiting rooms really well.

Participants stated that outreach helps to bring people including marginalised groups into service and has an important snowballing publicity effect. However it was recognised that maintaining contact is difficult and it is also difficult to monitor. The Armistead project in Liverpool, together with Knowsley youth service, is providing outreach services in Knowsley entitled GAY Knowsley.

Participants stated that branding is very important to ensure that services are accessible e.g. Abacus is a successful brand – otherwise it would still be called family planning. Similarly it was suggested that the success of *Think in the box* in Knowsley has a lot to do with its branding. In the past, people have seen that THINK was all about sexual health services, so young people would not come and access the services because it was at school and they would be affected peer pressure. Currently, *Think in the box* is re-branding to include other health issues e.g. - healthy eating attracts young women.

6.6 Prevention

Participants stated that there was a strong commitment to prevention by commissioners. However it was stated that PHSE in school needs to be made a priority by Government.

Participants reported that getting prevention services into schools has proved problematic in Knowsley and Liverpool, which has resulted in a variable and limited provision of contraception. It was reported that a faith school has allowed the delivery of sexual health prevention from a bus located in the school car park, but not within the school building. It was reported that school nurses in Knowsley have had success in distributing condoms in a variety of school and other informal youth settings.

Think in a box provides contraceptive services, which includes emergency contraception, condoms and chlamydia screening. It is a confidential service and young people are contacted with results via a text message to their mobile phone or by other arrangement.

It was reported that health-seeking behaviour is different in different parts of Merseyside. Young people attending Brook in Liverpool are more savvy; able to seek out services and aware of what is available and what they need. Young people in clinics in Knowsley tend to have more of a 'blame culture attitude' – they don't want to be responsible for their own health. E.g. will blame the pill for hair loss and weight gain rather than look at their very poor diet.

Concerns were raised about the link between alcohol, drugs and sexual risk taking.

Participants involved in the delivery of PHSE in schools reported that a lack of knowledge amongst parents regarding STIs and sexual health was a problem. It was suggested that a programme to educate parents is needed as well as support for PHSE teachers. It was reported that parenting programmes such as 'Speak Easy' help to promote sexual health to parents and teach them how to pass it on to their children.

Participants stated that the 'C-card scheme' should be rolled out in Knowsley. Discussion also focused on making condoms more attractive to young people e.g. flavoured condoms; mixed bags of different types of condoms. THINK in a box give out loads of freebies, which young people approve of.

7. Gap analysis

The gap analysis presented in this section is a result of the preceding needs and demands sections. The aim is to provide analysis on which to inform future service provision decisions to improve the sexual health of the local population.

7.1 Where need is not met

Section 4 explored the needs of different populations within Knowsley. Subsequently, the demand section presented data that were available from services across the PCT about service use specific to these populations. Accordingly, the following section concentrates on the differences between the two sections.

7.1.1 Unmet needs

MSM

The enhanced surveillance data do not include information on the route of infection (MSM acquired or heterosexually acquired). However data analysed by sex (table 4A) and findings show that there is prevalence for syphilis in the male population only. This is predominantly an MSM acquired infection and table 4B shows that it is males aged 25-29 years that have the highest prevalence. There is a smaller prevalence in males aged 15-19, 35-39 and 45-49 years. There is no population data available that reliably estimates MSM populations therefore we are unable to state the size and demography of this population in Knowsley and are subsequently unable to determine whether MSM are proportionally represented in the STI data for Knowsley. Heterosexual men are under represented in sexual health services in Knowsley and MSM represent a harder to reach group, therefore they are even less likely to access community sexual health services, especially when those services are predominantly aimed at heterosexuals. Findings from the Gay Men's Sex Survey also showed that many gay men in the North West would like other way to meet men that did not involve sex, which could be seen as an opportunity to reach out to the individuals through the formation of interest groups who in turn can be approached to promote good sexual health. A recent initiative by the Armistead Project has seen the development of GAY Knowsley which acts as an outreach service, and is the first such initiative in Knowsley. Therefore it would be valuable to know how well this service has been received by the gay population in Knowsley. With this specific population in mind it would be beneficial for this outreach service to provide syphilis screening, condoms, lubricants, STI information and information about relevant sexual health services. Armistead are an NHS service who offer a range of services to gay and bisexual men, including groups for people with learning difficulties, men with HIV (via a support group relating to sexual health promotion and one-to-one support to individuals) and their families or carers and sex workers. Their work involves support and social groups, drop in service, face-to-face advice and information, a telephone helpline, health promotion events and free condoms and lubricant and they work with partner services to meet the wider needs of MSM, such as mental health, drug harm reduction and victim support. They are also involved in the Gay Men's Sex Survey every year providing input into questions used and the dissemination and collection of the surveys. The information collected informs targeted health promotion within the local MSM population.

HIV positive populations

Data are available on the HIV positive MSM population through infection route information. With regard to the HIV positive population, the major need is in males aged 35-39 years. Consistent with the ethnic profile of Knowsley, there are low numbers of HIV positive people from BME groups. There is a relatively low proportion of HIV positive MSM accessing voluntary services across the region. Raising the profile of these groups (such as Body Positive) may help to support these individuals by giving them opportunities to access free confidential advice on health and social care issues amongst other services. There are also a low number of people accessing social service support for HIV, which is another area which could benefit from a raised profile to ensure HIV positive people are aware of the services they can receive. Further information and research is needed to establish why they may not be accessing services and any barriers they may be facing.

Non-UK nationals and asylum seekers

We are aware of migrant populations suffering with HIV that access care at GUM clinics in the North West. The HIV/AIDS Monitoring Unit at the Centre for Public Health is the only HIV surveillance system to record residency status of patients. This data field is not routinely collected on hospital systems therefore very little data are available to tell us if migrant populations are accessing services or not. This is also the case with travellers.

The needs of refused asylum seekers are even more difficult to establish as, in terms of health care, they are not a very visible group. Participants at the stakeholder meeting stated that there are some outreach services for asylum seekers at assessment centres. However, as a group, we have no way of knowing the needs of those who are awaiting deportation and this remains an unknown area.

Men/young men

Overall fewer men are accessing services than women. Findings show that the majority of men access sexual health services via GUM rather than community services. However, GUM data are likely to refer to care for sexually transmitted infections. Community services, although carrying out STI screening, primarily provide contraceptive

services. Data show that of all men accessing contraceptive services the majority (60%) are aged under 15–17 years. This indicates that services aimed at young men are reaching their target population. However, men aged over 18 years do not appear to engage with contraceptive or community based sexual health services to the same degree. Findings from the stakeholder meeting (for Liverpool) revealed that when Brook began providing a GUM service twice a week the numbers of men accessing Brook for contraceptives increased dramatically. Knowsley stakeholders raised the point that contraceptive services are still perceived to be female orientated and that work needs to be done to change the perception of 'family planning' services to something more acceptable and inviting to both men and women, especially those aged over 18 years.

Teenage girls

The teenage pregnancy rate in Knowsley is declining. 2004 saw a set back in the teenage pregnancy rate with a large increase in numbers (which increased from 39 to 50 conceptions per 100,000 girls aged 15-17 years between 2003 - 2004) and even though 2006 has seen a reduction the rates have not yet returned to the low of 2003. Furthermore, there has been an increase in the under 18 abortion rate (14% increase, figure 4E). These data reveal that young women continue to need access to appropriate contraceptive services, including emergency contraception. There are no data available on the causes of unplanned pregnancy in Knowsley. However, contraceptive failure could be a reason. Incorrect use of contraception and lack of knowledge and awareness of contraceptives and the morning after pill could also contribute to the rate of unplanned conceptions. Lack of understanding regarding the limitations of the contraceptive pill, for example, knowledge about the need to take it at regular intervals, not miss a pill, what to do if a pill is missed, the effects of vomiting and/or diarrhoea on the effectiveness of the pill could contribute to unplanned pregnancies. In a 2006/07 national study 53% of women (aged 16-49 years) questioned were aware that the emergency hormonal contraceptive pill could be taken 72 hours after sexual intercourse with 41% underestimating the time period in which EHC can be used and 1% overestimated it. Twelve percent of women were aware that the IUD could be used effectively up to five days after sexual intercourse, 38% underestimated the time period and 3% overestimated it. These data show a lack of awareness surrounding emergency contraception although these data are not specific to young women and therefore can only be used as a guide. Findings from an evaluation of sexual health services in Knowsley questioned a small sample of young people on the issue of the 'morning after pill' and showed that 96% had heard of EHC which is higher than the 68% of young people (16-19 years) questioned in the national 2006/07 study, however the evaluation in Knowsley did not ask about young people's knowledge on EHC effectiveness[74]. An understanding of young people's knowledge of sex and relationship education and knowledge of the practical application of contraceptives would help to inform the planning and promotion of skills-based interventions and education programmes.

Pregnant women

Women aged 20-24 years are the main group accessing contraceptive services in the community. However, they also have the highest rate of terminations in Knowsley (165 in 2006) and 23% of all women under 24 years had undergone at least one termination previously[55]. Overall Department of Health abortion statistics show that between 60-70% of NHS funded abortions were carried out under 10 weeks gestation which shows that women are being tested, referred and treated in a timely manner. However, Knowsley also has one of the poorest percentages of LARC prescriptions in the UK with only between 5.1 to 11.6% of all GP prescriptions given for LARC, compared to 16.9 to 24.5 in other PCTs[56]. Recent pharmacy data (2007) show that LARC prescriptions make up 7.2% of all prescribed female contraceptives. This low level of LARC prescription is not in line with NICE guidelines[15] and is an area that needs further attention. Contraceptive services and promotional campaigns could focus on the use of LARC as a more effective alternative for younger females seeking contraception in Knowsley.

Sex Workers

As known from the consultation on the managed zone for sex workers in neighbouring Liverpool, street sex workers do have health needs and sexual health needs in particular. It was found that sex workers would have used sexual health services if a managed zone were set up. Some services are already used substantially by sex workers, such as drug treatment services. However, less than half (44%) had used GUM services in the previous year. There are no outreach programmes in Knowsley working with sex workers; however there is an outreach service commissioned by the Armistead Centre in Liverpool. There was no managed zone set up so the needs identified by the sex workers involved in the consultation may still be outstanding needs. However, with little data relating to sex workers, this is something that cannot be fully established.

Very little is known about young people involved in sex work, male sex workers or 'off street' sex workers. There are no data available at a local level to be able to identify their needs. This is an area of service provision which needs more investigation to establish needs, unmet needs, demands, and gather information on the reasons why sex workers may not be accessing some sexual health services and the ways in which services may be created or adapted to meet the needs of this group.

Prisoners and young offenders

The health of prisoners is recognised as an important issue within the prison care system and sexual health needs are being addressed locally with the establishment of a service at HMP Liverpool, the nearest prison to Knowsley. This

clinic is run once a week and is diagnosing STIs. However, it was also noted that there was a large number of clients not attending appointments. It is not known why this is the case and whether it is only the case at HMP Liverpool or whether this is the case at other prisons. This represents a gap in Knowsley which needs investigating to firmly establish the needs of prisoners.

The health needs of female prisoners are outlined in national policy documents. However, there are not much data available on this group of the prison population in the region. The nearest all female prison is HMP Styal in Cheshire where chlamydia screening is being conducted. The uptake of the screening, as part of the National Chlamydia Screening service, shows that there are sexual health needs of women in prison. However, as is the case with male prisoners within Liverpool, there is little information available. Male and female prisoners, including young prisoners, will also have sexual health care needs on release from prison but we have no local data to assess what these needs are.

There are no specific local data on the sexual health needs of young offenders, whether in custody or not. However, some of the risk factors for youth offending are also risk factors for other issues such as teenage pregnancy (for instance, low achievement and disruption at school). We also do not know a lot about the sexual health needs of young people in prison locally, although we know that nationally they are a group who take risks with their sexual health.

7.2 Where there are insufficient services

7.2.1 Sexually transmitted Infections

The data presented in section 4.2 highlights specific problems within the STI rates. As expected there are high levels of chlamydia throughout the region, specifically in women between 15-29 years. It is not a trend unique to Knowsley as it is known to be a national problem; however, it is imperative to keep progressing with the programmes put in place (e.g. NCSP). There does appear to be issues in Knowsley with the distribution of free chlamydia testing kits. Many pharmacies are currently not supplying kits when they were previously thought to be (see section 5.13). Consequently, these services should be reinstated to ensure service provision matches the service advertised so that potential users can obtain the products.

There are high levels of gonorrhoea in males aged 15-19 years and particularly low levels of diagnosis in male chlamydia in community settings. Chlamydia testing in a community setting works well for testing females; which could suggest that the services are more in tune to the needs of testing females. There is certainly scope to improve the services offered to males in community testing settings.

The data showing the prevalence of the key five STIs across Knowsley shows that Prescot, Page Moss, Kirkby, and Halewood have a high prevalence of STIs. These high rates of STIs suggest a need for more services in these areas. Focusing on Prescot initially, there is no widely available facility for STI testing in the locality as the telephone audit found that there were no sites offering chlamydia and gonorrhoea testing and there is presently no other service for testing other STIs. There is the possibility of testing at the youth service for two evenings a week, but this is a limited service. In the area around Page Moss where there is also a high prevalence of STIs, a pharmacy offers free chlamydia testing and also a youth centre available two evenings a week. There is also a nearby train station which would allow for easy and quick access to the walk-in centre at Nutgrove Villa. With the area having high levels of STIs it may benefit from a more targeted approach to services. Kirkby also has high STI prevalence particularly around Southdene and Tower Hill. There are no services located centrally in Southdene, but a youth service runs in the area on two evenings a week, where service users can access STI testing. There is a pharmacy in the centre of Kirkby which can be easily accessed for free chlamydia testing for under 25s. However, it would appear that there is insufficient service in the area for STIs. Halewood's prevalence of STIs may also be attributable to the high prevalence of STIs in the south of Liverpool PCT, where there is also a dearth of services. Free chlamydia tests are available at pharmacies in the area, and there is also a youth service available on two nights a week where STI testing is available. Consequently high prevalence STI areas may reflect insufficient services in the area, however services may need to be available for longer and also with an increased profile.

Overall, STI prevalence is highest amongst 'Disadvantaged Households' and 'Urban Challenge' areas (See appendix 3 for all classification definitions). These two classifications share similar characteristics which can be used to help with marketing services. These groups are unlikely to own a car, which further highlights the needs for services to be easily accessible by public transport. The groups are also likely to live in housing association or council owned accommodation. Further, the groups will tend to shop at Asda and read tabloid newspapers. There is a high level of unemployment in these areas; therefore people may have more flexibility as to when they can access services. Services aimed at people in these classifications could be of great benefit as they are the groups with the highest STI prevalence. Further, it would be less beneficial to market and direct services for some classifications of people, such as qualified metropolitans, when there is no population and therefore no STI prevalence.

Contraception/ Emergency contraception

With specific regard to Kirkby, there is limited availability (Kirkby Walk-In Centre) of free emergency contraception on either Saturday or Sunday morning. This is clearly a time when people may seek emergency contraception and highlights a specific gap in Kirkby's service provision. There is also no youth service on Friday or Saturday nights which could provide an opportunity for a larger amount of potential service users to access the service prior to or during their weekend social activities.

This needs assessment has found some evidence that some young people's contraceptive services have to close their doors due to the demand upon them. The demand comes at specific times of the day and services are not equipped to cope, which leads to the suggestion that plans could be put in place to deal with this demand (e.g. extended opening hours).

Youth Service

In Knowsley, 62% of youth service users were male which represents a reversal in service use trend when compared to the KT31 contraceptive data. This finding suggests that the youth services may be the most appropriate service in which to target young men with sexual health promotion. It could be suggested that youth services with a male centred approach may attract greater numbers of young men to help increase the awareness in this problem population. The KT31 data indicates a particular decrease in male attendance in 16-17 year olds, which could be picked up by the youth service if correctly aligned. Further, findings from the recently conducted waiting room survey suggest that mixed waiting rooms are not favourable with service users; therefore specific services for males within the youth service may yield further success.

7.3 Where there is a mismatch of services

Services have been compared to deprivation indices (IMD 2007) split into local quintiles, under 18 conception rates, population density of young people, births to lone mothers and barriers to housing and services. Findings show that services are appropriately placed in or near areas of high deprivation, high under 18 conceptions and high densities of young people.

7.4 Where effort is being duplicated

There is some evidence of contraceptive and youth services operating at similar times in close proximity to each other in Knowsley. Map C shows some overlap on a Monday and Thursday evening; however one of the services is located in Knowsley Village and the other at Nutgrove Villa which are unlikely to attract the same users. Therefore the services, although operating at similar times, will appeal to different sets of people. Map D shows some overlap on a Thursday evening where similar services are available. Despite the youth service at Bryer Road appealing mainly to males, young men are also able to attend the service in Whiston and therefore the parallel running of these services could be seen as duplicated effort. Perhaps the local community would be better served if one of the services were moved to a Monday evening to enable evening access to services on Mondays through to Thursdays. Map E shows some overlap on a Wednesday evening; the Hilton Grace youth service appears to equally appeal to males and females in the area, and with the concurrent running of the Abacus service in the local area there is a case of duplication of effort. Considering the lack of services available on other nights of the week, it may be a more effective use of local service if one of the services was moved to another evening.

7.5 Where there are opportunities to support service reconfiguration

An issue highlighted throughout section 5.13 regarding the pharmacies was the accreditation process. This enables pharmacies to offer free emergency contraception in Knowsley. Some pharmacists contacted did not agree with the process and as such were not offering the service. Perhaps this process could be better explained or 'sold' to the pharmacists to ensure that enough local services are offering free products. Further, there were some instances were stock was low or depleted and the pharmacists were unsure of how to obtain further supplies; an issue that particularly applied to the chlamydia screening kits. In addition to problems obtaining the chlamydia screening kits, there where further obstacles within the pharmacies when distributing the kits. Although the pharmacists were trained to distribute the kits, the general pharmacy staff often became embarrassed and awkward with the customers when asked for the product. Perhaps there is scope to develop a short training package for general pharmacy staff working in pharmacies where the free kits are available.

Although service location seems to match, to a certain extent, Knowsley's population needs in terms of areas of high deprivation, and areas with high rates of under 18 conceptions, the high levels persist. Therefore perhaps there are issues regarding the marketing of the services to the relevant populations. A local survey in 2006 conducted in schools and youth services across Knowsley which sampled 483 young people (aged under 19) found that 77% stated that they were aware of local clinics, therefore almost a quarter had no knowledge of local services. Further, when questioned about what would encourage service use, the highest proportion responded that an increased awareness of services would help. The young people questioned would have liked services to be located in health buildings primarily, followed by the services being located in schools, and then youth centres. This is pertinent for Knowsley as there are services available in both health buildings and youth centres, but limited access to sexual health services in schools.

7.6 General findings

The stakeholder meeting which formed part of the needs assessment was an insightful process and provided an opportunity for members of the Knowsley sexual health system to meet and talk through current issues. The meeting was arranged at short notice but was well attended which demonstrates the commitment of stakeholders to the improvement of sexual health services across the PCT. Despite working in the same NHS area, many of the meeting attendees had never met each other or understood the roles of different fields. There was a common consensus that an annual event where all people involved in sexual health throughout the PCT could meet and share ideas would be beneficial.

One aim of the stakeholder meeting was to consult the service providers about service user views on service provision. However, the service providers had limited knowledge of the perceptions of service users and were unable to comment on behalf of the service users. This suggests that people working with the service users are not always fully aware of how the service is perceived and reinforces the need for regular feedback from the users. This would be a valuable process as consulting with current and potential service users is beyond the scope of this rapid needs assessment. This routine feedback could be in the form of questionnaires or take a more informal approach through oral questioning. If routine feedback were received and appropriately analysed it would allow for services to be highly responsive to any changes in trends or demands of service users.

There are many service user groups where data are not available for analysis as there are none is currently collected. Clearly this presents limitations when attempting to analyse gaps in needs and demands of the local population, and as such the present report has been unable to comment and inform upon some user groups.

7.7 Recommendations

- Implement routine collection of data on service users, specifically to gather knowledge of MSM, asylum seekers, sex workers, and other high risk groups. Further research is needed to establish their needs and service use.
- There is a need for service providers to identify the needs and demands of their service users. It is important that the views of service users are collected by services to inform the services of changing demands and trends in service use. It is recommended that this is done on a regular basis and can be done through the administering of questionnaires.
- Develop a system to monitor and liaise with pharmacies to enable them to re-order stock quickly, and also to address any concerns or barriers they may face when providing the free services.
- This rapid needs assessment has identified gaps in local level data as well as inconsistency of data and data fields. It is important that an integrated IT system is rolled out; it would make storing and sharing of information between services and evaluating service use more straightforward. It is essential that should an integrated system be established that comprehensive training be given to service providers in how to enter, access and analyse the data held on it.
- Currently, local HIV surveillance is detailed and comprehensive, providing information for PCTs in the North West region over and above what is available nationally. The recently established enhanced STI surveillance system in Cheshire and Merseyside collected and used disaggregated data. These data provided the opportunity for analysts at PCTs to analyse data at a small area level to identify hotspots of infection and inform services. It is recommended that this level of data collection for both HIV and STIs continues at a local level as the presentation of the data provides a useful local resource for commissioners, clinicians and HIV and STI specialists.
- Expand upon the youth service provision. This will help to address the unmet needs of young men.
- Further promotion and funding of Long Acting Reversible Contraception ought to take place.
- Provide a network or annual event for workers within sexual health to allow sexual health professionals to exchange of ideas and initiatives.

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Appendix 1

Service information sheet

Name of Service:

Contact Number:

Opening times:

SUN	MON	TUES	WED	THURS	FRI	SAT
-	-	-	-	-	-	-
-	-	-	-	-	-	-

Staffing Level:

	Nurse	Health Advisor	GP	Pharmacist	Other (specify)
F/T					
P/T					

Services offered:

Well-woman clinic	
Young persons sexual health clinic	
School links clinic	
Walk-in clinic	
Mobile service	
C-Card scheme	
Contraceptive services (non-emergency)	
Emergency contraception	
LARC	
Other (specify)	

Other information:

Appendix 2

Map B

	Youth Service	Opening times													
		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday	
		AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
1	Tower Hill Youth Service				6.45-9.15				6.45-9.15						
	Services:	*Advice, chlamydia testing, pregnancy testing, emergency contraception, male condoms.*													
2	Northwood Youth Service		6.45-9.15				6.45-9.15								
	Services:	*Advice, chlamydia testing, pregnancy testing, emergency contraception, male condoms.*													
3	Copthorne Youth Service				6.30-8.30										
	Services:	*Advice, chlamydia testing, pregnancy testing, emergency contraception, male condoms.*													
4	Westvale Youth Service		6.45-9.15				6.15-9.15								
	Services:	*Advice, chlamydia testing, pregnancy testing, emergency contraception, male condoms.*													
5	Southdene Youth Service				6.45-9.15		6.45-9.15								
	Services:	*Advice, chlamydia testing, pregnancy testing, emergency contraception, male condoms.*													

	Pharmacy	Opening times													
		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday	
		AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
1	Rowlands Pharmacy	8.45-1	2-6.30	8.45-1	2-6.30	8.45-1	2-6.30	8.45-1	2-6.00	8.45-1	2-6.30	9-1			
	Services:	*Community condom scheme.*													
2	Rowlands Pharmacy	9	5.30	9	5.30	9	5	9	5.30	9	5.30	9	5.30		
	Services:	*Community condom scheme.*													
3	Rowlands Pharmacy	9	5	9	5	9	1	9	5	9	5				
	Services:	*Community condom scheme, chlamydia testing (under 25s).*													
4	Rowlands Pharmacy	9-1.15	2.15-6.15	9-1.15	2.15-6.15	9-1.15	2.15-6.15	9-1.15	2.15-6.15	9-1.15	2.15-6.15			9.30-12.30	
	Services:	-													
5	Rowlands Pharmacy	9-1	1.30-6.15	9-1	1.30-6.15	9-1	1.30-6.15	9-1	1.30-6.15	9-1	1.30-6.15	9-1	1.30-5		
	Services:	*Community condom scheme.*													

	Contraceptive	Opening times													
		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday	
		AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
1	Tower Hill Primary Care Resource Centre				1 - 3		1 - 3								
	Services:	*Contraception, emergency contraception, pregnancy testing, sexual health advice, referrals for termination, chlamydia testing (under 25s).*													
2	THINK – Kirkby Health Suite		3 - 6						3 - 6						
	Services:	*THINK clinic. Contraception, emergency contraception, pregnancy testing, sexual health advice, chlamydia and gonorrhoea dual testing.*													

	Walk-In	Opening times													
		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday	
		AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
1	Kirkby Walk-In Centre	8	8	8	8	8	8	8	8	8	8	8	8	10	8
	Services:	*Emergency contraception.*													

Map C

	Youth Service	Opening times													
		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday	
		AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
1	Knowsley Village Youth Service		7-9				7-9								
	Services:	*Advice, chlamydia testing, pregnancy testing, emergency contraception, male condoms.*													
2	Heatwave Youth Service								5-7		5.30-9.30				
	Services:	*Advice, chlamydia testing, pregnancy testing, emergency contraception, male condoms.*													
3	Gate Youth Service				6.30-9.30										
	Services:	*Advice, chlamydia testing, pregnancy testing, emergency contraception, male condoms.*													
4	Mosscroft Youth Service								6.30-8.30						
	Services:	*Advice, chlamydia testing, pregnancy testing, emergency contraception, male condoms.*													
5	Swanside Youth Service				6.30-9.30				5-8						
	Services:	*Advice, chlamydia testing, pregnancy testing, emergency contraception, male condoms.*													

6	Roby Youth Service		6.30-8.30				6.30-8.30								
	Services:	*Advice, chlamydia testing, pregnancy testing, emergency contraception, male condoms.*													

	Pharmacy	Opening times													
		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday	
		AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
1	Care Pharmacy	9 - 1	1.45-5.45	9 - 1	1.45-5.45	9 - 1	1.45-5.45	9 - 1	1.45-5.45	9 - 1	1.45-5.45				
	Services:	*Emergency contraception*													
2	Stockbridge Pharmacy	9 - 1	1.45-5.45	9 - 1	1.45-5.45	9 - 1	1.45-5.45	9 - 1	1.45-5.45	9 - 1	1.45-5.45				
	Services:	*Emergency contraception, community condom scheme, chlamydia screening programme (under 25s).*													
3	Sedem Pharmacy	9	6.30	9	6.30	9-1		9	6.30	9	6.30				
	Services:	*Emergency contraception, community condom scheme, chlamydia screening programme (under 25s).*													
4	Rowlands Pharmacy	9 - 1	2 - 6.30	9-1	2 - 6.30	9	6	9-1	2 - 6.30	9-1	2 - 6.30				
	Services:	*Emergency contraception, community condom scheme, chlamydia screening programme (under 25s).*													
5	P Williams Chemist	9	6	9	6	9	6	9	6	9	6	9	5		
	Services:	*Community condom scheme.*													
6	Davey's Pharmacy	9 - 1	2 - 6.30	9 - 1	2 - 6.30	9 - 1	2 - 6.30	9 - 1	2 - 6.30	9 - 1	2 - 6.30				
	Services:	*Community condom scheme, chlamydia testing (under 25s).*													
7	Davey's Pharmacy	8.45 - 1	2 - 6.30	8.45 - 1	2 - 6.30	8.45	1	8.45 - 1	2 - 6.30	8.45 - 1	2 - 6.30				
	Services:	*Community condom scheme, chlamydia testing (under 25s).*													
8	Sedem Pharmacy	9	6.30	9	6.30	9	6.30	9	6.30	9	6.30				
	Services:	*Community condom scheme.*													
9	Lloyds Pharmacy	9	7	9	7	9	7	9	7	9	7	9	5.30		
	Services:	*Community condom scheme, chlamydia testing (under 25s).*													
10	Asda Pharmacy	8	11	7	11	7	11	7	11	7	11	7	10	10.30	4
	Services:	*Community condom scheme, chlamydia testing (under 25s).*													
11	Superdrug Pharmacy	9	5.30	9	5.30	9	5.30	9	5.30	9	5.30				
	Services	*Emergency contraception, community condom scheme, chlamydia testing (under 25s).*													

12	Boots Pharmacy	8.45	5.30	8.45	5.30	8.45	5.30	8.45	5.30	8.45	5.30	8.45	5.30		
	Services:	*Community condom scheme.*													
13	Lloyds Pharmacy	8.30	6.30	8.30	6.30	8.30	6.30	8.30	6.30	8.30	6.30				
	Services:	*Emergency contraception, community condom scheme, chlamydia testing (under 25s).*													
14	Davey's Pharmacy	8.30	6.15	8.30	6.15	8.30	6.15	8.30	6.15	8.30	6.15				
	Services:	*Community condom scheme, chlamydia testing (under 25s).*													

	Contraceptive	Opening times													
		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday	
		AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
1	Abacus Stockbridge Clinic for Children				1 - 3										
	Services:	*Contraception, emergency contraception, sexual health advice, pregnancy testing, referrals for terminations, chlamydia testing (under 25).*													
2	THINK – Page Moss Health Centre				3 - 5										
	Services:	*THINK clinic. Contraception, emergency contraception, pregnancy testing, sexual health advice, chlamydia and gonorrhoea dual testing.*													
3	Twig Lane Health Centre							9.30 – 11.30	5.30 – 7.15						
	Services:	*Contraception, emergency contraception, sexual health advice, pregnancy testing, referrals for terminations, chlamydia testing (under 25).*													
4	Abacus / THINK Nutgrove Villa		5.30 – 7.30									11	3		
	Services:	*THINK clinic. . Contraception, emergency contraception, pregnancy testing, sexual health advice, chlamydia and gonorrhoea dual testing.*													

	Walk-In	Opening times													
		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday	
		AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
1	Nutgrove Villa Walk In Centre	9	9.30	7	9.30	7	9.30	7	9.30	7	9.30	7	9.30	7	9.30
	Services:	*Emergency contraception, dual testing for chlamydia and gonorrhoea.*													

Map D

	Pharmacy	Opening times													
		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday	
		AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
1	Boots Pharmacy	9	5.30	9	5.30	9	5.30	9	5.30	9	5.30	9-1			
	Services:	*Emergency contraception.*													
2	Rowlands Pharmacy	9	6	9	6	9	6	9	6	9	6	9-1			
	Services:	*Community condom scheme, emergency contraception.*													
3	Sedem Pharmacy	9	6.30	9	6.30	9	6.30	9	6.30	9	6.30				
	Services:	*Community condom scheme.*													
4	Alliance Pharmacy	8.30-1	2-6.30	8.30-1	2-6.30	8.30-1	2-6.30	8.30-1	2-6.30	8.30-1	2-6.30	9-12			
	Services:	*Community condom scheme.*													

	Contraceptive	Opening times													
		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday	
		AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
1	Prescot Primary Care and Resource Centre				5.30 – 7.30										
	Services:	*Contraception, emergency contraception, sexual health advice, pregnancy testing, referrals for terminations, chlamydia testing (under 25).*													
2	Whiston Hospital gynaecology outpatients department								5.30 – 7.30						
	Services:	*Contraception, emergency contraception, sexual health advice, pregnancy testing, referrals for terminations, chlamydia testing (under 25).*													

	Youth Service	Opening times													
		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday	
		AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
1	Bryer Road Youth Service						6.45-9.15		6.45-9.15						
	Services:	*Advice, chlamydia testing, pregnancy testing, emergency contraception, male condoms.*													

Map E

	Pharmacy	Opening times													
		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday	
		AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
1	Jacobs Pharmacy	9	6	9	6	9	6	9	6	9	6				
	Services:	*Emergency contraception, community condom scheme, chlamydia testing (under 25s)*													
2	HA Chemist	9-12	1 -6.30	9-12	1-6.30	9-12	1-6.30	9-12	1-6.30	9-12	1-6.30	9-1			
	Services:	*Emergency contraception, community condom scheme.*													
3	Alliance Pharmacy	9	6	9	6	9	6	9	6	9	6				
	Services:	*Emergency contraception, community condom scheme, chlamydia testing (under 25s).*													

	Contraceptive	Opening times													
		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday	
		AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
1	THINK – Halewood Clinic						3 - 5								
	Services:	*THINK clinic. Contraception, emergency contraception, pregnancy testing, sexual health advice, chlamydia and gonorrhoea dual testing.*													
2	Abacus – Halewood Clinic						5.30 – 7.30								
	Services:	*Contraception, emergency contraception, sexual health advice, pregnancy testing, referrals for terminations, chlamydia testing (under 25).*													

	Youth Service	Opening times													
		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday	
		AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
1	Hilton Grace Youth Service				6.15-8.45		6-9								
	Services:	*Advice, chlamydia testing, pregnancy testing, emergency contraception, male condoms.*													

Appendix 3

Description of the P^2 People and Places Category
Adapted from Beacon Dodsworth Ltd, www.p2peopleand places.co.uk

1. **Mature Oaks**
   - Older, prosperous adults. May include pensioners;
   - Tend to live in large detached houses which they own outright having finished paying mortgage;
   - Live as married couples, grown up children who have moved away;
   - Tendency for them to have a car each, generally powerful;
   - Read broadsheet and black top newspapers and have keen interest in politics;
   - Use leisure time to go on holiday;
   - Tend to shop in Sainsbury's;
   - Likely to have worked as managers, professionals or employers, many work from home;
   - Likely to hold academic qualifications and command a good income.
2. **Country Orchards**
   - People working in agriculture in rural areas;
   - Older adults, mostly as part of family units;
   - Each household has two cars, which are likely to have powerful engines;
   - Keen interest in politics and read broadsheet newspapers;
   - Tesco supermarket of choice;
   - Split between land owners and less wealthy farmers and agricultural workers;
   - Many work from home on their own farms. Can have a high income and many also well educated.
3. **Blossoming families**
   - Young families with the parents being young adults aged 25-34 with young infants;
   - Parents likely to be a married couple;
   - Still paying a mortgage on their homes which tend to be detached properties or semi-detached or terraced;
   - These families have at least two cars. Majority have large powerful engines. Family cars with mid-sized engines also popular;
   - Black top newspapers are read and shopping mainly done in Sainsbury's, although Tesco is popular;
   - Adults well qualified and well paid. Tend to be professionals, managers or employers;
   - A large proportion of the females in this category work.
4. **Rooted households**
   - Made up of older adults, generally aged 45 and over. Also includes some young families where the parents are aged 25-34;
   - Generally semi-detached properties and mortgages are still being paid though some will own their houses outright;
   - Typically will have two or more cars, predominantly family cars with mid-sized engines;
   - Generally not interested in politics and read black top newspapers;
   - Tend to do grocery shopping at Tesco;
   - Tend to be skilled manual workers on high wages.
5. **Qualified metropolitans**
   - Mainly single, highly qualified adults living in cities, predominantly London;
   - Live in single households, mainly flats and bedsits and tend to rent their homes;
   - Tend not to have cars and use public transport to get to work, mainly trains;
   - Extremely interested in politics and read broadsheet newspapers;
   - Majority shop in Sainsbury's;
   - Hold higher qualifications and work as professionals in well paid jobs;
   - Also includes some cultural diversity
6. **Senior neighbourhoods**
   - Live in detached houses that they own, having finished off paying their mortgages. Some may own a second home;
   - Likely to have one car, varying sizes and power;
   - Very interested in politics and read broadsheet and black top newspapers;
   - Grocery shopping varies from Aldi and Lidl to Tesco, Morrisons and Somerfield;
   - Contains pensioners, incomes generally low. However, for some affluence comes from assets rather than income.
7. **Suburban stability**
   - The average group encompassing all ages living in the suburbs;
   - Families common with parents aged between 25 and 34. Also co-habiting couples in same age group and older adults up to pensionable age;
   - Tend to be buying the houses and will still have mortgages to pay. Some also live in rental accommodation, housing association and council properties. Mostly semi-detached or terraced properties;
   - Households likely to have one car, generally with a small engine;
   - Adults tend not to be interested in politics and read tabloids. Grocery shopping generally done in Asda but also Aldi, Lidl, Morrisons and Somerfield;
   - Tend to be skilled manual workers with some being in routine and semi-routine occupations and use cars, bus or foot to get to work.
8. **New starters**
   - Young adults aged between 16 and 34. Include students and young working adults;
   - Live mainly in single households and women are well represented amongst them;
   - Accommodation rented and tends to be bedsits and purpose built flats. Though many live in single households, also a high proportion of couples co-habiting;
   - New starters likely to not have a car;
   - Very interested in politics and read broadsheet newspapers;
   - Likely to smoke;
   - Shopping done cheaply in Aldi and Lidl;
   - Predominantly students with high levels of qualifications but do not work.
9. **Multicultural centres**
   - Predominantly families and includes a broad ethnic mix and includes those of different ethnicity and religion;
   - This category includes some richer and some poorer families;
   - Live mostly in terraces housing that is housing association or council property. Many also live in bedsits or purpose built flats;
   - Generally do not have a car, commuting by train;

- Quite interested in politics and predominantly read tabloid newspapers, although some read broadsheets;
- Some likely to be smokers. Shopping is split between Aldi and Lidl and Sainsbury's;
- Tend to be employed as semi-skilled manual and unskilled workers.

10. Urban producers

- Younger adults between the ages of 16 and 34, many with children. A lot of families are single parent households;
- Tend to live in terraced housing, many of these homes can be without central heating;
- Likely to have one car with a small engine per household;
- Not interested in politics and tend to read tabloid newspapers;
- Likely to be smokers and to shop in Asda;
- Do not hold academic qualifications and tend to work as in routine and semi-routine occupations as well as skilled manual, semi-skilled manual or unskilled labour;
- Incomes are low and unemployment and long-term unemployment are high, as is long-term illness.

11. Weathered communities

- Contains mostly pensioners but also some young adults, aged 16-24 years with children who tend to be single parent families;
- The pensioners in these communities tend to live alone;
- Housing likely to be housing association or council housing, small, semi-detached or purpose build flats;
- Households unlikely to have a car;
- Uninterested in politics and likely to read tabloid newspapers and likely to shop in Asda, Aldi and Lidl;
- Mostly made up of retired adults but some work in routine and semi-routine as well as semi-skilled manual and unskilled jobs which tend to be in manufacturing;
- Unemployment also high as is unemployment due to long-term illness.

12. Disadvantaged households

- Conventional and single parent families. Young adults between the ages of 25 and 34 with children;
- Live in council and housing association properties which are mainly purpose built flats and terraced houses which are unlikely to have central heating;
- Unlikely to have a car;
- Not interested in politics, read tabloid newspapers.
- Extremely likely to smoke and do their shopping at Asda;
- Unlikely to have qualifications and employed in routine and semi-routine as well as semi-skilled manual and unskilled labour.
- Many in this category are unemployed and also a lot of long-term illness preventing employment.

13. Urban challenge

- Mainly pensioners, particularly aged over 75. Also some young adults between 16 and 24 years, centred mainly in urban areas;
- Tend to be purpose built flats. Accommodation tends to be small and council or housing association owned;
- A lot of these households are pensioners who live alone;
- Very unlikely to own a car;
- Unlikely to be interested in politics and tend to read tabloid newspapers;
- Tend to be smokers and shop at Asda;
- Very unlikely to have any qualifications. Those with jobs work in routine and semi-routine occupations;
- Unemployment, including long term unemployment is high, as are incidences of long term illness.

Notes:
Unclassified: these describe people whose characteristics are too different for them to fall into another category;
Occupations: routine occupations include jobs such as machine operators, packers, cleaners, labourers, sales assistants, HGV drivers and bar staff. Semi-routine occupations include jobs such as salesmen, agricultural workers, those working in childcare and service industries.
Newspapers: Broadsheet sinclude The Times, The Telegraph, The Guardian, The Independent, Financial Times. Black tops include The Daily Mail and The Daily Express. Tabloids include The Sun, The Mirror, The Daily Star and The Daily Record.

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