V4.0

SEXUAL HEALTH NEEDS ASSESSMENT FOR THURROCK

2023 – Thurrock Public Health Team

Contents

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Glossary

ACE Adverse childhood experience

ART anti-retroviral therapy

ASC Adult Social Care

ASOP Aveley, South Ockendon and Purfleet

CGL Change Grow Live

CIPFA Chartered Institute of Public Finance and Accountancy

CLA children looked after

CSW commercial sex worker

DHSC Department of Health and Social Care

DPH Director Public Health

EHC emergency hormonal contraception

GBMSM Gay, bisexual, men who have sex with men

GP General Practitioners

GUMCAD Genitourinary Medicine Clinic Activity Data

HIV human immunodeficiency virus

HLS human learning systems

HP Health Protection

IAPT Improving access to psychological therapies

ICB Integrated Care Board

ICP Integrated Care Partnership

ICS Integrated Care System

IVT Inclusion Visions Thurrock

LARC long-acting reversable contraception

LGBTQQIP2SA lesbian, gay, bisexual, transgender, queer, questioning, intersex, pansexual, two spirited and asexual

LGV Lymphogranuloma

Mpox Monkeypox

NEET not in education, employment, or training

OHID Office for Health Improvement and Disparities

OI opportunistic infection

PC Primary Care

PH Public Health

PrEP Pre exposure prophylaxis

RSE Relationship and sex education

SEND Special Educational Needs and Disabilities

SERIC South Essex Rape and Incest Centre

SH Sexual Health

SHS Sexual Health Services

SLA service level agreement

SPH Solutions for Public Health

SRS sexual and reproductive Health

SRHS sexual and reproductive health services

STI sexually transmitted infection

TC Thurrock Council

THT Terrance Higgins Trust

TLS Thurrock Lifestyle Solutions

UASC Unaccompanied asylum-seeking children

UKHSA United Kingdom Health Security Agency

Executive Summary

This Sexual Health Needs Assessment is a comprehensive evaluation of sexual health, exploring the needs of people living in Thurrock who have accessed or who would benefit from accessing sexual and reproductive health services. It also reviews evidence about how services can effectively engage with under-represented groups and recent approaches to models of care to deliver sexual and reproductive health services to populations. This will be supported by qualitative and quantitative data collected to identify areas of good practice and gaps in the service provision to inform the co-design and future commissioning model.

Good sexual health enables healthy relationships, planned pregnancies, and prevention of disease. It is important for all individuals throughout their life course and contributes to maintaining and improving population health.

Thurrock is a unitary authority area with borough status in the county of Essex. It is part of the London commuter belt and an area of regeneration within the Thames Gateway redevelopment zone. Thurrock has a diverse population that is increasing by over 10% every decade.

Thurrock is in the south of Essex and lies to the east of London on the north bank of the river Thames. Thurrock is divided in to four localities (Primary Care Networks PCNs): Aveley and South Ockendon (ASOP); Grays; Stanford-le-Hope (SLH); and Tilbury and Chadwell (T&C). PCNs are groups of GP practices working closely together with other healthcare staff and organisations to provide more joined up care to local communities.

Based on the 2021 census data, the population of Thurrock was recorded as 176,000. However, as of May 2023, the number of patients registered as Thurrock patients was 185,247, which exceeds the estimated population of the borough. The available data indicates that 181,790 registered patients have a primary address in Thurrock, while an additional 3,457 patients reside outside the borough.

Thurrock Public Health within the local authority and along with members and partners of the Health and Wellbeing Board have endeavoured through the research and delivery of this document to consider options to improve the sexual health outcomes of the local population, these include further supporting groups considered either vulnerable or at risk.

This report includes nationally and locally collected quantitative data about the level of need and type of services required to support people with their sexual health needs. The report also draws on qualitative information gathered from stakeholders about where local services are working well, and where there are barriers to support that some people have experienced. In addition, how service providers and agencies work together, and the gaps in provision for some population cohorts, particularly those with co-occurring conditions or complex needs are explored.

The assessment process involved in collecting and reviewing data from various sources included a mixture of open-source data and health records made available to health professionals. Findings and data were analysed to identify the key sexual health issues affecting the population, the prevalence of sexually transmitted infections (STIs), contraceptive use, sexual behavioural patterns, and the availability and accessibility of sexual health services. The findings, insights and observations will then feed into the development of an

evidence-based strategy linking into interventions to effectively address the sexual health needs of Thurrock's local population.

The author used a mixed methods study combining quantitative and qualitative data collection and analysis in one study. Integrating both these methods helps to gain a more complete picture of need than a standalone quantitative or qualitative study.

Thurrock Council commissioned Solutions for Public Health to inform the qualitative element of the stakeholder engagement piece of the Sexual Health Needs Assessment (SHNA).

The sexual health service commissioned by Thurrock Council is currently extended into its sixth year. The current contract expires in 2024 and a retender will commence in September 2023. To inform the re-procurement process, the Public Health Team has completed this Sexual Health Needs Assessment with a view to identifying the gaps and barriers to accessing the sexual health service and to consider ways in which to encourage engagement, particularly for the services below:

- Condom distribution.
- Late diagnosis HIV and treatment.
- New and emerging threats/issues.
- STI testing and prevention including opportunistic chlamydia testing.
- Contraception including long-acting reversible contraception (LARC).
- Service engagement and communication with stakeholders.
- Accessibility of services.
- Reducing Teenage pregnancy (with a focus on relationship and sex education (RSE).
- To seek to identify any areas of quality improvement that might lend themselves to a Human Learning Systems (HLS) co-design approach.

The qualitative elements of the recommendations are supplied by: Thurrock Council Sexual Health Needs Assessment: Stakeholder engagement report 2023 produced by Solutions for Public Health (see appendix 1).

Findings and Recommendations

Figure 1:

Topic	Findings	Relevant Section	Recommendation
Access to services	• The site of services in Orsett Hospital is based at the back of an old building which isn't easily accessible • Service is appointment only. • Spoke clinics are not open. • There is limited inclusivity. • There is limited RSE provision by specialist services. • There is limited promotion of the service. • No community sexual health service for young people. • Opening hours are restrictive.	Pages 18 / 22/ 39 / 48	• The Provider and commissioner review the use of drop in or same day clinic appointments. • The Provider to further promote additional clinics (which have now been reinstated). • RSE to be a focus of commissioning. • RSE to be promoted to improve engagement. • The Provider and commissioner to attend meetings including Head teacher and CEO, Mace, MASH, MARIC where required to ensure sexual health access is highlighted. • The Provider to develop a communication plan • The Provider to move away from one central clinic. • The Commissioner review young people's sexual health services as part of commissioning process. • The Provider to promote inclusivity and to provide specialist clinics where necessary. • The Commissioner and Provider to review the clinic use of family hubs and women's hubs where possible. • The Provider to strengthen links with child exploitation team. • The Provider to promote the use of the hub clinic in Thurrock. • The Provider to ensure signposting to the clinic is in the main hospital. • The Provider to review the use of the buzzer access system to the clinic. • The Provider to review the opening hours with feedback from service users.
Service model	• Limited joint working with pharmacies and GPs. • Access within setting is restricted. • Service is difficult to engage.	Pages 13 / 115	• The Provider to adopt a whole systems approach to look at how commissioners and sexual health services link in with GPs, community pharmacy, probation, people in secure settings, drug, and alcohol services, • The Provider to adopt a whole system approach to those who support people who have experienced sexual violence and domestic abuse such as the refuge and SERIC.

	• The service doesn't allow chaperones supporting vulnerable people in the service. • The sexual health service no longer in reach into services where young people with LD lived to teach the support workers how to support them and talk about their bodies. • The service is clinical without a focus on inclusivity. • Cervical screening is not offered.		• The commissioners and Provider must attend meetings relevant to their work, included but not limited to Brighter Futures, Multi Agency Child exploitation (MACE), and CEO and head teacher's forum. • The commissioners and Providers should ensure they are well represented throughout Thurrock to increase their profile in the community, ensuring that stakeholders are aware of how to refer into services. • The commissioners and providers need to work together to ensure that the HLS model is embedded and work closely with other service providers and the community to build an integrated system in Thurrock. • The Provider to look at alternative sites such as Grindr, Scruff or Taimi may enhance profile. • The commissioner and Provider to ensure LD and chaperones entering the service of the expectation and rationale for seeing the service user alone for initial contact • The commissioner and Provider to ensure that dual trained clinician appointments are advertised throughout Thurrock. • The commissioners to review process for cervical screening (currently GP).
Joint Working	• Lack of integrated working within Thurrock. • Lack of integrated working with neighbouring services. • Lack of awareness of sexual health services in Thurrock. • Lack of visibility in specialist meetings (including MACE, headteachers forum and Primary Care).	Pages 102 / 103 / 115	• The Provider to improve joint working of services across Essex and neighbours to ensure equity of services and ease of access for service users. • Thurrock LGBTQQIP2SA residents will go to Chelmsford Pride as there isn't one in Thurrock, Providers need to be visible at this and other related events. • The Provider to develop joint working between sexual health services and the Child exploitation and missing team. • The Provider to develop an integrated systems approach to governance and the planning of services. • The Provider to improve networking and engagement with other services such as the drug and alcohol team. • The Commissioners and Provider to improve partnerships from both a strategic and operational perspective.

			• The development of a Sexual Health Strategy for Thurrock could be the catalyst to improve partnership work.
Training and Education	• RSE is recognised as an important first step into engagement with sexual health services and good relationship and sexual health care. • Schools are not aware of current offer. • The current contract focuses on a small element of training the trainers regarding sexual health. • There are no 1-1 sessions available in schools. • Staff don't appear to be trauma informed.	Pages 6 / 18 / 19 / 22 / 23 / 25 / 33 / 39 / 41 / 42 / 46 / 47 / 48 / 50 / 51 / 56 / 58 / 59 / 60 / 64 / 65 / 84 / 91 / 94 / 104 / 106 / 107 / 115 / 122 / 125 / 126 / 127	• The Provider should ensure staff receive training to support development of communication skills with different groups e.g., to become trauma informed, appropriately support people attending psychosexual and sexual assault, and communication with people with a learning disability. • The Provider must inform schools about service changes and the benefits of taking up staff training by the provider to ensure all schools are aware and become engaged. • The commissioner and Provider should attend CEO and headteacher forums to ensure education colleagues are aware of training offered and improve take up of offer. • For commissioners to review the RSE element of the sexual health contract. • The Provider to improve promotion in schools and colleges and drop in and assemblies to promote this would enhance access. • The Provider to deliver specialist education and training to deliver to ensure high quality provision.
STI Testing & Diagnosis	• The STI diagnosis rate has declined in Thurrock since 2017, and it is unclear how vulnerable groups are affected by the decline in diagnoses. • In the most recent data (2021), the diagnosis rate in Thurrock is lower than CIPFA neighbours but similar to East of England; the testing rate is lower than both CIPFA	Pages 6 / 19 / 20 / 29 / 32 / 49 / 50 / 76 / 77-80	• The Provider must continue to review and evaluate data recording to improve recording and reporting of protected characteristics to gain a better understanding of potential inequities in Sexual Health outcomes across Thurrock including older age STIs. • The Provider should develop an Action Plan to increase uptake of STI testing to reduce the burden of undiagnosed infection in Thurrock, including: ○ Increasing awareness of the need for regular STI testing among vulnerable groups and those at higher risk. ○ Increasing referrals from other services. • The Provider, working in collaboration with OHID, UKHSA and the commissioner must monitor and respond to new and emerging threats such as Mgen and drug resistant infections.

	neighbours and East of England; with a corresponding positivity rate that is similar to CIPFA but higher than East of England. • The CIPFA neighbours with the highest diagnosis rates also have high testing rates. • Qualitative feedback from stakeholders and residents suggested that a high proportion of Thurrock residents were not aware of Thurrock sexual health services, and that other professionals were not clear how to refer into the service.		
Chlamydia	• Chlamydia detection rates in Thurrock are some of the lowest among the CIPFA neighbours' group, with screening rates being only 10% of the 15–24-year-old population in 2021. The areas with the highest detection rates also have the highest screening rates.	Pages 6 / 18 / 20 / 32 / 34 / 35 / 37 / 40 / 52 / 55 / 57 / 78-80 / 82 / 84 / 118-119	• The Provider should develop an Action Plan to increase awareness and uptake of chlamydia screening among male and female 15–24-year-olds, to reduce the burden of undiagnosed infection in Thurrock.

HIV	• Since 2018, fewer new sexual health service attendees in Thurrock accept an HIV test than is typical across East of England or among CIPFA neighbours. The gap is greater for women. • Repeat testing in gay, bisexual, and other MSM compares well to England averages. In comparison to CIPFA neighbours, Thurrock is at the higher end of the range. • Thurrock's HIV prevalence rate is similar to the England average at 2.4 per 1,000 between 15-59 years, but late diagnoses have increased since 2016-18 across both England and Thurrock.	Pages 6 / 13 / 17-20 / 22 / 23 / 38 / 40 / 50 / 52 / 55 / 56 / 60 / 84 / 88 / 89 / 91 / 92 / 94-103 / 116-119	• The Provider must continue to closely monitor HIV testing vs HIV late diagnosis rates in Thurrock population and learn from HIV late diagnosis events through retrospective look backs to identify missed opportunities and a pro-active Human Learning System approach. • The Provider should develop an action plan to: ○ Increase HIV testing among new attendees, especially women. ○ Reduce late presentation for HIV testing. ○ Increase uptake of PrEP among those who have been identified as being able to benefit.
Hepatitis	There may be an under-identification of hepatitis C in Thurrock due to a lower-than-average proportion of injecting drug users being engaged in treatment. Referrals between sexual health and substance misuse services and joint working	Pages 41 / 55 / 102-104 / 116-118	The Provider should consider how to: • Increase engagement of injecting drug users in drug treatment and ensure uptake of hepatitis C testing. • Strengthen joint working between sexual health and substance misuse services.

	may increase uptake by those at risk.		
Conception and Abortion	• Under 18 conception rates have decreased since 2017 in line with national and regional trends. • Whilst the abortion rate in Thurrock has increased since 2017 and in 2021 was 22 per 1000 females; the percentage of U18 conceptions leading to abortion has remained stable, albeit higher than national, regional and CIPFA comparators. • The rate of repeat abortions in Thurrock has increased since 2017.	Pages 13 / 14 / 17 / 20 / 21 / 31 / 32 / 34 / 60-64 / 74 / 116 / 120 / 124 / 125	• The Provider should review the accessibility of contraception services across Thurrock and surrounding geographies to ensure that good quality contraception services are accessible at a time and place that is convenient for the service user. • The Provider to ensure consistent education and advice on the preferred method of contraception is available to service users through a range of formats, utilising a range of existing services as appropriate such as primary care and school nursing. • Thurrock PH team to conduct further analysis into why the rate of repeat abortions is increasing and the groups most at risk with the aim to identify appropriate preventative actions. The Provider, commissioner, and associated services to develop an action plan for focusing on groups most at risk of unplanned conception and/or abortion such as sex workers or those with addiction.
LARC	There are lower levels of LARC activity in Primary Care.	Pages 6 / 18 / 20 / 21 / 25 / 37 / 46 / 50 / 52 / 58 / 64-71 / 74 / 91 / 116 / 124 / 125	• The Provider must ensure the continued collection of data around LARC recovery rate following the pandemic, teenage pregnancy, repeat abortions, to respond better to those needs. • The Provider must work collaboratively with pharmacies delivering contraceptive services and monitor impacts of over-the-counter contraceptive pill availability. • The Provider must strengthen joint working between sexual health and Primary Care and support them to increase their skill base where necessary.

1. Introduction

Good sexual health enables healthy relationships, planned pregnancies, and prevention of disease. It is important for all individuals throughout their life course and contributes to maintaining and improving population health. Most of the adult population of England are sexually active and access to quality sexual health services improves the health and wellbeing of both individuals and populations.

Sexual health is a fundamental aspect of overall health and well-being and addressing sexual health needs is critical in reducing health inequalities and improving the quality of life of individuals and communities.

Sexual ill health is not equally distributed across the population, with some geographical areas and population groups experiencing disproportionate levels of poor sexual health. Strong links exist between deprivation and sexually transmitted infections (STIs), teenage conceptions, and abortions, with the highest burden borne by women, men who have sex with men (MSM), teenagers, young adults and black and minority ethnic (BME) groups. Similarly, Human Immunodeficiency Virus (HIV) infection in the UK disproportionately affects MSM and Black Africans. Some groups at higher risk of poor sexual health face stigma and discrimination, which can influence their decisions and ability to access services. (Office for Health Improvement and Disparities, 2023).

Assessing the sexual health needs of Thurrock service users is a continuous process for the public health team at Thurrock Council. This includes reviewing population level data and service usage, and comparing this with the views of service users, the public, and other key partners across the system.

The sexual health service will play a key role in delivering preventative interventions that will enable people to make informed decisions about relationships, planning a pregnancy, contraception, sex, and sexual health, building personal resilience, and promoting healthy choices.

An integrated sexual health service model aims to improve sexual health by providing non-judgmental and confidential services through open access, where most of the sexual health and contraceptive needs can be met on site, often by one health professional, in services with extended opening hours (evenings after 6pm and weekends), and locations that are accessible by public transport. STI self-tests kits are available to test for most common STIs, the kits can be ordered through the online portal and are delivered discreetly to a chosen address with the results available in a few days.

Changes in attitudes, sexual practices, and behaviour continue to evolve and naturally impact upon the way sexual and reproductive health services are delivered. Thurrock is dedicated to ensuring that sexual and reproductive health services are a public health priority, and that the local population can access high quality, confidential services that meet their needs.

The needs assessment outlines the expectation for delivering an integrated sexual health service in Thurrock and the current provision against expected outcomes.

Methodology

The author used a mixed methods study combining quantitative and qualitative data collection and analysis in one study. Individually, these approaches can answer different questions, so combining them can provide more in-depth findings.

Mixed methods research combines elements of quantitative and qualitative research to answer research questions. Mixed methods can help to gain a more complete picture than a standalone quantitative or qualitative study, as it integrates benefits of both methods.

Quantitative research methods are useful for gathering hard data to measure, validate and inform crucial decisions. Qualitative research is the process of gathering descriptive data. Rather than numerical data and hard facts, which result from quantitative research, qualitative research deals with more subjective topics like views, attitudes, and motivations. It seeks to answer *why* people believe certain things or act in certain ways.

The benefits to using mixed methods research include:

- combining quantitative and qualitative approaches can balance out the limitations of each method.
- it can provide stronger evidence and more confidence in your findings.
- it can give you more granular results than each individual method.

Drawbacks include:

- it can be more complex to carry out.
- it may require more expertise to collect and analyse data, and to interpret the results, than using one method would.
- combining different methods requires extra resources, such as time and money.

The methods of information gathering used for this HNA included:

1. A document review of publications about the current national and local strategic position concerning sexual and reproductive health services.
2. A literature search of evidence about how services can effectively engage with under-represented groups.
3. A further literature search conducted by the North East Essex Foundation Trust (NELFT) library to further explore sexual and reproductive health, including deprivation, abortion, young people and vulnerable groups (see appendix 2).
4. Qualitative information about the barriers, enablers, and gaps in service provision in Thurrock gathered from semi-structured interviews with 14 professionals.
5. Quantitative data is data represented numerically, including anything that can be counted, measured, or given a numerical value.
6. Quantitative data was explored from various sources included (but not limited to) Fingertips, Census 2021, The Office of National Statistics (ONS), and the Genitourinary

Medicine Clinic Activity Database (GUMCAD). This was used to explore correlations between local, regional, and national testing, treatment, and diagnosis rates.

7. A survey of the general population, including those who have used services, focussing on awareness and experiences of services.

To understand how the current services were provided to people in need of sexual health services in Thurrock, a range of key stakeholders were contacted by the council and asked if they were willing to share their views and experiences in a brief interview with Solutions for Public Health (SPH). A set of questions was drafted and agreed (see Appendix 1); these covered:

- How services were provided.
- Barriers and enablers to delivering the services.
- Service risks.
- Service gaps.
- The impact of the pandemic.
- Suggestions for improving services to residents.

Representatives from the following organisations and teams were invited for interview:

- Commissioners of sexual health services.
- East of England regional sexual health lead.
- Sexual health services providers:
    - Provide.
    - Brook.
    - Terrence Higgins Trust.
- Psychological therapies providing psychosocial support.
- Drug and alcohol services for adults and young people.
- School nursing service.
- Youth offending service.
- Child exploitation and missing team.
- South Essex Rape and Incest Centre (SERIC) rape and sexual abuse specialist service.
- Thurrock lifestyle solutions – providing most of the disability services for Thurrock Council.
- GP with an interest in sexual and reproductive health.

A total of 13 stakeholders and one commissioner were interviewed.

To gather the views of both service users and non-service users a survey was developed and distributed to Thurrock residents (Appendix 1). Questions covered demographic information about the responder (gender, sexuality, ethnic group, age band, resident ward, and any disability), awareness of individual services, use of individual services including location, satisfaction with staff and their support (e.g., treatment and advice giving) and whether they would recommend the service to family and friends.

The survey was distributed online via social media by Thurrock Council and the provider. In total, 119 surveys were completed, returned, and analysed.

One hundred and nineteen surveys were returned and analysed. The geographical spread and demographic range of respondents appeared representative overall, but relatively few young people responded. Thirteen (11%) were aged 20 – 29, and there were no respondents younger than age 20. Less than half (38%, n=45) of survey respondents had used services and 62% (n=74) had not. Of the 45 who had used a service, 62% said they had used services at Orsett Hospital, eight had accessed the walk-in clinic in Grays, Tilbury, or Corringham Health Centres and ten people had gone to a GP, had a telephone appointment or postal test. Forty-two service users and 69 non-service users went on to answer further questions about their experience.

A literature search was conducted by SPH to identify publications describing guidance, best practice, evaluations, or case studies about how sexual health services can effectively engage with under-represented groups. This included evidence about interventions aimed at improving engagement of sexual health services with under-represented groups. Searches were conducted between March and May 2023 using an internet-based search engine (Google) and the TRIP database. Evidence about engagement with or uptake of sexual health services was sought. No specific definition for under-represented groups was used, instead evidence was sought relating to engagement with groups that were described by the authors as under-represented, under-served, hard to reach, socially disadvantaged or in need of, but less likely to access sexual health services. The most recent guidance or evidence identified was prioritised. Additional studies and documents cited in the publications identified by the searches were followed-up.

A further literature search was completed by the NELFT library and Knowledge Services on behalf of the author. Evidence searches: [PH Bulletin] Evidence on Sexual Health Needs Assessment SN40868. Stephen Reid. (7th March 2023). ILFORD, UK: NELFT Library and Knowledge Service (Appendix 2).

Sources searched included:

British Pregnancy Advisory Service.

Faculty of Sexual & Reproductive Healthcare.

Local Government Association (LGA).

NICE Guidance.

Public Health England (PHE).

The Faculty of Sexual & Reproductive Healthcare.

UK Health Security Agency (UKHSA).

Office for Health Improvement and Disparities (OHID).

Nice Guidelines.

FSRH website.

Local Government Website.

Databases searched included:

Embase, HMIC, Medline, Social Policy and Practice, TRIP Medical Database.

2. National and Local Policy/Guidance

National Policy

Sexual health is an important area of public health and affects individuals throughout the life-course – from pre-conception to those living with sexually transmitted illnesses (STIs) later in life. This chapter describes the national and local approaches to sexual health.

Poor sexual health can lead to serious personal long-term health consequences for individuals. As Ian Green, Chief Executive of the Terrence Higgins Trust, stated,

"Sexual health is an issue for most people, but there are clear groups that are disproportionately affected."

The last full sexual health strategy 'A framework for Sexual Health Improvement in England'[1] was published by the Department of Health and Social Care (DHSC) in 2013 following the Health and Social Care Act 2012 and subsequent transfer of public health responsibilities to local authorities. The strategy focusses on the following objectives:

- Building knowledge and resilience among young people.
- Improving sexual health outcomes for young adults.
- Ensuring all adults have access to high quality services and information.
- Supporting people to remain healthy as they age.
- Prioritisation of prevention.
- Reducing rates of STIs among people of all ages.
- Reducing onward transmission of and avoidable deaths from HIV.
- Reducing unwanted pregnancies among women of fertile age.
- Continuing to reduce the rate of U16 and U18 conceptions.
- Counselling for all women requesting an abortion.

The stated ambitions resulting from meeting these objectives were to:

- Improve the sexual health of the whole population to remove inequalities and improve sexual health outcomes.
- Build an open and honest culture where everyone can make informed and responsible choices about relationships and sex.
- Recognise that sexual ill health can affect all parts of society.

Since the strategy was produced a decade ago a range of recent reports have outlined some of the challenges facing sexual and reproductive health services in England and include recommendations about future service provision. These include:

[1] Department of Health. A Framework of Health Improvement in England. 2013.

- Report of the inquiry by the House of Commons Health and Social Care Select Committee into sexual health (2019)[2].
- A report by the Local Government Association and English HIV and Sexual Health Commissioners Group (EHSHCG) Breaking Point: securing the future sexual health services (2022)[3].
- A report by British Association for Sexual Health and HIV and the Terence Higgins Trust 'Sexually Transmitted infections in England: The state of the Nation (2020)[4].
- The All-Party Parliamentary Group on Sexual and Reproductive Health in the UK: Women's lives, women's rights: Strengthening access to contraception beyond the pandemic (2020)[5].
- The 'Hatfield vision: A framework to improve women and girls' reproductive health outcomes' (2022) published by the Faculty of Sexual Health[6].

The House of Commons Health and Social Care Select Committee held an inquiry about sexual health services published in 2019[2]. The inquiry identified several priority areas which a new national strategy should address, this included:

- Ease of access to services.
- Provision of services to meet the needs of vulnerable populations.
- Access to cervical screening.
- Testing for the full range of sexually transmitted infections.
- Access to long-acting reversible contraception (LARC).
- Access to pre-exposure prophylaxis (PrEP) for those at risk of contracting HIV.
- Preventative interventions within all aspects of sexual health.

The House of Commons report in 2019 claimed the impact of STIs is greatest in young people. Among those aged 15 to 24, men were twice and women six times as likely to be diagnosed with an STI than their counterparts aged 25 to 59.7 Men who have sex with men (MSM) are also disproportionately affected by STIs. In 2017, 84% of syphilis diagnoses and 64% of gonorrhoea diagnoses in men were in MSM. Over half of those diagnosed with HIV in the UK in 2017 were gay or bisexual men.

In addition, the inquiry asked that the government strongly supported participation of students in Relationships and Sex Education sessions in schools.

According to the House of Commons Health and Social Care Committee, there are also disparities in the impact of STIs on minority ethnic groups. The rates of gonorrhoea and chlamydia in people from ethnic minority backgrounds are three times that of the general population, and the rate of the STI Trichomoniasis is eight times higher. Minority communities constitute 14% of the UK population but have a burden of late HIV diagnoses of 52% and 40% for people accessing HIV services. Although rates of HIV are declining in MSM overall, this is

[2] House of Commons Health and Social Care Committee. 'Sexual Health: Fourteenth report of session 2017-2019'. HC1419. June 2019.
[3] LGA and EHSHCG. 'Breaking Point: securing the future sexual health services'. 2022.
[4] BASHH and THT. 'Sexually transmitted diseases in England: The state of the nation'. 2020.
[5] All Party Parliamentary Group on Sexual and Reproductive Health in the UK. 'Women's lives, women's rights: Strengthening access to contraception beyond the pandemic'. 2020.
[6] Faculty of Sexual and Reproductive Health. 'The Hatfield vision: A framework to improve women and girls' reproductive health outcomes'. 2022.

not the case in all communities. The situation is worse for women, with80% of women living with HIV being from ethnic minority backgrounds, and 62% are of African heritage. In Thurrock the second highest ethnic group is black African/Caribbean/other black and whilst overall attendance at the sexual health services in Thurrock is predominantly female (70%), the split for females accessing the service for HIV concerns is nearly 55%. Service provision must take this into account when planning delivery.

Following the Health and Social Care bill in 2013; Local Authorities have had the commissioning responsibility for sexual health and certain reproductive health services. Responsibilities for commissioning different areas of sexual and reproductive health services are spread across Integrated Care Boards (ICBs), and NHS England.

Since 2013, local authorities have been primarily responsible for sexual health services in England. Sexual health services are paid for by a ring-fenced public health grant – funded by the national Government. There is no doubt that sexual health services are under intense pressure financially. The public health grant to local councils used to fund the sexual health services was reduced by over £1bn (24%) between 2016/17 and 20/21. Across England, spending on STI testing, contraception and treatment decreased by almost 17% between 2015/16 and 2020/21, as local councils adapted to these reductions.

In 2013, commissioning arrangements for sexual, reproductive health and HIV were introduced as part of the implementation of the Health and Social Care Act 2012 and were further detailed in 'The Local Authorities (Public Health Functions and entry to Premises by Local Healthwatch Representatives) Regulations 2013'. Move forward to 2022 and sexual and reproductive health services are commissioned by local councils to meet the needs of the local population, including:

- Contraception.
- STI testing and treatment.
- Sexual health aspects of psychosexual counselling.
- Sexual health specialist services.
- HIV social care.
- Wider support for teenage parents.

The Select Committee Inquiry noted that fragmentation of commissioning following the organisational changes in 2013 has meant that workforce planning, development and training has suffered with a subsequent impact on the number of likely of future specialists in sexual health. Figure 2 shows the commissioning responsibility for different elements of sexual health services. Appendix 4 describes the footprint and relevant responsibilities of LA/ICB/PCNs

Figure 2: Organisational responsibility for commissioning sexual and reproductive health services:

ICBs/ICPs	NHS England	Local Authorities
Most abortion services.	Basic contraception under the GP contract.	Contraceptive services and all prescribing costs including LARCS in GPs.
Gynaecology, including use of contraception for non-contraceptive purposes such as heavy bleeding.	HIV treatment and care.	STI testing and treatment including Chlamydia screening and HIV testing.
Permanent contraception (vasectomy and sterilisation.	STI testing and treatment under GP contract.	Specialist services: young people's sexual health, teenage pregnancy, services in schools, colleges.
Non-sexual health elements of psychosexual services.	Cervical screening.	HIV prevention.
	HPV programme.	Sexual health aspects of psychosexual counselling.
	Sexual assault referral centres.	Sexual health service in pharmacies.
	Specialist foetal medicine services.	Health promotion of sexual health services.
	Sexual health elements of prison health services.	Outreach.

Source: Health and Social Care Select Committee: Sexual health- fourteenth report of session 2017-19[2]

Unless appropriate commissioning arrangements are in place people must access different providers and settings for different aspects of their sexual and reproductive health, for example someone may be diagnosed with HIV at a sexual health clinic but will then receive medication and treatment including blood tests from an HIV specialist clinic which may not be co-located.

The increased use of smart phone dating apps, the rise in Chemsex (sexual activity while under the influence of stimulant drugs) where sexual encounters typically between gay, bisexual, and other men who have sex with men (GBMSM) are combined with taking drugs and the increased awareness of sexual health services have been suggested as the main drivers for the increase in demand for services (LGA, 2022). However, there is a lack of up-to-date research on why these trends have emerged. Another report by the British Association for Sexual Health and HIV and the Terence Higgins Trust called 'Sexually transmitted infections in England: The state of the nation' (2020)[4] outlined how despite declines in some STIs such as genital warts, others such as syphilis and gonorrhoea have increased by 165% and 249% respectively between 2010 to 2020. They also report how people from some ethnic minority communities and GBMSM are among those disproportionately impacted by STIs and that the current available research does not provide an understanding of the inequalities in sexual health and the impact of structural inequalities of STIs. The authors make the point that is there's a lack of sexual health champions speaking out about STIs and the lack of these voices, as well as visibility in the wider media, creates a barrier in the fight against STI stigma.

The LGA and EHSHCG[3] report outlines the problems across councils providing equitable access to contraception with women finding it harder to access the method they need. LARC fittings and removal have been particularly affected with services reporting a drop in access amongst young people, black women as well as women and girls from Asian and other ethnic

minority groups. This was also outlined in the 'All Party Parliamentary Group report on Sexual and Reproductive Health: Women's Lives, Women's Rights: Strengthening access to contraception beyond the pandemic' (2020). Although LARC waiting lists rose during the Covid-19 pandemic in Thurrock, additional services were funded to respond to this need. Although LARC waiting lists rose during the Covid-19 pandemic in Thurrock, additional services were funded to respond to this need. Increased use and access to contraception leads to a decrease in unintended pregnancies and although most will have a positive outcome, women are more likely to present late for antenatal care, more likely to experience postnatal depression and their babies more likely to experience low birth weight, mental health problems and poor health outcomes. Babies born to women under 20, years of age, the age group at highest risk of unintended pregnancy, also have higher rates of stillbirths, higher rates of infant mortality and low birth weight[5]. Around 45% of pregnancies and 33% of births in England are unplanned or associated with feelings of ambivalence. Overall, there has been a 60% decline in teenage pregnancies between 2007 and 2019, however there is a 7-fold difference in rates between LAs. In 2019 there were 16.7 teenage pregnancies per 1000 women under 18 years of age and of those 53% ended in abortion.

Responsibility for access to contraception is split across ICB/ICPs, NHS England and LAs (Table 1). This can lead to people having to engage with more than one service and could lead to confusion and disengagement. This can lead to people having to engage with more than one service and could lead to confusion and disengagement.

Another example where commissioning has led to fragmented delivery of services includes when women who attend a specialist service for contraception or an STI screen and are not able to access a cervical screen even though they are due for a test and staff are trained to take the sample. This is because cervical screening is commissioned by NHS England and is not a commissioning requirement of LAs. This results in either a lost opportunity to take a cervical sample from someone who may not go to her GP for the test, or a second unnecessary appointment made for an intimate examination the woman must undergo. This is in the context of a 20 year low in the uptake of cervical screening[5].

In 2022 the FRSH published the 'Hatfield vision: A framework to improve women and girls' reproductive health outcomes' setting out an ambition for 2030 that by this time 'reproductive health inequalities will have significantly improved for all women and girls, enabling them to live well and pursue their ambitions in every aspect of their lives'. There are 16 goals and 10 actions to tackle health disparities. The goals and actions are set out in appendix 5.

Overall, there is clearly significant focus from both Governmental and non-Governmental organisations to start to address the challenges of delivering a sustainable holistic comprehensive sexual and reproductive health services, however it is yet to be seen whether the resources and leadership required to make these changes will be available to ensure this is effective.

The 5 reports referenced here[2,3,4,5,6] call for a long-term vision for sexual and reproductive health in England and the urgent need for a national sexual health strategy. To provide sustainable holistic sexual and reproductive health services each of the reports have specific recommendations. Headline strategic priority areas that need to be addressed include:

- The DHSC working with local authorities, NHS England with input from providers and community groups should provide clarity on the future models of co-commissioning of sexual health services ensuring transparency and accountability.

- Commissioners, services, and the independent sector working with communities should co-design services and interventions that meet the sexual and reproductive health needs of all people, including underserved and unheard groups.
- With the increasing complexity of the needs of people using sexual health services there should be a greater emphasis on building relationships between services and settings (e.g., mental health, drugs and alcohol, violence against women and girls) and partnership working where feasible.
- There should be adequate long-term funding to cover increased cost pressures and investment in sexual and reproductive health services.
- There should be a drive to maximise the potential of statutory relationship sex and health education to equip young people with an understanding of fertility and contraception and ease access to services.
- A clear programme to re-establish training and development for both the current and future sexual health workforce should be a core requirement in commissioning and provision arrangements.
- Research about sexual and reproductive health inequality and impact on underserved and unheard groups and the systematic collection of data to support this.

Two strategies have recently been published by the Government and a third is expected soon. The 2 strategies are:

- Towards zero: Action plan towards ending HIV transmission, AIDS and HIV deaths in England 2022-2025[7].
- Women's health strategy for England[8].

The third document a National Sexual and Reproductive Health Action Plan has yet to be published. It is unclear yet how the 3 strategies will relate to each other.

Towards zero: Action plan towards ending HIV transmission, AIDS, and HIV deaths in England 2022-2025 [7].

The action plan sets out a commitment to reduce new HIV transmissions to zero by 2030 and outlines the actions required for the 3 years from 2022 to 2025[7].

The total number of people newly diagnosed with HIV decreased from 5,790 in 2014 to 3,770 in 2019. Of those new diagnoses 2,860 (76%) were first diagnosed in England and 905(24%) people were first diagnosed elsewhere.

In 2019, around £96,300 people were living with HIV in England and of those an estimated 18,200 (19%) had transmissible levels of virus. Estimates by the UKSHA suggest of these 18,200, around 5,900 (33%) were undiagnosed, 3,890 (21%) were diagnosed but not referred to specialist HIV care or retained in care, 1,630 (9%) attended for care but were not receiving treatment, and 2,110 people (12%) were on treatment but not virally supressed. The remaining 4,600 (25%) had attended for care but were missing evidence of viral suppression.

[7] Department of Health and Social Care. 'Towards Zero Action plan towards ending HIV transmission, AIDS and HIV related deaths in England 2022-2025'. 2021.

A range of objectives and actions from the strategy and are summarised below. The HIV independent commission published a report in 2020[9] with recommendations that informed the action plan. Appendix 5 shows how the recommendations from the HIV commission map to the objectives in the action plan.

The action plan has 3 specific objectives to reduce mortality and morbidity rates due to HIV. These are:

1. to reduce the number of people first diagnosed in England from 2,860 in 2019, to under 600 in 2025.
2. to reduce the number of people diagnosed with AIDS within 3 months of HIV diagnosis from 219 to under 110.
3. to reduce deaths from HIV/AIDS in England from 230 in 2019 to under 115.

There are 4 overall objectives:

1. Ensure equitable access and uptake of HIV prevention programmes by:
    a. Investing 3.5 million to deliver a National HIV Prevention programme over 2021 to 2024.
    b. Testing at least 20,000 people at higher risk of HIV during the annual National HIV Testing Week.
    c. Develop a plan and invest driving innovation in HIV PrEP delivery to improve access for key groups particularly in settings outside sexual and reproductive health services.
2. Scale up HIV testing in line with National Guidelines by:
    a. Working across clinical and professional communities to reduce missed opportunities for HIV testing and late diagnosis.
    b. Scale up capacity and capability for effective partner notification for people diagnosed with HIV.
3. Optimise rapid access to treatment, retention in care by:
    a. Reducing the people newly diagnosed with HIV who are not promptly referred to care.
    b. Support people living with HIV to increase the number of people retained in care and receiving effective treatment with innovative care models and support for complex needs.
4. Improving quality of life for people living with HIV and addressing stigma by:
    a. Enhancing training of the health and care workforce and drawing on innovation on public awareness and health promotion.

Women's Health Strategy for England

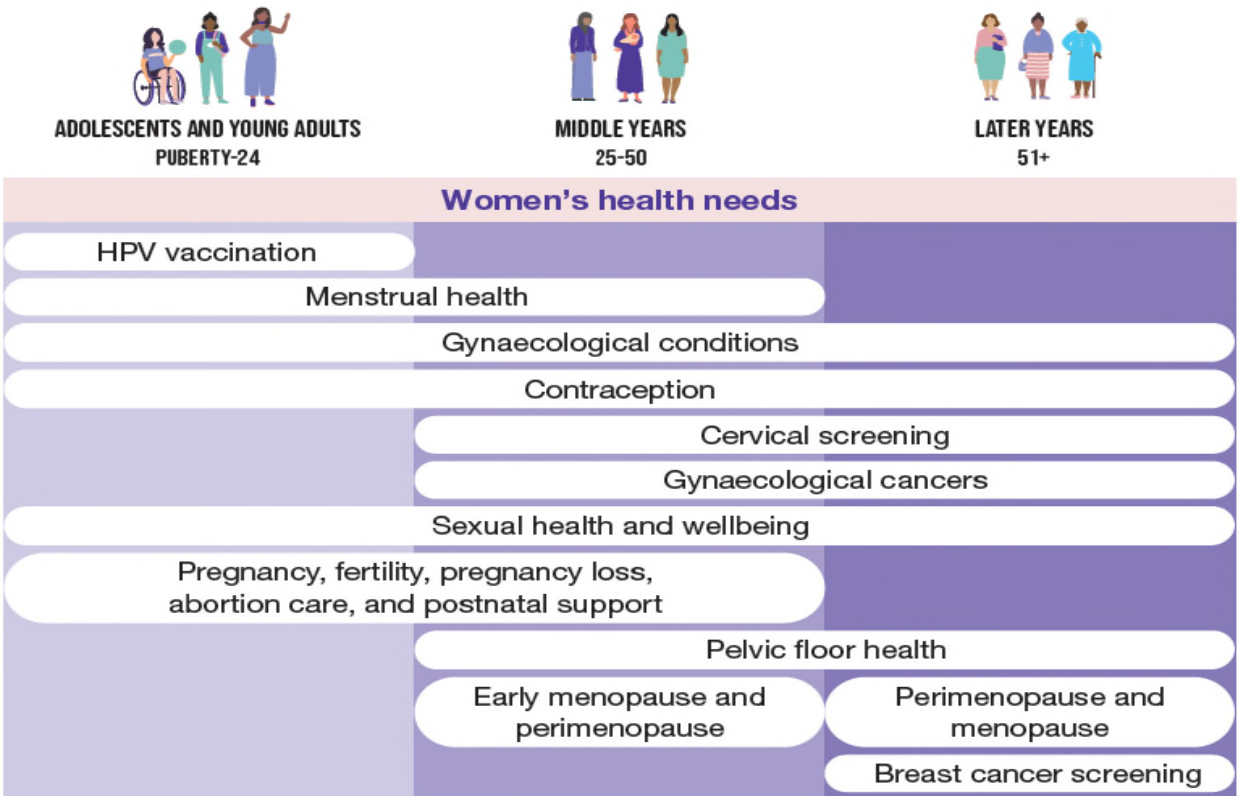
In August 2022 the Government published a strategy for women's health, including sexual and reproductive health[8]. The rationale for the strategy was that women spend a significantly greater proportion of their lives in ill health and disability compared to men and whilst women make up 51% of the population, the health and care system has historically been designed by men for men. It has resulted in women having to move from service to service to have

[8] Department of Health and Social Care. 'Women's Health Strategy for England'. 2022.
[9] HIV Commission. 'How England will end new cases of HIV: The HIV Commission final report and recommendations. 2020.

reproductive health needs met and they can struggle to access basic services such as contraception. The call for evidence for the inquiry resulted in nearly 100,000 responses and from this a 6-point plan aims to improve the way in which the health system engages and listens to girls and women over the next 10 years. This will be based on a life course approach and the ambitions include:

1. Ensuring women and girls are listened to and their concerns taken seriously at every stage of their journey.
2. Women and girls reporting better experiences of procedures and are well informed about the care they can expect for example conversations on pain relief before and intrauterine device is fitted or being offered a chaperone for intimate examinations. Disparities in experiences of services and procedures are reduced especially for women from under-served and seldom heard groups.
3. Personalised care and shared decision making embedded in all areas of women's health.
4. More research into women's experiences of health and care.
5. Increased leadership, accountability and representation of women and women's health expertise in all forums where decisions are made in the health and care system.

Figure 3: Women's reproductive and sexual health needs across the life course[8]



Source: Women's health strategy for England 2022[8]

Innovation and collaborative delivery of women's health services will be an important way to improve access and experience for women. Women's health hubs and similar models of 'one stop clinics' have been created in areas including Liverpool, Manchester, Sheffield, Hampshire, and Hackney. The models provide integrated women's health services at primary and community care level where services are centred on women's needs and reflect the life

course approach rather than being organised by individual condition or issue. Hub models can incorporate management of contraception, heavy menstrual bleeding, cervical screening, menopause, and other aspects of women's health care. A key aim would be to improve access to the full range of contraceptive methods in particular LARC. Public Health England (PHE) assessed the return on investment of contraception and estimated that the public sector had a return of £9 for every £1 invested[10].

To measure whether the strategy is making a difference a new reproductive health experiences survey will be commissioned every 2 years. This will gather data on women's experiences across all areas of reproductive health and include, menstrual health, contraception, pregnancy planning and menopause.

Core20PLUS5

An approach to reducing healthcare inequalities

Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement. The approach, which initially focussed on healthcare inequalities experienced by adults, has now been adapted to apply to children and young people (see appendix 3). Whilst not directly affecting the commissioning of sexual health services core20plus5 focusses on health inequalities and deprivation, sexual health is disproportionately affected scoio economic factors including deprivation.

Local Policy

The Health and Wellbeing Board published a strategy for the local community, presenting the Board's Vision for health and wellbeing in Thurrock for 2022-26. The Board's Vision of Levelling the Playing Field aims to tackle the many causes of poor health that are not level across Thurrock. These include individuals' health risk behaviours such as smoking and the quality of clinical care that people receive, but the greatest influences on overall community health are wider determinants of health. These include high-quality education, access to employment and other opportunities, warm and safe homes, access to green spaces and leisure, strong and resilient communities, and effective public protection. Thurrock experiences an unlevel playing field in each of these areas and the Health and Wellbeing Strategy aims to level up those inequities.

The strategy sets out goals and action across six broad domains that influence the determinants of health:

1. Staying Healthier for Longer.
2. Building Strong and Cohesive Communities.
3. Person-Led Health and Care.
4. Opportunity for All.
5. Housing and the Environment.
6. Community Safety.

[10] Public Health England. 'Contraceptive services: estimating the return on investment'. August 2018.

Human Learning Systems

Thurrock Council are exploring a Human Learning Systems (HLS) approach to integrated working. This way of working continuously explores the complex reality of how outcomes that matter to a person might be achieved in their unique life context. The Human Learning System approach has been described in 'Better Together Thurrock: the case for further change 2022-2026'[11] (BTT). This is a collective plan to transform improve and integrate health care and third sector services to improve people's wellbeing. The key messages for the SHNA within BTT are:

- **Chapter 4.4 The Impact of Thurrock's Approach and System "Ask"**

"Encourage culture change in providers – moving from competition to cooperation in the pursuit of best outcomes."

- **Chapter 10.6.1 – Adopting a Different Commissioning Model**

"Adopting the principles of HLS set out in Chapter 2 and developing a people-led health and care system means developing a very different model of commissioning. Providers must be able to provide flexible, bespoke support that responds to an individual's specific circumstances. Commissioning must operate differently to enable this to take place and the following describes how this will be achieved."

- **Chapter 10.6.2 – Recognising the Flexible Trusting Relationships are Key to Delivering 'Human' Solutions:**

"Establishing a commissioning model that enables this to occur by promoting providers who: Build effective and meaningful relationships with those they serve; Understand and respond to the unique strengths and needs contained by each person; and Act collaboratively with others to deliver what is required by the person."

This is an ongoing plan, and it is important to know which aspects of the HLS approach are being incorporated in the current Sexual Health Service provision. The HNA analysis of stakeholder views and the Thurrock resident survey conducted by Solutions for Public Health has informed the mapping of sexual health services against the HLS approach and these results are set out in the discussion and recommendations section.

Thurrock Council have a vision about how the integration of health, wellbeing and care for Thurrock residents will work in the future. (SPH,2022). This is a move away from a centralised, deficit driven approach with prescriptive interventions, to a way of working that recognises the uniqueness of each resident, the importance of co-designing solutions that meet their needs, based on the strengths and assets of the individual, their family and friends, the wider community, and the system. This aligns with Thurrock's Health and Care Transformation Programme[12].

The range of people and organisations involved in creating outcomes for residents is typically beyond the management control of a single person or organisation. When a resident comes to the attention of one of many health and social care services in Thurrock, the professional

[11] Thurrock Council. 'Better Together Thurrock: the case for further change 2022-2026. 2022.
[12] Thurrock Council. 'Better Together Thurrock: the case for further change 2022-2026. 2022.

may identify a range of needs that can be met by other services in addition to their own. What follows can be a winding path for the resident of repeating the same information to multiple professionals who do not always appear to talk to one another, have different criteria for the access to their service and may not be able to offer support until other actions by other organisations are completed. In the meantime, the outcome of most importance to the resident is lost amongst the various services offering prescribed interventions may not be what the resident needs.[13]

Acknowledgment that each resident is complex and unique, and the current arrangement of services may not meet their needs, leads to the search for a different strategy.

This way of working continuously explores the complex reality of how the outcomes that matter to each person might be achieved in their unique life context. The three elements of the HLS approach are:

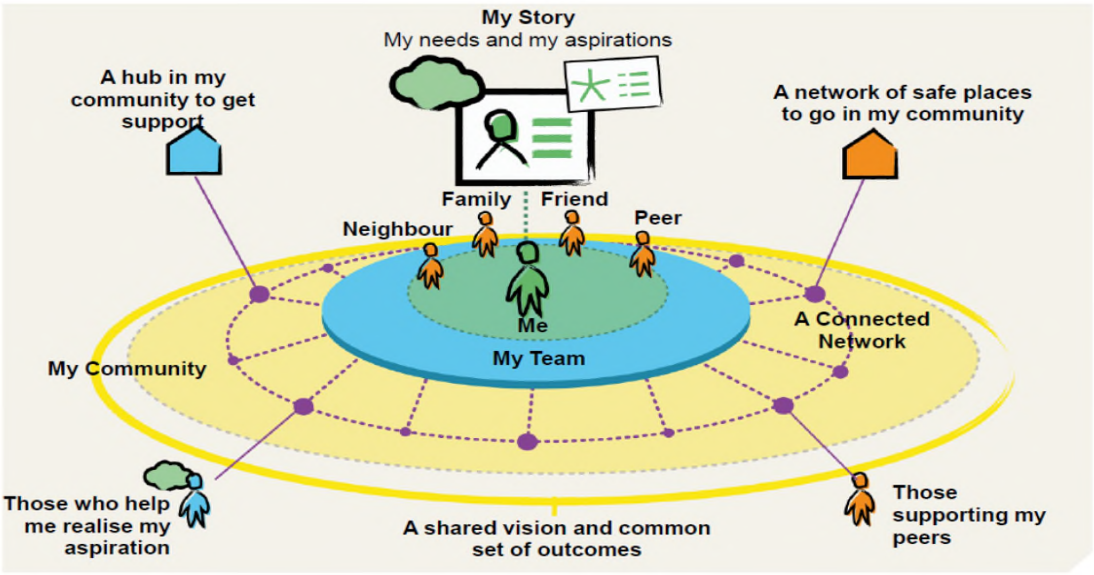
- The **capacity to respond to human variation** - recognising that individual strengths and needs are most effectively met by bespoke solutions that staff are empowered to provide.
- The **ability of the system and services to evolve and change** using continuous process of learning and adaptation. Interventions can be tweaked depending on circumstances with a recognition that 'what works today may not work for other individuals or the same individual in the future.
- The **ability to shape the chaotic system through collaboration and influencing**. Outcomes in response to interventions cannot be reliably predicted in chaotic human systems. However, building relationship, increasing visibility and emotionally intelligent engagement with residents, is helpful in shaping how residents and services relate to one another. This will have an impact on outcomes.

The sought-after outcomes for the individual and the community from this approach are represented in the figure below. The individual can voice the things that matter to them most, services are co-produced around a common vision and the existing strengths and assets within the community are harnessed.

[13] Solutions for Public Health. 'Integrated substance misuse needs assessment for Thurrock'. 2022.

Figure 4: The aim of the Human Learning System (HLS) approach:

Source: Plymouth City Council Alliance for people with complex needs- Alliance Specification 2018



The human learning systems approach has been described in 'Better care together: the case for further change 2022-2026' which is a collective plan to transform, improve and integrate, health, care and third sector services aimed at Thurrock's adults and older people to improve their wellbeing. In addition, the Health and Wellbeing strategy (2022-2026) aiming to tackle the causes of poor health unequally experienced by people across the population of Thurrock, and the Brighter futures Children's Partnership Strategy (2021-2026) focussed on the health and wellbeing of young people to the age of 19, underpin their vision with principles aligned to the human learning systems approach.

The plan to transform and integrate, health, care and third sector services is underway with the development of the first integrated medical centre (hub) based around Stanford le Hope and Corringham PCN footprint (Solutions for Public Health, 2022). Further hubs are being developed around the other three Thurrock PCN footprints. These hubs will be the basis of single locality networks with teams from health, care and third sector organisations building relationships, collaborating and co-designing single integrated solutions with residents rather than referring on or signposting elsewhere. Where specialist advice is required, staff from small teams will be allocated to each integrated locality network rather than being fully embedded. The key elements of this approach are:

- Staff are empowered to co-design solutions together with residents.
- The solutions are coordinated and timely with a focus of what matters to the residents.
- Staff are encouraged to develop a learning culture around what works and does not work.
- For people with the most complex challenges single integrated care plans will be developed.

In terms of the sexual health services, this would be a great opportunity to base staff at each of the hubs which will ensure the opportunity for effective relationship building between staff from different agencies. It will also be a venue where people who attend the hub may be more likely to talk to staff but who would not have attended a clinic. In this way it may be possible

to engage with harder to reach groups and shift the perception of support for sexual health services in a positive direction.

According to the stakeholder engagement conducted by Solutions for Public Health (appendix 1) as part of this needs assessment, overall, currently the way sexual health services in Thurrock are provided reflects the fragmented commissioning approach set out by the Government in 2013 and the local integrated service specification developed in 2017. The organisation 'Provide' deliver sexual health services across the whole of Essex and have a separate contract with Thurrock. The Essex and Thurrock contracts differ in funding and KPIs resulting in services that are essentially separate with little commonality on a day-to-day operational level.

3. Thurrock Overview and Demographics

Figure 5:

Key findings:

- **Overall levels of deprivation in Thurrock are lower than the national average according to the Indices of Deprivation (2019), but some areas of Thurrock are among the 20% most deprived in England.**
- **More than one in five children under 16 years-old in Thurrock are growing up in poverty (21.2%), this is higher than the national rate (20.1%).**
- **Sexual health and consequently sexual ill health is not equally distributed within the population.**
- **Nationally abortion rates increase as levels of deprivation increase.**
- **The 60+ year age group currently account for 19% of the Thurrock population and nationally there is a rise in STI diagnosis in this age group however there is low attendance rates at sexual health services in the 50 year plus age groups.**
- **The largest ethnic group in Thurrock is White British (65%, Census 2021).**
- **Nationally the population rates of STI diagnoses remains highest among people of Black ethnicity (2021).**
- **The highest attendance at the sexual health service in Thurrock are black ethnic followed by mixed ethnic groups.**
- **According to the Office for National Statistics, 91% of adult residents in Thurrock identify as Straight or Heterosexual.**
- **Gay, bisexual and MSM are among the groups of people most likely to be affected by STIs however in 2021 the total number MSM HIV diagnosis was less than. heterosexual men.**
- **Sexual Health Services appear to work in silos.**

Recommendations:

- **Sexual health services to raise awareness for MSM on how STIs are prevented, transmitted, diagnosed, and treated.**
- **Sexual health services to create a safe and comfortable environment in which gay, bisexual and MSM can discuss their needs.**

- **Sexual health services should make every contact count to ensure that wherever service users access help the services can offer the correct information and advice, also ensuring that online access is appropriate and accessible.**
- **To encourage ongoing collaboration with local partners and ensure an HLS approach in the design and delivery of sexual health promotion and interventions.**
- **Sexual health services to promote that MSM have repeat testing every 3 months if they are at increased risk of sexually transmitted infections.**
- **The Provider must ensure clear pathways into services**
- **Commissioners and Provider must work to enhance local data recording and collecting procedures to inform understanding regarding the uptake and usage of the Sexual Health service by CLA and Care Leavers, and this must highlight gaps in provision and relevant adaptations.**
- **The sexual health service should work in a way that ensures age-appropriate information is available to young people in care either through the local offer website or the NHS App.**
- **The Provider must work in collaboration to address the unmet need for CLA, those with learning difficulties, mental health, MSM and marginalised groups and those at higher risk of exploitation.**

Thurrock is in the south of Essex and lies to the east of London on the north bank of the river Thames. Thurrock is divided in to four localities (Primary Care Networks PCNs): Aveley, South Ockendon and Purfleet (ASOP); Grays; Stanford-le-Hope (SLH); and Tilbury and Chadwell (T&C). PCNs are groups of GP practices working closely together with other healthcare staff and organisations to provide more joined up care to local communities.

Within Thurrock there are 20 electoral wards which vary significantly by geographical area, with Orsett ward being the biggest and Chafford the smallest. Some wards like Orsett cover a larger area, predominantly rural, whilst others cover significantly smaller urban areas.

Overall levels of deprivation in Thurrock are lower than the national average according to the Indices of Deprivation (2019), but some areas of Thurrock are among the 20% most deprived in England. Chadwell St Mary, Tilbury and South Ockendon have the highest level of deprivation in Thurrock whilst South Chafford has the lowest.

Based on the 2021 census data, the population of Thurrock was recorded as 176,000. However, as of May 2023, the number of patients registered as Thurrock patients was 185,247, which exceeds the estimated population of the borough. The available data indicates that 181,790 registered patients have a primary address in Thurrock, while an additional 3,457 patients reside outside the borough.

The number of Thurrock residents residing across each PCN show that Grays has the highest concentration of registered patients with 34% of the total population, followed by 26% in ASOP; 25% in SLH; and 15% in T&C. (SystmOne GP Primary Care data – March 2023)

Regarding the age group of zero to nineteen years old, the ONS Census 21 data shows that there are 45,159 residents within this category. However, the number of registered patients in

the same age group is approximately 49,197, which accounts for around 27% of the registered patient population.

Figure 16 highlights the age groups within each PCN. All PCNS except SLH have a higher proportion of 0–19-year-olds. However, SLH has the highest proportion of 60+ year olds at 26% compared to an average of 16% in the other three PCNs.

Figure 6:

Age group	ASOP PCN	GRAYS PCN	STANFORD-LE-HOPE PCN	TILBURY AND CHADWELL PCN	Total
0-9	15%	13%	11%	15%	13%
10-19	14%	14%	12%	16%	14%
20-29	12%	12%	11%	12%	12%
30-39	17%	16%	14%	15%	16%
40-49	15%	15%	13%	13%	14%
50-59	12%	13%	14%	12%	13%
60-69	8%	8%	11%	8%	9%
70-79	5%	6%	10%	5%	6%
80-89	2%	2%	4%	3%	3%
90-99	0%	1%	1%	1%	1%
100-109	0%	0%	0%	0%	0%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

The gender split (where recorded) shows an almost equal number (50%) of males to females in the overall population, across all age groups.

Sexual health and consequently sexual ill health is not equally distributed within the population. Strong links exist between deprivation and STIs, teenage conceptions and abortions, with the highest burden borne by women, men who have sex with men (MSM), trans community, young people, and people from ethnic minority backgrounds. According to PHE,[14] (now OHID) in most aspects of sexual and reproductive health variations in outcomes are evident between and within local areas and populations or communities. Some of these differences have a clear relationship with social and health inequalities; and may be impacted by differences in behaviour, social networks, and risk exposures. Others may indicate geographic variation in local populations' demographics or in access to, and use of sexual and reproductive health services, or in the availability and provision of interventions. Therefore, understanding the population and deprivation within Thurrock is vital to the planning of services and interventions.

[14] Public Health England. "Variation in outcomes in sexual and reproductive health in England". 2019.

When considering socio–economic status, rates of new STI diagnosis are shown to be consistently higher in more deprived populations (as measured by the Index of Multiple Deprivation [IMD])[15]. The rates of chlamydia, genital warts, genital herpes, gonorrhoea, and syphilis and all STIs are highest in most deprived areas and lowest in least deprived areas as measured using Index of Multiple Deprivation quintiles.[16]

Nationally abortion rates increase as levels of deprivation increase. The rate in the most deprived decile (decile 1) was 26.1 per 1000 in 2019, this is over twice the rate in the least deprived decile (decile 10) of 12.0 per 1000.[17] The trend of abortion rates increasing in areas of increased deprivation remains consistent when abortion data is studied at both regional and national level.

Gender/Age

The 60+ year age group currently account for 19% of the Thurrock population, with the highest rates in SLH at 25%. Whilst the 60 + year age group is relatively small recent figures from UKHSA have revealed that the number of over-65s who caught common STIs rose from 2,280 in 2017 to 2,748 in 2019, an increase of 20 per cent. Indeed, a 2019 report by then PHE, stated that at that stage the rates of STIs in older age groups were increasing, with the largest proportional increase in gonorrhoea and chlamydia seen in people aged over 65, however attendance at sexual health clinic decreases rapidly for those over 50 years.

Approximately 30% of Thurrock's population are in the 30-49 age bracket, our largest population followed closely by the 0-19 age groups at 27% [figure 7]. The corresponding figures by area are 32% and 28% in ASOP, 31% and 27% in Grays, 26% and 23% in Stanford le-hope, and 28% and 30% in Tilbury and Chadwell.

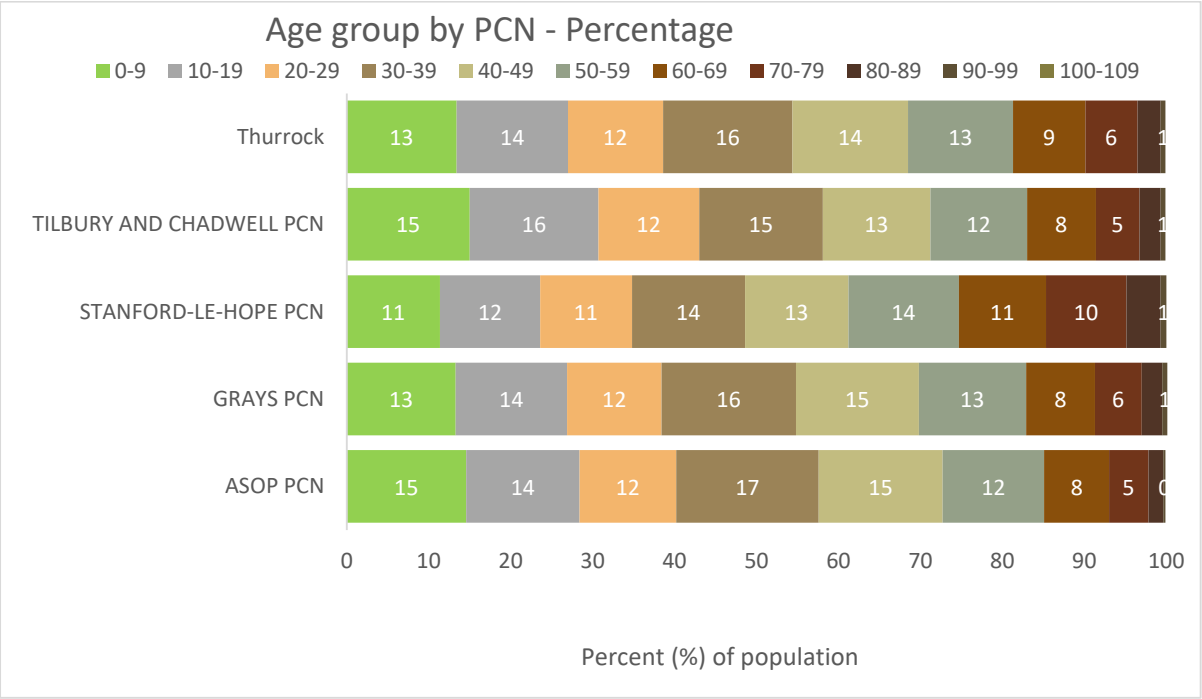
The population distribution in Stanford Le-Hope stands out as being skewed slightly more towards older populations compared to other areas of Thurrock.

[15] Examining the role of socioeconomic deprivation in ethnic differences in sexually transmitted infection diagnosis rates in England: evidence from surveillance data M Furegato 1, Y Chen 2, H Mohammed 1, C H Mercer 2, E J Savage 1, G Hughes 1

[16] Public Health England. "Health Matters: preventing STIs". Guidance. 2019.

[17] Department for Health and Social Care. "Abortion statistics for England and Wales: 2019". 2021.

Figure 7 Age Group by PCN:



A scoping review of twelve international studies by Ezhova et al.[18] on barriers to older adults seeking sexual health advice and treatment found that older people were less likely to disclose concerns and seek help around their sexual health owing to various cultural and social factors, in particular stigma and embarrassment attached to older age sexuality. Healthcare providers were also reluctant to initiate conversations and administer tests to this cohort, suggesting that without their needs being recognised, older people may represent a hidden patient group in sexual healthcare and related policy and campaigns. This review concluded that greater efforts need to be made by healthcare providers to recognise sexuality in older age by creating opportunities and spaces for more conversations (Ezhova).

An article in the Lancet Healthy Longevity by US based Steckenrider[19] also supported the idea of normalising sexual health conversations amongst older adults, attributing increases of sexual activity and STIs in over 65s to an aging global population who also had increased access to drugs and devices for sexual function and online dating for seniors. This age cohort may not have received as much sex and relationship education when they were younger. (Steckenrider).

Teenage pregnancy is both a cause and consequence of health and education inequalities. Teenagers have the highest rate of unplanned pregnancy with disproportionately poor outcomes.[20] Recent data shows that babies born to mothers in England and Wales under 20 years had a 30% higher rate of stillbirth than average, and a 60% higher rate of infant mortality than average. Rates of low birthweight in younger mothers were 30% higher than average,

[18] Ezhova et al. *Barriers to older adults seeking sexual health advice and treatment: A scoping review*. International Journal of Nursing Studies. 2020. Vol 107

[19] Steckenrider, J. *Sexual activity of older adults: let's talk about it*. Lancet Healthy Longevity. 2023

[20] Wellings, K; et al. *The prevalence of unplanned pregnancy and associated factors in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3).* Lancet. 2013. vol 382.

and this inequality is increasing.[21] Children born to teenage mothers have a 63% higher risk of living in poverty. Mothers under 20 have a 30% higher risk of poor mental health 2 years after giving birth.[22]

Babies born to mothers under the age of 20 are more likely to experience stillbirth, infant mortality, low birthweight, and an upbringing in poverty. Their mothers are also at greater risk of experiencing poor mental health after giving birth.[23] Child poverty and unemployment are most strongly associated with under-18 conception rates at an area level whilst free school meals eligibility, persistent school absence by age 14, poorer than expected academic progress between ages 11 and 14 and being looked after or a care leaver are the strongest associated risk factors at an individual level. First sex before 16, experience of sexual abuse or exploitation, alcohol, and experience of a previous pregnancy are also other associated risk factors for teenage pregnancy.[24]

Young people are more likely to be diagnosed with an STI, among heterosexuals attending sexual health services, most chlamydia and gonorrhoea diagnoses were in people aged 15 to 24 years. Whilst among heterosexuals aged 15 to 24 years, men are three and a half and women seven times more likely to be diagnosed with an STI, than their counterparts aged 25 to 64 years.[25]

Ethnicity

The largest ethnic group in Thurrock is White British (65%, Census 2021). This predominant representation has reduced from 85% since the 2011 Census. As per the 2021 census, the 'Black African/Caribbean/Other Black' ethnic group is the second largest ethnic group of Thurrock residents at 12%, as is the 'Other White' at also 12%. The highest attendance rates at the sexual health services are amongst black ethnic groups followed by mixed ethnic groups (see local provision data).

Figure 17 highlights that the most ethnically diverse PCNs are Grays and ASOP, both of which have a higher rate of ethnic groups who are not classified as British or Mixed British. Grays rate of patients, who are not British or Mixed British, is approximately 52% and in ASOP these ethnic groups account for 48%. This data is obtained from the Primary GP system for Thurrock registered patients (SystmOne, March 2023). [26]

[21] Office for National Statistics. "Live births, stillbirths and linked infant deaths: birthweight by age of mother, numbers and rates, 2016". 2018

[22] Teenage Pregnancy Unit. 'Long-term consequences of teenage births for parents and their children'. Research Briefing. 2004.

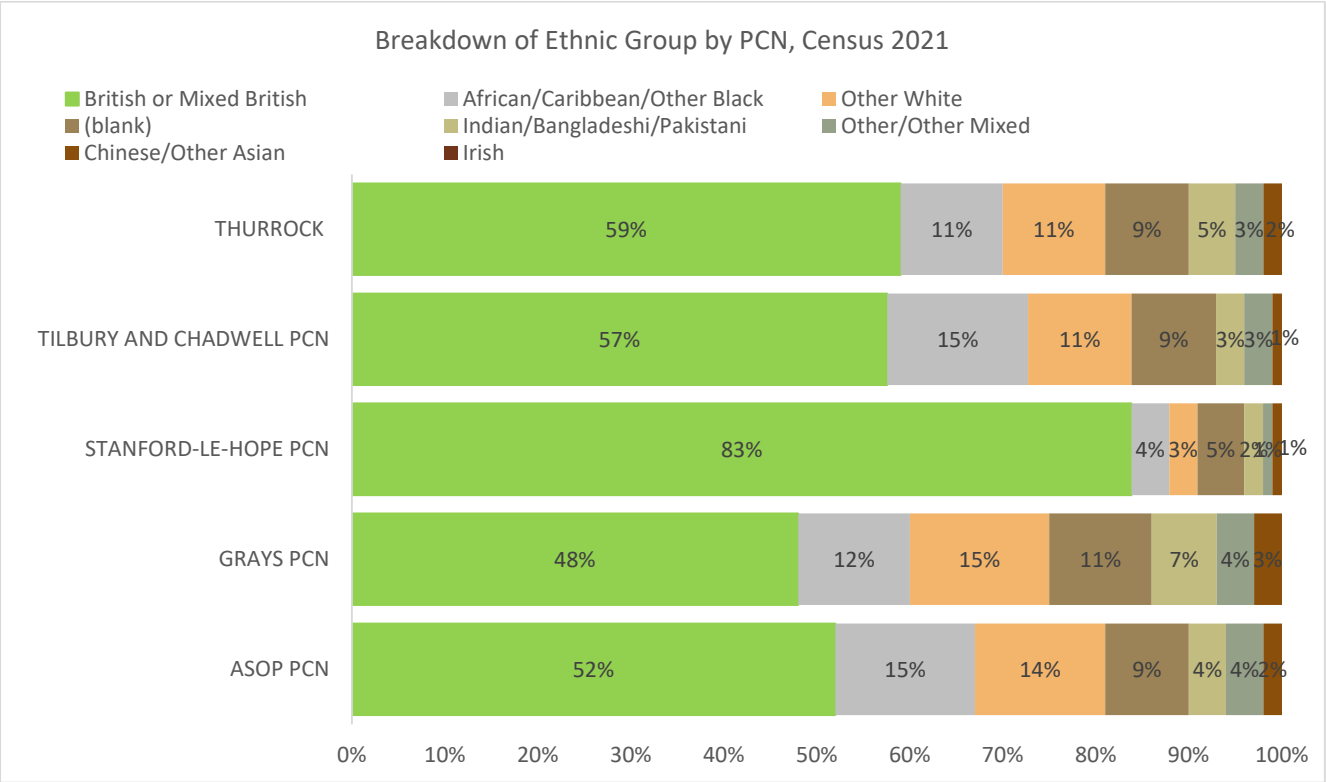
[23] HM Government. 'Child Poverty Strategy: 2014 to 2017'. 2014.

[24] Public Health England. 'Variation in outcomes in sexual and reproductive health in England: a toolkit to explore inequalities at a local level'. 2021.

[25] Public Health England. "Variation in outcomes in sexual and reproductive health in England". 2019.

[26] SystmOne data March 2023 – denominator only includes where Ethnicity was recorded on patient record

Figure 8 Ethnicity by PCN:

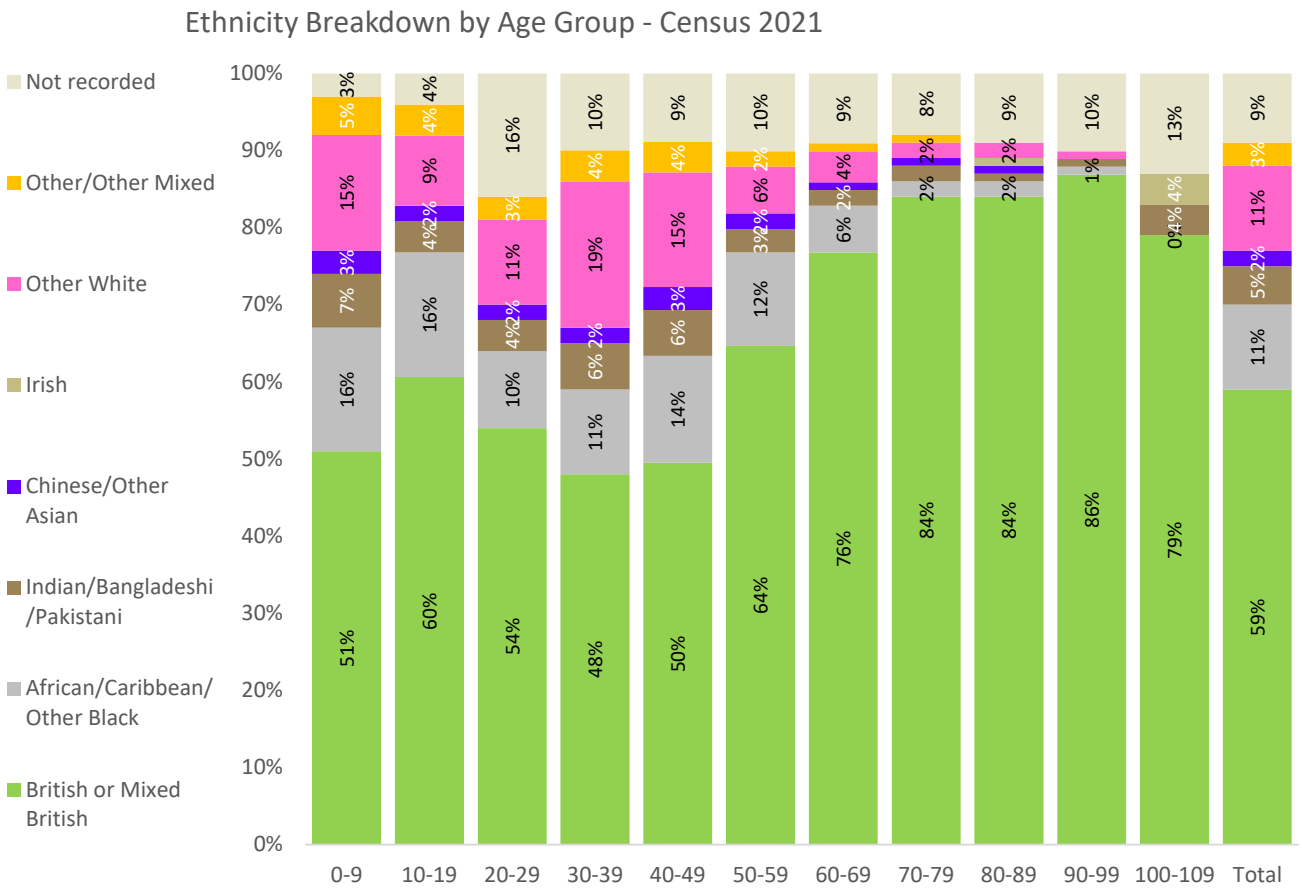


Research conducted through the Health Protection Research Unit (HPRU) on blood-borne and sexually transmitted infections in 2017 to 2018 found, when compared to all other ethnic groups, there were no unique clinical or behavioural factors explaining the disproportionately high rates of STI diagnoses among people of Black Caribbean ethnicity; this ethnic disparity in STIs is likely influenced by underlying socioeconomic factors and the role they play in the structural determinants of the health of this community. Of all ethnic groups nationally, the population rates of STI diagnoses remains highest among people of Black ethnicity in 2021, but this varied amongst Black ethnic groups. In 2021, people of Black Caribbean ethnicity had the highest diagnosis rates of chlamydia, gonorrhoea, herpes, and trichomoniasis, while people of Black African ethnicity had relatively lower rates than other ethnic groups. [27]

Figure 18 demonstrates that our most ethnically diverse populations in Thurrock are in age groups 20 to 59. This diversity then decreases as age increases to the point that on the chart the different groups are barely visible.

[27] UK Health Security Agency. "Sexually transmitted infections and screening for chlamydia in England: 2021 report". 2022

Figure 9 Ethnicity by Age Group:



Faith customs, traditions and societal expectations will undoubtedly influence the acceptability of sexual and reproductive health services, making it even more important for communities and individuals to be informed about options available to them so that they can make an informed decision about the choices that best align with their beliefs and values.

In Thurrock half of the residents describe themselves as Christian (52%), with a considerable percentage having no religion (35%), and a growing percentage of Muslims (5%).

It is observed that among the younger age groups such as those between the ages of 16 and 34 a larger percentage describe themselves as having no religion (44%).

Figure 10:

Religion	0- 15	16 to 24	25 to 34	35 to 49	50 to 64	65 and over	Total
Christian	43%	41%	42%	50%	61%	76%	52%
No religion	41%	46%	43%	34%	29%	16%	35%
Not answered	6%	5%	6%	5%	5%	5%	5%
Muslim	8%	5%	6%	6%	2%	1%	5%
Hindu	1%	1%	2%	2%	1%	1%	1%
Sikh	1%	1%	1%	2%	1%	1%	1%
Other religion	0%	1%	1%	1%	1%	0%	1%
Buddhist	0%	0%	0%	1%	0%	0%	0%
Jewish	0%	0%	0%	0%	0%	0%	0%

One qualitative study[28] into the views, attitudes and experiences of South Asian women concerning sexual health services in the UK found important barriers to access and entry. This included limited knowledge on the local provision of services (specialist and primary care), stigma and shame, and concerns about confidentiality. Overall women from this community felt it difficult to discuss their sexual health with anyone and were often met with judgement and a lack of joined up working from clinicians and community-based services. The authors recommended that service providers should collaborate with community-based organisations to ensure that services are discrete, confidential, and culturally appropriate.

Black and other women of colour in BPAS' report on LARC experienced racist stereotypes around sexuality, promiscuity, young parenthood, and pain thresholds, which impacted on the care and comfort they received from services. A lack of appropriate and relatable imagery in health promotion marketing also created barriers to accessing and using LARC for this group of women. Preliminary recommendations for LARC provision from this report promoted person and rights centred LARC services. This involves working to ensure that LARC provision and removal is legitimate, non-discriminatory, and equitable through challenging assumptions, norms, and stereotypes. It should be recognised that there is no universal one size fits all solution to sexual and reproductive health services. Resources should support safe spaces, conversations, and information sharing so that fully informed consent can be made (BPAS).

Inevitably a younger population would also benefit from an enhanced service which prevents and educates around teenage pregnancies, and accessing SRH services for contraception, as well as any STI prevention screening such as Chlamydia, Gonorrhoea, and Syphilis.

Sexual Orientation and Gender Identity

According to the Office for National Statistics, 91% of adult residents in Thurrock identify as Straight or Heterosexual; and one in fifty identify as Gay/Lesbian or Bisexual (2%). 94% of

[28] Kiridaran, Vaishali; Chawla, Mehar; Bailey, Julia V. ") Views, attitudes and experiences of South Asian women concerning sexual health services in the UK: a qualitative study". *The European Journal of Contraception & Reproductive Health Care*. (2022). 27:5, 418-423.

adult residents identify their gender the same as sex registered at birth. Figure 20 shows the sexual orientation and sexual orientation declared in Thurrock

Figure 11:

Sexual Orientation	Count	%
Straight or Heterosexual	124683	91%
Not answered	8954	7%
Gay or Lesbian	1259	1%
Bisexual	1095	1%
Pansexual	300	0.2%
Asexual	35	0.03%
Queer	7	0.01%
All other sexual orientations	30	0.02%

ONS Definitions and guidance on gender identity and sexual orientation: Guidance for questions on sex, gender identity and sexual orientation for the 2019 Census Rehearsal for the 2021 Census - Office for National Statistics

Gay, bisexual and MSM are among the groups of people most likely to be affected by STIs. According to Public Health England's toolkit for exploring inequalities in sexual and reproductive health, MSM accounted for 81% of syphilis cases,66% of gonorrhoea cases and 41% of new HIV diagnoses in 2019. Although HIV diagnosis rates have been declining amongst this cohort, they still account for the largest proportion of HIV cases diagnosed. (HIV: Annual data tables -Gov.UK 2021). MSM accounted for the highest share of HIV diagnosed in 2019 and 2021, compared to heterosexual men and heterosexual women. However, in 2021 the total number MSM HIV diagnosis was less than heterosexual men and women combined. HIV diagnosed were also more than three times more likely to be diagnosed with an acute bacterial STI than those who are HIV-negative or of unknown HIV status.

Public Health England identified four priorities in its evidence-based resource for professionals on STIs amongst gay, bisexual and MSM. This included raising awareness for MSM on how STIs are prevented, transmitted, diagnosed, and treated. Men who are HIV-negative or of unknown HIV status could benefit from increased knowledge around STIs.

The second priority was for services to be able to create a safe and comfortable environment in which gay, bisexual and MSM can discuss their needs. This means ensuring services are equipped to provide non-judgemental, confidential, professional, and empathetic approaches to sexual health care.

Thirdly, services should be provided in alternative and innovative ways, and strategies should be developed to facilitate targeted, appropriate, accessible, culturally sensitive, and inclusive access for gay, bisexual and MSM. This includes making every contact count to ensure that wherever service uses access help the services can offer the correct information and advice, also ensuring that online access is appropriate and accessible.

The final priority was to encourage ongoing collaboration with local partners and ensure the involvement of community members in the design and delivery of sexual health promotion and interventions (Public Health England).

The NICE sexual health quality standard QS178 advises that MSM have repeat testing every 3 months if they are at increased risk of sexually transmitted infections. This is to ensure any diagnoses of STIs are identified as soon as possible and further transmission prevented (NICE).

It is important to consider the diverse nature of sexual health service users as their needs will vary considerably and not all STI prevention and contraception methods will be beneficial or acceptable to all individuals. Some groups of people will experience barriers in accessing healthcare so extra measures should be taken by healthcare providers and commissioners to enable access for these groups. A single service is not likely to meet everyone's needs, so networks of services with clear pathways into them are important.

NICE guidance states that barriers to services can be reduced by emphasising confidentiality, empathy and a non-judgemental approach, offering access to professional translating and interpretation services, making sure staff understand that services are free and available to everyone without refusing anyone, supporting people to attend appointments and engage with treatments, and by providing outreach activities (NICE).

The use of online testing has become more popular, and benefits include not having to visit a sexual health service in person, not having to take time off work and maintaining anonymity. However, Roy et al. (2020)[29] explored service providers, user experiences and perspectives on behavioural interventions to reduce sexual behaviour risks and found some people were concerned about the use of automated methods to triage them into services. The study included heterosexual young people and MSM and found that they were all generally accepting of sexual health interventions for STIs, however, service users held some concerns about the potential use of automated triage methods and whether the way they were set up (e.g., algorithm design) might result in unfair restricted access to sexual health services for some people depending on the answers they submitted.

Vulnerable and Higher Risk Populations

Higher risk populations include but may not be limited to transgender and gender diverse populations, MSM and GBMSM, older people, intravenous drug users, - Learning disability, commercial sex workers, people who have sex whilst using chemicals, people from other countries with higher prevalence of STIs, people with multiple partners and intravenous drug users.

Sexual behaviour and the way in which sexual behaviour is practiced may lead to negative consequences. However, the definition of a sexual behaviour as risky varies with regards to culture, gender, age, and the threshold. Sexual behaviour is not limited to sexual intercourse and therefore education aimed specifically at target groups is necessary to ensure people are making informed decisions regarding their wellbeing and sexual good health. Open access to services with no fear of recrimination or labelling and assured anonymity must be at the forefront of sexual health services to ensure there is equity of access for all.

Not everyone in a high-risk category will see themselves as higher risk and therefore may not access services. In 2020, the Terence Higgins Trust reported that the sexual activity of older people remains taboo in many areas of society. There is a tendency to desexualise people

[29] Roy, A; et al. *Healthcare provider and service user perspectives on STI risk reduction interventions for young people and MSM in the UK*. Sexually Transmitted Infections. 2020. 96(1): 26-32.

once they reach a certain age, resulting in a reluctance among many health professionals to openly discuss sexual health with older service users, stating that:

"We are seeing increasing rates of STIs reported among older people, although numbers are still much lower than younger age groups. Between 2017 and 2018 the largest proportional increases of gonorrhoea and chlamydia were reported in people 65 years and older (gonorrhoea up 42%, from 236 to 336; and chlamydia up 24%, from 416 to 517)."[30]

Whilst one of the current key performance indicators for the local service is to provide information on the number of young adults opportunistically tested for chlamydia there is no current request to report on older adults receiving testing and treatment and this needs to be addressed locally.

Public Health England (now UKHSA and OHID) confirmed that between 2017 and 2018 sexually transmitted infections in England rose by 5%. Virtually every age group saw a rise in most infections, but gonorrhoea and chlamydia saw the biggest proportional increase in people over 65. This may be in part to divorce rates later in life are increasing and more older people are entering new relationships, they might not feel they are at risk due to their age or may not feel comfortable entering sexual health services due to the perceived stigma of doing so.

Similarly, the proportion of new HIV diagnoses reported in the over 50s has increased from 13% in 2009 to 21% in 2018, and the rate of late diagnoses continues to be highest in this age group (58% in 50-64 years; 64% in 65+).[31]

UKHSA's report Sexually Transmitted Infections and Screening for chlamydia in England (2022) stated that,

"Of all ethnic groups, the population rates of STI diagnoses remained highest among people of Black ethnicity in 2021, but this varied amongst Black ethnic groups. In 2021, people of Black Caribbean ethnicity had the highest diagnosis rates of chlamydia, gonorrhoea, herpes, and trichomoniasis, while people of Black African ethnicity had relatively lower rates than other ethnic groups"

The report also evidenced that between 2012 and 2019 the number of bacterial STI diagnoses among GBMSM increased persistently before dropping in 2020 and whilst increased testing and targeting may have played a role in the increase it could also be attributed to continued risky behaviours within this group. It is widely speculated that the use of dating apps has led to an increase in the incidence of sexually transmitted infections (STIs); among MSM and heterosexual populations, particularly in young adults. Indeed, there have been a few studies into the impact and role of dating sites and apps and links to increasing prevalence of STIs. Research has found that finding sexual partners through geosocial networks and dating apps enables users to have a greater number of sexual partners with increased turnover, consequently decreasing safe sexual practices and increasing the chance of contracting STIs. However, research is currently limited within this area.[32]

[30] Terrence Higgins Trust "It's time to face the taboo around older people having sex". 2020.
[31] UK Health Security Agency. "HIV: annual data tables". 2022
[32] Local Government Association and English HIV and Sexual Health Commissioners Group. "Breaking Point: securing the future of sexual health services". 2022.

The World Health Organisation reported in 2019 that dating apps and sexual health stigma are driving a surge in STIs and untreatable strains daily. Service providers need to use these platforms to promote safer sex and online testing.

It is important that people from high-risk groups are regularly screened for infections and, on some occasions, may have more in-depth testing depending on the circumstances.

Vaccinations are offered to some people in high-risk groups and their partners. These can include vaccination against Hepatitis A, Hepatitis B and Human Papilloma virus (HPV)

Children Looked After

According to the Local Authority Interactive Tool there was a rate of 66 Children Looked After (CLA) per 10,000 children aged under 18 in Thurrock on the 31 March 2021, which is equivalent to 298 CLA. In comparison, the rate of CLA in the East of England was 49 CLA/10,000 children, amongst statistical neighbours it was 65 CLA/10,000, and in England it was 67CLA/10,000 children.

The number of 0 to 19 year-olds in Thurrock is expected to pass 50,500 by 2037, and may increase further as a result of the local economic growth. The proportion of children under 15 years-old is highest in Tilbury, Chafford, North Stifford, West Thurrock and parts of Ockendon.

Children and young people looked after (CLA), and Care Leavers are a particularly vulnerable group with potentially greater health and social needs than their peers. CLA have long been viewed as one of the most vulnerable populations in society, facing inequalities in health, education and social factors that are harmful to their health and wellbeing outcomes, and ultimately their life potential and fulfilment. Evidence shows that certain Adverse Childhood Experiences (ACEs) are commonly linked to children entering the care system and increase the chances of poor health outcomes later in life. ACE include:

- verbal, physical, and sexual abuse.
- emotional and physical neglect.
- household challenges, including:
    - mental illness.
    - domestic violence.
    - problem drug and alcohol use.
    - parental incarceration.
    - parental separation.

Both chronic stress and increased health damaging behaviour which relieves this stress such as smoking, substance abuse and sexual risk-taking, can be associated with poor physiological development and experience of multiple ACEs. As a result, there are some children who, for a variety of reasons, are unable to live with their parent/s. In such circumstances, children, or young people, may either enter care through voluntary means or through a court order which enables the local authority to take on corporate parenting responsibilities to safeguard them. These children then become Children Looked After (CLA).

Care Leavers (CLs) are young people who have been cared for by the Local Authority and are on a path to transition into adulthood towards independent living with the option of accessing the support of the Local Authority care leaving services until age 25.

Nationally, the prevalence of CLA has been increasing year on year. Although Thurrock has had a larger number of children in care than comparator local authorities, this has now stabilised from 2018 and is currently in line with national and comparator local authorities. The CLA cohort includes children with special educational needs and disability (SEND) and Unaccompanied Asylum-Seeking Children (UASC). There were 298 CLA as of 31 March 2021. This is equivalent to a rate of 66 CLA per 10,000 children under the age of 18, which is similar to England and our Statistical Neighbours (SN) but higher than the regional average. As at March 2022, unpublished data shows the number of CLA were 295 equating to a rate of 65 per 10,000 population.

According to The Health and Wellbeing of Children Looked After Needs Assessment (2022)[33] The rate of children in care in Thurrock declined between 2016 and 2019, from 81 CLA per 10,000 children under the age of 18 in 2016 to 67 CLA per 10,000 in 2020 and has remained stable since. At the end of March 2021, 286 Care Leavers (compared to 254 in March 2020), including those 16-18 being supported, were receiving an Aftercare Service. This is a slight increase from March 2019, but this is largely dependent on the age of children in care.

From August 2020 to February 2021 during international COVID-19 restrictions, there had been a reduced number of UASC, but that trend reversed to reach as high as 33 UASC by September 2021. The number of UASC who were open at the end of each month has increased since September 2021, equating to 11% of the total CLA cohort. This is above the Thurrock ceiling of 0.07% and the allocated number of 31 UASC. There has been a reduction in this number since March 2022 (Thurrock Council Children Looked After Monthly Profile, 2022).

In Thurrock over half of children in care are male – 62% compared to 38% female. A larger proportion of Children Looked After are between the ages of 12 and 16 (44%) with the second largest group being the 5–11-year-olds (24%). There is a strong positive association between ward level deprivation and the rate of CLA in each ward in Thurrock with children living in the most deprived area of Thurrock being 4.3 times more likely to be taken into care than those living in the least deprived area of the borough. (Thurrock Council Children Looked After Monthly Profile, 2022)

A key finding in the needs assessment was a gap in the knowledge of the extent of sexual health need in CLA and Care Leavers. The recommendations were:

- commissioners and provider must work to enhance local data recording and collecting procedures to inform understanding regarding the uptake and usage of the Sexual Health service by CLA and Care Leavers, and this must highlight gaps in provision and relevant adaptations.
- The sexual health service should work in a way that ensures age-appropriate information is available to young people in care either through the local offer website or the NHS App.
- This must be considered within the next procurement of the Sexual Health Service.

[33] Thurrock Council. 'The Health and Wellbeing of Children Looked After: a health needs assessment for Thurrock'. 2022

Homeless Population

The Department for Levelling Up, Housing and Communities (DLUHC) (formerly the Ministry of Housing, Communities and Local Government) records local authority level statutory homelessness data. According to this, between April and June 2021 there were 184 households in Thurrock owed a homelessness prevention or relief duty. This included 89 households (a rate of 1.31/1000 households) threatened with homelessness within 56 days (prevention duty owed) and 95 households (a rate of 1.47/1000 households) which were homeless (relief duty owed). [34]

The Thurrock housing-strategy-2022-2027 aligns with other key council strategies including the Thurrock health-and-well-being-strategy-2022-2026 (health and well-being strategy 2022-2026), Better Care Together Thurrock Further Case for Change (adult health and care) Brighter Futures Strategy (children and young people's health and care). With a focus on integration, the housing strategy has reframed the approach to support households interacting with the council, to move away from dealing with issues in isolation by disconnected teams, to develop a strengths-based 'whole person' approach. This connects the wider system of adult social care, children's services, public health, NHS teams, voluntary and faith sector, and other assets within the community.

The Housing Strategy 2022-2027 also incorporates the previously developed Homelessness Prevention and Rough Sleeping Strategy (2020-2025)

There are four strategic priorities focussed on health and wellbeing, partnership and collaboration provision and accessibility and customer excellence. The Housing Strategy 2022-2027 aims to:

- Redefine and simplify pathways for vulnerable households to access health and wellbeing services across the borough, especially in relation to mental health.
- Increase awareness of the physical impact of homelessness and work with partners to improve access to primary care services for those experiencing rough sleeping.
- Explore opportunities to deliver improved services to armed forces veterans who are homeless or at risk of homelessness.
- Review and revise the existing joint protocol for supporting those at risk of homelessness because of fleeing domestic and sexual abuse.

The housing services are provided to adults, including young care leavers. The advice and support cover tenancy management, problems with anti-social behaviour, safeguarding, sheltered housing, hostels, and temporary accommodation. The team carry out homeless assessments, rent collection, leasehold management, repairs, and resettlement support to applicants.

A recent report cited in Your Thurrock (2023)[35] claimed that homelessness has increased by 20% due to the increase in rent and the lifting of the eviction ban (in place throughout the Covid-19 pandemic). This may not be sustained once the backlog from the pandemic has eased however homelessness may increase the risk factor of contracting or passing on STIs

[34] Department for Levelling Up, Housing and Communities. 'Statutory homelessness in England: April to June 2021'. *Official Statistics*. 2021.

[35] Your Thurrock. *Homelessness rises by a 'shocking' 20 per cent in Thurrock*. 13 January 2023.

due to several factors. It may lead to increased commercial sex work and a lack of willingness to engage with services due to the stigma attached to both homelessness and sex work.

Homelessness, as outlined by the NCFE, is defined as "not having a home". Whilst this includes those with nowhere to stay who are living on the street, it also includes many individuals who have a roof over their head.[36]

You count as homeless if you are:

- Staying with friends or family.
- Staying in a hostel, night shelter or B&B.
- Squatting (because you have no legal right to stay).
- At risk of domestic abuse.
- Experiencing violence in your home.
- Living in poor conditions which affect your health.
- Separated from your family because you do not have a place to live together.

The above factors can increase the individual's vulnerability and therefore their risk of contracting STIs as well as other mental and physical health issues especially amongst younger populations. According to the LGA (2017)[37] the risk is higher for several reasons, they may come under pressure to exchange sex for food, shelter, drugs and money, they may lack relationship and independent living skills, formal support and struggle to access services and are more likely to have experienced trauma, abuse and other adverse experiences.

Gypsy/Traveller Population

Thurrock Council manages two English and one Irish socially rented (authorised) Traveller sites which are situated within Aveley, North Stifford and Grays. Each site consists of 21-22 residential caravan pitches according to the DLUHC's Count of Traveller Caravans which was last taken in July 2021.

At this point in time the total count of authorised caravans in Thurrock (with planning permission) amounted to 200 (81 socially rented and 119 private). There were a further 33 unauthorised caravans (without planning permission) on Traveller's own land. This totalled 233 caravans in Thurrock in July 2021. The national dataset includes traditional and non-traditional traveller groups but excludes show people's caravans [38]. The precise number of caravan occupants is not collected in the caravan count but indicates that the local population of travellers extends beyond the managed sites. According to Thurrock's Traveller Liaison service each managed site houses just over 100 people which is broadly in line with the 2011 census which reported 308 people in Thurrock with Gypsy or Irish traveller ethnicity.

There is a further showman site with an estimated population of over 2000 people in Buckles Lane. This site is privately owned and divided into sub yards within the main site. Many of the plots on the site do not have permission and therefore accessing exact data is difficult. Initially the site was for travelling showman however the Buckles Lane Accommodation Assessment

[36] NCFE. *Homelessness the causes and the risks*. 2021.
[37] Local Government Association. "The Impact of Homelessness on Health: a guide for local authorities". 2017.
[38] Department for Levelling Up, Housing and Communities. 'Traveller caravan count: July 2021'. *Official Statistics.* 2021.

Report in 2018 claimed that it has a growing population of non-travelling showmen on the site and this continues to grow.

Generally, the majority of Travelling Show people yards are privately owned and managed. These result from individuals or families buying areas of land and then obtaining planning permission to live on them. Households can also rent plots on existing private yards – often owned and managed by the Showmen's Guild.

Romany Gypsy, Roma, and Irish Traveller communities are known to face some of the starkest inequalities in healthcare access and outcomes amongst the UK population, including when compared with other minority ethnic groups. The reasons for these poor health outcomes are complex, but include the impact of discrimination and stigmatisation, the complicated nature of health systems and the effects of wider social determinants of health. According to a 2022 briefing on health inequalities[39], Romany and Traveller people face life expectancies between ten and 25 years shorter than the general population. Romany and Traveller people experience significantly higher prevalence of long-term illness, health problems or disabilities, which limit daily activities or work. The health of a Romany or Traveller person in their 60s is comparable to an average White British person in their 80s.

There are several factors that contribute to poor health outcomes among Gypsy, Roma and Traveller communities. These relate to structural inequalities, social exclusion, and barriers to healthcare services. Key issues include:

- Chronic exclusion across the wider determinants of health.
- Invisibility in mainstream datasets, meaning needs aren't identified within services.
- Lack of trust in services because of fear of and experiences of discrimination.
- Wrongful registration refusal in primary care.
- Digital exclusion and lack of accessible information.
- Inequalities in access to healthcare waiting lists for nomadic populations.
- Inequalities in mental health and access to mental healthcare.
- A failure within services to account for premature onset of typically age-related conditions.

There is no 'one size fits all' approach, but as commissioning should be evidence and needs-based, services provided in an area should reflect the epidemiological profile and the level of need in the local population, however access remains a crucial issue for socially excluded groups, especially for primary care as the system gatekeeper. The role of the 'trusted individual' is invaluable to enable the 'bridge-building' and navigating work carried out by health and voluntary sector organisations working with excluded, high-need clients, in Thurrock there has been success in promoting and uptake of childhood and adult immunisations by using a hyper local model supported by the traveller liaison teams who are well known, trusted, and respected in the community. The use of trusted individuals would enable sexual health services to outreach into hard-to-reach environments and could encourage better engagement in the community.[40]

[39] Friends, Families & Travellers. 'Briefing: Health inequalities experienced by Gypsy, Roma and Traveller communities'. October 2022.

[40] Gill, Paramjit et al. 'Improving access to health care for Gypsies and Travellers, homeless people and sex workers: An evidence-based commissioning guide for Clinical Commissioning Groups and Health & Wellbeing Boards'. September 2013

Multi-disciplinary working should be encouraged from the beginning of clinical training, by stressing social inclusion aspects in formal education, as well as through secondments or volunteering. There is a need to systematically capture and share examples of good practice and success stories, as there are strong examples of creative and effective provision of services. Building capacity in the community is a valuable element of working with excluded groups, as it simultaneously engages these communities, and creates social and human capital as well as skills. Outreach work is often the first, most important step in re-connecting the system with the user.

Adults with Learning Disabilities

In 2020 approximately 2.4% of Thurrock's population age 18-64 were estimated to have a learning disability in Thurrock and for the population over 65 years of age this was about 2.1%. The proportion of people with learning disabilities is expected to remain broadly the same over the next twenty years, however, as the total population is expected to grow, so will the actual number of people with learning disabilities. Between 2022 and 2025 an additional 70 people aged 18-64 and 23 people age 65+ are expected to join the local cohort of people with learning, totalling an estimated 3271 people age 18+ with a learning disability in 2025.

Women with intellectual disabilities are often not visible in social research and policy and have experienced a history of denied reproductive freedom, forced sterilisation, and exclusion from information about sexual health, consent, and relationships (Wiseman and Ferrie, 2020)[41]. Their limited agency, choice, and information for making decisions diminishes their rights and places them at a greater risk of poor sexual health and wellbeing and sexual violence.

Wiseman and Ferrie (2020) recommend lifelong commensurate and accessible information and education for women with intellectual disabilities, to enable them to make informed decisions around their sexual health and wellbeing (P. a. Wiseman).

The British Pregnancy Advisory Service (BPAS)'s report into the use of LARC[42] also found that disabled people and those with mental health issues often found their autonomy was undermined, for example, clinicians assuming they knew best rather than taking on board the users' preferences (BPAS).

The Faculty of Sexual and Reproductive Healthcare (FSRH) guidance[43] states that appropriate arrangements should be in place to enable patients with special needs to access SRH services without undue delay. This includes people with communication difficulties and physical or learning difficulties. Sex workers, victims of sexual assault and young people including those in the care systems are also categorised as having special sexual health needs in this guidance (FSRH).

The qualitative study conducted by Solutions for Public Health found that certain services advocates had been discouraged from attending clinic appointments with the service user which may prevent the service users voice being heard.

[41] Wiseman, P and Ferrie, J. 'Reproductive (In)Justice and Inequality in the Lives of Women with Intellectual Disabilities in Scotland'. *Scandinavian Journal of Disability Research*. 2020. 22(1):318-329.
[42] British Pregnancy Advisory Service. 'Long-Acting Reversible Contraception in the UK'. 2021.
[43] Faculty of Sexual and Reproductive Healthcare. 'Service Standard for Sexual and Reproductive Healthcare'. 2022.

The NICE quality standard [QS129] on contraception states in its equality and diversity considerations that women with learning disabilities or cognitive impairment may have limited contraception options, in which case contraceptive services should make it clear to the women concerned why certain methods cannot be used (NICE).

According to Mencap (2016)[44] many people with a learning disability say that relationships are important to them. But only 3% of people with a learning disability live as a couple, compared to 70% of the general adult population. Many people with a learning disability would like to pursue intimate or sexual relationships, but they face multiple barriers to developing such relationships. These include (but not limited to)

- Meeting people is more difficult and social isolation is common.
- People are not receiving adequate relationships and sex education to give them the skills and knowledge to have healthy and fulfilling friendships and relationships, and to understand and explore their own sexuality.
- There is often a lack of privacy which restricts opportunities to explore and understand sexuality.
- The balance between risk and rights.

People who receive good relationships and sex education usually have better sexual knowledge, better sexual health, and reduced vulnerability to sexual abuse. The need to ensure that sexual health services are available to the whole population is vital. This may be with outreach clinics into specialist services, specific RSE training in Special Educational Needs and Disabilities (SEND) schools, training for health and social care staff and engaging with the community to understand what their needs are.

Adults with Physical Disabilities

The number of adults aged 18-64 and living with a physical disability is expected to increase in upcoming years, although the proportion of the population affected by physical disability will remain broadly the same in 2025 as in 2020. Having a physical disability doesn't change a person's sexuality or desire to express it. In fact, the World Health Organization says sexuality is a basic need and aspect of being human that cannot be separated from other aspects of life.

A physical disability is any condition that permanently prevents normal body movement or control.

Compared to the non-disabled community, people with disabilities are three times more likely to experience violence and sexual abuse.[45] Why would this be? For starters, there are a lot of negative assumptions toward people with disabilities. They often feel devalued, isolated from their community, and as if they are expected to comply with caregivers. Because they are more likely to be perceived as powerless and physically helpless (depending on their condition), people with disabilities usually have fewer opportunities to learn their sexual likes and dislikes, or to set emotional boundaries with an intimate partner. Research from the Baylor College of Medicine (cited by Perez, S.) found that when instances of violent sexual encounters occur, people with disabilities are more likely to perceive it as "their only choice."

[44] Mencap. 'Sexuality and Relationships Vision Statement'. 2016.
[45] Perez, Stephanie. "How Unhealthy Relationships Impact the Disabled Community". *One Love*.

The Equality Act 2010 prohibited discrimination against disabled people, however, according to the National Disability Strategy many disabled people still feel the stigma of being disabled; this can lead to them feeling hesitant or fearful about disclosing their disability or asking for help. The strategy[46] estimated that 1 in 5 people were disabled therefore estimating there may be over 35,000 people with a disability in Thurrock.

According to the National Disability Strategy, it has been found that when commuting just a quarter of train stations have step-free access between all platforms. When shopping or getting about, 2 in 5 disabled people had experienced difficulties shopping around for products or services, with reported barriers including a lack of appropriate facilities (16%), difficulty using public transport (15%), and difficulty moving around premises (13%). When accessing public services online, when tested in September 2020, the websites of nine of the 10 most populated English county councils did not meet accessibility standards. Access to services must be considered in the specification to ensure that the service is inclusive and accessible to all. Engagement has shown that some service users would prefer to travel Barking or Basildon as it is an easier commute.

If a disability impairs a person's physical ability to engage in a regular sex life, or makes them lack confidence, they may feel worried about having sex.

According to Aruma (2019 the ability to have 'traditional' sex can depend upon someone's disability, however, sex is not black and white – there are many ways to express sexual feelings such as kissing, touching, massaging, and other activities.

Ensuring all people are informed about sex education and have access to resources is of utmost importance. Learning about consent, STIs, contraception, pregnancy, and safe sex is all a part of this education. People with a disability need to be provided with a comfortable environment to talk openly about their experiences. They must be able to access services with ease and comfort via both personal and public transport, Services must be designed and located to accommodate access for all and there must be specialist clinicians that can discuss all matters of sexual health including disabilities and have resources available to share with individuals.

Adults with Mental Health Conditions

In 2020 19% of adults aged 18-64 (20,227 people) in Thurrock were reported as having a common mental health disorder, which was equivalent to 19% of this age group. There were also 12,327 people who were reported as being a survivor of childhood sexual abuse (12%), and 7693 people (7%) with two or more psychiatric disorders. These three indicators individually accounted for the three largest proportions of mental health disorders in Thurrock in 2020 and each of them are expected to increase by 5% between 2020 and 2025.

Other mental health disorders will also see similar growth of around 5% in this time frame, although they affect a smaller proportion of people (individually, between 0-4% of the population age 18-64).

[46] Secretary of State for Work and Pensions. "National Disability Strategy". 2021.

According to Ayelegne, Gebeyehu and Mulatie (2021)[47] people with severe mental health disorders are more likely to engage in high-risk sexual behaviours. As a result of these high-risk behaviours, they might contract sexually transmitted infections and become pregnant unintentionally. Despite the high burden of this problem, very little is known about the association between mental disorders and high-risk sexual behaviours.

High-risk sexual behaviour is an act that increases one's risk of contracting sexually transmitted infections and experiencing unintended pregnancy. It includes risky behaviours such as having multiple sexual partners, a history of unprotected sex/ failure to use condoms or intermittent use, exchanging money for sex, performing sexual intercourse while under the influence of alcohol. These behaviours in turn can increase the likelihood of both contracting and passing on STI's.

It is also important to recognise the effect of having or suspecting an STI can have on a person's mental wellbeing. In a survey conducted by Superdrug and cited by Paton, N (2022)[48] of 2000 sexually active people across the UK above the age of 18 more than a third of men (34%) said that a diagnosis of a sexually transmitted infection (STI) would have a negative effect on their mental health. 91% agreed an STI diagnosis would negatively affect their mental health, relationships, social life, love life, general confidence, and even their career.

Half of those polled admitted they wouldn't even feel comfortable speaking to their long-term partner about STIs.

Nearly two-thirds (63%) said they wouldn't feel comfortable speaking to their friends and 90% said the same about their parents or siblings.

There must be robust inter agency communication and integration between specialist services to ensure that people at risk (including those with mental health conditions) are able to access services.

[47] Ayelegne, Gebeyehu, Daniel & Mulatie, Missaye. "Risky sexual behaviour and its associated factors among patients with severe mental disorder in University of Gondar Comprehensive Specialized Hospital". *BMC Psychiatry.* (2021) v.21.

[48] Paton, Nic. "Third of men would find STI diagnosis damaging to mental health". 7 November 2022. *Personnel Today*.

4. Local Provision

Figure 12: Key Findings and Recommendations for Local Provision:

Key Findings:

- **The service sees an average of 15,422 appointments/record of engagements per year.**
- **Many appointments will be for more than one reason (testing and treatment) (testing and advice).**
- **Whilst there has been an increase in the over 65 population this has not been replicated in service attendance.**
- **The highest rates of attendance are amongst the White (72%) and Black (17%) ethnic groups.**
- **The young people's service delivered by Brook have not extended their contract and no longer provide services.**
- **RSE provision is limited.**
- **THT are providing additional support to the contract including engagement with professionals and outreach sessions.**
- **Satellite (spoke) clinics are limited, and one is closed.**
- **Related services are unsure of how to refer into sexual health.**
- **There is a limited visibility of sexual health services in Thurrock.**

Recommendations:

- **Sexual health services to advertise and communicate the offer of the clinic in Tilbury to increase use and awareness.**
- **Provider to review the accessibility of services across Thurrock and surrounding geographies to ensure that good quality services are accessible at a time and place that is convenient for the service user.**
- **Sexual health services to ensure consistent education and advice is available to all service users through a range of formats, utilising a range of existing services as appropriate such as primary care and school nursing.**
- **Sexual health and associated services to develop an action plan for communication and engagement with stakeholders.**

A service review by Thurrock Council in 2021 reported that since the contract started on 1 April 2018, Provide have successfully introduced several service delivery and other operational changes including a staff consultation, a series of subcontracting arrangements, implementation of a triage process, a central booking system, launch of a new electronic C-Card condom distribution scheme and the 'Test at Home' STI testing service. The contract was initially awarded for a 3-year term with the option to extend for a further 2 years. A Deed of Variation was signed by both parties to make the following variations to the contract:

- a 2-year extension until 31 March 2023 (which has now been extended for a further period).
- inclusion of the provision of a HIV Pre-Exposure Prophylaxis (PrEP) service which became a mandatory requirement in November 2020.
- a change to subcontracting arrangements, enabling Provide to subcontract LARC beyond Primary Care.

There are four subcontracted service providers (Healthy Living Partnership, Brook, Terrence Higgins Trust, and Primary Care) delivering community-based services to schools, young people and some underserved groups such as the lesbian, gay, bisexual, queer, questioning, intersex, pansexual, two-spirited and asexual (LGBTQQIP2SAQ) community. Some GP practices deliver contraceptive services including LARC fitting and removal. From April 1st, 2023, Brook withdrew their contract, and the Terence Higgins Trust has taken on the training of professionals to deliver Relationship and sex education in agreement with Essex Public Health.

Providers

The current provider information was informed by Solutions for Public Health as part of the stakeholder engagement element of the needs assessment. The full report can be found in appendix 1.

Current Provision

Provide

Provide Community Interest Company (CIC) are commissioned to deliver the Thurrock Integrated Sexual Health contract. The contract commenced on 1 April 2018. The contract has been extended and is due to end on 31 March 2023.

Orsett is the main hospital consultant led sexual health service in Thurrock offering STI screening, LARC and coil fittings and removal, support for people requiring complex care and a range of advice and support for people with sexual health needs from age 13 years onwards. Although satellite clinics have in the past been available at Tilbury and Corringham these are currently restricted.

Services across Essex including Thurrock are delivered by Provide and share the same InForm system to gather data. Data for each of the services is fed into the Key Performance Indicators which are different for each council. Provide report KPIs quarterly to each council.

The two faculty trainers in the Thurrock service can deliver training to external colleagues such as local GPs which was considered a strength of the service. The Orsett hospital service is open from 8am to 8pm Monday to Friday to improve accessibility for the working population. There is also access to a service for Thurrock residents on Saturdays.

There are two satellite services to deliver sexual health interventions at a locality setting, however the satellite clinic at Corringham does not currently offer any services due to limitations of staffing and equipment. The clinic at Tilbury was closed during Covid but is now operational.

Since the start of the contract (April 2023) Provide have seen 2043 residents, of these appointments 1790 were face to face with 253 being virtual. There were a further 334 follow up visits with only 5 of these being virtual. Of those seen 31.9% were male and just over 68% female. 59% of those attending were white British with the next frequent category being black or black British at 14%. Irish were the fewest with less than 0.3% attendance and Chinese slightly more at 0.5%. Asian British (Pakistani) Asian British (other) and Asian British (Indian) collectively only represented 3% of the overall attendance. This supports the National picture that attendance is lower for people from ethnic minority backgrounds.

60% of those seen reported identified as heterosexual; 1.3%, bisexual; 2.9% gay; and only 0.25% lesbian, however a further 35% were either not asked or declined to answer.

Non LARC contraception 179 appointments including condoms, contraception pill, injection, patches rings and diaphragm and emergency contraception. A further 41 IUS were fitted and 40 removed, 30 hormonal implants were fitted and 43 removed. In April and May 39 and 40% respectively of females attending for contraception were given LARC.

In clinic an average of 15% of those tested for chlamydia, gonorrhoea, syphilis, and HIV tested positive (there were no HIV positive results). In April 78% of those tested were positive for Herpes and in May 41%.

Data from Thurrock Sexual Health Service 2018-2022 – Provide CIC.

This analysis of service user data will illustrate the SHS use/demand between April 2018 to December 2022. The data will primarily focus on the activity levels across the SHS (appointments/engagement with SHS) to reflect the demand of the services. The data will also highlight the number of patients using the SHS, particularly those who have actually attended the appointments and/or used the SHS.

Patient Status/Annual trend

Between 2018 to 2022, the total number of appointments or SHS engagement has been recorded at 77,111 which is an average of 15,422 appointments/record of engagements per year. The number of appointments attended was recorded at 57,019, which is an average of 11,404 a year (74%).

Figure 13:

Year 2021 showed the highest use of/engagement with a SHS, equating to approximately 23%. The average number of appointments/engagement with an SHS pre-covid was 19% (2018/2019), and post-Covid (2021/22) the average was 22%.

Appointments/-Engagement with SHS	2018	2019	2020	2021	2022	Total
Attended	10004	10895	11349	14250	10521	57019
Cancelled By Patient	1881	2952	2368	2785	2827	12813
DNA	1595	1869	757	1218	1411	6850
Booked	30	12	108	96	49	295
Could Not Wait	46	8	8	22	50	134
Grand Total	**13556**	**15736**	**14590**	**18371**	**14858**	**77111**

The number of patients that have had an appointment/engagement with a SHS over this time was recorded as 22,882 which averages at 6,385 patients per year. Of these 22,882 patients, 20,178 have attended which is an average of 5,524 patients (88%), a small number have been booked but deferred for treatment or further testing. This equates to the likelihood of a patient attending a SHS/engaging with a SHS at an average of 2.1 times.

Figure 14:

Patients	2018	2019	2020	2021	2022	Total
Attended	6585	6375	4653	5165	4842	20178
Cancelled By Patient	1468	2257	1776	1988	1954	8019
DNA	1343	1555	664	1014	1115	4957
Booked	30	12	105	94	48	282
Could Not Wait	46	8	8	22	50	134
Grand Total	**7468**	**7800**	**5374**	**5712**	**5572**	**22882**

The data shows a higher demand of service use (attended/appointments booked) prior to the pandemic in 2020. During the pandemic, demand and use of sexual health clinics decreased as expected, and between 2021-2022, service demand/use has begun to increase as services resume to pre-pandemic years. Though during this recovery period, many patients are shown to have cancelled their appointments or were unable to wait at the clinic, indicating a potential resource, service provision issues or unmet expectation. Between 2018 to 2021, Thurrock's population grew from 172,525 in 2018 to approximately 176,000 (Census 2021) - a 2% increase. This could also be a contributory factor where the growth in the population is in excess of the SHS provision and resource.

Age/Ethnicity of attendees

This section only includes those 'attended' or 'booked'.

There were 20,228 patients who attended or booked an appointment at an SHS between 2018 to 2022. This equates to a rate of 115 SHS users per 1,000 Thurrock's population.

Figure 8 illustrates that of the 20,228 patients who has used a SHS service, the highest rate against the Thurrock population was amongst the Black ethnic group at a rate of 163 per 1,000, followed by 130 per 1,000 from the Mixed ethnic group; 107 per 1,000 from the White ethnic group; 61 per 1,000 in Asian ethnic group; and 47 per 1,000 from Other ethnic group. This data provides an insight as to what rate of the Thurrock population have attended or made use of a SHS.

Figure 15:

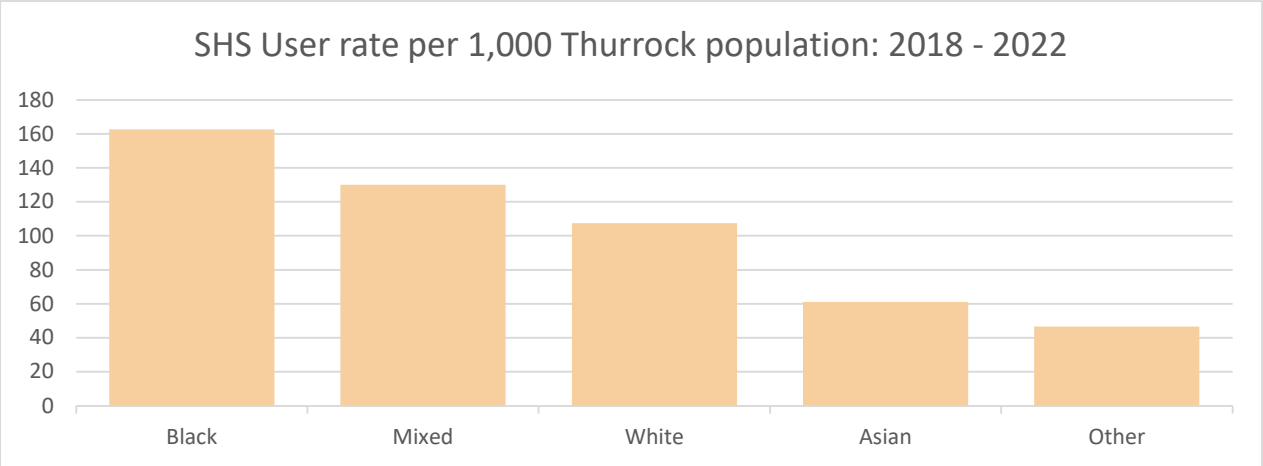


Figure 16 highlights that rate per 1,000 of service users within each age band and ethnic group. The highest use of SHS is amongst the Black and Mixed ethnic groups between the ages of 21 to 35 years; and the White ethnic group between 21 to 25 years of age. SHS use and engagement decreases from 50+ years, and SHS use and engagement is low amongst the under 15s.

Figure 16:

Service attendee rate /1,000 per age group	Asian	Black	Mixed	Other	U/K	White	Grand Total
11 - 15	2	5	13	5	216	21	17
16 - 20	54	189	252	28	263	278	256
21 - 25	155	542	476	142	265	435	441
26 - 30	172	511	488	102	315	332	351
31 - 35	124	449	383	80	323	230	252
36 - 40	108	354	227	81	289	181	202
41 - 45	85	241	230	89	355	127	149
46 - 50	52	162	192	27	330	92	105
51 - 55	42	94	148	36	361	61	70
56 - 60	24	47	81	29	369	39	41
61 - 65	9	33	57	11	357	20	21
66 - 70	11	5	0	0	250	13	13
70+	0	4	0	0	375	4	4
No Age	0	0	0	0	0	1	0
Total	61	163	130	47	285	107	115

Reasons for attendance (includes up to March 2023)

The following tables highlight the reasons for attendance at a sexual health clinic. However, it should be noted that there are overlaps in the reasons for attendance. For example, where someone has been recorded under ‘STI’, they may also have been recorded under ‘pregnant’ and/or ‘IUD removal’ and/or advice given. Another example is someone recorded under ‘Infection’ may also be recorded under ‘pregnant’, ‘STI’ and/or ‘treatment’.

Due to data quality, it is not possible to breakdown each reason individually and avoid duplication. However, the data presented in the tables gives an estimation of the key reasons for attendance amongst the sexual health clinics.

In each category, with the exception of screening, all patients have repeatedly visited a sexual health clinic, hence the elevated activity figures. This could be potentially due to recurrence of infections, a primary test followed by follow up testing, routine testing of a patient with an ongoing STI and other reasons where a patient needs to visit the clinic more than once.

Figure 17:

Reason	No. of Patients attended	No. of times patient attended	Average number of attendances per patient
Test	15162	27775	1.8
Advice	6030	14968	2.5
Infections	5270	9413	1.8
Treatment	5079	9254	1.8
STI	3126	5765	1.8
Contraceptive/ Reproductive/Pregnancy	2533	3412	1.3
Screening	30	33	1.1

Testing and advice appear to feature as the main reasons for attendance. The average number of attendances per patient for 'testing' is approximately two times, and for 'advice' 3 times.

Figure 18 shows the STIs for which most patients have been tested and/or treated.

Gonorrhoea and Chlamydia are showing as the STIs for which patients are testing or treated for, though it should be noted that other STIs are also included in the general STI related care such as warts, HIV (if necessary), Syphilis, and or Trichomonas Vaginalis.

Figure 18:

STI/Infection	No. of Patients attended	No. of times patient attended	Average number of attendances per patient
Gonorrhoea	10152	17638	0.6
Chlamydia	10575	18859	1.8
Hepatitis	2408	3825	1.6
Herpes	193	312	1.6
Pelvic Inflammatory Disease (PID)	79	80	1.0

In Thurrock, the STIs with the relatively higher prevalence are Chlamydia (diagnosis rate 209/100,000 all ages), Gonorrhoea (43 per 100,000 all ages) and PID admissions (229 per 100,000 15-54 years). The average number of attendances per patient for Chlamydia in Thurrock is approximately two times, and for Gonorrhoea and PID it is an average of one appointment/engagement.

Hepatitis and Herpes have a higher average of attendance patient (2 times). The rate of Herpes in Thurrock is 34 per 100,000 and ranks as the 4th highest STI in Thurrock as of 2021, hence, this higher average number of attendances per patient is expected. There is no latest prevalence data available for hepatitis in Thurrock.

Brook

Until April 2023 Brook was subcontracted by Provide to work with schools and other services for children and young people delivering training for staff, relationship, and sexual health education for students and 1 to 1 support through the My Life programme. Referrals to the My Life service were made primarily from teachers, school nurses and social care and the Brook Education and Wellbeing specialists would offer sessions tailored to the young person to support them around sexual health and relationships as well as address unhealthy attitudes and build resilience and self-esteem. Brook delivered a service from Thurrock Health Centre in Grays and if necessary, referrals were made to local sexual health services in Orsett if there were concerns about STIs or pregnancy. Education and training sessions with staff in other services such as Wize Up! have helped those services support their service users. In the last year of the contract Brook offered 60 sessions split evenly between RSE training and school assemblies, the RSE training engaged 72 professionals, however only 4 assemblies were accepted, delivering to a total of 1,310 students.

Terrence Higgins Trust

The Terrence Higgins Trust is subcontracted by Provide and provides community outreach for those at risk of HIV and training for professionals. The THT are subcontracted by Provide to deliver 12 professional or community-based education and training sessions about sexual health and specifically about HIV, per year. These sessions are delivered on site for example they have visited Inclusions Vision Thurrock to deliver an HIV awareness session to staff. Sessions can be attended by any staff offering services such as those involved with housing and homeless, mental health and probation. THT also offer in house testing monthly from Grays Health Centre for HIV and syphilis. At the testing appointment they can also offer advice about wider sexual health concerns and signpost or refer to other services. Community engagement in the form of outreach events with health promotion stands and information about how to access services alongside engagement with groups or community leaders to support the cascade of information. THT have taken on some of the role delivered by Brook in secondary schools.

In the last year of the contract THT delivered training to 39 professionals, ran 33 outreach sessions reaching 621 people and a further 108 awareness sessions were held posted on:

- Grindr.
- Gaydar.
- Squirt.
- Facebook.
- Instagram.

Throughout the year THT ran 4 community engagement sessions and engaged with 232 people. They also distributed 2152 condoms.

School Nursing

The School Nurse Service is not part of the sexual health contract with the Local Authority. It provides a range of services, including sexual health advice and support for school age children in the form of a school drop-in service to secondary schools around every two weeks.

There is also an e-drop-in service whereby children can scan a QR code, complete a form which is submitted to the service, and someone contacts them within 24 hours. They can also contact the service through their website. Support offered can include providing preventative advice, carrying out assessments for condoms, chlamydia testing and treatment, providing the morning after pill, referrals to the sexual health clinic, supporting teenage mothers and those who are pregnant. School nurses meet with GPs regularly, and have input to social workers, looked after children, the vulnerable and at risk and can refer into the multi-agency safeguarding hub (MASH). There is also a risk management group for children being exploited and missing and a plan is put in place for these young people to cover their needs.

Whilst this is the current position the following changes will be in place from September 2023:

- School health will only provide advice and signpost to the current provider. Therefore, direct support will not be available from NELFT e.g., for assessments for condom, chlamydia testing, providing the morning after pill etc.
- Only e-drop-ins, no more face-to-face drop ins.
- Collaborative working with partner agencies will continue.

Psychosexual Service

Inclusion Improving Access to Psychological Therapies Thurrock (Inclusion IAPT) is provided by Inclusion which is part of Midlands Partnership NHS Foundation Trust. Inclusion IAPT offer a gateway for adults across Thurrock to access talking therapies for common mental health difficulties, this includes a psychosexual service who employ one whole time equivalent of psychosexual therapy resource.

South Essex Rape and Incest Centre (SERIC)

Rape and sexual abuse specialists

The SERIC service is funded by the Police and Crime Commissioner and is in place to support people who have experienced rape and sexual abuse through 1 to 1 counselling; provision of Independent Sexual Violence Advisors to support people engaged with the criminal justice system; advocates to support people with other difficulties such as housing problems or dealing with debt and family support workers who work with families and children. SERIC make referrals to Thurrock sexual health service when concerns around STIs, pregnancy and the need for long term contraception arise.

Child exploitation and missing team in Thurrock Council

This team focuses on missing people and those vulnerable to exploitation from adolescence to young adulthood (around 13 to 25 years). A weekly missing children's panel meets to discuss cases when any issues of sexual exploitation are raised. For vulnerable exploited individuals the team try and link with each of the services they will need support from. This could be drugs and alcohol, mental health, or sexual health services in addition to social care.

Wize up!

Young people's drug and alcohol services (delivered by Change Grow Live)

This substance misuse service works with young people who have been affected by parental substance misuse and/or are misusing substances themselves. Generally, services work with young people to age 18 when they transition to adult services unless their needs are such that they need the greater level of support offered by the young people's service. As part of their initial assessment young people are asked questions about sexual health. If a need is identified sexual health advice is offered in-house and if there is a concern about STIs or pregnancy, then people are signposted to Thurrock Sexual Health Services. Staff have completed the training by Brook so they can assess young people for the C-card scheme to access free condoms. Although sexual health support has not been commissioned as part of the Wize Up! service staff are keen to offer a more holistic approach to support the young person.

Thurrock adult drug and alcohol services

(Delivered by Midlands Partnership Foundation Trust (MPFT)

As part of the initial assessment for adults accessing the drug and alcohol services questions about sexual health are asked. Many people put themselves at risk of contracting an STI or becoming pregnant whilst taking drugs and alcohol and this cohort of residents are likely to have a higher proportion of unplanned pregnancies compared to the general population. Currently the service is only able to sign-post individuals to the Thurrock Sexual Health Services and cannot offer support directly to service users.

Thurrock Lifestyle Solutions (TLS)

Providing disability services for Thurrock residents (delivered by Choice and Control)

Thurrock Lifestyle Solutions provides the physical and learning disability services for Thurrock residents. It is typically young people with learning disabilities who have most need for support around sexual health. This could be relationship and sexual health advice, support to access contraception, testing for STIs and unplanned pregnancy concerns. TLS provide the sexual health advice and will accompany someone to a clinic or other appointment to ensure the person understands the process and provides the information required by staff.

Youth offending service

The youth offending team become involved with a young person up to the age of 18 if they are arrested by the police, are charged with a crime involving a court appearance or are convicted of a crime and given a sentence. The Team has a specialist Gangs and Child Exploitation Worker, who works alongside Children's Social Care. Young people have an initial assessment which includes questions about sexual health.

GPs

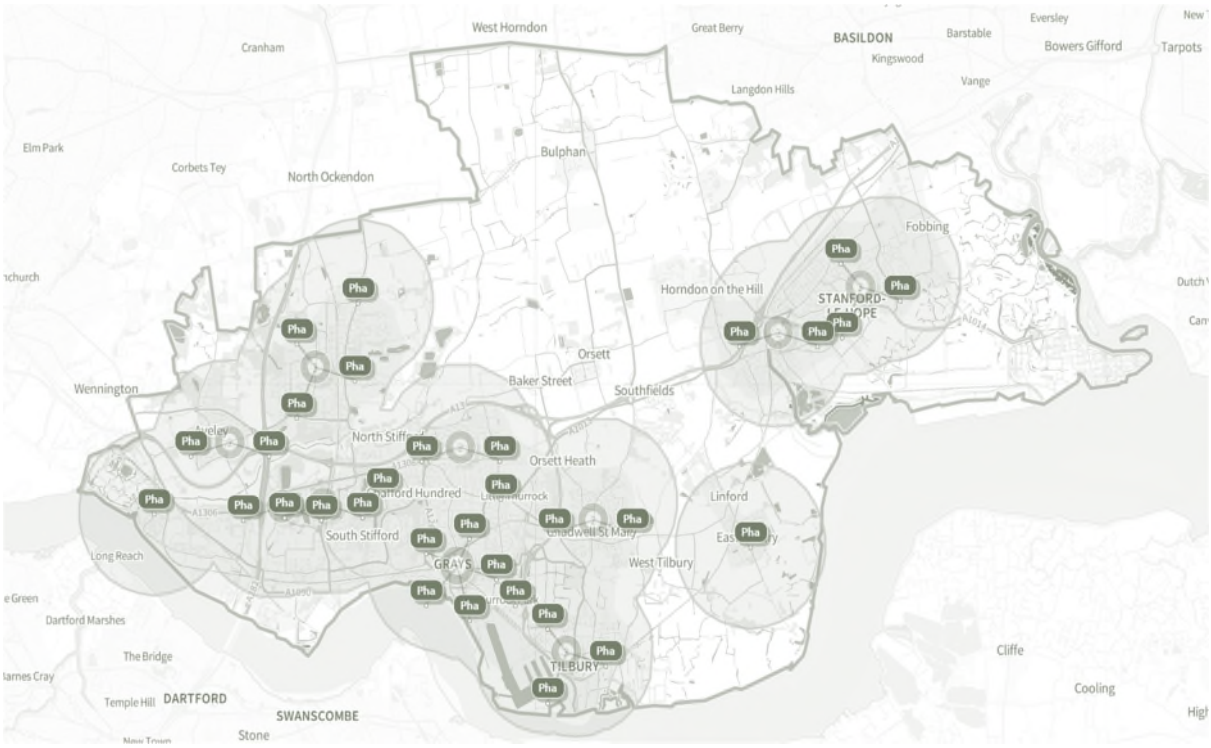
Provide managed the Service Level Agreements (SLAs) for GPs for LARC however this is now managed by the council Public Health team. People accessing services via the GP route are low and this may affect the number of service users waiting for the specialist services intervention. GPs can offer contraception (including emergency contraception) or tests and

treatments for STIs. Advice, information, and tests are free, but there may be a charge for prescriptions causing confusion.

Pharmacies

Pharmacies may be contracted by a variety of commissioners including Local Authority, NHSE and ICS's. Pharmacies in Thurrock providing emergency hormonal contraception (EHC) are contracted directly by the council. Last year only ten pharmacies delivered against the contract supplying 27 prescriptions of EHC, however this service is currently suspended awaiting contract renewal with TC and pharmacies. Figure 13 shows the potential coverage of services if all pharmacies signed up to provide enhanced sexual health services. A location list of all pharmacies in Thurrock is in appendix 6.

Figure 19:



SHAPE Place Atlas - exported on Thursday, April 13, 2023

5. Reproductive Health Data

Teenage pregnancy Framework

The Teenage Pregnancy Prevention Framework was published in 2018 (Public Health England), with the aim to help local areas assess their teenage pregnancy prevention programmes to prevent unplanned pregnancies and support young people to develop healthy relationships. As a key area of the specification, the lead provider is required to follow the framework to assess how improvements can be made and implemented to reduce teenage pregnancy rates.

The provision of integrated sexual health services is supported by current accredited training programmes and guidance from relevant professional bodies including:

- Faculty of Sexual and Reproductive Healthcare (FSRH).
- British Association for Sexual Health and HIV (BASHH).
- British HIV Association (BHIVA).
- Medical Foundation for HIV and Sexual Health (MEDFASH).
- Royal College of Obstetrics and Gynaecology (RCOG).
- National Institute for Health and Care Excellence (NICE).
- Department of Health & Social Care (DHSC).
- UKSHA, and the Office for Health Improvement and Disparities (OHID).

Conception data is collected via the statutory notifications of all births and abortions which are published quarterly by the Office of National Statistics. Data are supplied quarterly with a full annual dataset including district data. There is a 14-month lag whilst the data is processed, checked, and published.

Conceptions and Abortions

Figure 20:

Key Points:

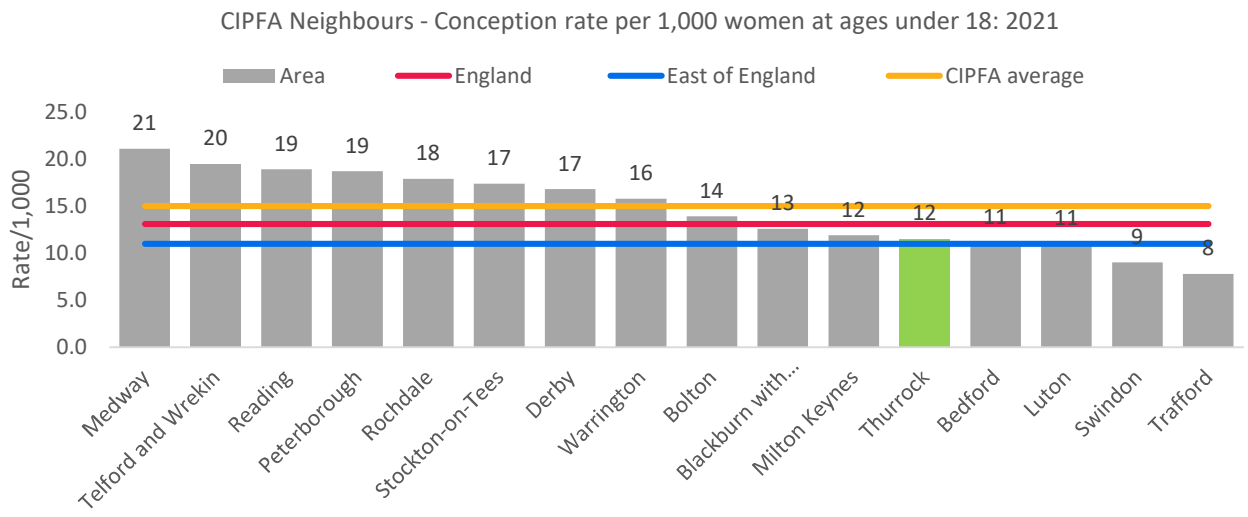
- **Under 18 conception rates have decreased since 2017 in line with national and regional trends.**
- **Whilst the abortion rate in Thurrock has increased since 2017 and in 2021 was 22 per 1000 females; the percentage of U18 conceptions leading to abortion has remained stable, albeit higher than national, regional and CIPFA comparators.**
- **The rate of repeat abortions in Thurrock has increased since 2017.**

Recommendations:

- **Sexual health services to review the accessibility of contraception services across Thurrock and surrounding geographies to ensure that good quality contraception services are accessible at a time and place that is convenient for the service user.**
- **Sexual health services to ensure consistent education and advice on the preferred method of contraception is available to service users through a range of formats, utilising a range of existing services as appropriate such as primary care and school nursing.**
- **Thurrock PH team to conduct further analysis into why the rate of repeat abortions is increasing and the groups most at risk with the aim to identify appropriate preventative actions.**
- **Sexual health and associated services to develop an action plan for focusing on groups most at risk of unplanned conception and/or abortion such as sex workers or those with addiction.**

Figure 21 below shows conception rates among females aged under 18 and figure 23 shows the abortion rates among females aged under 18 and over 25. Under-18 conceptions rates per 1000 females, including those aged 15-17 years, have decreased since 2017 in Thurrock. This downward trend has also been reflected in England, East of England region (EoE), and Thurrock's CIPFA neighbours.

Figure 21 Under 18 Conception rate/1000 – Thurrock/CIPFA 2021:



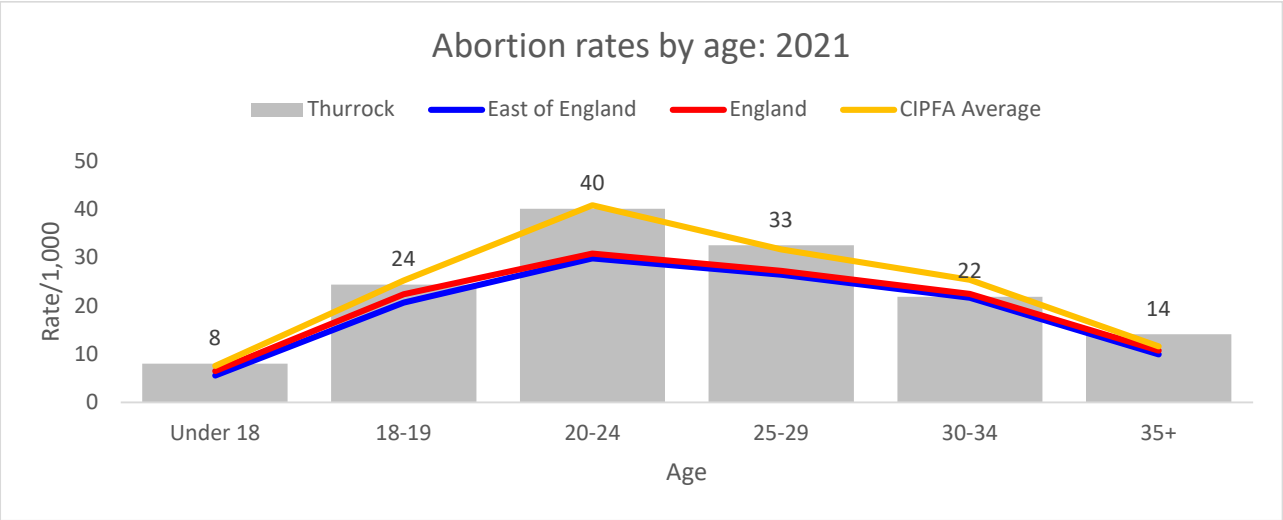
Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023 -Office for National Statistics (ONS)

Thurrock's under-18 conception rate for 2021 is low in comparison to most of its CIPFA neighbours but level with the regional average for 2021. Between a range of 8 per 1,000 females to as high as 21 per 1,000 females, Thurrock's rate of 12 per 1,000 is relatively low compared to its statistically similar local authorities, however it is not statistically significantly different from its CIPFA neighbours, EoE or England.

Abortion Rates

The total abortion rate amongst 15–44-year-olds in Thurrock has steadily increased since 2017, currently at 22 per 1,000 females in 2021. This is the same rate across CIPFA neighbours in 2021. Both Thurrock and its CIPFA neighbours are higher than the England rate (19 per 1,000) and East of England (18 per 1,000). Thurrock and its CIPFA neighbours' abortion rates for 2021 are statistically significantly higher than England and East of England.

Figure 22: illustrates the rate of abortions in 2021 for females under 18, 18-34 years, and 35-44 years of age. The denominator for each age band is the total number of females within that age band.



Source: Office for Health Improvement and Disparities. National Abortion Statistics England and Wales 2021 (Updated May 2023). www.gov.uk

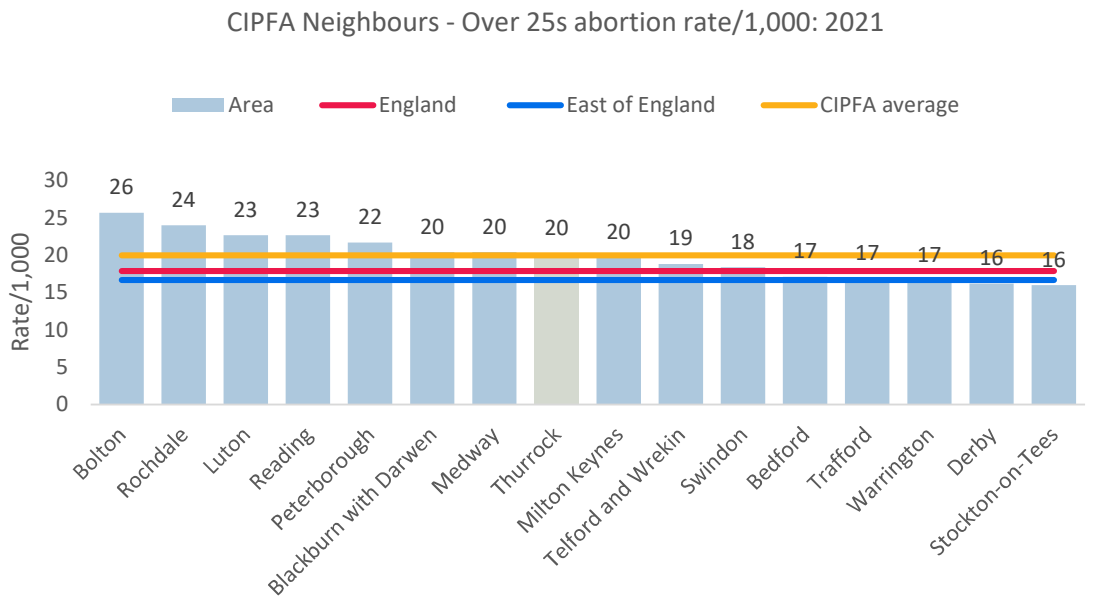
Across all areas, the peak ages for abortions are between 20-29 years of age, with Thurrock and it's CIPFA neighbours showing the highest rates in these age groups.

The Under-18 abortion rates per 1000 females follows a similar trend to decreasing conception rates since 2017. In 2021, in comparison to its CIPFA neighbours (ranging from 5 to 11 abortions per 1,000), Thurrock featured in the middle at a rate of 8 per 1000 females, though is not statistically significantly different to its CIPFA neighbours.

In contrast to the under-18 decreasing conception and abortion rates, the percentage of conceptions leading to an abortion amongst under-18s is showing a consistent and stable trend. This stable trend is also seen nationally, regionally and amongst our CIPFA neighbours, however the percentage of U18 conceptions leading to abortion are consistently higher in Thurrock in comparison.

Abortions in the over-25 age group has shown a steady increase between 2017 and 2021 in Thurrock, which is the same trend seen nationally, regionally and across CIPFA neighbours (see Figure 23).

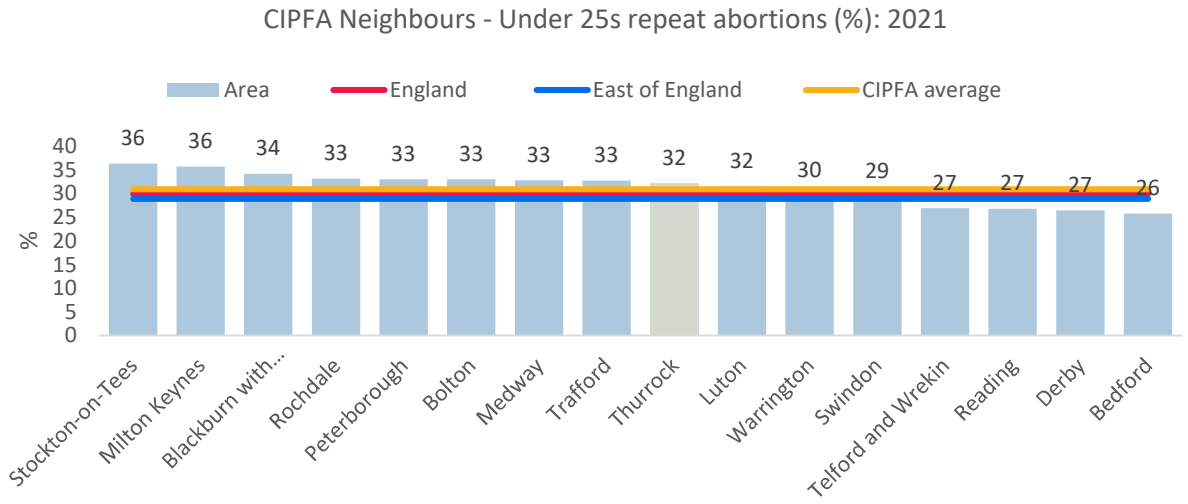
Figure 23: Rate of abortions in the over-25 years (2017-2021) – Thurrock/CIPFA neighbours 2021:



Source: Office for Health Improvement and Disparities, Department of Health and Social Care based on data from abortion clinics

Repeat abortions in under-25s have also increased across Thurrock, England, East of England, and CIPFA neighbours. Though Thurrock rates remain higher each year, and peak in 2020, Thurrock is not statistically different to its CIPFA neighbours. (See figure 24).

Figure 24: Under 25 Percentage of repeat abortions – Thurrock/CIPFA neighbours - 2021:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023 - Department of Health and Social Care based on data from abortion clinics

The rate of abortions under 10 weeks remains lower for Thurrock each year in comparison to national, regional and CIPFA averages since 2017 though this has increased year on year to 2021.

In summary, conception, and abortion (termination) rates are decreasing amongst the under-18s in Thurrock, apart from the percentage of conceptions leading to abortion which has remained consistent between 53% to 68% in the previous 5 years. Conversely the rate of

abortions in the over 25 years, repeat abortions under 25 years, and abortions under 10 weeks' gestation is increasing in Thurrock. Women living in the most deprived areas are more than twice as likely to have abortions than women living in the least deprived areas. The rate in the most deprived decile is 27.5 per 1,000 women, compared to 12.6 per 1,000 women for women living in the least deprived areas.[49] There are many factors affecting both conception and abortion, there may be a lack of access to high quality reproductive and sexual health training, there may be an inability to access the specialist service due to location, there may be higher levels of commercial sex work or addiction in Thurrock.

Abortion rates are an indicator of a lack of access to good quality contraception services and advice, as well as problems with individual use of contraceptive method. The earlier abortions are performed the lower the risk of complications. Prompt access to abortion, enabling provision earlier in pregnancy, is also cost-effective and an indicator of service quality. Services and advisory clinics must be accessible in the most deprived areas, schools, and areas of high young person footfall to ensure the population in Thurrock has equal access to specialist services.

Abortion is available without parental consent (even under the age of 16). The earlier the pregnancy is detected if abortion is required or wanted the more choices the person has as to what procedure is available to them.

Contraception

Figure 25:

Key Points:

Post pandemic the waiting time for LARC had increased.

Marie Stopes were commissioned to provide additional support to address the backlog which has now ceased.

- **The rate of males attending specialist contraceptive services increased from 2017 to 2019. In 2019, in Thurrock, 44 per 1,000 males attended specialist contraceptive services, compared to 18 per 1,000 across CIPFA neighbours and 20 per 1,000 in England in the same year.**

Recommendations:

- **Thurrock PH team, in collaboration with the sexual health service to conduct further analysis with primary care to understand why GP prescribed LARC rates continue to be low.**
- **Sexual health services to develop an action plan to work with primary care to ensure that barriers and challenges to providing LARC in primary care (identified through further analysis) are overcome.**

Contraception refers to a method or device that prevents pregnancy. As an essential component of sexual and reproductive healthcare, contraception gives people autonomy over their reproductive health, and lives, by enabling them to decide if, or when, they would like to become pregnant.

[49] Office for Health Improvement and Disparities. "Abortion Statistics, England and Wales: 2021". 2023.

Types of contraception range from short-term barrier methods, such as the male or female condom, to long-acting methods, such as the Intra-Uterine Device (or IUD), which can prevent pregnancy for up to 12 years. There are also permanent methods of contraception include tubal ligation and vasectomy, which are minor surgical procedures for people who do not want to have children in the future. The decision to use contraception especially those that may not be successfully reversed should be made with full knowledge and education including benefits and risks of each procedure and other methods available.

Long-Acting Reversible Contraception (LARC)

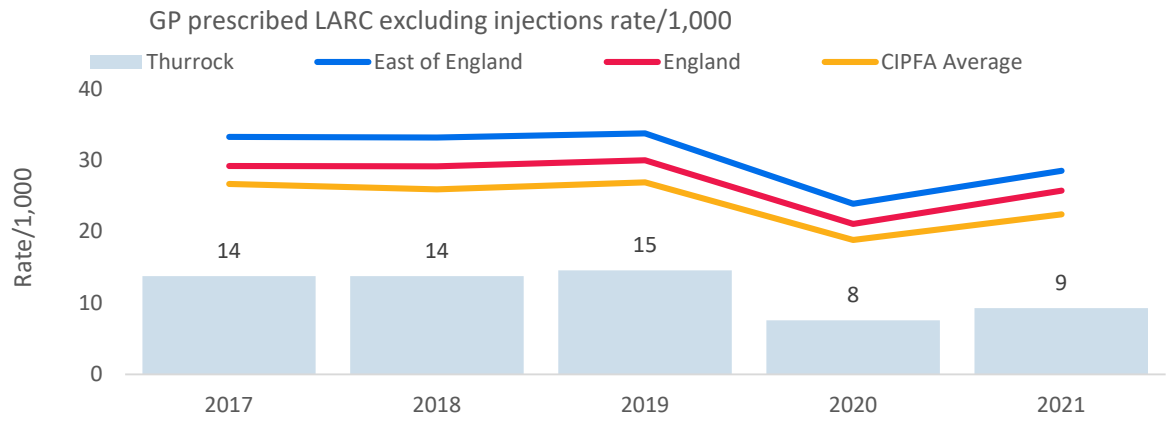
One form of contraception is long-acting reversible contraception (LARC). There are several types of LARC including intrauterine device (IUD), hormonal coil or intra uterine system (IUS), contraceptive injection, and hormonal implant. LARC does not prevent the transmission of sexually transmitted diseases like a condom does and therefore education regarding risk and behaviour should be part of the assessment when discussing LARC. LARC can be accessed for free on prescription but must be fitted by trained, specialist services including GPs, practice nurses, specialist sexual health services and young people services.

Long-acting reversible contraception (LARC) methods such as contraceptive injections, implants, the intra-uterine system (IUS), or the intrauterine device (IUD), are highly effective as they do not rely on daily compliance and are more cost effective than other methods. The following charts show the crude rate of GP prescribed LARC per 1,000 service user female population aged 15-44 years in Thurrock. It is based on prescriptions of contraceptive injections, implants, IUS, and IUD.

The waiting list for Long-Acting Reversible Contraception (LARC) has previously been a concern in Thurrock, action was taken to address this successfully but due to funding there has been a significant increase in the waiting times in the last two months. GP prescribed LARC remains low throughout the borough which has an ongoing affect to the specialist services. Further investigation is required to understand the hesitancy to deliver services by the GPs.

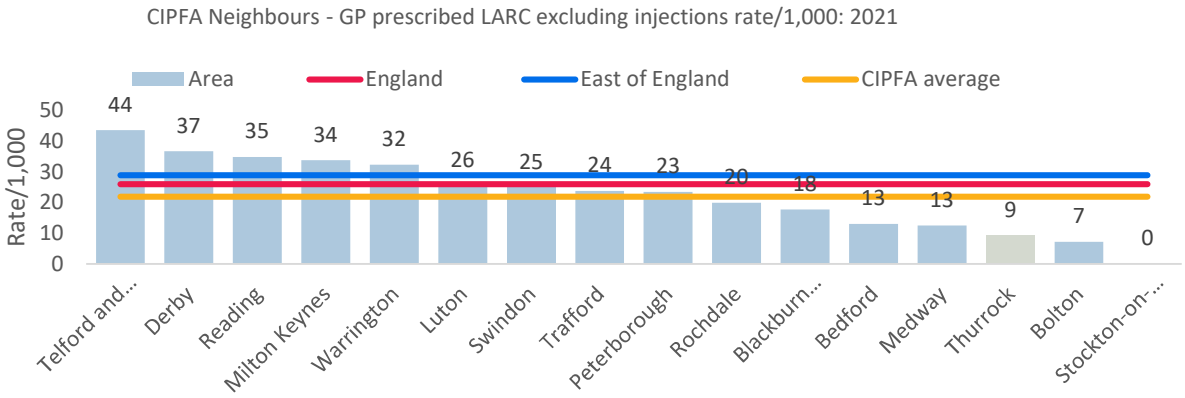
GP prescribed LARC has been almost consistent since 2017, between 14-15 per 1,000, followed by decrease to 8 per 1,000 in 2020 and then 9 per 1,000 in 2021. These rates remain much lower than England and CIPFA neighbour averages since 2017. This puts additional pressure on the specialist services to ensure the need is met. The latter two range between 22 to 29 per 1000, though the trend across all three remain consistent – stable to 2019, followed by an almost 50% decrease between 2019 to 2020. The 2021 rates indicate a potential upward trend, but this cannot be verified without more current data. Across CIPFA neighbours, Thurrock features as one of the local authorities with the lowest rates for GPs prescribing LARC to women in 2021, this may be due to a lack of engagement with the current providers or lack of training and confidence in providing the services and required further investigation (see figures 26 and 27).

Figure 26: GP prescribed LARC per 1,000 All ages (2017-2021)– Thurrock/England/EoE/CIPFA:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Figure 27: GP prescribed LARC per 1,000 All ages – Thurrock/CIPFA neighbours 2021:



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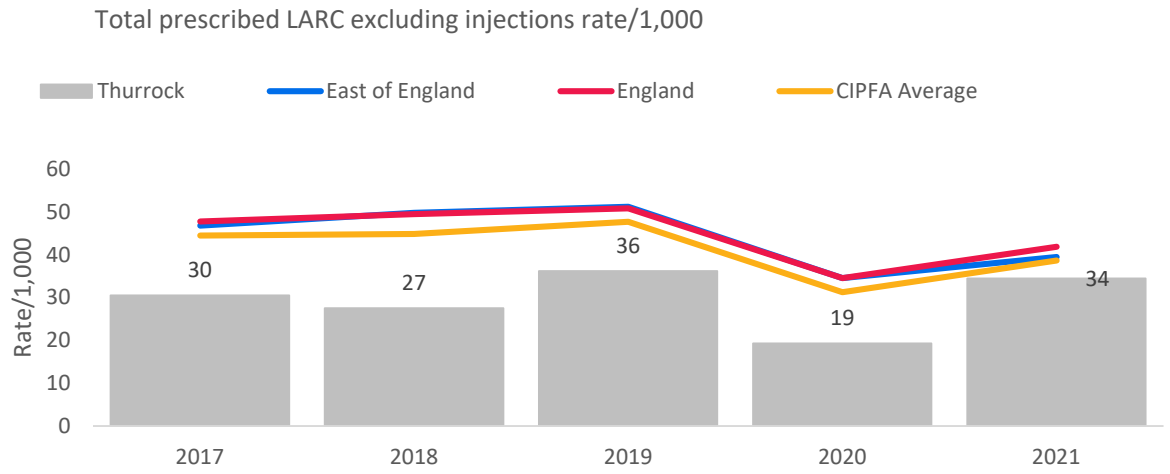
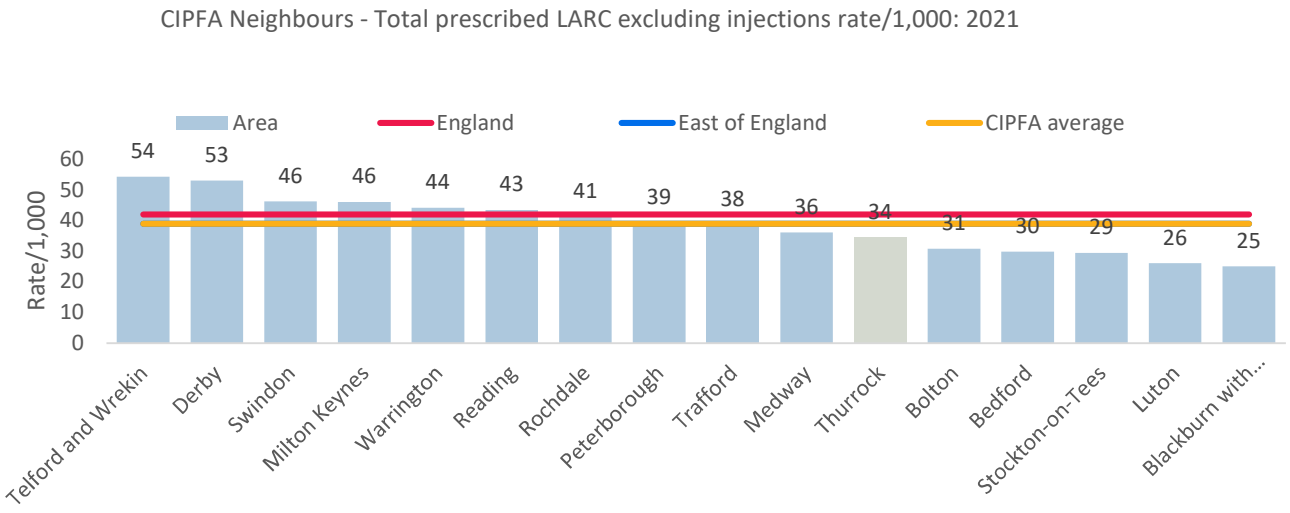
The rate of total LARC being prescribed that excludes injections has also remained lower in Thurrock over the reporting period in comparison to England, regional and CIPFA neighbours. Thurrock has one of the lowest rates across its comparative neighbours in 2021 (see figures 28 and 29).

Figure 28: Total prescribed LARC excluding injections rate/1,000 – Thurrock/England/EoE/CIPFA:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023:

Figure 29: Total prescribed LARC excluding injections rate/1,000 – Thurrock/CIPFA neighbours 2021



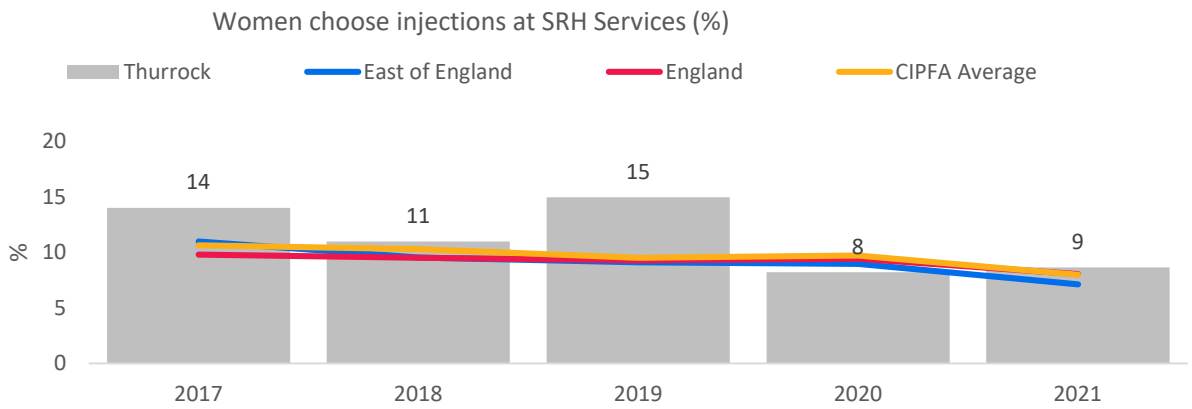
Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Sexual and Reproductive Health services

Sexual and Reproductive Health (SRH) services in England include family planning services, community contraception clinics, integrated Genitourinary Medicine (GUM) and SRH services, and young people's services. They provide a range of services including, but not exclusively, contraception provision and advice.

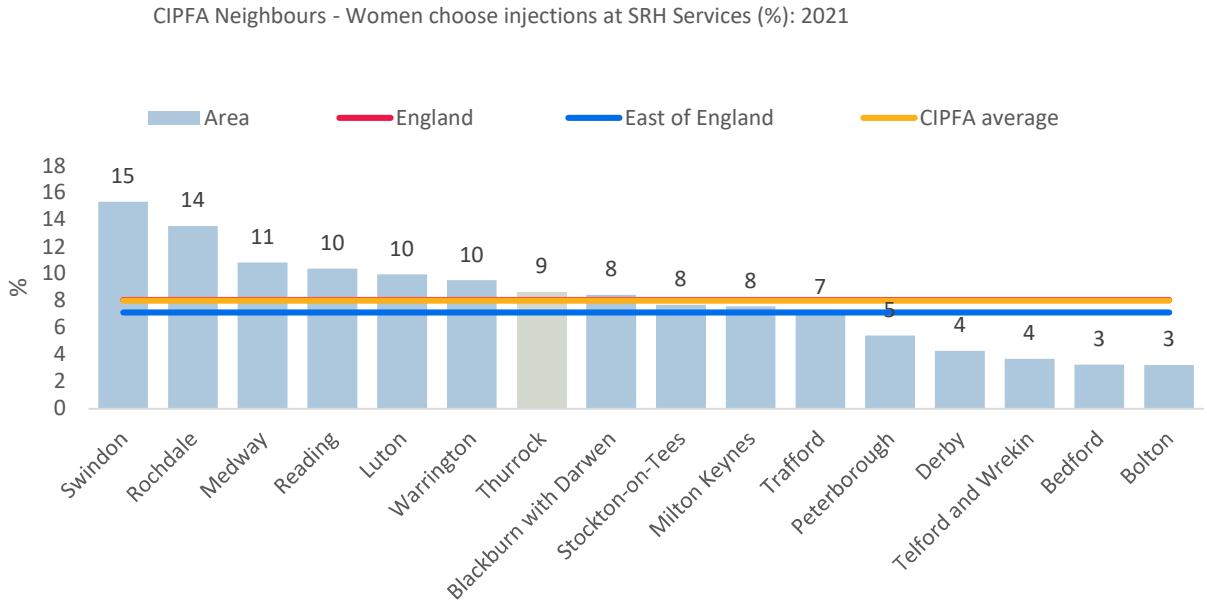
Figure 30 shows a decrease in women choosing contraceptive injections at sexual and reproductive health (SRH) services across Thurrock, England, and CIPFA neighbours between 2017 to 2021. However, Thurrock figures have generally remained higher than their geographic comparators (see figures 30-.43).

Figure 30: Percent of women choosing injections at SRH Services (2017-2021) - Thurrock/England/EoE/CIPFA:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Figure 31: Percent of women choosing injections at SRH Services (%) - Thurrock/CIPFA neighbours 2021:



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LARC (excluding injections) prescribed by SRH services has fluctuated across Thurrock between 2017 and 2021, whereas across England, East of England, and CIPFA neighbours there was a gradual increase between 2017 to 2019, followed by a sharp decrease in 2020. Thurrock currently has the highest uptake of SRH prescribed LARC in 2021.

Figure 32: SRH Services prescribed LARC excluding injections rate/1,000 (2017-2021) – Thurrock/England/EoE/CIPFA:

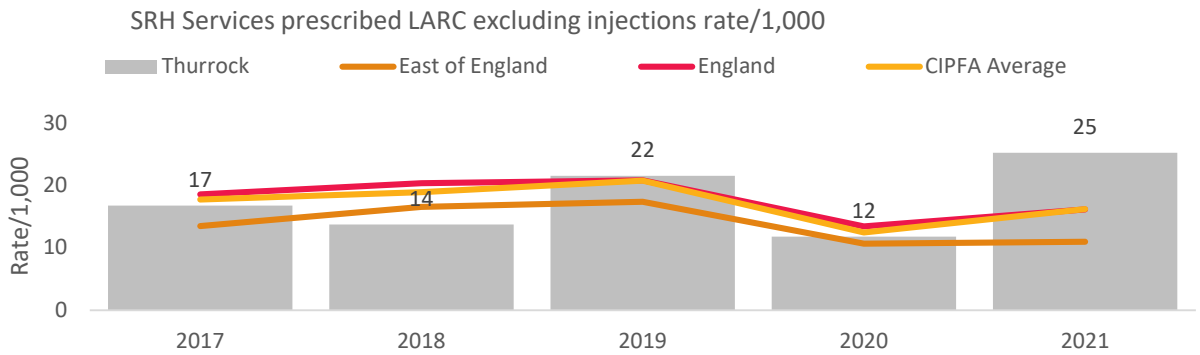

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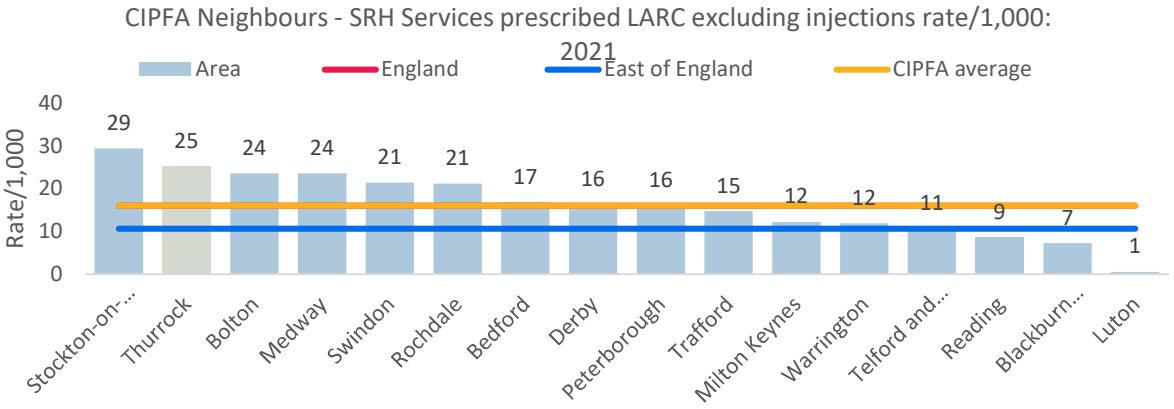
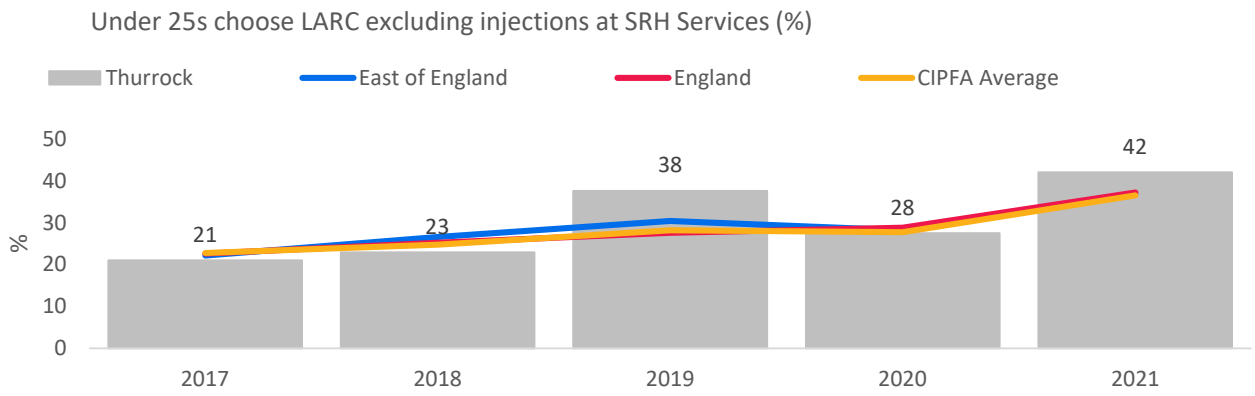
Figure 33: SRH Services prescribed LARC excluding injections rate/1,000 – Thurrock/CIPFA neighbours 2021:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Since 2017 there has been an increase in females in Thurrock choosing LARC (excluding injections) at SRH services. The under 25s choosing LARC has increased from 21% in 2017 to 42% in 2021. The over 25s choosing LARC has increased from 39% in 2017 and currently peaking at 61% in 2021. Thurrock had the highest uptake of LARC excluding injections at SRH services in 2021 and currently features in at the higher end of the range across CIPFA neighbours in 2021.

Figure 34: Under 25s choose LARC excluding injections at SRH Services (%) - Thurrock/England/EoE/CIPFA:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Figure 35: Under 25s choose LARC excluding injections at SRH Services (%) - Thurrock/CIPFA neighbours 2021:

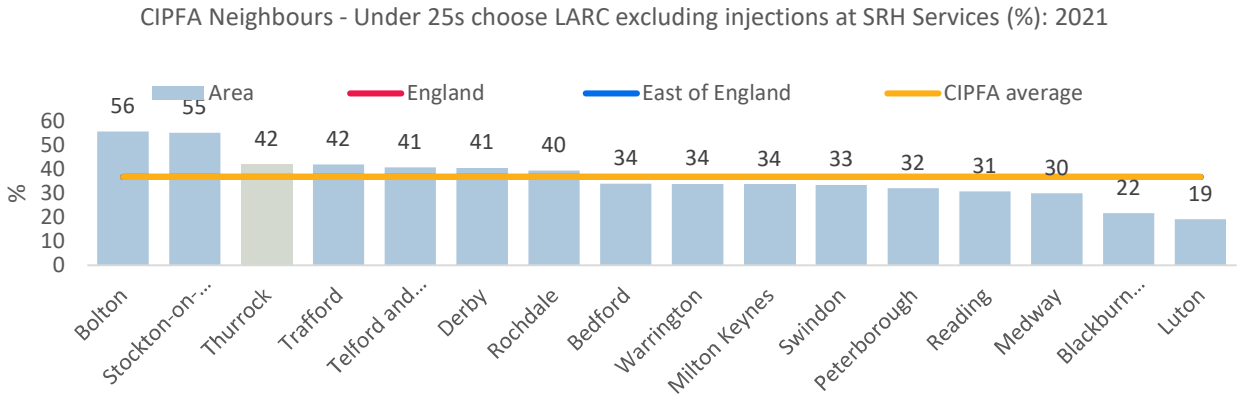


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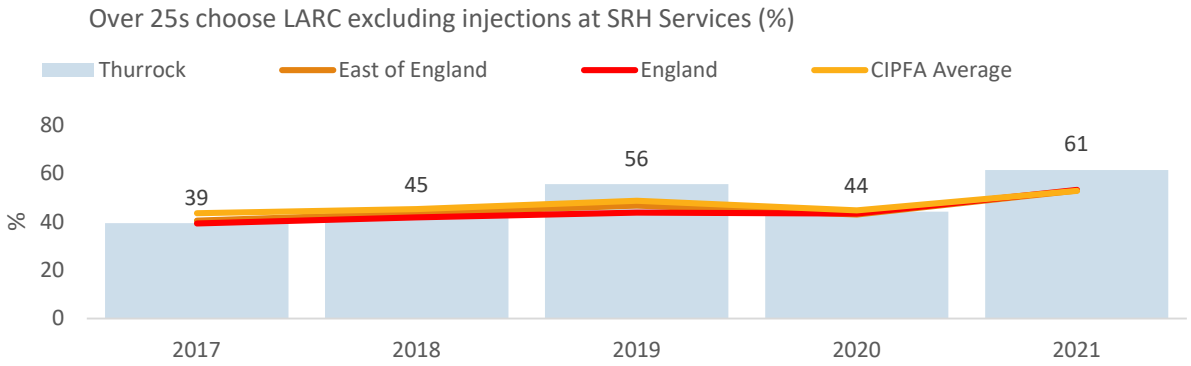
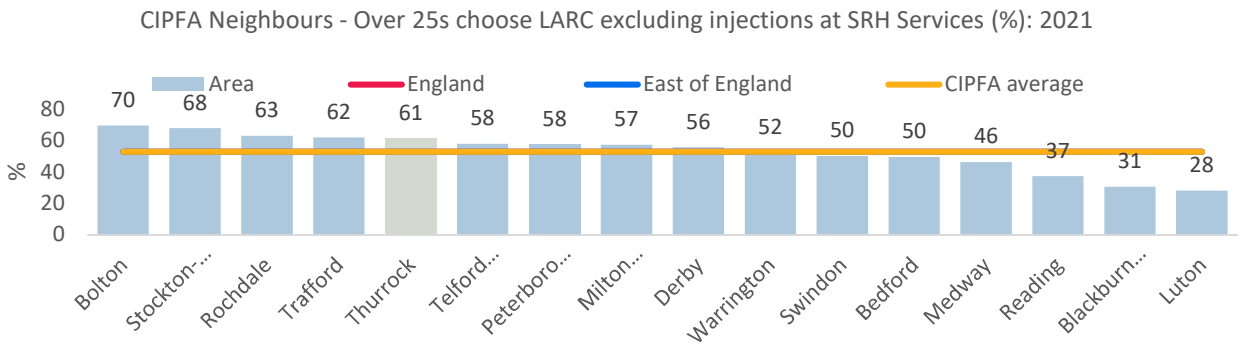
Figure 36: Over-25s choosing LARC excluding injections at SRH Services (%) - 2017-2021 Thurrock/England/EoE/CIPFA:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Figure 37: Over-25s choose LARC excluding injections at SRH Services (%) – Thurrock/CIPFA neighbours 2021:



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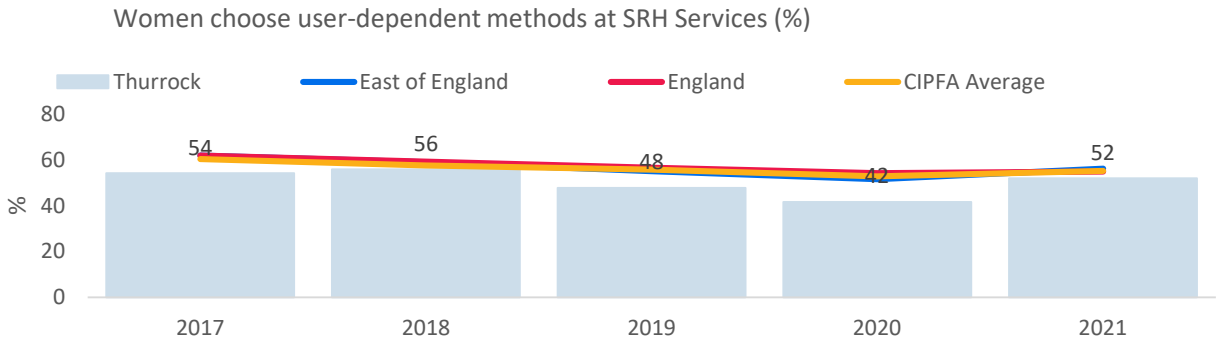
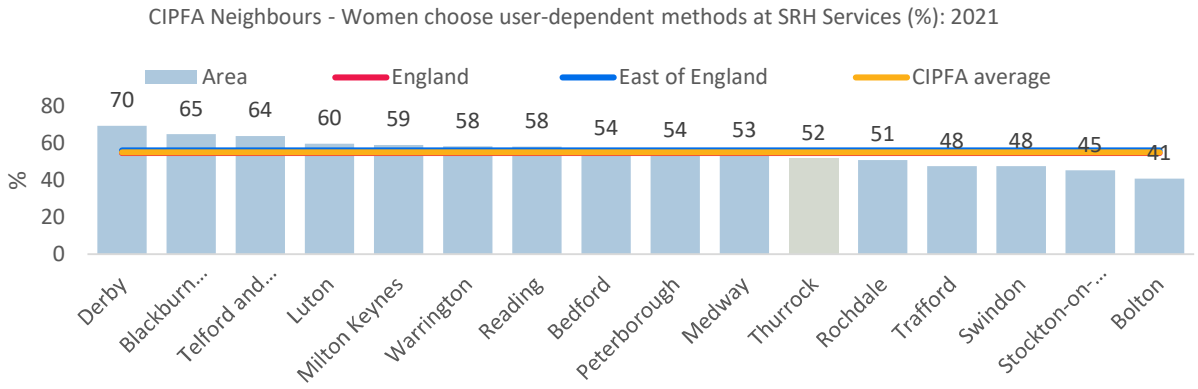
The percentage of women choosing user-dependent methods at SRH services is showing a downward shift between 2017 to 2020, followed by an increase in 2021. The percentage uptake in 2021 for user-dependent methods has remained higher for women than those choosing injections at SRH services.

Figure 38: Women choose user-dependent methods at SRH Services (%) –. Thurrock/England/EoE/CIPFA:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Figure 39: Women choose user-dependent methods at SRH Services (%) – Thurrock/CIPFA neighbours 2021:



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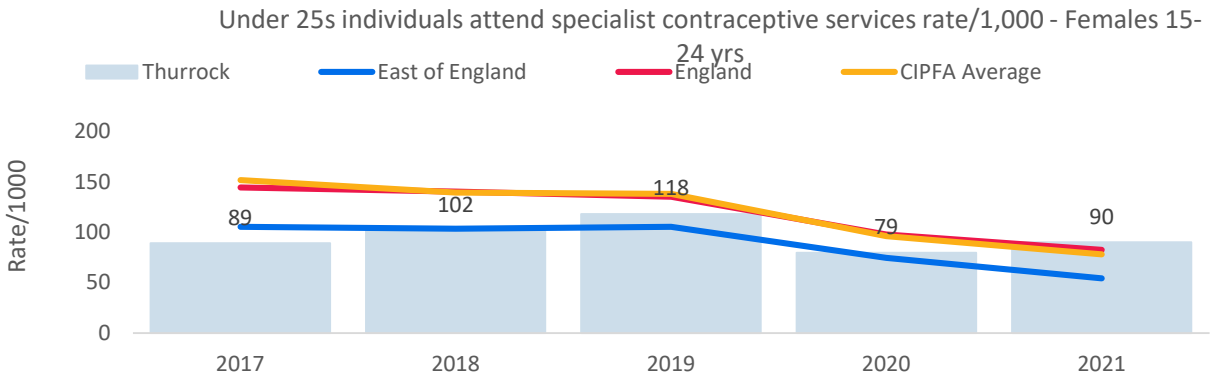
The rate of under-25 females attending specialist contraceptive services has remained almost consistent since 2017, with a peak in 2019 at 118 per 1,000. The current rate of 90 per 1,000 in 2021 is an increase of 79 per 1,000 in 2020. There is a downward trend illustrated since 2019 across England, East of England, and CIPFA neighbours, and Thurrock rates have been lower than its geographical comparators during the reporting period.

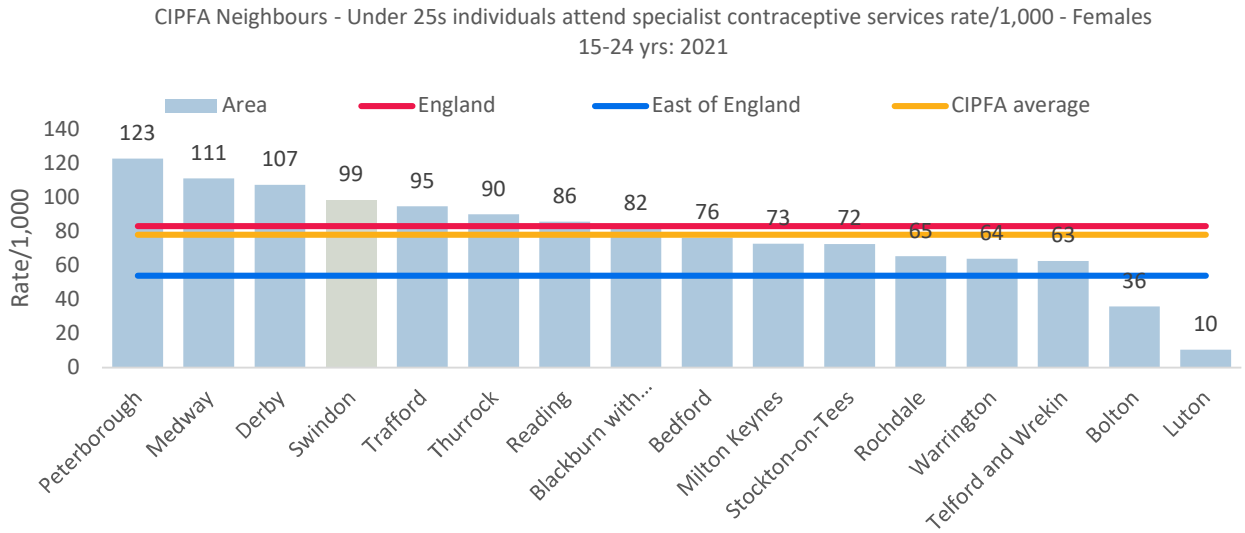
In comparison, the rate of males attending specialist contraceptive services is showing an increase between 2017 to 2019. The highest rate in Thurrock is in 2019 with 44 per 1,000 males attending specialist contraceptive services, compared to 18 per 1,000 across CIPFA neighbours and 20 per 1,000 in England in the same year. This indicates that prior to Covid-19, Thurrock was potentially successful in reaching out to under-25 males and encouraging them to attend specialist contraceptive services, there may be an aspect of better reporting at this time and whilst numbers did reduce during the Covid-19 pandemic they have begun to rise again

Figure 40: Under-25 individuals attend specialist contraceptive services rate/1,000 females (2017-2021) – Thurrock/England/EoE/CIPFA:



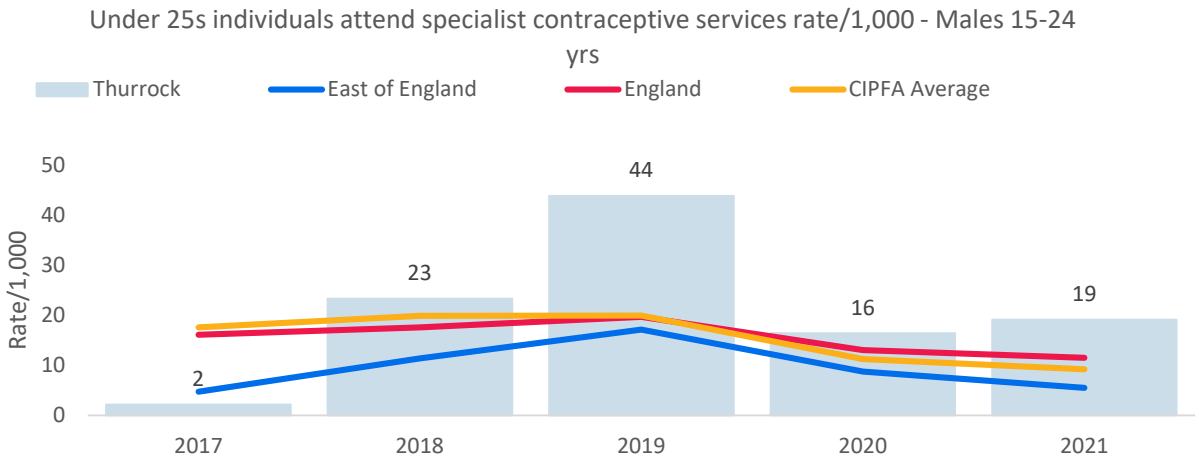
Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Figure 41: Under 25s individuals attend specialist contraceptive services rate/1,000 females – Thurrock/CIPFA neighbours 2021:



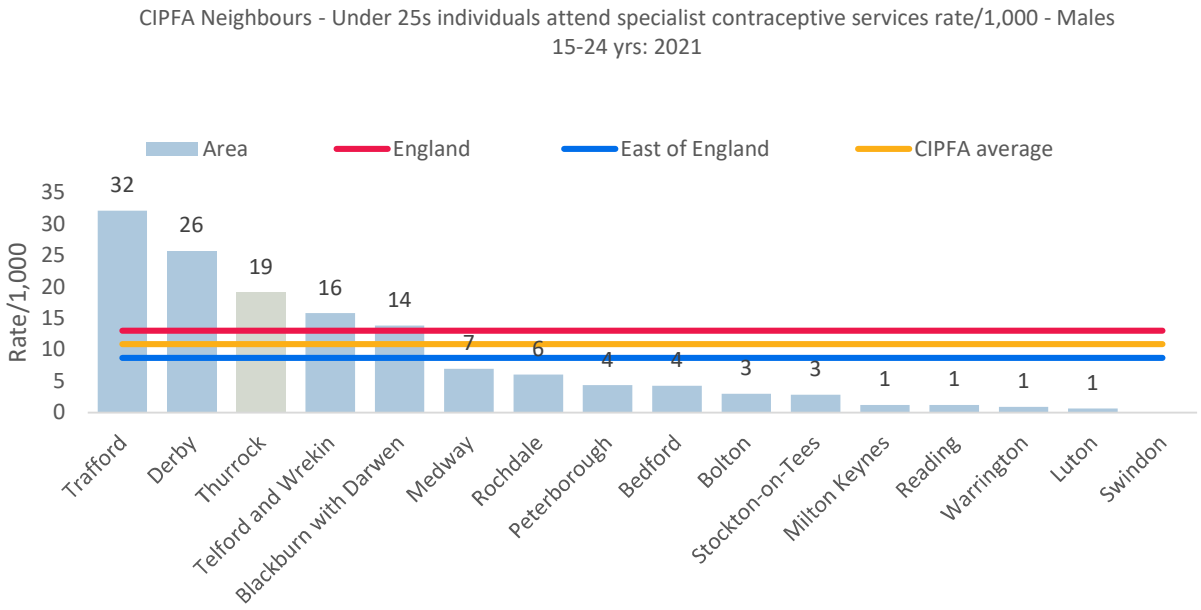
Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Figure 42: Under-25s individuals attend specialist contraceptive services rate/1,000 males (2017-2021) – Thurrock/England/EoE/CIPFA:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023 -

Figure 43: Under-25s individuals attend specialist contraceptive services rate/1,000 males – Thurrock/CIPFA neighbours 2021:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

The charts show is that there is a decrease in women choosing injections at specialist sexual health services, this may be as their GP or pharmacist is more accessible at times convenient to them. There is an increase in all women choosing long-acting contraception (except injection) and fewer young females are attending specialist contraceptive services. Whilst young male attendance is higher in Thurrock than its CIPFA neighbours and the east of England it has also reduced.

Generally, across all indicators measuring SRH service/LARC, 2021 figures are showing an increase from 2020 rates and percentages. This can potentially be interpreted as 2020 being an anomaly due to the pandemic, and from 2021, the use of SRH services and contraception services could begin to increase.

It is essential that woman have choice and control over their reproduction to ensure that pregnancies are wanted and planned. This allows the health of the woman to be optimised prior to conception and throughout the pregnancy and those that do not want to have children can effectively prevent becoming pregnant. If younger female attendance declines the risk of unwanted pregnancy and people living with undetected STIs that may affect their reproductive system later increases. It is vital that both women and men continue to access services to ensure that appropriate contraception is available and that they are supported to develop healthy relationships for their physical and emotional wellbeing.

According to PHEs publication, Health Matters: reproductive health and pregnancy planning (2018) effective contraception and planning for pregnancy means that women and men stay healthy throughout their life. The publication also states that a planned pregnancy is likely to be a healthier one, with unplanned ones having adverse health impacts for mother, baby, and children in later life.

In summary, the conception rate in U18s in Thurrock is decreasing in line with national trends, however the abortion rate is remaining stable, and in the over 25s, the rate of abortions is increasing as is the rate of repeat abortions.

We know that abortion rates are an indicator of a lack of access to good quality contraception services and advice, as well as problems with individual use of contraceptive method. We also know that in terms of contraception in Thurrock, prescribed LARC rates remain low compared to the national picture, particularly GP prescribed LARC. As LARC methods are highly effective, this means that a higher proportion of the Thurrock population, compared to other areas, is using other, less reliable forms of contraception or no contraception at all, and this means that a larger proportion of our local population is at greater risk of unplanned pregnancies.

Unplanned pregnancies are more likely to result in abortion, or if the pregnancy is continued, more likely to result in adverse health and life outcomes for the mother and child. If Thurrock sees greater unplanned pregnancies this will therefore have the knock-on effect of adversely affecting the health and wellbeing of the Thurrock population and result in increased need for other services to address these issues in the future.

To be able to address this, Thurrock sexual health services and associated services need to be better able to identify and encourage women of childbearing age to choose LARC as their method of contraception, and then be able to provide this service in a location and at times preferred by the individual. We know from the stakeholder engagement exercise that access to the existing sexual health clinic can be difficult for young people due to location, opening times and a lack of public transport links so there is a need to explore alternative locations for this service and / or greater provision through GPs for example, where we know that LARC provision is low in Thurrock, or through other providers.

6. Sexually Transmitted Infections (STIs)

Figure 44:

Key Findings:

People are most at risk of STIs if they are involved in high rates of condomless sex with multiple partners or frequently change partners.

People may be reluctant to access services because they do not know about them, they may have physical or learning disabilities, language barriers, learning difficulties, or stigma.

Reducing the risk of people getting and transmitting STIs is paramount to improving the sexual health of the population.

Recommendations:

An action plan should be developed to include (but not limited to):

- **Signposting and ensuring local pathways into service.**
- **Communication Plan including advertising of services, locations, online and non-clinical settings.**
- **Emphasising confidentiality, empathy, and a non-judgemental approach.**
- **Making sure stakeholders and the community understand that services are free and available to everyone regardless of where they live (or are from), and they do not refuse access to someone who is entitled to the service.**

People are most at risk of STIs if they are involved in high rates of condomless sex with multiple partners or frequently change partners. There may be more people practising these behaviours in some groups than others, but this does not mean that everyone in the group is necessarily at higher risk. For example, gay, bisexual, and other men who have sex with men are a higher risk group for STIs and HIV, but this does not mean that every person in that group is at higher risk. However, it does mean that attention needs to be given to ensure that the service is able to accommodate all groups and to be aware of the risks and mitigations required.

Some people find it more difficult to access sexual health services because of the location of services (most services are in urban rather than rural settings) or because they do not know that they are eligible for free services (for example, some refugees or asylum seekers may not know this). Others may find it difficult to access services because they do not know about them, physical accessibility issues, language barriers, learning difficulties, or stigma.[50]

Reducing the risk of people getting and transmitting STIs is paramount to improving the sexual health of the population. The National Institute for Health and Care Excellence (NICE), 2022 stated that accessing sexual health services should include ensuring that:

[50] NICE (2022)

- Everyone is signposted to, and can access, the care they need
- Local pathways are in place to link people, including underserved communities, to the best possible care.
- Details of the network are kept up to date and all staff understand what each service offers.
- Determine the most appropriate settings for services and interventions in consultation with groups with greater sexual health or access needs.
- Include online and non-clinical settings.
- Barriers to services for groups with greater sexual health or access needs should be mitigated by:
- Emphasising confidentiality, empathy, and a non-judgemental approach.
- Offering access to a professional translator or interpreter instead of waiting for the person to ask, to ensure they are fully able to communicate and to understand the discussion.
    - Making sure staff understand that services are free and available to everyone regardless of where they live (or are from), and they do not refuse access to someone who is entitled to the service.
    - Supporting people to attend appointments and engage with treatment.
    - Providing outreach activities.
    - Consider guidance on making services more welcoming and inclusive, such as the Department of Health and Social Care's 'You're welcome' quality criteria or UK Health Security Agency's (previously Public Health England) Inclusion health: applying all our health.

How well the service meets these requirements can be seen in detail in the findings and recommendations.

Testing and Diagnosis

Figure 45

Key Points:

- **The STI diagnosis rate has declined in Thurrock since 2017, and it is unclear how vulnerable groups are affected by the decline in diagnoses.**
- **In the most recent data (2021), the diagnosis rate in Thurrock is lower than CIPFA neighbours but similar to East of England; the testing rate is lower than both CIPFA neighbours and East of England; with a corresponding positivity rate that is similar to CIPFA but higher than East of England.**
- **The CIPFA neighbours with the highest diagnosis rates also have high testing rates.**
- **Qualitative feedback from stakeholders and residents suggested that a high proportion of Thurrock residents were not aware of Thurrock sexual health services, and that other professionals were not clear how to refer into the service.**

Recommendations:

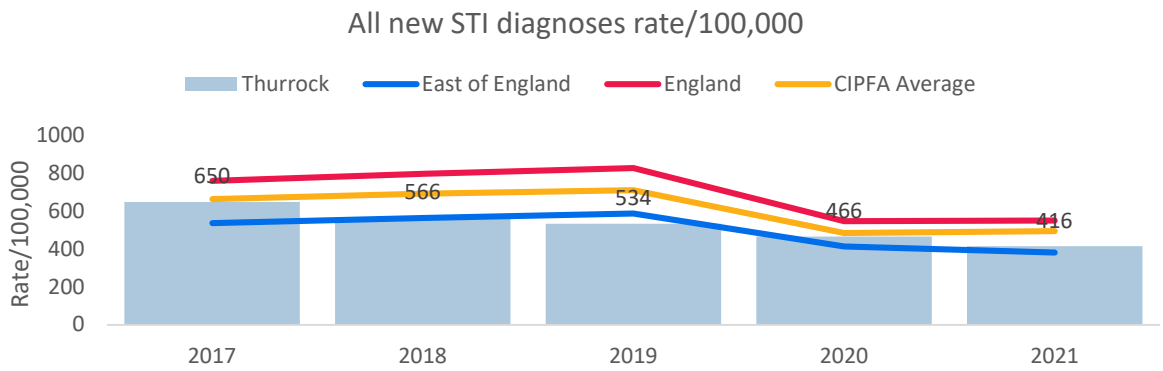
- **The Provider must continue to review and evaluate data recording to improve recording and reporting of protected characteristics to gain a better understanding of potential inequities in Sexual Health outcomes across Thurrock including older age STIs.**
- **Services should develop an Action Plan to increase uptake of STI testing to reduce the burden of undiagnosed infection in Thurrock, including:**

- **Increasing awareness of the need for regular STI testing among vulnerable groups and those at higher risk.**
- **Increasing referrals from other services.**

- **The Provider, working in collaboration with OHID, UKHSA and the commissioner must monitor and respond to new and emerging threats such as Mgen and drug resistant infections.**

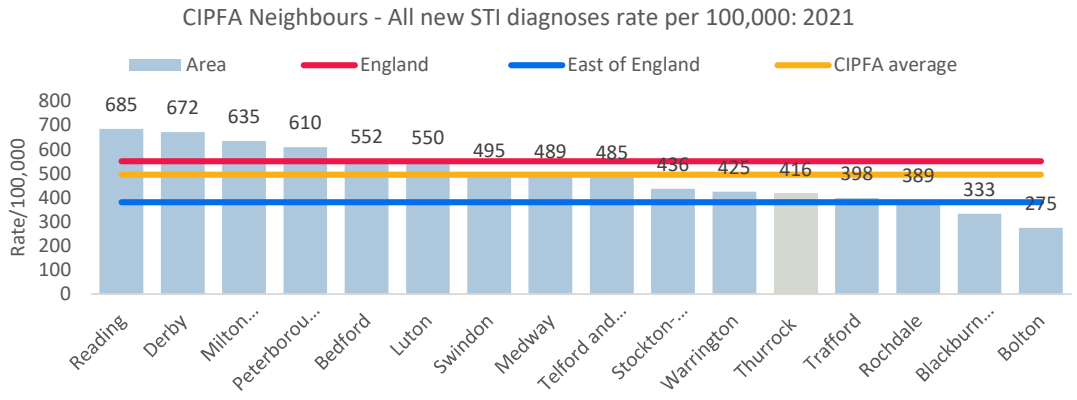
STI diagnosis rate has generally decreased in Thurrock since 2017, which is a trend illustrated across England, East of England, and CIPFA neighbours since 2019. Thurrock STI diagnosis rates remain lower than England and CIPFA neighbours, and in 2021, Thurrock features in the bottom five comparable local authorities for low STI diagnosis rates (see figures 46 – 52).

Figure 46: All new STI diagnosis rate/100,000 – Thurrock/England/EoE/CIPFA:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Figure 47: All new STI diagnosis rate/100,000 – Thurrock/CIPFA neighbours 2021:



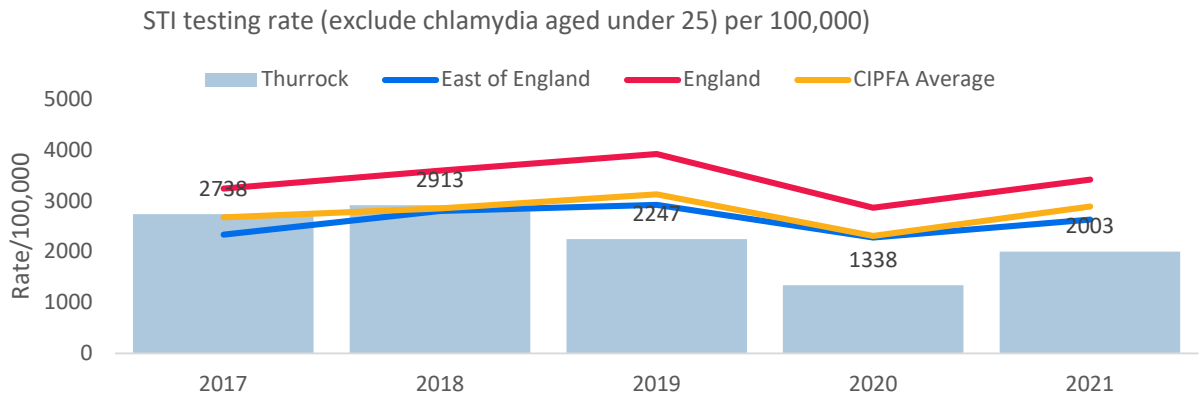
Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Testing rates in Thurrock decreased from 2,913 per 100,000 in 2018 to 1,338 in 2020, followed by a small increase in 2021 to 2,003 per 100,000. Nationally, and across the region and Thurrock's CIPFA neighbours, the trend was somewhat similar where 2020 showed the lowest testing rates followed by an upward trend witnessed in 2021. However, Thurrock rates have

consistently remained lower than its geographical comparators since 2018. This may be due in part to a reduction of need and availability due to the pandemic.

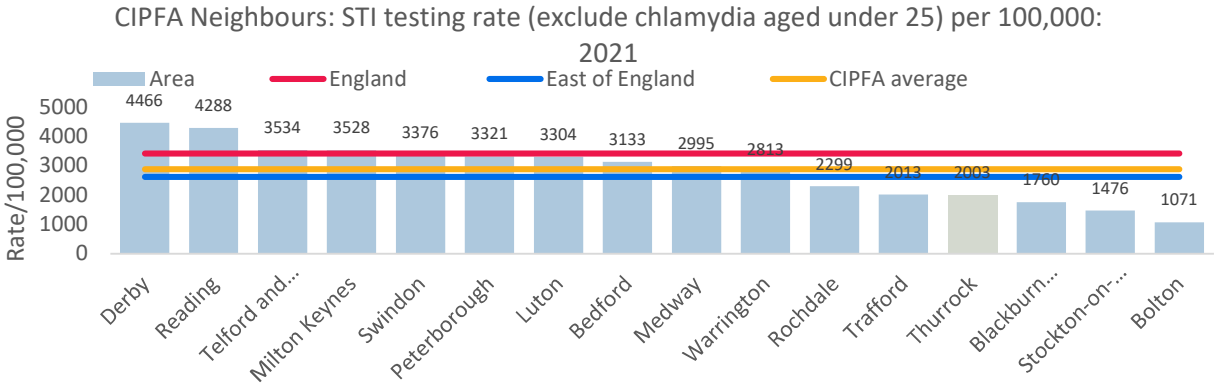
In 2021, Thurrock's testing rate is 4th lowest across the CIPFA neighbours.

Figure 48: STI testing rate (excluding Chlamydia under 25)/100,000 – Thurrock/England/EoE/CIPFA:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Figure 49: STI testing rate (excluding Chlamydia under 25)/100,000 – Thurrock/CIPFA neighbours 2021:



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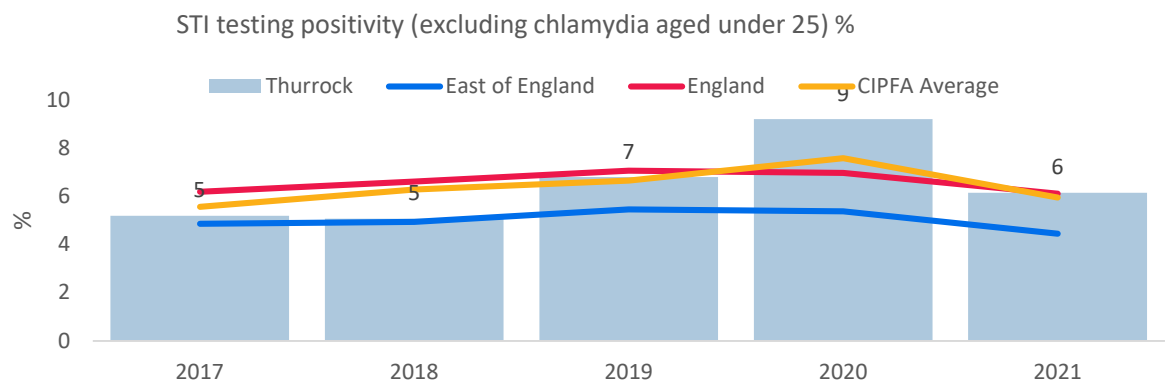
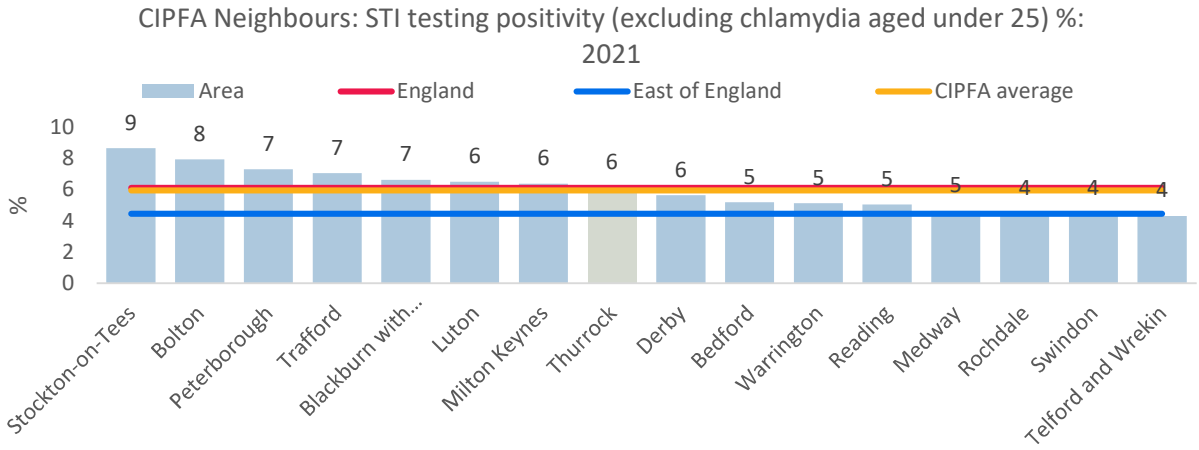
Conversely, with decreasing testing rates since 2018, the percentage positivity has steadily increased between 2018 to 2020. Testing positivity has consistently been higher than the regional average and was higher than the England and CIPFA figures between 2019 and 2020. This may be due to service users engaging when they know they have been at risk or have symptoms rather than testing as a precaution. It may be difficult to ascertain if this trend has continued due to the pandemic.

Figure 50: STI testing positivity (excluding Chlamydia under 25)/100,000 – Thurrock/England/EoE/CIPFA:



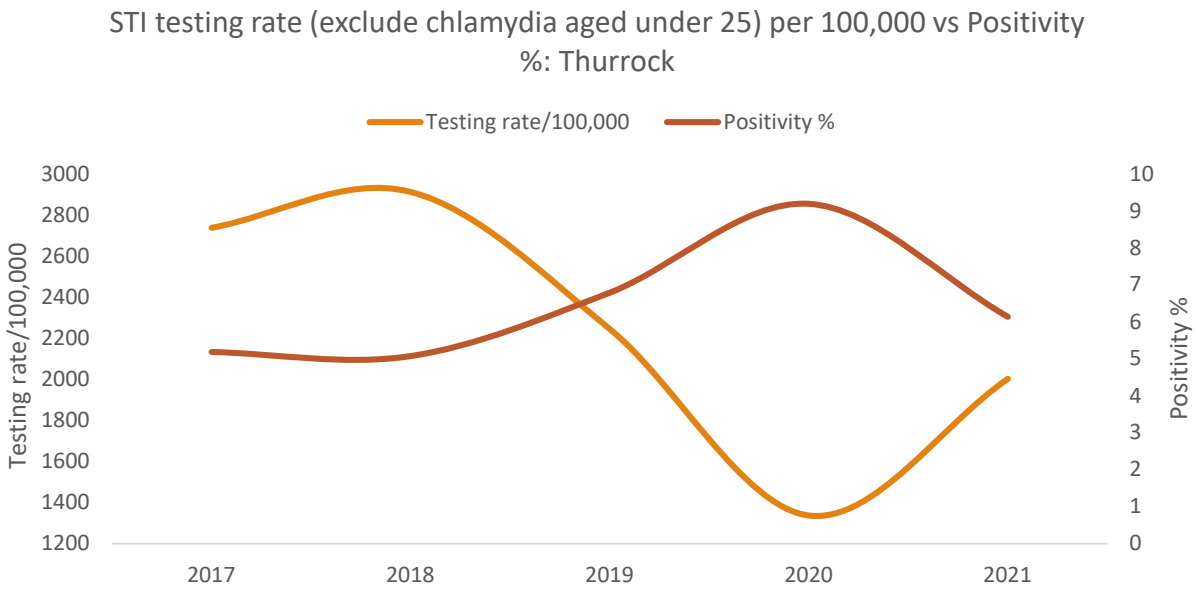
Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Figure 51: STI testing positivity (excluding Chlamydia under 25)/100,000 – Thurrock/CIPFA neighbours 2021:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Figure 52: STI testing rate vs Positivity (excluding Chlamydia under 25)/100,000 – Thurrock:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

- New STI diagnosis rate has declined steadily in Thurrock from 2017.
- Thurrock is in the bottom 5 out of 15 CIPFA neighbours for new STI diagnoses.
- STI testing rates (excl chlamydia) in Thurrock have been consistently lower than England, EoE, and CIPFA neighbours since 2018.
- In 2021, Thurrock was fourth from bottom among 15 CIPFA neighbours for STI testing rates (excluding chlamydia), significantly below England, EoE, and CIPFA averages
- STI test positivity rates in Thurrock had been increasing steadily to a peak in 2020 before decreasing to 2021. Positivity rates are currently higher than the regional average and similar to England and CIPFA neighbours.
- Between 2018 and 2020, the STI testing rate in Thurrock declined as the positivity rate increased, with both being the same in 2019. In 2021, testing rate increased in contrast to a declining positivity rate.

STIs remain prevalent and are increasing in several populations. Appropriate STI diagnosis is crucial to prevent the transmission and sequelae of untreated infection. STIs remain prevalent and a major burden of morbidity and mortality, impacting on quality of life, reproductive and child health, and national and individual economies. Failure to detect and treat STIs can lead to fertility problems, cancer, and higher risk of contracting further sexually transmitted diseases, including facilitating the sexual transmission of human immunodeficiency virus (HIV).

Some STIs may be difficult to detect, for example chlamydia in the early stages often has limited or no symptoms. Without detection, STIs can be transmitted to one or multiple partners. Increasing testing rates is therefore key to increasing diagnosis rates and reducing the burden of undiagnosed infections in Thurrock.

Regular screening for STIs and HIV, on at least an annual basis, is essential to maintain good sexual health for everyone having condomless sex with new or casual partners. In addition:

- women, and other people with a womb and ovaries, aged under 25 years who are sexually active should have a chlamydia test after having sex with a new partner or annually.
- gay, bisexual, and other men who have sex with men should have tests for HIV and STIs annually or every 3 months if having condomless sex with new or casual partners.

This information must be acted upon by the providers of sexual and reproductive health in Thurrock to ensure that testing, education, and condoms are available throughout the Borough and not just in certain wards or locations.

Chlamydia

Figure 53:

Key Points

- **Chlamydia detection rates in Thurrock are some of the lowest among the CIPFA neighbours' group, with screening rates being only 10% of the 15–24-year-old population in 2021. The areas with the highest detection rates also have the highest screening rates.**

Recommendations

- **Services should develop an Action Plan to increase awareness and uptake of chlamydia screening among male and female 15–24-year-olds, to reduce the burden of undiagnosed infection in Thurrock.**

Chlamydia screening and diagnosis

Chlamydia is the most common bacterial STI in England. By diagnosing and treating asymptomatic chlamydia infections, chlamydia screening can reduce the duration of infection. A shorter period of infection will reduce an individual's chance of developing complications and reduce the time when someone is at risk of passing the infection on, which in turn will reduce the spread of chlamydia in the population.

The National Chlamydia Screening Programme (NCSP) recommends that all sexually active under 25-year-old men and women be tested for chlamydia annually or on change of sexual partner (whichever is more frequent). Chlamydia is the most commonly tested-for STI in Thurrock, with 10,576 individuals having had Chlamydia screening since 2017 (service uptake data provided by Provide, 2023).

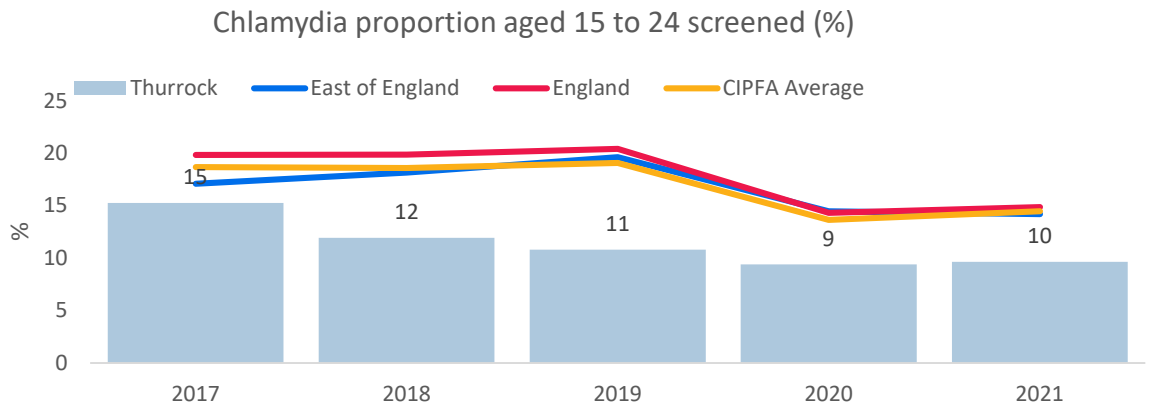
Figure 55 shows the rate of chlamydia detection per 100,000 young people aged 15 to 24. This is a measure of chlamydia control activity, aimed at reducing the incidence of reproductive sequelae of chlamydia infection and interrupting transmission onto others. An increased detection rate is indicative of increased control activity: detection rate is not a measure of morbidity.

Screening

The percentage of 15–24-year-olds screened for Chlamydia in Thurrock in 2017 was 15%, and this has steadily decreased to 10% in 2021. England, EoE and CIPFA neighbours' percentages have consistently remained higher than Thurrock since 2017 though their rates have also been decreasing over the last five years. The highest recorded rates across

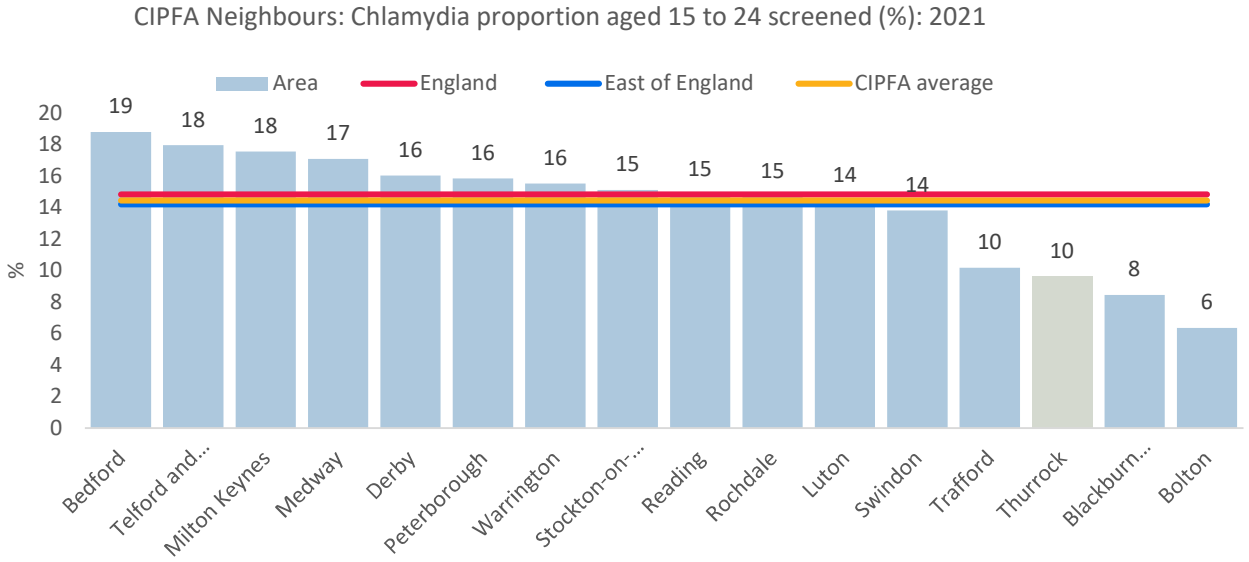
England, EoE, and CIPFA neighbours was in 2019 at approximately 20%. In comparison to its CIPFA neighbours, Thurrock features as one of the lowest performing local authorities after Blackburn and Bolton (see figures 54 – 58).

Figure 54: Proportion aged 15 to 24 screened for chlamydia – Thurrock/England/EoE/CIPFA:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Figure 55; Proportion aged 15 to 24 screened for chlamydia – Thurrock/CIPFA neighbours 2021:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

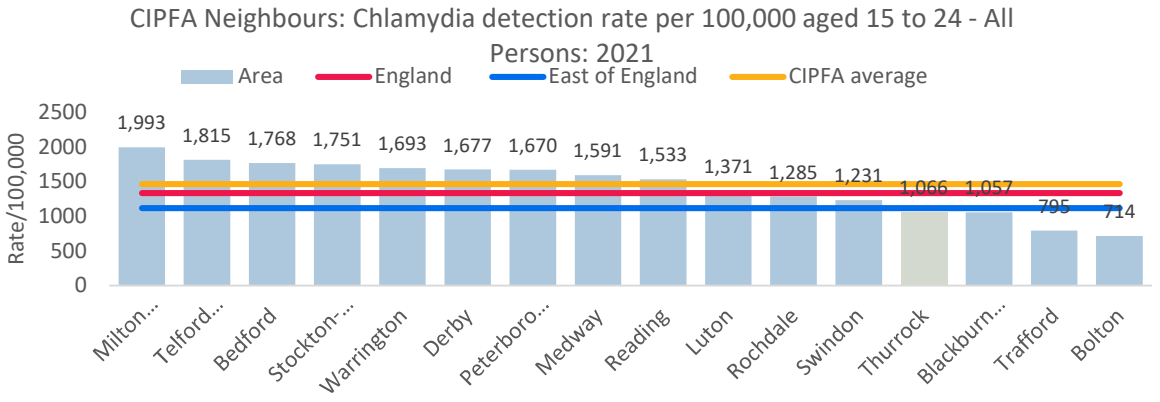
Detection

The chart below shows the chlamydia detection rate amongst under 25-year-olds for males and females respectively in Thurrock compared to the average for your chosen comparison group. This is a measure of chlamydia control activities.

The detection rate for Chlamydia amongst 15–24-year-olds has been lower for males than females between 2017 to 2021. Since 2020, the detection rates for 15–24-year-old males in Thurrock, England, EoE, and CIPFA neighbours have shown similar rates. However, the rates

for chlamydia detection in females in Thurrock have consistently remained much lower than England and CIPFA neighbours.

Figure 56: Chlamydia detection rate for all persons aged 15 to 24 per 100,000 population – Thurrock/England:



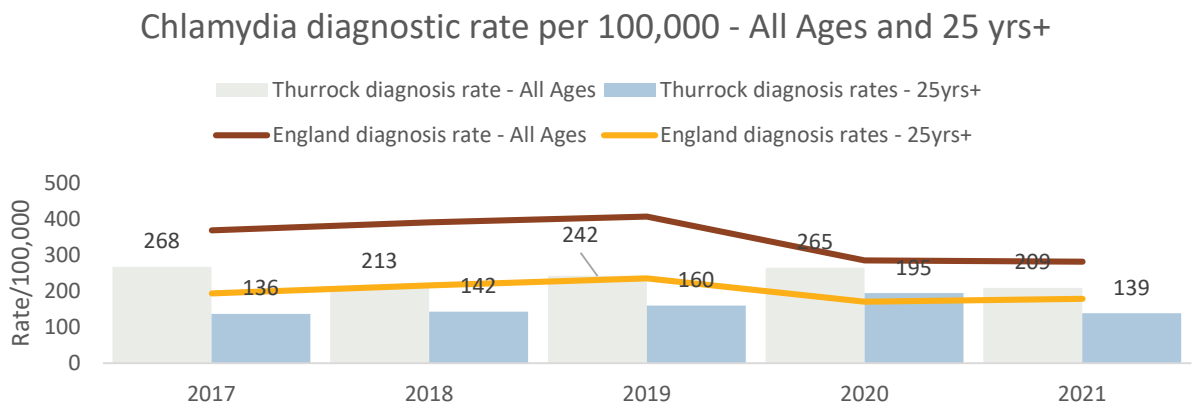
Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Diagnosis

The below chart shows the rate of all chlamydia diagnoses among people of all ages, as well as people aged 25 years and above specifically, accessing sexual health services, per 100,000 population.

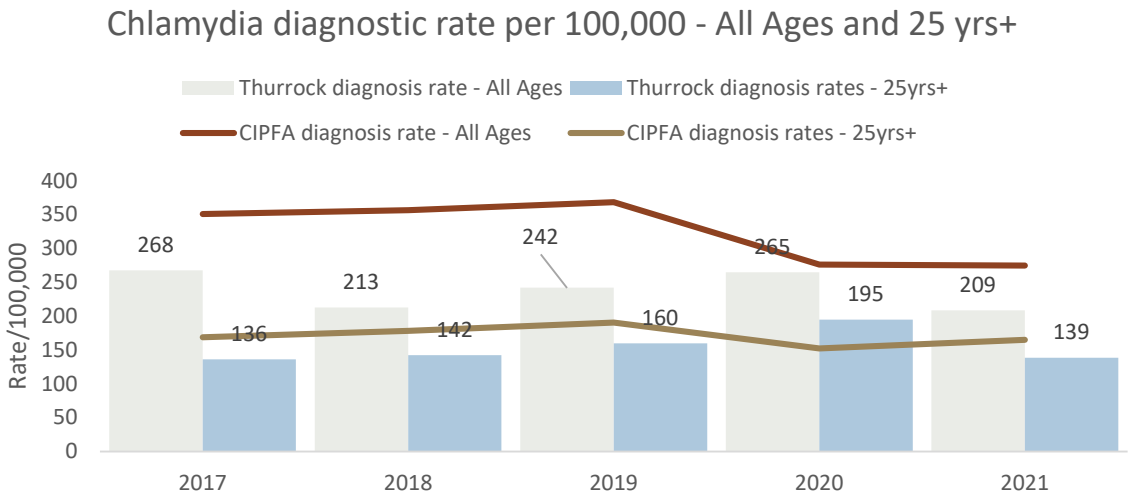
The rate of people of all ages and in those aged 25 years and over, accessing sexual health services leading to a diagnosis of chlamydia in Thurrock, had been steadily increasing since 2017, followed by a decrease in 2021. The England and CIPFA rates for all ages being diagnosed with Chlamydia has remained above Thurrock levels since 2017. This was also the trend for 25 years and over, except for 2020, where Thurrock recorded a slightly higher diagnosis rate than England and CIPFA neighbours.

Figure 57: Chlamydia diagnosis rate among all ages per 100,000 population & Chlamydia diagnoses rate per 100,000 population aged 25 years and over – Thurrock/England:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Figure 58: Chlamydia diagnosis rate among all ages/100,000 population & Chlamydia diagnoses rate/100,000 population aged 25 years and over – Thurrock/CIPFA:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

The percentage of 15–24-year-olds screened for Chlamydia in Thurrock has been steadily decreasing since 2017. This is significant as Thurrock is the third lowest performing LA for Chlamydia screening amongst CIPFA neighbours. The detection rate for Chlamydia amongst 15–24-year-olds in Thurrock in lower for males than females, this may be due to a lack of symptoms leading to a lack of urgency to be tested as a precaution. Rates for chlamydia detection in females in Thurrock have consistently remained much lower than England and CIPFA neighbours. The all-ages Chlamydia diagnosis rate in Thurrock has consistently been below England and CIPFA neighbours. Thurrock briefly out-performed England and CIPFA neighbours for over-25 Chlamydia diagnoses in 2020, this may be as a result of testing during the beginning of the pandemic, though this has now reverted to being lower in 2021.

Chlamydia can be cured with antibiotics from a health care provider. However, if chlamydia is left untreated, it can cause permanent damage. The risk of getting other STIs, like gonorrhoea or HIV, increases and in males, untreated chlamydia can lead to sterility (inability to make sperm). In women, untreated chlamydia can cause pelvic inflammatory disease (PID), ectopic pregnancy and infertility.

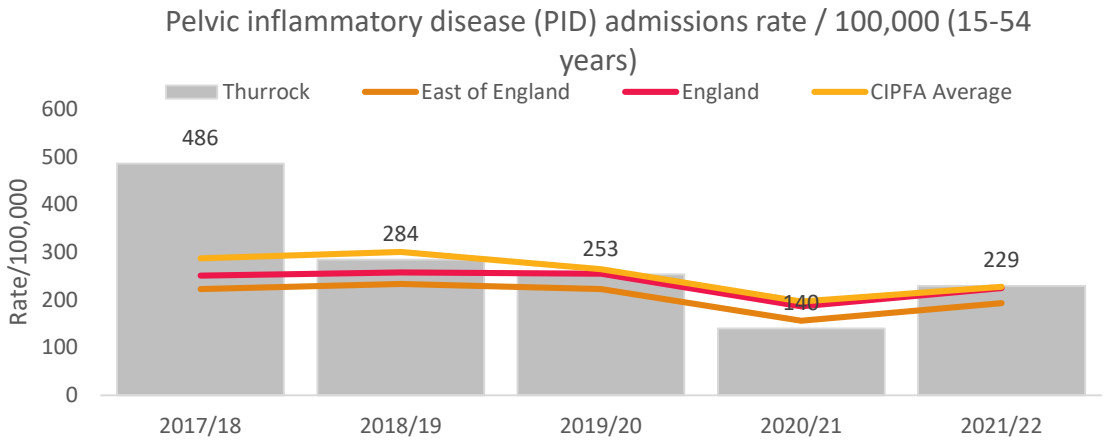
Women may be more willing to seek testing for chlamydia due to health risks associated with the STI in later life, however there may be lack of understanding regarding the risks if not getting tested and getting treatment early throughout Thurrock. The Provider should develop an action plan to improve communication, education and, engagement regarding the risks and consequences of contracting chlamydia and how people can mitigate this.

Without treatment chlamydia can persist for years in both men and women and this increases the risk of further complications. This can result in late-stage chlamydia spreading to the cervix, eyes, throat, and testicular tubes causing swelling and pain.

Pelvic inflammatory disease (PID)[51]

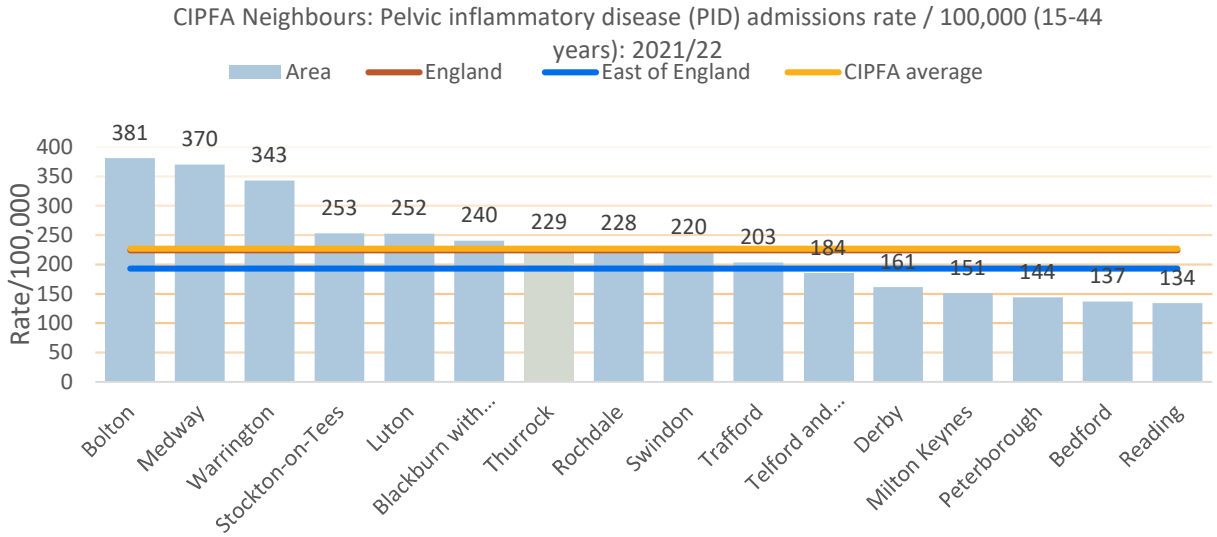
Pelvic inflammatory disease (PID) is a clinical syndrome referring to infection and inflammation of the upper female genital tract, which may lead to serious complications such as ectopic pregnancy, tubal factor infertility, and chronic pelvic pain. Chlamydial infection and other sexually transmitted infections are major causes of this condition. This indicator should be examined alongside the chlamydia screening and chlamydia diagnoses indicators. It is anticipated that high chlamydia screening coverage should lead to increased chlamydia diagnoses which, assuming successfully treated, should lead to a decrease in PID (see figures 59 – 60).

Figure 59: Rate of pelvic inflammatory disease (PID) admissions/100,000 female population aged 15-44 – Thurrock/England/EoE/CIPFA:



Source: LG Inform - Office for Health Improvement and Disparities

Figure 60: Rate of pelvic inflammatory disease (PID) admissions/100,000 female population aged 15-44 – Thurrock/CIPFA neighbours – 2021/22:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

[51] Office for Health Improvement and Disparities. 'Sexual and Reproductive Health Profiles, Rate of pelvic inflammatory disease (PID) admissions per 100,000 female population aged 15-44'. 2022.

Following higher rates of PID in 2017/18 (486 per 100,000), Thurrock rates have reduced significantly from 2017/18 to 2020/21 (486 per 100,000 to 140 per 100,000, respectively). This reduction between 2017/18 to 2020/21 is statistically significant. England, EoE, and CIPFA neighbours showed a steady trend of PID between 2017/18 to 2020/21, though the most recent rate of 2020/21 is almost 50% less than 2017/18, this may be due to increased awareness and engagement regarding PID Currently, Thurrock compares favourably against its CIPFA neighbours, featuring as one of the lower rates of PID per 100,000 in 2020/21.

Gonorrhoea

Figure 61:

Key Points:

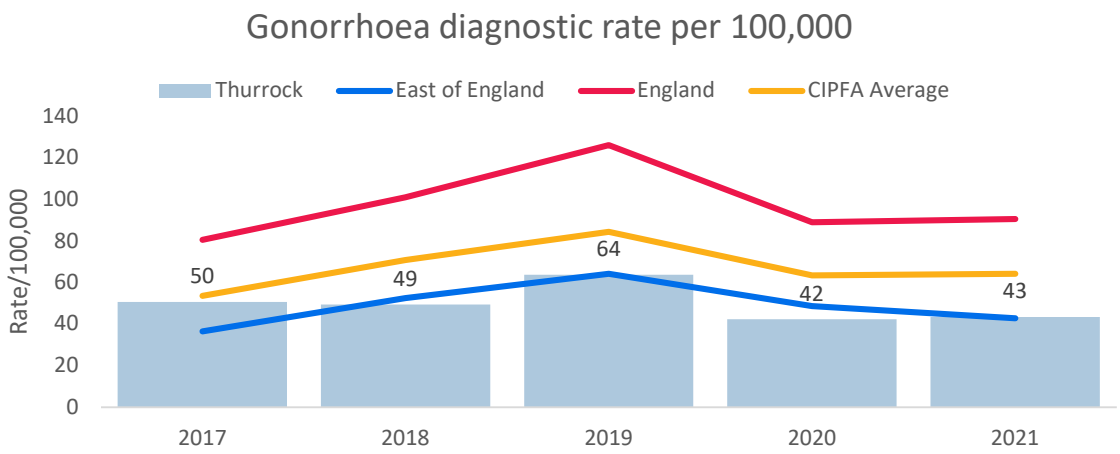
- **Gonorrhoea diagnosis rates in Thurrock have been lower than England and its CIPFA neighbours since 2018.**
- **There is a higher positivity test within older cohorts who may not access treatment services due to their age, stigma, or lack of knowledge regarding the risks and transmission of STIs.**
- **Gonorrhoea is the second most commonly tested-for STI in Thurrock, with 10,151 individuals being tested since 2017.**
- **Gonorrhoea is becoming increasingly resistant to antibiotics.**

Recommendations:

- **Services should develop an Action Plan to increase awareness and uptake of gonorrhoea screening among older service users, to reduce the burden of undiagnosed infection in Thurrock.**

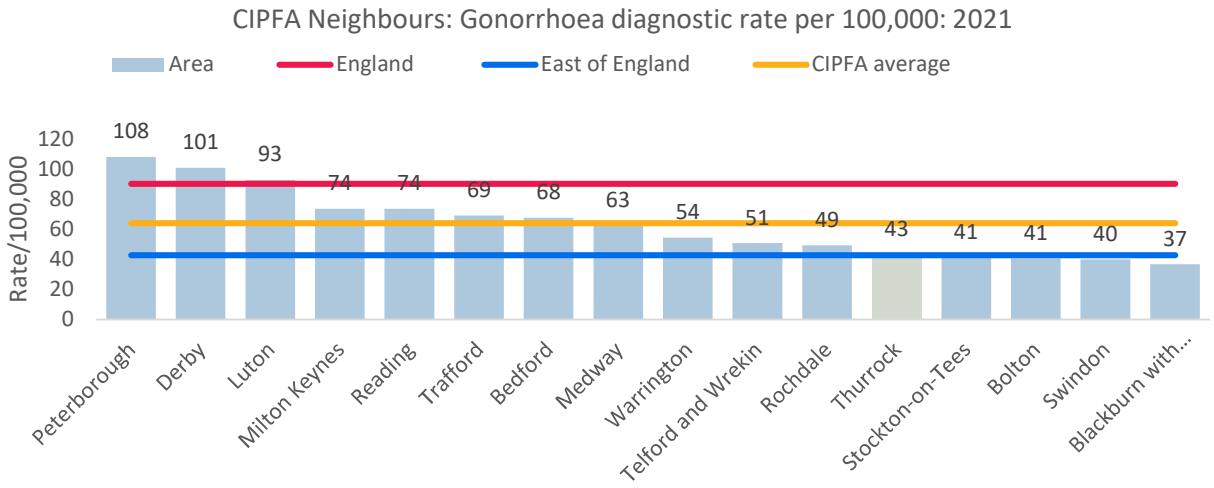
Gonorrhoea causes avoidable sexual and reproductive ill-health. Untreated Gonorrhoea can lead to complications such as long-term pelvic pain, pelvic inflammatory disease, ectopic pregnancy, and infertility in women. Prevalence is highest amongst young adults, black Caribbean people, and men who have sex with men (MSM). It is used as a marker for rates of unsafe sexual activity because the majority of cases are diagnosed in sexual health clinics, and consequently the number of cases may be a measure of access to STI treatment. Infections with gonorrhoea are also more likely than chlamydia to result in symptoms. The following charts show the rate of gonorrhoea diagnoses per 100,000 population (see figures 62 and 63).

Figure 62: Gonorrhoea diagnosis rate/100,000 – Thurrock/England/EoE/CIPFA:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Figure 63: Gonorrhoea diagnostic rate per 100,000 (2021) – Thurrock/CIPFA:



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Gonorrhoea diagnosis rates in Thurrock have been lower than England and its CIPFA neighbours since 2018. The current 2021 rate for Thurrock is 43 per 100,000 which is almost consistent with 2020 at 42 per 100,000, but a big decrease from 2019 where the rate was 64 per 100,000. This trend of rates peaking in 2019 is also evident across England and CIPFA neighbours. Currently in 2021, Thurrock is towards the lower end of diagnosis rates in comparison to CIPFA neighbours. There is a higher positivity test within older cohorts who may not access treatment services due to their age, stigma, or lack of knowledge regarding the risks and transmission of STIs. Gonorrhoea is the second most commonly tested-for STI in Thurrock, with 10,151 individuals being tested since 2017.

Recent surveillance published by The United Kingdom Health Security Agency (UKHSA) in June 2023[52] shows that gonorrhoea diagnoses increased last year and stated that people aged between 15-24 years remain the most likely to be diagnosed with sexually transmitted infections:

- Gonorrhoea diagnoses increased to 82,592 in 2022, an increase of 50.3% compared to 2021 (54,961) and 16.1% compared to 2019 (prior to the COVID-19 pandemic) – this is the highest number of diagnoses in any one year since records began in 1918.

Gonorrhoea is becoming increasingly resistant to antibiotics and at risk of becoming untreatable in the future, making it vital that people test early and diagnose the infection so that they can prevent passing it on.

Syphilis

Figure 64:

Key findings:

- **Syphilis is a bacterial infection easily treated with antibiotics.**
- **Syphilis rates are increasing nationally**
- **Men who have sex with men are disproportionately affected.**
- **There is an increased risk of HIV transmission for those infected with syphilis.**
- **Thurrock rates of infection are lower than England and CIPFA neighbours.**
- **The increase may be attributed to increased testing.**
- **scale of the increase in diagnoses strongly suggests that there is more transmission of STIs within the population**.

Recommendations:

- **Services should develop an Action Plan to increase awareness and uptake of screening among men who have sex with men, to reduce the burden of undiagnosed infection in Thurrock.**

Syphilis is a bacterial disease, which, if left untreated, can have very serious complications; however, it is easily treated with antibiotics. While anyone can contract syphilis, it disproportionately affects men who have sex with men (MSM), and high rates of syphilis are associated with risky behaviour and socioeconomic deprivation.[53] Those who are infected with syphilis are at increased risk of HIV transmission as well.[54]

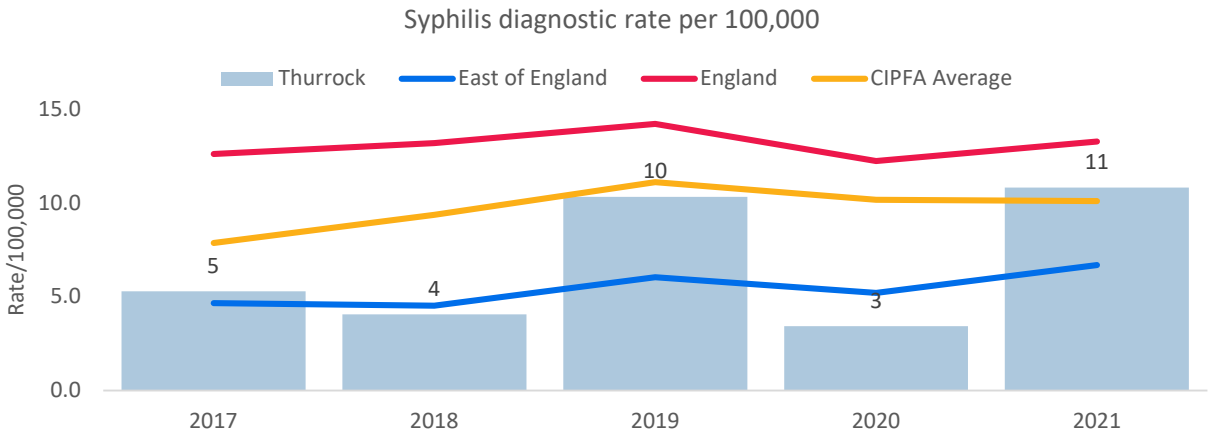
The charts below show the diagnosis rates of syphilis for people of all ages per 100,000 population (see figures 65 – 66).

The diagnosis rate for Syphilis in Thurrock has increased from 5 per 100,000 in 2017 to 11 per 100,000 in 2021, but rates do fluctuate year to year due to low absolute numbers. Thurrock

[52] UKHSA. 'Sexually transmitted infections and screening for chlamydia in England: 2022 report'. *Official Statistics*. 2023.
[53] Public Health England. "Tracking the syphilis epidemic in England: 2010 to 2019: an update on progress towards the Syphilis Action Plan prevention priorities". 2021.
[54] Public Health England. "Addressing the increase in syphilis in England: PHE Action Plan". 2019.

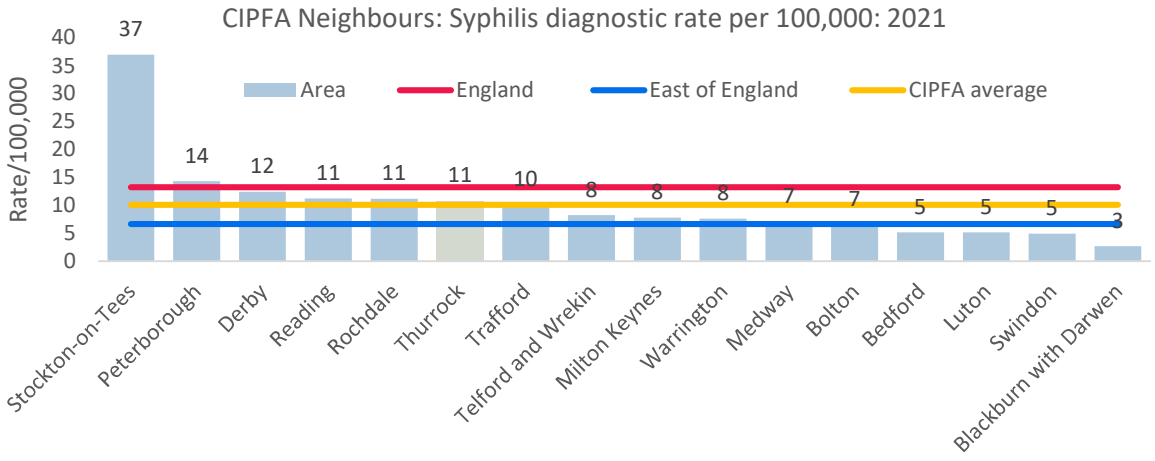
rates have consistently remained lower than England and CIPFA neighbours' rates over the reporting five-year period. Thurrock rates are similar to its CIPFA neighbours in 2021.

Figure 65: Syphilis diagnosis rate/100,000 – Thurrock/England/EoE/CIPFA:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Figure 66: Syphilis diagnosis rate/100,000 – Thurrock/CIPFA neighbours 2021:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Syphilis is caused by bacteria. It is an infection that spreads easily through anal, vaginal, and oral sex and can seriously damage your heart, brain, and nervous system. It is easy to treat and cure with antibiotics. The stages of syphilis can be found in appendix 7.

Having syphilis can also increase the likelihood of contracting or passing on HIV. Untreated syphilis will not go away on its own.

In 2019 Thurrock with 11 other local authorities across the East of England partnered with OHID (Public Health England at the time) and the Terence Higgins Trust to launch a media campaign aimed at raising awareness of the rise in syphilis. The campaign was primarily aimed at (but not restricted to) gay, bisexual and men who have sex with men (MSM) as this group represented 75% of the 301 syphilis cases diagnosed in 2017. It may account for the high positive test rate during this time.

UKHSA surveillance in June 2023[55] shows that syphilis diagnoses increased last year and stated that people aged between 15-24 years remain the most likely to be diagnosed with sexually transmitted infections:

- Infectious syphilis diagnoses increased to 8,692 in 2022, up 15.2% compared to 2021 (7,543) and 8.1% compared to 2019 – this is the largest annual number since 1948.

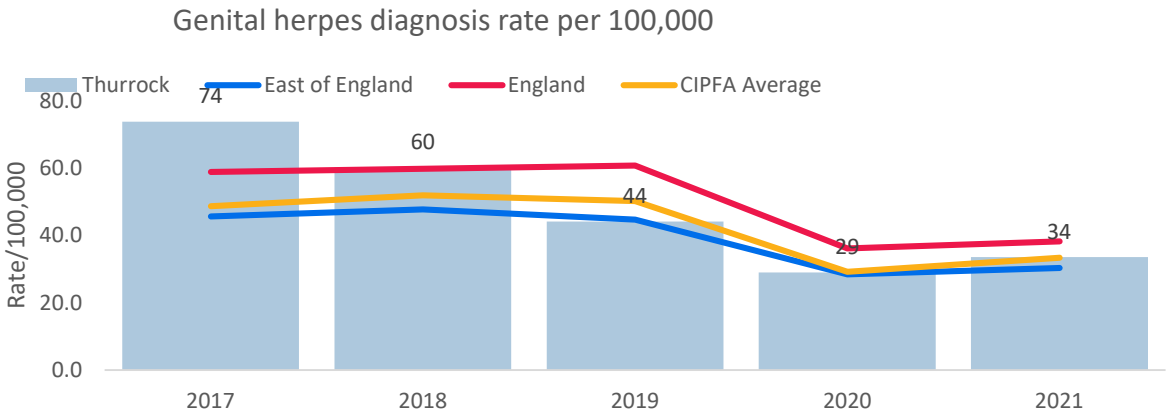
While the increase in gonorrhoea and syphilis diagnoses will in part be due to increases in testing, the scale of the increase in diagnoses strongly suggests that there is more transmission of STIs within the population.

Genital Herpes

Herpes is a long-term condition caused by the herpes simplex virus. There is no treatment for herpes, but medications can reduce the duration and frequency of herpes outbreaks.

The genital herpes diagnosis rate in Thurrock has decreased rapidly between 2017 (74 per 100,000) to 2020 (29 per 100,000). In 2021 the diagnosis rate was measured at 34 per 100,000. England and CIPFA neighbours followed a similar downward trend though between 2017 to 2019 the diagnosis rates remained consistent between 50-60 per 100,000. In 2021, Thurrock showed a lower diagnosis rate than CIPFA neighbours and England (see figures 67 -68).

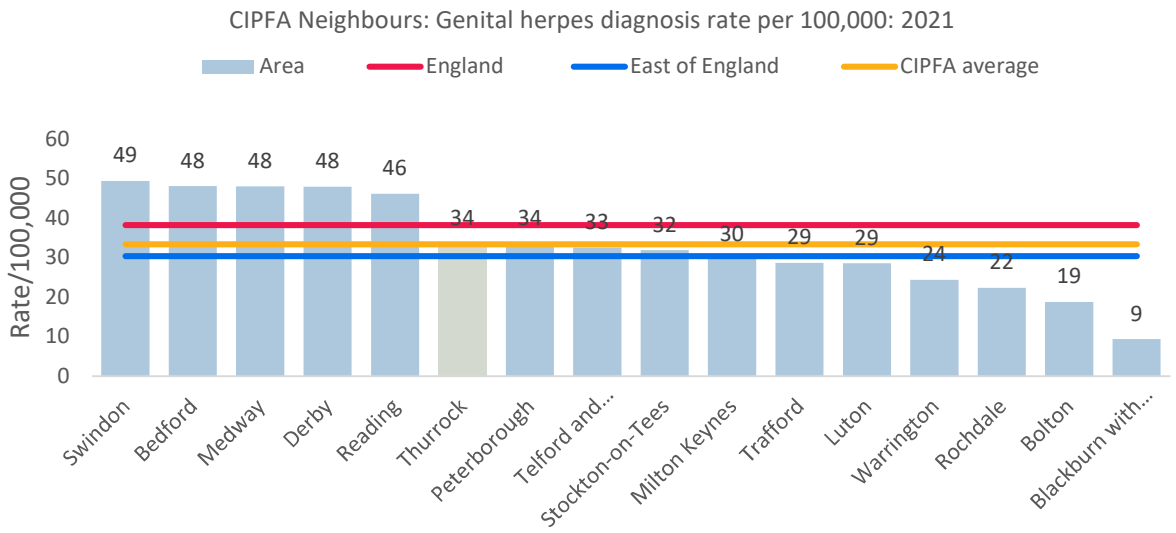
Figure 67: Genital herpes diagnosis rate/100,000 – Thurrock/England/EoE/CIPFA:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

[55] UKHSA. 'Sexually transmitted infections and screening for chlamydia in England: 2022 report'. *Official Statistics*. 2023.

Figure 68: Genital herpes diagnosis rate/100,000 – Thurrock/CIPFA neighbours 2021:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Herpes remains in the body for life, lying dormant in nerves between outbreaks. It can reactivate at any time however subsequent active outbreaks are usually less severe. Anti-viral treatments can help prevent outbreaks and reduce symptoms. LARC and other forms of contraception do not offer protection from genital herpes however the use of condoms can reduce the risk of transmission. The ability to reduce the infection rate for the population through education regarding sexual good health is vital as prevention is key with genital herpes. Sexual Health Services need to be available at the right time and in the right location to encourage all potential service users to access testing and treatment.

Genital Warts and Human Papillomavirus (HPV) Vaccination

Figure 69:

Key Findings:

Thurrock has above the East of England and England vaccination rate for HPV for females aged 12-13 years.

The HPV vaccine has only been available to boys since 2019.

The HPV vaccine is also offered to men (up to and including 45 years old) who have sex with men, some trans men and trans women, sex workers and people living with HIV.

Recommendations:

Providers to work with schools and immunisation colleagues to raise awareness of the risk of not vaccinating for HPV for boys and girls.

Providers to ensure that those accessing the service under the age of 25 or those at risk including (but not limited to) MSM, transgender women (if not previously treated) are offered the HPV vaccine.

Engagement with the community to ensure people are aware of signs and symptoms of genital warts and how to access treatment.

Genital warts are causes by strains of the HPV virus and can be very uncomfortable but can be treated. HPV is the name for a group of viruses that includes more than 100 types. More than 40 types of HPV can be passed through sexual contact. The types that infect the genital area are called genital HPV. HPV itself has no symptoms, so many people may have HPV without knowing it. HPV usually goes away without causing any problems. In 9 in 10 cases, HPV is cleared within 2 years.
In England, Scotland and Wales, cervical screening (previously called a 'smear test') looks for high-risk HPV first. This is called HPV primary screening is a way of testing the sample of cells taken at your cervical screening (smear test) appointment. It tests for a virus called high-risk human papillomavirus (HPV) that can cause cervical cell changes to develop into cervical cancer.

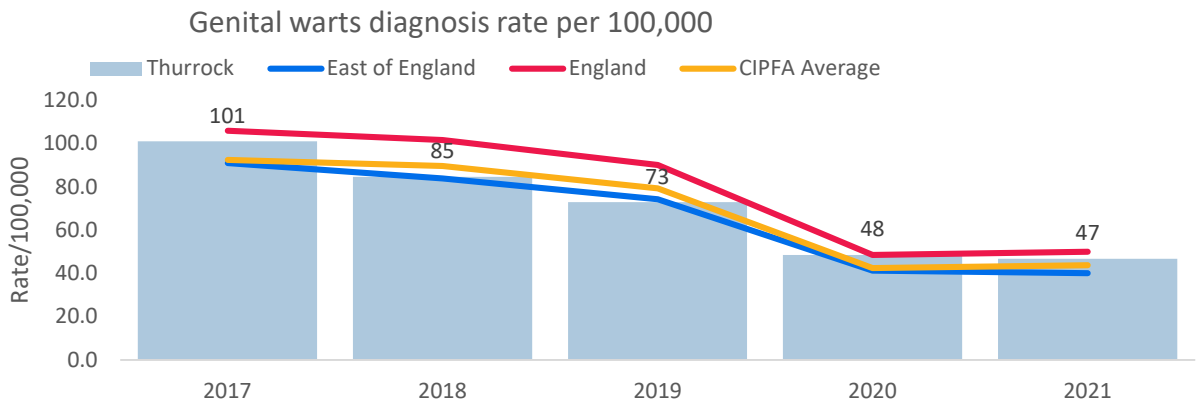
The HPV vaccine protects against four strains of HPV that can cause cancer and prevents genital warts. The HPV vaccine is offered to 12- to 13-year-old girls and boys in England protects against genital warts and some cancers (such as cervical cancer and anal cancer), however until 2019 only girls were offered the HPV vaccine.

The HPV vaccine is also offered to men (up to and including 45 years old) who have sex with men, some trans men and trans women, sex workers and people living with HIV.

The 2020/21 HPV vaccination coverage for 12–13-year-old females is 85.2%, which is higher than the East of England (71.8%) and England (76.7%), but still below the target of 90% coverage and the trend has been declining in recent years. In 2019/20, the England coverage of the HPV vaccine dropped very sharply, but Thurrock did not experience the same dramatic drop and coverage remained steady during the Covid-19 pandemic. Genital warts diagnosis in Thurrock has also decreased from 101 per 100,000 in 2017 to 47 per 100,000 in 2021. This downward trend was also illustrated across England and CIPFA neighbours. Any decrease in genital wart diagnoses may be due to a moderately protective effect of HPV-16/18 vaccination[56] (see figures 70 and 71).

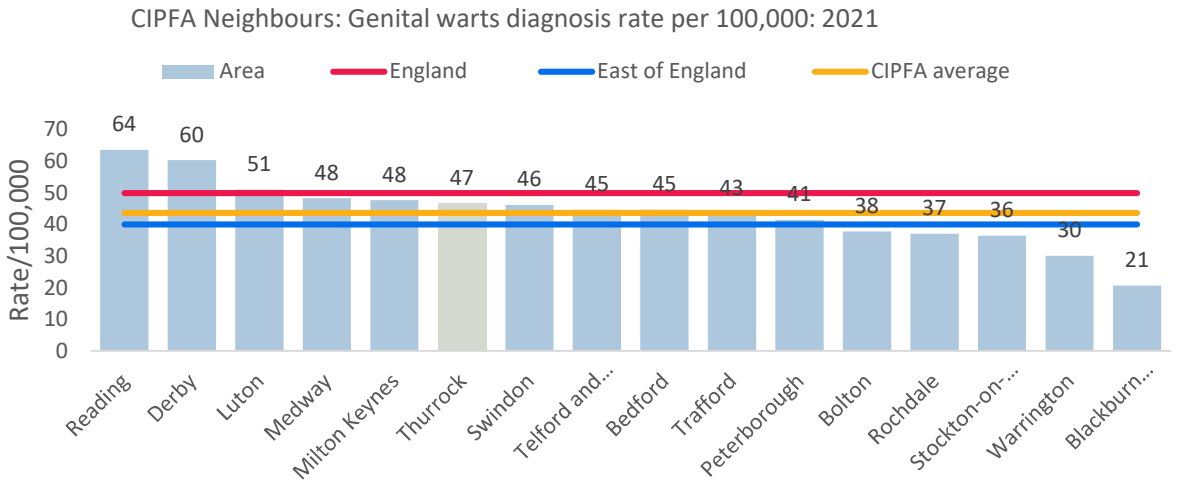
[56] UK Health Security Agency. "Spotlight on sexually transmitted infections in the East of England: 2021 data". 2023.

Figure 70: Genital warts diagnosis rate/100,000 – Thurrock/England/EoE/CIPFA:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Figure 71: Genital warts diagnosis rate/100,000 – Thurrock/ CIPFA neighbours - 2021



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

During sex, HPV is passed on when someone's skin touches another person's warts (which will not be visible if they are inside the rectum or vagina) This can be through genital contact, sharing sex toys, (very rarely) through oral sex. In extremely rare cases a mother can pass HPV to her baby during birth.

Using an external or internal condom reduces the risk of passing on warts – but only if the condom covers the skin where the wart virus is. Other forms of contraception do not offer any protection from transmission of genital warts.

Warts can be treated in a variety of ways including, freezing, topical creams and laser treatment, the earlier they are diagnosed, and the sooner treatment is started the more successful it will be. Genital warts are not always visible or painful and therefore may be passed on without knowing, the more sexual partners the greater the risk especially if practicing unprotected sex. Regular check-ups are important for early detections and treatment and to prevent the spread of genital warts.

Clinics need to be available in Thurrock to encourage regular check-ups in the same way that people may access a health check.

Human Immunodeficiency Virus (HIV) and Pre-Exposure Prophylaxis (PrEP)

Figure 72:

Key Points

- **Since 2018, fewer new sexual health service attendees in Thurrock accept an HIV test than is typical across East of England or among CIPFA neighbours. The gap is greater for women.**
- **Repeat testing in gay, bisexual, and other MSM compares well to England averages. In comparison to CIPFA neighbours, Thurrock is at the higher end of the range.**
- **Thurrock's HIV prevalence rate is similar to the England average at 2.4 per 1,000 between 15-59 years, but late diagnoses have increased since 2016-18 across both England and Thurrock.**

Recommendations

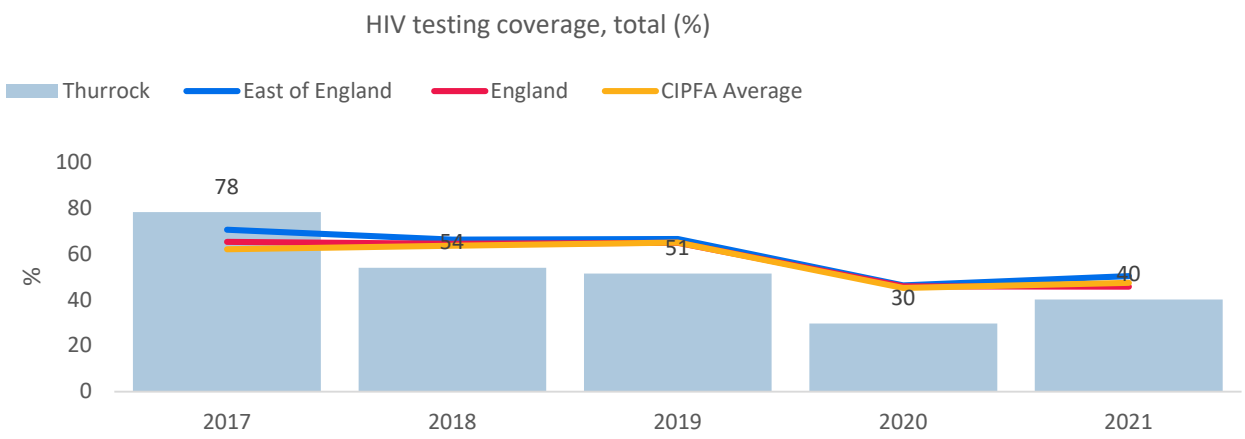
- **The Provider must continue to closely monitor HIV testing vs HIV late diagnosis rates in the Thurrock population and learn from HIV late diagnosis events through retrospective look backs to identify missed opportunities and a pro-active Human Learning System approach**.
- **Services should develop an action plan to:**
    - **Increase HIV testing among new attendees, especially women.**
    - **Reduce late presentation for HIV testing.**
    - **Increase uptake of PrEP among those who have been identified as being able to benefit.**
    - **Increase education to reduce the stigma of HIV.**

HIV screening

The following charts show the level of HIV testing coverage in Thurrock among all persons and among men and women specifically. Testing coverage is the proportion of new sexual health service attendees in whom a HIV test was accepted. Values are shown in quantiles of your chosen comparison group. All data is taken from PHE Fingertips.

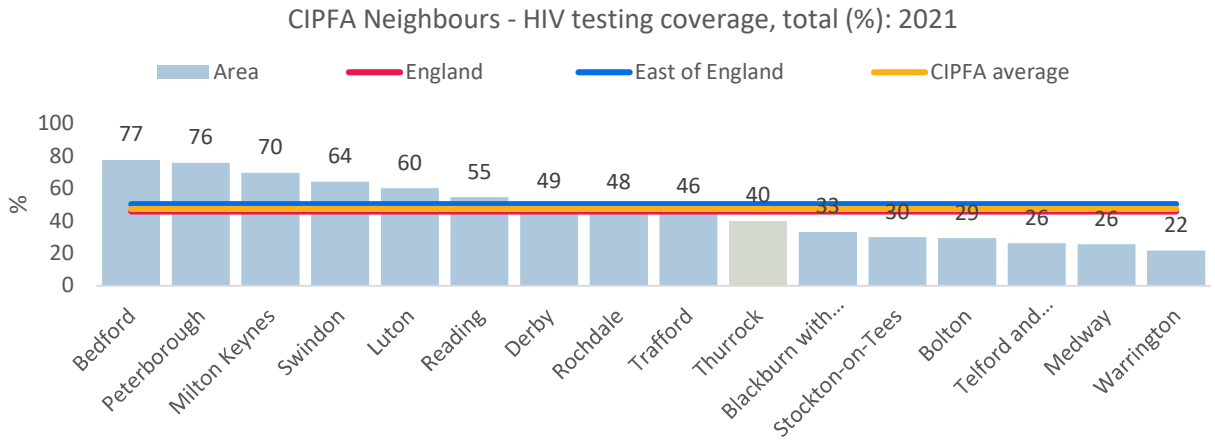
In Thurrock, 78% of new sexual health service attendees accepted an HIV test in 2017. This gradually decreased to an average of 53% over 2018 and 2019. This was followed by a further decrease to 30% in 2020. Year 2021 saw a 10% increase from 2020 to 40% coverage of HIV testing. Men's testing coverage was measured at 65% compared to women's coverage of 30%. Since 2018, Thurrock's HIV testing coverage has been lower than England and CIPFA neighbours, which are currently showing a coverage of 46% and 47% in 2021, respectively. England and CIPFA neighbours have also illustrated a gradual decline in testing coverage since 2017. This may be due to the syphilis awareness programme run in Thurrock, which was aimed at MSM, gay and bisexual residents who may also have been appropriate for HIV testing (see figures 73 – 79).

Figure 73: HIV Testing Coverage all persons – Thurrock/England/EoE/CIPFA:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Figure 74: HIV Testing Coverage all persons – Thurrock/CIPFA neighbours 2021:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

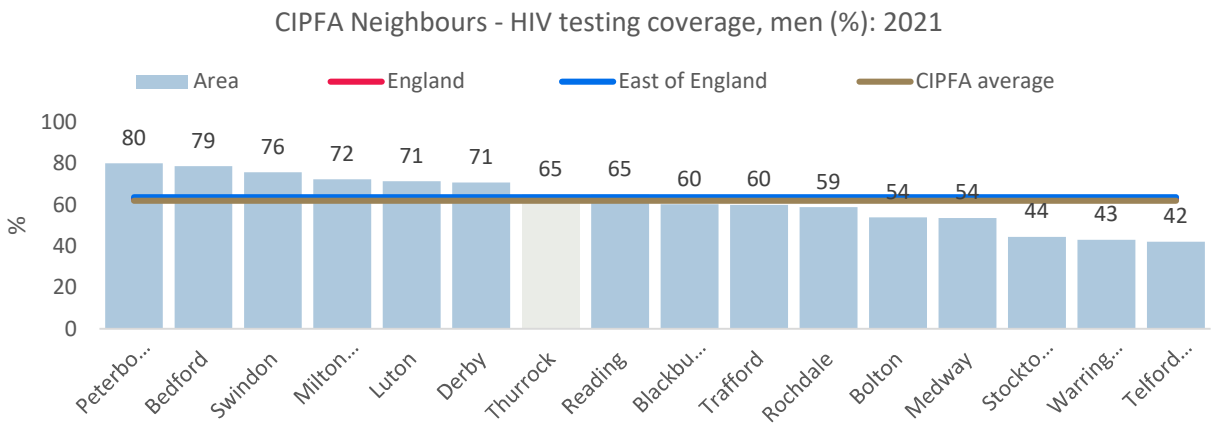
Men's testing coverage has followed a similar and closer trend to England and CIPFA neighbours' – a gradual decline since 2017, as has women's HIV testing coverage. The women's testing coverage was much lower than England and CIPFA neighbours' testing coverage. Men's testing coverage between 2017 to 2021 has reduced by 20%, but women's testing coverage has fallen by nearly 40% over the same period in Thurrock. The women's testing coverage in England and CIPFA reduced by an average of 12% between 2017 to 2021 which highlights that HIV testing amongst women in Thurrock has shown a more significant reduction than women across England and our comparable local authorities.

A study conducted by Columbia University Vagelos College of Physicians and Surgeons highlighted that women are underrepresented in HIV prevention and PrEP services.[57] They were less likely to receive adequate HIV screening compared to men. They were also less likely to receive any documentation of HIV prevention discussion. Considering this and that

[57] Yumori, Caitlin, et al. "Women are less likely to be tested for HIV or offered PrEP at time of STI diagnosis". *Sexually Transmitted Diseases*. (2021). 48(1) pg. 32-36.

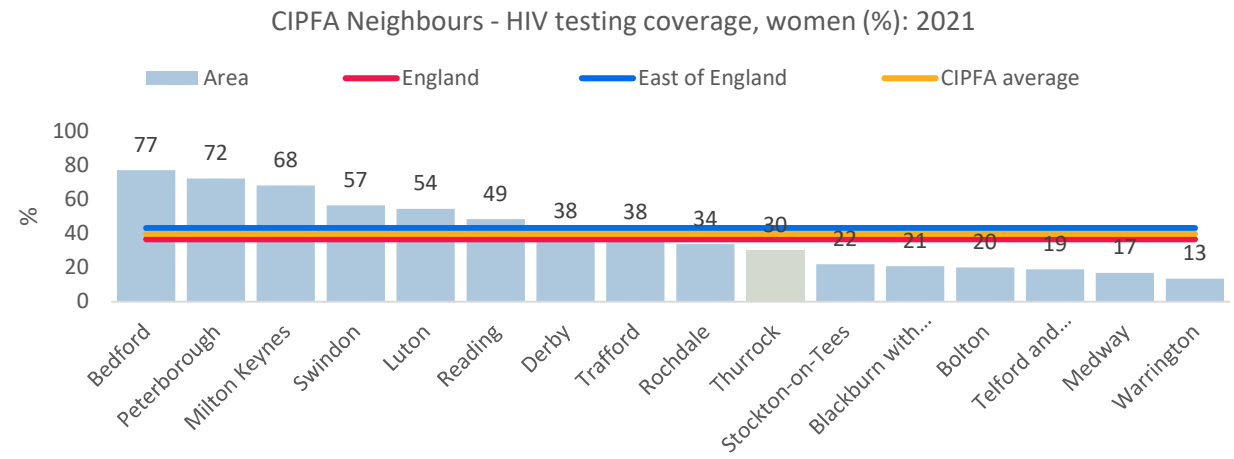
nearly one third of women live with HIV[58] in the UK, it is important for Thurrock to increase HIV testing amongst women.

Figure 75: HIV testing coverage men - Thurrock/CIPFA neighbours 2021:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Figure 76: HIV testing coverage women - Thurrock/CIPFA neighbours 2021

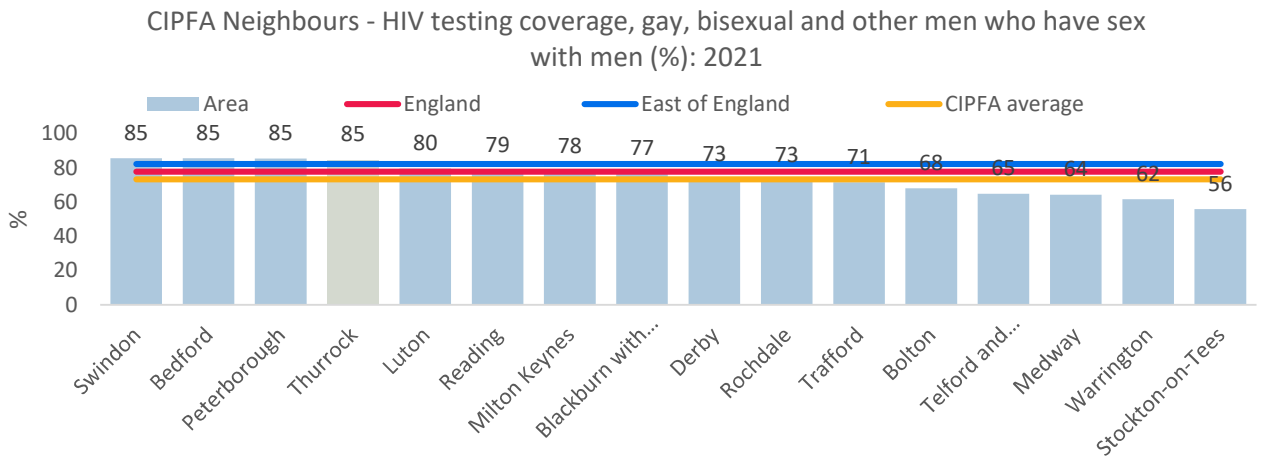


Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

There is a high percentage of HIV testing coverage in gay, bisexual, and other MSM across Thurrock as well as England and CIPFA neighbours – between 79 to 91% over the previous five years. The latest 2021 testing coverage is 85%. Thurrock features in the top 5 CIPFA neighbours with the highest testing coverage in 2021.

[58] Terrence Higgins Trust. "Women and HIV: Invisible No Longer". 2018.

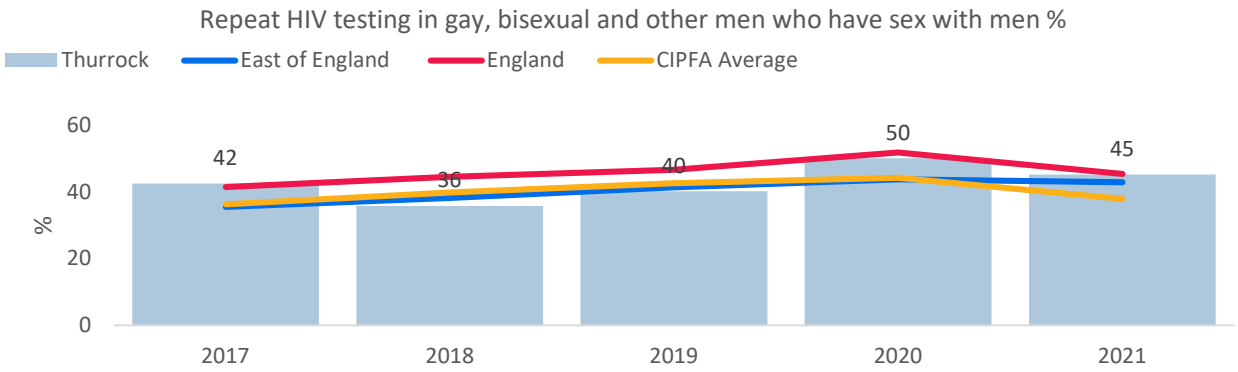
Figure 77: HIV Testing Coverage Gay, Bisexual and other Men who have sex with Men (MSM) – Thurrock/CIPFA neighbours 2021:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

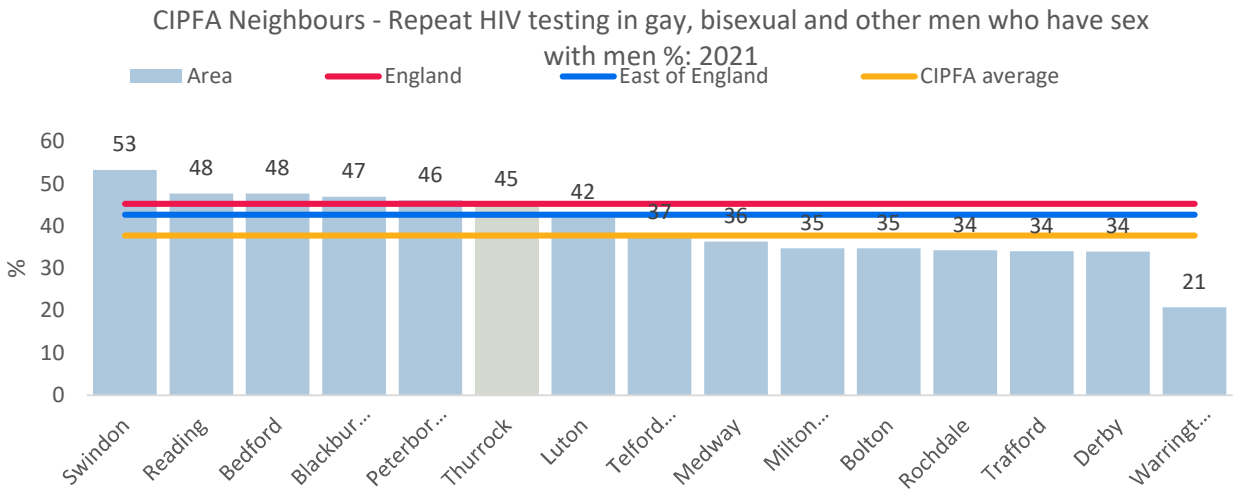
Repeat testing in gay, bisexual, and other MSM has ranged between 43% to 45% since 2017, which is similar to England and CIPFA neighbours. In comparison to CIPFA neighbours, Thurrock is on the higher end of repeat testing percentage. Testing should be in place for those at risk not based on ethnicity or gender.

Figure 78: Repeat HIV Testing Coverage Gay, Bisexual and other Men who have sex with Men (MSM) – Thurrock/England/EoE/CIPFA:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Figure 79: Repeat HIV Testing Coverage Gay, Bisexual and other Men who have sex with Men (MSM) – Thurrock/CIPFA neighbours – 2021:

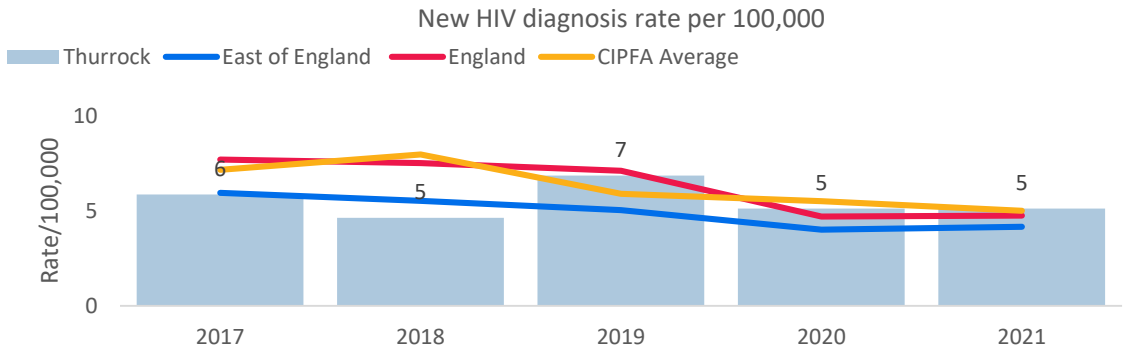


Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

HIV Diagnosis

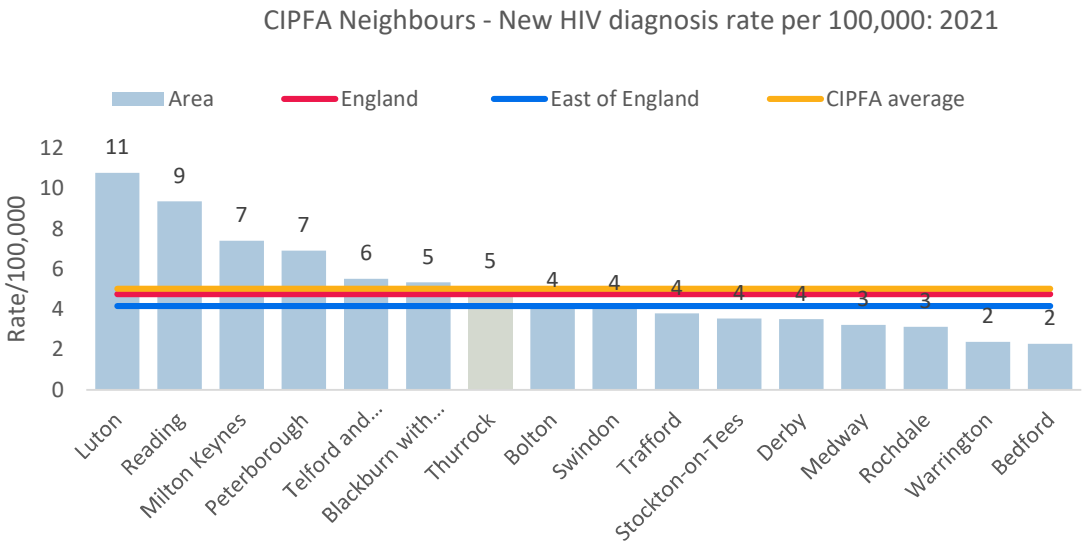
HIV diagnosis rates amongst 15+ year olds, who accepted a HIV test at a specialist sexual health service in Thurrock has remained steady between 2017 to 2021. This trend is also mirrored across England and CIPFA neighbours (see figures 80 – 85).

Figure 80: HIV Diagnosis rate/100,000 – Thurrock/England/EoE//CIPFA:



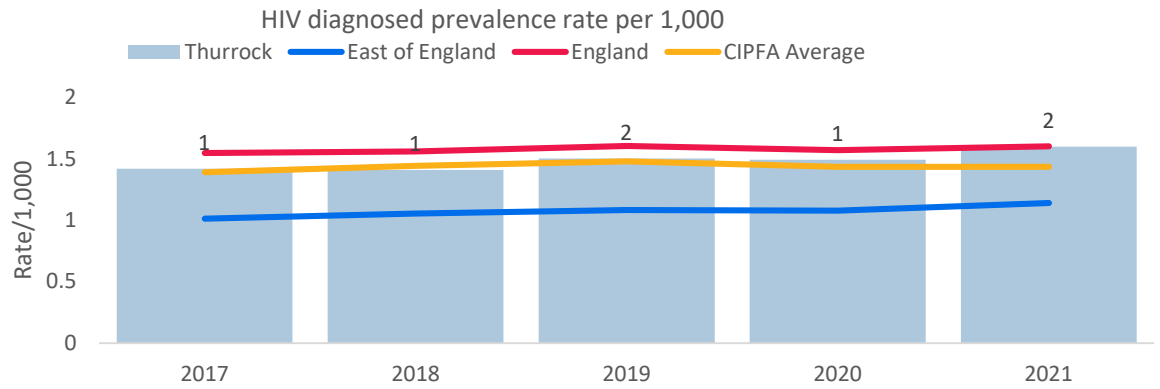
Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Figure 81: HIV Diagnosis rate/100,000 – Thurrock/CIPFA neighbours 2021:



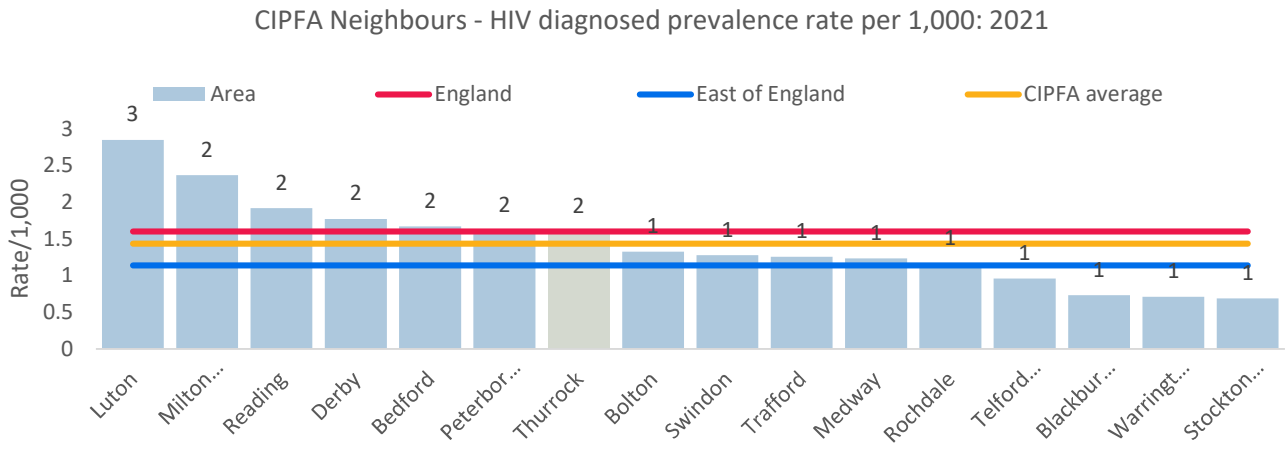
Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Figure 82: HIV diagnosed prevalence rate/1,000 – Thurrock/England/EoE/CIPFA:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

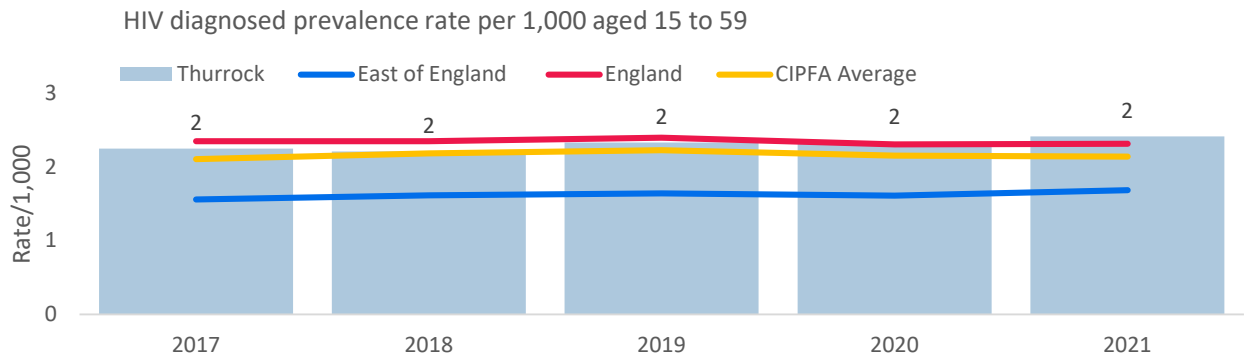
Figure 83: HIV diagnosed prevalence rate/1,000 – Thurrock/CIPFA neighbours 2021:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

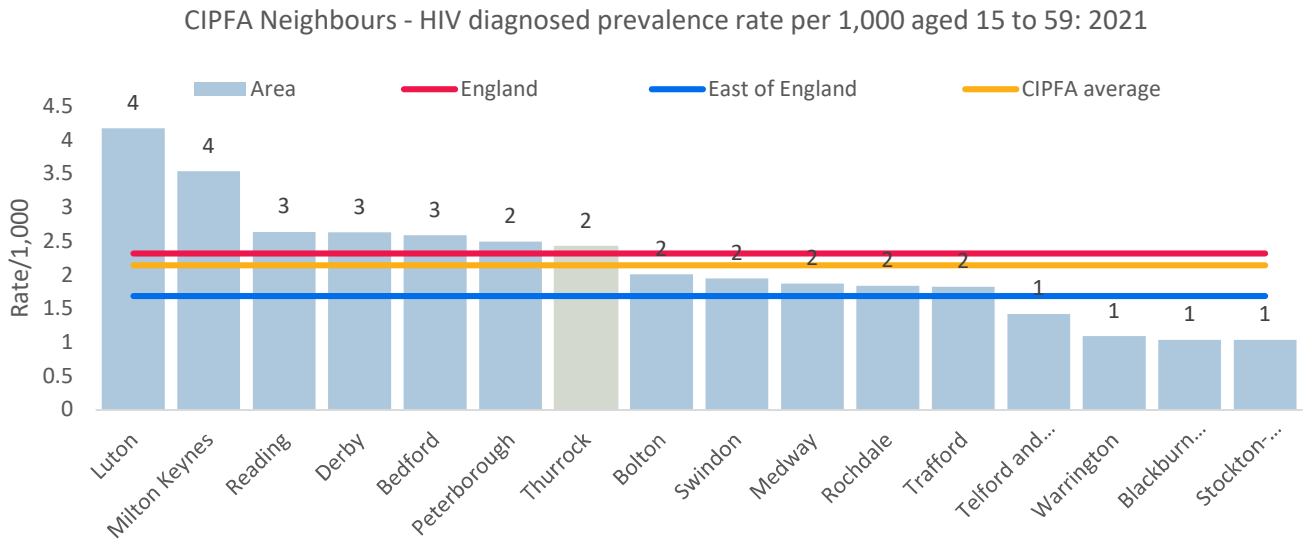
The prevalence rate amongst every 1000 people aged 15-59 years has remained consistent in Thurrock between 2017 to 2021 (fig 84). Currently Thurrock is showing its highest prevalence rate of 2.4 per 1,000 between 15-59 years diagnosed. Thurrock rates are currently higher than EoE and CIPFA neighbours' rates. The Provider and Commissioner need to understand why the prevalence is high and work to reduce this.

Figure 84: HIV diagnosed prevalence rate per 1,000 at ages 15 to 59 - Thurrock/England/EoE/CIPFA:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Figure 85: HIV diagnosed prevalence rate per 1,000 at ages 15 to 59 - Thurrock/CIPFA neighbours 2021:

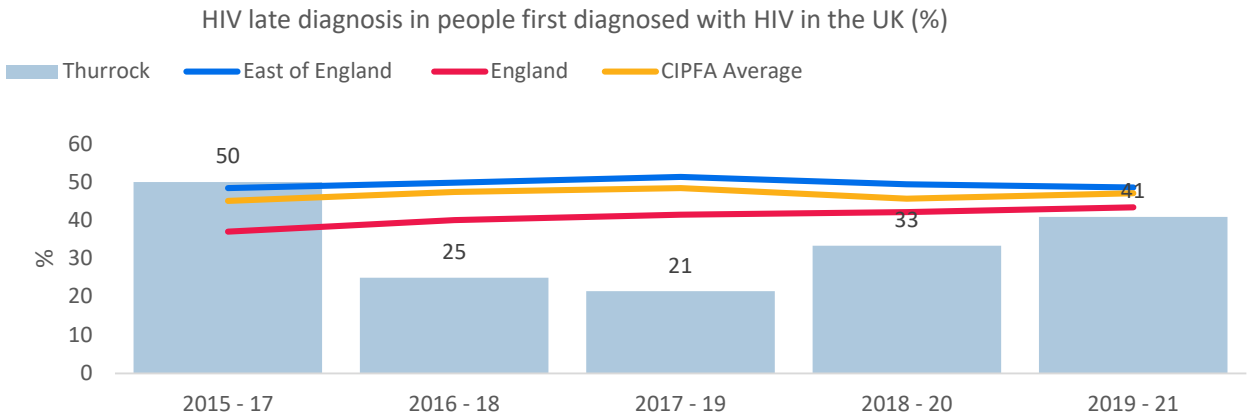


Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Late diagnosis is where a person tests positive for HIV after the virus has already started to damage their immune system. CD4 cell count is an indicator of immune function in service users living with HIV. CD4 cells are a type of white blood cell, called T cells, that move throughout your body to find and destroy bacteria, viruses, and other invading germs If the person is diagnosed when their CD4 count has dropped below 350 (or it reaches this point within three months of diagnosis) this is considered a late diagnosis.

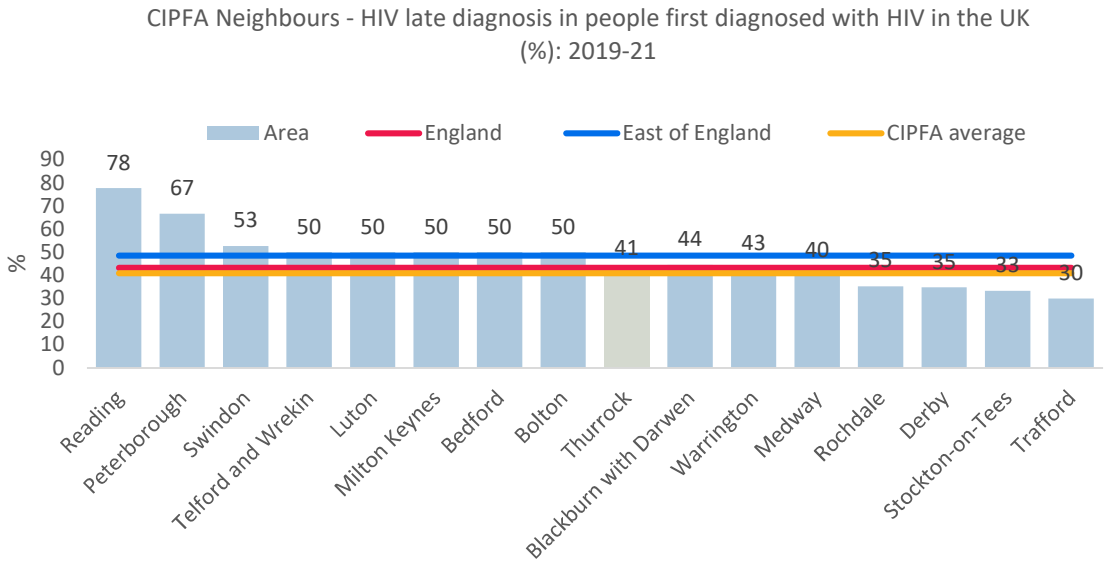
The rate of late diagnosis has also shown a slight increase in Thurrock between 2015-17 to 2019-21, During this period, England and CIPFA rates for late diagnosis has also gradually increased until 2020, followed by a drop in 2021. This could be due to several factors including (but not limited to) the Covid-19 pandemic. People may have been worried about coming forward towards the end of this time due to national restrictions of movement and concerns they may be penalised for doing so. People may have felt they had not been taking as many risks and therefore felt they did not require intervention and testing (See figures 86 and 87).

Figure 86: HIV late diagnosis aged 15 or above – Thurrock/England/CIPFA:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Figure 87: HIV late diagnosis aged 15 or above – Thurrock/CIPFA neighbours 2019-21:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Late diagnosis is the most important predictor of morbidity and mortality among those with HIV infection. Those diagnosed late have a 10-fold risk of death compared to those diagnosed

promptly. When diagnosed late the outcomes for those with HIV infection are significantly worse and the health costs are significantly worse.

PrEP (pre-exposure prophylaxis) is a drug that people at risk of HIV can take to prevent them contracting HIV in the event of exposure. PrEP can reduce your chance of getting HIV from sex or injection drug use. When taken as prescribed, PrEP is highly effective for preventing HIV.

In 2021, 3.5% (143 out of 4,090) of HIV-negative people accessing specialist Sexual Health Services in Thurrock were defined as having PrEP need. Among these, 55.2% (79 out of 143) initiated or continued PrEP The 3.5% identified as having a PrEP need in Thurrock in 2021 is like its CIPFA neighbours at 4%, but lower than England's 7%.

When HIV diagnosis and treatment are delayed, HIV continues to replicate. This can negatively impact the infected individual's health and increase the risk of transmitting the virus to others therefore early detection and treatment is vital for the health of the individual and any partners they have in the future.

Hepatitis

Figure 88:

Key Points

- **There may be an under-identification of hepatitis C in Thurrock due to a lower-than-average proportion of injecting drug users being engaged in treatment compared to the England average. Referrals between sexual health and substance misuse services and joint working may increase uptake by those at risk.**

Recommendations

- **Services should consider how to:**
    - **Increase engagement of injecting drug users in drug treatment and ensure uptake of hepatitis C testing.**
    - **Strengthen joint working between sexual health and substance misuse services.**

Hepatitis B and C are viral infections that affect the liver and are passed on through blood, semen, and vaginal fluids. UKHSA (2021) estimated that 206,000 people were living with a chronic hepatitis B infection in England and 92,900 people were living with hepatitis C infection in the UK.[59] Rates of Hepatitis C decreased by approximately 37% between 2015 and 2020 with many of the positive cases associated with injecting drug users.[60] In response to this 100% of service users in structured drug and alcohol service treatment are offered testing for Hepatitis C. However, the Diagnostic Outcomes Monitoring Executive Summary (DOMES), 2022[61] estimated that 79.2% of opioid users and 69.2 of non-opioid users were not engaged in treatment in Thurrock compared to the England average of 53.7% and 47% respectively, therefore several high-risk residents may not be offered testing or treatment.

[59] UK Health Security Agency. *Don't forget to check for hep- testing and treatment for hepatitis*. 18 May 2023.
[60] UK Health Security Agency. "Hepatitis C in England 2022: Working to eliminate hepatitis C as a public health problem". Full data report to end of December 2020. 2022.
[61] NDTMS. "Diagnostic Outcomes Monitoring Executive Summary Report for Thurrock". Q4 2021/22.

Based on 2016/17 estimates there are around 4.3 opiate users per 1,000 aged 16 to 64 years in Thurrock compared to the significantly higher England average of 7.4 per 1,000. There are similar rates of crack cocaine users (4 to 5 per 1,000) in people aged 16 to 64 years in England and Thurrock. When applied to 2021 populations these prevalence rates equate to around 493 people using opiates and 450 people using crack cocaine in Thurrock.

Most cases of hepatitis B are in migrants who have acquired infection overseas in endemic countries prior to arrival in the UK. Communities at higher risk of getting hepatitis B in the UK include people who inject drugs, gay, bisexual and men who have sex with men who are having sex with multiple partners, sex workers and people detained in prisons or immigration detention centres (UKHSA, 2023). To date this year 4.2% of service users have identified as gay or bisexual (compared to 2% of Thurrock residents in the 2021 Census; however 7% did not answer this question so the true prevalence could be higher), however 35% have either declined to give the information or not stated their sexuality when entering treatment or testing, this does not however cover men who identify as heterosexual but who have sex with men. There are no prisons or immigration centres in Thurrock and only one commercial sex establishment however this does not mean that there are no risk factors as associated with these groups.

Many people who have hepatitis are unaware they have the infection, because the viruses can be symptomless, therefore pro-active testing for those at risk is vital to ensure appropriate treatment and reduction of onward transmission and should be done as part of a regular routine sexual health check-up.[62] Referrals between sexual health and substance misuse service and joint working may increase uptake of testing by those at risk, the needs assessment engagement has shown that this needs to be strengthened.

Although not common, hepatitis C can also be transmitted through sexual activity. Having a sexually transmitted infection, having sex with multiple partners, and engaging in anal sex appear to increase a person's risk for hepatitis C. MSM with multiple sex partners who are coinfected with HCV and HIV have been shown to transmit hepatitis C.[63]

Early diagnosis and treatment for hepatitis can prevent progression to serious liver disease, and for hepatitis C, treatment can clear the virus. Hepatitis B infections can be prevented by having the hepatitis B vaccination. If left untreated chronic or long-term hepatitis can cause liver failure, which stops the liver working properly, and increases the risk of liver cancer. 93.2% of children in Thurrock were fully vaccinated against Hepatitis B by the age of two, this is slightly above the National average.

Transmission of hepatitis A virus can occur from any sexual activity with an infected person and is not limited to faecal-oral contact. People who are sexually active are considered at risk for hepatitis A if they are MSM, live with or are having sex with an infected person, or inject drugs.

Vaccination is the most effective means of preventing hepatitis A transmission among people at risk for infection. Someone with hepatitis A is most infectious two weeks before jaundice

[62] Centers for Disease Control and Prevention. "CDC Recommendations for Hepatitis C Screening Among Adults". Morbidity and Mortality Weekly Reports. April 10th, 2020.
[63] Centers for Disease Control and Prevention. "Sexual Transmission and Viral Hepatitis". September 21st, 2020.

appears. Although not as effective as vaccination risk may be reduced by avoiding sex that involves contact with faeces and using a latex barrier for genital, digital or oral sexual contact.[64]

Hepatitis D is a liver infection caused by the hepatitis D virus. Hepatitis D is not as common as A, B or C and only occurs in people who are also infected with the hepatitis B virus as it needs the hepatitis B virus to survive. Hepatitis D is spread when blood or other body fluids from a person infected with the virus enters the body of someone who is not infected. Hepatitis D can be an acute, short-term infection or become a long-term, chronic infection. Hepatitis D can cause severe symptoms and serious illness that can lead to life-long liver damage and even death. There is no vaccine to prevent hepatitis D however, prevention of hepatitis B with hepatitis B vaccine will help protect against it.[65]

Vaccination for hepatitis B and A and testing and treatments for hepatitis B and C are free and can be accessed via GP, sexual health services or home sampling. Completing a course of vaccination offers long term protection against hepatitis B infections. We do not have data for those attending pharmacies for testing however hepatitis B vaccine is given as part of the 6 in 1 vaccination given to children as routine, data is collected at 1 year and 2 years of age with coverage of 91.7% and 93.2% respectively (Fingertips, 2023). There is no vaccination for hepatitis C, but it can be cured with effective treatments. However, it is important to be aware that completing treatment for Hep C will not prevent reinfection.

In the current contract year, 2.77% of service users attending the sexual health clinic were tested for hepatitis A, B and C, and 0% were positive. Whilst the figure is low only those at risk are currently tested for hepatitis and due to the routine vaccination of children there will be a smaller percentage of the population thought to be at risk, however consideration should be given to testing all those at higher risk as routine.

Emerging Threats – Shigella, Lymphogranuloma and Mpox

Figure 89:

Key Findings:

There are three recognised emerging threats: Shigella, Lymphogranuloma and Mpox.
Men who have sex with men, gay or bisexual are most at risk.
Whilst all three can be treated shigella sonnei is becoming resistant to treatment.
There is a vaccination for mpox.

Recommendations:

- **The Provider and commissioner must work closely with UKHSA and OHID colleagues to monitor emerging threats in Thurrock and Nationally**
- **Services should develop an action plan to:**
    - **Increase awareness of emerging threats to target audiences.**
    - **Increase communication of emerging threats throughout Thurrock.**
    - **Increase education regarding emerging threats.**

[64] Terrence Higgins Trust. *Hepatitis A*. 9 December 2021.
[65] NHS Online. *Hepatitis*. 23 August 2023.

Shigella Spp.

Shigella spp. are bacterial enteric pathogens transmitted through faecal-oral contact, which can cause dysentery. Whilst diagnoses of shigellosis are often associated with exposure to contaminated food or water during travel to endemic countries, shigellosis is increasingly acquired domestically in England, mainly among men who have sex with men via direct oral-anal contact, oral sex after anal sex or play, including fingering and use of sex toys.

The previous Shigella Health Protection Report[66] described a reduction in the number of reported Shigella spp. diagnoses overall in 2020, likely due to the impact of coronavirus (COVID-19) related control measures, reduced international travel, limited domestic travel and social distancing.

Whilst the number of sexually transmitted Shigella spp. diagnoses reported in England by quarter 2 (Q2) 2022[67] had not yet reached pre-COVID-19 pandemic levels, reported, diagnoses among presumptive MSM increased from 67 to 152 between Q3 2021 and Q2 2022 indicating transmission has increased following the lifting of restrictions. London continued to account for most Shigella spp. diagnoses reported in the 12-month period between Q3 2021 and Q2 2022.

From Q3 2021 onwards, there was a substantial increase in Shigella sonnei diagnoses from the very low levels reported during the COVID-19 lockdown period, with 56 diagnoses reported in Q2 2022, in addition to increased reporting of Shigella flexneri diagnoses – this increase was driven by the return in late 2021 of a Shigella sonnei outbreak strain which had since become extensively drug-resistant.

Lymphogranuloma

Lymphogranuloma Venereum (LGV) is a type of chlamydia bacteria that attacks the lymph nodes. LGV is very rarely seen in heterosexual men and women in the UK, but cases are being seen among gay and bisexual men. Antibiotics cure LGV with no lasting effects if the infection is treated early enough however, left untreated, LGV can cause lasting damage to the rectum that may require surgery.

There have also been increases nationally in less frequently reported STIs such as lymphogranuloma venereum (LGV) (82.8%, from 570 in 2021 to 1,042 in 2022). There is evidence of a rebound in sexual mixing among GBMSM between 2020 and 2021, and this is likely to have contributed to the rise in STIs within this population in 2022.[68]

Mpox

Mpox (or monkeypox) is an illness caused by the monkeypox virus. It is a viral infection which can spread between people and occasionally from the environment to people via things and surfaces that have been touched by a person with mpox.

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[66] UKHSA Research and Analysis: Sexually Transmitted Shigella spp. In England: Data update to quarter 2 2022. Updated 28 September 2022

[67] UK Health Security Agency. "Sexually transmitted Shigella spp. in England: data up to quarter 2, 2022". 2022.

[68] UK Health Security Agency. "Sexually transmitted infections and screening for chlamydia in England: 2022 report". 2023.

Mpox is spread from person-to-person through close contact with someone who is infected with the monkeypox virus. Close contact includes being face-to-face, skin-to-skin, mouth-to-mouth, or mouth-to-skin contact. During the global outbreak that began in 2022, the virus mostly spread through sexual contact. Detection of cases of mpox infection, acquired within the UK, were confirmed in England from 6 May 2022. The outbreak has mainly been in gay, bisexual, and other men who have sex with men without documented history of travel to endemic countries.[69]

UKHSA modelling, found evidence of transmission of mpox before symptoms are identified (pre-symptomatic transmission). Researchers estimated that more than half (53%) of transmission occurred up to four days before symptoms were developed or were recognised, with an average incubation period of between 7-8 days.

Whilst the symptoms are generally mild, for those who are immunosuppressed, an mpox infection can be associated with more severe symptoms. There is a vaccine for mpox, and those eligible for the vaccine include gay, bisexual, or other men who have sex with men who have multiple sexual partners, participate in group sex or attend sex on premises venues. Staff who work in these premises are also eligible.[70]

7. Primary Prevention

Relationship and Sex Education (RSE)

The Relationships Education, Relationships and Sex Education and Health Education (England) Regulations 2019, made under sections 34 and 35 of the Children and Social Work Act 2017, make Relationships Education compulsory for all pupils receiving primary education and Relationships and Sex Education (RSE) compulsory for all pupils receiving secondary education. The regulations also make Health Education compulsory in all schools except independent schools. Personal, Social, Health and Economic Education (PSHE) continues to be compulsory in independent schools.

Schools are free to determine how to deliver the RSE agenda, in the context of a broad and balanced curriculum. Effective teaching in these subjects will ensure that core knowledge is broken down into units of manageable size and communicated clearly to pupils, in a carefully sequenced way, within a planned programme or lessons. Teaching will include sufficient well-chosen opportunities and contexts for pupils to embed new knowledge so that it can be used confidently in real life situations.[71]

There is good international evidence[72] that relationships and sex education, particularly when linked to contraceptive services, can have a positive impact on young people's knowledge and attitudes, delay sexual activity and/or reduce pregnancy rates.

[69] Sinka, Katy. "One year on: 7 things we've learnt about mpox". *UHKSA*. 2023.
[70] UK Health Security Agency. "Mpox (monkeypox) outbreak: epidemiological overview". 2 March 2023.
[71] Department for Education. "Relationships Education, Relationships and Sex Education (RSE) and Health Education Statutory guidance for governing bodies, proprietors, head teachers, principals, senior leadership teams, teachers". 2019.
[72] Wellings, K, et al. "The prevalence of unplanned pregnancy and associated factors in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3)". *Lancet* (2013) 382: 1807–1816.

This measure lays the foundations for universal prevention - equipping all children and young people to make safe, well-informed decisions about relationships, pregnancy, and sexual health. It also signals a fantastic opportunity for councils to work closely with schools and parents in their local areas to ensure high quality RSE gives children and young people age-appropriate knowledge and information on contraception, safe sex, and healthy relationships.

A comprehensive RSE delivery package could help to reduce the stigma associated with attending sexual health services and could through education, access and training reduce teenage and unwanted pregnancy. The Provider needs to work collaboratively with school nurses and stakeholders to ensure that high quality RSE is delivered to meet the needs of the population of Thurrock.

Stakeholder attendance at professional training to deliver RSE is low in Thurrock and feedback from Terrance Higgins Trust (and previously Brook) have found increasing attendance to be difficult, however stakeholders state they are unsure of how to access services. Increased collaboration and communication may close this gap and Providers should attend relevant meetings with Headteachers to ensure the service is visible.

Condom Distribution

Condoms are the only contraception that can prevent the transmission of STIs and reduce the number of unwanted pregnancies. Easily accessible condoms to young people and at-risk adults are an important intervention to protect health and reduce unwanted pregnancies. Condom distribution within educational settings and locations that target young people can provide a good introduction to wider sexual and reproductive health services.

Condom distribution schemes (CDS) need to be targeted so that they are available for local populations who are at increased risk of contracting a STI. For young people, multi-component schemes including condoms, lubricant, and information and/or training are recommended. Condom provision should include reliable information about sexual and reproductive health and clear pathways into services should be available.[73]

Provide have an eC-card app which can be accessed throughout Essex (excluding Southend). The app is available to everyone aged 16-24 years of age and enables young people to discretely collect free condoms and lubricant from a convenient pickup point. To access the service people must download the application, watch 3 short videos, and answer a simple questionnaire they are then given a unique QR code which they scan on arrival at their pickup point. People under 16 or that require additional support are signposted to the Thurrock Sexual Health help centre for advice and either face to face or virtual support.

Future provision of sexual health services should include a comprehensive offer providing condoms, lubrication, information, and advice throughout Thurrock.

8. Engagement

Solutions for Public Health (SPH) was commissioned to provide the qualitative data about the level of need and type of services required to support people requiring sexual health services.

[73] NICE. "Sexually transmitted infections: condom distribution schemes". *NICE Guideline [NG68]*. 2017.

The report also draws on qualitative information gathered from stakeholders about where local services are working well, and where there are barriers to support that some people experience. In addition, how service providers and agencies work together, and the gaps in provision for some population cohorts, particularly those with co-occurring conditions or complex needs are explored.

The key objectives for the engagement were agreed with Thurrock Council following contract award:

1. To present qualitative data concerning service needs and provision, to inform the recommissioning of local sexual health services. The focus is on organisations in contact with people with sexual health problems, and how services support the needs of the residents in Thurrock.
2. To identify gaps in the local service provision, including consideration of those who do not engage with services, and seeks to identify any barriers and potential solutions to lack of engagement.
3. To provide a literature review relevant to the subject matter and to include National and Local policy and structure.
4. To seek to identify any areas of quality improvement that might lend themselves to a Human Learning Systems (HLS) co-design approach.

The full document can be found in Appendix 1.

9. Future Service Provision

This Health Needs Assessment will inform future commissioning and strategy for Sexual Health in Thurrock. The below recommendations will be useful to develop a strategic ambition for sexual health in Thurrock, this should include aspirations for services and system wide approaches to prevention, early identification, and treatment of sexual health issues. These strategic ambitions will be realised over the long term, however there are some opportunities in the short to medium term to improve services and partnerships to deliver improvements in population sexual health.

10. Key Findings and Recommendations

Access to service and Service Model

Figure 90:

Topic	Findings	Relevant Section	Recommendation
Access to services	• The site of services in Orsett Hospital is based at the back of an old building which isn't easily accessible. • Service is appointment only. • Spoke clinics are not open. • There is limited inclusivity. • There is limited RSE provision from specialist services. • There is limited promotion of the service. • No community sexual health service for young people. • Opening hours are restrictive.	Pages 18 / 22/ 39 / 48	• The Provider and commissioner to review the use of drop in or same day clinic appointments. • The Provider to promote hub clinics. • RSE to be a focus of commissioning. • The Provider and commissioner to attend meetings including Head teacher and CEO, Mace, MASH, MARIC where required to ensure sexual health access is highlighted. • The Provider to develop a communication/promotion plan. • The Provider to move away from one central clinic. • The Provider to promote inclusivity and to provide specialist clinics where necessary. • The Provider and commissioner to review the clinic use of family hubs and women's hubs where possible. • The Provider to strengthen links with child exploitation team. • The Provider to promote the use of the hub clinic in Thurrock. • The Provider to ensure signposting to the clinic is in the main hospital. • The Provider to review the use of the buzzer access system to the clinic. • The Provider to review the opening hours with feedback from service users.
Service model	• Limited joint working with pharmacies and GPs. • Access within setting is restricted. • Service is difficult to engage.	Pages 13 / 115	• The Provider to adopt a whole systems approach to look at how commissioners and sexual health services link in with GPs, community pharmacy, probation, people in secure settings, drug, and alcohol services. • The Provider to adopt a whole system approach to those who support people who have experienced sexual violence and domestic abuse such as the refuge and SERIC. • The Provider should review the access to the service on arrival at the hospital.

	• The service doesn't allow chaperones supporting vulnerable people in the service. • The sexual health service no longer in reach into services where young people with LD lived to teach the support workers how to support them and talk about their bodies. • The service is clinical without a focus on inclusivity. • Cervical screening is not offered.		• The Commissioner and Provider for sexual health services must be more visible to key stakeholders. • The Commissioner and Providers must attend meetings relevant to their work, included but not limited to Brighter Futures, Multi Agency Child exploitation (MACE), and CEO and head teacher's forum. • The Commissioner and Providers should ensure they are well represented throughout Thurrock to increase their profile in the community, ensuring that stakeholders are aware of how to refer into services. • The Commissioner and providers need to work together to ensure that the HLS model is embedded and work closely with other service providers and the community to build an integrated system in Thurrock. • The Provider to look at alternative sites such as Grindr, Scruff or Taimi to enhance profile. • The Commissioner and Provider to ensure LD and chaperones entering the service of the expectation and rationale for seeing the service user alone for initial contact. • The Commissioner and Provider to ensure that dual trained clinician appointments are advertised throughout Thurrock. • The Commissioner to review process for cervical screening (currently GP).
Joint Working	• Lack of integrated working within Thurrock. • Lack of integrated working with neighbouring services. • Lack of awareness of sexual health services in Thurrock. • Lack of visibility in specialist meetings (including MACE, headteachers forum and Primary Care).	Pages 102 / 103 / 115	• The Provider to improve joint working of services across Essex and neighbours to ensure equity of services and ease of access for service users. • Thurrock LGBTQQIP2SA residents will go to Chelmsford Pride as there isn't one in Thurrock, so providers need to be visible at this and other related events. • The Provider to develop joint working between sexual health services and the Child exploitation and missing team. • The Commissioner and Provider to develop more integrated system approaches to governance and the planning of sexual health services. • The Provider to improve networking and engagement with other services such as the drug and alcohol team. • The Commissioner and Provider to improve partnerships from both a strategic and operational perspective.

			• The development of a Sexual Health Strategy for Thurrock could be the catalyst to improve partnership work.
Training and Education	• RSE is recognised as an important first step into engagement with sexual health services and good relationship and sexual health care. • Schools are not aware of current offer. • The current contract focuses on a small element of training the trainers regarding sexual health. • There are no 1-1 sessions available in schools. • Staff don't appear to be trauma informed.	Pages 6 / 18 / 19 / 22 / 23 / 25 / 33 / 39 / 41 / 42 / 46 / 47 / 48 / 50 / 51 / 56 / 58 / 59 / 60 / 64 / 65 / 84 / 91 / 94 / 104 / 106 / 107 / 115 / 122 / 125 / 126 / 127	• Sexual Health staff should receive training to support development of communication skills with different groups e.g., to become trauma informed, appropriately support people attending psychosexual and sexual assault, and communication with people with a learning disability. • The Provider must inform schools about service changes and the benefits of taking up staff training by the provider to ensure all schools are aware and become engaged. • The Commissioner and Provider should attend CEO and headteacher forums to ensure education colleagues are aware of training offered and improve take up of offer. • The Commissioner to review the RSE element of the sexual health contract. • The Provider to promote access to services for students referred by the school and related services. • The Provider to deliver specialist education and training to deliver RSE to ensure high quality provision.

Improving Diagnosis of New STIs

Figure 91:

Topic	Key Findings	Relevant Section	Recommendations
STI Testing & Diagnosis	• The STI diagnosis rate has declined in Thurrock since 2017, and it is unclear how vulnerable groups are affected by the decline in diagnoses. • In the most recent data (2021), the diagnosis rate in Thurrock is lower than CIPFA neighbours but similar to East of England; the testing rate is lower than both CIPFA neighbours and East of England; with a corresponding positivity rate that is similar to CIPFA but higher than East of England. • The CIPFA neighbours with the highest diagnosis rates also have high testing rates. • Qualitative feedback from stakeholders and residents suggested that a high proportion of Thurrock residents were not aware of Thurrock sexual health services, and that other professionals were not clear how to refer into the service.	Pages 6 / 19 / 20 / 29 / 32 / 49 / 50 / 76 / 77-80	• The Provider must continue to review and evaluate data recording to improve recording and reporting of protected characteristics to gain a better understanding of potential inequities in Sexual Health outcomes across Thurrock including older age STIs. • The Provider should develop an Action Plan to increase uptake of STI testing to reduce the burden of undiagnosed infection in Thurrock, including: ○ Increasing awareness of the need for regular STI testing among vulnerable groups and those at higher risk ○ Increasing referrals from other services. • The Provider, working in collaboration with OHID, UKHSA and the commissioner must monitor and respond to new and emerging threats such as Mgen and drug resistant infections.
Chlamydia	• Chlamydia detection rates in Thurrock are some of the lowest among the CIPFA neighbours' group, with screening rates being only 10% of the 15–24-year-old population in 2021. The areas with the highest detection rates also have the highest screening rates.	Pages 6 / 18 / 20 / 32 / 34 / 35 / 37 / 40 / 52 / 55 / 57 / 78-80 / 82 / 84 / 118-119	The Provider should develop an Action Plan to increase awareness and uptake of chlamydia screening among male and female 15–24-year-olds, to reduce the burden of undiagnosed infection in Thurrock.

HIV	• Since 2018, fewer new sexual health service attendees in Thurrock accept an HIV test than is typical across East of England or among CIPFA neighbours. The gap is greater for women. • Repeat testing in gay, bisexual, and other MSM compares well to England averages. In comparison to CIPFA neighbours, Thurrock is at the higher end of the range. • Thurrock's HIV prevalence rate is similar to the England average at 2.4 per 1,000 between 15-59 years, but late diagnoses have increased since 2016-18 across both England and Thurrock.	Pages 6 / 13 / 17-20 / 22 / 23 / 38 / 40 / 50 / 52 / 55 / 56 / 60 / 84 / 88 / 89 / 91 / 92 / 94-103 / 116-119	• The Provider must continue to closely monitor HIV testing vs HIV late diagnosis rates in Thurrock population and learn from HIV late diagnosis events through retrospective look backs to identify missed opportunities and a pro-active Human Learning System approach. • The Provider should develop an action plan to: ○ Increase HIV testing among new attendees, especially women. ○ Reduce late presentation for HIV testing. ○ Increase uptake of PrEP among those who have been identified as being able to benefit.
Hepatitis	There may be an under-identification of hepatitis C in Thurrock due to a lower-than-average proportion of injecting drug users being engaged in treatment. Referrals between sexual health and substance misuse services and joint working may increase uptake by those at risk.	Pages 41 / 55 / 102-104 / 116-118	• The Provider should consider how to: • Increase engagement of injecting drug users in drug treatment and ensure uptake of hepatitis C testing. • Strengthen joint working between sexual health and substance misuse services.

Contraception, Conception, and Abortion

Figure 92

Topic	Key Findings	Relevant Section	Recommendations
Conception and Abortion	• Under 18 conception rates have decreased since 2017 in line with national and regional trends. • Whilst the abortion rate in Thurrock has increased since 2017 and in 2021 was 22 per 1000 females; the percentage of U18 conceptions leading to abortion has remained stable, albeit higher than national, regional and CIPFA comparators. • The rate of repeat abortions in Thurrock has increased since 2017.	Pages 13 / 14 / 17 / 20 / 21 / 31 / 32 / 34 / 60-64 / 74 / 116 / 120 / 124 / 125	• The Provider must review the accessibility of contraception services across Thurrock and surrounding geographies to ensure that good quality contraception services are accessible at a time and place that is convenient for the service user. • The Provider must ensure consistent education and advice on the preferred method of contraception is available to service users through a range of formats, utilising a range of existing services as appropriate such as primary care and school nursing. • Thurrock PH team to conduct further analysis into why the rate of repeat abortions is increasing and the groups most at risk with the aim to identify appropriate preventative actions. • The Commissioner, Provider, and associated services to develop an action plan for focusing on groups most at risk of unplanned conception and/or abortion such as sex workers or those with addiction.
LARC	There are lower levels of LARC activity in Primary Care	Pages 6 / 18 / 20 / 21 / 25 / 37 / 46 / 50 / 52 / 58 / 64-71 / 74 / 91 / 116 / 124 / 125	• The Provider must ensure the continued collection of data around LARC recovery rate following the pandemic, teenage pregnancy, repeat abortions, to respond better to those needs. • The Provider must work collaboratively with pharmacies delivering contraceptive services and monitor impacts of over-the-counter contraceptive pill availability. • The Commissioner and Provider must strengthen joint working between sexual health and Primary Care and support them to increase their skill base where necessary.

11. Conclusion

Stakeholders on the whole described Thurrock Sexual Health Services as a competent effective service for people who accessed it. However overall professionals working in and around the service have described several ways that the service is not meeting the needs of the Thurrock population.

There are accessibility issues regarding the main site which are exacerbated due to there being no “spoke” sexual health clinics in Thurrock.

Stakeholders repeatedly mentioned that people were likely to go elsewhere for sexual health services due to better access and friendlier more approachable up to date staff and settings.

A clear theme was the lack of joint working or even informal networking with any other teams that would form the basis of a relationship and information sharing.

There is a need to expand the RSE element of the service and to build relationships either with community groups or schools. RSE is not a mandated function of the sexual health service or contract however the development of a comprehensive package to schools and community settings could form a vital part of the prevention work required to reduce STIs and unwanted pregnancy.

Whilst the sexual health service is currently delivering all the key performance indicators (KPIs) to the expected level this needs assessment has demonstrated that many of the aspects of the service that need to be reviewed in a new service model cannot be counted or numerated. A new service needs to be integrated into the wider community, the service leads need to be central to education, primary care, and stakeholder meetings.

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Your Thurrock. *Homelessness rises by a ‘shocking’ 20 per cent in Thurrock*. 13 January 2023.

Yumori, Caitlin, et al. “Women are less likely to be tested for HIV or offered PrEP at time of STI diagnosis.” *Sexually Transmitted Diseases* (2021): 48(1) pg.32-36.

Papers of Interest

Towards Zero: the HIV Action Plan for England 2022-2025

Sexual and reproductive health and HIV: applying All Our Health

A Framework for Sexual Health

Syphilis Action Plan

Teenage Pregnancy Prevention Framework (publishing.service.gov.uk)

hiv-sexual-and-reproductive-health-2014

promoting-the-health-and-wellbeing-of-gay-bisexual-and-other-men-who-have-sex-with-men

public-health-services-non-mandatory-contracts-and-guidance-published

commissioning-sexual-health-services-and-interventions-best-practice-guidance-for-local-authorities

sexual-and-reproductive-health-and-hiv-applying-all-our-health

sexual-health-commissioning-local-government-

NICE Sexual Health Quality Standard (QS178)

Further Reading

Acceptability of remote prescribing and postal delivery services for contraceptive pills and treatment of uncomplicated Chlamydia trachomatis

Access to healthcare for street sex workers in the UK: perspectives and best practice guidance from a national cross-sectional survey of frontline workers

Access to, usage and clinical outcomes of, online postal sexually transmitted infection services: a scoping review https://pubmed.ncbi.nlm.nih.gov/32380261/

Barriers to older adults seeking sexual health advice and treatment: A scoping review.

Changes in the prevalence and profile of users of contraception in Britain 2000-2010: Evidence from two National Surveys of Sexual Attitudes and Lifestyles

Expanding choice through online contraception: a theory of change to inform service development and evaluation https://srh.bmj.com/content/46/2/108

Healthcare provider and service user perspectives on STI risk reduction interventions for young people and MSM in the UK https://sti.bmj.com/content/96/1/26

Department of Health and Social Care. Health and Social Care Act 2012 Available http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted [accessed June 2021]

Department of Health and Social Care. Abortion Statistics, England and Wales: 2019. Available from: https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2019.

Hughes G, Field N. The epidemiology of sexually transmitted infections in the UK: impact of behaviour, services and interventions. 2015;10(1):35-51.

Appendices

Appendix 1 - Full Report Solutions for Public Health

Thurrock Sexual HNA - engagement report.

Appendix 2 - Literature Review

A literature review was conducted by The North East London NHS Foundation Trust on behalf of Public Health Thurrock. [PH Bulletin] Evidence on Sexual Health Needs Assessment SN40868. Stephen Reid. (7th March 2023). ILFORD, UK: NELFT Library and Knowledge Service

Sources searched British Pregnancy Advisory Service (1) Faculty of Sexual & Reproductive Healthcare (1) Local Government Association (LGA) (2) NICE Guidance (1) Public Health England (PHE) (2) The Faculty of Sexual & Reproductive Healthcare (2) UK Health Security Agency (UKHSA) (1)

Date range used (5 years, 10 years): 2020 - 2023 Limits used (gender, article/study type, etc.): English language; adults Search terms and notes (full search strategy for database searches below):

Searches were carried out in a range of databases: Embase, HMIC, Medline, Social Policy, and Practice. In addition, the researcher searched NICE guidance, TRIP, Google Scholar, gov.uk, the FSRH website, the Service user Experience Library and the Local Government Association website.

The search terms used varied according to the source. For some of the individual sites, simple searches for "sexual health" and then "reproductive health" were used. For Google Scholar and for TRIP, the terms used were ("sexual health" or "reproductive health") AND (commissioning or policy or procure or provide or provision). The searches in Embase, HMIC, Medline and Social Policy and Practice expanded upon these terms to include database specific subject headings.

Appendix 3 - Commissioning Responsibilities

The Responsibilities of Local Authorities, Integrated Care Boards, and Primary Care Networks

- **Integrated care systems (ICSs)** are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area. An ICS is made up of an Integrated Care Board (ICB); integrated Care Partnership (ICP); Local authorities; Alliances; and Provider Collaboratives.
- The organisations that make up the Mid and South Essex Integrated Care System are: Mid and South Essex Integrated Care Board and Three upper tier local authorities: Essex County Council, Southend-on-Sea City Council (unitary), Thurrock Council (unitary)

- **Integrated Care Board (ICB)** - A statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget**,** and arranging for the provision of health services in the ICS area. NHS Mid and South Essex Integrated Care Board (ICB) is responsible for deciding how the NHS budget for mid and south Essex is spent. It is also responsible for developing a plan to improve people's health, deliver higher quality care and better value for money.
- **ICP** - A statutory committee jointly formed between the NHS integrated care board and all upper-tier local authorities that fall within the ICS area. The ICP will bring together a broad alliance of partners concerned with improving the care, health, and wellbeing of the population, with membership determined locally. Integrated Care Partnerships (ICPs) are committees that bring the NHS together with other key partners like local authorities to develop a strategy to enable the ICS to improve health and wellbeing in its area.
- **PCNS –** Primary Care Networks: PCNs are groups of GP practices within a Local Authority (e.g., Thurrock) working closely together with other healthcare staff and organisations to provide more joined up care to local communities. Thurrock is divided in to 4 PCNs.

Appendix 4 - Core20PLUS5

Core20

The most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD). The IMD has seven domains with indicators accounting for a wide range of social determinants of health, many of which may affect either risk factors or engagement with sexual health services:

Income.

Employment.

Education.

Health.

Crime.

Barrier to housing and services.

Living environment.

PLUS

PLUS population groups should be identified at a local level. Populations we would expect to see identified are ethnic minority communities; people with a learning disability and autistic people; people with multiple long-term health conditions; other groups that share protected characteristics as defined by the Equality Act 2010; groups experiencing social exclusion, known as inclusion health groups coastal communities (where there may be small areas of high deprivation hidden amongst relative affluence).

The plus population may also be within the core group, this group may have difficulty accessing sexual health services due to fear, stigma, restrictions, and ability to travel and may benefit form a hyper local service.

Inclusion health groups include people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery and other socially excluded groups.

5 (adult)

There are five clinical areas of focus which require accelerated improvement. Governance for these five focus areas sits with national programmes; national and regional teams coordinate activity across local systems to achieve national aims.

1. Maternity

Ensuring continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups. This model of care requires appropriate staffing levels to be implemented safely.

2. Severe mental illness (SMI)

Ensuring annual health checks for 60% of those living with SMI (bringing SMI in line with the success seen in learning disabilities).

3. Chronic respiratory disease

A clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations.

4. Early cancer diagnosis 75% of cases diagnosed at stage 1 or 2 by 2028.

5. Hypertension case-finding and optimal management and lipid optimal management to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke.

5 (children)

The five areas of focus are part of wider actions for Integrated Care Board and Integrated Care Partnerships to achieve system change and improve care for children and young people. Governance for these five focus areas sits with national programmes; national and regional teams coordinate local systems to achieve aims.

1. Asthma Address over reliance on reliever medications; and decrease the number of asthma attacks.

2. Diabetes Increase access to real-time continuous glucose monitors and insulin pumps across the most deprived quintiles and from ethnic minority backgrounds; and increase proportion of those with Type 2 diabetes receiving recommended NICE care processes.

3. Epilepsy Increase access to epilepsy specialist nurses and ensure access in the first year of care for those with a learning disability or autism.

4. Oral health Tooth extractions due to decay for children admitted as inpatients in hospital, aged 10 years and under.

5. Mental health Improve access rates to children and young people's mental health services for 0–17-year-olds, for certain ethnic groups, age, gender, and deprivation.

Appendix 5 - Hatfield Model to Tackle Health Disparities

The 16 Goals to tackle reproductive health disparities.

Ability to choose if and when to have children Access and standards of contraceptive care:

Goal 1. The proportion of pregnancies which are unplanned, unintended and/or ambivalent is reduced to less than 30% of all pregnancies by 2030 to ensure positive physical and mental health outcomes for women and children.

Goal 2. The gap between rates of unplanned, unintended and/or ambivalent pregnancies in disadvantaged areas as compared to those in advantaged areas is halved by 2030.

Access and standards of contraceptive care:

Goal 3. Integrated Care Systems (ICS), local authorities and providers promote the fulfilment of SRH rights including offering women and girls the full range of contraceptive methods in the location of their choosing, with quick access to local general practice and specialist services when needed.

Goal 4. Face-to-face and remote contraceptive consultations are patient-centred, with users feeling able to openly discuss their preferences, participating in decision-making effectively, as well as being informed about possible side effects and how to deal with them as per FSRH Quality Standards.

Goal 5. Enhanced access to contraceptive care, addressing the needs of all those who are the least well-served, with a particular focus on populations that experience the worst inequalities such as, but not limited to, women and girls living with disabilities, from low socio-economic backgrounds, from Asian and ethnic minority groups, black women/girls and women/girls of colour.

Goal 6. Access to Long-Acting Reversible Contraception (LARC) is made equitable across ICS geographies and demographics.

Goal 7. By 2025, free oral emergency contraception is available and funded in all community pharmacies across England, including to under 25s.

Goal 8. ICS should ensure that all methods of contraception are discussed with women during pregnancy and, where possible, their method of choice should be initiated prior to discharge from maternity services. Rapid follow-up pathways for LARC should be in place when needed.

Access to preconception care:

Goal 9. All women are offered comprehensive preconception care when they attend their contraception appointments in general practice, specialist SRH and community gynaecology services.

Access to menstrual health support:

Goal 10. Women and girls have access to a practitioner who is able to provide support, diagnosis and treatment for their menstrual health including pain, heavy bleeding and premenstrual mood disturbance at their general practice, specialist SRH services and community gynaecology services.

Goal 11. Women and girls have universal access to free menstrual products within health services and schools.

Access and standards of abortion care:

Goal 12. As per NICE guidance, all women and girls seeking abortion have access to a choice of method (medical or surgical), including the option to self-refer directly to a service, as well as access to the full range of contraceptive methods. Access to menopause care Maternal health outcomes in black women and women of colour

Access to cervical screening:

Goal 13. Each local authority area meets the national NHS Cervical Screening Programme target of 80% coverage by 2025.

Access to information:

Goal 14. Every woman is able to access a practitioner in their local area, such as a member of their primary care health team, who is able to provide menopause care, support them to manage symptoms and choose appropriate treatment if required.

Maternal health outcomes in black women and women of colour:

Goal 15. By 2030, widespread reproductive health disparities, particularly in maternal health outcomes, experienced by black women and women of colour as well as women and girls from Asian and minority ethnic groups, are significantly reduced.

Goal 16. Information is easily available to support women and girls in making decisions about their own reproductive health, ranging from signs and symptoms of gynaecological cancers to where to access support and care, regardless of age, ethnicity, language, disability, postcode, socioeconomic status, levels of literacy or religious belief. 8

Priority actions to tackle reproductive health disparities Workforce

Realising the 2030 Ambition and achieving the Goals will require priority action on:

Action 1. Community SRH specialty training posts are fully funded, with one new fully funded specialty training post per Health Education England region for the next three years, to provide local leadership, training and governance to the SRH workforce and services.

Action 2. The primary care workforce is adequately resourced to provide LARC fittings, removals and training. Local contracts should fully cover the costs of provision, training and maintaining access to this essential service.

Action 3. Service specifications for specialist SRH services are designed to include training requirements in their contracts. Commissioning.

Action 4. The NHS and ICS are mandated to collaboratively commission SRH with local authorities, and contracts with care providers require them to adhere to nationally recognised quality standards such as FSRH's Standards for Sexual and Reproductive Healthcare Services. Accountability.

Action 5. A National Clinical Director for women's reproductive health or a National Specialty Adviser in SRH, or similar, is appointed, who would hold accountability for the commissioning and outcomes of women's reproductive health.

Action 6. A women's health lead, with accountability for reproductive health, is appointed in every ICS Board to ensure that holistic women's reproductive health is prioritised in ICS strategies. Realising the 2030 Ambition and achieving the Goals will require priority action on: 10 Data and information.

Action 7. A national digital service platform is developed for SRH, which will serve as a one-stop point of access for the public and will support the maintenance of access to essential SRH care operating seamlessly with existing regional / local digital offers.

Action 8. The London Measure of Unplanned Pregnancy is introduced as the standard national measure of unplanned pregnancy.

Action 9. The Department of Education signposts teachers to reliable and evidence-based information on issues across the breadth of SRH, to support effective implementation of statutory relationships and sex education guidance. Health promotion.

Action 10. Providers are well-resourced to ensure that service staff use every contact with patients and the public to promote positive SRH and wellbeing in accordance with Making Every Contact Count principle.

Faculty of Sexual and Reproductive Healthcare Hatfield Vision: A Framework to Improve Women and Girls' Reproductive Health Outcomes (July 2022)

Appendix 6 - Thurrock Pharmacies

Figure 93:

Code	Name	Address	Postcode
FA736	Allcures Pharmacy	62 High Street, Grays	RM17 6NA
FF646	Allcures Pharmacy	Allcures House, Arisdale Avenue, South Ockendon	RM15 5TT
FG775	Allcures Pharmacy	Unit 1, Stanford House, Princess Margaret Road, East Tilbury	RM18 8YP
FGW47	Allcures Pharmacy	16 Kings Parade, Stanford-Le-Hope	SS17 0HP
FQV22	Allcures Pharmacy	19 Lampits Hill, Corringham, Stanford-Le-Hope	SS17 9AA
FKK05	Allcures Plc	Purfleet Care Centre, Tank Hill Road, Purfleet	RM19 1SX
FNT96	Armada Pharmacies Ltd	1 Drake House, Drake Road, Chafford Hundred	RM16 6RX
FFP86	Asda Pharmacy	Thurrock Park Way, Tilbury	RM18 7HJ
FHF78	Boots	2 St Chads Road, Tilbury	RM18 8LB
FKD78	Boots	74/75 Thurrock Lakeside, Shopping Centre, West Thurrock, Grays	RM20 2ZG
FMX69	Boots	35-43 High Street, Grays	RM17 6NB
FNC41	Boots	1B Junction Retail Park, Western Avenue, Thurrock	RM20 3LP
FQ578	Boots	83-85 St. John's Way, Corringham, Stanford-Le-Hope	SS17 7NA
FQQ40	Boots	17 Derwent Parade, South Ockendon	RM15 5EF
FPW42	Dips Chemist	12 Defoe Parade, Chadwell St. Mary	RM16 4QR
FQK60	Dock Pharmacy	128 Dock Road, Tilbury	RM18 7BJ
FDN49	Essex Pharmacy	2 Civic Square, Tilbury	RM18 8AD
FT060	Hassengate Pharmacy	Southend Road, Stanford-Le-Hope	SS17 0PH
FNT35	Hemants Chemists	10 Derwent Parade, South Ockendon	RM15 5EE
FD776	LloydsPharmacy	Burghley Road, Chafford Hundred	RM16 6QQ
FLQ07	LloydsPharmacy	31 Lodge Lane, Grays	RM17 5RY
FTK09	Ohms Pharmacy	32 High Street, Aveley	RM15 4AD

FW514	Riverview Pharmacy	22 River View, Chadwell St. Mary, Grays	RM16 4BJ
FKL83	South Road Pharmacy	1 South Road, South Ockendon	RM15 6NU
FW449	Steve's Chemist	36 Bridge Road, Grays	RM17 6BU
FX248	Stifford Pharmacy	16 Crammavill Street, Stifford Clays, Grays	RM16 2BD
FJ599	Tesco in-Store Pharmacy	Tesco Store (Instore Phcy), Cygnet View, West Thurrock	RM20 1TX
FA673	Unicare Pharmacy	22 St Johns Way, Stanford-Le-Hope, Corringham	SS17 7LJ
FMM25	Unicare Pharmacy	34 East Thurrock Road, Grays	RM17 6SP
FQG23	Unicare Pharmacy	89 Orsett Road, Grays	RM17 5HH
FCJ06	Vision Pharmacy	11 Crammavill Street, Stifford Clays, Grays	RM16 2AP
FM809	Well	22 High Street, Aveley	RM15 4AD

Appendix 7 - Stages of Syphilis

Syphilis can be described in three stages, primary, secondary and tertiary each of these stages has symptoms specific to them.

First stage (primary syphilis)

- Ten days to three months after you become infected a painless sore (called a ‘chancre’) may appear where the infection is. This is usually on the penis or vagina, in the mouth or around the rectum. Some people get several sores.
- Glands in your neck, groin or armpits may swell.
- The sores are very infectious. They heal after about two to eight weeks and disappear.

Second stage (secondary syphilis)

- A few weeks after the sore disappears you may get:
- a blotchy rash on your body, often on the palms of your hands or soles of your feet.
- patchy hair loss.
- white patches in your mouth.
- growths like genital warts appearing near the anus and also near the vulva.
- The rash and growths are infectious.
- You might also feel ill, with a fever or headache, and swollen glands, and suffer weight loss.

Third or late stage (tertiary syphilis)

- Syphilis can go on to cause serious damage to your heart, brain, bones and nervous system, years later. This damage can be life-threatening.
- You could experience stroke, blindness, heart problems, dementia and loss of co-ordination.
- It can still be treated at this stage, but it might not be possible to repair damage that has been done.

If stage one is not treated it may advance to secondary or stage 2 syphilis. Between stage 2 and 3 you can't see or feel any signs or symptoms of syphilis. The disease becomes latent, which means hidden. It can still be passed on during this time for up to two years.