Sexual & Reproductive Health & Human Immunodeficiency Virus (HIV) Needs Assessment: North East Lincolnshire

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Abbreviations

ACT – Advice, Contraception, and Testing

AIDs – Acquired Immunodeficiency Syndrome

ALS – Adolescent Lifestyle Survey

APPG – All Party Parliamentary Group

APPG SRH – All Party Parliamentary Group on Sexual & Reproductive Health

ART– Antiretroviral Therapy

BASHH – British Association of Sexual Health and Human Immunodeficiency Virus (HIV)

CIPFA – Chartered Institute of Public Finance and Accountancy

CPD – Continued Professional Development

CSE – Child Sexual Exploitation

CSEW – Crime Survey for England and Wales

DoH – Department of Health

DPoW – Diana Princess of Wales

EHC – Emergency Hormonal Contraception

EHE – Elected Home Educated

FSF – Females who have Sex with Females

GPs – General Practitioners

GRAFT – Gaining Respect and Finding Trust

HCRG – Health Care Resource Group

HE – Health Education

HIV – Human Immunodeficiency Virus

HPV – Human Papillomavirus

HSAC – Hormonal Short Acting Contraceptives

IAG – Information, Advice, and Guidance

ICB – Integrated Care Board

IMD – Index of Multiple Deprivation

ISHS – Integrated Sexual Health Service

IUD – Intra-Uterine Device

IUS – Intra-Uterine System

IVF – In Vitro Fertilization

LA – Local Authority

LARC – Long-Acting Reversible Contraception

LETB – Local Education And Training Boards

LGA – Local Government Association

LGBT – Lesbian, Gay, Bisexual, and Transgender

LSOAs – Lower Super Output Areas
MASH – Multi-Agency Sexual Health
MH – Mental Health
MSM – Males who have Sex with Males
NCSP – National Chlamydia Screening Programme
NDTMS – National Drug Treatment Monitoring System
NEL – North East Lincolnshire
NEL – North East Lincolnshire Council
NELDO – North East Lincolnshire Data Observatory
NHS – National Health Service
NL – North Lincolnshire
NLISHS – Northern Lincolnshire Integrated Sexual Health Service
OHID – Office for Health Improvement and Disparities
ONS – Office for National Statistics
PANSI – Projecting Adult Needs and Service Information System
PEP – Post-Exposure Prophylaxis
PHE – Public Health England
PID – Pelvic Inflammatory Disease
PRC – Police Recorded Crime
PrEP – Pre-Exposure Prophylaxis
PSHE – Personal, Social, Health, and Economic Education
RSE – Relationships and Sex Education
SARCs – Sexual Assault Referral Centres
SCSs – Specialist Contraceptive Services
SEND – Special Educational Needs and Disabilities
SRHAD - Sexual and Reproductive Health Activity Data Set
SRHSs – Sexual and Reproductive Health Services
STI – Sexually Transmitted Infection
STIs – Sexually Transmitted Infections
ToPs – Termination of Pregnancies
UKHSA – United Kingdom Health and Security Agency
UNPF – United Nations Population Fund
YPSS – Young People's Support Service

Executive Summary

Population and Demographics

At the time of The Census 2021 – the last population-level survey of North East Lincolnshire (NEL) – there was 156,972 residents. 20.9% (32,838 people) of this were aged over 64 years, 61.5% (96,589 people) were aged 15 to 64 years, and 17.6% (27,545 people) were aged under 15 years. Also, out of the NEL population, 10.4%, or 16,372 people, were aged 15 to 24 years (an age group disproportionately affected by Sexually Transmitted Infections (STIs). Of the female population, 35.2%, or 28,217 females, were of reproductive age (15 to 45 years (Office for National Statistics (ONS), 2020)) and 14.5%, or 11,653 females, were of an age where they are most likely to be menopausal. Population projections from 2018 project the 15 to 19 and 20 to 24 age bands to grow up to 2030, while the number of females of reproductive age stays static and the number in the age range for the menopause falls.

The Census also provided demographic data for vulnerable groups, i.e., those with worse sexual and reproductive health outcomes. 96.2% of the NEL population was White, 1.6% were Asian, 0.5% were Black, 1% had a mixed/multiple ethnic group(s), and 0.7% had another ethnic group, like 'Arab;' 90.8% said they were heterosexual, 1.2% said they were gay or lesbian, 1.1% said they were bisexual, and 0.3% identified with another minority sexual identity; 94.2% said they were cisgender, and 0.46% said their gender was different to that assigned at birth, including 0.17% who were transgender men or women; 20.1% of the whole population are disabled, per The Equality Act (2010). Continuing with disability, Projecting Adult Needs and Service Information System (PANSI) states 2,230 that of those aged 18 to 64 in 2020, 2,230 had a learning disability, 17,399 had a common mental health disorder, 5,283 had impaired mobility, and 9,716 had some hearing loss (Oxford Brookes University; Institute of Public Care., 2020), suggesting they – along with those others with additional health needs – may need support to access the service.

Overall, NEL has a relatively small population of ethnic, sexual, and gender minorities and disabled people, though the Census 2011 shows the population that is an ethnic minority has grown and that the proportion of disabled people has fallen slightly. It is also of note that the Adolescent Lifestyle Survey (ALS) 2021 showed the proportion of secondary school children that are ethnic, sexual or gender minorities to be larger than the general population. Each of these groups face access issues specific to their needs, be it because healthcare providers misunderstand [lesbian, gay, or bi] health needs (as is the case nationally for 25% of Lesbian, Gay, Bisexual, and Transgender (LGBT) people (Stonewall, 2018)), or because of the experience of discrimination (as is the case nationally for 65% of black people (Black Equity Organisation, 2022)). This, combined with the wider determinants and other factors, leads to

inequalities, like Black people's Sexually Transmitted Infection (STI) rate being three to 3.5 times higher than White People's in the region (United Kingdom Health and Security Agency (UKHSA), 2022), or 27% of transgender people completely avoiding gendered healthcare (TransActual, 2021).

Deprived areas also suffer dire inequalities, like the linear, stepwise increase in pelvic inflammatory disease related admissions with deprivation at a national level. Per the Index of Multiple Deprivation (IMD), NEL is the 29th most deprived Local Authority (LA) in England – 30%, or 32, of its Lower Super Output Areas (LSOAs) are in the most deprived 10% in England and 10.3% of its LSOAs are in the most deprived 1%. West Marsh, East Marsh, and South have the lowest average decile rank for their LSOAs, with 1.0, 1.3, and 1.6, respectively (1 is the most deprived and 10 is the least).

The ALS 2021 also provided insights on young people as an overrepresented group in many sexual and reproductive health-related metrics. It indicated the amount that children in years 9 to 11 know about STIs is very little and has decreased since 2019; only as little as 11.7% had never heard of Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDs), and as much as 32.8% had never heard of genital warts. Moreover, 13.2% said they had had sex, 54.7% did not know where to go to get free condoms, 26.9% did not know where to go to get an abortion, and 97.5% did not have a C-Card.

Sexual Health in NEL

As the local authority emerged from the pandemic, there has been an apparent change in some areas of the provision of and demand for sexual health services. Screening for chlamydia and HIV [in women] fell sharply in 2020 and, by 2022, rebounded to the level they were at in 2019. But while testing heterosexual men and MSM for HIV saw similar drops in 2020, they have not yet rebounded to that earlier level. Overall, the STI testing rate – excluding chlamydia in the under 25s – is 2,590.4 in NEL, compared to 3,856.1 in England (OHID, 2022). And the proportion that test positive is 9.8% in NEL, relative to 7.6% in England (OHID, 2022). So low testing is likely to be obscuring a fuller picture with a higher, undiagnosed prevalence.

On chlamydia specifically, in 2022, 21.4% of 15-24 year—old residents were screened, with a considerable rise in the most recent year meaning NEL's coverage is statistically significantly higher than England. A diagnostic rate of 159 cases per 100,000 population for males and females over 25 puts NEL below England's (178), but not statistically significantly so.

NEL's total HIV testing coverage (39.6%) presents a broadly negative trend, as it is statistically significantly lower than England (48.2%) (OHID, 2022), which is likely due to the statistically

significant difference between the two in the case of testing women and heterosexual men. This is likely to affect NEL's status as having an HIV diagnosed prevalence rate per 1,000 people aged 15-59 (0.94) that is statistically significantly lower than England's (2.34) (OHID, 2022), just as it is likely to affect the rate of new diagnoses, though there was no significant difference between NEL and England in that case.

Other STI statistics from 2022 show that NEL's diagnostic rate [per 100,000] of infectious syphilis (primary, secondary, and early latent) was statistically significantly lower than England's. But there was no statistically significant difference between the national and the local rates in the case of Gonorrhoea, Genital Herpes, Genital Warts, or HIV; NEL's chlamydia detection rate in 15-24-year-olds was statistically significantly higher than England's in both males and females, but this is a positive trend – the diagnostic rate in those aged 25 and over is also statistically significantly higher, but this not positive.

PID is usually a consequence of untreated chlamydia. NEL had a rate of 163.8 admissions with PID as a primary or secondary diagnosis per 100,000 females (aged 15 to 44) in 2021/22 (OHID, 2022). The rise from that to England's figure (224.4) was statistically significant..

In the same vein of STI-related complications, HPV – a group of viruses – may also lead to cervical cancer. In NEL, the proportion of eligible females aged 25 to 49 screened for cervical cancer in the last 5.5 (73.2%) was statistically significantly higher than England (67.6%) in 2022 (OHID, 2022). For 50 to 64-year-olds, these figures were 75.8% and 74.6% (OHID, 2022), respectively, and a statistically significant difference is remains. Uptake among the older group has fallen year-on-year since 2015, while figures have only been falling since 2020 in the case of the younger group.

Vaccines protect against HPV and are administered to children once in year 8 and again in 9 as part of a national programme. All figures are for 2021/22: 64.9% of females received the first dose, which was statistically significantly lower than England's proportion (69.6%) (OHID, 2022); 77.5% of females received the second dose, which was statistically significantly higher than England's proportion (67.3%) (OHID, 2022); 53.8% of males received the first dose, which was statistically significantly lower than England's proportion (62.4%); and lastly, 72% of males received the second dose, which was significantly different to the 62.4% who received it nationally (OHID, 2021).

Reproductive Health in NEL

People's behavioural changes during the pandemic undoubtedly affected their reproductive health too. The restrictions on interpersonal interactions and consequent reductions in sexual

mixing and the amount of sex people had broadly, especially in young people, affected change. Similarly, the drop in access to contraception also affected change over this period, with provision of user-dependent methods, Long Acting Reversible Contraception (LARC), emergency contraception, and in some instances, oral contraception, all either ceasing or being substituted with a less resource-intensive method for the provider.

The pandemic also coincided with an increase in Child Sexual Exploitation (CSE) and domestic violence nationally. Local data suggests a spike in CSE, but per police recorded crime, domestic abuse had decreased year-on-year since 2018/19 (OHID, 2022), and sex offences had risen to a peak in the rate of 3.8 per 1,000 people in 2021/22 after falling every year since 2018/19 (England's rate was 3 in 2021/22 and was statistically significantly lower [than NEL] (OHID, 2022). However, police recorded crime data does not count unreported incidents or those the police do not pursue, so is a significant underreport in itself.

Sexual and reproductive health service data from NEL in 2021/22 suggests the implant was the most popular contraceptive method among females, with 32% having it as a main method, while 19% chose the pill, 14% chose an Intra-Uterine System (IUS), and 12% chose the male condom (National Health Service (NHS) Digital, 2022). The implant was the most common amongst individuals in their 20's while the Intra-Uterine System and Intra-Uterine Device (IUD) was the most common choice of LARC for women 35 years and over; the Dep-Provera injection was the least common choice of LARC for females in NEL.

In 2021, the rate of LARC (excluding injections) prescribed by General Practitioners (GPs) and sexual health services to females aged 15 to 44 in NEL was 55.9 per 1,000 females. This was statistically significantly higher than England's rate (44.9) (OHID, 2021). However, at one female receiving a prescription per 1,000 females in NEL, the provision of emergency contraception was much lower locally than nationally (3.5) (NHS Digital, 2023) (though this is not necessarily a statistically significant difference). Also, the attendance of 15 to 24-year-olds at Specialist Contraceptive Services (SCSs) is low in NEL – in males, NEL's rate (1.2 males attending per 1,000 males) is almost a tenth of the national rate (11.5) (a statistically significant difference) and has decreased yearly since 2015 (OHID, 2021). In females, NEL's rate (77.5) is below England's (82.6), but the gap is not statistically significant (OHID, 2021).

The conception rate for 15 to 44-year-olds was 54.6 live births per 1,000 females in NEL – just above England's (54.3) (OHID, 2021). This is much higher in more deprived wards, with West Marsh's and East Marsh's rates almost double Haverstoe's. Conceptions in under 18s and under 16s are concerns in NEL and have been since before 2015, although NEL's figures for these metrics are amongst the highest seven in the country. Specifically, the rate of

conceptions to 15-17-year-olds per 1,000 population in 2021 was 27.3 – over twice the England rate (13.1) (OHID, 2021) (a statistically significant difference). The conception rate for 13-15-year-olds was smaller, but the gap between NEL (5 conceptions per 1,000 population) and England (2.1) was also statistically significant (OHID, 2021).

Repeat abortions and those following a birth in the under 25s are both high in NEL, with its figures being amongst the top two highest in the country. Also, the under 18s abortion rate and the proportion of conceptions to under 18s that end in an abortion has fallen yearly since before the pandemic, though access is not implicated as a problem, as the proportion occurring under 10 weeks gestation is high (90.5%), relative to England. The total abortion rate for 15-44-year-olds is 20.6 per 1,000 females – not being statistically significantly different to England's (19.2).

Commissioning Sexual and Reproductive Health Services in NEL

In 2017, the sexual health contract in NEL was recommissioned together with North Lincolnshire (NL) Council. Both local authorities went out to market together with one service specification and one contract for a 'Northern Lincolnshire Integrated Sexual Health Service' (NLISHS) The provider was Virgin Care, but this has since been bought out by Health Care Resource Group (HCRG) and has been in place since December 1st, 2021.

North East Lincolnshire Council (NELC) also commissions a contract with participating General Practice (GP) surgeries to provide Long-Acting Reversible Contraception for the residents of NEL. This is open to all women and participating GP surgeries provide three types of LARC which are Implant, IUS, and IUD. There are also other sexual and reproductive health service providers in NEL. Providers include pharmacies, secondary care - Diana Princess of Wales (DPoW) hospital, some voluntary organisations, Youth services and school nurses.

The majority of NEL residents access sexual health care via Stirling Street Medical Centre in Grimsby, which is NLISHS's main hub in Grimsby and also, the majority of individuals who accessed sexual health services in NEL were from East Marsh. **NOTE:** Sexual health services provided by **NLISHS in NEL** is referred to as the **Integrated Sexual Health Service (ISHS)**.

Insight from sexual and reproductive health service providers in NEL revealed the following. Overall, in NEL, more females than male attend sexual health clinics. There was a decrease in the number of appointments made at the clinics between 2018/19 and 2021/22 and this is attributed to the Covid-19 pandemic. The highest **number of attendances** at sexual health services in the last 5 years was in the 20 to 24-year-olds. The period 2022-2023 saw a

significant increase of under 16s accessing sexual health services, 225 individuals, the highest in 5 years.

The sexual health offer delivered by pharmacies falls under the “Advice, Contraception, and Testing” (ACT) service. There are currently 34 pharmacies located within NEL and 30 of these are locally commissioned by the council to deliver the ACT service. Over a fifth of interactions between pharmacists and clients were with individuals aged under 20 years while two fifths were with individuals aged 20 to 29 years. Just under 40% of NEL interactions were with client’s resident in East Marsh, Heneage, and Sidney Sussex wards. Also**,** over 65% of all condom supply interactions were provided by Sai Dutt pharmacy located at Wellington Street in East Marsh.

Emergency hormonal contraception (EHC) known as the 'morning after pill' is used in the prevention of pregnancy after unprotected sex. In NEL, EHC is provided free to people aged between 13 to 18 years. Data shows that in 2022/23 only 23 ACT pharmacies in NEL were active for EHC and that over half of requests for EHC were due to unprotected sex. While almost two thirds of EHC consultations were with clients aged **under 30 years**, 35% of EHC consultations with NEL residents were with clients living in Heneage, East Marsh, and Sidney Sussex wards.

HIV treatment in NEL operates as part of a hub and spoke model with the central hub in Castle Hill Hospital inn Hull. Patients from NEL have a choice of 4 locations in which they can access treatment including Castle Hill Hospital in Hull, Hull Royal Infirmary, Scunthorpe General Hospital, and DPoW Hospital. A clinic is held DPoW Hospital once a week.

Positive Health (a sexual health charity) provides support to men who have sex with men (MSM) and men living with HIV. The team are commissioned by HCRG to provide outreach work in public sex areas in the borough with a focus on HIV education and prevention, distributing free condoms, and signposting to local sexual health services where necessary.

Emerge (a voluntary sector organisation in NEL) was established in 2019. This service exclusively provides support and holistic care to sex workers in the area through a 3-tiered approach namely practical support, therapy, and network integration.

Open Door – a GP surgery – also provides healthcare, social support services, information, advice, and guidance to vulnerable members of the community. Commissioned by the NEL Integrated Care Board (ICB), outreach support is given to female/male street sex workers in the area once a week. HIV testing is also provided once a month at a drop-in clinic at Open Door.

Young people in NEL are provided Relationships and Sex Education (RSE) and Health Education (HE) via Personal, Social, Health, and Economic Education (PSHE). A survey carried out in schools in NEL shows that all 36 responding schools had a designated lead to champion the importance of RSE, HE, and PSHE. However, four of these reported that the lead is **not sufficiently resourced** to fulfil their role effectively. Three of these exceptions reported that time was the issue, while the other reported that funding was the issue. Also, 7 of the 29 schools which specified a ***most pressing training need***, reported that RSE training in some form is needed, making this the most popular priority in terms of training.

Health visitors in NEL have some training in providing brief advice surrounding contraception and may signpost to the sexual health clinic if appropriate. It should be noted that health visitors are registered nurses or midwives who have had additional training in public health nursing.

Commissioned by the council, school nurses in NEL offer young people guidance, signposting, and support. The service is provided to all young people aged 4 ½ - 19 as required. As part of an extensive sexual health offer, school nurses deliver wellbeing clinics in which pupils can access a variety of sexual health support. A texting service is also available for students who wish to ask for help. However, school nurses reported that children who are Elected Home Educated (EHE) and those with additional needs are at risk of missing out on vital sexual education.

The Youth Justice team in NEL works with young people aged 10-18 years from entering the criminal justice system for the first time, preventing re-offending, and supporting young people to change behaviour and integrate back into the community. In NEL there is the Young People's Support Service (YPSS) within NEL Council. YPSS is an umbrella service for a range of teams and functions that support young people. Also, within NELC children's services, the Gaining Respect and Finding Trust (GRAFT) team works with missing and exploited young people aged 11 years plus.

Currently, women access terminations via the Gynaecology Outpatient Department at DPoW Hospital. Terminations are offered up to 18 weeks in NEL. However, surgical abortion is not available in NEL.

A teenage midwifery clinic is provided by the antenatal ward in the hospital. For young people a dedicated Teenage Midwife Consultant offers IAG surrounding after care provision available after a termination or birth.

For antenatal support, midwives routinely discuss with the mothers on the ward about their future plans for contraception before they are discharged. Midwives will also refer to the sexual health service any woman who presents at the clinic with symptomatic sexual health concerns or a risk of infection. Nurses also link in with Safeguarding team to offer additional support to women who present at the ward with Special Educational Needs and Disabilities (SEND).

Barriers to service provision

Several barriers were also identified by the various sexual and reproductive health service providers discussed above**.** The barriers identified by each service are as follows:

Health Care Resource Group:

Withdrawal of community-based outreach due to lack of new nurses, healthcare staff and limited funding

- Lack of walk-in clinics
- Stigma of attending sexual health services
- Increased demand on service due to primary care directing patients to attend sexual health for contraception

Pharmacy:

- Loss of points of access due to NEL losing 8 pharmacies in 2023 as Lloyd's pharmacies are no longer signing any service provision contracts
- Financial struggles within community pharmacy
- Declining relationship between pharmacy and sexual health services
- Lack of knowledge amongst pharmacists

Positive Health – (predominantly provide support for MSM):

- Positive Health are restricted to outreach support resulting in limited support to those people living with HIV in NEL.

Secondary Care Services - HIV Treatment:

- Lack of peer support in NEL for those living with HIV
- Lack of knowledge from residents and health care staff
- Lack of routine testing
- Missed opportunities for early HIV detection
- Patients' reluctance to attend sexual health clinic due to capacity issues and stigma
- HIV services lack of access to free condom provision

Emerge and Open Door - Sex Worker Support Services

- Stigma attached to attending the sexual health clinic.

- Issues with accessing sexual health clinic due to appointment-based model
- Difficulties with current model regarding testing, results, and treatment happening across different services.
- Not getting enough support from Primary Care to help in the reduction of sexual health clinics long waiting times.

Personal, Social, Health and Economic Education

- Delivery of PSHE is not consistent across NEL as teachers have expressed pressure and anxiety when speaking to students about sensitive topics.
- Lack of Multi-Agency Sexual Health (MASH) and young people's services

School Nurses

- School nurses not able to administer other forms of contraception such as LARC in Wellbeing Clinics
- Absence of Wellbeing Clinics in some schools due to schools' discretion
- Lack of confidentiality between students and school nurses due to parents wanting to know why their child is attending clinics

Young Peoples Support Service

- There are difficulties getting young people to attend sexual health services. Previously the team provided sexual health outreach via 'the johnny bus', a youth bus on wheels in which young people could access condoms and chlamydia testing. This is no longer available.

Gaining Respect and Finding Trust Team

- The lack of consistent sexual health representation at multi agency panels
- Young people reluctance to attend the sexual health clinic due to feeling embarrassed, layered with trauma the young people they support have experienced.

Secondary Care

- Midwives report that the pill is the most requested form of contraception, something that is not available on the ward due to financial constraints.
- Women over 18 are not routinely offered contraception upon discharge. Midwives still provide information surrounding contraceptive options but in order for women to access them, an appointment at their GP or sexual health clinic is needed.
- Midwives note a lot of mothers in the area are suffering with mental health issues, specifically with anxiety and depression.
- Midwifery have highlighted issues with repeat terminations in NEL.

- No Follow Up clinics post termination
- Women who have had a termination and are suffering with poor mental health have no specific mental health support in place.

Recommendations

The following recommendations have been made based on findings in the report. It is recommended that:

1. Community-based outreach of sexual and reproductive health services is in place ***(NELC).***
2. Capacity for administering contraception (such as LARC fitting) in the community needs to be increased ***(Commissioners of sexual health and reproductive health services working with providers across the health and care system i.e., Council, ICB and NHS providers)***
3. Stigma associated with attending sexual health clinic, and sexual health in general needs to be addressed through communications and marketing including social media (***Commissioners of sexual health and reproductive health services working with commissioner working with the provider- (HCRG and Primary Care)).***
4. There need to be more awareness raising of sexual and reproductive health services among residents, local services, and the local workforce i.e., increased visibility of sexual and reproductive health services ***(Commissioners of sexual health and reproductive health services working with providers across the health and care system i.e., Council, ICB and NHS providers).***
5. There needs to be improved access and availability to sexual and reproductive health service appointments i.e., need for walk in/ drop in clinics in sexual and reproductive health service for easier access services ***(Commissioners of sexual health and reproductive health services working with providers across the health and care system i.e., Council, ICB and NHS providers).***
6. Sexual and Relationships Health Education in schools and colleges need to be improved (***Commissioners of sexual health and reproductive health services working with schools/academies/ colleges),***
7. There is a need for reviewing and recommissioning of the pharmacy sexual health contract ***(Commissioners of sexual health and reproductive health services – NELC).***
8. There is a need for a multi- agency sexual and reproductive health forum/ better working between agencies / reduced fragmentation/ more information sharing ***(NELC with providers and system partners).***

9. There is a need for a peer support group for people living with HIV ***(Commissioners of sexual health and reproductive health services working with providers across the health and care system and service users).***
10. There is better HIV prevention – including improved HIV testing (this includes making testing more accessible, and making it routine), access to free condoms in HIV clinics, improved PrEP use, and workforce development HIV ***(Commissioners of sexual health and reproductive health services working with providers across the health and care system in liaison with service users).***
11. There is a relaunch of the C-card scheme across NEL ***(Commissioners of sexual health and reproductive health services working with providers across the health and care system.***
12. There is a need to provide specialist post termination counselling/mental health support to women who have had a termination ***(Commissioners of sexual health and reproductive health services working with providers across the health and care system).***
13. Something around HPV vaccine and screening for cervical cancer around 50 – 64 year olds – ***(Commissioners of sexual health and reproductive health services)***
14. *Offer the services of a sexual assault referral centre (SARC) i.e. medical, practical, and emotional support within the LA to anyone that is a victim of sexual violence.*
15. *Staff to be trained in the specific needs of all the service's user groups; ensure all systems use neutral language that does not make assumptions (**Providers of sexual health and reproductive health services)**.*
16. *There is a need to advertise the inclusivity of the offer, e.g., ensuring LGBTQ+ people are aware of contraceptive services (**Providers of sexual health and reproductive health services)**.*
17. *Advertise a written/free text submission portal for service users to make suggestions for service improvements on access; collate these (**Providers of sexual health and reproductive health services)**.*

1.0 Introduction

Sexual and reproductive health is a broad and important area of public health, affecting almost everyone during their lifetime since most adults in England are sexually active (PHE, 2018). It is an interesting and complex area of public health as it sits at the intersection of population health and individual healthcare, whilst also being connected to other areas of public health and public service such as education, substance misuse, and social care (PHE, 2015).

Sexual and reproductive health does not just involve preventing disease, infection, or dysfunction (Department of Health and Social Care (DHSC), 2018) (OHID, 2022). Instead, it relates to complete physical, mental, and social wellbeing in relation to sexuality and the reproductive system (United Nations Population Fund (UNPF), 2022) (OHID, 2022) (PHE, 2015).

Sexual and reproductive health therefore encompasses individuals having the freedom, self-esteem and emotional resilience to make their own decisions about the types of relationships they want to have, free from discrimination (Department of Health (DoH), 2013) (UNPF, 2022). It involves people having healthy, satisfying, safe and respectful sexual relationships, free from coercion and violence (OHID, 2022). and having the capability to reproduce and the freedom to decide if and when to do so (UNPF, 2022).

Sexual and reproductive health impacts everyone. At an individual level, the consequences of poor sexual and reproductive health can be lifechanging. At a population level, poor sexual and reproductive health impacts on the mortality, morbidity, and wider wellbeing of populations, incurring major financial costs (PHE, 2015) and having far reaching implications, such as on mental health and infant wellbeing. (DoH, 2013).

National government highlight the need for local commissioners to carry out a needs assessment of local sexual and reproductive health during the commissioning process to inform their service specification and ensure the service model meets the needs of the local community (PHE, 2018). Whilst national government provide a suggested national service specification for the commissioning of sexual and reproductive health services, it is expected that this service specification will be tailored to meet local needs.

This needs assessment is therefore being carried out to inform the recommissioning of the Northern Lincolnshire Integrated Sexual Health Service.

2.0 Background

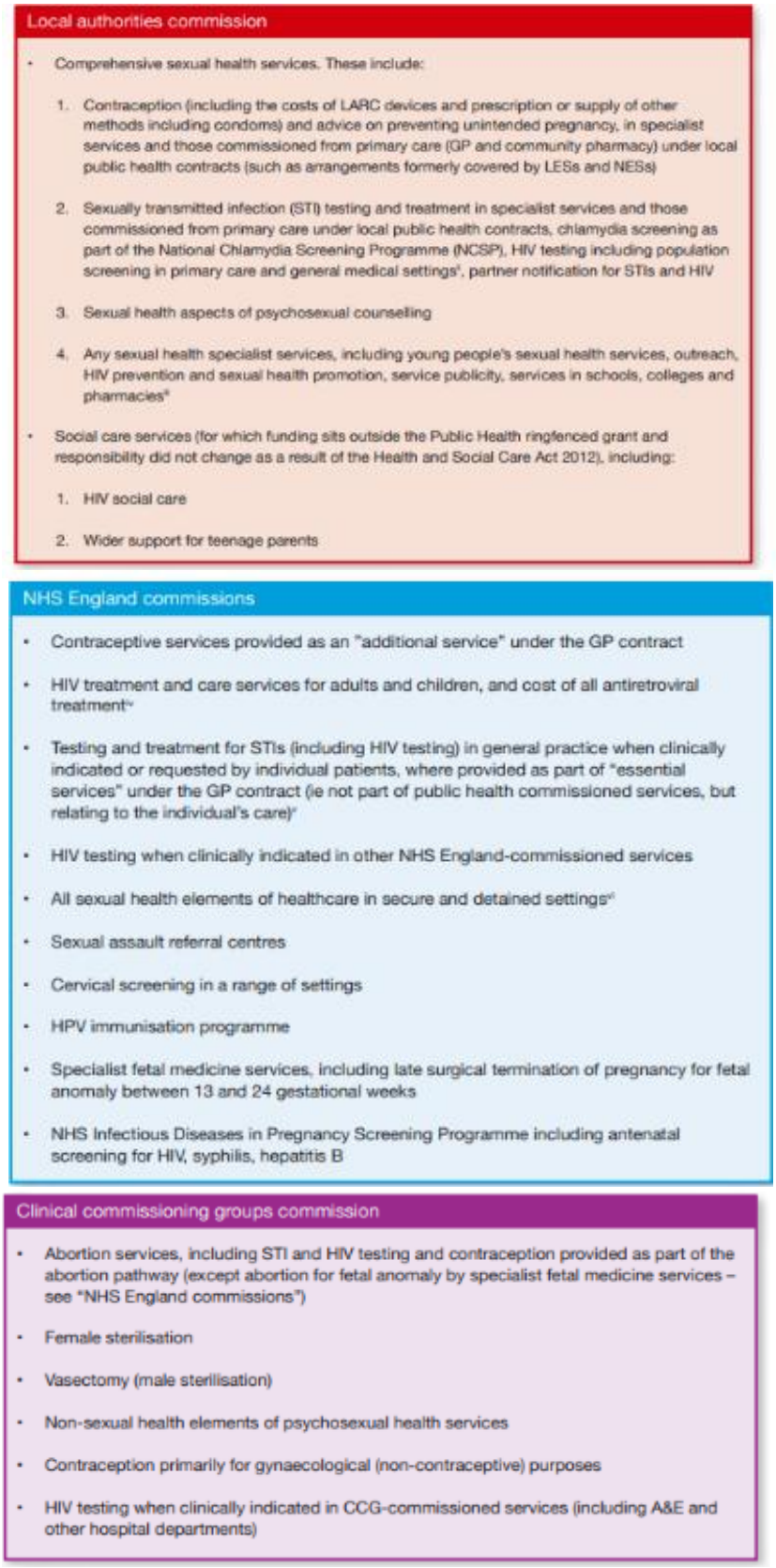
As a result of the Health and Social Care Act 2012, the way that public health services were commissioned in England changed from April 2013. Public Health England (PHE) was introduced as the national public health organisation on this date, and many public health responsibilities were transferred to local authorities from the NHS, set out in the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2012 (DoH, 2013) (PHE, 2015). This meant that the commissioning of these services now takes place closer to the communities they serve and hence can be done in a way which better meets people's needs (DoH, 2013).

As a result, local authorities now commission most sexual and reproductive health provision, including comprehensive open access sexual health services (offering free contraception provision, STI testing and treatment, and partner notification) with costs met through their ring-fenced public health grant (DoH, 2013) (PHE, 2015). This makes it more likely that the sexual health service is well integrated with other services commissioned by the local authority, whose work may influence (or be influenced by) sexual and reproductive health (such as children's services, domestic abuse services, education, etc.) (PHE, 2017). In April 2022, the statutory functions that sat with Clinical Commissioning Groups (CCGs) was conferred on newly created ICBs, along with staff, assets and liabilities (including commissioning responsibilities and contracts). The commissioning responsibilities of local authorities, defunct CCGs now ICBs and NHS England are laid out in Figure 1.

It should be noted that the regulations do not cover all preventative interventions related to sexual and reproductive health care. However, some preventative interventions may be crucial in a particular area to improving outcomes and reducing overall costs and demand for sexual health services, such as addressing behaviour change, targeting communications campaigns, combating stigma and discrimination, and addressing the wider determinants of health. This should be kept in mind during local commissioning (DoH, 2013) (PHE, 2017).

Also of note is the vital importance of a trained and skilled workforce for delivering high quality sexual and reproductive health services. It is recommended that sexual and reproductive health commissioners should work to address skills shortages and incapacity issues in their workforce, and also support the development and ongoing education of their current and future workforce, including defining in service specifications the expectations of providers in terms of education and training (PHE, 2015) (PHE, 2017).

Figure 1: Commissioning Responsibilities for Sexual Health, Reproductive Health and HIV, taken from (PHE, 2015)



The local education and training boards (LETBs) have responsibility for the planning and funding of local training provision, and sexual and reproductive health providers can receive

funding from LETBs when they employ trainees, as part of a learning development agreement. Therefore, commissioners should be aware of their local LETB, and work with them to support training provision, including writing into the service specification the number of training posts that are expected to be provided (PHE, 2015).

The report 'Making it work: A guide to whole system commissioning for sexual health, reproductive health, and HIV' gives advice around how whole system commissioning can be achieved in practice (PHE, 2015). The key messages from this guide are given in Figure 2.

Figure 2: Key Messages from 'Making It Work: A Guide to Whole System Commissioning for Sexual Health, Reproductive Health, and HIV (PHE, 2015)

It is also known that research and development has an important role in driving improvements in sexual and reproductive health care and services, and that research and evaluation contributes to improving outcomes. It is therefore recommended that commissioners support providers to take part in clinical studies, research, and evaluation; and that commissioning is based on the best available national and local research (PHE, 2015).

3.0 Aims

The aims of this needs assessment are to:

- Bring together an understanding of the local population's characteristics, health seeking behaviours, sexual health disease burden, wider determinants, and experiences and opinions relating to sexual and reproductive health (PHE, 2015).
- Gather insight around current and potential service users, including high risk and vulnerable groups, to ensure that the service is inclusive to everyone, including all genders, ethnicities, sexual orientations, and [dis]abilities.
- Ensure the new service model fixes any broken pathways resulting from the Health and Social Care Act 2012.

4.0 Methodology

A review of national literature was undertaken, bringing together up to date national guidance, evidence of effectiveness, and knowledge relating to population-level sexual and reproductive health, including the commissioning of services.

To understand how available support is meeting the needs of the local population both quantitative and qualitative research methods were undertaken:

- **Quantitative method:**
    - Data around local need was brought together from local and national sources to understand the state of sexual and reproductive health across NEL and to identify any local issues or inequalities between geographic or demographic groups.
    - Service activity and performance data was collated, analysed, and interpreted.
- **Qualitative method:**
    - One-to-one conversations were held with professionals across the wider public health system.
    - An online residents survey was produced and promoted via these channels: the council's website, social media pages and mailing lists, and education providers.

Following the collation, analysis using appropriate analytical methods, and interpretation of data, a report will be produced, and findings disseminated to appropriate audiences, such as NELC Leadership Team, NEL Public Health Team, NEL ICB), and the Assistant Directors Group. The needs assessment will then be used to inform the recommissioning of the NLISHS service.

5.0 Population and Demographics – NEL

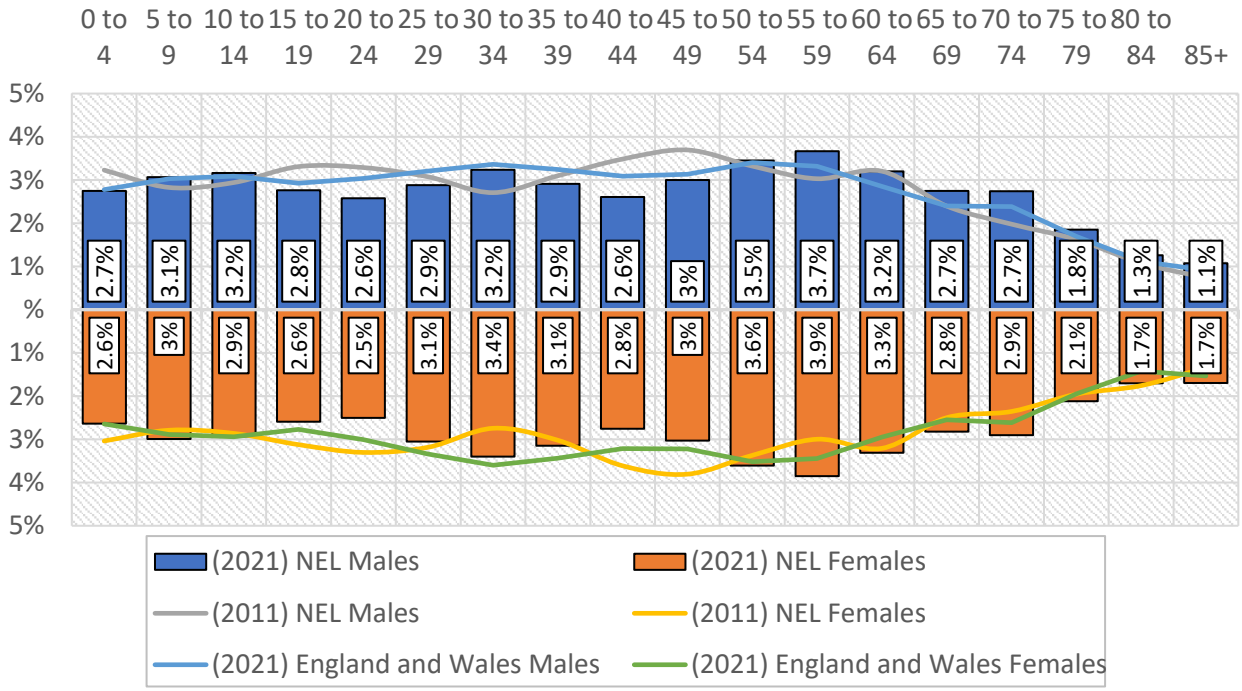
All figures for The Census 2021 are sourced from the ONS; all figures for The Census 2011 are sourced from Nomis, 2011.

5.1 Population Size, Age and Sex

The Census 2021 showed that NEL's population totalled 156,972 – a 1.7% decrease since 2011. Over this period, Yorkshire and the Humber's population increased by 3.7%, and England and Wales's increased by 6.3%.

The Census 2021 also highlighted an ageing population nationally and locally. In NEL, the number aged over 64 rose by 16.1%, leaving their percentage of the population at 20.9%, or 32,838 people, increasing from 17.7% in 2011. In contrast, the number of people aged under 15 fell by 2.4%, so the percentage they occupied was 17.6%, or 27,545 people, decreasing from 17.7% in 2011. Figure 3 below shows population distribution by sex and five-year age band for NEL.

Figure 3: Population Pyramid for NEL: 5-Year-Age-Band (2021).



Source: The Census 2021 (ONS, 2023); The Census 2011 (Nomis, 2011)

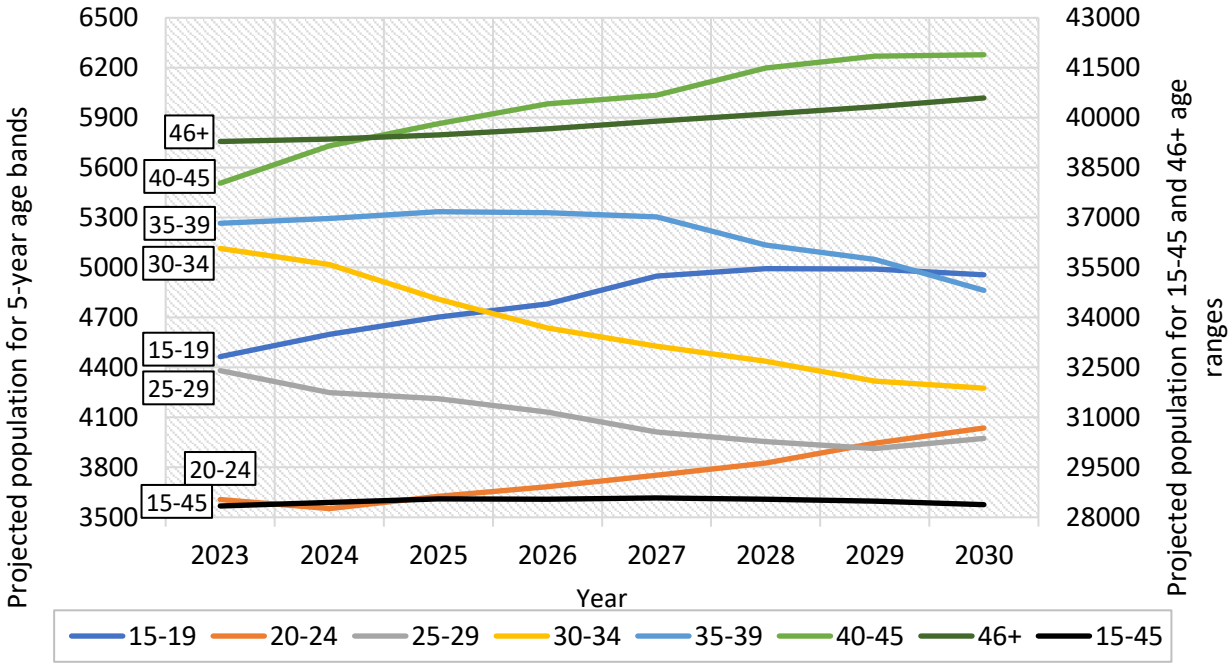
The population aged 15-64 also shrank from 2011 to 2021 in NEL, proportionally decreasing from 64.6% to 61.5% as well as decreasing as a number by 6.3%, or from 103,094 to 96,589. The number rose by 3.3% in England and Wales, leaving the proportion at 64.1% in 2021.

In terms of sexual health, those aged 15-24 are at the highest risk of contracting STIs (UKHSA, 2022); they made up 10.4% of NEL in 2021, and the ONS' 2018 population projections for

NEL estimate that both the 15-19 and 20-24 age bands will grow considerably up to 2030, with the smallest increase of 4.3% in the number of 15–19-year-old males and the largest increase of 16.4% in the number of 20–24-year-old males (ONS, 2020).

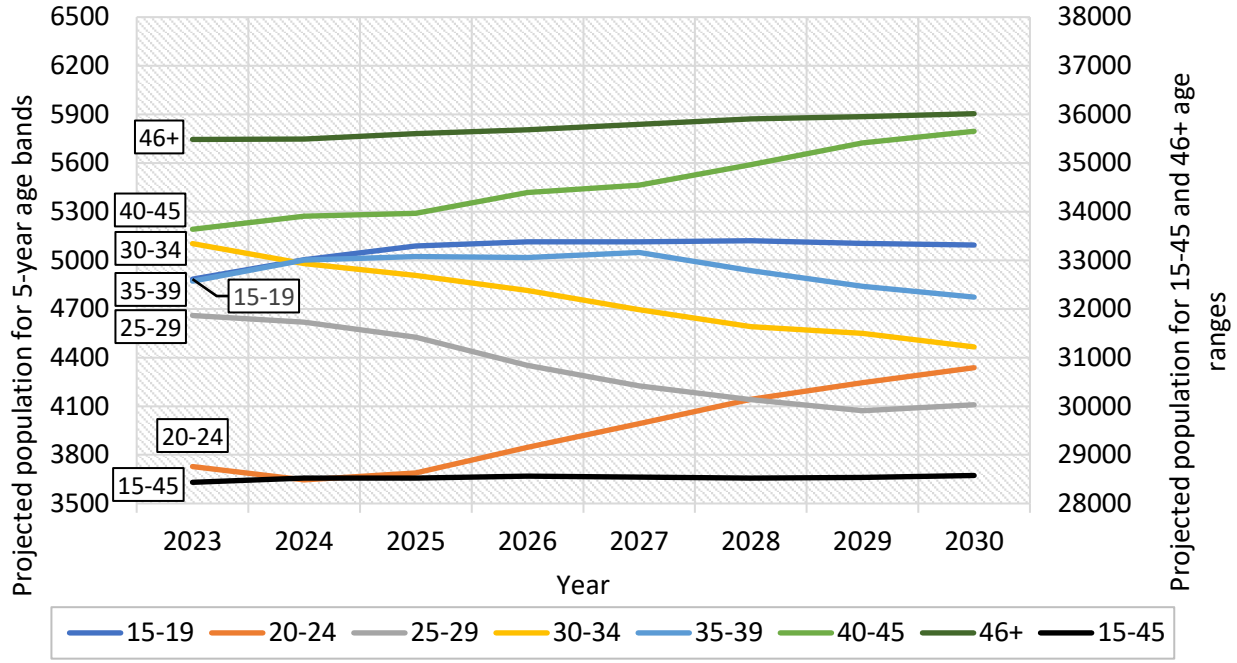
In NEL, the number of females of reproductive age has decreased by 10.6% since 2011 (this figure includes those who were assigned female at birth but did not necessarily identify as such in 2021), with their proportion of the whole female population falling from 38.8% to 35.2%. The ONS projects that this downward trend will slow, but will continue, with a figure of 34.8% projected for 2030 (ONS, 2020). Reproductive age is assumed to start at 15 and end the day before a female's 46th birthday; a small number reach the end of this period after this birthday, but these do not affect the overall patterns. (ONS, 2020). PHE estimated that 78% of the population aged 16 to 44 either want to conceive sexually or prevent a conception. (PHE, 2018). Figures 4 and 5 show the female and male population projections for the 5-year age-bands within female reproductive age for NEL respectively.

Figure 4: Female Population Projections for the 5-Year Age-Bands Within Female Reproductive Age for NEL (2018).



Source: 2018 Household projections (ONS, 2020)

Figure 5: Male Population Projections for the 5-Year Age-Bands Within Female Reproductive Age for NEL (2018).



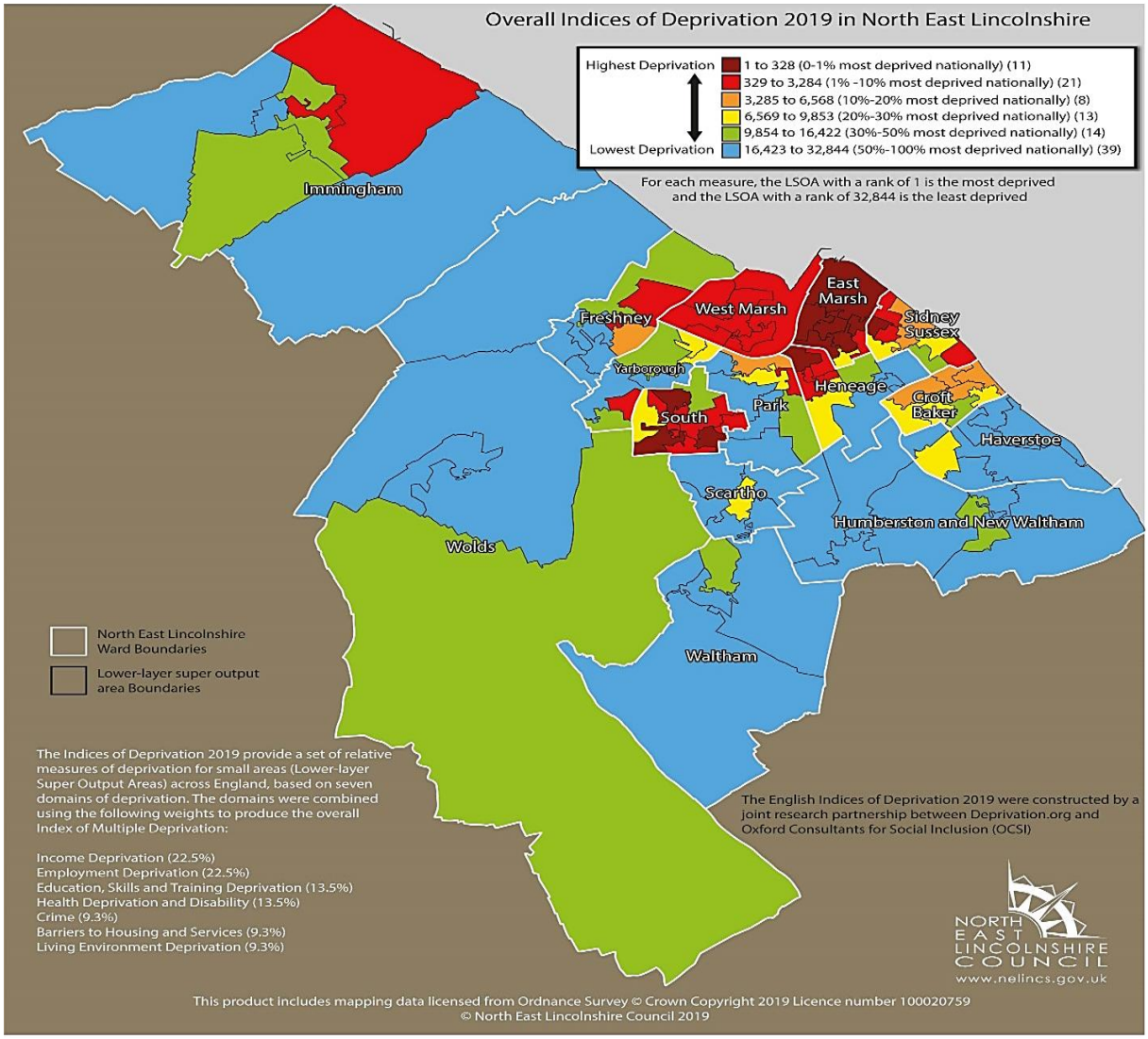
Source: 2018 Household Projections (ONS, 2020)

5.2 Deprivation

Deprivation's causal link to poor health is well-established, with avoidable variations at different geographies becoming explicable when their socioeconomic situation is considered as a barrier to accessing adequate healthcare, i.e., new STI diagnoses and under-18s conceptions are both positively correlated with Income, Health, and Education deprivation especially (PHE, 2021).

The Indices of Multiple Deprivation for 2019 ranked NEL as the 29th most deprived local authority in England (using the average score measure). Thirty-two (30%) LSOAs in NEL are in the most deprived 10% of LSOAs in England – we have the 17th highest proportion of LSOAs in the most deprived 10% of LSOAs nationally. Eleven of LSOAs in NEL are in the most deprived 1% of LSOAs in England, see map (Figure 6) below.

Figure 6: Indices of Multiple Deprivation (IMD) 2019, North East Lincolnshire Ward Map (2019).



Source: North East Lincolnshire Council Data Observatory (NELDO, 2021)

6.0 Vulnerable Groups

All figures for The Census 2021 are sourced from the ONS; all figures for The Census 2011 are sourced from Nomis, 2011.

6.1 Ethnicity

In England, ethnic minorities have broadly worse sexual and reproductive health outcomes than White British people, with these communities experiencing a higher prevalence of STIs and their sequelae. This is especially true of Black people, with an especially high prevalence in those with a Black Caribbean background, who catch STIs at almost 3.5 times the rate of White people (UKHSA, 2022). The wider determinants of health contribute to these

inequalities, but do not explain all variation. Holistic, evidence-based interventions that target modifiable risk factors are needed to address inequalities such as these (Wayal, et al., 2017).

From 2011 to 2021 in NEL, there was a 4.5% fall on the number of 'White: English, Welsh, Scottish, N. Irish, or British' people, whose proportion of the population fell from 95.4% to 92.6%, while that made up broadly by White people fell from 97.4% to 96.2%. In England and Wales, the proportion of the former fell from 80.5% to 74.4%, while the latter fell from 86% to 81.7%. The second largest ethnic group in NEL in 2021 was 'White: Other' (3.3%). Most of whom were Polish or Romanian (44.7%).

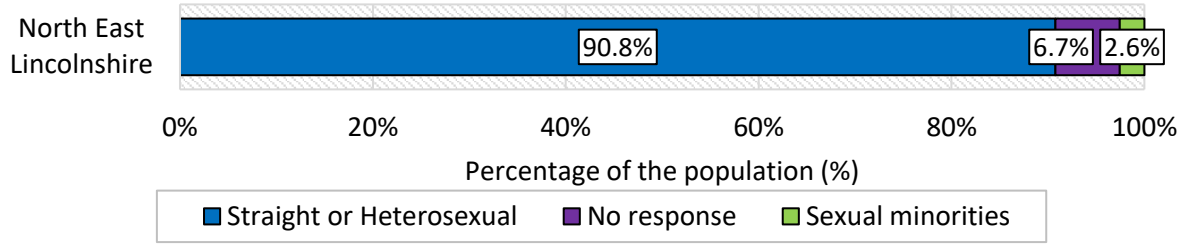
6.2 Sexuality

Need differs depending on sexuality. Firstly, MSM are disproportionately affected by STIs, with a higher prevalence of Chlamydia, Syphilis, Gonorrhoea, and HIV, for example. Females who have Sex with Females (FSF)'s needs are often understated, information on their sexual and reproductive health is scarce (relative to MSM), and they are overrepresented in terms of STIs – particularly bacterial vaginosis – with a greater chance of contraction if one or both sexual partners is menstruating (NHS, 2022) or menopausal. They are also screened for STIs and gendered cancers less than the general population, and, while FSFs are less likely to become pregnant, bisexual adolescent females are twice as likely to become pregnant (Hodson, et al., 2017). The wider determinants and sexual behaviours drive these inequalities, but both MSM and FSF face specific access barriers, including healthcare professionals' assumptions of heterosexuality and general lack of awareness of their issues (Stonewall, 2018); (PHE, 2018), though confidentiality and a lack of relatable promotional material are also factors, particularly for MSM (PHE, 2021). To meet sexual minorities' needs, an evidence-based understanding of those needs is required.

The question in The Census 2021 on sexuality was new, though it was voluntary – having a 93.5% response-rate in NEL – and only put to those aged 16 and over, so actual figures likely differ. It is also useful to note that sexuality is an umbrella term for a range of words to do with a person's romantic and sexual attraction, and as everyone interprets these words and their sexuality differently, this data is not evidence of a consensus among those selecting an option.

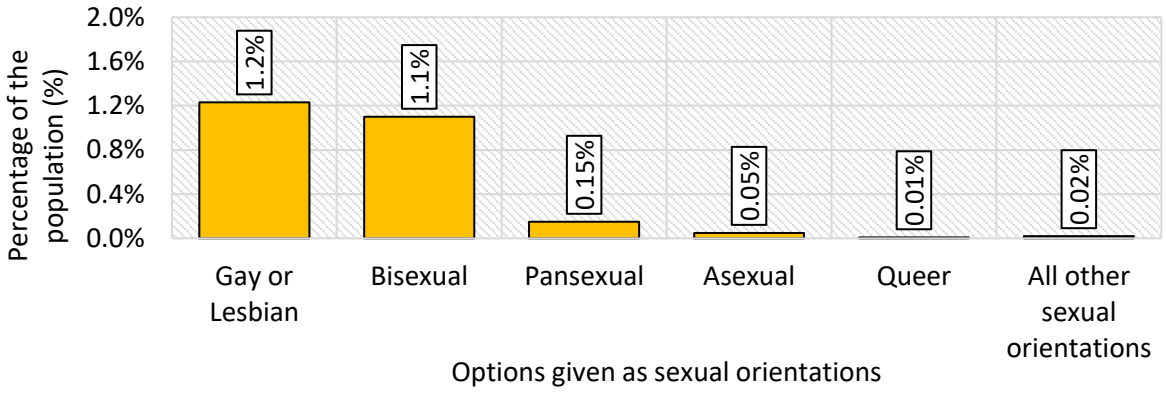
On the data – England and Wales and Yorkshire and the Humber recorded higher proportions of sexual minorities than NEL, where 2.6% were minorities, including 1.2% which were homosexual and 1.1% which were bisexual. These figures were 3.2%, 1.5%, and 1.3% for England and Wales, and 3.1%, 1.4%, and 1.3% for Yorkshire and the Humber, respectively. Figures 7 & 8 show the proportions of NEL [aged 16 and over] by sexuality.

Figure 7: Proportions of NEL [Aged 16 and Over] by Sexuality (2021).



Source: The Census 2021 (ONS, 2023)

Figure 8: Further Breakdown: Proportions of NEL [Aged 16 and Over] by Sexuality (2021).



Source: The Census 2021 (ONS, 2023)

6.3 Gender

Data on gender-diverse people is scarce. It is most abundant in the case of the prevalence of HIV in transgender women, with [international] research suggesting they are overrepresented in diagnoses (Hibbert, et al., 2021); (Van Gerwen, et al., 2020). Though the gender-diverse broadly suffer poorer health outcomes and access. Data capture is also a concern, as sources categorising based on birth sex or registered sex – while the latter is less likely to *other* Transgender people – does not facilitate analyses of inequalities. This is especially problematic for non-binary people, as that identity is not legally recognized in the UK.

Trans-specific medical interventions are not in scope, but it is notable that Stonewall showed that 23% of Transgender people in England had not yet started/undergone an intervention, despite wanting to (the reasons were illustrated by Stonewall (see appendix 1) (Stonewall, 2018). This highlights a substantial disparity in access to effective medical care and points to

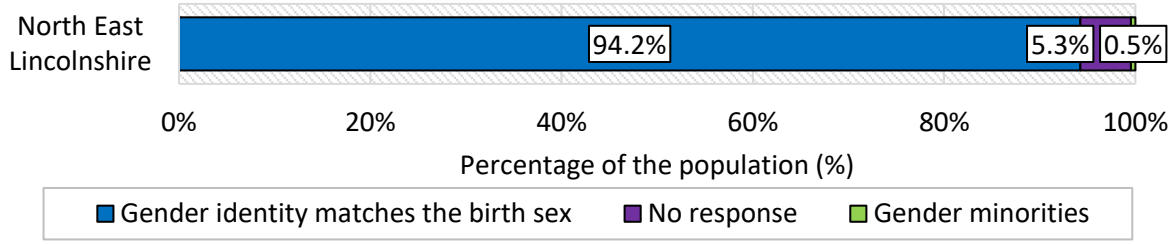
23% of transgender people's bodies not being in line with their gender identity. The same survey revealed 40% of transgender people and 52% of non-Binary people dress to avoid discrimination. Beyond a need to confront discrimination, this demonstrates a need for healthcare professionals to not assume a patient's identity.

On non-trans-specific healthcare, discontent is rife. In a national survey in 2021, 45% of transgender people said their GP did not understand their specific needs. This figure is 55% for non-binary people, and it is higher still for transgender ethnic minorities and disabled people (TransActual, 2021). Also, 71% of transgender men, 63% of transgender women, and 75% of non-binary people had experienced transphobia in healthcare, with 29% of the gender-diverse attending gendered healthcare saying they were refused access because they were transgender, while 27% avoided visiting their GP for gendered healthcare altogether, most of whom are transgender men or non-binary. Echoing this trend, a lack of awareness and discrimination – as well as long waiting times – have been implicated as factors in gender diverse people's poor health outcomes (Mikulak, et al., 2021). Whole system interventions that are evidence-based, target modifiable risk factors, and which optimise services are needed.

The gender identity question was new in The Census 2021, though it was voluntary – having a 94.7% response-rate in NEL – and only put to those aged 16 or over, so the actual figures likely differ. It is also useful to note that, like sexual orientation, all respondents relate to their gender and to the relevant terminology, i.e., Transgender, non-binary, etc., differently, so this data cannot be assumed to reflect a consensus among everyone selecting a particular option.

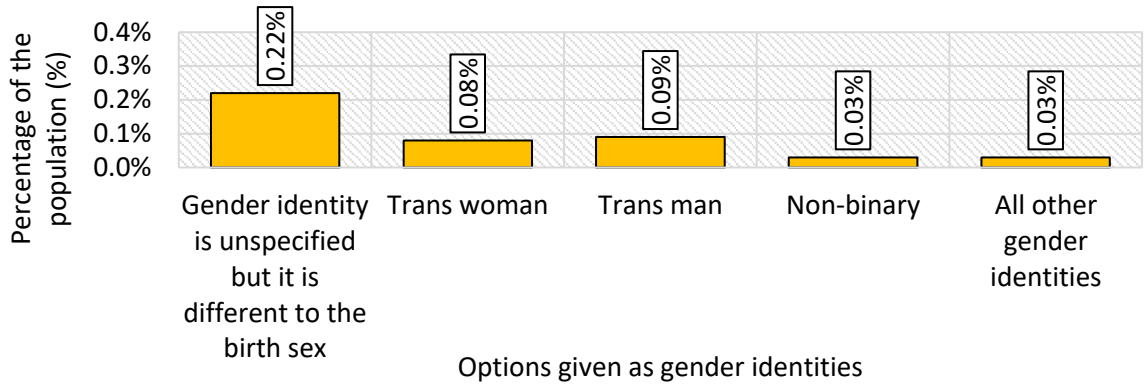
In NEL, 0.45% identified as a minority, including 0.17% who were transgender and 0.03% who were non-binary. These figures were 0.54%, 0.2%, and 0.06% for England and Wales, respectively. Figures 9 and 10 show the proportions of NEL [aged 16 and over] by gender.

Figure 9: Proportions of NEL [Aged 16 and Over] by Gender (2021).



Source: The Census 2021 from (ONS, 2023)

Figure 10: Further Breakdown: Proportions of NEL [Aged 16 and Over] by Gender (2021).



Source: The Census 2021 (ONS, 2023)

6.4 Disabilities

Evidence on the sexual health of those with disabilities is limited but suggests heterosexuals and MSM with mild learning disabilities are overrepresented in STI cases (Middleton, et al., 2021). This is likely due to those with mild to moderate learning disabilities being more likely to practice unsafe sex half of the time or more, relative to non-disabled people (Baines, et al., 2018). The same study also suggests people with learning disabilities are less likely to have sex by age 20, though most will have had sex by age 20, and that they are less likely to have sex by age 16 (although this point contrasts with data from the ALS in NEL). Other relevant considerations include vulnerability, and a lack of autonomy in sexual health-related decision-making by females with learning disabilities (Ledger, 2016). The mothers of children with intellectual disabilities have also been identified as taking a more cautious approach to discussing sex, with fewer relevant topics being discussed and discussions beginning later in life (Pownall, et al., 2012). These issues may explain some inequalities in-part, but a wider scope and specific, evidence-based interventions are necessary to begin addressing them.

Regarding Census data on disabilities and long-term health conditions, the question in The Census 2011 and 2021 are broadly comparable, but the question was rewritten from 'health problem or disability' in 2011, to 'physical or mental health conditions or illnesses' in 2021, and the option to count old age-related issues was removed. Overall, there was a slight decrease on the proportion who were disabled in NEL (per the Equality Act). When the numbers for The Census 2021 are standardised to account for age, the proportion of NEL that were disabled and whose day-to-day activites were limited was 20.1%, falling from 20.4% in 2011; these

figures were highest in East Marsh, Croft Baker, and South. Also, disabled people live in 35.5% of households in NEL, with 7.4% of households having 2 or more with disabilities.

Other data (Oxford Brookes University; Institute of Public Care., 2020) compliments the self-selecting sample data in The Census 2021; among those in NEL aged 18 to 64, there were:

- 5,283 with imparied mobility in 2020, and there will be 5,338 in 2025.
- 831 with a moderate or serious personal care disability in 2020; 2025 will see 818.
- 60 with a serious visual impairment in 2020, and there will be 58 in 2025.
- 9,716 with some hearing loss in 2020, and there will be 9,821 in 2025.
- 17,399 with a common Mental Health (MH) disorder in 2020, and there will be 17,014 in 2025.
- 2,230 with a learning disability in 2020, and there will be 2,179 in 2025.

6.5 Summary

- Ethnicity - NEL's population is mostly White British, however there is an increase in the proportion of BME groups, the majority of which are Polish and Romanian.
- Sexuality – MSM are disproportionately affected by STIs, with a higher prevalence across a range of STIs. FSF are less likely to be screened for STIs and gender-based cancers than the general population.
- Gender – data recording is an issue and therefore it is difficult to get a true picture of the inequalities in the transgender population. Additionally, 'non-binary' is not legally recognised as a gender in the UK.
- Gender – national research has shown that a high proportion of Transgender and Gender-diverse (TGD) people have experienced discrimination in a healthcare setting.
- Disabilities – One-fifth of NEL is disabled per the Equality Act.

7.0 Sexual Health in NEL

7.1 An Overview of Sexually Transmitted Infections in NEL

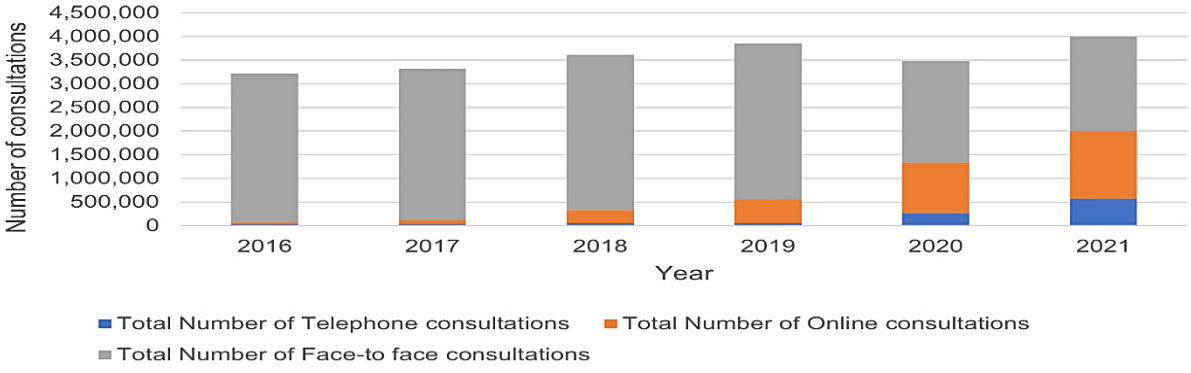
This section summarises the sexual health of NEL in terms of STI testing and treatment. It uses England, Yorkshire, and the Humber, and NEL's nearest statistical neighbours (the 15 LAs with the most similar socio-economic situation, per the Chartered Institute of Public Finance and Accountancy (CIPFA) (CIPFA, 2022)) as benchmarks. NL is also referred to as it is NEL's nearest neighbour both geographically and in terms of the CIPFA model.

Data is to be considered in the context of the recent Covid19 pandemic and all related policy change. There were notable changes in testing for and diagnosing STIs and HIV; figures for

these metrics fell sharply in 2020. And while some rose in 2021, others continued to fall. This fall was most apparent in STIs usually diagnosed at face-to-face-consultations, e.g., genital warts, a fact that may be attributed to a fall in transmission due to reduced mixing, *and* face-to-face consultations being replaced in most cases by an e-consultation or a conversation by phone (people avoiding healthcare settings for fear of Covid19 or to avoid affecting the demand for the NHS may also be factors). To this point, a national survey from April 2020 by the British Association for Sexual Health and HIV (BASHH) of 196 practicing members highlighted an 80% fall in capacity to see people in-person, as 53% were working at less than 20% of their pre-pandemic capacity; 80% reported their capacity to offer HIV appointments had decreased by at least half, and 12% reported the same of STI appointments; routine vaccination services couldn't be maintained in 54% of cases, and Pre-Exposure Prophylaxis (PrEP) in 9% of cases (PrEP is taken by HIV-negative people at risk of catching it to reduce their risk). Also, the survey found 38% of staff had been redeployed to the Covid19 workforce, 17% were shielding/isolating, and 53% of clinics had closed completely (BASHH, 2020).

But while services were diversified and engagement fell, complicating the interpretation of data for the years an area was affected by Covid19, there was a national increase to 4,394,404 consultations at SHSs from 2021 to 2022, representing an 8.1% increase from 2021 and a 13.6% increase from 2019 (UKHSA, 2023) (Figure 11 below breaks these down by method and year). But contacts at SHSs decreased by 27.5% from 2011/12 to 2022/23, when there was 1,790,000, which was an 11% uptick on the 2021/22 figure, itself following a 3% uptick on the 2020/21 figure (NHS Digital, 2023; 2022). The Kings Fund recorded that, between 2009/10 and 2019/20, the greatest drop in engagement was in females aged under 16, and then in females aged 16 to 17 (The King's Fund, 2021) Funding also complicates provision, with the Local Government Association connecting cuts of over £1 billion to the Public Health Grant [from 2015/16 to 2020/21] with a near-17% reduction in councils' spending on STI testing and treatment and the provision of contraception nationally.

Figure 11: Number of Consultations by SHSs by Method of Interaction in England (2021)

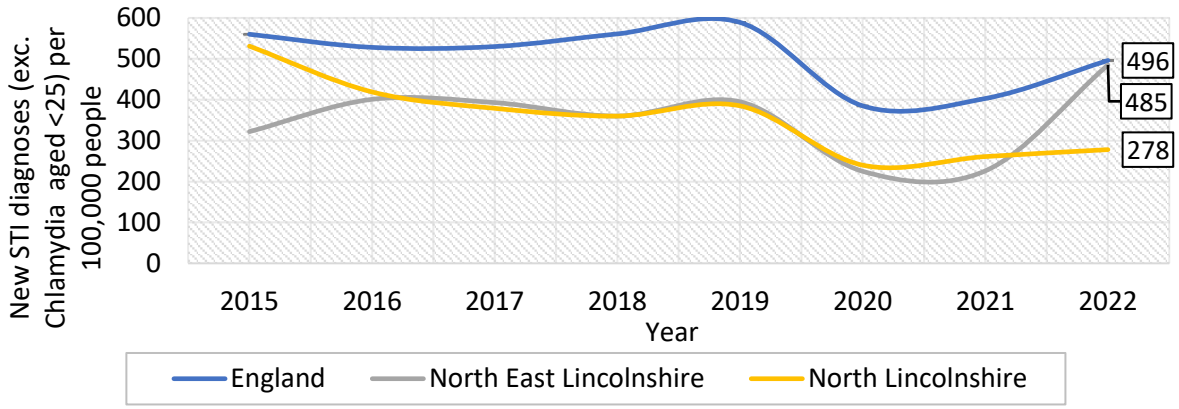


Source: UKHSA via (LGA, 2022)

In 2022, there was generally no statistically significant difference between NEL and England or NL in its diagnostic rates for STIs. This is, in-part, reflected in Figure 12 below, which shows the crude rate for new STI diagnoses for all ages (excluding chlamydia in the under 25s) per 100,000 people in NEL compared to England and NL. Also, NEL placed 43rd out of 153 Counties and UAs for new STI diagnoses excluding chlamydia in the under 25s in 2022 (OHID, 2022). However, interpreting STI data is complex; to identify and treat STIs, there must be increased testing, which may initially raise rates, but subsequent treatment should reduce that. So, while the rate of new STIs in NEL is moderate, this could be due to a lower prevalence, or lower levels of testing, so cases go undiagnosed. To understand which it is, demographics and testing must be considered. And as there are lower proportions of disproportionately affected groups, as well as lower testing rates (the STI testing rate (excluding chlamydia in the under 25s) per 100,000 was 2,590.4 in NEL, compared to 3,856.1 in England (OHID, 2022), while the STI testing positivity (also excluding chlamydia in the under 25s) is 9.8% in NEL, relative to 7.6% in England (OHID, 2022)), it is likely to be both.

Transmission of chlamydia in the under 25s is excluded as it is an outlier in terms of the prevalence, particularly in NEL (though a large proportion may be attributed to the National Chlamydia Screening Programme (NCSP). Including this metric takes NEL's rate of new STI diagnoses from 485 cases per 100,000 to 851, while England's rises from 496 to 694 (OHID, 2022); (OHID, 2022).

Figure 12: Crude Rate of New STI Diagnoses, All Ages (Excluding Chlamydia in Those Aged Under 25), Per 100,000 People – NEL Compared to England and NL, 2015 – 2022.



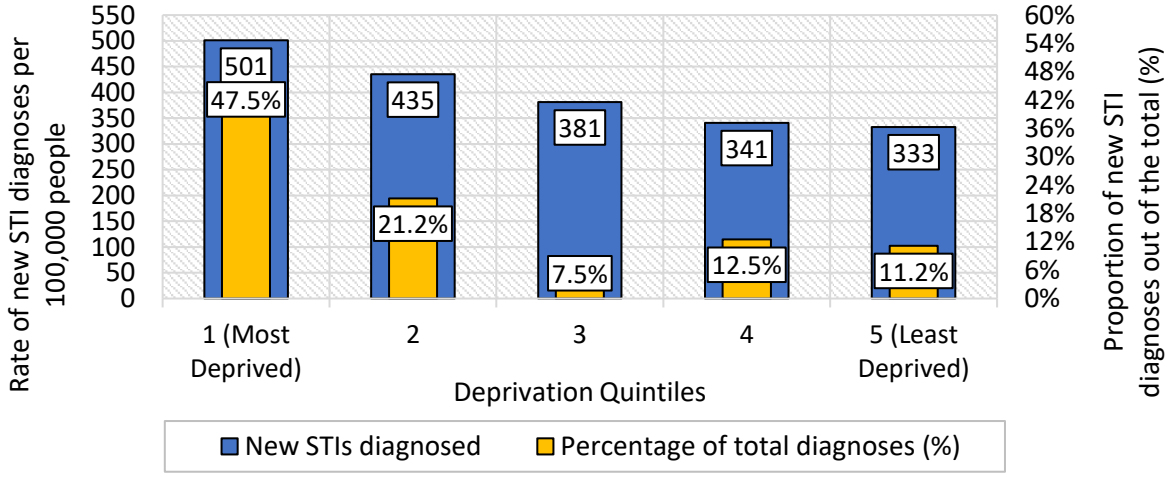
Source: UKHSA via (OHID, 2022)

In figure 12, NEL's and NL's trends are shown to resemble each other from 2016 to 2020, with England following their pattern from 2018 to 2022 too, though the national rate was much higher from 2016 to 2021. All three areas saw a peak in 2019, a significant drop in 2020, and a slight increase in 2021, which, except in the case of NL, preceded a sharp rise in 2022 (NEL

saw the largest fall in 2020 and the largest rise thereafter (43% and 114.6%, respectively). At 485 diagnoses per 100,000 people in 2022, NEL was only statistically significantly different [higher] to NL, placing 2nd out of 15 LAs (where 1st is the worst performing LA) regionally – being statistically significantly higher than the Yorkshire and the Humber average of 375, and 2nd out of 16 LAs (where 1st is the worst performing LA) in terms of its CIPFA nearest neighbours (the neighbours average is not calculable for this metric).

Figure 13 shows deprivation's effect on new STI diagnoses via the rate per 100,000 people and percentage of new diagnoses by deprivation quintile in NEL. STI data is from 2020, when diagnoses were unusually low; deprivation data is from 2019. Also, the UKHSA rounded the data used below to prevent deductive disclosure, so there may be a small margin of error.

Figure 13: Rate [Per 100,000 People] and Percentage of New Sexually Transmitted Infections (STIs) Diagnosed in SHSs by Deprivation Quintiles (2021; [IMD] 2019)



Source: Splash Report (UKHSA, 2022)

This figure shows a strong negative correlation between deprivation and new diagnoses of STIs. This is also evidenced by the high correlation coefficient (-0.97), which can be derived by plotting the rate against the quintile classes, indicating that the observed geographical difference in the rate of new STI diagnoses is *strongly* associated with the deprivation. Moreover, almost half the new diagnoses were in the most deprived 20% of NEL, and, except for quintile 3, there was a consistent increase in the proportion of diagnoses a quintile accounted for. But it should be noted that the main [physical] access point for the ISHS is Stirling Street Medical Centre, which is adjacent to one of the most deprived LSOA's in Sidney Sussex and sits in East Marsh – NEL's most deprived ward, and that the proportion of the population aged 15 to 24 in East Marsh, West Marsh, and South (NEL's most deprived wards) is 13.6%, 11.8%, and 12.5%, respectively, while in Humberston and New Waltham, Waltham, and Scartho (NEL's least deprived wards), it is 9.3%, 7.7%, and 9.4%, also respectively (15-

24 year-olds are broadly overrepresented in STI-related data). So, some of the additional diagnoses in the most deprived quintile(s) are attributable to factors relating to demography.

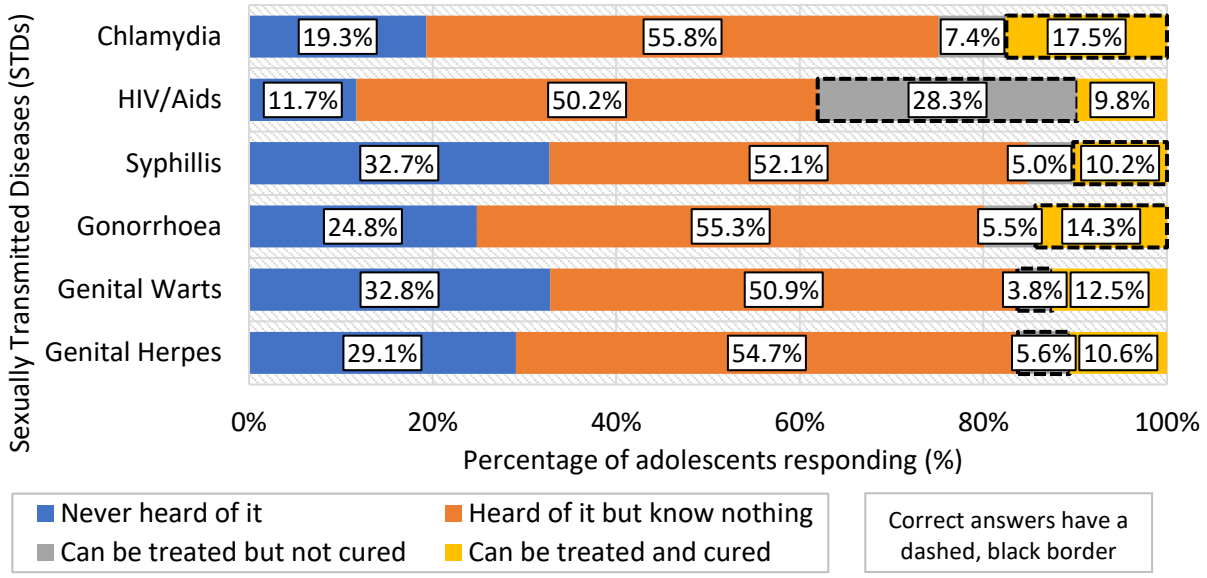
Besides deprived communities, MSM, black ethnic groups, and young people are the groups most disproportionately affected by STIs. This is true of a range of STIs too. For example, firstly on MSM: 74% of cases in an outbreak of Hepatitis A in 2016/17 were reportedly MSM, homosexual sex accounts for 17% of the reported risk of exposure to Hepatitis B and 36% of the new diagnoses of HIV [in England], an outbreak of monkeypox in 2022 involved mostly cases of MSM, and shigella and a particularly invasive form of chlamydia are all rife among MSM (UKHSA, 2023); on Black people, 18% of those living with HIV in NEL in 2020 had a Black African background (UKHSA, 2023); young people's risk is explored in detail below.

7.2 Young People's Sexual Health: Insights from the ALS

As 57% of all new diagnoses in NEL are in 15 to 24-year-olds, compared to 45.7% in England (UKHSA, 2022) and 59% in Yorkshire and the Humber (UKHSA, 2022), understanding their knowledge and needs is vital. So, this section draws on the ALS, which is a 2-4-yearly survey of children in years 7 to 11 (ages 11 to 16) in NEL; the 2021 ALS was completed under exam conditions in October 2021. The focus here is on one question, in which schoolyears 9 to 11 were asked what they knew about six STIs. Of the 4,271 respondents in those year groups, between 3,791 and 3,840 children answered[*]. Data from previous ALSs has been inputted alongside that from the 2021 ALS in Figure 15, though previous surveys had a lower take-up.

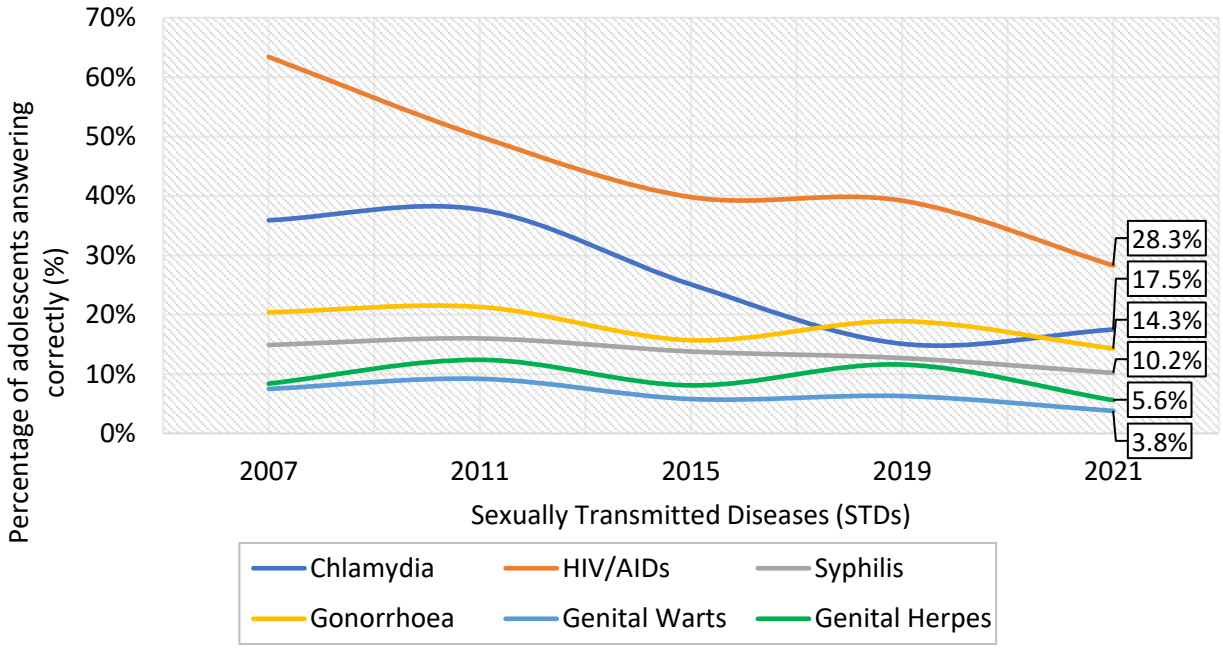
Figure 14: Secondary-School Children's Responses to Questions on a Given STI (%) (2021).

[*] The number of responses is presented as a range as this question was presented as six, separate questions – one for each STI – and each has a different number of responses, i.e., where a respondent answered about Chlamydia, but not about Syphilis, for example.



Source: ALS (NELC, 2021)

Figure 15: What Proportion of Secondary-School Children Answered Correctly When Asked if a Given STI was Treatable and/or Curable ? (%) (2021)



Source: ALS from (NELC, 2021), (NELC, 2019), (NELC, 2015), (NELC, 2011), and (NELC, 2007)

Both charts reflect a limited and decreasing awareness of the STIs listed. The first chart exemplifies the limits of the most recent group of respondents' knowledge, with 71.7% of people either incorrectly answering whether HIV/AIDS was curable or not having the knowledge to say. This is the case where the respondents were the most knowledgeable. In the two worst cases – Genital Herpes and Genital Warts – 94.4% and 96.2% could not answer correctly, respectively. There is also a lack of knowledge on Gonorrhea, Syphilis, and Chlamydia, too, with 85.7%, 89.8%, and 82.5% not being able to give a correct answer,

respectively, in these cases. Overall, the proportion answering correctly represented less than a fifth of respondents in every case except HIV/AIDS, where it is slightly over a quarter, and almost a third had never heard of genital warts and syphilis.

Figure 15 shows that in every case except Chlamydia, secondary-school-age children's lack of awareness in 2021 was the lowest it had been since 2007. Even with Chlamydia, awareness is the second lowest it has been historically. For more information on the ALS, please click the link InstantAtlas NE Lincolnshire – Children's JSNA (nelincsdata.net)

7.3 Trends in Chlamydia

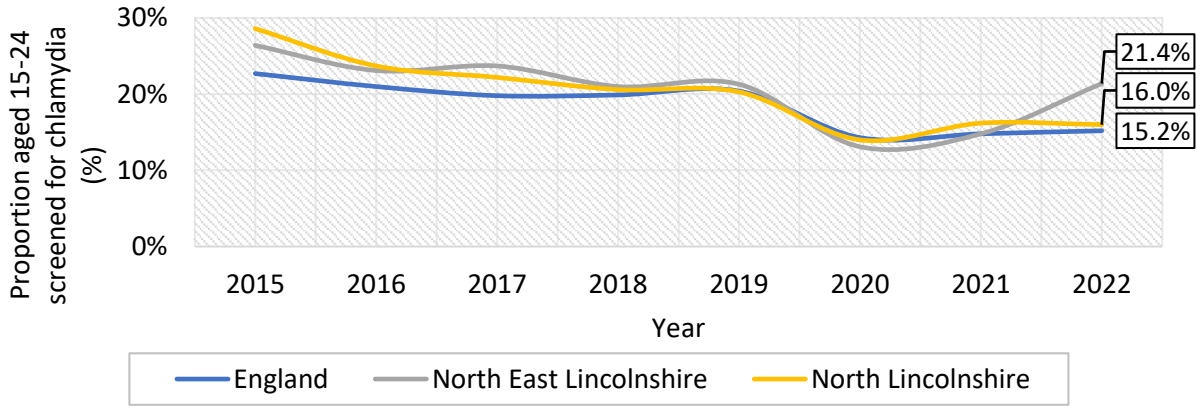
Chlamydia is the most frequently diagnosed STI in England. It may be transmitted via any unprotected sexual contact with an infected person, sharing sex toys, or by getting infected discharge in the eye. It cannot be transmitted by kissing/hugging or by touching the surfaces an infected person has touched; in-utero transmission is also possible (NHS, 2021). Chlamydia is usually asymptomatic, but may cause pain, unusual discharge, ectopic pregnancy, infertility, and PID in those assigned female at birth, Epididymitis in those assigned male, and reactive arthritis in males and females if it is left untreated.

On inequalities, MSM are vulnerable, with 14,980 new diagnoses in 2021 – 5.5% higher than in 2020, as are people from a Black Caribbean background, with rates of 1,200 and 900 cases per 100,000 males and females, respectively (relative to 200 among white males and females) (UKHSA, 2022). National intelligence from 2022 shows those in more deprived areas are also at a higher risk, with the overall [crude, diagnostic] rate being, per 100,000 people, 432.5 in the most deprived quintile, compared to 222 in the least deprived, though the second most deprived is the worst affected – its rate is 503.5 (OHID, 2022); this pattern has shown only minor changes since 2012. And screening data presents similarly, as the figure of 14.6% in the most deprived quintile is still higher than that of 12.4% in the least deprived (OHID, 2022) (the figure for the second-most deprived quintile is 18.3%).

Through treatment after a diagnosis, screening may reduce the duration of infection and the likelihood of transmission and the development of complications. To this point, the NCSP advocates for opportunistic screening and recommends testing at least annually, or even more if a person is aged 15-24, is a student, or has a new sexual partner, as these are high(er) risk populations (OHID, 2022). From June 2021, the NCSP has focussed on reducing re-infections and onward transmission, raising awareness of good sexual health, and – primarily – reducing the harms of untreated chlamydia (UKHSA, 2021), which predominantly arise in young people assigned female at birth (UKHSA, 2023). Only this group has been proactively offered a

screening from the second-to-last year charted in Figure 16 (2021), which shows the proportion of those attending SHSs and community-based settings screened for Chlamydia, ages 15-24, in England, NEL, and NL from 2015 to 2022.

Figure 16: Proportion Screened for Chlamydia, Ages 15-24 – NEL Compared to England and NL

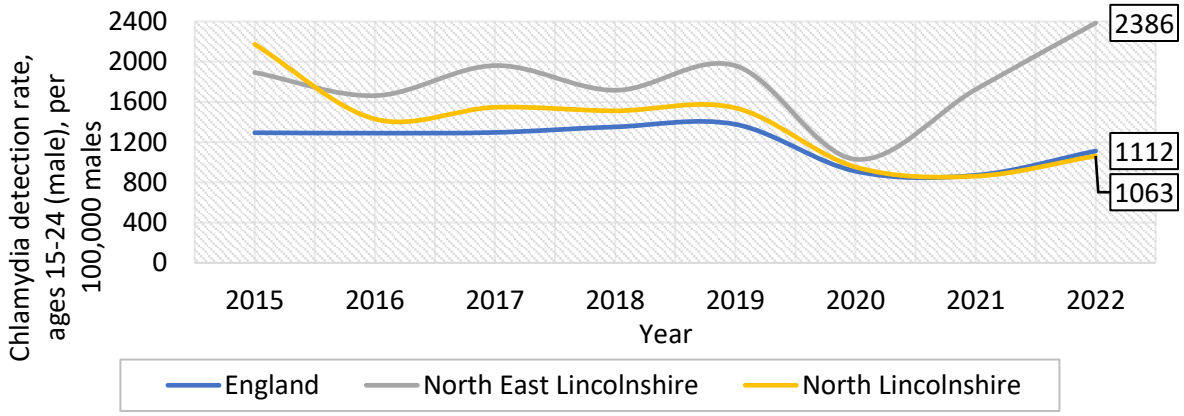


Source: UKHSA via (OHID, 2022)

NEL, England, and NL all reflected a similar, fluctuating downward trend in screening from 2015 to 2020. There was an average 33.1% drop in screening across all three geographies in 2020, but screening had already declined by an average of 19.5% from 2015-19. The proportion in all three areas rose slightly in 2021, but where it rose by a small amount again in NL in 2022, it fell in England and rose sharply in NEL. So, in 2022, NEL was statistically significantly higher than NL and England. And, as this figure stood at 21.4% in that year, NEL placed 2nd out of 15 LAs (where 1st is the worst performing LA) regionally – being statistically significantly higher than the Yorkshire and the Humber value of 16.2%, and 1st out of 16 LAs (where 1st is the worst performing LA) in terms of its CIPFA nearest neighbours – being statistically significantly higher than its neighbours average of 13.5%.

Below, Figure 17 shows the chlamydia detection rate in males attending SHSs and community-based settings, ages 15-24, per 100,000 males, from 2015 to 2022. It shows England's rate increasing gradually and NEL's and NL's rate fluctuating from 2016 to 2019, before the rates in all three fell sharply in 2020. In 2021, NL's and England's rate fell slightly, before rising by a larger amount in 2022, but NEL's rate rose in successive years, rising by 131.7% over both. And with a figure of 2386 in 2022, NEL's rate was statistically significantly higher than NL and England, and placed 1st out of 15 LAs (where 1st is the best performing LA) regionally – being statistically significantly higher than the Yorkshire and the Humber value of 1214, and 1st out of 16 LAs (where 1st is the best performing LA) in terms of its CIPFA nearest neighbours – the neighbours average is not calculable for this metric.

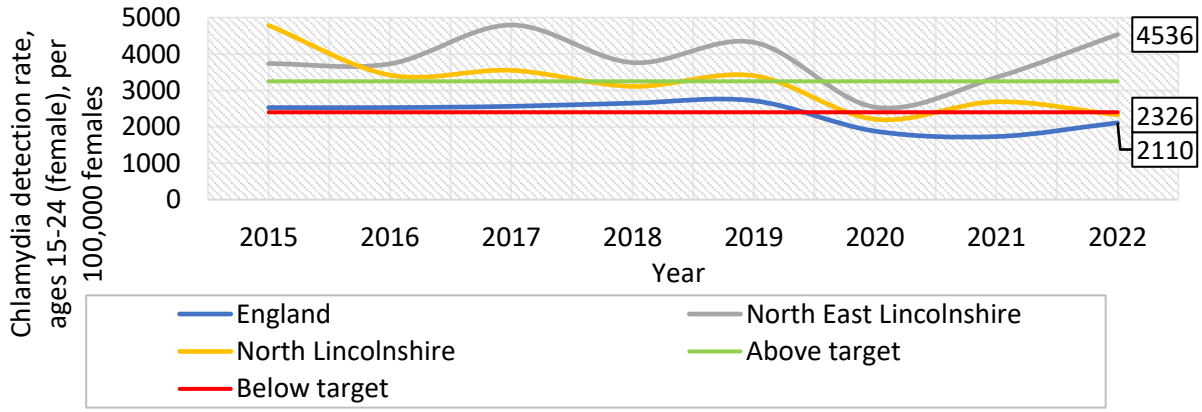
Figure 17: Chlamydia Detection Rate Among Males Attending SHSs and Community-Based Settings, Ages 15-24, per 100,000 Males – NEL Compared to England and NL, 2015 – 2022.



Source: UKHSA via (OHID, 2022)

Below, figure 18 shows the Chlamydia detection rate in females aged 15-24 that attend SHSs and community-based settings, per 100,000 females. The detection rate in females mirrors that in males across all three geographies, albeit with a much higher caseload. The only difference in the trend in this case is the increase in the rate in females in NL in 2021. In 2022, NEL's figure was statistically significantly higher than England's and NL's, and NEL was the only area to place above the benchmark in the last three years, which it did in 2021 and 2022.

Figure 18: Chlamydia Detection Rate Among Females Attending SHSs and Community-Based Settings, Ages 15-24, per 100,000 Females – NEL Compared to England and NL, 2015 – 2022.

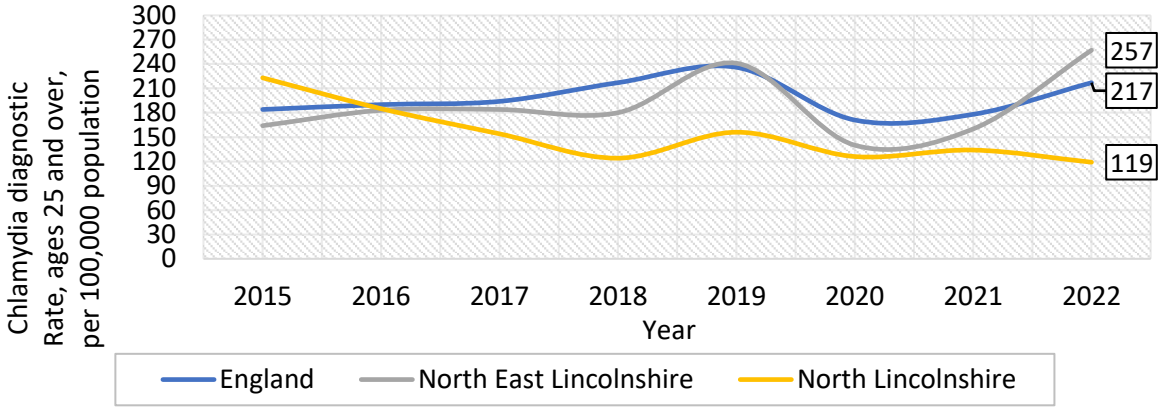


Source: UKHSA via (OHID, 2022)

With a figure of 4,536, NEL's rate put it 1st out of 15 LAs (where 1st is the best performing LA) regionally in 2022 – being statistically significantly higher than the Yorkshire and the Humber value of 2,528, and 1st out of 16 LAs (where 1st is the worst performing LA) in terms of its CIPFA nearest neighbours – the neighbours average is not calculable for this metric.

Figure 19 shows the chlamydia diagnostic rate among people attending SHSs, ages 25 and over, per 100,000 people. A similar waveform to that in Figures 17-18 is shown between 2018 and 2020 in all three areas, with the peak in 2019, and low-points in 2018 and 2020, though England's low-point was not pronounced in 2018, as its rate had increased consistently since 2015; all three areas saw a slight increase in 2021, but in 2022, NL saw a decrease, England saw a slight increase, and NEL saw a sharp increase - from a 13.6% rise to one of 60.6%; its most recent figure was statistically significantly higher than NL and England.

Figure 19: Chlamydia Diagnostic Rate Among People Attending SHSs, Ages 25 and Over, per 100,000 People – NEL Compared to England and NL, 2015 – 2022.



Source: UKHSA via (OHID, 2022)

At 257 cases per 100,000 people aged 25 and over in 2022. NEL placed 2nd out of 15 LAs (where 1st is the worst performing LA) regionally – being statistically significantly higher than the Yorkshire and the Humber value of 166, and 1st out of 16 LAs (where 1st is the worst performing LA) in terms of its CIPFA nearest neighbours – being statistically significantly higher than its neighbours average of 159.

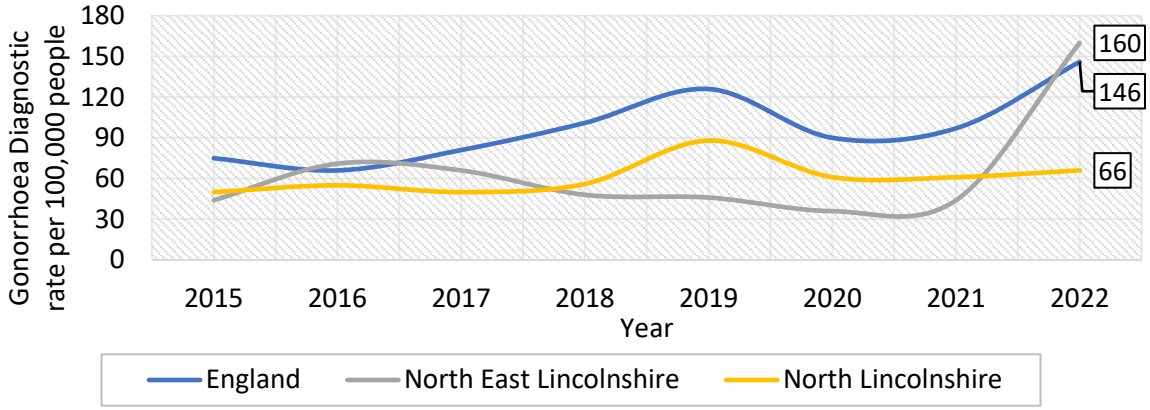
7.4 Trends in Gonorrhoea

Gonorrhoea is the second most common bacterial STI in England after chlamydia (NHS, 2021), and it is more likely to be symptomatic. It is easily transmitted and is usually passed on by performing an unprotected sexual act with an infected person. It can be indicative of a population having a high number of sexual partners and/or not observing preventative guidance (OHID, 2022).

Transmission is higher in MSM (MSM presented 27,123 cases in 2019 – a 9% uptick, or 66% of the total (PHE, 2021) and people from a Black Caribbean background (who are the most at-risk ethnic group (UKHSA, 2022)). And while LA data is unavailable, data for England suggests deprivation is also correlated, with a rate of 173 diagnoses per 100,000 people in the most deprived quintile, compared to 74.5 for the least deprived (OHID, 2022) (though the

2nd most deprived quintile is the worst affected – its rate is 239); this pattern has not changed since pre-2012. Pregnant people are also vulnerable, as gonorrhoea is transmissible in-utero and may result in miscarriage, premature birth, and sight issues in the baby (NHS, 2021).

Figure 20: Gonorrhoea Diagnostic Rate in People Attending SHSs, per 100,000 People – NEL Compared to England and NL, 2015 – 2022.



Source: UKHSA via (OHID, 2022)

Figure 20 above shows the gonorrhoea diagnostic rate in people attending SHSs, per 100,000 people. The figure shows the diagnosis rate in NEL contrasts with England and NL over this period, though NEL and England peaked in 2022, both seeing a significant rise following a year in which their rate remained relatively static (2020). NEL's rate rose by the most in 2022 (263.6%), and its value thereafter was above England's and NL's, although that difference is statistically significant in the case of NL *only*. Also, at 160 cases per 100,000 people in the most recent data point, NEL placed 2nd out of 15 LAs (where 1st is the worst performing LA) regionally – being statistically significantly higher than the Yorkshire and the Humber value of 120, and 1st of 16 LAs (where 1st is the worst performing LA) in terms of its CIPFA nearest neighbours – being statistically significantly higher than the neighbours average (108).

7.5 Trends in Syphilis

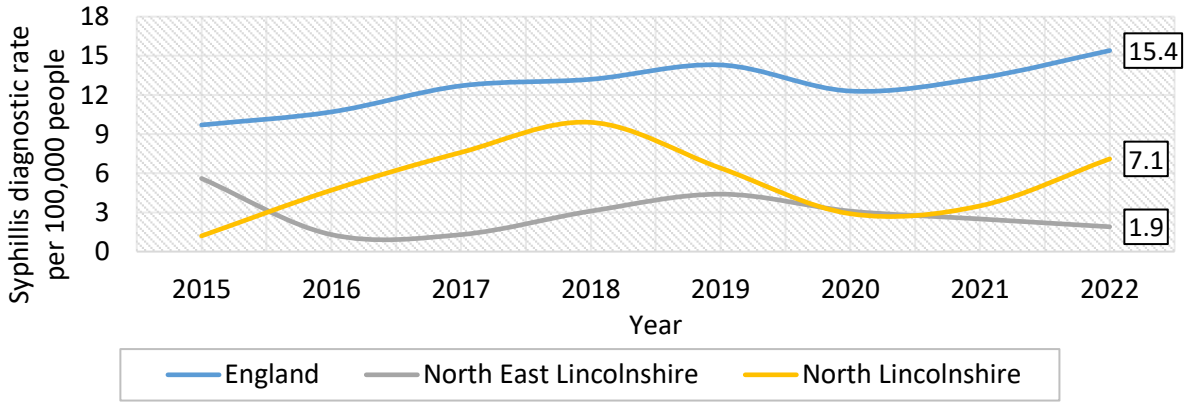
Syphilis is a relatively uncommon bacterial STI. Though symptoms are intermittent, it may have lasting and life-threatening complications if left untreated. Like Gonorrhoea, Syphilis may be transmitted by performing an unprotected sexual act with an infected person, or by being passed to a baby in-utero, but it may also be spread by kissing someone with syphilitic ulcers, by sharing needles with an infected person, or by receiving infected blood/organs, but thorough testing has made this a rarity (NHS, 2022).

On at-risk groups – MSM accounted for 79% of all diagnoses in England in Q4 of 2021; the figure feeding into this is considered an underestimate and rose from 78% in Q4 of 2019

(UKHSA, 2022). The median age of diagnosis for MSM is 32, which is older than in the general population – it is 28 in heterosexual males and 26 in females (including FSF); most infections occur in 25–34-year-olds in all groups. The Black Caribbean ethnicity is also an at-risk group, as it had the highest rate of infectious syphilis per 100,000 people in 2021 (approximately 38 (UKHSA, 2022)). People with a Mixed/Multiple and Other ethnic group were second and third, respectively (UKHSA, 2022). Deprivation is correlated nationally too – the worst affected quintile is the second-most deprived, with a rate of 25.5 diagnoses per 100,000, while the least deprived quintile is affected the least, with a rate of 8.2 (the most deprived quintile's rate is 16.7) (OHID, 2022); the most-deprived quintile's rate improved in 2014-15 and 2019 and the middle quintile's rate has been somewhat changeable, but otherwise this pattern has been static. Lastly, pregnant people are also at risk, due to possible in-utero transmission.

Figure 21 below shows the rate of diagnoses of infectious syphilis (primary, secondary, and early latent) in those attending SHSs, per 100,000 people. The figure shows trends in NEL, England, and NL all differed in this period, with NEL's rate beginning at a peak of 5.6 in 2015, falling to 1.3 in 2016 and 2017, then rising to a smaller peak in 2019 before falling year-on-year. NL's rate also fluctuated, while England's rose every year – excepting the fall from 2019 to 2020. NEL's value in 2022 was statistically significantly lower than England but not NL.

Figure 21: Rate of Diagnoses of Infectious Syphilis (Primary, Secondary, and Early Latent) in Those Attending SHSs, per 100,000 People – NEL Compared to England and NL, 2015 – 2022.



Source: UKHSA via (OHID, 2022)

At 1.9 cases per 100,000 people in the most recent data point, NEL placed 14th out of the 14 LAs which had data (where 1st is the worst performing LA) regionally – being statistically significantly lower than the Yorkshire and the Humber value of 8.1 – and 16th out of 16 LAs (where 1st is the worst performing LA) in terms of its CIPFA nearest neighbours – being statistically significantly lower than the neighbours average of 10.4.

7.6 Trends in Genital Herpes

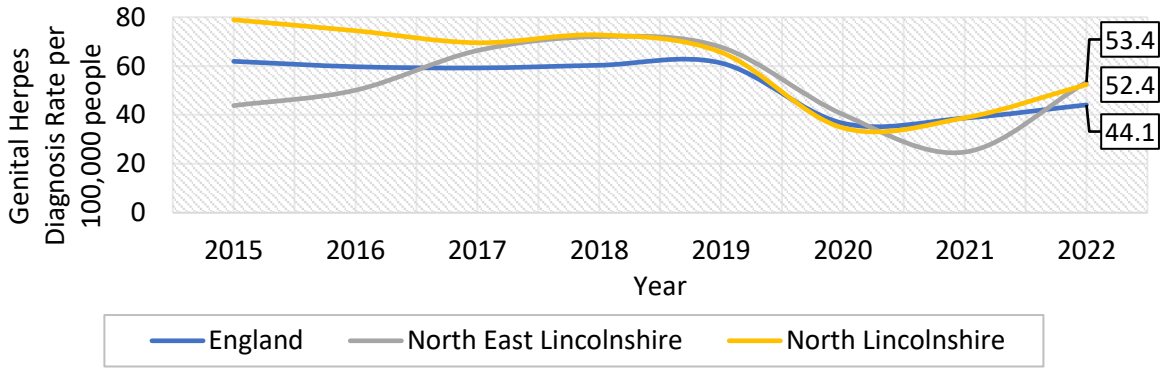
Genital Herpes is a virus and one of the most common ulcerative STIs in England. It is incurable, possibly painful, and fatal in rare cases, though immunosuppressed and pregnant people are at a higher risk of complications, especially if it is the latter's first case, with babies potentially developing neonatal herpes (NHS, 2020). Herpes is easy to transmit via skin-to-skin contact with an infected area on a person, even when there are no visible sores/blisters.

On inequalities, deprivation is weakly correlated with transmission nationally, with the highest rate (52.1 cases per 100,00) in the second-most deprived quintile in 2022. The least deprived quintile's rate was 35.9, while that in the most-deprived quintile was 43.6 (OHID, 2022); the most and second-most deprived quintiles had improved [relatively] in recent years, but the same pattern has been visible in the distribution of cases by deprivation since 2012. On ethnicity, Black [Caribbean] people bore the highest prevalence in 2021 (UKHSA, 2022).

Figure 22 below shows the rate of diagnoses of the first episode of genital herpes in those attending SHSs, per 100,000 people. NEL, England, and NL's trends are similar from 2017 to 2020, with all three geographies' rates rising slightly from 2017 to 2019, then falling sharply in 2020. But while NEL was the only area to see a fall in 2021, all three rose in 2022, including a 124.4% rise in NEL. NEL was not statistically significantly different to England or NL In 2022.

At 53.4 cases per 100,000 people in the most recent data point, NEL placed 3rd out of 15 LAs (where 1st is the worst performing LA) regionally – being statistically significantly higher than the Yorkshire and the Humber's value of 38, and 3rd out of 16 LAs (where 1st is the worst performing LA) in terms of its CIPFA nearest neighbours – not being statistically significantly different to the neighbours average of 42.8.

Figure 22: Rate of Diagnoses of the First Episode of Genital Herpes in Those Attending SHSs, per 100,000 People – NEL Compared to England and NL, 2015 – 2022.



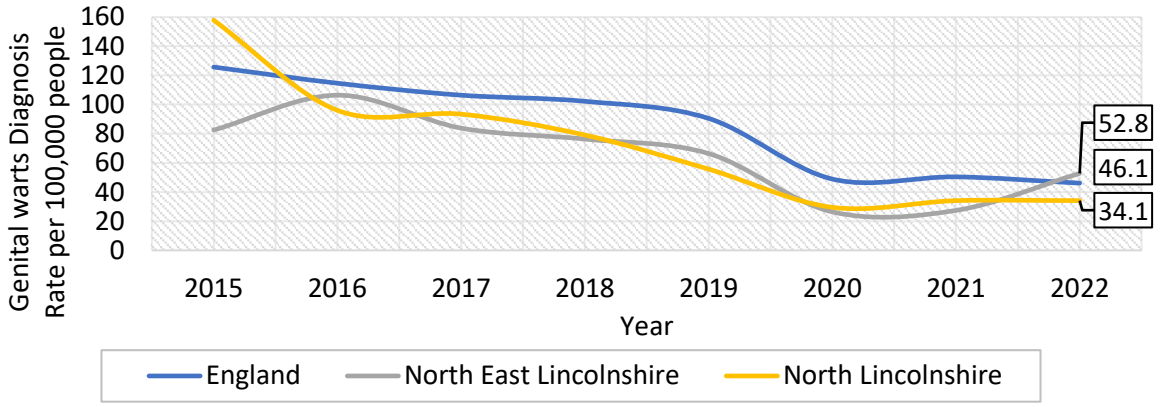
Source: UKHSA via (OHID, 2022)

7.7 Trends in Genital Warts

Genital Warts is the result of infection with certain strains of HPV and is the third most common STI in England. The infection is incurable, but it is often asymptomatic and the warts may be treatable if and when they do appear (this may be months after transmission). Plus, some of the warts-causing HPVs can be vaccinated against – the national vaccine programme has reduced genital warts, especially in the under 25s (UKHSA, 2023). Transmission may occur in-utero or via skin-to-skin contact, including sexual (though it is only rarely transmitted during oral sex) (NHS, 2020).

On inequalities, national data on deprivation shows the second-most deprived quintile bore the highest rate in 2022 (56.2 cases per 100,000), while the rate in the least deprived was 39.3 (the figure for the most deprived decile was anomalously low again, standing at 42.7). (OHID, 2022). The pattern in all but the most deprived quintile has been relatively static, but the most deprived decile in particular has improved significantly since 2018.

Figure 23: Rate of Diagnoses of the First Episode of Genital Warts in Those Attending SHSs per 100,000 People – NEL Compared to England and NL, 2015 – 2022.



Source: UKHSA via (OHID, 2022)

Rates of genital warts trended downwards from 2016 to 2020 in all three areas, as shown in Figure 23. After a sharp fall in 2020, all three areas shared a slight uptick in their rate in 2021, with NEL having the lowest (1), but a 92.7% increase meant NEL had the highest rate in 2022, though the differences are not statistically significant. At 52.8 cases per 100,000 people in the most recent data point, NEL placed 1st out of 15 LAs (where 1st is the worst performing LA) regionally – being statistically significantly higher than the Yorkshire and the Humber figure of 36.9, and 2nd out of 16 LAs (where 1st is the worst performing LA) in terms of its CIPFA nearest neighbours – being statistically significantly higher than the neighbours average of 37.4.

7.8 Trends in HIV

HIV is an incurable virus that impairs the immune response. Two to six weeks after infection, HIV causes a short-term illness resembling a cold, and can be asymptomatic thereafter, often meaning people are unaware they have it. AIDs describes the most advanced point of an infection, where the immune response is compromised and the person is infected with HIV and one or more AIDs-defining diseases. These may be opportunistic infections, such as pneumocystis pneumonia, or specific cancers – once they are at this point, a person is 100 times as likely to develop these cancers, e.g., Lymphoma and Kaposi's Sarcoma (NHS, 2021).

HIV is mostly contracted through unprotected, penetrative sex, as it is carried in semen, vaginal fluid, and the lining in the anus, but it is also in blood and breast milk. Oral transmission is unlikely, but that chance increases if the giver has ulcers, sores, or bleeding gums, or if the receiver has only recently been infected [and has a high viral load]; more recent infections are more easily transmitted (NHS, 2021). HIV may also be passed on while sharing drug paraphernalia. And there is a one-in-four chance of in-utero transmission when the pregnant person is untreated – treatment lowers this to one-in-one hundred (NHS, 2021), as it reduces the viral load. HIV-negative people at risk of contraction can take PrEP before engaging in a risky behaviour and PEP up to 72 hours afterwards to minimise the chance of contraction. 1.8% (44 out of 2,429) of HIV-negative people in NEL that accessed SHSs had PrEP need and 38.6% (17 of 44) of these initiated or continued PrEP use in 2021 (UKHSA, 2023).

There are also vulnerabilities among some demographic groups; evidence is only available at a national level. Among diagnoses first made in England, those aged 35 to 39 made up 37% of the total, while 25–34-year-olds made up 31% and the proportion that were 50 to 64 (19%) was over twice that aged 15 to 24 (9%) (UKHSA, 2023). Further, of the diagnoses in those exposed in sex between men, 58% were White – this ethnic group saw a decrease from 2021 to 2022, and of the remaining population, new diagnoses in black people stayed static and rose in people with Asian and mixed ethnic backgrounds (UKHSA, 2023). And in those exposed through heterosexual sex, the highest percentage were Black African (38%), followed by white (29%), but while the number of infections stayed static among white people last year, people with a Black African background saw a 34% decrease in infections, while 15% and 46% rises were seen among Black African and mixed or 'other' ethnic groups (UKHSA, 2023).

In terms of the proportion of diagnoses that were late in 2020-22, men exposed via heterosexual sex are the group with the highest value (58.9%), and 'injecting drug-use' is second (50.5%) – men exposed through sex between men have the lowest (34.2%) (exposure group 'not reported' has a value of 49.2%, however) (OHID, 2022). On the same topic, 52.9% of diagnoses in people with a Black African background are late (this group has been the worst

affected since recording began in 2009-11), but while figures vary amongst other black ethnic groups, the proportion for the 'Asian' group is second highest at 45.8% (OHID, 2022). And, generally, the older a person is, the more likely they are to receive their diagnosis late, with the proportion for 15-24-year-olds doubling from approximately 29% to 58% in people aged 60 or over (PHE, 2021). This was also true of those from less deprived areas in 2020-22, with a figure of 52% for the least deprived quintile, compared to 45.1% for the most deprived (OHID, 2022) (the fifth-least deprived decile had an anomalously low proportion at 33.2%, and the second-most deprived decile would have otherwise had the lowest at 40.8%); the pattern here has varied since 2009-11, when it showed an equally weak, but opposite trend – that more deprived areas had more late diagnoses.

Finally, on testing women, heterosexual men, and MSM [at SHSs], coverage is lowest amongst women and highest amongst MSM (seen in figures 27-29). Deprivation has a weak, positive correlation with testing coverage in MSM and heterosexual men (there has been no discernible difference in the case of women since 2019) – coverage among MSM is 71% in the least deprived quintile and 77.8% in the most deprived, and among heterosexual men it is 63% in the least deprived quintile and 68.4% in the most deprived (OHID, 2022).The pattern in coverage by deprivation amongst [all] men is changeable, especially among heterosexual men, where the visible, positive correlation only became positive in 2021, with the most deprived decile going from the lowest to the highest between 2020 and 2022 (OHID, 2022).

Testing confirms positivity, and at 39.6%, NEL's total testing coverage is statistically significantly lower than the England and regional averages (OHID, 2022), although it is statistically significantly higher than NL's. Insight from the current provider suggests low, local uptake is a case of people opting out of HIV tests/blood testing. In 2022, 99% of HIV-positive people accessing HIV care in NEL were prescribed Antiretroviral therapy (ART**)** (a treatment to stop HIV replicating) (OHID, 2022), which was not statistically significantly different to the national, regional, or NL values. 85.7% started promptly (within 91 days of diagnosis), based on a data-pool from 2020 to 2022 (OHID, 2022), which was also not statistically significantly different to the national, regional, or NL values. NEL's 97.3% virological success in adults accessing care is *only* slightly lower than in England (97.8) (UKHSA, 2023). Nationally, coverage of ART was not correlated with deprivation in 2022, but a weak negative correlation existed in the data from 2020-22 in relation to the metric on prompt initiation, so the proportion decreases as deprivation increases (OHID, 2022; OHID, 2022).

To combat HIV, the UK Government set up the HIV action plan for 2022 to 2025. This follows a 35% reduction in new diagnoses between 2014 and 2019 nationally. And the UK reached

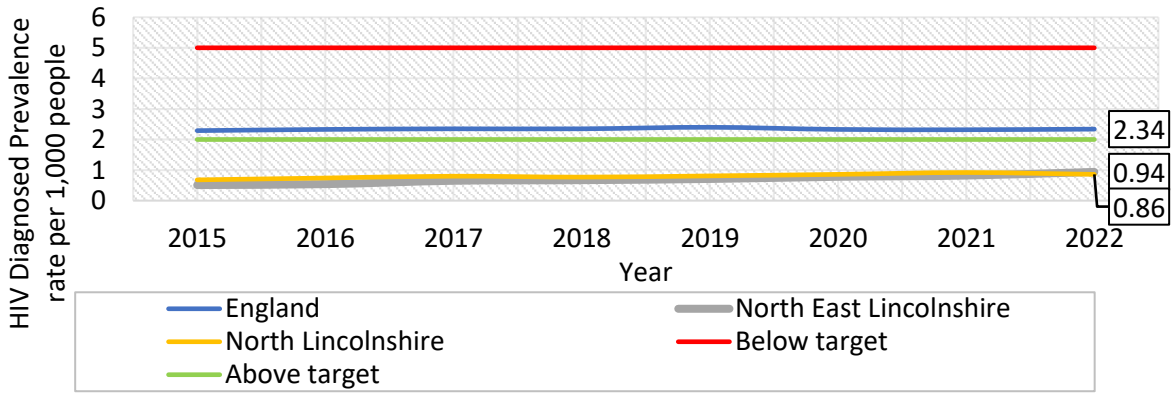
the UNAIDS 95-95-95 target for the first time in 2020, and then again in 2021, doing so by ensuring 95% of those living with HIV were diagnosed, 95% of those were on treatment, and 95% of those had an undetectable viral load (National AIDS Trust, 2021); (UKHSA, 2023). To continue this trend and reach a goal of zero new infections or AIDs/HIV-related deaths by 2030, the following have been set as realistic targets for 2025 (DHSC, 2021):

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

To help with this, Government identified a need to scale up HIV testing in line with national guidelines; optimise rapid access to treatment and retention in care; improve the quality of life of people living with HIV and address stigma; and ensure equitable access and uptake of HIV prevention programmes. More information can be found here.

Figure 24 below shows the diagnosed HIV prevalence per 1,000 population aged 15 to 59 from 2015 to 2022. It shows both LA's rates remaining above target and below England's rate. But where NL saw yearly increases but for slight drops in 2018 and 2022, and England's prevalence peaked in 2019 (falling thereafter), NEL's rate increased every year since 2014 and was, in 2022, statistically significantly different [lower] to England *only*.

Figure 24: HIV Diagnosed Prevalence Rate, Ages 15-59, per 1,000 Population* – NEL Compared to England and NL, 2015 – 2022.

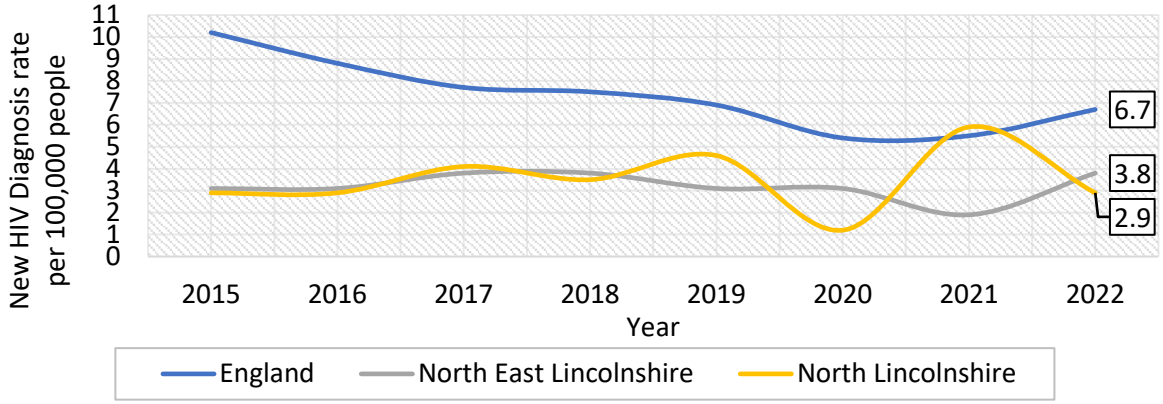


Source: UKHSA via (OHID, 2022)

** This only excludes cases where the diagnosis was made in England, but the patient does not reside there.*

With a figure of 0.94 in 2022, NEL placed NEL 11th out of 15 LAs (where 1st is the worst performing LA) regionally – being statistically significantly lower than the Yorkshire and the Humber value of 1.6, and 15th out of 16 LAs (where 1st is the worst performing LA) in terms of its CIPFA nearest neighbours – being statistically significantly lower than the neighbour's average of 1.44. Making up the 2022 figure [accessing HIV care] were 81 NEL residents aged 15 to 59 and 15 who were aged outside that range (OHD, 2021).

Figure 25: New HIV diagnosis rate, all ages, per 100,000 people* – NEL Compared to England and NL, 2015 – 2022.



Source: UKHSA* via (*OHID, 2022)

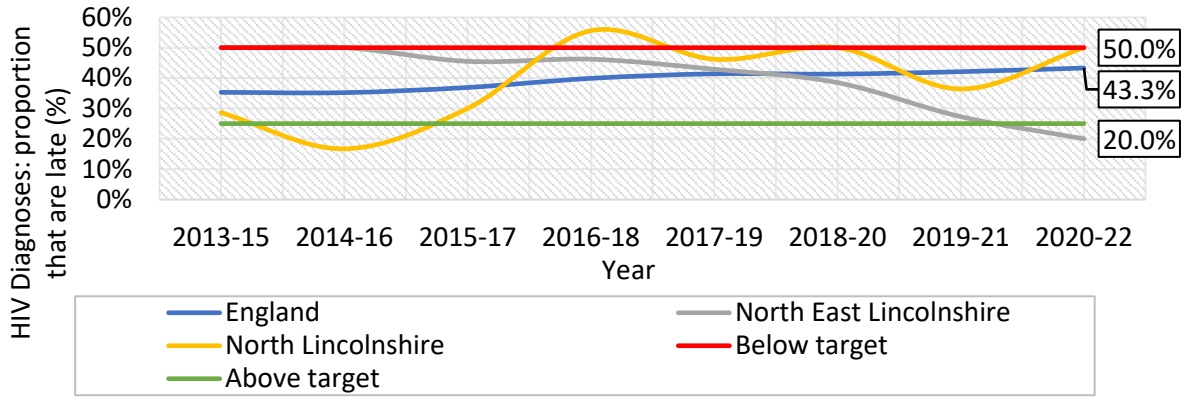
** This includes all HIV diagnoses regardless of which country a person first tested positive in), but it excludes cases where the diagnosis was made in England, but the patient does not reside there*.

Figure 25 above shows the rate of new HIV diagnoses for all ages, per 100,000 people. It shows all area's trends contrasting – all area's rates fluctuated, but England's peaks were in 2015, 2018, and 2022, NL's were in 2017, 2019, and 2021, and NEL's were in 2017-18, 2020, and 2022. Between 2021 and 2022, NEL's rate rose by approximately 1.9, while NL's rate halved to 2.9; England's rate rose by 1.2 in these years and was highest every year but 2021.

NEL's value in 2022 (3.8) was not statistically significantly different to England's or NL's. It put NEL 10th out of 15 LAs (where 1st is the worst performing LA) regionally – not being statistically significantly different to the Yorkshire and the Humber value of 6.5, and 9th out of 16 LAs (where 1st is the worst performing LA) in terms of its CIPFA nearest neighbours – the neighbours average is not calculable for this metric.

Figure 26 shows late diagnoses as a percentage of all diagnoses, late meaning cases where there was a CD4 count less than 350 cells per mm^3 within 91 days of a diagnosis. This excludes cases where the diagnosis was not made in the UK, where it was made in England but the patient lives elsewhere, and where there is evidence of recent seroconversion.

Figure 26: Proportion of [UK] HIV diagnoses that are late, people aged 15 or over (%) – NEL Compared to England and NL, 2013-15 – 2020-22.



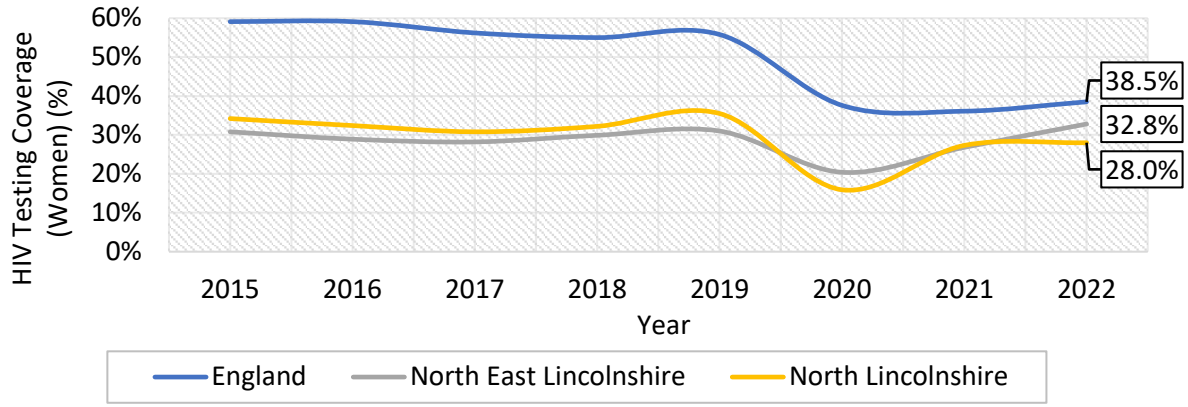
Source: UKHSA via (OHID, 2022)

** This only includes reports of HIV diagnoses first made in the UK, so it excludes cases where the diagnosis was made abroad, or where it was made in England, but the patient does not reside there.*

All three geographies' trends differ here: NEL's proportion decreased year-on-year but for a slight increase in 2016-18, England's increased yearly but for an even more marginal decrease in 2014-16, and NL only sustained a change in its figure once (2015-17). But due in-part to small counts, Confidence Intervals (CIs) for this metric are wide, so NEL's figure is not statistically significantly different to either comparator, though it was the lowest of the three in 2022, when it exceeded the benchmark for the first time. As this figure was 20%, NEL placed 14th out of the 14 LAs that supplied data (where 1st is the worst performing LA) regionally – not being statistically significantly different to the Yorkshire and the Humber value of 46.5, and 15th out of 16 LAs (where 1st is the worst performing LA) in terms of its CIPFA nearest neighbours – the neighbours average is not calculable for this metric.

Figure 27 below shows the proportion of **eligible** (a patient attending a SHS at least once in a calendar year) **women** tested for HIV (%)* in NEL compared to England and NL. This figure shows that the trends in all three areas were similar up to 2020, though NL's peak in 2019 and subsequent drop in 2020 were the most pronounced of the three. From 2020, England's proportion fell slightly – rising past that value in 2022 – as both LA's figures rose, with NEL sustaining its increase in 2022 as NL's slowed. NEL's 2022 value was statistically significantly higher than NL's, and lower than England's, whose rate was highest over the whole period.

Figure 27: Proportion of all eligible (a patient attending an SHS at least once in a calendar year) women tested for HIV (%)* – NEL Compared to England and NL, 2015 – 2022.



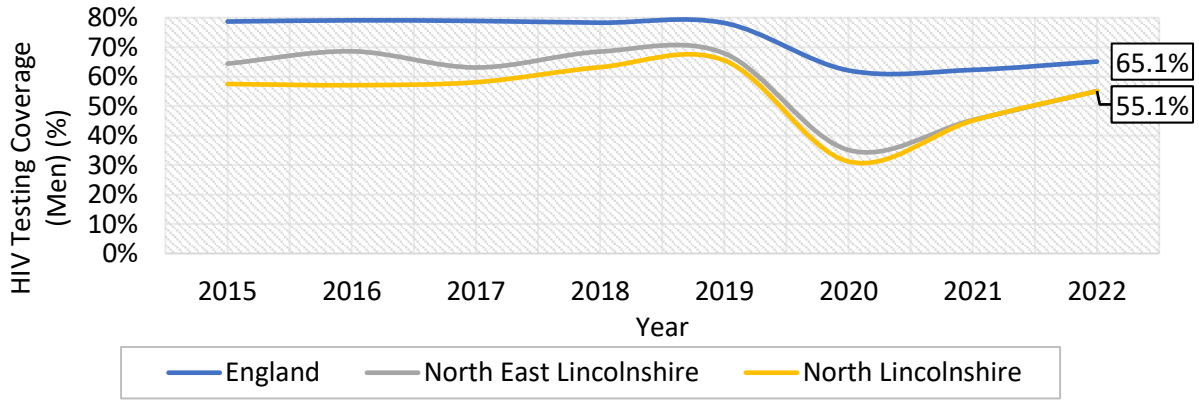
Source: UKHSA via (OHID, 2022)

** This excludes cases where the diagnosis was made in England, but the patient does not reside there; HIV-positive patients; those for whom a test is not appropriate; and those attending for Sexual and Reproductive Health **only**.*

As 32.8% of eligible women were tested in 2022, NEL placed 7th out of 15 LAs (where 1st is the best performing LA) regionally – being statistically significantly lower than the Yorkshire and the Humber value of 37.6%, and 8th out of 16 LAs (where 1st is the best performing LA) in terms of its CIPFA nearest neighbours – being statistically significantly lower than its neighbours average of 37.7%.

Figure 28 below shows the proportion of **eligible** (a patient attending an SHS at least once in a calendar year) **heterosexual men** tested for HIV (%). It shows NEL, England, and NL have similar trends, although England's figure has stayed consistently higher. From 2015 to 2019, England's figure fell slightly, while NEL's and NL's rose, but testing fell sharply in all three areas in 2020, rising at similar rates thereafter (though the national figure grew more slowly).

Figure 28: Proportion of all eligible (a patient attending an SHS at least once in a calendar year) heterosexual men tested for HIV (%) – NEL Compared to England and NL, 2015 – 2022.



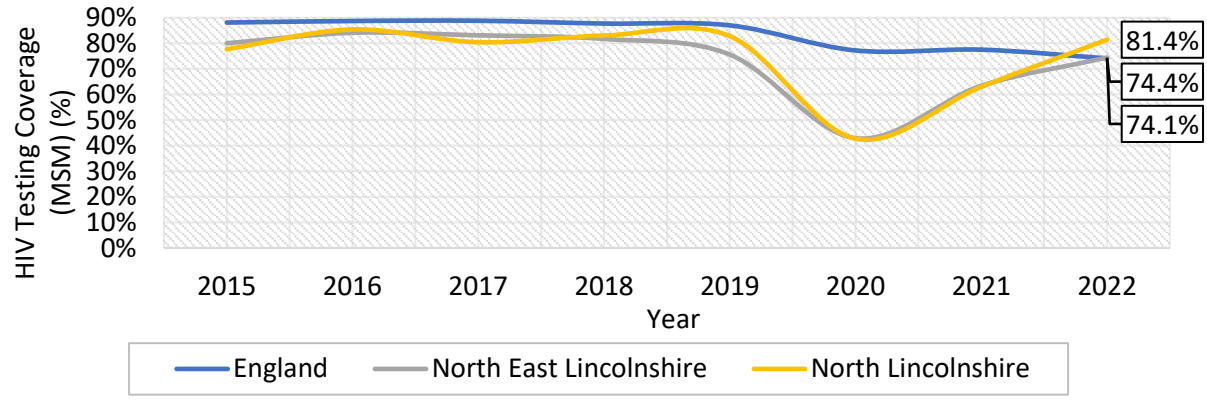
Source: UKHSA via (OHID, 2022)

* *This excludes cases where the diagnosis was made in England, but the patient does not reside there; HIV-positive patients; those for whom a test is not appropriate; and those attending for Sexual and Reproductive Health* ***only***.

As 55.1% of eligible heterosexual men were tested in 2022, NEL was statistically significantly different [lower] to England *only*, placing 10th out of 15 LAs (where 1st is the best performing LA) regionally – being statistically significantly lower than the Yorkshire and the Humber value of 60.4%, and 13th out of 16 LAs (where 1st is the best performing LA) in terms of its CIPFA nearest neighbours – being statistically significantly lower than its neighbours average of 64.9%.

Figure 28 below shows the proportion of **eligible** (a patient attending a SSRHS at least once in a calendar year) **MSM** tested for HIV (%). From 2015 to 2018 all three area's coverage stayed relatively static, though NL's figure fluctuated somewhat. Both LAs saw successive falls in 2019 and 2020 and successive increases in 2021 and 2022, with the most substantial changes in 2020 and 2022. The recent, upward trend in NEL slowed in 2022, though, leaving a figure [amongst MSM] which was not statistically significantly different to England or NL.

Figure 29: Proportion of all eligible (a patient attending an SHS at least once in a calendar year) MSM tested for HIV (%) – NEL Compared to England and NL, 2015 – 2022.



Source: UKHSA via (OHID, 2022)

* *This excludes cases where the diagnosis was made in England, but the patient does not reside there; HIV-positive patients; those for whom a test is not appropriate; and those attending for Sexual and Reproductive Health* ***only***.

As 74.4% of eligible MSM were tested in 2022, NEL placed 12th out of 15 LAs (where 1st is the best performing LA) regionally – not being statistically significantly different to the Yorkshire and the Humber value of 79.7%, and 13th out of 16 LAs (where 1st is the best performing LA) in terms of its CIPFA nearest neighbours – not being statistically significantly different to its neighbours average of 78.4%.

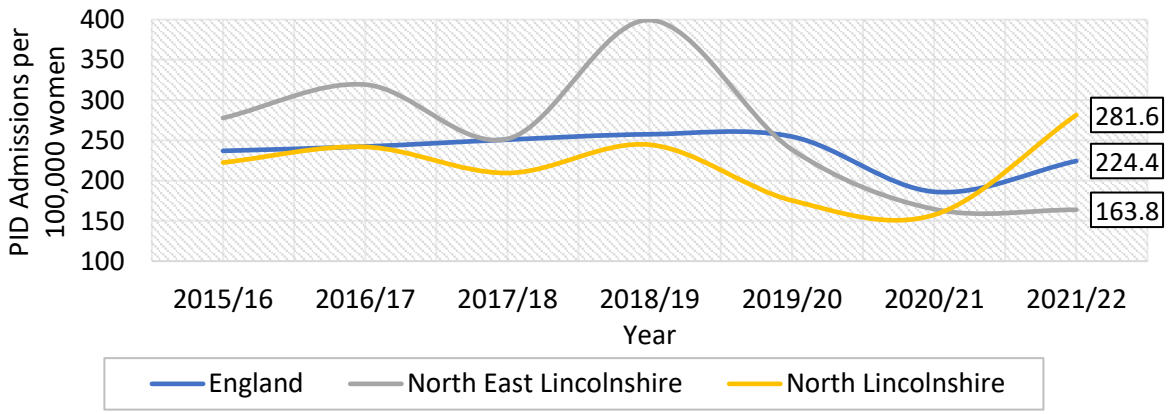
7.9 Trends in Pelvic Inflammatory Disease

Pelvic Inflammatory Disease (PID) refers to the infection and inflammation of the upper genital tract in people assigned female at birth, usually due to an STI, such as Chlamydia. PID is often asymptomatic, and most symptoms are mild, though it can cause chronic pain and ectopic pregnancy (NHS, 2022). National data suggests deprived areas are an at-risk group, with the most deprived quintile being the worst affected – its rate was 261.8 cases per 100,000 females in 2021/22, while the least deprived quintile's rate was 200.1 (OHID, 2022).

The prevalence of PID may be a proxy for untreated chlamydia, as, where a high screening coverage increases diagnoses, subsequent treatment reduces PID (OHID, 2023). So, these metrics should be interpreted alongside each other. But the validity of this link is subject to a locality's primary care centre's threshold for admission and the effectiveness of their outpatient treatment, for example.

Figure 30 shows females admitted with PID as a primary or secondary diagnosis, ages 15-44, per 100,00 females. Both NEL's and NL's rates fluctuated up to 2018/19, both seeing peaks in 2016/17 and 2018/19, then falling sharply thereafter. But while NEL's rate fell in 2022 too, NL's rose by 78.8% that year. Conversely, England's rate increased slightly and consistently up to 2019/20, fell by a quarter, and then rebounded by a relatively moderate amount. NEL's rate was the lowest in 2022 and was statistically significantly lower than both comparators. At 163.8 admissions per 100,000 people, NEL placed 12th out of 15 LAs (where 1st is the worst performing LA) regionally – being statistically significantly lower than the Yorkshire and the Humber value of 238.6, and 14th out of 16 LAs (where 1st is the worst performing LA) in terms of its CIPFA nearest neighbours – the neighbours average is not calculable for this metric.

Figure 30: Females Admitted to Wards with Pelvic Inflammatory Disease as a Primary or a Secondary Diagnosis, Ages 15-44, per 100,000 Females – NEL Compared to England and NL, 2015/16 – 2021/22.



Source: HES via (OHID, 2022)

7.10 Trends in Cancers, Cervical Screening and in HPV Vaccine Uptake

Sex-specific cancers may be communicated/observed at the point of contact, such as at opportunistic cervical smears. Cervical cancer is any cancer in the cervix, symptoms include pain between the hips when having sex and *unusual* vaginal bleeding or discharge (NHS, 2021). Most cervical cancers are caused by the HPV, and it is a contributing factor in many oral cancer cases. Except for some cases where painless lumps form around the genitals, a person infected with HPV is generally asymptomatic until further complications arise, including cancer. The risk is greater if a person is under 45, has a weakened immune system, i.e., if they are HIV-positive, has had children at an early age or multiple births, has been exposed to Diethylstilbestrol[*] in-utero, or has had vaginal, vulval, kidney, or bladder cancer before (NHS, 2021). HPV can be transmitted via penetrative and oral sex, sharing sex toys, and any contact with an infected person's genital area, so contraceptive barriers are unlikely to protect against it. This and the interrelationship between HPV and cancer rates compound the need to protect against it in other ways. Individually, a healthy diet and lifestyle may help to strengthen the immune system, but from a public health perspective, the national programme vaccinating against HPV is the cornerstone of the UK's preventative efforts, providing indicative proportions of immunised children and adults.

The NLISHS service covers vaccines for MSM under 45, and since September 2019, vaccines against HPV have been offered in two doses to all secondary-school children – first in year 8 and then again after 6 months – to provide protection (OHID, 2023). In 2021/22, male uptake of the first dose (53.8%) was lower than female (64.9%) in NEL, just as it was in 2019/20 and 2020/21, though this gap has widened OHID, 2022; 2022). The same is also visible in the uptake of the second dose, where male uptake in 2021/22 was 72% and female was 77.5% (OHID 2022; 2022); data only covers two years for the second dose for males, with both NEL's and England's figures increasing, and the former being statistically significantly higher than the latter in 2022 (OHID, 2022). Good uptake reduces demand for HPV and genital warts-related care long-term, but due to an inability to protect against all HPVs, vaccines must be taken alongside regular cervical screenings (NHS, 2019).

If a population is underrepresented in screening for cervical cancer, it may mean they have increased incidence and mortality. This is true of deprived areas. Nationally, people aged 25 to 49 in the most deprived quintile had an average screening coverage of 64.9% in 2022, while that was 72.7% for people aged 50 to 64, but these figures for the least deprived quintile was

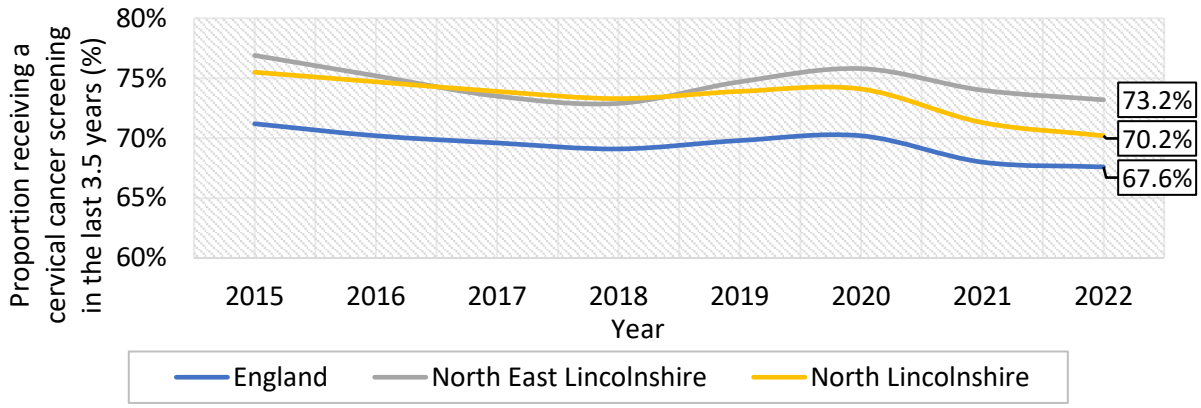
[*] Diethylstilbestrol is a synthetic estrogen product that has not been routinely prescribed since 1978 as it was found to be carcinogenic in 1971. (National Cancer Institute, 2021)

70.7% and 76.1%, respectively (OHID, 2022) (OHID, 2022) (also highlighting an age-related disparity). Also, there is a 65% higher incidence rate of cervical cancer in the most deprived quintile (relative to the least deprived quintile), and mortality related to cervical cancer is positively correlated with deprivation (Cancer Research UK, 2019). People with learning disabilities are also screened less than the general population. This disparity is significant across all ages but is largest in those aged 35 to 44 and 45 to 54. In the former, there was a 63% gap in coverage at ICB level in 2022/23, and in the latter, there was a gap of 41.1%(NHS Digital, 2023). Overall, 29.4% of people with learning disabilities were screened for cervical cancer at this level in 2022/23, relative to 73.2% of the general population; the gap has narrowed since 2021/22. But at 23.1% patient coverage in 2021/22 and 21.5% in 2022/23 the trends in these NHS statistics do not necessarily apply to the whole population.

Those who are White British are more likely to attend cervical cancer screenings than ethnic minorities too, particularly Indian, and Bangladeshi people. Bisexual females and those who have never had sex are also screened at a lower rate than exclusively heterosexual females, but females who have sex with females *only* are the least likely to be screened (Saunders, et al., 2021), with 15% of over 25-year-old FSF having never had a screening, compared to 7% of heterosexuals. It has been suggested that this is due to a misconception that FSF do not need to be screened (Meagher, 2019). Lastly, while research on attendance among transgender men and non-binary people assigned female at birth is scarce, a US study found only 50.5% of transgender men had had a screening within the last three years (Seay, et al., 2017), and there is UK-based anecdotal evidence that non-inclusive healthcare settings can cause anxiety and discourage attendance in the gender-diverse (Linfield, 2019).

Figure 31 below shows the proportion of females who are eligible for and have had a cervical cancer screening in the last 3.5 years, ages 25-49 (%), in NEL, as compared to England and NL – 2015 to 2022. NL's and England's trends were alike from 2015 to 2022, and while NEL's trend was similar, it started at a higher value and saw a greater increase in 2019 and 2020; NEL is the only area whose most recent value was not its lowest over the whole period, that value being statistically significantly higher than NL and England. Overall, both LA's provision was consistently higher than England's.

Figure 31: Eligible Females Who Have Had a Cervical Cancer Screening in the Last 3.5 Years, Ages 25-49 (%) – NEL Compared to England and NL, 2015 – 2022.

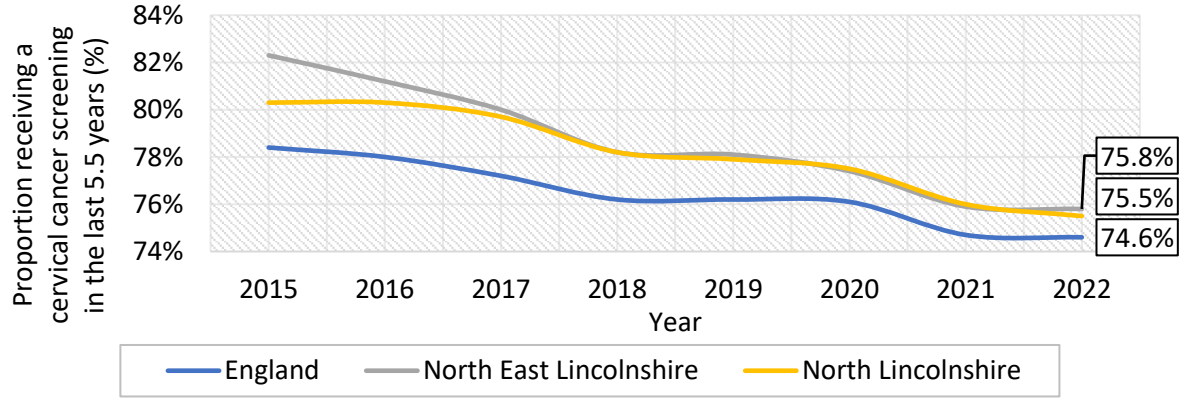


Source: Cervical Screening Programme via NHS Digital via (OHID, 2021)

The proportions in all three areas peaked in 2015, but there was a second peak in 2020, which was atypical in the context of all other datasets. As 73.2% of the relevant population were screened in the 3.5 years before 2022, NEL placed 5th out of 15 LAs (where 1st is the best performing LA) regionally – being statistically significantly higher than the Yorkshire and the Humber value of 70.3%. it's figure of 74% put it 5th out of 16 LAs (where 1st is the best performing LA) in terms of its CIPFA nearest neighbours in 2021, which was statistically significantly higher than the neighbours average of 71.8%.

Figure 32 below shows the proportion of females who are eligible for and have had a cervical cancer screening in the last 5.5 years, ages 50-64 (%), in NEL, as compared to England and NL – 2015 to 2022. While NEL saw the largest decrease in provision overall, screening is falling similarly in all three areas, and – like England's – NEL's figure fell by 0.1 in 2022, leaving a value statistically significantly different [higher] to England *only* (national provision has been consistently lower than in both LA's).

Figure 32: Eligible Females Who Have Had a Cervical Cancer Screening in the Last 5.5 Years, Ages 50-64 (%) – NEL Compared to England and NL, 2015 – 2022.



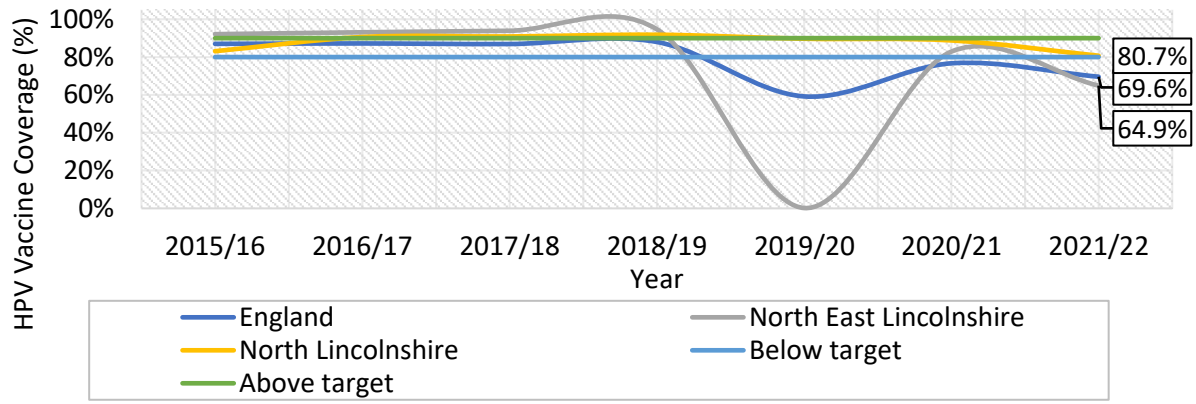
Source: Cervical Screening Programme via NHS Digital via (OHID, 2022)

As the relevant proportion screened stood at 75.8% in 2022, NEL placed 8th out of 15 LAs (where 1st is the best performing LA) regionally – not being statistically significantly different to the Yorkshire and the Humber value of 76.2%, and 5th out of 16 LAs (where 1st is the best performing LA) in terms of its CIPFA nearest neighbours – the neighbours average is not calculable for this metric.

Figures 33 to 35 explore the uptake of the HPV vaccine. It should be noted that delivery data for the first dose [for year 8s] in 2019/20 is incomplete in NEL – data had to be submitted up to the 20th of March, and the first national lockdown of the pandemic commenced the following Monday. At this point, the local programme had begun for the second dose [for year 9s] but not for the first dose, so when data was submitted, only children who had moved into the area from another LA and who had previously received the [first dose of the] vaccine, per their old LA's programme, could be counted. This count is five or less, corresponding with the 0.2% and 0.1% figures in Figure 33 and 35, respectively.

Figure 33 shows HPV vaccination coverage for one (priming) dose for females, ages 12-13 (%), in NEL, as compared to England and NL – 2015/16 to 2021/22. Uptake was relatively static in NL and England from 2016/17 to 2018/19, decreasing steadily in NL thereafter, while England's uptake dropped considerably in 2019/20, rebounded, and then fell.by a similar amount to NL in the next [two] years. Conversely, uptake in NEL increased consistently from 2015/16 to 2018/19, but like both comparators, its proportion fell between 2020/21 and 2021/22, though NEL's fell by the most (21.7%) (NEL's 2019/20 figure is not comparable as the vaccine was not rolled out due to the pandemic's onset, rendering that data point void).

Figure 33: HPV Vaccination Coverage for One (Priming) Dose for Females, Ages 12-13 (%) – NEL Compared to England and NL, 2015/16 – 2021/22.

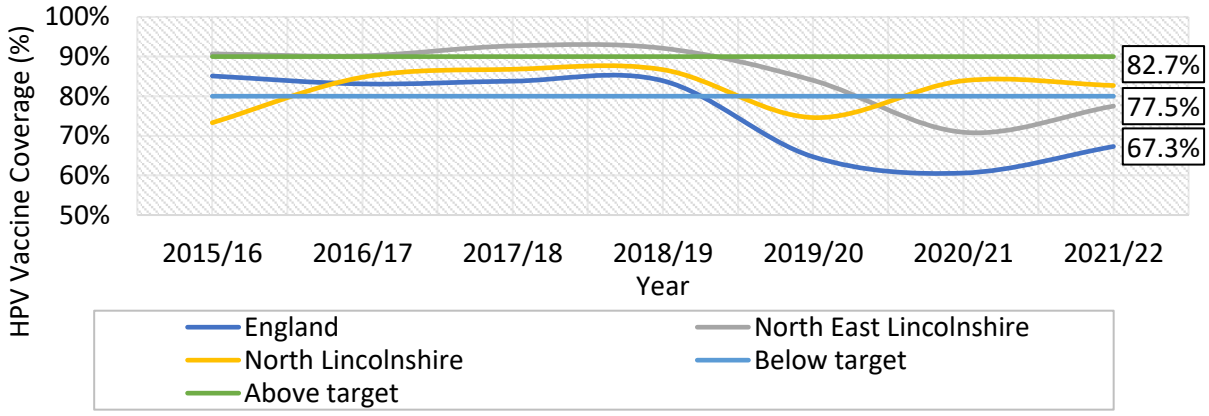


Source: UKHSA via (OHID, 2022)

As 64.9% of females aged 12-13 received the HPV vaccine in 2021/22, NEL's uptake was statistically significantly lower than England and NL. And NEL placed 14th out of 15 LAs (where 1st is the best performing LA) regionally – being statistically significantly lower than the Yorkshire and the Humber value of 74.5%, and 11th out of 16 LAs (where 1st is the best performing LA) in terms of its CIPFA nearest neighbours – the neighbours average is not calculable for this metric.

Figure 34 below shows HPV vaccination coverage for a second (completing) dose for females, ages 13-14 (%), in NEL, as compared to England and NL – 2015/16 to 2021/22. The trends are like those seen in the provision of the first dose, though the values are lower, and the recent downward trend in uptake is not apparent. All three areas' proportions increased between 2016/17 and 2018/19, then fell in 2019/20. NL's proportion rebounded the next year, then fell by only 1.2, while England's and NEL's fell in 2019/20 and 2020/21, before rising by similar amounts (6.6 and 6.7, respectively). NEL's most recent figure is statistically significantly lower than NL and higher than England.

Figure 34: HPV Vaccination Coverage for a Second (Completing) Dose for Females, Ages 13-14 (%) – NEL Compared to England and NL, 2015/16 – 2021/22.



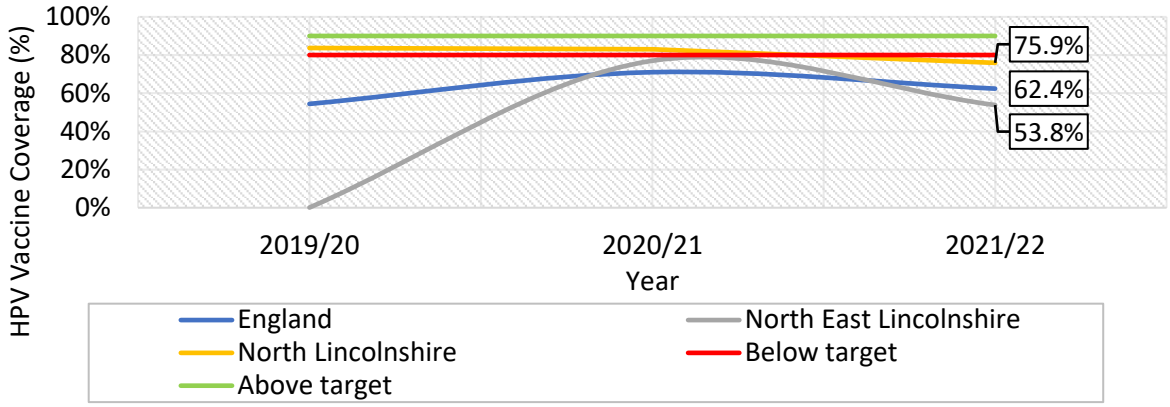
Source: UKHSA via (OHID, 2021)

As 77.5% of females aged 13-14 received the HPV vaccine in 2021/22, NEL placed 9th out of 15 LAs (where 1st is the best performing LA) regionally – being statistically significantly higher than the Yorkshire and the Humber value of 70.1%, and 7th out of 16 LAs (where 1st is the best performing LA) in terms of its CIPFA nearest neighbours – the neighbours average is not calculable for this metric.

Figure 35 shows HPV vaccination coverage for one (priming) dose for males, ages 12-13 (%), in NEL, as compared to England and NL – 2019/20 to 2021/22. This data is relatively new, so it is limited in terms of its discernible trends. In 2021/22, NEL's figure was statistically

significantly lower than England's and NL's; although the rate in all three fell that year, NEL's fell by the most (30.1%).

Figure 35: HPV Vaccination Coverage for One (Priming) Dose for Males, Ages 12-13 (%) – – NEL Compared to England and NL, 2019/20 – 2021/22.



Source: UKHSA via (OHID, 2022)

As 53.8% of NEL's males aged 12-13 were given an HPV vaccine in 2021/22, it placed 13th out of 15 LAs (where 1st is the best performing LA) regionally – being statistically significantly lower than the Yorkshire and the Humber value of 67.6%, and 11th out of 16 LAs (where 1st is the best performing LA) in terms of its CIPFA nearest neighbours – the neighbours average is not calculable for this metric.

7.11 Summary:

- Secondary-school age children's knowledge of STIs is low and decreasing.
- There was no statistically significant difference between NEL's and England's diagnostic rates for gonorrhoea, genital herpes, genital warts and HIV, although NEL's syphilis rate was statistically significantly lower. In NEL, all these rates except syphilis increased in the year up to 2022 in NEL, and the same trends were evident at a national level, except England's rate for syphilis rose and its rate for genital warts fell. However, NEL's rate of testing for all STIs – except chlamydia in the under 25s – was statistically significantly lower than England's, suggesting its diagnostic rates are underestimates.
- Provision of the 1st doses of the HPV vaccine [to males and females] and the screening of both age groups for cervical cancer all decreased in the year up to 2022 – the screening of 50 to 64-year-olds for cervical cancer has fallen yearly since 2015, though it was statistically significantly higher than in England in 2022. Provision of the 2nd doses and screening for HIV and chlamydia all increased.

- NEL's most recent figure for HIV screening in females was statistically significantly lower than the national and regional averages, and it was statistically significantly lower than England in the case of heterosexual males, and there's no significant difference in MSM; screening of women and heterosexual males is low, relative to MSM.
- Under two-fifths of those with a need, initiated or continued using PrEP in 2021.

8.0 Reproductive Health and Sexual Violence in NEL

8.1 An Overview of Reproductive Health in NEL

This section summarises the sexual health of NEL's residents in terms of their reproductive health, alongside a summary of sexual violence in the area. It uses England, Yorkshire, and the Humber, and NEL's Nearest Neighbours (the 15 LAs with the most similar socio-economic situation, per CIPFA (CIPFA, 2022)) as benchmarks. NL is also referred to in every indicator because it's NEL's nearest neighbour geographically, and in terms of the CIPFA model.

Again, the Covid19 pandemic is important contextually. As, firstly, sexual behaviours changed in that timeframe. In terms of sexual activity, national research found 63% of adults had sex during the first lockdown in 2020, over three-quarters of whom were cohabiting and 57% did not feel the amount of sex they had had changed relative to the three months before lockdown (Mercer, et al., 2022). The proportion of sexually active people who experienced no change falls to 40% among those aged 18 to 24, though two thirds experienced a decrease, and a similar proportion experienced a decrease in sexual satisfaction.

A separate study on a similarly representative sample observed changes between one cohort who had conceived prior to the first lockdown and another who had conceived after it (Balachandren, et al., 2022). The most prominent change was in planned pregnancies, with the proportion who did not plan to conceive increasing from 1.3% in the first cohort to 2.1% in the second, and the proportion who were ambivalent to their pregnancy increased from 16.1% to 20.5%. There was also a near 11-fold increase to 6.5% in the second cohort who said it was difficult to access contraception.

The inability to access contraception has also been raised in evidence submitted to the All Party Parliamentary Group on Sexual and Reproductive Health's (APPG SRH) report on access to contraception (APPG SRH in the UK, 2020), with 40% of respondents to a survey by the Advisory Group on Contraception saying accessibility had decreased. Similarly, a study by UCL and UCLH discussed survey respondents who had conceived during the pandemic and noting increased difficulty accessing services when a familiar one closed. This change in

accessibility shows the shift towards online services not wholly bridging the access gap at its outset.

But there are other considerations on SCSs, as the BASHH survey that found 53% of clinicians to be working at less than 20% of their pre-pandemic capacity also showed that rose to 65% in terms of contraception services (BASHH, 2020). Routine fitting of LARCs had also been substituted with oral contraception; 12% of services limited or ended fittings for emergency contraception; 39% limited or ended provision for LARC related complications, and 23% even limited or ended provision of oral contraceptives (APPG SRH in the UK, 2020). Patients 'self-censored' their need as a result (Pérez, et al., 2023).

Covid-19 also [indirectly] affected other areas, coinciding with a 103% increase in the number of cases of CSE raised by SHSs nationally and a 795% increase in domestic violence cases from 2019 to 2021 (LGA, 2022). This highlights the gap between Police Recorded Crime (PRC) and reported abuse, as the rate of domestic abuse-related incidents and crimes recorded by the police – per 1,000 people aged 16 and over – was 27.8 for England in 2018/19, increasing year-on-year to a seven-year-high of 30.8 in 2021/22; That figure was 35.1 for the Humberside Police force area in 2021/22, so it was in the middle quintile, having been in the highest quintile in the previous three years (OHID, 2022). On CSE, service data in NEL states the number of children with a social care assessment identifying CSE factors was 97 in 2021/22, falling from 164 in 2020/21 and 167 in 2019/20, but this had risen by 421.9% on the 2018/19 total of 32; this method of measuring CSE suggests a peak around 2020, but relative to its nearest neighbours and England, NEL's 2021/22 figure [as a proportion of all assessments] is consistent.

On abortion care, measures were taken under the emergency provisions of the Coronavirus Act 2020 to approve the use of telemedicine for patients whose last period was less than 10 weeks prior to a consultation, enabling phone consultations, and the postage of abortion-related medicine to patients at home. Going forwards, the cost-of-living is likely to have a larger impact on planned pregnancies, and therefore abortion care; there is evidence from East Yorkshire (Wokoma, et al., 2014) that money worries are the biggest consideration when deciding whether to abort, with contraceptive failure the second-most common reason.

Further on local maternal healthcare, NEL's service data for 2022/23 shows a large proportion of those conceiving are not 'birth ready' when they register with maternity services. On their health, data from NLAG maternity services for NEL residents shows the proportion that smoked at the time of booking was 19.9% (77.9% were from the most deprived quintile) – down from 20.2% the year before, and 20.2% smoked at the time of delivery (77.3% were

from the most deprived quintile) down from 20.3% the year before. Also, only 34.3% were a healthy weight on booking, while 59% were overweight or obese (53.4% were from the most deprived quintile), and 4.6% were underweight. Local data on alcohol consumption in pregnancy is not extractable, but research featuring in PHE guidance from December 2020 estimated 41.3% of pregnant women used alcohol in pregnancy (Popova et al, 2017); commissioned substance misuse service data states that, of all the female clients starting treatment in 2022/23, 3.1% were recorded as pregnant on the National Drug Treatment Monitoring System (NDTMS) at the start of that treatment journey, relative to 1.7% in 2021/22.

External pressures on people, e.g., Covid-19 and falling living standards, are compounded by pressures on existing services' funding streams, limiting their capacity to act in a broader sense, but also to engage constructively with the myriad number of inequalities that cause minorities' health outcomes to be worse than the respective majority. The limits of data collection in the current system also obscuring a full-picture-view of inequalities.

8.2 Young People's Reproductive Health and Knowledge of Services: Insights from the ALS

Nationally, conceptions in those aged 15 to 17 fell yearly from 41.6 conceptions per 1,000 females in 2007 to 13.1 in 2020. And there was a 16% decrease among 13 to 15-year-olds from 2019 to 2020 (ONS, 2022). NEL followed this trend, but it has been statistically significantly higher than England since 1998 (OHID, 2020), when formal recording began.

To improve on this and other, similar metrics, it is imperative to understand behavioural trends in our young people and their knowledge of our services. This section draws on the ALS, which is a 2-4-yearly survey of children in years 7 to 11 (ages 11 to 16) in NEL; the 2021 ALS was completed under exam conditions in October. The focus is on four questions, all of which were posed to years 9 to 11 *only*, except for the third question, which was put to years 7 to 11. In the first, respondents were asked if they had had sex, and out of the 4,271 respondents in years 9 to 11, 4,055 answered. In the second question, 3,898 said whether they knew where to get free condoms. 4,146 said whether they had heard of the C-Card scheme, and 3,858 answered the fourth question on they had a C-Card. A fifth question related to knowledge of access to abortion-care and was posed to those who had had sex and were heterosexual or bisexual, giving 431 answers, which only permits a summary statistic – 26.9% of respondents did not know where to go to get an abortion, rising from 20.4% in 2019.

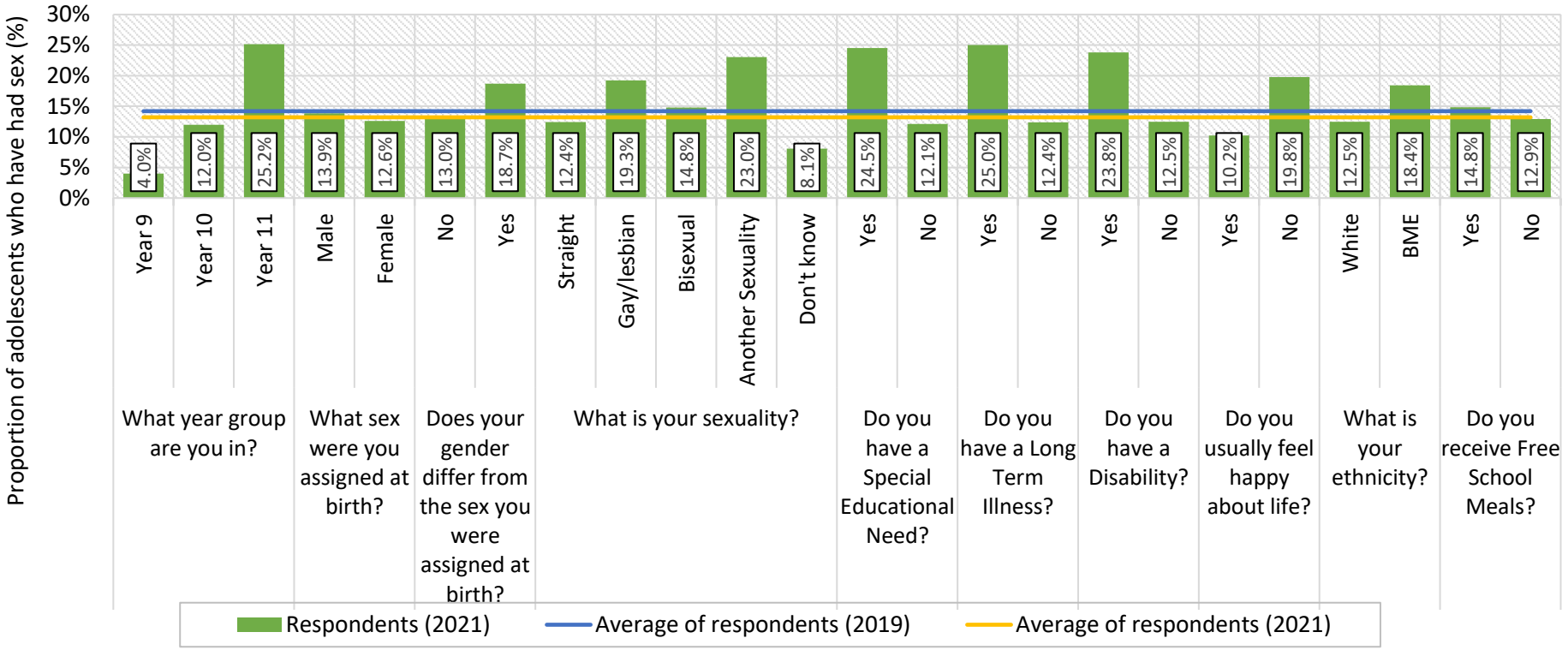
There was also a question on how many adolescents used [what kinds of] contraception when they last had sex. But similarly, the format only permits headlines: those whose gender is

different to that assigned at birth and those who self-described their sexuality were by far the most overrepresented in terms of the use of emergency contraception, followed by people with SEN. Younger years were also much more likely to have used no contraception.

Figures 36 to 39 show proportions for children's responses to the four questions, with a full demographic breakdown. Data from the 2019 ALS is shown alongside that from the 2021 ALS for reference where it exists. But there is a caveat in that a small portion of children were not NEL residents, so some will have travelled from other LAs to go to school in NEL. Also, the number in each demographic were in line with expectations, and the lowest number responding that was used for a proportion was 156 – the number of gay/lesbian people saying whether they had a C-Card; where a demographic is omitted, it is because there were not enough responses to that question from that demographic to get a representative figure.

On the percentage of secondary-school-age children who had had sex in 2021, Figure 36, the highest is found amongst minorities, with almost all having a percentage that is above the 2019 and 2021 average. On the highest disparities – those with a special educational need and those with a long-term illness are more than twice as likely to have had sex as the populations without. Also, a higher proportion of males had had sex, there is a six-fold increase on the proportion of year 9s who had had sex to get to that for year 11s – over a quarter of whom indicated they had had sex. Overall, there has been a slight decrease from 2019 to 2021.

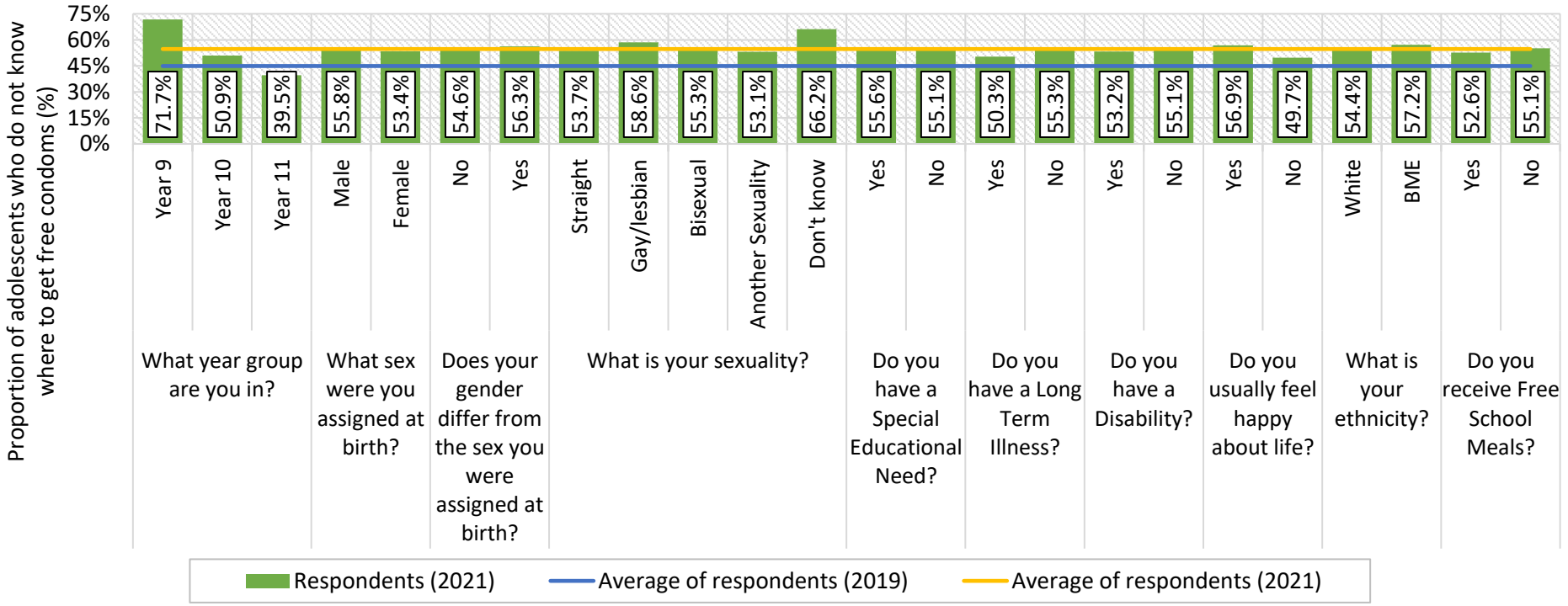
Figure 36: How Many Adolescents have had Sex? (2021).



Source: ALS (NELC, 2021) and (NELC, 2019)

On the proportion of secondary-school-age children who did not know where to go to get free condoms in 2021, Figure 38, there is a mixed picture in terms of whether minorities are as vulnerable as their respective majorities, as although those with a long-term illness are less aware, several – including racial minorities, gay/lesbian people, and those who do not know their sexuality – are above the 2021 average, with two thirds (66.2%) of the latter not knowing where to go. On age and sex, younger people and males are less aware. The percentage of adolescents who do not know where to go is 9.8% higher in 2021 than it was in 2019.

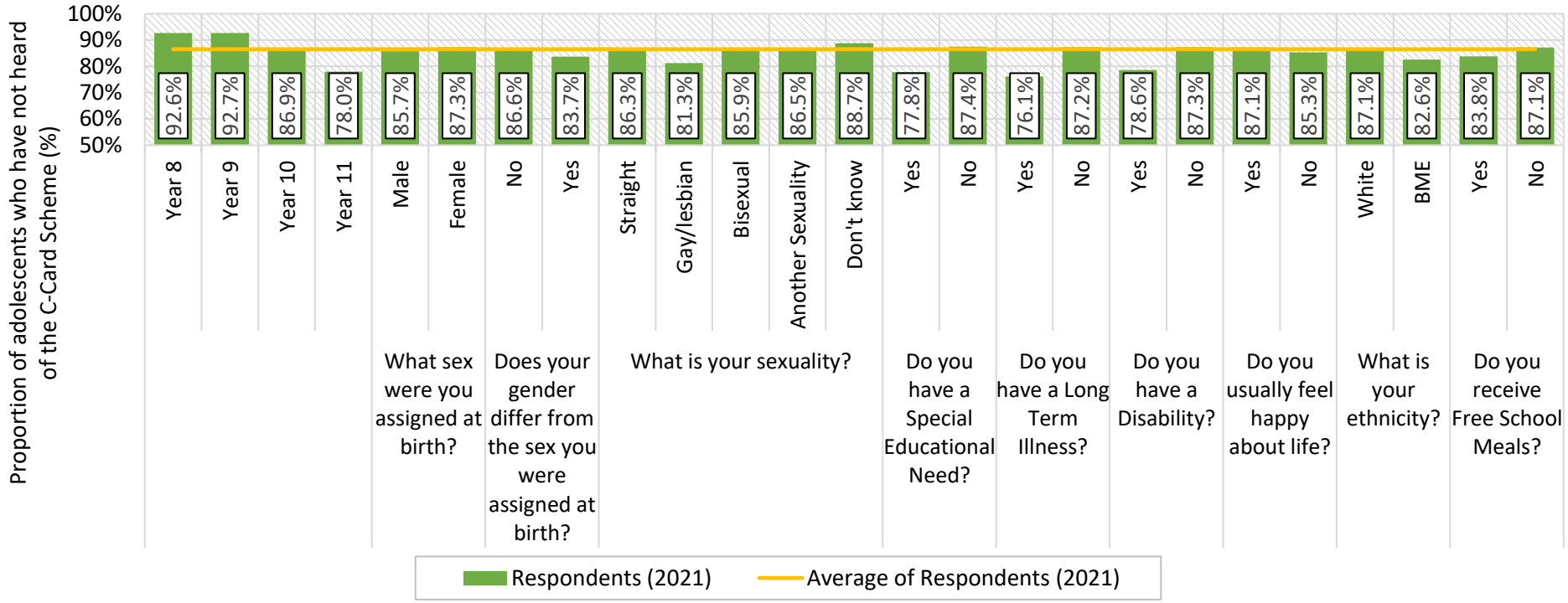
Figure 37: How Many Adolescents do *Not* Know Where to go to get Free Condoms? (%)



Source: ALS from (NELC, 2021) and (NELC, 2019)

On the proportion of secondary-school-age children who had not heard of the C-card scheme, figure 39, minorities were broadly more aware, except for those who do not know their sexuality and those who wrote-in their sexuality. The group with the highest proportion who had heard of it was those with a long-term illness (23.9%). Those in year 9 are the least aware (7.3%), and females and younger people are generally less aware. while there were sufficient responses in year 8, there were not enough respondents in year 7 to get a reliable, representative figure for them. This was the first ALS to ask about the C-Card, revealing only 13.5% had heard of it.

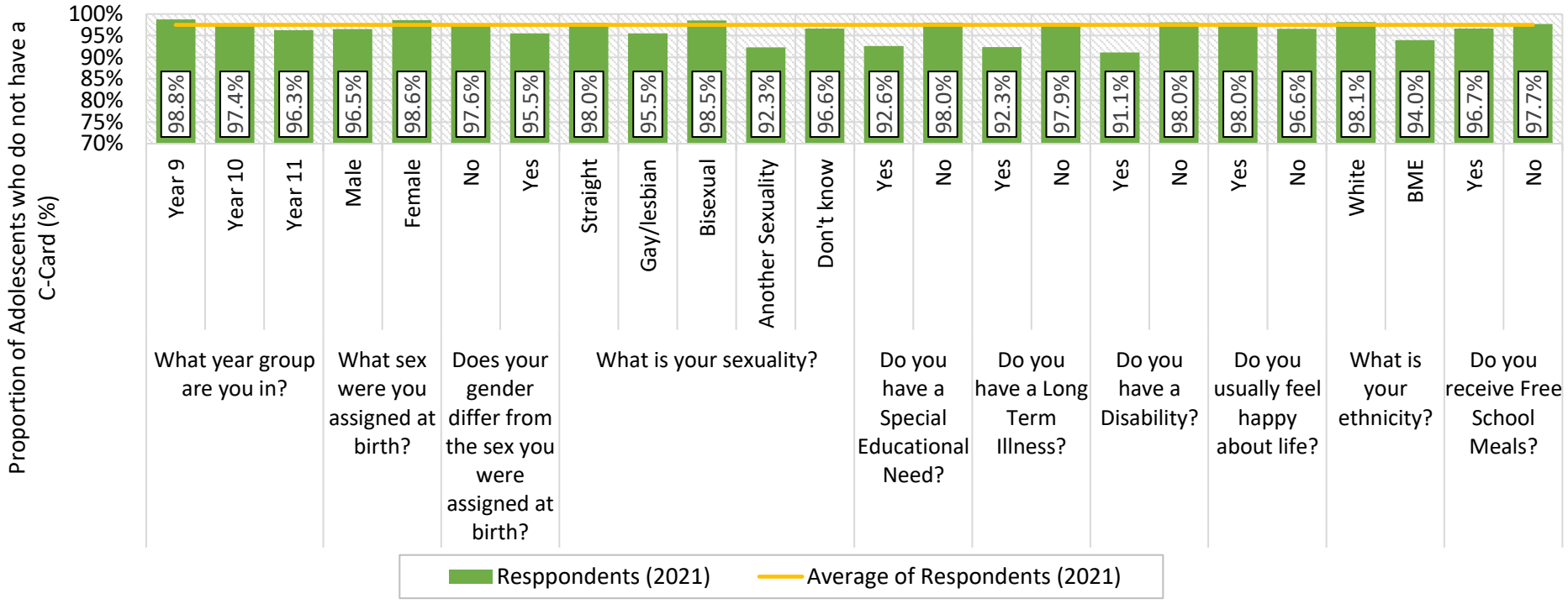
Figure 38: How Many Adolescents Have *Not* Heard of the C-Card Scheme? (%) - 2021



Source: ALS (NELC, 2021)

On the proportion of secondary-school-age children who had a C-card, figure 40, participation was higher amongst minorities, with the most engaged groups being those with a disability (8.9%), those who wrote-in their sexuality (7.7%), and those with a long-term illness (7.7%). But only 2% of heterosexuals, those without a disability, those without a special educational need, and those who usually feel happy about life had one, but participation is lower still for females (1.4%) and year 9's (1.2%), with a greater proportion of males and older children having one. This was the first ALS to ask about the C-Card, revealing only 2.5% of children had one.

Figure 39: How Many Adolescents Do *Not* Have A C-Card? (%) - 2021



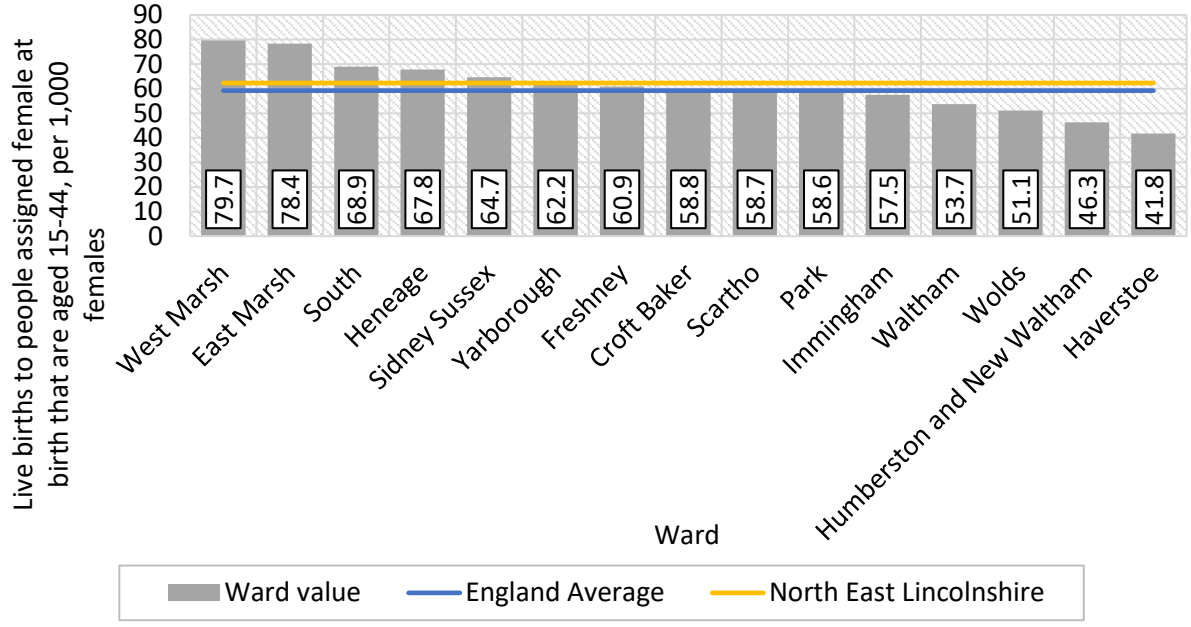
Source: ALS (NELC, 2021)

8.3 Fertility, Unplanned Pregnancies, and Teenage Pregnancies

Fertility rates are correlated with population growth and can be used to forecast future population change (OHID, 2022), allocate resources, and design services to help meet residents' needs, such as through the provision of postnatal care.

Figure 40 shows a pronounced skew in general fertility rates in NEL's wards over a five-year data-pool (2016 to 2020). The NEL average is statistically significantly above that of England.

Figure 40: General Fertility Rate - Number of Live Births Per 1,000 Females, Ages 15 to 44 (2016-2020 (5-Year-Datapool) by Electoral Ward in NEL).



Source: ONS via (OHID, 2020)

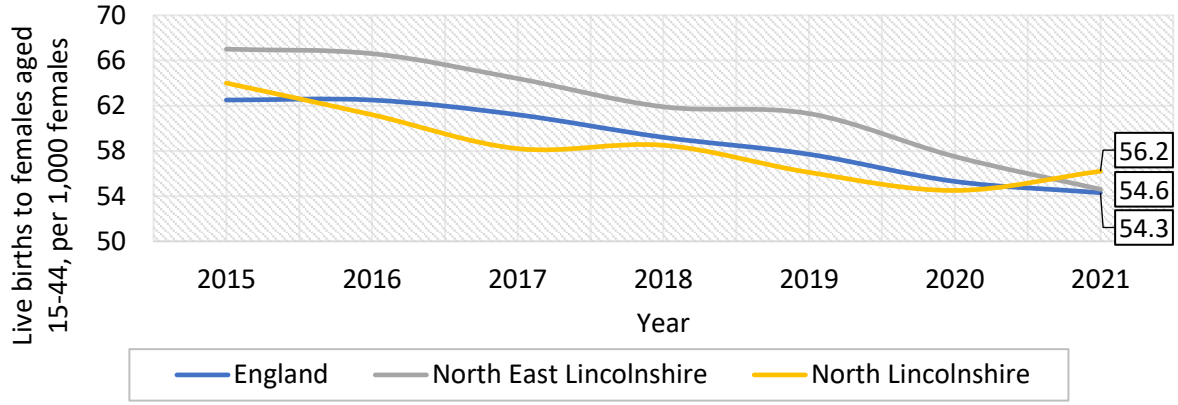
Also, by graphing each ward's average rank from the IMD (2019) (Department for Levelling Up & Ministry of Housing, 2019) with its general fertility rate, a correlation coefficient of -0.85 is derived, meaning these metrics are strongly correlated. So, the observed geographical difference in the rate of NEL's wards 2020 is unlikely to be due to natural variation and a large part is, instead, associated with differences in deprivation. This correlation is not as strong as it is at a national level. Haverstoe, Humberston and New Waltham, Wolds, and Waltham all have birth-rates that are statistically significantly lower than the NEL average [for 2016-2020], and Heneage, South, West Marsh, and East Marsh all have rates that are statistically significantly higher.

There are also disparities in the General Fertility Rate when it is analysed by ethnicity – when an ethnic group's population [according to The Census 2021 (ONS, 2022)] is paired with its

number for live births (ONS, 2021), the crude birth-rates for the Yorkshire and the Humber region are: Asian – 14.9; Black – 14; Mixed/Multiple – 23.4; White – 9.2; Any other ethnic group – 17.5. This shows the birth-rate amongst White people is less than half that of those with a Mixed/Multiple ethnic group and is 6.6 points below the average. Nationally, young females with mild to moderate learning disabilities also conceive and give birth more than the general population (Baines, et al., 2018).

Figure 41 shows the general fertility rate again but for single years and at a larger granularity. It shows there has been a large decline in birth-rates in NEL and England over since 2015, with NEL's birth-rate falling by 12.4 live births per 1,000 females and England's falling by 8.2. Subsequently, the gap between NEL and England has fallen from 4.5 in 2015 to 0.3 in 2021.

Figure 41: General Fertility Rate – Number of Live Births Per 1,000 Females, Ages 15 to 44 – NEL Compared to England and NL, 2015 – 2022.



Source: ONS via (OHID, 2020)

NL's rate also decreased by 7.8 overall, but it rose twice, and by 1.7 in 2021. In the most recent data point, NEL's rate of 54.6 births per 1,000 15 to 44 year-old females was not statistically significantly different to England or NL, and with it NEL placed 10th out of 15 LAs (where 1st is the LA with the highest birth-rate) regionally – not being statistically significantly different to Yorkshire and the Humber's value of 54.1, and 9th out of 16 LAs (where 1st is the LA with the highest birth-rate) in terms of its CIPFA nearest neighbours – not being statistically significantly different to its neighbours average of 57.9.

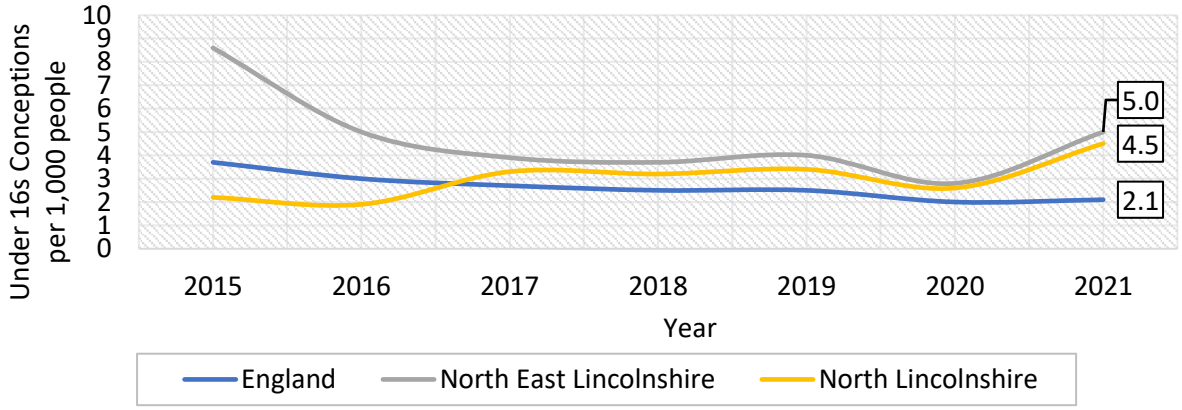
Teenage pregnancies are also important, as they are usually unplanned – 26% of pregnancies to that aged under 18 were aborted in NEL in 2021 (OHID, 2021) – and they are usually associated with poorer outcomes for both the pregnant person and the baby. On the disparities, longitudinal studies have shown the pregnant person may suffer with poor mental health up to three years after the pregnancy (PHE, 2018); is 22% more likely to live in poverty

at age 30 than someone who gave birth after 24 (LGA, 2018); is less likely to have good educational attainment and live in high quality housing (OHID, 2022). Plus, the mortality rate is approximately 60% higher for babies conceived by teenagers (ONS, 2023). This is a particular concern for NEL, as it had the 4th highest conception rate of any LA for 15 to 17-year-olds in 2021 (OHID, 2021), and the seventh worst for 13- to 15-year-olds (OHID, 2021).

In terms of vulnerabilities, national data implicates deprivation – the most deprived decile – per the IMD (2019) – has the highest under 18s conception rate at 18.2 per 1,000 females, while the least deprived decile has the lowest rate (6.8), and there is a linear, stepwise drop between them but for a disparity of 0.2 between the 3rd and fourth-least deprived deciles' figures (OHID, 2021). On the under 16s conception rate, this inequality is less pronounced, though there is still an increase from 1.2 in the least deprived and least affected quintile to 3.2 in the most-deprived and most affected quintile (OHID, 2021). Other factors associated include repeated school absence and being a Looked-After Child and/or an FSF (PHE, 2021).

Figure 42 shows the conception rate for ages 13-15, per 1,000 females. Trends in NEL, England, and NL mirrored each other from 2017 to 2020 – each seeing a slight fall. But while England's rose from 2 to 2.1 in 2021, the LAs rates rose sharply – by 78.6% in NEL's case, leaving NEL with the highest rate, that being statistically significantly different [higher] to England *only*.

Figure 42: Under 16s Conception Rate, Ages 13-15, per 1,000 Females – NEL Compared to England and NL, 2015 – 2021.

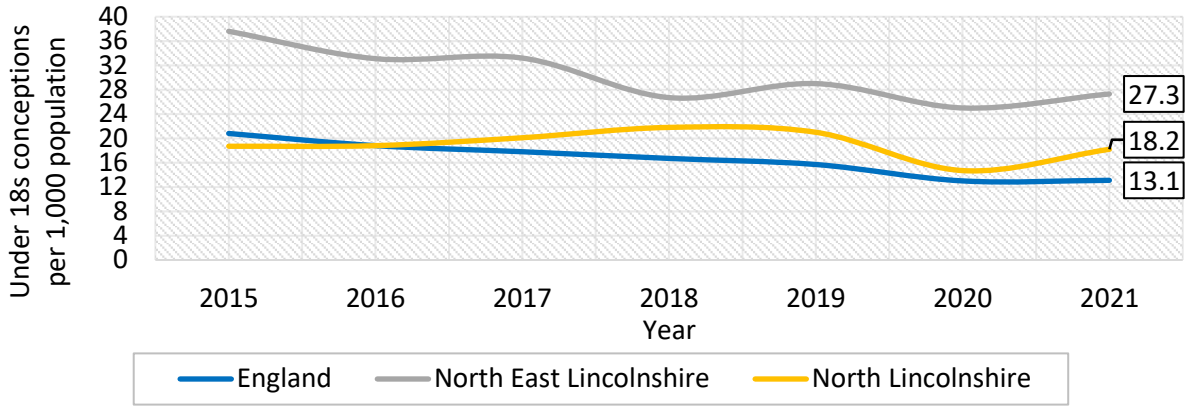


Source: ONS via (OHID, 2021)

At a rate of 5 in 2021, NEL placed 2nd out of 15 LAs (where 1st is the worst performing LA) regionally – not being statistically significantly different to Yorkshire and the Humber's value (3.2), and 2nd out of 16 LAs (where 1st is the worst performing LA) in terms of its CIPFA nearest neighbours – not being statistically significantly different to the neighbours average of 3.5.

Figure 43 shows the conception rate for ages 15-17, per 1,000 females. For under 18s, there is a broad downward trend in NEL and England, like that seen in the under 16s, but where England's rate fell year-on-year, NEL's fluctuated as it fell (both falling by 27.4% and 37% overall, respectively). NL's rate rose to a peak in 2018, before falling in two successive years, then rising in 2021 in a change that only NEL shared; NL only saw a 2.7% fall overall. In 2021, NEL's rate was highest and was statistically significantly different [higher] to England *only*.

Figure 43: Under 18s Conception Rate, Ages 15-17, per 1,000 Females – NEL Compared to England and NL, 2015 – 2021.

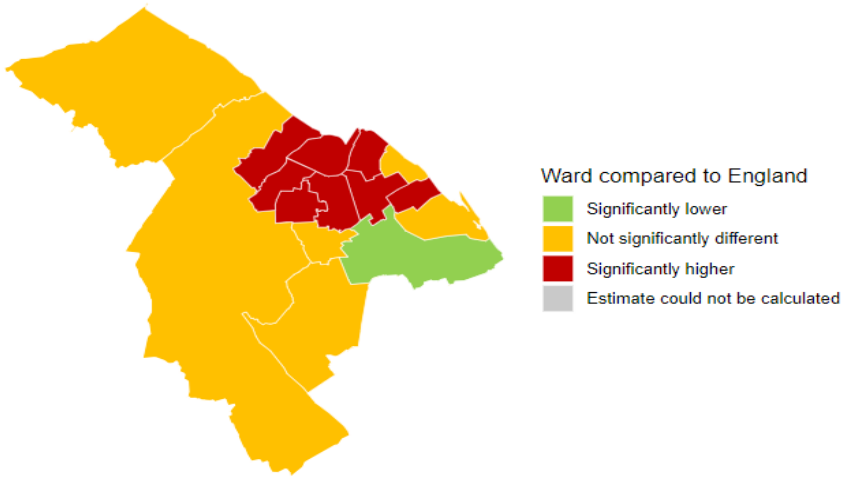


Source: ONS via (OHID, 2021)

With a rate of 27.3 for under 18s conceptions, NEL placed 2nd out of 15 LAs (where 1st is the worst performing LA) regionally – being statistically significantly higher than Yorkshire and the Humber's value of 17.1, and 1st out of 16 LAs (where 1st is the worst performing LA) in terms of its CIPFA nearest neighbours – the neighbours' average is not calculable for this metric.

2018-20 data (see figure 44) for under 18s conception rates shows that eight wards are statistically significantly higher than England, with only one (Humberston and New Waltham) being statistically significantly lower.

Figure 44: Under 18s Conception Rate, Ages 15-17, per 1,000 Females (2021).



Source: Ordnance Survey data and National Statistics data via (UKHSA, 2023)

8.4 Abortions

Accessible, safe abortions are a right and are fundamental to a good standard of [sexual and reproductive] health. There are two main methods in the UK: medical, where the person takes two medications over one or two days and passes the pregnancy vaginally (the most common method when the pregnancy is under 10 weeks), and surgical, with vacuum aspiration being used up to 14 weeks, and dilation and evacuation thereafter (NHS, 2020). Complications from surgical abortions arose at a rate of 1.2 per 1,000 abortions in 2020 (DHSC, 2022), and while both types have side-effects, e.g., stomach cramps, vaginal bleeding, etc. neither generally require a follow up when performed in a hospital.

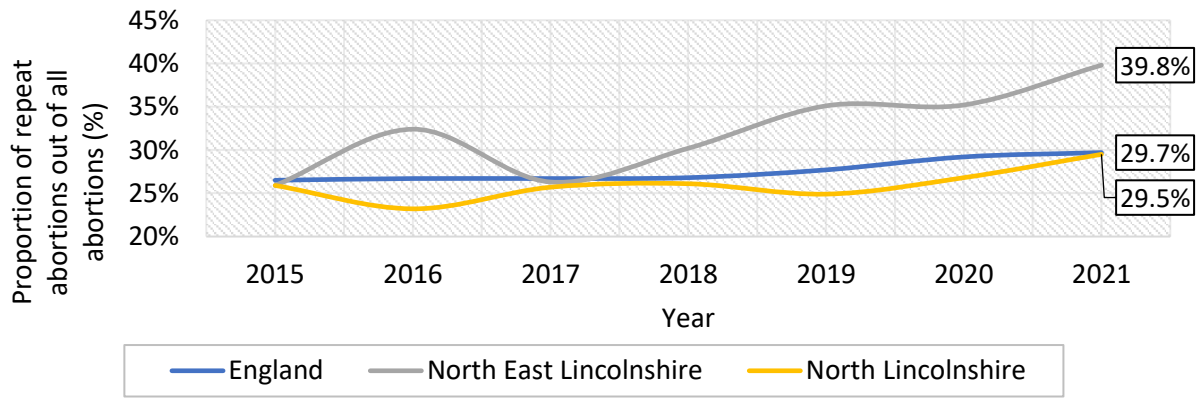
In 2021, the rate of abortion was increasing in every circumstance in England and in NEL, except where the pregnant person was aged under 18, and where the pregnant person was aged under 25 and had previously given birth; in both cases, there is a slight uptick nationally and a decrease locally. Multiple factors influence these trends, including economic (such as high housing costs and an insecure job market), the availability of contraceptives (with stakeholders suggesting provision was inadequate for not being user-friendly or holistic (The King's Fund, 2021)), changing sexual behaviours (with survey evidence suggesting a widening window in people's lives in which they're having sex, but that has accompanied a drop in the amount of sex people aged 16 to 44 are having (Wellings, et al., 2019)), and social attitudes (there was an increase in the acceptability of aborting a pregnancy in all cases in the UK from 2005 to 2016, with an increase to 70% public support for the pregnant person's right to abort where it is their wish (The King's Fund, 2021). However, prejudice remains a large part of the experience of having an abortion for some (Hoggart, 2017)).

In addition, there are differences amongst social groups and across the life course. Beginning with age, the 20 to 34 age group accounted for 71% of all abortions in 2020, and there has

been an increase over time in the rate of abortions performed in older people, with a jump from 16.5 to 21.9 abortions per 1,000 females in the 30 to 34 age group from 2011 to 2020 (DHSC, 2022). Meanwhile, the abortion rate for under 18s has fallen from 15 to 6.4 between 2011 and 2021 (DHSC, 2023). On abortions and deprivation – per national data – the total abortion rate per 1,000 females is 23.7 for the most deprived and most affected quintile, while it is 15.9 in the least deprived and least affected quintile (OHID, 2021). This trend has remained the same since 2012 (except for the relative drop in the figure in the third-most deprived decile), and in 2021, it was reflected in the abortion figures for over 25s, under 25s abortions after a birth, repeat abortions, and those in the under 18s, though it was most pronounced in the lattermost case. In this case, the abortion rate for the most deprived and overrepresented quintile is 8.4, almost halving to 4.7 in the least deprived and represented quintile (OHID, 2021); the trend is reversed in the proportion of under 18s conceptions leading to an abortion, where the figure for the most deprived and least affected quintile is 47.3%, compared to 59.9% for the least deprived and most affected (OHID, 2021). This has been the case since recording began in 1998. There are also sub-ethnic differences, with ethnic minorities making up 22% of abortions where the ethnicity was recorded (91% of cases) in 2021: 9% are in Asian people, 7% in Black people, 5% in those with a mixed ethnic background, and in 1% of cases there is an 'other' ethnicity (DHSC, 2023).

Figure 45 shows the proportion of abortions in females that are aged under 25 and have had an abortion previously. The data is for NEL and is compared to England and NL. England and NEL have both seen a consistent increase from 2017 to 2021, although that has been more acute in NEL, with the proportion of repeat abortions increasing from 26.3% to 39.8%, including a rise of 4.6% in 2021 (the most of all three comparators).

Figure 45: Proportion of Abortions which are Repeat [NHS-Funded Abortions] (Females Aged Under 25) (%) (Includes NHS-Funded Abortions O*nly)* – NEL Compared to England and NL, 2015 – 2021.



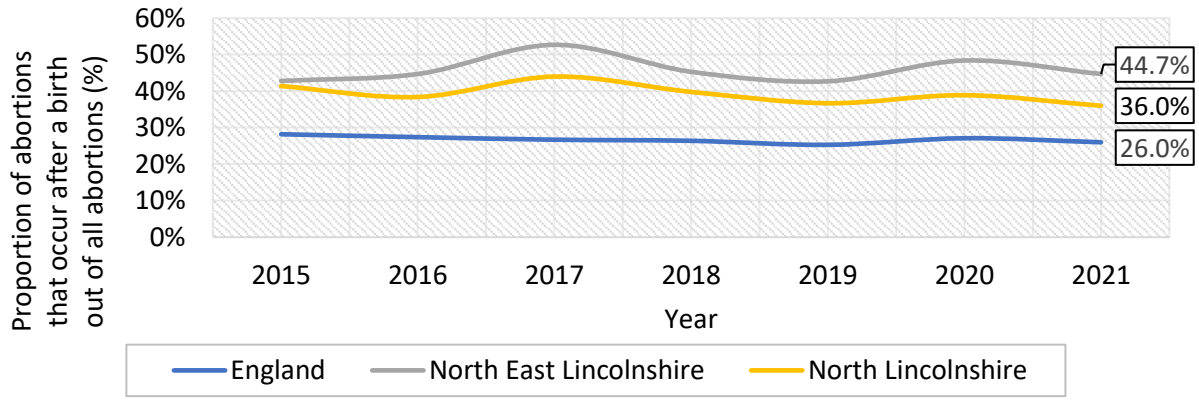
Source: Abortion Clinics via (OHID, 2021)

All three areas' trends were dissimilar from 2015 to 2017, with NEL and NL being at opposite points in a waveform, while England's figure was static. Most recently, NEL's value was statistically significantly different [higher] to England *only*. Also, as 39.8% of abortions were repeat abortions in the most recent data point, NEL placed 1st out of 15 LAs (where 1st is the worst performing LA) regionally – being statistically significantly higher than the Yorkshire and the Humber figure of 29%, and 1st out of 16 LAs (where 1st is the worst performing LA) in terms of its CIPFA nearest neighbours – being statistically significantly higher than the neighbours average of 31.4%.

On abortions after a birth to females aged under 25, Figure 46 shows NEL's and NL's trends are similar between 2016 and 2021, with peaks in 2017 and 2020, while England trended downwards from 2015 to 2020, where there was a small peak. From 2020 to 2021, the percentages decreased in all three areas, with the largest decrease (3.7%) in NEL, compared to 2.9% in NL and 1.1% in England. In 2021, NEL's value was statistically significantly higher than England, but not NL.

Also, as 44.7% of abortions involve someone who has previously given birth in the most recent data point, NEL placed 1st out of 15 LAs (where 1st is the worst performing LA) regionally – being statistically significantly higher than the Yorkshire and the Humber figure of 30.2%, and 1st out of 16 LAs (where 1st is the worst performing LA) in terms of its CIPFA nearest neighbours – being statistically significantly higher than the neighbours average of 34.9%.

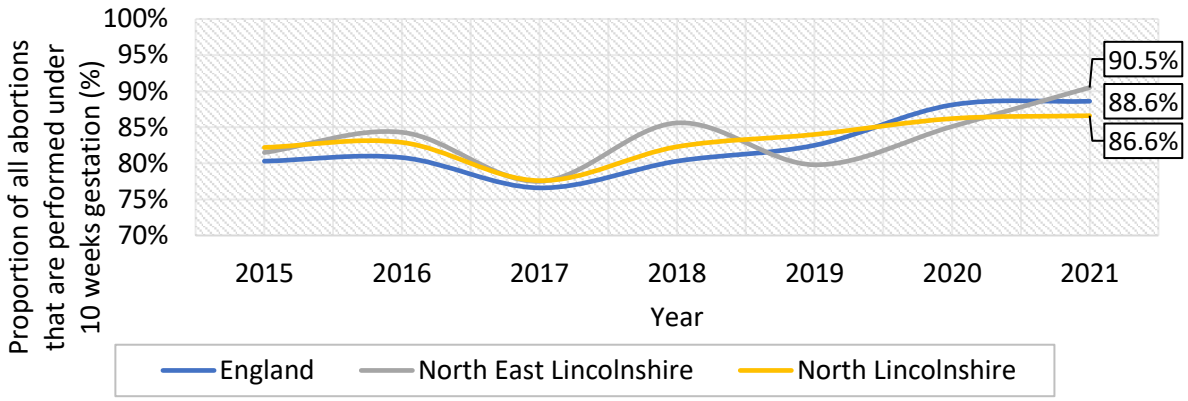
Figure 46: Proportion of Abortions After a Birth to Females Aged Under 25 (%) (includes NHS-Funded Abortions O*nly*) – NEL Compared to England and NL, 2015 – 2021.



Source: Abortion Clinics via (OHID, 2021)

On the proportion of abortions performed under 10 weeks, Figure 47, just over four-fifths of abortions met this criterion in NEL, England, and NL in 2015. This figure fluctuated thereafter, with all three areas having a trough in 2017, then increasing year-on-year from 2019 to 2021.

Figure 47: Proportion of NHS-Funded Abortions Done Under 10 Weeks Gestation (%) – NEL Compared to England and NL, 2015 – 2021.

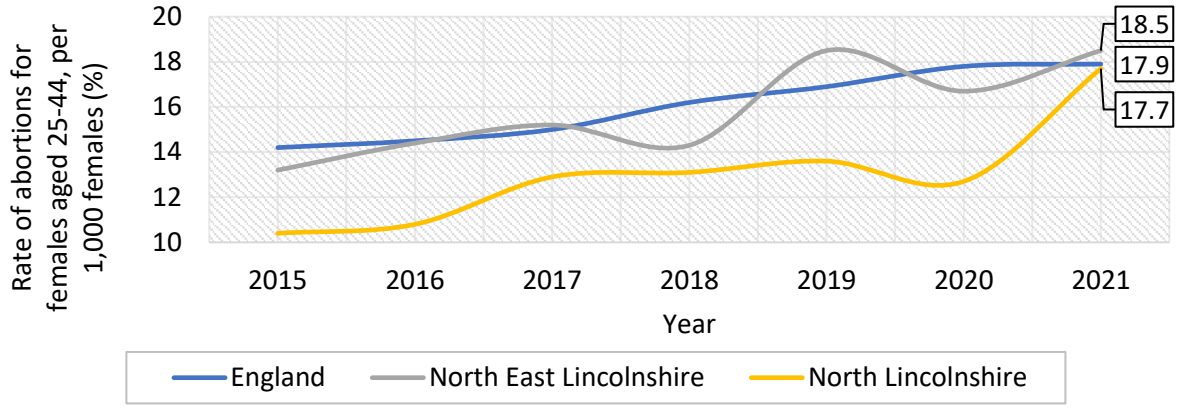


Source: Abortion Clinics via (OHID, 2021)

In 2021, 90.5% of NEL's abortions were performed before 10 weeks gestation, but while it was not statistically significantly different to England or NL, NEL placed 2nd out of 15 LAs (where 1st is the best performing LA) regionally – not being statistically significantly different to the Yorkshire and the Humber figure of 88.6%, and 3rd out of 16 LAs (where 1st is the best performing LA) in terms of its CIPFA nearest neighbours – not being statistically significantly different to the neighbours average of 88.9%.

Figure 48 shows abortion rate for females aged 25-44, per 1,000 females of the same age in England, NEL and NL. All three areas trends on abortions in 25 to 44-year-olds are somewhat similar – all fluctuate but trend upwards: England's value increased year-on-year; NL's increased variably up to 2019, when a fall of 0.9 preceded an increase of 5; and NEL's was variable from 2017 to 2020, but like other areas it increased overall and in 2021, when an increase of 1.8 to 18.5 gave NEL the highest rate.

Figure 48: Abortion Rate for Females Aged 25-44, per 1,000 Population (Includes NHS-Funded Abortions O*nly*) – NEL Compared to England and NL, 2015 – 2021.

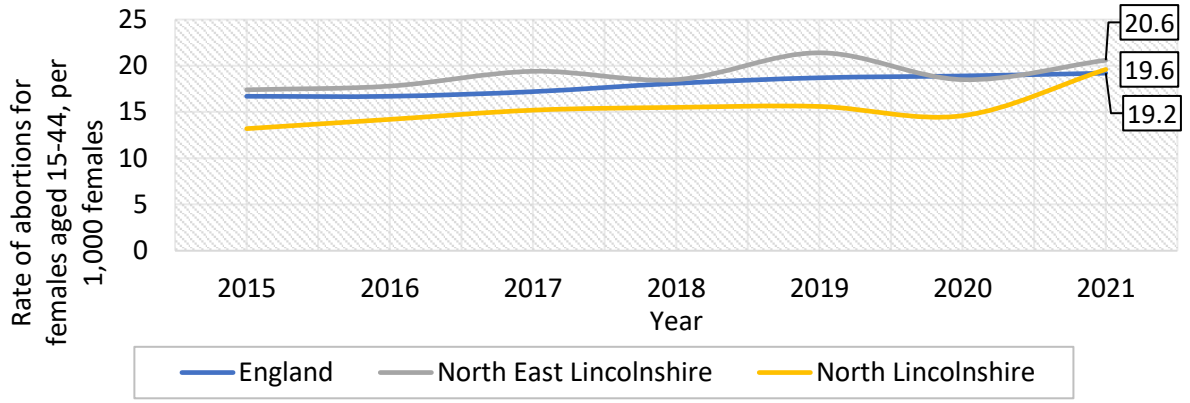


Source: Abortion Clinics via (OHID, 2021)

With a figure of 18.5 in 2021, NEL was not statistically significantly different to England or NL, placing 3rd out of 15 LAs (where 1st is the worst performing LA) regionally – not being statistically significantly different to the Yorkshire and the Humber figure of16.6, and 10th out of 16 LAs (where 1st is the worst performing LA) in terms of its CIPFA nearest neighbours – not being statistically significantly different to the neighbours average of 19.6.

Figure 49 shows the total abortion rate for females aged 15-44, per 1,000 females of the same age [and *only* for NHS-funded abortions] – 2015 to 2021 for England, NEL and NL. All three areas trends on the rate of *all* abortions are similar: England's value increased year-on-year except for 2016; NL's increased up to 2020, when a decrease in the rate by 1 preceded an increase of 5; NEL's fluctuated from 2016 to 2020, but as with the other localities, increased overall and from 2020 to 2021 [by 2.1], leaving it with the highest value in 2021 (20.6), but that was not statistically significantly different to either comparator. Most recently, NEL placed 2nd out of 15 LAs (where 1st is the worst performing LA) regionally – being statistically significantly higher than the Yorkshire and the Humber figure of 18.1, and 9th out of 16 LAs (where 1st is the worst performing LA) in terms of its CIPFA nearest neighbours – not being statistically significantly different to the neighbours' average of 21.8.

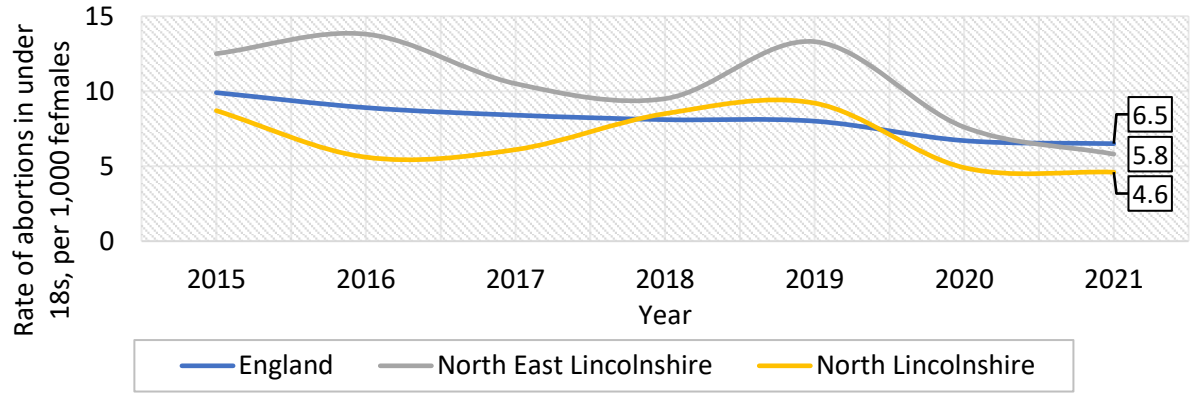
Figure 49: Total Abortion Rate for Females That are Aged 15-44, per 1,000 Females of the Same Age (Includes NHS-Funded Abortions O*nly*) – NEL Compared to England and NL, 2015 – 2021.



Source: Abortion Clinics via (OHID, 2021)

Figure 50 below shows the rate of abortions in under 18s per 1,000 females of the same age [and *only* for NHS-funded abortions] – 2015 to 2021 for England, NEL and NL. It shows NEL's and NL's rates were opposite up to 2018, after which they followed a very similar path (fluctuating all the while), though NEL's values remained ahead of NL's throughout the period charted. England's rate fell yearly from 2015 and before.

Figure 50: Abortion Rate for Females Aged Under 18, per 1,000 Population (includes NHS-funded abortions o*nly*) – NEL Compared to England and NL, 2015 – 2022.

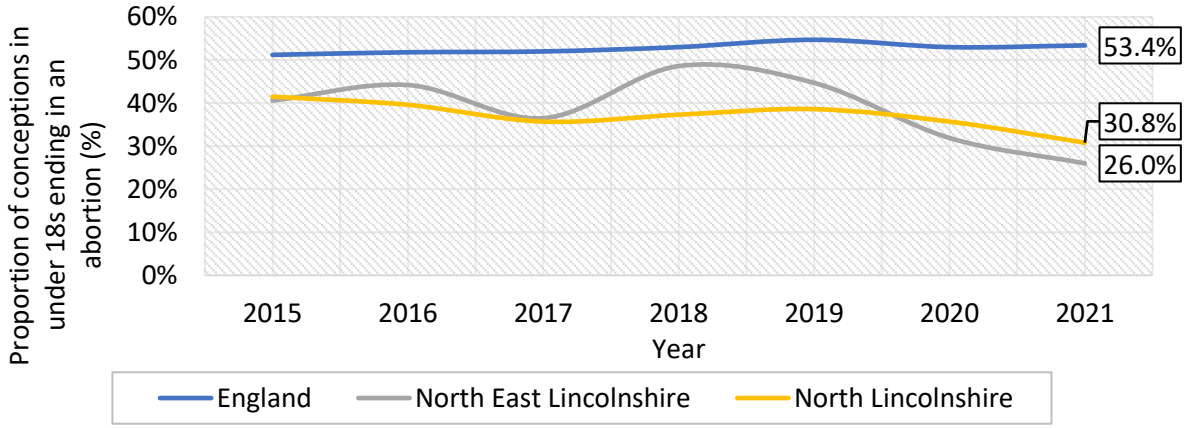


Source: Abortion Clinics via (OHID, 2021)

In 2022, a decrease can be seen in all three areas. This was slight in England's and NL's cases, where there were falls of 3% and 6.1%, respectively. But a more moderate fall was seen in NEL, whose rate fell by 23.7%. This fall left NEL with a rate of 5.8 for abortions in the under 18s population, meaning it was not statistically significantly different to England or NL, and placed 12th out of 15 LAs (where 1st is the LA with the highest figure) regionally – not being statistically significantly different to the Yorkshire and the Humber figure of 7.1%, and 14th out of 16 LAs (where 1st is the LA with the highest figure) in terms of its CIPFA nearest neighbours – not being statistically significantly different to the neighbours average of 8.4.

Finally, figure 51 shows the proportion of all conceptions in people aged under 18 that led to an [NHS-funded] abortion (%) for England, NEL, and NL. All three geographies' trends differ.: England's proportion increased overall, rising year-on-year up to 2019, then falling to its 2018 value (53%) before rising again to 53.4%. Conversely, NL's proportion decreased every year except 2018 and 2019, and in 2021 it fell to a seven-year-low. NEL's value has been falling since 2018 (a 46.5% fall [in the numbers]), leaving it with the lowest in 2021 – 26%. As 26% of under 18's conceptions ended in abortion in 2021, NEL was statistically significantly lower than England, but not NL, placing 15th out of 15 LAs (where 1st is the LA with the highest figure) regionally – being statistically significantly lower than the Yorkshire and the Humber figure of 44.5%, and 16th out of 16 LAs (where 1st is the LA with the highest figure) in terms of its CIPFA nearest neighbours – being statistically significantly lower than the neighbours average (46.7%).

Figure 51: Proportion of all Conceptions in Females Aged Under 18 That Led to an Abortion (%) (Includes NHS-Funded Abortions O*nly*) – NEL Compared to England and NL, 2015 – 2021.



Source: Abortion Clinics via (OHID, 2021)

8.5 Sexual Violence

Sexual Violence is a serious issue at any rate. Police Recorded Crime data also underestimates cases by underreporting and under-recording, with cases being no-crimed or recorded improperly, or where victims don't report to the police (with one-sixth of victims aged 16-59 reporting to the police in the year up to the last Crime Survey for England and Wales (CSEW) in 2021/22 (ONS, 2022), down from just under one-fifth in the CSEW in 2019/2020 (ONS, 2021)) all leading to an underestimation. Cultural changes and movements can also alter a person's inclination to report (Lynch & Addington, 2015), and they can lead to changes in the law which increases or decreases the scope of sexual violence, also making PRC data

liable to change in a way that does not necessarily reflect emerging trends. So, random probability surveys may be more useful, such as the CSEW. Per the CSEW, 1.2% of males and 3.3% of females aged 16 and over experienced sexual assault [including attempts] in the year up to 2022 in England, including 0.6% of females who experienced rape [including attempts] and 0.8% who experienced assault by penetration [including attempts] (disclosure constraints limit data for males) (ONS, 2022). But the sensitivity and subjectivity associated with sexual violence mean surveys like this are still subject to bias, e.g., the CSEW directly referred to the victim's emotive response, which narrowed the definition of sexual violence (Brunton-Smith, et al., 2020) and led to an underestimate, but provided figures which were invariably higher than PRC (see figure 52).

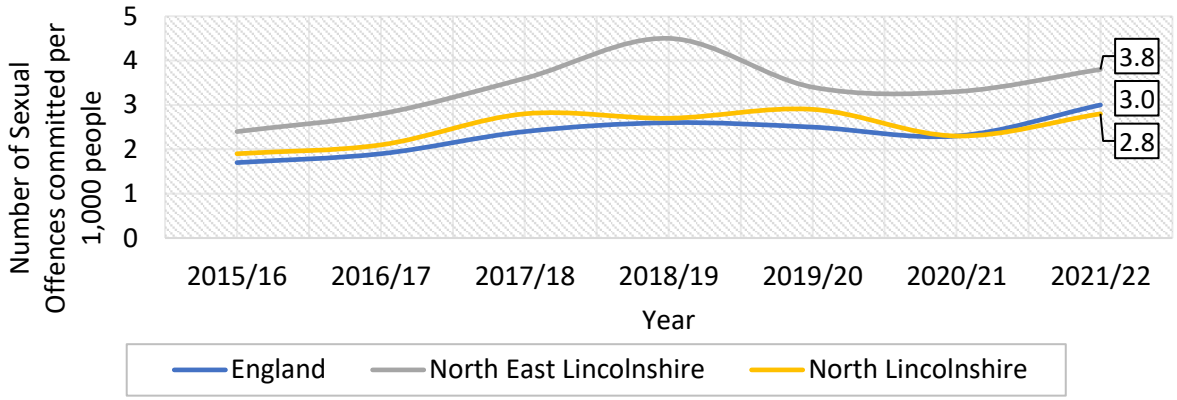
Inequalities in sexual violence are also likely to be underestimated for similar reasons. Data from the CSEW for the year up to March 2020 reaffirms that females are more likely to be victims and says males and females aged 16 to 19 (2.9% and 12.9% [of adult victims], respectively) and 20 to 24 (2.6% and 10.5% [of adult victims], respectively) are the most likely victims (ONS, 2021). But while the CSEW does not ask respondents under 16, PRC data shows males and females aged 10 to 14 are the most likely victims, with males in this age group being affected more than females. And a higher proportion of male 5 to 9-year-olds are affected than males aged 15-19 and 20-24. CSEW data also shows full-time students are the most at-risk occupation group (6.7% [of adult victims]), that a mixed ethnic background is the most overrepresented ethnicity (3.6% [of adult victims]) (followed by a Black or Black British background), that single people are far more at risk than any other legal partnership status, and that disabled females are sexually assaulted almost twice as much as non-disabled females (ONS, 2021). Public Health Scotland data echoes this, showing people with learning disabilities are sexually assaulted up to ten times as much as people without a learning disability, and that they may be targeted because of their disability (PHS, 2021). Finally, it is evident that more deprived areas also have a higher rate of sexual offences per 1,000 people – the least deprived decile has a rate of 2.1 while the most deprived decile has a rate of 4.1. Plus, the increase between these two deciles is almost linear, which has been the case since 2016/17 (OHID, 2022).

In practice, a victim of sexual violence can access medical, practical, and mental health support from Sexual Assault Referral Centres (SARCs), which have specially trained staff on site to assist people attending the service 24/7. But the nearest SARC is The Casa Suite in Hull, or Spring Lodge in Lincoln.

NEL, England, and NL all display a broadly upward trend from 2015/16 to 2021/22 – Figure 52, although NEL's rate peaked in 2018/19 at 4.5 cases per 1,000 people; the rate in all three

increased in the last year after a slight decrease, but while NEL's rate increased by a relatively small amount, it's most recent figure (3.8) remains above both England and NL and is statistically significantly higher than both, placing 5th out of 15 LAs (where 1st is the worst performing LA) regionally – being statistically significantly higher than Yorkshire and the Humber's value of 3.3, and 13th out of 16 LAs (where 1st is the worst performing LA) in terms of its CIPFA nearest neighbours – the neighbours average is not calculable for this metric.

Figure 52: Violent Crime – Sexual Offences Committed [Excluding those Relating to Exposure and Voyeurism], per 1,000 People – NEL Compared to England and NL, 2015/16 – 2021/22.



Source: Home Office crime data via (OHID, 2022)

8.6 Contraception Provided

A wide range of contraceptive methods are available (see appendix D for an inexhaustive list). Based on activity at SRH Services in NEL in 2021/22, the implant was the most popular among women, with 32% having it as a main method, while 19% chose the pill, 14% chose an IU system, 12% chose the male condom, 11% chose an IU device, 8% chose injectables, and 3% chose a patch (1% chose other methods) (NHS Digital, 2022).

Safe access to suitable contraception is fundamental to a good standard of [sexual and reproductive] health. But a third of women in England could not get contraception from their preferred source in 2018 (PHE, 2018). A study from the same year found 45.3% of women used GPs *only* for contraception and 16.6% used retail *only*, while 55.1% of males used retail *only*, their second-most popular source being community clinics (11.9%) (French, et al., 2018). There was a "strong and consistent" age gradient associated with female use too, with a majority of 16 and 17-year-olds choosing community clinics, while those in their 20's overwhelmingly chose GPs (French, et al., 2018).

Access issues may be more acute for deprived areas too, as, at a national level, the rates of GP prescribed LARC excluding injections, GP-prescribed progesterone only pill, and GP prescribed Short-Acting Combined Hormonal Contraception (SACHC) are all negatively correlated with deprivation, so fall with a proportionate rise in deprivation. Conversely, there is a weak, positive correlation with GP-prescribed injectable contraception (OHID, 2021). And when the SRH/SHS prescribing data for all these contraceptives is analyzed, it reveals four positive correlations, with prescriptions for injectable contraception [at SRHs] presenting the strongest link, with the most deprived and best represented quintile having 6.1 women receiving prescriptions for every 1,000 women, compared to 2.1 in the least deprived and least represented quintile (OHID, 2021). In the same vein, there is no correlation between deprivation and the proportion choosing LARC as a 'main' method at an SHS, per national data (data is not available on the link between deprivation and the proportion choosing any other individual method as a 'main' method). And there is no strong link between deprivation and the rate of under 25-year-old females attending SCSs, though a moderate, positive correlation exists there in the case of males (with the most deprived and best represented quintile attending at a rate of 13.4 males per 1,000 population, compared to 10.3 in the least deprived quintile (though the second most deprived quintile is the least represented – it's rate is 8.5) (OHID, 2021).

In addition, ethnic minorities were also less likely to attend a GP for contraception than White people, with Black Caribbean people being the least likely, and then Asian people; those with a Black Caribbean background are more likely to get theirs from a community-based clinic and Asian people are most likely to buy theirs in shops (French, et al., 2018). Institutional racism may factor into this, as this 'erodes trust and informed choice' for black people in particular (Briscoe-Palmer, 2022)).

Age was correlated with disuse, especially in 35 to 44-year-old females (French, et al., 2018). 35% of people identifying as bisexual do not use contraception, and FSF and Transgender people have been shown to be less confident talking about the use of contraception with a partner than heterosexual and cisgender people (APPG SRH in the UK, 2020). In those with learning disabilities, LARC is used more than user-dependent methods[*] and is used at a higher rate than in the general population; the contraceptive implant is the most popular method. Management of menstruation accounts for a much greater proportion of LARC prescriptions

[*] Contraception is categorised either as a LARC or as user-dependent, which – unlike LARC – is dependent on a person using it as regularly as is necessary to be effective, e.g., the pill or the male condom.

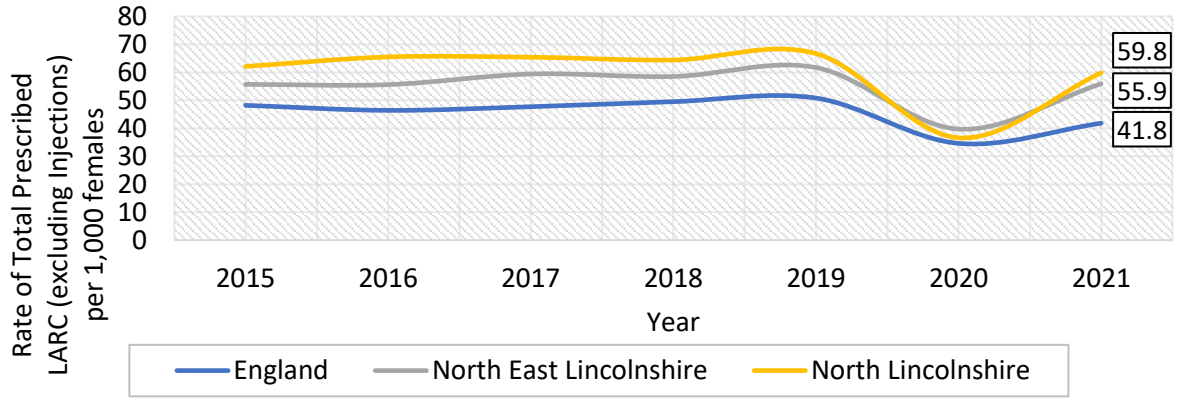
in those with learning disabilities than in those without, though (Ledger, et al., 2016). Use was more common in unmarried females, those with no children, those who had had an unplanned pregnancy in the last year, and those were STI-positive (French, et al., 2018).

The largest opportunity to improve access to contraception may be in pharmacies, as, nationally, 99% of those in the most deprived areas live within a 20-minute walk of one. And The Health and Wellbeing board has concluded that the population is *adequately* served in terms of pharmacy access in NEL (see appendix E), with all areas within either one mile [in a straight line] or a 15-minute drive-time of a pharmacy. Indeed, 89.1% of all items prescribed by a GP were dispensed at a pharmacy in NEL (NEL Health and Wellbeing Board, 2022).

Figures 53-62 show the various trends in contraception use. NEL has a mixed picture, with a decrease in use of services by males, an increase for females, and a decrease overall.

Figure 53 shows the rate of LARC (excluding injections) prescribed by GPs and sexual health services (SHSs) to women aged 15-44, per 1,000 women – 2015 to 2021. The figure shows that except where NL's rate decreased more sharply than that in NEL and England in 2020, all three areas followed the same trend from 2015 to 2021, with a slight, overall increase from 2015 to 2019, a large trough in 2020 – where NEL's rate fell by 22, and finally, a rebound in 2021 (but while England climbed back up to 82.3% of its 2019 rate, NEL and NL rose to 90.6% and 89.7% of theirs, respectively).

Figure 53: Total Rate of LARC (Excluding Injections) Prescribed Across the Area to Women, per 1,000 Women Aged 15-44 – NEL Compared to England and NL, 2015 – 2021.



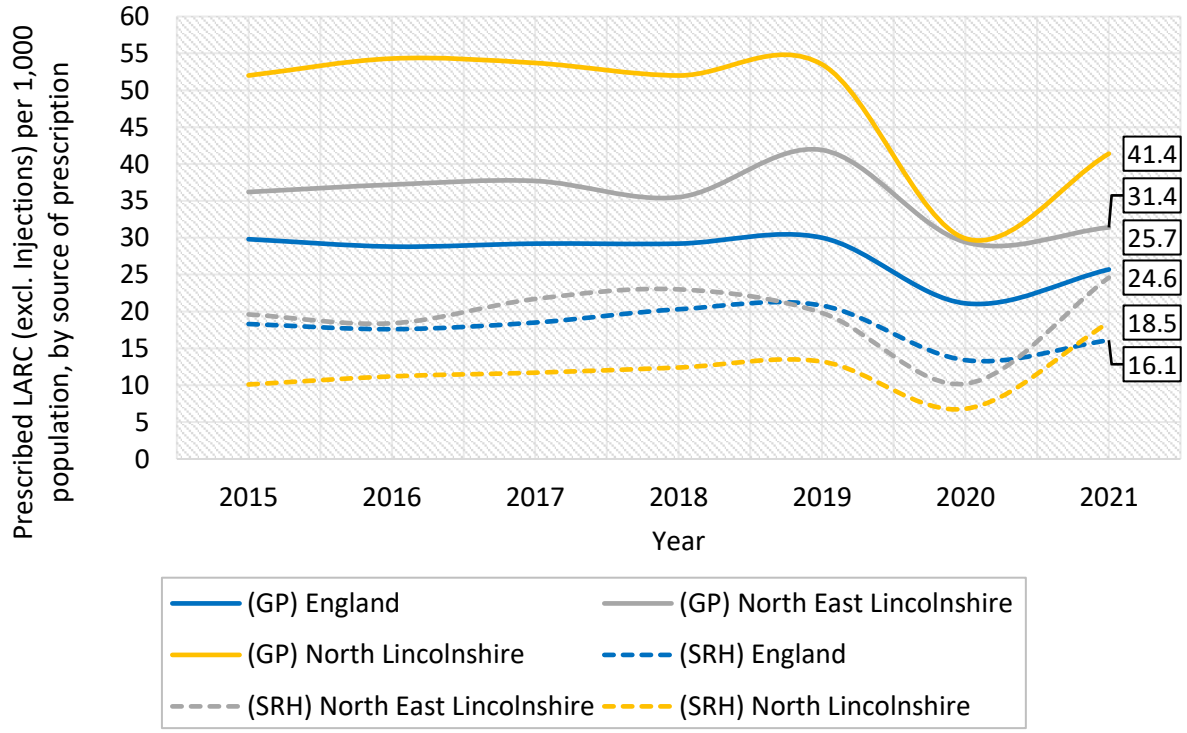
Source: NHS Digital Sexual and Reproductive Health Activity Data Set (SRHAD) and NHS Business Services Authority ePACT2 prescribing data via (OHID, 2021)

In 2021, NEL's rate was statistically significantly higher than England, but not NL. Also, as LARC was prescribed 55.9 times for every 1,000 women aged 15-44 in 2021, NEL placed 4th

out of 15 LAs (where 1st is the LA with the highest rate) regionally – being statistically significantly higher than the Yorkshire and the Humber value of 50.5, and 2nd out of 16 LAs (where 1st is the LA with the highest rate) in terms of its CIPFA nearest neighbours – the neighbours average is not calculable for this metric.

Figure 54 breaks down the figures in figure 53 by prescriber. Similar trends are seen in prescriptions from both GPs and SRHs, although the drop in 2020 was considerably smaller in the LAs prescribing rates at SRHs, and, unlike the other areas, the prescribing rate at NEL's SRH (SHS) saw a much sharper rise (141.2%) in 2022 than was seen in the equivalent metric for NEL's GPs (6.8%); NEL also did not see a pronounced peak in 2019. In 2022, NEL's prescribing rate for LARC at GPs [excluding injections] was statistically significantly higher than the corresponding figure at a national and regional level, and it is statistically significantly higher than the figure for NEL's CIPFA nearest neighbours. Also in 2022, that prescribing rate in NEL for SRHs (SHS) was statistically significantly higher than the corresponding figure at a national and regional level; the CIPFA nearest neighbours average is not calculable for SRHs.

Figure 54: **Rate of LARC (Excluding Injections) Prescribed Across the Area to Women, per 1,000 Women Aged 15-44– NEL Compared to England and NL, 2015 – 2021. Breakdown by Source of Prescription (GPs and SHSs).**



Source: (OHID, 2021; 2021)

Table 1 lists the current prescribing rates for Injectable contraception, the progesterone only pill, and short acting combined hormonal contraceptive, separated by source (GPs and SRHs). Text color indicates whether the difference between an area's value and the England value [for that metric] is statistically significant. Broadly, prescribing in SRHs is much lower than in GPs across all three of these contraceptive methods, following the same trend as was seen in the data for LARC. Also, like the regional figure, NEL's is statistically significantly higher than England's in four of these six metrics. But NEL's figure is more like England's in the case of prescribing short acting combined hormonal contraception and the progesterone only pill at SRHs, unlike the regional figure, which is statistically significantly lower.

Table 1: **Metrics relating to women being prescribed contraception methods (not LARC), per 1,000 women Aged 15-44 – NEL Compared to England and NL, 2015 – 2021. Blue means the value is statistically significantly higher than England, yellow means it is not statistically significantly different to England, and pink means it is statistically significantly lower than England.**

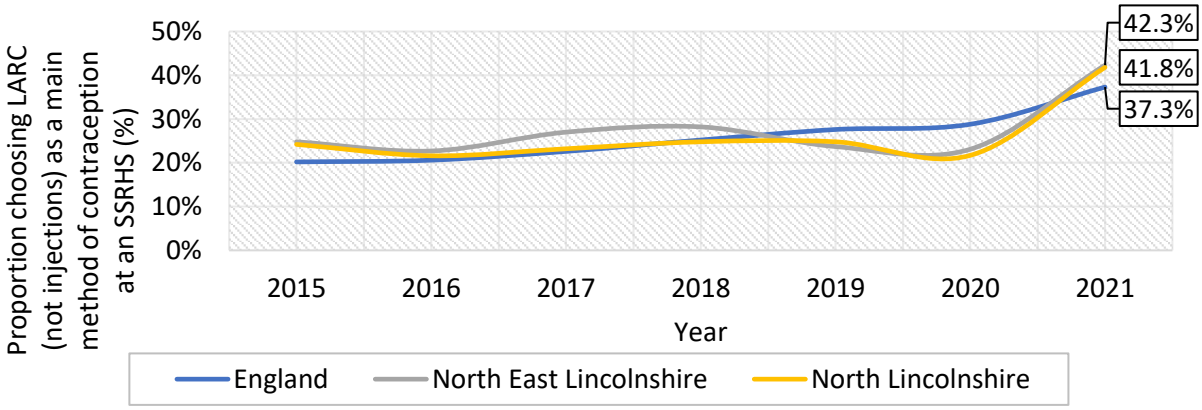
Indicator	Year	England value (women prescribed, per 1,000 women)	Regional value (women prescribed, per 1,000 women)	NEL uptake (women prescribed, per 1,000 women)	NL uptake (women prescribed, per 1,000 women)
Women prescribed injectable contraception at SRH services	2021	3.6	4	5.3	6.7
Women prescribed progesterone only pill at SRH services	2021	9.6	9.2	9.6	15.5
Women prescribed short-acting combined hormonal contraception at SRH services	2021	7.6	5.7	6.6	8.1
Women prescribed injectable	2021	26.5	36.3	51.3	53

contraception in GP practices					
Women prescribed progesterone only pill in GP practices	2021	137.2	159.8	176.3	176
Women prescribed short-acting combined hormonal contraception in GP practices	2021	128.4	130.7	134.3	156.1

Source: (OHID, 2021; 2021; 2021; 2021; 2021; 2021)

Moving on to preference, figure 55 shows the proportion of women aged under 25 who chose LARC (Not Injections) as a main method of contraception at a SSRHS (%) – 2015 to 2021. Here, England's rate rose year-on-year from 2015 to 2021, while NEL's and NL's rose overall, after having fallen from 2018 to a trough in 2020.

Figure 55: Proportion of Women Under 25 that Chose LARC (Not Injections) as a Main Method of Contraception at a SSRHS (%) – NEL Compared to England and NL, 2015 – 2021.



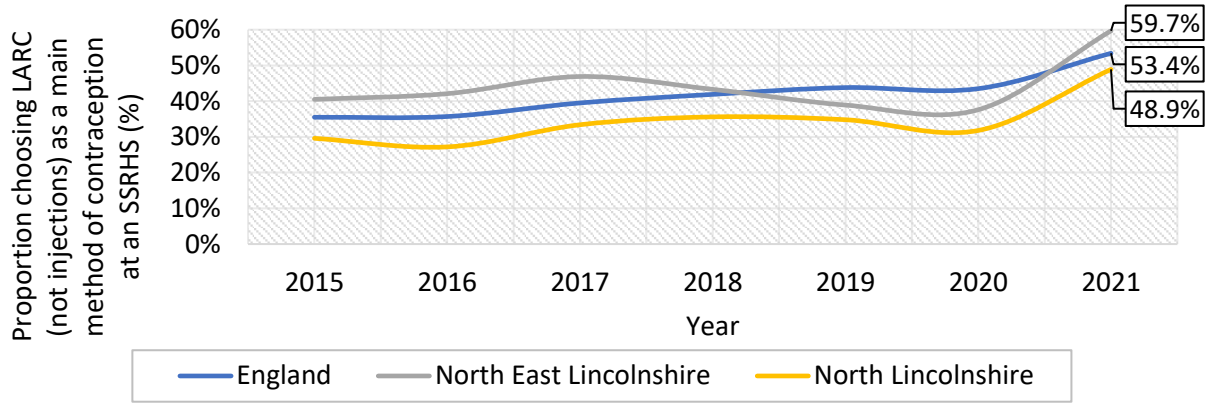
Source: NHS Digital SRHAD data via (OHID, 2021)

All areas' proportions almost doubled from 2015 to 2021, but at 42.3%, NEL's most recent figure was statistically significantly different [higher] to England *only*, placing 9th out of 15 LAs (where 1st is the LA with the highest rate) regionally – not being statistically significantly different to the Yorkshire and the Humber value of 42.8%, and 4th out of 16 LAs (where 1st is

the LA with the highest rate) in terms of its CIPFA nearest neighbours – the neighbours average is not calculable for this metric.

Figure 56 shows the proportion of women aged over 25 and chose LARC (not injections) as a main method of contraception at a SSRHS (%) – 2015 to 2021 for England, NEL and NL.

Figure 56: Proportion of women Over 25 that Chose LARC (Not Injections) as a Main Method of Contraception at a SSRHS (%) – NEL Compared to England and NL, 2015 – 2021.



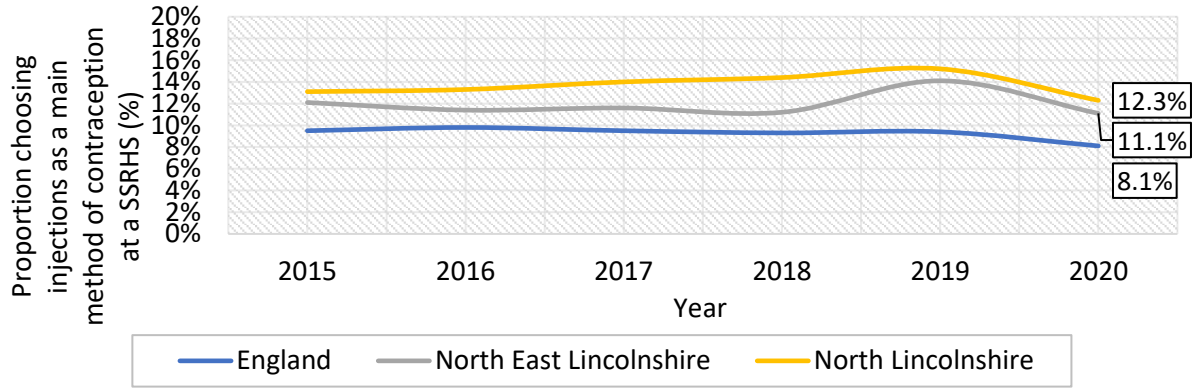
Source: NHS Digital SRHAD data via (OHID, 2021)

All three areas' proportions increased overall and followed the same trend as in the previous chart with three exceptions: England's figure decreased slightly in 2020; NL's figure decreased by a relatively large amount in 2016; and NEL's first peak was in 2017, not 2018.

Also, at 59.7%, NEL's 2021 figure was statistically significantly higher than both England *and* NL, and with it placed 8th out of 15 LAs (where 1st is the LA with the highest rate) regionally – not being statistically significantly different to the Yorkshire and the Humber value of 61.2%, and 5th out of 16 LAs (where 1st is the LA with the highest rate) in terms of its CIPFA nearest neighbours – the neighbours average is not calculable for this metric.

Figure 57 shows the proportion of women that chose injections as a main method of contraception at a SSRHS (%) for England, NEL and NL. The figure shows that there was little variability in England's and NL's trend from 2015 to 2020 – both fell to their lowest value in 2020, but where NL's proportion increased year-on-year up to 2019, England's was static. NEL's proportion fluctuated, rising by 2.9% in 2019, then falling by 3% to its own six-year low in 2020. CIPFA nearest neighbours – the neighbours average is not calculable for this metric, so it is impossible to describe variation between NEL and its neighbours as an aggregate. At this point it was statistically significantly higher than England, but not NL.

Figure 57: Proportion of Women that Chose Injections as a Main Method of Contraception at a SSRHS (%) – NEL Compared to England and NL, 2015 – 2020.

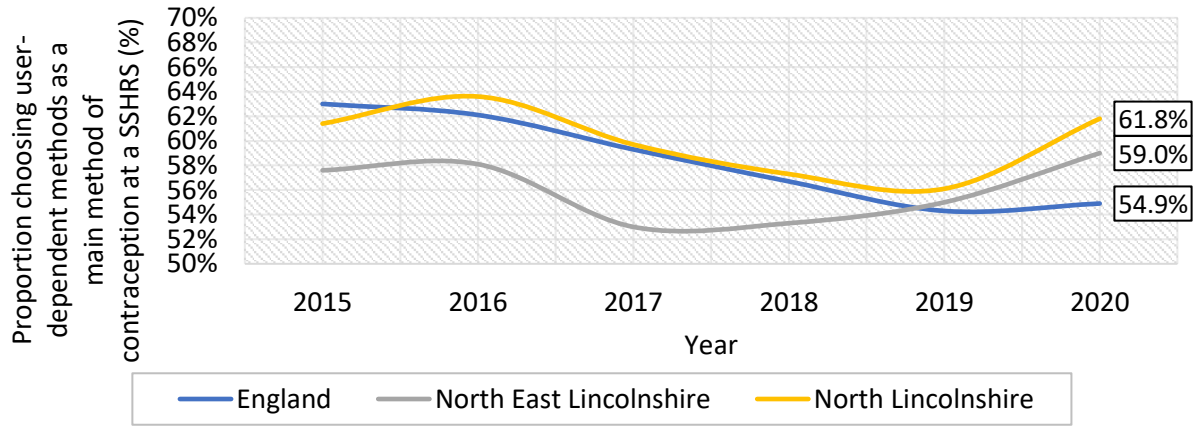


Source: NHS Digital SRHAD data via (OHID, 2020)

Also, as 11.1% of women chose injections as their main method of contraception in 2020, NEL placed 4th out of 15 LAs (where 1st is the LA with the highest rate) regionally – not being statistically significantly different to the Yorkshire and the Humber value of 10.1%, and 6th out of 16 LAs (where 1st is the LA with the highest rate) in terms of its statistical neighbours.

Figure 58 shows the proportion of women that chose user-dependent methods as a main method of contraception at a SSRHS (%) – 2015-2020. The figure shows that NEL's proportion increased marginally from 2015 to 2016, decreased by 5.1% from 2016 to 2017, then rose year-on-year, including a 4% rise in 2020. NL's proportion also increased.

Figure 58: Proportion of Females that Chose User-Dependent Methods as a Main Method of Contraception at a SSRHS (%) – NEL Compared to England and NL, 2015 – 2020.



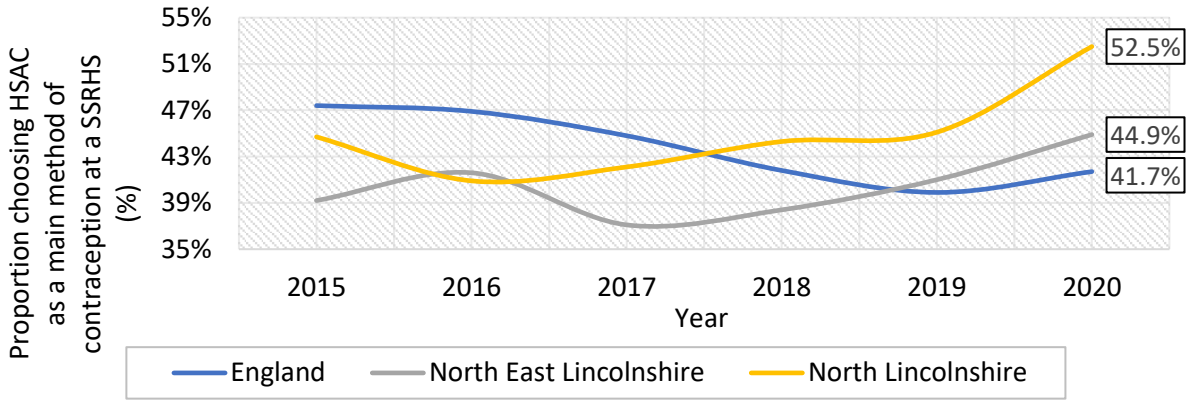
Source: NHS Digital SRHAD data via (OHID, 2020)

overall and had a similar trend, but it was consistently higher and decreased year-on-year from 2016 to 2019. England's proportion fell year-on-year from 2015 to 2019, before a slight increase in 2020. At 59%, NEL's figure in 2021 was statistically significantly different [higher] than England *only*, placing 3rd out of 15 LAs (where 1st is the LA with the highest rate) regionally – being statistically significantly higher than the Yorkshire and the Humber value of 50.6%, and 8th out of 16 LAs (where 1st is the LA with the highest rate) in terms of its CIPFA nearest neighbours – the neighbours average is not calculable for this metric.

Figure 59 below shows the proportion of women choosing hormonal short acting contraceptives (HSAC) as a main method of contraception at a SSRHS (%) – 2015 to 2020. On this metric, NEL and NL only differed in 2016, where NL saw a trough and NEL saw a peak. From 2017, both rose year-on-year up to their highest point in 2020. England's proportion decreased year-on-year before rising to just below its 2018 value in 2020.

At 44.9%, NEL's figure in 2020 was statistically significantly lower than NL and higher than England, placing 5th out of 15 LAs (where 1st is the LA with the highest rate) regionally – being statistically significantly higher than the Yorkshire and the Humber value of 39.5%, and 10th out of 16 LAs (where 1st is the LA with the highest rate) in terms of its CIPFA nearest neighbours – the neighbours average is not calculable for this metric.

Figure 59: Proportion of women choosing hormonal short-acting contraceptives (HSAC) as a main method of contraception at a SSRHS (%) – NEL Compared to England and NL, 2015 – 2020.

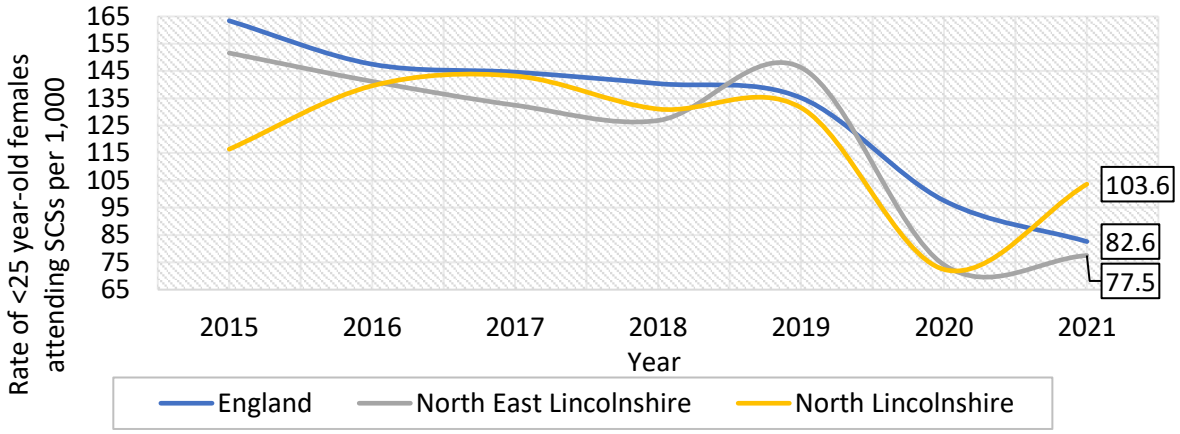


Source: NHS Digital SRHAD data via (OHID, 2020)

Figure 60 below shows the rate of females attending SCS, ages 15 to 24, per 1,000 females. The figure shows that NL and NEL followed the same general trend from 2016 to 2021. This included a moderate decrease up to 2018, an increase in 2019 – which was relatively large in NEL's case, a sharp decrease in 2020, where NEL's rate almost halved, and finally a rebound,

although this was smaller in NEL's case. England's rate decreased year-on-year from 2015 to 2021, though the decrease in 2020 was relatively large.

Figure 60: Rate of Females Attending Specialist Contraceptive Services, Ages 15 to 24, per 1,000 Females – NEL Compared to England and NL, 2015 – 2021.

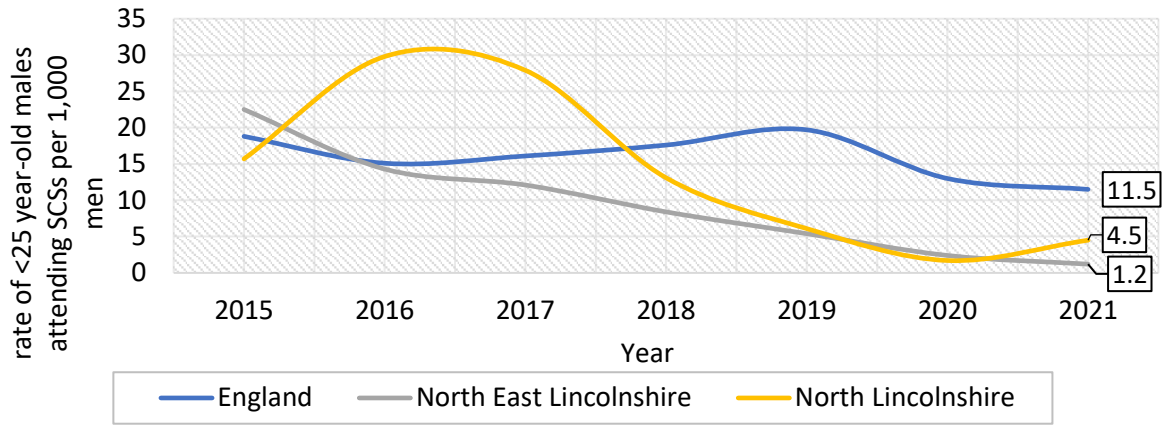


Source: NHS Digital SRHAD data via (OHID, 2021)

At 77.5, NEL had the lowest rate in 2021, and was statistically significantly lower than NL, but not England. It also placed 11th out of 15 LAs (where 1st is the LA with the highest rate) regionally – being statistically significantly lower than the Yorkshire and the Humber value of 86, and 8th out of 16 LAs (where 1st is the LA with the highest rate) in terms of its CIPFA nearest neighbours – the neighbours average is not calculable for this metric.

Figure 61 below shows the rate of males aged 15 to 24 attending SCSs, per 1,000 males. The figure shows that trends are different between females and males that are under 25 and have attended a SCS over this period, but all three areas' rates are trending downwards across both sexes. On males, NEL's rate decreased consistently from 2015 to 2021, falling from 22.5 to 1.2. the trend in England and NL varied, but NL was the only locality to see an increase in 2021, with a rise of 2.8 taking its figure above NEL's, whose figure was statistically significantly lower than both comparators.

Figure 61: Rate of Males Aged 15 to 24 Attending Specialist Contraceptive Services per 1,000 Males – NEL Compared to England and NL, 2015 – 2021.



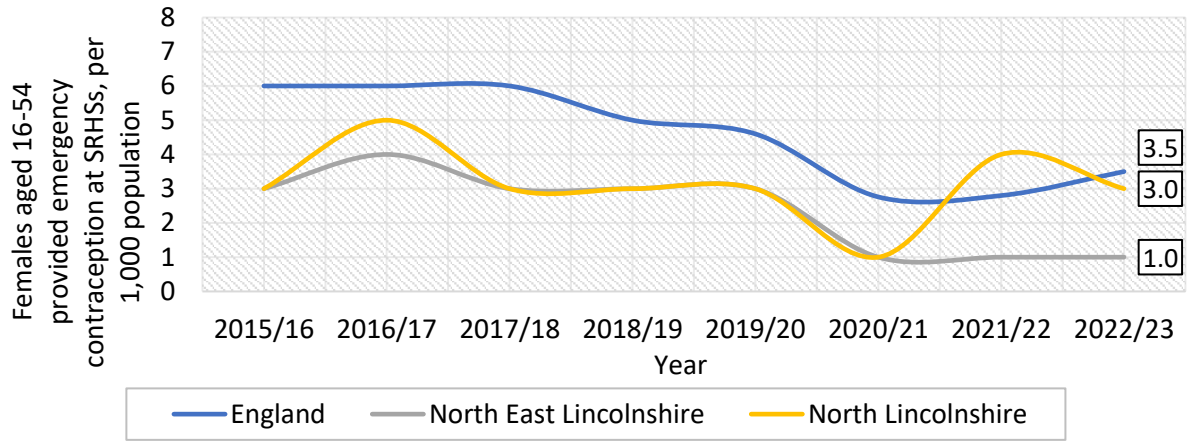
Source: NHS Digital SRHAD data via (OHID, 2021)

Also, as 1.2 males per 1,000 male residents had attended an SCS in the most recent data point, NEL placed 13th out of 15 LAs (where 1st is the LA with the highest rate) regionally – being statistically significantly lower than the Yorkshire and the Humber value of 18, and 13th out of 16 LAs (where 1st is the LA with the highest rate) in terms of its CIPFA nearest neighbours – the neighbours average is not calculable for this metric.

Figure 62 below shows the rate of emergency contraception provided to females aged 16 to 54 by SRHSs, per 1,000 females in England, NEL and NL. The caveats are that only one contact was counted where the same person received emergency contraception multiple times in the year and where multiple types of emergency contraception were dispensed in one contact, age is based on a person's *first* contact, small counts have been rounded up to prevent deductive disclosure, and non-residents have been excluded. Also, this data does not reflect the whole picture of provision of emergency contraception in NEL, as the emergency contraception prescribed by GPs and direct from pharmacies is not shown here.

The data shown in this figure highlights that all three areas trends followed a similar pattern up to 2020/21, that is that NEL, NL, and England all have a consistent stepwise decrease from 2016/17 to 2020/21. From this point, NEL's and England's figure continues to follow this trend, whereas NL's rate quadruples and then falls by 25%. It is also notable that NEL's rate was less than the regional and national rates in every year from 2015/16.

Figure 62: Rate of Females Aged 16 to 54 Being Provided Emergency Contraception by SRHSs, per 1,000 females – NEL Compared to England and NL, 2015/16 – 2022/23.



Source: (NHS Digital, 2023)

8.7 The Menopause

The menopause refers to a time when most of those affected will stop having their period and will be unable to conceive sexually thereafter. There is an increased risk of contracting STIs during sex, and symptoms may affect a person's sex life, and/or change how they experience sex. Symptoms can begin months to years before periods stop (perimenopause) and usually last up to the fourth year after the last period but can last much longer. Sub-ethnic differences mean White people assigned female at birth generally enter perimenopause much later than those with a Black background. Symptoms may also vary by race, as black people have been shown to be more likely to experience hot flushes than other ethnic groups, with Hispanic people the second-most likely (Hunter & Rendall, 2007), while White people experienced vaginal dryness and low energy more frequently (Hunter, et al., 2009). Other symptoms include mood changes, a reduced sex-drive, problems with memory, difficulty sleeping, and recurrent UTIs (NHS, 2022). Up to 80% of cisgender women have symptoms (Sussman, et al., 2015). The menopause mostly affects people assigned female at birth; transgender women won't go through the hormone changes as there is no need to reduce their prescribed oestrogen, but they will go through "limited, pseudo-menopausal symptoms" (Wales TUC Cymru, 2017), and transgender men will go through the menopause naturally without HRT and a trans-specific surgery, but symptoms may be complicated, lessened, or occur earlier if either of these interventions are in place. Around 51.3% of the NEL population have either already gone through or will go through the menopause in their life, per The Census 2021. This includes the 0.2% who identified as transgender, assuming they undergo HRT, or were assigned female at birth and will not transition medically (ONS, 2023). And as an All-Party Parliamentary Group (APPG on Menopause, 2022) notes, the age-range in which a person typically goes through the menopause is 45-55 – the average age being 51 (although 1 in 100 will be affected before the age of 40), the proportion of females at the time of the census can

be broken down further to highlight that 14.5% of those are currently within that age-range and may to be menopausal.

People also face barriers to seeking medical help, including a social stigma, and religious and cultural practices may also amplify taboos around talking about it. There may also be significant barriers upon reaching out for medical care, with increased deprivation (Hillman, et al., 2020) and being an ethnic minority (Fawcett Society, 2022) reducing the likelihood of being prescribed treatment for the menopause in a timely manner. The APPG on menopause echoed this, stating that, of the 79% of those surveyed who had been to their GP, only 37% were prescribed HRT, with 23% being given anti-depressants – contrary to NICE guidelines. For those receiving appropriate treatment, waiting times can be extremely long, with 12% of recipients waiting over five years. The APPG's recommendations note the effects of misinformation on the effects of HRT, as well as healthcare professionals' 'limited training' on the health and wellbeing of menopausal people. They recommend ensuring all minorities are accurately represented in research [and in services provided], carrying out health checks for all 'women' aged 45, mapping current services, assessing the need for other commissioned services, and measuring aspects of the menopause to incentivize a good standard of care.

8.8 Summary:

- Local secondary-school-age children's use of contraception fell from 2019 to 2021, and awareness of local SRHSs fell over the same period.
- The rate of under 18s conception leading to abortion is low and has decreased, just as the rate of under 18s abortions has, but NEL's value was only statistically significantly different [lower] to England in the former. Access does not appear to be an issue, though, as the proportion of abortions performed under 10 weeks gestation is higher than England and has increased; the total abortion rate in NEL is just above England.
- Repeat abortions and abortions following a birth are both exceptionally high in the under 25s (1st and 2nd worst in the country, respectively), and the under 16s and 18s conceptions rates are also exceptionally high relative to other LAs (7th and 4th worst in the country, respectively). These may be linked to lower and decreasing contacts at SCSs, which is likely to have increased unplanned pregnancies. A higher proportion of attendees than the England average choose LARC and/or the contraceptive pill.

9.0 Current Sexual and Reproductive Health Services in NEL and Insight from Service Providers

9.1 Health Care Resourcing Group

In 2017, the sexual health contract in NEL was recommissioned together with North Lincolnshire (NL) Council. This was because both local authorities had the same provider (Virgin Care) for their sexual health services. As a result, both local authorities went out to market together with one service specification and one contract for a 'Northern Lincolnshire Integrated Sexual Health Service'. Virgin Care provided the successful bid, but this has since been bought out by HCRG Care Group, who have been the provider since December 1st, 2021.

NLISHS offers a 'one stop shop' for residents of both NEL and NL. **NOTE:** When speaking about the sexual health services provided by **NLISHS in NEL** this is referred to as the **Integrated Sexual Health Service (ISHS)**. Within NEL the main sexual health clinic (the hub) is based at Stirling Street Medical Centre in Grimsby. This clinic offers a wide range of services which service users can access. These services are:

- Counselling and advice
- Contraception (all types)
- Emergency contraception (the emergency IUD and emergency contraceptive pills)
- Screening and treatment for all STIs including people living with HIV
- Express testing
- Postal testing
- Online condoms
- Hepatitis B vaccinations
- Smear tests
- Pregnancy testing
- Coil and implant fitting and removal
- Referral for termination of pregnancy
- PrEP (a drug taken by HIV-negative people before and after sex that reduces the risk of getting HIV)

Services can be accessed by contacting HCRG by telephone or via the Virtual Hub. Walk in appointments ceased during the pandemic but are now being reintroduced.

Health Care Resourcing Group operate a virtual hub accessible at https://www.thesexualhealthhub.co.uk/. The virtual hub provides IAG and allows for service users to book appointments online, order contraception such as condoms and EHC, and receive Sexual Transmitted Infection (STI) kits which can be sent to an address of their choice.

The integrated sexual health service in NEL is offered and available to all ages and genders. Commissioned to perform 755 pieces of activity per month, the sexual health service often

delivers at a much greater number than what is expected due to high demand. The service also works alongside local organisations which signpost people to the service, facilitating the best support from a holistic perspective, via the services discussed below.

9.1.1 C-Card scheme

The C-Card is a scheme aimed at 16–19-year-olds to allow them to access free condoms. In 2017, NELC launched a pilot C-Card scheme over the summer holiday period, in partnership with Virgin Care and participating pharmacies. The pilot ended in January of 2018. In 2022 training was delivered to ISHS staff and school nurses in the hope that HCRG would launch the scheme again. However, as of July 2023, the scheme has still not been formally reintroduced. Discussions between NELC and NEL pharmacies are ongoing with a view to launch the scheme again by the end of 2023.

9.1.2 LARC contraception

General Practice (GP) & Integrated Sexual Health Service

North East Lincolnshire Council commissions a contract with participating GP surgeries and also the ISHS to provide LARC for the residents of North East Lincolnshire. This is open to all women and provides three types of LARC:

- **Implant** – this is a small, flexible rod that is placed under the skin in the upper arm and provides up to 4 years of contraception.
- **Intra-Uterine System** – also known as the hormonal coil. This is a small T- shaped device that is placed in the womb and provides contraception up to 5 years.
- **Intra-Uterine Device** – also known as the non-hormonal coil. This is also a small T-shaped device that is inserted in the womb and provides contraception between 5 to 10 years.

The following is a **combination of GP and ISHS's data** relating to the fitting and removal of LARC in NEL.

9.1.2.1 Implants fitted

Table 2 below shows that the **uptake of Implants** in NEL was highest in 2018/19. The implant is most common in people in their 20's with 2,476 fittings over the past 6 years. Between 2016/17 – 2018/19, the number of implants fitted was highest in 20–24-year-olds. This changed in 2019/20 and 2020/21 when 25–29-year-olds had a slightly greater uptake before

numbers returned in 2021/2022. There was a significant drop in the number of implants fitted in women aged 35 years and over.

Table 2: Total Number of Implants Fitted by GPs and ISHS: April 2016/17 – March 2021/22

	16/17 Implant fitted	17/18 Implant fitted	18/19 Implant fitted	19/20 Implant Fitted	20/21 Implant Fitted	21/22 Implant Fitted	Total
Under 16	56	46	102	34	34	34	**306**
16-17	113	98	104	92	85	89	**581**
18-19	104	114	153	116	71	94	**652**
20-24	240	249	249	204	158	**197**	**1297**
25-29	214	210	195	**205**	**167**	188	**1179**
30-34	123	160	108	181	131	164	**867**
35-39	56	106	93	117	76	94	**542**
40-44	42	37	59	50	31	60	**279**
45-49	61	26	56	39	28	32	**242**
50+	17	4	9	20	8	14	**72**
Total	**1026**	**1050**	**1128**	**1058**	**789**	**966**	**6017**

9.1.2.2 Implants removal

Table 3 shows the number of implant removals from 2016/17 – 2021/22. The age group with the highest number of implants removed each year also corresponds with the highest number of implants fitted (Table 2). Removal of the implant was highest amongst 20–24-year-olds and 25–29-year-olds.

Table 3: Total Number of Implants Removed by GPs and ISHS: April 2016/17 – March 2021/22

	16/17 implant removed	17/18 Implant removed	18/19 Implant removed	19/20 Implant Removed	20/21 Implant Removed	21/22 Implant Removed	Total
Under 16	4	8	17	4	9	2	**44**
16-17	37	37	37	21	24	32	**188**
18-19	100	54	95	63	53	63	**428**
20-24	233	167	196	146	134	183	**1059**
25-29	193	131	144	162	139	162	**931**
30-34	105	89	78	112	118	145	**647**
35-39	55	43	54	67	74	79	**372**
40-44	37	26	32	35	32	58	**220**
45-49	34	23	16	25	25	44	**167**
50+	12	9	3	22	7	22	**75**
Total	**810**	**587**	**672**	**657**	**615**	**790**	**4131**

9.1.2.3 IUD/IUS fitted

Table 4 shows the number of IUD/IUS fittings between 2016/17 – 2021/22. IUD/IUS was the most common choice of LARC for women aged 35 years and over in the past 6 years (1,768 fittings). The data shows 30–34-year-olds had the highest uptake of IUD/IUS fittings (126) in 2021/22.

Table 4: Total Number of IUD/IUS Fitted by GPs and ISHS – April 2016/17 – March 2021/22

	16/17 IUD/IUS fitted	17/18 IUD/IUS fitted	18/19 IUD/IUS fitted	19/20 IUD/IUS fitted	20/21 IUD/IUS fitted	21/22 IUD/IUS fitted	Total
Under 16	0	0	23	0	<5	0	**24**
16-17	9	7	37	<5	<5	<5	**61**
18-19	18	16	127	6	<5	7	**178**
20-24	78	86	187	81	57	70	**559**
25-29	107	114	144	132	76	121	**694**
30-34	94	106	117	133	74	126	**650**
35-39	81	124	83	103	68	101	**560**
40-44	70	63	81	112	59	88	**473**
45-49	92	83	36	96	72	97	**476**
50+	38	35	3	66	62	55	**259**
Total	**587**	**634**	**838**	**733**	**475**	**667**	**3934**

9.1.2.4 IUD/IUS removal

Table 5 below shows the number of IUD/IUS removed by **GPs and ISHS** between 2016/17 – 2021/22. In certain age groups, there may be more removals than fittings, common reasons for this may be switching toanother form of contraception, getting replacement LARC from elsewhere, or choosing to stop contraception completely.

While the number of IUD/IUS fittings (shown in Table 4) was highest amongst 25-29 year olds overall, removals were higher amongst older age groups, particularly people aged 45 years and over. The removal of IUD/IUS has been highest among people aged 50 years and over except in 2016/17 and 2018/19 when figures for this age group fell significantly.

Table 5: Total Number of IUD/IUS Removed by GPs and ISHS – April 2016/17 – March 2021/22

	16/17 IUD /IUS removed	17/18 IUD /IUS removed	18/19 IUD /IUS removed	19/20 IUD/IUS remove	20/21 IUD/IUS remove	21/22 IUD/IUS remove	Total
Under 16	0	0	0	0	0	0	**0**
16-17	0	<5	<5	<5	0	0	**5**
18-19	<5	<5	12	<5	<5	<5	**23**
20-24	24	14	50	30	23	31	**172**
25-29	57	25	52	53	54	51	**292**
30-34	52	39	61	65	66	61	**344**
35-39	52	43	53	55	48	62	**313**
40-44	60	34	55	55	41	52	**297**
45-49	82	56	66	42	40	59	**345**
50+	64	77	18	78	67	77	**304**
Total	**395**	**291**	**369**	**381**	**342**	**394**	**2172**

9.1.2.5 Dep-Provera injections

Dep-Provera injections are only offered and administered by ISHS as **GPs do not offer** this service. Comparing Table 6 to Tables 2 and 4 shows that Dep-Provera injection is the least common choice of LARC in NEL. The period 2021/22 saw an increase in the number of

injections administered to (541) - the highest uptake in 6 years. 20–24-year-olds are consistently the age group with the greatest number of Dep-Provera injections.

Table 6: Total Number of Depo-Provera Injections Administered by ISHS – April 2016/17 – March 2021/22

	16/17 Depo-Provera injection	17/18 Depo-Provera injection	18/19 Depo-Provera injection	19/20 Depo-Provera injection	20/21 Depo-Provera injection	21/22 Depo-Provera injection	Total
Under 16	16	8	7	13	11	18	**73**
16-17	39	41	30	21	16	81	**228**
18-19	83	56	74	25	20	38	**296**
20-24	186	156	130	65	57	181	**775**
25-29	36	64	91	52	29	83	**355**
30-34	26	27	53	26	19	77	**228**
35-39	15	20	35	15	7	32	**124**
40-44	23	21	24	<5	<5	19	**93**
45-49	6	6	<5	<5	<5	11	**32**
50+	<5	0	0	0	0	<5	**3**
Total	**432**	**399**	**447**	**225**	**163**	**541**	**2207**

9.1.2.6 Reason for LARC removals

Some of the reasons given by women for removals of LARC devices include:

- Reaching menopause
- Expiry of device at 3 years of having them in or
- Wanting to try for a baby
- Change of contraception
- Heavy periods
- Replacement i.e., replacing contraception with the same
- Having side effects such as weight gain, skin changes, mood changes or intermittent bleeding
- Not being able to cope with the coil or not liking the coil
- Implant gone deep
    - There is a deep implant removal service where implants are removed under scan condition.

9.2 Service User Activity Information – Integrated Sexual Health Service

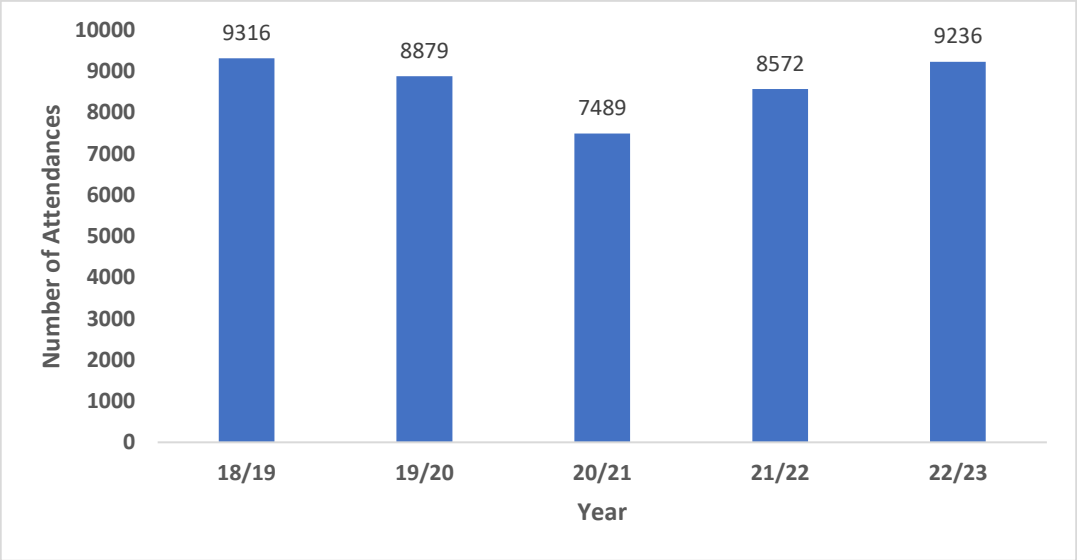
The following section contains service user activity information for the ISHS provided by HCRG.

9.2.1 Overall attendance

Overall attendance refers to the number of times the service has been accessed. **The number of attendances will be greater than the number of individuals accessing the service as the same person may attend the service multiple times.**

Figure 63 below shows the total number of attendances between April 2018/19 to March 2022/23. Between 2018/19 and 2021/22 there was a decrease in the number of appointments made at the clinics, this is attributed to the covid-19 pandemic. Due to restrictions, closures, and less socialising NEL clinics saw a significant drop in attendances.

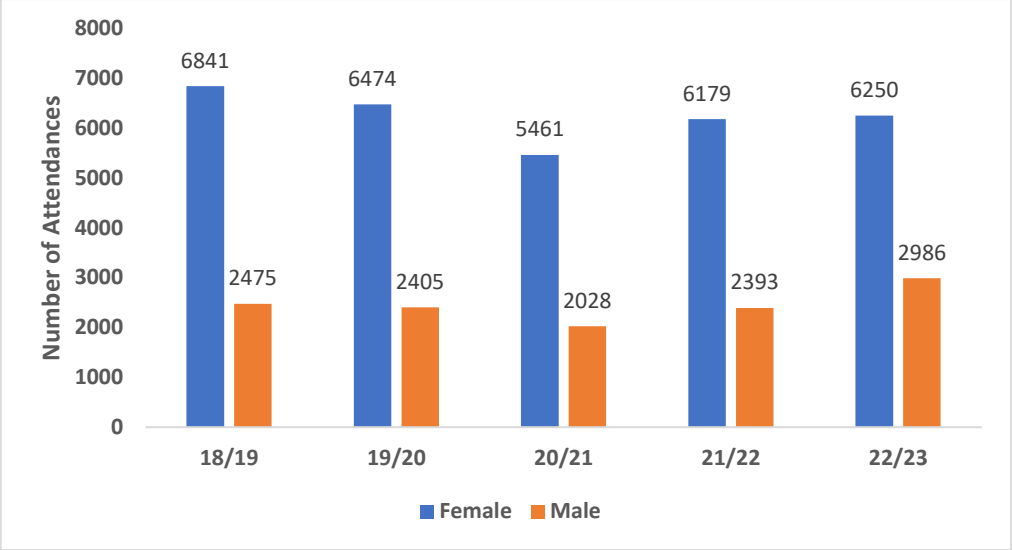
Figure 63: Total Number of Attendances for the Integrated Sexual Health Service – April 2018/19 – March 2022/23



9.2.2 Attendance by gender

Figure 64 below shows that overall **female attendances are consistently higher than male attendances**. This is due to women seeking further support from sexual health services for contraception, pregnancy, and termination support. 2022/2023 saw the highest number of male attendances in the 5 years under consideration at 2,986. The total number of attendances saw a dip during 2021/22 this could be attributed to the Faculty of Sexual and Reproductive Healthcare new guidelines surrounding contraception during the COVID-19 pandemic. Faculty of Sexual and Reproductive Healthcare advised certain LARC could be safely used longer than their licence period, reducing the number of attendances to the service.

Figure 64: Attendance by Gender: April 2018/19 – March 2022/23



9.2.3 Attendance by age

Table 7 below shows that the age group 20-24 year consistently have the highest **number of attendances** at sexual health services in the last 5 years. The second most common age group is the 25 to 29-year olds; showing that people in their 20s account for 20,754 (47.7%) of all appointments over the last 5 years. Though under 16s continuously have the lowest number of attendances annually, 2022-2023 saw a significant increase to 183 attendances, the highest in 5 years.

Table 7: Attendance by Age: April 2018/19 – March 2022/23

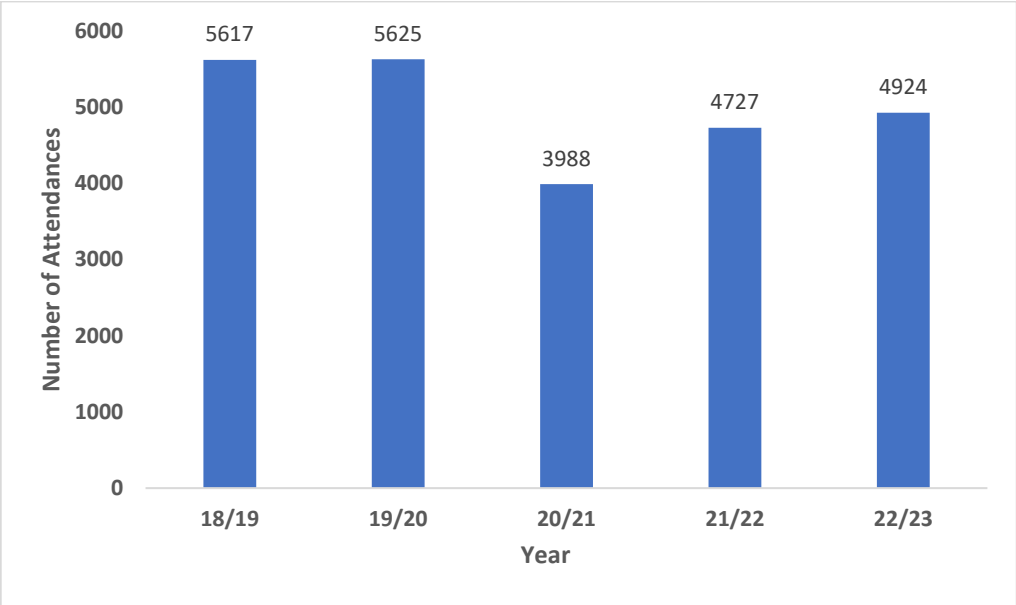
Age Group	2018/19	2019/20	2020/21	2021/22	2022/23	Total
Under 16	76	89	29	45	183	**422**
16 to 17	420	399	265	318	443	**1845**
18 to 19	937	730	489	660	782	**3598**
20 to 24	2623	2490	2217	2045	2177	**11552**
25 to 29	2067	1890	1717	1796	1732	**9202**
30 to 34	1184	1261	1028	1370	1397	**6240**
35 to 39	765	747	738	919	930	**4099**
40 to 44	434	462	418	596	595	**2505**
45 to 49	306	330	212	277	350	**1475**
50+	503	481	375	546	647	**2552**
Total	**9316**	**8879**	**7489**	**8572**	**9236**	**43492**

9.2.4 Number of people who have accessed the service

'Number of people' refers to the number of individuals who have accessed the service. **The number of people accessing the service will be lower than the number of attendances as we are not accounting for the same person accessing the service multiple times.**

Figure 65 below shows that the highest number of individuals attending the service is 5,625 individuals and this was in 2019/2020. There was a significant drop in the number of attendances during 2020/21, as previously mentioned, this is due to the COVID-19 pandemic. While numbers have been steadily rising, attendances have not reached pre-pandemic numbers.

Figure 65: Number of People Who Have Attended the Integrated Sexual Health Service: April 2018/19 – March 2022/23



9.2.5 Number of people who have attended the service by ward

Table 8 below shows that over the last 5 years (2018/19 to 2022/23), 3,108 (12%) individuals who accessed sexual health services were from East Marsh. Reasons for such high numbers could be attributed to HCRG's main hub (Stirling Street) being located in East Marsh, alongside higher numbers of young people residing in the ward. Previously, East Marsh had a significantly higher number of people attending than other wards in NEL however, since 2021, the gap has decreased. Residents of Waltham are consistently the lowest users of sexual health services, accounting for just 127 (2.5%) of all service users during 2022/2023.

Table 8: Number of People Who Have Attended the Service by Ward: April 2018/19 – March 2022/23

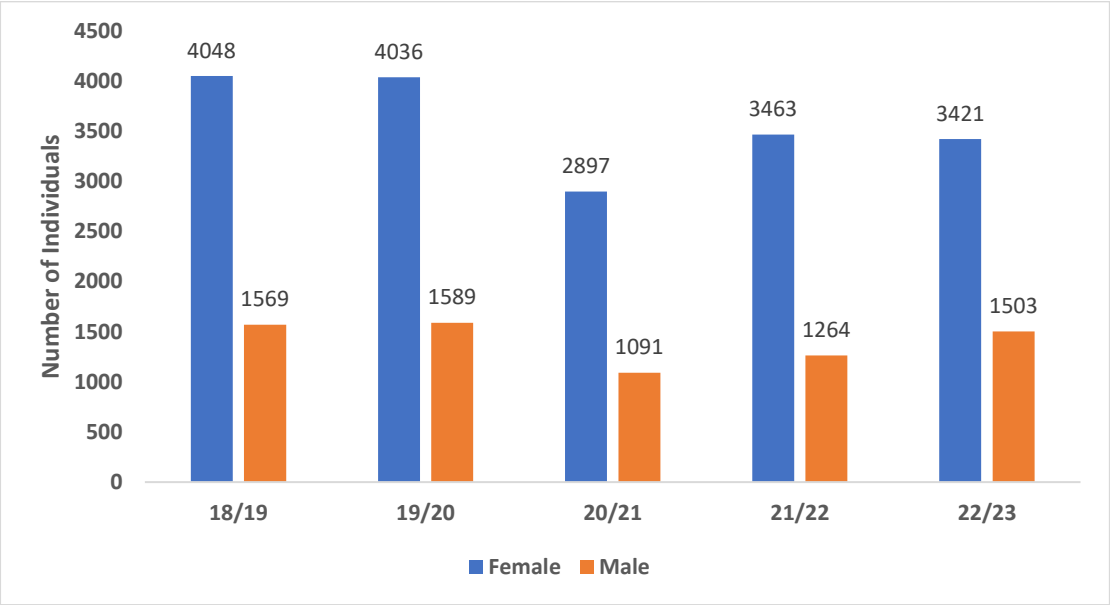
Ward	18/19	19/20	20/21	21/22	22/23	Total
East Marsh	732	769	501	538	568	**3108**
Sidney	644	595	425	590	533	**2787**
Heneage	508	515	338	384	408	**2153**
Croft Baker	458	466	347	400	421	**2092**

South	438	482	284	404	392	**2000**
Park	411	423	320	370	373	**1897**
Yarborough	357	381	279	304	330	**1651**
West Marsh	314	324	245	286	292	**1461**
Scartho	298	320	212	277	262	**1369**
Humberston and New Waltham	295	264	191	254	311	**1315**
Freshney	285	270	214	235	244	**1248**
Haverstoe	262	234	175	183	201	**1055**
Immingham	250	230	163	200	206	**1049**
Wolds	186	183	127	152	184	**832**
Waltham	149	143	120	119	127	**658**
Blank	30	26	47	31	72	**206**
Total	5617	5625	3988	4727	4924	24881

9.2.6 Number of People Who Have Attended the Service by Gender

Once again, Figure 66 below shows the amount of indiviudal females greatly outnumbers the amount of male individuals accessing the sexual health service. Data also shows female have a much higer number of repeat attendances than males.

Figure 66: Number of People Who Have Attended the Service by Gender: April 2018/19 – March 2022/23



9.2.7 Number of people who have attended the service by age

Table 9 below shows that 20 to 24-year-olds are the age band with highest number of individuals consistently accessing the sexual health service. 2019-2020 saw the highest number of individuals accessing sexual health services, at 5,625 individuals. Overall, 11,324 (45.5%) of service users in the past 5 years under consideration were in their 20s. Numbers

were also consistent with the rise of under 16s accessing the service in 2022-2023 (225 individuals) after previously being least attending age band. 45 to 49-year-olds in 2022-2023 now have the lowest individual attendance at 180 individuals.

Table 9: Number of People Who Have Attended the Service by Age: April 2018/19 – March 2022/23

Age Group	18/19	19/20	20/21	21/22	22/23	Total
Under 16	129	133	60	82	225	**629**
16 to 17	373	358	204	288	308	**1531**
18 to 19	681	581	352	373	432	**2419**
20 to 24	1513	1533	1183	1192	1117	**6538**
25 to 29	1119	1102	783	893	889	**4786**
30 to 34	689	751	581	760	737	**3518**
35 to 39	425	430	340	446	465	**2106**
40 to 44	260	272	188	290	288	**1298**
45 to 49	182	193	122	166	180	**843**
50+	245	272	174	237	283	**1211**
Total	**5617**	**5625**	**3988**	**4727**	**4924**	**24881**

9.2.8 Number of People Who Have Attended the Service by Ethnicity

The vast majority of individuals (23,363) attending sexual health services identify as white British accounting for 94% of all service users over the 5 years under consideration. Latest census data (2021) showed the population of NEL was predominantly white at 96%.

Table 10: Number of People Who Have Attended the Service by Ethnicity: April 2018/19 – March 2022/23

Ethnicity	18/19	19/20	20/21	21/22	22/23	Total
British	5289	5273	3744	4439	4618	**23363**
Any other White background	156	156	96	135	119	**662**
Not stated	47	55	41	17	22	**182**
African	20	22	13	25	22	**102**
Any other mixed background	14	15	15	13	14	**71**
Irish	8	11	12	12	26	**69**
Any other Asian background	15	15	7	11	18	**66**
White and Asian	11	14	7	16	17	**65**
Any other ethnic group	18	10	11	8	13	**60**
White and Black Caribbean	9	11	14	11	8	**53**
White and Black African	5	9	8	9	16	**47**
Any other Black background	10	7	<5	6	12	**38**
Chinese	6	5	<5	6	6	**26**
Bangladeshi	<5	8	5	<5	<5	**21**
Indian	<5	<5	<5	8	6	**21**
Pakistani	<5	<5	5	5	<5	**18**
Caribbean	<5	7	<5	<5	<5	**16**
Grand Total	**5617**	**5625**	**3987**	**4727**	**4924**	**24880**

9.2.9 Number of people who have attended the service by sexual orientation

Table 11 below shows 22,961 (93%) individuals who accessed sexual health in the 5 years being considered identified as heterosexual.

Table11: Number of People Who Have Attended the Service by Sexual Orientation: April 2018/19 – March 2022/23

Orientation	18/19	19/20	20/21	21/22	22/23	Total
Heterosexual	5263	5191	3685	4351	4471	**22961**
Homosexual	142	169	170	189	208	**878**
Bisexual	89	107	97	131	136	**560**
Not known / Declined to provide a response	122	21	27	52	107	**179**
Other sexual orientation not listed	<5	<5	<5	<5	<5	**9**
Person asked and does not know or is not sure	0	<5	<5	<5	<5	**6**
Grand Total	**5617**	**5493**	**3982**	**4727**	**4924**	**24743**

9.2.10 Location in which NEL Residents Accessed Sexual Health Support

Table 12 below shows where NEL residents are receiving sexual health care, and this includes locations in North Lincolnshire. The table shows that the majority of NEL residents (12,160) are accessing sexual health care via Stirling Street Medical Centre in Grimsby which is NLISHS's main hub. Table 12 also shows a decrease in the number of postal testing kits sent out in NEL from 2020/2021 onwards. There has been a significant decrease in the number of chlamydia outreach screenings from 2018 -2021 particularly during 2020 to 2021, these are completed by Termination of Pregnancies (ToPs), 0-19 service, midwifery and any other CT screening events completed by NLISHS such as freshers' fairs and college outreach though this number has started to rise as of 2022/2023.

Table 12: Location in which NEL Residents Accessed Sexual Health Support: April 2018/19 – March 2022/23

Location	18/19	19/20	20/21	21/22	22/23	Total
Stirling Street	4217	3053	1147	1836	1907	**12160**
Postal Testing	845	759	1262	1060	897	**4823**
Chlamydia Screening NEL	342	209	64	48	57	**720**
Birkwood Surgery	109	87	46	0	0	**242**
Ironstone Centre	44	24	60	59	47	**234**
Grimsby Institute	33	0	0	0	25	**58**
Central Surgery, Barton	15	8	0	13	8	**44**
Franklin College	0	9	0	0	19	**28**
Riverside Surgery	8	6	0	0	0	**14**
Central Surgery	<5	<5	0	0	0	**6**
Ormiston Academy	<5	<5	0	0	0	**6**

John Leggott College	0	0	0	<5	0	**<5**
North Lindsey College	0	0	0	<5	0	**<5**
NL Postal Testing	0	0	0	<5	<5	**<5**
Total	**5617**	**4168**	**2579**	**3021**	**2961**	**18346**

9.3 Barriers to Service Provision - HCRG

9.3.1 Withdrawal of community-based outreach

Numerous services in NEL have claimed community-based outreach would help improve uptake and access to the sexual health service. HCRG understands this and agrees that it would be beneficial in providing greater access in the local area. Historically, before changes to provision in 2013, outreach within the community was provided by the clinic, however, due to lack of new nurses and healthcare staff and limited funding, HCRG reported that it can no longer provide this service.

In North Lincolnshire, HCRG have previously attended schools and colleges in order to deliver chlamydia testing and offer IAG. Outreach within educational settings have had a very positive reaction from students with a good uptake of testing however, this has not been delivered in NEL.

9.3.2 Lack of walk-in clinics

Walk in clinics have not been available in NEL since pre-pandemic, this seems like a missed opportunity as HCRG report a large attendance when they are available. Plans to re-instate the clinics have been given the go ahead and are said to begin at the end of April 2023.

9.3.3 Stigma of attending sexual health services

Anecdotal evidence has shown patients attending the clinic to have LARC fitted have felt embarrassed to do so. Stigma of engaging with sexual health service also affects young people. Having recently met with the Youth Council, HCRG reported that young people are nervous to seek help from the clinic and are not fully informed on sexual and contraceptive health.

9.3.4 Increased demand on service

HCRG feel there is an issue with an increased demand on the service due to primary care directing patients to attend sexual health for contraception instead of completing a contraceptive consultation within their GP practice. HCRG note that ultimately, they are a sexual health service and therefore, have to find a balance between sexual health and contraception provision. For the service, priority is placed upon those attending the clinic

with symptomatic concerns often resulting in longer waiting times for those looking for contraception. Currently, the average waiting time is between 1 and 2 months for a LARC fit, however LARC counselling is completed before then for patients to consider the best method for them.

9.3.5 Access to service

The service is currently in the process of establishing an under 25s contraceptive clinic at the Raj medical centre on Laceby Road. This location is in much closer proximity to education centres than Stirling Street and therefore, it is hoped this will make the clinic more accessible to local school and college pupils.

10.0 Pharmacy ACT Service

The sexual health offer delivered by pharmacies falls under the ACT service. There are currently 34 pharmacies located within NEL and 30 (88%) of those are locally commissioned by the council to deliver this. The key elements of the original service specification remain, though needs improvement.

NEL residents can access the following:

- Emergency Hormonal Contraception
- Pregnancy Testing
- Chlamydia Testing
- IAG
- Condoms
- C-card scheme *(if and when reintroduced)*

Sexual health provision in pharmacies operate on a walk-in only basis and the administering of EHC is completed in line with Patient Group Directions (PGD), though the current documents are due for an update by September 2023.

10.1 ACT Pharmacy Data

ACT data from 2022/23 showed the following:

- During 2022/23 there were an average of 82 pharmacist/patient interactions per month.
- 23% of interactions were with individuals aged under 20 years, and 40% were with individuals aged 20 to 29 years.
- Monday was the peak day for ACT interactions accounting for just under 25% of all interactions.

- Just under 40% of NEL interactions were with clients resident in East Marsh, Heneage, and Sidney Sussex wards.
- Of the 30 pharmacies that are commissioned to provide ACT, 7 were inactive (that is, are part of the ACT contract but have not had any activity during 2022/23).
- Over 40% of interactions were with 2 pharmacies (Asda supermarket in Grimsby and Sai Dutt pharmacy on Wellington Street)
- LARC was discussed at approximately 14% of interactions when supplying females with condoms.
- Just over 65% of all condom supply interactions were provided by Sai Dutt Pharmacy (Wellington Street). This high number can be attributed to the location (East Marsh) alongside, the wide variety of services the pharmacy offers.
- There was a considerable reduction in the number of interactions from March 2019/20 with numbers not returning to pre-pandemic levels as shown in Table 13 below.

Table 13: Total Number of ACT Activity: May 2016/17 – March 2022/23

Month	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
April		147	182	156	40	72	87
May	60	167	174	147	49	73	109
June	95	148	183	145	70	78	97
July	113	137	149	141	117	111	90
August	128	116	138	134	105	99	106
September	119	114	138	159	121	78	58
October	139	167	147	138	111	76	86
November	125	146	145	140	73	87	74
December	169	136	127	101	73	75	72
January	143	141	147	133	47	115	81
February	142	124	113	123	51	79	54
March	201	155	140	62	54	74	68
Total	**1434**	**1698**	**1783**	**1579**	**911**	**1017**	**982**

10.2 Emergency Hormonal Contraception Uptake by ACT pharmacies in NEL 2021/22

Emergency hormonal contraception known as the 'morning after pill' is used in the prevention of pregnancy after unprotected sex. EHC is provided free to people aged between 13 to 18 years and in NEL. Data shows in 2022/23, the number of ACT pharmacies in NEL that were active for EHC is 23 (77%).

10.2.1 Overall emergency hormonal contraception activity

Table 14 below shows that between 2016/17 – 2019/20 there was a gradual increase in the number of EHC supplied by ACT pharmacies. The impact of the COVID-19 pandemic on activity can be seen during 2020/21 when there was a significant drop in activity. Numbers increased during 2022/23 compared to the previous two years but are still below pre-pandemic levels. During 2022/23 there were an average of 72 EHC consultations per month.

Table 14: Total Number of Emergency Hormonal Contraception Activity: 2016/17 – 2022/23

Month	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
April		83	110	119	28	54	78
May	51	92	100	95	39	62	97
June	67	84	111	94	53	64	84
July	80	69	99	102	96	82	79
August	92	67	95	96	92	73	93
September	70	60	84	125	94	52	51
October	84	98	103	96	88	60	70
November	66	87	98	108	49	71	66
December	94	87	89	78	58	63	61
January	70	72	98	102	37	84	67
February	78	72	76	96	36	65	49
March	99	102	85	49	39	61	60
Total	**851**	**973**	**1148**	**1160**	**709**	**791**	**855**

Consultations where EHC was **supplied by pharmacies in 2021/22 show the following:**

- **64.3%** of EHC consultations were with clients aged **under 30 years** while **26.4%** were with clients aged **between 30 and 39 years** and the remaining **9.2%** were with clients aged between **40 and 59 years.**
- Table 15 below shows 98% of all EHC consultation ended with EHC being supplied.

Table 15: Emergency Hormonal Consultations in Pharmacies in NEL 2022/23

Number of EHC consultations	855
Number of consultations where EHC supplied	841
Percentage of consultations where EHC supplied	98%

- Of the 841 EHC consultations where a supply was made, the majority of clients (93%) reported that condoms would be the method of continuing contraception that cycle.

- Service users reported previous use of EHC as a form of contraception at 55% of the 841 EHC consultations (n=463) where a supply was made.
- 35% of EHC consultations with NEL residents were with clients living in Heneage, East Marsh, and Sidney Sussex wards.
- A quarter of all EHC consultations in pharmacies were held on a Monday.
- 57% of service users presented within 24 hours of unprotected sexual intercourse.

10.2.2 Reasons given for requesting EHC at pharmacies

Table 16 below shows the reasons given for requesting EHC at the pharmacies. The table shows that over half of requests for EHC in 2022/23 were due to unprotected sex, 18 Chlamydia tests were supplied as part of EHC consultations. A further 33% of requests were reported as due to contraception failure. This indicates a lack of regular contraceptive compliance.

Table 16: Reasons for Requesting EHC – Pharmacies 2022/23

EHC request reason	Number	Percentage
Unprotected sex	520	61%
Failed condom	282	33%
Missed pill	44	5%
Other	9	1%

10.3 Barriers to Service Provision - Pharmacies

10.3.1 Loss of points of access

Though NEL has a good uptake in the number of pharmacies signed up to ACT, 8 of those pharmacies are Lloyds, a chain of pharmacies which going forward will no longer be signing any service provision contracts, meaning NEL will lose these points of access when the contract comes to an end in April 2023. Pharmacies are an essential part of sexual health provision, while NEL only has one sexual health clinic having multiple pharmacies allows communities to access advice and contraception conveniently.

10.3.2 Financial struggles within community pharmacy

Community pharmacy has been noted as a real issue in NEL, as many are finically struggling. During the pandemic GPs referred individuals to pharmacy which resulted in a larger uptake

without funding to support such an influx. NEL has a lot of static pharmacies that are willing to provide a good offer, but a more streamlined service is necessary.

10.3.3 Declining relationship between pharmacy and sexual health service

Historically, pharmacists had a much stronger relationship with the sexual health service than they do currently, this has been attributed to the changes in staff both within pharmacies and the ISHS. This good working relationship previously resulted in the clinic keeping appointment slots open, so service users could access contraception that otherwise could not be administered at the pharmacy. Pharmacists re-connecting with the sexual health service to strengthen working relationships could help prevent women falling through the cracks. Pharmacist delivering LARC has been explored by service development managers however, from a time and financial perspective it isn't feasible.

10.3.4 Lack of knowledge amongst pharmacists

School nurses have claimed that young people have previously attended pharmacies that have signed up to a C-Card scheme during the pilot where there has been no knowledge of the scheme when requesting condoms. This has been attributed to lack of promotion of the scheme and new staffing not been briefed.

11.0 HIV Services

Men who have sex with men (MSM) have a particularly high risk of acquiring STIs and HIV, and LGBT individuals are also reported as a high-risk group (PHE, 2015) (OHID, 2022). Unfortunately, many people living with HIV are diagnosed late (PHE, 2015). Research shows that HIV incidence can be reduced through an increase in HIV testing (PHE, 2015).

11.1 HIV treatment in NEL

While HIV treatment previously sat within Virgin Care as part of the sexual health offer, the service is now Hull based and commissioned by the ICB.

Operating as part of a hub and spoke model, in which the central hub (Castle Hill) is located in Hull, patients have a choice in of which location they access treatment including:

- Diana Princess of Wales Hospital – Grimsby
- Scunthorpe General - Scunthorpe
- Castle Hill Hospital - Hull
- Hull Royal Infirmary- Hull

All medical staff are based at Castle Hill (Hull) and travel out to these sites to undertake clinics A patient who is from Grimsby may choose to access treatment in Scunthorpe or Hull. Reasons for this may include ease of access for people who live and work in different places or may do so to seek further confidentiality.

Once individuals are referred into the service alongside medication the team offer:

- Partner testing
- Screening for STIs
- IAG
- Practical support (help with accessing benefits, housing, referrals to SPOA)

A clinic is held at DPoW Hospital every Wednesday and sits within infectious disease unit ensuring confidentiality at each stage. Here, patients can receive treatment and support. While the level and frequency of this support varies amongst individuals typically, once patients are stable, the service will see them every 6 months.

11.2 Positive Health

Positive health is a sexual health charity that predominantly provides support to men who have sex with men (MSM) and those living with HIV. Within NEL, the team are commissioned by HCRG to provide outreach work in public sex areas in the borough. This outreach work focuses:

- Education
- Prevention
- Importance of screening
- Benefits of PrEP (drug taken by HIV-negative people before and after sex that reduces the risk of getting HIV)
- Free condoms
- Signposting to local sexual health services where necessary.

HIV testing is also an important part of Positive Health's service, once a month the team provides a drop-in clinic at Open Door. In order to reach as many people as possible, twice yearly, the team hires a camper van to visit public sex environments and offer point of care testing there and then. Though the team feels this helps, particularly with men who may not attend clinical settings, much more work needs to be done in order to greatly improve HIV testing uptake as only 26 people were tested in Northern Lincolnshire (Grimsby and Scunthorpe) in September 2022 as part of their twice-yearly outreach work.

11.3 Barriers to Service Provision - Positive Health

11.3.1 Commissioning restraints of positive health

Due to the commissioning restraints Positive Health are restricted to outreach support resulting in limited support to those living in NEL. Compared to Lincolnshire, Positive Health team within Lincolnshire provides wrap around support including working with consultants, help with medication, assistance at medical appointments, emotional support, social care support, and help with housing and employment. For residents of NEL, those who have received a reactive result will be signposted to sexual health services and telephone support is offered.

11.3.2 Disjointed pathway of HIV detection and treatment

The way in which HIV is detected and treated has created a disjointed pathway. While HIV testing is within the parameters of the ISHS, treatment happens in the hospital. This can lead to confusion amongst residents, particularly those who have recently moved into the area with a positive HIV diagnosis. Patients have reported presenting to the sexual health clinic or their GPs to continue their HIV care only to be met with a long and painful process of being bounced between sexual health and their GP's before eventually being referred to DPoW Hospital. This pathway could and should be made a lot quicker and smoother for the patients.

11.3.3 Lack of peer support

Currently there are no peer support groups available in NEL for people living with HIV. The HIV care team feels this is a missed opportunity for patients to share their experiences and knowledge. The HIV care team do offer a buddy system, which is found to be helpful especially amongst those recently diagnosed.

Positive Health state that residents of Grimsby have travelled to Lincoln to attend Positive Health's HIV drop-in support group, but little could be done to support these residents due to them receiving treatment in Grimsby.

11.3.4 Lack of knowledge from residents and health care staff

People living with HIV in NEL have reported lack of understanding from healthcare staff who have limited knowledge on HIV, sexual health, and the referral process. This continues to cause unnecessary stress to patients and perpetuates unhelpful myths which adds to stigma surrounding HIV. The HIV care team report how patients, particularly in their 70s and 80s, struggle with being open about their diagnoses, often times sending their partners to collect medication or decanting the medication from labelled bottles.

Accessing healthcare still remains difficult to people living with HIV; facing long waiting times for surgery and cervical smears alongside registering at a dentist is a reality for many patients who disclose their status.

11.3.5 Missed opportunities for early detection

Lack of knowledge amongst healthcare staff alongside shortage of accessible testing has been attributed to missed opportunities for early detection. The majority of positive HIV diagnosis have resulted from self-initiated testing. Due to HIV's association with the MSM community often those in heterosexual or in heterosexual-presenting relationships are overlooked or not offered HIV tests despite displaying symptoms. There is also concern that due to the stigma surrounding HIV, tests may not be offered to such individuals for fear it may cause insult.

11.3.6 Need for routine testing

Currently, routine testing is only offered in areas with high prevalence of HIV however, we cannot accurately obtain NEL's true number of infections due to this lack of testing. Routine testing and an opt-out approach in hospitals and GP surgeries could help with early detection, reducing the number of late diagnoses. It would also be beneficial to seize the opportunity to test all patients who present at sexual health services for other STI screens.

11.3.7 Patients' reluctance to attend sexual health clinic

Patients have expressed reluctance to attend the sexual health clinic due to capacity issues and disorganisation. Lack of appointments has led to some people waiting up to 3 and half weeks to be treated. Service users have also reported feeling embarrassed to call up the sexual health clinic and explain they have symptoms over the phone, further adding to their reluctance to attend. With sexual health having no walk-in clinics to alleviate this anxiety or offering an alternative to appointment-based care it is concerning that people may not be accessing the treatment they need. The HIV clinic, therefore, offers STI screening to their patients alongside offering partner testing where necessary.

11.3.8 Lack of condom provision

The service does not currently have access to free condom provision, this is another missed opportunity to work preventatively in stopping the spread of STI's and further transmission of HIV if an individual becomes detectable. This is particularly frustrating as Hull clinics receive free condoms from Yorkshire Men who have Sex with Men – Action in the Community (MESMAC) however, despite the service being a Hull based clinic they cannot access this provision due to having a Grimsby postcode.

12.0 Sex Worker Support

12.1 Emerge

Established in 2019, Emerge is a voluntary sector organisation in NEL that exclusively provides support to sex workers in NEL. The service is run by a mixture of trauma informed volunteers and paid staff, including a clinical trauma therapist and two level 5 trained therapists. Though Emerge is available for all sex workers the team primarily supports female street sex workers 5 days a week.

The aim of the service is to provide holistic care through a 3-tiered approach. Practical support, therapy, and network integration.

- **Practical support** – It is crucial that the women have a stable foundation on which to build their lives, working with the council, private landlords, housing charities, and families Emerge ensures housing is secured for women who are supported by the team. Alongside signposting to jobs, providing clothes and household goods.
- **Therapy -** For Emerge, understanding and empowering women is at the forefront of what they do. Therefore, therapy is tailored to the needs of the individual. This can come in the form of 1 to 1 therapy, workbooks, group work, and through activities such as gardening, equine therapy, social skills training, cooking, self-care, and games.
- **Network integration** – Ensuring women have a strong support system around to support them.

Working together with local services ensures Emerge can deliver this approach. Having good working relationships with probation, police, women's aid, sexual health and drug and alcohol services ensure wrap around support is provided.

Promoting self-confidence and self-esteem is essential. Many of the women are frightened to talk to the therapists due to poor experiences and scepticism in the ability for therapy to work, having the service run by other women with lived experience helps increase trust and form a community with one another. Essentially, the hub becomes a safe space for women to confide and relax with one another. As a result, staff are trusted to attend doctors' appointments, births, and court with the women.

12.2 Open Door

Open Door is a GP surgery which provides healthcare, social support services, information, advice, and guidance to vulnerable members of the community. As part of this, the team has a dedicated outreach worker who supports sex workers and other vulnerable groups, such as

homeless people, that are registered at the practice. STI testing including screening for blood borne diseases are also offered to their service users.

12.3 Sex Worker Outreach

Commissioned by the ICB, every Monday outreach support is given to female/male street sex workers in the area. This includes handing out condoms, food, drinks, and providing welfare checks.

There are currently around 28 street sex workers in NEL. Having a good relationship with the women is key to gaining trust and therefore, uptake in seeking sexual health support. The outreach worker has also built strong relationships with the women who work in parlours, and from their own homes. Within the parlours, once a new woman has arrived to work in NEL, Open Door are informed, and the outreach worker is introduced offering their support.

12.4 Barriers to service provision- Emerge, Open Door and Sex Worker Outreach

12.4.1 Stigma attached to attending the sexual health clinic

It has been reported by both Emerge and Open Door that sexual health support is difficult to access for sex workers. Some of the women have reported feeling embarrassed to attend Stirling Street, stating they felt ashamed of people knowing they were attending a sexual health clinic.

12.4.2 Issues with accessing sexual health clinic

Open Door highlight how appointment-based access to sexual health furthers sex workers and other vulnerable groups reluctance to engage and doesn't meet the needs of the patients. Though Open Door report a good working relationship with HCRG, including the treatment of their patients when attending, they have reported difficulties in making appointments and contacting the service when needed. Open Door attribute this to short staff and high demand.

12.4.3 Difficulties with current model

Though Open Door's outreach provide STI testing; the results and treatment are delivered by the ISHS. Getting in contact with patients, waiting for results, arranging appointments with ISHS, alongside ensuring appointments are attended is very difficult to manage.

Open Door have highlighted how having a dedicated sexual health nurse to provide treatment at their surgery would help ease the anxiety of people attending the sexual health clinic.

12.4.4 Greater sexual health support needed in primary care

Having primary care take a greater role in providing sexual health treatment in NEL would help take the strain off the sexual health clinic. Patients have reported attending their GPs with sexual health concerns and being referred straight to the sexual health clinic but are met with long waiting times. Primary care providing a more extensive offer on sexual health could perhaps reduce the stigma attached to attending the sexual health clinic due to the anonymity the GP surgery waiting room provides.

13.0 Children and Young People

13.1 PSHE in Schools

Young people are provided relationships and sex education and health education via Personal, Social, Health, and Economic education. This is statutory across all schools across England with education beginning in primary schools. The curriculum evolves as students age beginning with healthy relationships before going on to sex education. Parents of pupils have the right to request their child be withdrawn from some or all of sex education but not the health education side.

'Together For All' website was created by NEL council to provide professionals and schools support when delivering PSHE. The website contains a one-stop-shop directory of services, key upcoming dates, and professional development training taken directly from the statutory guidance.

13.2 Annual Personal, Social, Health, and Economic Education Survey

A PSHE survey is sent out every Easter term from the Council asking schools to give an update on provision and what Continued Professional Development (CPD) needs are required. In the most recent survey (2023), 36 schools in NEL responded (23 primary schools, 7 secondary schools, 2 infant schools, 2 junior schools, 1 Pupil Referral Unit (PRU), and 1 special school).

The survey showed the following:

- All 36 responding schools said they had a designated lead to champion the importance of RSE, HE, and PSHE. All but four said the lead is sufficiently resourced to fulfil their role effectively. Three of these exceptions said time was the issue, while the other said it was funding.

- Of the 29 schools which specified a ***most pressing training need***, 7 said RSE training in some form is needed, making that the most popular priority in terms of training.
- 27 schools said there was CPD and training in place for all staff contributing to the delivery of RSE and, HE (PSHE), compared to 8 who said there was no CPD and training in place. One school had multiple respondents, and their answers to this question were inconsistent, so they have been omitted from the summary point for this question alone.
- All 36 schools were asked how they teach RSE & HE (PSHE) in a multiple-choice question with nine options, including an 'Other' option. Teaching RSE & HE (PSHE) through a dedicated one-hour lesson per week was the most popular method, with 25 schools selecting this option, 18 schools indicated it is integrated across the curriculum, 16 teach it with other subjects, and 12 teach it in *dedicated blocks throughout the year*, just as 12 built it into *pastoral/tutor groups*. Schools selecting multiple options are assumed to use multiple methods.
- In another multiple-choice question, 22 of 23 primaries and all secondaries said teachers teach RSE & HE (PSHE); only 2 schools said teachers did *not teach PSHE content*. 14 schools said other staff teach it (mostly teaching assistants), inc. 10 primaries and 1 secondary. 9 schools selected the *other* option. Again, schools selecting multiple options are assumed to use multiple methods.

13.3 Barriers in Delivering PSHE in Schools

13.3.1 Delivery of PSHE

With no external team teaching the more difficult parts of RSE, teachers expressed that they could feel pressure and anxiety when speaking to students about sensitive topics. Using the correct language has been raised as a concern amongst staff, this is particularly important as Grimsby does not have a large LGBT+ presence. While schools report a more tolerant attitude amongst students in recent years, education on identity and sexuality is lacking. It's important that young people learn not only for their development but crucial in ensuring the curriculum is representative and inclusive.

13.3.2 Lack of multi-agency sexual health and young people's services

Multiple young people's services are now no longer available in NEL. MASH was a virtual team made up of school nurses, police, youth workers, midwives, and other YPSSs which offered 4-6 weeks RSE lessons from years 9-11. Additionally, sexual health services for young

people such as COAST, which offered chlamydia screening and CHOICES a support service for any/all sexual health support and advice are now no longer available.

14.0 Health Visitors

Health visitors are registered nurses or midwives who have had additional training in public health nursing. They work with parents who have new babies, offering support and informed advice from the ante-natal period until the child starts school at 5 years. Though health visitors report not working directly with the sexual health service, they do provide brief advice surrounding contraception and may signpost to the sexual health clinic if appropriate.

15.0 School Nurses

Commissioned by the council, school nurses offer young people guidance, signposting, and support. The service is provided to all young people aged 4 ½ - 19 as required, though this will extend for young people who need additional support such as those with special education needs. Services Provided by school nurses are discussed below.

15.1 Wellbeing Clinics

As part of an extensive sexual health offer, school nurses deliver wellbeing clinics in which pupils can access;

- Chlamydia and Gonorrhoea testing,
- sexual health support
- developmental support (puberty)
- emergency contraception
- C-card scheme - which allows young people to access free condoms via pharmacies.
- provide support to accessing additional sexual health services.
- Support the PSHE programme in schools.

Wellbeing clinics can be delivered in different settings to increase student access including family homes and schools although, school nurses must work with schools in order to adhere to individual school discretion which at times can lead to a limited offer.

15.2 Texting Service

A texting service is also available for students who wish to ask for help, this can be anonymous, or the young person can share their details if they wish further face to face support. Students have the option to text for all types of health issues if they would feel a face-

to-face discussion would not be appropriate for their needs. This ensures the school nurses are providing a confidential, visible and confidential service. The text is reviewed each day by an allocated Text nurse who will review and respond accordingly. Sign posting material is sent on line to offer initial response with further support and follow up as required.

15.3 Clinical Health Forums

School Nurses have annual clinical health forums to discuss and update knowledge regarding many health-related issues including sexual health. This is delivered by a representative from an external company, Organon. Due to the positive relationship developed with the sexual health service, staff from HCRG have been open to opportunities to observe the practice in the clinics to support the school nurses work with young people.

15.4 Barriers to Service Provision - School Nurses

15.4.1 Administering other forms of contraception

School nurses not being a part of the wider sexual health offer for the community as they have previously supported Virgin Care's outreach clinics to aid young people in accessing them.

School Nurses are not able to administer other forms of contraception such as LARC which would help tackle unwanted pregnancies.

15.4.2 Absence of wellbeing clinics in some Schools

Not all schools in NEL have wellbeing clinics; this is due to some being uncomfortable with having a sexual health clinic operating inside their school. Furthermore, the school closures, as a result of the pandemic, resulted in some schools being reluctant to re-establish the clinics. The school nurses are therefore, limited not only in what they offer to young people in terms of types of contraception but are governed by individual school policies.

15.4.3 Confidentiality between students and school nurses

Confidentially is also an issue due to schools and parents wanting to know why pupils are attending wellbeing clinics. Though it is noted there are currently ongoing talking with schools to support understanding of confidentiality and responsibilities when working with young people and sexual health.

15.4.4 Sexual Education for the elected home educated

Children who are EHE and those with additional needs are also at risk of missing out on vital sexual education. There are around 300 young people who are home educated in NEL, with sexual education not being compulsory outside of schools and school nurses reporting not having a robust working relationship with the EHE. For those young people who are home educated, school nurses ensure that they receive the Text card so that they can contact them if they wish to access support. The school nurses service also features in the information letter sent by the Education team to those families who are registered as being EHE.

15.4.5 Communication

Communication across the borough for families, as well as young people, would go a long way to deliver a more effective service. For school nurses it seems that there is still a stigma surrounding contraception and attending sexual health clinics, a more accessible and open service would improve young people's understanding and confidence in attending.

16.0 Youth Justice

The Youth Justice team works with young people aged 10-18 years from entering the criminal justice system for the first time, preventing re-offending and supporting young people to change behaviour and integrate back into the community. Funded by the Youth Justice Board and working within the council, the team provides wrap around support through a variety of services such as mental health, police, courts, school nurses, and social workers.

While youth justice workers do not actively engage with the sexual health service regularly. The team report a positive experience when such interaction is necessary. Additionally, the service was trained in sexual health advice and signposting, including promoting the C-card scheme and making appointments at the sexual health clinic when appropriate.

16.1 Barriers to Service Provision - Youth Justice

16.1.1 Sexual health education

Youth Justice highlights how sexual health education may not be reaching children and young people in alternative provision. Many students may miss out on entire years of schooling and therefore, vital education.

16.1.2 Lack of knowledge around service

Though Youth Justice workers will make appointments for young people in their service, workers report the lack of knowledge about what the sexual health service offers. Alongside this, uncertainty surrounding what to expect during appointments has resulted in young people not attending.

It's not just young people who feel they lack knowledge, services report that though they receive training on sexual health advice; refreshers of these courses would help in their confidence when delivering sexual health information.

17.0 Young Peoples Support Service

The YPSS is part of NEL Council and is an umbrella service for a range of teams and functions that support young people. They work with a variety of services to support those aged 8-19 years. The service works both during the day and on the evening, working with outreach teams that support children with anti-social behaviour orders, children who are not attending school, and children on the SEN agenda.

17.1 Barriers to Service Provision – Young Peoples Support Service

17.1.1 Reluctance to attend service

YPSS spoke about how difficult it is to get young people to attend the sexual health service. Previously the team provided sexual health outreach via 'the johnny bus', a youth bus on wheels in which young people could access condoms and chlamydia testing. The team would drive to schools, parks, and any open spaces in which young people congregated. YPPS are hoping to bring this service back due to the positive uptake it had.

18.0 Gaining Respect and Finding Trust Team– Children's Services

Sitting within NELC children's services the GRAFT team works with missing and exploited young people aged 11 years plus. Using a youth work relationship model, the team supports young people through individualised care plans. For child exploitation cases, the team will support young people through accessing sexual health screening if required and providing emotional care.

Support is also given to young people's parents and carers, helping them to access guidance and information regarding healthy relationships and sex.

18.1 Barriers to Service Provision – GRAFT Team

18.1.1 Sexual exploitation

The GRAFT team reported that there has recently been an increase in 16–17-year-old girls being at risk from sexual exploitation in NEL. However, it is noted that collecting data on this is complex due to the cohort of girls being over 16 and therefore, legally allowed to give consent. There are also concerns that the data does not accurately reflect the true picture of sexual exploitation due to hidden harm, particularly with young boys. The lack of consistent

sexual health representation at multi agency panels has been highlighted as a missed opportunity by the GRAFT team.

18.1.2 Building strong relationships with young people

GRAFT report young people are reluctant to attend the sexual health clinic. Though GRAFT do not blame the current sexual health service for young people's reluctance to attend, they feel it's due to the perception that attending the clinic is embarrassing, layered with the trauma which their young people have experienced.

19.0 Terminations in NEL

Currently, women access terminations via the Gynaecology Outpatient Department (OPD) at DPoW Hospital. Terminations can be booked directly through the Gynaecology Number at the Trust or women may be referred through their GPs or the sexual health clinic. For any young person who wishes to have a termination, nurses at the Pregnancy Advisory Clinic will complete a Kings Youth Sex and Safeguarding form. The form is used to assess a patient's wellbeing and whether additional support is necessary including seeking consent to share information with the school nurses.

Terminations are offered up to 18 weeks in NEL. Depending on gestational age, individual assessments, and pathway taken, a medical termination to be home administered can be issued at the Outpatient Department and then completed in the individual's home. Alternatively, if women do not fit the criteria for having a medical termination at home (such as being 16 or under or classed as vulnerable) the first step of the termination is administered in the OPD. Women are then asked to return to the clinic 48 hours later to complete the procedure. Surgical abortion is not available in NEL.

Some teenagers who present pregnant at the service may be confused or unsure about their decision to have a termination. For young people to make an informed choice, support is provided by a dedicated Teenage Midwife Consultant who will offer advice and information surrounding after care provision available after termination or birth. Nurses find that though some teenagers access the service with the intention of keeping their decision to have a termination private from their parents and carers however, it is often the case that many choose to inform them after they have finished the appointment with the Nurse/ Midwife.

Nurses also link in with Safeguarding team to offer additional support to women who present at the ward with SEND. If there are concerns surrounding an individual's ability to consent social care may also be notified.

19.1 Antenatal Support

19.1.1 Teenage midwifery clinic

A teenage midwifery clinic is provided by the antenatal ward in the hospital every other Monday. Teenagers 17 years old and under are referred to the Consultant Teenage Pregnancy Midwife, she will also provide support for any 18- and 19-year-olds if there are complex issues. Teenagers can self-refer into maternity service directly and they will then be issued with an appointment to have their medical history and bloods taken, and then offered a follow up scan appointment around 12 weeks.

19.1.2 Contraception during perinatal period

For midwifes, it is important that anyone who attends an antenatal clinic has a discussion surrounding contraception regardless of age. Once a woman gives birth, midwives routinely discuss with the mothers on the ward about their future plans for contraception before they are discharged. Any women who expresses interest in accessing LARC or other forms of contraception will be signposted to the sexual health service or their GP. In exceptional circumstances the Depo-Provera (12-week contraception injection) is offered on ward. For teenage parents however, young mothers are offered condoms and the implant can be fitted on the ward by the Teenage Pregnancy Consultant Midwife.

19.1.3 STI Screening and referral

Midwives will also refer any woman who presents at the clinic with symptomatic sexual health concerns or are at risk of infection to the sexual health service. For women under 25 chlamydia screening is also offered.

19.2 Barriers Concerning Contraception

19.2.1 Lack of contraception offered on ward

Though under 18s are offered condoms and the implant upon discharge, midwives report that the pill is the most requested form of contraception, something that is not available on the ward due to financial constraints. Midwives have spoken about the limited uptake of LARC and reported that even when LARC is administered young people have returned wanting to have it removed; reasons for this are due to side effects such as bleeding or complaining of headaches. Nurses and midwives try and combat this by handling conversations surrounding LARC through a counselling approach in which young people are given information and time to assess what is best option for them.

Women over 18 are not routinely offered contraception upon discharge. During the pandemic, due to the lack of access to contraceptive provision, the Family Planning trained Midwives were able to provide the Pill, Depo-Provera, contraceptive patch, and all forms of LARC except

the coil. Having this available on the ward saw a greater take up of LARC, though this service is now no longer offered due to relaxing of restrictions and re-opening of services. Midwives still provide information surrounding contraceptive options but in order for women to access them, an appointment at their GP or sexual health clinic is needed. Often, this results in people not attending their appointment as once women return home from the hospital contraception may not be longer at the forefront of their mind due to caring responsibilities of their new baby.

19.2.2 Mental health issues amongst mothers

Midwives note a lot of mothers in the area are suffering with mental health issues, specifically with anxiety and depression. Teenage mums are considered more susceptible to poor mental health in the area due to differing circumstances such as isolation paired with lack of family support and other complex issues. Midwives will signpost mothers to local mental health services or are offered support by the Perinatal Mental Health Midwife.

19.3 Barriers Concerning Termination

19.3.1 Repeat terminations

Midwifery have highlighted issues with repeat terminations in NEL. The service feels more outreach work with vulnerable and young people could help prevent unwanted pregnancy, not only focusing upon an enhanced offer by the wellbeing clinics in schools but ensuring vulnerable people housed at the YMCA or other hostels have access to contraception.

19.3.2 No follow up clinics post termination

Previously, the hospital used to offer a follow up clinic for any person who has had a termination in NEL. This clinic was offered two weeks after termination in which a scan may be given, and contraception would be discussed and issued, if necessary, once again due to financial constraints this clinic is no longer offered. It was also in this clinic nurses had the chance to check in with the women's welfare.

19.3.3 No mental health support post termination

Unlike women who have given birth, women who have had a termination and are suffering with poor mental health have no specific support in place. Though the nurses signpost women who are displaying mental health issues during their consultation to local mental health services. There are currently none in NEL that specialise in post termination counselling.

20.0 Sexual and Reproductive Health Survey: Insight from Service Users and Residents

The Sexual Health Needs Assessment Steering Group also agreed to undertake a survey to better understand residents' knowledge of the [sexual health] services we provide, which ones they have accessed and where, what their experience of them has been, and what improvements they would make. This ran from the 20th of March until the 20th of April and was promoted on NELC's website, its social media pages, its mailing lists, and in its schools. At its closure, it had been interacted with by 468 people, generating 176 complete responses. But where 343 responses were from residents, 70 were not, and 54 did not say whether they were residents. Analysis has been done on the responses from NEL *only*, as those who did not say they were local could not be assumed to be the target population – current or potential service users. As a result of this and the fact that the response rate for each question varied widely, the number of responses the analyst refers to in each point fluctuates.

20.1 Equalities Information

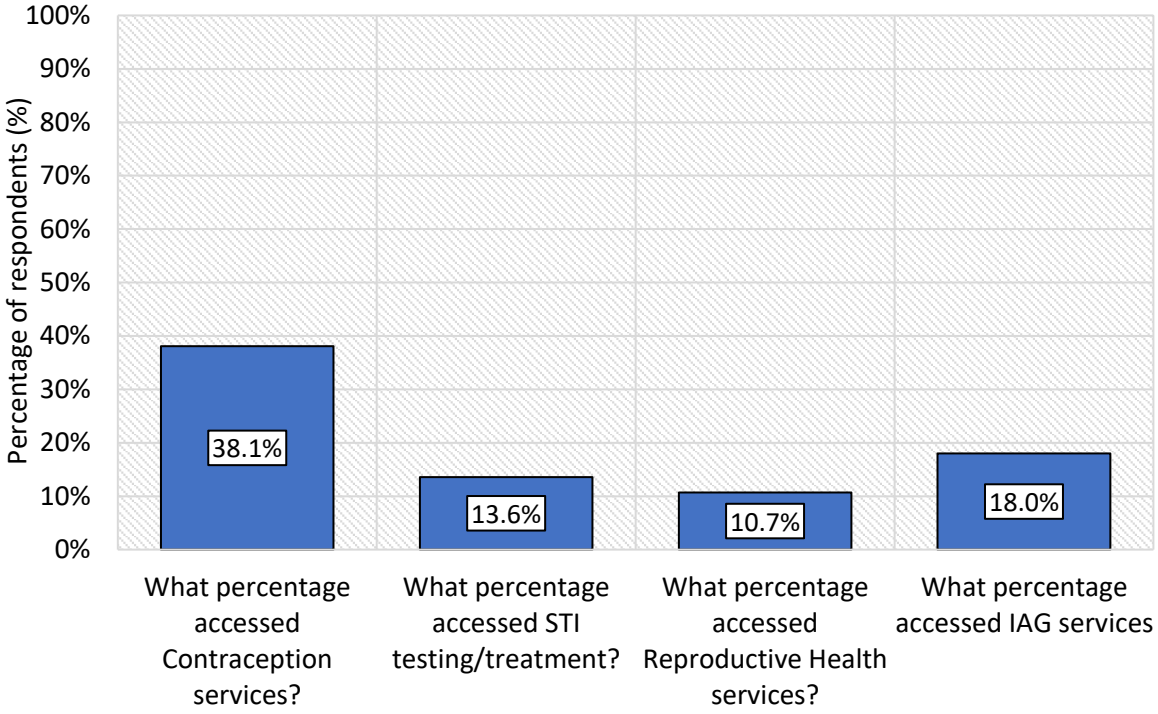
Out of the 176 complete responses, 163 completed the Equalities information:

- 96 were <18, 15 were 18-24, 14 were 25-34, 11 were 35-49, 8 were older, and 13 chose *prefer not to say*;
- 85 described themselves as women, 54 as men, 10 identified differently, and 6 chose *prefer not to say*; 6 had gone through a process to change their gender;
- 79 were single, 27 were in a relationship and not living together, 9 were in a relationship and living together, 12 were married, 13 chose another option, and 11 chose *prefer not to say*;
- 103 had no disabilities, 16 had mental health conditions, 13 had learning disabilities, 15 chose another option, and 11 chose *prefer not to say*;
- 102 had no religion, 25 were Christian, 13 identified with another religion, and 12 chose *prefer not to say*;
- 122 were White – English, Welsh, Scottish, Northern Irish, or British, 15 identified with another ethnic group, and 4 chose *prefer not to say*.

20.2 Response on Service Use

- Most NEL respondents had not used any services; at almost 40% of respondents, uptake of contraception services are more than double that of IAG services (figure 67), almost three times that of STI testing/treatment, and almost four times that of reproductive health services.

Figure 67: Proportion of respondents that are service users.



Source: NELC Sexual and Reproductive Health Survey data.

The question on **what individual services had been used** was multiple-choice…

- On contraception services, oral contraception has the highest uptake, and then there are small gaps between that and free condoms and LARC. The number that used emergency contraception is over half that which used free condoms. These trends are likely explained by the high number of female respondents, though uptake may be unexpectedly low amongst the predominantly adolescent respondents.
- In-clinic testing had the highest uptake of any service under the umbrella of STI testing/treatment, then there was a relatively large drop to the use of express/postal STI testing. Again, uptake may be unexpectedly low amongst the predominantly adolescent respondents.
- Cervical screening was used most by those who had used reproductive health services, then it was pregnancy testing. But the relatively high number of responses from females under 18 may misrepresent use.
- Most (half) of those who had used IAG services had accessed online services; In-clinic IAG was the second-most popular service.
- Questions on where respondents had accessed/heard of services were also posed as multiple-choice; six in ten respondents had accessed services through their GP, then there was a large drop to the second-most popular response – *pharmacy*, where three in ten accessed services, and only a quarter of those using services did so through

SHSs. Almost half of respondents said they already knew about the services they accessed, while almost a third received information about them in school – a relatively low figure given the overrepresentation of under 18s in this survey. Also, approx. a quarter said they heard of services from their GP, and the same figure chose *friends and family*.

- When asked to say where services were available, awareness was shown to be uneven among the 123 respondents from NEL. For this question, the service was broken down into seven strands: STI Testing and Treatment, HIV Testing, LARC, Repeat Oral Contraception, Condoms, Emergency Contraception, and Information, Advice, and Guidance (IAG). The most popular misassumption is the half suggesting repeat oral contraception is available at pharmacies. And only one-fifth are aware that condoms are available via online services, just as only just over a tenth are aware that HIV Testing is offered by community groups/organisations, and only three-tenths are aware Emergency contraception is provided in educational settings.
- Fourteen of the 141 NEL respondents wanted the same strands referred to in the bullet above to be available elsewhere. No more than one person chose the option – 'I cannot access this service. It should be offered in a new place' in response to any one strand. The free text option on this question garnered requests to make STI Testing/treatment and LARC available in pharmacies, to make LARC and repeat oral contraception available via mobile clinics, school nurses, and online services, to provide emergency contraception in hospitals and via online services, and to make condoms more widely available in schools.

20.3 Response on Ease of Access

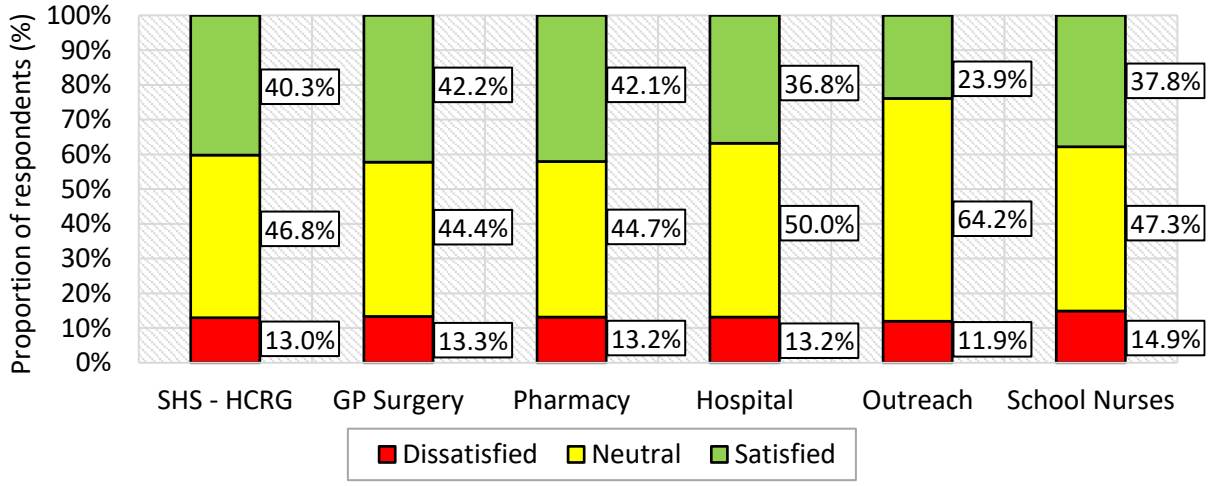
- Nine (3.5%) of the 255 NEL respondents said they had had to travel out-of-area for services.
- One in five of the 105 NEL respondents said they found accessing SRHSs in NEL *very difficult* or *somewhat difficult* (only 3.8% chose the former), while 62.9% said they found it *very easy* or *somewhat easy*; 24.8% chose *very easy*.
- The barriers question was multiple-choice. More than three in ten of the 139 NEL respondents said appointment availability was a barrier, and half that proportion said timely access was. Just under one-fifth said accessibility was ok *as is*. Just over a third said they did not need to use the service.
- One-tenth of the 78 NEL respondents said SRHSs in NEL are *never available at times that suit them*. And another fifth said they are only available at such times *once in a while*. 43.6% said availability suited them either *most of the time* or *always*, and the remaining quarter said the services' availability suited them *about half of the time*.

- On times that may improve accessibility, 61 out of 138 respondents from NEL said NA/the times were okay *as is* in another multiple-choice question, but the same number said *open on a Saturday* would make it easier for respondents to access face-to-face services, and 51 said the same of *open after 6pm*. Satisfaction with services' opening times may be misrepresented by the overrepresentation of under 18s, who are generally less likely to have scheduled commitments throughout opening hours.
- Of the 74 NEL respondents who had been to an appt., 40.5% usually drive, just under a quarter walk, and 13 *get a taxi or a lift off someone else* and another 13 get *public transport i.e., bus*.

20.4 Response on Satisfaction with the Offer of SRHSs in Different Places e.g. HCRG, GPs, etc.

- NEL respondents' satisfaction was relatively uniform (figure 68), with averages of 37.2% for satisfaction and 13.3% for dissatisfaction; satisfaction would have been approx. four in ten but for Outreach's [relatively low] figure of 23.9%. The polarised take on school nurses is also of note, with the largest proportion of respondents being *very dissatisfied* (9.5%) and *very satisfied* (23%) with them.

Figure 68: Service Users' Satisfaction with Services by Location.



Source: NELC Sexual and Reproductive Health Survey Data

20.5 Coding the Responses to some Questions Asked

On coding the responses to the questions on what respondents prized most about the service, what they would change, and if they had any other comments, there was …

- Equal numbers (22) referencing accessibility and inaccessibility; most comments were unspecific, with the most common issue being waiting times for appts., while most compliments related to the universality of the service's offer, or easy access to condoms.

- A focus on affordability, which was raised positively eight times (mostly in the context of condoms) and negatively seven times (mostly in the context of pregnancy tests (the pricing of which was called a “scam” five times)).
- 19 comments referring to a service that was limited in its provision, particularly on adequate education in schools and the range of condoms supplied; others referred to issues such as criteria for the availability of in vitro fertilization (IVF), the lack of GyneFix (type of IUD), and the apparent lack of support for the menopause and sexual assault victims.
- 13 comments referring to a lack of awareness around the service.
- 11 comments on *unhelpful* or *rude* staff, and 17 on *helpful* or *nice* staff – three people said they left with a negative feeling as a result of staff or processes commenting or focusing on their weight.

Further, two of the responses referring to the service as having a limited offer meant that they thought not enough information was provided to/about LGBTQ+ people or their needs, and one respondent said their interaction with the service had been negatively affected because of their identity in the sense that “any services [they] see are directed towards cisgender/heterosexual individuals or couples, especially regarding contraception.” This person wants to see “more services be more transparent about what they offer queer people.” 43 of the 147 respondents to this question wrote that they were *not sure* if their experience had been affected by their identity, and one other indicated it had, saying their age was the factor, but they did not give any more information.

Finally, there were a select number of other distinct text responses submitted. These were ‘[I would like] more information about sex rather than just pregnancy,’ ‘[…] current provision is too dependent on a small number of professional and […] it is failing,’ ‘[the SHS] has been run down in recent years. […] It is not fit for purpose for the local community,’ and I value [being able to ask questions anonymously about sexual health.’

21.0 Conclusions

22.0 Recommendations

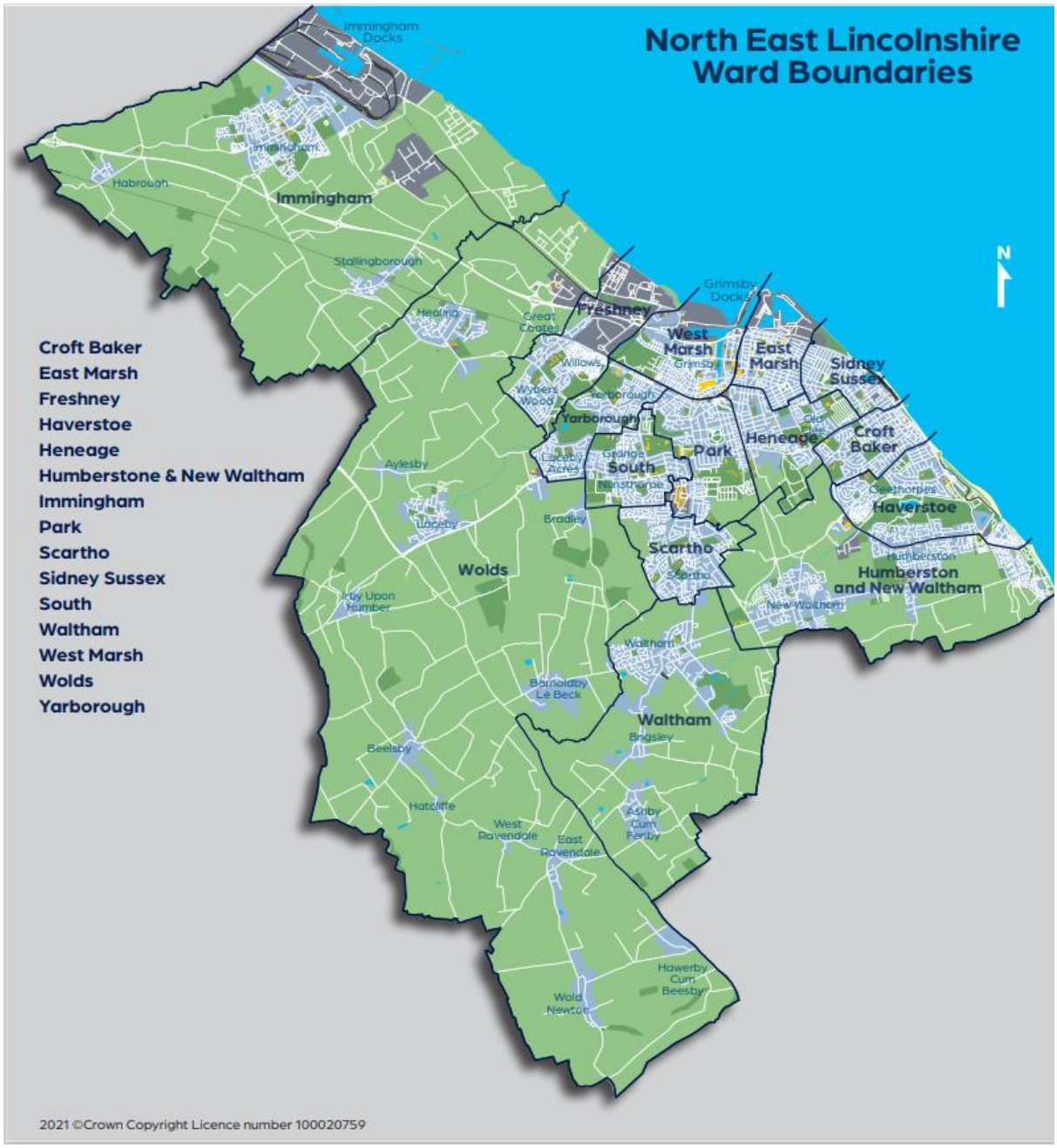
The following recommendations have been made based on findings in the report. It is recommended that:

1. Community-based outreach of sexual and reproductive health services is in place ***(NELC).***
2. Capacity for administering contraception (such as LARC fitting) in the community needs to be increased ***(Commissioners of sexual health and reproductive health services working with providers across the health and care system i.e., Council, ICB and NHS providers)***
3. Stigma associated with attending sexual health clinic, and sexual health in general needs to be addressed through communications and marketing including social media (***Commissioners of sexual health and reproductive health services working with commissioner working with the provider- (HCRG and Primary Care)).***
4. There need to be more awareness raising of sexual and reproductive health services among residents, local services, and the local workforce i.e., increased visibility of sexual and reproductive health services ***(Commissioners of sexual health and reproductive health services working with providers across the health and care system i.e., Council, ICB and NHS providers).***
5. There needs to be improved access and availability to sexual and reproductive health service appointments i.e., need for walk in/ drop in clinics in sexual and reproductive health service for easier access services ***(Commissioners of sexual health and reproductive health services working with providers across the health and care system i.e., Council, ICB and NHS providers).***
6. Sexual and Relationships Health Education in schools and colleges need to be improved (***Commissioners of sexual health and reproductive health services working with schools/academies/ colleges),***
7. There is a need for reviewing and recommissioning of the pharmacy sexual health contract ***(Commissioners of sexual health and reproductive health services – NELC).***
8. There is a need for a multi- agency sexual and reproductive health forum/ better working between agencies / reduced fragmentation/ more information sharing ***(NELC with providers and system partners).***
9. There is a need for a peer support group for people living with HIV ***(Commissioners of sexual health and reproductive health services working with providers across the health and care system and service users).***

10. There is better HIV prevention – including improved HIV testing (this includes making testing more accessible, and making it routine), access to free condoms in HIV clinics, improved PrEP use, and workforce development HIV ***(Commissioners of sexual health and reproductive health services working with providers across the health and care system in liaison with service users).***
11. There is a relaunch of the C-card scheme across NEL ***(Commissioners of sexual health and reproductive health services working with providers across the health and care system.***
12. There is a need to provide specialist post termination counselling/mental health support to women who have had a termination ***(Commissioners of sexual health and reproductive health services working with providers across the health and care system).***
13. Something around HPV vaccine and screening for cervical cancer around 50 – 64 year olds – ***(Commissioners of sexual health and reproductive health services)***
14. *Offer the services of a sexual assault referral centre (SARC) i.e. medical, practical, and emotional support within the LA to anyone that is a victim of sexual violence.*
15. *Staff to be trained in the specific needs of all the service's user groups; ensure all systems use neutral language that does not make assumptions (**Providers of sexual health and reproductive health services)**.*
16. *There is a need to advertise the inclusivity of the offer, e.g., ensuring LGBTQ+ people are aware of contraceptive services (**Providers of sexual health and reproductive health services)**.*
17. *Advertise a written/free text submission portal for service users to make suggestions for service improvements on access; collate these (**Providers of sexual health and reproductive health services)**.*

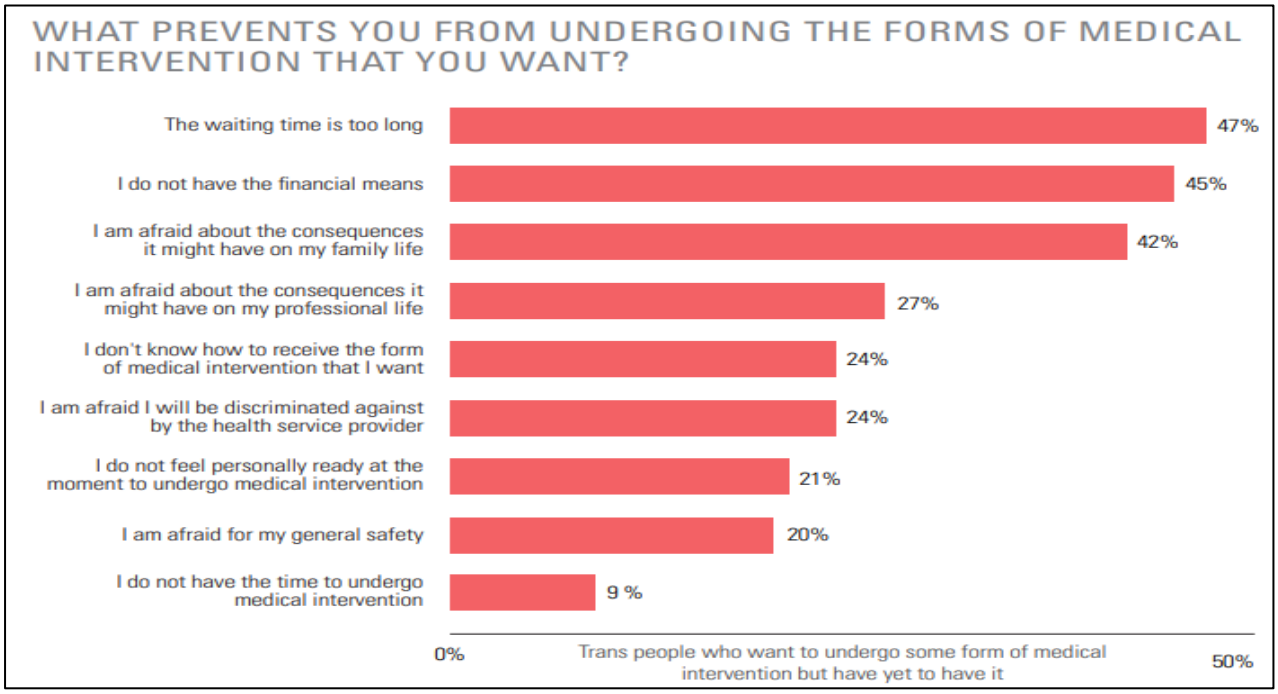
Appendix

Appendix 1: Map of North East Lincolnshire



Source: North East Lincolnshire Data Observatory (NELDO, 2021)

Appendix 2: Barriers to Transgender People Accessing Trans-specific Healthcare



Appendix 3: What kinds of contraceptives are available to people who need them?

Methods of contraception

Long Acting Reversible contraception (LARC)		
The contraceptive implant	The contraceptive implant is inserted under the skin on the upper arm. It releases the hormone progestogen which stops ovulation, thickens cervical mucus to prevent sperm reaching an egg, and thins the lining of the uterus (womb) to prevent a fertilised egg implanting	• LARC methods are fitted by a health care professional and depending on the type, are effective for between 4 months and 10 years. • With efficacy rates of over 99% long-acting reversible contraception or LARC is one of the most effective forms of contraception. • LARC does not depend on a user remembering to take it or using it correctly. • LARC methods do not prevent against Sexually Transmitted Infections. • Some methods of LARC, for example the IUS, can be used to treat gynaecological disorders.
The contraceptive injection	The injection also works by releasing progestogen.	
The intrauterine system (IUS)	The IUS is a small T-shaped plastic device, which is inserted into the uterus. It works by releasing progestogen.	
The intrauterine device (IUD)	The IUD is a small plastic and copper device which is inserted into the uterus. It works by stopping a sperm reaching an egg, and may also stop a fertilised egg implanting in the uterus.	
Barrier methods of contraception		
Male condom	Male condoms are put on the penis and prevent a sperm from entering the vagina.	• Barrier methods of contraception prevent a sperm reaching an egg. • If used as the instructions indicate they are between 92% and 98% effective. • However, barrier methods depend on correct use. With typical use, male condoms are around 82% effective, female condoms are 79% effective and diaphragms and caps are 72% effective. • Male and female condoms can help prevent against STIs.
Female condom	Female condoms prevent sperm from entering the vagina	
Cap	Caps and diaphragms are flexible device which are put into the vagina to cover the cervix, prevents a sperm entering the uterus. It must be used with spermicide.	
Diaphragm		
Short-term hormonal methods of contraception		
Combined Pill (COC)	COC contains oestrogen and progestogen. It stops ovulation, thickens cervical mucus to prevent sperm reaching an egg and thins the lining of the uterus (womb) to prevent a fertilised egg implanting.	• Short term hormonal contraceptive is around 99% effective when used perfectly. • However, these methods depends on being used correctly. With typical use they are around 91% effective. • Short term hormonal contraception does not protect against STIs. • Some methods such as POP, can be used to treat conditions such as heavy menstrual bleeding.
Contraceptive patch	A small patch stuck on the skin. It works in the same way as the combined pill.	
Contraceptive ring	A small, flexible plastic ring is put into the vagina. It works is the same way as the combine pill.	
Progesterone only pill (POP)	POP contains the hormone progestogen, which thickens cervical mucus to prevent sperm reaching an egg.	
Permanent methods of contraception		
Female sterilisation	The fallopian tubes are cut or blocked, preventing an egg and sperm meeting.	• These are permanent methods of contraception which are difficult to reverse and only suitable for people who are sure they don't want children in the future.
Male sterilisation	The tubes that carry sperm from the testicles to the penis are cut, sealed or tied.	
Fertility awareness		
Fertility awareness	This technique must be learnt. It relies on a person monitoring different fertility signals to identify when they are most likely to get pregnant and avoiding sex at these times.	• The fertility awareness method is up to 99% effective if used perfectly. With typical use it is around 76% effective.

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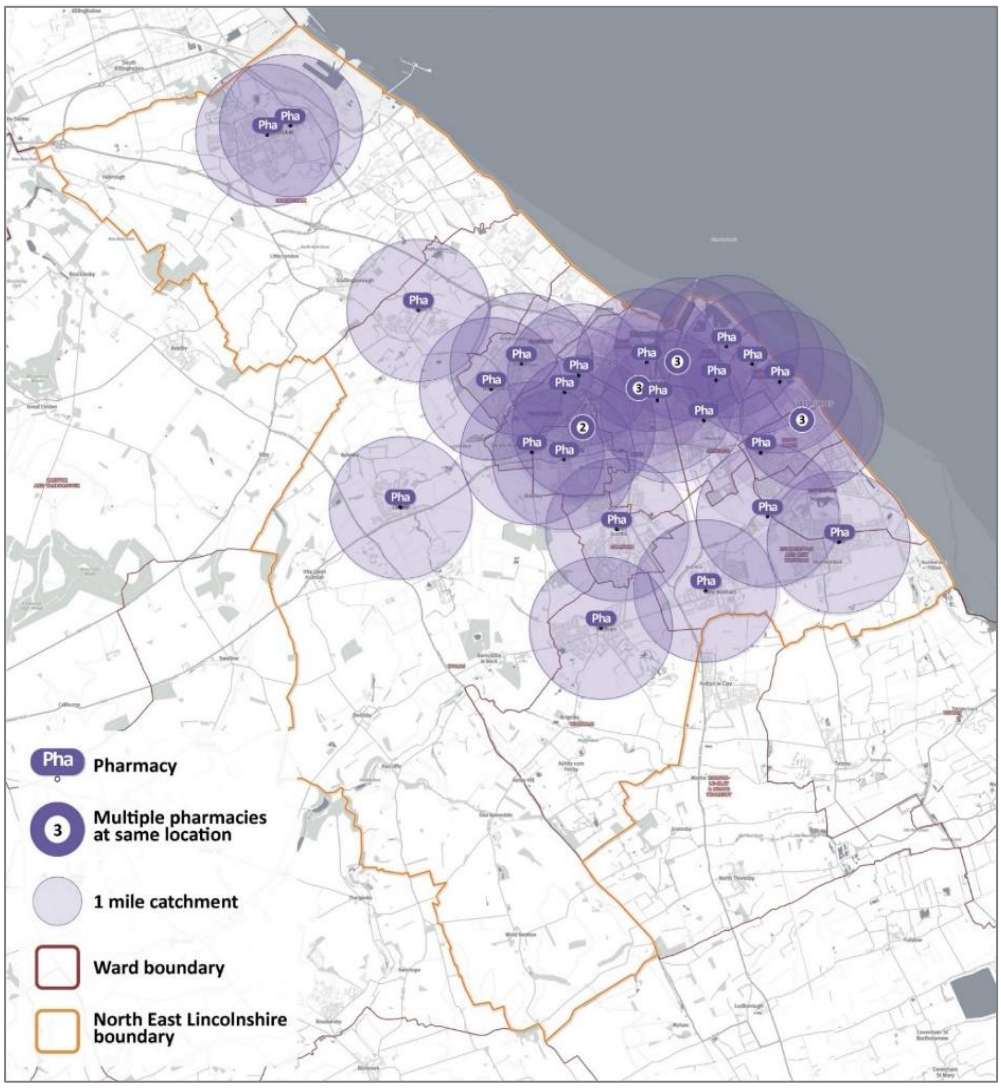
Source: APPG on Sexual and Reproductive Health in the UK, 2020

Appendix 4: 1.6km (1 mile) Catchment Areas of North East Lincolnshire Pharmacies



Source: (SHAPE Place Atlas © Crown Copyright and database rights 2022 Ordnance Survey 100016969)

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