Herefordshire Council

HEREFORDSHIRE COUNCIL'S SEXUAL HEALTH NEEDS ASSESSMENT

Date: April 2023

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ABBREVIATIONS

AMR	Antimicrobial resistance
ART	Antiretroviral therapy
EHC	Emergency hormonal contraception
GUMCAD	Genitourinary medicine activity database
HIV	Human immunodeficiency virus
IUD	Intra-uterine device
IUS	Intra-uterine system
OHID	Office for Health Improvement and Disparities
LARC	Long acting reversible contraceptive
LSOA	Lower super output area
MECC	Making every contact count
MSM	Men who have sex with men
MSW	Men who have sex with women
Natsal-3 Survey	National survey of sexual attitudes and lifestyles
NCSP	National chlamydia screening programme
NICE	National Institute for Health and Care Excellence
ONS	Office for National Statistics
PEP	Post-exposure prophylaxis
PGD	Patient group directive
PrEP	Pre-exposure prophylaxis
SHRAD	Sexual health and reproductive activity dataset
SHS	Sexual health service
SRH	Sexual and reproductive health services
STI	Sexually transmitted infection
TFR	Total fertility rate
WSM	Women who have sex with men

EXECUTIVE SUMMARY

Sexual health is an important public health issue both nationally and locally. Whilst there have been national improvements in some areas, such as HIV care, inequalities in sexual health outcomes persist and stigma can act as a barrier to accessing sexual health services.

Herefordshire Council and local authorities across England have a statutory duty to improve the sexual health of young people and adults whilst reducing inequalities. To inform local priorities and the commissioning cycle, national guidance recommends that local authorities undertake a sexual health needs assessment. This helps to ensure that there is a clear understanding of the needs of the population so that an effective service can be commissioned using evidence-based initiatives.

This needs assessment provides an overview of the sexual health outcomes of the local population and sexual health services in Herefordshire. Disruptions to services caused by the COVID-19 pandemic may have affected metrics from 2019 to 2020 and it is important that attention is given to continued monitoring and surveillance to review subsequent trends.

The sexual health outcomes of the local population show mixed results with indicators both above and below national averages. Whilst it is encouraging that Herefordshire have an increasing STI testing rate, this is still below the national average and therefore further improvement is required – including for chlamydia. The lower positivity rates of STI testing of the local population may indicate a lower prevalence of STIs but only if there is equitable access and uptake of testing – including by those at higher risk of infection.

There have been national improvements in the treatment available for individuals living with HIV that have significantly improved their prognosis. However, this requires prompt recognition and treatment of these individuals. This needs assessment found low levels of HIV testing and a high proportion of late diagnoses and these should be addressed as a priority.

One key challenge within the county is its rurality that can introduce geographical barriers to accessing healthcare services including sexual health services and long-acting reversible contraception provision. This was highlighted throughout the engagement process and is also noted for other healthcare services locally. Improving the outreach offer of the county should be seen as a priority to ensure equitable access is provided.

Primary preventative interventions that have a strong evidence-base should be prioritised to help improve sexual behaviours, and therefore outcomes, across the life course. Furthermore, multi-agency collaboration is key to ensure that a system-wide approach is used to meet the local population’s needs in an efficient and effective manner. The sexual health forum provides a platform for stakeholders to engage with each other and identify issues within the system and how best to resolve these.

Herefordshire Council

1.0 INTRODUCTION

AIM

The purpose of this needs assessment is to consider key sexual health needs of the Herefordshire population with a review of current provision and best practice. This provides an opportunity to improve the current services and to shape the future service offer.

This needs assessment will inform the re-commissioning and delivery of sexual health services when the current contract ends in March 2024.

OBJECTIVES

- Describe the current sexual health outcomes for the population of Herefordshire
- Outline the current provision of sexual health services
- Provide an insight into the perspectives of key groups such as stakeholders and service users
- Consider published evidence of best practice and effectiveness
- Identify gaps in the services provided and provide recommendations to address unmet need

APPROACH

Quantitative data has been drawn from national datasets and local services whilst qualitative data has been taken from stakeholders and population level surveys. Furthermore, best practice evidence has been taken from published literature including national policy guidance

2.0 BACKGROUND

SEXUAL HEALTH

The World Health Organisation state that sexual health is '*a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity*[1]' and that it is '*fundamental to the overall health and well-being of individuals, couples and families, and to the social and economic development of communities and countries*'.

The UK Government's report 'A Framework for Sexual Health Improvement in England' notes that sexual health covers the 'provision of advice and services around contraception, relationships, sexually transmitted infections (STIs) (including HIV) and abortion'[2].

SEXUALLY TRANSMITTED INFECTIONS

Sexually transmitted infections (STIs) are a major public health concern. If left untreated, STIs can cause complications such as pelvic inflammatory disease, infertility and neonatal infections. Early detection and treatment can reduce the risk of complications. However, given the high proportion of asymptomatic cases and the stigma surrounding these infections, there is a high risk of delayed detection and treatment. This is likely to result in a conservative diagnosis rate estimate.

Over 30 different micro-organisms (including bacteria and viruses) are known to be transmitted via sexual contact. Furthermore, cases can also result from vertical transmission during pregnancy, childbirth and breastfeeding[3].

The most commonly newly-diagnosed STIs within England in 2021 were[4]:

- Chlamydia (51% of diagnosed STIs)
- Gonorrhoea (16%)
- First episode genital warts (9%)
- First episode genital herpes (7%)

Other infections that may be seen at sexual health clinics include Human Immunodeficiency Virus (HIV), Syphilis and, more recently, monkeypox.

Effective interventions to reduce the risks associated with STIs include practicing safe sex (including consistent and correct use of condoms), vaccinations, routine screening and accessing

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[1] World Health Organisation, Sexual health

[2] UK Government (2013) A Framework for Sexual Health Improvement in England

[3] World Health Organisation (2022) Sexually transmitted infections

[4] UK Health Security Agency (2022) Sexually transmitted infections and screening for chlamydia in England

effective treatment promptly. Efforts to eliminate barriers to these initiatives include access to free and confidential services that are easily accessible.

Chlamydia

Chlamydia is the most commonly diagnosed bacterial STI within England. In 2021, Chlamydia made up over half of all new STI diagnoses with 159,448 individuals receiving a positive test within England[5]. The prevalence of the infection is approximately double that in the 16 to 24 year old female population compared to 16 to 44 year old age range (3.1% to 1.5%)[6]. Chlamydia is often asymptomatic but can cause serious complications if not treated promptly by antibiotics. These complications predominantly affect women and include conditions such as pelvic inflammatory disease, ectopic pregnancy and tubal factor infertility.

The National Chlamydia Screening Programme (NCSP)[30] was introduced in 2008 but in June 2021 changed its focus on reducing the harms from untreated chlamydia infections. Subsequently, the focus of opportunistic screening was on those who were at highest risk of complications (women and those with a womb or ovaries), combined with reducing time to test results and treatment, strengthening partner notification and re-testing after treatment. Therefore, chlamydia screening in community settings, such as within primary care, will only be proactively offered these populations. Services provided by sexual health services remain unchanged and everyone can still get tested if needed[7].

Gonorrhoea

Gonorrhoea is the second most commonly diagnosed bacterial STI in England. A key public health concern with this infection is that emergence of antimicrobial resistant (AMR) gonorrhoea strains – leading to the World Health Organisation's global Gonococcal AMR surveillance system. Gonorrhoea infection is particularly concentrated within certain risk groups such as men who have sex with men (48% of diagnoses), individuals of black Caribbean ethnicity and in areas of high deprivation[8].

Human Papillomavirus (HPV)

Human papillomavirus includes multiple strains that often cause no harm to the individual. Transmission methods of the virus include from any skin to skin contact of the genital area and sexual intercourse. In approximately 90% of cases HPV will self-resolve within 2 years without any illness experienced[9].

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[5] UK Health Security Agency (2022) Sexually transmitted infections and screening for chlamydia in England

[6] UK Health Security Agency (2021) NCSP: programme overview

[7] UK Health Security Agency (2022) SPLASH Herefordshire 2022-01-27 (phe.org.uk)

[8] Public Health England (2021) Guidance for the detection of gonorrhoea in England: updated guidance 2021

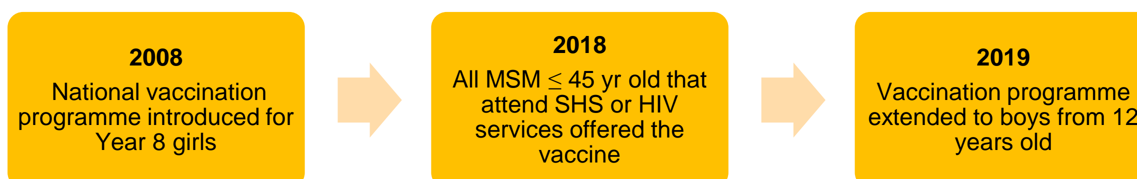
[9] Centers for Disease Control and Prevention (2022) HPV fact sheet

However, particular HPV strains can cause genital warts (HPV strain 6 and 11) and others have the potential to cause abnormal cell changes that increase the risk of certain cancers such as cervical and anal cancer.

HPV strain 16 and 18 are both risk factors for cervical cancer. In 2008, following advice of the Joint Committee on Vaccination and Immunisation, a HPV national vaccination programme was introduced for Year 8 girls (aged 12 to 13 years old) to reduce their risk of cervical cancer from these strains. At the same time a catch-up programme was initiated for girls aged 13 to 18 years old.

Subsequently, further 'at-risk' groups have been included in the offer of vaccination which includes men who have sex with men and individuals living with HIV. In 2019, the programme was extended to include boys from 12 years of age as expected benefits included direct protection against HPV infection that caused diseases such as anogenital warts and penile cancers and indirect protection for non-vaccinated males and females.[10]

Falcaro et al (2021) have noted a 'substantial reduction in cervical cancer and incidence of CIN3 in young women' following the introduction of the immunisation programme. In children aged 12-13 years that received the HPV vaccine, the relative reduction in cervical cancer rate was estimated at 87% when compared to those who were not vaccinated[11].



Herpes

Genital herpes is most commonly caused by Herpes Simplex Virus 2. There is no cure to eliminate the virus from the body but treatment can help to manage symptoms and reduce the risk of further outbreaks. Transmission of the virus occurs from sexual intercourse and oral sex with symptoms including blistering of the skin, tingling or burning around the genitals and dysuria.

Syphilis

Syphilis is caused by the transmission of the bacterium Treponema pallidum through direct contact during sexual intercourse as well as other methods, such as vertical transmission. The clinical presentation of the infection can be divided into 3 stages:

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[10] UK Health Security Agency (2022) HPV vaccination guidance for healthcare practitioners

[11] Falcaro et al. (2021) The Lancet. The effects of the national HPV vaccination programme in England, UK, on cervical cancer and grade 3 cervical intraepithelial neoplasia incidence: a register-based observational study

Primary syphilis: painless ulcer (chancre) which usually occurs in genital sites.

Secondary syphilis: systematic disease causing a symmetrical maculopapular rash involving the palms and soles

Latent stage and tertiary syphilis: This can include lesions of the skin, bone, viscera, central nervous system and cardiovascular system.

Alternatively, vertical transmission can result in 'congenital syphilis' within which the foetus is infected during pregnancy. This can result in stillbirth, neonatal death or symptoms after birth such as neurological complications and jaundice.

Public Health England[12] described '4 prevention pillars' that were fundamental to the prevention and control of Syphilis. These are:

'1. Increase testing frequency of high-risk MSM and re-testing of syphilis cases after treatment

2. Deliver partner notification to BASHH standards

3. Maintain high antenatal screening coverage and vigilance for syphilis throughout antenatal care

4. Sustain targeted health promotion.'

Human Immunodeficiency Virus (HIV)

HIV[13] is a virus that causes immunodeficiency and, if left untreated, can lead to acquired immune deficiency syndrome. The virus can be spread by multiple methods including sexual intercourse (vaginal or anal), vertical transmission and shared injecting equipment with those who have the virus.

If infected, individuals often experience a flu-like illness 2-6 weeks after infection and then may be asymptomatic for a prolonged period of time (years). However, if left untreated, during this time the virus can cause damage to the immune system that puts the individual at risk of recurrent and more serious illnesses.

Medications for preventing and treating HIV can take different forms. Pre-exposure prophylaxis (PrEP) can be taken prior to a high-risk activity to reduce the risk of contracting the virus. Alternatively, post-exposure prophylaxis (PEP) can be taken within 72 hours (ideally within 24 hours) of a potential exposure to the virus to prevent HIV infection. However, if an individual has tested positive for HIV, antiretroviral (ART) medications may be indicated that will not 'cure' the individual but work to stop the virus replication in the body. HIV treatments have transformed the

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[12] Public Health England (2019) Addressing the increase in syphilis in England: PHE Action Plan

[13] NHS (2021) HIV and AIDS

lives of individuals living with HIV with life expectancy increasing by over 15 years during 1996 and 2008 if detected early and treatment is adhered to[14].

The UK are working towards a goal of eliminating HIV transmission by 2030. To do this, a combined approach is required. This includes equitable access and uptake of HIV prevention programmes, scale up of HIV testing, optimise prompt and sustained treatment for those identified as living with HIV (undetectable=untransmissable), addressing stigma and improving the quality of those living with HIV.

Following the UK Government's 'HIV Action Plan', opt-out HIV screening was introduced in emergency departments in the highest prevalence local authorities – this does not include Herefordshire. Within this initiative's first 100 days 128 new HIV diagnoses had been made and a further 65 individuals living with HIV were identified who had previously disengaged from care[15]. This action plan also advised that local authority commissioners should set a target of 90% of first time sexual health service attendees to be offered a HIV test and that other services, such as prisons and substance misuse services, should also 'include opportunities for assessing integrated STI testing where relevant'[16].

In 2020, within England there were an estimated 97,740 individuals that were living with HIV of which an estimated 4,660 were unaware of their infection. This was the first year in England that the UNAIDS 95-95-95 targets were met as 95% of all individuals living with HIV were diagnosed, over 95% of individuals who had been diagnosed were on specialist treatment (estimated at 99%) and over 95% of those receiving antiretroviral treatment were virally suppressed (97%)[17].

Monkeypox

Monkeypox is caused by transmission of a virus from close contact with an infected animal, human or contaminated materials. This will usually result in a self-limiting illness with recovery expected within several weeks. However, more severe illness can occur[18].

On 6th May 2022 cases of monkeypox infection were confirmed in England. This predominantly affected men who are gay, bisexual or men who have sex with men. By 16th September 2022 there were 3,439 confirmed cases in the UK and 146 highly probably cases. Within the West Midlands in this time period, there were 124 confirmed or highly probable cases[19].

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[14] May et al. (2011) Impact of late diagnosis and treatment on life expectancy in people with HIV-1: UK Collaborative HIV Cohort (UK CHIC) Study | The BMJ

[15] NHS England (2022), Emergency department opt out testing for HIV, hepatitis B and hepatitis C: The first 100 days

[16] Department of Health & Social Care (2021 Towards Zero - An action plan towards ending HIV transmission, AIDS and HIV-related deaths in England - 2022 to 2025

[17] UK Health Security Agency (2022) SPLASH Herefordshire 2022-01-27 (phe.org.uk)

[18] UK Health Security Agency (2022) Mpox (monkeypox): background information

[19] UK Health Security Agency (2022) Monkeypox outbreak

CONTRACEPTION

CONTRACEPTIVES

There are many methods of contraception that can be used. These include (but are not limited to)[20],[21]:

Male condoms – this is a form of 'barrier contraception' and is the most effective method of preventing sexually transmitted infections. They are also 98% effective at preventing pregnancy if used correctly.

Combined pill– This pill is named 'combined' due to it containing both oestrogen and progestogen. It is considered to be over 99% effective at preventing pregnancy if taken correctly. In real-life circumstances the effectiveness is approximately 92% due to incorrect use such as forgetting to take the pill within the required timeframe. This alone will not provide protection against STIs.

Long-acting reversible contraceptives (LARC):

These methods of contraception can be useful for those who find it difficult to remember the need to use contraception for every episode of sexual intercourse (condoms) or on a daily basis (pill). This can mean these methods are more effective at preventing pregnancy. Importantly, they are reversible which means that fertility will return quickly following removal/cessation of treatment. However, they all require a procedure to administer/insert the contraception and they do not provide protection against STIs.

Examples of LARCs include:

Implant – The contraceptive implant is inserted subcutaneously in the upper arm and slowly releases progestogen into the body. It is more than 99% effective at preventing pregnancy and must be replaced every 3 years.

Injection – The contraceptive injection is an injection of progestogen. It is more than 99% effective at preventing pregnancy for approximately 8-14 weeks (depending on the type) when it should be re-administered. Fertility may take up to 1 year to return to normal following an injection.

Coil – Coil contraceptives are inserted into the womb and can be categorised as either hormonal (progestogen) or non-hormonal (copper coil). They are both over 99% effective at preventing pregnancy but will not prevent STI transmission. These are compared below:

- Intra-uterine system (IUS) – This is the hormonal coil and can remain in-situ for 3 to 6 years (depending on the type) whilst it released progestogen hormone is released directly into the womb.

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[20] NHS Inform, Contraception

[21] Patient (2023) Contraception Methods

- Intra-uterine device (IUD) – This coil does not contain hormones but instead is made of copper. It can stay in the womb for 5 to 10 years depending on the type and the indication of the coil.

Emergency contraception – Emergency contraception can be taken after sexual intercourse to prevent pregnancy after unprotected sex or if the contraceptive method used has failed (e.g. condom split). There are two methods of this contraception – an emergency contraceptive pill or an IUD. Both of these methods have a timeframe within which they need to have been administered to prevent pregnancy and they do not prevent transmission of STIs.

STERILISATION

Female sterilisation involves an operation that is usually performed under general anaesthetic. It aims to block the fallopian tubes that would usually connect the ovaries to the womb – preventing the sperm reaching the egg for fertilisation. This method of fertilisation is more than 99% effective but does not prevent against STIs.

Conversely, male sterilisation, also known as a 'vasectomy', blocks or seals the tubes that carry sperm from a man's testicles to the penis and is usually performed under local anaesthetic. As above, this method of fertilisation is more than 99% effective but does not prevent against STIs.

UNPLANNED PREGNANCIES

Evidence suggests that approximately one in three pregnancies are unplanned with a potential negative effect on both the mothers' and children's lives. Abortion rates, particularly if repeated, may be an indication of inadequate contraceptive services. Educating women on effective contraceptive methods and ensuring access to local services are key in empowering their decision making. Should an unplanned pregnancy occur, women should have the knowledge of, and access to, services that can facilitate an informed decision.

AT RISK GROUPS OF POOR SEXUAL HEALTH

Poor sexual health outcomes are disproportionately experienced by certain vulnerable groups. These include (but are not limited to)[22,23].

- Young people (aged 15 to 24 years)
  - For example, in the West Midlands region, individuals between the age of 15 and 24 accounted for 53% of all new STI diagnoses in 2020[24].
- Individuals from more deprived areas
  - Rates of new STI diagnoses are shown to be consistently higher in more deprived populations [25].
- Men who have sex with men

[22] Office for Health Improvement & Disparities (2022) Sexual and reproductive health and HIV: applying All Our Health

[23] Public Health England (2021) Variation in outcomes in sexual and reproductive health in England 2021

[24] UK Health Security Agency (2020) Spotlight on sexually transmitted infections in the West Midlands

    - MSM are more likely to be diagnosed with bacterial STIs than other men[25].
- Those who are of a Black, Asian and Minority Ethnic Group
    - 7% of new STI diagnoses in the West Midlands were in Black Caribbean individuals in 2020. Whilst this may be seen as a low absolute proportion of the whole population, given the low ethnic diversity in the region, this is a relatively high rate of infections at 1,895 per 100,000, which is 6 times the rate seen in the white ethnic group[8].
- Individuals with learning disabilities.
    - Cervical screening uptake is low in women with learning disabilities when compared to the general population

Ensuring these populations have good access to sexual health services is imperative.

COVID-19 PANDEMIC

Since the emergence of COVID-19 in 2020, adaptations of many clinical services have been required by national guidance. This resulted in a substantial reduction in the sexual health service's (SHS) face to face capacity with remote consultations and testing kits becoming increasingly used.

Consequently, large decreases in the number of sexual health diagnoses were noted. This was particularly apparent for those that are usually diagnosed clinically in face-to-face consultations (genital warts and herpes) but also for those diagnoses using laboratory samples[24]. Therefore, comparison in diagnosis rates between 2020 and 2021 must be interpreted with caution.

POLICIES AND FRAMEWORKS

POLICY DRIVERS

As part of the public health responsibilities of local authorities in the Health and Social Care Act (2012)[26], Herefordshire council are responsible for commissioning the majority sexual health services, with costs met from their ring-fenced public health grant. Whilst there are specific legal requirements set out in the Local Authorities Regulations 2013[27] – such as open access to sexual health services for everyone within the area - there is scope for tailoring these services according to the local population needs.

A 2023 'Integrated Sexual Health Services'[28] national specification was published to guide local authority's in recommended provision of services required to meet sexual health needs. This

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[25] Public Health England (2021) Variation in outcomes in sexual and reproductive health in England

[26] UK Legislation, Health and Social Care Act 2012

[27] UK Legislation, The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 (legislation.gov.uk)

[28] Office for Health Improvement & Disparities (2023) Integrated Sexual Health Services: A suggested national service specification

specification states that an integrated sexual health service provides users with ‘open access to confidential, non-judgemental services including sexually transmitted infections (STIs) and blood borne viruses (BBV) testing (including HIV), treatment and management; HIV prevention including pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP); the full range of contraceptive provision; health promotion and prevention including relevant vaccination.’ Quality Outcome Indicators were included such as 97% of those presenting to sexual health clinics should have a sexual health history and risk assessment undertaken.

The ‘Sexual Health – Report Summary’ [29] by the Health and Social Care Committee re-iterated the importance of good sexual health to health and wellbeing. The report stated that geographical variation in access to services is a national issue and that reduced funding and fragmentation of both commissioning and provision of services have had a negative impact. The committee noted that ‘cuts to spending on sexual health, as with other areas of public health expenditure, are a false economy because they lead to higher financial costs for the wider health system.’

Whilst these policies mainly focus on sexual health services, the wider system of sexual health has vital responsibilities in providing care to the local population. This includes sex education at schools and colleges[30], the provision of contraception in primary care and emergency contraception within some pharmacies.

OUTCOME DATA

Outcome data for Herefordshire is published in the Public Health Outcomes Framework 2019-2022[31] and key SH measures include:

- Prescribing of long-acting reversible contraception (C01)
- Under 18 and U16 conceptions (C02)
- New STI Diagnoses (D02)People presenting with HIV at a late stage of infection (D07)
- Cervical cancer screening coverage C24b/c
- Population vaccination coverage – HPV D04e/f

County level service data is collated locally.

[29] UK Parliament (2019), Sexual health - Report Summary

[30] Department for Education (2021) Relationships Education, Relationships and Sex Education and Health Education guidance

[31] Office for Health Improvement & Disparities (2023), Public Health Outcomes Framework - OHID (phe.org.uk)

3.0 OUR POPULATION

GEOGRAPHICAL LOCATION

Herefordshire County is located in the south of the West Midlands region of England, bordering Wales. It consists of one city (Hereford) and five market towns (Ledbury, Ross-on-Wye, Leominster, Kington and Bromyard). The county covers 2,180 square kilometres with 95% of the land classified as 'rural'. This places it as the fourth lowest population density county within England (86 people per square km[32]). Whilst this provides opportunities for sectors such as agriculture, the low population density can cause difficulties with transport and access to healthcare services.

THE LOCAL POPULATION

The following section describes some key demographics of the local population that are relevant to sexual health outcomes. These are important within the planning of sexual health services to ensure that services are designed to reduce any barriers to accessing healthcare.

POPULATION STRUCTURE

According to the 2021 Census[33], the Herefordshire population is approximately 187,100. This is a lower rate of population increase from the 2011 Census than the national average (2.0% to 6.6%, respectively) and of surrounding areas[5]. The number of deaths within the area continues to surpass the birth rate and therefore, migration is the driver of population growth.

The county has a relatively ageing population structure with a quarter of inhabitants aged 65 or older (higher than the national average) (see figure below[34]). However, there are 17,300 individuals aged 15-24 years and 28,600 females of child-bearing age (between 15-44 years old).

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[32] Herefordshire Council (2022) 2021 Census population and household estimate

[33] Office for National Statistics (2022) Population and household estimates, England and Wales: Census 2021

[34] Office for National Statistics (2022) Herefordshire population change, Census 2021

Age structure of the population of Herefordshire according to the 2021 National Census

AGE RANGE	POPULATION SIZE
Total Herefordshire population	187,100
0 - 14 years	28,000
15 - 24 years	17,300
25 – 39 years	30,400
40 - 59 years	49,200
60 years+	62,000

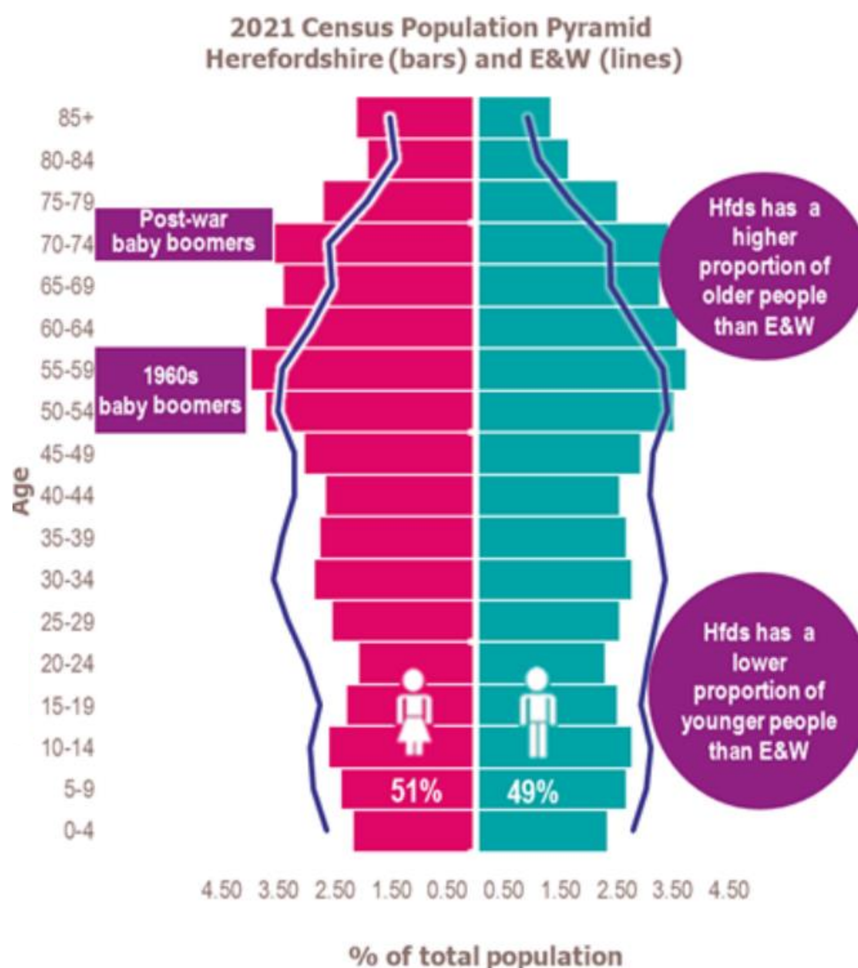
Source: Data from Population and household estimates, England and Wales: Census 2021 - Office for National Statistics (ons.gov.uk)

The total fertility rate (TFR)* of Herefordshire in 2021, according to Office for National Statistics[35], was 1.5 children per woman, compared to a national average of 1.62.

*TFR = 'average number of live children that a group of women would have if they experienced the age-specific fertility rates for the calendar year in question throughout their childbearing lifespan. It is a better measure of trends than the number of livebirths, since it accounts for the size and age structure of the female population of childbearing age'.

[35] Office for National Statistics (2022) Births in England and Wales

2021 Census Population Pyramid for Herefordshire



Source: Herefordshire Council (2022) 2021 Census population and household estimate

ETHNICITY

In 2011, the National Census recorded that 6.3% of the population in Herefordshire identified as being of BAME (non-white) ethnicity, compared to a 19.5% national average[36]. From 2001 to 2011 this population within Herefordshire had increased in proportion by more than two-fold (from 2.5%).

The recent 2021 National Census data shows a further increase in ethnic diversity within Herefordshire. Whilst it still remains much lower than the national average, 8.9% of the local population identified as being of another ethnic group to 'white British'. A total of 96.9% of the population reported being of white ethnicity - compared to 98.2% in 2011 and 81% nationally [37].

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[36] Herefordshire Council (2013) 2011 Census: headline results for Herefordshire

[37] Office for National Statistics (2022) Ethnic group, England and Wales

Research has shown that individuals of black and ethnic minority populations are disproportionately affected by STIs. For example, the rate of gonorrhoea in black minority ethnic populations is 3.5 times higher than the general population[38].

DISABILITY

In the 2011 National Census[9], 37,400 of Herefordshire individuals (19%) reported that they had some form of limiting long-term health problem or disability – a similar proportion to 2001 (18%), and to nationally (18%). Self-reported general health levels were similar to the national picture, with almost half of all residents (46%) in very good health and 5% in bad or very bad health.

According to the Census 2021[39], Herefordshire have 6.7% of their population who reported a disability under the equality act within which their day-to-day activities were 'limited a lot', 10.3% whose activities were 'limited a little' and 83% who were not disabled under the equality act. These proportions are compared to the national averages in the table below.

Comparison of the disability status of the Herefordshire and national population according to 2021 Census

Disability Status	Herefordshire (%)	England (%)
No disability	83.0	82.3
Disability	17	17.7

Data Source: Office for National Statistics - Census 2021

Public Health England[40] noted that there is lack of data on the prevalence of sexual health diagnoses amongst people with learning disabilities. However, it is known that cervical screening rates are low for women with learning disabilities compared to the general population but that this population had high uptake of long-acting reversible contraception amongst women with learning disabilities using contraception.

DEPRIVATION

Previous evidence has shown an association between deprivation and key sexual health outcomes such as sexually transmitted infections and teenage conceptions[41]. The graph below uses national-level data to compares new STI diagnoses rates between deprivation deciles. Whilst no clear gradient between rates of STI diagnoses and deprivation status can be noted, the

[38] Public Health England (2021) Variation in outcomes in sexual and reproductive health in England

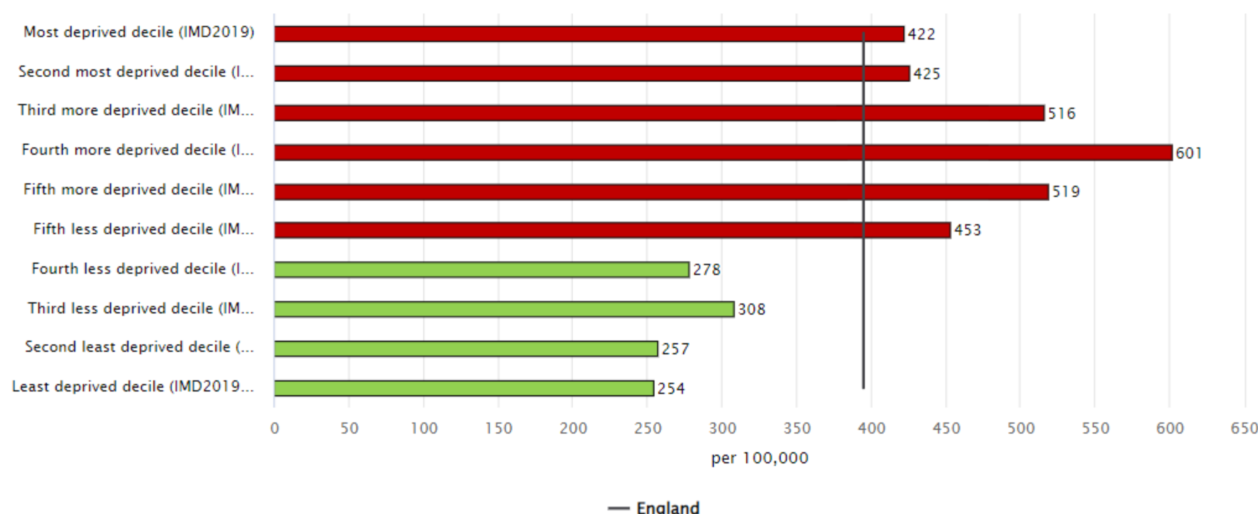
[39] Office for National Statistics (2023) Disability, England and Wales: Census 2021

[40] Public Health England (accessed 2023) Health Inequalities_Sexual health.pdf

[41] Office for Health Improvement & Disparities (2023) Integrated Sexual Health Services: A suggested national service specification

populations in the four least deprived deciles (at the bottom of the graph) had the lowest new STI rates.

Rates of new STI diagnoses per 100,000 (excluding chlamydia aged under 25) by national deprivation decile



Source: Office for Health Improvement and Disparities (2023), Fingertips Database

29 lower super output areas (LSOA) within Herefordshire are within the 25% most deprived nationally (see figure 2)[42]. 15 of the 29 are in Hereford city, eight are in the market towns and six are located in more rural areas.

Conversely, 22 LSOAs are within the 25% least deprived – indicating a range of deprivation spread throughout the county.

Within Herefordshire, the life expectancy at birth for males is 79.9 years and for females this is 83.8 years. Male total and health life expectancy is no longer better than average and health inequalities persist. Males born within the most deprived areas of Herefordshire can expect to live 6.3 years less than those in the least deprived areas. For females there is a 4.0 year difference[43].

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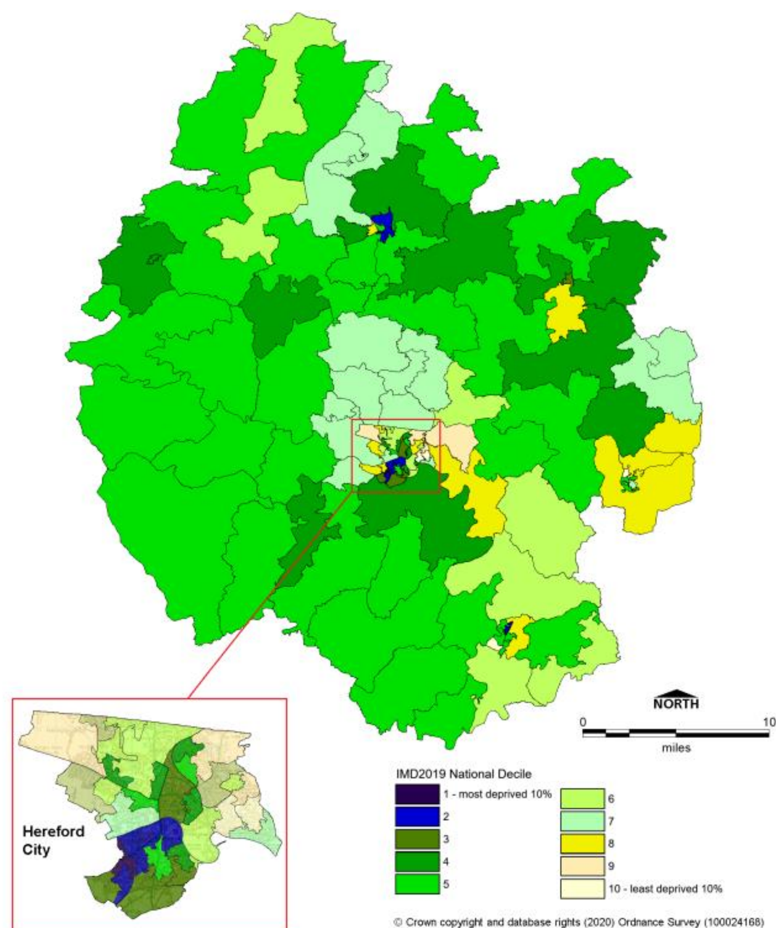
[42] Herefordshire Council (2020) The Indices of Deprivation 2019 - Findings for Herefordshire

[43] Herefordshire Council (2021) Herefordshire's Joint Strategic Needs Assessment

Map of Herefordshire with Indices of Deprivation 2019 colour coding



Source: The Indices of Deprivation 2019 - Findings for Herefordshire

SEXUAL ORIENTATION

The 2021 Census is the first to include topics on sexual orientation which it defines as 'an umbrella term covering sexual identity, attraction, and behaviour'. This was a voluntary question that was only asked of respondents aged 16 years and older. The table below demonstrates that Herefordshire have a similar population profile with regards to sexual orientation to the national averages.

Comparison of the sexual orientation of the national and Herefordshire population according to 2021 Census

Sexual orientation	Herefordshire (%)	England (%)
Straight or heterosexual	89.70	89.37
Gay or lesbian	1.04	1.54
Bisexual	0.90	1.29
Pansexual	0.16	0.23
Asexual	0.04	0.06
Queer	0.01	0.03
Another sexual orientation	0.02	0.02
Not answered	8.12	7.46

Data Source: Office for National Statistics - Census 2021

National data has shown that gay, bisexual and other men who have sex with men are more likely to be diagnosed with a bacterial STI compared to other men[44].

SUBSTANCE MISUSE

The misuse of substances – both alcohol and drugs – is associated with reduced inhibitions and an increase in risky sexual behaviours[45],[46],[47].

As noted in Herefordshire's substance misuse needs assessment[48], 'there is a lack of up-to-date data to estimate the prevalence of drug use within Herefordshire. The service activity data provides an insight into those who are accessing services, there is little indication as to how many individuals are using drugs but not accessing services.'

The National Drug Treatment Monitoring System's most recent drug use prevalence estimates are from 2016/17 (as noted in the table below). For all categories, the prevalence rates in Herefordshire are lower than that of the national averages.

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[44] Public Health England (2021) Variation in outcomes in sexual and reproductive health in England

[45] European Monitoring Centre for Drugs and Drug Addiction (2017) Joining up sexual health and drug services to better meet client needs

[46] Khadr et al. (2016) BMJ Open: Investigating the relationship between substance use and sexual behaviour in young people in Britain: findings from a national probability survey

[47] Paquette et al. (2017). PLOS ONE: Illicit drug use and its association with key sexual risk behaviours and outcomes: Findings from Britain's third National Survey of Sexual Attitudes and Lifestyles (Natsal-3)

[48] Herefordshire Council (2023). Herefordshire's substance misuse needs assessment

Substance use prevalence estimates for Herefordshire for 2016/17

Substance	Prevalence estimate (Confidence interval)	Rate per 100,000 for Herefordshire	Rate per 100,000 for England
Opiate and/or Crack Users	719 (632 to 871)	6.3	8.9
Opiate	671 (586 to 894)	5.1	7.3
Crack cocaine	462 (243 to 1001)	4.0	5.1
Alcohol (2018/19)	1812 (1371 to 2471)	11.6 per 1,000	13.7 per 1,000

Table source: Herefordshire's substance misuse needs assessment, 2022

However, it is worth noting that data from the Health Survey for England 2015-2018 estimates that Herefordshire have a higher number of adults drinking over the recommended weekly units than national averages[49].

Patterns of alcohol consumption for Herefordshire and England

Indicator	Local (%)	England (%)
Proportion of adults who abstain from drinking alcohol	6.9	16.2
Proportion of adults drinking over 14 units of alcohol a week	27.5	22.8

Table source: Herefordshire's substance misuse needs assessment, 2022

Furthermore, this association between substance use and sexual health was noted in a local survey. The Children and Young Person's Quality of life Survey 2021 found that out of the 600 Year 10 pupils surveyed, those who had had an alcoholic drink within the last 7 days (28%) were more likely to have been in a sexual relationship, used drugs and reported that they were less likely to know where to get advice for sexual health.

Data from the Young people substance misuse commissioning support pack by the Office for Health & Disparities showed that Herefordshire had a higher rate of under-18 year olds being admitted to hospital for alcohol-specific conditions compared to nationally.

Alcohol-specific admissions in under-18 year olds for Herefordshire and England

Indicator	2018/19 – 2020/21	
Admission episodes for alcohol-specific conditions in under 18 year olds per 100,000	Local	England
	42	29

Data source: OHID, Young people substance misuse commissioning support pack 2023-24

[49] Office for Health Improvement & Disparities (Accessed 2023) Local Alcohol Profiles for England

4.0 CURRENT SERVICE PROVISION

THE VISION

The sexual health service aims to align with the vision set out by the Herefordshire Health and Wellbeing Board that "Herefordshire residents are resilient; lead fulfilling lives; are emotionally and physically healthy and feel safe and secure". Services aim to be easily accessible with a confidential and non-judgemental approach.

The service activity ranges from:

- Prevention and self-management activities e.g. information and advice on safe sex, sexually transmitted infections (STIs) and HIV prevention including building resilience*
- Raising awareness of sexual health and contraception services
- Chlamydia screening through Basic and Intermediate**Error! Bookmark not defined.** (level 1 and 2) c are
- Testing and management of uncomplicated STIs
- Provision of a full range of contraception
- Assessments and referrals to specialist services when required e.g. management of complicated STIs and complex contraception and interface with HIV care and treatment services.
- Outreach services for vulnerable populations
- Online testing provision

*Sexual health services are only commissioned to provide testing and pre-exposure prophylaxis for HIV. Specialist HIV services are used for on-going management and treatment.

THE DELIVERY

In 2018, Solutions4health were awarded the 4 year contract for delivering the sexual health services in Herefordshire.

The service is expected to deliver under the following principles:

1. **Free of charge**: This is important to ensure universal access to services

2. **Open access**: A referral to services from a health professional is not required. This can enable anonymity whilst also ensuring rapid access to treatment which helps to prevent complications, onward transmission of disease or unplanned pregnancy

3. **No restrictions to age or place of residency**: Some people may choose to travel to services away from their area of residence, perhaps for convenience or for anonymity.

4. **Confidential:** Standards of confidentiality over and above other health services are important in addressing stigma associated with poor sexual health and to encourage people to come forward for testing and treatment. Individuals do not need to give their personal details in order to access services.

SEXUAL HEALTH CLINIC

The service provides one clinic space in the centre of Hereford city, near to Hereford train station, that opens 9am Monday-Friday with some later closing times of 7pm. The clinic is closed at the weekend. Within this clinic individuals can access STI testing, contraceptive methods and PrEP. Wednesday afternoons are reserved for a Young persons (≤ 19 years old) walk-in clinic that provides 'first come, first serve' slots. Home testing is also available that is delivered in blank packaging to an individual's home.

STAFFING

The current staffing within the service includes 14 staff members, one nurse who will be starting their role in April 2023 and two vacant posts:

- Consultant
- Consultant (part-time)
- Consultant vacancy (part-time)
- Doctor (part time) - Associate Specialist in Sexual Health
- Doctor (part-time)
- Band 8a Head of Service (full-time)
- Band 7 Lead Nurse for Sexual Health & Safeguarding (Starting on 3/4/23) (full-time)
- 3 x Band 6 Nurses (all part-time, 63 hours per week total)
- Band 5 development (or band 6) nurse vacancy (full-time)
- Band 4 IT and Data Lead (part-time)
- Band 3 Senior receptionist/Results co-ordinator (full-time)
- 3 x Band 2 Support Worker/Receptionist combined role (full & part-time, total 108 hours pw)
- Cleaner – part-time

Whilst recruitment of staff can be difficult for the service – likely due to both a national difficult in recruiting sexual health clinicians and Herefordshire's rural location. However, the service note that they have good staff retention.

OUTREACH

Plans to introduce a sexual health outreach hub in Leominster were stopped due to the COVID-19 pandemic and have not yet been re-initiated. The service are still looking into this option as they have identified a need for this within the area. Furthermore, they hope to join with other local services in attending 'pop-up- events.

CQC INSPECTION

A Care Quality Commission inspection took place at Solutions4Health in April 2022 which produced mixed results. Whilst the service was marked as 'good' for being effective, caring and

responsive, the rating ‘needs improvement’ was given for being well-led and safe. Some of the key findings included[50]:

- ‘Leaders had established policies, procedures and activities to ensure safe running of the service; however these were not effective or operating as intended.’
- ‘The provider did not have detailed fire plans in place to ensure the safe evacuation of the building in the case of an emergency, we also found that fire evacuation drills were not being carried out.’
- ‘Patients and staff were at risk of harm as systems were not in place or practised to ensure risk was effectively mitigated.’

Following this outcome, meetings having been held between senior management staff and public health commissioning staff to discuss the findings of the report with additional actions made including an improvement plan that includes monthly meetings with the commissioner to review progress. The issues highlighted by the CQC inspection have now been considered as addressed.

SERVICE FEEDBACK PROCESS

Solutions4Health continually requests feedback from service users via a feedback form. This information is then used as part of the service’s “You said, We Did” campaign, where changes that have been made to the service in response to feedback are shared. Examples of this include the following feedback and subsequent changes:

- "I think you should have an evening clinic available for those who can't make appointments in the day" → From the 1st April 2021 the service opened until 7pm on Thursday evenings

- "It would be good if you could provide a safe, dedicated space for the LGBTQAI community." → From the 1st April 2021 a dedicated LGBTQAI clinic twice a month was added

- "Can you supply information indifferent languages?"
→ The service information leaflet is now supplied in7 languages & we are able to provide face to face and telephone consultations with a translator!

Additionally, in 2021 the service worked with Healthwatch Herefordshire to further improve service provision. The service noted that this was particularly useful in gaining insight into some of our minority groups thoughts and views on how wider sexual health services could be delivered to meet their needs. Findings from this process can be found in the appendix.

GENERAL PRACTICE

Whilst general practices are the main service providers for cervical screening, within Herefordshire they are also subcontracted by Solutions4Health to deliver provision of long-acting

[50] Care Quality Commission (2022) Solutions 4 Health- Hereford

reversible contraceptives (LARC). Furthermore, they can give sexual health advice and provide other contraceptive services, including the emergency hormonal contraceptive pill.

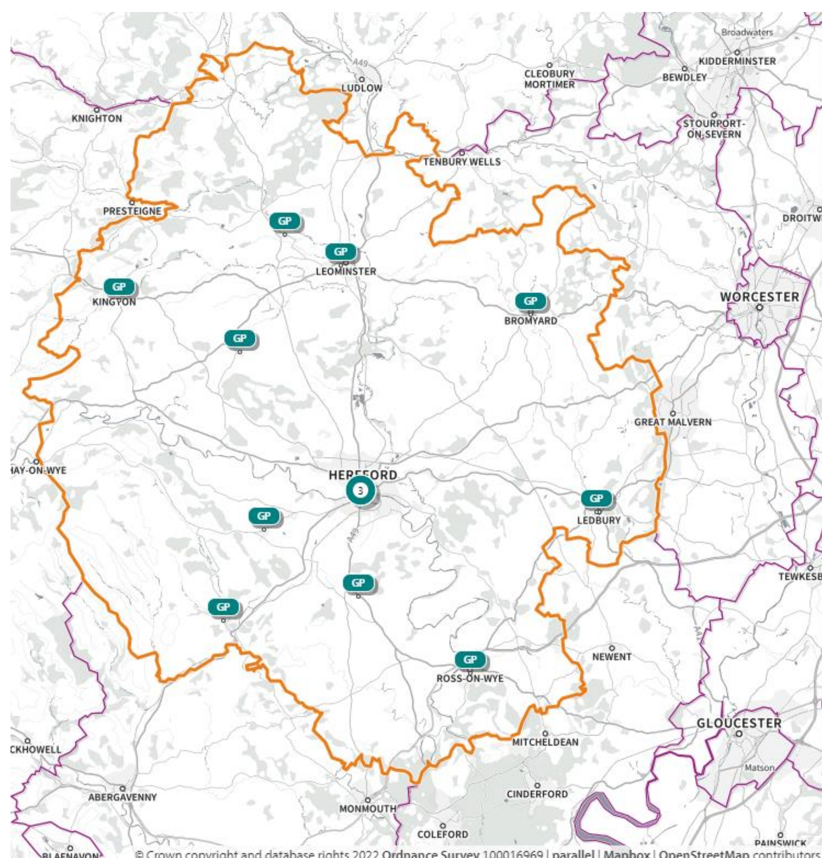
As of December 2022, there were 13 GP practices within Herefordshire that had contracts to deliver LARC provision. The website Strategic Health Asset Planning and Evaluation (SHAPE) has been used to produce the map below that shows the location of these practices throughout the county. SHAPE is managed by the Office for Health Improvement and Disparities (OHID) within the Department of Health and Social Care.

Reasons for low uptake on LARC provision by GP practices include:

- A number of trained, experienced GP’s in LARCS are retiring/have retired or left the profession.
- GP practices have a high demand and are short staffed so may not have the ability to take time out of clinical work for training in LARC provision
- Due to rurality of the county, some GP practices do not see enough patients who request/require LARCS so therefore they cannot meet the required competencies

This is reported to have created some geographical inequities with regards to LARC provision within the county.

Map of General Practices with contracts to deliver LARC provision in Herefordshire as of December 2022



Source: Solutions4Health data using SHAPE Atlas tool

PHARMACY

Herefordshire County Council commission the emergency hormonal contraceptive service within pharmacies. The following information has been taken from the Herefordshire Pharmaceutical Needs assessment 2022[51] but with some information updated:

Accredited community pharmacies currently offer emergency hormonal contraception (EHC). This service provides a consultation and a free supply of Levonorgestrel or Ulipristal under a Patient Group Directive (PGD). The service aims to reduce the number of unwanted pregnancies and terminations for eligible women aged 13 years and over and also provide advice on STIs and contraception and signposting to other sexual health services. When dispensing EHC, a practitioner is required to discuss LARC, ongoing contraception and chlamydia testing at two weeks post unprotected sex. This is a well-established service in Herefordshire and one which signposting from other service providers can help to manage other provider workload. Pharmacy opening hours on Saturday and Sunday are helpful towards earlier support for people seeking emergency contraceptive advice with no need for appointment.

14 pharmacies in Herefordshire currently provide this service (3 East Herefordshire, 7 Hereford City, 3 North and West, 1 South and West).

CLINIC SERVICE USE

The table below shows data on the SHS clinics that had more than 10 consultations by residents of Herefordshire in 2020. Just over half of consultations took place with PreventX, Herefordshire's online SHS provider which is closely followed by the specialist SHS clinic at Solutions4Health (45%).

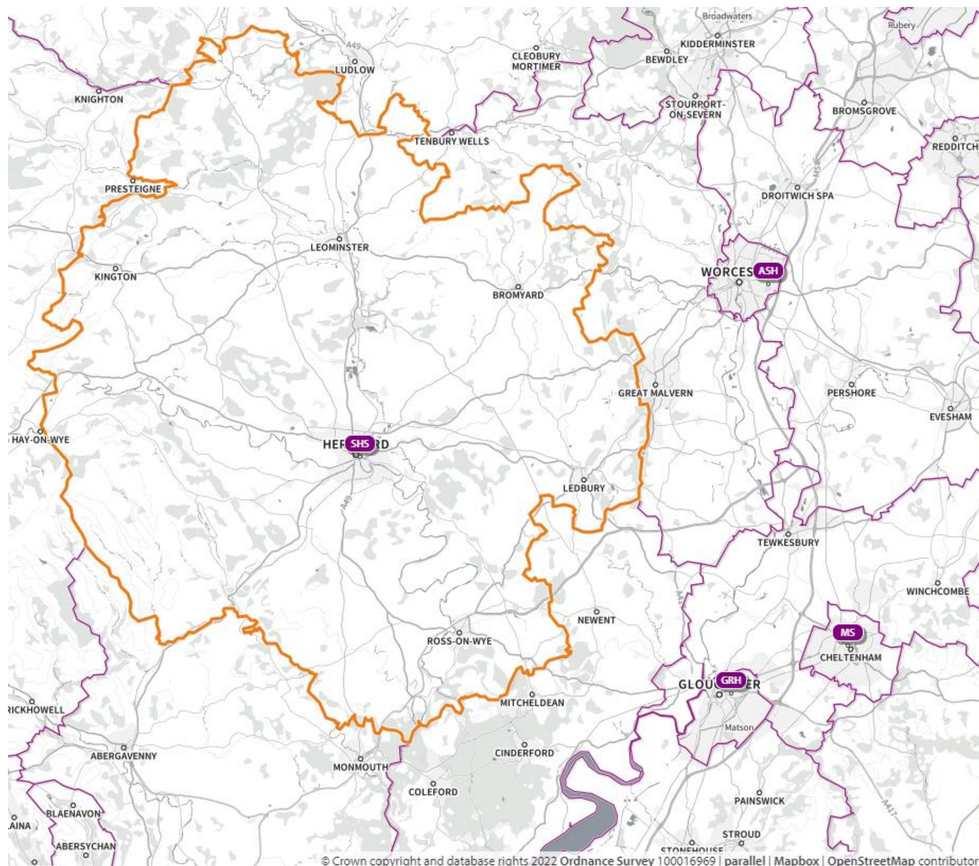
Number and percent of all consultations* by Herefordshire residents at SHSs: 2020 (only SHSs with more than 10 consultations included).

Clinic name	Number of consultations	% of all consultations
Preventx	3,975	50.2
Sexual Health Services 4 Herefordshire	3,595	45.4
Gloucester Royal Hospital	178	2.2
Aconbury Sexual Health Service	116	1.5
SH24	30	0.4
Milsom Street	13	0.2
Dean Street Clinic (GUM)	12	0.2

Source: UK Health Security Agency (2022), SPLASH Supplement Report

[51] Herefordshire Council (2022) Herefordshire Pharmaceutical Needs Assessment

Map to illustrate the location of sexual health clinics used by residents of Herefordshire



Source: UKHSA data using SHAPE Atlas tool

The map above shows the borders of Herefordshire (highlighted in orange) with the sexual health service (SHS) relatively central within Hereford City. However, this is considerable distance from other towns such as Bromyard (14 miles) and Ross-on-Wye (15 miles).

Gloucester Royal Hospital (GRH), Aconbury Sexual Health Service (ASH) and Milsom Street (MS) are also shown on the map. Dean Street is located in London and both PreventX and SH24 are online services.

5.0 SEXUAL HEALTH OUTCOMES

Most of the data in this section has been taken from the Office for Health Improvement and Disparities database 'Fingertips' and used the UK Health Security Agency's SPLASH and SPLASH supplement reports for Herefordshire.

Given the most recent data is from 2021, any comparison between 2021 and previous years should take into consideration the COVID-19 pandemic and the national lockdowns that required dramatic changes to the provision of sexual health services in 2020.

The figure below summarises Herefordshire's performance in the most recently published key sexual health indicators.

Key sexual and reproductive health indicators in Herefordshire compared to the national averages

The local result for each indicator is shown as a circle, against the range of results for England shown as a grey bar. The line at the centre of the chart shows the England average, the diamond shows the average for the West Midlands UKHSA Centre.

Compared to England:

Better | Similar | Worse *or* Lower | Similar | Higher *or* Not compared

Indicator	Period	Herefs			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Syphilis diagnostic rate per 100,000	2021	→	7	3.6	9.3	13.3	145.7		0.0
Gonorrhoea diagnostic rate per 100,000	2021	→	31	16	72	90	1,006		7
Chlamydia detection rate per 100,000 aged 15 to 24	2021	→	171	955	1,121	1,334	222		3,063
Chlamydia proportion aged 15 to 24 screened	2021	↓	2,421	13.5%	10.9%	14.8%	4.9%		40.6%
New STI diagnoses (excluding chlamydia aged under 25) per 100,000	2021	↓	356	184	291	394	2,634		103
HIV testing coverage, total	2021	↓	578	24.2%	49.8%	45.8%	14.1%		86.3%
HIV late diagnosis in people first diagnosed with HIV in the UK <25% 25% to 50% ≥50%	2019 - 21	–	1	100%	42.8%	43.4%	100%		0.0%
New HIV diagnosis rate per 100,000	2021	→	2	1.0	4.2	4.8	22.2		0.0
HIV diagnosed prevalence rate per 1,000 aged 15 to 59 <2 2 to 5 ≥5	2021	→	80	0.79	1.89	2.32	12.65		0.30
Total prescribed LARC excluding injections rate / 1,000	2020	→	-	40.7	27.3	34.6	4.7		74.9
Under 18s conception rate / 1,000	2020	→	30	10.4	15.1	13.0	30.4		2.1
Under 18s conceptions leading to abortion (%)	2020	→	20	66.7%	49.6%	53.0%	0.0%		100%
Violent crime - sexual offences per 1,000 population New data	2021/22	→	608	3.1	3.2*	3.0*	1.4		6.3

Source: Office for Health Improvement & Disparities, Sexual and Reproductive Health Profiles

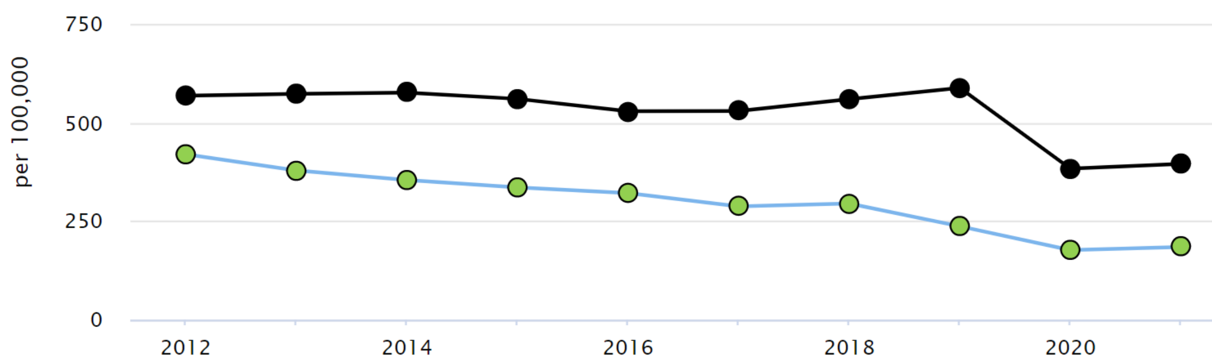
This figure indicates that whilst Herefordshire have a lower Syphilis and Gonorrhoea diagnostic rate per 100,000 than the national average (green dots), they are under-performing in other key measures such as HIV testing coverage (red dots). These measures will be evaluated in more depth below.

SEXUALLY TRANSMITTED INFECTION OUTCOMES

STI RATES

Excluding chlamydia diagnoses for individuals under the age of 25, the rate of new STI diagnoses within Herefordshire per 100,000 population in 2021 was 184 – less than the England average of 394.

Trend of new STI diagnoses rate (excluding chlamydia in under 25 year olds) per 100,000 population by year in Herefordshire (green) and England (black): 2012 to 2021



Source: Office for Health Improvement & Disparities, Sexual and Reproductive Health Profiles

The diagram above shows that this diagnosis rate is a small increase from the rate of 176 per 100,000 residents in 2020 but, as noted below, remains one of the lowest rates of all the West Midlands regions.

Comparison of new STI diagnoses rates for all areas in the West Midlands region: 2021

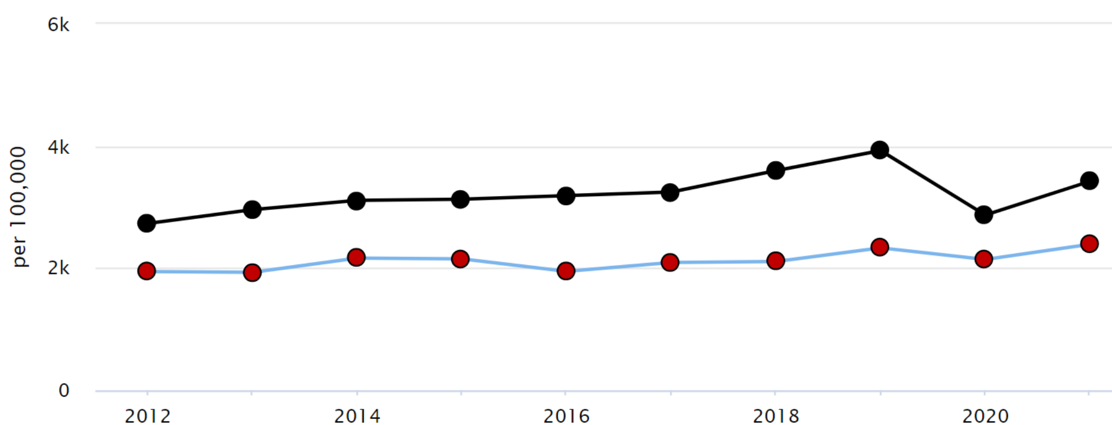
Area	Recent Trend	Count	Value
England	↓	-	394
West Midlands region	↓	-	291
Sandwell	↓	-	438
Wolverhampton	↓	-	412
Birmingham	↓	-	387
Coventry	↓	-	377
Walsall	↓	-	326
Stoke-on-Trent	↓	-	314
Telford and Wrekin	↓	-	274
Staffordshire	↓	-	244
Warwickshire	↓	-	241
Worcestershire	↓	-	216
Solihull	↓	-	201
Herefordshire	↓	-	184
Shropshire	↓	-	173
Dudley	↓	-	160

Source: UK Health Security Agency (UKHSA)

Source: Office for Health Improvement & Disparities, Sexual and Reproductive Health Profiles

Importantly, the STI testing rate per 100,000 (also excluding chlamydia in < 25 year olds) increased between 2020 and 2021 - this confirms that the reduction in the diagnosis rate was not due to a lower rate of testing. However, the testing rate remains lower than the both the West Midlands and the national averages (2391 per 100,000 compared to 2747 and 3422, respectively).

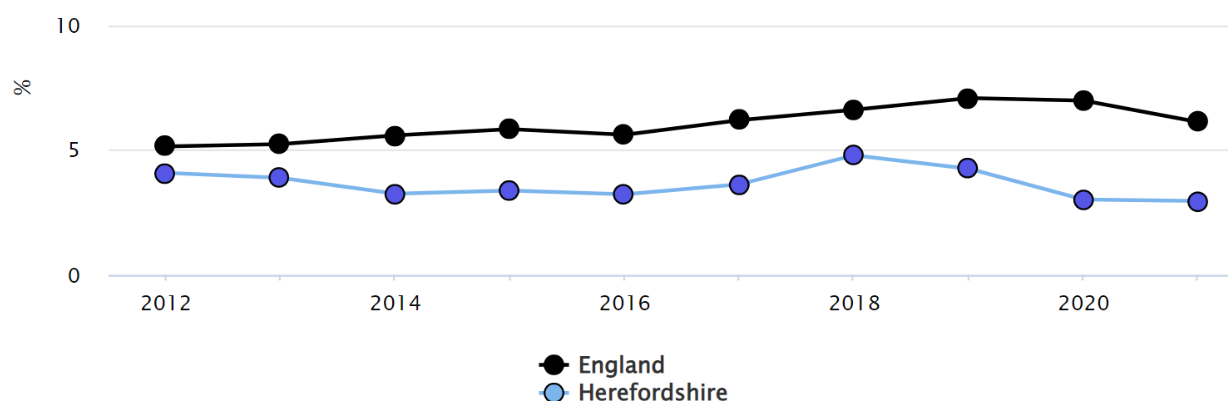
Trend of STI testing rate (excluding chlamydia in under 25 year olds) per 100,000 population aged 15 to 64 years by year in Herefordshire (red) and England (black): 2012 to 2021



Source: Office for Health Improvement & Disparities, Sexual and Reproductive Health Profiles

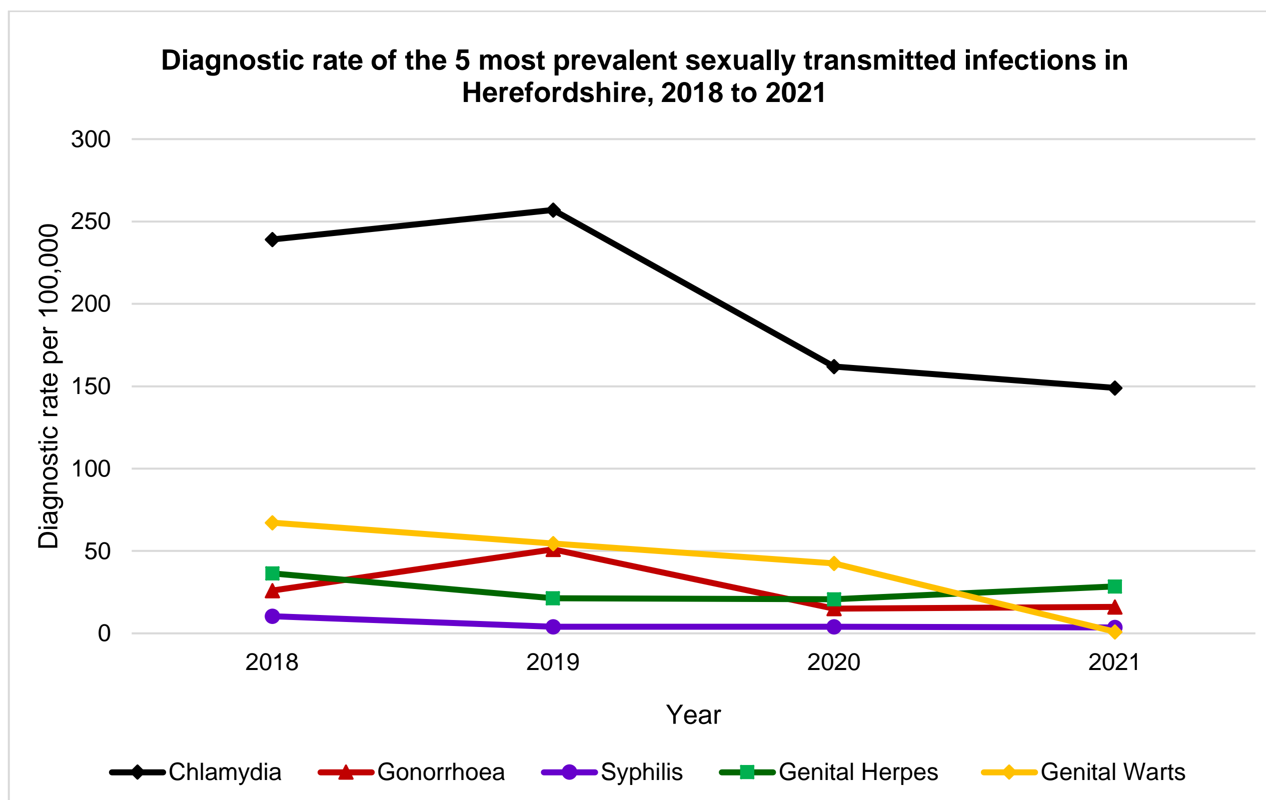
The STI positivity rate (which excludes chlamydia in individuals aged under 25) was 3.0% for Herefordshire in 2021 - lower than the national average of 6.1%. Positivity rates depend both on the number of diagnoses and the uptake of testing. Reasons for this lower positivity rate in Herefordshire may be that there is a lower-than-national average prevalence of STI infections or that those being tested are not representative of the local population but instead there is a higher proportion of lower risk individuals that are being tested. To determine this, an understanding of *who* is being tested is required.

STI positivity rate (%) excluding chlamydia in under 25 year olds by year in Herefordshire (blue) and England (black): 2012 to 2021



Source: Office for Health Improvement & Disparities, Sexual and Reproductive Health Profiles

The graph below identifies Chlamydia as the most commonly diagnosed STI amongst the Herefordshire population.



Data source: Office for Health Improvement & Disparities, Sexual and Reproductive Health Profiles

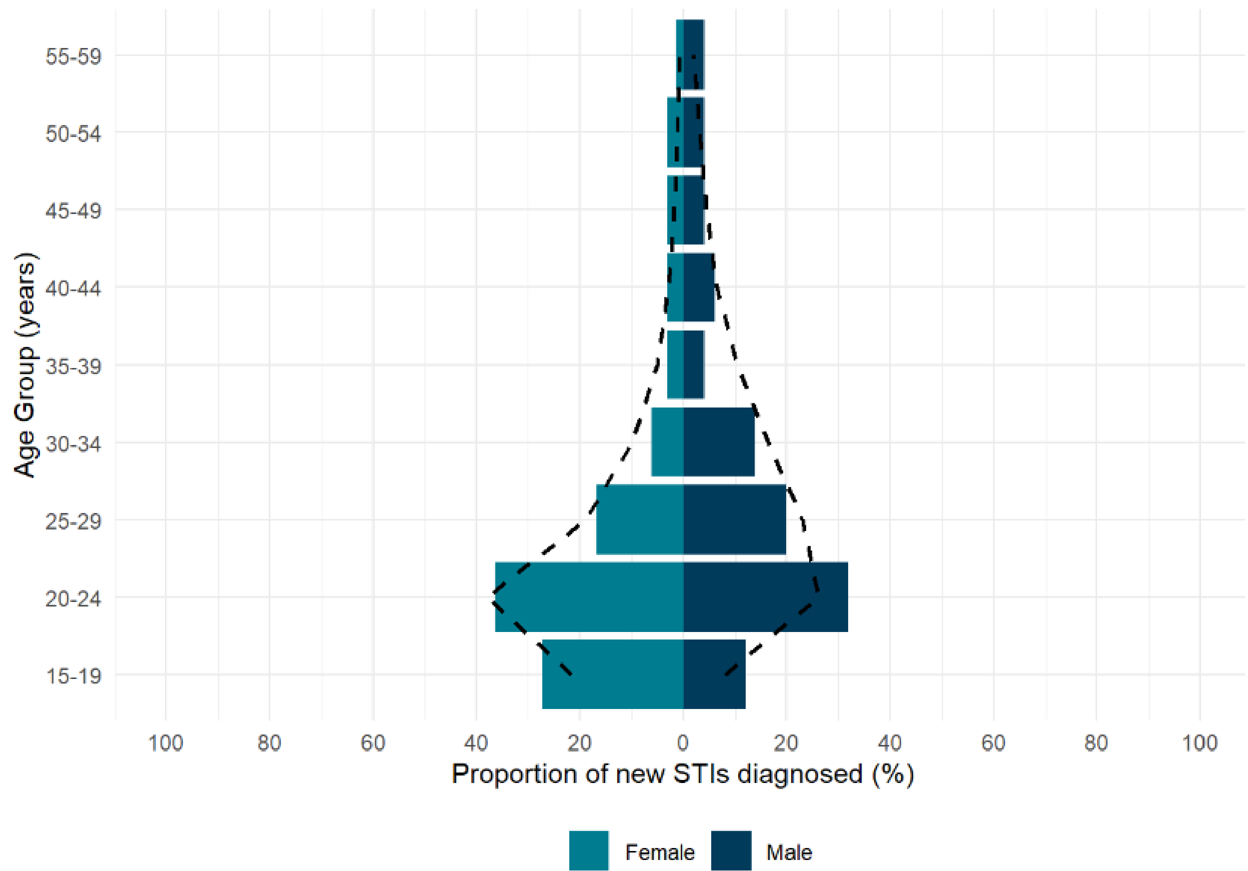
The data from this section indicates that Herefordshire have a lower testing and positivity rate than that of the national average. Whilst this may be due to the demographic profile of the population - an ageing population with lower risk of sexually transmitted infections, ensuring those at higher risk of infections are accessing sexual health tests is key.

BY AGE

The graph below compares the proportion of new STIs that were made in both sexual health services (SHSs) and non-specialist SHSs within Herefordshire in 2020 by age and gender. This can be compared to the national averages (dotted line).

55.6% of new STI diagnoses in 2020 within Herefordshire were in young people aged 15 to 24 years old. This compares to a 45.7% in national average.

Proportion of new STIs by age group and gender in Herefordshire, County of (bars) and England (lines): 2020.



Source: UK Health Security Agency (2022), SPLASH Supplement Report

BY GENDER AND SEXUALITY

Of the new STI diagnoses in Herefordshire in 2020, 43.1% were in men and 56.9% in women. This can be broken down by sexuality and type of infection:

Number* of new STIs, chlamydia, genital herpes, genital warts, gonorrhoea and syphilis in heterosexual men, men who have sex with men (MSM) and women in Herefordshire (SHS diagnoses only): 2016-2020

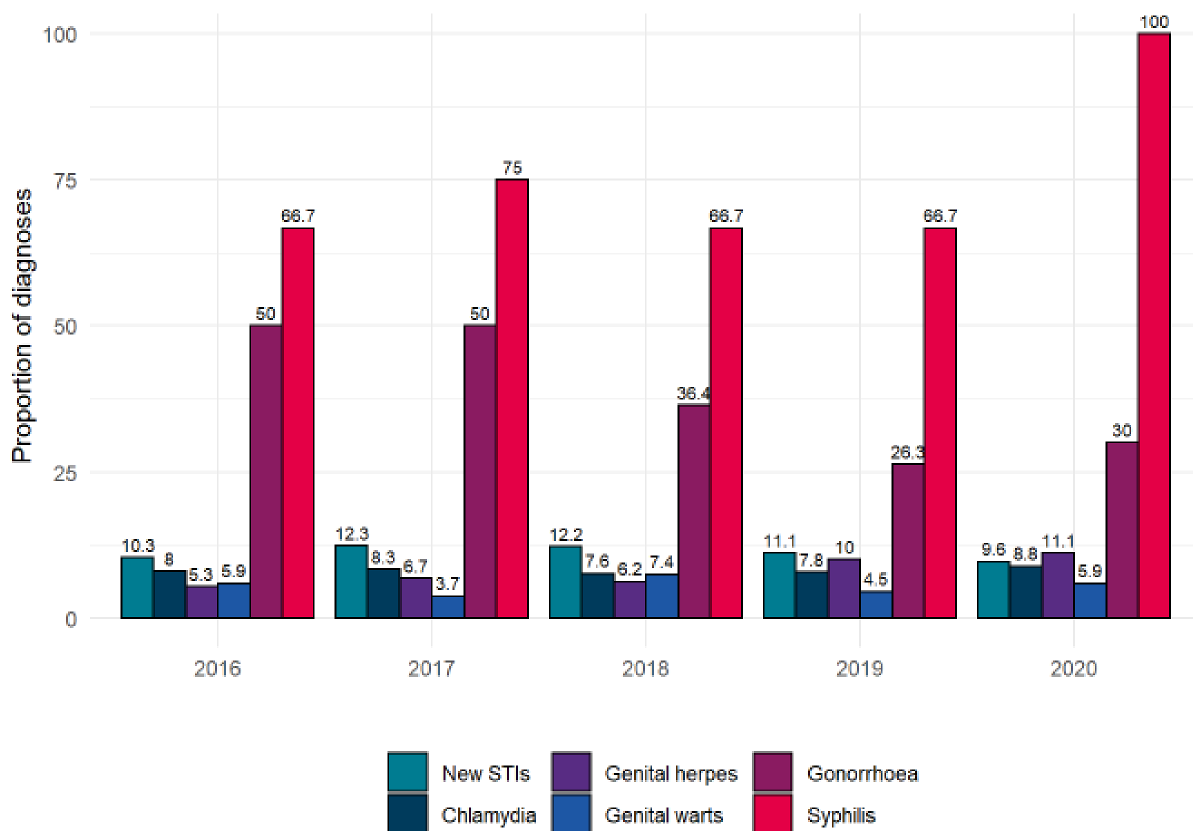
(*numbers have been rounded to nearest 5 to protect confidentiality)

Source: UK Health Security Agency (2022), SPLASH Supplement Report

Of those new diagnoses in which sexual orientation was known, 9.6% of new STI diagnoses in Herefordshire in 2020 were among MSM – much less than the national average of 23.7%. This may be surprising given that Herefordshire have a similar population profile with regards to sexual orientation to the national averages, as noted in Section 3 of this needs assessment. Reasons for this may include a low prevalence of STIs within the MDM population locally or that MSM are underrepresented within the locally tested population.

The proportion of each infection that is diagnosed in the MSM population can be noted, over time, in the graph below.

Proportion of new STIs, chlamydia, genital herpes, genital warts, gonorrhoea, and syphilis that are diagnosed in MSM in Herefordshire: 2016-2020



Source: UK Health Security Agency (2022), SPLASH Supplement Report

This graph shows that the majority of Syphilis diagnoses from 2016 to 2020 have occurred in MSM. Whilst half of Gonorrhoea diagnoses occurred in MSM in 2016 and 2017, this has reduced to approximately a third in the more recent years.

BY ETHNIC GROUP

The table below includes the proportion of new STIs that were diagnosed in 2020 within Herefordshire by ethnic group. From these groups, the majority of STIs (56%) were diagnosed in individuals of white ethnicity whilst all other ethnic groups were each < 2%. However, with 39.4% of individuals not having an ethnicity disclosed, these figures should be treated with caution. It is not currently possible to give an accurate picture of service use and outcome by ethnicity.

If those without an ethnicity specified are excluded, the white ethnic group would account for 92.5% of new STI diagnoses with a known ethnic group. This is slightly less than the proportion of Herefordshire population that this ethnic group make up. Conversely, all other ethnic groups would account for a higher proportion of new STI diagnoses than their population proportion.

However, this information assumes that there is a proportional representation of each ethnic group within the 'not specified' group which may not be accurate.

Proportion of new STIs by ethnic group (SHS diagnoses only in 2020) compared to proportion of Herefordshire population in each ethnic group according to Census 2021

Ethnic group	% of new STIs	% of new STIs with 'not specified' ethnic group excluded*	% of Herefordshire population according to 2021 Census
White	56.0	92.5	96.9
Black	0.9	1.5	0.3
Asian	0.9	1.5	1.3
Mixed	1.8	3.0	1.1
Other	0.9	1.5	0.5
Not specified	39.4	-	-

* These proportions assume that the 'not specific' ethnic group is made up of all other ethnic groups proportionately

Data Sources: UK Health Security Agency (2022), SPLASH Supplement Report and Office for National Statistics, Census 2021

BY DEPRIVATION

The subsection below compares the proportion of new STIs within Herefordshire in 2020 by deprivation quintile.

Number* and proportion of new STIs in Herefordshire, by deprivation category (SHS diagnoses only): 2020.

Deprivation category	Number of new STI diagnoses*	% of new STI diagnoses	% of Census 2021 Herefordshire population
Most deprived	65	12	8
2nd most deprived	100	18	19
3rd most deprived	205	37	43
4th most deprived	130	24	24
Least deprived	50	9	7

(*numbers have been rounded to nearest 5 to protect confidentiality)

Data Sources: UK Health Security Agency (2022), SPLASH Supplement Report; English indices of deprivation 2019, Ministry of Housing, Communities & Local Government; Census 2021, Office for National Statistics

Whilst higher deprivation has been found to be associated with poor sexual health outcomes in previous literature, this data shows that the highest proportion of the new STI diagnoses in 2020 in Herefordshire occurred in the middle three deprivation quintiles.

Comparisons can be made between the proportion of new STI diagnoses per quintile and the proportion of the local population within each quintile. For example, whilst there is a higher

percentage of new STI diagnoses in the most deprived quintile compared to the percentage of the population, this is also noted in the least deprived quintile.

No clear association between deprivation and new STI diagnoses can be reported from this data. Instead, data on how many tests were performed for each quintile would have been useful to determine their respective STI positivity rates. This has not been possible in this needs assessment.

REINFECTION RATES

An individual becoming re-infected with a new STI within 12 months indicates persistent high-risk behaviour. The table below shows this occurred less frequently in Herefordshire in both women and men from 2016-20 compared to national averages.

Proportion of individuals presenting with a new STI at a SHS that became re-infected with a new STI within 12 months: 2016-2020

	Women	Men
Herefordshire	4.6%	5.1%
England	6.7%	9.6%

Data Source: UK Health Security Agency (2022), SPLASH Supplement Report

This under-than-national-average trend is also noted when looking specifically at Gonorrhoea re-infection rates and at the young population in Herefordshire:

Proportion of individuals presenting with a new gonorrhoea diagnosis at a SHS that became re-infected with gonorrhoea within 12 months: 2016-2020

	Women	Men
Herefordshire	3.3%	6.1%
England	4.1%	11.2%

Data Source: UK Health Security Agency (2022), SPLASH Supplement Report

Proportion of young individuals (aged 15 to 19 years old) presenting with a new STI diagnosis at a SHS that became re-infected with a new STI within 12 months: 2016-2020

	15 – 19 year old Women	15 – 19 year old Men
Herefordshire	8.0%	6.3%
England	10.9%	9.8%

Data Source: UK Health Security Agency (2022), SPLASH Supplement Report

CHLAMYDIA

15 to 24 year old population

In 2021[52], the chlamydia detection rate in Herefordshire was 955 per 100,000 individuals aged 15 to 24 years old. This is defined by Office for Health Improvement and Disparities as 'all chlamydia diagnoses in 15 to 24 year olds attending sexual health services (SHSs) and community-based settings*, who are residents in England, expressed as a rate per 100,000 population'.

This indicator is on a decreasing trend within Herefordshire since 2019 and is lower than the average for both West Midlands and England (1,121 and 1,334, respectively). As chlamydia is often asymptomatic, higher detection rates can be referred to as a 'positive' outcome as they indicate success at identifying infections that may cause complications if untreated.

13.0% of individuals living in Herefordshire within the 15 to 24 year old age range had been screened for chlamydia in 2020 compared to 14.3% nationally. This highlights a lack of uptake in the recommended screening programme. The positivity rate within this cohort in 2020 was 8.98% locally compared to 9.84% nationally[53].

The map below, using data from 2020, highlights the disparity in chlamydia detection rates. This can be caused by a number of factors including[32]:

- differences in true prevalence
- screening coverage
- population screened – i.e. if the most high risk populations are being screened

Whilst data from 2020 showed that Hereford city, where the sexual health clinic is based, had a higher detection rate than other areas within Herefordshire, this has not persisted in 2021.

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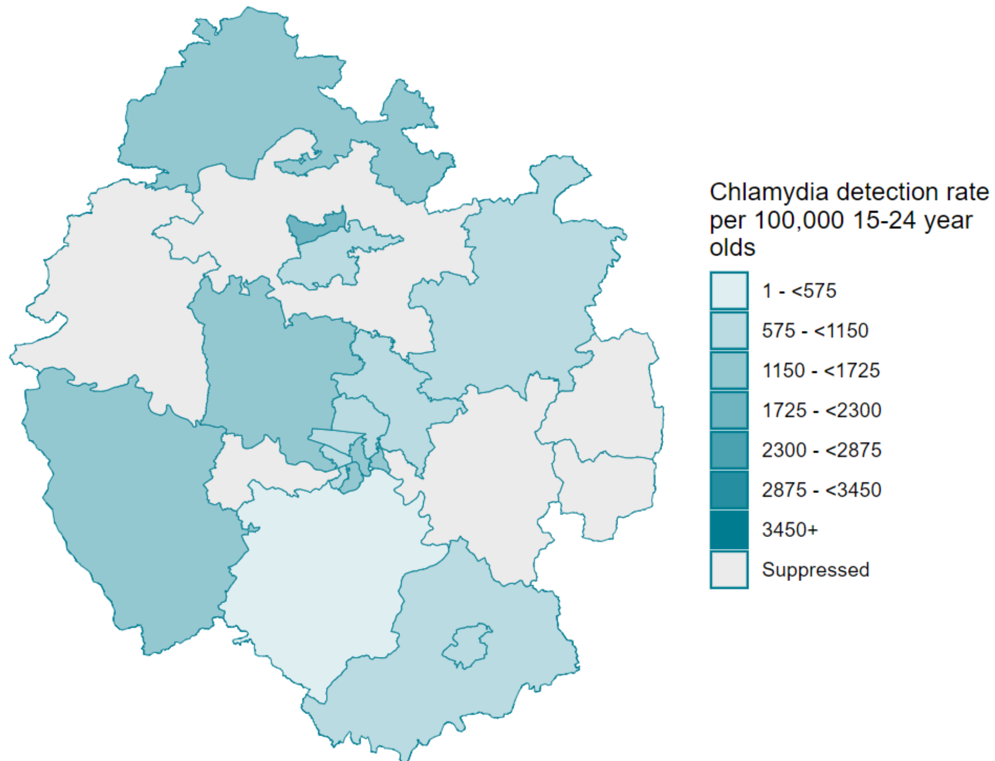
[52] Office for Health Improvement & Disparities (Accessed 2023), Sexual and Reproductive Health Profiles

[53] UK Health Security Agency (2022), SPLASH Supplement Report for Herefordshire

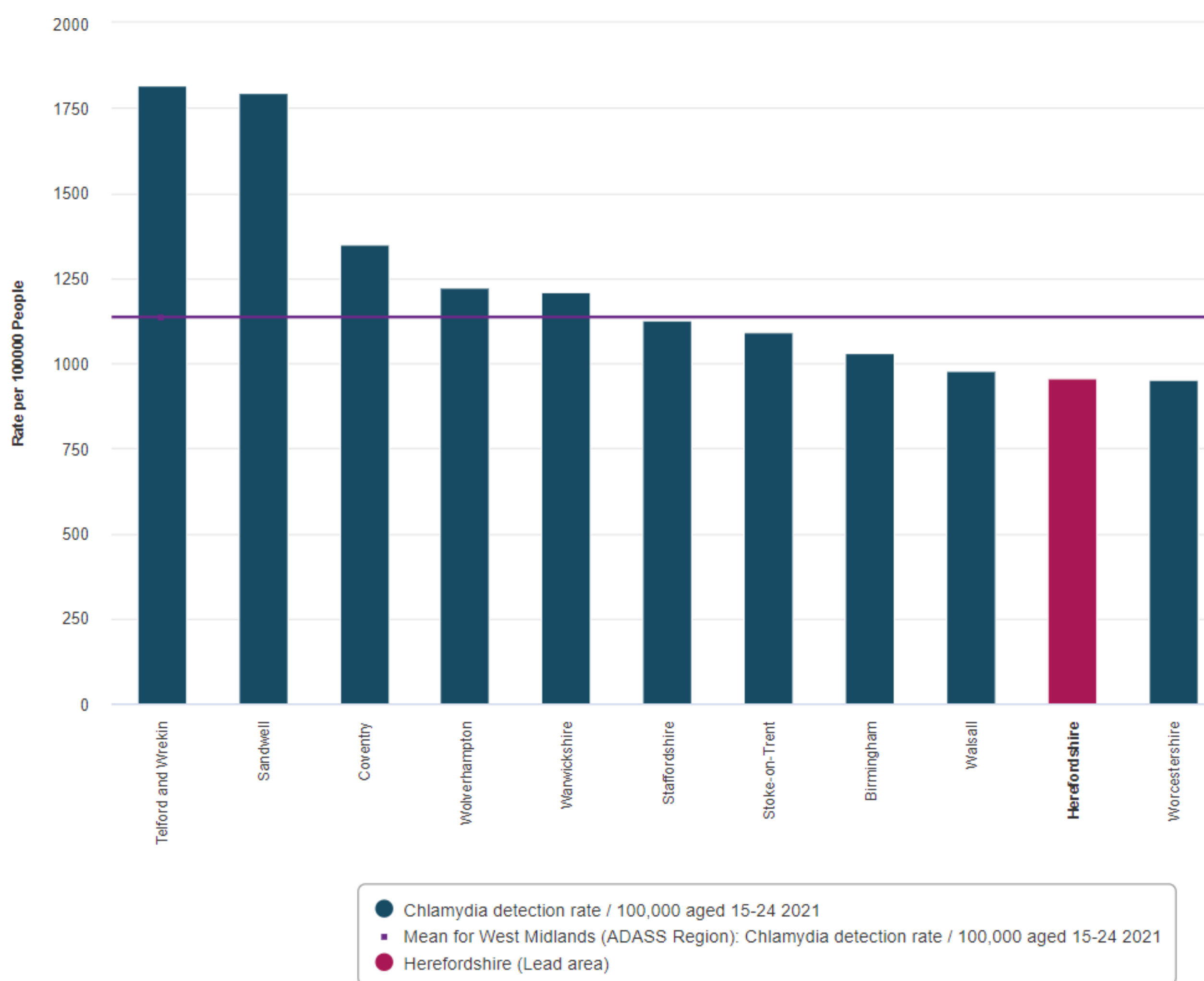
Map of chlamydia detection rate per 100,000 population in 15 to 24 years in Herefordshire by Middle Super Output Area, 2021



Contains Ordnance Survey data © Crown copyright and database right 2021
Contains National Statistics data © Crown copyright and database right 2021

Source: UK Health Security Agency (2023), SPLASH Herefordshire 2023-02-01 (phe.org.uk)

Chlamydia detection rate ages 15 to 24 per 100,000 population (2021) for West Midlands



Source: LG Inform (Accessed 2023), Chlamydia detection rate ages 15 to 24 per 100,000 population in Herefordshire

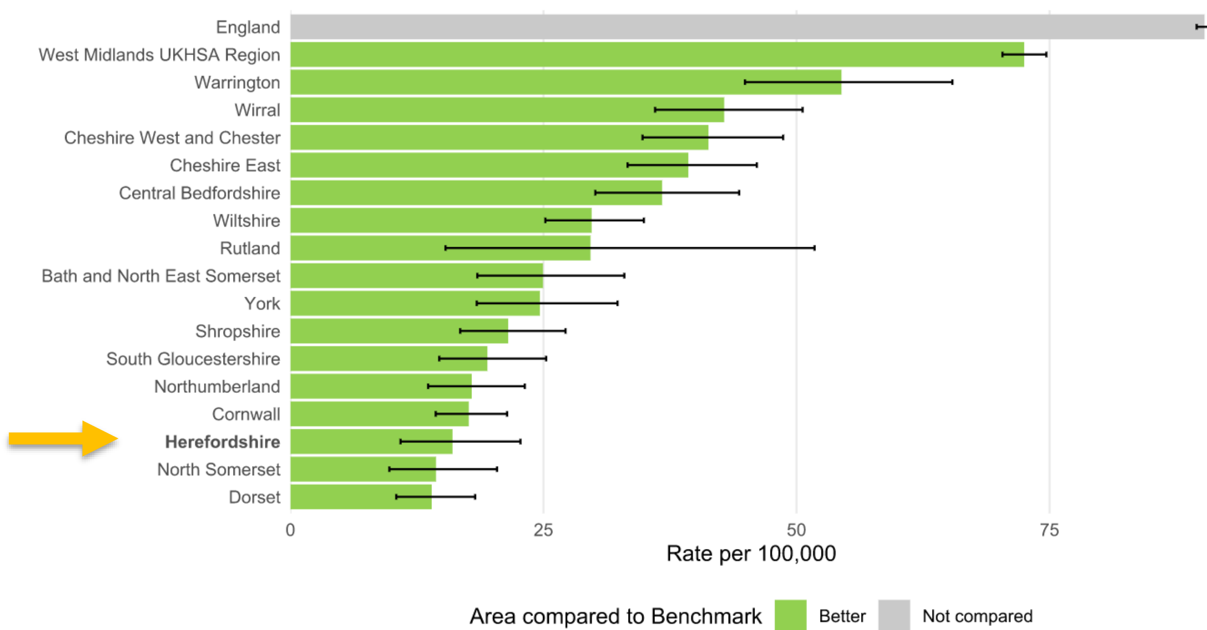
The data within this section indicates that Herefordshire have a lower than national average chlamydia screening rate for young people with a lower detection rate of the bacterial infection.

GONORRHOEA

Within Herefordshire in 2020, the Gonorrhoea diagnostic rate per 100,000 population is much lower than that of the national average (21 compared to 101 – as seen in the figure below). This relatively low rate of gonorrhoea may indicate low levels of risky sexual behaviour or low levels of help seeking behaviour. In a similar trend to the national picture, in 2021 the local gonorrhoea diagnostic rate decreased (to 16 per 100,000 locally and 90 per 100,000 nationally)[54].

[54] Office for Health Improvement and Disparities, Sexual and Reproductive Health Profiles

Rates of Gonorrhoea per 100,000 population in Herefordshire compared to 16 similar local authorities, the West Midlands UKHSA Centre and the national average in 2021



Source: UK Health Security Agency (2023), SPLASH Herefordshire 2023-02-01 (phe.org.uk)

HUMAN IMMUNODEFICIENCY VIRUS (HIV)

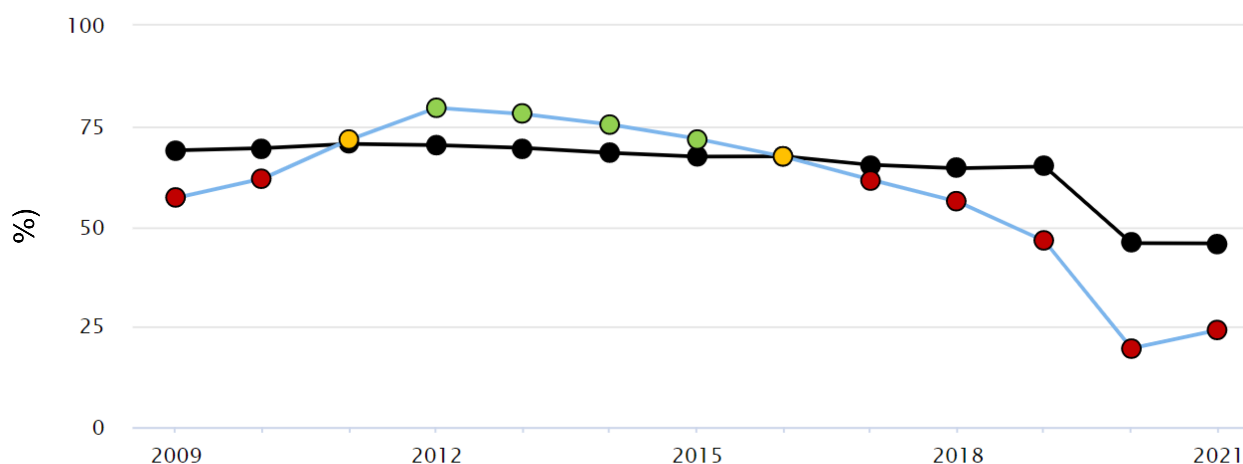
The on-going management of HIV within Herefordshire, with ART, is co-ordinated by specialist services. Within the sexual health services, HIV testing and prevention methods are provided.

HIV TESTING

As noted in the figure below, of the eligible sexual health service attendees within Herefordshire in 2020, 20% received an HIV test. This was significantly lower than the 46% national average. Whilst this proportion improved to 24% in 2021, it is still far below the national average of 46% and of the West Midlands region average of 50%[55]. The reasons for not receiving a test are not included within the dataset but may include the individual declining it.

[55] Office for Health Improvement and Disparities, Sexual and Reproductive Health Profiles

Trend of HIV testing coverage (% of those eligible sexual health service attendees who received an HIV test) by year in Herefordshire (colour) and England (black): 2009 to 2021



Source: Office for Health Improvement and Disparities, Sexual and Reproductive Health Profiles

The data from this graph has been used to form the table below:

Comparison of total HIV testing coverage by year between Herefordshire, West Midlands and England

Year	Herefordshire (%)	West Midlands Region (%)	England (%)
2018	56	65	64
2019	46	65	65
2020	20	50	46
2021	24	50	46

Data Source: Office for Health Improvement and Disparities, Sexual and Reproductive Health Profiles

Furthermore, the 2021 HIV testing coverage data can be broken down into different eligible sub-groups as included in the table below:

Comparison of total HIV testing coverage by sub-groups between Herefordshire, West Midlands and England

Sub-groups	Herefordshire (%)	West Midlands Region (%)	England (%)
Women	14	46	37
Men	55	69	63
Gay, bisexual and other men who have sex with men	83	80	78
Total coverage	24	50	46

Data Source: Office for Health Improvement and Disparities, Sexual and Reproductive Health Profiles

During a stakeholder discussion on this finding, it was noted that there has been a recent expansion of the online testing offering and that SHS staff have reported a perceived increase in HIV tests in 2022 when compared to 2021.

HIV TREATMENT AND CARE[56]

2021 data showed that 80 individuals aged 15 to 59 were seen at HIV services. This equates to a diagnosed prevalence rate of 0.8 per 1,000 residents aged 15 to 59 years old (compared to 2.3 per 1,000 in England). When including all ages, this rate increased to 0.6 per 1,000 residents in Herefordshire (115 individuals) compared to 1.6 per 1,000 nationally.

There were ≤5* new HIV diagnosis within Herefordshire in 2021 for individuals aged 15 years or older. These include all HIV diagnoses for local individuals that were made in the UK, regardless of country of first HIV positive test (i.e. this includes individuals who have previously been diagnosed with HIV abroad).

In 2021 98.3% of individuals who were accessing HIV care were prescribed ART were and 2019-21 data showed that 83.3% of those newly diagnosed with HIV started ART within 3 months of their diagnosis. Finally, 98% of people accessing HIV care had an undetectable viral load and therefore will not transmit the virus. These are important indicators as prompt and successful treatment will help to reduce onwards transmission of the virus and help to increase the life expectancy of the individual living with HIV.

LATE HIV DIAGNOSIS

Late HIV diagnosis is an important prognostic factor for HIV-related morbidity and mortality. This can be defined as a CD4 count <350cells/mm at diagnosis. Herefordshire have had a higher than national average proportion of late diagnoses from 2016-18 to 2019-21 (as noted in the graph below). In 2019-21, 100% of individuals who were first diagnosed with HIV in the UK by Herefordshire services (n ≤5*) were diagnosed at a late stage compared to a 43% West Midlands and national average. However, as this is a low number, this percentage is unstable and any conclusions from it should be made with caution.

* Please note to prevent deductive disclosure both numbers have been rounded up. Numbers from 0 to 4 are rounded up to the nearest 5.

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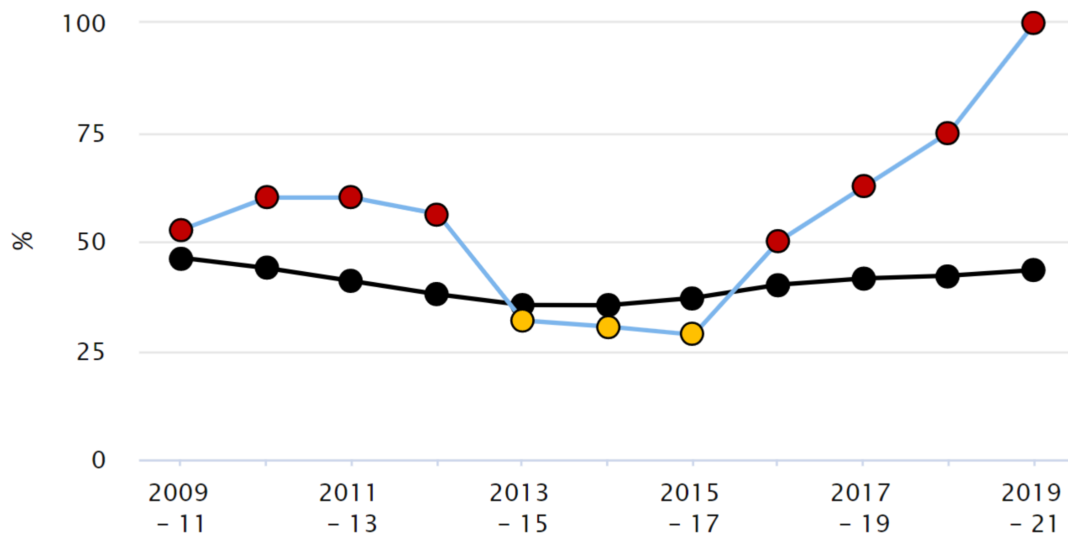
[56] Office for Health Improvement and Disparities, Sexual and Reproductive Health Profiles

Trend of late HIV diagnoses by year in Herefordshire (colour) and England (black): 2009-11 to 2019-21



Data Source: Office for Health Improvement and Disparities, Sexual and Reproductive Health Profiles

This data indicates that there are lower-than-national-average levels of detected HIV prevalence within Herefordshire. Whilst this is a positive finding, it is clear that the testing of HIV is much lower than the national average which may mean there is a high risk of individuals remaining undiagnosed. Furthermore, a low prevalence rate can make identifying those living with undiagnosed HIV more difficult to reach.

HIV DIAGNOSIS BY ETHNICITY

The table below compares the number of people living with HIV by ethnicity in 2016 and 2020. The number of diagnoses remained relatively consistent over this time.

In both 2016 and 2020 the vast majority of individuals living with HIV were of white ethnicity. However, according to the ethnicity data from Census 2021, this is slightly lower than the proportion of the general Herefordshire population that are of white ethnicity. This indicates that individuals of non-white ethnicity are at a relatively higher risk of HIV than those of white ethnicity in the county. The interpretation of the other ethnic groups should be done with caution as rounding of these small numbers has taken place (see table footnote).

Number* of people living with diagnosed HIV by ethnicity in Herefordshire: 2016 and 2020.

Ethnicity	2016	2020
White	95	95
Black African	5	10
Black Caribbean	5	5
Other	10	5
Not known	5	10

*Please note to prevent deductive disclosure the number of people living with diagnosed HIV has been rounded up. Numbers from 0 to 4 are rounded up to the nearest 5.

Data Source: UK Health Security Agency (2022), SPLASH Supplement Report

HIV DIAGNOSIS BY EXPOSURE GROUP

In both 2016 and 2020 the most frequent route of infection of HIV was in MSM followed by heterosexual sex. As with the previous table, some of the data in this may have been rounded to prevent identifiable information from being disclosed which limits its interpretation.

Number* of people living with diagnosed HIV by exposure route in Herefordshire: 2016 and 2020.

Probable route of infection	2016	2020
Sex between men	65	65
Sex between men and women	40	40
Injecting drug use	5	5
Other/Not known	10	5

*Please note to prevent deductive disclosure the number of people living with diagnosed HIV has been rounded up. Numbers from 0 to 4 are rounded up to the nearest 5.

Data Source: UK Health Security Agency (2022), SPLASH Supplement Report

Whilst MSM account for 56% of the probable routes of HIV infection in 2020, heterosexual sex accounts for 35%. This is a relatively large proportion and of individuals living with HIV in Herefordshire – contrary to the common media attention that HIV mainly affects MSM.

OTHER SEXUALLY TRANSMITTED INFECTIONS

Monkeypox

Whilst there are no data on the number of monkeypox cases, in July to December of 2022, a total of 129 monkeypox vaccinations were given. These are displayed in the table below by month and by dose schedule.

Monkeypox Vaccination	2022						
	July	**August**	**September**	**October**	**November**	**December**	**Total**
1st Dose	5	29	21	13	23	8	99
2nd Dose	0	0	0	3	10	17	30
3rd Booster	0	0	0	0	0	0	0

Data Source: Solutions4Health Data

Syphilis, Genital Warts and Genital Herpes

The table below indicates the decreasing diagnostic rate of both syphilis and genital warts within Herefordshire from 2020 to 2021. The on-going declining trend of genital wart diagnoses is often considered a consequence of the National HPV vaccination Programme that is achieving high coverage[57]. Conversely, the rate of genital herpes has increased.

In 2021 all three of these infections had a lower diagnostic rate in Herefordshire than nationally.

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[57] UK Health Security Agency (2020), Spotlight on sexually transmitted infections in the West Midlands

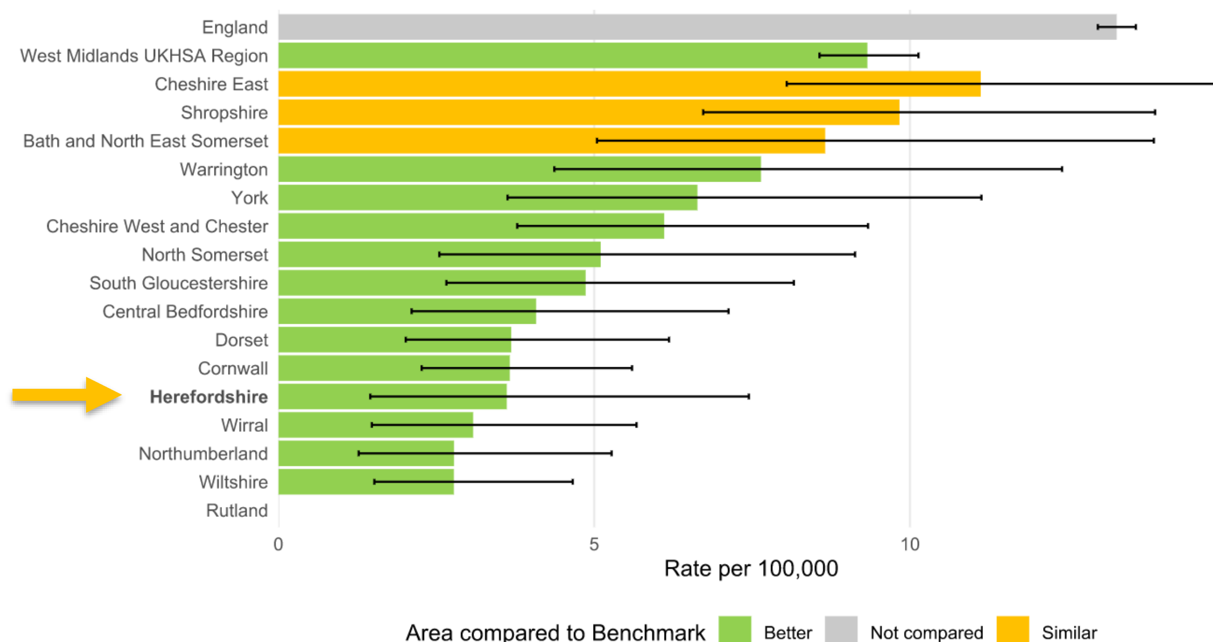
Diagnostic rate of sexually transmitted infections per 100,000 population within Herefordshire and England

	Herefordshire 2020	Herefordshire 2021	England 2021
Syphilis	4.1	3.6	13.3
Genital Warts	42.4	35.6	50.0
Genital Herpes	20.7	28.4	38.3

Data Source: Office for Health Improvement & Disparities, Sexual and Reproductive Health Profiles

From this data alone it is not possible to determine whether these indicate a true lower prevalence of these infections or whether there are a high number of undiagnosed individuals within the population.

Rates of syphilis per 100,000 population in 16 similar local authorities and the West Midlands UKHSA Region, compared to England: 2021.



Source: UK Health Security Agency (2022), SPLASH Herefordshire 2023-02-01 (phe.org.uk)

UNDER-18 CONCEPTIONS

This indicator is included in the Public Health Outcomes Framework as well as an indicator in the child poverty strategy. It is considered important as most teenage pregnancies are unplanned and approximately 50% end in an abortion. Whilst pregnancy can be a positive experience for some young women, it can also lead to 'poor outcomes for both the teenage parent and the child, in terms of the baby's health, the mother's emotional health and well-being and the likelihood of both the parent and child living in long-term poverty'.[58]

[58] Office for Health Improvement and Disparities, Public health profiles

Over the last two decades, under-18 conception rates have been on a downward trend both nationally and within Herefordshire (see graph below). Data from 2020 shows that compared to England, Herefordshire have a lower rate of under 18s conception (10.4 per 1,000 females aged 15-17 in Herefordshire compared to 13 per 1,000 nationally) but that a higher proportion of the local cohort have an abortion (66.7% compared to 53%).

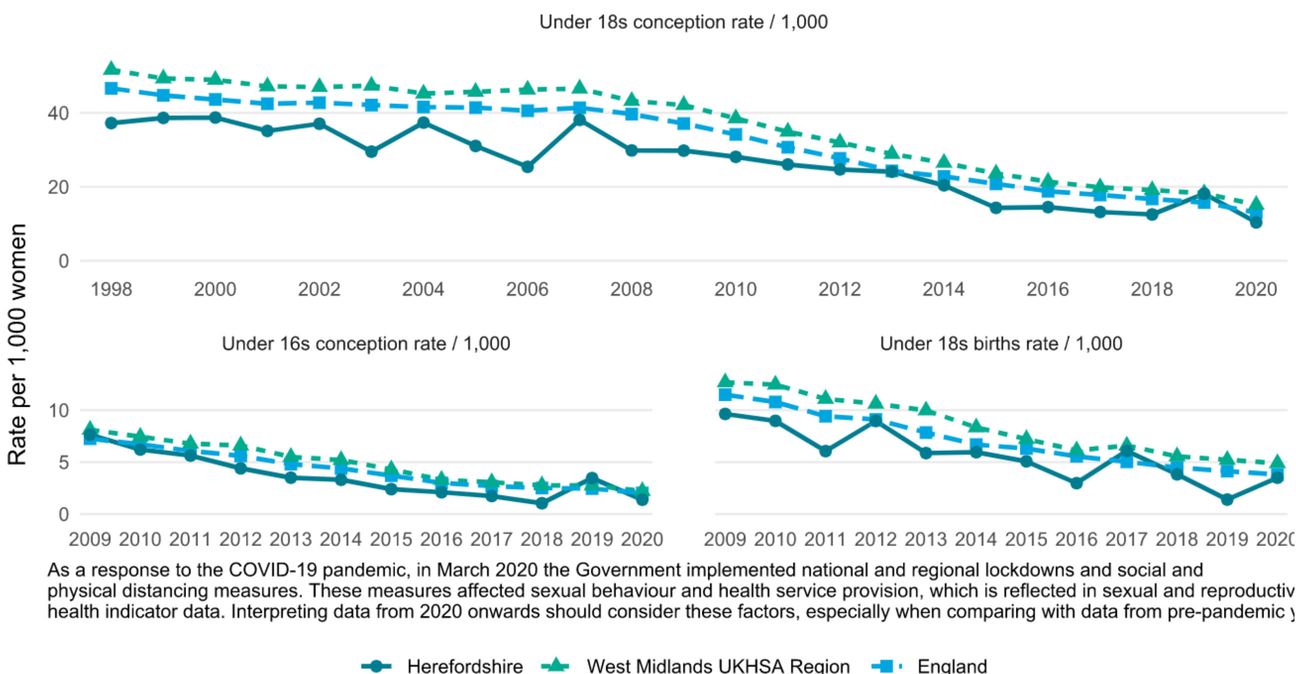
Chart showing under-18s conception indicators in Herefordshire compared to the rest of England

Compared to England:
Better, Similar, Worse *or* Lower, Similar, Higher *or* Not compared

Indicator names	Period	LA count	LA value	England value	England lowest/worst		England highest/best
Under 18s conception rate / 1,000	2020	30	10.4	13.0	30.4		2.7
Under 16s conception rate / 1,000	2020	4	1.4	2.0	5.7		0.5
Under 18s births rate / 1,000	2020	10	3.5	3.8	12.8		0.0
Teenage mothers	2020/21	10	0.7	0.6	1.8		0.0
Under 18s conceptions leading to abortion (%)	2020	20	66.7	53.0	24.3		82.9

Source: UK Health Security Agency (2023), SPLASH Herefordshire 2023-02-01 (phe.org.uk)

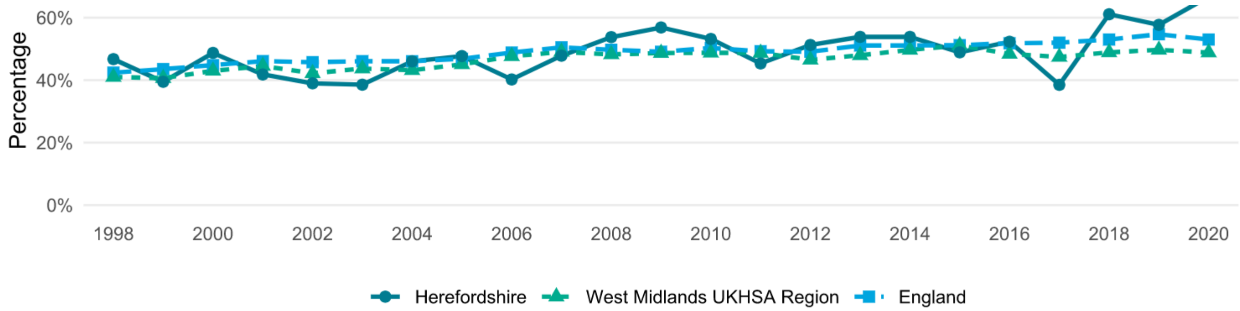
Comparison of rates of under-18s conception and births in Herefordshire, the West Midlands UKHSA Centre and England over time (1998 to 2020)



Source: UK Health Security Agency (2023), SPLASH Herefordshire 2023-02-01 (phe.org.uk)

The graph above indicates that bot h the under 18s and under 16s conception rates have both decreased in Herefordshire from 2019 to 2020. However, the graph below shows that the percentage of under-18 conceptions leading to abortion has increased within this time period to 66.7% and is markedly different from the national and regional picture.

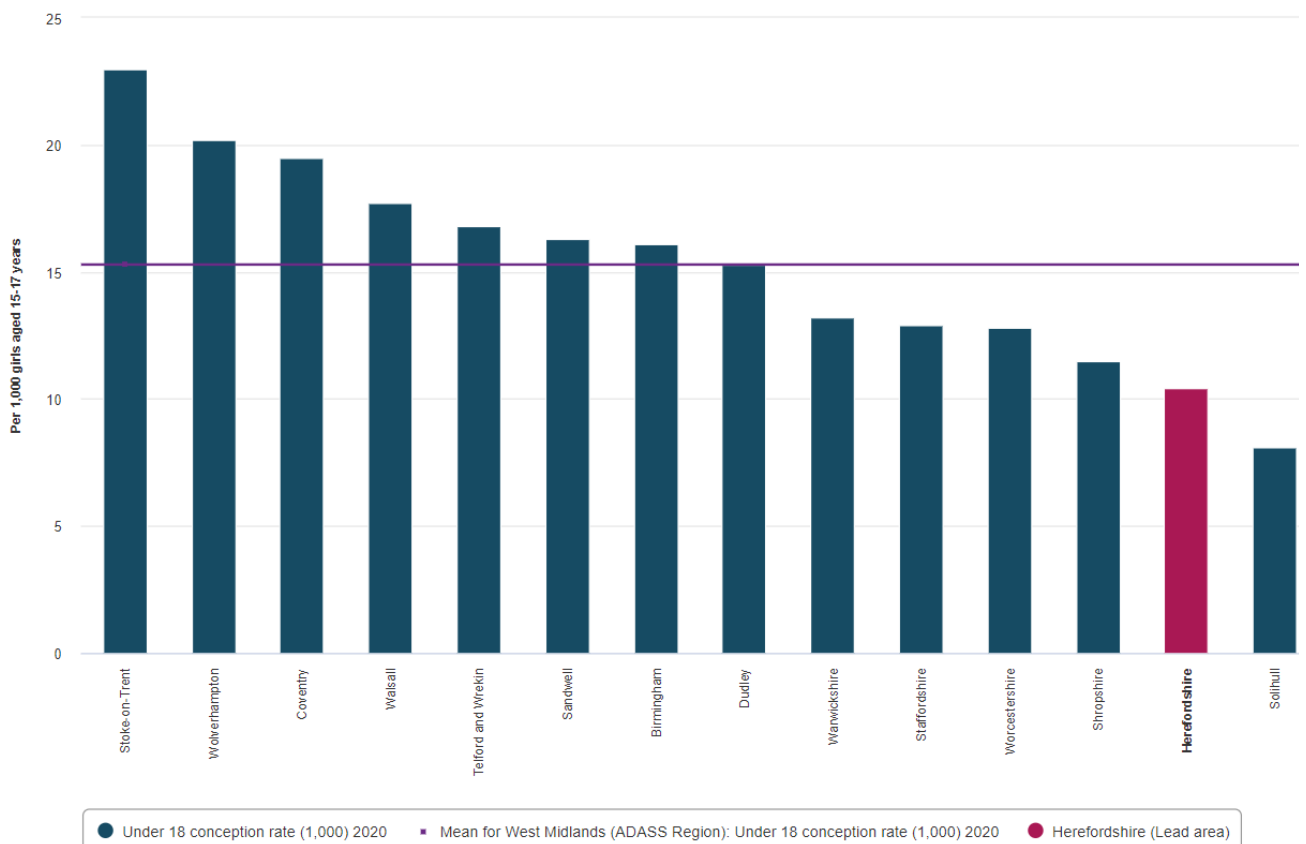
Percentage of under-18 conceptions leading to abortion, over time in Herefordshire compared to the West Midlands UKHSA Region and England: 1998 to 2020



Source: UK Health Security Agency (2023), SPLASH Herefordshire 2023-02-01 (phe.org.uk)

The bar graph below compares Herefordshire's under-18 conception rate per 1,000 women to other areas within the West Midlands region. Herefordshire are below the West Midlands Region average (indicated by the purple horizontal line).

Under-18 conception rate per 1,000 women for West Midlands ADASS Region, 2020



Source: LG Inform (Accessed 2023), Conception rate per 1,000 women at ages under 18 in Herefordshire

ABORTION RATES

Within Herefordshire, there is a lower than national average total abortion rate per 1,000 female aged 15 to 44 years old (16.2 to 19.2, respectively). However, this has been increasing from 2019 to 2021. This increasing trend is also seen in other measures included in the table below such as over 25s abortion rate and under 25s repeat abortion (the % of abortions in women aged under 25 years that involve a women who has had a previous abortion in any year). Conversely, under 18 year old abortion rates have been decreasing locally.

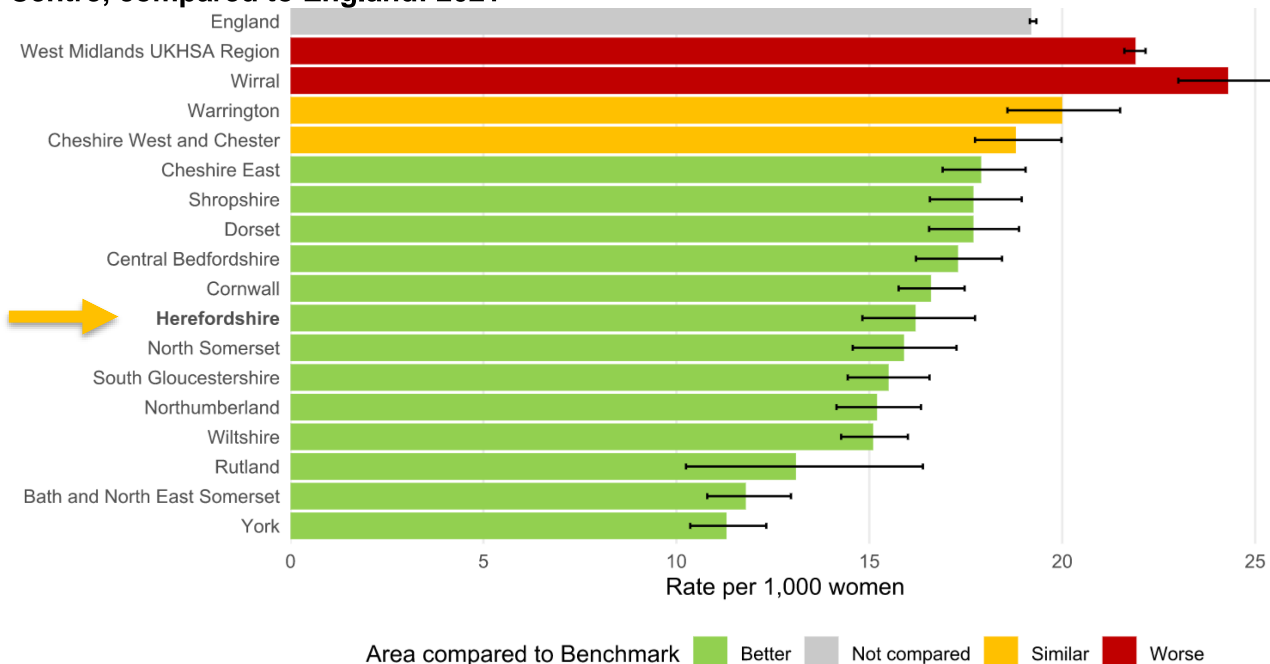
	Herefordshire 2019	Herefordshire 2020	Herefordshire 2021	England 2021
Total abortion rate/1,000	13.7	15.6	16.2	19.2
Under 18s abortions rate/1,000	9.1	7.6	6.6	6.5
Over 25s abortion rate/1,000	10.9	13.6	14.3	17.9
Under 25s repeat abortions (%)	19.9	25.7	29.9	29.7
Under 25s abortion after a birth (%)	22.7	25.7	32.1	26.0

Data Source: UK Health Security Agency (2022; 2023), SPLASH Herefordshire 2022-01-27 and SPLASH Herefordshire 2023-02-01 (phe.org.uk)

This total increase in abortion rates may be a result of the restricted access to effective contraceptive services during the COVID-19 pandemic.

The graph below indicates that despite this increase, Herefordshire still has a lower abortion rate than the West Midlands and national average.

Abortion rate per 1,000 women in 16 similar local authorities and West Midlands UKHSA Centre, compared to England: 2021



Source: UK Health Security Agency (2023), SPLASH Herefordshire 2023-02-01 (phe.org.uk)

Should an abortion be chosen, earlier provision helps to lower the risk of complications. In Herefordshire, the percentage of NHS-funded abortions that were under 10 weeks was 87.1% in 2021, similar to the percentage in England of 88.6% and a 2.4% increase from 2020 (when it was 85.1% of abortions)[59].

CONTRACEPTION

Comparison of key contraception indicators in Herefordshire to the rest of England, 2020

Indicator	Period	Herefordshire (change from 2019)	England
GP prescribed LARC (excl. injections) rate / 1,000	2020	27.1 (↓)	21.1
Total prescribed LARC (excl. injections) rate / 1,000	2020	40.7 (↓)	34.6
SRH services prescribed LARC (excl. injections) rate/ 1,000	2020	13.6 (↑)	13.4
Women choosing injections at SRH services (%)	2020	3.5% (↓)	8.1%
Women choosing hormonal short-acting contraceptives at SRH services (%)	2020	23.4% (↓)	41.7%
Under 25s choosing LARCs (excl. injections) at SRH services (%)	2020	45.2% (↑)	28.8%
Over 25s choosing LARCs (excl. injections) at SRH services (%)	2020	62.9% (↑)	43.5%
Under 25s individuals attending specialist contraceptive services rate / 1,000 - females	2020	46.7 (↓)	97.6
Under 25s individuals attending specialist contraceptive services rate / 1,000 - males	2020	2.7 (↓)	13.0

Data Source: UK Health Security Agency (2023), SPLASH Herefordshire 2023-02-01 (phe.org.uk)

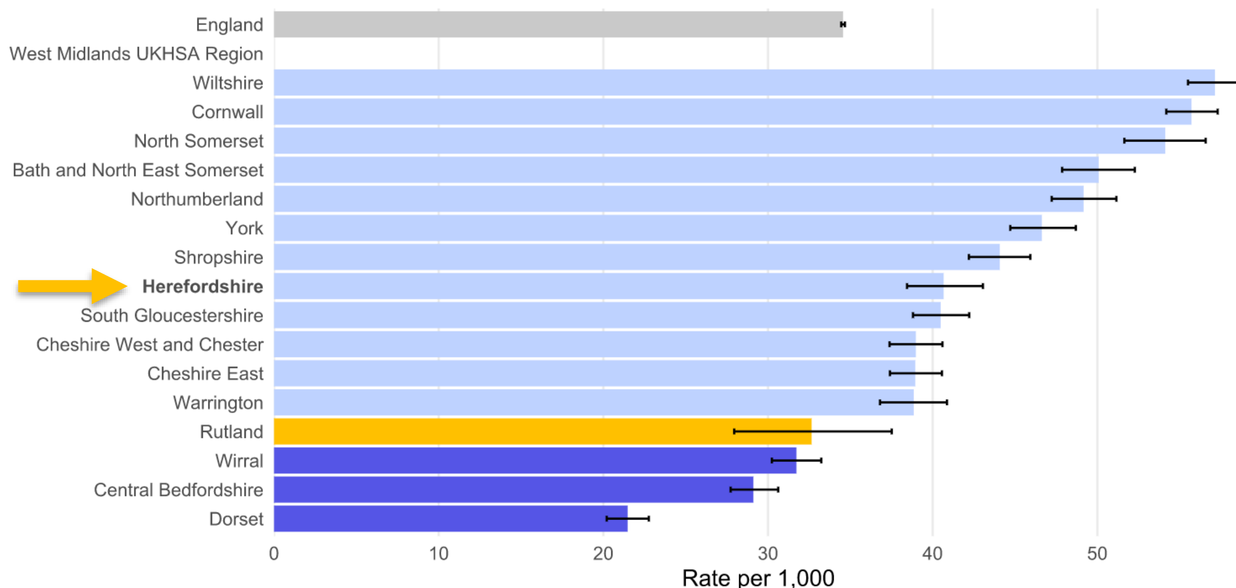
The most recent data available for contraceptive outcomes are from 2020. Whilst there are a higher proportion of individuals that are opting for long-acting reversible contraceptives (LARC), Herefordshire are under-performing in other indicators such as the rate of under 25 year olds attending specialist contraceptive services (which has declined from 2019).

The two largest relative decreases from 2019 to 2020 were GP prescribed LARC rate per 1,000 (excluding injections) which almost halved (from 53.1 to 27.1) and in women choosing injection contraceptives at SRH services (from 6.4% to 3.5% - a 45% relative reduction).

Conversely, SRH services LARC prescribing rate (excluding injections) per 1,000 increased from 10.6 to 13.6 (28% relative increase) and both the rate of under and over 25 year olds choosing long-acting reversible contraceptives (LARC) – excluding injections – were becoming increasingly popular (9.2% and 4.8% relative increase, respectively).

[59] UK Health Security Agency (2023), SPLASH Herefordshire 2023-02-01 (phe.org.uk)

Total rate of LARC (excluding injections) prescribed in primary care and in SRH services per 1,000 women aged 15 to 44 years in 16 similar local authorities and the West Midlands UKHSA Region, compared to England: 2020



Source: UK Health Security Agency (2023), SPLASH Herefordshire 2023-02-01 (phe.org.uk)

The graph above shows that Herefordshire have a higher LARC prescribing rate per 1,000 women than the national average (40.7 per 1,000 women aged 15 to 44 years compared to 34.6 per 1,000).

LARC DATA

Sexual health service

The table below displays the LARC activity that took place within Solutions4Health in 2021/22.

Sexual health service LARC activity level in 2021/22

LARC Activity	21/22
Number of Contraception prescribed - overall total	998
Number of LARCS prescribed - overall total	693
Number of coils fitted and removed	555
Number of contraceptive implants fitted and removed	629

Data source: Solutions4Health

This can be compared to the general practice LARC data below.

General Practice

The GP data (below) shows a large reduction in LARC activity within general practice between 2019/20 and 2020/21. This is mainly attributed to the COVID-19 pandemic but, according to stakeholder activities (as seen in the Stakeholder engagement section), may have been compounded by several local practitioners who were trained in LARC provision retiring and a GP system that is 'under immense pressure'.

GP LARC activity level from 2019/20 to 2021/22

GP LARC Activity	19/20	20/21	21/22
Implant Insertion	642	212	495
Implant Removal	613	238	472
Coil Insertion	559	200	389
Coil Removal	475	176	334
Total LARC Activity	2289	826	1690

Data Source: Taurus GP LARC Activity Data provided to Solutions 4 Health

On comparing the LARC activity of 2021/22 between the two services, general practices account for 57% of coil activity (fitting and removal) and 61% of implant activity (fitting and removal).

Comparison of LARC activity in 2021/22 between the sexual health service and general practices

LARC Activity 2021/22	Sexual health service	GP
Number of coils fitted and removed	555	723
Number of contraceptive implants fitted and removed	629	967

HPV VACCINATION UPTAKE

Within Herefordshire in 2020/21, 90.7% and 92.7% of male and female 12 to 13 year old children (respectively) have had one dose of HPV vaccination. 86.3% of 13 to 14 year old females had completed two doses of the vaccine. These proportions are all higher than the national averages and place Herefordshire highly when compared to other local areas within the West Midlands region.

HPV vaccination coverage in 2020/21

Indicator	Period	England	West Midlands region	Birmingham	Coventry	Dudley	Herefordshire	Sandwell	Shropshire	Solihull	Staffordshire	Stoke-on-Trent	Telford and Wrekin	Walsall	Warwickshire	Wolverhampton	Worcestershire
Population vaccination coverage: HPV vaccination coverage for one dose (12 to 13 year old) (Male) <80% 80% to 90% ≥90%	2020/21	71.0	69.8	63.0	75.9	85.0	90.7	63.0	65.9	81.5	61.9	50.1	63.0	65.3	74.2	66.6	88.3
Population vaccination coverage: HPV vaccination coverage for one dose (12 to 13 year old) (Female) <80% 80% to 90% ≥90%	2020/21	76.7	76.4	71.6	78.6	91.4	92.7	73.1	74.3	92.6	67.4	61.8	71.4	73.4	77.3	73.6	92.5
Population vaccination coverage: HPV vaccination coverage for two doses (13 to 14 years old) (Female) <80% 80% to 90% ≥90%	2020/21	60.6	61.0	44.6	36.2	86.4	86.3	31.3	71.7	46.1	77.4	74.2	82.6	74.1	48.4	71.3	75.0

Source: Office for Health Improvement & Disparities, Public health profiles

CERVICAL SCREENING

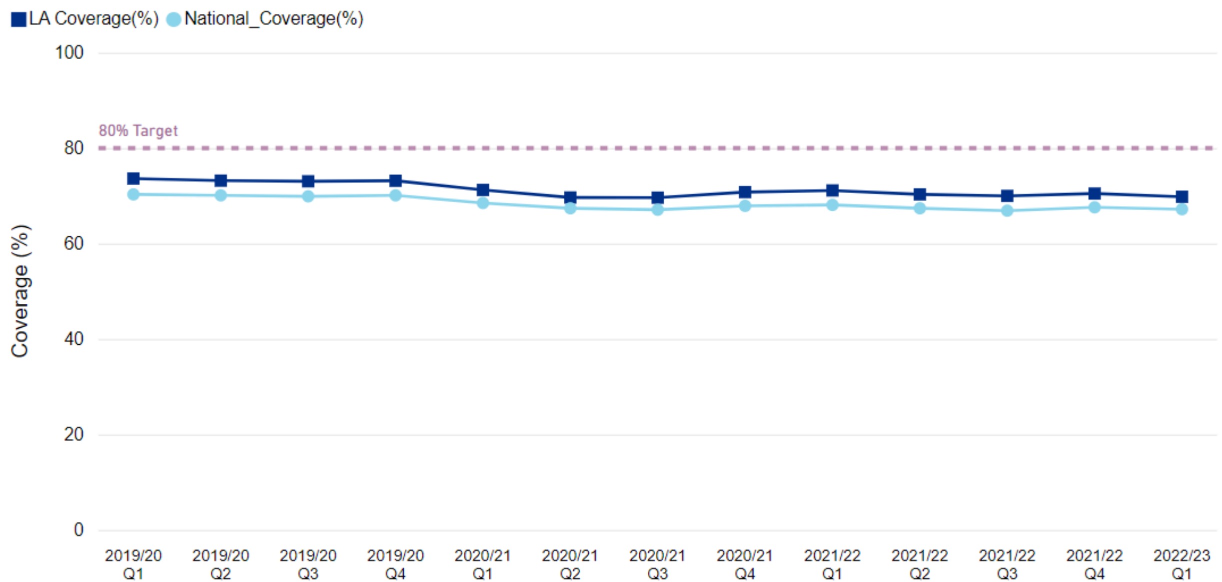
Cervical screening is available in England to all women and transgender men assigned female at birth aged 25 to 64 years. Invitations are sent automatically to those registered to a GP as female within this age range but transgender men (assigned female at birth), although entitled to screening, will not automatically receive invitations if registered as male with their GP.

The screening requires a cervical smear test that is tested for the HPV – the most common cause of pre-cancerous and cancerous cells in the cervix. Therefore, this can be seen as a secondary prevention intervention, identifying pre-symptomatic disease, compared to HPV vaccination that is primary prevention, aiming to prevent the disease from developing in the first place.

Within Q1 of 2022/23, Herefordshire have screened 69.8% of eligible 25-49 year olds and 75.6% of 50-64 year olds[60]. Whilst these are relatively consistent proportions over the last two years, they both remain below the 80% national targets.

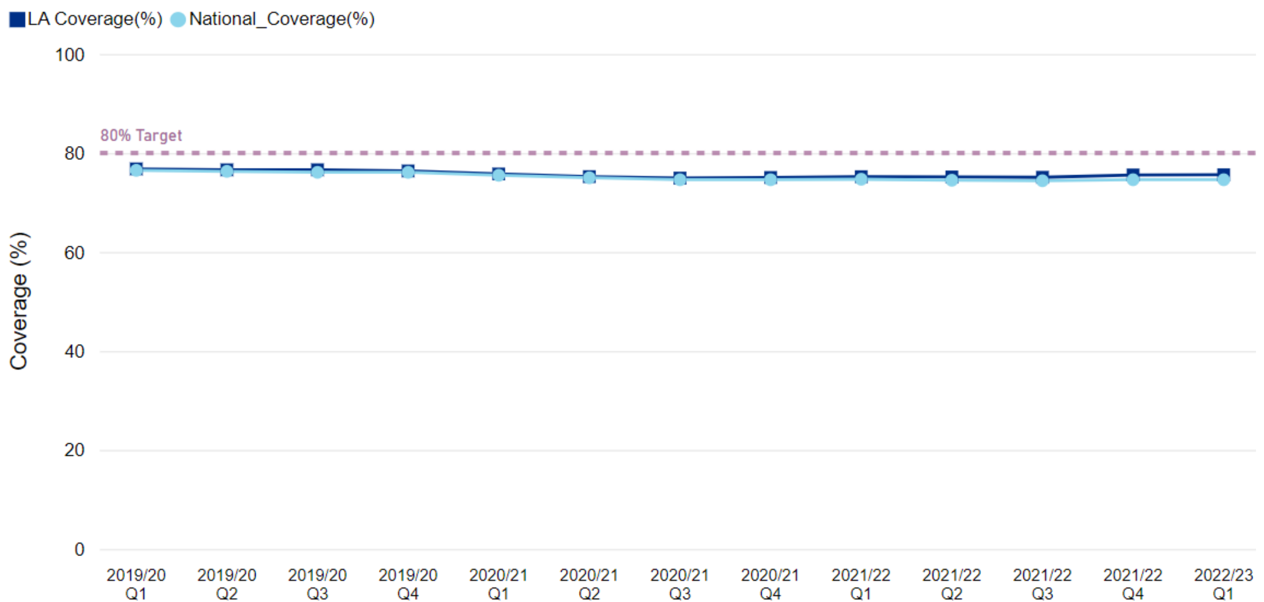
[60] NHS Digital (2023), Cervical Screening Programme - Coverage Statistics

Herefordshire and national cervical screening coverage by quarter for 25-49 year old population



Source: NHS Digital (2023) Cervical screening interactive resource for local authorities

Herefordshire and national cervical screening coverage by quarter for 50-64 year old population



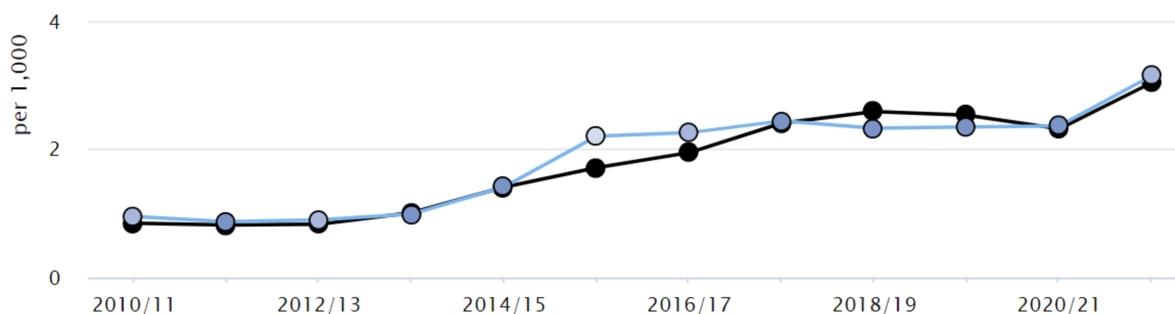
Source: NHS Digital (2023) Cervical screening interactive resource for local authorities

VIOLENT CRIME

Based on police recorded crime data, Herefordshire's rate of sexual offences per 1,000 population in 2021/22 is 3.1 (blue dots in the diagram below). This is between the national average of 3.0 per 1,000 and the West Midlands region average of 3.2 per 1,000.

This follows the national trend (black dots in the diagram below) of an increasing rate of sexual offences since 2010/11 with a noticeably large increase within the last year.

Trend of sexual offences per 1,000 population in Herefordshire and England from 2010/11 to 2020/21



Source: Office for Health Improvement and Disparities, Sexual and Reproductive Health Profiles

SEXUAL HEALTH SERVICE OUTCOME DATA

Solutions4Health services outcome data for 2021/22 is presented below for the 5224 attendances were noted in the service over this 12 month period.

Gender

Whilst Herefordshire have a slightly higher proportion of women to men (ratio of 100:97[61]), this does not account for the large difference in attendances between genders with 65% of attendances by females.

[61] Herefordshire Council (2022), 2021 Census population and household estimates

Age

Attendances to Solutions4Health Sexual Health services by age in Herefordshire for 2021/22

Age range (yrs)	Number of attendees	Proportion of attendees
<15	50	1%
15-19	846	16%
20-24	1079	21%
25-34	1593	30%
35-44	861	16%
45+	795	15%

Data source: Solutions4Health Data

The table above shows that the highest proportion of attendances in 2021/22 were for individuals aged 25 to 34 years old followed by 20-24 years old. Whilst these proportions do not reflect that of the general Herefordshire population, it is encouraging that there are disproportionately high numbers of attendees in higher risk age categories (those aged 15 to 24 years old).

Sexual orientation

83% of attendances were for individuals who reported that they were heterosexual, 9.5% gay or lesbian and 5.8% as bi-sexual. This data can be compared to the sexual orientation results of the 2021 Census to indicate that individuals from the LGBTQIA+ population are more likely to attend the service than those who identify as heterosexual. However, it must also be noted that disclosure of this information is optional in both the Census and within the service and therefore these results may not accurately represent the whole population responding.

Attendances to Solutions4Health Sexual Health services by sexual orientation in Herefordshire for 2021/22

Sexual orientation	Herefordshire (%)	England (%)
Straight or heterosexual	89.70	89.37
Gay or lesbian	1.04	1.54
Bisexual	0.90	1.29
Pansexual	0.16	0.23
Asexual	0.04	0.06
Queer	0.01	0.03
Another sexual orientation	0.02	0.02
Not answered	8.12	7.46

Data source: Solutions4Health Data

Cross-border attendances

331 of the 5224 attendances to the services were cross-border attendees from Wales. This equates to 6.34% of attendances in the year 2021/22.

Referral method

Of those attendances that have a referral method recorded, 79% in 2021/22 were self-referrals, 19% GP referrals and 1% contact advice. The remaining referrals, which were each less than 1% of the total, were recorded as being from specialist services for victim survivors of sexual assault and violence or from hospital.

FEMALES USING SHS BY AGE GROUP

NHS digital provide data on the proportion of females that use Sexual and Reproductive Health services by area and age group, as noted in the table below.

Females using Sexual and Reproductive Health Services by age group, 2021/22

	Percent of resident population that attend Sexual and Reproductive Health Services 2021/22							
	Total (13-54)	**13-15**	**16-17**	**18-19**	**20-24**	**25-34**	**35-44**	**45-54**
England (%)	4	2	6	9	9	6	3	1
West Midlands region (%)	3	1	4	5	5	4	2	1
Herefordshire (%)	3	2	6	8	6	3	2	1

Data source: NHS Digital (2022), Statistics on Sexual and Reproductive Health Services (Contraception)

This data indicates that Herefordshire have a similar proportion of attendees to their services than national averages except for the age groups of 20-24 and 25-34 for which they are below national averages by 3%. Enabling as many of the local population to attend the SRH as possible is important in ensuring good sexual health outcomes with particular consideration to those that may be at higher risk of poor outcomes (e.g. 15 to 24 year olds).

ONLINE TESTING SERVICE – PREVENTX

TEST ORDER AND RETURN RATE

Approximately two thirds of test orders in Q2 of 2022/23 were made by females and over 80% were for individuals who identified as heterosexual (WSM and MSW). MSM, the next most frequent population for ordering tests, accounted for approximately 5% of orders.

Within this time period, 78.4% of ordered tests were returned to the service for testing. Those in the age category of 55 years + were most likely to return their test (94.1%) and the youngest age category, 16-17 years, were the least likely (55.6%).

CHLAMYDIA POSITIVITY RATES

Despite being less likely to order tests, males had a higher chlamydia positivity rate at 9.3% compared to 5.5% in females from April-September 2022.

When accounted for sexual preferences, the top three chlamydia positivity rates were:

- MSW at 9.7%
- MSM at 8.7%
- WSM at 5.7%

With regards to age groups, 16-17 year olds had the highest positivity rate at 29.4% followed by 18-21 year olds (10.4%) and 22-24 year olds (9.7%). All other age ranges had a positivity rate of below 5%.

Whilst there was no clear association between deprivation and chlamydia positivity rates, decile one (the most deprived) had the highest rate of positive tests at 14.3% followed by decile three and eight. Decile 10 (the least deprived) was the fourth highest positivity rate at 8.3%.

KEY PERFORMANCE INDICATORS FOR ONLINE SERVICES 2022/23

The table below compares the results of the key performance indicators for Q1 and Q2 in 2022/23 to the stated thresholds. There is one occasion within which the threshold has been exceeded (highlighted in yellow) – '% of specimens not processed by the lab due to sampling error' in Q1.

Results of Key performance indicators used by online service 'PreventX'

Key Performance Indicator	Q1 Result (%)	Q2 Result (%)	Threshold (%)
Users Reporting Positive Experience 4 or More Stars	93.7	97	90
Kits dispatched Within 2 Days of Order	99.6	100	95
Kits Returned to Lab within 30 days of Request	76.2	74	60
% of specimens not processed by the lab due to sampling error	12.3	1.5	10
Sexual Health Signposting	100	100	100
Negative Results Communicated within 5 Working days of Receiving Sample	100	100	100
Kits Processed Within 5 Days of Receipt	100	100	95
Results Reported Within 4 Working Days of Receiving Sample	100	99.9	95
Equivocal Results	0.2	0.9	5
Invalid Samples - We don't Report Inhibitory	0.0	0.0	3
Positive Results Reported Within 1 Working Days of Completed Test	100	100	95
Negative Results Reported Within 1 Working Days of Completed Test	100	100	95

Data source: Preventx, Online Testing Dashboard for Solutions4Health

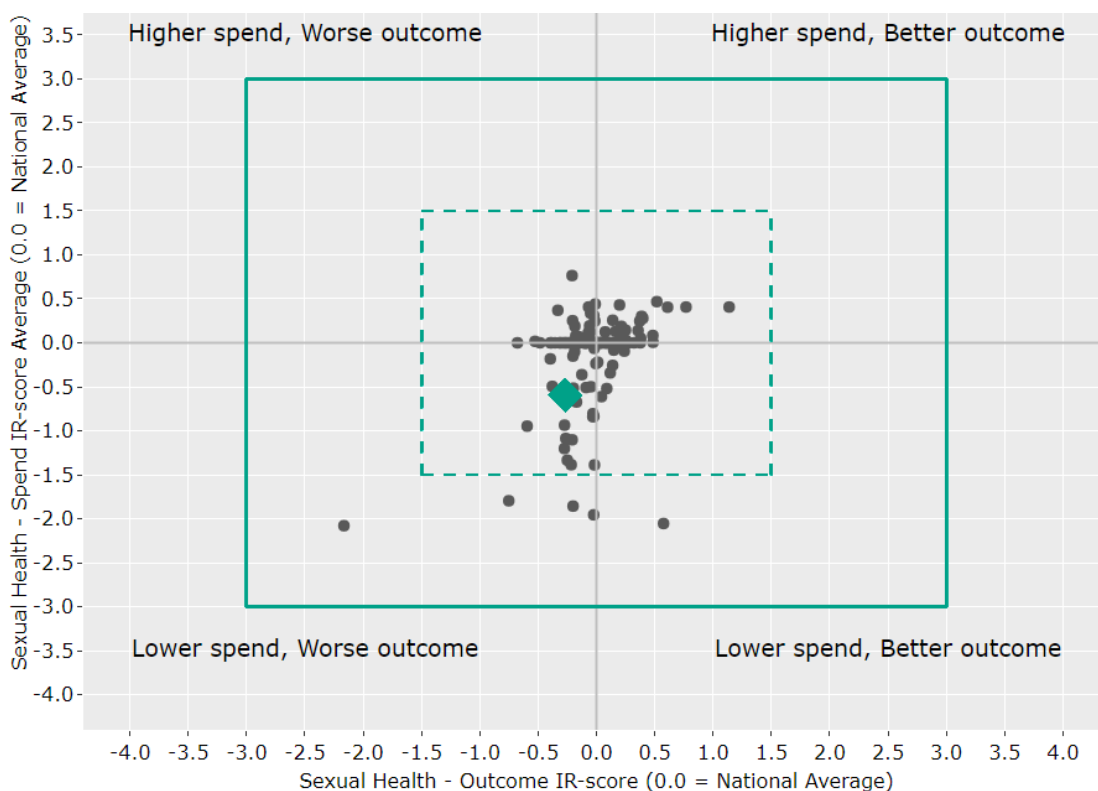
6.0 SPEND AND OUTCOMES TOOL

The figure below compares the spend and outcomes of sexual health services within Herefordshire to national data. Any points outside of the dotted green box can be assumed to be 'outliers'. The green diamond in the bottom left quadrant represents Herefordshire. This positioning indicates a lower than national-average spend with worse than national-average outcomes for its sexual health service.

According to the 2017 Public Health England Guidelines[62], improvements within the service can be made by considering

- Increasing investment in this area for example through training, resources, access to services and health promotion
- Target the most at need or vulnerable
- Support those affected by the below average outcome for example if your rates of teenage pregnancy are high improve local support services

Spend and Outcomes Tool 2019/20 data



Source: Office for Health Improvement and Disparities, Spend and Outcomes Tool

[62] Public Health England (2017) Practical Guidance to SPOT for Improving Sexual and Reproductive Health

7.0 STAKEHOLDER ENGAGEMENT

For this needs assessment, multiple methods of engagement were used to explore the perspectives of key individuals. This included online meetings with various stakeholders such as primary and secondary care colleagues, conducting interviews at the young-persons drop in clinic at the sexual health service and a survey for the local population that gathered 92 responses. Further details about each of these activities and a more detailed analysis of each one is included within the appendix along with previous Healthwatch engagement activity results for comparison.

The key, consistent emergent themes from these activities are described within this section below.

Prevention and education

The need for earlier prevention and education work with a consistent offering to all the young population was noted during these sessions using multiple settings including education.

Access to services

Whilst it was noted that the main SHS hub is central and easy to find, it was also noted that certain communities may find accessing the service more difficult if they do not have access to private transport. Furthermore, the timings of the young person clinic was well received by the individuals who had attended that clinic but these were noted by other stakeholders to be unsuitable for all students.

Collaborative working

Multi-agency working with good communication was seen as vital in improving the sexual health of the local population. Further consideration into how services can effectively work together to meet the needs of the local population is needed with one practitioner noting that there should be 'no wrong door'. However, it is also acknowledged that there are resource barriers to be overcome to facilitate this including funding and timing.

Service experience

The majority of comments from the range of methods of engagement reported positive experiences of the local SHS. 'Safe' and 'comfortable' were adjectives used to describe the service in both the interviews with the young people in clinic and the survey of the local population.

8.0 EVIDENCE BASE AND BEST PRACTICE GUIDELINES

The Government set out ambitions for improving the sexual health of the national population in the report: A Framework for Sexual Health Improvement in England[63] in 2013 and it is yet to be updated. This report notes that sexual health should be considered across the life course with services that are evidence-based with collaborative working at local level.

National Guidance

Public Health England's report 'What Good Sexual Health, Reproductive Health and HIV Provision Looks Like'[64] states that services should have successful system leadership, build individual and community resilience, promote safe and effective practice whilst putting patient experience at their centre.

Some of the proposed key features of what this may include are listed below:

- Work together across organisational boundaries to develop and support consistent and coherent services and pathways in response to population need
- Support the delivery high quality relationships and sex education in schools, or other education
- or young peoples' settings, in line with current legislation to support young people to make
- informed choices
- Developed on evidence-based guidance that recognises the three key areas of safety, effectiveness and patient experience
- Maintain a focus on primary prevention including the use of condoms and effective contraception and the delivery of vaccinations (including HPV and Hepatitis B as indicated)
- Ensure new areas of innovation are identified, implemented where appropriate and evaluated
- Offer appropriate digital technologies to support access to services and information
- Implement evidence-based interventions and new models of service delivery which are flexed to meet the needs of key groups

Education settings

The UK Department of Health state that 'all schools delivering sex and relationship education are required to ensure that their pupils receive high-quality information on the importance of good sexual health'[63].

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[63] Department of Health (2013) A Framework for Sexual Health Improvement in England

[64] Public Health England (2019) What Good Sexual Health, Reproductive Health and HIV Provision Looks Like

Statutory guidance for schools, published by the Department for Education (2021)[65] details the requirements of Relationships Education in all primary schools in England, Relationships and Sex Education compulsory in all secondary schools, as well as making Health Education compulsory in all state-funded schools.

This provides a basis for the Department of Health's ambition[63] to 'build knowledge and resilience among young people'. Within their report, it is stated that all children and young people should receive good-quality sex and relationship education at home, school and within their community. This should provide them with the knowledge and tools to know where and how to ask for help and advice, to understand consent and the benefits of delaying sexual contact.

International evidence shows that young people who have received good-quality relationships and sex education are at lower-risk of STIs and unplanned pregnancy and are more likely to delay having sex until they are older[66,67].

Making Every Contact Count

The OHID report 'Sexual and reproductive health and HIV: applying All Our Health'[68] promotes the use of the initiative Making Every Contact Count (MECC). This requires frontline health and care professionals to provide consistent and concise health and wellbeing information, which can include sexual and reproductive health, in different health and non-health settings – using this as an 'opportunistic moment'.

National Guidelines

The National Institute for Health and Care Excellence (NICE) is a national governmental body that produce evidence-based recommendations and guidelines for health and social care topics.

NICE guideline 221[69] – 'Reducing sexually transmitted infections' - includes recommendations on how to prevent STIs in people after 16 and over. Some of these are included below:

- Reduce barriers to services for groups with greater sexual health or access needs
    - emphasise confidentiality
    - offer personal translator or interpreter
    - providing outreach activities
- Delivering and evaluating interventions to reduce STI transmission

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[65] Department for Education (2021) Relationships Education, Relationships and Sex Education (RSE) and Health Education

[66] Public Health England (2019) Health matters: preventing STIs

[67] LGA and sex education forum (2017) Relationships and Sex Education

[68] Office for Health Improvement & Disparities (2022) Sexual and reproductive health and HIV: applying All Our Health

[69] NICE (2022) NICE Guidelines 221: Reducing sexually transmitted infections

- Deliver interventions to reduce STIs across a range of services, including within broader support interventions and community services (for example, in drug and alcohol services, abortion care services, HIV care and mental health services).
- Improving uptake and increasing the frequency of STI testing
    - Offer a range of STI testing options based on local need – include self-sampling, specialist clinics, community pharmacies, primary care and outreach services
    - Monitor the provision and return rates of kits to identify any groups that have low rates of accessing or returning them. Take action to try to address the reasons for the low rates

NICE guideline 60[70] provides recommendations on how to increase the uptake of HIV testing in health settings and in the community. Some of the recommendations have been included below:

- Offer and recommend an HIV test to everyone who attends for testing or treatment
- Ensure that people who decline or are unable to consent to a test are offered information about other local testing services, including self-sampling.
- Provide promotional material tailored to the needs of local communities.
- Promote HIV testing when delivering sexual health promotion and HIV prevention interventions. This can be carried out in person (using printed publications such as leaflets, booklets and posters) or through electronic media.
- Use or modify existing resources, for example TV screens in GP surgeries, to help raise awareness of where HIV testing (including self-sampling) is available
- Consider a range of approaches to promote HIV testing, including:
    - Local media campaigns
    - Digital media, such as educational videos
    - Social media, such as online social networking, dating and geospatial apps
    - Printed materials, such as information leaflets.

Outreach work

In this instance, outreach refers to the provision of health and social care within local community settings – outside of the clinical setting. This can be an effective way to access ‘hard to reach’ groups.

NICE guideline 51[71] (‘Contraceptive services for under 25s’) recommends the provision of ‘outreach contraceptive services that offer information, advice, and the full range of options’. Furthermore, it notes that this should include the provision of these services for those who live in rural areas and cannot reach existing clinics and services.

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[70] NICE (2016) NICE Guidelines 60: HIV testing: increasing uptake among people who may have undiagnosed HIV

[71] NICE (2014) Public health guideline PH51: Contraceptive services for under 25s

This recommendation is based on moderate-strength evidence that outreach programmes that encourage young people to attend mainstream sexual health services may be effective in increasing service user, increase consistent condom use and reduce unintended pregnancies.

9.0 RECOMMENDATIONS

Improving the sexual health of a population requires a system-wide approach with consideration of the three levels of prevention:

Primary prevention: Universal activities that aim to reduce the incidence of an illness – this may include educational interventions on safe sexual practices

Secondary prevention: Targeted activities that aim to detect and treat pre-symptomatic disease – this may be achieved by ensuring local populations can attend regular sexual health screenings with effective partner notification systems.

Tertiary prevention: Reducing the impact of a disease including the prevention of complications – for example, the prevention of pelvic inflammatory disease by prompt treatment of infection

PRIMARY PREVENTION

- Strengthen the current educational offer of primary prevention to local schools and colleges, including staff, to ensure there is a consistent high standard of awareness of safe sexual practices, healthy relationships and contraception

- Review LARC training offer to healthcare professionals within the Herefordshire to promote uptake and increase provision

- Ensure key messages about the service and safe sexual practices are disseminated through community asset-based services such as TalkCommunity

- Empowering front-line healthcare staff to feel comfortable and equipped to provide opportunistic sexual health advice as part of the 'Making Every Contact Count' initiative

SECONDARY AND TERTIARY PREVENTION

- Ensure equitable access to sexual health services, including LARC provision, within the local population. This should consider those at highest risk of facing barriers of access and those who have been identified as having low attendances in this needs assessment – including the young population, men and the rurally dispersed. This is likely to require a system-wide approach with initiatives such as:
    - Encourage local health promotion services to signpost individuals to other appropriate services for health behaviour advice and support.
    - Consider the possibility of sharing outreach hubs, mobile services and attendance at local events with other services
    - Promote the availability of sexual health advice and services within other healthcare settings such as pharmacies
    - Explore the opportunities for increasing the provision of coils for all indications (i.e. not only contraceptive purposes)

- Ensure all populations that are at risk of poor sexual health outcomes are captured on the demographics recorded by the sexual health service – this should consider the

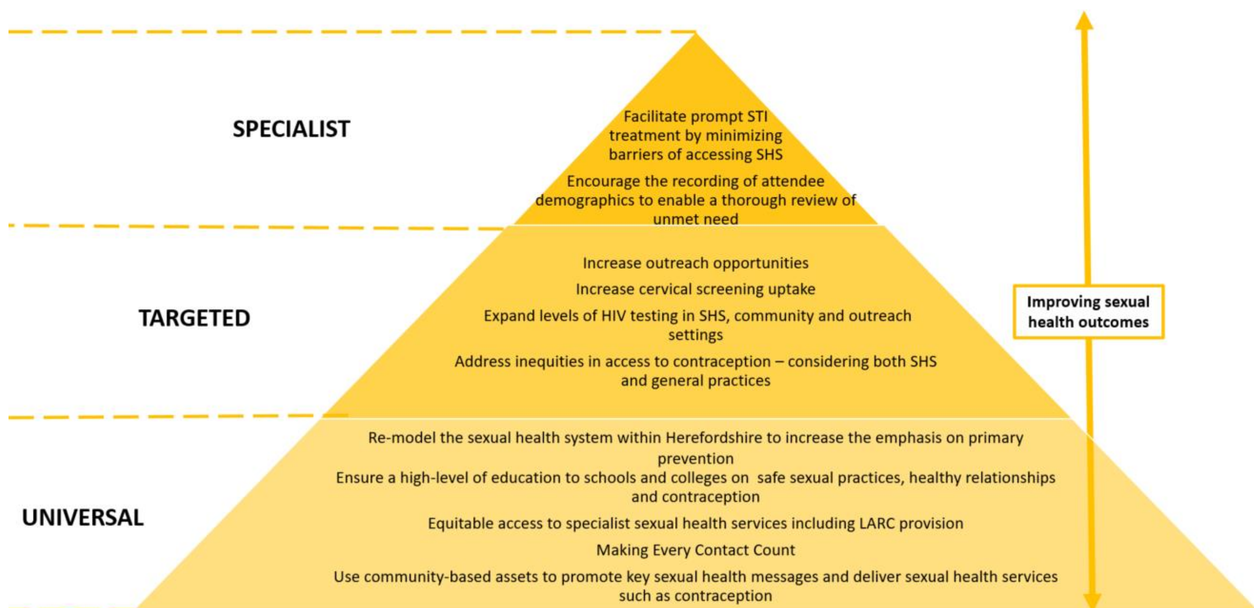
introduction of recording of disability status and ethnicity of individuals attending the service

- Increase cervical screening uptake to meet than national target of 80% of the eligible population
    - Explore possible options for opportunistic cervical screening within the SHS

- Determine how to increase HIV testing uptake and reduce late HIV diagnoses within local health services including the sexual health service. This should include co-production with the relevant populations.

- Review the current online testing offer to improve uptake in number of kits order and in the return rates of kits

- Regular attendance of key stakeholders at the quarterly Sexual Health forum to enable collaborative working



10.0 APPENDIX

NEEDS ASSESSMENT ENGAGEMENT ACTIVITES

SPECIALIST COMMUNITY PUBLIC HEALTH NURSES

An online meeting with two Specialist Community Public Health Nurses ('school nurses') who work within schools and colleges within Herefordshire took place in December 2022. These professionals have a great insight into the experiences and perspectives of the young population within Herefordshire and are key to 'primary prevention' aspect of sexual health.

Prevention work: This meeting with the nurses made it apparent that whilst PSHE is compulsory, how it is delivered can vary substantially between schools with some schools delivering the content themselves whilst others ask for specific teachings by the nurses. There was a mutual agreement between the nurses that much of the sexual health information that those under 18 years old could access from the internet can facilitate unrealistic expectations and inaccurate knowledge.

The nurses provide 'drop-in' days at schools and colleges that students can attend or, if required, they may also pro-actively contact the nurses on other days. During COVID these sessions had to be changed to appointment-only. This meant the students had to advise the staff at the school of the need to see the nurse and were sometimes required to give a reason for this. The nurses noted that within this time there was a large decrease in the number of sexual health related consultations - they felt the appointment system introduced a barrier to accessing the nurses. Following the easing of lockdown restrictions, drop-in days have now been re-instated and there has been a subsequent increase in consultations regarding sexual health (for example, sexual health education, condom provision, pregnancy testing and facilitating further specialist input).

Access to services: On potential barriers for students to access sexual health services, the nurses had noted students reporting that:

- They were 'scared' to go to the service
- They felt 'embarrassment' and/or 'stigma' attached to attending
- The geographical barrier of the service was described as 'mammoth' with many schools having poor transport links into the service meaning students would need to have transport from their parents - who some did not want to discuss their sexual health with. A 'high level of need' in Leominster was noted.
- Timing – Young person's clinic occurs on a Wednesday afternoon within which some students are meant to be at school and therefore cannot attend

On discussing how the sexual health of the young population within Herefordshire can be improved, the nurses described the following:

- The need for earlier prevention and education work for the young population of Herefordshire
- Access to more readily available data on sexual health within this population
- Tackle the misconception with regards to education encourages earlier sexual engagement and the stigma associated to discussions about sex

- Consider emergency contraception training for public health school nurses – there was an opinion that funding may be the barrier to this but it was noted that it was common practice in other counties.
- Improve access to the service for the young population – considering both geographical and timing barriers.

STAKEHOLDER ENGAGEMENT ONLINE FORUM

An online forum took place in January 2023 for 90 minutes with attendees from a variety of organisations:

- Solutions4Health (service providers)
- Healthwatch
- Children's Centre
- Taurus Healthcare
- Community pharmacy
- Turning Point
- Consultant in sexual health/sexual health consultant
- Specialist Community Public Health Nurses

The session begun with a presentation on some of the key data findings from this needs assessment (including data from Fingertips and the Children and Young Person's Quality of life Survey 2021) followed by a discussion between all meeting attendees.

Access to services: Geographical access inequities, particularly for rural communities, was noted as an issue for the provision of sexual health to the local population. Different initiatives to help reduce these inequities were proposed by members of the meeting:

- It was noted that the sexual health service had begun an outreach opportunity in Leominster before the COVID-19 pandemic prevented this from progressing. However, the service providers noted that on certain days the service tended to have better staffing levels and therefore further outreach opportunities could be explored during this time.
- The school nurses discussed their desire to be able to provide emergency contraception to school and college students. They discussed the barriers to accessing the specialist services as well as the need for timely interventions in these individuals. This was well received by all members of the meeting who felt this would be extremely beneficial for the students and noted that they were 'highly experienced' and 'ideally placed' for this service.
- The sexual health and substance misuse service providers agreed that a 'link role' between the two services may help to improve the reach of services to those at 'highest risk'.
- The community pharmacy representative highlighted a new nationwide voluntary pharmacy service that is initiating in March 2023. This will enable pharmacies to administer certain contraceptives depending on their chosen 'tier' (one to four – which ranges from ongoing monitoring and supply of repeat oral contraceptive prescriptions (tier one) to the initiation of LARCs (tier four)). There is currently no indication as to how many pharmacies within Herefordshire will choose to provide this service but, if enough pharmacies throughout the county do, eventually this may help reduce the geographical inequities of access to long-acting contraceptives.

A second theme from the session was an emphasis on the need for **prevention work**. It was also proposed that widely available cross-organisational training on sexual health (including

contraceptive provision) would be beneficial. This must also take into consideration the 'time pressures' that staff are under and therefore be flexible in its delivery.

Finally, a strong theme from the session was the need for **multi-agency working** with one attendee noting that 'collaboration is key'. Ensuring good communication between the organisations was considered vital and productive discussions regarding the use of 'link' roles between different organisations were proposed to help with this.

GP LEADERSHIP ONLINE FORUM

This engagement activity included only a short slot within Herefordshire's 'GP Leadership Team Meeting'. This is attended by healthcare professionals from primary care. Whilst only lasting 15 minutes, this took the same format as the previous online forum described above with a presentation followed by an open discussion.

Key findings from this brief session are described below:

Geographical access: One general practitioner stated that the sexual health service was an 'incredibly important service to get right' but that could be 'challenging to access'. The particularly noted this was the case for 'young people who don't drive' and would not want to attend their local general practice or pharmacy for sexual health related-matters as these can often be 'people they know' within small rural communities. Instead, they described the importance of a 'discrete service…with excellent transport and availability of appointments'. This was agreed by other attendees with one commenting that 'a large number of our young people are reliant on their parents for transport'.

However, for those who did feel comfortable attending their local pharmacy, it was highlighted that inequities in pharmacy access and dispensing practices may also be of a concern.

Prevention work: An initiative to help reach the young population was suggested by an attendee and well received. This included school promotion activities with promotional posters used that provided the reader with information on the sexual health service, numbers to ring and, ideally, an ability to include a 'texting' service to access.

Multi agency working: The need for 'collaboration' with regards to provision of emergency hormonal contraception was mentioned by one participant. This included non-medical health professionals being able to issue EHC via PGD. One further participant, who had attended the previous forum, re-iterated the idea of enabling school nurses to provide the service.

LARC provision: The provision of coil fitting in the community was discussed by two participants. Firstly, it was recognised that GPs are currently 'under immense pressure' and that coil fitting requires multiple appointment slots – potentially exacerbating the situation. One practitioner also wrote that coil funding was 'currently not cost effective for practices'.

Additionally, the difficulties in the current use of different contract for different coil fitting indications (sexual health or menorrhagia) was raised. It was suggested that there should be a 'no wrong door' policy with regards to individuals trying to access LARC – no matter the indication.

SURVEY

The sexual health survey was open online to all residents of Herefordshire from October 2022 to February 2023 and hard copies were made available within the sexual health service. There were a total of 92 respondents - the majority of these individuals were reported as female, aged 20-44 years old, heterosexual and white British (as noted below).

Demographics of respondents

Gender	Proportion of Respondents
Male	27%
Female	71%
Prefer not to say	2%

Age	Proportion of Respondents
< 15 years	0%
15 – 19 years	13%
20 – 24 years	17%
25 – 34 years	17%
35 – 44 years	20%
45 – 49 years	10%
50 + years	17%
Prefer not to say	5%

Sexual orientation	Proportion of Respondents
Straight/Heterosexual	69%
Gay or Lesbian	7%
Bisexual	10%
Other	3%
Prefer not to say	10%

Ethnic Group	Proportion of Respondents
White British	89%
Other White	3%
Any other ethnic group	0%
Prefer not to say	9%

79% of the respondents had used the Integrated Sexual Health Service at St Owen's Street before.

Service reviews

Do you have problems visiting and accessing the clinic?

- Yes – 24% (n=21)
- No – 76%

There were 21 respondents said that they had problems visiting and accessing the clinic. A total of 24 respondents provided reasons for why they had problems including 3 respondents who previously said that they did not have problems visiting and accessing the clinic. The problems that they had were:

- Waiting times to get an appointment (9 respondents)

- Opening times do not suit you (9 respondents)

- Transport difficulties accessing the Hereford clinic (7 respondents)

- Drop in clinics too busy (3 respondents)

- Other reasons (7 respondents) such as - long wait time for implant removal, unaware of new location, difficult getting appointment, work, lack of personal transport.

76% of individuals who booked an appointment in advance were able to be seen when they wanted to be.

Of those who attended the service, the main indications were reported as testing for STIs (48%), contraception (45%) and for advice and information (22%). 91% of individuals were happy with the service they received.

Other services

64% of individuals reported that they would use sexual health services (such as testing kits and emergency contraceptives) in community pharmacies if they became available. However, it is also noted that 81% of individuals also stated that their preferred way to access sexual health services were within specialist clinics. This was followed by community pharmacies and online services (30% each) and General practices (29%).

35% of individuals reported that they had previously used online testing services with 85% stating that they would use this again and 76% would recommend the service to others.

General sexual health information

Furthermore, respondents were asked:

Where would you go for general information about sexual health?

- Internet e.g NHS website – 54%

- In person at the Sexual Health Service – 49%
- Internet –Local Sexual health service website – 40%
- GP – 36%
- Friends and Family – 9%
- Other, please specify – 2% - community pharmacy, school/college

When was your last sexual health check-up?

- Within the last 3 months – 20%
- 3 - 6 months ago – 18%
- 6 - 12 months ago – 8%
- 1 year – 2 years ago – 12%
- Over 2 years ago – 25%
- Never had one – 17%

Further comments:

Comments regarding how individuals felt within the service included being 'safe and comfortable' and that they had been 'seen in a timely manner'. One respondent noted that they felt the entrance/reception of the service was not 'very private'.

The majority of comments were positive about interactions with staff with descriptions such as 'approachable, non-judgemental and discreet' and 'warm, welcoming and professional'. One individual reported an 'embarrassing experience' within which they had been 'rudely dismissed' when trying to access the clinic for an appointment regarding erectile dysfunction.

Whilst one individual noted that the online testing was easy to use, another mentioned that whilst it was 'good', it was limited in the tests that could be performed.

Other comments included a long wait for contraception and frustration at the inability to have a cervical smear at the same time as a contraception appointment.

Recommendations by respondents:

- For the service to 'be better advertised especially through schools, colleges and colleges online'
- To implement 'more services county wide, available after school/college times, and more online - order kits online, or maybe phone/video consultations about contraception or easy to discuss topics'
- To 'please make more coil apps. available to all ages of women for contraception and HRT' as the wait times have consequences in 'terms of physical and emotional health'
- Ensure good communication between GP and clinic

YOUNG PERSONS CLINIC

Two members of the public health team at Herefordshire council attended the 'Young persons drop-in' sexual health clinic in March 2023. The experiences and opinions of this population were sought using opportunistic interviewing of attendees. All 8 individuals who attended the clinic that afternoon agreed to be interviewed and were 19 years old or younger. There was a mix of first-

time attendees and those who had attended previously. Whilst their perspectives are taken into account, perspectives on perceived barriers to attending the service should be interpreted with caution given these individuals have been able to attend.

Service experience:

All individuals were happy with the layout of the clinic with one individual acknowledging the tinted shade on the waiting room windows that allows individuals to see out to the road but distorts the view for members of the public looking in. The two most commonly used adjectives to describe how they felt in the service were 'safe' and 'comfortable'. Furthermore, the staff were noted to be 'easy to talk to' which prevented the experience from being 'awkward'.

Service access:

Whilst it is acknowledged that these are individuals that have attended the service and therefore are less likely to experience access barriers, the location of the clinic was described by respondents as 'very accessible', 'central' and 'easy to find'.

The provision of a Wednesday afternoon drop-in clinic was popular amongst the young population with some individuals mentioning that Wednesday is a half-day in college and so they can walk to the clinic from there.

Potential barriers to attendance that were proposed by respondents included social anxiety, embarrassment and that not all their friends 'take their sexual health seriously'. During COVID-19 one individual noted that there was an introduction of a doorbell and a requirement to wait outside to be let in. They felt this could have prevented some individuals from attending the service during this time if they wanted to be discrete about their attendance. (It is acknowledged that this was a temporary measure due to the pandemic).

Whilst none of the individuals had used the online testing offer, there was a positive response to its provision including one individual noting that would work particularly well for their friends that were more 'socially anxious'.

Prevention and education:

Limited sexual health sessions at schools were noted by 3 of the respondents. One individual noted that their teaching had focussed on relationships and consent by 'an external company' whilst 2 others (from the same college) had attended a talk that gave a 'quick' overview of contraception and infections by one of their teachers.

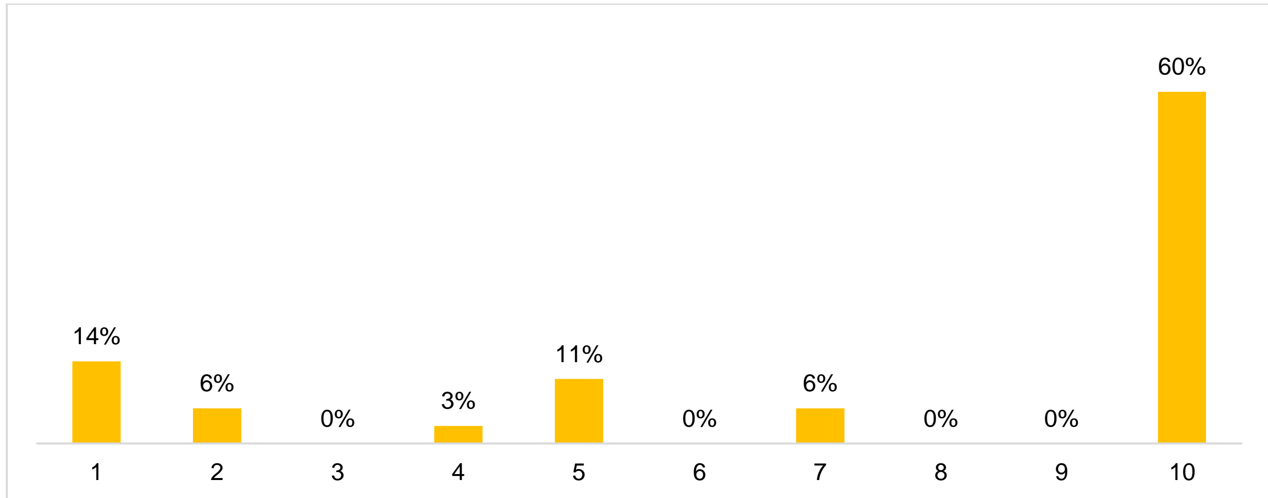
PREVIOUS HEALTHWATCH SEXUAL HEALTH ENGAGEMENT ACTIVITY FEEDBACK

The data below comes from both a survey and focus group that were conducted in 2021 by Healthwatch in collaboration with Solutions4health sexual health services in Herefordshire. The analysis had already been completed prior to this needs assessment and therefore only extracts have been included.

SURVEY

A sexual health survey took place in March 2021. Whilst some parts of the service will have changed since then, this provides an additional insight into the perspective of local service users.

How would you rate the experience which you have received from Sexual Health Services 4 Herefordshire (1 = Lowest score; 10 = Highest score)

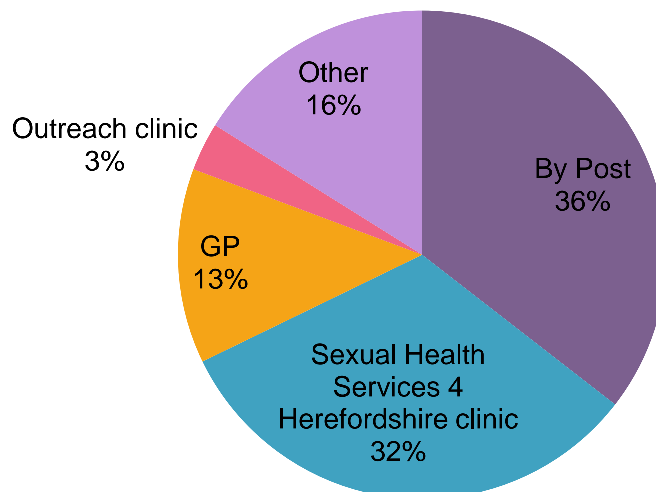


Does the current service meet all of your needs? Please explain your answer.

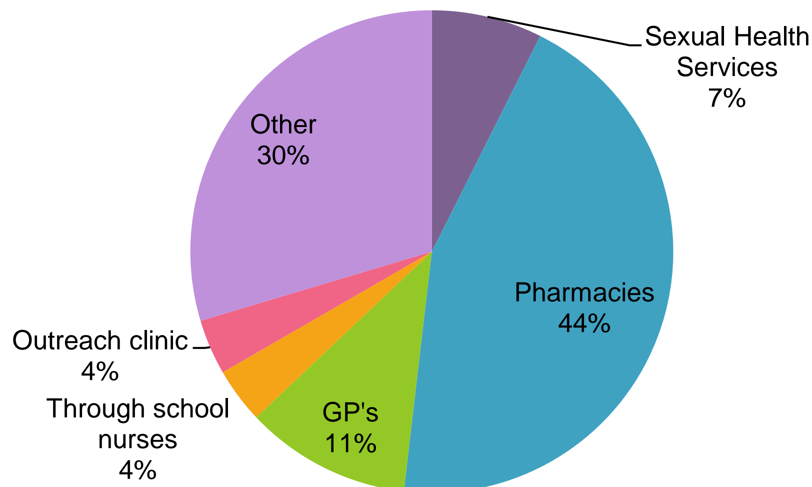
23/35 responded: Yes it does.

One comment was about having a coil fitted by a male and was not warned about this in advance.

What would be your preferred method for STI testing?



What would be your preferred method of accessing emergency contraception?



Other themes from the survey:

- The website received a mixed response with some positive comments such as “very welcoming & informative”; “Everything I needed to know”. However, negative comments included “poor amount of info”; “Not easy to find information required” and “Could do with more information on where to go if not clinic”.
- There were are a couple of comments regarding postal kits and that they only screen for 2 STI’s (“It’s only for two STI’s on the postal kit which isn’t good enough”; “the postal kit I prefer only screens for two STI’s and wanted a full screen”)
- Mixed opinions about having a consultation with a clinician via an online video consultation or virtual clinic, some are happy with this approach, still a good number saying they would prefer to see someone face to face.
- 25 / 35 responses would be happy to attend a sexual health clinic in an outreach space.
- As mentioned at the last board meeting, comments about opening times include having some availability outside of 9 – 5 working hours.

HEALTHWATCH LGBTQ FOCUS GROUP FEEDBACK

This focus group included 3 students from the foundation course at Hereford College of Arts. This session highlighted that none of the participants were aware of the sexual health service (and therefore, consequently, none had used the service).

The group felt that the methods of advertising the service needed to be broadcasted more in accessible places such as Instagram, posters, brochures.

Other issues highlighted during the session was the likely need for a hybrid service so that individuals can opt for either virtual or in-clinic consultations, the need for outreach due to potential geographical barriers in accessing the service hub, a preference for a less corporate website format, the inclusion of name badges with pronouns for staff and the provision of a 'safe space' for LGBTQ.