



**North
Somerset**
Council



**Bristol, North Somerset
and South Gloucestershire**
Integrated Care Board

Bristol, North Somerset and South Gloucestershire Sexual Health Needs Assessment 2022

For any queries, please contact:

Filiz Altinoluk-Davis
Principal Public Health Specialist
Bristol City Council
filiz.altinoluk-davis@bristol.gov.uk

Abbreviations

A&E	Accident and Emergency
ADPH	Association of Directors of Public Health
AGC	Advisory Group on Contraception
APPG (SRH)	All Party Parliamentary Group (on Sexual and Reproductive Health)
ART	Antiretroviral therapy
BaNES	Bath and North East Somerset
BASHH	British Association for Sexual Health and HIV
BBV	Blood-borne virus
BNSSG	Bristol, North Somerset and South Gloucestershire
CCG	Clinical Commissioning Group
COVID-19	Coronavirus
cuIUD	Copper intrauterine device
DHSC	Department of Health and Social Care
DI	Digital intervention
DNA	Did not attend
EC	Emergency contraception
EHC	Emergency hormonal contraception
FSRH	Faculty of Sexual and Reproduction Health
GBMSM	Gay, bisexual and other men who have sex with men
HAV	Hepatitis A virus
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
HPV	Human papillomavirus
HRT	Hormone replacement therapy
HSV	Herpes simplex virus
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
IMD	Index of multiple deprivation
IUD	Intrauterine device
LARC	Long-acting reversible contraception
LGBTQ+	Lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual, and more
LGV	Lymphogranuloma venereum
NCSP	National Chlamydia Screening Programme
NICE	National Institute for Health and Care Excellence
ONS	Office for National Statistics
PEP	Post-exposure prophylaxis
PHE	Public Health England
PLWHIV	People living with human immunodeficiency virus
PrEP	Pre-exposure prophylaxis
PSHE	Personal, social and health education

RSE	Relationships and sex education
RSHE	Relationships, sex and health education
SEND	Special educational needs and disabilities
SHNA	Sexual health needs assessment
SPLASH	Summary Profile of Local Authority Sexual Health
SRHS	Sexual and reproductive health service
STI	Sexually transmitted infection
THT	Terrence Higgins Trust
UKHSA	UK Health Security Agency
UPSI	Unprotected sexual intercourse
WHO	World Health Organization

Executive summary

Good sexual and reproductive health matters to individuals and communities, whose needs will vary according to a range of physical, emotional, social, cultural and economic factors. There are certain core needs common to all, including the availability of high-quality information and education to make informed decisions, freedom from stigma and discrimination, and access to high quality prevention, testing, diagnostic and treatment services and interventions.¹

Sexual health needs assessment

This needs assessment aims to identify the sexual health needs of the Bristol, North Somerset and South Gloucestershire (BNSSG) population and how well these are being met. It brings together a wide range of evidence from published outcomes and local service data, the views of the public, service users and professionals, and national policy and guidelines. Data analysis by demographics is carried out wherever possible, although the availability of this data is a notable shortcoming. This is the first time that a sexual health needs assessment (SHNA) has been carried out for the combined BNSSG area and is a key tool used to inform future commissioning intentions.

Impact of COVID-19

Along with many other services, COVID-19 had a considerable impact on sexual health services across BNSSG with the suspension of most face-to-face activity. For Unity Sexual Health, the integrated sexual and reproductive health service (SRHS) for BNSSG, this posed challenges in maintaining business continuity and ensuring that the most vulnerable members of the population were still able to access services and not be disproportionately disadvantaged. The biggest change was to the way people accessed Unity services. Remote (phone) consultations replaced face-to-face consultations in the first instance, and face-to-face appointments were only booked when deemed clinically necessary. Unity also extended its postal STI test kit service through the launch of online accounts in late 2020.

Community provision of contraception was also impacted by COVID-19, resulting in a decline in GP prescriptions for coils and implants (also known as long-acting reversible contraception, LARC) as most practices moved to an appointment-only system with telephone triage. Similarly emergency hormonal contraception (EHC) provision in pharmacies fell during the pandemic, as did provision of emergency coils at Unity. Abortion services were permitted to enable early medical terminations to be undertaken fully at home through a 'pills by post' service, reducing the need for face-to-face contact.

The impacts of COVID-19 are still being felt as SRHS recover.

¹ [What Good Sexual and Reproductive Health and HIV Provision Looks Like.pdf \(adph.org.uk\)](#) (published in 2019)

Sexual and reproductive health services

Local authorities are responsible for commissioning integrated SRHS for their local populations, including testing and treatment for sexually transmitted infections (STIs), HIV prevention and testing, sexual health outreach and health promotion, contraception services, including LARC in general practice and EHC in pharmacies. Integrated Care Boards (ICB) are responsible for commissioning abortion services.

Across BNSSG, integrated SRHS and abortion services are co-commissioned by the three local authorities and the ICB in a good example of system-level collaboration. University Hospitals Bristol and Weston Trust (UHBW) is contracted to provide BNSSG's SRHS, which they deliver through Unity – a partnership of a number of providers.

The sexual and reproductive health of BNSSG: a brief overview

Bristol, North Somerset and South Gloucestershire are vibrant and dynamic areas in South West England with a mix of urban and rural populations. Around a million people live across the three areas, with Bristol having a more ethnically diverse and younger student population. Nationally published outcomes data for 2021 show that across BNSSG there were:

- 2,920 new STI diagnoses (excluding chlamydia in <25s) plus 1,284 chlamydia diagnoses in young people aged 15-24 years old
- 12,145 LARC prescriptions for coils and implants
- 5,558 EHC consultations in BNSSG pharmacies
- 3,069 abortions

It is important to note that these figures represent post-COVID-19 lockdown recovery and are lower than pre-COVID-19 figures.

Key themes identified

Levels of STI testing were relatively stable in BNSSG until the introduction of postal test kits by Unity in 2018 saw these numbers climb. Following the introduction of the online STI test kit portal, Unity issued just under 35,000 kits in 2021-22 with 66% returned. While testing fell considerably during COVID-19, local data indicates that this has since increased and stabilised. Although the overall numbers of new STI diagnoses (excluding chlamydia in under 25s) and new chlamydia diagnoses in 15-24 year olds are still lower than pre-COVID-19 levels across BNSSG, an increase in the number of recent gonorrhoea cases in Bristol now exceeds pre-pandemic levels.

Unlike STI testing, HIV testing at Unity has been falling since 2018, with just over 4,000 tests accepted by eligible attendees in 2021. The number of new HIV diagnoses in BNSSG (whether diagnosed in the UK or abroad) has continued to reduce over time from 71 in 2011 to 36 in 2021. However, the proportion of those newly diagnosed that were diagnosed late

has increased over time, raising concerns about prompt access to HIV testing and availability of testing in a range of settings.

Another area still feeling the impact of COVID-19 is LARC provision in general practice, where the vast majority of fits take place across BNSSG. In 2021, 10,676 GP prescriptions for coils and implants were made, which was 88% of all LARC prescriptions issued in BNSSG. Bristol women in particular have experienced unequal levels of access to LARC largely due to a shortage of trained fitters; although this is an issue across the whole of BNSSG.

Access to EHC for young people in BNSSG is still freely available through pharmacies, with more than 5,500 prescriptions made to young women aged 15-24 during 2021. The pharmacy consultation data also provides some behavioural insights as 62% of consultations were the result of not using a condom, and 18% had used EHC in the previous 3 months. This combined with the under-18s conceptions data for 2021, which shows that Bristol's rate in particular has risen and is now higher than the England average, suggests a renewed focus on relationships, sex and health education (RSHE) and health promotion strategies is needed.

In BNSSG the total abortion rate remains low in 2021 and lower than the England average but repeat abortions in under-25s have risen and were proportionally highest in South Gloucestershire at 28% in 2021. Although all women should be provided with post-abortion contraception, with the move to many abortions now taking place at home, data suggests this is not always happening.

In addition to the above, the following provides some more information on the key findings in the SHNA.

STI testing and new diagnoses fell from 2019-21

Published outcomes data for BNSSG shows that STI testing and new diagnoses (excluding chlamydia in <25s) fell considerably from 2019 to 2021, with Bristol experiencing the biggest decreases. The observed reduction in new diagnoses is likely linked to the fall in testing, which in turn is likely to be due to access issues during COVID-19, as well as due to changes in sexual behaviour during the pandemic. Recent local data for 2022 is suggesting an increase in chlamydia and gonorrhoea cases. There are discrepancies between the different sources in relation to testing and new diagnoses data, which are being investigated. Numbers of STIs are higher in women than men in young people under 25 but in over 25s they are more common in men. There are more STIs diagnosed in people from deprived areas and re-infection is common especially in young people.

Partner notification rates are low

Only 768 people were seen in our SRHS as partners of identified cases in 2021. With over 4000 STIs diagnosed, this figure appears low.

Chlamydia screening in 15-24 year olds has reduced

The national chlamydia screening programme aims to reduce the harms from untreated chlamydia in young women. The chlamydia detection rate in young people aged 15-24 years old fell by 42% in BNSSG from 2019 to 2021, which mirrors the trend nationally. BNSSG's detection rate has been lower than the England average since 2014. Given the high proportion of young people living particularly in Bristol, the low detection rate suggests poor awareness of, access to and/or uptake of screening. Distribution of chlamydia screening kits in pharmacies is particularly low.

Gonorrhoea and syphilis are most common among GBMSM

Across men and women regardless of sexual orientation, and even with chlamydia in <25s excluded, chlamydia was the most common STI between 2017-2021. Among gay, bisexual and other men who have sex with men (GBMSM) in BNSSG gonorrhoea is the most commonly diagnosed STI. Most cases of syphilis diagnosed in BNSSG are amongst GBMSM. Gonorrhoea is used as a marker for rates of unsafe sexual activity in a population and an indicator of local burden of STIs in general.

New STI diagnoses in Black communities are lower than expected

Nationally, new diagnoses of selected STIs in people of Black ethnicity were 2.4 times higher than in the general population, which would be expected to be reflected in the Bristol data, perhaps more so as Bristol's Black population is larger (5.9%) than England's (4.2%). However, this is not the case, and local data suggests that people from Black communities are less likely to access testing and services. This needs further exploration to ensure services are welcoming and accessible for all.

HIV testing has fallen

HIV testing appears to have fallen across BNSSG by 68% between 2019 and 2021. The national HIV action plan sets out to end new HIV transmissions by 2030, with increased testing a key pillar of the prevention plan. Locally, Bristol is an HIV Fast Track City, which aims to deliver on the national HIV action plan and the UNAIDS 95:95:95 targets. There is a focus on improving testing for the population through several initiatives including a pilot of STI and HIV test vending machines. In addition, there has been lobbying of national government to release funding to high HIV prevalence areas, such as Bristol, to offer HIV and other blood borne virus opt-out testing in emergency departments, which has proven successful in emergency departments in areas of very high prevalence and supports the normalisation of HIV testing.

HIV testing is very low among women and heterosexual men

HIV testing coverage in all men attending specialist sexual health services in BNSSG was lower than the England average in 2021, largely driven by the 63% of heterosexual men and 68% of women either not offered or not accepting an HIV test.

HIV diagnoses have fallen but an increasing proportion of those who are diagnosed are diagnosed late

The number of new cases of HIV has reduced in Bristol and other areas but of those newly diagnosed, an increasing proportion were late diagnoses between 2012-14 and 2019-21. In England, those diagnosed late in 2019 had more than a 7-fold increased risk of death within a year of diagnosis compared to those diagnosed promptly. A late look back exercise in both acute trusts has identified that among those diagnosed late, there were several missed opportunities where people could have been diagnosed earlier.

PrEP uptake is low among women and racially minoritised groups

The numbers of people accessing PrEP through Unity has increased over 2021 and 2022, however only half the people who would benefit from PrEP appear to be accessing it according to local data. The vast majority of people obtaining PrEP in BNSSG are young, white GBMSM. Uptake is very low among ethnic minoritised groups and women.

LARC-prescribing is recovering but access is variable and needs improving for vulnerable groups

LARC (coils and implants) is the most effective and cost-effective form of contraception. Access to LARC across BNSSG, which takes place predominantly in general practice, has shown promising signs of post-pandemic recovery based on published outcomes data and local activity data. LARC activity in North Somerset and South Gloucestershire practices has already recovered to pre-COVID-19 levels. However, this is not the case for all practices in Bristol where limited access to LARC continues, with local data suggesting that practices at 60% or less of pre-COVID-19 activity are in more deprived areas. The impact of COVID-19 is likely to have been greater on those from marginalised groups, who may be more likely to access walk-in and specialist services than booked appointments and may not approach GPs for contraceptive help.

Variability in access to LARC in BNSSG could be improved through increased access to LARC training by practice nurses and improved access support for the homeless, sex workers, drug and alcohol users, asylum seekers and care leavers.

Condom uptake has decreased significantly among young people

Issuing of condoms across community and specialist services, and through the C-Card scheme, has decreased significantly across BNSSG, posing a risk to safe sex practices in terms of preventing unwanted pregnancies and STIs. Further work is needed to understand why young people are not accessing free condoms.

Teenage conceptions remain low but have seen recent rises with some wards having particularly high rates

Teenage conceptions have fallen significantly since 2008 in BNSSG, however the most current data available appear to show signs of a slight increase in Bristol during the last two reported quarters to June 2021. Despite the low rates of teenage conceptions in BNSSG, there is variation within the local authority areas, with higher than England rates of under-18s conceptions found in Weston-Super-Mare South and Weston-Super-Mare Hillside wards in North Somerset, and in Filwood ward in Bristol in 2018-2020.

There is a lack of awareness of local sexual health services

Data from Bristol's 2022 Pupil Voice survey found that 47% of Year 10 pupils said they know where they would go if they needed a contraception/sexual health service (54% in 2019). Only 24% of all year 10 pupils were aware of local Brook sexual health services (41% in 2019), and rather fewer (less than 10%) were aware of Unity. South Gloucestershire young people suggested that online services were preferable for young people.

Wider engagement as part of the SHNA process revealed that many people felt that there was a lack of awareness about Unity services. The website was considered outdated, clunky and difficult to navigate and often did not communicate the information needed by people. A lack of adequate social media presence was considered a key issue preventing full engagement with the public.

Relationships and sex education (RSE) is now statutory but may still not be meeting needs

RSE is now statutory, but the quality of this education may not be meeting the needs of our young people. The Bristol Pupil Voice survey found that 15% of secondary school pupils did not find lessons on sex, relationships and STIs useful at all. After school lessons, as young people get older, they turn more to their friends instead of their parents as their main source of sexual health knowledge. The combined role of the internet, TV, films and porn as a source of information was also high.

EHC uptake has reduced

Over the last few years the provision of free EHC in pharmacies, general practice and Unity services has fallen. Although the pandemic may have restricted access, the reasons for the ongoing reduction are not fully understood.

Pharmacy data provides an insight into the risk behaviours of individuals seeking EHC as, across BNSSG in 2021-22, 62% of all 5,558 consultations in people aged <25 were requesting EHC after not using contraception and 30% after condom failure. Furthermore, 18% had already used EHC in the previous 3 months.

Access to emergency coils is variable across BNSSG

Coils are the most effective form of emergency contraception. A greater proportion of emergency coils are provided in Bristol than elsewhere in BNSSG. Access to emergency coils is poor in more rural areas of BNSSG, more deprived areas, and for non-White ethnicities.

Total abortion rate remains low but repeat abortions have increased

The total abortion rate in BNSSG remains low in 2021, and lower than the England average, but repeat abortions in under-25s have risen and were proportionally highest in South Gloucestershire at 28% in 2021.

Access to contraception following abortion or birth is low

Although all women should be provided with post-termination contraception, with the changes to processes such as many abortions now taking place at home, data suggests this is not always happening across abortion services in BNSSG with almost half of women not receiving contraception.

In addition, in line with national guidance, pregnant women should be provided with antenatal contraception counselling and access to their chosen contraception immediately post-partum to prevent short interpregnancy intervals. This is not delivered in most areas but a pilot of post-partum contraception is due to commence in BNSSG in 2023.

Access to specialist services is an issue

In recent public feedback about SRHS across BNSSG, collected via a survey of 643 respondents in summer 2022, 42% of all respondents were positive about staff and the service in general, but 43% had negative feedback about appointments, location of services and accessibility.

The survey findings were also echoed in a series of semi-structured interviews conducted with healthcare staff, in which there was almost universal agreement that once patients get into the Unity service they receive a high quality, safe and effective service from a multidisciplinary team that works well together. However, several significant issues were highlighted by these interviews, including that access to services is a problem particularly for the most vulnerable clients who need additional support with this.

Difficulties in accessing Unity include the lack of an online appointment booking system, a telephone triage service that has extensive waiting times resulting in patients not always getting through, and the ongoing closure of some community clinics affecting South Gloucestershire residents in particular.

Recommendations for commissioners

The following recommendations are drawn from the findings of the needs assessment and will provide the basis for future sexual health commissioning intentions. Working in partnership across the three BNSSG local authorities and the ICB, these recommendations will be used to shape the sexual health services of the future.

SRHS for the increasing and increasingly diverse BNSSG population

- The population of BNSSG is growing and projected to increase in size by 6% in 2030. SRHS need to be aware of predicted changes and adaptable to meet rising future demand.
- The ethnic diversity of Bristol's population continues to increase, especially in younger groups. The SRHS workforce should be trained to understand the impact of racial injustices and strive to be representative of the population it serves. They should continue to work with these communities to support greater access from minoritised ethnic groups.
- Service user engagement needs to be meaningfully increased.

Prevention, health promotion and outreach

- Prevention needs to be integrated throughout our sexual health system to improve sexual wellbeing, and to reduce repeat presentations and poor outcomes (such as STIs and the consequences of STIs, and unplanned pregnancies), particularly for those in high-risk groups.
- There is a need to promote much greater awareness of SRHS in BNSSG. This should include a strong social media presence, and an accessible, highly publicised and informative website which empowers service users to look after their own sexual health and to know when and how to seek help.
- RSE lessons at schools should include information about local services and how to access them as a priority.
- There is a need for closer working with public health nursing services in schools to improve the sexual health outcomes of young people, especially in areas where teenage pregnancies remain high.
- Repeat abortions in under 25s have increased suggesting a lack of access to good quality contraception services and advice for younger people. SRHS need to provide services that are friendly and approachable for young people, available in a range of settings.
- SRHS need to provide outreach services that engage with a wide range of vulnerable groups, broadening out from a focus on GBMSM.
- Health promotion efforts should:
 - take a 'sex-positive' approach, focusing on building confidence in making informed choices and consent.
 - respond to changing cultures (including the increasing use of natural cycles by young people rather than using hormonal methods)
 - take full advantage of technical developments, such as social media.
 - address concerns around online porn and online exploitation and the impact on young people.
- Education around sexual health should also be targeted at parents and the wider community, not just those who may benefit from accessing the service themselves.

Increasing access to services

- There have been no SRHS community clinics in South Gloucestershire since the start of COVID-19. This should be resolved as soon as possible.
- Community and outreach clinics should be situated according to need, appropriateness of setting and offering accessible opening hours to the local population. This should include the consideration of the large student population within BNSSG.
- There is evidence of low uptake of SRHS by Black people and those living in the most deprived areas in Bristol. Services need to work with communities to ensure they are accessible and welcoming to all high risk and equalities groups and promote their services appropriately.
- Tailored support to access specialist and community services, including walk-in services, should be offered to the groups most at risk of poor sexual and reproductive health outcomes, including:
 - people involved in sex work
 - people with physical and learning difficulties
 - people of African and Caribbean heritage
 - LGBTQ+
 - homeless people
 - young people
- Findings from the SHNA revealed negative feedback about appointments, location of services and accessibility:
 - access to a range of SRHS via digital (online) routes should be increased.
 - SRHS need to be accessible at times of the day and week that will have highest demand, including Saturdays and Sundays.
 - walk-in sessions should be available to ensure that those most at risk can access services quickly when needed.
 - different appointment booking methods should be available, including telephone and online.
 - the long waiting times reported for telephone access to Unity services should be addressed as soon as possible.

STI and HIV service provision

- STI testing and diagnoses have continued to fall in BNSSG since 2019 and the COVID-19 pandemic. Ongoing monitoring of this data in collaboration with SRHS is needed, as well as seeking assurance that testing is widely, readily and rapidly available through clinic and outreach settings.
- Access to online testing needs to be improved to ensure that people can be tested and treated rapidly. Process issues that hinder the timeliness of this service need to be addressed.

- Partner notification is a key part of reducing transmission of STIs. Further work needs to be undertaken to ensure that this can be provided across our health system, regardless of where the test was performed.
- An action plan is required as soon as possible to address the reduction in chlamydia screening in 15–24-year-olds.
- HIV testing has fallen and is particularly low among women and heterosexual men, who should be consistently offered an HIV test upon every attendance at SRHS (opt out rather than opt in). More work is needed by the provider to understand the barriers and facilitators for non-GBMSM men and women to accessing HIV testing and to implement interventions to address this.
- An increased focus on HIV testing is particularly important following the increase in the proportion of late diagnosis of HIV. Initiatives such as Common Ambition Bristol are key in reducing stigma and promoting the importance of testing in a culturally competent way within African and Caribbean heritage communities.
- PrEP needs to be widely promoted and available beyond specialist SRHS settings.
- PrEP uptake for those not currently accessing it (including women and people of Black African heritage) needs to be explored and addressed.
- Opportunities to address the separation of provision of sexual health and HIV treatment services should be explored by the BNSSG ICS, especially considering future delegation of HIV treatment to BNSSG ICB from NHSE.

Reproductive health service provision

- Access to LARC in the community was greatly impacted by COVID-19 and despite recovering well in North Somerset and South Gloucestershire, access is still patchy in Bristol. Consideration should be given to how LARC training can be incentivised for practice nurses, and the potential role of LARC PCN hubs to address inequity.
- LARC training should be made available for all clinicians needing this skill (including in maternity services), to encourage equitable and timely access to this most effective form of contraception.
- LARC delivery should be considered as well as care for menopause and heavy menstrual bleeding as part of the BNSSG response to the Women's Health Strategy for England.
- Access to emergency coils in North Somerset and South Gloucestershire needs to be improved as this service is currently only available in the centre of Bristol.
- Teenage pregnancies in BNSSG have shown a steep decline since 2007 but the most recent data shows a slight increase in Bristol and high rates in certain wards. The local authority data should be monitored quarterly, and a review of potential actions to address areas where teenage pregnancy rates are high should be considered in North Somerset and Bristol.

- A collaborative and digitised approach to condom distribution across BNSSG is recommended to address the significant decrease in condom uptake in young people, particularly in relation to the C-Card scheme.
- Access to abortions for women in North Somerset needs to be addressed to ensure they have the full choice of accessible options.
- All women undergoing an abortion should be provided with advice and their choice of contraception at the time (or soon after) an abortion.
- All women should be provided with advice and their choice of contraception soon after the delivery of their baby.
- Where appropriate (such as when LARC is removed, or women choose less effective or no contraception methods) women should be offered pre-conception advice.

Improving data quality

- There are a number of concerns regarding data quality and transparency which has limited our understanding of local sexual health needs in BNSSG. The following recommendations should be actioned as soon as practicable:
 - service data should include numbers of unique attendees, episodes of care, methods of consultation, types of appointments, repeat attendees.
 - attendance data should be treated separately to online STI test requests.
 - demographic data should be available for all performance reporting, including ethnicity and sexual orientation. This is vital to understand need and address inequalities.
- Where possible, the same electronic record should follow the service user along the integrated SRHS pathway to ensure that records are comprehensive and readily accessible by health professionals working in different parts of the SRHS.
- Data discrepancies between published outcomes, GUMCAD and Unity reports need to be explored further by providers, supported by commissioners.

Working effectively as a sexual health system

- There needs to be a clear, shared strategic vision and goals for sexual and reproductive health across the system.
- Effective collaborative working between providers, between providers and commissioners, and between commissioners needs to be promoted and supported.
- Audit, evaluation and research should continue to be an important element of improving sexual health including within SRHS. Areas identified in this SHNA which may benefit from further research or exploration include:
 - understanding and addressing impact of social media on sexual behaviour.
 - exploring innovative interventions to promote safe sex in young people.
 - understanding and addressing barriers to condom use.
 - understanding the causes of the increase in gonorrhoea rates among young people.

- exploring how effective the RSE offer is in BNSSG schools.
- increasing digital access to sexual health services and exploring how it impacts on demand.
- exploring innovations to improve awareness and uptake of LARC.
- investigating the effectiveness of post-partum and post abortion contraception.
- investigating how to increase post abortion contraception for women undergoing home abortions.
- exploring how to improve awareness of and access to emergency coils.
- gaining an in-depth understanding of how to make service accessible for the most vulnerable groups within BNSSG.
- addressing the consequences of racial discrimination on access to SRHS.
- determining the barriers to provision and acceptance of HIV testing in SRHS.
- raising awareness of PrEP and investigating the acceptability and feasibility of provision outside of specialist SRHS.
- exploring how to develop rapid partner notification across the whole sexual health system.
- understanding the reasons for the decline in chlamydia screening and identifying interventions to address this.
- developing a system wide approach to the improvement of sexual health outcomes and exploring what aids collaboration.

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1. Introduction

Most adults are sexually active and good sexual and reproductive health matters to individuals and communities. Although needs vary according to factors such as age, gender, sexuality, ethnicity, mental wellbeing, sensory difficulties, education and literacy, and cultural factors, there are certain core needs common to everyone including; high quality information and education to enable people to make informed decisions, a reduction in stigma and discrimination, and access to high quality prevention, testing, diagnostic and treatment services and interventions.²

1.1 Aim of the sexual health needs assessment (SHNA)

This SHNA aims to systematically assess and gain an understanding of the sexual health needs of the people of Bristol, North Somerset and South Gloucestershire (BNSSG), as well as identifying where current services are meeting these needs. This will enable unmet need and gaps in service provision to be identified along with recommendations for action to improve the availability and accessibility of services for the population and to address inequalities.

The needs assessment is a key tool used to inform future commissioning intentions. It provides a rationale for changes to services in order to meet these needs, including by collecting a wide range of views from the public and professionals who access and work in sexual health services. Working collaboratively across BNSSG councils and the Integrated Care Board (ICB), the needs assessment will form the foundation of a new BNSSG sexual health strategy that will be developed to shape the sexual health services of the future sexual health system for BNSSG Integrated Care System (ICS). For more information on the structure of the health system in BNSSG, see section [3.1](#).

1.2 Objectives of the SHNA

The key objectives of this needs assessment are to:

- provide an overview of the current sexual health of the BNSSG population
- map current provision of sexual health services across BNSSG
- provide an overview of the evidence of effectiveness and cost effectiveness around sexual health interventions
- identify any unmet and/or emerging sexual and reproductive health needs of the BNSSG population
- consider the needs of key population groups at greater risk of poor sexual health
- identify possible solutions which could meet any unmet and/or emerging sexual and reproductive health needs with a focus on addressing inequalities

² [What-Good-Sexual-and-Reproductive-Health-and-HIV-Provision-Looks-Like.pdf \(adph.org.uk\)](#) (published in 2019)

- inform the future commissioning of sexual and reproductive health services for BNSSG

1.3 Scope of the SHNA

The SHNA focuses on the population health needs and demands on services for which the councils across BNSSG are directly responsible for commissioning. This includes:

- all contraceptive services provided across BNSSG via specialist sexual health services
- long-acting reversible contraceptive (LARC) services provided by general practices
- emergency hormonal contraception (EHC) provided by pharmacies
- all testing and treatment of sexually transmitted infections (STIs) across BNSSG via specialist sexual health services
- all chlamydia screening conducted as part of the National Chlamydia Screening Programme (NCSP)
- all HIV testing across BNSSG via specialist sexual health services
- partner notifications for STIs and HIV when diagnosed in specialist sexual health services
- HIV pre-exposure prophylaxis (PrEP)
- all specialist sexual health services, including young people's sexual health services
- sexual health outreach, HIV prevention and sexual health promotion and service publicity

Abortion services are funded by the ICB, and are included in the integrated specialist sexual health services contract across BNSSG, and therefore will be in scope for this needs assessment.

Due to limited capacity and availability of data for areas not directly commissioned jointly, the following related services are out of scope for a detailed exploration in this needs assessment:

- HIV, STI and hepatitis B screening tests across BNSSG via maternity services
- HIV treatment (although population health outcomes will be referred to)
- cervical screening
- vasectomy and female sterilisation
- psychosexual services
- fertility treatment
- human papillomavirus (HPV) routine vaccination programme for school-aged children and opportunistic vaccination programme for gay, bisexual and other men who have sex with men (GBMSM) aged 45 and under
- sexual health elements of health and justice services
- sexual assault referral centres

While it has not been possible to undertake a truly system wide sexual health needs assessment for BNSSG, due consideration of key pathways and dependencies with other services is acknowledged throughout, where appropriate. The system map in figure 1.1 aims to illustrate the complexities and interlinked nature of the services provided that impact on individuals' sexual and reproductive health.

1.4 Methodology

This needs assessment has been undertaken using a best-practice mixed methodology approach that combines qualitative and quantitative data in order to assess sexual health needs across BNSSG. The guidance included in 'Sexual health needs assessments: a how to guide' advises that the core elements of a sexual health needs assessment are to map need, examine demand, map service provision and then assess the gaps between these factors.³ Therefore, this needs assessment includes the following elements.

Outlining the national policy context and evidence

The key policies that have shaped the current sexual health landscape are summarised, and an overview of the commissioning functions across councils, ICBs and NHS England is provided. This section also describes the challenges currently being faced by sexual health services nationally due to coronavirus (COVID-19) and mpox (previously referred to as monkeypox).

Understanding the population's needs

Using a combination of local service data and published national indicators, this element explores the sexual health outcomes for BNSSG as a whole compared to the South West region and England, as well as for each council area compared to similar local authorities. A key requirement of this analysis is to understand which groups are most at risk from poor sexual health outcomes.

Identifying the level of demand for services

Using data from primary care and specialist sexual health services (for example, waiting list or backlog data), as well as feedback from service users and stakeholders, it is possible to obtain a broad understanding of the level of demand for sexual health services across BNSSG.

Mapping current services across BNSSG

The level and geographic spread of sexual health services is mapped to highlight the supply of services across BNSSG and identify any potential gaps. Providers of sexual health services include general practice, community services, acute hospitals, pharmacies and the voluntary, charitable and independent sector.

³ [Sexual Health Needs Assessments \(SHNA\) - A How to Guide \(nationalarchives.gov.uk\)](https://www.nationalarchives.gov.uk/sexual-health-needs-assessments-shna-a-how-to-guide/) (published August 2007)

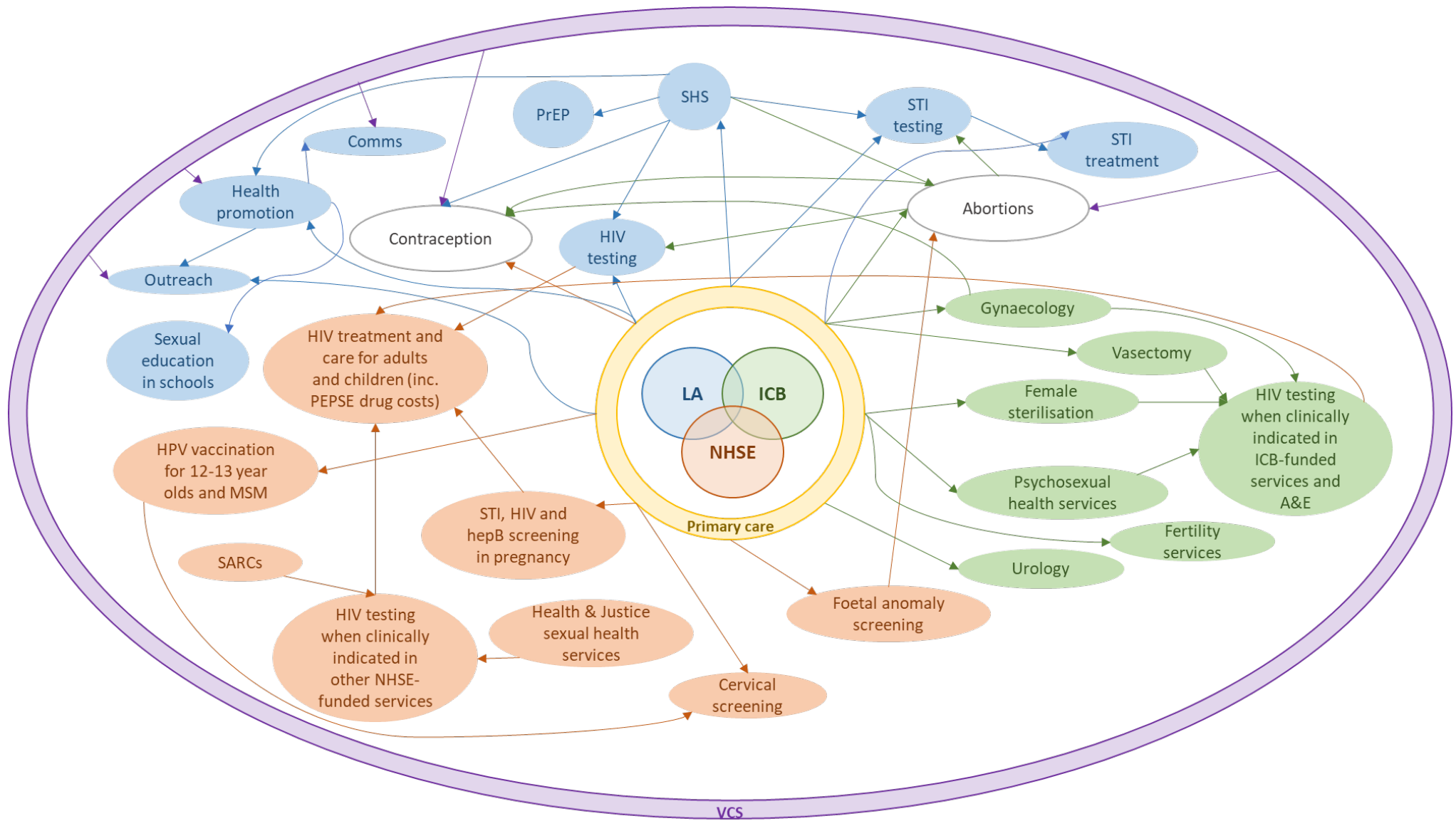
Listening to what service users and other stakeholders say

To understand what is working well with existing services and what could be better, as well as hearing from the public about what the barriers and facilitators to access are, a widely disseminated survey was carried out across BNSSG for eight weeks. In addition, health professionals working within the BNSSG sexual health services were also asked to complete the survey for their views. Semi-structured interviews were conducted with vulnerable groups and health professionals from the BNSSG specialist sexual health service.

Analysing the gaps and making recommendations

The gap analysis pulls together the information collected about need, supply and demand in order to identify key issues and gaps or mismatches in provision, such as geographical gaps, over supply, insufficient supply or a mismatch against need. This analysis enables evidence-based recommendations to be made that inform commissioning intentions to address the issues and close the gaps identified.

Figure 1.1: BNSSG sexual health services system map



2. National policy context

2.1 Commissioning sexual health services in England

In England, sexual health services are locally commissioned to be tailored to the needs of the local population and include the provision of information, advice and support on a range of issues, such as STIs, contraception, relationships and unplanned pregnancy.^{4,5} Figure 1.1 highlights the complexity of the sexual health commissioning landscape and the cross-over between services that are commissioned by different organisations.

Public health teams in councils are responsible for commissioning comprehensive, integrated sexual health services that include:

- all methods of contraception in specialist sexual health services, LARC in general practice, and EHC in pharmacies (the cost of LARC devices and EHC drugs in pharmacies are mostly covered by the ICB)
- advice on preventing unintended pregnancy in specialist services and those commissioned from primary care under local public health contracts
- STI testing and treatment and HIV testing in specialist services, including partner notification, chlamydia screening as part of the NCSP, and HIV PrEP consultation and administration (drug costs are covered by NHS England)
- chlamydia screening in primary care as part of the NCSP
- any sexual health specialist services, including young people's sexual health services, outreach, HIV prevention and sexual health promotion and service publicity

Direct commissioning of some local specialised services is the responsibility of ICBs, including:

- most abortion services, including STI and HIV testing, and contraception provided as part of the abortion pathway (except abortion for foetal anomaly – see NHS England responsibilities below)
- contraception provided as an additional service under the GP contract
- promotion of opportunistic testing and treatment for STIs and patient-requested testing by GPs
- female sterilisation
- vasectomy (male sterilisation)
- psychosexual services
- gynaecology, including any use of contraception for non-contraceptive purposes
- HIV testing when clinically indicated in ICB-commissioned services (including A&E and other hospital departments)

⁴ [Commissioning local HIV sexual and reproductive health services - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/publications/commissioning-local-hiv-sexual-and-reproductive-health-services) (last updated 26/03/2018)

⁵ [Making it work \(publishing.service.gov.uk\)](https://publishing.service.gov.uk/government/publications/making-it-work) (last updated 02/03/2015)

NHS England is also nationally responsible for the direct commissioning of some local specialised services, including:

- HIV treatment and care for adults and children (including drug costs for post-exposure prophylaxis (PEP))
- HIV PrEP drug costs
- HIV testing when clinically indicated in other NHS England-commissioned services
- all sexual health elements of healthcare in secure and detained settings
- sexual assault referral centres
- cervical screening in a range of settings
- specialist foetal medicine services, including surgical termination of pregnancy for foetal anomaly between 13 and 24 gestational weeks
- HPV routine vaccination for school-aged children and opportunistic vaccination for GBMSM aged 45 and under
- NHS Infectious Diseases in Pregnancy Screening Programme including antenatal screening for HIV, syphilis, hepatitis B

To support councils in the commissioning of integrated specialist sexual health services, the Department for Health and Social Care (DHSC) in partnership with (the now disbanded) Public Health England (PHE) published a suggested national service specification in August 2018 with the intention to provide an updated specification in 2023.⁶ The specification is not designed to be prescriptive and acknowledges that councils will need to design their services based on an up to date SHNA. It does, however, stress that collaborative working with ICBs and NHS England is necessary to ensure that services and patient pathways are planned according to need.

For those councils that choose to commission integrated sexual health services with their neighbours, an arrangement that is currently in place across BNSSG, advice on whole system commissioning can be found in *Making it work: a guide to whole system commissioning for sexual health, reproductive health and HIV*.⁷

2.2 National policy context

2.2.1 A framework for sexual health improvement in England

In 2013, the Department of Health published the Framework for Sexual Health Improvement⁸ following the changes to the health landscape brought about by the Health and Social Care Act 2012.⁹ The new legislation outlined that councils would be responsible for commissioning most sexual health services from April 2013 (as outlined above), with additional roles for CCGs (now ICBs) and NHS England. The Framework aimed to:

⁶ [Integrated sexual health service specification \(publishing.service.gov.uk\)](https://publishing.service.gov.uk) (published 03/2023)

⁷ [Making it work \(publishing.service.gov.uk\)](https://publishing.service.gov.uk) (last updated 02/03/2015)

⁸ [A Framework for Sexual Health Improvement in England \(publishing.service.gov.uk\)](https://publishing.service.gov.uk) (published 15/03/2013)

⁹ [Health and Social Care Act 2012 \(legislation.gov.uk\)](https://legislation.gov.uk)

- provide the information, evidence base and support tools to enable those involved in sexual health improvement to work together effectively
- ensure that accessible high-quality services and support are available to everyone

The Framework outlines the government's ambition and objectives for good sexual health for the whole population (see figure 2.1), as well as providing some key principles of best practice in sexual health commissioning to support councils, ICBs and NHS England. These include:

- prioritising the prevention of poor sexual health
- strong leadership and joined-up working
- focusing on outcomes
- addressing the wider determinants of sexual health
- commissioning high-quality services, with clarity about accountability
- meeting the needs of more vulnerable groups
- good-quality intelligence about services and outcomes for monitoring purposes

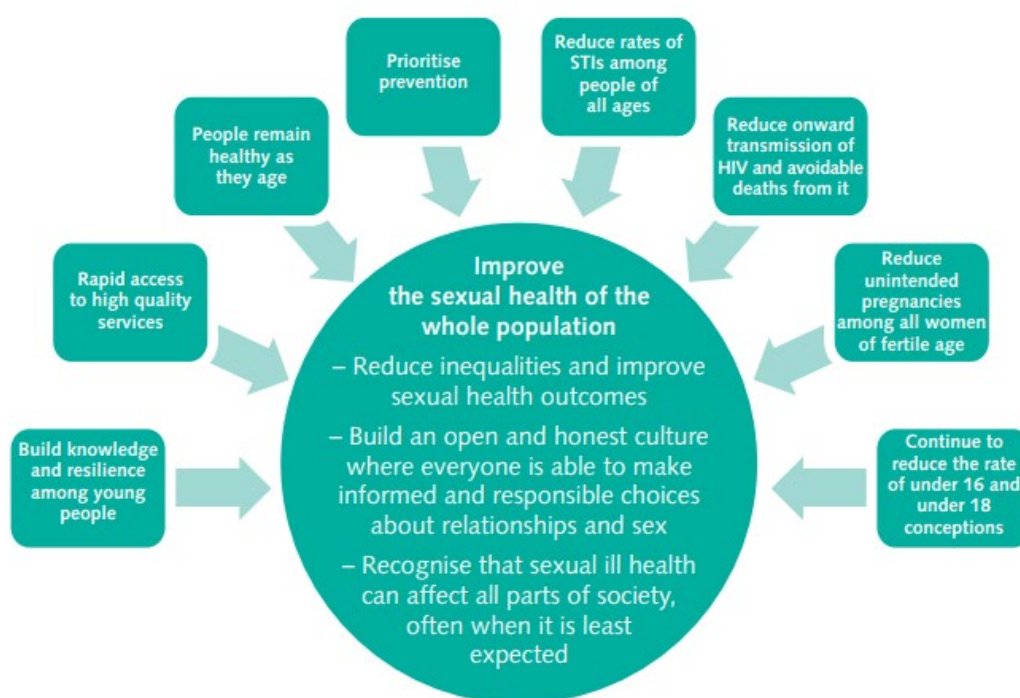


Figure 2.1: The ambition and objectives of the government's 2013 'A framework for sexual health improvement in England'

2.2.2 Teenage pregnancy strategy and national pregnancy prevention framework

The Teenage Pregnancy Strategy, launched in 1999, aimed to halve the teenage pregnancy rate by 2010. While the target was not met, the rate was 13.3% lower in 2010 than 1998, and teenage conceptions and births were at their lowest level for over 20 years.¹⁰ Recent action to further reduce teenage pregnancies has continued with the Teenage Pregnancy

¹⁰ [Teenage Pregnancy Strategy: Beyond 2010](#) (published 2010)

Prevention Framework¹¹, which aims to help local areas assess their teenage pregnancy prevention programmes to see what's working well, identify any gaps and take a multi-agency whole-system approach.

2.2.3 Public health outcomes framework (PHOF)

The PHOF¹² provides the national indicators underpinning the sexual health framework above. The PHOF is reviewed every three years to ensure that it remains fit for purpose and meets the needs of users. In its first three years from 2013-2016, the PHOF included the following three indicators: ¹³

- under-18 conceptions
- chlamydia diagnoses (15–24-year-olds)
- people presenting with HIV at a late stage of infection

However, by the 2019-2022 iteration, the indicators directly relevant to sexual and reproductive health have changed in places and increased to include the following six:¹⁴

- chlamydia detection rate / 100,000 aged 15-24
- new STI diagnoses (excluding chlamydia aged <25) / 100,000
- HIV late diagnosis (%)
- total prescribed LARC excluding injections rate / 1,000
- under 18s conception rate / 1,000
- under 16s conception rate / 1,000

The increase in sexual and reproductive health metrics monitored nationally indicates that concerns around new STI diagnoses, teenage pregnancy and the prescribing of LARC have become more prominent health needs for the population over the years.

2.2.4 National sexual health and reproductive health strategy

Following sector-wide calls, the government committed in October 2019 to delivering an updated national sexual health and reproductive health strategy to replace the 2013 framework. It is expected that the new strategy will be in the form of an action plan and will be published in 2023.

2.2.5 All Party Parliamentary Group on Sexual and Reproductive Health

The All Party Parliamentary Group on Sexual and Reproductive Health in the UK (APPG SRH) is a group of MPs and Peers seeking to raise awareness in Parliament of the needs of women seeking abortion and the importance of improving the sexual and reproductive health of people in the UK. In recent years, the APPG SRH has held inquiries into access to contraception and the need for accountability and integration in sexual health, reproductive

¹¹ [Teenage pregnancy prevention framework - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/678417/teenage_pregnancy_prevention_framework.pdf) (published 15/01/2018)

¹² [Public Health Outcomes Framework - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/678417/public_health_outcomes_framework.pdf) (last updated 04/05/2022)

¹³ [Public Health Outcomes Framework 2013 to 2016 - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/678417/public_health_outcomes_framework_2013_to_2016.pdf) (last updated 10/12/2015)

¹⁴ [Public Health Outcomes Framework: indicator changes 2019 to 2022 - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/678417/public_health_outcomes_framework_indicator_changes_2019_to_2022.pdf) (last updated 02/08/2019)

health and HIV care. Events have been hosted in Parliament on female genital mutilation, relationships and sex education and women's reproductive health, to name but a few. The APPG SRH are continuing work to improve access to contraception for women in England following opening an Inquiry into Access to Contraception in 2019. The publication of 'Women's Lives, Women's Rights: Strengthening Access to Contraception Beyond the Pandemic'¹⁵ found that:

- women in England are facing increasing difficulty in accessing contraception which suits their needs
- this is due to a combination of funding cuts and a fragmented commissioning system which means that care is not structured around women's needs
- there is an urgent need to structure care around the needs of women, especially underserved groups such as ethnic minority groups, young women and women from poorer communities.¹⁶

2.2.6 Health and Social Care Act 2022

The Health and Care Act 2022 contains the biggest reforms to the NHS in nearly a decade, laying the foundations to improve health outcomes by joining up NHS, social care and public health services at a local level and tackling growing health inequalities.

The majority of the Act is focused on developing system working with integrated care systems (ICSs) being put on a statutory footing through the creation of integrated care boards (ICBs). It also moves the NHS away from competitive retendering by default and towards collaborative delivery. More detail on what the new system structures are and what their roles are is provided later in section [3.1](#).¹⁷

2.2.7 Breaking point: securing the future of sexual health services

This report was published in November 2022 by the Local Government Association (LGA) and English HIV and Sexual Health Commissioners' Group. The report focuses on demand and funding pressures and delves into the trends since local authorities took responsibility for sexual health services in 2013, looking at the social and economic context in which they occur. The key messages are:

- there has been a significant increase in the number of consultations at sexual and reproductive health services (SRHS) over the last 10 years
- the number of screens and the overall number of services offered has increased, public awareness of STIs and contraception has grown

¹⁵ [Full report \(December\) - Women's Lives, Women's Rights - Faculty of Sexual and Reproductive Healthcare \(fsrh.org\)](#) (published 10/12/2020)

¹⁶ [All Party Parliamentary Group on Sexual and Reproductive Health - Faculty of Sexual and Reproductive Healthcare \(fsrh.org\)](#)

¹⁷ [Health and Care Act 2022 - NHS Providers](#)

- local councils have been engaged in one of the biggest modernisation exercises in the history of public health, such as a rapid channel shift to online consultations, app, home testing and home sampling
- evidence from across the sector shows the capacity of councils to further innovate and create greater efficiencies is now limited
- unless greater recognition and funding is given to councils to invest in prevention services, a reversal in the encouraging and continuing fall in some STIs and more unwanted pregnancies is now a real risk as is their ability to respond to unforeseen challenges such as mpox (previously referred to as monkeypox)
- behavioural change has increased demand
- equitable access to contraception remains a problem¹⁸

2.2.8 State of the nation: sexually transmitted infections in England

The 2020 'State of the nation'¹⁹ report published by THT and BASHH aims to '*bring together the current knowledge on STIs in England - looking at the trends in STIs, and who they are affecting, why we are seeing these trends, and why some groups are more affected than others*'. The report explores the following themes and makes broad recommendations for each (adapted from the report):

- inequalities:
 - there is little research looking at the impact of discrimination, including racism, homophobia and transphobia, on the trends seen in STIs
 - the limited information on inequalities does little to inform a holistic approach to STIs and needs resolving to tackle them
- national vision and priority:
 - there is an urgent need for a national sexual health strategy, as well as more specific STI national outcome measures in the PHOF
- behaviours:
 - there is limited up-to-date research on behaviours, and a lack of research on what is driving behaviours
- a lack of prevention options:
 - there is a need to take learning from PrEP and the HPV vaccination when considering alternative prevention methods for STIs that may be acceptable beyond the use of condoms and STI testing
- the need for sustainable sexual health services:

¹⁸ [Breaking point: Securing the future of sexual health services | Local Government Association](#) (published 15/11/2022)

¹⁹ [State of The nation Report \(tth.org.uk\)](#) (published 02/2020)

- there is a need for improved national investment in sexual health services and proposed co-commissioning needs to urgently improve integrated working across services
- access:
 - public health funding cuts have compromised service user access by facilitating service closures and staff cuts, leading to longer waiting times and reduced outreach services
 - positive methods of access to sexual health services, including self-sampling and pharmacies, cannot substitute for face-to-face sexual health clinics
- awareness and information:
 - compulsory relationships and sex education (RSE) is a positive step to increase young people's awareness of STIs and safer sex practices, but schools must be fully funded to deliver it at high quality across the country
 - health promotion messaging should be inclusive of key groups, such as older people, migrants and people who have low levels of either health literacy or English literacy
- visibility and stigma:
 - the invisible voices of people affected by poor sexual health leaves the fight against STIs without clear community advocates (in contrast to combating HIV stigma)
 - the lack of voices, champions and visibility of sexual health in mass media runs the risk of perpetuating stigmatising attitudes
- the bigger picture:
 - HIV, STIs and sexual health should no longer be considered in silo
 - the relationship between sexual health and the wider determinants of health should not be overlooked
 - a holistic approach is vital for ensuring future planning and strategies regarding STIs and sexual health

2.2.9 Towards zero - an action plan towards ending HIV transmission, AIDS and HIV-related deaths in England, 2022 to 2025

In December 2021, the DHSC published 'Towards zero - an action plan'.²⁰ This action plan outlines the government's commitment to achieving zero new HIV infections, AIDS and HIV-related deaths in England by 2030. It builds on the 35% reduction in HIV new diagnoses recorded in England between 2014 and 2019.

²⁰ [Towards Zero: the HIV Action Plan for England - 2022 to 2025 - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/101444/towards-zero-the-hiv-action-plan-for-england-2022-to-2025.pdf) (last updated 21/12/2021)

Since the UNAIDS 95-95-95 targets for 2025 were set in 2021²¹, England has reached these each year in 2020 and 2021, with 95% of people living with HIV had been diagnosed, 99% of those diagnosed were on treatment, and 98% of those on treatment had an undetectable viral load in 2021 – meaning they cannot pass on the infection.²²

In order to achieve the 2030 goals, the action plan outlines four objectives.

1. Ensure equitable access and uptake of HIV prevention programmes
2. Scale up HIV testing in line with national guidelines
3. Optimise rapid access to treatment and retention in care
4. Improving quality of life for people living with HIV and addressing stigma

2.2.10 Women's health strategy for England

On 20 July 2022, the DHSC published the 'Women's health strategy for England'²³, which acknowledges that women live on average for longer than men but spend more of their life in poor health, often limiting their ability to work and participate in day-to-day activities. In developing the strategy, DHSC received more than 100,000 responses to a call for evidence and have developed their commitments based on an assessment of the issues raised by women. The 10-year strategy outlines a six-point long-term plan for transformational change.

1. Ensuring women's voices are heard
2. Improving access to services
3. Addressing disparities in outcomes amongst women
4. Better information and education
5. Greater understanding of how women's health affects their experience in the workplace
6. Supporting more research, improving the evidence base and spearheading the drive for better data

The priority health areas that the strategy focuses on are menstrual health and gynaecological conditions; fertility, pregnancy, pregnancy loss and post-natal support; menopause; mental health and wellbeing; cancers; the health impacts of violence against women and girls; and healthy ageing and long-term conditions.

The strategy also outlines eight top commitments that require immediate action, one of which encourages the expansion of women's health hubs around the country and other models of 'one-stop clinics', bringing essential women's services together to support women to maintain good health and create efficiencies for the NHS. The strategy states that a women's health accreditation mechanism will be developed to recognise commissioners

²¹ [2025 AIDS TARGETS - UNAIDS](#)

²² [HIV Action Plan monitoring and evaluation framework - GOV.UK \(www.gov.uk\)](#) (published 01/12/2022)

²³ [Women's Health Strategy for England - GOV.UK \(www.gov.uk\)](#) (published 20/07/2022)

and providers who offer services in these ways and promote best practice across the country. This is in response to views from women that there should be more cohesion in the way services are provided, making it as simple as possible for women to access the healthcare they need.

It is important to note that the ongoing and outstanding actions from PHE's women's reproductive health programme have been integrated into the DHSC's new women's health strategy, as well as the pending sexual and reproductive health strategy.²⁴

2.2.11 Variation in outcomes in sexual and reproductive health in England

In May 2021, PHE published a toolkit to guide sexual health commissioners, public health teams and sexual health service providers to explore inequalities at a local level in England.²⁵ Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society that arise because of the conditions in which individuals are born, grow, live, work and age. These conditions influence opportunities for good health, and how people think, feel and act, shaping mental health, physical health and wellbeing.

At a national level, it is known that there is variation in sexual and reproductive health outcomes within and between different populations. Inequalities in uptake of or access to interventions can make inequalities in ill health worse, with some parts of the population affected by more than one area of sexual and reproductive ill health. The toolkit focuses on comparing data from sexual and reproductive health indicators between and within different council areas to understand where variation occurs, identifying the principal causes and underlying factors of any variation, and informing ways to target and reduce sexual and reproductive health inequality and improve outcomes.

2.2.12 The pharmacy offer for sexual health, reproductive health and HIV

This resource discusses the capacity and capability of pharmacy teams, in both the primary and community sector, to provide consistent and high quality SRHS. It aims to help commissioners and providers further embed pharmacy into key sexual health, reproductive health and HIV work streams to:

- improve delivery of sexual and reproductive health, and HIV services through pharmacies
- increase public access to sexual and reproductive health and HIV services
- help reduce inequalities within the community
- improve sexual health
- reduce the burden on other health services

²⁴ [Women's reproductive health programme: progress, products and next steps - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/publications/women-s-reproductive-health-programme-progress-products-and-next-steps) (published 14/07/2021)

²⁵ [Variation in outcomes in sexual and reproductive health in England 2021 \(publishing.service.gov.uk\)](https://publishing.service.gov.uk/government/publications/variation-in-outcomes-in-sexual-and-reproductive-health-in-england-2021) (published 12/05/2021)

The update to the Community Pharmacy Contractual Framework 2019-2024 includes a new specification that will permit pharmacies to provide ongoing monitoring and supply of the progestogen-only pill and the combined oral contraceptive pill from January 2023 as the first of four tiers of an enhanced contraception service.²⁶ From October 2023, subject to positive evaluation, Tier 2 of the enhanced service will be introduced, enabling community pharmacists to also initiate oral contraception, via a PGD, and provide ongoing clinical checks and annual reviews. The other two tiers are: ongoing monitoring and management of repeat LARC, excluding intrauterine systems and intrauterine devices, and initiation of LARCs.²⁷

2.2.13 What good sexual health, reproductive health and HIV provision looks like

This co-produced publication forms part of the Association of Directors of Public Health (ADPH) and PHE's 'What good looks like' programme and was developed collaboratively through the synthesis of existing evidence, examples of best practice, practitioners' experiences and consensus expert opinions.²⁸ It aims to facilitate the collective efforts of local organisations and the wider system towards improvements in population health outcomes. It outlines the four core themes of what good quality sexual health, reproductive health and HIV provision looks like in any defined place, which are listed below with some of the key features of each theme. This is a particularly useful publication in light of the absence of an up-to-date national strategy.

- 1) Successful system leadership
 - having identifiable leadership and governance that supports local decision making, informed by evidence and population need, whilst considering inequalities and cost-effectiveness
 - having a clear, shared strategic vision and goals that are agreed by all partners
 - working together across organisational boundaries to develop and support consistent and coherent services and pathways in response to population need
- 2) Building individual and community resilience
 - supporting and evaluating initiatives across the local system which focus on enhancing individual and community resilience and promoting self-care
 - addressing stigma and working together to make everyone, including professionals, more comfortable in discussing sexual and reproductive health
- 3) Safe and effective practices/services
 - ensuring delivery in accordance with current standards and regulations
 - maintaining a focus on primary prevention including the use of condoms and effective contraception and the delivery of vaccinations

²⁶ [NHS England » NHS Pharmacy Contraception Service Tier 1 – Ongoing supply of oral contraception](#) (published 10/01/2023)

²⁷ [Community Pharmacy Contractual Framework 5-year deal: year 4 \(2022 to 2023\) and year 5 \(2023 to 2024\) - GOV.UK \(www.gov.uk\)](#) (published 22/09/2022)

²⁸ [What Good Sexual and Reproductive Health and HIV Provision Looks Like \(adph.org.uk\)](#) (published in 2019)

- utilise patient feedback to develop and improve practice and service provision on a continual basis
- 4) Promoting equity
- the local system uses population health data and service data to identify inequalities in access and uptake of services across the local system and to maximise effectiveness of resources
 - key populations are engaged in the development and delivery of strategies to improve SH, RH and HIV, and in the evaluation and development of local services

2.2.14 The Hatfield vision: a framework to improve women and girls' reproductive health outcomes

The Faculty of Sexual and Reproductive Healthcare (FSRH) has developed the Hatfield Vision in honour of their first CEO, Jane Hatfield, who died from ovarian cancer in 2021.²⁹ The vision aims to leverage commitment and accountability at national and regional levels to achieve comprehensive, joined-up women's reproductive healthcare. The vision was launched on 20 July 2022 and is endorsed by 28 leading organisations and groups across healthcare, public health, the charity sector and Parliament. The vision sets out an ambition that by 2030 *'reproductive health inequalities will have significantly improved for all women and girls, enabling them to live well and pursue their ambitions in every aspect of their lives'*. This ambition is underpinned by 16 goals covering:

- the ability to choose if and when to have children
- access and standards of contraceptive care
- access to preconception care
- access to menstrual health support
- access and standards of abortion care
- access to cervical screening
- access to menopause care
- maternal health outcomes in black women and women of colour
- access to information

The vision goes on to outline priority actions in the following areas in order to achieve the goals above and the ambition as a whole: workforce; commissioning; accountability; data and information; health promotion.

2.2.15 At home early medical abortions made permanent

Since the 30th August 2022, an amendment to the Abortion Act now allows eligible women in the first 10 weeks of pregnancy (9 weeks and 6 days) to continue to access pills for early medical abortion through a teleconsultation, and for both pills to be taken at home. This amendment to the legislation makes permanent the temporary changes that were put in place during COVID-19 to allow for both pills (instead of only the second pill) to be taken

²⁹ [FSRH Hatfield Vision](#) (published 20/07/2022)

outside of a health setting, enabling women to have continued access to early medical abortions whilst adhering to the requirement to stay at home during the lockdowns.

Doctors are required to certify in 'good faith' that the gestation period is below 10 weeks if the doctor terminating the pregnancy prescribes the abortion pills from their home, or if one or both pills for early medical abortion are to be taken by the pregnant woman at her home.³⁰

2.2.16 Changes to the National Chlamydia Screening Programme (NCSP)

In June 2021 it was announced that the focus of the NCSP would shift to reducing the harms from untreated chlamydia infection combined with reducing time to test results and treatment, strengthening partner notification and re-testing after treatment. As the harms from untreated chlamydia occur predominantly in young women and other people with a womb or ovaries – this includes transgender men, non-binary people assigned female at birth, and intersex people – opportunistic screening now focuses on these groups only. In practice this means that chlamydia screening in community settings (e.g. GP surgeries and community pharmacies) will only be proactively offered to young women and other people with a womb or ovaries. Services provided by sexual health services remain unchanged and everyone can still get tested if needed.

Given the change in programme aim, the PHOF detection rate indicator benchmarking thresholds have been revised and increased and will be measured against females only. This new indicator has been included in the PHOF since January 2022 and will be reported in 2023. The new thresholds for females will be:

- green = >3,250 / 100,000 (changed from >2,300)
- amber = 2,400-<3,250 / 100,000 (changed from 1,900-<2,300)
- red = <2,400 / 100,000 (changed from <1,900).³¹

2.2.17 Young People's RSE Poll 2022

A survey of 1,002 young people aged 16-17 in England was carried out by Censuswide between 2 and 13 December 2022 and commissioned by the Sex Education Forum to collect young people's view of RSE delivered in schools. The key findings include:³²

- the percentage of young people saying the quality of RSE is 'good' or 'very good' is 40%, on par with the data from 2019 – highlighting that there hasn't been any improvement in the quality since the statutory curriculum was introduced in 2020
- topics that are often missed from the curriculum include pornography, LGBTQ+ relevant information, power imbalances and healthy relationships

³⁰ [At home early medical abortions made permanent in England and Wales - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/news/at-home-early-medical-abortion-pills-made-permanent) (published 23/08/2022)

³¹ [Changes to the National Chlamydia Screening Programme \(NCSP\) - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/news/changes-to-the-national-chlamydia-screening-programme) (published 24/06/2021)

³² [Young People's RSE Poll 2022 | sexeducationforum.org.uk](https://sexeducationforum.org.uk) (published 02/03/2023)

- respondents were split about whether enough time was dedicated to RSE in school, with 37% agreeing schools offered enough hours of RSE and 38% disagreeing
- over a third (35%) of young people said they wanted more open discussion of issues
- 56% learnt not enough or nothing about how to access local sexual health services

2.3 National specialist organisations

2.3.1 British Association for Sexual Health and HIV (BASHH)

BASHH is the largest and oldest association in the field of STI and HIV with membership including medical practitioners, nurses, health advisers, scientists in the field of medicine and other healthcare workers who have shown a commitment to the specialty. The object of BASHH is to:

- promote, encourage and improve the study and practice of diagnosing, treating and managing sexually transmitted infections, HIV and other sexual health problems
- innovate and deliver excellent tailored education and training to health care professionals, trainers and trainees in the UK
- determine, monitor and maintain standards of governance in the provision of sexual health and HIV care
- advance public health in relation to sexually transmitted infections, HIV and other sexual health problems
- champion and promote good sexual health and provide education to the public

2.3.2 Faculty of Sexual and Reproductive Health (FSRH)

The FSRH are a multi-disciplinary professional membership organisation that offers:

- evidence-based clinical guidance and standards
- a range of qualifications and training in sexual and reproductive health
- webinars and events

The FSRH develops and manages the Community Sexual and Reproductive Health (CSRH) specialty programme, which trains future sexual and reproductive health consultants. It also provides a voice for clinicians, including doctors, nurses, midwives, pharmacists and physician associates, and influences policy, legislation and public opinion working with national and local governments, MPs, commissioners, policymakers, the media, patient groups and other decision-makers.³³

2.4 NICE guidance

2.4.1 Reducing sexually transmitted infections (NG221)³⁴

This new guideline, published in June 2022, covers interventions to prevent STIs in people aged 16 and over. It aims to reduce the transmission of all STIs, including HIV, and includes

³³ [About us - Faculty of Sexual and Reproductive Healthcare \(fsrh.org\)](#)

³⁴ [Reducing sexually transmitted infections | Guidance | NICE](#) (published 15/06/2022)

ways to help increase the uptake of STI testing and vaccines for HPV and hepatitis A and B. The guideline includes recommendations on:

- reducing the risk of people getting and transmitting STIs by
 - reducing barriers to accessing sexual health services
 - meeting the needs of groups with greater sexual health or access needs
 - co-producing interventions to reduce STI transmission
 - delivering and evaluating interventions to reduce STI transmission
- improving uptake and increasing the frequency of STI testing by
 - offering self-sampling
 - tailoring interventions to service users' needs
- partner notification
- HPV and hepatitis A and B vaccination in gay, bisexual and other men who have sex with men
- PrEP for HIV
 - raising awareness of pre-exposure prophylaxis for HIV
 - designing welcoming, accessible and well-advertised services
 - prescribing PrEP and providing ongoing support and advice

The guideline is supported by two quality standards: Sexual health (QS178)³⁵ and HIV testing: encouraging uptake (QS157)³⁶. The former covers sexual health, focusing on preventing STIs and does not cover harmful sexual behaviour or contraception, and the latter covers interventions to improve the uptake of HIV testing among people who may have undiagnosed HIV. It focuses on increasing testing to reduce undiagnosed infection in people at increased risk of exposure.

2.4.2 Abortion care (NG140)³⁷

This guideline was published in 2019 and covers care for women of any age (including girls and young women under 18) who request an abortion. It aims to improve the organisation of services and make them easier for women to access. Detailed recommendations on conducting abortions at different gestational stages are also included, to ensure that women get the safest and most effective care possible. The guideline is supported by two quality standards: Abortion Care (QS199)³⁸ and Contraception (QS129)³⁹. The former covers care for women of any age who request an abortion, and the latter covers contraception for women, including emergency contraception.

³⁵ [Sexual health | Quality standards | NICE](#) (published 05/02/2019)

³⁶ [HIV testing: encouraging uptake | Quality standards | NICE](#) (published 07/09/2017)

³⁷ [Overview | Abortion care | Guidance | NICE](#) (published 25/09/2019)

³⁸ [Overview | Abortion care | Quality standards | NICE](#) (published 26/01/2021)

³⁹ [Overview | Contraception | Quality standards | NICE](#) (published 08/09/2016)

2.4.3 Sexually transmitted infections: condom distribution schemes (NG68)⁴⁰

This guideline, published in 2017, covers condom distribution schemes. The aim is to reduce the risk of sexually transmitted infections (STIs). In addition, these schemes can provide a good introduction to broader sexual and reproductive health services, especially for younger people, and help prevent unplanned pregnancies.

2.4.4 HIV testing: increasing uptake among people who may have undiagnosed HIV (NG60)⁴¹

This guidance, published in 2016, covers how to increase the uptake of HIV testing in primary and secondary care, specialist sexual health services and the community. It describes how to plan and deliver services that are tailored to the local prevalence of HIV, promote awareness of HIV testing and increase opportunities to offer testing to people who may have undiagnosed HIV.

2.4.5 Contraceptive services for under 25s (PH51)⁴²

This public health guideline was published in 2014 and aims to ensure all under-25s are given advice and information on all types of contraception. This includes additional tailored support to meet the particular needs and choices of those who are socially disadvantaged or who may find it difficult to use these services.

2.4.6 Long-acting reversible contraception (CG30)⁴³

This clinical guideline about LARC was published in 2005. It aims to increase the use of LARC by improving the information given to women about their contraceptive choices.

2.4.7 Postnatal care (NG194)⁴⁴

This guideline, published in 2021, covers the routine postnatal care that women and their babies should receive after birth, of which one of the recommendations around assessment and care of the woman includes a discussion about post-partum contraception to support planned choices about future pregnancies and improve maternal and child outcomes through optimum spacing between children.

2.5 Outbreaks impacting sexual health services nationally

2.5.1 COVID-19

For more than two years, the impacts of the COVID-19 pandemic have been felt across health services, including sexual health services delivered at all levels. PHE undertook analyses to assess the impact of the early pandemic response on STIs, HIV and viral hepatitis

⁴⁰ [Overview | Sexually transmitted infections: condom distribution schemes | Guidance | NICE](#) (published 06/04/2017)

⁴¹ [HIV testing: increasing uptake among people who may have undiagnosed HIV | Guidance | NICE](#) (published 01/12/2016)

⁴² [Contraceptive services for under 25s | Guidance | NICE](#) (published 26/03/2014)

⁴³ [Long-acting reversible contraception | Guidance | NICE](#) (last updated 02/07/2019)

⁴⁴ [Overview | Postnatal care | Guidance | NICE](#) (published 20/04/2021)

service provision and epidemiology.⁴⁵ The study found that between March and May 2020, there was a reduction in:

- consultations undertaken by SRHS and specialised HIV services
- testing for viral hepatitis in drug services, prisons, general practice and SRHS
- testing for HIV and STIs in SRHS
- vaccination of GBMSM against HPV, hepatitis B (HBV) and hepatitis A (HAV)
- diagnoses of viral hepatitis, HIV and STIs
- hepatitis C (HCV) treatment initiations

From June 2020, the easing of national lockdown restrictions saw a resurgence in HIV, STIs and hepatitis tests and diagnoses, and an increase in HCV treatment initiations, reflecting a partial recovery in service provision and demand. Despite this increase though, numbers of consultations, vaccinations, tests, diagnoses, and treatment initiations in the summer of 2020 were considerably lower than in corresponding months in 2019.

While rapid innovations in service delivery, such as online or tele-consultations for HIV and hepatitis, STI and blood-borne virus (BBV) self-sampling kits, enabled access to services during the COVID-19 response, there are concerns about the impact of these changes on sexual health inequalities, particularly among socially disadvantaged and/or marginalised groups who already experience poor health outcomes, including people who inject drugs and experience homelessness, and certain black and Asian ethnic minorities.

The report concludes that these findings from early on in the COVID-19 pandemic suggest that the pandemic response, including social and physical distancing measures, led to a re-prioritisation and disruption in provision of, and patient access to, sexual health services. Reduced demand for services during this time may also have been influenced by compliance with social distancing measures as well as changes in risk perception and behaviour.

The Advisory Group on Contraception (AGC), which is an expert advisory group that came together in 2010 made up of leading clinicians and advocacy groups to discuss and make policy recommendations concerning the contraceptive needs of women of all ages in England,⁴⁶ published a briefing on access to contraception during and after the COVID-19 pandemic.⁴⁷ In it, they highlight three key factors that have impacted contraception provision during the pandemic. These are:

Compounding funding pressures

Successive budget cuts prior to the pandemic left services unable to cope with the pressures of COVID-19, particularly as they faced a range of competing spending priorities, for example, from 2016/17 to 2018/19, 66% of councils cut their spending on sexual and reproductive health. While public health funding allocations have received inflationary

⁴⁵ [COVID-19: impact on STIs, HIV and viral hepatitis - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/news/covid-19-impact-on-stis-hiv-and-viral-hepatitis) (published 15/12/2020)

⁴⁶ [The Advisory Group on Contraception \(theagc.org.uk\)](https://theagc.org.uk/)

⁴⁷ [AGC Securing sustainability briefing \(theagc.org.uk\)](https://theagc.org.uk/) (published 2022)

uplifts since the beginning of the pandemic, these have not been in line with the national rate of inflation, which has climbed considerably since the pandemic began resulting in an overall decrease in the value of the funding. Inadequate funding is particularly damaging for delivery of LARC as staff must be highly trained and appointments longer to allow for counselling and insertion. The viability of services continuing to deliver or restart delivery of LARC as the pandemic has eased is called in to question, particularly in primary care with many GPs underfunded or not commissioned to deliver LARC services.

Impeding service delivery and uptake

NHS data for England shows that in 2020/21, contraception-related contacts with dedicated SRH services were almost 50% lower than 2014/15, with a particularly steep drop in 2019/20. This correlates with a stark decline in the uptake of LARC in England, with strains on service capacity that already existed prior to COVID-19 exacerbated by the pandemic. Between 2019 and 2020, total LARC prescribing fell from 50.8 per 100,000 to 34.6 per 100,000. This represents a 33% decline in GP-prescribed LARC and a 36% decline in LARC prescribed in specialist SRH services in the first year of the pandemic alone. Delivery of LARC in the voluntary sector has also been adversely affected. During the first months of the pandemic, abortion provider MSI Reproductive Choices saw a 22% reduction in the number of LARC fittings it was able to provide in England, thanks to a forced reduction in face-to-face appointments and cancellation of post-abortion LARC appointments.

Intensifying pressure on an already strained workforce

An AGC member, the Faculty of Sexual and Reproductive Healthcare (FSRH) carried out several surveys with sexual health service providers throughout the pandemic, identifying increased pressures and strains on a stretched workforce within specialist and primary care services – see figure 2.2 below.

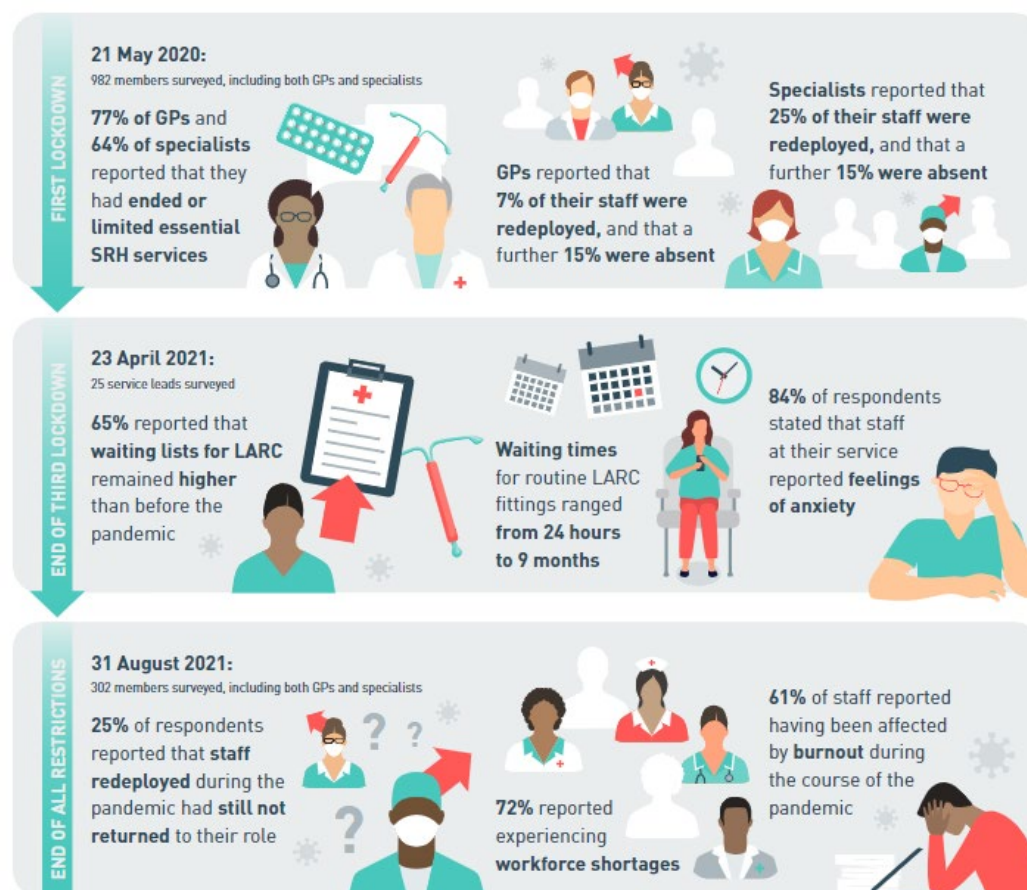


Figure 2.2: Infographic summarising key findings from the FSRH COVID-19 surveys (from the AGC 'Securing sustainability' briefing)

Some of the impacts to service provision are that the proportion of unplanned pregnancies almost doubled in England during lockdown, from 1.3% to 2.1% of pregnancies. Also, 2020 saw the highest abortion rate since the Abortion Act was introduced, at 18.2 per 1,000 women in England and Wales, with the highest rise in women aged 30 to 34, from 16.5 per 1,000 in 2010 to 21.9 per 1,000 in 2020.⁴⁸

The AGC have issued a call to action to ensure that provision of contraceptive services are sustainable now and in the future through targeted funding and enhancing accessibility to the full range of contraceptive methods in all settings.

2.5.2 Mpox (previously referred to as monkeypox)

Mpox is a rare viral infection that does not spread easily between people as it requires close contact with an infected person. It is usually a mild self-limiting illness, and most people recover within a few weeks. However, severe illness can occur. On 7 May 2022, the UK Health Security Agency (UKHSA) confirmed that an individual had been diagnosed with mpox in England following recent travel to Nigeria, where mpox is endemic. Almost three months later, there were 2,115 reported cases in England on 21 July 2022. So far, the

⁴⁸ [Abortion statistics, England and Wales: 2020 - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/statistics/abortion-statistics-england-and-wales-2020) (updated 04/05/2022)

evidence suggests that transmission is occurring primarily within interconnected sexual networks, predominantly among groups of GBMSM.⁴⁹

On 23 July 2022, the World Health Organization (WHO) declared the mpox outbreak a public health emergency of international concern, following a worldwide increase in cases. The current risk level is assessed as moderate globally and high in Europe.⁵⁰ In response to this declaration, BASHH advised that this development underlines the critical need to ensure a robust and effectively resourced response to the public health challenge in the UK.⁵¹

This comes on the heels of a consensus statement issued jointly on 12 July 2022 by a coalition of organisations working in sexual health calling for urgent action to eliminate mpox in the UK before it becomes endemic.⁵² It states that mpox, which is largely being managed within specialist sexual health services, is destabilising services for STIs, HIV PrEP and LARC, with many services reporting significant reductions in non-mpox activity and some describing a 90% reduction in PrEP and LARC access. This raises concerns about exacerbating the health inequalities experienced by GBMSM.

The organisations call for urgent action on the following:

- system-wide co-ordination with clear lines of accountability
- funding to achieve outbreak control, optimise mpox care, protect existing sexual health services and support people required to isolate
- an appropriately resourced vaccine programme with a clear delivery plan

In relation to funding, the organisations are calling for £51 million from the DHSC to control the outbreak, optimise mpox care, protect the wider service delivery of sexual health services and to support people who are required to isolate because of mpox. The coalition is also calling for appropriate resourcing for the targeted vaccine programme for GBMSM to be delivered, with BASHH estimating a cost of £62.63 per person to deliver two vaccine doses.⁵³ There has not been a response from the DHSC yet.

2.6 Sexual health inequalities

In most aspects of sexual and reproductive health, variations in outcomes are evident between and within local areas and populations or communities. Some of these differences have a clear relationship with social and health inequalities and may be impacted by differences in behaviour, social networks and risk exposures. Others may indicate geographic variation in local populations' demographics or in access to and use of sexual

⁴⁹ [Monkeypox cases confirmed in England – latest updates - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/news/monkeypox-cases-confirmed-in-england-latest-updates) (updated 22/07/2022)

⁵⁰ [WHO Director-General's statement at the press conference following IHR Emergency Committee regarding the multi-country outbreak of monkeypox - 23 July 2022](https://www.who.int/director-general/statement/20220723-mpox) (published 23/07/2022)

⁵¹ [BASHH statement in response to World Health Organisation \(WHO\) declaring monkeypox global health emergency. | British Association for Sexual Health and HIV](https://www.bashh.org.uk/news/2022/07/25/bashh-statement-in-response-to-world-health-organisation-who-declaring-monkeypox-global-health-emergency) (published 25/07/2022)

⁵² [Consensus statement on response to the monkeypox outbreak \(bhiva.org\)](https://www.bhiva.org/consensus-statement-on-response-to-the-monkeypox-outbreak) (published 12/07/2022)

⁵³ [ADPH £51m urgently needed to stop monkeypox becoming endemic in the UK - ADPH](https://www.adph.org.uk/news/2022/07/12/adph-51m-urgently-needed-to-stop-monkeypox-becoming-endemic-in-the-uk) (published 12/07/2022)

and reproductive health services, or in the availability and provision of interventions. There are many reasons why it is important to explore variations in outcomes, including:⁵⁴

- many sexual and reproductive health indicators are deteriorating nationally – a review and action at a local level is needed to halt or reverse the trend
- a good overall picture can mask inequalities within an area which need to be addressed
- to make more impact and guide best use of resources to improve outcomes
- to ensure that interventions do not widen existing inequalities in sexual and reproductive health
- as a system we have a desire and a requirement to improve health and reduce inequalities

The following highlights some of the factors that can lead to poor sexual health outcomes, particularly when an individual cuts across multiple factors.

Deprivation

There is an evident link between deprivation and poor sexual health, with the most deprived areas of England experiencing the highest rates of STIs. This may be through limited access to education and information, to prevention interventions (such as condoms, contraception or PrEP), and sexual health treatment services or by diminishing the power, autonomy and efficacy an individual has to negotiate safer and consensual sex.⁵⁵ Variation in sexual and reproductive health outcomes can be seen in the rates of STI diagnosis, under-18s conception and abortion, which are all greatest in the most deprived deciles.⁵⁶

Black, Asian and minoritised ethnic communities

There are obvious differences in STI rates by ethnicity with Black Caribbean individuals and Black non-Caribbean/non-African individuals generally seeing the highest rates of new diagnoses among many STIs, particularly gonorrhoea. In contrast, Asian and Asian British individuals have the lowest diagnosis rate at half that of the general population.⁵⁷ Black, Asian and minoritised ethnic communities are disproportionately affected by STIs with the rate of gonorrhoea three and a half times that of the general population, and for trichomoniasis⁵⁸, the rate is nine times that of the general population. Furthermore, higher proportions of Black ethnic minorities are also diagnosed late with HIV.⁵⁹

Repeat abortions

⁵⁴ [Sexual health: variation in outcomes and inequalities - GOV.UK \(www.gov.uk\)](#) (published 12/05/2021)

⁵⁵ [State of the Nation | Terrence Higgins Trust \(tth.org.uk\)](#) (published 06/02/2022)

⁵⁶ [Sexual health: variation in outcomes and inequalities - GOV.UK \(www.gov.uk\)](#) (published 12/05/2021)

⁵⁷ [State of the Nation | Terrence Higgins Trust \(tth.org.uk\)](#) (published 06/02/2022)

⁵⁸ Trichomoniasis is a curable bacterial sexually transmitted infection affecting mostly people aged 15 to 49 years.

⁵⁹ [Sexual health: variation in outcomes and inequalities - GOV.UK \(www.gov.uk\)](#) (published 12/05/2021)

Those who have sought abortion on more than one occasion are more likely (than those who have had one abortion) to be Black, have left school at an earlier age, be living in rented accommodation, report an earlier age at first sexual experience, be less likely to have used a reliable method of contraception at sexual debut and report a greater number of sexual partners.⁶⁰

Sexual orientation

Men who have sex with men are disproportionately affected by both syphilis and gonorrhoea. More than half (51%) of gonorrhoea diagnoses in 2021 were in GBMSM in England, an increase from 47% in 2018. In contrast, 39% of all new HIV diagnoses and 68% of all new syphilis diagnoses in 2021 were in this group, which is a decline from 43% and 75% respectively in 2018 but still remains disproportionately high.^{61,62}

The high levels of syphilis, gonorrhoea and chlamydia diagnoses among GBMSM is possibly associated with behavioural changes such as an increase in partner numbers, condomless sex with new or casual partners, and with HIV PrEP becoming more widely available. For some GBMSM, chemsex and group sex facilitated by geosocial networking applications may have also contributed.⁶³

Gender identity

Globally, transgender people face higher rates of HIV with risk of transmission up to 12 times greater than the general population. We do not know about STI rates in trans and non-binary people, including gender diverse people, in England as this data is not available.⁶⁴

Children and young people under 25 years

Research has shown that teenage pregnancy is associated with poorer outcomes for both young parents and their children. Teenage mothers are less likely to finish their education, are more likely to bring up their child alone and in poverty and have a higher risk of mental health problems than older mothers. Infant mortality rates are 60% higher for babies born to teenage mothers. As children they have an increased risk of living in poverty and are more likely to have accidents and behavioural problems. Access to safe and free abortion and contraception are key issues when it comes to teenage pregnancy.⁶⁵

Young people aged 15 to 24 years old experience the highest diagnosis rates of the most common STIs, likely due to higher rates of partner change. Sixty-one percent of chlamydia

⁶⁰ [Who presents more than once? Repeat abortion among women in Britain - PubMed \(nih.gov\)](#) (published 10/2011)

⁶¹ GUMCAD data (accessed 25/01/2023)

⁶² [State of the Nation | Terrence Higgins Trust \(tth.org.uk\)](#) (published 06/02/2022)

⁶³ [Health matters: preventing STIs - GOV.UK \(www.gov.uk\)](#) (published 21/08/2019)

⁶⁴ [State of the Nation | Terrence Higgins Trust \(tth.org.uk\)](#) (published 06/02/2022)

⁶⁵ [Teenage pregnancy | The Nuffield Trust](#) (updated 31/03/2022)

and 36% of gonorrhoea diagnoses are among young people. Young women are more likely to be diagnosed with an STI than young men, partly due to chlamydia screening through the NCSP, as well as sexual mixing between younger women and older male partners.⁶⁶

People aged 45 and over

Although rates of STIs among older people remain low, increases are being recorded in this population, particularly of gonorrhoea. In 2018, there was an 18% increase in new STI diagnoses among older men (45-64) and a 4% increase among older women since 2014. For older people over the age of 65, both men and women experienced a 23% increase in new STI diagnoses over this time period.⁶⁷

People with learning difficulties

There is little information available estimating the prevalence of sexual health issues in people with learning disabilities. While rates of cervical screening are low for women with learning disabilities compared to the general population, usage of LARC is high among women with learning disabilities using contraception. People with learning disabilities face barriers to having a sex life due to concerns around the ability to consent, vulnerability and the possibility of exploitation.⁶⁸ Mothers with learning disabilities in England are also more likely than other mothers to be single and socio-economically deprived, to give birth at a young age, to smoke during pregnancy, and less likely to breastfeed.⁶⁹

Homeless people

Homelessness is a term often used to refer to people 'sleeping rough', who are either sleeping or bedding down outside or in places unfit for habitation. However, the term can refer to any of the following:⁷⁰

- rooflessness (without a shelter of any kind, sleeping rough)
- houselessness (with a place to sleep but temporary, in institutions or a shelter)
- living in insecure housing (threatened with severe exclusion due to insecure tenancies, eviction, domestic violence, or staying with family and friends known as 'sofa surfing')
- living in inadequate housing (in caravans on illegal campsites, in unfit housing, in extreme overcrowding)

People who are homeless can experience higher rates of STIs, however it is unclear whether current research on STIs refers to all forms of homelessness or just one or two. There is also a lack of understanding of how homelessness increases difficulties in accessing sexual health

⁶⁶ [Health matters: preventing STIs - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/news/health-matters-preventing-stis) (published 21/08/2019)

⁶⁷ [State of the Nation | Terrence Higgins Trust \(tht.org.uk\)](https://www.tht.org.uk/state-of-the-nation) (published 06/02/2022)

⁶⁸ [Learning Disability Profiles - OHID \(phe.org.uk\)](https://phe.org.uk/learning-disability-profiles)

⁶⁹ [Childbirth in women with intellectual disability: characteristics of their pregnancies and outcomes in an archived epidemiological dataset - PubMed \(nih.gov\)](https://pubmed.ncbi.nlm.nih.gov/26111111/) (published 07/2015)

⁷⁰ [Homelessness: applying All Our Health - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/news/homelessness-applying-all-our-health) (published 06/06/2019)

services, and the links with increased sexual risk behaviours. As homelessness in all its forms is rising in England, increasing by 3% in 2018 from 2017, the group of people impacted is getting bigger and more varied.⁷¹

People who inject drugs (PWID)

PWID experience worse health outcomes than the general population and are at greater risk of acquiring BBVs including hepatitis B, hepatitis C and HIV through sharing needles, syringes and other injecting equipment. In 2021 there were 90 new HIV diagnoses in the UK that were likely acquired through injecting drug use, with 36% receiving a late diagnosis. There were also 5 new diagnoses among GBMSM also reporting injecting drug use in the UK in 2021. This places PWID at risk of both acquiring and transmitting BBVs through sexual activity as well as through injecting drug use. Of PWID surveyed in 2021 in England, Wales and North Ireland:

- 56% reported anal or vaginal sex in the last year
- of these, 37% of those reported 2 or more partners
- of these, only 17% reported always using condoms
- 13% reported ever having traded sex for money, goods or drugs
- among men who reported sex in the past year, the proportion of men who reported sex with another man during that time was 7.6%

PWID that are at an ongoing risk of HIV should test regularly to ensure early detection and a timely initiation of treatment.⁷²

Sex workers

In England, certain elements of sex work are criminalised including the purchase of sex and soliciting for sex in a public place. This can place sex workers at risk of harms, such as violence, by limiting their capacity to ensure their clients will not harm them. Further to this a large-scale review of 33 countries (including the UK) found that in places where there was 'repressive policing' of sex work, sex workers were 'twice as likely to have HIV and/or another STI' and 1.5 times more likely to engage in condomless sex with clients. Although sex workers are found to have high engagement with sexual health services, and test regularly, there are evident associations between the criminalisation of sex work and STIs. However, there is limited research based in England. Further to this, transactional sex, for example in exchange for food or shelter, is evident among some homeless people, as well as some people who are receiving universal credit, and the impact of this on sexual health or STIs is not clear.⁷³

⁷¹ [State of the Nation | Terrence Higgins Trust \(tht.org.uk\)](https://www.tht.org.uk) (published 06/02/2022)

⁷² [Shooting Up: infections among people who inject drugs in the UK - GOV.UK \(www.gov.uk\)](https://www.gov.uk) (published 22/03/2023)

⁷³ [State of the Nation | Terrence Higgins Trust \(tht.org.uk\)](https://www.tht.org.uk) (published 06/02/2022)

Asylum seekers and refugees

Asylum seekers and refugees can have greater sexual health needs than the general population if there is a high prevalence of HIV or STIs in the countries where individuals spent time before coming to the UK. For example, a high rate of HIV in a country can be taken as an indicator of likely high rates of other STIs. Also, in some countries screening programmes for infectious diseases, such as HIV and hepatitis, may not be easily accessible, or people may not seek testing due to fear of stigma or lack of treatment options. There can also be concerns around female genital mutilation, sexual and domestic violence.^{74,75}

Modern slavery: sexual exploitation

Modern slavery is a complex crime that covers all forms of slavery, trafficking and exploitation. Modern slavery crimes may involve, or take place alongside, a wide range of abuses and other criminal offences such as grievous bodily harm, assault, rape or child sexual abuse. Sexual exploitation is one of the five main types of modern slavery, where victims are exploited through non-consensual abuse or another person's sexuality for the purpose of sexual gratification, financial gain, personal benefit or advantage, or any other non-legitimate purpose, bringing with it a high prevalence of STIs, injuries of a sexual nature, gynaecological or anogenital symptoms and infertility.⁷⁶ Health needs of potential victims should be addressed as thoroughly as possible, with investigations and treatment offered whilst the potential victim is still there, rather than delayed options.⁷⁷ Data on referrals to the National Referral Mechanism, which is the process for identifying victims of human trafficking and modern slavery, show that in 2021 11% of referrals made by Avon & Somerset Police were for sex-related crimes.⁷⁸ Unity Sexual Health follow UHBW's safeguarding practices in relation to modern slavery and human trafficking. Between April 2021 and December 2023, Unity reported 5 cases where the primary concern was recorded as trafficking.⁷⁹

2.7 Horizon scanning

Since 1 July 2022, ICSs have been formalised as statutory bodies following changes brought about by the 2022 Health and Care Act. ICSs are partnerships that bring together providers and commissioners of NHS services across a geographical area with councils and other local partners to collectively plan health and care services to meet the needs of their population. The central aim of ICSs is to integrate care across different organisations and settings,

⁷⁴ [Unique health challenges for refugees and asylum seekers - Refugee and asylum seeker patient health toolkit - BMA](#) (updated 13/04/2022)

⁷⁵ [Sexually transmitted infections \(STIs\): migrant health guide - GOV.UK \(www.gov.uk\)](#) (updated 14/09/2021)

⁷⁶ [Modern slavery and public health - GOV.UK \(www.gov.uk\)](#) (published 07/12/2017)

⁷⁷ [Modern slavery: how to identify and support victims - GOV.UK \(www.gov.uk\)](#) (last updated 13/12/2022)

⁷⁸ [National Referral Mechanism statistics - GOV.UK \(www.gov.uk\)](#) (updated 03/11/2022)

⁷⁹ Email correspondence with Unity Matron and Senior Safeguarding Nurse (sent 23/12/2022)

joining up hospital and community-based services, physical and mental health, and health and social care. All parts of England are now covered by one of 42 ICSs.⁸⁰

NHS England are working closely with ICSs to delegate a range of direct commissioning functions to the newly established ICBs that replaced CCGs on 1 July 2022. Delegation of commissioning functions will give systems responsibility for managing local population health needs, tackling inequalities and addressing fragmented pathways of care.⁸¹

In relation to sexual health services, a key function that is likely to be delegated from NHS England to ICBs from 1 April 2024 is the responsibility for HIV treatment and care. This is currently a specialised commissioning responsibility of NHS England. This will offer an opportunity to join up the commissioning of HIV treatment more closely with the sexual health services that councils are responsible for commissioning and strengthen pathways with other services including drugs and alcohol, domestic abuse, and mental health services. Through delegating HIV treatment services to ICBs, local systems will be able to take a joint approach to delivering the recommendations from the HIV action plan (see [2.2.9](#)), including developing innovative ways to support workforce, service resilience and exploring opportunities in service delivery.⁸²

⁸⁰ [Integrated care systems explained | The King's Fund \(kingsfund.org.uk\)](#) (published 11/05/2021)

⁸¹ [NHS England commissioning functions for delegation to Integrated Care Systems](#) (updated 09/06/2022)

⁸² [Specialised commissioning roadmap \(england.nhs.uk\)](#) (updated 09/06/2022)

3. BNSSG: the local context

3.1 Local policy context

3.1.1 Health and wellbeing boards (HWBs) and joint strategic needs assessments (JSNAs)

HWBs have been a key mechanism for driving joined up working at a local level since they were established in 2013. They are a statutory responsibility for each local authority with social care and public health responsibilities, providing a forum for discussions about strategic and operational co-ordination in the delivery of services already commissioned, including sexual health services. A key responsibility of HWBs is the assessment of the health and wellbeing needs of their population and publishing a JSNA.⁸³

3.1.2 BNSSG Integrated Care System (ICS)

The BNSSG ICS is comprised of 10 partner organisations, including Bristol City, North Somerset and South Gloucestershire Councils, University Hospitals Bristol and Weston and North Bristol NHS Trusts, the new ICB, as well as community and general practice providers. The ICS is also known as the [Healthier Together Partnership](#) and became a statutory entity in July 2022, as formalised in the new Health and Care Act. The ICS is designed to ensure that health and care services join up around individual needs – breaking down the boundaries between physical health, mental health and social care services. The ICS is working to improve health and wellbeing, reduce inequalities, and provide integrated services for the one million people living in Bristol, North Somerset and South Gloucestershire.⁸⁴

3.1.3 BNSSG Integrated Care Board (ICB)

The BNSSG ICB is a key partner in the ICS and is responsible for the day-to-day running of the NHS, taking account of population needs, arranging for the provision of services and managing the NHS budget. ICBs were also legally established in July 2022 to replace CCGs.⁸⁵

3.1.4 BNSSG Locality Partnerships

There are six Locality Partnerships in BNSSG working at a local level with their communities to improve health and wellbeing. Each partnership focuses on a given area and population, and designs services that fit in with people's lives (see figure 3.1). Locality Partnerships are made up of local health, social care, and the voluntary sector – with citizens and community as equal partners. Together they work as one team to understand what matters most to their local community. They then share their expertise, experiences, and knowledge to improve services for their population and ensure people are at the heart of every decision.⁸⁶

Within each Locality Partnerships there are a number of primary care networks (PCNs) typically serving a population of 30,000-50,000. PCNs are groups of GP practices working

⁸³ [Health and wellbeing boards – guidance - GOV.UK \(www.gov.uk\)](#) (published 22/11/2022)

⁸⁴ [Our local Integrated Care System - NHS BNSSG ICB](#)

⁸⁵ [What is the Integrated Care Board \(ICB\)? - NHS BNSSG ICB](#)

⁸⁶ [Locality Partnerships - NHS BNSSG ICB](#)

closely together, along with other healthcare staff and organisations, providing integrated services to the local population. In BNSSG there are 76 General Practices and 20 PCNs.⁸⁷

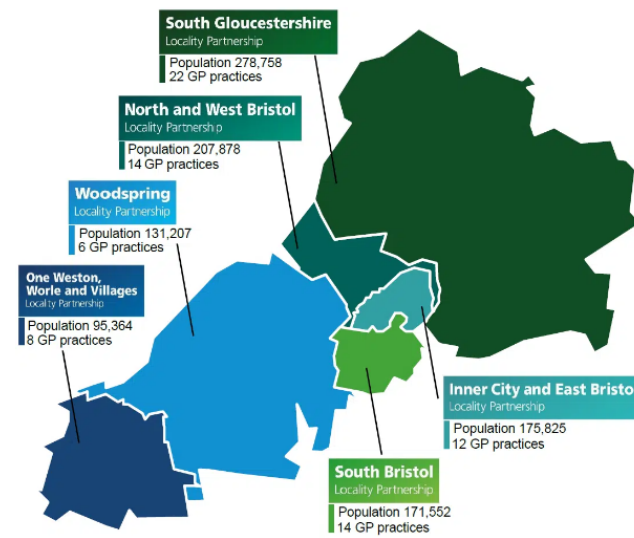


Figure 3.1: Map of the six Locality Partnerships in BNSSG, with their population size and number of GP practices (BNSSG ICB)

3.1.5 BNSSG Integrated Care Partnership (ICP)

The BNSSG ICP brings together representatives from each ICS partner organisation, from each of the six Locality Partnerships, and from local voluntary sector and community groups. The ICP sets the strategy to meet the population's health, care and wellbeing needs and is jointly chaired on rotation by the three constituent Health and Wellbeing Board chairs from Bristol City, North Somerset and South Gloucestershire.⁸⁸

3.1.6 Bristol One City

The One City Approach brings together a huge range of public, private, voluntary and third sector partners within Bristol. They share an aim to make Bristol a fair, healthy and sustainable city. The current mayor, Marvin Rees, published the city's first ever co-designed One City Plan in January 2019, a first written attempt to set out the challenge and bring the city together around its common causes. The One City Plan has six themed aims and supporting boards (children and young people, economy and skills, environment, health and wellbeing, homes and communities, transport) working together to deliver on projects that will improve Bristol and encourage other organisations to take the lead in working collaboratively.

Bristol Fast Track Cities is about bringing city partners and the public together to accelerate work towards ending HIV, and it is included in the Bristol One City Plan. As HIV and its appropriate responses are influenced by a range of social, environmental and economic factors, the One City Plan offers a unique opportunity to influence a range of other domains

⁸⁷ [Our practices | One Care](#)

⁸⁸ [Our Integrated Care Partnership \(ICP\) - NHS BNSSG ICB](#)

across the city (e.g. housing, social integration, substance misuse) to improve the response to HIV/AIDS.⁸⁹ For more information about Bristol Fast Track Cities, see section [5.3.2.5](#).

3.1.7 Previous SHNAs

This is the first time that a joint SHNA for BNSSG has been conducted. It will be instrumental in understanding the current and emerging needs and ensure that high quality services and interventions are available to meet them. SHNAs have previously been carried out separately for each council. The most recent SHNAs for Bristol, North Somerset and South Gloucestershire were completed in 2016, 2015 and 2019, respectively.

3.2 Geographical characteristics

Bristol, North Somerset and South Gloucestershire are vibrant and dynamic areas in South West England with a mix of urban and rural populations. Bristol is a largely urban area, whilst both North Somerset and South Gloucestershire are more rural. Figure 3.2 below shows the variation in rural and urban areas across BNSSG. In terms of population density as recorded in 2010, Bristol reportedly had 4,026 people / km². This is compared to North Somerset with 568 people / km² and South Gloucestershire with 533 people / km², however the proportion of residents living in rural areas is higher in North Somerset (1 in 3 in 2012) than South Gloucestershire (1 in 5 in 2015).^{90,91} These figures on population density are out of date and are likely to now show a greater number of people living in each km², as the new Census data for 2021 shows that the population of BNSSG is now 979,629, an increase of 9.6% (86,062) on the Census 2011 data.

⁸⁹ [Fast Track Cities - Bristol One City](#)

⁹⁰ North Somerset Council (2015) Sexual Health Needs Assessment [BNSSG Sexual Health Joint Commissioners Group - NS Sexual Health Needs Assessment Final 2 Nov 2015.pdf - All Documents \(sharepoint.com\)](#)

⁹¹ South Gloucestershire Council (2020) Relationships and sexual health needs assessment [BNSSG Sexual Health Joint Commissioners Group - SOUTH GLOS 2020 Final draft Needs Assessment Relationships and Sexual Health.pdf - All Documents \(sharepoint.com\)](#)

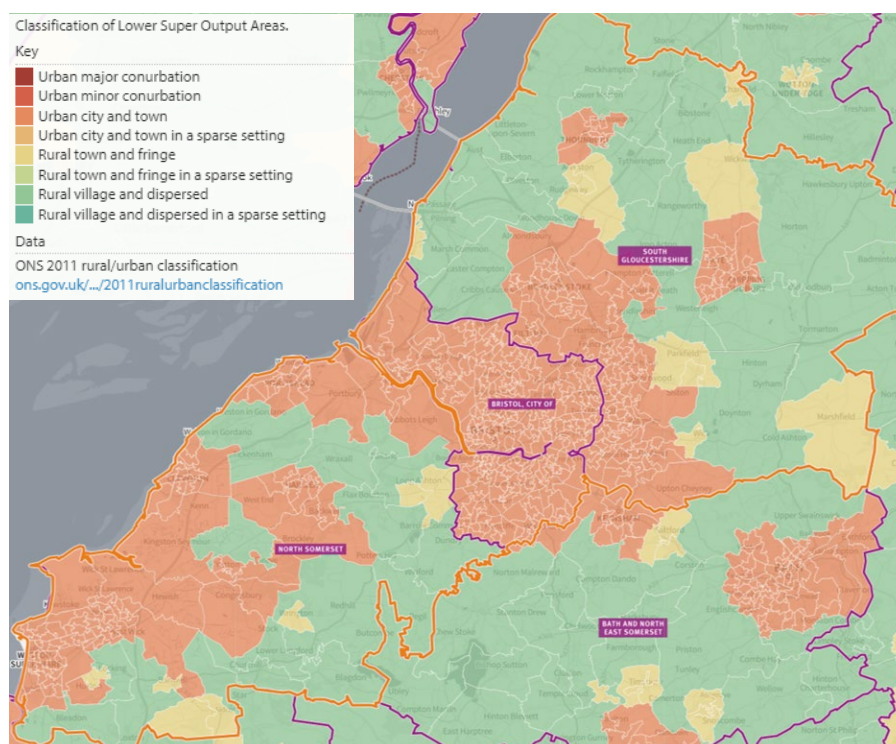


Figure 3.2: Map showing the urban and rural variation across Bristol, North Somerset and South Gloucestershire (ONS 2011, SHAPE Tool)

3.3 Population characteristics

3.3.1 Age and gender

Table 3.1 below shows that Bristol has a younger population with a particularly large proportion of 20-34 year olds compared to England. By comparison, North Somerset has a larger proportion of older adults aged 65 and over. South Gloucestershire's population structure is broadly similar to the national average.

Table 3.1: Local authority population by age, Bristol, North Somerset, South Gloucestershire, BNSSG, 2021 (ONS Census 2021)⁹²

Age	2021								
	Bristol		North Somerset		South Gloucestershire		BNSSG		England
	Value	%	Value	%	Value	%	Value	%	%
All usual residents	472,462	100.0	216,727	100.0	290,423	100.0	979,612	100.0	100.0
Aged ≤4 years	25,942	5.5	10,660	4.9	16,119	5.6	52,721	5.4	5.4
Aged 5 to 9 years	26,764	5.7	12,251	5.7	17,128	5.9	56,143	5.7	5.9
Aged 10 to 15 years	30,051	6.4	15,251	7.0	19,812	6.8	65,114	6.6	7.2
Aged 16 to 19 years	25,141	5.3	8,410	3.9	13,115	4.5	46,666	4.8	4.6
Aged 20 to 24 years	47,538	10.1	9,784	4.5	18,098	6.2	75,420	7.7	6.0
Aged 25 to 34 years	88,256	18.7	23,125	10.7	39,885	13.7	151,266	15.4	13.6
Aged 35 to 49 years	96,078	20.3	40,612	18.7	55,813	19.2	192,503	19.7	19.4
Aged 50 to 64 years	71,935	15.2	44,764	20.7	56,261	19.4	172,960	17.7	19.4
Aged 65 to 74 years	32,868	7.0	26,475	12.2	27,565	9.5	86,908	8.9	9.8
Aged 75 to 84 years	19,481	4.1	18,043	8.3	19,089	6.6	56,613	5.8	6.1
Aged ≥85 years	8,408	1.8	7,352	3.4	7,538	2.6	23,298	2.4	2.4

By local authority, the largest proportion of the BNSSG population is located in Bristol (472,473, 48.2%), followed by South Gloucestershire (290,421, 29.6%) and North Somerset

⁹² [2021 Census Profile for areas in England and Wales - Nomis \(nomisweb.co.uk\)](https://nomisweb.co.uk/)

(216,735, 22.1%). Bristol is also the 6th largest of the core cities in England and Wales and was the fastest growing core city in the last decade with a population increase of 10.3% (44,239 people). South Gloucestershire's population has increased by 10.5% (27,654 people) in the last decade and North Somerset's by 7.0% (14,169 people).

In Bristol there has been an increase of 5.6% in children aged under 15 years, an increase of 11.8% in people aged 15 to 64 years and an increase of 8% in people aged 65 years and over. All age groups increased except for 0-4 year olds, reflecting a decade of falling birth rates, and people aged 80 and over. Overall, there were 234,500 men (49.6%) and 237,900 women (50.4%) living in Bristol in 2021.⁹³

In North Somerset there has been an increase of 4.5% in children aged under 15 years, an increase of 2.6% in people aged 15 to 64 years and an increase of 22.0% in people aged 65 years and over. The age groups that have seen decreases in population since 2011 are those aged 0-4, 15-19, 40-44, 45-49, and 60-64.⁹⁴ There were 105,306 men (48.6%) and 111,422 women (51.4%) living in North Somerset in 2021.⁹⁵

In South Gloucestershire there has been an increase of 7.7% in children aged under 15 years, an increase of 7.6% in people aged 15 to 64 years, and an increase of 18% in people aged 65 years and over. The age groups that have seen decreases in population since 2011 are those aged 15-19, 40-44, and 45-49. There has been a 16.5% decrease in residents aged 40 to 49 in South Gloucestershire since 2011.⁹⁶ There were 143,769 men (49.5%) and 146,655 women (50.5%) living in South Gloucestershire in 2021.

The map below in figure 3.3 shows that the highest concentrations of young people aged 15-24 in BNSSG are found clustered around the student hotspots in the centre of Bristol and to the north of Bristol and into South Gloucestershire according to ONS 2020 mid-year estimates.

⁹³ [Bristol Census 2021 Data Profile](#)

⁹⁴ [North Somerset population change, Census 2021 – ONS](#)

⁹⁵ [2021 Census Profile for areas in England and Wales - Nomis \(nomisweb.co.uk\)](#)

⁹⁶ [Microsoft Word - Census2021 - Briefing Note \(02\) Demography and Migration 04.11.22 \(southglos.gov.uk\)](#)
(published 04/11/2022)

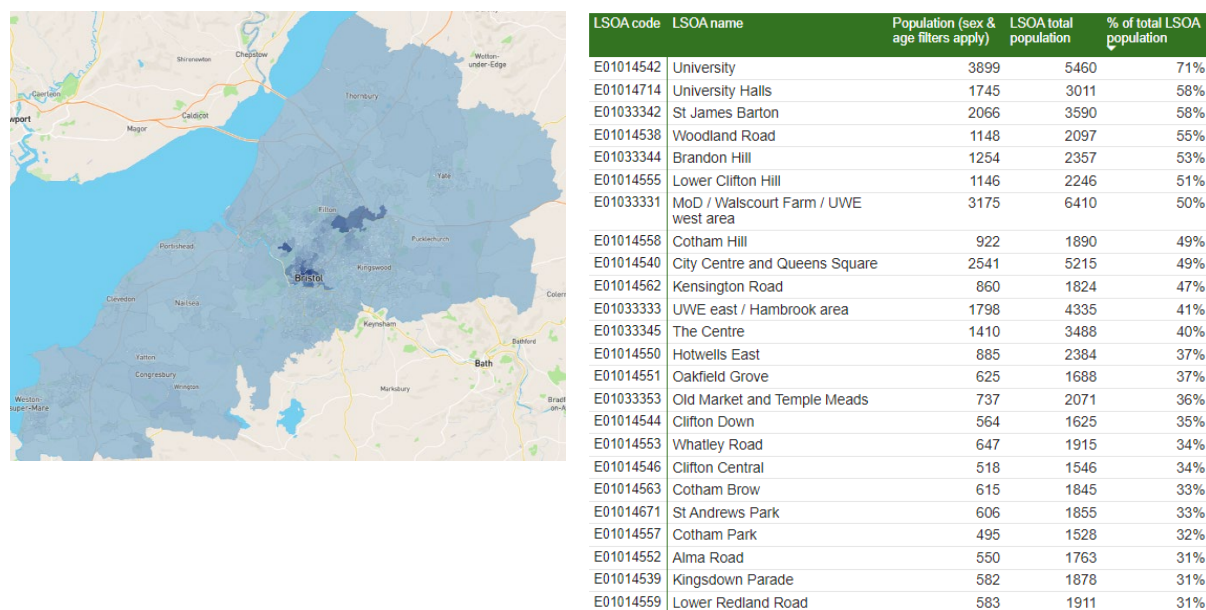


Figure 3.3: Map and table of the highest concentrations of 15–24-year-olds across BNSSG (darkest areas) (ONS 2020 mid-year estimates)

Looking to the future, ONS projections from 2018 estimated the BNSSG population to be 992,931 in 2022, growing further to 1,050,280 (+6%) by 2030 and 1,116,535 (+12%) by 2040. The population projections by 5-year age band can be found in table 3.2.

Table 3.2: BNSSG population projections from 2018 (ONS 2018 latest principal projection)

Age group	2022 (baseline)	2030		2040	
		Projected population	% change (from 2022)	Projected population	% change (from 2022)
0-4	56,140	61,328	9%	67,015	19%
5-14	115,062	111,741	-3%	120,589	5%
15-24	133,970	152,003	13%	148,218	11%
25-44	291,358	307,129	5%	326,033	12%
45-64	225,731	226,253	0%	243,087	8%
65-69	43,257	51,808	20%	48,586	12%
70-74	41,492	42,133	2%	48,868	18%
75-79	37,159	35,452	-5%	44,068	19%
80-84	24,113	32,601	35%	32,563	35%
85-89	15,512	19,232	24%	21,808	41%
90+	9,138	10,600	16%	15,699	72%
All ages	992,931	1,050,280	6%	1,116,535	12%

Individual council populations are projected to increase by 5% in Bristol, 5% in North Somerset and 8% in South Gloucestershire by 2030 from the 2022 baseline. By 2040, the populations are projected to increase from the 2022 baseline by 10% in Bristol, 11% in North Somerset and 17% in South Gloucestershire.⁹⁷

⁹⁷ It should be noted that these projections do not include allowance for the extra housing planned, therefore areas with significant housing stock increases could see a rise higher than that predicted by ONS.

The ONS projections estimate that the size of the BNSSG 65+ population in 2022 is 170,670 and is anticipated to grow to 191,826 (+12.4%) by 2030, and 211,592 (+24%) by 2040.

3.3.2 Deprivation

The Index of Multiple Deprivation (IMD) is the official measure of relative deprivation in England. It follows an established methodological framework in broadly defining deprivation to encompass a wide range of an individual's living conditions. The IMD is based on 39 separate indicators, organised across seven distinct domains of deprivation (income, employment, education, skills and training, health and disability, crime, barriers to housing and services, and living environment), which are combined and weighted to calculate the IMD 2019. Every lower-layer super output area (LSOA, around 1,500 people), is then ranked from 1 (most deprived area) to 32,844 (least deprived area).⁹⁸

BNSSG was ranked 118 out of 191 CCGs (now ICBs) as of 2019 and was considered less deprived than other areas. Deprivation within each council area differs across BNSSG (see figure 3.4). Bristol is ranked 59 out of 151 upper-tier unitary authorities and is considered more deprived than almost two-thirds of other councils. Almost 16% of the LSOAs in Bristol are in the most deprived 10% nationally, and more than a quarter of the population lives in the most deprived areas.

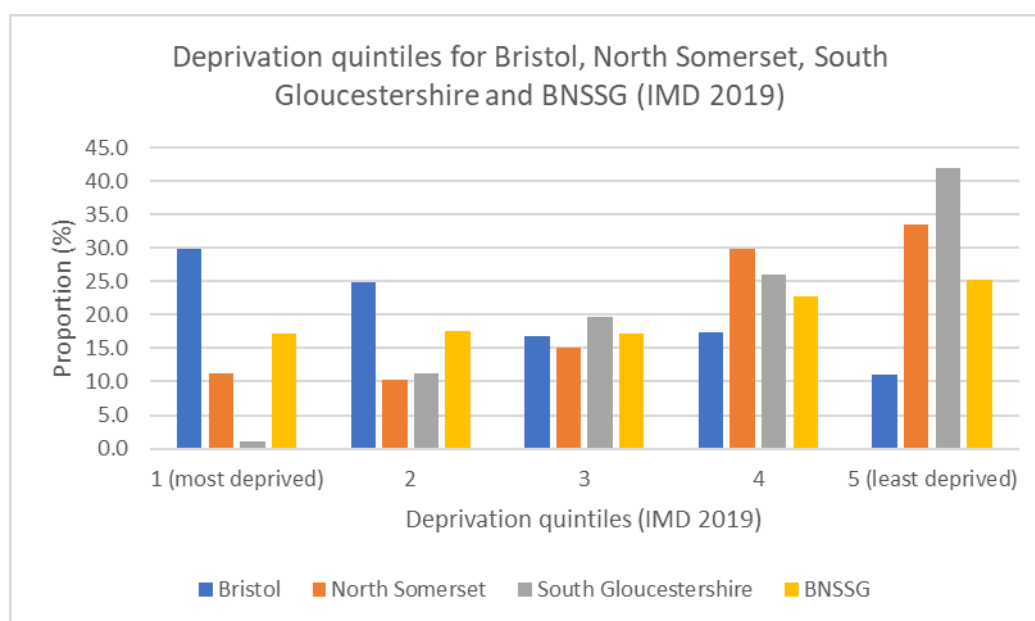


Figure 3.4: Population by deprivation quintile (IMD2019), Bristol, North Somerset, South Gloucestershire, BNSSG (ONS)

This is in contrast to North Somerset and South Gloucestershire, which are ranked 128 and 139 out of 151, respectively, and are near the upper end of the least deprived rankings. Despite this, North Somerset has almost 6% of LSOAs in the most deprived 10% nationally.⁹⁹

⁹⁸ [The English Indices of Deprivation 2019 \(publishing.service.gov.uk\)](https://publishing.service.gov.uk) (published 26/09/2019)

⁹⁹ [English indices of deprivation 2019 - GOV.UK \(www.gov.uk\)](https://www.gov.uk) (published 26/09/2019)

Figure 3.5 below shows the IMD mapped onto BNSSG LSOAs, with areas that are more deprived a darker shade and lighter areas less deprived.

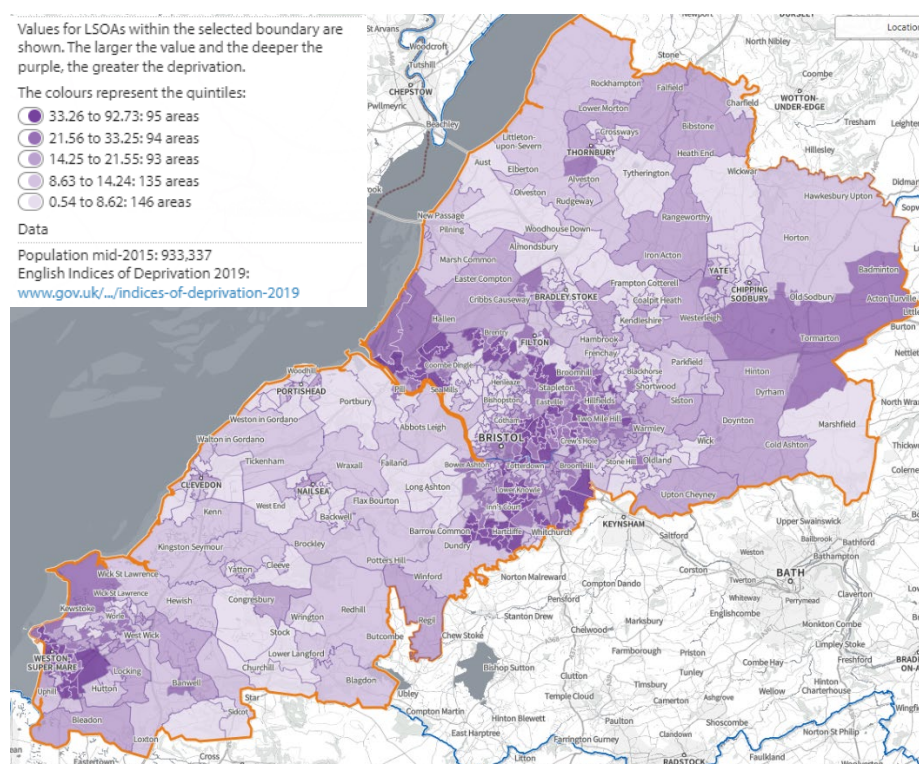


Figure 3.5: Map showing IMD 2019 by LSOA for BNSSG (SHAPE Tool)

3.3.3 Ethnicity

The 2021 Census data show that the populations of both North Somerset and South Gloucestershire are less ethnically diverse than England and Bristol (see table 3.3 and figure 3.6). Black, Asian and minoritised ethnic communities account for 8.8% of the population in South Gloucestershire and 4.3% in North Somerset – substantially lower than the national average of 19.0%. Bristol is similarly diverse as England with 18.9% of the population from Black, Asian and minoritised ethnic communities. Across BNSSG as a whole, 12.7% of the population are from non-White backgrounds (see table 3.3).¹⁰⁰

¹⁰⁰ [Ethnic group - Office for National Statistics \(ons.gov.uk\)](https://www.ons.gov.uk/peoplepopulationandcommunity/ethnicity/articles/ethnicgroup/2021) (published 29/11/2022)

Table 3.3: The populations of BNSSG, Bristol, North Somerset and South Gloucestershire, by ethnicity, compared to the national and regional population (Census 2021)

Area	Asian, Asian British or Asian Welsh	Black, Black British, Black Welsh, Caribbean or African	Mixed or Multiple	Other ethnic group	White
Bristol	6.6%	5.9%	4.5%	1.9%	81.1%
North Somerset	1.5%	0.5%	1.7%	0.6%	95.7%
South Gloucestershire	3.8%	1.6%	2.5%	0.9%	91.2%
BNSSG	4.7%	3.4%	3.3%	1.3%	87.3%
South West	2.8%	1.2%	2.0%	0.9%	93.1%
England	9.6%	4.2%	3.0%	2.2%	81.0%

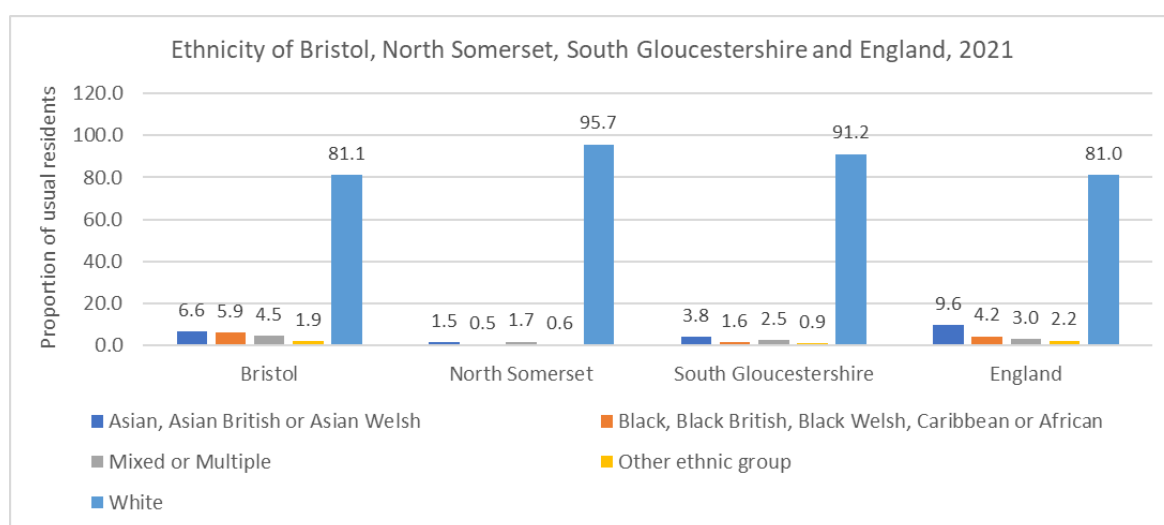


Figure 3.6: Ethnicity by local authority and England (Census 2021)

Figure 3.7 below shows that in Bristol younger people being more ethnically diverse than older people.

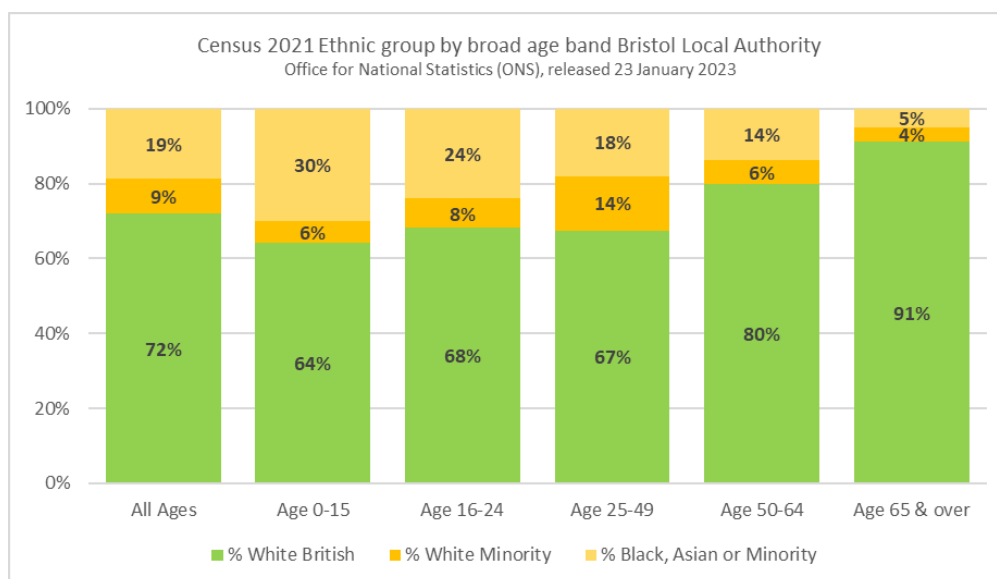


Figure 3.7: Ethnicity by broad age band in Bristol, 2021 (Census 2021)

3.3.4 Sexual orientation

The 2021 Census included a new, voluntary question on sexual orientation, which is shown below with the possible answers:¹⁰¹

- which of the following best describes your sexual orientation?
 - straight or heterosexual
 - gay or lesbian
 - bisexual
 - other sexual orientation (free text box to complete)

In Bristol, 6.1% of the population (23,649 people) aged 16 years and above identified with an LGB+ orientation, which is higher than the England and Wales average of 3.2%. Brighton and Hove had the largest LGB+ population proportionally (10.7%), with Bristol ranked 15th. However, based on overall size of the LGB+ population, Bristol was ranked 5th nationally after Manchester, Leeds, Birmingham and Brighton and Hove.¹⁰²

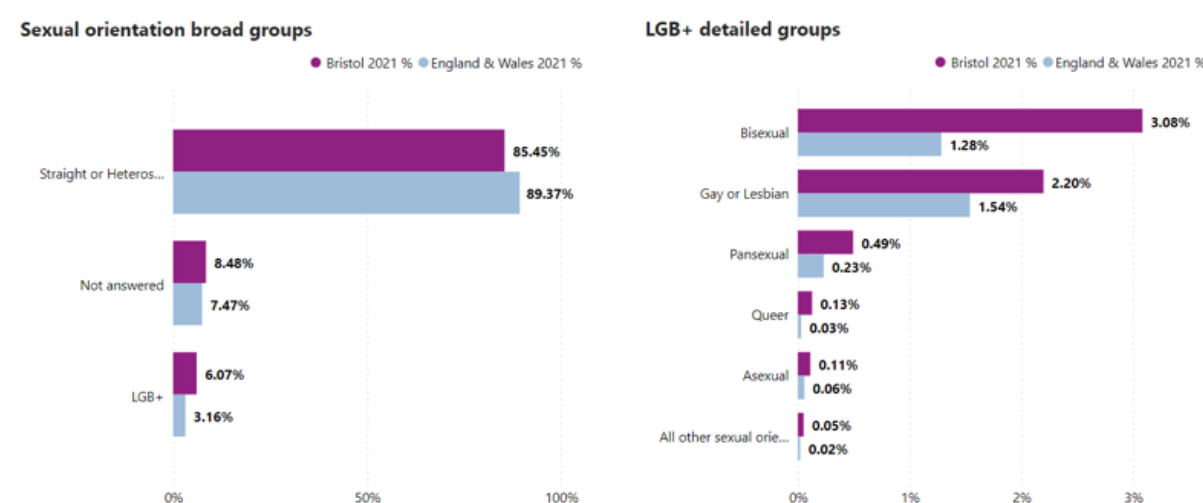


Figure 3.8: The sexual orientation of the Bristol population by: broad groups (left); LGB+ detailed groups (right), 2021 (Census 2021)

The charts above (figure 3.8) provide the full breakdown of sexual orientations, including LGB+ orientations, of which Bristol, out of 331 local authorities, ranked:

- 10th with 8,568 lesbian or gay people
- 2nd with 12,020 bisexual people
- 3rd with 1,928 pansexual people
- 4th with 435 asexual people
- 2nd with 496 queer people

¹⁰¹ [Sexual orientation question development for Census 2021 - Office for National Statistics \(ons.gov.uk\)](https://ons.gov.uk/census/2021/census-questions/sexual-orientation) (updated 22/06/2022)

¹⁰² [Bristol City Council Census 2021 dashboard](https://www.bristol.gov.uk/census-2021-dashboard) (accessed 27/01/2023)

A further 202 individuals (0.05%) wrote in a different sexual orientation to those given above, and 8.5% (33,051 people) did not answer the question, higher than the England and Wales average of 7.5%.¹⁰³

North Somerset and South Gloucestershire proportional data were almost identical, with each having 90.6% of the population identifying as straight or heterosexual, which is higher than the England and Wales average of 89.4%. Respectively, 2.7% (4,709 people) and 2.8% (6,699 people) identified with an LGB+ orientation, both lower than the England and Wales average of 3.2%. A total of 6.8% (12,080 people) and 6.5% (15,510 people), respectively, did not answer this question.¹⁰⁴

3.3.5 Gender identity

As with sexual orientation, the 2021 Census included a new, voluntary question on gender identity, which is shown below with the possible answers:

- is the gender you identify with the same as your sex registered at birth?
 - yes
 - no (free text box to complete)

The gender identity question enables people to identify that their gender is different to the sex registered at birth if they want to. This includes but is not restricted to those with the protected characteristic of “gender reassignment”.¹⁰⁵

In Bristol, 3,220 people aged 16 years and over (0.83%) indicated that their gender identity was different from their sex registered at birth. This is a higher proportion of the population than the England and Wales average of 0.54%. Based on the overall size of the Trans population, Bristol ranked 7th nationally but was not in the top 10 of local authorities with the largest proportion of the population aged 16 years and over whose gender identity was different from their sex at birth, eight of which were in London. The two non-London local authorities were Oxford (1.25%), which was 3rd, and Norwich (1.07%), which was 9th.¹⁰⁶

¹⁰³ [Bristol City Council Census 2021 dashboard](#) (accessed 27/01/2023)

¹⁰⁴ [2021 Census Profile for areas in England and Wales - Nomis \(nomisweb.co.uk\)](#) (accessed 27/01/2023)

¹⁰⁵ [Sex and gender identity question development for Census 2021 - Office for National Statistics \(ons.gov.uk\)](#) (updated 22/06/2022)

¹⁰⁶ [Bristol City Council Census 2021 dashboard](#) (accessed 03/02/2023)

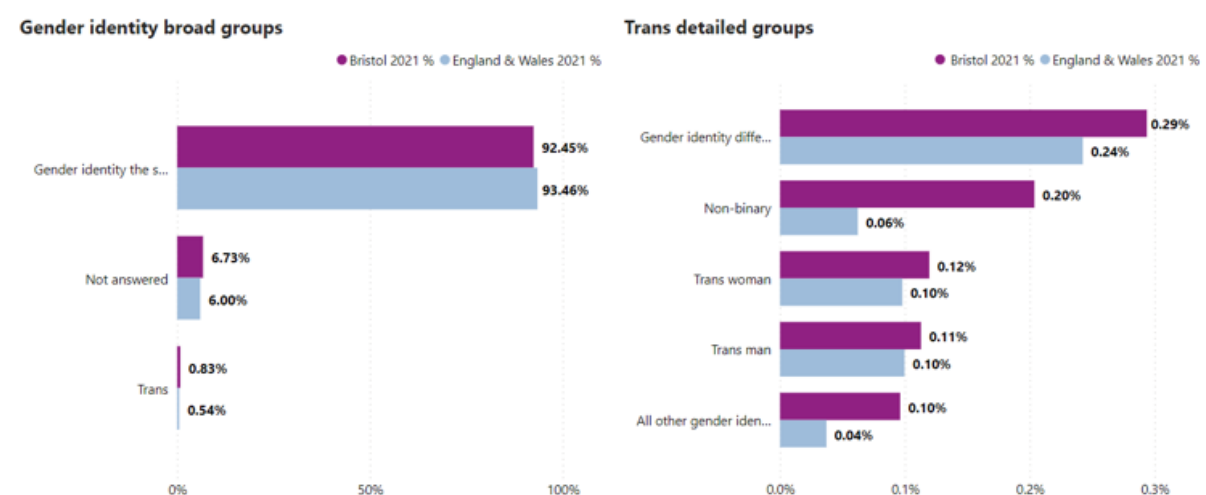


Figure 3.9: The gender identity of the Bristol population by: broad groups (left); Trans detailed groups (right), 2021 (Census 2021)

The charts in figure 3.9 provide the detailed breakdown of gender identities in Bristol, which had the second largest non-binary population out of 331 local authorities in England and Wales with 794 people (0.20%); Brighton had the largest with 835 people. Bristol also had the second largest number of people identifying as any other gender identity with 375 people (0.10%); Leeds had the largest with 395 people.¹⁰⁷

Table 3.4 below provides the detailed breakdown of the gender identities of the populations of North Somerset and South Gloucestershire.

Table 3.4: Gender identities of North Somerset and South Gloucestershire populations from (Census 2021)

Gender identity	North Somerset		South Gloucestershire	
	Count	%	Count	%
All usual residents aged 16 and over	178,568	100.0	237,366	100.0
Gender identity the same as sex registered at birth	168,676	94.5	224,526	94.6
Gender identity different from sex registered at birth but no specific identity given	185	0.1	326	0.1
Trans woman	129	0.1	177	0.1
Trans man	135	0.1	178	0.1
Non-binary	84	0.0	145	0.1
All other gender identities	71	0.0	91	0.0
Not answered	9,288	5.2	11,923	5.0

¹⁰⁷ [Bristol City Council Census 2021 dashboard](#) (accessed 03/02/2023)

4. Current sexual health services in BNSSG

The term sexual and reproductive health services (SRHS) refers to genitourinary medicine, which is dedicated to sexual health, and contraception services. As abortion services are also included in the BNSSG integrated service model, they are also a key feature of the local SRHS offer. In BNSSG, services are available at all levels and in a range of settings, for example:

- health promotion and information on self-care in the community
- advice, contraception and some STI testing in primary care
- specialist and community clinics providing STI testing and treatment and contraception including complex cases
- abortion services accessible through a single point of access

The current integrated SRHS is known as Unity and is available to the whole population of BNSSG and is based on the levels of service model (Levels 1-3) for provision of sexual and reproductive health services (see appendix 1). Level 3 is a specialist SRHS for complex cases including individuals with complex medical problems or requiring complex procedures. Level 2 is a SRHS providing an enhanced level of care. Level 1 is a basic level of SRHS provision. SRHS in primary care settings are provided at GP surgeries and pharmacies across BNSSG.

4.1 National and local outcomes

The BNSSG SRHS and wider system is working collaboratively to achieve the following three PHOF measures:

- 1) Reducing the rate of under 18 conceptions
- 2) Achieving a chlamydia diagnosis rate of 2,300 per 1,000 (15-24 year olds)
- 3) Reducing the proportion of people presenting with HIV at a late stage of infection.

Locally, the BNSSG SRHS and wider system are trying to achieve the following outcomes.

Contraception:

- reducing the rate of termination and repeat termination
- reducing the proportion of repeat conceptions in the under 20s
- reducing sexual health inequalities in termination rates among groups at high risk of unplanned pregnancy including
 - young people
 - looked after children
 - women living in deprived areas
 - Black, Asian and minoritised communities with high rates of terminations and teenage conceptions
 - other vulnerable groups

Sexually transmitted infections and HIV:

- reducing the rate of HIV, STIs and blood borne viruses
- reducing the number of people treated repeatedly for STIs
- reducing late diagnosis of HIV
- reducing inequalities in STI and HIV rates, with a focus on:
 - young people
 - GBMSM
 - people living in deprived areas
 - Black, Asian and minoritised communities with high rates of STIs
 - other vulnerable groups

Termination of pregnancy:

- proportion of women accessing a procedure within nine weeks and six days of gestation
- proportion of repeat terminations
- proportion of women receiving a LARC method following a termination
- proportion of early medical and proportion of surgical terminations

Service user reported outcomes:

- service user satisfaction scores and survey feedback

4.2 Unity integrated sexual health service

The Unity sexual health service is commissioned collectively by Bristol City Council, North Somerset Council, South Gloucestershire Council and BNSSG ICB to provide integrated sexual health services across BNSSG including termination of pregnancy services.

Unity Sexual Health Service is provided by [University Hospitals Bristol and Weston NHS Foundation Trust](#) (UHBW) in partnership with the following organisations that are experts in sexual health delivery:

- [British Pregnancy Advisory Service](#): deliver abortion services
- [Brook](#): deliver specialist young people's sexual health services to under age 20
- [MSI Reproductive Choices](#): deliver abortion services
- [North Bristol NHS Trust](#) (NBT): deliver abortion services
- [Terrence Higgins Trust](#): deliver health promotion and outreach services

The free and confidential Unity service for BNSSG includes all types of contraception, testing and treatment of STIs, abortion care and HIV prevention services, which includes testing for HIV and treatment to help stop an individual getting HIV e.g. PrEP and PEP. Service users access the service by telephone initially and following triage will either be offered a face-to-face or telephone appointment if symptomatic or will be advised to order an online postal test kit through the Unity sexual health service website: www.unitysexualhealth.co.uk, if asymptomatic. All of the sexual health clinics can provide basic sexual health screening (tests), advice and contraception. There is also a system-wide partner notification service.

The Unity sexual health free postal self-sampling kit service is for people over age 16 and provides testing for chlamydia, gonorrhoea, syphilis and HIV, for all people living in BNSSG. It can be ordered online via the Unity website.

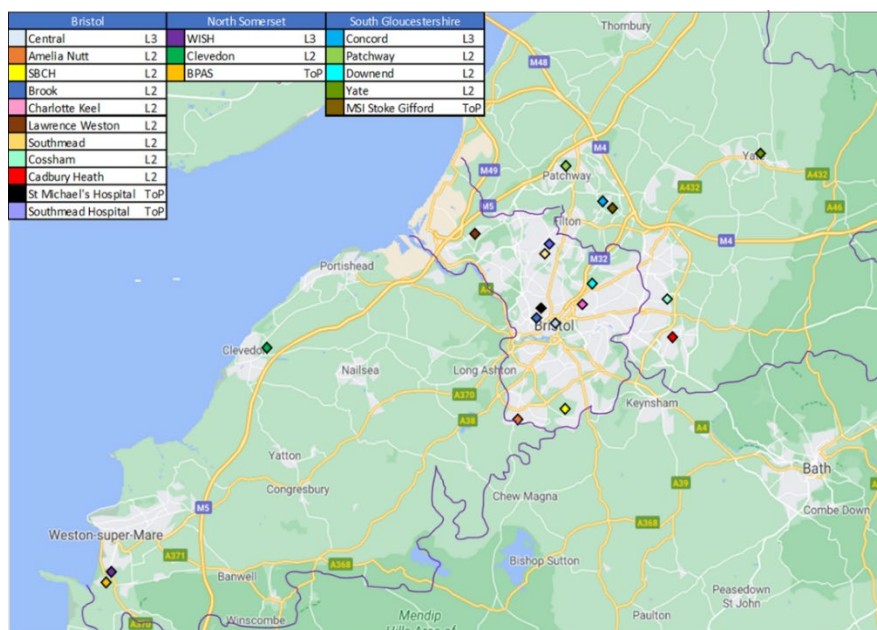


Figure 4.1: Map of Unity sexual health clinic locations across BNSSG

4.2.1 Unity sexual and reproductive health clinics

In BNSSG, there are three Level 3 specialist sexual health clinics. As well as providing routine care, they also provide specialist sexual health services such as STI testing and treatment for GBMSM, management of men with STI symptoms, management of pregnant women with sexual infections, or symptoms and management of gonorrhoea and syphilis.

- Bristol: Unity @ Central Health Centre
- North Somerset: Unity @ Weston Integrated Sexual Health (WISH), Weston General Hospital
- South Gloucestershire: Unity @ Concord Medical Centre

Services include:

- free testing, advice and treatment for STIs
- contraception advice and provision (including emergency contraception)
- free condoms
- hepatitis B vaccinations for those who have or will be at risk
- HIV testing and referral when needed
- PEP and PrEP
- consultation for those who have been sexually assaulted
- specialist clinics (e.g. complex contraception)
- telephone advice for public and professionals
- chlamydia screening services
- pregnancy testing and advisory services

Across BNSSG Unity staff a number of community-based clinics that aim to target areas of highest deprivation, including dedicated young people's clinics for under 25s. The community clinics meet routine sexual health needs and are delivered in community venues (see figure 4.1). As of December 2022, there are four community clinic venues (five clinics) that have not been able to reopen following the COVID-19 lockdowns due to a range of factors, which are currently under review: Charlotte Keel (currently only open once a month for a dedicated clinic for people of African and Caribbean heritage), Cadbury Heath, Downend and Yate (this venue hosts separate young people's and all age clinics).

There are also the following Level 2 sexual health clinics in BNSSG:

- Bristol:
 - Unity @ Southmead Health Centre (young people clinic)
 - Unity @ Lawrence Weston, Ridingleaze (young people clinic)
 - Unity @ Amelia Nutt, The Withywood Centre (young people clinic)
 - Unity @ Charlotte Keel Health Centre – currently only open once a month for HIV testing for people of African and Caribbean heritage
 - Unity @ South Bristol Community Hospital
- North Somerset:
 - Unity @ Clevedon Health Centre (young people clinic)
- South Gloucestershire:
 - Unity @ Cossham Hospital
 - Unity @ Cadbury Heath Healthcare (young people clinic) – currently closed
 - Unity @ Downend Community Sexual Health Clinic – currently closed
 - Unity @ Patchway (young people clinic)
 - Unity @ Yate Westgate Centre, West Walk Surgery (young people clinic) – currently closed

Services include:

- contraception advice and provision
- sexual health advice
- full STI screening
- free condoms and C-Card Scheme
- chlamydia testing and treatment as part of the NCSP
- pregnancy testing and advice
- referral to other services when appropriate

4.2.2 Unity Brook

Brook is a national charity that offers both clinical sexual health services, education and wellbeing services for young people, plus training and support for professionals.

As part of Unity, Brook provides free and confidential sexual health services for young people aged under 20. Unity @ Brook The Station is a Level 2 service located in the centre of Bristol, which offers the following services:

- advice and information about all aspects of sexual health

- pregnancy testing and advice
- contraception (condoms and LARC)
- condoms and lubricant (young people can use their C-Card)
- emergency contraception
- STI testing and treatment
- PrEP (taken before sex to prevent HIV infection)
- counselling
- abortion referrals

Brook also operates in schools in Bristol and South Gloucestershire through an education team, which is discussed further in section [4.3.2](#).

4.2.3 Terrence Higgins Trust (THT) and Eddystone Trust

THT is the leading HIV and sexual health charity in the UK that aims to end the transmission of HIV, empower and support people living with HIV to lead full and healthy lives, and enable all people to enjoy good sexual health.

As part of Unity, THT deliver outreach and digital social marketing campaigns to help support and improve the sexual health of our local communities across BNSSG. This includes:

- community-based HIV and STI testing, including at night clubs (mainly in Bristol) and university campuses
- sexual health information and advice
- training in HIV awareness and working with LGBTQ+ and Black, Asian and minoritised ethnic communities
- a dedicated health and wellbeing support number for BNSSG
- a senior wellbeing specialist service for:
 - one-to-one emotional support for people living with HIV, including supporting clinic attendance and adherence to medication
 - a therapeutic group with a health and wellbeing focus for individuals living with HIV across Bristol and South Gloucestershire. This includes a women's group and the All-In groups which are run in partnership with Brigstowe
 - support groups are for people who have been living with HIV long term and those newly diagnosed with HIV
- a number of volunteers who support service users in groups as well as on a one-to-one basis
- finger-prick HIV and syphilis testing for GBMSM, Black African communities, those living in deprived areas, sex workers and LGBTQ+
- free condoms by post for people aged 18+ covering North Somerset and South Gloucestershire for specific groups (GBMSM, trans or non-binary, sex workers, Black, Asian and minoritised ethnic communities); Bristol residents can collect condoms in person from various venues (including Sparta, Bear Bar, Dare 2) in the city

- ‘Champions of Change’ volunteers offering free training to reduce racialised barriers in sexual health (currently Bristol-based, in the community/at events)

THT provide outreach services at the following venues in Bristol:

- East Trees Community Centre, Eastville
- University of Bristol
- C’aafi Health, Wellspring Settlement, St Pauls

THT sub-contract the Eddystone Trust to work in partnership with them to provide the following outreach services to the populations of South Gloucestershire and North Somerset:

- sexual health promotion and awareness raising across South Gloucestershire and North Somerset areas, including HIV and PrEP (including online outreach)
- specialist support to swingers, Black, Asian and minoritised ethnic communities, GBMSM, homeless and LGBTQ+ communities
- offering community-based HIV and STI testing. For South Gloucestershire this includes at university campuses, when requested
- promoting free condoms by post for people aged 18+ covering BNSSG areas for specific groups only (GBMSM, trans or non-binary, sex workers and Black, Asian and minoritised ethnic communities) and sending out the orders for South Gloucestershire and North Somerset

On behalf of THT, the Eddystone Trust provide outreach services at the following venues in North Somerset and South Gloucestershire:

- North Somerset
 - Healthy Living For All Centre, Weston-Super-Mare
 - Somewhere to Go (homeless shelter), Weston-Super-Mare
 - Faces Café, Weston-Super-Mare
 - Route 69 Swingers Club - Weston-Super-Mare
 - Homeless Outreach with YMCA, Weston-Super-Mare
 - North Somerset LGBT Forum, Weston-Super-Mare
 - Weston College (pop-up sessions), Weston-Super-Mare
- South Gloucestershire
 - Ridgeway Community Centre Outreach, Yate
 - South Gloucestershire and Stroud College (Filton and WISE campuses)
 - University of the West of England
 - Frenchay Campus (South Gloucestershire)
 - City Campus, Bower Ashton (Bristol)
 - Glenside Campus, Fishponds (Bristol)
 - Outreach at public sex environments (linked to online outreach offer)

4.2.4 Abortion services in BNSSG

In BNSSG there is a single point of access to abortion services via a central booking telephone service, following which service users are offered a consultation with choices on how to proceed. The full range of contraceptive choices are available for those proceeding to an abortion. Abortions are provided by St Michael's Hospital (UHBW) and Southmead Hospital (NBT), as well as MSI Reproductive Choices, which is located in Stoke Gifford, South Gloucestershire, and the British Pregnancy Advisory Service (BPAS), located at Western General Hospital and in Taunton (for surgical abortions).

4.3 Primary care

4.3.1 GP practices

All GP practices are required to provide a minimum level of sexual health services as part of their contract with the ICB. This includes:

- sexual health advice and information
- advice about contraceptive methods and medical examination of patients seeking this advice, where appropriate
- prescribing of contraceptive medications and devices (except coils and implants)
- advice on emergency contraception and supplying/prescribing emergency hormonal contraception
- pregnancy testing and referral to specialist services, where appropriate
- referrals to gynaecology/specialist sexual health services
- providing contraceptive injections
- providing STI and HIV testing if risk is identified
- providing STI treatment for those testing positive in primary care

In addition, councils in BNSSG directly commission (at variable funding) the following sexual health services from GPs:

Chlamydia screening

This requires practices to proactively encourage women aged 15 to 24 to test for chlamydia either in the context of a booked appointment or via a self-sample kit that, once complete, can be passed to surgery staff for return to the Unity chlamydia screening office.

LARC implant/intrauterine devices (IUD) fitting and removal

Fitting and removal of contraceptive implants or coils. This requires a practitioner with appropriate accreditation to be available.

C-Card scheme

GPs can be a C-Card venue for registration and/or pick-up to provide free condoms to young people who have a C-Card.

4.3.2 Pharmacies

The local authorities in BNSSG directly commission chlamydia screening and treatment services, and EHC services from pharmacies. Pharmacies can sign up to a contract with their

respective public health team in Bristol City, North Somerset or South Gloucestershire Councils to provide either or both of these two services. Pharmacies in Bristol and North Somerset can also sign up to offer the C-Card scheme, while in South Gloucestershire pharmacies can volunteer to be a C-Card venue for registration and/or pick-up to provide free condoms to young people (age 13 – 19) who have a C-Card.

Pharmacies sell a range of items (including condoms, pregnancy tests and EHC) as part of their private offer, and under the general pharmacy contract are required to signpost people to other relevant services/sources of advice and fulfil all prescriptions. There is also a requirement to undertake annual health promotion campaigns, as determined by NHSE.

In early 2023, NHSE will be commissioning the new Pharmacy Contraception Service as an advanced service within the Community Pharmacy Contractual Framework. Initially, community pharmacists will provide ongoing management of routine oral contraception that was initiated in general practice or a sexual health clinic. If there is a positive evaluation of an ongoing pilot, in 2024 community pharmacists may also be able to initiate oral contraception. Both aspects of the service will be delivered via a Patient Group Direction (PGD) with appropriate ongoing clinical checks and annual reviews offered. From April 2023, community pharmacy is expected to become a delegated responsibility of the BNSSG ICB.

4.4 Education and health promotion

4.4.1 Sexwise

Sexwise is a free national online resource produced by the Family Planning Association on behalf of the DHSC's National Health Promotion Programme for Sexual Health and Reproductive Health. The website provides easily accessible advice and information on contraception, pregnancy, STIs and pleasure to enable people to make well-informed choices about their bodies, and to know the options that are available to them.¹⁰⁸

4.4.2 Health promotion

Unity THT is responsible for sexual health promotion within BNSSG and subcontracts some of this to Eddystone Trust (see above). THT convene the Unity health promotion sub-group that meets quarterly to oversee BNSSG sexual health promotion activities. The aim is for all Unity providers and commissioners to work together to analyse local data to design and implement targeted health promotion of existing and emerging sexual health issues. These include raising awareness through campaigns and social marketing and signposting to local services and provision of outreach to groups at risk. Unity's website provides information and promotes self-management, giving regular updates and advice on emerging issues such as Mpox, and offers a resource for professionals seeking advice or training.¹⁰⁹

¹⁰⁸ [Let's talk about sex! | Sexwise](#)

¹⁰⁹ [Welcome to Unity Sexual Health | Unity Sexual Health](#)

4.4.3 Relationship, sex and health education (RSHE)

Relationships education for primary school-age children and relationships and sex education for secondary school-age children is compulsory under Sections 34 and 35 of the Children and Social Work Act 2017. Since September 2020, schools have been required to teach a statutory RSHE curriculum that consists of 13 core modules. Relationships education in primary schools focuses on positive relationships with friends, family and others and teaches children about boundaries, privacy and reporting concerns. The science curriculum includes puberty and reproduction, but sex education is not compulsory. Relationships and sex education (RSE) in secondary schools includes intimate relationships, safe sex (including contraception and STIs), the law and consent. Schools can create their own resources based on templates provided by the Personal, Social and Health Education (PSHE) Association¹¹⁰, or they may choose to purchase a tailored programme, such as Jigsaw.¹¹¹

As part of Unity, Brook provides school-based services in Bristol and South Gloucestershire for young people under the age of 20. This includes provision of:

- sexual health promotion assemblies for each year group
- C card scheme activity following assemblies (Bristol schools only)
- 'My Life', a targeted 1:1 RSE programme delivered upon referral to high-risk/vulnerable young people, including those with special educational needs and disabilities (SEND), needing a personalised RSE intervention
- free professional training for those working in schools
- professional training in delivering RSHE for young people with SEND and the Brook Traffic Light Tool for identifying and responding to harmful sexual behaviours
- peripatetic outreach nurse service, which schools across Bristol and South Gloucestershire can refer into, offering contraception, including emergency contraception, pregnancy testing/support, STI testing/treatment and C-Card registration

4.4.4 Public Health Nursing Service

The Public Health Nursing Service (formally known as the school nursing service) are contracted by each local authority to deliver a core offer that provides an open access point of contact for health advice, information and guidance for all children and young people aged 5-19 years old and their families. Young people can access the service directly via face to face support, direct telephone contact with a school health nurse, and information on the website.

The Public Health Nursing Team, in partnership with school staff for each local authority school, academy and free school, undertake annual school health reviews or use existing data sources to identify individual school health needs. This informs the need for bespoke health promotion activities to improve outcomes for children and young people. The views

¹¹⁰ [PSHE Association | Charity and membership body for PSHE education \(pshe-association.org.uk\)](https://www.pshe-association.org.uk/)

¹¹¹ [Jigsaw PSHE The Mindful Approach to PSHE](https://www.jigsaw.org.uk/)

of children and young people are collated and evaluated to ensure activities are linked to pupils' and family's needs.

Evidence based health promotion activities include healthy eating, sexual health, mental health, smoking cessation, substance misuse, healthy bladders and bowels, oral health and the promotion of Immunisations. The Public Health Nursing Service are registered to provide condoms to young people as part of the C-Card scheme, which is discussed further below. The service in Bristol and South Gloucestershire is not commissioned to provide young people with pregnancy tests, unlike the service in North Somerset, but they will advise where they can access one. This is an example of variation in what the public health nurses are commissioned to provide across BNSSG.

4.4.5 Condom distribution scheme (C-Card)

C-Card scheme providers across BNSSG provide free condoms to young people with a C-Card who are aged 13–19, or up to age 24 with a learning disability. The scheme also provides access to instruction on effective use of condoms and signposting to local sexual health services.

- Brook run the Bristol C-Card scheme on behalf of Unity, including the provision of training
 - a map of all Bristol C-Card providers can be found [here](#)
- South Gloucestershire Council run the South Gloucestershire scheme, including all training requirements
 - a list of all South Gloucestershire C-Card providers can be found [here](#)
- North Somerset Council run the North Somerset scheme, including all training provision
 - a list of all North Somerset C-Card providers can be found [here](#)

Young people registered across BNSSG with a C-Card can pick up free condoms at provider locations anywhere in BNSSG if the C-Card provider offers open access for collection.

4.4.6 HIV

Brigstowe are a Bristol-based HIV support charity that focuses on supporting people living with HIV. Bristol City Council, North Somerset Council and South Gloucestershire Councils all fund Brigstowe directly for provision of support to people living with HIV across BNSSG. In addition Bristol City Council provides a small grant to help reduce HIV stigma.

The support Brigstowe offers includes:

- HIV group peer support/1-1 mentoring programme
- HIV awareness raising and training
- tackling HIV stigma
- a support service for migrants and asylum seekers
- advice and support for people living with HIV (PLWHIV)

- improving access to sexual health services for African and Caribbean heritage communities (supporting Common Ambition Bristol)
- provision of online information on HIV

4.5 Training and workforce development

Unity provide an education and training programme to offer professional development opportunities for health and non-health professionals working in BNSSG who wish to get more involved in the provision of sexual health and contraception care, or who are working with people who may need support with their sexual health or contraceptive needs. Unity also offer a tailored programme of free training events aimed at health and non-health professionals working with and supporting young people to have healthy and safe sexual relationships.¹¹²

Unity engage with other organisations to provide support, advice and training and contribute to the upskilling of staff in the sexual health system and wider network to maximise opportunities to improve sexual health outcomes and share best practice and expertise. This includes:

- running monthly update meetings for qualified LARC fitters including colleagues from general practice
- regularly hosting medical and nursing students on rotation
- hosting a wide variety of doctors in other specialities for taster days
- offering training for FSRH qualifications in LARC provision and a Diploma of FSRH training
- providing GP update events

4.5.1 Training for pharmacists

In order to provide sexual health services, such as emergency contraception, pharmacists must undertake PGD training, which is funded by the BNSSG councils and delivered in collaboration with Unity. The public health teams at the councils also work collaboratively to organise a free BNSSG-wide pharmacy sexual health services annual update event for all community pharmacies currently providing, or seeking to provide, emergency hormonal contraception and chlamydia treatment services. Unity provide the clinical expertise for this training event and the BNSSG ICB's medicines management team also contribute.

4.5.2 Training providers across BNSSG

There are a number of associated organisations that Unity work with who provide training on sexual and reproductive health and contraception across BNSSG. These include:

Avon Group for Contraception and Sexual Health

The Avon Group for Contraception and Sexual Health is a membership group providing training and updates for health professionals who have a special interest in contraception

¹¹² [Professional development \(unitysexualhealth.co.uk\)](https://unitysexualhealth.co.uk)

and sexual health. The group aims to provide high-quality educational meetings (three per year) to doctors, nurses and health advisers in primary care and specialist services.

Brook

As a partner organisation of Unity, Brook are responsible for delivering all the C-Card training in Bristol and many of Unity's young people training events to RSE and non-RSE specialists, governors and support staff, such as:

- SHIELD training (sexual health information, empowerment, learning and development)
- healthy relationships, pleasure and consent
- RSHE and SEND
- peer-on-peer sexual violence and managing disclosures
- pornography and youth-produced sexual imagery

THT

THT provide training as part of Unity's young people programme on working with young people from LGBTQ+ or Black, Asian and minoritised ethnic communities, as well as HIV awareness.

University of the West of England (UWE) Bristol

UWE Bristol currently run two professional modules suitable for practice nurses and allied health professionals: Promoting Sexual Health in Practice¹¹³ and Integrated Practice for Sexual and Reproductive Healthcare.¹¹⁴

Pharmaceutical companies

The manufacturers of both the IUS and contraceptive implant run pharmaceutical organised forum events for LARC fitters (which are separate and in addition to the monthly Unity led-fitters forum). Clinical professionals can contact their pharmaceutical representatives directly for details of such events.

¹¹³ [Promoting Sexual Health in Practice - Professional/Short course - UWE Bristol: Courses](#)

¹¹⁴ [Integrated Practice for Sexual and Reproductive Health - Professional/Short course - UWE Bristol: Courses](#)

5. Sexual health outcomes in BNSSG

5.1 Access to Unity integrated sexual health service

The following sections use data that has been provided by the Unity sexual health service for performance monitoring purposes. Due to a historic data quality issue, it has not been possible to reliably include data earlier than 2021-22 in most cases, and trends over time have not been included because of this.

5.1.1 Clinic attendances

Data on attendances to Unity sexual health services have been collated by UHBW for 2021-22 and includes attendances at Brook, Central Health Clinic, Concord, Unity community clinics, WISH and postal test kits. It does not include any abortion services attendances, psychosexual attendances or condom collections. The data reported represents episodes of care (service users who had contact with the service as new and follow-up appointments, either through a physical attendance, telephone consultation or video consultation).

Over the course of 2021-22 there were 74,215 attendances recorded across the different Unity sites, an increase of 13,035 (21%) on 2020-21. With repeat attendances for the same individuals removed, a total of 32,990 unique individuals accessed the service during 2021-22. Out of these individuals, 31,549 (96%) had a BNSSG LA of residence. The charts below in figure 5.1 compare the number of attendances to the number of individuals by local authority.

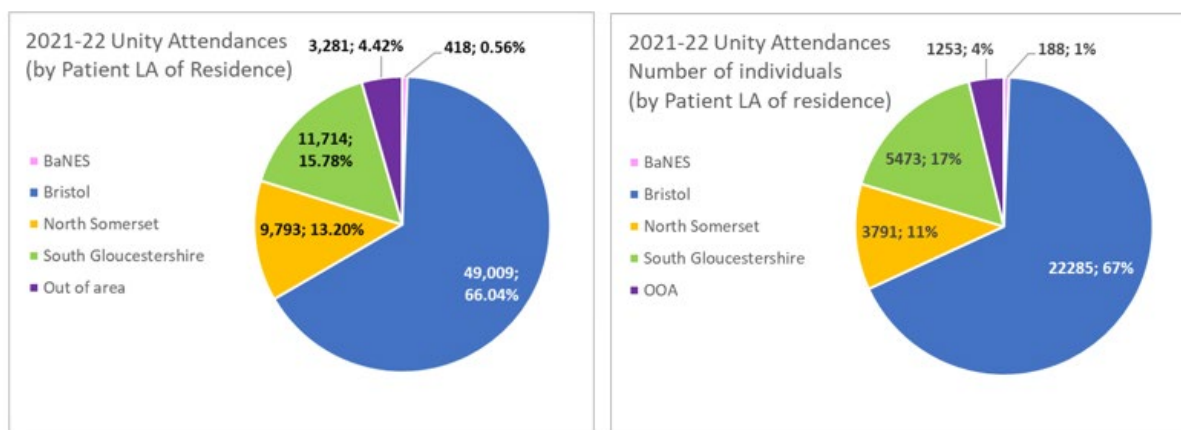


Figure 5.1: Charts comparing the total Unity attendances (episodes of care) to the number of individuals attending Unity by local authority, 2021-22

Figure 5.2 below charts monthly attendances from April 2020 to September 2022. This shows that monthly attendances have increased from 1,361 in April 2020 at the start of the COVID-19 restrictions to a high of 6,777 in February 2022. However, data on the number of attendances pre-COVID-19 is not available to compare with, so it is unclear if attendances have recovered to pre-COVID-19 levels. Attendances from April 2022 have decreased to a monthly average of 5,981 from an average of 6,429 between October 2021 and March 2022.

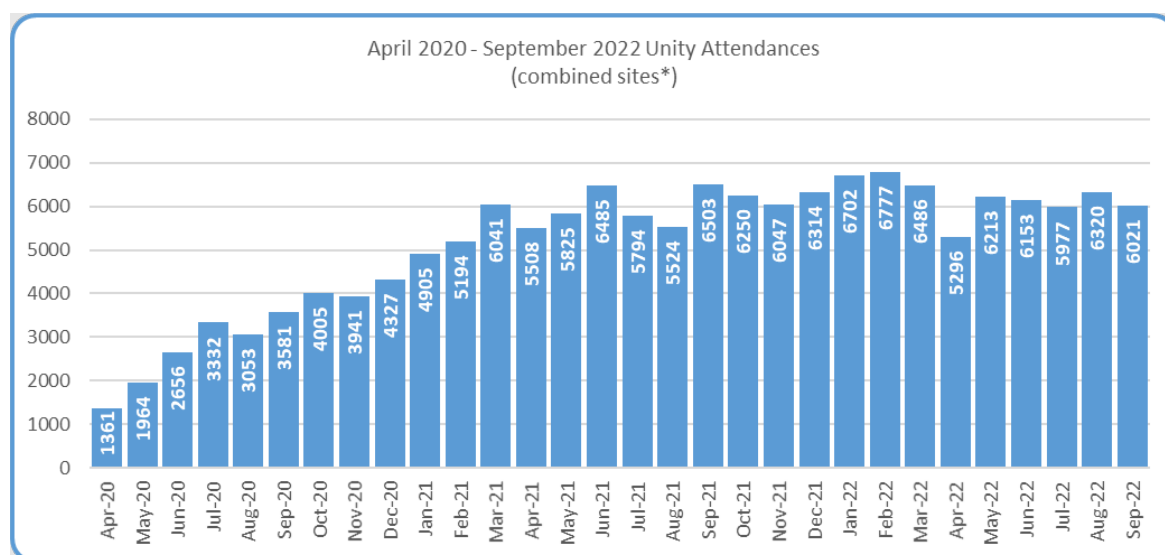


Figure 5.2: Unity attendances by month, April 2020 to September 2022 (UHBW)

As mentioned above the attendance figure includes postal test kits. In 2021-22, there were a total of 34,831 postal test kits issued, which are requested through an online portal and do not require a consultation with a health professional. If these are removed from the total of 74,215, then the number of face-to-face and telephone consultations is reduced by almost half to 39,384 (53%). The postal test kits are issued from Unity Central, which brings down the number of attendances at the clinic over the year from 59,378 to 24,547 (41%). There is a data gap in understanding the numbers of face-to-face and telephone consultations that occur on an individual service user basis, as well as by episode of care, broken down by demographic factors (age, gender, etc.).

The following sections are all based on the total attendance data. Due to staffing and time pressures, it has not been possible to remove the postal kits from the overall dataset.

Out of area attendances

In total, 3,699 (5%) attendances were from outside the BNSSG area in 2021-22, of which 418 (11%) were from Bath and North East Somerset (BaNES). The majority of out of area patients from BaNES attended Unity Central clinic. BaNES Council currently fund Unity to provide the NCSP to its population. The vast majority (89%) of non-BaNES out of area service users attended the WISH clinic in Weston. It is possible that the WISH attendees are Somerset residents that attend the clinic site in Weston by preference.

Attendances by clinic site

The chart below in figure 5.3 shows the attendances each month by location. Unity Central clinic was consistently the site with the most attendances throughout 2021-22 at 59,378 (this includes people going online to request a postal STI sampling kit), followed by the WISH clinic in Weston with 8,055 attendances.

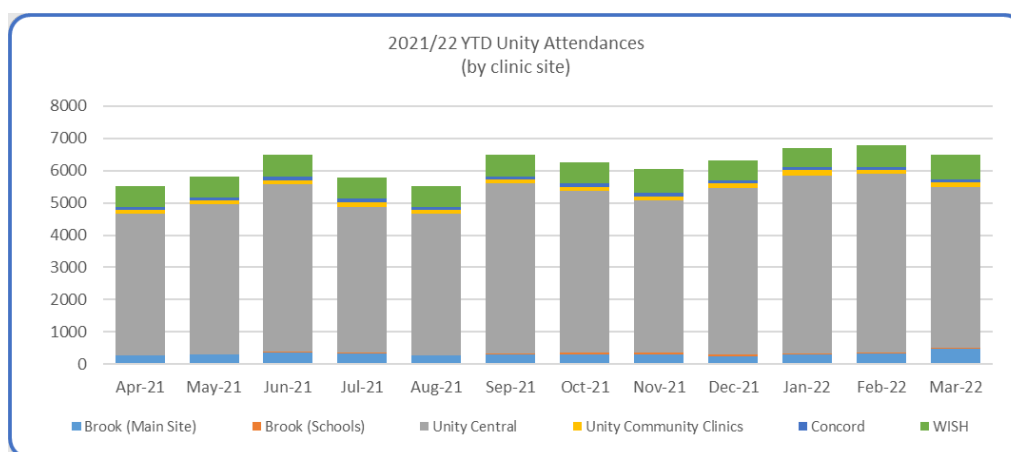


Figure 5.3 Unity attendances (episodes of care) by clinic site, 2021-22

Attendances at Level 3 services

Unity provide one Level 3 services for complex cases in each council area: Unity Central in Bristol, Concord Medical Centre in South Gloucestershire and WISH in North Somerset. In 2021-22, attendances at specialist Level 3 clinics rose by 20% from 57,094 in 2020-21 to 68,488. Again, this increase is likely due to the opening up of services following the COVID-19 lockdowns in 2020 and 2021.

Attendances at community clinics

Looking in more detail at the community clinic attendances shows that there are a number of sites that had not reopened following the COVID-19 lockdowns by the end of March 2022. As of September 2022, the following clinics remain closed due to facilities and/or staffing issues: Charlotte Keel, Cadbury Heath, Downend and Yate (this venue hosts separate young people's and all age clinics). This has an impact on local accessibility to sexual health services in South Gloucestershire in particular. In total, throughout 2021-22 there were 1,548 in community clinics, representing 2.1% of total episodes of care at Unity. Between Q1 and Q4 2021-22 there was a 29% increase in community clinic attendances, suggesting that as COVID-19 restrictions eased during 2021-22, there was an increasing preference by some individuals to use community clinics. With the four community clinics mentioned above remaining closed, this is a barrier to access for individuals, especially in South Gloucestershire where only one of four community clinics is open.

Attendances by age

Total Unity attendances by age show that 42.5% of attendances were in people aged 15-24 years old, followed by 35.7% in people aged 25-34. The proportional age split of attendances shown in figure 5.4 is largely replicated across all three council areas in BNSSG.

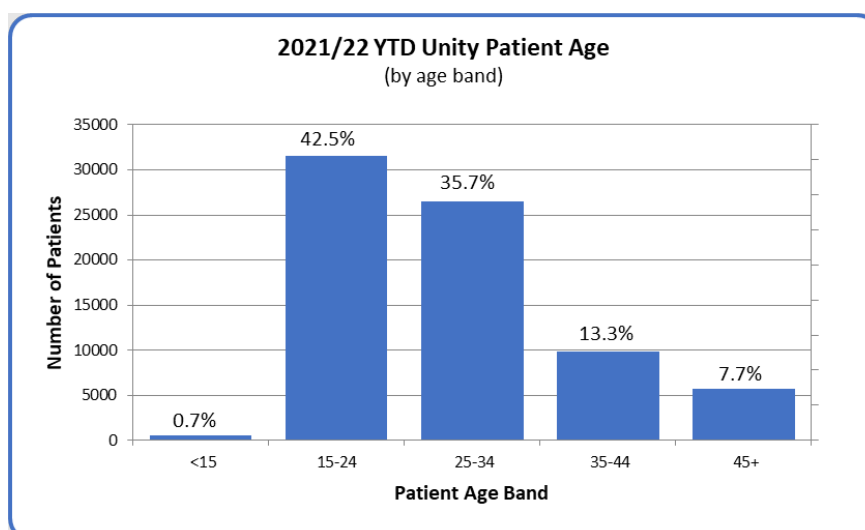


Figure 5.4: Unity attendances by age, 2021-22

Attendances by gender

A noticeably larger proportion of females (59%) attended Unity during 2021-22, compared to 39.5% of males and 1.5% of people who did not have a gender recorded. Female attendance at each clinic site was consistently greater than males, with 75% of females attending Unity Central followed by 12% at WISH and 7% at Brook. In contrast, 87% of all male attendances were at Unity Central followed by 9% at WISH. The greater proportion of females may reflect the additional services beyond STI and HIV testing that females will use, such as contraception and abortion services.

Attendances by ethnicity

Black and mixed ethnic communities are disproportionately affected by STIs in England, as shown in table 5.1 below, shaded in red. Asian communities historically have seen lower rates of STIs.

Table 5.1: Calculation of the risk of STIs to Black, Asian and minoritised ethnic communities in England compared to the general population, 2021 (GUMCAD)

Selected STI	Asian population			Black population			Mixed population			Other ethnicity		
	Count	Rate/ 100,000	Risk ratio	Count	Rate/ 100,000	Risk ratio	Count	Rate/ 100,000	Risk ratio	Count	Rate/ 100,000	Risk ratio
Chlamydia	5128	94.5	0.4	13837	581.0	2.7	7972	477.5	2.2	2364	192.3	0.9
Gonorrhoea	2897	53.4	0.6	5463	229.4	2.6	3429.0	205.4	2.3	1524	124.0	1.4
Herpes	906	16.7	0.4	1418	59.5	1.6	971	58.2	1.5	326	26.5	0.7
Syphilis	495	9.1	0.7	462	19.4	1.5	374	22.4	1.7	264	21.5	1.6
Warts	1502	27.7	0.6	1438	60.4	1.2	1048	62.8	1.3	579	47.1	1.0
Total	10928	201.4	0.5	22618	949.6	2.4	13794	826.3	2.1	5057	411.4	1.0

Comparing the greater risk of STIs, particularly in the Black population, to the Unity attendance data in figure 5.5, it is reasonable to expect an overrepresentation of attendances from the Black population of BNSSG assuming the rates of STIs are similar.

For example, since 3.4% of the population of BNSSG identifies as Black, it is expected that roughly 2.4 times this proportion would be Unity attendances by Black people. However, Unity report that only 4.1% of attendances were by Black people.

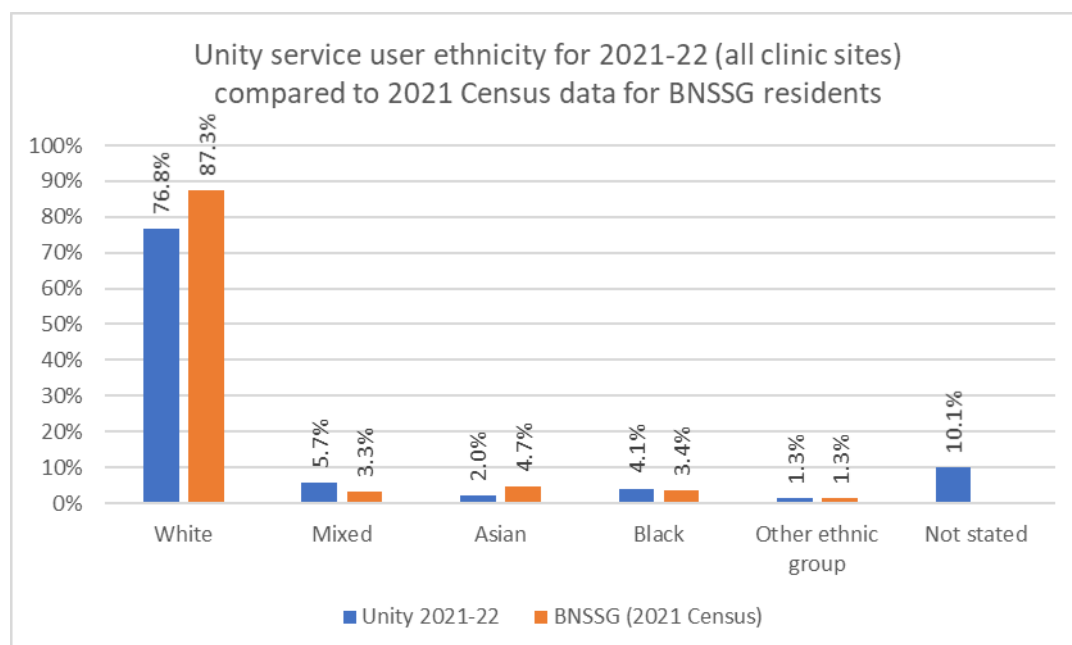


Figure 5.5: Unity attendances by ethnicity, 2021-22, compared to 2021 Census data for BNSSG residents (UHBW/ONS)

It is important to note that 10% of Unity attendees did not share their ethnicity, which could change the interpretation. Also, the Unity attendance data was not available at local authority level, which would have enabled the proportion of people from Black, Asian and minoritised ethnic communities in the more diverse area of Bristol to be explored further. However, this underrepresentation suggests either a lower need, or, more likely, access issues.

Attendances by deprivation

Figure 5.6a-c below maps resident attendances by deprivation quintile for each council area (blue bars) and compares it to the respective council's resident population by deprivation quintiles (orange bars). Evidence shows that people living in the most deprived decile are at greater risk of STIs and therefore it is expected that the charts below would show a greater proportion of Unity attendees from the most deprived quintile when compared to the actual proportion of the population living in the most deprived quintile.

In Bristol, the chart below shows that the most deprived residents are underrepresented as attendees at Unity. Even though there are more clinics in Bristol compared to North Somerset and South Gloucestershire, the latter two local authorities have an over-representation of attendances from people living in the most deprived quintile.

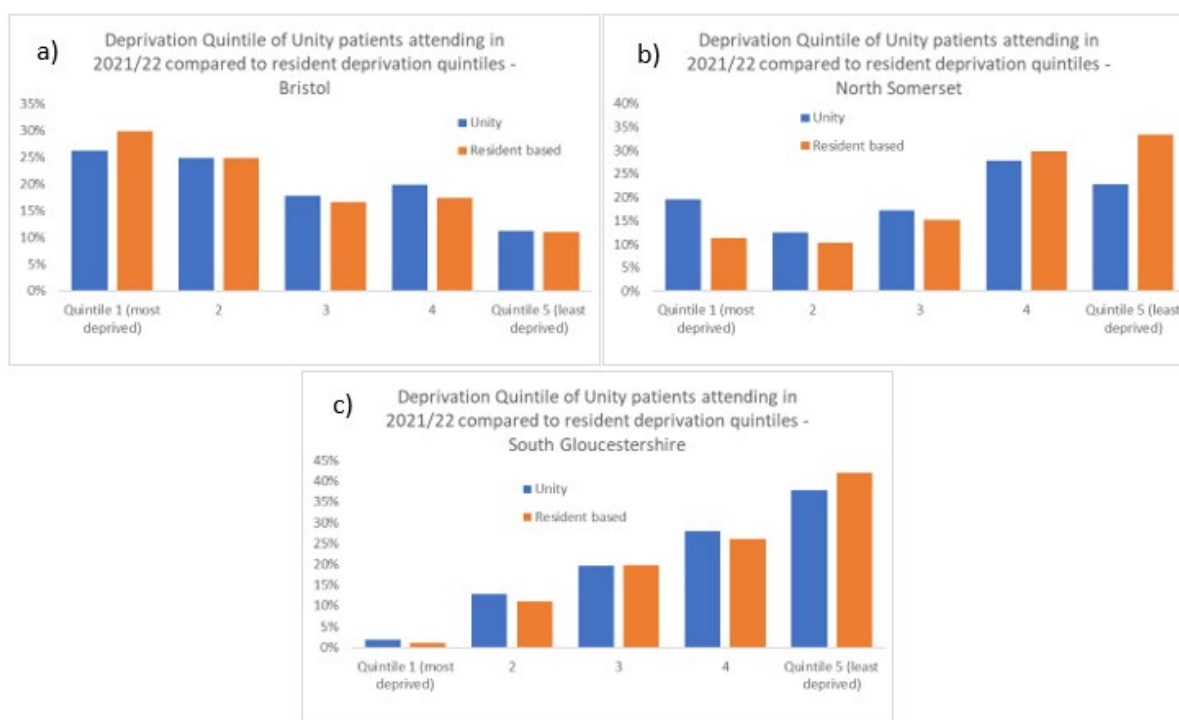


Figure 5.6a-c: Unity attendances from BNSSG compared to the population as a whole by deprivation quintile, Bristol (a), North Somerset (b), South Gloucestershire (c), 2021-22

Attendances by sexual orientation

For a third of service users (34%) that attended Unity clinics in 2021-22, there is no recorded sexual orientation, which is a large gap. Fifty percent of attendees were recorded as heterosexual, 12% as homosexual and 4% as bisexual. The new question on sexual orientation included in the 2021 Census provides a valuable indication of the proportion of the local populations identifying as heterosexual, gay, lesbian, bisexual or other (see above).

DNAs and cancellations

DNAs (did not attend) refer to an appointment that is booked but the service user does not attend. In 2021-22, there were 3,944 DNAs, around 5% of total activity. This is an increase of 1,608 (69%) compared to 2,336 DNAs in 2020-21. This increase may relate to the scaling back up of services in 2021-22 with the easing of COVID-19 restrictions, meaning that more people were able to book appointments, and therefore potentially not attend. Figure 5.7 plots the DNAs by month (blue line), which suggests there is a seasonality to attendances, with troughs noticeable around the Easter, summer and Christmas holidays. More information on the characteristics of the service users that DNA would be helpful to understand whether there are any particular population groups choosing to DNA.

In relation to patient cancellations, where the patient chooses to cancel or reschedule their appointment for any reason, there were 1,495 recorded in 2021-22 on an upward trend month-by-month (see figure 5.7, orange line), which may again relate to the fact that as restrictions eased and appointment availability increased more service users may then have

had to change their appointment. As with the DNAs, more information on the characteristics of service users cancelling their appointments would help to identify if there are any patterns that should be addressed.

Finally, 603 service users in 2021-22 had their appointments cancelled by Unity (see figure 5.7, grey line), usually due to a clinic list created in error (before the patient is aware of their appointment) or in instances where a clinician is absent from clinic (e.g. COVID-19 isolation). The increasing cancellations at the start of 2022 may relate to the Omicron COVID-19 wave impacting on staff sickness.

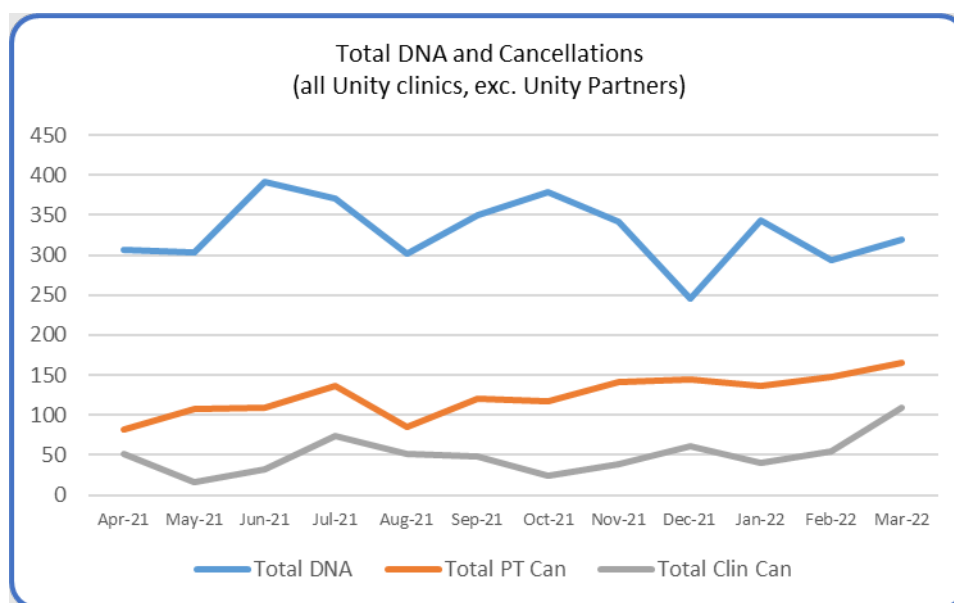


Figure 5.7: Total DNAs, patient cancellations and clinical cancellations, 2021-22

5.1.2 Referrals

The Unity service regularly receives referrals from GPs for routine and complex LARC fits and removals. The possible reasons for these referrals to Unity are listed below:

- GP not signed up to a council contract with public health to deliver a type of LARC
- no professionals currently trained in this method
- patient prefers to be seen at Unity due to a previous difficult fit/ failed removal/insertion
- medical concerns

In 2021-22, there was a 14% increase in LARC referrals received by Unity, rising from 1,368 in 2020-21 to 1,560 in 2021-22. Ninety-eight percent of the referrals in 2021-22 were from BNSSG practices.

5.1.3 Website views

The Unity website (www.unitysexualhealth.co.uk) is an essential way to inform the public about what services are available and how they can be accessed. The Unity website provides:

- information and promotes self-management
- regular updates and advice on how emerging issues, such as mpox, COVID-19, or a lack of postal self-sample kit components, are affecting the service
- a resource for professionals seeking advice or training

Unity collect data on the number of users, the number of page views, and the five most visited pages on the website. From 2020-21 to 2021-22 there was a 10% decrease in the number of website users from 292,527 to 262,410, and a 0.6% increase in the number of page views from 769,299 to 773,954.

The five most visited web pages in 2021-22 were the 'home' page (24%), 'request a postal kit using online account' page (14%), 'how to set up an online account with Unity sexual health' page (11%), 'STIs and testing' page (4%), and 'coronavirus information on what services are currently available' (3%).

The website currently does not allow service users to book an appointment online.

5.1.4 Impact of COVID and Mpox

Service delivery was impacted considerably in 2020/21 with the suspension of face-to-face activity in response to the COVID-19 pandemic. This posed challenges for Unity to maintain business continuity and ensure that the most vulnerable members of the population were still able to access services and not be disproportionately disadvantaged. The biggest impact was on the way people accessed Unity services. Digital technology became an essential means of enabling the service to be delivered when walk-in services were suspended from 23 March 2020. Remote consultations by telephone replaced face-to-face consultations in the first instance. As much information as possible was collected as part of the remote consultation, and face-to-face appointments were only booked when deemed clinically necessary.

In 2019-20 and 2020-21, the number of attendances was reported without the inclusion of postal test kits, and totalled 42,536 and 44,360, respectively, an increase of 4.3% between years. Compared to 2021-22 attendance data once the postal test kits are removed, the total attendance episodes are 39,384, which is an 11% decline in attendance compared to 2020-21. It is possible that there may have been a reduction in the number of attendances but not of individuals attending (repeat attendances), however this data is not available pre-2021-22. The COVID-19 lockdowns were times of heightened health anxiety for all individuals, which, when coupled with the inaccessibility of sexual health services for those that needed them, may have resulted in greater numbers of contact with the service per service user. However, as mentioned earlier, not all of the community clinics that were open before COVID-19 have reopened with the easing of restrictions, which will be a barrier to access for many individuals that are unable to or choose not to travel to Unity Central or WISH.

During the pandemic, medication was either posted to or collected by service users and condoms were sent by post, and both processes are still in place. One of the benefits reported by Unity of the telephone consultations was that service users could be directly signposted to the website to order a postal self-sample kit, which was particularly helpful for those who were asymptomatic.

As COVID-19 restrictions eased early in 2022, from May 2022 mpox took its place as the infectious disease that is heavily impacting Unity services, requiring a large amount of the workforce at all levels to support the response. GBMSM are currently most at risk of getting mpox through large and complex networks of sexual partners. As members of this population routinely use sexual health services for STI and HIV testing, Unity has become a trusted service for those worried about mpox to find out more information, and for those who think they may have mpox to attend for a test. As of 20 December 2022, there have been 3,552 confirmed and highly probable cases of mpox in England, of which 93 have been in the South West. Across BNSSG, there have been less than 23 cases, of which 13 have occurred in Bristol residents.¹¹⁵ Although the total number of cases across BNSSG is low, this does not truly reflect the amount of time and resources that the service are expending as they are testing a far higher number of individuals, which requires full PPE use and an extended appointment slot to allow time for the consultation room to be cleaned afterwards.

5.1.5 Evidence of what works to increase access to specialist sexual health services

The evidence-based recommendations in the recent NICE guidance (NG221)¹¹⁶ on reducing STIs provide some good practice examples to increase access generally and for those most at risk, including:

- forming a network of services, including online services, providing sexual healthcare for an area, ensuring that:
 - everyone is signposted to, and can access, the care they need
 - local pathways are in place to link people, including underserved communities, to the best possible care
 - details of the network are kept up to date and all staff understand what each service offers
- determining the most appropriate settings for services and interventions in consultation with groups with greater sexual health or access needs, including online and non-clinical settings
- reducing barriers to services for groups with greater sexual health or access needs by:
 - emphasising confidentiality, empathy and a non-judgemental approach

¹¹⁵ [Monkeypox cases confirmed in England – latest updates - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/news/monkeypox-cases-confirmed-in-england-latest-updates) (updated 16/08/2022)

¹¹⁶ [Recommendations | Reducing sexually transmitted infections | Guidance | NICE](https://www.nice.org.uk/guidance/ng221) (published 15/06/2022)

- offering access to a professional translator or interpreter instead of waiting for the person to ask, to ensure they are fully able to communicate and to understand the discussion
 - making sure staff understand that services are free and available to everyone regardless of where they live (or are from), and they do not refuse access to someone who is entitled to the service
 - supporting people to attend appointments and engage with treatment
 - providing outreach activities
- targeting interventions at groups with greater sexual health or access needs. Identifying local needs and priorities using data from the Joint Strategic Needs Assessment and other data sources
- engaging with groups with greater sexual health or access needs to understand how best to meet their sexual health and wellbeing needs, taking into account factors such as existing barriers to access (for example, for people with learning difficulties, or because of their gender or sexuality), language and other socioeconomic factors, including deprivation
- co-producing (plan, design, implement and evaluate) services and interventions in consultation with the groups that they are for
- ensuring that interventions are culturally competent. This includes being delivered in a suitable language for people whose main language is not English. It might also involve recognising that people may be engaged in activities that are stigmatised by their communities (therefore, discretion may be particularly important for them)
- tailoring interventions to the needs of the groups identified by taking into account safety concerns (such as sexual violence or coercion), stigma and discrimination

An evidence briefing produced by UKHSA in April 2022 to explore the question ‘What evidence is there about the effectiveness of digital interventions (DIs) for sexual health?’ found that DIs have the potential to improve public health by combining effective interventions with relevant demographic groups.¹¹⁷ They are appropriate for promoting sexual health because access can be:

- private and confidential
- conveniently timed to suit the user
- useful for self-help and increased knowledge
- self-paced in terms of learning
- personalised or targeted to a particular population (e.g. GBMSM, school-age children, etc)

Examples of DIs include text messaging, evidence-based and interactive websites, social media, mobile phone apps, online games, online chat, video appointments, secure online

¹¹⁷ [UKHSA KLS Briefing: What evidence is there about the effectiveness of digital interventions for sexual health?](#) (published 05/04/2022)

testing and online photo-diagnosis, which can all help to improve sexual health. During the COVID-19 lockdowns, access to DIs was crucial to prevent the worsening of sexual, mental, and physical health. Evidence shows that the use of DIs can have positive effects not only for the testing, prevention, and management of a range of sexual health conditions, such as HIV and chlamydia, but also for changing behaviours, such as the frequency of condom use. DIs can be an opportunity for 'teachable moments', for example, when a user submits an online test, tailored information can be sent to help modify existing behaviours. DIs can also help to engage with hard-to-reach populations, particularly as they 'expand clinical interactions into home settings and expect active participation by users'.

It is suggested that online services which facilitate self-sampling at home could improve access to testing for STIs, but the same paper found that clinics are still important for some groups. Another paper found that 'remote STI self-testing and online care appeals to young people', as it overcomes their embarrassment, and concerns about privacy and being seen by people they know. However, self-sampling and self-testing might not suit all populations, particularly those with low literacy levels, as most information is only provided in written format.

Online sexual health services are potentially less expensive than clinical settings as there is a greater focus on self-testing or self-sampling reducing clinical staffing costs, and the processes are automated requiring less administrative oversight and staff. At the moment, sexual health clinics offer one-to-one structured sessions, so potentially, DIs could save clinical staff time as they do not require much support in terms of delivery and training. Teenagers, in particular, may find it hard to access reliable, useful, and age-appropriate sexual health information and services. They may not have access to the right technology or not understand the terminology required to search for the right information. Text messaging is an effective way to engage with teenagers and provides them with a discreet way to access quality sexual health information. Text messaging has the added benefit of being able to reach large numbers of people at fairly low costs.

A systematic review¹¹⁸ of 99 studies conducted between 1996 and 2017, found that text messaging significantly improved antiretroviral therapy (ART) adherence, while internet-based interventions improved clinical attendance, ART adherence, self-care, and reduced risky behaviours. Two-thirds of the papers were from America/Europe, and one third were from Africa/Asia. Other studies showed that DIs can have a moderate impact on improving frequency of condom use, and therefore safer sex intention, and increasing knowledge and self-efficacy. An in-depth NICE guideline¹¹⁹, published in 2020, reviewed 15 primary studies, published between 2000 and 2019. The findings were less positive than other studies included in the briefing, and found that condom use, risk of STIs or unwanted pregnancy did

¹¹⁸ [Do digital innovations for HIV and sexually transmitted infections work? Results from a systematic review \(1996-2017\) - PubMed \(nih.gov\)](#) (published 03/11/2017)

¹¹⁹ [NG183 Behaviour change: digital and mobile health interventions Evidence review D: sexual health behaviour \(nice.org.uk\)](#) (published 07/10/2020)

not change as a consequence of DIs. The authors suggested that DIs should be used as an option for behaviour change in conjunction with existing physical services.

5.1.5.1 SPOT tool

The SPOT tool is used to explore the relationship between council spend and associated outcomes. For sexual health, a total of 23 public health outcome indicators are used to map to council spend. These relate to service-level and population-level outcomes. Examples of this include: STI testing and diagnosis rates, spend on sexual health services, as well as outcome measures such as teenage conceptions.

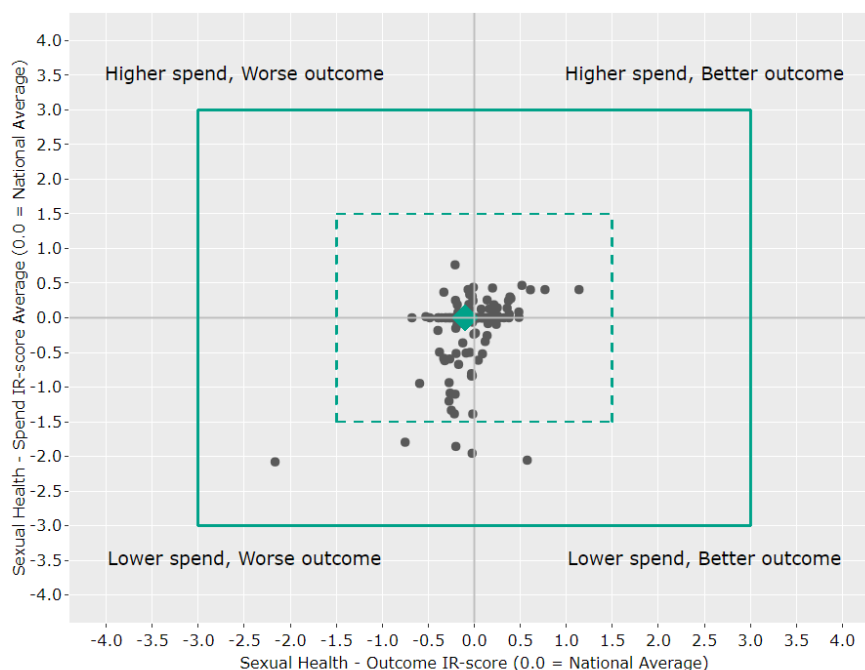


Figure 5.8: Spend versus sexual health outcomes for Bristol City Council compared to England (OHID SPOT 2022)

It is not possible to look at spend versus outcomes for BNSSG as a whole, so each council will be reviewed separately. Bristol is categorised as having a “Same Spend, Worse Outcome” in comparison to the England average (figure 5.8). Bristol and its 15 neighbouring CIPFA areas are categorised as below:

- 2 areas had a rating of ‘Higher Spend, Better Outcome’
- 1 area had ‘Higher Spend, Worse Outcome’
- 6 areas had ‘Same Spend, Better Outcome’
- 1 area had ‘Same Spend, Same Outcome’
- 6 areas had ‘Same Spend, Worse Outcome’

Within the category of ‘Same Spend, Worse Outcome’, Bristol was second worst for sexual health outcomes among the 5 other neighbouring local authority areas at -0.1. It should be noted that the only local authority area in the ‘Higher Spend, Worse Outcome’ category had worse sexual health outcomes than Bristol at -0.53. It would be valuable to find out how the

6 council areas in the 'Same Spend, Better Outcome' category commission their services to benefit from any learning that may help to improve outcomes in Bristol (Southampton, Salford, Coventry, Swindon, Portsmouth and Medway).

Compared to England, North Somerset Council is also categorised as 'Same Spend, Worse Outcome', with an outcome score that is almost identical to Bristol's (-0.11). The categories for North Somerset compared to its 16 CIPFA neighbours are as follows:

- 1 area had 'Same Spend, Better Outcome'
- 8 areas had 'Same Spend, Worse Outcome'
- 1 area had 'Lower Spend, Better Outcome'
- 6 areas had 'Lower Spend, Worse Outcome'

Of the 8 areas in the 'Same Spend, Worse Outcome' category, North Somerset is third from the top in terms of sexual health outcome score (-0.11). The area with comparatively the worst sexual health outcomes is categorised in the 'Lower Spend, Worse Outcome' group and had a score of -0.59. To understand how services could be delivered differently, it would be worthwhile contacting the two areas that achieve better outcomes with the same spend or less to find out how they deliver sexual health services locally (Central Bedfordshire and Bedford).

In contrast to Bristol and North Somerset, South Gloucestershire has a lower spend than England and also worse outcomes with a score of -0.27. South Gloucestershire and its CIPFA neighbours fall in to the following categories:

- 4 areas had 'Same Spend, Better Outcome'
- 7 areas had 'Same Spend, Worse Outcome'
- 1 area had 'Lower Spend, Better Outcome'
- 4 areas had 'Lower Spend, Worse Outcome'

South Gloucestershire Council has the lowest sexual health outcome score of the four areas in the 'Lower Spend, Worse Outcome' category, however the lowest overall score of the neighbours was -0.38 (figure 5.9). It would be worthwhile to identify the different models adopted in the five areas that have better outcomes with either the same or lower spend than the England average (Trafford, Bury, Bedford, Central Bedfordshire, Swindon).

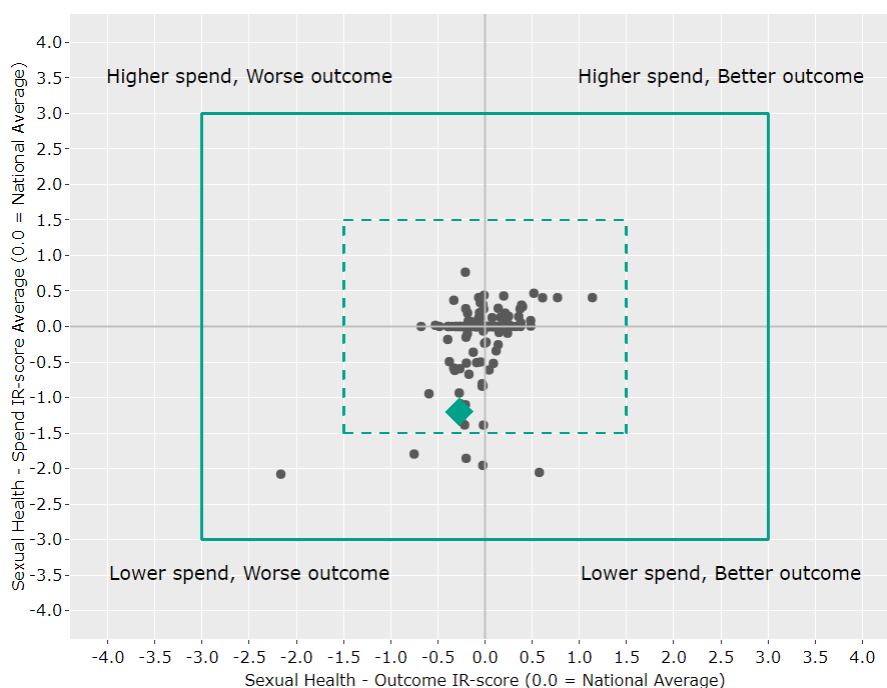


Figure 5.9: Spend versus sexual health outcomes for South Gloucestershire Council compared to England (OHID SPOT 2022)

5.1.6 Issues identified

The following gaps have been identified following a review of the Unity service data.

Data recording

1. Individual attendances and method of consultation (in-person, telephone) broken down by demographic factors are not available.
2. Attendances reported by type of appointment (new, follow-up or rebooked) and by demographic factors are not available. Also, those attending again for a new episode of care after 6 months can indicate a lack of behaviour change.
3. Postal test kits issued skews the overall attendance data, and it is not possible to analyse the test kits data by different demographic features.
4. Data from annual DNA and cancellation audits to identify the demographic features of those not attending appointments is not available.
5. Increasing the recording of service users' ethnicity and sexual orientation would provide valuable inequalities data.

Inequalities

6. Some of the community clinics that closed during the COVID-19 pandemic remain closed now, which is disproportionately affecting South Gloucestershire.
7. In Bristol the most deprived residents are underrepresented as attendees at Unity.
8. Attendances from Black and Mixed ethnic communities in Bristol are lower than expected.

Digital services

9. Online appointment booking is not available.
10. Digital interventions for service users may promote behaviour change and increase sexual health knowledge but should robustly evaluated to determine their effectiveness in any future service model.

Patient and public engagement

11. Regular and extensive consultation of service users by sexual health service providers has been impacted by COVID-19. It is vital for services to gain views on how to improve accessibility of information and services online and in person.

5.2 Genito-urinary infections

A note on the STI/HIV data: all of the data reported below are crude. Age-sex standardisation has not been carried out and, therefore, it is important to consider when making comparisons between the different BNSSG council areas that the confounding factors of age and sex have not been adjusted for.

5.2.1 Sexually transmitted infections (STIs)

STIs are spread primarily through sexual contact and are among the most common infectious illnesses, particularly among young people. If not treated, STIs can cause acute symptoms, chronic infections and serious later consequences such as infertility, ectopic pregnancy and cervical cancer. Sexual behaviour is a major determinant of sexual and reproductive health. Certain behaviours are associated with increased transmission of STIs, including:^{120,121}

- lower age at first sexual intercourse
- high number of lifetime partners
- concurrent partnerships
- payment for sexual services
- alcohol
- substance misuse

Many people with STIs, including HIV and associated blood-borne viruses, are asymptomatic and thus remain undiagnosed for many years. STIs are communicable diseases that once acquired need to be diagnosed and treated quickly to prevent onward transmission to partners. It is therefore essential to provide accessible screening, diagnosis and treatment management for those affected and their partners. Prevention methods and advice are a crucial part of the care pathway to minimise infection rates in the community. HIV will not be included in this section as it has its own section in [5.3.2](#). Data is reported nationally by

¹²⁰ [Health matters: preventing STIs - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/news/health-matters-preventing-stis)

¹²¹ [Ethnic variations in sexual behaviours and sexual health markers: findings from the third British National Survey of Sexual Attitudes and Lifestyles \(Natsal-3\) \(thelancet.com\)](https://www.thelancet.com/journal/S0140-6736(19)30156-1)

UKHSA, further to data cleaning, and is therefore always less timely than local service data. Most data on STIs is available at the time of writing, for 2021.

5.2.1.1 STI testing and diagnoses in BNSSG

In 2021, the new STI diagnosis rate (excluding chlamydia in people aged <25) in BNSSG was 302 per 100,000 residents of all ages, a total of 2,930 diagnoses, which is now lower than the national average of 394 per 100,000 (see figure 5.10). In BNSSG, the new STI diagnosis rate (excl. chlamydia <25) had been slowly increasing from 519 per 100,000 in 2012 to 593 per 100,000 in 2019, before falling significantly to 335 per 100,000 in 2020 due to COVID-19 and falling again in 2021. The continued decline seen in BNSSG from 2020 to 2021 is not mirrored by the England average. Recently, however, local service data for 2022 suggests an increase in chlamydia and gonorrhoea cases. Gonorrhoea rates have risen more quickly than expected and to a level greater than that seen before the pandemic, particularly in Bristol.

When chlamydia is included, the total number of all new STIs diagnosed among residents of BNSSG in 2021 was 4,215, a rate of 435 per 100,000, of which 1,285 (30.5%) were chlamydia diagnoses in 15-24-year-olds.

Unity reported a total of 3,506 new STI diagnoses in specialist SRHS in 2021 which includes chlamydia in people aged 15-24 and also includes diagnoses for people living out of area as individual council-area data was not available.¹²² The Unity total is different to that reported above as it only includes diagnoses given within Unity clinics, while the figure above also includes chlamydia diagnoses in over 25s from general practices.

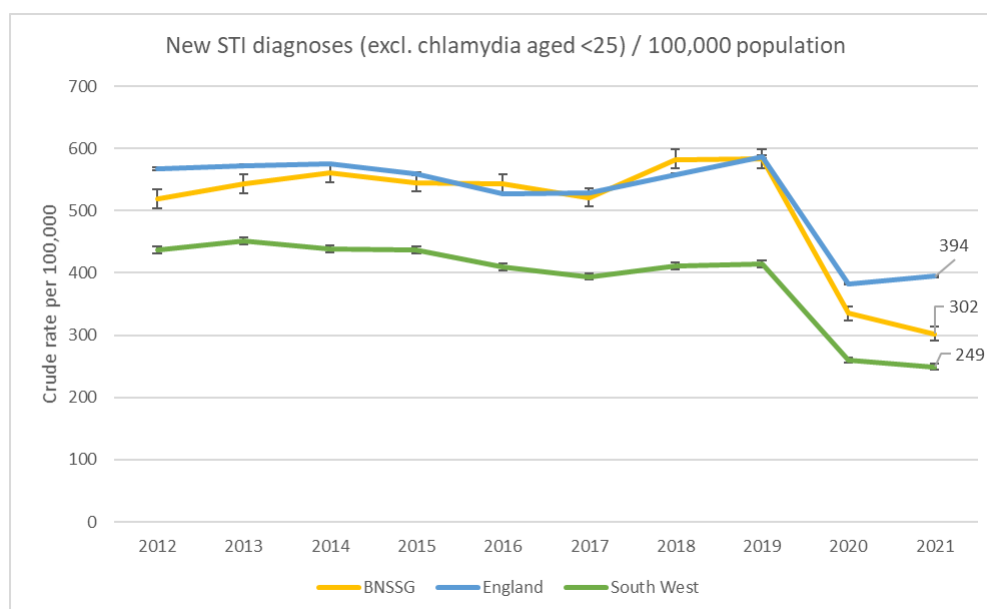


Figure 5.10: New STI diagnoses (excl. chlamydia aged <25) / 100,000, BNSSG, SW and England (UKHSA)

Bristol ranked as one of the councils with the highest rates of new STI diagnoses excluding chlamydia in young people aged <25 in 2021 when compared to its 15 nearest CIPFA

¹²² Unity performance data, Q4 2020-21 and Q1, Q2 and Q3 2021-22 (internal)

neighbours, with a rate of 437 per 100,000 residents of all ages (nearest neighbours range: 193-666 per 100,000), and significantly higher than the England average. Overall, the total number of all new STIs diagnosed among residents of Bristol in 2021 was 2,872, of which 833 were chlamydia diagnoses in 15-24-year-olds.

In contrast, North Somerset had the lowest rate of new STI diagnoses (excl. chlamydia in young people <25) when compared to its 15 nearest neighbours, with a rate of 158 per 100,000 residents of all ages (nearest neighbours range: 158-388 per 100,000), which is significantly lower than the England rate. The number of all new STIs diagnosed among residents of North Somerset in 2021 was 495, of which 153 were chlamydia diagnoses in 15-24-year-olds.

South Gloucestershire had one of the lowest rates for new STI diagnoses (excl. chlamydia in young people <25) when compared to its 15 nearest neighbours, with a rate of 192 per 100,000 residents of all ages (nearest neighbours range: 158-368 per 100,000), which is significantly better than the England rate. The total number of new STIs diagnosed among residents of South Gloucestershire in 2021 was 856, of which 299 were chlamydia diagnoses in 15-24-year-olds.

The differences above are largely due to the difference in age structure and deprivation levels with Bristol having a younger and more deprived demographic.

Across all three council areas there was variation at ward-level in the rate of new STI diagnoses (excl. chlamydia in young people <25) in 2020. Unfortunately, ward-level data for 2021 was not available at time of writing. It is important to note that there were methodological changes between 2020 and 2021, which may have an impact on the interpretation of the data below. Despite this, the 2020 data is still valuable to be aware of. Across BNSSG, Cabot Ward in Bristol and Weston-Super-Mare – Uphill Ward in North Somerset both fall into the highest national category for rates of new STI diagnoses with >2,500 per 100,000 in people aged 25 to 64. In contrast, Filton, Kings Chase, Rodway, and Staple Hill Wards have the highest rates for South Gloucestershire but each fall within the 500-<1,000 per 100,000 category.

Compared to the local Unity service data, which suggests that testing has increased post-2020 (19,061 tests in 2020-21 to 41,015 tests in 2021-22), the published outcomes data for 2021, shows that the number of STI tests (excl. chlamydia in young people <25) taken by people aged 15-64 years old in SRHS has fallen from 44,707 tests in 2019 to 24,988 in 2020 to 8,374 tests in 2021. The rate in each local authority area in BNSSG is lower than the England average and continuing to fall from 2019 (see figure 5.11). There have been methodological changes nationally in how the published outcome data are cleansed and reported, and the impacts of these changes on the data provided by Unity are being explored further for quality assurance purposes.

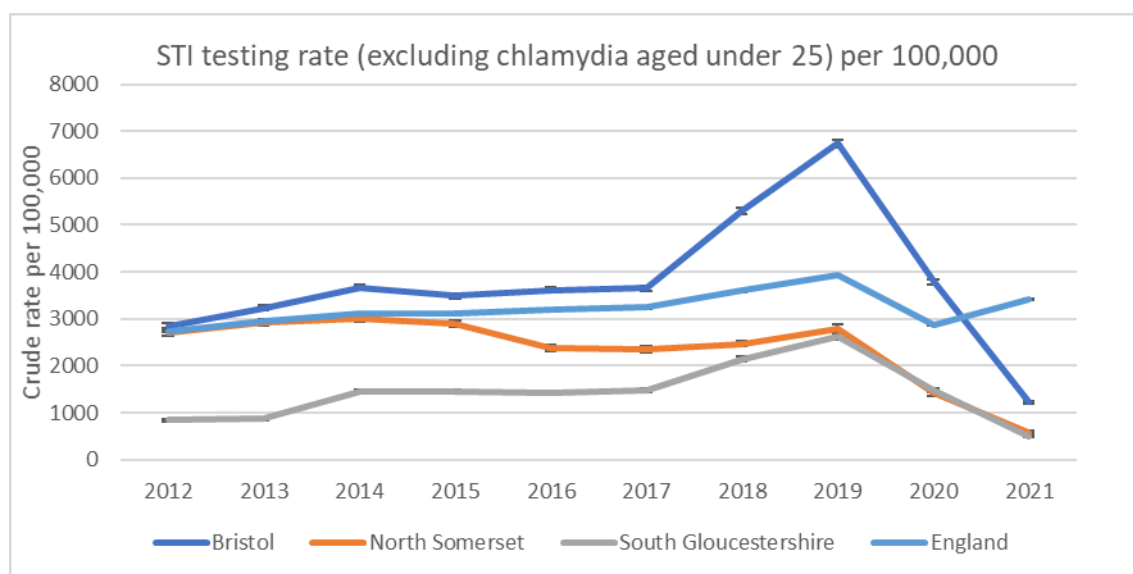


Figure 5.11: STI testing rate (excluding chlamydia aged <25) per 100,000, Bristol, North Somerset, South Gloucestershire, England, 2012-2021

The positivity rate in 2021 was 9.8% in Bristol, 7.3% in North Somerset, and 10.3% in South Gloucestershire. The rates in Bristol and South Gloucestershire are each higher than the England average of 6.1%, while North Somerset's rate is similar. Positivity rates depend both on the number of diagnoses and the offer of testing: higher positivity rates compared with previous years can represent increased burden of infection, decreases in the number of tests, or both. From 2021 the method for calculating STI testing positivity has been amended. The denominator has changed from the total number of tests recommended for routine STI screening in sexual health services (SRHS) to total number of people tested for one or more infections for syphilis, HIV, gonorrhoea and chlamydia (in people aged 25+) at a new attendance. The positivity rates across BNSSG have increased noticeably from 2020 despite the changes also being applied to the historic data (Bristol +5.8%; North Somerset +3.5%; South Gloucestershire +5.6%). This correlates with the considerable decline in testing recorded in the published outcomes data for 2021, as discussed above.

5.2.1.2 Chlamydia

Chlamydia trachomatis is the most commonly diagnosed bacterial STI in England, with rates substantially higher in young adults than any other age groups. It causes avoidable sexual and reproductive ill-health, including symptomatic acute infections and complications such as pelvic inflammatory disease, ectopic pregnancy and tubal-factor infertility.¹²³ The burden of STIs remains greatest in young people aged 15-24 years, certain Black ethnic groups, and GBMSM.¹²⁴ Since April 2022, the BNSSG chlamydia screening programme has focused on reducing the harms from untreated chlamydia infection in young women and those with a

¹²³ Office for Health Improvement and Disparities (2022) Sexual and Reproductive Health Profiles, Indicator Definitions, Chlamydia Detection rate [Online], Available from: <https://fingertips.phe.org.uk/>

¹²⁴ [Sexually transmitted infections and screening for chlamydia in England: 2021 report - GOV.UK](https://www.gov.uk/government/publications/sexually-transmitted-infections-and-screening-for-chlamydia-in-england-2021-report) (www.gov.uk) (updated 04/10/2022)

womb or ovaries aged 15-24 in response to the changes announced to the NCSP in England. Services provided by sexual health services remain unchanged and everyone can still get tested if needed.

Chlamydia detection in 15–24-year-olds

The SHNA draws on 2021 data and the benchmarking thresholds in place prior to NCSP changes. These thresholds recommend that local areas achieve a detection rate of at least 2,300 per 100,000 people aged 15 to 24 years, however the UKHSA recommends that local authorities should be working towards the revised female only PHOF benchmark detection rate indicator of 3,250 per 100,000 aged 15 to 24. Since chlamydia is most often asymptomatic, a high detection rate reflects success at identifying infections that, if left untreated, may lead to serious reproductive health consequences.

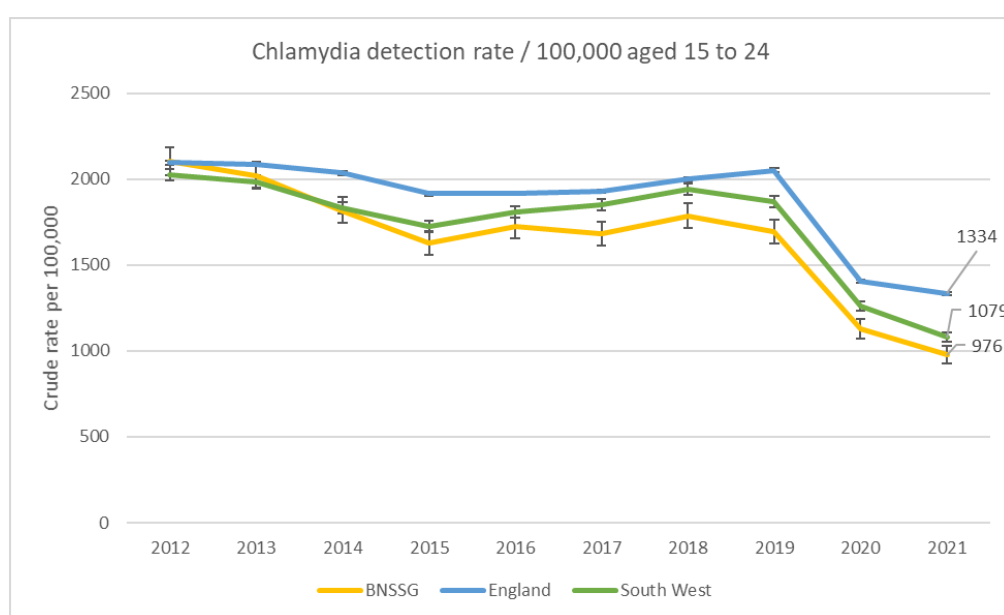


Figure 5.12: Chlamydia detection rate / 100,000 aged 15 to 24 (UKHSA)

Data on all chlamydia detection in people aged 15 to 24 years attending sexual health services and community-based settings (GPs and Pharmacies) in BNSSG show that between 2014 and 2019 chlamydia detection has been largely stable with a small increase, ranging from 1,625-1,817 per 100,000. The detection trend in BNSSG has mirrored that of the SW and England averages, all of which saw a noticeable drop in 2020 (BNSSG = 1,126; SW = 1,262; England = 1,407), likely due to COVID-19 restrictions, which has continued to decline in 2021 (BNSSG = 976; SW = 1,079; England = 1,334). The detection rate in BNSSG has been significantly lower than that of the SW and England for the last 5 years since 2017 (see figure 5.12).

The detection of chlamydia in males and females separately also mirrors the trend seen for males and females combined in BNSSG from 2012 to 2020, but with females having a much higher rate than males. For males, the detection rate was 582 per 100,000 in 2021, lower than both the SW and England rates of 674 and 860, respectively. For females, the detection

rate in 2021 was 1,336 per 100,000, lower than 1,428 in the SW and 1,762 in England. It is worth noting that only 9 councils in England achieved the >2,300 per 100,000 detection rate in 2021, ranging from 548 to 3,408 per 100,000.

In 2021, all three council areas in BNSSG had detection rates in people aged 15 to 24 that were both lower than the England rate of 1,334 per 100,000 and the 2,300 per 100,000 target. In Bristol, the chlamydia detection rate was 1,065 per 100,000 in 2021 (833 positives out of 7,997 screened). Compared to its 15 nearest neighbours, Bristol has the second lowest detection rate after Bolton, (the nearest neighbours' rates range from 714 to 2,426 per 100,000). Compared to 14.8% nationally and 13.8% in the SW, 10.2% of 15- to 24-year-olds in Bristol were tested for chlamydia. Of those tested in Bristol, 10.4% were positive, compared to a 9.0% national positivity rate.

South Gloucestershire had a chlamydia detection rate of 904 per 100,000 in 2021 (299 positives out of 3,224 screened), with 9.7% of 15- to 24-year-olds tested for chlamydia with a 9.3% positivity rate. Compared to its nearest neighbours, ranging from 735 to 1,768 per 100,000, South Gloucestershire's rate is lower than the average.

Of the three council areas, North Somerset has the lowest detection rate in BNSSG at 752 per 100,000 in 2021 (153 positives out of 1,921 screened) and, compared to its 15 nearest neighbours (ranging from 735 to 1,768 per 100,000), also has the second worst detection rate after Solihull. In 2021, 9.4% of North Somerset residents aged 15 to 24 years old were tested for chlamydia with an 8.0% positivity rate.

There is variation in detection of chlamydia in 15- to 24-year-olds within each council footprint as illustrated in figure 5.13, which shows detection at ward level in 2021. Variation in rates of chlamydia detection may represent differences in prevalence but are influenced

by screening coverage and whether most at risk populations are being reached (i.e. the proportion testing positive).¹²⁵

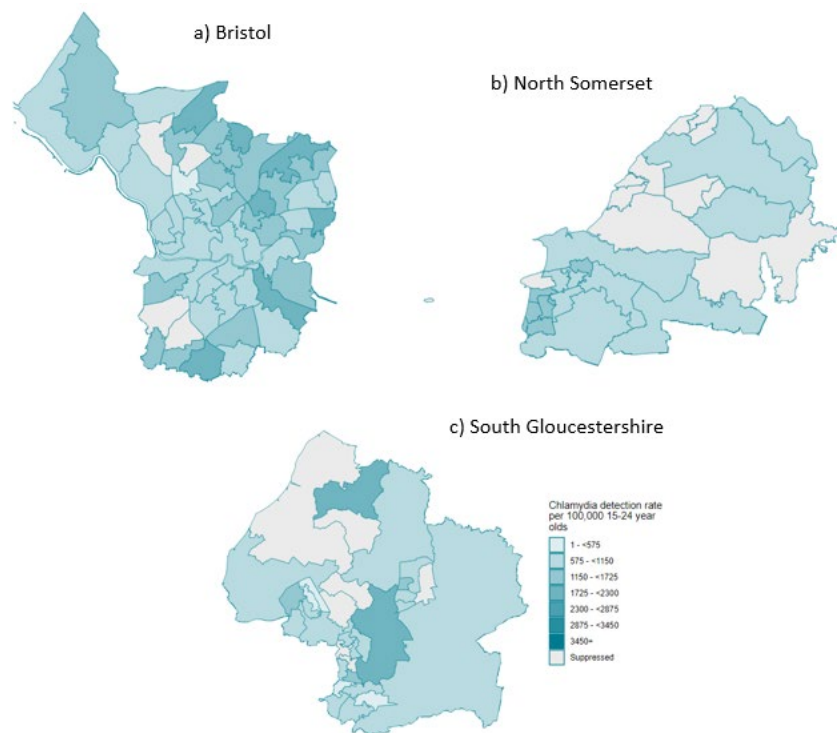


Figure 5.13: Map of chlamydia detection rate per 100,000 population in 15 to 24 years in a) Bristol, b) North Somerset and c) South Gloucestershire by ward, 2020 (UKHSA)

Data on chlamydia screening activity in 15-24-year-olds within GPs across BNSSG shows that a total of 7,564 tests were accessed via GP settings with a positivity of 5.7%. There is a noticeable difference in positivity between males and females tested in GPs. Positivity among males was 11.2% (based on 1,103 tests) compared to 4.7% in females (based on 6,438 tests). This could suggest that males are more likely to visit a GP for a test if they are highly likely to have chlamydia (e.g. following partner notification) or when already symptomatic. In contrast, chlamydia screening activity data for 15-24-year-olds accessing pharmacies across BNSSG shows that a total of 846 tests were taken with a positivity of 9.7%. There was little difference in positivity between males and females. Positivity among males was 9.4% (based on 170 tests) compared to 9.5% in females (based on 671 tests). Given the widespread availability of pharmacies on local high streets across BNSSG, it is surprising to see so few tests undertaken- just 6.4% of all chlamydia tests in people aged 15-24 in BNSSG were accessed in pharmacies. This could suggest a lack of awareness in young people that they can access chlamydia screening tests in pharmacies or supply or capacity issues within pharmacies. In both GP and pharmacy settings, females tested in far greater numbers than males; almost 6 times more in GP and just over 4 times more in pharmacy settings. Of a total number of 13,249 chlamydia tests taken in all settings across BNSSG,

¹²⁵ Summary Profile of Local Authority Sexual Health (SPLASH) in Sexual & Reproductive Health Profiles <https://fingertips.phe.org.uk/profile/sexualhealth>, UKHSA (published 01/02/2023)

63.5% occurred in GP and pharmacy settings compared to 21.4% in specialist and non-specialist SRHS combined, with the remaining 14.3% of tests undertaken in abortion service settings, through online services, 'other' settings, or the setting was not known.¹²⁶

Chlamydia diagnoses in 25+ year olds

While chlamydial infections are more commonly found among young adults aged <25 years, women and men aged 25 years and over are also at risk of chlamydia. In BNSSG, chlamydia diagnoses in people aged 25+ have exceeded the SW average every year between 2012 and 2021 but, since 2019, have been below the England average. In 2021, there was a continued decline in the 25+ year olds' diagnostic rate in BNSSG, dropping from 153 per 100,000 in 2020 to 120 per 100,000 in 2021. The SW rate also fell but to a lesser degree from 108 per 100,000 in 2020 to 99 per 100,000. The England average, however, saw an increase from 171 per 100,000 in 2020 to 178 per 100,000 in 2021.

The high diagnostic rates for BNSSG have been driven by Bristol. In 2021, Bristol's diagnostic rate in 25+ year olds was 178 per 100,000, compared to 53 per 100,000 in North Somerset and 87 per 100,000 in South Gloucestershire (see figure 5.14). Bristol's high diagnostic rate has consistently been higher than the England average until 2021, when it was similar to England. North Somerset and South Gloucestershire, which have both consistently been lower than the England average. Compared to the average rate of Bristol's 15 nearest neighbours (182 per 100,000), Bristol's rate is similar.

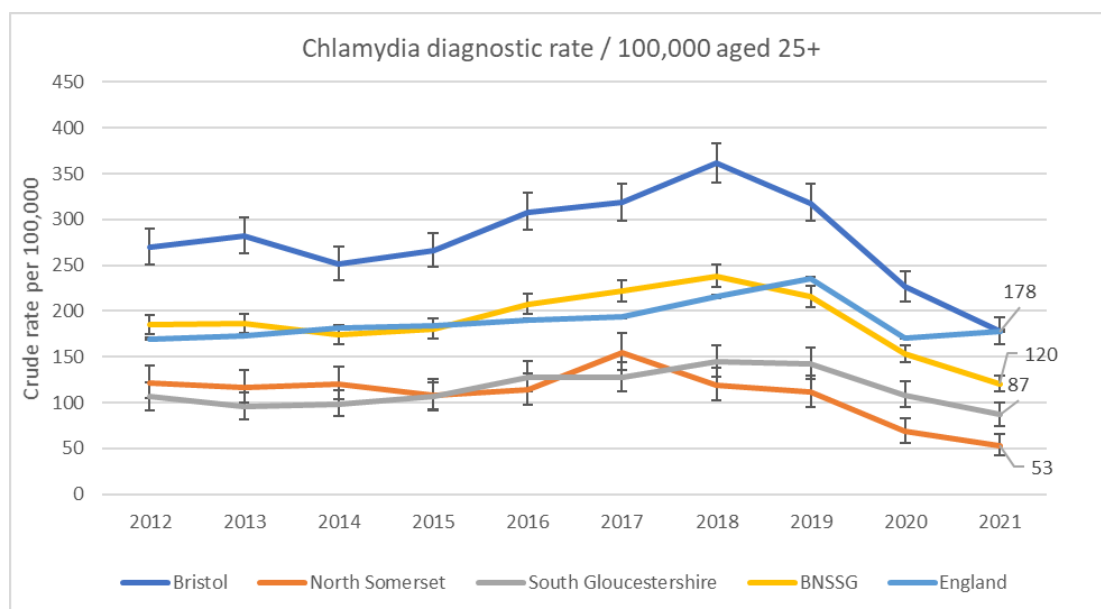


Figure 5.14: Chlamydia diagnostic rate / 100,000 in 25+ year olds, 2012-2020, Bristol, North Somerset, South Gloucestershire and BNSSG (UKHSA)

Unity data on chlamydia

¹²⁶ Chlamydia testing activity database (CTAD) (accessed 04/01/2023)

Performance data for 2021 report that Unity diagnosed 1,539 all age cases of chlamydia across BNSSG. There were 1,081 diagnoses in Bristol, 180 in North Somerset, and 278 in South Gloucestershire in 2021. These figures represent the total number of diagnoses that occurred in any Unity clinic setting in 2021, which includes individuals who received more than one diagnosis of chlamydia within this time period. Unity reported that in 2021, there were 183 people in Bristol with a repeat diagnosis of chlamydia within 6 months, 26 people in North Somerset and 48 people in South Gloucestershire. Unity also report on the total number of positive cases of chlamydia in 15–24-year-olds for BNSSG and BaNES in 2021, which was 2,017 (6.2%). This includes cases detected using tests from pharmacies, GPs, NCSP and Unity. It is not possible to break this down further by council.¹²⁷ This figure is less than the total published for BNSSG and BaNES, 2,436, as this also includes diagnoses provided via abortion services, and other sexual health settings accessed by BNSSG residents.

5.2.1.3 Gonorrhoea

Gonorrhoea is caused by the bacterium *Neisseria gonorrhoeae*. It is the second most common bacterial STI in the UK and is seen more commonly GBMSM and younger people. Occasionally, gonorrhoea can cause serious complications such as pelvic inflammatory disease, ectopic pregnancy and infertility. Gonorrhoea is used as a marker for rates of unsafe sexual activity. This is because the majority of cases are diagnosed in sexual health clinics, and consequently the number of cases may be a measure of access to STI treatment. Infections with gonorrhoea are also more likely than chlamydia to result in symptoms.¹²⁸

Our BNSSG chlamydia screening programme tests for both gonorrhoea as well as chlamydia. Despite this, and the younger profile of the Bristol population, the gonorrhoea diagnostic rates for BNSSG have been low compared to the England average between 2012 and 2021. The noticeable drop-off in diagnoses in 2020 was likely the result of the COVID-19 lockdowns, but the rate has continued to decrease in 2021. In 2020, the BNSSG diagnostic rate was 47 per 100,000 (451 cases) and dropped to 31 per 100,000 (303 cases) in 2021, compared to 89 per 100,000 in 2020 and 90 per 100,000 in 2021 nationally. Until the drop in diagnoses in 2020, there was an increasing trend in diagnoses seen across BNSSG, the SW and England from 2017. Nationally, the diagnostic rate started to increase again in 2021 but has declined further in BNSSG and the SW.

Looking at the rates for the individual councils, Bristol is the driver for the overall BNSSG diagnostic rate, dropping from a peak of 134 per 100,000 in 2019 to 46 per 100,000 in 2021 (see figure 5.15), and is lower than the England rate. When compared to its nearest neighbours (ranging from 33 per 100,000 to 180 per 100,000), in 2021 Bristol had one of the lowest gonorrhoea diagnostic rates which is unexpected.

¹²⁷ Unity performance data, Q4 2020-21 and Q1, Q2 and Q3 2021-22 (internal)

¹²⁸ [Sexual and Reproductive Health Profiles - Data - OHID \(phe.org.uk\)](https://phes.org.uk/data-reports/sexual-reproductive-health-profiles) (updated 07/09/2021)

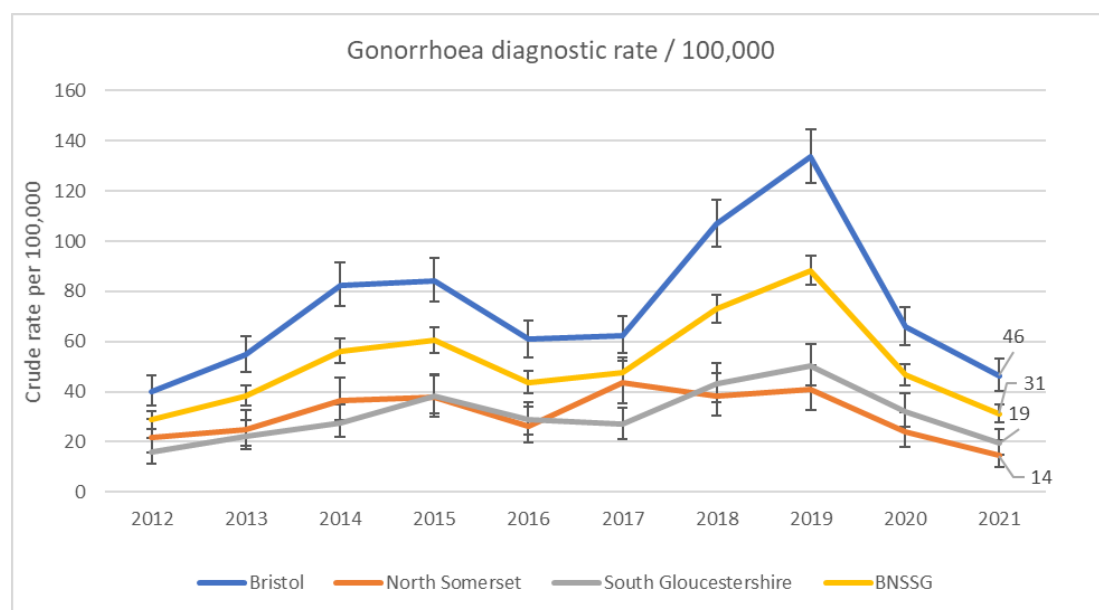


Figure 5.15: Gonorrhoea diagnostic rate / 100,000, 2012-2021, Bristol, North Somerset, South Gloucestershire and BNSSG (UKHSA)

Unity data on gonorrhoea

Data from Unity for 2021 report a total of 457 all age cases of gonorrhoea across BNSSG. There were 339 diagnoses in Bristol, 37 in North Somerset, and 81 in South Gloucestershire in 2021. These figures represent the total number of diagnoses that occurred in any Unity clinic setting in 2021, which includes individuals who received more than one diagnosis of gonorrhoea within this time period. Unity reported that in 2021, there were 133 people (39.2%) in Bristol with a repeat diagnosis of gonorrhoea within 6 months, 13 people (35.1%) in North Somerset and 31 people (38.3%) in South Gloucestershire.¹²⁹

This contrasts to data from UKHSA¹³⁰ on gonorrhoea reinfections, shown in table 5.2 below. Across BNSSG the proportion of gonorrhoea reinfections is lower than the England average, which is notable in Bristol particularly given the size of the LGBTQ+ population (6.1% in Bristol – the 5th largest in number, compared to 3.2% in England and Wales), of whom GBMSM are at a higher risk of gonorrhoea. For example, in 2021 in BNSSG, 54.6% of all gonorrhoea cases reported were in GBMSM (see section [5.3.1.8](#)).

Table 5.2: Estimated gonorrhoea reinfection within 12 months, Bristol, North Somerset, South Gloucestershire, England, 2016-2020 (UKHSA)

Gonorrhoea reinfection within 12 months, 2016-2020 (estimated)	Bristol	North Somerset	South Gloucestershire	England
Women	1.7%	0.0%	2.5%	4.1%
Men	8.6%	7.1%	6.6%	11.2%

¹²⁹ OHID (2022) Definition of chlamydia detection rate in 15-24 year olds indicator: [Sexual and Reproductive Health Profiles - Data - OHID \(phe.org.uk\)](https://phe.org.uk/data/sexual-reproductive-health-profiles)

¹³⁰ UKHSA Supplementary Summary Profiles of Local Authority Sexual Health (issued 2022)

The differences in the number of total cases and reinfections reported by Unity and nationally are likely to relate to the de-duplication methodology used by the national team for repeat diagnoses which ensures that a patient receives a diagnostic code only once for each episode of care.

Local Unity data for 2022 shows a higher than expected increase in gonorrhoea rates, particularly in Bristol, which are now at a level greater than that seen before the pandemic. The cases are being monitored closely locally and with support from UKHSA.

5.2.1.4 Syphilis

Treponema pallidum (syphilis) is a bacterial infection usually spread by sexual contact. The disease starts as a painless sore — typically on the genitals, in the rectum or mouth. Syphilis spreads from person to person via skin or mucous membrane contact with these sores. Pregnant women are screened for syphilis to prevent congenital spread. If not treated the bacterium will remain dormant in the body and can cause serious and life threatening complications sometimes years later, syphilis is therefore an important public health issue in GBMSM among whom incidence has increased over the past decade.¹³¹

In England, by the end of 2021, diagnoses of infectious syphilis returned to pre-COVID-19 pandemic levels at the end of 2019. The national data indicate that GBMSM remain disproportionately affected by syphilis (71% of all infectious syphilis diagnoses in 2021 are amongst this group). The rate of diagnoses varies by ethnicity, with the rate remaining highest in people of Black Caribbean backgrounds.¹³²

The syphilis diagnostic rates for BNSSG have generally been lower than those for England, and higher than those for the SW from 2012 to 2021, although the number of cases overall are low (74 cases in 2021). The diagnostic rate in BNSSG was 8 per 100,000 in 2021, compared to 13 per 100,000 for England and 5 per 100,000 for the SW (see figure 5.16).

Once again, the BNSSG rate is driven by Bristol, which in 2021 had a diagnostic rate of 11 per 100,000, compared to 5 in South Gloucestershire and 5 in North Somerset. Bristol's diagnostic rate for syphilis was similar to the England average and the average rate of its nearest neighbours (ranging from 2.9 per 100,000 to 38.3 per 100,000). Both North Somerset and South Gloucestershire were lower than the England rate, and both were similar to the average rates for their respective nearest neighbours (North Somerset: range 2.3 per 100,000 to 11.1 per 100,000; South Gloucestershire: range 1.9 per 100,000 to 11.1 per 100,000).

¹³¹ [Sexual and Reproductive Health Profiles - Data - OHID \(phe.org.uk\)](https://phe.org.uk/data) (updated 07/09/2021)

¹³² [Syphilis in England, 2019 to 2021 - GOV.UK \(www.gov.uk\)](https://www.gov.uk) (published 22/11/2022)

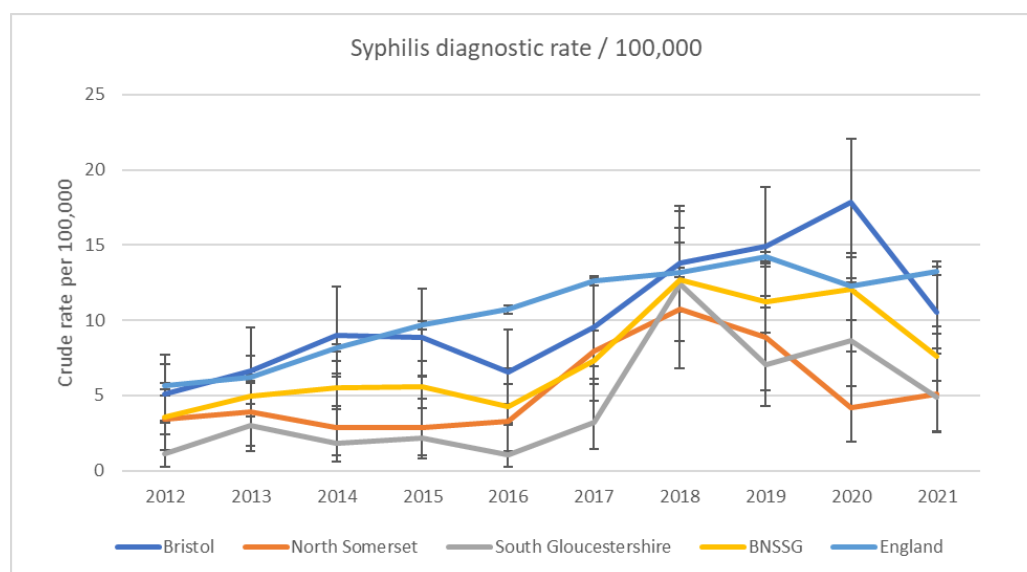


Figure 5.16: Syphilis diagnostic rate / 100,000, 2012-2021, Bristol, North Somerset, South Gloucestershire, BNSSG, England (OHID Fingertips)

Unity data on syphilis

Data from Unity for 2021 report a total of 146 all age cases of syphilis across BNSSG – double the figure that is reported nationally. There were 104 diagnoses in Bristol, 20 in North Somerset, and 22 in South Gloucestershire in 2021. These figures represent the total number of diagnoses that occurred in any Unity clinic setting in 2021, which includes individuals who were recorded more than once with a diagnosis of syphilis within this period. Unity reported that in 2021, there were 50 people in Bristol with a repeat recording of a diagnosis of syphilis within 6 months, 8 people in North Somerset and 9 people in South Gloucestershire.¹³³ Although this explains some of the discrepancies compared to the national data, these are being investigated further.

5.2.1.5 Genital herpes

Genital herpes is caused by the genital herpes simplex virus (HSV). It is the most common ulcerative STI in the UK. It is not curable – the virus can be reactivated – causing recurrent ulcers. The virus can cause severe systemic disease in new-born infants and the immunosuppressed and it may facilitate HIV transmission. Many HSV infections are not detectable as there are no signs or symptoms of disease. There are two distinct subtypes of HSV:

- type 1, which primarily causes oral herpes (or cold sores), but can also cause genital infections
- type 2, which is almost exclusively associated with genital infection

The genital herpes first episode diagnostic rates for BNSSG from 2012 to 2021 have followed a more turbulent trend than those for England and the SW being, on the whole, similar to the England average and higher than the SW region (see figure 5.17). As seen with

¹³³ Unity performance data, Q4 2020-21 and Q1, Q2 and Q3 2021-22 (internal)

gonorrhoea and syphilis, there was a considerable decline in the rates reported for 2020, likely due to COVID-19, but unlike chlamydia, gonorrhoea and syphilis the rates have not further reduced in 2021. The BNSSG genital herpes diagnostic rate in 2021 was 32 per 100,000 (311 cases), up from 31 per 100,000 in 2020, compared to 38 per 100,000 in England, up from 36 per 100,000 in 2020, and 35 per 100,000 in the SW, up from 32 per 100,000 in 2020.

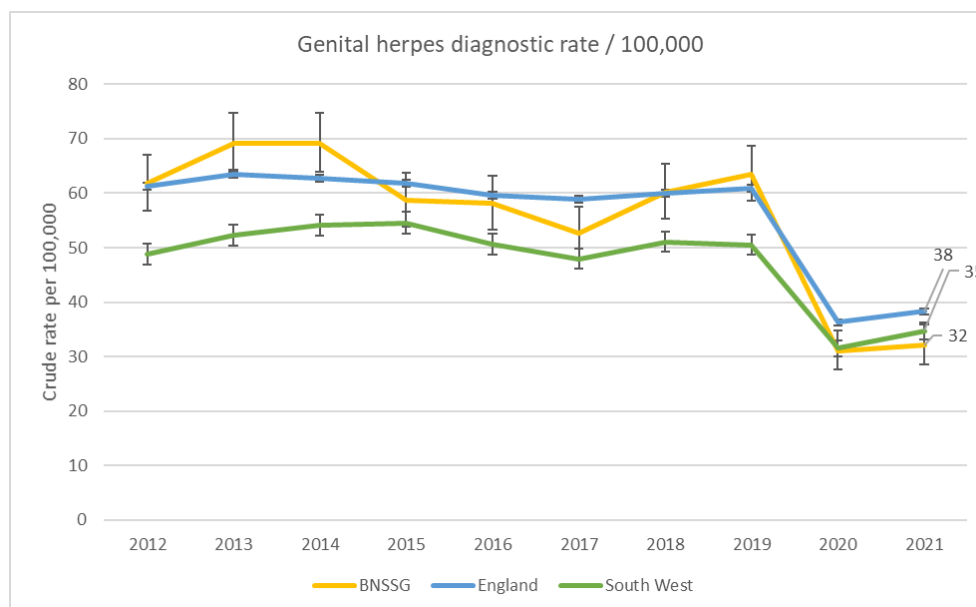


Figure 5.17: Genital herpes diagnostic rate / 100,000, 2012-2021, BNSSG, England and SW (OHID Fingertips)

At a council level, Bristol's genital herpes diagnostic rate was highest in 2021 at 43 per 100,000, which is similar to the England average and the average of Bristol's nearest neighbours (38 per 100,000). North Somerset's rate in 2021 was 29 per 100,000, which is lower than the English average and similar to its nearest neighbours average (29 per 100,000). Finally, South Gloucestershire had a genital herpes diagnostic rate of 18 per 100,000, which is lower than the England average and its nearest neighbours average (29 per 100,000).

Unity data on genital herpes

Data from Unity for 2021 report a total of 334 all age cases of genital herpes across BNSSG. There were 216 diagnoses in Bristol, 64 in North Somerset, and 54 in South Gloucestershire in 2021. These figures represent the total number of diagnoses that occurred in any Unity clinic setting in 2021, which includes individuals who received more than one diagnosis of genital herpes within this time period. Unity reported that in 2021, there were 33 people in Bristol with a repeat diagnosis of genital herpes within 6 months, 8 people in North Somerset and 6 people in South Gloucestershire.¹³⁴ There are discrepancies in the greater number of genital herpes cases reported by Unity (334 cases) compared to the national data

¹³⁴ Unity performance data, Q4 2020-21 and Q1, Q2 and Q3 2021-22 (internal)

(311), which are being investigated further but may relate to the de-duplication methodology used by the national team for repeat diagnoses.

5.2.1.6 Genital warts

Genital warts are the most common viral STI diagnosed in the UK. Genital warts are found on or around the penis, anus or vagina and are largely caused by the human papillomavirus (HPV).

In England, there has been an HPV vaccination programme for girls aged 12-13 since 2008 and for boys since 2019. In addition, GBMSM are eligible for the vaccine. Gardasil9, an HPV vaccine that protects against 9 different strains of HPV, was rolled out during the 2021-22 academic year, and replaces the previous Gardasil vaccine that protected against four strains of HPV. HPV types associated with cancer are called 'high risk' types (16, 18, 31, 33, 45, 52 and 58). HPV types that do not cause cancer are termed 'low risk'. Two of these 'low risk' types (6 and 11) cause 90% of genital warts. Gardasil9 provides protection against all of the strains outlined above.¹³⁵ The national HPV vaccination programme has resulted in a decreasing trend in cases of genital warts, as described below.

In BNSSG the genital warts diagnostic rates have been decreasing since 2012, more slowly than for England and the SW (see figure 5.18). In 2020 there was a steeper decline, likely the result of COVID-19 restrictions. However, 2021 has seen a slight increase in the diagnostic rate for genital warts. The genital warts diagnostic rate in BNSSG was 56 per 100,000 in 2021 (544 cases), up from 49 per 100,000 in 2020, compared to the SW rate of 49 per 100,000 and the England rate of 50 per 100,000.

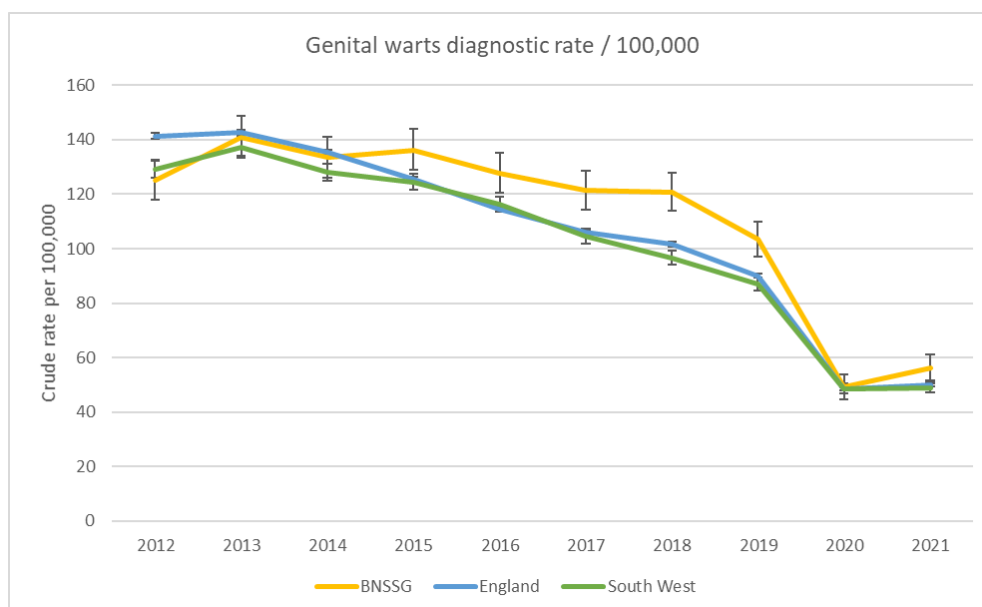


Figure 5.18: Genital warts diagnostic rate / 100,000 population, 2012-2021, BNSSG, SW and England (OHID Fingertips)

¹³⁵ [HPV vaccine overview - NHS \(www.nhs.uk\)](https://www.nhs.uk) (updated 10/05/2022)

Again, the Bristol diagnostic rates are largely driving the BNSSG average at 81 per 100,000, which is higher than the England average and, compared to its nearest neighbours, Bristol has the highest diagnostic rate (range 12 per 100,000 to 81 per 100,000). The rates for North Somerset and South Gloucestershire, by contrast, are 33 and 34 per 100,000, respectively, and are both similar to their nearest neighbours' averages of 39 and 40 per 100,000.

Unity data on genital warts

Data from Unity for 2021 report a total of 550 all age cases of genital warts across BNSSG. There were 369 diagnoses in Bristol, 79 in North Somerset, and 102 in South Gloucestershire in 2021. These figures represent the total number of diagnoses that occurred in any Unity clinic setting in 2021, which includes individuals who received more than one diagnosis of genital warts within this time period. Unity reported that in 2021, there were 45 people in Bristol with a repeat diagnosis of genital warts within 6 months, 15 people in North Somerset and 8 people in South Gloucestershire.¹³⁶

5.2.1.7 Other STIs (hepatitis, shigella, LGV, M. Gen and trichomoniasis)

Hepatitis

Hepatitis is a liver infection that can be caused by different viral strains. Hepatitis A is spread in the faeces of an infected person. It is uncommon in the UK, but certain groups are at increased risk. This includes travellers to parts of the world with poor levels of sanitation, GBMSM and people who inject drugs.¹³⁷ Hepatitis B is spread through blood, semen and vaginal fluids. It is more common in Asia and Africa than in the UK.¹³⁸ The most commonly reported risk is heterosexual exposure (50%), followed by sex between men (17%).¹³⁹ Most people in England acquire hepatitis C through injecting drug use.¹⁴⁰ However, GBMSM are also a risk group for hepatitis C transmission. GBMSM living with diagnosed HIV, especially those reporting high risk sexual practices, are disproportionately affected by hepatitis C compared to HIV-negative GBMSM, therefore guidance for hepatitis C testing in SRHS has been targeted towards this group.¹⁴¹ There are effective vaccines available against hepatitis A and B, which can prevent infection and are recommended for GBMSM, individuals with multiple sexual partners and for individuals who place themselves at risk through sexual activity when travelling to high prevalence countries. According to GUMCAD data for 2021-22, there were <5 cases of hepatitis A, B or C diagnosed in sexual health services in BNSSG residents. There were a total of 326 hepatitis A first dose vaccinations and 159 subsequent

¹³⁶ Unity performance data, Q4 2020-21 and Q1, Q2 and Q3 2021-22 (internal)

¹³⁷ [Hepatitis A - NHS \(www.nhs.uk\)](https://www.nhs.uk) (updated 11/03/2022)

¹³⁸ [Hepatitis B - NHS \(www.nhs.uk\)](https://www.nhs.uk) (updated 01/07/2022)

¹³⁹ [Laboratory reports of Acute Hepatitis B in England, 2018 \(publishing.service.gov.uk\)](https://publishing.service.gov.uk) (04/2020)

¹⁴⁰ [Hepatitis C - NHS \(www.nhs.uk\)](https://www.nhs.uk) (updated 27/10/2021)

¹⁴¹ [Hepatitis C in England 2022: Full report \(publishing.service.gov.uk\)](https://publishing.service.gov.uk) (03/2022)

dose vaccinations, and 366 hepatitis B first dose vaccinations and 539 subsequent dose vaccinations given in 2021 across BNSSG.¹⁴²

Shigella

Some gastro-intestinal infections, typically linked to contaminated food or water can also be spread faecal-orally during sexual activity and are known as sexually transmissible enteric infections (STEl) e.g. hepatitis A and shigella. Cases of shigellosis can be severe, leading to dehydration and sepsis. Due to its presentation as an enteric illness, most symptomatic cases present to primary care (GPs, A&E) rather than SRHS. Only a minority of GBMSM are thought to be aware of shigella and how to avoid it, however surveillance shows transmission of these infections is commonly associated with high-risk behaviours such as sexualised drug-use (including 'chemsex') and multiple casual sex partners. While the number of cases of sexually transmitted shigella among GBMSM in England has increased since 2012, with concerning increases in antimicrobial resistance, there were zero reported cases in BNSSG in 2021-22.^{143,144}

Lymphogranuloma venereum (LGV)

LGV, an invasive form of chlamydia, is an STI which disproportionately affects GBMSM. In the past decade, the number of LGV diagnoses has increased substantially in England. Historically, LGV was mainly concentrated among GBMSM living with HIV. However, in recent years, a greater proportion of cases have been among GBMSM who are HIV negative.¹⁴⁵ In BNSSG in 2021, there were <5 cases recorded, all in men.¹⁴⁶

Mycoplasma genitalium (M. Gen)

M. Gen is a less common STI and whilst routine screening is not recommended, women with pelvic inflammatory disease and men with non-gonococcal urethritis should be tested as well as their sexual partners.¹⁴⁷ In 2021/22 Unity reported 45 cases (including out of area service users) and GUMCAD reported 43 cases in BNSSG residents.

Trichomoniasis

Trichomoniasis is a curable bacterial STI. It is a less common STI affecting mostly people aged 15 to 49 years. It may cause complications in pregnancy and is treated with antibiotics. It is not routinely tested through Unity postal kits. In 2021-22 Unity reported 93 cases (including out of area service users) and GUMCAD reported 68 cases in BNSSG residents.

¹⁴² GUMCAD Report: All STI Diagnosis and Services (GUM & Non-GUM), UKHSA 2020

¹⁴³ [Sexually transmitted Shigella spp. in England: data up to quarter 2, 2022 - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/statistics/sexually-transmitted-shigella-spp-in-england-data-up-to-quarter-2-2022) (28/09/2022)

¹⁴⁴ SPLASH report in Sexual & Reproductive Health profiles <https://fingertips.phe.org.uk/profile/sexualhealth>, UKHSA (updated 06/2022)

¹⁴⁵ [Trends of Lymphogranuloma venereum \(LGV\) in England: 2019 \(publishing.service.gov.uk\)](https://publishing.service.gov.uk/government/statistics/trends-of-lymphogranuloma-venereum-lgv-in-england-2019) (09/12/2020)

¹⁴⁶ SPLASH report in Sexual & Reproductive Health profiles <https://fingertips.phe.org.uk/profile/sexualhealth>, UKHSA (updated 06/2022)

¹⁴⁷ [BASHH Mycoplasma genitalium 2018 guidelines](https://www.gov.uk/government/publications/bashh-mycoplasma-genitalium-2018-guidelines) (published 03/01/2019)

5.2.1.8 Inequalities and STIs in BNSSG

Age and gender

In 2021, 1,988 (48.3%) of all new BNSSG diagnoses made in SRHS and non-specialist SRHS were in people aged 15 to 24 years old. Within this age group, the burden of all new STI diagnoses was higher in young females (1,213 diagnoses) than young males (775 diagnoses). The opposite was true for those aged 25 and over in BNSSG with 1,277 diagnoses in males and 843 in women. Table 5.3 shows the proportion and number of all new STIs by age group and gender for each local authority, BNSSG and England in 2021, which each show a similar pattern to each other.¹⁴⁸

Of all female diagnoses in BNSSG the highest proportion occurred in 20-24 year olds (40.3%, 831 diagnoses), and of all male cases, the highest proportion occurred in 25-34 year olds (41.6%, 855 diagnoses). This is further illustrated in figure 5.19.

Table 5.3: All new STI diagnoses (%) made in SRHS and non-specialist SRHS, by age group and gender, Bristol, North Somerset, South Gloucestershire and England, 2021 (the colour coding is on a scale of lightest red (lowest % of new diagnoses) to darkest red (highest % of new diagnoses) (UKHSA GUMCAD)

Area		All new STI diagnoses (%) breakdown by age group and gender (male, M; female, F), 2021													
		15-19		20-24		25-34		35-44		45+		N/K		Total	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F
Bristol	%	5.6	16.3	33.4	40.3	41.6	32.8	11.8	7.5	7.4	2.9	0.1	0.0	100.0	100.0
	n	81	220	485	545	604	443	172	102	108	39	1	0	1,452	1,351
North Somerset	%	9.2	24.8	19.7	40.9	41.7	24.0	14.7	6.3	14.7	3.5	0.0	0.0	100.0	100.0
	n	20	63	43	104	91	61	32	16	32	9	0	0	218	254
South Glos	%	11.7	21.7	26.3	39.8	41.7	24.5	11.2	8.8	9.1	4.6	0.0	0.2	100.0	100.0
	n	45	99	101	182	160	112	43	40	35	21	0	1	384	457
BNSSG	%	7.1	18.5	30.6	40.3	41.6	29.9	12.0	7.7	8.5	3.3	0.0	0.0	100.0	100.0
	n	146	382	629	831	855	616	247	158	175	69	1	1	2,054	2,062
England		%	7.2	20.2	23.9	36.4	39.4	29.7	17.6	9.1	11.8	4.5	0.0	100.0	100.0

¹⁴⁸ GUMCAD Report: New STI Diagnosis Numbers and Rates (GUM & Non-GUM), UKHSA 2020

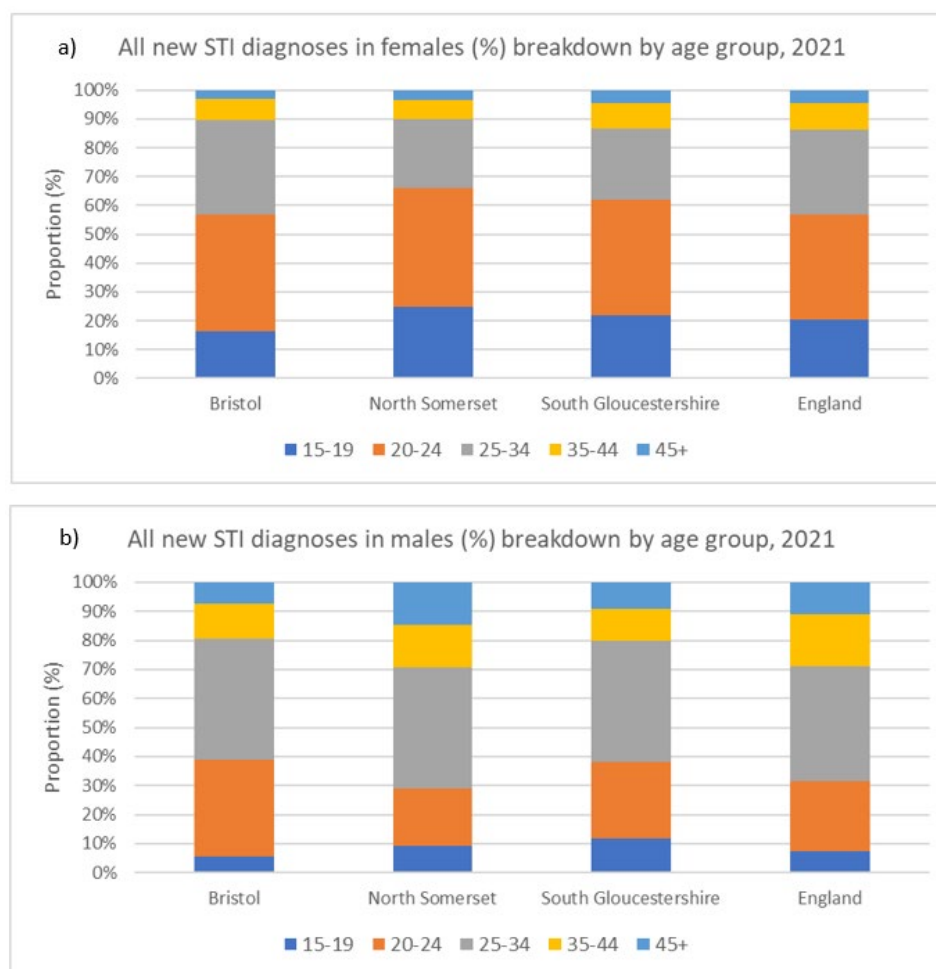


Figure 5.19: Scarf chart of all new STI diagnoses in a) females and b) males, by age group, Bristol, North Somerset, South Gloucestershire and England (UKHSA)

Sexual risk

The crude data reported below in table 5.4 show the proportion and number of cases of chlamydia, genital herpes, genital warts, gonorrhoea, syphilis and all STIs that were diagnosed (in SRHS only) in heterosexual men, GBMSM and women in the collective five years from 2017 to 2021 in BNSSG and England.¹⁴⁹

The greatest proportion of new STI diagnoses in BNSSG occurred in women (9,775 cases, 41.2%) between 2017 and 2021, compared to heterosexual men (9,014 cases, 38.0%), and GBMSM (4,199 cases, 17.7%). However, as a collective 'male' group, heterosexual men and GBMSM combined had more diagnoses in total (13,213, 55.8%). The data show that STI diagnoses by sexual risk group in BNSSG follow the same broad pattern seen nationally.

¹⁴⁹ [Sexual and Reproductive Health Profiles - OHID \(phe.org.uk\)](https://phe.org.uk) (published 06/2022)

Table 5.4: New STIs diagnosed (%) in BNSSG by selected STI and sexual risk, BNSSG and England, 2017-2021; LCI – lower confidence interval; UCI – upper confidence interval (red shading indicates that the value is lower than the England average; green shading indicates that the value is higher than the England average) (UKHSA GUMCAD)

			Heterosexual Men			GBMSM			Women			Unknown gender/ sexual risk
			%	LCI	UCI	%	LCI	UCI	%	LCI	UCI	
BNSSG	Chlamydia	%	32.5%	31.4%	33.5%	16.0%	15.2%	16.8%	49.0%	47.9%	50.1%	2.5%
		n	2,474			1,220			3,736			194
	Gonorrhoea	%	18.1%	16.7%	19.6%	54.6%	52.7%	56.5%	25.1%	23.5%	26.7%	2.2%
		n	498			1,505			691			62
	Herpes	%	31.4%	29.5%	33.3%	4.8%	4.0%	5.7%	60.1%	58.1%	62.1%	3.8%
		n	722			110			1,384			87
	Syphilis	%	13.6%	10.9%	17.0%	74.7%	70.7%	78.4%	7.9%	5.9%	10.7%	3.7%
		n	67			367			39			18
	Warts	%	50.9%	49.4%	52.4%	6.2%	5.5%	6.9%	40.2%	38.8%	41.7%	2.7%
		n	2,202			267			1,742			118
	All new	%	38.0%	37.4%	38.7%	17.7%	17.2%	18.2%	41.2%	40.6%	41.9%	3.0%
		n	9,014			4,199			9,775			710
England	Chlamydia		31.6%	31.4%	31.7%	15.2%	15.1%	15.2%	49.0%	48.9%	49.2%	4.3%
	Gonorrhoea		20.8%	20.6%	20.9%	48.8%	48.7%	49.0%	25.3%	25.1%	25.4%	5.1%
	Herpes		28.0%	27.7%	28.2%	5.3%	5.2%	5.5%	63.4%	63.2%	63.7%	3.3%
	Syphilis		11.4%	11.1%	11.8%	74.4%	74.0%	74.9%	7.4%	7.2%	7.7%	6.7%
	Warts		48.6%	48.4%	48.8%	5.9%	5.8%	6.0%	41.5%	41.3%	41.8%	3.9%
	All new		34.1%	34.1%	34.2%	19.4%	19.3%	19.4%	42.2%	42.1%	42.2%	4.3%

Key points to note from the BNSSG data are:

- In heterosexual men, the greatest proportion of STIs was attributable to genital warts (50.9%, 2,202 cases) but the greatest number of STIs was attributable to chlamydia (2,474 cases, 32.5%); see figure 5.20a
- In GBMSM, the greatest proportion of STIs was attributable to syphilis (74.7%; 367 cases) but the greatest number of STIs was attributable to gonorrhoea (1,505, 54.6%); see figure 5.20b
- In women, the greatest proportion of STIs was attributable to genital herpes (60.1%, 1,384 cases) but the greatest number of STIs was attributable to chlamydia (3,736, 49.0%); see figure 5.20c

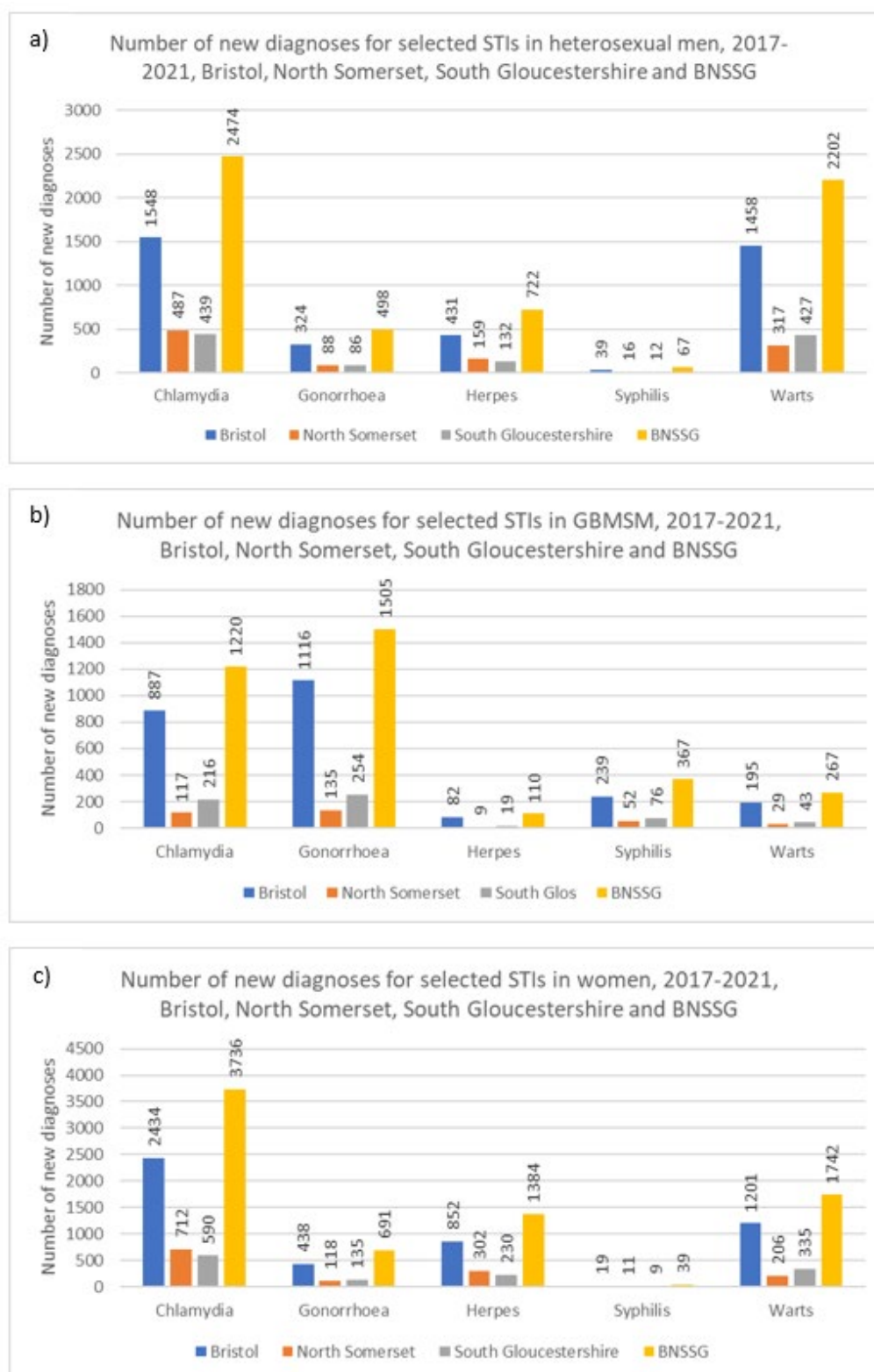


Figure 5.20: Number of new diagnoses for selected STIs in a) heterosexual men; b) GBMSM; and c) women, Bristol, North Somerset, South Gloucestershire, BNSSG, 2017-2021 (UKHSA GUMCAD)

Ethnicity

Black, Asian and minoritised ethnic communities are disproportionately affected by STIs and national data for 2021 show that population rates of selected STI diagnoses (chlamydia

(excluding <25 year olds), gonorrhoea, herpes, syphilis and warts) remained highest among people of Black ethnicity at 2.4 times the risk compared to the general population (see [table 5.1](#)). This varied among Black ethnic groups: people of Black Caribbean ethnicity had the highest diagnosis rates of chlamydia, gonorrhoea, herpes, and trichomoniasis, while people of Black African ethnicity had relatively lower rates than other ethnic groups.¹⁵⁰

A comparison of the national rates of selected STIs by ethnicity with the rates for Bristol highlights the underrepresentation of Black ethnic groups in Bristol (Figure 5.21). The proportion of the population in Bristol who are Black (5.9%) is greater than that in England (4.2%), which suggests that less new diagnoses than expected occurred in Black people.

This data suggests that people from Black ethnic communities are either not being tested perhaps due to access issues or the rate of STIs is lower in the Black population in Bristol. It is possible that behaviours around testing are different in Black ethnic groups.

Research conducted through the Health Protection Research Unit (HPRU) on blood-borne viruses and STIs in 2017 to 2018 found, when compared to all other ethnic groups, there were no unique clinical or behavioural factors explaining the disproportionately high rates of STI diagnoses among people of Black Caribbean ethnicity. The report concluded that the ethnic disparity in STIs is likely influenced by underlying socioeconomic factors and the role they play in the structural determinants of the health of the Black Caribbean community.¹⁵¹

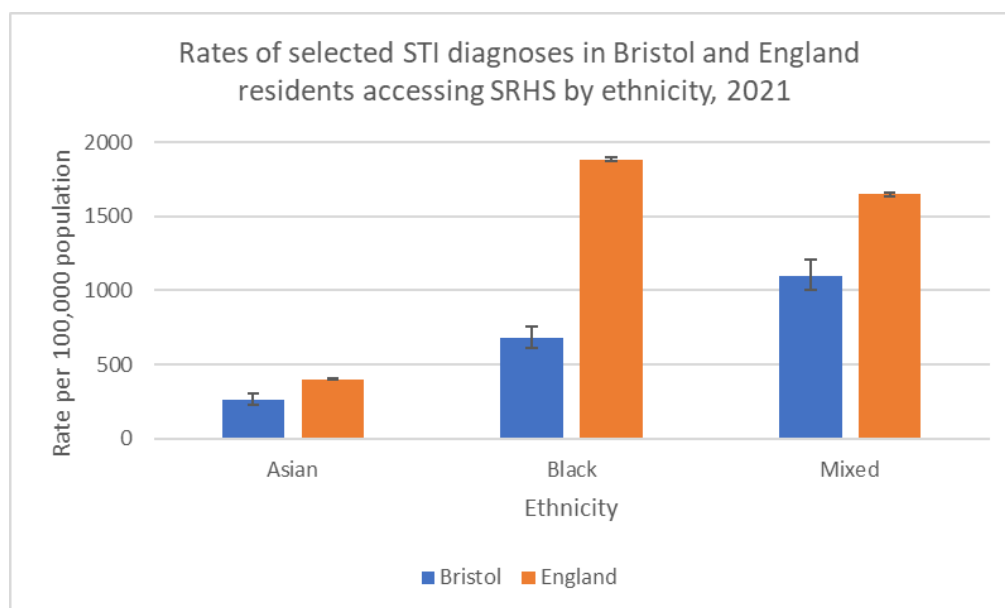


Figure 5.21: Calculated rates of selected STI diagnoses (chlamydia (excluding <25 year olds), gonorrhoea, herpes, syphilis and warts) / 100,000 in residents accessing SRHS by ethnicity, Bristol and England, 2021 (GUMCAD)

¹⁵⁰ [Sexually transmitted infections and screening for chlamydia in England: 2021 report - GOV.UK \(www.gov.uk\)](#) (published 04/10/2022)

¹⁵¹ [Promoting the sexual health and wellbeing of people from a Black Caribbean background: an evidence-based resource - GOV.UK \(www.gov.uk\)](#) (published 29/09/2021)

Deprivation

Table 5.5 below shows the number and proportion of new STI diagnoses (excluding chlamydia in <25 year olds) in 2020 by deprivation category, comparing this to the proportion of people in each BNSSG council area residing in each deprivation category. It has not been possible to explore the 2021 data by deprivation as it was not available at time of writing. It is important to note that there have also been methodological changes between 2020 and 2021, which may have an impact on the interpretation of the data below.

The data below show that there was an overrepresentation of new diagnoses (excluding chlamydia in <25s) in the most deprived and 2nd most deprived quintiles for each BNSSG local authority, which would be expected. However, this data should be contrasted with the Unity attendance data reported by deprivation, which shows an underrepresentation in attendances in Bristol from those in the most deprived quintile for 2021. This suggests that, in Bristol, although there are proportionally less attendances at Unity from the most deprived quintile, of those attending there is a greater burden of disease in this group, borne out by the higher proportion of new STI diagnoses. Although we know that deprivation is a risk for STIs, we are unable to quantify the level of risk within each quintile. There is a stark difference between the three local authorities, with South Gloucestershire having three times the proportion of new STIs in the most deprived quintile (although the numbers are small).

Table 5.5: Number and proportion of new STI diagnoses (excluding chlamydia in <25 year olds) in SRHS, by deprivation category and compared to population deprivation, Bristol, North Somerset and South Gloucestershire, 2020 (GUMCAD; IMD 2019)

Deprivation category	Bristol			North Somerset			South Gloucestershire		
	Count	%	Pop. %	Count	%	Pop %	Count	%	Pop %
Most deprived	730	32.5	29.9	120	25.5	11.3	20	3.3	1.1
2 nd most deprived	585	26.1	24.9	70	14.9	10.3	80	13.0	11.2
3 rd most deprived	390	17.4	16.7	60	12.8	15.1	125	20.3	19.7
4 th most deprived	365	16.3	17.4	105	22.3	29.8	170	27.6	26.0
Least deprived	175	7.8	11.1	115	24.5	33.5	220	35.8	42.0

Reinfection of STIs

Reinfection with an STI is a marker of persistent high-risk behaviour with young people more likely to become reinfected with STIs, contributing to infection persistence and health service workload. Unity data report that in 2021 there were a total of 8,262 STIs diagnosed in all ages across BNSSG, and there were 3,179 people who had repeat infections of STIs (39%) within 12 months. In Bristol, there were 2,240 people with repeat infections within 12 months (40%) of a total of 5,669 STIs diagnosed in 2021. In North Somerset, there were 403

people with repeat infections reported within 12 months (35%) of a total 1,155 diagnosed STIs in 2021, and in South Gloucestershire there were 536 people with STI re-infections within 12 months (37%) of a total 1,438 diagnosed STIs in 2021.¹⁵²

The Unity data is in contrast to the estimated figures provided by UKHSA reported in table 5.6 below, which are much lower.¹⁵³ The differences in the data provided by Unity and the national data are likely to relate to the de-duplication methodology used by the national team for repeat diagnoses which ensures that a patient receives a diagnostic code only once for each episode of care.

Of note is that men aged 15-19 in North Somerset have a higher estimated proportion of reinfection than in England. Also, in England women aged 15-19 years had the higher proportion of reinfection to men aged 15-19, but the reverse is true for Bristol and North Somerset. This could suggest greater high-risk sexual behaviours in young men in these areas, a lack of access/desire to test, and potentially greater asymptomatic infections that are not being picked up.

Table 5.6: Data on reinfection of STIs within 12 months, Bristol, North Somerset, South Gloucestershire, England, 2016-2020 (UKHSA)

Reinfection within 12 months, 2016-2020 (estimated)	Bristol	North Somerset	South Gloucestershire	England
Gender				
Women	5.4%	5.9%	4.6%	6.7%
Men	8.8%	8.5%	7.0%	9.6%
Young people (15-19 years old)				
Women	6.9%	9.3%	7.0%	10.9%
Men	7.4%	10.8%	5.1%	9.8%

5.2.1.9 Impact of COVID-19 nationally and locally

Implications for prevention, early diagnosis and treatment

During the COVID-19 pandemic in 2020, the UK government implemented national and regional lockdowns and social and physical distancing with a focus on staying at home. This led to a marked reduction in the capacity for SRHS to provide face-to-face consultations. With a reduction of face-to-face consultations, there was a rapid reconfiguration to increase access to STI testing online (postal) and via telephone consultations leading to an increase of consultations of both types in 2020 that has persisted in to 2021.

Impact on STIs

¹⁵² Unity performance data

¹⁵³ UKHSA Supplementary Summary Profiles of Local Authority Sexual Health (issued 2022)

The reduction in STI diagnoses between 2019 and 2021 nationally and locally was likely due to a combination of reduced testing due to SRHS service disruption and changes in behaviour, nonetheless the considerable numbers of diagnoses in 2020 and 2021 is clear evidence of sustained STI transmission. This is supported by evidence from community surveys which suggest that, although fewer people reported meeting new sexual partners during 2020 compared to previous years, a substantial proportion still had an ongoing risk of STIs (for example, condomless sex with new or concurrent sex partners).¹⁵⁴

The impact of STIs remained greatest for young people, GBMSM and Black ethnic minorities. The high rates of STIs among young people aged 15 to 24 years are likely to be due to greater rates of partner change. While numbers remain high, the number of new STI diagnoses among 15–24-year-olds fell in 2020, with considerable decreases seen in first episodes of genital warts, first episodes of genital herpes and trichomoniasis. These decreases, especially in STIs usually diagnosed at face-to-face medical consultations, such as a first episode of genital warts or herpes, may partly be due to the reduction in these appointments during the pandemic. Gonorrhoea and infectious syphilis showed less of a fall as they can be diagnosed using self-sampling kits via internet testing. The larger fall in genital warts, particularly in women, likely reflects the expected continuing decline in diagnoses due to the national HPV vaccination programme. When it was introduced in 2008, the vaccination programme was just for girls in school years 8 and 9 (ages 12-14). It was expanded to include boys from 2019, which is expected to lead to similar declines in genital warts in males.

Unity online activity data 2020

With the shift/reduction in face-to-face consultations during the pandemic more and more services were made accessible online. As part of this hybrid model, Unity provided STI testing by freepost service users living in BNSSG. In October 2020, it launched online accounts allowing postal self-sample kits to be ordered and the information linked to the electronic patient record. Previously the ordering of and adding results to the medical record involved two separate processes. In 2020-21, there were 14,103 new online accounts created. Prior to the launch of online accounts, postal self-sample kits could be ordered through a standalone system. In total, 11,359 kits were ordered through this service and returned to Unity Central for processing in 2020-21.

Unity have reported that the online accounts have been a popular option for accessing test kits across BNSSG and service user feedback continues to be analysed following the launch of the online accounts. From June to December 2021, a survey was sent to service users for feedback on the online account system, which received 130 responses:

- 77% indicated that the 'online account' section was 'good' or 'very good' and 23% indicated that it was either 'not good', or they were 'not sure'

¹⁵⁴ Spotlight on STI series, UKSHA, June 2022

- 72% indicated that the 'postal kit' section was 'good' or 'very good' and 28% indicated that it was either 'not good', or they were 'not sure'
- 83% indicated that the overall website was 'good' or 'very good' and 17% indicated that it was either 'not good', or they were 'not sure'

Unity used the survey responses to make changes to the website and improve service user experience and now a postal self-sample kit can now be ordered in three clicks, with the process taking less than three minutes if the triage questions are completed.¹⁵⁵

Impact on partner notification

A total of 768 partners were notified in BNSSG in 2021 according to GUMCAD data for SRHS¹⁵⁶, which is modest given the total number of new STIs diagnosed in BNSSG in 2021 in people accessing SRHS (4,223, 18%). Unity report that there were 389 attendances by partners notified who were receiving treatment in 2021 across BNSSG. Partner notification processes may have been impacted by COVID-19 through lack of capacity; this data suggest there is scope to improve partner notification systems in BNSSG to ensure that all people diagnosed with a STI are supported to notify their partner(s) in accordance with NICE guidance and the BASHH statement on partner notification for STIs.^{157,158,159}

5.2.1.10 Evidence of what works to prevent/reduce STIs

Primary prevention is a key way to prevent the transmission of STIs; however, the options for this are limited. Currently primary prevention consists of condom distribution schemes, information and advice (including health promotion campaigns), behavioural change interventions such as motivation-based approaches, cognitive behavioural therapy and cognitive approaches¹⁶⁰, the HPV vaccine for genital warts, and PrEP. Testing and treatment for STIs and HIV 'treatment as prevention' and partner notification are important secondary prevention interventions to prevent spread of STIs and HIV. A restrictive choice of options, such as a focus on condoms and regular testing, may prevent people from engaging with these methods, particularly if these methods are not keeping pace with current behaviours that may impact on STI trends. Also, a better understanding of partner notification in the context of anonymous partners and online dating is needed.¹⁶¹

¹⁵⁵ Unity annual report 2021-22 (internal)

¹⁵⁶ UKHSA Supplementary SPLASH reports for Bristol, North Somerset and South Gloucestershire 2022

¹⁵⁷ [Recommendations | Reducing sexually transmitted infections | Guidance | NICE](#) (published 15/06/2022)

¹⁵⁸ [Proposed uniform contact tracing questions for NAG Audit Proformas \(bashh.org\)](#) (published 03/07/2012)

¹⁵⁹ See 'Model schematic for an index patient, partner notification' and 'Partner notification and diagnostic assumptions': [PHE SRH Tool User Guide and Technical Report \(publishing.service.gov.uk\)](#) (published 06/2020)

¹⁶⁰ [NG221 Evidence review A: interventions to reduce the acquisition and transmission of STIs in higher risk groups \(nice.org.uk\)](#) (published 06/2022)

¹⁶¹ State of the Nation, THT, 2020 <https://www.tht.org.uk/sites/default/files/2020-02/State%20of%20The%20nation%20Report.pdf>

As testing can have a positive impact on sexual health by preventing onward STI transmission, aiding the treatment of STIs and engaging people in safer sex practices, it is evidently a key prevention method. The positive impact of testing highlights the need for testing methods to keep up with public preference. A pilot run by SH:24 found that there was a preference for STI self-testing as opposed to self-sampling.¹⁶²

The early diagnosis and treatment of STIs is a key intervention for their prevention and control, and to reduce the harms of untreated infections. As of June 2022, the NCSP promotes screening for chlamydia, the most commonly diagnosed bacterial STI, in sexually active young women and other people with wombs or ovaries, on change of partner or annually.

Chlamydia data within this report is up to December 2020, at a time when the NCSP provided opportunistic screening to all young people aged 15 to 24 years. Despite a decrease in chlamydia testing and diagnoses across all regions during 2020, chlamydia positivity remained stable, suggesting ongoing transmission among young people in 2020. There has been a long-term decline in the chlamydia detection rate among 15- to 24-year-olds and notable variations by geographic area, often reflecting rates of testing. Given the large drops in national testing and the high positivity of women within sexual and reproductive health services, it is likely that some infected women and other people with wombs or ovaries remain undiagnosed. On a positive note, the increase of accessing chlamydia testing services on the internet in 2020 suggests that these services are acceptable to young people, although this may just reflect the disruption to service provisions during the pandemic.

Several HIV prevention activities can also have an impact on STI control and promote safer sexual behaviours. OHID has commissioned THT to deliver a new National HIV Prevention Programme from November 2021 to March 2024. The programme aims to improve knowledge, understanding and uptake of a combination of HIV prevention interventions among populations most at-risk of HIV in England, particularly aimed at GBMSM and people of Black ethnicity, and other groups in whom there is a higher or emerging burden of infection.

Health promotion and education remain vital for STI prevention, through improving risk awareness and encouraging safer sexual behaviour. How this is best approached in an increasingly digital age needs further exploration. Consistent and correct condom use substantially reduces the risk of being infected with an STI. Prevention efforts should include condom provision, ensuring open access to SRHS with STI screening and robust contact tracing, and should focus on groups at highest risk such as young people, Black ethnic minorities and GBMSM.

¹⁶² R. Pebody, 2019, Nam aidsmap, [Two thirds prefer self-testing over self-sampling | aidsmap](#)

5.2.1.11 Issues identified

The following issues have been identified following a review of the STI outcome data for BNSSG.

Detection and diagnosis

1. According to published outcomes data, rates and numbers of STI testing in all three BNSSG councils dropped considerably between 2019 and 2021, which is at odds with the Unity service data for 2020-21 to 2021-22. The data quality is currently being investigated.
2. The reported fall in testing rates in 2021 has resulted in a considerable increase in STI test positivity (i.e. those who get a test are more likely to be infected than before).
3. Gonorrhoea cases in Bristol have risen rapidly in 2022 and are now above pre-COVID-19 levels.
4. Detection of chlamydia in 15–24-year-olds across BNSSG is low and does not meet either the current NCSP chlamydia detection rate target, or the England average. Bristol and North Somerset have particularly low detection rates when compared to their nearest neighbours.
5. There are particularly low numbers of people accessing chlamydia tests from pharmacy settings across BNSSG.
6. Bristol has a high crude rate of new STI diagnoses (excluding chlamydia in <25s) that is higher than the England average and the average of Bristol's 15 nearest neighbours and is partly reflective of the young population.
7. Partner notifications across BNSSG were very low in 2021 compared to the number of STIs diagnosed.
8. There is evidence of persistent high-risk behaviour across BNSSG in the high proportion of new STIs diagnosed that are repeat diagnoses within 12 months.

Inequalities

9. There have been high rates of chlamydia in people aged 25+ in Bristol, although rates have fallen in the last couple of years.
10. Despite the national success of the HPV vaccination programme in reducing genital warts, the genital warts diagnostic rate is high in Bristol compared to England.
11. There is a higher proportion of new STI diagnoses in young people aged 15-24 across all three individual BNSSG councils compared to the England average.
12. In people aged 15 to 24 years old, the burden of all new STI diagnoses in 2021 was higher in young females (1,213 diagnoses) than young males (775 diagnoses), but in those aged 25 and above, the opposite was true with 1,277 diagnoses in males and 843 in women.
13. The most common STI in heterosexual men was chlamydia. Heterosexual men experienced the greatest proportion of genital warts in BNSSG (50.9% of warts diagnoses are amongst heterosexual men).

14. Gonorrhoea was the most common STI amongst GBMSM. They experienced the greatest proportion of syphilis diagnosed in BNSSG (74.7% of syphilis is amongst GBMSM).
15. The most common STI in women was chlamydia. Women experienced the greatest proportion of genital herpes in BNSSG (60.1% of herpes diagnosed was amongst women).
16. The number of new STI diagnoses in Black communities in Bristol is lower than expected based on the size of the population and some national studies suggest this may relate to possible access issues.
17. The data shows that new STI diagnoses are more likely amongst residents in the most deprived quintiles in each BNSSG local authority in keeping with known risk factors

5.2.2 Human immunodeficiency virus (HIV)

England has set an ambition to end new HIV transmission, AIDS and HIV-related deaths by 2030. The England HIV Action Plan 2022-2025 sets out intermediate commitments for the next 4 years to achieve the 2030 ambition, including how HIV transmission will be reduced by 80% by 2025. To achieve these aims, a combination prevention approach will be implemented focusing on 'prevent, test, treat and retain', which is discussed further under section [5.3.2.8](#). This approach needs to be replicated for all those at risk of acquiring HIV, whoever they are and wherever they live.

Free and effective ART in the UK has transformed HIV from a fatal infection into a chronic but manageable condition. People living with HIV in the UK can now expect to have a near normal life expectancy if diagnosed promptly and they adhere to treatment. In addition, those receiving appropriate treatment may be unable to pass on HIV (undetectable=untransmissible [U=U]), even if having unprotected sex.

A total of 90,587 people were accessing HIV care in England in 2021, which can be used as an estimate of the number of people living with diagnosed HIV in England. In 2021, there were 2,692 people newly diagnosed with HIV in England which is a 0.7% rise from 2,671 in 2020, and a 33% fall from 4,016 in 2019. Of the 2,692 new HIV diagnoses, 669 (25%) were among people who had had their initial HIV diagnosis abroad.

From 2021, HIV surveillance includes three new indicators:

- HIV diagnosed prevalence rate per 1,000 population aged 15 years and over (alongside HIV diagnosed prevalence rate per 1,000 population aged 15 to 59)
- new HIV diagnoses among persons first diagnosed in the UK rate per 100,000 aged 15 years and over (alongside all new HIV diagnoses, which includes those first diagnosed outside the UK)
- ART coverage in adults accessing HIV care (%)

The purpose of these indicators is to include older patients living with HIV, to measure HIV transmission in the UK more accurately and to monitor the proportion of people living with transmissible levels of virus, respectively.¹⁶³

5.2.2.1 Testing coverage

A note on the data: in December 2022 UKHSA advised commissioners of an anomaly with the HIV testing coverage indicator whereby, in some areas, there may be lower numbers presented, especially in recent years. The testing coverage indicator currently only uses data from Level 3 specialist SRHS, which typically excludes data from digital providers. In light of the shift towards online testing this is particularly acute for councils where a digital provider undertakes most of the testing. Although this is not currently the case in BNSSG, it makes comparison between areas difficult. UKHSA are looking to create a new indicator or modifying existing indicators, as a more long-term solution.¹⁶⁴

Nationally, HIV testing coverage saw a 53% fall in the number of people accepting an HIV test at SRHS in England between 2019 and 2020, likely the result of the COVID-19 lockdowns. Coverage increased slightly by 3% between 2020 and 2021. However, there were still 52% fewer people tested in 2021 than in 2019. The increase in people having an HIV test between 2020 and 2021 was likely to have been driven by a rise in internet testing (postal kits), which accounted for 98% of the testing increase seen across the UK.¹⁶⁵

HIV testing coverage presents the number of persons tested for HIV (and not the number of tests reported) out of those people considered eligible for a HIV test when attending specialist sexual health services. An eligible attendee is defined as a patient attending specialist SRHS at least once during a calendar year. Patients known to be HIV positive, or for whom a HIV test was not appropriate, or for whom the attendance was related to sexual and reproductive healthcare only, are excluded.¹⁶⁶ Across BNSSG in 2021, HIV testing coverage was noticeably lower than in previous years at 32.1% (4,086 people attending SRHS accepted an HIV test), decreasing from 64.6% in 2019 (12,688 tests accepted) and 51.2% in 2020 (7,534 tests accepted). The BNSSG total testing coverage is also lower than the England average of 45.8% and the South West average of 35.9% (see figure 5.22).

¹⁶³ [Sexual and Reproductive Health Profiles - OHID \(phe.org.uk\)](https://phe.org.uk)

¹⁶⁴ Email correspondence from UKHSA (received 05/12/2022)

¹⁶⁵ [HIV testing, PrEP, new HIV diagnoses, and care outcomes for people accessing HIV services: 2022 report - GOV.UK \(www.gov.uk\)](https://www.gov.uk) (updated 06/10/2022)

¹⁶⁶ [Sexual and Reproductive Health Profiles - Data - OHID \(phe.org.uk\)](https://phe.org.uk) (updated 04/10/2022)

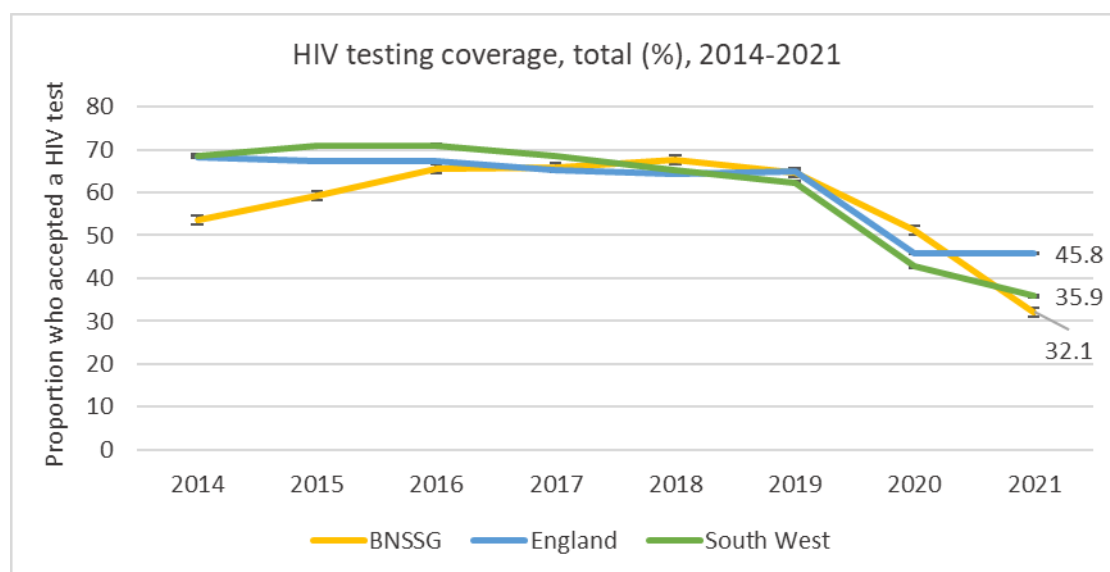


Figure 5.22: HIV testing coverage, total (%), BNSSG, South West and England, 2014-2021 (UKHSA)

The data in table 5.7 below suggest that GBMSM are driving the overall testing coverage for men and that, in BNSSG, 62.9% of heterosexual men were either not offered or did not accept an HIV test compared to 24.9% of GBMSM. Similarly, 67.9% of women attending SRHS across BNSSG were either not offered an HIV test or did not accept one.

Table 5.7: HIV testing coverage data (tests accepted and percentage of eligible attendees): total, by gender, by sexual risk, and repeat testing, Bristol, North Somerset, South Gloucestershire, BNSSG and England, 2021 (red shading = lower than England; amber shading = similar to England) (UKHSA)

HIV testing coverage 2021	Bristol		North Somerset		South Gloucestershire		BNSSG (calculated)		England
	Tests accepted	%	Tests accepted	%	Tests accepted	%	Tests accepted	%	%
Total	2,830	34.3	558	26.0	698	29.8	4,086	32.1	45.8
Gender									
Male	1,625	51.3	290	40.2	423	48.0	2,338	49.0	62.8
Female	1,120	34.8	236	23.8	252	31.5	1,608	32.1	36.6
Sexual risk									
GBMSM	793	76.3	108	61.0	219	79.9	1,120	75.1	77.8
Repeat testing (testing more than once in the previous year)									
GBMSM	303	38.4	38	36.2	93	42.5	434	39.0	45.3

All three councils had decreased coverage across all HIV testing coverage indicators compared to 2020. Compared to its nearest neighbours, North Somerset has one of the worst, if not the worst testing coverage across all HIV testing coverage indicators.

Unity data on HIV testing

Unity reported that 38.9% (14,688) of service users 'attending' for a new episode of care accepted an HIV test in 2021 across BNSSG, with 41.5% (11,100 service users) in Bristol,

26.5% (1,285 service users) in North Somerset, and 37.4% (2,303 service users) in South Gloucestershire. In terms of gender and sexual risk, across BNSSG 45.2% (6,679) of male service users attending for a new episode of care accepted an HIV test compared to 34.9% (7,994) of women, and 50.8% (1,653) of GBMSM. Finally, 39.0% (595) of service users attending for a new episode of care who accepted an HIV test were from African, Caribbean and other Black backgrounds, of which the majority of tests in the group were taken up by African people. These figures represent the number of tests accepted in any Unity clinic setting in 2021, which includes individuals who attended for more than one episode of care within this time period.

In addition to accessing HIV testing through SRHS and primary care, there are other routes in place to encourage the uptake of HIV testing among at-risk members of the population. Some of these are described below.

Partner notification

In England in 2021 a total of 820 people attended specialist SRHS as a contact following partner notification for HIV. Of these, 76% (622 people) were tested, and 4.5% (28 people) were newly diagnosed with HIV. The largest group of people who attended following partner notification were GBMSM (287 people), but the greatest number of new diagnoses amongst those who were tested was seen in heterosexual men (11 men, 40%) and heterosexual and bisexual women (8 women, 29%).¹⁶⁷ This data is not available at a local level but highlights the vital role that partner notification plays in testing for HIV as soon as possible.

Infectious diseases in pregnancy screening

HIV is one of the infectious diseases that pregnant women are offered a test for during their antenatal care. Locally, HIV coverage data in pregnant women is not available at council level but at trust level, which includes out of area pregnant women as well. Across North Bristol and University Hospitals Bristol and Weston Trusts in BNSSG, the proportion of pregnant women eligible for HIV screening for whom a confirmed screening result was available was 99.8% (11,418 pregnant women) in 2021-22, mirroring the national coverage. Both local and national coverage is consistently high, and in England has increased from 98.9% in 2013-14 to 99.8% in 2020-21.¹⁶⁸ In England in 2021, there were 15 cases of HIV exposure through vertical transmission, which accounts for 0.7% of new diagnoses for that year. Between 2017 and 2021 in Bristol, there were <5 cases of exposure to HIV through vertical transmission. Numbers were too small to be reported for South Gloucestershire and North Somerset.

Tuberculous (TB) testing

¹⁶⁷ [HIV testing, PrEP, new HIV diagnoses, and care outcomes for people accessing HIV services: 2022 report - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/statistics/hiv-testing-prEP-new-hiv-diagnoses-and-care-outcomes-for-people-accessing-hiv-services-2022-report)

¹⁶⁸ [NHS screening programmes: KPI reports 2021 to 2022 - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/statistics/nhs-screening-programmes-kpi-reports-2021-to-2022) (last updated 30/09/2022)

In 2020, 97.4% (3,630 cases) of notified TB cases in England, with previously unknown HIV status and where testing information was available, were offered an HIV test. Increasing the proportion of TB cases offered an HIV test was a key indicator in the Collaborative Tuberculosis Strategy for England 2015-2020.¹⁶⁹ Across BNSSG in 2020, 100% (53 cases) of TB cases were offered an HIV test, which was an increase from 96.9% (62 cases) in 2019. Neither data for 2021 nor data on the proportion tested who were positive for HIV were available.

Prisons

In March 2018, opt-out testing of blood-borne viruses, including HIV, was implemented in all adult prisons in England. New arrivals and people transferring between prisons should now be offered HIV tests, unless they have been tested within the last year and are not at risk, or they have a known HIV positive status. Between April 2020 and March 2021, 86% of people in the justice system were offered HIV testing within 7 days of reception. Among those who were eligible, 49% were tested. It was not possible to access local data on HIV testing in prisons prior to publishing this report.

5.2.2.2 Diagnosed prevalence of HIV

There are two HIV diagnosed prevalence indicators published nationally, one for ages 15 and above, and one for ages 15-59, both of which exclude people diagnosed with HIV in England but who are resident in Wales, Scotland, Northern Ireland or abroad. In BNSSG in 2021, the HIV diagnosed prevalence rate in those aged 15 and above was 1.3 per 1,000 and was 1.8 per 1,000 in 15-59-year-olds. Both of these rates are higher than the South West averages (0.9 and 1.3 per 1,000 respectively) and lower than the England averages (1.6 and 2.3 per 1,000 respectively). Although the overall BNSSG prevalence is low this masks considerable differences between and within the 3 local authorities.

Bristol is an area of high HIV prevalence (2.46 per 1,000 people aged 15-59), as defined by NICE (low prevalence: <2, high: 2-5, very high: ≥5)¹⁷⁰, and is similar to the England average. Compared to its nearest neighbours, Bristol's prevalence is lower than the nearest neighbours' average (2.84 per 1,000 people aged 15-59). In contrast, North Somerset (0.97 per 1,000 people aged 15-59) and South Gloucestershire (1.23 per 1,000 people aged 15-59) are both low prevalence areas that are similar to their respective nearest neighbours' average.

The maps below in figure 5.23 show the variation within each council area in terms of HIV diagnosed prevalence in those aged 15 and above.¹⁷¹

¹⁶⁹ [Tuberculosis \(TB\): collaborative strategy for England - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/61444/tb_strategy_for_england_2015-2020.pdf)

¹⁷⁰ [Quality statement 2: General practice in areas of high and extremely high HIV prevalence | HIV testing: encouraging uptake | Quality standards | NICE](https://www.nice.org.uk/guidance/qs222/chapter/1-What-you-should-know-about-quality-statement-2-General-practice-in-areas-of-high-and-extremely-high-HIV-prevalence)

¹⁷¹ SPLASH report in Sexual & Reproductive Health profiles <https://fingertips.phe.org.uk/profile/sexualhealth>, UKHSA (published 01/02/2023)

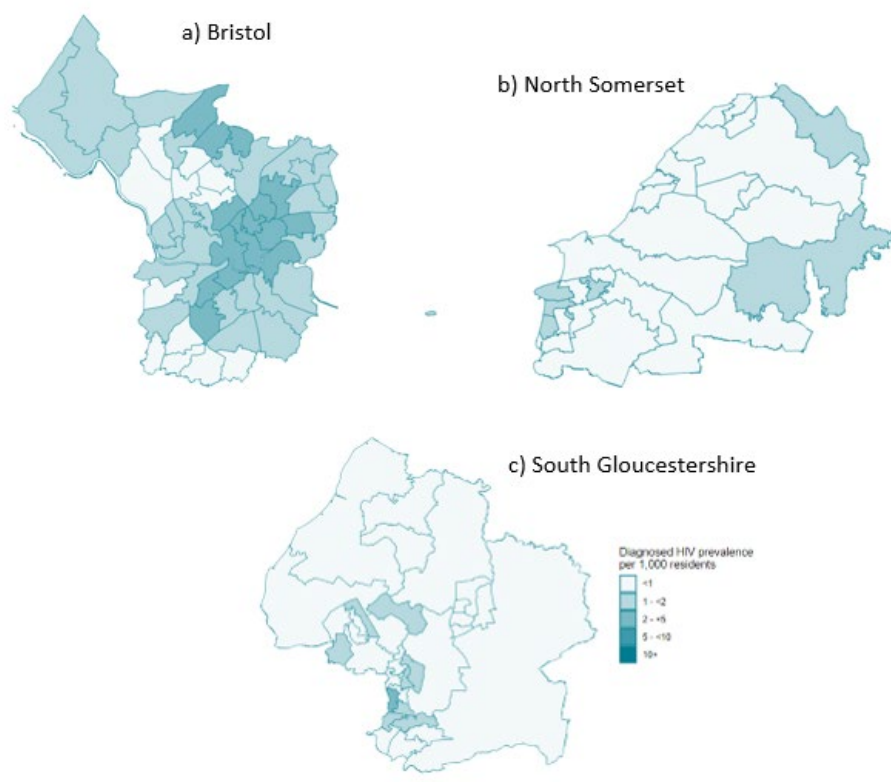


Figure 5.23: Maps of diagnosed HIV prevalence among people aged 15 and above in a) Bristol, b) North Somerset, and c) South Gloucestershire by Middle Super Output Area (approx. 7-10,000 population): 2021 (UKHSA)

5.2.2.3 Rates of new HIV diagnoses

Nationally, regionally and locally, the crude rate of new HIV diagnoses in all ages, which includes all people in the UK irrespective of what country they received their diagnosis in, has been on a downward trend. In England in 2021, there were 2,692 new diagnoses in all ages, of which 25% (669 new diagnoses) were in individuals previously diagnosed abroad; a similar proportion to previous years. These diagnoses are unlikely to reflect HIV transmission in the UK, and so would not be preventable by public health measures taken in the UK. Among the 2,023 new diagnoses first made in England, men exposed through sex between men accounted for 36%, women exposed by heterosexual contact for 21%, men exposed by heterosexual contact for 18%, injecting drug use for 2%, those exposed by vertical transmission, for 0.7%, and those exposed by blood products for a further 0.4%.¹⁷²

People of White ethnicity constituted 43% of those first diagnosed in England, remaining the largest ethnic group, followed by 19% in people of Black African ethnicity.

Among GBMSM first diagnosed in England, people of White ethnicity constituted 65%.

Among people exposed by heterosexual contact, diagnoses among those first diagnosed in

¹⁷² [HIV testing, PrEP, new HIV diagnoses, and care outcomes for people accessing HIV services: 2022 report - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/publications/hiv-testing-prEP-new-hiv-diagnoses-and-care-outcomes-for-people-accessing-hiv-services-2022-report)

England were highest among those of Black African ethnicity (37%) followed by those of White ethnicity (32%).¹⁷³

The rate of all new diagnoses in BNSSG has decreased from 8 per 100,000 in 2014 (74 new diagnoses) to 3.7 per 100,000 in 2021 (36 new diagnoses). The rate in 2021 is similar to those for England (4.8 per 100,000) and the South West (2.3 per 100,000). In contrast, the second indicator reports the crude rate of new HIV diagnoses among people of all ages newly diagnosed in the UK with no previous diagnoses abroad reported. As with the first indicator, this also shows a downward trend nationally, regionally and locally.

Figure 5.24 shows that, in BNSSG, this rate has decreased from 5.7 per 100,000 in 2014 (53 new diagnoses) to 2.2 per 100,000 in 2021 (21 new diagnoses). The rate in BNSSG in 2021 is lower than England (3.6 per 100,000). Comparing the two indicators shows that in BNSSG, approximately 42%, or 15 new diagnoses, in 2021 were in people who were previously diagnosed with HIV abroad.

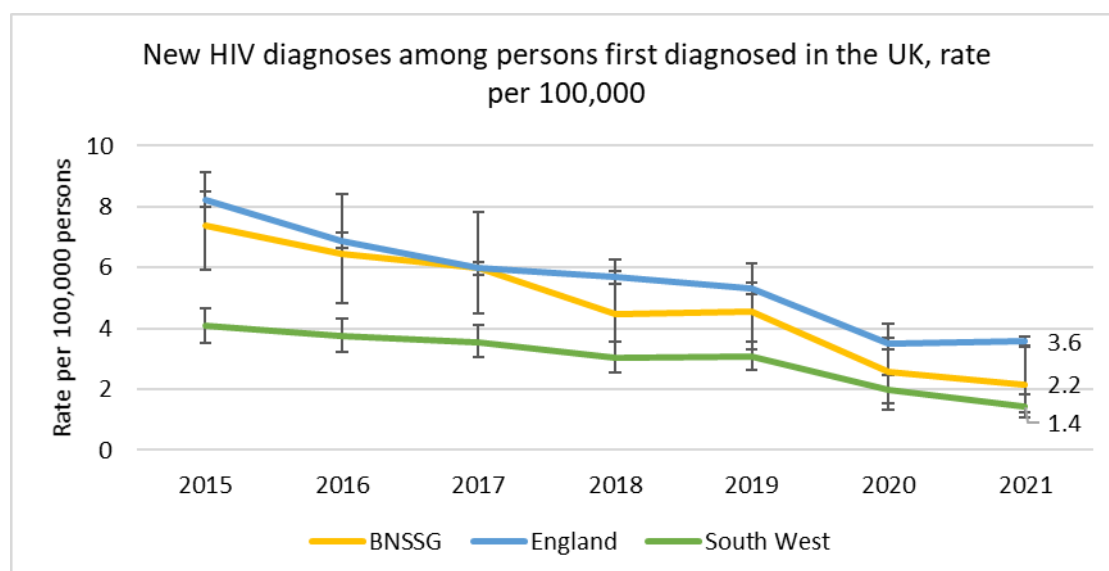


Figure 5.24: New HIV diagnoses among persons first diagnosed in the UK, rate per 100,000, all ages (UKHSA)

Bristol had the highest rate of all new HIV diagnoses (whether diagnosed firstly in the UK or abroad) in 2021 in BNSSG at 6.0 per 100,000 (28 new diagnoses). This is compared to 1.4 per 100,000 (3 new diagnoses) in North Somerset and 1.7 per 100,000 (5 new diagnoses) in South Gloucestershire. The Bristol rate is similar to England. Compared to its nearest neighbours Bristol is in the middle of the group, ranging from Plymouth at 1.5 per 100,000 (4 new diagnoses) to Manchester at 13.1 per 100,000 (73 new diagnoses). In terms of ethnicity, 64% were White, and a third were Black African, Black Caribbean or Mixed ethnicity.

¹⁷³ [HIV testing, PrEP, new HIV diagnoses, and care outcomes for people accessing HIV services: 2022 report - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/103111/hiv-testing-prEP-new-hiv-diagnoses-and-care-outcomes-for-people-accessing-hiv-services-2022-report.pdf)

Similarly when looking at the rate of new HIV diagnoses among people newly diagnosed in the UK with no previous diagnoses abroad reported, Bristol has the highest rate at 3.6 per 100,000 (17 new diagnoses), compared to 0.9 per 100,000 (2 new diagnoses) in North Somerset and 0.7 per 100,000 (2 new diagnoses) in South Gloucestershire. The rate in Bristol is similar to England. The nearest neighbours comparison is the same as that described above, with Bristol similar to the neighbours' average (4.8 per 100,000).

Unity data on HIV new diagnoses

The Unity performance data for 2021 reports a total of 64 HIV diagnoses, of which 7 were new and the remaining 57 were in patients previously diagnosed. This data include BNSSG and out of area diagnoses.

5.2.2.4 Late diagnosis

Late diagnosis is the most important predictor of morbidity and mortality among those with HIV infection and is defined in the UK as a CD4 count below 350 cells per mm³ of blood within 91 days of diagnosis, excluding those with evidence of recent infection. This indicator is essential to evaluate the success of expanded HIV testing.¹⁷⁴ The denominator includes the number of adults (aged 15 years or more) newly diagnosed with HIV infection with CD4 count available within 91 days, who are resident in England and diagnosed in the UK (which is different to the definition used for new diagnoses).

In those diagnosed late in England the highest mortality rates were amongst those over the age of 65, those between 50 and 64 years old, and those who were men, in particular those exposed by heterosexual contact. The proportion of first diagnoses in people aged 15 and above that were diagnosed late in England in 2019, 2020 and 2021 were 41%, 44% and 46%, respectively. Though the proportion of late diagnoses in England increased from 2019 to 2021, the total number of late diagnoses in 2021 remained below that seen in 2019 (961 late diagnoses in 2019 compared to 786 in 2021), despite an increase between 2020 and 2021 (from 724 in 2020). The increase between 2020 and 2021 is likely to, in part, reflect diagnoses deferred from 2020 due to factors including access to SRHs, access to general healthcare, and changes in health-seeking behaviour as a result of the COVID-19 pandemic.¹⁷⁵

In GBMSM in England, the proportion diagnosed late increased, from 29% in 2019, to 30% in 2020, to 37% in 2021. In men exposed by heterosexual contact, the proportion late diagnosed had similarly increased since 2019, from 54% in 2019, to 58% in 2020, and 63% in 2021. In both groups, the number of late diagnoses decreased between 2019 and 2020, before increasing between 2020 and 2021, but remaining below what was seen in 2019. Among women exposed through heterosexual contact in contrast, the proportion diagnosed late was relatively stable, increasing from 48% in 2019 to 51% in 2020, and 50% in 2021,

¹⁷⁴ [Sexual and Reproductive Health Profiles - Data - OHID \(phe.org.uk\)](https://phe.org.uk/data/data-hub/publications/data-hub-sexual-reproductive-health-profiles) (update 04/10/2022)

¹⁷⁵ [HIV testing, PrEP, new HIV diagnoses, and care outcomes for people accessing HIV services: 2022 report - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/publications/hiv-testing-prep-new-hiv-diagnoses-and-care-outcomes-for-people-accessing-hiv-services-2022-report)

with total late diagnoses remaining below the number seen in 2019. The proportion diagnosed late was highest among people of Black African ethnicity, 55% in 2019 to 57% in 2020, to 56% in 2021, compared to people of White ethnicity, 39% in 2019, 41% in 2020, and 45% in 2021.

Late diagnoses in BNSSG and at council level are aggregated in to 3-year groups due to small numbers of cases. In BNSSG, the trend shows an increase in the proportion of late diagnoses in people first diagnosed with HIV in the UK between 2012-2014 and 2019-2021, although in terms of actual numbers of late diagnoses, this has declined. In 2012-2014, there were 39.0% of late diagnoses in BNSSG (53 late diagnoses), compared to 37.8% in England. By 2019-2021, this had increased to 53.5% in BNSSG (38 late diagnoses), which is similar to 43.4% in England (see figure 5.25).

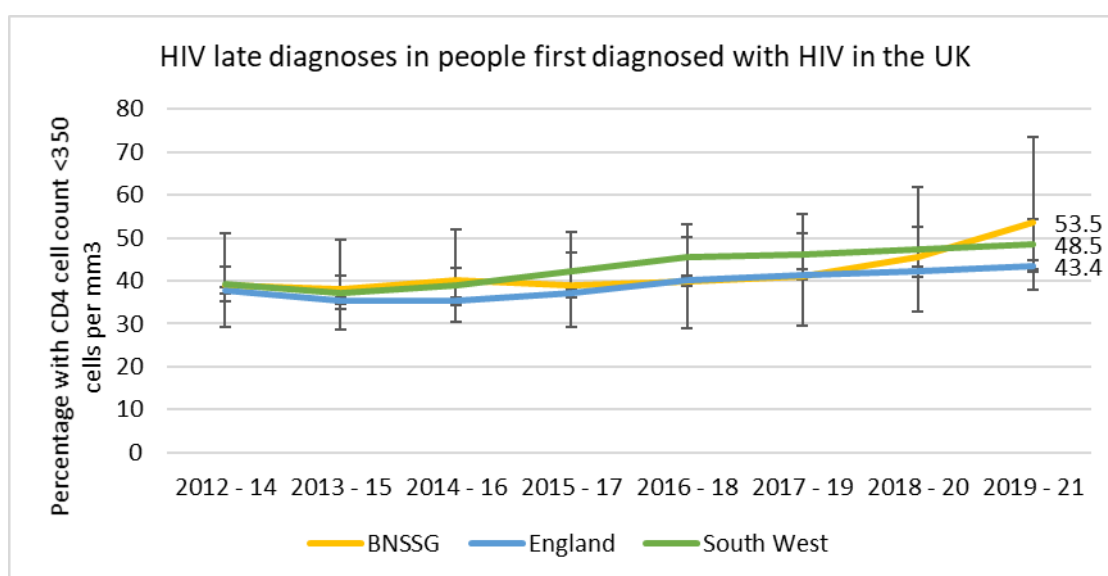


Figure 5.25: HIV late diagnoses in people first diagnosed with HIV in the UK, BNSSG, South West and England, 2012-14 to 2019-21 (UKHSA)

Late diagnoses by sexual risk show that BNSSG has higher proportions of late diagnoses in heterosexual men, heterosexual and bisexual women and GBMSM, compared to the England averages. However, due to the relatively small numbers of late diagnoses in BNSSG in each of these sexual risk categories, the data should be interpreted with caution.

In 2019-2021, in BNSSG 14 cases (77.8%) of HIV were made late in heterosexual men, compared to 58.1% in England. 8 cases (72.7%) in heterosexual and bisexual women were made late, compared to 49.5% in England.

Due to disclosure control, the GBMSM data for BNSSG in 2019-2021 only includes cases for Bristol, of which 46.4% were late diagnoses (13 cases), compared to 31.4% in England. The proportion of late diagnoses reported in North Somerset was 33.3%, and 22.2% in South Gloucestershire for this group.

Of the three councils, Bristol had the greatest number of late diagnoses in BNSSG in 2019-21 with 29 late cases amongst 50 new diagnoses (58.0%), compared to 5 (out of 7 new diagnoses) in North Somerset (71.4%) and 4 (out of 14 new diagnoses) in South Gloucestershire (28.6%).

In heterosexual men, there were 9 late diagnoses (out of 12 new diagnoses; 75.0%) in Bristol, 3 late diagnoses (out of 3 new diagnoses; 100.0%) in North Somerset and 2 late diagnoses (out of 3 new diagnoses; 66.7%) in South Gloucestershire between 2019-21. Of all new HIV diagnoses in heterosexual and bisexual women, there were 7 late diagnoses (out of 9 new diagnoses; 77.8%) in Bristol, 1 (out of 1 new diagnosis; 100.0%) in North Somerset, and none in South Gloucestershire.

Unity data on HIV late diagnosis

From 2020-21 to 2021-22, Unity reported a total of 3 late diagnoses and 1 very late diagnosis of HIV, which may include service users from outside of BNSSG.

Late diagnosis look back

In 2021, a late diagnosis look back exercise was undertaken by NBT and UHBW and presented to Bristol Fast Track Cities. The exercise aimed to retrospectively analyse the demographics of late presenters with HIV and identify missed opportunities for diagnosis. A total of 48 patient cases were reviewed:

- 83% were male (n=40) and 17% female (n=8). No patients in the cohort openly identified as transgender.
- 46% were aged 21-39 (n=22), 35% aged 40-59 (n=17) and 19% aged 60+ (n=9).
- 14% were born in a country with a high prevalence of HIV (n=7).
- 28 were White British (58.3%), 9 were Black and British African (18.7%), 6 European (12.5%), of these 5 from Eastern Europe, and 5 patients were "other" (10.4%). The female cohort comprised of 6 Black and British African and 2 White British women.

A missed opportunity was defined as a delay in diagnosis of at least 3 months from presentation to a service with a clinical indicator condition. Of the 48 cases, 11 patients were identified to have had a missed opportunity for diagnosis on at least one occasion ranging from 3 months to 10 years (mean = 55 months or 4.5 years). The exercise concluded by suggesting ways of improving diagnosis in primary care as the setting that people typically attend if they develop symptoms of clinical indicator conditions (e.g. unexpected weight loss, unexplained chronic diarrhoea or pneumonia).¹⁷⁶

¹⁷⁶ Guest et al. (2021) Review of late presenters to Bristol HIV services. Learning from missed opportunities within primary care. Poster held internally.

5.2.2.5 HIV treatment and care

HIV treatment and care is currently the commissioning responsibility of NHS England; however it is expected to become the responsibility of ICBs from April 2024. Table 5.8 below provides data for all ages on the following indicators, with benchmarking at council level:

- prompt ART initiation in people newly diagnosed with HIV (within 91 days of diagnosis), benchmarked against England average
- ART coverage in people accessing HIV care, benchmarked against the UNAIDS goal of >95%
- virological success in adults accessing HIV care, benchmarked against England average

Table 5.8: HIV treatment and care indicators (UKHSA)

Indicator, % (n)	BNSSG	South West	England	Bristol	North Somerset	South Gloucestershire
Prompt ART initiation, 2019-2021	85.5% (106)	87.2% (451)	83.5% (6,887)	86.0% (74)	75.0% (9)	88.5% (23)
ART coverage, 2021	99.0% (1,262)	98.9% (5,124)	98.4% (89,926)	99.1% (867)	99.3% (152)	98.4% (243)
Virological success, 2021	98.6% (1,128)	98.6% (4,781)	97.8% (80,254)	98.3% (774)	99.3% (133)	99.1% (221)

On the whole, BNSSG is doing well in terms of HIV treatment and care. Although the data are promising, anyone lost to treatment and/or follow-up is at great risk of passing on HIV and it is recognised that some patients struggle to engage with treatment.

Local data for 2017 to 2021 show that of the 4,285 Bristol residents seen for HIV care, 30% were of African, Caribbean or other Black heritage, with 24% alone of African heritage.¹⁷⁷

The HIV Action Plan and Fast Track Cities

During 2021–22, a national action plan for ending HIV transmission was launched.¹⁷⁸ This aligns to the Fast Track Cities initiative, which is a global partnership between cities and municipalities around the world and four core partners – the International Association of Providers of AIDS Care, the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Human Settlements Programme, and the City of Paris.¹⁷⁹ The initiative aims to end HIV stigma and focus on exceeding the UNAIDS 95:95:95 HIV targets:

- 95% of people living with HIV knowing their status

¹⁷⁷ UKHSA Bristol local authority HIV data tables, 2017-2021

¹⁷⁸ [Towards Zero - An action plan towards ending HIV transmission, AIDS and HIV-related deaths in England - 2022 to 2025 - GOV.UK \(www.gov.uk\)](#)

¹⁷⁹ [Welcome to Fast-Track Cities | Fast-Track Cities](#)

- 95% of people with diagnosed HIV on treatment
- 95% of people on treatment with suppressed viral loads

In England in 2021 there were 95% of people living with HIV who had been diagnosed with HIV, of which 99% of people diagnosed with HIV were on ART, of which 98% of people on ART were virally suppressed.¹⁸⁰

Bristol City Council signed up to Fast Track Cities at the end of 2019. The initiative is led by the Bristol Fast Track Cities Steering Group with membership from Bristol City Council Public Health, Brigstowe, the University of Bristol, Unity Sexual Health, North Bristol NHS Trust, Terence Higgins Trust, and members of the public.¹⁸¹ Figure 5.26 below shows the continuum of HIV care in Bristol using 2021 data. It is estimated that approximately 50 people (5%) living with HIV in Bristol have not been diagnosed.

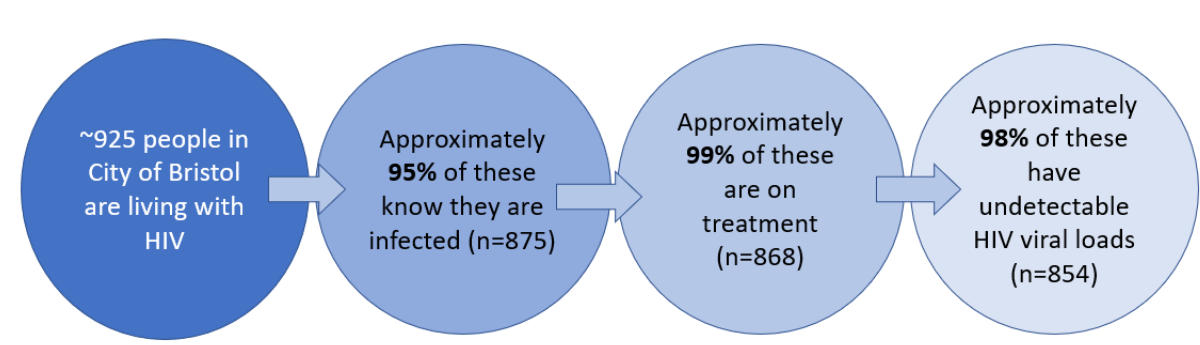


Figure 5.26: The continuum of HIV treatment and care in Bristol, 2021 (UKHSA)

5.2.2.6 Access to PrEP in BNSSG

In England, PrEP was made available in certain areas through the Impact Trial, which recruited 24,255 participants between October 2017 and July 2020. Participants enrolled up to February 2020 were more likely to identify as gay and bisexual men (96%), to be White (76%) and aged 25 to 39 years (median age 33 years). Just under 3% of the participants identified as women and 1.5% as Black African.¹⁸² Since the autumn of 2020, oral PrEP, using a fixed dose combination of emtricitabine and tenofovir, has been available through routine commissioning at specialist SRHS.

The 2020 UK PrEP user survey recruited 1,500 participants (86% gay and bisexual men, 85% White) from October to November 2020. The most recent survey showed that among people using PrEP, 60% of respondents obtained PrEP from the Impact trial, 20% sourced PrEP from the internet and the remainder from Scottish and Welsh clinics, from other services, friends and other sources. However, there are indications that show a decrease in the use of PrEP during social restrictions periods in 2020.¹⁸³

¹⁸⁰ UKHSA England Fast Track Cities Update 2022

¹⁸¹ [Fast Track Cities - Bristol One City](#)

¹⁸² [PrEP | The PrEP Impact Trial](#)

¹⁸³ [Better access to PrEP in the UK, especially through NHS services | aidsmap](#)

In BNSSG, PrEP has been available since the second half of 2020. The data below from Unity provide insight into the classification and number of patients accessing PrEP in BNSSG for August 2020-March 2021, April 2021-March 2022, and April 2022-September 2022. There have been some data quality issues with the PrEP data from Unity, so these figures should be taken as only an estimate of activity.

Table 5.9: Unity PrEP activity data for BNSSG, August 2020 to September 2022 (UHBW)

PrEP category	August 2020- March 2021	April 2021- March 2022	April 2022- September 2022
Started daily PrEP	91	199	226
Continued daily PrEP	187	573	822
Started event PrEP	37	100	124
Continued event PrEP	28	81	113
PrEP continued through other source	7	6	14
PrEP offered and declined	7	13	78
Total	357	972	1,377

The data in table 5.9 above show a positive increase in PrEP uptake at Unity since August 2020. Accompanying data from Unity on PrEP service user characteristics indicate that the vast majority of service users are:

- GBMSM/transgender women
- from Bristol
- aged 20-39
- White British
- attend Unity Central clinic for PrEP

This data suggest that there are likely to be population groups unable to access PrEP or unaware of its availability in BNSSG, particularly heterosexual women and people of African and Caribbean heritage.

PrEP monitoring and evaluation

Nationally, there is a PrEP Monitoring and Evaluation Framework¹⁸⁴ and UKHSA staff continue to work with SRHS providers to improve the quality of PrEP coding through reviewing PrEP clinic reports. The first phase of PrEP indicators was published in December 2022 relating to determining PrEP need and starting/continuing PrEP for 2021.

The indicator 'Determining PrEP need' is used to determine PrEP need among people accessing specialist SRHS. It assesses the proportion of all HIV negative people accessing specialist SRHS who are at substantial HIV risk, and therefore could benefit from receiving PrEP. The assessment of risk is based on a combination of clinical codes reported through GUMCAD within the previous 12 months of each consultation including PrEP eligibility

¹⁸⁴ [HIV pre-exposure prophylaxis \(PrEP\): monitoring and evaluation - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/publications/hiv-pre-exposure-prophylaxis-prEP-monitoring-and-evaluation) (published 09/03/2022)

codes, and other clinical or behavioural markers known to indicate higher risk of HIV seroconversion in the year following an attendance.¹⁸⁵ The indicator includes people who are having their need for PrEP met by receiving PrEP (met need) as well as those with need who are not currently receiving PrEP (unmet need). This indicator does not relate to better or worse performance as it will vary between services depending on local populations.

In Bristol, of the 8,441 HIV negative people that accessed SRHS in 2021, 7.2% of them (605 people) were determined to have a need for PrEP. In North Somerset, this was 5.1% (112 out of 2,206 people), and in South Gloucestershire this figure was 5.8% (138 out of 2,394 people). Bristol is similar to England's 7.4% need, while North Somerset and South Gloucestershire are both lower than the England average (see table 5.10 below).

Table 5.10: Table showing PrEP need numbers and proportion of HIV negative people attending SRHS, and initiation or continuation of PrEP among those with PrEP need, Bristol, North Somerset, South Gloucestershire, BNSSG and England, 2021 (UKHSA)

Indicator	Bristol		North Somerset		South Gloucestershire		BNSSG		England	
	No.	%	No.	%	No.	%	No.	%	No.	%
Determining PrEP need, 2021	605	7.2%	112	5.1%	138	5.8%	855	6.6%	87,828	7.4%
Initiation or continuation of PrEP among those with PrEP need, 2021	292	48.3%	65	58.0%	80	58.0%	437	51.1%	61,092	69.6%

The second indicator, 'Initiation or continuation of PrEP among those with PrEP need' assesses what proportion of individuals accessing specialist SRHS with PrEP need start or continue PrEP. The higher the proportion, the better PrEP need is being met through providing PrEP. A lower proportion indicates that more people with need are leaving the service without PrEP, the reason for which will be multifactorial.

In 2021, 48.3% of people in Bristol defined as having PrEP need initiated or continued PrEP use (292 people). In North Somerset this proportion was higher at 58.0% (65 people), and the 58.0% (80 people) in South Gloucestershire. All three councils were lower than the England average of 69.6%, which suggests that there may be 418 (48.9%) people with an unmet PrEP need across BNSSG (see table 5.10 above).

The published data do not match the Unity figures for 2021. In Bristol, 513 people started/continued with PrEP according to Unity, compared to 292 published. In North Somerset, 167 (compared to 65) and in South Gloucestershire there were 153 compared to 80. This data discrepancy is being investigated.

¹⁸⁵ [Sexual and Reproductive Health Profiles - Data - OHID \(phe.org.uk\)](https://phe.org.uk/data) (published 06/12/2022)

5.2.2.7 Impact of COVID on HIV in UK

In response to the COVID-19 pandemic, the UK government enforced strict national and regional lockdowns from March 2020 onwards and encouraged people to stay at home and practice social distancing. People living with diagnosed HIV with advanced infection were advised to self-isolate and many consultations for HIV care shifted from face-to-face to telephone appointments. The COVID-19 social restrictions changed patterns of sexual behaviour, patient interactions with SRHS, HIV testing and HIV outpatient care in 2020. Compared to 2019, the number of people tested for HIV at SRHS decreased by 30% in 2020 and almost half (47%) of people testing in 2020 did so online.

Those first diagnosed late in the UK in 2020 were 11 times more likely to die within a year of their diagnosis, compared to those who were diagnosed promptly, with those first diagnosed late in England 13 times more likely to die within a year. These figures are substantially higher than those for people diagnosed at a late stage of infection in 2019, who were 6 times more likely to die within a year, and 8 times more likely to die within a year respectively. This increase reflects the higher than usual number of deaths among those diagnosed late in 2020 (40, the highest number since 51 in 2014), and the sharp reduction in new diagnoses in 2020. This may in turn reflect the direct impact of COVID-19 infection, as well as its indirect impact through disruption to healthcare services.¹⁸⁶

Three UK-based studies on people with HIV in England all concluded that while crude mortality rates were low, people living with HIV were twice as likely to die from COVID-19 infection compared with the rest of the population during the first wave of the pandemic in 2020; echoing reports in other countries. Two of these studies reported that the increased risk was only seen in people living with HIV who also had other chronic health conditions, such as cardiovascular disease or diabetes.^{187,188,189}

5.2.2.8 Evidence of what works to increase HIV prevention and early detection

In 2020, the HIV Commission published a set of recommendations as an innovative approach to end HIV transmissions in England by 2030. The DHSC responded with the 'HIV Action Plan', published in December 2021, which proposes a set of actions building on the HIV Commission recommendations. The HIV Action Plan describes the progress that can be

¹⁸⁶ [HIV testing, PrEP, new HIV diagnoses, and care outcomes for people accessing HIV services: 2022 report - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/101444/HIV_testing_PrEP_new_HIV_diagnoses_and_care_outcomes_for_people_accessing_HIV_services_2022_report_-_GOV.UK_(www.gov.uk).pdf)

¹⁸⁷ Brown, AE and others. 'COVID-19 mortality among people with diagnosed HIV compared to those without during the first wave of the COVID-19 pandemic in England'. HIV Medicine 2021: pages 1 to 13

¹⁸⁸ Bhaskaran, K and others. 'HIV infection and COVID-19 death: a population-based cohort analysis of UK primary care data and linked national death registrations within the OpenSAFELY platform'. The Lancet HIV 2021: volume 8, pages e24 to e32

¹⁸⁹ Geretti, AM and others. 'Outcomes of Coronavirus Disease 2019 (COVID-19) Related Hospitalization Among People With Human Immunodeficiency Virus (HIV) in the ISARIC World Health Organization (WHO) Clinical Characterization Protocol (UK): A Prospective Observational Study'. Clinical Infectious Diseases 2020: volume 73, pages e2095 to e2106.

made by 2025 using a combination prevention approach focussing on ‘prevent, test, treat and retain’ to:¹⁹⁰

- reduce the number of people first diagnosed in England by 80% from 2,860 in 2019, to under 600 in 2025
- reduce the number of people diagnosed with AIDS within 3 months of HIV diagnosis by 50% from 219 to under 110
- reduce deaths from HIV/AIDS in England by 50% from 230 in 2019 to under 115

Underpinning the HIV Action Plan, a monitoring and evaluation framework was published in December 2022 to check progress towards the 2025 ambition at national, regional and local levels, as well as measuring the extent to which the actions set by the plan are implemented.¹⁹¹

In order to achieve these outcomes, the HIV Action Plan has four key objectives, which are listed below with some of the proposed actions that will be taken to support local areas achieve these:

1. Primary prevention: ensure equitable access and uptake of HIV prevention programmes, partly achieved by:
 - development of an HIV prevention toolkit to support council and NHS partners drive improvements in prevention delivery and outcomes
 - OHID and UKHSA, working with regional sexual health and other relevant networks, will ensure sexual health promotion messages are promoted outside sexual health services, such as drug and alcohol settings
 - additional investment in PrEP, including a plan for provision of PrEP in settings beyond sexual and reproductive health services, e.g. drug and alcohol services and pharmacies. NHS/ICB is also taking forward a pilot for accessing PrEP in prisons
2. HIV testing: scale up HIV testing in line with national guidelines, partly achieved by:
 - NHS/ICB will expand opt-out testing in emergency departments in the highest prevalence council areas and will invest £20m over the next three years to support this activity
 - In the first hundred days of the emergency department opt-out blood-borne virus testing pilot (April to July 2022), which includes HIV, hepatitis B and hepatitis C testing, there were 128 new HIV diagnoses recorded and 65 people with known HIV not engaged in care. The pilot is taking place in very

¹⁹⁰ [Towards Zero: the HIV Action Plan for England - 2022 to 2025 - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/consultations/towards-zero-the-hiv-action-plan-for-england-2022-to-2025) (updated 21/12/2022)

¹⁹¹ [HIV monitoring and evaluation framework - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/consultations/hiv-monitoring-and-evaluation-framework) (published 01/12/2022)

high HIV prevalence areas: London, Brighton, Salford, Manchester and Blackpool¹⁹²

3. Secondary prevention: optimise rapid access to treatment and retention in care, partly achieved by:
 - following BHIVA guidelines, which state 90% of people should be referred into HIV care 2 weeks after diagnosis, which will be monitored and reported on by UKHSA
4. Empowerment and wellbeing: improving quality of life for people living with HIV and addressing stigma, partly achieved by:
 - investment in peer support pathways, particularly in areas of high and very high prevalence, or for newly diagnosed and older people living with HIV and multiple other conditions, has the potential to improve wellbeing and support retention in HIV care
 - developing an audit tool to enable local areas to understand provision of HIV mental health, psycho-social and peer support services for people living with HIV across the life-course
 - OHID-NHS/ICB modernising occupational policies on anti-HIV stigma, promoting their development and dissemination across sectors and become more proactive in ending HIV stigma
 - ensuring all sexual health or HIV social marketing and health promotion campaigns raising awareness of U=U and 'treatment as prevention' to reflect the latest developments in HIV prevention and tackling stigma as one of their objectives

Nationally, an HIV Implementation Steering Group has been created to support the delivery of the HIV Action Plan, and has commissioned three task and finish groups to support commissioners in relation to: ¹⁹³

- PrEP access and equity: identifying current challenges to PrEP access, scaling up and equity in England, and to develop a plan to significantly improve PrEP access, with a particular focus on ethnic minority and other underserved groups
- workforce: to review, collate and promote existing HIV training materials, identifying any gaps, and undertaking a workforce planning exercise for retention and support for HIV care and the partner notification workforce
- low prevalence areas: providing advice on HIV control strategies in low prevalence areas with a specific focus on prevention, monitoring and evaluation, testing, and treatment

¹⁹² [NHS England » Emergency department opt out testing for HIV, hepatitis B and hepatitis C: The first 100 days](#) (published 29/11/2022)

¹⁹³ OHID Briefing 7 September 2022.

In 2019/20 Bristol, having a high prevalence of HIV, undertook an HIV needs assessment ([HIV Health Needs Assessment 2020 \(bristol.gov.uk\)](https://www.bristol.gov.uk/hiv-health-needs-assessment-2020)). This highlighted a number of key issues, including the lack of testing and ongoing stigma and that HIV inequalities were particularly experienced by Black ethnic groups. As a result, Bristol signed up to become a Fast Track City for HIV and developed an action plan to address the key issues.¹⁹⁴ Unity is working as part of Fast Track Cities Bristol to improve access to HIV testing across the city, including a current pilot building on findings from a similar study in Brighton using free vending machines that stock HIV point of care tests and STI sampling kits for posting, which can be accessed from two central locations in Bristol and one location each in North Somerset and South Gloucestershire.¹⁹⁵ Other local research initiatives just commencing include exploring GP HIV testing and the feasibility of PrEP provision in pharmacies. Stigma is known to prevent people coming forward for testing and partners have continued to develop campaigns around U=U and have developed specific new resources for healthcare professionals ([About | Hearts and Minds \(bristolheartsminds.wixsite.com\)](https://www.bristolheartsminds.wixsite.com/about)).

Common Ambition Bristol launched in February 2021 and aims to address the HIV inequalities experienced by people of African and Caribbean heritage communities¹⁹⁶. In 2021, six African and Caribbean heritage community members were recruited and work alongside healthcare, public health and academic partners to develop and test interventions to establish effectiveness and acceptability. The evaluation is being undertaken with five African and Caribbean heritage community researchers and Bristol University. Common Ambition Bristol have undertaken a community consultation and a number of community engagement events to hear the views of African and Caribbean heritage communities. Some of the initiatives that have been put in place have included health promotion work delivered through barbers in barber shops, and a community clinic has been set up at GP practice in Bristol, specifically for people of African and Caribbean heritage and this is offering point of care testing and PrEP.

In addition, understanding that some people struggle to engage with HIV treatment, a new pilot Engagement Support Service has been set up by Brigstowe and is being evaluated.

In 2021 Bristol Fast Track Cities reviewed itself against the HIV action plan. Whilst Bristol is already working towards many of the areas that the plan advised upon, they highlighted some gaps including improving health promotion messages and pathways with other services (such as drug and alcohol services, maternity), expanding the use of condoms, driving for higher HIV testing within SRHS (target is 95%), and delivering testing in other settings.

¹⁹⁴ [Fast Track Cities - Bristol One City](https://www.bristol.gov.uk/hiv-health-needs-assessment-2020)

¹⁹⁵ [Introducing vending machines for HIV self-testing and STI self-sampling kits - ARC West \(nihr.ac.uk\)](https://www.nihr.ac.uk/introducing-vending-machines-for-hiv-self-testing-and-sti-self-sampling-kits)

¹⁹⁶ <http://commonambitionbristol.org.uk/>

5.2.2.9 Issues identified

The following issues have been identified following a review of the HIV data for BNSSG.

HIV testing

1. HIV testing coverage among SRHS attendees fell in BNSSG in 2021 from 2020 and 2019 and is lower than the England average. 63% of heterosexual men and 68% of women were either not offered or declined an HIV test. This is far short of the HIV Action Plan target of 95% testing offer rate to first time attendees.
2. In 2021 there was a decline in the proportion of GBMSM in BNSSG who tested more than once in the previous year when compared to 2020. Repeat testing is encouraged for those at continued risk due to behavioural changes such as an increase in partner numbers and condomless sex with new or casual partners. This decline is driven by Bristol
3. Local data on HIV tests offered in alternative settings, such as following partner notification, alongside TB testing and in prisons and GPs was not available.
4. There are evidence-based opportunities to increase the offer of testing in other BNSSG settings, such as emergency departments.
5. The results of the FTC vending machines project evaluation in which HIV and STI test kits are available in accessible community settings are awaited and should be available in 2023.

HIV prevalence and new diagnoses

6. The number of people diagnosed with HIV has continue to fall in BNSSG, but Bristol remains an area of high HIV prevalence in 2021.
7. Just under 60% of new HIV diagnoses in BNSSG were first diagnosed in the UK.
8. The proportion of late diagnoses in BNSSG has increased in 2021 compared to 2019 but the number has reduced.
9. Late diagnoses are higher in BNSSG compared to the England and South West averages. Heterosexual people are more likely to be diagnosed late compared to GBMSM
10. Nationally, late diagnosis was highest among people of Black African ethnicity. It is not possible to confirm if this is the case locally as the data isn't available.
11. It is estimated that approximately 50 people (5%) are living with HIV in Bristol and have not been diagnosed.

Access to PrEP

12. The number of people accessing PrEP from Unity should be interpreted with caution due to data quality issues.
13. The Unity data suggests that access could be improved for heterosexual and bisexual women and people of African and Caribbean heritage.

14. Across BNSSG there may be around 418 people (49% of those that are HIV negative but estimated to be at a high risk of HIV) with an unmet PrEP need.

Health promotion, HIV prevention and reducing stigma

15. Health promotion messages and pathways with other services, such as drug and alcohol and maternity services, require improvement.
16. Access to condoms in BNSSG to prevent transmission of HIV and STIs needs to be reviewed and expanded.
17. Some key projects including Common Ambition Bristol and the HIV Engagement Support Service are pilots and evidence of effectiveness and future sustainability needs to be determined.

Future commissioning of HIV treatment and care

18. The transfer of responsibility for the future commissioning of HIV treatment and care from NHSE to the ICB in April 2024 presents an opportunity to fully integrate HIV testing, treatment and care across BNSSG to ensure a seamless pathway for residents. There is currently a lack of information about the transfer.

5.3 Reproductive health

A note on the contraception, conceptions and abortions data: all of the data reported below are crude. Age-sex standardisation has not been carried out and, therefore, it is important to consider when making comparisons between the different BNSSG council areas that the confounding factors of age and sex have not been adjusted for.

Also, in the following sections Sexual and Reproductive Health Activity Dataset (SRHAD) data published by NHS Digital is reported by financial year. The SRHAD data is also used in analyses carried out by OHID, but this is by calendar year, so not comparable. The figure captions will make it clear if the data used is from SRHAD or OHID and the years referred to will relate to the data source accordingly.

5.3.1 Contraception

Access to a choice of contraceptives, in addition to health education, helps prevent unwanted pregnancy. A range of methods are available from different providers in England. Table 5.11 summarises the contraceptive options available from commissioned services and their efficacy.¹⁹⁷

The right decision for an individual will depend on their unique priorities, which go beyond efficacy to prevent pregnancy. These may include ease of access, speed of reversibility, bleeding pattern, side effect profile, non-contraceptive benefits, adherence required by the user, how discreet the method may be, among many other considerations.¹⁹⁸

¹⁹⁷ adapted from p56 [Integrated Sexual Health Services: A suggested national service specification \(publishing.service.gov.uk\)](#) some conflict of where services are available in body of text vs appendix.

¹⁹⁸ [FSRH Quality Standard Contraceptive Services - Faculty of Sexual and Reproductive Healthcare](#)

Research suggests that variance exists in contraceptive use and outcomes in the following groups, although there is limited demographic data collected nationally, with nothing available on ethnicity, sexual or gender identity, disability, or inclusion health groups:

- NATSAL 3 showed that pills and injection use was lower among Asian women than White women.^{199,200} There was no significant difference in LARC use between those of different ethnicities according to NATSAL 3
- women of colour are less likely to go to their GP to access contraception²⁰¹
- efforts are being made to increase access to LARC in underrepresented groups, but results from a public survey have raised concerns about discrimination and undue pressure to use LARC placed on Black and people of colour in the UK²⁰²
- lesbian and bisexual teenagers are at greater risk of unplanned pregnancies than their heterosexual counterparts²⁰³
- contraceptive and unplanned pregnancy knowledge is needed by trans men and the health professionals caring for them, as limited research in this field suggests there is sometimes misunderstanding about pregnancy risks while on testosterone treatment²⁰⁴
- women with disabilities appear to have limited knowledge and access to the range of contraceptives.²⁰⁵ In the new Women's Health Strategy for England, public engagement highlighted that women with disabilities felt less comfortable talking to their health professionals about contraception than women without disabilities²⁰⁶

The best markers of good contraceptive provision are access to adequate contraceptive education/counselling, and timely access to the full range of contraceptives so that

¹⁹⁹ Black, K. I., Geary, R., French, R., Leefe, N., Mercer, C. H., Glasier, A., Macdowall, W., Gibson, L., Datta, J., Palmer, M., & Wellings, K. (2016). Trends in the use of emergency contraception in Britain: evidence from the second and third National Surveys of Sexual Attitudes and Lifestyles. *BJOG : an international journal of obstetrics and gynaecology*, 123(10), 1600–1607. <https://doi.org/10.1111/1471-0528.14131>

²⁰⁰ Wayal, S., Hughes, G., Sonnenberg, P., Mohammed, H., Copas, A. J., Gerressu, M., Tanton, C., Furegato, M., & Mercer, C. H. (2017). Ethnic variations in sexual behaviours and sexual health markers: findings from the third British National Survey of Sexual Attitudes and Lifestyles (Natsal-3). *The Lancet. Public health*, 2(10), e458–e472. [https://doi.org/10.1016/S2468-2667\(17\)30159-7](https://doi.org/10.1016/S2468-2667(17)30159-7)

²⁰¹ French RS, Geary R, Jones K, et al. (2018), Where do women and men in Britain obtain contraception? Findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3). *BMJ Sexual & Reproductive Health*.

²⁰² <https://www.bpas.org/media/3477/larc-report-final-laid-up.pdf>

²⁰³ Hodson K, Meads C, Bewley S. Lesbian and bisexual women's likelihood of becoming pregnant: a systematic review and meta-analysis. *BJOG*. 2017 Feb;124(3):393-402. doi: 10.1111/1471-0528.14449. Epub 2016 Dec 15. PMID: 27981741; PMCID: PMC5299536.

²⁰⁴ Light et al (2018) Contraception, Volume 98, Issue 4, Pages 266-269, <https://www.sciencedirect.com/science/article/pii/S0010782418302221>

²⁰⁵ Horner-Johnson et al (2019) Contraceptive knowledge and use among women with intellectual, physical, or sensory disabilities: A systematic review, *Disability and Health Journal*, Volume 12, Issue 2, Pages 139-154 <https://www.sciencedirect.com/science/article/pii/S1936657418302103>

²⁰⁶ [Women's Health Strategy for England - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/publications/womens-health-strategy-for-england)

individuals can make the choice that is right for them, at the time that is right for them.²⁰⁷ However, these factors are difficult to measure. For example, there is no accepted standard for a reasonable waiting time for LARC procedures.

Access to LARC is a priority, as outlined in the national framework for sexual health improvement²⁰⁸, NICE LARC guidelines²⁰⁹ and FSRH young people's guidelines.²¹⁰ LARC is defined as a method that requires less than monthly compliance by the user to be effective. Some methods require action only every 5 or 10 years. They are therefore more effective at preventing pregnancy over time and are more cost-effective than the pill or condoms.²¹¹ However, obtaining a LARC device requires face to face consultations and procedures, and they are fitted with additional specialist training. Therefore, prescription of LARC per 1,000 women is a proxy indicator of access to contraceptive options overall. LARC will therefore be a focus of this chapter.

COVID-19 had a major impact on all contraception provision, resulting in a drop in most indicators between 2019 and 2020, with a tentative picture of recovery emerging with the 2021 national data. COVID-19 is likely to have had a greater impact on those from marginalised groups, who may previously have been more likely to access walk-in and specialist services than booked appointments and may not approach GPs for contraceptive help.²¹² The impact of the pandemic will be discussed further in section [5.4.1.7](#), and differences between 2019 and 2020 will be highlighted in relevant sections below.

²⁰⁷ All Party Parliamentary Group on Sexual and Reproductive Health (2022) 'Addressing the backlog in LARC and future-proofing access'. Personal notes from seminar

²⁰⁸ [A Framework for Sexual Health Improvement in England \(publishing.service.gov.uk\)](#)

²⁰⁹ [Overview | Long-acting reversible contraception | Guidance | NICE](#)

²¹⁰ [fsrh-guideline-contraception-young-people-may-2019.pdf](#)

²¹¹ [Overview | Long-acting reversible contraception | Guidance | NICE](#)

²¹² [Full report \(December\) - Women's Lives, Women's Rights - Faculty of Sexual and Reproductive Healthcare \(fsrh.org\)](#)

Table 5.11: Summary of contraceptive methods and their effectiveness

Method of contraception	Failure rate (pregnancy rate) in first year of typical use ²¹³
User-dependent methods	
Male condom	18%
Female condom	12%
Fertility awareness methods	24%
Progestosterone only pill (POP)	9%
Combined hormonal contraceptive (CHC) including rings and patches	9%
Emergency only	
Emergency hormonal contraception (EHC)	-
LARC	
Progestosterone-only injection (POI)/‘depo’	6%
Progestosterone sub-dermal implant (SDI)	0.05%
Progestosterone intrauterine system (IUS)/‘coil’	0.2%
Copper intrauterine device (IUD)/‘coil’ – emergency use also	0.8%
Long acting, permanent contraception	
Female sterilisation	0.5%
Male sterilisation	0.15%

5.3.1.1 Contraceptive choice

Choice of contraceptive differs across time, patient age and other factors. The most common method among all ages is the oral hormonal contraceptive, which is user-dependent, followed by the implant, which is a type of LARC. The most important distinction is between user-dependent methods and LARC, which will be covered below.

Over time, the proportion of women choosing LARC as the main method of contraception at SRHS in BNSSG has increased in all age groups from 39% (4,800 women) in 2014-15 to 51% (1,990 women) in 2021-22, although the overall number of women with a method of contraception in place has decreased from just over 12,000 in 2014-15 to around 3,900 in 2021-22.²¹⁴ The relative increase in LARC uptake has resulted in a decrease in the proportion choosing user-dependent methods, particularly of oral contraceptive methods. LARC is a more common choice among older women, whilst user dependent methods are more common among younger women.

²¹³ [FSRH Clinical Guideline: Contraceptive Choices for Young People \(March 2010, amended May 2019\) - Faculty of Sexual and Reproductive Healthcare](#)

²¹⁴ The numbers quoted are rounded and to the nearest 5.

During the COVID-19 pandemic, access to services reduced and this had an impact on the range of contraceptives available. For example, LARC device fits (implants, coils) were more difficult to access even when people could access specialist clinics, and patients may then have been offered alternatives such as short-acting hormonal pills or progesterone only injections (Depo-Provera ‘depo’ injections). Nationally and locally until 2020, the proportion of women choosing short-acting hormonal contraception at SRHS had been in decline in BNSSG, from 51% in 2014 to 40% in 2019 (see figure 5.27), but then rose to 42% in 2020. There was also a marked increase in the proportion of women choosing injections in SRHS in BNSSG (see figure 5.28), largely driven by North Somerset which increased from 10% to 16% of women between 2019 and 2020. This is double the figure for England (8%) and more than double the near neighbours average for North Somerset (7%).

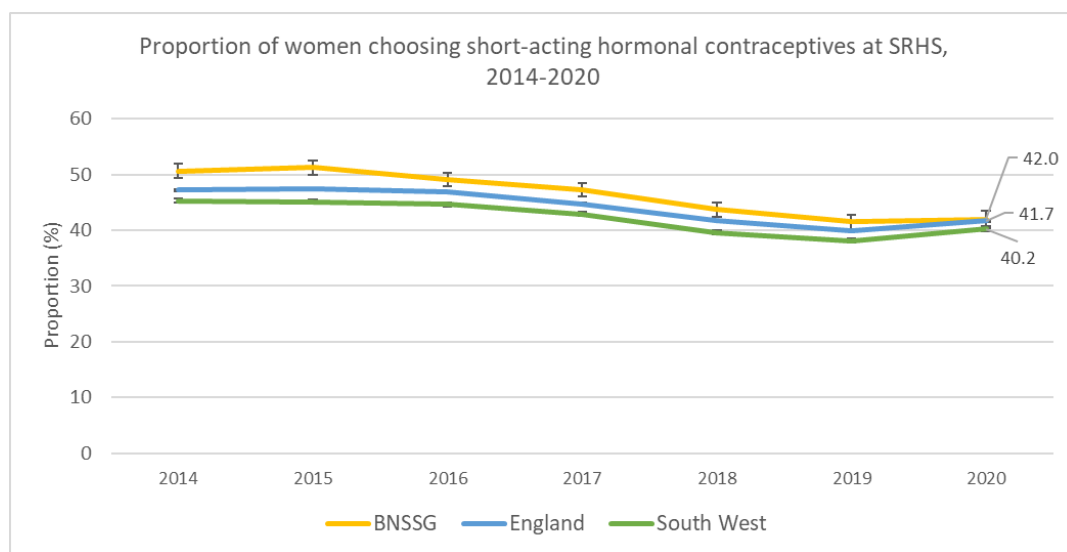


Figure 5.27: Proportion of women choosing short acting hormonal contraceptives at SRHS in England, South West, BNSSG 2014-2020 (OHID)

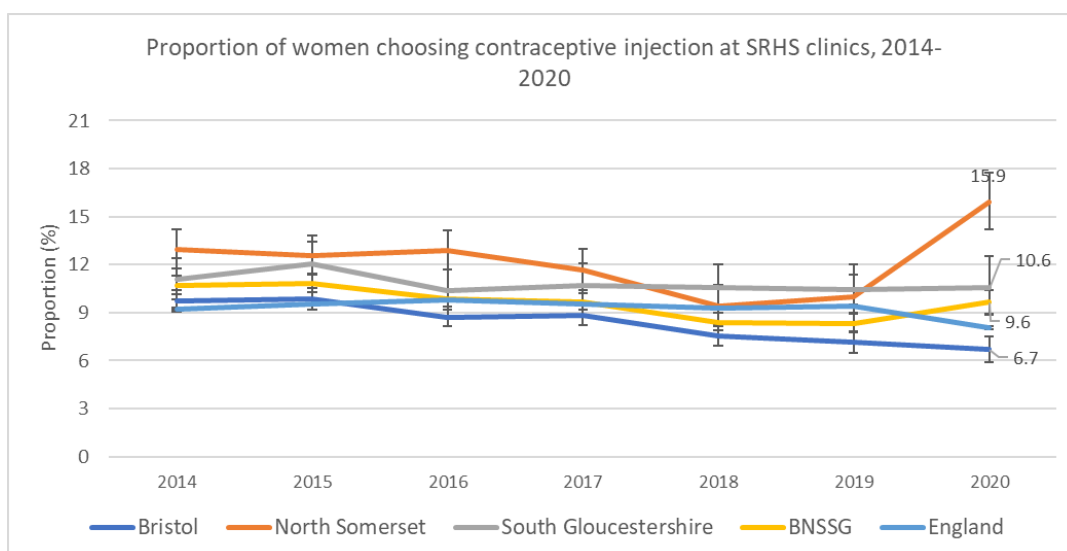


Figure 5.28: Proportion of women choosing contraceptive injection at SRHS clinics, Bristol, North Somerset, South Gloucestershire, BNSSG, England, 2014-2020 (OHID)

5.3.1.2 Attendance and service provision at SRHS and in primary care

The two main locations for accessing the majority of contraception options are SRHS (such as provided by Unity level 3 clinics: Central Health Clinic, Concord and WISH and/or community clinics) and general practice.

GPs provide oral contraception (combined and progesterone only), emergency hormonal contraception and contraceptive injections as part of their general contract, and practices are commissioned by public health teams in the 3 councils to also deliver LARC with variable payments. They can also act as a C-Card registration and pick-up point for free condoms for young people under 20. Across BNSSG there are 76 general practices, with 39 in Bristol, 14 in North Somerset and 23 in South Gloucestershire.

Pharmacies are commissioned by the local authorities to issue EHC under a PGD and to refer on for emergency copper coils. They also act as a place to register for a C-Card and collect condoms under this scheme. Pharmacies are also able to sell condoms and EHC (without a PGD for those who choose to pay for it, regardless of age). The update to the Community Pharmacy Contractual Framework 2019-2024 includes a new specification that will permit pharmacies to provide ongoing monitoring and supply of the progestogen-only pill and the combined oral contraceptive pill from January 2023 as the first of four tiers of an enhanced contraception service.²¹⁵ The remaining tiers are:

- tier 2: initiation of oral contraception via a PGD
- tier 3: ongoing monitoring and management of repeat LARC, excluding intrauterine systems and intrauterine devices
- tier 4: initiation of LARCs

Data on the rate of young people's (under 25) attendance at SRHS is collected nationally and is available up to 2021. No equivalent publicly available source is available for national primary care contraceptive attendances. Nationally there has been a downward trend for female attendances at SRHS, and this has been more pronounced in BNSSG, declining from 169.9/1,000 in 2015 (higher than the England average of 163.4/1,000 in England), to 62.8/1,000 in 2021 (now lower than the England average of 82.6/1,000). Figure 5.29 below shows that the downward trend in under-25 females attending specialist contraceptive services in each BNSSG local authority is consistent, with all three areas lower than the England average in 2021. This trend may in part reflect changes in the way activity data is recorded²¹⁶ but it also may be due to changes in the commissioning and structure of services resulting in a greater emphasis on primary care provision.

²¹⁵ [NHS England » NHS Pharmacy Contraception Service Tier 1 – Ongoing supply of oral contraception](#) (published 10/01/2023)

²¹⁶ [Part 1: Contacts with Sexual and Reproductive Health Services - NHS Digital](#)

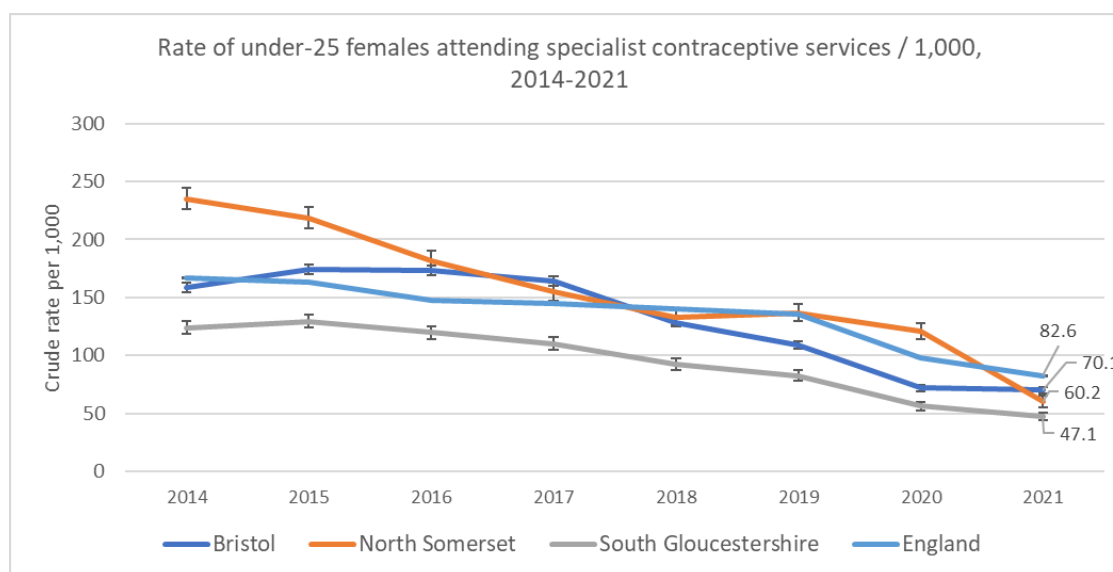


Figure 5.29: Rate of under-25 females attending specialist contraceptive services / 1,000, 2014-2020, Bristol, North Somerset, South Gloucestershire, BNSSG, England (OHID)

Male attendances at specialist contraceptive services have consistently been far lower. Nationally, from a low in 2016 (15.1/1,000) there was an indication of increasing male attendances up until 2019 (19.7/1,000), but this was not sustained during the COVID-19 pandemic and fell to 11.5/1,000 in 2021. In BNSSG, male attendances have decreased steadily from 15.9/1,000 in 2015 to 3.1/1,000 in 2020. It is not possible to calculate the BNSSG rate for 2021 as the values for North Somerset and South Gloucestershire have been suppressed for disclosure control. In Bristol, the rate has continued to fall in 2021 to 0.1/1,000, or 10 attendances.

Men make fewer specialist contraception visits overall and return for fewer repeat visits in a year.²¹⁷ This may reflect the different range of choice/complexity between the sexes (condoms are the only male contraceptive offer). The decline over time may represent a move to accessing condoms from retail or condom distribution schemes, a reduction in the use of condoms generally, or it may also represent a change in the way attendances are recorded and coded. For example, a male attending a specialist service for STI screening may also be provided with condoms, but the visit will not necessarily be coded as a contraception attendance as condoms are a mainstay of preventing STIs and may be used for that purpose. Meanwhile, a female patient may attend for STI screening but be coded for both screening and contraception.

5.3.1.3 Long-acting reversible contraceptives (LARC)

Access to LARC is a priority and is used as a proxy indicator of access to contraception overall. The prescription of LARC rate per 1,000 (excluding injections) is therefore a key indicator in this chapter. There are a few important caveats when interpreting this indicator. LARC may be used for non-contraceptive purposes such as bleeding control, or as part of

²¹⁷ [Sexual and Reproductive Health Profiles - Data - OHID \(phe.org.uk\)](https://phe.org.uk/data/sexual-reproductive-health-profiles)

hormone replacement therapy (HRT). The HRT aspect is mostly mitigated as only women 15-44 are included in the indicator. Additionally, the OHID indicator does not include LARC prescribed in post-pregnancy contexts such as after abortion, miscarriage or delivery, which is another important priority. Finally, the progesterone 'depo' injection is excluded in OHID indicators, as it does not require such specialist training, nor does it last as long before user compliance is needed (12-14 weeks). It is, however, included in NHS SRHAD data.

The national rate of total LARC (excluding injections) prescribed by GPs and SRHS for 15-44 year old women fell during the COVID-19 pandemic from 50.8/1,000 in 2019 to 34.6/1,000 in 2020. The data for 2021 show that the rate has started to recover at 41.8/1,000.

Throughout this time, BNSSG has mirrored the national trend but remained consistently higher than the national average and was 58.3/1,000 in 2021 (see figure 5.30). All three local authorities had a total LARC prescribed rate that was higher than the national average in 2021.

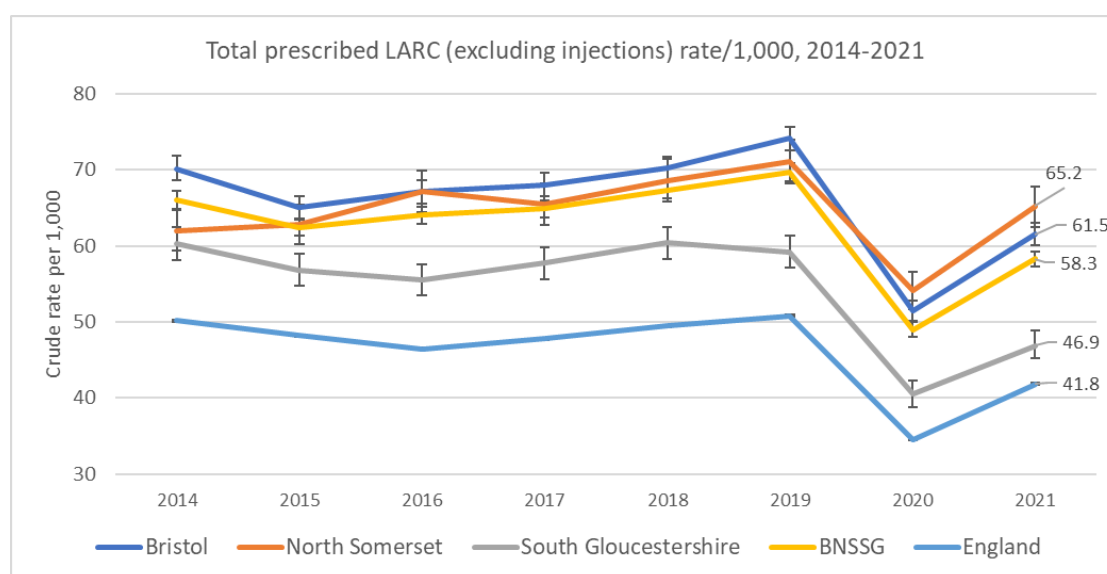


Figure 5.30: Total LARC prescribed in GP and SRHS (excluding injections) rate / 1,000, 2014-2020, Bristol, North Somerset, South Gloucestershire, BNSSG, SW and England (OHID)

A BNSSG LARC audit with GPs for 2020-21 noted that South Gloucestershire had longer waiting times and fewer LARC fitters per 1,000 population than other areas in BNSSG (0.88 coil fitters/1,000 in South Gloucestershire compared to 0.92 coil fitters/1,000 in BNSSG).²¹⁸ The audit will be repeated in April 2023 to cover the period 2021-22 to 2022-23.

There is significant variance in available total LARC prescribing data according to location of fit, age and deprivation. Nationally, more LARC are prescribed in GP practices (30/1,000 in 2019, 21/1,000 in 2020 and 26/1,000 in 2021) than in SRHS (21/1,000 in 2019, 13/1,000 in 2020 and 16/1,000 in 2021). This pattern is also seen in BNSSG, but is more pronounced

²¹⁸ Internal analysis

with BNSSG GP prescribing well above, and BNSSG SRHS prescribing below England figures (see figure 5.31).

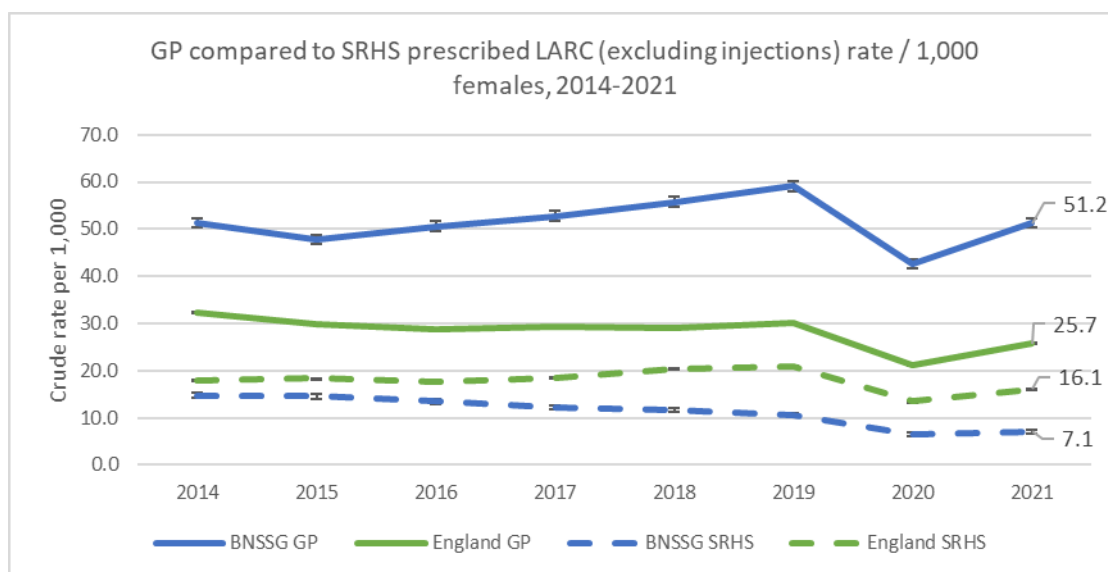


Figure 5.31: GP compared to SRHA prescribed LARC (excluding injections) rate / 1,000 females, 2014-2021, BNSSG and England (OHID)

Prior to COVID-19, GP LARC prescribing had been gradually increasing within BNSSG and all three council areas (see figure 5.32 below), while SRHS LARC prescribing was continuing to decrease. The biggest contrast is in North Somerset, where GP prescribing is now over 15 times higher than SRHS prescribing (61/1,000 in GPs compared to 4/1,000 in SRHS in 2021). This is compared to 1.6 times in England (26/1,000 in GP compared to 16/1,000 in SRHS).

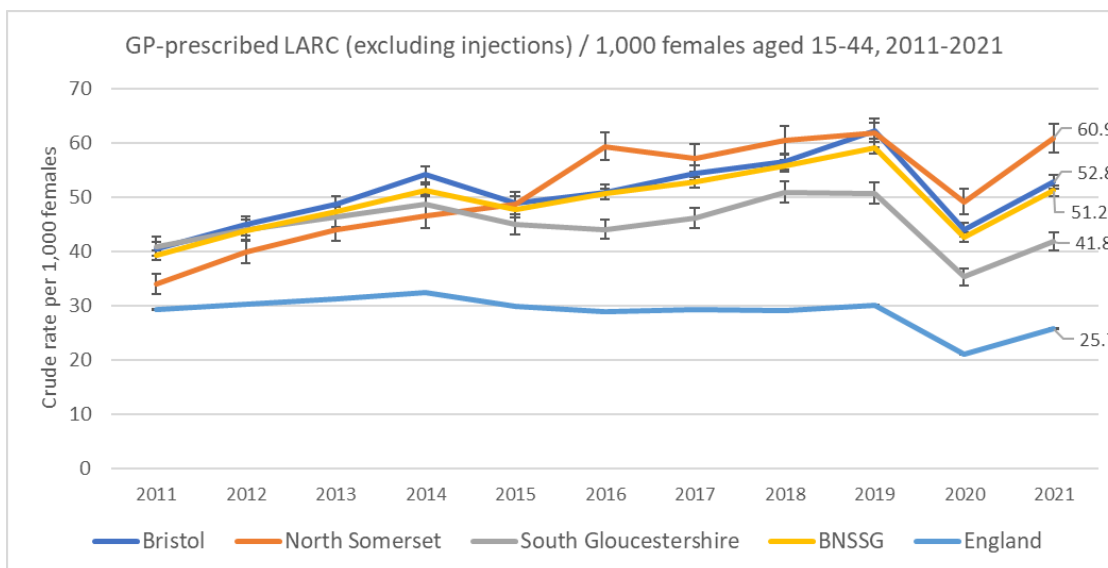


Figure 5.32: GP-prescribed LARC (excluding injections) / 1,000 females aged 15-44, Bristol, North Somerset, South Gloucestershire, BNSSG, England, 2014-2021 (OHID)

Differences in location of LARC fit are thought to be due to local service design and geography. In more rural locations, GP services may be used more frequently than SRHS as

people live further from clinics.²¹⁹ This is likely relevant in North Somerset, where the overall population density is 568 people/km², compared to Bristol's 4,026 people/km² in 2010²²⁰. The overall population density of North Somerset is similar to South Gloucestershire's 533 people/km² in 2010, but note the proportion of residents living in rural areas is higher in North Somerset (1 in 3 in 2012) than South Gloucestershire (1 in 5 in 2015).^{221,222} With this broadly similar demography in mind, South Gloucestershire also has a big difference between GP and SRHS LARC prescribing at 8 times the amount in 2021 (41.8/1,000 in GP compared to 5.2/1,000 in SRHS). North Somerset's high rates may also be secondary to different payment models across BNSSG for GP LARC provision.

There are advantages and disadvantages to GP compared to SRSH provided LARC. It is thought that patients may prefer GP access overall (>50% in one national survey²²³), and it may ameliorate the effect of poor public transport in isolated communities. However, there is a suggestion that GP practices may see fewer people from deprived backgrounds.²²⁴ Nationally, there is a correlation between affluence and LARC prescription²²⁵, whereby the least deprived areas had the highest rates of LARC prescription. When broken down by location of fit, GP-prescribed LARC conforms to this pattern (figure 5.33), whereas in SRHS this is not the case (figure 5.34). This suggests a gap in access to LARC for the most deprived parts of the population within both GP and SRHS settings in England.

²¹⁹ SPLASH report in Sexual & Reproductive Health profiles <https://fingertips.phe.org.uk/profile/sexualhealth>, UKHSA (updated 06/2022)

²²⁰ [Population Density Tables - Office for National Statistics \(ons.gov.uk\)](https://ons.gov.uk/population/density)

²²¹ North Somerset Council (2015) Sexual Health Needs Assessment [BNSSG Sexual Health Joint Commissioners Group - NS Sexual Health Needs Assessment Final 2 Nov 2015.pdf - All Documents \(sharepoint.com\)](#)

²²² South Gloucestershire Council (2020) Relationships and sexual health needs assessment [BNSSG Sexual Health Joint Commissioners Group - SOUTH GLOS 2020 Final draft Needs Assessment Relationships and Sexual Health.pdf - All Documents \(sharepoint.com\)](#)

²²³ All Party Parliamentary Group on Sexual and Reproductive Health (2022) 'Addressing the backlog in LARC and future-proofing access'. Personal notes from seminar

²²⁴ [Full report \(December\) - Women's Lives, Women's Rights - Faculty of Sexual and Reproductive Healthcare \(fsrh.org\)](#)

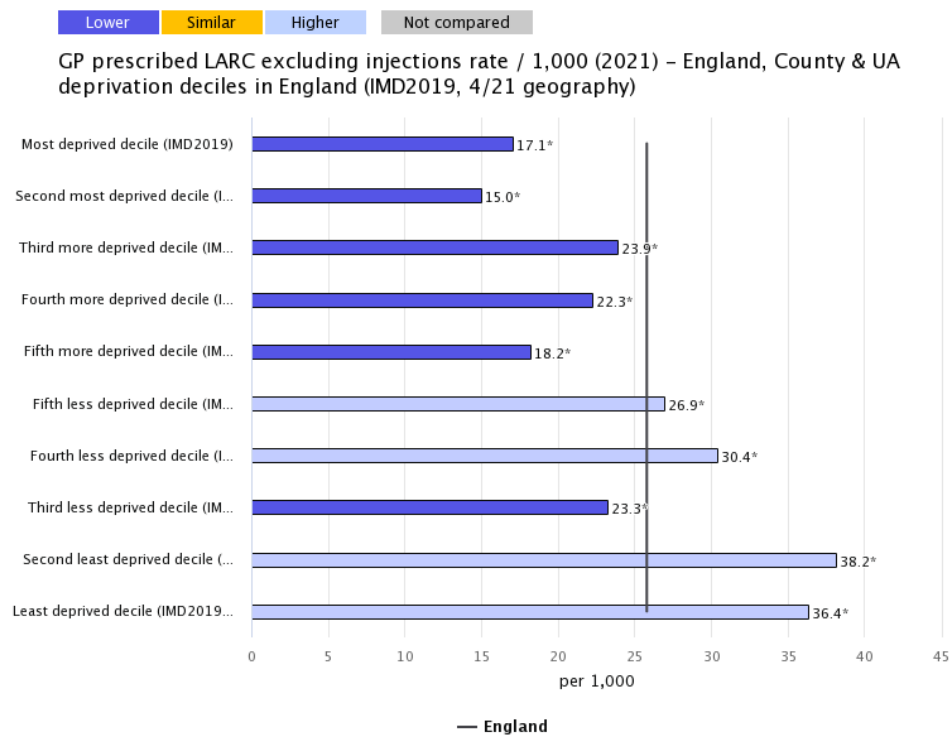


Figure 5.33: GP prescribed LARC (excluding injections) rate per 1,000 females, England, 2021, by IMD 2019 deciles. (OHID)

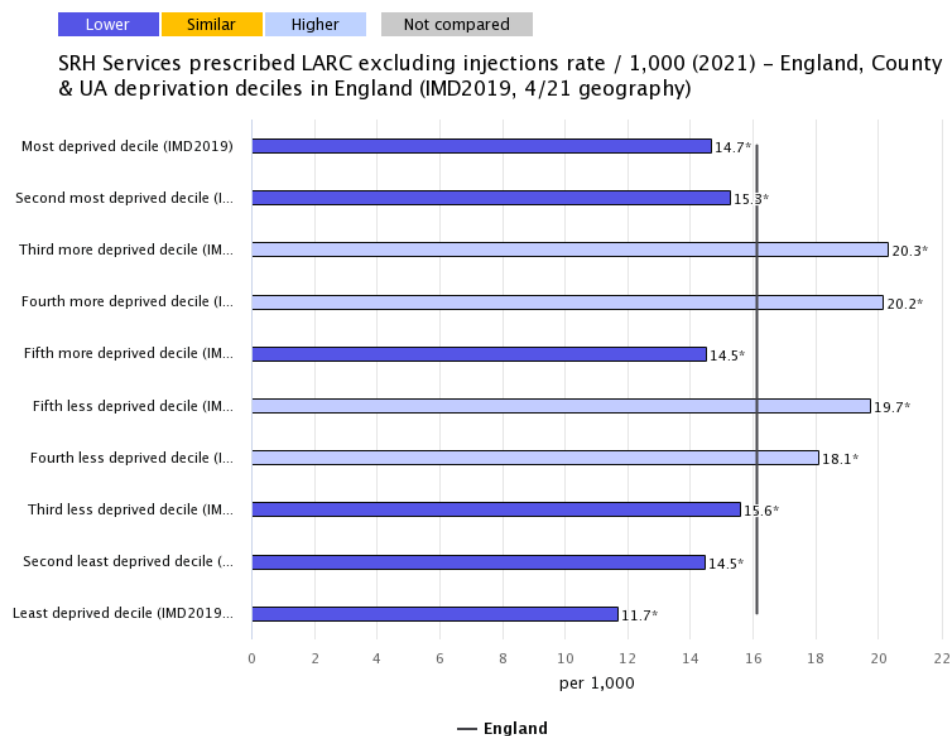


Figure 5.34: SRHS prescribed LARC (excluding injections) rate per 1,000 females, England, 2021, by IMD 2019 deciles (OHID)

Differences between the appeal of GP and SRHS for LARC fits may be due to specialist training and tailored outreach in SRHS which actively seeks to reach marginalised groups

including those from deprived backgrounds. So, even though crude numbers seen in GP are higher, where SRHS fits are not available those from deprived backgrounds may be more disadvantaged than those from affluent backgrounds. During COVID-19 this correlation became weaker nationally. Possibly changes during the pandemic limited the open access and specialist outreach activities in SRHS that may have been underpinning the trend.

Locally, slightly different data is collected about deprivation by Unity. LARC as a proportion of all contraception appointments is recorded, and this can be split by IMD groups, and other demographic features. This data includes depo as a form of LARC. BNSSG-wide, 54.2% (3,201 LARC provisions) of all contraception methods provided in 2021-22 were for LARC, which breaks down to 53.1% (1,931 LARC) for Bristol, 55.3% (690 LARC provisions) for North Somerset and 56.9% (580 LARC provisions) for South Gloucestershire. Unity saw more patients from IMD 1-2 (most deprived) than from IMD 9-10 (least deprived) for contraception in 2021-22: 1,376 service users from the most deprived decile compared to 903 in the least. The proportion receiving LARC at these appointments was similar in both groups, but slightly lower among the most deprived (BNSSG total 55%: 52% in the most deprived and 54% in the least deprived). Within Bristol, three times as many service users from the most deprived households were seen, and the proportion receiving LARC was 53% compared to 52% in the least deprived, and 53% overall. The other council areas had smaller patient numbers in these categories so results should be interpreted with caution, but North Somerset and South Gloucestershire combined saw 51% of service users in the most deprived areas receive LARC compared with 55% in the least deprived. The similarity of the uptake of LARC at Unity across the deprivation deciles does not strongly suggest that access to those from the most deprived areas of BNSSG is as high as would be expected given the greater need and poorer reproductive health outcomes that are experienced by those living in more deprived areas.

The data below in table 5.12 show the LARC activity in GP practices across Bristol, North Somerset and South Gloucestershire in 2021-22 and the first 6 months of 2022-23. The data show that in Bristol, after the first six months of 2022-23, there are less than half the number of coils and implants that were fitted in 2021-22. This may be the result of an increase in the number practices not undertaking coil or implant fits in Bristol in 2022-23 compared to 2021-22.

Table 5.12: The number of LARC items prescribed and the number of practices with no activity, Bristol, North Somerset, South Gloucestershire, BNSSG, 2021-22 and the first six months of 2022-23 (internal activity data)

Local authority (total number of practices)	Number of LARC items prescribed				Number of practices with no activity			
	IUDs		Implants		IUDs		Implants	
	2021-22	2022-23 (Apr-Sept)	2021-22	2022-23 (Apr-Sept)	2021-22	2022-23 (Apr-Sept)	2021-22	2022-23 (Apr-Sept)
Bristol (39)	3,098	1,364	1,980	777	1 (2.6%)	7 (17.9%)	4 (10.3%)	9 (23.1%)
North Somerset (14)	1,378	822	740	427	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
South Gloucestershire (23)	1,274	685	874	428	1 (4.3%)	2 (8.7%)	2 (8.7%)	3 (13.0%)
BNSSG (76)	5,750	2,871	3,594	1,632	2 (2.6%)	9 (11.8%)	6 (7.9%)	12 (15.8%)

Limited analysis of the impact of deprivation on GP LARC fits was available for this report. An initial analysis of COVID-19 recovery data for Bristol practices found that, while overall the system was recovering well to pre-pandemic levels of GP LARC activity (93% of 2019-20 activity in 2021-22²²⁶), there were differences according to the location of practices. Of the 39 practices in Bristol, those who had only reached 60% or less of their 2019-20 activity (excluding those with crude fit rate still in excess of the average number of fits) had an average IMD decile of 3. This was compared to those exceeding 100% of 2019-20 activity (excluding those whose crude fit rate was below average), who had an average IMD decile of 5.²²⁷

LARC prescribing also varies according to patient age. In England, women under 25 are less likely to choose LARC in SRHS (37% in 2021) than women over 25 (53% in 2021).²²⁸ Figure 5.35 shows the uptake of user-dependent contraception compared to LARC (including injections) at SRHS in 2020-21 broken down by age brackets from under 16 to over 45s.

²²⁶ Internal analysis

²²⁷ Internal analysis

²²⁸ [Sexual and Reproductive Health Profiles - Data - OHID \(phe.org.uk\)](https://phe.org.uk/data/sexual-reproductive-health-profiles)

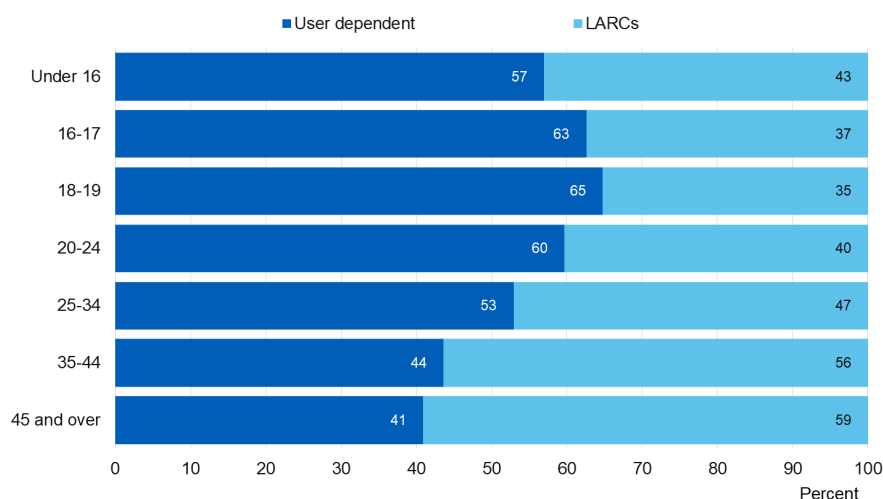


Figure 5.35: Uptake of user-dependent contraception compared to LARC (including injections) at SRHS, England, 2020-21, by age (NHS SRHAD)

However, over time, more under 25s are choosing LARC (excluding injections) when they attend SRHS both nationally and locally (figure 5.36 below). A quarter of under-25s in North Somerset chose LARC (excluding injections) when attending SRHS in 2021, which is lower than the national average at 25% (compared to 37%) and has not been on an upward trend since 2018. This could suggest that young people are accessing LARC in GP settings, or that there is a greater preference for injections in this age group, or they are using user-dependent method or possibly no contraception at all.

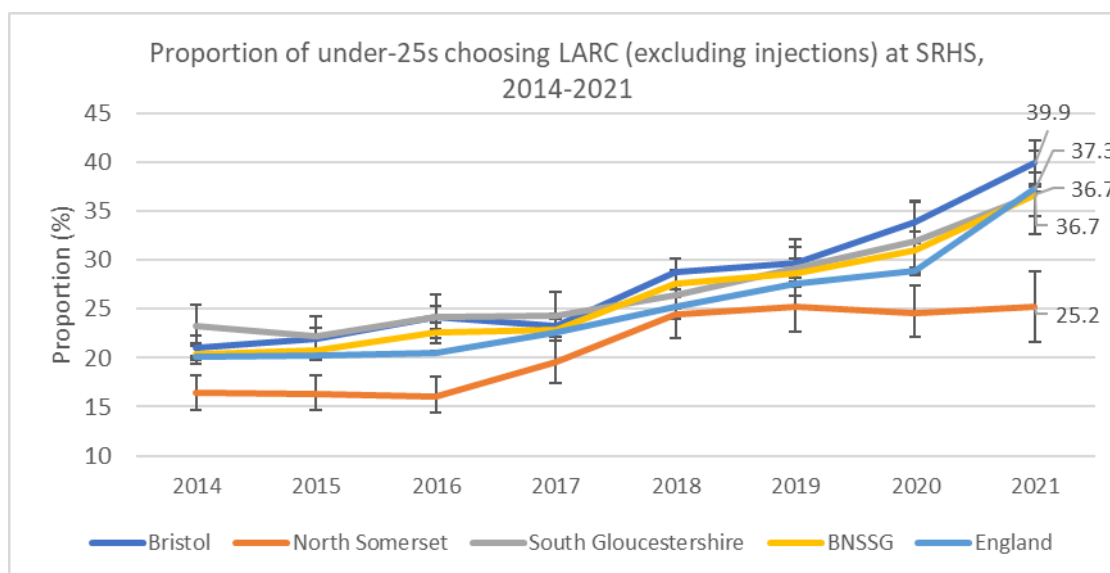


Figure 5.36 Proportion of under-25s choosing LARC (excluding injections) at SRHS, 2014-2021, Bristol, North Somerset, South Gloucestershire, BNSSG and England (OHID)

By comparison, while more over-25s choose LARC overall, the increase in over-25s choosing LARC (excluding injections) in SRHS has been more modest (figure 5.37).

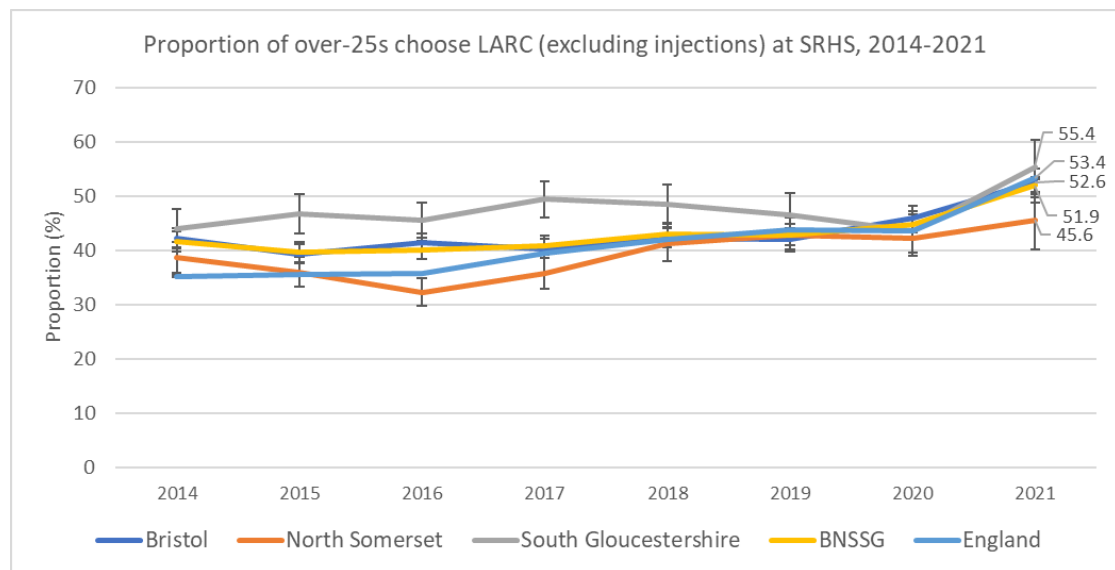


Figure 5.37: Proportion of over-25s choosing LARC (excluding injections) at SRHS, 2014-2021, Bristol, North Somerset, South Gloucestershire, BNSSG and England (OHID)

Although there has been an increase in the percentage of under- and over-25s taking up LARC (excluding injections) between 2020 and 2021 across BNSSG, the actual number of women taking up LARC (excluding injections) has fallen from 1,115 to 1,075 (-4%) in under-25s, and from 1,270 to 1,080 (-15%) in over-25s (see figure 5.38 below). As has the number of women accessing SRHS for contraceptive purposes in BNSSG, from 3,595 to 2,930 (-19%) in under-25s, and from 2,840 to 2,080 (-27%) in over-25s.

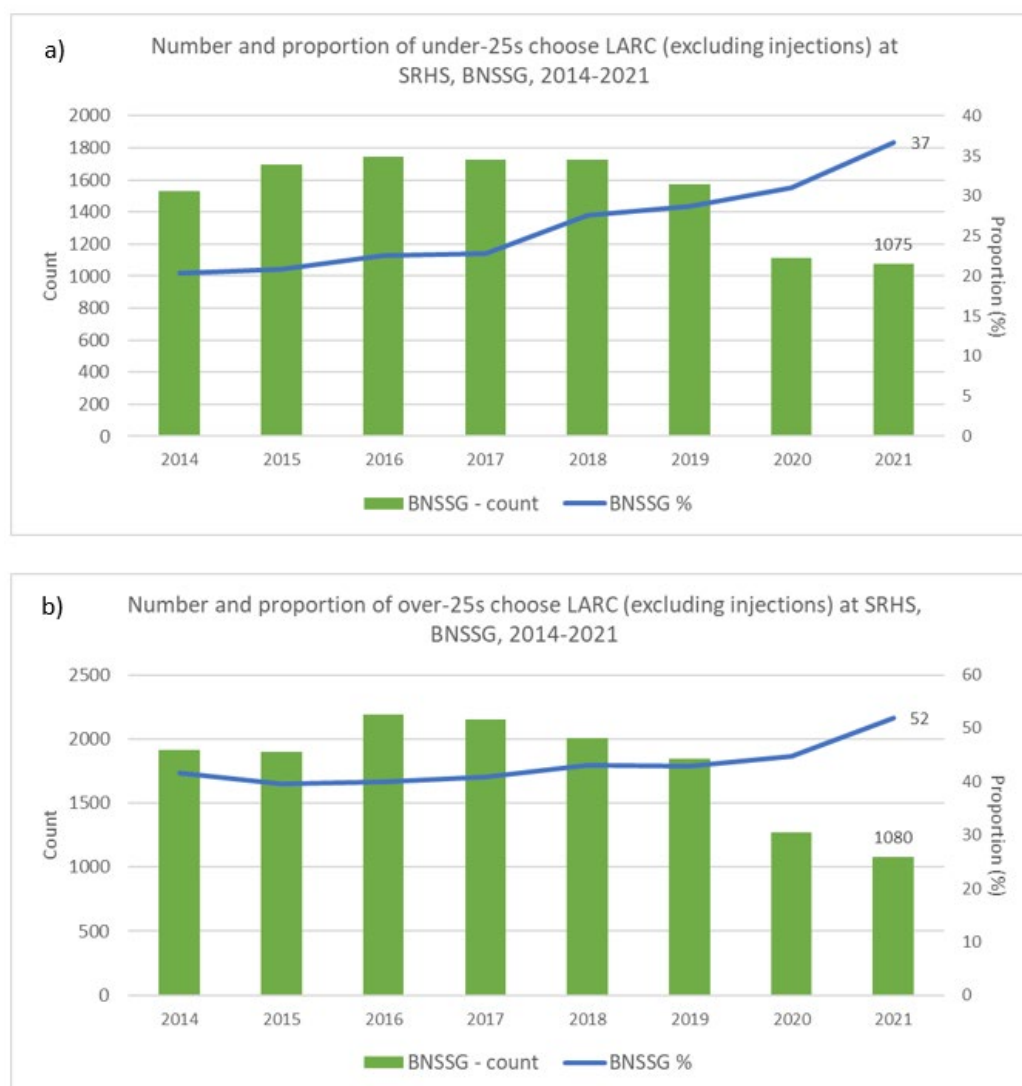


Figure 5.38: Number and proportion of women a) under-25 and b) over-25 choosing LARC (excluding injections) at SRHS, BNSSG, 2014-2021

LARC provision at Unity

Local BNSSG data from Unity for 2021-22 suggest the proportion choosing LARC may still be increasing, with 49% of under-25s and 69% of over-25s choosing LARC. It is important to remember that the local data is not directly comparable with national data as the contraceptive injection is included. Of interest, the proportion of LARCs provided to under-25s within the service in 2021-22 as a proportion of all main method contraceptives is particularly high in North Somerset at 53%, but this should be interpreted with caution given small numbers and the inclusion of injections, as previously mentioned.

The under-25s service provided by Brook saw 935 children and young people in 2021-22 for contraception provision, of which 39% was LARC. This service is available to all BNSSG residents but is based in Bristol. The discrepancy may be due to fewer LARC fitters available at the service to cover the surrounding areas.

No national data is collected on ethnicity and LARC fits. Regionally, data was collected and will be discussed in section [5.4.1.6](#).

5.3.1.4 Emergency contraception

Emergency contraception (EC) allows people to prevent unwanted pregnancy after having unprotected sexual intercourse (UPSI), for those not on contraception, or where contraception has failed. Emergency contraception use can be an indicator of high-risk sex (no ongoing contraception/barrier use, multiple partners) and is associated with several risk factors for unplanned pregnancy.²²⁹

There are two main types of EC, emergency hormonal contraceptives (EHC) and the copper coil (cuIUD). The highest risk of conception from UPSI is in the 6 days up to and including the day of ovulation, with a 30% pregnancy risk. However, real-world estimations of this high-risk time are imprecise, and therefore the FSRH recommends that people are offered EC at any point in their cycle after UPSI.²³⁰

Importantly, it is recommended that anyone seeking EC be offered and assessed for a cuIUD²³¹, as this is the most effective method.²³² However, as a medical device requiring a minor procedure performed by a specialist, there are issues with access, as with other LARC. The procedure is most commonly provided by SRHS. NICE and FSRH state those providing EHC alone should have knowledge of their local SRHS and referral pathway to enable rapid referrals for any woman requiring an emergency cuIUD.

Nationally, in 2021-22 there were 32% fewer emergency contraceptive items provided by SRH services compared to 2019-20, and over the last ten years there has been a steady decline in the number of emergency contraception items provided by both SRHS and at other locations in the community.²³³ The most common type of EC provided in SRHS in England in 2021-22 continues to be EHC. The proportion of cuIUD stayed stable at 14%, although this has increased over the years from 5% in 2014-15.²³⁴

National Survey of Sexual Attitudes and Lifestyles (NATSAL) studies look at sexual behaviour trends across Britain. Between 2000 (NATSAL 2) and 2010 (NATSAL 3), there was an increase in EC use, most significantly among those buying it from retail outlets (pharmacy over the counter) rather than clinical settings (including pharmacy prescription). Changes in the law

²²⁹ Black, K. I., Geary, R., French, R., Leefe, N., Mercer, C. H., Glasier, A., Macdowall, W., Gibson, L., Datta, J., Palmer, M., & Wellings, K. (2016). Trends in the use of emergency contraception in Britain: evidence from the second and third National Surveys of Sexual Attitudes and Lifestyles. *BJOG : an international journal of obstetrics and gynaecology*, 123(10), 1600–1607. <https://doi.org/10.1111/1471-0528.14131>.

²³⁰ [FSRH Clinical Guideline: Emergency Contraception \(March 2017, amended December 2020\) - Faculty of Sexual and Reproductive Healthcare](#)

²³¹ [Quality statement 2: Emergency contraception | Contraception | Quality standards | NICE](#)

²³² [FSRH Clinical Guideline: Emergency Contraception \(March 2017, amended December 2020\) - Faculty of Sexual and Reproductive Healthcare](#)

²³³ [Sexual and Reproductive Health Services, England \(Contraception\) 2021/22 - NDRS \(digital.nhs.uk\)](#)

²³⁴ [Part 3: Emergency contraception - NHS Digital](#) (published 23/09/2021)

in 2001 allowed EHC to be provided without prescription to those aged 16 and above.²³⁵ No data is available for retail sales to see if there has been an increasing trend that may explain the decrease in prescriptions.

EC prescribing at SRHS differs according to age (figure 5.39). In England in 2021-22, EC prescribing in under-25s was higher than over 25s, with the highest in 18-19 year olds at 8/1,000 followed by 7/1,000 in 20-24 year olds. This compared to 4/1,000 in 25-34 year olds and 1/1,000 in 35-44 year olds. However, the rate of EC prescriptions to under-16s (and proportion of under-16s as a total of the whole) has dropped over the decade. In 2010-11 there were 14,490 items prescribed to under-16s in SRHS (10% of all EC prescribed), in 2021-22 there were 1,671 items prescribed (3% of all EC prescribed). This trend may be due to better access to effective education or contraception use but may also indicate a preference among young people today to access EC in the community, such as in pharmacies, or even online.

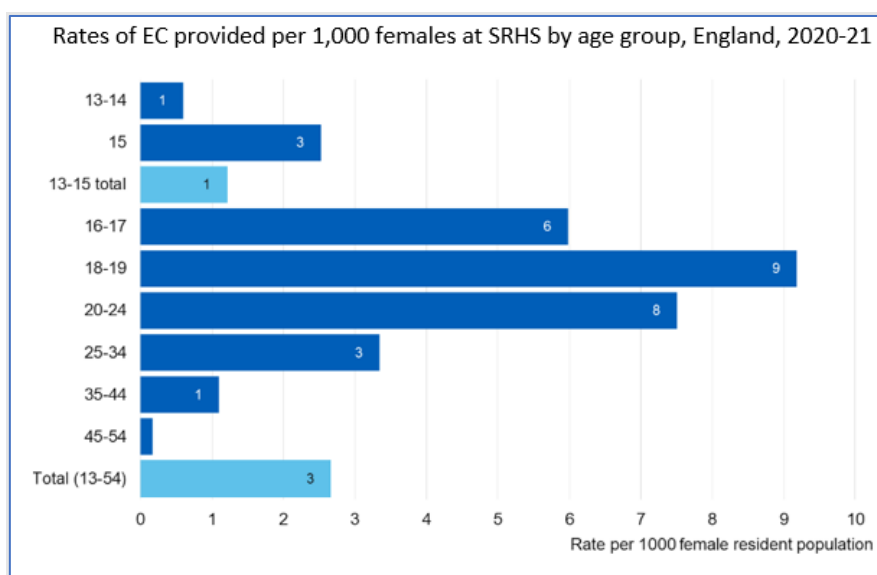


Figure 5.39 Rates of EC provided per 1,000 females at SRHS by age group, England, 2020-21 (NHS SRHAD)

The type of EC a patient receives at SRHS also differs with age. For example in England in 2021-22, 7% of under-18s were provided with a cuIUD compared to 17% of 25+ year olds. This has increased in both categories over time, from 1% of under-18s compared to 11% of over-25s in 2014/15. These trends are broadly in line with age and time trends for LARC in general (see section 5.4.1.3 above).

There is limited national data on EC prescription by deprivation decile. With an approximate sample size of 1,400, the 2021-22 SRHAD data for 13-15-year-olds seeking emergency contraception showed that those in the most deprived regions were twice as likely to be provided EC than those in the least: 2/1,000 in the most deprived deciles compared to

²³⁵ Black, K. I., Geary, R., French, R., Leefe, N., Mercer, C. H., Glasier, A., Macdowall, W., Gibson, L., Datta, J., Palmer, M., & Wellings, K. (2016). Trends in the use of emergency contraception in Britain: evidence from the second and third National Surveys of Sexual Attitudes and Lifestyles. *BJOG : an international journal of obstetrics and gynaecology*, 123(10), 1600–1607. <https://doi.org/10.1111/1471-0528.14131>

1/1,000 in the least deprived deciles.²³⁶ This association has been more pronounced in previous years, for example in 2017-18, the rate of EC prescription was 8/1,000 in IMD 1 compared to 2/1,000 in IMD 10 and suggests that the number of 13-15 year olds seeking emergency contraception at SRHS has fallen in that time. This may be an actual decrease in 13-15 year olds living in the most deprived areas needing to access EC, or it may be that this cohort is not accessing EC at SRHS or at all.²³⁷

In BNSSG, Bristol is the highest provider of EC in SRHS at 3/1,000 females aged 16-54 in 2021-22, just above the England rate of 2.8/1,000, which is in-keeping with a younger population. North Somerset has a rate of 2/1,000 and South Gloucestershire 1/1,000. Apart from South Gloucestershire, whose rate has stayed low and stable since 2014-15, Bristol and North Somerset have mirrored the England average in having a falling trend in EC provided by SRHS.

In 2021-22, across BNSSG SRHS and primary care settings, EC was provided on 7,893 occasions. Most EC was provided by pharmacies, a total of 5,626 items across BNSSG. In contrast, in 2020-21 Unity provided EC to 595 individuals, of which 27% were for the IUD. This increased to 40% in 2021/2. The increase between these two years may be due to the easing of COVID-19 restrictions, allowing more face-to-face procedures. BNSSG GPs provided EC to 1,672 patients in 2021-22. It was not possible to break this data down by age group or type of EC.

There was variation in the proportion provided with IUDs according to council resident address, age, IMD decile and ethnicity. According to Unity data, a greater proportion (43.4%, 197 people) of those living in Bristol (when compared to North Somerset's and South Gloucestershire's data) who attended Unity for EC accepted an emergency IUD. In contrast, 26.0% (26 people) of those living in North Somerset and accessing EC at Unity accepted an emergency IUD, and 34.8% (31 people) of those living in South Gloucestershire. At a BNSSG level, those under 25 (31%) were less likely to receive an IUD than those over 25 (42%), which was most pronounced in South Gloucestershire at a local level (29% compared to 53%). However, in Bristol, under 25s were more likely to receive an IUD than over 25s (45% compared to 39%). There was also a stark difference in prescribing patterns between different IMD groups. Those from the most deprived areas (IMD 1-2) received an IUD 27% of the time whilst for those in the least deprived areas (IMD 9-10) it was 55%. This was most pronounced in Bristol (26% vs 69%). There were 28 of 150 (19%) women who described themselves as an ethnicity other than White British/Irish seeking EC and received an IUD, compared to 113 of 350 (33%) women that described themselves as White British/Irish. The denominators for North Somerset and South Gloucestershire, and for IMD 1-2 were small and therefore should be interpreted with caution for these groups.

²³⁶ [Part 3: Emergency contraception - NHS Digital](#) (published 23/09/2021)

²³⁷ [Part 3: Emergency contraception - NHS Digital](#) (published 23/09/2021)

The variation seen here between councils may be secondary to the location of the service's main clinic in central Bristol. Only this site is able to run emergency IUD services across the working week during standard working hours (9am to 5pm). Those living elsewhere may not be able to travel or not have been considered for referral. Differences according to age fit with patterns seen nationally around age and choice of LARC but it is encouraging that IUD is being offered and taken up more frequently, in all age groups, over time. More research is needed into the role of deprivation and ethnicity on choice of contraceptives including emergency methods.

GP EHC prescribing (data for emergency IUD fits was unavailable) can be compared by historic CCG using open access data. BNSSG is in the upper third of GP prescribers of EHC in England, see figure 5.40. Local data provided to the commissioners for 2021-22 from individual practices shows variation in EHC prescribing across age groups and location.

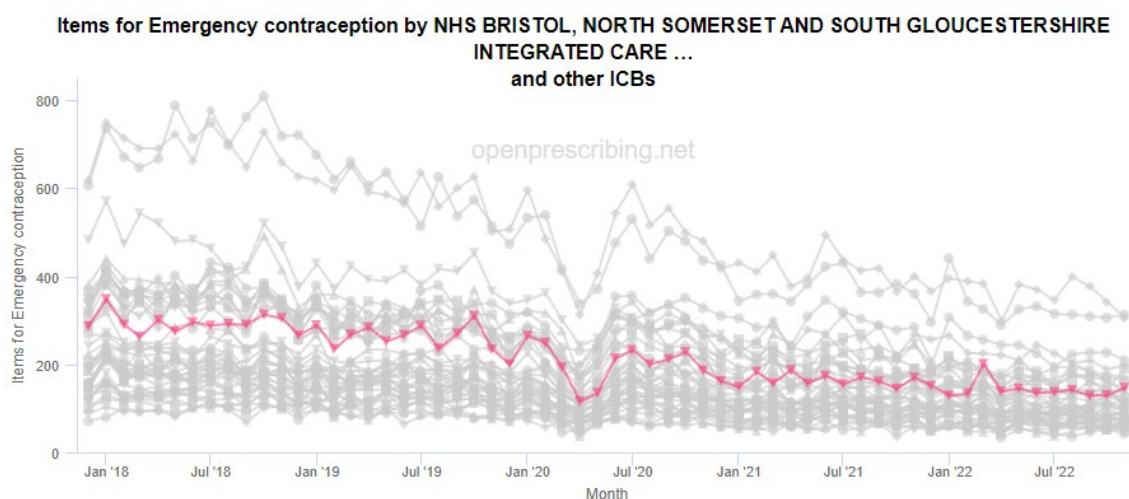


Figure 5.40: Individual EC items prescribed by GPs in the historic BNSSG CCG area (now ICB), compared with all England CCGs (ICBs), 2018-22 (Open Prescribing²³⁸)

In 2021-22 there were a total of 1,672 EC items prescribed by BNSSG GPs, of which 66% were for over-25s and 34% were for under-25s. Although different indicators are used in GP and SRHS, the strong association between young age and EC is not seen in our GP practices, which suggests that GP surgeries are not the most common place that young people chose to access EC.

Locally the link between deprivation and increased prescription of EHC is not clear. There were a total of 5 practices who prescribed 50 or more items over the year and, of these, 4 were also the top 5 prescribers to under-25s. There were a total of 16 practices who prescribed 10 or less items, 5 of which prescribed no EHC to under-25s over the year. The top prescribing practices had an average IMD decile of 4, whilst the lowest prescribers had an IMD decile of 6. Note, however, that there was a spread across the groups. Three of 7 lowest prescribing Bristol practices were in IMD deciles 1-2 while 5 of 8 lowest prescribing

²³⁸ [Analyse | OpenPrescribing](#)

South Gloucestershire practices were in IMD deciles 8-10.²³⁹ Given that emergency contraception use is associated with high-risk sex and may be associated with deprivation, it would be hoped that higher prescribing would occur in areas of high deprivation, but the BNSSG GP EHC activity data discussed above gives mixed results.²⁴⁰

In BNSSG there are 168 pharmacies, of which 161 (95.8%) are accredited to provide under-25s with free EHC following a PGD. The following data for BNSSG have been collated from PharmOutcomes.²⁴¹ In 2021-22, a total of 5,626 EHC consultations took place within BNSSG pharmacies, with 73% occurring in Bristol, 6% in North Somerset and 21% in South Gloucestershire. The vast majority (5,558, 99%) were with young people aged 15-24 years old. There were a small number of consultations with young people under the age 15 years (29, 0.5%), and those aged 25 years and above (39, 0.7%), the latter of which are at the discretion of the pharmacist.

Across BNSSG pharmacies, the most commonly recorded ethnic group for EHC consultations in 2021-22 was White (including White British, White Irish and White Other) at 3,780 times (67%), followed by 'not stated' or 'prefer not to say' at 1,064 times (19%). In contrast, a non-White ethnicity (including all Black, Mixed, Asian and other ethnicities) was recorded 782 times (14%), of which the vast majority were recorded in Bristol. In Bristol alone, 15% of total consultations were completed with people of a non-White ethnicity, which is lower than the proportion of the Bristol population that is non-White, which is 19%. This indicates that there is an underrepresentation of non-White ethnicities accessing EHC through pharmacies in Bristol, however in the NATSAL studies, women identifying as Asian (NATSAL 2) and Black/other (NATSAL 3) were the greatest users of EC.²⁴²

Across BNSSG pharmacies in 2021-22, 10% of people attending for an EHC consultation were referred for an emergency IUD via a referral pathway into Unity, although this varied across council areas: Bristol 11%; North Somerset 4%; South Gloucestershire 7%. In 97% of attendances a full consultation had taken place including signposting to future contraception by way of a generic national leaflet, and in 98% of cases EHC was issued. This should be contrasted with findings of a national mystery shopper study in 2021, which found that 20% of attendees were not provided with contraception due to lack of available trained staff to provide the consultation, and less than half (49%) of those receiving EC were

²³⁹ Internal analysis

²⁴⁰ [Part 3: Emergency contraception - NHS Digital](#)

²⁴¹ [Home Page - PharmOutcomes](#)

²⁴² Black, K. I., Geary, R., French, R., Leefe, N., Mercer, C. H., Glasier, A., Macdowall, W., Gibson, L., Datta, J., Palmer, M., & Wellings, K. (2016). Trends in the use of emergency contraception in Britain: evidence from the second and third National Surveys of Sexual Attitudes and Lifestyles. *BJOG : an international journal of obstetrics and gynaecology*, 123(10), 1600–1607. <https://doi.org/10.1111/1471-0528.14131>

Wayal, S., Hughes, G., Sonnenberg, P., Mohammed, H., Copas, A. J., Gerressu, M., Tanton, C., Furegato, M., & Mercer, C. H. (2017). Ethnic variations in sexual behaviours and sexual health markers: findings from the third British National Survey of Sexual Attitudes and Lifestyles (Natsal-3). *The Lancet. Public health*, 2(10), e458–e472. [https://doi.org/10.1016/S2468-2667\(17\)30159-7](https://doi.org/10.1016/S2468-2667(17)30159-7)

signposted to ongoing contraception.²⁴³ Similar anecdotal concerns have been raised post-COVID-19 in the SW region.

Finally, pharmacy data provides an insight into the risk behaviours of individuals seeking EHC as, across BNSSG in 2021-22, 62% requested EHC after not using contraception and 30% after condom failure. Requests due to failure or issues with effective contraception (hormonal or LARC) were much lower at 8% combined. Furthermore, 18% had used EHC in the last 3 months, and 5% had had other UPSI in the same cycle. This emphasises the importance of this moment of care for positive health promotion strategies.

5.3.1.5 Condoms

Barrier methods are used for both STI prevention and contraception. When used consistently and correctly male (external) condoms are 98% and female (internal) condoms are 95% effective at preventing pregnancy, and both are highly effective at preventing HIV/STI transmission.²⁴⁴ Other barriers such as diaphragms and caps can be up to 96% effective at preventing pregnancy but cannot be used reliably for STI/HIV prevention.²⁴⁵ Dental dams provide protection from STIs when performing oro-anal or oro-vaginal sex but are not a contraceptive.

NATSAL 2, carried out in 2000, reported that 51% of men and 39% of women had used a male condom in the last year. Ten years later in 2010, NATSAL 3 reported 50% and 36% respectively.²⁴⁶ Promoting condom use among young people is a priority, as condom use at sexual debut is associated with ongoing condom use.^{247,248,249} The NATSAL 3 study found that 81% of male and 82% of female participants aged 16-24 used a condom at the time of heterosexual sexual debut. This figure dropped as participants' age increased, which, allowing for recall bias, may suggest that in previous years condom use at first sex was less common.²⁵⁰ Conversely, sexual competence at heterosexual debut (a combination of four factors: both partners willing, contraception use, autonomy of choice, 'right time') was less common among 16-24 year olds than older participants: 44% in 16-24-year-old males and

²⁴³ Glasier et al (2021) Emergency contraception from the pharmacy 20 years on: a mystery shopper study. *BMJ Sex Reprod Health*. 2021 Jan;47(1):55-60 [Emergency contraception from the pharmacy 20 years on: a mystery shopper study - PubMed \(nih.gov\)](#)

²⁴⁴ [UK national guideline on safer sex advice \(bashguidelines.org\)](#)

²⁴⁵ [FSRH Clinical Guideline: Barrier Methods for Contraception and STI Prevention \(August 2012, amended October 2015\) - Faculty of Sexual and Reproductive Healthcare](#) (published 01/10/2015)

²⁴⁶ www.natsal.ac.uk

²⁴⁷ Shafii T, Stovel K, Holmes K. Association between condom use at sexual debut and subsequent sexual trajectories: a longitudinal study using biomarkers. *Am J Public Health*. 2007 Jun;97(6):1090-5. doi: 10.2105/AJPH.2005.068437. Epub 2007 Apr 26. PMID: 17463388; PMCID: PMC1874201.

²⁴⁸ Lantos H, Bajos N, Moreau C. Determinants and Correlates of Preventive Behaviors at First Sex With a First Partner and Second Partner: Analysis of the FECOND Study. *J Adolesc Health*. 2016 Jun;58(6):644-51. doi: 10.1016/j.jadohealth.2016.03.006. PMID: 27210009; PMCID: PMC4914384.

²⁴⁹ Palmer MJ, Clarke L, Ploubidis GB, Mercer CH, Gibson LJ, Johnson AM, Copas AJ, Wellings K. Is "Sexual Competence" at First Heterosexual Intercourse Associated With Subsequent Sexual Health Status? *J Sex Res*. 2017 Jan;54(1):91-104. doi: 10.1080/00224499.2015.1134424. Epub 2016 Feb 18. PMID: 26891245; PMCID: PMC5214675.

²⁵⁰ www.natsal.ac.uk

56% in 45-54-year-old males, and the proportion having first sex under-16 became more common: 31% in 16-24-year-old males and 27% in 45-54-year-old males.²⁵¹

Not all those who use condoms at debut continue to use them. A 2017 YouGov survey in Britain found that 47%, and a 2021 Scottish study found that 38% of young people at the time of interview had had sex with a new partner for the first time without using a condom.^{252,253,254} Condom use as a main method of contraception by women in England has reduced from 23% in 2011-12 to 12% by 2021-22, which may be associated with an increase in more effective methods, such as LARC. Of the 12% of women reporting male condoms as their main form of contraception in 2021-22, 9% were aged under-16 and 12% were aged 35-44, compared to 17% of under-16s and 15% of 35-44-year-olds in 2017-18.²⁵⁵

NICE recommends free condom distribution schemes for young people, such as the C-Card Scheme. This consists of a co-ordinating organisation, registration sites and distribution sites. Through the co-ordinating organisation, community partners such as GPs, pharmacies, youth workers, sports venues, schools or supported living centres are provided with:

- training to deliver a brief assessment and education intervention as part of a 'registration' process for young people
- resources for distribution such as condoms (male and female), dams and lubrication, along with written materials

Registered young people can then collect condoms from distribution outlets.²⁵⁶ A PHE study of C-Card schemes in England in 2015-16 estimated that schemes were available across most of the country, with 768,992 condoms distributed during this time. The most common outlet type (30%) was community pharmacy.²⁵⁷

Although local commissioning arrangements vary, C-Card schemes target young people up to the age of 19 years, (or 24 years in some areas). In 2015-16, 3% of 15-24-year-olds, and 6% of 15-19-year-olds living in areas covered by the scheme were registered with it. Users of the C-Card scheme in 2015-16 were 49.6% male, 46.7% female, 3.7% other. It is believed that men are less likely to access SRHS, and that the community-based C-Card scheme may

²⁵¹ www.natsal.ac.uk

²⁵² [Understanding young people's use and non-use of condoms and contraception: a co-developed, mixed-methods study with 16-24 year olds in Scotland. Final report from CONUNDRUM \(CONdom and CONtraception UNDERstandings: Researching Uptake and Motivations\) - Enlighten: Publications \(gla.ac.uk\)](#) (published 03/2021)

²⁵³ [Campaign to protect young people from STIs by using condoms - GOV.UK \(www.gov.uk\)](#) (published 15/12/2017)

²⁵⁴ <https://docs.cdn.yougov.com/o1cf0eyi4f/YG-Archive-201117-Freuds.pdf> (published 17/11/2020)

²⁵⁵ [Sexual and Reproductive Health Services, England \(Contraception\) 2021/22 - NDRS \(digital.nhs.uk\)](#) (published 29/09/2022)

²⁵⁶ [C-Card condom distribution schemes - What why and how? \(brook.org.uk\)](#) (published 07/2014)

²⁵⁷ [Condom Distribution Schemes in England 2015/16 \(publishing.service.gov.uk\)](#) (updated 12/2017)

help to redress this imbalance.^{258,259} In 2015-16, the SW had the second highest number of C-Card outlets (n=855).²⁶⁰

Apart from the 2015-16 study, there is no national data available regarding condom provision including C-Card schemes. The landscape for C-Card schemes has changed since the study was conducted. A study in Scotland found that between 2015-2020 uptake of free condoms had declined.²⁶¹ Changes have been most marked due to the COVID-19 pandemic, which will be discussed further below.

In Bristol, the C-Card scheme is run by Brook, while in North Somerset and South Gloucestershire, the respective councils run the local C-Card scheme, however, the Brook service will support North Somerset and South Gloucestershire residents who attend Bristol clinics. The C-Card scheme is commissioned across BNSSG to provide free condoms to young people with a C-Card who are aged 13–19, or up to age 24 with a learning disability. The scheme also provides access to instruction on effective use of condoms and signposting to local sexual health services. Table 5.13 shows the council-level C-Card data for 2021-22. Activity across BNSSG was severely hit by COVID-19. In 2021-2, Unity reported just 416 (3.86%) young people were provided with a C-Card, which has been described as a significant decline from pre-COVID-19 levels²⁶² but this has increased noticeably in the first two quarters of 2022-23 (April to September 2022) with 309 registrations compared to 140 for the same time period in 2021-22.²⁶³

²⁵⁸ Brook, PHE (2014) C Card condom distribution schemes guidance [C-Card condom distribution schemes - What why and how - July 2014.pdf \(brook.org.uk\)](https://www.brook.org.uk/what-why-and-how/condom-distribution-schemes/)

²⁵⁹ [Condom Distribution Schemes in England 2015/16 \(publishing.service.gov.uk\)](https://www.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/304441/condom-distribution-schemes-in-england-2015-16.pdf)

²⁶⁰ [Condom Distribution Schemes in England 2015/16 \(publishing.service.gov.uk\)](https://www.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/304441/condom-distribution-schemes-in-england-2015-16.pdf)

²⁶¹ Lewis, R., Blake, C., McMellon C., Riddell J., Graham C., Mitchell K. (2021). Understanding young people's use and non-use of condoms and contraception: A co-developed, mixed-methods study with 16-24 year olds in Scotland. Final report from CONUNDRUM (CONdom and CONTRaception UNDERstandings: Researching Uptake and Motivations). MRC/CSO Social and Public Health Sciences Unit: University of Glasgow.

²⁶² Professional interview, SHNA engagement process June 2022

²⁶³ Unity performance data, 2021-22 and 2022-23 (internal)

Table 5.13: Table showing C-Card scheme data for Bristol, North Somerset and South Gloucestershire, 2021-22
(Unity / North Somerset Council / South Gloucestershire Council)

C-Card scheme data for 2021-22	Bristol		North Somerset		South Gloucestershire	
	2021-22	2022-23 (Apr-Sept)	2021-22	2022-23 (Apr-Sept)	2021-22 ²	2022-23 ³ (Apr-Sept)
Number of young people registering on to the C-Card scheme	416	309	162	89	81	28
Number of condom collections after registration on the scheme	268	160	35	15	73	44
Number of active C-card outlets (for registration & pick up, and pick up only)	154	128	4 ¹		35	41

¹ Does not include pharmacies, who report take-up through PharmOutcomes and not Therapy Audit. Includes Sirona as one active pick-up point covering all North Somerset schools.

² For South Gloucestershire's C-Card scheme, 2021-22 data does not represent activity of all providers (24 of 35 active C-Card providers due to some data being currently unavailable). The School Nursing C-Card activity data included (representing 18 schools) covers the months of November 2021 – March 2022; data was not available for April 2021 – October 2021. There is no data available from pharmacies who may have been providing condom collections.

³ For South Gloucestershire's C-Card Scheme, April to September 2022 data does not represent activity of all providers (23 of 41 active C-Card providers due to some data being currently unavailable). There is no data available from pharmacies who may have been providing condom collections.

Further to the C-Card scheme condoms are also supplied to service users attending Unity sexual health clinics, as well as free condoms by post from THT for people aged 18+ covering North Somerset and South Gloucestershire for specific groups (GBMSM, trans or non-binary, sex workers and Black, Asian and minoritised ethnic communities), while Bristol residents can collect condoms in person from various venues (including Sparta, Bear Bar, Dare 2) in the city.

In 2021-22, within Unity clinics 1,102 service users were provided with condoms, and 46,041 condoms were distributed by THT via the post and at various venues. THT's condoms by post scheme was accessed by 1,621 people in 2021-22.²⁶⁴ In BNSSG pharmacies during 2021-22, of those individuals attending for EHC 19% were also given condoms at the same time.²⁶⁵

²⁶⁴ Unity 2021-22 performance data

²⁶⁵ BNSSG pharmacy 2021-22 activity data

5.3.1.6 Are we addressing inequalities?

The 'Variation in outcomes in sexual and reproductive health in England' PHE toolkit recommends focusing on the indicator 'total prescribed LARC rate' as a measure of good access to contraception to address inequality.²⁶⁶ BNSSG and each of its councils are well above the England rate and, therefore, access to contraception is considered adequate. However, there is significant between-area and within-area variation. Key examples are:

- lower LARC prescribing rate and longer waits in South Gloucestershire
- lower proportions of young people choosing LARC in North Somerset
- greater proportions of IUD provided as emergency contraception in Bristol than elsewhere.

In the South West region, some data is available on the ethnicity of those accessing contraception. Within SRHS, among ethnicities other than White British/Irish, LARC formed a slightly higher proportion of all contraception provided. After White British/Irish and not disclosed, Asian/Asian British and mixed heritage were the highest users of EC by ethnicity.

Other domains recommended in the PHE document as indicative of a system addressing inequalities are active promotion strategies and post-pregnancy contraception, which will be covered in the abortion care section. More local and national data is needed to assess our impact on addressing inequalities within contraceptive care.

5.3.1.7 Impact of COVID-19 and recovery on contraception

During the COVID-19 pandemic lockdowns in 2020 and 2021, access to contraception was severely limited across the country²⁶⁷, and almost all contraceptive indicators showed a steep decline. Additionally, mode of delivery rapidly changed, with most services switching to an appointment-only system with telephone triage, and in some cases, completely remote services with posting out or collection of medication.²⁶⁸ This may have led to a slight increase in the use of user-dependent methods that could be dispensed by post, or LARC requiring lower-intensity clinical interaction (injection). This effect was pronounced in North Somerset.

LARC

The total LARC prescribing rate dropped significantly in England to 35/1,000 in 2020 from 51/1,000 in 2019, recovering slightly in 2021 to 42/1,000. In the first quarter of 2020-21, OHID reported that England LARC rates fell by 80%, whilst over the whole year there was a

²⁶⁶ PHE 2021 Variation in outcomes in sexual and reproductive health in England. A toolkit to explore inequalities at a local level. [Variation in outcomes in sexual and reproductive health in England 2021 \(publishing.service.gov.uk\)](https://www.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/98444/variation-in-outcomes-in-sexual-and-reproductive-health-in-england-2021-appg-full-report-4-1.pdf)

²⁶⁷ [appg-full-report-4 \(1\).pdf](https://www.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/98444/variation-in-outcomes-in-sexual-and-reproductive-health-in-england-2021-appg-full-report-4-1.pdf)

²⁶⁸ Hammond N, Steels S, King G. Contraceptive and pregnancy concerns in the UK during the first COVID-19 lockdown: A rapid study. Sex Reprod Healthc. 2022 Jul 9;33:100754. doi: 10.1016/j.srhc.2022.100754. Epub ahead of print. PMID: 35842979; PMCID: PMC9270775.

33% decline in GP-prescribed LARC, and a 36% decline in SRHS-prescribed LARC.²⁶⁹ As of February 2022, there was an estimated backlog of 200,000 LARC procedures nationally.²⁷⁰ There is some evidence to suggest that access was worst in rural areas.²⁷¹ This is thought to reflect dramatic reduction in access to services providing the procedures, and other contraceptive services. Despite the lower rate of LARC provision in 2020, the proportion of users attending SRHS choosing LARC (both under- and over-25s) increased – in BNSSG from 29% to 31% in under 25s between 2019 and 2020. However, as described previously, the total number of women under 25 and over 25 attending SRHS and going on to choose LARC in BNSSG has actually decreased.

Within BNSSG, prior to COVID-19, LARC prescribing rates for women aged 15-44 were consistently higher than England and nearest neighbours averages, which was due to high prescribing within general practices. Prescribing dropped during national lockdowns but remained above national average, and rates dropped less dramatically. For example, a BNSSG-wide LARC audit of GP prescriptions in 2020-21 documented a 25% decrease in coils and a 27% decrease in implants fitted during 2020-21 when compared with the previous year.²⁷²

National LARC recovery strategies focus on improving access in primary care, and LARC prescribing performance for a region is dependent on primary care provision. In BNSSG, GP data suggests good recovery, with North Somerset reporting 101% of expected IUCD insertion activity in 2021/22, Bristol reporting 93% of total LARC insertions when compared to pre-COVID-19 levels, and South Gloucestershire estimated to reach 104% of LARC insertion activity seen in 2021-22 in 2022-23.²⁷³ This recovery isn't necessarily equal across all areas however. Primary Care Network models are being explored and promoted as a way to improve and increase access to LARC in the community.^{274,275}

Emergency contraception and condoms

Nationally, EC provision dropped between 2019-20 and 2020-21 by 44% at SRHS, and by 18% in primary care²⁷⁶. Calls to a free PHE helpline for people struggling to access to emergency contraception rapidly rose during the lockdowns.²⁷⁷ In BNSSG, provision of EC

²⁶⁹ Advisory Group on Contraception. Securing sustainability: Access to contraception during and after Covid-19 [AGC-Securing-sustainability-briefing.pdf \(theagc.org.uk\)](#) accessed 1/7/22

²⁷⁰ All Party Parliamentary Group on Sexual and Reproductive Health (2022) 'Addressing the backlog in LARC and future-proofing access'. Personal notes from seminar

²⁷¹ [Women's reproductive health programme: progress, products and next steps - GOV.UK \(www.gov.uk\)](#)

²⁷² Internal analysis

²⁷³ Internal analysis

²⁷⁴ All Party Parliamentary Group on Sexual and Reproductive Health (2022) 'Addressing the backlog in LARC and future-proofing access'. Personal notes from seminar

²⁷⁵ DHSC 2022. Women's Health Strategy for England [Women's Health Strategy for England - GOV.UK \(www.gov.uk\)](#) accessed 8/8/2022

²⁷⁶ [Part 3: Emergency contraception - NHS Digital](#)

²⁷⁷ [Women's reproductive health programme: progress, products and next steps - GOV.UK \(www.gov.uk\)](#)

also fell. Additionally, the proportion of cIUD provided as a total of all EC was lower in 2020-21 than 2021-22 (however no data from previous years was available).

There is evidence to suggest that the COVID-19 pandemic and lockdowns have changed the landscape significantly regarding condom distribution schemes for young people. A study in Scotland found that 46% of respondents in a 2021 study did not know where to access free condoms. The study found that young people now prefer online services for ordering condoms, with minimal face to face contact, noting ‘embarrassment about face-to-face interactions’, among other barriers.²⁷⁸ Given the large number of young people entering their teenage years during the pandemic, where remote interactions and online ordering were the norm, this shift may be relevant for planning future condom distribution services going forward. In BNSSG, although data was not available to make pre/post-covid comparisons, C-Card activity is anecdotally reported to have dramatically decreased.

5.3.1.8 Evidence of what works to increase uptake and access to contraception

The Women’s Health Strategy for England, NICE guidelines and FSRH guidelines all emphasise the importance of access to information and the full choice of contraceptive methods, especially LARC.

The Women's Health Strategy for England stresses the importance of improving women’s experiences of seeking contraception and having devices fitted, including better pain management. It also sets the intention to see more integrated women’s health services so that contraception can be provided at the same time as gynaecological assessments for menstrual problems or menopause care, or after pregnancy. Contraception, especially LARC is highly cost effective . The return on investment of post-partum contraception in maternity settings is particularly strong: £32 is saved for every £1 invested in postpartum contraception, compared to a £9 saving for overall contraceptive investment.²⁷⁹

The APPG on Sexual and Reproductive Health gives more detail on women’s health hubs and a primary care network model for LARC delivery alongside emergency contraception, menstrual health care and menopause care. It emphasises the importance of co-commissioning and learning lessons from COVID-19 around innovative and collaborative service delivery, and disaster preparedness.^{280,281,282}

²⁷⁸ Lewis, R., Blake, C., McMellon C., Riddell J., Graham C., Mitchell K. (2021). Understanding young people’s use and non-use of condoms and contraception: A co-developed, mixed-methods study with 16-24 year olds in Scotland. Final report from CONUNDRUM (CONdom and CONTRaception UNDERstandings: Researching Uptake and Motivations). MRC/CSO Social and Public Health Sciences Unit: University of Glasgow.

²⁷⁹ [Contraception: Return on Investment \(ROI\) report \(publishing.service.gov.uk\)](https://publishing.service.gov.uk)

²⁸⁰ <https://www.fsrh.org/documents/full-report-december-womens-lives-womens-rights/>

²⁸¹ [APPG SRH meeting summary - July 2022 - Faculty of Sexual and Reproductive Healthcare \(fsrh.org\)](https://www.fsrh.org/documents/full-report-december-womens-lives-womens-rights/)

²⁸² Hammond N, Steels S, King G. Contraceptive and pregnancy concerns in the UK during the first COVID-19 lockdown: A rapid study. Sex Reprod Healthc. 2022 Jul 9;33:100754. doi: 10.1016/j.srhc.2022.100754. Epub ahead of print. PMID: 35842979; PMCID: PMC9270775.

There are a number of FSRH guidelines that outline steps to improve contraceptive access. The Hatfield Vision recommends that the NHS and ICS are mandated to collaboratively commission SRHS with local authorities in order to address inequalities in access to contraceptives for marginalised groups.²⁸³ ‘Teletriage for sexual and reproductive health’ brought together learning about remote SRH services, including a focus on safeguarding.²⁸⁴ ‘Contraception for young people’ highlights the benefits of LARC in reducing the impact of non-adherence, discontinuation and issues with access for repeat attendance, which are particular issues for young people.²⁸⁵ Finally, emergency contraception guidelines recommend that providers of EC always inform patients that the IUD is the most effective method, and have clear pathways into services providing IUD fits. Providers must also give information regarding ongoing contraception, and if unable to provide this, signpost the patient to local services.²⁸⁶

NICE have also produced a range of guidelines around contraception, including ‘Long-acting reversible contraception’ (CG30)²⁸⁷, which provides guidance on LARC including implants and coils. It also emphasises the importance of offering all methods of contraception, and where these are not immediately available, offering ‘bridging methods’ until a preferred method can be arranged. ‘Contraceptive services for under 25s’ (PH51)²⁸⁸ recommends universal and inclusive services, balanced with tailored support and outreach for those experiencing social disadvantage. In relation to condoms, ‘Reducing sexually transmitted infections’ (NG221) recommends that providers adopt a sex-positive, identity-positive approach in their condom interventions²⁸⁹, and ‘Sexually transmitted infections: condom distribution schemes’ (NG68) recommends the use of a range of condom distribution schemes in different settings to reach different groups, summarised in Table 5.14.²⁹⁰

²⁸³ [FSRH Hatfield Vision July 2022 - Faculty of Sexual and Reproductive Healthcare](#)

²⁸⁴ [Teletriage for Sexual and Reproductive Healthcare Services in Response to COVID-19: Triage Integration Considerations to Prioritise Vulnerable Groups - Faculty of Sexual and Reproductive Healthcare \(fsrh.org\)](#)

²⁸⁵ [FSRH Clinical Guideline: Contraceptive Choices for Young People \(March 2010, amended May 2019\) - Faculty of Sexual and Reproductive Healthcare](#) (published 01/05/2019)

²⁸⁶ [Emergency Contraception - Faculty of Sexual and Reproductive Healthcare \(fsrh.org\)](#)

²⁸⁷ [Overview | Long-acting reversible contraception | Guidance | NICE](#) (updated 02/07/2019)

²⁸⁸ [Overview | Contraceptive services for under 25s | Guidance | NICE](#) (published 26/03/2014)

²⁸⁹ [Overview | Reducing sexually transmitted infections | Guidance | NICE](#) (published 15/06/2022)

²⁹⁰ [Overview | Sexually transmitted infections: condom distribution schemes | Guidance | NICE](#) (published 06/04/2017)

Table 5.14: Comparison of condom distribution schemes recommended by NICE (NG68)

	Multi-component schemes	Single component schemes	Cost price schemes
Includes	Free condoms, lube, information, support	Free condoms +- lube	Cost-price condoms +- lube
		NICE recommends provision alongside written health information and links to local services	
Recommended for	Under 18s Consider for under 25s	Reaching high-risk groups e.g. commercial sex venues, sexual health charities, universities	Websites for the general public May help tackle inequality of access for some groups e.g. rural, those facing stigma
Cost effective for	Under 25s	GBMSM Black Africans	May be cost effective if schemes very low cost

5.3.1.9 Issues identified

The issues below have been identified following a review of the contraception outcome data for BNSSG.

Impacts of COVID-19

1. The impact of COVID-19 is likely to have been greater on those from marginalised groups, who may be more likely to access walk-in and specialist services than booked appointments and may not approach GPs for contraceptive help.
2. The recovery of GP LARC and EC services following COVID-19 is still underway and limiting community access to contraceptive services in some parts of BNSSG.

Funding and data

3. There are differences in the funding of GP LARC services across the three councils in BNSSG, which may be incentivising some and disincentivising other GP practices to offer LARC, creating an inequality in provision.
4. There is limited demographic data collected nationally on contraceptive outcomes, with nothing available on ethnicity, sexual or gender identity, disability, or inclusion health groups.
5. Based on the data reviewed above, it is not clear what the barriers and enablers are to accessing community contraceptive services in BNSSG.
6. We have not got data from practices broken down by different demographics to better understand inequalities of LARC provision.

Inequalities in LARC access

7. Data for 2021 show that the rate of total prescribed LARC is recovering across BNSSG but has not yet reached pre-COVID levels.

8. BNSSG GP prescribing is very high compared to SRHS prescribing, especially in rural North Somerset (more than 15 times higher).
9. The number of women accessing SRHS for contraceptive purposes in BNSSG has fallen by 19% in under-25s, and by 27% in over-25s.
10. There has been an increase in the percentage of under- and over-25s attending SRHS for contraception choosing LARC (excluding injections) between 2020 and 2021 across BNSSG, however the actual number of women taking up LARC (excluding injections) has fallen by 4% in under-25s, and by 15% in over-25s.
11. There are fewer attendances at SRHS from people living in the most deprived parts of North Somerset and South Gloucestershire which suggests inequalities in access.
12. Longer waiting times were reported for LARC in South Gloucestershire in the 2020-21 BNSSG GP LARC audit, for which there is no national standard to benchmark against.
13. Local data suggests that those practices at 60% or less of pre-COVID activity are in more deprived areas.
14. There are low rates of LARC uptake at young people specific services run by Brook.
15. Post-partum LARC is not routinely commissioned. The results of an evaluation of a pilot project at both acute hospitals need to be considered.

Inequalities in EC access

16. EHC prescriptions for free EHC have significantly fallen over the last several years – we need to understand the causes of this.
17. 18% of people receiving a consultation for EHC at a BNSSG pharmacy in 2021-22 had received EHC in the previous three months.
18. Outside of Bristol, GP practices provide more EHC to those from more deprived areas.
19. There are greater proportions of IUDs provided as emergency contraception in Bristol than elsewhere in BNSSG possibly due to easier physical access to the Unity Central clinic.
20. Access to emergency IUDs is worse in more rural areas outside of Bristol, more deprived areas, and for non-White British/Irish ethnicities.
21. Community services may not be reaching the most vulnerable members of the population by age in terms of GP EC provision.

Access to condoms

22. Issuing of condoms across community and SRH services, and through the C-Card scheme, has decreased significantly across BNSSG.
23. Evidence suggests that an online condom offer may be preferable for young people.
24. A low proportion of condoms are given out at EHC consultations in pharmacies.

5.3.2 Unplanned pregnancies and abortion

5.3.2.1 Unplanned pregnancies

Unplanned pregnancies can end in maternity, miscarriage or abortion. Many unplanned pregnancies that continue will become wanted. However, unplanned pregnancy can cause financial, housing and relationship pressures, negative health impacts and have impacts on existing children. Restricting access to contraceptive provision can therefore be counterproductive and ultimately increase costs. Contraception is highly cost-effective and a key part of preventing unplanned pregnancies

A planned pregnancy is likely to be a healthier one, as unplanned pregnancies represent a missed opportunity to optimise pre-pregnancy health. A PHE report in 2018 stated that 45% of pregnancies and one third of births in England are unplanned or associated with feelings of ambivalence.²⁹¹

Prevalence of unplanned pregnancies is also strongly associated with lower educational attainment, current smoking, recent drug use, lack of sexual competence at first sex and with receiving sex education mainly from sources other than school, supporting the importance of the recent statutory RSHE requirement for all schools in England.²⁹²

5.3.2.2 Under-18s conceptions

Teenage pregnancy is a cause and consequence of education and health inequality for young parents and their children. Babies born to mothers under 20 years old have a 75% higher rate of infant mortality and a 30% higher rate of low birthweight than average. Children born to teenage mothers have a 63% higher risk of living in poverty (see figure 5.41), and at age five are more likely to have developmental delay on verbal ability.²⁹³

Teenage mothers are more likely than other young people to not be in education, employment or training. By the age of 30 years, teenage mothers are 22% more likely to be living in poverty than mothers giving birth aged 24 years or over. Young fathers are twice as likely to be unemployed aged 30 years, even after taking account of deprivation. Child poverty and unemployment are the two area deprivation indicators with the strongest influence on under-18 conception rates.²⁹⁴

²⁹¹ [Health matters: reproductive health and pregnancy planning - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/publications/health-matters-reproductive-health-and-pregnancy-planning) (published 26/06/2018)

²⁹² [UKHSA summary profile of local authority sexual health \(published 27/01/2022\)](https://www.ukhsa.gov.uk/data-and-evidence/summary-profiles/summary-profile-of-local-authority-sexual-health)

²⁹³ [Good progress but more to do: Teenage pregnancy and young parents \(local.gov.uk\)](https://www.local.gov.uk/government/publications/good-progress-but-more-to-do-teenage-pregnancy-and-young-parents) (published 30/05/2018)

²⁹⁴ [Variation in outcomes in sexual and reproductive health in England 2021 \(publishing.service.gov.uk\)](https://publishing.service.gov.uk/government/publications/variation-in-outcomes-in-sexual-and-reproductive-health-in-england-2021) (published 12/05/2021)

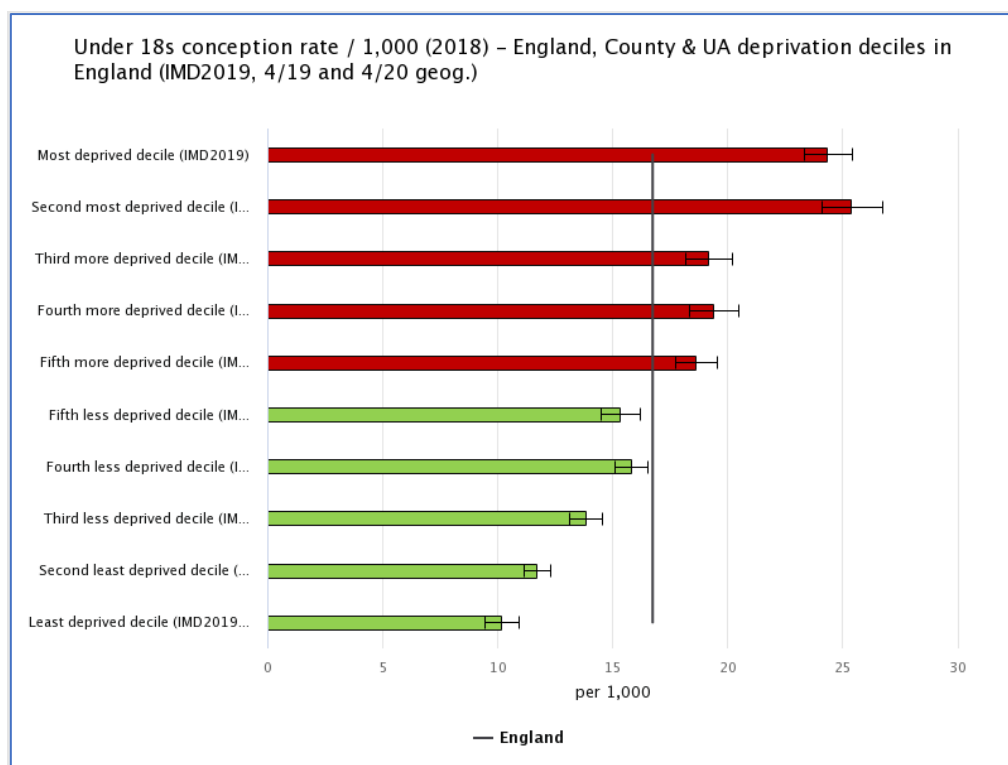


Figure 5.41: Under 18s conception rate per 1,000 by deprivation decile, England (OHID 2022)

Since the introduction of the Teenage Pregnancy Strategy in 1999, England has achieved a 72% reduction in the under-18 conception rate between 1998 and 2021. This reduction is clear to see in figure 5.42 below, which also shows that BNSSG’s under-18 conception rate per 1,000 females aged 15-17 years old has decreased from 42.6 per 1,000 in 1998 (580 conceptions) to 9.6 per 1,000 in 2020 (138 conceptions) and has been lower than the England average since 2011.

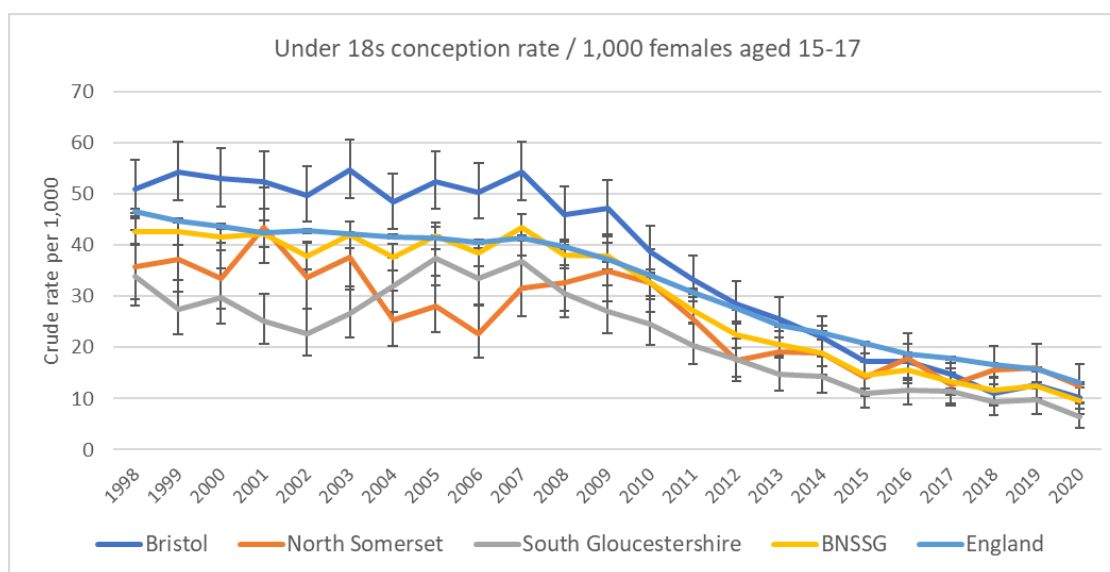


Figure 5.42 Under-18s conception rate per 1,000 (females aged 15-17) in Bristol, North Somerset, South Gloucestershire, BNSSG, England (OHID)

More recently published under-18s conception rates for 2021 reveal that the rates in Bristol and South Gloucestershire have increased from 2020, while North Somerset's has decreased. In Bristol, the rate of under-18s conceptions increased from 10.2 to 13.3 per 1,000 (an increase of 24 conceptions; see figure 5.43), and from 6.4 to 9.7 per 1,000 (an increase of 15 conceptions) in South Gloucestershire. Bristol's rate is now higher than that for England (13.1 per 1,000).^{295,296}

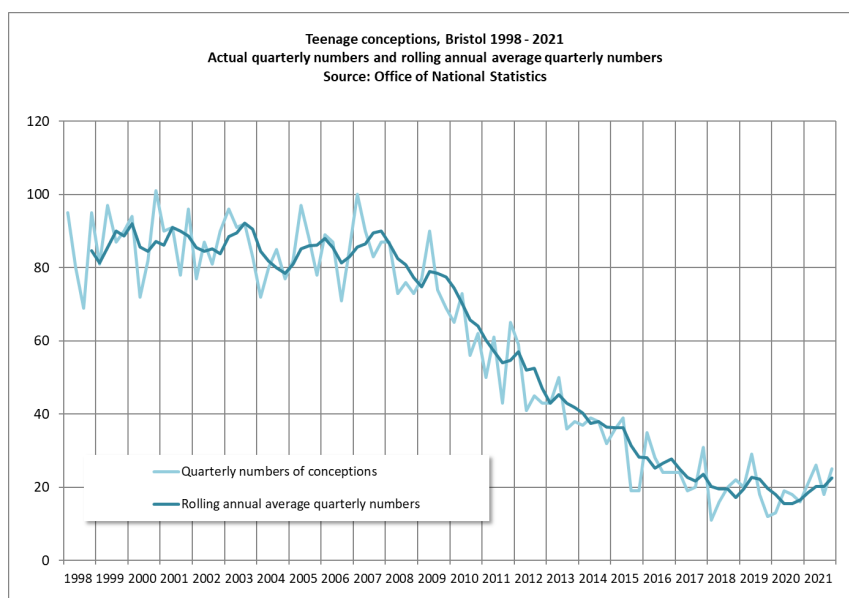


Figure 5.43: Teenage conceptions in Bristol, rolling annual average and quarterly numbers of conceptions, 1998 to 2021 (ONS)

At ward level, further inequalities can be identified. Three-year data on under-18s conceptions in North Somerset from 2018-2020, when compared to the England average, shows that Weston-Super-Mare South and Weston-Super-Mare Hillside wards have higher rate of under-18s pregnancies (see figure 5.44).

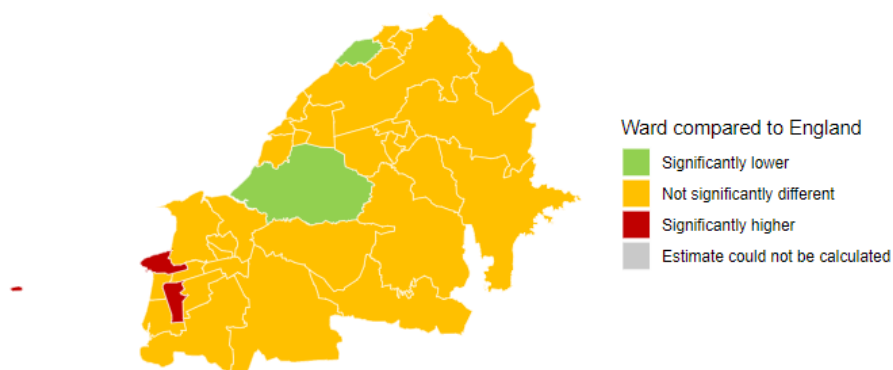


Figure 5.44: Under-18s conception in North Somerset by ward, compared to England: three-year period between 2018-2020 (OHID)

²⁹⁵ [Conceptions in England and Wales - Office for National Statistics](#) (published 30/03/2023)

²⁹⁶ [UKHSA summary profile of local authority sexual health](#) (published 01/02/2023)

Similarly, comparing the 3-year data on under-18s conceptions in Bristol wards to the England average shows that Filwood has a higher rates of under-18s conceptions (see figure 5.45).

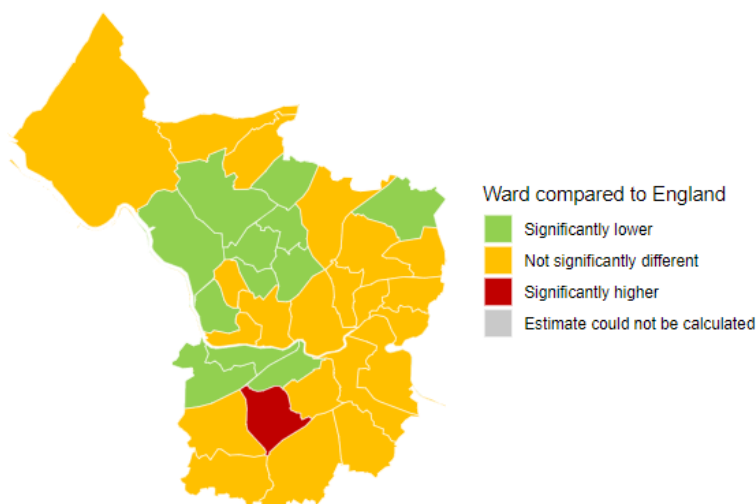


Figure 5.45: Under-18s conception in Bristol by ward, compared to England: three-year period between 2018-2020 (OHID)

In South Gloucestershire, all wards are either similar to or better than the England average (figure 5.46).

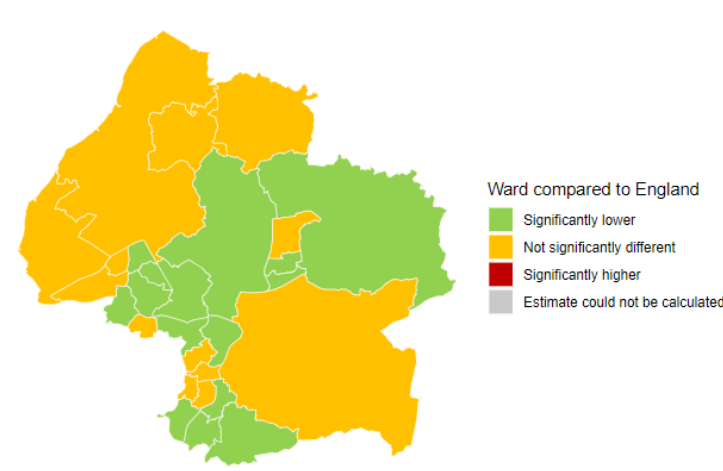


Figure 4.46: Under-18s conception in South Gloucestershire by ward, compared to England: three-year period between 2018-2020 (OHID)

The rate of conceptions in under-16 year olds (13-15 years) in Bristol has increased from 1.8 to 2.9 per 1,000 (an increase of 8 conceptions) between 2020 and 2021, which is now higher than the England rate of 2.1 per 1,000. In comparison, the rate in North Somerset has fallen from 2.8 to 0.8 per 1,000 (a decrease of 7 conceptions), and South Gloucestershire's rate is similar to 2020 (see table 5.15).

Table 5.15: Number and rate / 1,000 of under-16 conceptions (13-15 year olds), 2020 and 2021, Bristol, North Somerset, South Gloucestershire, England (ONS)

Area	Under-16s conceptions in 13-15 year old females			
	Number, 2021	Rate / 1,000, 2021	Number, 2020	Rate / 1,000, 2020
Bristol	21	2.9	13	1.8
North Somerset	3	0.8	10	2.8
South Gloucestershire	3	0.6	4	0.8
England	2,053	2.1	1,955	2.0

The increases in under-18s and under-16s conceptions in Bristol are a concern and are indicators of inequality in the reproductive outcomes for young people.²⁹⁷

Under-18s conceptions leading to an abortion

At a national level, there has been an increasing trend in the proportion of under-18s conceptions resulting in an abortion from 1998 to 2020, and this is replicated across all deprivation deciles. However, as the chart below (figure 5.47) shows, there is a considerable gap in the proportion of under-18s conceptions resulting in an abortion between the most and least deprived deciles of the population in England. The gap had gradually been closing since 1998, when there were 51.3% of abortions in the least deprived and 34.0% in the most deprived deciles of the population – a gap of 17.3%, until in 2014 when it started to widen again from 59.9% of abortions in the least deprived and 49.1% in the most deprived deciles – a gap of 10.8%. In 2020 there were 60.2% of abortions in the least deprived and 45.7% in the most deprived deciles – a gap of 14.5%. Regionally and locally, a lower than England average proportion of under-18s conceptions leading to an abortion may indicate a higher proportion of young women choosing to continue a pregnancy but it can also reflect barriers in accessing abortion care.

²⁹⁷ [Variation in outcomes in sexual and reproductive health in England 2021 \(publishing.service.gov.uk\)](https://publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/978442/Variation_in_outcomes_in_sexual_and_reproductive_health_in_England_2021.pdf) (12/05/2021)

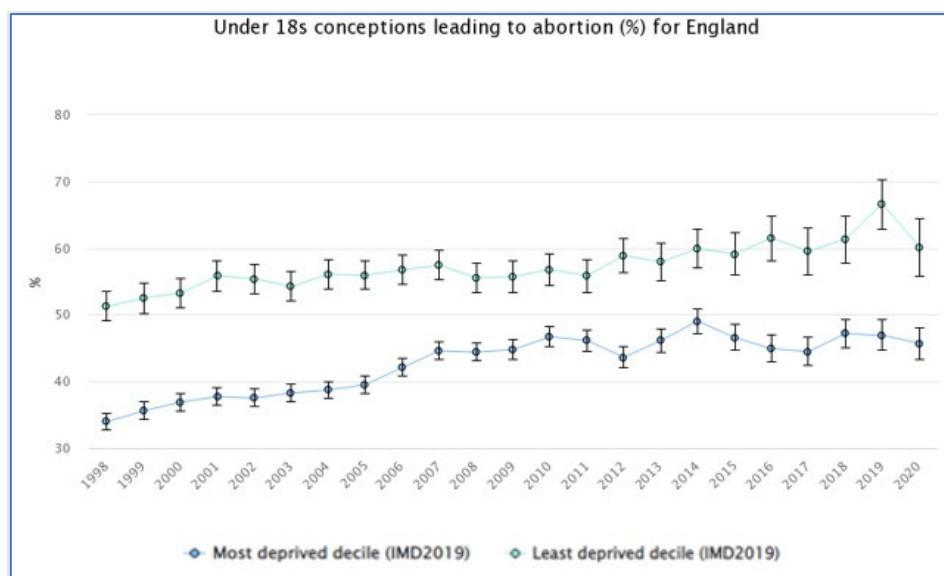


Figure 5.47: Under-18s conceptions leading to an abortion (%), 1998-2020 trends for most and least deprived deciles of England (OHID)

Teenagers are more likely to present late for abortion and to book late for antenatal care. The higher risk of unplanned pregnancy, late confirmation of pregnancy and fear of disclosure, all contribute to delays in accessing abortion and maternity services. Early pregnancy diagnosis, unbiased advice on pregnancy options and swift referral to maternity or abortion services are required to minimise delays. Young people who have experienced pregnancy are also at higher risk of subsequent unplanned conceptions.²⁹⁸

In BNSSG, the trend in under-18s conceptions leading to abortion has been similarly upward (see figure 5.48), reaching 48.6% in 2020, similar to the England average.

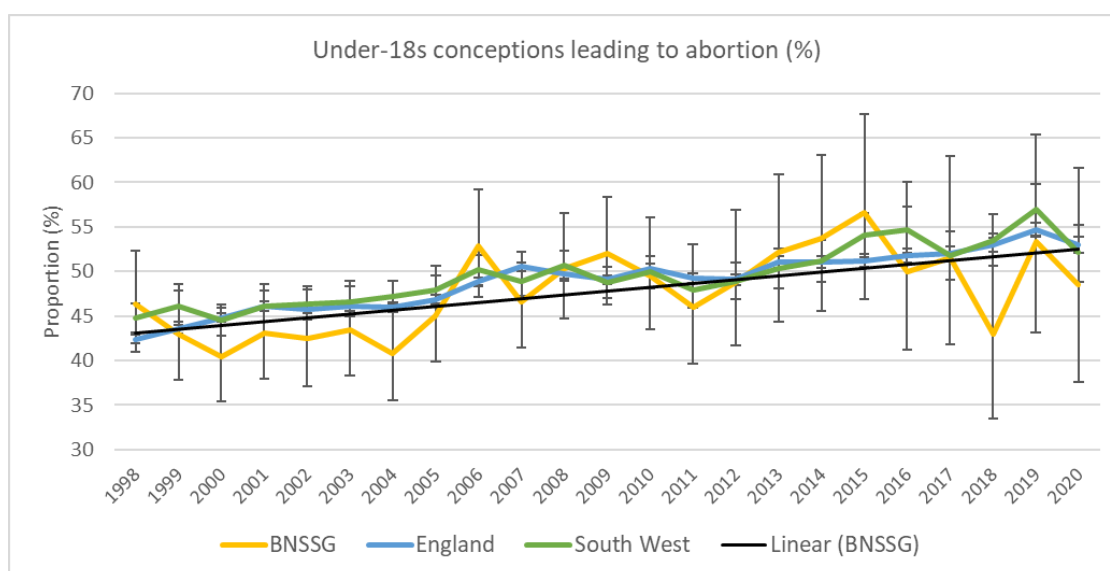


Figure 5.48: Under-18s conceptions leading to an abortion (%), BNSSG, South West and England (OHID)

²⁹⁸ [UKHSA summary profile of local authority sexual health \(published 27/01/2022\)](#)

New published data for 2021 shows that the percentage of under-18s conceptions leading to an abortion stayed the same in Bristol, fell slightly in North Somerset and increased more noticeably in South Gloucestershire (see table 5.16 below), compared to 2020 data. All BNSSG areas had a lower percentage than the England average.

Table 5.16: Percentage of under-18s conceptions leading to an abortion, 2020 and 2021, Bristol, North Somerset, South Gloucestershire, England (ONS)

Area	Under-18s conceptions leading to an abortion	
	Percentage, 2021	Percentage, 2020
Bristol	45.6	45.5
North Somerset	51.4	53.5
South Gloucestershire	52.3	48.3
England	53.4	53.0

Teenage pregnancy outreach nurses

Teenage pregnancy outreach nurses (TPON) are commissioned from Unity by Bristol City and South Gloucestershire Councils to support pregnant teenagers under the age of 19 who attend the Pregnancy Advisory Service (PAS). Most of these teenagers will book to have a termination but the TPONs also work with those who decide to continue with their pregnancies or who miscarry. The TPONs meet the teenagers in PAS, ensure they have a supporting adult, make a contraception plan and then support them afterwards for up to six months or until they are using a reliable method of contraception, ideally LARC. TPONs are able to give all methods of contraception via PGDs including implants and IUDs. They also offer home visits and support young people to attend other services. In 2021-22, 49.7% of all young people aged 18 or under who accessed abortion services in BNSSG were referred to the TPONs, compared to a local target of 90%. Of those followed up by a TPON:

- 81.1% of young women reported they were using regular contraception
- 58.3% of whom were using LARC

The TPONs work closely with PAS, primary care, the UHBW safeguarding team, children's social care, the Family Nurse Partnership, Brook in schools, local young people's clinics, Off the Record, Children and Adolescent Mental Health Service (CAMHS), Creative Youth Network, and a number of other organisations. The TPONs also offer contraception and sexual health awareness training (including Pregnancy Choices training) to the young people workforce.

Abortion is an avoidable experience for a young person, and the data suggests that there is room to improve the prevention of pregnancy in under-18s across BNSSG, which could be achieved by ensuring that each council is offering high quality RSHE, and commissioning

age-appropriate contraception services that are welcoming, in the right place, and open at the right time, with friendly, non-judgmental staff.²⁹⁹

5.3.2.3 Abortion

Abortion services have changed significantly in the last few years in response to COVID-19. In particular, the Abortion Act was amended with effect from late August 2022 to allow women in England and Wales to permanently access early medical abortions at home, if appropriate following a telephone consultation, via 'pills by post', and for both pills required to be taken at home for gestation of up to 9 weeks and 6 days.

In BNSSG there is a single point of access to abortion services via a telephone consultation, following which service users are offered choices on how to proceed, including the full range of contraceptive choices available for those proceeding to an abortion. Abortion services are provided by St Michael's Hospital (UHBW) and Southmead Hospital (NBT) and include theatre/clinic space and support staff for surgical abortions including manual vacuum aspiration. St Michael's also provides nurse-led, ward-based medical abortions. In addition, MSI Reproductive Choices, an independent provider of sexual and reproductive health services in the UK, provides specialist medical and surgical abortion care services for BNSSG which includes termination of pregnancy up to a maximum gestation of 23+6 weeks, and BPAS, a UK abortion care specialist charity, provides specialist medical and surgical abortion care services for BNSSG which includes surgical termination of pregnancy up to a maximum gestation of 17+6 weeks.

Nationally, abortion rates vary by age. The abortion rate for England and Wales in 2021 was highest for women aged 22 (at 31.0 per 1,000 women). In 2020 the highest rate was for women aged 21 (30.6 per 1,000 women), and in 2011 it was highest for women aged 20 (at 32.6 per 1,000 women). There has been an increase in the rates for all ages 22 and above over the last 10 years. The largest increases in abortion rates by age are among women aged 30 to 34 which have increased from 17.2 per 1,000 in 2011 to 22.1 per 1,000 in 2021.

Abortion rates for those aged under 18 have declined over the last 10 years (from 15.0 to 6.4 per 1,000 between 2011 and 2021), which is in line with the successes in decreasing the rate of conceptions in this age group. The decline since 2011 is particularly marked in the under 16 age group, where the rates have decreased from 3.4 per 1,000 women in 2011 to 1.1 per 1,000 women in 2021. However, there is significant variation between local areas in the proportion of under-18 conceptions that end in abortion, ranging from 32% to over 70%. This may reflect individual choice of young women, perhaps influenced by socio-economic factors, and/or differences in the ease of access to abortion services. The abortion rate for 18- to 19-year-olds has also declined from 28.8 per 1,000 women to 22.0 per 1,000 women in the same period.³⁰⁰

²⁹⁹ [Good progress but more to do: teenage pregnancy and young parents | Local Government Association](#) (published 30/05/2018)

³⁰⁰ [Abortion statistics, England and Wales: 2021 - GOV.UK \(www.gov.uk\)](#) (published 25/08/2022)

Women living in the most deprived areas of England are more than twice as likely to have abortions than women living in the least deprived areas (figure 5.49). The rate in the most deprived decile is 27.5 per 1,000 women, compared to 12.6 per 1,000 women for women living in the least deprived areas. The trend of rates increasing as levels of deprivation increase is also consistent across all age ranges in England.³⁰¹

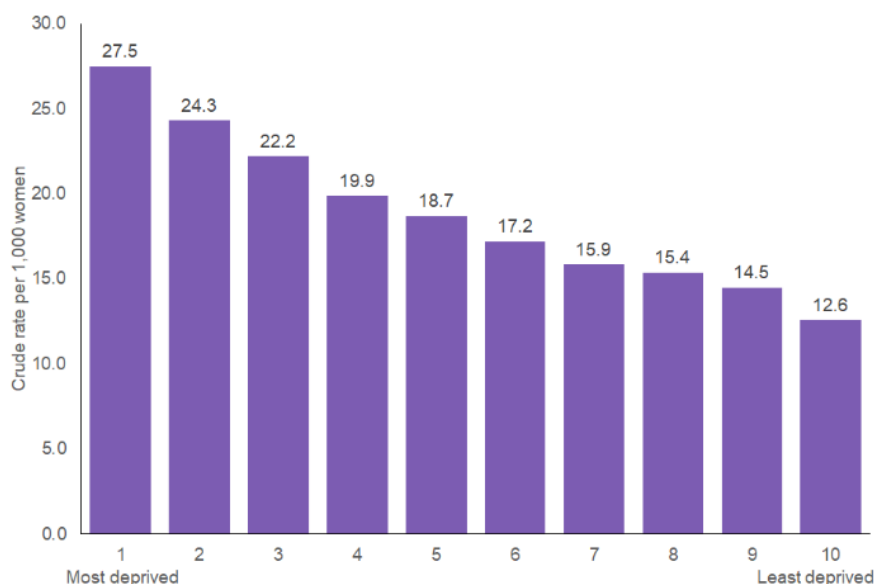


Figure 5.49: Total abortion rate per 1,000, by deprivation decile, England 2021 (OHID)

Ethnicity was recorded in 91% of the abortion data returns received nationally for 2021; this compares to 95% of forms received for 2020. Where ethnicity was recorded, 78% of women having abortions reported their ethnicity as White, 9% as Asian, 7% as Black, 5% as Mixed and 1% as Other. This suggests inequalities also exist by ethnicity as, for example, 7% of abortions are occurring in women self-reporting as Black, who represent 3% of the general population. Though national datasets do not monitor variations by ethnicity in the uptake of contraception, this suggests an unmet need for contraception among Black communities.^{302,303}

Total abortion rate

BNSSG has a low total abortion rate for all ages when compared nationally. The total abortion rate in BNSSG is 15.2 per 1,000 in 2021, which has gradually increased since 2012 (see figure 5.50). The BNSSG rate is lower than the England rate of 19.2 per 1,000. There is little variation in the individual rates for the BNSSG councils, ranging from 14.9 to 15.9 per 1,000. In 2021, 3,069 abortions were recorded across BNSSG, which is a small increase on the 3,018 abortions recorded for 2020. Of these, 1,689 were in Bristol, 547 in North Somerset and 833 in South Gloucestershire. Each of the three council areas have one of the

³⁰¹ [Abortion statistics, England and Wales: 2021 - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/statistics/abortion-statistics-england-and-wales-2021) (published 25/08/2022)

³⁰² [Full report \(December\) - Women's Lives, Women's Rights - Faculty of Sexual and Reproductive Healthcare \(fsrh.org\)](https://www.fsrh.org/publications/full-report-december-women-s-lives-women-s-rights) (published 10/12/2020).

³⁰³ [Abortion statistics, England and Wales: 2021 - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/statistics/abortion-statistics-england-and-wales-2021) (published 25/08/2022)

lowest total abortion rates when compared to their respective CIPFA neighbours and are each lower than the England rate.

This may suggest that there is good access to contraceptive services and advice across BNSSG, as well as relatively few problems with individual use of contraceptive method. However, it is not possible to explore whether there are particular inequalities in abortion rates within BNSSG according to ethnicity or deprivation, for example.

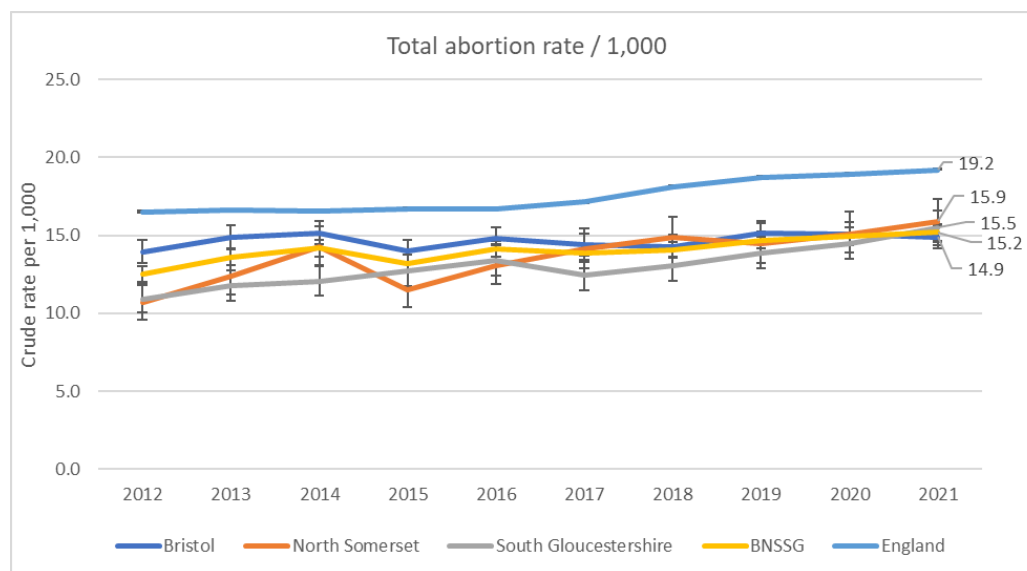


Figure 5.50: Total abortion rate per 1,000, 2012-2021, Bristol, North Somerset, South Gloucestershire, BNSSG, England (OHID)

Under-25s repeat abortions

Repeat abortions in individuals aged under-25 (who have had a previous abortion in any year) is an indicator of lack of access to good quality contraceptive services and advice for younger people as well as problems with individual use of contraceptive method. In BNSSG, the number of abortions has stayed fairly stable between 2012 and 2021, ranging from 232-300 repeat abortions per year (268 on average), and has consistently been either similar to or lower than the England average (figure 5.51). In 2020 and 2021 the proportion and number of repeat abortions in under-25s are the highest they have been since 2012-2013, which may have links to the COVID-19 lockdowns affecting access to timely contraception services.

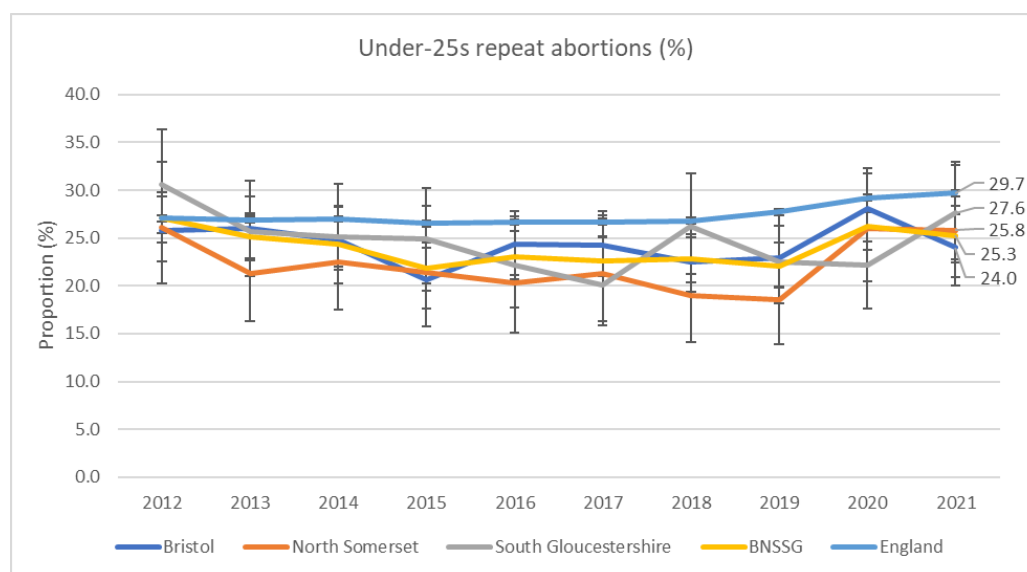


Figure 5.51: Repeat abortions in under-25s, 2012-2021, Bristol, North Somerset, South Gloucestershire, BNSSG, England (OHID)

At an individual council level, South Gloucestershire had the highest proportion of under-25s repeat abortions in 2021 at 28% and reported its highest number of repeat abortions since 2012 at 81. In contrast, Bristol had the lowest proportion at 24% but the highest number of repeat abortions at 152, which is a decrease from the 172 reported in 2020.

These data show that the proportion of repeat abortions in under-25s across BNSSG are, overall, lower than the England average. However, without more granular detail to explore potential inequalities it is not possible to be assured that there are no concerns regarding access to abortion services.

Under-25s abortion after a birth

This indicator aims to increase awareness of post-partum contraception need at the local level. Councils can use this indicator to help identify maternity and contraception needs within their area, and work with ICBs where appropriate.³⁰⁴ In BNSSG, a fifth of women under the age of 25 had an abortion who had previously had a birth, lower than the national average of 26% (see figure 5.52).

Locally and nationally there has been a general downward trend in the proportion of under-25s having an abortion after a previous birth since 2014, except in North Somerset which has seen an increase over the last couple of years. This may relate to fluctuations in the denominator for this indicator – the number of abortions in under-25s, which has fallen from that reported in 2020 in North Somerset while the number of abortions in under-25s following a birth in 2021 increased by 10 compared to 2020.

³⁰⁴ [Sexual and Reproductive Health Profiles - Data - OHID \(phe.org.uk\)](https://phe.org.uk/data) (updated 02/11/2021)

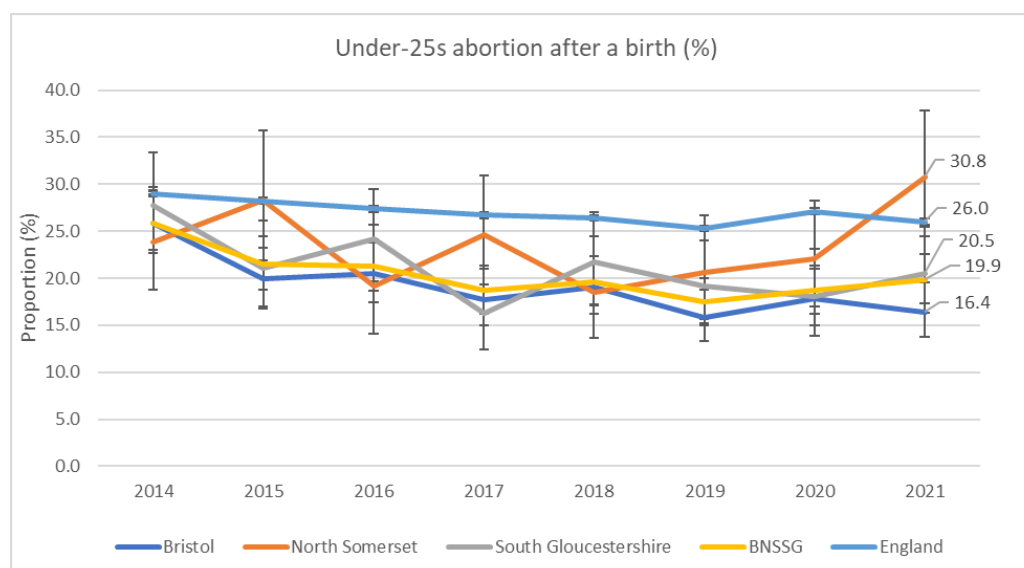


Figure 5.52: Proportion of women aged under-25 having an abortion who have previously had a birth, 2014-2021, Bristol, North Somerset, South Gloucestershire, BNSSG, England (OHID)

In 2021, North Somerset had the highest proportion of under-25s abortions after a birth of the three councils at 31% (56 abortions), but Bristol had the highest number at 104. In recent years, Bristol and South Gloucestershire have been consistently lower than the England average while North Somerset has been similar.

Without the ability to scrutinise this data based on deprivation, ethnicity or other factors, it is not possible to determine whether access to post-partum contraception is available to all parts of the population that may need or want it. To improve timely access to post-partum contraception across BNSSG, a new 2-year pilot has been launched with the local maternity units to:

- offer and provide postpartum contraception to all women prior to discharge from maternity units within BNSSG to prevent unplanned pregnancies, reduce termination of pregnancies and optimise inter-pregnancy intervals to ensure improved health outcomes for women and children
- improve antenatal contraception counselling and educational patient resources, so that women are better informed about the effectiveness of different methods of contraception
- give women greater choice and control to make informed decisions and improve equity of access to contraception
- evaluate the impact of the provision of postpartum contraception to inform future provision

Abortions under 10 weeks

The earlier abortions are performed the lower the risk of complications. Prompt access to abortion, enabling provision earlier in pregnancy, is also cost-effective and an indicator of service quality. This indicator includes all NHS-funded abortions performed under 10

weeks.³⁰⁵ Until 2019, BNSSG was higher than England for the proportion of abortions under 10 weeks, increasing year-on-year from 2017 and then dropping slightly in 2020, possibly due to local changes to services in response to COVID-19 (see figure 5.53). In 2020 and 2021, BNSSG was similar to England in proportion of abortions performed under 10 weeks.

The variation between the three councils is minimal, with North Somerset and South Gloucestershire achieving 86% and 85% respectively, and Bristol a little higher at 87% in 2021. North Somerset and Bristol are similar to the England average, while South Gloucestershire is lower than the England average. Also, compared to its CIPFA neighbours South Gloucestershire has the lowest proportion of abortions performed under 10 weeks, which ranges up to 91% (Trafford).

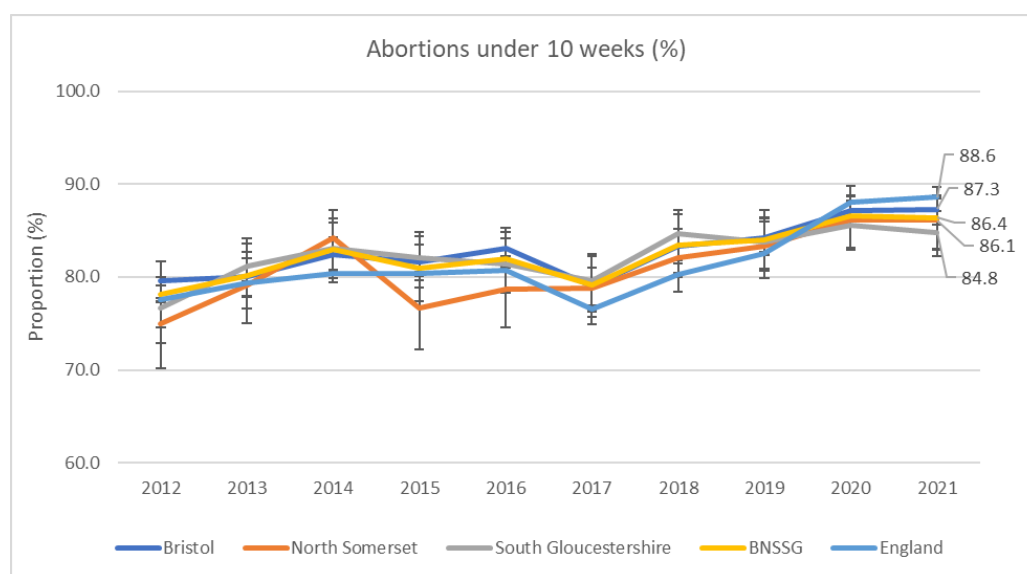


Figure 5.53: Abortions under 10 weeks, 2012-2021, Bristol, North Somerset, South Gloucestershire, BNSSG, England (OHID)

Abortions under 10 weeks that are medical

Different methods can be used to terminate a pregnancy, depending on the gestation, and other circumstances relating to the individual woman. There are medical methods which involve the use of drugs (for example, mifepristone) and there are surgical methods, such as vacuum aspiration or dilatation and evacuation.³⁰⁶ The 'abortions under 10 weeks that are medical' indicator aims to improve transparency at a local level of the extent of medical and surgical services available to women and acts as an indicator of patient choice.

There has been a general upward trend in medical abortions nationally and locally, and the data suggest that the vast majority of women in BNSSG are able to access early medical abortions within 10 weeks of conception (see table 5.17). However it is not possible to explore this data by ethnicity, deprivation or other factors to determine if there are any inequalities in access. Locally, Bristol was the only BNSSG local authority lower than England

³⁰⁵ [Sexual and Reproductive Health Profiles - Data - OHID \(phe.org.uk\)](https://phe.org.uk/data) (updated 02/11/2021)

³⁰⁶ [Abortion statistics, England and Wales: 2021 - GOV.UK \(www.gov.uk\)](https://www.gov.uk) (updated 25/08/2022)

in 2021 and has one of the lowest values when compared to its CIPFA neighbours (range: 76.7% to 99.1%).

Table 5.17: Abortions under 10 weeks that are medical, 2014 and 2021, Bristol, North Somerset, South Gloucestershire, BNSSG, England (OHID; orange shading means the value is similar to England; red shading means the value is lower than England)

Area	Abortions under 10 weeks that are medical, 2014		Abortions under 10 weeks that are medical, 2021	
	Number	Percentage (%)	Number	Percentage (%)
Bristol	691	52.5	1,356	92.9
North Somerset	189	45.3	445	94.9
South Gloucestershire	281	55.6	670	95.9
BNSSG	1,161	51.9	2,471	94.1
England	82,185	57.9	169,729	93.1

Unity service data on abortions

Abortions are provided by BPAS, MSI and PAS (NHS services at NBT and UHBW) as part of Unity. Across BNSSG in 2021-22, Unity reported 2,836 abortions in all ages, of which 241 (8.5%) were in people aged 19 or under, 859 (30.3%) were in people aged 20-24, and 1,736 (61.2%) were in people aged 25 and over. Almost a third of abortions occurred in the 20-24 age bracket but whether this is higher than might be expected for a large urban population with a high proportion of young people under the age of 25, as found in Bristol, is not clear.

Of the total number that had an abortion, 2,493 (87.9%) were undertaken before 10 weeks gestation in 2021-22, of which 8.5% were in people aged 19 or under, 30.4% were aged 20-24, and 61.1% were aged 25 and over. The proportion undertaking an abortion before 10 weeks in each of the age brackets described above varied minimally, ranging from 87.7% to 88.2%. The Unity proportion of abortions undertaken before 10 weeks in 2021-22 (88.0%) is slightly lower than the England proportion in 2021 (88.6%) but it is actually an increase for Unity compared to 2020, which was 86.5%. Data from Unity's 2021-22 annual report states that the proportional method of abortion under 10 weeks was:

- medical: 93.4%
- manual vacuum aspiration: 0.6%
- surgical: 6.0%

A locally reported outcome reveals that only 55.9% of people of all ages that attended for an abortion received a method of contraception at the time of their abortion. Of these, 8.4% were aged 19 or under, 31.0% were aged 20-24, and 60.6% were aged 25 and over. However, within each age band described, the uptake was similar ranging from 55.2% to 57.2%. The NICE clinical standard states 'Women having an abortion who want contraception receive their chosen method before discharge either at the time of their

abortion or as soon as possible after expulsion of pregnancy'.³⁰⁷ The Unity data may suggest that a lot of women attending choose not to have a method of contraception on the day of their procedure, are not being offered contraception, or choose to go elsewhere for their contraception (i.e. to their GP).

A clinical audit of contraception after an abortion at UHBW during the COVID-19 pandemic (March 2020 to February 2021)³⁰⁸ sheds some more light on this. The audit found that 96% (287 people) of the sample of 300 had a recorded discussion about future contraception on their file, with 83% (238/287) wanting future contraception, 7% (21/287) undecided, 5% (15/287) not recorded, and 5% (14/287) not wanting it. Figure 5.54 below shows the route of access to contraception for the 238 people that wanted future contraception, of which 37% received their chosen contraceptive method directly at Unity and 36% of patients went to a different abortion provider. The audit reported that 86% of patients receiving an abortion at Unity have their chosen contraceptive received, offered or planned before discharge. Of note is that 9% had no record of contraception given. To address this, the audit resulted in changes to the abortion proforma used to include tick boxes for:

- patient accepts or declines future contraception
- source of future contraception: e.g. PAS, GP, patients own supply, other provider
- partner vasectomy as a contraception option

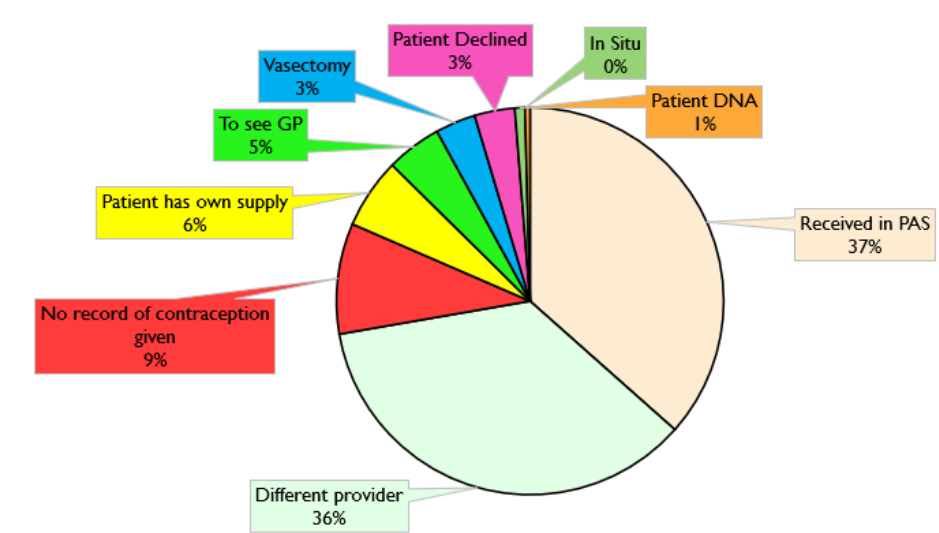


Figure 5.54: Routes of access to contraception for the 238 people choosing to have future contraception when attending Unity for an abortion between March 2020 and February 2021 (UHBW/University of Bristol)

The data below in table 5.18 show the number and proportion of repeat abortions in the previous 2 years in BNSSG residents recorded by Unity in 2021-22. Of particular note are that more than a sixth (17.5%) of young people aged under 25 years attending Unity for an

³⁰⁷ [Overview | Abortion care | Quality standards | NICE](#) (published 26/01/2021)

³⁰⁸ Mr Harry Higgins, Dr Manika Singh & Dr Frederica Von-Hawrylak, A Clinical Audit of Contraception after termination of pregnancy at Unity Sexual health Clinic during the COVID-19 Pandemic (26/05/2021)

abortion in 2021-22 had had a previous abortion in the last 2 years, and that of those young people, a greater proportion of repeat abortions occurred in people from a non-White ethnicity (25.6%) compared to a White ethnicity (16.7%). This data suggests that availability of contraceptive advice and services for young people generally and particularly for people from Black, Asian and minoritised ethnic communities is a gap.

Table 5.18: Number of repeat abortions within 2 years as a percentage of the total proceeding to abortion, broken down by age, ethnicity, and age and ethnicity combined, 2021-22 (UHBW)

BNSSG residents attending Unity, 2021-22	Repeat abortions	Total proceeding to abortion	Percentage (%)
Total	699	2,836	24.7
Age			
19 year olds and under	23	241	9.5
20-24 year olds	169	859	19.7
Under-25 year olds	192	1,100	17.5
25+ year olds	507	1,736	29.2
Ethnicity			
White	583	2,361	24.7
Non-White	103	392	26.3
Not stated	13	83	15.7
Age and ethnicity			
White, under-25 year olds	156	936	16.7
Non-White, under-25 year olds	33	129	25.6
White, 25+ year olds	427	1425	30.0
Non-White, 25+ year olds	70	263	26.6

Finally, there were very few abortions reported within 6-months of a birth in 2021-22, a total of 32 (1.1%). This is a local indicator and cannot be benchmarked against the national indicator of women having an abortion after a previous birth at any time.

5.3.2.4 Impact of COVID

Early medical abortions are defined as taking place within the first 10 weeks of pregnancy using medical methods. There are 2 stages to a medical abortion. In the first the woman is assessed and given mifepristone, and then the second stage takes place 1-2 days later when the woman is given misoprostol to induce the abortion. Since December 2018 in England, women have been allowed to administer the second stage of treatment (misoprostol) for early medical abortions at home. Until late March 2020, the first stage of treatment (mifepristone) had to be administered at an NHS hospital or independent sector abortion clinic approved by the Secretary of State for Health and Social Care. From 30th March 2020, the Secretary of State for Health and Social Care approved temporary measures in England to limit the transmission of COVID-19 by approving the use of both pills for early medical abortion at home, without the need to first attend a hospital or clinic. These temporary measures remained in place throughout 2020 and 2021. From 30th August 2022, the

Abortion Act was amended to allow women in England and Wales to permanently access early medical abortions at home via a teleconsultation, and for both pills to be taken at home for gestation of up to 9 weeks and 6 days.

The proportions of different methods used to administer abortions have changed since the temporary approval of both pills for early medical abortion without needing to first visit a hospital or clinic (although it is worth noting there has been a general increase in medical abortions over time; figure 5.55). Taking both medications at home is the most common procedure, accounting for 52% of all abortions in 2021. Medical abortion overall accounted for 87% of abortions in 2021. Medical abortions where mifepristone is taken in clinic and misoprostol is taken at home increased from 14% of abortions in the first quarter (January to March) of 2021 to 22% of abortions in the last quarter (October to December) of 2021. Taking both mifepristone and misoprostol at a hospital or clinic has become a less common method of abortion, decreasing from 37% of abortions in the first quarter (January to March) of 2020 to 24% in the fourth quarter (October to December) of 2020. This trend has continued in 2021, where taking both mifepristone and misoprostol at a hospital or clinic decreased from 25% of abortions in the first quarter (January to March) of 2021 to 12% in the fourth quarter (October to December) of 2021.³⁰⁹

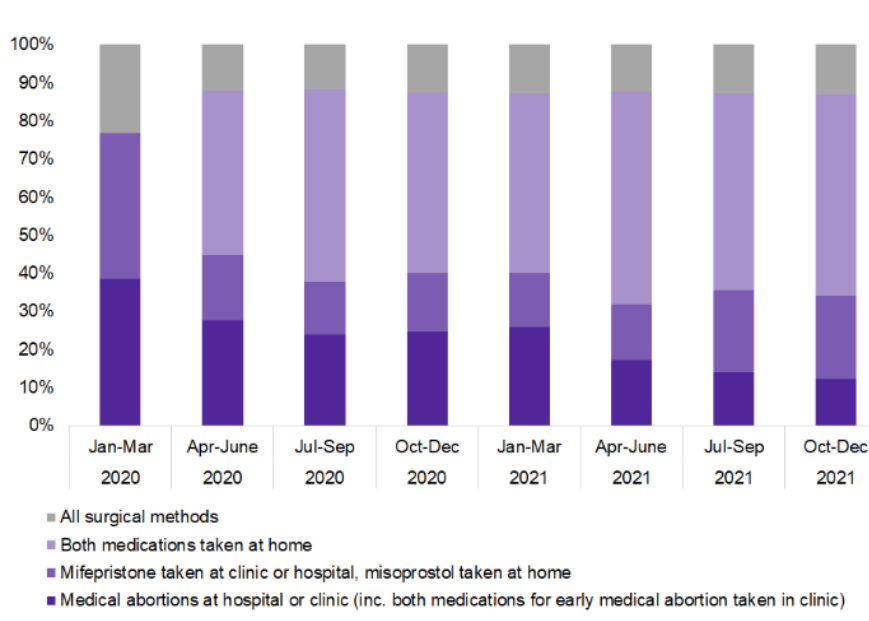


Figure 5.55: Percentage of abortions performed by method, residents of England and Wales, quarterly, 2020 and 2021 (OHID 2022)

The FSRH report that the COVID-19 pandemic has seen an increased gap in reproductive outcomes for females, particularly for those in more deprived areas, as outreach services (via specialist SRHS) targeting vulnerable groups were unable to operate due to the first lockdown measures.³¹⁰ Also, during the pandemic, abortion providers found that the gap

³⁰⁹ [Abortion statistics, England and Wales: 2021 - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/statistics/abortion-statistics-england-and-wales-2021) (updated 25/08/2022)

³¹⁰ [Full report \(December\) - Women's Lives, Women's Rights - Faculty of Sexual and Reproductive Healthcare \(fsrh.org\)](https://www.fsrh.org/full-report-december-women-s-lives-women-s-rights/) (published 10/12/2020)

between the least and the most deprived seeking abortion widened, with 16.5% of all those seeking abortion at BPAS being from the most deprived backgrounds compared to 5.9% from the least deprived.³¹¹

5.3.2.5 Evidence of what works to reduce unplanned and teenage pregnancies

The success of the Teenage Pregnancy Strategy, launched in 1999, in reducing England's under-18 conception rate has been recognised by the World Health Organization with the lessons being shared internationally with countries seeking to address high rates. However, despite the significant progress, England's teenage birth rate remains higher than comparable Western countries, and inequalities in the under-18 conception rate persist between and within local areas. Further progress in both reducing the under-18s conception rate and improving the outcomes for young parents is central to improving young people's sexual health and narrowing the health and educational inequalities experienced by young parents and their children.³¹²

International evidence identifies the provision of high quality, comprehensive relationships and sex education linked to improved use of contraception as the areas where the strongest empirical evidence exists on impact on teenage pregnancy rates. In September 2020, statutory guidance was introduced in England that requires all primary schools to provide relationships education, all secondary schools to provide relationships and sex education and both primary and secondary schools to provide health education, including puberty. This includes specific reference to ensuring all secondary school pupils know about local services providing confidential sexual and reproductive health advice and care.³¹³

Contraceptive services need to be accessible and youth friendly to encourage early uptake of advice, with consultations that recognise and address any knowledge gaps about fertility and concerns about side effects and support young people to choose and use their preferred method. Some young people will be at greater risk of early pregnancy and require more intensive relationships and sex education and contraceptive support, combined with programmes to build resilience and aspiration, providing the means and the motivation to prevent early pregnancy. Reaching young people most in need involves looking at area and individual level associated risk factors. Child poverty and unemployment are the two area deprivation indicators with the strongest influence on under-18 conception rates. At an individual level, the strongest associated factors for pregnancy before 18 years are free school meal eligibility, persistent school absence by age 14 years, poorer than expected academic progress between ages 11-14 years, and being looked after or a care leaver.³¹⁴

³¹¹ BPAS [ONS report on conceptions in England and Wales in 2020 released today](#) (published 14/04/2022)

³¹² [UKHSA summary profile of local authority sexual health \(published 27/01/2022\)](#)

³¹³ [Relationships and sex education \(RSE\) and health education - GOV.UK \(www.gov.uk\)](#) (updated 13/09/2021)

³¹⁴ [UKHSA summary profile of local authority sexual health \(published 27/01/2022\)](#)

The LGA and PHE's 'Good progress but more to do' report on teenage pregnancy and young parents highlights ten key factors for effective local action.³¹⁵

1. Senior level leadership (through the health and wellbeing board) and accountability across local authorities and health services is essential
2. Work with schools to ensure high quality relationships and sex education in schools and colleges. Ensure that RSE and PHSE is integrated with commissioning of school nursing, sexual health services, safeguarding and emotional wellbeing programmes, with clear links to one-to-one advice
3. Ensure contraceptive and sexual health services are youth-friendly, easily accessible and well publicised in schools, colleges and other settings used by young people
4. Target additional prevention at those most at risk, including looked after children and care leavers, and link in with relevant early intervention programmes, such as Troubled Families
5. Use parenting programmes to ensure sexual health advice and communication support for parents to enable them to discuss relationships and sexual health with their children
6. Train both the health and non-health workforce in sexual health and teenage pregnancy, working in partnership with CCGs (now ICBs) to target front line professionals who are in touch with vulnerable young people, such as foster carers, youth services, youth offending teams and supported housing workers
7. Provide advice and access to contraception and sexual health services in non-health settings used by young people
8. Ensure consistent messages on healthy relationships and delaying pregnancy are promoted to young people, parents and professionals
9. Use robust local data for commissioning and monitoring progress and local intelligence from surveys and consultation with young people
10. Provide dedicated support for teenage mothers and young fathers using the LGA-PHE Teenage Pregnancy Prevention Framework to ensure all agencies contribute to a joined-up care pathway

The Teenage Pregnancy Prevention Framework referred to above is designed to help local areas to identify things that are working well, identify any gaps and develop an action plan to maximise opportunities to improve the prevention pathway for all young people. In addition to this there is a framework for supporting teenage mothers and young fathers.³¹⁶ This requires a whole-system approach to achieve the best possible outcomes for young people that follows the 10 key factors for effective local action that are listed above.³¹⁷

³¹⁵ [Good progress but more to do: Teenage pregnancy and young parents \(local.gov.uk\)](#) (published 30/05/2018)

³¹⁶ [Teenage mothers and young fathers: support framework - GOV.UK \(www.gov.uk\)](#) (updated 18/04/2019)

³¹⁷ [Teenage pregnancy prevention framework - GOV.UK \(www.gov.uk\)](#) (published 15/01/2018)

Measures to reduce teenage pregnancy need to be delivered through proportionate universalism. Although two thirds of young people do not have sex before 16, by the age of 20, 85% will have experienced vaginal intercourse, so all young people need good relationships and sex education and access to services to prevent early pregnancy and look after their sexual health. Universal prevention programmes are also essential to reduce rates by a substantial margin.³¹⁸

In the new Women's Health Strategy for England³¹⁹, published in summer 2022, includes the following 10-year ambitions in relation to education and contraception:

- girls and boys receive high-quality, evidence-based education from an early age on fertility, contraception and pregnancy planning, maternity care and pregnancy loss. These issues are no longer taboo subjects in any part of society
- women are supported through high-quality information and education to make informed decisions about their reproductive health, including if and when to have a child
- all women who want contraception are able to access their preferred type of contraception in a convenient way
- women and their partners are supported to optimise their health and wellbeing prior to conception to improve pregnancy outcomes and give their child the best start in life

The strategy also has a range of case studies dotted throughout, including one from North West London relating to postnatal contraception in which a study with women who had just given birth found that 33% of pregnancies were unplanned, 51% of women had not planned future contraception and yet 42% wanted to take home contraception after the birth of their child. In follow-up surveys, over half of women were using no contraception after 7 months. Regional data showed 5% had a second birth within a year, and 3% were estimated to have become pregnant and had a termination within a year.

5.3.2.6 Issues identified

The issues below have been identified following a review of the unplanned pregnancy and abortions outcome data for BNSSG.

Teenage conception

1. Teenage conception has risen after a long downward trend. Data for 2021 show that under-18s conceptions have increased in Bristol and South Gloucestershire, and under-16s conceptions have increased in Bristol. Both rates are now higher than the England average in Bristol.
2. The following wards had higher rates than the England average of under-16s and under-18s conceptions in 2018-2020:

³¹⁸ [Child and Maternal Health - Data - OHID \(phe.org.uk\)](#) (updated 05/2019)

³¹⁹ [Women's Health Strategy for England - GOV.UK \(www.gov.uk\)](#) (updated 30/08/2022)

- a. Weston-Super-Mare South, North Somerset
 - b. Weston-Super-Mare Hillside, North Somerset
 - c. Filwood, Bristol
3. The local RSE curriculum should include knowledge of local services and how to access them.
4. There is a need for closer working with public health nursing services in schools to improve the sexual health outcomes of young people.
5. The proportion of teenage pregnancy outreach nurse referrals in 2021-22 for those aged 18 and under accessing Unity services was 50% compared to a local target of 90%.

Abortions in under-25s

6. Evidence suggests that repeat abortions in under-25s may be increasing across BNSSG and was proportionally highest in South Gloucestershire (28%) in 2021.
7. The number of abortions after a birth in under-25s increased in North Somerset in 2021 despite the total number of abortions in under-25s decreasing.
8. A 2-year pilot to improve access to post-partum contraception in maternity services across BNSSG is planned. The evaluation is needed to inform future provision.

Abortions under 10 weeks

9. The proportion of abortions undertaken within 10 weeks in South Gloucestershire was lower than the England average in 2021 and the lowest when compared to its CIPFA neighbours. There is a need to ensure access to abortion services is maximised to reduce waits.
10. Bristol had a lower proportion of early medical abortions (under 10 weeks) than England and similar areas. There is a need to ensure that early medical abortions can be accessed easily and quickly as they are less invasive than surgical procedures and carry less risk by not involving instrumentation or use of anaesthetics. Medical abortions are also less costly than surgical interventions.

Inequalities in abortion services

11. There is a lack of granularity in the published abortion statistics at a local level to explore inequalities in access to and uptake of abortions, such as deprivation and ethnicity data.
12. Of abortions reported by Unity in 2021-22, 30% were in 20–24-year-olds.
13. Around a quarter of women attending Unity for an abortion in 2021-22 had had an abortion in the previous 2 years.
14. Of those young people under-25 attending Unity for a repeat abortion, a greater proportion occurred in people of non-White ethnicity (26%) compared to White ethnicity (17%) in 2021-22.
15. In 2021-22, 56% of people attending Unity for an abortion in BNSSG received a method of contraception at the time of abortion. However, the results of a clinical

audit from March 2020-February 2021 show that 86% of patients receiving an abortion at UHBW have their chosen contraceptive received, offered or planned before discharge.

6. Stakeholder and community engagement

6.1 Public survey

The BNSSG Sexual Health Needs Assessment Engagement Survey was available on Bristol City Council's Ask Bristol Consultation and Engagement Hub between 20th June and 14th August 2022. It aimed to gather the views of local BNSSG residents, current and previous users of sexual health services, health professionals and wider partners and stakeholders.

6.1.1 Survey information

The survey contained a description of what sexual health services are currently provided by the local authorities and ICB in BNSSG as context for the survey questions.

6.1.2 Survey questions

The survey questions sought respondents' feedback on the following:

1. Whether the respondent is a member of the public, a professional, or a representative of a group or organisation
2. How easy it is to get help for sexual health
3. How satisfied they are with a range of factors of accessing sexual health services
4. Reasons they could not access sexual health services
5. What they think is working well about sexual health services
6. What they think is not working well about sexual health services
7. How they think sexual health services could be made better

Respondents were also invited to provide comments in a free text box.

6.1.3 Response rate to the survey

The Sexual Health Needs Assessment Engagement Survey received 643 responses, all of which were completed online. 46% of responses were received from postcodes within the Bristol City Council area, 10% from North Somerset, and 14% were from South Gloucestershire. 27% did not provide a postcode.

6.1.4 Demographics of survey respondents

Of the 643 respondents:

- 75% (482) were members of the public
- 70% (336) had used sexual health services in the last 5 years
- 22% (144) were professionals (working in sexual health clinics, GPs, or pharmacies)
- 3% (17) were representatives of a group or organisation
- 75% were aged 25-54
- 66% were female
- 16% were bisexuals; 20% were gay men; 2% were lesbians; 59% were heterosexuals; and 3% selected 'other'
- 13% were disabled respondents
- 70% were people with no religion

- 1% of people were pregnant
- ethnic representation was similar to the BNSSG population

6.1.5 Results of survey

6.1.5.1 How easy it is to get help for sexual health?

335 respondents answered this question.

- professionals responded with 34% saying it was “very easy” or “quite easy” for residents to get help and 38% “quite difficult” or “very difficult”
- members of the public responded with 58% saying it was “very easy” or “fairly easy” to get help and 29% “fairly difficult” or “very difficult”

6.1.5.2 Satisfaction with access to appointments, knowledge of staff, attitude of staff, and quality of treatment

- professionals were most satisfied with the attitude of staff (85%) followed by the knowledge of staff (83%) and the treatment (82%). They were least satisfied with making appointments (38%) and waiting times (38%)
- members of the public were most satisfied with the attitude of staff (84%), knowledge of staff (83%) and treatment (78%). They were least satisfied with waiting times to be given an appointment (36%) and times available for appointments (36%)

6.1.5.3 Reasons for not accessing sexual health services

Only 28 people answered this question.

- 36% (10 people) said the location of the services made it difficult for them to get there (several community clinics are currently closed)
- 29% (8) said they could not get through on the phone
- 21% (6) said it was due to waiting times
- 18% (5) said they couldn't find information online
- the rest were smaller percentage responses and 'other' responses

6.1.5.4 What is working well?

489 (76%) respondents to the survey responded with free text to the question ‘What do you think is already working well about sexual health services, and why?’. The main themes are summarised in figure 6.1 below.

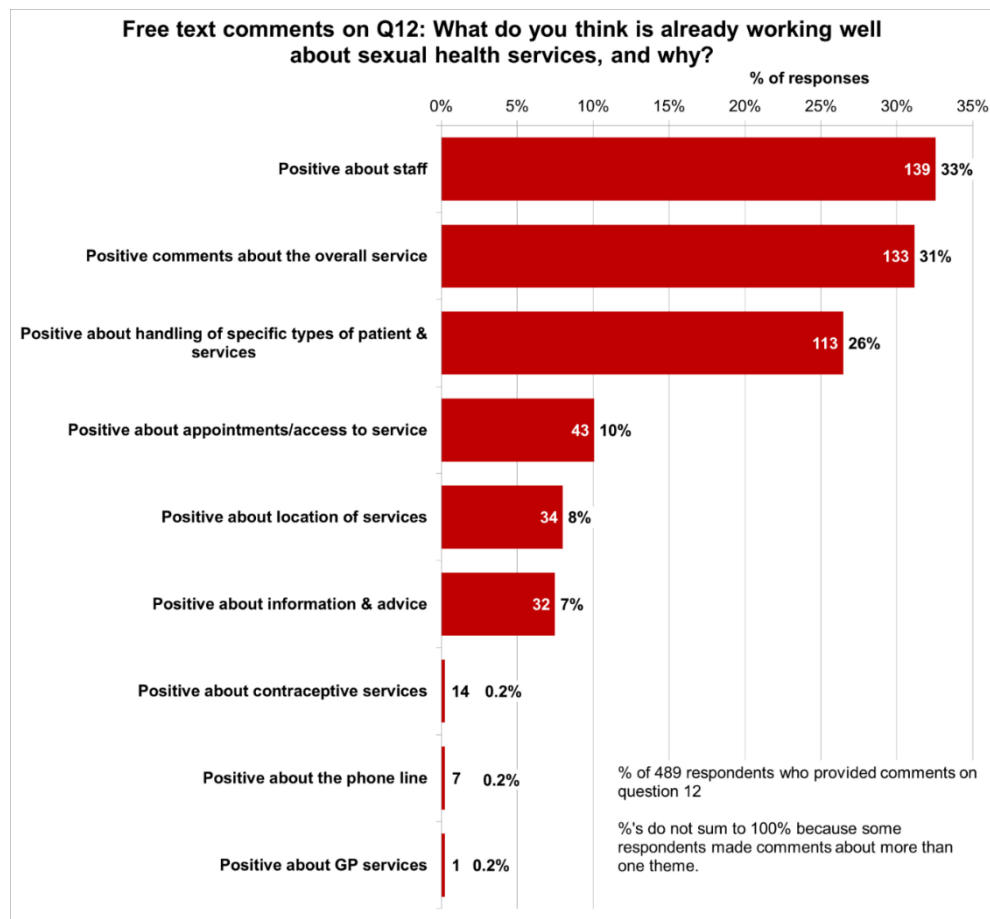


Figure 5.1: The main themes from the free-text responses to the survey question 'What do you think is already working well about sexual health services, and why?' (Bristol City Council)

6.1.5.5 What is not working well

505 (79%) respondents to the survey responded to the question 'What do you think is not working so well about sexual health services, and why?'. The main themes are summarised in figure 6.2 below.

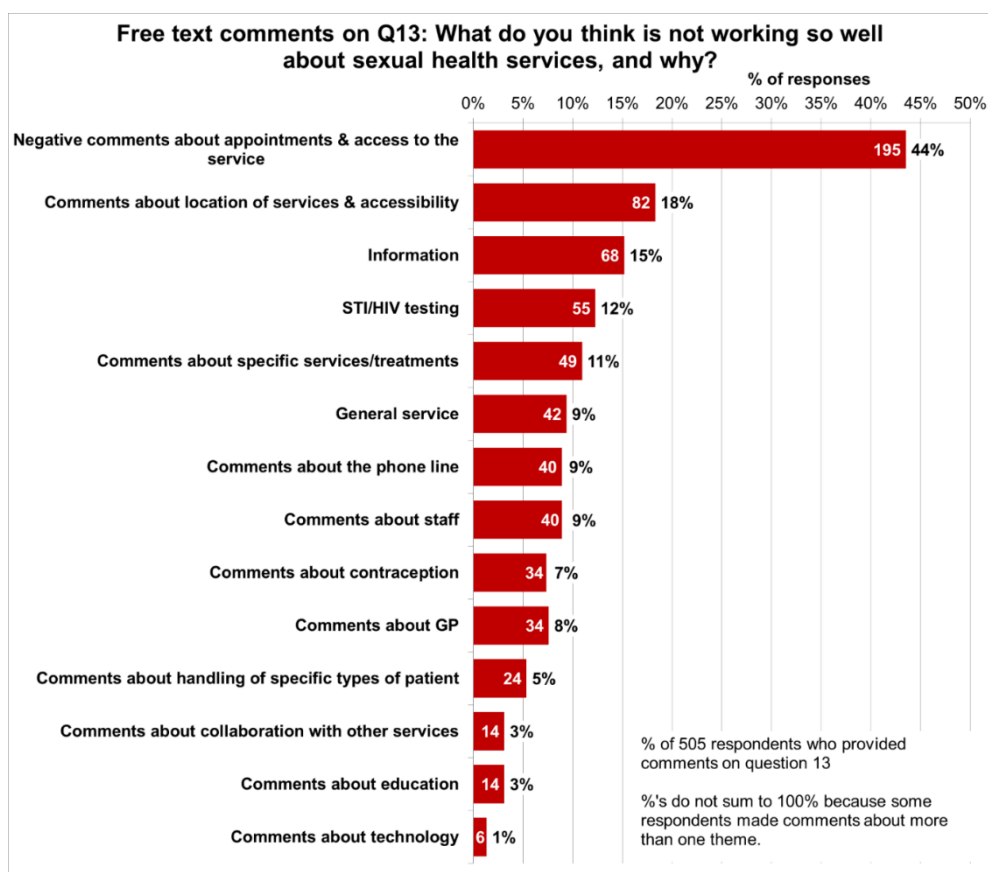


Figure 6.2: The main themes from the free-text responses to the survey question 'What do you think is not working so well about sexual health services, and why?' (Bristol City Council)

6.1.5.6 What could be improved

496 (77%) respondents to the survey responded to the question 'How do you think we could make our sexual health services better?'. The main themes are summarised in figure 6.3 below.

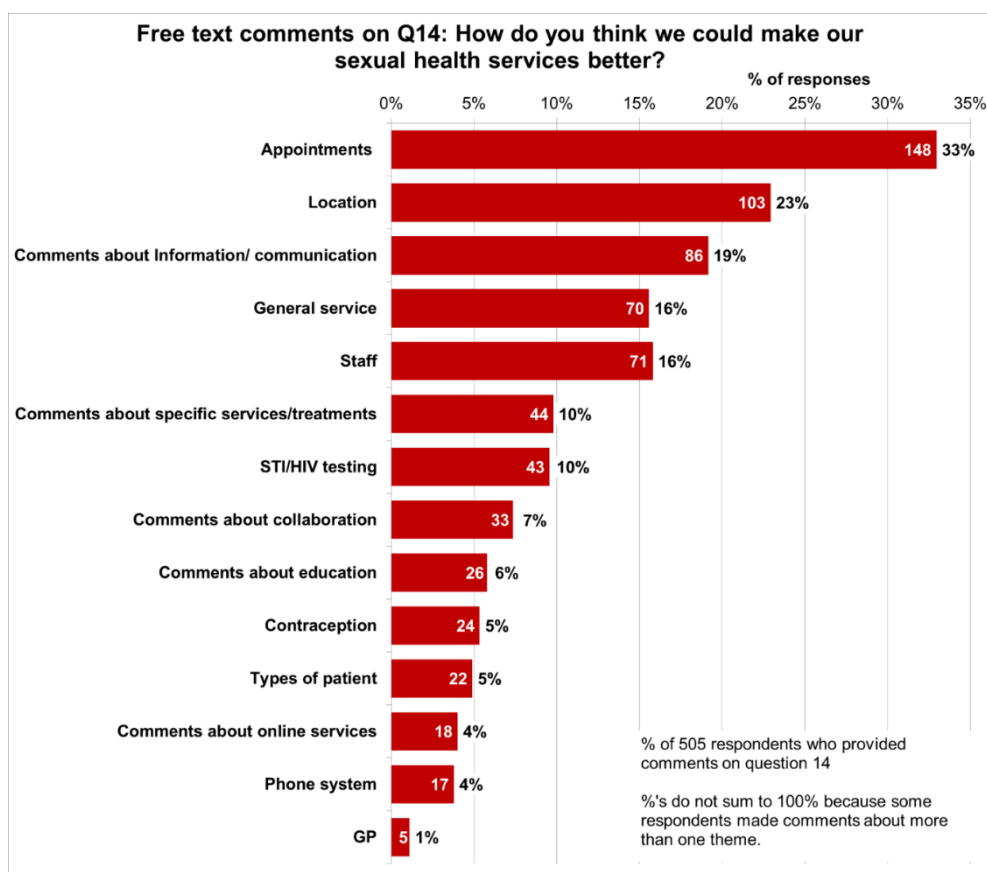


Figure 6.3: The main themes from the free-text responses to the survey question 'How do you think we could make our sexual health services better?' (Bristol City Council)

6.1.5.7 Anything else we should be doing to improve local sexual health?

329 (51%) respondents to the survey responded to the question 'Is there anything else that you think we should be doing to improve the sexual health of people in Bristol, North Somerset and South Gloucestershire?'.

- half the comments were about improving access to services
- a third of the comments were about improving health promotion, education and communications
- others included equalities and inclusion suggestions

6.2 Semi-structured interviews

In addition to the public survey, 26 semi-structured interviews were also conducted with Unity staff, subcontractors, and partners.

6.2.1 Summary of findings

Although it was agreed by almost all that once patients get into the Unity service they receive a high quality, safe and effective service from a multidisciplinary team that works well together, there were several significant issues highlighted by these interviews.

6.2.1.1 Access to services is a problem

This was the most common concern, with difficulty getting through on the phone and long waits for certain services being problematic even amongst those groups with priority access

Phone triage

It was recognised by all that the phone service is 'flawed' and 'not fit for service' and causes significant frustration to both patients who are unable to get through to book an appointment or who get cut off. This has consequences – admin staff turnover is high, and patients are being turned away.

Technical issues: no on-line booking service, no data sharing, poor data manipulation

Many respondents mentioned the lack of promised online booking of appointments that was recognised as an issue some time ago causing frustration to staff and limiting access as the phone lines are inadequate. Subcontractors also raised the issue of lack of ability to view Unity information which can lead to unnecessary tests and lack of co-ordinated care. Pulling data to fully understand the demographics of those accessing the service was also highlighted as an issue.

Appointment slots: number and timing

It was felt generally that Unity were not offering enough slots for patients to meet the demand. This is particularly the case for evenings and weekends as very few clinics are held out of routine office hours, which is a problem for many of the clients. Unity surveys have suggested that these would be clients preferred times. Some services such as emergency coils and intramuscular injections for gonorrhoea require very timely treatment which is not currently available.

Admin staff shortage and high turnover

Staff shortages were felt to be an issue mostly around admin staff who have a high level of turnover. A lack of such staff means that clinical staff are being used to undertake admin duties which is inefficient and further reduces capacity for appointments. Although many said how great the postal kits were, the delays in getting these kits out due to a lack of dedicated staff meant that the service was not as efficient or timely as it needs to be to meet needs.

6.2.1.2 Vulnerable clients need additional support

Partners highlighted the fact that the lives of their vulnerable clients are often chaotic, and services need to be available when they present with an issue - they often don't keep appointments nor wait and a traditional SRH service is not necessarily the best model. Many will not have a smart phone and/or are not digitally literate and some have language issues. Many of them will not travel, and most have suffered trauma and psychologically informed services with translation available within community locations need to be provided for these groups. The lack of walk-in services and community-based services was considered a

problem for many such groups as was the lack of 'one stop shop' appointments in all locations where all sexual health issues can be addressed at the same time. For many clients there is a lack of trust in health services, and local, community-based services were seen as essential to fully engage. For people from non-White backgrounds, having a diverse staff group was also felt to be key. Many partners expressed the need for better joint working with Unity, and with a greater focus on outreach. North Somerset has less access to some services like teenage pregnancy outreach.

6.2.1.3 Lack of awareness about Unity services and how to access them

Many people felt that there was a lack of awareness about Unity services. The website was considered outdated, clunky and difficult to navigate and often did not communicate the information needed by people. A lack of adequate social media presence was considered a key issue preventing full engagement with the public.

6.2.1.4 Health promotion and outreach services are too limited

Several people felt the level of population understanding around sexual and reproductive health was poor. They mentioned the false information circulating through social media such as the Tik Tok campaign promoting natural family planning and the need to have highly effective health promotion social media to counter these harmful messages.

It was felt that currently health promotion and outreach work was too focused on MSM and that the outreach needs to be broader. Schools work including working with school nurses was mentioned by several as a gap and the need to address issues such as children's access to porn.

A few highlighted the lack of condom provision and others suggested that many women were declining contraception post-termination as they believed the side effects would be worse than dealing with an unintended pregnancy.

6.2.1.5 Integration with subcontractors is variable

Responses around how well integrated the partnership were somewhat variable with some stating good integration and others feeling there was no true integration at all. Some staff were unaware who the subcontracted partners were, and many were unaware what they were doing. Meet ups of providers had not been face-to-face since COVID-19 and some expressed a sense of disconnection. Although the lack of full integration was recognised by most, some felt this was appropriate as subcontractors had their own identities which they wanted to keep. Partners valued the expertise and shared learning around quality and safeguarding but an inability to access NHS records was a hindrance. Others felt the clinical service was too Bristol-centric and clinic focussed and didn't value the need for partnership work. Some found the loss of direct access to commissioners difficult.

6.2.1.6 Wider partnership work would be helpful

Responses from partners working with vulnerable clients are summarised above. In addition, some partners felt there should be closer proactive working with the voluntary sector as often they were sharing the same clients.

HIV treatment was considered good but the fact that it is provided by another trust was considered the wrong approach by many, with patients needing to navigate two separate services. Suggestions for addressing this included sharing staff across sites. Accessing Unity data is a barrier for HIV services.

Although many felt that Unity was both the system and clinical leader for sexual health in BNSSG, others clearly disagreed.

6.2.1.7 Gaps in funding and commissioning are limiting provision

There were a number of comments around funding and what things Unity were or were not commissioned to provide, and that budget constraints were preventing the service meeting demand.

Unity clinicians felt they could offer HIV treatment, menopause care and services for transgender people and people with gender dysmorphia but are not currently commissioned for these. Some felt there were a number of areas that GPs should be commissioned to provide, including genital wart treatment, and PrEP continuation to enable Unity to focus on the most complex patients.

6.3 Other engagement

6.3.1 Bristol Pupil's Voice survey

The 2022 Bristol Pupil's Voice survey³²⁰ included questions on sources of information about sex and relationships. Among primary school children in year 6, 50% responded that they would like their parents/carers to talk to them about body changes and growing up, and 66% had already talked to parents/carers about body changes and growing up. Secondary school pupils were asked about their sources of information about sex and relationships and school lessons were the most commonly chosen source for 69% of pupils (76% in 2019). However 15% of secondary school pupils found lessons on sex, relationships and STIs not useful at all. The combined role of the internet, TV/films and porn as a source of information was also high. The findings also suggest that as young people get older they turn more to their friends instead of their parents as their main source of sexual health knowledge, after school lessons.

The survey also found that 47% of year 10 pupils said they know where they would go if they needed a contraception/sexual health service (54% in 2019) but only 24% of all year 10 pupils were aware of local Brook sexual health services (41% in 2019), and rather fewer (less than 10%) were aware of Unity.

³²⁰ Bristol Pupil's Voice survey 2022 – internal analysis

6.3.2 South Gloucestershire Young People's Drugs and Alcohol Service survey

Over 600 young people and some parents and professionals in South Gloucestershire filled in a survey commissioned by South Gloucestershire Public Health about young people's drug and alcohol services and access to other health services, including sexual health services.

The engagement consultation took place between 19th May and 15th July 2022.

All survey groups agreed that anxiety and lack of money stops young people from accessing services generally. Young people report a lack of time as a common barrier to access. Young people felt the best way to improve access to sexual health (and other) services was to provide an online service. Responses to the survey question 'Ways to improve engagement with sexual health services' are found in table 6.1 below.

Table 6.1: Responses to the survey question 'Ways to improve engagement with sexual health services?' for South Gloucestershire young people and parents, 2022 (South Gloucestershire Council; numbers in italics are number of young people who ticked that option)

Possible responses	Young people's survey sample groups						Adult survey sample groups						Total
Walk in appointments	74	93	25	4	5	4	7	22	5	5	3	1	248
Online service	130	153	36	8	6	5	8	26	4	4	1	1	382
Community venues	54	30	19	2	3	3	6	30	8	4	3	1	163
Weekend service	32	30	12	2	2	1	7	23	5	3	3	1	121

Young people gave some supporting comments about why online services were useful, including:

- because people are shy online is best (3)
- online services make it accessible (1)
- online service are a good starting point to getting help as a lot of people feel uncomfortable going in person. (1)
- more people are online with this generation (1)

6.3.3 UWE student survey 21-22

The annual student survey includes questions about sex and relationships. The areas of greatest concern about sex and relationships at university were 'stalking/harassment' (21%), 'risk of sexually transmitted infections' (19%), and 'risk of experiencing sexual violence' (19%)

6.3.4 UWE students

Feedback from engagement undertaken with UWE students in summer 2022 regarding access to sexual health services included:

- distance to Unity clinics and logistical barriers to visiting

- an on-campus specialist service would greatly improve access. This point was emphasised throughout the interviews.
- requested more presence on campus (sexual health education, resources including condoms, clinics)

6.3.5 GPs

Some GPs offered specific feedback about access to sexual health services, including

- increase LARC training for nurses
- LARC access for homeless, sex workers, and drug and alcohol service users, racially minoritised communities
- easier access to contraception and condoms for young people including C-card and school sexual health workshops

6.3.6 Sexual health clinic staff

Staff were offered semi-structured interviews in addition to the online survey.

Similar themes to the larger BNSSG Sexual Health Needs Assessment survey were raised:

- the need to improve access, capacity, patient pathways and waiting times.
- the positive impact of collaboration and teamwork
- suggestions for improvement included a wider offer of services in primary care and other partners; a stronger digital offer; integration with HIV treatment services.

Specific points:

- more flexible access to Progesterone Only and Combined Oral Contraception
- take a life-course approach in line with women's health strategy to better integrate broader menstrual, gynaecological, reproductive and sexual health.
- improve abortion provision in North Somerset.
- address lack of teenage pregnancy outreach provision in North Somerset

6.3.7 Homeless Health (and outreach more broadly)

A clinical representative for Homeless Health said three main challenges are access, design, and follow-up. Access because Homeless people, in the main, like other vulnerable people, may not keep appointments and do not have stable mobile phone numbers. Services therefore have to be drop-in and immediately available. Design because services have to be psychologically informed at every level from the front door, reception, waiting room, and above all consultation. Conducting a consultation with complex homeless people needs training and practice. Follow-up depends on a care plan shared with a wider team of health link and outreach workers who refuse to accept 'lost to follow-up or DNA'.

6.3.8 Commissioners

Two workshops were convened with local authority and ICB sexual health commissioners across BNSSG to determine key issues in current services and to consider the future of sexual health services across the locality.

The first workshop, held on 28th June 2022, had the following objectives:

- discuss what is working and what is not working with the current service model
- think about what health system landscape and what it will look like post-April 2024, and how organisations and services will relate to one another in the future
- consider how that may be different to the current ways of working
- consider how the new future will 'feel'

The themes that came out of the workshop for future consideration included:

- ensuring that services are cost-effective and sustainable
- working collaboratively within the system
- reducing inequalities
- ensuring services are evidence based
- ensuring services are high-quality
- expanding joint ICB commissioning

The second workshop was held for local authority and ICB sexual health commissioners on 9th November 2022. Initially, the early findings of this SHNA, in terms of the data and the engagement results, were shared and discussed. The second half of the session involved two mapping sessions working in three separate groups. The first session required the groups to map their interpretations of the current service model and to identify what elements they would like to see in a future model. The second mapping session required the groups to design a preliminary service model for the future with consideration of the SHNA findings presented earlier in the session and the first mapping exercise. These suggested models will be subject to further discussion of their potential merits and challenges as the recommissioning phase gets underway.

6.4 Sector-led improvement (SLI) assessment

The English HIV and Sexual Health Commissioners' Group SLI tool³²¹ was completed as part of this SHNA to self-assess sexual health, reproductive health and HIV service provision across BNSSG to help identify areas for future focus and to understand what is working well and what could be strengthened. Usually the tool is completed for an individual local authority area, but as BNSSG commission integrated sexual health services together, it was felt that a combined self-assessment was appropriate.

The tool assesses the four key feature areas of 'what a good sexual health service looks like'³²² and asks a series of questions, which are then scored accordingly. 0 - Early (no evidence), 1 - Developing (some evidence), 2- Mature (strong evidence), 3 – Transformational. The four features of a good sexual health service are: successful system leadership; building individual and community resilience; safe and effective practice; and

³²¹ [ADPH The English HIV & Sexual Health Commissioners' Group - ADPH](#) (updated 27/01/2022)

³²² [EHSCHG Self-Assessment Tool: Local HIV, Reproductive Health and Sexual Health Service Provision | ADPH](#) (published 27/01/2022)

promoting equality. An explanation of how each standard is met is added to the tool and future plans for actions documented. The tool can also be used for a peer-review process.

The tool categorises each area with a score of achievement as follows: 0-25% is early achievement, 25-50% developing achievement, 50-75% mature achievement and 75% is an outstanding achievement. The tool showed that services across BNSSG achieved a score of 63% which indicates a mature achievement overall but with room for improvement in relation to areas such as:

- ensuring there is a clear, shared strategic vision and goals for sexual and reproductive health across the system
- strengthening the role of patient and public involvement to develop and improve services
- working as a system to build resilience by offering more support to parents and carers of young people to understand the role of consent, the risks of non-consensual sex and online exploitation, and to recognise the characteristics of a healthy relationship
- services offering appropriate digital technologies to support access to services and information

The BNSSG integrated sexual health service scored the following across the four areas:

- system partnership: 61%
- building resilience: 67%
- safe and effective services: 62%
- promoting equity: 60%

7. Issues identified

The following summarises the key issues identified in this SHNA for 2022.

STI testing and new diagnoses fell from 2019-21

Published outcomes data for BNSSG shows that STI testing and new diagnoses (excluding chlamydia in <25s) fell considerably from 2019 to 2021, with Bristol experiencing the biggest decreases. The observed reduction in new diagnoses is likely linked to the fall in testing, which in turn is likely to be due to access issues during COVID-19, as well as due to changes in sexual behaviour during the pandemic. Recent local data for 2022 is suggesting an increase in chlamydia and gonorrhoea cases. There are discrepancies between the different sources in relation to testing and new diagnoses data, which are being investigated. Numbers of STIs are higher in women than men in young people under 25 but in over 25s they are more common in men. There are more STIs diagnosed in people from deprived areas and re-infection is common especially in young people.

Partner notification rates are low

Only 768 people were seen in our SRHS as partners of identified cases in 2021. With over 4000 STIs diagnosed, this figure appears low.

Chlamydia screening in 15-24 year olds has reduced

The national chlamydia screening programme aims to reduce the harms from untreated chlamydia in young women. The chlamydia detection rate in young people aged 15-24 years old fell by 42% in BNSSG from 2019 to 2021, which mirrors the trend nationally. BNSSG's detection rate has been lower than the England average since 2014. Given the high proportion of young people living particularly in Bristol, the low detection rate suggests poor awareness of, access to and/or uptake of screening. Distribution of chlamydia screening kits in pharmacies is particularly low.

Gonorrhoea and syphilis are most common among GBMSM

Across men and women regardless of sexual orientation, and even with chlamydia in <25s excluded, chlamydia was the most common STI between 2017-2021. Among gay, bisexual and other men who have sex with men (GBMSM) in BNSSG gonorrhoea is the most commonly diagnosed STI. Most cases of syphilis diagnosed in BNSSG are amongst GBMSM. Gonorrhoea is used as a marker for rates of unsafe sexual activity in a population and an indicator of local burden of STIs in general.

New STI diagnoses in Black communities are lower than expected

Nationally, new diagnoses of selected STIs in people of Black ethnicity were 2.4 times higher than in the general population, which would be expected to be reflected in the Bristol data, perhaps more so as Bristol's Black population is larger (5.9%) than England's (4.2%).

However, this is not the case, and local data suggests that people from Black communities are less likely to access testing and services. This needs further exploration to ensure services are welcoming and accessible for all.

HIV testing has fallen

HIV testing appears to have fallen across BNSSG by 68% between 2019 and 2021. The national HIV action plan sets out to end new HIV transmissions by 2030, with increased testing a key pillar of the prevention plan. Locally, Bristol is an HIV Fast Track City, which aims to deliver on the national HIV action plan and the UNAIDS 95:95:95 targets. There is a focus on improving testing for the population through several initiatives including a pilot of STI and HIV test vending machines. In addition, there has been lobbying of national government to release funding to high HIV prevalence areas, such as Bristol, to offer HIV and other blood borne virus opt-out testing in emergency departments, which has proven successful in emergency departments in areas of very high prevalence and supports the normalisation of HIV testing.

HIV testing is very low among women and heterosexual men

HIV testing coverage in all men attending specialist sexual health services in BNSSG was lower than the England average in 2021, largely driven by the 63% of heterosexual men and 68% of women either not offered or not accepting an HIV test.

HIV diagnoses have fallen but an increasing proportion of those who are diagnosed are diagnosed late

The number of new cases of HIV has reduced in Bristol and other areas but of those newly diagnosed, an increasing proportion were late diagnoses between 2012-14 and 2019-21. In England, those diagnosed late in 2019 had more than a 7-fold increased risk of death within a year of diagnosis compared to those diagnosed promptly. A late look back exercise in both acute trusts has identified that amongst those diagnosed late, there were several missed opportunities where people could have been diagnosed earlier.

PrEP uptake is low among women and racially minoritised groups

The numbers of people accessing PrEP through Unity has increased over 2021 and 2022, however only half the people who would benefit from PrEP appear to be accessing it according to local data. The vast majority of people obtaining PrEP in BNSSG are young, white GBMSM. Uptake is very low amongst ethnic minoritised groups and women.

LARC-prescribing is recovering but access is variable and needs improving for vulnerable groups

LARC (coils and implants) is the most effective and cost-effective form of contraception. Access to LARC across BNSSG, which takes place predominantly in general practice, has shown promising signs of post-pandemic recovery based on published outcomes data and

local activity data. LARC activity in North Somerset and South Gloucestershire practices has already recovered to pre-COVID-19 levels. However, this is not the case for all practices in Bristol where limited access to LARC continues, with local data suggesting that practices at 60% or less of pre-COVID-19 activity are in more deprived areas. The impact of COVID-19 is likely to have been greater on those from marginalised groups, who may be more likely to access walk-in and specialist services than booked appointments and may not approach GPs for contraceptive help.

Variability in access to LARC in BNSSG could be improved through increased access to LARC training by practice nurses and improved access support for the homeless, sex workers, drug and alcohol users, asylum seekers and care leavers.

Condom uptake has decreased significantly among young people

Issuing of condoms across community and specialist services, and through the C-Card scheme, has decreased significantly across BNSSG, posing a risk to safe sex practices in terms of preventing unwanted pregnancies and STIs. Further work is needed to understand why young people are not accessing free condoms.

Teenage conceptions remain low but have seen recent rises with some wards having particularly high rates

Teenage conceptions have fallen significantly since 2008 in BNSSG, however the most current data available appear to show signs of a slight increase in Bristol during the last two reported quarters to June 2021. Despite the low rates of teenage conceptions in BNSSG, there is variation within the local authority areas, with higher than England rates of under-18s conceptions found in Weston-Super-Mare South and Weston-Super-Mare Hillside wards in North Somerset, and in Filwood ward in Bristol in 2018-2020.

There is a lack of awareness of local sexual health services

Data from Bristol's 2022 Pupil Voice survey found that 47% of Year 10 pupils said they know where they would go if they needed a contraception/sexual health service (54% in 2019). Only 24% of all year 10 pupils were aware of local Brook sexual health services (41% in 2019), and rather fewer (less than 10%) were aware of Unity. South Gloucestershire young people suggested that online services were preferable for young people.

Wider engagement as part of the SHNA process revealed that many people felt that there was a lack of awareness about Unity services. The website was considered outdated, clunky and difficult to navigate and often did not communicate the information needed by people. A lack of adequate social media presence was considered a key issue preventing full engagement with the public.

Relationships and sex education (RSE) is now statutory but may still not be meeting needs

RSE is now statutory, but the quality of this education may not be meeting the needs of our young people. The Bristol Pupil Voice survey found that 15% of secondary school pupils did not find lessons on sex, relationships and STIs useful at all. After school lessons, as young people get older, they turn more to their friends instead of their parents as their main source of sexual health knowledge. The combined role of the internet, TV, films and porn as a source of information was also high.

EHC uptake has reduced

Over the last few years the provision of free EHC in pharmacies, general practice and Unity services has fallen. Although the pandemic may have restricted access, the reasons for the ongoing reduction are not fully understood.

Pharmacy data provides an insight into the risk behaviours of individuals seeking EHC as, across BNSSG in 2021-22, 62% of all 5,558 consultations in people aged <25 were requesting EHC after not using contraception and 30% after condom failure. Furthermore, 18% had already used EHC in the previous 3 months.

Access to emergency coils is variable across BNSSG

Coils are the most effective form of emergency contraception. A greater proportion of emergency coils are provided in Bristol than elsewhere in BNSSG. Access to emergency coils is poor in more rural areas of BNSSG, more deprived areas, and for non-White ethnicities.

Total abortion rate remains low but repeat abortions have increased

The total abortion rate in BNSSG remains low in 2021, and lower than the England average, but repeat abortions in under-25s have risen and were proportionally highest in South Gloucestershire at 28% in 2021.

Access to contraception following abortion or birth is low

Although all women should be provided with post-termination contraception, with the changes to processes such as many abortions now taking place at home, data suggests this is not always happening across abortion services in BNSSG with almost half of women not receiving contraception.

In addition, in line with national guidance, pregnant women should be provided with antenatal contraception counselling and access to their chosen contraception immediately post-partum to prevent short interpregnancy intervals. This is not delivered in most areas but a pilot of post-partum contraception is due to commence in BNSSG in 2023.

Access to specialist services is an issue

In recent public feedback about SRHS across BNSSG, collected via a survey of 643 respondents in summer 2022, 42% of all respondents were positive about staff and the

service in general, but 43% had negative feedback about appointments, location of services and accessibility.

The survey findings were also echoed in a series of semi-structured interviews conducted with healthcare staff, in which there was almost universal agreement that once patients get into the Unity service they receive a high quality, safe and effective service from a multidisciplinary team that works well together. However, several significant issues were highlighted by these interviews, including that access to services is a problem particularly for the most vulnerable clients who need additional support with this.

Difficulties in accessing Unity include the lack of an online appointment booking system, a telephone triage service that has extensive waiting times resulting in patients not always getting through, and the ongoing closure of some community clinics affecting South Gloucestershire residents in particular.

8. Recommendations for commissioners

The following recommendations for commissioners have been drawn from the findings of this SHNA. These should be given due consideration when making variations to existing contractual arrangements and/or when designing future service models for procurement, balancing value for money and the ability to offer safe, high quality and comprehensive SRHS.

SRHS for the increasing and increasingly diverse BNSSG population

- The population of BNSSG is growing and projected to increase in size by 6% in 2030. SRHS need to be aware of predicted changes and adaptable to meet rising future demand.
- The ethnic diversity of Bristol's population continues to increase, especially in younger groups. The SRHS workforce should be trained to understand the impact of racial injustices and strive to be representative of the population it serves. They should continue to work with these communities to support greater access from minoritised ethnic groups.
- Service user engagement needs to be meaningfully increased.

Prevention, health promotion and outreach

- Prevention needs to be integrated throughout our sexual health system to improve sexual wellbeing, and to reduce repeat presentations and poor outcomes (such as STIs and the consequences of STIs, and unplanned pregnancies), particularly for those in high-risk groups.
- There is a need to promote much greater awareness of SRHS in BNSSG. This should include a strong social media presence, and an accessible, highly publicised and informative website which empowers service users to look after their own sexual health and to know when and how to seek help.
- RSE lessons at schools should include information about local services and how to access them as a priority.
- There is a need for closer working with public health nursing services in schools to improve the sexual health outcomes of young people, especially in areas where teenage pregnancies remain high.
- Repeat abortions in under 25s have increased suggesting a lack of access to good quality contraception services and advice for younger people. SRHS need to provide services that are friendly and approachable for young people, available in a range of settings.
- SRHS need to provide outreach services that engage with a wide range of vulnerable groups, broadening out from a focus on GBMSM.
- Health promotion efforts should:

- take a 'sex-positive' approach, focusing on building confidence in making informed choices and consent.
 - respond to changing cultures (including the increasing use of natural cycles by young people rather than using hormonal methods)
 - take full advantage of technical developments, such as social media.
 - address concerns around online porn and online exploitation and the impact on young people.
- Education around sexual health should also be targeted at parents and the wider community, not just those who may benefit from accessing the service themselves.

Increasing access to services

- There have been no SRHS community clinics in South Gloucestershire since the start of COVID-19. This should be resolved as soon as possible.
- Community and outreach clinics should be situated according to need, appropriateness of setting and offering accessible opening hours to the local population. This should include the consideration of the large student population within BNSSG.
- There is evidence of low uptake of SRHS by Black people and those living in the most deprived areas in Bristol. Services need to work with communities to ensure they are accessible and welcoming to all high risk and equalities groups and promote their services appropriately.
- Tailored support to access specialist and community services, including walk-in services, should be offered to the groups most at risk of poor sexual and reproductive health outcomes, including:
 - people involved in sex work
 - people with physical and learning difficulties
 - people of African and Caribbean heritage
 - LGBTQ+
 - homeless people
 - young people
- Findings from the SHNA revealed negative feedback about appointments, location of services and accessibility:
 - access to a range of SRHS via digital (online) routes should be increased.
 - SRHS need to be accessible at times of the day and week that will have highest demand, including Saturdays and Sundays.
 - walk-in sessions should be available to ensure that those most at risk can access services quickly when needed.
 - different appointment booking methods should be available, including telephone and online.
 - the long waiting times reported for telephone access to Unity services should be addressed as soon as possible.

STI and HIV service provision

- STI testing and diagnoses have continued to fall in BNSSG since 2019 and the COVID-19 pandemic. Ongoing monitoring of this data in collaboration with SRHS is needed, as well as seeking assurance that testing is widely, readily and rapidly available through clinic and outreach settings.
- Access to online testing needs to be improved to ensure that people can be tested and treated rapidly. Process issues that hinder the timeliness of this service need to be addressed.
- Partner notification is a key part of reducing transmission of STIs. Further work needs to be undertaken to ensure that this can be provided across our health system, regardless of where the test was performed.
- An action plan is required as soon as possible to address the reduction in chlamydia screening in 15–24-year-olds.
- HIV testing has fallen and is particularly low among women and heterosexual men, who should be consistently offered an HIV test upon every attendance at SRHS (opt out rather than opt in). More work is needed by the provider to understand the barriers and facilitators for non-GBMSM men and women to accessing HIV testing and to implement interventions to address this.
- An increased focus on HIV testing is particularly important following the increase in the proportion of late diagnosis of HIV. Initiatives such as Common Ambition Bristol are key in reducing stigma and promoting the importance of testing in a culturally competent way within African and Caribbean heritage communities.
- PrEP needs to be widely promoted and available beyond specialist SRHS settings.
- PrEP uptake for those not currently accessing it (including women and people of Black African heritage) needs to be explored and addressed.
- Opportunities to address the separation of provision of sexual health and HIV treatment services should be explored by the BNSSG ICS, especially considering future delegation of HIV treatment to BNSSG ICB from NHSE.

Reproductive health service provision

- Access to LARC in the community was greatly impacted by COVID-19 and despite recovering well in North Somerset and South Gloucestershire, access is still patchy in Bristol. Consideration should be given to how LARC training can be incentivised for practice nurses, and the potential role of LARC PCN hubs to address inequity.
- LARC training should be made available for all clinicians needing this skill (including in maternity services), to encourage equitable and timely access to this most effective form of contraception.
- LARC delivery should be considered as well as care for menopause and heavy menstrual bleeding as part of the BNSSG response to the Women's Health Strategy for England.

- Access to emergency coils in North Somerset and South Gloucestershire needs to be improved as this service is currently only available in the centre of Bristol.
- Teenage pregnancies in BNSSG have shown a steep decline since 2007 but the most recent data shows a slight increase in Bristol and high rates in certain wards. The local authority data should be monitored quarterly, and a review of potential actions to address areas where teenage pregnancy rates are high should be considered in North Somerset and Bristol.
- A collaborative and digitised approach to condom distribution across BNSSG is recommended to address the significant decrease in condom uptake in young people, particularly in relation to the C-Card scheme.
- Access to abortions for women in North Somerset needs to be addressed to ensure they have the full choice of accessible options.
- All women undergoing an abortion should be provided with advice and their choice of contraception at the time (or soon after) an abortion.
- All women should be provided with advice and their choice of contraception soon after the delivery of their baby.
- Where appropriate (such as when LARC is removed, or women choose less effective or no contraception methods) women should be offered pre-conception advice.

Improving data quality

- There are a number of concerns regarding data quality and transparency which has limited our understanding of local sexual health needs in BNSSG. The following recommendations should be actioned as soon as practicable:
 - service data should include numbers of unique attendees, episodes of care, methods of consultation, types of appointments, repeat attendees.
 - attendance data should be treated separately to online STI test requests.
 - demographic data should be available for all performance reporting, including ethnicity and sexual orientation. This is vital to understand need and address inequalities.
- Where possible, the same electronic record should follow the service user along the integrated SRHS pathway to ensure that records are comprehensive and readily accessible by health professionals working in different parts of the SRHS.
- Data discrepancies between published outcomes, GUMCAD and Unity reports need to be explored further by providers, supported by commissioners.

Working effectively as a sexual health system

- There needs to be a clear, shared strategic vision and goals for sexual and reproductive health across the system.
- Effective collaborative working between providers, between providers and commissioners, and between commissioners needs to be promoted and supported.

- Audit, evaluation and research should continue to be an important element of improving sexual health including within SRHS. Areas identified in this SHNA which may benefit from further research or exploration include:
 - understanding and addressing impact of social media on sexual behaviour.
 - exploring innovative interventions to promote safe sex in young people.
 - understanding and addressing barriers to condom use.
 - understanding the causes of the increase in gonorrhoea rates among young people.
 - exploring how effective the RSE offer is in BNSSG schools.
 - increasing digital access to sexual health services and exploring how it impacts on demand.
 - exploring innovations to improve awareness and uptake of LARC.
 - investigating the effectiveness of post-partum and post abortion contraception.
 - investigating how to increase post abortion contraception for women undergoing home abortions.
 - exploring how to improve awareness of and access to emergency coils.
 - gaining an in-depth understanding of how to make service accessible for the most vulnerable groups within BNSSG.
 - addressing the consequences of racial discrimination on access to SRHS.
 - determining the barriers to provision and acceptance of HIV testing in SRHS.
 - raising awareness of PrEP and investigating the acceptability and feasibility of provision outside of specialist SRHS.
 - exploring how to develop rapid partner notification across the whole sexual health system.
 - understanding the reasons for the decline in chlamydia screening and identifying interventions to address this.
 - developing a system wide approach to the improvement of sexual health outcomes and exploring what aids collaboration.

Appendix 1 – Description of levels of sexual and reproductive health services

Level 1 and 2

- Information on services provided by local voluntary sector sexual health providers including referrals and/or signposting
- Full sexual history taking and risk assessment (all practitioners)
- Pregnancy testing
- Supply of male and female condoms and lubricant
- All methods of oral emergency contraception and the intrauterine device for emergency contraception
- First prescription and continuing supply of combined hormonal contraception (combined and progestogen only) including oral, transdermal, transvaginal methods of delivery and a choice of products within each category where these exists
- First prescription and continuing supply of injectable contraception
- IUD and IUS uncomplicated insertion, follow up and removal
- Diaphragm fitting and follow up
- Uncomplicated contraceptive implant insertion, follow up and removal
- Assessment and referral for difficult implant removal
- Natural family planning
- Opportunistic cervical screening (no consultations specifically for screening)
- Direct referral for antenatal care
- Direct referral for abortion care and to support self-referral
- Counselling and direct referral for male and female sterilisation
- Domestic abuse screening and referral (all practitioners)
- Assessment and referral for psychosexual issues
- Assessment and referral for Brief Alcohol Interventions (BAIs)
- Referral for Female Genital Mutilation (FGM) specialist advice and care
- STI testing and treatment of symptomatic but uncomplicated infections in men (except GBMSM) and women excluding:
 - Men with dysuria and/or genital discharge
 - Symptoms at extra-genital sites e.g. rectal or pharyngeal
 - Pregnant women (except women with uncomplicated infections requesting abortion)
 - Genital ulceration other than uncomplicated genital herpes
- Chlamydia screening for sexually active under 25 year olds
- Case Management of uncomplicated Chlamydia
- HIV and syphilis testing and pre and post-test discussions (with referral pathways in place)

- Initiation of Post Exposure Prophylaxis with referral to Level 3 for on-going management
- Promotion and delivery of Hepatitis A and B vaccination, with a particular focus on key target groups
- Hepatitis C testing and discussion (with referral pathways in place)
- Uncomplicated contact tracing/partner notification
- Management of first episode uncomplicated vaginal discharge (low risk)
- Management of contacts of gonorrhoea and TV (excluding symptomatic men)
- Assessment & treatment of genital ulceration with appropriate referral pathways for those at high risk of syphilis/LGV (Lymphogranuloma Venereum)
- Assessment and referral of sexual assault cases
- Holistic sexual health care for young people including child protection/safeguarding assessment
- Outreach services for STI prevention and contraception
- Problems with choice of contraceptive methods
- Management of problems with hormonal contraceptives
- Urgent and routine referral pathways to and from related specialties (general practice, urology, A&E, gynaecology) should be clearly defined. These may include general medicine /infectious diseases for inpatient HIV care
- Urgent and routine referral pathways to and from social care
- Regular audit against national guidelines

Level 3

- Management of complex contraceptive problems including UK Medical Eligibility Criteria (UKMEC)
- Management of complicated/recurrent STIs (including tropical STIs) with or without symptoms
- Management of STIs in pregnant women (except women with uncomplicated infections requesting abortion)
- Management of HIV partner notification
- Management of organic sexual dysfunction
- Coordination of outreach clinical services for high risk groups including point of care testing for HIV
- Interface with specialised HIV services as commissioned by NHS England
- Specialist contraception services e.g. IUD/IUS problem clinics, difficult implant removal etc. with appropriate diagnostic services (e.g. ultrasound) to support this
- Provision and follow up of post-exposure prophylaxis after sexual exposure to HIV
- Coordination of contraceptive and STI care across a system including:
 - Clinical leadership of contraceptive and STI management
 - Co-ordination of clinical governance

- Co-ordination and oversight of training in SRH and GUM
- Co-ordination of pathways across clinical services
- Co-ordination of partner notification for STIs HIV

Other related services may also be delivered but paid for from different sources e.g. pre-cancers, routine cervical cytology (NHS England funded)