Wolverhampton Joint Strategic Needs Assessment

Sexual Health

August 2024

Contents

1. Scope

The purpose of this needs assessment is to identify any existing unmet sexual health needs across the population, and any gaps in service provision. Insights from this needs assessment can be used to inform local re-commissioning decisions and the shaping of sexual health primary care services in line with the needs of the community.

2. Executive Summary

2.1 Background

2.1.1 Overview of sexual health

Good sexual health offers benefits beyond individual wellbeing, positively impacting society as a whole. Access to comprehensive sexual health services enables informed contraceptive choices, resulting in planned pregnancies and improved health outcomes for both mothers and children. Reducing the incidence of sexually transmitted infections and diseases (STIs/STDs) decreases the risk of chronic health issues and disabilities, enhancing quality of life and alleviating pressure on healthcare services. This also helps prevent disruptions to education or work due to STIs or unplanned pregnancies, encouraging a more educated and productive workforce. Together, these advantages can encourage a healthy, thriving, and economically successful community.

The sexual health status of a population is closely linked to its demographic profile. Disparities in sexual health outcomes are influenced by factors such as age, gender, ethnicity, socioeconomic status, education, geography, cultural and social norms, marital status, and immigration status. These disparities between population groups often stem from individual, cultural, social, and economic barriers that hinder access to appropriate care, widening health inequalities. Young adults aged 15-24 years, individuals of Black ethnicity, and men who have sex with men (MSM) experience the highest rates of STIs. Additionally, higher levels of deprivation, which often intersects with vulnerabilities like mental or physical illness, disability, lack of support or education, cultural barriers, and experiences of abuse or stigma, further contributes to poor sexual health outcomes. Ensuring equitable access to sexual health services across all population groups is essential to reducing these disparities.

2.1.2 Commissioning responsibilities

The commissioning of sexual and reproductive healthcare (SRH) services is complex and involves multiple bodies. The commissioning responsibilities for sexual health services are divided among three main entities.

1. **Local Authorities:** Manage contraception (including LARC), STI testing and treatment, chlamydia screening, HIV testing and outreach (including PrEP), sexual health promotion,

psychosexual (sexual health aspects) counselling, and services for young people and schools.

2. **Integrated Care Boards (ICBs):** Handle most abortion services (including any STI testing in this setting), HIV testing in hospitals, sterilisation, vasectomy, gynaecology, and psychosexual (non-sexual health aspects) health services.

3. **NHS England:** Oversee cervical screening, sexual assault referral centres, sexual health in prisons, HIV treatment (including Post-Exposure Prophylaxis after Sexual Exposure (PEPSE), contraception including emergency contraception under the GP contract and contraception in pharmacies, opportunistic testing and treatment for STIs in primary care, HPV immunisation, and antenatal medicine services and screening programs.

   These arrangements ensure comprehensive coverage of SRH services across different settings and needs.

2.2 Local Context

2.2.1. Wolverhampton's demographic profile and health needs

- Wolverhampton's younger age-structure, high deprivation levels, and diverse ethnic makeup highlight the need for robust sexual health services. Targeted efforts for at-risk groups, including young people, MSM, Black individuals, and those experiencing higher deprivation, are essential to ensure equitable provision and reduce health inequalities across the city.

2.2.2. STI diagnoses, testing and demographic trends

- In 2022, Wolverhampton had a significantly higher rate of all new STI diagnoses at 768 per 100,000, compared to regional (502) and national (694) averages.

- For new STI diagnoses (excluding chlamydia in those aged <25 years), Wolverhampton had the 36th highest rate out of the 147 upper-tier and unitary authorities, with a rate of 550 per 100,000, worse than the regional (340) and national (496) averages.

- With regards to STI testing (syphilis, HIV, gonorrhoea, and chlamydia over 25 years) Wolverhampton performs similar to the regional average but falls behind the national average. The STI positivity rate in Wolverhampton is notably higher (11%) than the regional (7%), national (8%) and CIPFA neighbours (9%) averages, indicating a higher burden of STIs locally.

- Over two-thirds (69%) of new STI diagnoses in Wolverhampton come from the most deprived (quintile) areas. Black residents, though only 9% of the population, account for nearly a quarter (23%) of all STI diagnoses, reflecting regional and national health inequalities. Additionally, women in Wolverhampton have higher STI re-infection rates than men, and when compared to the national average.

2.2.3 Chlamydia

- In 2022, Wolverhampton's chlamydia detection rate for 15-24-year females (2,676 per 100,000) was significantly higher than the regional (1,745) and national (2,110) averages. Data from local sexual health service Embrace has also shown that there has been a concerning rise in chlamydia positivity among those aged 15-24 years in recent years.

- Among those aged over 25, the chlamydia detection rate in Wolverhampton was 266 per 100,000, significantly higher than regional (152) and national (217) averages, with Wolverhampton having the highest rate across the West Midlands region.

2.2.4 Syphilis

- In 2022, the syphilis diagnostic rate in Wolverhampton was 15.5 per 100,000. This was similar to the national rate (15.4) but higher than the regional (10.6) average. Rates of syphilis have risen over the last decade, with a 10-fold increase in diagnoses rates per 100,000 since 2012.

2.2.5 Gonorrohea

- In 2022, the gonorrohea diagnostic rate in Wolverampton was 148 per 100,000, similar to the national average (146), but higher than the regional (101) average. Rates in Wolverhampton have been increasing since 2015.

2.2.6 Pelvic Inflammatory disease (PID)

- Pelvic Inflammatory Disease (PID) can result from undiagnosed chlamydia and gonorrhoea. In 2021/22, PID diagnosis rates in Wolverhampton was 334 per 100,000, higher than the regional (252) and national (224) averages, with the highest hospital admission rates (334 per 100,000) across the West Midlands region.

2.2.7 Human Immunodeficiency Virus (HIV)

- In 2022, HIV prevalence among people aged 15-59 years in Wolverhampton was 3.7 per 1,000, significantly higher than the regional (1.9), national (2.3), and CIPFA neighbours (2.3) averages. Trend data indicates an increase in HIV prevalence in Wolverhampton since 2011.

- Between 2020-2022, the late diagnosis rate for HIV was 30% in Wolverhampton, lower than regional (46%) and national (44%) averages, indicating that despite higher prevalence of HIV, local efforts for timely diagnoses of HIV are effective.

- In 2022, 68% of eligible sexual health service attendees in Wolverhampton received an HIV test, exceeding regional (54.4%) and national (48%) averages. Among those needing Pre-exposure Prophylaxis (PrEP), 60% initiated or continued its use, higher than the regional

average (52%) but lower than the national average (71%). Additionally, Asian, Black, and other ethnic minorities are underrepresented in local PrEP prescriptions.

2.2.8 Human Papillomavirus (HPV) and Cervical Cancer

- The HPV vaccination coverage amongst 12–13-year-olds (females) has declined since 2019. In 2021/22, nearly two-thirds (65%) received their HPV vaccination in Wolverhampton, which is significantly lower than the regional (67%) and national averages (70%).

- In 2022/23, cervical screening coverage amongst eligible adults didn't meet the national target to screen 80% of the eligible population, with only 61% of 25–49-year-olds and 70% of 50–64-year-olds being screened.

2.2.9 Contraception and abortion

- In 2021, the total rate of long-acting reversible contraception (LARC) prescriptions in Wolverhampton was 29.8 per 1,000, below pre-pandemic levels and lower than regional (35) and national (42) averages, indicating potential gaps in access and education. Intrauterine contraceptives (IUC) were more common in those over 45, likely related to its off label uses for non-contraceptive purposes. Public Health Outcomes Framework indicators for LARC do not include prescriptions for those over 45.

- The total abortion rate in Wolverhampton has steadily increased since 2012, reaching 29.8 per 1,000 in 2021, significantly higher than regional (22) and national (19) averages. The proportion of White & Black Caribbean and Black African clients accessing abortion services are higher than their respective representations in the city's overall population, indicating higher needs among this population group.

- Teenage pregnancy rates remain high, with fewer abortions among under-18s despite higher conception rates, resulting in more teenage mothers compared to regional and national averages.

2.2.10 Local Sexual Health Service – Embrace

- Data from 2022/23 shows there are marginally more 15-29-year-olds (44.5%) attending Embrace, closely followed by 30-44-year-olds (40.25%). The majority of 15-24-year-olds that accessed the service were White (51.5%) followed by Black (15.6%), and Mixed (11.3%) ethnicity. The positivity distribution rate is highest among the White population. There was a high proportion (13.2%) recording no ethnicity which could indicate a data quality issue with ethnicity coding.

- The large majority (81%) of Embrace users were residents of Wolverhampton. Residents of St Peter's ward were most likely to attend local sexual health services (135 per 1000) followed by Heath Town ward (112.4) and Ettingshall North ward (101.8). There were fewest attendances from residents of Tettenhall Regis ward (49.9 per 1000).

2.2.11 Local Consultation

- Around half (47%) of those who responded to the survey, reported having not heard of Embrace. This lack of awareness around what the local sexual health service is called was also observed in the focus groups.
- Over two -thirds (64%), of all those surveyed, reported having heard of LARC, which means there are still a significant number who have not heard of it. Those of White ethnicity were most likely to have heard of LARC (84%), with fewer residents of Black those surveyed (38%) and Asian (38%) ethnicity.
- Around 7 in 10 (73%), of those who responded, said the availability and cost does not stop them from using condoms, but still a high proportion (82%) said that they would make use of free provision across GP/sexual health services.
- Around half (51%) of those who responded, said they do not test for STIs before having sex with a new partner.

2.3 Recommendations

2.3.1 Overarching recommendations

- Use the findings from the local consultation to understand residents' sexual health attitudes and service experiences and to inform improvements to service delivery.
- Establish a multi-agency Sexual Health Partnership to oversee the implementation of needs assessment recommendations.
- Form a task and finish group to implement recommendations from the Health-Related Behaviour Survey.
- Outreach work to promote sexual health, focusing on high-risk groups and those with lower access.
- Develop and review pathways for accessing sexual healthcare, annually, especially for high-risk and vulnerable groups like children leaving care, sex workers, and those experiencing homelessness or substance misuse.
- Ensure comprehensive staff training on service provision, cultural sensitivities, and the needs of vulnerable groups.
- Raise awareness of Embrace and enhance its visibility by ensuring its name and services are clearly communicated in all related health communications, especially at local sexual health clinics.

2.3.2 STI Prevention and Management

- Continue to raise awareness of the importance of STI testing before having a new sexual partner.
- Increase chlamydia screening in pharmacies, GP practices, and voluntary sector organisations.
- Enhance city-wide awareness of STI testing options online and in healthcare settings.
- Improve signposting to sexual health services in primary and secondary care, and promote Chat Health and Chat Sexual Health.

- Maintain high HIV testing coverage and support outreach for hard-to-reach populations. Treat late HIV diagnoses as critical incidents and follow NICE HIV testing guidelines to reduce undiagnosed cases.
- Raise awareness of PrEP availability and improve access for high-risk groups.

2.3.3 Contraception, abortion and teenage pregnancies

- Develop local campaigns to address low uptake of LARC, low cervical screening rates, and increased STIs.
- Increase LARC training for healthcare professionals and improve data collection on primary care LARC provision and service user engagement.
- Develop a universal, city-wide primary care referral pathway to Embrace for complex contraception cases.
- Raise awareness in primary care about immediate postpartum contraception options and support provision by RWT and ensure a comprehensive contraceptive offer is available on the same day as an abortion procedure to reduce repeat abortions.
- Develop referral pathways for STI testing and contraception, especially LARC, for home abortion cases.
- Continue to promote LARC and create culturally sensitive educational campaigns to raise awareness, with a focus on underrepresented ethnic groups like Black and Asian communities.
- Assess the feasibility of establishing a Women's Health Hub to promote a life-course approach to women's health.
- Complete the Teenage Pregnancy Framework self-assessment and respond to the action plan to support teenage pregnancy prevention initiatives.

2.3.4 Education and schools

- Establish a task and finish group to implement the Health Related Behaviour Survey (HRBS) recommendations.
- Ensure early delivery of Relationship and Sex Education (RSE) in primary schools, before the onset of puberty, and enhance RSE in secondary schools to cover sensitive topics like sexual harassment.
- Improve access to hygiene facilities and practices at schools, to help reduce stigma.
- Increase awareness among children and young people about contraceptive and sexual health services, and promote chat health services for timely support.
- Enhance the School Nurse offer to support RSE and sexual health delivery, with scrutiny of provision across the different settings.
- Complete the self-assessment within the Teenage Pregnancy Prevention Framework.

2.3.5 Equitable provision

- Improve awareness of Wolverhampton's local sexual health service, Embrace, and available service offers, including the availability of specialist clinics such as PrEP, Young Persons, and LGBT+ clinics.
- Improve data collection around service users, with routine monitoring and quality checks, particularly around capturing ethnicity and vulnerabilities.
- To explore the requirements for becoming a young person friendly service, adhering the standards laid out in the 'Your Welcome' guidance pack prepared by the Office for Health Improvements and Disparities (OHID).
- To explore behavioural change strategies to address STI reinfections, with a particular focus on women.

3. Introduction

Good sexual health positively impacts upon all of society, across all age groups – not just those who are sexually active. Good sexual health reduces the burden of disease, affords people more choice and freedom to have the sex they want as safely as possible. It allows people more contraceptive choice and enables planned pregnancy. The repercussions of good sexual health have a positive impact on physical and reproductive health and wellbeing, but also interpersonal, educational, and financial wellbeing.

Conversely, the consequences of poor sexual health also impact upon all of society, affecting both health and social outcomes. The treatment and management of these outcomes and their wider negative repercussions incur costs to society and to the public purse.

It also reinforces that certain groups are at greater risk of poor sexual health outcomes. These groups experience inequality in various forms. Deprivation and poverty are closely linked with poor sexual health, but other inequalities also impact upon outcomes, often intertwining with and exacerbating financial hardship. Groups that are more vulnerable and have less capability and capacity (through mental or physical illness, disability, lack of support or education, cultural and societal barriers or those who are victims of abuse, exploitation or stigma) are less able to make positive, informed choices and tend to experience poorer outcomes.

As Sexually Transmitted Infections (STIs) are often asymptomatic, frequent screening of groups at risk is important. Early detection and treatment can reduce important long-term consequences, such as infertility and ectopic pregnancy. While vaccination is a measure that can be used to control Human Papilloma Virus (HPV), Hepatitis A and Hepatitis B and Pre and Post Exposure Prophylaxis can be utilised for the prevention of HIV acquisition; control of STIs relies on consistent and correct condom use, behaviour change to decrease overlapping and multiple partners, ensuring prompt access to testing and treatment, and ensuring partners of cases are notified and tested.

The burden of STIs in England continues to be greatest in young people aged 15-24 years and men who have sex with men (MSM)[1]. In England, people of Black ethnicity were more likely to report a history of STI diagnosis. Research shows that there are no specific clinical or behavioural factors that can account for this, therefore sexual health inequalities must be addressed amongst this population[2] [3].

Reproductive choice allows someone to decide if and when they conceive, contraception is a keystone to enable this. A planned pregnancy after adequate preconception care is more likely to have a healthier outcome than those unplanned. Unplanned pregnancies are at greater risk of maternal physical and mental health complications and low birth weight, neonatal and infant morbidity and mortality. Health and socio-economic outcomes of young parents (conceived under the age of 18) and their children are disproportionately poor. A proportion of unplanned pregnancies will end in abortion and therefore access to contraception reduces abortion rates.

As a response to the COVID-19 pandemic, the Government implemented national and regional lockdowns and social and physical distancing measures since March 2020. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. When interpreting data from 2020/21 these factors should be considered, especially when comparing with data from pre-pandemic years[4]. In addition to this, since the lockdown measures, more people are using online services as a means of accessing sexual healthcare and this may be changing the way sexual health services are delivered. COVID-19 caused significant societal changes and therefore data for the years post-pandemic may show notable differences.

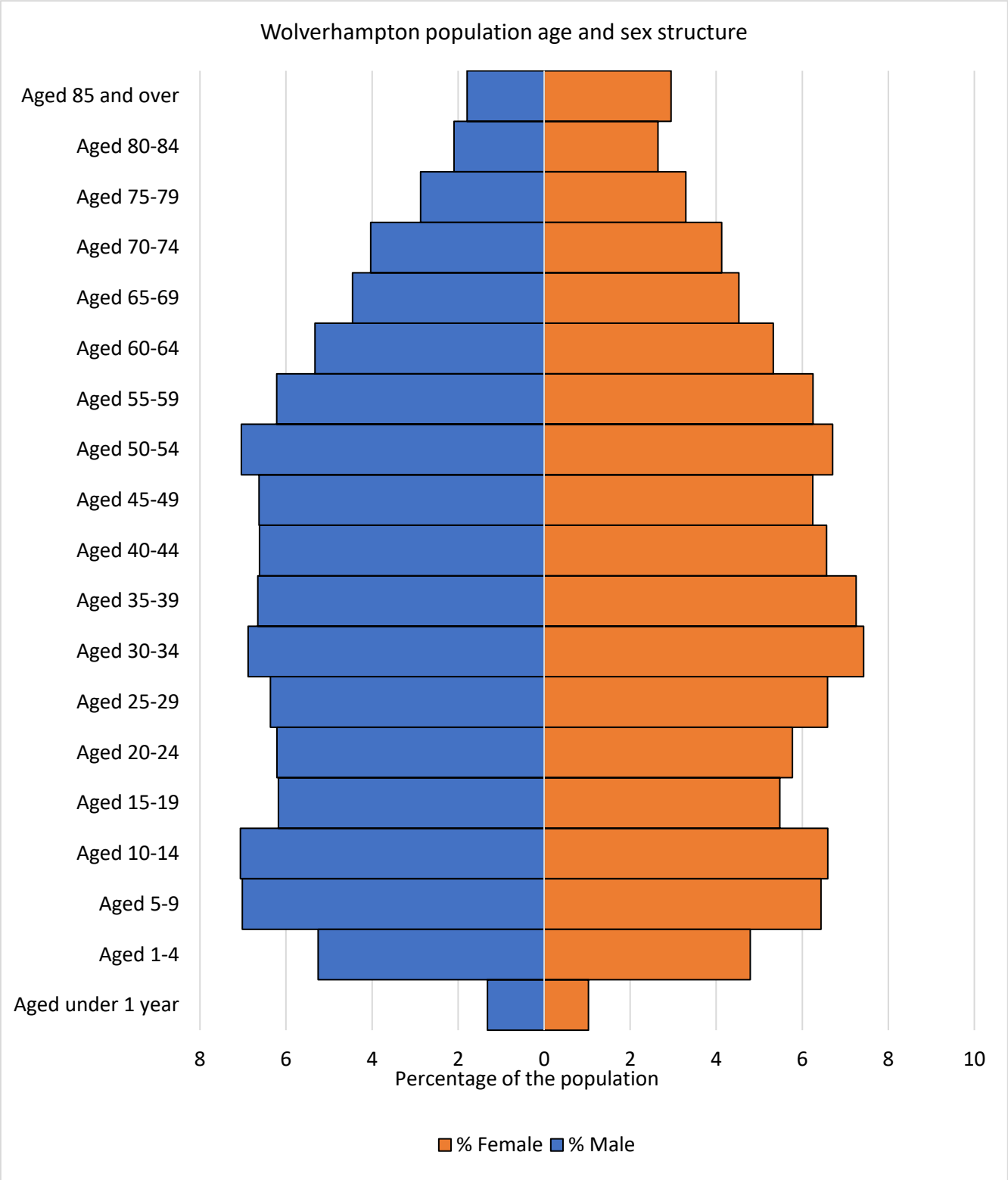
3.1 Understanding the needs of our City: Our changing population

3.1.1 Wolverhampton's population structure

Wolverhampton's population has been growing in recent years and in 2021 was 263,700. The population increase over the last decade (+5.7%) is associated with more births, and some international migration. People who arrive in Wolverhampton tend to settle in the city[5].

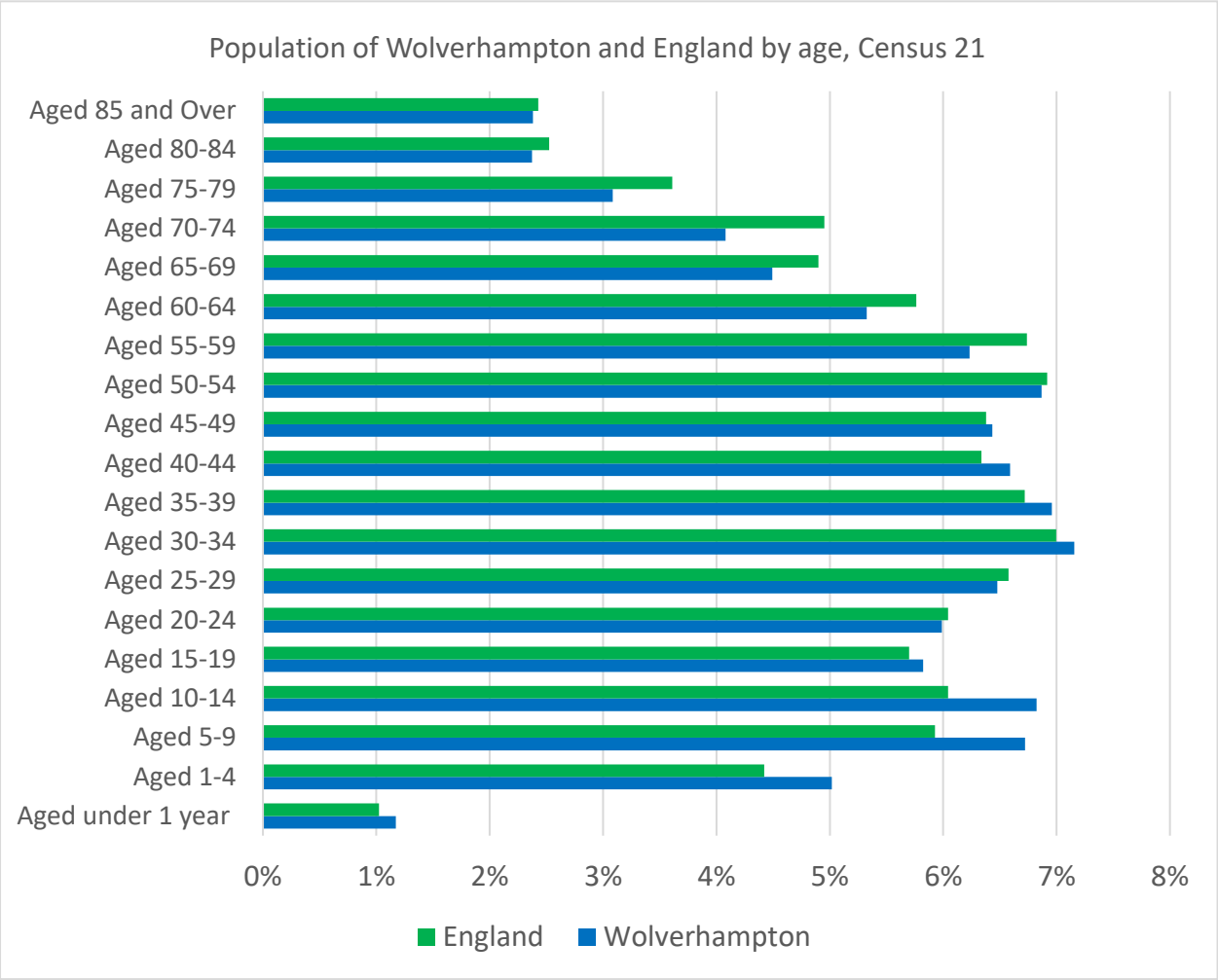
As can be seen in Figures 1 and 2, Wolverhampton has a younger age structure. Wolverhampton has a higher proportion of people in the younger age groups, compared to England, which as a whole has a greater proportion of older people. In 2021, Wolverhampton was estimated to have around a quarter (25.6%) of its residents aged under 20 years, compared to England with 23.1%. Wolverhampton had a smaller proportion of people aged 60 and over, 21.7%, compared to England, 24.2% (Figure 2).[6]

Figure 1: Wolverhampton population broken down by age and gender, 2021



Source: Census 2021

Figure 2: National and local population age profiles, 2021



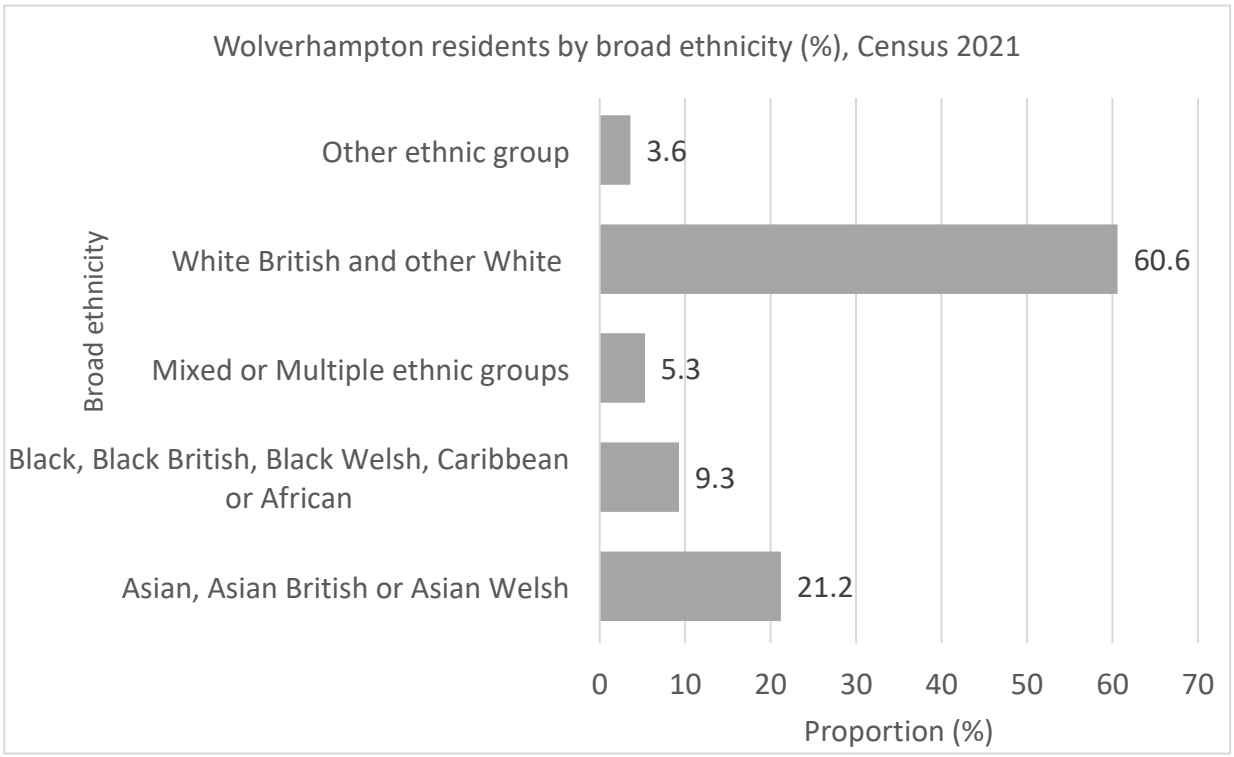
Source: Census 2021

In Wolverhampton, there are approximately 102,800 residents considered to be of reproductive age (15-44 years), equating to 39% of the local population. Over half (51%) of this age group are female. This equates to approximately 52,400 females aged 15-44 years.[7] These values are similar to the total population in England of which 38% are aged between 15-44-years-old and 51% of this age group are female.[8]

3.1.2 Diversity within the Wolverhampton population

Wolverhampton celebrates a population from a wide range of national, ethnic, and religious backgrounds. More than a third (39.4%) of the population are from ethnic minority backgrounds, around 1 in 5 (22.9%) of Wolverhampton residents were born outside of the UK and 1 in 10 (10.9%) of all Wolverhampton households do not have an adult who speaks English as their first language in the household[9] (Figure 3).

Figure 3: Ethnicity of Wolverhampton Population (%), 2021

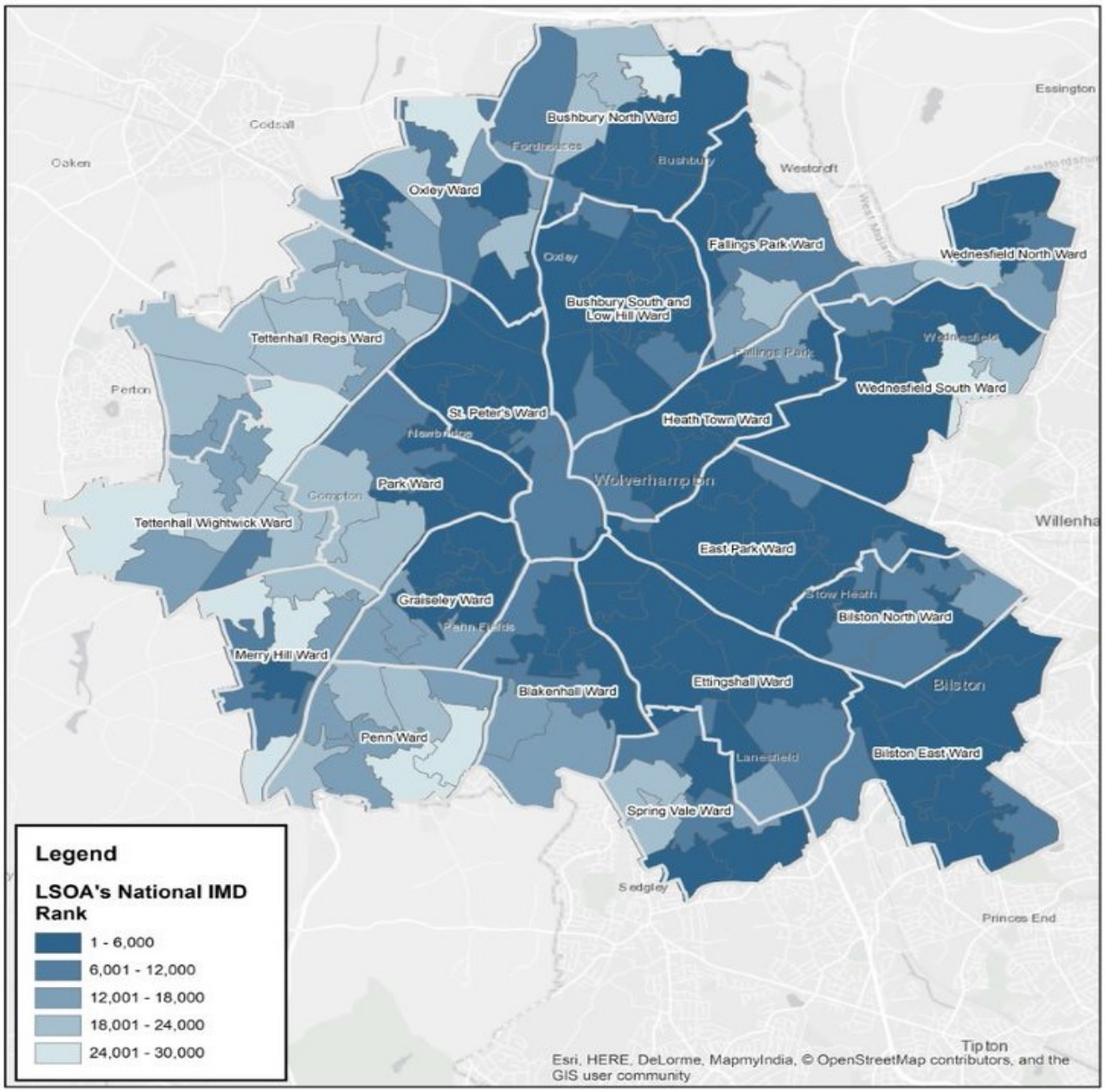


Source: 2021

3.1.3 Deprivation, employment, child poverty and health within Wolverhampton

There is a high level of deprivation in Wolverhampton, with 60.1% of Lower Super Output Areas (LSOA) in the three most deprived Indices of Multiple Deprivation (IMD) deciles (Figure 4). This means that almost two-thirds of the city are in the top 30% most deprived areas in England. Whereas, only 9.5% of the city are in the 30% most affluent areas in England.[10]

Figure 4: Map of Lower Super Output Areas (LSOAs) by Index of Multiple Deprivation, Wolverhampton, 2021



Source: Indices of Multiple Deprivation

Wolverhampton has comparatively high unemployment rates and similarly high levels of low paid employment rates. These are linked to the skills gap that exists locally with residents having lower skill and qualification levels than the national average. An estimated 14.9% (30,287) of the working age population in Wolverhampton had no formal qualifications in 2021, compared to the national average of 9.9%.[11]

Weekly full-time earnings for Wolverhampton residents were £569.30 on average in 2022, meaning they earn £76.50 less per week than the England average (£645.80). [12] The most recently released English indices of deprivation show that 21.1% of the Wolverhampton population were income deprived.[13]

In 2022, the employment rate in Wolverhampton was 66% compared to 75.8% for England.[14] The percentage of 16-66-year-olds claiming universal credit was 22% compared to 13.7% for England.[15] The city currently has the highest unemployment rate for 18-24 year olds in the UK at 13.5%, meaning there are 2,795 young people claiming benefits.[16]
Around 49.5% of the residents in Wolverhampton, live in homes that have dependent children (aged up to 18). Of residents living in homes with dependent children, 22.3% live in lone parent households, compared to a national average of 29.7%.[17]
According to estimates by End Child Poverty report [18], 43.3% of children were in poverty in Wolverhampton in 2021/22, this equates to approximately 27600 children. This is a 10% increase since 2014/15.

Around a quarter (23.5%) of Wolverhampton residents assessed their day-to-day activities as limited by long-term physical or mental health conditions or illnesses. While 44.8% of residents assessed their general health as very good, 34.4% as having good health, 14.4% have fair health and 6.3% have poor or very poor health.[19]

3.1.4 Gender identity and sexuality in Wolverhampton

Approximately 2.4% of residents over 16 identify as lesbian, gay, bisexual, or pansexual (LGB). This would equate to just under 5,000 adults in Wolverhampton. Around 0.7% of residents have a gender identity different from the sex under which they were registered at birth, including trans male, trans female and nonbinary, accounting for 1,673 individuals. It is likely that this is an under representative of the true population given that over 17,000 people did not disclose their sexual orientation or gender identity.[20]

The changing age, ethnic, social and cultural structure of the population has important implications for the city's sexual and reproductive health.

3.1.5 Inclusion Health within Wolverhampton

According to Wolverhampton's Homeless Health Needs Audit (2023), less than one in five participants (19.1%) had had a sexual health check in the previous 12 months; more than a quarter (27.5%) did not know where to access free contraception and around a quarter (24%) did not know where to access sexual health advice.

4. Sexually Transmitted Infections (STIs)

4.1 All STIs

Sexually transmitted infections (STIs) are a major public health concern, which may seriously impact the health and wellbeing of affected individuals, as well as being costly to healthcare services. STIs impact enormously on morbidity ranging from the acute and chronic disease manifestations of HIV to complications such as pelvic inflammatory disease, ectopic pregnancy and tubal factor infertility from untreated chlamydial and gonococcal infection.

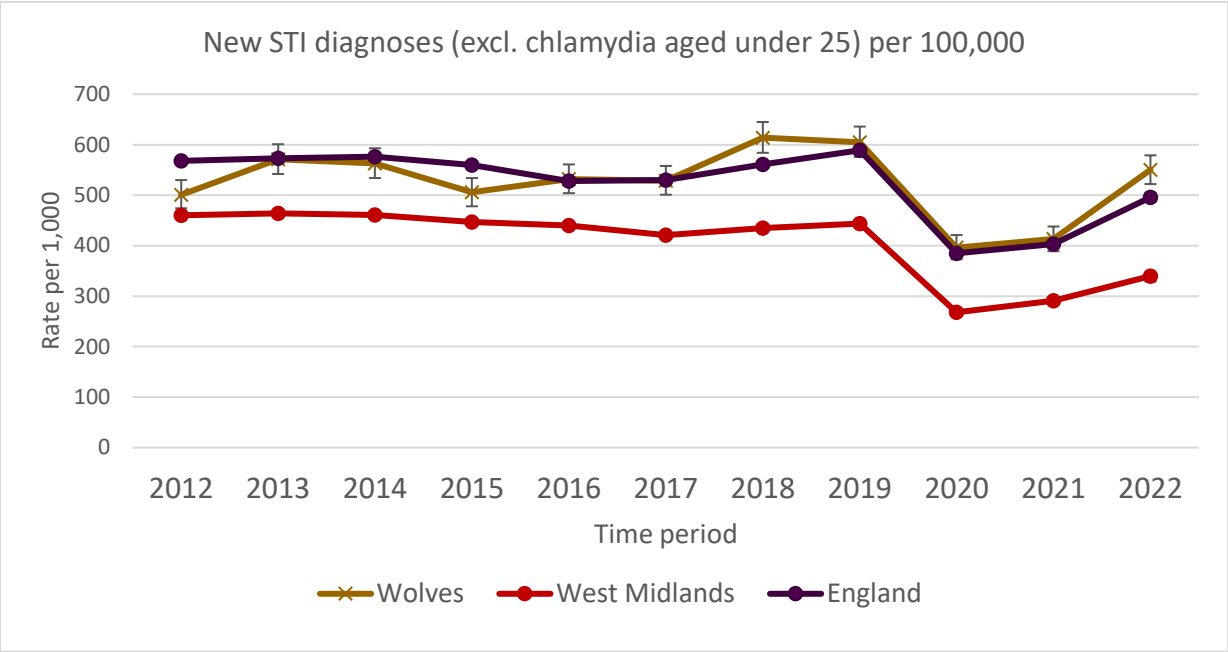
4.1.1 New STI diagnoses

In 2022, there were 2,027 new sexually transmitted infections (all STIs) diagnosed among Wolverhampton residents accessing sexual health services. This is equivalent to a rate of 768 per 100,000 residents which is higher than the national rate (694) and average rate of our regional neighbours (502).[21]

Figure 5 illustrates the number of new STI diagnosis rates (excluding chlamydia in those aged under 25) in Wolverhampton. This has shown some variability over the last 5 years, albeit broadly in line with the national picture.[22] In the latest year, Wolverhampton has seen a sharp increase in the number of new diagnoses seen locally. This may indicate that people are testing more, indicating improved awareness and access, or it may indicate a rise in STIs due to increased risky sexual activity, or lack of knowledge or access to protective measures such as condoms.

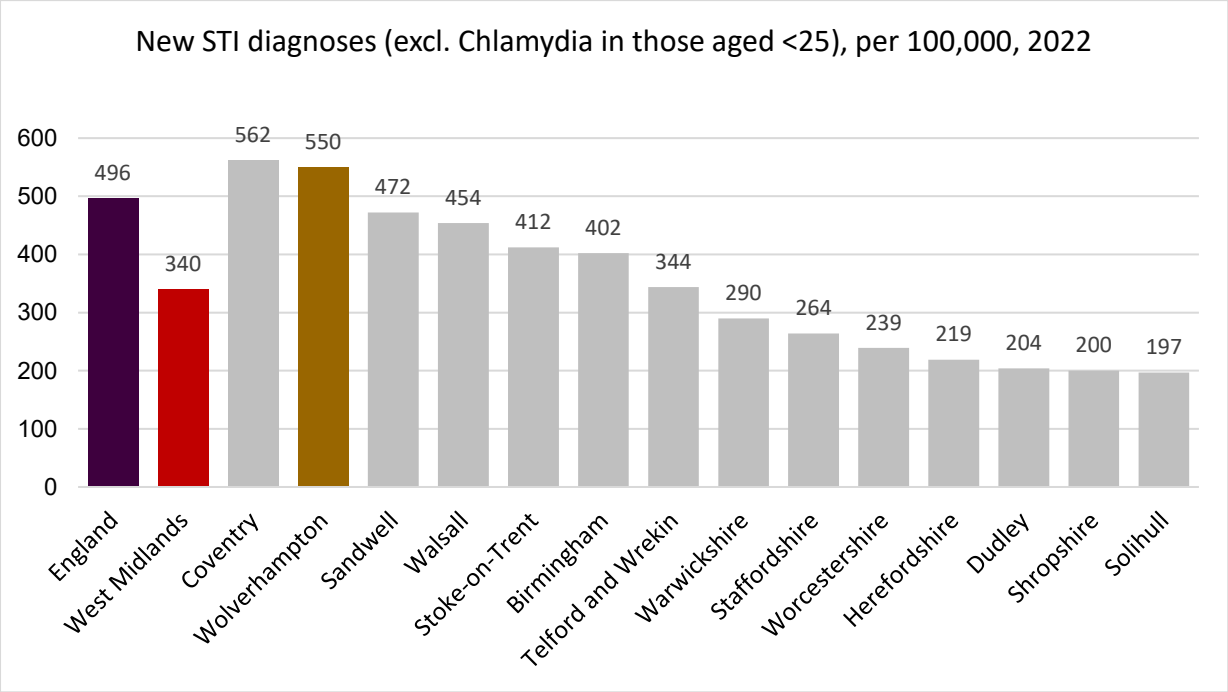
In the same period, Wolverhampton had the 2nd highest rate in the region for new STI diagnoses, (excluding chlamydia) in under 25-year-olds (550 per 100,000). This is statistically higher than both the regional average rate (340) and the England rate (496) (Figures 5 and 6).

Figure 5: The number of new STIs by year in Wolverhampton, 2012-2022



Source: Fingertips

Figure 6: Rates of new STI diagnoses (excl. chlamydia in those <25 years old) locally, regionally and nationally



Source: Fingertips

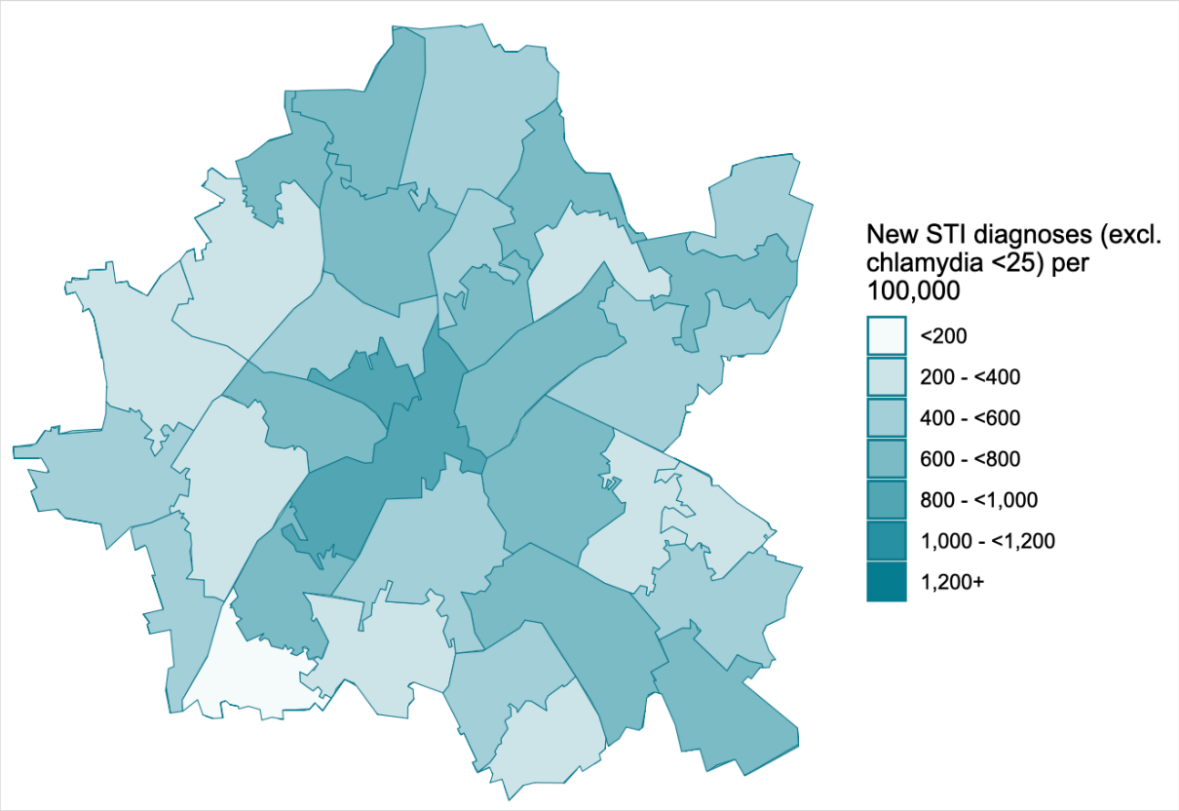
Socio-economic deprivation (SED) is a known determinant of poor health outcomes, including sexual health outcomes. There is a strong positive correlation between rates of

new STIs and SED. In the 2018 Public Health England Local Authority STI and HIV Epidemiology Report (LASER) more than two thirds (69%) of new STIs diagnosed within Wolverhampton were within people from the most deprived quintile[23].

Figure 7 shows that the MSOAs with higher rates of STI diagnoses are central and eastern parts of the city, including areas such as St Peters, Heath Town, Bilston South, Ettingshall, Graiseley, Bushbury and Low Hill. MSOAs with lower rates of STI diagnoses tend to be located towards the west of the city, including areas such as Tettenhall and Penn.

4.1.2 STI diagnoses and deprivation

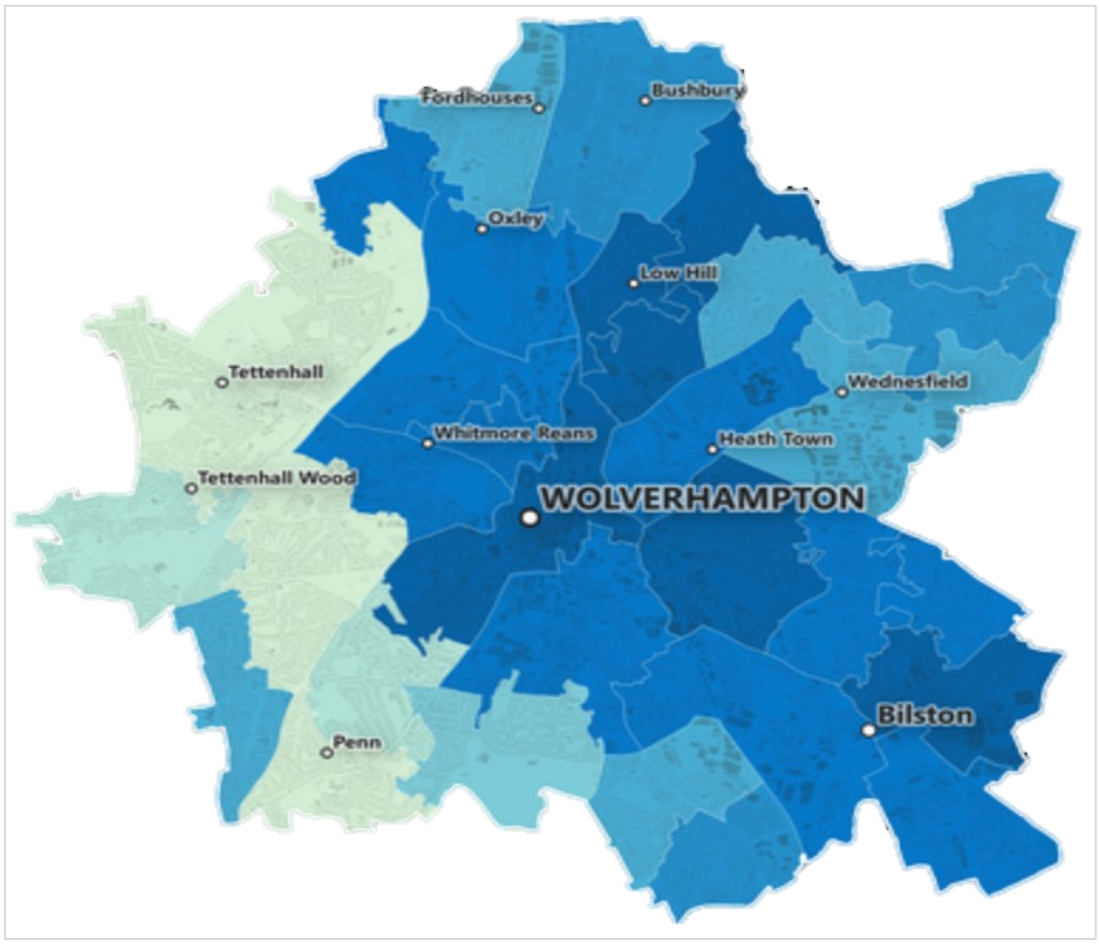
Figure 7: The number of new STIs by year in Wolverhampton by Middle Super Output Area (MSOA), 2022



Source: Wolverhampton SPLASH report

Comparing Figure 7 to Figure 8, which shows the Wolverhampton MSOAs by their most recent 2019 Index of Multiple Deprivation (IMD) ranking (the darker the colour the higher the IMD, the more deprived the MSOA). There is a positive correlation between the more deprived areas within the city and the number of new STI diagnoses amongst their residents. This is supported by Table 1 which shows the number and proportion of new STI diagnoses are greater in those residents in the most deprived category.

Figure 8: Middle Super Output Areas by Index of Multiple Deprivation, Wolverhampton 2019



Source: Index of Multiple Deprivation (IMD)

The relationship between STIs and SED is likely influenced[2425] by a range of factors such as the provision of and access to health services, education, health awareness, healthcare seeking behaviour and sexual behaviour.

Table 1: The table shows the number and proportion of new STIs in Wolverhampton by deprivation (SHS diagnoses only) category, 2018

Deprivation category	Number	%
Most deprived	1,370	69
4th least deprived	250	12.6
3rd least deprived	165	8.3
2nd least deprived	175	8.8
Least deprived	25	1.3

Source: Public Health England, Laser Report, 2018

4.1.3 STI diagnoses and ethnicity

Wolverhampton residents from a Black or Black British ethnic group are over-represented in the breakdown of STI diagnosis by ethnicity. Almost a quarter (22.9%) of all STI diagnoses were from residents with a Black or Black British ethnic background. This is significantly higher compared to the Wolverhampton population, where 9.3% of the population have a Black or Black British ethnic background.

This is in keeping with both the regional and national picture, that those who are of Black British or other Black backgrounds are overrepresented in the proportion of diagnosed STIs[26]. The reasons behind this are numerous and complex, however SED and poverty have an impact. Behavioural and structural factors could also be responsible, for example, health inequalities, racial discrimination in healthcare, attitudes regarding sexual health, health-seeking and sexual behaviours[27 28].

4.1.4 Reinfection with an STI

Reinfection with an STI is a marker of persistent risky behaviour. Between 2014 – 2018, an estimated 9.7% of women and 9.9% of men in Wolverhampton who were diagnosed with new STIs became re-infected with another new STI within 12 months.

This is higher than the reinfection rate seen nationally during the same period where an estimated 7.0% of women and 9.7% of men respectively represented with a new STI within 12 months[29]. Whilst the rate of reinfection for Wolverhampton men is similar to the national rate, the reinfection rate amongst Wolverhampton women is higher.

There could be a number of reasons for this. Clinical reasons, for example incomplete partner notification meaning reinfection from untreated partners and biologically the female anatomy is more at risk of being infected when exposed to an STI compared to male anatomy[30]. Behavioural reasons, for example following their recent STI infection Wolverhampton women were more likely to seek repeat testing, or conversely did not perceive themselves at risk of reinfection and undertook riskier sexual behaviours.

Structural reasons, for example found it difficult to obtain or use condoms either due to lack of access or inability to negotiate use with sexual partners.

In the four-year period between 2014 – 2018, 13% of young women and 11.4% of young men aged 15-19 years diagnosed with a STI, had presented again with a new STI within 12 months. Teenagers may be at increased risk of re-infection because they may not have awareness about infection risk and can lack the skills and confidence to negotiate condom use with partners.[31]

4.1.5 STI Testing

STI testing rates give an indication of how proactively the population are tested for STIs both in specialist and non-specialist sexual health services. This indicator excludes chlamydia testing in under 25-year-olds as this is a specific target group. If an area is not carrying out many tests, diagnosis rates may underrepresent the true burden of disease. It is not possible to know the burden of disease amongst those who are not tested, only those who are.

Between 2020 and 2021, the STI testing rate decreased both in Wolverhampton and nationally. This was due to the COVID-19 pandemic where access to routine healthcare was limited to those requiring urgent and emergency care.

In 2022, the rate of STI testing (excluding chlamydia in under 25-year individuals) in sexual health services in Wolverhampton was 3,019 per 100,000 aged 15 to 64 years, a significant increase compared with 1,568 in 2021. This shows an increasing rate of STI testing post-pandemic, but the rate is lower than national average of 3,856 per 100,000. This included tests requested online.

Comparing the STI testing rate to the rest of the West Midlands region, Wolverhampton ranked 7th out of the 14 areas, but ranked higher for the rates of diagnoses and positivity (see testing positivity below). This would be suggestive of a high burden of STIs within Wolverhampton, some of which would be undiagnosed. Comparatively the area that had the highest rate of all STI diagnoses (Coventry), also had the highest STI testing rate in the West Midlands region.

4.1.6 Testing positivity

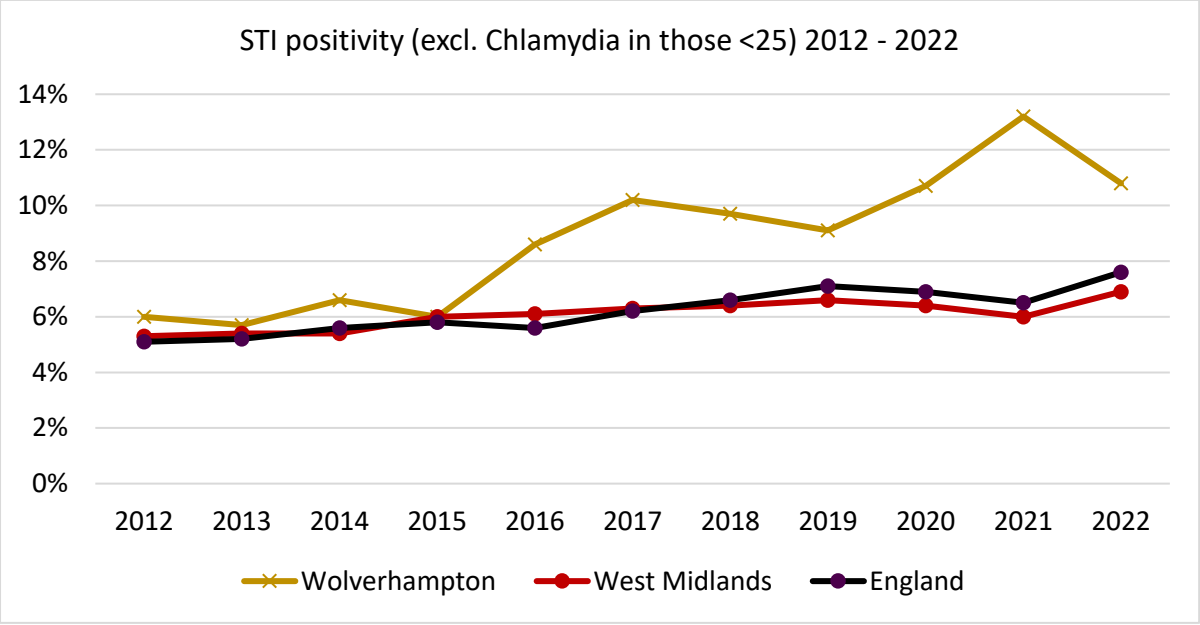
The STI positivity testing indicator gives new STI diagnoses (excluding chlamydia in under 25-year-olds) among people accessing specialist and non-specialist sexual health services, expressed as a percentage of the total number of STI tests performed among 15-64-year-olds.

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[32].

The Wolverhampton STI positivity rate has shown an increasing trend since 2015. Until 2015 Wolverhampton positivity rates were similar to those regionally and nationally. However,

there has been a significant divergence from the regional and national rates since this time with a sharper rise in 2020 (10.7%) and 2021 (13.2%) during the COVID-19 pandemic (Figure 9). The most recent 2022 positivity rate in Wolverhampton was 10.8%, higher than that of the West Midlands (6.9%) and for England (7.6%) who did not see a sharp rise in positivity during this time.

Figure 9: The trend for STI positivity (excluding Chlamydia diagnoses <25 years old), 2012 – 2022



Source: Fingertips

Positivity rates are calculated as a percentage of those tested for STIs as a whole. Therefore, this increase in positivity during the pandemic may be due to sexual health services prioritising the testing of those who were symptomatic of an STI, who were therefore more likely to test positive for an STI. However, the trend since 2015 is suggestive of an increasing burden of STIs in the Wolverhampton population in comparison to the regional and national population.

The increasing positivity trend correlates with the timeline of cuts made to the Public Health Grant that is paid by Department of Health and Social care to local authorities. The grant is used to provide preventative services that help to support health, sexual health services included.

Unfortunately, the reduction in spending has been greater in areas of deprivation, which has known associations with poorer health outcomes. Wolverhampton is a city with areas of high deprivation (Index Multiple Deprivation for Local Authority district rank 19 out of 317 – the lower the score the more deprived an area)[33]. These historic cuts have resulted in a -£28.11 real-terms (adjusted for inflation) spend per Wolverhampton resident since

2015/16[34]. A reduction in funding means a reduction in the preventative services that can be provided to the populace; the consequence being preventable outcomes such as STIs.

4.2 Chlamydia

Chlamydia is the most common STI, particularly in young people who are sexually active. As chlamydia is usually asymptomatic, it requires proactive testing of those who are most at risk of having it. If left untreated, chlamydia infections can lead to serious, irreversible long-term health problems such as pelvic inflammatory disease (PID) or infertility.

Chlamydia detection rates in 15-24-year-olds are an important indicator of young people's sexual health and their access to services. The higher the detection rate, the more proactively 15-24-year-olds are being invited to be tested which means there is a better chance of finding, treating and therefore controlling the infection. The benchmark for detection is based on expected rates of chlamydia nationally.

Chlamydia diagnoses in under 25's are excluded from other Fingertips STI testing, diagnoses and positivity indicators (except 'All new STI diagnoses rate per 100,000). This is due to the National Chlamydia Screening Programme (NCSP) targeting under 25's for chlamydia screening and collating this data on the CTAD Chlamydia Surveillance System.

4.2.1 Changes to the National Chlamydia Programme

The National Chlamydia Screening Programme (NCSP) focuses on reducing reproductive harm of untreated infection in young women.

National policy changes led by UKSHA have determined that opportunistic screening (that is the proactive offer of a chlamydia test to young people without symptoms) should focus on women, combined with:

- reducing time for test results and treatment
- strengthening partner notification
- re-testing after treatment

This change removes the offer of opportunistic chlamydia screening to asymptomatic men outside sexual health services only and does not change the STI testing services offered by sexual health services. All young people will still be able to access chlamydia tests at sexual health services and young men will continue to be contacted and tested through partner notification procedures. The detection rate indicator (DRI) will be changed to reflect the focus on opportunistic screening for young women.

4.2.2 Chlamydia detection benchmark

In June 2021, the National Chlamydia Screening Programme (NCSP) changed to focus on reducing the harms from untreated chlamydia infection. These harms 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 with a womb or ovaries. Therefore, opportunistic screening should focus on these groups, combined with reducing time to test results and treatment, strengthening partner notification and re-testing after treatment if indicated.

In practice this means that chlamydia screening in community settings (e.g. GP and Community Pharmacy) 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 Public Health Outcome Framework (PHOF) Detection Rate Indicator (DRI) benchmarking thresholds have been revised and will be measured against females only. A new female-only PHOF benchmark DRI of ≥3,250 per 100,000 aged 15-24-years will be included in the PHOF from January 2022 (to be reported in Autumn 2023)[35].

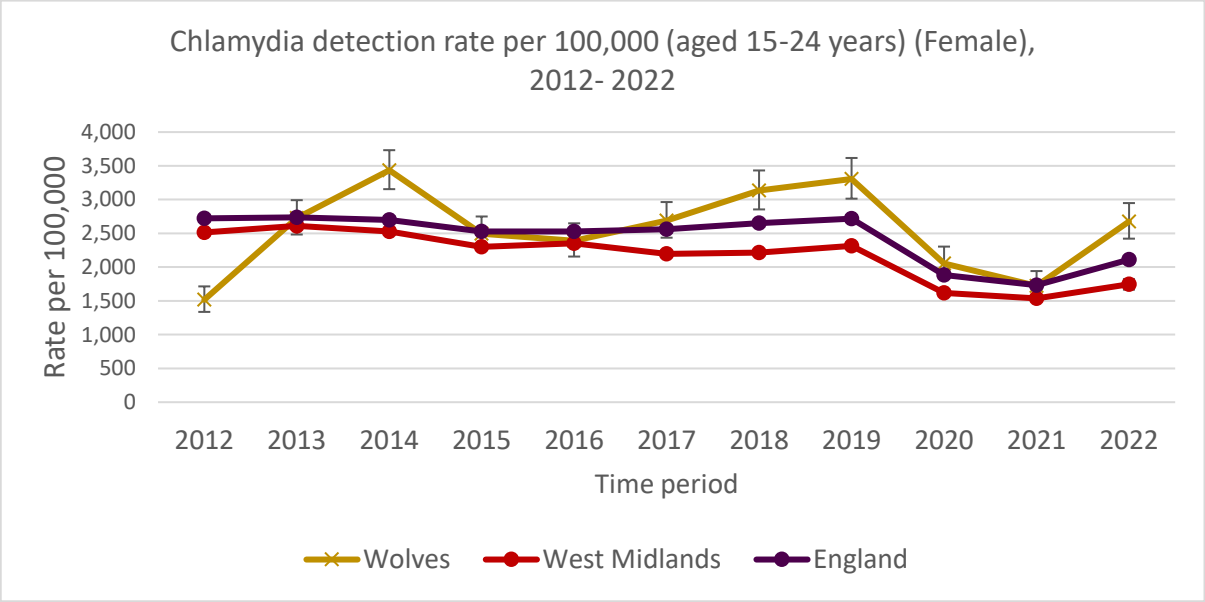
4.2.3 Chlamydia detection in Wolverhampton's 15-24-year-olds

The chlamydia detection rate per 100,000 population (all persons) in Wolverhampton 15-24-year-olds was 1,828, higher than the regional rate (1,337) and the rate for England (1,680). Wolverhampton was ranked 3rd in the West Midlands region for chlamydia detection and ranked 6th when compared to Wolverhampton's nearest statistically similar neighbours (CIPFA).

But with the focus of the NCSP moving to screening young women and other people with a womb or ovaries, the chlamydia detection rate per 100,000 Wolverhampton residents aged 15-24-years-old (Female) has been presented in Figure 10 below.

The most recent 2022 data has shown the detection rate to be 2,676 per 100,000 (Figure 10). The PHOF DRI benchmarking goal is ≥3,250 per 100,000. Wolverhampton's was greater than regional (1,745) and national rates (2,110). Wolverhampton ranked 2nd amongst our West Midlands neighbours and 3rd amongst CIPFA neighbours. There has been improvement in the detection rate since a drop during 2020-2021.

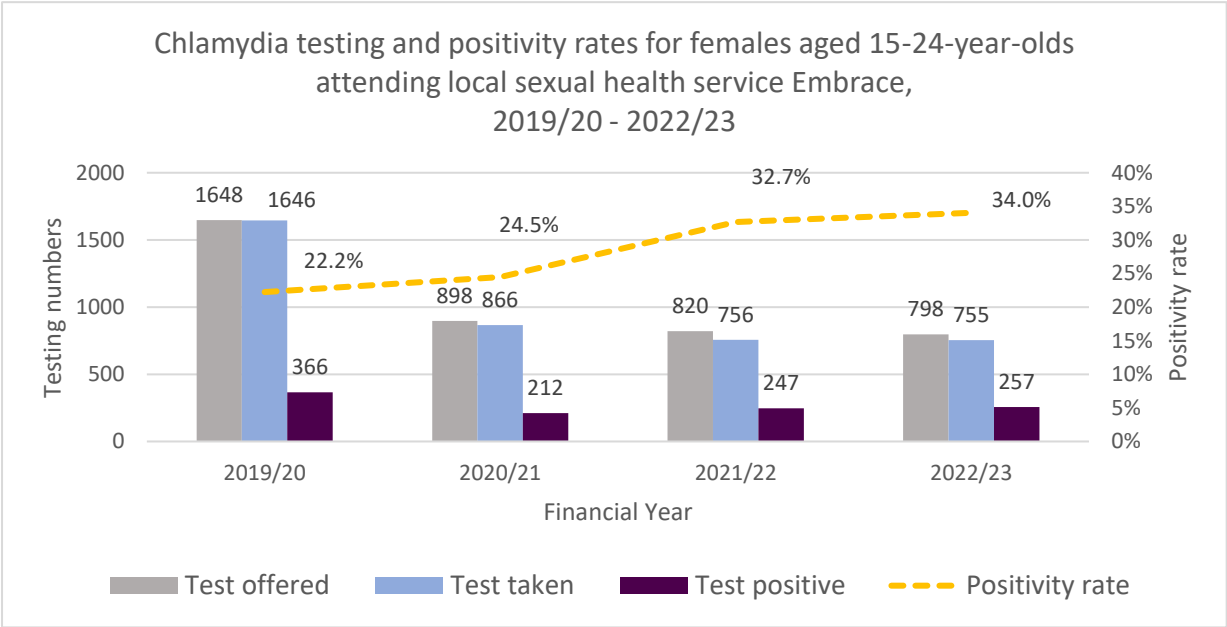
Figure 10: Chlamydia Detection Rate per 100,000 aged 15-24-years-old (Female)



Source: Fingertips

Figure 11 shows sexual health service specific data for the number of chlamydia tests offered, uptake and positivity for females aged 15-24-years-old attending the service. It shows the drop off in face-to-face attendances, likely related to the move to online testing. Whilst sexual health attendances in person have been dropping across all age groups, it has been most notable in the 15-24-years age bracket with a decrease of over 40% when comparing pre-and post-pandemic data.

Figure 11: Chlamydia testing numbers and positivity rates for female 15-24-year-olds attending local sexual health services



Source: Embrace Wolverhampton

There is good uptake of chlamydia testing when offered (94.6% in 2022-23) but this has shown a decrease since pre-pandemic rates (99.9%). There is high positivity, with 34% (1 in 3) of tests detecting a chlamydia infection in the 15-24-year-old female attendees who tested 2022-23. This has shown a rising trend since 2019-20 but must be taken into context that those with symptoms of an STI are advised to attend the service for a face to face appointment and testing, those without symptoms are actively encouraged to request an online test.

This is supported by Table 2 which shows testing numbers for all 15- 24-year olds (males and females) and the positivity for in-person verses online testing. The positivity for in-person tests was more than double (31.4%) that for online tests (12.8%). Overall, the positivity for all tests taken was 20.6% or 1 in 5 in the 15-24-year age group.

Table 2: The total number of tests taken online and in-person and test positivity for 15-24-years-olds 2022/23

Test type	Tests	Positives	Test positivity (%)
Online	1669	213	12.8%
In person	1204	378	31.4%
Total	2873	591	20.6%

4.2.4 Chlamydia test numbers and positivity across the wards for 15-24-year-old females

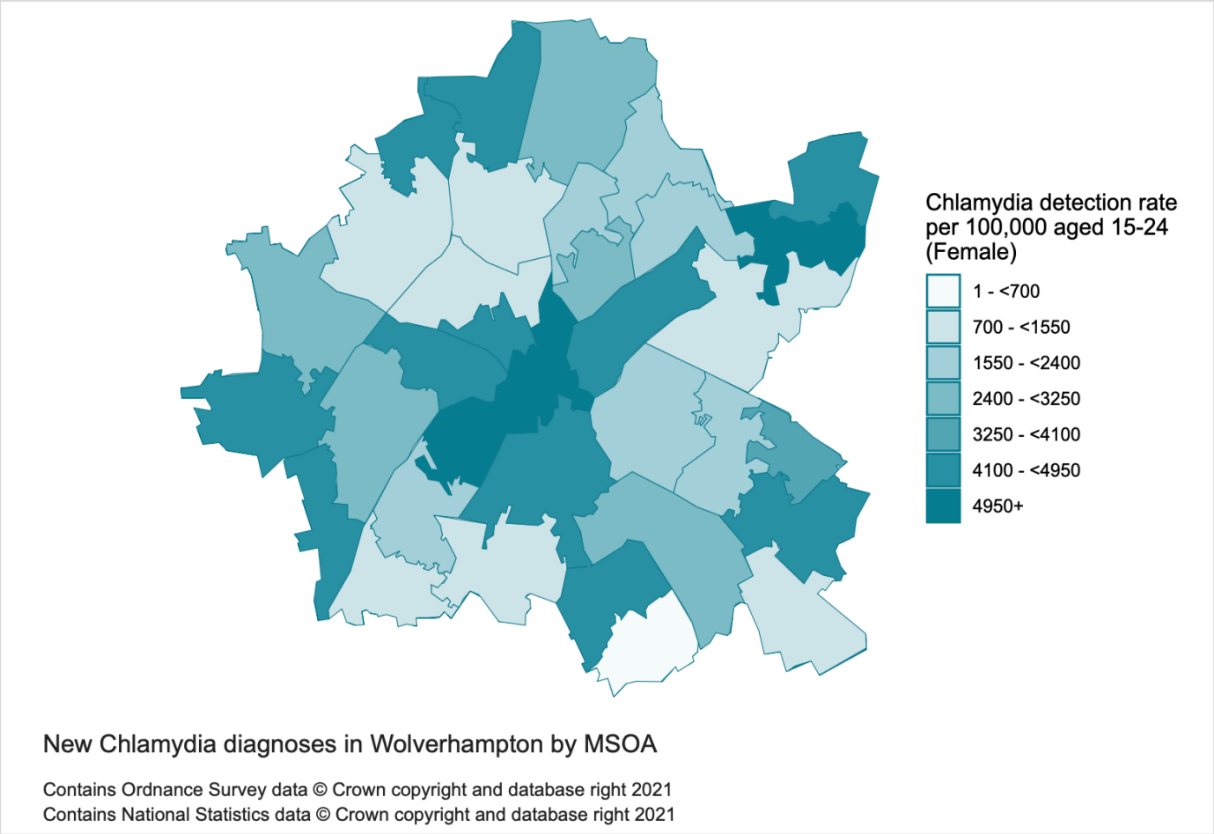
Local sexual health service data for 2022/23 showed the wards that took the most tests in person were Heath Town (81 tests taken), St Peter's (69), Bushbury South & Low Hill (41) and Park (41). This showed a higher number of tests taken by those living in the central, more deprived wards that are located nearer local sexual health services.

Wards that took the least tests were Tettenhall Regis (7), Penn (11), Oxley (13) and Tettenhall Wightwick (13). However, the highest rates of positivity in 15-24-year-old females were seen in Tettenhall Regis (71.4% of tests taken were positive) followed by Bilston South (57.1%), Oxley (53.9%) and Tettenhall Wightwick (53.9%). This likely represents in-person testing being used for those with symptoms and therefore more likely to have an infection rather than as a screening tool.

Wards with the lowest positivity were Bushbury North (17.7%), Wednesfield South (23.3%) and Fallings Park (25%). This data excluded tests requested online.

Figure 12 shows a more variable distribution of detected chlamydial infection in the 15-24-year-old female population across the city. Areas with high rates of chlamydia detection per 100,000 include both deprived and less deprived wards. This shows the need for targeted screening in this population across all areas of the city.

Figure 12: Chlamydia detection rate per 100,000 by middle super output area (MSOA), 2022



Source: Wolverhampton SPLASH report

4.2.5 Testing Coverage

Alongside detection rate, the proportion of the 15-24-year-old population screened should be considered. This helps build a picture of whether enough young people in the local population are being tested, and whether those who are being tested are those most likely to be at risk of infection.

Around 1 in 10 (10.2%) of Wolverhampton's 15-24-year-olds were tested for chlamydia in 2022, compared to 11.1% regionally and 15.2% nationally. Whilst this was lower than the regional and national average and ranked 9 of 14 regional authorities; the testing coverage in Wolverhampton has shown recovery following a sustained period of deviation from the national pattern. A lower-than-expected figure would either suggest a lower prevalence of chlamydia, or that screening coverage has not reached the most at-risk population. Positivity rates are therefore useful to consider in the context of testing coverage.

Local Wolverhampton sexual health service data for 2022/23 showed that an average of 62.5% of all attendees aged 15-24-year-olds were screened for chlamydia. Of the 1,198 screened during this period 378 were positive (31.6% or 1 in 3). This suggests that there were a proportion of 15-24-year-olds who either were not offered, perhaps a reason for this being that they were attending for contraception related activity or that they declined

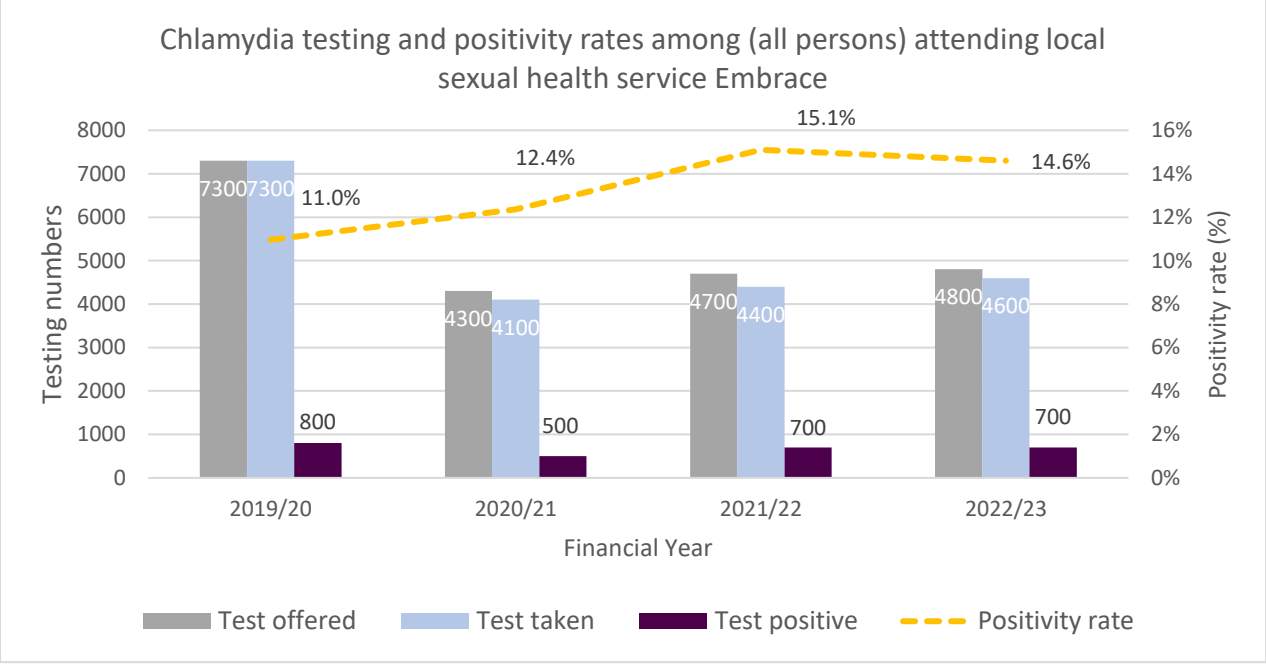
screening. Overall, the data indicates a high prevalence of chlamydia in Wolverhampton's young population. Regional variations of this programme may have a skewing effect on the data, making it difficult to compare the indicator across different areas.

4.2.6 Chlamydia detection and the over 25s

15-24-year-olds are overrepresented in the rates of chlamydial infection, however for completeness the over 25-year age group should be considered in order to have an awareness of sexual health across the population. In 2022, the chlamydia detection rate in Wolverhampton was 266 per 100,000. This was significantly more than regional (152) and national (217) rates and Wolverhampton had the highest rate in the West Midlands region. This shows that there is an ongoing need for regular chlamydia testing within the over 25-year age group who have risk factors for chlamydia infection such as new or multiple partner(s), having condom-less sex.

Figure 13 shows local service data of the number of tests offered for chlamydia verses the uptake and test positivity across all ages attending the service. This excludes online tests.

Figure 13: Chlamydia testing numbers and positivity rates across all ages attending local sexual health services, 2019/20 - 2022/23



Source: Embrace Wolverhampton

Figure 13 shows that in 2022/23 across all age groups attending local sexual health services there was good uptake when chlamydia screening was offered (95.8%). This has shown a drop off since pre-pandemic >99.9% in 2019-20. The reduction in face-to-face chlamydia testing is likely due to the increasing uptake of online testing since this time. The most recent positivity was 14.6% meaning that more than 1 in 10 tests taken detected chlamydia,

having seen a rise since the start of the pandemic 2019-20 (11%). This supports the need for regular chlamydia testing for at risk over 25s. As service provision moved towards face-to-face screening for those who had symptoms (and are therefore more likely to be infected with an STI) and signposting to online testing for asymptomatic persons this could explain the increased positivity despite reduction in testing.

When looking at the positivity of online testing verses in-person testing, those taking in-person tests have a higher positivity than those requested online (Table 3). However, overall, the positivity of chlamydia tests taken in Wolverhampton 2022/23 was 11.1% or 1 in 10 tests were positive.

Table 3: The total number of chlamydia tests taken online and in-person and test positivity for all ages, 2022/23

Test type	Tests	Positives	Test positivity (%)
Online	4721	365	7.7%
In person	4644	678	14.6%
Total	9365	1043	11.1%

Source: Embrace Wolverhampton

4.2.7 Chlamydia test numbers and positivity across the wards for all age groups

Looking at positivity rates for all ages across the city, local service data from 2022/23 showed that for face-to-face attendances the wards with the highest positivity were Heath Town (22.2% of tests taken were positive), Merry Hill (22%) and Wednesfield North (20.4%). Wards with lowest rates of positivity were Penn (9.8%), Blakenhall (13%) and Tettenhall Regis (13.3%). This data excluded tests requested online.

The wards that took the most tests in person at the local sexual health service were St Peter's (368 tests), Heath Town (311) and Bushbury South & Low Hill (275). Wards who took the least tests were Tettenhall Regis (98), Wednesfield North (108) and Tettenhall Wightwick (110). This showed higher concentrations of tests taken from the more deprived central wards located closer to sexual health services. However, it should be considered that even for the ward with the least tests taken in person, Tettenhall Regis, the positivity was 13.3% or near 1 in 10 tests were positive.

4.2.8 Pelvic Inflammatory Disease

Pelvic inflammatory disease (PID) is an infection and inflammation of the female genital tract including the uterus, tubes or ovaries. Aetiology is multifactorial but include untreated infection with chlamydia, gonorrhoea or mycoplasma genitalium. Complications include abscess, chronic pain, tubal infertility and ectopic pregnancy. Therefore, wider coverage of chlamydia screening across the Wolverhampton population could support the reduction of Pelvic Inflammatory Disease (PID).

In Wolverhampton during 2021/22, 175 people were admitted to hospital with PID at a rate of 333.7 per 100,000, the highest in the West Midlands region (252.1) and higher than national rate (224.4). Wolverhampton ranked 2nd amongst statistically similar CIPFA neighbours. Available data showed an increasing trend from 2017 of people admitted to hospital with PID, although this number decreased in 2021/22 (230 in 19/20).

This indicator should be examined alongside the chlamydia screening and chlamydia diagnoses indicators. It would be anticipated that high chlamydia screening coverage should lead to increased chlamydia diagnoses which, assuming successfully treated, should lead to decreased in PID admissions. It should be noted that PID is a clinical diagnosis and so there may be those who were admitted and coded as presumed PID but did not have PID. Conversely there may be those who had PID but were managed in the community and so avoided admission.

The data for hospital admissions with ectopic pregnancy correlates with the PID data. Wolverhampton had the highest rate of admissions (190.7 per 100,000 population) in the West Midlands region in 2021/22. This was at least double the West Midlands (93.9) and national rate (90.6). Wolverhampton was also highest when compared to statistically similar CIPFA neighbours. This was likely an underestimate of the incidence of ectopic pregnancy as there will be some managed in the outpatient setting.

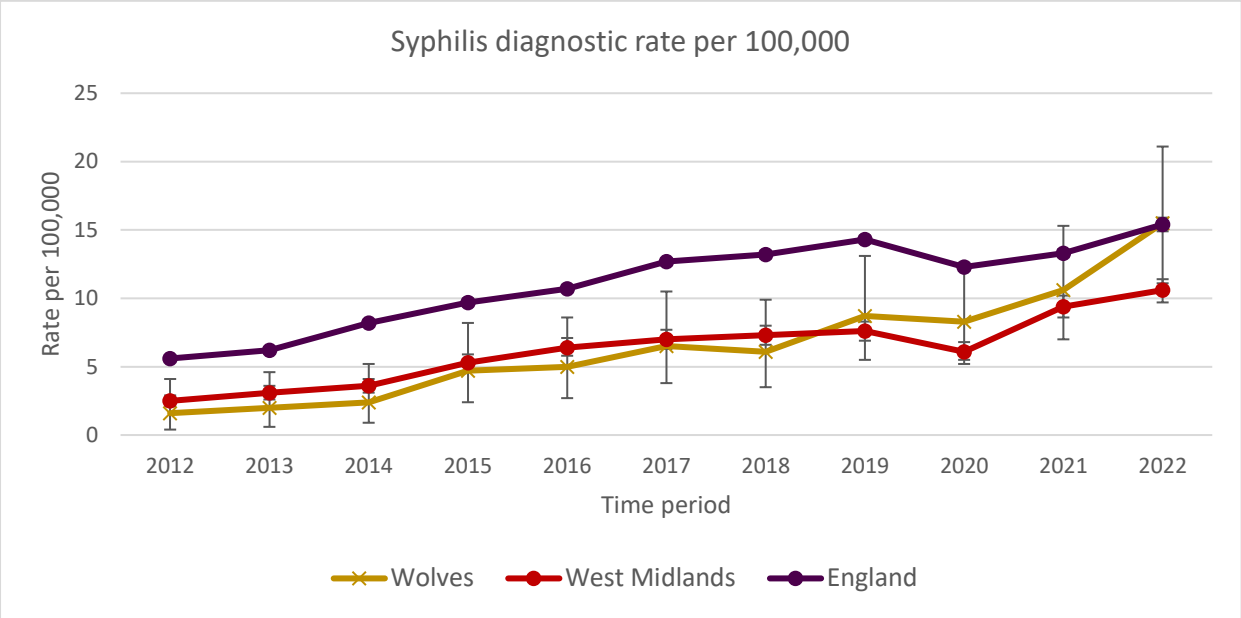
4.3 Other STIs

4.3.1 Syphilis

Syphilis is a rare infection but with severe consequences if left untreated or transmitted to a baby during pregnancy. Infection rates have risen in the last decade, mainly within GBMSM groups (Gay, Bisexual and other Men who have Sex with Men). Rates are therefore an important indicator of safe sex practices within this group.

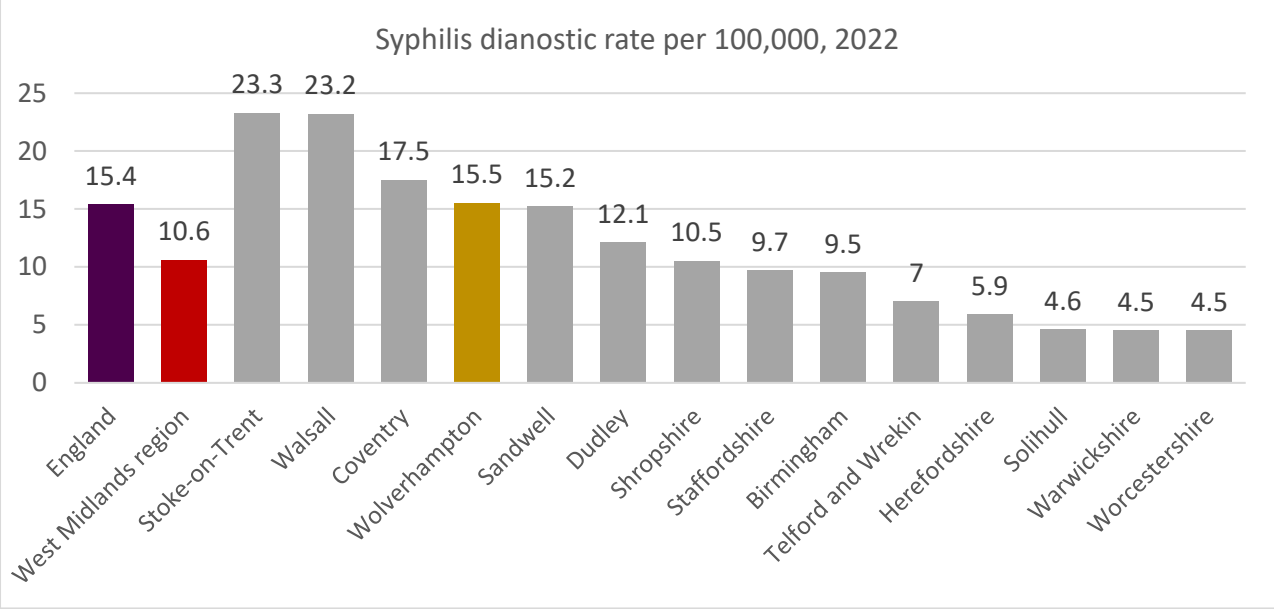
In 2022, there were 41 new cases of syphilis in Wolverhampton. This was a diagnostic rate of 15.5 per 100,000 which was comparable to that of England (15.4), higher than the region (10.6) and slightly lower than CIPFA neighbours (16.2) (Figures 14 and 15).

Figure 14: The Wolverhampton syphilis diagnostic rate per 100,000 trend, 2012-2022



Source: Fingertips

Figure 15: The syphilis diagnostic rate per 100,000 compared to regional and national rates, 2022



Source: Fingertips

Absolute numbers are very small, but the trend indicates a year-on-year increase in Wolverhampton with a steeper increasing rate since 2020 as shown in Figure 14. Whilst an increasing trend was not unexpected and is reflected in the national trend of increasing

rates after the relaxation of COVID-19 lockdown rules with the resumption of socialisation. However, this does not fully account for the steeper rise in Wolverhampton. There could be several reasons for this. For example, socioeconomic factors (syphilis is more common in areas of deprivation), population factors (syphilis rates are higher in Black and Black African backgrounds) and behavioural reasons (lack of awareness and education regarding syphilis amongst the general population and healthcare professionals, lack of preventative strategies (condoms))[36].

This rise should be closely monitored, with strategies adopted to try and halt this accelerated trend. Strategies for addressing the rise in syphilis in England were outlined in the June 2019 PHE action plan and include advice regarding increased testing among high-risk groups (GBMSM), follow up testing of treated cases, identification and treatment of partners, maintenance of antenatal screening coverage with awareness of risk factors that would put someone at risk of infection during pregnancy, health promotion and education amongst general population and healthcare providers[37].

4.3.2 Syphilis testing numbers and positivity across the wards

The wards that had the most tests taken were St Peter's (1550), Health Town (1323) and Bushbury South & Low Hill (1153).

Both Wednesfield North (2.34%), Park (2.1%) and Bilston South (1.7%) are in the top three wards with highest positivity, both border the western Walsall wards*. Despite having the highest positivity rate for in-person syphilis tests in 2022-23, Wednesfield North is among the three wards with the fewest tests conducted: Tettenhall Regis (400 tests), Wednesfield North (427 tests), and Tettenhall Wightwick (437 tests). This indicates a high prevalence of syphilis within the Wednesfield North population.

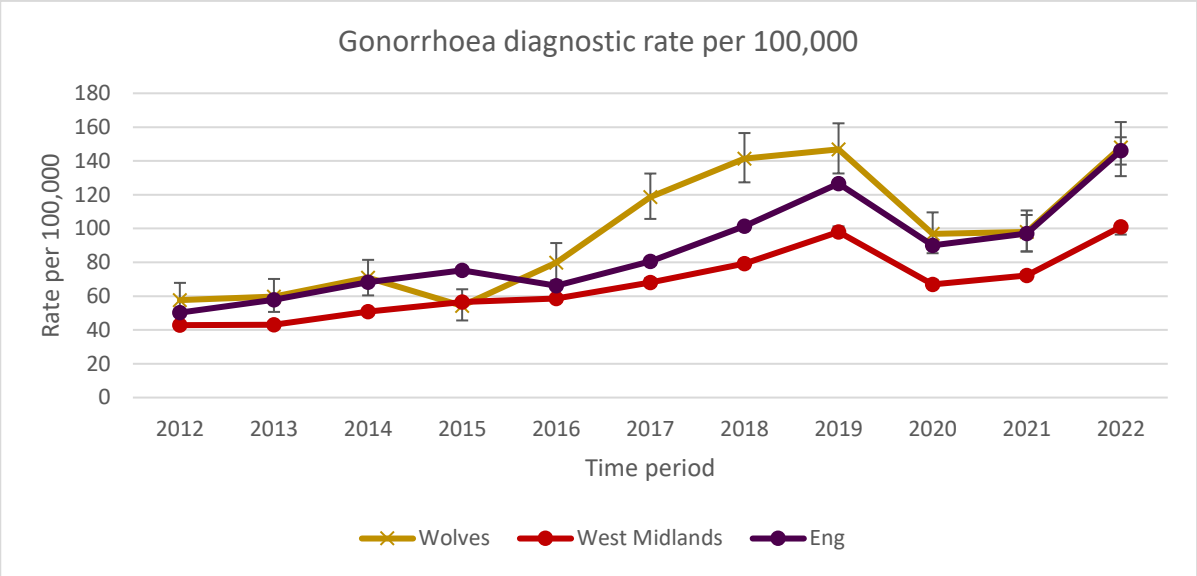
*Walsall has the 2nd highest Syphilis diagnostic rate per 100,000 in the West Midlands region (23.2) compared to Wolverhampton's 4th (15.5). Western Walsall wards are also the more deprived wards with higher rates of STI diagnoses[38]. This may reflect the higher positivity in the border wards due to fluidity of the population across the local authority boundaries.

4.3.3 Gonorrhoea

Gonorrhoea causes avoidable sexual and reproductive ill-health. The gonorrhoea rate is used as a marker for rates of unsafe sexual activity. This is because most cases are diagnosed in sexual health clinics, consequently the number of cases can be used as a measure of access to sexually transmitted infection (STI) treatment. Infections with gonorrhoea are also more likely than chlamydia to result in symptoms.[39]
In 2022, there were 390 new cases of gonorrhoea in Wolverhampton. The number of gonorrhoea infections has been increasing since 2015. This is a diagnostic rate of 148 per 100,000 which is higher than the national rate (146), the regional rate (100), and CIPFA neighbours (126). This figure has been increasing locally in line with the national trend but

has seen a significant increase since 2020, back to where rates were prior to the COVID-19 pandemic (Figure 16).

Figure 16: The Wolverhampton gonorrhoea diagnostic rate per 100,000, 2012-2022



Source: Fingertips

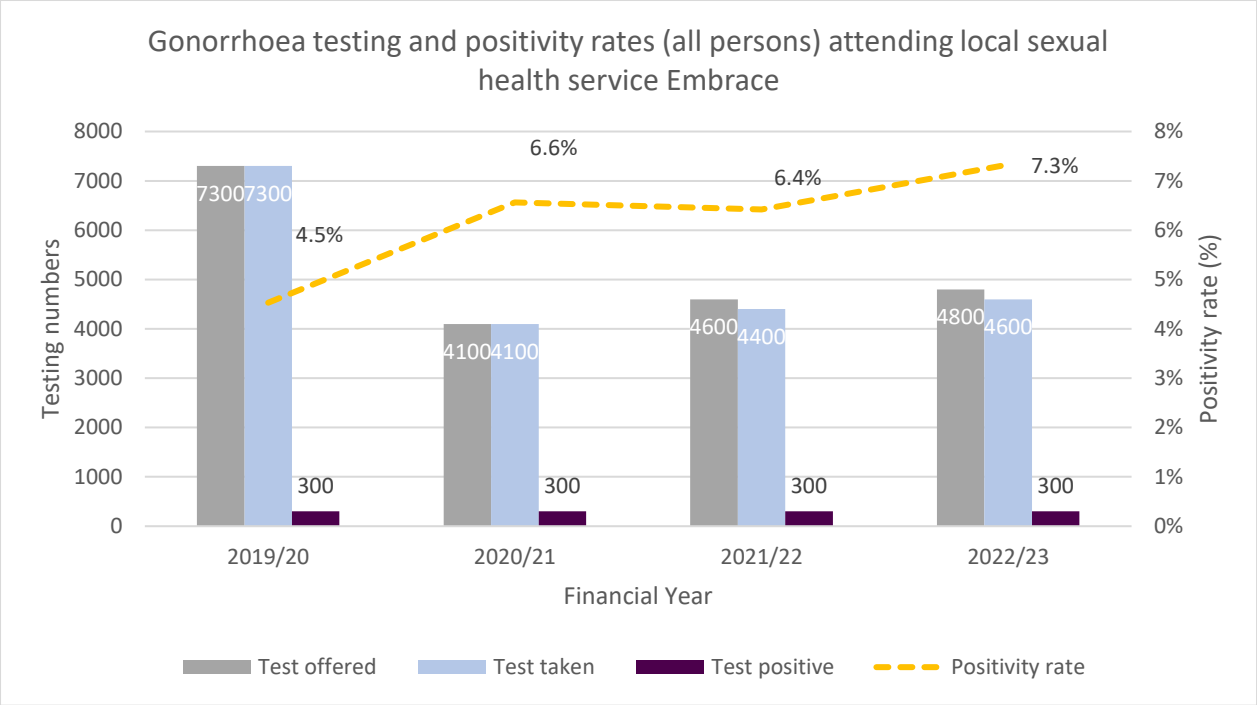
It should be noted that if high rates of gonorrhoea and syphilis are observed in a population, this can reflect higher levels of risk-taking sexual behaviour. Awareness of what influences Wolverhampton resident's sexual health related behaviours and attitudes would be invaluable to inform prevention strategies and local health promotion.

Gonorrhoea is becoming increasingly resistant to antibiotics and at risk of becoming untreatable in the future. This means it is crucial that cases are diagnosed and treated early to prevent transmission.[40]

4.3.4 Local service gonorrhoea testing and positivity rates

Figure 17 shows the trend for in-person testing at the local sexual health service between 2019/20 and 2022/23. It shows that there has been a decrease in the overall testing numbers since 2019/20, the most exaggerated being during the initial year of the pandemic 2020/21. This represents a 40% decrease in overall in-person testing numbers comparing between 2019/20 and 2022/23. The positivity rate has increased during this time from 4.5% to 7.3%.

Figure 17: The gonorrhoea testing numbers and positivity rates across all ages attending local sexual health services, 2019/20 – 2022/23



Source: Embrace Wolverhampton

This should be interpreted in the context that these were tests taken in-person and excluded online requested tests. The service encourages those with symptoms to present for in-person testing, gonorrhoea infection is often symptomatic and so it would be understandable that the positivity rate amongst those testing with symptoms to be high.

4.3.5 Gonnorhoea test numbers and positivity across the wards for all age groups

In 2022/23, local service data for face-to-face attendees undergoing testing for gonorrhoea showed that wards who took the most tests were St Peter's (367), Heath Town (310) and Bushbury South & Low Hill (274). Wards who took the least tests were Tettenhall Regis (98 tests taken), Wednesfield North (108) and Tettenhall Wightwick (109). This data excluded tests requested online.

Of the tests that were taken in 2022/23, the wards with highest positivity rates were Bilston South (14.6% positivity), Wednesfield North (11.1%) and Graiseley (10.2%). The wards with lowest positivity were Penn (3.3% tests taken), Ettingshall North (4.4%) and Oxley (5.5%).

4.3.6 Anogenital warts

Anogenital warts are the second most diagnosed sexually transmitted infection (STI) in the UK and are caused by infection with specific subtypes of human papillomavirus (HPV). Recurrent infections are common, with patients returning for treatment.

In 2022, the local diagnostic rate for anogenital warts was 40.9 per 100,000[41], which is higher than regional average (32.3) but not significantly different from the national rate (46.1). This figure had been reducing year on year locally and nationally, but since 2020 has seen an increase. The previous reduction was likely due to the protective effect of HPV vaccination and is particularly evident in the younger age groups who have been offered the vaccine as part of the UK HPV vaccination programme.[42]

Anogenital warts are diagnosed for the most part by clinical examination. However, it could be reflective of the reduction in HPV vaccine uptake seen since 2018/19 as shown in Figure 23. Gardisil-9, used in the UK HPV vaccination programme, is protective against HPV subtypes 6 & 11 (amongst others), the subtypes that cause most genital warts.

4.3.7 Anogenital herpes

Anogenital herpes is the most common ulcerative sexually transmitted infection seen in England. Infections are frequently due to herpes simplex virus (HSV) type 2, although HSV-1 infection is also seen. Recurrent infections are common, with patients often returning for treatment.

The trend in diagnostic rates for first episodes of anogenital herpes has been variable over the past decade. Rates showed an annual decrease since 2018-2020 (61.8 – 50.9 – 32.1 per 100,000), with an increase 2020/21 (32.1 – 43.9 per 100,000) The most recent data shows that in 2022, the rate for anogenital herpes was 45.4 per 100,000. This was higher than the West Midlands region (31.6), similar to the England average of (44.1) and higher than CIPFA neighbours (34.5).

As with anogenital warts, the diagnosis of anogenital herpes is via clinical examination, sometimes aided by a positive viral swab. The increase in rates from 2020/2021 for anogenital herpes and warts may therefore be reflective of the greater availability of face-to-face appointments following easing of COVID-19 service adaptations where access to services was often virtual. It could also be reflective of variability when coding a diagnosis of anogenital herpes. As anogenital herpes is often managed before a positive viral swab confirms the presence of HSV, diagnoses could have been coded without confirmation that the person has anogenital herpes. This variation has since been addressed by coding education within the service and future data should show an accurate representation of the diagnostic rate.

4.3.8 Mycoplasma Genitalium and Trichomonas Vaginalis

Mycoplasma genitalium (M. gen) is a bacterium that is transmitted via sex. First isolated in 1981, it is estimated that between 1-2% of the general population are infected.[43] It is often asymptomatic but can cause urethritis in men, proctitis and pelvic inflammatory disease in a female reproductive tract. Not everyone infected will develop symptoms and may clear the infection without requiring antibiotics. Therefore, screening is undertaken in those who have persisting symptoms or who do not respond to initial management in sexual health services.

Risk factors include having multiple sexual partners, non-white ethnicity, younger age and bring a smoker. There are concerns that the current treatment for M.gen can be associated with increasing antimicrobial resistance and so resistances are checked when specimens are sent. Identification and treatment of infected individuals and their partners is the mainstay of controlling spread, transmission can be prevented by consistent condom use.

In 2022, the rate of Mycoplasma Genitalium infection in Wolverhampton was 3.8 per 100,000, representing 10 cases of infection. Rates have been variable since data collection started in 2019, where there were 37 cases at a rate of 14 per 100,000. Wolverhampton has equivalent rates to that of the West Midlands (3.8) and less than that of England (12.8).

Trichomonas vaginalis (TV) is a sexually transmitted protozoon. Symptoms are mostly prevalent in females and can include vaginal discharge, painful urination, painful sex and vaginal inflammation. Men often do not get symptoms but sometimes experience penile irritation, urethral irritation and discharge. TV is diagnosed either by seeing the organism on microscopy or by taking a vaginal swab. There is currently no swab available to detect TV infection in males.

TV infection is associated with Black and Black Caribbean ethnicity, older age and current gonorrhoea or chlamydia infection. Complications of TV may include preterm delivery and low birth rate if a pregnancy person is infected. There is also evidence that TV infection may increase risk of HIV transmission and there may be an increased risk of TV infection among HIV positive individuals.[44] Prevention of spread relies on the identification and treatment of those infected and their partners; correct condom use prevents transmission.

In 2022, Wolverhampton had a Trichomoniasis diagnostic rate of 50 per 100,000, the 2nd highest in the West Midlands region and amongst statistically comparable CIPFA neighbours. Rates were higher than regionally (16.9) and nationally (13.1) and have been for the past decade.

There has been a steep increase between 2021 (23.1 per 100,000) and 2022 rates (50 per 100,000) and it was at the highest since data collection began. This may be partly due to diagnosis of TV requiring an examination, with access to face to face healthcare improving post-pandemic but could be due to an increasing prevalence within the Wolverhampton population.

4.3.9 Mpox

Prior to 2022 Mpox was a relatively unknown and rare virus. Mpox is a zoonotic (transmission of infection is possible between animals and humans) infection caused by the Monkeypox Virus. Mpox is endemic in Central and Western parts of Africa and prior to 2022, infections in the UK were travel related. As spread is via direct contact with infection skin or body fluid, Mpox can be transmitted via sex.

Most Mpox infections are mild (blistering rash, swollen lymph nodes, fatigue, fever, joint and muscle pains) and those infected recover within a few weeks without needing any treatment. However, pregnant people, children and those with weakened immune systems are at risk of developing a more severe infection requiring hospitalisation.

The 2 dose Smallpox vaccine can be used to reduce the risk of Mpox acquisition up to 85% (Smallpox and Mpox being part of the same Orthopoxvirus family). At the time of the outbreak, vaccine supplies were limited. This was due to small stockpiles produced by a single manufacturer worldwide. Wolverhampton's local sexual health service did not have access to or provide vaccination. A small supply was available within the region at Birmingham sexual health services. GBMSM who were identified as high risk were signposted to this service. The outbreak vaccination service ended in July 2023 but continues at vaccination sites in Greater Manchester and London to GBMSM identified as high risk or staff who work at sex-on-premises venues.

In May 2022, there were identified Mpox cases that had acquired the infection from within the UK. This outbreak mainly affected Gay, Bisexual or Men who have sex with Men (GBMSM). To date there have been a total of 3,636 cases within England, of which 10 were within Wolverhampton, with no reported deaths related to Mpox[45].

Whilst the total Mpox cases within the city were low, Mpox did prompt a global health emergency and highlights the need for local services to be responsive to emerging infections.

4.4 HIV and Pre-Exposure Prophylaxis

4.4.1 HIV

Free and effective antiretroviral therapy (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 if they adhere to treatment. With effective treatment, the viral load for an individual is reduced (suppressed) to such a level that that person can no longer transmit the virus to another person. Late diagnosis means greater risk of HIV-related complications, spread to partners and mortality.

HIV indicators are taken from the HIV and AIDS Reporting System (HARS) data set that underpins national HIV surveillance[46]. The most recently released data is from 2022[47]. It

must therefore be read in the context of the unprecedented COVID-19 pandemic which was prevalent at this time.

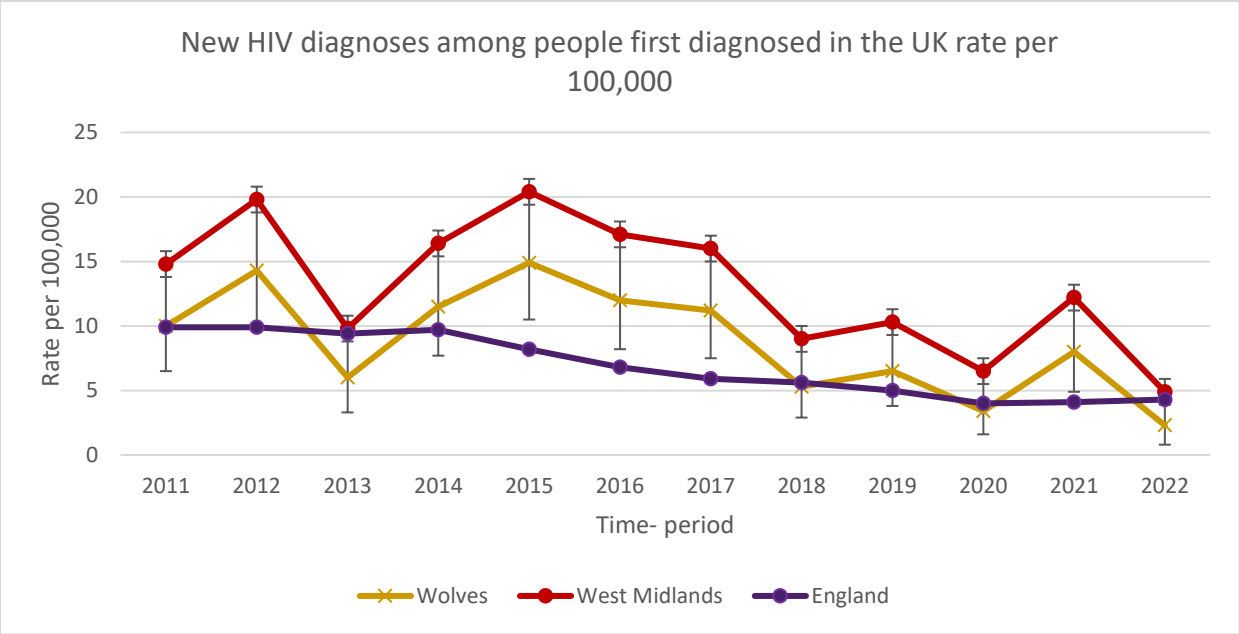
4.4.2 New HIV diagnoses

In 2022, 6 Wolverhampton residents received a diagnosis of HIV (first time diagnosed in the UK), giving a rate of 2.3 per 100,000 (Figure 18). This was not statistically different from the rate seen for the region (4.9), nationally (4.3) or CIPFA neighbours (3.7).

The trend for new diagnoses of HIV has been variable over the past decade as shown in Figure 18. There was a significant 71.4% decrease in number of diagnoses comparing 2021 to 2022. 2021 appears to be an outlier in the overall decreasing trend seen since 2015. This could be reflective of increased testing or increased transmission of infection.

New diagnoses in both Black African and Black Caribbean heterosexuals in the UK have been decreasing steadily over the past 10 years.[48]

Figure 18: New HIV diagnoses among people first diagnosed in the UK rate per 100,000, 2011- 2022



Source: Fingertips

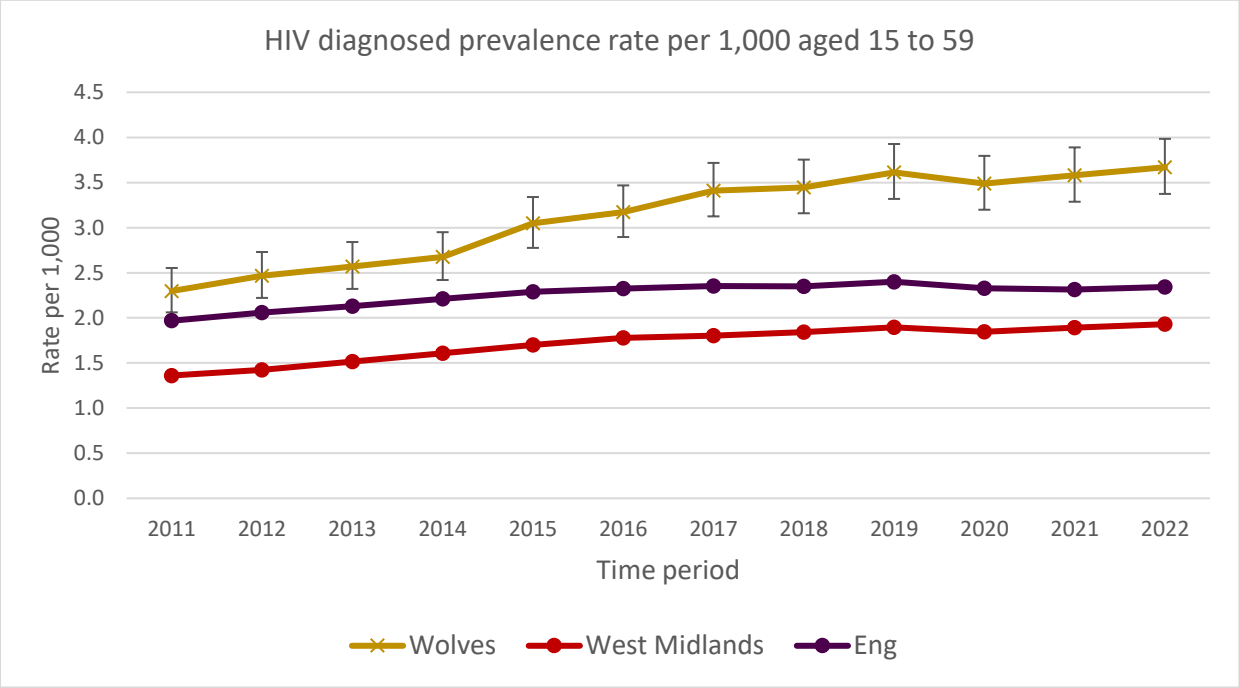
4.4.3 Living with HIV

In 2022 there were 566 Wolverhampton residents aged between 15-59-years-old living with diagnosed HIV. The prevalence of HIV in Wolverhampton is 3.7 per 1,000 of all people aged 15-59. This is higher than regional (1.9), national (2.3) and CIPFA neighbours (2.3). This shows that Wolverhampton is an area of high HIV prevalence.

High prevalence is not necessarily concerning as these are residents who have been diagnosed and are therefore accessing NHS HIV health services. Prevalence should always be taken into context alongside rates of new and late diagnoses as an indicator for the rates for undiagnosed HIV. As people are living with HIV with an improved life expectancy and reduced transmission risks due to antiretroviral therapy (ART) use; prevalence will rise within a population (as shown in Figure 19). Increasing prevalence is indicative of high rates of testing and diagnoses, or movement of those living with HIV into a particular area.

In 2022, Wolverhampton had a HIV diagnosed prevalence rate (3.7 per 1,000), significantly higher than the national (2.3) and regional (1.9) rate (Figure 19). Wolverhampton also had the 2nd highest rate of diagnosed HIV prevalence in the West Midlands region and when compared to statistically similar CIPFA neighbours.

Figure 19: HIV diagnosed prevalence rate per 1,000 aged 15 – 59, 2011- 2022



Source: Fingertips

Six local authorities in the West Midlands had a diagnosed HIV prevalence in excess of 2 per 1,000 population aged 15-59 years in 2022. They were Coventry (3.8), Wolverhampton (3.7), Sandwell (2.8), Birmingham (2.7), Walsall (2.4) and Stoke-on-Trent (2.3)[49]. A rate of 2 per 1,000 population is the threshold for expanded HIV testing, which includes opt-out bloodborne virus testing within point of access care settings (e.g. the Emergency Department). Testing tends to consist of HIV, Hepatitis B (HBV) and Hepatitis C (HCV) screening; infection with HBV and HCV also being possible via sexual transmission.

Despite this, Birmingham is the only one of the six areas working towards becoming a Fast Track City, yet of the 7 Fast-Track Cities in England, only 3 (London (5.3), Manchester (5.8)

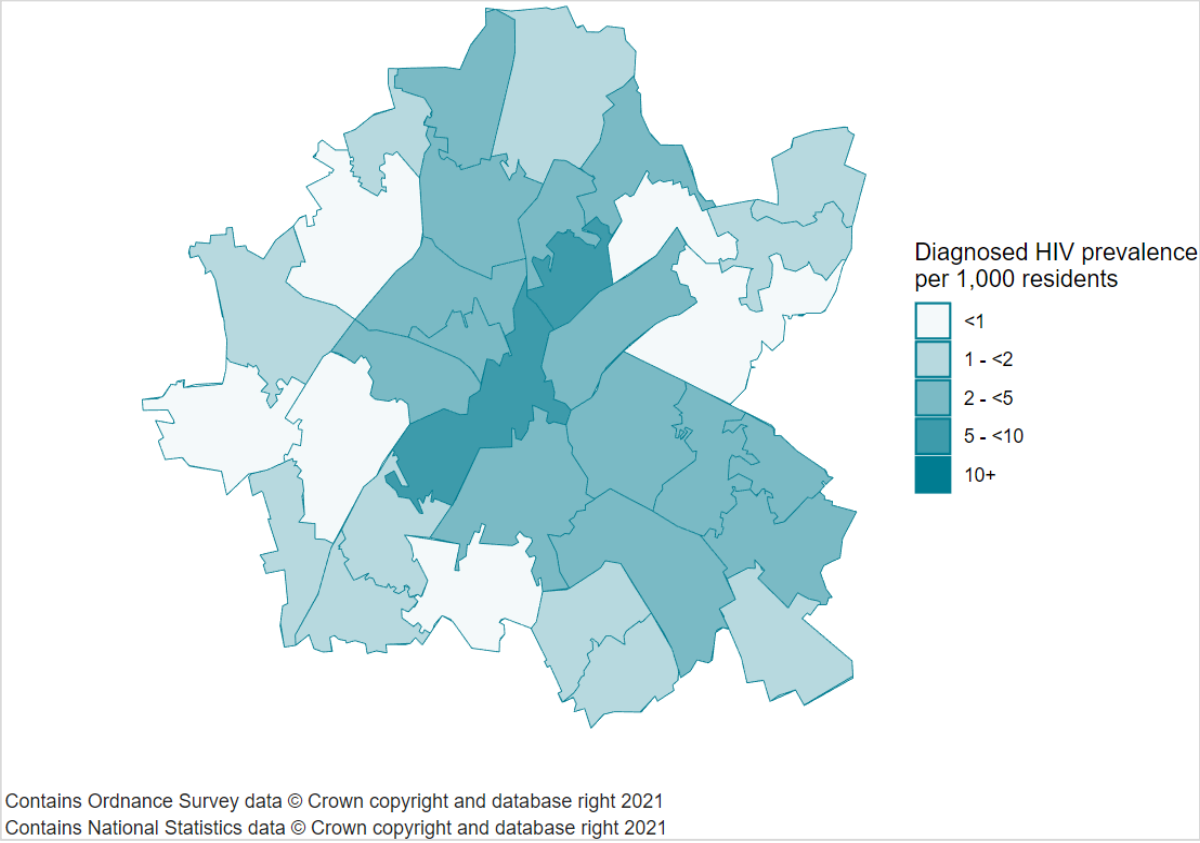
and Brighton (7.3)) have a higher prevalence of HIV per 1,000 population aged 15-59 years than Wolverhampton.

The Fast-Track Cities initiative is a global partnership between cities around the globe and the International Association of Providers of AIDS Care (IAPAC), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Human Settlements Programme (UN-Habitat), and the City of Paris. Becoming a designated Fast-Track City means committing to objectives aimed at achieving The Joint United Nations Programme on HIV/AIDS (UNAIDS) 90-90-90 targets[50]:

- 90% of people living with HIV are diagnosed.
- 90% of people diagnosed are receiving anti-retroviral therapy.
- 90% of people on treatment are virally suppressed and unable to pass on the infection.

Within Wolverhampton, the highest diagnosed prevalence of HIV in 2022 was seen in the central, northern and south-eastern parts of the city (Figure 20). This included parts of St Peter's, Graiseley, Bushbury South and Low Hill wards. The geographical trend of diagnosed HIV prevalence was similar to the geographical location of deprived areas within the city, therefore areas with a greater HIV prevalence tended to be more deprived areas of the city.

Figure 20: HIV diagnosed prevalence rate per 1,000 by ward, 2021



Source: Wolverhampton SPLASH report

4.4.4 Late diagnosis of HIV

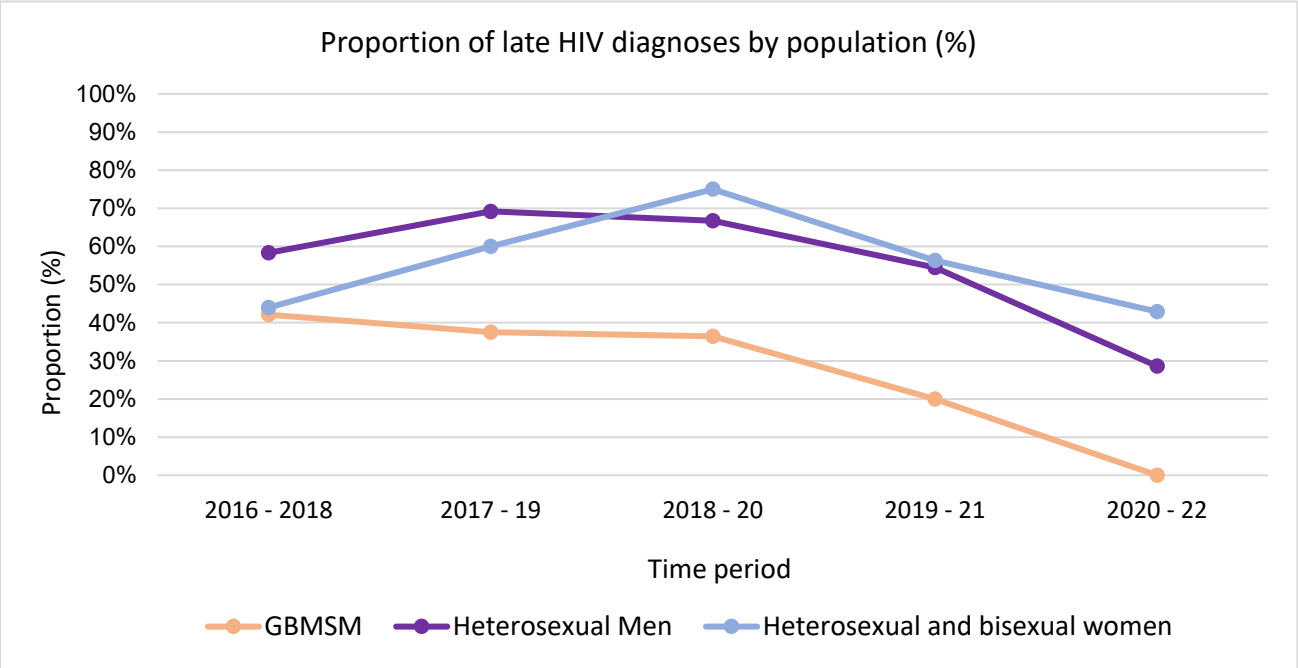
Nationally, the number of HIV diagnoses made at a late stage of infection has been gradually decreasing over the last decade. Despite this, the proportion of late diagnoses in England remained high at 43.3% between 2020 and 2022. During this same period, the late diagnosis rate in Wolverhampton was 29.6%, which was lower than the regional (45.9%) and national (43.2%) proportions.

From 2020 to 2022, there were no late diagnoses of HIV among GBMSM in Wolverhampton. However, 2 heterosexual men in Wolverhampton received a late diagnosis, accounting for 28.6% of HIV diagnoses in this group, which was lower than the regional (60.7%) and national (58.9%) proportions.

In the same period, 6 heterosexual and bisexual women in Wolverhampton were diagnosed late with HIV, making up 42.9% of all HIV diagnoses in this population. This proportion was also lower than the regional (50.4%) and national (49.9%) averages (Figure 21).

Figure 21 shows the trend in late HIV diagnoses by the three populations included in the Fingertips HIV indicators. This shows that since 2016 there has been a decline in late HIV diagnoses, the population this has been most apparent in is the GBMSM group. There has been less of a decline in heterosexual and bisexual women after an increase between 2016 – 2020. This highlights that HIV testing should be offered proactively to all groups within the Wolverhampton population.

Figure 21: The proportion of HIV diagnoses by population (%) 2016– 2018 to 2020 – 2022



Source: Fingertips

The overall reduction in transmission highlights that preventive measures have been working, such as condom provision, pre-exposure prophylaxis (PrEP), expanded HIV testing and prompt initiation of treatment after diagnosis.

4.4.5 HIV testing coverage

In 2022, among Wolverhampton residents, the percentage of eligible SHS attendees who received an HIV test was 68.3%, better than regionally (54.4%) and nationally (48.2%). This represented a 3.3% increase since 2020, and a 12.7% decrease since 2019.

For 2022/23, service data from the local sexual health service showed that of the 4,465 attendees who were offered an HIV antibody test, 3,876 accepted testing. This gave a testing uptake of 86.8%, the national target is 95%.

For 2022, the percentage of GBMSM in Wolverhampton presenting to sexual health services who received an HIV antibody test was 82.5%. This was better than regional (81.6%) and national (74.1%) percentages. The percentage of GBMSM receiving repeat HIV testing, that is testing more than once in a year, was 48.8%, similar to regional (49%) and national (47.3%). This was the first time that Wolverhampton has been similar in this indicator, having been less than regional and national percentages since data collection started in 2018. This is important as NICE testing guidance recommends GBMSM test at least annually or every 3 months if having condom-less sex with new or casual partners to promptly identify HIV infection.[51]

4.4.6 HIV testing for those with Tuberculosis

As HIV affects the immune system, those with this virus are at greater risk of having other infections such as TB; subsequently managing the viral load will improve TB outcomes. This means that people who are positive for TB should also be tested for HIV.

Improving treatment and care services is a key action in the Collaborative Tuberculosis Strategy for England 2015 – 2020 and increasing the proportion of TB cases offered an HIV test is a key indicator of success. In 2021, 100% of TB cases in Wolverhampton were offered an HIV test (100% for the 2nd year in a row); better than regionally (98%) and nationally (98.4%).

4.4.7 Managing HIV

The indicator of successful treatment with antiretroviral therapy (ART) presents the number and proportion of people accessing HIV care with an undetectable viral load (VL) (an undetectable viral load is <20 – 50 copies/ml).

The percentage of people (aged 15 years and over) in Wolverhampton accessing HIV care who were prescribed ART in 2022 was 98.9%, similar to West Midlands (99.1%) and England (98.1%). This meets the benchmarking of >95% set as part of the UNAIDS target of 95-95-95 by 2025 (95% of all people living with HIV to know their HIV status, 95% of all people with

diagnosed HIV infection to receive sustained treatment and 95% of all people receiving treatment with viral load suppression by 2025).[52]

The percentage of people in Wolverhampton newly diagnosed with HIV in the three-year period between 2020 – 2022 who attended for HIV care and started ART promptly (within 91 days of their diagnosis) was 67.4%, this was lower than the West Midlands (87.5%) and England (85.4%). It should be mentioned that there has been a decrease from 2019 – 2021 data when 76.4% of newly diagnosed Wolverhampton residents commenced ART within 91 days of diagnosis.[53] Barriers to commencing antiretroviral therapy promptly include, denial and perceived stigma/fear about HIV diagnosis, concerns about the medication e.g. side effects and difficulties engaging with healthcare.

The percentage of adults in Wolverhampton accessing HIV care in 2022 who were virally suppressed (viral load ≤200 copies/mL) was 95.8%, less than 97.8% in the West Midlands region and 97.7% in England. This could be due to many factors, for example recently commencing medication (see above regarding the proportion of Wolverhampton residents who commence ART promptly), poor pill-taking practises, drug resistance and having vulnerabilities that make it difficult to engage with medication/healthcare or those who disengage from healthcare are all risk factors for having a detectable viral load.

5. The national human papillomavirus (HPV) immunisation and Cervical Screening programmes

5.1 Human Papillomavirus

Human papilloma virus (HPV) is a very common virus that can be spread via sex. Some types of HPV are linked with genital and head and neck cancers.

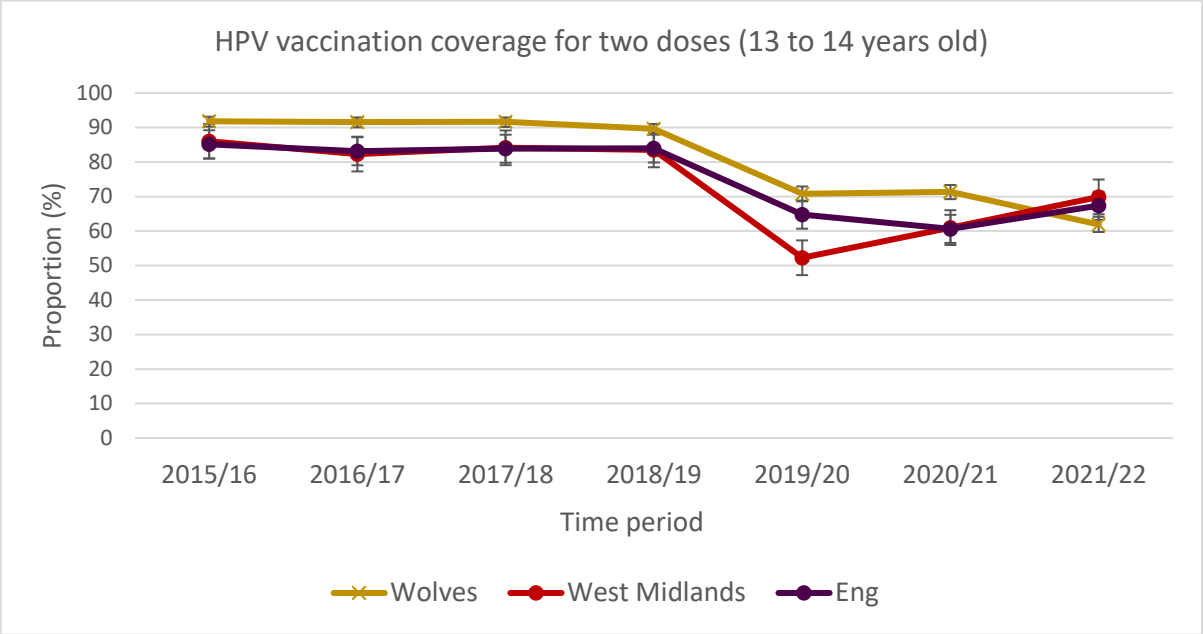
The HPV vaccination programme was introduced in 2008 for secondary school Year 8 females (12-13 years of age) to protect them against the main causes of cervical cancer. It was extended to include eligible males in September 2019 to prevent HPV-related cancers and strengthen herd immunity. In 2023, the HPV vaccination schedule moved to a single dose of HPV vaccine that is usually offered to Year 8 students (aged 12-13 years).

The indicator for HPV coverage is children aged 12-13 years who have received the first (priming) dose of the HPV vaccine within each reporting area (local authority - LA) as a percentage of all children aged 12-13 years within each area. In 2021/22, Wolverhampton had a rate of 64.5% which is lower than the averages regionally (66.9%) and nationally (69.6%).[54]

This may be reflective of the disruption to vaccine provision caused during the COVID-19 pandemic, where schools were closed for face-to-face learning and healthcare staff were redeployed to deliver the COVID-19 vaccine programme or to acute healthcare services. There have also been high levels of pupil absence post-pandemic with 7% of school sessions missed in the academic year 2021/22 by Wolverhampton students aged 5-15 years, meaning less opportunity for Relationships and Sex Education (RSE) to raise awareness of

the importance of HPV vaccination but also more pupils absent at times of vaccine administration. This could all contribute to lower vaccination uptake.

Figure 22: Wolverhampton HPV vaccination coverage, 2015/16 – 2021/22



Source: Fingertips

5.2 Cervical Screening

Cervical screening is offered to those with a cervix, 3 yearly for 25-49-year-olds and 5 yearly for 50-64-year-olds. It identifies the presence of HPV and if the virus is present, any changes to the cervical cells that over time could progress to cervical cancer. In 2022/23 Wolverhampton's average coverage rate was 61% of eligible 25-49-year-olds and 70% of eligible 50-64-year-olds.[55] The national target is to screen 80% of the eligible population.

However, compared to the 80% target the national coverage rates were also lower at 66% (25-49-year-olds) and 74% (50-64-year-olds) of those eligible received screening. Rates do not appear to have been impacted by the COVID-19 pandemic, with a falling trend in coverage from 2020/21 rates (64.3%) for ages 25-49-years-old and stable rates for those aged 50-64 years (71%).[56] As the highest incidence rates of cervical cancer are in the 30 to 34 age group[57] those most at risk (25-49-years-olds) may not be being screened. This could be due to lack of awareness of the importance of cervical screening, worries about the screening process or lack of access to receive screening.

6. Specialist Sexual Health Services - Embrace

Royal Wolverhampton NHS Trust are commissioned by City of Wolverhampton Council to provide sexual health services known as Embrace Wolverhampton.

Since 2016, the integration of contraceptive and Genito-urinary medicine (GUM) has been key to develop a single appointment rather than several appointments. The benefits being that any sexual health needs can be identified and acted on within one appointment, by the same clinician, within the same service. The following services are provided by the Embrace service:[58]

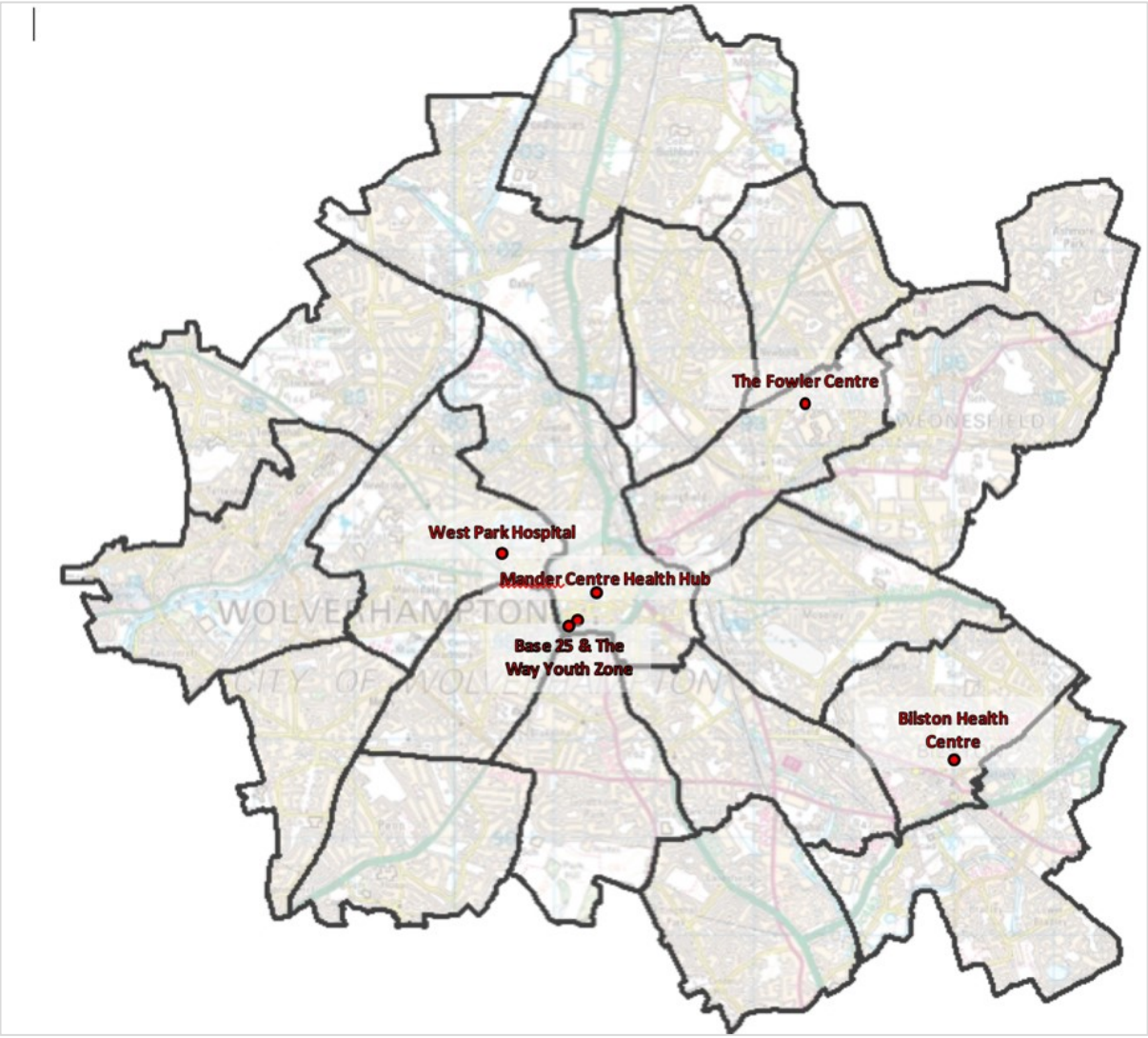
Table 4: Shows services provided by Embrace

Sexual Health:	Reproductive Health:
Online Sexual Health screening (routine chlamydia, gonorrhoea, HIV and syphilis)	Emergency Contraception including Cu-IUD
Full STI testing, including for chlamydia, gonorrhoea, HIV and syphilis (other tests are available depending on clinical circumstances)	Long-Acting Reversible Contraception (Injectables, Implant, non-hormonal Cu-IUD, hormonal LNG-IUD)
HIV care	Pregnancy Testing
Hepatitis A, B and C testing and vaccination for groups assessed as at risk	Contraception (pills, patches, rings, diaphragm, male/external condoms, female/internal condoms)
HPV vaccination for men having sex with men between the ages of 14 and 45 years.	Sexual health advice
Treatment for genital warts	Cervical screening
Post Exposure prophylaxis for HIV (PEP)	Advice and LARC training to professionals
Pre-exposure prophylaxis (PrEP)	Pharmacy EHC provision
Herpes diagnosis & care	C Card scheme
Advice and information for patients (face to face and via Advise Line)	CHAT sexual health (texting/information & signposting service)
Advice and information to professionals	Psycho-sexual Services
Online STI postal service	Complex contraception (those with co-morbidities, complicated LARC procedures)

Source: Embrace Wolverhampton

The service operated a hub and spoke model. The main hub is the Fowler Centre site with several spokes providing an integrated service. The spokes were located at West Park Hospital and Bilston Health Centre, with sexual health screening clinics at the Mander Centre. Youth specific venues are located at Base 25 and The Way Youth Zone in the city centre.

Figure 23: The locations of sexual health services in Wolverhampton, 2022



Source: City of Wolverhampton

6.1 Impact of COVID-19 on Sexual Health Service Delivery

The global pandemic in April 2020 resulted in rapid changes to service provision in order to prevent transmission of the COVID-19 virus and redeploy staff to acute areas of the hospital.

The spoke locations and clinics specifically for young people were closed and all face-to-face services were delivered from the main hub location only.

'Walk-in' services were no longer available. Consultations moved to a telephone triage model with only those with complex contraception needs, HIV-care related blood tests and sexual health symptoms being seen face-to-face.

Saturday appointments that had been available at the service since 2016 ceased in Q1 – 2020 and have not been reinstated. A total of 1,616 patients were seen on Saturdays during

2016 – 2020, which equates to 3% of overall activity. Discussions are ongoing within the service about a return to weekend working.

Medication-only requirements were undertaken through either a postal model or collection from the main hub. An enhanced full screening digital offer became available and postal STI testing kits were offered to limit face-to-face contact.

Because of the significant changes to service delivery during the pandemic, it is important to note that data for the period 2020 – 2022 should not be directly compared. For a more accurate picture, 2019 data should be used as the base comparator.

Post-pandemic, with the return of redeployed staff and reduced risks from COVID-19 related to vaccination, clinics at the spoke locations and young person's clinics have been reinstated.

Those wishing screening for STIs are first directed to request online testing to complete at home. There has been a return to face-to-face working, albeit alongside telephone consulting depending on service user preference; with a mix of pre-booked and book-on-the-day appointments available. Routine contraceptive care and sexual health outreach provided by Embrace nursing staff have resumed.

6.2 Service Activity

6.2.1 Attendance

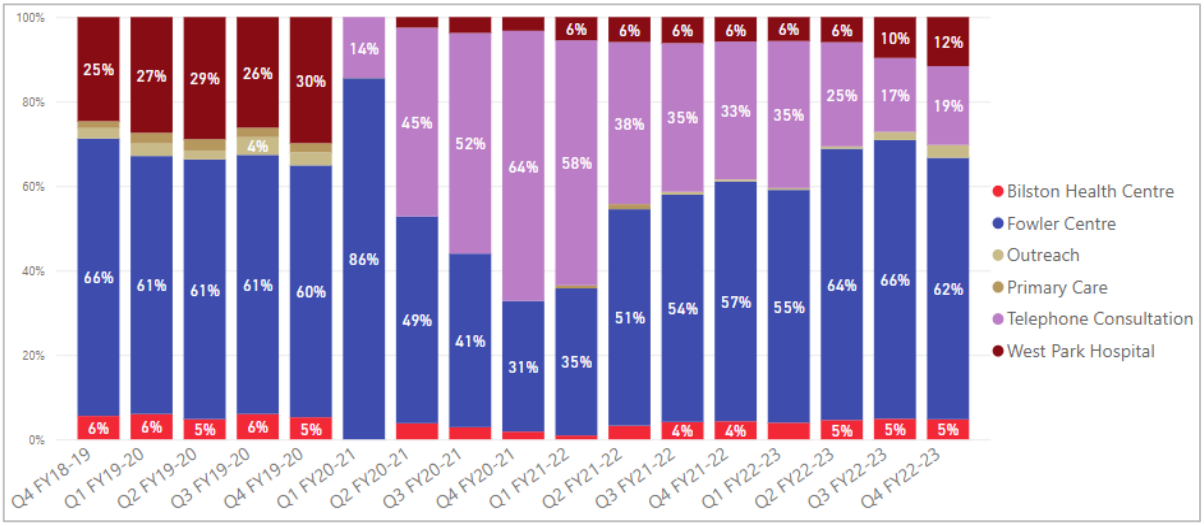
The total number of attendances at Embrace in 2022/23 was 13,356. Of those, 2,956 were new patients, 4,485 were rebook (recent contact with the service but attending with an ongoing or new issue), 6,515 were follow up appointments following an initial appointment. In 2022/23 79.4% of all appointments were booked and 20.6% were walk-in appointments.

When compared to previous years there has been an increase in the number of appointments that are booked compared to walk-in. This is consistent with the service changes that were made during the COVID-19 pandemic to try and reduce face-to-face contact and since then Embrace has not returned to a walk-in model.

The benefits of this being that walk-ins could mean a long wait for service users should they attend on a particularly busy day. A set appointments system also gives greater control to staff for work scheduling. There is the proviso within the service that anyone with vulnerabilities who may be at risk should they not have been seen by a healthcare professional is accommodated should they 'walk-in.'

Figure 24 shows the location of attendances across the Embrace hub and spoke model. It demonstrates the cessation of hub working during the first COVID-19 lockdown (Q1 20 – 21), at this time the service ran entirely from the Fowler Centre with telephone consultations established to reduce face to face contact.

Figure 24: Location of attendances across the Embrace hub, 2018- 2023



Source: Embrace Wolverhampton

The percentage of attendances to the Fowler Centre have returned to pre-pandemic levels. However, attendances at some hub locations, such as West Park Hospital and in Primary Care have not.

Possible reasons for this being people may prefer to attend the main hub, are unaware of the spoke locations or the number of clinics being run at spoke locations have not returned to pre-pandemic levels. Possibly with the integration of telephone consultations and more sexual healthcare being provided remotely, staffing and resources are being put towards this method of healthcare delivery rather than spoke location clinics.

In 2022/23, 45.4% of residents were seen by a nurse, followed by 23.7% by a doctor and 20.2% by a consultant (43.9% seen by medical staff). Since 2016 these figures have remained stable, with a small increase in those being seen by medical staff in the 2022/23 data.

This shows that patient needs can be addressed by nursing professionals. However, an almost equal percentage are being seen by medical professionals, these are often those with complexities, for example requiring complex LARC procedures or complex genitourinary presentations.

6.2.2 Demographics of attendances

6.2.3 Geography

In 2022/23, 81.4% of people who accessed Embrace lived in Wolverhampton (18.6% provided a postcode outside of Wolverhampton). The figure for those out-of-area utilising Embrace has remained stable since 2016. Wolverhampton is closely located to the urban areas of Walsall, Sandwell and Dudley, some residents will choose to attend the sexual health services in these areas and vice-versa. The main out-of- area activity utilising

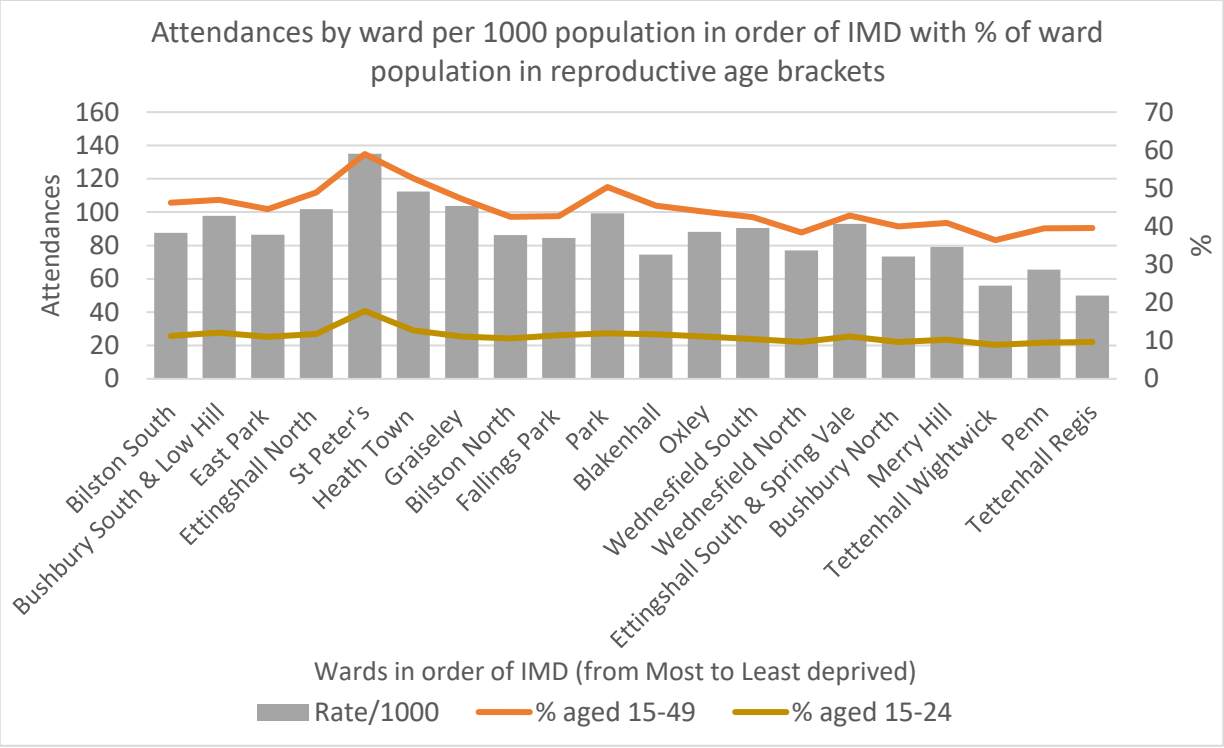
Embrace is from South Staffordshire (561 patients), with Walsall (382 patients), Dudley (186 patients) and Sandwell (84 patients) being the other areas most accessing the service[59].

6.2.4 Deprivation

In 2022/23, attendances from the most deprived wards remained stable (Bilston South, Bushbury South & Low Hill, East Park, Ettingshall North, St Peters). Previous data from 2016 – 20 regarding ward level attendance numbers show that that the COVID-19 lockdowns in 2020 did not affect residents from the most deprived areas from accessing the service.

Figure 25 shows the breakdown of Embrace attendances by ward represented as a rate per 1000 population with wards in order of index of multiple deprivation.

Figure 25: Rate of 2022/23 total attendances to Embrace by Ward per 1000 population with percentage Ward population by reproductive age brackets.



Source: Embrace

People from St Peter's ward were most likely to attend local sexual health services (135 per 1000) followed by Heath Town ward (112.4) and Ettingshall North ward (101.8). There were fewest attendances from residents of Tettenhall Regis ward (49.9 per 1000).

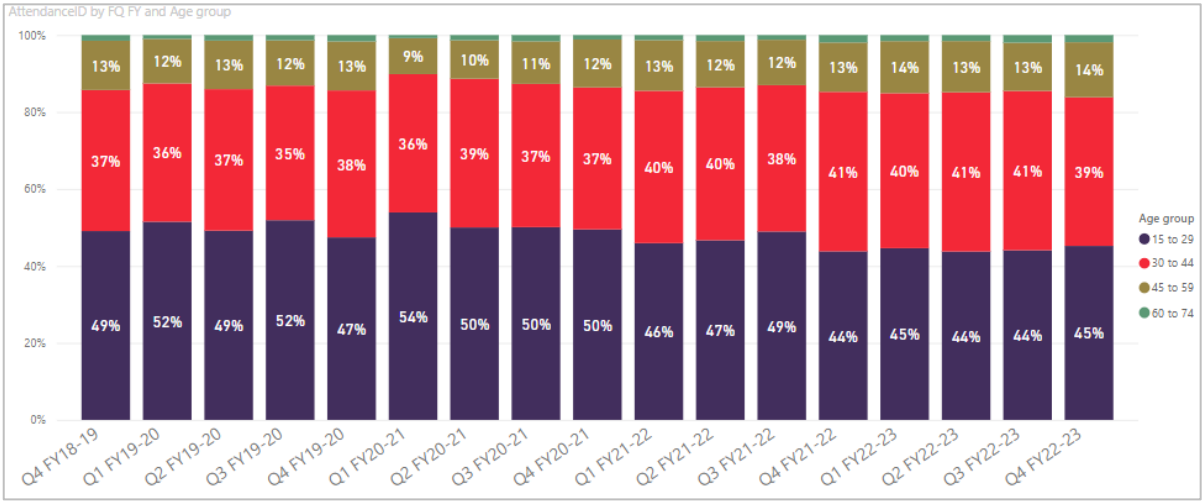
It can be seen that attendance rates are variable across the wards, with a modest difference between the most and least deprived wards. The factor that seems to have a greater influence on the rate of attendees was the percentage of the ward population who were of reproductive age (15-44 years).

When comparing the number of attendees by ward to the percentage of the ward population that are of reproductive age (15 – 49-year-olds) that wards with higher rates of attendances tended to have a greater proportion of their population in the reproductive years. For example, St Peter's ward had the highest rate of attendees per 1000, it was also the ward with the biggest proportion of its population in their reproductive years (59%) and therefore more likely to require sexual and reproductive healthcare. This trend was mirrored across most of the wards, however this effect was less noticeable when looking at the percentage of the ward population that were 15-24-years-old. This may be because this age group represent a very narrow age bracket within each ward population as a whole.

6.2.5 Age of service users

Wolverhampton 15-29-year-olds and 30-44-year-olds were most likely to attend local sexual health services in the City (44.5% and 40.3% respectively). Comparing this to the Census 21 data, Wolverhampton residents aged 15-29-years-old make up 36.6% of the population and 30-44-year-olds 41.4%. This shows overrepresentation of 15-29-year olds attending sexual health services for healthcare. When thinking about the age bracket that have the greatest proportion of STIs and who are also targeted for screening, this is not unexpected.

Figure 26: Age range of Embrace attendants from 2018/19 to 2022/23



Source: Embrace

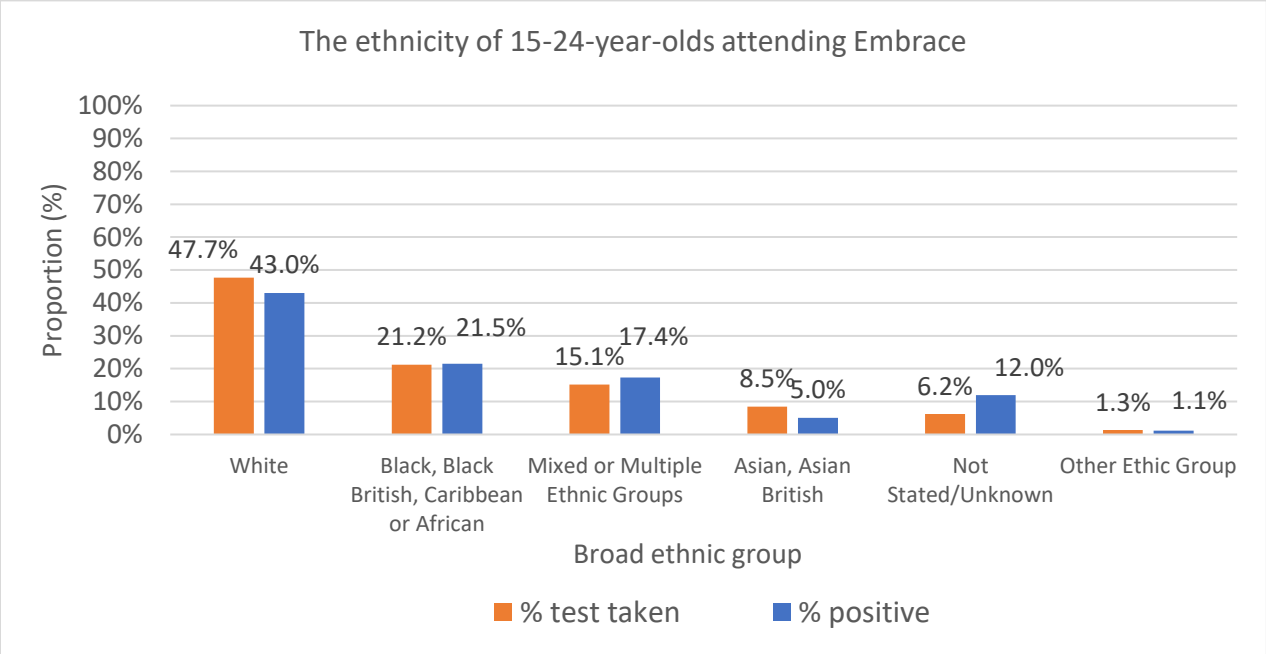
Data from 2022/23 showed there are marginally more 15-29-year-olds (44.5%) attending the service closely followed by 30-44-year-olds (40.2%).

6.2.6 Ethnicity of service users

Service data from 2022 to 2023 shows that for attendees across all age groups, 47.7% those tested were White, 21.2% were Black, 15.1% were Mixed and 8.5% Asian/Asian British. The

proportions of 15-24-year-olds who tested positive were White (43.0%) followed by Black (21.5%), Mixed (17.4%) and Asian (5.0%).

Figure 27: The ethnicity of 15-24-year-olds attending Embrace, 2022/23



Source: Embrace

Compared with census data this shows that those of Asian/Asian British ethnicity are underrepresented as a percentage of Embrace attendees (8.5%) considering 22.8% of the 15-24-year-old living in Wolverhampton are Asian/Asian British (Census, 21). However, this group represented a small percentage of 15-24-year-olds who tested positive for sexually transmitted infections (4.7%).

Black (21.2%) and Mixed (15.1%) ethnicity are overrepresented in the percentages who tested positive for STIs in this population; considering 11.4% and 8.9% of the 15-24-year-old living in Wolverhampton identified as Black and Mixed ethnicity respectively (Census, 21).

6.2.7 Gender identity and sexuality of service users

In 2022/23, 72% of women accessed the service compared to 28% of males. This is not unexpected as a proportion of the female attendees will be presenting for reproductive care. New for 2023, all service users are asked whether they are living in the sex they were given at birth. This is to try and better understand the sexual health needs and outcomes for those living in a sex different to that which they were assigned at birth.

During the 2022/23 period 80% of attendees were heterosexual followed by 7% not stated, 6.8% gay/lesbian and 5% bisexual.

6.3 Local consultation

6.3.1 Objectives

To support the Sexual Health Needs Assessment, a local consultation was undertaken within the community to gather the views, attitudes and experiences about Sexual Health services.

6.3.2 Methodology

The consultation employed a mixed methods approach, utilising both quantitative and qualitative methodologies. Quantitative data collection was carried out via an online survey housed on Citizen space, targeted at any Wolverhampton residents aged 16 and over. This survey was compiled by colleagues from CWC Public Health and Embrace, Royal Wolverhampton NHS Trust's Sexual Health Services.

The survey was piloted for accessibility and suitability by Equality, Diversity and Inclusion Forum members (LGBTQ+ and Disability and Age Forums) at CWC, University Health Champions from University of Wolverhampton and staff and volunteers from Wolverhampton HealthWatch.

Focus groups were facilitated by community organisations to gather qualitative insights into key themes. Those organisations who facilitated focus groups were incentivised through a £300 payment. Some organisations also supported with recruiting those surveyed and for this they were paid £100 plus £2 per survey.

The main online survey was shared through various channels, including the Wolverhampton Voluntary Community Association, Black Country ICB People's Pane, l and across social media. It was also incentivised through Costa coffee, both at the Civic Centre building and the University of Wolverhampton.

A short version of the survey was developed to be completed by users of the Good Shepherd, who support those living in severe poverty and experiencing homelessness. It was felt that their service users were unlikely to complete the full survey and it was important to hear their voices through this engagement work.

Data from both the full and short surveys were collated and presented using Microsoft Power BI. Data from the focus groups were collated and analysed using thematic analysis, highlighting key themes and shared responses.

Results were presented and discussed with colleagues and recommendations have been aligned with the Wolverhampton Sexual Health Needs Assessment.

6.3.3 Results

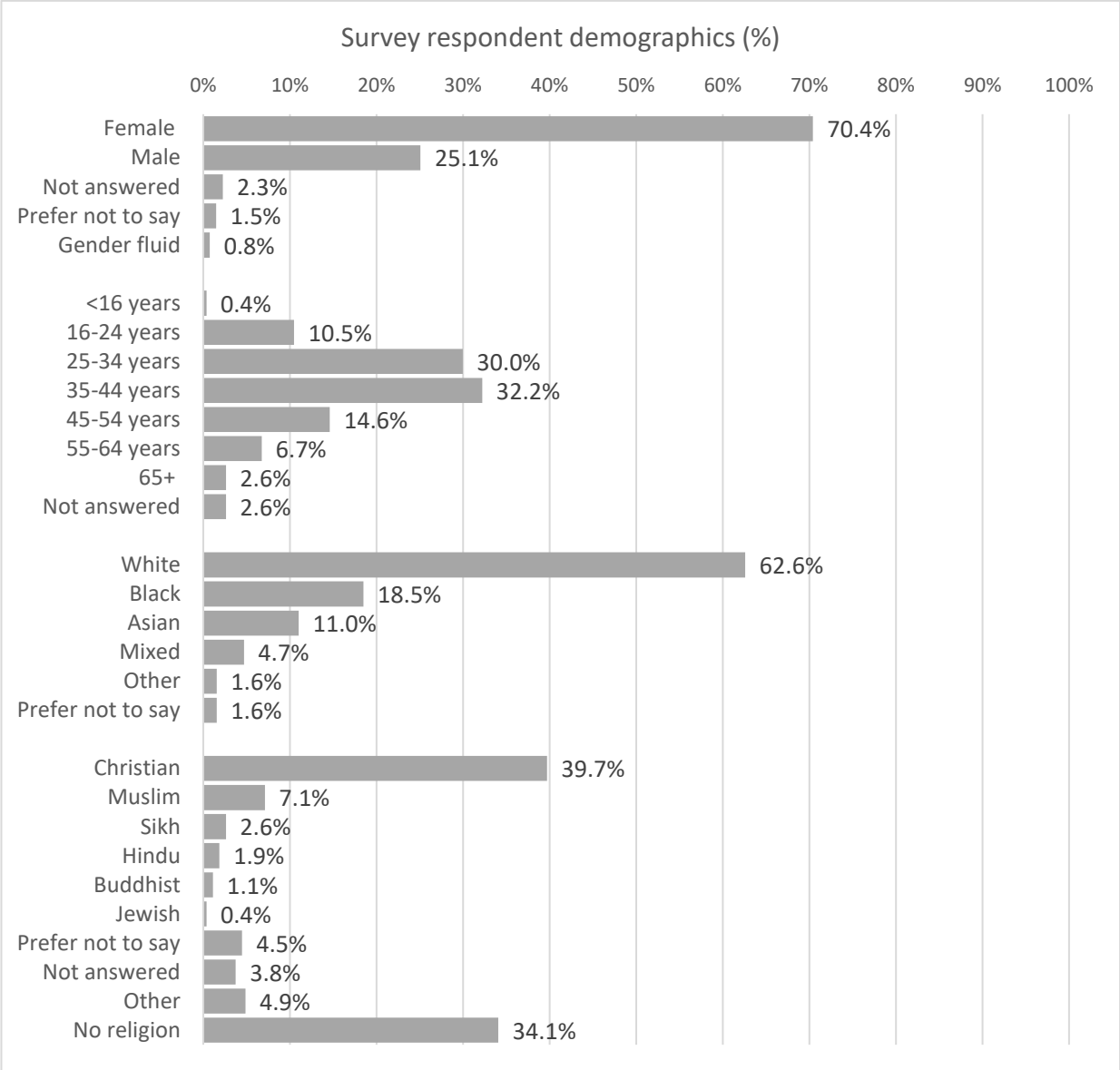
Table 5. Engagement with local consultation, 2023

Distribution of survey	N	%
Online survey	267	72.4%
Good Shepherd short survey	45	12.2%
Wolverhampton LGBT+ focus group	9	2.4%
Changing Lives focus group	6	1.6%
Together in Pennfields focus groups	21	5.7%
Good Shepherd focus group	9	2.4%
Black Country ICB People Panel	12	3.3%
Total engagement	**369**	

Respondent demographics

- Around 7 in 10 (70%) of those surveyed identified as female, around a quarter (25%) identified as male, and 5% identified as gender fluid, or preferred not to say.
- Nearly two-thirds (62%) of respondents were aged between 25-44 years.
- The large majority (63%) of those surveyed were of White ethnicity, around 2 in 10 (19%) were Black, around 1 in 10 (11%) were Asian, and a smaller proportion were Mixed (5%), Other (2%) or preferred not to disclose their ethnicity (2%). The demographics of the those surveyed do not fully reflect the Wolverhampton population, as there was a higher representation of White and Black those surveyed, and a lower representation of Asian individuals compared to the overall population.

Figure 28. Survey respondents, by demographics (%), 2023



Source: Public Health, City of Wolverhampton Council

Getting information

- Nearly around 9 in 10 (88%) of all those surveyed, reported using online searches to get information around sexual health.
- Over half (55%) of all those surveyed, report going to the GP to get information around sexual health, and around a quarter (27%) of people report using their sexual health service.
- Around a third (32%), of all those surveyed, said they find posters and leaflets useful, with those surveyed reporting that these are most likely to be seen in GP surgeries (27%), Embrace (17%), Pharmacies (15%) and at School (12%). Whilst online sources

were reported as commonly used as a means to gain information, this shows there is still value in posters and leaflets.

Sexual Health Services/Embrace

- Around half (47%), of those who responded, reported having not heard of Embrace.
- From the focus groups, people referred to the local sexual health clinic, but when asked if they knew what Embrace was, they were unsure, indicating more awareness work is needed to promote that the local service is called Embrace.
- Features considered across the focus groups to be or 'important' or 'very important' for local sexual health services were:
  - Being able to book an appointment online
  - Being able to book an appointment by telephone
  - 'On the day' appointments
  - Evening and weekend appointments
  - Drop in clinic
  - Confidentiality
  - Being accessible via public transport.

Condom Use

- These findings were based on responses from those where the question was applicable i.e. using condoms and not in long-term relationship.
- Around 7 in 10 (73%), of those who responded, said the availability and cost does not stop them from using condoms.
- Around 8 in 10 (82%) of those who responded, said they would use condoms if they were free and available from GP/sexual health service.
- Around 8 in 10 (85%), of those who responded, reported that they would use them if they could be ordered online and posted home.
- Only around 1 in 10 (9%) of all those surveyed knew about the C-Card scheme and where it could be accessed.
- Slightly less than a third (31%), of all those surveyed, knew what dental dams were, and 2% reported using them.
- The most common reasons for not using condoms were 'self or partner feel sensation is reduced', 'I don't want to use them', 'too embarrassed to get condoms', or 'can't get partner to use them'.
- From the focus groups it was understood residents generally have good awareness around the importance of condom use and where to access them. Changing Lives focus group identified a strong link in accessing condoms through Changing Lives, Embrace and Recovery Near You, which demonstrates the importance of this outreach access model.

PrEP

- Nearly two-thirds (63%), of those who responded, had not heard of PrEP.
- All participants within the Wolverhampton LGBTQ+ Focus group had reported having heard of PrEP, showing a very good awareness around what it is and where to access it, suggesting good education within this population.
- By contrast, participants within the Changing Lives focus group reported having very little awareness of PrEP, which is concerning given the high levels of risky sexual behaviour within this group.

Contraception including LARC

- Over two -thirds (64%), of all those surveyed, reported having heard of LARC, this means there are still a significant number who have not heard of it. Those of White ethnicity were most likely to have heard of LARC (84%), with fewer residents of Black those surveyed (38%) and Asian (38%) ethnicity.
- Of those that use LARC, around 6 in 10 (61%) of those surveyed said they go to the GP for LARC while 31% said they go to the sexual health service.
- With regards to increasing LARC uptake, some general recommendations were provided:
  - "Make sure there is plenty of information and testimonials from other users to say how easy it is to use and side effects etc.''
  - ''Raising awareness of long-acting contraception will help educate those who wish to use it, but also raise awareness to those who may not have considered it or know about it''.

STIs/Testing

- Around 4 in 10 (41%), of those who responded, reported (where it was applicable) that they do not get tested for an STI before having sex with a new partner.
- Around 1 in 10 (10%), of those who responded, reported to get tested after they have had sex with a new partner, demonstrating that people need to know the importance of testing.
- Around two-thirds (64%) of those surveyed said they thought people don't know where to get tests from when asked why they think people may not do STI tests.
- A similar proportion (62%) reported they thought this was because they had no symptoms, supporting the notion that people think symptoms are necessary before testing.
- The majority of participants within focus groups know the importance of testing for STIs. Most would go to the GP but for many, only if they notice unusual symptoms.
- Participants from the Changing Lives focus group all had regular tests and receive support from Changing Lives to facilitate this, which demonstrates the importance of this outreach access model.

- Participants from the Wolverhampton LGBTQ+ focus group, either no STI test was needed, or they were very recently tested showing a good awareness of the importance of testing in this community.
- From the Good Shepherd focus group, it was observed that alcohol and risky sexual behaviour has an impact on STI transmission. STIs can make participants feel dirty and have an impact on their mental health.

Table 6: Headline statements from focus groups, 2023

By reducing stigma	Information and education
• 'Normalising the conversation' • 'Demystifying certain kinds of contraception' • 'Empower people to make their own choices'	• 'Clear information in public places' • 'more campaigns about looking after your sexual health; where and how to access services in the City' • 'Workshops and webinars to educate our community' • 'We need age relevant discussions in school'
By being inclusive	**Presence in Schools/Colleges/Universities**
• 'Being accessible with lots of advice which caters for different literacy levels' • 'Clear easy to read information'. • 'The older age brackets also need to be targeted, there is an increasing number of adults who are starting new relationships, who may feel immune at their age but they are actually just as at risk as an 18 year old' • 'Sex work specific clinics or dedicated point of contact, a code word when making an appointment'	• 'More sex education in schools' • 'Sexual health staff attendance in Schools, Colleges and Universities.' • 'More talks in the education sector'

6.4 Online STI testing

It has been acknowledged that healthcare services will need to evolve to meet the changing needs of their users. This includes the way healthcare is accessed and provided, with increasing use of remote consultations and technology to enable flexibility to both service users and clinicians[60].

Over the past decade online requests have become increasingly utilised as a way to expand access to STI testing. It allows asymptomatic individuals to order a free self-sampling STI test kit to their homes, reducing the need to attend the clinic setting unless they subsequently require treatment or develop symptoms. During the COVID-19 pandemic there was a move across all aspects of healthcare to reduce face to face contacts which accelerated the use of online requesting as a way to preserve asymptomatic STI testing[61].

Remote consultations via telephone or video call became integrated into both sexual health and primary care services to manage those experiencing symptoms, with those requiring examination as part of their care booked to attend a face-to-face appointment. Online testing requires user knowledge of how to access STI test kits, usually via a request on a website, comprehension and willingness to self-sample, the dexterity to be able to self-sample and ability to return the kit and receive the results (usually by text message or telephone).

Therefore, online testing can be difficult for certain groups for example, where English is not a first language, those without a fixed or secure address, those without internet literacy/access, those who find taking their own samples unacceptable or have a disability that may make self-sampling challenging or impossible. Safeguarding vulnerable

The benefits of online testing mean that residents can request free STI testing 24/7, maintaining anonymity without the need for travelling to or waiting for an appointment in a healthcare setting[62] which was pertinent during the pandemic to reduce transmission of COVID-19.

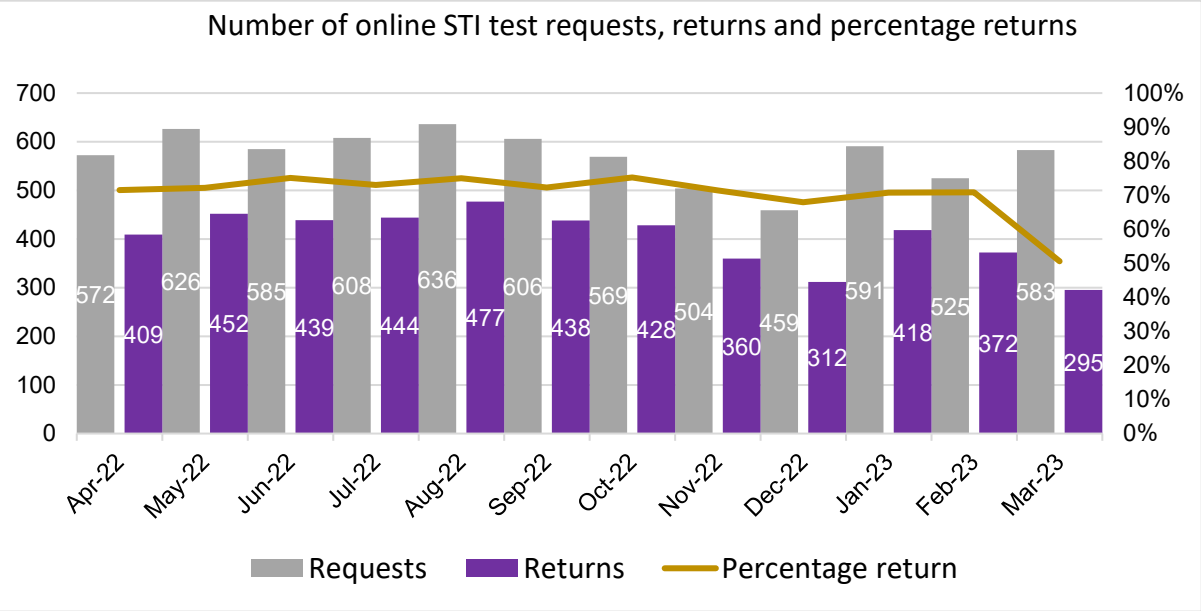
6.4.1 SH:UK

SH:UK were commissioned by RWT for online STI testing provision on 1 April 2022. From April 22 to March 23, a total of 6,864 STI test kits were ordered and 4,844 returned, giving a return rate of 70.6%.

The return rate in March 23 shows a decrease to 50.6%. However, it is likely at time of the data collection that some requesters would have yet to return their testing kits. Therefore, this return rate is expected to be higher than is represented in Figure 29.

The monthly rates of kits ordered has remained high since 2020/21 suggesting that since the lockdown measures, more people are accessing STI kits online than before.

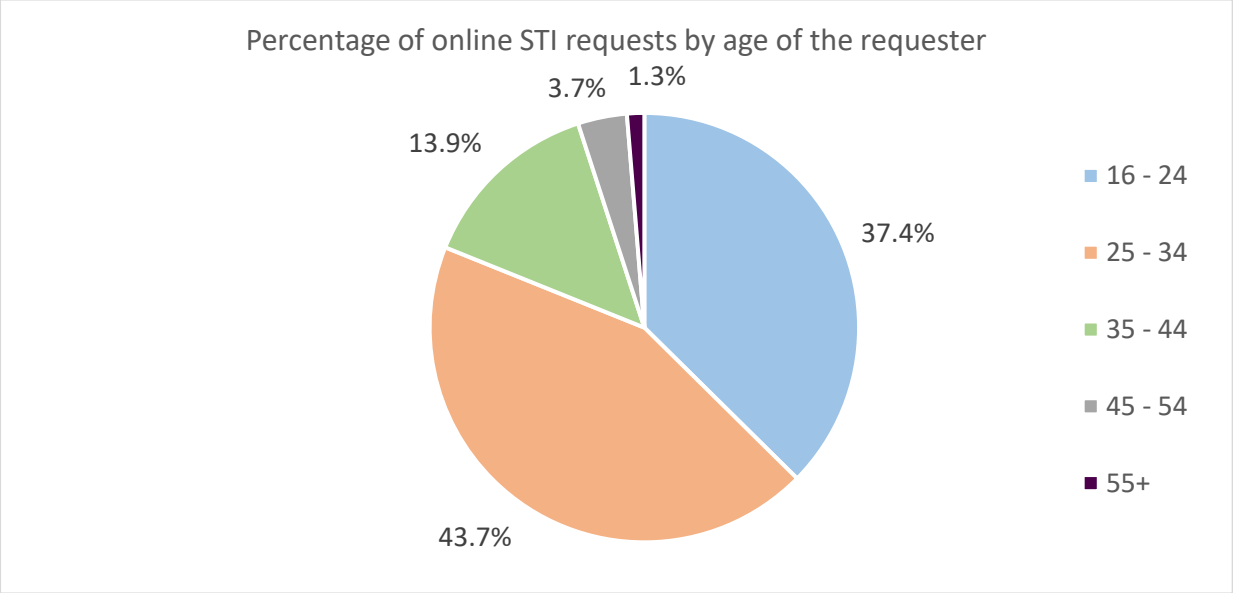
Figure 29: The number of online STI test requests, returns and percentage returns, 2022-23 (Financial Year)



Source: Wolverhampton SH:UK service review report

Between April 22 – March 23, the majority of test kits were ordered by those aged 25-34-years-old (43.7%), followed by aged 16-24-years-old (37.4%) and aged 35-44 years-old (13.9%). This indicates a change in behaviours given that in both 2019/20 and 2020/21, the majority of test kits were ordered by those aged 16-24-years-old, followed by age 25-34-years-old. Previous data showed that since January 2021 the demand for on-line testing has increased.

Figure 30: Breakdown of online STI tests by age, 2022-23 (Financial Year)



Source: Wolverhampton SH:UK service review report

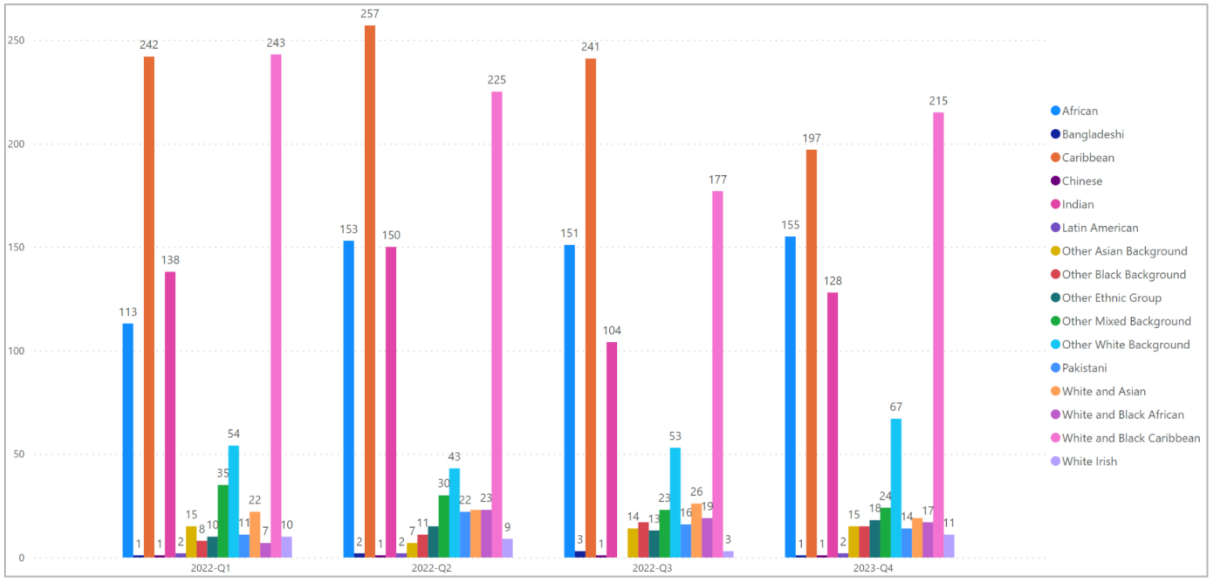
Between April 22 – March 23, the majority of tests were requested by individuals who were White British (46.9%), followed by Caribbean (13.7%), White and Black Caribbean (12.5%), African (8.3%), Indian (7.6%) and Other White Background (3.2%). Please note all other ethnicity populations only represent 1% or less of the STI tests. The data provided from SH:UK specifies different ethnicity groups to the previous provider Preventex.

From Preventex data between August 2020 – July 2021, the majority of tests were requested by individuals who were White British (44.9%), followed by Black Caribbean (12.4%), White and Black Caribbean (10.6%), Black African (9.7%), Indian (6.9%), Unknown or not specified (5.3%), any other White Background (3.7%), any other Mixed Background (1.4%), White and Asian (1.2%) and Pakistani (1.1%).

The proportion of White British individuals accessing a test decreased by 7.1% between 2019 – 20 and 2020 – 21. The proportion of Black African and Indian individuals accessing a test increased by 3.7% and 1.78% respectively. The proportions of Black Caribbean, White and Back Caribbean, Mixed background and any other White backgrounds accessing showed no significant change in this timeframe.

There does not appear to be any significant differences in the proportions of those accessing tests by ethnicity for 2022/23 when compared to 2020/21 requests, remembering that the ethnicity parameters are different between the two online testing providers.

Figure 31: Breakdown of online STI tests by ethnicity (White removed), 2022-2023



Source: Wolverhampton SH:UK service review report

6.4.2 Pre-Exposure Prophylaxis

Pre-exposure prophylaxis (PrEP) is antiretroviral medication (ART) taken by HIV-negative individuals before they have sex to stop them acquiring HIV. PrEP is indicated for those at higher risk of HIV infection, the eligibility criteria advised in the British Associated of Sexual Health and HIV (BASHH) PrEP guideline is included in Table 6.[63]

Table 7: shows BASHH PrEP eligibility guidance

PrEP advised *(Higher risk of HIV acquisition)*	• HIV negative men who have sex with men (MSM) or trans women who have had condom-less sex in the last 6 months and on-going condom-less sex • HIV negative persons having condom-less sex with partners known to be HIV positive, unless the partner is on ART for at least 6 months with a viral load <200 copies/ml
PrEP considered *(Medium risk of HIV acquisition)*	• Case by case basis, risk factors include: ○ **Sexual health:** repeated Post Exposure Prophylaxis (PEPSE) use (antiretroviral medication used after sex has happened if there was a risk of HIV acquisition) Recent STI especially rectal STIs Condom-less sex with partners of unknown HIV status or with partners who are at higher risk of HIV, especially anal sex Chemsex (sex whilst using drugs) or group sex ○ **Population risks:** sex workers, transwomen, intravenous drug users, heterosexual black African men and women

	○ **Vulnerabilities:** unable to negotiate condom use, coercive relationships, sexual exploitation or trafficking, unstable housing

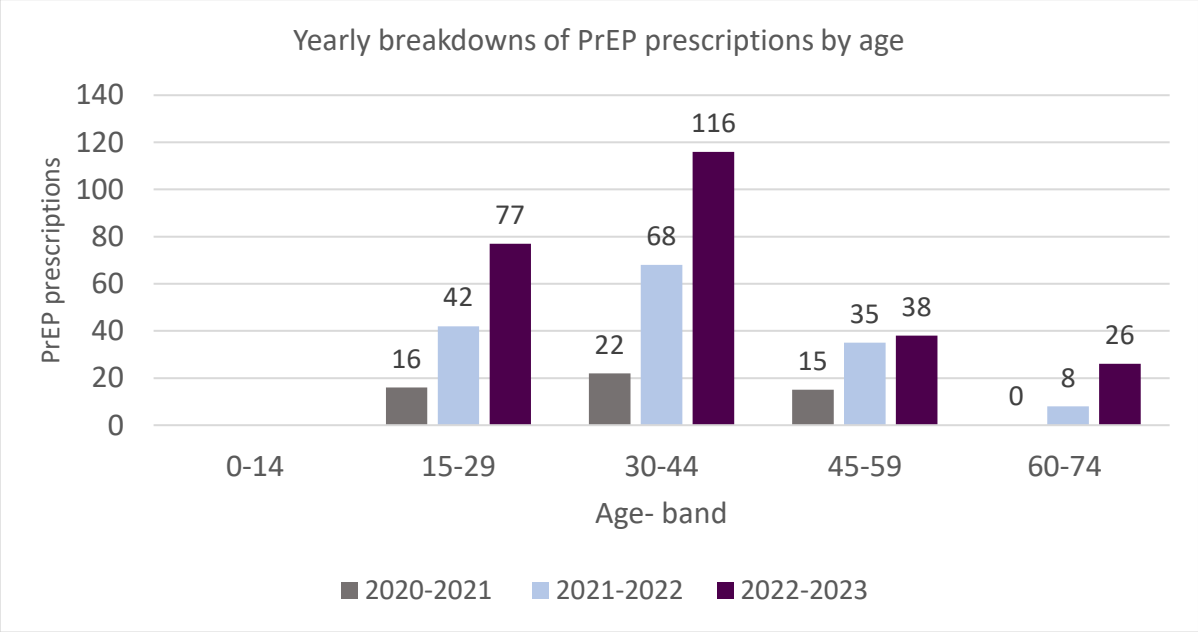
Source: BASHH

The proportion of all HIV negative individuals accessing specialist sexual health services (SHS) with pre-exposure prophylaxis (PrEP) need in 2022 was 5.0% which is similar to the West Midlands region (5.6%) but lower than England (9.7%). This is directly related to characteristics of the population living in an area.

In 2022, 60.1% of people who were identified as having a PrEP need, that is HIV negative individuals at high risk of HIV exposure, initiated or continued with PrEP in Wolverhampton. This was greater than the West Midlands region (52.0%), similar to statistically similar CIPFA neighbours (61.1%) but lower than national (71.0%) uptake. There has been a notable increase in PrEP initiation and continuation from 2021 (44.3%) likely related to the implementation of dedicated PrEP clinics within local sexual health services. However, there remains a proportion of Wolverhampton residents who could benefit from using PrEP that are either not accessing, being offered, taking or continuing with this medication.

PrEP can also be obtained by Wolverhampton residents from sexual health clinics out of area or purchased from an online chemist.[64] There will always be those who initially start on PrEP but decide to discontinue, for example due to side effects of medication.

Figure 32: Yearly breakdown of PrEP prescriptions by age 2020/21 – 2022/23

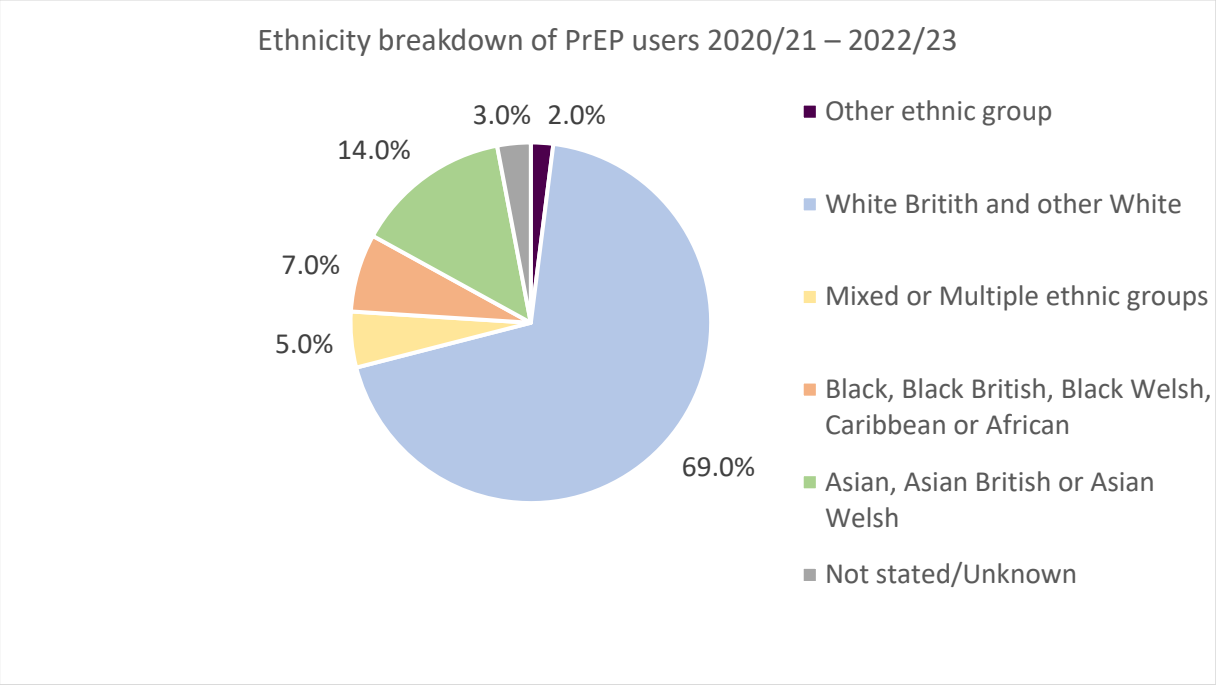


Source: Embrace

Between April 20 and March 23, the majority of PrEP prescriptions were to those aged 30-44-years-old (44%), followed by aged 15-29-years-old (29%) and aged 45-59 years-old (19%).

Figure 21 shows that the number of PrEP prescriptions issued have increased across all age brackets (>15 years old) each year.

Figure 33: Breakdown by ethnicity of those receiving PrEP, 2020/21 – 2022/23)



Source: Embrace Wolverhampton

Between April 2020 – March 2023, the majority of PrEP prescriptions were to individuals who were White backgrounds (69%), followed by Asian backgrounds (14%), Black backgrounds (7%), Mixed (5%) and other Ethnic groups (2%).

When comparing the ethnicity of those receiving PrEP prescriptions to the Census 21 breakdown for ethnicities in Wolverhampton (Figure 3), there was overrepresentation of White ethnicities (60.6% of the Wolverhampton population) and underrepresentation of Asian, Black and Other ethnic groups (21.2%, 9.3% and 3.6% of the Wolverhampton population respectively).

The majority of those PrEP prescriptions were to individuals who were Gay or Lesbian (72%). 14% of PrEP receivers were Bisexual, 11% were Heterosexual and 3% were either not known or not stated. This may explain why 95% of prescriptions were to those identifying as male and just 5% to those identifying as female.

Using the above service information, it can be seen that PrEP users within Wolverhampton were largely gay, bisexual or men who have sex with men, the majority of which were white.

Using the PrEP criteria in Table 4 there may be groups that are not accessing PrEP but who could benefit. For example, HIV negative persons having condom-less sex with partners known to be HIV positive, unless the partner is on ART for at least 6 months with a viral load

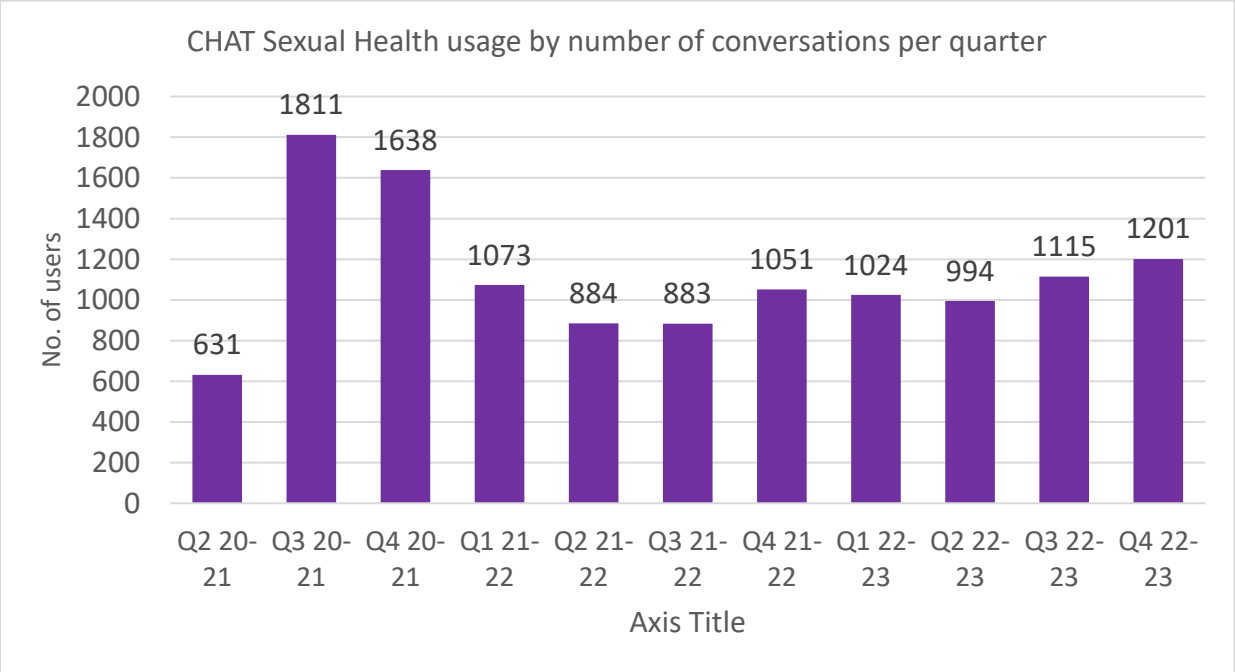
<200 copies/ml. Wolverhampton being an area of high prevalence of people living with HIV there may be partners of those diagnosed who may benefit from PrEP. In addition to those with medium risk factors for acquiring HIV based on their individual vulnerabilities, sexual health and population risk factors.

6.4.3 CHAT Sexual Health

A new service called CHAT Sexual Health was launched in August 2020 which provides a confidential texting service for residents, as well as information and advice from a healthcare professional which ensures that residents are signposted appropriately.

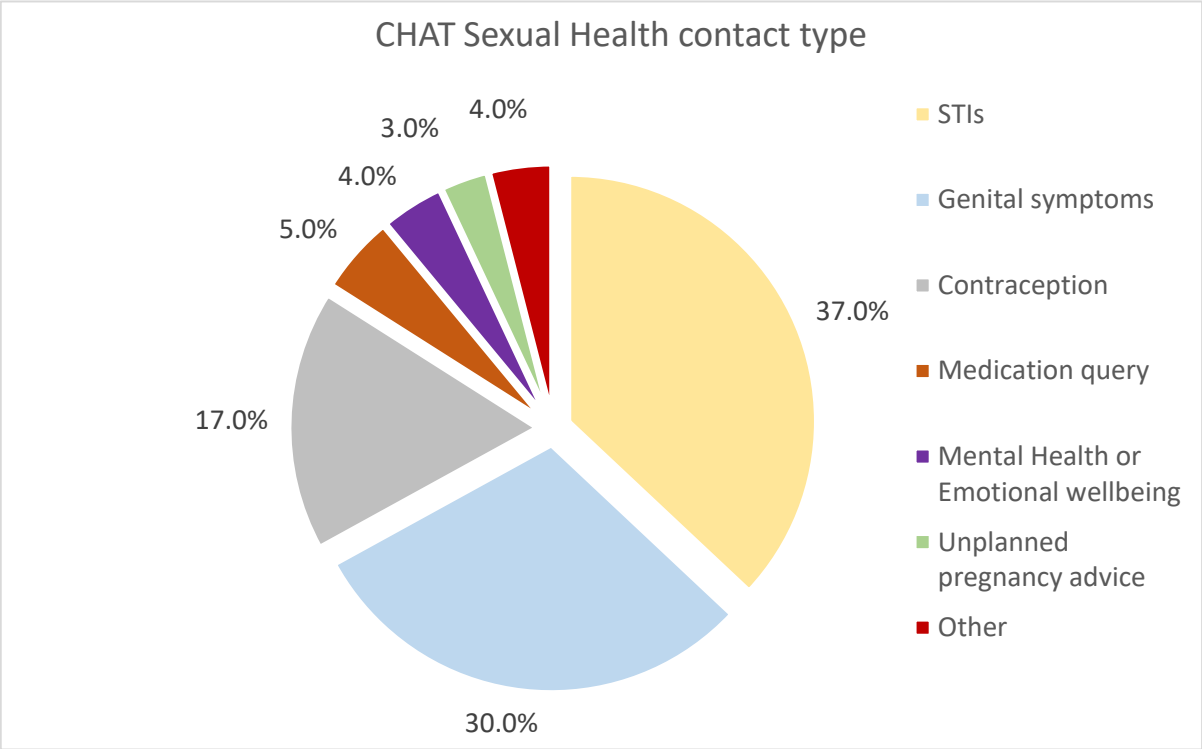
Figure 34 shows usage since the CHAT Sexual Health commenced. Outgoing messages from healthcare professionals to service users peaked in Q3 20 – 21, near tripling from the previous quarter when the service commenced. This could have been related to increased awareness among staff and users or increased demand, possibly corresponding with the 2nd UK lockdown (5th November – 2nd December 2020). Demand has remained consistent with outgoing messages averaging over 1000 per 2022 – 23 quarter.

Figure 34: CHAT Sexual Health usage since service commenced, 2020/21- 2022/23



Source: Embrace Wolverhampton

Figure 35: CHAT Sexual Health contact type, 2020/21- 2022/23



Source: Embrace

Breaking down the CHAT sexual health contacts by type it can be seen that STI, genital symptoms and contraception make up the majority of service user queries.

6.5 Contraception

Contraception refers to methods used to prevent unplanned pregnancy, almost everyone in the UK uses some form of contraception during his or her lifetime. There are a variety of different methods available, all of which are extremely safe compared with the risks associated with pregnancy and childbirth. Some methods of contraception are also used for managing medical problems such as heavy menstrual bleeding which can coexist with contraceptive needs.

The range of contraceptive methods can be divided into those that are user-dependent: fertility awareness, condoms, diaphragms, pills, patches and vaginal ring and Long-Acting Reversible Contraceptives (LARC): injectables, subdermal implants and intrauterine coils. LARC methods are more effective at preventing pregnancy as they do not rely on the user to do anything.

The government and the Faculty of Sexual and Reproductive Healthcare (FSRH) both highlight the importance of knowledge, access and choice for all women and men to all methods of contraception to help reduce unwanted pregnancies. Good contraception services have been shown to lower rates of teenage conceptions.

6.5.1 Access to contraception

Findings from the most recent National Survey of Sexual Attitudes and Lifestyles (NATSAL-3) was that the majority of women accessed contraception via primary care (59.1%). Whereas for men this was via retail outlets (54.6%). Specialist sexual and reproductive health clinics were less used for accessing contraception (23% of women and 21.3% of men surveyed). However, these users were likely to be younger and have greater sexual health risk. It should be noted that more than one source of contraception was used by 27.3% of women and 30.6% of men[65].

Both local primary care and specialist sexual and reproductive health (SRH) service data from Embrace Wolverhampton have been included in this need's assessment. Attendance and service provision at sexual and reproductive (SRH) health services are reflective of local service models and geography e.g. urban areas could have greater attendance at specialist SRH health services due to ease of access; whereas in more rural areas it could be easier to attend general practice than travel to a specialist clinic.

6.5.2 Access to contraception during the COVID-19 pandemic

During the COVID-19 pandemic there were fewer attendances across primary care and specialist sexual and reproductive health services; and fewer face-to-face attendances due to COVID-19 control measures and service availability. The provision of LARC was significantly reduced with many users given advise on extended use of their current LARC method or to temporarily use a short-acting method to try and reduce the need for face-to-face attendances.

6.5.3 Contraceptive provision by specialist sexual and reproductive health service (Embrace)

Embrace Wolverhampton as an integrated sexual health service is able to provide all methods of reversible contraception. Contraceptive services are also available for those with complex comorbidities or whom require specialist LARC procedures**.**

Embrace service data for 2022/23 showed that 3,188 women accessed the service for sexual and reproductive health. 50.8% of attendances were to maintain their chosen contraception method (e.g. ongoing contraceptive pill prescription, regular injectable contraceptive administration or refit of an implant or intrauterine coil).

15.4% of attendances were by users who wished to change from one method to another and 8.3% were first time initiation of contraception. Around a quarter (25.5%) were for a LARC consultation, that is counselling and consent prior to a fit or removal of an implant or intrauterine coil or those experiencing any problems with their current LARC method. These percentages showed a stable trend from the year 2020/21.

This data showed that there was consistent use of local SRH services by those wishing to maintain a contraceptive method with a quarter of SRH attendees receiving counselling or consenting for a LARC method.

6.5.4 SRH attendees under 25-years-old

The ambition to improve sexual health outcomes includes ensuring that young people have easy access to high-quality sexual and reproductive health (SRH) services. Monitoring the attendance of under-25s at these services helps gauge the effectiveness of targeting this age group and also supports outcomes like reducing teenage pregnancies and promoting chlamydia screening because of opportunistic screening during appointments. The key metrics are the number of 15-24-year-olds accessing SRH services per 1,000, and the under 25s choosing a LARC method (excluding injectables).

In 2021, 46.8 per 1,000 15-24-year-old females living in Wolverhampton attended specialist contraceptive services (Embrace). This was similar to the West Midlands regional rate (47.5 per 1,000 15-24-year-old females) but significantly less than the national rate (82.6 per 1,000 15-24-year-old females).

In 2021, the attendance rate for 15-24-year-old females in Wolverhampton at specialist contraceptive services (Embrace) was 46.8 per 1,000, comparable to the regional rate (47.5 per 1,000 15-24 year old females) but lower than the national rate (82.6 per 1,000). This rate has been declining since 2014, with a notable drop during the COVID-19 pandemic due to reduced face-to-face appointments.

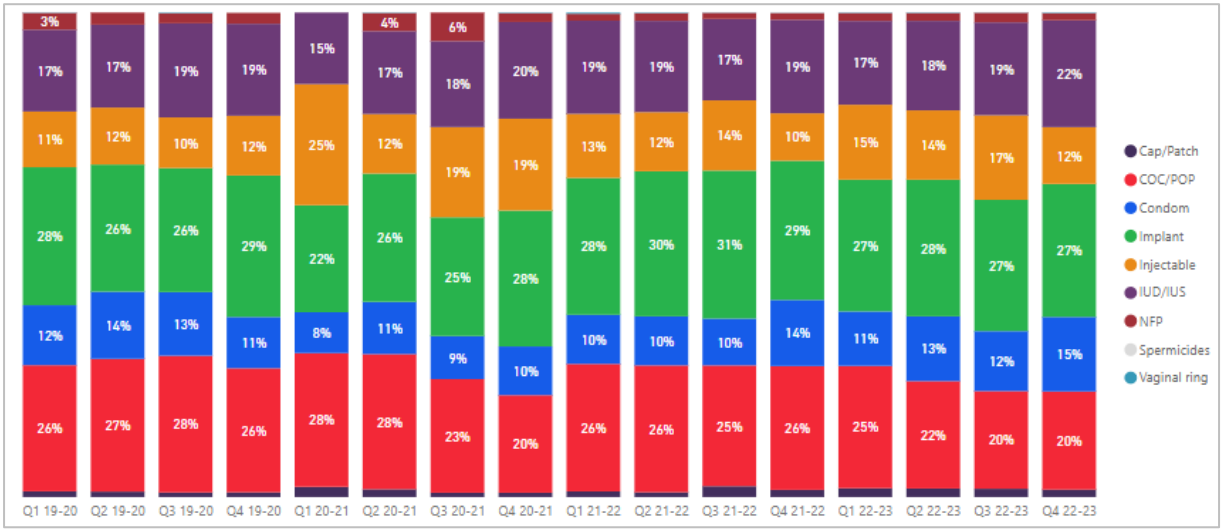
For males, the attendance rate was 1.2 per 1,000, significantly lower than both regional (6.4 per 1,000) and national (11.5 per 1,000) rates. Male contraceptive options are limited to condoms and vasectomy, with the latter not provided in specialist sexual services in Wolverhampton. This raises questions about whether men prefer accessing condoms outside of SRH services, like in pharmacies or stores, and if there are barriers such as lack of awareness about available services. Data coding issues regarding how attendances at sexual health services are recorded, might also affect these figures, as male visits for additional reasons like sexual health screenings are not captured in the same dataset.

The way attendances were recorded at sexual health services might have affected the reported rates. The indicator used data which only included men who visited specifically for contraception (condoms or vasectomy). However, many men visit for other reasons, like sexual health screenings, recorded in a different system (GUMCAD). As a result, condom distribution during these visits wasn't reflected in the SRHAD data, potentially underestimating the number of men accessing contraceptive services.

6.5.5 Embrace SRH attendances by contraceptive method

Figure 36 shows the percentage of contraceptive methods used by attendees. Each method has shown a relatively stable trend from 2019 – 2023. There was an increasing trend for use of injectable contraceptives at 18.1% (up from 9% 2016 – 2020) of contraception attendances by type 2019 – 2023. This resulted from increasing usage in Q1 20 – 21 and Q3 and Q4 20 – 21 which corresponded to the timings of national lockdowns. This could reflect a move to a method that didn't require a procedure but that still provided longer acting, effective contraceptive cover in times of uncertainty about healthcare access.

Figure 36: Contraception methods by Embrace attendees (%), 2019 – 2023



Source: Embrace

Subdermal implants are one of the most effective methods at preventing pregnancy. There has been an increase of users at 36.2% (up from 26.5% 2016 – 2020). Attendees using condoms have shown a rising trend at 15.4% (6.6% 2016 – 2020), although this could have also been related to STI prevention in addition to use as a contraceptive.
Contraceptive pill (32.6%) and intrauterine contraceptive (24.2%) attendances have shown a stable trend (30% and 25.2% respectively in 2016 – 2020).

6.5.6 Embrace SRH contraceptive choices by age group

Figure 37 shows the contraception choices of Embrace SRH attendees broken down by age group.

For those ≤14-years-old and 15-29-years-old there was an even split between those using user dependent methods such as condoms, contraceptive pills (COC/POP) and cap/patches and those using a LARC method such as injectables, implant or intrauterine contraception (48% of ≤14-years-olds and 54% of 15-29-years-olds).

These age groups were more likely to opt for the subdermal implant (SDI) as opposed to the hormonal or non-hormonal intrauterine devices. This could reflect that these age groups are less likely to wish an intrauterine procedure, are more likely to be nulliparous (not contraindicative but more likely to influence someone's preferences for intrauterine procedures), or that they are less likely to be offered this method during their appointment.

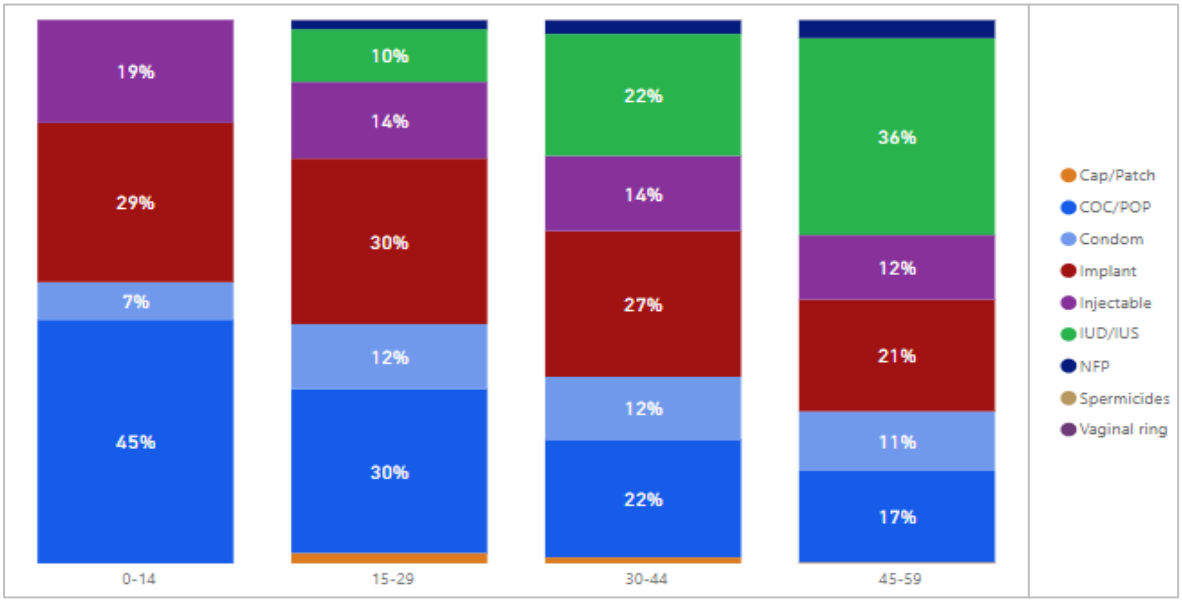
LARC usage increased across the age groups. 63% of 30-44-year-old SRH and 69% of SRH attendees opting to use a highly effective LARC method. Intrauterine contraceptive use increased across the age groups, with the greatest number of users in the over 45 age group. However, PHOF does not collect data of women above the age of 45. The local data

showed a considerable number of women over the age of 45 choosing LARC which was not accounted on PHOF.

The FSRH advises contraception up to the age of menopause (of which 51 years old is the average for the UK) or age 55 when it can be assumed the chance of pregnancy is so low that contraception is no longer required. Over 45's are more likely than the other ages groups to be experiencing symptoms such as irregular menstrual cycles and heavy menstrual bleeding, particularly during the perimenopausal years. The hormonal coil can be used to manage these complaints alongside fulfilling the need for highly effective contraception. It should also be noted that some users will be using their hormonal coil as part of Hormone Replacement Therapy (HRT), to manage the symptoms of perimenopause/menopause. This could be contributing to the percentage of women choosing LARC in the over 45 age group.

Condom usage was relatively steady across all age groups, this could be related to use for STI prevention alongside contraceptive needs.

Figure 37: Contraception of choice by distribution for each age group at Embrace from 2019 – 23



Source: Embrace

6.5.7 Current user-dependent method users in SRH services

User-dependent contraception include the short-acting hormonal methods (pills, patch and ring), 'natural-family planning' and condoms. The indicator is the number of women in all age groups attending SRH services in the last year that recorded this type of contraception (as opposed to LARC).

In 2020 1,045 (44.4%) women in Wolverhampton were using user-dependent methods at SRH services. This was statistically less than the West Midlands regional (54.7%) and national average (54.9%). Overall, 705 (29.9%) of SRH attendees coded as using a method of contraception were using hormonal short-acting contraceptives (pills, patch or vaginal rings). Again, this proportion was statistically less than that of the region (39.9%) and nationally (41.7%).

The general trend locally and nationally has been a decline in user dependent (including hormonal short-acting contraceptives) usage 2015 to 2017 but then steady usage 2017 to the most recent 2020.

This could reflect a preference of users to get their contraception from alternative locations e.g. primary care, community pharmacy. As 2020 was the most recent data, subsequent years should show any impact of the COVID-19 pandemic on user numbers of these methods.

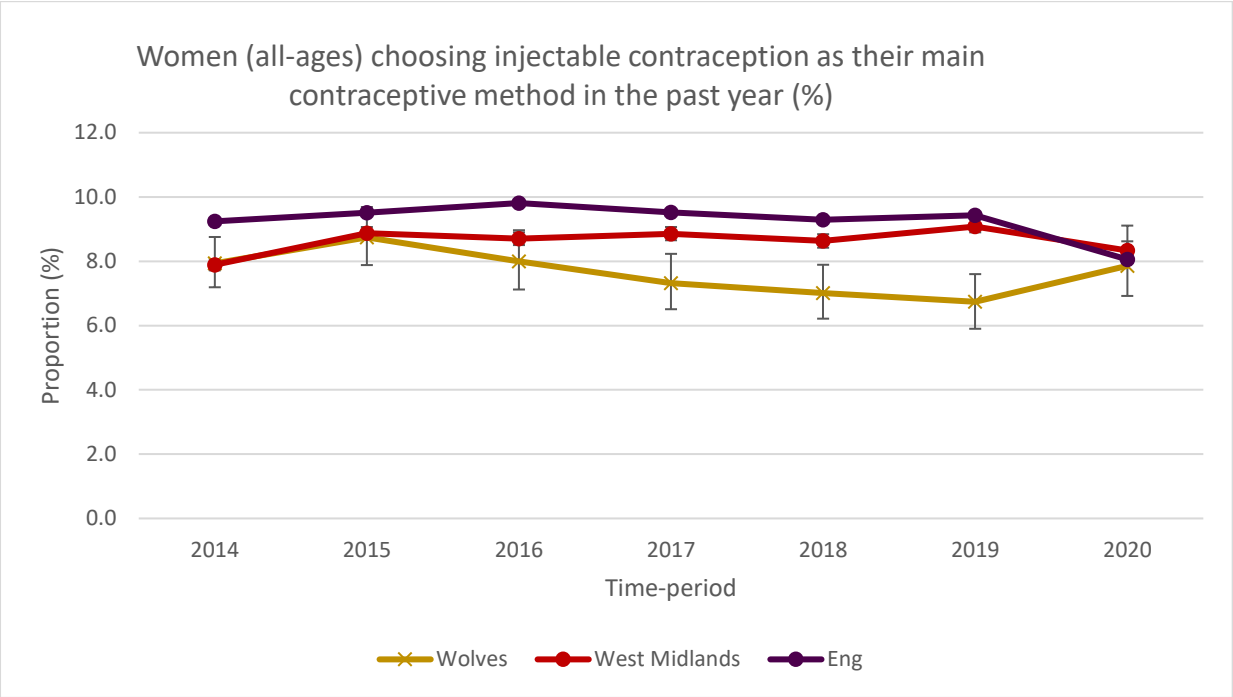
This would include those people who wished for a LARC method or whose implant or intrauterine contraception had reached expiry, but as there was reduced access to these procedures were advised to use an alternative user dependent or short-acting hormonal method.

6.5.8 Current users of injectable contraceptives in SRH services

Fingertips data for injectable contraception is presented separately from other LARC methods as injectables require repeat administration, typically every 3 months and so have a higher failure rate related to missed doses. Injectables do not require a procedure to use and so the training and resources required are less than that of the other LARC methods.

Figure 37 shows that 7.9% of women attending SRH services in 2020 were coded as injectable users as their main contraceptive method within the last year. This was statistically similar to that of the region (8.3%) and nation (8.1%). The trend in current users has re-joined that of the region and nation, having deviated between 2017 and 2019. This indicates an increase in those opting for injectables as their main method in SRH services in 2020. This could be pandemic related as injectables were an option that was more reliable than user-dependent methods but without a procedure requiring greater face to face contact with healthcare professionals.

Figure 38: Women choosing injections at SRH services (%), 2014- 2020

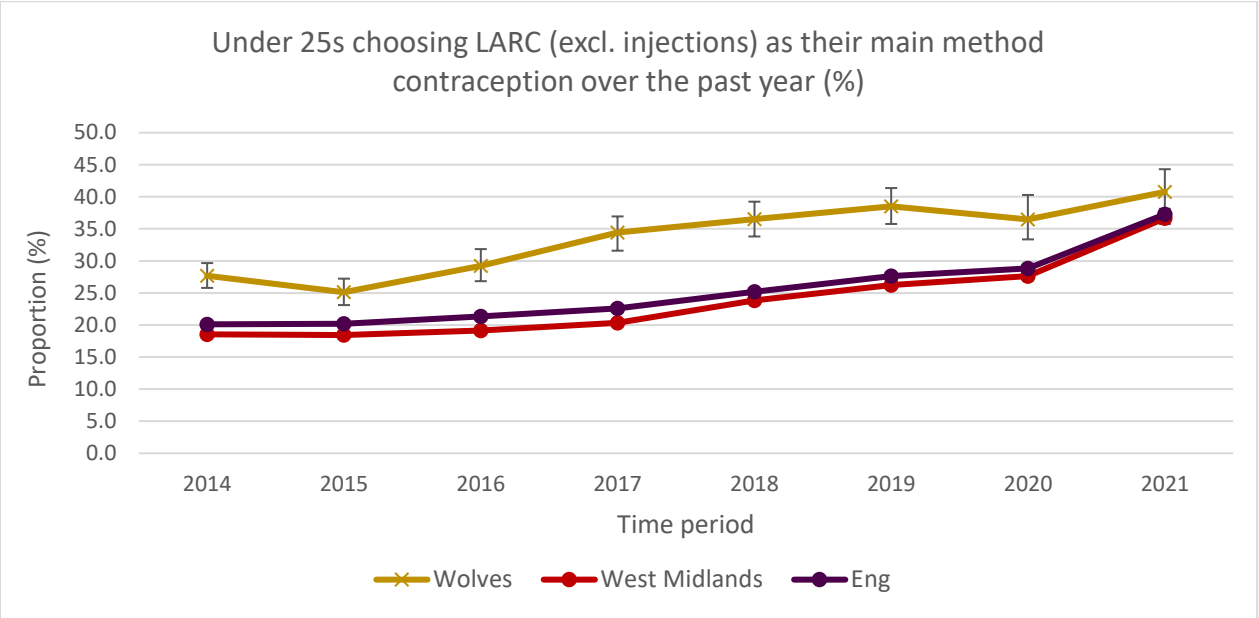


Source: Fingertips

6.5.9 Under 25s currently using subdermal implant or intrauterine contraception in SRH services

For women under 25 attending Wolverhampton SRH services in 2021, 265 or 40.8%, had a LARC method (excluding injections) coded as their main method of contraception within the last year prior to their attendance. This was statistically similar to that for the West Midlands region (36.7%) and England (37.3%) (Figure 39).

Figure 39: Under 25s choosing LARC excluding injections at SRH services (%), 2014- 2021



Source: Fingertips

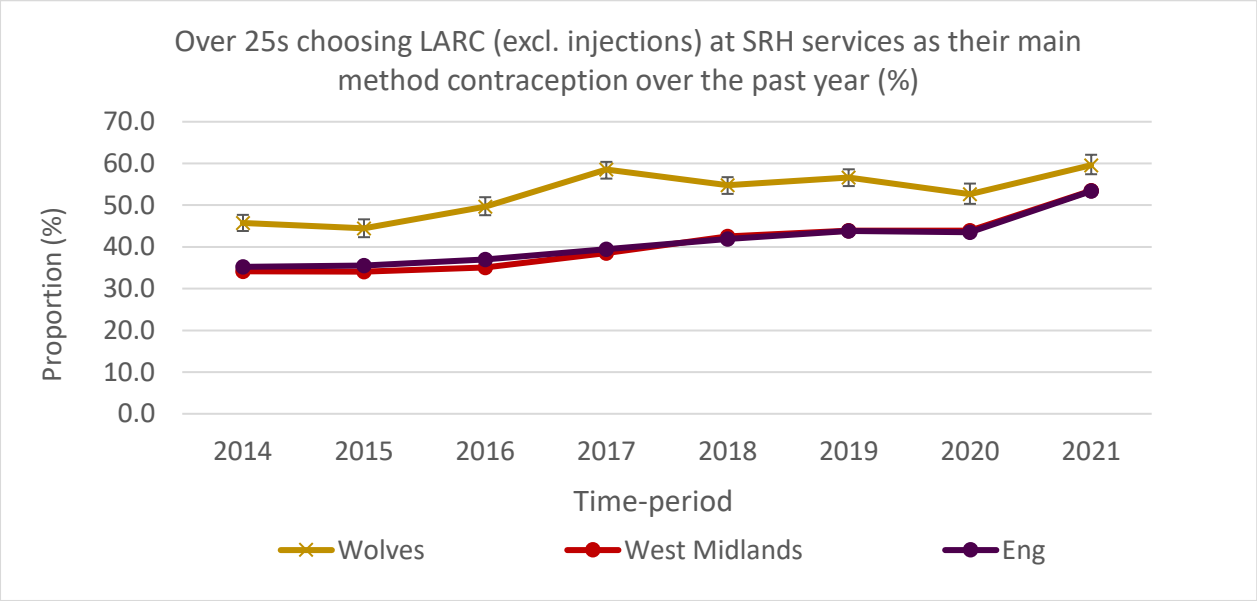
There has been an overall increasing trend since 2015 showing over a third of under 25-year-olds attending SRH services were LARC users, as shown in figure 38. The COVID-19 pandemic does not seem to have impacted greatly on this trend, with a small increase in those coded as current LARC users between 2020/21. This could indicate high levels of continuation with LARC methods amongst established users under 25.

6.5.10 Over 25s currently using subdermal implant or intrauterine contraception in SRH services

For over 25s attending Wolverhampton SRH services in 2021 1,010 or 59.6% had a LARC method (excluding injections) coded as their main method of contraception within the last year prior to their attendance. This was statistically higher than regional (53.5%) and national rates (53.4%) (Figure 40).

There has been an overall increasing trend since 2015 showing more over 25-year-olds coded as current LARC method users in SRH services, as shown in Figure 39. The COVID-19 pandemic does not seem to have impacted greatly on this trend, with an increase in those coded as current LARC users seen 2020/21. This could indicate high levels of continuation with LARC methods amongst established users over 25.

Figure 40: Over 25s choosing LARC excluding injections at SRH services (%), 2014-2021



Source: Fingertips

6.5.11 New prescriptions of hormonal short-acting contraception in SRH services

Hormonal short-acting contraceptive prescriptions are broken down into combined (oestrogen + progestogen) methods (pill, patch or vaginal ring) and progestogen-only pills (POP).

In 2021 230 women were prescribed combined hormonal methods giving a rate of 4.4 per 1,000 women aged 15-44). This was statistically more than that of the West Midland region (3.5 per 1,000 women aged 15-44) but less than that of the nation (7.6 per 1,000 women aged 15-44).

For progestogen-only pill prescriptions there were 760 users in 2021, giving a rate of 14.5 per 1,000 women aged 15-44. This was statistically more than that of the West Midland region (7.7 per 1,000 women aged 15-44) and nation (9.6 per 1,000 women aged 15-44).

There could be a number of reasons for the differing rates between combined and progestogen-only pill prescriptions. POP has relatively few medical contraindications and does not require monitoring. Whereas, the combined hormonal methods should not be prescribed to those with risk factors for venous thromboembolism (VTE) and requires annual blood pressure and BMI check. Common risk factors for VTE include hypertension, high BMI and smoking, alongside migraine with aura, previous personal and family history. In 2021/22, Wolverhampton had a high rate of smokers aged 18+; 15.1% of patients were recorded as current smokers compared to regional (13.4%) and national (12.7%) proportions[66]. There was a high prevalence of obesity amongst the Wolverhampton population with 69.7% of adults aged 18 plus being classed as overweight or obese in 2021/22[67]. This was similar regionally (67.2%) and greater than nationally (63.8%). The

proportion of Wolverhampton residents with a diagnosis of hypertension is 14.5%, less than that of the region (15.2%) and similar to that nationally (14.4%)[68].

It could be that the population characteristics of those attending SRH services mean that POP prescriptions were safer to prescribe over combined methods. It could also be that SRH attendees were more likely to be offered POP over combined methods by healthcare professionals.

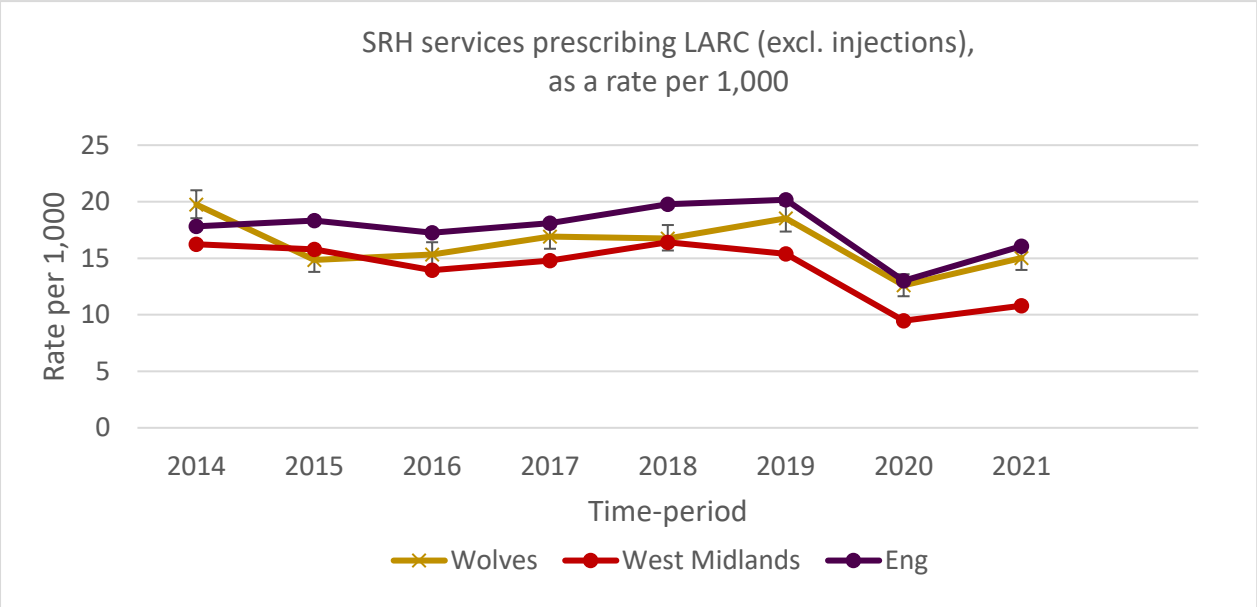
6.5.12 New prescriptions of injectable contraception in SRH services

For women prescribed injectable contraception at SRH services in 2021, the rate of 3.8 per 1,000 women aged 15-44 was greater than that of the West Midlands region (2.3 per 1,000 women aged 15-44) and similar to that nationally (3.6 per 1,000 women aged 15-44). This was a new indicator for 2021 and so future years would be able to give an indication of the effect of the COVID-19 pandemic and post pandemic years on injectable use.

6.5.13 New prescriptions of subdermal implant and intrauterine contraception in SRH services

In 2021 the rate of LARC (excluding injections) prescribed by SRH services in Wolverhampton was 15.1 per 1,000 women aged 15-44. This was greater than regional (10.8 per 1,000 women aged 25-44) prescriptions rates and similar to national (16.1 per 1,000 women aged 25-44) prescription rates. There was a notable reduction in LARC prescriptions over 2020/21 consistent with the COVID-19 pandemic where access to LARC procedures (insertion of subdermal implants and intrauterine contraception) was affected (Figure 41).

Figure 41: SRH services prescribed LARC excluding injections/1,000, 2014-2021



Source: Fingertips

6.5.14 Contraceptive provision in primary care

The GP contract outlines the contraceptive services that should be provided in primary care. This includes the giving of advice regarding all methods of contraception and emergency contraception and the prescribing of contraceptive substances and appliances (excluding the fitting and implanting of intrauterine devices and implants[69].

Intrauterine devices and implants are provided as part of enhanced primary care services and as such not all primary care services will provide these methods but should be able to advise and refer on should someone wish to use this method.

6.5.15 New prescriptions of hormonal short-acting contraception in primary care

Hormonal short-acting contraceptive prescriptions are broken down into combined (oestrogen + progestogen) methods (pill, patch or vaginal ring) and progestogen-only pills (POP).

In 2021, 4,885 women were prescribed combined hormonal methods giving a rate of 93.1 per 1,000 women aged 15-44). This was statistically less than that of the West Midland region (117.1 per 1,000 women aged 15-44) but less than that of the nation (128.4 per 1,000 women aged 15-44).

For progestogen-only pill prescriptions there were 6,055 users in 2021, giving a rate of 115.5 per 1,000 women aged 15-44. This was statistically less than that of the West Midland region (139.8 per 1,000 women aged 15-44) and nation (137.2 per 1,000 women aged 15-44).

This shows that there are less short-acting contraceptive prescriptions being acquired in Wolverhampton primary care than regionally and nationally. It could mean that Wolverhampton primary care attendees are more likely to be prescribed or advised other methods such as LARC including injectables or other user dependent methods such as condoms or natural family planning.

Conversely, this could represent under-prescribing, barriers to accessing primary care contraception consultations or that Wolverhampton residents prefer to access their hormonal short-acting contraceptive elsewhere e.g. SRH services, pharmacy or purchased online.

6.5.16 New prescriptions of injectable contraception in primary care

In 2021, the rate of injectable contraception prescribed in primary care was 30.3 per 1,000 women aged 15-44. This was more than the regional (27.4 per 1,000 women aged 15-44) and national (26.5 per 1,000 women aged 15-44) rates. The differences in the rates of injectable contraception use between primary care and SRH services could reflect that users

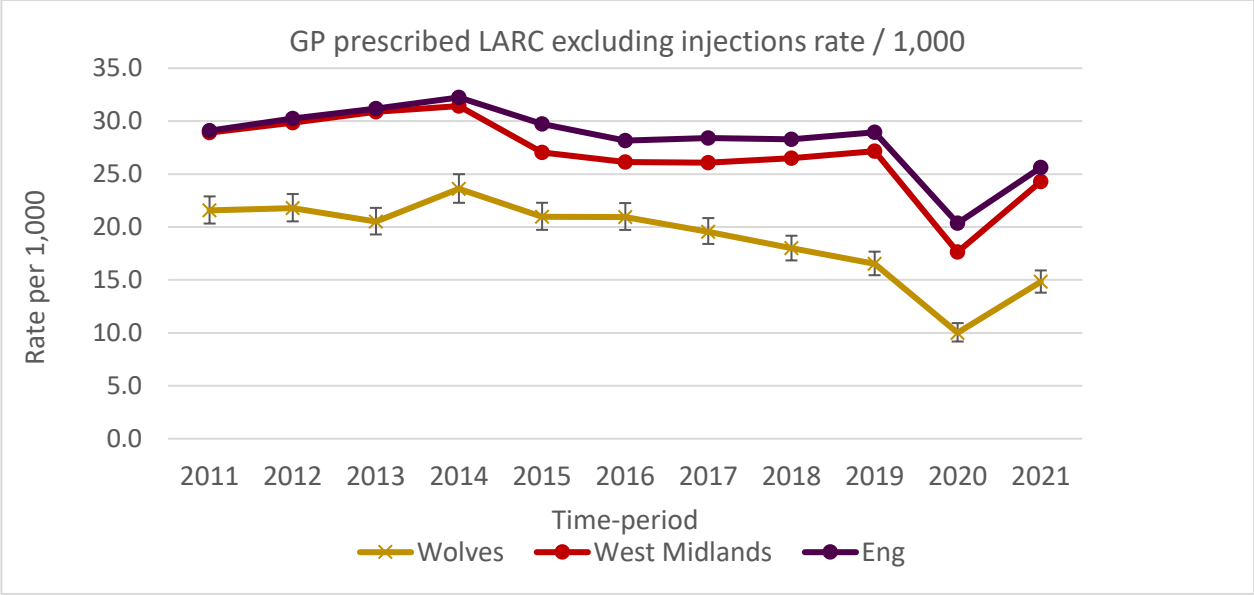
preferred to receive their injectable in their GP practice or that GP practices use injectables preferentially over other methods.

6.5.17 New prescriptions of subdermal implant and intrauterine contraception in primary care

In 2021, the rate of LARC (excluding injections) prescribed by GPs in Wolverhampton was 14.9 per 1,000 women aged 15-44. This was significantly below regional (24.3 per 1,000 women aged 15-44) and national rates (25.7 per 1,000 women aged 15-44) (Figure 42).

Locally there has been an increase of 4.4 per 1,000 women aged 15-44 from 2020 for GP prescribed LARC from 2020 – 2021. The increase of LARC prescriptions from 2020 rates are likely to reflect the increasing availability of LARC procedure appointments after COVID-19 pandemic changes to contraceptive services in 2020. However, LARC prescriptions were still not back to pre-pandemic rates in the most recent data available.

Figure 42: GP prescribed LARC excluding injections rate /1,000, 2011-2021



Source: Fingertips

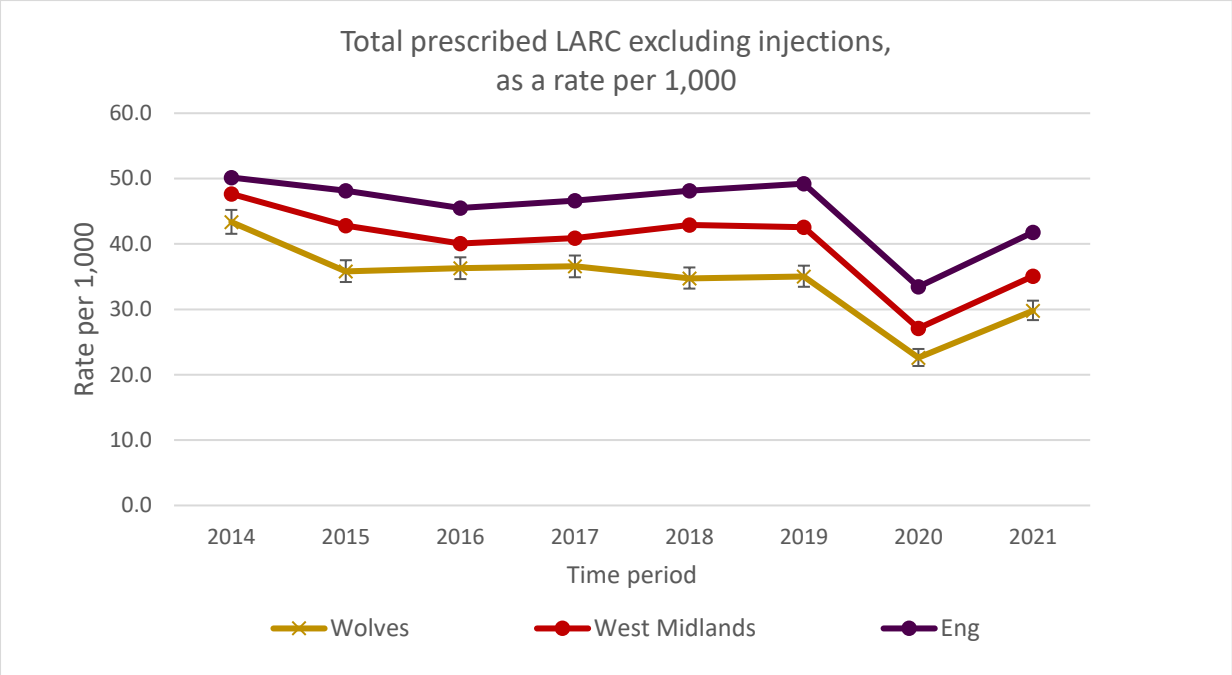
6.5.18 Total LARC prescriptions across both primary care and SRH service

In 2021 in Wolverhampton the total (GPs and SRH) rate of LARC prescribed (excluding injectables), was 29.8 per 1,000 women aged 15-44-years. This is a lower rate than the West Midlands region (35.1 per 1,000 women aged 15-44) and the national rate (41.8 per 1,000 women aged 15-44) (Figure 43).

LARC prescriptions (excluding injectables) from primary care contribute the greatest to the deviations between Wolverhampton and the regional and national rates. Increasing

provision and access to LARC in primary care should see an improvement in this longstanding divergence.

Figure 43: Total prescribed LARC excluding injections rate /1,000, 2014-2021



Source: Fingertips

6.5.19 Primary care LARC provision in Wolverhampton

Enhanced Primary Care Services were re-commissioned in September and available through a mixed model of delivery through individual practices and Primary Care Trusts (PCN's). GP practices provide Long-Acting Reversible Contraception (LARC), this includes hormonal and non-hormonal intrauterine devices (IUD) and sub-dermal implants (SDI), with the costs reimbursed by the Local Authority[70]. GP practices choose to 'opt in' to this for their patients based on whether they have clinicians holding the Letter of Competence (LOC) certification from The Faculty of Sexual and Reproductive Health.

This service supports a systems approach to delivery and access closer to people's home. Activity data is provided by registered GP Practices. Coverage is spread across the city and illustrated in Figure 42 for IUDs and SDI or both.

Figure 44 shows that there were total of 54 GP practices in Wolverhampton in 2023. In 2023 14 GP practices offered both SDI and IUD procedures, 1 offered SDI only and 1 offered IUD only. 6 practices were registered to provide LARC but showed no current activity. Compared to the last needs assessment in 2021 there has been a reduction in GP LARC activity, with 20 practices who previously offered SDI and IUD procedures and 4 offering SDI only.

The map represents practices where there is a single clinician trained to fit LARC working within the practice, there is also a wider PCN based approach with trained fitters working across multiple sites.

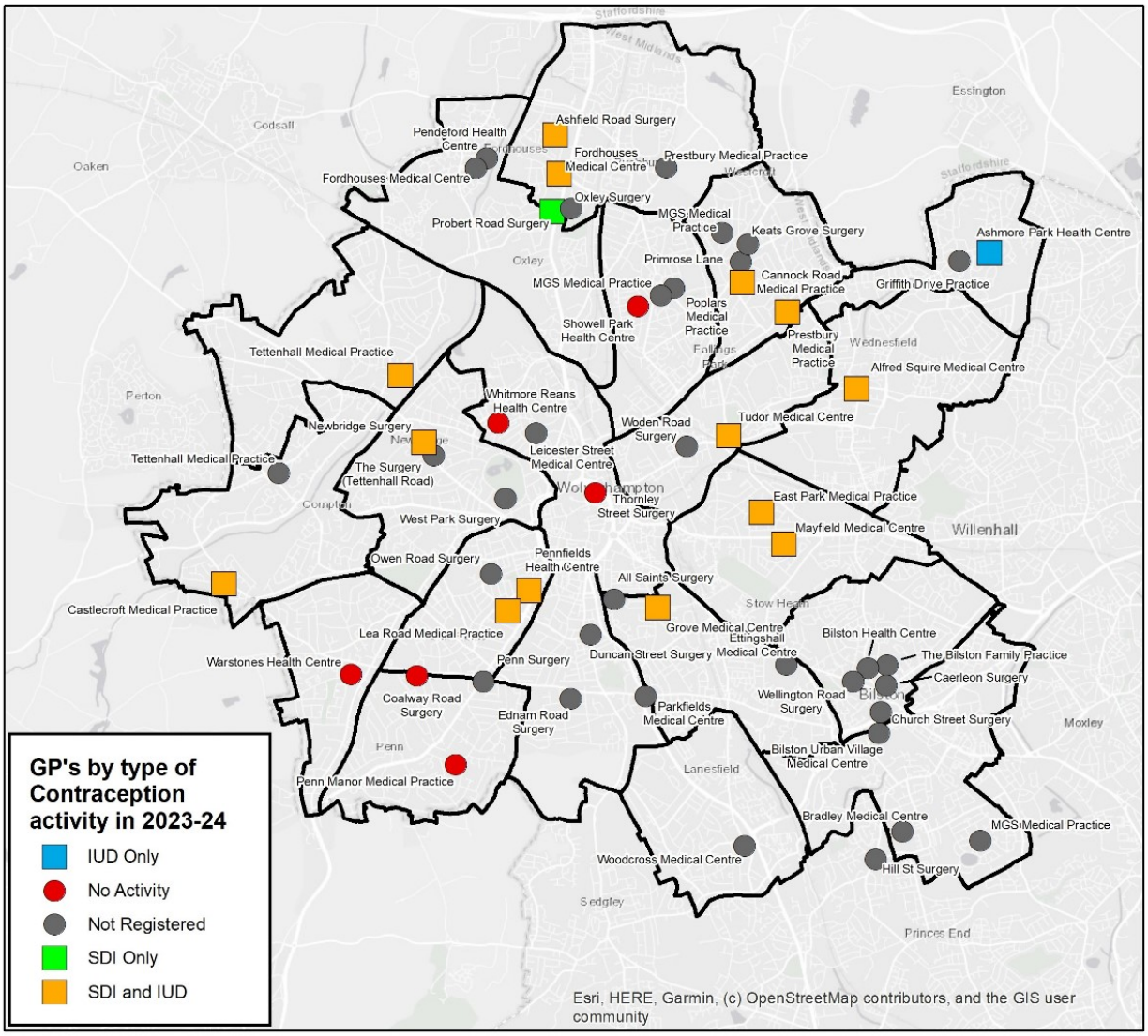
There is a noticeable gap in coverage in Ettingshall North, Ettingshall South & Spring Vale and Bilston North and South wards. These wards are amongst some of the most deprived within the city when looking at key indicators for deprivation.

The overall reduction in GP LARC activity may be representative of the loss of primary care LARC fitters, either due to retirement, choosing not to recertify their Letter of Competence (required every 5 years to demonstrate maintaining clinical skills) or redistribution of workloads during the pandemic and beyond to maintain routine primary care services among increasing demand.

During the pandemic the prioritisation of essential services meant that the formal training programme to obtain a Letter of Competence in SDI and/or IUD procedures were suspended. This meant less fitters were trained during this time. Training has since resumed and 6 clinicians across the city have applied to commence the educational process to become LARC fitters.

In addition to training, LARC procedures require time, more than the standard 10 minutes allocated for a GP appointment. They also require resources, for example, additional staff to chaperone, specialist equipment and space. These can influence a practice's ability to offer this enhanced service.

Figure 44: IUD and SDI coverage and activity across Wolverhampton, 2023

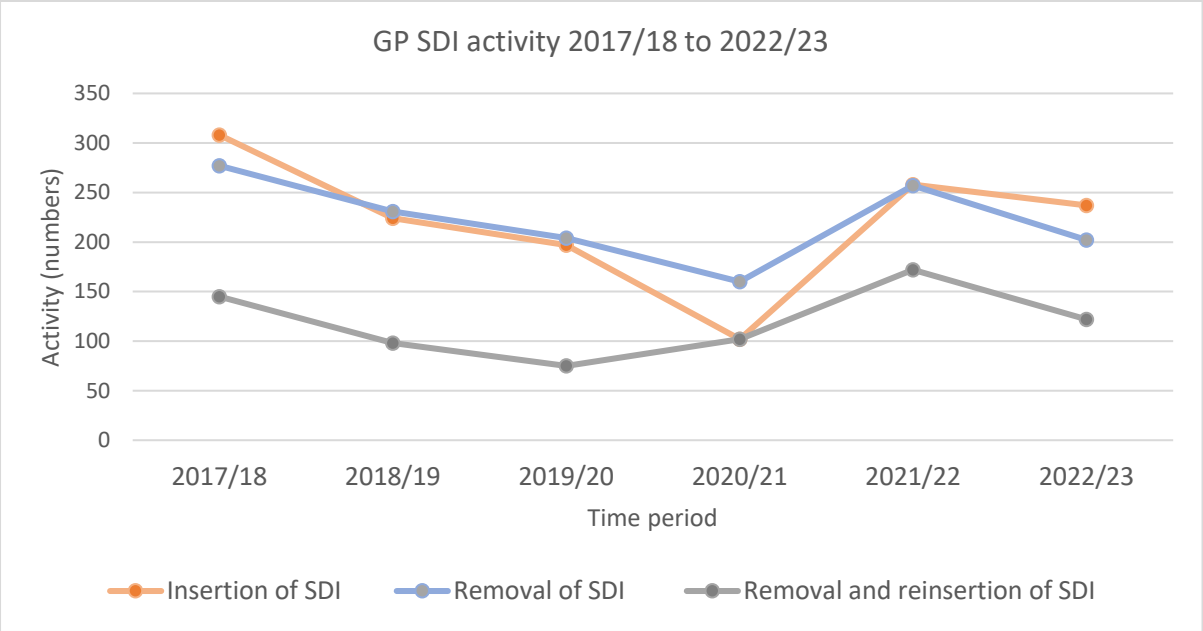


Source: GP LARC activity

Between 2017 – 2023 a total of 2,040 implant insertions were undertaken. In this timeframe there were 1,331 removals (without being refitted). Pre-pandemic there was a 40% decline in implant fits 2017/18 compared to 2019/20, with an expected steeper decline during the pandemic years 2020/21.

Post-pandemic, comparing 2020/21 to 2022/23, there has been a 76% increase in the number of implant fits, showing recovery of activity. Removal numbers without reinsertion have remained relatively stable with an expected decline during the pandemic 2020/21. Numbers of removals without reinsertion post-pandemic are not dissimilar to pre-pandemic.

Figure 45: GP subdermal implant procedural activity, 2017/18 to 2022/23



Source: Graphnet

Between 2017 – 2023 a total of 1,621 IUC (intrauterine contraception including both hormonal and non-hormonal intrauterine device) insertions were undertaken. In this timeframe there were 798 removals (without being refitted). Pre-pandemic there was a 63% decline in IUD fits 2017/18 compared to 2019/20. There was no significant decline seen in IUD fits during the pandemic 2020/21.

Post-pandemic, comparing 2020/21 to 2022/23 there has been a 130% increase in the number of IUC fits, showing not only recovery but an increase in activity. Removal numbers without reinsertion showed a 70% decline 2017/18 compared to 2019/20. There were similar numbers throughout the pandemic 2020/21 compared to the previous year.

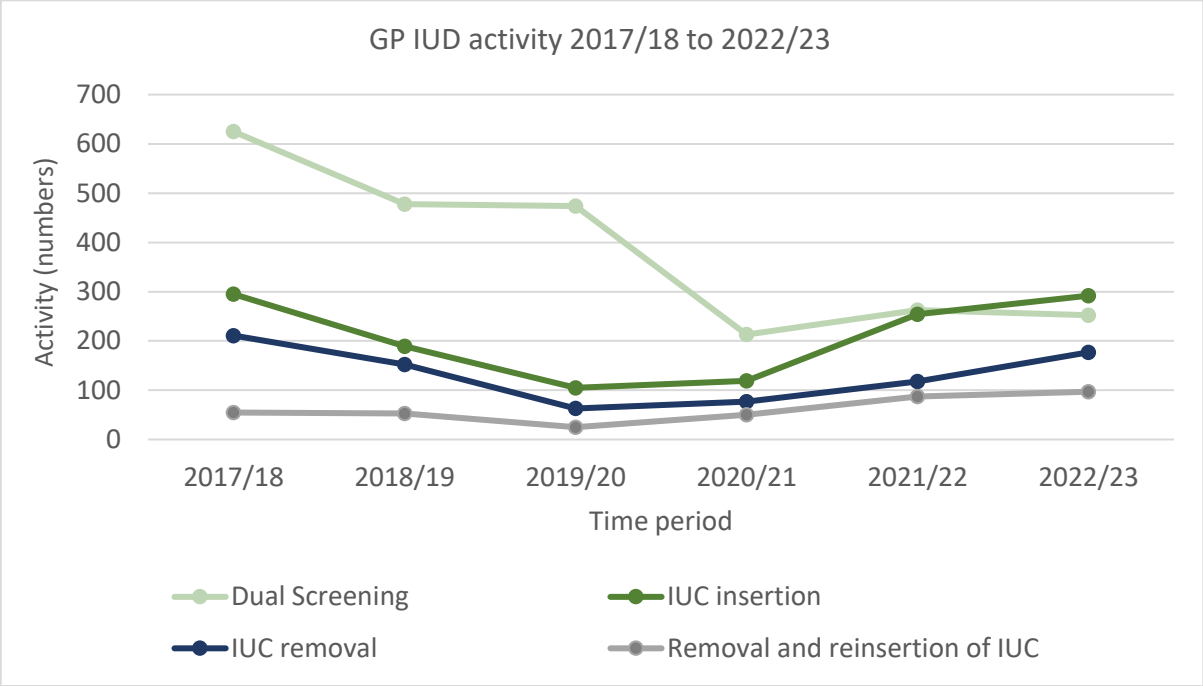
Post-pandemic the number of removals has risen 130% comparing 2020/21 to 2022/23. This could be due to the greater ease of accessing an appointment for removal for those who were due to have an IUC removed during the pandemic, more people accessing removal via their GP rather than SRH services or more people are choosing to remove their IUC post-pandemic, either to conceive, change to another method of contraception or who no longer require contraception.

As part of the service offer, GP practices also signed up to test for gonorrhoea and chlamydia. The routine screening of higher risk individuals is advised by the FSRH to try and reduce the risk of STI related pelvic inflammatory disease at time of IUC fit. Comparing 2017/18 to 2022/23 there has been a 60% reduction in those having screening sent which could represent a missed opportunity to identify infection. There are discrepancies between Graphnet data that is pulled from GP EMIS data system and activity data that the local authority receives with regard to coding of procedures. There needs to be assurances that

appointments are being coded consistently and a description on the type of procedure completed.

Furthermore, it has not been possible to distinguish the longevity for each LARC, which is important to access effectiveness. That is, how long are people using their LARC methods, for the full lifetime of the device or having earlier removals due to problems/issues.

Figure 46: GP IUC procedural activity, 2017/18 to 2022/23



Source: Graphnet

Graphnet data shows that, between April 2017 – September 2021 the majority of those who attended a LARC appointment were aged between 15-29 (48.4%) followed by 30-44 (42.9%), 45-59 (8.6%), 60-74 (0.2%) years.

Between April 2017 – September 2021, the majority of appointments attended were individuals who were White (61.8%), followed by Asian (11.4%), Black (9.7%), Unknown (8.5%), Mixed (5.5%) and Other (3.1%).

Figure 47 shows that there is underrepresentation of Black and Asian individuals attending for LARC procedures in primary care when compared to the population of Wolverhampton, Census 21 Females aged 15-44 by ethnicity. There are a high percentage of appointments (8.5%) where ethnicity has been categorised as 'Unknown' which may affect the accuracy of this data comparison. This could again be reflective of a data quality issue related to the coding of ethnicity as outlined on page 66.

Between April 2017 – September 2021 63.2% of appointments were attended at 9 GP practices that had the highest activity out of a possible 26 practices. The highest activity being at Prestbury Medical Practice (11.7%), followed by Tudor Medical Centre (7.5%), Castlecroft Medical Practice (6.8%), Health and Beyond (6.8%), Mayfield Medical Centre (6.8%), East Park Medical Practice (6.3%), Showell Park Health Centre (6.3%), Ashfield Road Surgery (5.6%) and Thornley Street Surgery (5.5%).

Between April 2017 – September 2021 73.3% of appointments were attended in 5 postcode areas. The highest attendance being postcode WV10 (30.5%), followed by WV10 (11.4%), WV11 (10.9%), WV6 (10.5%) and WV3 (10%).

Between April 2017 – September 2021 0.7% of those who attended a LARC appointment were identified as having learning disabilities. Between April 2017 – September 2021 the majority of individuals who were identified as having learning difficulties were aged between 15-29 (55.4%), followed by 45-59 (28.6%), 30-44 (16.1%). There may therefore be under provision of contraceptive choice to these individuals. This could be due to lack of recognition of the contraceptive needs of those with learning disabilities by healthcare providers, a lack of accessible information for this group to make contraceptive choices or difficulty accessing healthcare.[71]

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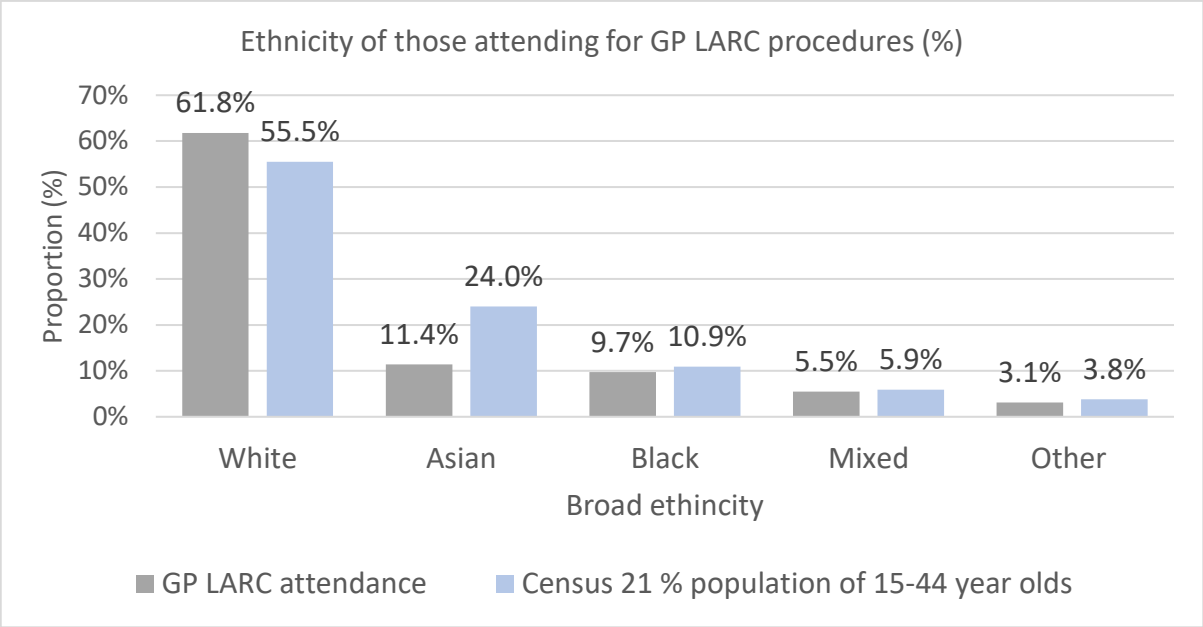
Figure 47: The ethnicity of those attending for GP LARC procedures compared to the Wolverhampton population demographics, 2017 to 2020



Source: GP LARC activity

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6.5.20 Spotlight on: Women's Health Clinic pilot – Wolverhampton South East Collaborative Primary Care network

Spotlight on: PCN LARC model - Wolverhampton North Network

Wolverhampton North Network are an example of a primary care network in Wolverhampton to operate a dedicated LARC clinic, having successfully completed a pilot in 2020 and 2021. The pilot supported weekly contraception clinics which were developed based on the demand, as opposed to ad-hoc appointments.

The pilot commenced in July 2020 and was mainly delivered at Showell Practice and Prestbury Medical Practice, where the clinic continues to run. In the year 2022/23, 66 IUD (both hormonal and non-hormonal IUDs included) insertions, 54 implant insertions and 55 chlamydia and gonorrhoea tests were completed.

The high numbers can be attributed to the Care Co-ordinator role being utilised to call patients prior to appointments, reducing the number of DNAs and ensuring the clinic is booked in advance. In 2022/23 284 appointments were booked from the available 299 (95%).

Having carried out a consultation in 2023 to invite feedback about the LARC clinic, it was found that 92.6% of respondents (204 in total) felt they had excellent service on the day of their appointment, and 100% of respondents would recommend this service to others.

This was the establishment of a GP led women's health clinic supported by GP practice nurse, both with an interest in women's health. Whilst this pilot was largely GP led, increasing the nurse led clinics once the competency exists within the nursing workforce may be an option in the longer term.

The clinics included both LARC and gynaecology related appointments. The aims of the clinics were to reduce waiting times and provide access at a neighborhood level to those who would have otherwise had to access secondary care services.

The 3-month pilot saw a clinic held fortnightly on a Saturday, with a high rate of appointment utilisation (78%). This helped to relieve concerns regarding appointment wastage related to those not attending their booked appointment.

19% of the appointments attended were for LARC procedures (implant insertion or removal and coil insertion), with a small percentage 0.05% used for coil removals which generally require less time and resources.

Guidance regarding what problems could be managed in the gynaecology related appointments were distributed amongst practice staff. A care coordinator screened the referrals to ensure appropriate usage of appointment slots, it was reported that the

preparatory work by the care coordinator was integral to the success of attendance and outcome of the appointment.

Any new service must demonstrate that it is financially viable and that the service can be maintained. The women's health clinic pilot was shown to be profitable once overheads were deducted for the LARC procedures. Less than 1% of service costs where attributable to unused or unattended appointments.

The service received positive user feedback with 18 out of 54 patients giving feedback. The feedback is included in Figure 48.

Figure 48: Women's Health Clinic collated patient satisfaction questionnaire results

Women's Health Clinic

Wolverhampton South East Collaborative Primary Care Network

Collated Patient Satisfaction Questionnaire Results for Larc Clinic

	Excellent	Very Good	Good	Fair	Poor
Ease of scheduling the appointment	10	5	3		
Appointment available within a reasonable amount of time	9	5	1	2	
Convenience of clinic location	14	2	2		
The quality of the care you received	16	1	1		
Explanation of procedure (if applicable)	13	1	1		
Did the consultation meet your expectations?	16	1			1
What do you think of this service?	17				1
Would you like to see this service continue?	16	1		1	
Any other comments?					

Freehand comments made regarding the service give a voice to the users, notable examples include:

- *'Amazing – I feel like I've been given a lifeline – thank you'*
- *'Need to continue to offer this service'*
- *'The service I received today was more than excellent, 5 stars for the patience of your receptionists'*
- *'First impressions, this is a very good service which offers convenient appointments*
- *for women, Dr was very helpful & supportive'*

- *'Great clinic for women of a certain age'*

Whilst the pilot has now ended and no further clinics planned at present this pilot has shown the established need, viability and ongoing demand for a women's health specific clinic at a primary care level.

6.5.21 Spotlight on: New Cross maternity postnatal contraception service

In the UK 1 in 3 pregnancies are unintended and 1 in 3 pregnancies end in an abortion[73 74]. A short interpregnancy interval (less than 12 months) is associated with adverse maternal and infant outcomes, including preterm delivery, low birthweight, stillbirth and infant mortality[75 76]. Therefore, the World Health Organisation advise 24-months between pregnancies to optimise the outcomes for both mother and future child. Nationally, 1 in 13 of people giving birth or receiving abortion care will have conceived within 1 year of their last delivery[77]. Post-pregnancy contraceptive counselling and provision is therefore critical for allowing women to space their pregnancies.

The concept of contraception after childbirth is not new but its importance has been long underrecognized. Traditionally it was a topic left to the 6-week postnatal check with a person's GP, at which time it is thought approximately 50% of attendees will have already had sex. With fertility returning as early as 21 days post-delivery there can already be a pregnancy risk.

The COVID-19 pandemic placed barriers to accessing contraception, with many appointments delayed or taking place virtually in the interest of infection prevention. However, it did accelerate service's goals to be able to deliver contraception care to women before they are discharged. Pregnancy is a time of high and regular contact with healthcare professionals, it therefore gives opportunities to raise awareness of contraceptive choices after delivery and help someone make decisions pre-emptively.

Within maternity services at The Royal Wolverhampton NHS Trust a working group has been established to oversee the development of a sustainable postnatal contraception service. This includes obstetric and SRH medical staff, pharmacy staff and senior midwives holding management roles across antenatal, postnatal and community care.

To date the group have worked to implement:

- The administration of contraceptive injectables under patient guided directive (PGD) administered prior to discharge.

- The availability of pre-packed prescriptions of 3 months of progestogen-only-pills to be given prior to discharge from maternity care
- The insertion of intrauterine contraception (IUDs or hormonal LNG-IUDs) at elective caesarean section commenced with future aims that this will eventually be expanded to include vaginal deliveries.

- At present there are two trained Nexplanon subdermal implant fitters working within the department with the training of a 3rd fitter underway. The aim being to fit Nexplanon for all women who wish to use this method prior to their discharge.

Not all women wish for or are suitable for all contraceptive methods immediately postnatal. Education regarding contraceptive choices is being delivered in a stepwise approach to all midwives and support staff working within the department.

The goal being that they will be able to inform and signpost women for when they are ready to decide regarding their contraception, supported by contraception champions working within their team. For those requesting LARC methods or whom have complex medical histories a referral pathway has been implemented on the online Badgernet maternity system to SRH services (Embrace).

6.5.22 Emergency Hormonal Contraception Pharmacy Data

Emergency contraception can be given following sexual intercourse that could result in a pregnancy, for example after condom-less sex or where there has been contraceptive failure.

The most effective method at preventing pregnancy is the copper IUD. Acting by preventing fertilisation and implantation or a pregnancy, it can be inserted up to 120 hours following intercourse or up to 5 days after the earliest date of ovulation. This is provided by Embrace Wolverhampton with those requesting this option self-referring or signposted by other healthcare professionals.

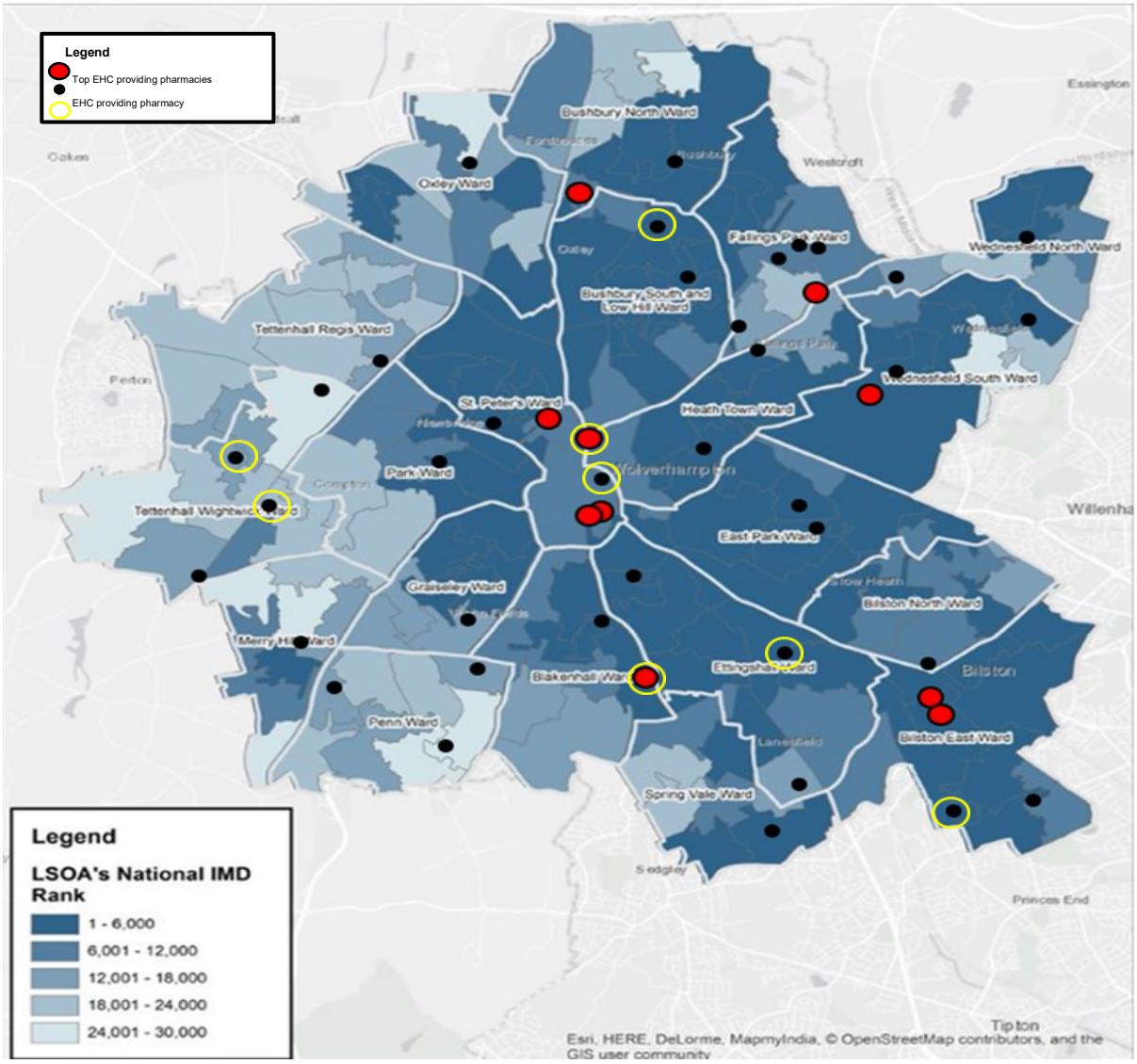
The hormonal methods of emergency contraception are the two oral progestogens available for use in the UK; Levonorgestrel, effective up to 72 hours after sexual intercourse and Ulipristal Acetate, effective up to 120 hours after sexual intercourse. These act by delaying ovulation in order to prevent fertilisation.

Since 2016 approximately 43 pharmacies have been sub-contracted by RWT to provide Emergency Hormonal Contraception (EHC), with 34 of these showing recent activity. The service covers a wide geographic spread in Wolverhampton and dispenses EHC free of charge to females across Wolverhampton. From 2018 to 2020, approximately 12,991 women have accessed the service.

6.5.23 Location of pharmacies offering emergency hormonal contraception

Figure 49 shows a fair geographical spread and access across Wolverhampton, particularly among the more deprived wards. Pharmacy data on patient postcodes showed that more females from the postcode area of WV10/WV14 have accessed the service.

Figure 49: Map of Wolverhampton of Pharmacies who are involved in the EHC scheme with LSOA's national IMD breakdown for Wolverhampton



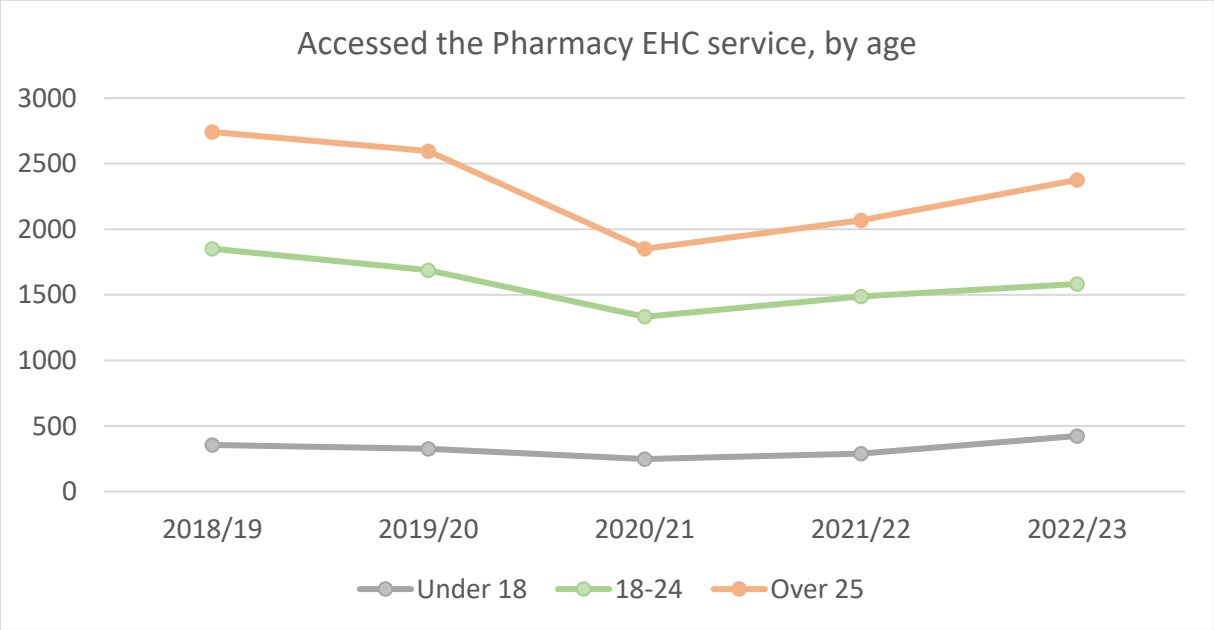
Source: Pharmacy service data

6.5.24 Age breakdown of those accessing emergency hormonal contraception

Figure 50 shows that across all age groups from 2018 and 2020, access to the service has remained fairly stable. 55% of total activity is by over 25-year-olds, clearly highlighting that females over 25 mainly access this service. Rates in 2020/21 showed that there was a decline in those accessing the service during the COVID-19 pandemic. This highlights that the pharmacy model is effective in terms of access and operating days and times and potentially should be considered for other sexual health interventions.

The service was particularly effective in residents accessing EHC from deprived wards, addressing the gap between health inequalities and access to services. However, the data does not enable us to look at repeat attendances for EHC and ideally women accessing this service should be addressing their ongoing contraception needs.

Figure 50: Access to pharmacy EHC scheme by age, 2018/19-2022/23



Source: Pharmacy service data

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

Regarding ongoing contraceptive needs, including post EHC, The Pharmacy Offer for Sexual Health, Reproductive Health and HIV[25] highlights the role community pharmacies can play in supporting ongoing contraception. As outlined in Table 6, a tiered pharmacy contraception service has been designed nationally to offer greater choice of where people can access their contraceptive method of choice.

Table 8: Tiered pharmacy contraception service design

Tier 1	Ongoing monitoring and supply of repeat oral contraception (OC) prescriptions
Tier 2	Initiation of OC via a Patient Group Direction (PGD)
Tier 3	Ongoing monitoring and management of repeat LARC, excluding intrauterine systems (IUS) and intrauterine devices (IUD)
Tier 4	Initiation of LARC methods

From Spring 2023 pharmacies have the option of registering for the pharmacy contraception advanced service and undergo training to deliver contraceptive care. 8 pharmacies in the Wolverhampton area have registered to deliver the Tier 1 pilot service, that is the ongoing monitoring and supply of repeat oral contraception prescriptions. At time of this consultation no Wolverhampton pharmacies have signed up beyond the Tier 1 pilot. This would be the next step in the evolution of reproductive health provision within the community setting.

6.6 Teenage Pregnancy

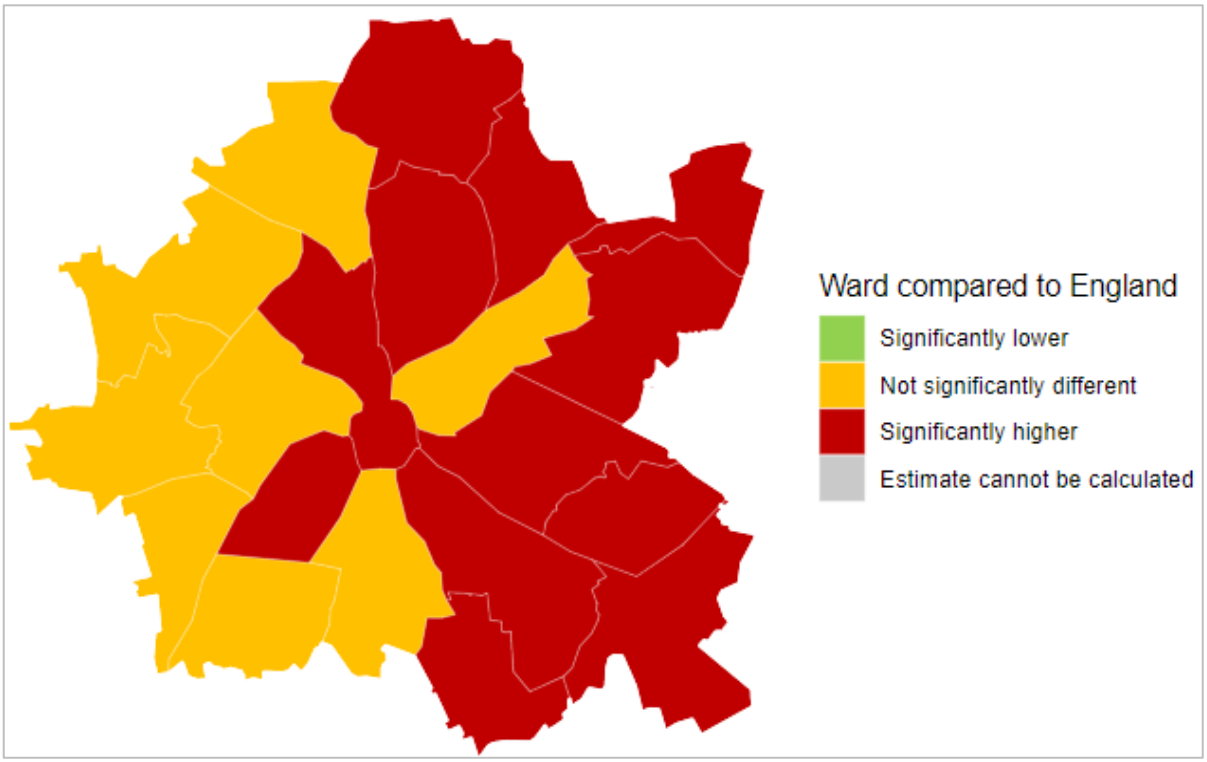
Teenage pregnancy is an important indicator as most teenage pregnancies are unplanned and around half end in an abortion. As well as it being an avoidable experience for the young woman, abortions represent an avoidable cost to the NHS. And while for some young women having a child when young can represent a positive turning point in their lives, for many more teenagers bringing up a child is extremely difficult and often results in poor outcomes for both the teenage parent and the child, in terms of the baby's health, the mother's emotional health and wellbeing and the likelihood of both the parent and child living in long-term poverty.

The indicator for teenage pregnancy is defined as conceptions in women aged under 18 per 1,000 females aged 15-17, that result in either one or more live or still births or a legal abortion.

Children born to teenage mothers have 60% higher rates of infant mortality and are at increased risk of low birthweight and other poor health outcomes. Teenage mothers are three times more likely to suffer from postnatal depression and experience poor mental health for up to three years after the birth. Teenage parents and their children are at increased risk of living in poverty. The teenage mother indicator is the percentage of all delivery episodes (in any setting) that were to females aged between 12 and 17 years old[78].

Figure 51 shows that teenage pregnancy is an issue in Wolverhampton, with the highest rates in East Park and Falling Park wards.

Figure 51: Wolverhampton Teenage Pregnancy by Ward, 2019

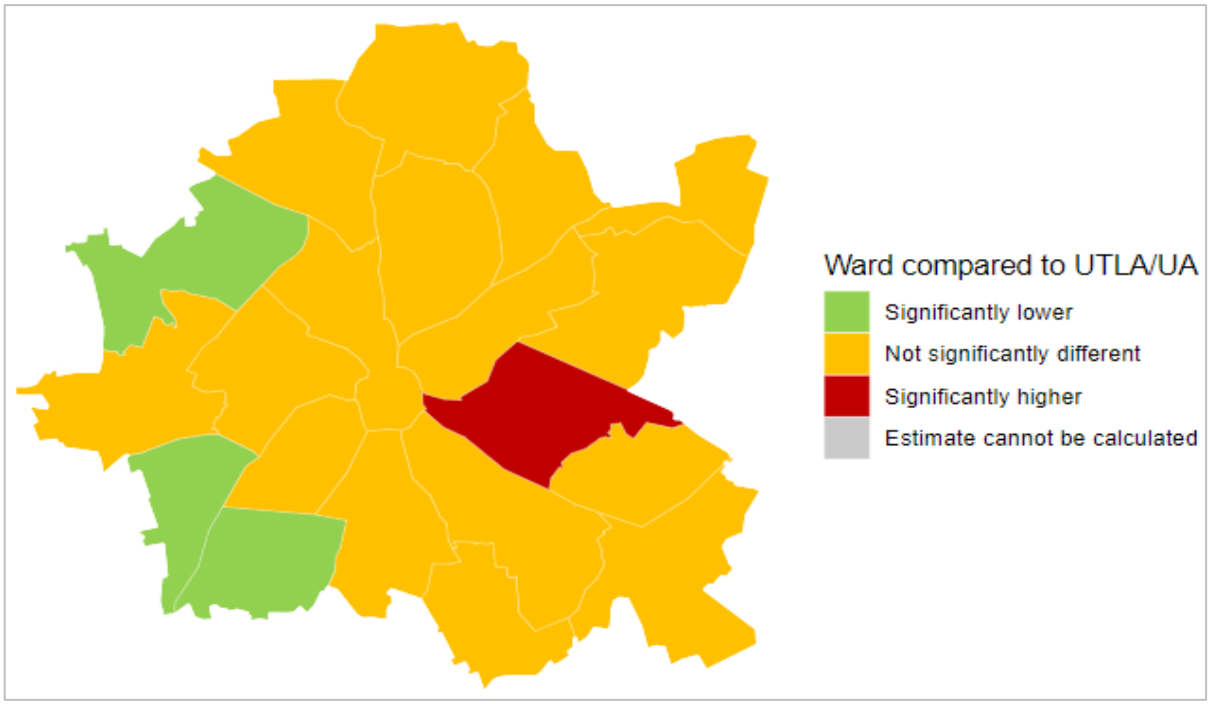


Source: SPLASH report, 2023

In 2021, there were 87 under-18 conceptions, a rate of 18.5 per 1,000 15-17-year-old women. The regional and national rates were both lower, at 15.2 and 13.1 per 1,000 15–17-year-old women respectively. Local rates have shown a gradual reduction over the last 20 years (116 under-18 conceptions or 27.7 per 1,000 15-17-year-olds).

Under 16-year-old conceptions is defined as the number of pregnancies that occur in young women aged under 16 resulting in either one or more live or stillbirths or legal abortion. The indicator is the number of conceptions per number of young women aged 13-15 years living in that area. In 2021 there were 14 under-16 conceptions in Wolverhampton, similar to the 15 in 2018 or a rate of 2.7 per 1,000 young women aged 13-15. The regional and national were both statistically similar to the England average due to the small numbers, at 2.4 and 2.1 per 1,000 women aged 13-15 years respectively.

Figure 52: Wolverhampton Teenage Pregnancy by Ward compared to Upper Tier Local Authorities, 2019



Source: SPLASH report 2023

In 2021/22, the percentage of delivery episodes of teenage mothers under 18 years was 1%, greater than 0.7% regionally and 0.6% in England. Conversely the percentage of conceptions amongst under 18s leading to an abortion was 37.9%. This was significantly less than the proportions in the West Midlands region (51.4%) and nationally (53.4%). This indicates that Wolverhampton's under 18s who conceive are more likely to continue with the pregnancy than have an abortion compared to their regional and national counterparts.

6.7 Abortion

6.7.1 Abortion provision in England

Abortion is a healthcare intervention to end a pregnancy. The majority of abortions in the UK are within the first trimester (<12 weeks gestation), with most in the first 10 weeks of pregnancy (early abortion). The most common method is by using two different medications taken 24-48 hours apart to end the pregnancy (medical abortion). Some people require or choose a surgical procedure to end their pregnancy (surgical abortion) which can be under a local or general anaesthetic. Abortion is overall very safe and most people undergoing either medical or surgical abortions do not have any complications; the earlier gestation an abortion is the less likely the person is to have complications.

The COVID-19 pandemic has changed the way abortion care is provided in the UK. Before 2020 the first of the two medications used for a medical abortion needed to be taken in a hospital or clinic for early medical abortions (<10 weeks gestation), the second medication could be used at home. It was recognised that access to safe abortion care needed to be preserved during the pandemic, where social distancing and lockdown measures aimed at

preventing spread of COVID-19 may be a barrier to those needing an abortion accessing healthcare.

In response, the UK Government allowed temporary approval of a person's home as a place where abortions could be undertaken. This allowed for the postage of the medications for use at home those less than 10 weeks gestation who met set criteria and for doctors to prescribe the medications from their own homes (remote working). Telemedicine (telephone or video consultations) meant that face to face appointments could be reduced, although safety measures were put in place by services to ensure those who had complex medical histories or complications could be seen by healthcare professionals. Following the pandemic in 2022, the UK Government made these measures permanent in England and Wales[79].

6.7.2 Abortion rates in Wolverhampton

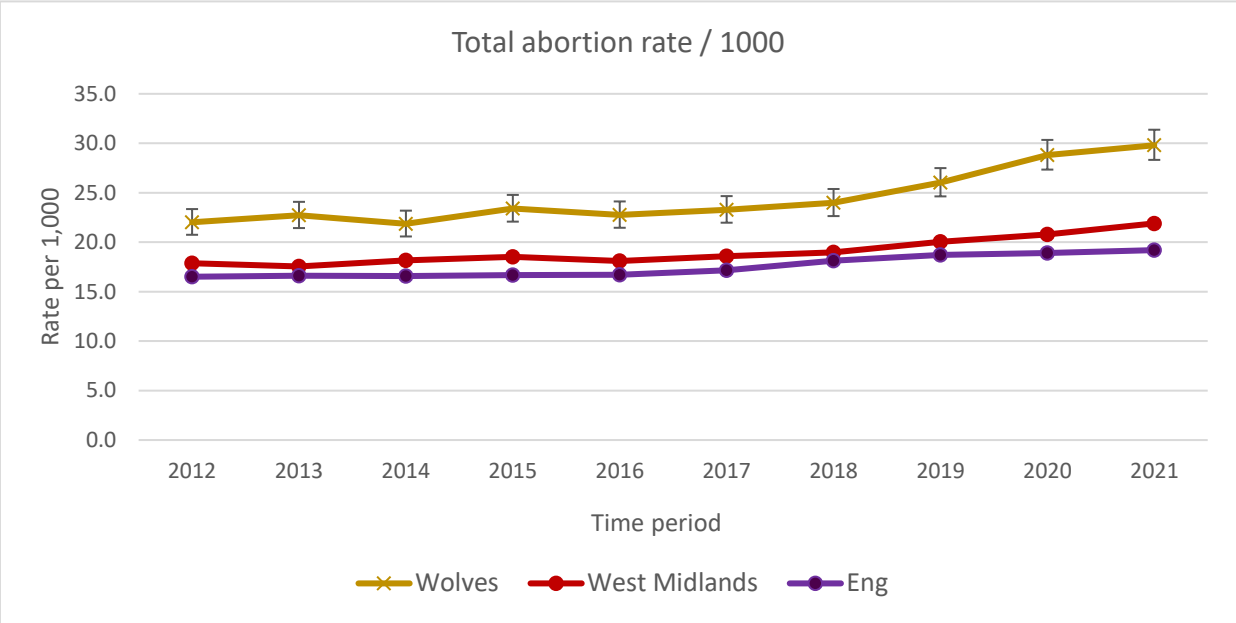
The total abortion rate is considered to be an indicator of access to good quality contraception services and advice, as well as individual use of contraception method. Over the past decade there has been both national and locally rising abortion rates. The 2022 Abortion statistics for England and Wales are due to be released January 2024, however preliminary data for January – June 2022 confirms this increasing trend nationally.

The abortion rate for under 18s has shown a decreasing trend, with the most recent 2021 rate at 6.3 per 1,000 women aged 15-17-years, similar to that of the West Midlands region (7.3 per 1,000 women aged 15-17-years) and nationally (6.5 per 1,000 women aged 15-17-years).

Despite a decrease amongst the under 18s, over the past decade the general trend has been an increase in the total abortion rate. In Wolverhampton the most recent 2021 total abortion rate was 29.8 per 1.000 women aged 15-44-years. Wolverhampton's total abortion rate is significantly higher compared to the West Midlands and national rates, 21.9 and 19.2 per 1,000 women aged 15-44-years, respectively.

Figure 53 shows that whilst the national picture shows an increasing abortion rate, there has steeper increases in Wolverhampton's rate. The COVID-19 pandemic does not appear to have had a great impact on this trend. The forecast for the 2022 data for Wolverhampton is a continued increase in the abortion rate with 884 abortions in January – June 2022.

Figure 53: Total abortion rate per 1,000 locally and nationally, 2012-2021



Source: Fingertips

In 2021, nationally almost a third (29.7%) of abortions in under 25-year-olds were repeat abortions; that is someone undergoing an abortion who has already had one or more abortions in any year prior. This indicator could represent poor access, limited or problematic use of contraception.

The percentage of abortions in under 25's that were repeat abortions in Wolverhampton is 33.8%, accounting for 142 abortions. Whilst there was a slight reduction in the percentage of under 25-year-old having a repeat abortion in 2020 (29.7%), this could have been due to national lockdown measures leading to a reduction in demand or reflect a reduction in access amongst this group. The percentage in 2021 was greater than the pre-pandemic levels (33.8%) showing rates of repeat abortions are significant in Wolverhampton's under 25s.

Abortion is largely a safe procedure and the earlier that someone can access an abortion the less risk of any potential complications. The percentage of those accessing an abortion under 10 weeks in Wolverhampton was 85.3%. This was less than the West Midlands region (88.3%) and England (88.6%). This percentage had been increasing since 2017 (68.9%) and but remained static 2020 to 2021 (85.1% - 85.3%). This indicator showed access to early abortion was preserved during the COVID-19 pandemic. However, there was a proportion of Wolverhampton residents undergoing abortions later than 10 weeks. This could be due to factors such as late recognition of pregnancy, decision time regarding method or choice of abortion, discovery of fetal abnormalities (most of which are diagnosed when a pregnancy is greater than 10 weeks) or delay in accessing abortion care.

6.7.3 Local abortion data

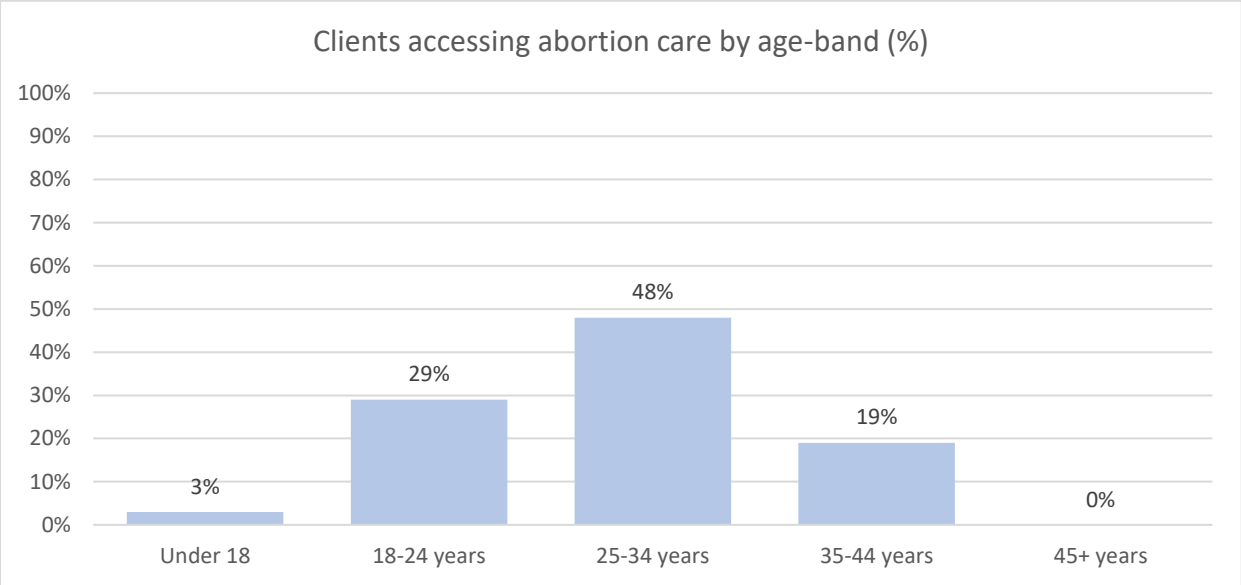
Local abortion services are commissioned by the CCG and delivered by British Pregnancy Advisory Service (BPAS) in Wolverhampton. The new service commenced in 2020. Access is mainly via client self-referral, although healthcare professionals are able to refer into the service. Service data for 2021/22 shows that 98% of clients self-referred for their care.

6.7.4 Age breakdown of those accessing abortion care in Wolverhampton

In 2021/22, the age group making up the greatest attendances were 25-34-years-olds (48%) followed by followed by 18-24 years (29%). Only 3% were under 18. This has shown an increase from 2020/21 where 45% where 25-34-years-old followed by the age group 18-24 years (29%) (Figure 53). A similar age breakdown has also been observed in the latest figures (Q1 of 2022/23).

There could be many reasons for this, for example the client may already have children and they do not feel able to manage a new addition, medical reasons, the client may be in education or not have the financial resources to be able to look after a child. This mirrors the data for the ages of those accessing emergency contraception and highlights the continuing need and awareness of contraception throughout the reproductive lifespan.

Figure 54: The percentage of clients accessing abortion care in Wolverhampton, by age, 2021/22 (Financial Year)



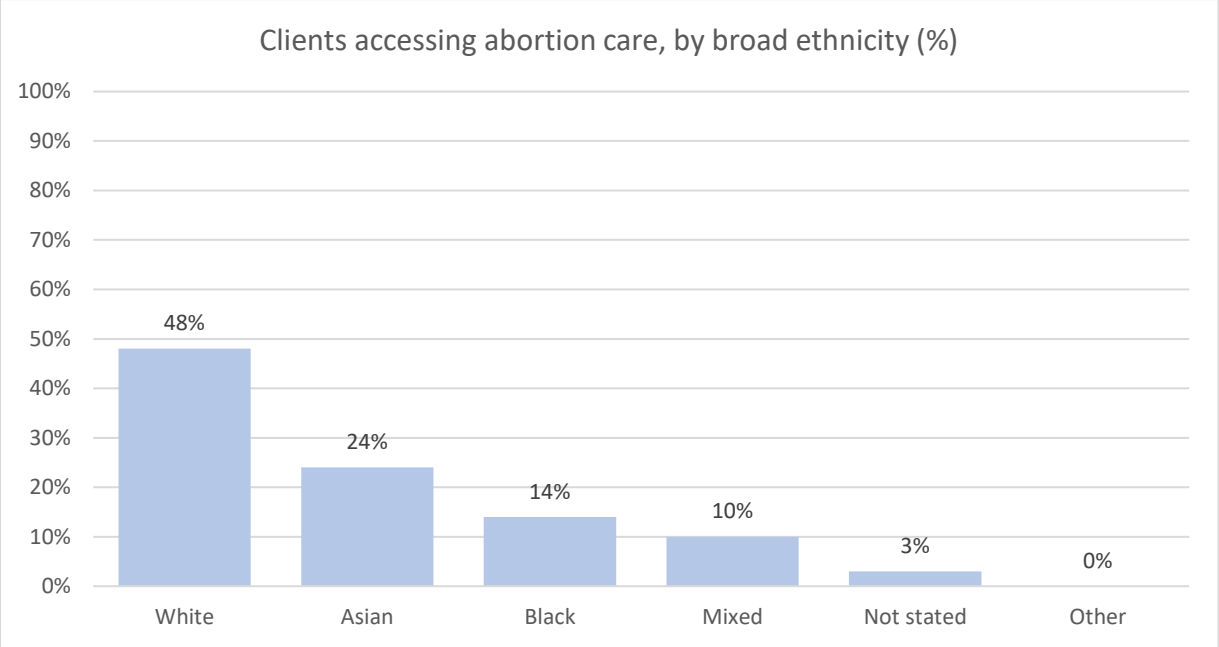
Source: BPAS local service data

6.7.5 Ethnicity breakdown of those accessing abortion care in Wolverhampton

In 2021/22, the majority of clients treated were White British (42%), followed by Indian (20%) Black African (8%), White and Black Caribbean (7%) and Black Caribbean (5%) (Figure 55). This breakdown by ethnicity is also reflected within the latest figures (Q1 of 2022/23).

There is a higher-than-expected proportion of White & Black Caribbean and Black African clients accessing an abortion compared to the city's populations. In 2021, the city's White & Black Caribbean population made up 3% of the total population, whereas 8% of all clients accessing an abortion in 2020/21 were from this population group (Census 21).

Figure 55: The percentage of clients accessing abortion care in Wolverampton, by ethnicity, 2021/22 (Financial Year)



Source: BPAS local service data

6.7.6 Repeat abortion rates amongst those accessing abortion care in Wolverhampton

In 2021/22, 46% of clients treated had already had 1 or more abortions. Over half (53%) of repeat abortions were among those aged 25+, followed by around 3 in 10 (32%) aged between 24 and under. A similar age breakdown has also been observed in the latest figures (Q1 of 2022/23).

Reasons why clients may have had repeat abortions include contraception failures, domestic abuse, or economic disadvantage.

Depending on the method in which clients were consulted, either face-to-face with a health care professional or via teleconsulting, would impact on their access to contraceptive methods following their abortion. Fertility can return 5 days after an abortion and so ongoing contraception is important in reducing the risk of a further unwanted pregnancy.

In 2021/22 only 5% of clients treated received LARC. If someone is receiving pills-via-the-post for an early medical abortion, of which the majority of abortions will be, the immediate contraceptive choice is limited to oral contraceptives or condoms. These can be posted alongside the abortion medication but are user-dependent methods with a higher failure rate. The access to the more efficacious LARC methods would require a subsequent visit to BPAS, primary care or SRH services, of which some people will not attend. There is a need to ensure robust provision of all contraceptive methods for those undergoing all methods of abortion care to try and reduce the need for repeat abortion.

6.7.7 STI testing amongst those accessing an abortion in Wolverhampton

The STI testing rates of attendees during the year 2021/22 was very low. Of the eligible population, only a small minority were tested for chlamydia (11%), gonorrohea (10%), HIV (5%), and syphilis (0%).

These low testing numbers could be as a result of the 'pills by post' option during the pandemic where clients did not physically attend the clinic and were therefore unable to be tested in person or not undertaking opportunistic screening at face to face contacts.

Solutions to address the lack of STI screening amongst the population accessing abortion care could be utilising postal STI testing kits sent to clients prior to an appointment or better signposting could be available for the service. Pregnancy having resulted from condom-less sex means that there are risk factors for sexually transmitted infection and this represents a missed opportunity to identify undiagnosed infection.

8. Health Related Behaviour Survey (HRBS) 2022[80]

The HRBS is commissioned biannually and schools across Wolverhampton participate where specific health related questions are asked of all primary and secondary pupils. Key Stage 3-4 pupil (ages 11-16-years-old) feedback in 2022 highlighted:

- They were less likely to know about the contraception and sexual health services available in Wolverhampton for young people than they did in previous years (22% in 2022 vs. 35% in 2018).

- There continued to be a downward trend in the students who wished to get contraception from the School Nurse (29% in 2022, 37% in 2018, 42% in 2016). This may reflect that less than half of students knew when their school nurse is available (35%).

- The top places Key Stage 3-4 secondary pupils said they would like to be able to get contraception included the GP/doctor (64%), pharmacy (50%) and 'Sexual Health Services such as Embrace' (34%).

- 12% of Year 10 (aged 14-15-years-old) knew about how to get free emergency hormonal contraception, this increased to 28% of Year 12+ (16-18-year-olds).

- Students were less likely to know about chlamydia (45%) than in 2018 (51%). Just 12% of students knew how to request a free postal chlamydia testing kit online.

- Less than a third knew where to access free condoms (28%) which was a reduction from previous years (39% in 2018, 42% in 2016).

- A similar number of secondary pupils reported experiencing controlling partner behaviour in 2022 when compared to previous years.

- When pupils had Relationship Sex Education (RSE) lessons they were significantly more likely to know about Chlamydia, knew where to get condoms free of charge and have an awareness of the School Nurse drop-in service.

The 2020 HRBS was cancelled due to school closures caused by the COVID-19 pandemic. It is not possible to identify the full extent of how COVID-19 has impacted the survey results in 2022. What is known is that young people's school attendance was severely disrupted, with much of their education provided virtually using online platforms during the pandemic. This meant less access to PHSE, School Nurse service, peer support and pastoral care which could account for some of the trends outlined above.

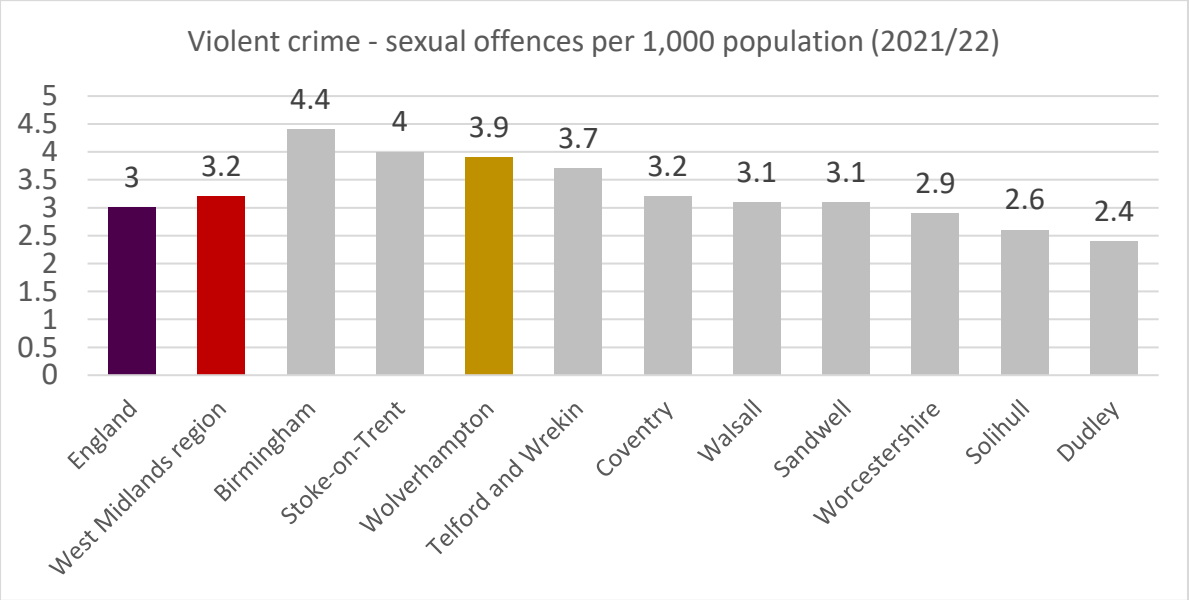
9. Sexual Exploitation, Coercion and Violence

Sexual health outcomes should not need to include violence and exploitation but seeking to improve the sexual health of our population demands a broader view of prevention and treatment, including the involvement of education and criminal justice systems.

The sexual offences indicator is the rate of sexual offences per 1,000 population, based on police recorded crime data. In 2021/22 there were 1,035 recorded sexual offences, giving a rate of 3.9 per 1,000 of the population of Wolverhampton. As sexual offences are notoriously underreported this was likely to be a conservative representation of the true rate[81]. The rate has shown a steady increase since 2010/11 from 0.9 per 1,000. However, there has been a steep increase in the rate of sexual offences since 2020, with 240 more offences reported in the year 2021/22 than the year prior.

As Figure 56 shows, regional and national average rates were both statistically lower compared to Wolverhampton at 3 per 1,000 population and 3.2 per 1,000 population respectively. Wolverhampton was in the highest quintile for number of sexual offences occurring in England.

Figure 56: The rate of sexual offences per 1,000 population of West Midlands local authorities, 2021/22



Source: Fingertips

Whether there has been any history of non-consensual sex should be asked as part of the routine sexual health history. Where a history of sexual offense is identified there should be support of the survivor and consideration of onward referral to a sexual assault referral centre, especially if the assault occurred <7 days ago or the person is under 18.

The local service to Wolverhampton is the Horizon Sexual Assault Referral Centre located in Birmingham. Alongside the collection of forensic evidence, safeguarding and ongoing psychological support; referrals a[82]re made to local sexual and reproductive health services (Embrace) for STI screening, emergency contraception and risk assessments for commencing hepatitis B vaccination schedule and HIV post-exposure prophylaxis.

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Appendices

- Public Health England (2022) SPLASH Report 2023