



Liverpool Sexual Health Needs Assessment

November 2020

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Description	This document aims to provide an overview of issues relating to sexual health in Liverpool. As part of the Joint Strategic Needs Assessment (JSNA), its purpose is to provide an evidence base to support policy makers and commissioners within the City Council, and local NHS. Whilst the document is primarily aimed at policy makers and commissioners, it is also available to members of the public and other organisations. It was completed during the Coronavirus Pandemic and thus makes recommendations for service restoration, and will be assessed for required updates on data and local issues annually post publication.

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Key Findings & Recommendations

The following section outlines the key findings and recommendations emerging from the needs assessment. They are defined and shaped by a range of evidence, national direction of travel, current service provision and known strengths and weaknesses associated with our local system.

Overarching recommendations:

1. Commission an integrated all-age sexual and reproductive health service through one block LCC contract as soon as possible. The service will provide system leadership and deliver a range of services including education, prevention and clinical interventions targeted at those most at risk of poor sexual and reproductive health;
2. Commissioners should use a whole systems approach to Sexual & Reproductive Health commissioning (exploring all potential co-commissioning opportunities) to mitigate against the profound impact of the Health and Social Care Act (2012);
3. Commissioners are advised to use a single funding mechanism (tariff or block) within integrated services and consider how to mitigate provider/system instability that result from short tendering rounds;
4. Develop a sexual health strategy for Liverpool and ensure that this engages and integrates the whole sexual health system, has clearly defined priorities, roles and responsibilities and considers sexual health across the life-course.
5. Ensure Liverpool residents have access to the full range of SRH services (STI self-sampling, remote prescribing) via a robust digital (e-SRH) offer to improve access to testing and contraception city-wide;
6. Ensure that any commissioned e-SRH service is well promoted and its key benefits adequately explained to patients to encourage improved uptake;
7. Engage with potential service users to understand which aspects of an online/e-SRH offer matter most to them and use that to influence service design;
8. Ensure that future digital provision contains a blend of remote consultation (video, webchat) with a suitable online triage/booking system for patients;
9. Continue to research the effectiveness of differing online service offers with a view to ensuring that current practice is evidence based and up to date;

10. Undertake a review of service opening hours and clinic mix (bookable and walk in appointments) as part of any pending service redesign to ensure patients have robust access across the week and into weekends and at multiple sites;
11. Modernise the way in which outreach services engage and deliver testing and brief interventions across the city, with particular emphasis on how we reach a wider range of those people most at risk of sexual ill-health;
12. Ensure effective Partner Notification targets and outcomes are built into any future new integrated service design to improve our ability to assess local performance;
13. Make one single service, via integration, responsible for all partner notification and subsequent treatment to be more effective at preventing onward spread of infection;
14. Include a targeted clinical outreach offer within any newly commissioned offer to target vulnerable groups and test at point of care/intervention;
15. Ensure system education and training are fundamental, mandatory aspects of sexual health provider contracts;
16. A high quality, tailored, life course approach to sexual health education and awareness is key to ensuring individuals make well informed choices about their sexual health. Thus any service redesign/future provision needs to consider and factor in support required to teachers/professionals in delivering high quality, robust statutory RSE in schools;
17. Develop even more sophisticated data collection systems and a dashboard to enable improved targeting of community engagement, insight and outreach functions in order for us to address the specific needs of high risk groups;
18. It is critical that local services share information and offer a wide range of support to sex workers to minimise risk and harm;
19. It is vital that the local authority continue to work with its partners with the aim of finding a 'designated and manageable area' in the city where street sex can be controlled;
20. Drug and alcohol services and sexual health service providers should meet the specific needs of MSM involved in 'chemsex'. Joint working between alcohol and drug services and SHSs should be established to ensure an

integrated approach to care, including specific treatment pathways for ‘chemsex’ according to need, hepatitis C testing and treatment and hepatitis B vaccination;

21. Provision should be made for post-abortion counselling, particularly within abortion services and for those with a diagnosed mental health condition;
22. Ensure that the needs of people (in relation to clinic location and accessibility) are met across all parts of the city and that SRH services offer multiple ‘sites’ as part of the service model;
23. Ensure that the needs of young people are specifically met across the city, with particular focus placed upon services ensuring young people feel comfortable and at ease to discuss their sexual health needs in full;

STI recommendations:

1. To reduce the risk of STI and HIV complications and infection spread, sexual health services should be open-access, providing rapid treatment and partner notification;
2. Services for the prevention, diagnosis, treatment and care of STIs need to be delivered to the general population as well as focus on groups with greater sexual health needs, including young adults, black ethnic minorities and MSM;
3. Continue to promote the availability of condoms, including through the C-card scheme;
4. Ensure prompt diagnosis & treatment of gonorrhoea according to national treatment guidelines;
5. Test for antibiotic resistance in gonorrhoea cases;
6. Identify & manage potential treatment failures effectively to control infection of gonorrhoea;
7. Sustain or increase the chlamydia detection rate above 2,300 per 100,000;
8. Maintain at least the present proportion of young people screened for chlamydia locally to allow for the ongoing effective diagnosis of infection in the local population;
9. Couple the robust screening and detection rates seen across the city with timely partner notification with the aim of reducing the prevalence of infection in young people city-wide;
10. Focus on those services that serve populations with the highest need, based on positivity;

11. Ensure an effective, high quality patient pathway is in place with treatment & partner notification standards being met, re-testing after a positive diagnosis within 3 months of initial diagnosis, and screening annually & on change of sexual partner.

HIV recommendations:

1. HIV tests should be routinely offered in primary care and at hospital admission;
2. Sexual Health Services should continue to offer and recommend HIV testing to all eligible attendees, especially MSM, black Africans, and attendees born in countries with a diagnosed HIV prevalence 1%;
3. MSM and black Africans should be encouraged to have frequent and regular HIV tests;
4. Efforts to reduce stigma and other socio-cultural barriers that prevent people from testing and seeking long-term care must be strengthened.

Reproductive Health Recommendations:

1. The public health response to reduce unplanned pregnancies should include marketing, easy access to the full range of contraception, and accessible free pregnancy testing with rapid referral to abortion services;
2. Every effort should be made to eliminate local barriers to pregnancy diagnosis, provision of unbiased pregnancy options information, referral to maternity or abortion services, and STI testing & contraception provision;
3. Prevention programmes are required for populations known to be at risk of exclusion from routine contraception, pregnancy testing & abortion provision;
4. Ensure the full range of contraceptive options is available in every service with pathways that enable rapid & easy access to the method of choice;
5. Use the many opportunities after pregnancy to offer contraception, particularly long-acting methods, such as in maternity, early pregnancy units & post abortion;
6. Ensure that LARC provision effectively meets the need of the population (there has been a decline in the provision of LARC in General Practice over the last few years due to reduced capacity but with wide geographical variations);
7. Ensure that the emergency IUD is offered to all & take the opportunity to refer on to local services to ensure provision of the chosen method;

8. Improve post termination of pregnancy LARC uptake, across all settings, most notably at Liverpool Women's Hospital Trust;
9. Work with LWH, Liverpool CCG and key consultant leads to form a multi-agency approach and partnership to improving the contraceptive offer to women postpartum (and have the conversation about preferred method much earlier in the maternity pathway);
10. Consider the alignment of budget to support the provision of LARC devices postpartum to ensure wider choice of contraceptive methods as part of the maternity pathway;
11. Improve LARC access and uptake across the city and ensure that any myths or lack of understanding around this method are addressed during choices discussions;
12. Continue to improve contraceptive access across General Practice and via Primary Care Networks (PCNs) to support women to be able to access their preferred choice promptly and when required;
13. Continue to explore co-commissioning opportunities in relation to reproductive health hub development in order to provide a more joined-up approach to women's health, ensuring that women receive the best possible care by providing all of their healthcare needs in one location;
14. Ensure that a choice of abortion services are easily available & accessible to women seeking an abortion up to 24 weeks gestation;
15. Continue to improve the SRH offer delivered via pharmacy, in relation to EHC and wider user-dependent methods such as bridging contraception, pills and depo-provera access for both starters and continuation.

Key recommendations for high risk/vulnerable groups:

1. Sexual Health Services should offer MSM vaccination against Hepatitis A and Hepatitis B;
2. Sexual health providers should support work to make MSM aware of sexually transmissible enteric infections such as Shigella
3. It is critical that local services share information and offer a wide range of support to sex workers to minimise risk and harm.
4. It is vital that the local authority continue to work with its partners with the aim of finding a 'designated and manageable area' in the city where street sex can be controlled

5. Drug and alcohol services and sexual health service providers should meet the specific needs of MSM involved in 'chemsex'. Joint working between alcohol and drug services and SHSs should be established to ensure an integrated approach to care, including specific treatment pathways for 'chemsex' according to need, hepatitis C testing and treatment and hepatitis B vaccination
6. Provision should be made for post-abortion counselling, particularly within abortion services and for those with a diagnosed mental health condition.
7. Joint working should be established between alcohol and drug services and SHSs to ensure an integrated approach to meet the specific needs of MSM involved in 'chemsex', including hepatitis C testing and treatment and hepatitis B vaccination;
8. Sexual Health services are well placed to support those people engaging in ChemSex and so inclusion of discussion related to 'Chems' (party drugs) in templates locally is key.
9. A dedicated local Chemsex clinic should be offered by trained leads locally in order to support people to put a risk reduction plan in place.

Psychosexual:

1. Local commissioners should continue to commission and specify a need for psychosexual therapy within local service provision to support those patients in need of that care

1. Introduction

Good sexual health is an intrinsic part of good overall physical, mental and emotional health. Most adults in Liverpool are sexually active. Sexual health is an important public health matter. Poor sexual health can, significantly, add to the burden of disease in the local population with diagnosed, and undiagnosed, sexually transmitted infections (STIs). We know that while everyone who is sexually active risks exposure to a STI, there are some groups at a higher risk, these are:

- men who have sex with men;
- younger adults;
- people from black and ethnic minority groups;
- people in prisons and immigration removal centres (IRCs).

There is also clear association between STIs and deprivation.

Furthermore, sexual health should not be isolated from other issues. Decisions sexually active people make cannot be separated from other aspects of their health and wider wellbeing, especially their mental and emotional wellbeing. This means that effective links and pathways between services are important. This includes services tackling substance misuse, mental health and those that support vulnerable young people and adults, including young people in care and people with learning disabilities.

1.1 Aims of the needs assessment

This needs assessment provides an in-depth review of sexual health in the city. The purpose is to give all those with an interest in improving sexual health in its broadest sense, a holistic view of the sexual health needs of the population, and to gather evidence to inform priority setting and resource allocation to improve sexual health and reduce inequalities locally. Crucially the data, needs and issues presented here will be the rationale and evidence base for our decision making, resource allocation and service design. It will highlight clear areas for cross-sector partnership working, considerably needed in what is a complex and fragmented agenda. In particular, the document sets out to provide an overview of:

- The national and local policy context in relation to sexual health
- The sexual health needs in the city and how these compare to other areas
- The needs of groups that may be more at risk of poor sexual health
- How the city is responding to the sexual health agenda
- The views of service providers and wider stakeholders on the key pressures, gaps and weaknesses within the current sexual health system
- Evidence of what works in relation to the key sexual health issues within the city

The information covered and presented aims to answer critical questions in relation to sexual & reproductive healthcare, as follows:

1. What are the key characteristics of our population in Liverpool?
2. What are the risk factors and protective factors affecting the sexual health of the population?
3. What are the current sexual health conditions and needs requiring key commissioned services?
4. What services are currently provided to support and cater to those needs?
5. What guidance and national direction of travel is in place to help us shape our services more effectively?
6. How well are services able to deliver to the needs of our population and how do we design services to address that need?

1.2 Objectives

1. Gather information that provides an overview and increased understanding of current provision and need in our city
2. Better understand the demand for and use of sexual health provision in Liverpool
3. Utilise this critical data and information to assess whether resources are being used as effectively as possible
4. Make recommendations in relation to current provision, capacity, service design and delivery
5. Make recommendations related to how we might approach the issue of inequalities and what services need to do in the future to improve outcomes for all

1.3 Vision – what do we want to achieve in Liverpool?

Improving the sexual and reproductive health of the resident population is one of the Public Health priorities for Liverpool. We aim to:

- Reduce the number of unintended conceptions among women of all ages
- Reduce the number of under-18 conceptions
- Reduce the number of abortions performed for women of all ages
- Increase the proportion of abortions performed under 10 weeks
- Reduce the prevalence of undiagnosed sexually transmitted infections
- Reduce the prevalence of undiagnosed HIV
- Control the transmission of sexually transmitted infections including HIV
- Reduce the proportion of residents receiving an HIV diagnosis at a late stage of infection
- Reducing the proportion of residents participating in high risk practices – e.g. ChemSex

1.4 What do we feel we need to do to achieve this?

In order to improve the sexual and reproductive health of the local population, we need to:

- Improve knowledge and understanding of the risks associated with unprotected sex.
- Improve awareness of sexually transmitted infections including HIV
- Improve awareness and availability of contraception and the benefits of using a reliable method
- Improve the uptake of HIV testing (in particular among most at-risk populations)
- Improve the uptake of STI testing and treatment
- Improve the uptake of PEP
- Ensure safe, routine commissioning of PrEP (Pre-Exposure Prophylaxis) via services (drug taken in advance of sexual activity to prevent HIV transmission)
- Improve the uptake of contraception - in particular, long-acting reversible methods across all settings
- Improve the uptake of emergency contraception
- Enhance the options available to patients by offering an appropriate blend of physical clinics and online/digital e-SRH services

All of the above will contribute to a range of national and local strategic outcomes and align with our forthcoming city-wide Sexual & Reproductive Health Strategy and Action Plan development.

1.5 Inequalities in Sexual Health

At the heart of our plan to improve sexual health & wellbeing across the population is the need to address the issues of inequality and vulnerability. By considering the needs of groups that may be more at risk of poor sexual health and including intelligence related to those who might be most vulnerable, we can design services that are responsive to emerging issues and concerns and support those individuals or groups towards better health.

Research shows that sexual ill health is not equally distributed within the population¹. Strong links exist between deprivation and STIs, teenage conceptions and abortions, with the highest burden borne by women, men who have sex with men (MSM), teenagers, young adults and black and minority ethnic groups². Similarly, HIV infection in the UK disproportionately affects MSM and Black Africans in the UK. Additionally, those who find it most difficult to access services include asylum seekers, sex workers and their clients and those who are homeless³. Some groups at higher risk of poor sexual health face stigma and discrimination, which can influence their ability to access services.

There is an opportunity locally to develop more sophisticated data collection systems and thus target community engagement, insight and outreach functions in order for us to address the specific needs of high risk groups. In essence, we need to be involving the public/service users in shaping, designing and co-creating services with us⁴. This critical thinking ‘public services for the public’ not ‘to the public’ will be at the heart of our response moving forward. This will allow us to ensure that high quality prevention and treatment is available for all, regardless of age, gender, background, education, disability, pregnancy, race, religion or sexual orientation yet crucially addresses differing needs.

A targeted outreach function will enable us to reach people who ordinarily would not access services, for example young people who have entered or at risk of entering the criminal justice system, looked after children, women who are leading chaotic lives and undergoing numerous abortions, sometimes alongside drug and alcohol problems.

This needs assessment, combined with the data available to us around a whole range of sexual health issues (eg. new STI diagnoses, teenage pregnancy and so on), will inform us clearly where we need to be targeting our efforts.

2. National Context

2.1 Health & Social Care Act (2012)/Commissioning Arrangements

In April 2013, following publication of the Healthy Lives, Healthy People white paper⁵ and changes introduced in the Health & Social Care Act 2012⁶, local authorities took on a new public health role. These mandated local authorities to commission confidential, open access services for STIs and contraception as well as reasonable access to all methods of contraception.

The arrangements for the commissioning of sexual health services are summarised in Public Health England’s ‘Making it Work’ Guidance (2015) and are set out below⁷:

Local authorities commission the following services –

- Contraception in the form of implants and intra-uterine devices, along with all prescribing costs, but excluding contraception provided as an additional service under the GP contract;
- Sexually transmitted infection (STI) testing and treatment, Chlamydia screening as part of the National Chlamydia Screening Programme (NCSP), and HIV testing;
- Sexual health aspects of psychosexual counselling;

- Any sexual health specialist services, including young people's sexual health and teenage pregnancy services, outreach, HIV prevention and sexual health promotion services in schools, colleges and pharmacies.

Clinical Commissioning Groups (CCGs) commission:

- Most abortion services;
- Vasectomy;
- Aspects of psychosexual counselling unrelated to sexual health;
- Gynaecology (including the use of contraception for non-contraception purposes);

NHS England commissions:

- Contraception provided as an additional service under the GP contract;
- HIV treatment and care (includes the drug costs of post-exposure prophylaxis after sexual exposure);
- Promotion of opportunistic testing and treatment for STIs, and patient-requested testing by GPs;
- Sexual health elements of prison health services;
- Sexual Assault Referral Centres (SARCs);
- Cervical screening;
- Specialist foetal medicine services.

Local Authorities	Clinical Commissioning Groups (CCGs)	NHS England
<ul style="list-style-type: none"> ✓ Contraception and advice on unplanned pregnancies in SRH services ✓ LARCs in primary care ▫ STI testing and treatment in SRH services and primary care; partner notification ▫ HIV testing and partner notification ▫ Sexual health specialist services incl. young people's services, outreach and promotion ✓ Support for teenage parents ✓ Chlamydia Screening ▫ Sexual health aspects of psychosexual counselling 	<ul style="list-style-type: none"> ✓ Abortion services, incl. contraception, STI & HIV testing in abortion pathway ✓ Contraception for gynaecological purposes ✓ Female sterilisation ▫ Male sterilisation ▫ Non-sexual health aspects of psychosexual health services ▫ HIV testing when clinically indicated in CCG-commissioned services 	<ul style="list-style-type: none"> ✓ Contraception under GP contract ✓ Cervical screening ✓ Specialist foetal medicine services, incl. late termination of pregnancy for foetal anomaly between 13 and 24 gestational weeks ▫ HIV treatment ▫ STI & HIV testing and STI treatment in general practice when clinically indicated / requested by patient ▫ HIV testing when clinically indicated in NHSE-commissioned services ✓ HPV immunisation ✓ Sexual assault referral centres (SARCs) ▫ Sexual health in secure and detained settings ✓ NHS Infectious Diseases in Pregnancy Screening

Figure 1: Current SRH commissioning arrangements in England

Therefore, there remains a complex picture in terms of the responsibility, planning and delivery of sexual health services. The current system has inherent faults across the SRH spectrum, whereby there is not a single body vested in ensuring the holistic needs of the population, particularly adversely affected are women⁸. While this needs assessment focuses largely on parts of the system which fall to the local authority to commission, it can and will need to review data, evidence and make recommendations for delivery of services commissioned by others (CCG, NHSE) and recommends areas and options for collaboration and co-commissioning.

It is recognised nationally that there is still a considerable requirement to commission and design services collaboratively across the sexual & reproductive healthcare landscape. Poorly connected care increases the risk of service users falling out of the system, which may reduce treatment adherence and worsen subsequent health outcomes⁹. It is recognised that needs cut across organisational boundaries. Outcomes in one area can have lifelong implications, for example early detection and treatment of STIs can reduce infertility and ectopic pregnancies.

2.2 Public Health Outcomes Framework

In January 2012, the Government published the 2013-2016 Public Health Outcomes Framework for England 2013-16 '*Healthy lives, healthy people: Improving outcomes and supporting transparency*'. That framework set out a vision for Public Health in England, to improve and protect the nation's health and wellbeing across the life course, and to reduce inequalities in health; the desired outcomes for Public Health; and the indicators by which improvements are measured¹⁰.

The document concentrates on two high-level outcomes to be achieved across the Public Health system, and groups further indicators into four 'domains' that cover the full spectrum of public health¹¹. The outcomes reflect the focus on how long people live, and on how well they live at all stages of life.

Vision: To improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest

Outcome 1: Increased healthy life expectancy, taking account of the health quality as well as the length of life

Outcome 2: Reduced differences in life expectancy and healthy life expectancy between communities, through greater improvements in more disadvantaged communities

DOMAIN 1: Improving the wider determinants of health	DOMAIN 2: Health Improvement	DOMAIN 3: Health protection	DOMAIN 4: Healthcare, Public Health & preventing premature mortality
Objective: Improvements against wider factors which affect health and wellbeing and health inequalities	Objective: People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities	Objective: The population's health is protected from major incidents and other threats, whilst reducing health inequalities	Objective: Reduce the number of people living with preventable ill health and dying prematurely, whilst reducing the gap between communities

Figure 2: Public Health Outcomes Framework domains

It has since been updated twice, with 'Improving outcomes and supporting transparency: Part 2' released in 2016¹². This revised some indicators and removed others, however there was no impact upon those used to assess sexual and reproductive health. The latest iteration announced by PHE following a national consultation (2019) made additions to those directly relating to the SRH agenda¹³.

The Public Health Outcomes Framework therefore now contains the following measures which are of particular relevance to sexual health:

- 3.02: Chlamydia detection rate (15 – 24 year olds)
- 3.04: People presenting with HIV at a late stage of infection
- 2.04: Under-18 conceptions
- New sexually transmitted infection (STIs) diagnoses (excluding chlamydia)
- Rate of prescribing of long-acting reversible contraception (LARC), excluding injections, in females aged 15-44

2.3 National Framework – A Framework for Sexual Health Improvement in England

Following publication of the Public Health Outcomes Framework, the Department of Health published "A Framework for Sexual Health Improvement in England"¹⁴. The National Framework for Sexual Health Improvement in England (2013) highlights the Government's ambition to improve the sexual health and wellbeing of the whole population by reducing inequalities and improving sexual health outcomes; building an honest and open culture where everyone is able to make informed and responsible choices about relationships and sex, and recognising that sexual ill health can affect all parts of society.

Ambitions and objectives are illustrated in the diagram overleaf:

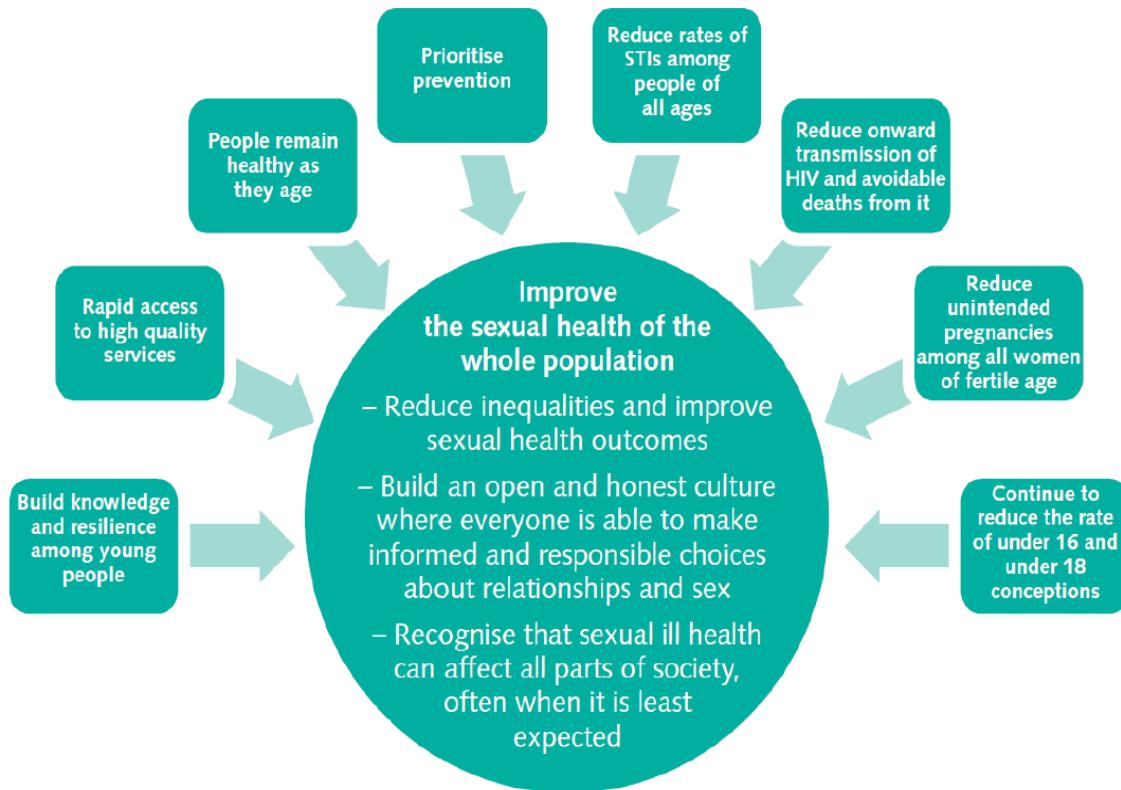


Figure 3: National Sexual Health Framework Key Objectives

Source: DOH (2013) National Framework for Sexual Health

2.3.1 National Sexual Health Framework Key objectives

1. Improve the sexual health of the whole population
2. Reduce inequalities and improve sexual health outcomes
3. Build an open and honest culture where everyone is able to make informed and responsible choices about relationships and sex
4. Recognise that sexual ill health can affect all parts of society, often when it is least expected.

2.3.2 Framework Ambitions

1. Build knowledge and resilience among young people:

- all children and young people receive good-quality sex and relationship education at home, at school and in the community;
- all children and young people know how to ask for help, and are able to access confidential advice and support about wellbeing, relationships and sexual health;

- all children and young people understand consent, sexual consent and issues around abusive relationships;
- young people have the confidence and emotional resilience to understand the benefits of loving, healthy relationships and delaying sex.

2. Improve sexual health outcomes for young adults:

- all young people are able to make informed and responsible decisions, understand issues around consent, see the benefits of stable relationships, and are aware of the risks of unprotected sex;
- prevention is prioritised;
- all young people have rapid and easy access to appropriate sexual and reproductive health services;
- all young people's sexual health needs – whatever their sexuality – are comprehensively met.

3. All adults have access to high quality services and information:

- individuals understand the range of choices of contraception and where to access them;
- individuals with children know where to access information and guidance on how to talk to their children about relationships and sex;
- individuals with additional needs are identified and supported;
- individuals and communities have information and support to access testing to increase earlier diagnosis and prevent the transmission of HIV and STIs.

4. People remain healthy as they age:

- people of all ages understand the risks they face and how to protect themselves;
- older people with diagnosed HIV can access any additional health and social care services they need;
- people with other physical health problems that affect their sexual health can get the support they need for sexual health problems.

5. Prioritise prevention:

- build a sexual health culture that prioritises prevention and supports behaviour change;

- ensure that people are motivated to practise safer sex, including using contraception and condoms;
- increased availability and uptake of testing to reduce transmission;
- increase awareness of sexual health among local healthcare professionals and relevant non-health practitioners, particularly those working with vulnerable groups.

6. Reduce rates of sexually transmitted infections (STIs) among people of all ages:

- individuals understand the different STIs and associated potential consequences;
- individuals understand how to reduce the risk of transmission;
- individuals understand where to get access to prompt, confidential STI testing and provision allows for prompt access to appropriate, high-quality services, including the notification of partners;
- individuals attending for STI testing are also offered testing for HIV.

7. Reduce onward transmission of and avoidable deaths from HIV:

- individuals understand what HIV is and how to reduce the risk of transmission;
- individuals understand how HIV is prevented;
- individuals understand where to get prompt access to confidential HIV testing;
- individuals diagnosed with HIV receive prompt referral into care, and high quality care services are maintained;
- individuals diagnosed with HIV receive early diagnosis and treatment of STIs.

8. Reduce unwanted pregnancies among all women of fertile age:

- increase knowledge and awareness of all methods of contraception among all groups in the local population;
- increase access to all methods of contraception, including long- acting reversible contraception (LARC) methods and emergency hormonal contraception, for women of all ages and their partners.

9. Improve termination of Pregnancy Counselling:

- all women requesting an abortion should be offered the opportunity to discuss their options and choices with a trained counsellor.

10. Continue to reduce the rate of under-16 and under-18 conceptions:

- all young people receive appropriate information and education to enable

This needs assessment, and any subsequent service redesign, will hold all of these ambitions and objectives at its core, with the aim of improving sexual health outcomes for all across the whole city.

2.4 Updated Sexual & Reproductive Health Strategy

The Government response to the Health and Social Care Committee report on Sexual Health was published on 24 October 2019¹⁵. This firmly set out the national commitment to develop an updated sexual and reproductive health strategy, working with PHE, NHSE&I, local government and other partners. It is envisaged that this document will provide clear national leadership in this area. It was highlighted that key focal points of this new strategy should include funding, commissioning, services, prevention and the sexual health workforce.

The priority for an updated strategy is for the Department of Health and Social Care (DHSC) to work with all partners to achieve the ambition that sexual and reproductive health services are more holistic and that system mechanisms support co-commissioning and joined up patient pathways. Work is now underway to consider the scope, content and timetable for strategy development.

In the meantime, the aims and objectives of “A Framework for Sexual Health Improvement in England” remain valid and are supported by existing programmes of work at both national and local level.

In addition, there Government are delivering new commitments on sexual and reproductive health and HIV which include:

- A commitment by the Secretary of State for Health to end new HIV transmissions in England by 2030.
- Development of a Reproductive Health Action Plan co-ordinated by PHE that will be published this year.
- Delivery of the Pre-Exposure Prophylaxis (PrEP) Impact Trial by NHS E&I, PHE and trial investigators and development of an approach to future commissioning of PrEP nationwide

Whilst the aforementioned new strategy has at present been delayed (at time of writing) it is worthwhile bearing in mind that when it arrives it may very well have an impact upon recommendations made (and service delivery) in this needs assessment and offer different opportunities to collaborate and co-commission in the future.

2.4 PHE Making It Work Guidance

In 2015 Public Health England (PHE) produced 'Making it Work', a commissioning guide that discusses the interfaces in commissioning responsibility caused by the Health and Social Care Act (2012) and the need for commissioning bodies to work together to ensure that the individual experiences seamless delivery of services to meet their needs.

The guide highlights the importance of putting service users at the centre of commissioning decisions that are based on up to date needs assessments, clinicians' expertise and service user views. Collaborative relationships are needed between the key commissioning organisations (local authorities, CCGs and NHS England) to provide a larger commissioning footprint that can generate a sustainable sexual health system as well as innovation and improvement in patient outcomes and efficiency savings. The document acknowledges the economic pressures on the system and that there is no right way to overcome some of the system fragmentation issues, therefore commissioning teams need to identify the best approach locally.

In Liverpool, work has already started in relation to how we can use the 'Making it Work' guidance to influence and shape our local sexual health commissioning. The diagram below shows the key responsibilities across the system.

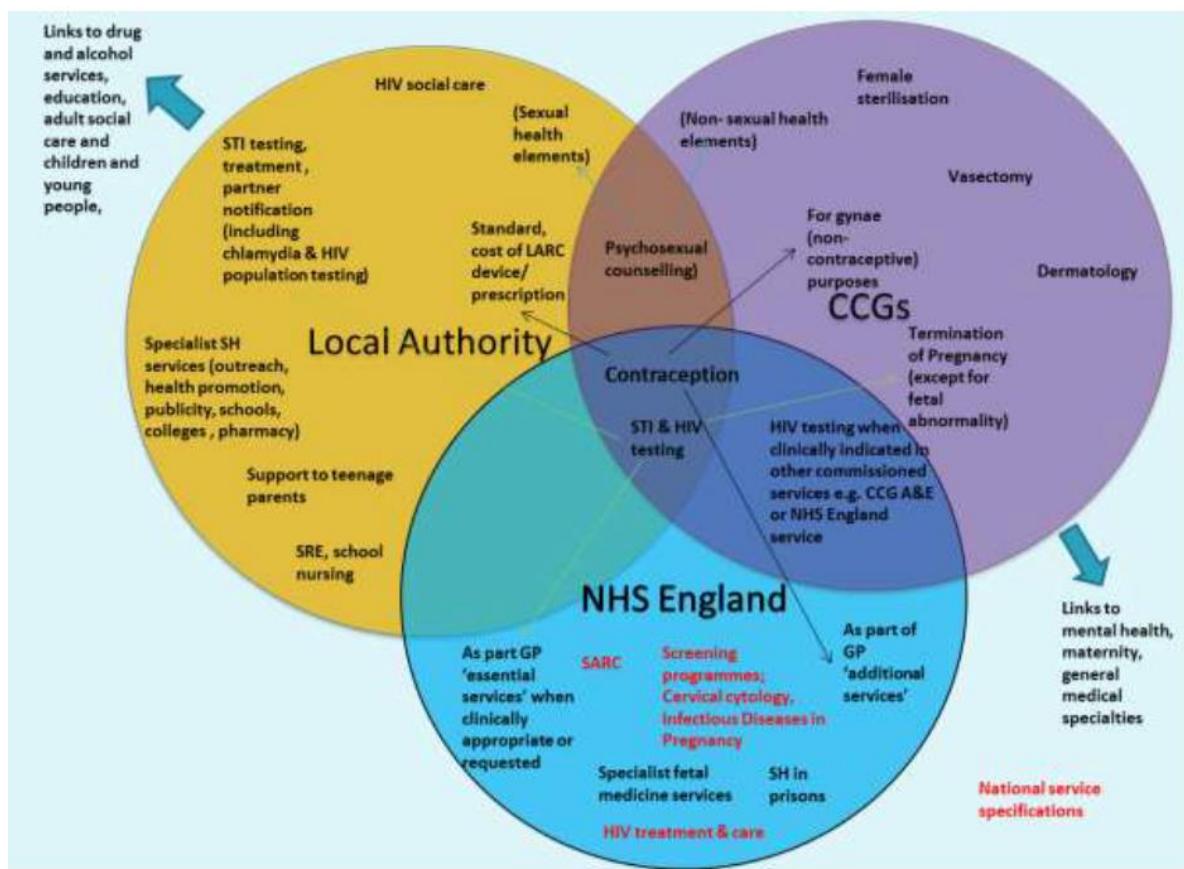


Figure 4: Commissioning Responsibilities/Landscape

Source: PHE (2015) Making it Work Commissioning Guidance

It can be seen that from April 2013 the majority of core sexual health services (including open access delivery of contraception, Sexual Transmitted Infection (STI) testing and treatment) moved into the local authority. However many other sexual health services are currently commissioned by CCGs and NHS England. For example GP contraception and STI testing, HIV services, cervical screening and sexual assault referral services are commissioned by NHS England, with termination of pregnancy, dermatology and gynaecology services commissioned by CCGs.

There are further complexities where some services are commissioned by local authorities and CCGs depending on the patient's reason for the attendance. For example intra-uterine systems (IUSs) and psychosexual counselling are both commissioned by the local authority, however CCGs have the responsibility for intra-uterine devices (IUDs) for non-contraceptive use and for psychosexual counselling for non-sexual health issues such as sex addiction. These complexities have resulted in confusing and fragmented patient pathways, and potential gaps in current commissioning arrangements.

There are likely to be increasing opportunities to review arrangements and assess how we address gaps across the system locally over the coming months and years. For example, we know that nationally the rate of abortions continues to rise, and that one way to reduce unintended pregnancy is to ensure that we provide a more joined-up approach to women's health, diminish unnecessarily long referral times and ensure

that women receive the best possible care by providing all of their healthcare needs in one location and at one time. This is one of the key principles set out in the Royal College of Obstetricians & Gynaecologists (RCOG) 'Better for Women'¹⁶ report and Faculty of Sexual & Reproductive Health (FSRH)¹⁷ which both highlight the need to collaborate, co-commission and embed SRH services into new models of care (eg. Primary Care Networks) to offer more holistic community based delivery to women.

2.5 All Party Parliamentary Group (APPG) on Sexual & Reproductive Health in the UK

The All-Party Parliamentary Group on Sexual and Reproductive Health in the UK (APPG) aims to raise awareness in Parliament of the needs of women seeking abortion and the importance of improving all aspects of the sexual health of women and men in the UK.

The APPG is chaired by Baroness Gould of Potternewton and supported by FPA, the Faculty of Sexual and Reproductive Healthcare and the British Association for Sexual Health and HIV.

2.5.1 APPG Inquiry – Breaking down the Barriers: The need for accountability and integration in sexual health, reproductive health and HIV

The All-Party Parliamentary Group on Sexual and Reproductive Health in the UK (APPGSRH) conducted an inquiry 'Breaking down the barriers: The need for accountability and integration in sexual health, reproductive health and HIV service in England'¹⁸ into the impact of the Health and Social Care Act (2012) reforms on sexual health services and patient outcomes.

The inquiry concluded;

- **Accountability** - the need for national accountability and clarification across a range of sexual health commissioning responsibilities
- **Commissioning Responsibilities** - A whole system approach to sexual health commissioning is needed to mitigate against the profound impact of the Health and Social Care Act and avoid silo services that do not meet patients' needs. These must be informed by regular sexual health needs assessments and epidemiological data.
- **Monitoring, evaluation and data** - Further work is needed to monitor performance against the national sexual health framework, to develop the PHE sexual and reproductive sexual health profiles to become more comprehensive and to ensure effective public and patient feedback supplements other data sources in commissioning decisions.

- **Payment, tendering and contracting barrier** - Commissioners are advised to use a single funding mechanism (tariff or block) within integrated services. Concerns were raised about the instability that short tendering rounds can have on services and the need to complete a sexual health needs assessment before any re-tendering to ensure the most appropriate service is commissioned. Service specifications should follow a common national quality and standards framework.
- **Future funding** - Sexual health services account for about a quarter of the public health budget. The inquiry urges the government to maintain the ring fence around the public health budget and ensure there is sustainable funding for sexual health services following the announced £200M cuts from the national public health budget in summer 2015.
- **Workforce education and training** - There is a need to ensure education and training are fundamental, mandatory aspects of sexual health provider contracts. Local education and training boards (LETBs) are encouraged to complete a local needs assessment and Health Education England should take a stronger national lead on sexual health and HIV training and development.
- **School and population wide education** - A high quality, tailored, life course approach to sexual health education and awareness is key to ensuring individuals make well informed choices about their sexual health. The inquiry recommends the government implements the February 2015 recommendation of the Education Select Committee that sex and relationships education and PHSE should be statutory subjects in all primary and secondary schools.
- **Patient and user involvement** - Patient and user involvement must be established to help commissioners and service users to help build local services around practical considerations of service users.

2.5.2 APPG Inquiry – Inquiry into Access to Contraception – Women’s Lives, Women’s Rights

The All-Party Parliamentary Group on Sexual and Reproductive Health in the UK (APPGSRH) (Chaired by Dame Diana Johnson DBE MP) have recently invited submissions and evidence from commissioners, leading bodies, clinicians and senior figures in healthcare and government as part of their ‘Inquiry into Access to Contraception’¹⁹. There have already been a raft of concerns and issues raised by a range of key bodies including FSRH, RCOG and the Primary Care Women’s Health Forum (PCWHF) related to:

- Funding and reduced budgets;
- Service delivery models/fragmentation;
- Workforce and Training Challenges.

With around 8 million women of reproductive age now living in an area with reduced budgets for contraceptive care and services²⁰, and the access to LARC down 8% nationally (source PHE data¹) it is now more vital than ever that a review of this kind takes place.

The final report '*Women's Lives, Women's Rights*'²¹ was launched recently (September 2020) and further included and considered the impact of the Coronavirus pandemic on access to contraception as part of its work. The APPG fed back 'key opportunities' as part of its recommendations, these were:

Commissioning Structures & Accountability:

- The forthcoming national Sexual and Reproductive Health Strategy from the Department of Health and Social Care should incorporate all aspects of women's sexual and reproductive health needs and recognise the changing needs of women throughout their lives. This will provide a consistent, joined up vision around which providers can work to ensure that population contraceptive needs are met.
- Co-commissioning should be mandated to ensure that all women can access the full range of contraception via clear, streamlined and well-publicised pathways until the Department of Health and Social Care's engagement on future options for PHE, which presents an opportunity for a broader review of SRH commissioning responsibilities. In the context of the current review of PHE responsibilities, the Department should consider introducing an integrated commissioning model for SRH, with one body maintaining oversight and holding accountability for all commissioning decisions.
- The use of incentivised payment systems such as CQUIN and QOF should be considered to encourage universal provision of all methods of contraception across all providers.
- New service models, such as Primary Care Networks (PCNs), should prioritise examining how they can ensure women have good access to high quality care for their contraceptive, reproductive, gynaecological and sexual health needs. As part of this, PCNs should engage with colleagues within the voluntary, pharmacy and community sector to maximise reach according to local population need. PCNs should also prioritise optimisation of training opportunities.

Workforce & Training:

- Health Education England and the Department of Health and Social Care should collaborate to develop a workforce needs analysis and strategy based on population need for the future delivery of SRH services. They should plan and publish analysis of appropriate current and future skill mix and training needs of specialist and generalist contraceptive providers. Local areas should conduct workforce capacity assessment based on their population need.

¹ PHE SHRAD data/Reproductive Health Profiles – via NHS Digital (2018)

- The Community SRH training programme should be expanded and funded to enable leadership for all local areas to meet specialist and Primary Care contraceptive workforce needs with a recommended specialist capacity of 1:125,000 population. This should include dedicated provision for LARC training.
- The quality and breadth of contraception provision should be improved by the introduction of national standards for specialist contraception training for nursing, and ensuring that basic contraception is a core part of nursing, midwifery and health visitor curricula.

Improving access to contraception:

- The forthcoming national Sexual and Reproductive Health Strategy from the Department of Health and Social Care should prioritise the need for local streamlined women-centred contraceptive service provision for underserved populations, who are less likely to have frequent and easy access to contraceptive services.
- The forthcoming national Sexual and Reproductive Health Strategy from the Department of Health and Social Care should consider how best to integrate SRH care into existing women's healthcare pathways in the NHS. Integrating care around the needs of individual women would improve access by removing the institutional silos which create obstacles for women seeking care.
- Local authorities should embrace the introduction of evidence-based technologies to improve access to contraceptive provision. They should also assess the impact of technology on marginalised groups.
- The Department of Health and Social Care should consider the development of a national digital contraception service. At a minimum, commissioners should ensure there is a dedicated digital contraceptive offer to widen access, and to preserve access if face to face services are suspended. Commissioners should identify digitally excluded groups and ensure they are reached through outreach and other means.
- The full range of immediate post pregnancy contraception should be made available in abortion, maternity and early pregnancy settings.
- The role of pharmacy Independent Prescribers and of Patient Group Directions (PGDs) should be maximised for a wider range of prescription-only contraceptives to increase access to these methods of contraception.
- Progestogen-Only Pills should be reclassified as pharmacy medicines (made available over the counter without a prescription) to widen access while maintaining public funding for this contraception.

- A single national commissioning specification for Emergency Hormonal Contraception services should be established to ensure patients experience consistent ease of access across the country.
- Guidance should be offered on the improvement of pharmacy settings to make it easier for women to access contraception. This may include elements such as offering more privacy for women to discuss needs;
- DHSC should publish the revised ‘You’re Welcome’ standards for young people friendly health services to provide clear criteria for local commissioning of accessible SRH services and outreach work.

As services are restored following the first phase of the pandemic, there is still considerable learning about the new challenges faced and what opportunities exist for contraceptive care to be delivered in a different and positive way. The report fully reflects those opportunities and presents some strong recommendations.

2.6 Integrated Services

National guidance is supportive of the model of integrated sexual and reproductive health provision. The integrated model can improve the sexual health of patients through the provision of open access, ‘one stop shops’ that can address most sexual and reproductive health needs within a single consultation. Integrated services need to be accessible for local populations with convenient opening hours.

The provision of integrated sexual and reproductive health services is supported by current accredited training programmes and guidance from relevant professional bodies including the Faculty of Sexual & Reproductive Health (FSRH), British Association for Sexual Health & HIV (BASHH), British HIV Association (BHIVA), and the Royal College of Obstetricians and Gynaecologists (RCOG). Department of Health and Public Health England policies and guidance also support this approach. Indeed the Department of Health ‘Best Practice Guidance’ for Local Authorities, developed in 2013, suggested that a national service specification for the commissioning of integrated GUM, SRH and NCSP delivery was being prepared for use at that time and recommended it as an approach to seamless patient care².

The aforementioned Department of Health Integrated Service Specification was formulated and released in June 2013 and referred to the need to pull together familiar overlapping disciplines to allow for a better patient journey. This would typically see services able to deliver all aspects of sexual & reproductive healthcare across all 3 levels of care, in one place under one dual trained nurse/health professional.

This national service specification was then updated further in August 2018, as can be seen in the next section (2.6.1).

² DOH (2013) Commissioning Sexual Health Services & Interventions: Best Practice Guidance for Local Authorities

2.6.1 Integration nationally

Public Health England provides a national service specification²² for integrated sexual health services to help local authorities commission effective, high-quality, integrated sexual health care.

It covers:

- the rationale for commissioning effective and easy to access services
- the objectives of service provision
- key outcomes to consider
- a description of what should be offered at various levels of service
- professional and other quality standards covering sexual health
- a description of the need to work in partnership with other services such as termination of pregnancy, general practice, and mental health services

The specification is offered as a tool to help local authorities and their providers. It can be adapted to fit local needs. The integrated model of sexual health services aims to provide easy access to services through open access ‘one stop shops’. These sites provide a single location where the majority of sexual health and contraceptive needs can be met at, usually by one health professional. Ideally such services should have extended opening hours and be in accessible locations.

The aims of the integrated sexual health service are to improve sexual health by:

- Promoting sexual health, including information and advice that reduces the stigma associated with STIs, HIV and unwanted pregnancy
- Providing rapid and easy access to services for the prevention, detection and management (treatment and partner notification) of STIs to reduce prevalence and transmission
- Facilitating rapid and easy access to the full range of contraceptive services (including LARC) for all age groups
- Preventing unwanted pregnancy including unwanted pregnancy among teenagers
- Providing rapid access to services to diagnose, counsel and manage unwanted pregnancy (including rapid access to NHS funded abortion services for those who choose this option)
- Supporting women and couples to plan pregnancy
- Reducing late diagnoses of HIV

- Improving the sexual health of people living with HIV
- Continuously improving services through development, innovation, and consultation with service users and the local population
- Developing a sexual health economy that provides a comprehensive service with clear referral pathways between providers, enabling effective planning through clinical leadership and clinical networks
- Providing accredited training to doctors, nurses and other practitioners working in both the Service, NHS and local authority commissioned services.

Objectives include:

- Providing sexual health information and advice in order to develop increased knowledge, especially in high-need communities
- Ensuring that services are acceptable and accessible to people disproportionately affected by unwanted pregnancy and sexual ill health based on up to date sexual health needs assessment
- Providing opportunities for people to manage their own sexual health either independently or with support
- Rapid and easy access to services for the prevention, detection and management (treatment and partner notification) of sexually transmitted infections to reduce prevalence and transmission
- Provision of chlamydia screening as part of the National Chlamydia Screening Programme (NCSP)
- Access for all age groups to a complete range and choice of contraception including long acting methods, emergency contraception, condoms and support to reduce the risk of unwanted pregnancy
- Access to free pregnancy tests and appropriate onward referral to abortion services or maternity care
- Promoting access and reduce waiting times to abortion services and maternity care through the provision of information on client self-referral (where available)
- Increasing the uptake of HIV testing and rapid referral to HIV care services following diagnosis with timely initiation of treatment when clinically indicated³

³ HIV Standards suggest that people who have a new diagnosis of HIV should be informed of their CD4 count and have the opportunity to discuss management, antiretroviral therapy and opportunistic infection prophylaxis within 2 weeks of this initial assessment (i.e. within 1 month)

- Engaging local prevention groups and non-governmental organisations to facilitate collaboration with service development and health promotion
- Developing the sexual health workforce through delivery of the full range of FSRH and BASHH accredited postgraduate training including specialist training Programmes
- Delivering undergraduate training when linked to a university that trains health care professionals
- Coordinate and support the delivery of sexual health care across a locality through expert clinical advice, clinical governance and clinical networks⁴
- Maintenance of undergraduate and postgraduate medical and nurse training if service provision is taken over by another provider
- Supporting evidence-based practice in sexual health (this should include participation in audit and service evaluations and may include research)
- Promoting service and key sexual health messages to the local population, via the use of innovative and appropriate media and marketing techniques tailored to specific audiences.

2.6.2 Integration locally

Presently, Liverpool has a complex system of separately commissioned services (as shown/identified in Section 14 – Services delivering) all working tightly to try and ensure that the system is connected and that pathways are as optimal as possible.

However, these services are not truly integrated, and we do not currently have clear system leadership and modernised delivery that would so greatly impact upon and improve sexual health outcomes across the city. To improve patient pathways and outcomes there is need to first and foremost organise our own Local Authority Public Health commissioned services so that they themselves are integrated. As part of this process we can then be keenly working with commissioning colleagues across the system to collaborate and join up more fully beyond our own service commissions as the national guidance suggests (PHE Making it Work, 2015).

Despite repeated attempts to work with local authority commissioned sexual health providers (in 2014, and 2018) it has never been possible to integrate these services

⁴ This should include providing specialist expert advice to other service providers and organisations; training of nursing and medical sexual health experts; delivering multidisciplinary postgraduate training, including to primary and secondary care; and may include delivering undergraduate training and postgraduate training including placements for medical and nursing students and training and education for specialty medical trainees which should be in line with the latest GMC curriculum.

and achieve the desired model. Nor has a digital e-SRH service ever been funded. This must change if we are to progress and improve pathways for patients locally.

As earlier sections have highlighted, the commissioning agenda for SRH is highly complex and fragmented. In order to appropriately draw together a range of commissioned offers to ensure seamless patient care, it is critical that we continue to explore co-commissioning opportunities across commissioning bodies wherever possible.

Furthermore, it is vital that we produce a system-wide strategy that addresses the sexual and reproductive health needs of the entire population of Liverpool, with a focus on reducing inequalities.

Recommendation: To commission/procure an integrated all-age sexual and reproductive health service through one LCC contract as soon as is feasibly possible. A range of services will be provided including education, prevention and clinical interventions targeted at those most at risk of poor sexual and reproductive health.

Recommendation: Explore co-commissioning opportunities across the major commissioning bodies to ensure that services offer seamless patient care wherever possible.

Recommendation: Develop a sexual health strategy for Liverpool and ensure that this engages and integrates the whole sexual health system, has clearly defined priorities, roles and responsibilities and considers sexual health across the life-course.

3. Local Context

3.1 One Liverpool 2019-2024

Liverpool City Council, the local NHS and key partners have published a five year strategy detailing how the city's health and care system will work together to improve the health and wellbeing of local people.

The One Liverpool Strategy²³ sets out a clear vision for a healthier, happier, fairer Liverpool for all.

Liverpool has a diverse and complex health and care system, with 86 GP practices collaborating across 12 neighbourhoods and 11 Primary Care Networks (PCNs). Additionally it has 7 NHS provider trusts (including a newly merged adult acute hospital, a children's acute trust, women's acute trust and 3 specialist trusts located in the city yet serving a wider region).

The key partners within the Liverpool health and care system are:



Figure 5: Key Partners - One Liverpool Strategy 2019-2024

Partners have come together around 4 main objectives:

1. Targeted action on inequalities, at scale and with pace;
2. Empowerment and support for wellbeing;
3. Radical upgrade in prevention and early intervention;
4. Integrated and sustainable health and care services.

All 4 of these objectives will be at the centre of thinking in this needs assessment, subsequent recommendations and any related service design/redesign. A clear focus will be placed upon how we engage with, talk to, involve and respond to the needs of those in our population most at risk of sexual ill-health. Furthermore, prevention will obviously be at the core, with future service provision most certainly needing to utilise the views of those who access (and do not access) current offers to be effective.

3.2 Mayoral Inclusive Growth Plan

The Mayor of Liverpool's Inclusive Growth Plan²⁴ is about making Liverpool one of the best cities in the world, a city that is known for its creative reinvention, passion, resilience, and its commitment to community and fairness.

The plan provides an ambitious vision for Liverpool: a strong and growing city, built on fairness.

There are six aims that will deliver the vision:

1. Investing in our children and young people;
2. People who live well and age well;
3. Quality homes in thriving neighbourhoods;
4. A strong and inclusive economy;
5. A connected and accessible city with quality infrastructure;
6. Liverpool - the most exciting city in the UK.

The Inclusive Growth Plan is supported by a Transformation Plan, which sets out how the council will change the way it works with residents and stakeholders, and an Investment Strategy, which formalises the council's approach to investing its resources to deliver the plan's priorities.

As with the 'One Liverpool Plan', these aims and objectives detailed within the Mayor's Inclusive Growth Plan will flow through the thinking of this needs assessment when we aim to maximise sexual health and wellbeing outcomes of Liverpool residents.

3.3 Centre for Public Scrutiny (CfPS) – Sexual & Reproductive Health Services Scrutiny Session 2018

During 2018, the Centre for Public Scrutiny (CfPS) worked with Liverpool City Council and West Sussex County Council to produce a guide that is designed to aid council scrutiny committees/panels in relation to pertinent and key questions to ask about the commissioning, delivery and outcomes from local SRH services.

In Liverpool, this document was informed and shaped via a large event attended by local authority staff, members and provider leads. The key themes that emerged for questioning were:

1. System leadership and collaboration
2. Sustainability of funding and value for spend
3. Commissioning and delivery models
4. Workforce continuity, training and skills
5. Health Inequalities and inequalities access to services
6. Performance and outcomes of services
7. Choice and access to contraception
8. Public voice and patient experience
9. Relationships and sex education
10. Screening and diagnosis

The guide and process aimed to help councillors build their knowledge and understanding about sexual and reproductive health and to use scrutiny functions to review local services.

During this process a range of key points and issues emerged:

- That it was vital to engage other commissioners across the system to reduce the fragmentation of service delivery across the whole of sexual and reproductive health;
- That local authority commissioned services were fragmented in their commissioning in the first instance;
- That patient pathways across the system were sub-optimal;
- That there was a need to commission and resource local services in a way that allowed them to respond to emerging threat and infections more effectively;
- That there was either limited, or no digital provision and delivery (e-SRH services) within the current system;
- There was no single location or place within which a Liverpool resident could receive all SRH care;
- That outreach provision currently is not integrated and responsive to local need;
- That value can be added to the current system and local intelligence by involving more voluntary and charitable sector organisations to engage local residents in vital insight work;
- We need to reduce our comparatively high new STI rates in the city;
- We need to promote LARC and its benefits more effectively to move more women from user-dependent methods (UDMs) to a longer-acting method (a rather high % of Liverpool women choose a less reliable UDM above a LARC).

4. Liverpool Sexual Health Services

The following section describes the current service provision across Liverpool.

4.1 Community Sexual Health Services

4.1.1 All-age Community Sexual Health Service

Abacus Clinics for Sexual and Reproductive Healthcare provide a free and confidential community sexual health service which is available to men and women of all ages. It aims to provide advice, counselling and information on all aspects of sexual health, including access to all methods of reversible contraception; screening for some sexually transmitted infections; and advice about unplanned pregnancy and referral for abortions.

ABACUS – *contraceptive and sexual health clinics for all ages*

Free, confidential service for men and women of all ages including under 16s, offering:

Advice, counselling and information; contraception (including pills, IUD/ coil, IUS, injection, implant); free condoms; pregnancy testing; emergency contraception; chlamydia testing and treatment; and referral for abortion. Psychosexual counselling is also offered for people with a Liverpool GP (referral and appointment required).

- Abacus Central
The Beat, 6 David Lewis Street, L1 4AP
- Abacus Kensington
Kensington Neighbourhood Health Centre, 155 – 157 Edge Lane, L7 2PF
- Abacus Townsend Lane
Townsend Lane Neighbourhood Health Centre, 98 Townsend Lane, L6 0BB

- Abacus Garston
South Liverpool NHS Treatment Centre, 32 Church Road, L19 2LW

Most services are offered on a drop-in/walk-in basis. However, appointments are bookable via telephone and online.

Website: www.merseycare.nhs.uk/our-services/physical-health-services/abacus

Pre-COVID (and therefore normal opening times for Abacus) are:

The Beat: Mon – Thur: 10.00 a.m. to 6 p.m.
Fri: 10.00 a.m. to 4 p.m.
Sat: 11.00 a.m. to 4 p.m.
Sun: 12.00 p.m. to 3 p.m.

Garston: Tues: 12.30 p.m. to 6.30 p.m.
Fri: 10.30 a.m. – 4.00 p.m.

Townsend: Mon & Wed: 12.30 p.m. to 6.30 p.m.

Kensington: Mon & Thurs: 12.30 p.m. to 6.30 p.m.

4.1.2 Young People's Sexual Health Service

Brook currently provide a specialist Sexual Health Service for young people in Liverpool, offering high quality advice and treatment; counselling; information; and practical help around sexual health, contraception, healthy relationships and general health and wellbeing.

BROOK LIVERPOOL – *contraceptive and sexual health clinic for under-25s*

Free, confidential service for men and women under-25s, including under-16s, offering:

Advice, information, contraception, condoms, pregnancy testing, emergency contraception; counselling; Chlamydia / Gonorrhoea screening; and full STI testing during GUM clinics.

- Brook Liverpool
81 London Road, L3 8JA

All services are offered on a drop-in/walk-in basis. However, it may be possible to book an appointment & reduce your waiting time (this depends on which service you require). Call the service for details.

For more info and detailed opening times visit their website. Please visit their website.

Website: www.brook.org.uk/find-a-service/regions/liverpool

4.1.3 National Chlamydia Screening Programme

Liverpool's chlamydia screening programme is provided by Mersey Care NHS Foundation Trust. This service provides free, confidential chlamydia testing to young people aged between 15 and 24 years.

Tests can be accessed by visiting the 'Love is Infectious' website which explains where to get tested and receive treatment should that be required. Free postal kits are available via the site and there is also a community chlamydia outreach team that access a range of settings to test young people across the city.

4.1.4 General Practice Services

GPs offer sexual health services in Liverpool in line with the GP core contract (for those methods excluding LARC).

Long-Acting Reversible Contraception (LARC) is commissioned via a locally enhanced service by the local authority to GPs who then offer Intra-Uterine Device (IUD), Intra-Uterine Systems (IUS) and Implant fitting in line with Faculty Standards (FSRH). There are currently 52 practices signed up to (across 11 Primary Care

Networks) and practising against the local authority LES. There has been much development of this area over the last 12 months or so, commissioning on a hub and spoke (PCN) basis, signalling a shift to more focused clinics acting as hubs for each network as we move forward.

4.1.5 Pharmacy Services

The Emergency Hormonal Contraception (EHC) service allows pharmacists in Liverpool to facilitate the supply of appropriate and specified emergency contraception and pregnancy tests. The specified emergency contraception for this service is Levonelle (Levonorgestrel), which is supplied by a pharmacist, as outlined under the current Patient Group Direction.

The aims of the service are to:

- Improve quick access to emergency contraception in order to reduce unintended pregnancies.
- Reduce referrals to abortion services.
- Help service user's access additional services than those offered in primary care or sexual health services such as health promotion material and sign posting where appropriate.
- Assist in the delivery of the Sexual Health indicators in the Public Health Outcomes Framework.

4.1.6 Community Outreach - Sexual Health Promotion and HIV Prevention

The Armistead Centre (service) was established in 1997 as a HIV prevention outreach service for Gay and Bisexual men. Since then it has developed to encompass a range of services for people who identify as Lesbian, Gay, Bisexual and Transgender (LGBT) as well as expanding to meet the needs of those involved in sex work, in particular female street-based sex workers. The service aims to improve the health of these groups with a specific focus on addressing their sexual health needs.

Services are delivered via premises in Liverpool City Centre and via outreach on the commercial gay scene; in community venues; and public sex environments. Additionally mobile outreach is delivered across the city in the areas where Female Street based workers work.

Armistead

The Armistead Centre is a free and confidential sexual health promotion service for Lesbian, Gay, Bisexual and Trans (LGBT) people and for male and female sex workers in Liverpool.

The Armistead Centre also offers an easy access Rapid HIV testing service, consisting of:

- A quick and simple finger prick test
- Same day results in 20 minutes

HIV tests can be arranged/booked via phone call to Armistead or drop in via the HIV testing drop-in session, Wednesday 2.00pm – 3.30pm.

Email: info@armisteadcentre.co.uk

4.1.7 Sahir House

Sahir House is a support and information centre offering a wide range of services to individuals and families living with, or affected by HIV across Merseyside. Liverpool City Council commission Sahir to work with residents of Liverpool and offer support, counselling, advice and signposting to ensure that they feel confident about their diagnosis and how to receive treatment and care. Additionally, they are also responsible for leading a range of campaigns, including World Aids Day, and deliver an array of educational and promotional pieces to help combat stigma.

Sahir can be contacted via a confidential helpline to offer information around safe sex, routes of transmission, local testing facilities and housing/benefit support and advice.

4.2 Specialist Services

4.2.1 Specialist Sexual Health services

Axess Sexual Health – Liverpool University Hospitals Foundation Trust (LUHFT)

LUHFT provide Liverpool's specialist GUM service for STI related treatment and care. This offers access to testing and treatment for all sexually transmitted infections (STIs) including HIV.

The service offers provision of all 3 levels of care in line with BASHH standards, from basic STI testing, screening and partner notification to more complex testing and treatment of MSM, men with dysuria and discharge and STIs at extra genital sites.

All services are offered on a walk in/drop in basis:

- 1st Floor, Royal Liverpool Hospital, Prescott Street, L7 8XP

Website: www.rlbuht.nhs.uk/axess

4.2.2 Termination of Pregnancy Services

4.2.2.1 British Pregnancy Advisory Service (BPAS)

BPAS are commissioned by Liverpool CCG to provide high quality, non-judgemental abortion care for residents of Liverpool. In addition to abortion advice and treatment they provide pregnancy testing, counselling, Sexually Transmitted Infection (STI) screening, contraception, and vasectomy through a network of reproductive healthcare centres nationally. The Merseyside service is based in Aigburth, close to Princes Park and Sefton Park.

Critically BPAS also link in with other local providers to offer a seamless care pathway wherever possible for those women that present to service.

4.2.2.2 Bedford Clinic – Liverpool Women's Hospital (LWH)

Liverpool Women's NHS Foundation Trust runs Liverpool Women's Hospital, a major obstetrics, gynaecology and neonatology research hospital in Liverpool.

The Bedford Clinic is a dedicated NHS outpatient and day care service located within the Liverpool Women's Crown Street site providing a confidential and accessible service including consultations for women seeking a termination of pregnancy.

LWH fully supports choice and provision of a non-judgemental approach in assisting women with their decision regarding their pregnancy. The Bedford Clinic also provides contraceptive advice, advice related to sexual health and on healthy lifestyle choices.

4.2.3 Sexual Assault Referral Centre (SARC) – Safe Place Merseyside

SAFE Place Merseyside is the Sexual Assault Referral Centre for the Merseyside area. The service offers forensic medical examination services for both males and females who have been sexually assaulted.

SAFE Place further offers emergency contraception, preventative treatments for sexually transmitted infections (STI's), including HIV post-exposure prophylaxis (PEP) and advice on screening for STI's at a later date.

SAFE Place also offers a referral mechanism to an independent sexual violence advisor (ISVA) who can help advise around contacting the Police and provide links to counselling services and offers.

The service operates 24 hours a day, 365 days a year.

SAFE Place can be contacted on 0151 295 3550.

4.3 Prevention & Early Identification Services

4.3.1 Young People's Relationships and Sexual Health Education

Liverpool City Council commission a number of services to provide high quality, health promotion information and advice around sexual health, contraception, healthy relationships, sexually transmitted infections, and general health and well-being.

4.3.2 Brook outreach Education

Brook Liverpool has been commissioned to provide high quality, health promotion information and advice around sexual health, contraception, healthy relationships and

general health and wellbeing for young people under the age of 25 who live, study or socialise in Liverpool, so that they are supported to make informed decisions about their sexual health and access sexual health services when necessary.

- Provide evidence-based sexual health promotion information and advice on a wide range of sexual health issues so as to:
 - Increase knowledge and awareness around relationships; sexuality; use of condoms; contraception; the prevention of STIs and unplanned conceptions; termination; adoption etc. as appropriate.
 - Enable Liverpool young people to make safe, informed choices about their sexual and reproductive health.
 - Reduce the stigma associated with STIs, HIV and unplanned conceptions.
- Raise awareness of the service so that all Liverpool residents under the age of 25, and staff working with this cohort, are aware of its accessibility.
- Promote service-specific and key sexual health messages to the local youth population, via the provision of general advertising; press releases about the service, key campaigns, and locally relevant issues; the use of safer sex educational materials; and innovative and appropriate media and marketing techniques tailored to target audiences. This includes, but is not limited to, developing, or supporting the dissemination of local or national campaigns including key Public Health England Sexual Health Campaigns aimed at reducing stigma and promoting inclusivity, at a local and appropriate level.
- Contribute to the on-going development of multi-agency training regarding sexual health promotion.

4.3.3 So to Speak

So To Speak are a young person's health education and outreach service specialising in relationships, sexual health and risk-taking behaviour. The service is hosted by Liverpool Community Health NHS Trust and operates across Liverpool, primarily targeting young people aged 13 -19 years that live, socialise, work or receive education in the Liverpool area, focusing on groups who are more vulnerable to poor sexual health and early parenthood, such as those young people described as NEET (Not in Education, Employment or Training).

So To Speak are commissioned to deliver the following:

- Relationships and sexual health promotion, information and advice in order to promote key sexual health messages; increase knowledge and awareness of

local sexual health services; encourage uptake of contraception provision and STI testing; challenge the stigma associated with STIs, HIV and unwanted pregnancy; and support young people to develop the skills necessary to make informed positive choices about their relationships and sexual health

- Support capacity and capability to deliver relationships and sexual health education (RSHE) / awareness raising across the local health and children's services economy, by providing professionals who work with young people with the information and skills to feel confident and competent to deliver RSHE to young people in their working environment, and signpost to local sexual health services
- Coordinate a young people-friendly condom distribution scheme in community settings that are well used by young people
- Provide ad-hoc access to Chlamydia screening, as part of relationships and sexual health education sessions in community settings

4.3.4 Condom Distribution Scheme

The factors influencing high STI and under-18 conception rates among the UK's young population are manifold. However, one significant factor is the low use of contraception by sexually active teenagers, compared with other European countries. Young people under-16 are the group least likely to use contraception. The reason young people give for this is ignorance about contraception, lack of access to contraceptive services, and lack of confidence in discussing contraceptive use with a partner:

In July 2007, the Department for Education and Skills issued the document 'Teenage Pregnancy Next Steps: Guide for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies'. The document set out key findings from the 'deep dive' reviews carried out by the Teenage pregnancy Unit in 2005 to identify factors that were responsible for the significant variation in performance towards under-18 conception targets across the country. The key factors present in areas that had achieved the greatest reduction in under-18 conception rates were:

- Provision of young people focused contraception / sexual health services, trusted by teenagers, easily accessibility in the right location with opening hours convenient to young people; and with a strong focus on sexual health promotion.
- Condom distribution schemes involving a wide range of local agencies and / or access to emergency contraception in non-clinical settings.
- Targeted work with at risk groups of young people, and in areas with high under-18 conception rates.

Condom distribution schemes offered an opportunity to address each of these factors highlighted in the DfES 'Next Steps' documents.

The Liverpool C-card / R U Ready? scheme, which is coordinated by So To Speak, Liverpool Community Health NHS Trust, aims to:

- To support young people, including identified target groups, to make informed choices about their sexual health
- To promote the Department of Health's 'R U ready' / Lets Leave it Till Later' initiative which aims to support young people to make positive choices about sex and relationships, and to delay early sex, until they feel ready for a sexual relationship.
- To increase the availability, accessibility and acceptability of condoms and information on sexual health issues to young people, thus enabling them to make better-informed choices about their sexual health and practice.
- To raise awareness of STIs and encourage sexually active young people to access the local Chlamydia screening programme.
- To ensure that young people within the target groups who access the scheme are aware of appropriate sexual health services available in the locality.
- To encourage condom use by sexually active young males within identified target groups.

5. Liverpool Demography

5.1 Deprivation

The English Indices of Deprivation 2019 (IMD 2019) combine a range of economic, social and housing indicators to provide the most up to date and comprehensive picture of deprivation in England. They provide a measure of relative deprivation, i.e. they measure the position of areas against each other.

The table below shows the ranking for each Local Authority in the Liverpool City Region for each of the seven domains, in addition to the two sub-domains on income. Results show that Liverpool remains one of the most deprived local authorities in the country, and the City Region is ranked as the most deprived Local Enterprise Partnership areas in England.

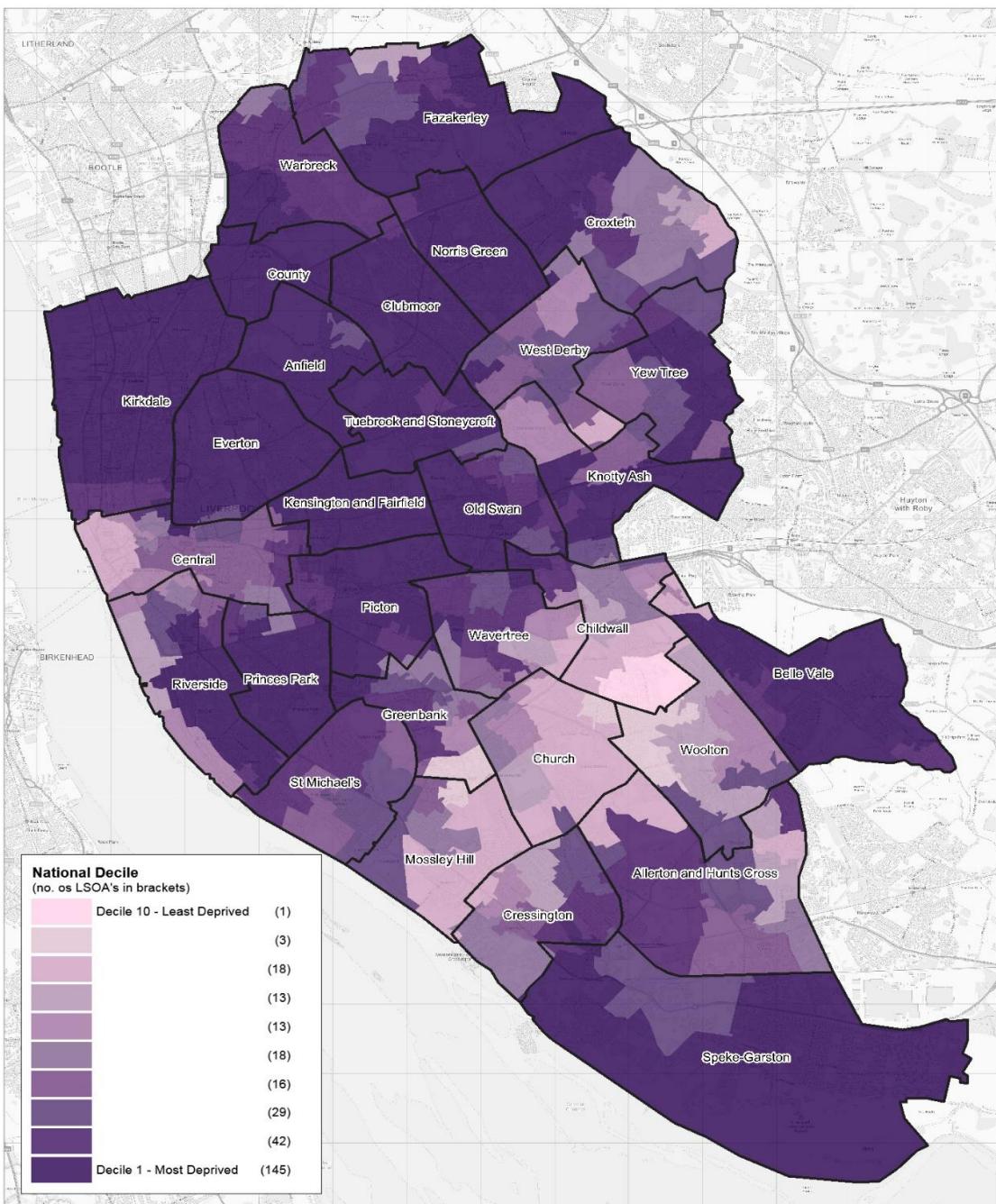
Domain	Liverpool	Halton	Knowsley	St. Helens	Sefton	Wirral	Liverpool City Region
Income	7	22	3	33	30	12	1
Employment	4	30	2	34	55	38	1
Health & Disability	29	56	3	72	140	130	1
Education	43	70	6	94	162	177	6
Barriers to Housing & Services	280	259	229	301	309	313	39
Crime	40	61	99	116	156	184	9
Income Deprivation Affecting Children	4	30	3	33	89	54	1
Income Deprivation Affecting Older People	8	58	11	73	72	76	1

Table 1: Local Authority Rank of Ranks

Source: Indices of Deprivation 2019

Note: Local Authority ranks: 1 = most deprived, 326 = least deprived, Local Enterprise Partnership ranks: 1 = most deprived, 39 = least deprived

A substantial proportion of our local residents live in areas of high deprivation. The severity and extent of deprivation in the city has significant implications for the health and wellbeing of local people, and is strongly associated with poor health outcomes from childhood through to old age. The map opposite shows that levels of deprivation within Liverpool are particularly high in the north of the city, where virtually all of the neighbourhoods are ranked in the most deprived one or ten percent nationally. The map below shows that large areas of Everton, Anfield and Kirkdale are particularly deprived. This concentration of high deprivation also encircles the City Centre, this “inner core” area goes from Everton in the north through Kensington and on to Princes Park and Riverside to the south of the City Centre. Outside of the inner core, Speke Garston, Belle Vale, Croxteth and Norris Green also have some of the highest levels of deprivation in the country.



Index of Deprivation 2019 - Overall Index National Rank Deciles (Decile 1 = Most Deprived)

Date created: April 2020

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5.2 Population Trends

Latest population estimates from the Office for National Statistics show there are currently around 498,042 people living in Liverpool, representing a 12.6% increase in the population since 2009.

Population projections suggest the increase in the number of residents in Liverpool will continue in the medium term, with the number of local residents increasing by a further 50,568 by 2039. It is worth noting that population projections should be treated with a degree of caution.

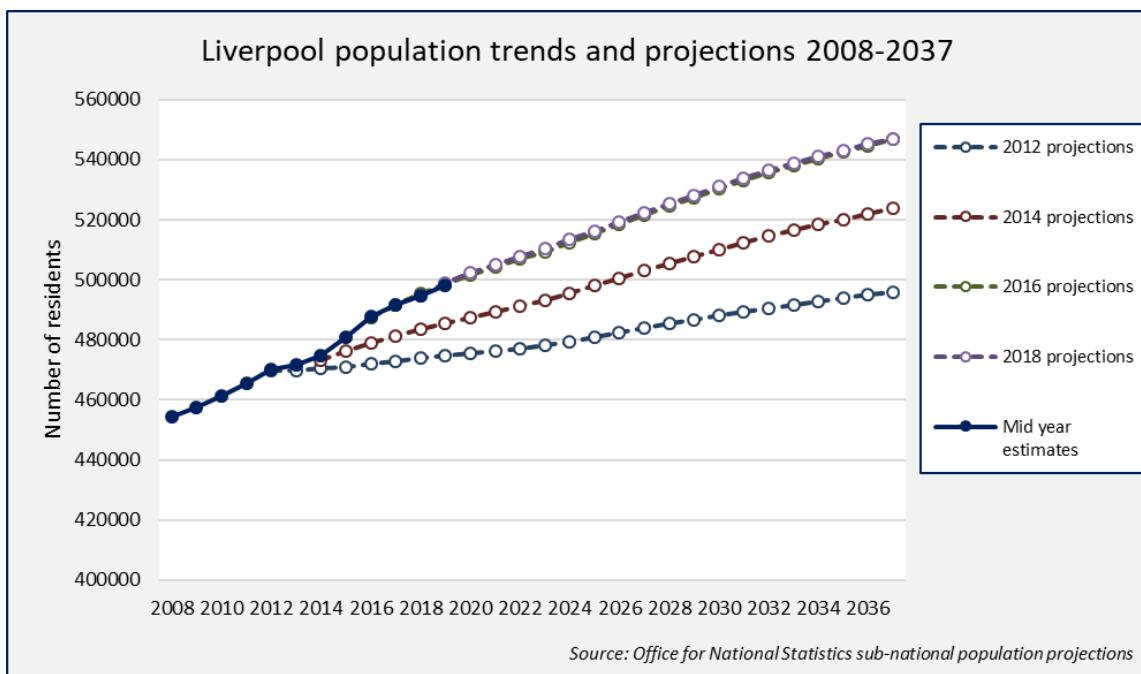


Figure 6: Liverpool Population Projections 2008-2037
Source: ONS, 2019

5.3 Age & Gender – Population Trend

The chart below shows the current population structure of the city. The large 20-24 population is immediately apparent and is reflective of the large student population within Liverpool. There are over 52,000 people in this age group, representing more than 11% of the population. There is also significant variation in the age profile of people across Liverpool, with the average age in Central ward being 26 years, reflecting the large student population in the area, compared to 47 years in Woolton ward.

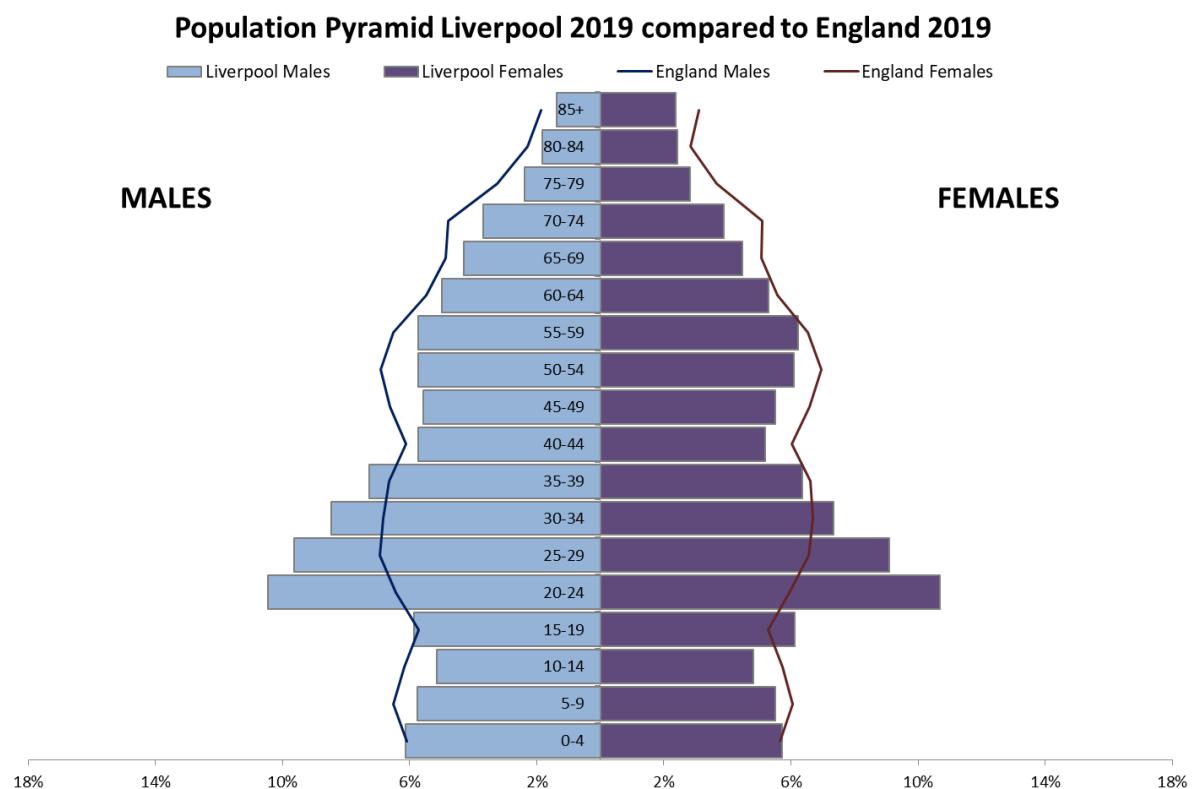


Figure 7: Liverpool population pyramid, 2019

Source: ONS mid-year resident population estimates

5.4 Ethnicity

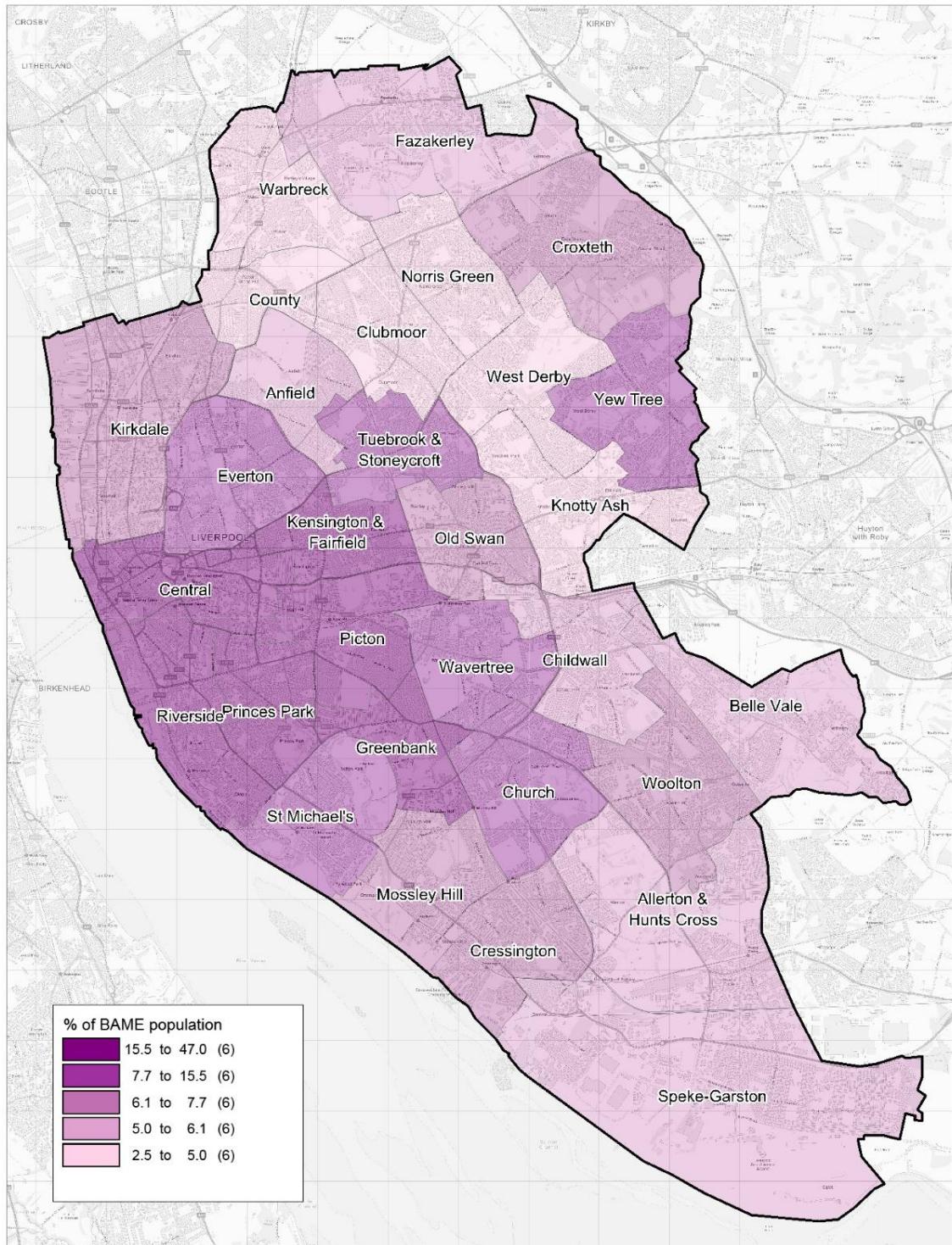
Our local population is becoming increasingly diverse. At the time of the 2001 Census, just under 93% of people in Liverpool identified themselves as being “White - English/Welsh/Scottish/Northern Irish/British”. However, by the time of the 2011 Census this had decreased to 84.8%, with around 1 in 7 of the Liverpool population now classing themselves as part of a minority ethnic group, equating to almost 71,000 residents. The largest minority groups in the city are:

- White Other (including eastern European)
- Black African
- Chinese
- White Irish
- Arab

Ethnic Group	Liverpool		England
	Number	Percentage of Total	
All usual residents	466,415	100.00%	100.00%
White	414,671	88.90%	85.40%
English/Welsh/Scottish/Northern Irish/British	395,485	84.80%	79.80%
Irish	6,729	1.40%	1.00%
Gypsy or Irish Traveller	185	0.00%	0.10%
Other White	12,272	2.60%	4.60%
Mixed/multiple ethnic groups	11,756	2.50%	2.30%
White and Black Caribbean	3,473	0.70%	0.80%
White and Black African	3,164	0.70%	0.30%
White and Asian	2,283	0.50%	0.60%
Other Mixed	2,836	0.60%	0.50%
Asian/Asian British	19,403	4.20%	7.80%
Indian	4,915	1.10%	2.60%
Pakistani	1,999	0.40%	2.10%
Bangladeshi	1,075	0.20%	0.80%
Chinese	7,978	1.70%	0.70%
Other Asian	3,436	0.70%	1.50%
Black/African/Caribbean/Black British	12,308	2.60%	3.50%
African	8,490	1.80%	1.80%
Caribbean	1,467	0.30%	1.10%
Other Black	2,351	0.50%	0.50%
Other ethnic group	8,277	1.80%	1.00%
Arab	5,629	1.20%	0.40%
Any other ethnic group	2,648	0.60%	0.60%

Table 2: Ethnic diversity in Liverpool

Source: 2011 Census



BAME Communities (%) 2011 Census data

Date created: July 2018

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The map below shows that there is a significant concentration of the ethnic minority population in the Princes Park, Picton and Central wards in the city, with far fewer people from minority groups living in neighbourhoods on the periphery of the city.

NB: BAME is an abbreviation for Black, Asian, and Minority Ethnic Groups.

5.5 Sexual Orientation

Sexual orientation usually refers to the emotional, sexual or romantic attraction to a particular gender, to both genders, or to neither gender. There are three standard categories of sexual orientation utilised for monitoring purposes:

- **Heterosexuality** – attraction to the opposite sex
- **Homosexuality** – attraction to the same sex and usually referred to as gay (for both men and women) or lesbians (used for women only)

A recent survey by the Office for National Statistics (2018) estimates that 2.2% of the population is lesbian, gay or bi-sexual (LGB). Regional variations were found in the proportion of adults identifying as LGB, ranging from the highest at 2.8% in London, to the lowest at 1.2% in Northern Ireland. In the North West, the proportion was the same as the UK average (2.1%). It should be noted that the survey's statistics are considered experimental as they have not yet been assessed by the UK Statistics Authority.

Link to survey:

<https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/bulletins/sexualidentityuk/2018#sexual-orientation-by-uk-countries-and-english-regions>

The latest GP patient Survey for England includes a question relating to sexual orientation. The survey indicates that 90% of patients registered with Liverpool General Practices define themselves as being heterosexual / straight, with around 4% stating their sexual orientation as being either Gay, Lesbian, Bisexual or Other (the remaining 5% preferring not to say). This mirrors the national pattern of results.

Results for each Clinical Commissioning Group are available via: <https://gp-patient.co.uk/surveysandreports>

6. High Risk Groups/Vulnerability/Burden of Sexual Ill-Health

The needs assessment process must consider those groups within the population who may have more urgent need than the general population.

As referred to in above sections, the impact of STIs remains greatest in young heterosexuals aged 15 to 24 years, black and minority ethnic (BAME) and MSM. Public Health England (PHE) is conducting and managing a number of initiatives to help address this inequality and locally service provision is, and will increasingly be, targeted at those most in need of support. Liverpool City Council leads continue to

work with providers of sexual health services to make a difference where it is most required.

There are also however a number of other groups in the population who may have hidden needs or difficulties in accessing services. This chapter considers the likely need in these groups based on available data and current services that are available.

6.1 Young People

Young people undoubtedly still bear the burden of sexual ill-health in the population and are very often the target of key interventions to address this issue. It is a widely held view that they are most at risk of STIs and re-infection as a result of more frequent partner change²⁵. Crucially, high quality relationships and sex education (RSE) equips young people with the knowledge and information that they need to make sensible and informed decisions about the sexual health and wellbeing. The introduction of statutory RSE across schools in the UK, including Liverpool, will help us to build a generation of young people who are in control of their wellbeing and critically who know where to go to receive the care and support they need.

The data section(s) look at this in more detail, but the evidence suggests that 15-24 year olds in Liverpool accounted for the greatest proportion of STI diagnoses in sexual health services overall. Similarly there is still much to do in relation to the teenage pregnancy agenda locally, where figures have declined but not at the same rate as seen nationally.

As stated above, there is a large 20-24 population in the city, largely caused by the considerable student population. There are over 52,000 aged 20-24 representing more than 11% of the population, making it critical that services are welcoming, young person friendly and effective at educating and informing our younger generation around how to have positive relationships and stay healthy.

There are a number of University sites located across the city, and so access to care for students staying in those locations (of which a large proportion are centrally placed) is vital.

6.2 MSM

The number of STI diagnoses in MSM has risen sharply in England over the past decade, with MSM continuing to experience high rates of STIs. Several factors may have contributed to this, including condomless sex associated with HIV seroadaptive behaviours and 'chemsex' (the use of drugs before or during planned sexual activity to sustain, enhance, disinhibit or facilitate the experience). More screening of extra-genital (rectal and pharyngeal) sites in MSM using NAATs will also have improved detection of gonococcal and chlamydial infections, although this will have had less impact in recent years as these developments have become more established. As a

result of these sustained increases, MSM remain a priority for targeted STI prevention and health promotion work. HIV Prevention England have been contracted to deliver, on behalf of PHE, a range of activities which include promoting condom use and awareness of STIs, which are particularly aimed at MSM.

Drug and alcohol services and sexual health service providers should meet the specific needs of MSM involved in ‘chemsex’. Joint working between alcohol and drug services and SHSs should be established to ensure an integrated approach to care, including specific treatment pathways for ‘chemsex’ according to need, hepatitis C testing and treatment and hepatitis B vaccination.⁷

6.3 BAME

STIs disproportionately affect black and minority ethnic (BAME) groups and Black Africans populations are disproportionately affected by HIV infection. Nationally it is recognised that more needs to be done to improve access to sexual health services for BAME communities and so future service design and provision needs to carefully consider access for this population (and targeting) or we risk widening sexual health inequalities further in this group.

Circa 700 residents in Liverpool currently receive HIV-related care. Among these, 56.9% were white, 36.0% black African and 1.4% black Caribbean. The concern held locally, and indeed nationally, is that BAME communities are typically far harder to engage and reach, and so accessing clinics, support and testing is not something they ordinarily do. Our online HIV self-sampling service saw around 800 kits ordered for self-testing last year, with only 60 of those going to people in Black African and Black Caribbean populations.

Recent engagement work (identified in section 14.2.1) suggested that there is some lack of understanding in those communities related to testing and treatment options, particularly in relation to HIV. The work further identified that there are effective ways of engaging faith leaders and community leads to encourage self-sampling, digital access and to offer a clinical outreach offer that ensures rapid access to advice, support and point of care (POC) testing in the communities themselves.

6.4 Substance Misuse – Drugs & Alcohol

Drug misuse is a complex issue, both in terms of the law and in relation to its impact, not only on the individual, but also their family, friends and wider society. Drugs can cause significant and cumulative harm, are often highly addictive, and associated with a wide range of issues such as homelessness, family breakdown and criminal activity²⁶.

The way in which we now consume alcohol is changing. Stronger alcoholic drinks, generous home measures and the availability of cheap alcohol result in people consuming more alcohol than they realise and this contributes negatively to our health.

The cost of alcohol to health is significant and continues to rise. Excessive alcohol consumption can lead to dependence and significantly impact on the lives of individuals, their families and friends. When used irresponsibly alcohol has an impact on the levels of crime, violence and anti-social behaviour experienced in our communities whilst also reducing levels of productivity in the workplace.

Alcohol

Estimates of alcohol consumption vary widely, and it is difficult to obtain a true picture of the extent of alcohol misuse. While there are a range of definitions of problem drinking, the figures shown in table 6 below show the estimated number of people drinking using the categories and definitions most commonly used in Liverpool.

Category	Definition	Number of People
Lower risk drinkers	Drink within the recommended alcohol guidelines.	244,987 (74%)
Increasing risk drinkers	Drink above the recommended level which increases the risk of damaging their health.	60,972 (18%)
High risk drinkers	Drink at very heavy levels which significantly increases the risk of causing damage to their health and may have already caused some harm to their health. Higher risk drinkers will have a higher alcohol tolerance, which may make them especially vulnerable to alcohol dependency	23,145 (7%)

Table 3: Prevalence of alcohol misuse in Liverpool

Source: Alcohol Concern²⁷

It is worth noting that the estimates produced by Alcohol Concern potentially underestimate the extent of problem drinking in Liverpool, as surveys can drastically underreport the level of alcohol consumption.

Drugs

The Crime Survey for England & Wales measures the level of drug use in the last month, year, or ever within the persons' lifetime.

The table below applies the prevalence figures from the Crime Survey to the Liverpool population, to give an estimate of the number of people in the city who might be using illicit drugs. These should only be used to give an indication of the prevalence of substance, rather than an exact figure.

Drug	Last	Month	Last	Year	Ever	
	Prevalence	Liverpool Estimate	Prevalence	Liverpool Estimate	Prevalence	Liverpool Estimate
Powder Cocaine	0.9%	4,100	2.3%	10,500	9.7%	44,200
Ecstasy	0.7%	3,200	1.7%	7,700	9.2%	41,900
Cannabis	3.7%	16,900	6.7%	30,500	29.2%	133,000
Any Class A Drug	1.4%	6,400	3.2%	14,600	15.5%	70,600
Any Drug	4.7%	21,400	8.6%	39,200	34.7%	158,100

Table 4: Estimated prevalence of drug use in Liverpool by type

Source: Crime Survey for England & Wales²⁸

While Local Authority Public Health teams are responsible for commissioning both sexual health services (including outreach) and drug and alcohol services, it is important to recognise that for interventions to be truly effective, partnership working is crucial. As recommended across a range of 'vulnerable and high risk group' profiles (notably sex work and ChemSex) it is vital that Public Health, Children's Services, Adult Services, the NHS, Police and other criminal justice agencies, Jobcentre Plus and the Work Programme, and many others, all have a vital role to play.

6.5 Sex Workers

There are studies that reveal sex workers to be at higher risk of poor sexual health outcomes than others. Sex workers also experience vulnerabilities such as violence, rape and sexual assault, homelessness, and drug and alcohol problems that may impact on their sexual health needs.

Findings from the Natsal-3 survey identifies men who pay for sex (MPS) as a bridging population for STIs and concludes that MPS in Britain remain at greater risk of STI

acquisition and onward transmission than men who do not pay for sex. The study estimated that one in 10 of all men reported ever paying for sex.

The concentration of street sex work predominantly lies in the Sheil Road area of Fairfield. It is estimated that around 100 women have worked in the area, and/or are known to services and receiving interventions and support of some kind. Sexual Health services have further identified and worked with those who have taken their services online, attempting to reach and support via various social media/netreach work.

Locally we have a range of services able to deliver a blend of sexual health testing, advice, support, counselling and harm reduction and it is important that future provision in the city sees these offers become even more aligned in their approaches.

Whilst the vulnerabilities of street sex workers are significant and often complex, it is important also to hear the community voice. The impact of street sex work activity on people who live and work in that area can be life changing. In some areas of Kensington street sex work can be seen clearly in daylight hours, in cars, on streets, in vegetation outside houses, in parks and near schools. As well as witnessing the activity, local young people and adults are propositioned directly, and the detritus of sex work (used condoms and wet wipes) litter their gardens and where they walk. It can lead to a fear of going out, families moving away from the area, inability to use the park (which may be their only green space they have access to) and a concern that people are desensitised to it. There are links to drug taking. Naturally the police do conduct police operations when reports come in, but this is not a solution to the problem and is resource intensive and short term. Whilst many residents are sympathetic to the plight of the street sex workers, they will tolerate only certain levels and types of behaviour before the social and economic impact on the area becomes inescapable. It is therefore critical that the council continues to work with its partners to develop a longer-term managed solution to the street sex scene in Liverpool, and that local services delivering interventions, support and harm reduction provision link closely to ensure holistic joined up care. Ideally, all services will be able to respond and work outreach wherever any future 'designated area' or 'managed zone' might be situated.

6.6 Mental Health & Wellbeing – stigma, fulfilment, assault, post abortion, support needs

Sexual health is defined by the World Health Organisation (WHO) as 'a state of physical, emotional, mental and social well-being in relation to sexuality'²⁹. As highlighted in the national Mental Health strategy, 'No health without mental health,' (DH, 2011)³⁰, it is important to consider both the cause and effect of mental health on an individual's overall sexual health and wellbeing in particular the impact of stigma and discrimination, and mental health support following sexual violence or termination of pregnancy.

The prevalence of mental health problems in England is significant. At least one in four people will experience a mental health problem at some point in their life³¹ and at any one time, one in six adults report a mental health problem or issue in any given week³².

Latest Liverpool statistics and issues are highlighted in the infographic overleaf:

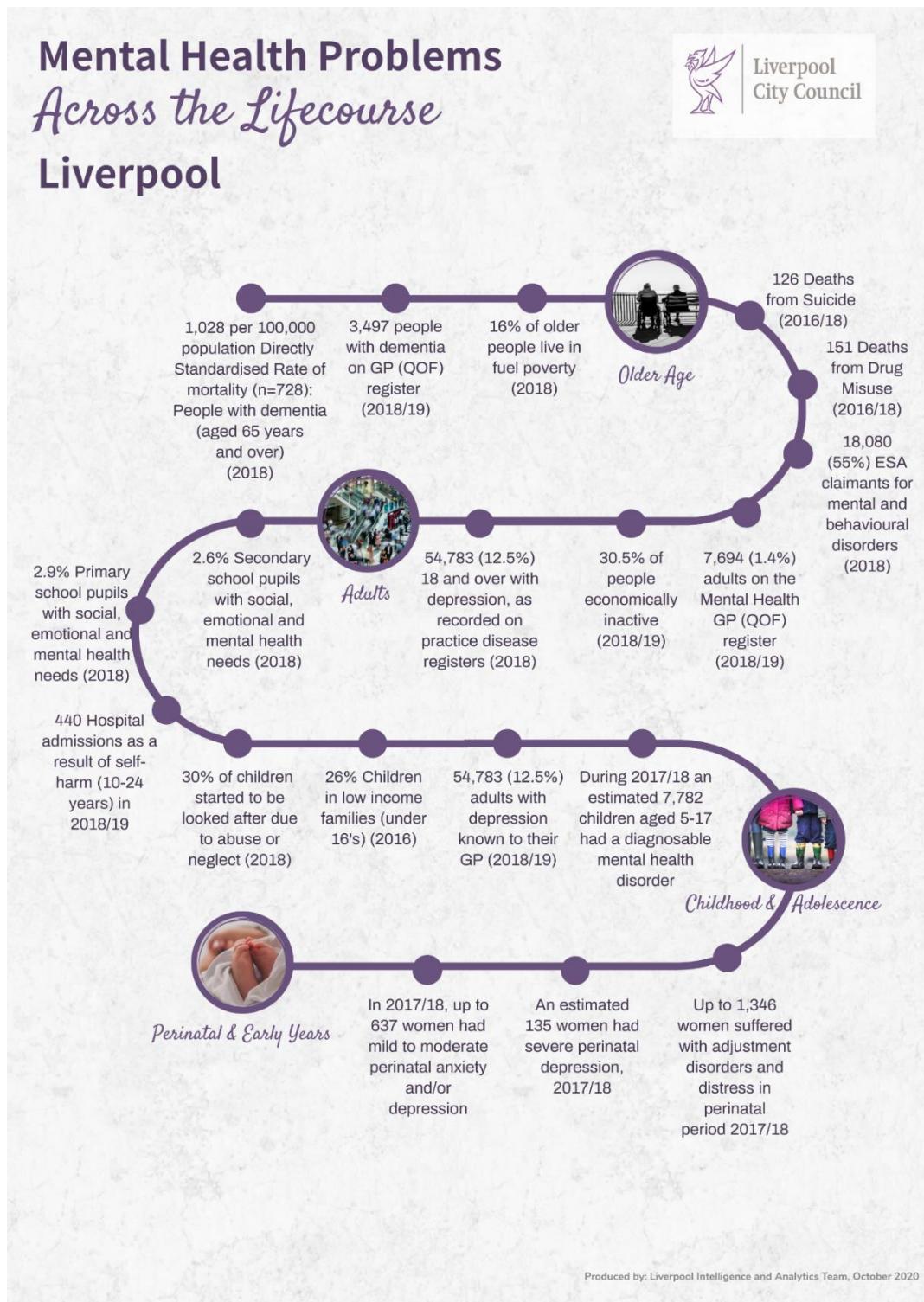


Figure 8: Mental Health Problems across the Lifecourse
Source: Liverpool Intelligence & Analytics Team, October 2020

6.6.1 Stigma and Embarrassment

Stigma is still associated with poor sexual health. Feelings of embarrassment or fear of being judged stop some people from getting information or from asking for early help. This can have a very real impact³³. Discrimination resulting from sexual health status can have an effect on quality of life and mental health.

Stigma linked to HIV can deter people from getting tested and accessing their treatment. If STIs, including HIV, are not diagnosed and treated early, there is a greater risk of onward transmission to uninfected partners, and a greater risk that complications might occur for the person diagnosed.

Equally, not accessing and using contraception when required significantly increases the risk of unintended pregnancy and can therefore result in significant personal cost and trauma to both those women attending for an abortion and to the NHS budget. Timely access to high quality contraceptive provision, support and advice is vital.

Furthermore, there are some healthcare professionals who feel embarrassed to offer an HIV (or STI) test, even if a patient is presenting with possible symptoms.

Therefore additional work is needed to reduce the stigma associated with accessing sexual health services to increase timely diagnosis and treatment which will reduce the likelihood of complications from unwanted pregnancy, STIs and HIV.

6.6.2 Victims of Sexual Assault

Sexual Assault and Referral Centres (SARCs) aim to promote recovery and health following a rape or sexual assault, whether or not the victim wishes to report it to the police. A SARC typically provides specialist clinical care and follow-up to victims of acute sexual violence, including sexual health screening and emergency contraception, usually in one place, regardless of gender, age, ethnicity or disability.

In addition, victims can choose to undergo a forensic medical examination if they want. Additional ongoing mental health support may be desired or needed (for example counselling) following an incident of sexual assault. There are services available to Liverpool residents in relation to Sexual Assault (detailed in services section), and any newly designed integrated system and model will have counselling and support in relation to this issue built into its core.

Breakdown by local authority of residence of the client accessing SARC locally is not available due to potentially patient identifiable information.

6.6.3 Post Abortion Counselling and Support Needs

Every woman will experience different feelings and emotions after an abortion, and some will require additional support. While research indicates that having an abortion does not lead to long-term emotional or psychological problems, some women will benefit from counselling to discuss how they are feeling. Provision should be made for post-abortion counselling, particularly within abortion services and for those with a diagnosed mental health condition.

6.7 Disability

The sexuality of people with disabilities is often ignored, neglected or stigmatised by society. People with disabilities have the right to sexual health and wellbeing and should be acknowledged as sexual beings. All practicable steps should be taken to help a person make a decision, which includes decisions about sexuality.

Ongoing relevant and practical relationships and sex education (RSE) for people with disabilities is crucial to their sexual and emotional development. People with disabilities can be more vulnerable to sexual abuse and require protection in these circumstances. A 2015 report³⁴ found that young people with learning disabilities are vulnerable to child sexual exploitation due to factors that include 'overprotection, social isolation and society refusing to view them as sexual beings'. The research also found that significant numbers of children with learning disabilities are not being adequately protected due to a lack of specialist services and a failure to implement existing national and local policies.

Safeguarding processes acknowledge and take account of the needs of people with learning disabilities. Local SRH services have excellent safeguarding capability and provide support and training on the issue locally and nationally. As commissioner of any future integrated SRH provision city-wide, Liverpool City Council should use its role to ensure that other services working with people with learning disabilities across the health and social care system receive appropriate safeguarding training. Public health prevention principles will be built into the core of any newly procured integrated sexual health service, with expectation placed upon providers to Make Every Contact Count (MECC) via an effective training and communications plan.

Staff working with and caring for people with disabilities should:

- Respect the confidentiality and privacy of the individual's sexual expression as far as possible
- Take a holistic view of sexuality to encompass sensuality and intimacy
- Place focus on the needs of the individual rather than on the disability

The training and support needs of people working with and caring for people with disabilities must be addressed. There is a need for clear policies and guidance for professionals working with people with disabilities in the field of sexual health and relationships. Sexual health professionals and services should meet the practical, emotional and physiological needs of people with disabilities.

6.8 Homelessness

Homelessness is a social determinant of health associated with severe poverty, adverse health, education and social outcomes, particularly for children. To be deemed statutorily homeless a household must have become unintentionally homeless and must be considered to be in priority need. Households that are accepted as being homeless or are in temporary accommodation can have greater public health needs than the population as a whole. As such, statutorily homeless households contain some of the most vulnerable and needy members of our communities. Preventing and tackling homelessness requires sustained and joined-up interventions by central and local government, health and social care and the voluntary sector.

There are currently circa 700 people listed as homeless and in priority need across the Liverpool City Region, with 187 of these situated in Liverpool. Homeless people are at increased risk of STIs and unwanted pregnancies and can come under pressure to exchange sex for food, shelter, drugs and money³⁵. This pressure means they may also be members of the other vulnerable groups as previously discussed, hence the need to ensure services are accessible to this group.

Key recommendations for vulnerable groups:

- Sexual Health Services should offer MSM vaccination against Hepatitis A and Hepatitis B
- Sexual health providers should support work to make MSM aware of sexually transmissible enteric infections such as Shigella
- It is critical that local services share information and offer a wide range of support to sex workers to minimise risk and harm.
- It is vital that the local authority continue to work with its partners with the aim of finding a ‘designated and manageable area’ in the city where street sex can be controlled
- Drug and alcohol services and sexual health service providers should meet the specific needs of MSM involved in ‘chemsex’. Joint working between alcohol and drug services and SHSs should be established to ensure an integrated approach to care, including specific treatment pathways for ‘chemsex’ according to need, hepatitis C testing and treatment and hepatitis B vaccination
- Provision should be made for post-abortion counselling, particularly within abortion services and for those with a diagnosed mental health condition.

7. Liverpool Data - Sexual & Reproductive Health (SRH) Profile

This section provides an overview of the sexual & reproductive healthcare data relevant to Liverpool.

7.1 Sexually transmitted infections

Sexually transmitted infections (STIs) are often asymptomatic and, when left untreated can result in significant long-term consequences, including infertility and ectopic pregnancy. Genital warts, hepatitis A and hepatitis B are all preventable by vaccination, however the control of other STIs relies heavily on individuals' behaviour. Healthy sexual behaviour, which reduces STI transmission, includes consistent and correct condom use, fewer sexual partners who do not overlap, regular testing and treatment, and partner notification and testing.

Nearly 6,000 new STIs were diagnosed in Liverpool in 2018, at a rate of 1,212 per 100,000 people. After excluding chlamydia in 15-24 year olds (the most prevalent STI in the riskiest age group), this rate lowers to 1,123 per 100,000 but is still significantly higher than in both England and the North West. Although this rate has remained fairly constant in recent years, Liverpool ranks in the top 20% of English local authorities for new STI diagnoses excluding chlamydia in 15-24 year olds. It is also high when compared to the other seven English Core Cities (the largest outside of London); only Manchester and Bristol are higher than Liverpool.

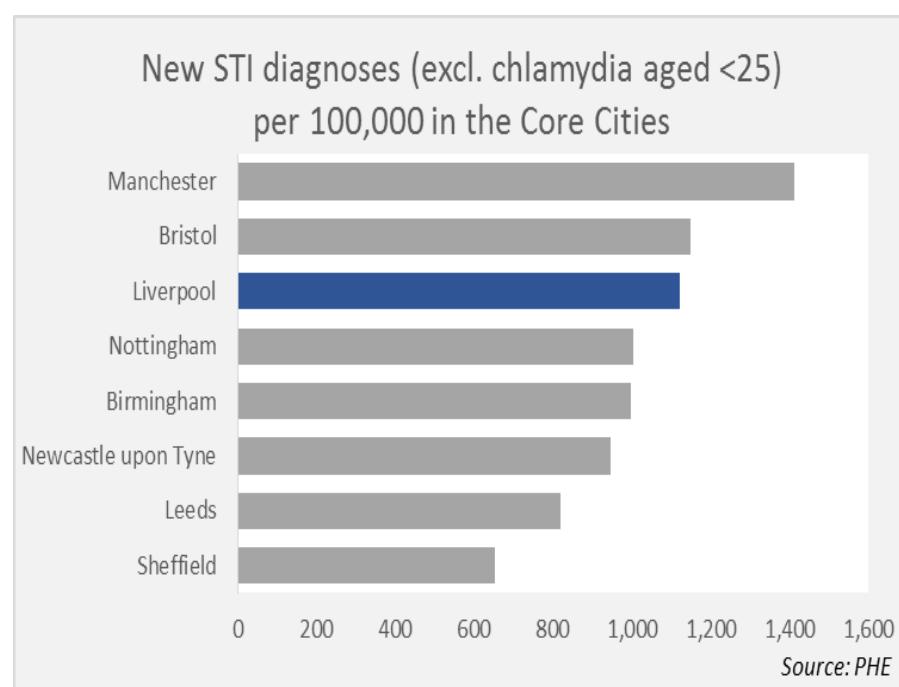


Figure 9: New STIs diagnoses (excluding chlamydia among young people aged under 25 years), 2018
Source: Liverpool Intelligence & Analytics Team, October 2020

Chlamydia is by far the most common STI in Liverpool, much higher than in England and the North West, reflecting the large student population in Liverpool. Chlamydia is followed by genital warts, gonorrhoea, genital herpes, then syphilis, all of which are higher than in England and the North West. High levels of gonorrhoea and syphilis are markers of risky sexual behaviour.

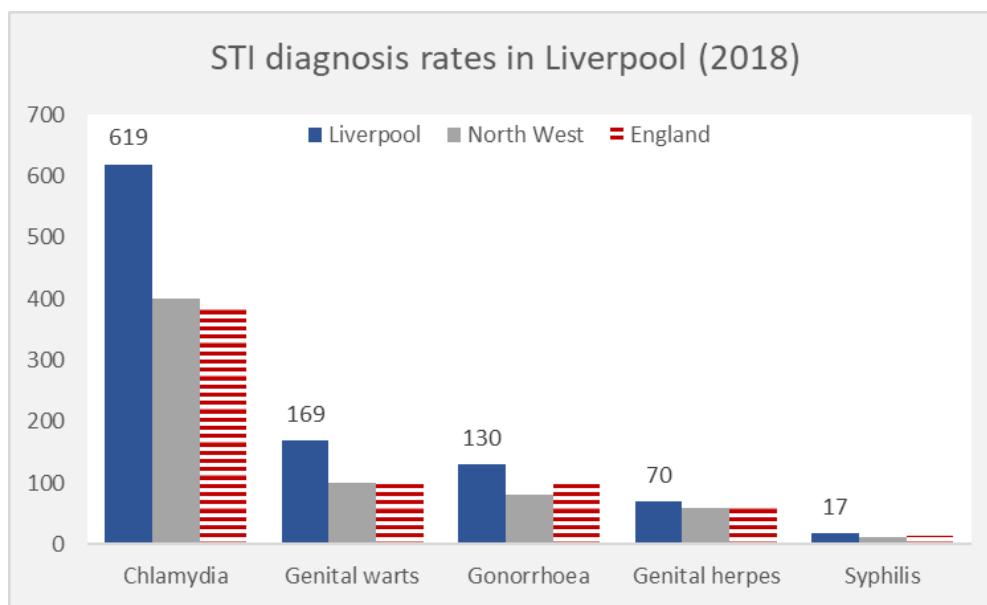
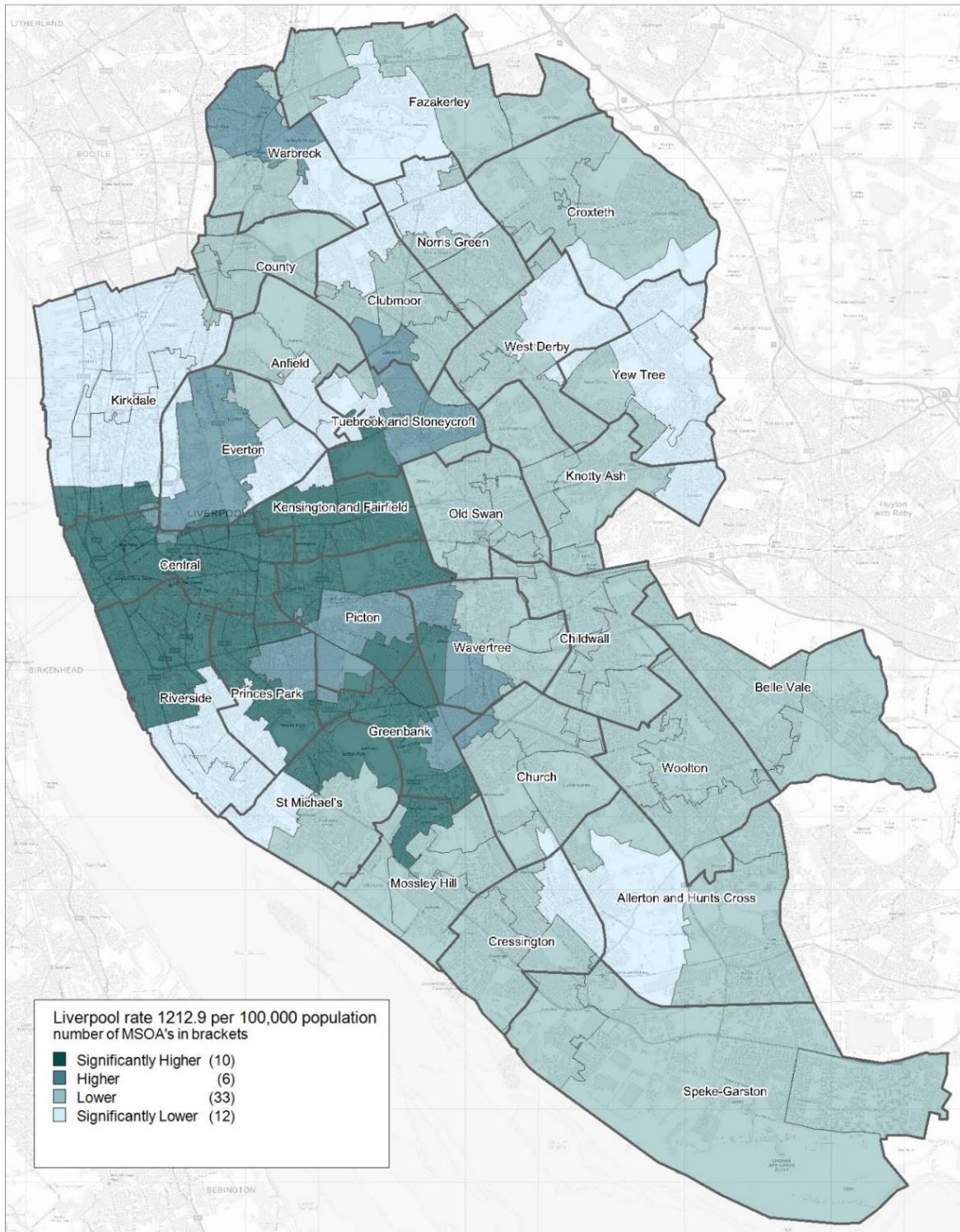


Figure 10: STIs diagnosis rates in Liverpool, 2018
Source: Liverpool Intelligence & Analytics Team, October 2020

New STI diagnoses are particularly concentrated around the Central, Kensington & Fairfield, Princes Park, Greenbank, and Riverside areas of Liverpool.



All new STI diagnosis rate, statistical Significance compared to Liverpool Rate, Middle Super Output Area level

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7.1.1 Gonorrhoea & syphilis

Although the new STI diagnosis rate has not changed much in Liverpool, trends of gonorrhoea and syphilis diagnoses suggest that risky sexual behaviour is on the rise, both locally and nationally. Both STIs have increased considerably over the last decade. This has been particularly stark in Liverpool, with a 125% and 302% increase respectively between 2012 and 2018. In 2018 there were 130 cases of gonorrhoea and 17 cases of syphilis per 100,000 people in Liverpool, both significantly higher than in England and the North West. This suggests that Liverpool has particularly high levels of risky sexual behaviour.

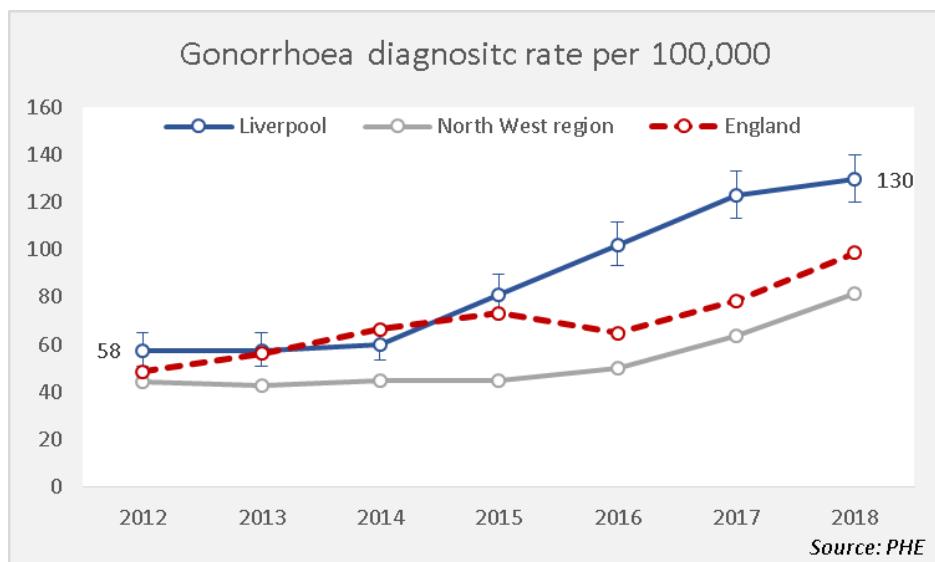


Figure 11: Gonorrhoea diagnostic rates in Liverpool, 2012 - 2018

Source: Liverpool Intelligence & Analytics Team, October 2020

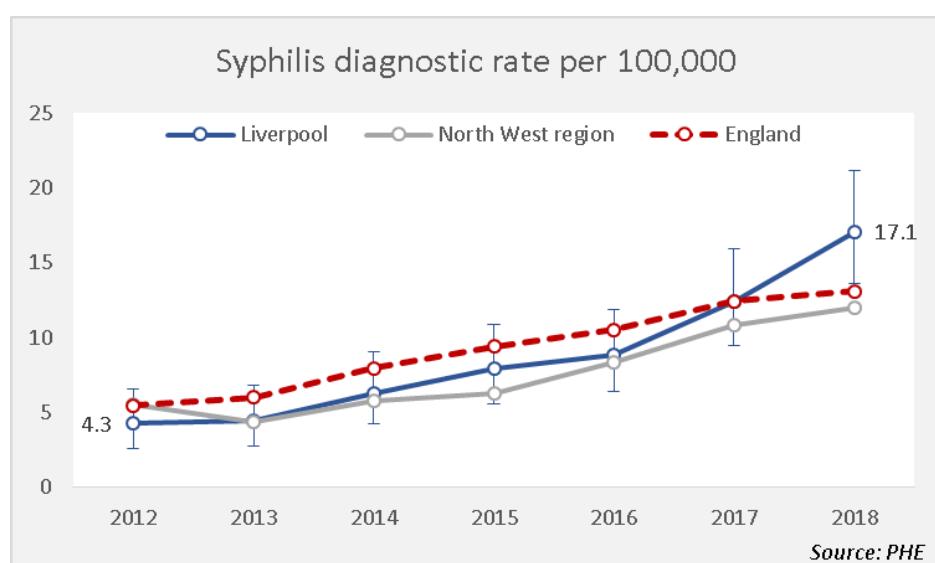


Figure 12: Syphilis diagnostic rates in Liverpool, 2012 - 2018

Source: Liverpool Intelligence & Analytics Team, October 2020

High levels of gonorrhoea transmission are of particular concern given the emergence of gonococcal resistance, including high-level resistance to azithromycin (HiLAzi-R). Cases of HiLAzi-R among heterosexuals were initially identified in Leeds but spread across England into sexual networks of MSM as the outbreak continued. Additionally, the first detected case of extensively drug resistant *Neisseria gonorrhoea* with resistance to ceftriaxone and high-level resistance to azithromycin, the two antibiotics currently used as first-line dual therapy, was detected in the UK in March 2018.

7.1.2 Chlamydia

Diagnoses of chlamydia, the most common STI across the UK, are also on the rise and are also significantly higher in Liverpool than in England and the North West. The diagnosis rate in Liverpool's 25+ population currently sits at 277 per 100,000, a 56% increase on the rate in 2012. This is a much larger increase than has been seen in England (31%) and the North West (26%).

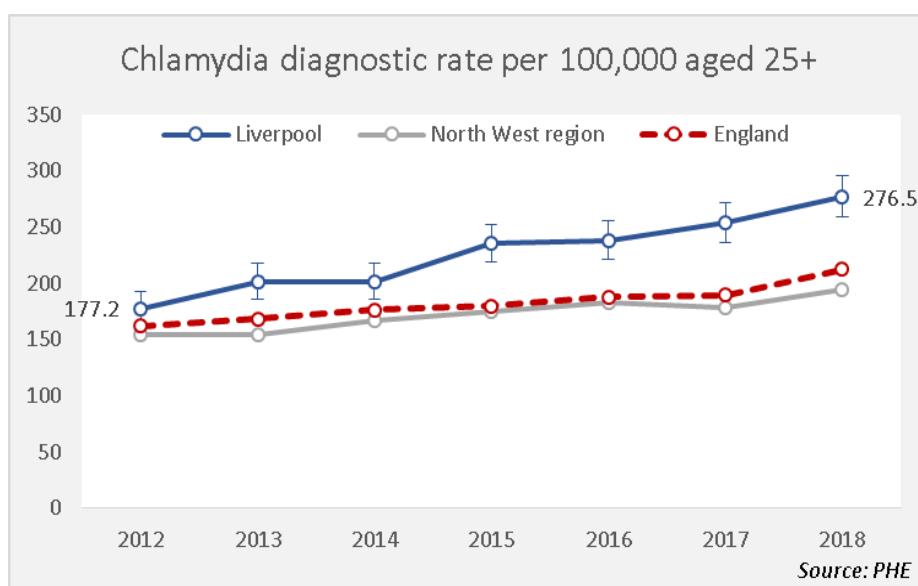


Figure 13: Chlamydia diagnostic rates in Liverpool among persons aged 25+ years, 2012 - 2018
Source: Liverpool Intelligence & Analytics Team, October 2020

7.1.2.1 National Chlamydia Screening Programme

Chlamydia diagnoses in young people aged 15-24 are substantially higher than any other STI in any other age group. The National Chlamydia Screening Programme (NCSP), established in 2002, aims to control chlamydia through early detection and treatment of asymptomatic infection in those aged under 25. It also aims to normalise the idea of regular chlamydia screening among young adults so they expect to be screened annually or when they change partner.

PHE recommends that local areas achieve a detection rate of at least 2,300 per 100,000 15-24 year olds, a level which is expected to produce a decrease in chlamydia prevalence. This reflects both good coverage and a high proportion of people testing positive and is not a measure of prevalence.

In 2018, the detection rate in Liverpool was 2,557 per 100,000 aged 15-24, significantly higher than in England and the North West. This has been rising since 2015 and exceeded the national target in 2017. This is opposite to the North West which has seen a steady decline in chlamydia detection rates since 2015. Liverpool's high detection rate reflects the successful identification of this common bacterial infection.

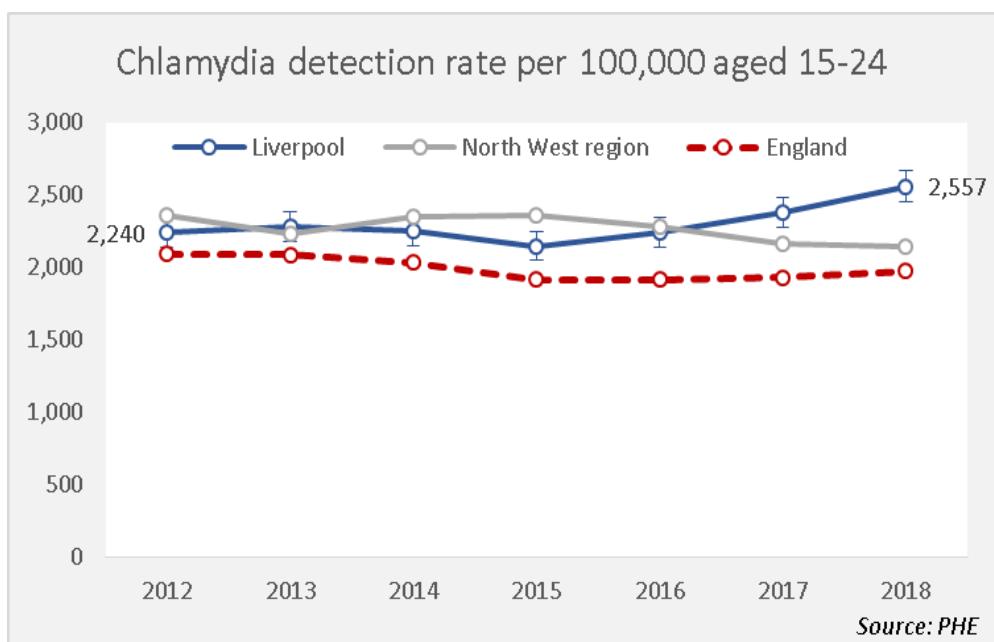


Figure 14: Chlamydia diagnostic rates in Liverpool among persons aged 15-24 years, 2012 - 2018
Source: Liverpool Intelligence & Analytics Team, October 2020

Recommendation: Ensure the present high chlamydia detection rate is maintained or increased.

Screening Volume:

In both England and the North West, the proportion of 15-24 year olds being screened for chlamydia has been falling since at least 2012. In Liverpool however, the proportion screened has stayed relatively constant, sitting at 25% in 2018, with 10.3% testing positive, higher than England's 9.7%. This might explain why Liverpool has exceeded the national target for chlamydia detection while England and the North West have not.

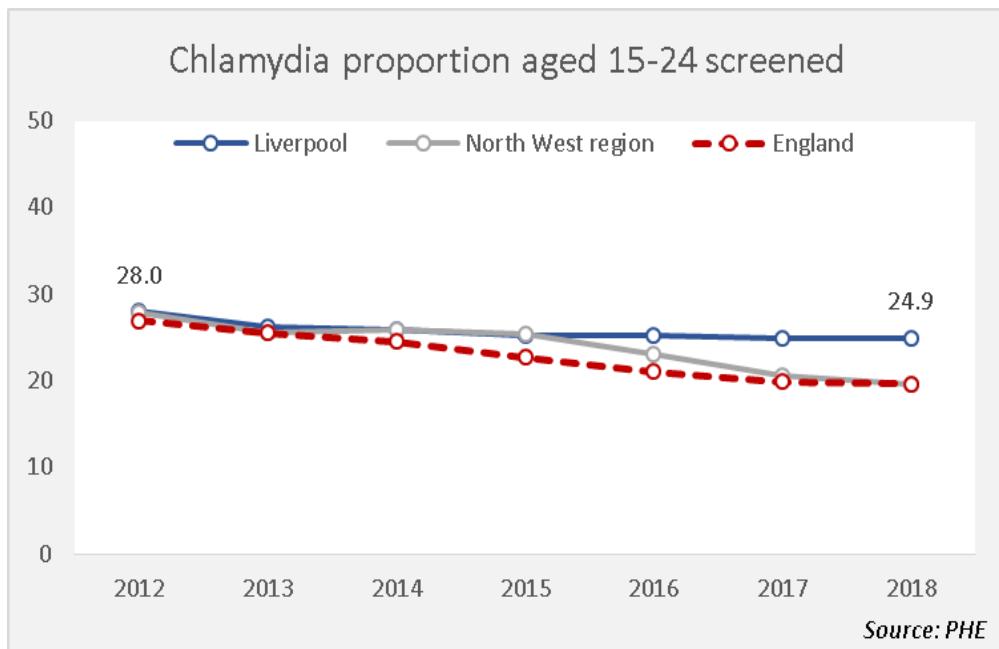


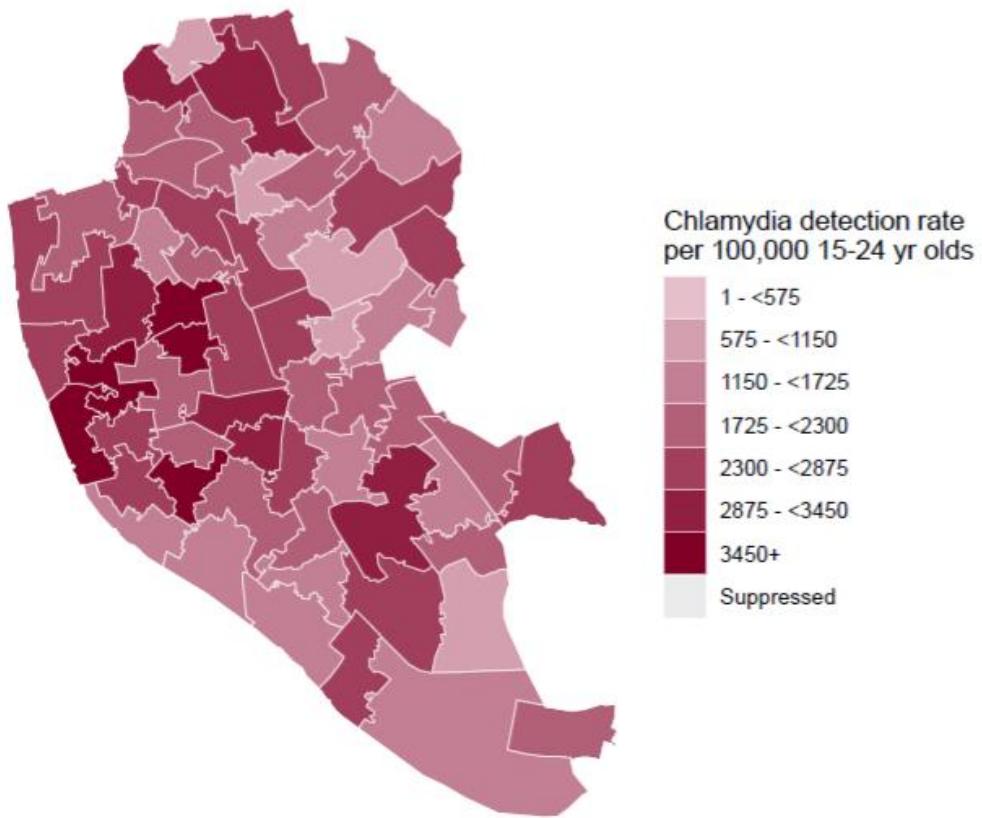
Figure 15: The proportion of 15-24 year olds being screened for chlamydia, 2012 - 2018
Source: Liverpool Intelligence & Analytics Team, October 2020

Recommendation: Maintain at least the present proportion of young people screened for chlamydia locally to allow for the ongoing effective diagnosis of infection in the local population.

Recommendation: Couple the robust screening and detection rates seen across the city with timely partner notification with the aim of reducing the prevalence of infection in young people city-wide.

NCSP detection rates vary across Liverpool. This may represent differences in prevalence, but are influenced by screening coverage and whether most at risk populations are being reached (i.e. proportion testing positive). The fact that Liverpool has exceeded the national target and that our positivity rate is higher than England suggests that chlamydia tests are better targeted in Liverpool.

Please note that this data is not available on the online Sexual and Reproductive Health profiles. Data is sourced from the CTAD Clamydia Surveillance System (CTAD).



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Figure 16: Map of chlamydia detection rate per 100,000 population 15-24 years in Liverpool by Middle Super Output Area (MSOA) (2018)

7.1.3 Genital warts & genital herpes

Unlike the previous STIs, genital warts diagnoses are decreasing both locally and nationally, particularly in younger age groups, demonstrating the success of the national HPV vaccination programme aimed at girls and boys in school year 8 [see section **Error! Reference source not found.**]. Genital herpes diagnoses have fluctuated in Liverpool in recent years but are generally on the decrease. In Liverpool, there were 169 cases of genital warts and 70 cases of genital herpes per 100,000 people in 2018, both significantly higher than in England and the North West.

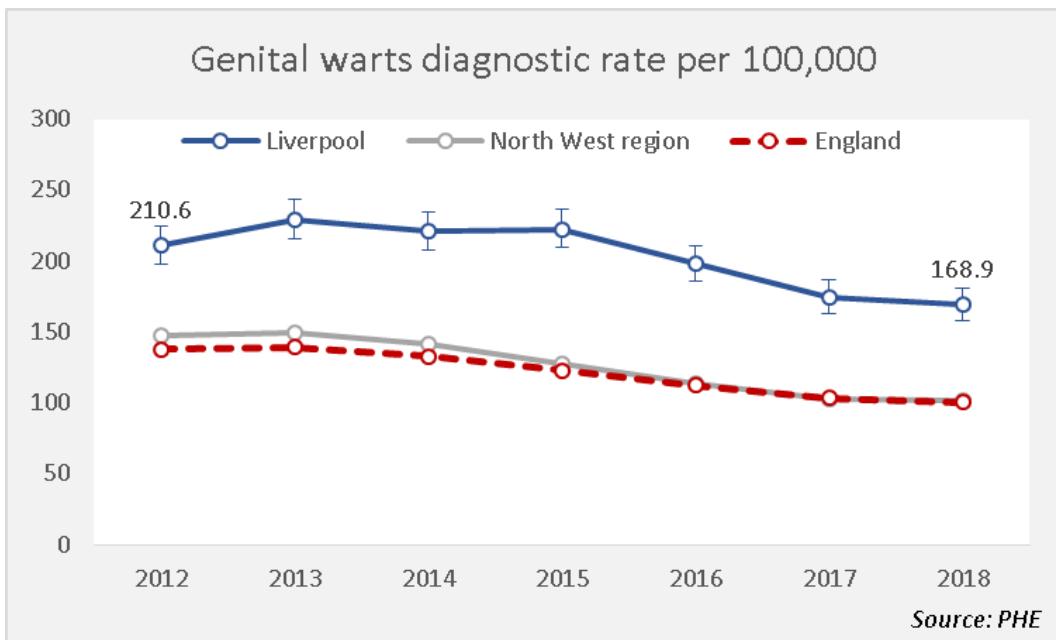


Figure 17: Genital warts diagnostic rates, 2012 - 2018
Source: Liverpool Intelligence & Analytics Team, October 2020

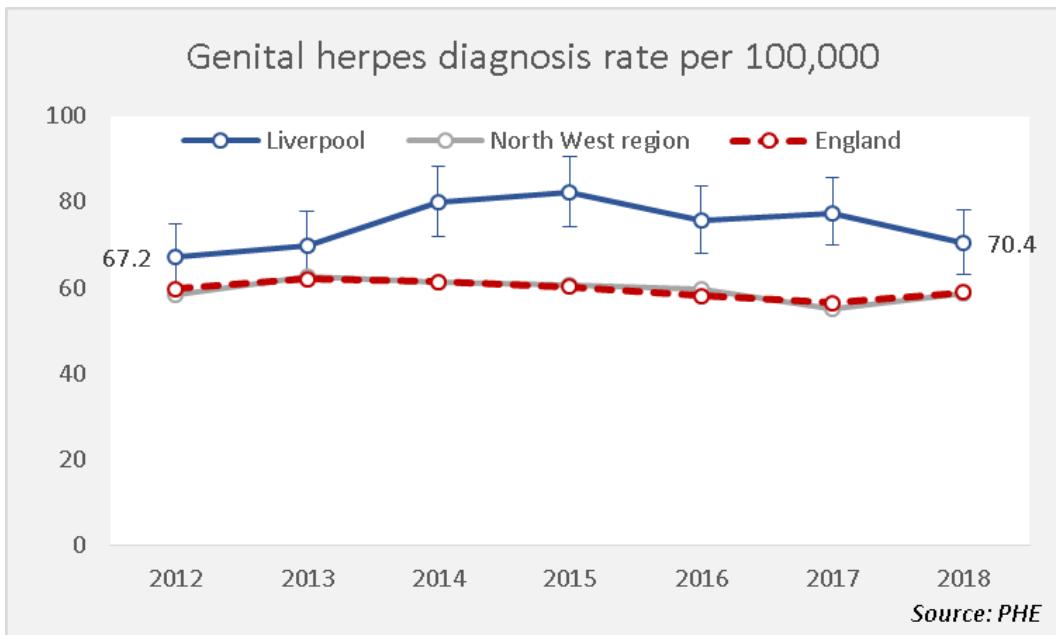


Figure 18: Genital herpes diagnostic rates, 2012 - 2018
Source: Liverpool Intelligence & Analytics Team, October 2020

7.1.4 Reinfection of STIs

Reinfection with an STI is a marker of persistent risky sexual behaviour. In Liverpool, an estimated 6.3% of women and 10.2% of men presenting with a new STI at a sexual health service between 2014 and 2018 became re-infected with a new STI within 12

months. Gonorrhoea re-infection is lower than this at 2.8% of women and 9% of men. With new STI rates also higher in men, this suggests that men are more likely to engage in risky sexual behaviour and persist in this way.

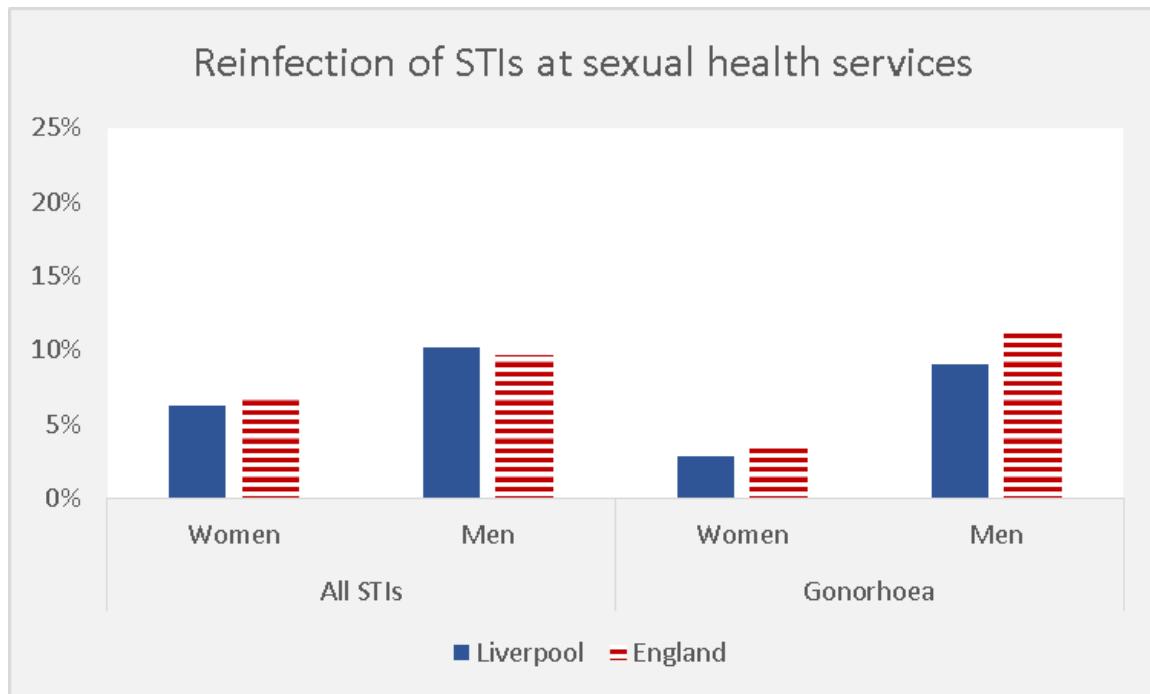


Figure 19: Reinfection of STIs within 12 months by gender, 2018
Source: Liverpool Intelligence & Analytics Team, October 2020

7.1.5 Partner notification

Partner notification is a vital tool in preventing the onward transmission of STIs. By tracing, contacting and treating as many partners associated with a positive case as we can, we have a far greater chance of directly reducing the levels of infection present in the population.

In relation to screening, and subsequent partner notification (follow up), local areas should focus on those services that serve populations with the highest need based on positivity to improve detection. Services need to ensure that an effective, high quality patient pathway is in place with treatment and partner notification standards being met. Providing appropriately timed re-testing in line with guidance is also critical to the whole partner notification and infection/re-infection process. The national standards suggest that ideally, to control and prevent onward spread of infection, on average 0.6 cases per index for Chlamydia and 0.4 cases per index for Gonorrhoea should be achieved to make an impact on prevalence (in large conurbations)⁵.

⁵ BASHH Standard 4 (Clinical management) (2019); NCSP Standard 4 (Result notification and treatment) (2017)

Due to the fragmentation of the system locally it has not been clear how services combine in performance across the city in relation to partner notification and follow up (PN rates). Each service provides an insight into how effective they are at contacting partners and treating, however it is known that there is a risk locally that no single service owns the task of joining up PN across the system and hence this is a reporting and knowledge gap. A future, more integrated sexual health system would undoubtedly allow local rates to be assessed and for us to become even more effective at contacting, screening and treating positive partners.

Recommendation: Ensure effective Partner Notification targets and outcomes are built into any future new integrated service design to improve our ability to assess local performance

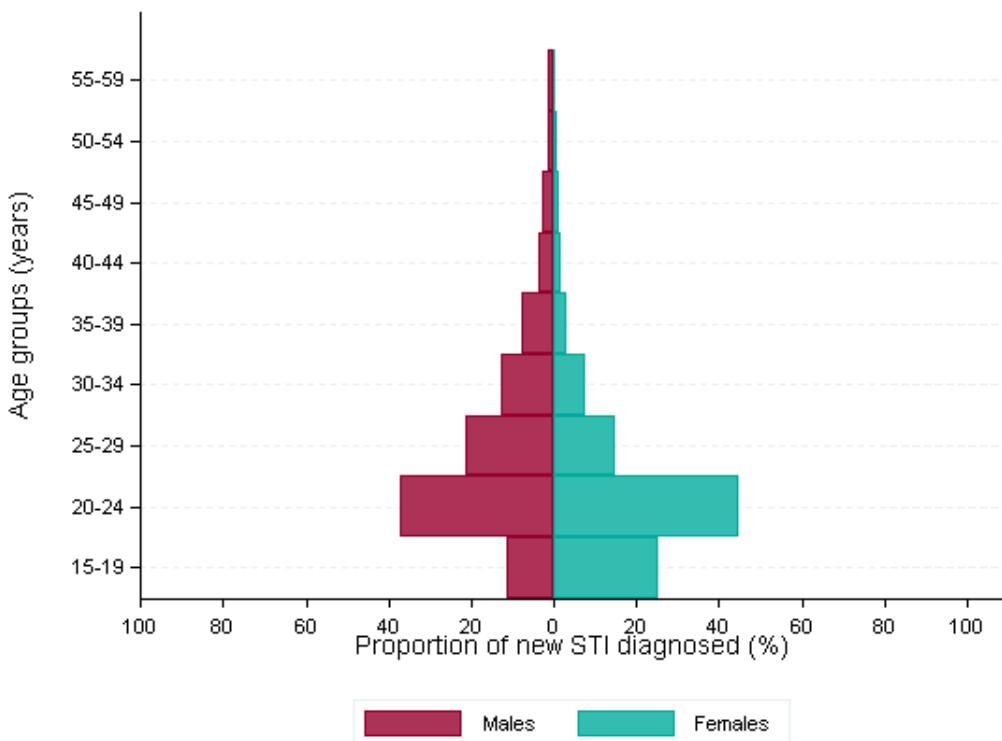
Recommendation: Make one single service, via integration, responsible for all partner notification and subsequent treatment to be more effective at preventing onward spread of infection

7.1.6 High risk group data

The burden of STIs continues to be greatest in young people, MSM and black ethnic minorities. Of all age-groups, the highest STI diagnosis rates in England are in young people aged 15-24 years.

7.1.6.1 Young people

In Liverpool 15-24 year olds accounted for 59% of diagnoses in sexual health services in 2018. This group are also most likely to become re-infected with STIs, contributing to infection persistence and health service workload. In Liverpool an estimated 8.2% of 15-19 year old women and 13.2% of 15-19 year old men presenting with a new STI at a SHS between 2014 and 2018 became re-infected with an STI within 12 months. Teenagers may be at increased risk of re-infection because they lack the skills and confidence to negotiate safer sex.



Source: Data from routine specialist and non-specialist sexual health services' returns to the GUMCAD STI Surveillance System and routine non-specialist sexual health services' returns to the CTAD Chlamydia Surveillance system. *Please note that to prevent deductive disclosure the number of STI diagnoses has been rounded up to the nearest 5.

Figure 20: Proportion of new STIs diagnosed by age group and gender in Liverpool (2018)
Source: Public Health England

7.1.6.2 Gay, bisexual and other men who have sex with men (MSM)

Over the last decade, the number of STI diagnoses in MSM has risen sharply in England. Several factors may have contributed to this, including condom-less sex associated with sero-adaptive behaviours and 'chemsex' (the use of drugs before or during planned sexual activity to sustain, enhance, disinhibit or facilitate the experience).

In Liverpool, for cases in men where sexual orientation was known, 28.1% of new STI diagnoses in 2018 were MSM. This is a slight decrease on the previous year but, the proportion of men with chlamydia and genital warts who identify as MSM is continuing to rise. MSM also accounted for 35% of all gonorrhoea diagnoses and 71% of all syphilis diagnoses in Liverpool.

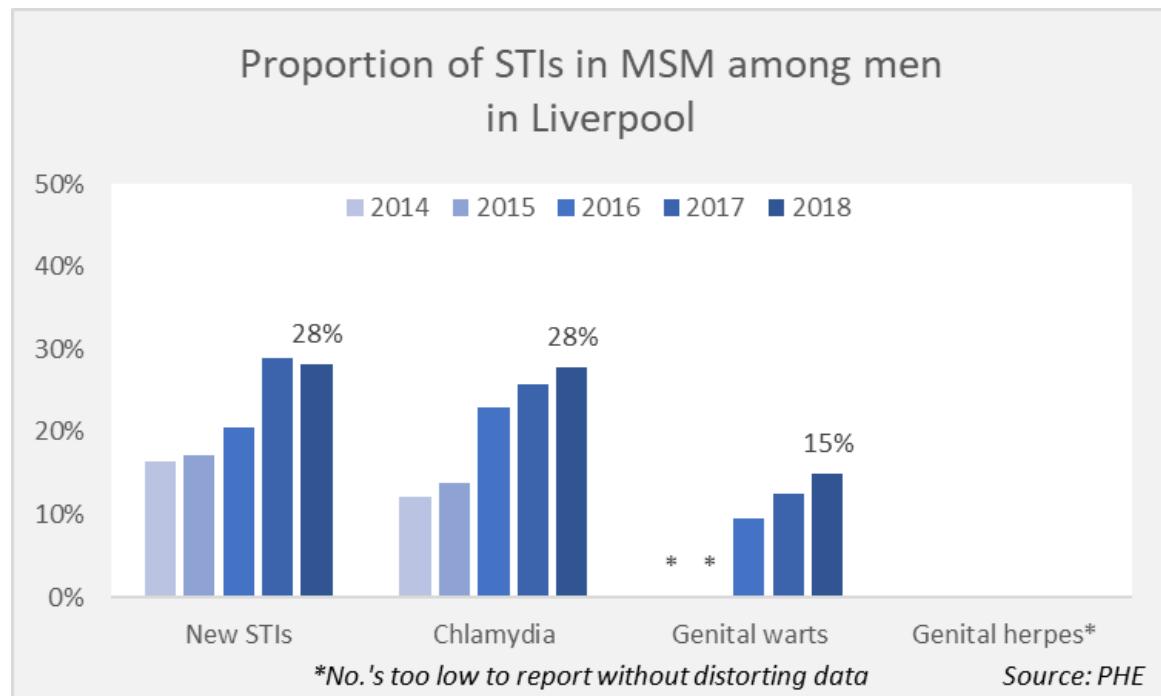
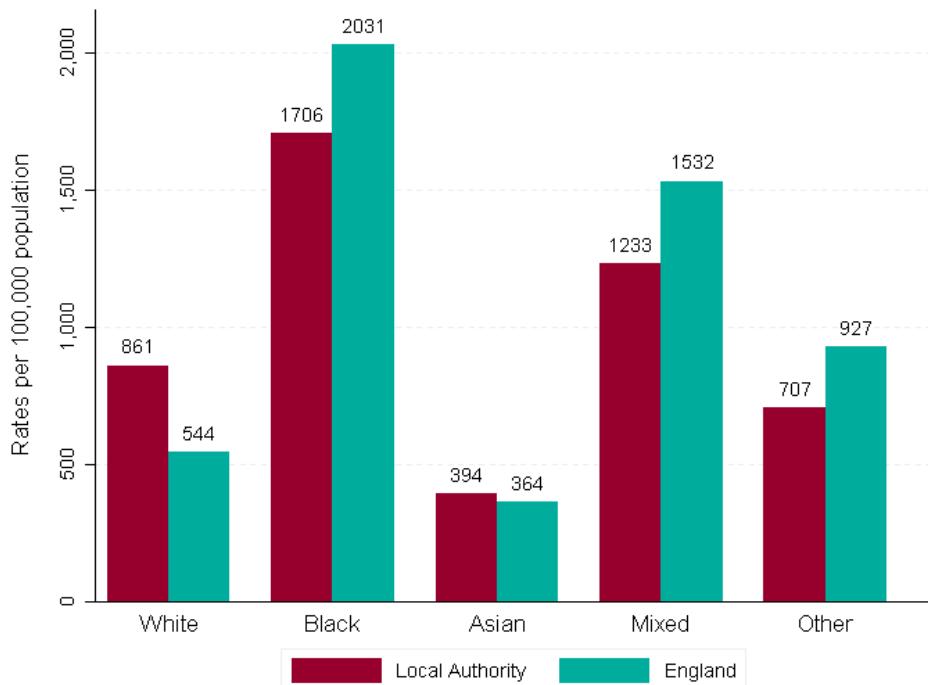


Figure 21: Proportion of new STIs diagnosed in MSM by type of infection in Liverpool (2018)
Source: Liverpool Intelligence & Analytics Team, October 2020

7.1.6.3 Ethnicity & country of birth

Rates of new STIs are particularly high in those of black ethnicity.



Source: Data from routine specialist and non-specialist sexual health services' returns to the GUMCAD STI Surveillance System. Excludes chlamydia data from routine non-specialist sexual health services' returns to the CTAD Chlamydia Surveillance system. Rates based on the 2011 ONS population estimates.

Figure 22: Rates per 100,000 population of new STIs by ethnic group in Liverpool and England (SHS diagnosis only) (2018)

Source: Public Health England

7.1.6.4 Recommendations in relation to STIs:

16. To reduce the risk of STI and HIV complications and infection spread, sexual health services should be open-access, providing rapid treatment and partner notification
17. Services for the prevention, diagnosis, treatment and care of STIs need to be delivered to the general population as well as focus on groups with greater sexual health needs, including young adults, black ethnic minorities and MSM
18. Continue to promote the availability of condoms, including through the C-card scheme
19. Ensure prompt diagnosis & treatment of gonorrhoea according to national treatment guidelines
20. Test for antibiotic resistance in gonorrhoea cases
21. Identify & manage potential treatment failures effectively to control infection of gonorrhoea
22. Sustain the chlamydia detection rate above 2,300 per 100,000

23. Maintain at least the present proportion of young people screened for chlamydia locally to allow for the ongoing effective diagnosis of infection in the local population.
24. Couple the robust screening and detection rates seen across the city with timely partner notification with the aim of reducing the prevalence of infection in young people city-wide.
25. Focus on those services that serve populations with the highest need, based on positivity
26. Ensure an effective, high quality patient pathway is in place with treatment & partner notification standards being met, re-testing after a positive diagnosis within 3 months of initial diagnosis, and screening annually & on change of sexual partner

7.1.6.5 Recommendations in relation to Partner Notification:

1. Ensure effective Partner Notification targets and outcomes are built into any future new integrated service design to improve our ability to assess local performance
2. Make one single service, via integration, responsible for all partner notification and subsequent treatment to be more effective at preventing onward spread of infection

7.2 HIV

First diagnoses, AIDS at HIV diagnosis & deaths

- There were 49 new HIV diagnoses in individuals aged 15 years and above in Liverpool, compared to 73 in 2014.

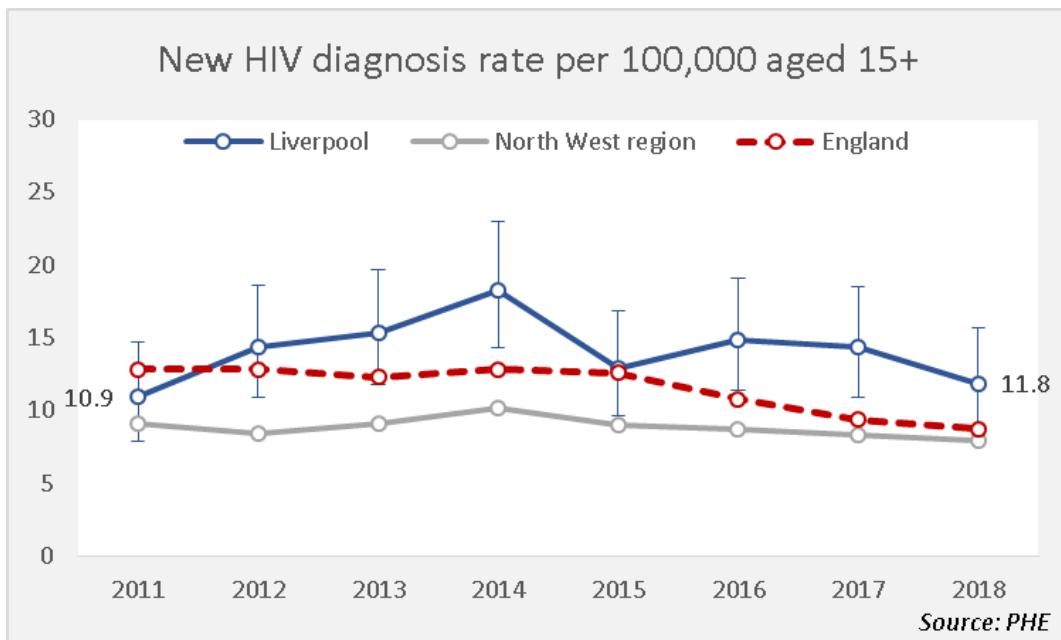


Figure 23: New HIV diagnosis rates, 2011 - 2018
Source: Liverpool Intelligence & Analytics Team, October 2020

CD4 cell count measures & late HIV diagnosis

- In Liverpool, between 2016 and 2018, 45% of 143 HIV diagnoses were made at a late stage of infection (CD4 count ≤ 350 cells/mm³ within 3 months of diagnosis), compared to 43% overall in England. (Please note that the number of new HIV diagnoses [especially those made at a late stage of infection] are small, therefore these figures must be interpreted with caution).

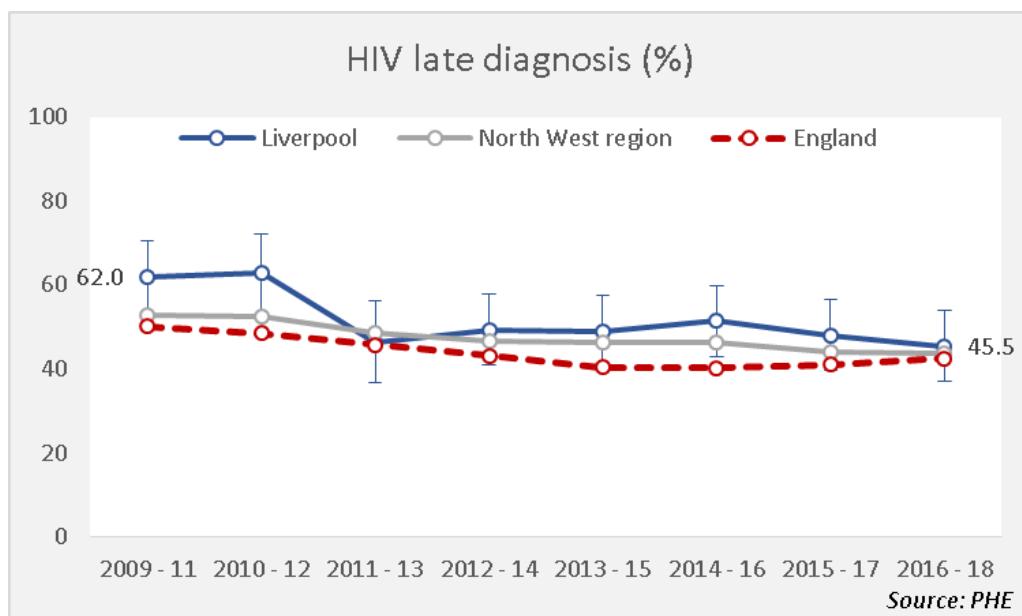


Figure 24: HIV late diagnosis rates, 2009-11 to 2016-18
Source: Liverpool Intelligence & Analytics Team, October 2020

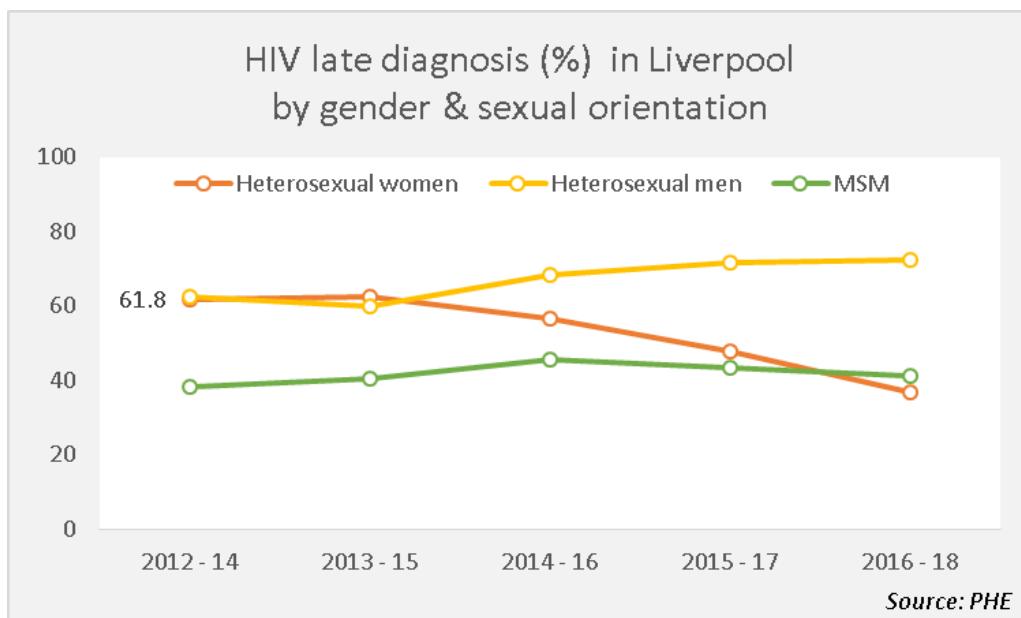


Figure 25: HIV late diagnosis rates by gender and sexual orientation, 2019-11 to 2016-18
Source: Liverpool Intelligence & Analytics Team, October 2020

Diagnosed HIV prevalence

- The diagnosed HIV prevalence was 2.2 per 1,000 population aged 15-59 years in people being seen for HIV care resident in Liverpool, compared to 2.4 per 1,000 in England.

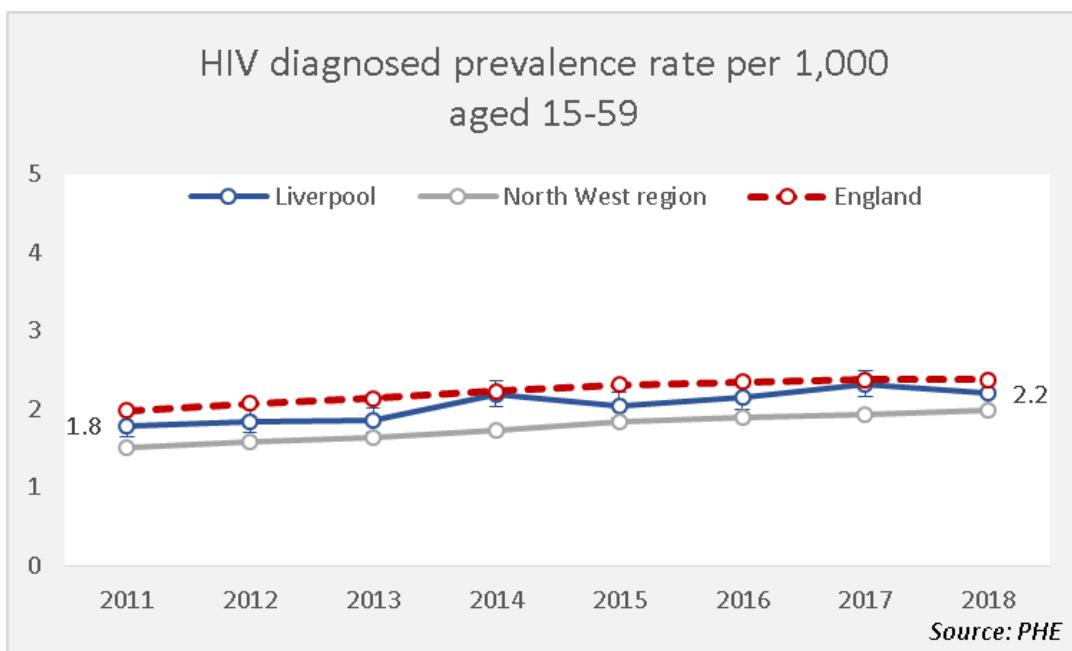
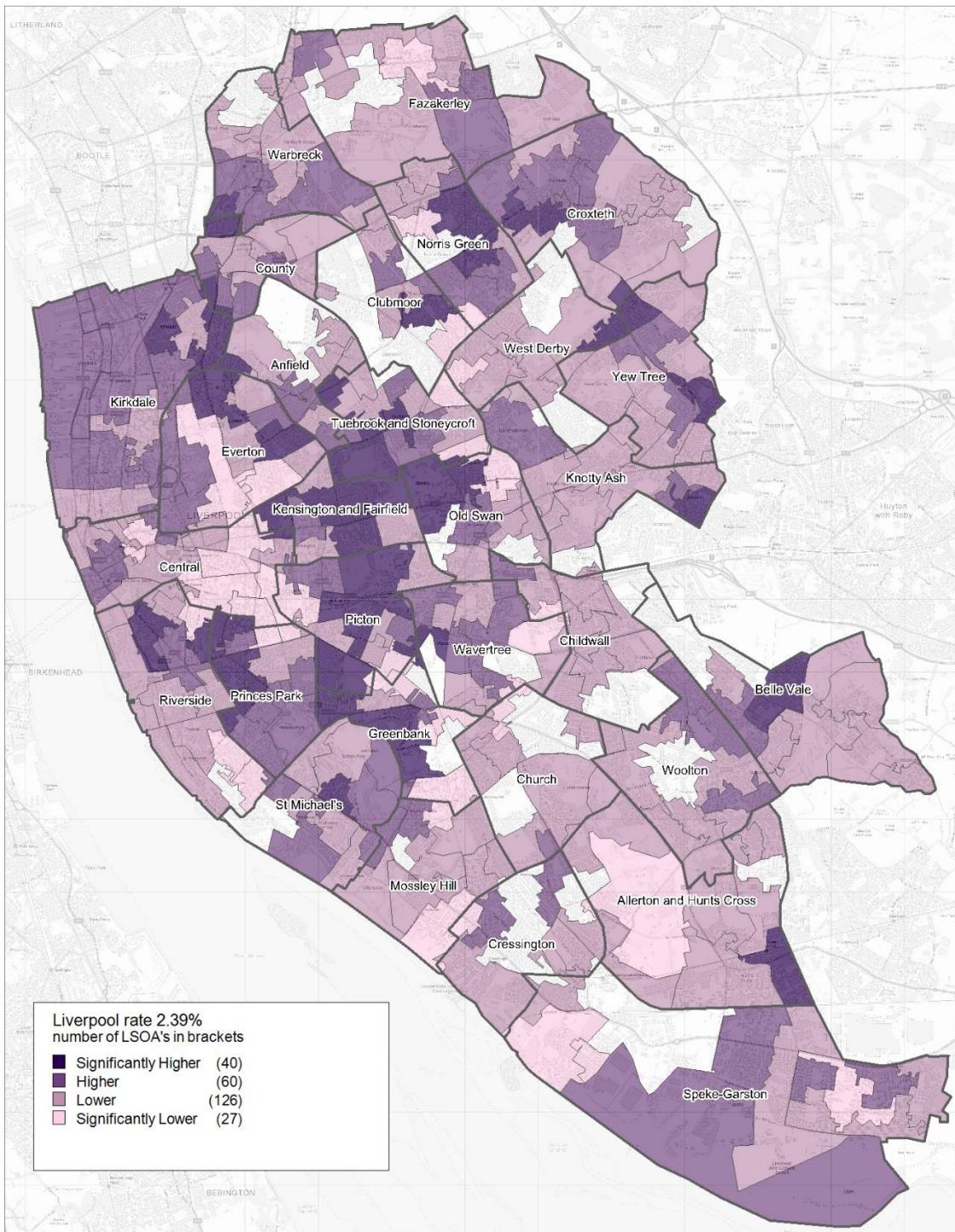


Figure 26: HIV diagnosed prevalence rates per 100,000 persons aged 15-59 years, 2011 - 2018
Source: Liverpool Intelligence & Analytics Team, October 2020



HIV Prevalence Rate 2016-18, statistical Significance compared to Liverpool Rate, Lower Super Output Area level

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Figure 27: HIV Prevalence rate 2016-2018 - LSOA

People seen for HIV care

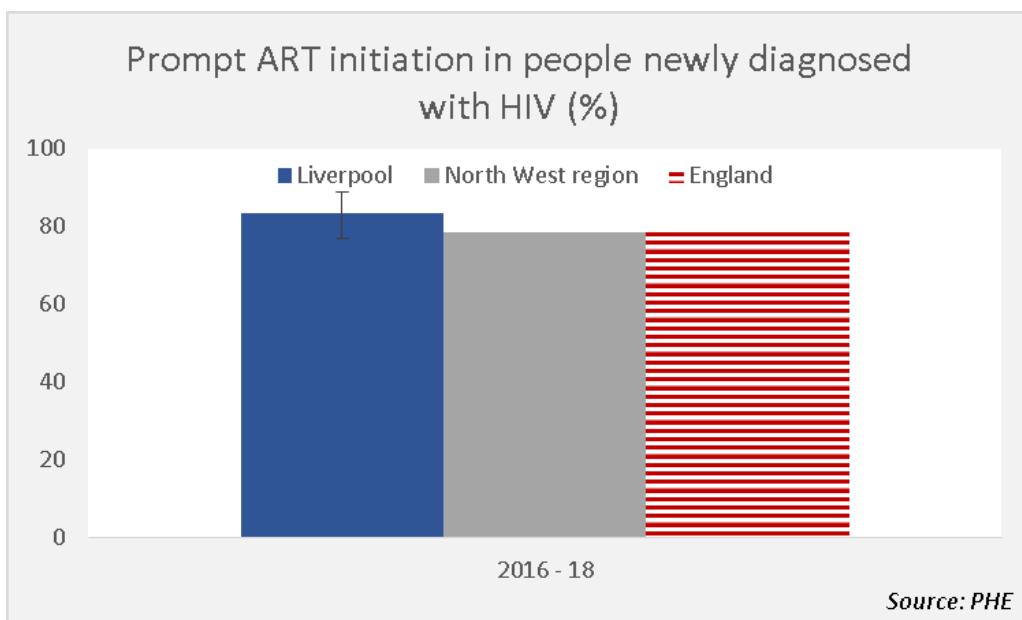


Figure 28: Prompt ART initiation in people newly diagnosed with HIV, 2016-18
Source: Liverpool Intelligence & Analytics Team, October 2020

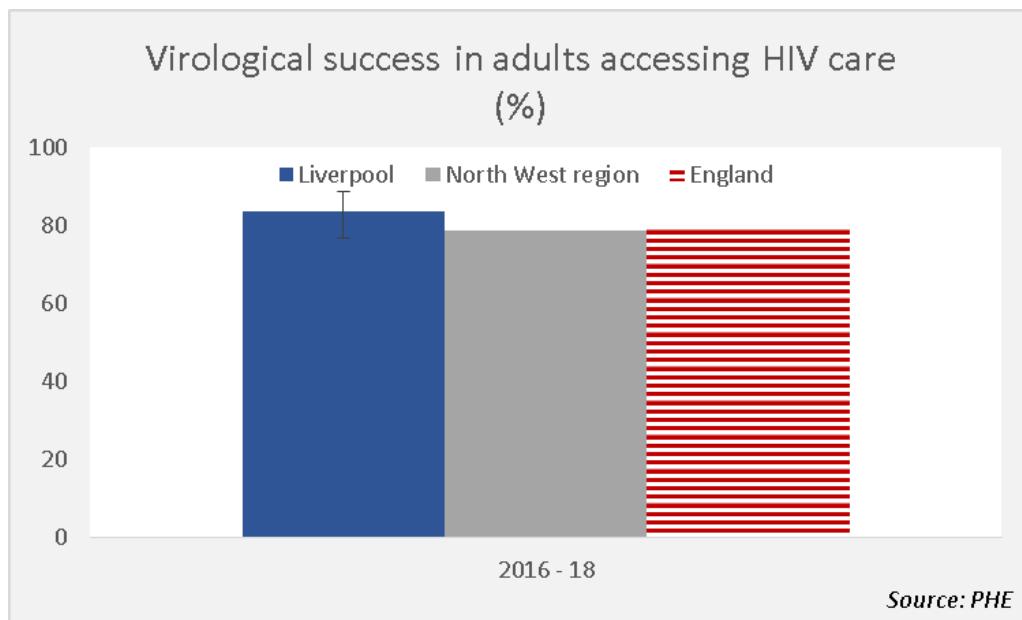


Figure 29: Virological success rates among adults accessing HIV Care, 2016-18
Source: Liverpool Intelligence & Analytics Team, October 2020

Uptake of HIV testing in GUM clinic attendees

- Among specialist SHS patients from Liverpool who were eligible to be tested for HIV, 72% were tested compared to 65% in England.

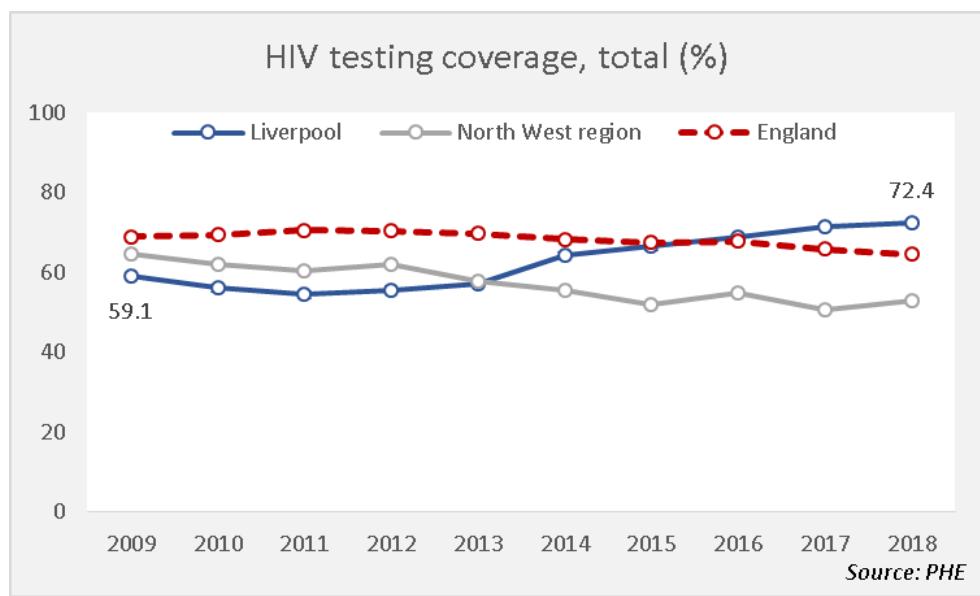


Figure 30: HIV testing coverage, 2009 - 2018

Source: Liverpool Intelligence & Analytics Team, October 2020

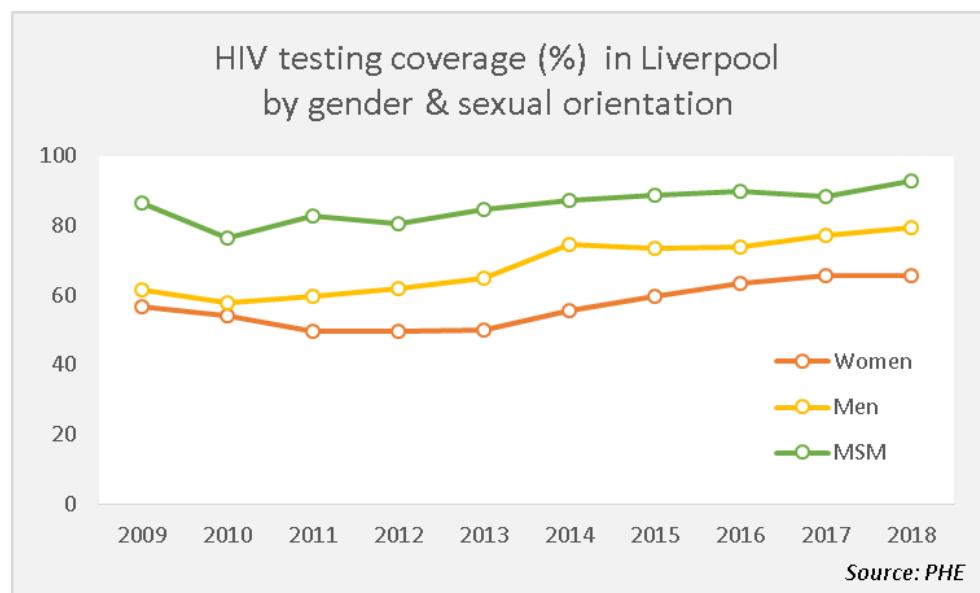


Figure 31: HIV testing coverage by gender and sexual orientation, 2009 - 2018

Source: Liverpool Intelligence & Analytics Team, October 2020

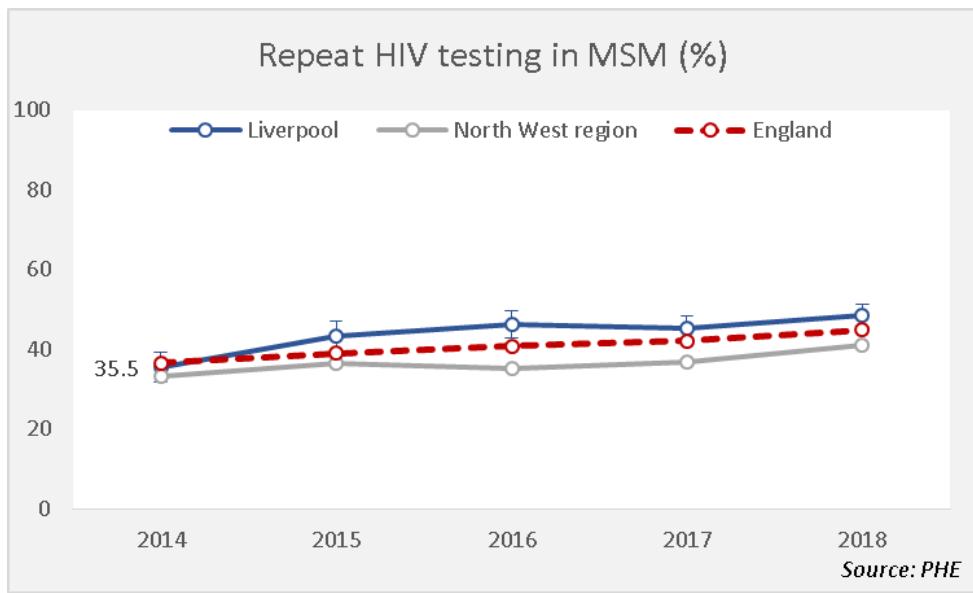


Figure 32: Repeat HIV testing in MSM, 2014 - 2018
Source: Liverpool Intelligence & Analytics Team, October 2020

7.2.1 Recommendations in relation to HIV:

5. HIV tests should be routinely offered in primary care and at hospital admission
6. Sexual Health Services should continue to offer and recommend HIV testing to all eligible attendees, especially MSM, black Africans, and attendees born in countries with a diagnosed HIV prevalence 1%
7. MSM and black Africans should be encouraged to have frequent and regular HIV tests
8. Efforts to reduce stigma and other socio-cultural barriers that prevent people from testing and seeking long-term care must be strengthened

7.2.2 Liverpool – a HIV Fast Track City

In November 2018 Liverpool City Council and its partners committed to, and signed, the Paris Declaration, which saw the city join a network of cities around the world committed to ending HIV by promoting early diagnosis.

On the eve of the 30th World AIDS Day (2018), Mayor Joe Anderson announced the city would become part of the 'Fast-Track Cities' network, joining London, Manchester and Brighton in the UK and 250 others around the world aiming to eradicate AIDS as a public health threat by 2030.

There are currently 650 people in the city with HIV – a level comparable with other big 'core' cities. However, it is estimated there are up to 115 people that are infected but unaware – and over half of people in Liverpool are diagnosed late, meaning they don't

start treatment as early as they could, which can lead to them becoming unnecessarily ill.

When signing up, the city committed to:

- Working with its partners to make sure 90 percent of people with HIV know their status
- Increasing the percentage of all people with diagnosed HIV infection who are on treatment
- Increasing the percentage of people already on treatment who stay on medication long-term thus reducing the likelihood of transmission
- Reduce the negative impact of stigma and discrimination

Plans have been formulated in Liverpool to:

- Develop a city-wide governance group to drive improvements
- Review services to make sure most vulnerable and at risk groups are tested
- Produce a city-wide action plan to reduce the spread of HIV and encourage more routine testing
- Implement best practice from around the world

The most recent analysis of performance against 'triple 90' (90-90-90) targets shows:

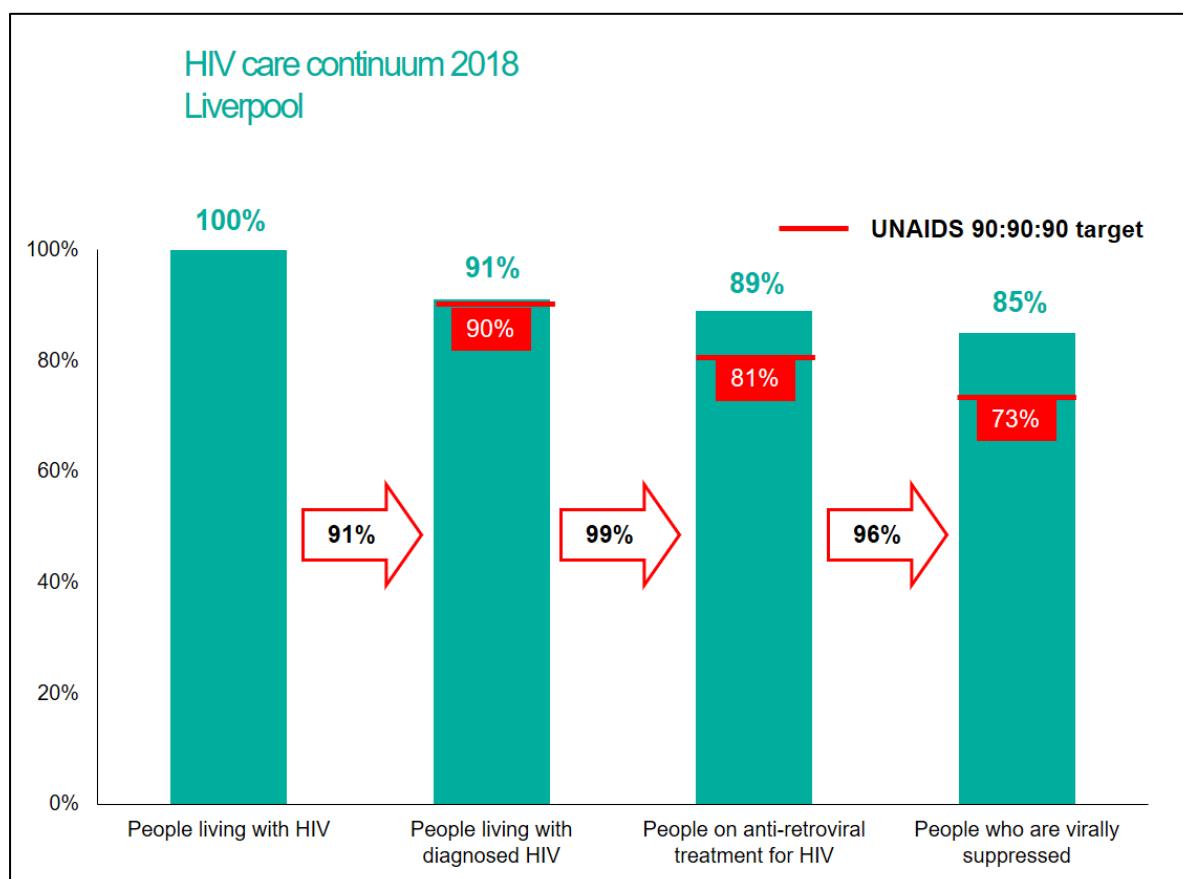


Figure 33: HIV care continuum, 2018, Liverpool

7.3 Reproductive Health

Reproductive health affects both men and women but women bear the brunt of Reproductive ill-health, not only as a result of their biological status but also because of a wider social, economic and political disadvantage. There are public health, human rights and economic reasons for investment in reproductive health. In the UK, women make up 51% of the population and 47% of the working population³⁶. Whilst the Maternity Review³⁷ has focused efforts on improving healthcare for women and their babies during the crucial period of pregnancy and childbirth, the greater proportion of women's lives exists outside these events. Reproductive wellbeing for the non-pregnant woman is vital both for the woman herself and for the protection of future generations through the whole life course³⁸. The non-pregnancy related aspects of reproductive health are often overlooked compared with the short and intense healthcare needs of a pregnancy.

The World Health Organisation (WHO) define reproductive health and healthcare as:

"A state of physical, mental, and social well-being in all matters relating to the reproductive system. It addresses the reproductive processes, functions and system at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so."

Reproductive healthcare is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted infections."

There are major opportunities, supported by national bodies RCOG, FSRH and others to improve care particularly for women across community settings in relation to the reproductive health agenda. Indeed, Reproductive health hubs are recommended as a positive way forward in both the Royal College of Obstetricians & Gynaecologist's (RCOG) 'Better for women' report, Faculty of Sexual & Reproductive Health (FSRH) and Public Health England's pending Women's Reproductive Health Action Plan (WRHAP). We must provide a more joined-up approach to women's health, diminish unnecessarily long referral times and ensure that women receive the best possible care by providing all of their healthcare needs in one location and at one time. This needs to be backed by a solid training plan across primary and community care.

Reproductive healthcare services could and should be available from an extensive range of locations and delivered by a multi-disciplinary team of clinicians to include General Practitioners, nursing staff and allied health professionals. It is evidenced that this would undoubtedly improve the present situation and reduce fragmentation of care for women. Thus, there is potential to co-commission a more dedicated community gynae service both via an Integrated SRH provider and across General Practice to manage more gynae related issues in those settings.

Liverpool City Council and Liverpool Clinical Commissioning Group (LCCG) commissioners have been looking to increase access to contraception, notably LARC, across General Practice utilising the Primary Care Network (PCN) formation in the last 12 months or so. We have moved this model effectively, have reached a stage where women can access GPs for both contraceptive and non-contraceptive purposes, but need to grow and develop (and crucially fund) that model, and community more to drive change.

The call on gynaecology services is rising in line with population demands on the NHS. Workforce issues within secondary care which requires Consultant Gynaecologists to also perform the role of Consultant Obstetricians means waiting times can be adversely affected in times of short staffing.

The Five Year Forward View (2014) states '*one of the most important changes will be to expand and strengthen primary and ‘out of hospital’ care*' and goes on to commit to '*give GP-led Clinical Commissioning Groups (CCGs) more influence over the wider NHS budget, enabling a shift in investment from acute to primary and community services.*'

There are opportunities for us to explore how more of this acute care can be legitimately managed and funded in community (utilising PCNs as a recommended approach) to reduce wait times, improve patient outcomes (ie. they can receive all care in one place, with a GP), shift and improve contraceptive uptake and access and improved patient journeys and care for women.

7.3.1 Contraception

On the whole, women across Liverpool choose user-dependent methods (UDMs) in the majority of cases when accessing contraception. This is the case in many areas, however, the shift towards oral and user dependent methods in Liverpool is more stark. Of those attending clinics last year, 20% chose a LARC, 12.1% chose an injectable method and 67.9% went for a UDM. This compares to national figures of 34% LARC, 9.3% injectable and 56.7% UDM. This highlights the work that can be done locally to move more women (where appropriate) onto more reliable and long-term cost-effective methods such as LARC to help reduce local unintended pregnancy across all ages.

7.3.1.1 Long-Acting Reversible Contraception (LARC)

Long acting reversible contraception (LARC) methods such as contraceptive injections, implants, intra-uterine system (IUS) or intrauterine device (IUD) are more effective as they do not depend on daily concordance. They are also considered to be more cost effective than User Dependent Methods (UDM), and their increased uptake could further help to reduce unintended pregnancy. All currently available LARC methods are more cost effective than the combined oral contraceptive pill even at 1 year of use. The duration of use is 3 years for the Implant, 3-5 years for the IUS and

5-10 years for the IUD, dependent on the specific device. The injectable contraceptive method requires repeat injection every 8 or 12 weeks dependent on type. LARC methods are suitable for most women. However, for adolescents, the injectable method is only recommended if other methods are unacceptable or not suitable, primarily due to potential effect on bone density in this age group.

By setting, across the board, we need to be working on improving the uptake of longer-acting, more reliable methods of contraception and having the full range of contraceptive choices/options offered at the optimal point.

The charts below illustrate the number of attendances at SRH services:

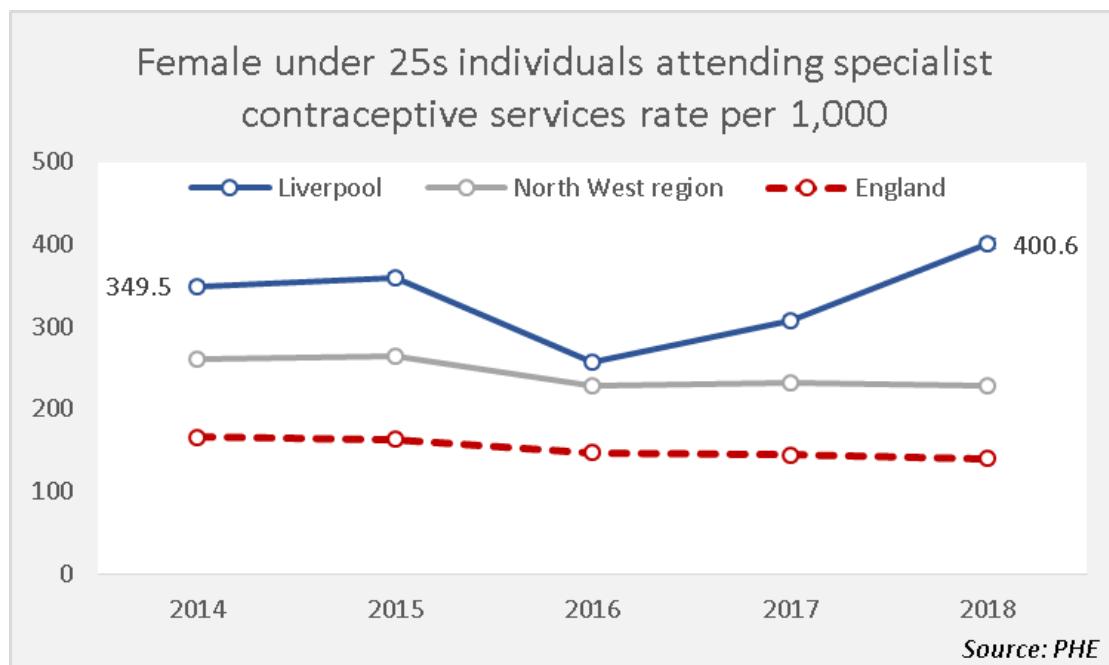


Figure 34: Rate per 1,000 females under 25 years attending specialist contraceptive services, 2014 – 2018

Source: Liverpool Intelligence & Analytics Team, October 2020

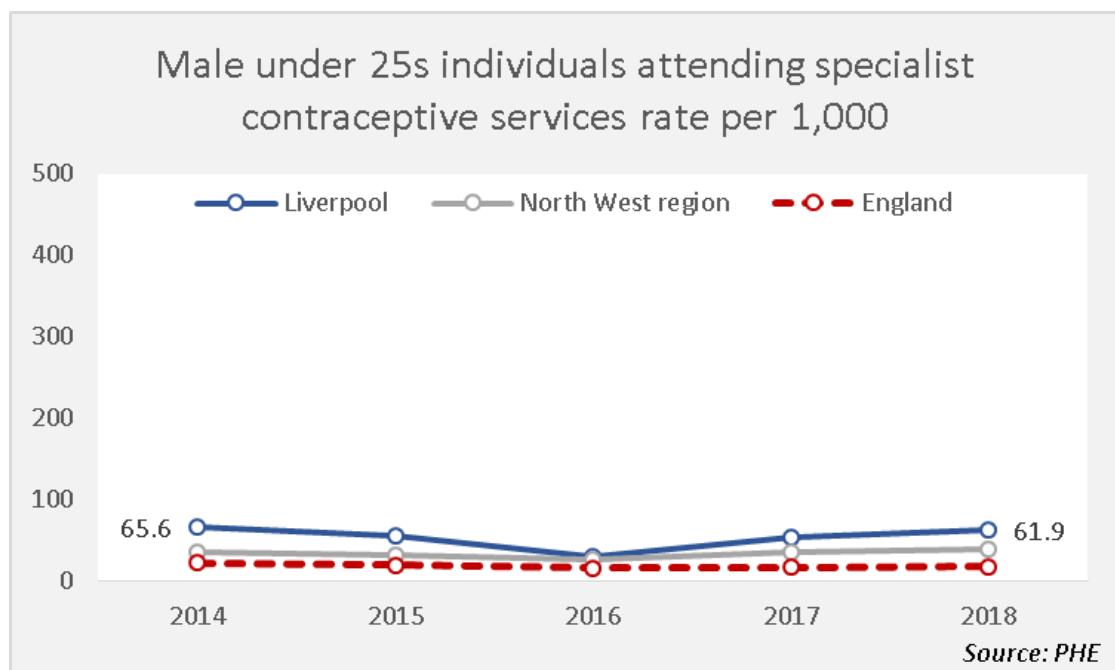


Figure 35: Rate per 1,000 males under 25 years attending specialist contraceptive services, 2014 – 2018

Source: Liverpool Intelligence & Analytics Team, October 2020

The following are breakdowns by primary methods of contraception (e.g. oral, LARC)

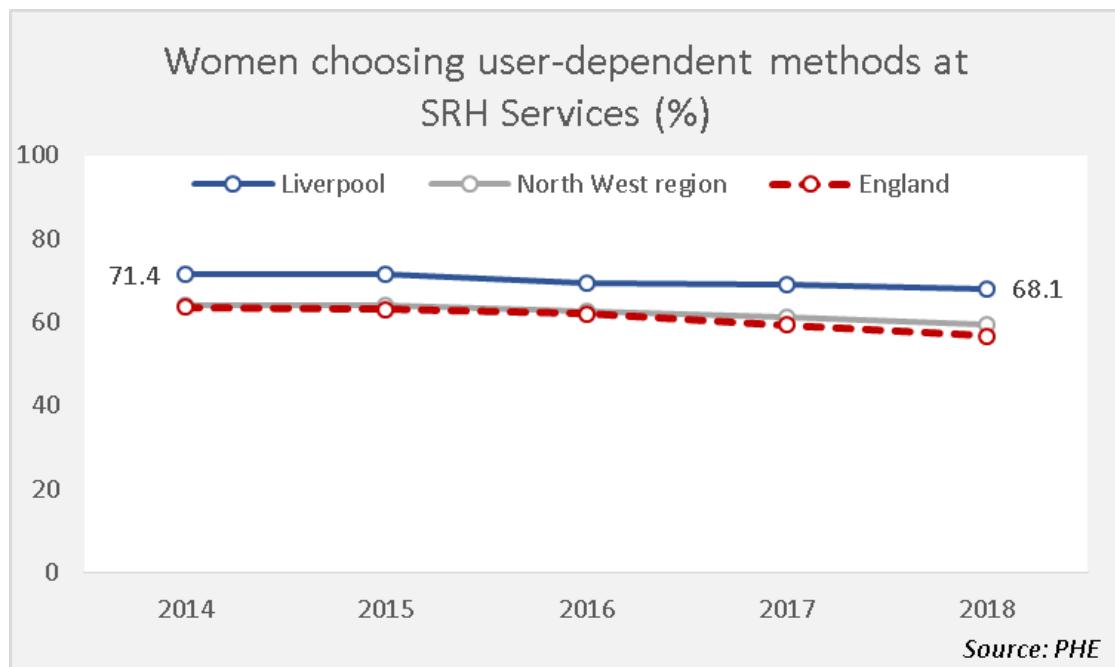


Figure 36: Rate per 1,000 females choosing user-dependent methods at SRH services, 2014 – 2018
Source: Liverpool Intelligence & Analytics Team, October 2020

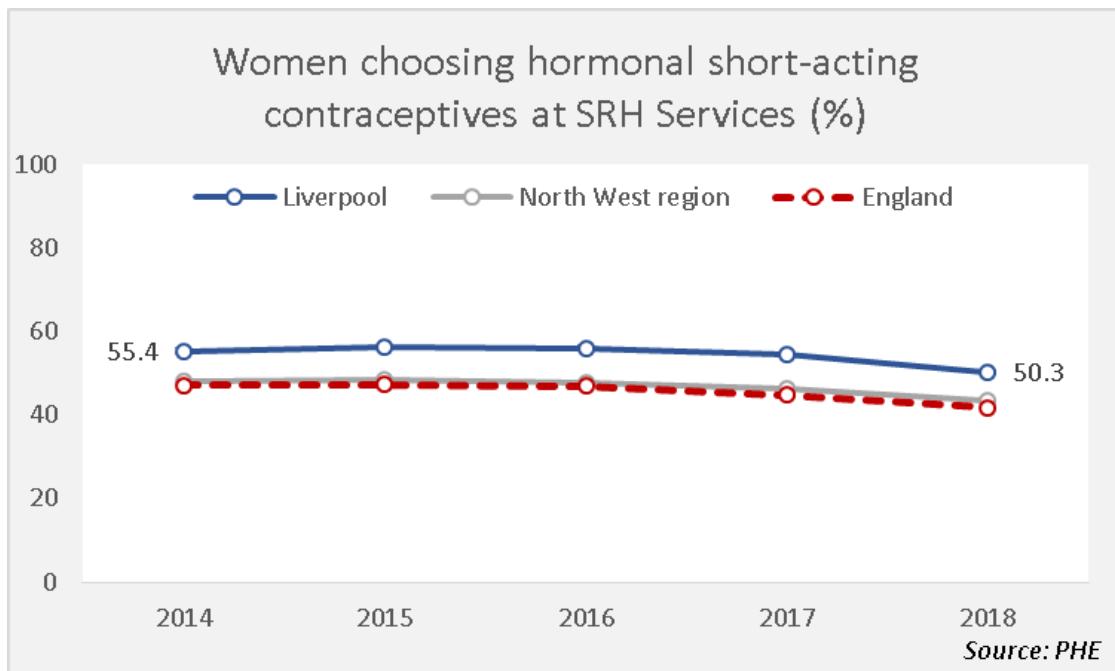


Figure 37: Rate per 1,000 females choosing hormonal short-acting contraceptives at SRH services, 2014 – 2018

Source: Liverpool Intelligence & Analytics Team, October 2020

- The total rate of long-acting reversible contraception (LARC) excluding injections prescribed in primary care, specialist SHSs and non-specialist SHSs was 31.9 per 1,000 women in Liverpool, compared to 49.5 per 1,000 women in England
- The rate prescribed in primary care was 13.0 per 1,000 women in Liverpool, compared to 29.2 per 1,000 women in England. The rate prescribed in other settings was 18.8 per 1,000 women aged 15 to 44 years, compared to 20.3 for England

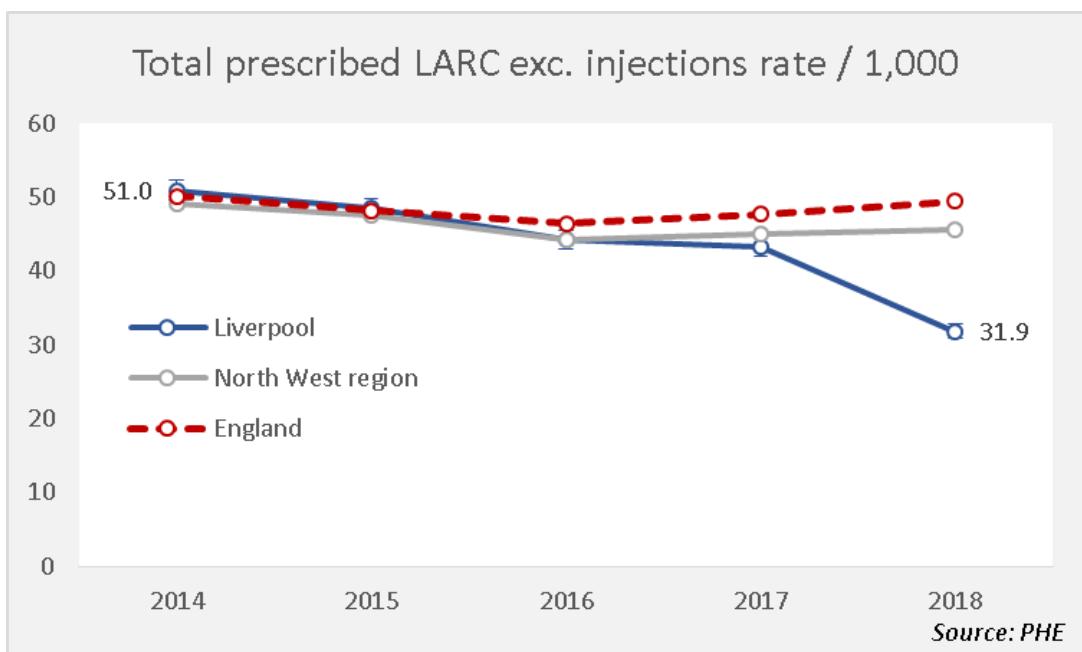


Figure 38: Rate per 1,000 females prescribed LARC excluding injections, 2014 – 2018
Source: Liverpool Intelligence & Analytics Team, October 2020

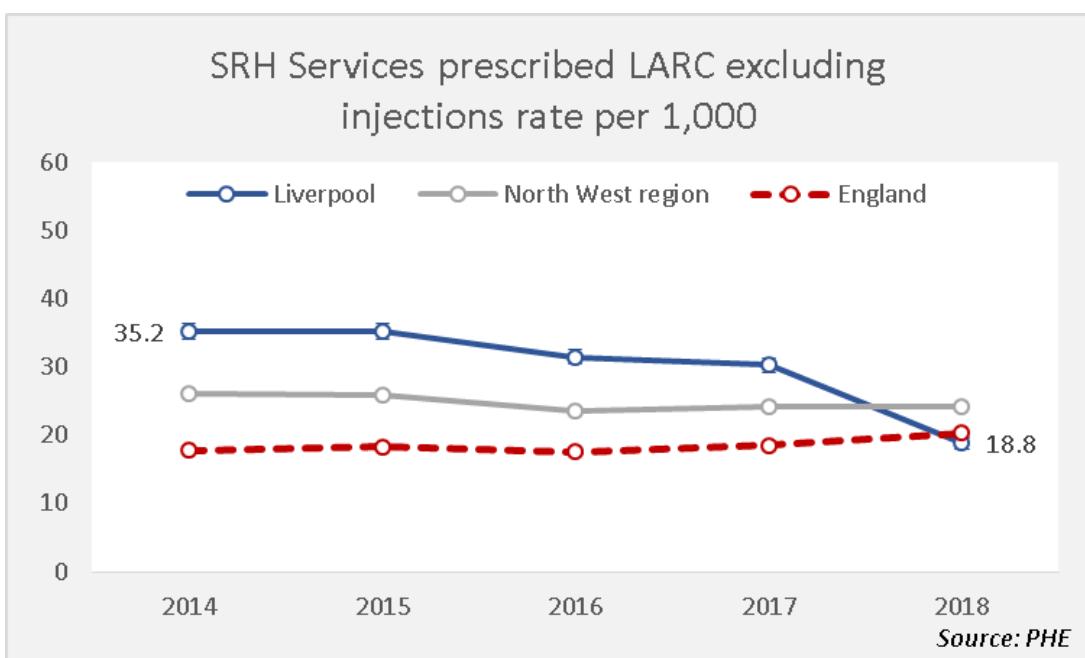


Figure 39: Rate per 1,000 females prescribed LARC excluding injections at SRH services, 2014 – 2018
Source: Liverpool Intelligence & Analytics Team, October 2020

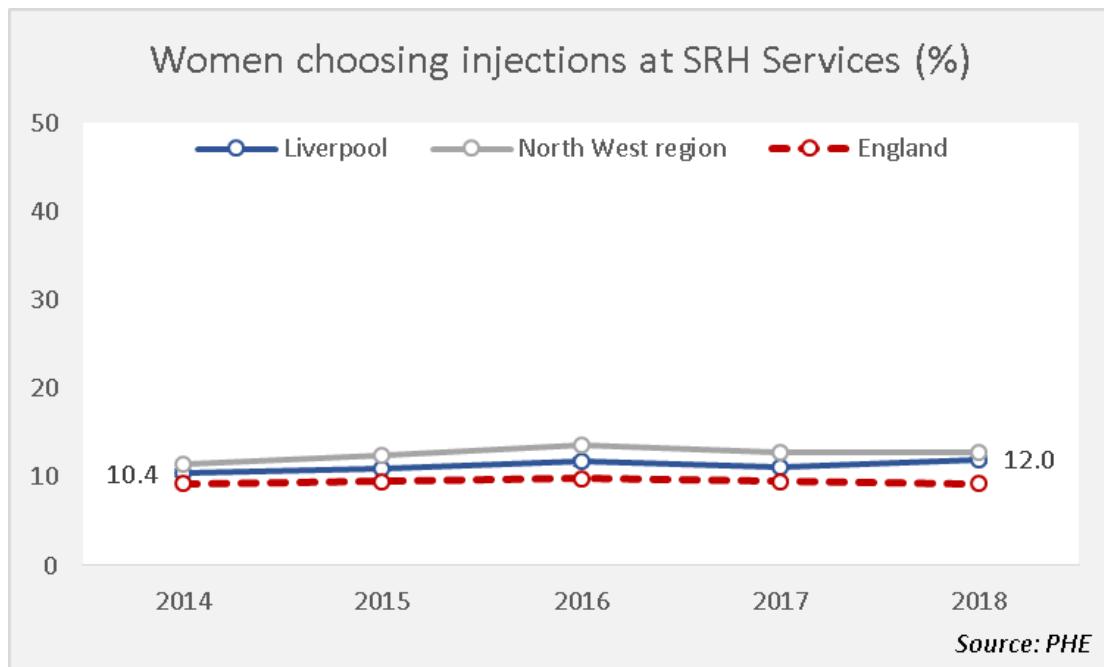


Figure 40: Rate per 1,000 females choosing injections at SRH services, 2014 – 2018

Source: Liverpool Intelligence & Analytics Team, October 2020

The following graphs highlight the uptake breakdowns by population characteristics

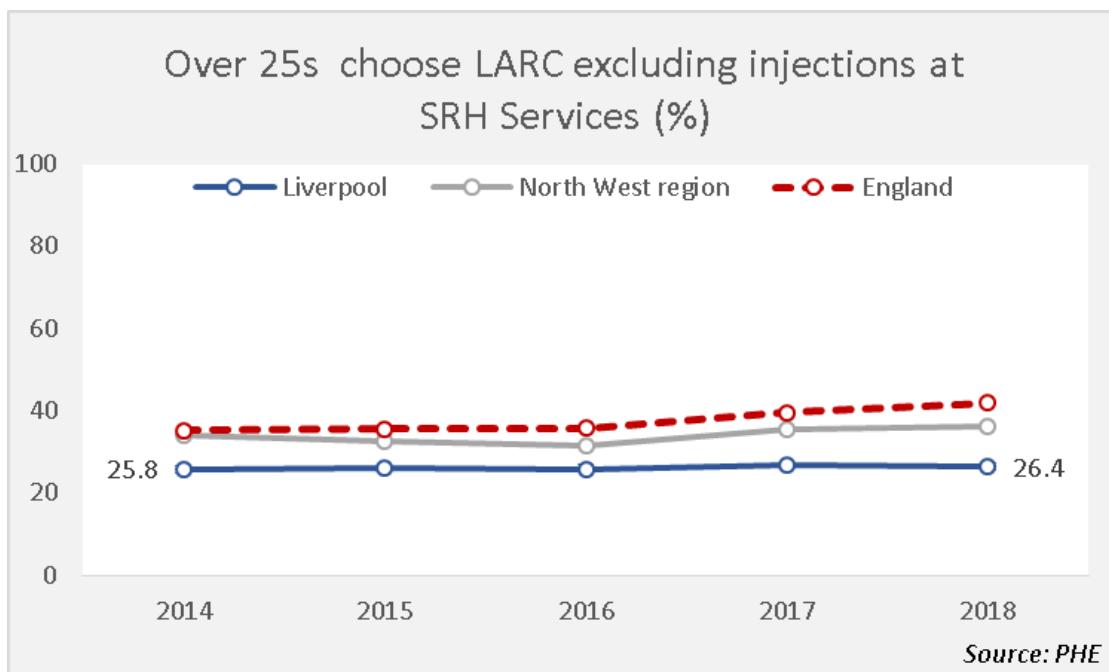


Figure 41: Rate per 1,000 persons aged 25 and over choosing LARC, excluding injections at SRH services, 2014 – 2018

Source: Liverpool Intelligence & Analytics Team, October 2020

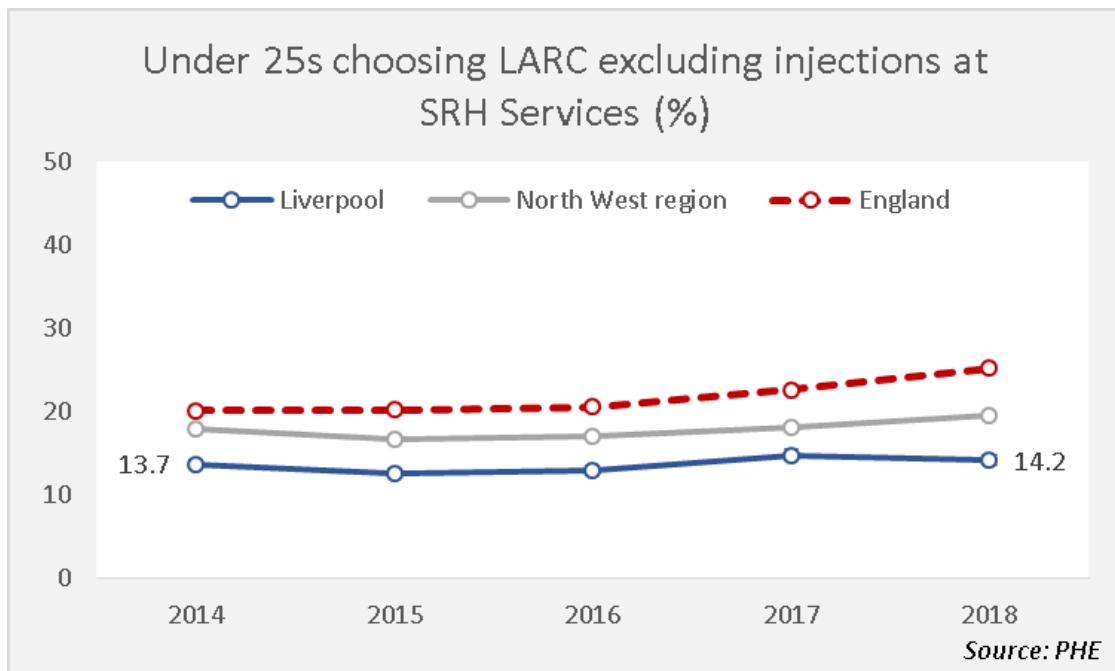


Figure 42: Rate per 1,000 persons aged under 25 years choosing LARC, excluding injections at SRH services, 2014 – 2018

Source: Liverpool Intelligence & Analytics Team, October 2020

It is clear that there is a greater discrepancy between national and local data for U25s choosing LARC than there is for those over 25. In other words, Liverpool is further away from the national and indeed regional averages for LARC uptake rates in the younger age group. Lifting these rates in both age profiles needs to be a focal point moving forward.

The Liverpool LASER report states: “Provision of contraception at the time of abortion is recommended practice and is almost always commissioned as part of this service; offer of the immediate provision of contraception postpartum is also recommended practice (FSRH guideline on post pregnancy contraception) but is less frequently explicitly commissioned. A significant proportion of post pregnancy contraception is thought to be the most effective long acting reversible contraception (LARC) methods (implants, intra-uterine systems [IUS] and intrauterine devices [IUD] but not injections) but this data is not recorded in SRHAD or captured through General Practice.”

Although we do not routinely collect information on post-TOP and post-partum LARC uptake, we understand from LWH and the consultant lead in SRH and gynaecology that figures are low and that we could support training to improve offer and uptake.

7.3.1.2 GP Prescribed LARC

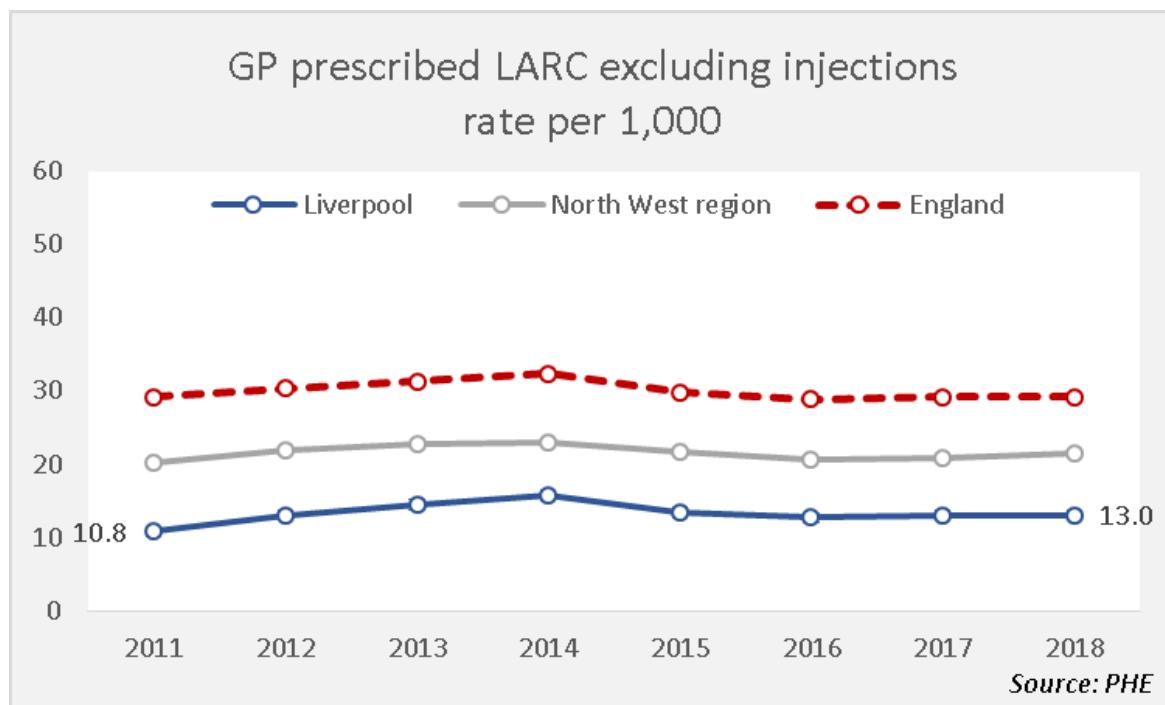
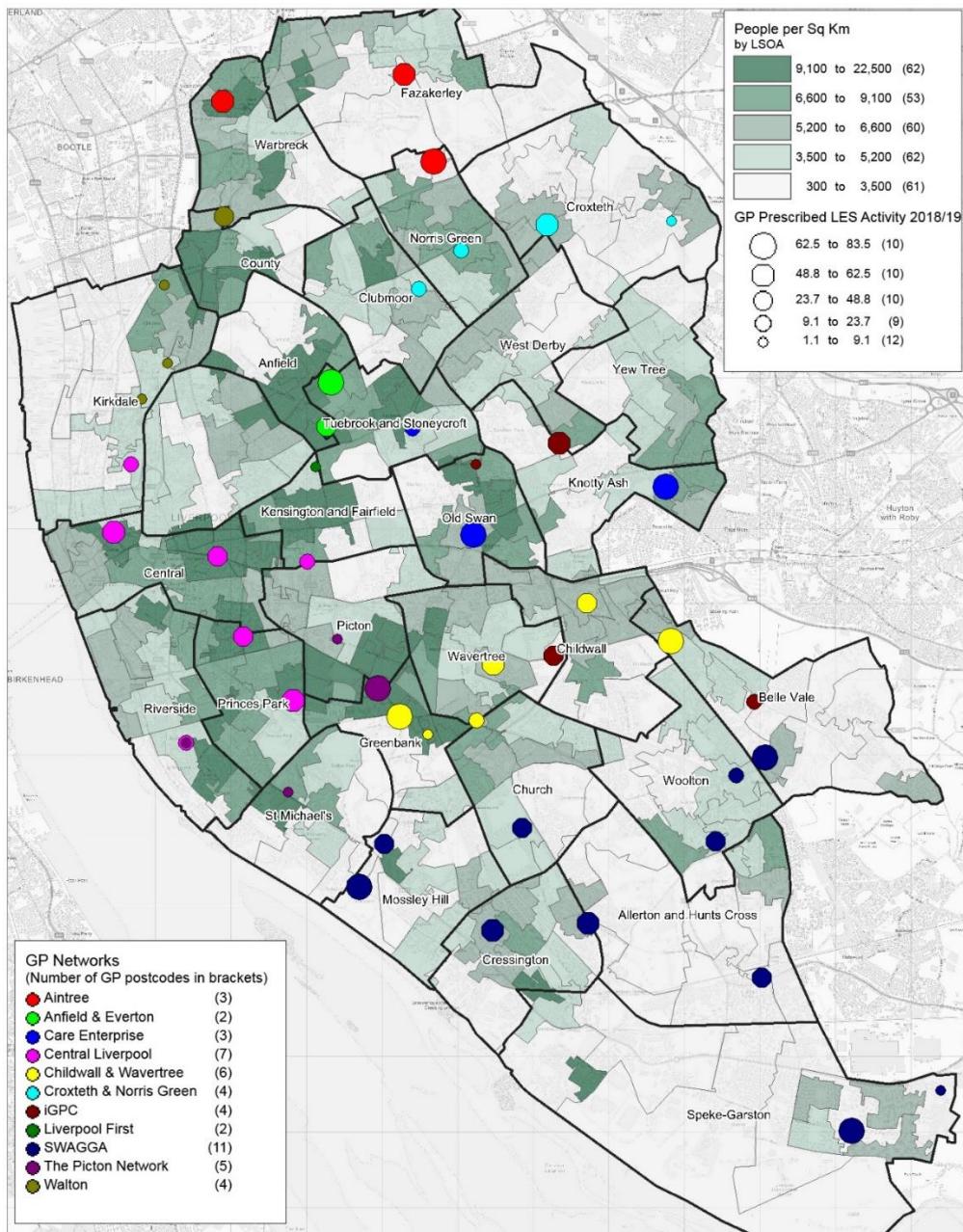


Figure 43: Rate per 1,000 persons prescribed LARC, excluding injections by their GP, 2014 – 2018
Source: Liverpool Intelligence & Analytics Team, October 2020

It is also recognised that GP LARC uptake has been fairly static and at a low rate for some time across Liverpool. There is considerable system work presently taking place across Primary Care Networks (PCNs), specifically centred on how General Practice (who have formed into PCNs) operate hub and spoke services for their populations and thus improve the access to and uptake of LARC. Continued development of this model as recognised by the APPG Inquiry into access to contraception, RCOG and FSRH guidance is critical to ensure better choice and access to healthcare for women city-wide.



Local Enhanced Sexual Health Activity 2018/19 per 1,000 females aged 15-44 years by GP Network and Population Density

Date created: January 2020

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Figure 44: Local Enhanced Sexual Health activity, 2018/19

Increasing knowledge, access, choice & provision of all methods of reversible & irreversible contraception, including the most effective LARC methods & emergency contraception, both oral-hormonal & the more effective IUD, for women of all ages & their partners can reduce unwanted pregnancies. Providing young people with the

facts about the full range of contraceptive choices, efficacy & options available is a requirement of the DoE's Relationships, Sex & Health Education (RSE) guidance which will be statutory in all schools from September 2020.

7.3.1.3 General Practice Prescribing Data – User Dependent Methods

Prescribing Analysis and Cost (PACT) data provide information on prescribed contraception from general practice. NHS Prescription Services, which is part of the NHS Business Services Authority (NHSBSA), uses NHS prescription forms to calculate how much pharmacists, GPs who dispense and appliance contractors should be paid as reimbursement and remuneration for medicines and medical devices dispensed to patients within primary care settings in England.

PACT data excludes: prescriptions that were not collected (i.e. not dispensed); data from community sexual and reproductive health services, pharmacies and young people's services; and contraception provided within general practice where devices are bought by a local authority or community SRH service.

The different methods of contraception prescribed within a primary care setting are presented below:

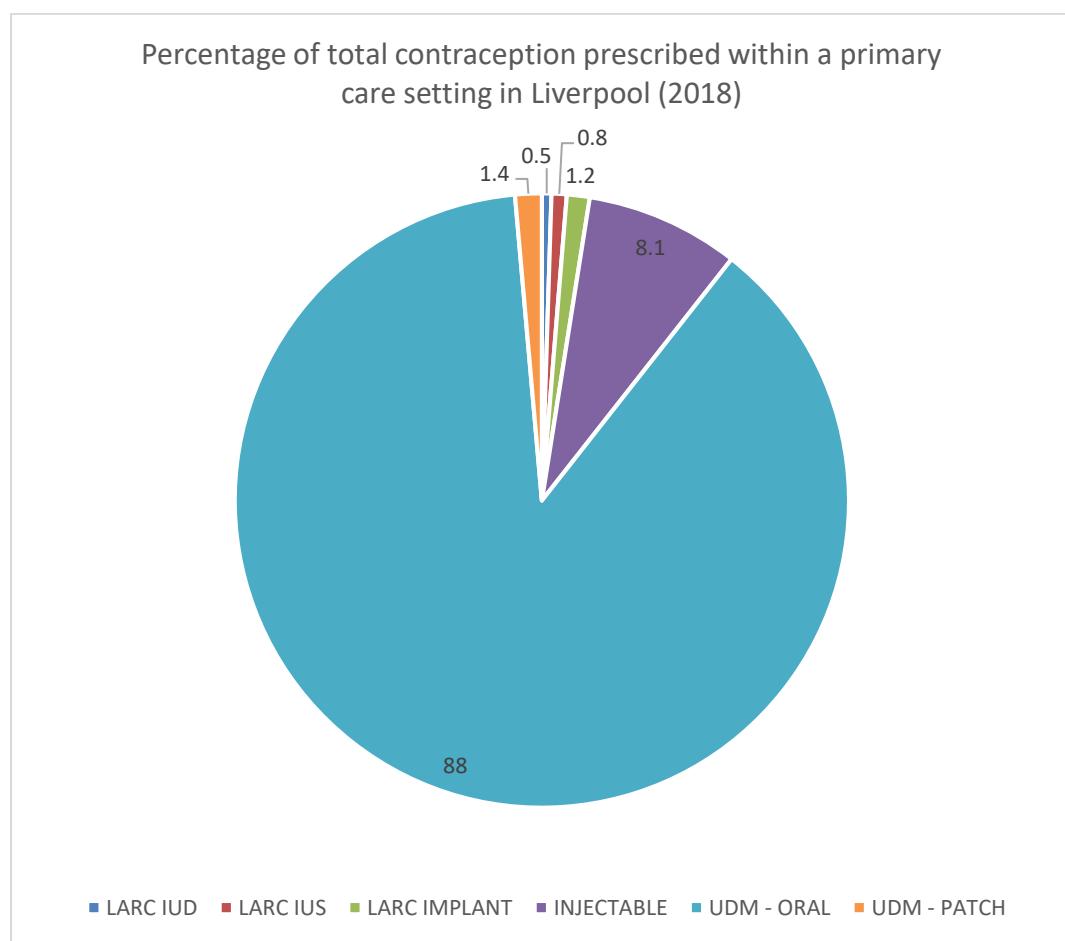


Figure 45: Total contraception prescribed in a primary care setting, 2018

It is clear that oral contraceptives are the method of choice across General Practice. The next closest method to this is injectable contraception, or shorter acting LARC.

As mentioned above in section 7.3.1 women across Liverpool largely choose user-dependent methods (UDMs) in the majority of cases when accessing contraception. This is the case in many areas, however, the shift towards oral and user dependent methods in Liverpool is more stark. There is more we can do across all settings to move women (where appropriate) to longer term methods to support their needs and offer more reliable forms of contraception.

7.3.1.4 Conceptions

This section analyses and presents the data relating to the number, percentages and rates of conceptions across Liverpool and compares them regionally and nationally.

- In 2017, the under-18s conception rate in Liverpool was 28.1 per 1,000 females aged 15-17 years, while in England the rate was 17.8 per 1,000.

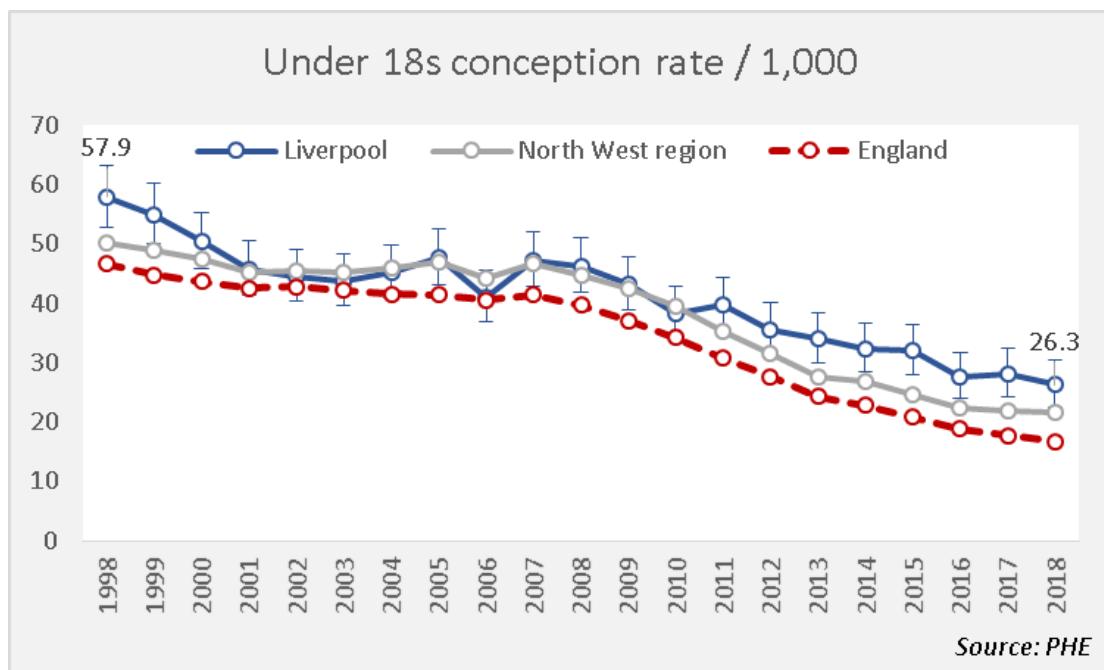
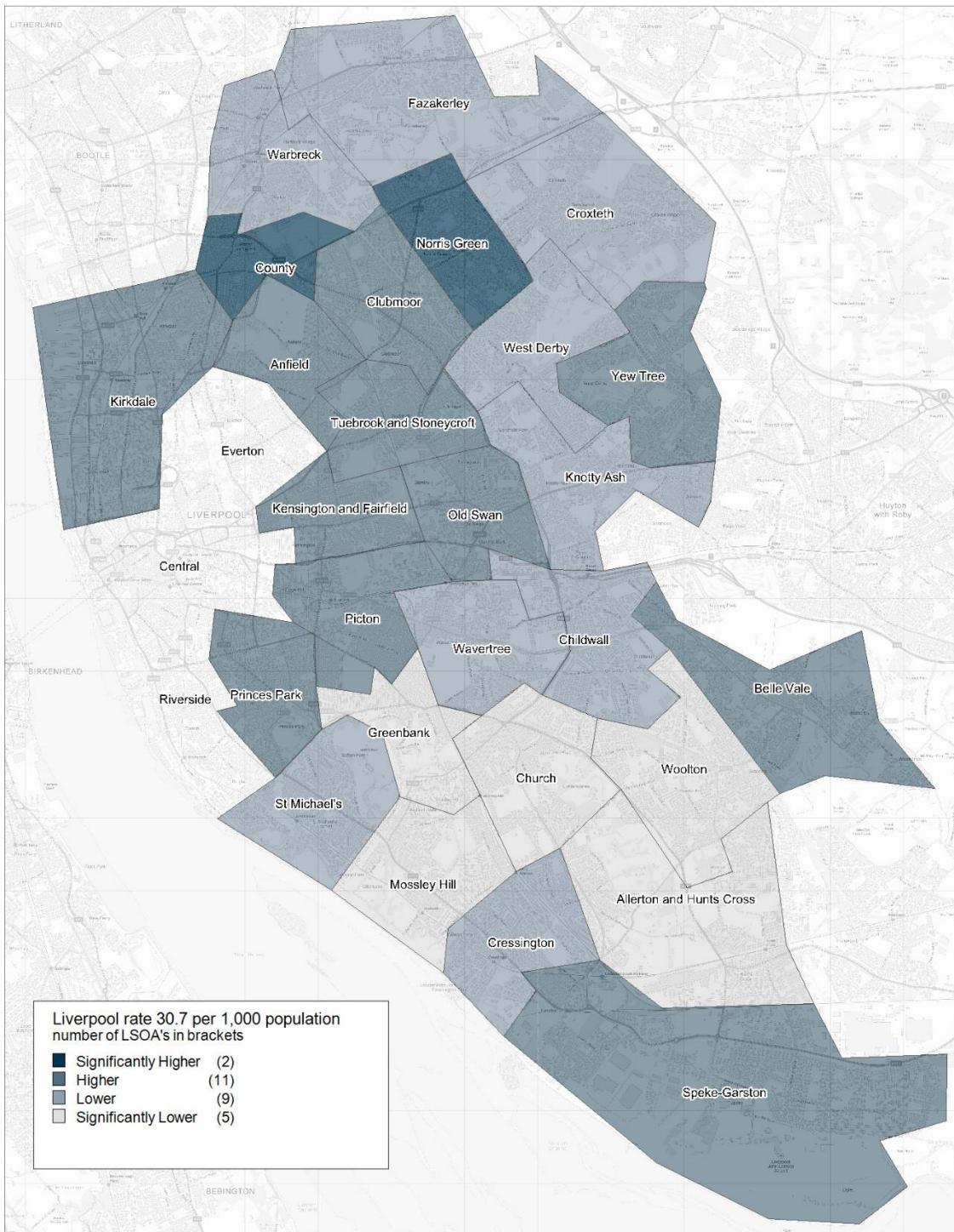


Figure 46: Under 18s conception rate per 1,000, 1998 - 2018
Source: Liverpool Intelligence & Analytics Team, October 2020



Under 18s conceptions rate, statistical Significance compared to Liverpool Rate, Ward level

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**Liverpool
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Figure 47: Under 18s conception rates per 1,000 by Liverpool ward, 2014-16

Recommendations:

- The public health response to reduce unplanned pregnancies should include marketing, easy access to the full range of contraception, and accessible free pregnancy testing with rapid referral to abortion services.
- Every effort should be made to eliminate local barriers to pregnancy diagnosis, provision of unbiased pregnancy options information, referral to maternity or abortion services, and STI testing & contraception provision.
- Prevention programmes are required for populations known to be at risk of exclusion from routine contraception, pregnancy testing & abortion provision.⁶

7.3.1.4 Abortion

Abortions carried out under the terms of the Abortion Act 1967

Overall no. & rate of abortions

- In Liverpool, the total abortion rate was 21.7 per 1,000 female population aged 15-44 years, while in England the rate was 18.1 per 1,000.

Breakdown by characteristics

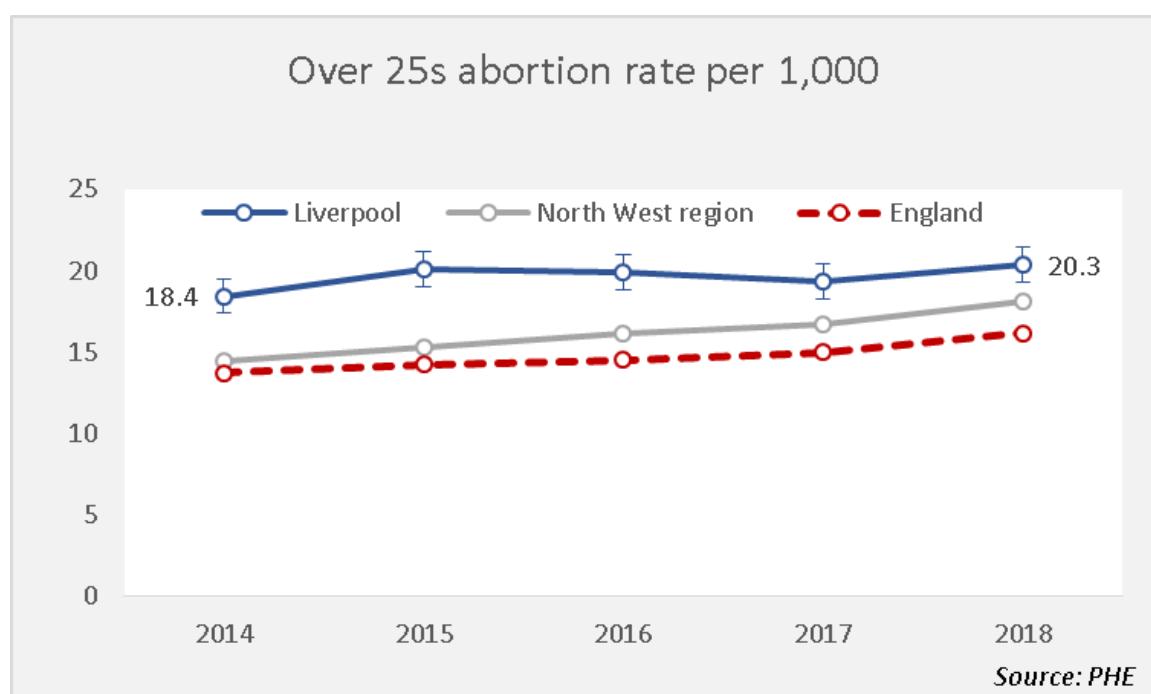


Figure 48: Over 25s abortion rate per 1,000, 2014 - 2018

Source: Liverpool Intelligence & Analytics Team, October 2020

⁶ These include teenagers, the homeless, asylum seekers & refugees, those with mental health problems, women involved in the criminal justice system, victims of sexual violence, those suffering from domestic abuse or from alcohol & drug problems

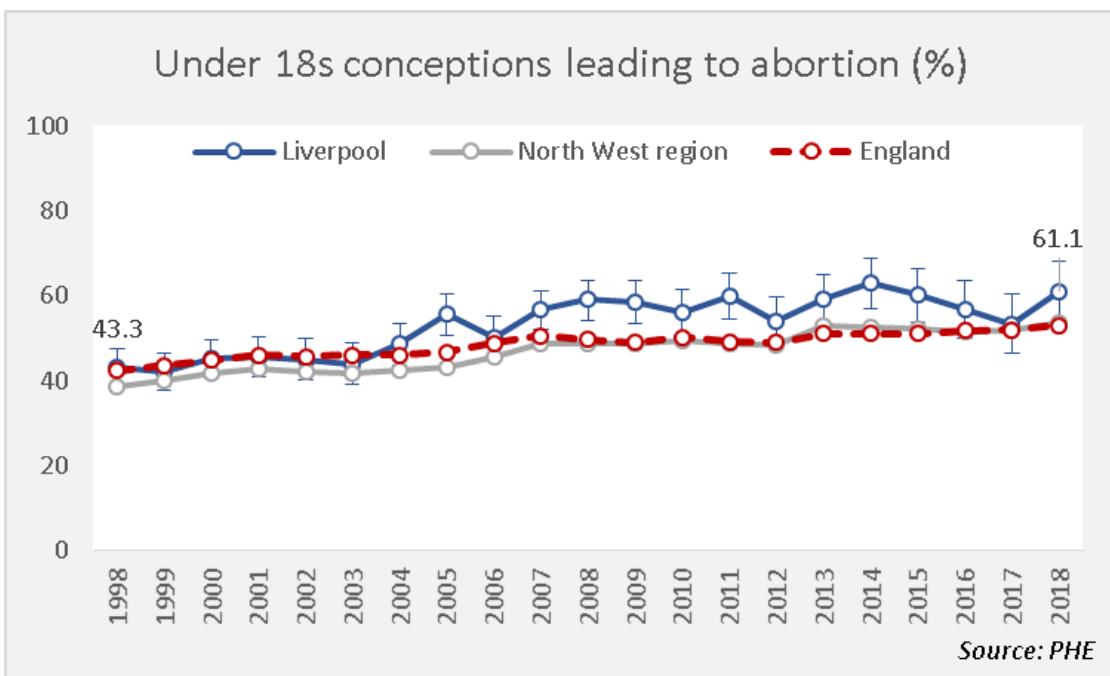


Figure 49: Under 18s conceptions leading to abortions (%), 2014 - 2018
Source: Liverpool Intelligence & Analytics Team, October 2020

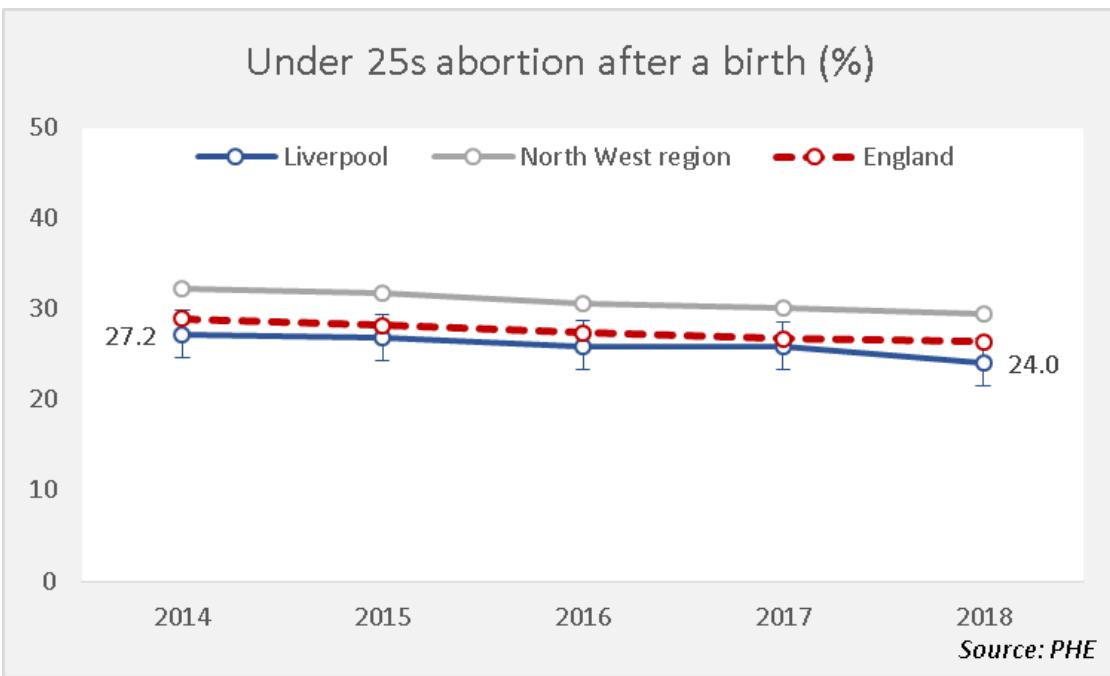


Figure 50: Under 25s who had an abortion after a birth (%), 2014 - 2018
Source: Liverpool Intelligence & Analytics Team, October 2020

- Of those women under 25 years who had an abortion in that year, the proportion in Liverpool who had previously had an abortion was 26.1%, compared to 26.8% in England.

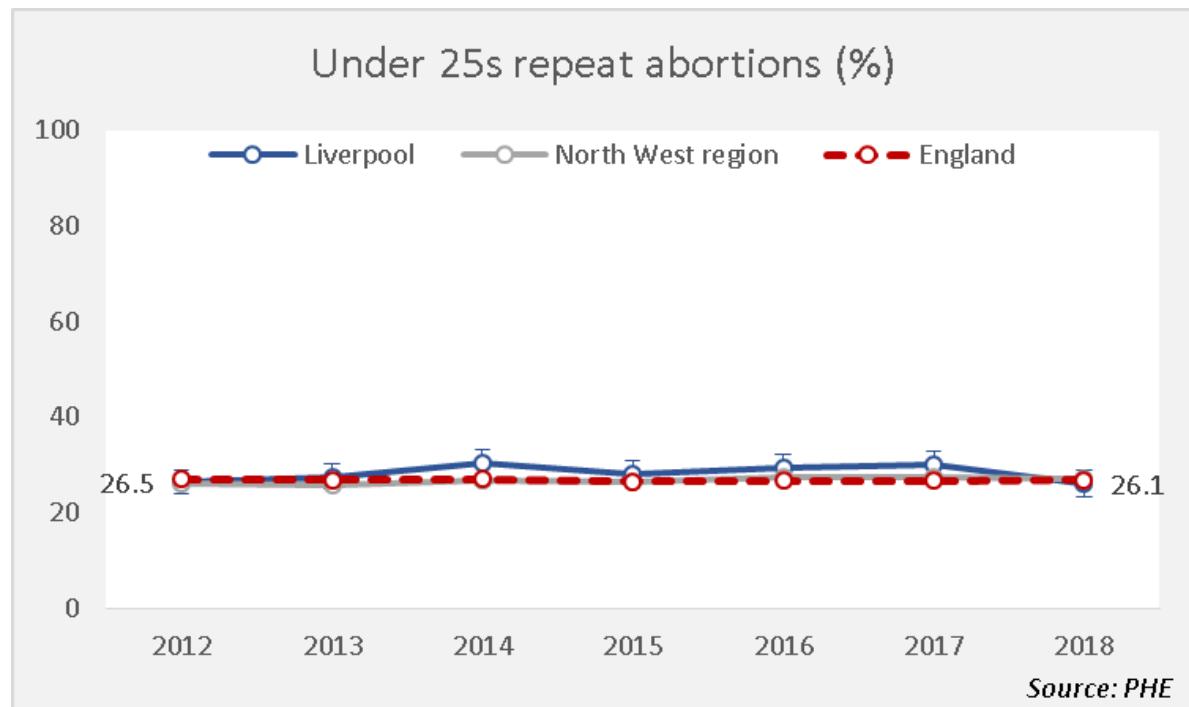


Figure 51: Under 25s who had repeat abortions (%), 2014 - 2018

Source: Liverpool Intelligence & Analytics Team, October 2020

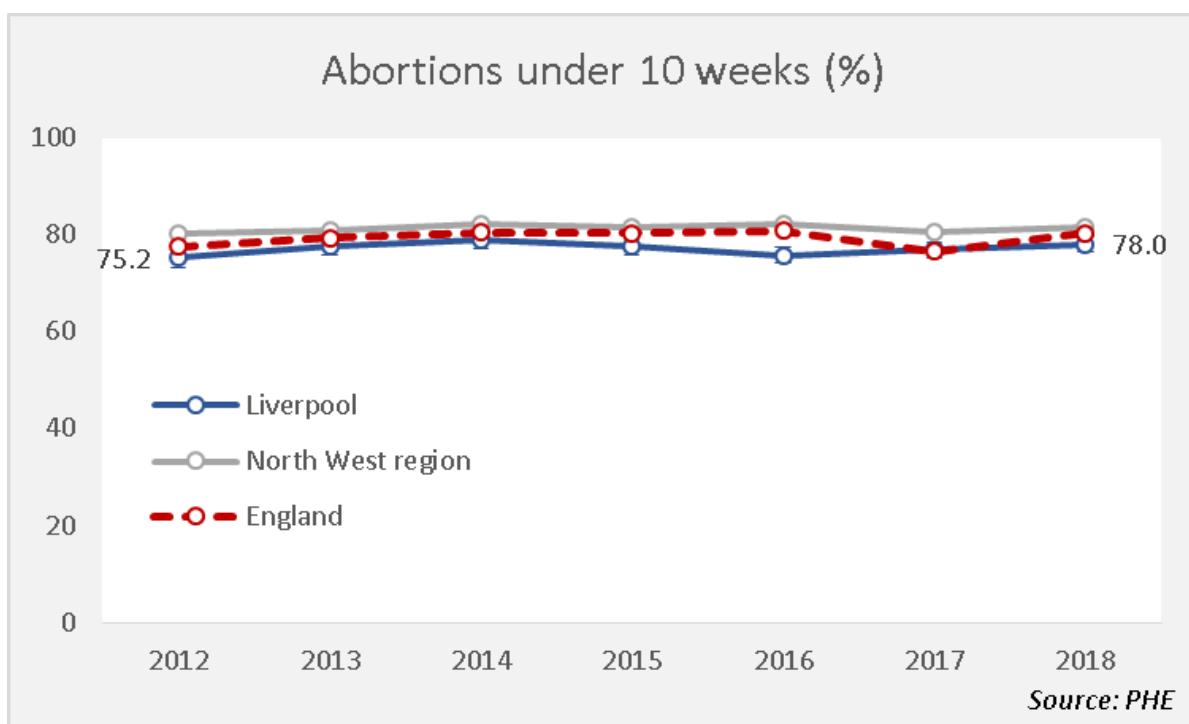


Figure 52: Abortions under 10 weeks (%), 2012 - 2017

Source: Liverpool Intelligence & Analytics Team, October 2020

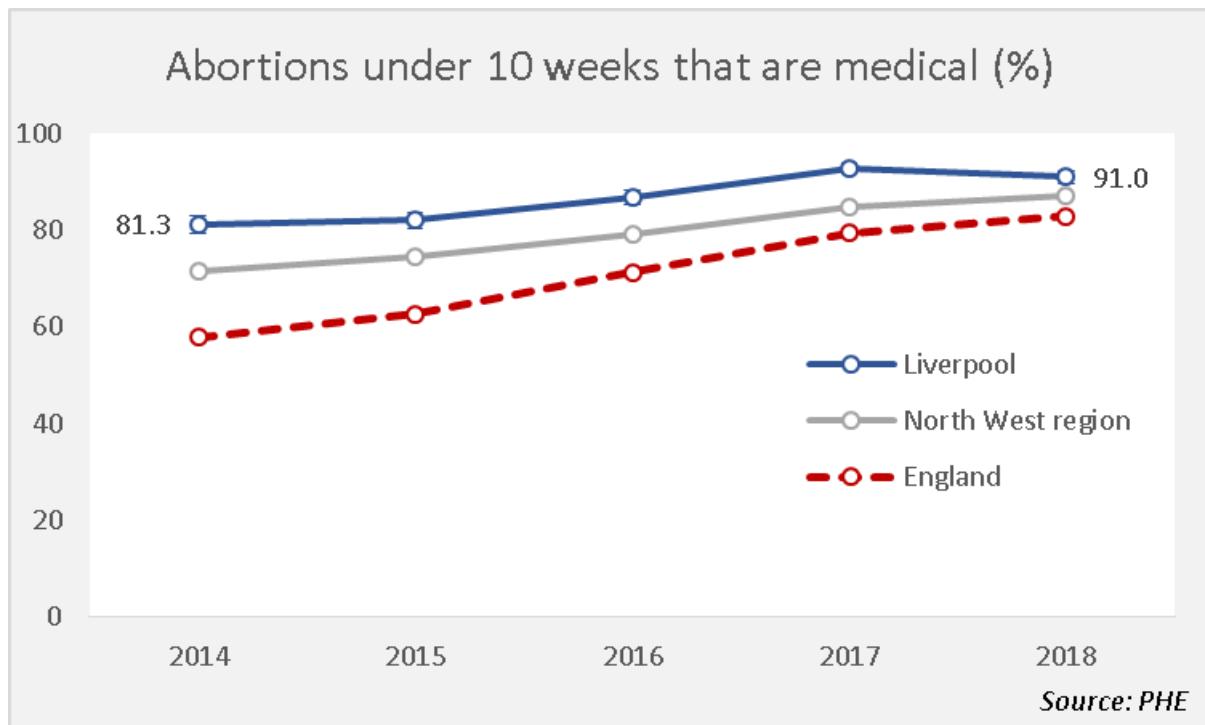


Figure 53: Abortions under 10 weeks that are medical (%), 2014 - 2018

Source: Liverpool Intelligence & Analytics Team, October 2020

Recommendations:

- Ensure that a choice of abortion services are easily available & accessible to women seeking an abortion up to 24 weeks gestation.

7.3.1.5 Maternity

Liverpool Women's Hospital (LWH) is the largest single site maternity hospital in the UK. The team there consists of highly skilled consultants, obstetricians and midwives with the aim of meeting the specific needs of every woman and their family that attend and access care. There are roughly 8,000 deliveries per annum, on average 2 babies born per day, and therefore many women who can have access to a robust and caring conversation about their contraceptive and reproductive health needs.

Whilst current data around contraception consultations/discussions and uptake postpartum are not fully known, maternity services represent a significant opportunity to have that vital and timely conversation with women about their future planning and methods when evidence suggests they are in a good place to have it.

In relation to this area, we need to:

- Work with LWH, Liverpool CCG and key consultant leads to form a multi-agency approach and partnership to improving the contraceptive offer to women postpartum
- Consider the alignment of budget to support the provision of LARC devices postpartum to ensure wider choice of contraceptive methods as part of the maternity pathway

7.3.1.6 Reproductive health complications

Pelvic Inflammatory Disease (PID)

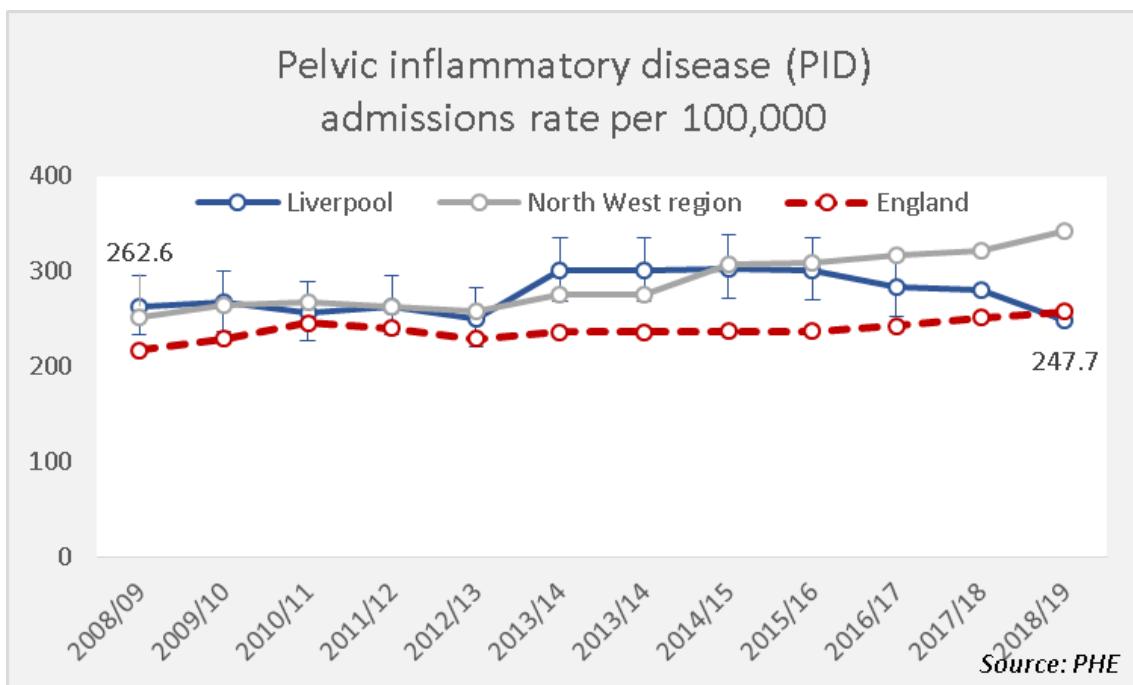


Figure 54: Admissions for pelvic inflammatory disease rates per 100,000, 2008/9 – 2018/19
Source: Liverpool Intelligence & Analytics Team, October 2020

Ectopic pregnancy

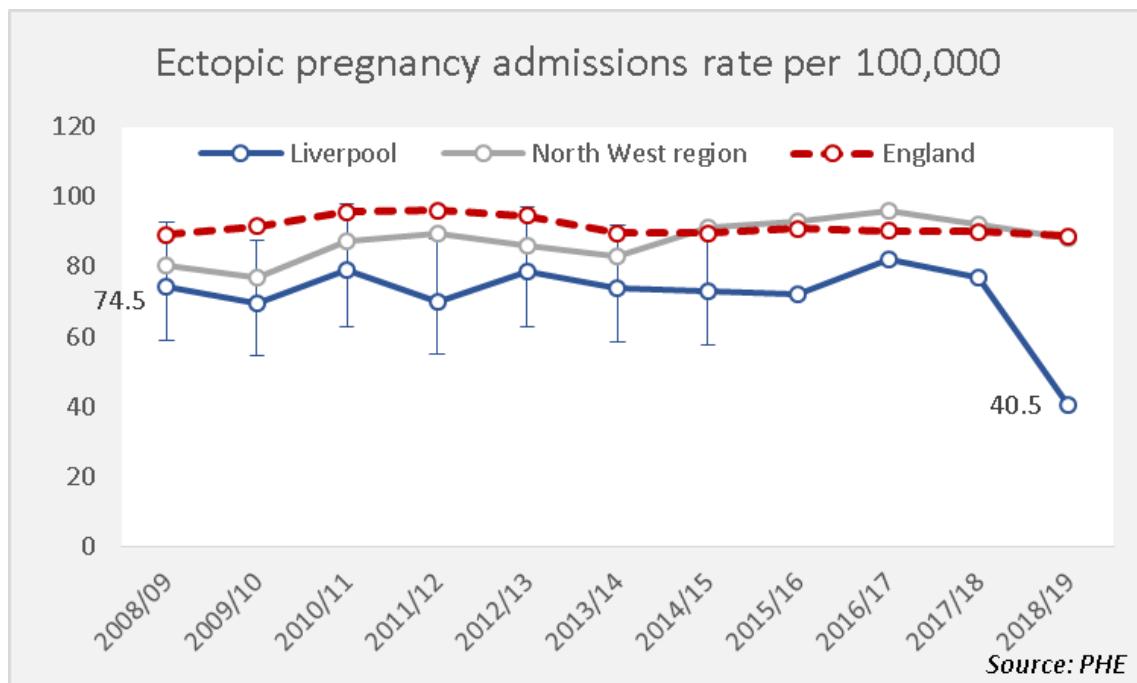


Figure 55: Admissions for ectopic pregnancy rates per 100,000, 2008/09 – 2018/19
Source: Liverpool Intelligence & Analytics Team, October 2020

Cervical cancer

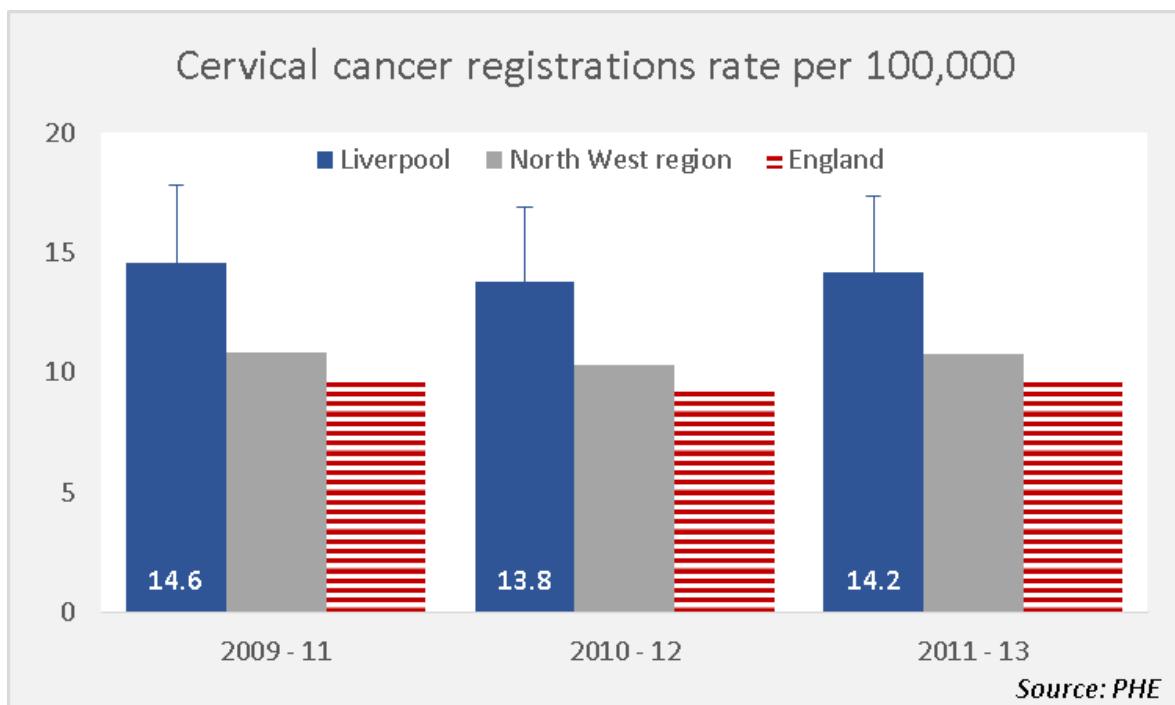


Figure 54: Cervical cancer registration rates per 100,000, 2009/11 – 2011/13
Source: Liverpool Intelligence & Analytics Team, October 2020

7.3.1.3 Emergency Contraception

The Emergency Hormonal Contraception (EHC) service, as commissioned by Liverpool City Council, allows pharmacies in Liverpool to facilitate the supply of appropriate and specified emergency contraception, pregnancy tests and signposting/advice. There are currently two specified medications used for emergency contraception for this service; Levonorgestrel (branded as Levonelle) and Ulipristal acetate (branded as EllaOne). Both medications are supplied by a pharmacist as outlined under the current Patient Group Direction (PGD). (NB. It is worth noting that separately from this commissioned service, patients are able to purchase EHC medication over the counter from most pharmacies).

The aims of the service are:

- To improve quick access to emergency contraception in order to reduce unintended pregnancies.
- To reduce referrals to abortion services.
- To help service user's access additional services than those offered in primary care or sexual health services such as health promotion material and sign posting where appropriate.
- To assist in the delivery of the Sexual Health indicators in the Public Health Outcomes Framework.

Liverpool City Council has commissioned 32 pharmacies across Liverpool to deliver this service.

Background

Since December 2018, the Pharmacy EHC service has undergone changes to enhance the offer made to service users.

- The service was recommissioned in December 2018 with the number of pharmacies commissioned to provide the service expanded from 6 to 32.
- Levonorgestrel was previously the only EHC medication permitted for use as part of this commissioned service and can be effectively used up to 72 hours since unprotected sexual intercourse (UPSI). However, Ulipristal acetate was added to the PGD for this service in June 2019 and this medication increases the effective use period to 120 hours since UPSI. Also, in March 2017, Emergency Contraception guidance published by The Faculty of Sexual & Reproductive Healthcare advised that Ulipristal acetate had been demonstrated to be more effective than Levonorgestrel (2017).³⁹

Previously

During 2018/19, the following EHC activity took place:

Number of consultations	1,889
Levonorgestrel issued	1,862
Pregnancy tests	25

Compared to the previous year 2017/18:

- The number of consultations increased from 1608 consultations by 17.5% (n=281)
- The number of Levonorgestrel issued increased from 1588 by 17.3% (n=274)
- The number of pregnancy tests taken increased from 22 by 13.6% (n=3)
- NB, the EHC service was expanded in December 2018 from 6 pharmacies to 32

2019/20 - Overview

During 2019/20, the following activity took place:

Number of consultations	4590
Ulipristal acetate issued	2858
Levonorgestrel issued	1668
Pregnancy tests	273

Compared to the previous year 2018/19:

- The number of consultations increased from 1889 consultations by 143% (n=2701)
- The number of pregnancy tests taken increased from 25 by 992% (n=248)

The increase in consultations during 2019/20 will have occurred due to the expansion of the service in December 2018 and the addition of Ulipristal acetate in June 2019.

2019/20 - Liverpool Wards

Liverpool is split into 30 local authority wards. 27 of these wards have pharmacies which have been commissioned by Liverpool City Council to provide EHC services:

Ward	Number of EHC pharmacies
Allerton and Hunts Cross	1
Anfield	1
Belle Vale	1
Central	1

Childwall	1
Church	1
Clubmoor	1
County	1
Cressington	1
Croxteth	1
Everton	1
Fazakerley	0
Greenbank	2
Kensington and Fairfield	1
Kirkdale	1
Knotty Ash	1
Mossley Hill	1
Norris Green	1
Old Swan	1
Picton	1
Princes Park	1
Riverside	1
Speke-Garston	3
St Michael's	0
Tuebrook and Stoneycroft	2
Warbreck	2
Wavertree	1
West Derby	1
Woolton	1
Yew Tree	0
TOTAL	32

During 2019/20, EHC consultations took place within the following wards:

Pharmacy (Ward location)	Consultations	%
Central	1,613	35.1%
Greenbank	1,122	24.4%
Speke-Garston	414	9.0%
Clubmoor	297	6.5%
Warbreck	279	6.1%
Tuebrook and Stoneycroft	145	3.2%
Everton	118	2.6%
Belle Vale	70	1.5%
Childwall	70	1.5%
Wavertree	64	1.4%
County	55	1.2%
Old Swan	50	1.1%
Knotty Ash	43	0.9%

Mossley Hill	42	0.9%
Croxteth	35	0.8%
West Derby	31	0.7%
Kensington and Fairfield	29	0.6%
Norris Green	19	0.4%
Riverside	19	0.4%
Woolton	16	0.3%
Allerton and Hunts Cross	16	0.3%
Princes Park	14	0.3%
Picton	11	0.2%
Kirkdale	10	0.2%
Cressington	8	0.2%
Anfield	0	0.0%
Church	0	0.0%
TOTAL	4,590	

- 59.5% of all consultations (n=2,735) took place across only two wards, Central and Greenbank.
- Central and Greenbank wards both have large university student populations.

EHC consultations took place at the following pharmacies:

Pharmacy	TOTAL	%	WARD
Boots Pharmacy, 9 Church Street, L1 1DA	1,613	35.1%	Central
Asda Pharmacy, Smithdown Road, L15 3JR	908	19.8%	Greenbank
Boots Pharmacy, Unit 9, New Mersey Retail Park, Speke Road, L24 8QB	377	8.2%	Speke-Garston
Asda Pharmacy, Utting Avenue, L4 9XU	297	6.5%	Clubmoor
Boots Pharmacy, 1a Greenbank Road, L18 1HG	214	4.7%	Greenbank
Orrell Park Pharmacy, 65 Moss Lane, L9 8AE	212	4.6%	Warbreck
Asda Pharmacy, Breck Road, L5 6PX	118	2.6%	Everton
Lloyds Pharmacy, 629-631 West Derby Road, L13 8AG	77	1.7%	Tuebrook and Stoneycroft
Boots Pharmacy, 12/14 Childwall Abbey Road, L16 0JN	70	1.5%	Childwall
Boots Pharmacy, Units 1/2, Belle Vale Shopping Centre, Childwall Valley Road, L25 2QY	70	1.5%	Belle Vale
Cohens Chemist, Townsend Lane HC, 96 Townsend Lane, L6 0BB	68	1.5%	Tuebrook and Stoneycroft
Lloyds Pharmacy, Sainsburys, Rice Lane, L9 1NL	67	1.5%	Warbreck
Cohens Chemist, Childwall HC, Queens Drive, L15 6YG	64	1.4%	Wavertree
McKeevers Chemist, Breeze Close HC, 2 Rice Lane, L9 1AD	55	1.2%	County
Lloyds Pharmacy, 23/25 St Oswalds Street, L13 5SA	50	1.1%	Old Swan
Lloyds Pharmacy, Sainsburys, 112 East Prescot Road, L14 5PT	43	0.9%	Knotty Ash
Boots Pharmacy, 43 Booker Avenue, L18 4QZ	42	0.9%	Mossley Hill
Lloyds Pharmacy, Unit 8, 38 Langley Close, L12 0NB	35	0.8%	Croxteth
Mill Lane Pharmacy, 30 Mill Lane, L12 7JB	31	0.7%	West Derby
Boots Pharmacy, 19 Prescot Road, L7 0LA	29	0.6%	Kensington and Fairfield
Lloyds Pharmacy, 30 Church Road, L19 2LW	21	0.5%	Speke-Garston
Boots Pharmacy, Unit 5, 46 Landford Avenue, L9 6BR	19	0.4%	Norris Green
Cohens Chemist, 30 Argyle Street, L1 5DL	19	0.4%	Riverside
Greencross Pharmacy, West Speke HC, Blacklock Hall Road, L24 3TY	16	0.3%	Speke-Garston
Lloyds Pharmacy, Sainsburys, 1 Sainsbury's Centre, James Road, L25 5QA	16	0.3%	Woolton
Woolton Late Night Chemist, 267 Hunts Cross Avenue, L25 9ND	16	0.3%	Allerton and Hunts Cross
Rowlands Pharmacy, 1 The Elms, L8 3SS	14	0.3%	Princes Park
Durning Pharmacy, Crosfield Road, L7 5NZ	11	0.2%	Picton
P Robinson Pharmacy, Vauxhall HC, Limekiln Lane, L5 8XR	10	0.2%	Kirkdale

Greencross Pharmacy, 79 Garston Old Road, L19 9AD	8	0.2%	Cressington
Green Lane Pharmacy, 167-169 Allerton Road, L18 6HG	0	0.0%	Church
Rowlands Pharmacy, 74-78 Priory Road, L4 2SH	0	0.0%	Anfield
TOTAL		4590	

- 54.9% of all consultations (n=2521) took place at only two pharmacies.
- 18.5% of all consultations (n=851) took place across 23 pharmacies

Area	Consultations	%
Liverpool	3,337	72.7%
Halton	22	0.5%
Knowsley	241	5.3%
Sefton	252	5.5%
St. Helens	19	0.4%
Wirral	98	2.1%
LCR Authorities TOTAL	632	13.8%
Outside-LCR	380	8.3%
Unknown	187	4.1%
No Fixed Abode	54	1.2%
Out of Area TOTAL	1253	27.3%
GRAND TOTAL	4590	

2019/20 - Out of Area service users

The Pharmacy EHC service can be accessed by anyone, this includes service users who may not live within Liverpool.

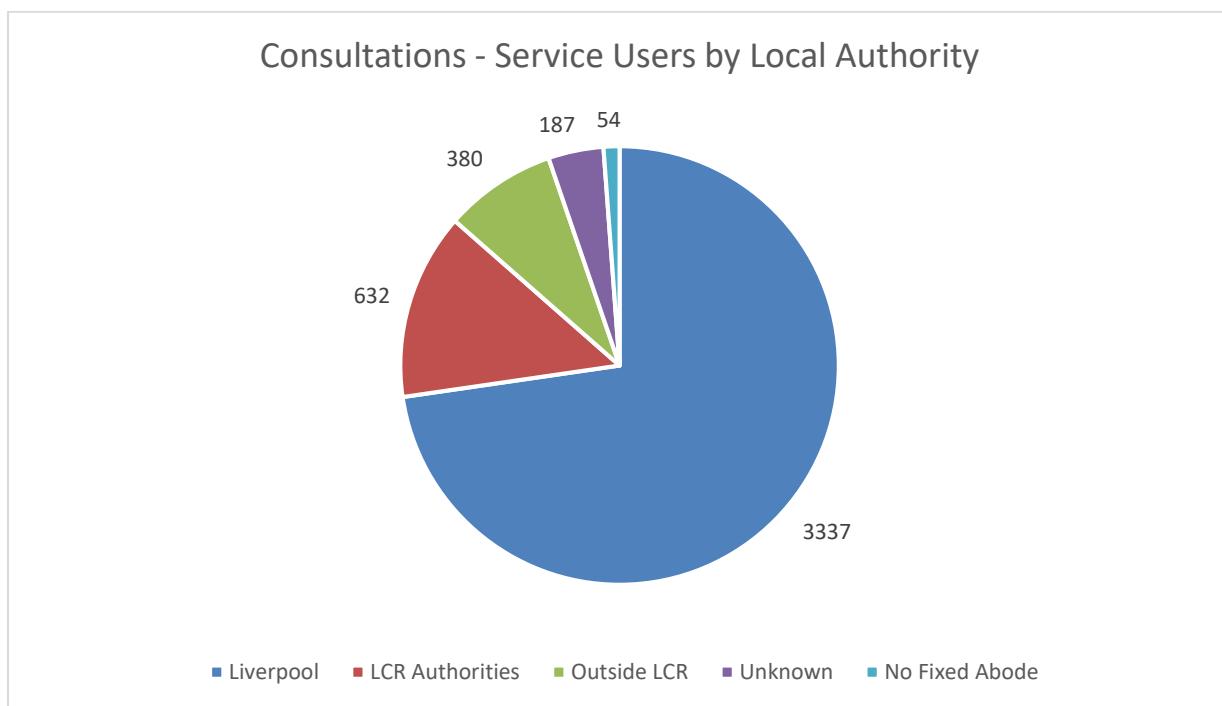


Figure 55: Consultations – service users by local authority, 2019/20

Local Authority	Consultations	%
Liverpool	3337	72.7%
Sefton	252	5.5%
Knowsley	241	5.3%
Wirral	98	2.1%
Cheshire West and Chester	34	0.7%
Manchester	26	0.6%
Halton	22	0.5%
West Lancashire	22	0.5%
St. Helens	19	0.4%
Birmingham	17	0.4%
Other Local Authorities	281	6.1%
Unknown	187	4.1%
No Fixed Abode	54	1.2%
TOTAL	4590	

- 72.7% (n=3,337) of all consultations were for Liverpool residents.
- 13.8% (n=632) of all consultations were for clients living in neighbouring Liverpool City Region (LCR) authority areas.
- 13.5% (n=621) of all consultations were for clients living outside of LCR.
- In total, 27.3% (n=1,253) of all consultations were for clients living outside Liverpool.
- 4.1% (n=187) of all consultations were for clients with no place of residence recognised (this could be due to the client providing the wrong post code or data entry error).
- 1.2% (n=54) of all consultations were for clients of no fixed abode.
- Clients accessing Pharmacy EHC services had their place of permanent residence recorded at 132 different local authority areas across the country (excluding Liverpool and other LCR authorities).

2019/20 - Age

There are currently no age limits in place for service users accessing this service. However, the PGD outlines a number of requirements for services users who may fall into a certain age group, specifically for younger service users:

- Under 18 years of age: a risk assessment should be undertaken to determine whether the child is at risk of harm and any concerns should be discussed with the local safeguarding lead.
- Under 16 years of age: the service user must be competent as assessed under the Fraser Guidelines on consent to medical treatment.

- Under 13 years of age: service users in this age group must be discussed with the local safeguarding lead.

Age Group	Consultations	%
15 and under	14	0.3%
16-19	904	19.7%
20-24	1585	34.5%
25-29	861	18.8%
30-34	682	14.9%
35-39	353	7.7%
40-44	130	2.8%
45-49	51	1.1%
50-54	10	0.2%
TOTAL	4590	

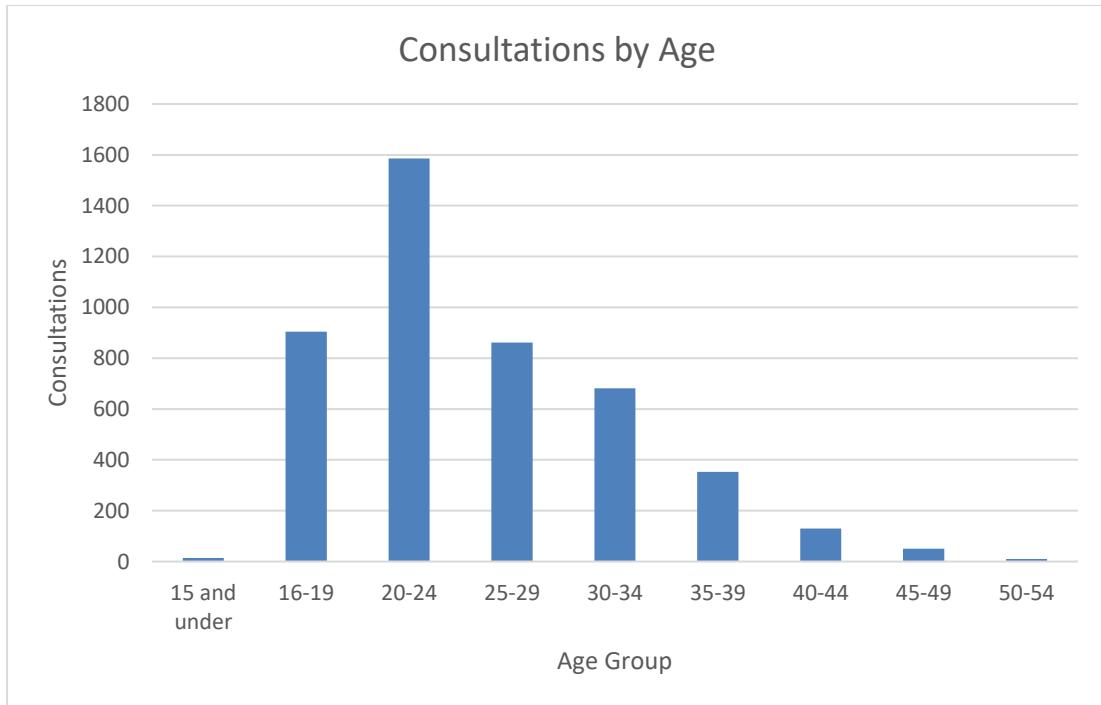


Figure 56: Consultations – service users by age, 2019/20

- 54.5% (n=2,503) of all consultations occurred among those aged 24 and under

Age Group	Consultations					
	Liverpool	LCR	Outside LCR	Unknown	NFA	TOTAL
15 and under	8	4	1	1	0	14
16-19	569	125	125	71	14	904
20-24	1,164	183	150	67	21	1585

25-29	654	129	50	19	9	861
30-34	513	117	30	18	4	682
35-39	288	43	14	6	2	353
40-44	92	27	3	5	3	130
45-49	43	2	5	0	1	51
50-54	6	2	2	0	0	10
TOTAL	3,337	632	380	187	54	4590

2019/20 - Repeat Consultations

Service users are able to access the EHC service on more than one occasion if needed.

Have you previously accessed the EHC service?	Consultations	%
Yes	2980	64.9%
No	1610	35.1%
TOTAL	4590	

- 64.9% (n=2980) of all consultations, the service users stated they had previously accessed EHC services.

There were 2183 consultations by Liverpool residents where the service users stated they had previously accessed the EHC service. This is 65.4% of all consultations for Liverpool residents.

Ward	Consultations	%
Greenbank	622	28.5%
Central	558	25.6%
Clubmoor	229	10.5%
Speke-Garston	201	9.2%
Warbreck	105	4.8%
Everton	76	3.5%
Tuebrook and Stoneycroft	67	3.1%
Wavertree	42	1.9%

Belle Vale	38	1.7%
Childwall	36	1.6%
County	34	1.6%
Mossley Hill	30	1.4%
Knotty Ash	24	1.1%
Old Swan	23	1.1%
Croxteth	19	0.9%
West Derby	17	0.8%
Norris Green	12	0.5%
Kensington and Fairfield	12	0.5%
Princes Park	10	0.5%
Riverside	9	0.4%
Allerton and Hunts Cross	6	0.3%
Woolton	5	0.2%
Cressington	4	0.2%
Kirkdale	2	0.1%
Picton	2	0.1%
Anfield	0	0.0%
Church	0	0.0%
Fazakerley	0	0.0%
St Michael's	0	0.0%
Yew Tree	0	0.0%
TOTAL	2,183	

- 73.8% (n=1,610) of repeat consultations were from Liverpool residents across four wards (Greenbank, Central, Clubmoor, Speke-Garston)

Service users may have previously accessed the EHC service (pharmacy or other) on multiple occasions within the previous 12 month period.

Number of times service user has accessed the EHC service in previous 12 months	Consultations	%
1	1,320	71.4%
2	356	19.3%
3	116	6.3%
4	29	1.6%
5	22	1.2%
6	3	0.2%
7	3	0.2%
TOTAL	1,849	

- Of the 2980 consultations where the service users stated they had previously accessed EHC services, 62% (n=1849) had accessed EHC services in the previous 12-month period. This is 40.3% of all consultations where the service user had accessed EHC services in the previous 12 months.
- 11.5% (n=529) of consultations, the service users stated they had accessed the EHC service previously on more than one occasion.

Reason for accessing EHC service

Service users can access the EHC service for a range of different reasons.

Reason for Attendance	Consultations	%
No contraception used	2,939	64.0%
Barrier method failure	879	19.2%
Contraception failure	717	15.6%
Other	55	1.2%
TOTAL	4,590	

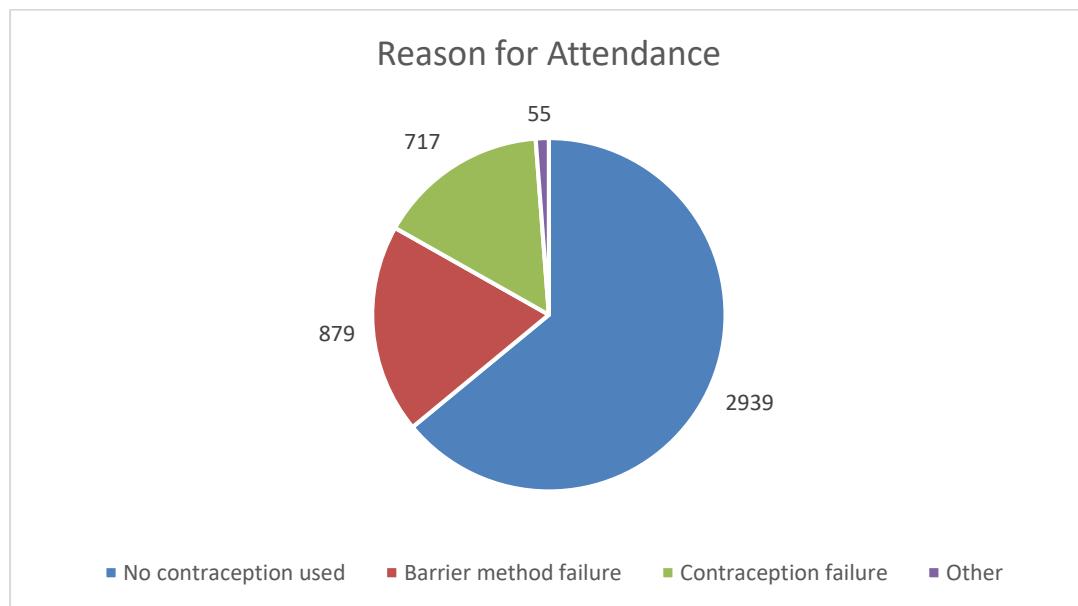


Figure 57: Reason for attendance at EHC service, 2019/20

Service users are also asked if alcohol was a contributing factor in their need to access the EHC service.

Was alcohol a factor?	Consultations	%
No	3,170	69.1%
Yes	1,165	25.4%
Declined to answer	255	5.6%
TOTAL	4,590	

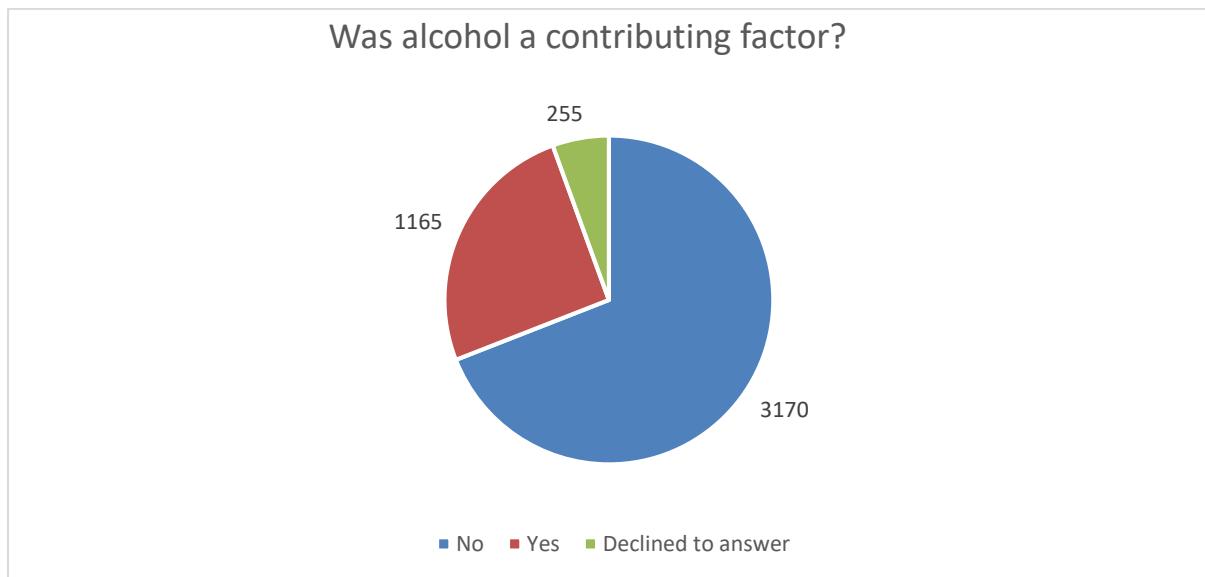


Figure 58: Was alcohol a contributing factor for attendance at EHC service, 2019/20

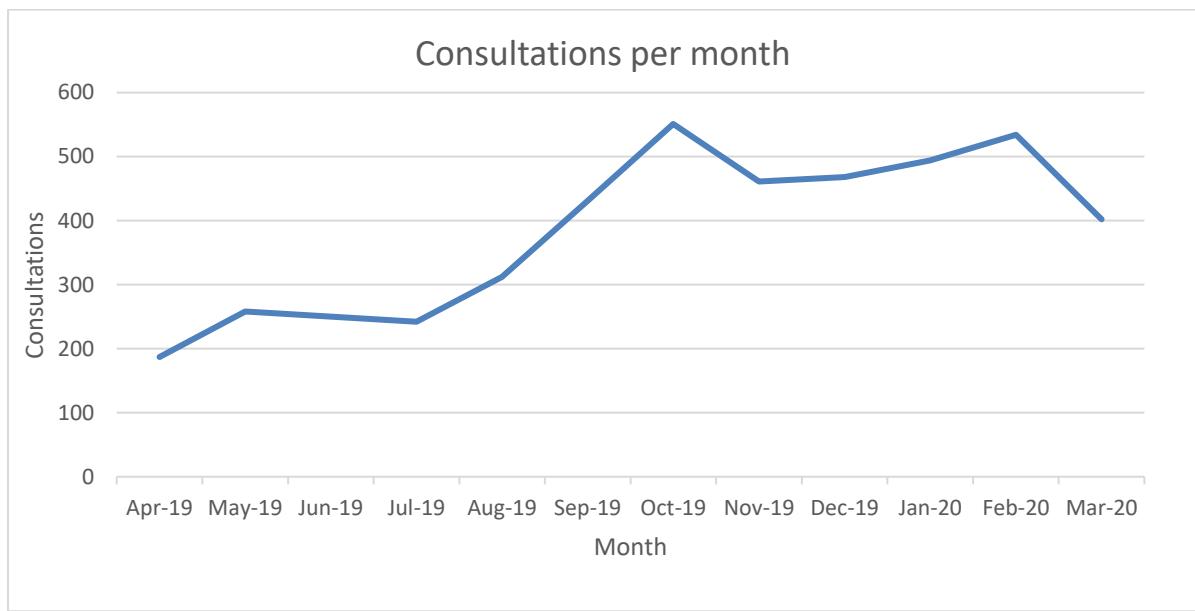


Figure 59: Consultations per month, 2019/20

Consultations per month

Month	TOTAL	%
Apr-19	187	4.1%
May-19	258	5.6%
Jun-19	250	5.4%
Jul-19	242	5.3%
Aug-19	312	6.8%
Sep-19	431	9.4%
Oct-19	551	12.0%
Nov-19	461	10.0%
Dec-19	468	10.2%
Jan-20	494	10.8%
Feb-20	534	11.6%
Mar-20	402	8.8%
TOTAL	4,590	

- Between April and July, the number of consultations remained fairly static.
- From August the number of consultations started to increase, peaking during October.
- Between November and February the number of consultations remained at a high level before reducing in March.
- NB, COVID-19 may have had a negative effect on the number of consultations during March 2020.

7.4 Recommendations for Reproductive Health/Contraception:

1. Ensure the full range of contraceptive options is available in every service with pathways that enable rapid & easy access to the method of choice.
2. Use the many opportunities after pregnancy to offer contraception, particularly long-acting methods, such as in maternity, early pregnancy units & post abortion.
3. Ensure that LARC provision effectively meets the need of the population (there has been a decline in the provision of LARC in General Practice over the last few years due to reduced capacity but with wide geographical variations).
4. Ensure that the emergency IUD is offered to all & take the opportunity to refer on to local services to ensure provision of the chosen method.
5. Improve post-TOP and post-partum LARC uptake and gather better data and intelligence on this.
6. Improve LARC access and uptake across the city and ensure that any myths or lack of understanding around this method are addressed during choices discussions

7. Continue to improve contraceptive access across General Practice and via Primary Care Networks (PCNs) to support women to be able to access their preferred choice promptly and when required
8. Continue to explore co-commissioning opportunities in relation to reproductive health hub development in order to provide a more joined-up approach to women's health, ensuring that women receive the best possible care by providing all of their healthcare needs in one location
9. Work with LWH, Liverpool CCG and key consultant leads to form a multi-agency approach and partnership to improving the contraceptive offer to women postpartum
10. Continue to improve the SRH offer delivered via pharmacy, in relation to EHC and wider user-dependent methods such as bridging contraception, pills and depo-provera access for both starters and continuation.

7.4 Clinic Access – Cross Boundary Activity

Cross boundary use of services

The most detailed analysis of clinic flows and activity across both Liverpool and Cheshire & Mersey region was worked on by Halton Borough Council analysts in 2019. It highlighted that 91.5% of Liverpool residents attend a clinic within their own area. Other than St Helens this is the highest in the region and illustrates that most local residents use a local service for care.

	Cheshire East	CWAC	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
LA of residence	12898	15880	9424	10199	53419	19110	19101	10401	21884
Total	15309	18558	12442	16531	58388	25270	20793	12167	24383
% LA of residence	84.3%	85.6%	75.7%	61.7%	91.5%	75.6%	91.9%	85.5%	89.8%

Table 5: % attendances in own local authority by postcode of residence

When analysed regionally, 99% of Liverpool residents opt to stay in Cheshire & Mersey to access their services – with main cross boundary outflow heading to Knowsley, Sefton and Wirral.

	Cheshire East	CWAC	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral	C&M
C&M LAs	13525	17953	12281	16128	57810	24936	20266	11571	24100	198570
Total	15309	18558	12442	16531	58388	25270	20793	12167	24383	203841
% C&M	88.3%	96.7%	98.7%	97.6%	99.0%	98.7%	97.5%	95.1%	98.8%	97.4%

Table 6: Percentage of attendances for each local authority which occurred within the Cheshire & Merseyside area

Table 6 shows that for 8 out of the 9 LAs more than 95% of residents attended sexual health services within their local authority boundary.

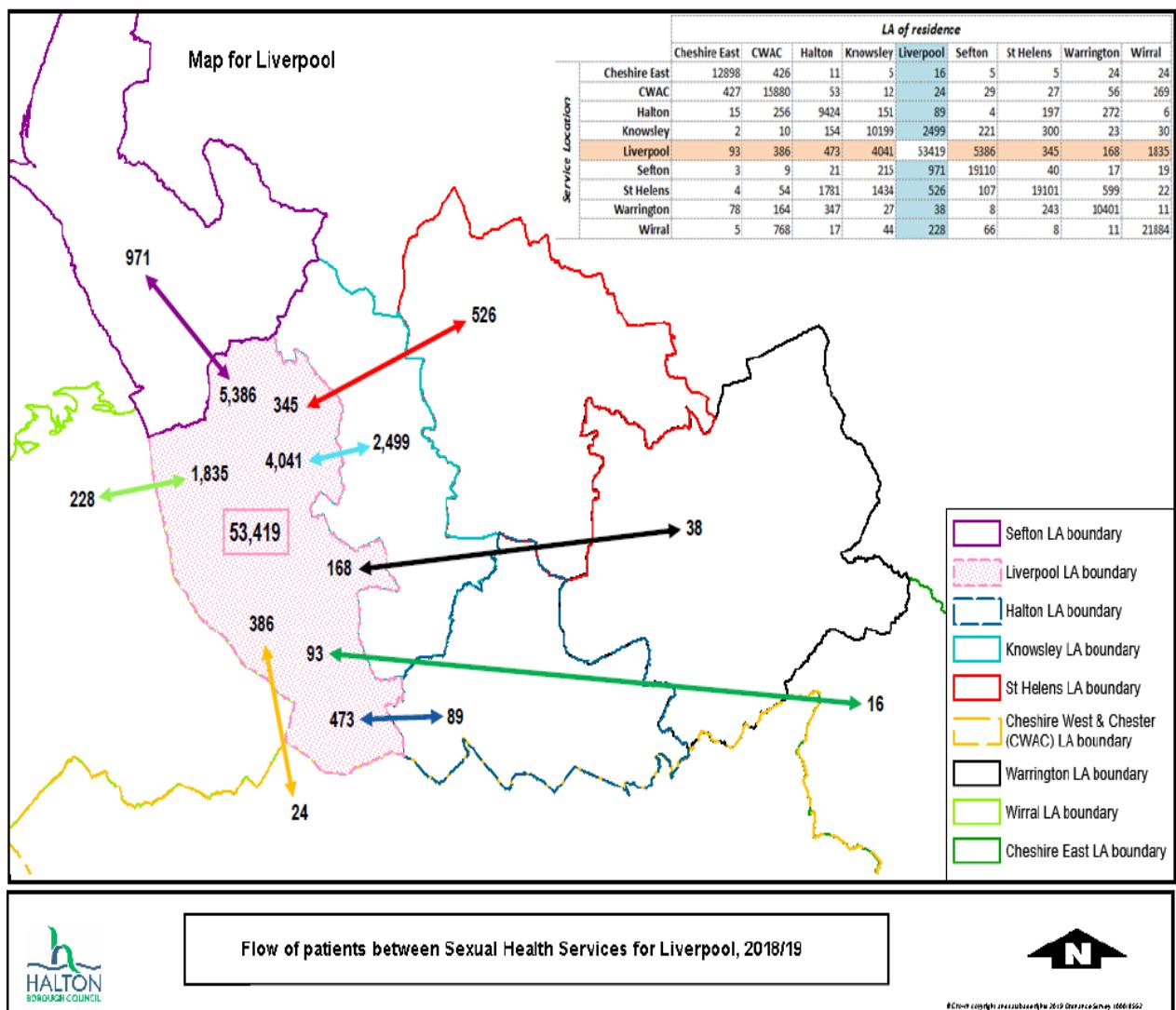


Figure 60: Flow of patients between Sexual Health Services for Liverpool, 2018/19

It can be seen that Liverpool, as a major city, imports a lot of patients from other areas. The highest number of patients attending clinics in Liverpool come from Sefton, Knowsley, and then to a lesser extent, Wirral.

8. Young People

8.1 Teenage Pregnancy & the role of RSE

Nationally teenage conception rates are falling. During 2018, conception rates for under 18-year-olds in England and Wales declined by 6.1% to 16.8 conceptions per 1,000 women aged 15 to 17 years. Since 1999, conception rates for women aged under 18 years have decreased by 62.7%⁴⁰. However, in Liverpool we still have the fifth highest rate of teenage conceptions in the North West. These rates are also higher among more deprived communities creating further health inequalities.

Liverpool currently has a lower rate than many of our neighbours and core cities with respect to under-25s choosing LARC. This means that more people are relying on less effective barrier methods or the pill. Reducing access to these offers further could have serious consequences. It must be an aim of commissioners during service redesign to increase the availability of, and access to, longer-term contraceptive methods (LARCs) to women of all ages, including younger people where deemed clinically appropriate.

International evidence identifies the provision of high quality, comprehensive relationships and sex education (RSE) linked to improved use of contraception as the areas where the strongest empirical evidence exists on impact on teenage pregnancy rates. RSE also has wider safeguarding and health benefits but to have impact, provision needs to reflect the internationally recognised effectiveness factors.

Contraceptive services need to be accessible and young people friendly to encourage early uptake of advice with consultations that recognise and address any knowledge gaps about fertility and concerns about side effects. They must also support young people to choose and use their preferred method. An open and honest culture around sex and relationships is also associated with lower teenage pregnancy rates.

Countries with more open approaches to young people's sexual health, as assessed by better RSE, more parental communication and more accessible contraceptive services, have lower conception rates. Relationships education in primary schools and relationships and sex education in secondary schools will become statutory in all schools in England during the 2020/21 academic year. The original start date of September 2020 was delayed by the Department for Education (DfE) due to the Coronavirus pandemic. However, schools will still be expected to introduce it into the new curriculum as a compulsory element as soon as possible.

There are many opportunities to embed the sexual, reproductive health and relationship needs of young people at the heart of other services. The provision of contraception via Family Nurse Partnership (FNP) models, across PB-19 (25) services (school health) and more robustly within maternity care postpartum offer real potential to ensure that young people can and do access care at the time they need it.

8.2 Recommendations for young people

Throughout this needs assessment there are a raft of recommendations tailored to young people in relation to:

- STI screening, treatment and care
- The National Chlamydia Screening Programme and opportunistic screening for chlamydia
- Reproductive Health including access to all forms of contraception
- Young person friendly service requirements
- The importance of early intervention, prevention and relationships and sex education (RSE)

9. Psychosex/Sex Addiction

Psychosexual Therapy relates to the treatment and support provided for individuals or couples who experience difficulty with sex or intimacy including complex cases. Such problems can arise from anxiety or lack of confidence and culminate with an individual, or couple, feeling confused and distressed.

Sexual problems can impact anyone at any stage in life, and someone does not have to be in a relationship to experience these issues.

Sometimes the way we think about sex can have a negative effect on sexual performance, experience and pleasure.

Specialist psychosexual therapy can be offered to help with:

- Premature ejaculation or rapid ejaculation – inability to control ejaculation (“coming” too soon)
- Delayed ejaculation or absent ejaculation – difficulty in reaching ejaculation
- Erectile dysfunction (impotence) – inability to get or keep an erection
- Impaired sexual interest – no interest in sex, causing concern in the individual
- Impaired arousal – difficulty in becoming sexually aroused
- Orgasmic dysfunction or anorgasmia – finding it difficult to reach orgasm despite adequate sexual stimulation
- Dyspareunia – pain when starting or having sexual intercourse
- Vaginismus – not being able to tolerate any vaginal penetration

Liverpool has a local service offer provided by Mersey Care (via Abacus Clinical) related to psychosexual support. It is offered by specialty leads with qualifications in this particular discipline to guide individuals or couples through a range of issues.

Recommendation: That local commissioners continue to commission and specify a need for psychosexual therapy within local service provision to support those patients in need of that care.

10. ChemSex

Chemsex means using drugs as part of your sex life, and it's most common among gay and bi men. It is linked inextricably to the phenomenon of the gay online hook-up

culture. This refers to the use of smartphone apps such as Grindr and their role in gay culture and sexuality, the proliferation of chems among this population, and other uniquely gay cultural idiosyncrasies that affect concepts of sexual well-being. There are typically three specific 'chems' (drugs) involved. Evidence from discussions with those people involved in Chemsex suggests that these drugs make them feel less inhibited and increase pleasure. The three main drugs people take as part of chemsex are methamphetamine, mephedrone and GHB/GBL. In many scenarios, people inject or 'slam' crystal meth and mephedrone to heighten the experience or reduce inhibition during sex. When this occurs there is an increased risk of injection-related infections and blood-borne viruses (BBVs) like HIV, hepatitis C (HCV) and hepatitis B. When under the influence of drugs, a condom may not be used, which can put those involved at much higher risk of HIV and other sexually transmitted infections (STIs). People who are high on certain drugs will often have rougher sex than usual, which can cause bleeding.

The second European Chemsex Forum, held in Berlin, highlighted a number of difficulties and harms experienced by chemsex users, including non-consensual sex. There are many stories of men who, during sexual marathons that last for days, pass out on GHB or GBL, while the sex continues to take place. When they come around, they often have no recollection of what happened. There are also reports of 'days lost' due to the drugs involved, where the person involved is not fully aware of what has happened (and the risk taken), until it is outside of the initial 72-hour recommended window for initiation of PEPSE.

Evidence suggests that drug and alcohol services and sexual health service providers should collaborate to meet the specific needs of those people in the population involved in Chemsex activity.

During the 2018-19 reporting period, 20% of gay or bisexual men presenting to drug treatment reported problematic use of one of the three substances most commonly used in relation to chemsex (GBL, methamphetamine and/or mephedrone). This proportion was much higher than among heterosexual men (0.3%). Among individuals who used these drugs, rates of current injecting were also much higher among gay/bisexual men than among heterosexual men (34% compared to 18%) (LASER 2018).

In 2018/19 financial year, 34 gay or bisexual men presented to drug treatment in Liverpool upper tier local authority (UTLA). Of these, fewer than five cited use of one of these drugs, of which none further indicated they were injecting. It is important to note that this data may be a reflection of the effectiveness of treatment pathways and there may be unmet need not reflected in the data.

Recommendations:

1. Joint working should be established between alcohol and drug services and SHSs to ensure an integrated approach to meet the specific needs of MSM involved in 'chemsex', including hepatitis C testing and treatment and hepatitis B vaccination;
2. Sexual Health services are well placed to support those people engaging in ChemSex and so inclusion of discussion related to 'Chems' (party drugs) in templates locally is key.
3. A dedicated local Chemsex clinic should be offered by trained leads locally in order to support people to put a risk reduction plan in place.

11. Sexual Abuse/Exploitation

11.1 Sexual Violence

As acknowledged by the WHO, sexual violence is a serious public health and human rights problem with both short- and long-term consequences on women's physical, mental, sexual and reproductive health. Whether sexual violence occurs in the context of an intimate partnership; within the larger family or community structure; or during times of conflict, it is a deeply violating and painful experience for the survivor.

The government brought out an action plan in 2010 entitled '*Call to end violence against women and girls*'⁴¹. According to the latest figures published on the PHOF and via the Liverpool LASER, the rate of sexual offences being reported have increased significantly since 2010/11. The rate now stands at 2.4 per 1,000, which is a rise on recent datasets. In 2015/16 the rate of sexual offences in Liverpool was 1.7 per 1,000 people - a total of 803. This figure is similar to the national figures for that same time period. The latest figures suggest a drop off in relation to offences in Liverpool (compared to 2017-18) and now mean that locally our figures are lower than the regional and national averages.

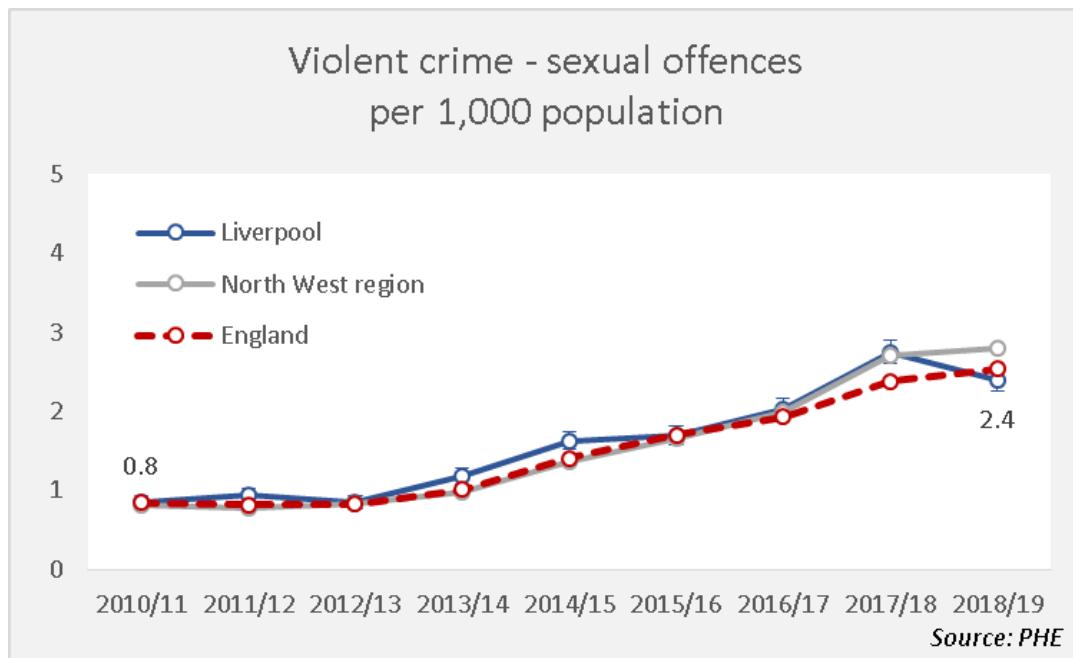


Figure 61: Violent crime - sexual offences rates per 100,000, 2010/11 – 2018/19

Source: Liverpool Intelligence & Analytics Team, October 2020

- During the examined period of October 2018 to September 2019 there have been 1054 sexual offences reported. A 5% reduction from the previous year. For current offences (offences recorded in the current year) there has been a slightly bigger reduction of 6%, (898 to 840 offences).
- Historical reports of sexual violence have remained static year on year (213 to 214 offences). Historical reports tend to increase when there are public enquiries into sex abuse cases (such as Operation Yewtree).
- Non historical rape offences (including attempted rape) have reduced by 2% from last year (368 to 361 offences).
- Since 2015, trends in current offences have increased at a higher rate than historically reported offences.

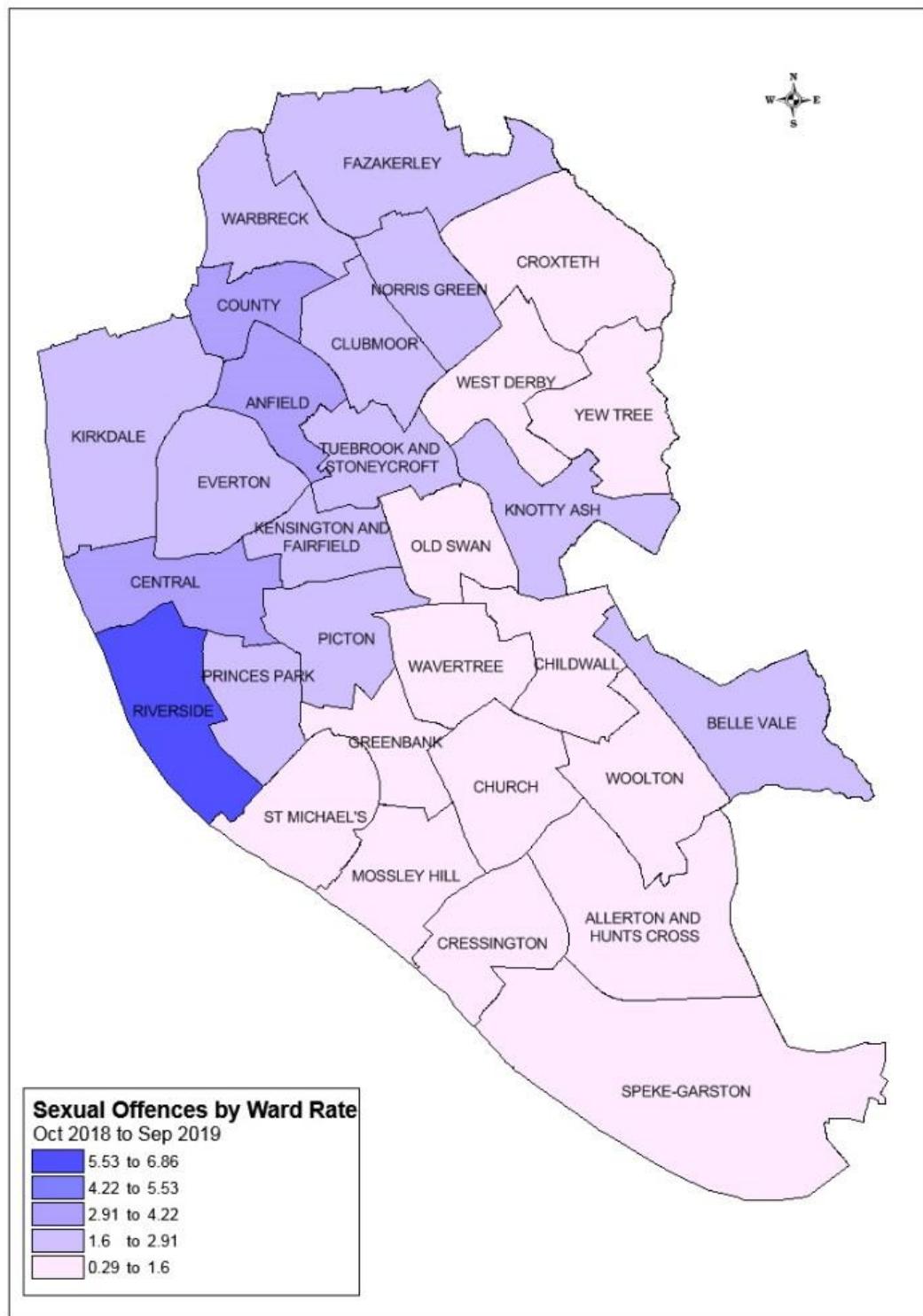


Figure 62: Sexual offences rates by ward, 2010/11 – 2018/19

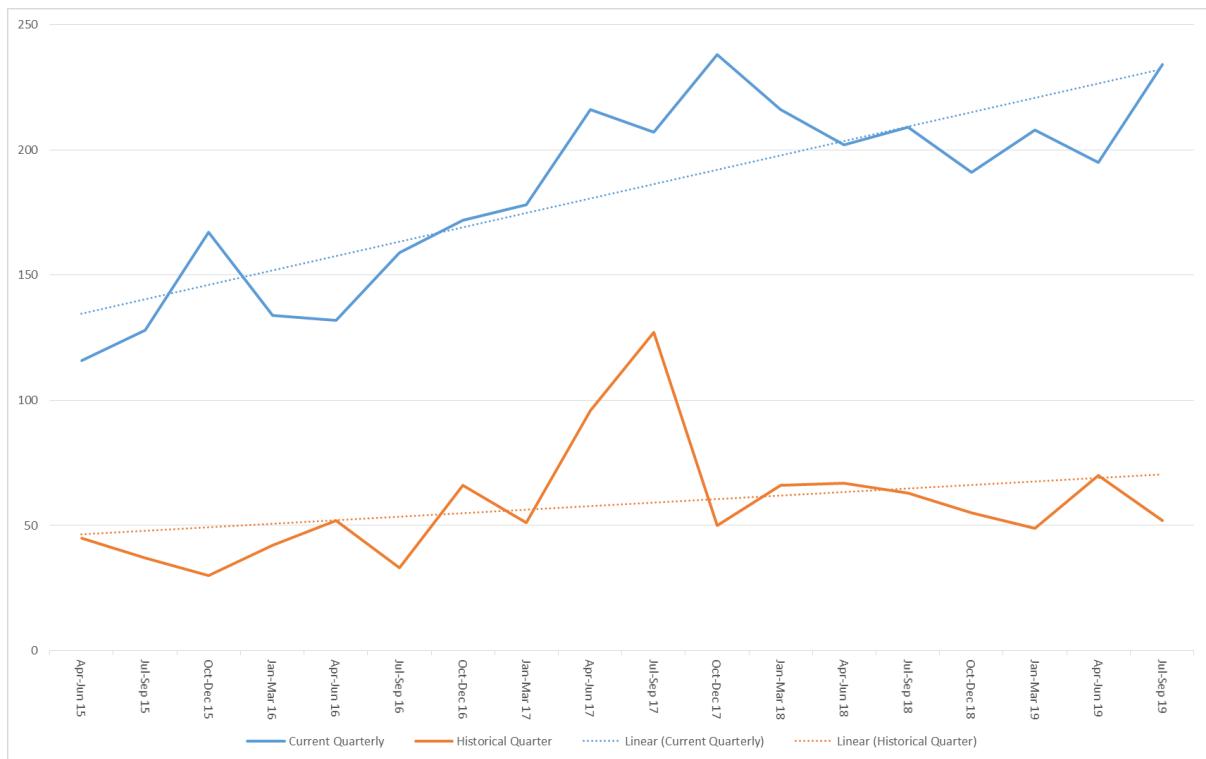


Figure 63: Quarterly trends in sexual offences, Apr-Jun 2015 to Jul-Sep 2019

Source: Merseyside Police Delphi System, October 2019

The data above clearly highlights that we have seen, and are continuing to see, considerable increases in the numbers of reported crimes/sexual offences across the city. This is clearly an area for concern and is continually discussed by policy and decision makers at a range of boards locally, including City Safe.

11.2 Female Genital Mutilation (FGM)

Female Genital Mutilation (FGM) is a serious form of child abuse and violence against women and girls, and a violation of human rights. It has been illegal in this country since 1985 and Local Authorities have a statutory duty to safeguard children and protect and promote the welfare of all women and girls⁴².

Female Genital Mutilation (FGM) is defined by the World Health Organisation as “*all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.*” There are four different types of FGM that have been identified by the WHO:

- Type 1: Clitoridectomy – Partial or total removal of the clitoris and/or prepuce
- Type 2: Excision – Partial or total removal of the clitoris and the labia minora, with or without removal of the labia majora

- Type 3: Infibulation – Narrowing of the vaginal orifice with creation of a covering seal by cutting and repositioning the labia minora and/or the labia majora, with or without excision of the clitoris
- Type 4: All other harmful procedures to female genitalia for non-medical purposes - for example pricking, piercing, incising, scraping and cauterisation

FGM can take place for a variety of reasons, and is often seen as a cultural custom. It can also be seen as a rite of passage in some communities, preparing a girl for adulthood and marriage. Research by *Equality Now* suggests that up to 60,000 women and girls in the UK may be at risk from FGM, with 125,000 already living with the consequences.

FGM can have serious short and long-term consequences for women and girls, emotionally and psychologically as well as physically. These can include severe pain, infections, damage to other body organs, complications during child birth, depression and post-traumatic stress. In the most severe cases FGM can also result in death.

In 2014, the Government identified a number of risk factors that are associated with FGM with the release of multi-agency practice guidelines⁴³.

Alongside information about a child's community or country of origin, there are a number of factors that can also be used to determine a child's potential level of risk:

- Communities traditionally affected by FGM and who are less integrated into the UK may be at greater risk of carrying out FGM
- If a child's mother has undergone FGM, then any of her female children could also be at risk
- Any child with an older sibling who has had FGM can be considered at risk of the practice
- A child who is withdrawn from personal, social and health education or personal and social education could be at risk as parents may wish to keep her uninformed about the procedure and her rights.

Professionals should also be aware of a number of other risk factors that can indicate that FGM may be about to happen, including:

- Children may talk of having a long holiday to their country of origin where the practice is prevalent, children talk of undergoing a "special procedure" or having a ceremony to "become a woman"
- Parents state that a relative may be taking the child out of the country for an extended visit
- A child may confide in a teacher or another person if she is at immediate risk

- A professional may hear a reference to FGM in children's conversation
- Families may perform FGM when a senior female family member is in the country, particularly if she is visiting from their country of origin.

Source: Multi-Agency Practice Guidelines: Female Genital Mutilation, HM Government 2014

www.gov.uk/government/publications/female-genital-mutilation-guidelines

At the time of the 2011 Census, around 2.5% of the Liverpool population were born in countries with a high prevalence of FGM, equating to over 11,800 people. The most common country of origin was Nigeria (1,951), followed by Somalia (1,249).

The Government has introduced a mandatory requirement for NHS professionals to record incidences of FGM, and all Acute Trusts provide a monthly return to the Health & Social Care Information Centre.

11.3 Non-volitional sex

Natsal-3 found that 1 in 10 women and 1 in 71 men said they had experienced non-volitional sex since age 13. The study found that experiencing sex against your will could happen at any age but was more common at younger ages. The median age for males was 16 and for females was 18.26.

The study found that people who said that they had experienced sex against their will were more likely to report potentially harmful health behaviours and poorer physical, mental and sexual health, including treatment for depression or another mental health condition in the past year, a long-term illness or disability, and a lower sexual function score. It is not known whether these things happened before or after experiencing sex against their will. It must be noted that not all non-volitional sex will result in reporting of a sexual offence.

11.4 Child Sexual Exploitation

Child Sexual Exploitation (CSE) is child abuse, and children and young people who are targeted face huge risks to their physical, emotional and psychological health and wellbeing. Liverpool has adopted the definition of sexual exploitation that is set out in

Safeguarding Children and Young People from Sexual Exploitation, Supplementary Guidance to Working Together to Safeguard Children (2009).

“Child Sexual Exploitation of children and young people under-18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive ‘something’ (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, attention, gifts, money) as a result of them performing, or others performing on them, sexual act or activities....”

In all cases, those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence and coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person’s limited availability of choice resulting from their social/economic and/or emotional vulnerability.”⁴⁴

In 2011, the Inquiry into Child Sexual Exploitation in Gangs and Groups⁴⁵ identified thirteen different types of sexual exploitation in addition to that from a single perpetrator. Though this is not considered an exhaustive list, it does identify key types:

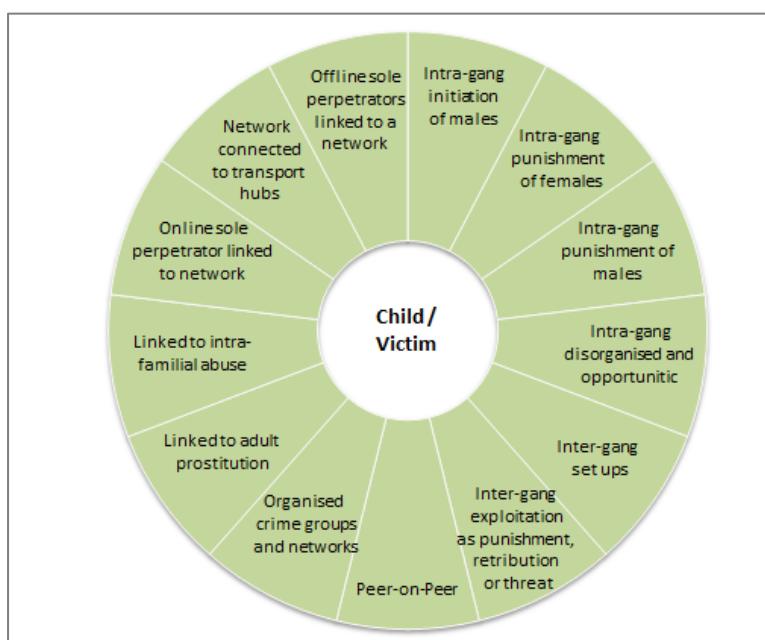


Figure 64: Forms of Child Sexual Exploitation

Source:

www.childrenscommissioner.gov.uk/sites/default/files/publications/If%20it%27s%20not%20better%20Appendices.pdf

Between 2012-13 and 2013-14, the NSPCC reported that there was a 39% increase in police recorded sexual offences against children in England⁴⁶. The research suggests part of this increase will relate to the media focus on child sexual exploitation in recent years, which has led to more people willing to come forward to the police and

report abuse. However, the increase in reports of CSE has not been matched by an equivalent increase in the available support, and the NSPCC suggest there is a significant national shortfall in therapeutic support available to those who have suffered child sexual abuse.

Almost 90% of all CSE referrals from Liverpool are for girls, with only a small number of cases involving boys. The most prevalent age groups are for young people aged 15 to 16. Together these account for just over half of all Liverpool referrals.

Over half of referrals (58.3%) live with family and have no experience of care. 21.5% of referrals had experience of the care or foster system. It should be noted that on 33 referrals (20.2%) information on care status was unavailable.

11.5 Domestic Abuse

The Government's definition of domestic abuse now encompasses all forms of abuse;

'Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional), between two adults who are, or who have been, intimate partners or family members, regardless of gender or sexuality.'

Domestic Abuse is a widespread issue, nationally, 76 women and 15 men were killed by their current or former partner in 2012/13. It costs the tax payer an estimated £3.9bn per year, of which nearly £2.4bn is caused by high risk domestic abuse. In Leicestershire it is estimated that the total cost of domestic abuse in Leicestershire is £66m a year. This includes cost to public services and economic output cost, but not emotional and personal cost, estimated at a further £113.8m.

Domestic abuse has adverse impacts on the health and wellbeing of victims, and is closely associated with child abuse and neglect, as well as a range of other social issues including homelessness and substance abuse. It can cause long-term problems for children, families and communities and has inter-generational consequences in terms of the repetition of abusive and violent behaviours.

A comprehensive report into domestic abuse in Liverpool was completed in September 2019, to inform commissioning of services from 2020. Thus, this needs assessment merely presents the data and scale of the problem here and does not make its own recommendations in relation to this work.

An overview of domestic abuse crimes across Liverpool reveals:

During the examined period of October 2018 to September 2019 there have been:

- 8,575 domestic crimes recorded;

This represents an increase of 18% compared to the previous year.

Domestic Crimes made up 15% of total recorded crimes in 2018-19 in the city; higher than the previous year, when the figure was 13%.

Quarter	Oct - Dec'17	Jan - Mar'18	Apr - June'18	July - Sept'18	Oct - Dec'18	Jan - Mar'19	Apr - June'19	Jul - Sept'19
Count	1426	1656	2147	2036	2054	1968	2144	2409
Qtr on Qtr Change								

Table 7: Recorded Domestic Abuse Crime Counts

Source: Merseyside Police Delphi System, October 2019

Over the past two SIA years, quarterly counts were highest between July to September 2019 (2409 reports). Counts fell during the same quarter of the previous year. The last two quarters (Apr-June 19 and Jul-Sep 19) have seen two of the highest recorded figures in recent years.

12. HPV Vaccinations

Human papillomavirus, or HPV, is the name given to a very common group of viruses. There are many types of HPV, some of which are called "high risk" because they're linked to the development of cancers, such as cervical cancer, anal cancer, genital cancers, and cancers of the head and neck. Other types can cause conditions like warts or verrucas.

High risk types of HPV can be found in more than 99% of cervical cancers. There is a lesser association between HPV and some of the anal and genital cancers, and cancers of the head and neck. HPV infections do not usually cause any symptoms, and most people will not know they're infected.

Girls and boys aged 12 to 13 years are offered the human papillomavirus (HPV) vaccine as part of the NHS vaccination programme. The HPV vaccine helps protect against cancers caused by HPV.

As the graph below illustrates vaccination coverage for HPV is slightly below average in Liverpool when compared to the regional and national figures. It presently stands at 80.2%, having been far higher back in 2015-16 and 2016-17. The aim locally has to be to continually increase the uptake in this area in future datasets.

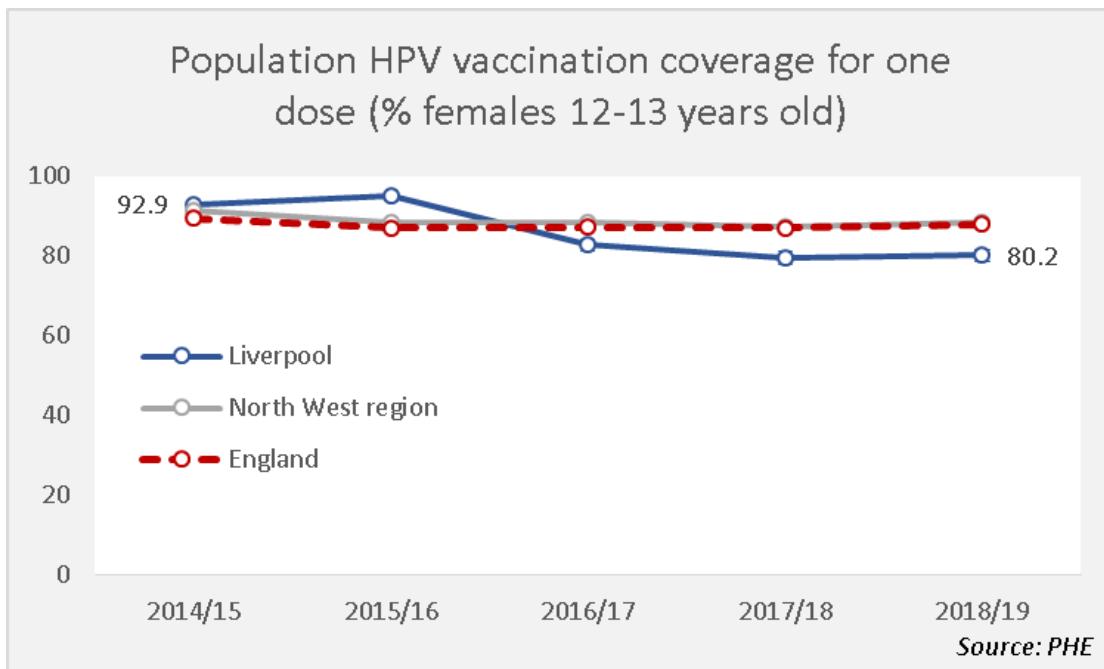


Figure 65: Population HPV vaccination coverage for one dose (females aged 12-13 years), 2014/15 – 2018/19

Source: Liverpool Intelligence & Analytics Team, October 2020

13. Digital – e-SRH services

This section discusses the concept and range of digital sexual health provision available to service users. Furthermore it assesses the effectiveness and acceptability of these forms of e-service and remote consultation in order to inform service design and make recommendations for local commissioners.

Worth noting is the fact that this needs assessment is being finalised/completed during the Coronavirus pandemic (published during Recovery Phase) and so the necessity to develop and drive digital innovation in its various forms is perhaps more pertinent than ever.

13.1 Introduction to online services

Technological/digital innovations provide a raft of potential for improving sexual health service access, proximity and outcomes. According to latest Ofcom statistics⁴⁷ (late 2018) we now live in an age where circa 80% of the population own a smartphone or digital device ideal for remotely accessing services. This rises to 95%+ amongst the 16-24 year old population, which as sexual health statistics show, is a group disproportionately affected by sexual ill-health. Most people in the UK are dependent on their digital devices and need a constant connection to the internet, this provides

an excellent platform on which to link people into discreet sexual health advice, information, support and testing/care like never before.

People in the UK now check their smartphones, on average, every 12 minutes of the waking day. Two in five adults (40%) first look at their phone within five minutes of waking up, climbing to 65% of those aged under 35. Similarly, 37% of adults check their phones five minutes before lights out, again rising to 60% of under-35s. This is in stark contrast to a decade ago, where only 17% owned a smartphone and there was nowhere near the same reach offered by running a digital or remote service. Things have changed, and fast.

All of the above, coupled with the fact that (in most cases) response times and results turnaround times can be cut to significantly shorter timescales providers of digital services, produces a perfect blend to be able to test, treat and prevent the spread of infection more effectively than ever. There is also the recognised potential that this offers the chance to reach certain ‘non-service users’ or a previously undiagnosed pool of infections, reducing the prevalence of STIs and possible onward transmission yet further.

The Faculty of Sexual and Reproductive Health Care (FSRH) and the British Association for Sexual Health and HIV (BASHH) have led the way in being the first professional bodies to issue standards in online service provision in the UK⁴⁸. It is becoming an increasingly accepted and utilised method of provision, with studies showing that e-SRH/e-STI services can and do increase the uptake of testing and wider provision across all groups (including high risk).⁴⁹

This section of the needs assessment analyses the technological innovations made in the sexual health world over the last few years and reviews the associated acceptability of those techniques amongst service users.

Liverpool does not yet have a secure and functional digital e-SRH offer provided to patients. Nor does it have a truly centrally run and managed website/front door that provides advice, information, clinic times and the ability to book, or order remote SRH services via triage. There is an existing Liverpool City Council run webpage ‘Liverpool Sexual Health’ that provides service information, advice and support to residents across the city (which receives good footfall), yet is not effectively embedded at the heart of a co-ordinated communications plan and/or integrated service encompassing all features.

13.2 Form of online services & enablers

Online sexual health services & enablers can take many different forms –

- STI self-sampling – e-Service

These self-test kits screen for a range of STIs, including HIV, and can be made available via an online ordering process. Included are home testing kits which check for infections such as chlamydia and gonorrhoea that can be sent back to a service/laboratory for fast results turnaround. Kits contain swabs, urine and

bloods testing methods and can screen at multiple sites (triple site) for high risk populations such as MSM.

- Remote prescribing and dispensing of contraception

There is now the potential for service users to access information about and receives supplies of a range of contraceptive methods via online services. This includes the consultation, remote prescribing and dispense and supply of oral methods including emergency contraception.

- Remote prescribing and treatment of Chlamydia

On being screened for a range of STIs (as stated above in STI self-sampling) it is also possible for patients to have the treatment they require for chlamydia posted to them, or available to collect at a nearby pharmacy or convenient location. This reduces the need for those patients symptomatic with chlamydia infection to physically attend a clinic.

Enablers

- Online booking

This is where a person/service user can request an appointment at a sexual health clinic via the service website.

- Remote consultations

This is where using services such as Skype and other video consultation packages allows for symptoms to be discussed in a confidential setting where the patient may be more comfortable and can access/discuss at a convenient time. This method does still require the use of physician time and diagnosis of symptomatic infections may be better suited to health care venues overall. It is worth noting that this method, along with photo diagnosis are becoming increasingly popular in the SRH arena, but have limitations in terms of their ability to truly spot certain infections and their location (eg. Internal).

13.3 Effectiveness and acceptability of digital/online service offers

Based on several studies of this kind of online testing, users tend to be young, white, heterosexual women. There are higher rates of online testing among MSM and BAME in London compared to outside London. Return rates are critical, studies show a range of 48-76%. Return rates were highest among women, MSM, people with an asymptomatic infection, in less deprived areas and for kits provided to the patient's home rather than in a clinical setting. In

some pilots it was not possible to ascertain differences in return rates for specific audiences, usually because of small sample sizes.

There are sometimes issues with sample rejection rates. Users of kits sometimes find it difficult to supply viable samples. In one pilot in Hampshire, around 1 in 6 blood samples were ineligible⁵⁰. Online testing is generally acceptable to users, though many pilots do not include a comparator arm of patients who access the service as usual. For asymptomatic individuals, the proportion of online tests testing positive was found to be comparable to GU clinic rates. Many studies did not send kits to symptomatic people, but in studies where symptomatic people were considered, test positivity was higher than in comparable clinic populations. Treatment outcomes vary from service to service. Generally the time to test was shorter for people accessing services online but many studies found no differences in the time taken to receive treatment. Further evaluations of online services need to examine the barriers to delivery of treatment to those testing positive. Health promotion messaging and partner notification are also crucial for preventing onward transmission.

Nadarzynski et al (under review) carried out an attitudinal in-clinic and online research survey⁵¹ to assess the acceptability of remote prescribing and medication delivery services, with particular emphasis on treatment of uncomplicated chlamydia trachomatis. It showed that 83% of patients were willing to receive chlamydia treatment and contraception by post, with delivery preferences being 60% by post, 28% via a pharmacy and 10% collection at clinic. There was lower acceptability in those aged 45+, infrequent screeners, those concerned about confidentiality and those unwilling to register their name. Thus, it can be largely assumed here that e-prescribing/remote prescribing and home delivery are highly acceptable. Key though is the fact that patients should be offered the choice of delivery methods when diagnosed in order to provide a successful, inclusive offer.

A recent piece of digital acceptability research in SRH services suggested that both video consultations and webchat services for remote consultation appear largely acceptable to many service users⁵². Chatbots however do not, suggesting a clear lean towards a more human interaction in relation to remote consultation.

A further study⁵³ designed to establish if online STI testing has compromised access for vulnerable patients and review the pros and cons of online versus in-clinic testing (5,688 patient cohort) found that females, non-heterosexual and white people were more likely to use online testing offers. There was no impact or difference across age or deprivation with conclusions suggesting that if targeted correctly to high risk populations (MSM, BAME, Under-25s) online STI screening is a highly adequate method to increase capacity and access to services. The study further evidenced that treatment times 'in-clinic' were longer than those managed 'online'. Effective promotion of these available methods is key, with studies showing that a well-advertised, simple and clear digital programme and kit ordering process can result in huge increases in kits ordered and tests successfully returned⁵⁴. Social media advertising in one particular

instance saw a 277% increase in site visits, a 41% rise in test requests and a 36% increase in positive results.

A systematic review of web-based medical appointment systems⁵⁵ suggested that there is indeed a growing trend for the adoption of web-based appointment systems, and that the major findings of that review highlighted clear benefits to a variety of improved patient outcomes (improved access, reduced DNAs, more timely appointments, decreased staff labour, decreased waiting times and improved satisfaction).

13.4 Opportunities provided by online/e-SRH services

By expanding access to testing for asymptomatic infections, there is the chance to increase testing and treatment of infections such as chlamydia and gonorrhoea. The convenience of online testing could lead to greater frequency of testing without the need to add extra clinical resources beyond laboratory capacity.

The service could expand to become more equitable in this situation, particularly if cultural barriers to access are preventing some groups from attending in person. Online services will need to be able to communicate in a direct and discreet fashion for this to be successful. Emphasis needs to be placed on quick delivery of treatment in the event of a positive test. If online testing can reduce the time it takes for a positive diagnosis to be reached, then robust processes must be in place for delivery of treatment. Moreover, delays in the return of samples need to be minimised. This necessitates the need for clear instructions and health promotion material that will convince the service user to return the kit upon receipt.

Successful treatment depends upon robust partner notification, particularly if the patient is at risk of re-infection by a partner or engaging in high risk behaviour. If partner notification is to be a major issue, then there will also need to be alternative mechanisms to get high risk individuals into clinics where appropriate contact tracing can be performed. By freeing up resources that are normally used for testing of asymptomatic infections, capacity for complex and symptomatic cases can be made available. This could take the form of offering appointments, particularly for high risk individuals accessing the online testing that the service believes would achieve better outcomes from an in-person consultation. This could create capacity for outreach into the vulnerable populations identified elsewhere in this needs assessment.

If online testing causes the cases seen in clinic to become more complex, this may necessitate staff changing their skill mix and provide opportunities for training and new learning.

Allowing people to test for asymptomatic infections by kit based testing could convince people (particularly young people) to get tested as regularly as PHE recommends, providing opportunities to increase chlamydia detection rates and

deliver regular health promotion messages. Such testing could also synergise with delivery of repeat LARC implants or other forms of contraception, an important group of service users who may not be using condoms to prevent against STIs.

Digital Recommendations –

- Ensure Liverpool residents have access to the full range of SRH services (STI self-sampling, remote prescribing) via a robust digital (e-SRH) offer to improve access to testing and contraception city-wide
- Engage with potential service users to understand which aspects of an online/e-SRH offer matter most to them and use that to influence service design
- Ensure that any commissioned e-SRH service is well promoted and its key benefits adequately explained to patients to encourage improved uptake
- Ensure that future digital provision contains a blend of remote consultation (video, webchat) with a suitable online triage/booking system for patients
- Continue to research the effectiveness of the differing online service offers with a view to ensuring that current practice is evidence based and up to date

14. Engagement

Engagement with service users, and crucially those not presently accessing services, is a vital tool that helps us understand how to improve the design, reach and effectiveness of service provision.

14.1 National Survey of Sexual Attitudes and Lifestyles (NATSAL)

The National Survey of Sexual Attitudes and Lifestyles (NATSAL) reveals the changing sexual attitudes and behaviour of the British population⁵⁶. NATSAL surveys have been carried out every 10 years since 1990. More than 45,000 people have been interviewed and the findings have helped to shape sexual and reproductive health policy. Results from the latest NATSAL survey reveal the following information⁵⁷:

Changing sexual behaviour:

- Young people are having sex earlier than previous generations
- Increase in partners but decrease in frequency of sex
- People continue to have sex into later life
- Rise in the number of people (women in particular) reporting same-sex partners

Changing attitudes to sex and relationships:

- Increased acceptance of same-sex relationships
- Increased acceptance of 'one night stands' by women only
- Greater disapproval of non-exclusivity in marriage

Furthermore, it highlighted:

- More varied sexual practices (eg. Oral and anal sex)
- Sexual activity was increasingly continuing into people's 8th decade
- There was an increase in chlamydia diagnoses – this affects just over 1% of the population and peaks in younger age groups
- Gonorrhoea and HIV affects less than 1 in 1000 people
- 1 in 10 women aged 16-24 had had a pregnancy. Of these, 16.2% were unplanned and 29% were ambivalent about the pregnancy
- 9.8% of women and 1.4% of men recorded/reported sex against will (non-consensual sex) and in most cases the perpetrator was known to the victim

A full set of infographics relating to NATSAL (2013) are available at <https://www.natsal.ac.uk/media/2102/natsal-infographic.pdf>, however pertinent ones are pulled out below –

- % reporting a health condition that sought help or advice:

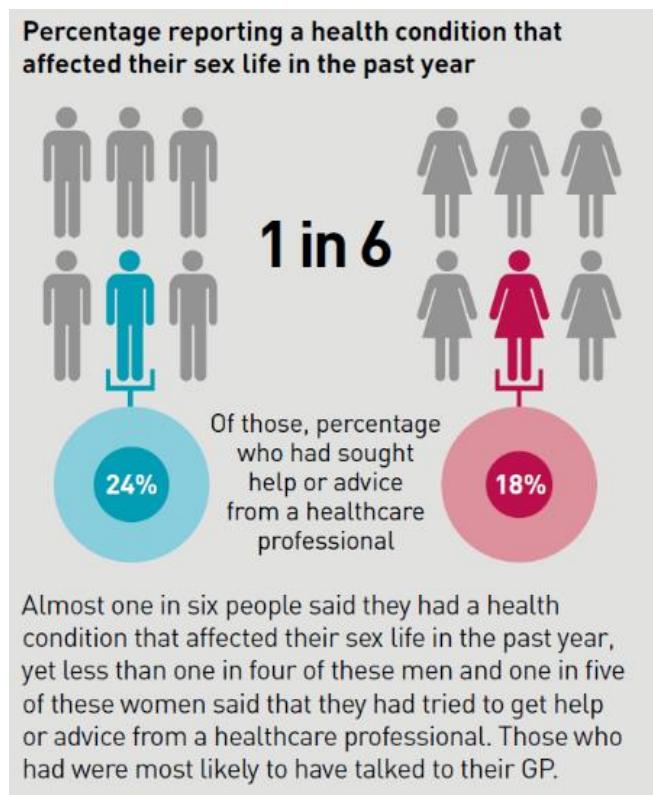


Figure 66: Percentage reporting a health condition that affected their sex life in the last year

- Statistics regarding chlamydia infection:

Overall, around one in a hundred people aged 16-44 had chlamydia, although this varied by age, peaking at almost one in twenty women aged 18-19 and one in thirty men aged 20-24. Although people who reported more partners in the past year were more likely to have chlamydia, a lot of the chlamydia was found in people who reported only one partner in the past year, because most people only had one partner.

Percentage of people in the population with chlamydia

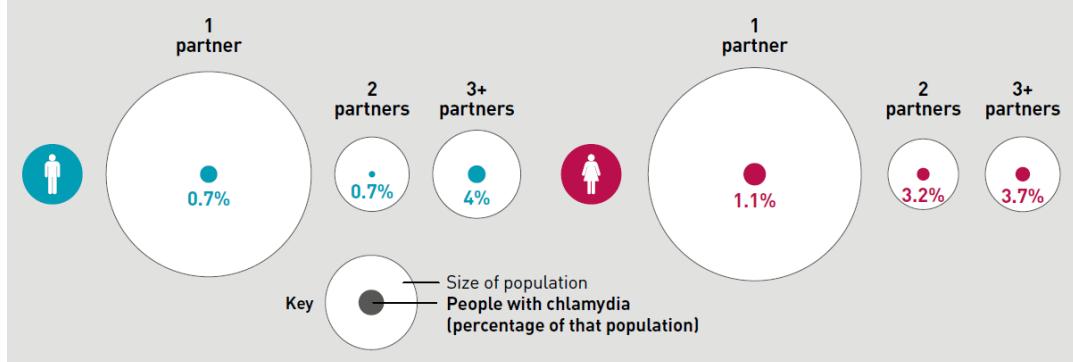


Figure 67: Percentage of people in the population with chlamydia

Urine samples were collected from a sample of men and women aged 16-44 and tested anonymously for STIs. These findings are for men and women who have ever had sex. HPV was the common STI, followed by chlamydia. HIV and Gonorrhoea were found in around 1 in 1,000 people.

It is indeed still the case that people who report more partners are more likely to have chlamydia, or another STI, and thus highlights the importance of re-testing and robust partner notification services.

14.2 Local Consultation and Insight undertaken in recent years

Crucially, there are plans to undertake a full service user and non-service user consultation exercise later in 2020. The production and necessary dissemination of a survey designed to gauge the opinion of a wide array of stakeholders in relation to elements such as service provision, satisfaction, access (both by time and by location), clinic mix (walk-in/bookable appointments) and digital preferences was hampered by the onset of the Coronavirus pandemic.

The intention is to run an online survey to engage key populations during Autumn 2020. This will further assist with service design, modelling and planning, offering a more detailed assessment of local need and requirements. It will be available as an addendum to this needs assessment when finalised.

14.2.1 HIV – Understanding Barriers to testing 2019

During 2019 a piece of work led by the Liverpool School of Tropical Medicine (LSTM), and supported by Liverpool City Council as part of the HIV Fast Track Cities agenda, centred on understanding the barriers to testing within specific BAME populations in Liverpool.

The proposal aimed to understand and map these barriers, then design and deliver a tailored approach to testing and make recommendations to support commissioning and service provision. Key informant interviews were used, with the route in being key faith leaders and community leads, to identify issues. Barriers such as confidentiality, intercept, knowledge and awareness were all raised.

Selected BAME communities:

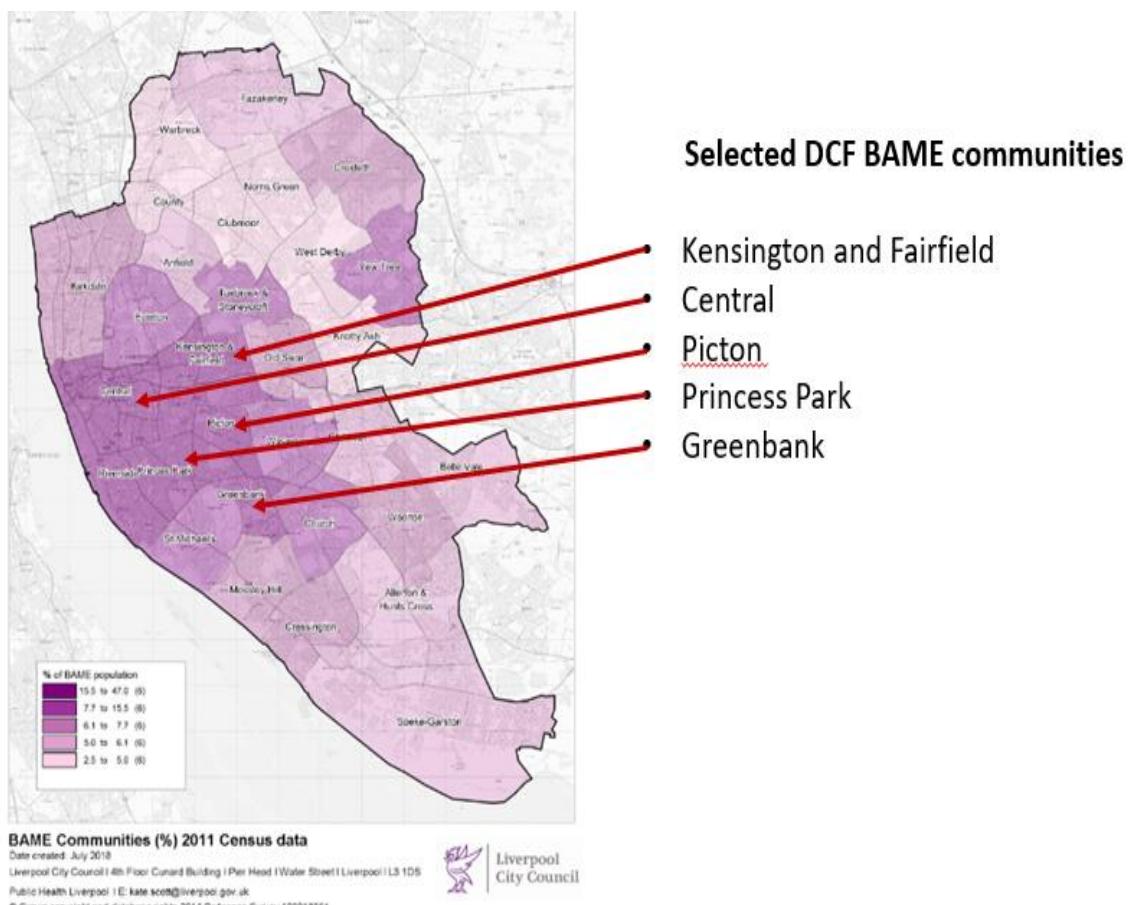


Figure 68: Percentage BAME communities by ward in 2011

The interviews identified a lack of knowledge and understanding relating to HIV and AIDS, the testing and treatment associated and transmission routes.

The early findings suggest that there are opportunities to engage this population with a robust and well promoted self-sampling and digital offer, coupled effectively with clinical outreach interventions that allow for testing at locations within the community.

Recommendation: Include a targeted clinical outreach offer within any newly commissioned offer to target vulnerable groups and test at point of care/intervention.

14.2.2 Long-Acting Reversible Contraception (LARC) Insight work – 2015

In 2015, Public Health undertook a piece of insight work⁵⁸ designed to understand how to increase access to LARCs, with specific focus on General Practice.

There are four types of long acting reversible contraception (LARCs), including: intrauterine device (IUD), intrauterine system (IUS), contraceptive implant and contraceptive injection. Unlike some other methods of contraception, such as the pill or condoms, LARCs don't require users to remember to take them on a daily basis or every time they have sex. In addition, these methods are highly effective in preventing unplanned pregnancy and can be stopped with a quick return to fertility should the user decide they want to get pregnant.

There are significant benefits to the health system too. Increasing the uptake of LARC contraception is expected to reduce the numbers of unintended pregnancies. NICE estimates that about 30% of pregnancies are unplanned and with the barrier method and contraceptive pills relying on correct use, LARCs offer contraceptive methods that are less subject to user error⁷.

The main findings and recommendations emerging from this insight work that require local consideration (and in many cases are already being acted upon) are as follows:

- Research found that current knowledge of LARCs and their benefits is low among non-users, with most knowing the basics only
- Once women were exposed to more detailed information about LARC methods through this research, some became more interested in using at least one of these methods

⁷ NICE states that LARCs are more effective than barrier methods or oral contraceptives because they demand much less or are independent of the need for adherence

- Women in the study were split in terms of their preferred service provider with regard to LARCs – with some wanting their GPs to provide all LARC services and others preferring to go to sexual health clinics – therefore a blend of offer would make sense
- Awareness needs to be increased so women know that Abacus is able to offer appointments but that they can be referred to other GP surgeries if they wish to be – in an inter-referral fashion
- Cross-referral between GP surgeries was seen as acceptable by Healthcare Practitioners (HCPs) in our sample whose practices did not offer all LARC services. HCPs working at such practices see this as a better solution to allowing their patients to access LARC services at GP practices if they do not provide the full offer themselves
- Age and life stage seem to be the key indicator for fit with different LARCs. For example, IUS and IUD have more appeal among (some) women who have completed their families and/or are aged 40 and over, with devices used for both contraceptive and non-contraceptive benefit. Whereas younger women aged 16-30 seem to be more open to using the implant both because of its shorter timescale and lack of internal examination/uterine fitting

14.2.3 Sexual Health and Young People Insight Research - 2014

A piece of insight work with young people⁵⁹ was undertaken by Liverpool City Council in 2014, and still remains highly relevant in terms of its findings today.

The specific aims of the work were to:

- Understand young people's attitudes towards sexual health services
- Understand what young people want from a sexual health service e.g. confidentiality, advice, convenient location
- Understand what young people would prioritise as important in terms of service and location, e.g. would they use a local sexual health service clinic or would they prefer to travel to the city centre?
- Identify which days and times the service would most likely be utilised
- Identify potential barriers to visiting local sexual health clinics
- Understand what would help break those barriers down
- Identify which sexual health clinic they would be happy to visit, and why
- Identify whether there is a requirement for a young person only sexual health service in the Speke-Garston area particularly

Stage 1 included respondents from Garston, Speke and Hunts Cross, although all respondents were orientated towards Garston. The findings from this piece of work were as follows:

- A considerable proportion of respondents were locally focussed around the Garston area, with a couple of respondents spending more time in the city centre due to work or education
- Many respondents had experience of visiting a clinic; Abacus South was the most well visited, followed by Brook
- A convenient location was a key factor in choice of clinic, based on the place where respondents spent their time; but equally confidentiality was an essential aspect of a service for young people
- Many respondents could see the appeal of a young-person specific service in terms of a greater feeling ease/comfort – but prioritised location and convenience

Recommendations:

- Ensure that the needs of people (in relation to clinic location and accessibility) are met across all parts of the city and that SRH services offer multiple ‘sites’ as part of the service model
- Ensure that the needs of young people are specifically met across the city, with particular focus placed upon services ensuring young people feel comfortable and at ease to discuss their sexual health needs in full

14.2.4 Centre for Public Scrutiny (CfPS) – Sexual & Reproductive Health Scrutiny Session 2018

This piece of work with members of the Adult Health & Social Care Select Scrutiny committee was an excellent way to engage across the whole SRH landscape in terms of provider services and their critical views on future design/re-design. It offered members the chance to assess local provision and ask key questions to ensure a robust piece of analysis took place in relation to our local offer. The main findings are detailed in Section 3.2 earlier in the document.

15. Conclusion & Summary

Overall, the needs assessment evidences that there is work to do across the Liverpool Sexual Health system to improve sexual and reproductive healthcare outcomes for

our population. There is a need to pull together what is still a fragmented commissioning framework, and to examine all opportunities to co-commission to design better and more streamlined patient pathways.

This is evidenced by our high STI rates when compared to regional and national averages, and indeed against core cities as comparators. Liverpool services screen a high percentage of the 15-24 year old population for chlamydia screening and detection rates remain high (above Public Health England targets). We need to continue that robust screening, find infection and break the chain of that infection with improved and centralised partner notification within services. An integrated sexual & reproductive health service should assist with that vital partner notification and re-test frequency in the not too distant future.

In relation to HIV, Liverpool signed up and committed to being a Fast Track City (FTC) during 2018 and this has produced a galvanised response to HIV Testing, Treatment and Care across the spectrum. There is still work to do (see HIV testing uptake rates)

Under-18 conception rates have been reducing consistently over the last decade or so, yet these are still sit higher than comparator areas and work is still required in relation to education, early intervention and healthy relationships advice for young people. Equally, good access to the full range of contraceptive methods across the city will reduce the unintended and unplanned.

Each section of the needs assessment (demography, high risk groups, STIs, HIV, Reproductive Health, young people, sexual abuse and engagement) provides specific implications for sexual health services following the review of evidence of need and recommendations are presented in the summary at the top.

When triangulating these sections, key areas for improvement across Liverpool include:

- Bringing the sexual health commissioning system together to deliver a more integrated service offer;
- Ensuring modernisation occurs via e-SRH (online) service provision;
- Prioritising prevention and access for vulnerable groups (including young people, men who have sex with men (MSM), sex workers, BAME communities and people with disability);
- More effective and targeted clinically focused outreach that allows for the rapid support and identification of STIs and BBVs in high risk populations;
- Improved local partner notification to curb the onward spread of infection;
- There is a need to nurture, support and develop the sexual health workforce locally (including non-specialist provision within primary care, school nursing and substance misuse/harm reduction).

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