S2 Analytics

BIRMINGHAM AND SOLIHULL SEXUAL HEALTH NEEDS ASSESSMENT

FULL DOCUMENT v3.2

September 2021

Solihull Metropolitan Borough Council

Birmingham City Council

CONTENTS

1 - EXECUTIVE SUMMARY

INTRODUCTION

- INTRODUCTION TO THE SEXUAL HEALTH NEEDS ASSESSMENT
- GENERAL INTRODUCTION TO SEXUAL HEALTH

KEY FINDINGS AND RECOMMENDATIONS

- KEY FINDINGS
- INDEX OF RECOMMENDATIONS

INTRODUCTION

INTRODUCTION TO THE SEXUAL HEALTH NEEDS ASSESSMENT

This Sexual Health Needs Assessment is part of the commissioning process being run by Birmingham City Council and Solihull Metropolitan Borough Council. The needs assessment analyses quantitative and qualitative data and reports and summarises findings in a concise and detailed manner.

This needs assessment seeks to identify gaps, opportunities, and efficiencies in current services based on identifiable unmet needs of the children and adult populations of Birmingham and Solihull.

GENERAL INTRODUCTION TO SEXUAL HEALTH

INTRODUCTION

The World Health Organization (WHO) defines sexual health as a state of physical, emotional, mental and social wellbeing in relation to sexuality - not just the absence of disease, dysfunction or infirmity.[1]

In England, the definition of sexual, reproductive and HIV health promotion includes the provision of advice, information, education and services around contraception, sexually transmitted infections (STIs), HIV and termination of pregnancy.[2]

WHAT ARE THE MAIN EXTERNAL IMPACTS ON GOOD SEXUAL HEALTH?

The WHO identifies five factors that influence sexual health:[3]

- Laws, policies and human rights
- Education
- Society and culture
- Economics
- Health systems.

In the UK:

- Social determinants can impact the risk of unintended pregnancy and sexually transmitted infections, healthcare- seeking behaviour[4], and access to and use of preventive services, care and treatment[5]
- Poor sexual health disproportionately affects those experiencing poverty and social exclusion: regional inequalities in teenage pregnancy rates persist throughout the UK, and young women's access to emergency contraception varies according to the level of deprivation where they live. (Further information on the impact of deprivation on sexual health can be found on page 24).
- Laws and policies affecting sexual health include NICE guidelines and the government's Framework for Sexual Health Improvement in England.

[1] WHO, Sexual and Reproductive Health and Research (SRH), including the Human Reproduction Programme (HRP). Accessed April 2021.
[2] Public Health England: Sexual and reproductive health and HIV: applying All Our Health. Updated 16 December 2019.
[3] Developing sexual health programmes: a framework for action. Geneva: World Health Organization; 2010.
[4] Healthcare seeking behaviour is any action or inaction undertaken by individuals who perceive themselves to have a health problem. (Latunji, O O, and O O Akinyemi. "FACTORS INFLUENCING HEALTH-SEEKING BEHAVIOUR AMONG CIVIL SERVANTS IN IBADAN, NIGERIA." Annals of Ibadan postgraduate medicine vol. 16,1 (2018): 52-60.)
[5] WHO (2010), Social determinants of sexual and reproductive health.

- Local authorities will be required to commission open-access sexual health (STI and contraception) services that meet the needs of their local population.[6]
- Relationships and Sex Education has been compulsory in secondary schools since 2020[7]
- Spending on sexual health services has been cut in most parts of the country, with the biggest cuts to upstream, primary prevention services that work to promote safe sexual behaviour.[8]

WHAT ARE THE MAIN POLICY DRIVERS?

The consequences of poor sexual health include:[9]

- unplanned pregnancies and abortions
- psychological consequences, including from sexual coercion and abuse
- poor educational, social and economic opportunities for teenage mothers, young fathers and their children
- HIV transmission
- cervical and other genital cancers
- hepatitis, chronic liver disease and liver cancer
- recurrent STIs including genital herpes and genital warts
- pelvic inflammatory disease, which can cause ectopic pregnancies and infertility
- poorer maternity outcomes for mother and baby

All of these consequences add up to greater cost for health and social care services. According to Public Health England, increased investment in prevention is needed to reduce future costs associated with poor health and wellbeing. PHE aims to improve public sexual and reproductive health and to prevent HIV by using health promotion to:[10]

- reduce onward HIV transmission, acquisition and avoidable deaths
- reduce rates of sexually transmitted infections
- reduce unplanned pregnancies
- reduce the rate of under-16 and under-18 conceptions.

PHE FRAMEWORKS

Commissioning Sexual Health Services and Interventions: Best Practice Guidance for Local Authorities[11] is designed to help local authorities to commission high quality sexual health services for their local area.

Commissioning sexual health, reproductive health and HIV services guidance[12] is for commissioners of sexual health, reproductive health and HIV services in local government, clinical commissioning groups (CCGs) and NHS England. (See page 35 for overview of the commissioned services).

The *Teenage Pregnancy Prevention Framework* is designed to help local areas assess their local programmes to see what's working well, identify any gaps, and maximise the assets of all services to strengthen the prevention pathway for all young people.[13]

[6] Department of Health, (2013), *A Framework for Sexual Health Improvement in England*
[7] Department for Education: Relationships education, relationships and sex education (RSE) and health education: FAQs
[8] Kings Fund (2018), Sexual health services and the importance of prevention.
[9] PHE (2019), Sexual and reproductive health and HIV: applying All Our Health.
[10] Public Health England (2015), Health promotion for sexual and reproductive health, and HIV: Strategic action plan, 2016 to 2019.
[11] Department of Health and Social Care (2013), Commissioning Sexual Health Services and Interventions: Best Practice Guidance for Local Authorities.
[12] PHE (2014), Commissioning sexual health, reproductive health and HIV services guidance. Last updated 2 March 2015.
[13] PHE (2018), Teenage Pregnancy Prevention Framework.

OTHER STATUTORY BODIES

The Department of Health's *Framework for sexual health improvement in England*[14] sets out the government's ambitions for improving sexual health outcomes. The document aims to provide the information, evidence base and support tools to enable those involved in sexual health improvement to work together effectively.

The Department for Health and Social Care and Public Health England published *Integrated Sexual Health Services: A suggested national service specification* in 2018.[15] This covers the specialist integrated sexual health services that local authorities are responsible for commissioning, including testing and treatment for sexually transmitted infections and provision of the full range of contraception.

NICE has over 30 publications including guidance, advice, NICE Pathways and quality standards relating to sexual health.[16] These include Quality Standard [QS178] on Sexual Health, which focuses on preventing sexually transmitted infections (STIs)[17] and Quality Standard [QS129] on contraception[18].

In addition, clinical guidance, standards and policy recommendations are published by a number of academic bodies, professional membership associations and national charities including:

- British Association of Sexual Health and HIV (BASHH)[19]
- British HIV Association
- Brook[20]
- Children's HIV Association
- Faculty of Sexual and Reproductive Healthcare (FSRH)[21]
- Family Planning Association (now a sexual health company owned by McCorquodale (Midlands) Ltd).[22]
- The Royal College of Obstetricians and Gynaecologists[23]
- Terence Higgins Trust[24]

LOCAL AUTHORITY RESPONSIBILITIES

Since 1 April 2013, local authorities have been responsible for commissioning most sexual health interventions and services as part of their wider public health responsibilities, with costs met from their allocated public health grant. These include:[25]

- Contraception, including LESs (implants) and NESs (intrauterine contraception) including all prescribing costs – but excluding contraception provided as an additional service under the GP contract
- STI testing and treatment, chlamydia testing as part of the National Chlamydia Screening Programme and HIV testing
- Sexual health aspects of psychosexual counselling

[14]Department of Health (2013), A Framework for Sexual Health Improvement in England.
[15] Department of Health and Social Care and Public Health England (2018), Integrated Sexual Health Services: A suggested national service specification.
[16] NICE: Sexual health. Accessed May 2021.
[17]NICE (2019), Sexual health. Quality standard [QS178] Published: 05 February 2019
[18] NICE (2016), Contraception. Quality standard [QS129] Published: 08 September 2016.
[19] BASHH: Publications. Accessed May 2021.
[20] Brook: Our publications and reports. Accessed May 2021.
[21] FSRH: Standards and guidance. Accessed May 2021.
[22] FPA: Leaflet and booklet downloads. Accessed May 2021.
[23] Royal College of Obstetricians and Gynaecologists: Guidelines & research services. Accessed May 2021.
[24] Terence Higgins Trust: Our campaigns. Accessed May 2021.
[25] Department of Health and Social care (2013), Commissioning Sexual Health Services and Interventions: Best practice guidance for local authorities.

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

KEY FINDINGS AND RECOMMENDATIONS

KEY FINDINGS

DEMOGRAPHICS

In the UK, poor sexual health disproportionately affects those experiencing poverty and social exclusion.

43% of the population living in LSOAS[26] in Birmingham are in the 10% most deprived areas in England.

Birmingham is the 7th most deprived local authority in England and the 3rd most deprived English Core City. Deprivation is most heavily clustered around the city centre.

Solihull is the 32nd least deprived upper tier local authority in England, and the least deprived upper tier local authority across the West Midlands.

Despite the overall low average deprivation for Solihull, there is significant polarisation between the neighbourhoods.

Over half of the North Solihull population live in the most deprived 10% of LSOA neighbourhoods in England, including one in five living in the most deprived 5% LSOAs.

Young people as a demographic have particular needs regarding sexual health in relation to high diagnoses of the most common STIs, low 'sexual competence', and unplanned pregnancies.

At 43, the median age in Solihull ranks near the median of the nearest neighbours.

There is a higher average age in the south of the borough.

At 33, the median age in Birmingham ranks as one of the lower median ages of local authorities.

Birmingham is 'Europe's youngest city', with under 25s accounting for nearly 40% of its population. Wards in the centre of the city have median ages of between 21 and 28.

REPRODUCTIVE HEALTH

CONCEPTION

Birmingham has seen a decrease in all conceptions when using 2009 as the baseline.

The rate of decrease is greater than that of the CSSSNBT[27] nearest neighbours.

Solihull has seen an increase in conceptions since 2009, with the numbers peaking in 2015 and 2016.

The rates have declined and stabilised between 2017 and 2019.

[26]Lower Layer Super Output Areas (LSOA) are a geographic hierarchy designed to improve the reporting of small area statistics in England and Wales. Lower Layer Super Output Areas are built from groups of contiguous Output Areas and have been automatically generated to be as consistent in population size as possible, and typically contain from four to six Output Areas. The minimum population is 1,000 and the mean is 1,500.
There is a Lower Layer Super Output Area for each postcode in England and Wales.

[27] CSSNBT Children's Services Statistical Neighbours Benchmarking Tool (CSSNBT). Statistical neighbour models provide one method for benchmarking progress.

TEENAGE PREGNANCIES

Nationally, the teenage pregnancy rate in the UK fell by over 60% between 2000 and 2018. England still experiences higher teenage birth rates than peers in Western European countries. Outcomes for young parents and their children are still disproportionately poor.

Using 2009 as the baseline, Birmingham experienced decreases in teenage pregnancies of around 60% to 2019.

Using 2009 as the baseline, Solihull experienced decreases in teenage pregnancies of around 60% to 2019.

CONTRACEPTION

The provision of contraception is widely recognised as a highly cost-effective public health intervention, reducing the number of unplanned pregnancies which bear high social and economic costs to individuals, the health service and to the state.

In Birmingham, Umbrella has partnered with GPs and pharmacies to offer a comprehensive contraception service including LARCs (available via GPs). There is a plan for pharmacists to start delivering the contraceptive injection, improving coverage.

The total abortion rate, at 21 per 1,000 females aged 15-44 years old, is higher than that of the nearest neighbours (20.4) and the national rate (18.7).

The total prescribed LARCs excluding injections rate, at 42.1 per 1,000 females aged 15-44, is lower than that of the nearest neighbours (47.7) and the national rate (50.8).

In Solihull, GPs and pharmacies are not contracted with Umbrella. GPs and pharmacies are commissioned directly by Solihull Metropolitan Borough Council (SMBC) to offer LARCs (GPs) and emergency hormonal contraception (pharmacies).

The total abortion rate, at 22.1 per 1,000 females aged 15-44 is higher than that of the nearest neighbours (16.7) and the national rate (18.7).

The total prescribed LARCs excluding injections rate, at 47.9 per 1,000, is lower than that of the nearest neighbours (57.3) and the national rate (50.8).

There are a number of wards where there have been no LARC insertions by SMBC-commissioned GPs (2020-21).

In parts of North Solihull there were no LARC insertions by SMBC-commissioned GPs in either 2019-20 or 2020-21.

There is a strong correlation coefficient[28] between abortion rate and total prescribed LARCs rate, based on Solihull and the nearest neighbours.

LONG-ACTING REVERSIBLE CONTRACEPTION

In Birmingham, total prescribed LARCs (excluding injections) rate PER 1,000 females aged 15-44 is lower than the England average and is also lower than that of the nearest neighbours.

The rate of 42.1 per 1,000 in 2019 was below 47.7 for the nearest neighbours and 50.8 for England. The rate of LARCs prescribed by GPs was comparable to the nearest neighbours and England; however, the rate of sexual

[28] The correlation coefficient is a statistical measure of the strength of the relationship between the relative movements of two variables.

health services prescribing LARCs was low. LARCs rank low as a choice of contraception at sexual health services in Birmingham.

In Birmingham, LARC insertions at GPs were severely impacted by COVID-19 at the beginning of lockdown.

Activity during April to June 2021 saw a significant decrease; however, performance resumed to normal levels.

In Solihull, the total prescribed LARCs (excluding injections) rate is less than that of England and its nearest neighbours.

The total abortion rate, at 22.1 per 1,000, is higher than that of the nearest neighbours (16.7) and the national rate (18.7). The total prescribed LARCs excluding injections rate, at 47.9 per 1,000, is lower than that of the nearest neighbours (57.3) and the national rate (50.8). There is a strong correlation score between abortion rate and total prescribed LARC rate based on Solihull and the nearest neighbours.

In Solihull, GP IUCD fittings and reviews saw notable decreases in 2020-21; however, removals increased.

IUCD fittings saw a decrease of 18% when comparing 2020-21 against 2019-20. This is likely due to COVID-19. The number of IUCD removals saw an increase of 14%. Contraceptive implant insertions and removals increased.

VASECTOMIES AND STERILISATIONS

The pause on elective surgeries during the COVID-19 pandemic meant there was a reduction in the number of vasectomies.

There has been a reduction in total vasectomy consultations between 2019-20 and 2020-21 in Birmingham.

Consultations reduced by 38%.

There has been a reduction in total vasectomies between 2019-20 and 2020-21 in Birmingham.

Vasectomies reduced by 41%.

There has been a reduction in total vasectomy consultations between 2019-20 and 2020-21 in Solihull.

Consultations reduced by 55%.

There has been a reduction in total vasectomies between 2019-20 and 2020-21 in Solihull.

Vasectomies reduced by 46%.

EMERGENCY HORMONAL CONTRACEPTION

Pharmacy provision is particularly important for young people requiring emergency hormonal contraception, in terms of convenient locations and flexible hours.

In Birmingham, there are 0.4 pharmacies per square kilometre providing free EHC.

In Birmingham, there is a rate of 1,569 EHCs prescribed per 100,000 of the female 16-45 population.

In Solihull, there are 0.1 pharmacies per square kilometre providing free EHC.

In Solihull, there is a rate of 723 EHCs prescribed per 100,000 of the female 16-45 population.

ABORTIONS

Reducing abortion rates is linked to the provision of good quality sexual and reproductive health care and effective contraception.

There has been a slight reduction in abortion consultations in Birmingham.

There has been a slight increase in abortions in Birmingham.

There has been a slight reduction in abortion consultations in Solihull.

There has been a slight increase in abortions in Solihull.

STIs AND HIV

GENERAL

COVID-19 had a greater impact on STI-related indicators in Birmingham compared to its nearest neighbours.

Between 2019 and 2020 (all excluding chlamydia):

- The STI testing rate fell by 50% (nearest neighbours fell by 17%).
- The new STI diagnoses rate fell by 54% (nearest neighbours fell by 30%).
- STI positive testing rates fell by 45% (nearest neighbours fell by 20%).
- The proportion of 15-24-year-olds screened for chlamydia was below national rates and that of the nearest neighbours.
- There was a significant decrease in gonorrhoea diagnoses.

COVID-19 had a greater impact on STI-related indicators in Solihull compared to its nearest neighbours.

Between 2019 and 2020 (all excluding chlamydia):

- The STI testing rate fell by 48% (nearest neighbours fell by 25%).
- The new STI diagnoses rate fell by 58% (nearest neighbours fell by 31%).
- STI positive testing rates fell by 43% (nearest neighbours fell by 21%).
- The proportion of 15-24-year-olds screened for chlamydia was below national rates and that of the nearest neighbours.

- There was a significant decrease in gonorrhoea diagnoses.

GONORRHOEA

In 2020, there was a significant decrease in gonorrhoea diagnoses in Birmingham.

In 2020, there was a significant decrease in gonorrhoea diagnoses in Solihull.

These decreases can be linked to the reductions in testing and diagnosing as a result of the COVID-19 pandemic.

SYPHILIS

In 2020, there was a decrease in syphilis diagnoses in Birmingham.

Syphilis diagnoses remained low in Solihull.

These decreases can be linked to the reductions in testing and diagnosing as a result of the COVID-19 pandemic.

GENITAL HERPES

In 2020, there was a significant decrease in herpes diagnoses in Birmingham.

In 2020, there was a significant decrease in herpes diagnoses in Solihull.

These decreases can be linked to the reductions in testing and diagnosing as a result of the COVID-19 pandemic.

HIV

Up until 2019, Birmingham had greater testing coverage compared to its nearest neighbours and England.

Up until 2019, Birmingham had a lower rate of HIV late diagnosis compared to its nearest neighbours and England.

In 2019, Birmingham's HIV testing coverage was greater than that of its nearest neighbours and England.

Up until 2019, Solihull had greater testing coverage compared to its nearest neighbours and England.

Up until 2019, Solihull had a lower rate of HIV late diagnosis compared to its nearest neighbours and England.

Up until 2019, Solihull's HIV testing coverage was lower than that of its nearest neighbours and England.

INDEX OF RECOMMENDATIONS

The full recommendations can be found in the Executive Summary document.

Key Finding	Title	Summary
1	POST-NATAL CONTRACEPTION	Post-natal contraceptive services should be offered to all women in line with FRSH guidance.
2	PREGNANCY TESTING	Offer of free pregnancy testing.
3	LARC PRESCRIBING IN SOLIHULL	Review LARC delivery model in Solihull.
4	LARC PRESCRIBING IN BIRMINGHAM	Improve access to LARCS in Birmingham.
5	SOLIHULL PHARMACY PROVISION	Expand accessibility to sexual health services through pharmacy provision in Solihull.
6	VASECTOMIES AND STERILISATIONS	Improved pathways and increase practitioner knowledge.
7	SOLIHULL ABORTION RATE	Improve availability of LARCs. Review contraception provision at abortion services.
8	ACCESSING SEXUAL HEALTH APPOINTMENTS	Improve availability of walk-in clinics.
9	UMBRELLA WEBSITE	Improvements to pharmacy information on website.
10	SOLIHULL CLINIC LOCATIONS	Ensure those in the North of the borough have good access to clinics.
11	SEXUAL HEALTH OUTREACH	Clear Outreach Strategy including plan for 'pop up' clinics to meet needs of hard to engage groups.
12	PHARMACY OFFERINGS	Ensure good promotion of sexual health offerings in pharmacies.
13	STI SELF-TESTING KITS	Develop purchasing strategies to reduce risks of kit shortages.
14	COVID-19 IMPACT	Follow PHE initiatives regarding mitigating impacts of COVID-19.
15	HIV TESTING	Enhance HIV testing in GPs and other health settings.
16	CHILD-SPECIFIC ABUSE SURVIVORS' CLINIC	A child-specific Abuse Survivors' Clinic should be set up.
17	CHEMSEX	Improved response from sexual health and substance misuse services to those who engage in chem sex.
18	GENDER DYSPHORIA	Review of guidance and pathways for gender dysphoria services.
19	IMPROVE RESPONSE TO THOSE FROM SOUTH ASIAN COMMUNITIES	Clear engagement plan to understand fully the needs of this cohort.
20	NEEDS OF THOSE WITH A DISABILITY	Improve response to those with a disability, including increasing the confidence and knowledge of those working with and for this cohort.
21	TRAINING NEEDS FOR THOSE WORKING WITH HARD TO REACH GROUPS.	Ensure all information on sexual health is accessible to all.
22	HOMELESS COHORT	Improved joined up working with this cohort.
23	SUBSTANCE MISUSE COHORT	Improved joined up working with this cohort.
24	CERVICAL SCREENING	Complete cervical screening in sexual health services to increase access.

2 – DEMOGRAPHICS

OVERVIEW

BIRMINGHAM

- POPULATION NUMBERS
- DEMOGRAPHICS
- DEPRIVATION

SOLIHULL

- POPULATION NUMBERS
- DEMOGRAPHICS
- DEPRIVATION

OVERVIEW

IN THE UK, POOR SEXUAL HEALTH DISPROPORTIONATELY AFFECTS THOSE EXPERIENCING POVERTY AND SOCIAL EXCLUSION.

IN BIRMINGHAM

- Birmingham, like most urban conurbations, has areas of high deprivation. 43% of the population live in the 10% most deprived areas of England.

IN SOLIHULL

- Solihull is the 32nd least deprived upper tier local authority in England, and the least deprived upper tier local authority across the West Midlands.
- Over half of the North Solihull population live in the most deprived 10% of LSOA neighbourhoods in England, including one in five living in the most deprived 5% LSOAs.

YOUNG PEOPLE AS A DEMOGRAPHIC HAVE PARTICULAR NEEDS REGARDING SEXUAL HEALTH

- Young people under 25 report relatively larger numbers of sexual partners than other age groups.
- Young people experience the highest diagnosis rates of the most common STIs, and this is likely due to higher rates of partner change among 16-to-24-year-olds.
- A high proportion of 16-to24-year-olds were not 'sexually competent' at their first sexual intercourse.
- Unplanned pregnancy can be associated with lack of sexual competence.
- The House of Commons report into sexual health (2019) listed pornography and online dating applications as two influences on the risky sexual behaviour amongst younger people.

IN BIRMINGHAM

- Birmingham is 'Europe's youngest city', with under 25s accounting for nearly 40% of its population.
- Wards in the centre of the city have median ages of between 21 and 28.

IN SOLIHULL

- Solihull has a higher average age than Birmingham; however, there are wards in the north of the borough where there is a high proportion of younger people.

BIRMINGHAM

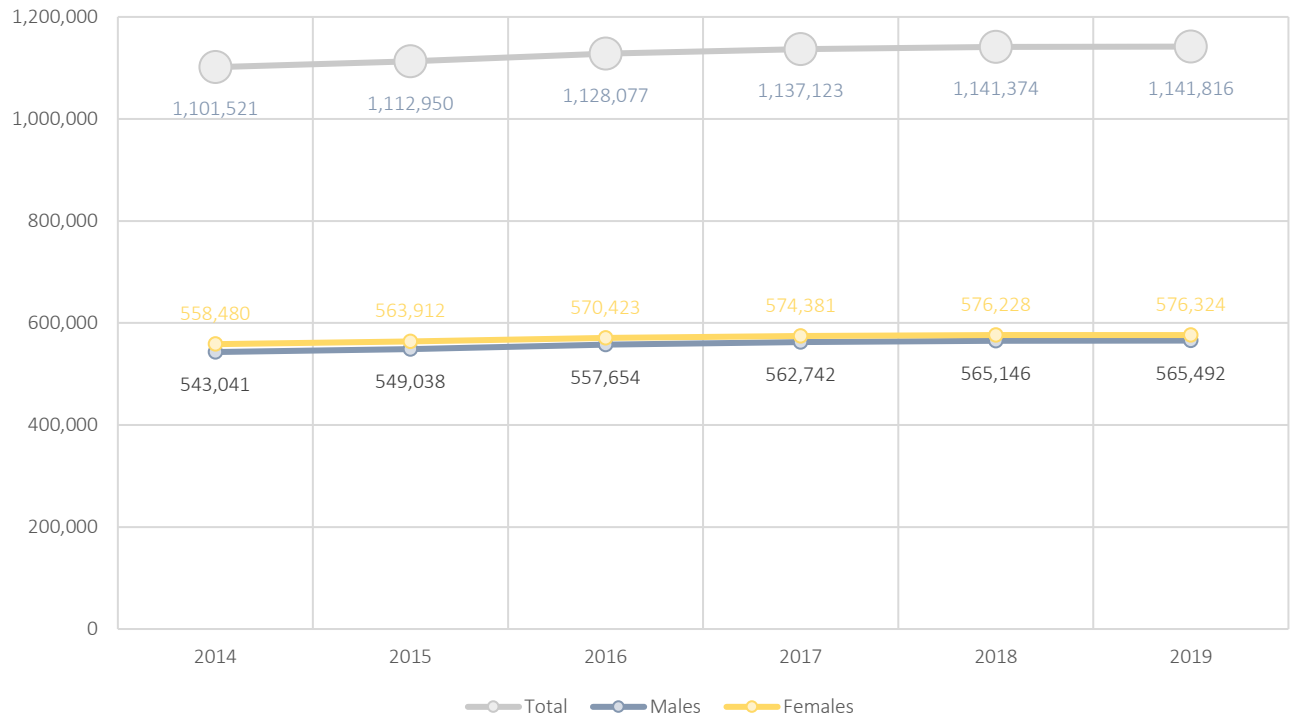
POPULATION NUMBERS

POPULATION OF BIRMINGHAM

The latest available ONS Mid-Year Estimate for 2019 provides a population figure of 1,141,816 for Birmingham. Since 2014, the population has grown on average by 8,059 per year, equating to less than 1% annually. The rate of growth has decreased in the last few years.

The split between males and females is even at 50% to 50% respectively.

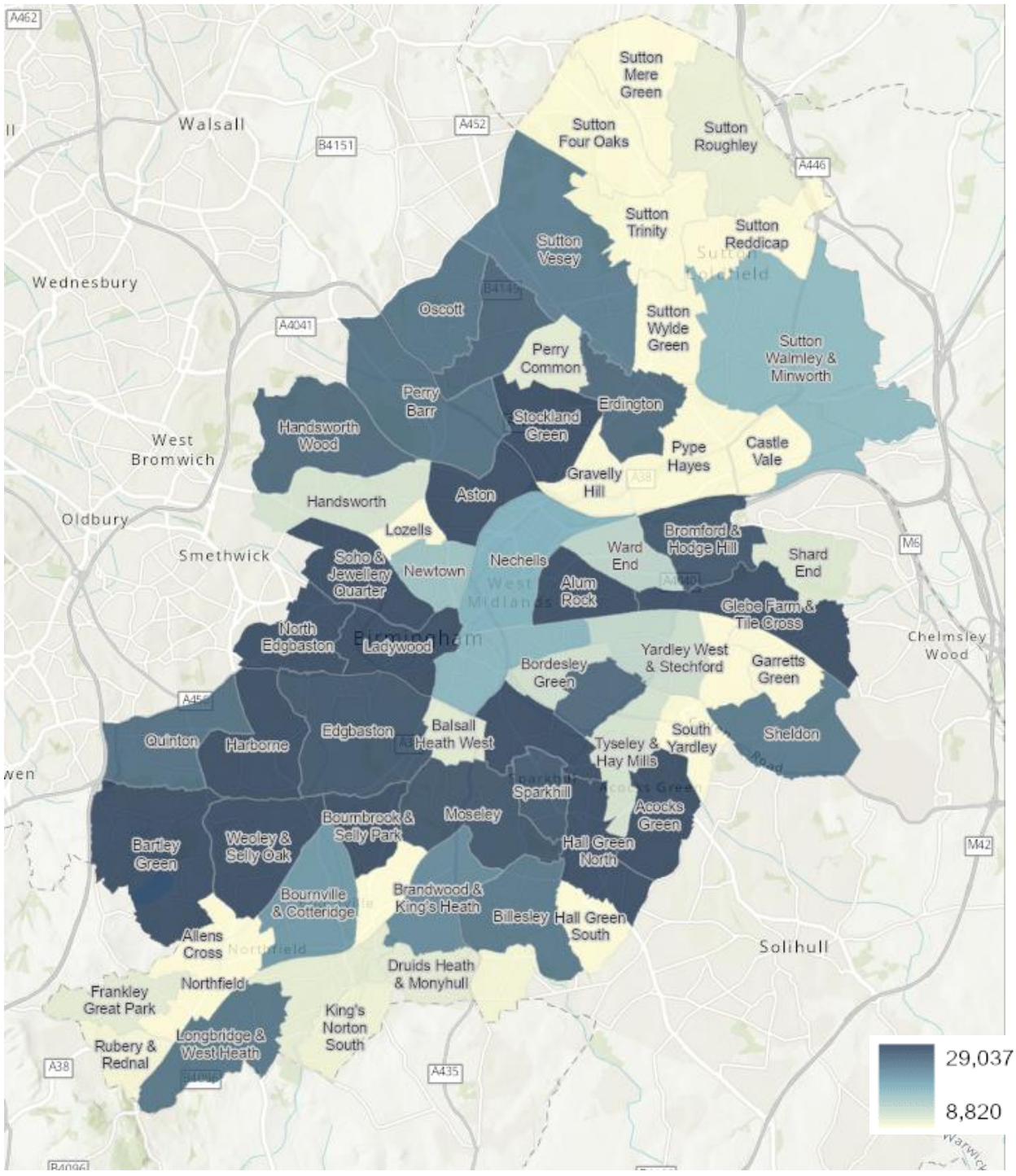
Figure 2.1: Population of Birmingham based on ONS Mid-Year Estimates.



POPULATION BY WARD

Birmingham is made up of 69 wards. The population by ward ranges from 8,820 in Sutton Wylde Green to 29,037 in Ladywood. The map shows that in terms of population numbers by ward, in general the north of Birmingham shows lower numbers.

Figure 2.2: Population of Birmingham by Ward; 2019 MYE



DEMOGRAPHICS

AGE

Figure 2.3 shows the median age in Birmingham compared against the CIPFA Nearest Neighbours. At 33, the median age in Birmingham ranks as one of the lowest among local authorities.

Figure 2.4 shows a comparison against England and Wales, the United Kingdom, and regions within England. This chart shows Birmingham has a relatively low median age.

Figure 2.3: Median age of Birmingham comparison against CIPFA Nearest Neighbours.

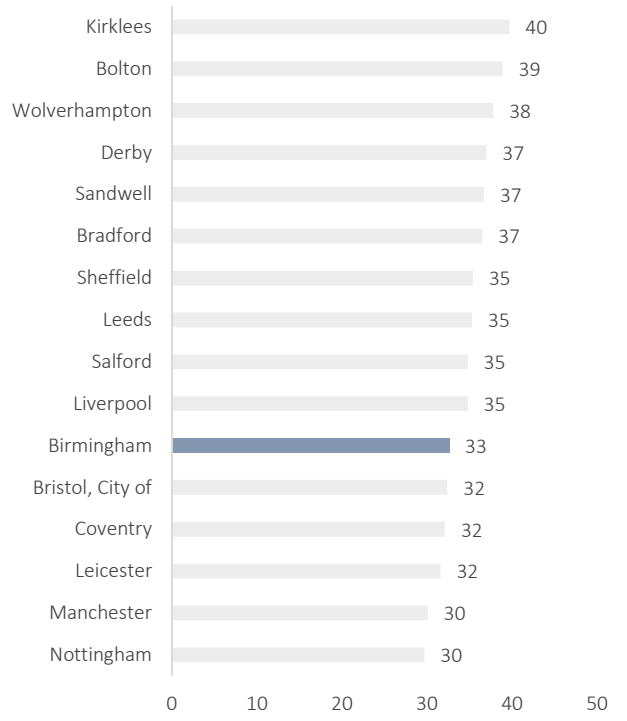


Figure 2.4: Median age of Birmingham comparison against England and Wales, the United Kingdom, and regions within England.

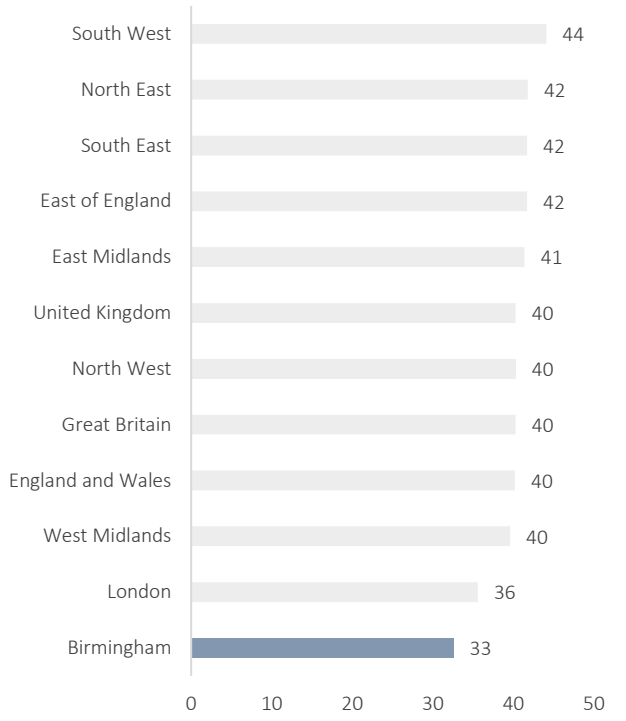
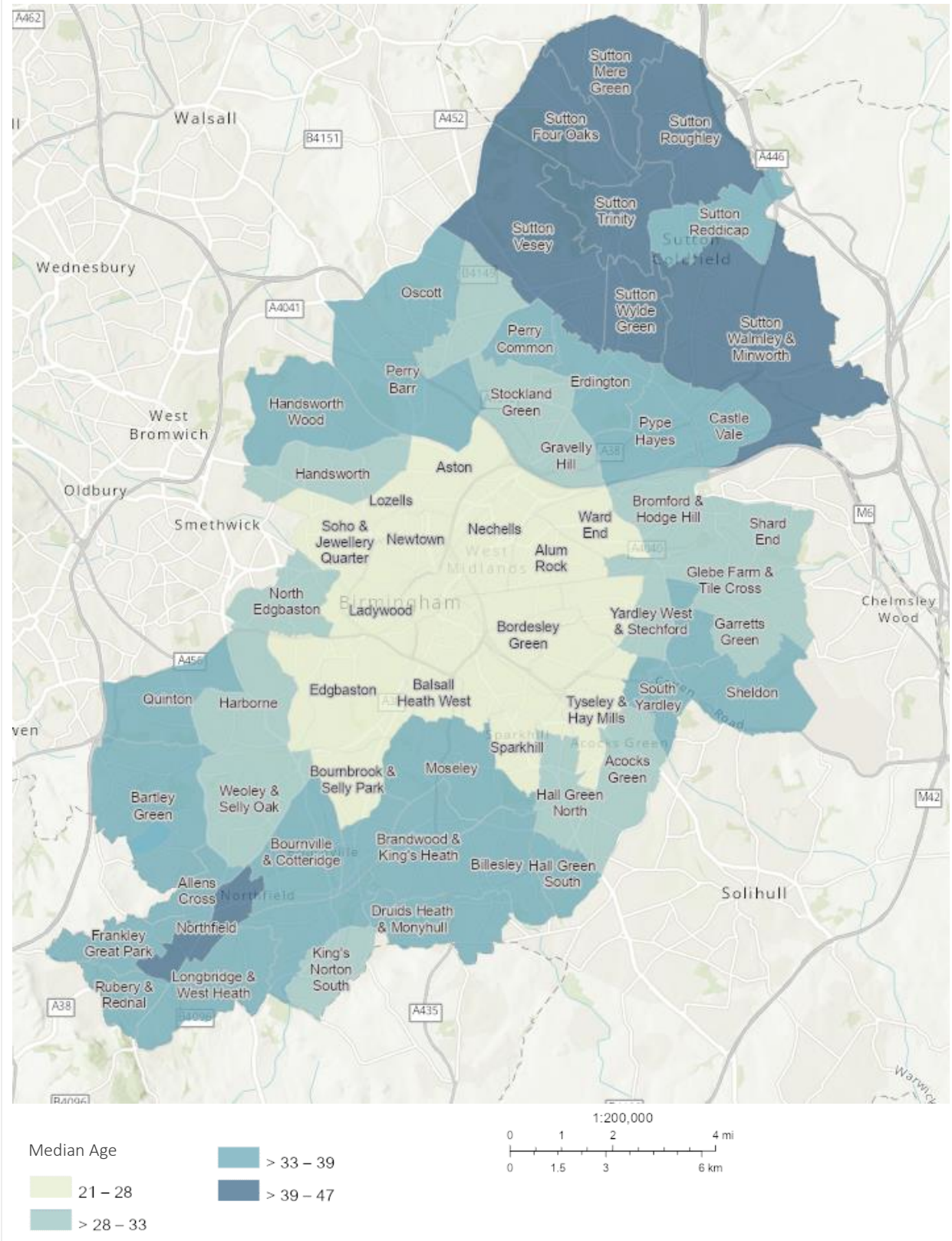


Figure 2.5 shows the median age in Birmingham by ward. The map highlights that the centre of the Birmingham has the lowest median age, whilst the north shows the highest median age.

Figure 2.5: Median age in Birmingham by ward.



ETHNICITY

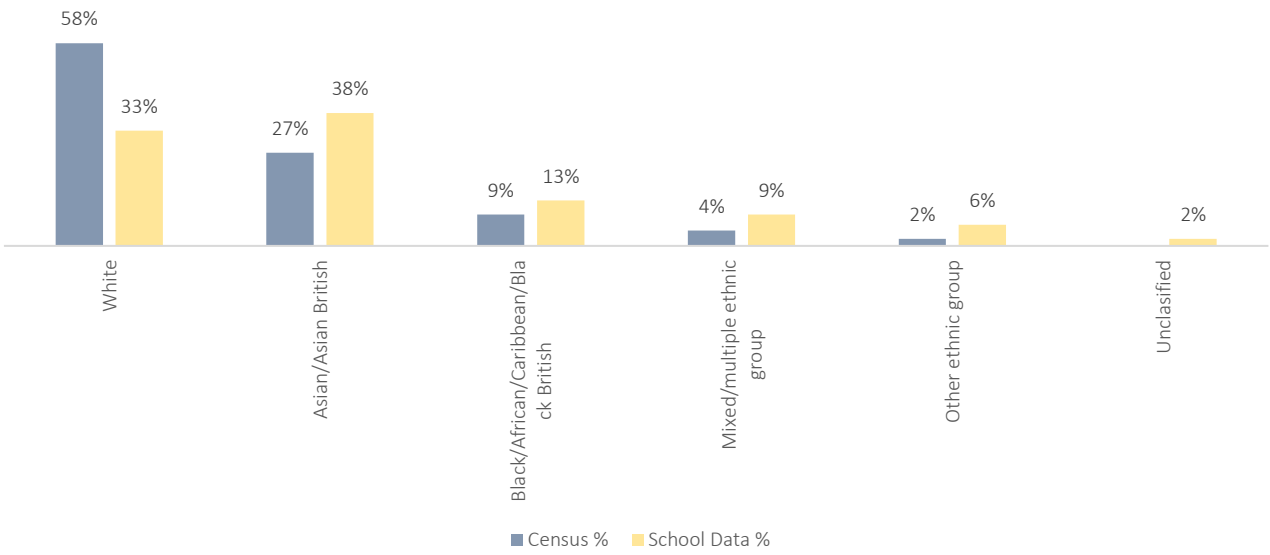
Ethnic and racial disparities in sexually transmitted infections (STIs) and other sexual health outcomes in the UK are well recognised, but the drivers of these disparities are not fully understood. [29]

- The rates of gonorrhoea and chlamydia in black and minority ethnic (BME) populations are three times that of the general population, and the rate of the STI Trichomoniasis is eight times higher.[30]
- Minority communities constitute 14% of the UK population but make up 52% of late HIV diagnoses and 40% of people accessing HIV services. [31]
- 80% of women living with HIV are BAME, and 62% are of African heritage. [32]
- The disparity in STI rates may not be accounted for by individual behaviours. Research suggests that sexual history and outcomes are likely to be influenced by factors beyond the individual, including partner behaviour and sexual networks.[3334] "It is critical that research in this area seeks to understand the breadth of determinants of sexual health and does not stigmatise ethnic groups who have a disproportionate prevalence of STI disease."[35]
- In one recent study, 45.5% of BAME people said that fears about a lack of cultural sensitivity from doctors deter them from seeking sexual health support.[36]
- Cultural factors that currently impact Black African and Caribbean, Latin American and South Asian communities are varied but include stigma and insensitivity relating to HIV, sexually transmitted infections (STIs), sex and relationships. [37]

[29] Rachel Jewkes and Kristin Dunkle (2017), Drivers of ethnic disparities in sexual health in the UK. *The Lancet Public Health*, Volume 2, Issue 10, E441-E442, October 01, 2017.
[30] House of Commons Health and Social Care Committee, Sexual health, Fourteenth Report of Session 2017–19.
[31] House of Commons Health and Social Care Committee, Sexual health, Fourteenth Report of Session 2017–19.
[32] House of Commons Health and Social Care Committee, Sexual health, Fourteenth Report of Session 2017–19.
[33] Coyle RM, Miltz AR, Lampe FC on behalf of the AURAH Study Group, et al, Ethnicity and sexual risk in heterosexual people attending sexual health clinics in England: a cross-sectional, self-administered questionnaire study. *Sexually Transmitted Infections* 2018;94:384-391.
[34] Rachel Jewkes and Kristin Dunkle (2017), Drivers of ethnic disparities in sexual health in the UK. *The Lancet Public Health*, Volume 2, Issue 10, E441-E442, October 01, 2017.
[35] Coyle RM, Miltz AR, Lampe FC on behalf of the AURAH Study Group, et al, Ethnicity and sexual risk in heterosexual people attending sexual health clinics in England: a cross-sectional, self-administered questionnaire study. *Sexually Transmitted Infections* 2018;94:384-391.
[36] Love Sex Life LSL Partnership (2020), Transforming Sexual and Reproductive Health for BAME Communities in Lambeth, Southwark and Lewisham.
[37] Love Sex Life LSL Partnership (2020), Transforming Sexual and Reproductive Health for BAME Communities in Lambeth, Southwark and Lewisham.

The last comprehensive dataset relating to ethnicity was the 2011 census, with the 2021 census data not expected to be released until March 2022. An alternative data source is from school data[38] which provides an indicative picture taken from a snapshot of the academic year. Figure 2.6 shows how the 2011 census compares to the 2020-21 academic year data.

Figure 2.6: Breakdown by ethnic groups in Birmingham; 2011 census and 2020-21 academic year school data.



DEPRIVATION

INTRODUCTION

Deprivation is a major factor in sexual health inequality. Rates of STIs, teen pregnancy, emergency contraception and abortion are all consistently higher in more deprived populations[39]. In addition, access to sexual health services (such as emergency contraception) can vary according to the levels of deprivation where people live.[40]

TEENAGE PREGNANCY

- Teenage pregnancy rates have fallen consistently since 2007, but rates vary depending on area, with the highest rates of teenage conception in the most deprived areas[41]. Socio-economic disadvantage can be both a cause and a consequence of teenage pregnancy[42].
- Areas with high rates of child poverty and unemployment are associated with higher under-18 conception rates. The strongest risk factors on an individual level are free school meals eligibility, persistent school absence by age 14, poorer than expected academic progress from 11 to 14, and being looked after or a care leaver[43].

[38] DoE, Statistics
[39] NICE (2019), Nice impact sexual health.
[40] NICE (2019), Nice impact sexual health.
[41] Public Health England (2021), Variation in outcomes in sexual and reproductive health in England: A toolkit to explore inequalities at a local level.
[42] NICE (2019), Nice impact sexual health.
[43] Public Health England (2021), Variation in outcomes in sexual and reproductive health in England: A toolkit to explore inequalities at a local level.

ABORTION

- Across all age ranges, women in more deprived areas are more likely to have abortions[44]. In 2019, the abortion rate in the most deprived decile was 26.1 per 1,000 - over twice the rate in the least deprived decile (12.0 per 1,000)[45].

EMERGENCY CONTRACEPTION

- There are regional inequalities in rates of emergency contraception use. Women's access to emergency contraception varies according to the level of deprivation in their area of residence. [46]
- Women from the most deprived areas are more likely to be provided with emergency contraception than those in the least deprived areas[47].

SEXUALLY TRANSMITTED INFECTIONS

- Rates of new STI diagnosis (including chlamydia, anogenital warts, anogenital herpes, gonorrhoea and syphilis) are consistently higher in more deprived populations[48].
- Rates of HIV are highest in the most deprived areas[49].
- Research suggests that the likelihood of having an infection diagnosed and treated varies by deprivation. For example, although chlamydia screening coverage was uniform by area-level deprivation, chlamydia prevalence was higher in those living in more deprived areas[50].

CERVICAL SCREENING

- Research has shown that women in deprived areas are around 40 per cent less likely to attend cervical screening[51].
- In 2006, women living in the most deprived areas of England were nearly twice as likely to be diagnosed with cervical cancer than their affluent counterparts[52].

ACCESS AND UPTAKE IN SERVICES

- Cuts to spending on sexual health in recent years have been severe, with a 14% real term reduction in local authority spending on sexual health between 2013/14 and 2017/18[53].
- Problems with accessibility disproportionately affect certain population groups, to the extent that some groups have inadequate access to sexual health services[54].

---

[44] Department of Health (2019), Abortion Statistics, England and Wales: 2019.
[45] Public Health England (2021), Variation in outcomes in sexual and reproductive health in England: A toolkit to explore inequalities at a local level.
[46] NICE (2019), Nice impact sexual health.
[47] Statista (2020), Share of women provided emergency contraceptives by sexual and reproductive health services in England in 2019/20, by deprivation decile.
[48] Public Health England (2021), Variation in outcomes in sexual and reproductive health in England: A toolkit to explore inequalities at a local level.
[49] Department of Health (2013), A Framework for Sexual Health Improvement in England.
[50] Woodhall SC, Soldan K, Sonnenberg P, et al (2015), Is chlamydia screening and testing in Britain reaching young adults at risk of infection? Findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3), Sexually Transmitted Infections 2016;92:218-227.
[51] https://news.cancerresearchuk.org/2008/12/02/deprivation-doubles-cervical-cancer-risk/
[52] https://news.cancerresearchuk.org/2008/12/02/deprivation-doubles-cervical-cancer-risk/
[53] House of Commons Health and Social Care Committee (2019), Sexual health: Fourteenth Report of Session 2017–19.
[54] House of Commons Health and Social Care Committee (2019), Sexual health: Fourteenth Report of Session 2017–19.

- One GP in Bradford observed that "the cuts hit the most deprived most severely, because they cannot always negotiate the social, cultural or financial factors; they cannot navigate the hurdles put in their way when access is changed[55].

BEST PRACTICE

- NICE guidance can help to achieve improvements in the population's sexual health and address sexual health inequalities.
- For example, the 2005 NICE guideline on long-acting reversible contraception (LARC) had a positive impact in increasing the uptake of LARCs, the most effective methods of contraception to prevent unplanned pregnancies. Likewise, the guideline on STIs and under-18 conceptions has played a role in mainstreaming the importance of prevention to tackle the historically high rates of teenage pregnancies in the UK[56].

DEPRIVATION IN BIRMINGHAM

Key points taken from the analysis of deprivation in Birmingham:

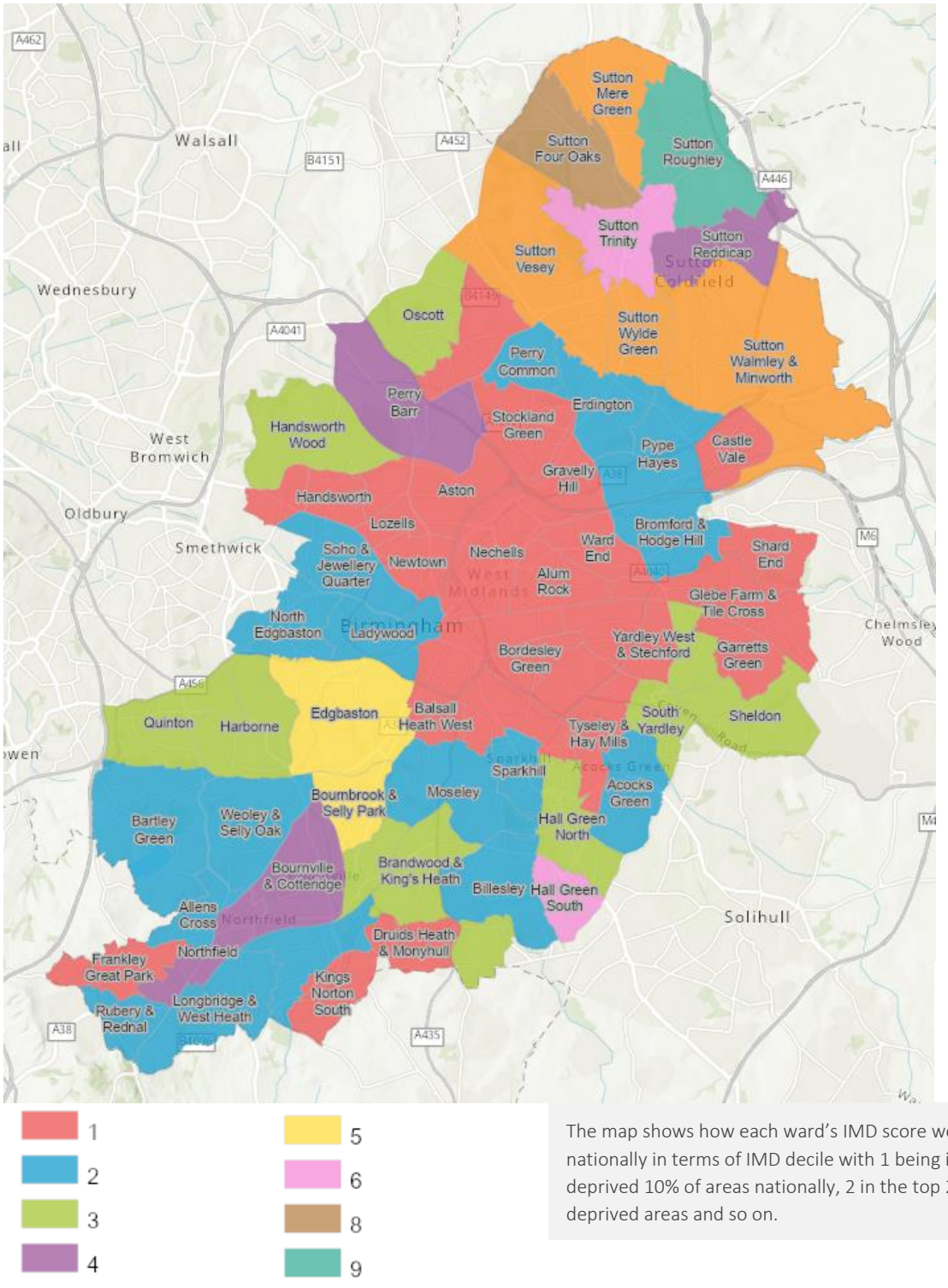
- 43% of the population living in LSOAs are among the 10% most deprived in England.
- Birmingham is the 7th most deprived local authority in England and the 3rd most deprived English Core City.
- Deprivation is most heavily clustered around the city centre.
- Hodge Hill is the most deprived constituency in the city; Sparkbrook & Balsall Heath East, Bordesley Green and Lozells are the top 3 most deprived wards.

The MHCLG do not produce deprivation data for wards, but LSOA IMD scores can be aggregated to calculate ward deprivation rankings.

[55] House of Commons Health and Social Care Committee (2019), Sexual health: Fourteenth Report of Session 2017–19.
[56] NICE (2019), NICE impact sexual health. Accessed September 2021.

The map shows how each ward's IMD score would rank it nationally in terms of IMD decile, with 1 being in the most deprived 10% of areas nationally, 2 in the top 20% of deprived areas and so on.

Figure 2.7: IMD decile in Birmingham by ward; 2019.



The map shows how each ward's IMD score would rank it nationally in terms of IMD decile with 1 being in the most deprived 10% of areas nationally, 2 in the top 20% of deprived areas and so on.

SOLIHULL

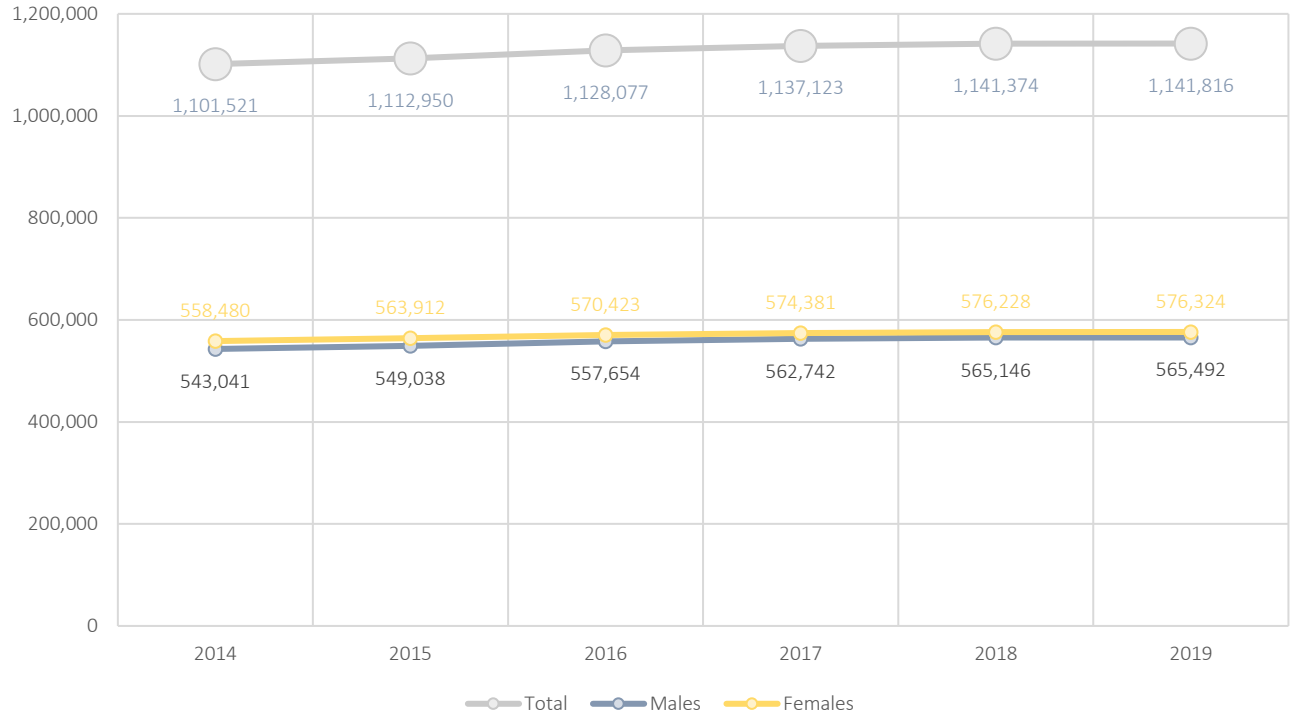
POPULATION NUMBERS

POPULATION OF SOLIHULL

The latest available ONS Mid-Year Estimates provide a figure of 371,521 for the population of Solihull. Since 2014, the population has grown on average by 1,229 per year, equating to around 1% annually.

The split between males and females is relatively even, at 51% to 49% respectively.

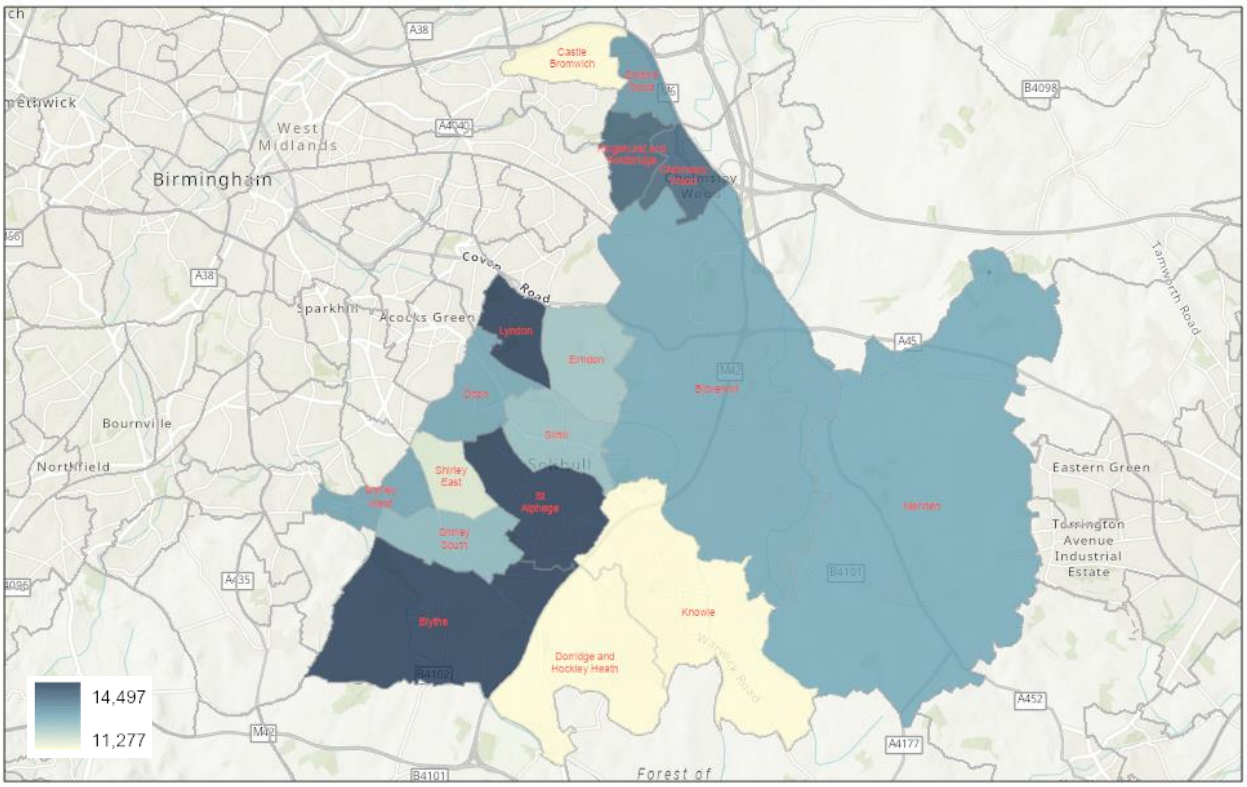
Figure 2.8: Population of Solihull based on ONS Mid-Year Estimates.



POPULATION BY WARD

Solihull is made up of 17 wards. The population by ward ranges from 11,277 in Knowle to 14,497 in Blythe. Figure 2.9 shows the change in population by ward since 2014. The wards that have seen the highest percentage increase are Shirley West, Blythe, and Chelmsley Wood.

Figure 2.9: Population of Solihull by ward; 2019 MYE



DEMOGRAPHICS

AGE

Figure 2.10 shows the median age in Solihull compared against the CIPFA Nearest Neighbours. At 43, the median age in Solihull ranks near the median of the nearest neighbours.

In comparison to England and Wales, the United Kingdom, and regions within England, the median age in Solihull is on the higher end.

Figure 2.10: Median age in Solihull comparison against CIPFA Nearest Neighbours.

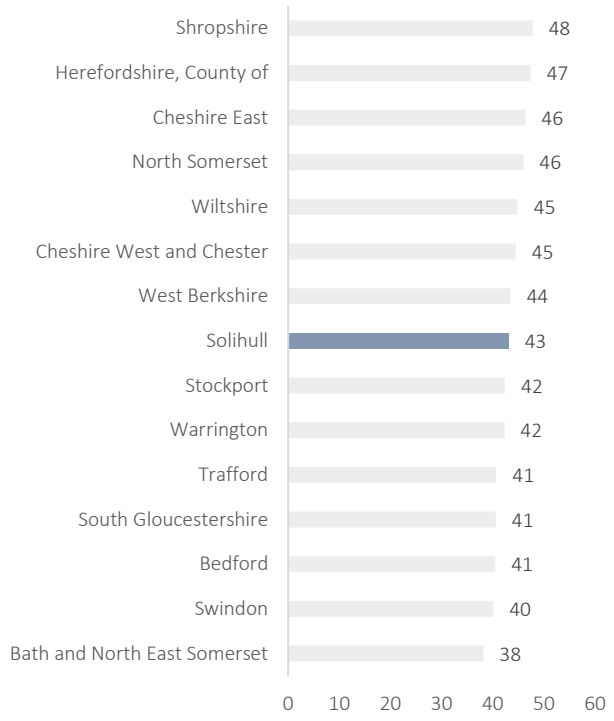


Figure 2.11: Median age in Solihull comparison against England and Wales, the United Kingdom, and regions within England.

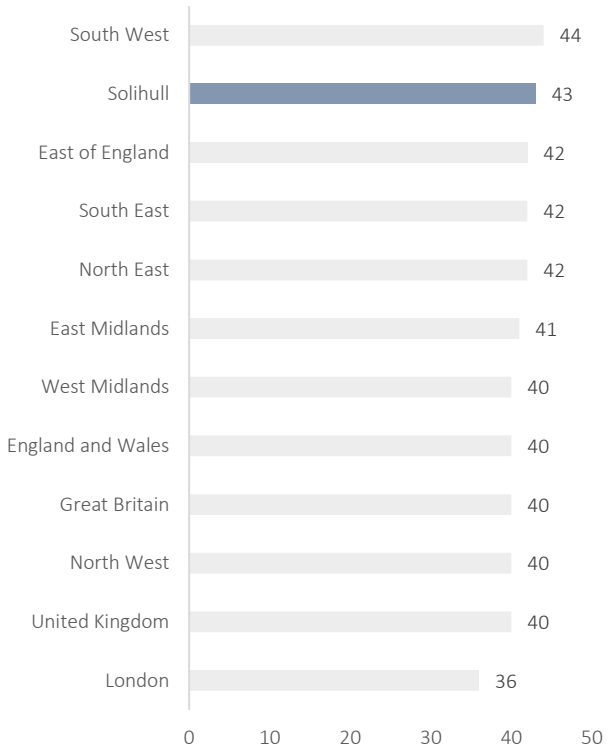
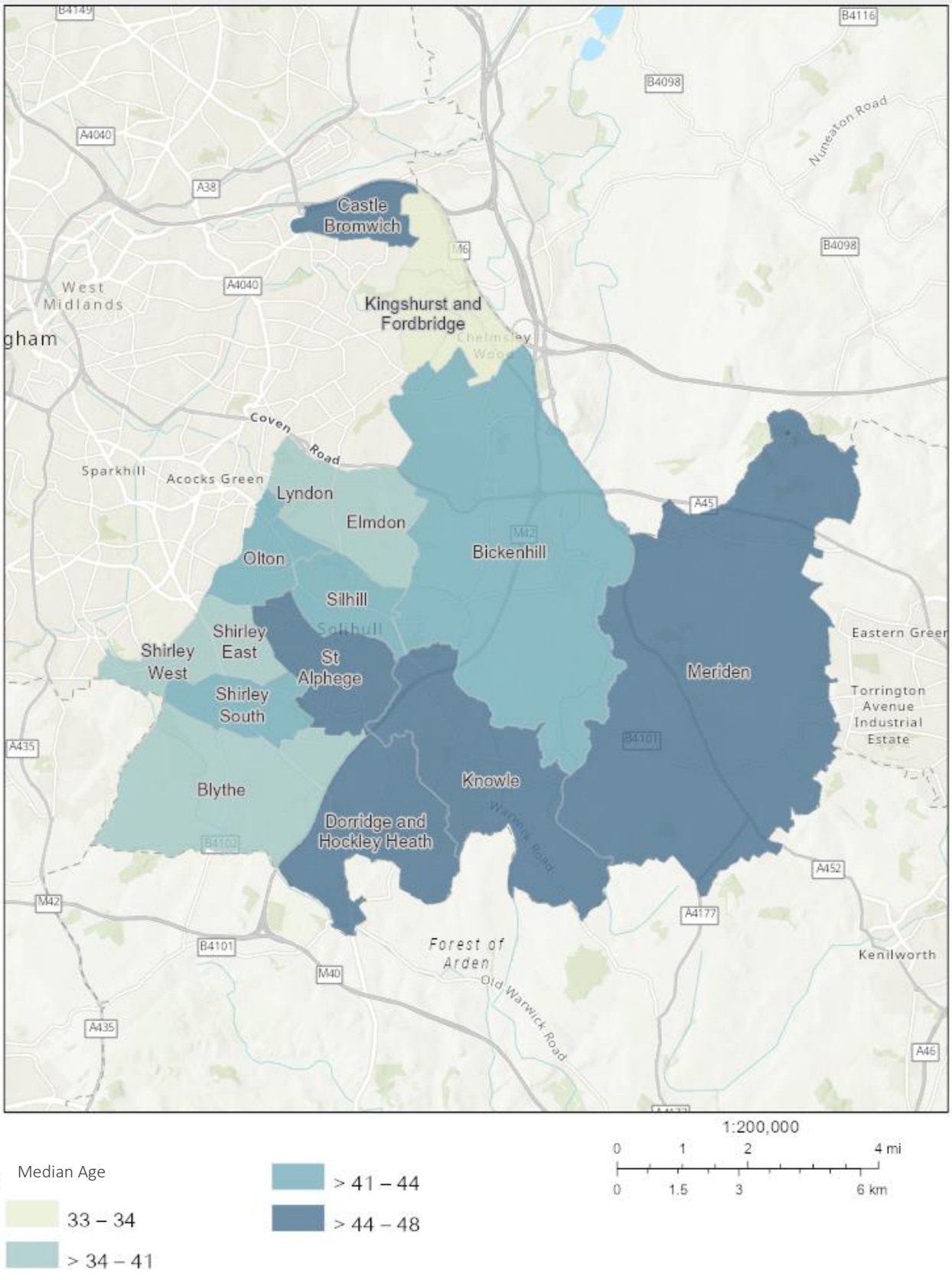


Figure 2.12 shows the median age in Solihull by ward. The breakdown by ward shows notable variances ranging from 33 in Chelmsley Wood to 48 in Knowle.

Figure 2.12: Median age in Solihull by ward.

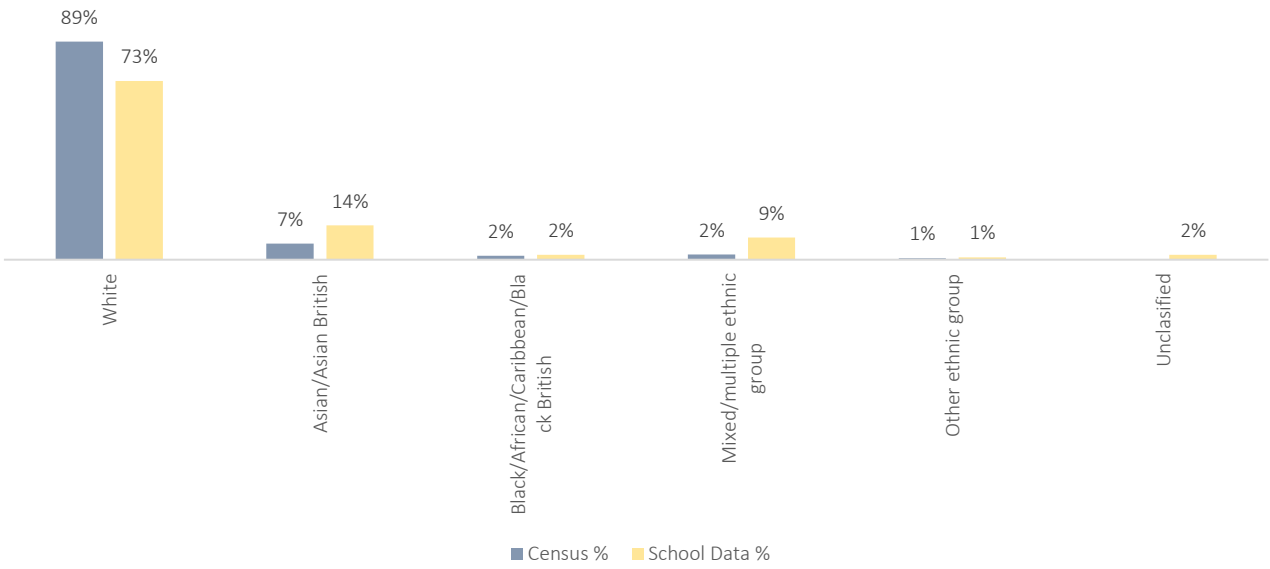


ETHNICITY

The last comprehensive dataset relating to ethnicity was the 2011 census, with the 2021 census data not expected to be released until March 2022. An alternative data source is from school data[57] which provides an indicative picture taken from a snapshot of the academic year. Figure 2.13 shows how the 2011 census compares to the 2020-21 academic year data.

Based on the census data, 10.9% of the population were from a Black or Minority Ethnic (BAME) background, which is slightly lower than the England (14.6%) and West Midlands (17.3%) averages. The school data provides a higher figure of 27%.

Figure 2.13: Breakdown by ethnic groups in Birmingham; 2011 census and 2020-21 academic year school data.



[57] DoE, Statistics

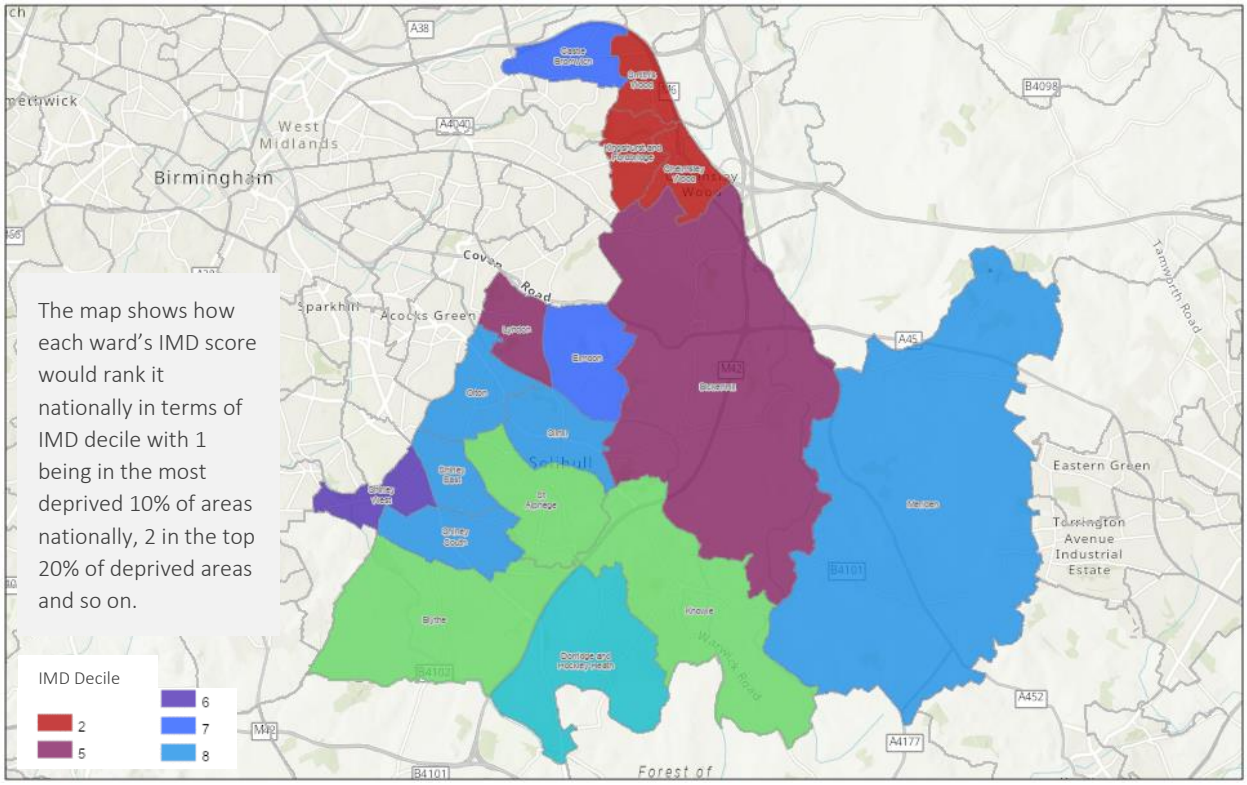
DEPRIVATION

DEPRIVATION IN SOLIHULL

Based on the 2019 Index of Multiple Deprivation (IMD), Solihull is the 32nd least deprived upper tier Local Authority in England, and the least deprived upper tier Local Authority across the West Midlands.

Despite the overall low average deprivation for Solihull, there is significant polarisation between the neighbourhoods as demonstrated in Figure 2.14. The following map shows the IMD decile by ward, where 1 is the most deprived 10% and 10 is the least. Note that the calculations are the average of the Lower Super Output Areas in the ward, as IMD is not produced at ward level.

Figure 2.14: IMD decile in Solihull by ward; 2019.



3 – LOCAL SERVICE PROVISION

INTRODUCTION

- OVERVIEW

PATIENT FLOW

- PATIENT CONSULTATIONS AT GUM (LEVEL 3) SERVICES IN BIRMINGHAM AND SOLIHULL
- PATIENT CONSULTATIONS AT GUM (LEVEL 3) SERVICES FOR RESIDENTS FROM BIRMINGHAM AND SOLLIHULL
- SEXUAL HEALTH SCREENS

ENGAGEMENT

- GP
- PHARMACISTS
- PRACTITIONER SURVEY
- COMMUNITY SURVEY

INTRODUCTION

SERVICE	BIRMINGHAM	SOLIHULL
LOCAL AUTHORITY		
Long-acting reversible contraception (LARC) and ease of access to	Umbrella	GPs
User dependent contraception	Umbrella	Pharmacists
STI testing and treatment	Umbrella	Umbrella
Specialist Services[58]	Umbrella	Umbrella
BIRMINGHAM AND SOLIHULL CCG		
Abortion Services	BPAS	BPAS
Sterilisation	BPAS, UHB, BWCH	BPAS, UHB
Vasectomy	BPAS	BPAS
Gynaecology	UHB	UHB
NHS ENGLAND		
User-dependent contraception provided as an additional service under the GP contract	GPs	GPs
HIV treatment and care	UHB NHS Foundation Trust	UHB NHS Foundation Trust
Promotion of opportunistic testing and treatment for STIs and patient-requested testing by GPs	GPs, Services outside SHS	GPs
Sexual health elements of prison health services	Birmingham Community Healthcare NHS Foundation Trust	n/a
SARCs	Horizon Sexual Assault Referral Centre	Horizon Sexual Assault Referral Centre
Cervical screening	NHS Birmingham and Solihull Clinical Commissioning Group	NHS Birmingham and Solihull Clinical Commissioning Group

[58] Young people's sexual health, teenage pregnancy services, outreach, HIV prevention, sexual health promotion, and services in schools, colleges and pharmacies.

OVERVIEW

University Hospitals Birmingham NHS Foundation Trust (UHB) provides an integrated sexual health service across Birmingham and Solihull. The service, known as Umbrella, was launched in August 2015.

Umbrella is a partnership between UHB and other statutory, community, and voluntary organisations including general practitioners, community pharmacists and a number of third-sector organisations.

Figure 3.1: Diagram of Umbrella services (taken from the Umbrella Annual Report 2018-19)

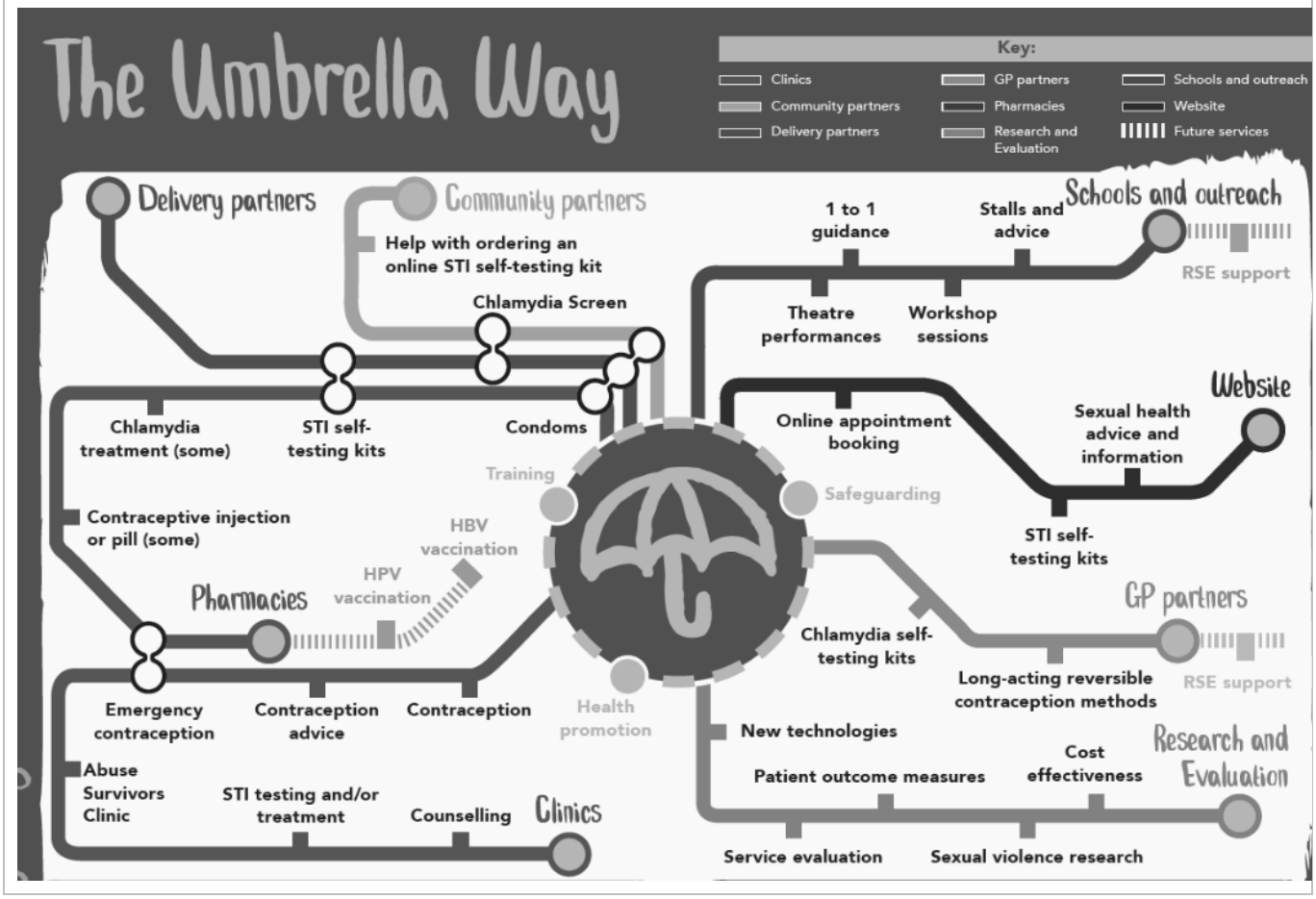


Figure 3.2 below shows the service provision (pre-COVID-19).

Figure 3.2: Service provision and available treatment.

Service	Treatment
Whittall Street Clinic (Umbrella Hub) Boots Birmingham, Hawthorn House, Erdington, Northfield Community Partnership, Boots Solihull, Chelmsley Wood (Umbrella Spokes)	Basic genitourinary medicine
	Complex genitourinary medicine [including syphilis and chronic sexually transmitted infection (STI) problems]
	Basic contraception
	Complex contraception
	Complex implant removal
	Psychosexual counselling
	Vulval Dermatology
	Post-exposure prophylaxis
	Young person's clinic (Boots Birmingham)
GP Partners	Chlamydia self-testing kits
	Long-acting reversible contraception methods
Community Pharmacists	Emergency Hormonal Contraception
	STI testing kits
	Advanced provision of Emergency Hormonal Contraception
	Condom distribution
	Continuation of Hepatitis B vaccination
	Initiate / ongoing contraception injections (planned)
	Dispense treatment for chlamydia
	Initiate STI testing
Delivery partners	Condoms
	Chlamydia screen
	STI self-testing kits
Community partners	Condoms
	Chlamydia screen
	Help with ordering an online STI self-testing kit

The service follows a 'hub and spoke' model, with a central hub in the centre of Birmingham at Whittall Street Clinic (WSC) plus six spoke clinics. WSC offers basic and complex genitourinary medicine clinics [including syphilis

and chronic sexually transmitted infection (STI) problems], basic and complex contraception and complex implant removal, psychosexual counselling, vulval dermatology and post-exposure prophylaxis after sexual exposure to HIV.[59]

Six spoke clinics offer sexual health services 7 days a week. There is a specific under-25s service at a Boots chemist located in central Birmingham.

In Birmingham, 180 out of 280 community pharmacies are sub-contracted to Umbrella. Sexual health services have been moved to community pharmacies. Patients can access a range of services at partner pharmacies: EHC, chlamydia screens, STI treatment, chlamydia treatment, and hepatitis B vaccinations. There is a plan for LARC injections to be offered in partner pharmacies. No Solihull pharmacies are partnered with Umbrella.

In Birmingham, partner GPs provide a complete contraceptive service with Umbrella-incentivised LARC provision and chlamydia screening. Chlamydia testing is also promoted via GPs.

Although Umbrella operate clinics in Solihull, Solihull GPs and pharmacists are not part of this integrated Umbrella service. A smaller number of services are being provided in Solihull which means that Solihull residents do not have the same level of provision.

59 Jewell S, et al. J Fam Plann Reprod Health Care 2017;43:229–231. doi:10.1136/jfprhc-2016-101561

PATIENT FLOW

PATIENT CONSULTATIONS AT GUM (LEVEL 3) SERVICES IN BIRMINGHAM AND SOLIHULL

This section looks at the activity of GUM (Level 3) services in Birmingham and Solihull, regardless of where the patient is resident.

The data is taken from the GUMCAD sexual health information database.

BIRMINGHAM

All the services accessed were recorded as "University Hospital Birmingham"; this is the Trust that provides Umbrella Sexual Health Services.

Prior to the COVID-19 period, activity was relatively stable.

There was a promotional screen run in October 2018 focussing on chlamydia screening. This could account for the spike in patients accessing services in this quarter. STI and reproductive health campaigns generally lead to increased activity.

Figure 3.3: Number of patients accessing GUM (Level 3) Services in Birmingham.

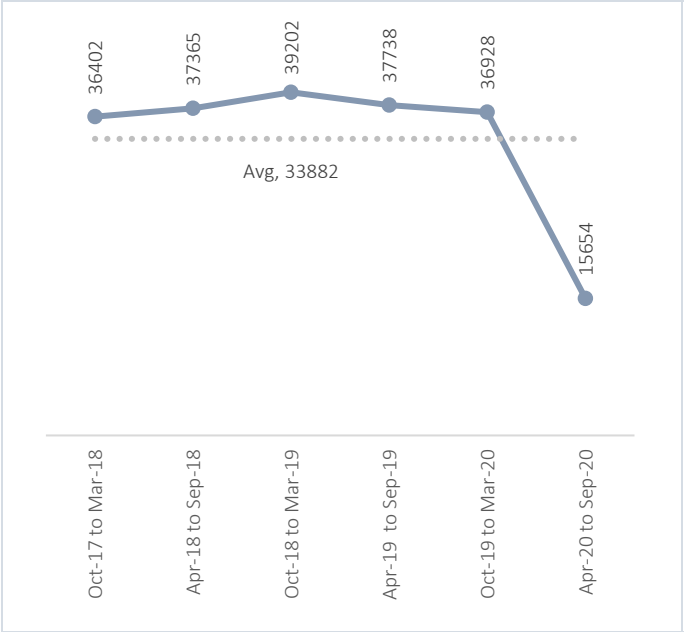
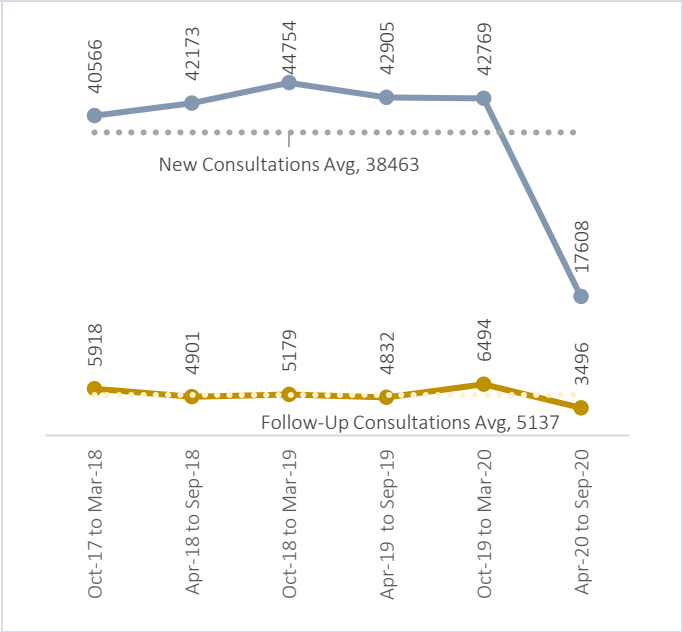


Figure 3.4: New consultations and follow-up consultations.



Approximately 77-79% of the patient consultations at GUM (Level 3) services in Birmingham are from those residing in Birmingham, with the second largest group from Solihull (10%).

Since COVID-19, when patients from outside Birmingham and Solihull contact Umbrella they are guided towards services in their own local area. This does not impact patients who are particularly vulnerable or emergency cases.

Figure 3.5: Patients accessing GUM (Level 3) services in Birmingham broken down by LA of residence.

LA of Residence	01/10/2017 to 31/03/2018	01/04/2018 to 30/09/2018	01/10/2018 to 31/03/2019	01/04/2019 to 30/09/2019	01/10/2019 to 31/03/2020	01/04/2020 to 30/09/2020	Total
Birmingham	28,481	28,738	31,114	29,340	29,124	12,714	159,511
Solihull	3,466	3,946	3,564	3,842	3,562	1,780	20,160
Sandwell	1,324	1,508	1,403	1,408	1,255	233	7,131
Not Known	661	646	777	849	890	349	4,172
Walsall	449	478	472	491	466	177	2,533
Bromsgrove	237	315	314	313	257	114	1,550
Dudley	230	251	237	229	204	26	1,177
Wolverhampton	187	171	168	172	187	16	901
North Warwickshire	134	143	147	174	175	106	879
Coventry	131	119	136	145	132	47	710
Other	1,156	1,164	1,021	927	806	99	5,173
Total	36,456	37,479	39,353	37,890	37,058	15,661	203,897

LA of Residence	01/10/2017 to 31/03/2018	01/04/2018 to 30/09/2018	01/10/2018 to 31/03/2019	01/04/2019 to 30/09/2019	01/10/2019 to 31/03/2020	01/04/2020 to 30/09/2020	Total
Birmingham	78%	77%	79%	77%	79%	81%	78%
Solihull	10%	11%	9%	10%	10%	11%	10%
Sandwell	4%	4%	4%	4%	3%	1%	3%
Not Known	2%	2%	2%	2%	2%	2%	2%
Walsall	1%	1%	1%	1%	1%	1%	1%
Bromsgrove	1%	1%	1%	1%	1%	1%	1%
Dudley	1%	1%	1%	1%	1%	0%	1%
Wolverhampton	1%	0%	0%	0%	1%	0%	0%
North Warwickshire	0%	0%	0%	0%	0%	1%	0%
Coventry	0%	0%	0%	0%	0%	0%	0%
Other	3%	3%	3%	2%	2%	1%	3%

SOLIHULL

There was no activity linked to GUM (Level 3) services in Solihull. This is captured within UHB figures.

PATIENT CONSULTATIONS AT GUM (LEVEL 3) SERVICES FOR RESIDENTS FROM BIRMINGHAM AND SOLLIHULL

This section looks at the activity of GUM (Level 3) services access by residents from Birmingham and Solihull.

BIRMINGHAM

95% of the people who accessed Umbrella services reside in Birmingham.

Following the move towards more people working from home, fewer people from out of area access Umbrella services. In this case, people will be more likely to access services nearer to their home address or online.

Figure 3.6: GUM (Level 3) services access by residents from Birmingham.

Service Location	Service name	01/10/2017 to 31/03/2018	01/04/2018 to 30/09/2018	01/10/2018 to 31/03/2019	01/04/2019 to 30/09/2019	01/10/2019 to 31/03/2020	Total
Birmingham	University Hospital Birmingham	28481	28738	31114	29340	29124	146797
Sandwell	The Lyng Health Centre	446	460	470	446	375	2197
Walsall	The Manor Hospital	204	206	190	207	188	995
Dudley	Russells Hall Hospital	86	74	105	100	94	459
Lichfield	Sir Robert Peel Hospital	76	103	111	108	90	488
Redditch	The Arrowside Unit	71	60	68	73	62	334
Coventry	Coventry & Warwickshire Hospital	59	55	61	57	62	294
Wolverhampton	New Cross Hospital	30	24	29	26	31	140
Nuneaton and Bedworth	George Eliot Hospital	27	14	19	11	16	87
Westminster	Dean Street Clinic (GUM)	39	48	44	44	38	213
Other		477	511	492	501	447	2428
Total		29996	30293	32703	30913	30527	154432

Service Location	Service name	01/10/2017 to 31/03/2018	01/04/2018 to 30/09/2018	01/10/2018 to 31/03/2019	01/04/2019 to 30/09/2019	01/10/2019 to 31/03/2020	Total
Birmingham	University Hospital Birmingham	95%	95%	95%	95%	95%	95%
Sandwell	The Lyng Health Centre	1%	2%	1%	1%	1%	1%
Walsall	The Manor Hospital	1%	1%	1%	1%	1%	1%
Dudley	Russells Hall Hospital	0%	0%	0%	0%	0%	0%
Lichfield	Sir Robert Peel Hospital	0%	0%	0%	0%	0%	0%
Redditch	The Arrowside Unit	0%	0%	0%	0%	0%	0%
Coventry	Coventry & Warwickshire Hospital	0%	0%	0%	0%	0%	0%
Wolverhampton	New Cross Hospital	0%	0%	0%	0%	0%	0%
Nuneaton and Bedworth	George Eliot Hospital	0%	0%	0%	0%	0%	0%
Westminster	Dean Street Clinic (GUM)	0%	0%	0%	0%	0%	0%
Other		2%	2%	2%	2%	1%	2%

SOLIHULL

95% of those who accessed Umbrella services reside in Solihull.

Figure 3.7: GUM (Level 3) services access by residents from Solihull.

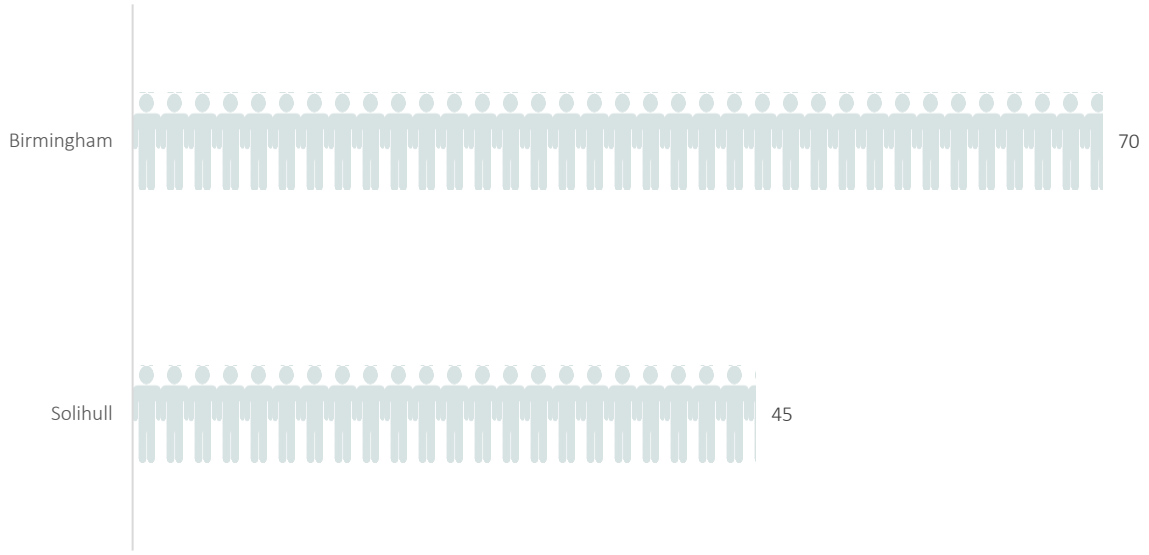
Service Location	Service name	01/10/2017 to 31/03/2018	01/04/2018 to 30/09/2018	01/10/2018 to 31/03/2019	01/04/2019 to 30/09/2019	01/10/2019 to 31/03/2020	Total
Birmingham	University Hospital Birmingham	3466	3946	3564	3842	3562	18380
Coventry	Coventry & Warwickshire Hospital	36	51	55	45	49	236
Stratford-on-Avon	Hathaway centre	15	22	17	19	22	95
Redditch	The Arrowside Unit	13	9	11	8	11	52
Nuneaton and Bedworth	George Eliot Hospital	11	4	4	10	15	44
	Other	118	102	102	94	92	508
	Total	3659	4134	3753	4018	3751	19315
Service Location	Service name	01/10/2017 to 31/03/2018	01/04/2018 to 30/09/2018	01/10/2018 to 31/03/2019	01/04/2019 to 30/09/2019	01/10/2019 to 31/03/2020	Total
Birmingham	University Hospital Birmingham	95%	95%	95%	96%	95%	95%
Coventry	Coventry & Warwickshire Hospital	1%	1%	1%	1%	1%	1%
Stratford-on-Avon	Hathaway centre	0%	1%	0%	0%	1%	0%
Redditch	The Arrowside Unit	0%	0%	0%	0%	0%	0%
Nuneaton and Bedworth	George Eliot Hospital	0%	0%	0%	0%	0%	0%
	Other	3%	2%	3%	2%	2%	3%

COMBINED

Figure 3.8 shows the rate of residents from Birmingham and Solihull accessing GUM (Level 3) services during 2019-20 as a rate per 1,000 of the 16-and-over population[60].

The higher rates of patients accessing services in Birmingham compared to Solihull is likely to be due to the demographics of Birmingham. There is a younger population and a greater population of MSM (men who have sex with men).

Figure 3.8: GUM (Level 3) services access by residents from Birmingham and Solihull as a rate per 1,000 of the 16+ population.



LA of Residence	2019-20	2019 MYE 16+ Population	Rate per 1,000
Birmingham	61,440	883,045	70
Solihull	7,769	173,810	45

[60] 2019 MYE.

SEXUAL HEALTH SCREENS

This chapter looks the number of sexual health screens taken at a first attendance.

A sexual health screen is where a combination of two or more of the following tests are taken: chlamydia, gonorrhoea, HIV & syphilis.

A first attendance includes new and re-booked 'face-to-face' attendances at the start of a new sexual health episode[61]. The way the data is collected means that sexual health screens taken at follow-up attendances are not included.

AGE AND GENDER

The number of first attendances in 2019-20 as a rate per 100,000 population is significantly higher in Birmingham compared to Solihull.

A reoccurring theme is the 20-24 age group showing higher rates (of first attendances) for both males and females in Solihull compared to Birmingham.

The percentage of sexual health screens taken (at first attendance in 2019-20) is higher for males than females.

For males, the rates are higher across all age groups apart from those aged 65+, in Solihull compared to Birmingham.

For females, the overall rate is comparable between the two areas.

[61] The episode starts on the date the patient first sees or is in contact with a care professional in respect of a referral request from either a Health Care Provider or a self-referral. The episode ends when either the patient is formally discharged or has not had face to face contact with the service for at least 6 weeks.

COMBINED (BIRMINGHAM AND SOLIHULL)

The following charts show the number of first attendances in 2019-20 as a rate per 100,000 population and the percentage that resulted in a sexual health screen being taken.

MALES

Figure 3.9: Number of 1st attendances in 2019-20 - Rate per 100,000.

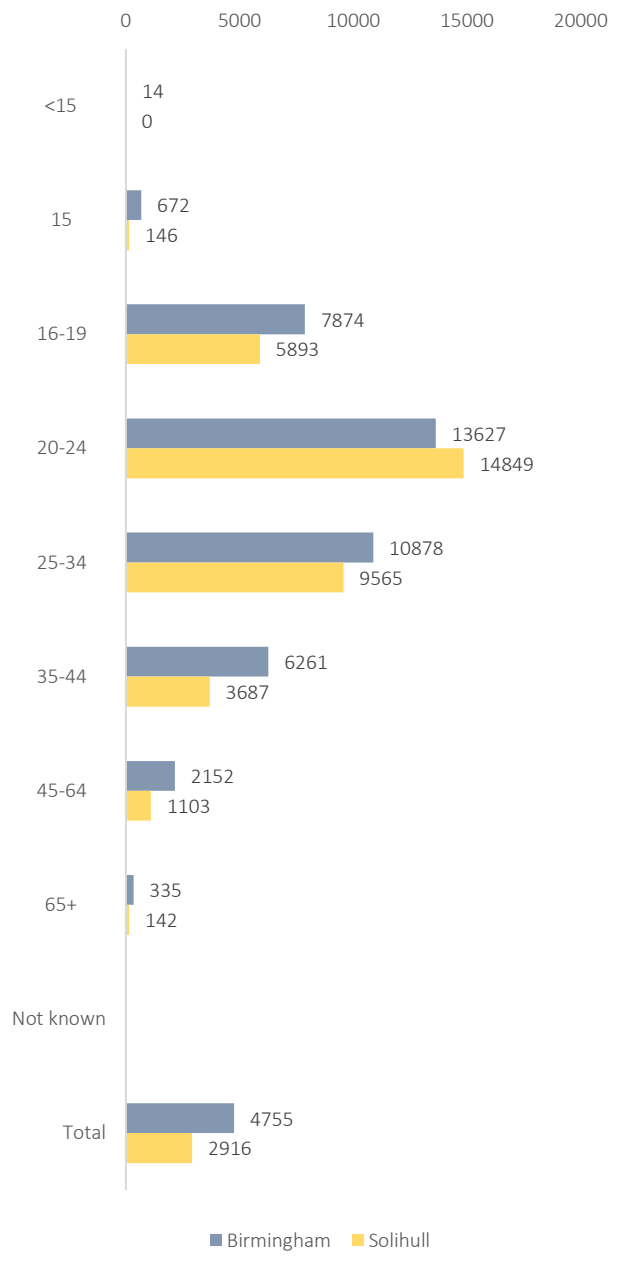
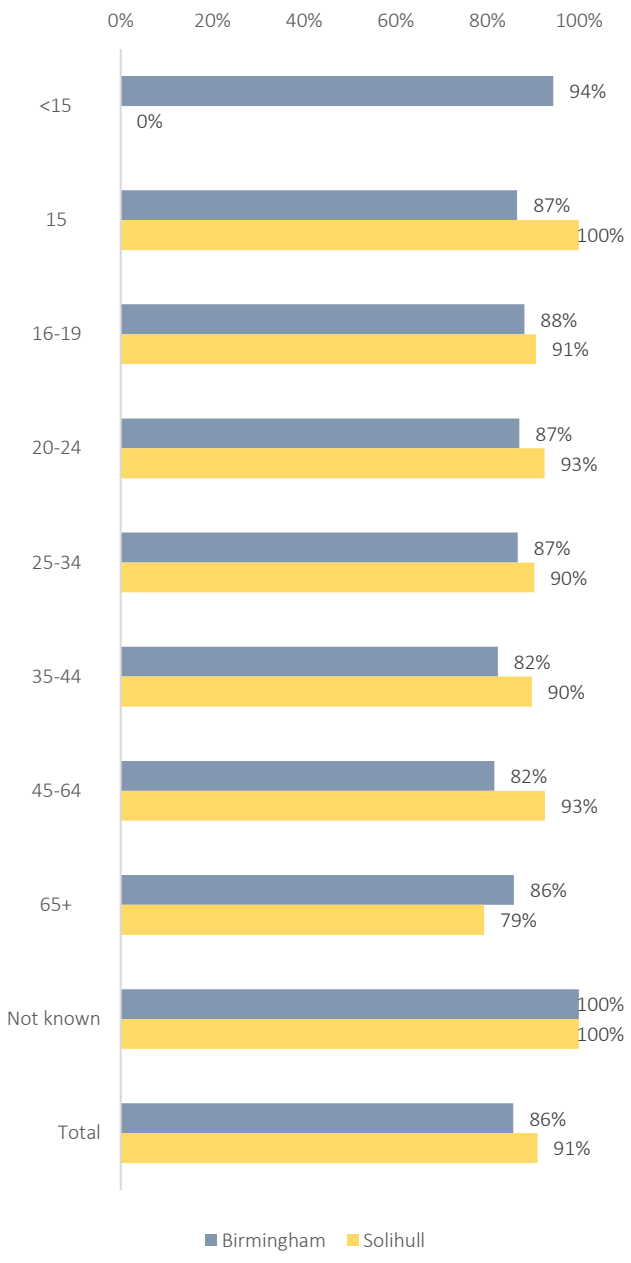


Figure 3.10: % of sexual health screens taken (at 1st attendance) - 2019-20.



FEMALES

Figure 3.11: Number of 1st attendances in 2019-20 - Rate per 100,000.

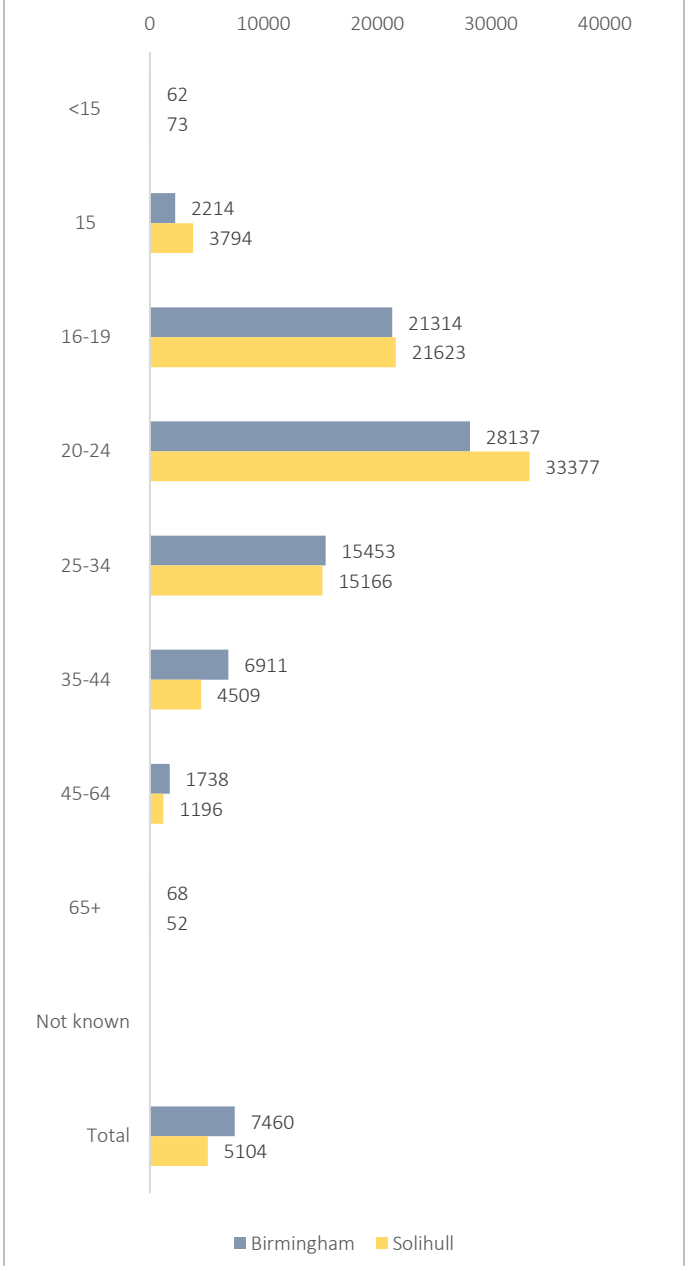
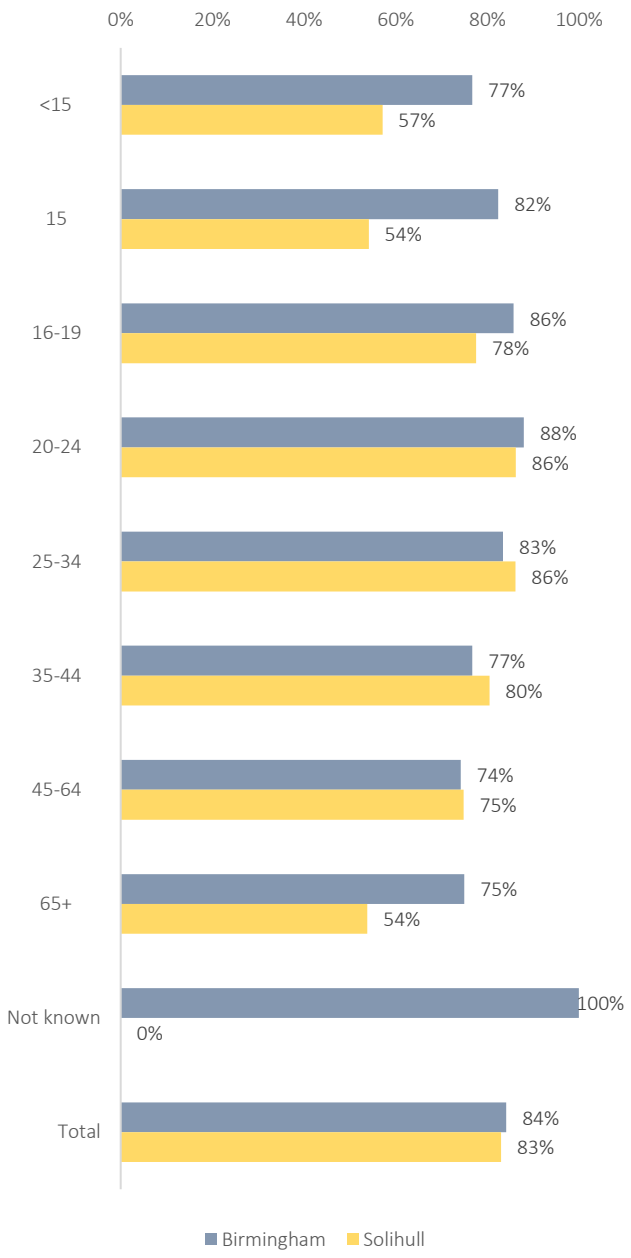


Figure 3.12: % of sexual health screens taken (at 1st attendance) - 2019-20.



COMBINED (BIRMINGHAM AND SOLIHULL)

The data for females shows that 100% of patients were heterosexual. Umbrella reported that females are not asked about their sexuality in the same way that men would be due to there being more sexual health risks in men who have sex with men.

Men who have sex with men are an at-risk group for STI diagnoses and HIV. It is recommended that men who have sex with men have a sexual health check-up every 6 months to identify STIs that may or may not be symptomatic.[62]

The breakdown by sexuality for males is roughly comparable between the two areas. 18-22% of males at first attendance are recorded as gay. A high percentage are recorded as "not stated".

BIRMINGHAM

Figure 3.13: Number and percentage of 1st attendances in 2019-20: Males / Sexuality.

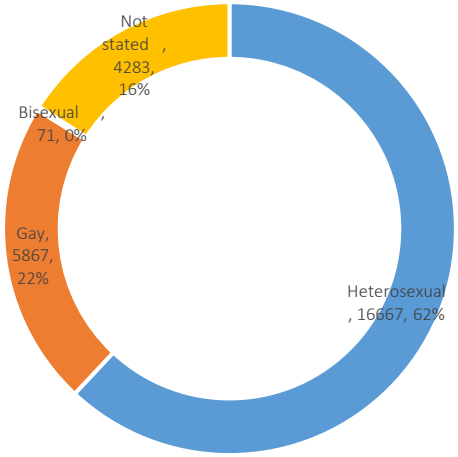
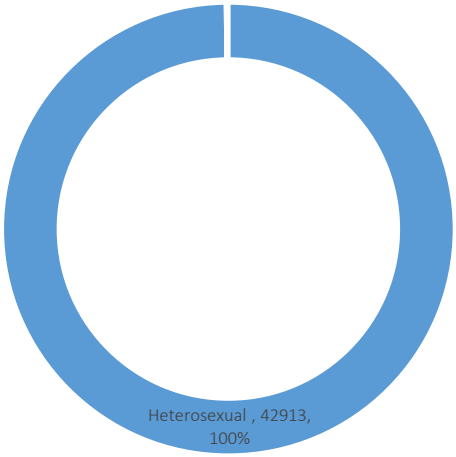


Figure 3.14: Number and percentage of 1st attendances in 2019-20: Females / Sexuality.



SOLIHULL

Figure 3.15: Number and percentage of 1st attendances in 2019-20: Males / Sexuality.

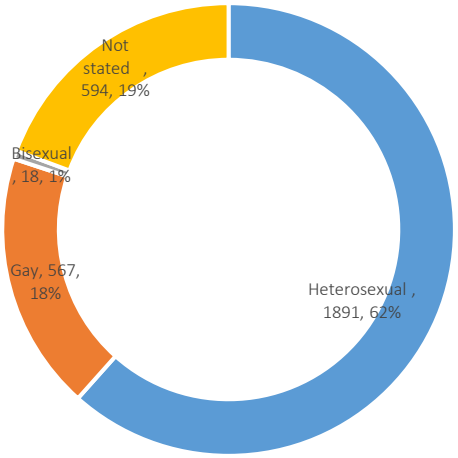
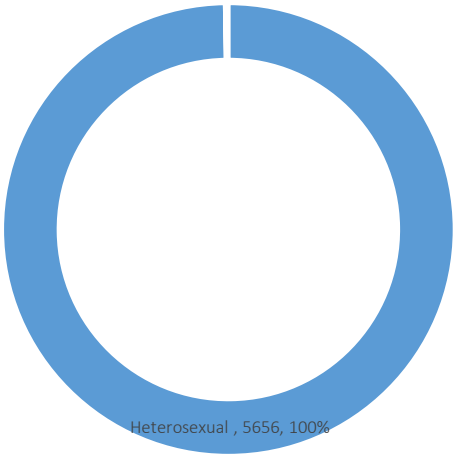


Figure 3.16: Number and percentage of 1st attendances in 2019-20: Females / Sexuality.



[62] NHS Online

COUNTRY OF ORIGIN

BIRMINGHAM

A high percentage of first attendances did not have a country of origin recorded (56%) and those from the UK account for a high percentage (33%).

Those from Bangladesh, Pakistan, and India show a low rate of sexual health screens taken at first attendance.

Umbrella fed back that women from the South Asian community often only access the service for contraceptives.

Figure 3.17: Number and percentage of 1st attendances in 2019-20: Females / Country of Origin.

Country / 2019-20	Number of 1st Attendances	Number of 1st Attendances: % of Total	Number of sexual health screens taken	Number of sexual health screens taken: % of Total	% of sexual health screens taken (at 1st attendance)
Unknown	39404	56%	34941	59%	89%
United Kingdom of Great Britain and Northern Ireland (the)	23185	33%	18706	31%	81%
Jamaica	833	1%	718	1%	86%
Pakistan	569	1%	341	1%	60%
Zimbabwe	419	1%	347	1%	83%
Nigeria	388	1%	305	1%	79%
Romania	371	1%	290	0%	78%
Poland	289	0%	214	0%	74%
India	245	0%	144	0%	59%
Italy	188	0%	133	0%	71%
Bangladesh	188	0%	84	0%	45%
Somalia	182	0%	157	0%	86%
China	164	0%	131	0%	80%
Iran (Islamic Republic of)	162	0%	132	0%	81%
Portugal	147	0%	122	0%	83%
Spain	130	0%	104	0%	80%
Iraq	119	0%	86	0%	72%
Eritrea	117	0%	80	0%	68%
France	100	0%	78	0%	78%
Afghanistan	99	0%	67	0%	68%
Other	2858	4%	2246	4%	79%
Total	**70157**		**59426**		**85%**

SOLIHULL

A high percentage of first attendances did not have a country of origin recorded (58%) with those from the UK accounting for a high percentage (40%).
Similar to Birmingham, those from Pakistan show a low rate of sexual health screens taken at first attendance. Umbrella fed back that women from the South Asian community often only access the service for contraceptives.

Figure 3.18: Number and percentage of 1st attendances between October 2017 and March 2020: Females / Country of Origin.

Country	Number of 1st Attendances	Number of 1st Attendances: % of Total	Number of sexual health screens taken	Number of sexual health screens taken: % of Total	% of sexual health screens taken (at 1st attendance)
Unknown	12432	58%	10972	60%	88%
United Kingdom of Great Britain and Northern Ireland (the)	8546	40%	6906	38%	81%
Poland	44	0%	35	0%	80%
India	40	0%	29	0%	73%
Jamaica	38	0%	32	0%	84%
Pakistan	35	0%	20	0%	57%
Zimbabwe	34	0%	24	0%	71%
Ireland	33	0%	31	0%	94%
South Africa	26	0%	20	0%	77%
Romania	19	0%	14	0%	74%
France	17	0%	13	0%	76%
Australia	17	0%	17	0%	100%
Iran (Islamic Republic of)	15	0%	12	0%	80%
Germany	11	0%	7	0%	64%
Greece	11	0%	7	0%	64%
Latvia	11	0%	9	0%	82%
Spain	11	0%	8	0%	73%
Italy	10	0%	9	0%	90%
United States of America (the)	10	0%	8	0%	80%
Other	234	1%	182	1%	78%
Total	**21594**		**18355**		**85%**

ETHNICITY AND SEXUALITY

BIRMINGHAM

For males, 62% of the total first attendances were heterosexuals, with the second largest group being gay males.

The analysis shows the percentage of sexual health screens taken (at first attendance). There is a low uptake rate for male heterosexuals who are Asian or Asian British.

Figure 3.19: Percentage of total 1st attendances; 2019-20, males.

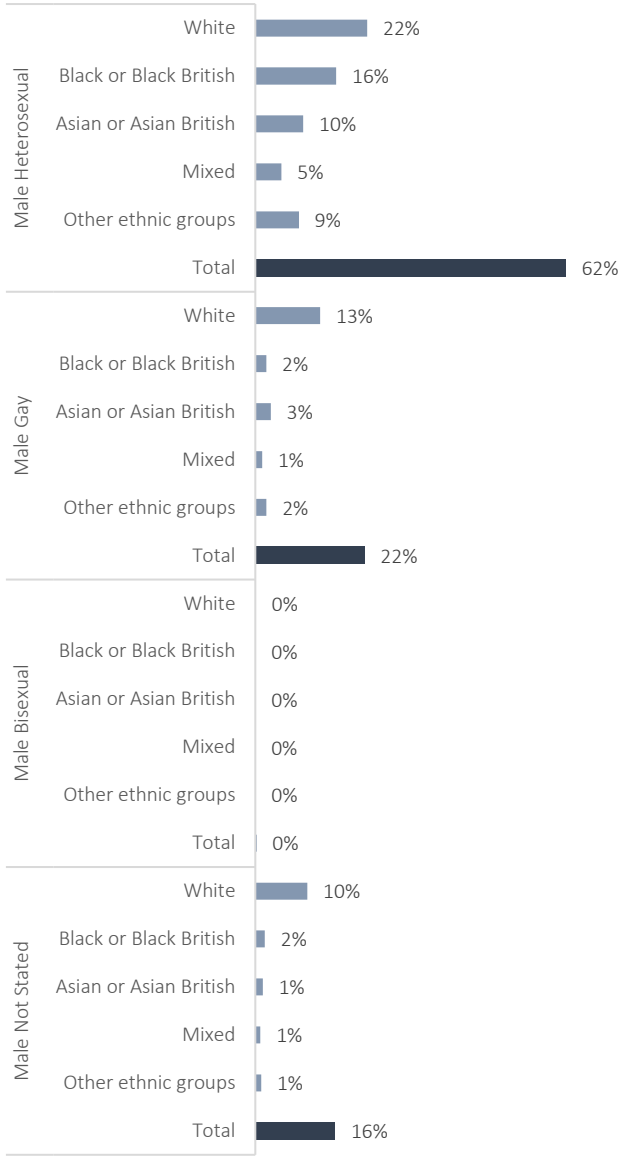
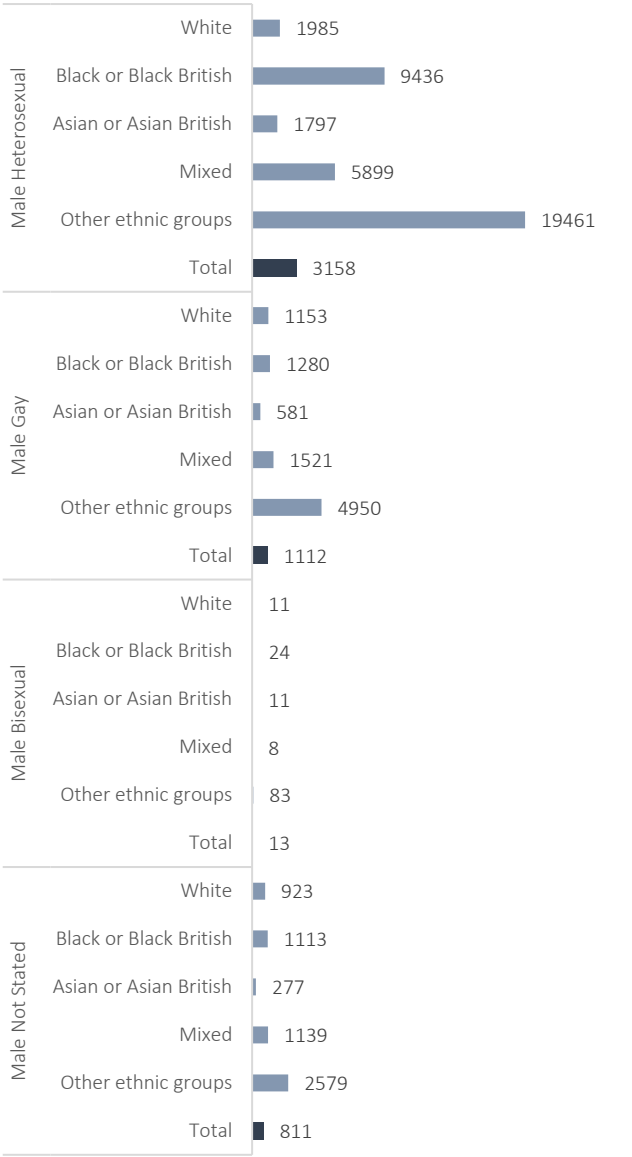


Figure 3.20: As a rate per 100,000 population[63]; 2019-20, males.



[63] 2011 census.

As previously highlighted, females are not asked about their sexuality in the same way that men would be due to there being more sexual health risks in men who have sex with men.

Figure 3.21: Percentage of total 1st attendances; 2019-20, females.

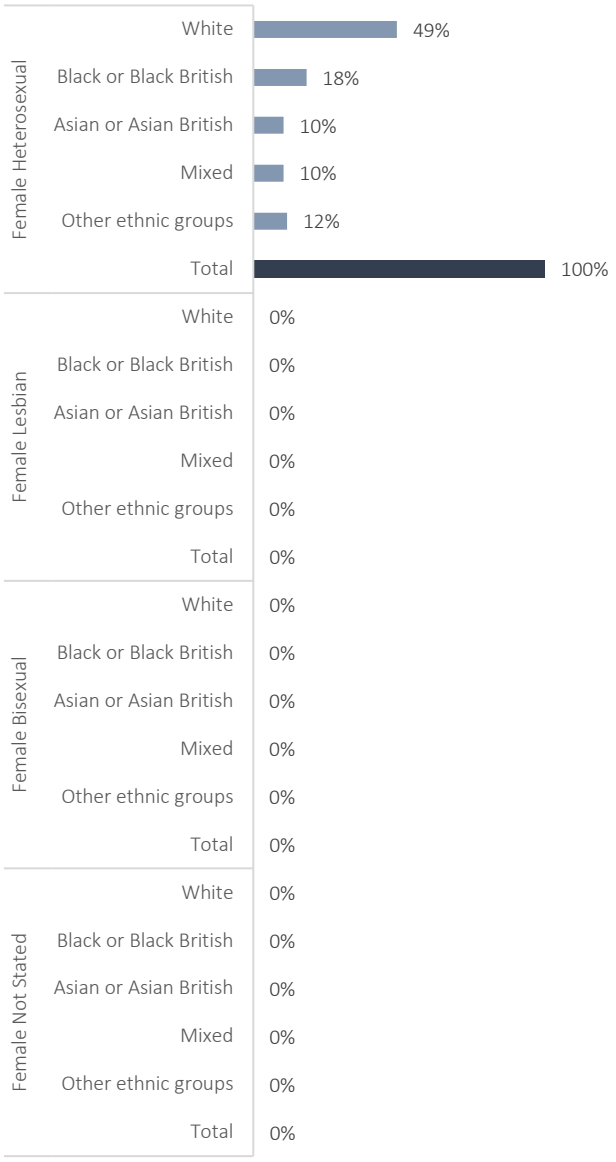


Figure 3.22: As a rate per 100,000 population[64]; 2019-20, females.

[64] 2011 census.

ENGAGEMENT

GP

As part of their sexual health offering, Umbrella Sexual Health Services partner with GPs in Birmingham to deliver sexual health services. GPs are funded by Umbrella to provide a contraceptive service (including LARCs) to patients.

As part of the needs assessment, the Umbrella GP Advisor was interviewed.

INTRODUCTION

The GP Advisor is contracted by Umbrella to provide one session a month as an advisor. The advisor provides a voice for GPs in the partnership and acts as a link between GPs and Umbrella. The advisor answers queries from GPs.

GP PROVISION (THE FOLLOWING INFORMATION RELATES TO GPs PARTNERED WITH UMBRELLA)

- Umbrella encourage patients to be diverted to GPs when appropriate.
- GPs provide a contraceptive service, including LARCs.
- GPs get paid to do contraceptive fittings. GPs may say that they need more funding due to the length of time and resources needed to fit the contraceptives.

REFERRAL ROUTES

- There is a clinic-to-GP referral pathway. Patients can go to any GP service that provides LARC. Most GPs do not require the patient to be registered at that practice.
- Some GPs operate as partnerships or consortia (such as the Midlands Medical Partnership and Our Health Partnership) and within these some GPs tend run a centralised appointment scheme in their area, with one clinic within the group offering the coil fitting.

HIV TESTING

- To encourage the uptake of HIV testing and reduce late diagnosis, GPs in areas of high and extremely high prevalence are recommended to routinely test for HIV. GPs in areas of Birmingham did explore HIV testing with all new patients; this has not progressed due to the disruption caused by the COVID-19 pandemic.
- New patients are not routinely offered a blood test for HIV.

BBV TESTING

- The point-of-care test is not always 100% accurate at identifying BBVs (Hepatitis B and C, and HIV).
- Feedback from the GP advisor was that blood tests are costly for a GP so they may not complete them routinely with new patients.

COVID-19

The GP advisor fed back on the impact that COVID-19 had on provision:

- The redeployment of staff from sexual health services to assist with the COVID-19 response impacted provision.
- Home testing kits were not available to order online from August 2020 to December 2020. If a patient called Umbrella during this time and following a telephone triage was identified as being symptomatic, they would have been invited in for testing or provided with a home testing kit.
- Workload for GPs was an issue. During the COVID-19 pandemic, more patients were referred to GPs.
- Some sexual health clinics were closed during the pandemic, although Boots in the city centre and the Whittall Street Clinic were open from late May 2020 for face-to-face, pre-booked appointments.
- There has been difficulty in keeping up with the demand for sexual health services, particularly LARCs.
- Following the COVID-19 pandemic, the waiting times for coils and implants have increased.

GAPS / AREAS FOR DEVELOPMENT

PERI-MENOPAUSE

- This is an area for development. There is an opportunity to increase knowledge amongst practitioners about the pathways available.
- The coil is only funded for women aged up to 55 for contraception. Hormonal IUCDs are not covered by sexual health services and are available via GPs and gynaecological services.
- It should be ensured that there are appropriate links in relation to hormonal IUCDs between sexual health services and GPs/ gynaecology services.

JOINT WORKING

- The IRIS programme[65] has been pro-active with GPs in Birmingham and Solihull. There is a clear pathway of referral into IRIS.

GENDER DYSPHORIA

- These patients are supported but have to wait to start pharmaceutical/surgery treatment until they have been assessed by an NHS service.
- Waiting lists are long for NHS services (2 years) so some patients go via private clinics. GPs are not encouraged to provide medication for these patients.
- Most GPs have not been trained in this area and require specialist advice.

COMPLEX CONTRACEPTION CASES

- These can be referred to Umbrella; however, it would be useful to have a direct contact line where advice could be gained straight away.

[65] IRIS is a specialist domestic violence and abuse (DVA) training, support and referral programme for General Practices that has been positively evaluated in a randomised controlled trial.

ACCESS

- There is a feeling that it is difficult to access specialist services; for example, services for patients who require help with pelvic infections, or for those with herpes.
- Patients feedback that they cannot get through to Umbrella services via phone.

PHARMACISTS

As part of the needs assessment, the Local Pharmacy Committee Lead was interviewed.

BIRMINGHAM

- In Birmingham there are 280 pharmacies. 180 pharmacies are sub-contracted by Umbrella.
- Umbrella commissioned a needs assessment at ward level to see where pharmacies were needed.
    - Information such as data on pregnancies and terminations was interrogated.
- Core sexual health clinics have transitioned treatments to community pharmacies.
- Patients can access the following services in pharmacies:
    - EHC
    - Chlamydia screen
    - STI treatment
    - Chlamydia treatment
    - Contraception (LARC injections)
        - This is not completed in community pharmacies at the moment. The plan is to introduce this into the community.
    - Hepatitis B vaccinations
        - These are normally offered in a series of three, with the first offered at a clinic and the next two offered in the pharmacy.
        - There has been a three-year shortage of hepatitis B vaccinations.
- Pharmacies can offer the various services once staff have been appropriately trained.
- From September 2020 all Umbrella partnered pharmacies provide the same level of service provision. There are no longer two tiers of pharmacy provision.
- Prior to COVID-19, pharmacies provided 4,000 activities per month. 2019/20 should be used to show actual performance. COVID-19 impacted delivery.
    - During the COVID-19 pandemic, there were significantly reduced numbers of university students, and therefore reduced social interactions.
- Hotspots of need have been identified, for example areas with a high student population.

SOLIHULL

- Solihull pharmacies are not partnered with Umbrella.
- There are approximately 30 pharmacies in Solihull which offer EHC. Pharmacies in Solihull require information on chlamydia screening kits and the STI testing kits.
- The LPC lead fed back that in Solihull, community pharmacies want to do more and can do more.
- For Solihull pharmacies to offer provision, the pharmacist has to offer a declaration of competence for each service.

COVID-19

- During COVID-19, pharmacy activity dropped by half.
- Pharmacies stayed open but controlled access for face-to-face consultations.
- To prescribe contraception, patients could access pharmacies via a phone call.
- Pharmacists had a smaller face-to-face window with clients. This may have impacted the identification of safeguarding issues.

GAPs / AREAS FOR DEVELOPMENT

- There is a gap relating to a prompt emergency coil fitting pathway. There is a low uptake for emergency contraception; however, it is an important service provision so requires a robust pathway.

PRACTITIONER SURVEY

PHARMACISTS

Pharmacists were invited to complete surveys relating to the sexual health needs and the responses of sexual health services in Birmingham and Solihull.

FREE TEXT COMMENTS

Below are the free text comments that were left by pharmacists

> "Solihull does not have a condom distribution service."
>
> Pharmacist, Solihull (B90)

> "Very limited service offered in Solihull through community pharmacy settings."
>
> Pharmacist, Solihull (B90)

GPs

GPs were invited to complete surveys relating to the sexual health needs and the responses of sexual health services in Birmingham and Solihull.

FREE TEXT COMMENTS

Access

The following areas were highlighted as issues:

- Some difficulties in getting a sexual health appointment.
- GPs described having to book appointments on behalf of patients.
- Young people do not use the Umbrella website.
- Long waiting times for rape and sexual violence services.
- Chaotic patients and those without access to the internet will have difficulty in accessing services.
- Face-to-face sexual health appointments at convenient times and locations are difficult to find.

> "We provide inhouse sexual health coil and implant service to registered and non-registered patients including our PCN - We have been doing during the pandemic also."
>
> GP, Birmingham (B9)

> "As GPs we cannot do STI checks, and this is a big gap in patient care as not many are happy to attend SHC or do online requests."
>
> GP, Birmingham (B23)

> What gaps in current sexual health services?
>
> "Referral for IUS/IUD STI testing and implant fitting appointment for complicated contraception"
>
> GP, Birmingham (B23)

> "Reports from GUM clinic are not fed back to the practice - Need this resolving."
>
> GP, Birmingham (B9)

> "It is difficult for patients to get [sexual health] appointment - long waiting lists if referred to other practices and there is a problem, they refer back to us to deal with."
>
> GP, Birmingham (B23)

> "I often have to book online for patients as they struggle to book an appointment or get information."
>
> GP, Birmingham (B23)

"As long as people are aware and wanting to be tested- there is wide access but still great number of people ignorant, do not know where to get these, or that they should use these opportunities."

GP, Birmingham (B13)

"RSVP have waiting times which are far too long, the need for counselling after sexual abuse is huge."

GP, Birmingham (B13)

"Umbrella has done a good job in trying to provide services- but sometimes waiting times long.

Chaotic patients, homeless, drug users without access to internet will have difficulties accessing some of their services. There might be walk-in services for those groups at SIFA, but no other places

Need more provision of counselling for historic sexual abuse, quicker access to face to face consultations and testing sometimes, homiest kit takes 2 weeks to arrive..."

GP, Birmingham (B13)

"We will test for HIV if patient is requesting but do not do this routinely with all new patients -we have not enough capacity to do blood test for all our new patients (usual turnaround of 200 new patients a month)."

GP, Birmingham (B13)

"Would be happy to offer assessment and symptomatic treatment to patients in our surgery again if funded appropriately."

GP, Birmingham (B13)

"We are struggling to meet demand for LARCs because other clinics locally are not working still - I know you ask for pre-covid information but why ignore the current problems? Complex clinics have a very long waiting list."

GP, Birmingham (B35)

"Secondary care clinics for gender dysphoria are hard to access. I am not sure about current access to PEP and PREP".

GP, Birmingham (B35)

"We are not able to treat patients for STIs if they are not registered with us even when they come for LARCs, and some have less good access to STI treatments from their own practices."

GP, Birmingham (B35)

What gaps in current sexual health services?

"Lack of funding for refugee and homeless outreach affects care.

We are not able to treat patients for STIs who are not registered with us even when they come for LARCs".

GP, Birmingham (B35)

"Patients have difficulty booking appointments at a convenient time and location."

GP, Birmingham (B29)

"Currently not offering implant fitting/ removal (set to resume soon) I stopped IUD fittings."

GP, Birmingham (B32)

"Young people can be more reluctant to access sexual health services via their GP as their entire households are often registered with us too, and they can have misconceptions about their entitlement to confidentiality."

GP, Birmingham (B32)

"[There are] long waits for complex contraception (like lost IUD's or complicated fittings)- vasectomies are done by other organisation so do not know how long waiting time is, sterilisation long wait for hospital appointment."

GP, Birmingham (B13)

"It has been extremely difficult to order any STI self-testing kits."

GP, Birmingham (B29)

"We have short waiting lists for coil and implant fittings in house and we can almost always accommodate emergency coil insertions across both sites. However, very long waiting times for complex contraception provision via Umbrella. I am not aware current waiting lists for vasectomy/sterilisation..."

GP, Birmingham (B32)

"RSVP service poor and long waits gaps in psychosexual counselling especially for young men and poor access for patients with any type of disability".

GP, Birmingham

"I think people who want information can find it- still a lot of young people do not know or access umbrella website, lots of misinformation and ignorance still around, lots of information about gender dysphoria available but services are very limited and distance to London and Nottingham big obstacle at times."

GP, Birmingham (B13)

COMMUNITY SURVEY

As part of this needs assessment, a community survey was run exploring the sexual health needs of the populations of Birmingham and Solihull. The survey also explored the populations' experiences of sexual health services.

In total there were 106 responses. Demographics for those who completed the survey can be found on page 228.

USE OF SEXUAL HEALTH SERVICES PRIOR TO AND DURING COVID-19

62 respondents (59%) used (some form of) sexual health services before the COVID-19 pandemic. Of those who used services, there was good feedback about their experiences of services.

Lower numbers of respondents used services during the COVID-19 pandemic (27 respondents, 26%). Respondents who used services scored their experiences as lower compared to those who used services pre-pandemic.

Figure 3.23: Did you use sexual health services (including the Umbrella website) **before the COVID-19** pandemic (before March 2020)?

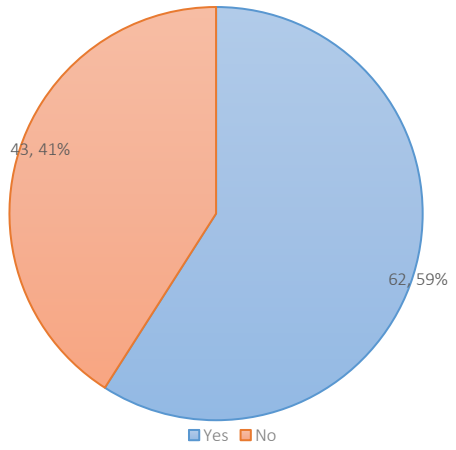


Figure 3.24: Did you use sexual health services (including the Umbrella website) **during the COVID-19** pandemic (since March 2020)?

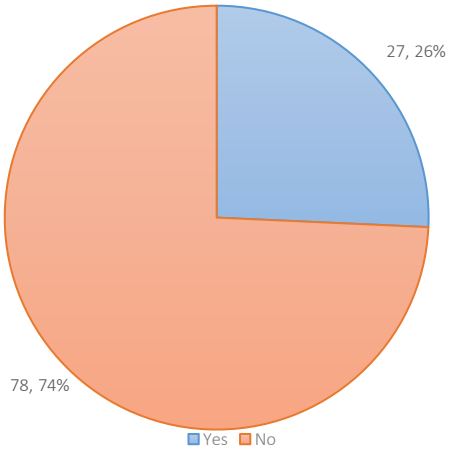


Figure 3.25: Thinking about your experiences **before the COVID-19 pandemic**, please rate your experience of the following services that you may have used.

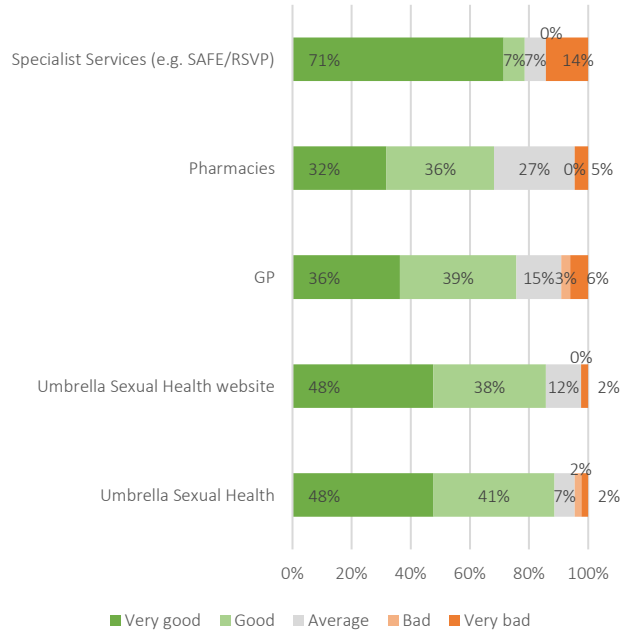
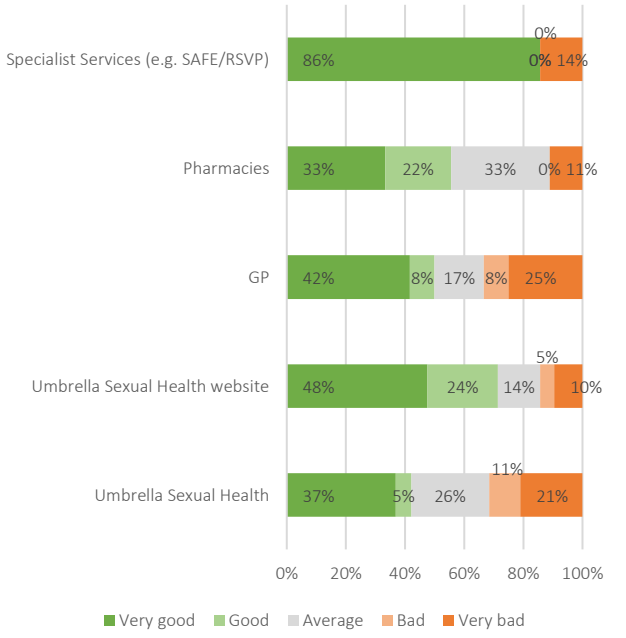


Figure 3.26: Thinking about the support that you received **during the COVID-19 pandemic**, please rate your experience



Respondents who used services during the COVID-19 pandemic were asked to rate ease of access. Access to Umbrella Sexual Health services was impacted during the pandemic, and this is reflected in the scores, with 10 respondents (52%) saying services were difficult or very difficult to access.

7 (27%) respondents said it took more than 14 days between seeking an appointment and accessing the service, 9 accessed a service within 7 days, and 4 took between 8 and 14 days.

6 respondents (26%) said that they were not very satisfied or not satisfied with the length of time it took to have their need resolved. 14 (61%) said that they were very satisfied or satisfied with the length of time to have their need resolved.

Figure 3.27: Thinking about your experience **during the COVID-19 pandemic**, please rate how easy or difficult it was to access the service that you used for your sexual health needs.

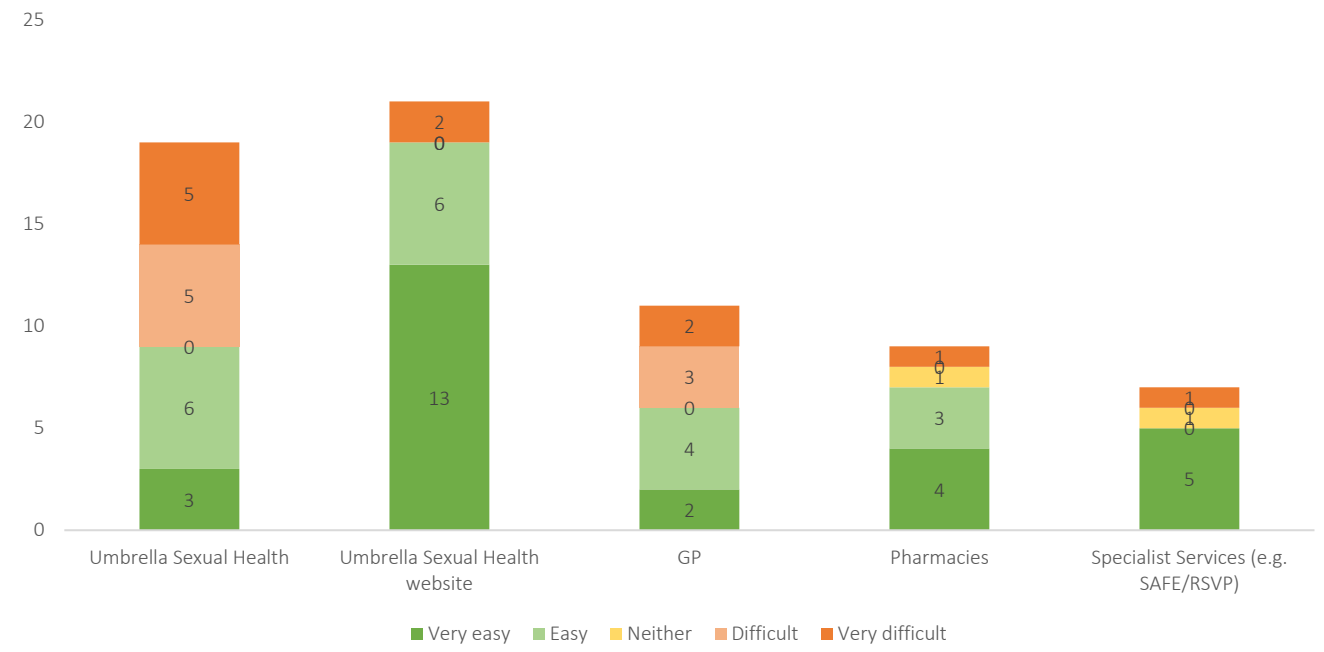
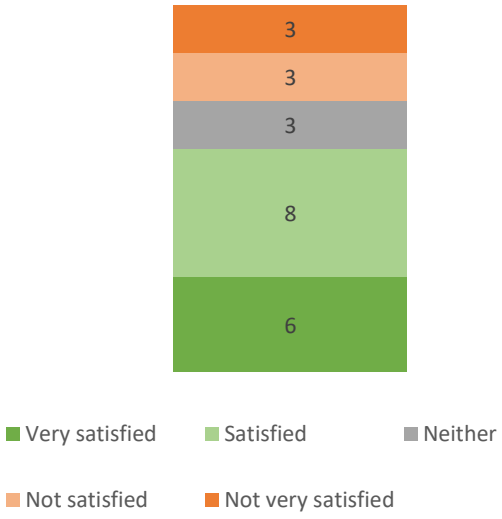


Figure 3.28: **During the pandemic**, roughly how long did it take between seeking an appointment and accessing the service?

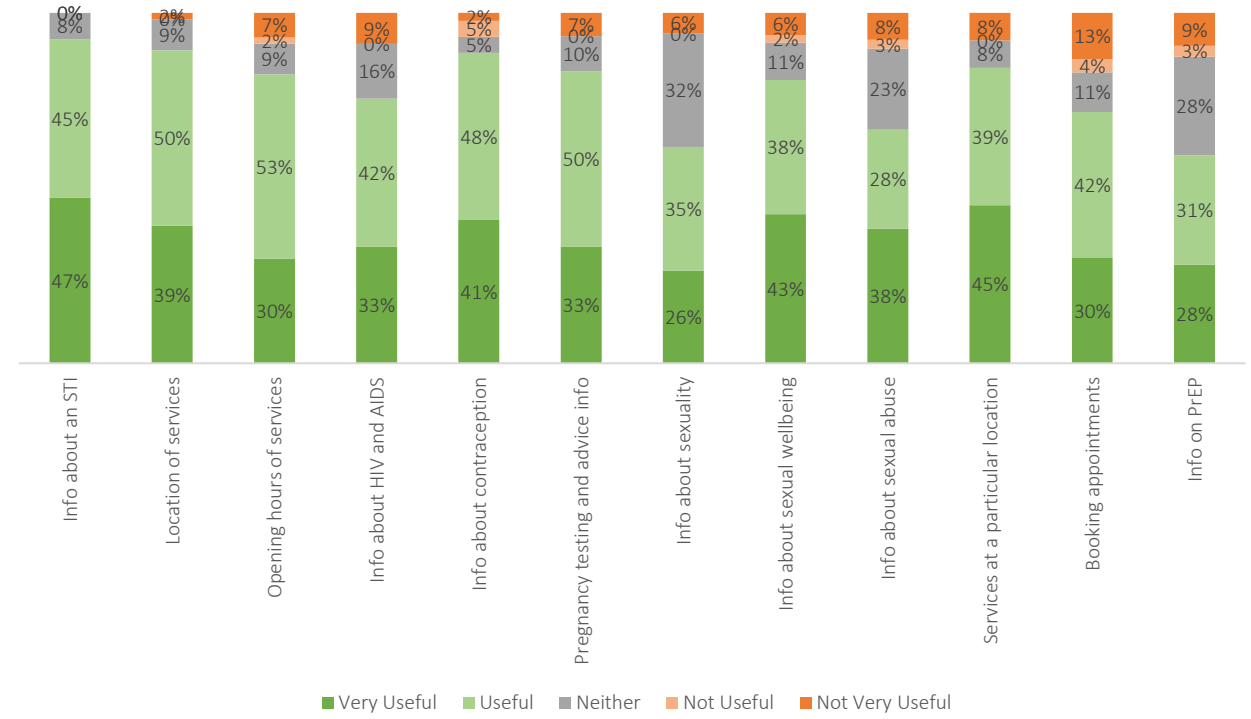
	Number	Percentage
Within 1 day	1	4%
Between 1-3 days	5	19%
Between 4-7 days	3	12%
Between 8-14 days	4	15%
More than 14 days	7	27%
Did not use any service during the pandemic	6	23%

Figure 3.29: Were you satisfied with the length of time it took to have your sexual health need resolved?



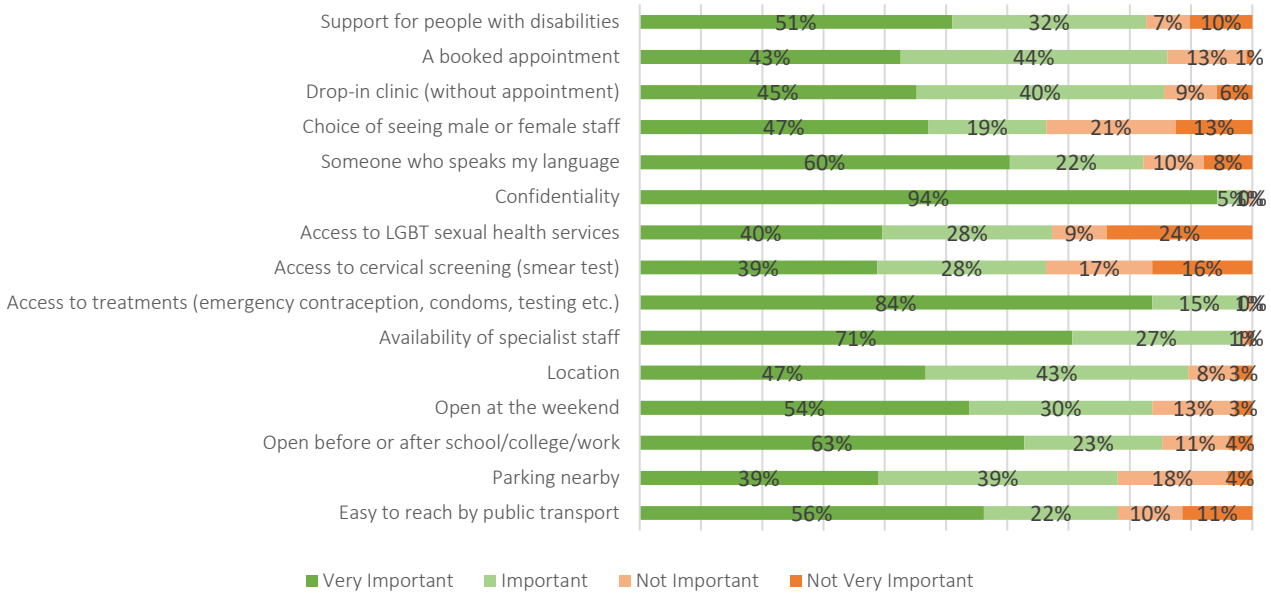
Respondents were asked to indicate how useful they found the Umbrella website. Overall, the website scored well; however, information about sexuality and information about Pre-Exposure Prophylaxis (PrEP) scored the lowest.

Figure 3.30: Please indicate how useful you found the umbrella website for the following activities.



Respondents were asked what was important for them when they visited a sexual health clinic. Confidentiality scored the highest, with 99 (94%) saying it was "very important". Booked appointments and drop-in clinics (without an appointment) seemed to be equally important to respondents, with both scoring similar rates of 'very important' and 'important' responses.

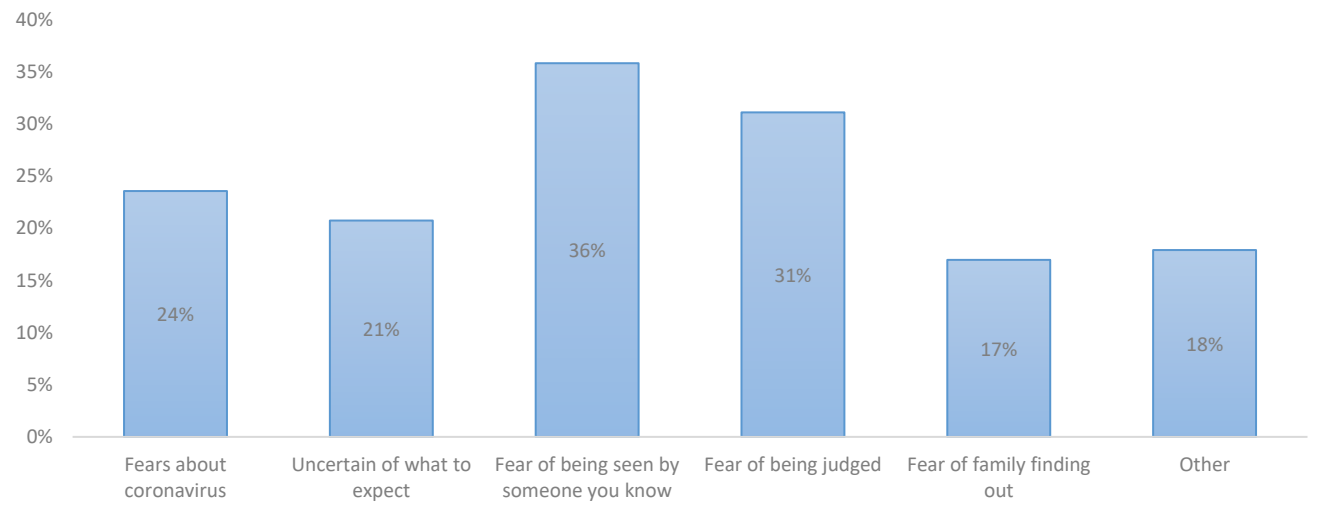
Figure 3.31: If you had to attend a sexual health clinic, how important are the following to you?



Respondents were asked what would stop them accessing sexual health services:

- 38 (36%) stated that fear of being seen by someone they know would stop them attending.
- 22 (21%) stated that uncertainties about what to expect would stop them attending.

Figure 3.32: What would stop you accessing a sexual health service in Birmingham and Solihull?



SEXUAL HEALTH INFORMATION

Respondents were asked where they would go for various sexual health-related information and advice. For sexual health information, the sexual health clinic and the Umbrella website scored highly. For contraceptive advice, GPs and the sexual health clinic scored the highest.

Figure 3.33: For the following sexual health related information and advice, where would you go for help?

	Sexual health information	Face to face sexual health advice	Advice about having a baby	Contraceptive advice	Abortion advice	HIV advice
GP	49%	48%	48%	51%	37%	42%
Local pharmacy	23%	9%	2%	25%	5%	5%
Pharmacy further away	9%	4%	1%	6%	3%	1%
A Sexual Health clinic	66%	71%	16%	46%	35%	60%
Specialist services	27%	26%	10%	17%	19%	23%
Umbrella website	61%	25%	15%	32%	24%	36%
Other website	44%	12%	18%	19%	18%	26%
Social media	19%	5%	5%	7%	4%	4%
Telephone helpline	28%	10%	9%	10%	11%	16%
School / College / Uni	16%	10%	3%	9%	4%	3%
Friends/ family	24%	11%	25%	16%	6%	6%
Don't know	3%	3%	5%	2%	3%	2%
Other	4%	3%	3%	1%	4%	3%

FREE TEXT COMMENTS

Barriers/ Access

"I believe it is important for everybody regardless of ethnicity, religion, disabilities to have the same access to those without barriers. Therefore interpreters, accessibility would be very high on my list".

Female 25-34, Birmingham

"Easy access to all contraception without a waiting list is essential and please do smears at the same time as it is not acceptable to make women have 2 examinations just to save money".

Female 25-34, Birmingham

"Location and access are critical. Drop-in appointments essential so services can be accessed by everyone at a time that is convenient for them and would not stop them getting support due to their personal circumstances and where questions may be raised from partners or friends should they not be able to simply go and get support at a time of worry and/or convenience.".

Male, 45-64, Solihull

"[Services] needs to be accessible-not everyone drives and greater distance increases cost.".

Female, 45-64, Birmingham

"Local services [are] really key.".

Female 35-44, Solihull

"Confidentiality is essential, location is important".

Male 45-64, Birmingham

"Mentally it's hard to go to a clinic and it needs to be welcoming and local.".

Male 65+, Birmingham

"Access to further LGBT+ services are very important to me in an LGBT+ friendly environment".

Male 45-64, Birmingham

"I do not understand why umbrella only offer on the day bookings during covid. It's a farce. They go too fast, and they could quite easily just book appointments for weeks ahead with no additional risk from Covid".

Male 26-34, Birmingham

"It wasn't possible to get an appointment and the online service wasn't available for a year and then was extremely slow when it did revive".

Male 45-64, Birmingham

4 – REPRODUCTIVE AND WOMEN'S HEALTH

CONCEPTION

- PREGNANCY AND MATERNITY
- ALL CONCEPTIONS

TEENAGE PREGNANCIES

- OVERVIEW
- UNDER-18 CONCEPTIONS

CONTRACEPTION

- OVERVIEW
- GENERAL POINTS
- LONG-ACTING REVERSIBLE CONTRACEPTION (LARC)
- EMERGENCY HORMONAL CONTRACEPTION (EHC)
- VASECTOMIES AND STERILISATIONS
- POST-NATAL CONTRACEPTION
- ENGAGEMENT

ABORTION

- INTRODUCTION
- ABORTION ACTIVITY

CERVICAL SCREENING

- INTRODUCTION
- LOCAL PERFORMANCE

CONCEPTION

PREGNANCY AND MATERNITY

PRE-CONCEPTION CARE

A planned pregnancy is likely to be a healthier one, as unplanned pregnancies represent a missed opportunity to optimise pre-pregnancy health. This can lead to adverse health impacts for the mother, including obstetric complications and antenatal and postnatal depression, as well as for the child, including low birthweight and developmental abnormalities. [66]

Pre-conception care[67] can include:[68]

- ensuring vaccinations are up to date
- ensuring sexual health checks and cervical screening are up to date
- taking vitamin D and folic acid supplements
- eating a healthy balanced diet
- undertaking regular moderate intensity physical activity
- reducing alcohol consumption
- giving up smoking
- using contraception for family spacing

Whilst traditionally, pre-conception care has focused on women planning a pregnancy, with 45% of pregnancies in England being unplanned at the time of conception, the timing of addressing pre-conception risks poses a challenge.

STIs IN PREGNANCY

If left undiagnosed and untreated, common STIs can cause a range of complications and long-term health problems, from adverse pregnancy outcomes to neonatal and infant infections.[69]

ECTOPIC PREGNANCY AND MISCARRIAGE

Approximately 20% of pregnancies miscarry, and miscarriages can cause considerable distress. Early pregnancy loss accounts for over 50,000 admissions in the UK annually. The rate of ectopic pregnancy is 11 per 1,000 pregnancies, with a maternal mortality of 0.2 per 1,000 estimated ectopic pregnancies.

66 Gov.uk, Public Health Matters Blog
67 NICE Topics: Pre-conception - advice and management. Last revised in March 2021.
68 Gov.uk, Public Health Matters Blog
69 Public Health Matters: Health Matters: Preventing STIs. Blog published 21 August 2019.

POSTPARTUM FAMILY PLANNING (SEE PAGE 107)

Postpartum family planning (PPFP) aims to prevent unintended pregnancy and closely spaced pregnancies after childbirth. Childbirth presents an opportunity for providing contraception at a time when women are attending a service staffed by healthcare providers with the skills to offer a full range of methods and when women may be highly motivated to start using an effective method.[70]

LOCAL SERVICE PROVISION

University Hospitals Birmingham cover maternity care in Birmingham and Solihull. There are four hospitals covered by UHB:

- Queen Elizabeth Hospital in Birmingham
- Heartlands Hospital in Birmingham – the majority of Solihull residents deliver at Heartlands Hospital
- Good Hope Hospital in Birmingham
- Solihull Hospital in Solihull

Within the UHB midwifery service, there is:

- 1x named midwife for safeguarding children
- 1.2x specialist midwife support roles for domestic abuse safeguarding.
- There are 12 specialist midwives within the team, specialising in teenage pregnancies, refugees, FGM and abuse).

70 Royal College of Obstetricians and Gynaecologists (2015), Best practice in postpartum family planning.

ALL CONCEPTIONS

Birmingham has seen a decrease in conceptions when using 2009 as the baseline. The rate of decrease is greater than that of the CSSSNBT nearest neighbours.

Solihull has seen an increase in conceptions since 2009, with the numbers peaking in 2015 and 2016. The rates declined and stabilised between 2017 and 2019.

The increase in Solihull is in contrast to the national and CSSSNBT nearest neighbours' average rates, which have decreased since 2009.

Figure 4.1: All conceptions; Birmingham.

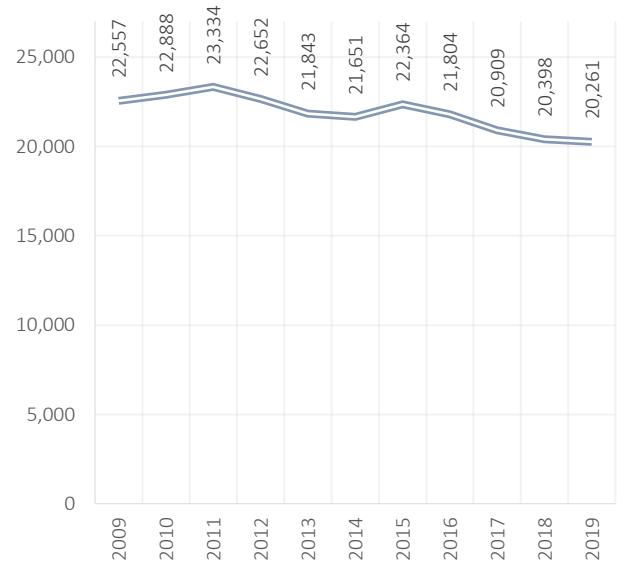


Figure 4.2: All conceptions; Solihull.

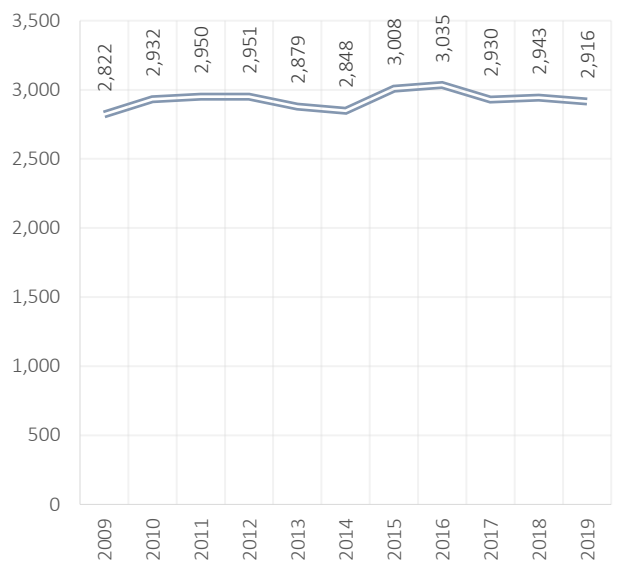


Figure 4.3: All conceptions; Birmingham comparison against CSSNBT Nearest Neighbours. Change against 2009 baseline.

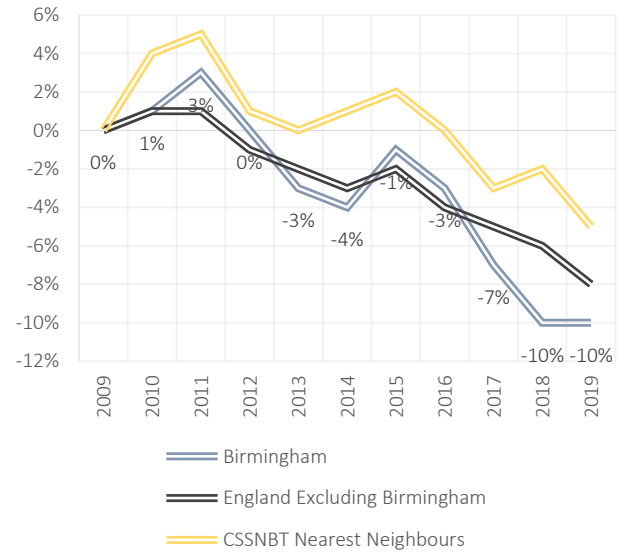


Figure 4.4: All conceptions; Solihull comparison against CSSNBT Nearest Neighbours. Change against 2009 baseline.

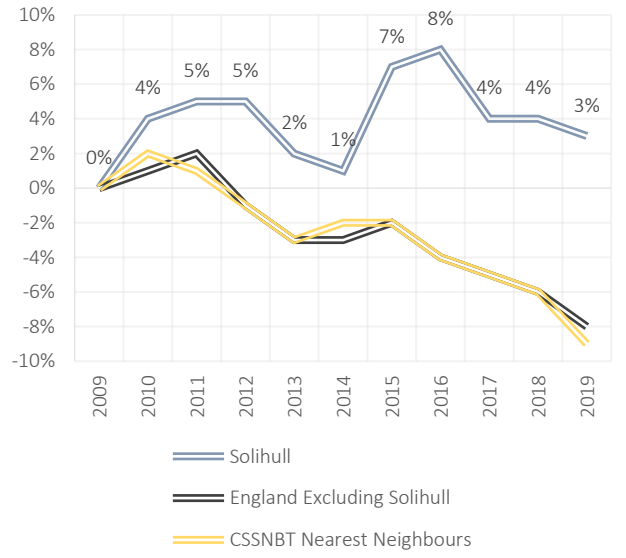
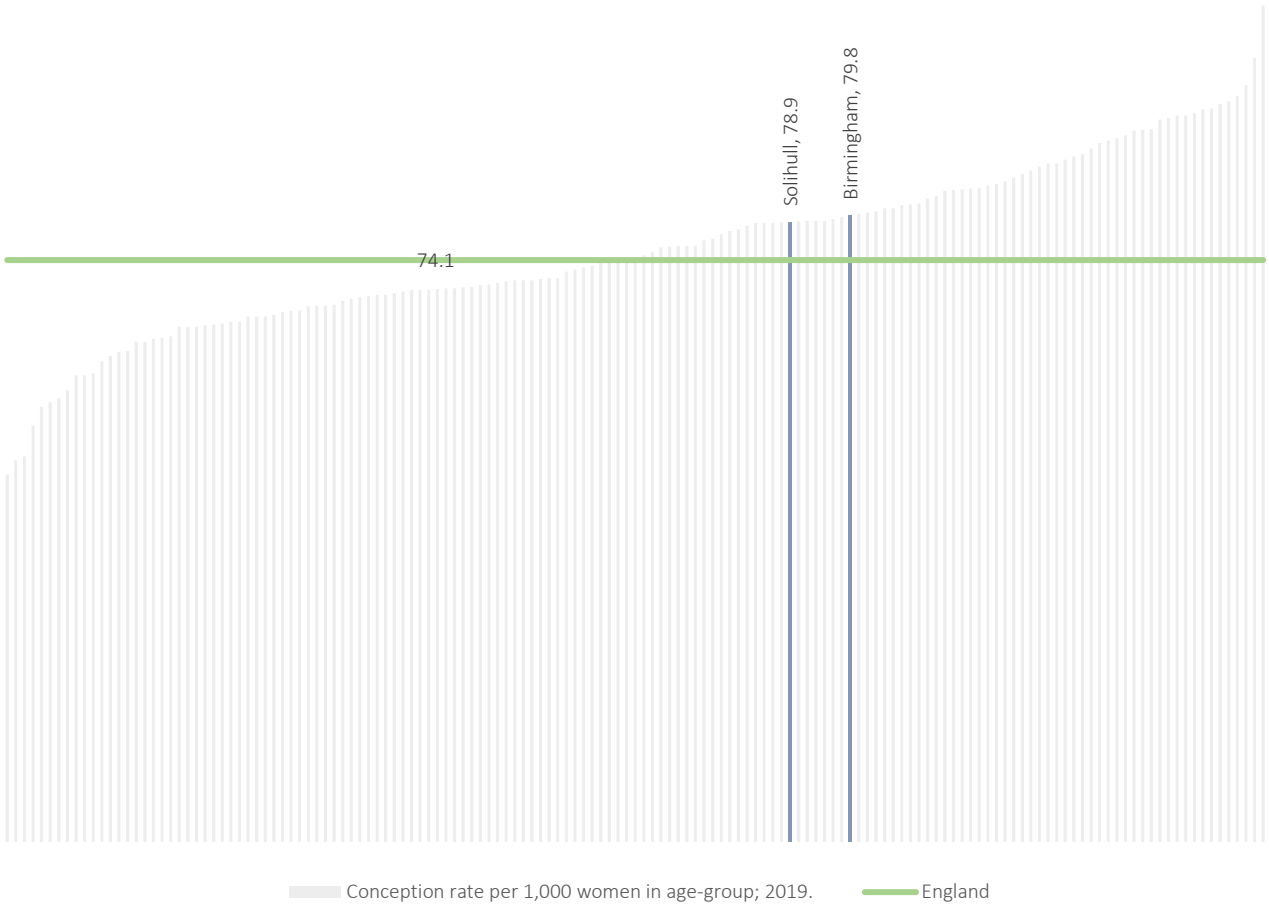


Figure 4.5 looks at the conception rate compared to the local authorities in England, and the average for England and Wales. The rates in both Solihull and Birmingham are greater than the 74.1 rate for England.

Figure 4.5: Conception rate per 1,000 women in age-group; 2019. Comparison against other local authorities.



TEENAGE PREGNANCIES

OVERVIEW

Between 2000 and 2018, the teenage pregnancy rate in the UK fell by over 60%, the result of a long-term evidence-based teenage pregnancy strategy. However, despite this success, young people in England still experience higher teenage birth rates than their peers in Western European countries, teenagers remain at highest risk of unplanned pregnancy, inequalities in rates persist between and within local authorities, and outcomes for young parents and their children are still disproportionately poor, contributing to inter-generational inequalities.[71]

BEST PRACTICE

The 10 key factors of effective local teenage pregnancy strategies are: [72]

- Strategic leadership and accountability
- Relationships and sex education in schools and colleges
- Youth friendly contraceptive and sexual health services
- Targeted prevention for young people at risk
- Support for parents to discuss relationships and sexual health
- Training on relationships and sexual health for health and non-health professionals
- Advice and access to contraception in non-health education and youth settings
- Consistent messages and service publicity to young people, parents and practitioners
- Support for pregnant teenagers and young parents – including prevention of subsequent pregnancies
- Strong use of data for commissioning and monitoring of progress.

COLLATION OF KEY GUIDANCE

Key guidance relating to teenage pregnancy includes:

- NICE Public Health Guideline [PH3]: *Sexually transmitted infections and under-18 conceptions: prevention*[73]
- NICE Public Health Guideline [PH51]: *Contraceptive services for under 25s*[74]
- Public Health England: *Teenage pregnancy prevention framework*[75]
- Public Health England: *A framework for supporting teenage mothers and young fathers*[76]

71 PHE (2018), Teenage Pregnancy Prevention Framework.
72 PHE (2018), Teenage Pregnancy Prevention Framework.
73 NICE (2007), Public health guideline [PH3] Published: 28 February 2007. Sexually transmitted infections and under-18 conceptions: prevention.
74 NICE (2014), Contraceptive services for under 25s. Public health guideline [PH51]. Published: 26 March 2014
75 PHE (2018), Teenage Pregnancy Prevention Framework.
76 PHE (2019), Young Parents Support Framework.

WHAT ARE THE KEY DRIVERS?

Key drivers relating to teenage pregnancies include factors relating to child health, mental health and emotional wellbeing, and economic wellbeing: [77]

- Adverse childhood experiences: people with four or more ACEs are six times more likely to have had or caused a teenage pregnancy[78]
- Domestic abuse: Experience of sexual abuse and exploitation is a risk factor for teen pregnancy[79]
- Mental health: teenage mothers have higher rates of poor mental health for up to 3 years after the birth[80]
- Alcohol: this is associated with under-18 conception and STIs, independent of deprivation. One in 12 women under 20 accessing drug and alcohol services is either pregnant or a teenage mother[81], and 1 in 6 young men under 25 accessing drug and alcohol services are young fathers[82]
- Harmful sexual behaviours
- Pre-conception care: The majority of teen pregnancies are unplanned[83], so pre-conception care is not possible. Teenage mothers are twice as likely to smoke before pregnancy than older mothers[84]
- Infant mortality: Babies of teenage mothers have a 30% higher rate of stillbirth, a 60% higher rate of infant mortality and are 1.9 times more likely to die of SIDS[85]
- Child development: At age 5, children of teenage mothers are 4 months behind on spatial ability, 7 months behind on non-verbal ability and 11 months behind on verbal ability[86]
- Poverty: Children born to teenage mothers are 63% more likely to live in poverty, and men who were young fathers are twice as likely to be unemployed at 30. [87]

77 PHE (2019), Young Parents Support Framework.
78 Scottish Government (2019): Pregnancy and parenthood in young people: second progress report.
79 PHE (2018), Teenage Pregnancy Prevention Framework.
80 PHE (2019), Young Parents Support Framework.
81 PHE (2019), Young Parents Support Framework.
82 PHE (2018), Teenage Pregnancy Prevention Framework.
83 Nuffield Trust: Teenage pregnancy. Accessed May 2021.
84 PHE (2019), Young Parents Support Framework.
85 PHE (2019), Young Parents Support Framework.
86 PHE (2019), Young Parents Support Framework.
87 PHE (2019), Young Parents Support Framework.

UNDER-18 CONCEPTIONS

- Using 2009 as the baseline, both Birmingham and Solihull experienced decreases of around 60% to 2019.
- This change is in-line with the nearest neighbours and England.

Figure 4.6: Under-18 conceptions; Birmingham.

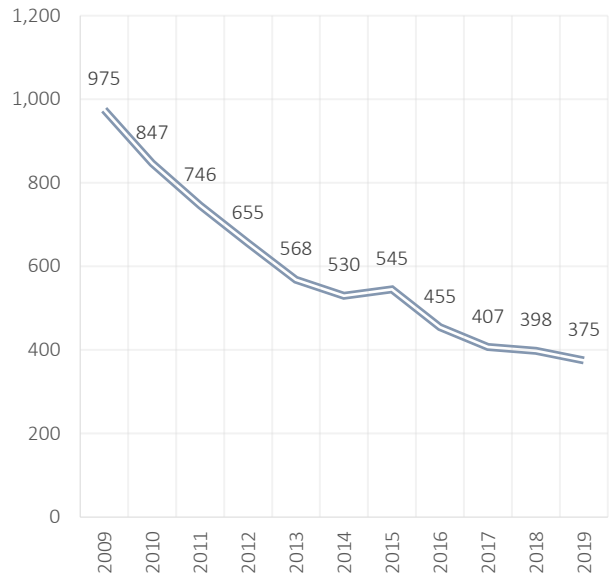


Figure 4.7: Under-18 conceptions; Solihull.

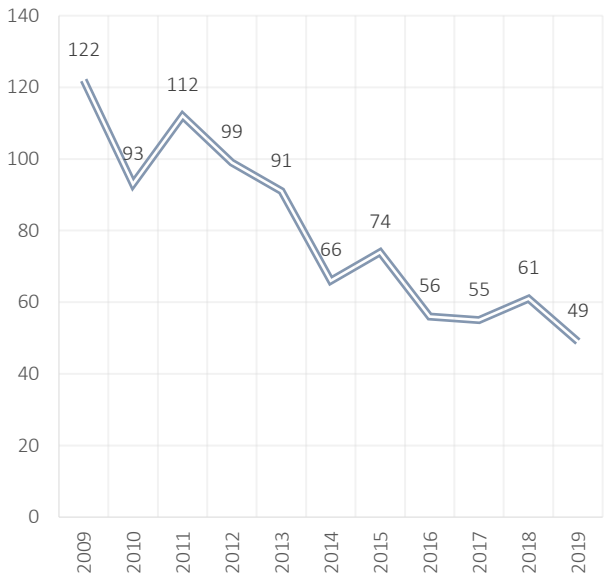


Figure 4.8: Under-18 conceptions; Birmingham comparison against CSSNBT Nearest Neighbours. Change against 2009 baseline.

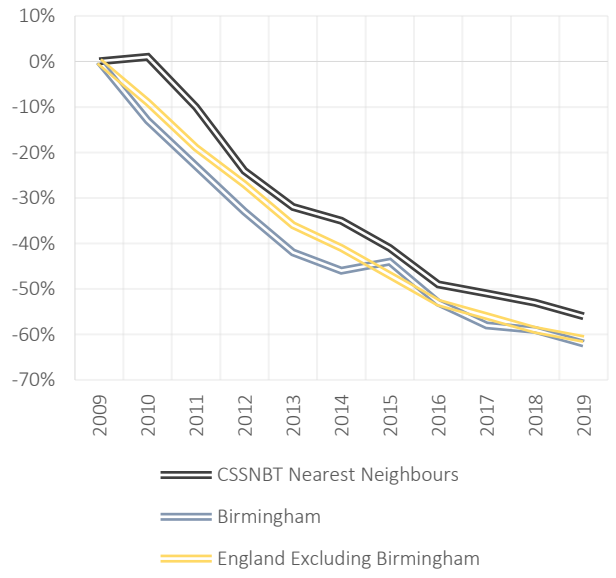
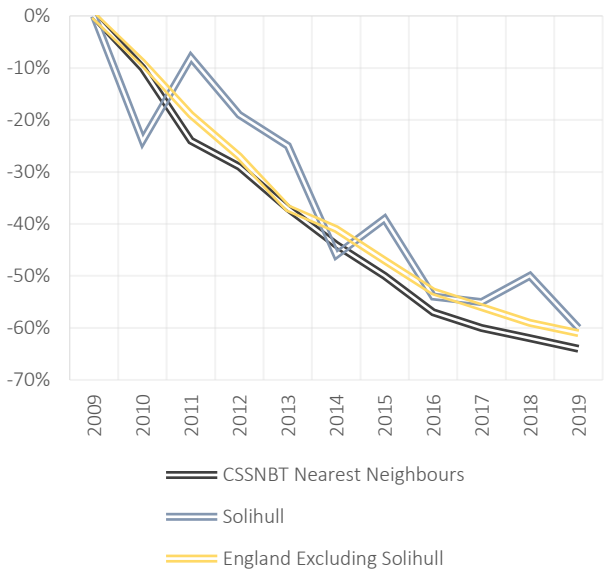


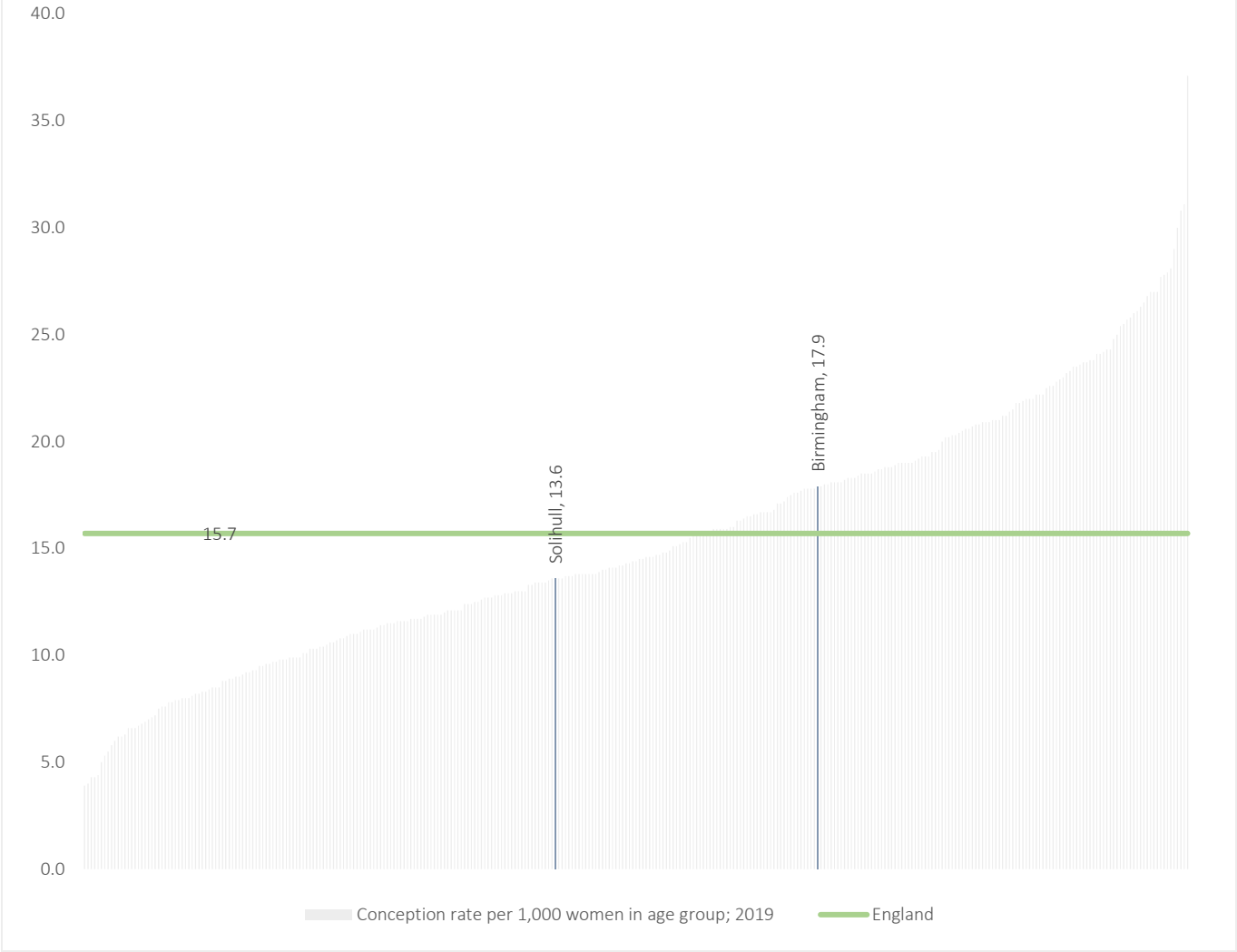
Figure 4.9: Under-18 conceptions; Solihull comparison against CSSNBT Nearest Neighbours. Change against 2009 baseline.



The following chart looks at the conception rate for the under-18 age group compared to the local authorities in England and Wales, and the average for England.

The rate for Birmingham, at 17.9, is higher than both the Solihull rate and the England average.

Figure 4.10: Conception rate per 1,000 women in under-18 age group; 2019. Comparison against other local authorities.



CONTRACEPTION

OVERVIEW

The provision of contraception is widely recognised as a highly cost-effective public health intervention, reducing the number of unplanned pregnancies which bear high financial costs to individuals, the health service and the state.

Following the shift of public health functions from the NHS to local authorities in 2013, the majority of sexual health commissioning is now the responsibility of public health teams in local government.

Contraceptive services are also available in general practice.[88]

KEY GUIDANCE AND BEST PRACTICE

- The Department of Health and Social Care's best practice guidance[89] requires local authorities to arrange for the provision of a broad range of contraception and advice on preventing unintended pregnancy, and all contraception supplied must be free to the patient.
- The Faculty of Sexual and Reproductive Healthcare publishes a range of clinical guidance including:
    - *Emergency contraception*[90]
    - *Contraception After Pregnancy*[91]
    - *Male and female sterilisation*[92]
- NICE publishes a range of guidance on contraception, including
    - Quality Standard [QS129][93] covering contraception for women, including emergency contraception
    - Public health guideline [PH51] on contraceptive services for under 25s[94]
    - Clinical guideline [CG30] on long-acting reversible contraception[95]
    - Public health guideline [PH3] on Sexually transmitted infections and under-18 conceptions[96]

88 PHE (2018), Contraception: Economic Analysis Estimation of the Return on Investment for publicly funded contraception in England.
89 Department of Health and Social care (2013), Commissioning Sexual Health Services and Interventions: Best practice guidance for local authorities.
90 FSRH Clinical Guideline: Emergency Contraception (March 2017, amended December 2020).
91 FSRH Clinical Guideline: Contraception After Pregnancy (January 2017, amended October 2020).
92 FSRH Clinical Guideline: Male and Female Sterilisation (September 2014).
93NICE (2016), Contraception Quality standard [QS129]. Published: 08 September 2016
94 NICE (2014), Contraceptive services for under 25s. Public health guideline [PH51]. Published: 26 March 2014
95 NICE (2005), Long-acting reversible contraception Clinical guideline [CG30]. Published: 26 October 2005 Last updated: 02 July 2019.
96NICE (2007): Sexually transmitted infections and under-18 conceptions: prevention public health guideline [PH3.] Published: 28 February 2007.

WHY IS CONTRACEPTION IMPORTANT?

There is a clear public health benefit in comprehensive contraception services, through the prevention of unintended pregnancies and sexually transmitted infections (STIs). One study estimates that there is an £9 saving for every £1 invested in contraception provision in England.[97]

High-quality services can also deliver social, economic, health and personal benefits to individuals and their families, giving them greater control over their lives.[98]

There is a correlation between good contraception services and lower rates of teenage conceptions, which is one of the indicators in the Public Health Outcomes Framework.

OVERVIEW OF TYPES OF CONTRACEPTION

There are fifteen different methods of regular contraception:[99]

- caps
- combined pill
- condoms (female)
- condoms (male)
- contraceptive implant
- contraceptive injection
- contraceptive patch
- diaphragms
- intrauterine contraceptive device (IUCD)
- intrauterine system (IUS)
- natural family planning
- progestogen-only pill
- vaginal ring
- female sterilisation
- male sterilisation (vasectomy).

In addition, emergency contraception can be used after unprotected sex or if regular contraception fails.

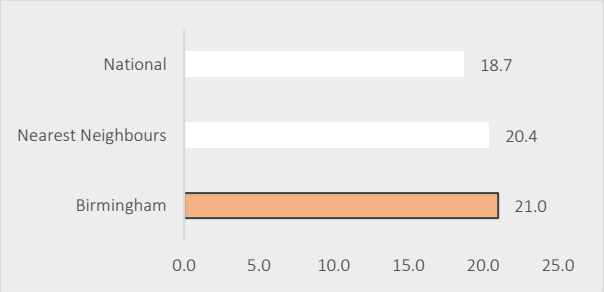
Ideally, all forms of contraception should be made available at the point of access or through an established referral pathway, to provide the full range of choice for women. Longer acting methods - implants and Intra-uterine contraceptive devices (IUCDs) are more effective and cost-effective than others and women should be informed of this. However, it is recognised that there are large regional variations in what is offered and spending on contraception differs across the country. 51% of local authorities decreased their budget allocation to contraceptive services in the 3 years between 2014/15 and 2016/17.[100]

97 PHE (2018), Contraception: Economic Analysis Estimation of the Return on Investment for publicly funded contraception in England.
98 FPA (2019): FPA policy statement: Contraception, 2019.
99NHS: What is contraception? Your contraception guide. Last reviewed 2019. Accessed May 2021.
100 PHE (2018), Contraception: Economic Analysis Estimation of the Return on Investment for publicly funded contraception in England.

GENERAL POINTS

BIRMINGHAM

Figure 4.11: SLIGHTLY HIGHER ABORTION RATES



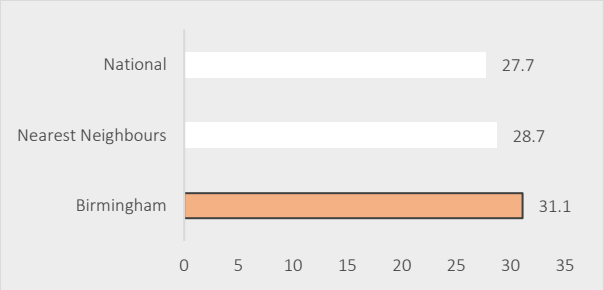
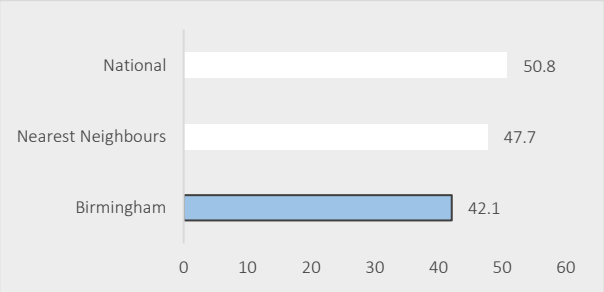


Figure 4.12: LARC RATES ARE LOW

TOTAL PRESCRIBED LARCs EXCLUDING INJECTIONS RATE / 1,000



GP PRESCRIBED LARCs EXCLUDING INJECTIONS RATE / 1,000

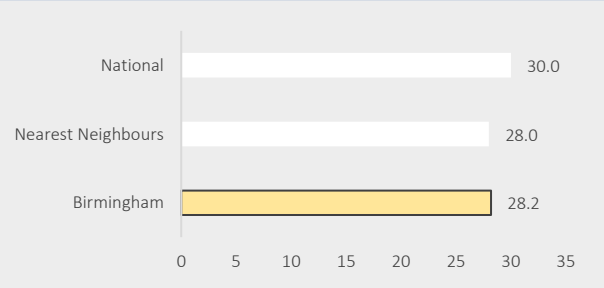
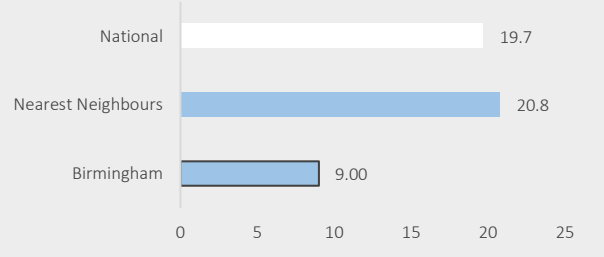
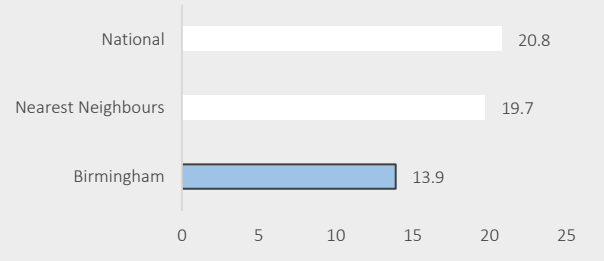


Figure 4.13: LOW RATES OF MALES ATTENDING SPECIALIST CONTRACEPTIVE SERVICES

UNDER-25 INDIVIDUALS ATTEND SPECIALIST



SRH SERVICES PRESCRIBED LARCs EXCLUDING INJECTIONS RATE / 1,000



UNDER 25s CHOOSE LARCs EXCLUDING INJECTIONS AT SRH SERVICES (%)

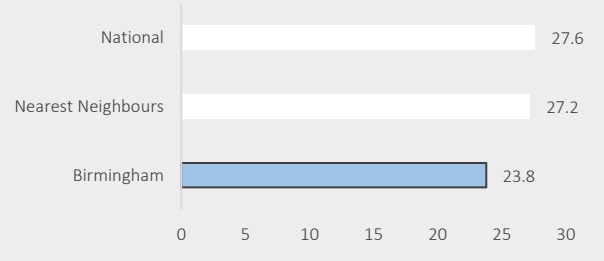


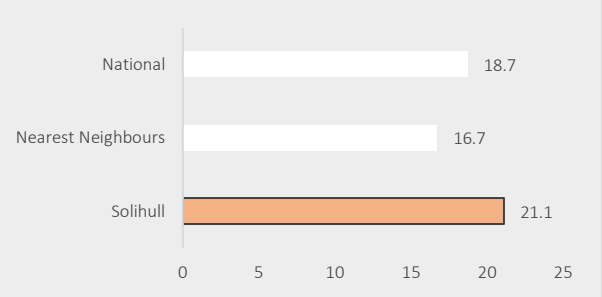
Figure 4.14: Reproductive health indicators – Birmingham.

Better 95%	Similar	Worse 95%		Lower	Similar	Higher

Indicator Name	England	Birmingham Nearest	**Birmingham**	Leeds	Bradford	Sheffield	Sandwell	Coventry	Leicester	Liverpool	Bristol	Kirklees	Wolverhampton	Nottingham	Manchester	Salford	Derby	Bolton
Total abortion rate / 1000	18.7	20.4	21.0	19.5	19.4	14.1	26.8	20.1	21.1	23.6	15.2	19.1	26.0	18.7	22.7	25.6	17.1	23.0
Under 25s repeat abortions (%)	27.7	28.7	31.1	27.1	29.3	23.9	37.1	29.6	27.1	30.2	22.9	29.8	33.3	24.6	30.7	29.7	18.8	25.3
Under 25s abortion after a birth (%)	25.3	26.5	25.6	24.2	36.4	24.8	41.4	25.7	22.2	25.0	15.8	29.8	36.9	24.0	21.3	24.6	29.9	32.8
Over 25s abortion rate / 1000	16.9	19.3	20.7	18.0	17.2	12.8	25.2	18.8	21.3	22.5	14.2	16.7	24.1	20.4	22.2	21.8	15.1	20.8
Abortions under 10 weeks (%)	82.5	81.6	79.1	84.0	83.8	77.8	80.9	78.3	81.9	77.9	84.3	84.9	78.5	80.3	86.6	88.0	74.2	82.5
Abortions under 10 weeks that are medical (%)	84.3	86.6	85.1	88.0	90.7	87.1	85.7	89.0	92.1	88.5	81.9	93.2	86.8	86.4	85.4	84.4	61.9	88.8
Total prescribed LARC excluding injections rate / 1,000	50.8	47.7	42.1	61.6	48.4	51.0	33.2	41.1	28.3	45.7	74.1	47.9	36.7	54.3	39.6	37.4	63.5	42.9
GP prescribed LARC excluding injections rate / 1,000	30.0	28.0	28.2	45.9	28.8	42.3	3.1	27.7	7.9	13.0	62.2	21.6	17.3	30.6	15.3	12.3	40.2	8.3
SRH Services prescribed LARC excluding injections rate / 1,000	20.8	19.7	13.9	15.8	19.6	8.8	30.1	13.4	20.4	32.7	11.9	26.4	19.4	23.7	24.3	25.1	23.2	34.6
Under 25s choose LARC excluding injections at SRH Services (%)	27.6	27.2	23.8	30.0	32.7	41.4	28.7	39.3	30.6	16.7	29.7	34.0	38.5	33.6	24.4	30.8	40.5	39.0
Over 25s choose LARC excluding injections at SRH Services (%)	43.8	45.3	38.6	44.1	46.5	64.8	48.1	63.3	56.0	29.1	41.9	50.9	56.7	54.5	45.6	49.4	57.8	66.3
Women choose injections at SRH Services (%)	9.4	8.7	6.6	8.5	9.6	6.5	13.0	7.3	5.5	11.1	7.2	6.5	6.7	6.0	12.0	7.2	6.8	5.1
Women choose user-dependent methods at SRH Services (%)	54.3	54.8	60.9	54.8	49.3	42.6	46.1	39.6	51.4	66.8	57.7	49.3	42.6	51.0	53.5	51.9	43.4	39.5
Women choose hormonal short-acting contraceptives at SRH Services (%)	39.9	37.9	31.5	35.8	39.5	32.3	32.4	28.1	37.1	52.7	40.2	37.5	30.1	37.0	36.0	29.9	33.1	19.5
Under 25s individuals attend specialist contraceptive services rate / 1000 - Females	135.2	119.9	76.6	75.7	80.9	48.4	130.1	44.4	121.6	361.4	109.2	106.7	88.6	146.9	181.2	138.1	150.3	99.0
Under 25s individuals attend specialist contraceptive services rate / 1000 - Males	19.7	20.8	9.0	6.5	0.9	3.3	21.0	0.7	32.5	50.9	2.5	3.0	9.5	61.8	58.0	25.2	55.2	9.7
Pelvic inflammatory disease (PID) admissions rate / 100,000	254.7	0.0	283.6	166.5	273.4	190.1	280.4	188.2	314.4	286.5	319.2	374.7	462.7	190.0	473.4	385.6	208.9	333.3
Ectopic pregnancy admissions rate / 100,000	90.0	0.0	74.8	86.1	172.7	63.4	109.1	82.3	98.6	44.8	62.1	79.9	150.9	55.2	91.9	215.2	109.4	114.3

Figure 4.15: HIGH ABORTION RATES

TOTAL ABORTION RATE / 1,000



UNDER 25s REPEAT ABORTION RATE

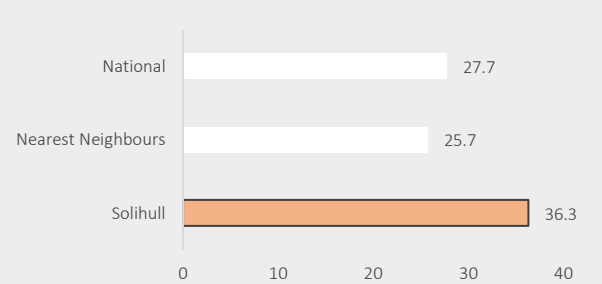
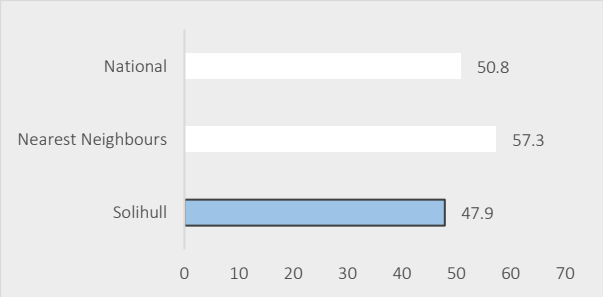
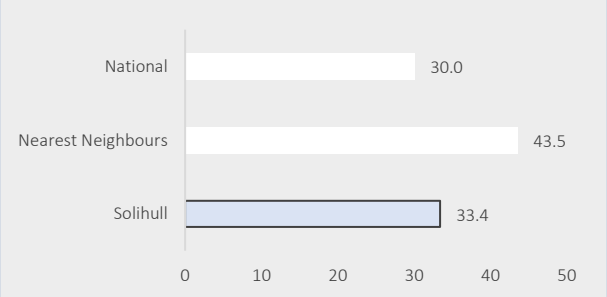


Figure 4.16: LARC RATES ARE LOW

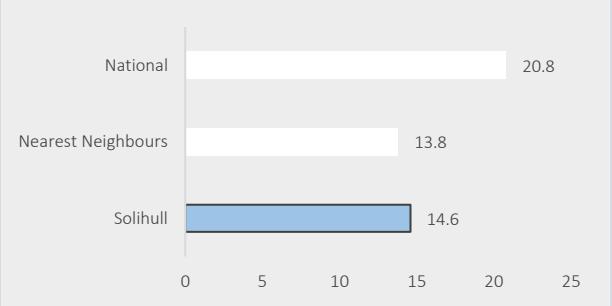
TOTAL PRESCRIBED LARCs EXCLUDING INJECTIONS RATE / 1,000



GP PRESCRIBED LARC EXCLUDING INJECTIONS RATE / 1,000



SRH SERVICES PRESCRIBED LARC EXCLUDING INJECTIONS RATE / 1,000



UNDER 25s CHOOSE LARC EXCLUDING INJECTIONS AT SRH SERVICES (%)

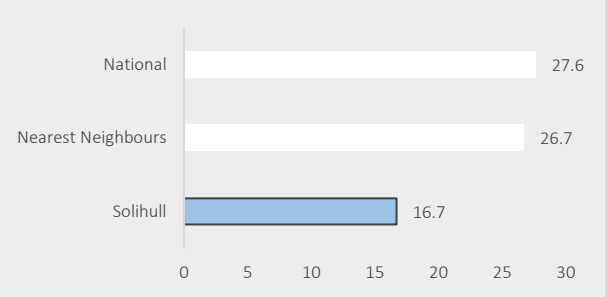


Figure 4.17: LOW RATES OF MALES ATTENDING SPECIALIST CONTRACEPTIVE SERVICES

UNDER 25s INDIVIDUALS ATTEND SPECIALIST

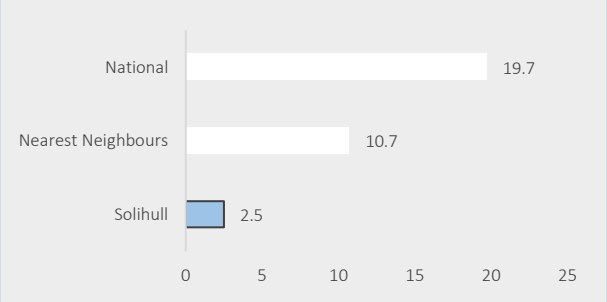


Figure 4.18: Reproductive health indicators – Solihull.

Better 95%	Similar	Worse 95%					Lower				Similar				Higher			
Indicator Name	England	Solihull nearest neighbours	**Solihull**	Stockport	Cheshire East	Cheshire West and Chester	South Gloucestershire	Bedford	Warrington	Trafford	North Somerset	Bath and North East Somerset	Swindon	Herefordshire	Shropshire	Wiltshire	West Berkshire	Central Bedfordshire
Total abortion rate / 1000	18.7	16.7	22.1	19.6	15.9	16.9	13.8	19.6	18.6	18.7	14.5	12.9	19.0	13.7	15.6	14.9	15.1	17.1
Under 25s repeat abortions (%)	27.7	25.7	36.3	28.9	22.9	26.5	22.5	30.4	24.2	27.6	18.6	18.4	24.8	19.9	23.4	23.5	32.6	28.1
Under 25s abortion after a birth (%)	25.3	23.0	29.7	24.0	24.5	20.4	19.1	28.6	23.5	16.9	20.6	17.1	22.1	22.7	27.7	25.0	21.0	21.1
Over 25s abortion rate / 1000	16.9	14.4	19.2	16.4	13.8	14.9	11.9	17.2	15.4	16.3	12.1	12.6	16.0	10.9	13.7	12.5	14.1	14.6
Abortions under 10 weeks (%)	82.5	83.3	81.9	83.4	82.9	80.5	83.8	82.7	78.7	87.6	83.4	82.5	87.1	85.9	81.7	85.1	84.3	83.1
Abortions under 10 weeks that are medical (%)	84.3	82.8	88.8	72.7	67.3	85.6	83.7	86.4	83.8	81.2	84.1	72.9	84.2	97.8	93.7	82.2	88.3	86.7
Total prescribed LARC excluding injections rate / 1,000	50.8	57.3	47.9	50.9	54.4	62.6	59.2	42.4	56.6	42.1	71.1	64.3	49.8	63.7	68.2	68.4	63.1	46.3
GP prescribed LARC excluding injections rate / 1,000	30.0	43.5	33.4	31.1	33.6	40.9	50.7	23.2	33.8	25.2	61.9	56.1	30.1	53.1	59.9	63.3	54.3	36.8
SRH Services prescribed LARC excluding injections rate / 1,000	20.8	13.8	14.6	19.8	20.8	21.7	8.5	19.2	22.8	16.8	9.1	8.2	19.7	10.6	8.3	5.0	8.9	9.5
Under 25s choose LARC excluding injections at SRH Services (%)	27.6	26.7	16.7	29.8	27.5	23.2	29.2	24.4	25.8	25.4	25.2	34.5	25.5	41.4	35.7	36.3	24.2	35.8
Over 25s choose LARC excluding injections at SRH Services (%)	43.8	46.4	37.8	62.5	44.5	37.8	46.5	49.1	42.8	53.6	42.8	44.7	45.1	60.0	50.4	49.7	56.9	53.7
Women choose injections at SRH Services (%)	9.4	9.8	7.5	9.1	10.5	10.9	10.4	6.5	12.7	7.5	10.0	9.2	14.5	6.4	5.2	8.1	13.4	5.5
Women choose user-dependent methods at SRH Services (%)	54.3	53.7	65.5	44.6	52.9	59.1	53.0	56.1	53.3	51.9	57.0	52.3	49.5	44.0	51.8	47.9	49.7	49.5
Women choose hormonal short-acting contraceptives at SRH Services (%)	39.9	40.6	44.4	32.1	43.8	49.7	39.6	37.2	34.7	36.1	46.6	37.4	41.5	28.7	34.7	35.9	40.1	33.3
Under 25s individuals attend specialist contraceptive services rate / 1000 - Females	135.2	102.3	136.4	149.6	139.1	190.9	82.2	116.5	148.8	131.1	136.5	40.5	143.8	58.2	54.7	26.7	65.4	60.8
Under 25s individuals attend specialist contraceptive services rate / 1000 - Males	19.7	10.7	2.5	41.3	6.7	13.6	1.7	5.2	6.5	36.7	36.9	1.7	1.7	3.8	4.6	1.6	0.0	8.9
Pelvic inflammatory disease (PID) admissions rate / 100,000	254.7	0.0	203.0	347.7	273.3	161.3	254.6	189.3	285.1	614.6	332.8	141.1	219.2	218.5	173.7	163.8	150.7	198.7
Ectopic pregnancy admissions rate / 100,000	90.0	0.0	94.7	164.2	58.0	101.9	84.9	126.2	67.9	104.4	72.4	64.1	60.9	67.2	71.5	75.6	75.4	75.7

LONG-ACTING REVERSIBLE CONTRACEPTION (LARC)

KEY FINDINGS

For the total prescribed LARCs (excluding injections), the rates in 2019 for both Birmingham and Solihull were lower than their nearest neighbours.

In both Birmingham and Solihull, the rates for total prescribed LARCs (excluding injections) are lower than both their nearest neighbours and the national average. Historically, this has been the case.

Birmingham is below average for LARC prescribed via Sexual and Reproductive Health (SRH) services, whilst in Solihull GP-prescribed LARC is below the average.

The rate of GP-prescribed LARC in Birmingham is similar to the nearest neighbours; however, the rate for SRH prescribed LARC is lower than that of the nearest neighbours.

In Solihull, the rate for SRH-prescribed LARC is comparable to the nearest neighbours; however there appears to be a gap in provision for GP-prescribed LARC.

The percentage of women in contact with Sexual and Reproductive Health Services who choose LARC (excluding injections) as their main method of contraception is low in both areas, particularly for Solihull.

For the under 25s, the average for the nearest neighbours to Birmingham and Solihull is similar at 27%. The rate for Birmingham is slightly lower at 24%, with Solihull at only 17%.

The rate for over-25s shows that both Birmingham and Solihull report lower rates than their nearest neighbours. In contrast to the under-25 age group, Birmingham and Solihull have similar over-25 rates to each other.

Geographical analysis in Solihull has found areas with low rates of LARC activity.

The local data for 2020-21 shows that some wards (based on GP location) have had no LARC insertions (Blythe, Dorridge and Hockley Heath, Elmdon, Olton, St Alphege, and Shirley West).

In Solihull, there has been a decrease in IUCD insertions whilst Implanon insertions have seen an increase.

Comparing 2020-21 against 2019-20, there has been a decrease from 416 IUCD insertions to 332. In contrast, Implanon insertions have increased from 184 to 203.

The analysis by ward shows different patterns for method of insertion. For example, Chelmsley Wood has seen a decrease in IUCD insertions and an increase in Inplanon insertions. Conversely, Shirley East has seen the opposite trend.

Below provides a summary of the LARC indicators for Birmingham and Solihull. They are explored in further detail on the following pages.

Lower	Similar	Higher

Figure 4.19: LARC Indicators, Birmingham.

Indicator Name	England	Birmingham Nearest Neighbours	Birmingham
Total prescribed LARC excluding injections rate / 1,000	50.8	47.7	42.1
GP prescribed LARC excluding injections rate / 1,000	30.0	28.0	28.2
SRH Services prescribed LARC excluding injections rate / 1,000	20.8	19.7	13.9
Under 25s choose LARC excluding injections at SRH Services (%)	27.6	27.2	23.8
Over 25s choose LARC excluding injections at SRH Services (%)	43.8	45.3	38.6

Figure 4.20: LARC Indicators, Solihull

Indicator Name	England	Solihull nearest neighbours	Solihull
Total prescribed LARC excluding injections rate / 1,000	50.8	57.3	47.9
GP prescribed LARC excluding injections rate / 1,000	30.0	43.5	33.4
SRH Services prescribed LARC excluding injections rate / 1,000	20.8	13.8	14.6
Under 25s choose LARC excluding injections at SRH Services (%)	27.6	26.7	16.7
Over 25s choose LARC excluding injections at SRH Services (%)	43.8	46.4	37.8

TOTAL PRESCRIBED LARC EXCLUDING INJECTIONS RATE / 1,000

INTRODUCTION (PHE FINGERTIPS)

The National Institute for Health and Clinical Excellence (NICE) Clinical Guideline CG30[101] advises that LARC methods, such as contraceptive injections, implants, the intra-uterine system (IUS) or the intrauterine contraceptive device (IUCD), are highly effective as they do not rely on daily compliance and are more cost effective than condoms and the pill. Implants, the IUS and IUCD can remain in place for up to 3, 5 or 10 years depending on the type of product. This indicator excludes injections because:

- injections rely on timely repeat visits/administration within the year and consequently have a higher failure rate than the other LARC methods
- injections are easily given, thus do not require the resources and training that other LARC methods require
- injections are outside local authority contracts

A strategic priority is to ensure access to the full range of contraception is available to all. An increase in the provision of LARCs is a proxy measure for wider access to the range of possible contraceptive methods and should also lead to a reduction in rates of unintended pregnancy.

Red-green colouring has not been applied to this indicator to indicate significantly 'worse'/'better' values as the intention is to encourage choice rather than to promote LARC methods at the expense of other contraceptive methods.

TOTAL PRESCRIBED LARC EXCLUDING INJECTIONS RATE / 1,000 – BIRMINGHAM

- In Birmingham, the rates of prescribed LARCs (42.1 per 1,000 females aged 15-44) were lower than their nearest neighbours and the national average.

Figure 4.21: Long term trend.

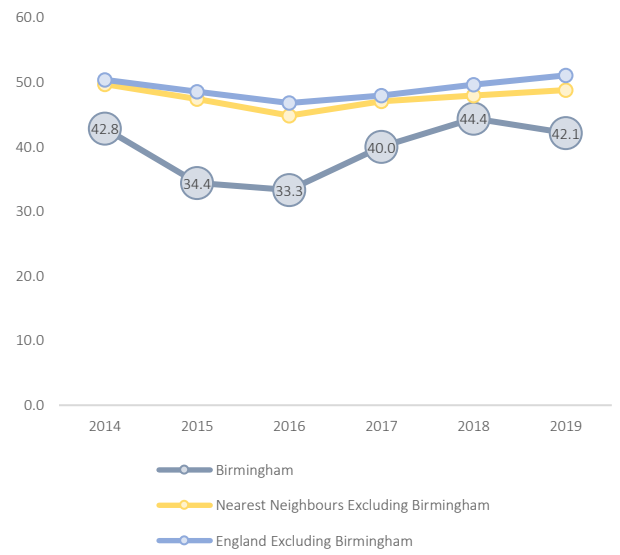
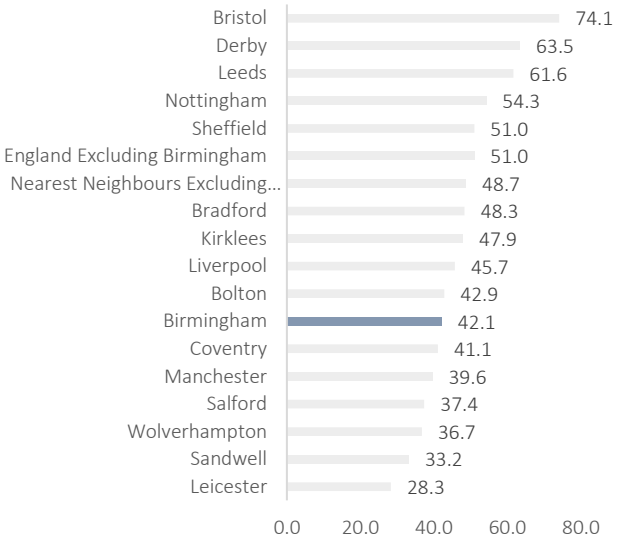


Figure 4.22: Comparison against nearest neighbours.



Year	2014	2015	2016	2017	2018	2019
Denominator	245382	247154	249666	252745	253261	253922
Count	10503	8502	8313	10108	11237	10700
Value	42.8	34.4	33.3	40.0	44.4	42.1

[101] NICE, NICE Clinical Guidance 30

TOTAL PRESCRIBED LARC EXCLUDING INJECTIONS RATE / 1,000 – SOLIHULL

- In Solihull, the rates of prescribed LARCs (47.9 per 1,000 females aged 15-44) were lower than their nearest neighbours and the national average.

Figure 4.23: Long term trend.

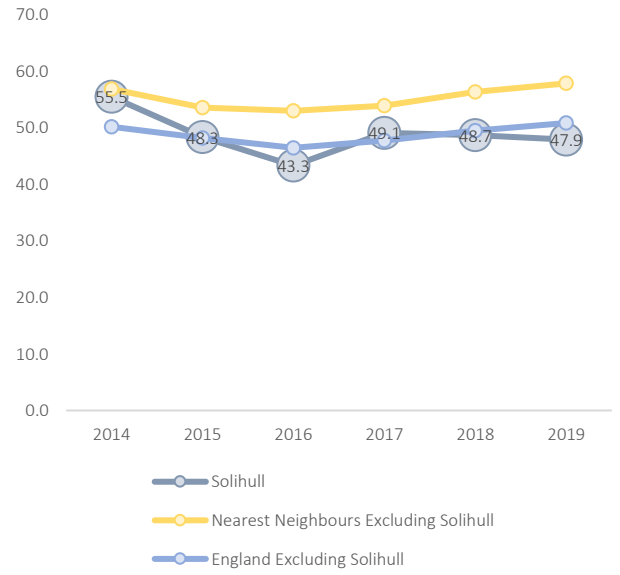
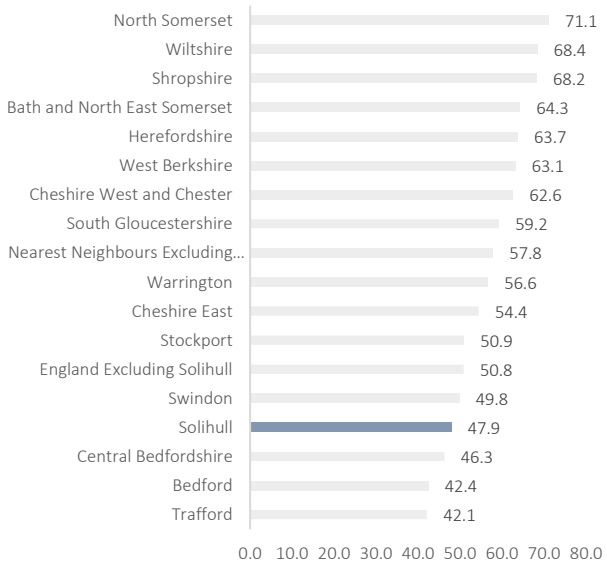


Figure 4.24: Comparison against nearest neighbours.



Year	2014	2015	2016	2017	2018	2019
Denominator	36909	36517	36347	36548	36603	36953
Count	2047	1765	1574	1795	1782	1770
Value	55.5	48.3	43.3	49.1	48.7	47.9

Denominator: ONS, Mid-year population estimates: single year of age and sex for local authorities in England (ages 15-44 years)

Numerator: Total number of implants, IUS and IUCDs prescribed in the calendar year (January to December) for women in all age groups.

IUC INSERTIONS - BIRMINGHAM

The following analysis is based on data is taken from Umbrella GP datasets and covers April 2019 to March 2021.

The analysis shows that the numbers fell below the average during the first period of lockdown. Excluding the 15-17 age group, the numbers show a trend towards pre-lockdown activity levels. However, there were relatively low numbers for the 15–17-year-old age group.

Figure 4.25: IUC Insertions 15-17 age group

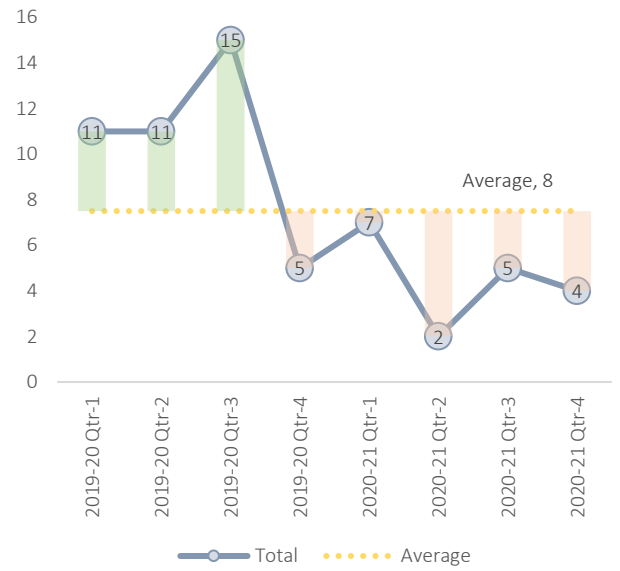


Figure 4.26: IUC Insertions 18-44 age group

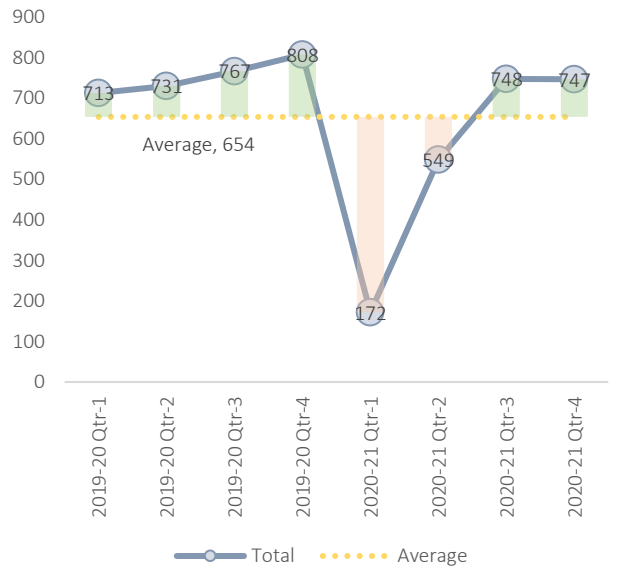


Figure 4.27: IUC Insertions 45+ age group

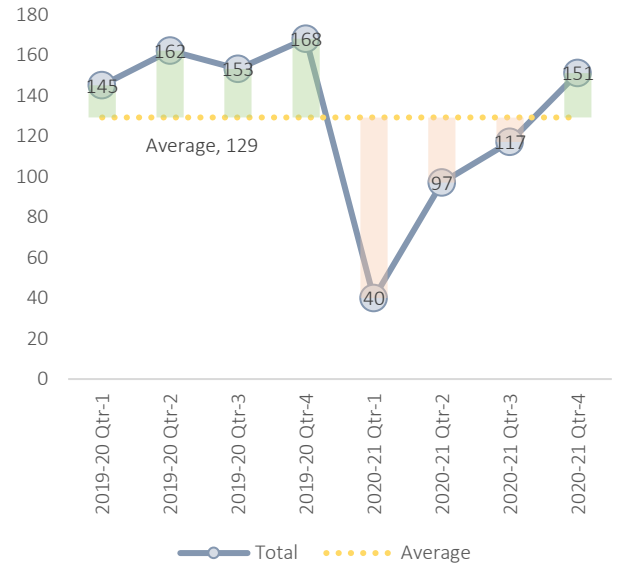


Figure 4.28: Breakdown by year.

Year	2019-20	2020-21
IUC Insertions 15-17	42	18
IUC Insertions 18-44	3019	2216
IUC Insertions 45+	628	405
Total	3689	2639

The graphs below show the total number of IUC insertions by age, and the number of IUC insertions as a rate per 100,000 of the population.

Figure 4.29: Total number of IUC insertions: Apr-2019 to Mar-2021.

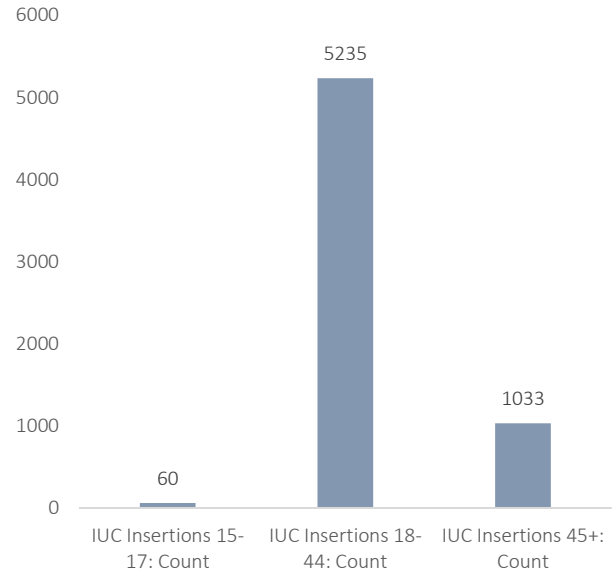
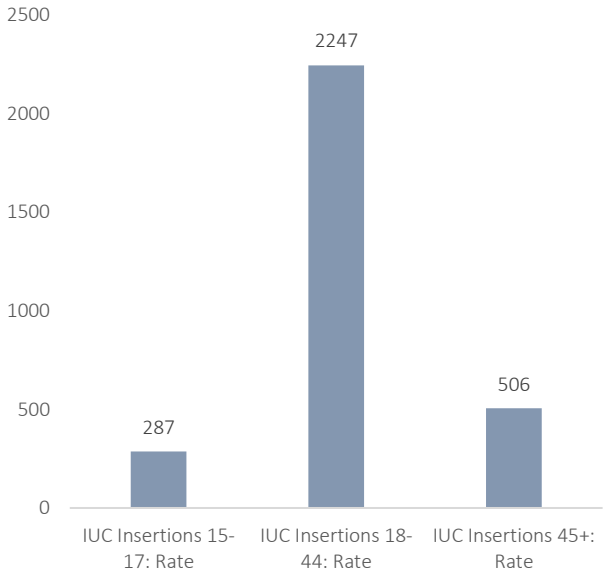
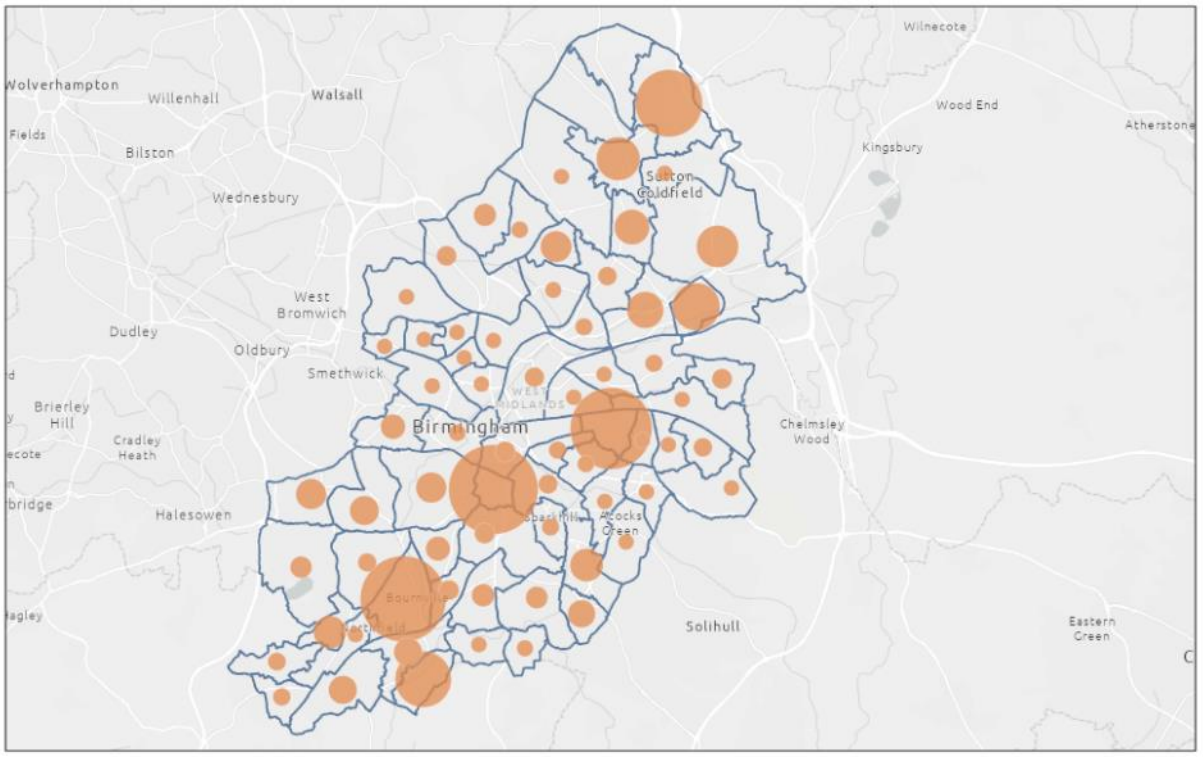


Figure 4.30: Rate of IUC insertions per 100,000 population: Apr-2019 to Mar-2021.



The map below shows the rates per 100,000 for IUC insertions by ward in Birmingham.

Figure 4.31: IUC Insertions for 18-44 age group: Rate per 100,000 population. Based on GP ward.



SDI INSERTIONS - BIRMINGHAM

For 15–17-year-olds, the number of SDI insertions decreased below the average for Q1 2020-21. The number fell below the average (of 40) in the final quarter of 2020-21.

For 18–44-year-olds, the number of insertions fell below the average in the first 2 quarters of 2020-21. Numbers increased in the final 2 quarters of 2020-21.

Figure 4.32: SDI Insertions 15-17 age group.

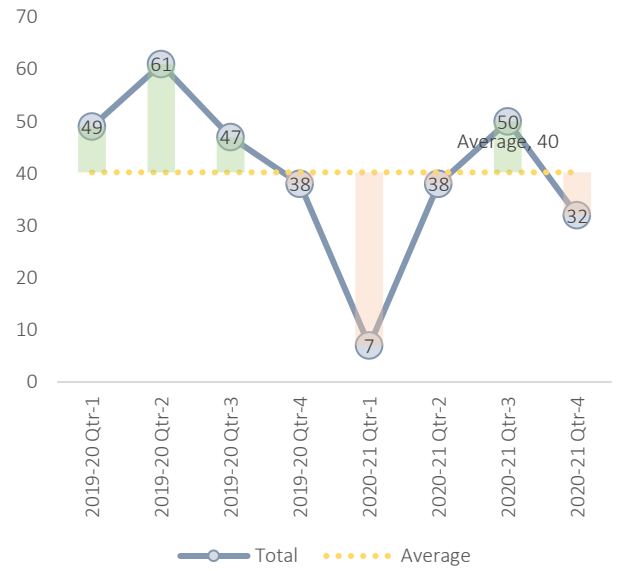


Figure 4.33: SDI Insertions 18-44 age group.

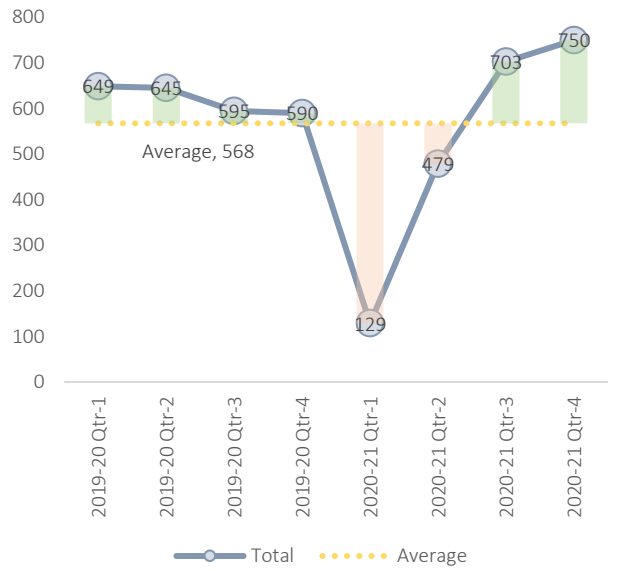


Figure 4.34: SDI Insertions 45+ age group.

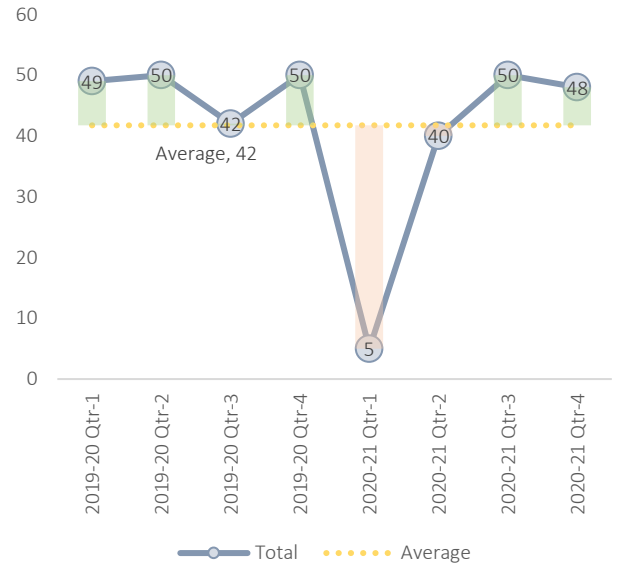


Figure 4.35: Breakdown by year.

Year	2019-20	2020-21
SDI Insertions 15-17	195	127
SDI Insertions 18-44	2479	2061
SDI Insertions 45+	191	143
Total	2865	2331

The graphs below show the total number of SDI insertions by age, and the number of IUC insertions as a rate per 100,000 of the population.

Figure 4.36: Total number of SDI insertions: Apr-2019 to Mar-2021.

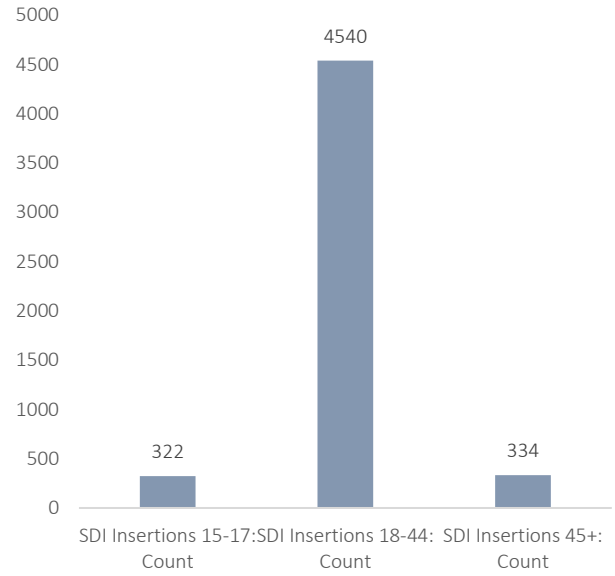
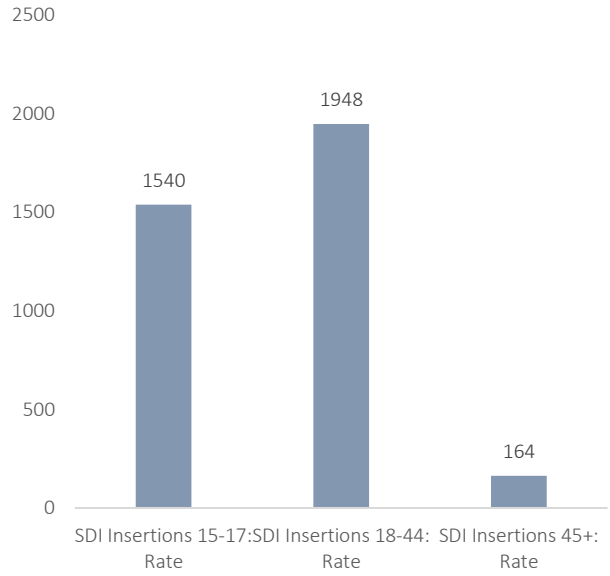


Figure 4.37: Rate of SDI insertions per 100,000 population: Apr-2019 to Mar-2021.



The maps below show the rates per 100,000 for SDI insertions by ward in Birmingham.

Figure 4.38: SDI Insertions for 15-17 age group: Rate per 100,000 population. Based on GP ward.

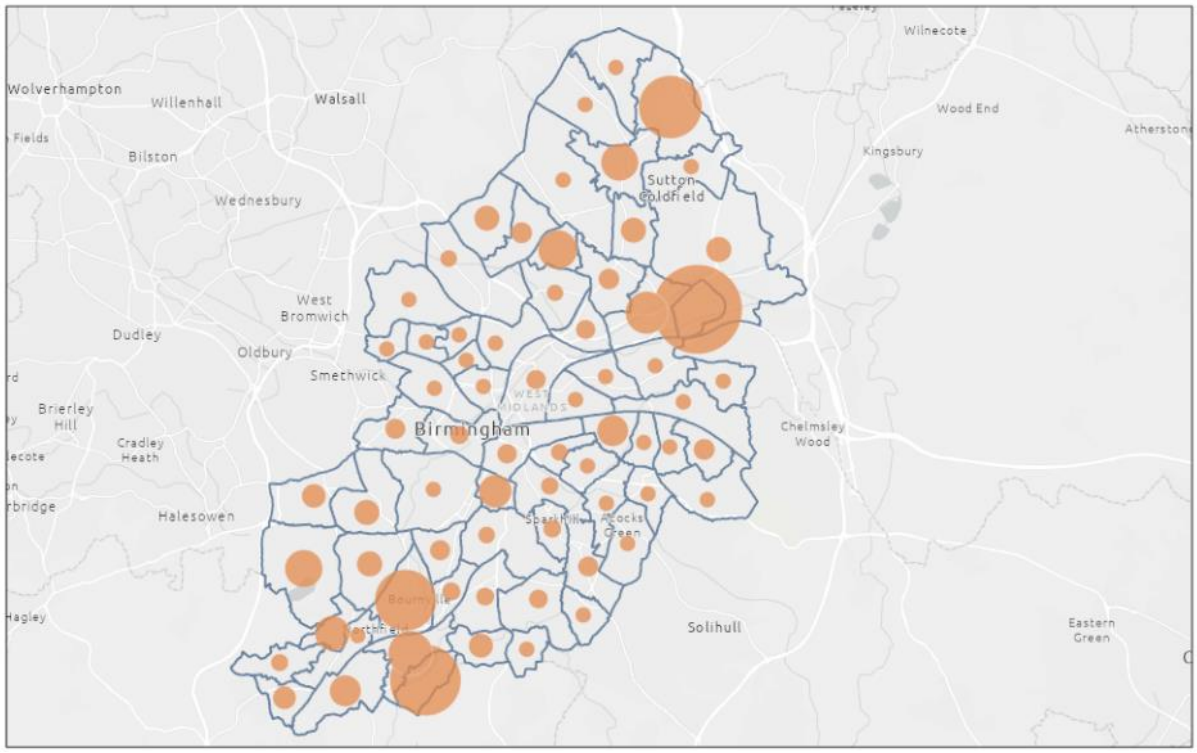


Figure 4.39: SDI Insertions for 18-44 age group: Rate per 100,000 population. Based on GP ward.

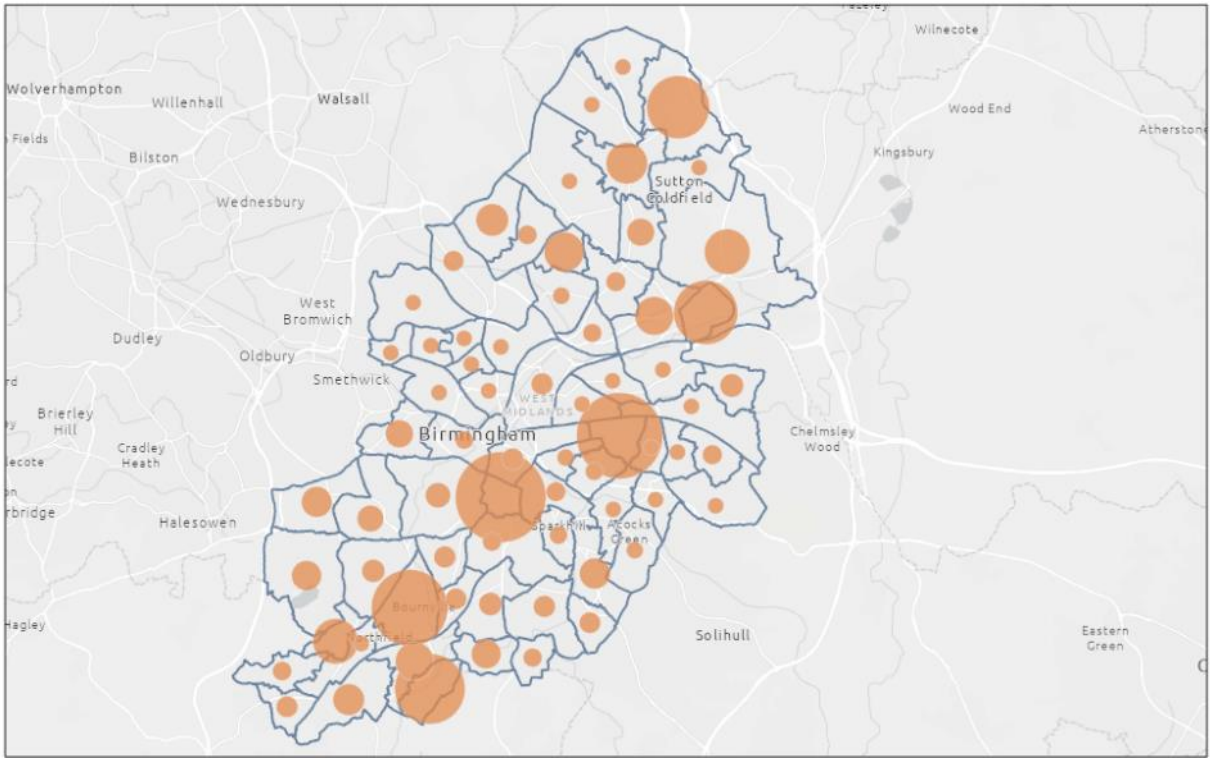
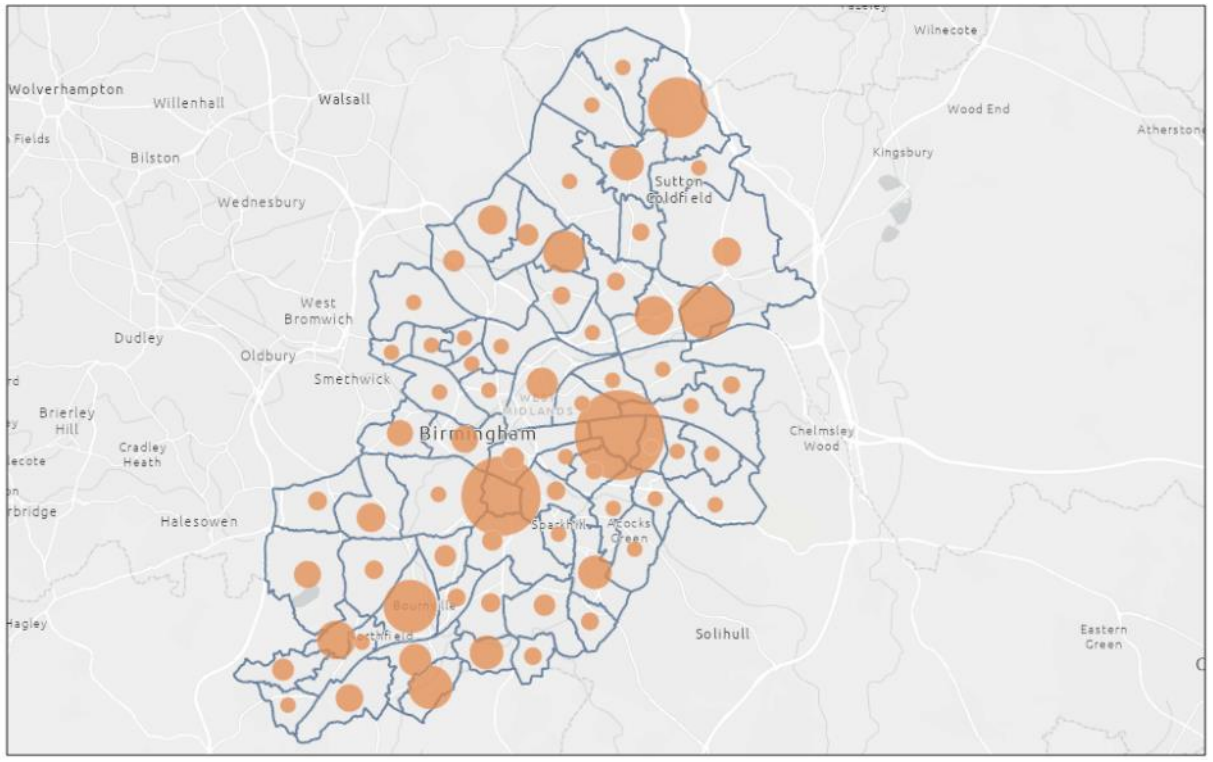


Figure 4.40: SDI Insertions for 45+ age group: Rate per 100,000 population. Based on GP ward.



IUCD INSERTIONS - SOLIHULL

The following analysis is based on local data provided for use in this needs assessment.

Figure 4.40 shows the number of IUCD insertions based on the ward of the GP surgery.

The majority of Wards show a decrease when comparing 2020-21 against 2019-20. Exceptions to this include Meriden and Shirley East.

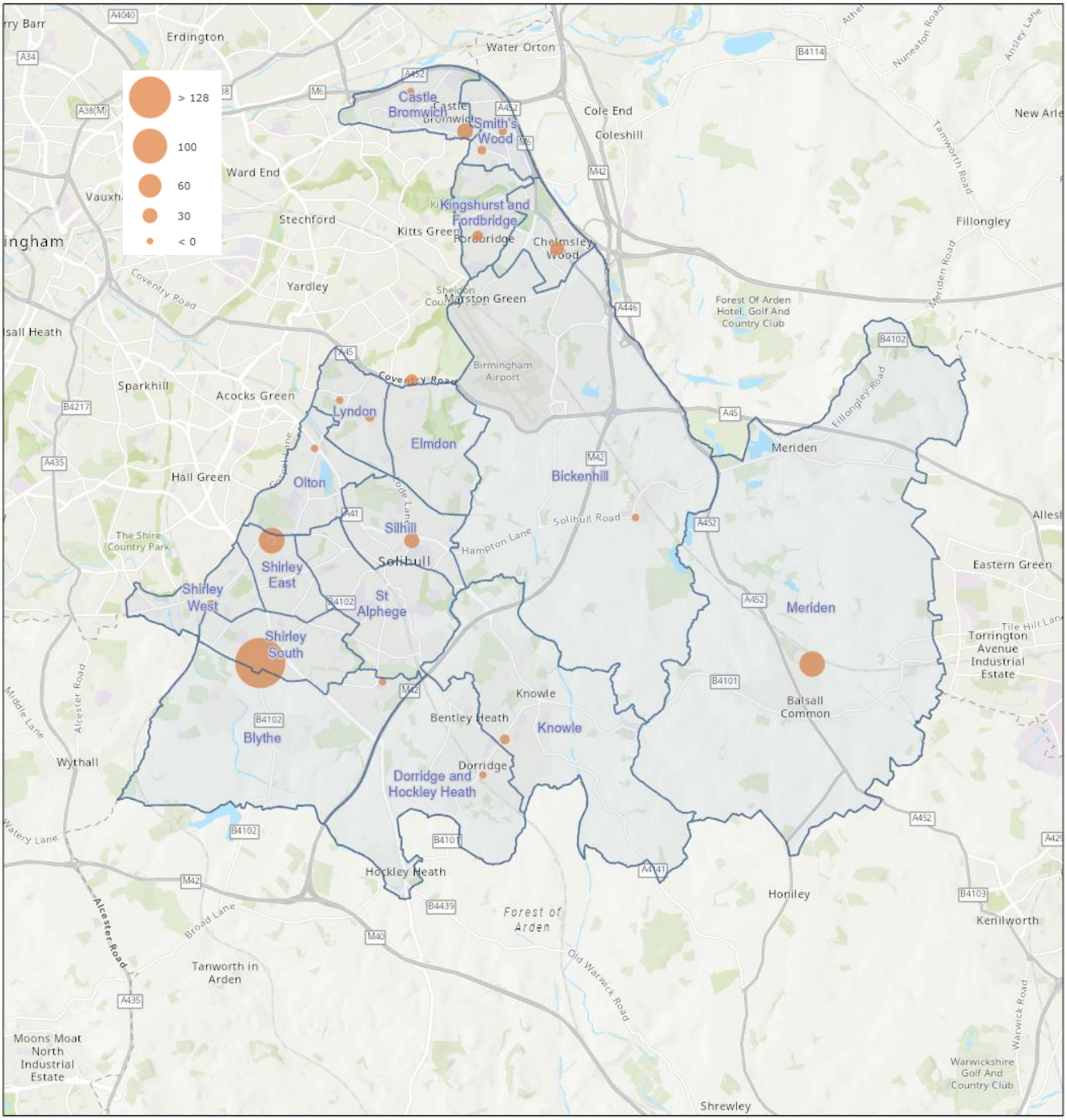
Figure 4.41 shows the mapping of the activity in 2020-21 and highlights the high activity in Shirley South Ward.

Figure 4.41: The number of IUCD insertions based on location of GP surgery.

Ward Name	2019-20	2020-21	Change
Bickenhill	0	0	0
Blythe	15	0	-15
Castle Bromwich	30	25	-5
Chelmsley Wood	32	19	-13
Dorridge and Hockley Heath	2	0	-2
Elmdon	0	0	0
Kingshurst and Fordbridge	14	9	-5
Knowle	26	7	-19
Lyndon	0	6	6
Meriden	35	54	19
Olton	0	0	0
St Alphege	0	0	0
Shirley East	40	55	15
Shirley South	133	128	-5
Shirley West	10	0	-10
Silhill	55	23	-32
Smith's Wood	24	6	-18
Total	416	332	-84

The map below shows the number of IUCD fittings by Solihull ward.

Figure 4.42: IUCD fittings based on GP ward; Solihull 2020-21.



IMPLANON INSERTION

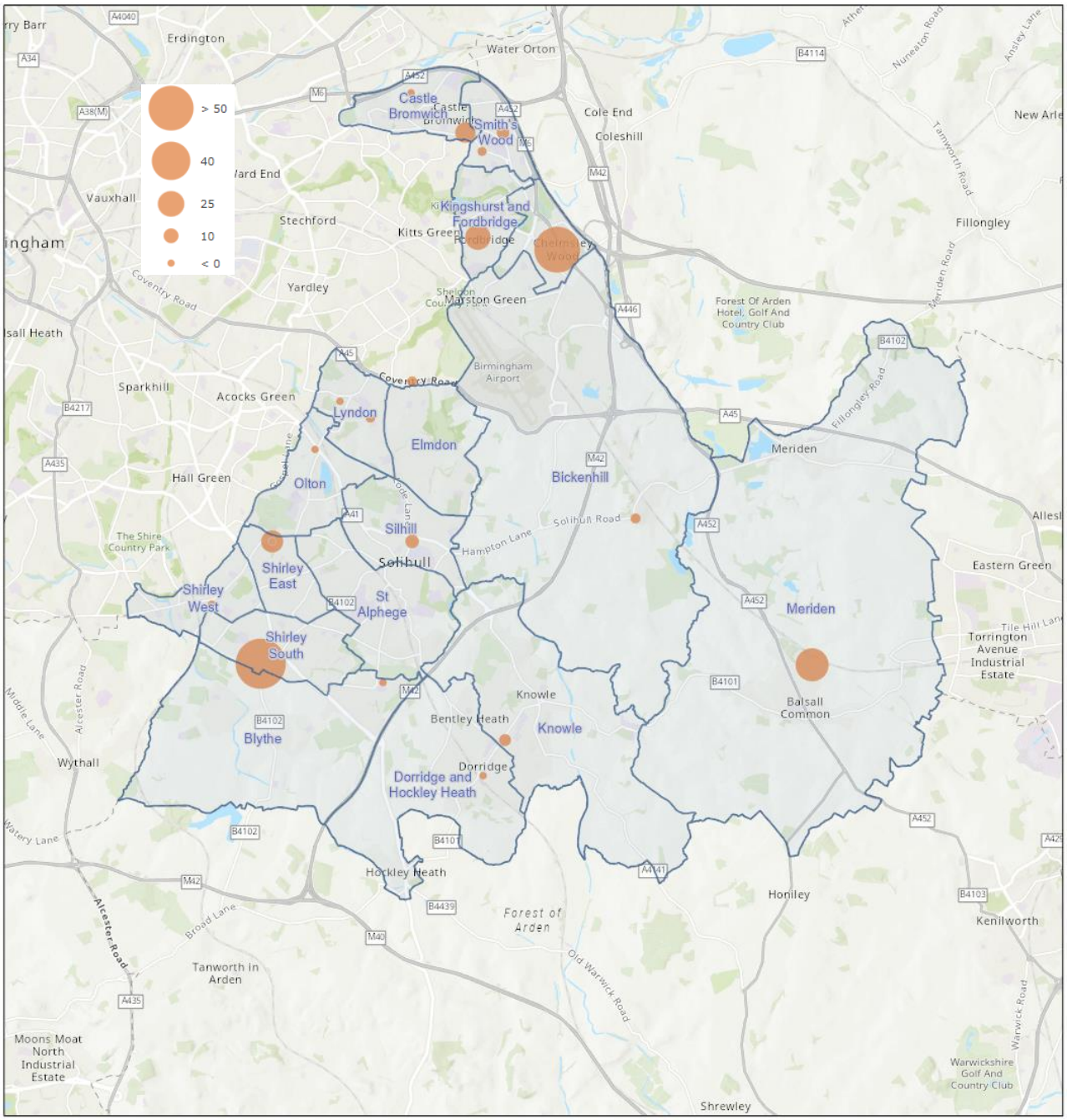
Figure 4.43 shows the number of implanon insertions based on the ward of the GP surgery. There has been an increase in activity when comparing 2020-21 against 2019-20, with Chelmsley Wood and Meriden both seeing an increase. Note that Meriden Ward also saw in increase in IUCD fittings.

Figure 4.43: The number of implanon insertions based on location of GP surgery.

Ward Name	2019-20	2020-21	Change
Bickenhill	2	3	1
Blythe	5	0	-5
Castle Bromwich	8	15	7
Chelmsley Wood	14	45	31
Dorridge and Hockley Heath	6	0	-6
Elmdon	0	0	0
Kingshurst and Fordbridge	17	21	4
Knowle	8	5	-3
Lyndon	0	2	2
Meriden	9	30	21
Olton	0	0	0
St Alphege	0	0	0
Shirley East	29	17	-12
Shirley South	43	50	7
Shirley West	9	0	-9
Silhill	17	7	-10
Smith's Wood	17	8	-9
Total	184	203	19

The map shows the number of Implanon insertions by Solihull Ward.

Figure 4.44: Implanon insertion; Solihull 2020-21.



EMERGENCY HORMONAL CONTRACEPTION (EHC)

OVERVIEW

Pharmacy provision is particularly important for young people requiring Emergency Hormonal Contraception.

Levonorgestrel is effective if taken within 72 hours (3 days) of unprotected sexual intercourse (UPSI) and may also be used between 72 and 96 hours after UPSI [unlicensed use], but efficacy decreases with time. Ulipristal acetate is effective if taken within 120 hours (5 days) of UPSI. Ulipristal acetate has been demonstrated to be more effective than levonorgestrel for emergency contraception[102].

Figure 4.45: EHC offered across Solihull and Birmingham.

Area	LEVONORGESTREL	ULIPRISTAL ACETATE
Solihull	Available.	Available
Birmingham	Available.	Available

COMPARISON BETWEEN BIRMINGHAM AND SOLIHULL[103]

ACTIVITY

The following table looks at EHC activity during April-21 and May-21[104] across Birmingham and Solihull, and how the two areas compare.

In Birmingham, there were 110 pharmacies with EHC activity compared to 19 in Solihull. Taking into account the are size of the two areas, there is better coverage in Birmingham.

An additional measure looks at EHC activity as a rate per 100,000 16-45 female population. In Birmingham, the rate was 1,569 across the two months, which is significantly higher than the 723 in Solihull.

Figure 4.46: EHC activity comparison between Birmingham and Solihull.

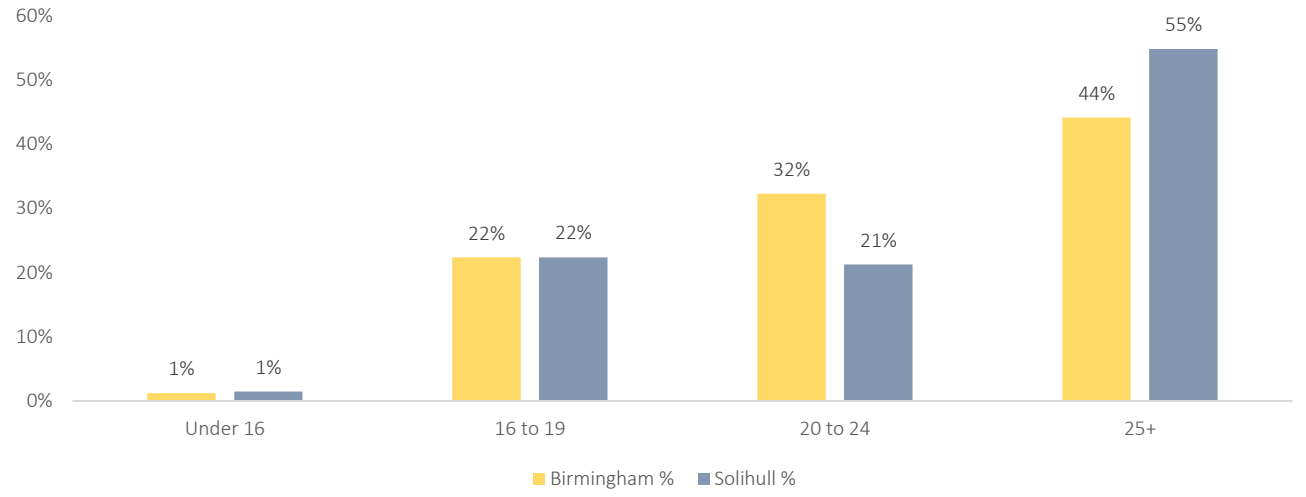
	Birmingham	Solihull
Area Size (km2)	268	182
Pharmacies (>0 EHC During April 21 - May 21)	110	19
Per Square KM	**0.4**	**0.1**
EHC Activity (During 2020-21)	3970	268[105]
16-45 Population (Females 2019 MYE)	253001	37082
Rate Per 100,000	**1569**	**723**

[102] NICE, Emergency Contraception
[103] Covers April and May 2021.
[104] UPA data for Solihull was not available before this time period.
[105] 133 LNG + 135 UPA.

AGE

The breakdown analysis by age group shows that there are differences between the two areas. 55% of EHC activity in Solihull was for the 25+ age group compared to 44% in Birmingham.

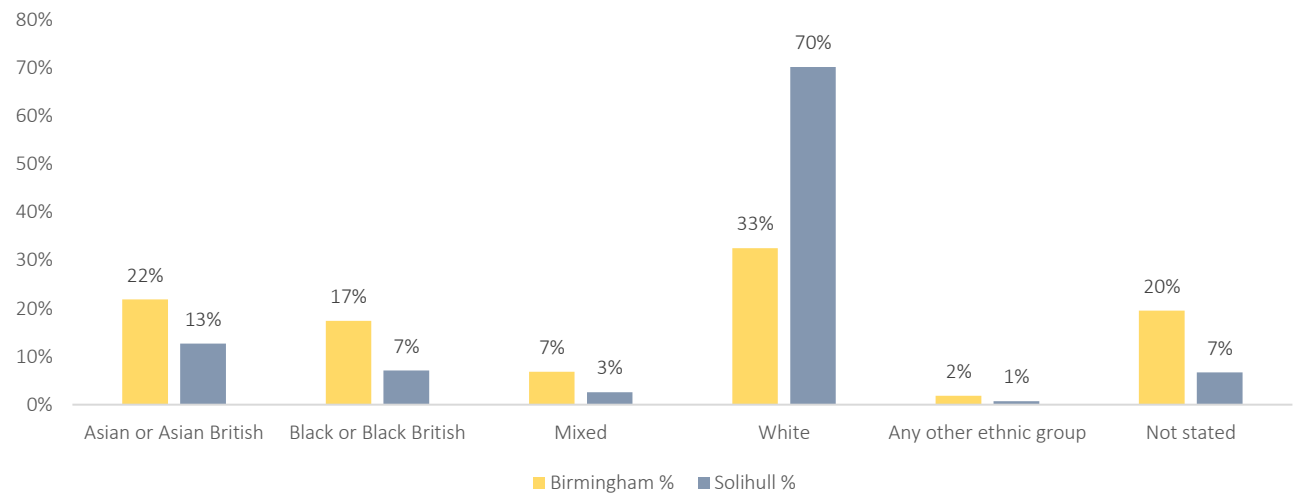
Figure 4.47: Comparison of age groups between Birmingham and Solihull.



ETHNICITY

The analysis by ethnicity highlights the different demographics between the two areas. 70% of those accessing EHC in Solihull were of White ethnicity. For Birmingham, the rate was significantly lower at 33%; however, note that a high rate did not have their ethnicity recorded.

Figure 4.48: Comparison of ethnic groups between Birmingham and Solihull.



LOCATION

In Birmingham, 3300 (80%) of those accessing EHC were residing in Birmingham. 148 (4%) were from Sandwell, 118 (3%) were from Solihull, and 560 (14%) were from other areas.

SOLIHULL

INTRODUCTION

Solihull Metropolitan Borough Council (SMBC) commission a number of local pharmacies to provide free EHC. EHC is available from pharmacies not commissioned by SMBC; however, this is a charged-for service. The following data is from the pharmacies commissioned by SMBC.

Solihull pharmacies offer Levonorgestrel (LNG) and Ulipristal Acetate (UPA). For the first two months of 2021-22, there were 133 LNG and 135 UPA records for Solihull.

There are differences in the distribution of the two types of EHC when broken down by ward. 43% of LNGs were for Castle Bromwich. For UPA, the rate was lower with Shirley South and St Alphege also seeing high rates.

Figure 4.49: LNG and UPA offered by ward of pharmacy.

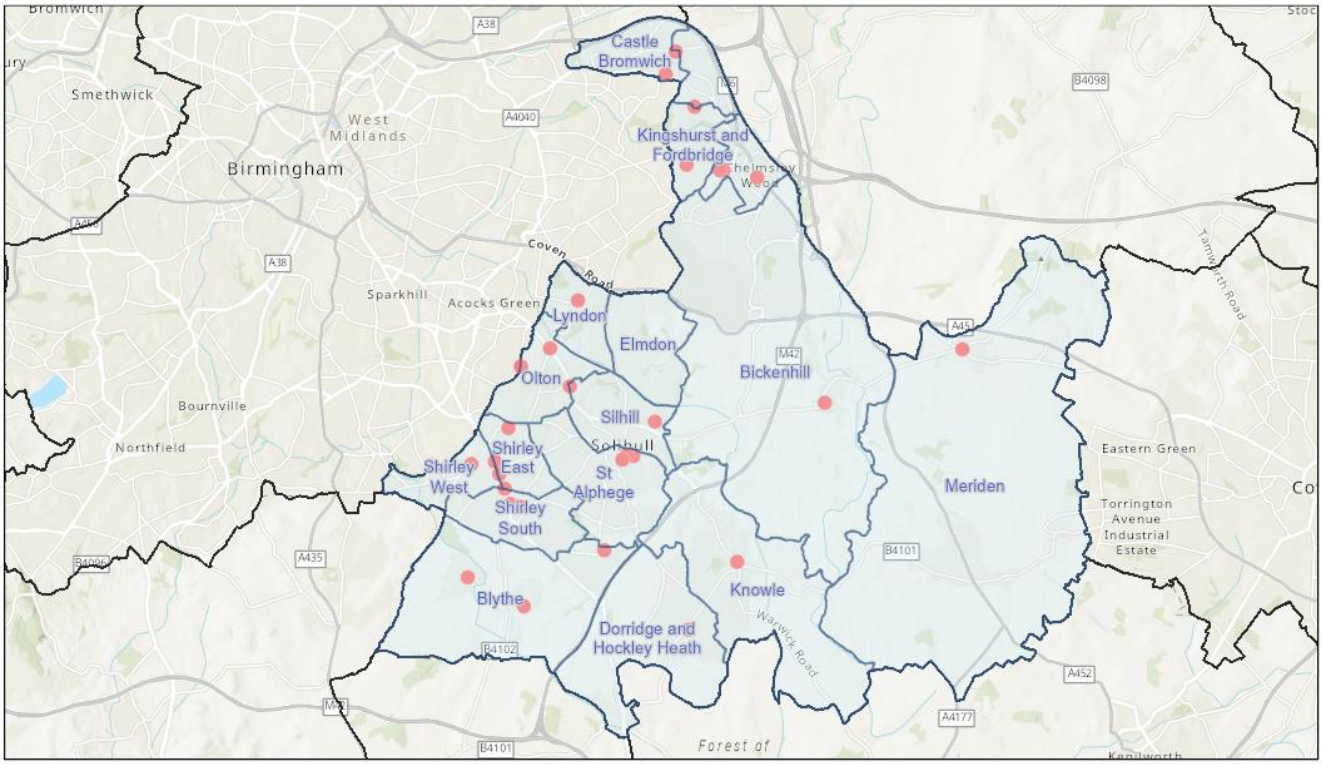
Ward Name	EHC_LNG_2021-22	EHC_LNG_2021-22 %	EHC_UPA_2021-22	EHC_UPA_2021-22 %
Bickenhill	0	0%	0	0%
Blythe	2	2%	5	4%
Castle Bromwich	57	43%	24	18%
Chelmsley Wood	18	14%	24	18%
Dorridge and Hockley Heath	0	0%	4	3%
Elmdon	0	0%	0	0%
Kingshurst and Fordbridge	0	0%	0	0%
Knowle	0	0%	0	0%
Lyndon	0	0%	0	0%
Meriden	0	0%	0	0%
Olton	11	8%	5	4%
St Alphege	17	13%	23	17%
Shirley East	6	5%	14	10%
Shirley South	7	5%	23	17%
Shirley West	3	2%	5	4%
Silhill	0	0%	3	2%
Smith's Wood	12	9%	5	4%
Total	133		135	

LOCATIONS

Between April 2018 and May 2021, there was EHC activity across 30 pharmacies in Solihull. The following map shows the locations of these pharmacies.

The map shows that in addition to clusters of pharmacy provision, geographically there are areas where there are great distances between locations.

Figure 4.50: Locations of pharmacies with EHC activity between April 2018 and May 2021.



LEVONORGESTREL (LNG)

The following relates to Levonorgestrel 1500mg (stage 2) and covers April 2018 to May 2021.

The table shows activity relating to Levonorgestrel by location of the pharmacies, based on ward location.

There were four wards where there was no activity in 2020-21.

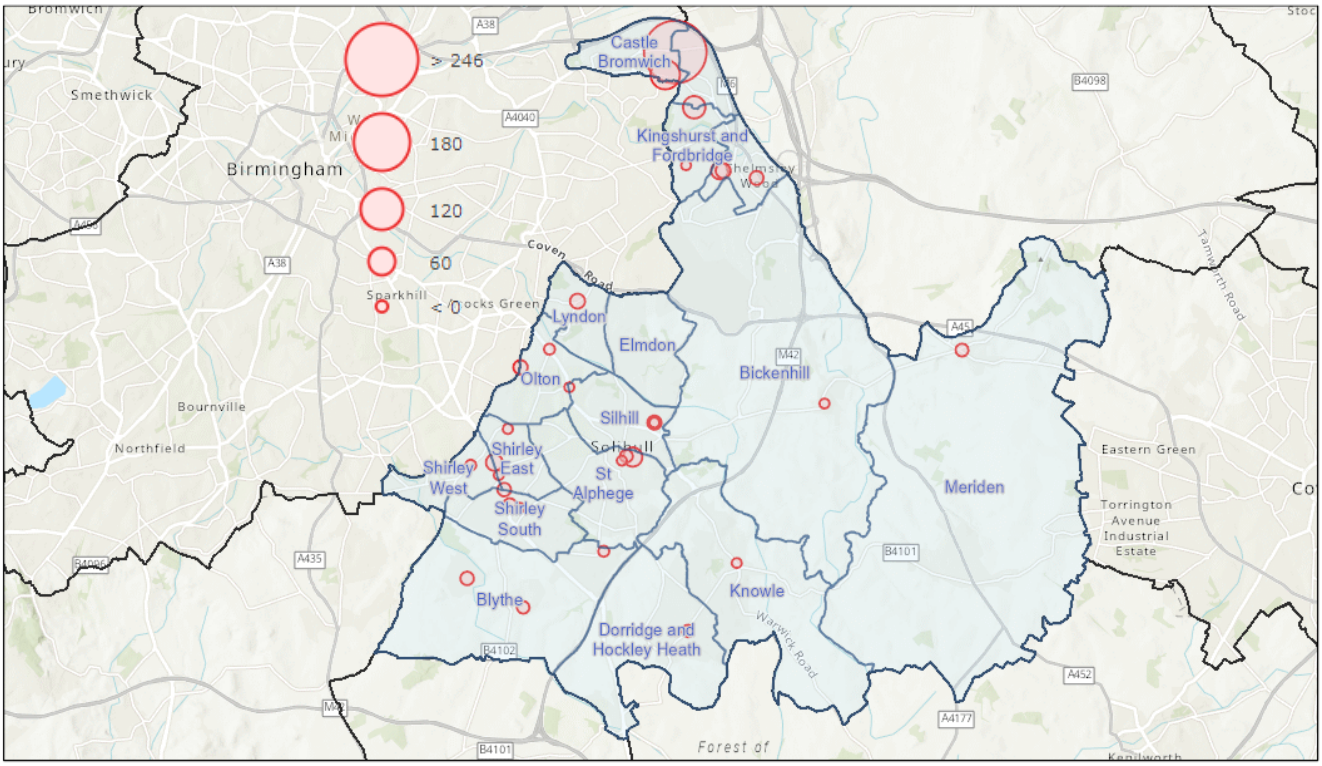
Figure 4.51: LNG offered by ward of pharmacy.

Ward Name	2018-19	2019-20	2020-21	2021-22[106]
Bickenhill	0	2	0	0
Blythe	31	24	33	2
Castle Bromwich	291	338	337	57
Chelmsley Wood	167	181	74	18
Dorridge and Hockley Heath	11	10	11	0
Elmdon	0	0	0	0
Kingshurst and Fordbridge	12	1	0	0
Knowle	3	2	0	0
Lyndon	31	33	23	0
Meriden	0	9	14	0
Olton	51	26	25	11
St Alphege	131	68	57	17
Shirley East	125	105	48	6
Shirley South	149	88	16	7
Shirley West	9	2	4	3
Silhill	58	32	20	0
Smith's Wood	54	51	58	12
Total	1123	972	720	133

[106] April and May 2021.

Figure 4.52 shows the EHC LNG activity in 2020-21 by pharmacy location. There is a high concentration in Castle Bromwich. In contrast, the wards of Bickenhill, Knowle, and Meriden show little activity.

Figure 4.52: EHC LNG activity in 2020-21 by pharmacy location.



The following table provides a breakdown by pharmacy. The two Boots Pharmacies have both seen decreases.

Figure 4.53: EHC LNG activity by pharmacy.

Provider	2018-19	2019-20	2020-21	2021-22[107]
Bickenhill				
St Marys Pharmacy (Fentham Road)	0	2	0	0
Blythe				
Dudley Taylor Pharmacy (Cheswick Green)	5	1	12	1
MR Pharmacy (Shelly Shopping Centre)	12	6	5	1
Daltons Pharmacy (Dickens Heath)	14	17	16	0
Castle Bromwich				
Lloyds Pharmacy (Branch: 0011 - Chester Road)	50	95	91	16
Saydon Pharmacy (Green Lane)	241	243	246	41
Chelmsley Wood				
Croft Pharmacy (Dudley Taylor Pharmacies Ltd)	18	18	18	3
Boots UK Ltd (Branch: 0217 - Greenwood Way)	112	125	23	7
Asda (Branch: 5881 - CHELMSLEY WOOD)	37	38	33	8
Dorridge and Hockley Heath				
Dorridge Pharmacy, Dudley Taylor Pharmacies Limited (Dudley Taylor Pharmacies Ltd)	11	10	11	0
Elmdon				
Kingshurst and Fordbridge				
Boots Pharmacy (Branch: 5376 - Crabtree Drive)	12	1	0	0
Knowle				
Windridges	3	2	0	0
Lyndon				
Boots (Branch: 6200 - Lyndon Road)	31	33	23	0
Meriden				
Lloyds Pharmacy (Branch: 0642 - The Green)	0	9	14	0
Olton				
Olton Pharmacy; The	10	4	5	3
Gospel Lane Pharmacy	41	22	20	8
St Alphege				
Morrisons Pharmacy (Branch: 261 - George Road)	69	29	43	11
Boots UK Ltd (Branch: 0335 - Mell Square)	49	19	14	6
Superdrug Pharmacy (Branch: 0859 - Solihull-Touchwood)	13	20	0	0
Shirley East				
Northbrook Ltd. (Adam Myers Ltd)	8	9	1	1
Boots UK Ltd (Branch: 2094 - Stratford Road)	52	58	31	3
Lloyds Pharmacy (Branch: 0183 - Union Road)	12	21	16	2
Morrisons Pharmacy (Branch: 399 - Stratford Road)	53	17	0	0
Shirley South				
Lloyds Pharmacy in Sainsburys (Branch: 5160 - Marshall Lake)	3	5	16	7
Boots UK Ltd (Branch: 6580 - Sears Retail Park)	146	83	0	0
Shirley West				
Haslucks Green Pharmacy	9	2	4	3
Silhill				
Late Night Yew Tree Pharmacy	34	25	19	0
Lloyds Pharmacy (Branch: 0046 - Yew Tree)	5	2	1	0
Dovehouse Pharmacy (WM Browns Kinghurst Ltd)	19	5	0	0
Smith's Wood				
WM Brown (Kingshurst) Ltd	54	51	58	12

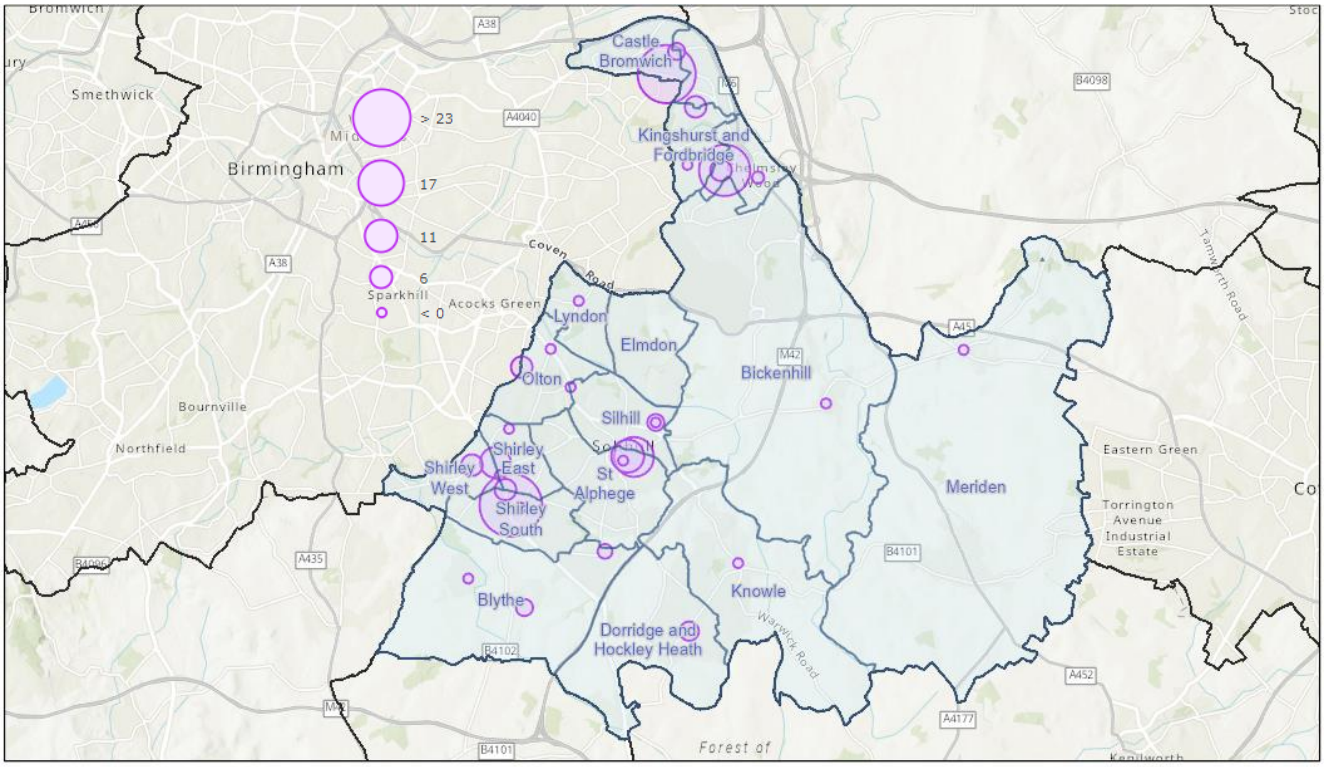
[107] April and May 2021.

ULIPRISTAL ACETATE (UPA)

The following relates to ulipristal acetate 30mg (stage 2) and covers April to May 2021. Data prior to this date was not available.

Figure 4.54 shows the EHC UPA activity in April and May 2021 by pharmacy location. Similar to the LNG activity, there is high concentration to the north of Solihull. Shirley South and St Alphege also show high numbers which are not demonstrated in the LNG data.

Figure 4.54: EHC UPA activity in April and May 2021 by pharmacy location.



The following table provides a breakdown of UPA activity by pharmacy.

Figure 4.55: EHC UPA activity in April and May 2021 by pharmacy.

Provider	2021-22
Bickenhill	
St Marys Pharmacy (Fentham Road)	0
Blythe	
Dudley Taylor Pharmacy (Cheswick Green)	3
MR Pharmacy (Shelly Shopping Centre)	2
Daltons Pharmacy (Dickens Heath)	0
Castle Bromwich	
Lloyds Pharmacy (Branch: 0011 - Chester Road)	21
Saydon Pharmacy (Green Lane)	3
Chelmsley Wood	
Croft Pharmacy (Dudley Taylor Pharmacies Ltd)	1
Boots UK Ltd (Branch: 0217 - Greenwood Way)	18
Asda (Branch: 5881 - CHELMSLEY WOOD)	5
Dorridge and Hockley Heath	
Dorridge Pharmacy, Dudley Taylor Pharmacies Limited (Dudley Taylor Pharmacies Ltd)	4
Elmdon	
Kingshurst and Fordbridge	
Boots Pharmacy (Branch: 5376 - Crabtree Drive)	0
Knowle	
Windridges	0
Lyndon	
Boots (Branch: 6200 - Lyndon Road)	0
Meriden	
Lloyds Pharmacy (Branch: 0642 - The Green)	0
Olton	
Olton Pharmacy; The	0
Gospel Lane Pharmacy	5
St Alphege	
Morrisons Pharmacy (Branch: 261 - George Road)	13
Boots UK Ltd (Branch: 0335 - Mell Square)	10
Superdrug Pharmacy (Branch: 0859 - Solihull-Touchwood)	0
Shirley East	
Northbrook Ltd. (Adam Myers Ltd)	0
Boots UK Ltd (Branch: 2094 - Stratford Road)	9
Lloyds Pharmacy (Branch: 0183 - Union Road)	5
Morrisons Pharmacy (Branch: 399 - Stratford Road)	0
Shirley South	
Lloyds Pharmacy in Sainsburys (Branch: 5160 - Marshall Lake)	23
Boots UK Ltd (Branch: 6580 - Sears Retail Park)	0
Shirley West	
Haslucks Green Pharmacy	5
Silhill	
Late Night Yew Tree Pharmacy	3
Lloyds Pharmacy (Branch: 0046 - Yew Tree)	0
Dovehouse Pharmacy (WM Browns Kinghurst Ltd)	0
Smith's Wood	
WM Brown (Kingshurst) Ltd	5

TIME SINCE UNPROTECTED SEXUAL INTERCOURSE (UPSI)

The following charts show the time since UPSI to LNG / UPI activity.

Figure 4.56: Time since UPSI: LNG activity during April and May 2021.

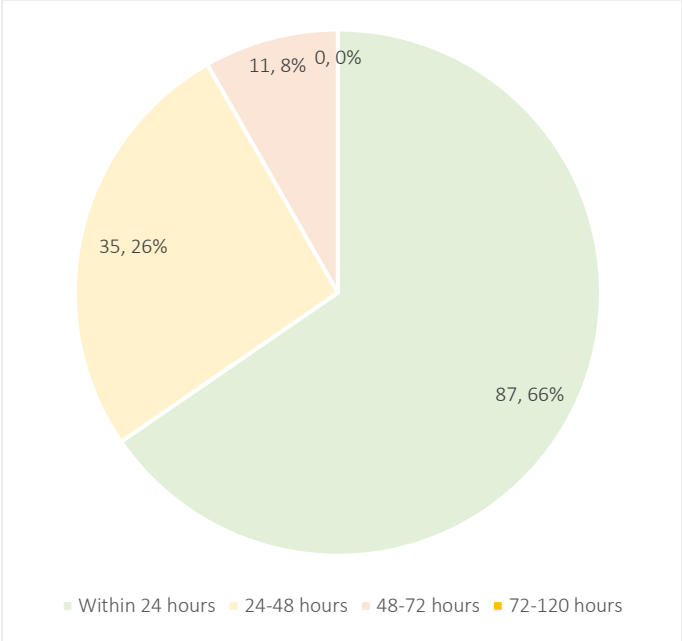
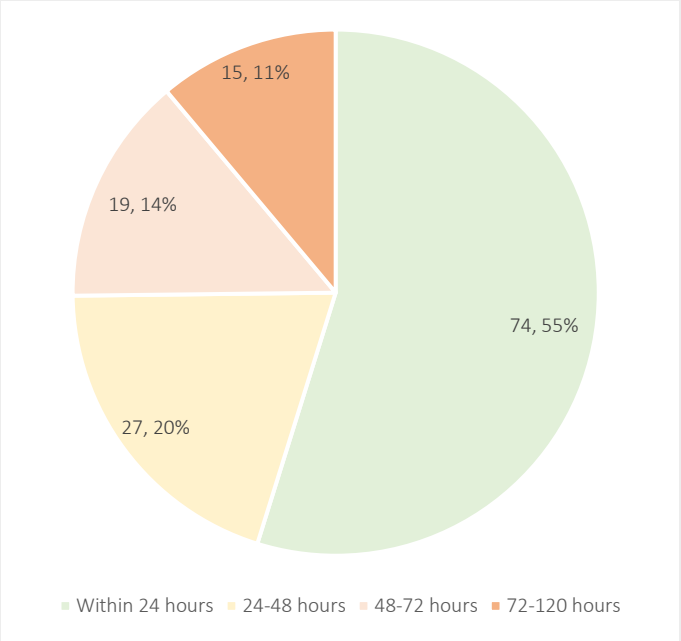


Figure 4.57: Time since UPSI: UPA activity during April and May 2021.



REASON

Unprotected sex account for the majority of the reasons for EHC activity. Failed condom and missed pills rate varies between LNG and UPA activity.

Figure 4.58: Reason for EHC: LNG activity during April and May 2021.

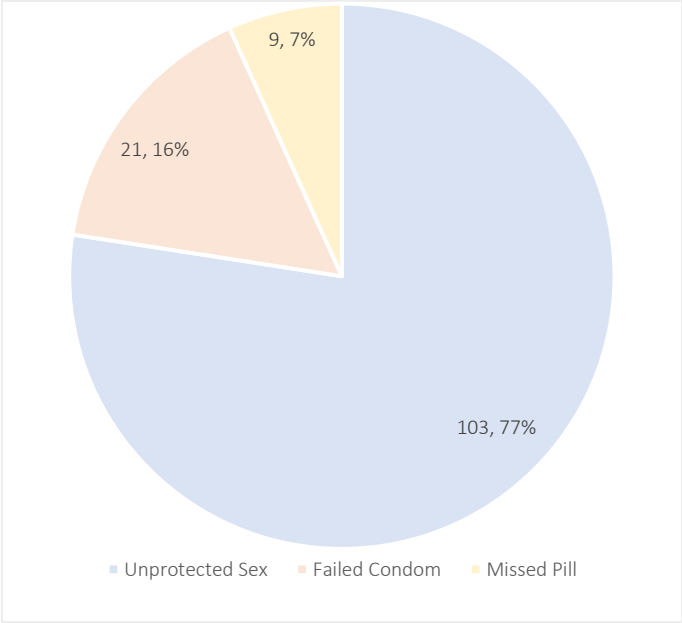
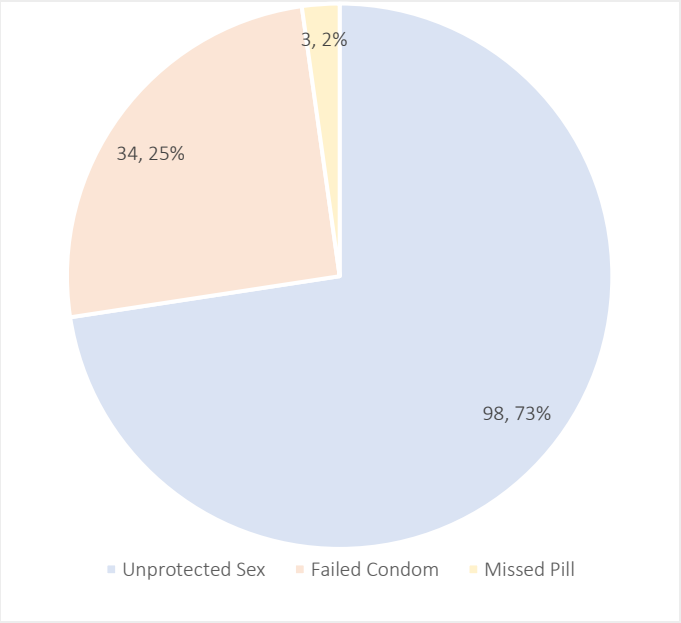


Figure 4.59: Reason for EHC: UPA activity during April and May 2021.



AGE

The analysis by age group shows that there are no significant differences between LNG and UPA activity.

Figure 4.60: EHC activity by age group.

Age Group	LNG #	LNG %	UPA #	UPA %	Total #	Total %
Under 16	2	2%	2	1%	4	1%
16 to 19	36	27%	24	18%	60	22%
20 to 24	24	18%	33	24%	57	21%
25+	71	53%	76	56%	147	55%
Total	133	-	135	-	268	-

ETHNICITY

Analysis EHC activity for LNG and UPA by ethnicity show some differences:

- There is a higher rate of Asian or Asian British using UPA in comparison LNG.
- Conversely, there is a higher rate of those of White ethnicity using LNG in comparison to UPA.

Figure 4.61: EHC activity by ethnicity.

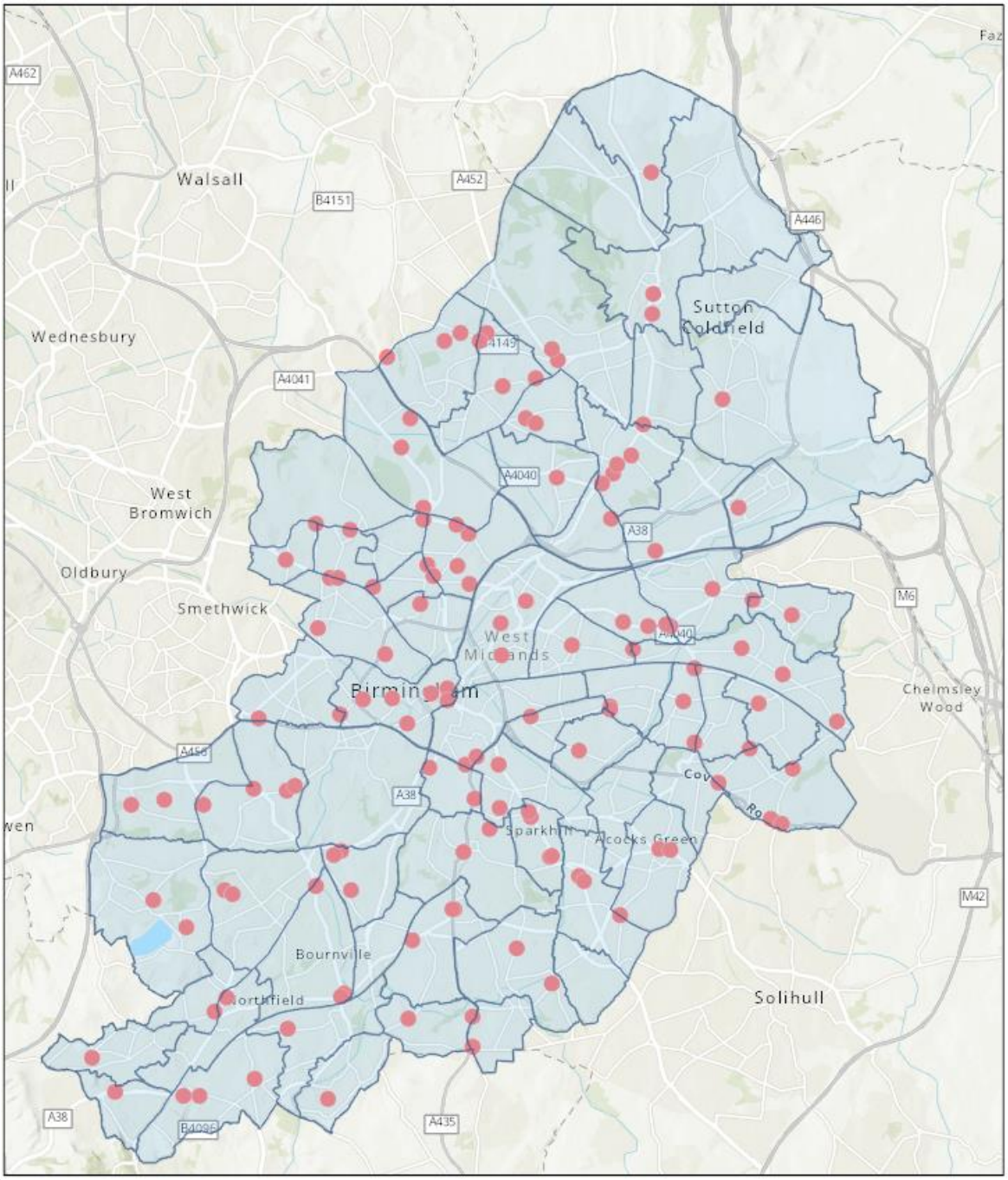
Ethnicity	LNG #	LNG %	UPA #	UPA %	Total #	Total %
Asian or Asian British	8	6%	26	19%	34	13%
Black or Black British	9	7%	10	7%	19	7%
Mixed	5	4%	2	1%	7	3%
White	104	78%	84	62%	188	70%
Any other ethnic group	1	1%	1	1%	2	1%
Not stated	6	5%	12	9%	18	7%
Total	133	-	135	-	268	-

BIRMINGHAM

LOCATIONS

In Birmingham, EHC is available free of charge from pharmacies partnered with Umbrella. In addition to EHC, Umbrella-partnered pharmacies also provide a range of sexual health interventions and information. Between April 2020 and March 2021, there was EHC activity across 132 pharmacies in Birmingham. The following map shows the locations of these pharmacies.

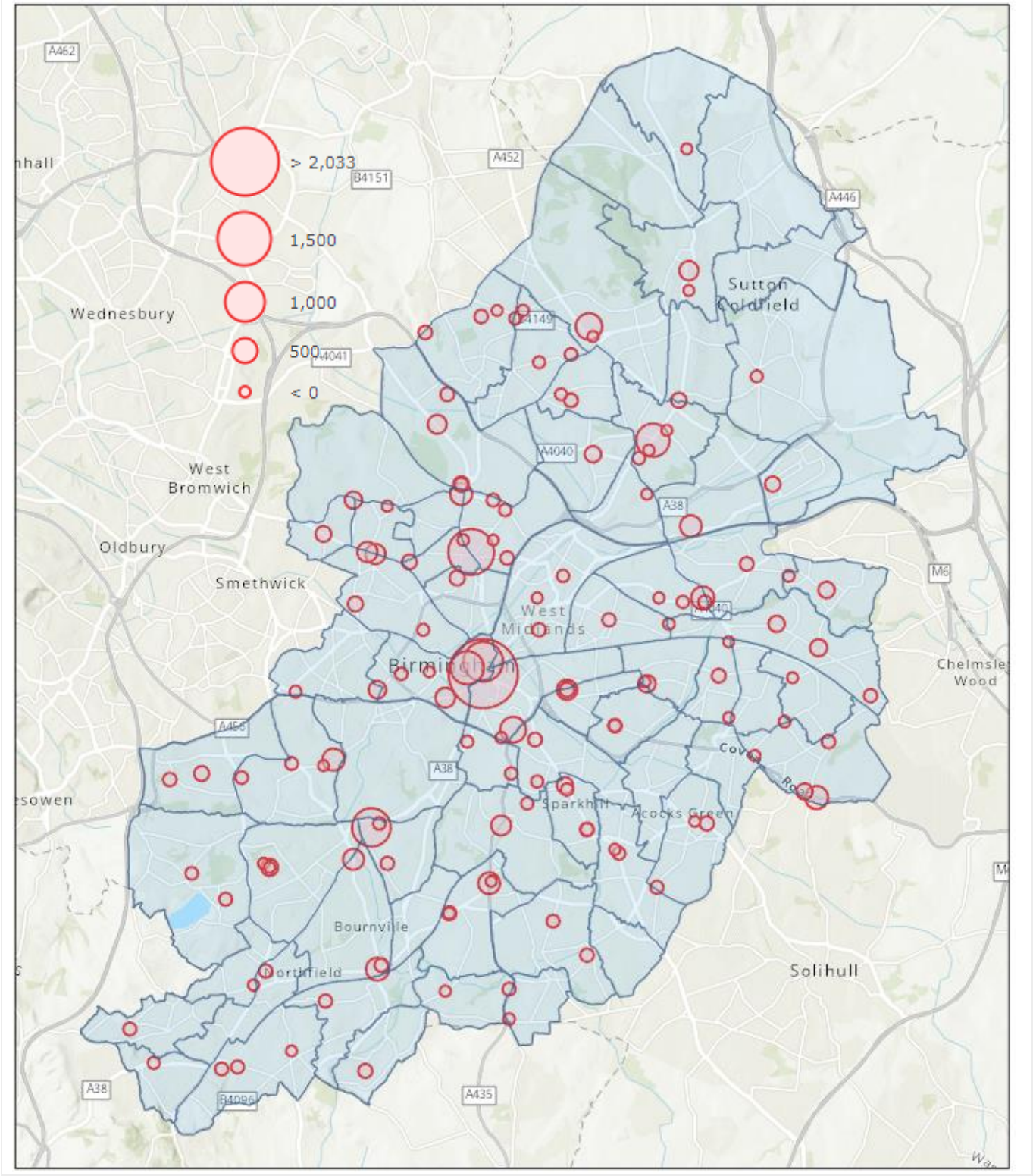
Figure 4.62: Locations of pharmacies with EHC activity between April 2020 and March 2021.



The map shows a high concentration in the City Centre with Boots in the Bullring accounting for 10% of the activity. There are an additional two Boots in close proximity to the Bullring which combined accounted for 9% of the total.

There is low activity towards the north of Birmingham.

Figure 4.63: EHC activity in 2020-21 by pharmacy location.



VASECTOMIES AND STERILISATIONS

Between 2019-20 and 2020-21, there was a reduction in vasectomy consultations and vasectomies in both Birmingham and Solihull. The number of vasectomies was impacted by the halting of elective NHS surgeries for part of the COVID-19 pandemic period.

Figure 4.64: Vasectomy Consultations – Birmingham, by age

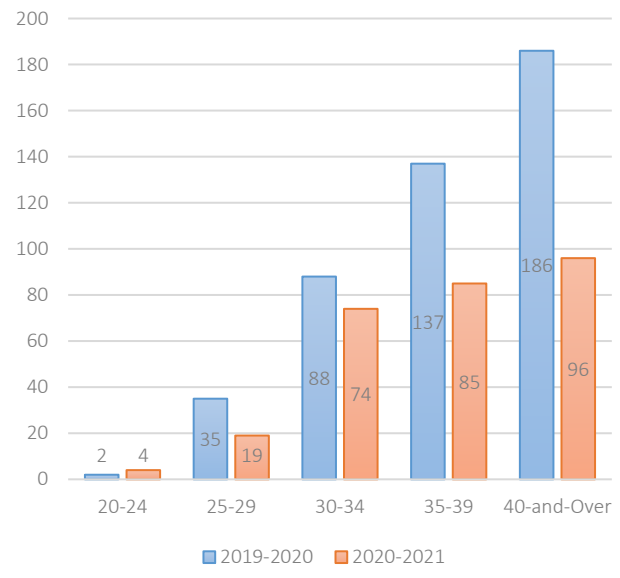


Figure 4.65: Vasectomy Consultations – Solihull, by age

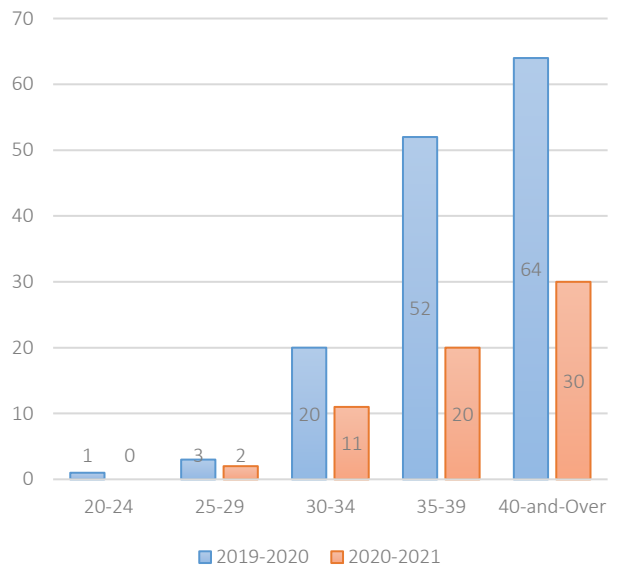


Figure 4.66: Vasectomies – Birmingham, by age

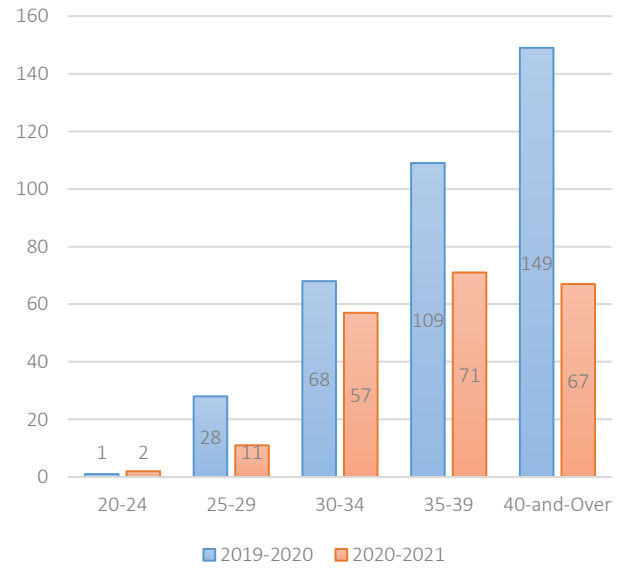


Figure 4.67: Vasectomies – Solihull, by age

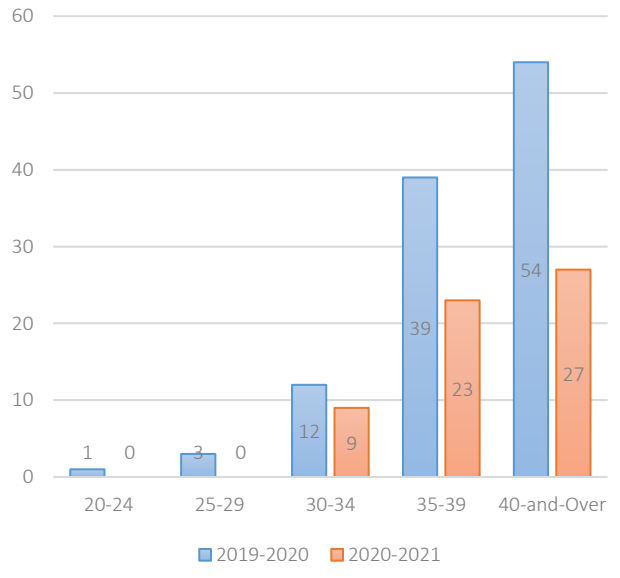


Figure 4.68: Reduction in total consultations 2019-20 to 2020-21

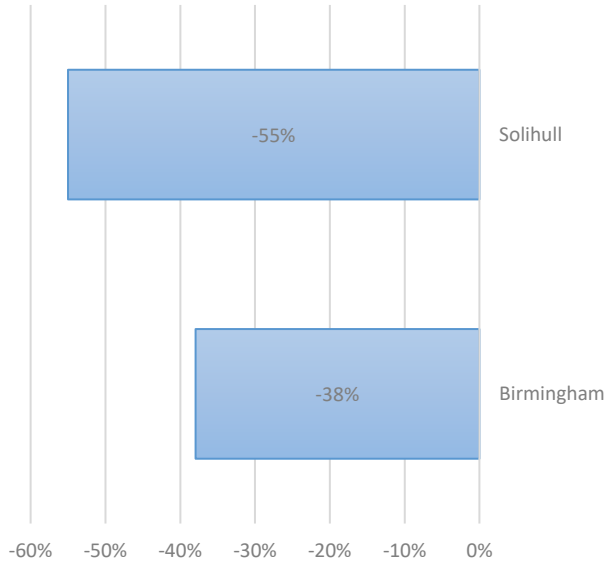
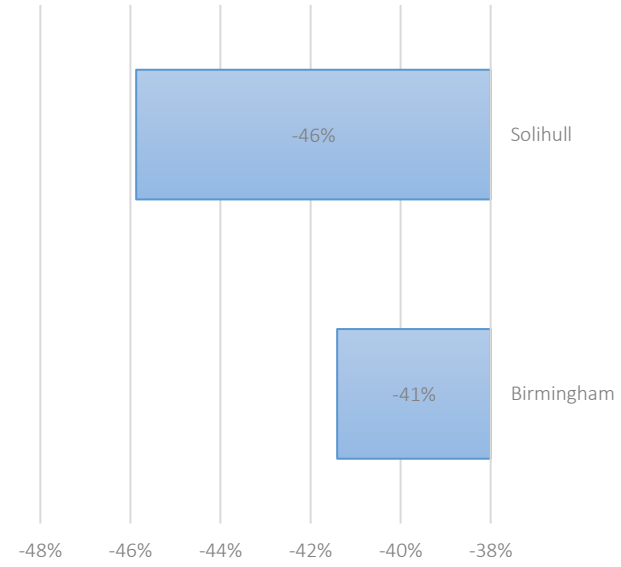


Figure 4.69: Reduction in total vasectomies 2019-20 to 2020-21



POSTNATAL CONTRACEPTION

The provision of postnatal contraception can prevent rapid repeat pregnancies, which are associated with worse outcomes for mother and child[108] such as premature birth, lower birth weight and neonatal death. [109]

With almost one in 13 women presenting for abortion or delivery having conceived within 1 year of giving birth[110], providing long-acting reversible contraception (LARC) to new mothers also reduces the likelihood of abortion in the 1-2 years following childbirth.[111]

Providing postpartum contraception and advice in postnatal wards, where it is currently rare, could help reach more vulnerable groups, including women with drug, alcohol or mental health problems, who may not attend for routine postnatal care or proactively seek contraception. [112]

BEST PRACTICE

According to NICE: "Supporting women to make an informed choice about contraception after childbirth will reduce the risk of future unplanned pregnancies. Advice and information should be given as soon as possible after delivery, and within the first week, because fertility may return quickly, including in women who are breastfeeding. Providing advice about contraception after childbirth also helps avoid the risk of complications associated with an interpregnancy interval of less than 12 months."[113]

The Faculty of Sexual and Reproductive Healthcare recommends that "Maternity services (including services providing antenatal, intrapartum and postpartum care) should give women opportunities to discuss their fertility intentions, contraception and preconception planning" and that "Maternity service providers should ensure that all women after pregnancy have access to the full range of contraceptives, including the most effective LARC methods, to start immediately after childbirth."[114]

UNMET NEEDS

NICE quality standards on contraception recommend that women who give birth are given information about, and offered a choice of, all contraceptive methods by their midwife within seven days of delivery. [115][116] However, provision of postpartum contraception and advice is patchy, and it is rare in postnatal settings. [117] In a 2018 patient survey, 12% of new mothers were not given information or offered advice from a health professional about contraception.[118]

Issues causing this unmet need include:

- Lack of training and support for midwives and nurses[119]

---

[108] Public Health England (2018), Case study: Understanding the contraceptive needs of postnatal women.
[109] FSRH (2017), FSRH Guideline: Contraception after pregnancy. Amended October 2020.
[110] FSRH (2017), FSRH Guideline: Contraception after pregnancy. Amended October 2020.
[111] Karin Lichtenstein Liljeblad, Helena Kopp Kallner & Jan Brynhildsen (2020) Risk of abortion within 1–2 years after childbirth in relation to contraceptive choice: a retrospective cohort study, The European Journal of Contraception & Reproductive Health Care, 25:2, 141-146, DOI: 10.1080/13625187.2020.1718091
[112] Thwaites A, et al (2018), Immediate postnatal contraception: what women know and think. BMJ Sex Reprod Health 2018;0:1–7.
[113]NICE (2016), Quality standard [QS129], Quality statement 4: Contraception after childbirth.
[114] FSRH (2017), FSRH Guideline: Contraception after pregnancy. Amended October 2020.
[115]NICE (2016), Quality standard [QS129], Quality statement 4: Contraception after childbirth.
[116] NHS Patient Survey Programme (2019), 2018 survey of women's experiences of maternity care: Statistical release
[117] All Party Parliamentary Group on Sexual and Reproductive Health in the UK (2020), Women's Lives, Women's Rights: Strengthening Access to Contraception Beyond the Pandemic
[118] NHS Patient Survey Programme (2019), 2018 survey of women's experiences of maternity care: Statistical release
[119] All Party Parliamentary Group on Sexual and Reproductive Health in the UK (2020), Women's Lives, Women's Rights: Strengthening Access to Contraception Beyond the Pandemic

- Postnatal contraception only being commissioned between 9-5, and unavailable for women who deliver out of hours[120]
- During the COVID-19 pandemic, access to sexual health and primary care contraceptive services have been significantly reduced[121]
- One study found that almost half of women would welcome provision of postnatal contraception on the postnatal ward, but that women currently lack the knowledge to make informed choices in this setting – for example, falsely believing that LARC is not safe while breastfeeding. [122]

CURRENT PROVISION

At the time of this assessment, there was no formal approach to postnatal contraception in Birmingham. During the COVID-19 pandemic, as sexual health practitioners were redeployed across other hospital services, including maternity services, some postnatal contraception services were implemented in Birmingham Women's Hospital. Practitioners completing the postnatal contraception treatments reported that there was good uptake of contraception despite resource limitations.

Some initial findings from the initial postnatal contraception offerings were that pathways for ongoing care for postnatal contraceptives were complex and involved multiple practitioners and services including:

- Obstetricians
- Labour ward midwives
- Community midwives
- GPs
- Sexual health practitioners

Any formalised post-natal contraception service will require a partnership approach that covers antenatal counselling, initial consultations, fitting of contraceptives, and any ongoing follow-up work that is required to ensure patient safety and efficacy of the contraceptive.

There are examples of successful implementation of immediate postpartum intrauterine contraception services in Edinburgh[123], Cardiff[124], Leeds[125], and Lewisham[126]. In July 2021, Public Health England released a contraception return on investment tool, which included offering contraception in maternity settings. The tool includes the following estimate:

Offering contraception in all maternity services in England would require an estimated £31 million to be spent in maternity services over one year. This would be a net increase of £24 million in total contraception spend by the NHS. By contrast, overall cost savings to the system as a result of the intervention would be far greater at an

[120] All Party Parliamentary Group on Sexual and Reproductive Health in the UK (2020), Women's Lives, Women's Rights: Strengthening Access to Contraception Beyond the Pandemic

[121] RCOG (2021), Guidance on the provision of contraception by maternity services after childbirth during the COVID-19 pandemic, Version 1: Published Wednesday 3 February 2021.

[122] Thwaites A, et al (2018), Immediate postnatal contraception: what women know and think. BMJ Sex Reprod Health 2018;0:1–7.

[123] Cameron ST, Craig A, Sim J, Gallimore A, Cowan S, Dundas K, Heller R, Milne D, Lakha F. Feasibility and acceptability of introducing routine antenatal contraceptive counselling and provision of contraception after delivery: the APPLES pilot evaluation. BJOG. 2017 Dec;124(13):2009-2015. doi: 10.1111/1471-0528.14674. Epub 2017 May 19. PMID: 28380288.

[124] BMJ Sexual & Reproductive Health 2019; 45 1-2 Published Online First: 08 Jan 2019. doi: 10.1136/bmjsrh-2018-200292

[125] Crow M, Walker V, Braunholtz-Speight J, et al, Improving the provision of postnatal contraception within inpatient wards: a UK pilot study. BMJ Sexual & Reproductive Health 2020;46:313.

[126] Thwaites A, Logan L, Nardone A, et al. BMJ Sex Reprod Health Published Online First: [please include Day Month Year]. doi:10.1136/bmjsrh-2018-200078

estimated £150 million, split between the NHS (£59 million), local authorities (£9 million) and other government departments (£82 million). These figures represent the estimated savings from avoiding unintended pregnancies. Overall, it is estimated that for every additional £1 invested, postnatal contraception could lead to savings of £30 over a 10-year period for the system as a whole.[127]

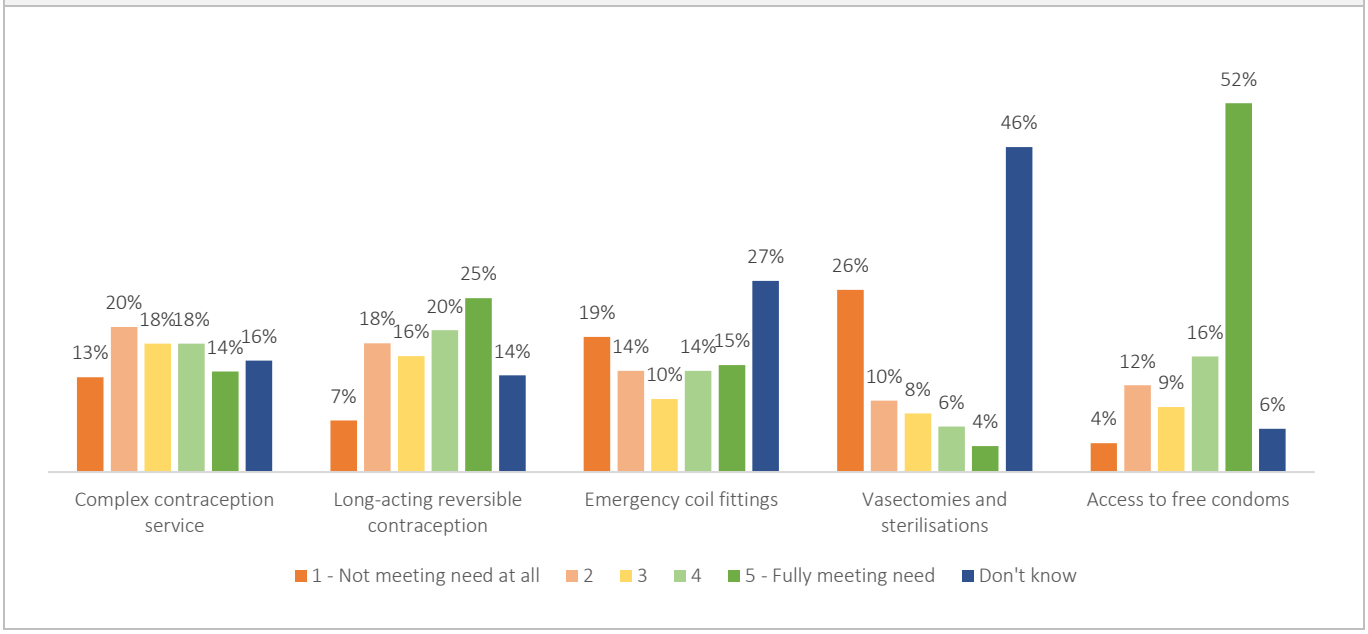
ENGAGEMENT

PRACTITIONER SURVEY

Practitioners were asked if current provision relating to contraception was meeting need. 130 practitioners across a range of services responded.

- There was a feeling that emergency coil fittings (19% - not meeting need at all) and vasectomies and sterilisations (26% - not meeting need at all) were not meeting need.
- 46% of respondents did not know if vasectomies and sterilisations were meeting need, indicating a knowledge gap.
- Access to free condoms was meeting need (52% - fully meeting needs).

Figure 4.70: In relation to contraception, on a scale of 1 to 5, how well are the following sexual health needs of those you work with being met? (Please answer based on the service offering before the COVID-19 pandemic (before March 2020))



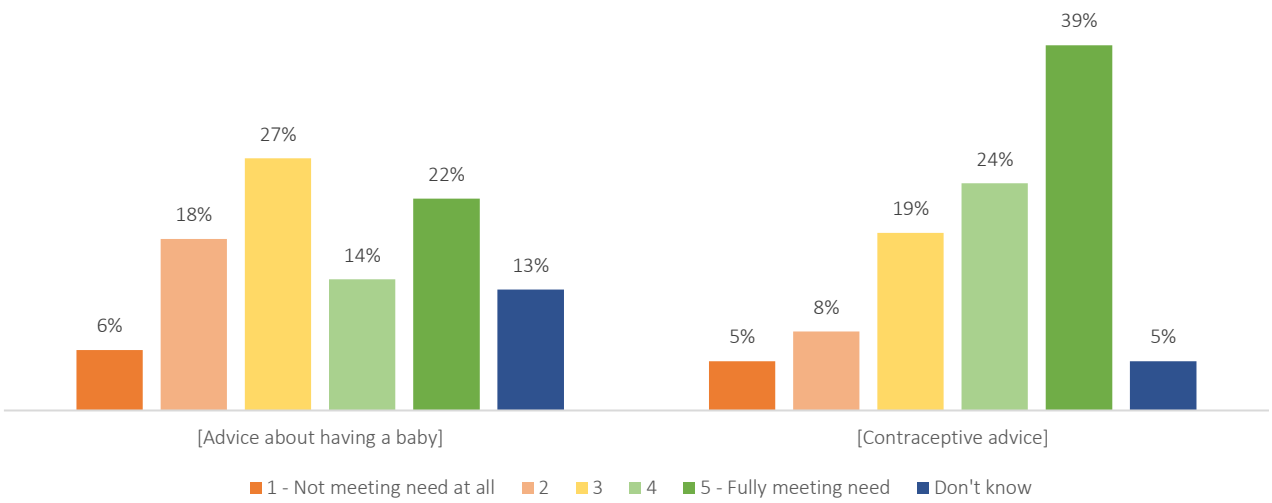
Practitioners were asked if there was appropriate information and advice relating to various areas of sexual health. Below are the responses for the areas relating to Reproductive Health.

63% of respondents scored contraception advice as 4 or 5 out of 5 in terms of meeting need.

Advice about having a baby received lower scores. 24% of respondents scored the current service response as 1 or 2 out of 5.

[127] PHE, (2021), Extending Public Health England's contraception return on investment tool Maternity and primary care settings

Figure 4.71: In relation to advice and information, on a scale of 1 to 5, how well are the following sexual health needs of those you work with being met?



COMMUNITY SURVEY

As part of this needs assessment, a community survey was run exploring the sexual health needs of the populations of Birmingham and Solihull. The survey also explored the populations' experiences of sexual health services.

In total there were 106 responses. Demographics for those who completed the survey can be found on page 228.

CONTRACEPTION SERVICES

Respondents were asked where they would go for various contraception services.

For emergency contraception and condoms, local pharmacies scored the highest.

GPs scored the highest for LARCs.

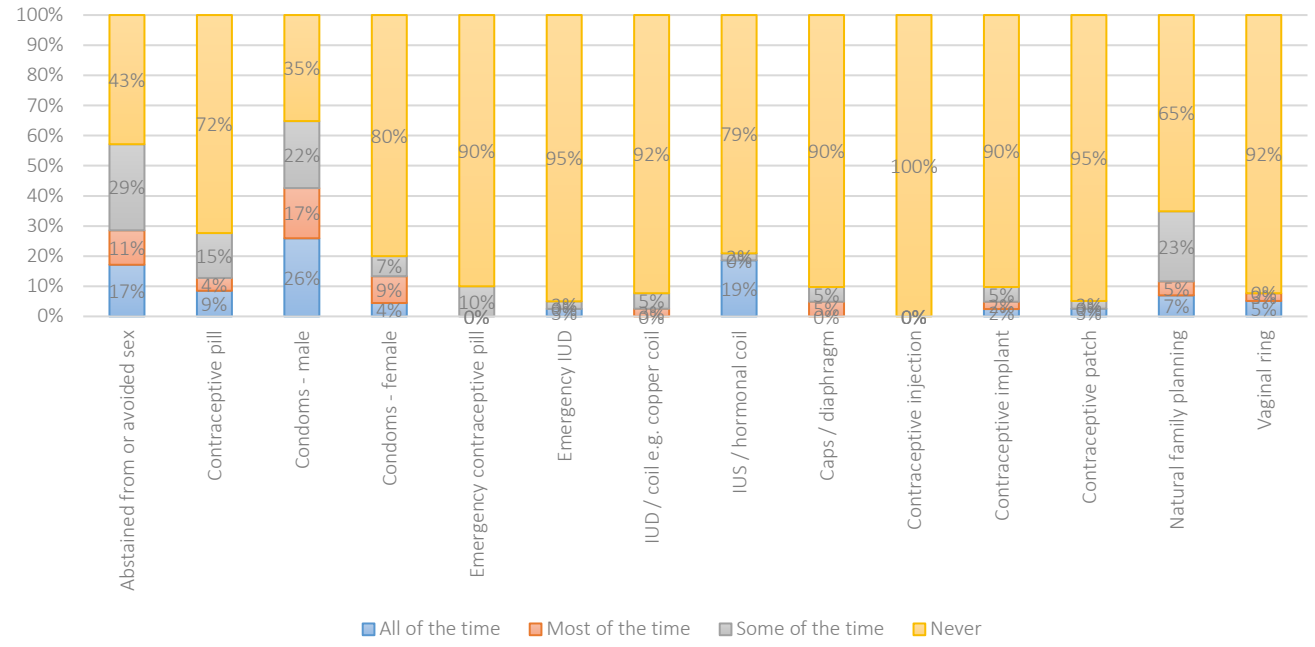
Figure 4.72: For the following contraception services, where would you go for help?

	To receive a contraceptive	Long-acting reversible contraception	Emergency contraception	Condoms	Vasectomies and sterilisations
GP	62%	50%	31%	23%	54%
Local pharmacy	28%	8%	49%	52%	2%
Pharmacy further away	8%	3%	16%	12%	1%
A Sexual Health clinic	42%	32%	41%	47%	18%
Specialist services	15%	10%	16%	21%	11%
Umbrella website	16%	14%	14%	20%	11%
Other website	8%	4%	5%	10%	4%
Social media	5%	2%	3%	5%	2%
Telephone helpline	4%	3%	7%	8%	5%
School / College / Uni	7%	3%	6%	9%	2%
Friends/ family	6%	2%	3%	6%	2%
Don't know	3%	2%	3%	3%	7%
Other	3%	1%	2%	8%	3%

Respondents were asked which methods of contraception they had used in the last 12 months.

- Of the methods asked about, most respondents used condoms (male) as their contraception method.

Figure 4.73: In the last 12 months, did you use any of the following contraception methods?



	Abstained from or avoided sex	Contraceptive pill	Condoms - male	Condoms - female	Emergency contraceptive pill	Emergency IUD	IUD / coil e.g., copper coil	IUS / hormonal coil	Caps / diaphragm	Contraceptive injection	Contraceptive implant	Contraceptive patch	Natural family planning	Vaginal ring
All of the time	12	4	14	2	0	1	0	8	0	0	1	1	3	2
Most of the time	8	2	9	4	0	0	1	0	2	0	1	0	2	1
Some of the time	20	7	12	3	4	1	2	1	2	0	2	1	10	0
Never	30	34	19	36	36	38	36	34	37	39	37	37	28	36
Sub Total	**70**	**47**	**54**	**45**	**40**	**40**	**39**	**43**	**41**	**39**	**41**	**39**	**43**	**39**

ABORTION

INTRODUCTION

BEST PRACTICE

The Royal College of Obstetricians and Gynaecologists recommends that:[128]

- Women should be informed about their pregnancy options so that they can make an informed choice about their preferred course of action.
- All women who require more support in deciding whether to continue the pregnancy or have an abortion should be identified and offered further opportunities to discuss their decision.
- Before they leave the healthcare facility, all women should receive contraceptive information and, if desired, the contraceptive method of their choice. If the chosen method is not available, they should be referred to a service where the method can be provided
- Before leaving the facility, women should receive instructions about how to care for themselves after they go home.

KEY GUIDANCE

Key guidance for abortion care includes:

- NICE guideline [NG140]: Abortion care covers care for women of any age (including girls and young women under 18) who request an abortion.[129]
- NICE Quality Standard [QS199]: Abortion care covers care for women of any age (including girls and young women under 18) who request an abortion. It describes high-quality care in priority areas for improvement.[130]

At the end of 2018, the government amended the approval for the class of place where abortion drugs can be administered for the second stage of early medical abortion to include the place in England where a pregnant woman has her permanent address or usually resides.

- The Royal College of Obstetricians and Gynaecologists (RCOG) / Faculty of Sexual & Reproductive Healthcare (FSRH) / British Society of Abortion Care Providers (BSACP) have published Clinical Guidelines for Early Medical Abortion at Home – England[131]
- In response to the COVID-19 pandemic the Department of Health and Social Care has issued temporary approval of home use for both stages of early medical abortion.[132]

[128] RCOG (2015), Best practice in comprehensive abortion care.
[129] NICE (2019), Abortion care. NICE guideline [NG140]. Published: 25 September 2019
[130] NICE (2021), Abortion care. Quality standard [QS199] Published: 26 January 2021.
[131] Royal College of Obstetricians and Gynaecologists (RCOG) / Faculty of Sexual & Reproductive Healthcare (FSRH) / British Society of Abortion Care Providers (BSACP): Clinical Guidelines for Early Medical Abortion at Home – England (2018).
[132] Department of Health and Social Care and The Rt Hon Matt Hancock MP, Temporary approval of home use for both stages of early medical abortion, 30 March 2020.

KEY DRIVERS

Women living in more deprived areas are more likely to have abortions than women living in less deprived areas. The rate in the most deprived decile is 26.1 per 1000 women, which is more than double the rate in the least deprived decile of 12.0 per 1000 women.[133]

In 2019, there were 207,384 abortions for women resident in England and Wales, the highest number since the Abortion Act was introduced in 1967. The abortion rate for women aged under 18 remained the same as in 2018 (8.1 per 1,000) but increased for women over 35 (from 9.2 to 9.7 per 1,000 between 2018 and 2019).[134]

The British Pregnancy Advisory Service (BPAS) believes economic uncertainty and the shift towards smaller family sizes are significant factors in the increased abortion rate. It recommends that contraception services must better meet the needs of older women – particularly access to emergency contraception and after a baby.[135]

A 2017 report from LSE reinforces this view: "The number of abortions still undertaken is an indicator of the potential price of failing to provide good quality sexual and reproductive health care, and of the importance of providing effective contraception to all women able to benefit from it."[136]

COVID-19

During COVID-19, exceptional approval was given for remote consultations and postal medication for early medical abortions (under 10 weeks gestation). A consultation has taken place on whether to make these changes permanent; the outcome of this consultation is pending.[137]

Figures 4.88 and 4.89 below show that there was an increase in abortions in the first 7 weeks of pregnancy in both Birmingham and Solihull.

[133] Department of Health and Social care: Abortion statistics for England and Wales: 2019.
[134] Department of Health and Social care: Abortion statistics for England and Wales: 2019.
[135] BPAS: Unplanned pregnancy among older women reflected in increased abortion rate. Press release 11 June 2020.
[136] LSE (2017), Improving access to contraception.
[137] DHSE, (2020), Home use of both pills for early medical abortion up to 10 weeks gestation

ABORTION ACTIVITY[138]

The following data is from the latest available published by the ONS.

At 29%, the percentage of conceptions leading to abortion for Solihull residents is an increase on previous years and is the highest rate across the analysed time-series. This rate is higher than both England and Birmingham.

Historically, Solihull has reported high rates in comparison to the England average. At 69% in 2019, this continues to be the case. The rate for the under-18 group in Birmingham continues to be lower than the England average.

Figure 4.74: Percentage of conceptions leading to abortion (all ages); Birmingham.

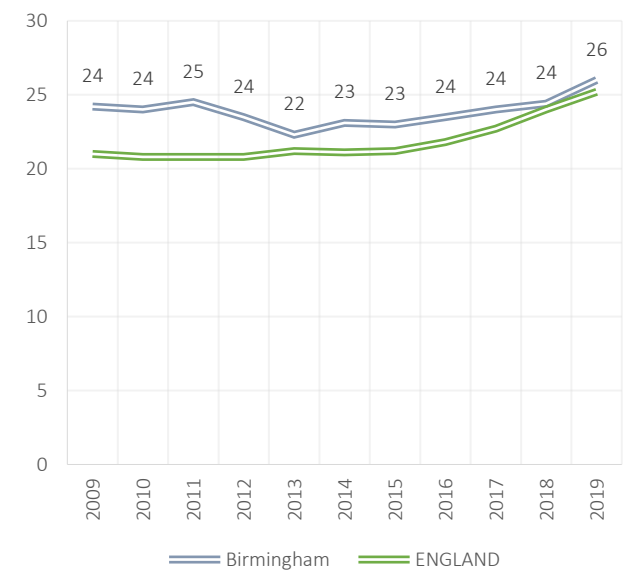


Figure 4.75: Percentage of conceptions leading to abortion (all ages); Solihull.

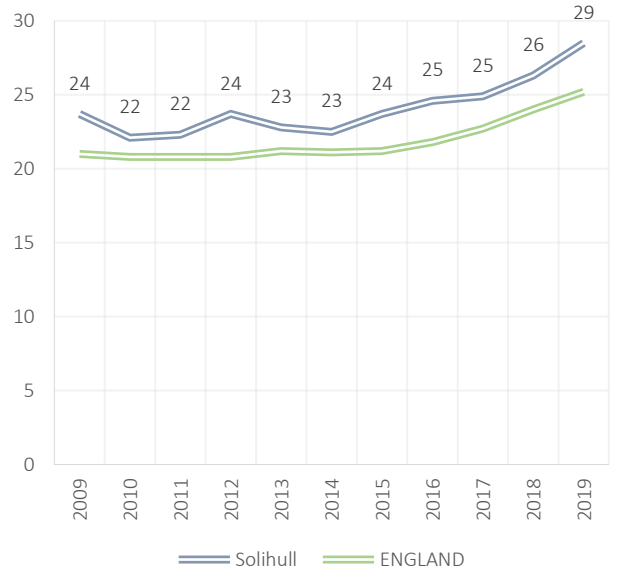


Figure 4.76: Percentage of conceptions leading to abortion (under-18); Birmingham.

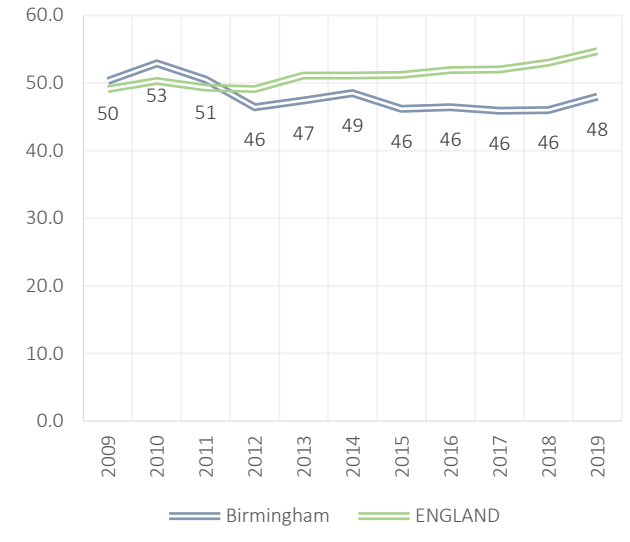
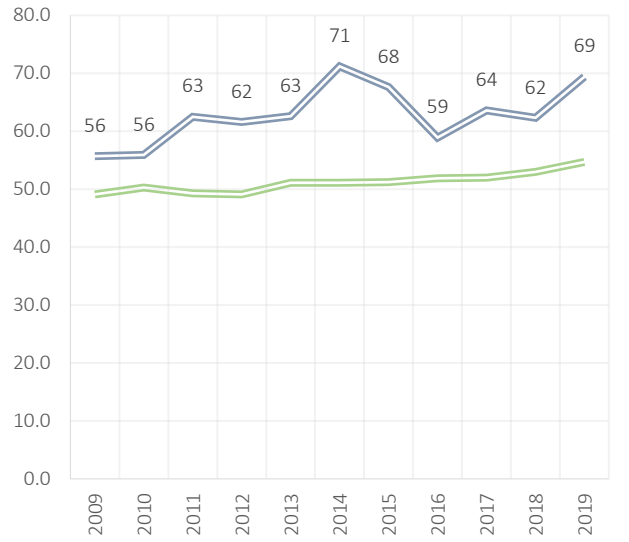


Figure 4.77: Percentage of conceptions leading to abortion (under-18); Solihull.



[138] ONS

ABORTIONS DURING COVID-19

Department of Health and Social Care report, Abortion statistics during the coronavirus pandemic January to June 2020 found that:

- Between January and June 2020, there were 109,836 abortions performed on residents of England and Wales. This compares with 105,540 over the same period in 2019.
- Between January and June 2020, medical abortions accounted for 82% of abortions. This compares with 72% of abortions over the same period in 2019.
- Between April and June 2020, there were 23,061 medical abortions where both medicines (antiprogesterone and prostaglandin) were administered at home; this represents 43% of abortions during this time. The percentage of abortions using this method increased between April and June, accounting for 33% of abortions in April and increasing to 51% of abortions in June.
- Between January and June 2020, 86% of abortions were performed at under 10 weeks. This compares with 81% in January to June 2019, an increase of 5 percentage points.
- Almost 50% of abortions were performed before 7 weeks from January to June 2020, compared to almost 40% for the same period in 2019.

Figures for Birmingham and Solihull are found below.

ABORTION CONSULTATIONS AND COUNSELLING

- The following analysis is based on local data.
- There were slight reductions in abortion/Termination of Pregnancy (TOP) consultations in both Birmingham and Solihull.
- The 25-29 and 30-34 age bands saw increases in both Birmingham and Solihull.

Figure 4.78: All Consultations – Birmingham, by age

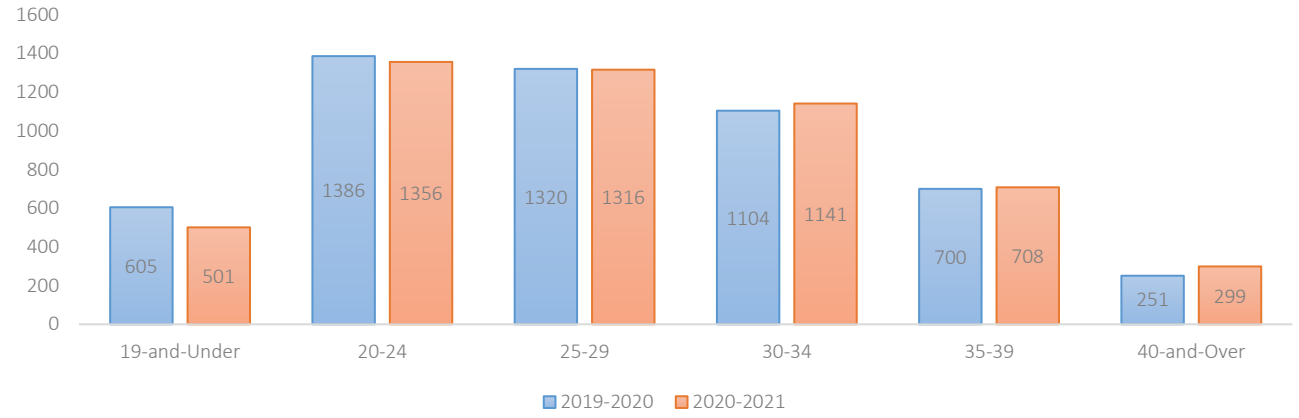


Figure 4.79: All Consultations – Solihull, by age

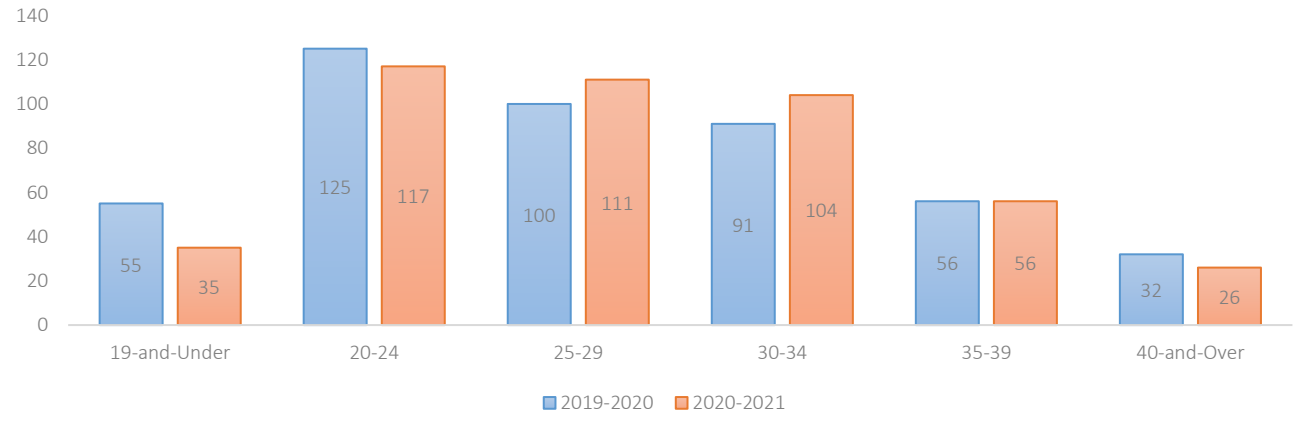


Figure 4.80: All Consultations - Birmingham

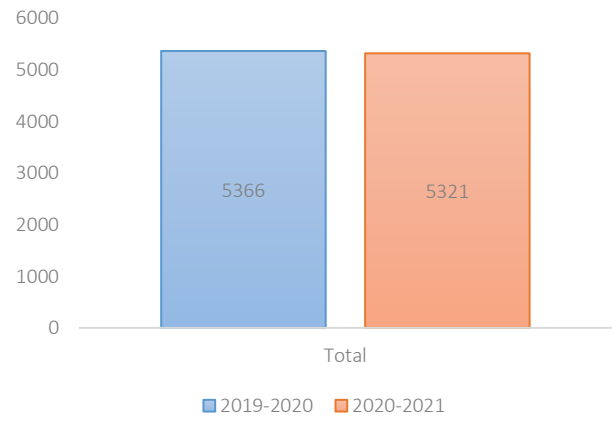
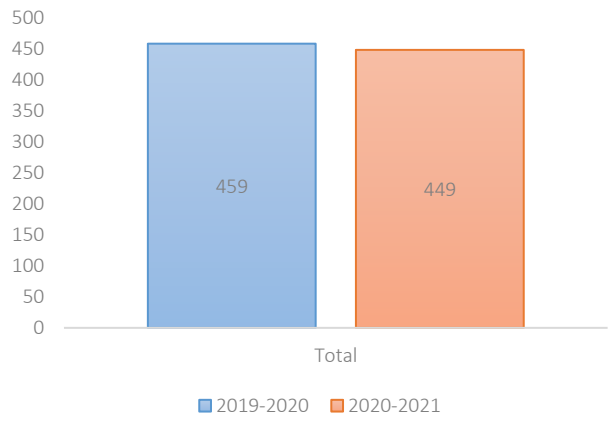


Figure 4.81: All Consultations - Solihull



- COVID-19 impacted the delivery of consultations. There has been a decrease in face-to-face consultations and an increase in telephone consultations.

Figure 4.82: Abortion Consultations/Counselling – Birmingham, type *(TOP = Termination of Pregnancy)

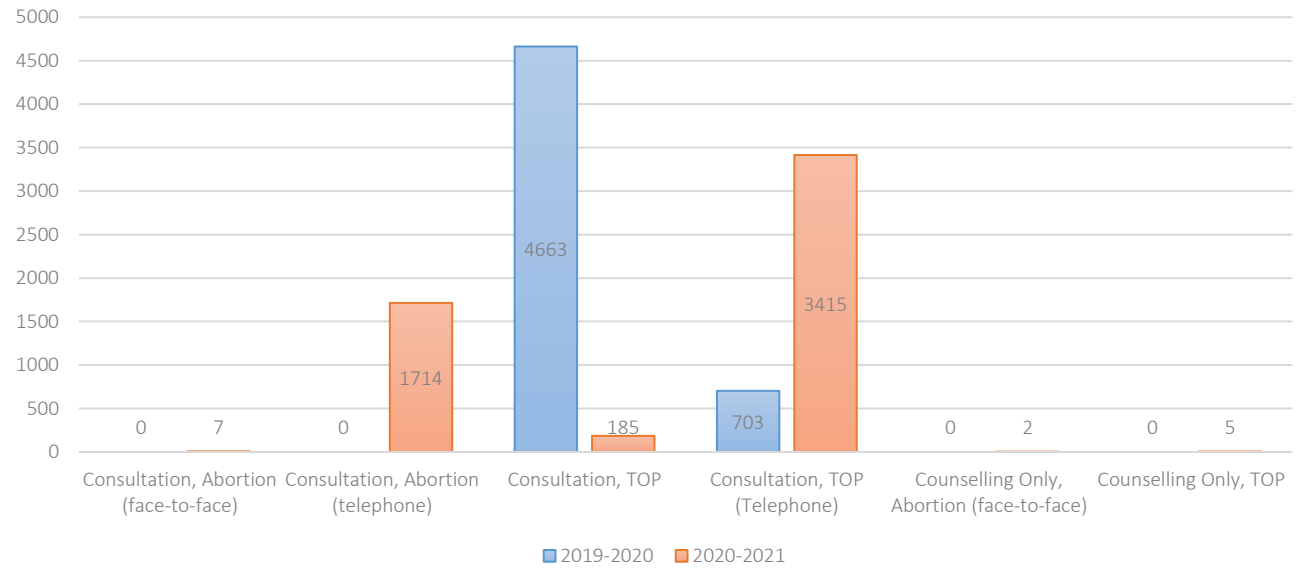
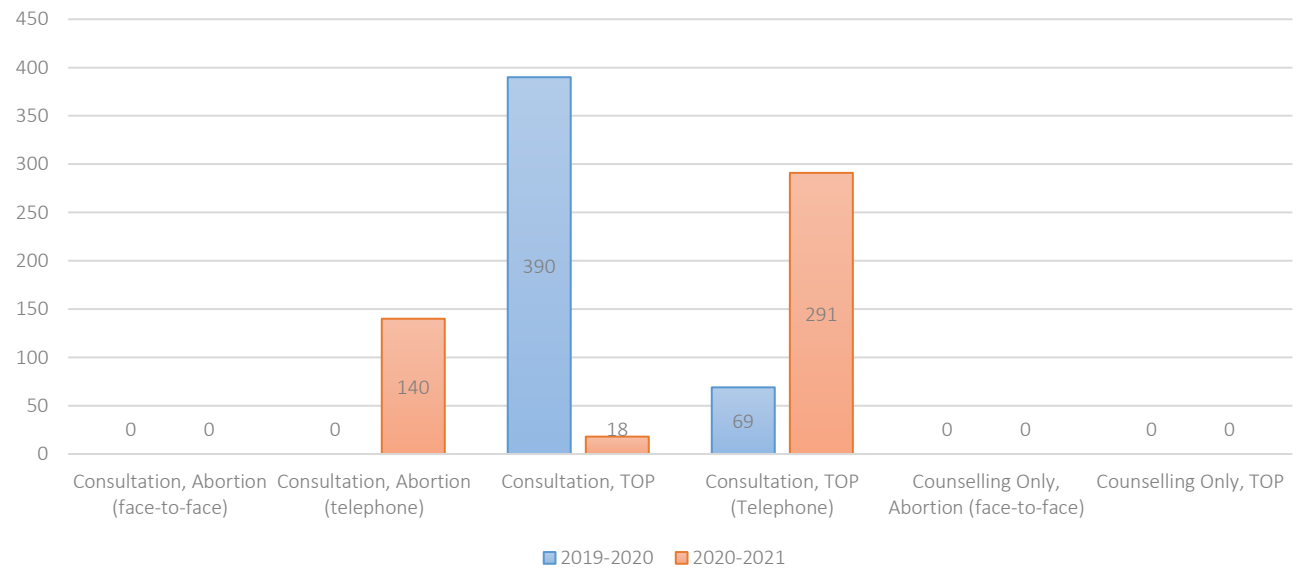


Figure 4.83: Abortion Consultations/Counselling - Solihull, type *(TOP = Termination of Pregnancy)



- In total, there were increases in TOPs in both Birmingham and Solihull.
- In both areas, there was a decrease in the number of TOPs for those aged 19 and under.

Figure 4.84: All Termination of Pregnancies – Birmingham, by age

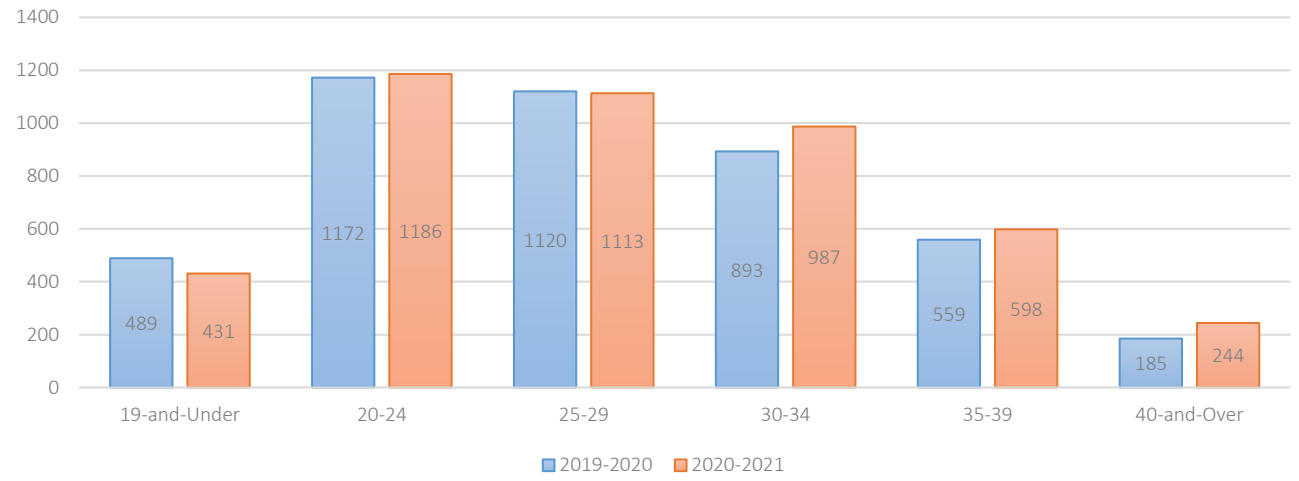


Figure 4.85: All Termination of Pregnancies – Solihull, by age

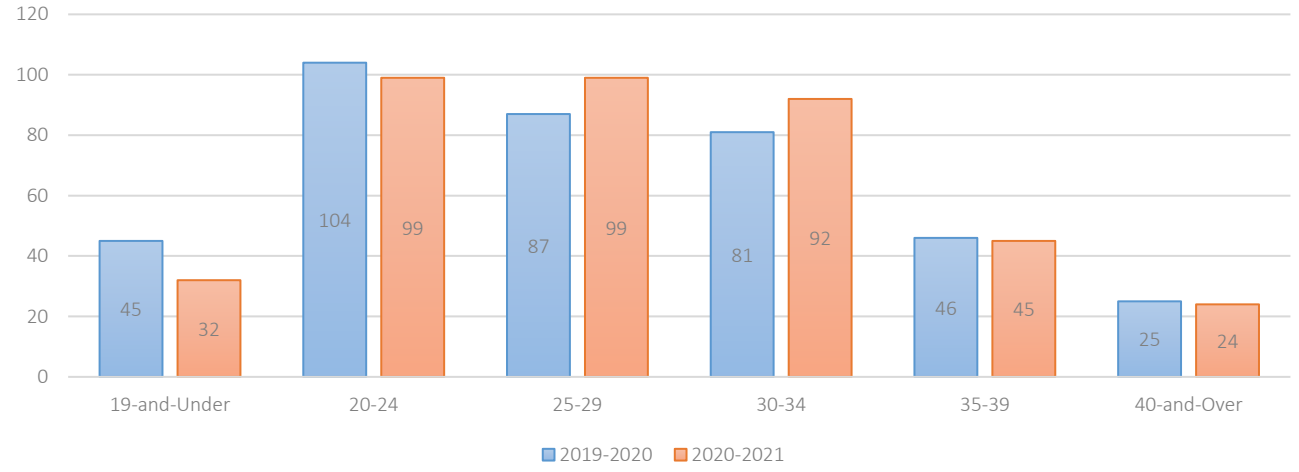


Figure 4.86: All Termination of Pregnancies - Birmingham

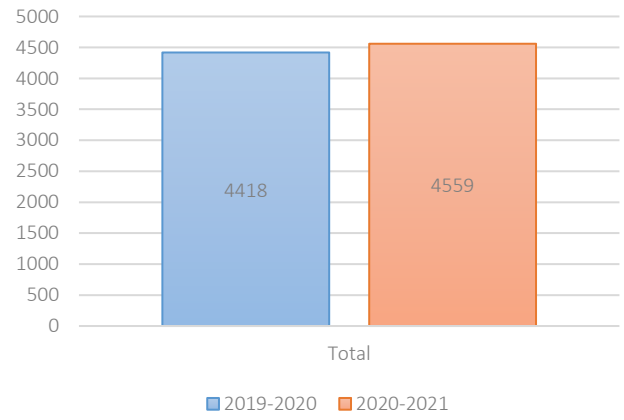
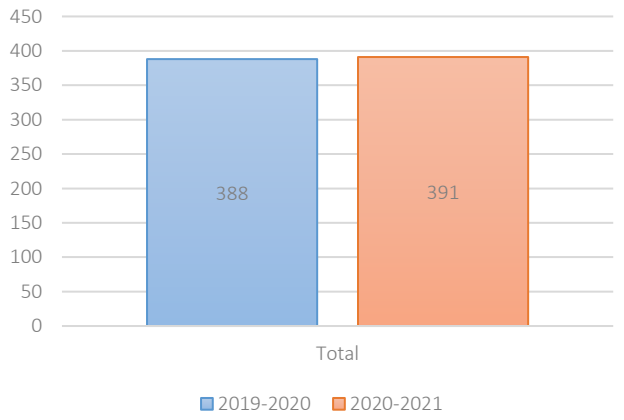


Figure 4.87: All Termination of Pregnancies - Solihull



- During COVID-19, exceptional approval was given for remote consultations and postal medication for early medical abortions.
- As reflected in national data, there has been an increase in the number of terminations of pregnancies that took place within the first 7 weeks of pregnancy during the period covered by COVID-19.
- In Birmingham the proportion of TOPs within the first 7 weeks increased from 56% to 69%. In Solihull the rate increased from 56% to 71%.
- It is likely that this is related to the increase of the distribution of medication via postal services.
- Accessing abortion using EMA rather than later in pregnancy helps to reduce the risk of complications, which are more likely the longer the gestation.[139]

Figure 4.88: Gestation period at time of TOP – Birmingham

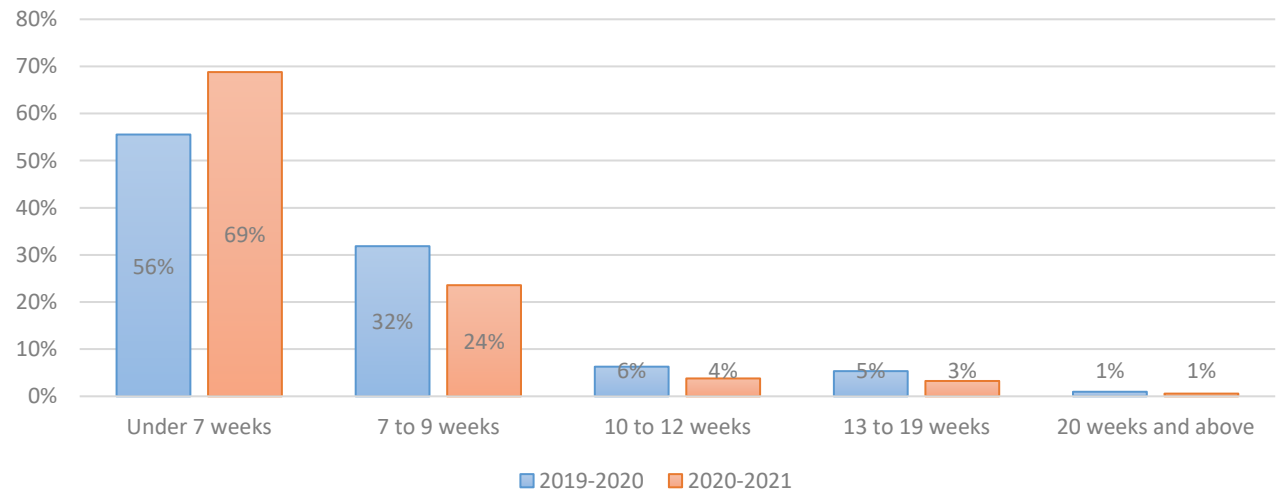
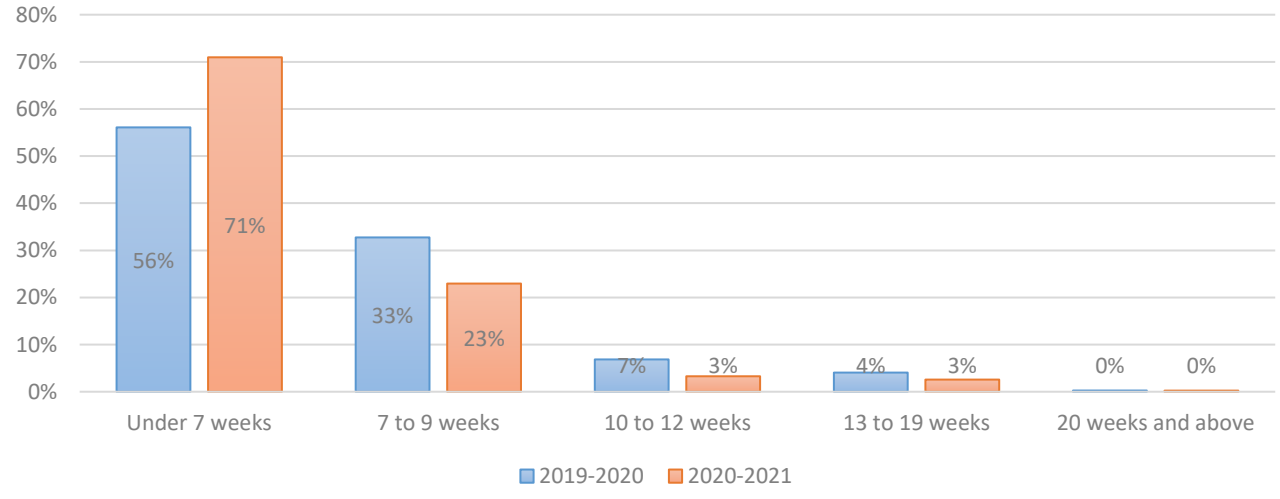


Figure 4.89: Gestation period at time of TOP – Solihull



[139] DHSE, (2020), Home use of both pills for early medical abortion up to 10 weeks gestation

- COVID-19 impacted the delivery of TOP. There has been a decrease in patients being given their medication to take in clinic, and an increase in patients receiving medication via post or via collection.
- There were reductions in Manual Vacuum Aspirations, Electric Vacuum Aspirations, and Dilation and Evacuations.

Figure 4.90: Termination of Pregnancy (method) – Birmingham

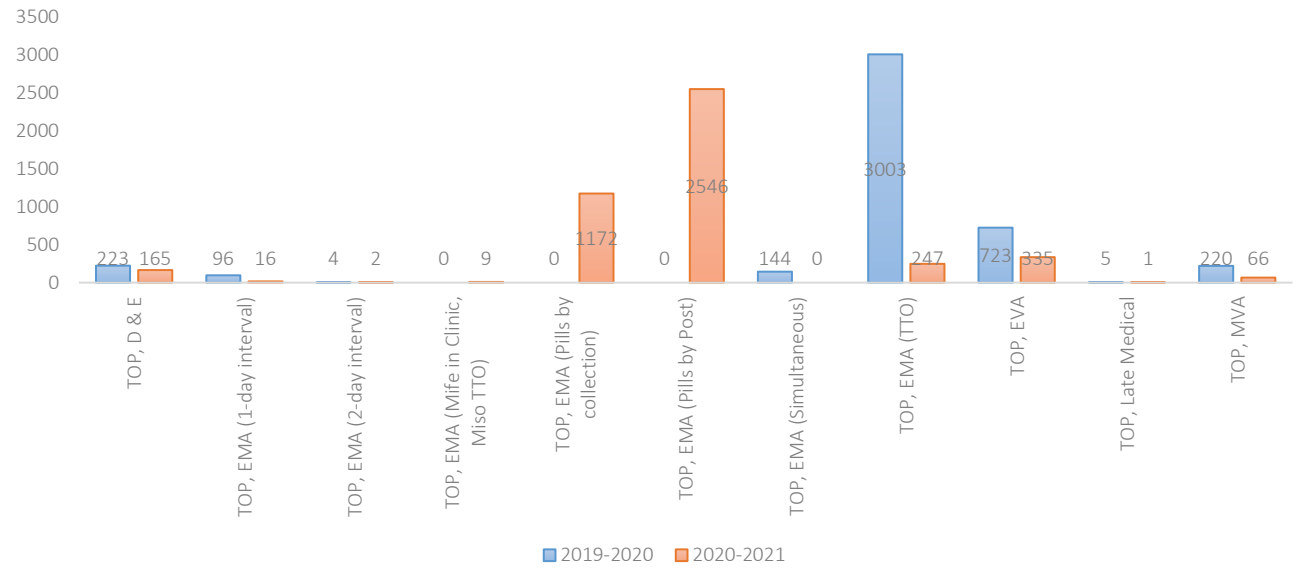


Figure 4.91: Termination of Pregnancy (method) – Solihull

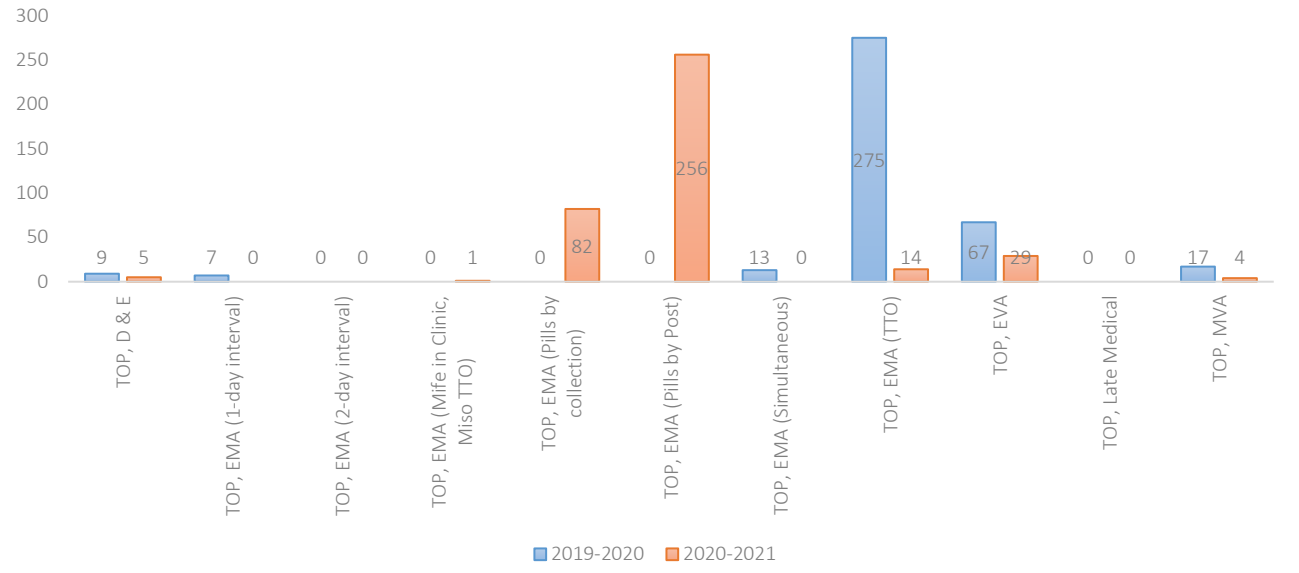
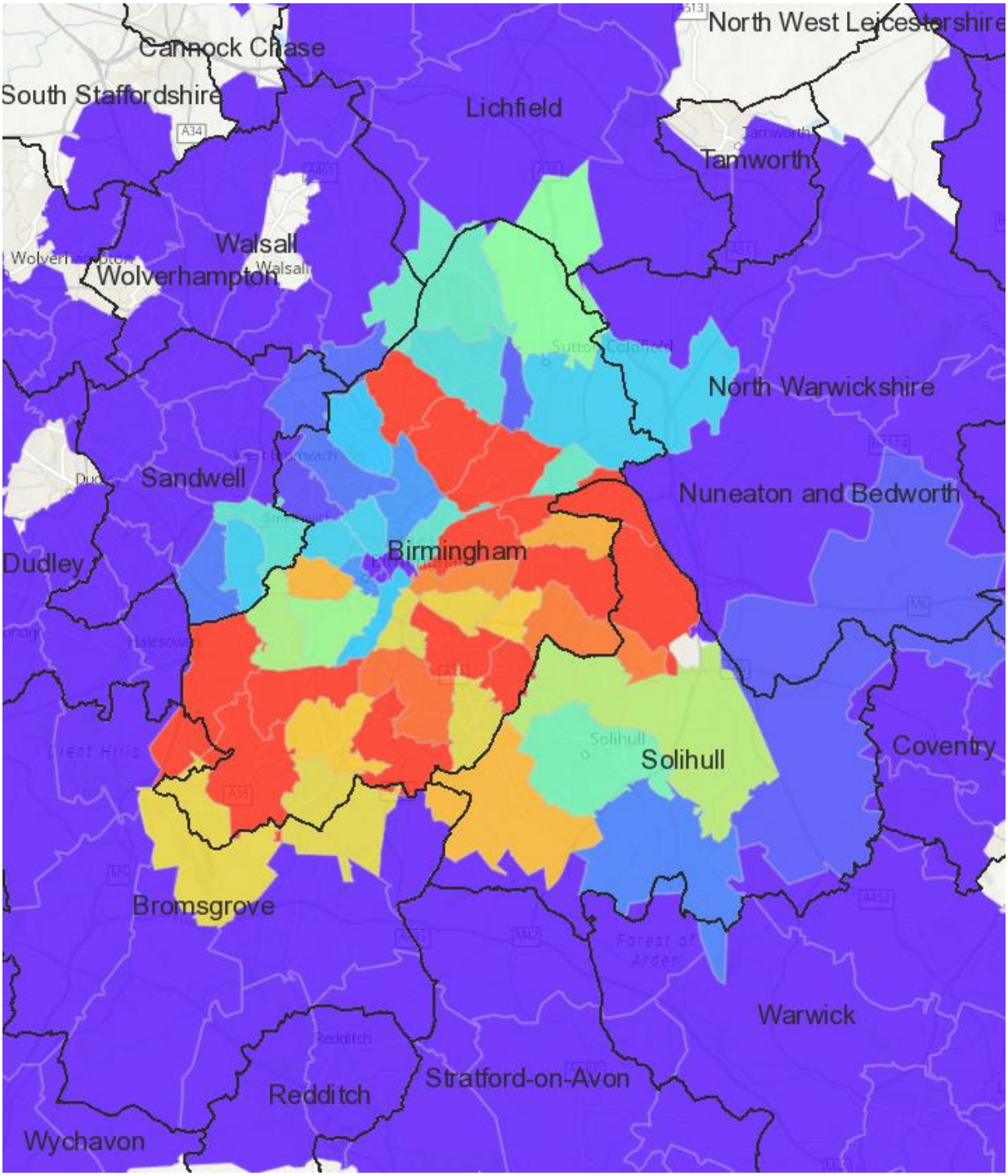


Figure 4.92: Postcode district of residence of those who have had a termination of pregnancy.



CERVICAL CANCER SCREENING

INTRODUCTION

OVERVIEW

The NHS Cervical Screening Programme was introduced in the 1980s. The purpose of the programme is to screen all eligible women for cells which may develop into cervical cancer and ultimately reduce the number of women who develop cervical cancer and the number of women who die from the condition. The Cervical Screening programme is commissioned by NHS England.

Cervical screening (a smear test) is a method to help prevent cancer that detects abnormal tissue or cells in the cervix before cancer develops. All women and people with a cervix aged 25 to 64 should be invited to a cervical screening by letter.

GOOD PRACTICE

Public Health England highlight the following initiatives to address areas of low coverage.

INVITATION LETTER

Evidence demonstrates that GP endorsement has a positive effect on cervical screening uptake.

The cervical screening programme sends a standard invitation letter and a reminder letter 18 weeks later to women who are eligible for cervical screening. Standard letters sent by the programme can include an additional paragraph of free text specific to a GP practice.

The registered GP sends out a second reminder letter to non-attenders. This provides an opportunity to tailor the practice invitation according to the services the practice provides and the practice population. Helpful content includes:

- surgery opening times
- reassurance that the sample taker will be female
- offering opportunities for a conversation about any screening concerns

WOMEN WITH SPECIFIC NEEDS OR WITH DISABILITIES

It is important to consider specific needs in relation to cervical screening in order to maximise opportunities for women to attend.

Primary care settings are well placed to know their practice population needs, and to identify reasons why women are not attending. These reasons may include:

- access problems
- lack of time, or inability to attend during usual clinic hours
- disability (physical or mental)

- language barriers
- cultural beliefs

Women with disabilities have the same right of access to cervical screening as other women. No disabled woman can be assumed to be sexually inactive. All women are entitled to information to make their decision about cervical screening and are entitled to reasonable adjustments to support them attending an appointment.

Primary care should consider the clinic facilities for women with a physical disability, including:

- access to the venue (can an alternative be offered?)
- the height of the couch
- the woman's physical limitations
- the possibility of a domiciliary visit
- the need for assistance and seeking specialist advice if necessary

In the case of paraplegic women, the sample taker may need to make special arrangements, for example with the local colposcopy service, to take a sample at a clinic where a hoist is available.

A local learning disabilities team can offer support, including assistance with consent, and individuals to accompany women to appointments. An easy-read leaflet is available which has been designed to be used by women with learning disabilities alongside family members or carers. The leaflet is intended to help them to make their own decisions about cervical screening, and to prepare them for the screening process.

Language and cultural differences can affect understanding or the screening process. It is important to take measures to ensure all women understand the purpose of the screening programme and the procedure for taking the sample. Language translations of the screening invitation leaflet are available to download, and alternative formats (such as braille) can be made available on request.

Primary care is responsible for sourcing and offering language support during sample taking if needed.

PRE-APPOINTMENTS

Women who have never been screened may benefit from being offered a no obligation pre-test appointment to discuss the procedure and raise any questions or concerns. This may also be beneficial for women who have previously had negative experiences of screening.

OPEN EXETER

Sample takers may wish to use the Open Exeter IT system to check screening status and follow up non-responder notifications. They can also use the system to download the electronic HMR 101 (cytology request) forms.

SCREEN PROMPTS AND ALERTS

The use of alerts or screen prompts for defaulters provides an opportunity for clinicians to raise awareness that screening is available and that individuals remain eligible.

AWARENESS CAMPAIGNS

2019 saw the first PHE national multimedia cervical screening campaign, highlighting the risks of cervical cancer and the preventative benefits of screening. The campaign website includes information, case studies and resources that local providers can access.

Practice campaigns to raise awareness of cervical screening and invite women who are overdue have been shown to be useful to increase attendance for screening.

Methods for prompting women who are overdue or who have never attended include:

- reminder letters
- text reminders
- postcards
- telephoning women directly
- Posters in waiting rooms and toilets to raise awareness and promote screening.

Jo's Cervical Cancer Trust provides awareness-raising resources for primary care, and there is a cervical screening awareness week in June each year.

DATA CLEANSING

GP list validation and list cleansing is helpful to ensure removal of 'ghost' patients to support the practice in identifying eligible women.

An audit of hysterectomised women at a practice level will identify women who no longer need to be invited for screening. Women who have undergone a sub-total hysterectomy will continue to be eligible for screening as the cervix is not removed.

CONSULTING ROOM

There are steps that sample takers can take to ensure that the consulting room is a suitable environment for cervical screening:

- Review the consulting room where screening takes place
- Consider the layout and location of rooms to ensure there is a confidential quiet, private area that is welcoming
- Make sure all equipment is ready at hand before you start and that you will not be disturbed.

POSITIVE EXPERIENCE

Fear and embarrassment are some of the main influencing factors for women who choose not to have screening.

Previous experience is important when women are deciding whether to make an appointment. Sample takers should ensure that women are put at ease and all their questions are answered during their appointment. They may tell their family and friends if their experience was positive or negative.

ACCESS

Providing a variation of appointment times during the day and in the evening will help women in choosing when they can attend for screening. Limiting access to screening appointments can impact on coverage.

A whole-team approach is important to ensure women can access screening. It is therefore important that all clinicians and reception staff are aware of the importance of cervical screening.

MAKING AN INFORMED CHOICE

All women must be given the opportunity to make an informed choice about whether or not to attend for cervical screening. The decision should be based on an understanding of:

- why they are being offered screening
- what happens during the test?
- the benefits and risks of screening
- the potential outcomes (including types of result, further tests and treatment)
- what happens to their screening records?

If a woman is provided with the above information about the programme and chooses not to attend screening, then this is a valid choice and must be respected.

LOCAL PERFORMANCE

The tables below show that the area covered by NHS Birmingham and Solihull CCG has relatively low coverage rates for cervical screens in both the 25-to-49 and the 50-to-64 age groups.

Figure 4.93: Cervical screening coverage rates age 25 to 49

Coverage for **25-to-49** age group: -	Eligible women on last day of review period	Women with adequate screen in previous 3.5 years	3.5-year coverage %	Screens needed to meet 80%	RANK of 135 CCGs
ENGLAND - 135 CCGs	10,264,947	7,071,719	68.89	1,140,239	
Midlands and East region - 40 CCGs	2,943,335	2,079,243	70.64	275,425	
NHS BIRMINGHAM AND SOLIHULL CCG	227,069	146,906	64.70	34,750	113

Figure 4.94: Cervical screening coverage rates age 50 to 64

Coverage for **50-to-64** age group: -	Eligible women on last day of review period	Women with adequate screen in previous 5.5 years	5.5-year coverage %	Screens needed to meet 80%	RANK of 135 CCGs
ENGLAND - 135 CCGs	5,199,083	3,897,682	74.97	261,585	
Midlands and East region - 40 CCGs	1,574,596	1,192,800	75.75	66,877	
NHS BIRMINGHAM AND SOLIHULL CCG	102,172	74,627	73.04	7,111	104

5 – STI TESTING

INTRODUCTION

- OVERVIEW

PHE FINGERTIP ANALYSIS

- OVERVIEW

GUMCAD ANALYSIS

- SEXUAL HEALTH SCREENS

LOCAL SERVICE PROVISION

- OVERVIEW

INTRODUCTION

OVERVIEW

INTRODUCTION

Sexually transmitted infections (STIs) are a major public health concern, which may seriously impact the health and wellbeing of affected individuals, as well as being costly to healthcare services. If left undiagnosed and untreated, common STIs can cause a range of complications and long-term health problems, from adverse pregnancy outcomes to neonatal and infant infections, and cardiovascular and neurological damage.[140]

Sexually transmitted infections include:

- chlamydia
- gonorrhoea
- genital herpes
- genital warts
- syphilis

In 2019, there were 468,342 diagnoses of STIs made in England, a 5% increase since 2018. The impact of STIs remains greatest in young heterosexuals, 15-to-24-year-olds; black ethnic minorities; and gay, bisexual and other men who have sex with men (MSM).[141]

Since 1 April 2013, local authorities have been responsible for commissioning most sexual health interventions and services as part of their wider public health responsibilities, with costs met from their allocated public health grant. These include STI testing and treatment, and chlamydia testing as part of the National Chlamydia Screening Programme and HIV testing.[142]

BEST PRACTICE

Key messages from Public Health England: [143]

- Open access to sexual health services that provide rapid treatment and partner notification can reduce the risk of STI complications and infection spread.
- Local services for the prevention, diagnosis, treatment, and care of STIs, supported by national partners, need to be made available to the general population as well as focus on groups with greater sexual health needs.
- Prioritisation of STI testing should follow national guidance and take account of local context, including the impact of the COVID-19 response on routine sexual health service provision.

[140] PHE blog: Health Matters: Preventing STIs. 21 August 2019.
[141] PHE (2020), Sexually transmitted infections and screening for chlamydia in England, 2019.
[142] Department of Health and Social care (2013), Commissioning Sexual Health Services and Interventions: Best practice guidance for local authorities.
[143] PHE (2020), Sexually transmitted infections and screening for chlamydia in England, 2019.

- Local authorities should ensure continued access to chlamydia screening for 15- to 24-year-olds through a range of settings including internet services; this should include partner notification and retesting those who are diagnosed to ensure reductions in onward transmission and subsequent harm.
- An informed and positive attitude to relationships and sexual health will be enhanced by effective implementation of statutory, high-quality Relationships Education in primary schools and Relationships and Sex Education (RSE) in secondary schools; RSE will also equip young people with the skills to maintain their sexual health and overall wellbeing.
- Vaccination against HPV (MSM and school-aged adolescents) and hepatitis A and hepatitis B (MSM and other groups with greater sexual health needs) will reduce the risk of infection with these viruses and should continue to be offered according to national guidelines.
- PHE's Syphilis Action Plan includes recommendations for PHE and partner organisations to address the continued increase in syphilis diagnoses in England.
- Consistent and correct use of condoms can significantly reduce risk of STIs; the availability of condoms should be promoted by local services including through condom distribution schemes.
- Regular testing for HIV and STIs is essential for good sexual health, and everyone should have an STI screen, including an HIV test, annually if having condomless sex with new or casual partners.

COLLATION OF KEY GUIDANCE

NICE guidance on:

- Sexual health Quality standard [QS178]. Covers sexual health, focusing on preventing sexually transmitted infections (STIs). It describes high-quality care in priority areas for improvement.
- Sexually transmitted infections and under-18 conceptions: prevention. Public health guideline [PH3]. Covers one-to-one interventions to prevent sexually transmitted infections (STIs) and under-18 conceptions. The aim is to reduce the transmission of chlamydia and other STIs, including HIV, and reduce the rate of pregnancies among women aged under 18.
- British Association for Sexual Health and HIV (BASHH) Standards for the management of sexually transmitted infections (STIs).[144]

[144] BASSH (2019), Standards for the management of STIs.

PHE FINGERTIPS ANALYSIS

OVERVIEW

The following table highlights how 2020 impacted Birmingham and how the area compared against the nearest neighbours.

The analysis for Birmingham shows that the number of tests, diagnoses, and numbers testing positive all had significant decreases in comparison to what the nearest neighbours have reported. This trend is also similar for Solihull.

	BIRMINGHAM	NEAREST NEIGHBOURS
STI testing rate (excluding chlamydia aged <25) / 100,000 Number outside brackets shows the rate. Number inside bracket shows the number tested[145].		
2019	8,113 (60,733)	5,304 (183,467)
2020	4,078 (30,558)	4,352 (151,943)
Change in numerator	-50%	-17%
New STI diagnoses (exc chlamydia aged <25) / 100,000 Number outside brackets shows the rate. Number inside bracket shows new STI diagnoses[146].		
2019	1,058 (7,921)	910 (31,483)
2020	485 (3,633)	631 (22,018)
Change in numerator	-54%	-30%
STI testing positivity (exc chlamydia aged <25) % Number outside brackets shows the percentage. Number inside bracket shows a sum of all positive diagnoses[147].		
2019	7% (4,187)	7% (13,703)
2020	8% (2,318)	7% (11,011)
Change in numerator	-45%	-20%

145 Total number of people tested for one or more infections for syphilis, HIV, gonorrhoea and chlamydia at a new attendance.
146 The number of new STI diagnoses (excluding chlamydia in those aged under 25 years) among people aged 15 to 64 accessing sexual health services.
147 A sum of all positive diagnoses of syphilis, HIV, gonorrhoea and chlamydia. Chlamydia diagnoses are only included in people aged 25 to 64 years.

	SOLIHULL	NEAREST NEIGHBOURS
STI testing rate (exc chlamydia aged <25) / 100,000 Number outside brackets shows the rate. Number inside brackets shows the number tested[148].		
2019	5,711 (7471)	4,052 (95,252)
2020	2,966 (3907)	3,019 (71,300)
Change in numerator		
New STI diagnoses (exc chlamydia aged <25) / 100,000 Number outside brackets shows the rate. Number inside bracket shows new STI diagnoses[149].		
2019	646 (845)	550 (12,933)
2020	269 (354)	379 (8,949)
Change in numerator		
STI testing positivity (exc chlamydia aged <25) % Number outside brackets shows the percentage. Number inside brackets shows a sum of all positive diagnoses[150].		
2019	5% (393)	5% (4,883)
2020	6% (223)	5% (3,871)
Change in numerator		

148 Total number of people tested for one or more infections for syphilis, HIV, gonorrhoea and chlamydia at a new attendance.
149 The number of new STI diagnoses (excluding chlamydia in those aged under 25 years) among people aged 15 to 64 accessing sexual health services.
150 A sum of all positive diagnoses of syphilis, HIV, gonorrhoea and chlamydia. Chlamydia diagnoses are only included in people aged 25 to 64 years.

ANALYSIS

INTRODUCTION

The following chapter provides an analysis of the indicators relating to STI testing as taken from the PHE Fingertips resource.

The analysis covers 9-year trends, comparisons against the nearest neighbours, and comparisons against England.

NEW STI DIAGNOSES (EXC CHLAMYDIA AGED <25) / 100,000 – KEY INDICATOR

RATIONALE / INTRODUCTION

A high diagnosis rate is indicative of a high burden of infection; however, a low diagnosis rate may be explained by other factors as well. To help interpret the data, please refer to the latest annual report on Sexually transmitted infections and screening for chlamydia in England.

LOCAL PERFORMANCE

Figure 5.1: New STI diagnoses (exc chlamydia aged <25) / 100,000

BIRMINGHAM	SOLIHULL
485	269
BIRMINGHAM NEAREST NEIGHBOUR	**SOLIHULL NEAREST NEIGHBOUR**
631	379

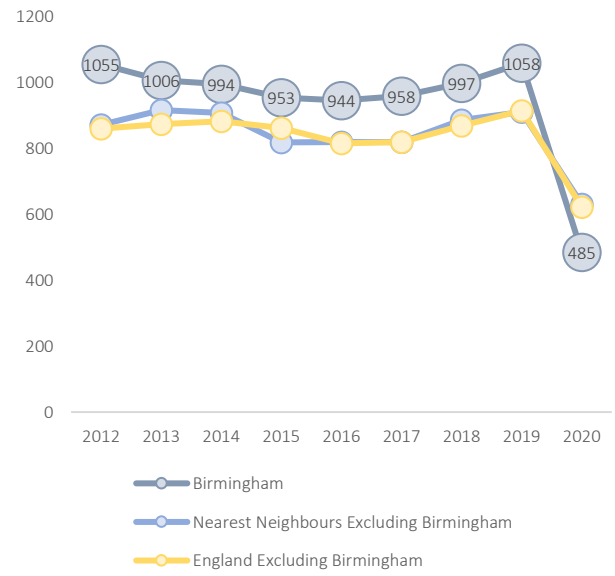
In Birmingham, there were 3,633 new STI diagnosis (exc chlamydia aged <25) in 2020, representing a decrease of -54% in comparison to 2019. This decrease is significantly higher than the 30% decrease experienced by the nearest neighbours (excluding Birmingham) and the 32% decrease for England (excluding Birmingham).

Looking specifically at the indicator, which is expressed as a rate per 100,000 population, Birmingham has historically tracked above the nearest neighbours and England; however, 2020 is the first time that Birmingham has been below these two areas.

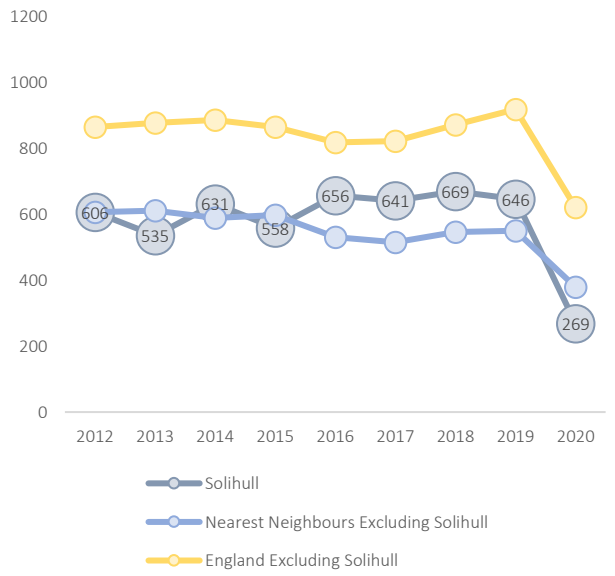
Solihull has also experienced a significant decrease of 58% in comparison to the 31% decrease for the nearest neighbours. 2020 is the first year since 2015 in which Solihull has shown a lower rate than its nearest neighbours.

Figure 5.2: New STI diagnoses (exc chlamydia aged <25) / 100,000; Trends against Nearest Neighbours and against England.

BIRMINGHAM



SOLIHULL



COUNT BY YEAR	2012	2013	2014	2015	2016	2017	2018	2019	2020
BIRMINGHAM	7504	7185	7157	6943	6986	7145	7456	7921	3633
SOLIHULL	785	695	819	722	850	834	871	845	354

The following chart shows how Birmingham and Solihull ranked against their nearest neighbours in 2019 and in 2010. The charts emphasises that both areas have decreased in the rankings; for example, Solihull ranked the 4th highest in the Nearest Neighbours group in 2019; however, they are now ranked with the lowest rate in 2020.

Figure 5.3: BIRMINGHAM – 2019

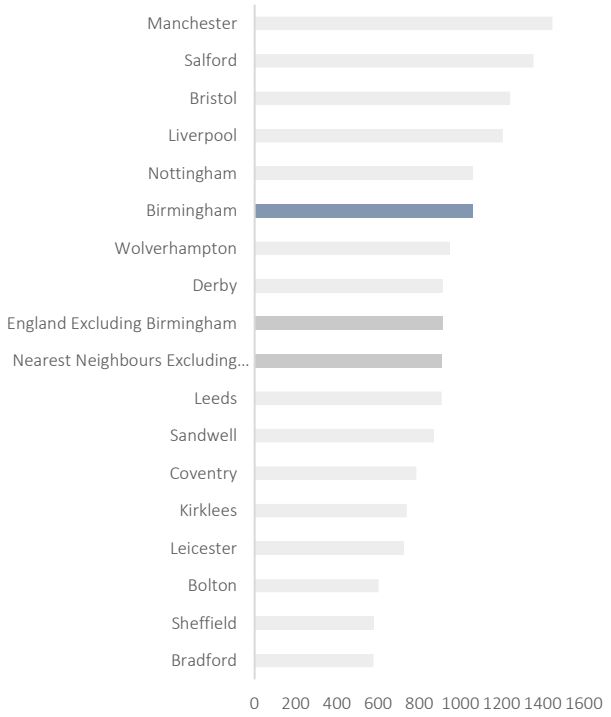


Figure 5.4: SOLIHULL - 2019

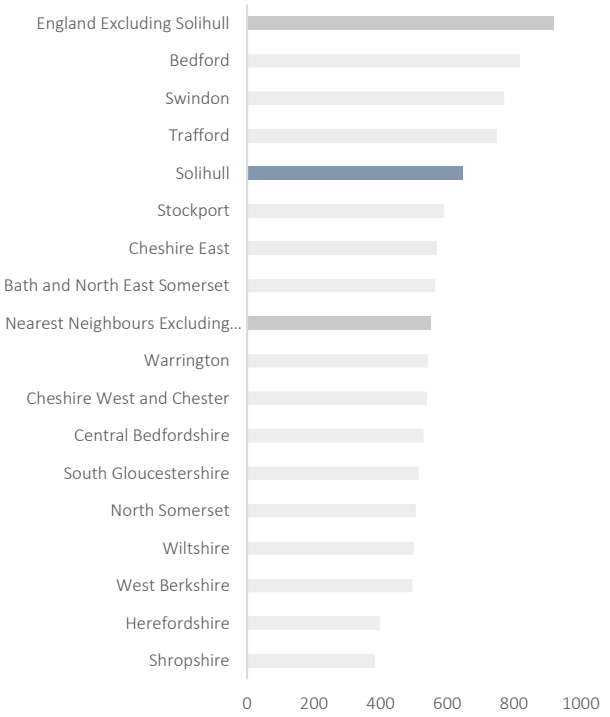


Figure 5.5: BIRMINGHAM - 2020

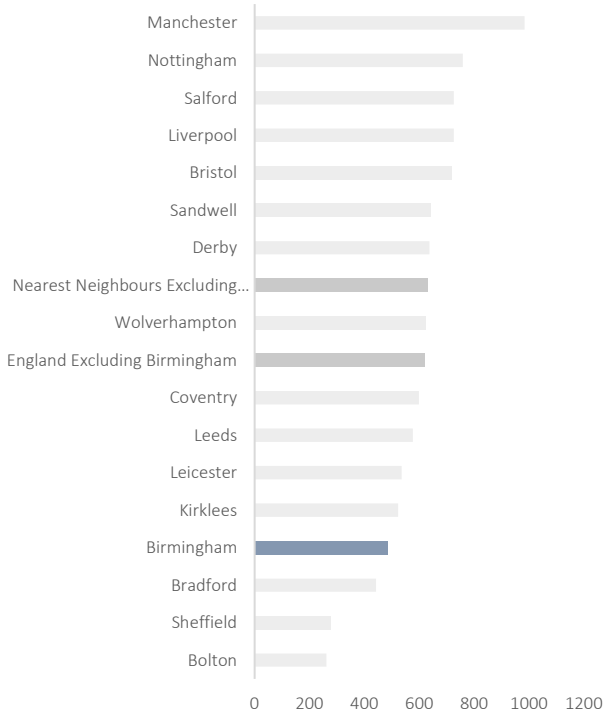
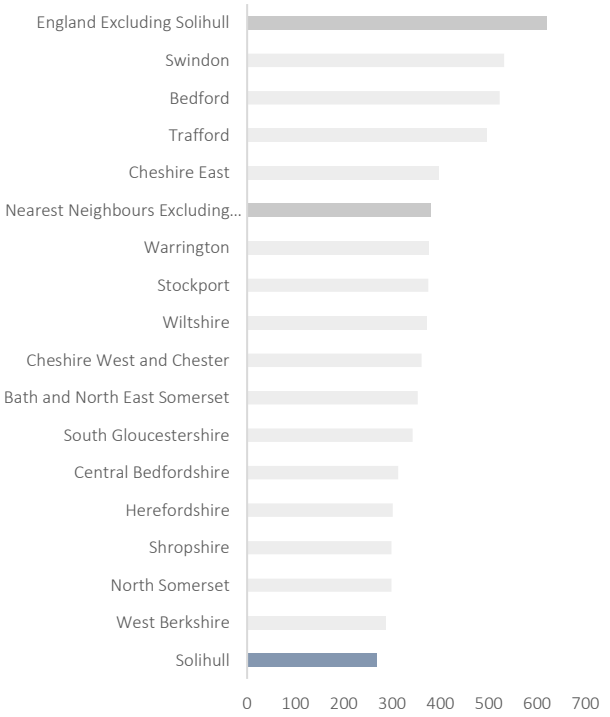


Figure 5.6: SOLIHULL – 2020



ALL NEW STI DIAGNOSIS RATE / 100,000

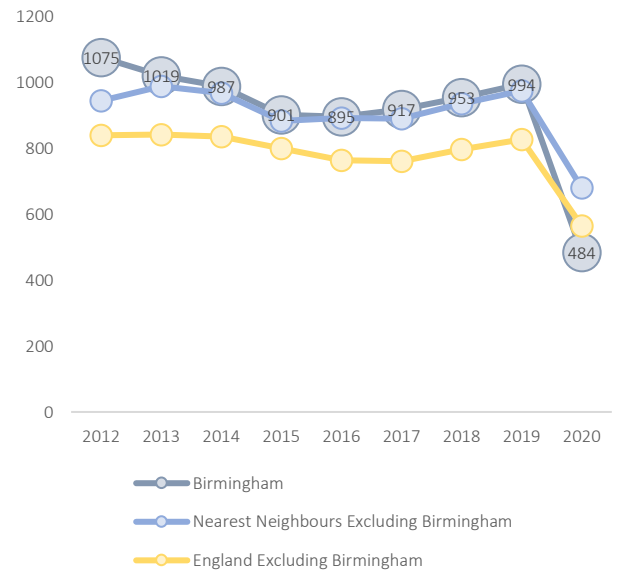
LOCAL PERFORMANCE

The trends and analysis are similar to what has been experienced for key indicator “New STI diagnoses (exc chlamydia aged <25) / 100,000”.

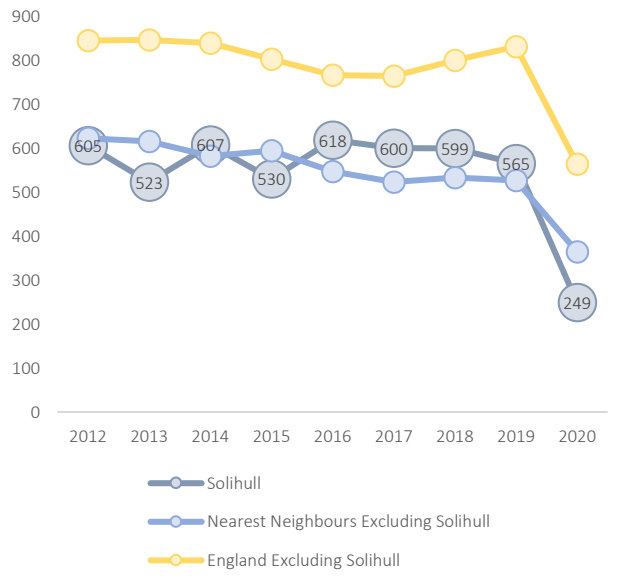
In both Birmingham and Solihull, and across the nearest neighbours there was a large reduction in STI diagnoses in 2020.

Figure 5.7: All new STI diagnoses rate / 100,000; Trends against nearest neighbours and against England.

BIRMINGHAM



SOLIHULL



COUNT BY YEAR	2012	2013	2014	2015	2016	2017	2018	2019	2020
BIRMINGHAM	11665	11131	10876	10030	10100	10433	10881	11350	5518
SOLIHULL	1256	1093	1277	1118	1312	1284	1287	1223	541

STI TESTING RATE (EXC CHLAMYDIA AGED <25) / 100,000

INTRODUCTION / RATIONALE

Testing rates and diagnosis rates are closely linked. These figures are complementary to the New STI diagnoses (excluding chlamydia in under 25-year-olds) and STI testing positivity (excluding chlamydia in under 25-year-olds) indicators.

The testing rate is a summary figure of all the people who had STI testing, excluding chlamydia tests, in the age group targeted by the National Chlamydia Screening Programme (NCSP).

This measure includes GUMCAD data only.

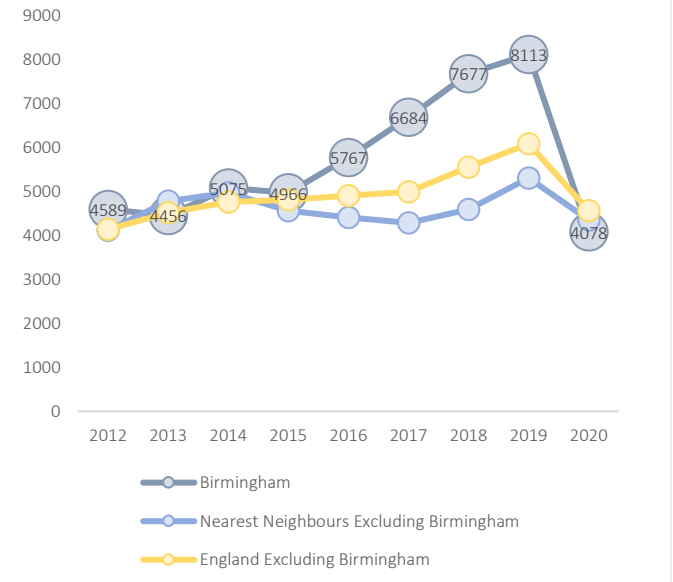
LOCAL PERFORMANCE

Between 2016 and 2019, Birmingham had increased the rate of testing and had moved away from the nearest neighbour average. 2020 saw a 50% decrease in STI testing rate in Birmingham, in comparison to a 17% decrease for the nearest neighbours, and testing rates in Birmingham and the nearest neighbours are now comparable.

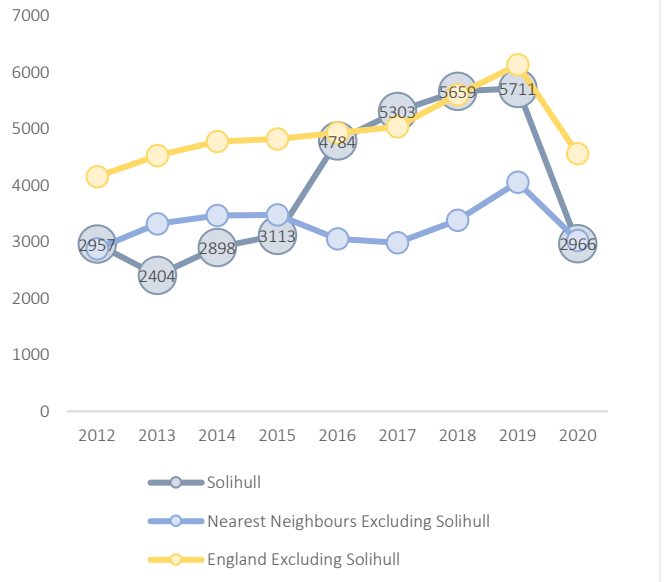
Similar to Birmingham, Solihull saw an increase in testing between 2016 and 2019 and was at a level similar to the national average. 2020 saw a 48% decrease in the STI testing rate in Solihull, in comparison to a 25% decrease for the nearest neighbours and testing rates in Solihull and the nearest neighbours are now comparable.

Figure 5.8: STI testing rate (exc chlamydia aged <25) / 100,000; Trends against nearest neighbours and against England.

BIRMINGHAM



SOLIHULL



COUNT BY YEAR	2012	2013	2014	2015	2016	2017	2018	2019	2020
BIRMINGHAM	32648	31832	36554	36166	42659	49832	57433	60733	30558
SOLIHULL	3829	3122	3759	4027	6195	6897	7367	7471	3907

STI TESTING POSITIVITY (EXC CHLAMYDIA AGED <25) %

INTRODUCTION / RATIONALE

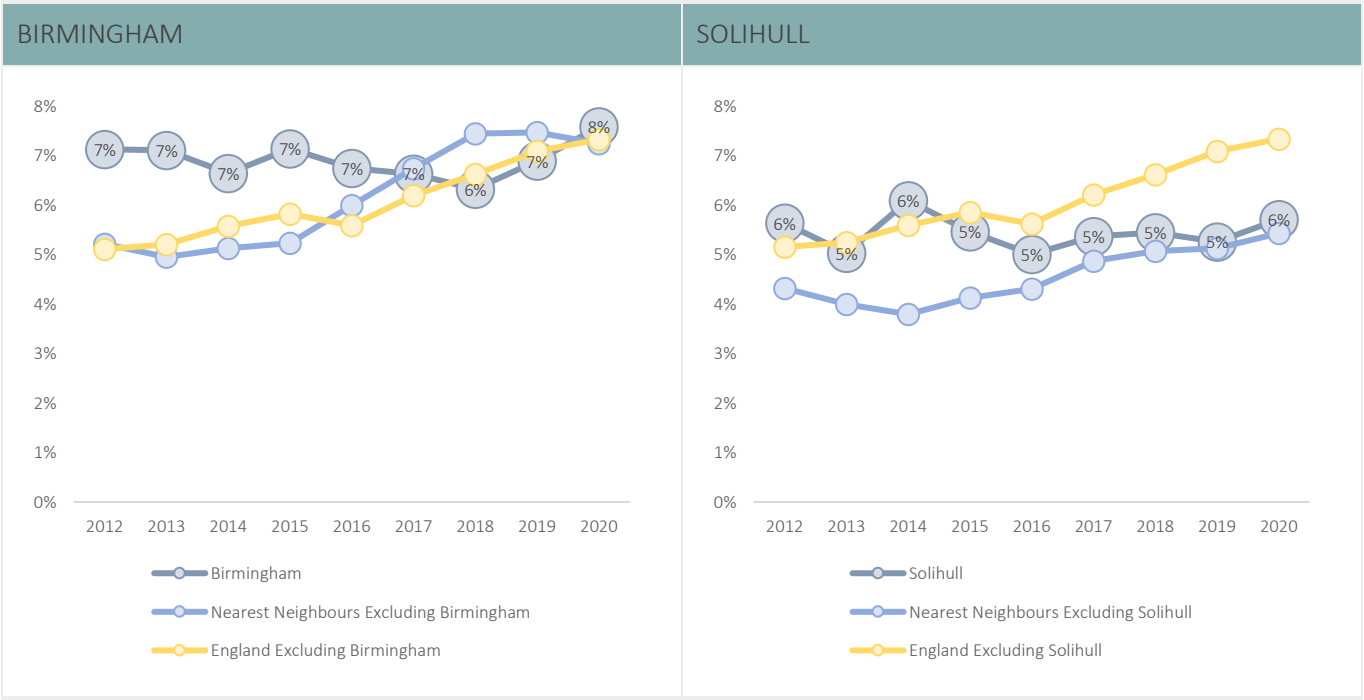
Testing rates and diagnosis rates are closely linked. These figures are provided to help interpret the New STIs diagnosis rate and STI testing rate (excluding chlamydia in under-25-year-olds). STI tests and diagnoses counted here are only for HIV, syphilis, gonorrhoea and chlamydia (in those aged 25 and above).

The testing rate is a summary figure of all the people who had STI testing, excluding chlamydia tests in the age group targeted by the National Chlamydia Screening Programme (NCSP).

LOCAL PERFORMANCE

In both Birmingham and Solihull, there was an increase in STI testing positivity in 2020. There was an increase nationally and amongst the nearest neighbours.

Figure 5.9: STI testing positivity (exc chlamydia aged <25) %; Trends against nearest neighbours and against England.



COUNT BY YEAR	2012	2013	2014	2015	2016	2017	2018	2019	2020
BIRMINGHAM	2327	2262	2427	2583	2878	3305	3633	4187	2318
SOLIHULL	216	157	229	220	310	370	401	393	223

GUMCAD ANALYSIS

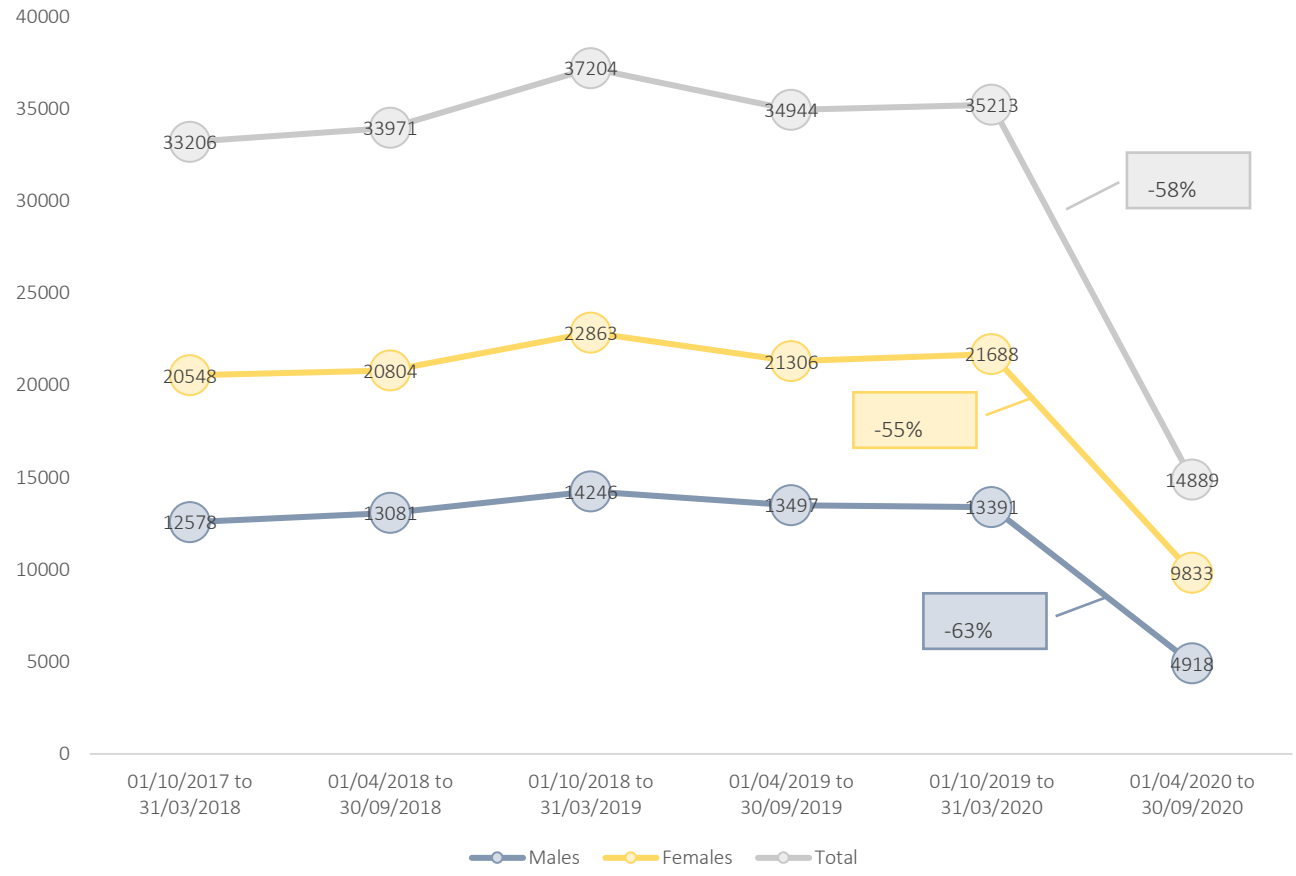
SEXUAL HEALTH SCREENS

BIRMINGHAM

The following looks at the number of sexual health screens taken at first attendance for patients from Birmingham attending GUM (Level 3) services.

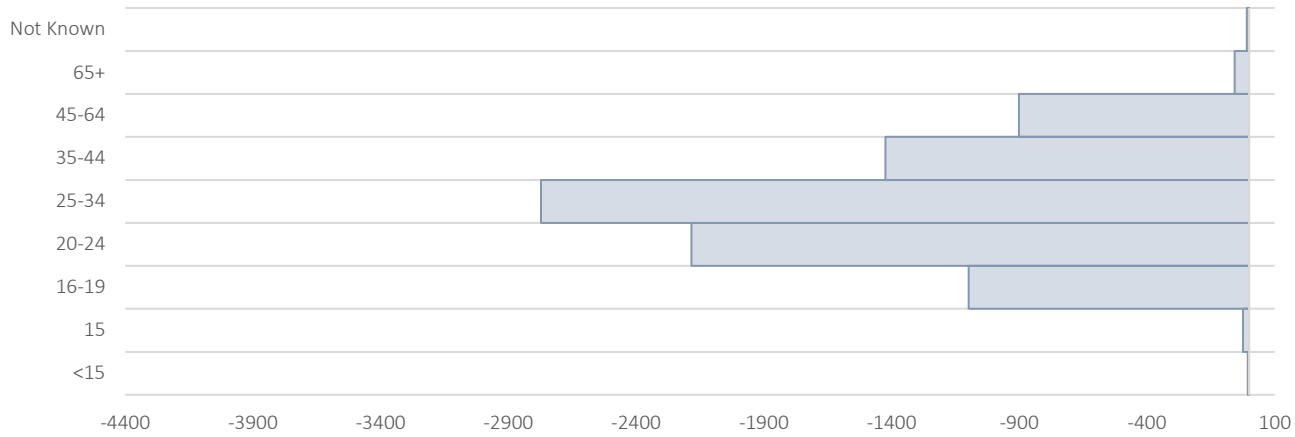
Between April 2020 and September 2020, there was a 58% decrease in the number of first attendances. Broken down by gender, the decrease was greater in males than it was for females.

Figure 5.10: Number of first attendances.



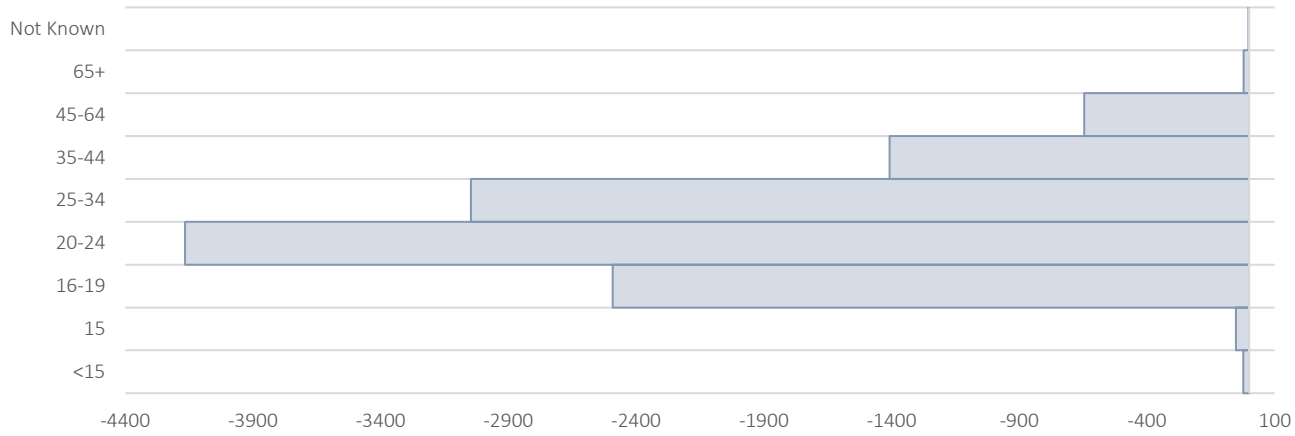
The analysis by age and gender shows that the change has been different between males and females. For males, it is the 25-34 age group which has seen the biggest decrease, whereas for females, it is the 20-24 age group.

Figure 5.11: Apr-2020 to Sep-2020 change against previous 6 months; males and age group.



	<15	15	16-19	20-24	25-34	35-44	45-64	65+	Not Known
% Change	-42%	-89%	-77%	-60%	-58%	-66%	-72%	-58%	-75%
Change #	-5	-24	-1098	-2183	-2772	-1424	-901	-57	-9

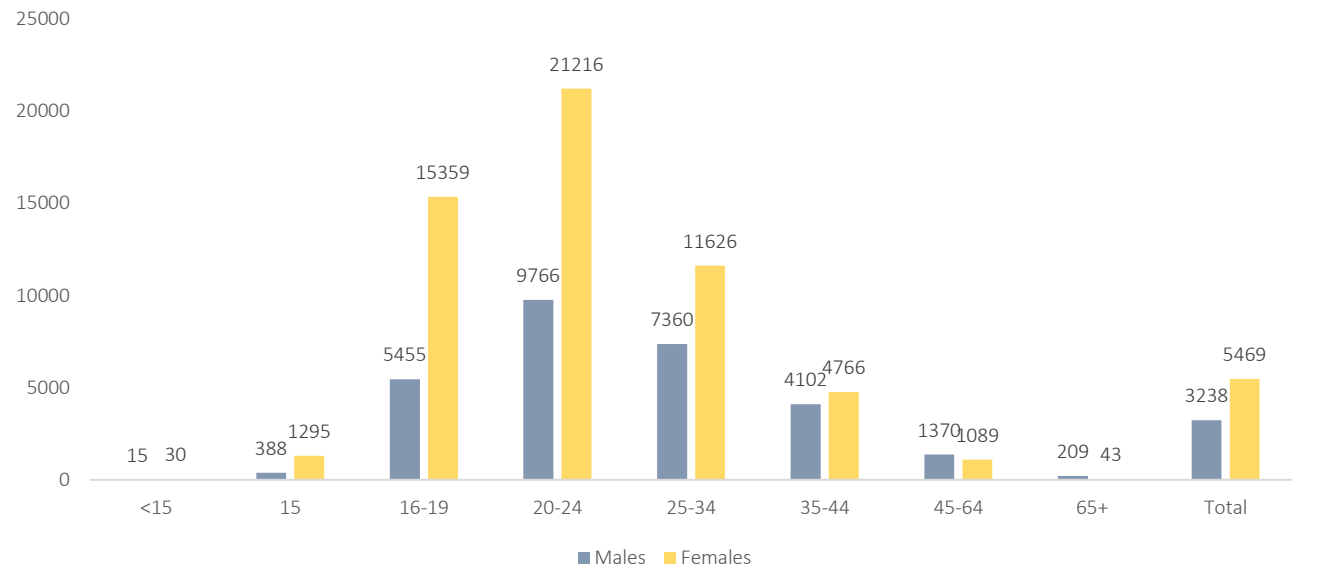
Figure 5.12: Apr-2020 to Sep-2020 change against previous 6 months; males and age group.



	<15	15	16-19	20-24	25-34	35-44	45-64	65+	Not Known
% Change	-79%	-71%	-67%	-54%	-45%	-58%	-65%	-75%	-100%
Change #	-23	-51	-2491	-4166	-3047	-1407	-646	-21	-3

As a rate per 100,000 population, for both males and females the most prevalent group is the 20-24 age group. The second most prevalent group for females is the 16-19 age group, whereas for males it is the 25-34 age group.

Figure 5.13: Rate per 100,000 population by age group; 12 months to September 2020.



LOCAL SERVICE PROVISION

OVERVIEW

Testing for STIs is provided by Umbrella Health. The following table provides an overview of the available provision in relation to STI testing.

GP

- There is a chlamydia screening programme offered by Umbrella partner GPs.
  - This programme started in April 2018. To increase GP participation, there is an adjusted tariff based on higher positive results.
- Chlamydia treatment is available at Umbrella-partnered GPs in Birmingham.

PHARMACY

- Chlamydia screening is offered at Umbrella partner pharmacies in Birmingham.
  - There are no pharmacies in Solihull partnered with Umbrella.
- Patients can pick up an STI testing kit at Umbrella partnered pharmacies.

SEXUAL HEALTH CLINICS

- All patients attending Umbrella clinics are offered HIV and STI testing.

KEY FINDINGS

- GPs and other practitioners fed back that chlamydia swabs were available intermittently during the COVID-19 pandemic.
  - This impacted the number of tests being completed.
- STI testing kits can be ordered from Umbrella Sexual Health Services.
  - A number of different services highlighted that there were limited numbers of kits available during the COVID-19 pandemic.
  - The blockage in kit availability was due to a shortage of appropriate components.

6- SELECTED STI ANALYSIS

OVERVIEW

- KEY POINTS AND OVERVIEW

CHLAMYDIA

- PHE FINGERTIPS ANALYSIS
- GUMCAD ANALYSIS
- LOCAL SERVICE PROVISION

GONORRHOEA

- PHE FINGERTIPS ANALYSIS

SYPHILIS

- PHE FINGERTIPS ANALYSIS

HERPES

- PHE FINGERTIPS ANALYSIS

HIV

- INTRODUCTION
- PHE FINGERTIPS ANALYSIS
- LOCAL SERVICE PROVISION

ENGAGEMENT

- COMMUNITY SURVEY

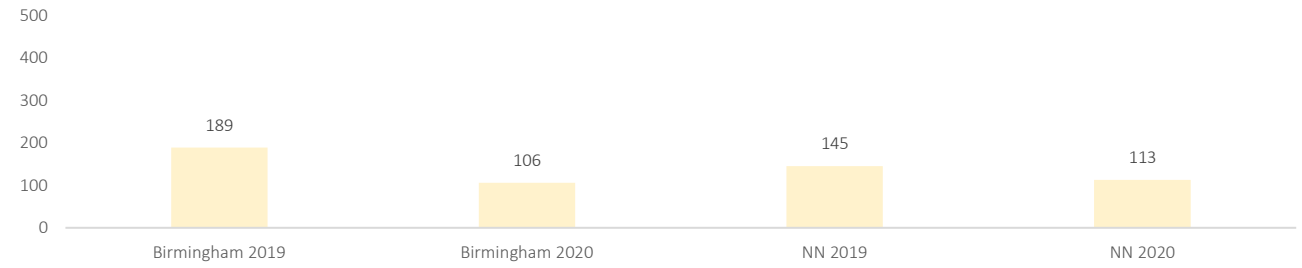
OVERVIEW

KEY POINTS AND OVERVIEW

In Birmingham, there was a reduction in diagnostic rates per 100,000 across all STIs between 2019 and 2020. The nearest neighbours also saw a reduction in rates per 100,000.

	BIRMINGHAM	NEAREST NEIGHBOURS

Figure 6.1: Gonorrhoea diagnostic rate / 100,000



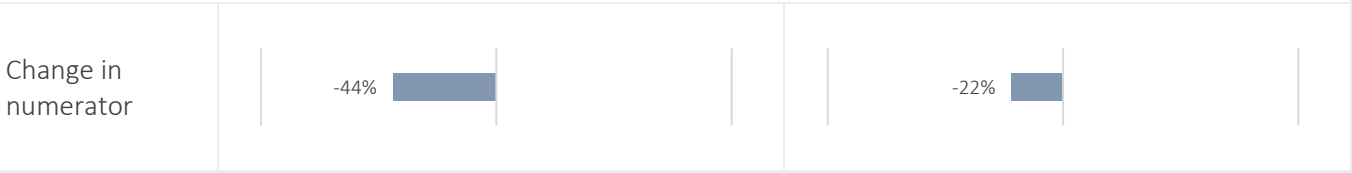
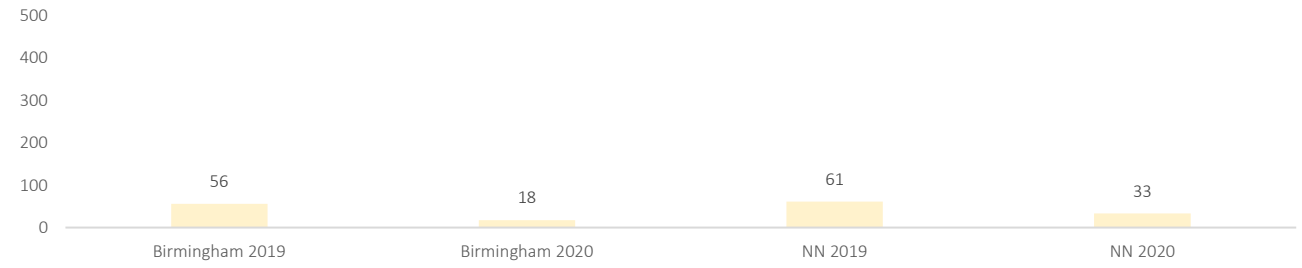


Figure 6.2: Genital herpes diagnosis rate / 100,000



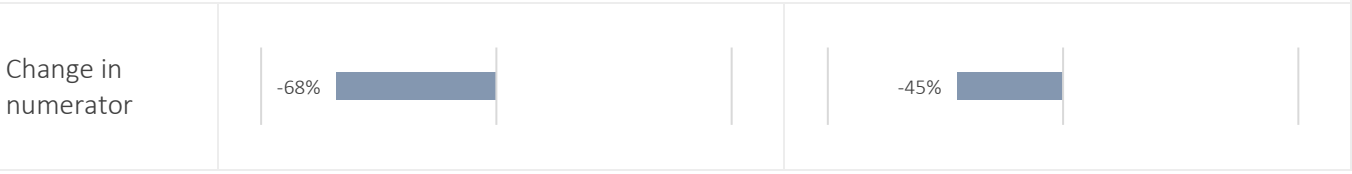
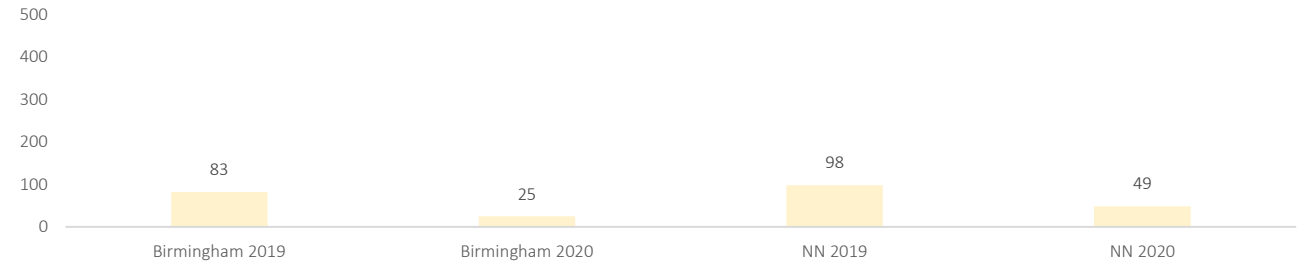


Figure 6.3: Genital warts diagnostic rate / 100,000



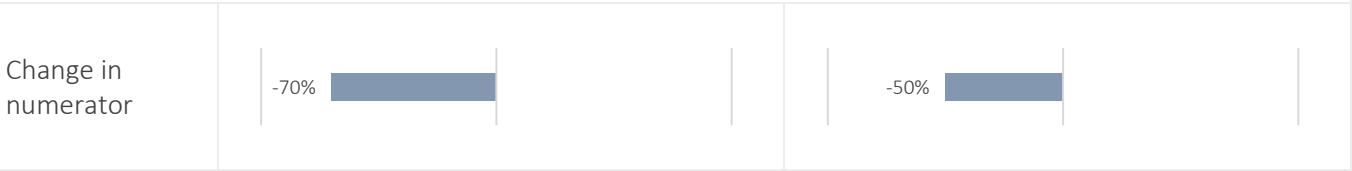
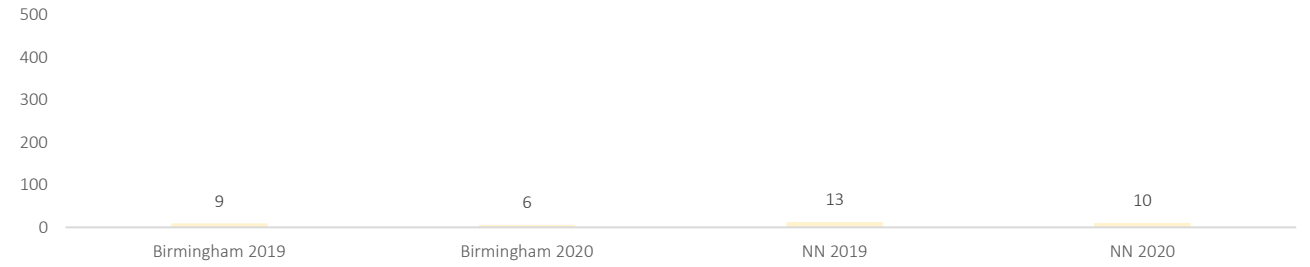


Figure 6.4: Syphilis diagnostic rate / 100,000



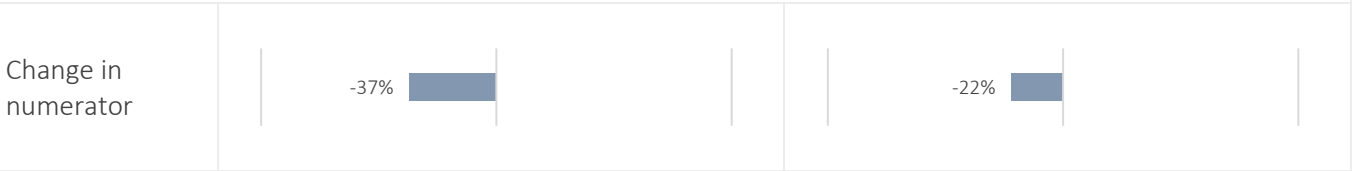
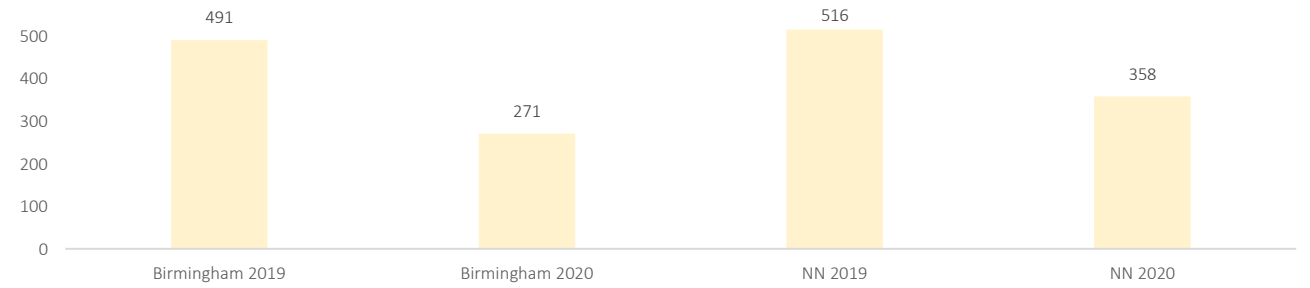
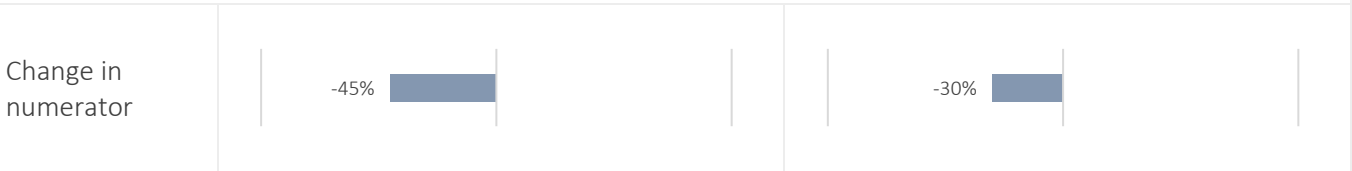


Figure 6.5: Chlamydia diagnostic rate / 100,000





In Solihull, there was a reduction in diagnostic rates per 100,000 across all STIs (apart from syphilis) between 2019 and 2020. The nearest neighbours also saw a reduction in rates per 100,000. There were low numbers of syphilis diagnoses 3 per year in both 2019 and 2020).

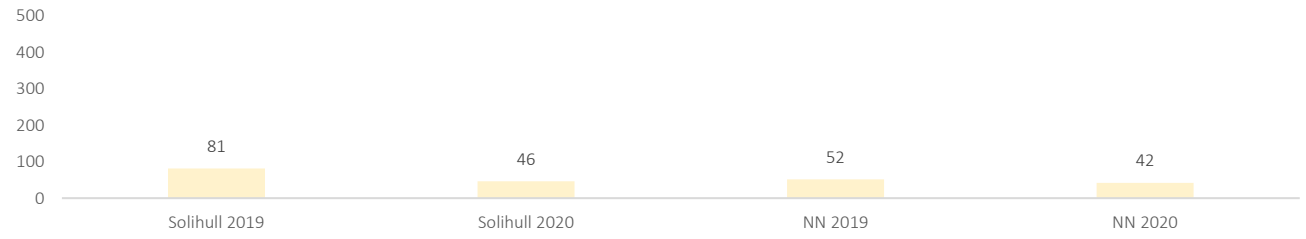
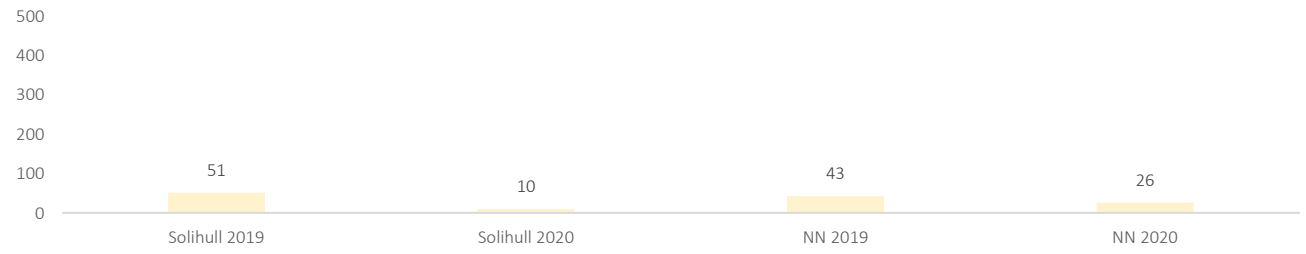
	SOLIHULL	NEAREST NEIGHBOURS
Figure 6.6: Gonorrhoea diagnostic rate / 100,000		
		
Change in numerator		
Figure 6.7: Genital herpes diagnosis rate / 100,000		
		
Change in numerator		

Figure 6.8: Genital warts diagnostic rate / 100,000

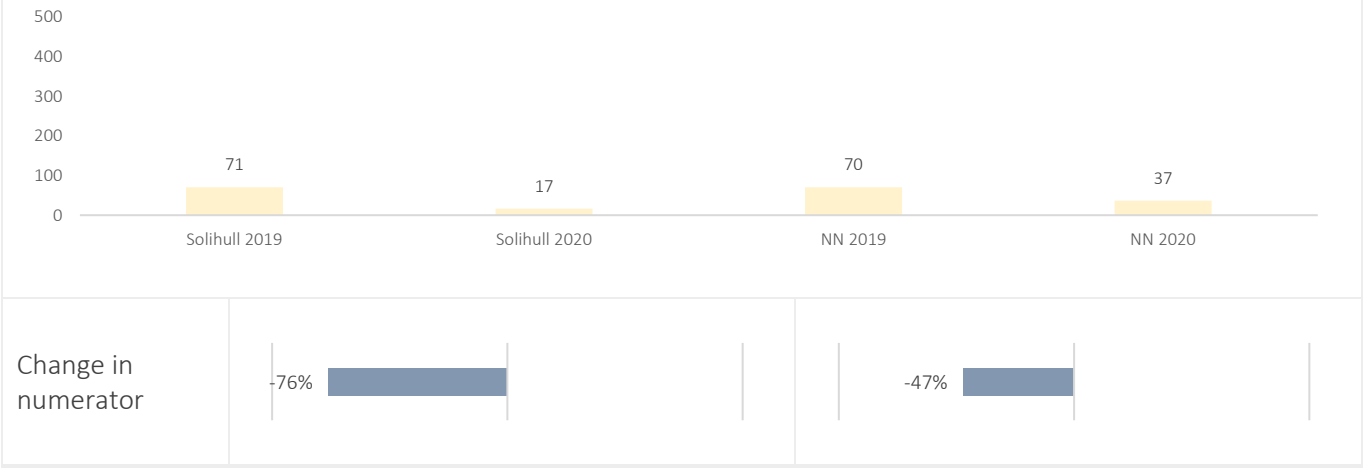


Figure 6.9: Syphilis diagnostic rate / 100,000

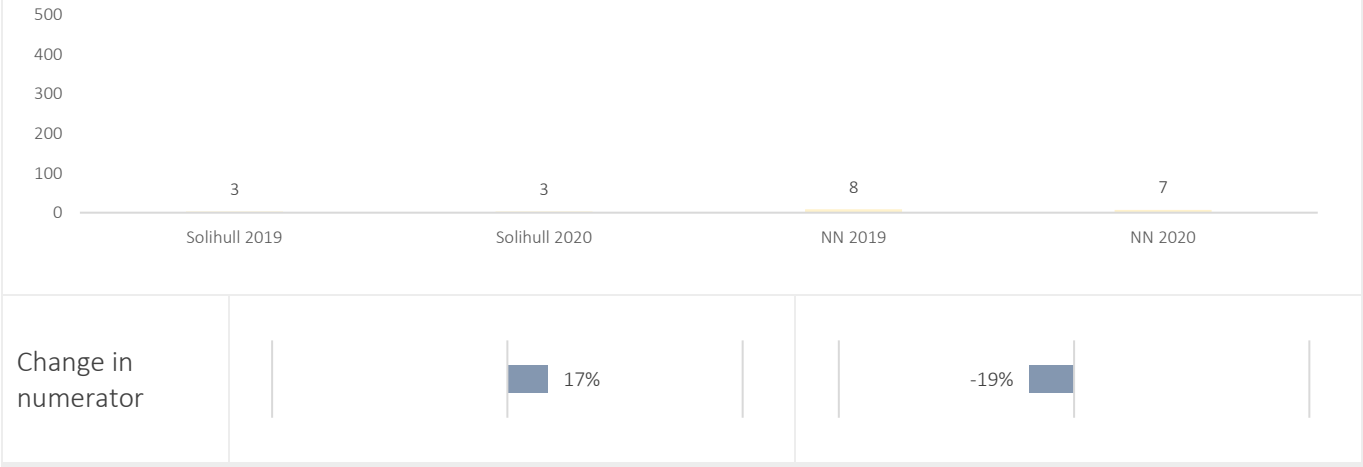
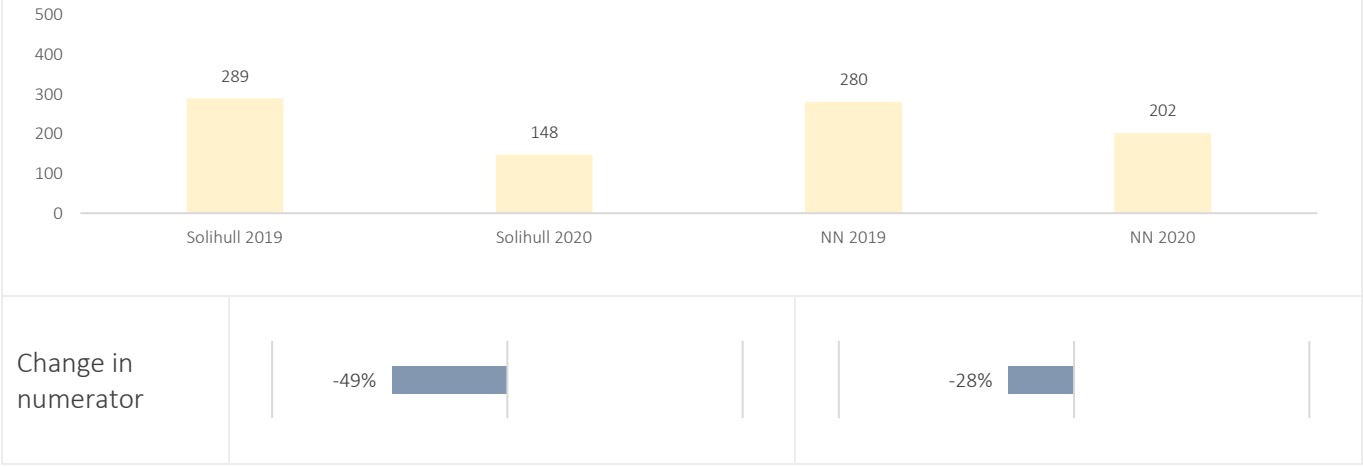


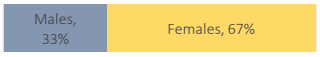
Figure 6.10: Chlamydia diagnostic rate / 100,000



BIRMINGHAM

The table below show the male/female split in the STI diagnosis rates in Birmingham.

Figure 6.11: RATE PER 100,000 POPULATION (2019-20)

	MALES	SPLIT	FEMALES
Chlamydia	Rate - 369 Actual - 2088		Rate - 490 Actual - 2823
Gonorrhoea	Rate – 228 Actual - 1288		Rate – 138 Actual - 793
Herpes	Rate - 36 Actual - 203		Rate – 71 Actual - 411
Syphilis	Rate – 14 Actual - 81		Rate – 3 Actual - 18
Warts	Rate – 91 Actual - 512		Rate – 64 Actual - 369

SOLIHULL

The table below show the male/female split in the STI diagnosis rates in Solihull.

Figure 6.12: RATE PER 100,000 POPULATION (2019-20)

	MALES	SPLIT	FEMALES
Chlamydia	Rate - 205 Actual – 216		Rate - 299 Actual – 332
Gonorrhoea	Rate - 96 Actual – 101		Rate - 72 Actual – 80
Herpes	Rate - 31 Actual – 33		Rate - 59 Actual – 66
Syphilis	Rate - 8 Actual – 8		Rate - 1 Actual – 1
Warts	Rate - 86 Actual – 91		Rate – 47 Actual – 52

CHLAMYDIA

PHE FINGERTIPS ANALYSIS

CHLAMYDIA PROPORTION AGED 15 TO 24 SCREENED – KEY INDICATOR

RATIONALE / INTRODUCTION

Chlamydia is the most common bacterial sexually transmitted infection in England, with rates substantially higher in young adults than any other age group.

By diagnosing and treating asymptomatic chlamydia infections, chlamydia screening can reduce the duration of infection, which will reduce an individual's chance of developing chlamydia associated complications, and also reduce the amount of time someone is at risk of passing the infection on, which in turn will reduce the spread of chlamydia in the population[151].

PERFORMANCE

The National Chlamydia Screening Programme (NCSP) recommends that all sexually active under-25-year-old men and women should be tested for chlamydia annually or on each change of sexual partner (whichever is more frequent).

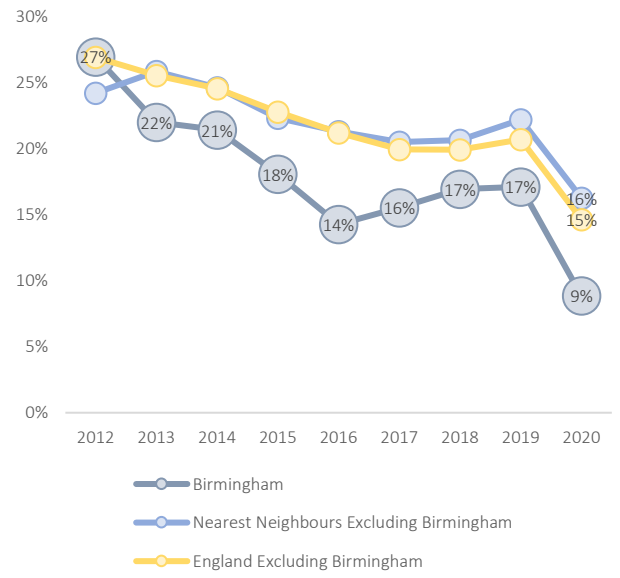
- Nationally, the rates of chlamydia testing have declined since 2012.
- Birmingham has historically tracked below the national and nearest neighbour averages.
- Testing rates in Birmingham decreased from 17% to 9%, equating to an 8 percentage point change. Both England and the nearest neighbours saw decreases of 6 percentage points.
- Similar to Birmingham, Solihull saw a significant decrease in 2020.
- It would appear that both Birmingham and Solihull were impacted more by COVID-19 than the nearest neighbours and the national average.

151 PHE Fingertips

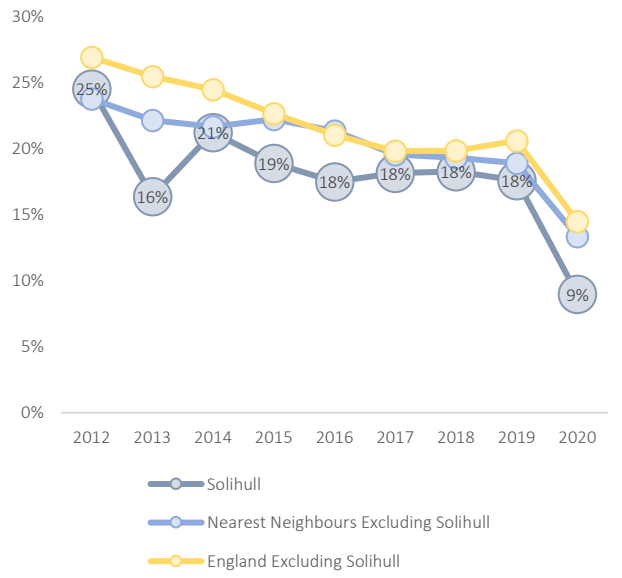
There were reductions in the proportions of 15- to 24-year-olds screened for chlamydia in Birmingham and Solihull.

Figure 6.13: Chlamydia proportion aged 15 to 24 screened; trends against nearest neighbours and against England.

BIRMINGHAM



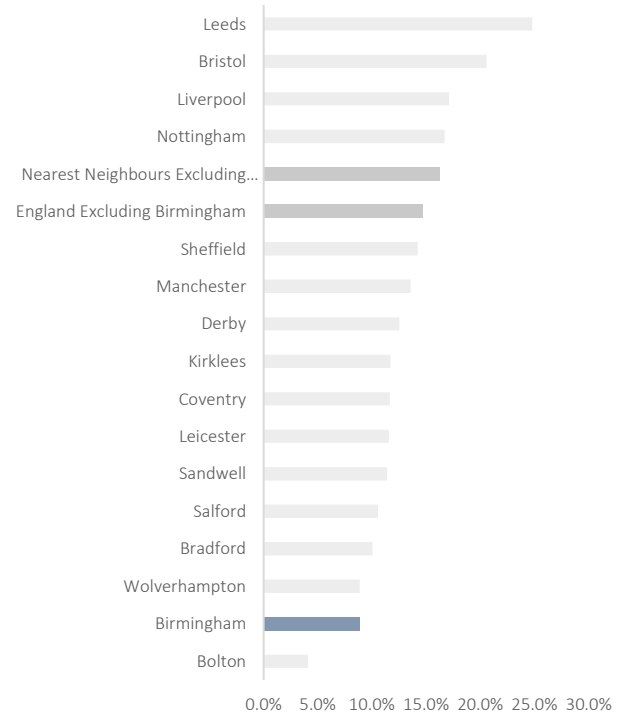
SOLIHULL



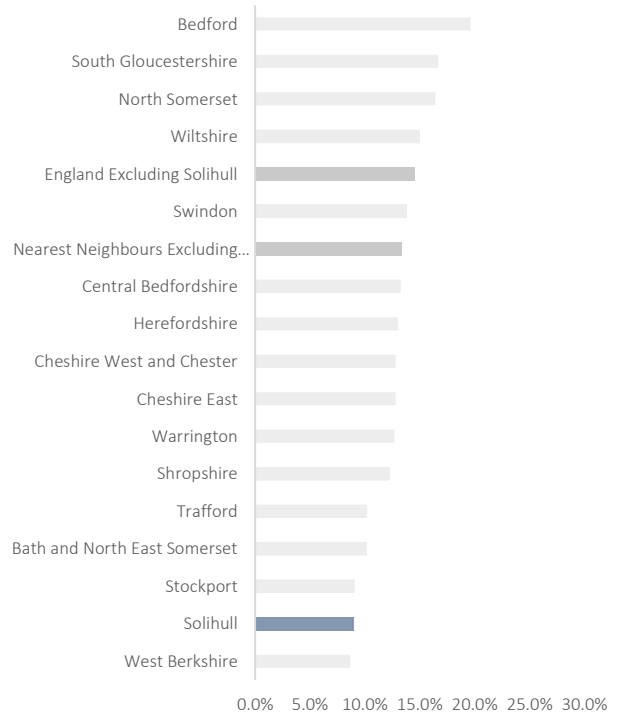
- The following charts shows that for Birmingham and Solihull, both rank poorly in comparison to their Nearest Neighbours.

Figure 6.14: Chlamydia proportion aged 15 to 24 screened; comparison against nearest neighbours in 2020.

BIRMINGHAM



SOLIHULL



CHLAMYDIA DETECTION RATE / 100,000 AGED 15 TO 24 – KEY INDICATOR

RATIONALE / INTRODUCTION

Chlamydia is the most commonly diagnosed bacterial sexually transmitted infection in England, with rates substantially higher in young adults than any other age group. It causes avoidable sexual and reproductive ill-health, including symptomatic acute infections and complications such as pelvic inflammatory disease (PID), ectopic pregnancy and tubal-factor infertility.

The National Chlamydia Screening Programme (NCSP) promotes opportunistic screening to sexually active young people aged under 25 years. In June 2021 changes to the programme were announced with a focus on reducing reproductive harm of untreated infection through opportunistic screening offered to young women aged under 25 years. This indicator relates to data until December 2020 when the NCSP offered screening to all young people under 25.

The chlamydia detection rate among under-25-year-olds is a measure of chlamydia control activity, aimed at reducing the incidence of reproductive sequelae of chlamydia infection and interrupting transmission. An increased detection rate is indicative of increased control activity; the detection rate is not a measure of morbidity.

Inclusion of this indicator in the Public Health Outcomes Framework (PHOF) allows monitoring of progress to control chlamydia and the delivery of accessible, high-volume chlamydia screening.

Public Health England (PHE) recommends that local authorities should be working towards achieving a detection rate of at least 2,300 per 100,000 population aged 15 to 24. The recommendation was set as a level that would encourage high volume screening and diagnoses, be ambitious but achievable, high enough to encourage community screening, rather than specialist sexual health clinic only diagnoses, and would be likely to result in a continued chlamydia prevalence reduction, according to mathematical modelling[152].

152 PHE Fingertips

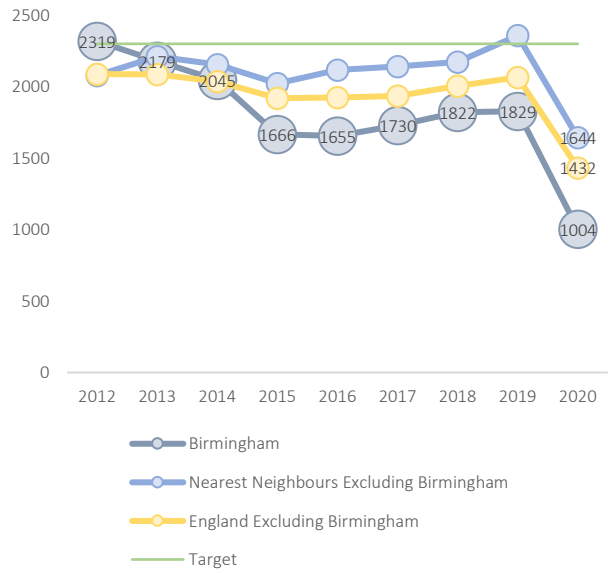
PERFORMANCE

Birmingham has tracked below the national and nearest neighbours' averages since 2015; however, there was a decrease of 45% for the number of diagnoses of chlamydia among 15-to-24-year-olds when comparing 2020 against 2019. The nearest neighbours saw a decrease of 29%, whilst England saw a decrease of 31%.

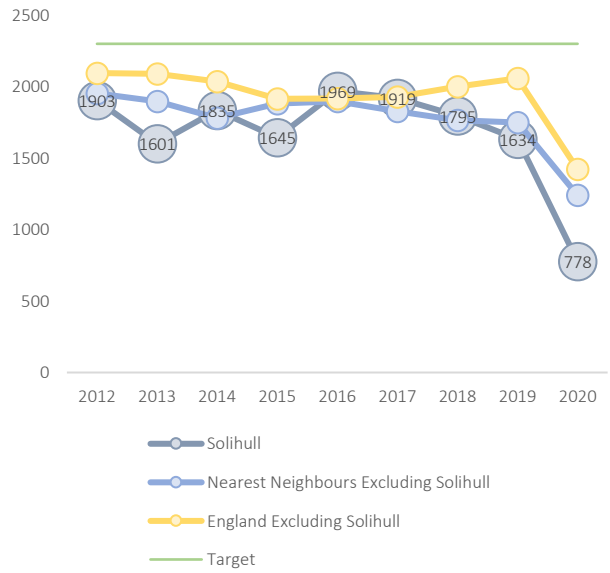
Solihull has seen a drop in performance in comparison to the nearest neighbours since 2016. Solihull saw a decrease of 52% for the number of diagnoses of chlamydia among 15-to-24-year-olds when comparing 2020 against 2019. The nearest neighbours saw a decrease of 29% whilst England saw a decrease of 31%.

Figure 6.15: Chlamydia detection rate / 100,000 aged 15 to 24; trends against nearest neighbours and against England.

BIRMINGHAM

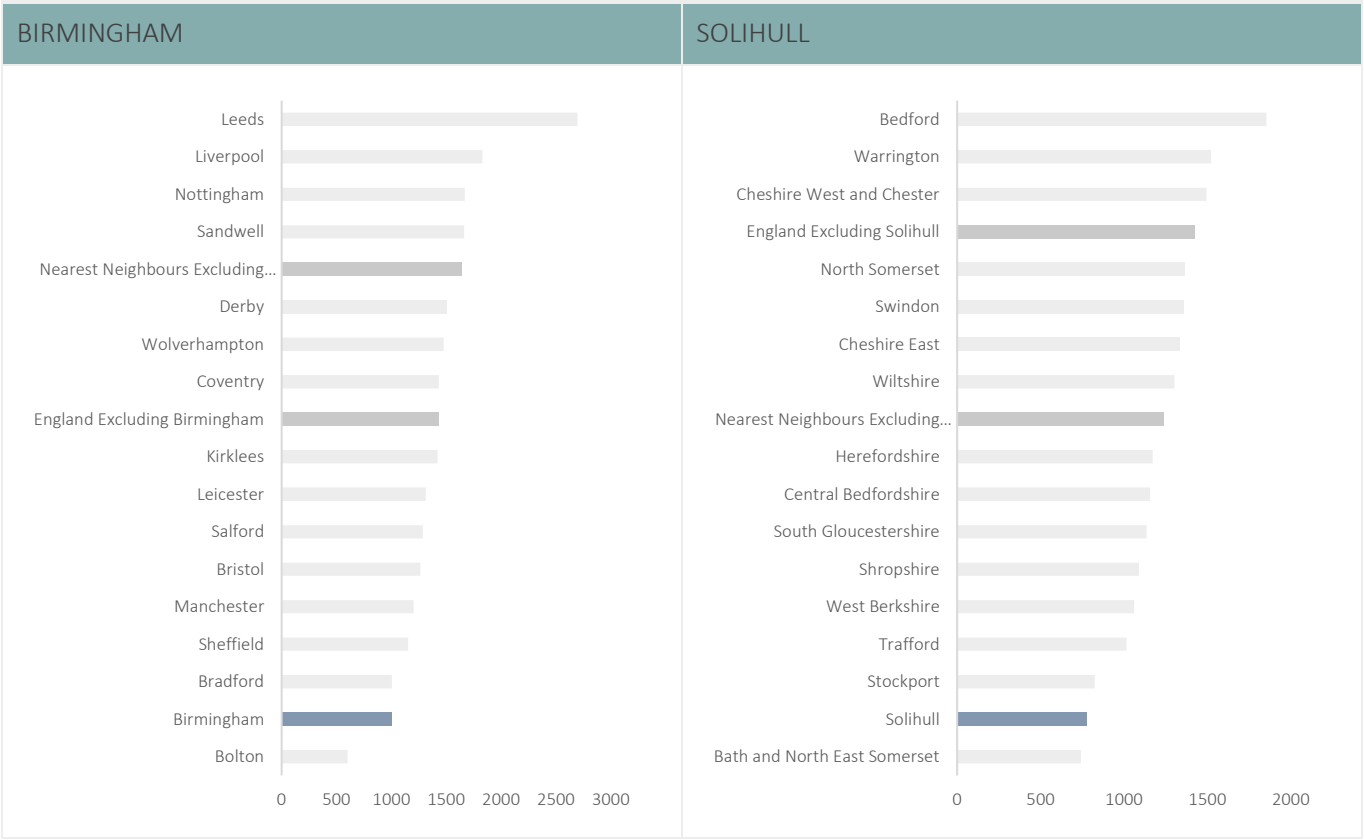


SOLIHULL



Compared to the nearest neighbours, both Birmingham and Solihull are among the lowest rates.

Figure 6.16: Chlamydia detection rate / 100,000 aged 15 to 24; comparison against nearest neighbours in 2020.



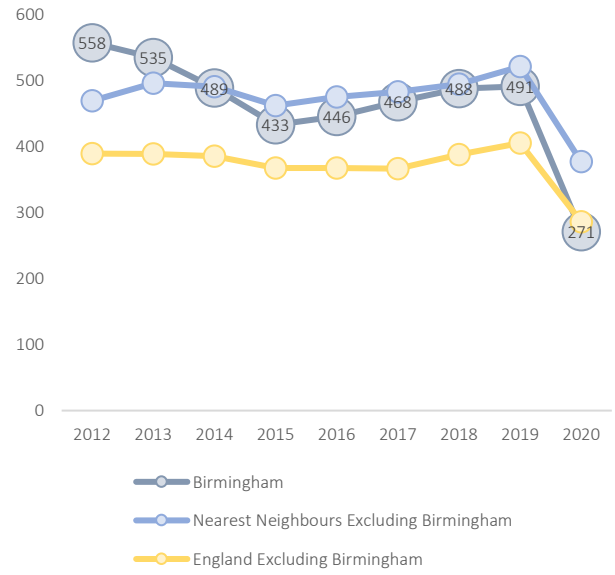
CHLAMYDIA DIAGNOSTIC RATE / 100,000

There is a higher rate of chlamydia diagnoses in Birmingham in comparison to Solihull.

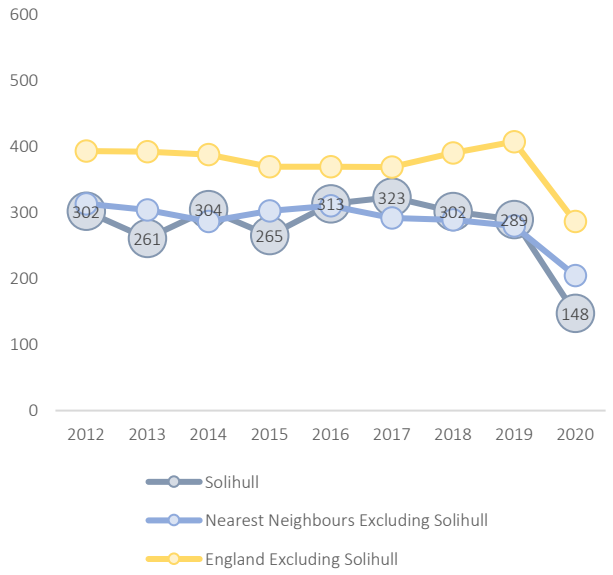
Prior to 2020, both Birmingham and Solihull had rates similar to the nearest neighbours. 2020 saw a decrease for both these areas, and Birmingham and Solihull both now have notably lower rates than their nearest neighbours.

Figure 6.17: Chlamydia diagnostic rate / 100,000; Trends against nearest neighbours and against England.

BIRMINGHAM



SOLIHULL



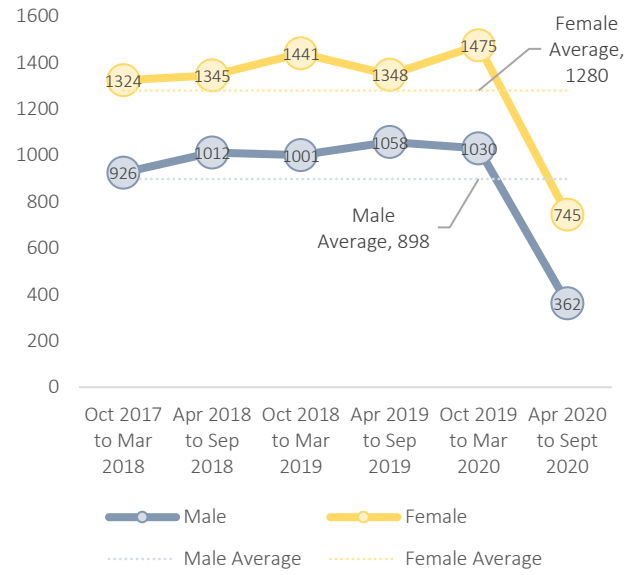
GUMCAD ANALYSIS

NUMBER OF NEW DIAGNOSES

- Both Birmingham and Solihull saw a significant decrease in the number of new diagnoses when comparing April September 2020 against previous periods.

BIRMINGHAM	SOLIHULL

Figure 6.18: Number of new diagnoses (6-month periods)



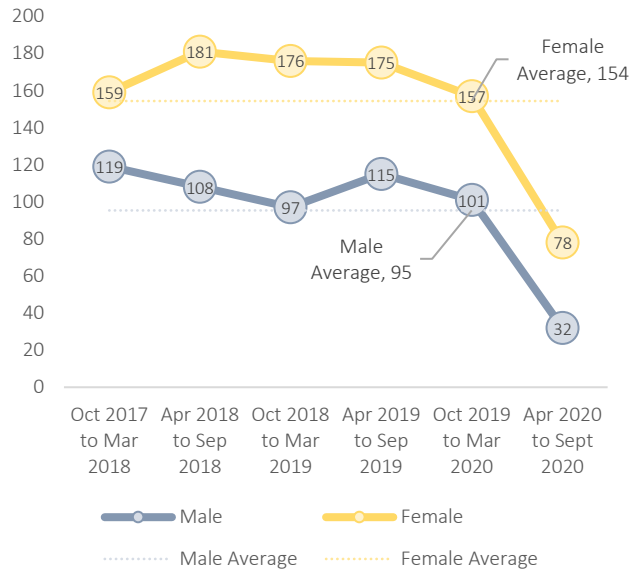
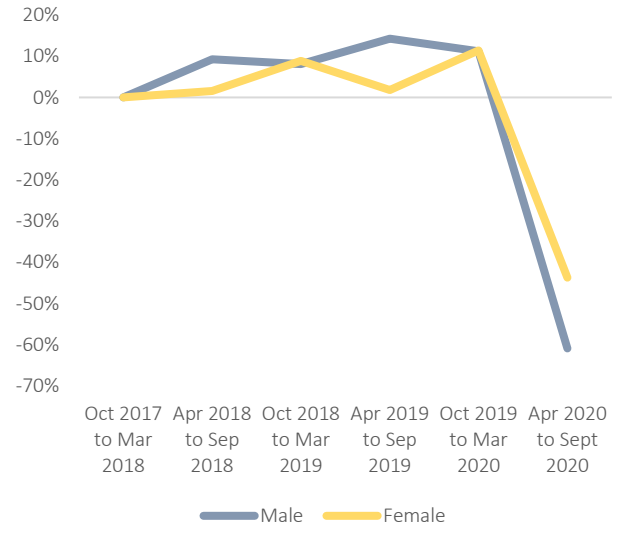
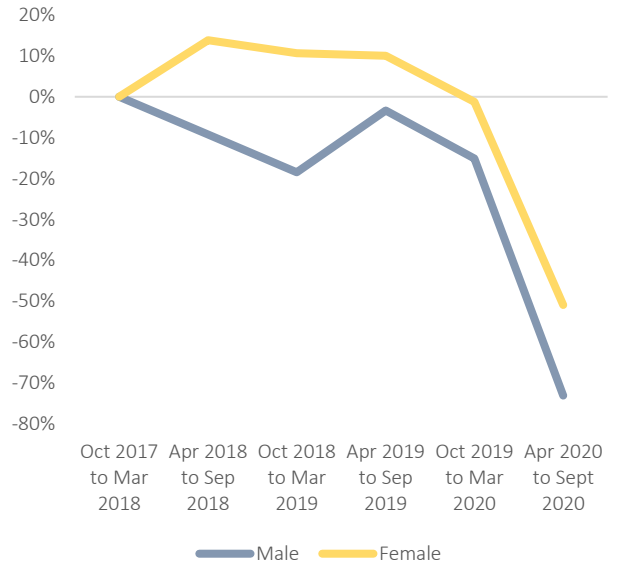


Figure 6.19: Change against October 2017 to March 2018 baseline.





MALES	FEMALES
Figure 6.20: Rate of new diagnoses for year to September 2020 by age; rate per 100,000 population.	

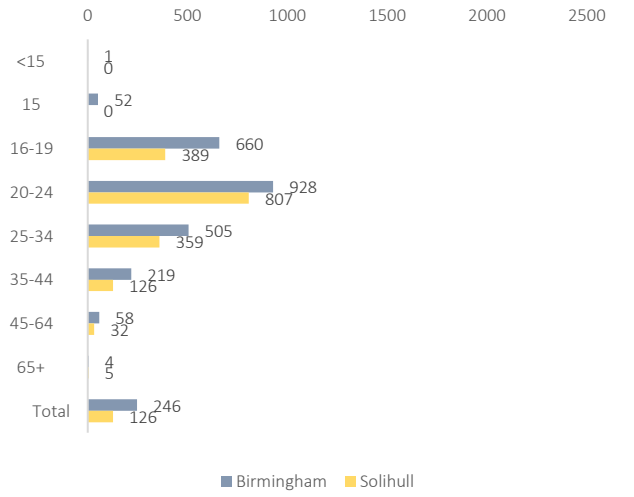
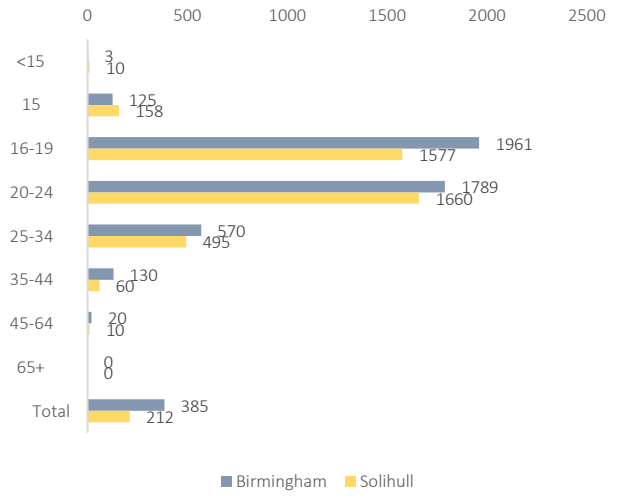
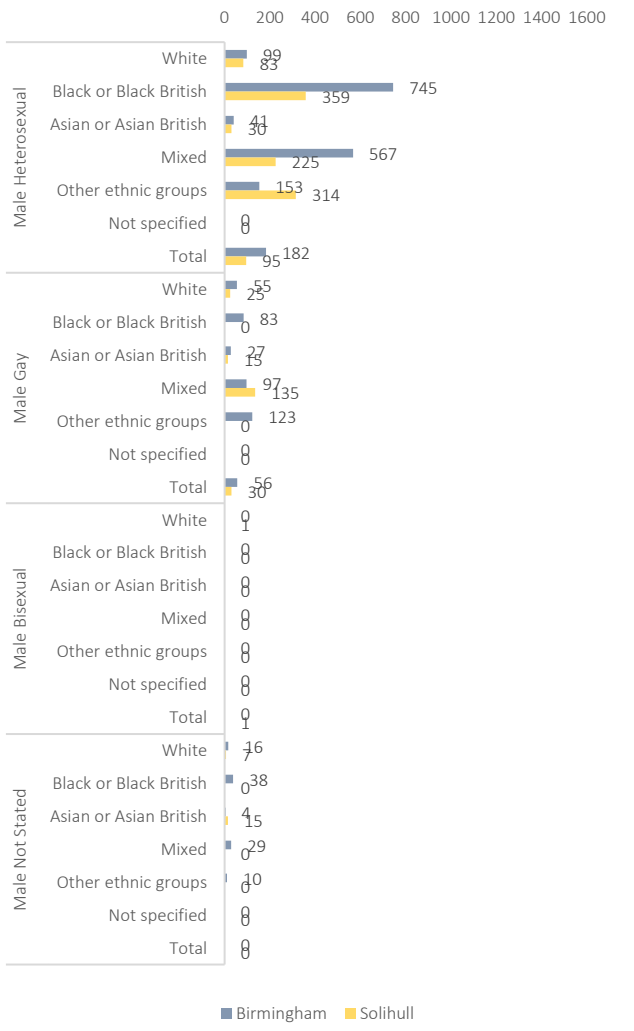
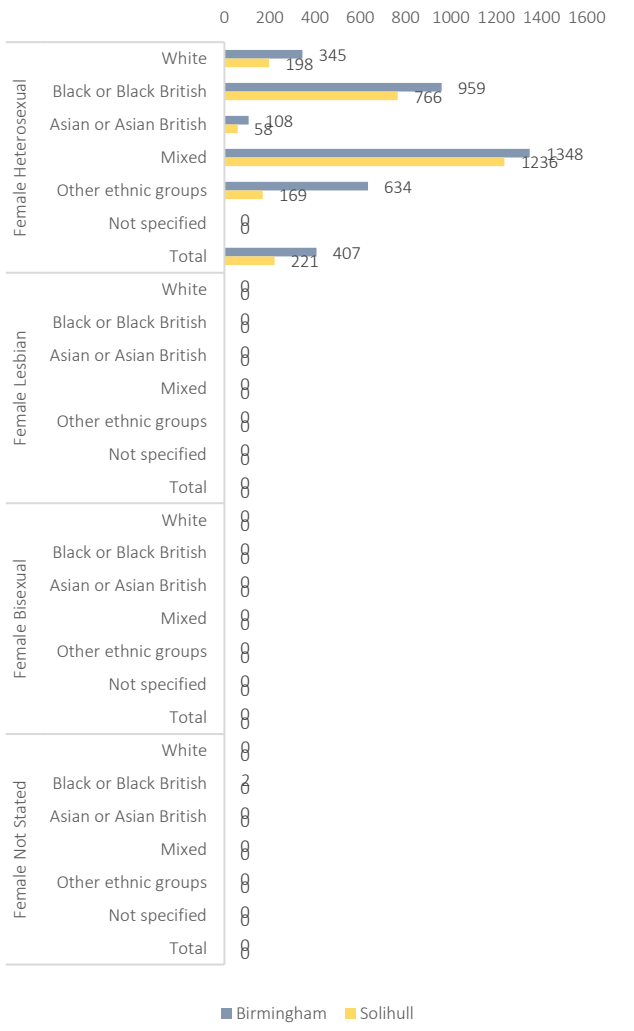

	

Figure 6.21: Rate of new diagnoses for year to September 2020 by ethnicity and risk; rate per 100,000 population.	
	

LOCAL SERVICE PROVISION

OVERVIEW

Provision is provided by Umbrella Health. The following table provides an overview of the available provision.

GP

- There is a chlamydia screening programme offered by Umbrella partner GPs.
  - This programme started in April 2018. To increase GP participation, there is an adjusted tariff based on higher positive results.
- Chlamydia treatment is available at Umbrella-partnered GPs in Birmingham.

PHARMACY

- Chlamydia screening is offered at Umbrella partner pharmacies in Birmingham.
  - There are no pharmacies in Solihull partnered with Umbrella.
- Chlamydia treatment is available at Umbrella-partnered pharmacies in Birmingham and in pharmacies in Solihull.

SEXUAL HEALTH CLINICS

- All patients attending Umbrella clinics are offered HIV and STI testing.
  - This includes a chlamydia screen.
- Chlamydia treatment is available at Umbrella sexual health clinics.

KEY FINDINGS

- GPs and other practitioners fed back that chlamydia swabs were available intermittently during the COVID-19 pandemic.
  - This impacted the number of tests being completed.
- Chlamydia screening is included as part of the home STI testing kits which are offered through Umbrella clinics and via their community and delivery partners. Kits can also be ordered from the Umbrella website.
  - A number of different services highlighted that there were limited numbers of kits available during the COVID-19 pandemic.
  - The blockage in kit availability was due to a shortage of appropriate components.

ACTIVITY

Umbrella Health are measured on the following key contractual targets:

1. Percentage of patients who received treatment within 6 weeks of test dates.
    - This is currently below the contractual threshold.
2. Percentage of all results notified to the young person within 10 days of test date.
    - Umbrella performs strongly against this indicator, with each quarter exceeding the 90% target.
3. Percentage of all eligible 15–24-year-olds attending sexual health clinics screened for Chlamydia.
    - The Trust has performed above the contractual threshold of 80% since Q3 2017/18. Exceptions – such as Q2 and Q3 2020/21 – and the reasons for variation in performance have been shared with Commissioners, including mitigating actions taken to address performance. Umbrella is also above the new threshold – due to take effect from April 2021 – of 80%. [153]

Performance for those screened in clinics has now improved in Q4 from 54.8% to 82.5%. The increase in performance may be due to Umbrella now having a quick test clinic for STI testing and chlamydia testing which was set up in Q4. The percentage of patients notified of results within 10 working days has remained static, with performance at 98.5%. [154]

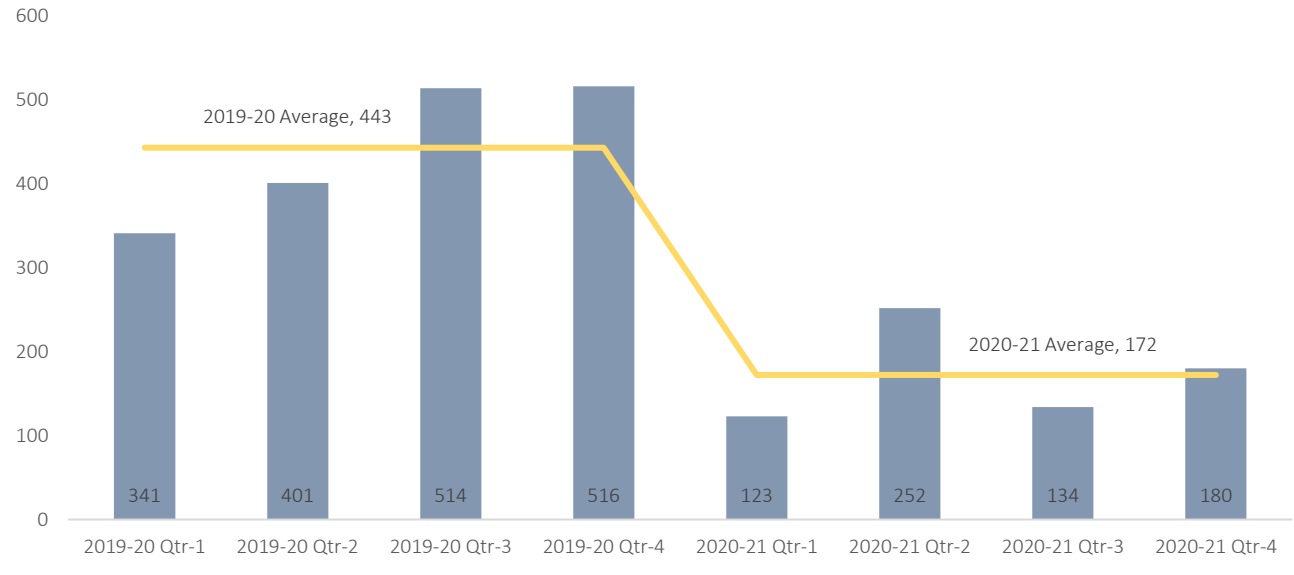
Additional indicators are:

4. Percentage contribution to chlamydia screening by core services

Chlamydia screening continues to be mainly accessed via self-test kits. This is despite the fall in Q3 due to the impact of national shortages in testing kits. Mitigation actions taken by Umbrella have seen performance for self-test kits improve from 31.9% in Q3 to 76.8% in Q4. [155]

5. Chlamydia Treatment – Pharmacy

Figure 6.23: Chlamydia Treatment - Pharmacy



6. Chlamydia Tests Processed - GP

[153] From Umbrella Performance Report
[154] From Umbrella Performance Report
[155] From Umbrella Performance Report

- The number of tests processed was similar in 2018-19 and 2019-20. 2020-21 saw a significant decrease.
- The number of screens conducted by GPs continues to be lower than pre-pandemic levels. This is partly due to GPs conducting appointments remotely and social distancing restrictions in place; GPs currently do not have the footfall of young people aged 15-24 years attending the practices. In March, Umbrella sent notification to all GPs contracted to provide chlamydia screening to highlight that screening kits can now be ordered for their patients. This will continue to be monitored. [156]
- Although the number of tests in 2019-20 was the same as the previous year, the numbers testing positive increased.

Figure 6.24: Number of Chlamydia tests processed and positive; 15-24 years of age.

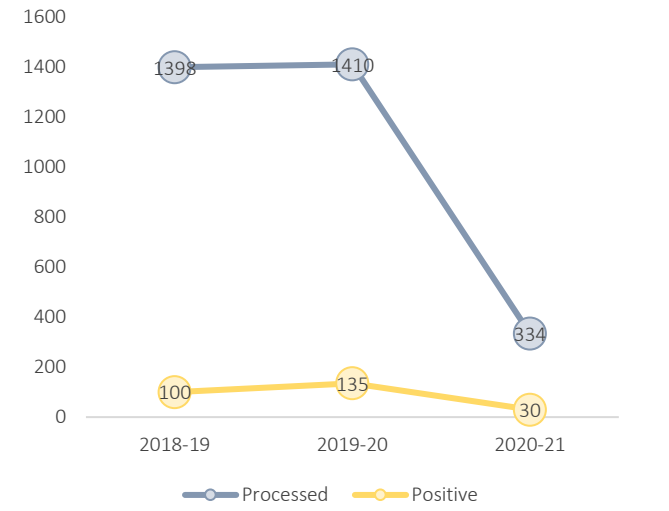


Figure 6.25: Positive Chlamydia test rate; 15-24 years of age.

Figure 6.26: Number of Chlamydia tests processed and positive; all ages excluding 15-24 years of age.

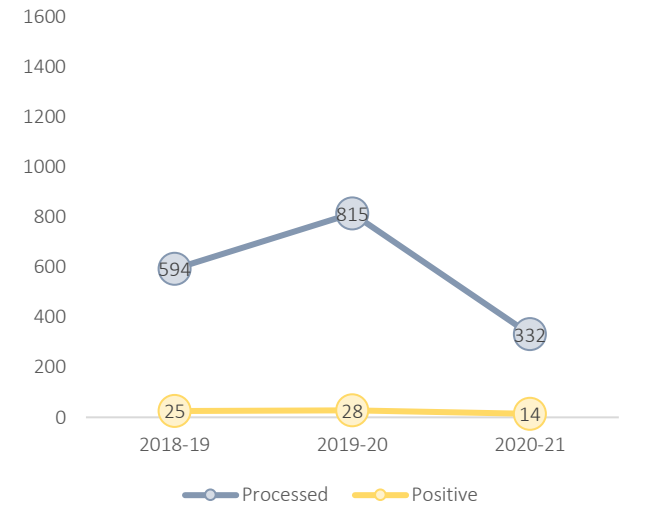


Figure 6.27: Positive Chlamydia test rate; all ages excluding 15-24 years of age.

GEOGRAPHICAL ANALYSIS

- These figures show both the actual number of tests processed and the percentage as a rate of the population.
- There are higher rates where the university is based.
- 22 of the 69 wards had 0 tests processed.

[156] From Umbrella Performance Report

- In Edgbaston there was a high testing rate with a low positive rate.

Figure 6.28: Number of processed tests for the 15-24 age group in 2019-20 by GP ward; count.

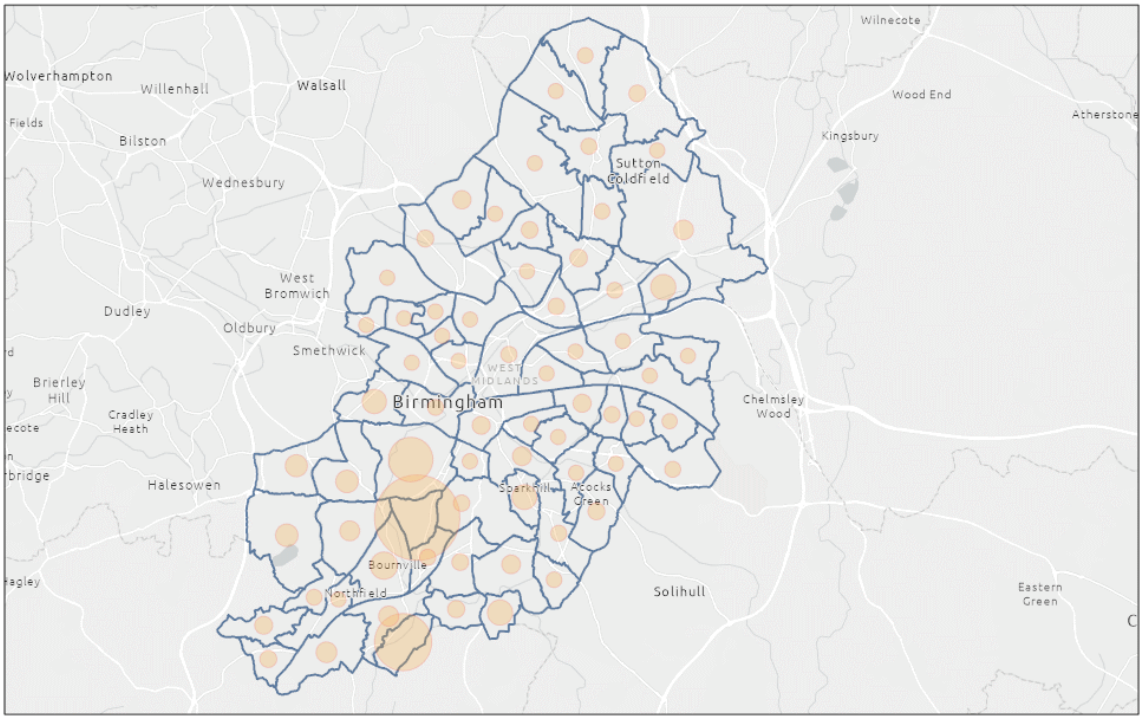
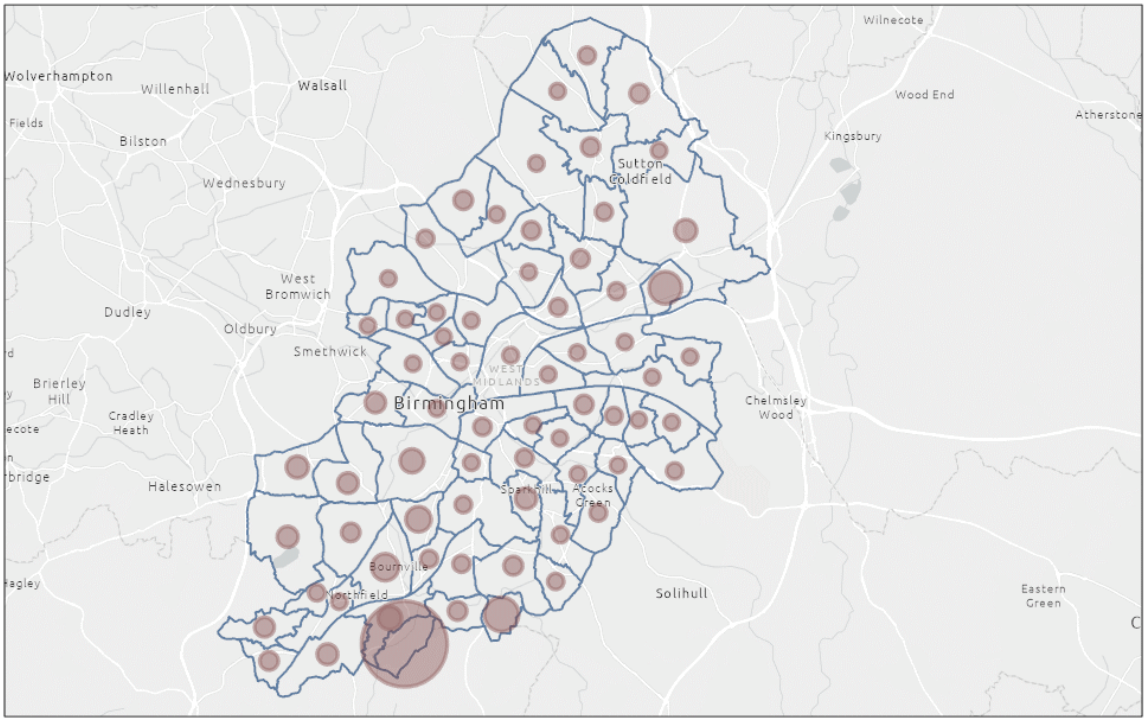


Figure 6.29: Number of processed tests for the 15-24 age group in 2019-20 by GP ward; rate per 100,000 population.



Ward Name	201920_Processed	201920_Processed_Rate	201920_Positive	201920_Positive_Rate
Acocks Green	9	2.69	0	0%
Allens Cross	3	2.23	1	33%
Alum Rock	0	0.00	0	-
Aston	0	0.00	0	-
Balsall Heath West	1	0.39	0	0%

Bartley Green	37	12.37	5	14%
Billesley	18	7.36	3	17%
Birchfield	0	0.00	0	-
Bordesley & Highgate	14	4.33	0	0%
Bordesley Green	0	0.00	0	-
Bournbrook & Selly Park	354	22.30	19	5%
Bournville & Cotteridge	61	26.14	4	7%
Brandwood & King's Heath	8	3.71	1	13%
Bromford & Hodge Hill	0	0.00	0	-
Castle Vale	51	38.40	11	22%
Druids Heath & Monyhull	10	6.95	2	20%
Edgbaston	147	18.86	4	3%
Erdington	12	5.27	0	0%
Frankley Great Park	14	9.66	3	21%
Garretts Green	0	0.00	0	-
Glebe Farm & Tile Cross	0	0.00	0	-
Gravelly Hill	7	4.02	0	0%
Hall Green North	4	1.17	0	0%
Hall Green South	2	1.67	0	0%
Handsworth	0	0.00	0	-
Handsworth Wood	0	0.00	0	-
Harborne	37	11.40	7	19%
Heartlands	15	6.38	1	7%
Highter's Heath	51	42.75	4	8%
Holyhead	0	0.00	0	-
King's Norton North	25	18.10	3	12%
King's Norton South	212	157.86	22	10%
Kingstanding	0	0.00	0	-
Ladywood	4	0.60	0	0%
Longbridge & West Heath	28	11.75	5	18%
Lozells	0	0.00	0	-
Moseley	6	2.26	1	17%
Nechells	5	0.87	1	20%
Newtown	0	0.00	0	-
North Edgbaston	46	11.04	8	17%
Northfield	0	0.00	0	-
Oscott	16	7.02	4	25%
Perry Barr	9	3.13	1	11%
Perry Common	8	5.61	2	25%
Pype Hayes	4	3.41	0	0%
Quinton	35	14.66	4	11%
Rubery & Rednal	9	6.96	0	0%
Shard End	0	0.00	0	-
Sheldon	4	1.73	1	25%
Small Heath	0	0.00	0	-
Soho & Jewellery Quarter	0	0.00	0	-
South Yardley	0	0.00	0	-
Sparkbrook & Balsall Heath East	19	4.25	0	0%
Sparkhill	49	12.77	5	10%

Stirchley	4	3.55	0	0%
Stockland Green	0	0.00	0	-
Sutton Four Oaks	0	0.00	0	-
Sutton Mere Green	3	3.15	0	0%
Sutton Reddicap	0	0.00	0	-
Sutton Roughley	9	7.60	1	11%
Sutton Trinity	5	6.31	1	20%
Sutton Vesey	0	0.00	0	-
Sutton Walmley & Minworth	23	14.91	3	13%
Sutton Wylde Green	3	3.31	1	33%
Tyseley & Hay Mills	0	0.00	0	-
Ward End	0	0.00	0	-
Weoley & Selly Oak	24	6.62	7	29%
Yardley East	0	0.00	0	-
Yardley West & Stechford	5	2.73	0	0%
	1410	7.63	135.00	10%

GONORRHOEA

PHE FINGERTIPS ANALYSIS

GONORRHOEA DIAGNOSTIC RATE / 100,000– KEY INDICATOR

INTRODUCTION / RATIONALE

Gonorrhoea causes avoidable sexual and reproductive ill-health. Gonorrhoea is used as a marker for rates of unsafe sexual activity. This is because the majority of cases are diagnosed in sexual health clinics, and consequently the number of cases may be a measure of access to sexually transmitted infection (STI) treatment. Infections with gonorrhoea are also more likely than chlamydia to result in symptoms.[157].

PERFORMANCE

Birmingham

- Prior to 2020, Birmingham has historically had higher rates of gonorrhoea than both the nearest neighbours average and the England average.
- Birmingham saw a significant decrease in 2020, which resulted in the rates now being comparable to the nearest neighbours and to England.
- Figure 6.32 shows that in 2019, Birmingham had the third-highest rate in the Nearest Neighbours group. In 2020, Birmingham was 12th.
- Between 2016 and 2019, there was a significant increase in gonorrhoea rates Birmingham. This reflects the same trend as the nearest neighbours and England.

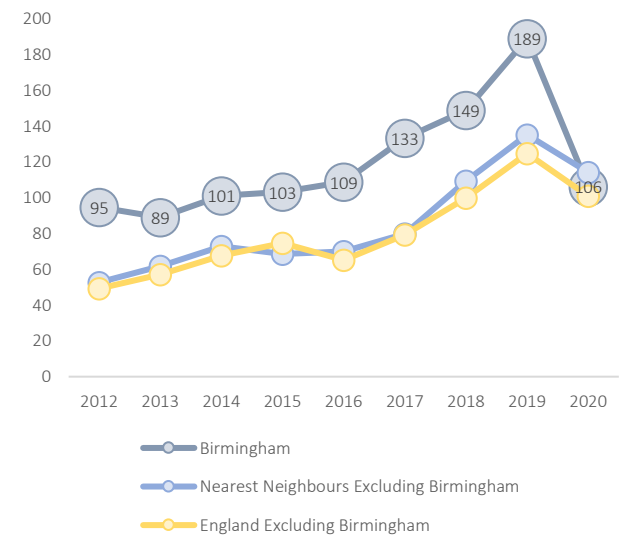
Solihull

- Between 2014 to 2019, Solihull had higher rates of gonorrhoea than the nearest neighbours.
- A significant drop in 2020 resulted in the rates now being comparable to the nearest neighbours.
- Figure 6.33 shows that in 2019, Solihull had the highest rate in the Nearest Neighbours group. In 2020, Solihull had the second lowest.

157 PHE Fingertips

Figure 6.30: Gonorrhoea diagnostic rate / 100,000; trends against nearest neighbours and against England.

BIRMINGHAM



SOLIHULL

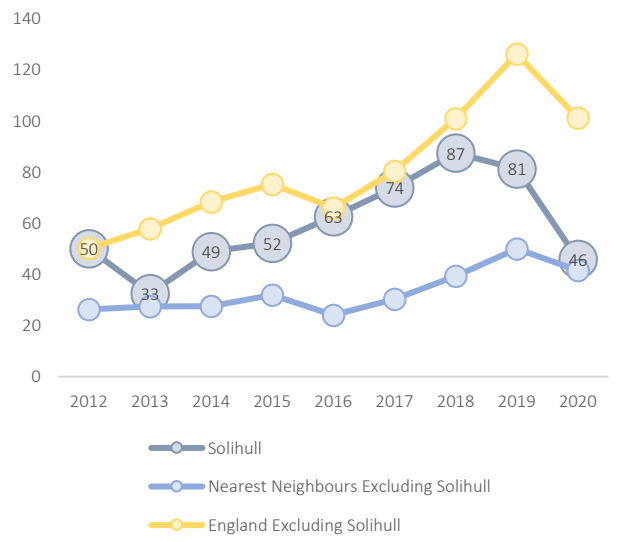


Figure 6.31: Actual count.

	2012	2013	2014	2015	2016	2017	2018	2019	2020
Birmingham	1027	972	1114	1148	1227	1516	1699	2157	1210
Solihull	104	68	103	110	133	158	188	176	100

Figure 6.32: BIRMINGHAM – 2019

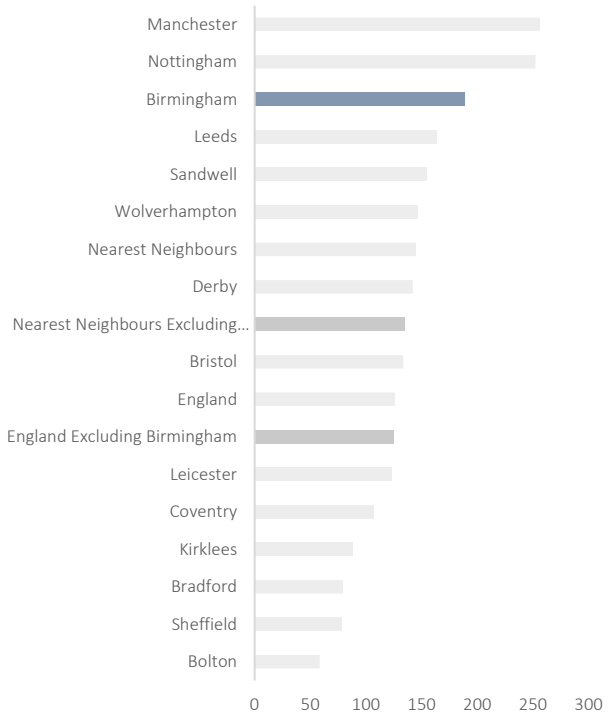


Figure 6.33: SOLIHULL - 2019

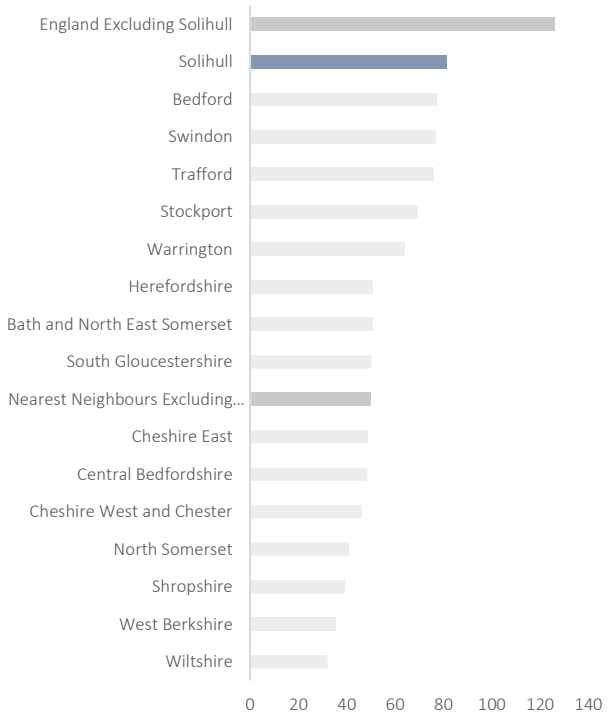


Figure 6.34: BIRMINGHAM – 2020

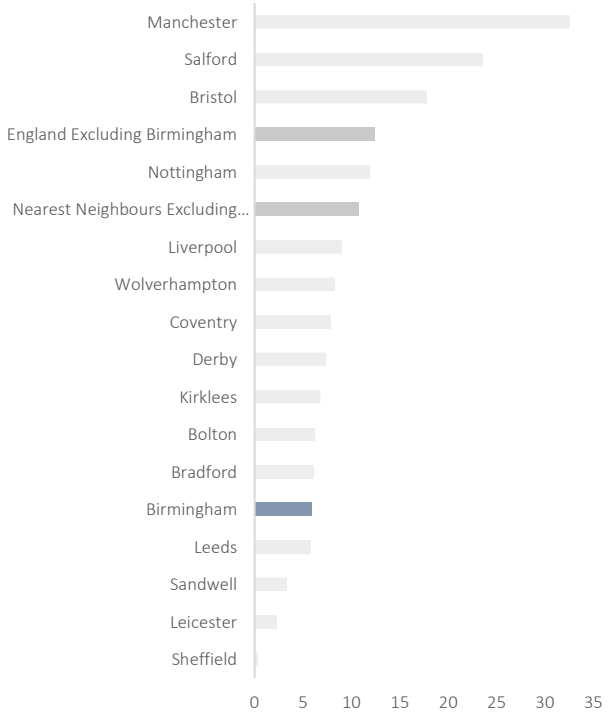
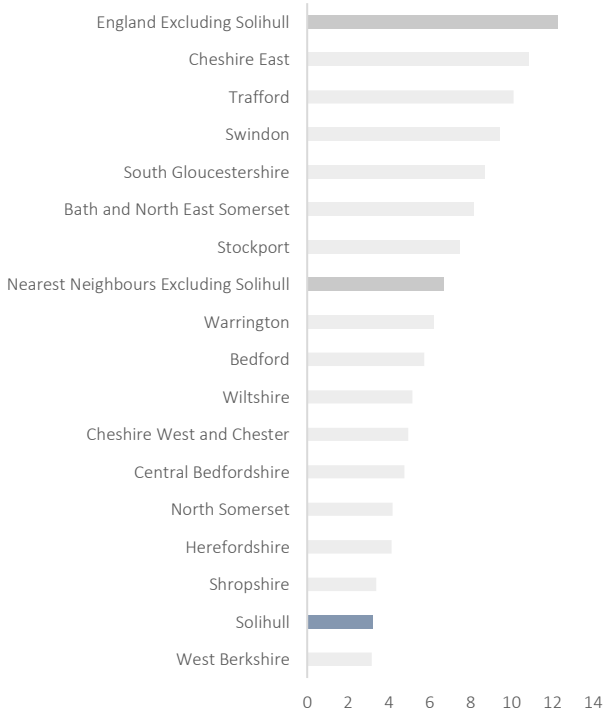


Figure 6.35: SOLIHULL – 2020



SYPHILIS

PHE FINGERTIPS ANALYSIS

SYPHILIS DIAGNOSTIC RATE / 100,000 – KEY INDICATOR

INTRODUCTION / RATIONALE

Syphilis is an important public health issue in men who have sex with men (MSM), among whom incidence has increased over the past decade.[158].

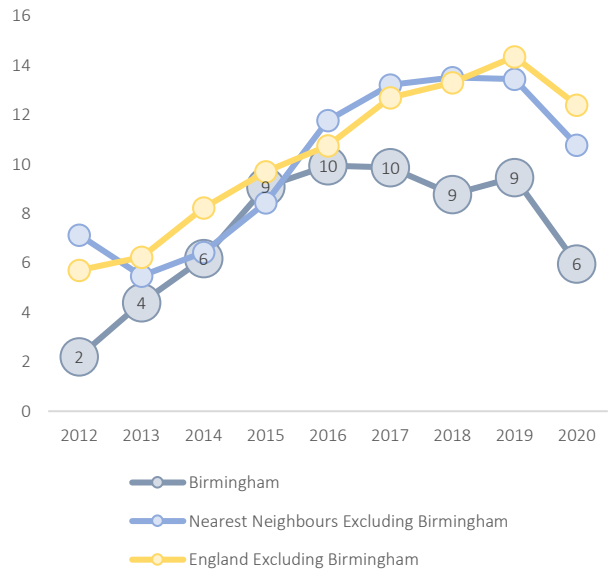
PERFORMANCE

Birmingham and Solihull

- There were low rates in both Birmingham and Solihull.
- Both areas were below the national and nearest neighbour rates.

Figure 6.36: Syphilis diagnostic rate / 100,000; trends against nearest neighbours and against England.

BIRMINGHAM



SOLIHULL

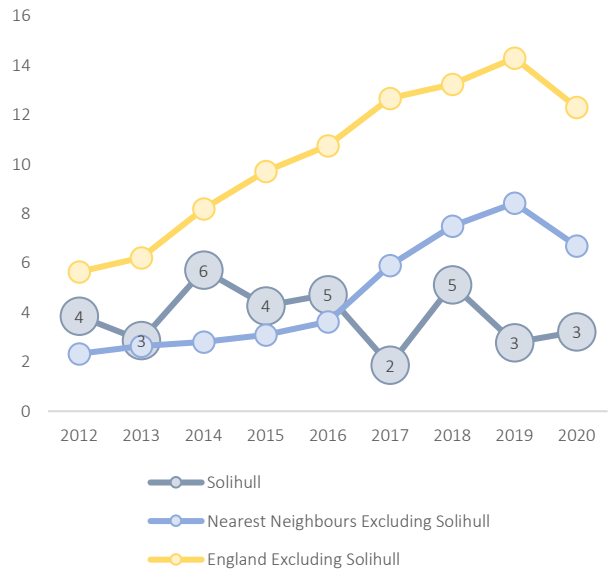


Figure 6.37: Actual count.

	2012	2013	2014	2015	2016	2017	2018	2019	2020
Birmingham	24	48	68	101	112	112	100	108	68
Solihull	8	6	12	9	10	4	11	6	7

158 PHE Fingertips

HERPES

PHE FINGERTIPS ANALYSIS

GENITAL HERPES DIAGNOSIS RATE / 100,000

INTRODUCTION / RATIONALE

Genital herpes is the most common ulcerative sexually transmitted infection seen in England. Infections are frequently due to herpes simplex virus (HSV) type 2, although HSV-1 infection is also seen. Recurrent infections are common, with patients returning for treatment.[159].

PERFORMANCE

Birmingham

- There was a large drop in genital herpes diagnoses in 2020.

Solihull

- There was a large drop in genital herpes diagnoses in 2020.

Figure 6.38: Genital herpes diagnostic rate / 100,000; trends against nearest neighbours and against England.

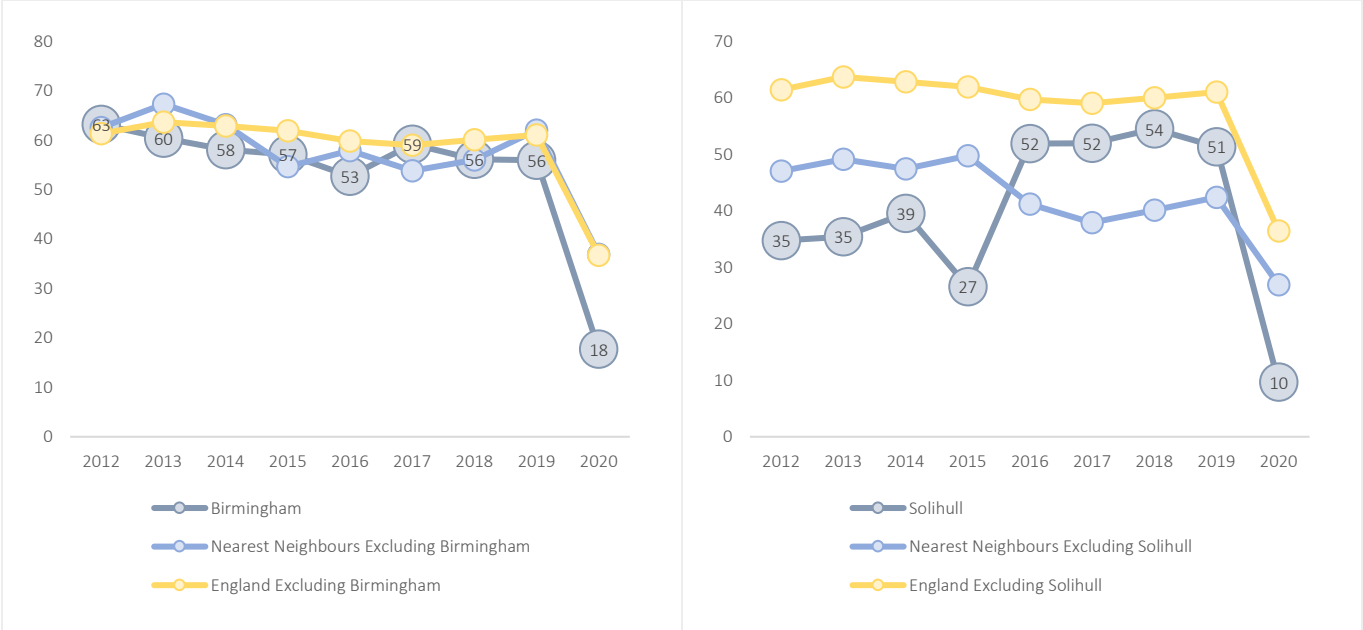


Figure 6.39: Actual count.

	2012	2013	2014	2015	2016	2017	2018	2019	2020
Birmingham	685	659	639	635	594	672	640	638	202
Solihull	72	74	83	56	110	111	117	111	21

159 PHE Fingertips

HIV

INTRODUCTION

More people than ever before are living with HIV in England. Although today's medicines make HIV manageable, it continues to have a major impact on people's lives. The number of people living with HIV, and living longer, will carry on increasing due to continuing incidence and highly effective treatment. [160]

In 2018, BHIVA issued a new statement on 'Undetectable=Untransmittable (U=U)[161]'.

"Consistent use of ART by people living with HIV to maintain an undetectable viral load is a highly effective strategy to prevent the sexual transmission of HIV. We urge health care professionals to discuss U=U proactively with all people living with HIV at appropriate points during care including, but not limited to: - at diagnosis, when initiating treatment, to encourage adherence, when undetectable, and if planning to conceive.

We recommend consistent and unambiguous terminology when discussing U=U such as "no risk" or "zero risk" of sexual transmission of HIV, avoiding terms like "negligible risk" and "minimal risk."

We encourage clinics to display and provide information on the use of ART to maintain an undetectable viral load as a highly effective strategy to prevent the sexual transmission of HIV. We also advise explaining the scientific evidence behind U=U, emphasising the importance of excellent adherence to ART and highlighting that U=U is dependent on maintaining a sustained undetectable viral load."

BEST PRACTICE

HIV Commission recommendations affecting local authorities include:[162]

- All national and local HIV treatment and prevention initiatives should explicitly plan and evaluate how they will address HIV-related stigma, discrimination and health inequalities.
- Partner notification should be prioritised by local government, particularly in relation to key populations.
- All late HIV diagnoses must be investigated as a serious incident by the National Institute for Health Protection, working with BHIVA, NHS Trusts, local authorities, and Clinical Commissioning Groups.
- Local authorities should each develop their own local plan on how they will contribute to the recommendations of the HIV Commission, to ensure the 2025 and 2030 goal is met.
- NHS England and local authorities, working with the Department of Health and Social Care and its agencies, should collaborate more closely on the commissioning of sexual health and HIV services; and ensure greater integration of services to ensure seamless, patient-centred care.
- Commissioners should work with local providers and community organisations to ensure better co-delivery between drug and alcohol services (including sensitivity to the specificity of chemsex), domestic violence, mental health and sexual health services.

The King's Fund recommends:[163]

- Directors of public health and lead HIV clinicians should work together to ensure effective system leadership that will get all key stakeholders on board with a single, overarching plan for developing future HIV services across the HIV pathway.

[160] King's Fund (2017), The future of HIV services in England: Shaping the response to changing needs.
[161] https://i-base.info/u-equals-u/
[162] HIV Commission (2020), How England will end new cases of HIV: Final report and recommendations.
[163] King's Fund (2017), The future of HIV services in England: Shaping the response to changing needs.

- The plan should establish a shared understanding of how roles fit together to respond to changing care and prevention needs, governance across these roles, and relationships and ways of working that connect the currently fragmented system. It should focus on quality of life, including access to social support.
- Local HIV services should further develop relationships with other services for people with long-term conditions (cancer services, for example) to support common approaches and enable mutual learning.
- Local services need to test and develop future models for long-term HIV care, building on the work of pioneering services that have already started developing shared care. These models will not be 'one size fits all' but must be locally appropriate to reflect differing needs and circumstances.

COLLATION OF KEY GUIDANCE

- NICE guidance and quality standards include:
    - Guideline [NG60]: HIV testing: increasing uptake among people who may have undiagnosed HIV[164]
    - Quality standard [QS157]: HIV testing: encouraging uptake.[165]
- The British HIV Association publishes guidelines on antiretroviral treatment, HIV-2 management, Post-Exposure Prophylaxis (PEPSE), managing the sexual and reproductive health of people living with HIV and more. See https://www.bhiva.org/guidelines

WHAT ARE THE KEY DRIVERS?

In 2019, Health Secretary Matt Hancock announced a new goal of eradicating HIV transmission in England by 2030. The HIV Commission recommends that to meet this ambition, the government should also adopt the new interim milestone recommended by the HIV Commission to see an 80% reduction by 2025.[166]

CHEMSEX

Chemsex involves sex whilst under influence of drugs – "chems" – typically Crystal Meth, M-Cat and G.[167]

29.9% of gay men living with HIV reported having had chemsex in the last year. Men who practiced chemsex were also more likely to have anal sex without a condom, including anal sex without a condom with someone with an unknown HIV status.[168]

There is evidence that chemsex is more prevalent in MSM living with HIV than MSM in the general population.[169]

Evidence suggests that in some instances there are insufficient linkages between sexual health, drug and alcohol services to support people engaged in chemsex, and in some cases there is insufficient drug and alcohol screening at sexual health clinics.[170]

[164]NICE (2016), NICE guideline [NG60] HIV testing: increasing uptake among people who may have undiagnosed HIV. Published: 01 December 2016
[165] NICE (2017), Quality standard [QS157]. HIV testing: encouraging uptake Published: 07 September 2017
[166] HIV Commission (2020), How England will end new cases of HIV: Final report and recommendations.
[167] Terence Higgins Trust (2020), Sexually Transmitted Infections in England: The State of the Nation.
[168]Avert: Chemsex is an issue among gay men living with HIV in the UK, study reveals.
30 January 2018.
[169] Terence Higgins Trust (2020), Sexually Transmitted Infections in England: The State of the Nation.
[170] Terence Higgins Trust (2020), Sexually Transmitted Infections in England: The State of the Nation.

NATIONAL TRENDS

After a peak of new HIV diagnoses in the United Kingdom in 2014, a rapid decline has been observed, from 6,278 in 2014 to 4,453 in 2018. The decline in new HIV diagnoses in recent years is largely driven by a steep fall in diagnoses among gay and bisexual men.

An estimated 13,100 to 15,600 people were living with transmittable levels of virus in 2018, equivalent to 13% to 15% of all people living with HIV. Overall, 7,500 were undiagnosed and up to 8,100 were people living with diagnosed HIV.

The UK has made good, but uneven progress towards reducing HIV transmission. Estimates of undiagnosed HIV infection have fallen slightly, but in the UK, twice as many people live with undiagnosed HIV infection outside London compared to London. The fall in HIV incidence in GBM is matched by the halving of new HIV diagnoses first made in the UK among GBM between 2015 and 2019, but the fall in diagnoses first made in the UK among heterosexual adults was less apparent. Further work is needed to address the inequalities in the progress towards reducing undiagnosed infection and HIV transmission that exist in relation to exposure to HIV, geography and ethnicity.[171]

WHO SHOULD BE TESTED?

HIV testing guidelines 2020[172] recommends that the following groups are tested.

1) People belonging to groups at increased risk of exposure to HIV
   - HIV testing should be routinely recommended to the following individuals (all Grade 1A):
     - o MSM
     - o Female sexual contacts of MSM
     - o Black Africans
     - o People reporting current or prior injecting drug use
     - o Sex workers
     - o Prisoners
     - o Trans women
     - o People from a country with high diagnosed seroprevalence (>1%) *
     - o People reporting sexual contact with anyone from a country with high diagnosed seroprevalence regardless of where contact occurs
     - o Individuals known to have/have had a mother living with HIV and who do not have documented HIV-negative status (see guidance from the Children's HIV Association [CHIVA]: https://www.chiva.org.uk/files/3114/2738/8429/dont-forget.pdf).
   - HIV testing should be considered for the following individuals (Grade 2D):
     - o Trans men.
2) People attending certain healthcare settings
   - HIV opt-out testing is recommended for all patients attending the following settings (Grade 1C):
     - o Sexual health services

[171] PHE (2019), HIV in the United Kingdom: Towards Zero HIV transmissions by 2030: 2019 report.
[172] BHIVA, (2020), British HIV Association/British Association for Sexual Health and HIV/British Infection Association Adult HIV Testing Guidelines 2020

- o Addiction and substance misuse services
- o Antenatal services
- o Termination of pregnancy services
- o Healthcare services for hepatitis B and C, TB and lymphoma.

- Individuals commencing chemotherapy or immunosuppressive or immunomodulatory therapy should be offered an HIV test in line with relevant NICE/speciality guidelines (GPP).

3) People presenting with symptoms and/or signs consistent with an HIV indicator condition
   - All individuals presenting to any healthcare provider in any healthcare setting with an indicator condition should be recommended to have an HIV test (Grade 1C–2D; 1D for AIDS-defining conditions).
   - Individuals who decline on first offer should have at least one repeat offer made at a subsequent visit (Grade 1D).
   - Services providing HIV testing should have adequate results governance and agreed documented transfer to care pathways (Grade 1D).
4) All patients accessing primary and secondary healthcare in areas of high and extremely high HIV seroprevalence, including emergency departments.
   - Routine HIV testing is recommended for all individuals who have not previously tested who are (Grade 1B):
     - o Accessing healthcare in areas of high HIV prevalence (2–5 per 1,000) and undergoing venepuncture
     - o Accessing healthcare in areas of extremely high HIV prevalence (>5 per 1,000), whether or not they are undergoing venepuncture for another indication.
5) Sexual partners of those with diagnosed HIV (Grade 1A)

All sexual partners of an individual diagnosed with HIV should be offered and recommended an HIV test.

FAST-TRACK CITIES+

PURPOSE AND VISION

The purpose of the Birmingham Fast-Track Cities+ initiative is to ensure availability and access to effective testing and treatment to significantly reduce and therefore eradicate new cases of blood-borne viruses (BBVs); HIV, Hep B, Hep C and tuberculosis (TB). The aim is to strengthen communities and ensure timely provision of services that support the population living with these conditions, without prejudice or stigma. Enigma Consultancy Ltd has been contracted to work with third-sector organisations to carry out a community engagement exercise that will inform a final report. The purpose of the engagement exercise and therefore the report will:

- Identify the needs of the Birmingham population pertaining to HIV, Hep B, Hep C and TB.
- Consider the needs of people pre-exposure, once infected but not diagnosed, once diagnosed and in treatment, and consider the wider needs of those they have close personal relationships with and help us understand current testing and treatment pathways.
- Identify which areas and demographics in the city are at a higher risk of exposure and in higher need whilst also understanding the varying needs of these groups.
- Understand additional prevention activity required for all citizens to enable the delivery of the Fast-Track Cities vision by 2030.
- Understand the interconnections in services and support between Birmingham, Sandwell and Solihull for people living with, and affected by HIV, hepatitis and TB.

PHE FINGERTIPS ANALYSIS

HIV TESTING COVERAGE, TOTAL (%) – KEY INDICATOR

INTRODUCTION / RATIONALE

HIV test coverage data represent the number of persons tested for HIV and not the number of tests reported. HIV testing is integral to the treatment and management of HIV infection. Knowledge of HIV status increases survival rates, improves quality of life and reduces the risk of onward transmission.

PERFORMANCE

Birmingham

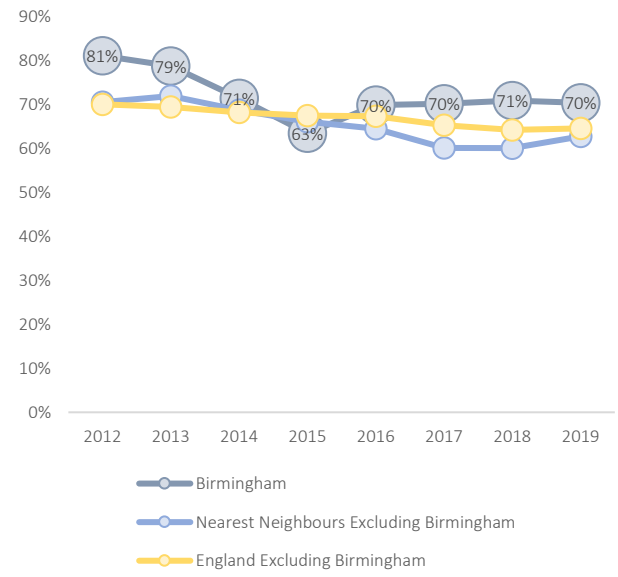
- HIV Coverage has remained relatively constant since 2016.

Solihull

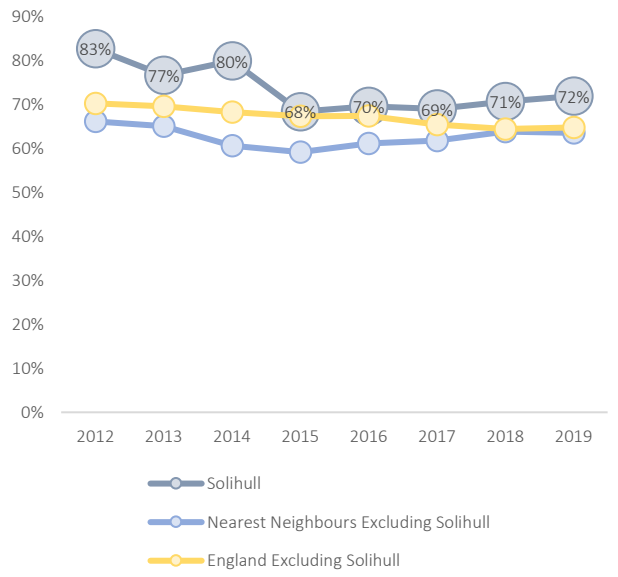
- HIV Coverage has remained relatively constant since 2015.

Figure 6.40: HIV testing coverage, total (%); trends against nearest neighbours and against England.

BIRMINGHAM



SOLIHULL



Count	2012	2013	2014	2015	2016	2017	2018	2019
Birmingham	24,775	24,739	27,440	28,625	30,459	36,671	38,748	39,340
Solihull	2,999	2,601	2,954	3,133	4,196	4,846	4,852	4,934

HIV LATE DIAGNOSIS (%) – KEY INDICATOR

INTRODUCTION / RATIONALE

A HIV key strategic priority is to decrease HIV-related mortality and morbidity through reducing the proportion and number of HIV diagnoses made at a late stage of HIV infection.

Late diagnosis is the most important predictor of morbidity and mortality among those with HIV infection. Those diagnosed late have a tenfold risk of death compared to those diagnosed promptly and is essential to evaluate the success of expanded HIV testing.

This indicator directly measures late diagnoses and indirectly informs our understanding of the proportion of HIV infections undiagnosed.

PERFORMANCE

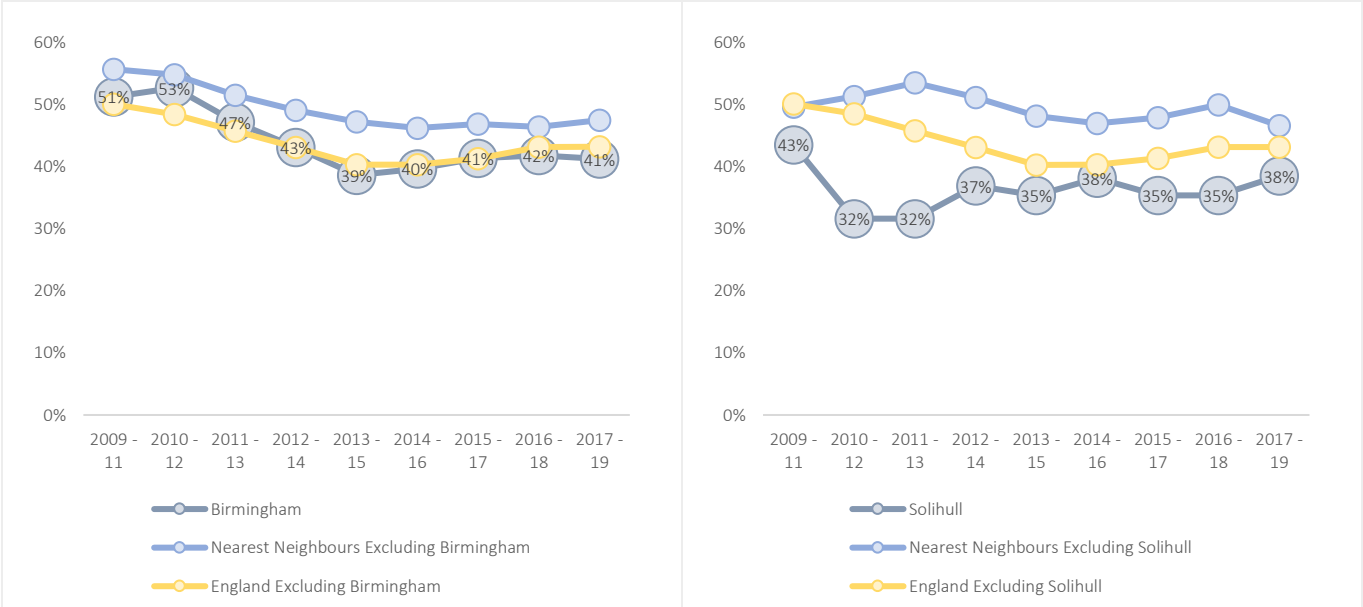
Birmingham

- HIV late diagnosis figures remained relatively constant.

Solihull

- HIV late diagnosis figures remained relatively constant.

Figure 6.41: HIV late diagnosis (%); trends against nearest neighbours and against England.



Count	2009 - 11	2010 - 12	2011 - 13	2012 - 14	2013 - 15	2014 - 16	2015 - 17	2016 - 18	2017 - 19
Birmingham	214	211	171	152	152	156	145	127	119
Solihull	10	6	6	7	6	8	6	6	5

NEW HIV DIAGNOSIS RATE / 100,000 AGED 15+ – KEY INDICATOR

INTRODUCTION / RATIONALE

New HIV diagnosis is not synonymous with incidence; however, it provides a timely insight into the onward HIV transmission in a country and consequently allows targeting efforts to reduce transmission. Although the majority of HIV diagnoses are made in genitourinary medicine (GUM) services, HIV testing has been introduced in a variety of different medical services and non-medical settings, including the expansion of self-sampling/self-testing.

PERFORMANCE

Birmingham

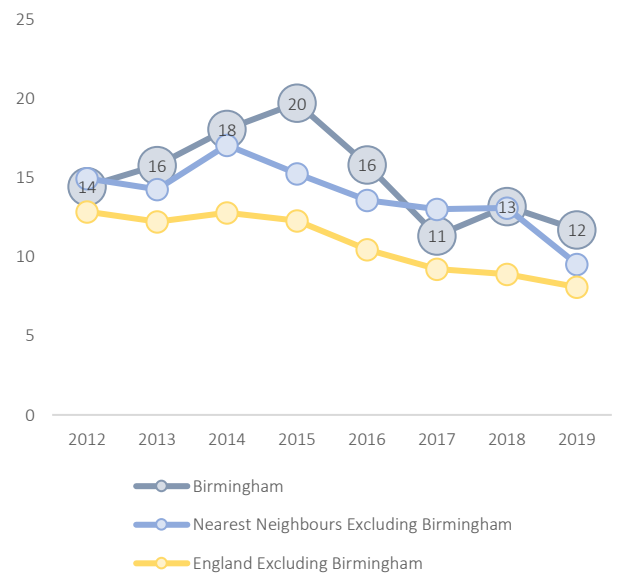
- Since 2015, the HIV diagnosis rates has reduced.

Solihull

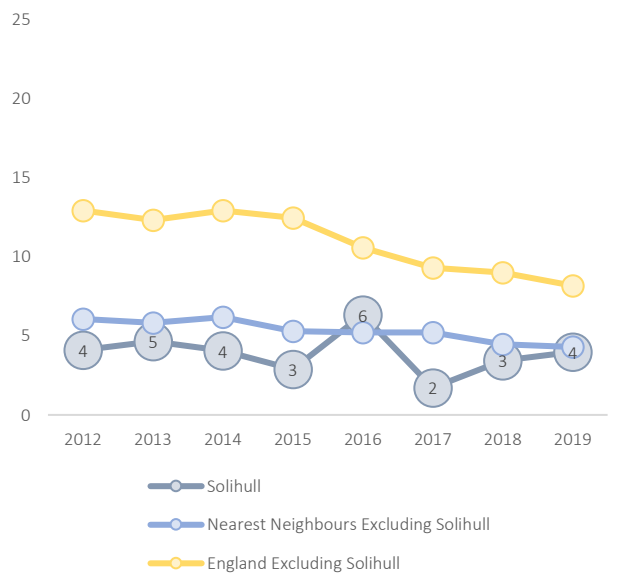
- HIV diagnosis rates remain low.

Figure 6.42: New HIV diagnosis rate/ 100,000, total (%); trends against nearest neighbours and against England.

BIRMINGHAM



SOLIHULL



Count	2012	2013	2014	2015	2016	2017	2018	2019
Birmingham	14	16	18	20	16	11	13	12
Solihull	123	135	156	172	140	101	118	105

LOCAL SERVICE PROVISION

ACCESS TO HIV TESTING

Testing for STIs is provided by Umbrella Health. The following table provides an overview of the available provision in relation to STI testing.

GP

- Nice Quality Standard 157 states that "Young people and adults in areas of high or extremely high HIV prevalence are offered an HIV test by their GP practice when registering or when having a blood test if they have not had an HIV test in the past 12 months."
- This currently does not happen in Birmingham or Solihull. This was mentioned in the Umbrella Annual Report 2018-19.

PHARMACY

- Patients can pick up an STI testing kit at Umbrella-partnered pharmacies.
    - HIV testing kits are included as part of the STI self-sampling kits.

SEXUAL HEALTH CLINICS

- All patients attending Umbrella clinics are offered HIV and STI testing.

PARTNERS

- Prior to the COVID-19 pandemic, Birmingham LGBT offered a drop-in service, where people could access HIV point of care kits and assisted self-sampling.
    - Pre-pandemic the busiest times for the drop-in service was evenings and weekends.
    - The drop-in service runs:
        - Monday to Friday – 10am to 9pm
        - Saturday – 11.30 to 7pm
    - The drop-in service was paused during the pandemic.
- Birmingham LGBT practitioners reported a low take-up of the point-of-care HIV tests.

OTHER TESTING

- HIV testing is performed in a number of other settings including acute hospital settings, as part of antenatal screening and as part of the response from drug and alcohol services.

KEY FINDINGS

- GPs are not routinely testing all new patients for HIV.

SEXUAL HEALTH CLINICS

- PEPSE is available from Umbrella clinics during their opening hours. PEPSE is also available from Hospital A&E Departments.
- Prior to COVID-19, there were two PrEP clinics that accepted referrals via studies and trials.
  - Demand for these clinics has increased.
- Umbrella is now offering PrEP funded by the NHS.

  - Patients are placed on a waiting list and those deemed at a higher risk are prioritised.
  - Those eligible for PrEP are:
    - Men (cis and trans) and trans women
      - HIV-negative test in previous year
      - Anal sex without a condom in previous six months
      - Likely to have anal sex without a condom
    - HIV-negative partner of HIV-positive person
      - Partner not known to be viral load-suppressed (<200 copies/ml) and on antiviral therapy for six months or more
      - Sex without a condom likely before viral load is fully suppressed
    - Other HIV-negative people who are assessed as being at similarly high risk of HIV

PARTNERS

- Training for PrEP assessments has been rolled out via nursing staff to staff at Birmingham LGBT.

KEY FINDINGS

- COVID-19 impacted the waiting lists for PrEP. Waiting lists had returned to normal at the time of this assessment.

ENGAGEMENT

COMMUNITY SURVEY

As part of this needs assessment, a community survey was run exploring the sexual health needs of the populations of Birmingham and Solihull. The survey also explored the population's experiences of sexual health services.

In total there were 106 responses. Demographics for those who completed the survey can be found on page 228.

STI/BBV SERVICES

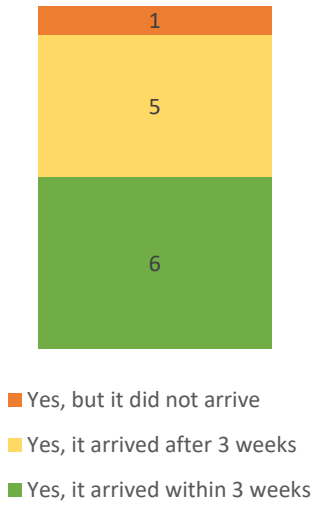
Respondents were asked where they would go for various BBV services. A sexual health clinic scored the highest for all services.

Figure 6.43: For the following STI/BBV services, where would you go for help?

	Taking an STI test at home	Sexual health check	Treatment of infection/symptoms	Reporting/Talking to someone about sexual abuse	HIV, Hepatitis B, Hepatitis C and/or TB test
GP	37%	42%	51%	32%	54%
Local pharmacy	26%	7%	11%	5%	12%
Pharmacy further away	10%	7%	7%	2%	6%
A Sexual Health clinic	50%	70%	65%	44%	64%
Specialist services	21%	24%	21%	41%	22%
Umbrella website	38%	22%	18%	14%	20%
Other website	10%	4%	3%	8%	6%
Social media	4%	4%	3%	4%	3%
Telephone helpline	7%	5%	3%	17%	7%
School / College / Uni	7%	6%	4%	8%	5%
Friends/ family	2%	4%	3%	19%	3%
Don't know	6%	6%	4%	8%	6%
Other	3%	4%	3%	10%	7%

Respondents were asked if they had ordered a postal self-test kit. Of those who ordered a self-test kit via the post, 1 (8%) said it did not arrive, 5 (42%) said it arrived after 3 weeks, and 6 (50%) said it arrived within 3 weeks.

Figure 6.44: Did you order a postal self-test kit?



7 – SPECIFIC COHORTS

HOMELESS

SUBSTANCE MISUSE

YOUNG PEOPLE

LGBTQ

BAME

OLDER PEOPLE

DISABILITIES

ASYLUM SEEKERS AND NEWLY ARRIVED MIGRANTS

RAPE AND SEXUAL VIOLENCE

RELIGION

SWINGERS

PRISONERS

SEX WORKERS

HOMELESS

INTRODUCTION

OVERVIEW

Homelessness includes any state of being without a permanent, safe home. It encompasses rough sleeping, but also refers to those who may be staying with friends or family, squatting, staying in a hostel, living in poor conditions that are bad for health, living somewhere where they are at risk of violence or abuse, or living apart from their family because they do not have a place to live together.[173]

- Homeless people as a group can struggle to access health and social care services, and report much poorer health than the general population. [174] Homeless Link found that 18% of homeless people were refused registration with a GP or dentist.[175]
- Homeless people are often unable to conform to the rigid access times and conditions of mainstream clinics. [176]
- Some homeless people are lesbian, gay bisexual or transgender, and may have become homeless because of the reactions of other people in their lives. Fear of negative reactions to their sexuality may be a barrier to accessing sexual health services.[177]
- Homeless people are at increased risk of STIs.[178]
- Young homeless people are at more risk of sexually transmitted infections (STIs) and unwanted pregnancies and can come under pressure to exchange sex for food, shelter, drugs and money.[179]
- Sex workers frequently experience homelessness[180]. Whilst some sex workers are engaged with services, advice and sex work networks that promote safety, others, including those in poverty, may fall through the gaps due to barriers of criminalisation, and better understanding is needed around transactional sex, sex work, and criminalisation.
- Although women are in a minority among the homeless population, they are highly vulnerable, have multiple unmet health needs and are more likely than women in the general population to become pregnant and have a sexually transmitted infection. They often use drugs and alcohol to cope with their situation and then turn to selling sex to support their consumption.[181]
- Factors influencing homeless women's use of contraception and cervical screening attendance are poorly understood, and little is known about the sexual health of homeless men. [182]

[173] Shelter, What is Homelessness? Accessed August 2021.
[174] Local Government Association (2017), The impact of homelessness on health: A guide for local authorities.
[175] Homeless Link: Health Needs Audit. Accessed August 2021.
[176] McGregor F et al (2018) Nurse-led sexual health clinics in hostels for homeless people. Nursing Times [online]; 114: 5, 42-46.
[177] NHS Greater Glasgow and Clyde, Sexual Health Team
[178] Stockwell S, Dean G, Cox T, et alP224 *The sexual health of the homeless – an outreach sexual health screening project*. Sexually Transmitted Infections 2015;91:A90.
[179] Local Government Association (2017), The impact of homelessness on health: A guide for local authorities.
[180] Local Government Association (2017), The impact of homelessness on health: A guide for local authorities.
[181] McGregor F et al (2018) Nurse-led sexual health clinics in hostels for homeless people. Nursing Times [online]; 114: 5, 42-46.
[182] McGregor F et al (2018) Nurse-led sexual health clinics in hostels for homeless people. Nursing Times [online]; 114: 5, 42-46.

- One study screened homeless people for STIs. A total of 59 instances of STIs were diagnosed among the 161 clients. These STIs – including three cases of syphilis, which has potentially disastrous long-term consequences – might otherwise have remained undetected and untreated. [183]

BEST PRACTICE

- GP practices have a responsibility to register people who are homeless or of no fixed abode.[184]
- Sexual health clinics in hostels for the homeless may encourage screening for infections and use of reliable contraception methods.[185]
- Homeless Link provides research and resources to inform local commissioning and support improvements in practice, including a free-to-use homeless health needs audit.[186]
- There is evidence that acting early to prevent homelessness can help to reduce health inequalities.[187] The Homeless Reduction Act 2017 significantly reformed England's homelessness legislation by placing duties on local authorities to intervene at earlier stages to prevent homelessness in their areas. It also requires housing authorities to provide homelessness services to all those affected, not just those who have 'priority need.'[188]

LOCAL NEED

In Birmingham in 2020, there were 17 rough sleepers identified. This compares to the 9 identified in 2010.

In Birmingham in 2020/21 quarter 4, there were 3,316 households in temporary accommodation. This is a rate of 375 per 100,000 of the over 16 population. This is the second highest rate of all its nearest neighbours (Manchester has a higher rate of 572 per 100,000).

In Solihull in 2020, there was 1 rough sleeper identified. This compares to the 3 identified in 2010.

In Solihull in 2020/21 quarter 4, there were 156 households in temporary accommodation. This is a rate of 89 per 100,000 of the over 16 population. Of its nearest neighbours, Bedford (224 per 100,000) and Shropshire (95 per 100,000) have higher rates.

[183] McGregor F et al (2018) Nurse-led sexual health clinics in hostels for homeless people. Nursing Times [online]; 114: 5, 42-46.
[184] Care Quality Commission: GP mythbuster 29: Looking after homeless patients in General Practice. Accessed August 2021.
[185] McGregor F et al (2018) Nurse-led sexual health clinics in hostels for homeless people. Nursing Times [online]; 114: 5, 42-46.
[186] Homeless Link, Health Needs Audit Toolkit
[187] Public Health England and Homeless Link: Preventing homelessness to improve health and wellbeing. Accessed August 2021.
[188] Ministry of Housing, Communities & Local Government (2018), Homelessness Code of Guidance for Local Authorities.

ENGAGEMENT

SIFA FIRESIDE / TRIDENT REACH / SHELTER/ ST BASILS

INTRODUCTION

Practitioners from homeless organisations in Birmingham and Solihull were interviewed regarding the sexual health needs of the homeless cohort and the responses of current services.

SIFA Fireside work with adults (over 25) experiencing homelessness. SIFA Fireside support adults through meeting their immediate and long-term needs. Part of the SIFA Fireside offering is a day centre for homeless and vulnerably housed adults.

Trident Reach's specialist Homeless Services help people break the cycle of homelessness by supporting them to become independent and to safeguard themselves from future risk.

Shelter provides support, guidance, and advice to the homeless and those at risk of homelessness in Birmingham and Solihull.

St Basils works with young people aged 16-25 who are homeless or at risk of homelessness, to enable them to find and keep a home, grow their confidence, develop their skills, increase opportunities and prevent homelessness. St Basils have hubs in both Birmingham and Solihull.

HOMELESS HEALTH EXCHANGE

Practitioners from all services highlighted the importance of the Homeless Health Exchange in meeting the health needs of the people they worked with. Practitioners at the Homeless Health Exchange were seen as sympathetic towards the barriers experienced by homeless people towards attending healthcare services.

Regarding meeting the health needs of their clients, SIFA Fireside work with the Homeless Health Exchange[189] in Birmingham. The Homeless Health Exchange offers a drop-in clinic in its Central Birmingham site and also outreach clinics, for example a clinic at the SIFA Fireside location in Digbeth.

Practitioners from SIFA Fireside fed back that it was not thought sexual health issues were routinely covered by the primary care practitioners. The appointments with nurses are short and the homeless cohort are likely to have more acute health needs.

Via the Homeless Health Exchange, the client group have access to other visiting clinicians such as opticians, podiatrists and mental health practitioners.

PREVIOUS SEXUAL HEALTH CONTRACT

Previously, SIFA Fireside were contracted by Umbrella to deliver some sexual health interventions.

Feedback from SIFA Fireside practitioners was that there were some issues with delivering the contract, notably:

- There were some barriers to testing, such as people requiring a mobile phone to get their sexual health results.
- The client group were unlikely to use the take-away testing kits.
- The education part of the contract was difficult to deliver due to inappropriate behaviour from patients.

[189] The Homeless Health Exchange offers: Comprehensive primary care assessments, nursing care and treatment for people who are homeless in Birmingham. Drop-in clinic Mon-Fri 1pm-4pm for registered patients only. Referral to other social and health care services. City-wide outreach visits to hostels and drop-in centres. Alcohol assessments, information, advice and support, counselling, acupuncture and referral for detox and rehab placements.

- The supplied promotional material was not suitable for the homeless cohort.

SEXUAL HEALTH NEEDS

Feedback from practitioners at Trident Reach highlighted that it is very hard to address sexual health needs with the rough sleeper cohort. This group tend to have more pressing issues, such as finding accommodation. Those working with this cohort said that this group can be 'chaotic and volatile'.

It was highlighted that there is crossover between rough sleepers and commercial sex work. People can be linked into the SAFE Project if this is the case.

Feedback from SIFA Fireside was that sexual health is not a priority for the service users that they work with. A high proportion of the cohort are males, and they tend not to engage with health services.

Practitioners from Trident Reach highlighted that there was previously a link sexual health practitioner post between Trident Reach and Umbrella. Feedback was that this post was used by complex females with potential needs relating to sexual health and ran as a drop-in session. Currently patients are referred to GPs or Umbrella clinics to have sexual health needs met.

The homeless cohort may not always turn up for appointments, which can lead to patients potentially being removed from GP lists.

HOMELESS YOUNG PEOPLE

St Basils work specifically with young people aged 16-24. Practitioners found that this cohort was difficult to engage with regarding any health issue, not just sexual health. To ensure that service users engage with services, practitioners should accompany them to their appointments.

A multi-disciplinary team, including primary care staff, provide a service from the St Basils youth hubs in Birmingham and Solihull. This would be a good place to engage young people as they are potentially in the youth hubs all day.

St Basils practitioners reported limited usage of the BBV self-test kits.

GAPS/DEVELOPMENT

Practitioners were asked for their feedback on any potential areas for service development. The following points were made:

- A link nurse between the sexual health service and SIFA Fireside could be a possible service development.
- It will be necessary to have a different approach to those who are in tenancies but at risk of homelessness.
- Provision of sexual health services from existing homeless hubs (e.g., St Basils hubs in Birmingham and Solihull) would reduce the barriers to accessing services.

PRACTITIONER SURVEYS

Practitioners were invited to complete surveys relating to the sexual health needs and the responses of sexual health services in relation to the client groups that they work with.

FREE TEXT COMMENTS

Below are the free text comments that were left by practitioners working specifically with the homeless population.

"Clients are unable to book appointments due to internet and phone issues."

Team Leader, Shelter

"No one from sexual health services sees the client group I work with."

Team Leader, Shelter

What are the gaps in current sexual health services?

"No outreach to the vulnerably housed and rough sleeping. [Services are needed] outside of office hours"

Engagement Worker to Entrenched Rough Sleepers

"Online / delivery is not instant and access to free condoms should be held by the accommodation services."

Youth Services Manager / Youth Homeless

What gaps in current sexual health services?

"Only have Whittall street and particularly through COVID pandemic has been closed, or at least felt like it was closed even if it wasn't"

Engagement Worker to Entrenched Rough Sleepers

"Specific advice online is great, but the homelessness client group don't necessarily engage in this way."

Youth Services Manager / Youth Homeless

SUBSTANCE MISUSE

INTRODUCTION

Sexual health needs and substance use needs can be linked in the following ways:

- Drug use makes people intoxicated and lose their inhibitions, resulting in sexual activity (or a specific aspect of it, such as no condom use) that would not have happened unless the drug was consumed.
- People dependant on substances may engage in activities that put their sexual health at risk, such as engaging in sex work or transactional sex in order to fund drug use.
- People using psychoactive drugs immediately before or during sex to enhance pleasure.
- Drugs are used to cope with the emotional distress associated with a sexual health problem such as a new diagnosis, ongoing debilitating symptoms or associated stigma. [190]

Substance use is strongly associated with sexual risk and adverse sexual health outcomes among young people.[191]

Young people, men who have sex with men, and people working within the sex industry appear to be at the highest risk of co-occurring harms relating to drug use and sexual activity. [192]

Alcohol use can affect sexual health and wellbeing:

- Early alcohol use is associated with earlier sexual activity that is more likely to be regretted, and clusters with other risk behaviours, including smoking and drug use.
- People who drink hazardously are more likely to have multiple sexual partners. Hazardous consumption of alcohol is more common in people attending genitourinary medicine departments than the general population
- Use of alcohol by both victim and perpetrator is common in cases of sexual assault.[193]

COVID-19 IMPACT

The following is taken from PHEs analysis: *Impact of COVID-19 on STIs, HIV and viral hepatitis, 2020 report*:

Preliminary data from the PHE Unlinked Anonymous Monitoring (UAM) Survey of People Who Inject Drugs (PWID) indicate that the COVID-19 response has affected access to essential services for PWID in England. Just over a third (61/166) of PWID participants reported that in 2020 drug and alcohol services were more difficult to access than in 2019, with 22% (30/136) reporting difficulties accessing HIV and/or hepatitis testing and accessing equipment for safely using and/or injecting drugs (29%; 40/137). Eleven per cent (10/87) of participating PWID reported some form of HCV treatment disruption. More detailed analysis from the survey will be published in 2021.

[190] Bowden-Jones (2017), Joining up sexual health and drug services to better meet client needs: Background paper commissioned by the EMCDDA for Health and social responses to drug problems: a European guide.
[191] Khadr SN, Jones KG, Mann S, et al, Investigating the relationship between substance use and sexual behaviour in young people in Britain: findings from a national probability survey. BMJ Open 2016;6:e011961. doi: 10.1136/bmjopen-2016-011961
[192] Bowden-Jones (2017), Joining up sexual health and drug services to better meet client needs: Background paper commissioned by the EMCDDA for Health and social responses to drug problems: a European guide.
[193] Royal College of Physicians and BASSH (2011), Alcohol and sex: a cocktail for poor sexual health. A report of the Alcohol and Sexual Health Working Party.

LOCAL NEED

NDTMS prevalence estimates[194] indicate that there are 10,525 opiate and crack users in Birmingham (a rate of 14.23 per 1,000 of the population). In Solihull there is an estimate of 1,015 opiate and crack users (a rate of 7.84 per 1,000).

Figure 7.1: Opiate and crack expected prevalence

	Opiate and Crack Users	Opiates	Crack	Alcohol
Birmingham				
Number of users	10,525	8,779	6,817	12,667
Rate per 1,000	14.23	11.87	9.22	14.20
Solihull				
Number of users	1,015	825	612	1,812
Rate per 1,000	7.84	6.37	4.73	10.36
West Midlands rate	9.61	8.28	5.9	
UK rate	8.85	7.37	5.1	

[194] Gov.uk, National and local prevalence estimates and rates per 1,000 population of opiate and crack users aged 15 to 64 with 95% confidence intervals (CI) - 2016-17

CHEMSEX

According to NDTMS data from 2019-20, small proportions of those entering treatment used the three most common substances in relation to chemsex (GBL, methamphetamine and/or mephedrone).

The graphs below show the numbers of males in Birmingham and Solihull using GHB, methamphetamine, and mephedrone.

It is important to note that this data may indicate that users of chemsex are not using drug and alcohol services and that there may be unmet need that is not captured in the data.

Figure 7.2: Birmingham, use of GHB/GBL, methamphetamine, mephedrone; males in treatment (NDTMS)

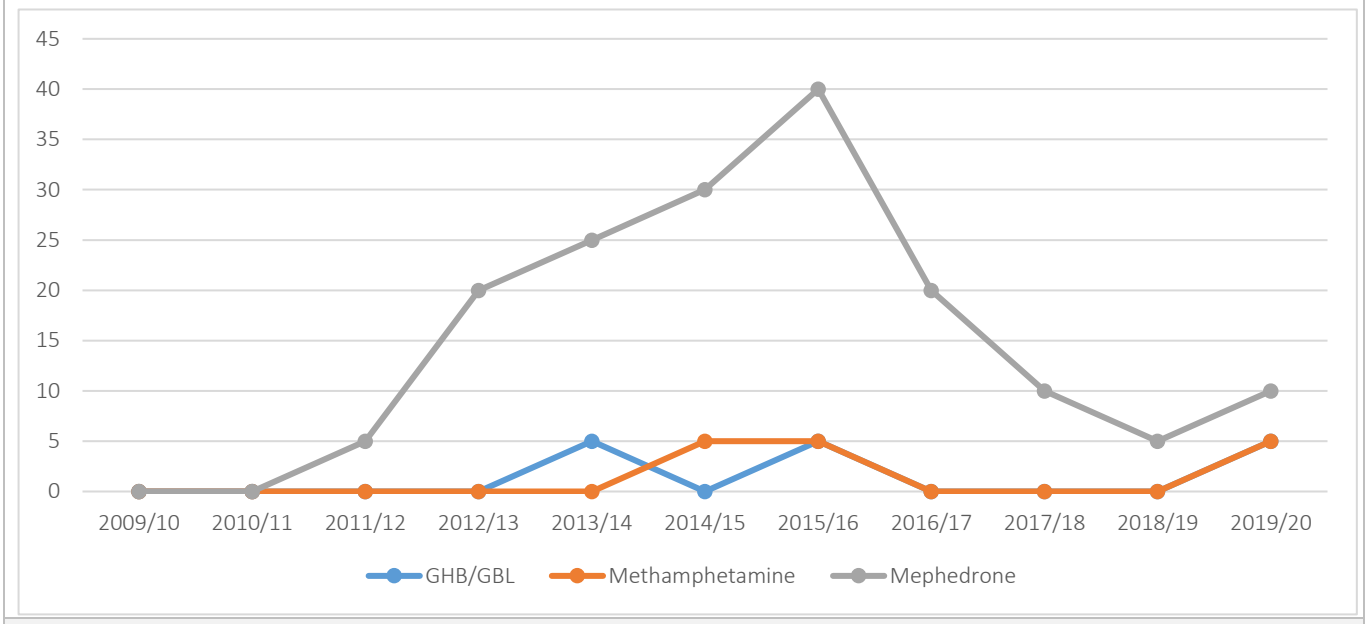
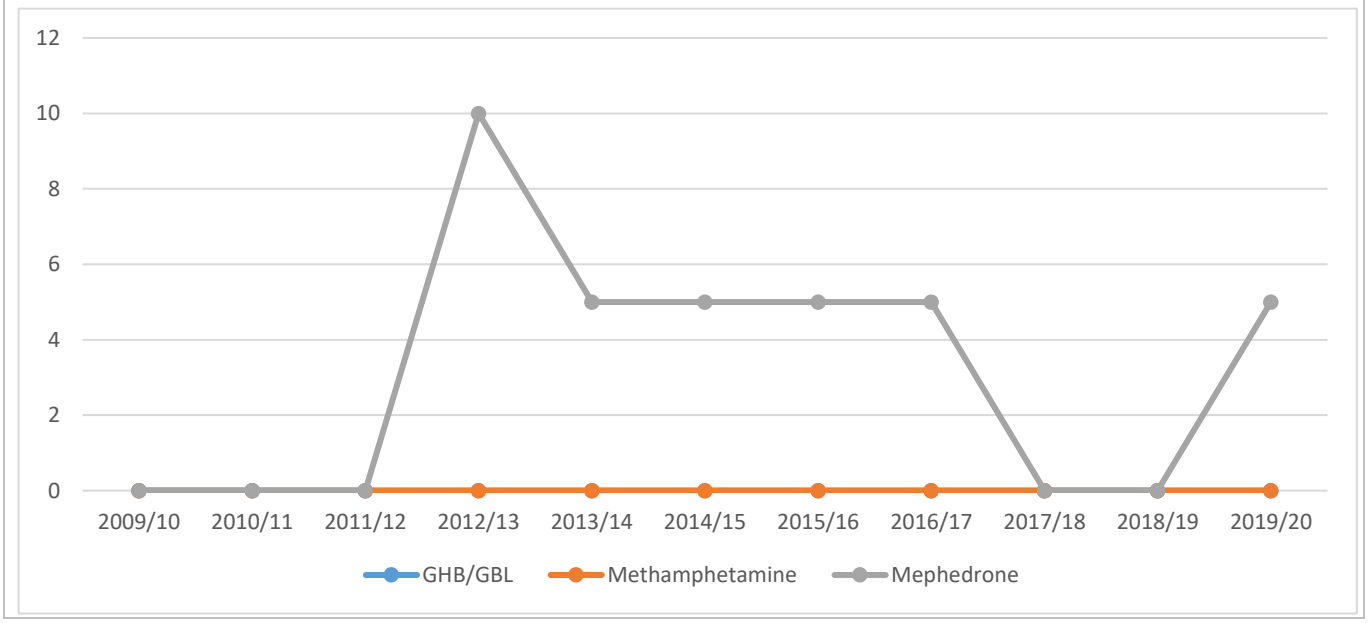


Figure 7.3: Solihull, use of GHB/GBL, methamphetamine, mephedrone; males in treatment (NDTMS)



In terms of service provision, Birmingham LGBT offer 'Chemfidential', a free and confidential service for over-18s which is designed to offer support for those who may need some support relating to chems or chemsex. There is also a possibility that men engaging in chemsex will use Umbrella Sexual Health Services. It should be ensured that

practitioners in these clinics are aware of how to identify substance misuse problems and that there are appropriate referral pathways through to substance misuse services.

At the time of this assessment, men who want to be considered for PrEP are asked about drug and alcohol use, including the use of 'chems'.

Birmingham LGBT also offer a chemsex awareness training package aimed at practitioners.

ENGAGEMENT

CHANGE GROW LIVE

INTRODUCTION

Change Grow Live provide the Drug and Alcohol Service in Birmingham. The service is delivered from four hubs across the city, South, Central and West, East, and North.

In Solihull, the drug and alcohol service is provided by Solihull Integrated Addiction Service (SIAS).

SEXUAL HEALTH NEEDS

Practitioners were asked about the sexual health needs of those with a substance misuse need. It was fed back that for the majority of clients that are receiving an intervention from a drug and alcohol service, attending appointments was difficult. The majority of clients require active engagement and outreach to encourage them to attend appointments.

The client group did not tend to attend appointments during normal working hours, and it was thought that sexual health services should be available outside of normal working hours.

Those with a drug and alcohol problem were generally seen as being hard to reach. There may be limited access to the internet and phones.

The substance misuse service in Birmingham has a proportion of female sex workers as service users. Practitioners fed back that this group required a lot of assistance to engage with sexual health services. In Birmingham, CGL have a complex women's team. Previously, the Safe Project visited one of the CGL hubs and delivered services, this outreach work was not running at the time of this assessment.

There are pathways into the Safe Project, a service that promotes the health and wellbeing of women who have worked, are working, or are at risk of becoming involved in the commercial sex industry.

At the time of this assessment, the self-test kits were not available at any of the CGL hubs in Birmingham.

There is a precedent for health teams to visit the CGL hubs; practitioners from Hepatitis C and HIV services currently provide outreach work in the CGL hubs.

GAPS/AREAS FOR DEVELOPMENT

Practitioners identified a training need in relation to sexual health knowledge amongst drug and alcohol practitioners.

Practitioners believed that there more sexual health interventions could be delivered within drug and alcohol services.

PRACTITIONER SURVEYS

Practitioners were invited to complete surveys relating to the sexual health needs and the responses of sexual health services in relation to the client groups that they work with.

FREE TEXT COMMENTS

Below are the free text comments that were left by practitioners working specifically with those with a substance misuse problem.

"Previous outreach services have been cut. These services assertively engaged vulnerable sectors of the community.

This service was previously provided by Umbrella Sexual Health and contraception services via SAFE and Healthy gay life, and African focused outreach services.

Since COVID, there has been some liaison with services and follow up work, however the provision of assertive engagement is much reduced."

Drug and Alcohol Practitioner

"We are actively engaging clients in BBV testing, Hep B vaccinations are on offer, however, I am unsure how many are being taken up.

We have no rapid STI testing as a service however we can refer to Umbrella. I think that an on the spot self-taken kit would be beneficial to the people we work with, so they are not having to make another appointment."

Drug and Alcohol Practitioner

"[There needs to be] one stop provision of services to engage patients at a time when they are motivated and engaging with a service, this sometimes encourages the patient then going forwards to engage in further testing or in treatment."

Drug and Alcohol Practitioner

"I think part of the service gives information about HIV etc when discussing BBV testing. Also, general sexual health may be covered.

I think we identify those who have suffered sexual abuse but wonder if across the service the correct follow up is followed."

Drug and Alcohol Practitioner

"Change Grow Live run Hep C and BBV clinics all the time and encouraging staff to continue this in 1-2-1s."

Drug and Alcohol Practitioner

"It is difficult to get into a doctor's surgery as it is so there needs to be more localised provisions or even resources available at local community centres."

Drug and Alcohol Practitioner

What are the gaps in sexual health provision?

"NHS stigmas, female health being taken seriously, lack of open-door clinics for everyone."

Drug and Alcohol Practitioner

What are the gaps in sexual health provision?

"Assertive outreach.

Self taken STI tests that could be used in clinical / outreach situations with vulnerable groups that are less likely to attend additional services, however, may be engaged as they visit different clinics for example drug treatment. Follow up appointments can be made as necessary.

Outreach to complete STI/BBV testing & SMEARs for vulnerable women who are not registered at GPs.

Assertive outreach to engage vulnerable women in contraceptive options to avoid repeated unplanned pregnancies and the subsequent emotional trauma which may be involved."

Drug and Alcohol Practitioner

YOUNG PEOPLE

INTRODUCTION

Young people as a demographic have particular needs regarding sexual health:

- Young people under 25 years report relatively larger numbers of sexual partners than other age groups[195]
- Young people experience the highest diagnosis rates of the most common STIs, and this is likely due to higher rates of partner change among 16- to 24-year-old people.[196]
- The introduction of the HPV (human papilloma virus) vaccination in adolescent girls through the National HPV Vaccination programme may potentially have had an impact on recent trends in new diagnoses of genital warts which have gone down.[197] From September 2019 the national Human papillomavirus (HPV) vaccination programme became universal with 12- to 13-year-old males becoming eligible alongside females.[198]
- A high proportion of 16- to 24-year-olds were not 'sexually competent' at their first sexual intercourse [i.e., with equal willingness of partners, autonomy of decision (not due to peer pressure, drunkenness or drugs), acceptable timing (that it happened at the 'right time') and using a reliable method of contraception]. [199]
- Unplanned pregnancy is associated with lack of sexual competence.[200] Between 2000 and 2018, the teenage pregnancy rate in the UK fell by over 60%; however, young people in England still experience higher teenage birth rates than their peers in Western European countries and teenagers remain at highest risk of unplanned pregnancy.[201]
- Many young people are getting their education through pornography. This is informing their expectations of sex and influencing what they perceive as acceptable. Condomless sex, different types of sex, such as anal sex, and rougher sex have become increasingly normalised. These behaviours, without the use of appropriate protection, increase the risk of poor sexual health.[202]
- Apps have led to more casual sexual encounters, which can mean there is less communication and less negotiation of safe sex, which increases STI transmission. The geo-spatial nature of these apps also means that STIs are increasingly passed between what would have otherwise been disconnected sexual networks.[203]

[195] Bailey J, Mann S, Wayal S, et al. Sexual health promotion for young people delivered via digital media: a scoping review. Southampton (UK): NIHR Journals Library; 2015 Nov. (Public Health Research, No. 3.13.) Chapter 1, Introduction.
[196] PHE: Sexually transmitted infections (STIs): annual data tables. Last updated 14 October 2020.
[197] Association for Young People's Health (2019), Key data on young people 2019: Latest information and statistics.
[198] PHE (2020), Human papillomavirus (HPV) vaccination coverage in adolescent females and males in England: academic year 2019 to 2020. Health Protection Report Volume 14 Number 19, 20 October 2020.
[199] Bailey J, Mann S, Wayal S, et al. Sexual health promotion for young people delivered via digital media: a scoping review. Southampton (UK): NIHR Journals Library; 2015 Nov. (Public Health Research, No. 3.13.) Chapter 1, Introduction.
[200] Bailey J, Mann S, Wayal S, et al. Sexual health promotion for young people delivered via digital media: a scoping review. Southampton (UK): NIHR Journals Library; 2015 Nov. (Public Health Research, No. 3.13.) Chapter 1, Introduction.
[201] PHE (2018), Teenage Pregnancy Prevention Framework.
[202] House of Commons Health and Social Care Committee, Sexual health, Fourteenth Report of Session 2017–19.
[203] House of Commons Health and Social Care Committee, Sexual health, Fourteenth Report of Session 2017–19.

ENGAGEMENT

BIRMINGHAM YOUTH SERVICE / URBAN HEARD

INTRODUCTION

Birmingham Youth Service (BYS) is a universal service open to any young person. The service runs out of 16 projects located across Birmingham.

Urban Heard is based in Solihull and engages with young people via workshops, and a youth club.

SEXUAL HEALTH PROVISION

Umbrella fund 2 full time sexual health practitioners at Birmingham Youth Service. The workers support with prevention work, condom distribution, 1-2-1 conversations and support. The workers run stalls at events across the city. The stalls signpost and support young people to sexual health services.

BYS run a participation and peer education scheme called Young Umbrella Champions. These are managed by BYS Support Workers and are commissioned to complete work with Umbrella, such as mystery shopping.

The Umbrella website was not seen as 100% accurate. The pharmacy opening times were not matched with the times that the Umbrella pharmacist was in the pharmacy. This meant that a young person may not be able to access contraception and advice on that day. There were also issues if the Umbrella-trained pharmacist was not working in the pharmacy.

SEXUAL HEALTH NEEDS OF YOUNG PEOPLE

Practitioners fed back that during the COVID pandemic, it was harder for young people to access services. During the pandemic, contact with services was primarily via telephone triages. Prior to the COVID-19 pandemic, practitioners said that accessing sexual health services was much easier.

Young people fed back negatively regarding the telephone lines. They reported that they could not access Umbrella services this way. Adults may have to refer young people into services on their behalf.

Practitioners working with young people fed back that there are long waits for sexual health appointments with Umbrella. There had also been delays with accessing the STI self-testing kits. The lack of availability of testing was highlighted as a major issue by practitioners.

At the time of this assessment, Umbrella offered a walk-in clinic at a Boots Chemist in the centre of Birmingham. Feedback from practitioners was that young people wanted services close to them.

GAPS/DEVELOPMENT

It was highlighted that the lack of a free pregnancy testing service with Umbrella was a missed opportunity to engage with young people regarding their wider sexual health needs such as underage sex, and exploitation. Currently, young people were advised to buy a pregnancy testing kit, which was not confidential.

The lack of availability of the self-testing kits was highlighted as a major issue by practitioners.

PRACTITIONER SURVEYS

Practitioners were invited to complete surveys relating to the sexual health needs and the responses of sexual health services in relation to the client groups that they work with.

FREE TEXT COMMENTS

Below are the free text comments that were left by practitioners working specifically with young people.

"The services require the people I work with to come to the sexual health clinic, there needs to be more done to make the service more accessible for people who have anxiety over this."

Children's Practitioner

"I work with young people under 18 years, I have taken a young person who was autistic to the Umbrella service. She was a bit dis-orientated; she didn't want me with her, but she became frustrated when the nurse rushed her. I had to intervene and explain that she was autistic and needed her to give her space instead of rushing her to choose."

Young Person's Practitioner

"Young people with communication difficulties need support but sometimes won't access support due to previous experiences with health professionals."

Young Person's Practitioner

"Disabilities seems to be the forgotten service"

"There is [a] very limited service for the disabled community especially under 18."

Young Person's Practitioner

"Information is available if we visit the [sexual health] service but otherwise young people don't receive the information. They are not always honest with us and may find it easier to speak to someone who specialises [in sexual health]."

Children's Practitioner

"[There is] not enough availability [of sexual health services] for young people in the settings that they feel comfortable.

The clinics are great, but they are very medical, they [young people] need professionals to come to them and work with them where they are comfortable. There is not enough education for young people to teach them about domestic violence, sexual harassment, what is acceptable and what isn't."

Young Person's Practitioner

"[Umbrella] clinics are good services and very important. A lot of looked after children have negative experiences at these centres or similar looking centres."

Young Person's Practitioner

LGBTQ+

INTRODUCTION

Mainstream sexual health services may lack awareness of the specific needs of LGBTQ+ communities or lack confidence and knowledge in providing advice that is affirmative of someone's sexual orientation or their trans status. [204]

- Gay, bisexual and men who have sex with men have seen large increases in diagnoses of STIs in recent years. Between 2014 and 2018, there were large increases in diagnoses of chlamydia (61%; from 11,760 to 18,892), syphilis (61%; from 3,527 to 5,681), and gonorrhoea (43%; from 18,568 to 26,574).
- Less than half of lesbian and bisexual women have ever been screened for sexually transmitted infections, and half of those who had been screened had an STI. Many lesbian and bisexual women do not access testing as they do not think they're at risk.
- Trans people face a range of barriers to accessing mainstream services, and often avoid accessing services altogether. 80% of trans people experience anxiety before accessing hospital treatment due to fears of insensitivity, misgendering and discrimination, with intimate care causing the most concern.

A 2018 survey by Stonewall found that:

- 23% of LGBTQ+ people have at one time witnessed anti-LGBTQ+ remarks by healthcare staff.
- 14% of LGBTQ+ people have avoided treatment for fear of discrimination because they're LGBTQ+.
- 13% of LGBTQ+ people have experienced some form of unequal treatment from healthcare staff because they're LGBTQ+.

COVID-19 IMPACT

The following is taken from PHEs analysis: I*mpact of COVID-19 on STIs, HIV and viral hepatitis, 2020 report*:

An online community-based survey conducted through the National Institute of Health Research Health Protection Research Unit in Blood Borne and Sexually Transmitted Infections suggested that, although there had been a decline, there was ongoing risk of STI and HIV acquisition and need of healthcare among MSM, including HIV preexposure prophylaxis (PrEP), during nationwide restriction measures ('lockdown') implemented in response to the COVID-19 pandemic [xiii]. The survey found that during lockdown beginning in mid-March, 47% (447/956) of MSM reported one or more new sexual partners and 20% (194/956) reported condomless sex with multiple partners. This compared to 71% (1127/1585) and 31% (559/1812), respectively, from the same period in the equivalent survey conducted during 2017. Of the MSM reporting condomless sex with multiple partners during lockdown, 57% had not accessed STI testing at time of survey completion. The full findings from this study will be published in due course.

MEN WHO HAVE SEX WITH MEN (MSM)

The majority of men who have sex with men identify as gay or bisexual. Within the category of men who have sex with men, there are cohorts who identify with different orientations including heterosexual identifying men who

[204] LGBT Foundation (2020), Hidden Figures: LGBT Inequalities in the UK.

have sex with men.[205] Data from NATSAL-3[206], a nationally representative survey of British adults aged 16-74 conducted in 2010-2012, suggest that around 22% of men with same-sex partners in the previous year identified as heterosexual, a little more than the number of those identifying as bisexual (19%). There is a risk that heterosexual-identifying men who have sex with men may not disclose the sex they have with men to healthcare providers, reducing the possibility of them receiving sexual health information and testing for STIs and HIV.

MSM have poor health outcomes compared to the general population in relation to HIV, STIs, mental health, the use of alcohol, drugs and tobacco.[207] PHE suggest that these health inequalities are shaped by a range of factors including families and social networks, schools, workplaces, faith organisations, media, legislation and the wider cultural and social context in which men grow, live and age.

In its framework, *Promoting the health and wellbeing of gay, bisexual and other men who have sex with men*, PHE suggest a more holistic approach to reducing HIV infections, with the interconnected problems of mental health, substance use and sexual health being considered together.

LESBIAN AND BISEXUAL WOMEN WHO HAVE SEX WITH WOMEN (LBWSW)

PHEs document, *Improving the health and wellbeing of lesbian and bisexual women and other women who have sex with women*[208], highlights a number of inequalities amongst the LBWSW cohort in relation to their experiences of sexual health, maternity, and infertility treatment services. "This mirrors the international research on LBWSW's uptake of sexual and reproductive health services and suggests opportunities to improve access for this population." [209]

Regarding general health inequalities, there is evidence that in general, lesbian and bisexual women report worse general health than their heterosexual counterparts. [210]

LOCAL SERVICES

As part of their service delivery, Umbrella clinics offer a specific health screen for men who identify as MSM. Umbrella routinely offer vaccinations for HPV and Hepatitis A and B to MSM. PrEP is also offered by Umbrella services.

Umbrella are also partnered with Birmingham LGBT to deliver services targeted at the LGBTQ+ population. (See below).

[205] UCL, (2019), Heterosexual-identifying men who have sex with men: an understudied population
[206] Natsal, Natsal-3
[207] PHE (2016), Promoting the health and wellbeing of gay, bisexual and other men who have sex with men
[208] PHE (2018), Improving the health and wellbeing of lesbian and bisexual women and other women who have sex with women
[209] PHE (2018), Improving the health and wellbeing of lesbian and bisexual women and other women who have sex with women
[210] PHE (2018), Improving the health and wellbeing of lesbian and bisexual women and other women who have sex with women

ENGAGEMENT

BIRMINGHAM LGBT

INTRODUCTION

Birmingham LGBT are a third sector organisation who provide information and support to lesbian, gay, bisexual and trans (LGBT) people in Birmingham and Solihull. Birmingham LGBT provide services from a premises in central Birmingham, there is not an equivalent LGBT location in Solihull. Caseworkers can travel to Solihull to see service users.

BIRMINGHAM LGBT WALK-IN CLINIC

Birmingham LGBT have been a partner organisation of Umbrella since 2015.

Prior to the COVID-19 pandemic, Birmingham LGBT ran a walk-in clinic 7 days a week. The drop-in clinic provided sexual health information and access to rapid HIV testing and assisted STI testing. Feedback from Birmingham LGBT practitioners was that the walk-in clinic was busiest during evenings and Saturdays.

The Birmingham LGBT premises were closed at the start of the pandemic, meaning the sexual health services were not run. Between September 2020 and January 2021, the building was open 3 days a week, before closing again between January and March 2021.

During the COVID-19 pandemic, there was no access to the STI home testing kits. Practitioners fed back that these were the most popular kits and their absence impacted engagement with sexual health services and additional services such as BBV testing. The kits were made available again from May 2021.

At the time of this assessment, the walk-in clinic's hours have reduced to 6 days a week:

- Monday to Friday: 10am to 9pm.
- Saturday: 11.30am to 7pm.

The walk-in clinic is available to anyone from Birmingham or Solihull.

BIRMINGHAM LGBT OUTREACH SERVICES

Prior to the COVID-19 pandemic, Birmingham LGBT staff ran outreach interventions across Birmingham and Solihull. Outreach activity included LGBTQ+-focussed activity in bars, clubs, universities and colleges. Work was also completed in public sex environments such as dogging sites. The outreach work focussed on providing healthy lifestyle information and promotion of STI testing.

Outreach work was paused during the COVID-19 pandemic.

BIRMINGHAM LGBT GROUPWORK

Prior to the COVID-19 pandemic, Birmingham LGBT staff ran in-person group work sessions. This is now offered online. The following sessions are run:

- A women's forum for LBT women. There are up to 250 people on the forum.
- RANG offer support for men who have sex with men who are from a South Asian and Middle Eastern ethnicity.
- A GBT men's group.

- A new group is being created for men who have sex with men who are from a Black and African Caribbean background.

UMBRELLA SEXUAL HEALTH SERVICE AT BIRMINGHAM LGBT

Prior to the COVID-19 pandemic, Umbrella provided a sexual health clinic in the Birmingham LGBT premises in central Birmingham. The clinic ran twice a week and offered a full range of sexual health services. The service was run by Umbrella practitioners with support from Birmingham LGBT volunteers.

Prior to the COVID-19 pandemic, a trans-focused sexual health group was run by Umbrella once a month. Birmingham LGBT practitioners fed back that this was a very popular service.

Umbrella Sexual Health clinics were halted during the COVID-19 pandemic.

Prior to the COVID-19 pandemic, the following services were run:

Clinic	Frequency	Location
Abuse Survivors' Clinic	2 x per month	Whittall Street Clinic
General Clinic	2 x per week	Birmingham LGBT
PrEP Advice Clinic	3 x per month	Birmingham LGBT
PrEP Follow-up Clinic (3 separate clinics)	1 x per week 3 x per month 1 x per month	Birmingham LGBT
Trans Clinic	1 x per month	Birmingham LGBT
Well Woman Clinic	1 x per month	Birmingham LGBT

PrEP SERVICES

Pre-COVID-19, there were two PrEP clinics run at Birmingham LGBT premises that accepted referrals via studies and trials. Demand has increased for this over time. Training for PrEP assessments has been rolled out via nursing staff.

TRAINING

Birmingham LGBT offer one day of LGBT awareness training. The training is offered via Umbrella Essentials package. Chemsex awareness training is also offered.

GAPS / DEVELOPMENT

Birmingham LGBT practitioners believed that there was a gap in substance misuse services for those in the LGBTQ+ community who engaged in chem sex usage.

The lack of specialist refuge provision for LGBTQ+ community in the West Midlands was seen as a gap.

PRACTITIONER SURVEYS

Practitioners were invited to complete surveys relating to the sexual health needs and the responses of sexual health services in relation to the client groups that they work with.

FREE TEXT COMMENTS

Below are the free text comments that were left by practitioners working specifically with those from the LGBT community.

What are the gaps in sexual health services?

"Access to more variety of rapid testing in community for STI's other than HIV."

LGBT Practitioner

"We live in Birmingham where there is a significant amount of people who may struggle with English. Some words just do not translate back to their first language. This could cause barriers to accessing services actual and online..."

Outreach Worker

What are the gaps in sexual health services?

"Information about PEP could be more widespread and access to vaccinations"

Outreach Worker

"I could comment on many areas, but the Trans community has an overrepresentation of people with ASD. We could also do with support and pathways for this in the Trans clinic"

GU Consultant

What are the gaps in sexual health services?

"Language barriers for clients whose first language is not English. More Trans awareness training in team as well as cultural/race training."

Outreach Worker

"Some people are afraid to access our services because it is clearly identified as LGBT."

Outreach Worker

"It is important to offer services in a safe and friendly environment that is familiar to the clients making them feel safe."

Outreach Worker

"Overall, I think prior to COVID, Umbrella was doing a reasonable job of doing all [sexual health related] things. The biggest issue from my perspective involves issues around thing which cross the boundaries between NHS England CCGs and LA such as cervical screening, hormone testing and provision to the Trans community. I also feel that the availability of blood spot testing would be useful for HIV testing and Hep C testing in some instances. Again, this crosses commissioning boundaries."

GU Consultant

"Generally, I would say that the service is meeting the needs of the community I would like to see us introduce the Rapid test for syphilis."

Sexual health practitioner

"From feedback I regularly receive, clients appreciate the safe space provided by Birmingham LGBT and the cultural and social awareness of the needs of the community offered by the staff. I think its important to keep some separation between the expertise and proficiencies of the staff within RSVP and the team at Birmingham LGBT."

Sexual health practitioner

What are the gaps in sexual health services?

"Support with substance misuse chem sex, access to PrEP for everyone who needs it"

Birmingham LGBT Employee

"Overall MSM are used to accessing sexual health services the lack of access to services during the pandemic has been an issue"

Birmingham LGBT Employee

"One area we could develop would be reintroduction of safer (slamming packs) perhaps in collaboration with the CGL."

Sexual health practitioner

"Generally, service users have been very patient and understanding on the constraints placed upon us due to Covid 19. However, I would like to see a return full operation and responsiveness to the needs of the LGBT community as soon as safely possible. I would like to see us take advantage of the learnings we have made about delivering services digitally such as Virtual appointments via video calls and assisted postal testing as an add on to face to face physical testing / support services."

Sexual health practitioner

"The main barrier [to services] is combating service user's own fear of attending"

Birmingham LGBT Employee

What are the gaps in sexual health services?

“Support for Transgender people who are self-medicating. Due to the extremely long waiting times for Gender Dysphoria Clinics, many trans people resort to self-administration of grey-market hormones bought online. This can involve the self-administration of injectable hormones, depending on the circumstances of the particular trans individual, this can increase risk of contracting certain STI's. This is particularly concerning given that HIV prevalence is far higher amongst trans people than the general population for example.

It would be useful for professionals to be aware of this issue when interacting with trans clients, but additionally it would be good to provide blood tests for self-medicating trans people. Unfortunately, GP practices will often refuse to provide blood tests for self-medication trans people as it is seen as "encouraging" this practice (this is including those tests such as liver and kidney function tests which are essential to establish whether hormone treatments have negatively affected the trans individual). I believe it would be hugely beneficial to contact the NHS Gender Dysphoria Clinics to establish what blood tests we could be offering to self-medicating trans clients to protect their sexual and general health; especially given the lack of provision elsewhere.”

Birmingham LGBT Employee

FOCUS GROUP

A focus group was completed with LGBTQ+ patients. The following feedback was received:

- Where do people normally go/or think to go if they had a sexual health need?
    - Sexual Health clinic not great was a preference to go to GP rather than clinic for Sexual Health needs and HIV testing.
    - Will use Sexual Health Clinic for Condoms and emergency HIV tests.
    - One patient described risky sexual behaviour – "occasionally got drunk and not as careful as should be"
    - Sometimes people use Sexual Health clinic as they don't want their GP to know that they have had unprotected sex as GP are thought of as a family unit.
    - The GP will request them to attend the Sexual Health clinic.
- What barriers do people face in relation to accessing sexual health services?
    - Sexual Health Services are not the same anymore (prior to COVID) you need to book an appointment online preference for walk in option.
    - Reason prefer walk in clinic as there is a 3 day wait for online booking.
    - Those will HIV Diagnosis regular attend 6 monthly appointments at Hawthorn House and having a HIV test conducted by Umbrella.
    - GP should have a prompt for them to check on regular sexual health screening.
- Issues raised - Were any issues raised by participants in relation to sexual health?
    - Multiple touch points and duplication for people with a diagnosis of GP.
    - People said they preferred to walk in and wait to book an appointment for a sexual health need than book online and have to wait 3 days for appointment confirmation to come through.

BLACK AND MINORITY ETHNIC GROUPS

INTRODUCTION

Ethnic and racial disparities in sexually transmitted infections (STIs) and other sexual health outcomes in the UK are well recognised, but the drivers of these disparities are not fully understood.[211]

- The rates of gonorrhoea and chlamydia in black and minority ethnic (BME) populations are three times that of the general population, and the rate of the STI Trichomoniasis is eight times higher.[212]
- Minority communities constitute 14% of the UK population but have a burden of late HIV diagnoses of 52% and 40% for people accessing HIV services.[213]
- 80% of women living with HIV are BME, and 62% are of African heritage.[214]
- The disparity in STI rates may not be accounted for by individual behaviours. Research suggests that sexual history and outcomes are likely to be influenced by factors beyond the individual, including partner behaviour and sexual networks.215 216"It is critical that research in this area seeks to understand the breadth of determinants of sexual health and does not stigmatise ethnic groups who have a disproportionate prevalence of STI disease."[217]
- In one recent study, 45.5% of BAME people said fears about a lack of cultural sensitivity from doctors deters them from seeking sexual health support.[218]
- Cultural factors that currently impact Black African and Caribbean, Latin American and South Asian communities are varied but include stigma and insensitivity relating to HIV, sexually transmitted infections (STIs), sex and relationships.[219]

[211] Rachel Jewkes and Kristin Dunkle (2017), Drivers of ethnic disparities in sexual health in the UK. *The Lancet Public Health*, Volume 2, Issue 10, E441-E442, October 01, 2017.
[212] House of Commons Health and Social Care Committee, Sexual health, Fourteenth Report of Session 2017–19.
[213] House of Commons Health and Social Care Committee, Sexual health, Fourteenth Report of Session 2017–19.
[214] House of Commons Health and Social Care Committee, Sexual health, Fourteenth Report of Session 2017–19.
[215] Coyle RM, Miltz AR, Lampe FC on behalf of the AURAH Study Group, et al, Ethnicity and sexual risk in heterosexual people attending sexual health clinics in England: a cross-sectional, self-administered questionnaire study. *Sexually Transmitted Infections* 2018;94:384-391.
[216] Rachel Jewkes and Kristin Dunkle (2017), Drivers of ethnic disparities in sexual health in the UK. *The Lancet Public Health*, Volume 2, Issue 10, E441-E442, October 01, 2017.
[217] Coyle RM, Miltz AR, Lampe FC on behalf of the AURAH Study Group, et al, Ethnicity and sexual risk in heterosexual people attending sexual health clinics in England: a cross-sectional, self-administered questionnaire study. *Sexually Transmitted Infections* 2018;94:384-391.
[218] Love Sex Life LSL Partnership (2020), Transforming Sexual and Reproductive Health for BAME Communities in Lambeth, Southwark and Lewisham.
[219] Love Sex Life LSL Partnership (2020), Transforming Sexual and Reproductive Health for BAME Communities in Lambeth, Southwark and Lewisham.

FOCUS GROUP

A focus group was completed with a group of women of reproductive age from South Asian communities. The group covered the following areas:

- Explore what people understand 'sexual health' to mean, and their awareness of options around contraception?
    - Most participants knew about the pill, condoms, implant and coil.
    - A number of participants had a bad experiences with the implant.
    - Some participants did not realise they could go on to a different one.
- Where do people normally go/or think to go if they had a sexual health need?
    - Number of participants mentioned Umbrella and they had seen adverts for it on the local buses.
    - Number of participants from Universities around Birmingham said they would like a drop-in sexual health service at the university and also more information on sexual health around campus.
    - Participants did not feel comfortable going their GPs – if it would be on their records.
- What barriers do people face in relation to accessing sexual health services?
    - Stigma
    - Lack of knowledge of sexual health
    - Not sure where to go or what happens at sexual health services.
    - People don't think they will catch an STI.
- Questions Raised - Were any questions raised by participants in relation to sexual health?
    - Questions around sexually transmitted infections (in particular BBVs), around what happens to information stored about participants at sexual health services.
- Issues raised - Were any issues raised by participants in relation to sexual health?
    - Not enough information provided by sexual health services when attending the clinic about the different contraception methods.
    - Some participants would like to be able to access STI testing easier and quicker – for example chlamydia testing kits in pharmacies that you can pick up – same for all STIs.
- Themes/Recommendations - Were there any themes/recommendations to be put forward for the sexual health needs assessment?
    - More education about sexual health – in schools, in colleges and at universities – in particular for international students as they don't get any at home.
    - More social media advertisements.
    - More awareness of sexual health services – in particular access after COVID-19 pandemic.
    - Sexual Health Ambassadors – more knowledge in the community, run sexual health training for community groups to teach others.

OLDER PEOPLE

INTRODUCTION

OVERVIEW

Sex is an important part of later life. The English Longitudinal Survey of Ageing found that sex is an important part of a relationship to two-thirds of men and women aged 50-90 and that people are still sexually active into their 80s and 90s. The study also found that good sexual health is associated with better general health and wellbeing among older people. [220]

Issues affecting sexual health in older people include:

- Stigma. Older people's sexuality is often ignored or marginalised, and stigma around older people's sexuality can stop people from seeking professional advice. Research has found that the belief that older people don't, or shouldn't, experience sexual desire is a significant barrier to accessing sexual health services.
- STIs. Public Health England data on sexually transmitted infections (STIs) shows that STI rates in people aged over 45 have risen in recent years, with new STI diagnoses increasing by 18% between 2011 and 2015.
- Health issues related to sexual wellbeing, such as the menopause or erectile dysfunction.
- Ill health including conditions such as dementia, arthritis and heart conditions, which can impact on older people's sex lives.

The *Framework for Sexual Health Improvement in England* aims to ensure that "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, and people with other physical health problems that affect their sexual health can get the support they need for sexual health problems."

ENGAGEMENT

ADULT SOCIAL CARE

SEXUAL HEALTH NEEDS

Practitioners fed back a number of key points about older people:

- Older adults do not actively seek out support. The topic of sexual health is possibly more taboo with older people.
- Adult social care works with the acute end of need in relation to older people.
- Questions arise in relation to consent and a person's ability to consent.
- Service users are often based in residential care and extra care settings.

[220] FPA (2017), Older people policy.

- These needs tend to be at a safeguarding level. Sexual health needs are not raised as part of the Care Act Assessment.

EXTRA CARE

- There is not a lot of outreach into extra care settings.
- This population are quite able and quite active.

DISABILITIES

LEARNING DISABILITY

- Most young people with mild/moderate intellectual disabilities have had sexual intercourse by age 19/20.[221]
- Both men and women with intellectual disabilities are more likely to have unsafe sex 50% or more of the time than their peers. [222]
- One study found that compared to college students, participants with mild intellectual disability were less likely to have experienced sexual intimacy or intercourse but, if they had engaged in sexual intercourse, were more likely to have had an unwanted pregnancy or an STI[223]
- People with learning disabilities report they have been denied the ability to make informed choices around relationships, as well as lacking the necessary information to do so.[224]
- A lack of sex education resources and low levels of sex education among people with learning disabilities leads to low awareness of safe sex practices, contraception, sexually transmitted diseases, sexual consent and abuse. [225]
- Many people with a learning disability may not have been taught about sexual health, contraception, LGBTQ+ relationships, masturbation and legal and emotional aspects of sex. They often do not receive accessible sex education information.[226]
- Furthermore, sex education resources and campaigns for people with a learning disability may not be designed with the specific needs of lesbian, gay or bisexual people in mind, and instead treat everybody as heterosexual. [227]
- People with learning disabilities are at greater risk of sexual violence and abuse. [228]
- One study compared the sexual understanding of young people with and without learning disabilities. Their results showed those without learning disabilities had higher levels of knowledge and greater access to larger networks of informal sources of information on sexual development. [229]

[221] Baines, S., Emerson, E., Robertson, J. et al. Sexual activity and sexual health among young adults with and without mild/moderate intellectual disability. BMC Public Health 18, 667 (2018).
[222] Baines, S., Emerson, E., Robertson, J. et al. Sexual activity and sexual health among young adults with and without mild/moderate intellectual disability. BMC Public Health 18, 667 (2018).
[223] Baines, S., Emerson, E., Robertson, J. et al. Sexual activity and sexual health among young adults with and without mild/moderate intellectual disability. BMC Public Health 18, 667 (2018).
[224]Scottish Commission for Learning Disability (2018), Safe and Healthy Relationships: Empowering & supporting people with learning disabilities through education.
[225]Scottish Commission for Learning Disability (2018), Safe and Healthy Relationships: Empowering & supporting people with learning disabilities through education.
[226]Mencap: Let's talk about sex. Blog post, 11 December 2017.
[227]Mencap: Let's talk about sex. Blog post, 11 December 2017
[228]Scottish Commission for Learning Disability (2018), Safe and Healthy Relationships: Empowering & supporting people with learning disabilities through education.
[229]Scottish Commission for Learning Disability (2018), Safe and Healthy Relationships: Empowering & supporting people with learning disabilities through education.

- Women with learning disabilities have lower levels of knowledge than men: "on each of the subscales converting Physical Changes that occur at puberty, reproduction, contraception, and sexually transmitted infections, the men with LD always achieved higher scores than the women." [230]
- Just 19% of women with learning disabilities have had a recent cervical cancer screening test, compared to 73% in the general population.[231]

PHYSICAL DISABILITY

In sexual and reproductive health, barriers to access might be physical, such as a lack of an accessible entrance into a clinic, or to do with knowledge or attitudes, such as encountering staff who are dismissive and judgemental or who lack an understanding of specific impairments. [232]

- 88% of women with physical disabilities said it is harder for women with physical disabilities to attend or access cervical screening, 63% said that they have been unable to attend cervical screening because of their disability and 49% said that they have chosen not to attend cervical screening in the past for reasons such as previous bad experiences related to their disability or worries about how people might react.
- Adolescents with chronic medical conditions are as likely to need contraception as their peers.[233]
- Some people with disabilities may be dependent on their families, staff or other carers in order to have relationships or engage in sexual activity.[234]

[230]Scottish Commission for Learning Disability (2018), Safe and Healthy Relationships: Empowering & supporting people with learning disabilities through education.
[231] Learning Disability Today, (2019), Cervical cancer screenings: addressing the health inequality founded upon misconception
[232]FPA (2017): Disability and sexuality policy statement.
[233] Dickson et al (2017), Contraception for adolescents with disabilities: taking control of periods, cycles and conditions. *BMJ Sexual and Reproductive Health*.
[234]FPA (2017): Disability and sexuality policy statement.

ENGAGEMENT

DISABILITY RESOURCE CENTRE

INTRODUCTION

The Disability Resource Centre, covering Birmingham and Solihull, is an independent organisation and a registered charity, which has disabled people at the centre of its decision making. The centre has a large information, advice and guidance service, offering advice on:

- Fuel poverty and debt
- Benefits
- Employment and education

There is a health and wellbeing service promoting activity and a healthy lifestyle. The Disability Resource Centre provides social and leisure activities. The charity works with 4,500 disabled people each year.

SEXUAL HEALTH NEEDS

Practitioners fed back the following about the sexual health needs of those with disabilities:

- The organisation does not do much in terms of sexual health.
- Sexual health can be a taboo subject.
- Disabled people are not seen as sexual beings.

GAPS/DEVELOPMENT

Practitioners fed back the following gaps in sexual health provision and possible areas for development:

- The organisation has reports of disabled people not getting access to smear tests.
- There is a need to make information on sexual health accessible and to make sure issues are followed up correctly.
- There are occasions where if a person with learning disability does not have a carer to support them, then help cannot be accessed.
- Those with learning disabilities will need help to book a GP.
- Accessibility is a big issue.
- Those with learning disabilities may mask understanding about health questions.
- Health practitioners may not understand the needs of those with learning disabilities.
- Staff training and upskilling is a need. Staff need confidence to raise issues with the people they are working with.
- People with learning disabilities require face-to-face contact to process information. Online consultations are difficult for them.
- Disabled people are more likely to be digitally excluded.

ENGAGEMENT

PRACTITIONER SURVEY

Practitioners were invited to complete surveys relating to the sexual health needs and the responses of sexual health services in relation to the client groups that they work with.

FREE TEXT COMMENTS

Below are the free text comments that were left by practitioners working specifically with those with disabilities.

"This [sexual health needs] is not something I have ever asked in a social work assessment. Sometimes people will raise questions about their sexual health, but I have not had this experience recently."

Social Worker Disabled Adults

"Accessible sexual health information and advice for people with cognitive impairments and mental capacity issues, for example, people with learning disabilities or brain injury."

Social Worker Disabled Adults

"Most of the young people I support require more support than is given and often require an advocate to support them in meetings. They require more understanding in how to put a condom on, how they can say no, what sex is! What oral sex is, how to keep safe and what contraception is used for. This is not offered by any current services. It has always been a taboo subject that the learning disability community nursing team do not meet. It is a huge issue."

Social Worker

"My answers are based on difficulty accessing sex and relationships education for people with learning disabilities. There is no service available. I have not encountered the other issues directly as they have not been raised by the people I work with."

Social Worker Disabled Adults

"Many people I work with need to attend appointments with a carer so need this to be booked in advance."

Social Worker Disabled Adults

"Many of my young people do not understand what the actual sex act is, what oral sex is, sexually inappropriate touching. They are shamed into keeping secrets and often any sexual abuse is not disclosed until many years later. They do not understand the full acts of having a baby, the risks of how this happens/how to avoid it until they are ready to manage. There are no services which support our adults with LD to understand any of the above in my experience if they have milder LD meaning they find out things which are often incorrect from their peers or the internet."

Social Worker

"All of the other scores are mainly relating to staff members supporting people to source and find / have these tests. They [Those with LD] would not have been able to source or perform the test themselves independently and it is not offered as a regular appointment. Health and sexual health of people with learning disabilities is poorly screened from my experience".

Social Worker

"The only expertise which has been fantastic is the RSVP and CRASAC sexual violence and abuse groups who provide expertise. However, they would value from more support around people counselling people with autism".

Social Worker

"There seem to be difficulties with people with learning disabilities accessing appropriate contraceptive advice for their needs and difficulties with monitoring whether they have missed an appointment for their contraception."

Social Worker

"There does not appear to be expertise regarding offering sexual health advice for people with learning disabilities."

Social Worker

"There is so little partnership between schools and external specialist services for disabled young people that information is not well shared, and practice will be different between leisure and learning environments."

Social Worker

"[Accessibility] is more about the expertise, teaching of varying information in an accessible way and that makes sense to the individual rather than the accessibility. The accessibility issue is not a location issue or opening hours issue. It is an issue about the expertise of teaching these young people what sex is, what a condom / contraception is, they have a right to say no, (consent and what that means) what sexual abuse is and how to report it, what oral sex is, that sex is natural and normal not something to be told off for having or desiring (reducing shame they have for self masturbation). How to keep safe, what are the risks, how to have sex if they desire and that its needs to be consensual and what that means.".

Social Worker

"There does not appear to be specialist advice available for people with learning disabilities.

Social Worker

"They often require someone to go with them and support them in appointments along with outside the appointments and the clinic sometimes have not engaged with carers when required which has missed vital information and context. They also do not understand the reasons for sexual health as no one has ever explained it to them in a way they understand.".

Social Worker

"There appears to be nominal support for young disabled people to establish boundaries around sexual behaviours which puts them at risk all ways and nominal input to allow them to make safe choices around their own needs.".

Social Worker

ASYLUM SEEKERS AMD NEWLY ARRIVED MIGRANTS

INTRODUCTION

Asylum seekers and refugees are not sexually different to other populations. The sexual health issues that asylum seekers and refugees may face are not unique to people who seek asylum – nearly all are also experienced by British citizens.

However, many factors combine to make asylum seekers and refugees vulnerable to poor health, including poor sexual health. These include:

- experiences of persecution, oppression and flight
- inadequate health care in the country of origin
- insecurity, poverty and powerlessness in the UK
- loss of community and being in an unfamiliar environment.[235]

Sexual issues may form part of the application for asylum, for example:

- homophobic persecution
- FGM
- trafficking for sexual exploitation
- sexual torture, rape or sexual violence.

Best practice includes:

- Reassuring clients about confidentiality
- Awareness of the differing needs of sectors of the refugee population, such as men and women, or different age groups, to develop services and projects that are useful and accessible
- Clear policies on managing disclosure of trauma, abuse or persecution
- Refugee community organisations, specialist sexual health services, health promotion units, local authorities, refugee agencies, housing providers, voluntary sector projects, strategic bodies, commissioners, funders and others working in partnership
- Involving refugees and asylum seekers
- Using trained community interpreters to ensure effective and accurate communication, culturally sensitive services, efficiency and confidentiality
- Ensuring awareness and sensitivity to the cultural norms of different communities

[235] FPA (2007), Sexual health, asylum seekers and refugees: A handbook for people working with asylum seekers and refugees in England.

ENGAGEMENT

ENTRAID / BIRMINGHAM ASYLUM REFUGEES AND MIGRANTS SUPPORT

Birmingham Asylum Refugees and Migrant Support are a commissioned service for refugees and migrants. The service supports the voluntary sector. The service has recently worked with 550 Syrian refugees and up to 80 Afghan migrants.

Practitioners fed back that health is explored constantly. Sexual health is not something that has been brought up in discussions.

RAPE AND SEXUAL VIOLENCE

ENGAGEMENT

RAPE AND SEXUAL VIOLENCE PROJECT (RSVP)

INTRODUCTION

RSVP offer services and support to children and adults who have been subject to sexual violence and abuse. RSVP cover Birmingham and Solihull.

SEXUAL HEALTH PROVISION

All services are available across Birmingham and Solihull. The service provides:

- Counselling and access to mental health practitioners
    - In Solihull, counselling is offered as an outreach service in central Solihull and Chelmsley Wood.
- Independent Sexual Violence Advocates (part-funded by Umbrella)
- Services to Refugee and Asylum Seekers
- Groups for those from Black and Minority Ethnic groups.
- Psychoeducational and self-help resources.
- In August 2020, RSVP took on a role with Birmingham Children's' Trust.
- Bespoke and specialist training.
- Mixed-gender and women-only social groups
- Coffee mornings
- Sex worker support service
- Specialist LGBTQ+ support, helpline and webchat.

SARC

- The SARC commission RSVP to run short-term interventions for adults and children.
- This includes short-term time-limited counselling:
    - 10 sessions for adults
    - 9 sessions for children
- There is no SARC in Solihull. Survivors have to travel large distances to access a SARC.

BUILDING

- The RSVP building is in central Birmingham.

- The building contains offices and counselling rooms.
- For outreach work, RSVP use other premises such as GPs and Children's Centres.
- For clinical work, RSVP use the Whittall Street Clinic and the LGBT Centre.

REFERRALS

- Referrals are made via a number of sources:
    - Self-referrals
    - SARCs
    - GPs
    - Umbrella
    - Midwives
    - Police
    - Social Care
    - Mental Health

ABUSE SURVIVORS' CLINIC (ASC)

- The ASC runs at the Umbrella Whittall Street Clinic once a month. There is also an ASC run at Umbrella locations in Solihull. These ASC are funded by Umbrella but run by RSVP.
- The RSVP ASC in Solihull is led by an ISVA.
- The ASC in Birmingham is led by a ISVA in conjunction with a consultant.
- In Solihull, the uptake for the ASC is lower. It is believed that this is related to the lack of healthcare provision in the clinic.

ISVAs

- ISVAs can support survivors in court and in clinics.
- There is an LGBT ISVA who is funded by Umbrella. Every week the LGBT ISVA attends the LGBT centre.
- There is a Sex Worker ISVA who is not funded by Umbrella.

TRAINING

- Umbrella part fund training that is delivered.
    - The training covers sexual abuse and sexual violence.
    - There is a training course for Vicarious and Sexual Trauma.
- There is a wide need relating to abuse training.

NEED

Practitioners highlighted a possible need relating to the screening tools used in sexual health clinic:

- There is a possible need relating to the screening tools used in sexual health clinics.
- The screening tools lend themselves to a 'box checking' exercise as opposed to engaging personally with the patient.
    - Exellicare is the database that practitioners use. The screening questions relating to sexual violence have been looked at but not changed.
- Some of the questions can be triggering for the patient.
- The approach needs to be different for different survivor groups, such as BAME, commercial sex workers and men.

GAPS/DEVELOPMENT

Practitioners fed back the following:

- Young Person's ASC
    - There used to be a dedicated Young Person's ASC; however, this was not well-attended. There is a feeling that it was not promoted well.
    - This ASC was run in 2019 and was in a more youth-friendly environment.
    - The Adult ASC sees patients aged 13 and above. Those younger than this are seen by a paediatrician in a SARC.
- Sex Workers
    - There is a lack of specialist provision relating to sex workers.
    - There is a lack of training on how to respond to online sex working.

ENGAGEMENT

PRACTITIONER SURVEY

Practitioners were invited to complete surveys relating to the sexual health needs and the responses of sexual health services in relation to the client groups that they work with.

FREE TEXT COMMENTS

Below are the free text comments that were left by practitioners working specifically with victims of rape and sexual violence.

"I do believe that sexual health professionals in the Birmingham area have good knowledge and access to other complimentary services such RSVP and BSWA. in my opinion I think the services are well utilized by health advisers."

ISVA

"RSVP supported at ASC pre-pandemic and have continued to provide such support via phone during and this face-to-face support has now resumed. Currently, an ISVA is based at Umbrella WSC, 2 days p/w which will increase to 4. They are on hand to meet with patients, to provide initial advice and information, brief support and to take referrals, as well as being on hand to support the health advisors and Doctors with any queries they may have."

ISVA

"Resuming female/male only waiting areas, as it can be sometimes triggering to survivors to sit in waiting areas with the opposite gender or a separate space for survivors of sexual abuse, I have supported clients who have had panic attacks which can be even more distressing when in a busy waiting room with many others."

ISVA

"Alternative location for appointments is vital. I have worked with clients who have requested an appointment at the RSVP office as sexual health clinics can be triggering for some clients after they have experienced trauma. A clinical setting is not always the right location when offering support to survivors, therefore having RSVP offices as an alternative location for nonmedical appointments is needed."

ISVA

What are the gaps in current provision?

"Virtual appointments.

Remote/outreach/pop up clinics

Rapid testing - STI's

Information about STI's - perhaps in video/DVD format, something that external partners could show to clients. Something informative, that dispels any myths and stereotypes around sexual health. There are still so many people that are reluctant to access sexual health services especially for a routine check. This should also be accessible to deaf patients too. If this could include patient (anon) testimonies which may help encourage individuals to access services, particularly those that have been through abuse and trauma."

ISVA

"If Sexual health staff have knowledge around sexual abuse and trauma, this helps with how they conduct the appointment which can help the client to feel more relaxed. Also, this may enable the client to feel able to open up about any intimate concerns they have."

ISVA

"Some survivors may have some concerns about accessing sexual health services due to their culture or background, they may have fears that someone they know them, or their relatives may see them.

Some survivors have concerns due to not being sure about what to expect, whilst the ISVA will give some information to try to alleviate these concerns, perhaps having some more specialist/clinical information about the types of testing/vaccinations that could be offered and what is likely to take place in the appointment, including any questions that will be asked and if follow up appointments may be required, may be helpful for survivors of abuse."

ISVA

"I have found all umbrella staff informative and really helpful in this area."

ISVA

"Choice of the gender of the staff member is extremely important as it may be triggering for some survivors to have their appointment with a particular gender. This can cause the survivor to shut down and not discuss their concerns, this can impact on how they feel post appointment, and this can create a reluctance to engage in any follow up appointments."

ISVA

"The Solihull clinic hasn't been operating however we have been able to sign post to available umbrella services via the telephone and support clients at court"

C & YP ISVA

"It can be an embarrassing time for clients to access sexual health services, it's important we make it easy and remove barriers to accessing services."

C & YP ISVA

"I feel some of my clients have struggled as they would like someone to accompany them to the appointments. They do not want to wait outside the building for fear of being seen."

ISVA

RELIGION

INTRODUCTION

There is a wide range of religious groups in the UK. The 2011 Census for England and Wales showed that just under three-quarters of the total population of England and Wales reported following a religion.

Religion can be a powerful influence on sexual attitudes and behaviour for many individuals, including around contraception and abortion. [236] Personal interpretations of faith and religious teaching can vary greatly.[237]

Religious beliefs may influence attitudes and behaviour in relation to: [238]

- Sex outside marriage
- Virginity[239]
- Personal hygiene and cleanliness[240]
- The role and rights of women[241]
- Same-sex relationships
- Contraception and emergency contraception
- Abortion
- Transsexuality [242]
- Circumcision[243]
- FGM[244]

In addition, some aspects of religious practice and belief can influence people's understanding of what causes sexually transmitted infections, and their attitudes to treatment. For example, some people may find it difficult to take medicines at certain times of the year, such as periods of fasting. Others may believe in traditional remedies or may be advised by a spiritual guide to rely on prayer instead of medication.[245]

In some religious cultures, such as Islamic societies, talking about sex can be taboo, leading to poor knowledge about sexual health.[246]

[236]FPA (2016): Religion, contraception and abortion factsheet. Accessed May 2021.
[237] Department of Health (2013), A Framework for Sexual Health Improvement in England. https://www.gov.uk/government/publications/a-framework-for-sexual-health-improvement-in-england
[238]FPA (2016): Religion, contraception and abortion factsheet. Accessed May 2021.
[239] FPA (2007), Sexual health, asylum seekers and refugees: A handbook for people working with asylum seekers and refugees in England.
[240] FPA (2007), Sexual health, asylum seekers and refugees: A handbook for people working with asylum seekers and refugees in England.
[241] FPA (2007), Sexual health, asylum seekers and refugees: A handbook for people working with asylum seekers and refugees in England.
[242] Department of Health (2009), Religion or belief: a practical guide for the NHS.
[243] Department of Health (2009), Religion or belief: a practical guide for the NHS.
[244] Department of Health (2009), Religion or belief: a practical guide for the NHS.
[245] FPA (2007), Sexual health, asylum seekers and refugees: A handbook for people working with asylum seekers and refugees in England.
[246] Alomair, N., Alageel, S., Davies, N. et al. Factors influencing sexual and reproductive health of Muslim women: a systematic review. Reprod Health 17, 33 (2020).

BEST PRACTICE

- Clinicians, counsellors and others giving advice on contraception should be aware of the issues related to different religions or beliefs and sensitive to the individual needs and beliefs of those they are treating and advising[247]
- The personal religious or other beliefs of staff should not be allowed to influence any advice given to a patient[248]
- Organisations that want to improve their understanding of different faiths and the ways they are practised in different countries and cultures, should talk to refugee community organisations and to refugees themselves. [249]

[247] Department of Health (2009), Religion or belief: a practical guide for the NHS.
[248] Department of Health (2009), Religion or belief: a practical guide for the NHS.
[249] FPA (2007), Sexual health, asylum seekers and refugees: A handbook for people working with asylum seekers and refugees in England.

SWINGERS

INTRODUCTION

Swingers are members of a heterosexual couple who, as a couple, have sex with others. They constitute a hidden subpopulation that is at risk for sexually transmitted infections (STIs).

- Although swingers are members of heterosexual couples and identify as heterosexual, many of them engage in same-sex sexual behaviours; therefore, they are bisexual by behaviour.[250]
- There is some evidence of risk associated behaviours among swingers engaging in group sex.[251]
- In one study, patients who, when asked, identified as swingers and/or who reported partner-swapping, having sex with other couples together with their partner or visiting sex clubs for couples, also reported other behaviours known to be important for STI/HIV transmission including larger numbers of partners, condomless sex, paid and same-sex partners.[252]
- People participating in swing sex may underestimate the risk of their swing sex partner having an STI.[253]
- More research is needed to fully understand the impact of swinging on STIs and sexual health.[254]

[250] Niekamp, AM., Spauwen, L.W.L., Dukers-Muijrers, N.H.T.M. et al. How aware are swingers about their swing sex partners' risk behaviours, and sexually transmitted infection status?. BMC Infect Dis 21, 172 (2021).
[251] Terence Higgins Trust (2020), Sexually Transmitted Infections in England: The State of the Nation.
[252] Mercer, Catherine. (2017). Swinging: If you do not ask you may not find, but you need to. Sexually Transmitted Infections. 93. sextrans-2017. 10.1136/sextrans-2017-053187.
[253] Niekamp, AM., Spauwen, L.W.L., Dukers-Muijrers, N.H.T.M. et al. How aware are swingers about their swing sex partners' risk behaviours, and sexually transmitted infection status?. BMC Infect Dis 21, 172 (2021).
[254] Terence Higgins Trust (2020), Sexually Transmitted Infections in England: The State of the Nation.

PRISONERS

INTRODUCTION

- People in prison and detention often come from populations or groups at higher risk of certain infectious diseases, including HIV and sexually transmitted infections.[255]
- Sharing needles for drug use, the unavailability of condoms and rape are persistent issues within prison environments which increase the risk of HIV and STI transmission.[256]
- NICE guidelines recommend that professionals should offer people in prison information about sexually transmitted infections and available sexual health services and ensure that people in prison have discreet access to condoms, dental dams and water-based lubricants without the need to ask for them.[257]
- Numerous characteristics of male prisoners (for example, social disadvantage, drug dependency, younger age, black ethnic origin, on remand), their offences (drug, sex, violent) and overcrowded prisons (for example, sharing cells, staff shortages, enforced idleness, transfers) are also considered 'high risk' from a sexual health perspective, especially the spread of STIs between prisoners and into the wider population when they are released.[258]
- Female offenders have disproportionately high levels of risk factors for poor sexual health, including socio-economic deprivation, substance abuse and a previous history of gender-based violence, in comparison to the general female population. They also have specific sexual healthcare needs related to their gender including prevention of unplanned pregnancy and cervical screening.[259]
- Research figures estimate that over 600 women receive antenatal care in prison each year, with over 100 actually giving birth during their sentences. There is no Prison Service Order (PSO) relating to the treatment of pregnant prisoners.[260]
- People living with HIV in prison live in fear of breaches of their confidentiality and the resulting discrimination if their HIV status becomes known to staff and other prisoners. There are recorded incidents of bullying and ostracism by other prisoners.[261]
- Living with a stigmatising condition such as HIV and being unable to talk to anyone about it within the prison can have a severely detrimental effect on people's mental health.[262]
- As a result of HIV-related stigma, many people incarcerated will not inform other support services, such as drug rehabilitation programmes, that they are HIV positive.[263]
- There are often barriers to accessing healthcare services and appointments in prison. These can include clashes with visits or court attendance.

[255] Health Protection Agency and Department of Health (2013), Prevention of infection and communicable disease control in prisons and places of detention.
[256] Avert: Prisoners, HIV and AIDS. Accessed May 2021.
[257] NICE (2016), Physical health of people in prison. NICE guideline [NG57]. Published: 02 November 2016.
[258] Elaine C. Stewart (2007), The Sexual Health and Behaviour of Male Prisoners: The Need for Research. Howard Journal Vol 46 No 1. February 2007.
[259] Dr Lucy Michie, Sandyford Sexual Health, Glasgow (2017), The sexual health needs of women within the criminal justice system in Greater Glasgow and Clyde.
[260] The Maternity Alliance (2013), Getting it right? Services for pregnant women, new mothers and babies in prison.
[261] Positively UK (2013), HIV Behind Bars: A review of care for people living with HIV in UK prisons and the role of peer support.
[262] Positively UK (2013), HIV Behind Bars: A review of care for people living with HIV in UK prisons and the role of peer support.
[263] Positively UK (2013), HIV Behind Bars: A review of care for people living with HIV in UK prisons and the role of peer support.

SEX WORKERS

INTRODUCTION

- Although sex workers are found to have high engagement with sexual health services, and test regularly, there are evident associations between the criminalisation of sex work and STIs. However, there is limited research based in England. A large-scale review of 33 countries (including the UK) found that in places where there was "repressive policing" of sex work, sex workers were "twice as likely to have HIV and/or another STI" and 1.5 times more likely to engage in condomless sex with clients.[264]
- Transactional sex, for example in exchange for food or shelter, is evident among some homeless people, as well as some people who are receiving universal credit under conditions of austerity. The impact of this type of sex work on sexual health or STIs is not clear. Whilst sex workers may be engaged with services, advice and sex work networks that promote safety, others, including those in poverty, may fall through the gaps due to barriers of criminalisation, and better understanding is needed around transactional sex, sex work, and criminalisation.
- Female sex workers in England have access to high-quality care through the GUM clinic network, but there is evidence of geographical inequality in access to these services. A minority do not appear to access STI/HIV testing through clinics, and some STIs are more prevalent among female sex workers than other female attendees.[265]
- Among male sex workers, some STIs are more prevalent and some reinfections more common than in other male attendees. A minority of male sex workers do not appear to access STI/HIV testing through GUM clinics.[266]

[264] Terence Higgins Trust (2020), Sexually Transmitted Infections in England: The State of the Nation.
[265] McGrath-Lone L, Marsh K, Hughes G, et al (2014), The sexual health of female sex workers compared with other women in England: analysis of cross-sectional data from genitourinary medicine clinics. *Sexually Transmitted Infections* 2014;90:344-350.
[266] McGrath-Lone L, Marsh K, Hughes G, et al (2014), The sexual health of female sex workers compared with other women in England: analysis of cross-sectional data from genitourinary medicine clinics. *Sexually Transmitted Infections* 2014;90:344-350.

ENGAGEMENT

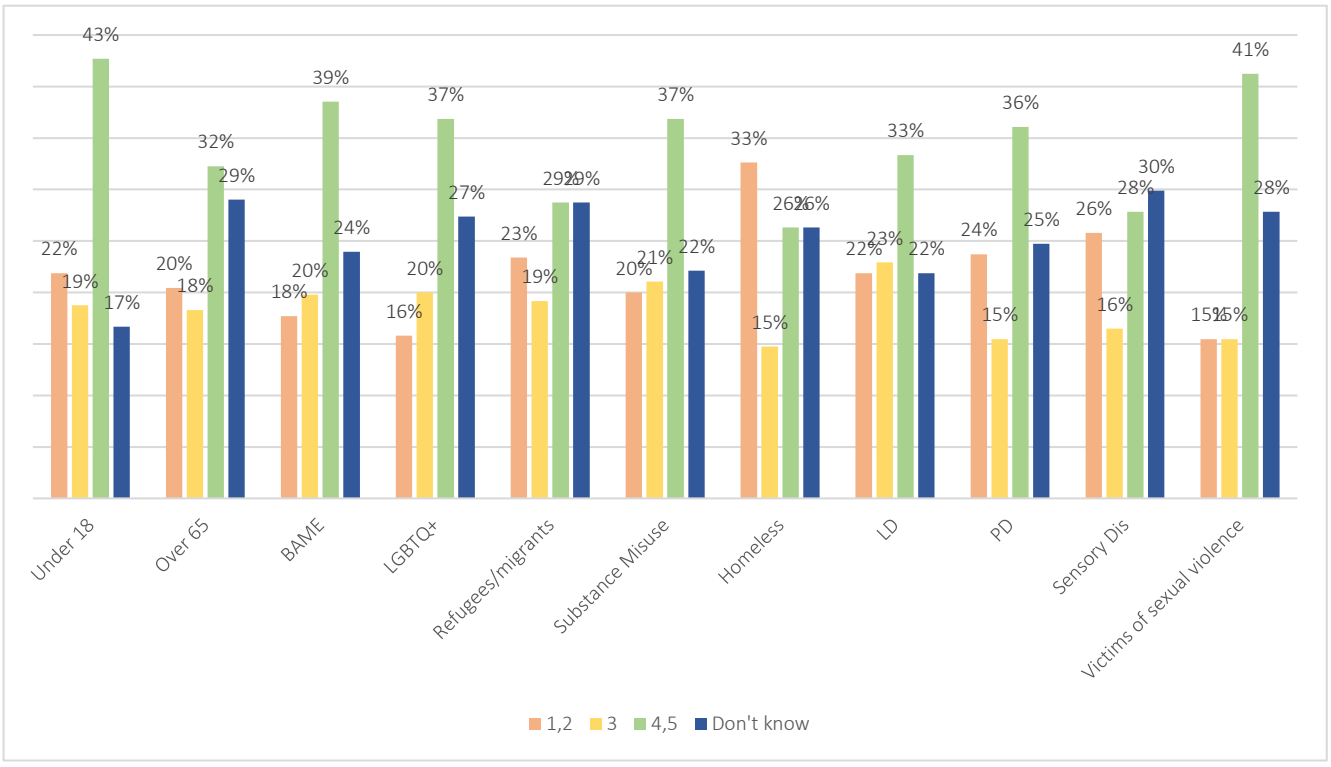
PRACTITIONER SURVEY

Practitioners were asked if current provision relating to specific cohorts were meeting needs. 130 practitioners across a range of services responded.

- 33% of respondents believed that services for homeless people were not meeting needs (selecting 1 or 2 out of 5)
- 43% of respondents believed that services for under 18s were meeting needs (selecting 4 or 5 out of 5)

Figure 7.4: On a scale of 1 to 5, how well are the sexual health needs of the following patient groups met? (Please answer based on the service offering before the COVID-19 pandemic (before March 2020))

Range – 1 = Not meeting need at all, 5 = Fully meeting need



8 – PREVENTION

RELATIONSHIPS AND SEX EDUCATION

RELATIONSHIPS AND SEX EDUCATION

INTRODUCTION

OVERVIEW

Evidence shows that young people who learn about sex and relationships mainly at school are less likely to report poor sexual health outcomes. They are also more likely to delay sex, less likely to experience a sexually transmitted infection (STI) and less likely to report unsafe, distressing or non-consensual sex.[267]

POLICY CONTEXT

Under sections 34 and 35 of the Children and Social Work Act 2017 Act, from September 2020, Relationships Education has been compulsory for all primary school pupils, and Relationships and Sex Education (RSE) has been compulsory for all secondary pupils. Health Education is compulsory in primary and secondary schools.[268] The statutory requirements do not apply to sixth form colleges, 16-19 academies or Further Education (FE) colleges, although the DfE and the NEU encourage all education providers to support students by offering these subjects.[269]

KEY GUIDANCE

- Department for Education: Relationships Education, Relationships and Sex Education (RSE) and Health Education: Statutory guidance for governing bodies, proprietors, head teachers, principals, senior leadership teams and teachers.[270]
- The National Education Union has the following guidance:[271]
    - Relationships Education and Relationships and Sex Education (RSE): NEU guidance for members in England
    - RSE Model Policy for Secondary Schools
    - Relationships Education Model Policy for Primary Schools

WHY IS RSE IMPORTANT?

Reviews of international research show that school-based Relationships and Sex Education, particularly when linked to contraceptive services, does not increase sexual activity, but can have a positive impact on young people's knowledge and attitudes, delay sexual activity and/or reduce pregnancy rates by the use of contraception and safer sex.[272]

In England, a review of the teenage pregnancy strategy identified strong delivery of SRE and PSHE by schools as a key feature of high-performing local authorities where teenage pregnancy rates had gone down.[273]

---

[267] FPA: Our views on relationships and sex education. Accessed May 2020.
[268] Department of Education (2019, updated 2020): Relationships and sex education (RSE) and health education.
[269] National Educational Union (2019), Relationships Education and Relationships and Sex Education: NEU guidance for members in England.
[270] Department of Education (2019, updated 2020): Relationships and sex education (RSE) and health education.
[271] National Educational Union (2019), Relationships Education and Relationships and Sex Education: NEU guidance for members in England.
[272] FPA: Sex and relationships education.
[273] FPA: Sex and relationships education. https://www.fpa.org.uk/factsheets/sex-and-relationships-education#lEpz

CURRENT PROVISION

BIRMINGHAM AND SOLIHULL APPROACHES TO RELATIONSHIPS AND HEALTH EDUCATION IN PRIMARY SCHOOLS

In 2015, Birmingham City Council published an equalities toolkit for schools, *All Different; All Equal*, along with the Birmingham Curriculum Statement which set out aspirations for children and young people in Birmingham. The toolkit was updated based on the changes to Relationships and Sex Education affected by the Children's and Social Work Act. Birmingham City Council have also developed a standalone resource to support primary schools to meet the requirements of the statutory teaching of relationships and health education in primary schools.

The standalone resource includes documents to enable staff and parent consultation, advice for governors, model letters and a set of resources and lesson plans from Year 1 to Year 6, all of which meet the statutory requirements for September 2020. There are additional optional resources for sex education, which although not compulsory for primary schools, will be helpful for those schools that wish to include sex education in their offer to pupils. This resource will enable schools to meet the minimum requirements of the mandatory curriculum changes, and to build on this to ensure that all children are included.[274]

In Solihull, schools are advised to follow the guides found on the Gov.uk site.[275]

UMBRELLA SEXUAL HEALTH SERVICES

YOUNG PERSON'S HEALTH ADVISORS

Umbrella have young person's health advisors who provide Relationships and Sex Education work in the community. It is the role of the Young Person's Health Advisor to provide specialist RSE to Key Stages 3,4 and 5. The Young Person's Health Advisor also supports the development of RSE for schools and further education settings, including Train the Trainer courses.

LOUDMOUTH EDUCATION AND TRAINING

Loudmouth are an Umbrella partner who run theatre programmes with young people aged 13 and above aimed at supporting some of Umbrella's aims in relation to RSE.

Loudmouth run three programmes that support Umbrella's aims:

- Basic sexual health – 'Trust Me'
- Teenage partner abuse – 'Safe and Sound'
- Exploitation and sexual exploitation – 'Working for Marcus'

Following a performance, Loudmouth run a workshop afterwards based on the themes raised.

A key part of the Loudmouth work with young people is signposting them towards the Umbrella website.

[274] Birmingham City Council, Approach_to_relationships_and_health_education_in_primary_schools
[275] Gov.uk, (2019), Relationships, sex and health education: guides for parents

9 – ENGAGEMENT

COMMUNITY SURVEY DEMOGRAPHICS

COMMUNITY SURVEY DEMOGRAPHICS

COMMUNITY SURVEY

As part of this needs assessment, a community survey was run exploring the sexual health needs of the populations of Birmingham and Solihull. The survey also explored the population's experiences of sexual health services.

In total there were 106 responses.

DEMOGRAPHICS

- Of the 106 responses, 86 were from Birmingham and 12 were from Solihull. 7 were from outside of both areas.
- 64 respondents were female and 36 were male. There were 2 non-binary respondents.
- In terms of ethnicity, the majority of respondents were white English/ Welsh/ Scottish/ Northern Irish or British.

Figure 9.1: Respondents' location

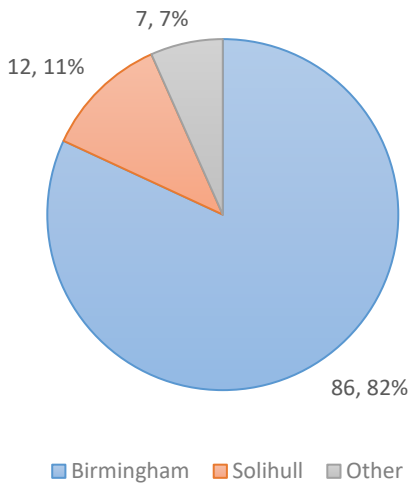


Figure 9.2: Respondents' gender

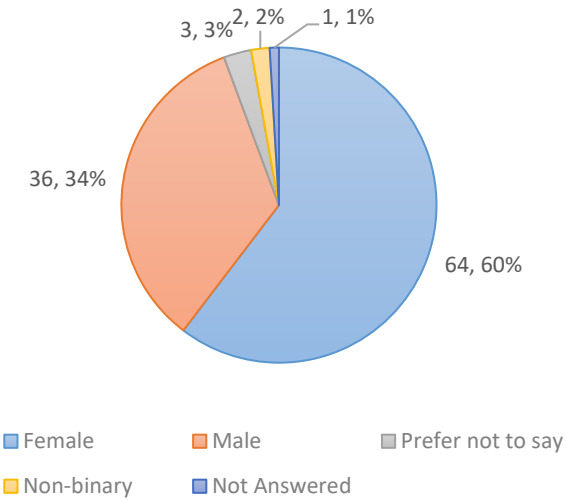


Figure 9.3: Respondents' ethnicity

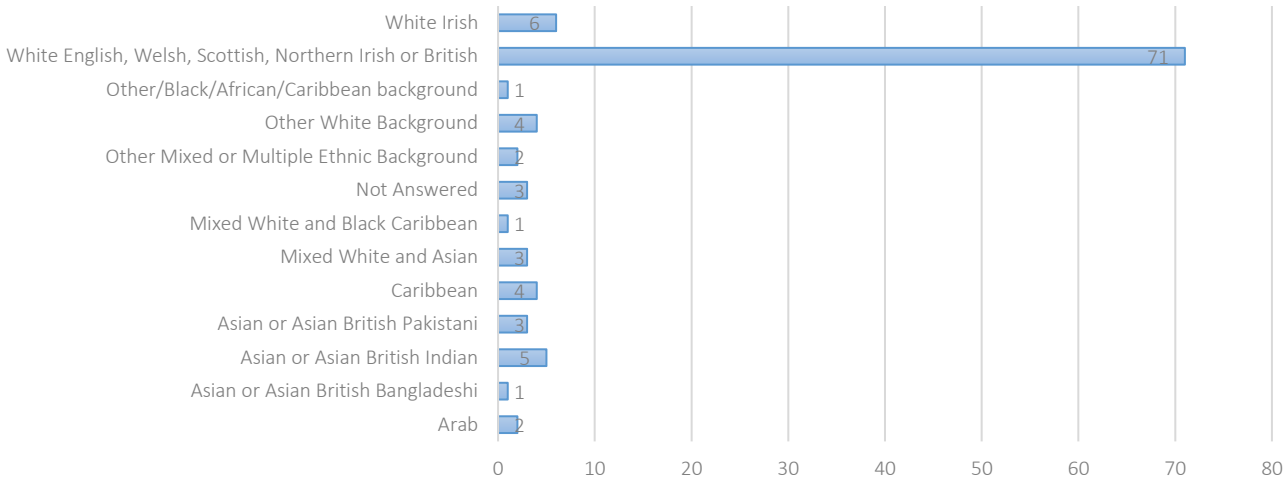


Figure 9.6 shows that 26 respondents had a disability that limited their day-to-day activities somewhat. Of these respondents, 11 had a physical disability, 3 had a learning disability, and 2 had a sensory impairment. 6 respondents listed their disability as 'other'.

In terms of age, just over half of respondents were aged 45-64. There were no respondents aged under 24, and 20 were aged between 25-34. 9 respondents were aged 65 or over.

Figure 9.4: Respondents' age

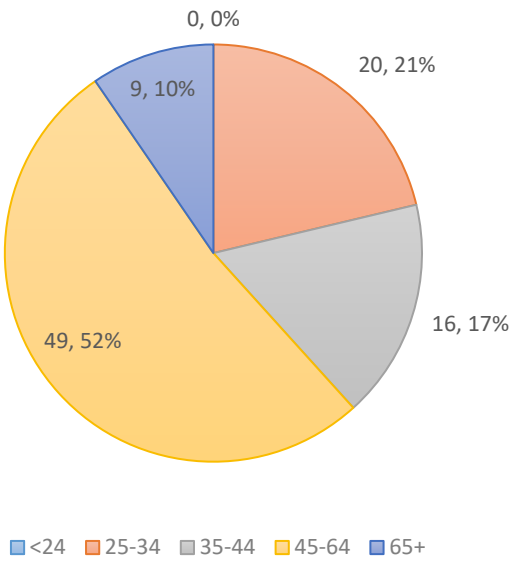


Figure 9.5: Respondents' sexuality

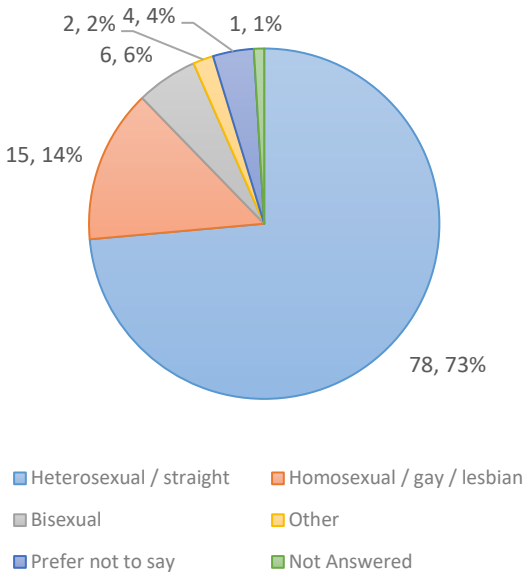
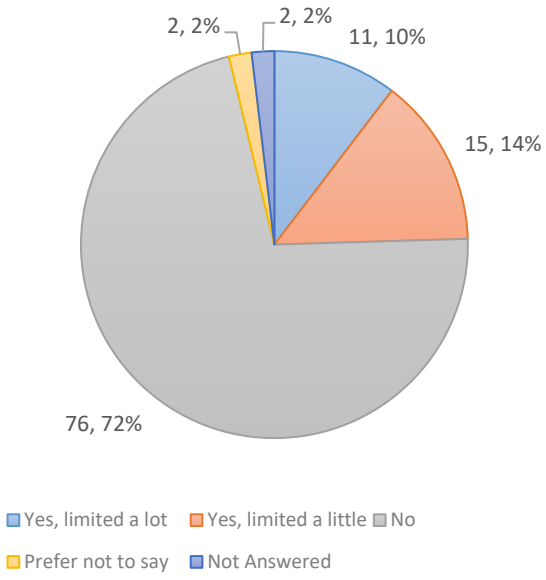


Figure 9.6: Respondents' disability



SEXUAL ACTIVITY

Respondents were asked about their sexual activity.

- 54 had had unprotected sex in the past 12 months.
- Most respondents had had sex with one person in the last 12 months.

Figure 9.7: Have you had unprotected sex in the last 12 months?

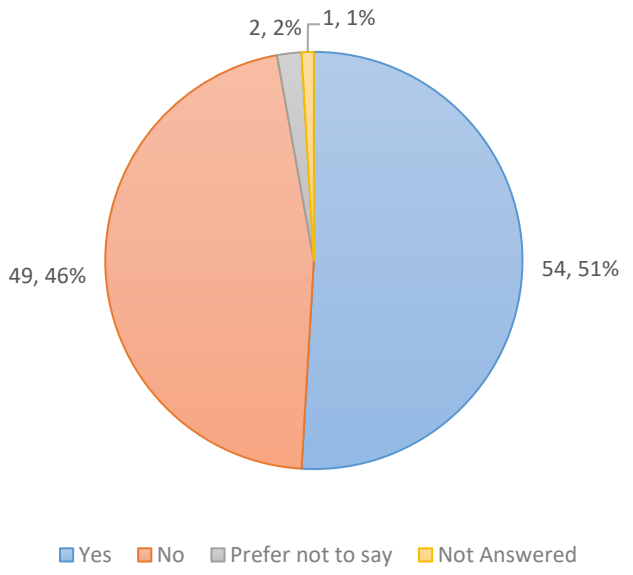


Figure 9.8: How many people have you had sex with in the last 12 months?

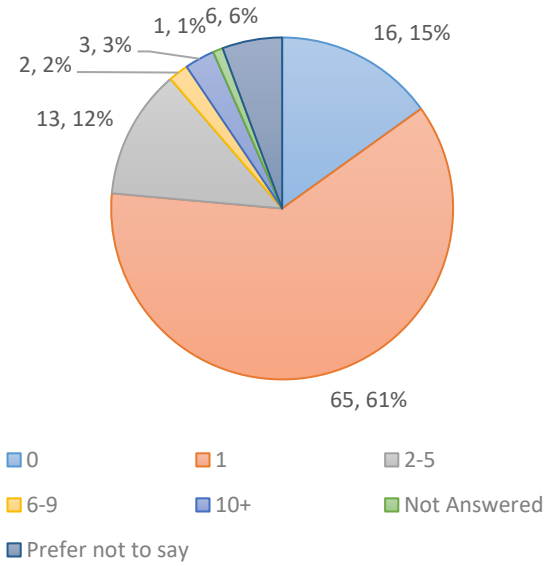


Figure 9.9: How often do you get a sexual health check?

	Number	Percentage
I have never had a sexual health check	24	23%
On a regular basis	20	19%
Other	16	15%
When I have symptoms	14	13%
Always after sexual relations with a new partner	8	8%
After sex with a new partner without contraception	7	7%
Prefer not to say	7	7%
Not Answered	6	6%
After sex with more than one sexual partner	4	4%

APPENDIX

CHAPTER 3

Number and rate of sexual health screens taken at a first attendance.

AGE

BIRMINGHAM

MALES

Number of 1st Attendances	01/10/2017 to 31/03/2018	01/04/2018 to 30/09/2018	01/10/2018 to 31/03/2019	01/04/2019 to 30/09/2019	01/10/2019 to 31/03/2020	2019-20
<15	4	6	7	6	12	18
15	20	27	24	25	27	52
16-19	1355	1189	1552	1121	1434	2555
20-24	3363	3381	3919	3467	3637	7104
25-34	4691	5070	5222	5188	4747	9935
35-44	1875	2064	2178	2271	2165	4436
45-64	1162	1222	1215	1278	1258	2536
65+	96	113	118	127	99	226
Not known	12	9	11	14	12	26
Total	**12578**	**13081**	**14246**	**13497**	**13391**	**26888**

Number of sexual health screens taken	01/10/2017 to 31/03/2018	01/04/2018 to 30/09/2018	01/10/2018 to 31/03/2019	01/04/2019 to 30/09/2019	01/10/2019 to 31/03/2020	2019-20
<15	3	0	5	5	12	17
15	15	23	15	22	23	45
16-19	1067	1001	1376	975	1276	2251
20-24	2876	2976	3499	3017	3165	6182
25-34	4011	4419	4598	4524	4082	8606
35-44	1518	1715	1813	1872	1779	3651
45-64	897	1002	1009	1036	1032	2068
65+	79	97	99	105	89	194
Not known	10	7	10	14	12	26
Total	**10476**	**11240**	**12424**	**11570**	**11470**	**23040**

FEMALES

Number of 1st Attendances	01/10/2017 to 31/03/2018	01/04/2018 to 30/09/2018	01/10/2018 to 31/03/2019	01/04/2019 to 30/09/2019	01/10/2019 to 31/03/2020	2019-20
<15	55	46	39	44	29	73
15	74	82	102	87	72	159
16-19	3517	3192	4064	3121	3705	6826
20-24	7113	7206	8244	7245	7728	14973
25-34	6394	6825	6850	7073	6707	13780
35-44	2360	2416	2477	2572	2427	4999
45-64	1011	1012	1052	1136	989	2125
65+	23	23	34	28	28	56
Not known	1	2	1	0	3	3
Total	**20548**	**20804**	**22863**	**21306**	**21688**	**42994**

Number of sexual health screens taken	01/10/2017 to 31/03/2018	01/04/2018 to 30/09/2018	01/10/2018 to 31/03/2019	01/04/2019 to 30/09/2019	01/10/2019 to 31/03/2020	2019-20
<15	45	36	32	34	22	56
15	47	61	71	70	61	131
16-19	2938	2698	3520	2658	3196	5854
20-24	6034	6257	7282	6315	6863	13178
25-34	5010	5569	5701	5886	5616	11502
35-44	1596	1797	1845	1946	1891	3837
45-64	678	708	778	824	753	1577

65+	18	15	24	20	22	42
Not known	0	1	0	0	3	3
Total	**16366**	**17142**	**19253**	**17753**	**18427**	**36180**

SOLIHULL

MALES

Number of 1st Attendances	01/10/2017 to 31/03/2018	01/04/2018 to 30/09/2018	01/10/2018 to 31/03/2019	01/04/2019 to 30/09/2019	01/10/2019 to 31/03/2020	01/10/2017 to 31/03/2018
<15	2	0	1	0	0	2
15	2	2	4	1	1	2
16-19	146	154	130	155	133	146
20-24	408	518	426	460	368	408
25-34	480	575	534	578	593	480
35-44	204	219	205	202	237	204
45-64	140	175	138	153	159	140
65+	20	18	25	16	13	20
Not known		0	0	0	1	
Total	**1402**	**1661**	**1463**	**1565**	**1505**	**1402**

Number of sexual health screens taken	01/10/2017 to 31/03/2018	01/04/2018 to 30/09/2018	01/10/2018 to 31/03/2019	01/04/2019 to 30/09/2019	01/10/2019 to 31/03/2020	01/10/2017 to 31/03/2018
<15	2	0	1	0	0	2
15	2	2	1	1	1	2
16-19	128	145	123	138	123	128
20-24	362	476	389	433	333	362
25-34	437	533	480	530	527	437
35-44	173	199	183	182	212	173
45-64	123	157	123	143	146	123
65+	15	13	19	13	10	15
Not known		0	0	0	1	
Total	**1242**	**1525**	**1319**	**1440**	**1353**	**1242**

FEMALES

Number of 1st Attendances	01/10/2017 to 31/03/2018	01/04/2018 to 30/09/2018	01/10/2018 to 31/03/2019	01/04/2019 to 30/09/2019	01/10/2019 to 31/03/2020	01/10/2017 to 31/03/2018
<15	8	8	3	8	6	8
15	30	23	14	21	27	30
16-19	551	549	506	487	459	551
20-24	830	1026	877	982	807	830
25-34	796	908	898	950	951	796
35-44	253	288	291	298	307	253
45-64	140	150	153	173	181	140
65+	2	10	2	10	3	2
Not known	1	0	0	0	0	1
Total	**2611**	**2962**	**2744**	**2929**	**2741**	**2611**

Number of sexual health screens taken	01/10/2017 to 31/03/2018	01/04/2018 to 30/09/2018	01/10/2018 to 31/03/2019	01/04/2019 to 30/09/2019	01/10/2019 to 31/03/2020	01/10/2017 to 31/03/2018
<15	6	6	1	5	3	6
15	12	10	11	13	13	12
16-19	398	417	365	367	367	398
20-24	703	885	759	843	700	703
25-34	658	771	765	827	811	658
35-44	184	234	227	237	250	184
45-64	99	115	118	129	136	99
65+	2	10	1	4	3	2
Not known	1	0	0	0	0	1
Total	**2063**	**2448**	**2247**	**2425**	**2283**	**2063**

SEXUALITY

BIRMINGHAM

MALES

Number of 1st Attendances							
Male Heterosexual	2019-20	**Male Gay**	2019-20	**Male Bisexual**	2019-20	**Male Not Stated**	2019-20
White	6005	White	3487	White	32	White	2793
Black or Black British	4341	Black or Black British	589	Black or Black British	11	Black or Black British	512
Asian or Asian British	2578	Asian or Asian British	834	Asian or Asian British	16	Asian or Asian British	397
Mixed	1404	Mixed	362	Mixed	2	Mixed	271
Other ethnic groups	2339	Other ethnic groups	595	Other ethnic groups	10	Other ethnic groups	310
Total	**16667**	**Total**	**5867**	**Total**	**71**	**Total**	**4283**
Number of sexual health screens taken							
Male Heterosexual	2019-20	**Male Gay**	2019-20	**Male Bisexual**	2019-20	**Male Not Stated**	2019-20
White	5181	White	2821	White	25	White	2689
Black or Black British	3733	Black or Black British	472	Black or Black British	10	Black or Black British	487
Asian or Asian British	2021	Asian or Asian British	656	Asian or Asian British	15	Asian or Asian British	384
Mixed	1249	Mixed	297	Mixed	2	Mixed	258
Other ethnic groups	2064	Other ethnic groups	457	Other ethnic groups	10	Other ethnic groups	209
Total	**14248**	**Total**	**4703**	**Total**	**62**	**Total**	**4027**
% of sexual health screens taken (at 1st attendance)							
Male Heterosexual	2019-20	**Male Gay**	2019-20	**Male Bisexual**	2019-20	**Male Not Stated**	2019-20
White	86%	White	81%	White	78%	White	96%
Black or Black British	86%	Black or Black British	80%	Black or Black British	91%	Black or Black British	95%
Asian or Asian British	78%	Asian or Asian British	79%	Asian or Asian British	94%	Asian or Asian British	97%
Mixed	89%	Mixed	82%	Mixed	100%	Mixed	95%
Other ethnic groups	88%	Other ethnic groups	77%	Other ethnic groups	100%	Other ethnic groups	67%
Total	**85%**	**Total**	**80%**	**Total**	**87%**	**Total**	**94%**

FEMALES

Number of 1st Attendances							
Female Heterosexual	2019-20	**Female Lesbian**	2019-20	**Female Bisexual**	2019-20	**Female Not Stated**	2019-20
White	21150	White	8	White	9	White	21
Black or Black British	7843	Black or Black British	2	Black or Black British	1	Black or Black British	7
Asian or Asian British	4465	Asian or Asian British	0	Asian or Asian British	3	Asian or Asian British	6
Mixed	4473	Mixed	1	Mixed	0	Mixed	5
Other ethnic groups	4982	Other ethnic groups	0	Other ethnic groups	1	Other ethnic groups	17
Total	**42913**	**Total**	**11**	**Total**	**14**	**Total**	**56**
Number of sexual health screens taken							
Female Heterosexual	2019-20	**Female Lesbian**	2019-20	**Female Bisexual**	2019-20	**Female Not Stated**	2019-20
White	18525	White	4	White	6	White	16
Black or Black British	6731	Black or Black British	1	Black or Black British	1	Black or Black British	6
Asian or Asian British	3210	Asian or Asian British	0	Asian or Asian British	3	Asian or Asian British	3
Mixed	3868	Mixed	1	Mixed	0	Mixed	5
Other ethnic groups	3788	Other ethnic groups	0	Other ethnic groups	1	Other ethnic groups	11
Total	**36122**	**Total**	**6**	**Total**	**11**	**Total**	**41**
% of sexual health screens taken (at 1st attendance)							
Female Heterosexual	2019-20	**Female Lesbian**	2019-20	**Female Bisexual**	2019-20	**Female Not Stated**	2019-20
White	88%	White	50%	White	67%	White	76%
Black or Black British	86%	Black or Black British	50%	Black or Black British	100%	Black or Black British	86%
Asian or Asian British	72%	Asian or Asian British	-	Asian or Asian British	100%	Asian or Asian British	50%
Mixed	86%	Mixed	100%	Mixed		Mixed	100%
Other ethnic groups	76%	Other ethnic groups	-	Other ethnic groups	100%	Other ethnic groups	65%
Total	**84%**	**Total**	**55%**	**Total**	**79%**	**Total**	**73%**