

Sexual Health Needs Assessment for Nottingham and Nottinghamshire 2022

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List of abbreviations used in this report

CCG	Clinical Commissioning Group
COVID-19	Coronavirus disease 2019
CTAD	Chlamydia Surveillance System
EHC	Emergency Hormonal Contraception
GUMCAD	Genitourinary Medicine Clinic Activity Dataset
HIV	Human Immunodeficiency Virus
HNA	Health Needs Assessment
IMD	Index of Multiple Deprivation
ISHS	Integrated Sexual Health Services
IUD	Intrauterine device
IUS	Intrauterine system
LARC	Long-acting reversible contraception
MSM	Men who have sex with men
OHID	The Office for Health Improvement and Disparities
ONS	Office for National Statistics
PCN	Primary Care Network
PHOF	Public Health Outcomes Framework
PrEP	Pre-exposure prophylaxis
SRH	Sexual and Reproductive Health
SHS	Sexual Health Service
STI	Sexually Transmitted Infection
UKHSA	UK Health Security Agency

1 Background

The Integrated Sexual Health Services (ISHS) in Nottingham and Nottinghamshire are due to be recommissioned. These are currently commissioned from three service providers across the area: Nottingham University Hospitals (NUH) for Nottingham, Broxtowe, Gedling and Rushcliffe; Sherwood Forest Hospitals (SFH) for Mansfield, Ashfield, and Newark & Sherwood; and Doncaster and Bassetlaw Hospitals (DBH) for Bassetlaw.

A Health Needs Assessment (HNA) is an important part of the commissioning cycle. It is used to update the understanding of the sexual health needs of people in the local area, in particular people who may be at greater risk of poor sexual health outcomes. It is intended that this information will be used to improve the sexual health of people in Nottinghamshire and Nottingham by informing future commissioning, planning and design of services.

2 Aims and Objectives

2.1 Aim

To understand the levels of sexual health need amongst the population of Nottingham and Nottinghamshire in order to inform future commissioning of sexual health services that are acceptable and accessible to those that have the greatest need for them.

2.2 Objectives

- To estimate the level of need in relation to sexual health in Nottingham and Nottinghamshire particularly relating to sexually transmitted infections (STIs) and HIV, contraception and abortion, and how need varies by population group.
- To utilise data on service activity in ISHS to illustrate demand at a population level, and how demand varies by population group.
- To identify gaps between need and demand in the general population and in specific groups.

3 Outline of report

This HNA was undertaken by Matthew Osborne and David Gilding during April and May 2022. This Sexual Health Needs Assessment will include a description of:

- The population of Nottingham and Nottinghamshire focusing on factors which influence sexual health, primarily based on Office for National Statistics (ONS) data;
- Population need in relation to sexual health (including STIs and reproductive health) using Public Health Outcomes Framework (PHOF) and GUMCAD (national sexually transmitted infection surveillance) data
- Use of ISHS using data from service providers, including data recorded via the Pathway Analytics system.

The toolkit produced by Public Health England on understanding variation in sexual health outcomes has been used to guide the analysis.

The report is structured into four main sections:

- Overview of the population of Nottingham and Nottinghamshire
- Sexually Transmitted Infections
- Reproductive Health (including contraception and abortion)
- Population use of Integrated Sexual Health Services.

4 Methodology

4.1 Data sources and definitions

Headline indicators and trends over time presented in this report have generally been taken from the Sexual and Reproductive Health Profiles available from the Office for Health Improvements and Disparities (OHID) Fingertips tool.

Maps have been produced from local data provided by ISHS, which has been verified by comparing counts for a single year to counts on Fingertips. Maps were produced using annualised rates for 2018 to 2020. Data for NUH and SFH were available to at least March 2021. For DBH, data was only available to the end of July 2020, so the denominator of person-years for Bassetlaw was adjusted to reflect this.

Maps included in this report represent number of people, e.g. the number of people diagnosed with a particular STI or number of people who receive a LARC prescription. This differs from national figures and trends from Fingertips/OHID, which generally present number of infections or number of prescriptions. This should be borne in mind when interpreting the data.

Where data is described for Nottinghamshire, this is for the Nottinghamshire County Council area only and excludes Nottingham City Council area. In any circumstances where data is provided for both local authorities combined, this will be described as “Nottingham and Nottinghamshire”.

4.2 Interpretation of data since 2020

Sexual health services in England substantially reduced capacity to deliver face-to-face consultations during the COVID-19 pandemic. As a result, the data reflects this disruption. Interpreting data from 2020 should consider these factors, especially when comparing with data from pre-pandemic years. The majority of the data presented in this HNA covers the period up to the end of 2020, so it does not show the full impact of COVID-19 on the reduction of face-to-face services or the restoration of services thereafter

4.3 Limitations

There are a number of limitations to this HNA. A key limitation is that data on STIs only includes people who have attended a health service and been diagnosed with an STI; it does not reflect people who have not been reached by services and may have undiagnosed infections. These are the people with the highest need.

In addition, local (and indeed national) data on specific groups who are already known to be at high risk (such as sex workers) was very limited. Even data on key risk factors which affect the whole population is not always optimal; local data on sexuality is based on estimates derived from a national survey which was undertaken in 2013-15, and may not therefore accurately reflect the current, local picture. Related to this, data can only reflect the predefined categories which were collected, and data on sex and sexuality may not therefore fully or accurately reflect the range of ways people may self-define.

The data in this HNA must therefore be considered alongside other sources of information, including engagement with communities and groups at high risk.

Other limitations include:

- The majority of the data presented in this HNA covers the period up to the end of 2020, so it does not show the full impact of COVID-19 on the reduction of face-to-face services or the restoration of services thereafter;

Gaps in the analysis include:

- Some analyses relate to Nottinghamshire (County) only, and not Nottingham (City), due to data availability; for example, in the section on emergency hormonal contraception (EHC). There is no description of sexual health services provided outside ISHS in Nottingham City, e.g. chlamydia testing in pharmacies, online provision of EHC, Health Shop;
- There is limited analysis of the demographics of ISHS service users vs. online testing, due to differing denominators;
- Mapping of reproductive need and abortion at a small area level has not been undertaken;
- Variation in contraception provision/use in different demographic groups has not been examined.

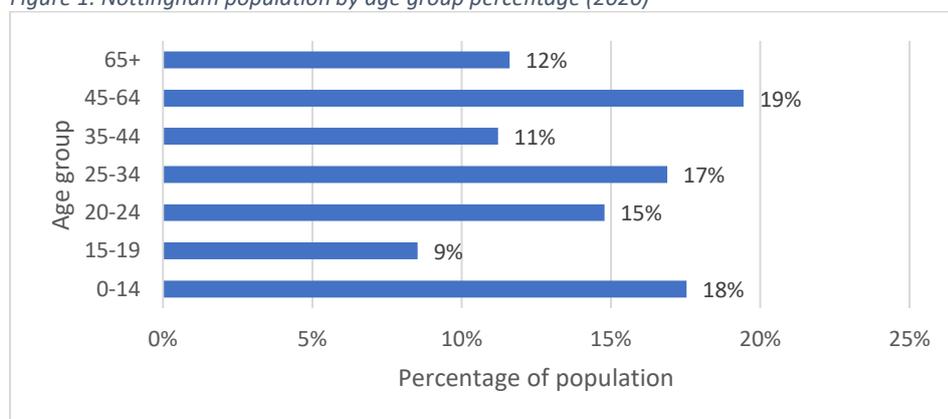
These gaps are all under consideration for ongoing or future work.

5 Overview of the population of Nottingham and Nottinghamshire

5.1 Age

Nottingham has a total population of 337,098. Figure 1 shows the breakdown of the population by age group. Figure 2 shows the population age profile of Nottingham compared to the East Midlands and England. Both charts show that population of Nottingham is younger than other areas, with 24% of the population aged between 15 to 24. This is partly due to the number of university students and city status that attracts younger people to work and live. This has implications for the need and demand for sexual health services; young people are more likely to be diagnosed with an STI, and represent the majority of chlamydia and gonorrhoea diagnoses. Women in this age group are at particularly increased risk compared to women aged 25 to 64.¹

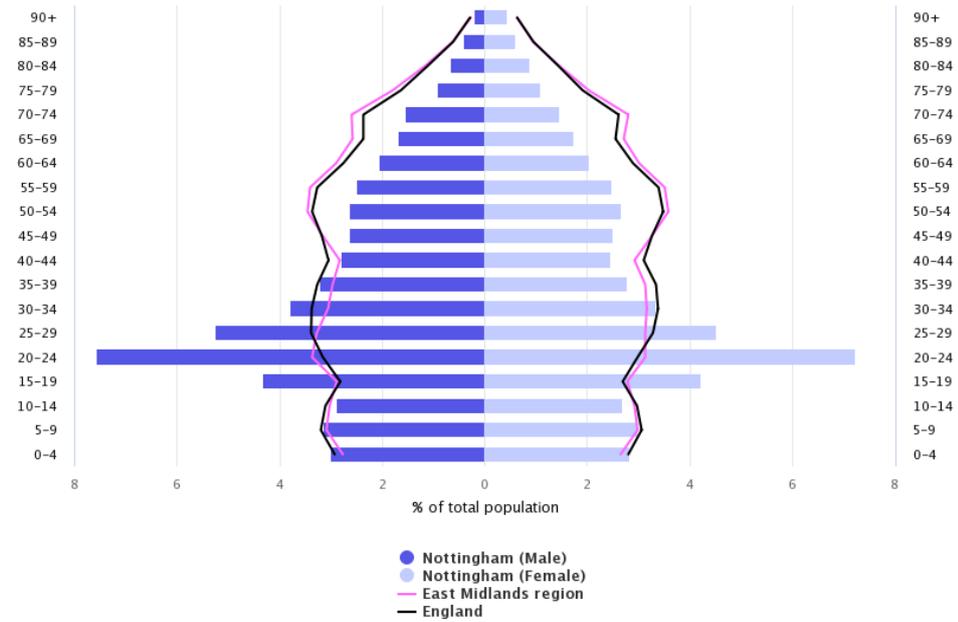
Figure 1: Nottingham population by age group percentage (2020)



Source: ONS Mid-year 2020 population estimates

¹ [Sexual health: variation in outcomes and inequalities - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/consultations/sexual-health-variation-in-outcomes-and-inequalities)

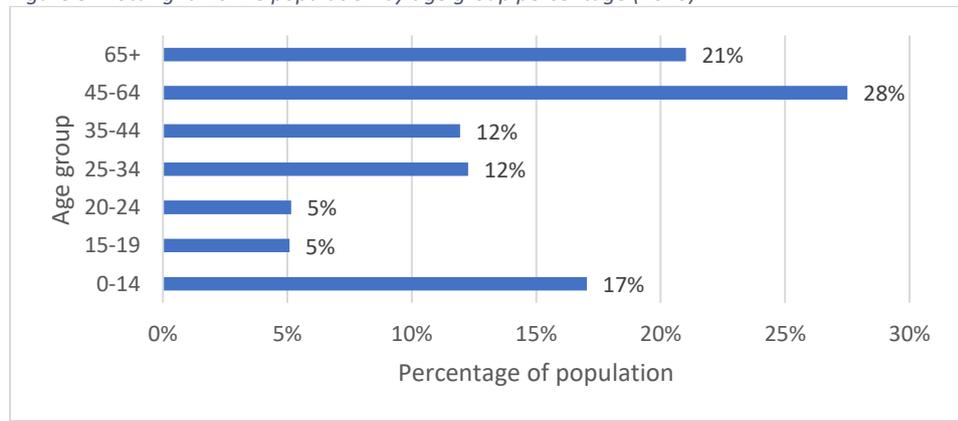
Figure 2. Population age profile of Nottingham, East Midlands and England (2020)



Source: OHID Fingertips

The total population of Nottinghamshire is 833,377. Figure 3 shows the breakdown by age. Compared to Nottingham (and England), Nottinghamshire has a higher proportion of older people and a lower proportion of younger people as shown in Figure 4. Whilst young people are a known at-risk group, the sexual health needs of people over 45 years old need to be considered and not neglected.²

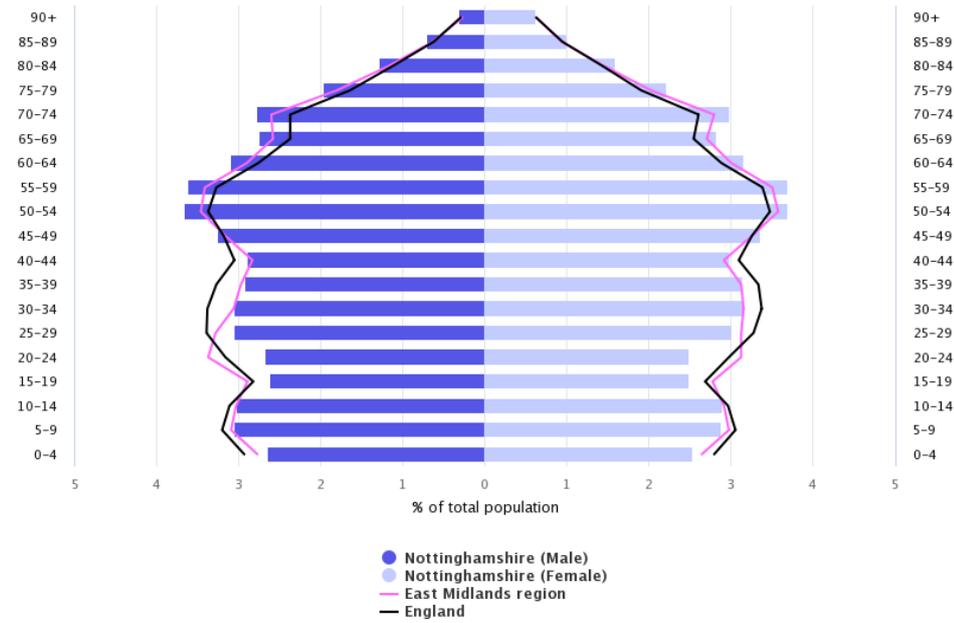
Figure 3. Nottinghamshire population by age group percentage (2020)



Source: ONS Mid-year 2020 population estimates

² See I. Ezhova, L. Savidge and C. Bonnett et al. (2020) Barriers to older adults seeking sexual health advice and treatment: A scoping review International Journal of Nursing Studies 107,103566 [Online] Available at: [Barriers to older adults seeking sexual health advice and treatment: A scoping review - PubMed \(nih.gov\)](https://pubmed.ncbi.nlm.nih.gov/35111111/) [Accessed 13th April 2022].

Figure 4. Population age profile of Nottinghamshire, East Midlands and England (2020)

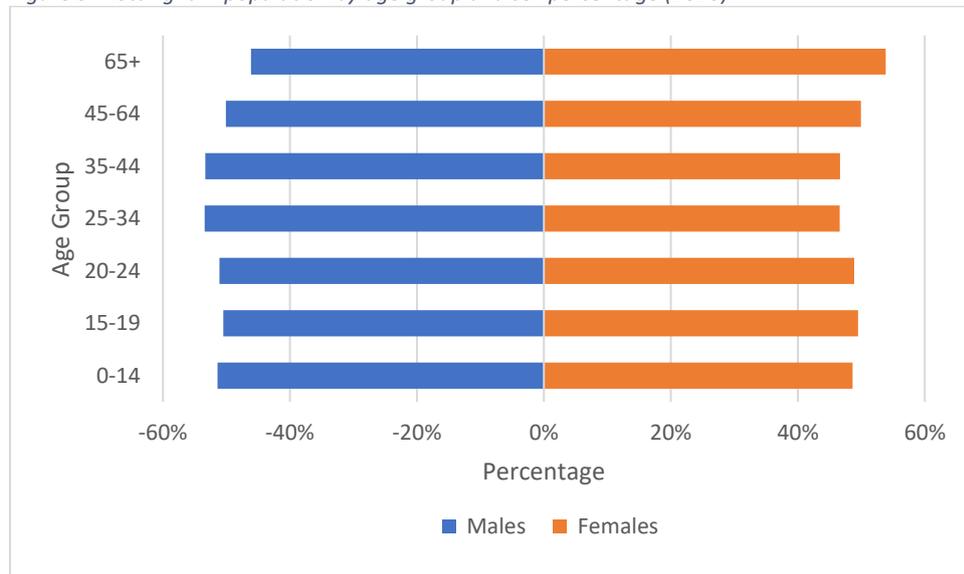


Source: OHID Fingertips

5.2 Sex

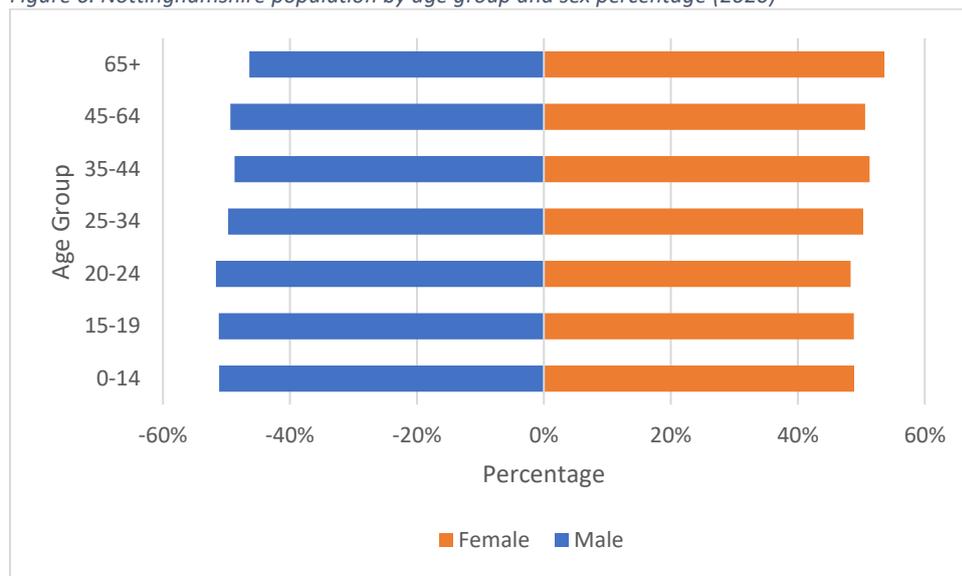
Of the population of Nottingham, 51% are male and 49% are female. In Nottinghamshire, 49% of the population are male and 51% are female. Figure 5 and Figure 6 show the breakdown of Nottingham and Nottinghamshire by age group and sex.

Figure 5. Nottingham population by age group and sex percentage (2020)



Source: ONS Mid-year 2020 population estimates

Figure 6. Nottinghamshire population by age group and sex percentage (2020)



Source: ONS Mid-year 2020 population estimates

5.3 Ethnicity

Table 1 shows the ethnicity percentage breakdown by local authority. Whilst in Nottinghamshire 95% of the population is White, in Nottingham there is a significantly higher population of minority ethnicities, in particularly Asian (14%) and Mixed ethnicity (9%). Of the Asian group population, 6% are Asian/Asian British Pakistani and 3% Asian/Asian British Indian (see Appendix Table 23).

Looking at both age and ethnicity in Nottingham, the older the population group is, the less diverse the population is. For example, 89% of people aged 65 years are White compared to 62% aged between 20-24 years old (see Appendix 1 Table 24). This reflects a higher proportion of people from minority ethnicities amongst the student population and young people working and living in a major university city.

Amongst Black and other minority ethnic populations, the risk of STIs, particularly gonorrhoea and trichomoniasis is increased compared to White ethnic groups.³ This is influenced by deprivation and other socioeconomic factors, as well as stigma, discrimination and obstacles which may prevent members of some ethnic minority groups from easily accessing sexual health services.⁴

³ [Sexual health: variation in outcomes and inequalities - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/news/sexual-health-variation-in-outcomes-and-inequalities)

⁴ Wayal S, Hughes G, Sonnenberg P, Mohammed H, Copas AJ, Gerressu M, et al. Examining ethnic variations in sexual behaviours and sexual health markers: evidence from a British national probability sample survey. *The Lancet Public Health* 2017; 2(10): e458-e472.

Table 1. Ethnicity percentage breakdown for Nottingham and Nottinghamshire (2019)

LA	White	Other	Black	Asian	Mixed	Total
Nottingham	226,653 68%	5,123 2%	26,391 8%	45,213 14%	29,471 9%	332,900 100%
Nottinghamshire	786,198 95%	2,273 0%	5,612 1%	19,534 2%	14,609 2%	828,224 100%

Source: ONS - Population denominators by broad ethnic group - 2019 (Experimental)

5.4 Sexuality

Sexuality is a key factor in sexual and reproductive health. One example of this is that gay, bisexual and other men who have sex with men (MSM) are more likely to be diagnosed with bacterial STIs than other men, and in particular represent 81% of syphilis and 66% of gonorrhoea diagnoses. MSM with a diagnosis of HIV are at even higher risk of other STIs.³

Data on sexuality comes from the ONS Annual Population Survey, a national survey. This asks people whether they think of themselves as heterosexual or straight, gay or lesbian, bisexual or “other”. It does not capture further details of the “other” category or allow people to self-define their sexuality. This is then used to estimate proportions at a local level, but local estimates are only available for 2013-15. The estimates include 95% confidence intervals, which can roughly speaking be interpreted as the range of values within which we are 95% confident that the true value lies.

Table 2 shows sexuality breakdown by local authority. In Nottingham, 1.4% (95% CI 0.7-2.1%) of people identified as gay or lesbian and 0.4% (95% CI 0.1-0.7%) as bisexual. In Nottinghamshire, 0.8% (95% CI 0.3-1.3%) identified as gay or lesbian and 0.5% (95% CI 0.1-0.9%) as bisexual. This local data is from 2013-15 but according to the ONS Annual Population Survey, there has been a decreasing trend in the number of people identifying themselves as heterosexual or straight (from 95.2% in 2015 to 93.7% in 2019), and a corresponding increase in the other categories.⁵ We can therefore anticipate that the proportions of those identifying as gay or lesbian, bisexual and other in Nottingham and Nottinghamshire will also have increased over this period. It should also be noted that in Nottinghamshire a particularly large proportion responded, “don’t know or refuse”, which may affect the accuracy of the estimates.

Table 2. Sexuality breakdown for Nottingham and Nottinghamshire (2013-15)

	Nottingham		Nottinghamshire	
	Estimate (95% CI)	% (95% CI)	Estimate (95% CI)	% (95% CI)
Heterosexual or straight	247,000 (244,000-250,000)	97.0 (96.0-98.0)	610,000 (603,000-618,000)	95.2 (94.1-96.3)
Gay or lesbian	3,000 (1,00-5,000)	1.4 (0.7-2.1)	5,000 (2,000-8,000)	0.8 (0.8-1.3)
Bisexual	1,000 (0-2,000)	0.4 (0.1-0.7)	4,000 (1,000-6,000)	0.5 (0.4-0.9)
Other	1,000 (0-2,000)	0.3 (0.1-0.7)	3,000 (0-6,000)	0.5 (0-1.0)
Don't know or refuse	3,000 (2,000-4,000)	1.0 (0.5-1.5)	19,000 (14,000-24,000)	3.0 (2.2-3.8)

Source: Subnational Sexual identity for 2013 to 2015

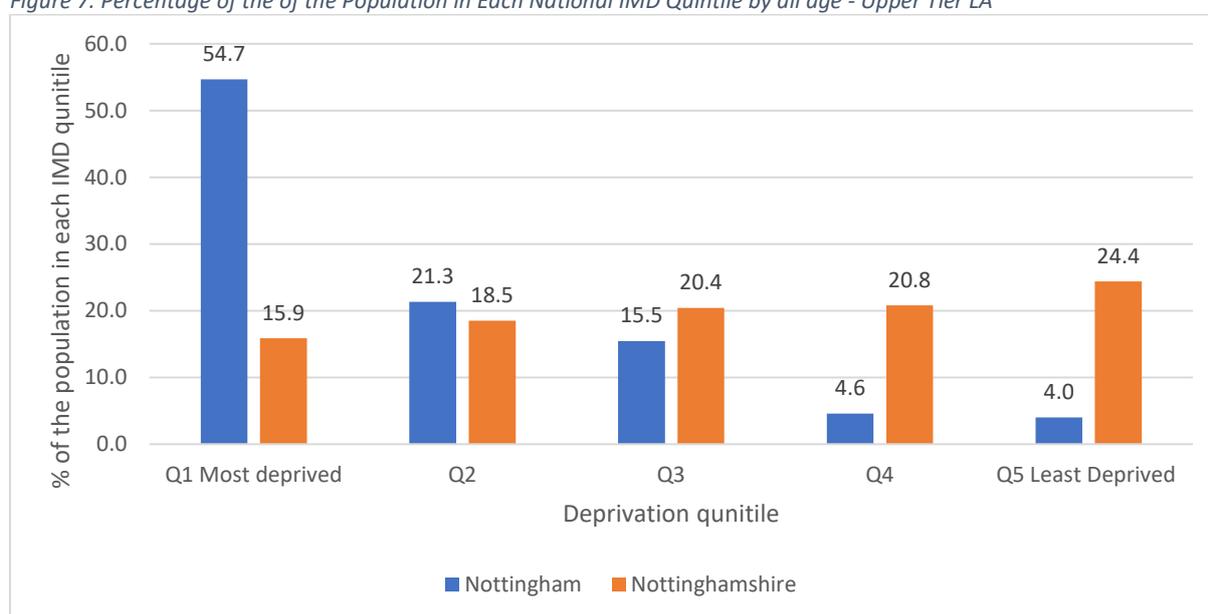
⁵ ONS Annual Population Survey: Sexual orientation, UK: 2019 [Sexual orientation, UK - Office for National Statistics \(ons.gov.uk\)](https://www.ons.gov.uk/peoplepopulationandcommunity/sexualorientationanddiversity/articles/sexualorientationintheuk/2019)

5.5 Deprivation

The Index of Multiple Deprivation (IMD) is an overall measure of deprivation experienced by people living in an area and is calculated for 32,844 Lower layer Super Output Areas (LSOA) in England. Every such neighbourhood in England is ranked according to its level of deprivation. Nationally, there is a clear link between more deprived areas and higher rates of STI diagnosis. This includes chlamydia, gonorrhoea, syphilis, herpes and genital warts.

The percentage of the population in each IMD decile is more evenly spread in Nottinghamshire compared to Nottingham (Figure 7). In Nottingham, 55% of neighbourhoods are in the most deprived quintile and in Nottinghamshire, only 16%. When looking at deprivation within the 15 to 64-year-olds only, the deprivation patterns are very similar.

Figure 7. Percentage of the of the Population in Each National IMD Quintile by all age - Upper Tier LA



Sources: English indices of deprivation 2019, ONS 2020 Mid-year population estimates (MYE)

Within Nottinghamshire, large proportions of Mansfield (53%), Ashfield (39%) and Bassetlaw (36%) fall within the top 30% most deprived areas, whereas virtually half (49%) of Rushcliffe falls in the top 10% of *least* deprived areas (Table 3). As deprivation is known as a risk factor for poorer sexual health outcomes, consideration needs to be given either that services are situated or targeted in areas of higher deprivation, and that any changes to services do not hinder access in these areas, which could further increase sexual health inequalities.

Table 3. Percentage of the Population in Each National IMD Decile – Districts of Nottinghamshire

Index of Multiple Deprivation (IMD)	Ashfield	Bassetlaw	Broxtowe	Gedling	Mansfield	Newark and Sherwood	Rushcliffe
1 Most Deprived	16%	8%	0%	1%	15%	5%	0%
2	12%	14%	6%	1%	26%	10%	0%
3	11%	14%	2%	10%	12%	9%	0%
4	18%	9%	11%	10%	9%	10%	2%
5	14%	10%	10%	10%	4%	12%	2%
6	13%	13%	12%	13%	10%	16%	3%
7	6%	13%	14%	11%	4%	9%	10%
8	4%	13%	11%	16%	10%	12%	13%
9	4%	8%	19%	14%	7%	8%	20%
10 Least Deprived	2%	0%	16%	14%	3%	9%	49%
Grand Total	100%	100%	100%	100%	100%	100%	100%

Sources: English indices of deprivation 2019, ONS 2020 Mid-year population estimates (MYE)

5.6 Groups at high risk of poor sexual health outcomes

The sections above have noted a number of groups disproportionately at risk of poor sexual health based on age, sex, sexuality, ethnicity, deprivation. However, there are many other factors which influence sexual health and some specific population groups are believed to be at particularly high risk. Unfortunately, for many of these groups, there has been little research into their sexual health needs, and what has been done is often focused on specific issues rather than wider sexual health and wellbeing. The Joint Strategic Needs Assessment (JSNA) chapter for sexual health completed in 2017 identified a number of groups; Table 4 is adapted and updated from the JSNA chapter.

In terms of addressing needs of these groups, recent NICE guidance noted that “there was little evidence about how to tailor outreach services to best meet the needs of specific groups to improve their access to sexual health services and uptake of STI testing” and recommended further research in this area, but also noted that any interventions should be culturally competent.

Table 4. Groups at high risk of poor sexual health (adapted from 2017 Nottinghamshire JSNA chapter)

Group at risk	Rationale for risk	What is known about this group in Nottingham/Nottinghamshire
People with a mental health problem	People with a mental illness, especially those with a serious mental illness are at increased risk of sexual violence, domestic abuse and may also suffer from side effects of antipsychotic medication which can affect libido or sexual function. ⁶	Around 6000 people in Nottinghamshire are recorded by their GP as having schizophrenia, bipolar disorder or another psychosis. This figure is around 3800 for Nottingham. ⁷

⁶ Hughes E, Bassi S, Gilbody S, Bland M and Martin F. (2016) Prevalence of HIV, hepatitis B, and hepatitis C in people with severe mental illness: a systematic review and meta-analysis. *Lancet Psychiatry* 3: 40–48.

⁷ [National General Practice Profiles - Data - OHID \(phe.org.uk\)](http://nationalgeneralpracticeprofiles.org.uk) [National General Practice Profiles - Data - OHID \(phe.org.uk\)](http://nationalgeneralpracticeprofiles.org.uk)

People with a learning disability and/or autism	Coping with puberty, sexual identity and sexual feelings can be more difficult for people with learning disabilities who might be struggling to understand their emotions and body. People with learning disabilities often do not have good access to sexual health services, and may face exclusion, stigma and discrimination. ⁸	See Section 5.6.1 below.
Transgender and non-binary people	Anyone, including transgender people, can be affected by STIs. Need for contraception and reproductive health services will vary according to gender. However, transgender and non-binary people may not be included in mainstream health information, and experiences of stigma/discrimination may affect access to services. ⁹	Even at a national level there are currently no robust data sources on gender identity. Data from the 2021 Census will help to address this gap.
People Who Inject Drugs (PWID)	PWID are vulnerable to infection through their injecting practices and associated sexual behaviour. There is a high prevalence of Hepatitis C and late diagnosis of HIV. PWID have low rates of consistent condom use; frequently report having multiple sexual partners and can face barriers to HIV/STI testing and treatment. ¹⁰	In 2016-17 it was estimated that there were 2250 opiate users in Nottingham and 3608 in Nottinghamshire (though not all opiates are injected). ¹¹
People who are homeless	Homeless people are at an increased risk of STIs and unwanted pregnancies and can come under pressure to exchange sex for food, shelter, drugs and money.	In 2020/21, 2768 households in Nottingham and 1431 in Nottinghamshire were homeless or within 56 days of becoming homeless. The autumn 2020 rough sleeping snapshot estimated 31 people in Nottingham and 26 in Nottinghamshire were sleeping rough on a single night. ¹²
People in the criminal justice system	People convicted of a crime who are accommodated in prison have a higher risk of STIs and HIV because of injecting drug use and high risk sexual behaviour. ¹³	There are three prisons in Nottinghamshire – Ranby, Whatton and Lowdham Grange plus one in Nottingham – with around 3500 prisoners in total.

⁸ Cambridge P. (2003) The sexual health needs of people with learning disabilities. *Nursing Times*, 99 (35), 48-49. Available at: <https://www.nursingtimes.net/Journals/2012/11/16/z/o/f/030902The-sexual-health-needs-of-people-with-learning-disabilities.pdf>

⁹ [Sexual health for trans and non-binary people | Terrence Higgins Trust \(tth.org.uk\)](https://www.terrencehiggins.org.uk/sexual-health-for-trans-and-non-binary-people/)

¹⁰ [Shooting Up: infections among people who inject drugs in the UK - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/news/shooting-up-infections-among-people-who-inject-drugs-in-the-uk)

¹¹ [Opiate and crack cocaine use: prevalence estimates by local area - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/news/opiate-and-crack-cocaine-use-prevalence-estimates-by-local-area)

¹² [Rough sleeping snapshot in England: autumn 2020 - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/news/rough-sleeping-snapshot-in-england-autumn-2020)

¹³ WHO Europe. (2014) *Prisons and Health*. Available from: http://www.euro.who.int/_data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf

People involved in sex work	People involved in sex work are at higher risk of STIs. They are also more likely to experience violence, rape and sexual assault, homelessness, and drug and alcohol problems which multiply their risk of poor sexual health outcomes. ¹⁴	There are no accurate figures for number of sex workers at a local level. Current estimates suggest around 32,000 sex workers in England, but estimates are highly dependent on how sex work is defined. ¹⁵
Looked after children and young people	Children who are looked after by the local authority are at higher risk of teenage pregnancies and STIs than children who have not been in care. ¹⁶ They are also at risk of child sexual exploitation (CSE), particularly if placed out of the local authority or frequently moved between placements.	In 2021, there were 685 and 996 children looked after by the local authority in Nottingham and Nottinghamshire respectively. Of these, just over 40% were assessed as having poor emotional wellbeing. ¹⁷
Refugees and asylum seekers	Whilst refugees and asylum seekers will have varied levels of need, multiple factors may contribute to risk of poor sexual health, including experiences of violence and persecution; lack of access to healthcare in their country of origin and whilst fleeing; poverty, difficulty accessing services and lack of social support in the UK. Some may also be vulnerable due to factors such as age or sexuality.	As of March 2022, there were 1133 asylum seekers in Nottingham and 85 in Nottinghamshire receiving support under Section 95 or Section 4 of the Immigration and Asylum Act 1999. This does not include people given refugee status and resettled in the area, asylum seekers not eligible for support, or those not known to the asylum system.
Women experiencing gender-based violence	Those experiencing gender-based violence and domestic abuse may be unable to access sexual health and contraceptive services and experience poorer pregnancy outcomes, as well as increased risk of STIs.	Domestic abuse affects 24.9% of women and 10% of men aged 16 to 59. For Nottinghamshire (including Nottingham) this equates to 56,756 women and 22,606 men. In 2021, there were 3322 sexual offences in total in Nottingham and Nottinghamshire. These are all likely to be underestimates due to underreporting.
Survivors of childhood sexual abuse	Child sexual abuse has significant psychological and psychosexual impacts which may impact on sexual health – and wider health outcomes – in later life.	In Nottinghamshire, there are estimated to be 57,492 people aged 18 to 64 who are survivors of childhood sexual abuse (40,160 females and 17,332 males). In

¹⁴ 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 Infection*; 90:344–350.

¹⁵ House of Commons Home Affairs Committee (2016). *Prostitution: Third Report of Session 2016-17*. Available from: <https://publications.parliament.uk/pa/cm201617/cmselect/cmhaff/26/26.pdf>

¹⁶ [Preventing Unplanned Pregnancy and Improving Preparation for Parenthood for Care-Experienced Young People | Coram](#)

¹⁷ [Child and Maternal Health - OHID \(phe.org.uk\)](#)

		Nottingham this is 25,463 (17,280 females and 8,183 males).
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5.6.1 Learning Disabilities

Table 5 shows the number and percentage of people with a learning disability recorded on GP practice register. In Nottingham, 0.5% of patients have a learning disability and in Nottinghamshire this is 0.6%, similar to the averages for England and the East Midlands. However, it is estimated that 2% of the population will have a learning disability, and a large proportion of these are not known to their GP or adult social care. It is estimated that we have over 15,000 people in Nottinghamshire (county) with a learning disability, which is anticipated to rise to over 16,500 by 2035.¹⁸

Table 5. Number and percentage of patients with learning disabilities, as recorded on GP practice, 2019

	Number of patients with learning disabilities recorded by their GP	Percentage of Registered Patients
England	308,237	0.5%
East Midlands	29,720	0.6%
Nottingham	2,093	0.5%
Nottinghamshire	4,898	0.6%

Source: OHID Fingertips

5.7 Key Points

- The age and ethnicity profiles of Nottingham and Nottinghamshire are very different. This has implications for need and demand for sexual health services, and needs to be considered in future service planning.
- There are significant differences in deprivation between Nottinghamshire and Nottingham. As deprivation is known as a risk factor for poorer sexual health outcomes, consideration needs to be given either that services are situated or targeted in areas of higher deprivation or access to services is not hindered by changes to the current service model which could further increase sexual health inequalities.
- In addition to factors such as age, sex, sexuality and ethnicity, there are specific groups which are believed to be at particularly high risk of poor sexual health outcomes. However, in many cases there has been little systematic assessment of their sexual health needs in national research, and we may not even have a clear idea of the number of people affected locally (for example, the number of people involved in sex work). These factors will not be captured in the detailed analysis of STIs and reproductive health in the remainder of this report, as the data is not collected. It is essential to consider these groups in service planning and design, and to undertake engagement to better understand their needs.

¹⁸ [Learning Disabilities \(2019\) - Nottinghamshire Insight](#)

6 Sexually transmitted infections

6.1 Background

Sexually transmitted infections (STIs) can seriously affect the health of those affected. Unless treated promptly, STIs can cause long-term physical complications in women including pelvic inflammatory disease, ectopic pregnancy and infertility and increased risk of adverse pregnancy outcomes such as miscarriage and preterm delivery. In men, complications can include genital cancers, infertility and urinary problems. Syphilis in particular can also cause cardiovascular and neurological damage.¹⁹ The costs to the health system are also high, with treatment costs (excluding HIV) estimated at £620 million in the UK in 2011.

The most commonly diagnosed STI in England is chlamydia (49%) followed by gonorrhoea (13%), first episode of genital warts (13%), and first episode of genital herpes (8%). There have been large increases in gonorrhoea nationally in recent years, with smaller increases in chlamydia, syphilis and genital herpes.

This section will report the latest data and trends over time in Nottingham and Nottinghamshire to estimate level of need in relation to STIs and inform future commissioning.

As noted in the methodology section, in response to the COVID-19 pandemic, the Government implemented national and regional lockdowns and social and physical distancing measures since March 2020. Sexual health services in England had substantially reduced capacity to deliver face-to-face consultations but underwent rapid reconfiguration to increase access to STI testing via telephone or internet consultations. STI testing and diagnoses decreased across all infections between 2019 and 2020. Over this period, larger decreases in diagnoses were observed for STIs that are usually diagnosed clinically at a face-to-face consultation, such as genital warts or genital herpes, when compared to those that could be diagnosed using remote self-sampling kits such as chlamydia and gonorrhoea

These measures affected sexual behaviour and health service provision. Interpreting data from 2020 and later should consider these factors, especially when comparing with data from pre-pandemic years.

6.2 Overall burden and trends of new STIs

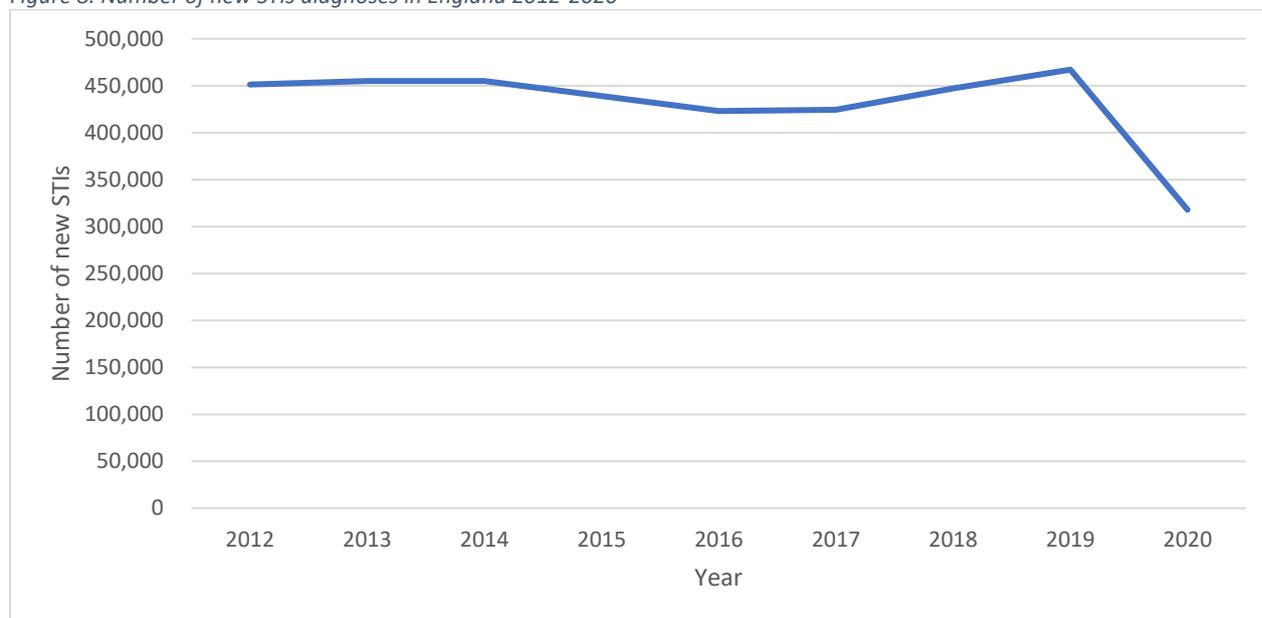
In England in 2020, there were 317,901 diagnoses of new STIs, a 32% decrease compared to 2019. Looking at trends over time, new STIs were increasing from 2017 up until 2020 when COVID-19 affected services as access to services and screening was reduced (Figure 8).

In Nottingham, a total of 3,129 new STIs were diagnosed in 2020 (Figure 9). New diagnoses of STIs were decreasing from 2013 until 2015 when numbers hovered around 4000 diagnoses. There was a slight spike in 2019 until a significant drop in 2020 as a result of COVID-19.

¹⁹ [Health matters: preventing STIs - GOV.UK \(www.gov.uk\)](https://www.gov.uk/health-matters/preventing-stis)

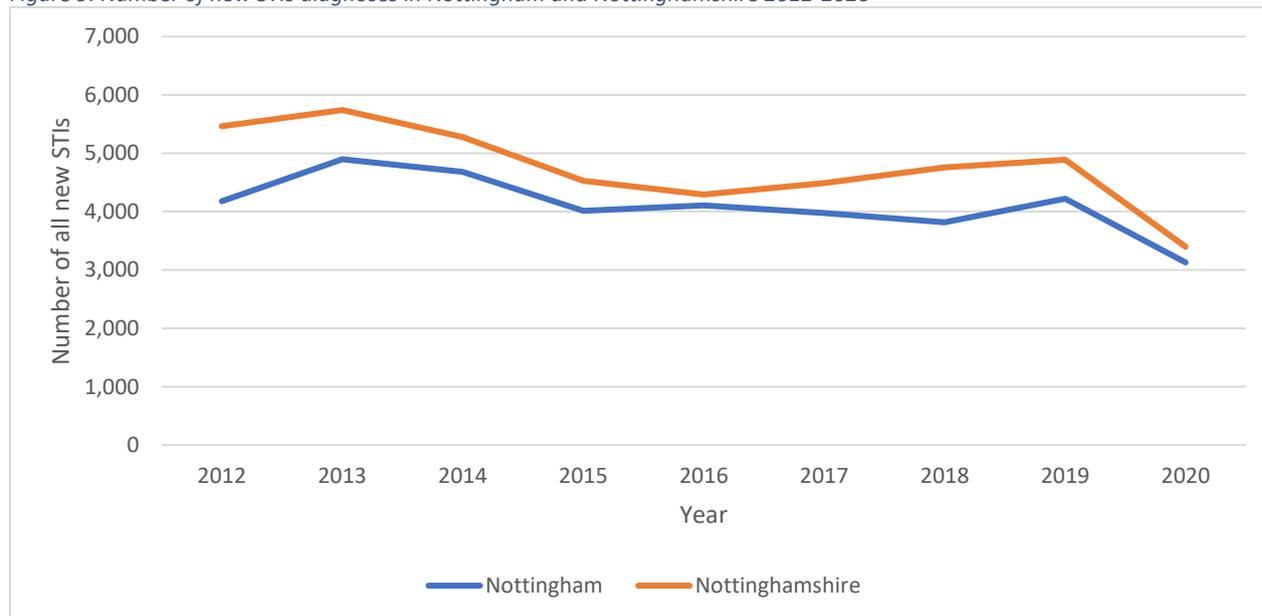
In Nottinghamshire, a total of 3,398 new STIs were diagnosed in residents in 2020 (Figure 9). Numbers of new diagnoses were decreasing from 2013 until 2015. Numbers of diagnoses then steadily increased until a significant drop in 2020 as a result of COVID-19.

Figure 8. Number of new STIs diagnoses in England 2012-2020



Source: Data from routine sexual health services' returns to the GUMCAD STI Surveillance System

Figure 9. Number of new STIs diagnoses in Nottingham and Nottinghamshire 2012-2020



Source: Data from routine sexual health services' returns to the GUMCAD STI Surveillance System

6.3 STI testing

The STI testing rate is a measure of the number of people tested for one or more infections of syphilis, HIV, gonorrhoea and chlamydia at a new attendance within sexual health services, amongst the general population aged 15 to 64, but excluding chlamydia tests in under 25s.

In Nottingham (2020), the STI testing rate is 6059.2 per 100,000 (Figure 10). This has consistently been above the England rate but has been decreasing since 2017. Nottingham is 3rd out of 16 similar local authorities.²⁰ This high rate may be due to higher proportions of young adults (students and others) and of MSM and other groups who use services and are frequently tested. Nottingham has a testing rate similar to nearby cities such as Derby and Leicester. However, this is a crude rate so does not individually examine testing rates specifically amongst young people or other at-risk groups.

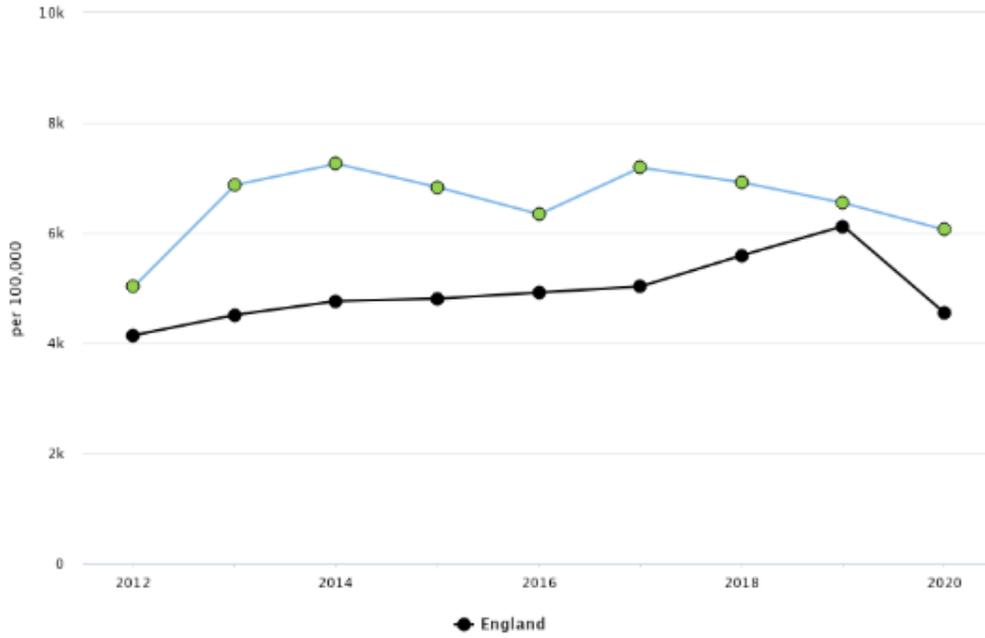
Nottinghamshire has an STI testing rate of 1900.8 per 100,000 (2020) which has consistently been below the England rate (Figure 11). Nottinghamshire is 15th out of 16 similar local authorities, though this is partly because testing dropped more in Nottinghamshire than the other authorities in this group in 2020.²¹ Prior to 2020 the testing rate had been stable, neither increasing nor decreasing substantially since 2013. Whilst the testing rate is low, the STI positivity rate across the county is high at 9.1%, compared to 7.3% for England (Figure 12). This increase started before COVID-19 but a sharper increase was seen when high-risk cases were prioritised due to the restrictions on health services during the pandemic. High positivity suggests that higher-risk groups are being appropriately targeted, but in combination with lower levels of testing and diagnosis could also highlight a risk that some cases are missed.

There is some variation across the county with lower levels of testing in Rushcliffe (917 per 100,000) (Table 6). The highest levels of testing were in Bassetlaw (2019 per 100,000) and Mansfield (2215 per 100,000), but positivity varied widely in these areas from 5.0% in Bassetlaw to 10.8% in Mansfield. Nevertheless, in all districts testing is substantially lower than the England average.

⁸ Salford, Manchester, Bristol, Southampton, Liverpool, Wolverhampton, Kingston upon Hull, Coventry, Gateshead, Derby, Plymouth, Newcastle upon Tyne, Sandwell, Leicester, Sheffield.

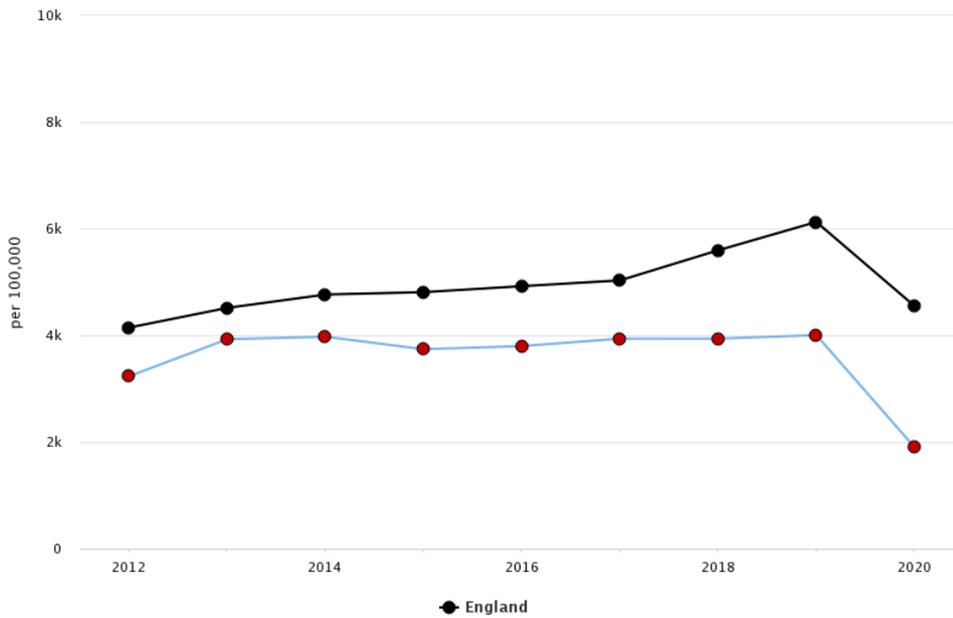
²¹ Kent, Staffordshire, Gloucestershire, Cumbria, Lincolnshire, Worcestershire, Essex, Warwickshire, Derbyshire, Suffolk, Leicestershire, Norfolk, Somerset, Northamptonshire

Figure 10. STI testing rate (exc chlamydia <25) / 100,000 for Nottingham



Source: OHID Fingertips

Figure 11 STI testing rate (exc chlamydia <25) / 100,000 for Nottinghamshire



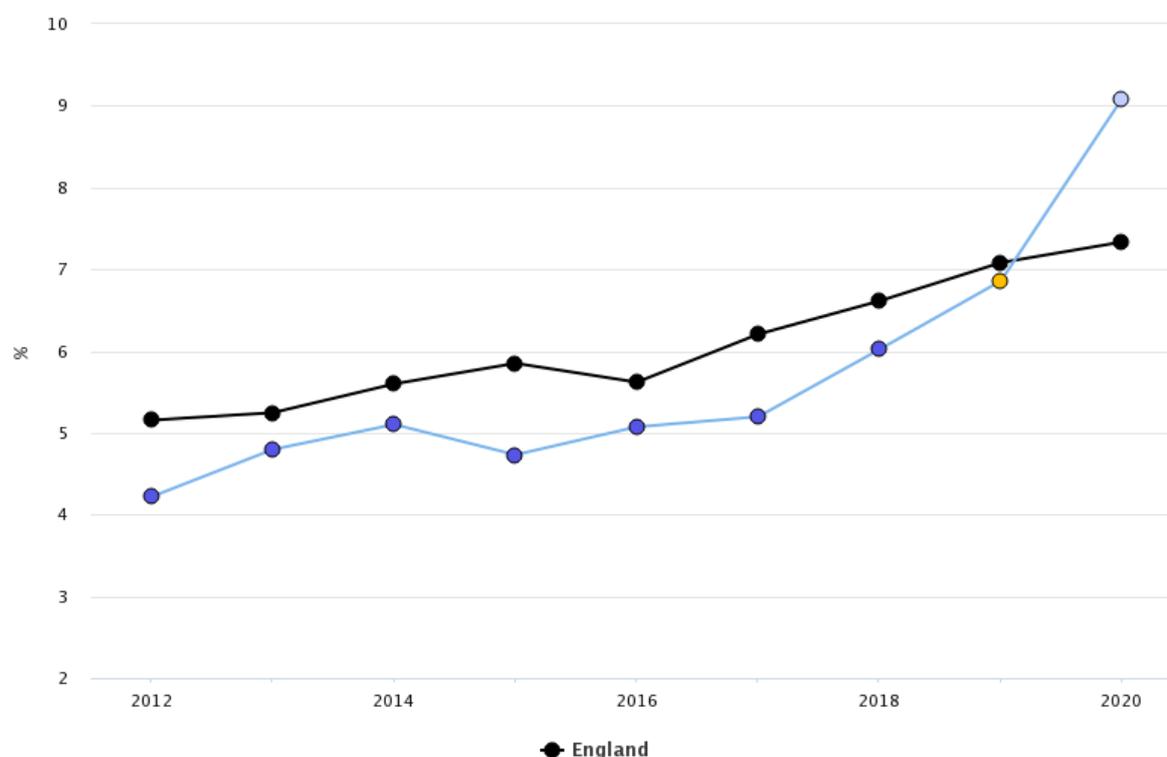
Source: OHID Fingertips

Table 6 STI testing rate and positivity (excluding chlamydia in under 25s) for districts and boroughs in Nottinghamshire

Area	STI testing rate (exc chlamydia <25) / 100,000	STI positivity %
England	4,549	7.3
Nottinghamshire	1,900	9.1
Ashfield	1,670	13.0
Bassetlaw	2,019	5.0
Broxtowe	1,021	7.9
Gedling	1,427	9.9
Mansfield	2,215	10.8
Newark and Sherwood	1,247	8.9
Rushcliffe	917	8.6

Source: OHID Fingertips

Figure 12 STI testing positivity (exc chlamydia aged <25) % for Nottinghamshire

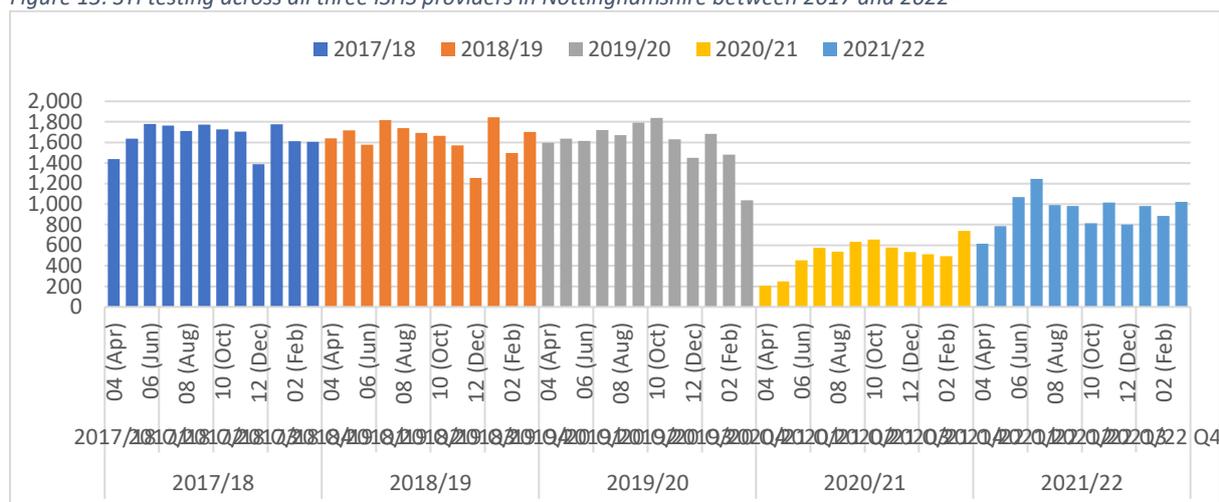


Source: OHID Fingertips

6.4 STI testing at Integrated Sexual Health Services and online

National data in the previous section reaches up to the end of 2020 and does not reflect later changes in activity as COVID-19 restrictions have changed. The most recent data (Pathway Analytics) available to commissioners locally (Figure 13) shows that, overall, STI testing within ISHS across all providers has not returned to pre-pandemic levels. Figure 13 shows the number of currencies triggered by providers when offering testing to people. There is also variation in testing levels across all providers.

Figure 13: STI testing across all three ISHS providers in Nottinghamshire between 2017 and 2022²²



Source: Activity data from the three contracted providers (DBHT, SFHT and NUH)

Some of this testing may have transferred to locally commissioned online testing services. This service offer was enhanced in May 2021 to cover the full range of sexual health testing.

An evaluation of the online testing service found that between May 2021 to Dec 2021, 6146 kits were ordered and 4763 were returned with a return rate of 77.5%. This service has a daily testing cap and although demand exceeded this cap, it is not known exactly what this demand is. It is also unclear whether online testing attracts new people who did not regularly test previously, or whether it is used by existing service users who have been directed to use online testing.

Using the data for ISHS it is also possible to take a different perspective and consider how likely individuals in different groups are to be tested following a new attendance. Looking at age, those aged 20 to 34 were most likely to be tested (86.5%) and those aged 15 or under were least likely (69.7%), with other age groups all appearing similar (82% to 83%). In terms of ethnicity, Black Caribbean (89.2%) and White ethnic groups (88.6%) were most likely to be tested, with Black African (84.2%) and all others (85.4%) slightly – but statistically significantly – less likely. Those where ethnicity was not known had particularly low rates of testing (as low as 56.6%). This requires further investigation.

In terms of sexuality, those most likely to be tested were men who identified as homosexual (94.6%) or bisexual (94.3%). Those least likely to be tested were those where sexuality was not recorded. Again, this requires further work to understand possible reasons.

²² Testing refers to T2 (Chlamydia and Gonorrhoea), T3 (Chlamydia, Gonorrhoea and Syphilis) T4 (Chlamydia, Gonorrhoea and Syphilis) and T7 (HIV)

6.5 STI diagnoses

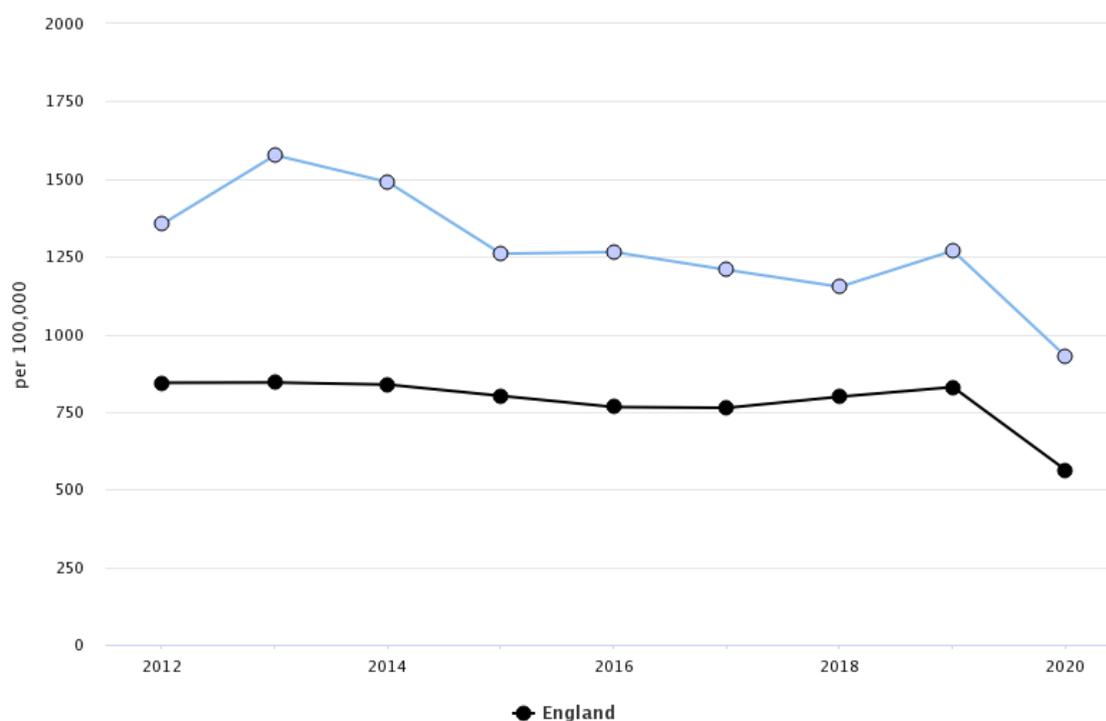
The all new STI diagnosis rate is the number of new STI diagnoses (excluding chlamydia in those aged under 25 years) among people aged 15 to 64 accessing sexual health services in England who are also residents in England over the general population aged 15-64.

In Nottingham (2020), the diagnosis rate (928/100,000) is higher than the England rate and is 2nd out of 16 similar local authorities. This rate has been decreasing since 2014 (Figure 14). The high rate is similar to other student cities such as Manchester. This is a crude rate so does not specifically examine rates within young people or other at-risk groups. Deprivation is also likely to be a key contributing factor.

In Nottinghamshire (2020), the all new STI diagnosis rate is 408/100,000 (Figure 15). This is lower than the England rate of 619/100,000 and Nottinghamshire is 3rd out of 16 similar local authorities. In 2019, the rate of all new STIs for Nottinghamshire was 590.2 with the highest rate in Mansfield (741.9) and lowest in Rushcliffe (424.6), reflecting higher need in areas of higher deprivation.

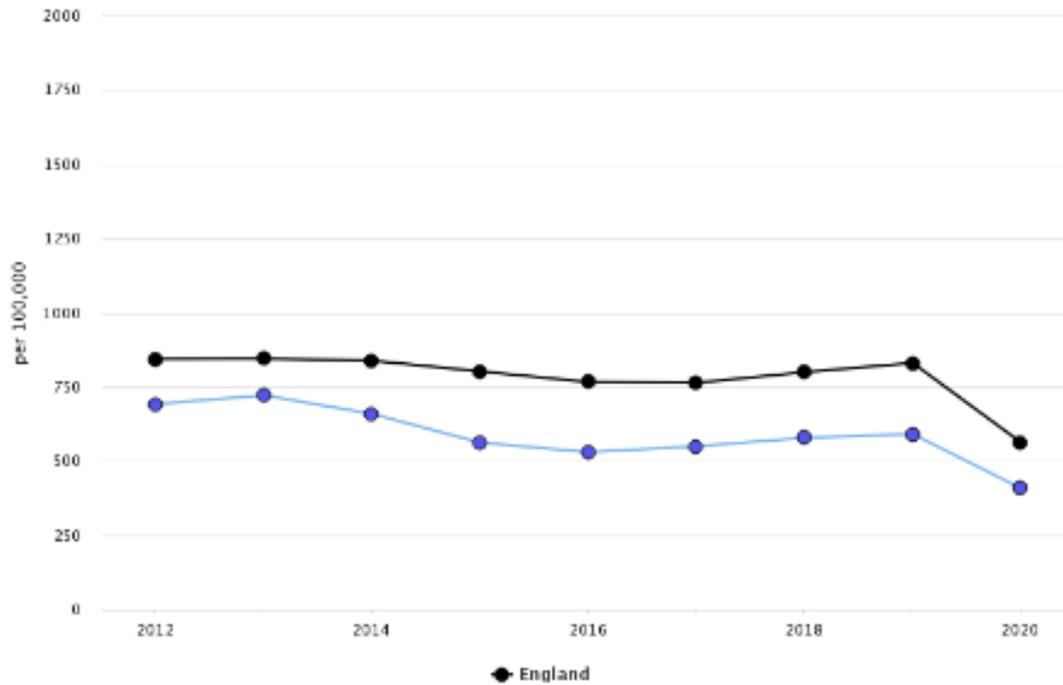
Despite low rates overall in Nottinghamshire, the highest rates were found in young people aged 20-24 (3996.5) and 15-19 (2824.2), groups known to be at risk for poor sexual health outcomes. Rates were particularly high amongst females in these age groups (4152.1 amongst 15-19 year olds and 4720.6 amongst 20-24 year olds). In males, rates were highest amongst 20-24 year olds (3251.6) but not as high in 15-19 year olds (1528.7).

Figure 14. All new STI diagnosis rate/100,000 for Nottingham



Source: OHID Fingertips

Figure 15. All new STI diagnosis rate/100,000 for Nottinghamshire



Source: OHID Fingertips

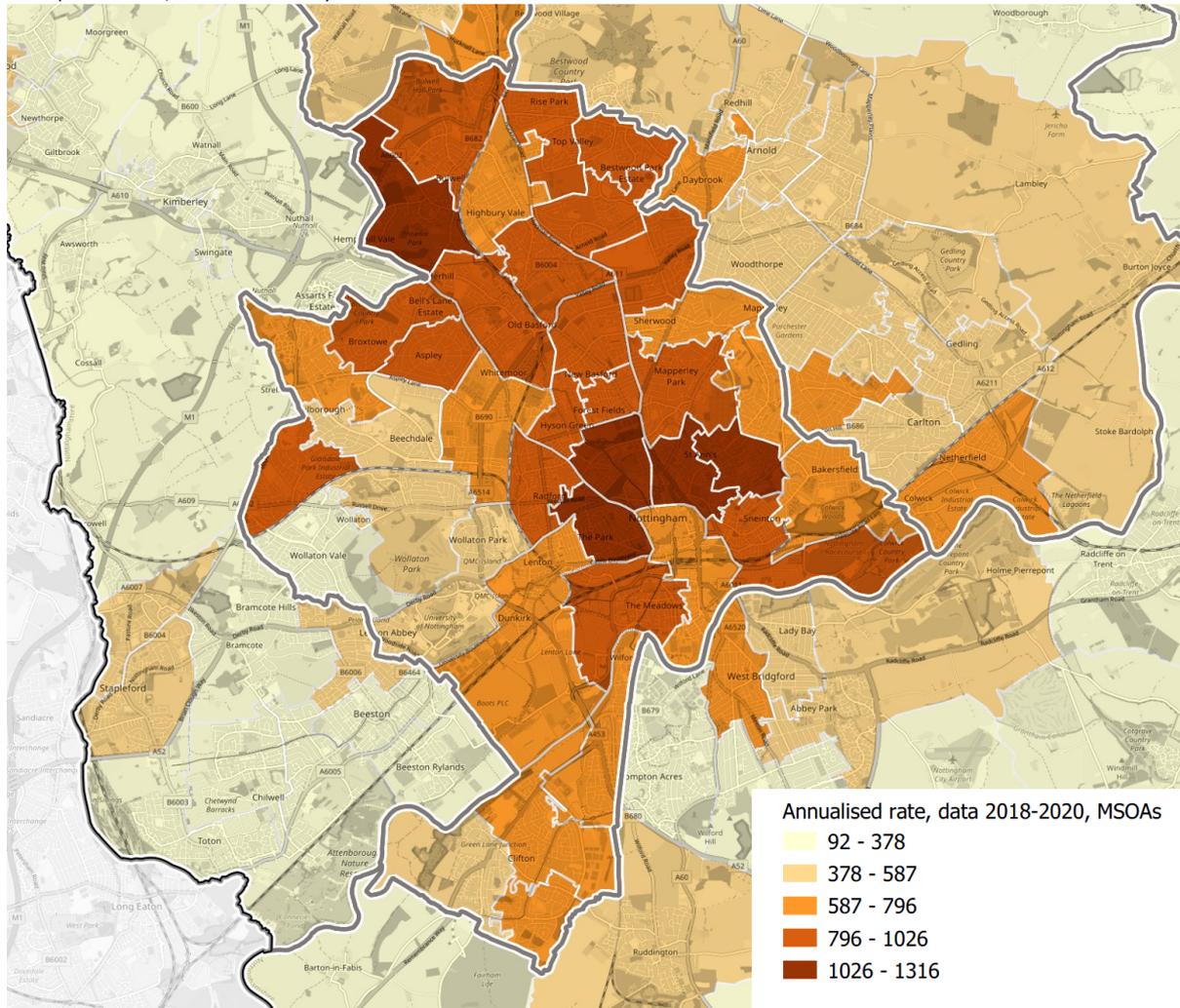
6.6 STI diagnoses at Integrated Sexual Health Services

The following section refers to data about STI diagnoses amongst all individuals who attended ISHS services in Nottingham and Nottinghamshire between 1st April 2017 and 31st March 2021. Unless otherwise stated, all counts represent individuals. This means that the data are different to counts shown in OHID Fingertips profiles or the STI/HIV data exchange, which are based on diagnoses.

6.6.1 STI diagnoses by area

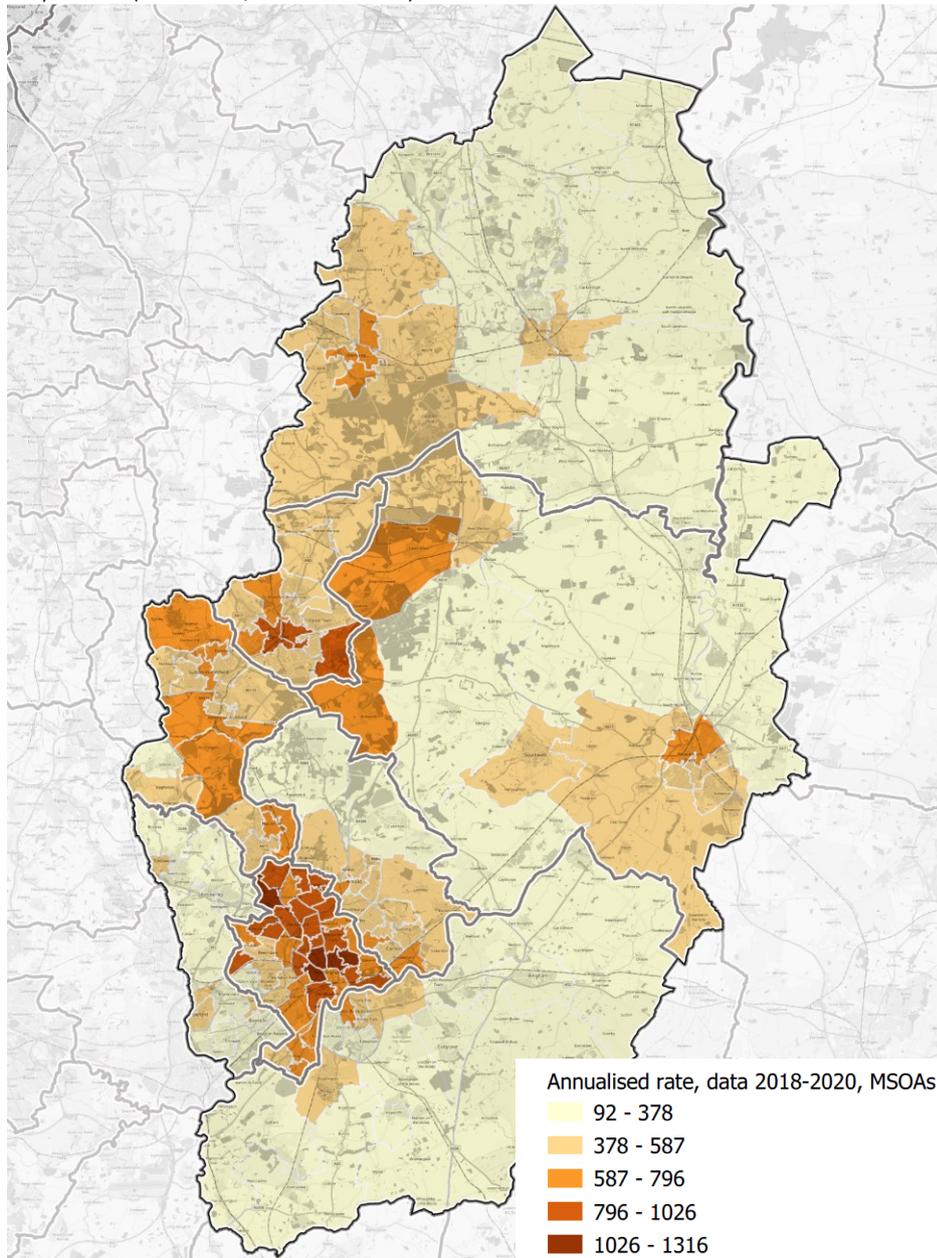
Figure 16 and Figure 17 show rates of individuals diagnosed with any STI in Nottingham and Nottinghamshire from 2018 to 2020 (per 100,000 aged 15 to 64 years). The areas with the highest rates in Nottingham are Kimberley North & Watnall, and a band across the Park & Castle; Arboretum, Forest & Trent University; St Ann’s West and St Ann’s East. In Nottinghamshire, parts of Mansfield (Town Centre & Broomhill, Newgate & Carr Bank, Oak Tree & Ransom Wood) have the highest rates, with parts of Worksop, Sutton-in-Ashfield, Hucknall, Rainworth and Newark following, though no areas in Nottinghamshire have rates as high as the highest in Nottingham City.

Figure 16 Individuals diagnosed with any STI per 100,000 population aged 15–64 years in Nottingham by Middle Super Output Area (2018–2020, annualised rate)



Source: Pseudonymised provider data from the three contracted providers (DBHT, SFHT and NUH)

Figure 17 Individuals diagnosed with any STI per 100,000 population aged 15–64 years in Nottinghamshire by Middle Super Output Area (2018-2020, annualised rate)



Source: Pseudonymised provider data from the three contracted providers (DBHT, SFHT and NUH)

6.6.2 STI diagnoses by sex and sexuality

Amongst people from Nottingham attending ISHS, 46% (3069) of those diagnosed with an STI were female and 54% (3571) were male (Table 7). In Nottinghamshire, 48% (3849) of STI diagnoses were amongst females and 52% (4231) amongst males.

Around 82% of diagnoses in Nottingham and 87% in Nottinghamshire were amongst people recorded as being heterosexual. 8.2% of diagnoses in Nottingham and 7.2% in Nottinghamshire were amongst people who were recorded as homosexual. Only 1.4% of the population of Nottingham and 0.8% of the population of Nottinghamshire were estimated to be gay or lesbian according to the Annual Population Survey (see section 5.4), so this group appears much more likely to be diagnosed with an

STI. It is important to note that the vast majority of those diagnosed with an STI and recorded as homosexual in ISHS services were male.

Sexuality is either not known or not recorded for about 8% of people with diagnoses from Nottingham and 5% from Nottinghamshire.

Table 7. People diagnosed with any STI at ISHS by sex and sexuality in Nottingham and Nottinghamshire between April 2017 and March 2021

	Female	Male	All persons
Nottingham			
Bisexual	37 (1.2)	76 (2.1)	113 (1.7)
Heterosexual	2,768 (90.2)	2,694 (75.4)	5,462 (82.3)
Homosexual	17 (0.6)	530 (14.8)	547 (8.2)
Orientation not known	18 (0.6)	20 (0.6)	38 (0.6)
Orientation not recorded	229 (7.5)	251 (7.0)	480 (7.2)
Nottingham total	3,069	3,571	6,640
Nottinghamshire			
Bisexual	29 (0.8)	68 (1.6)	97 (1.2)
Heterosexual	3,629 (94.3)	3,405 (80.5)	7,034 (87.1)
Homosexual	21 (0.5)	566 (13.4)	587 (7.3)
Orientation not known	10 (0.3)	20 (0.5)	30 (0.4)
Orientation not recorded	158 (4.1)	172 (4.1)	330 (4.1)
Nottinghamshire total	3,847	4,231	8,078

Source: Pseudonymised provider data of activity between 1/4/2017 and 31/3/2021 from the three contracted providers (DBHT, SFHT and NUH)

6.6.3 STI diagnoses by age

In Nottingham, over 40% of all STI diagnoses are within the 16 to 24 age group and 38% amongst 25 to 34-year-olds. In Nottinghamshire, around a third (32.6%) are in 16 to 24-year-olds and 42% are amongst 25 to 34-year-olds. This probably reflects the older age profile of Nottinghamshire.

With increasing age, males represent a greater proportion of those diagnosed with an STI (Table 8). Amongst 16 to 19-year-olds diagnosed with an STI from both Nottingham and Nottinghamshire, over 60% are female, and in 20 to 24-year-olds the split between males and females is roughly 50/50, but amongst 35 to 64-year-olds, around 60% of diagnoses are amongst males. The reason for this difference is unclear.

Table 8. People diagnosed with any STI at ISHS by age in Nottingham and Nottinghamshire between April 2017 and March 2021

Age group	Female	Male	All persons
Nottingham			
00 to 15	<10 (0.3)	<10 (0.1)	11 (0.2)
16 to 19	463 (15.1)	276 (7.7)	739 (11.1)
20 to 24	1,006 (32.8)	1,005 (28.1)	2,011 (30.3)
25 to 34	1,058 (34.5)	1,493 (41.8)	2,551 (38.4)
35 to 44	366 (11.9)	503 (14.1)	869 (13.1)
45 to 64	159 (5.2)	265 (7.4)	424 (6.4)
65 older	<20 (0.3)	<30 (0.7)	35 (0.5)
Nottingham total	3,069	3,571	6,640
Nottinghamshire			
00 to 15	<20 (0.5)	<20 (0.1)	25 (0.3)
16 to 19	493 (12.8)	275 (6.5)	768 (9.5)
20 to 24	914 (23.8)	953 (22.5)	1,867 (23.1)
25 to 34	1,611 (41.9)	1,794 (42.4)	3,405 (42.2)
35 to 44	466 (12.1)	644 (15.2)	1,110 (13.7)
45 to 64	330 (8.6)	494 (11.7)	824 (10.2)
65 older	14 (0.4)	65 (1.5)	79 (1.0)
Nottinghamshire total	3,847	4,231	8,078

Source: Pseudonymised provider data of activity between 1/4/2017 and 31/3/2021 from the three contracted providers (DBHT, SFHT and NUH)

6.6.4 STI diagnoses by ethnicity

Table 9 shows that in Nottingham, 52% of people diagnosed with any STI were white, 11.4% were from Black African or Black Caribbean ethnic groups, and 16.6% were from any other ethnic group. Black African and Black Caribbean people therefore represented a higher proportion of those diagnosed with an STI than in the general population, reflecting that this group is known to be at high risk of poor sexual health.

It is difficult to further interpret the ethnicity breakdown in Nottingham, as there was a very high proportion (20%) of diagnoses where ethnicity was not recorded or not known.

In Nottinghamshire, 85% of people diagnosed with an STI in ISHS were white (Table 9), 1.5% were Black African or Black Caribbean and 5.3% were from any other ethnic group. This is a slightly higher proportion of Black African, Black Caribbean and other ethnic groups than amongst the general population but again this is difficult to interpret given that ethnicity was not recorded or not known for around 9% of people.

Table 9. People diagnosed with any STI at ISHS by ethnicity in Nottingham and Nottinghamshire between April 2017 and March 2021

	Female	Male	All Persons
Nottingham			
All other ethnic groups	506 (16.5)	595 (16.7)	1,101 (16.6)
Black African	127 (4.1)	165 (4.6)	292 (4.4)
Black Caribbean	164 (5.3)	300 (8.4)	464 (7.0)
Not recorded	208 (6.8)	289 (8.1)	497 (7.5)
Not known	358 (11.7)	472 (13.2)	830 (12.5)
White	1,706 (55.6)	1,750 (49.0)	3,456 (52.0)
Nottingham total	3,069	3,571	6,640
Nottinghamshire			
All other ethnic groups	179 (4.7)	251 (5.9)	430 (5.3)
Black African	16 (0.4)	38 (0.9)	54 (0.7)
Black Caribbean	28 (0.7)	38 (0.9)	66 (0.8)
Not recorded	101 (2.6)	136 (3.2)	237 (2.9)
Not known	187 (4.9)	278 (6.6)	465 (5.8)
White	3,336 (86.7)	3,490 (82.5)	6,826 (84.5)
Nottinghamshire total	3,847	4,231	8,078

Source: Pseudonymised provider data of activity between 1/4/2017 and 31/3/2021 from the three contracted providers (DBHT, SFHT and NUH)

6.6.5 STI diagnoses by deprivation

In both Nottingham and Nottinghamshire, the most deprived quintile was overrepresented amongst those diagnosed with an STI and the least deprived quintile was underrepresented (data not shown).

6.7 Multiple STIs

One marker of ongoing risky sexual behaviour is having more than one STI diagnosis over a period longer than 12 months apart. From 1st April 2017 to 31st March 2021 there were 755 people in Nottingham who had multiple STI diagnoses over a period longer than 12 months: this represents 1.9% of all individuals who used the service and 10.2% of all individuals who were diagnosed with any STI. In Nottinghamshire, 739 people had multiple STIs over a period longer than 12 months: 1.4% of all attendees or 8.2% of individuals diagnosed with any STI.²³

Groups at higher risk of multiple STIs (i.e. representing a higher proportion of individuals with multiple STIs than the proportion of all STIs or all attendances at services) included young people aged 20 to 24 years, homosexual men, and the most deprived quintile. In Nottingham, those in the Black Caribbean and “all other” ethnic groups (i.e. other than Black Caribbean, Black African and White) also appeared to be at higher risk. This was less clear in Nottinghamshire due to the small numbers

²³ Pseudonymised provider data from the three contracted providers (DBHT, SFHT and NUH) over the time period 1 April 2017 to 31 March 2021

involved. However, it should be noted that the majority of people with multiple STIs were heterosexual and of White ethnicity, due to the larger number of people in these groups overall. This group may be an important focus for health promotion, as safer sex for this group would reduce personal health consequences and also reduce the demand on ISHS services. Table 10 shows the number of individuals diagnosed with multiple STIs over more than 1 year and those with specific STIs (total across City and County).

Table 10. Number of individuals diagnosed with multiple STIs over more than 1 year compared with specific STIs (total across City and County) between April 2017 to March 2021

1,494 individuals with multiple STIs over more than 1 year
3,430 individuals diagnosed with gonorrhoea
2,267 diagnosed with herpes
328 with syphilis
3,828 with genital warts
26 with HIV

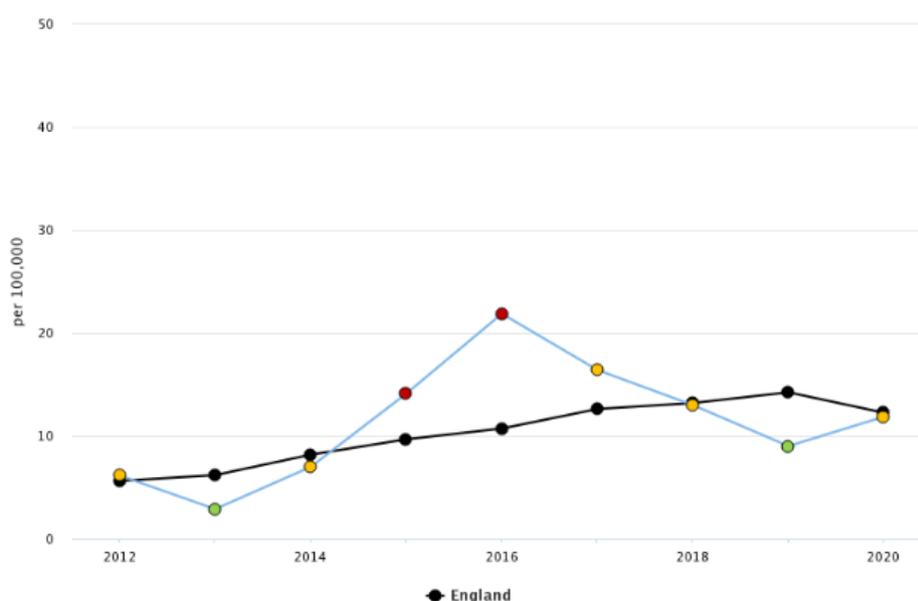
Source: Pseudonymised provider data of activity between 1/4/2017 and 31/3/2021 from the three contracted providers (DBHT, SFHT and NUH)

6.8 Syphilis

The syphilis diagnosis rate per 100,000 for Nottingham (2020) is 11.9, close to the England rate of 12.2 (Figure 18). This has generally been decreasing since a peak at over 20 per 100,000 in 2016.

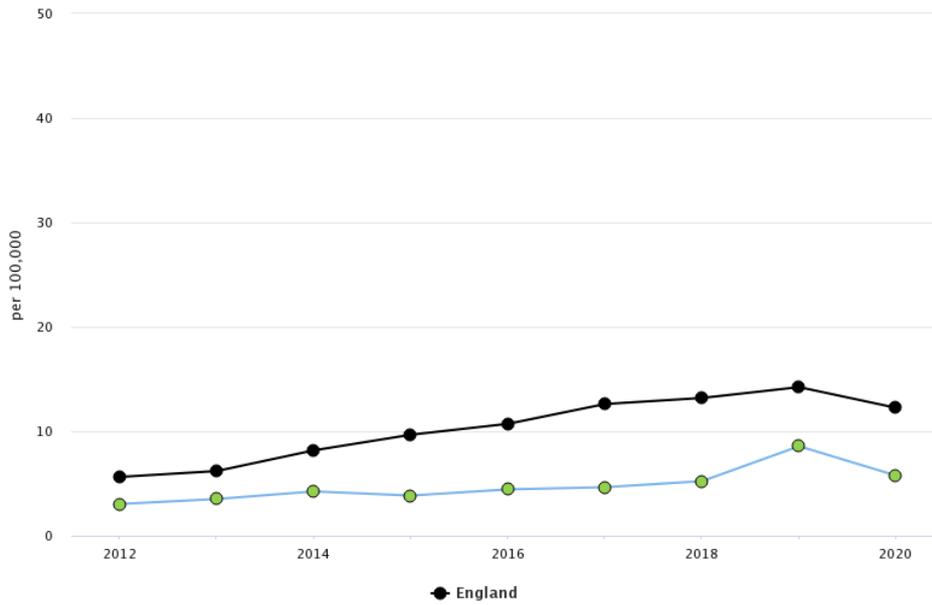
Figure 19 shows the syphilis rate for Nottinghamshire at 5.8 which is around half of the England rate, but there was a spike in 2019. Cases increased from 43 in 2018 to 71 in 2019. There is also variation across districts and boroughs where rates reach 9.7 in Newark & Sherwood and 9.3 in Bassetlaw. In Bassetlaw, the number of syphilis cases doubled in 2019. Although the number of cases is small, the situation has been closely monitored by public health and local services. The situation in Bassetlaw is unusual as it has involved a number of cases within low-risk groups.

Figure 18. Syphilis diagnosis rate /100,000 for Nottingham 2012-2020



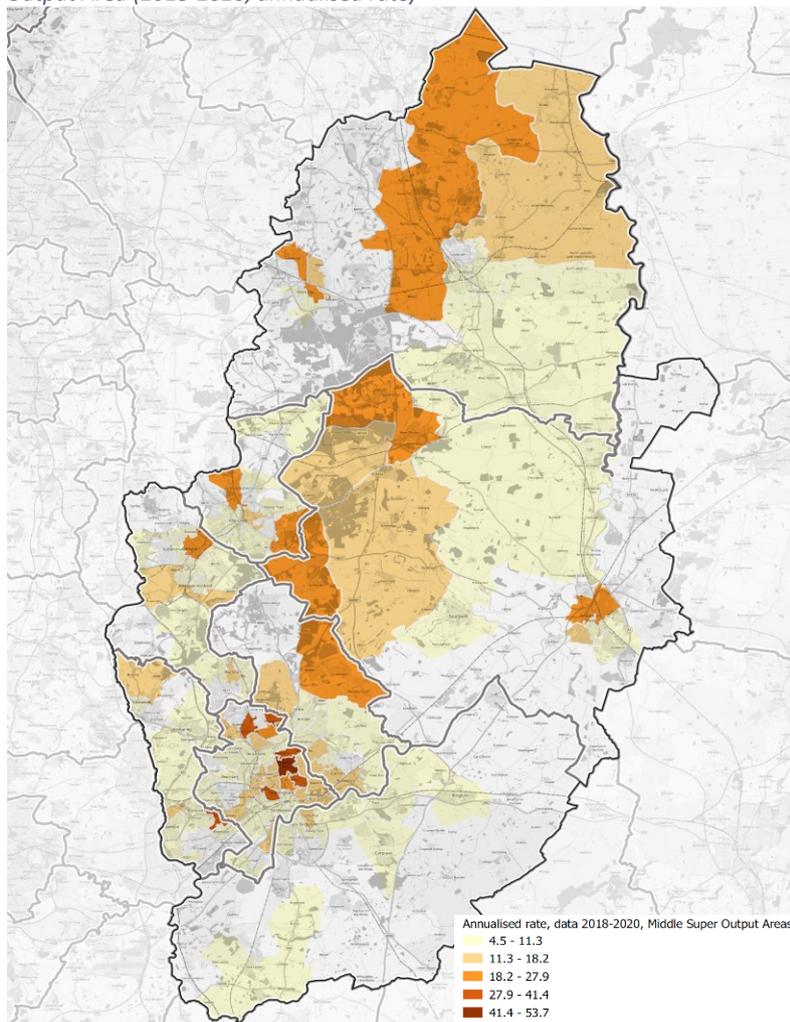
Source: OHID Fingertips

Figure 19. Syphilis diagnosis rate /100,000 for Nottinghamshire 2012-2020



Source: OHID Fingertips

Figure 20 Individuals diagnosed with syphilis per 100,000 population aged 15–64 years in Nottinghamshire by Middle Super Output Area (2018-2020, annualised rate)



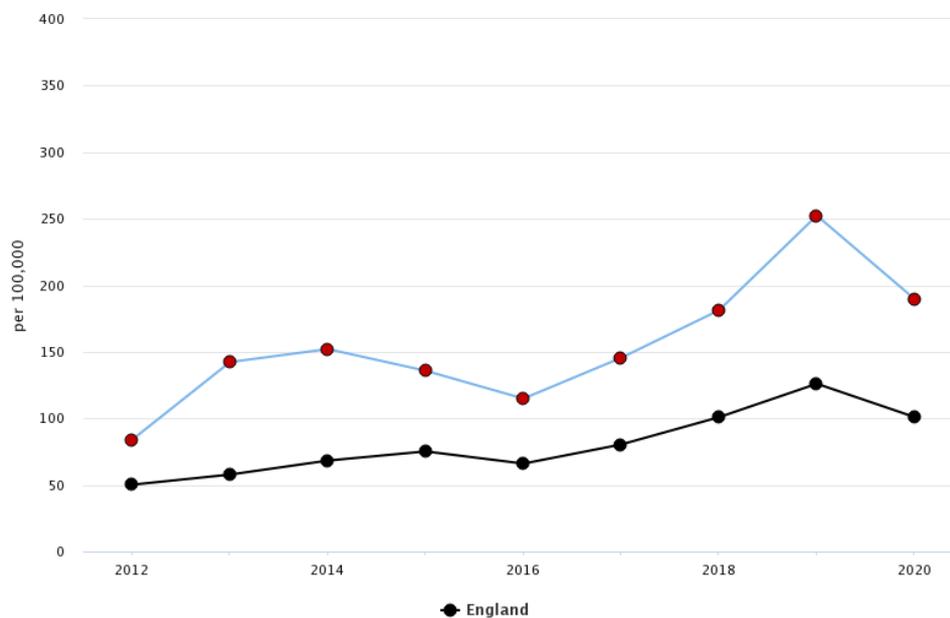
Source: Pseudonymised provider data from the three contracted providers (DBHT, SFHT and NUH)

6.9 Gonorrhoea

Gonorrhoea is a marker of risky sexual activity. Nottingham (Figure 21) has a gonorrhoea diagnosis rate of 190 per 100,000; worse than the rate of 101 in England. This rate was increasing until 2020 when service activity levels were reduced. The rank for gonorrhoea diagnoses in Nottingham was 21st highest (out of 149) in 2020. It is possible that there may be double counting of cases diagnosed through online testing and subsequently treated in ISHS. However, even allowing for this, the rate of gonorrhoea diagnoses would remain above 150 per 100,000 in Nottingham in 2020.

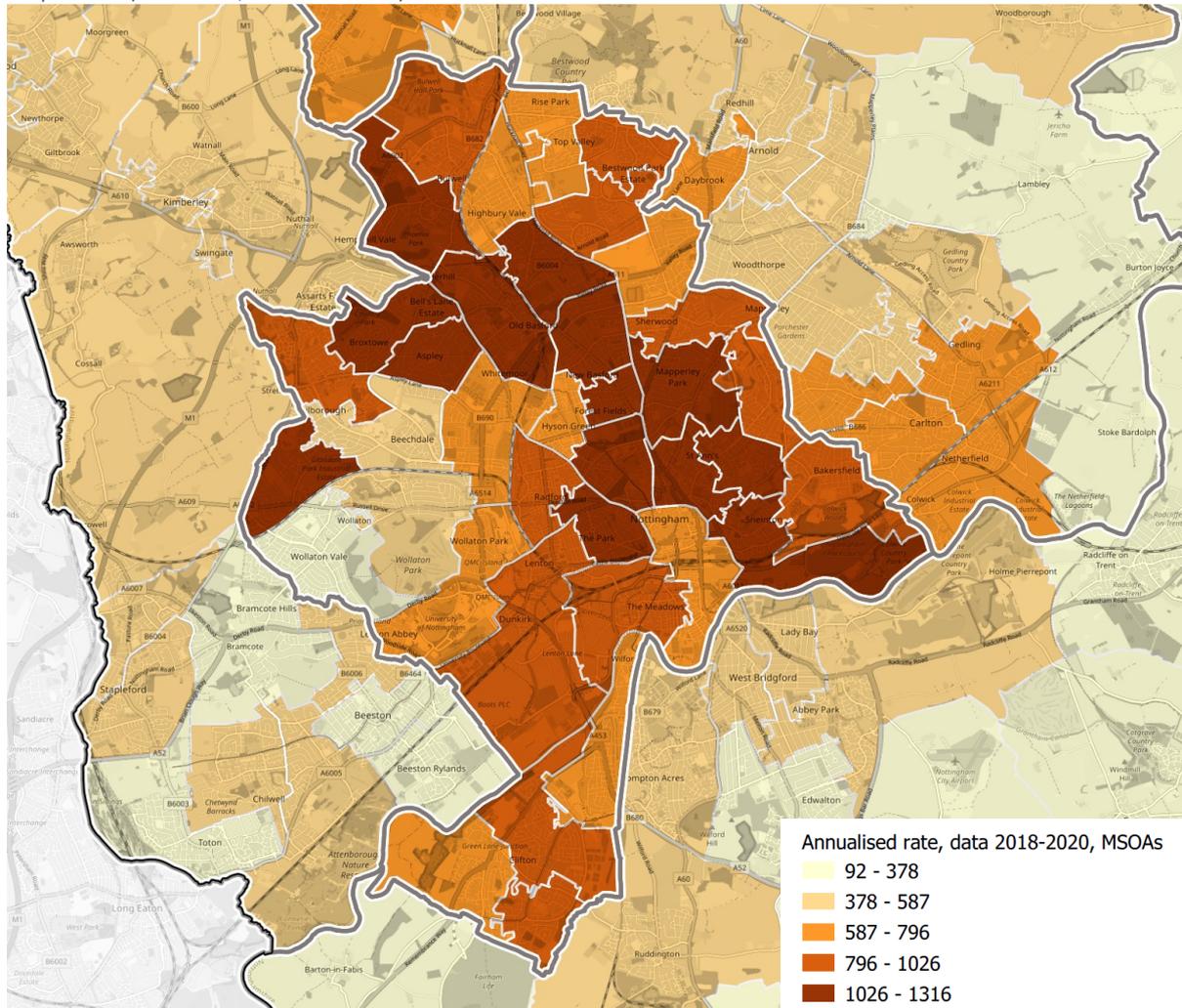
The rate in Nottinghamshire is 45.5 per 100,000 which is better than the England rate of 101 per 100,000 although Ashfield has a rate of 72 per 100,000 higher than that of Nottinghamshire but still lower than England. The rank for gonorrhoea diagnoses in Nottinghamshire was 100th highest (out of 149) in 2020.

Figure 21. Gonorrhoea diagnosis rate /100,000 for Nottingham 2012-2020



Source: OHID Fingertips

Figure 22 Individuals diagnosed with gonorrhoea per 100,000 population aged 15–64 years in Nottingham by Middle Super Output Area (2018-2020, annualised rate)



Source: Pseudonymised provider data from the three contracted providers (DBHT, SFHT and NUH)

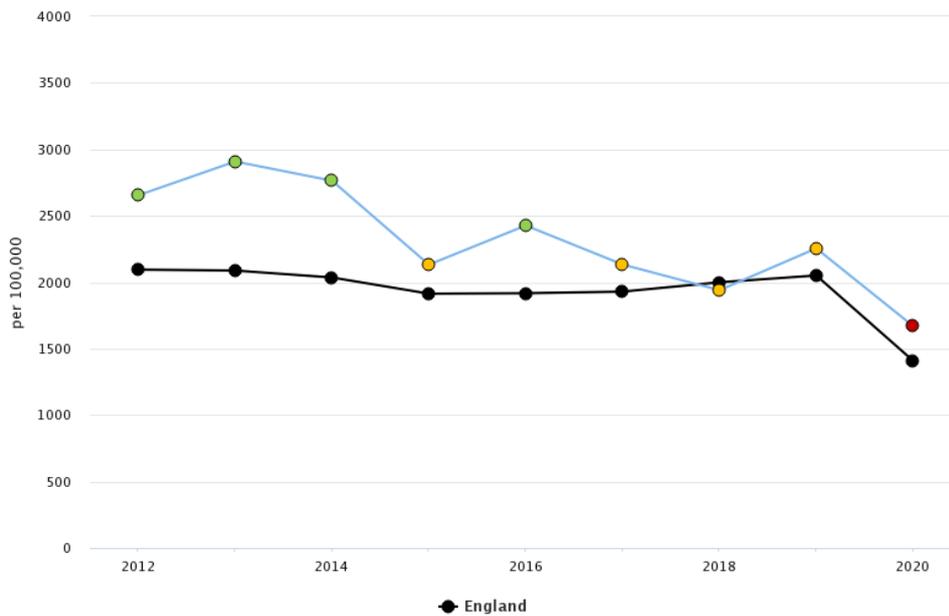
6.10 Chlamydia

6.10.1 Chlamydia detection rate

As the most common STI, the National Chlamydia Screening Programme has aimed to reduce the impact of chlamydia since it was introduced in 2003. Variation in rates of chlamydia detection may therefore represent differences in prevalence but are also influenced by screening coverage and whether the most at risk populations are being reached.

Figure 23 shows the chlamydia detection rate per 100,000 young people aged 15 to 24 years in Nottingham was 1,669 per 100,000 in 2020, higher than the rate of 1,408 per 100,000 for England. Local areas should work towards a chlamydia detection rate of at least 2,300 per 100,000 population among 15 to 24-year-olds and Nottingham has been consistently around this level, except for the impact of COVID-19 in 2020. However, in the five years from 2015 to 2020, there was a 22% decrease in the chlamydia detection rate among 15 to 24-year-olds in Nottingham. Nottingham ranks 3rd out of 16 similar local authorities and 31st of out 149 England local authorities.

Figure 23 Chlamydia detection rate /100,000 aged 15 to 24 for Nottingham 2012-2020



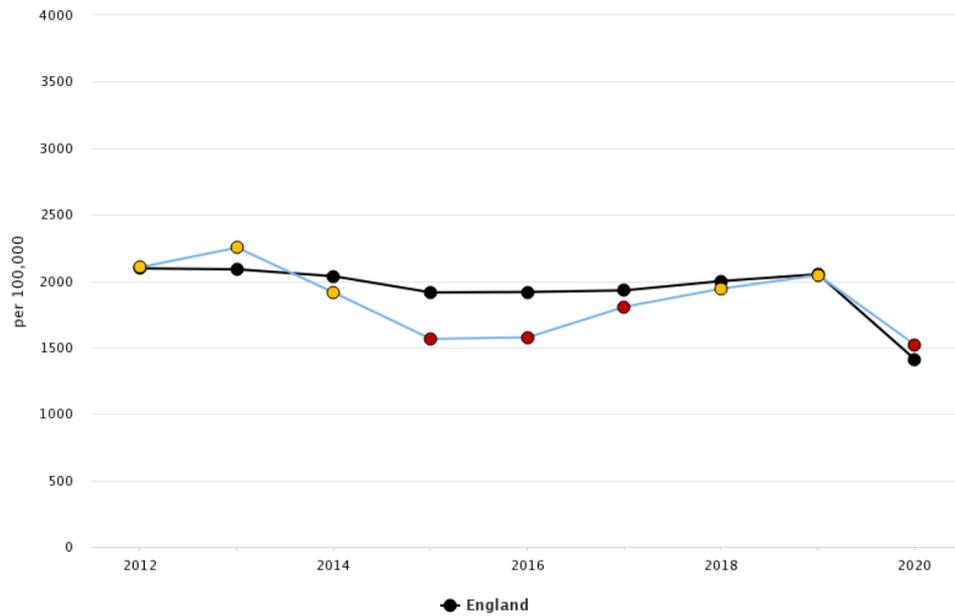
Source: OHID Fingertips

In Nottinghamshire, the chlamydia detection rate per 100,000 young people aged 15 to 24 years was 1,518 in 2020, better than the rate of 1,408 for England but lower than the 2,300 target (Figure 24). The detection rate in Nottinghamshire has previously been below the England average but made substantial progress and reached the national average in 2019, followed by a 26% drop in the detection rate from 2019 to 2020. Nottinghamshire ranks 2nd out of 16 similar local authorities and 46th of out 149 local authorities in England.

The chlamydia detection rate has been a focus of attention for public health since around 2017. This has involved regular updates to the Adult Social Care and Public Health Committee and working with providers to ensure that people are offered tests according to national guidelines. It also led to the implementation of online chlamydia testing in 2018.

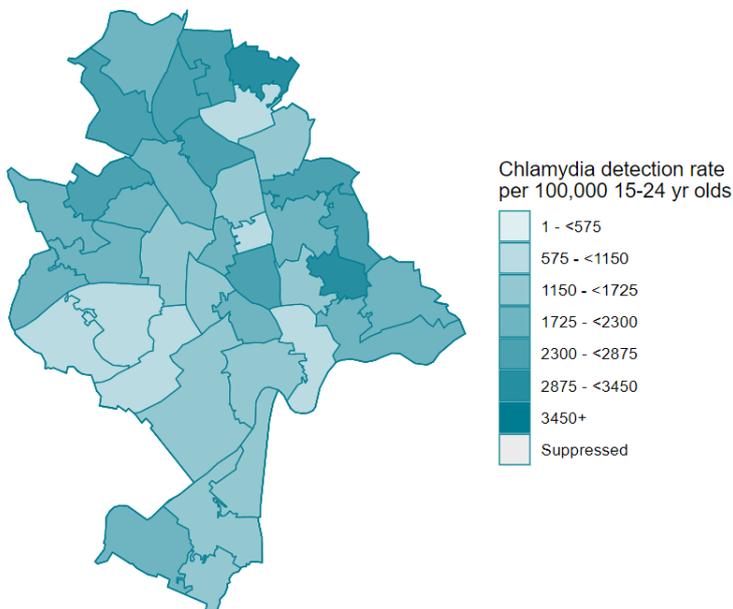
There is variation across Nottinghamshire in chlamydia detection rate with the highest rates in Mansfield (2083/100,000) and Ashfield (2018/100,000) and the lowest rates in Broxtowe (944/100,000) and Rushcliffe (1059/100,000). There are also small areas with higher detection rates around Worksop, Retford and Newark. This may represent differences in prevalence, which would be expected given variation in levels of deprivation but is also influenced by screening coverage. Figure 26 shows the variation in chlamydia detection rate by Middle Super Output Area.

Figure 24. Chlamydia detection rate /100,000 aged 15 to 24 for Nottinghamshire 2012-2020



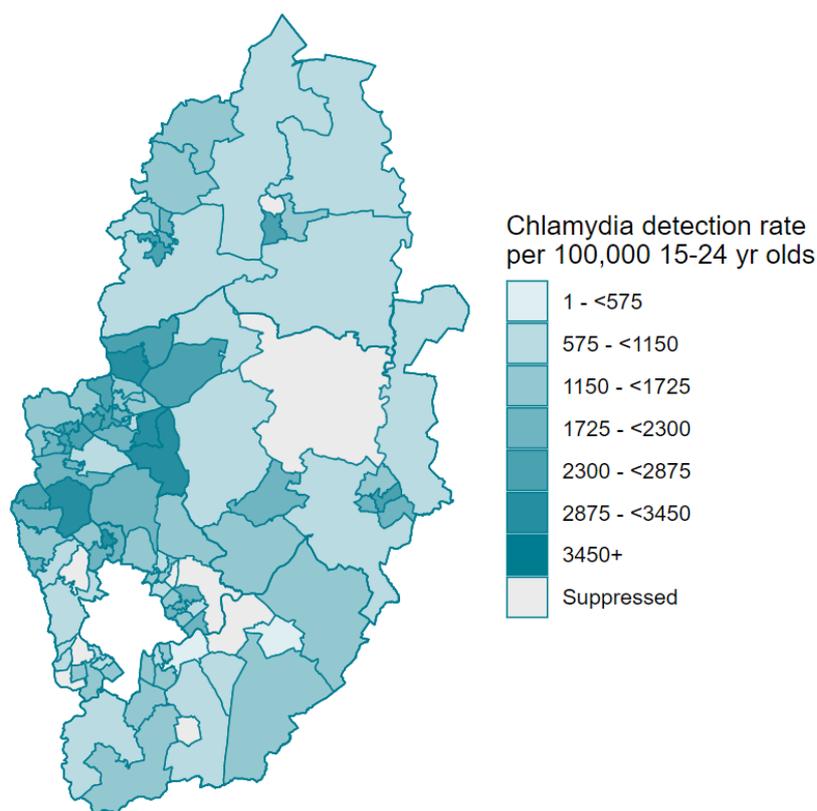
Source: OHID Fingertips

Figure 25: Map of chlamydia detection rate per 100,000 population in 15 to 24 years in Nottingham by Middle Super Output Area: 2020



Source: CTAD Chlamydia Surveillance System (CTAD)

Figure 26 Map of chlamydia detection rate per 100,000 population in 15 to 24 years in Nottinghamshire by Middle Super Output Area: 2020



Source: CTAD Chlamydia Surveillance System (CTAD)

6.10.2 Chlamydia proportion aged 15 to 24 years old screened

In Nottingham the proportion of 15 to 24-year-olds screened for chlamydia in 2020 was 16.7%, compared to 14.3% nationally (Figure 27), and 13.7% amongst similar local authorities (“nearest neighbours”). (This includes testing across the sexual health system including primary care and online tests).

Across Nottinghamshire, the proportion of 15 to 24-year-olds screened for chlamydia in 2020 was 14.3% (Figure 28). The proportion has historically been under the England average but is now in line as the national average dropped in 2020. It ranks 5th amongst similar local authorities (“nearest neighbours”), amongst which the average is 12.6%. There is some variation across Nottinghamshire with Bassetlaw the highest at 15.3% and Newark & Sherwood the lowest at 13.2%

Table 11 Table 11 shows the number of chlamydia tests for 15 to 24-year-olds and positivity rate in Nottinghamshire from 2018 to 2020. Current national guidance suggests that a positivity rate between 5% and 12% represents a balance between efficiency and accessibility, and most settings are in this range. The majority of tests are carried out in sexual health services where the highest positivity rates (15-20%) are also found. This is to be expected as services see people with symptoms or who may suspect that they have an STI. The number and proportion of people testing has increased since 2016 whilst positivity has broadly stayed the same. The number of people accessing online testing for chlamydia has been increased since this method was introduced in 2017. There was a decline in testing

as services were restricted in 2020 due to COVID-19, which corresponded with an increase in online testing as people were directed online.

Figure 27. Chlamydia proportion screened aged 15 to 24 in Nottingham 2012-2020

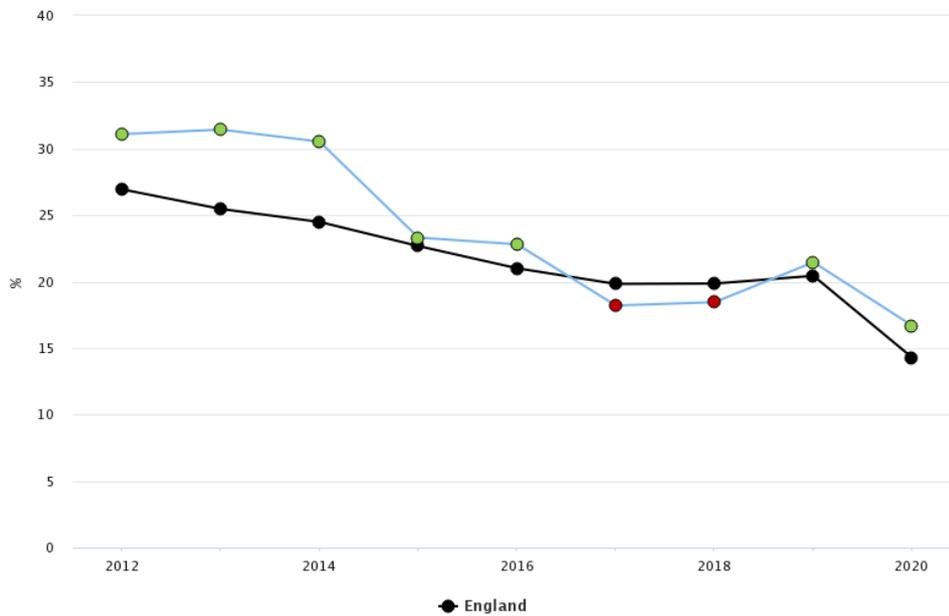
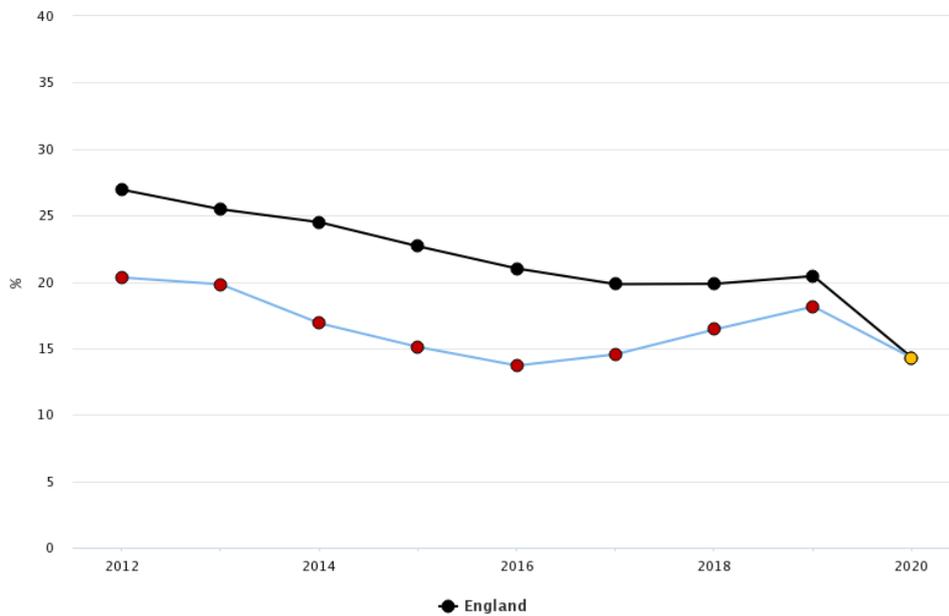


Figure 28. Chlamydia proportion screened aged 15 to 24 in Nottinghamshire 2012-2020



Source: CTAD Chlamydia Surveillance System

Table 11. Chlamydia testing and positivity(%) 2018-2020 in Nottinghamshire (excluding Nottingham City)

	Specialist SHS ²⁴	SRH (non-specialist) ²⁵	GP	Pharmacy	TOP	Internet ²⁶	Unknown	Other ²⁷	Total
Jan 2018 - Dec 2018	6516 (16%)	162 (14%)	3405 (7%)	<5 (0%)	273 (9%)	1964 (10%)	19 (0%)	1725 (9%)	14,067
Jan 2019 - Dec 2019	6840 (15%)	174 (7%)	3592 (7%)	26 (4%)	447 (11%)	3109 (10%)	<5 (50%)	1190 (8%)	15,380
Jan 2020 - Dec 2020	3023 (20%)	47 (11%)	2711 (5%)	12 (0%)	98 (12%)	5217 (9%)	0 (0%)	1083 (6%)	12,191

Source: CTAD Chlamydia Surveillance System

There has been a high volume of testing in primary care. In Nottinghamshire, primary care is not commissioned to carry out testing as part of the National Chlamydia Screening Programme (primary care is commissioned to do so in the Nottingham). This table suggests that young people are nevertheless accessing chlamydia testing in primary care. There are also high levels of testing from ‘other’ sources. A definition of ‘other’ cannot be found.

It should be noted that there have been recent changes made to the National Chlamydia Screening Programme (NCSP) to focus on reducing on the health harm caused by untreated chlamydia infection. Focus will be given to opportunistic screening (that is the proactive offer of a chlamydia test to young people without symptoms) and focus on women combined with reducing time to test results and treatment, strengthening partner notification and re-testing after treatment. This means that chlamydia screening in community settings, such as GPs and pharmacies, will only be proactively offered to young women. Services provided by sexual health services remain unchanged. Nottingham offers opportunistic screening in primary care and pharmacies whilst Nottinghamshire does not. Consideration needs to be given for future chlamydia control in the new service model to reflect changes to the NCSP and possible expectations for testing with sexual health services.

²⁴ Specialist sexual health services refers to services offering level 3 GUM services.

²⁵ Non-specialist sexual health services refers to contraceptive services, many of which also offer a level 2 GUM service.

²⁶ Internet includes all tests from self-sampling kits sourced from online sexual health services.

²⁷ Other includes testing in outreach settings, prisons, education settings and other settings.

6.11 HIV

6.11.1 HIV testing coverage

Among specialist sexual health service (ISHS) patients from Nottingham who were eligible to be tested for HIV, the percentage tested in 2020 was 23.7%, lower than the 46.0% in England (Figure 29)²⁸. This represented a 59% decrease since 2019, and a 68% decrease since 2015. National guidance suggest that services should aim towards testing 60% of eligible people. This decrease started in 2019 before COVID-19. Nottingham is ranked 16 out of 16 amongst comparable neighbours and 133 out of 149 local authorities

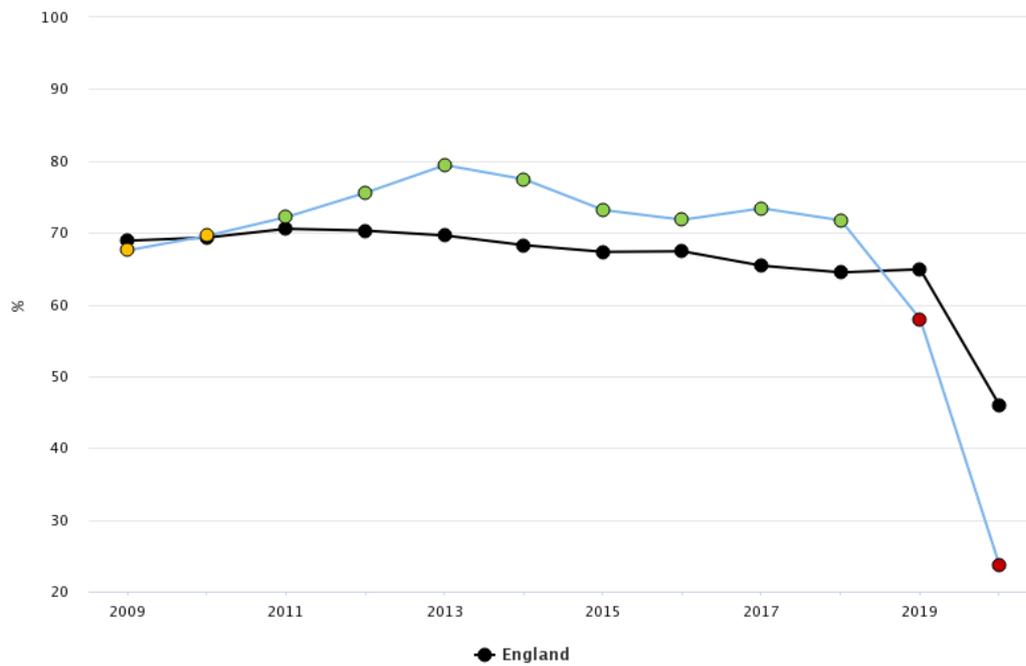
In Nottinghamshire, the HIV testing coverage is significantly lower than England, there was a sharp drop in 2016 (Figure 30). This is seen across all the districts and boroughs within Nottinghamshire. This drop was seen across all people attending sexual health services²⁸.

Table 12 Table 12 shows that the decrease in the HIV coverage in Nottingham that occurred in 2019 was due to an increase the number of people eligible for a HIV test in 2019 whilst the number of people tested remained similar to those tested in 2017 and 2018. In Nottinghamshire, the decrease in the HIV testing coverage occurred in 2016.

Table 13 shows that whilst the number of people who were tested decreased in 2016, the number of people eligible for testing increased, so there was a much sharper decline in the percentage being tested. The increase in people eligible for testing was mainly amongst women. The reason for the increase in people eligible is not completely clear but is believed to be an artefact rather than a real change in people attending services. Commissioners have been assured that services are following national guidelines and are offering tests in appropriate circumstances.

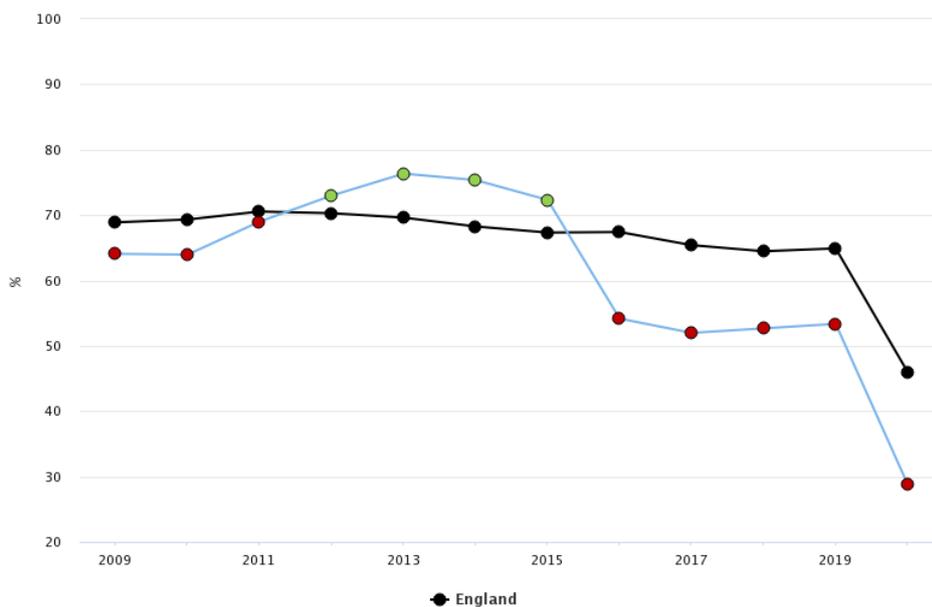
²⁸ This indicator presents the number of persons tested for HIV (and not the number of tests reported) out of those people considered eligible for a HIV test when attending specialist sexual health services. An eligible attendee is defined as a patient attending specialist SHS at least once during a calendar year. Patients known to be HIV positive, or for whom a HIV test was not appropriate, or for whom the attendance was related to Sexual and Reproductive Health (SRH) care only, are excluded.

Figure 29. HIV testing coverage % for Nottingham 2009-2020



Source: Data from routine sexual health services' returns to the GUMCAD STI Surveillance System

Figure 30 HIV testing coverage % for Nottinghamshire 2009-2020



Source: Data from routine sexual health services' returns to the GUMCAD STI Surveillance System

Table 12. The proportion and number of eligible attendees at specialist sexual health services who accepted a HIV test in Nottingham 2009-2020

Area Name	Year	% tested	Number tested	Number eligible
Nottingham	2009	67.5	206	305
Nottingham	2010	69.6	4829	6941
Nottingham	2011	72.2	6466	8959
Nottingham	2012	75.6	6748	8929
Nottingham	2013	79.4	7110	8954
Nottingham	2014	77.4	7019	9064
Nottingham	2015	73.2	7166	9796
Nottingham	2016	71.8	5419	7548
Nottingham	2017	73.4	6063	8261
Nottingham	2018	71.7	5725	7983
Nottingham	2019	58.0	5944	10257
Nottingham	2020	23.7	2147	9052

Source: Data from routine sexual health services' returns to the GUMCAD STI Surveillance System

Table 13. The proportion and number of eligible attendees at specialist sexual health services who accepted a HIV test in Nottinghamshire 2009-2020

Area Name	Year	% tested	Number tested	Number eligible
Nottinghamshire	2009	64.1	5505	8592
Nottinghamshire	2010	63.9	8477	13257
Nottinghamshire	2011	69.0	9558	13853
Nottinghamshire	2012	73.0	10567	14481
Nottinghamshire	2013	76.3	11001	14411
Nottinghamshire	2014	75.3	10841	14388
Nottinghamshire	2015	72.3	10898	15071
Nottinghamshire	2016	54.2	9784	18065
Nottinghamshire	2017	52.0	10397	20004
Nottinghamshire	2018	52.7	10450	19843
Nottinghamshire	2019	53.4	10919	20465
Nottinghamshire	2020	28.8	4152	14418

Source: Data from routine sexual health services' returns to the GUMCAD STI Surveillance System

6.11.2 HIV diagnoses

In Nottingham, 17 people aged 15 years and above were diagnosed with HIV in 2020. The prevalence of diagnosed HIV per 1,000 people aged 15 to 59 years in 2020 was 2.3, similar to the rate of 2.3 in England. In terms of prevalence, Nottingham was 56th highest out of 148 local authorities.

In Nottingham, from 2018 to 2020, the percentage of HIV diagnoses made at a late stage of infection (CD4 count ≤ 350 cells/mm³ within 3 months of diagnosis) was 35.1%, similar to 42.4% in England. Compared to England, a higher proportion of HIV diagnoses amongst heterosexual men were late diagnoses, although numbers are relatively low. The proportion of late HIV diagnoses for MSM and women are similar to England.

In Nottinghamshire, 18 people aged 15 years and above were diagnosed with HIV in 2020. The prevalence of diagnosed HIV per 1,000 people aged 15 to 59 years in 2020 was 0.9, lower than the rate of 2.3 in England. Nottinghamshire was 127th out of 148 local authorities based on prevalence.

In Nottinghamshire, from 2018 to 2020, the percentage of HIV diagnoses made at a late stage of infection (CD4 count ≤ 350 cells/mm³ within 3 months of diagnosis) was 42.9%, similar to 42.4% in England. Compared to England, a higher proportion of HIV diagnoses amongst heterosexual men were late diagnoses, although numbers are relatively low. The proportion of late HIV diagnoses for MSM and women are similar to England.

6.12 Key points: STIs

6.12.1 STI diagnoses

- In Nottingham, new STI diagnoses remained fairly constant in Nottingham from around 2016 until they spiked in 2019, followed by a significant drop in 2020 as a result of COVID-19. In Nottinghamshire, new diagnoses increased steadily from 2016 and then dropped in 2020.
- The areas with the highest rates of people being diagnosed with new STIs were all in Nottingham City, but the parts of Nottinghamshire with the highest rates compared to the rest of Nottinghamshire were in Mansfield.

6.12.2 STI testing

- In Nottinghamshire, the STI testing rate has consistently been under the England rate and is also low compared to similar local authorities, particularly in 2020. The STI positivity rate is high suggesting that the right people are being tested, but there may also be a risk some cases are missed, particularly in the context of a slightly increasing diagnostic rate. Testing and positivity rates are highly variable across the county, with the highest positivity in Ashfield and Mansfield followed by Gedling, and lowest in Bassetlaw.
- Further work is needed relating to the drop in STI tests undertaken in ISHS as a result of COVID-19, particularly to understand how much this has been compensated by online testing, and what the appropriate balance is between online and face-to-face services in future.
- Amongst people attending ISHS, the likelihood of being tested for STIs varied by age, sex, ethnicity and sexuality. Some of this variation is likely to reflect differences in underlying risk, but further work is needed to understand why Black African people were less likely to be tested than other ethnic groups. Further work is also needed to understand why people where ethnicity and sexuality were not recorded had particularly low rates of testing.

6.12.3 Specific STIs and multiple STIs

- Around 8% to 10% of people diagnosed with an STI in ISHS will receive more than one STI diagnosis over a period longer than 12 months. Groups at higher risk of this included young people aged 20 to 24, homosexual men, the most deprived quintile and some ethnic groups. This population is at high risk and a possible focus for health promotion to reduce health consequences and demand on services.
- Syphilis has been a recent concern in Nottinghamshire, particularly Bassetlaw, given a sharp increase in cases in 2018-19, albeit from a low baseline.
- Gonorrhoea in Nottingham is significantly higher than the England average and 21st highest out of 149 local authority areas in 2020. This is the focus of ongoing work for the local authority and UKHSA.

- Chlamydia testing and detection is consistently at or above the national average in Nottingham, whereas in Nottinghamshire it has increased following a significant focus of work, but remains somewhat below the national target.
- HIV testing coverage has dropped substantially in Nottingham from 2019 onwards and in Nottinghamshire from 2016 onwards, apparently due to an increase in the number of people eligible for a test. The reason for this is not completely clear but investigations in Nottinghamshire suggested it was likely to relate to a change in how data was recorded rather than a change in the people attending services.
- In Nottingham and Nottinghamshire, late HIV diagnoses are similar to the England average. A higher proportion of HIV diagnoses amongst heterosexual men were late diagnoses, although numbers are relatively low.

7 Reproductive health and contraception

7.1 Background

The UK government states that reproductive health and reproductive choice is critical because:

“Effective contraception and planning for pregnancy means that women and men stay healthy throughout life and take steps to improve the health of the baby they might have some time in the future.”²⁹

Contraception aims to prevent unintended pregnancy, which can have serious negative effects on both physical and mental health. Barrier methods of contraception (such as condoms) also protect against sexually transmitted infections (STIs). Easy access to high-quality contraception provision is therefore essential to population health and wellbeing. Research also suggests that contraception is very effective in reducing financial costs to public services, saving over £11 over a 10 year period for every £1 invested.³⁰

The following methods of non-permanent contraception are available in the UK³¹:

- Combined hormonal contraception, including the combined oral contraceptive pill (COCP), combined transdermal patch, and combined vaginal ring;
- Progestogen-only contraception, including the progestogen-only pill (POP), progestogen-only implant and progestogen-only injection;
- Intrauterine contraception, including the copper intrauterine device (IUD, or “coil”) and progestogen intrauterine system (IUS);
- Barrier methods, i.e. condoms, and diaphragm or cap plus spermicide;
- “Natural family planning” or “fertility awareness”, i.e. identifying times of the menstrual cycle when a woman is more or less likely to become pregnant.

²⁹ [Health matters: reproductive health and pregnancy planning - GOV.UK \(www.gov.uk\)](https://www.gov.uk/health-matters-reproductive-health-and-pregnancy-planning)

³⁰ [Contraceptive services: estimating the return on investment - GOV.UK \(www.gov.uk\)](https://www.gov.uk/contraceptive-services-estimating-the-return-on-investment)

³¹ [Contraception - assessment | Health topics A to Z | CKS | NICE](#)

Some methods of contraception, such as condoms and pills, rely on the user remembering to use the method consistently. Implants, IUD and IUS are often referred to collectively as “long-acting reversible contraception” (LARC), and do not rely on the user’s memory, so prevent pregnancy more reliably and effectively. Wider uptake of LARC is encouraged by national guidance due to their high effectiveness and cost-effectiveness, although individual choice remains the most important factor.

Emergency contraception can prevent pregnancy after unprotected sex or failure of contraception. This may be emergency hormonal contraception (EHC, or “the morning after pill”) or an IUD.

7.2 Overview of commissioning arrangements for contraception

Commissioning of contraception is complex. Some provision is commissioned by local authority public health, some by Clinical Commissioning Groups and some by NHS England (Table 14).

Table 14. Sexual health commissioning bodies across the sexual health system

Public health	Contraception provision via integrated sexual health services Locally commissioned public health services (LCPHS) for LARC in primary care LCPHS for emergency contraception in community pharmacies Health promotion services including C-card
CCGs	Termination of pregnancy (including contraception) Contraception for non-contraceptive purposes (e.g. for management of dysmenorrhoea/painful periods, or menorrhagia/heavy bleeding) Permanent contraception (sterilisation)
NHS England	Contraceptive advice and supply/prescribing of contraception in primary care as part of the core primary care (GMS) contract (including EHC but excluding LARC)

7.3 Contraceptive need

In Nottingham there are 91,000 women of “reproductive age” (15 to 44). In Nottinghamshire, there are 174,000 women in this age group.

The National Survey of Sexual Attitudes and Lifestyles (NATSAL) in 2013/14 estimated the percentage of women of varying ages nationally who did not need contraception (because they had not had vaginal sex in the last year, were pregnant or trying to conceive, were using permanent contraception or were no longer fertile) and those who used effective contraception (LARC), used less effective contraception (user-dependent methods) or no contraception.

Applying the national percentages to the age profile of women locally:

- In Nottingham, an estimated 52,000 women have a need for effective contraception; of these 11,500 use less effective or no contraception
- In Nottinghamshire County 97,100 women have a need for effective contraception; of these 24,900 use less effective or no contraception

This assumes that the proportion of women in each category was the same locally and nationally, and that the proportions have not changed since the survey was last undertaken in 2013/14.

7.4 Long-acting reversible contraception (LARC)

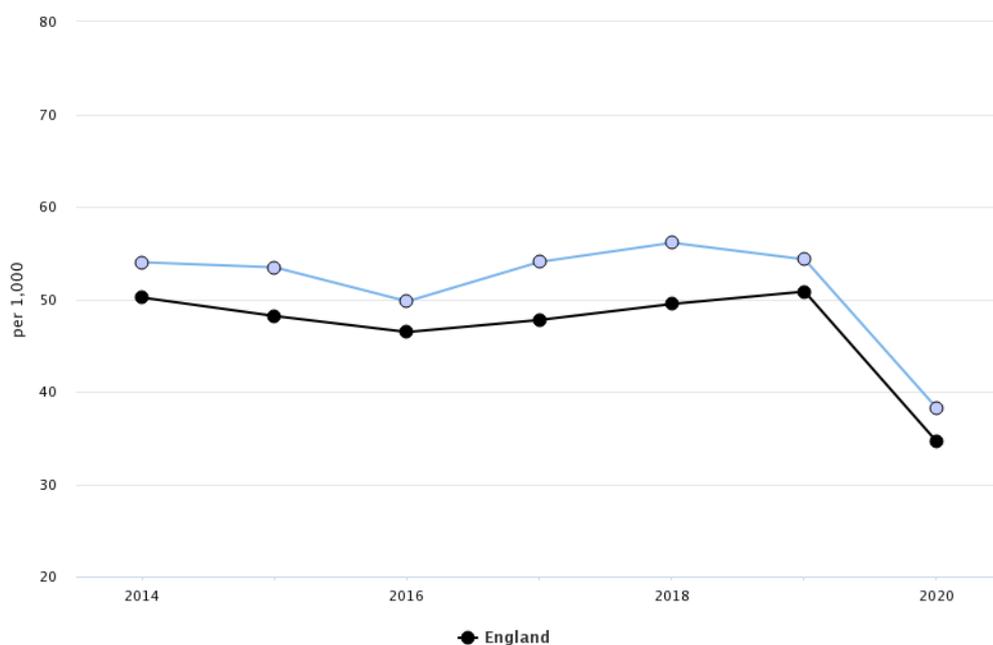
7.4.1 Total LARC prescribing

National prescribing data shows that there was a significant drop in prescribing of long-acting reversible contraception (LARC), including IUD, IUS and implants, from April 2020 with significant national recovery in prescribing by December 2020. However, no month during 2020 was prescribing above 2019 baseline rates, so significant backlogs in provision likely remain. National recovery also masks significant regional and local variation.

In Nottingham, the total rate of LARC (excluding injections) prescribed in primary care, specialist and “non-specialist” sexual health services was 38.2 per 1,000 women aged 15 to 44 years in 2020, remaining higher than the rate of 34.6 per 1,000 women in England (Figure 31) despite significant drops in the local and national rate in 2020.³² Nottingham currently ranks 5th out of 16 amongst similar local authorities and 53rd out of 149 local authorities in England. Before COVID-19, Nottingham was consistently above the England rate.

In Nottinghamshire, the total rate of LARC (excluding injections) prescribed in primary care, specialist and non-specialist sexual health services was 42.9 per 1,000 women aged 15 to 44 years in 2020. As for Nottingham, this remained higher than the rate of 34.6 per 1,000 women in England (Figure 32) despite drops in prescribing due to COVID-19. Nottinghamshire ranks 6th out of 16 similar local authorities and 36th out of 149 local authorities in England. Before COVID-19, Nottinghamshire was consistently above the England rate.

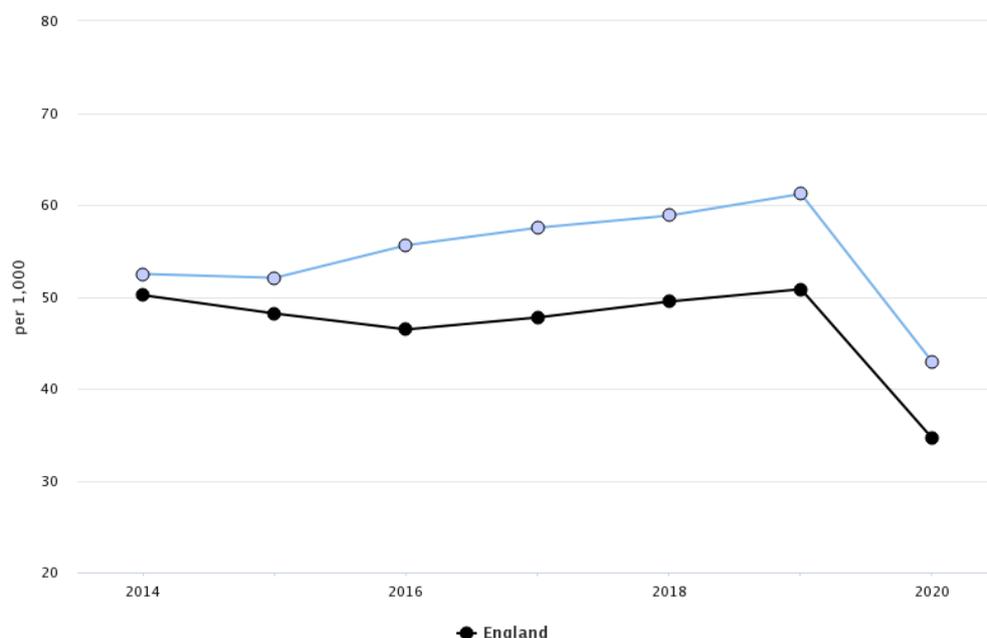
Figure 31. Total prescribed LARC excluding injections rate per 1,000 for Nottingham



Source: OHID Fingertips

³² It is unclear precisely what a non-specialist service is. A search of guidance suggests that a non-specialist service is one that is not a sexual health services, online provider, primary care setting, outreach or prison. This may refer to maternity settings or TOP clinics.

Figure 32. Total prescribed LARC excluding injections rate per 1,000 for Nottinghamshire



Source: OHID Fingertips

7.4.2 LARC prescribing in primary care

In Nottingham, the rate of LARC prescribed in primary care was 21.0 per 1,000 women in 2020, similar to the rate of 21.1 in England (Figure 33). The rate has hovered around the England rate since 2014. Nottingham ranks 6th out of 16 similar local authorities and 64th out of 149 local authorities across England.³³

In Nottinghamshire, the rate prescribed in primary care was 27.5 in 2020, higher than the rate of 21.1 in England (Figure 34). Nottinghamshire has consistently been higher than the England rate and currently ranks 9th out of 16 similar local authorities and 43rd out of 149 local authorities across England.³⁴

Using local data,

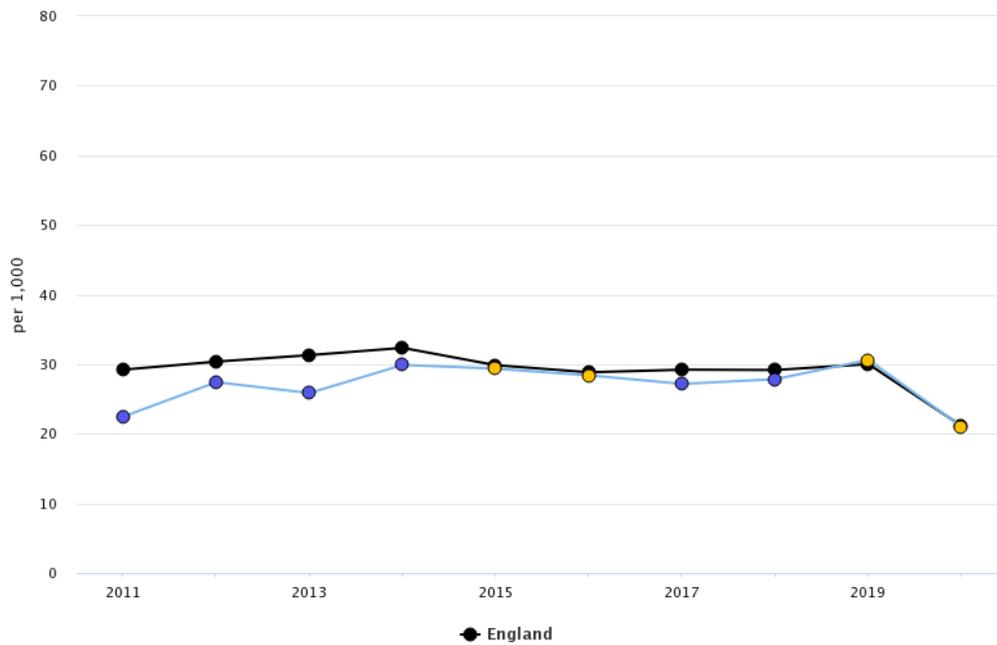
Figure 35 shows more recent GP prescribing in Nottinghamshire (excluding Bassetlaw and Nottingham City) up until the end of December 2021. This shows that the overall GP prescribing of LARC in this area is close to pre-pandemic levels, despite GP practices being under a variety of pressures. Looking at the former CCG level (data not shown), activity in 2021/22 was equal to or greater than activity in 2018/19 in all areas except Newark & Sherwood, where it was around 7% lower.

³³ Summary profile of local authority sexual health for Nottingham (January 2022).

³⁴ Summary profile of local authority sexual health for Nottinghamshire (January 2022).

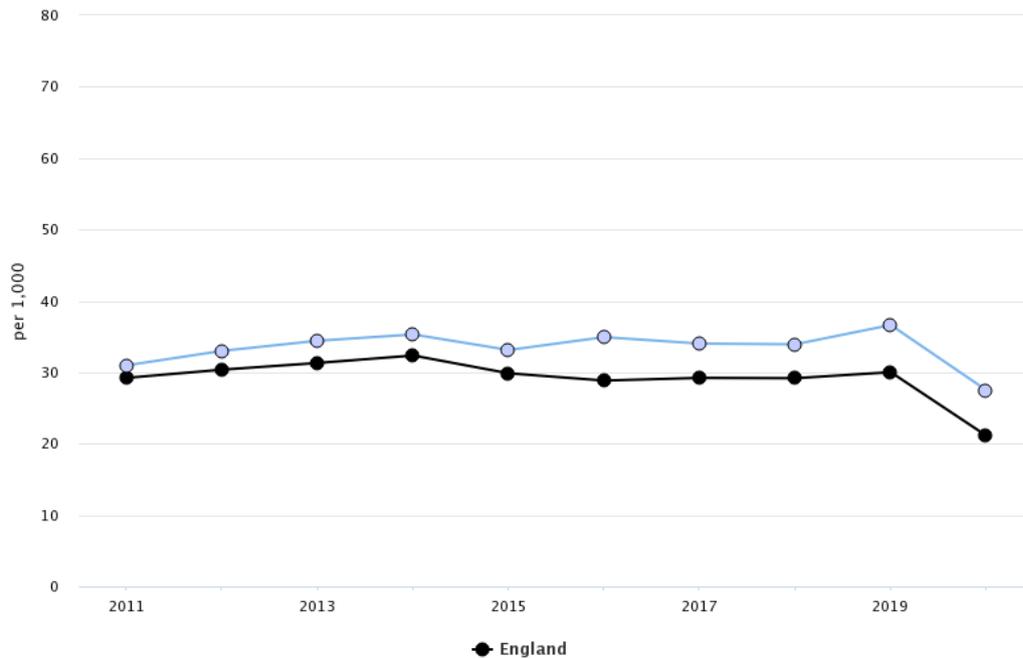
Figure 36 shows local variation in GP prescribing across Nottingham and Nottinghamshire using data from 2018-2020, with the darker green areas showing a higher crude rate of prescriptions per 100,000 women aged 15 to 44. Overall, there are higher rates of GP prescribing in the south and east of the county, i.e. Rushcliffe and Newark & Sherwood.

Figure 33. GP prescribed LARC excluding injections rate per 1,000 for Nottingham



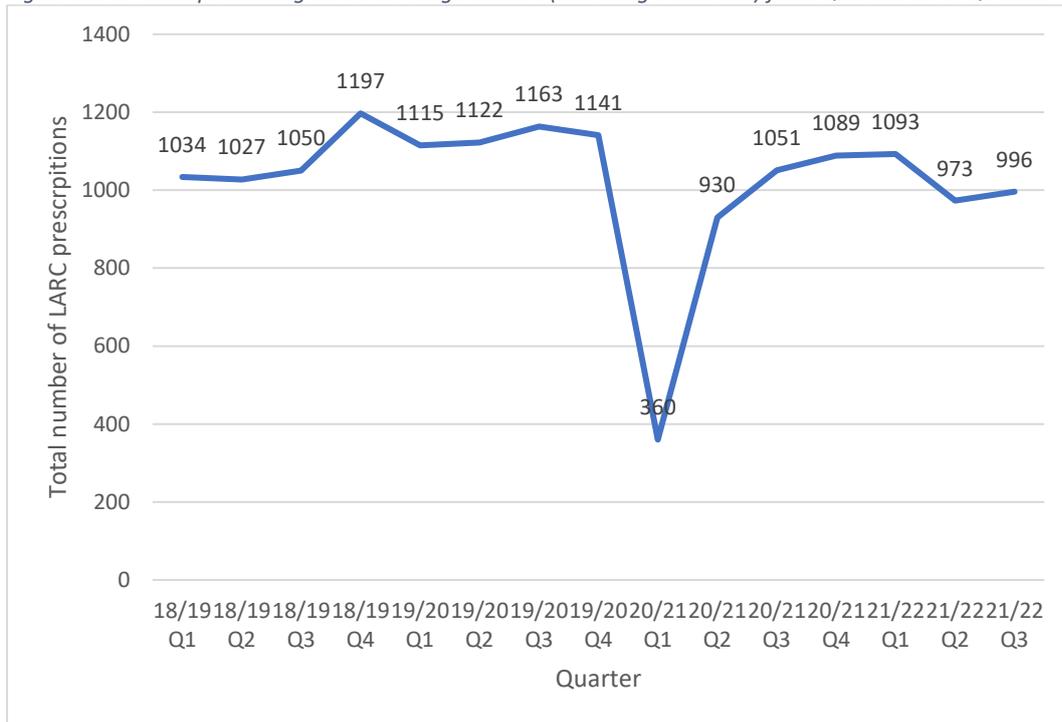
Source: OHID Fingertips

Figure 34. GP prescribed LARC excluding injections rate per 1,000 for Nottinghamshire



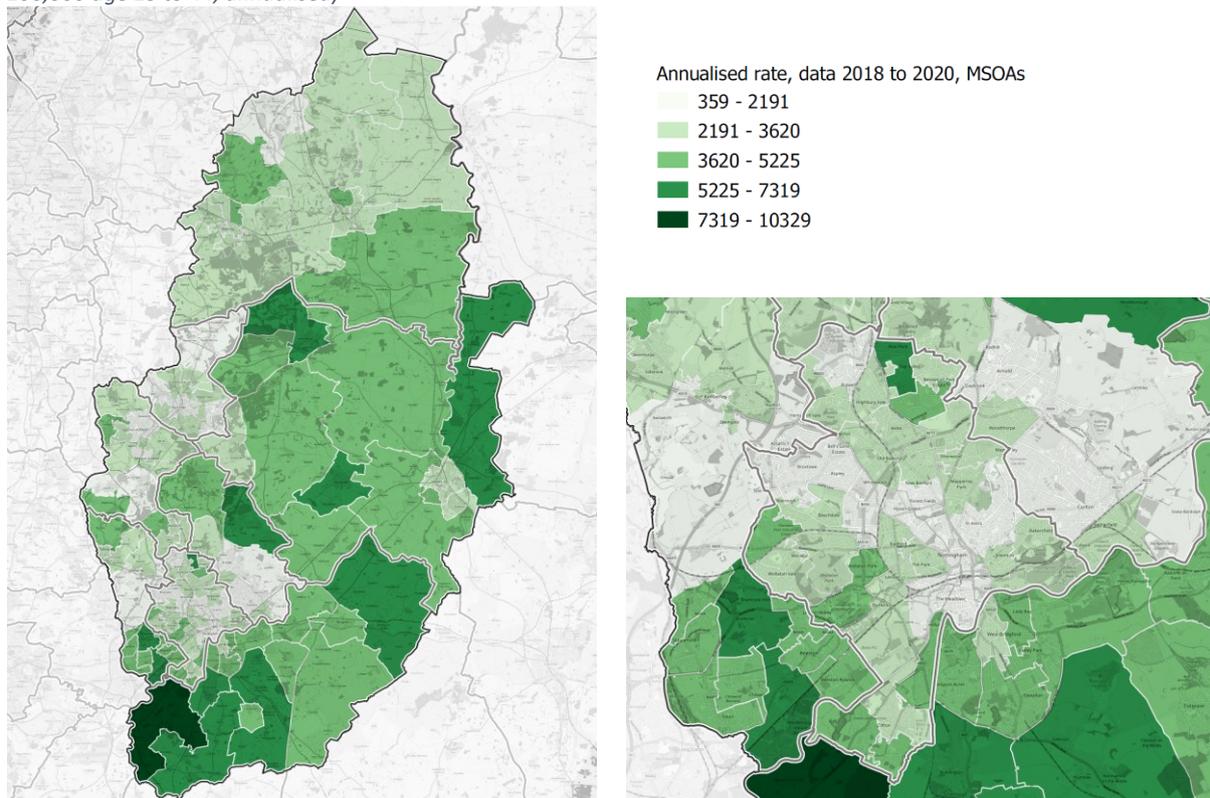
Source: OHID Fingertips

Figure 35. GP LARC prescribing across Nottinghamshire (excluding Bassetlaw) from Q1 2018-19 to Q3 2022



Source: Mid Notts and South Nottinghamshire prescribing data providing by CCG

Figure 36. GP LARC prescriptions by MSOA in Nottinghamshire (left) and Nottingham (right) 2018-2020 (crude rate per 100,000 age 15 to 44, annualised)



Sources: GP prescribed LARC from Open Prescribing, verified by comparing single year data to data on Fingertips.

7.4.3 LARC prescribing in sexual health services

In Nottingham, the rate prescribed in sexual health services was 17.2 in 2020, higher than the rate of 13.4 in England (Figure 37). The rate has always been above the England rate and Nottingham currently ranks 4th out of 16 similar local authorities and 43rd out of 149 local authorities across England. In Nottinghamshire, the rate prescribed in sexual health services was 15.4 in 2020, higher than the rate of 13.4 in England (Figure 38). The rate has always been above the England rate and Nottinghamshire currently ranks 2nd out of 16 similar local authorities and 58th out of 149 local authorities across England. These comparisons and trends are from national data which includes specialist and non-specialist sexual health services, but it is believed that virtually all LARC activity locally takes place in specialist services (ISHS).

Looking specifically at local data from ISHS, Figure 39 shows that there is variation in LARC prescribing across Nottingham and Nottinghamshire with the darker purple areas showing a higher prescription crude rate per 100,000 age 15-44. Overall, there are higher rates of LARC prescribing in Worksop, Mansfield, Ashfield and Nottingham City.

Table 15 shows the main method of contraception following the latest consultation for women in ISHS between 2017-21. It shows that LARC (implant, IUD and IUS) is the main method of contraception with 45.1% of contraception activity in Nottingham and 45.5% in Nottinghamshire. This is closely followed by contraceptive pills (combined and POP).

Figure 37. ISHS prescribed LARC excluding injections rate per 1,000 for Nottingham

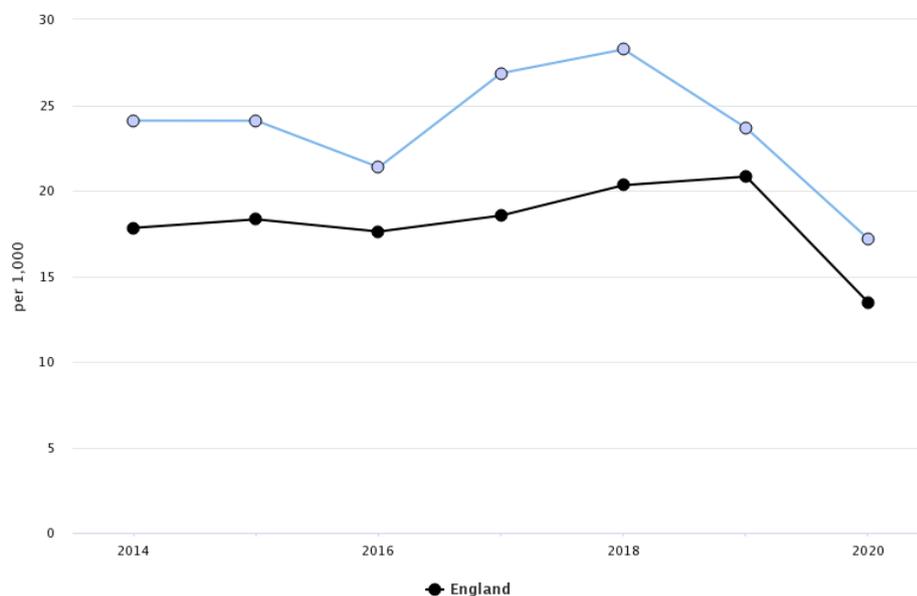


Figure 38. ISHS prescribed LARC excluding injections rate per 1,000 for Nottinghamshire

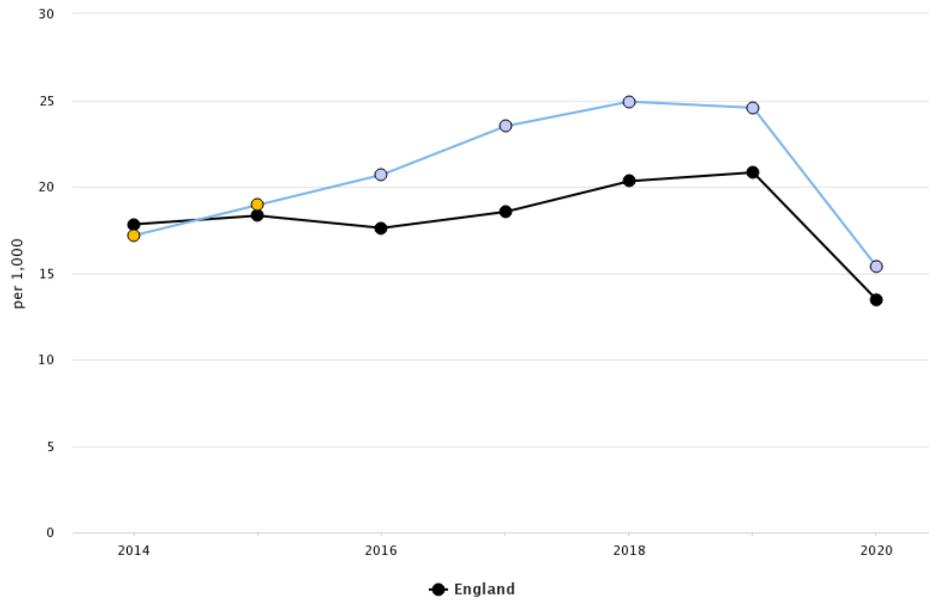
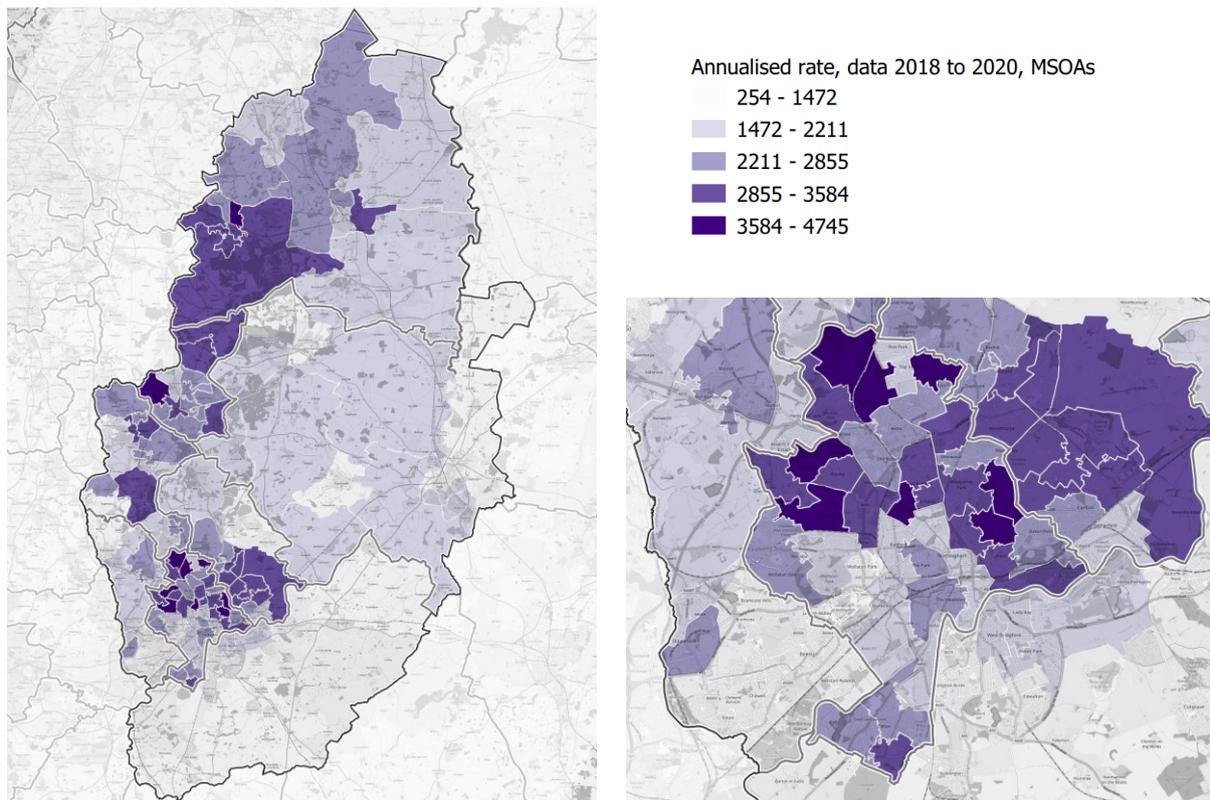


Figure 39. ISHS LARC prescriptions by MSOA in Nottinghamshire (left) and Nottingham (right) 2018-2020 (crude rate per 100,000 age 15 to 44, annualised)



Sources: ISHS row-level dataset, verified by comparing single year data to data on Fingertips.

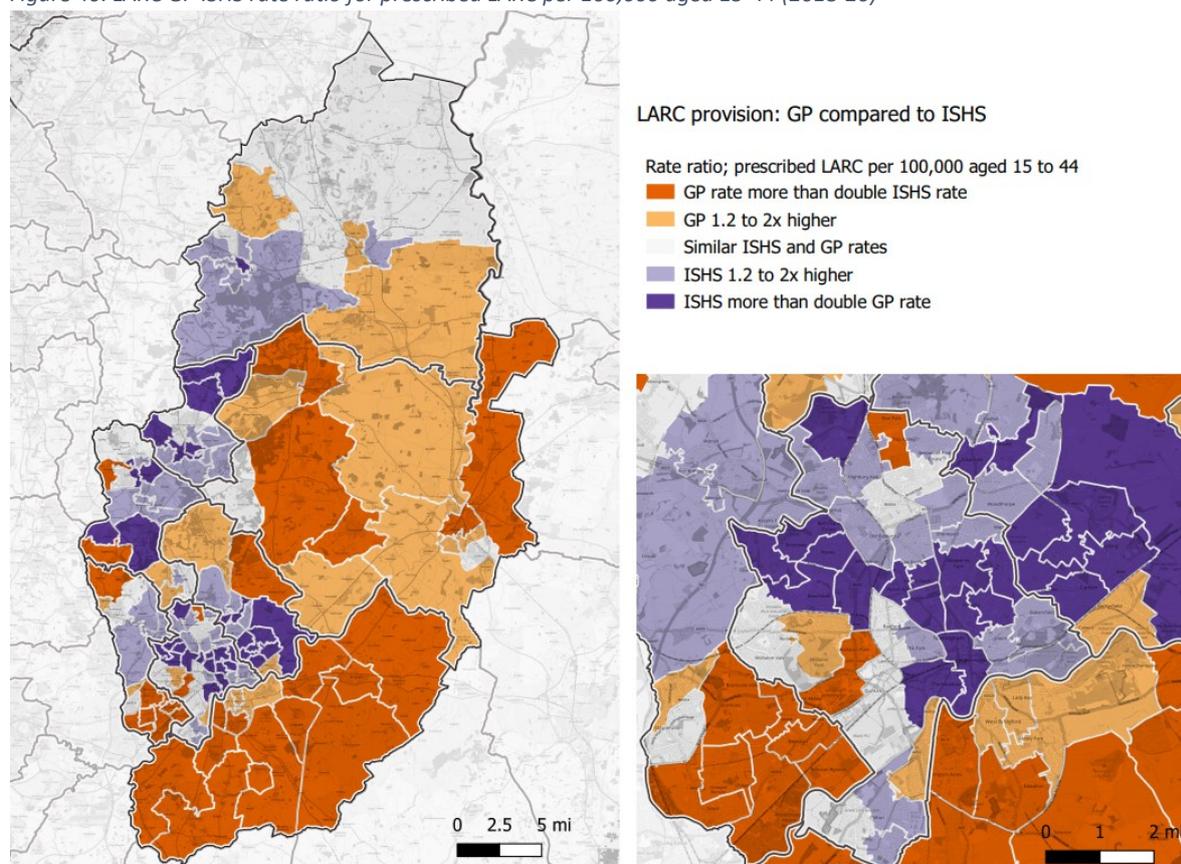
Table 15. Main method of contraception following latest consultation for women in ISHS 2017-21

Contraception method	Nottingham		Nottinghamshire	
	Number	%	Number	%
Implant	4105	19.5	5851	20.9
IUD	2539	12.1	2394	8.5
IUS	2893	13.8	4394	15.7
Patch	403	1.9	365	1.3
Injectable contraception	1105	5.3	2211	7.9
Pills (combined + POP)	7287	34.7	10,189	36.3
Male condoms	2512	12.0	2440	8.7
Other (female condoms, cap/diaphragm, vaginal ring, “natural family planning”)	176	0.8	213	0.8
TOTAL	21,020	100	28,057	100

Source: ISHS row-level dataset, verified by comparing single year data to data on Fingertips.

7.4.4 Comparing GP and ISHS LARC provision

Figure 40. LARC GP ISHS rate ratio for prescribed LARC per 100,000 aged 15-44 (2018-20)



Sources: ISHS row-level dataset, GP prescribed LARC from Open Prescribing, verified by comparing single year data to data on Fingertips.

In Nottingham, the proportion of LARC prescribing taking place in GP varied between 50 to 57% between 2014 and 2020. In Nottinghamshire, roughly 60% or more of LARC prescribing takes place in GP, each year from 2014 to 2020. However, this varies widely across the county. In Figure 40, areas in dark orange are where GP LARC prescribing rates more than double the ISHS rate. These areas include:

- nearly all of Rushcliffe and Newark & Sherwood,
- parts of Broxtowe (including the Beeston, Chilwell and Bramcote areas),
- northern parts of Gedling (including Calverton and Ravenshead areas),
- some parts of Nottingham city (one centred around University Park and one Top Valley/Rise Park).

The areas in dark purple show where ISHS prescribing of LARC is more than double GP prescribing and areas in lighter purple show ISHS prescribing is higher than GP but less than double. These areas include:

- all of Mansfield,
- most of Nottingham city,
- most of Ashfield,
- southern parts of Gedling (including Carlton, Woodthorpe, Arnold, Lambley).

Figure 40 shows that the provision of LARC varies dramatically across city and county. In general, it appears that areas close to ISHS “hubs” tend to have higher rates of ISHS prescribing, but this is not universally the case and it is likely that multiple factors are involved.

Figure 40 includes data from 2018, 2019 and 2020 so does not show the changes in access to LARC since 2020. Access to LARC fittings and removals were particularly impacted by the pandemic due to the requirements for face-to-face interactions. As well as a lack of access to services, people may have avoided seeking contraception due to fear of acquiring COVID-19 or due to changes in sexual behaviour. As services have started to restore, there is anecdotal evidence that there is reduced access to LARC in primary care; however, activity data shows that GP LARC activity across Nottinghamshire is at around 90% of pre-pandemic levels. This mismatch may be due to some additional demand due to a backlog arising from national advice during the early pandemic to continue to use many LARC devices for a longer period than usual, to avoid unnecessary face-to-face appointments. Some areas with high ISHS LARC prescribing may reflect patient preference to travel to a nearby ISHS hub for convenience, whilst others may reflect lower access in primary care.

Overall, the analysis of what is happening is complex and may in turn require a bespoke solution in a particular area to address that issue. Local provision in primary care can be affected by a number of factors including access to training, the time and financial demands of training, high demand on primary care for other (non-contraception) appointments and services, availability of suitable rooms and staff to chaperone, and the price paid by the local authority per intervention. These issues could change quickly in a particular area – for example, if a particular staff member leaves. Many of the issues affecting LARC provision in primary care are highlighted in the report ‘*Workforce Needs*

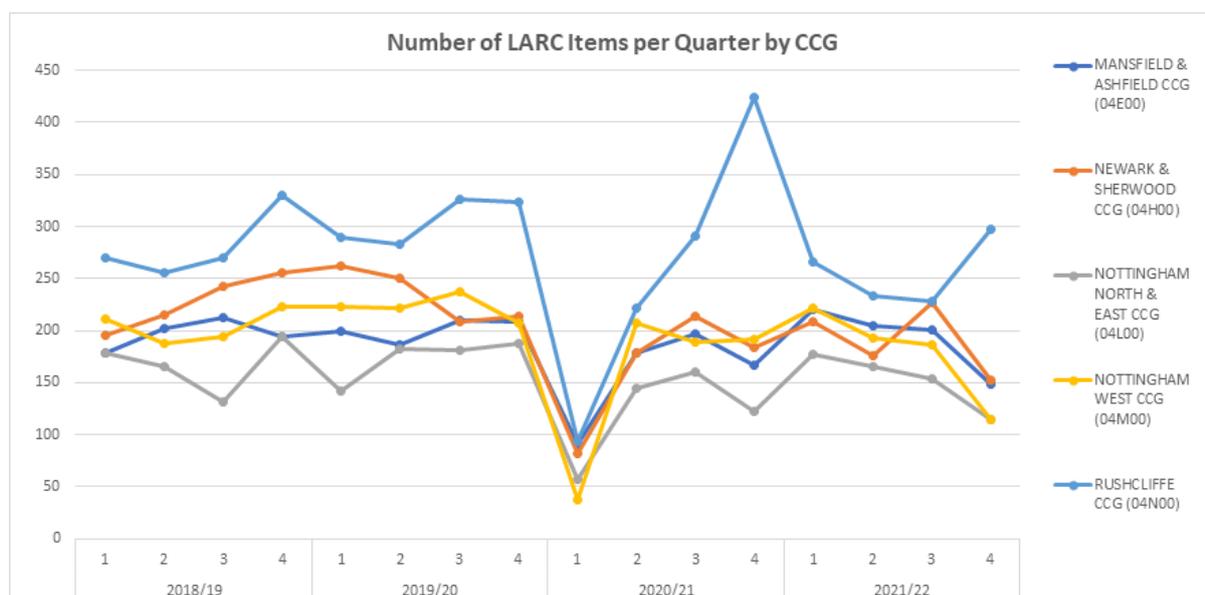
Assessment to deliver patient access, provision and sustainability of Long-Acting Reversible Contraception (LARC) in primary care' by the Primary Care Women's Health Forum³⁵.

7.5 Mapping of LARC provision in primary care

In Nottinghamshire, there is a total of 89 GP practises 72 (81%) are under contract with Nottinghamshire County Council to prescribe LARC, while 17 are not (19%). These practises are grouped into 15 Primary Care Networks (PCN). In this section, the latest LARC prescription data has been analysed to map out provision in primary care³⁶.

Figure 41 shows LARC prescription activity in Nottinghamshire (not including Nottingham or Bassetlaw) has largely restored to pre-pandemic levels at a CCG level. At a PCN level Table 16 (not including Nottingham or Bassetlaw), shows LARC provision has also mostly returned to pre-pandemic levels. In some cases, provision has risen (as in Ashfield South). Where provision is lower (as in Newark), this appears to be due to individual practices rather than area wide. However, comparisons between individual practices are not included here because of the small numbers of LARC involved, and variations in reporting from quarter to quarter, making comparisons difficult. It is also important to take into account contextual factors to understand why provision may have changed at a given practice.

Figure 41. GP LARC activity by CCG area 2018/19 to 2021/22



Source: LARC prescription data provided by Nottingham and Nottinghamshire CCG

³⁵ [Access, provision and sustainability of LARC in primary care | Primary Care Women's Health Forum \(pcwhf.co.uk\)](https://pcwhf.co.uk)

³⁶ A pivot table was created using the data to breakdown the level of LARC activity by GP practise, covering the pre-pandemic period to March 2022. This has helped to identify trends and understand whether LARC provision has recovered and resumed to pre-pandemic levels.

Table 16 GP LARC activity by PCN

PCN	Number of LARC Items				Trend
	2018/19	2019/20	2020/21	2021/22	
Arnold and Calverton PCN	230	215	139	219	No change
Arrow Health PCN	11	23	27	40	No change
Ashfield North PCN	221	239	203	257	No change
Ashfield South PCN	186	147	109	216	Increase
Byron PCN	299	352	291	349	No change
Mansfield North PCN	209	214	169	219	No change
Newark PCN	495	504	318	410	Decrease
Nottingham West PCN	876	940	645	874	No change
Rosewood PCN	211	231	190	200	No change
Rushcliffe PCN	1009	1113	957	1035	No change
Sherwood PCN	361	378	321	375	No change
Synergy PCN	187	184	61	156	No change
Total	4295	4540	3430	4350	

Source: LARC prescription data provided by Nottingham and Nottinghamshire CCG. Trend compares 2019/20 to 2021/22 using Poisson confidence intervals. Where confidence intervals overlap, this is indicated as “no change”.

In Nottingham 39 of the 47 (83%) practices are under contract with Nottingham City Council to prescribe LARC. Figure 42 and Table 17 show the trend prior to and since the onset of COVID-19 in 2020. Of the 8 PCNs in Nottingham the LARC activity in 5 PCNs has returned to that of what it was prior to the pandemic or slightly increased. LARC activity in 3 PCNs (Radford and Mary Potter PCN, Clifton and Meadows PCN and Bulwell and Top Valley PCN) has reduced since 2019/20.

Figure 42 LARC provision in General Practice in Nottingham by PCN 2018-2022

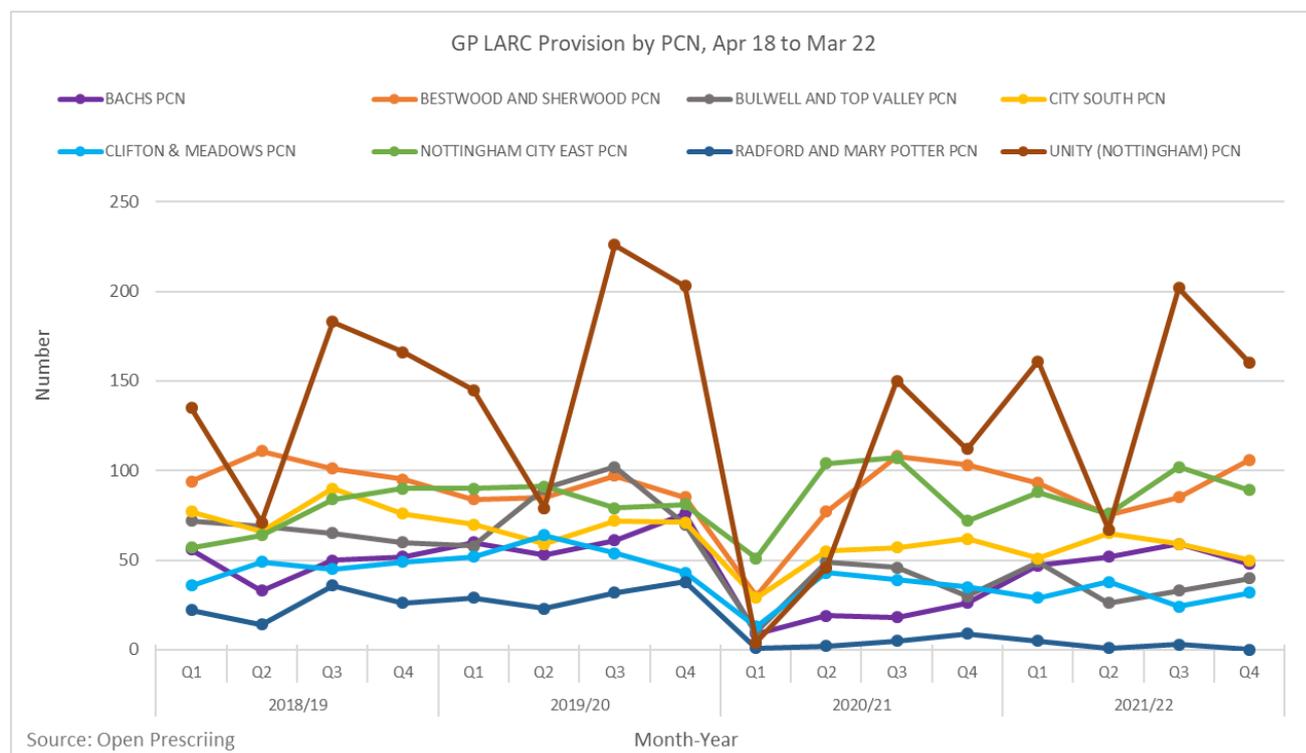


Table 17 LARC activity by Nottingham PCN 2018/19 to 2021/22

PCN	Number of LARC Items				Trend
	2018/19	2019/20	2020/21	2021/22	
Unity (Nottingham) PCN	555	653	312	590	No change
Bestwood and Sherwood PCN	401	351	318	359	No change
Nottingham City East PCN	295	341	334	355	No change
City South PCN	309	272	203	225	No change
Bulwell and Top Valley PCN	266	320	135	148	Decrease
BACHS PCN	191	250	72	206	No change
Clifton & Meadows PCN	179	213	130	123	Decrease
Radford and Mary Potter PCN	98	122	17	9	Decrease

Source: Open Prescribing.net. Trend compares 2019/2020 to 2021/22 using Poisson confidence intervals. Where confidence intervals overlap, this is indicated as “no change”

7.6 Emergency hormonal contraception

7.6.1 EHC in pharmacies

Nottinghamshire County Council and Nottingham City Council commission local community pharmacies to provide free Emergency Hormonal Contraception (EHC) as part of a locally commissioned public health service (LCPHS). In Nottinghamshire, this is available to anyone of any aged over 13, whilst in Nottingham it is available to under 25s.

It is also possible for women aged 16 and over to purchase EHC over-the-counter without a prescription at a pharmacy, and both EHC and intrauterine emergency contraception can be accessed via ISHS and primary care (though not all primary care providers may be able to provide intrauterine methods). Nationally there has been a fall in emergency contraception over the last ten years. There was a notably larger fall of 44% from 2019/20 to 2020/21 in SRH services and 18% in GP and pharmacy settings (though this data does not include provision through LCPHS arrangements), likely due to changes in behaviour during the COVID-19 pandemic.³⁷

In Nottinghamshire, there are currently 80 pharmacies accredited to deliver EHC as part of the LCPHS (out of around 118 pharmacies in total) but only 67 who have recorded at least one interaction with a patient or prescription made. In 2021-22, 2247 interactions with these services were made in Nottinghamshire and 2226 prescriptions/medications were given out. Figure 43 shows the number of provisions or interactions by community pharmacies. Data is missing from August 2019³⁸ but the overall trend is that after a sharp decline followed by a recovery around the first COVID-19 lockdown. EHC activity is not consistently reaching pre-pandemic levels and may be decreasing from a peak in August 2021, although this could also reflect seasonal trends in sexual behaviour. Reduced levels of

³⁷ [Part 3: Emergency contraception - NHS Digital](#)

³⁸ This may be due to changes within the PharmOutcomes portal

activity could reflect changes in sexual behaviour, changes in behaviour in accessing services, or changes in service provision.

Figure 44 shows that most patients using the service are between 20-25 years, closely followed by patients between 16-19 and 25-29 years. Over 50% of those accessing the service are aged over 25.

Table 18 shows the ten most active community pharmacies that deliver EHC. There are a small number of pharmacies undertaking particularly high levels of activity in relation to EHC, notably Boots pharmacies at two retail parks (Giltbrook, Newark). This may be due to patients being directed to these pharmacies as they are well known to sexual health services and primary care. There are anecdotal reports that people cannot always consistently access free EHC from pharmacies that are under contract from the local authority.

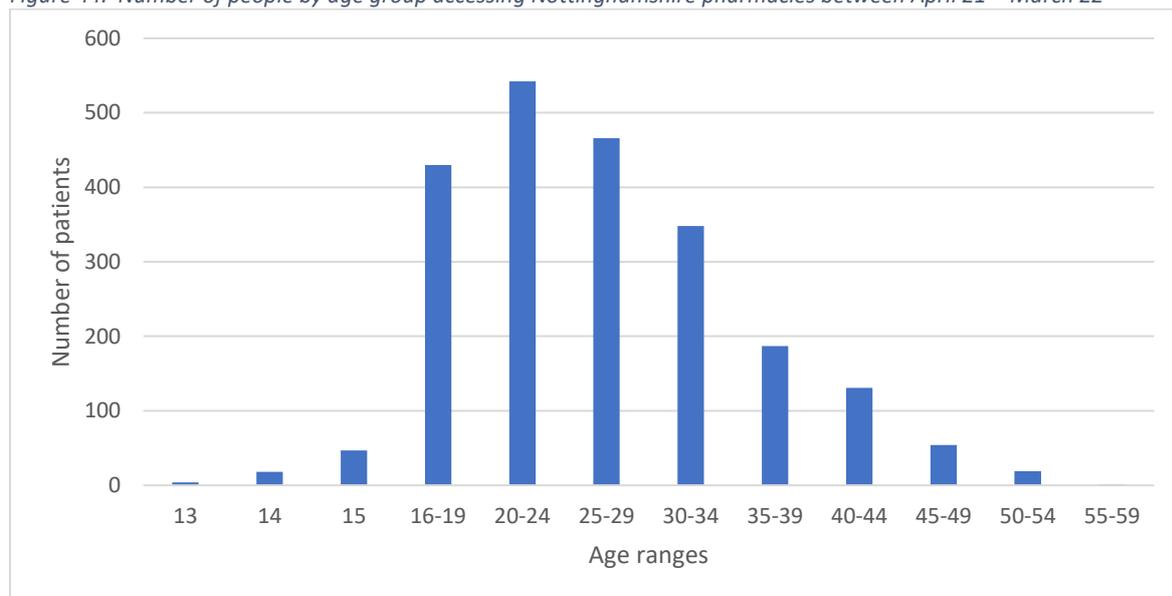
In Nottingham City currently 22 of the 63 (35%) pharmacies are delivering EHC. Data on provision of EHC is pending.

Figure 43. Number of patient interactions for EHC in community pharmacy from April 2019 to April 2022



Source: PharmOutcomes

Figure 44. Number of people by age group accessing Nottinghamshire pharmacies between April 21 – March 22



Source: PharmOutcomes

Table 18. Top 10 active community pharmacies for delivering EHC services in Nottinghamshire (April 21-March 22)

Pharmacy	Number of people
Boots Pharmacy - Giltbrook	248
Boots Pharmacy - Newark, Northgate Retail Park	193
Medina Chemist (Netherfield)	122
Harts Chemist (Hucknall)	109
Manor Pharmacy (Arnold)	103
Boots Pharmacy (Newark, Stodman St)	90
Bridgegate Pharmacy (Retford)	75
Manor Pharmacy (Brook Street Sutton-in-Ashfield)	70
WM Morrison Pharmacy (Gamston)	70
Manor Pharmacy (Loughborough Road)	66

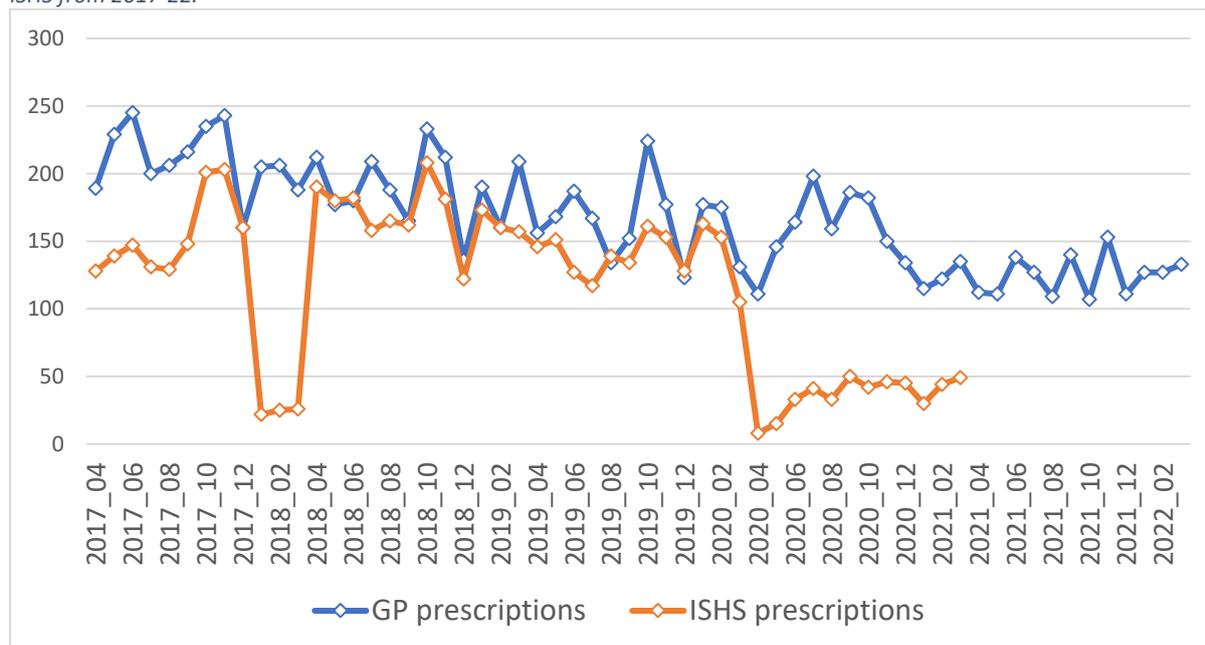
Source: PharmOutcomes

7.6.2 EHC in ISHS and primary care

EHC can also be accessed via primary care and ISHS. Using data from Open Prescribing, in 2021-22, 1492 prescriptions were issued from primary care across Nottinghamshire compared to 2226 items issued in pharmacies.

Figure 45 shows emergency contraception prescribed (including both EHC and IUDs) in primary care and ISHS from 2017-22. In primary care there appears to have been a gradual decline over time, whilst in ISHS a sharp drop in 2020 had not returned to pre-pandemic levels by April 2021. Alongside the reduction in EHC activity in pharmacies, this requires further work to ensure people can access EHC if required.

Figure 45. Emergency contraception prescribed (number of items: hormonal contraception and IUDs) in primary care and ISHS from 2017-22.



Source: Pseudonymised service data from ISHS providers, April 2017 to March 2021; OpenPrescribing, March 2017 to March 2022

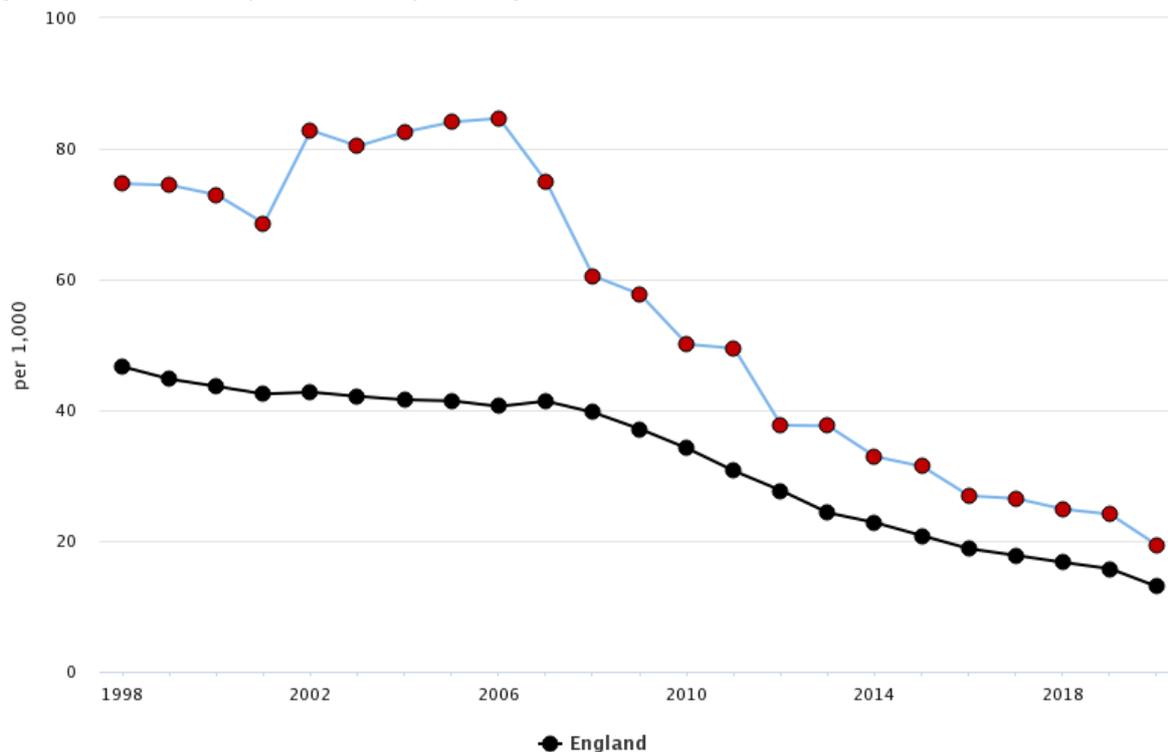
7.7 Teenage pregnancy

Teenage pregnancy is both a cause and consequence of inequalities in education and health for young parents and their children. Babies born to mothers under 20 years consistently have a higher rate of stillbirth, infant mortality and low birthweight than average, though the difference fluctuates from year to year due to relatively low numbers.

In 2019, the under-18s conception rate per 1,000 females aged 15 to 17 years in Nottingham was 19.3 (Figure 46), worse than the rate of 15.7 per 1,000 in England.

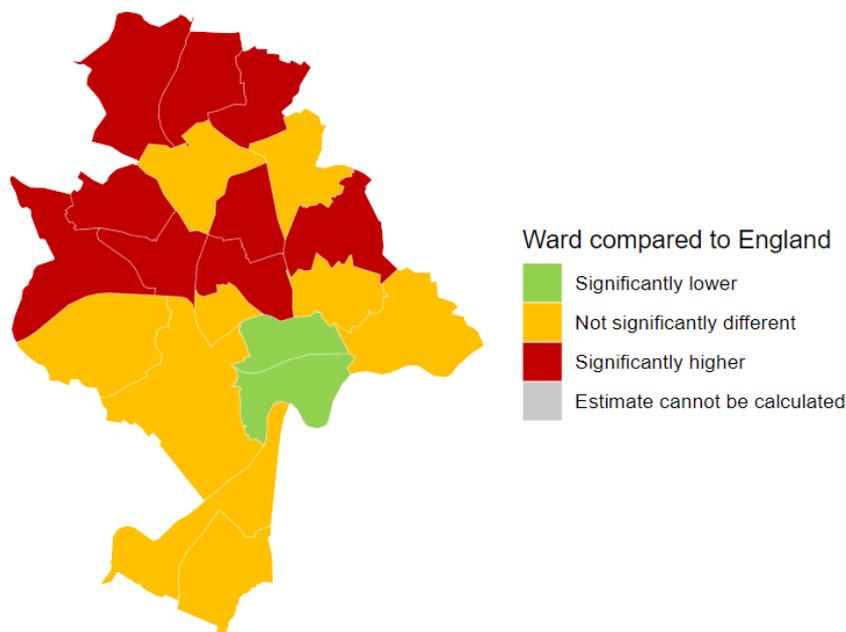
The rank within England for the under-18s conception rate was 17th highest out of similar local authorities. Nottingham has significantly reduced the gap in under 18 pregnancies since 2006. Figure 47 shows Under-18s conceptions in Nottingham by ward, compared to England: three-year period between 2017-19. The map highlights rates in the north of the city were statistically significantly higher than that of England whereas wards in the south of the city were similar or lower than the England rate.

Figure 46. Under 18s conception rate/1,000 for Nottingham



Source: OHID Fingertips

Figure 47. Under-18s conception in Nottingham by ward, compared to England: three-year period between 2017 – 19

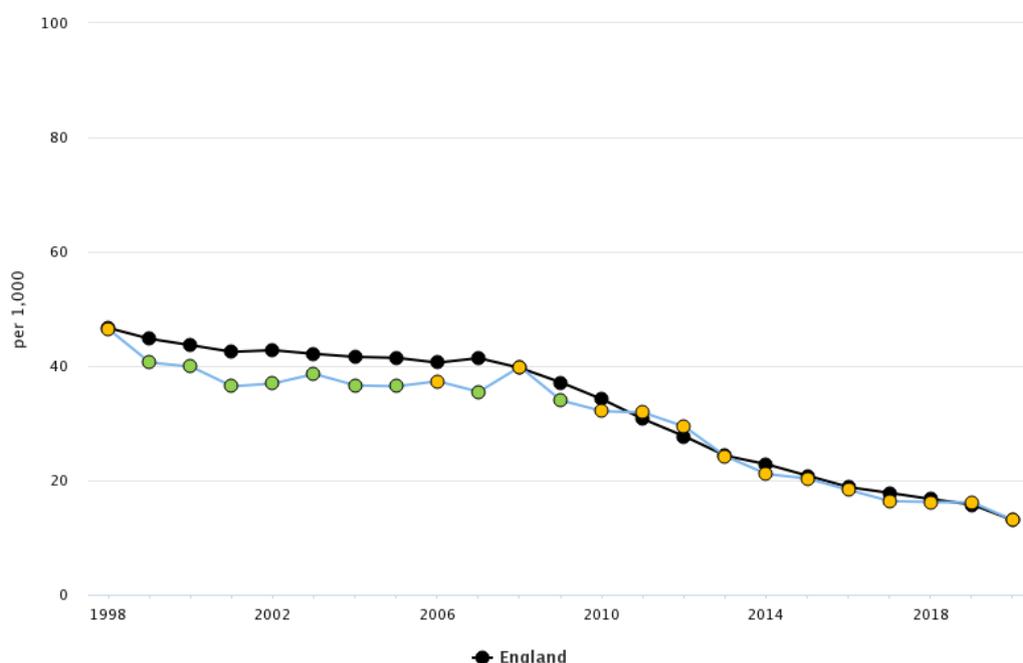


Source: ONS conception statistics Nottingham SPLASH report PHE Fingertips

In Nottinghamshire, the under-18s conception rate per 1,000 females aged 15 to 17 years in 2019 was 16.1, similar to the rate of 15.7 per 1,000 in England (Figure 48). The change from 2018 was 0%. The rank within England for the under-18s conception rate was 79th highest (out of 149 UTLAs/UAs).

Between 1998 and 2019, the decrease in the under-18s conception rate in Nottinghamshire was 65%, compared to a 66% decrease in England.

Figure 48. Under 18s conception rate/1,000 for Nottinghamshire



Source: OHID Fingertips

7.8 Abortions

7.8.1 Total abortions

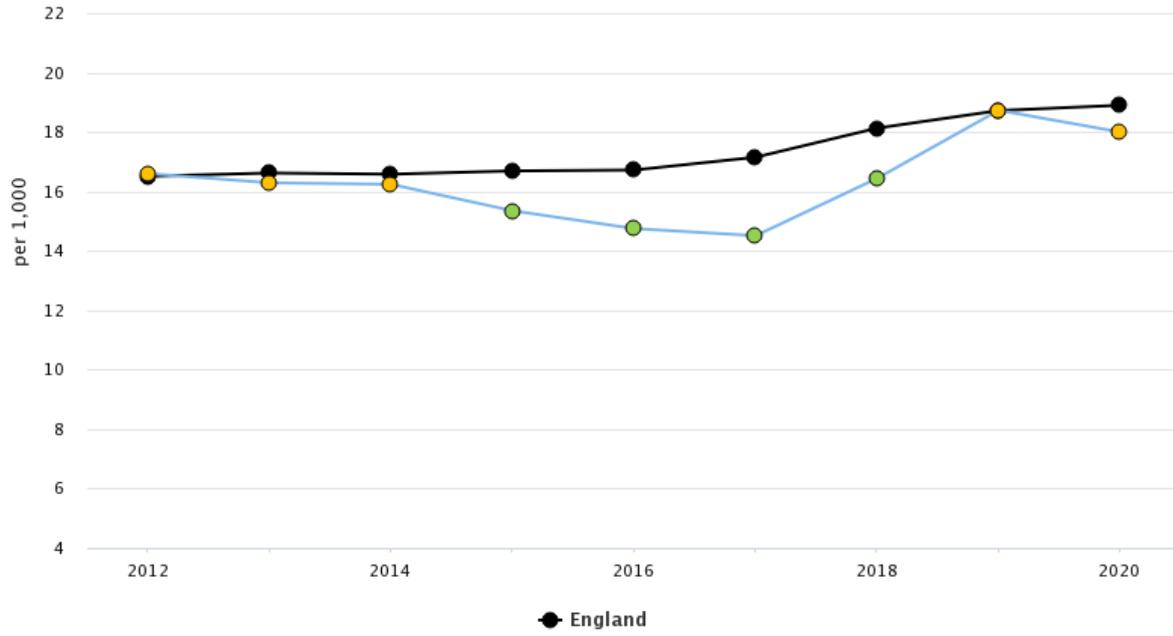
The total abortion rate, under 25 years repeat abortion rate, under 25 years abortions after a birth, and over 25 years abortion rates may be indicators of lack of access to good quality contraception services and advice, as well as problems with individual use of contraceptive method.

In Nottingham the total number of abortions in 2020 was 1,488. The total abortion rate per 1,000 female population aged 15 to 44 years was 18.0, similar to the rate in England of 18.9 per 1,000 (Figure 49). Nottingham rank 92nd (out of 149 UTLAs/UAs) within England. Of those women over 25 years the rate was 19.7/1000 in 2020 which was above the England rate of 17.6 (Figure 50). Nottingham has been around the England rate since 2014 but the trend has been increasing over time.

In Nottinghamshire the total number of abortions in 2020 was 2,388. The total abortion rate per 1,000 female population aged 15 to 44 years (Figure 51) was 16.6, lower than the rate in England of 18.9 per 1,000.

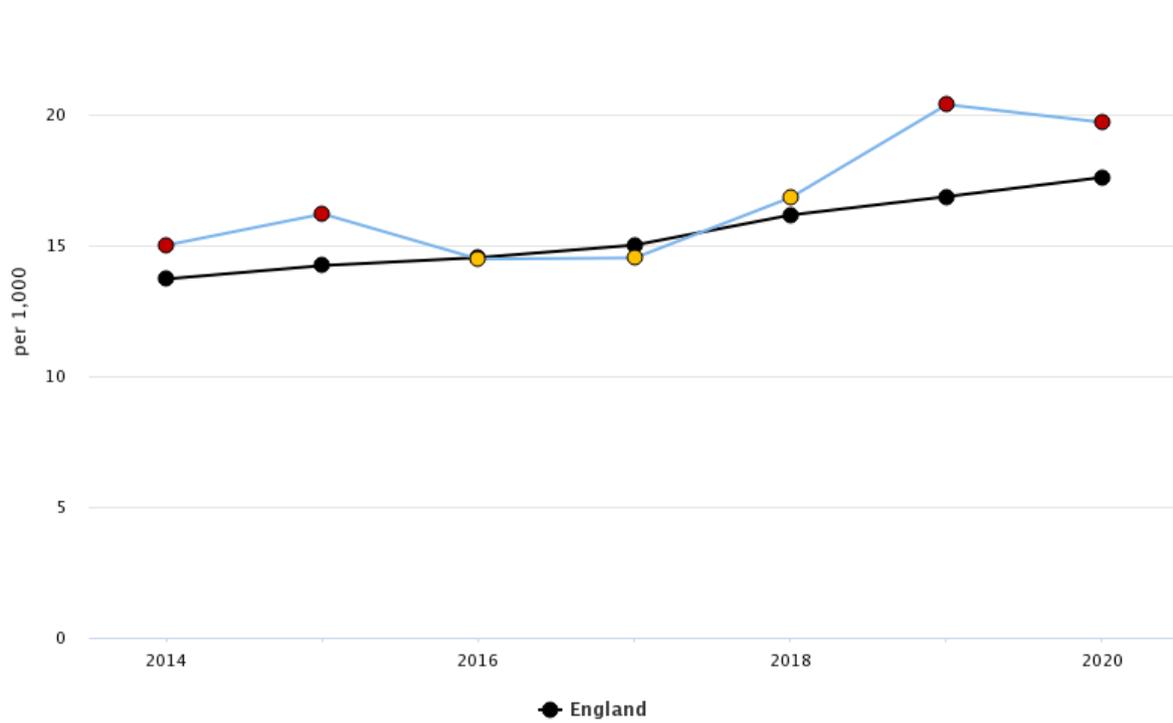
Nottinghamshire rank 102nd (out of 149 UTLAs/UAs) within England for the total abortion rate. Of those women over 25 years the rate was 14.8/1000 in 2020 which was below the England rate of 17.6 (Figure 52). Nottinghamshire has been below the England rate since 2014 but is increasing.

Figure 49. Total abortion rate /1000 for Nottingham 2014-2020



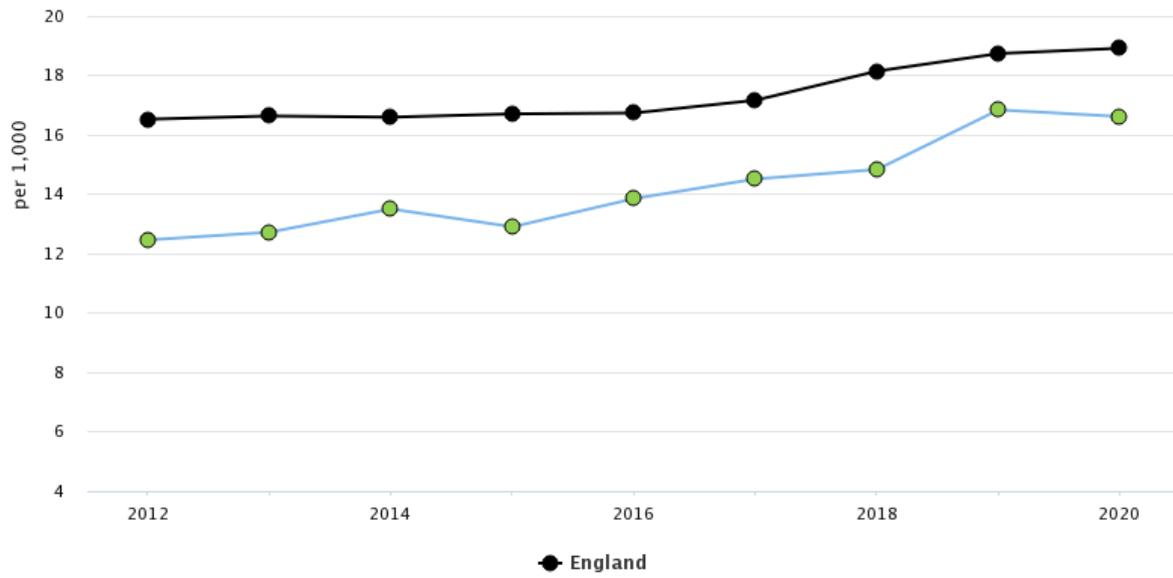
Source: OHID Fingertips

Figure 50. Over 25s abortion rate /1000 for Nottingham 2014-2020



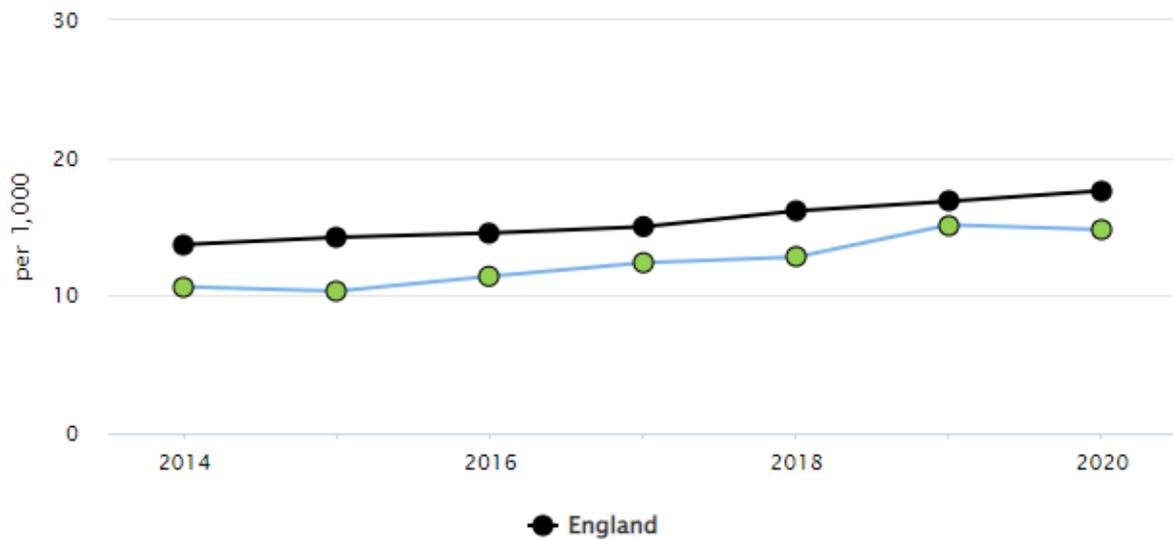
Source: OHID Fingertips

Figure 51. Total abortion rate /1000 for Nottinghamshire 2014-2020



Source: OHID Fingertips

Figure 52 Over 25s abortion rate /1000 for Nottinghamshire 2014-2020



Source: OHID Fingertips

7.8.2 Abortions under 10 weeks

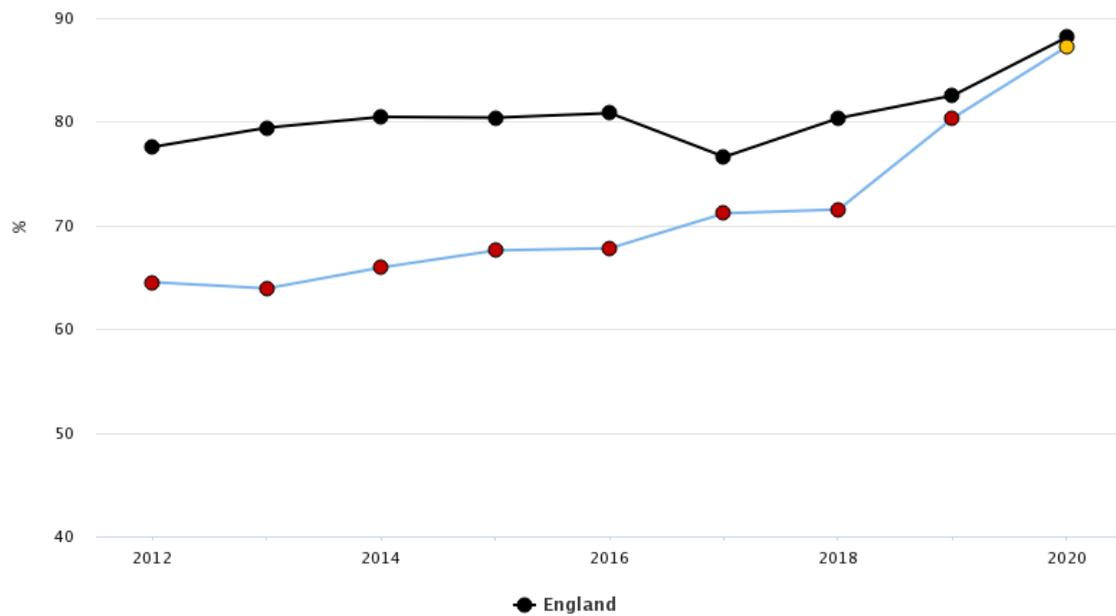
The earlier abortions are performed the lower the risk of complications, such as bleeding and pain. Prompt access to abortion, enabling provision earlier in pregnancy, is also cost-effective and an indicator of service quality. Whilst this indicator is largely influenced by availability and accessibility of

abortion services, information provision and prompt referral/signposting from sexual health services is an important aspect.

In Nottingham, the percentage of NHS-funded abortions that were under 10 weeks was 87.2% in 2020, similar to the percentage in England of 88.1 (Figure 53). The rank within England for this indicator was 105th highest (out of 149 UTLAs/UAs).

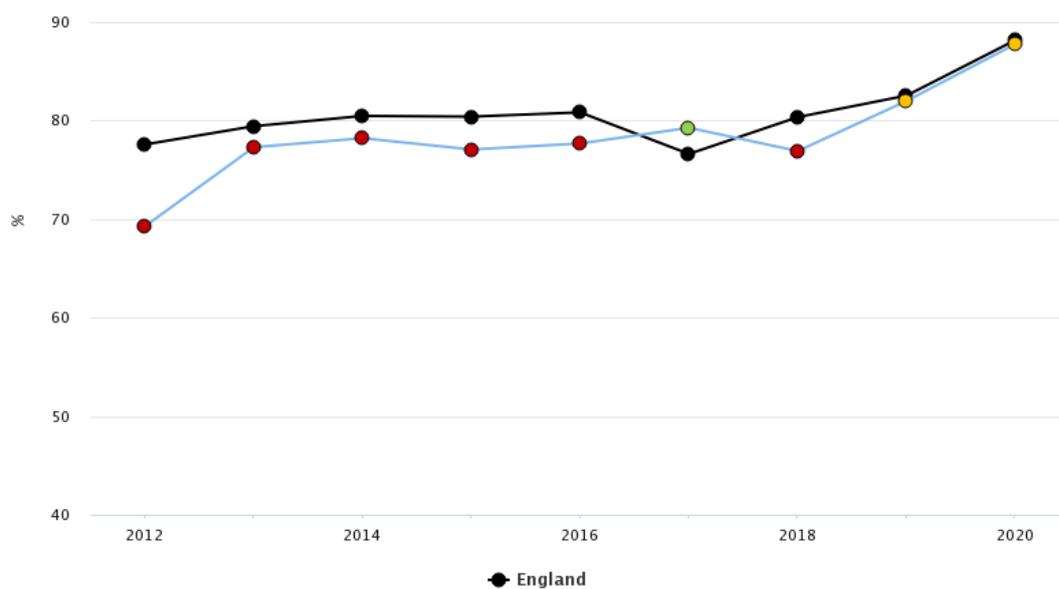
In Nottinghamshire, the percentage of NHS-funded abortions that were under 10 weeks was 87.7% in 2020, similar to the percentage in England of 88.1 (Figure 54). The rank within England for this indicator was 95th highest (out of 149 UTLAs/UAs).

Figure 53. Abortions under 10 weeks for Nottingham 2012-2020



Source: OHID Fingertips

Figure 54. Abortions under 10 weeks for Nottinghamshire 2012-2020



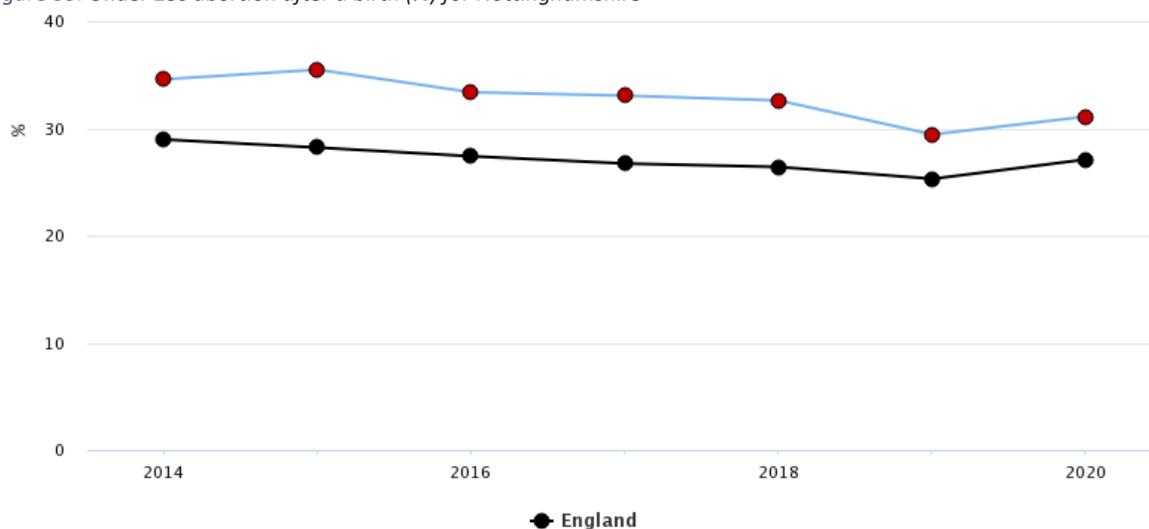
Source: OHID Fingertips

7.8.3 Under 25s abortion after a birth

Ensuring women have access to a method of contraception of their choice post-abortion is recommended practice. Provision of LARC methods post-abortion has been shown to lower subsequent unintended pregnancy rates.

In Nottingham, the proportion of those under 25 years who had an abortion after a birth was 27.2% which is in line with the England proportion 27.1%. However, in Nottinghamshire this proportion is 31.1% (Figure 55) which is higher than that of England. This may be an indicator of need for post-partum contraception.

Figure 55. Under 25s abortion after a birth (%) for Nottinghamshire



7.9 Key points: reproductive health and contraception

7.9.1 LARC

- Total prescribing of LARC in primary care in Nottinghamshire (excluding Bassetlaw and Nottingham City) is close to pre-pandemic levels. This is also the case in most PCNs in Nottinghamshire. However, there is substantial geographical variation in prescribing rates in primary care.
- In general, it appears that areas close to ISHS “hubs” tend to have higher rates of ISHS prescribing, but this is not universally the case and it is likely that multiple factors are involved.
- Because of the complexity and differences in LARC provision and access geographically, a single solution may not be appropriate. Factors like the number of local fitters and clinic capacity are important. It is important that a newly commissioned ISHS service can adapt to changing local circumstances and support the local system in increasing availability of LARC.
- Comparing LARC provision before (2019/20) and after (2021/22) the interruption of services due to COVID-19, in most PCNs there is no significant difference. In Newark PCN, LARC activity has significantly decreased whilst in Ashfield South it has increased.

7.9.2 EHC

- Provision of EHC by community pharmacies has not returned to pre-pandemic levels. There are multiple possible reasons for this which should be explored.
- Further analysis is required to collate EHC data across pharmacies, primary care and ISHS. Early analysis suggests that EHC prescriptions/activity are lower than pre-pandemic levels, particularly in pharmacy and ISHS, and further work is required to ensure people can access EHC when they need it.
- Any changes to age eligibility for EHC should be carefully considered as within Nottinghamshire, the majority of people accessing the service are over 25 years old.
- The data on EHC in pharmacies does not capture anecdotal reports about people not always being able to access free EHC when they use a pharmacy that is under contract. A separate piece of work should be undertaken to review whether and why people cannot always access EHC from pharmacies that are contracted by the local authority.

7.9.3 Teenage pregnancy and abortions

- Whilst teenage pregnancy levels have dropped significantly, the impact on families and services is still high. There are still areas within Nottingham and Nottinghamshire where under 18s conception rate is significantly higher than the England average.
- In both Nottingham and Nottinghamshire, the total abortion rate, the rate in over 25s and abortions under 10 weeks are equal to or better than national average but recent trends are increasing for both.
- Nottinghamshire is consistently higher than the England average for under 25 abortions after a birth. This may be an indicator of need for improved access to contraception after giving birth.

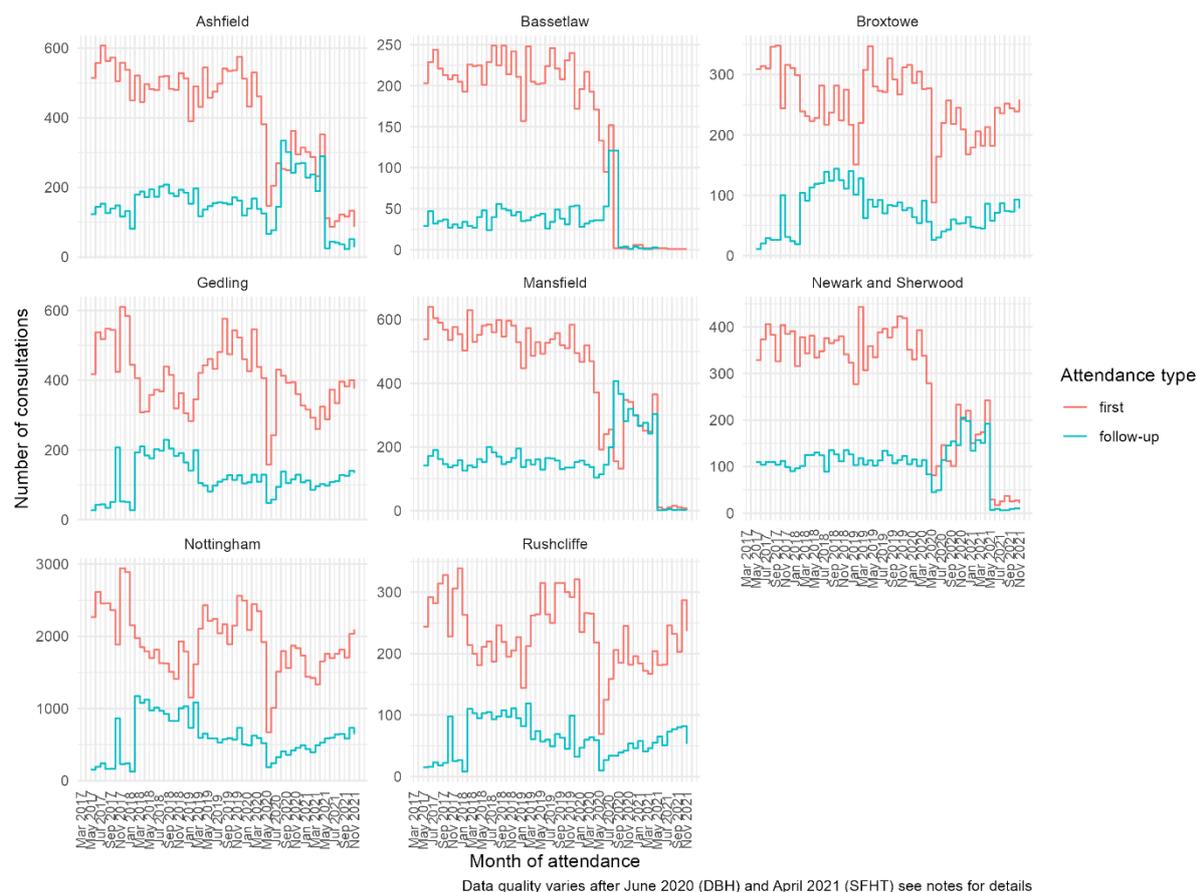
8 Population use of Integrated Sexual Health Services

8.1 Attendance at Integrated Sexual Health Services by population groups

The following section refers to data about individuals who attended ISHS services in Nottingham and Nottinghamshire between 1/4/2017 and 31/3/2021. Unless otherwise stated, all counts represent number of people/individuals rather than the number of attendances, tests etc. This means that the data are different to counts shown in UKSHA fingertips profiles or the STI/HIV data exchange.

Figure 56 shows the change over time in new and follow-up attendances at ISHS providers by people living in Nottingham or Nottinghamshire (divided into lower tier local authority for Nottinghamshire). A large drop is seen in early 2020 in all areas due to the COVID-19 pandemic, with variable recovery in number of consultations up to November 2021. It is important to note that there were major data quality issues from June 2020 for Doncaster and Bassetlaw Hospitals and from April 2021 for Sherwood Forest Hospitals, seen particularly on the figures for Bassetlaw, Mansfield, Ashfield and Newark and Sherwood, accounting for apparent drops in activity to zero (or close to zero) at those times.

Figure 56. Number of individuals resident in Nottingham or Nottinghamshire who attended ISHS between April 2017 and March 2021 (first and follow-up attendances) by local authority



Source: Pseudonymised provider data of activity between 1/4/2017 and 31/3/2021 from the three contracted providers (DBHT, SFHT and NUH)

8.1.1 Individual attendance by sex

Between 2017-2021, a total of 48,916 people attended ISHS from Nottingham and 62,012 from Nottinghamshire. For both local authorities, over two thirds were female (Table 19).

Table 19. Nottingham and Nottinghamshire individuals' attendance at ISHS by sex between April 2017 and March 2021

Local Authority	Female	Male	All persons
Nottingham	33,074 (67.6)	15,842 (32.4)	48,916
Nottinghamshire	43,301 (69.8)	18,711 (30.2)	62,012
Total	76,375 (68.9)	34,553 (31.1)	110,928

Source: Pseudonymised provider data of activity between 1/4/2017 and 31/3/2021 from the three contracted providers (DBHT, SFHT and NUH)

8.1.2 Individual attendance by age

Across both local authorities, the most common age groups accessing ISHS are those between 20 and 34, but people from Nottinghamshire accessing the services have a slightly older age profile (Table 20). This is to be expected as it reflects the overall age distribution of the local authorities.

As the age group increases, the difference in attendance between attendance by sex reduces. In all age groups, females attending services greatly outnumber males, except amongst the oldest age group (65 and over), amongst whom more men attend, but numbers of both sexes are small. This analysis did not differentiate the reason for attendance, so attendances for females will include consultations about contraception, which men generally do not access. In addition, analyses of STI diagnoses (section 6.4) noted that the proportion of men amongst those diagnosed with an STI increases with increasing age.

Table 20. Individuals attending ISHS by age between April 2017 and March 2021

	Female	Male	All persons
Nottingham			
00 to 15	378 (1.1)	143 (0.9)	521 (1.1)
16 to 19	4,949 (15.0)	1,936 (12.2)	6,885 (14.1)
20 to 24	10,724 (32.4)	4,683 (29.6)	15,407 (31.5)
25 to 34	9,780 (29.6)	5,145 (32.5)	14,925 (30.5)
35 to 44	4,807 (14.5)	2,233 (14.1)	7,040 (14.4)
45 to 64	2,379 (7.2)	1,530 (9.7)	3,909 (8.0)
65 and older	57 (0.2)	171 (1.1)	228 (0.5)
TOTAL	33,074	15,841	48,915
Nottinghamshire			
00 to 15	801 (1.8)	135 (0.7)	936 (1.5)
16 to 19	5,826 (13.5)	1,936 (10.3)	7,762 (12.5)
20 to 24	9,894 (22.8)	4,231 (22.6)	14,125 (22.8)
25 to 34	14,344 (33.1)	6,557 (35.0)	20,901 (33.7)
35 to 44	7,263 (16.8)	2,864 (15.3)	10,127 (16.3)
45 to 64	5,035 (11.6)	2,603 (13.9)	7,638 (12.3)
65 and older	137 (0.3)	385 (2.1)	522 (0.8)
TOTAL	43,300	18,711	62,011

Source: Pseudonymised provider data of activity between 1/4/2017 and 31/3/2021 from the three contracted providers (DBHT, SFHT and NUH). %s are % of all female/male/persons within the relevant age group.

8.1.3 Individual attendance by sexuality

Across both local authorities there are similar proportions of people attending ISHS who are recorded as homosexual (approximately 0.6% of females, 9% of males) but a slightly higher proportion recorded as bisexual in Nottingham compared to Nottinghamshire (Table 21). A high percentage of female (10.2%) and male (11.5%) Nottingham residents chose not to disclose their sexuality compared to Nottinghamshire (female 4.9%, male 6.5%). This may require further analysis to assess whether there is variation in recording by different services, or whether people in the city are less likely to disclose their sexuality.

Table 21. People attending ISHS by sexuality between April 2017 and March 2021

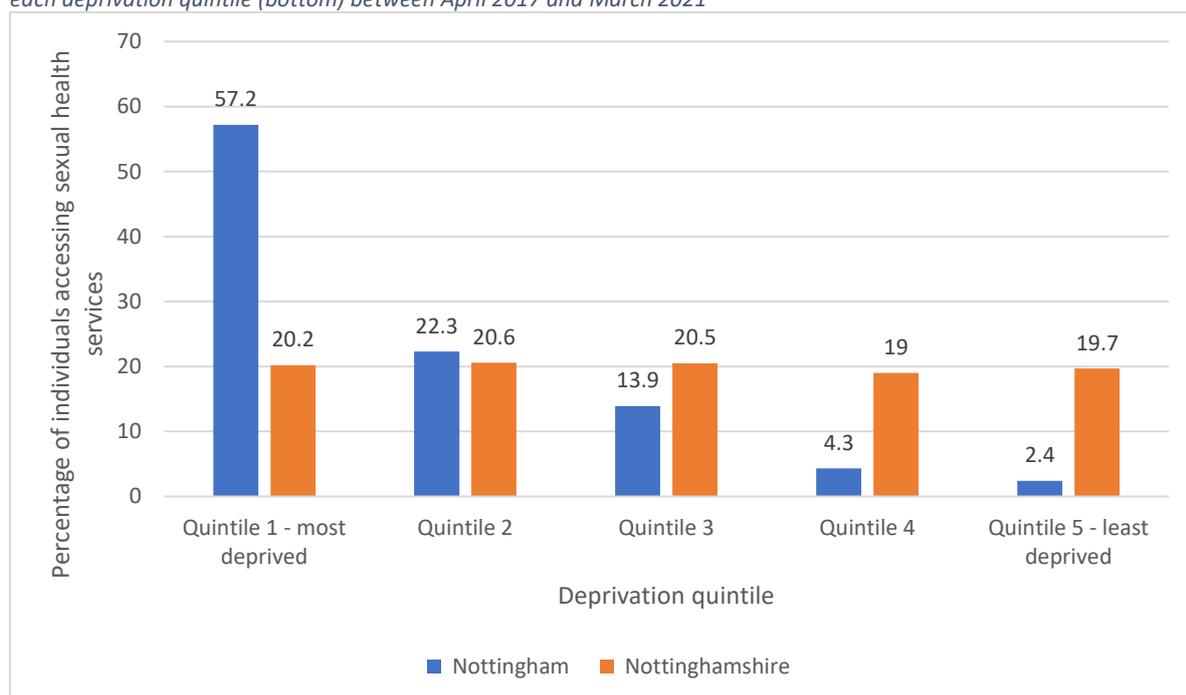
	Female	Male	All persons
Nottingham			
Bisexual	351 (1.1)	301 (1.0)	652 (1.3)
Heterosexual	28,856 (87.2)	12,176 (76.9)	41,032 (83.9)
Homosexual	185 (0.6)	1,411 (8.9)	1,596 (3.3)
Orientation not stated	3,384 (10.2)	1,825 (11.5)	5,209 (10.6)
Orientation not known	298 (0.9)	129 (0.8)	427 (0.9)
TOTAL	33,074	15,842	48,916
Nottinghamshire			
Bisexual	296 (0.7)	296 (1.6)	592 (1.0)
Heterosexual	40,237 (92.9)	15,402 (82.3)	55,639 (89.7)
Homosexual	267 (0.6)	1,683 (9.0)	1,950 (3.1)
Orientation not stated	2,126 (4.9)	1,208 (6.5)	3,334 (5.4)
Orientation not known	375 (0.9)	122 (0.7)	497 (0.8)
TOTAL	43,301	18,711	62,012

Source: Pseudonymised provider data of activity between 1/4/2017 and 31/3/2021 from the three contracted providers (DBHT, SFHT and NUH). %s are % of all female/male/persons within the relevant category.

8.1.4 Individual attendance by deprivation

Across both local authorities there are similar proportion of individuals attending services by deprivation quintile compared to deprivation demographics as shown in (Figure 57). In both areas, there is a slightly higher percentage of individuals attending from the most deprived areas and slightly less from the least deprived areas. This suggests that services are meeting the needs of a known at-risk groups in terms of deprivation.

Figure 57. Proportion of people attending ISHS by deprivation quintile (top) compared with proportion of the population in each deprivation quintile (bottom) between April 2017 and March 2021



Source: Pseudonymised provider data of activity between 1/4/2017 and 31/3/2021 from the three contracted providers (DBHT, SFHT and NUH)

8.1.5 Individual attendance by ethnicity

This analysis focused on Black African and Black Caribbean ethnic groups as per national guidance, as these groups are known to be at higher risk of poor sexual health outcomes.

In Nottingham, Black ethnic groups represented a larger proportion of those attending ISHS than amongst the general population. This was less clear in Nottinghamshire given the very small proportion of the population involved. This will be examined further in the section on equity. It is also important to note the very large proportions where ethnicity was not recorded or not stated, particularly in Nottingham (Table 22).

Table 22. Number of individuals attending ISHS by ethnic group between April 2017 and March 2021

Ethnic group	Female	Male	All persons
Nottingham			
All other ethnic groups	5,202 (15.7)	2,446 (15.4)	7,648 (15.6)
Black African	1,840 (5.6)	839 (5.3)	2,679 (5.5)
Black Caribbean	1,356 (4.1)	995 (6.3)	2,351 (4.8)
Ethnicity not stated	4,359 (13.2)	2,349 (14.8)	6,708 (13.7)
White	16,621 (50.3)	7,142 (45.1)	23,763 (48.6)
Ethnicity not recorded	3,696 (11.2)	2,071 (13.1)	5,767 (11.8)
TOTAL	33,074	15,842	48,916
Nottinghamshire			
All other ethnic groups	1,952 (4.5)	1,010 (5.4)	2,962 (4.8)
Black African	300 (0.7)	171 (0.9)	471 (0.8)
Black Caribbean	237 (0.5)	172 (0.9)	409 (0.7)
Ethnicity not stated	2,889 (6.7)	1,538 (8.2)	4,427 (7.1)
White	36,017 (83.2)	14,716 (78.6)	50,733 (81.8)
Ethnicity not recorded	1,906 (4.4)	1,104 (5.9)	3,010 (4.9)
TOTAL	43,301	18,711	62,012

Source: Pseudonymised provider data of activity between 1/4/2017 and 31/3/2021 from the three contracted providers (DBHT, SFHT and NUH)

8.2 Equity of access to Integrated Sexual Health Services

This section compares the proportion of individuals in a particular group of the population who attended ISHS with the proportion who were diagnosed with an STI. An “equity of access” score of 100 means that the ratio of the two proportions for that group is the same as the proportion for the whole population. The data used for these analyses included all individuals attending ISHS between 1st April 2017 and 31st March 2021.

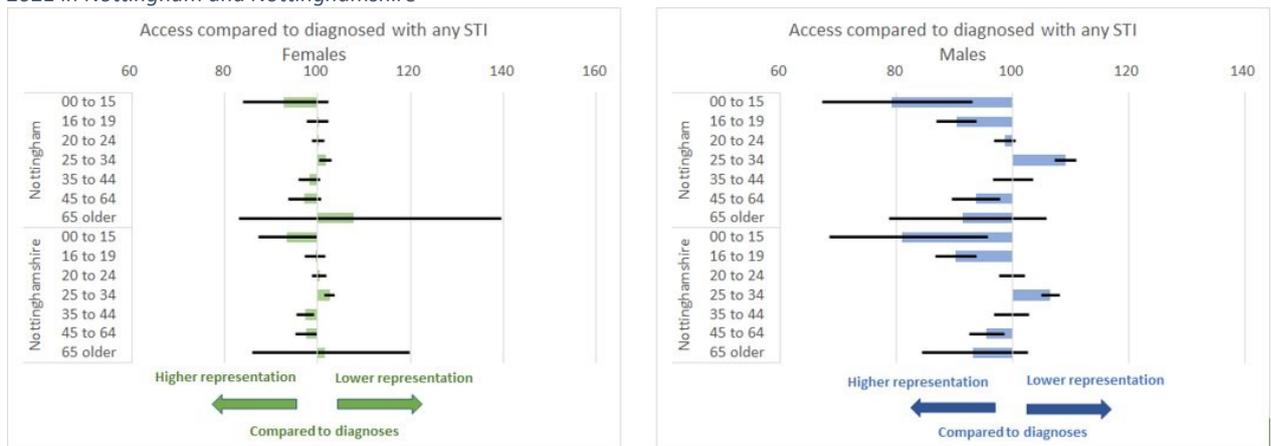
Groups with a score of greater than 100 and bars to the right of the plot have lower representation amongst those attending services compared to their share of STI diagnoses. The thin black bars represent the confidence intervals; if these overlap 100, the difference may be due to chance. If they do not overlap 100, these groups might be considered for culturally sensitive ways to improve access or take-up of services.

Groups with a score of less than 100 and bars to the left of the plot have higher representation amongst those attending services, compared to their share of STI diagnoses. This does not mean that attendance by these groups should be discouraged but they may be a lower priority for action.

8.2.1 Equity of access by age

Amongst men, those aged 25 to 34 had a higher proportion of STIs than their share of attendances (Figure 58). This also appeared to be the case amongst women in this age group in Nottinghamshire, but the difference was very small.

Figure 58. Equity measures: individuals' access to ISHS by age compared to diagnosis with any STI April 2017 and March 2021 in Nottingham and Nottinghamshire



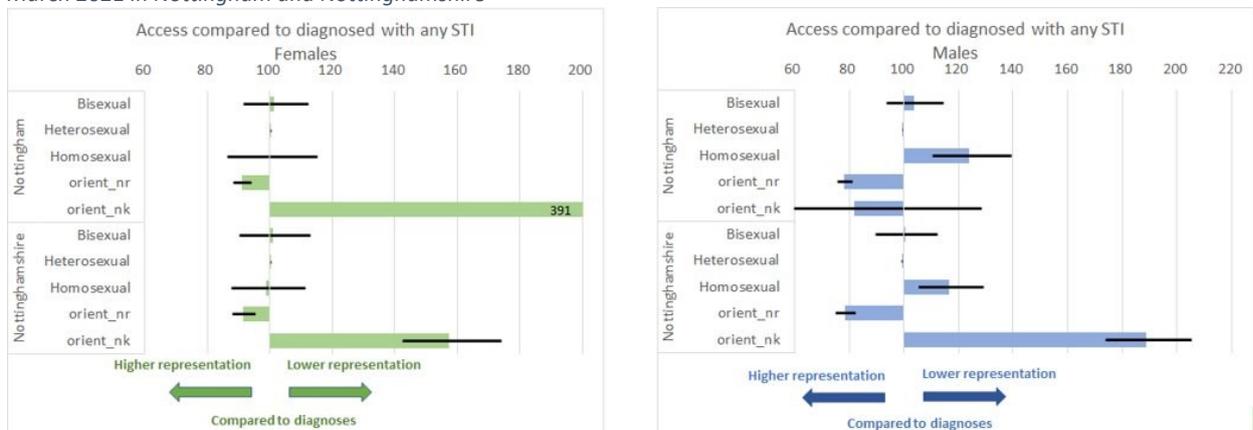
Source: Pseudonymised provider data of activity between 1/4/2017 and 31/3/2021 from the three contracted providers (DBHT, SFHT and NUH)

8.2.2 Equity of access by sexuality

Bisexual, heterosexual and homosexual females in both Nottingham and Nottinghamshire have very a similar share of attendances compared to the share diagnosed with STI (Figure 59). Those where sexuality was not known (“orient_nk”) had a much higher share of STIs than attendances, particularly in Nottingham. This is thought to represent individuals who were not asked about their sexuality, but requires further clarification and discussion with ISHS providers. It may be that this represents a group with poor access to services.

Men recorded as homosexual had a higher share of STI diagnoses compared to the share of those attending. This suggests that access amongst this group could be improved. As for females, individuals where sexuality was not known (“orient_nk”) had a much higher share of STIs than attendances, requiring further investigation with providers.

Figure 59. Equity measures: individuals access to ISHS by sexuality compared to diagnosis with any STI April 2017 and March 2021 in Nottingham and Nottinghamshire



Source: Pseudonymised provider data of activity between 1/4/2017 and 31/3/2021 from the three contracted providers (DBHT, SFHT and NUH)

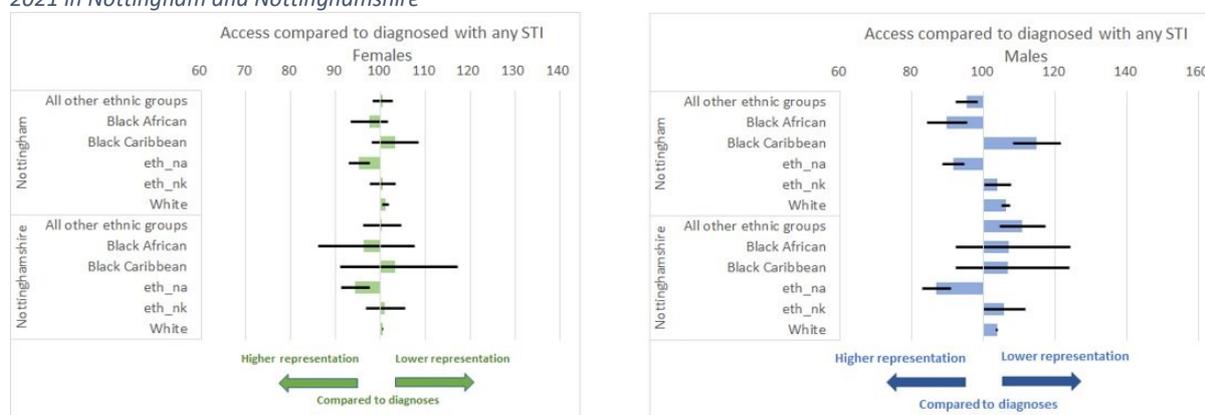
8.2.3 Equity of access by ethnicity

There were no significant differences by ethnicity amongst females (Figure 60).

Amongst males, those with Black Caribbean ethnicity in Nottingham had a higher proportion with STIs than their share of attendances. In Nottinghamshire, those from ethnic groups other than White, Black African and Black Caribbean had a higher share of STIs than attendances. This suggests that access could be improved for these groups. In both Nottingham and Nottinghamshire, males of White ethnicity had a slightly higher share of STIs than attendances. This suggests that access amongst these groups could be improved.

However, it is important to note that recording of ethnicity may influence these analyses, and requires further work to understand and improve recording.

Figure 60. Equity measures: individuals access to ISHS by ethnicity compared to diagnosis with any STI April 2017 and March 2021 in Nottingham and Nottinghamshire

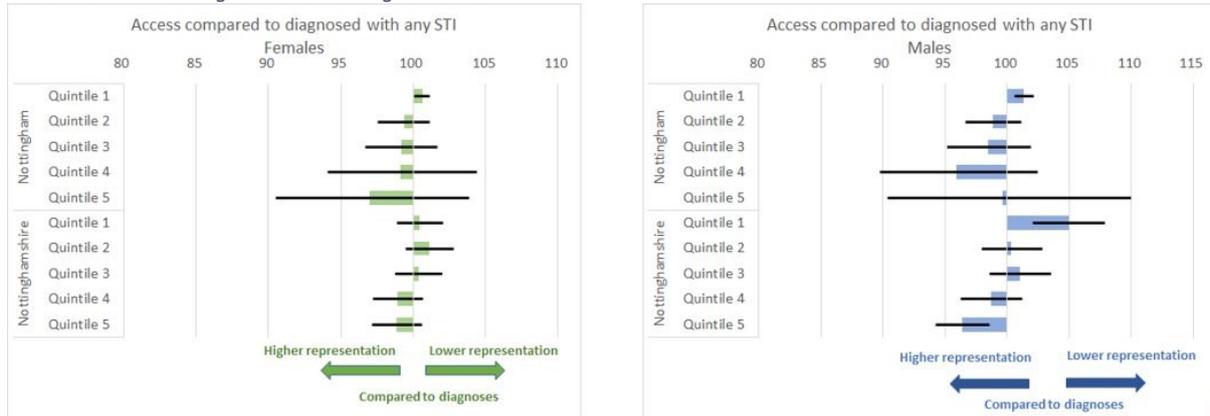


Source: Pseudonymised provider data of activity between 1/4/2017 and 31/3/2021 from the three contracted providers (DBHT, SFHT and NUH)

8.2.4 Equity of access by deprivation

Generally, access by quintile of deprivation appeared to reflect the share of STIs amongst each group. Male resident in the 20% most deprived areas in England (quintile 1) had a slightly higher proportion diagnosed with STIs compared to the share of attendances, although the difference was small (Figure 61).

Figure 61. Equity measures: individuals access to ISHS by deprivation compared to diagnosis with any STI April 2017 and March 2021 in Nottingham and Nottinghamshire

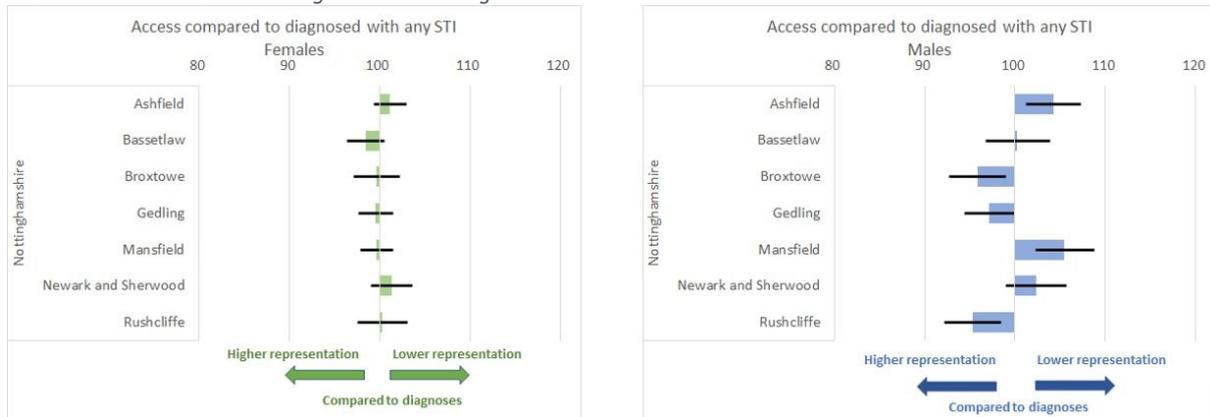


Source: Pseudonymised provider data of activity between 1/4/2017 and 31/3/2021 from the three contracted providers (DBHT, SFHT and NUH)

8.2.5 Equity of access by lower tier local authority area (Nottinghamshire only)

In terms of access by lower tier local authority areas in Nottinghamshire, males from Ashfield and Mansfield had a slightly higher proportion diagnosed with STIs compared to the share of attendances, although the difference was small (Figure 62).

Figure 62. Equity measures: individuals access to ISHS by lower tier local authority compared to diagnosis with any STI April 2017 and March 2021 in Nottingham and Nottinghamshire



Source: Pseudonymised provider data of activity between 1/4/2017 and 31/3/2021 from the three contracted providers (DBHT, SFHT and NUH)

8.3 Key points: use of ISHS

- Across both local authorities, the most common age groups accessing ISHS are those between 20 and 34, but people from Nottinghamshire accessing the services have a slightly older age profile.
- In all age groups, females attending services greatly outnumber males, except amongst the oldest age group (65 and over), amongst whom more men attend, but numbers of both sexes are small. This analysis did not differentiate the reason for attendance, so attendances for females will include consultations about contraception.

- Sexuality and ethnicity were not known/stated/recorded for a large proportion of people, particularly those from Nottingham. Further work is required to better understand and improve this.
- Groups in both Nottingham and Nottinghamshire which may have poorer access to ISHS services compared to their share of STI diagnoses include men aged 25-34 and homosexual men. Individuals where sexuality was not known (“orient_nk”) also had a much higher share of STIs than attendances, requiring further investigation with providers.
- There are ethnic groups which have variable access to services in Nottingham and Nottinghamshire, but recording of ethnicity may also influence the analyses of equity and requires more work to understand.
- Generally, access by deprivation appeared to reflect need, although men in the most deprived quintile may be slightly underrepresented compared to their share of STI diagnoses. Men from Ashfield and Mansfield were also slightly underrepresented.

9 Summary

This HNA is a first attempt to look at a comprehensive range of data to inform the commissioning of future sexual health services. It is intended to be used alongside other pieces of work such as stakeholder engagement, a survey of local residents and a service review.

Below is a summary of key findings and themes from the health needs analysis.

9.1 Overview of the population of Nottingham and Nottinghamshire

- The age and ethnicity profiles of Nottingham and Nottinghamshire are very different. This has implications for need and demand for sexual health services, and needs to be considered in future service planning.
- There are significant differences in deprivation between Nottinghamshire and Nottingham. As deprivation is known as a risk factor for poorer sexual health outcomes, consideration needs to be given either that services are situated or targeted in areas of higher deprivation or access to services is not hindered by changes to the current service model which could further increase sexual health inequalities.
- In addition to factors such as age, sex, sexuality and ethnicity, there are specific groups which are believed to be at particularly high risk of poor sexual health outcomes. However, in many cases there has been little systematic assessment of their sexual health needs in national research, and we may not even have a clear idea of the number of people affected locally (for example, the number of people involved in sex work). These factors will not be captured in the detailed analysis of STIs and reproductive health in the remainder of this report, as the data is not collected. It is essential to consider these groups in service planning and design, and to undertake engagement to better understand their needs.

9.2 Sexually transmitted infections

9.2.1 STI diagnoses

- In Nottingham, new STI diagnoses remained fairly constant in Nottingham from around 2016 until they spiked in 2019, followed by a significant drop in 2020 as a result of COVID-19. In Nottinghamshire, new diagnoses increased steadily from 2016 and then dropped in 2020.
- The areas with the highest rates of people being diagnosed with new STIs were all in Nottingham City, but the parts of Nottinghamshire with the highest rates compared to the rest of Nottinghamshire were in Mansfield.

9.2.2 STI testing

- In Nottinghamshire, the STI testing rate has consistently been under the England rate and is also low compared to similar local authorities, particularly in 2020. The STI positivity rate is high suggesting that the right people are being tested, but there may also be a risk some cases are missed, particularly in the context of a slightly increasing diagnostic rate. Testing and positivity rates are highly variable across the county, with the highest positivity in Ashfield and Mansfield followed by Gedling, and lowest in Bassetlaw.
- Further work is needed relating to the drop in STI tests undertaken in ISHS as a result of COVID-19, particularly to understand how much this has been compensated by online testing, and what the appropriate balance is between online and face-to-face services in future.
- Amongst people attending ISHS, the likelihood of being tested for STIs varied by age, sex, ethnicity and sexuality. Some of this variation is likely to reflect differences in underlying risk, but further work is needed to understand why Black African people were less likely to be tested than other ethnic groups. Further work is also needed to understand why people where ethnicity and sexuality were not recorded had particularly low rates of testing.

9.2.3 Specific STIs and multiple STIs

- Around 8 to 10% of people diagnosed with an STI in ISHS will receive more than one STI diagnosis over a period longer than 12 months. Groups at higher risk of this included young people aged 20 to 24, homosexual men, the most deprived quintile and some ethnic groups. This population is at high risk and a possible focus for health promotion to reduce health consequences and demand on services.
- Syphilis has been a recent concern in Nottinghamshire, particularly Bassetlaw, given a sharp increase in cases in 2018-19, albeit from a low baseline.
- Gonorrhoea in Nottingham is significantly higher than the England average and 21st highest out of 149 local authority areas in 2020. This is the focus of ongoing work for the local authority and UKHSA.
- Chlamydia testing and detection is consistently at or above the national average in Nottingham, whereas in Nottinghamshire it has increased following a significant focus of work, but remains somewhat below the national target.
- HIV testing coverage has dropped substantially in Nottingham from 2019 onwards and in Nottinghamshire from 2016 onwards, apparently due to an increase in the number of people eligible for a test. The reason for this is not completely clear but investigations in Nottinghamshire suggested it was likely to relate to a change in how data was recorded rather than a change in the people attending services.

- In Nottingham and Nottinghamshire, late HIV diagnoses are similar to the England average. A higher proportion of HIV diagnoses amongst heterosexual men were late diagnoses, although numbers are relatively low.

9.3 Reproductive health and contraception

9.3.1 LARC

- Total prescribing of LARC in primary care in Nottinghamshire (excluding Bassetlaw and Nottingham City) is close to pre-pandemic levels. This is also the case in most PCNs in Nottinghamshire. However, there is substantial geographical variation in prescribing rates in primary care.
- In general, it appears that areas close to ISHS “hubs” tend to have higher rates of ISHS prescribing, but this is not universally the case and it is likely that multiple factors are involved.
- Because of the complexity and differences in LARC provision and access geographically, a single solution may not be appropriate. Factors like the number of local fitters and clinic capacity are important. It is important that a newly commissioned ISHS service can adapt to changing local circumstances and support the local system in increasing availability of LARC.
- Comparing LARC provision before (2019/20) and after (2021/22) the interruption of services due to COVID-19, in most PCNs there is no significant difference. In Newark PCN, LARC activity has significantly decreased whilst in Ashfield South it has increased.

9.3.2 EHC

- Provision of EHC by community pharmacies has not returned to pre-pandemic levels. There are multiple possible reasons for this which should be explored.
- Further analysis is required to collate EHC data across pharmacies, primary care and ISHS. Early analysis suggests that EHC prescriptions/activity are lower than pre-pandemic levels, particularly in pharmacy and ISHS, and further work is required to ensure people can access EHC when they need it.
- Any changes to age eligibility for EHC should be carefully considered as within Nottinghamshire, the majority of people accessing the service are over 25 years old.
- The data on EHC in pharmacies does not capture anecdotal reports about people not always being able to access free EHC when they use a pharmacy that it under contract. A separate piece of work should be undertaken to review whether and why people cannot always access EHC from pharmacies that are contracted by the local authority.

9.3.3 Teenage pregnancy and abortions

- Whilst teenage pregnancy levels have dropped significantly, the impact on families and services is still high. There are still areas within Nottingham and Nottinghamshire where under 18s conception rate is significantly higher than the England average.
- In both Nottingham and Nottinghamshire, the total abortion rate, the rate in over 25s and abortions under 10 weeks are equal to or better than national average but recent trends are increasing for both.

- Nottinghamshire is consistently higher than the England average for under 25 abortions after a birth. This may be an indicator of need for improved access to contraception after giving birth.

9.4 Population use of Integrated Sexual Health Services

- Across both local authorities, the most common age groups accessing ISHS are those between 20 and 34, but people from Nottinghamshire accessing the services have a slightly older age profile.
- In all age groups, females attending services greatly outnumber males, except amongst the oldest age group (65 and over), amongst whom more men attend, but numbers of both sexes are small. This analysis did not differentiate the reason for attendance, so attendances for females will include consultations about contraception.
- Sexuality and ethnicity were not known/stated/recorded for a large proportion of people, particularly those from Nottingham. Further work is required to better understand and improve this.
- Groups in both Nottingham and Nottinghamshire which may have poorer access to ISHS services compared to their share of STI diagnoses include men aged 25-34 and homosexual men. Individuals where sexuality was not known (“orient_nk”) also had a much higher share of STIs than attendances, requiring further investigation with providers.
- There are ethnic groups which have variable access to services in Nottingham and Nottinghamshire but recording of ethnicity may also influence the analyses of equity and requires more work to understand.
- Generally, access by deprivation appeared to reflect need, although men in the most deprived quintile may be slightly underrepresented compared to their share of STI diagnoses. Men from Ashfield and Mansfield were also slightly underrepresented.

10 Recommendations

10.1 Understanding need through better collection and use of data

Understanding need through better collection and use of data	Providers	Commissioners
Commissioners should undertake further engagement and exploration of the needs of groups at higher risk of poor sexual health outcomes, particularly where little data was available to inform this HNA as set out in section 5.6, during the design and commissioning of sexual health services, particularly the design of health promotion and outreach services.		x
Sexuality and ethnicity were not known/stated/recorded for a large proportion of people attending sexual health services, particularly those from Nottingham. Some of these categories appeared to have notably lower rates of accessing services relative to their share of STI diagnoses, or low rates of STI testing compared to other groups. ISHS providers should undertake further work to understand the reasons for this and improve completeness of recording.	x	
Consideration should be given to whether improved data collection on the specific groups at higher risk identified in section 5.6 is feasible to better inform future commissioning exercises.	x	x
Consideration should be given to how data such as that presented in this HNA can be used on an ongoing basis to inform quality improvement within sexual health services and the sexual health system. This would allow commissioners and clinicians to work together to interrogate the data, explore causes of any issues identified, and prioritise areas for improvement.	x	X

10.2 Designing services to meet need

Design services to meet need	Providers	Commissioners
Location of services should take into account the distribution of sexual health need geographically, should avoid increasing barriers access in the areas with the highest level of need and as far as possible aim to improve access in these areas, whilst balancing with the need for efficient and sustainable services.	x	x
Services should incorporate ongoing co-production with service users, particularly those identified as at high risk of poor sexual health outcomes.	x	

The model of outreach and health promotion from ISHS should be reviewed and refined to ensure the groups at highest risk, and groups with poorer access to ISHS compared to their share of STI diagnoses, are reached.		x
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10.3 Improving access to STI testing

Improving access to STI testing	Providers	Commissioners
Further analysis is required to understand how STI testing within ISHS in Nottingham and Nottinghamshire compares with testing that is undertaken through online services, in terms of the number of people tested and their characteristics. This is important to understand how much the reduction in testing in ISHS is compensated by increases in online testing and whether these different routes are reaching different groups of people, and may inform decisions on the appropriate balance between online and face-to-face testing in future.	x	x
Consideration should be given to increasing levels of STI testing in Nottinghamshire, focusing on areas where testing is lower but positivity is higher. Focus should not solely be on the volume of testing but that people from higher risk groups are prioritised. This includes those identified as more likely to be diagnosed with multiple STIs over a 12 month period, including young people, homosexual men, the most deprived quintile and some ethnic groups.	x	x
Further analysis should be undertaken to understand why Black African people attending ISHS were less likely to have an STI test than other ethnic groups.	x	x
Continue monitoring rates of gonorrhoea diagnosis in Nottingham and syphilis in Nottinghamshire and ensure ISHS providers have systems in place to identify and respond to exceedances and outbreaks, relating to these or other STIs.	x	x
Continue monitoring HIV testing coverage to assess whether coverage changes in a new service model and ensure that people are being offered tests appropriately.	x	x
Ensure local services reflect changes to the National Chlamydia Screening Programme to ensure that the progress of improving the chlamydia detection rate, particularly in Nottinghamshire, are maintained but whilst targeting those at most risk.	x	x

10.4 Improving access to LARC

Improving access to LARC	Providers	Commissioners
Whilst recognising that provision of LARC is not limited to ISHS (and indeed that primary care is central to LARC provision), commissioners and providers of ISHS should seek to ensure that their services are not only agile and responsive to changes in local systems, but are able to innovate and lead change in the system for the benefit of service users.	x	x
Given the complex and varied landscape of LARC provision across Nottingham and Nottinghamshire, and the range of factors which influence availability of provision in primary care, ³⁹ commissioners should engage with local stakeholders to understand barriers and develop solutions at a local level, with a focus on increasing access for service users and ensuring sustainability/resilience of services over time. This could include funding training for fitters, establishing bespoke local training pathways, inter-practice referral systems, embedding specialist staff/staff with a special interest within primary care settings.		x
To inform the above, commissioners should undertake mapping of the geographical location of ISHS and primary care settings that provide LARC.		x
Commissioners should consider the feasibility of pilot projects offering LARC (and/or other methods of contraception) in maternity services, given the high rate of abortions after a birth.		x

10.5 Improving access to emergency contraception

Improving access to emergency contraception	Providers	Commissioners
Work should be undertaken to determine whether the decrease in EHC provision seen in Nottinghamshire since the COVID-19 pandemic is also reflected in Nottingham.		x
Commissioners should engage with pharmacies and/or the Local Pharmaceutical Committee to review EHC via LCPHS.		x

³⁹ [Access, provision and sustainability of LARC in primary care | Primary Care Women's Health Forum \(pcwhf.co.uk\)](https://www.pcwhf.co.uk)

Commissioners should consider alternative routes for access to EHC (for example, online) to improve access, taking into account feasibility, safety, acceptability and cost. They should consider whether this would form part of an integrated service.		x
Commissioners should ensure that the LCPHS in Nottinghamshire remains accessible to all ages, as a large proportion of those accessing EHC through this route currently are over 25.		x

10.6 Other recommendations

Other recommendations	Providers	Commissioners
Commissioners and providers should consider how they might strengthen joint working with commissioners and providers of abortion services and services with a role in teenage pregnancy and relationships and sex education (RSE).	x	x
PrEP (pre-exposure prophylaxis) to prevent HIV has not been considered in this HNA. Uptake of PrEP in general and in higher risk groups should be reviewed.	x	x

11 Appendix

Table 23 Ethnicity percentage breakdown for Nottingham and Nottinghamshire 2019

Area name	All categories: Ethnic group	White:	White: Irish	White: Gypsy or Irish Traveller	White: Other White	Mixed/multiple ethnic group: White and Black Caribbean	Mixed/multiple ethnic group: White and Black African	Mixed/multiple ethnic group: White and Asian	Mixed/multiple ethnic group: Other Mixed	Asian/Asian British: Indian	Asian/Asian British: Pakistani	Asian/Asian British: Bangladeshi	Asian/Asian British: Chinese	Asian/Asian British: Other Asian	Black/African/Caribbean/Black British: African	Black/African/Caribbean/Black British: Caribbean	Black/African/Caribbean/Black British: Other Black	Other ethnic group: Arab	Other ethnic group: Any other ethnic group
ENGLAND AND WALES	56,075,912	81%	1%	0%	4%	1%	0%	1%	1%	3%	2%	1%	1%	2%	2%	1%	1%	0%	1%
ENGLAND	53,012,456	80%	1%	0%	5%	1%	0%	1%	1%	3%	2%	1%	1%	2%	2%	1%	1%	0%	1%
EAST MIDLANDS	4,533,222	85%	1%	0%	3%	1%	0%	1%	0%	4%	1%	0%	1%	1%	1%	1%	0%	0%	0%
Nottingham UA	305,680	65%	1%	0%	5%	4%	1%	1%	1%	3%	6%	0%	2%	2%	3%	3%	1%	1%	1%
Nottinghamshire	785,802	93%	1%	0%	2%	1%	0%	0%	0%	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Ashfield	119,497	96%	0%	0%	1%	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Bassetlaw	112,863	95%	0%	0%	2%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Broxtowe	109,487	90%	1%	0%	3%	1%	0%	0%	0%	2%	1%	0%	1%	1%	0%	0%	0%	0%	0%
Gedling	113,543	90%	1%	0%	2%	1%	0%	1%	0%	1%	1%	0%	0%	1%	0%	1%	0%	0%	0%
Mansfield	104,466	93%	0%	0%	4%	1%	0%	0%	0%	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Newark and Sherwood	114,817	94%	1%	0%	3%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Rushcliffe	111,129	90%	1%	0%	2%	1%	0%	1%	0%	2%	1%	0%	1%	1%	0%	0%	0%	0%	0%

Source ONS population by ethnic group

Table 24 Local Authority Ethnic Breakdown by Age (Numbers and Percentage)

LA	Age Group	White	%	Other	%	Black	%	Asian	%	Mixed	%	Grand Total	%
Nottingham	0-14	33,746	57%	1,280	2%	5,630	10%	8,564	14%	9,994	17%	59,214	18%
	15-19	15,878	58%	494	2%	2,459	9%	4,573	17%	3,743	14%	27,147	8%
	20-24	30,177	62%	568	1%	4,217	9%	7,281	15%	6,109	13%	48,353	15%
	25-24	38,411	68%	962	2%	3,456	6%	9,581	17%	3,980	7%	56,390	17%
	35-44	24,612	65%	974	3%	3,199	8%	6,193	16%	2,662	7%	37,640	11%
	45-64	49,288	75%	778	1%	5,844	9%	6,862	10%	2,605	4%	65,377	20%
	65+	34,540	89%	119	0%	1,585	4%	2,158	6%	377	1%	38,779	12%
Nottingham Total		226,653		5,173		26,391		45,213		29,471		332,900	100%

Source: ONS - Population denominators by broad ethnic group - 2019 (Experimental)