Sexual Health Needs Assessment 2023

SOMERSET

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Abbreviations:

Abbreviation	
ART	Antiretroviral therapy
BASHH	British Association for Sexual Health and HIV
BBV	Blood borne virus
BMI	Body mass index
CTAD	Chlamydia Testing Activity Dataset
EC	Emergency contraception
EHC	Emergency hormonal contraception
EMA	Early medical abortion
GBMSM	Gay and bisexual men and other men who have sex with men
GP	General practice
GUM	Genitourinary medicine
GUMCAD	Genitourinary Medicine Clinic Activity Dataset
HAV	Hepatitis A
HBV	Hepatitis B
HCV	Hepatitis C
HIV	Human immunodeficiency virus
HPV	Human papillomavirus
ICB	Integrated Care Board
ICP	Integrated Care Partnership
IMD	Index of Multiple deprivation
IUD	Intrauterine device
IUS	Intrauterine system
LARC	Long-acting reversible contraception
LGBTQ+	Lesbian, gay, bisexual, transgender, queer/questioning
MSM	Men who have sex with men
MSOA	Medium level super output area
NCSP	National Chlamydia Screening Programme
NHSE	NHS England
OHID	Office for Health Improvement and Disparities
ONS	Office for National Statistics
PCN	Primary care network

PEP/SE	Post exposure prophylaxis / after sexual exposure
PGD	Patient Group Direction
PHE	Public Health England
POP	Progesterone only pill
PrEP	Pre exposure prophylaxis for HIV
RSE / SRE	Relationships and sex education
RSHE	Relationship sex and health education
SHS	Sexual health service
SO	Sexual offences
SPLASH	Summary Profile of Local Authority Sexual Health
SRH	Sexual reproductive healthcare
STI	Sexually transmitted infection
SWAT	South West and Taunton
SWISH	Somerset Wide Integrated Sexual Health Service
UA	Unitary Authority
UKHSA	UK Health Security Agency
UN	United Nations
UPSI	Unprotected sexual intercourse
UTLA	Upper Tier Local Authority
WHO	World Health Organisation
WISH	Weston Integrated Sexual Health service

Executive Summary

Sexual health is an important area of public health and needs to be considered in the context of wider determinants of health including economic status, social and cultural norms, education and health literacy and access to health services, as well as sex, gender identity and sexual orientation. Sexual health is not equally distributed within the population with women, gay and bisexual men and other men who have sex with men (GBMSM), the trans community, young people, and people from ethnic minority backgrounds experiencing the biggest burden of poor sexual health.

The COVID-19 pandemic led to measures which influenced sexual behaviour and health service provision and changed the way many services were offered, with a shift to online and tele-consultations and online testing for HIV and asymptomatic STIs (sexually transmitted infections) increasing.

Overall the population of Somerset experiences good sexual health relative to the rest of England and many areas in the South West. Rates of new STI diagnoses and HIV prevalence is comparatively low, whilst uptake of the most effective forms of contraception are generally higher. However, despite this there remain inequalities in both knowledge of sexual health and in access to sexual health services. Uptake of chlamydia screening by young people remains below that recommended impacting on identification and treatment. Whilst HIV prevalence is low, the percentage of those who are diagnosed late with HIV remains persistently high, leading to poorer health outcomes and increased risk of transmission. Significant progress has been made in reducing teenage conceptions but some areas still see higher numbers of teenagers becoming pregnant, and surveys of young people demonstrate a lack of knowledge of the services available to them. In addition sexual health services are experiencing increasingly higher numbers of attendances and demands on their services than ever before.

This needs assessment has contributed to an understanding of the sexual and reproductive health of the Somerset population and has informed the recommendations in Section 5. The findings and recommendations will be shared with the Somerset Sexual Health Network for review and to develop an action plan to address identified areas.

1 Purpose and Scope

The purpose of this sexual health needs assessment is to offer a review of sexual health need, current service provision and delivery, and to gain an understanding of actions needed to improve the sexual and reproductive health of the Somerset population.

The needs assessment predominantly presents an analysis of sexual health outcomes and indicators using data available from a number of sources. Other than the schools health and wellbeing survey it does not include qualitative data; public engagement has been identified as a priority over the next two years to inform future sexual health strategy, service models and commissioning intentions.

All numbers lower than 5 have been supressed and reported as <5, additionally where this could then be deduced from the other numbers reported these have been rounded to the nearest multiple to 10.

A sexual violence needs assessment and strategy for Somerset is being developed and so is not in scope for this sexual health needs assessment.

2 Context and Sexual Health Policy Drivers

Sexual health is “a state of physical, emotional, mental and social wellbeing in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity” (WHO[1]). Sexual health is an important area of public health and needs to be considered in the context of wider determinants of health including economic status, social and cultural norms, education and health literacy and access to health services, as well as sex, gender identity and sexual orientation.

Sexual health is not equally distributed within the population. Strong links exist between deprivation and STIs (sexually transmitted infections), teenage conceptions and abortions, with the highest burden borne by women, gay and bisexual men and other men who have sex with men (GBMSM), the trans community, young people, and people from ethnic minority backgrounds. Similarly, HIV infection in the UK disproportionately affects GBMSM, and black African populations. Some groups at higher risk of poor sexual health face stigma and discrimination, which can influence their ability to access services.

Many sexually transmitted infections can be asymptomatic (symptomless) meaning that individuals can remain unaware of their condition; this not only can impact individual health but can put others at risk. Additionally unplanned pregnancies, especially those in young people can have long-term health, social, and psychosocial consequences - for both parents and child.

Poor sexual health can have significant consequences, in the long, and short-term – impacting individuals mental and physical wellbeing:

- Teenage parenthood reduces the life chances of children and young people, and their children
- Sexual exploitation may lead to lifelong mental wellbeing problems

- STIs can cause long term and life-threatening complications, including infertility
- Bullying and discrimination can occur on the basis of sexuality and gender identity
- Late diagnosis of HIV leads to avoidable serious illness and premature death as well as increased HIV transmission

Ensuring good sexual health of a population encompasses:

- prevention and reduction in STI transmission
- reduction of the prevalence of undiagnosed STIs and HIV
- reduction of unplanned pregnancy
- reduction of stigma
- reduction of riskier sexual behaviours

2.1 Key sexual and reproductive health policy drivers

Most of the adult population of England are sexually active and access to quality sexual health services improves the health and wellbeing of both individuals and populations.

In 2013 the government set out its ambitions for improving sexual health in its Framework for Sexual Health Improvement in England. The framework gives the key aims to improve sexual health and wellbeing of the whole population as:

- reducing inequalities and improving sexual health outcomes
- building an honest and open culture where everyone is able to make informed and healthy choices about relationships and sex
- recognising that sexual ill-health can affect all parts of society and particularly the most vulnerable

And that sexual health outcomes can be improved by:

- accurate, high-quality and timely information that helps people to make informed decisions about relationships, sex and sexual health
- preventative interventions that build personal resilience and self-esteem and promote healthy choice
- rapid access to confidential, open access, integrated sexual health services in a range of settings, accessible at convenient times
- early, accurate and effective diagnosis and treatment of STIs, including HIV, combined with the notification of partners who may be a at risk
- joined-up provision that enables seamless patient journeys across a range of sexual health and other services (to include community gynaecology, antenatal and HIV treatment and care services in primary, secondary and community settings)

The 2018 Teenage Pregnancy Prevention Framework aims to reduce inequalities of teenage pregnancy rates within wards in local authorities. Evidence shows that "building the knowledge, skills, resilience and aspirations of young people, and providing easy access to welcoming contraceptive services, helps them to delay sex until they are ready to enjoy healthy, consensual relationships and to use contraception to prevent unplanned pregnancy." The framework identified ten key factors for an effective strategy to reduce teenage conceptions using evidence of what works from the previous 20 years. These include:

- relationships and sex education in schools and colleges
- youth friendly contraceptive and sexual health services and condom schemes
- targeted prevention for young people at risk
- support for parents to discuss relationships and sexual health
- training on relationships and sexual health for health and non-health professionals
- advice and access to contraception in non-health education and youth settings
- consistent messages and service publicity to young people, parents and practitioners
- support for pregnant teenagers and young parents – including prevention of subsequent pregnancies

In December 2021, the government published an Action Plan Towards Ending HIV Transmission, AIDS and HIV-related Deaths in England 2022-2025. This sets an ambitious target for an 80% reduction in all new HIV infections in England by 2025. The objectives of the national HIV Action plan are to:

- ensure equitable access and uptake of HIV prevention programmes
- scale up HIV testing in line with national guidelines
- rapid access to treatment and retention in care
- improving the quality of life for people living with HIV and addressing stigma

In July 2022, the government published the Women's Health Strategy for England which sets out its 10-year ambitions to improve the health and wellbeing of women and girls in England. The strategy takes a life course approach to a different range of health needs including sexual and reproductive health, menopause, violence against women and girls, cervical screening and breast cancer screening.

There is a range of NICE guidance and standards for sexual health; a list of some of the key publications can be found in appendix 1.

2.2 Impact of the COVID-19 pandemic

In response to the COVID-19 pandemic the government implemented national and regional lockdowns, as well as social and physical distancing measures. These measures influenced sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicators. When interpreting data from 2020 these

factors should be considered, especially when comparing to data from pre-pandemic years.

The COVID-19: impact on STIs, HIV and viral hepatitis, 2020 report states that between March and May 2020 there was a reduction in:

- consultations undertaken by sexual health services and specialised HIV services
- testing for viral hepatitis in drug services, prisons, general practice and SHSs
- testing for HIV and STIs in SHSs
- vaccination of GBMSM against HPV, HBV and HAV
- diagnoses of viral hepatitis, HIV and STIs
- HCV treatment initiations

There was a resurgence in HIV, STIs and hepatitis tests and diagnoses from June 2020 reflecting a partial recovery in service provision and demand. This increase has been more marked since 2022.

The pandemic led to a change in the way many services were offered, with a shift to online and tele-consultations and online testing for HIV and asymptomatic STIs increasing. Many of these changes had started before the pandemic but their development was accelerated. These changes in service delivery have continued with online asymptomatic STI testing now the norm in Somerset as elsewhere, along with digital access to consultations. For many this has been positive with the opening up of access to sexual health services and promotion and acceptability of self-managed care. However, it is important that these changes don't further contribute to inequalities in sexual health with those who may be excluded from digital and online access, including many of those who already experience poor sexual health outcomes. The 2020 data on internet access revealed that 5% of the adult population of Great Britain has not used the internet in the last 3 months and 16% of the population do not use a smartphone for private use. It is therefore imperative that services continue to offer a mixture of face to face and digital access to meet the needs of their local population[2].

The SWISH Friends and Family questionnaire of service users over the last 18 months consistently show that on average 13.5% prefer telephone consultations, 37.6% prefer face to face consultations and just under 50% don't mind.

The COVID-19 pandemic also impacted on the provision of contraceptive services with the reduction in face to face consultations particularly impacting access to LARC in SHSs and general practice.

2.3 Sexual health services in Somerset

Following the Health and Social Care Act 2012 the commissioning responsibilities for sexual health were fragmented in 2013 across local authority and NHS commissioning bodies (Table 1). Local authorities are mandated to commission comprehensive open access sexual health services, including free STI testing and treatment, notification of

sexual partners of infected persons, advice on, and reasonable access to, a broad range of contraception, and advice on preventing unplanned pregnancy[3].

Table 1 – Sexual Health Commissioning Responsibilities

Local Authorities	Integrated Care Boards	NHS England
• Comprehensive sexual health services including most contraception services and prescribing costs, (excluding GP additionally provided contraception) • STI testing and treatment, chlamydia screening and HIV testing • Specialist services, including young people's sexual health, teenage pregnancy services, outreach, HIV prevention (including delivery of PrEP), sexual health promotion, services in schools, colleges and pharmacies	• Most abortion services • Sterilisation • Vasectomy • Non-sexual health elements of psychosexual health services • Gynaecology including any use of contraception for non-contraceptive purposes	• Contraception provided as an additional service under the GP contract • HIV treatment and care (including drug costs for PEPSE and PrEP) • Promotion of opportunistic testing and treatment for STIs and patient-requested testing by GPs • Sexual health elements of prison health services • Sexual assault referral centres (SARC) • Cervical screening • HPV vaccination • Specialist fetal medicine services

This split of commissioning responsibility has led to complexities and challenges within the sexual health system in terms of pathways for service users, especially women's reproductive health, as well as funding streams and system wide response to meet the needs of the local population. The Health and Care Act 2022 has created opportunities for a more integrated response to meeting the health and care needs of local populations through the development of Integrated Care Partnerships (ICP) and Integrated Care Boards (ICB). The ICB in Somerset, NHS Somerset, took on the commissioning responsibilities of the former Somerset Clinical Commissioning Group. Some of the commissioning responsibilities of NHSE are transferring to ICBs, with pharmacy commissioning (who the government plan to have more of a role in providing contraception) having transitioned from 1 April 2023; and HIV treatment and care services due to transition by April 2024. These new commissioning responsibilities and the ICBs leading role in the development of women's health hubs in the response to the Women's Health Strategy for England should drive a more integrated approach to meeting the sexual and reproductive health needs of Somerset.

The main sexual health service provision for the Somerset population are detailed below. More information on sexual health and services in Somerset can be found on the SWISH Website.

Table 2 – Somerset-Wide Integrated Sexual Health Service [4,5].

Service	Short description	Provider	Commissioner
SWISH (Somerset-Wide Integrated Sexual Health Service	• Comprehensive integrated specialist Level 1 to Level 3 sexual health and contraceptive services • Online STI testing • Targeted outreach to young people and adults with a higher risk of poor sexual health. • PrEP, and postal condoms for adults with high risk of HIV and other STIs • HPV vaccination for GBMSM and cervical screening (commissioned by NHSE)	Somerset NHS Foundation Trust	Somerset Council
LARC provision in general practice	• Implant and IUS/IUD fitting and removal for contraceptive and non-contraceptive purposes	General Practices	Somerset Council
EHC in community pharmacies (up to age 25)	• Free emergency hormonal contraception up to 120 hours after UPSI for those aged under 25	Community Pharmacies	Somerset Council
HIV Prevention and Health and Wellbeing Service	• Targeted community prevention interventions for those with higher risk of HIV • Support to people newly diagnosed with HIV and advocacy and support to access health and social care services where there is an identified need • Improve knowledge and understanding to reduce stigma	The Eddystone Trust	Somerset Council
HIV Treatment and Care	• Confidential HIV care, treatment and support to people diagnosed with HIV	The Starling Clinic, Somerset NHS Foundation Trust	NHSE
Abortion services	• Pregnancy advisory service and access to medical and surgical abortion and abortion pill treatment at home. • Professional and self-referral through central booking service	BPAS (British Pregnancy Advisory Service)	NHS Somerset
C-Card condom distribution service	• Free service offering condoms and sexual health information to young people aged 13-19 • Includes a new click and collect service	Somerset Council	Somerset Council

In addition Somerset Council commissions out of area sexual health services accessed by Somerset residents. Notably this includes WISH (Weston Integrated Sexual Health Service) in Weston-Super-Mare who provide GUM and contraceptive services with approximately 30% of their service users coming from Somerset, and the Riverside Clinic in Bath which provides GUM services accessed by Somerset residents living in East Mendip.

2.4 Somerset Population:

Population Density: Somerset has a population density of 166 (number of usual residents per square kilometre), this is highest in Sedgemoor (222), then South Somerset (180), Mendip (157), and lowest in SWAT (133). Somerset has a total population of 571,600 (2021 Census), age, sex, and district breakdowns for this are below.

2.4.1 Age and sex

Table 3 - Somerset populations by age, per district[6] (numbers may not sum due to rounding in the released data)

	All persons	Under 15	15-19	20-24	25-44	45+
Somerset	571,600	90,100	29,800	26,000	125,700	299,900
Mendip	116,100	18,700	6,700	4,800	24,800	61,200
Sedgemoor	125,400	20,100	6,400	6,100	28,000	64,500
Somerset West and Taunton	157,400	24,500	8,200	6,800	35,100	83,200
South Somerset	172,700	26,900	8,600	8,200	37,800	91,100

Table 4 - Somerset populations by sex, per district[7] (numbers may not sum due to rounding in the released data)

	All Population	Female	Male
Somerset	571,600	292,100	279,400
Mendip	116,100	59,700	56,400
Sedgemoor	125,400	63,300	62,100
Somerset West and Taunton	157,400	81,000	76,500
South Somerset	172,700	88,200	84,500

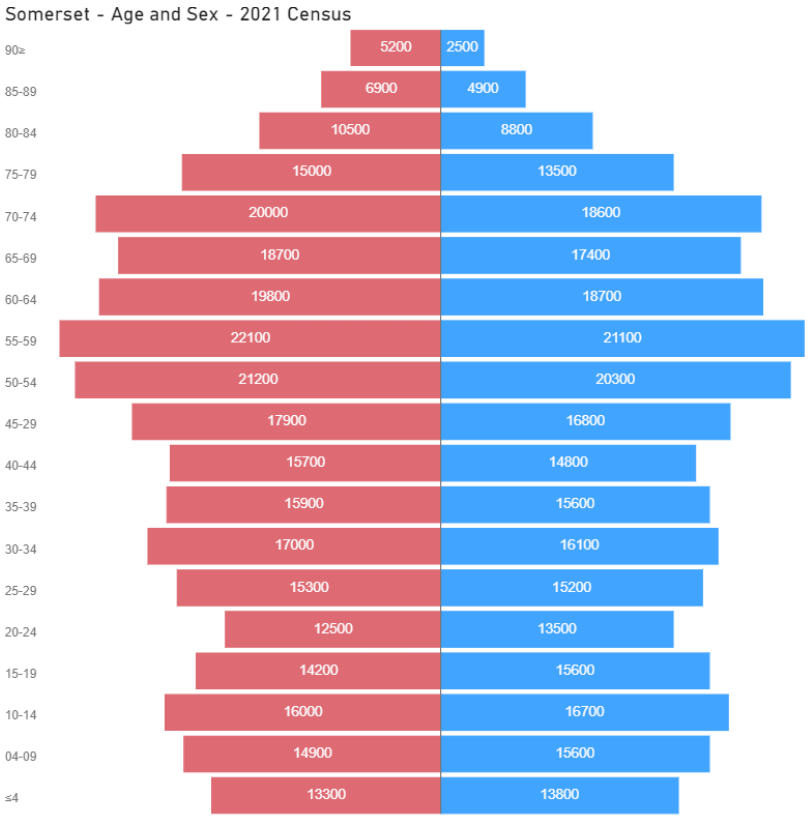

Figure 1 - Somerset population pyramid, age, and sex[8]

The age bands with the highest population are 50-54 and 55-59. In 2021 84,700 people were in their 50s accounting for nearly 15% of the total population.

Most 5-year age bands saw an increase in population between 2011 and 2021. The largest increase was seen in the 70-74 age band with over 13,000 more people in 2021 than in 2011. The largest decreases are in the 40-44 and 45-49 age bands, however there is a similarly sized increase in the 25-29 and 30-34 age bands. In 2021 there was approximately 30,000 more people aged 65+ than in 2011, with 3/4 of the population growth between 2011 and 2021 was in the 65+ age range.

2.4.2 Sexual orientation & gender identity[9]

In Somerset, 89.9% of individuals identified as being Straight or Heterosexual. The next largest groups were Gay or Lesbian (1.2%), Bisexual (1.1%), and Pansexual (0.2%). Approximately 12,000 Somerset residents selected a sexual orientation other than Straight or Heterosexual; around 1 in 40 people. 7.5% of the Somerset population did not respond to this question. Nationally, the proportion of people with a sexual orientation other than Straight or Heterosexual was slightly higher, at 3.2%; around 1 in 31 people (Census, 2021).

Over 1,600 individuals across Somerset stated that their gender identity differs from their sex as registered at birth: approximately 0.35% of the population (Aged 16+). Trans women and trans man were the most commonly identified with over 300 in each

group. 5.7% did not respond to this question. Nationally proportion of individuals with a gender identity different from their sex at birth was higher than Somerset at 0.54% (Census, 2021).

2.4.3 Ethnicity

Somerset is less diverse than nationally, 96.4% of the population in Somerset are 'White', compared to 81.1% nationally. 1.5% are 'Asian, Asian British, or Asian Welsh', 1.3% 'Mixed or Multiple Ethnic groups', 0.4% 'Black, Black British, Caribbean, or African', and 0.4% 'Other ethnic group' (Census, 2021)[10]. The greatest relative change since 2011 comes amongst those from Black ethnic groups, with the number of residents from those groups having more than doubled from 1,013 in 2011 to 2,436 in 2021.

2.4.4 Socioeconomic status and deprivation

Sedgemoor is the worst performing district in IMD 2019 with an overall IMD rank of 121 out of 317. Nine Somerset LSOAs are amongst the most deprived 10% nationally, these are in parts of Taunton (3), Bridgwater (3), Yeovil (1), Highbridge (1), Glastonbury (1)[11].

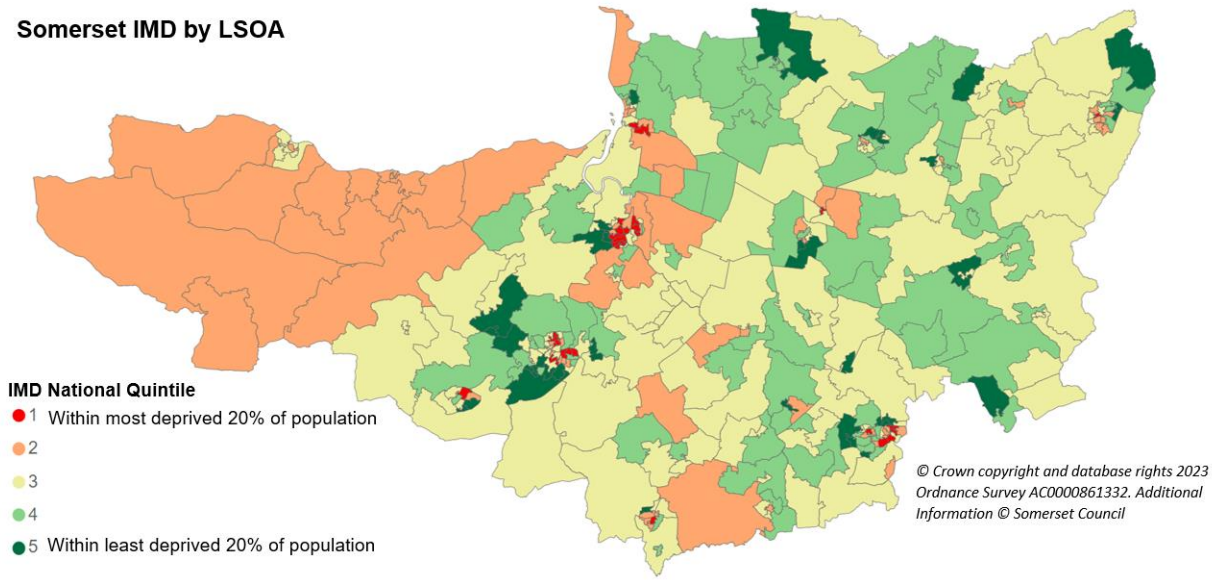

Figure 2 – Source IMD 2019

3 Key Outcomes:

There are 5 sexual health Public Health Outcomes Framework measures:

- under 18 conceptions
- chlamydia detection rate (under 25s)
- new STIs diagnosis (excluding chlamydia in the under 25s)
- prescribing of long-acting reversible contraception (LARC) excluding injections (females aged 15 to 44)
- people presenting with HIV at a late stage of infection

Other sexual health outcomes include:

- clear, accessible, and up-to-date information in a range of formats available about services providing contraception and sexual health services for the whole population, including preventative information targeted at those at highest risk of sexual ill health
- increased uptake of effective methods of contraception, including rapid access to the full range of contraceptive methods (including LARC) for all age groups
- a reduction in unplanned pregnancies in all ages as evidenced by teenage conception and abortion rates
- improved access to services among those at highest risk of sexual ill health
- reduced sexual health inequalities among young people
- increased timely diagnosis and effective management of STIs and BBVs (blood borne viruses)
- repeat and frequent testing of those that remain at risk and contact tracing completed when people test positive
- increased uptake of HIV testing with particular emphasis on first time service users and repeat testing of those that remain at risk
- improved access to HIV PrEP (pre-exposure prophylaxis) among those at highest risk of HIV infection
- monitor late diagnosis and uptake of partner notification
- increase availability of condoms and adoption of safer sex practices

3.1 Reproductive Health

Maintaining good reproductive health and wellbeing has profound and positive long-term effects on the individual and society. Many women and girls experience poor reproductive health outcomes, with almost half of all pregnancies in the UK being ambivalent or unplanned[12].

COVID-19 pandemic led to sexual health services (SHS) in England having a significantly reduced capacity to deliver face to face consultations, however services adapted to increase access via phone and internet consultations. SRH delivery in England was impacted, with the long-term implications of this still largely unknown. Access to LARC fitting and removals was especially impacted due to the requirements

of face-to-face interaction. Bridging methods of contraception (such as progesterone only pill) were used when LARC fitting was unavailable[13].

In Somerset between 2019 – 2020 there was a 15.9% decrease in females attending specialist contraceptive services.

3.1.1 Contraception

Contraception in the UK is widely available and is provided free at point of use to anyone through the NHS. Contraception is available free of charge from GPs, SRH services, young person's clinics, accident and emergency (only for emergency contraception), and some pharmacies under Patient Group Directions (PGDs).

Provision of contraception at the time of abortion is recommended, and should be commissioned as part of this service, particularly LARC methods. Condoms are provided for free at SHS, as well as through local condom distribution methods, such as the C-Card scheme. Emergency hormonal contraception such as levonorgestrel and ulipristal acetate, can be provided for free in pharmacies, as well as being available for over counter purchases at some pharmacies and clinics.

3.1.1.1 LARC

Long-acting reversible contraception (LARC) is the most effective form of contraception as it does not rely on daily compliance; these methods include implants, intrauterine devices (IUD) and intrauterine systems (IUS). Sometimes contraceptive injections are described as a LARC method however they still require some user dependency to ensure compliance with repeat visits required within the year. Implants, IUS and IUD can remain in place for up to 3, 5 or 10 years and are more cost effective than condoms and the pill. Low levels of LARC provision would indicate poor access to contraception and subsequently higher numbers of unplanned pregnancies.

Nationally there was a significant reduction in prescribing of IUD, IUS, and implants from April 2020, however recovery was seen by December 2020. Consistently throughout 2020 the prescribing rates were lower than the baseline rates of 2019, leading to some backlogs in provision. There was a reduction in LARC provision in Somerset general practices and SWISH in 2020/21 as shown in the tables below. SWISH were able to reduce their backlog in 2021/22. Somerset Council invested in additional support to general practices to a reduction of their backlog which led to a higher than normal provision in 2021/22; early data shows this appears to have now returned to more usual levels in 2022/23.

Table 5 - SWISH LARC activity. Source: SWISH. Note incomplete data for some years

	Implant fit	Implant refit	Implant removal	IUS/IUD fit	IUS/IUD refit	IUS/IUD removal
2022/23 (x3 Qtr)	237	206	254	269	161	239
2021/22 (x3 Qtr)	267	227	256	321	158	204
2020/21 (x 4 Qtr)	258	204	318	338	136	228
2019/20 (x2 Qtr)	195	118	198	243	90	142

Table 6 – LARC – Total IUCD for contraception and non-contraceptive purposes, implant fit and removals – by year. (Provision in General Practice)

Year	IUCD Fits	IUCD Fits non contraception	Nexplanon Fits	Nexplanon Removals
2018/19	1,881	170	2,251	1,913
2019/20	1,811	209	2,272	1,958
2020/21	1,456	130	1,631	1,702
2021/22	2,102	261	1,966	1,999
2022/23 *	1,969	296	1,862	1,907

*2022/23 figures not finalised so may increase

LARC Fittings at Somerset GP Practices - 2021/22 Audit

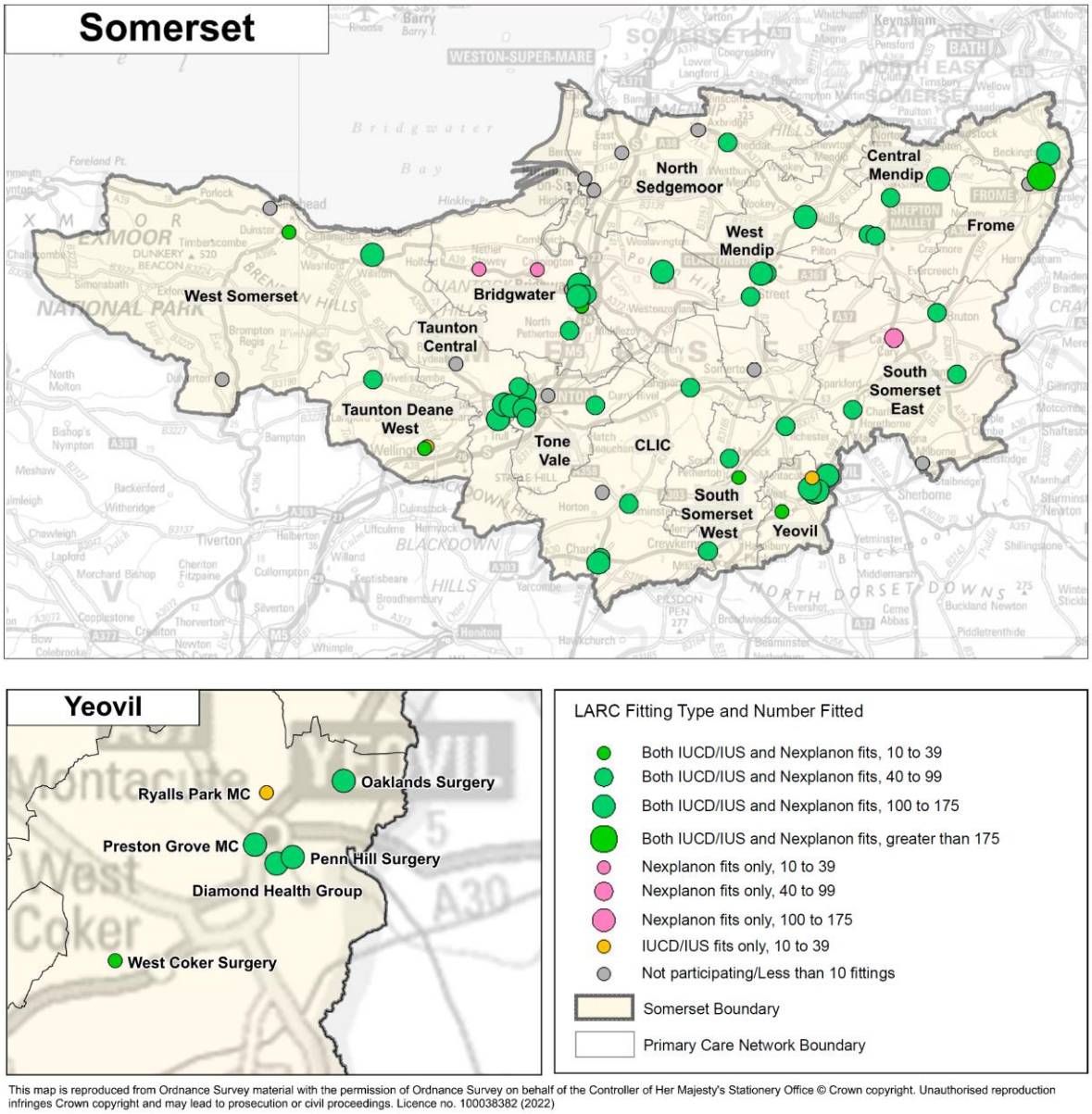

Figure 3 – LARC fittings at Somerset GP Practices, for more information see appendix 2.

Table 7 - LARC prescribing 2021. Rate /1,000 women aged 15-44. Source: OHID[14] (Trends are based on the 5 most recent time points)

decreasing trend no significant change increasing trend

	GP Prescribed LARC, excl. injections. Rate /1,000 (2021)	SRH Services prescribed LARC, excl. injections. Rate /1,000 (2021)	Total prescribed LARC, excl. injections. Rate /1,000 (2021)
England	25.7	16.1	41.8
Somerset	51.8	13.1	65.4
Mendip	60.8	6.0	66.7
Sedgemoor	40.8	19.1	60.6
South Somerset	53.4	11.7	65.1
SWAT	52.5	15.9	68.3

In 2021 the total rate of LARC (excl. injections) prescribed in Somerset (primary care, specialist, and non-specialist SHS) was 65.4 per 1,000 women aged 15-44 (table above). This compared to 41.8 in England and 58.1 in the South West and shows a 9.8% increase from 2020. LARC is more common in women over 25, with 50.3% over 25's choosing LARC (excl. injections at SRH services) in Somerset; and 34.2% of under 25's choosing LARC (excl. injections at SRH services), 2021. From 2020 to 2021 there was a 1% increase in over 25's choosing LARC (excl. injections at SRH services) in Somerset. When compared to the CIPFA's nearest neighbours for under 25's choosing LARC (excl. injections at SRH services) Somerset ranked 13/16, showing a trend of no significant change[15].

As the table illustrates, the provision of LARC through general practices remains an essential service in a large rural county such as Somerset, enabling a wider choice of access. Supporting general practices in training GPs and Practice Nurses to fit LARC remains a priority for Somerset Council as is the development of inter-practice referrals so that practices who do not provide the service can refer women their patients to an alternative practice. This enables SWISH to prioritise complex procedures and support to vulnerable young people and adults, including providing LARC to women who are part of the Pause Programme in Somerset.

3.1.1.2 Other contraceptive data

Women prescribed short-acting combined hormonal contraceptive at SRH services, is 7.9% in Somerset, this is higher than the South West regional average (6.7%), but lower than nationally (7.6%) (2021)[16]. Additionally, women choosing hormonal short-acting contraceptives (at SRH services) is 33.7% in Somerset, which is lower than nationally which is 41.7% (2020). Women prescribed injectable contraception at SRH services is 4.0 per 1,000 women aged 15-44 in Somerset, this is similar to regionally (3.0%) and nationally (3.6%) (2021). Furthermore, women prescribed injectable contraception in GP practices is 37.3% in Somerset, which is higher than nationally (26.5%) and regionally (30.8%)[17].

Between 2019-2020 there was a 0.2% decrease in spending on contraceptives in Somerset, with Bridgwater seeing the largest reduction in spending with a 7% decrease[18]. In Somerset there was a total of 102,796 prescriptions for contraceptives in 2018/19, this remained similar in 2019/20 at 102,763[19]. 95,678 contraceptives prescribed in Somerset CCG 2020-21, and 96,268 contraceptives prescribed in 2021-22[20].

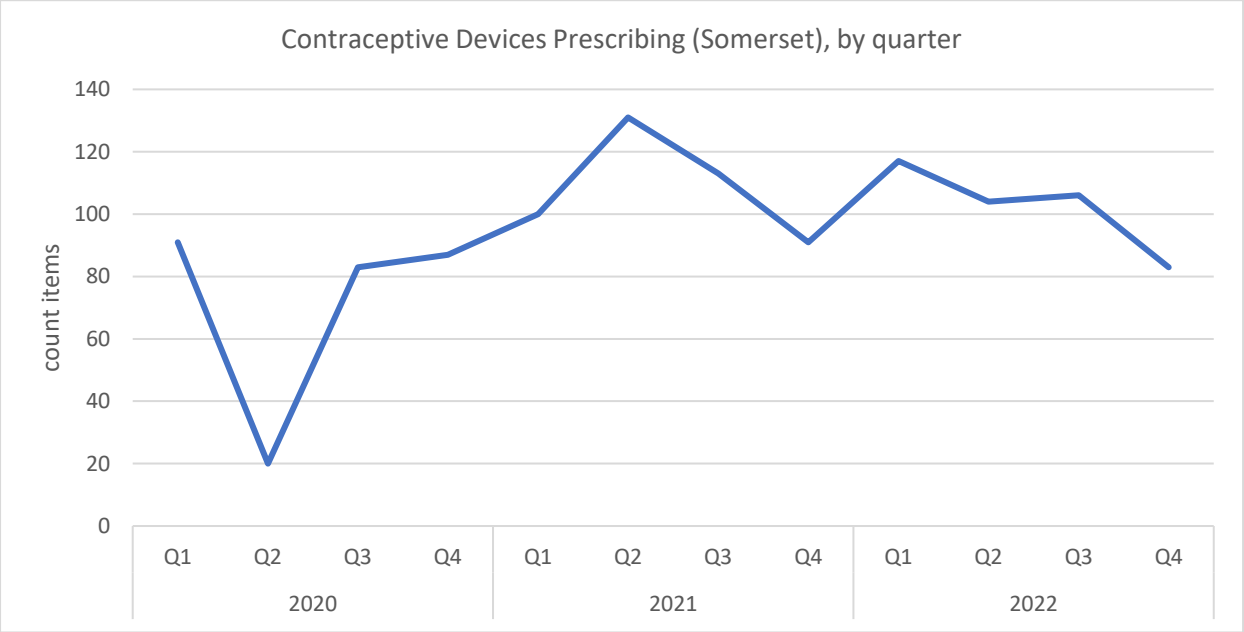

Figure 4 – Contraceptive devices prescribing (Somerset), by quarter[21].

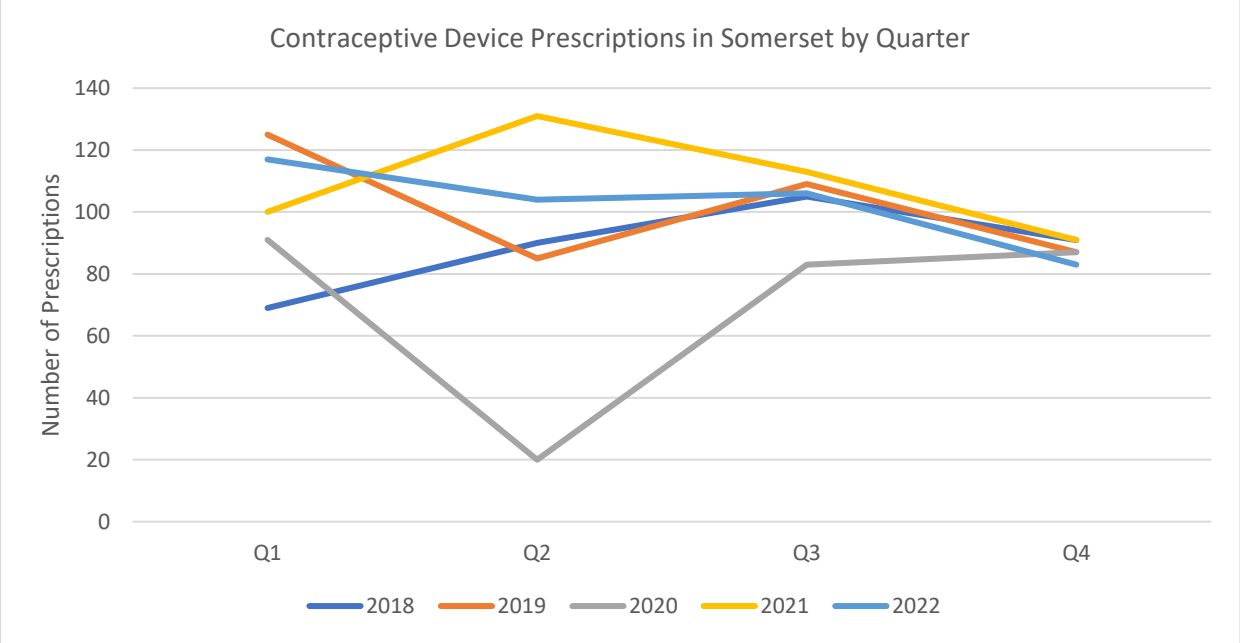

Figure 5 – Trends of contraceptive prescribing in Somerset 2018-2022[22]

As seen in the figures above there was a notable reduction in prescriptions for contraceptive devices in Q2, 2020 – this coincides with the covid-19 pandemic.

3.1.1.3 Emergency Contraception

Emergency contraception (EC) is an intervention aimed at the prevention of unintended pregnancy after unprotected sexual intercourse (UPSI) or contraceptive failure. It can be obtained free across Somerset from several sources including: SWISH, GP practices, Minor Injury Units (MIU), School Nursing Teams, and many local community pharmacies who can provide access to advice along with the provision of emergency hormonal contraception (EHC) for those aged under 25.

Emergency contraception comes in two methods: copper intrauterine device (IUD), and emergency hormonal contraceptive pill (EHC).

Copper coil (Cu-IUD) is the most effective contraception method and should be offered to all individuals seeking emergency contraception (unless they are unsuitable). The Cu-IUD can be inserted up to 5 days after the first unprotected sexual intercourse in a cycle or within 5 days of the earliest estimated date of ovulation[23,24]. It must be fitted by a trained doctor or nurse.

Emergency Hormonal Contraceptive oral pill – should be taken as soon as possible to maximise efficacy[25]:

- Levonorgestrel (Levonelle) – is more commonly used, which should be taken within 72 hours after unprotected sexual intercourse (UPSI). It may also be used up to 96 hours although efficacy decreases over time. The Faculty of Sexual and Reproductive Health (FSRH) produced guidance recommending a double dose of levonorgestrel for those with a high Body Mass Index (BMI)
- Ulipristal acetate (ellaOne) – this can be used up to 5 days after UPSI (120 hours)

Community pharmacy

Emergency hormonal contraception is provided free under PGD to women in Somerset; from June 2018 this was limited to those aged under 25 (with pharmacies able to provide to vulnerable women aged over 25 at their discretion). EHC is currently provided in approximately 67 different locations across Somerset.

Table 8 – Provision of emergency hormonal contraception in community pharmacies under PGD in Somerset. Source PharmOutcomes

		2017-18	2018-19	2019-20	2020-21	2021-22
Total	total n	2157	1175	875	568	714
	Ulipristal Acetate	-	28.1%	38.9%	41.2%	37.3%
	Levonorgestrel	-	42.3%	61.0%	58.6%	62.0%
	No treatment suitable	-	0.1%	0.1%	0.2%	0.7%
	n/a	100.0%	29.5%	-	-	-
Under 18's	total n	327	294	263	133	210
	failed condom	36.7%	32.0%	35.7%	24.1%	30.0%
	unprotected sex	54.7%	60.2%	56.7%	65.4%	62.9%
	missed pill	6.7%	5.4%	5.7%	10.5%	7.1%
	Reduced pill efficacy	1.8%	2.0%	1.9%	-	-
	Other (e.g., vomited previous EHC)	-	0.3%	-	-	-
18-25	total n	887	700	598	428	490
	failed condom	37.3%	35.7%	32.3%	25.0%	29.4%
	unprotected sex	52.2%	55.4%	57.2%	43.1%	63.3%
	missed pill	8.8%	7.1%	8.4%	5.8%	5.5%
	Reduced pill efficacy	1.7%	1.7%	2.2%	0.9%	1.8%

	Other (e.g., vomited previous EHC)	-	-	-	0.2%	-
% aged over 25		43.7%	15.4%	1.6%	1.2%	2.0%
BMI over 26, or weight over 70kg (aged under 25)		4.4%	16.3%	12.3%	11.8%	10.4%

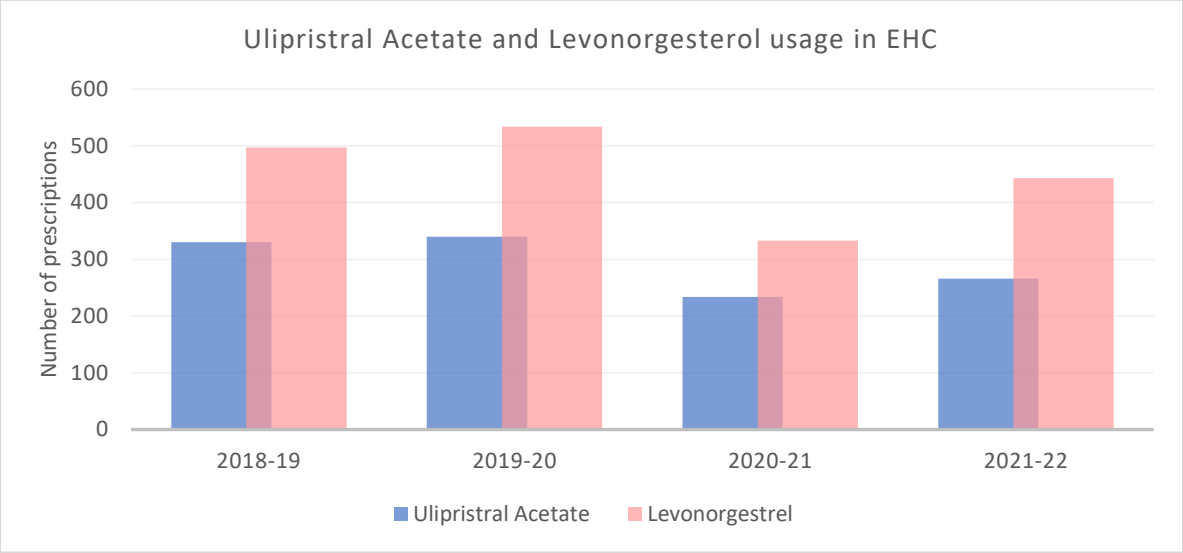

Figure 6 – Breakdown of Ulipristal Acetate and Levonorgestrel usage in EHC

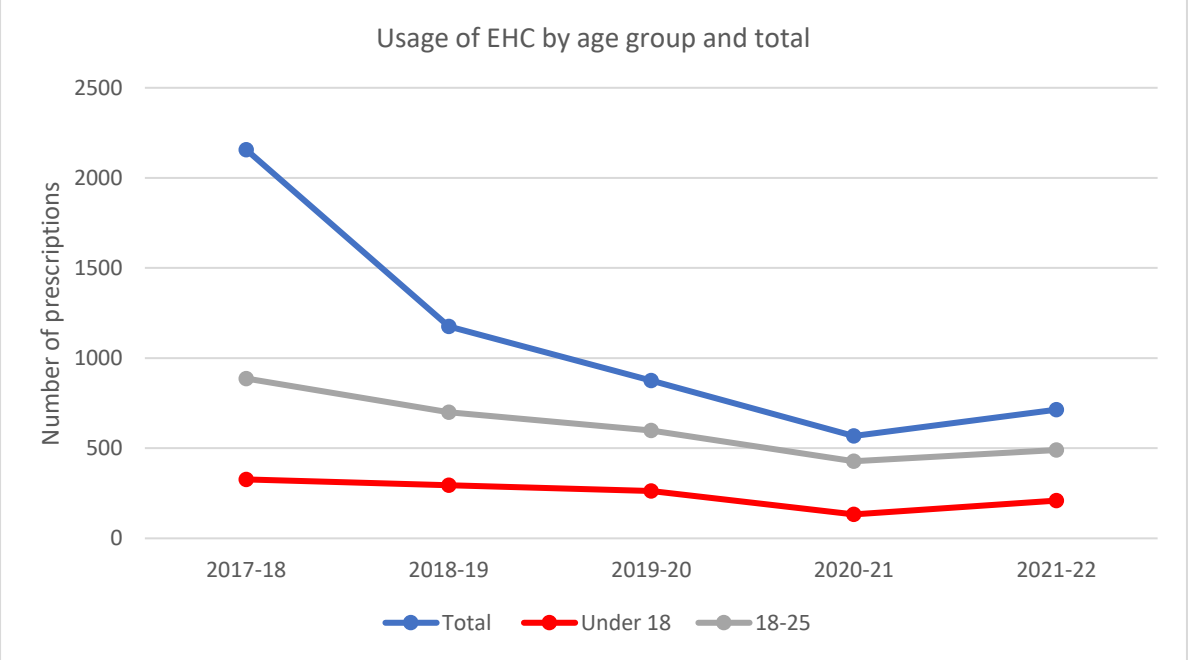

Figure 7 - Usage of EHC by age group (Under 18, and 18-25) and total

In all age groups EHC was most commonly used due to unprotected sex, followed by failed condoms, missed pills and reduced pill efficacy. The number of EHC provided through community pharmacies decreased during the pandemic in 2019/20. This is slowly increasing although still remains below previous levels. There could be a number of factors as to the decreasing trend with increasing access to LARC and other contraceptive methods being a positive contributor; however, it is important to

understand if this is also due to issues regarding access, further exacerbated by pressure on community pharmacies and the closure of some pharmacies across the county and others now not providing the service. Pharmacies play an important role in supporting sexual health by providing advice and signposting as well as EHC, and it is intended they will have a future role in the provision of oral contraception.

3.1.1.4 Post-natal Contraception

The NICE Quality Standard on Contraception After Childbirth states that women who have given birth should be provided with information about, and offered a choice of, all contraceptive methods by their midwife[26]. This reduces the risk of future unplanned pregnancies and helps to avoid the risk of complications associated with an interpregnancy interval of less than 12 months.

Meeting this standard is a challenge for maternity services across England particularly due to midwife capacity to undertake the required training as well as to offer the full range of contraception post-partum. In addition, fragmented commissioning arrangements mean it is often unclear how this service would be funded. In Somerset there is not currently a systematic offer of post-partum contraception but it has been identified as an area for development. Initially this will focus on information given at the antenatal stage and post-partum, pathways to provision in general practice and SWISH and exploring the provision of oral contraception post-partum.

One indicator of effective post-partum contraception is the percentage of women under 25 who have had an abortion having previously given birth:

Under 25's abortion after a birth (%), when compared to nationally (26.0%), or regionally (22.2%) there is a similar rate in Somerset (23.6%), which has shown a recent trend of no significant change[27].

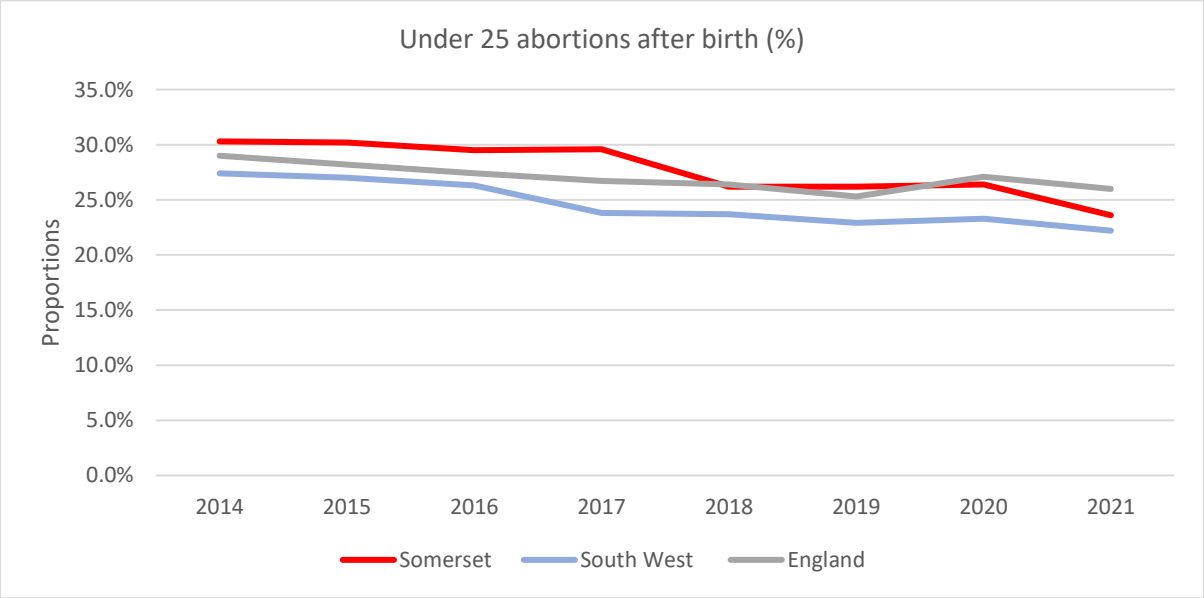

Figure 8 – Percentage of women aged under 25 years having an abortion who have previously had a birth (%)[28]

3.1.2 Teenage Conceptions

Young people who have experienced pregnancy are at a higher risk of subsequent unplanned conceptions, as well as potentially having negative impacts on education, livelihoods and health. Teenage parenthood reduces the life chances of children and young people and their children.

As of 2021 the teenage conception rate in Somerset was 11.9 per 1,000 women under 18, this is higher than the South West regional average (11.1 per 1,000), but lower than nationally (13.1 per 1,000)[29]. This has decreased from 38.8/1,000 in 1998, with Somerset consistently having lower rates than nationally. Somerset rates have shown consistent trends of decreasing since 2007. There were 111 conceptions in Somerset (2021), with 59.5% leading to abortion (South West region, 56.7%, England 53.4%). From 2020 – 2021 there was an 11% increase in the conception rate of women aged under 18 (8.4% in the South West, 4.1% in England). Additionally, Somersets under 18 conceptions from 1998-2021 have shown a decreasing trend with a 68.5% decrease (% change 1998 to 2020 conception rate per 1,000 women in age group).

From 2019-2021 there was a 0.9% increase in the teenage conception rate per 1,000. Sedgemoor is of particular concern as the district in Somerset with the most significant increase in teenage conceptions with 75.3% increase 2020-2021 (25.9% increase 2019- 2021), compared to Mendip at 0.0%, South Somerset with a 13.4% decrease, and SWAT with a 2.8% decrease. Whilst this is only a slight increase overall it is unclear what the longer term impact the pandemic might have had on young people's behaviour, knowledge and access to services and it will be important to understand and respond to the level of increase in Sedgemoor in particular.

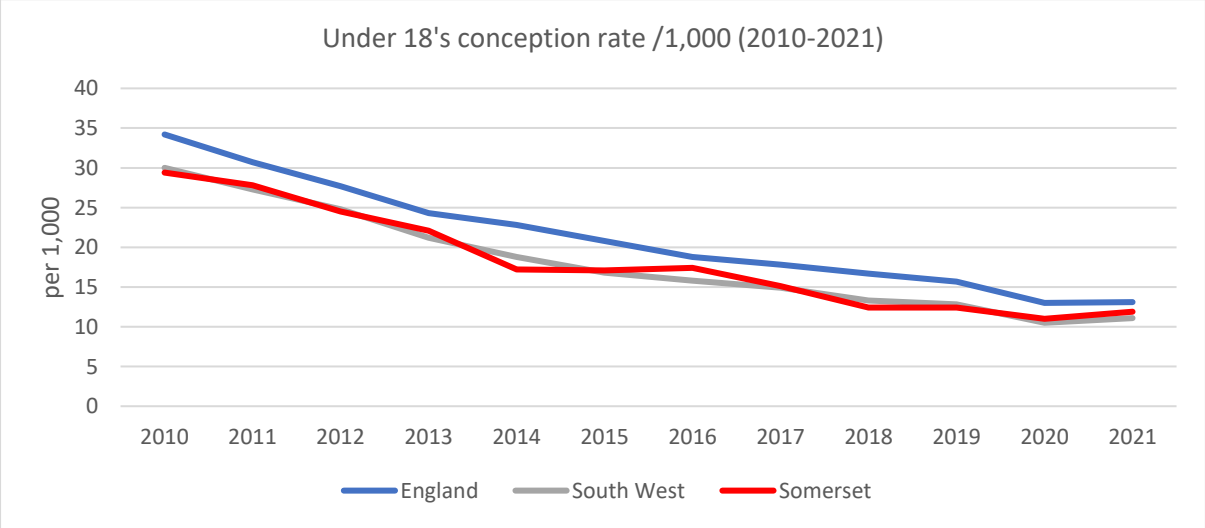

Figure 9 - Conceptions in women aged under 18 per 1,000 females aged 15-17 – Somerset compared to England and Southwest Averages[30]

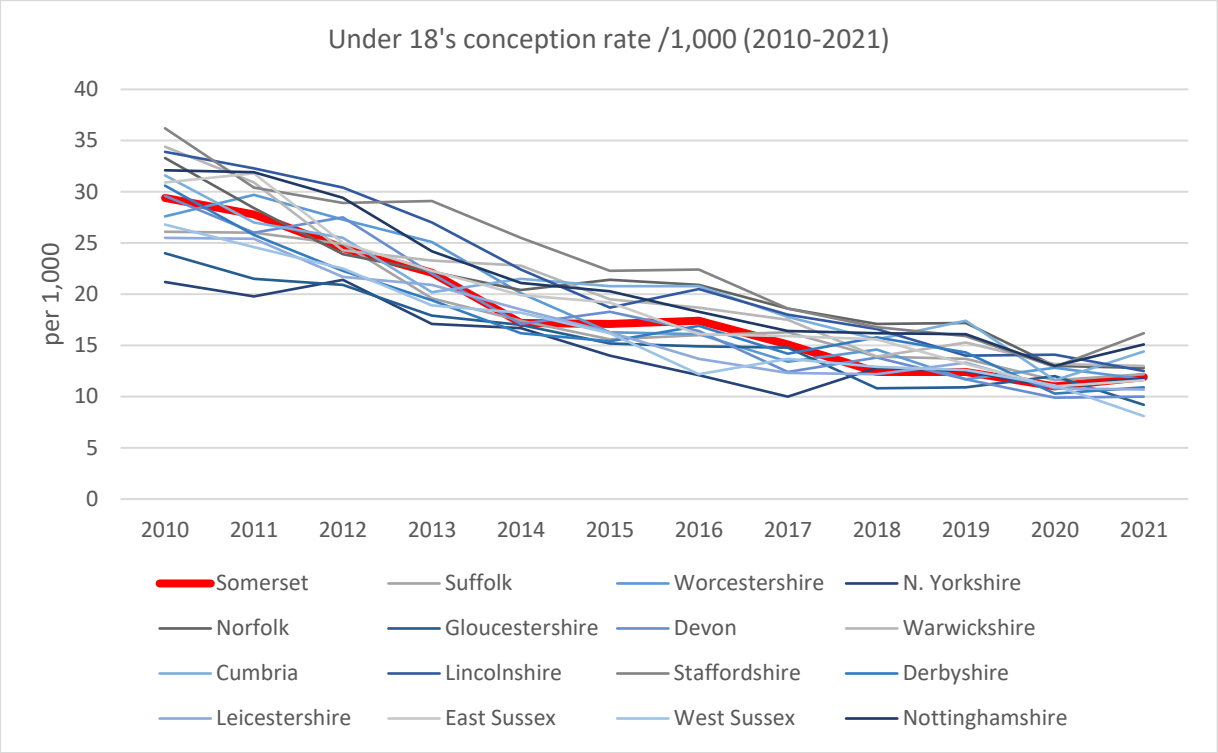

Figure 10 - Conceptions in women aged under 18 per 1,000 females aged 15-17 – Somerset compared to CIPFA Nearest Neighbours[31]

Table 9 – Somerset teenage (15–17-year-olds) conception rates, and percent change by count[32]

	2021 teenage conceptions (under 18) /1,000	% Change (count) of teenage conceptions 2000 - 2021	% Change (count) of teenage conceptions 2020 - 2021
Somerset	**11.9**	**-67%**	**11%**
Mendip	9.1	-72%	0%
Sedgemoor	17.0	-63%	74%
South Somerset	11.6	-63%	-11%
SWAT	10.6	-70%	4%

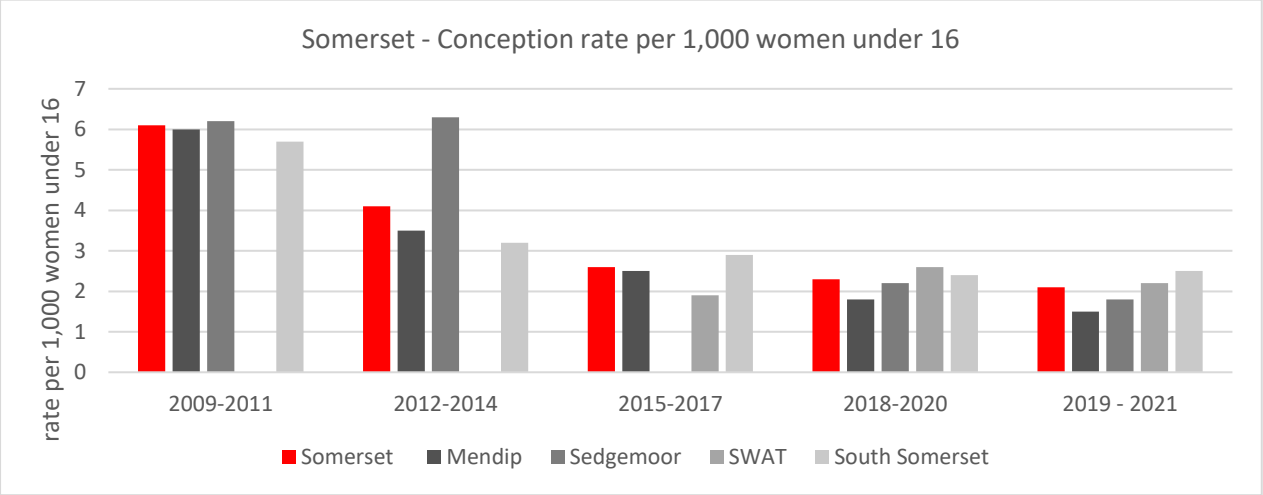

Figure 11 – Somerset Conception Rate per 1,000 women under 16[33]

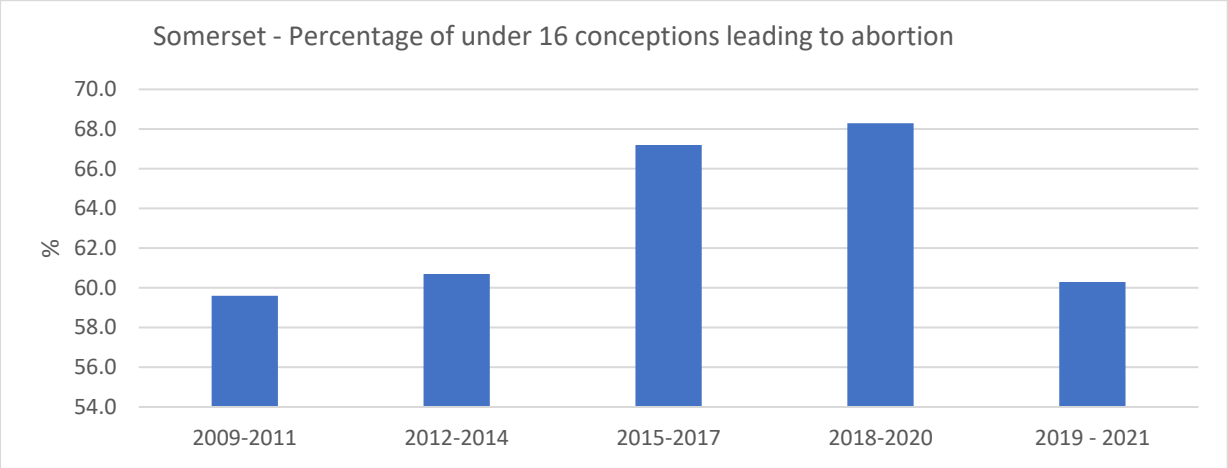

Figure 12 – Somerset. Percent of under 16 conceptions leading to an abortion[34]

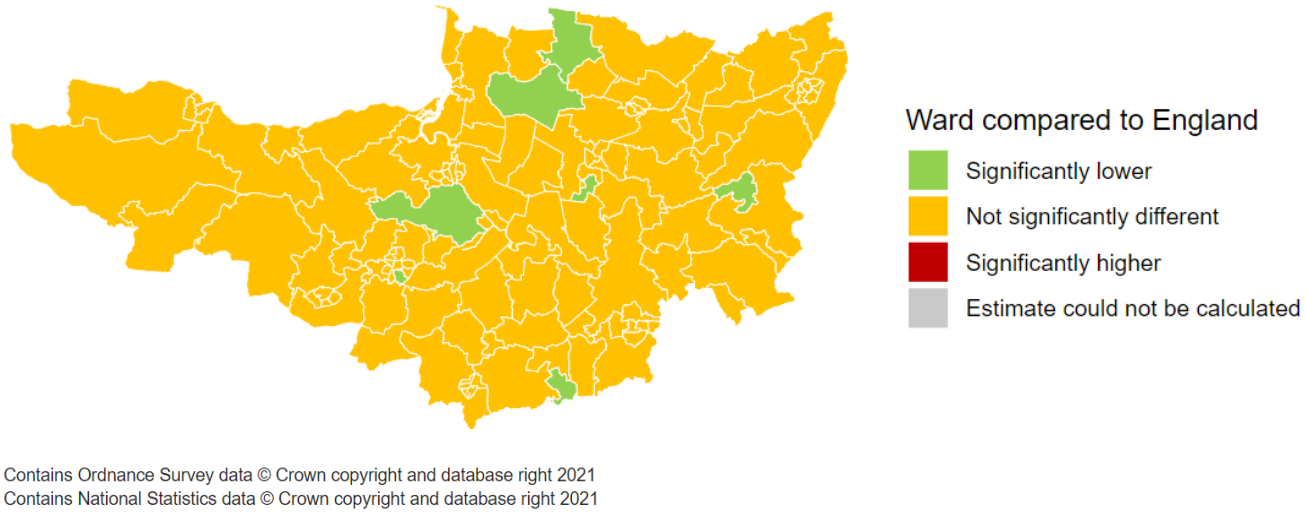

Figure 13 – Under 18 conceptions in Somerset by ward, compared to the rate for Somerset: three-year period between 2018-2020[35]

3.1.3 Abortion

The earlier abortions are performed the lower the risk of complications. Prompt access to abortion, enabling provision earlier in pregnancy, is also cost-effective and an indicator of service quality. In Somerset in 2020 88.0% of abortions were within the first 10 weeks and Somerset was not significantly different from the national average of 88.6%, or regional average (87.7%) This indicates good access to abortion services, including early medical abortions.

Under 18's conceptions leading to abortion - in Somerset 59.4% of under 18 conceptions lead to abortion (66) (2021), this is statistically similar to the national average of 53.4%, and the Southwest regional average of 56.7%, the recent trend has shown no significant change.

Repeat abortions under 25 is an indicator of a lack of access to good quality contraceptive services and advice. In Somerset 27.4% of abortions in women aged under 25 years involve a woman who has had a previous abortion in any year, this is similar to nationally (29.7%), and regionally (25.5%) (2021)[36].

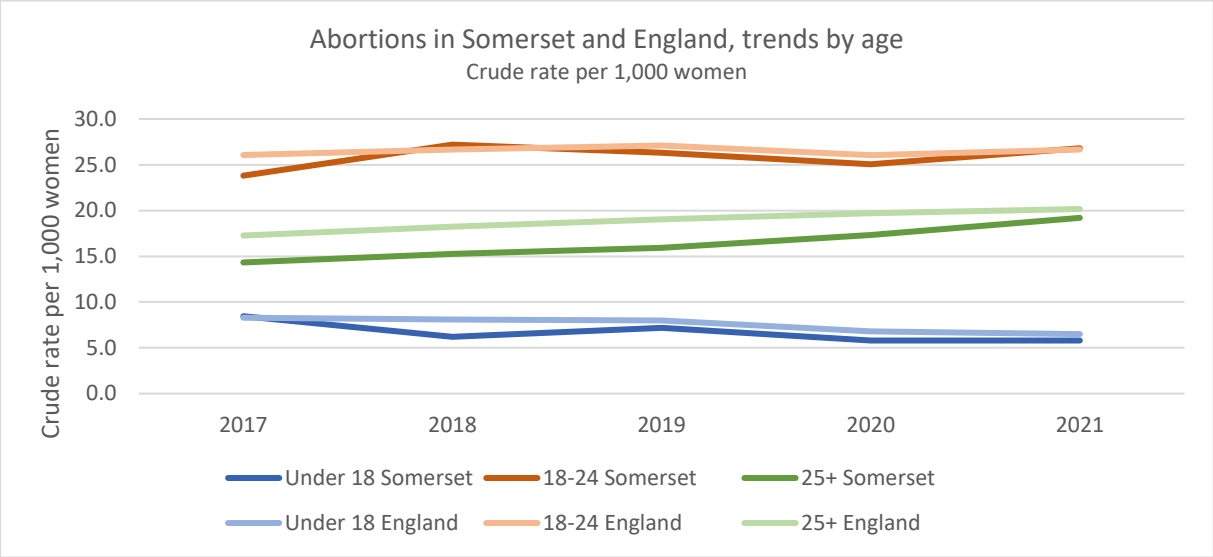

Figure 14 - Abortions in Somerset CCG compared to England, Source: ONS Abortion Statistics[37]

Abortions in Somerset in the Under 18, and 25+ age groups are consistently lower than in England (as can be seen in the figure above). The total number of abortions since 2017 (count 1,269) have increased gradually and as of 2021 have a count of 1,531 – the rate per 1,000 women is consistently highest in the 18-24 age group.

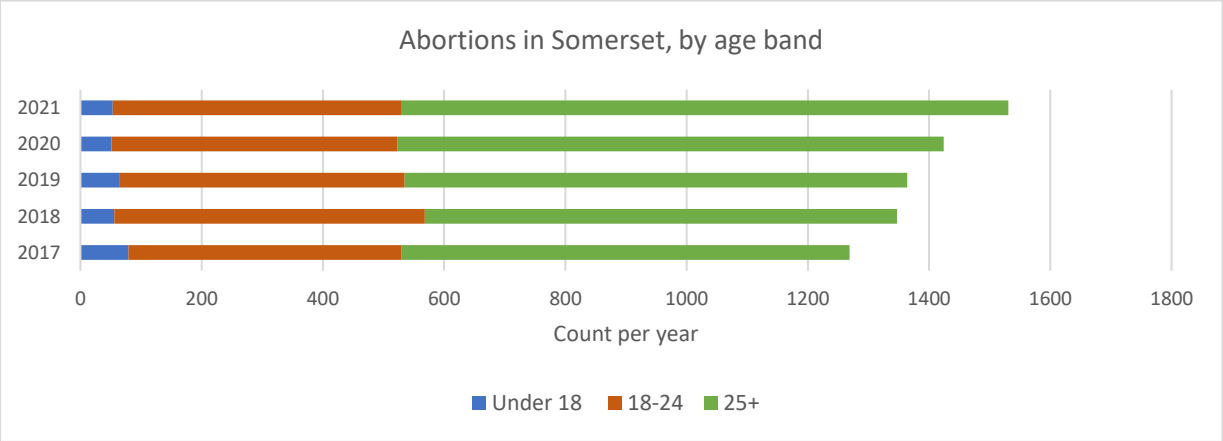

Figure 15 - Abortions Somerset CCG - number of individuals per age band[38]

The increase in abortions across all age groups is an indicator of decreased access to contraception including LARC. During the COVID-19 pandemic the government introduced a temporary approval in England enabling women and girls to take both pills for early medical abortion (EMA) up to 10 weeks gestation in their own homes. This scheme benefitted lots of women providing timely access and subsequently in 2022 MPs voted to make this a permanent service. Whilst 'pills by post' provides a safe and effective option for women it has meant that it is more difficult to offer women

access to contraception and LARC at the time of procedure which was an important strategy in reducing repeat abortions. This can still be offered to women who attend abortion clinics but for those having EMA at home other options need to be considered including initial prescribing of oral contraception and signposting to general practice and SHSs for ongoing contraception including LARC.

Under 18 conceptions, rate of abortion per 1,000 has shown a gradual decline since 2010, however since 2020 there has been a slight increase this is especially pronounced in Sedgemoor (see figure below) which has experienced an increase in teenage conceptions.

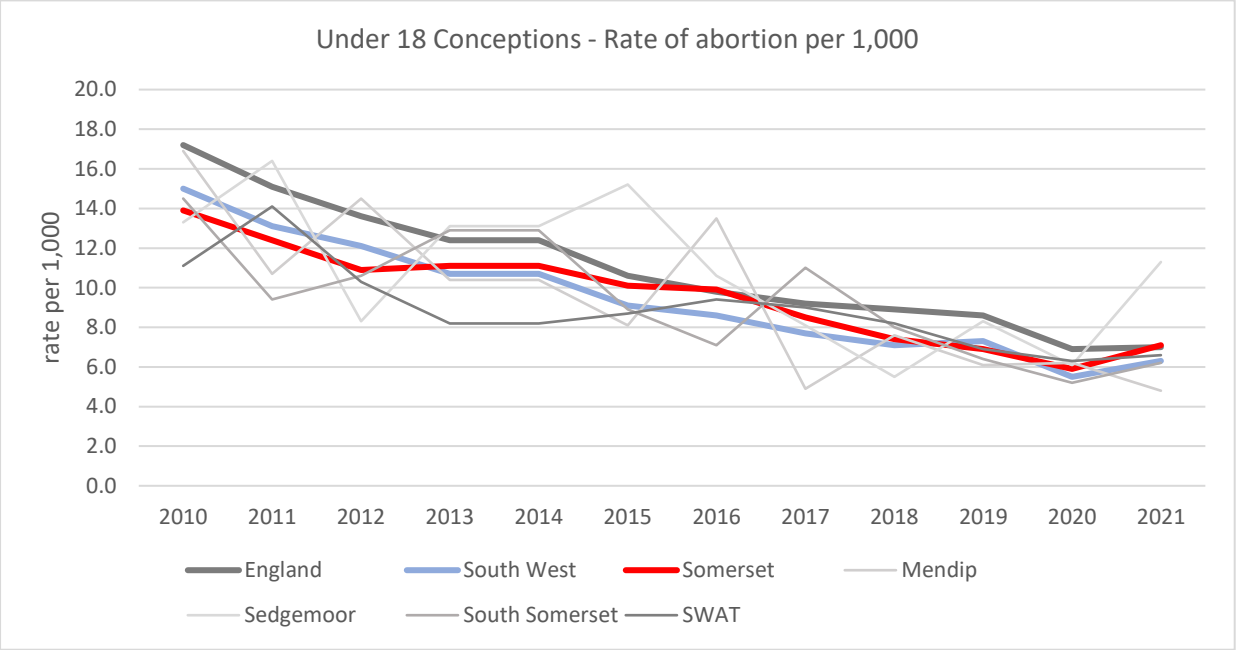

Figure 16 - Under 18 conceptions leading to abortion, trend 2010-2020. (Somerset compared to South West region and England)[39]

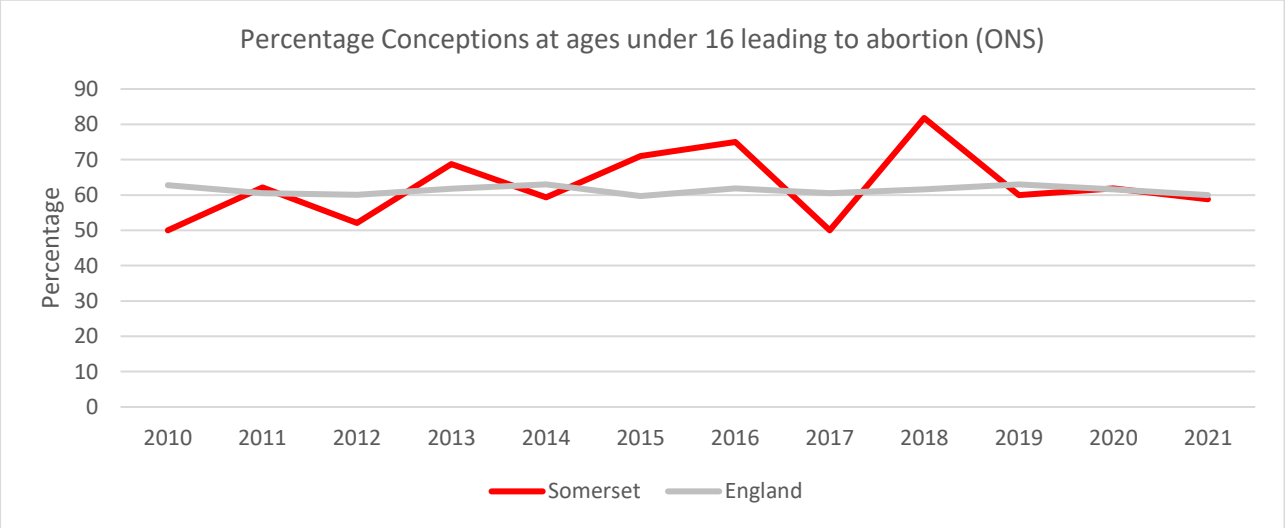

Figure 17 - percentage of conceptions of individuals at ages under 16 leading to abortion. Somerset compared to England. Source: ONS[40]

3.2 Sexually Transmitted Infections (STIs)

Sexually transmitted infections (STIs) may seriously impact the health and wellbeing of affected individuals, as well as being costly to healthcare services. The most common STIs in England are chlamydia, genital warts, gonorrhoea, genital herpes and syphilis. If left undiagnosed and untreated, common STIs can cause a range of complications and long-term health problems including pelvic inflammatory disease, ectopic pregnancy, infertility, adverse pregnancy outcomes, neonatal and infant infections and blindness, urethral strictures and epididymitis in men, genital malignancies, proctitis, colitis and enteritis in GBMSM, and cardiovascular and neurological damage. In addition increasing resistance and decreased susceptibility to antimicrobials used to treat STIs has reduced treatment options, particularly in relation to gonorrhoea[41].

Due to the Covid-19 pandemic strict non-pharmaceutical interventions were implemented, in the form of lockdowns, and social and physical distancing measures including staying at home. Sexual health services (SHS) 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 during 2020. Diagnosis which usually would occur at face-to-face consultations, such as genital warts or genital herpes saw larger decreases than STI's which can be diagnosed using self-sampling kits, such as chlamydia and gonorrhoea[42]. Testing levels largely recovered in 2021, with diagnosis generally remaining lower. STIs continue to disproportionately impact GBMSM, young people aged 15 to 24 years, and people of black Caribbean ethnicity.

Some STIs are particularly associated with high risk sexual behaviour, notably syphilis and gonorrhoea as well as HIV. High risk sexual behaviour includes having anal, vaginal or oral sex without a condom, having multiple partners and having sex while under the influence of alcohol or drugs, especially Chemsex (the use of drugs before or during planned sexual activity, often with multiple partners, to sustain, enhance, disinhibit or facilitate the experience).

STI's are often asymptomatic thus frequent screening, especially of groups who are at higher risk is essential. Screening should be undertaken in line with national guidance. Early identification and treatment of STI's can reduce long term complications as well as reduce transmission.

Vaccination can be used as an intervention to control some STI's, such as hepatitis A, Hepatitis B, and genital warts. Control of other STI's relies upon consistent condom use, behaviour changes, access to testing and treatment, and notifying and testing sexual partners of cases.

A total of 1,726 new STIs were diagnosed in 2021 (in Somerset residents). From 2020 to 2021 there was a 2.7% decrease in new STI diagnoses. Somerset ranked 129th out of 149 UTLAs and UAs for new STI diagnosis, with a rate of 306.1 per 100,000 population, compared to 551 per 100,000 nationally[43].

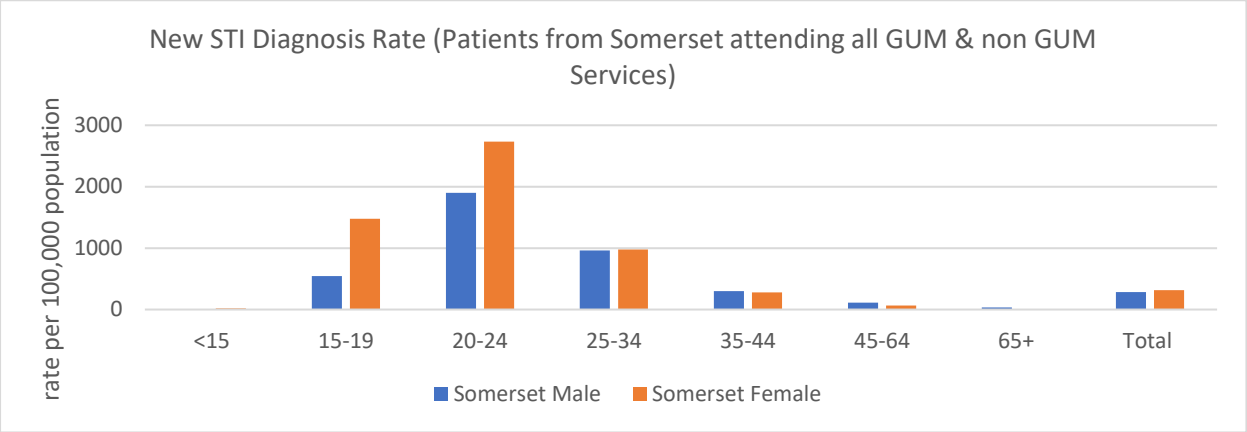

Figure 18 - New STI Diagnosis Rate (Patients from Somerset attending all GUM & non-GUM Services), by age group. 2021 Q1 – 2021 Q4. Source: GUMCAD

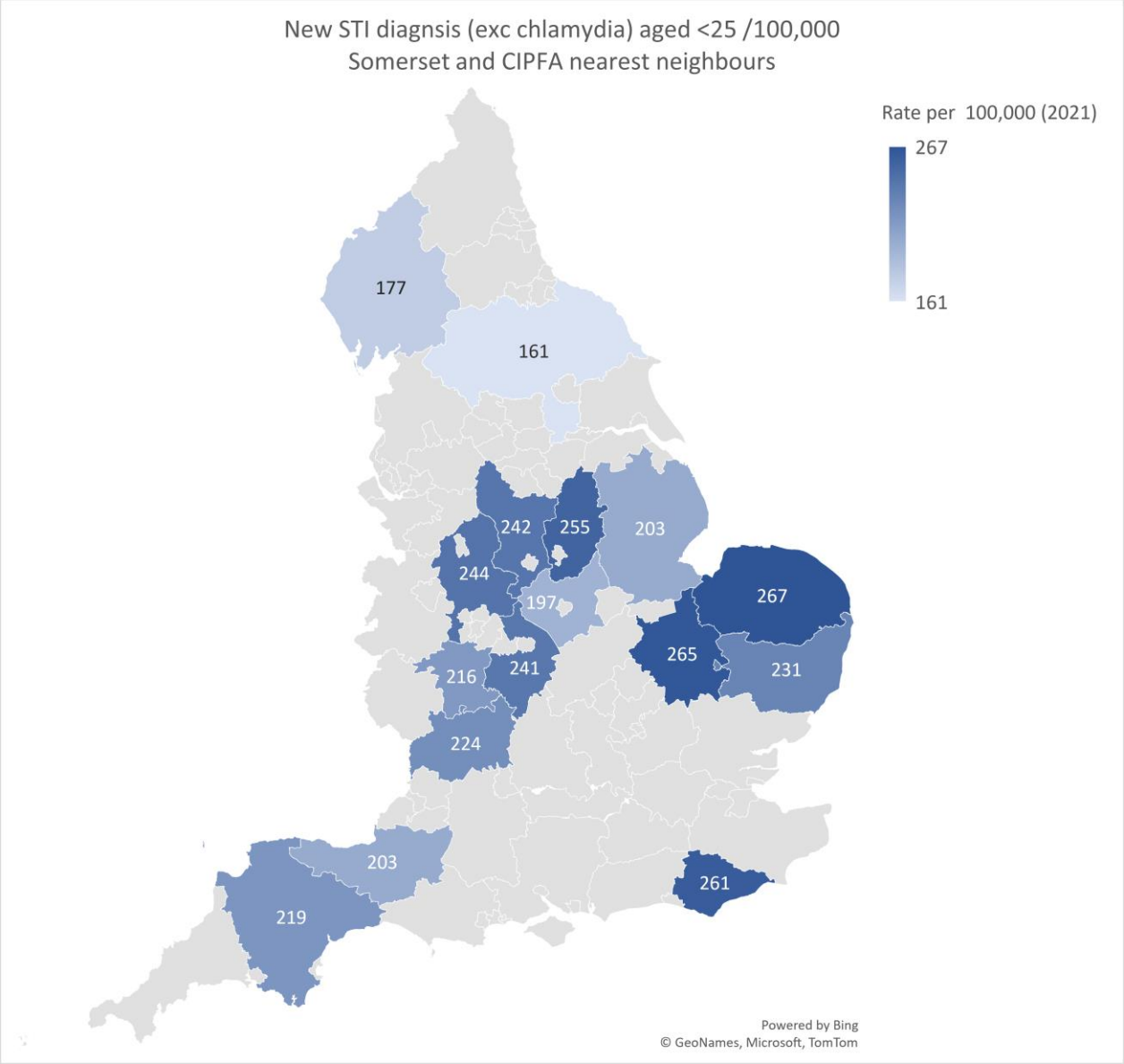

Figure 19 - New STI diagnosis (excluding chlamydia) aged <25 /100,000. Somerset and CIPFA nearest neighbours (2021)

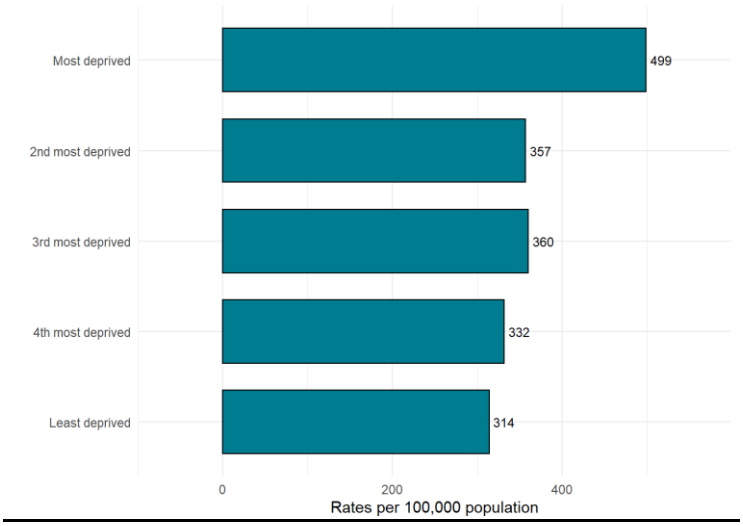

Figure 20 - Distribution of new STIs and Deprivation - Rates per 100,000 population of new STIs by deprivation category in Somerset (SHS diagnoses only): 2020. Source: SPLASH supplement [44].

New diagnosis of STIs are most seen in the most deprived population.

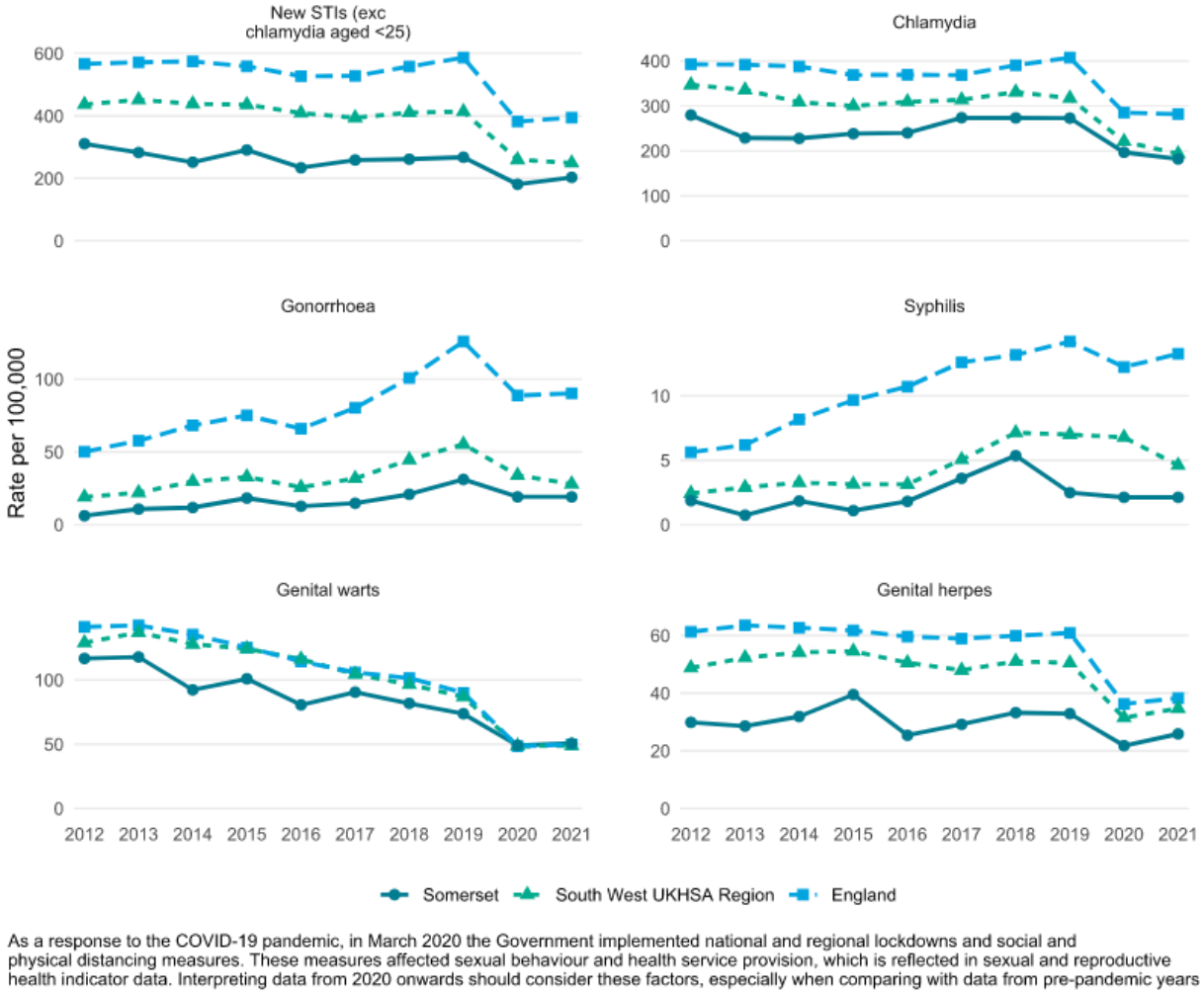

Figure 21 - Rates per 100,000 population by diagnosis by year in Somerset compared to rates in the South West UKHSA Region and England: 2012 to 2021 (Please note the charts have different y axis scales)[45]

Understanding trends in the diagnosis of STIs and HIV are important in monitoring levels of diagnosis and the groups most impacted. However, reliance on GUMCAD data inevitably leads to a delay in understanding any new or emerging trends that sexual health services may be seeing in a timely way. SHSs play an important role in identifying unexpected increases in STI diagnosis and alerting local and regional health protection teams. Most recently this has included mpox associated with individuals with high risk sexual behaviour where SHSs played an important role in raising awareness and offering vaccines. Increases are also being seen in the diagnosis of syphilis and gonorrhoea in the South West. Gonorrhoea levels have increased beyond those seen in 2019 before the pandemic, which in itself saw the highest level of diagnosis. Early identification of such trends enables timely incident management and enhanced surveillance to inform understanding of behaviours, groups impacted and to co-ordinate targeted responses.

3.2.1 Chlamydia

The Covid-19 pandemic led to a reduction in chlamydia screening smart kits, due to services being closed or reduced; there has however been an increase in online requests for screening. In 2020/21 Q4 1290 tests were requested online, with 921 of these being returned (equalling a 71.4% return rate). Of these tests there was a 7.6% positivity for chlamydia (117) and 0.1% positivity for gonorrhoea (<5).

Increasing diagnosis rates for chlamydia, are predominantly driven by changes in testing behaviour due to the National Chlamydia Screening Programme (NCSP). This provides opportunistic screening to all sexually active young people aged 15-24 years. This programme aims to control chlamydia within the population, interrupt transmission and reduce the incidence of conditions arising subsequently to a chlamydia infection. The effectiveness is monitored though an indicator in Public Health outcomes framework – the target was set at 2,300 per 100,000 detection rates in the 15-24 years old population. After a review of evidence, from 2022 the NCSP changed its focus to reducing reproductive harm of untreated infection in women, and ending opportunistic chlamydia screening for asymptomatic men outside of sexual health services. Consequently the chlamydia detection target changed to 3,250 per 100,000 aged 15 to 24 (female) from January 2022 but this has not yet been reported on.

Screening – the trend for the proportion aged 15-24 screened for chlamydia is decreasing and getting worse nationally, in Somerset, and for the whole South West region. In Somerset the proportion was 13.9%, which is significantly worse than nationally (14.8%), and similar to regionally (13.8%) (2021)[46].

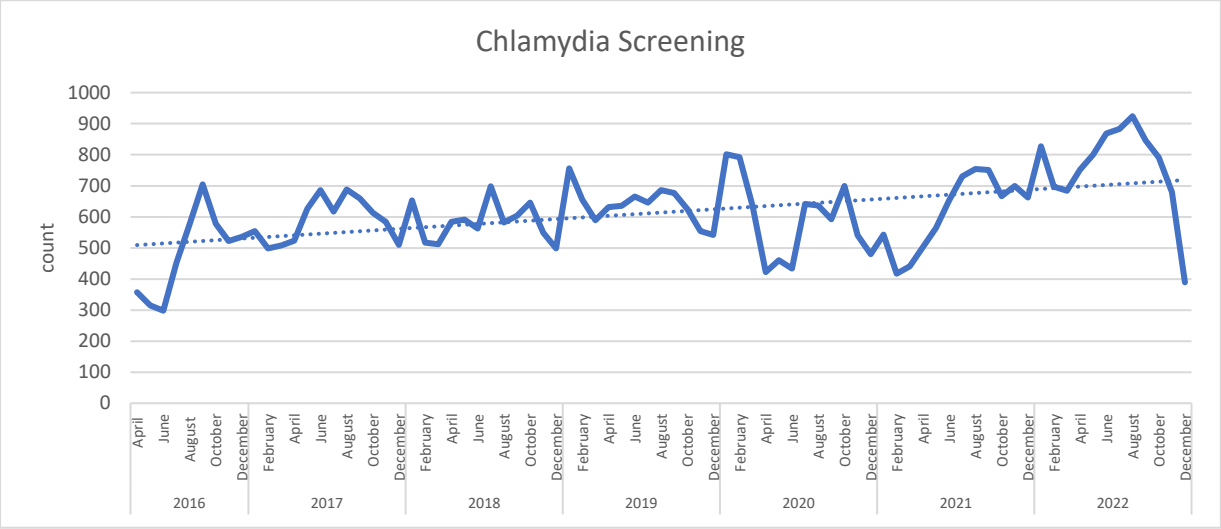

Figure 22 - Chlamydia screening, with a linear trend. Source: SWISH. The had been a steady increase in the number of chlamydia screenings, as shown by the linear trend line. Additionally, there are some dips in screening which correlate with lockdowns for the COVID-19 pandemic (March – June 2020, January – March 2021)

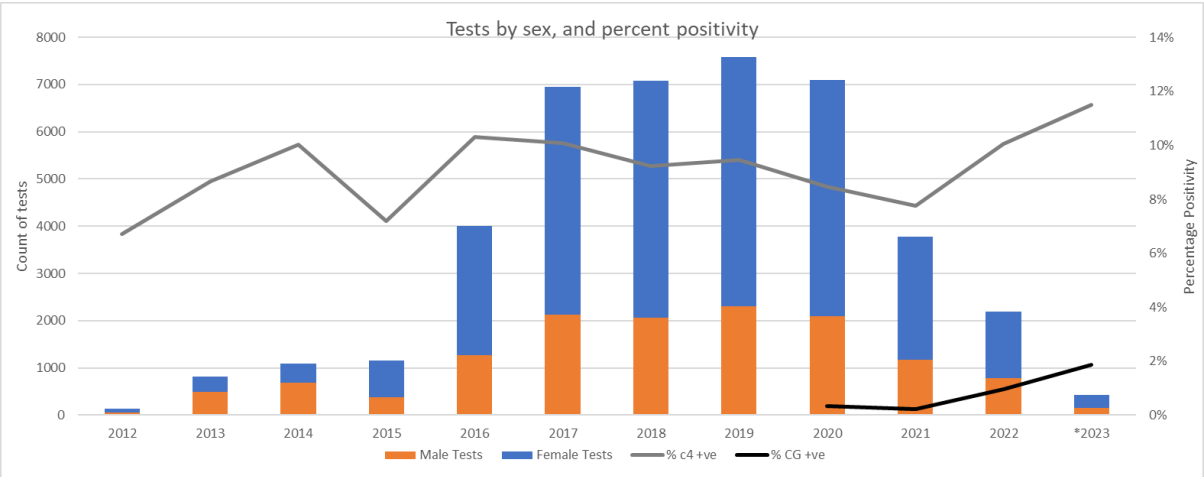

Figure 23 - Freetestme chlamydia and gonorrhoea testing ages 15-25, with percent positivity.

Chlamydia detection rate (aged 15-24), Somerset has 1,078/100,000 (2021) which has a recent trend of getting worse based of the most recent 5 years, when benchmarked against England (1,334 per 100,000) Somerset is significantly worse, but similar to regionally (1,079 per 100,000)[47].

Table 10 - Somerset Chlamydia Detailed Local Report as Published. 2021 Q1 – 2022 Q3. Source CTAD (number rounded to nearest 10, and less than 5 supressed)

		Total Tests	Test Result	Total tests by Gender		
			Positive	Male	Female	Not Known
<15	**no.**	130	<5	20	110	0
	%	0.4	2.4	11.8	88.2	0.0
15	**no.**	160	<5	20	140	<5
	%	0.5	1.2	11.7	86.4	1.9
16-19	**no.**	3620	370	690	2910	20

	%	10.0	10.3	19.0	80.4	0.7
20-24	no.	9030	760	2310	6670	50
	%	25.0	8.4	25.6	73.9	0.6
15-24	no.	12810	1130	3010	9720	80
	%	35.4	8.8	23.5	75.9	0.6
25-34	no.	12380	550	3100	9210	70
	%	34.3	4.5	25.1	74.4	0.6
35+	no.	10830	220	2650	8110	60
	%	29.9	2.1	24.5	74.9	0.6
Unknown	no.	10	0	<5	10	<5
	%	0.0	0.0	36.4	54.6	9.1
Total	no.	36160	1910	8790	27160	210
	%	-	5.3	24.3	75.1	0.6

Table 11 – Somerset Chlamydia by district 2021 Q1 – 2022 Q3. Source CTAD

District	No. tests	Tests rate per 1,000 population	% positive
Somerset	36,157	63.3	5.3
SWAT	10,860	69.0	5.4
South Somerset	10,075	58.3	5.4
Mendip	6,804	58.6	5.1
Sedgemoor	8,420	67.1	5.1

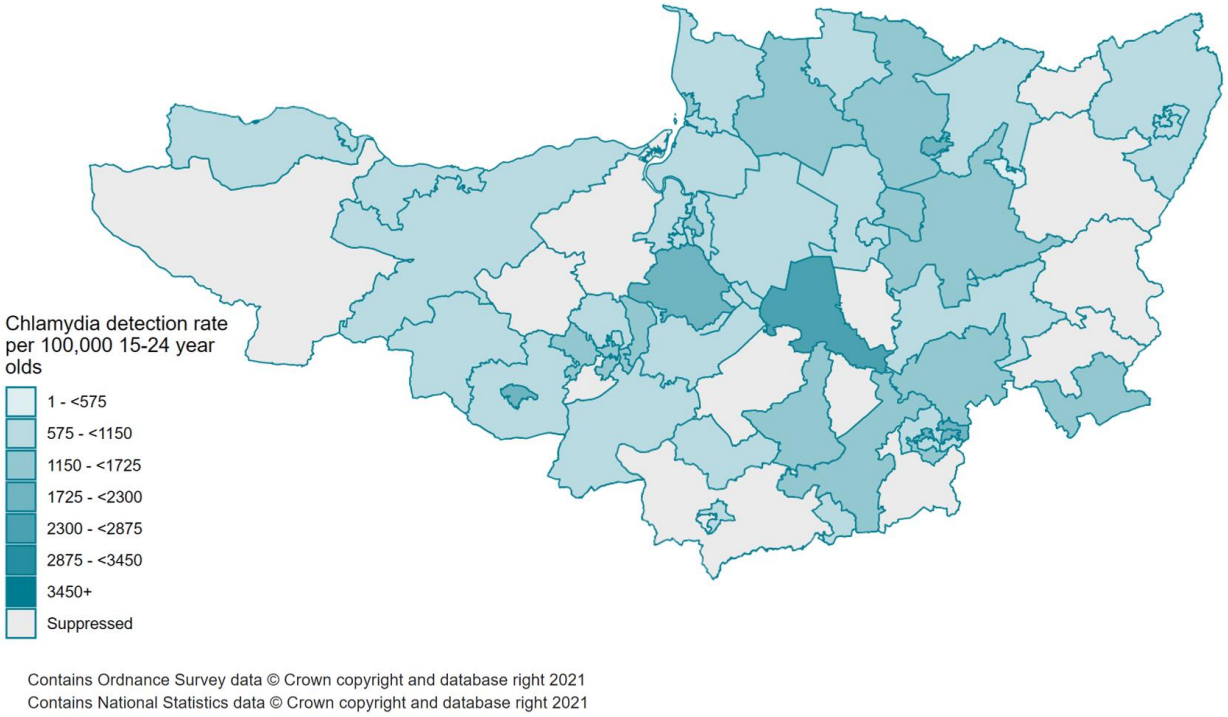

Figure 24 - Map of chlamydia detection rate per 100,000 population in 15 to 24 years in Somerset by Middle Super Output Area: 2021[48]

3.2.2 Gonorrhoea

In Somerset gonorrhoea diagnosis rate is 19/100,000 (2021). This shows a trend of no significant change, this is significantly better than the South-West rate (28/100,000) and the national rate (90/100,000), which both also show a worsening trend[49]. However, as described earlier, emerging data is showing an increasing trend in gonorrhoea diagnosis which is being seen across the South West including to some extent in Somerset.

Table 12 - Gonorrhoea diagnosis. Source: GUMCAD

Condition	Sex	Number of diagnoses in Somerset			Rate of diagnoses		
		2019	2020	2021	2019	2020	2021
Gonorrhoea	Male	116	101	78	42.25	36.69	28.3
	Female	59	45	25	20.51	15.59	8.7
	Total	**175**	**146**	**104**	**31.13**	**25.89**	**18.4**

Table 13 - Gonorrhoea cases by sex, sexual orientation, and ethnicity (2019 Q1 – 2021 Q2). Source: GUMCAD

		Number of Gonorrhoea Cases (rounded to nearest 10)	% of Gonorrhoea Cases
Sex	Male	250	66.8
	Female	120	33.2
Sexual Orientation	Heterosexual/Straight	200	52.7
	Gay	130	35.9
	Lesbian	<5	0.3
	Bisexual	30	8.9
	Not Known	10	2.2
Ethnic Group	White	310	82.4
	Black or Black British	<5	0.8
	Asian or Asian British	<5	0.5
	Mixed	<5	0.8
	Other Ethnic groups	<5	1.4
	Not Specified	50	14.1

3.2.3 Syphilis

Syphilis diagnostic rate (2021) is 2.1/100,000 in Somerset, which is the lowest in the South-West region. Syphilis diagnosis rate in Somerset is significantly better than both the national average 13.3/100,000 and the South-West regional average of 4.6/100,000. When compared to CIPFA nearest neighbours Somerset also has the lowest rate of syphilis diagnosis, with the highest being in West Sussex at 9.7/100,000.

The ‘neighbours’ average is 4.8/100,000 (Somerset is also significantly better when compared to its CIPFA nearest neighbours, which average is 4.8%)[50].

*Table 14 – Syphilis diagnosis in Somerset, by sex. Source GUMCAD (*rounded to nearest 10 avoid deductive disclosure)*

Condition	Sex	Number of diagnoses in Somerset			Rate of diagnoses		
		2019	2020	2021	2019	2020	2021
Syphilis	Male	10*	12	10*	4.73	4.36	3.6
	Female	<5	0	<5	0.35	-	0.3
	Total	**20***	**12**	**10***	**2.49**	**2.13**	**2.1**

Table 15 - Syphilis diagnosis in Somerset, by sex, sexual orientation, and ethnicity (2019 (Q1) – 2021 (Q2)). Source: GUMCAD

		Number of Syphilis Cases (rounded to nearest 10)	% of Syphilis cases
Sex	Male	30	93.5
	Female	<5	6.5
Sexual Orientation	Heterosexual/Straight	10	19.4
	Gay	20	67.7
	Lesbian	<5	0.0
	Bisexual	<5	9.7
	Not Known	<5	3.2
Ethnic Group	White	30	80.6
	Black or Black British	<5	3.2
	Asian or Asian British	<5	0.0
	Mixed	0	0.0
	Other Ethnic groups	<5	3.2
	Not Specified	<5	12.9

3.2.4 Herpes/Genital warts[51]

It is thought that recent decreases in genital warts diagnoses are because of the protective effects of the HPV vaccination. Genital herpes diagnosis rate (2021) is 25.9/100,000 in Somerset, this has shown a trend of no significant change. When benchmarked against England (38.3/100,000) and the whole South-West region (34.7/100,000) this is significantly better.

Genital warts diagnostic rate shows an improving trend in Somerset, with the rate in 2021 being 50.7/100,000 (2021). This is similar to the national rate of 50.0/100,000 and the South-West regions average rate of 49.0/100,000.

Population vaccination coverage targets for HPV vaccine are 90%. 2021/22 population vaccination coverage of one dose of HPV (females 12-13) has a worsening trend in Somerset with 68.1% coverage. This is worse to nationally (69.6%), and regionally (68.5%). HPV vaccination coverage (2 doses – 13–14-year-old, females), in Somerset,

73.1%, which is better than nationally (67.3%) and regionally (61.6%). In Somerset this is significantly improved from 24.1% coverage in 2020/21, as this reduction in coverage was largely as it is a vaccination that is delivered through the school-based immunisation teams, whose access to children was reduced when schools were closed in 2020 and 2021, due to covid-19 pandemic lockdowns. Additionally, population vaccination coverage for 1 HPV dose (12–13-year-old, male) is 56.9% (worse than nationally – 62.4% and regionally – 58.6%)[52].

Table 16 – Herpes in Somerset, by sex – count and rate. Source: GUMCAD

Condition	Sex	Number of diagnoses in Somerset			Rate of diagnoses		
		2019	2020	2021	2019	2020	2021
Herpes	Male	70	49	57	25.5	17.8	20.7
	Female	115	74	86	40.0	25.6	29.8
	Total	**185**	**123**	**146**	**32.9**	**21.8**	**25.9**

Table 17 - Warts in Somerset, by sex – count and rate. Source: GUMCAD

Condition	Sex	Number of diagnoses in Somerset			Rate of diagnoses		
		2019	2020	2021	2019	2020	2021
Warts	Male	230	163	172	83.3	59.2	62.5
	Female	185	113	110	64.3	39.2	38.1
	Total	**415**	**277**	**286**	**73.8**	**49.1**	**50.7**

Table 18 - Herpes and Warts cases by sex, sexual orientation, and ethnicity (2019 Q1 – 2021 Q2). Source GUMCAD

		Number of Herpes Cases (rounded to nearest 10)	% of Herpes Cases	Number of Warts Cases (rounded to nearest 10)	% of Warts Cases
Sex	Male	140	38.3%	480	58.5
	Female	230	61.7%	340	41.5
Sexual Orientation	Heterosexual/Straight	360	94.7%	750	92.0
	Gay	10	2.1%	30	3.4
	Lesbian	<5	0.0%	<5	0.2
	Bisexual	10	2.4%	20	2.2
	Not Known	<5	1.1%	20	2.3
Ethnic Group	White	340	89.7%	730	89.4
	Black or Black British	<5	0.5%	<5	0.1
	Asian or Asian British	<5	0.3%	20	2.6
	Mixed	10	2.1%	10	1.2
	Other Ethnic groups	<5	0.3%	<5	0.2
	Not Specified	30	7.4%	70	8.5

3.3 HIV[53]

HIV targets the immune system and weakens people's defence against common infections and disease. As the virus destroys and impairs the function of immune cells, infected individuals gradually become immunodeficient. Immune function is typically measured by CD4 cell count. The most advanced stage of HIV infection is acquired immunodeficiency syndrome (AIDS), which can take many years to develop if not treated, depending on the individual[54,55].

HIV can be transmitted via the exchange of a variety of body fluids from infected people, such as blood, breast milk, semen and vaginal secretions. HIV can also be transmitted from a mother to her child during pregnancy and delivery. Individuals with HIV who are taking ART (antiretroviral therapy) and are virally suppressed do not transmit HIV to their sexual partners. Early access to ART and support to remain on treatment is therefore critical not only to improve the health of people with HIV but also to prevent HIV transmission.

Most individuals experience short flu-like illness 2-6 weeks post HIV infection, which then lasts a few weeks; once these symptoms end there may not be any others although the virus will continue to damage an individual's immune system – therefore meaning individuals frequently do not know they are infected. HIV is tested for by a blood or saliva test, early identification of potential infection can lead to use of post-exposure prophylaxis (PEP) which can prevent an individual becoming infected if started within 72 hours of possible exposure[56].

In 2021, England again achieved the UNAIDS 95-95-95 target nationally, with 95% of people living with HIV being diagnosed, 99% of those diagnosed being on treatment and 98% of those on treatment having an undetectable viral load[57].

3.3.1 Testing

A caveat to the HIV data from OHID fingertips is that this is not a true reflection of the performance of services due to a shift to online testing, and this not being captured. There may be lower numbers presented in this indicator, especially in recent years. The testing coverage indicator currently only uses data from Level 3 specialist sexual health services, which will typically exclude data from online services. Therefore the data below is not representative on the actual level of HIV testing by SWISH

In 2020, among Somerset residents, the percentage of eligible SHS attendees who received an HIV test was 32.3%, worse than 46.0% for England – this is a 46% decrease between 2019-2020. HIV testing coverage total (2021), in Somerset is 21.2% which has a decreasing trend and is lower than regionally (35.9%) and nationally (45.8%). Additionally, HIV testing coverage for MSM, gay and bisexual men (2021) was 61.0% in Somerset, which is significantly worse than the national

percentage of 77.8%. in Somerset this is showing a worsening trend. Testing in all categories was significantly worse in Somerset than nationally[58].

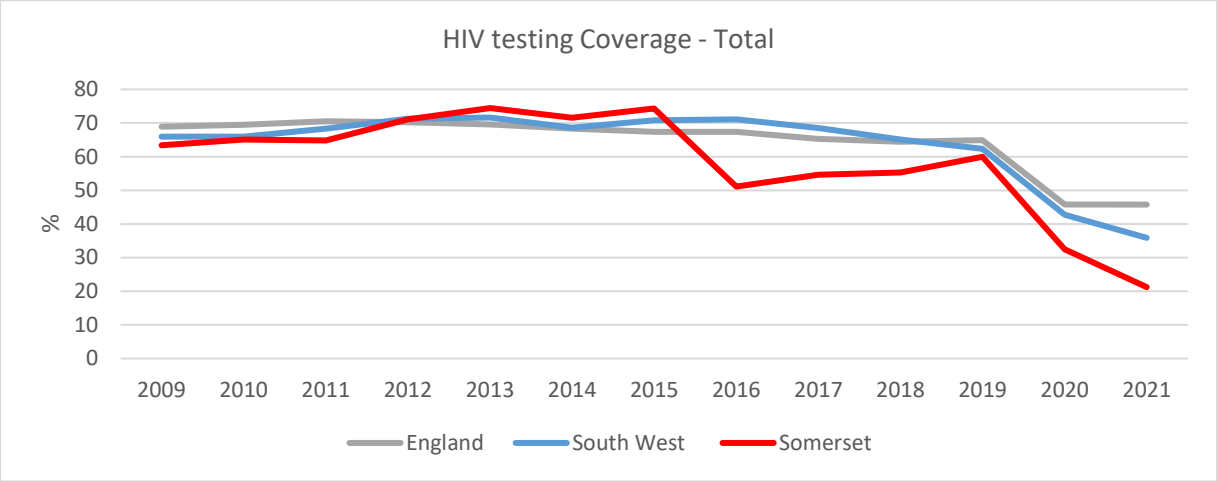

Figure 25 – HIV testing coverage - number of persons tested for HIV (and not the number of tests reported) out of those people considered eligible for a HIV test when attending specialist sexual health services. Source: OHID Fingertips

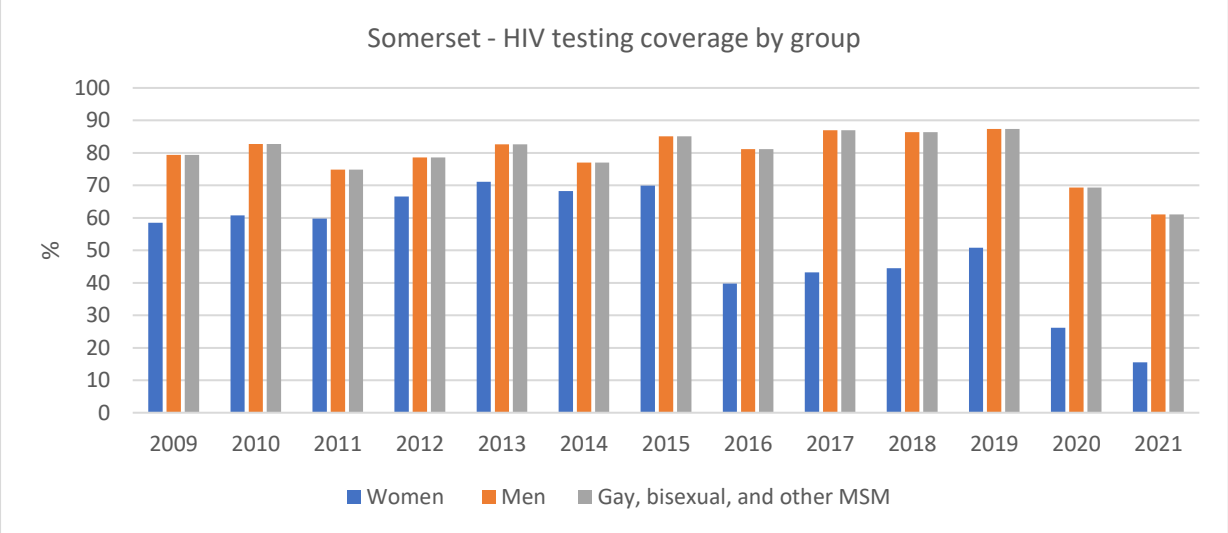

Figure 26 – Somerset - HIV testing Coverage by group. Source: OHID Fingertips

In addition to the caveat provided earlier, a coding error at SWISH led to the underreporting of HIV testing reflected above. This has been rectified and recently SWISH undertook an audit on the uptake of HIV tests by patients attending SWISH clinics against BASHH recommendations. This showed that from April 2022 100% of new patients had been offered an HIV blood test and to date 84% had accepted the test.

3.3.2 Diagnosis

In Somerset HIV diagnosed prevalence (aged 15-59) is 0.93/1,000, which is significantly better than the national prevalence of 2.32/1,000 (2021). New HIV diagnosis rate (all ages) (2021) in Somerset is 1.4/100,000, this is significantly better

than nationally (4.8/100,000). Furthermore, new HIV diagnosis amongst those first diagnosed in the UK was 45.5% in Somerset (2019-21), which is significantly better than the national value of 43.4%[59].

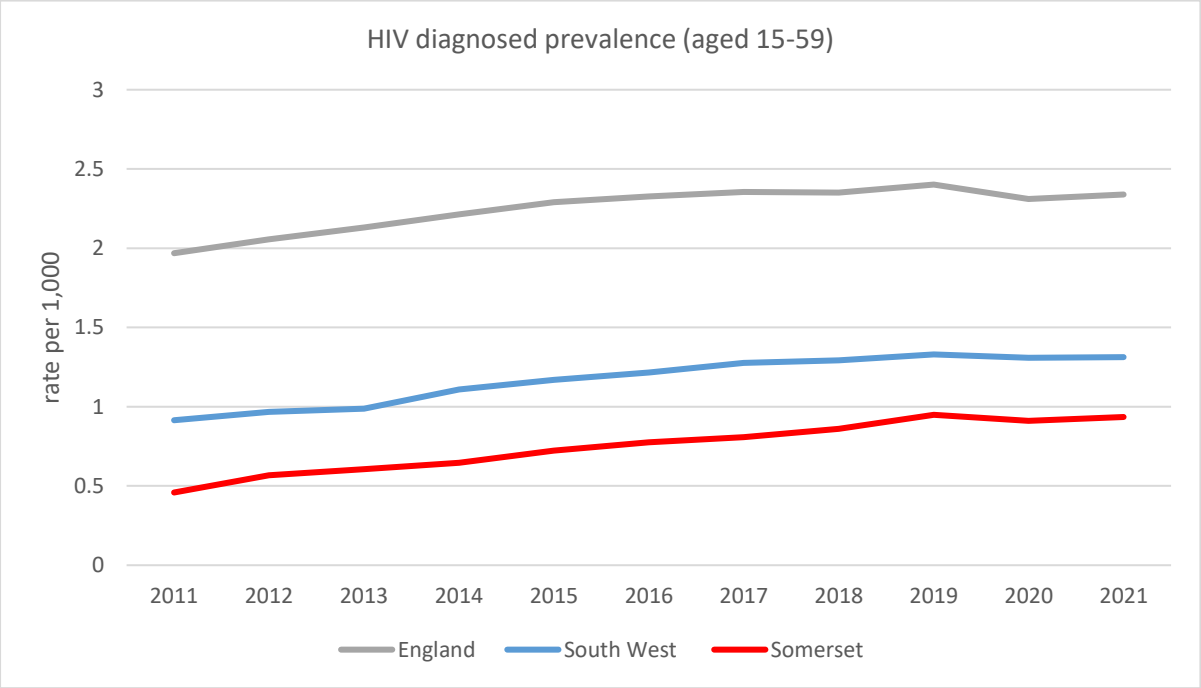

Figure 27 – People aged 15 to 59 years seen at HIV services in the UK, presented by area of residence. Rate per 1,000. Source: OHID Fingertips

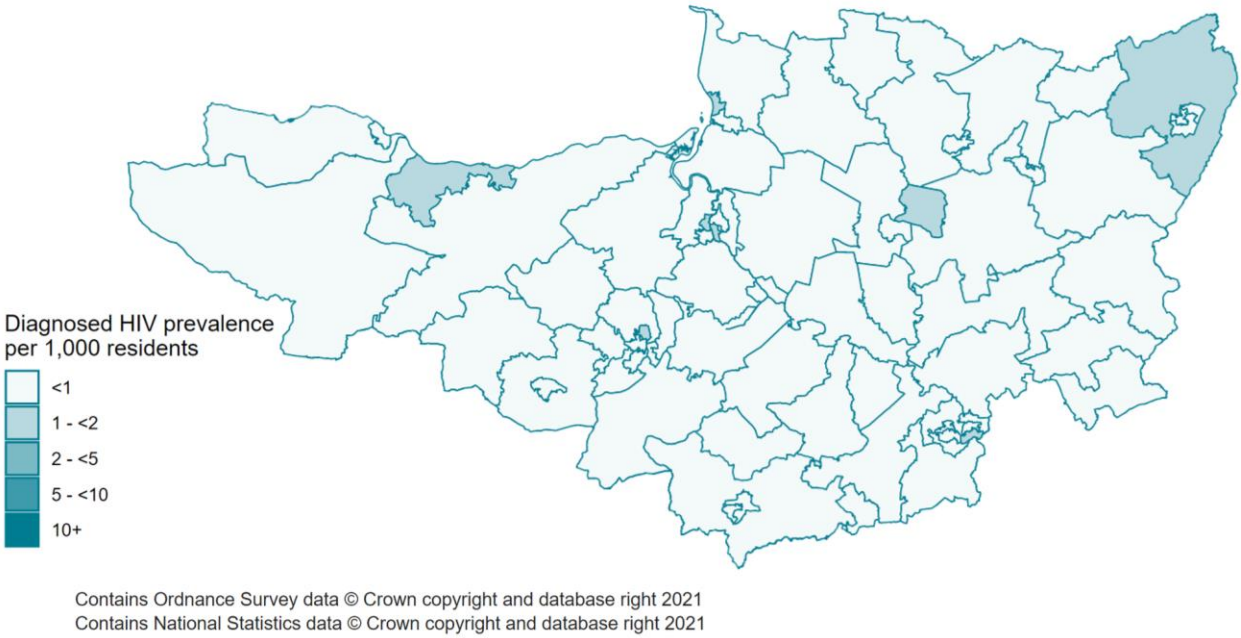

Figure 28 - Map of diagnosed HIV prevalence among people of all ages in Somerset by Middle Super Output Area: 2021[60]

People living with diagnosed HIV

Table 19 - Number of people living with diagnosed HIV by ethnicity in Somerset: 2016 and 2020. Source: HIV and AIDS Reporting System (HARS)/SPLASH Report* [61]

Ethnicity	2016	% 2016	2020	% 2020
White	220	81	285	84
Black African	30	11	35	10
Black Caribbean	0	0	0	0
Other	25	9	25	7
Not known	5	2	5	1
Actual total	270	100	340	100

*(*Please note to prevent deductive disclosure the number of people living with diagnosed HIV has been rounded up. Numbers from 0 to 4 are rounded up to the nearest 5. The totals have not been rounded, and therefore may not equal the sum of their parts)*

Table 20 - Number of people living with diagnosed HIV by exposure group in Somerset: 2016 and 2020Source: HIV and AIDS Reporting System (HARS)/SPLASH Report*

Probable route of infection	2016	% 2016	2020	% 2020
Sex between men	145	54	190	56
Sex between men and women	110	41	125	37
Injecting drug use	10	4	10	3
Other/Not known	15	6	20	6
Actual total	270	100	340	100

*(*Please note to prevent deductive disclosure the number of people living with diagnosed HIV has been rounded up. Numbers from 0 to 4 are rounded up to the nearest 5. The totals have not been rounded, and therefore may not equal the sum of their parts)*

As of 2020 there were 340 people in Somerset who were diagnosed with HIV. The majority with diagnosed HIV were White at 84%, followed by Black African (10%). The most common exposure groups for HIV was sex between men at 56%, followed by sex between men and women (37%).

3.3.3 Late diagnosis

Late diagnosis is a crucial predictor of HIV-related morbidity, as well as short-term mortality. Monitoring can also be used to assess the success of HIV testing. HIV late diagnosis in GBMSM first diagnosed in the UK (2019-2021) is 60.0% in Somerset compared to 31.4% nationally, and 42.7% regionally. HIV late diagnosis in heterosexual men first diagnosed in the UK (2019-21) in Somerset was 100%, compared to 63.0% regionally, and 58.1% nationally. Additionally late diagnosis in heterosexual and bisexual women first diagnosed in the UK (2019-21), in Somerset there was a count of <5[62].

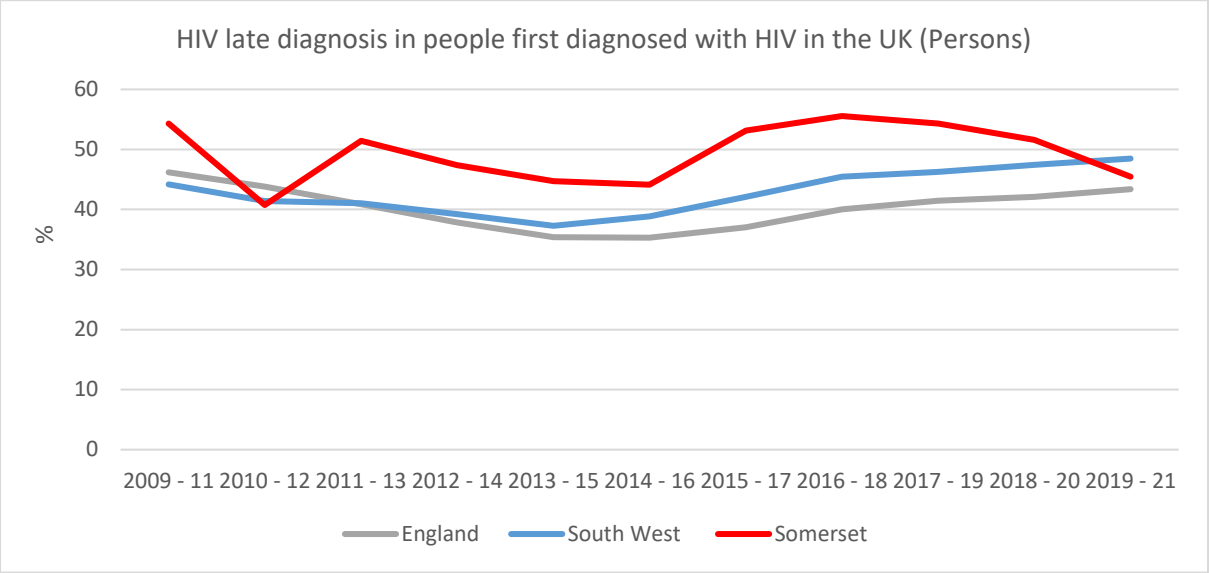

Figure 29 - Percentage of adults (aged 15 years or more) newly diagnosed with HIV with a CD4 count less than 350 cells per mm3 within 91 days of diagnosis, excluding those with evidence of recent seroconversion. These include only reports of HIV diagnoses first made in the UK (which excludes those previously diagnosed with HIV abroad).

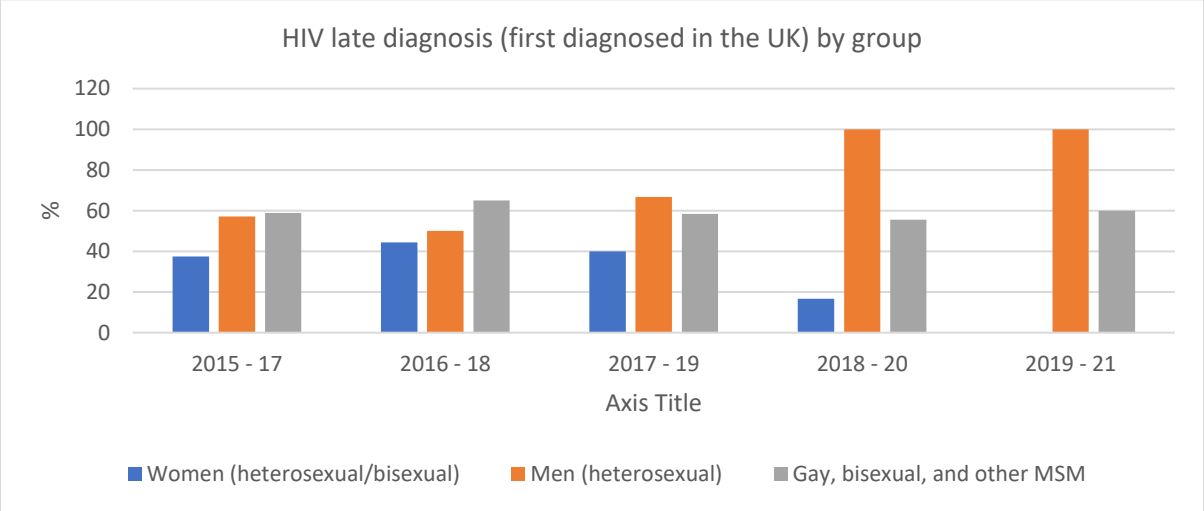

Figure 30 - Percentage of each group newly diagnosed with HIV with a CD4 count less than 350 cells per mm3 within 91 days of diagnosis, excluding those with evidence of recent seroconversion.

3.3.4 Treatment and Care

In England the UN AIDS 95-95-95 targets were met, with 95% of all diagnosed, 99% of those in care on treatment, 97% of those with treatment being virally supressed. Antiretroviral therapy (ART) coverage in people accessing HIV care (all ages) (2021), in Somerset was 98.9% (regionally was also 98.9%) nationally is 98.3%. Prompt antiretroviral therapy (ART) initiation in people newly diagnosed with HIV (all ages) (2019-21) in Somerset was 80.5% this is similar nationally (83.5%) and regionally (86.8%). Subsequently virological success in those adults accessing HIV care (2021) in Somerset was 98.6% similar to the rate nationally of 90.7%[63].

Pre-exposure prophylaxis (PrEP) is a drug taken by HIV-negative individuals before they have sex to stop them acquiring HIV. As part of a combination approach to HIV prevention, the roll out of routine PrEP commissioning began in England in the autumn of 2020. Specialist sexual health services (SHS) are responsible for the delivery of PrEP to those at higher risk of acquiring HIV.

Proportion of all HIV negative individuals accessing specialist sexual health services (SHS) with pre-exposure prophylaxis (PrEP), determining the PrEP need in Somerset is 4.5%, this is lower than nationally (7.4%), and regionally (4.9%) (2021). The initiation or continuation of PrEP among those with PrEP need in Somerset is 60.4%, this is lower than nationally (69.6%), and regionally (62.6%).

Table 21 - PrEP attendances by Somerset resident by quarter Q1-3 2022-2023. Source SWISH

	New	Continuation	Discontinued/lost to follow up/moved
Q1	30	84	22
Q2	39	112	18
Q3	40	128	27

The table above provides information as of Q3 2022/23 on the number of new PrEP initiations, the number of attendances for those continuing PrEP, and the number who for a range of reasons have discontinued PrEP in each quarter. A small number of Somerset residents also access PrEP outside of the county, particularly at WISH. The majority of those accessing PrEP in Somerset are GBMSM. Regionally sexual health commissioners are leading work with an external partner commissioned to raise awareness of PrEP in those groups underrepresented, including women and some ethnic minority groups.

The HIV Prevention and Health and Wellbeing Service provided by The Eddystone Trust provides outreach services to GBMSM and other groups at higher risk of acquiring HIV in Somerset. This includes providing condoms and information through public sex environments and raising awareness in dating applications through ‘netreach’, encouraging uptake of HIV and STI testing, promoting PrEP and structured interventions. The service also provides support to those newly diagnosed with HIV as well as support and advocacy for people living with HIV where there is an identified need.

3.4 SWISH Activity

The following tables provide information on the use of SWISH services. Other than Table 22 which relates to GUM related attendances only, the following tables refer to attendances at SWISH for Level 1 to Level 3 sexual health and contraceptive services.

Table 2222 - GUM Patient Consultations at the Somerset-Wide Integrated Sexual Health service by Somerset patients and for all patients. Source GUMCAD

Time Period	Service	Number of patients	% of total patients	New consultations	Follow-up Consultations	Total Consultations
Q1-2 2022/23	Preventx (online)	6422	56.7%	8711		8711
	SWISH Somerset patients	4618	40.8%	6227	2709	8936
	SWISH all patients.	4985	100%	6752	2865	9617
2021/22	Preventx (online)	9790	51.8%	14684		14684
	SWISH Somerset patients	8090	42.8%	12634	5584	18227
	SWISH all patients	8642	100%	13528	5898	19426
2020/21	SWISH Somerset patients	6725	94.1%	9703	4220	13923
	SWISH all patients	7102	100%	10229	4371	14600
2019/20	SWISH Somerset patients	9750	90.5%	12887	3845	16732
	SWISH all patients	10674	100%	14127	4074	18201
2018/19	SWISH Somerset patients	9624	90.7%	12716	3484	16200
	SWISH all patients	10542	100%	13892	3670	17562
2017/18	SWISH Somerset patients	9262	90.6%	11144	4563	15707
	SWISH all patients	10130	100%	12234	4864	17098

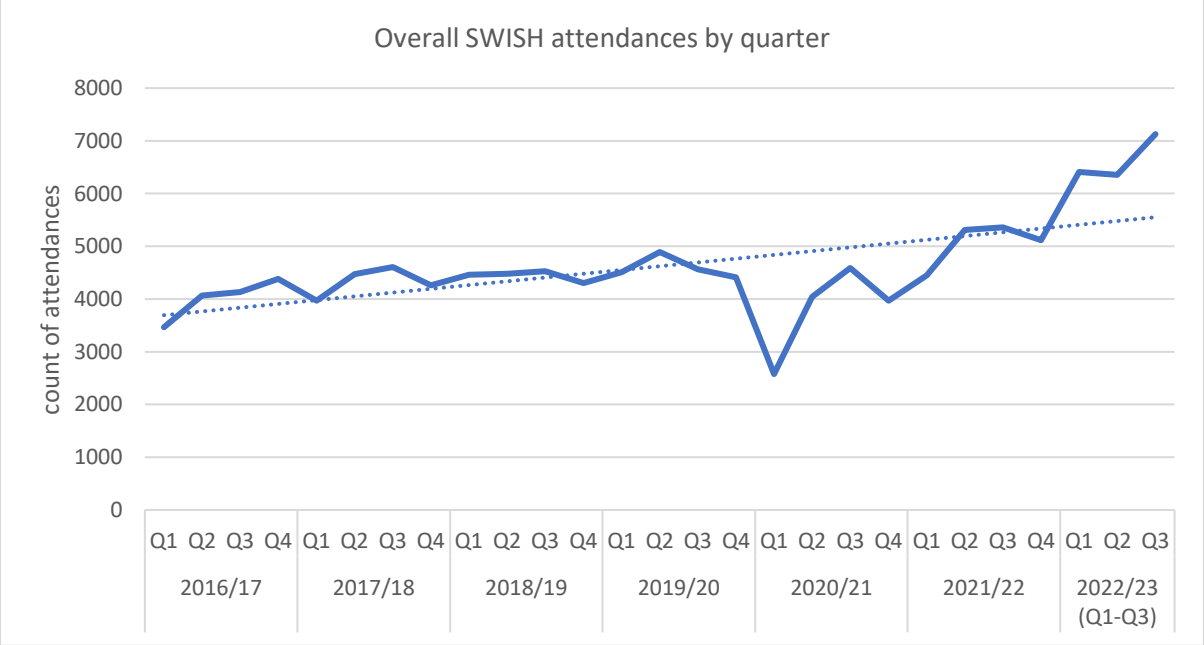

Figure 31 – SWISH total attendances by quarter, with a linear trend line. There was a notable decrease in the numbers of attendance to sexual health services in 2020 Q2, caused by the covid-19 pandemic. The linear trend line shows there has been an increase in attendances since 2016/17 up to 2022/23 YTD.

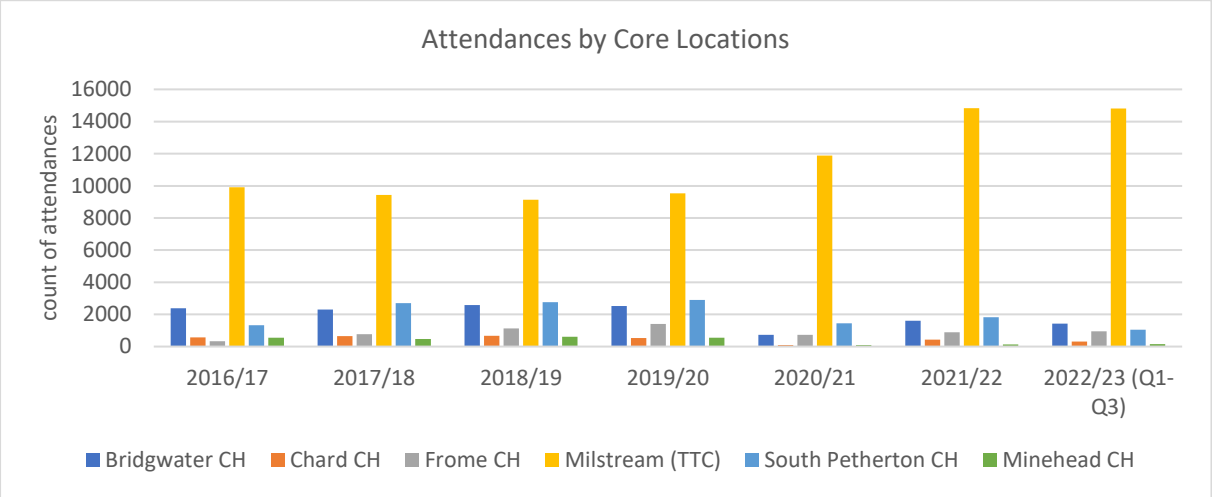

Figure 32 – SWISH Attendances by core locations. Millstream consistently has the highest count of attendances. as the main hub and shift to online and tele-consultations.

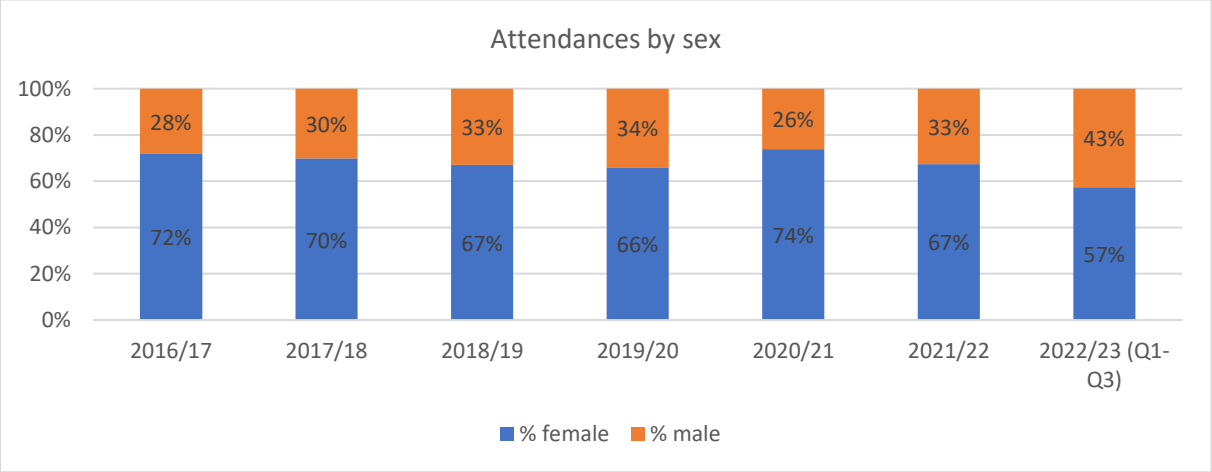

Figure 33 – SWISH Attendances by sex. The attendances are consistently since 2016/17 higher for female due to access to contraceptive services.

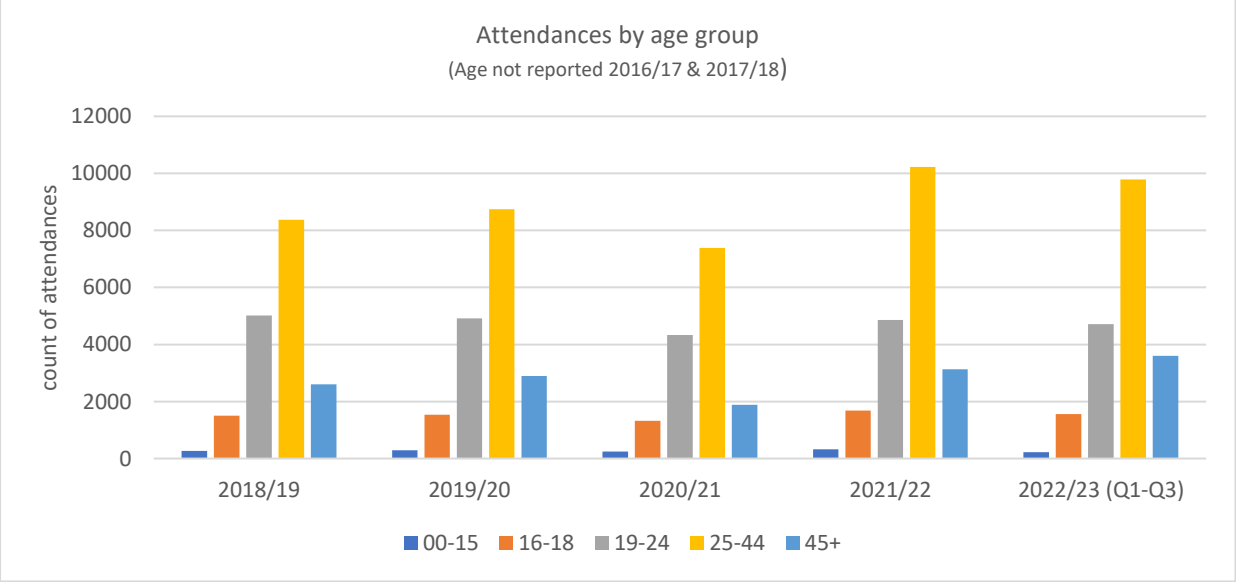

Figure 34 -SWISH attendances by age group. The count of attendances was consistently highest in individuals aged 25-44, followed by 19–24-year-olds.

It has not been possible to get data on the ethnicity and gender identity of SWISH attendances; this has been prioritised to enable an understanding of service demand and need and inform future service planning.

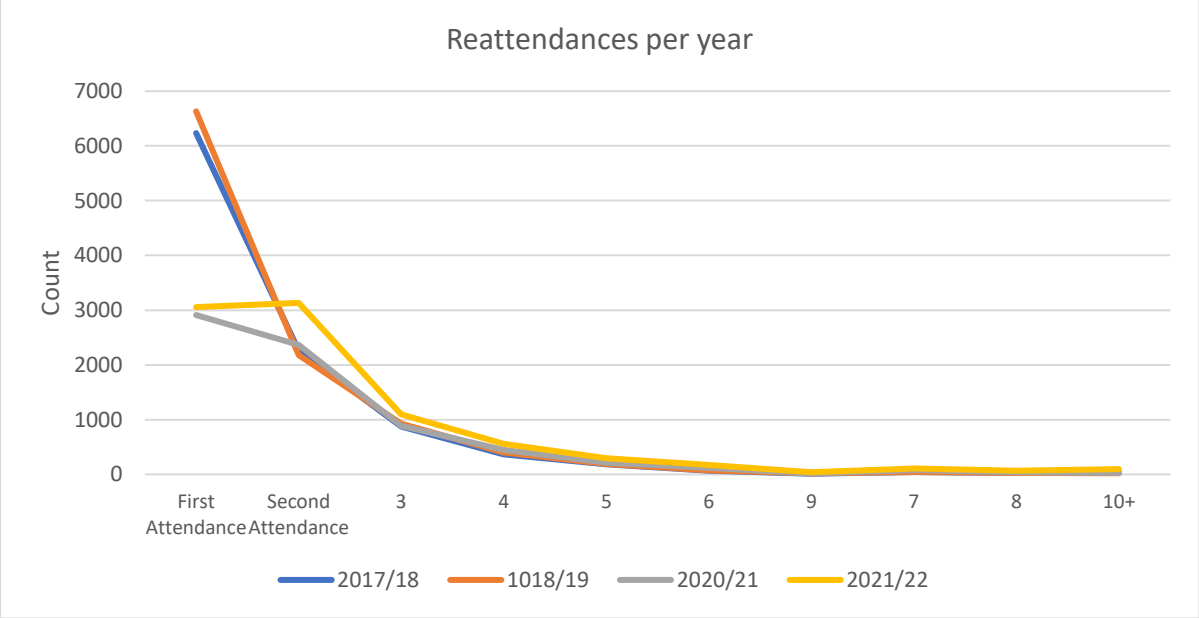

Figure 35 - SWISH reattendances per year in Somerset.

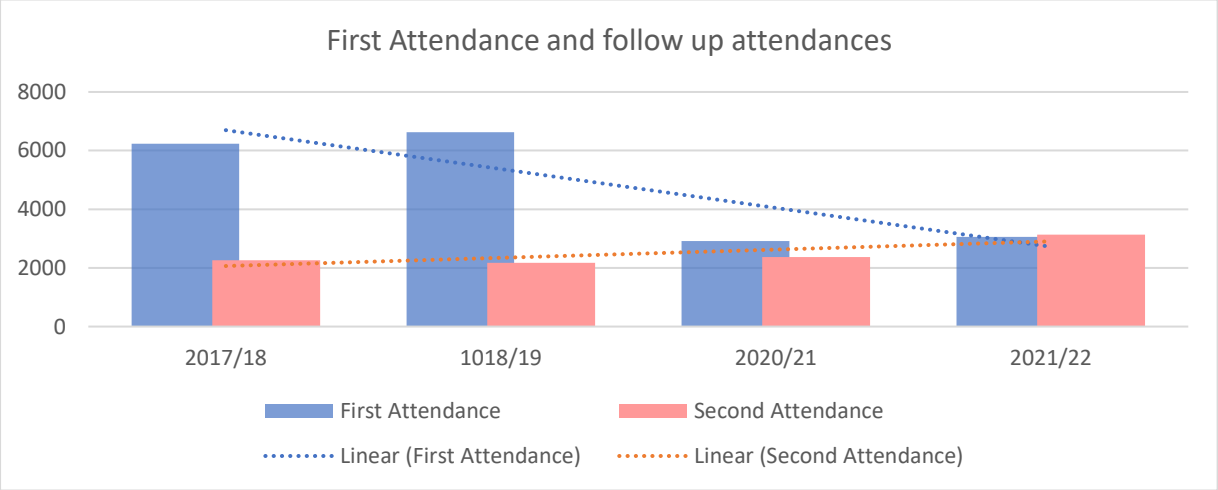

Figure 36 – SWISH First attendance and follow up attendances.

As seen in the figure above the number of first attendances is showing a decreasing trend, comparatively the second attendances are increasing. This is due to the changing nature of how services are delivered particularly with the use of telephone and online consultations. The majority of first attendances are consistently seen in the 25-34 age group. Additionally, as expected the majority of individuals attending are heterosexual or straight, but there has been increasing attendance by GBMSM; this will in part be due to the offer of PrEP. Those with high risk sexual behaviour are advised to attend SHSs regularly for STI and HIV testing which contribute to reattendance figures, as will additional attendances required for the provision of PrEP services.

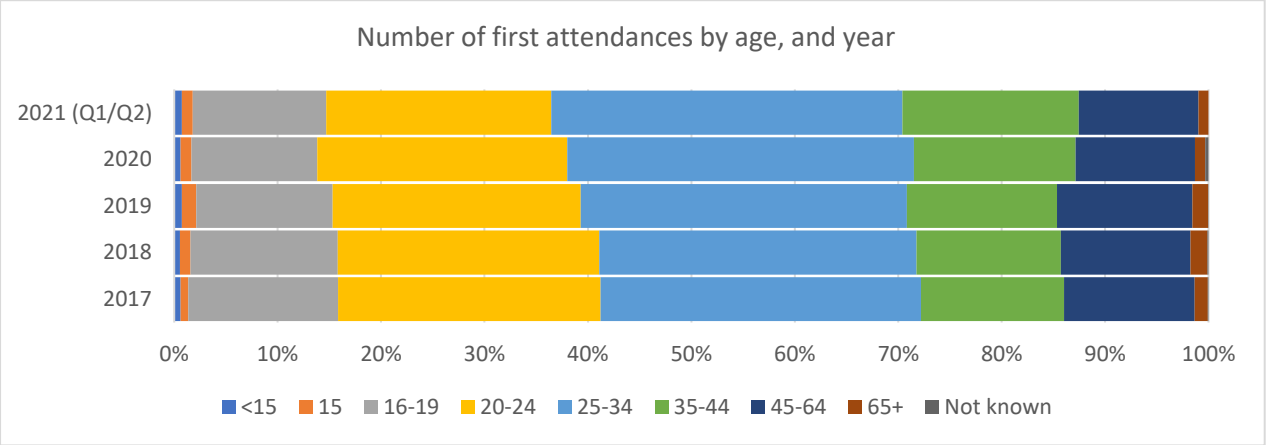

Figure 37 - Number of first attendances by age, and year[64]

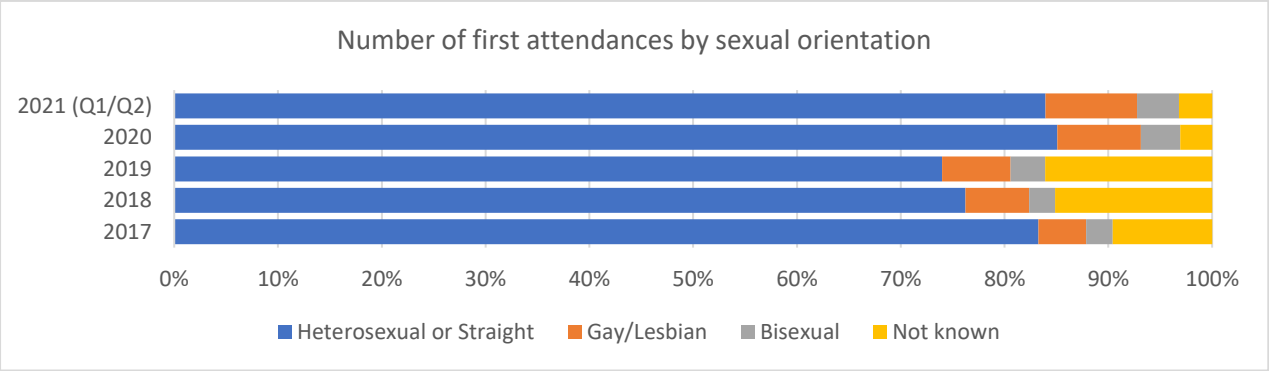

Figure 38 - Number of first attendances by age, and year[65]

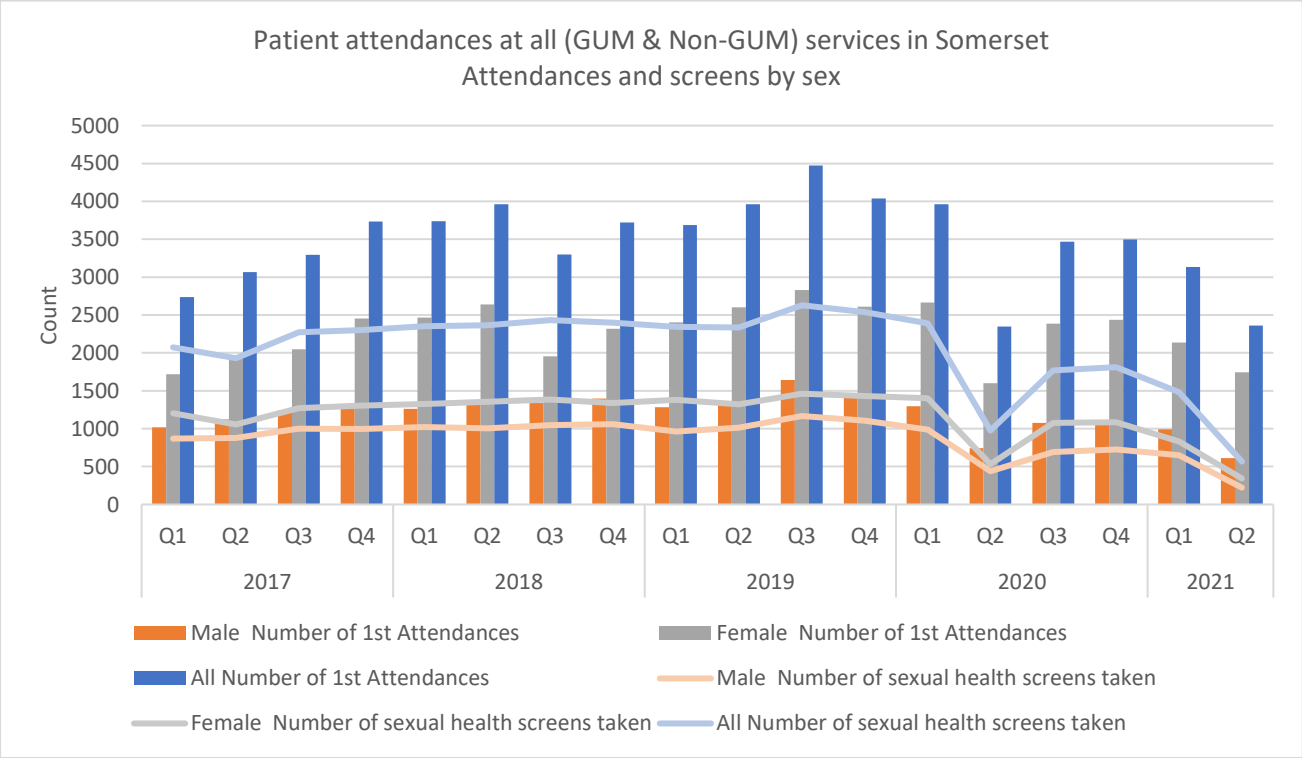

Figure 39 - Patient attendances at all (GUM & Non-GUM) services in Somerset, Attendances and screens by sex[66]

3.4.1 Online Testing

Access to online testing for NCSP has been in place in Somerset for a number of years. In 2019/20 access to other online testing was piloted for groups with high risk sexual behaviour. Due to the COVID-19 pandemic the offer of asymptomatic testing for STIs for the population of Somerset became a routine offer. The table below shows the number of tests completed and positivity rates since 2021.

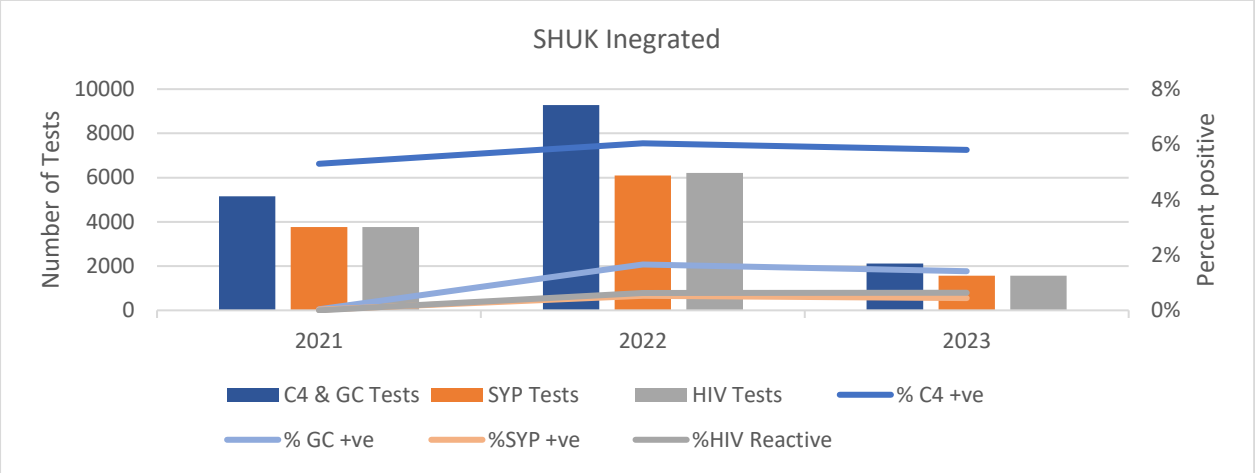

Figure 40 - SHUK integrated online tests.

Online Testing: Attendances by Somerset residents by district (2020/21):

- Mendip - 45.4% online testing
- Sedgemoor - 35.3% online testing
- SWAT - 46.4% online testing
- South Somerset - 46.2% online testing

3.4.2 Out of Area Testing

As the chart below shows, a small proportion of Somerset residents access GUM services outside of Somerset. Most of this out of area activity will be in counties bordering Somerset, with most being at WISH in North Somerset.

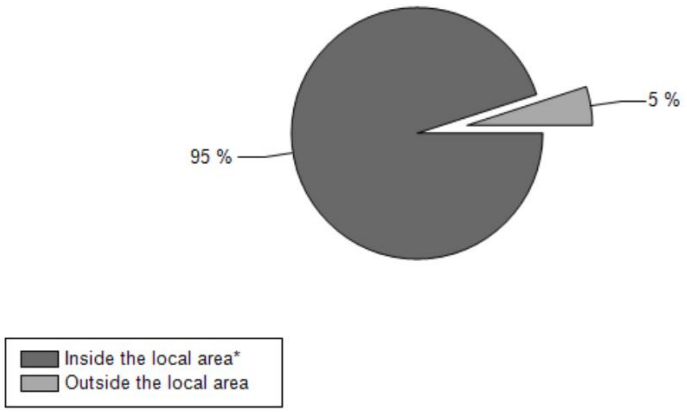

Figure 41 – All (GUM and non-GUM service in England. Patient screening - % patients in Somerset Accessing services inside/outside local area – All services. Time period: 01/04/21 – 31/03/22 Source: GUMCAD (Online Services are counted as 'inside local area')

GUMCAD / HIV/STI Data Exchange - Consultations at Weston Integrated Sexual Health service (WISH) for Somerset residents.

Table 23 23 - Somerset Residents Accessing GUM services at WISH, Weston. Source: GUMCAD

	No. of pts	% of pts	First	Follow Up	Total attendances
2021/22	421	25.4	389	363	752
2020/21	657	23.3	702	656	1358
2019/20	1156	23.8	1713	609	2322
2018/19	1128	24.7	1595	400	1995
2017/18	1041	21.7	1478	323	1801
2016/17	1187	22.2	1780	397	2177
2015/16	1276	19.9	2027	374	2401

3.5 Sexual Violence

As stated at the beginning of this needs assessment, a separate needs assessment is being completed for Sexual Violence. However, the table below provides some information on police date on sexual offences.

Table 24 24 – source sexual offences in police data[67]

Somerset	2019	2020	2021	% Change
Sexual offences (SO)	1,214	1,113	1,410 (92% by male offenders, 169 by child offenders, 190 by stranger or unknown, 162 by partner or ex-partner, 325 by acquaintances)	+14
SO against women and girls	879	910	1,150	+24
SO against girls	199	275	432	+54
SO against children (boys and girls under 18)	252	364	542	+54

There has been an increase in reported sexual violence from 2019 – 2021, as can be seen in the table above.

4 Key risk factors & at-risk populations

Whilst individuals who are sexually active are at risk to exposure to STIs and unplanned pregnancy, some groups are at an increased risk.

4.1 Young people

In 2020, 54.9% of diagnoses of new STIs made in SHSs and non-specialist SHSs in Somerset residents were in young people aged 15 to 24 years old. This compares to 45.7% in England[68]. In Somerset 26% of the population are under 25, with 21% being under 18[69]. Mendip has the youngest population with 22% of individuals under 18, and 27% under 25, both which are the highest in Somerset.

Teenage pregnancy is associated with the most deprived and socially excluded young people. Difficulties in young people's lives such as poor family relationships, low self-esteem and unhappiness at school also put them at greater risk. Rates of teenage pregnancy are higher in more deprived communities; thus, the potential negative consequences are disproportionately concentrated in populations who are already disadvantaged. Poorer outcomes associated with teenage parenthood can also lead to the impacts of deprivation and social exclusion being passed from one generation to the next[70]. Early childhood and youth development programmes, interventions that address the social disadvantage associated with early parenthood, have been evidenced as effective at reducing unintended teenage pregnancy[71].

4.1.1 C-Card condom distribution scheme

The C-Card launched in Somerset in 2006 as part of a teenage pregnancy strategy to promote the availability, accessibility, and acceptability of condoms, as well as providing sexual health advice from trained workers. This is for young people (currently available to 13–19-year-olds, and 25 in some circumstances) who have had a consultation with a trained worker, and will have met the legal framework called the 'Fraser Guidelines' if they are under 16 years of age. The consultation includes:

- consideration of Child Exploitation as well as consent and sexual wellbeing.
- A discussion and information of other forms of contraception (where appropriate)
- a discussion on what is safer sex and a condom demonstration
- an STIs discussion and where testing can be accessed
- emergency contraception and where it can be accessed
- different types of condoms and the importance of size
- allowing time for questions about sexual health and relationships

C-Card+ is an addition to the C-Card, where members can access click and collect options, as well as signposting.

There are currently 1869 registered users in Somerset. It has not been possible to interrogate the C-Card system for data on where registered users are actively using the C-Card and demographics of service users. The system has recently undergone an extensive update and this will enable effective reporting to monitor demand and need to inform future priorities.

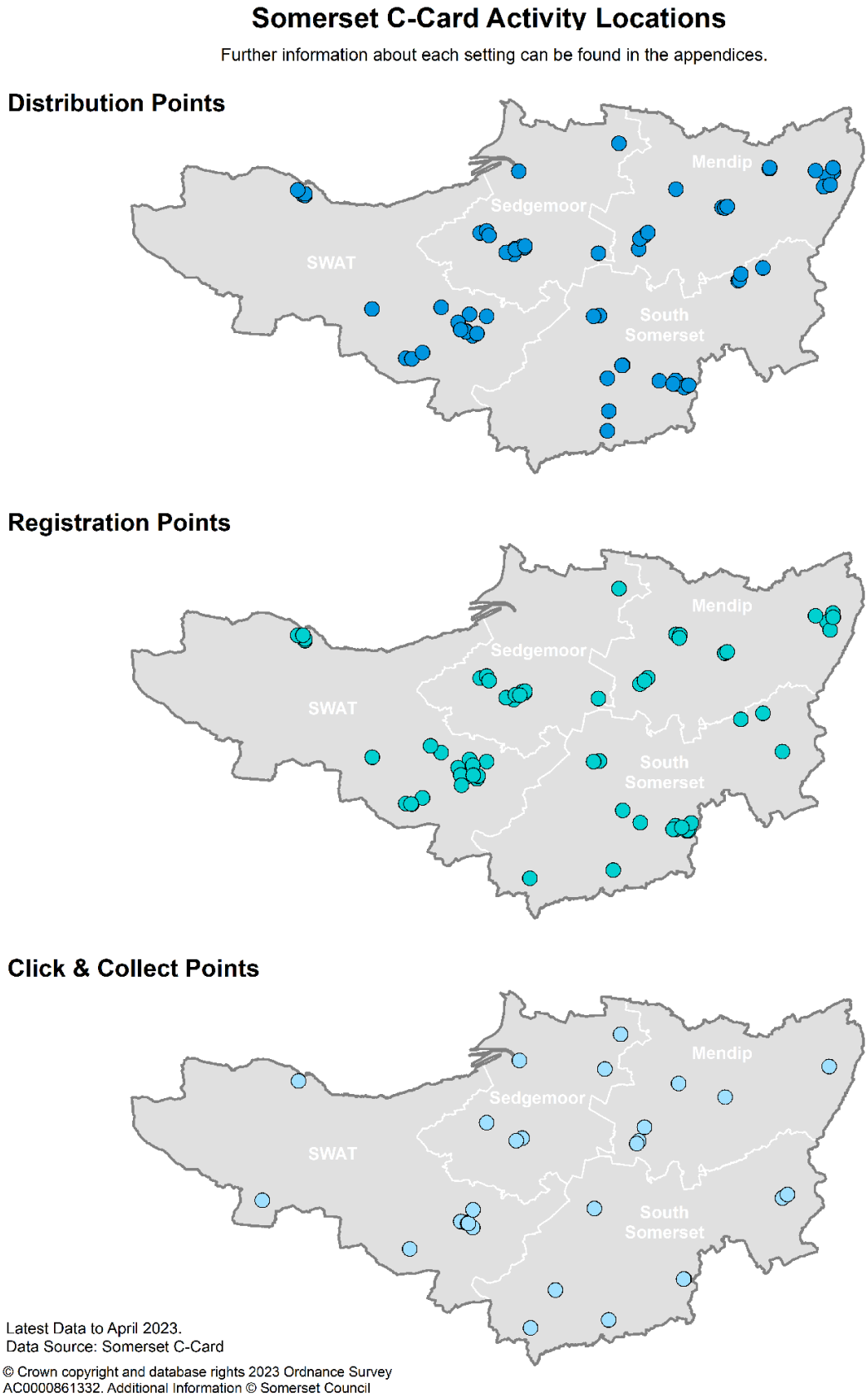

Figure 42 – C-Card locations across Somerset. For a full list of the locations see the appendix 3

4.1.2 Sex and Relationship Education

SRE (sex and relationship education) became compulsory in English Secondary Schools from March 2017, with relationships education becoming mandatory in primary schools from September 2020, this provides the opportunities for young people to develop healthy relationships and prevent unwanted pregnancies[72].

Relationship education in primary schools has a focus on teaching understanding of positive relationships and covers five compulsory areas which are: families and people who care for me, caring friendships, respectful relationships, online relationships, and being safe.

Secondary school RSE aims to aid development of healthy, nurturing relationships all types, not just intimate. This should cover contraception, developing intimate relationships, and resisting pressure to having sex (as well as not applying pressure), as well as what is and is not acceptable behaviour in relationships. Knowledge on safer sex, and sexual health are fundamental in ensuring young people feel able to make decisions which are safe, informed and healthy choices. This education includes the areas of: families, respectful relationships including friendships, online and media, being safe, and intimate and sexual relationships including sexual health.

Somerset Council have partnered with the youth charity LIFEbeat to provide an evidence-based RSHE teacher training programme and range of resources and activities to support RSHE Somerset children & young people RSHE. This is delivered as part of the Somerset Wellbeing Framework for schools and other educational establishments.

4.1.2.1 Somerset School Health and Wellbeing Survey 2021

Somerset Council in partnership with local schools and other settings conducts the Somerset Schools Health and Wellbeing Survey every 2 years so that children and young people can share their views and experiences in relation to their own health and wellbeing in and out of school. Over 10,000 children and young people take part in the survey. Year 4 and 6 pupils complete the primary version of the questionnaire, Years 8 and 10 complete the secondary questionnaire, and sixth form and further education colleges utilise the further education version. All surveys are taken anonymously, and cover themes which are appropriate to each group. Findings from the survey help to inform service planners and commissioners about the health needs of children and young people in Somerset.

The survey includes questions relating to relationships and sexual health and knowledge of sexual health services, as well as bullying and online safety. Key findings from the 2021 survey are in the infographics below and include[73]:

Year 10: 72% had not had sex, and 43% thought most young people have sex for the first time aged 15. In Year 8 6% worried about their gender identify and 8% about sexual orientation, this was higher in Year 10 with 8% worried about gender identity, and 12% about sexual orientation (Figure 43).

Relationships Health and Sex Education Lessons:

Primary: 22% didn't remember/didn't have education on how babies are made, and 62% found 'keeping my body safe' a useful topic

Secondary: More individuals did not find the topics covered useful than did (Figure 43).

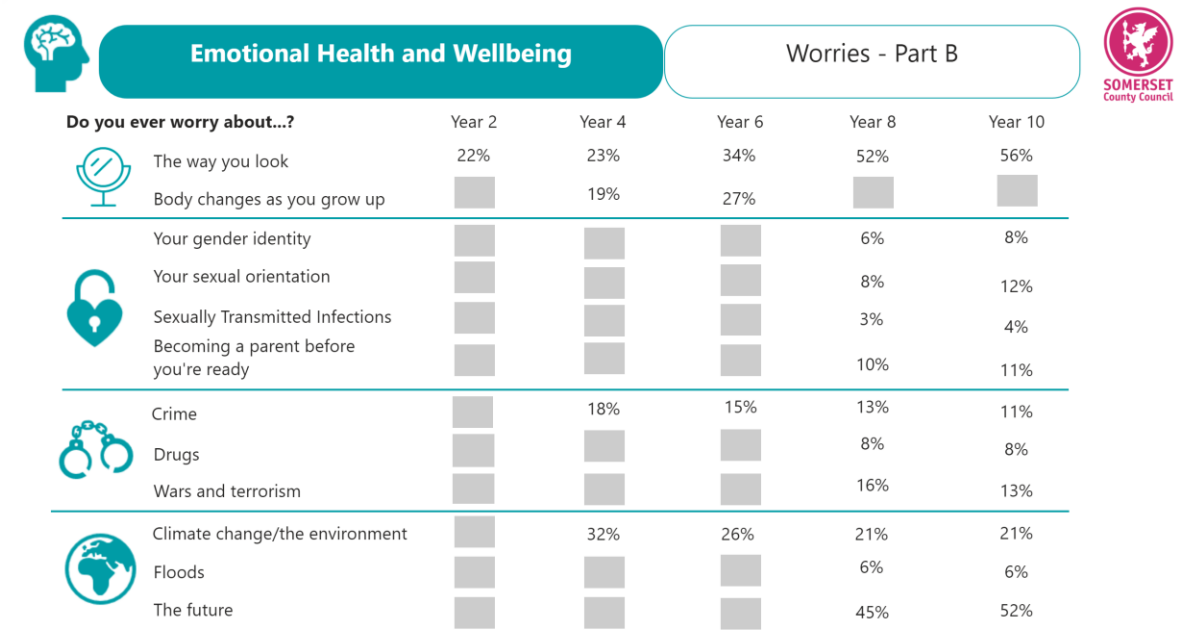

Figure 43 - Somerset Schools Health and Wellbeing Survey 2021 – Emotional Health and Wellbeing

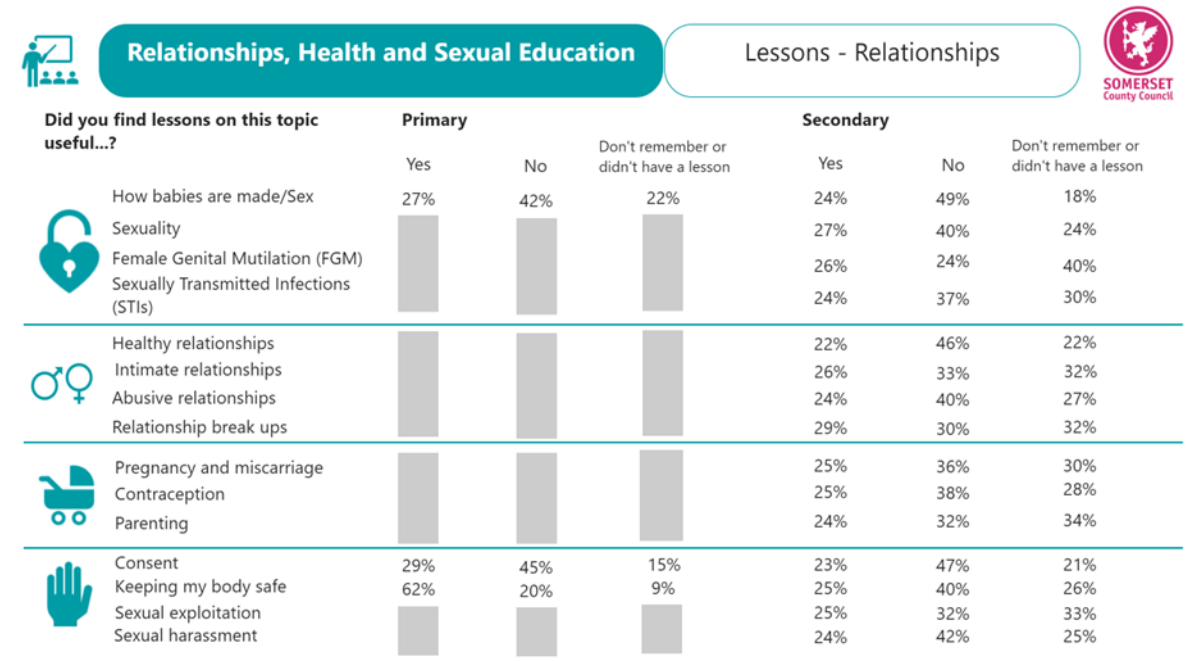

Figure 44 – Somerset Schools Health and Wellbeing Survey 2021 – Relationships, health and sexual education

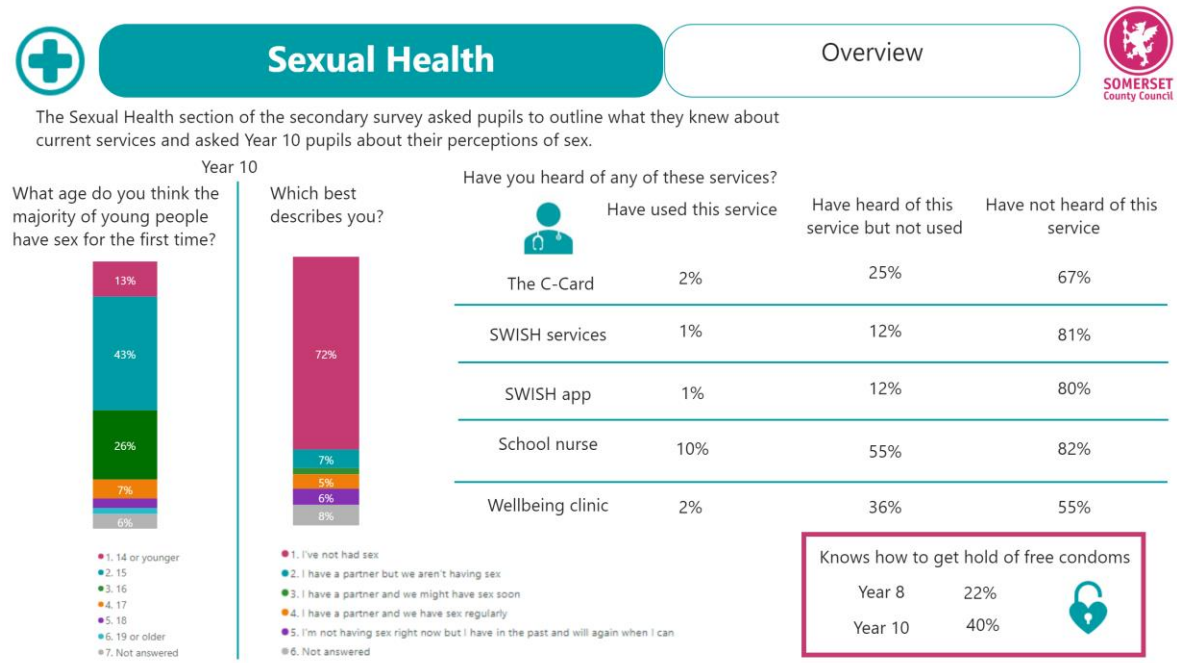

Figure 45 - Somerset Schools Health and Wellbeing Survey 2021 – Sexual Health

40% of year 10 knew how to get hold of free condoms. 76% of year 10 had not heard of the SWISH Services or SWISH app (Figure 45).

4.2 Gay men, Bisexual men, other MSM

In Somerset, 89.9% of individuals identified as being Straight or Heterosexual. The next largest groups were Gay or Lesbian (1.2%), Bisexual (1.1%), and Pansexual (0.2%). Approximately 12,000 Somerset residents selected a sexual orientation other than Straight or Heterosexual; around 1 in 40 people. 7.5% of the Somerset population did not respond to this question. Nationally, the proportion of people with a sexual orientation other than Straight or Heterosexual was slightly higher, at 3.2%; around 1 in 31 people[74].

Table 25 25 – Sexual orientation, by percentage of population (2021 Census)

%	England	SW	Somerset	SWAT	Sedgemoor	Mendip	South Somerset
Heterosexual/ straight	89.37	89.51	89.93	89.90	90.17	89.32	90.33
Gay or Lesbian	1.54	1.43	1.16	1.24	1.19	1.15	1.06
Bisexual	1.29	1.43	1.10	1.10	1.07	1.23	1.01
Pansexual	0.23	0.22	0.17	0.17	0.22	0.17	0.13
Asexual	0.06	0.07	0.05	0.05	0.04	0.06	0.04
Queer	0.03	0.03	0.02	0.02	0.01	0.03	0.01
All other sexual orientations	0.02	0.02	0.02	0.01	0.03	0.03	0.01
Not answered	7.46	7.29	7.55	7.51	7.28	8.01	7.41

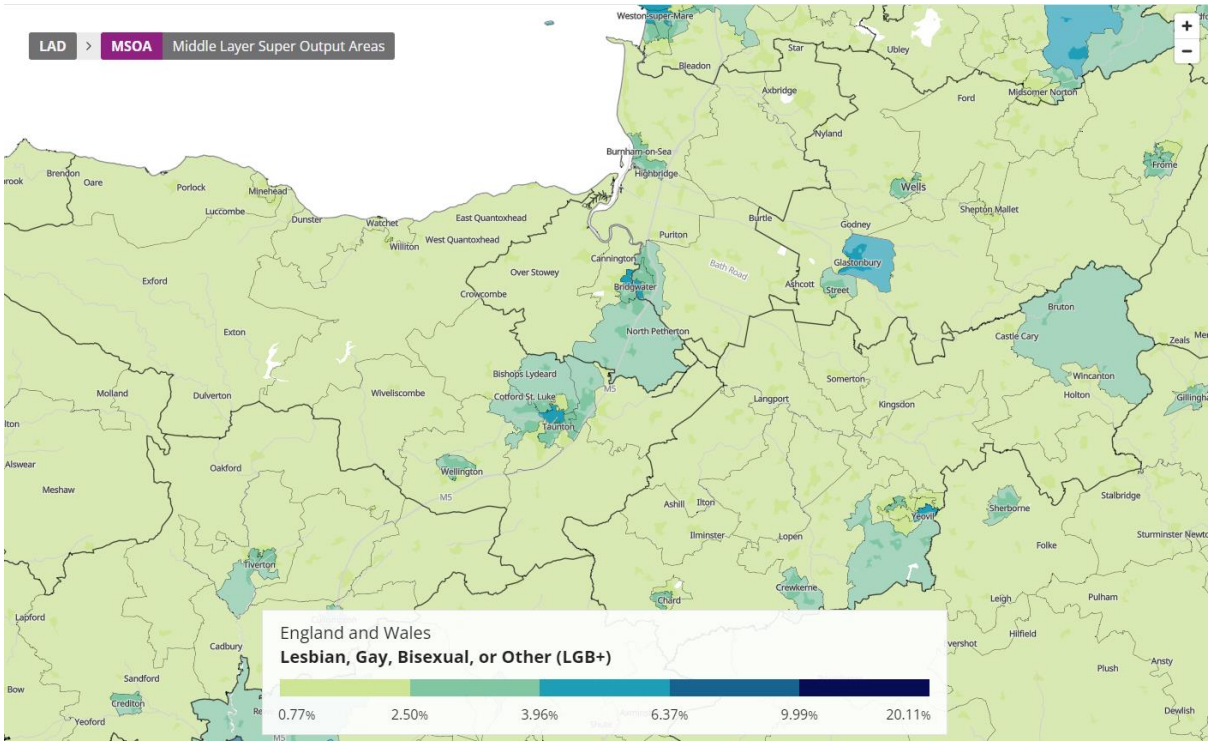

Figure 46 – Lesbian, Gay, Bisexual or Other (LGB+), by MSOA[75]

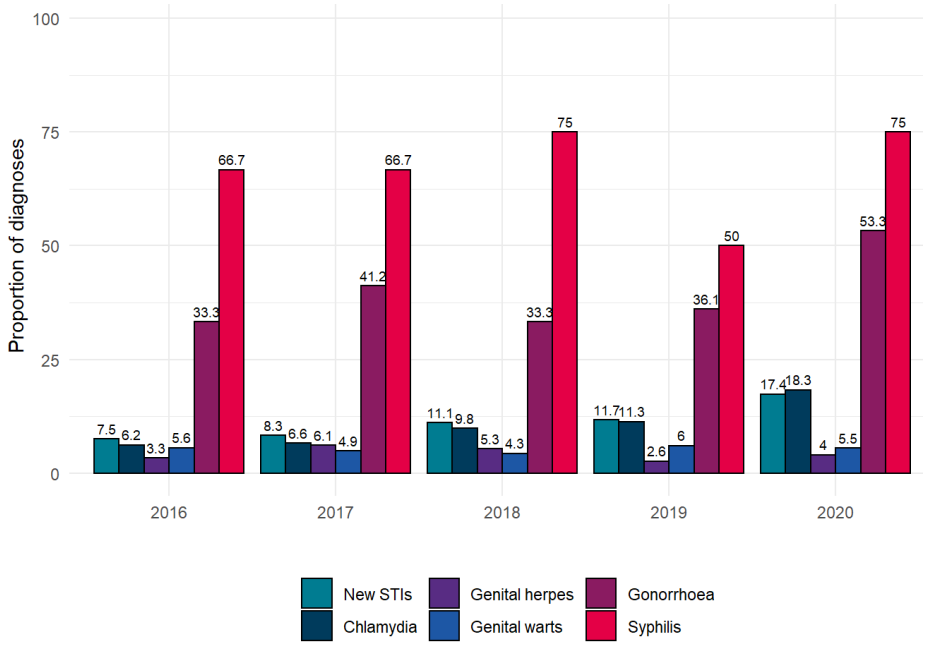

Figure 47 - Proportion of new STIs, chlamydia, genital herpes, genital warts, gonorrhoea, and syphilis that are diagnosed in MSM in Somerset: 2016-2020[76]. Source: SPLASH Supplement

In Somerset 2016-2020 the most common diagnosis for GBMSM is syphilis, followed by gonorrhoea, as seen in the figure above.

4.3 Black, minority ethnic and eastern European

In Somerset, 96.4% of the population are 'White', compared to 81.1% nationally. The ethnic minority population in Somerset is comprised of, 1.5% who identify as 'Asian, Asian British, or Asian Welsh', 1.3% 'Mixed or Multiple Ethnic groups', 0.4% 'Black, Black British, Caribbean, or African', and 0.4% 'Other ethnic group'. The greatest relative change since 2011 comes amongst those from black ethnic groups, with the number of residents from those groups having more than doubled from 1,013 in 2011 to 2,436 in 2021. Somersets non- 'White British' populations tend to be concentrated around the county's towns.

In Somerset, 91.5% of the population was born in the UK. Of those born outside of the UK the majority were born in Europe including Ireland, (5.0%), followed by the Middle East and Asia (1.7%), Africa (0.9%), Americas and the Caribbean (0.6%), and Antarctica and Oceania (including Australasia) (0.3%). Poland is the most common non-UK county of birth for Somerset residents (1.3%), followed by Romania (0.75%). Since the previous census (2011) the number of Somerset residents born in Romania has seen the biggest percentage change, with an almost 4,000 population increase (from 377 in 2011)[77,78].

Sexual health within these groups is often poorer when compared to general population, due to:

- Issues in accessing services.
- Issues in accessing, understanding, and empowerment of women to access contraceptives.
- HIV prevalence – stigmas associated with testing for HIV and STI's

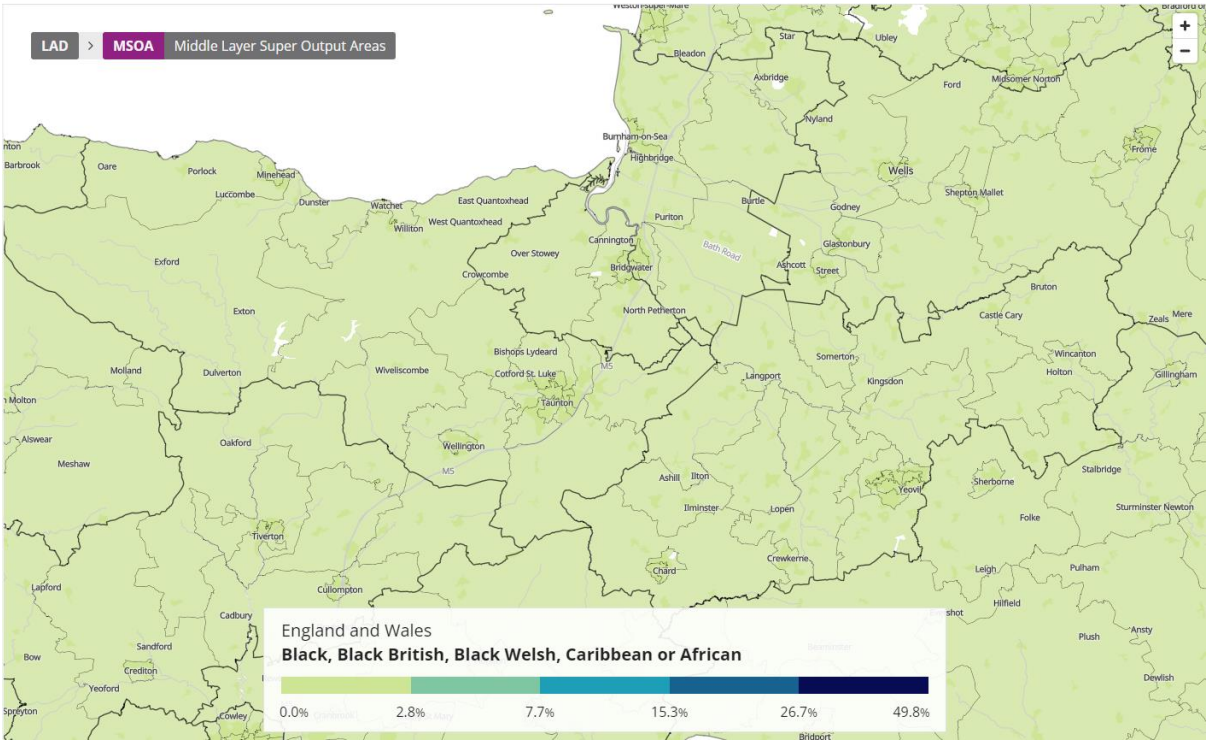

Figure 48 - Source: Ethnic Group identity, Black, Black British, Black Welsh, Caribbean or African by MSOA[79]

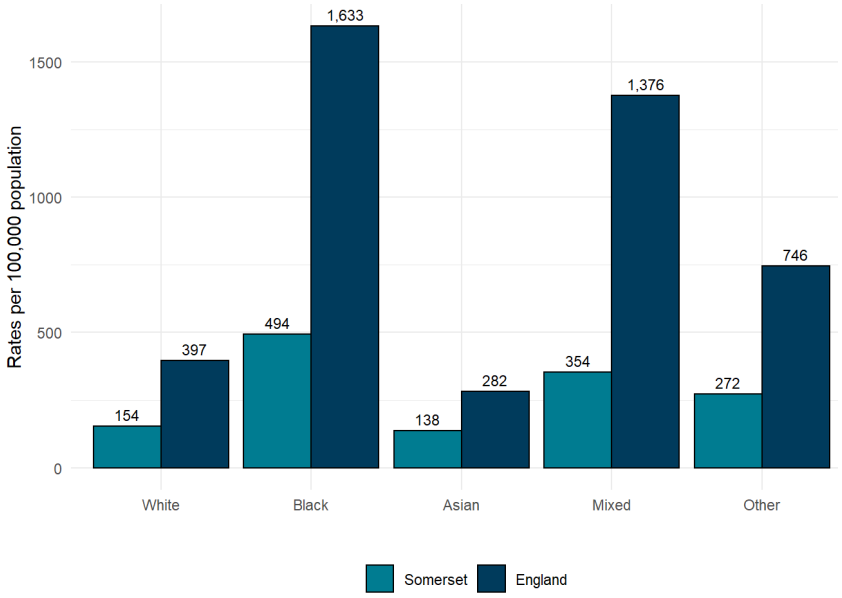

Figure 49 - Rates per 100,000 population of new STIs by ethnic group in Somerset and England (SHS diagnoses only): 2020[80]. Source: SPLASH Supplement

In Somerset STI rates per 100,000 population, follows the same pattern as seen nationally. The highest rates are found in 'Black' individuals, followed by 'Mixed', then 'Other', the rates are lowest in the 'Asian' population, as can be seen in the figure above.

5 Recommendations

This needs assessment has contributed to an understanding of the sexual and reproductive health of the Somerset population and has informed the following recommendations:

1. The Somerset Sexual Health Network should complete the 'Local HIV, reproductive health and sexual health self-assessment tool' (developed by the English HIV and Sexual Health Commissioners Group), to enable an assessment of the resilience of local systems and services since the COVID-19 pandemic and to ensure health inequalities are recognised and planned for across the system.

2. The Somerset Sexual Health Network should use the framework provided through the national 'HIV Action Plan 2022 to 2025' to assess where the Somerset system is in achieving the ambitions to achieving zero new HIV infections, and AIDS and HIV related deaths by 2030, and identify priorities for local action.

3. To review LARC provision and the wider offer of contraception across a range of provision (including abortion services and antenatal/postnatal services), to improve access and pathways for women seeking contraception and inform the future model of delivery. This should include improving provision in areas with little or no access such as Burnham-On-Sea and Highbridge, the further development of inter-practice referrals and the development of the primary care workforce, also;

4. To collaborate with NHS Somerset in the development of the 'Women's Health Hub' offer to improve access to sexual and reproductive health and screening services.

5. To complete public engagement to further understand knowledge and need in relation to sexual and reproductive health. This should include engagement with women on access to contraception and other health needs identified through the 'Women's Health Strategy', and with other groups and communities experiencing inequalities in sexual health outcomes and access to services.

6. To ensure robust reporting of C-Card condom distribution scheme data to better understand the reach of the service, identify need and gaps in service provision and identify priorities to ensure equality of access.

7. To review the provision of EHC to those aged under 25, identify any gaps in service provision and ensure young people know how to access the service.

8. To raise awareness of HIV, opportunities for testing and access to PrEP, targeting those not currently accessing these services, and;

9. The Sexual Health Network should review the causes of late diagnosis of HIV and identify opportunities for raising awareness amongst healthcare professionals.

10. To review provision of the compulsory RSHE curriculum in education establishments in Somerset to support children and young people to develop healthy relationships and to keep themselves safe, both on and offline.

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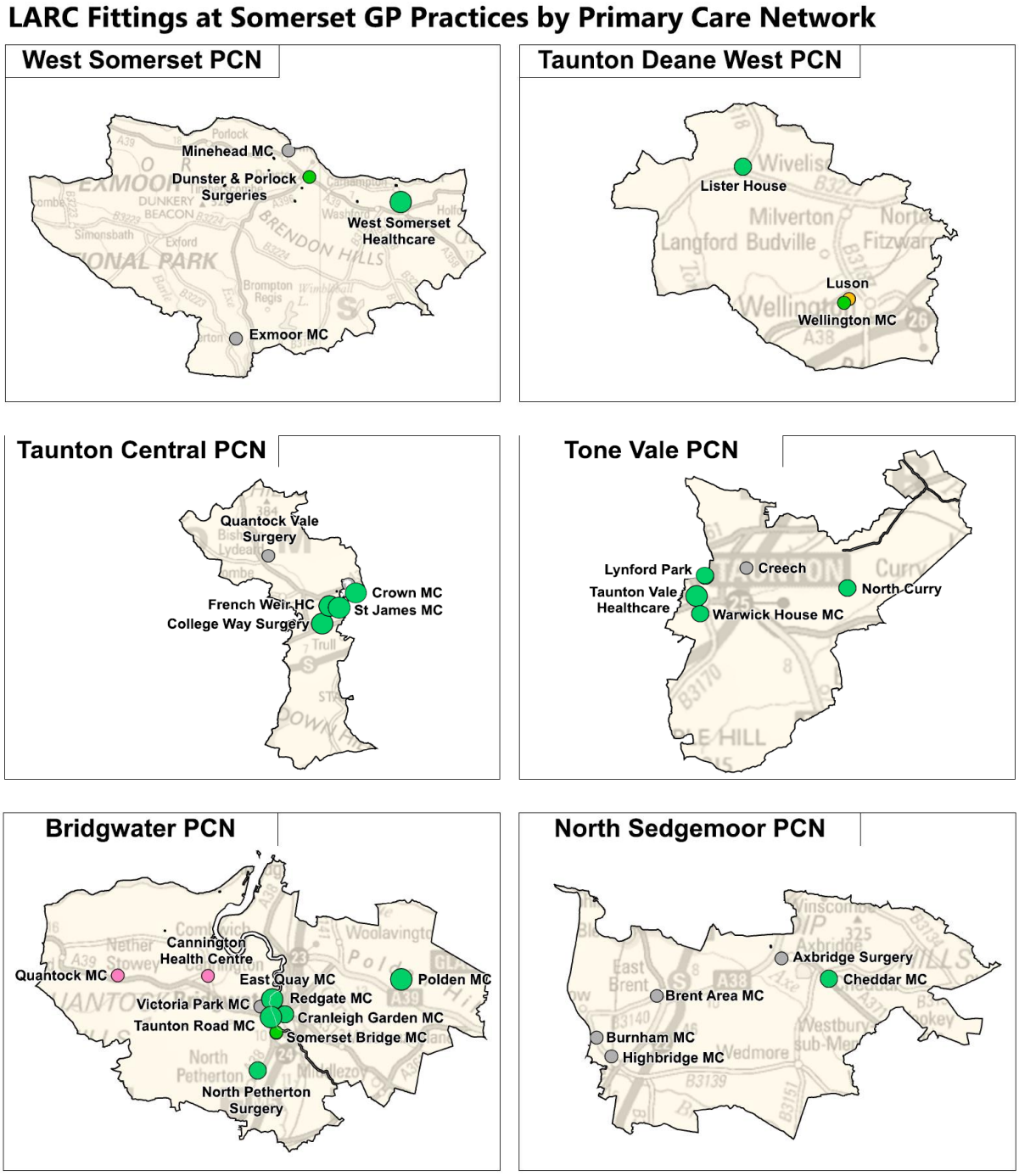
Appendices:

Appendix 1: Sexual Health Service Standards

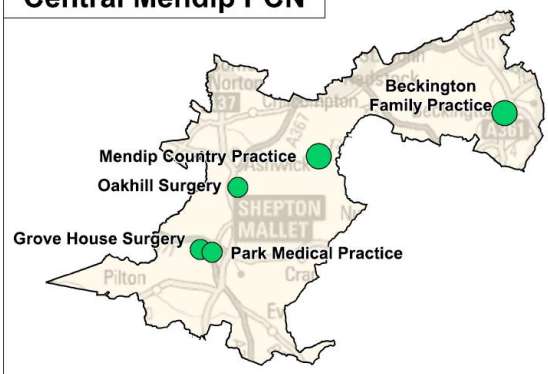
- BASHH and Brook. Spotting the signs: a national proforma for identifying risk of CSE in sexual health services (2014)
- BASHH standards for the management of STIs in outreach services (2016)
- Link to all BASHH Guidelines
- BHIVA and BASHH UK guideline for the use of HIV PEP (2021)
- BHIVA and BASHH guidelines on the use of HIV PrEP (2018)
- BHIVA standards of care for people living with HIV (2018)
- BHIVA UK national guidelines on safer sex advice (2012)
- Link to all BHIVA guidelines
- FSRH service standards for SRH care (2016)
- FSRH standards for emergency contraception (2017 amended 2020)
- FSRH service standards for confidentiality in SRH services (2020)
- FSRH quality standard for contraceptive services (2014)
- Link to all FSRH standards and guidelines
- NICE NG68 STIs: condom distribution schemes (2017)
- NICE NG221 reducing STIs (2022)
- NICE QS129 quality standard contraception (2016)
- NICE QS129 quality statement on emergency contraception (2016)
- NICE QS157 HIV testing, encouraging uptake (2017)
- NICE PH51 contraceptive services for under 25s (2014)
- NICE NG60 HIV testing: increasing uptake among people who may have undiagnosed HIV (2016)
- NICE PH49 behaviour change; individual approaches (2014)
- NICE CG30 LARC (2005 updated July 2019)
- NICE Quality Standard on Contraception After Childbirth

Appendix 2: Map showing LARC fitting at Somerset GP Practices by Primary Care Network



West Mendip PCN

Central Mendip PCN



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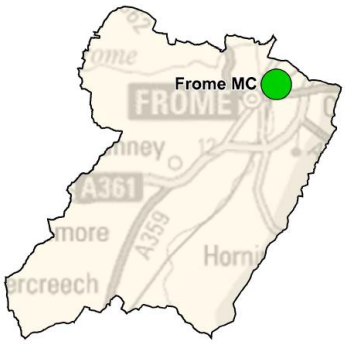

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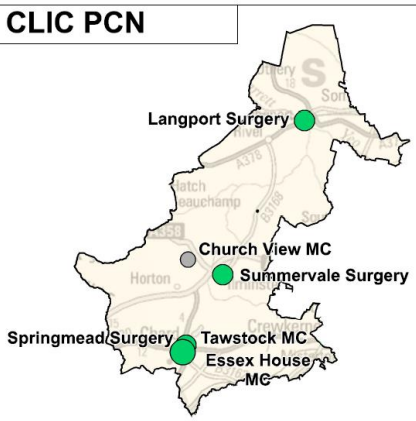
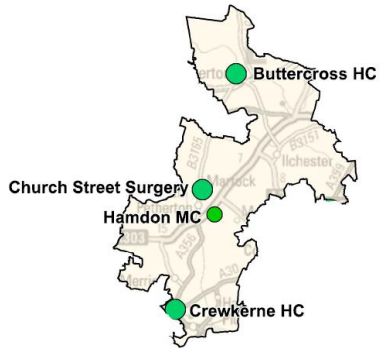
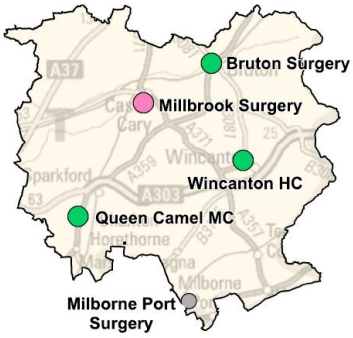


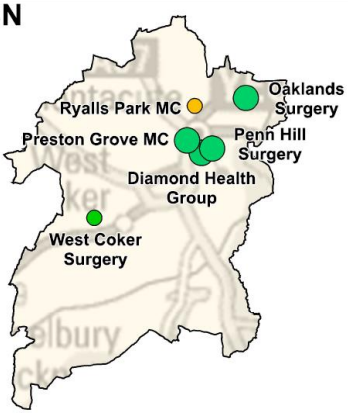
South Somerset West PCN



South Somerset East PCN



Yeovil PCN



Appendix 3: C-Card locations

Setting Name	Postcode	District	Distribution Point	Registration Point	Click & Collect
Glastonbury Surgery	BA6 9LP	Mendip	Yes	Yes	Yes
Bridgwater and Taunton College	TA6 4PZ	Sedgemoor	Yes	Yes	Yes
Bridgwater College Cannington Centre	TA5 2LS	Sedgemoor	Yes	Yes	Yes
Bridgwater and Taunton College	TA1 5AX	SWAT	Yes	Yes	Yes
SWISH Taunton	TA1 4AS	SWAT	Yes	Yes	Yes
Blue School	BA5 2NR	Mendip	Yes	Yes	
Christopher House	BA20 2DN	Mendip	Yes	Yes	
Frome College	BA11 2HQ	Mendip	Yes	Yes	
Frome Young Peoples Clinic	BA11 1EZ	Mendip	Yes	Yes	
Kings of Wessex Academy	BS27 3AQ	Mendip	Yes	Yes	
Sexeys School	BA10 0DF	Mendip	Yes	Yes	
Shape Mendip	BA4 5BT	Mendip	Yes	Yes	
Shared Earth Learning	BA11 3JQ	Mendip	Yes	Yes	
St Dunstanas School	BA6 9BY	Mendip	Yes	Yes	
St Dunstans School	BA6 9BY	Mendip	Yes	Yes	
The Key Centre	BA11 5AJ	Mendip	Yes	Yes	
Tor School Clinic	BA6 9NS	Mendip	Yes	Yes	
Westfield Academy	BA21 3EP	Mendip	Yes	Yes	
Whitstone School	BA4 5PF	Mendip	Yes	Yes	
Bridgwater College Academy	TA6 4QY	Sedgemoor	Yes	Yes	
Brymore Academy	TA5 2NB	Sedgemoor	Yes	Yes	
Haygrove School Clinic	TA6 7HW	Sedgemoor	Yes	Yes	
Reach Alternative Education	TA12 6WN	Sedgemoor	Yes	Yes	
Robert Blake School Clinic	TA6 6AW	Sedgemoor	Yes	Yes	
Routes Hub Bridgwater	TA6 3LT	Sedgemoor	Yes	Yes	
The Rollercoaster	TA6 4RL	Sedgemoor	Yes	Yes	
Young Somerset	TA7 9BF	Sedgemoor	Yes	Yes	
Barnardo's (Taunton Office)	TA2 6BJ	SWAT	Yes	Yes	
Castle School Clinic	TA1 5AU	SWAT	Yes	Yes	
Courtfields School	TA21 8SW	SWAT	Yes	Yes	
Foxes Academy	TA24 5TY	SWAT	Yes	Yes	
Futur3s South West Limited	TA5 2RJ	SWAT	Yes	Yes	
Heathfield Community School Clinic	TA2 8PD	SWAT	Yes	Yes	
Leaving Care	TA1 4DY	SWAT	Yes	Yes	
Minehead MIU	TA24 6DF	SWAT	Yes	Yes	
Project 1	TA2 6PN	SWAT	Yes	Yes	
Somerset Activity Sports Partnership	TA21 9JQ	SWAT	Yes	Yes	
Taunton Deane Partnership College	TA1 2JD	SWAT	Yes	Yes	
The SPACE Clinic	TA21 8PD	SWAT	Yes	Yes	
The Taunton Academy PHSN	TA2 7QP	SWAT	Yes	Yes	
West Somerset College	TA24 6AY	SWAT	Yes	Yes	

Ansford Academy	BA7 7JJ	South Somerset	Yes	Yes	
Buckler's Mead Academy	BA21 4HN	South Somerset	Yes	Yes	
Huish Episcopi Academy	TA10 9SS	South Somerset	Yes	Yes	
Preston School Academy	BA21 3JD	South Somerset	Yes	Yes	
South Somerset Partnership Schools	BA21 4EN	South Somerset	Yes	Yes	
The Langport Young Peoples Centre	TA10 9PQ	South Somerset	Yes	Yes	
Wincanton Health Centre	BA9 9FQ	South Somerset		Yes	Yes
Frome Medical Practice	BA11 2FH	Mendip		Yes	
Glastonbury Young Peoples Clinic	BA6 9LP	Mendip		Yes	
Wellington School	TA21 8NT	Mendip		Yes	
Wells Cathedral School	BA5 2SS	Mendip		Yes	
YMCA Mendip	BA5 1SL	Mendip		Yes	
Sedgemoor Centre	TA6 5HT	Sedgemoor		Yes	
Minehead Eye	TA24 5BJ	SWAT		Yes	
Quantock Vale Surgery	TA4 3NS	SWAT		Yes	
Queens College Medical Centre	TA1 4QS	SWAT		Yes	
Sky Academy	TA2 7HW	SWAT		Yes	
The Base Youth Centre	TA4 2NE	SWAT		Yes	
Victoria Gate Surgery	TA1 3EX	SWAT		Yes	
YMCA Taunton	TA1 2LB	SWAT		Yes	
Holyrood School Clinic	TA20 1JL	South Somerset		Yes	
Oaklands Surgery	BA21 5RL	South Somerset		Yes	
Reckleford Children's Centre	BA21 4ET	South Somerset		Yes	
Stanchester School Clinic	TA14 6UG	South Somerset		Yes	
Wadham School PHSN Clinic	TA18 7NT	South Somerset		Yes	
Yeovil College	BA21 4DR	South Somerset		Yes	
Strode College	BA16 0AB	Mendip	Yes		Yes
Richard Huish College	TA1 3DZ	SWAT	Yes		Yes
Superdrug Yeovil	BA20 1RQ	South Somerset	Yes		Yes
Boots Pharmacy Castle Cary	BA7 7BG	Mendip	Yes		
Boots Shepton Mallet	BA4 5TZ	Mendip	Yes		
Castle Cary Surgery	BA7 7EE	Mendip	Yes		
Coleford Pharmacy	BA3 5NH	Mendip	Yes		
Lloyds Pharmacy in Frome Sainsburys	BA11 4DH	Mendip	Yes		
Mendip County Practice	Ba3 5NQ	Mendip	Yes		
St Aldhelm's Pharmacy	BA11 2FH	Mendip	Yes		
Boots	TA8 1NX	Sedgemoor	Yes		
Boots Pharmacy Bridgwater	TA6 3NG	Sedgemoor	Yes		
South Petherton Pharmacy	TA13 5EF	Sedgemoor	Yes		
YMCA Bridgwater	TA6 3RF	Sedgemoor	Yes		

Alcombe Pharmacy	TA24 6BD	SWAT	Yes		
Day Lewis Pharmacy Wiveliscombe	TA4 2JT	SWAT	Yes		
Cambian Lufton College	BA22 8ST	South Somerset	Yes		
Crewkerne Pharmacy	TA18 8BG	South Somerset	Yes		
Merriot Pharmacy	TA16 5QG	South Somerset	Yes		
Penn Hill Pharmacy	BA20 1QE	South Somerset	Yes		
Sexey's School Health Centre	BA10 0DF	South Somerset	Yes		
Well Pharmacy	TA12 6JL	South Somerset	Yes		
Cheddar Library	BS27 3NB	Mendip			Yes
Frome Library	BA11 1BE	Mendip			Yes
Ilminster Library	TA19 0BW	Mendip			Yes
Shepton Mallet Library	BA4 5AZ	Mendip			Yes
Street Community Library	BA16 0HA	Mendip			Yes
Wells Library	BA5 2PU	Mendip			Yes
Bridgwater Library	TA6 3LF	Sedgemoor			Yes
Burnham-on-Sea Library	TA8 1EH	Sedgemoor			Yes
Wedmore Pharmacy	BS28 4AB	Sedgemoor			Yes
Boots Pharmacy Taunton	TA1 3PT	SWAT			Yes
Dulverton Library	TA22 9EX	SWAT			Yes
Minehead Library	TA24 5DJ	SWAT			Yes
Priorswood Community Library	TA2 7HD	SWAT			Yes
Taunton Library	TA1 3XZ	SWAT			Yes
Wellington Library	TA21 8AQ	SWAT			Yes
Chard Library	TA20 2YA	South Somerset			Yes
Crewkerne Library	TA18 7JS	South Somerset			Yes
Langport Library	TA10 9RA	South Somerset			Yes
Wincanton Library	BA9 9JS	South Somerset			Yes
Yeovil Library	BA20 1PY	South Somerset			Yes
Frome Foyer	BA11 1DN	Mendip			
Glastonbury Library	BA6 9JB	Mendip			
Martock Library	TA12 6DL	Sedgemoor			
The King Alfred School	TA9 3EE	Sedgemoor			
2BU Taunton	TA1 3PY	SWAT			
French Weir Avenue	TA1 1NW	SWAT			
Superdrug Wellington	TA21 8AA	SWAT			
YMCA	BA21 4HL	South Somerset			