DPH Annual Report draft

Short Version

Healthy Sexually

Working hand-in-hand to improve the sexual and reproductive health of young people in the City of London and Hackney

"Holding Hands" in Hoxton Square, sculpture by STIK

Introduction & Recommendations

This year my annual report focuses on Sexual and Reproductive Health (SRH). It coincides with, and draws upon, work being undertaken by The City of London and Hackney public health team on a SRH Needs Assessment and a five year SRH strategy. It has also benefited from interviews conducted with a wide range of stakeholders, commissioners and service providers.

Promoting good sexual and reproductive health throughout our communities is an overarching goal for the many organisations and individuals who work to improve public health. Enhancing access to existing SRH services is a key element of achieving that goal. The quality of access is determined, on the one hand, by the design of the services themselves; and on the other hand, by people's awareness of those services and willingness to access them. Access is, therefore, a two-way street, with both aspects deserving attention.

While the issue of access is relevant to all services and all communities, this report will focus on young people, meaning those people under 30 years old, and our strategies for reducing sexually transmitted infections (STIs). This is not to deny the importance of other aspects of SRH. Rather, it is recognition of the large number of young people already accessing services and the very high level of STIs among this group. By addressing STIs, other issues such as access to contraception can also be improved and will be covered in more depth in the 5 year strategy.

The City and Hackney have recorded a higher rate of newly diagnosed STIs than the London or England averages for the past nine years of available data. The rate in 2021 was over four times the average for England.[1] At the same time, we have seen a large reduction in the number of STI tests being performed. Over ten thousand fewer tests were undertaken in 2021/22 compared to before the pandemic.[2]

Ensuring prompt diagnosis, effective partner notification and treatment of STIs is the mainstay of SRH services and an area where improvements can, and must, be made. Furthermore, initiatives taken to promote SRH among young people can provide wider benefits to our communities. By examining current challenges facing young people and considering how to address them, we throw light on other aspects of SRH and propose general principles to guide future work.

There are five areas in which recommendations are proposed to address the high levels of local need and reduce health inequalities. The first relates to embedding collaboration and co-production principles and is the cornerstone for implementation of the other recommendations. While these recommendations focus on young people, the principles are applicable across SRH and should be applied to work with other specific groups and communities.

1. Community involvement is essential to providing high quality services: health providers and commissioners should reconfirm, and put into action, their commitment to collaborate with young people in the co-production of services.

2. Services must be easily accessible to young people: refine existing SRH services and explore new initiatives in collaboration with young people to make accessing services as easy as possible.

3. Young people must be aware of when and how to access support: improve young people's awareness of services and their willingness to access them.

4. Focus on enhancing collaboration and partnership working: continue to develop collaborative working practices across SRH and beyond to mitigate pressures on services and improve user experiences.

5. Continue to identify and address inequalities in SRH: ongoing research and audit, undertaken in collaboration with communities, is recommended to identify inequalities and communicate findings to all concerned partners. Such research should be coupled with a commitment to address inequalities that are identified.

Key Messages

Public health is concerned with health creation - our approach must be community based and participatory. We need to find a shared purpose with the communities we serve and be guided by meaningful collaboration and a desire for true co-production of services.

We need to recognise how important sexual and reproductive health (SRH) is to our entire population. SRH goes beyond the presence or absence of an infection. It involves choice, consent, pleasure, and good relationships. The World Health Organisation describes sexual health as "fundamental to the overall health and well-being of individuals, couples and families".[3]

We must support every individual's right to enjoy a fulfilling sexual life and loving relationships. We need to empower people and foster their sense of control. People engage in sexual activity for different reasons, but they should be able to choose whether or not to have sex, free from coercion or violence, choose whether or not to get pregnant, and know what to do and where to go if they have problems. We must adopt a "sex-positive" approach that is "open, frank and positive about sex, that challenges negative societal attitudes to sex and that emphasises sexual diversity at the same time as emphasising the importance of consent".[4]

Issues related to sexual and reproductive health are deeply linked to our individual identities and cultures; and remembering this underlines the importance of working with communities. It is only through collaboration that we can develop the services we all need. Services must not only prevent ill health but also be able to address problems when they do occur or be able to refer effectively to services that can. Services need to be trusted so that individuals are confident and comfortable in accessing testing and treatment. As one person interviewed during the preparation of this report observed, *"we are good at commissioning services but there is something beyond creating services, it's about talking to people and communities, it's about how to engage"*. Without ongoing engagement with individuals and communities, SRH services cannot flourish.

We need to normalise conversations about sex while at the same time being sensitive to the concerns of the communities and individuals with whom we work. Our aim should be to reduce embarrassment and by doing so help communities and individuals feel comfortable accessing the services they need. Services that reduce inequalities and promote the enjoyment of rich and fulfilling lives.

Contents

Background - where are we now?

What is special about The City of London and Hackney? What characterises this area of London and the people who live here? We will consider how The City of London and Hackney differs from other areas of London, and the nation, in terms of sexual and reproductive health (SRH).

The City of London and Hackney is young; ethnically, sexually and linguistically diverse; and proud

Approximately 260,000 people live in Hackney and around 9,000 people live in the City of London.[5] In addition to these residents, it is thought that over 400,000 people commute into the square mile to work on many weekdays.

The City of London and Hackney has a young population, with almost two thirds of the population 40 years old or less.[6] According to the 2021 census, 54% of the population are white but only 34% are white British.[7] There are large black African and black Caribbean communities, and the Charedi, or Orthodox Jewish, community makes up approximately 7% of Hackney's total population.[8] The Turkish and Kurdish communities are also large, with around 6% of Hackney's residents born in Turkey. In the City, which has a less diverse, albeit much smaller, population there is a large Bangladeshi community. Across The City of London and Hackney, there are a range of other distinct communities, including Chinese, Somali and Vietnamese. In short, there is a rich cultural mix as demonstrated by the 100 different languages that are estimated to be spoken across The City of London and Hackney.[9]

According to the 2021 Census, 7% of the population in The City of London and Hackney was lesbian, gay or bisexual (LGB). A further 0.9% responded as having an "other sexual orientation" and 12.5% chose not to answer.[10] Taking the 2021 census data for England and Wales as a whole, 2.8% of the population was LGB, 0.3% responded as "other" and 7.5% chose not to answer. The proportion of the local population that is LBG is, therefore, much higher than the national average. Furthermore, according to the 2021 Census data, the percentage of men in The City of London and Hackney who are gay or bisexual was 8.23% compared to the average over England and Wales of 2.74%.[11]

Notwithstanding the vibrance and wealth of communities living in The City of London and Hackney, there is considerable socio-economic deprivation present across the local authorities. Hackney as a whole had, in 2019, an Index of Multiple Deprivation (IMD) score[12] of 32.5 which was the 18th worst in England (out of 152 areas) and the second worst in London (out of 33 local authorities).[13] The City of London, however, had a score of 14.7 which was the 26th best in England and the sixth best in London.[14] Recognising the level of deprivation affecting the local population is important when considering sexual health because deprivation is associated with a range of poor health outcomes, including sexual health problems.[15]

People who live and work in The City of London and Hackney are proud of their communities and their colleagues. There is a strong sense of place and of history. There is a civic pride

that stems from these roots and an earnest belief in the important role public, private and community organisations play in fostering change and improving conditions for the community as a whole. Many of the people interviewed while preparing this report talked with pride about the services that have been provided in the context of sexual health and the initiatives being taken. There is a recognition of the challenges but also hope and determination. Without forgetting that optimism, let us turn now to look at some of the challenges.

How does The City of London and Hackney compare with other parts of London?

In this section we consider areas in which the data from The City of London and Hackney differ from other areas of London and England. We are interested in where we are an outlier, understanding why this may be the case, and where we need to focus our attention.

The City of London and Hackney have been relative outliers compared to other London local authorities in two key areas of SRH, namely the provision of Long-Acting Reversible Contraception (LARC) and the prevalence of Sexually Transmitted Infections (STIs). While it is true that the most recent data available suggests that rates of LARC prescription are coming back in line with London averages, Hackney remains with above average rates of abortions in certain demographics and ensuring good access to contraception options, including LARC, is a key requirement. Here we outline some of the key data relating to LARC provision and STIs, as well as key data on teenage pregnancies and abortions.

Long-Acting Reversible Contraception (LARC)

LARC is considered the most effective method of contraception.[16] It can help people to plan pregnancies as they wish, resulting in better outcomes for mother, child and the wider family.[17] The total rate of LARC prescribed in Hackney in 2020 was 19.3 per 1,000 women, and 13.6 per 1,000 women for the City of London.[18] These figures are considerably lower than the rate in England as a whole which was 34.6 per 1,000 women, and lower than the London average of 27 per 1,000 women. This difference is particularly high between the rate of LARC prescriptions in primary care in Hackney (7.2 per 1,000 women) compared to the rate of prescriptions in primary care in England as a whole (21.1 per 1,000 women).[19]

New data made available in February 2023 show, however, that in 2021, rates of LARC prescriptions rose in both The City of London and Hackney to 37.5 and 20.8 respectively. Hackney was, therefore, once more above the London average of 30.4 for the same period, but still lower than the England average of 41.8 per 1,000 women.[20] While the provision of LARC has started to recover, and Hackney at least is no longer below the London average, it has not yet returned to pre-pandemic levels when, in 2019, the rate of prescription was 45.9 per 1,000 and in the City of London it was 24.3 per 1,000. The City of London has the third lowest rate of LARC in London and the 12th lowest in England.[21] Ensuring appropriate access to LARC, together with other forms of contraception, is one element of helping people achieve planned pregnancies. Whilst many of the recommendations in this report equally apply to increase access to and uptake of LARC this will be fully considered in the sexual health strategy.

Teenage pregnancies and repeat abortions in women under 25 years of age

Teenage pregnancy is associated with significantly poorer outcomes for both young parents and their children.[22] The City of London and Hackney have been effective at reducing the rate of teenage pregnancies over the last ten years of available data and has, since 2018, seen a rate consistently below the average for England.[23] At the same time, figures show that the percentage of teenage conceptions ending in abortion is higher than London and national averages (70.5% in Hackney and City compared to 63.2% in London and 53% in England). While it would be desirable to help people prevent unwanted pregnancies, the relatively high proportion of teenage conceptions ending in abortion is an indication of good access to abortion services.

The available data on the rate of teenage pregnancies is encouraging but only goes up to 2020. More recent data is available for the under 18s abortion rate in Hackney, which rose in 2021 for the first time since 2016. From 2020 to 2021, Hackney saw a 29.7% increase in the number of women under 18 years old needing an abortion, with a rate of 8.3 per 1,000 women[24] compared to a London average of 5.5 and an average in England of 6.5.[25] It is possible, therefore, that the number of conceptions in women under 18 will also be seen to have risen when 2021 data becomes available.

Another area of concern is the data relating to abortions in women under 25 years old where the women have had one or more previous abortions. This is a key indicator of a lack of access to good quality contraception services and advice for a group of women who have, by definition, previously been in contact with SRH services. In 2021, 34.1% of abortions involving women under 25 in Hackney were repeat abortions. Hackney had the third highest rate compared to its 15 statistically nearest neighbours.[26] In the City of London, however, the 2021 figure for repeat abortions under 25 was 28.6%, lower than both the London and England averages (31.6% and 29.7% respectively).

Notwithstanding relatively high rates in Hackney for abortions in under 18s, and repeat abortions in under 25s, the absolute abortion rate in Hackney was similar to that in its closest comparable neighbours and lower than the London average, although higher than the England average. This suggests that interventions should be targeted to support women under 18, and those under 25 who have already had an abortion, in order to redress this difference between them and the rest of the population.

Sexually Transmitted Infections (STIs)

The detection and treatment of STIs is a fundamental component of Sexual and Reproductive Health services. Even when treated, STIs can cause long-term complications affecting health and some require ongoing management. Detection is necessary to ensure effective treatment and timely partner notification to prevent onward transmission. [27] Prompt detection can also reduce the significant costs of treatment and management.

The City of London and Hackney have recorded a significantly higher rate of newly diagnosed STIs than the London or England averages for the past ten years of available data. In 2021, Hackney ranked fourth highest out of 150 local authorities[28] for new STI diagnoses.[29] The rate in Hackney was over four times the England average: 1,687 per 100,000 residents compared with a rate of 394 per 100,000 for England as whole.[30]

Furthermore, both the City of London and Hackney are areas of very high prevalence of HIV.[31]

Access to testing for STIs is key for treatment of individuals and their partners and to prevent further infections. The COVID pandemic has seen a large reduction in the overall number of tests being performed with fewer than half the number of tests being performed in 2021 compared to 2019.[32] This is notwithstanding the welcome increase in the numbers of people self-testing through the Sexual Health London digital service (SHL).[33] The shift away from face-to-face appointments that occurred in both primary and secondary care as a result of the pandemic seems to be a major factor explaining the reduction in the level of testing for STIs across the City of London and Hackney. While it is true that the number of new STIs diagnosed has also dropped between 2019 and 2021, and this might appear to be encouraging, it is in the context of a much larger drop in the amount of testing being performed.[34] This means that the fall in the number of new STIs being diagnosed is more likely to reflect the reduction in testing rather than a reduction in the burden of disease in the community.

In the following chapter, we focus on the successes and challenges relating to providing services in these areas and how we can encourage and promote appropriate access, with a particular focus on young people.

How do we improve access?

"Every report talks about improving access" (stakeholder)

While it is true that there is frequently a call to improve access to services, in this section we will discuss why this is central to SRH services and what barriers to exist. We will consider what impact the COVID pandemic has had, both on the services themselves and how people access them. We will then briefly explore which groups or communities have higher needs before explaining why, for the rest of the report, we will focus predominantly on the experiences of younger people.

What are the services we're talking about?

We should consider services as activities that promote the wellbeing of communities rather than using the medical model where we focus on treating the ill health of individuals. As such, SRH services include initiatives to raise awareness and knowledge - steps taken to empower people so that they are more in control of their sexual health and wellbeing.

There are many services across the range of SRH but they all require people to choose to access them. Access can be in a variety of ways. They can be through self-referral or attendance at a drop-in clinic, or may require referral by a professional. Some services proactively seek engagement from individuals and communities.[35]

Services are provided in many different settings including GP surgeries, pharmacies, specialist clinics, in schools and the community, and on-line through platforms such as Sexual Health London. Services may be funded through local authorities and regional NHS bodies working within the Integrated Care System, by national NHS bodies, or by individual grants provided to Voluntary Sector Organisations (VSOs). Often, the same organisation is commissioned by different bodies to run multiple services. The SRH field is, therefore, complex.[36] Services cover a wide range of activities including:

- testing, treatment and management of infections, including contact tracing and partner notification[37]
- provision of routine and emergency contraception
- maternity care and gynaecology care, including support for menopause symptoms and abortion services
- psychology services, including psychosexual services, and services focusing on high-risk behaviours including the use of drugs, domestic violence, and sexual assault
- social support services including mentoring and health advice
- health promotion, such as Relationships and Sex Education (RSE) in schools; and awareness campaigns such as "can't pass it on"
- disease prevention, such as through provision of pre-exposure prophylaxis[38] (PrEP) for HIV, and immunisations that can prevent infections that may be spread through sexual contact, such as HPV[39], Mpox, Hepatitis A and B.

In this report, some services will necessarily be discussed in greater detail than others. It is important, nonetheless, to acknowledge the complexities and interconnected nature of activities undertaken in the SRH field. We use the term "sexual and reproductive health"

(SRH) precisely because of its breadth. Initiatives taken to improve outcomes in one area of SRH will often have positive outcomes throughout the wider system.

What are the potential barriers to accessing services?

Staff working in the City of London and Hackney are rightly proud of the SRH services they provide and for the history of service innovation and development in this field. Both staff and users generally agree that services are good but there are issues about accessing those services and who can benefit from them. These concerns have become particularly pronounced since the COVID pandemic. In this section we will briefly explore the nature of access before, in the next section, considering the impact of the pandemic.

Access to services is a two-way process. Services must be available, and people must able and willing to access them. Ensuring access, particularly to SRH services, therefore involves considering both (1) the services that are being provided; and (2) the willingness of people to access those services - their access potential.

Barriers relating to service provision

While people can only access services that are being provided, there is a wide range of services available in the City of London and Hackney and, furthermore, residents are able to use services across London.[40] Gaps may exist because a specific service has not been created, or as a result of how services define their access criteria, but these concerns are relatively rare and affect small numbers of people.[41] Potential barriers to accessing those services that already exist may relate to any of the following issues:

- location: people must be able to access the service and feel comfortable doing so
- opening hours: the timing of services affects how accessible they are and will impact different patients to varying degrees[42]
- booking process: where appointments are required, booking systems must be in place that are easy to navigate, support different languages and meet accessibility standards[43]
- capacity: services must have the capacity to provide support to the numbers of people trying to access them in a time-appropriate manner[44]

Increasing collaboration between the many actors working in the SRH field - service providers and commissioners - and with the communities they serve, will help mitigate many of these potential barriers.[45] Where new services need to be commissioned, configured or promoted then they should be designed in collaboration with the communities they aim to serve, not least in order to reduce the risk of creating any unintended barriers to access.[46]

Barriers relating to access potential

Going beyond the design of the services, there are issues relating to people's awareness of services and their willingness to use them. We describe this as a service's "access potential".

Knowing about services, and where to find them, is often more complex in the SRH field than in other areas of healthcare. This is why public awareness and information is so important. A recent evaluation of SRH services in East London noted difficulties with accessing accurate information on websites and by telephone.[47]

Furthermore, while all health issues are personal, SRH issues are often deeply related to identity and culture. This means that people can feel discouraged from accessing services for reasons related to their individual, or their community's, beliefs rather than because of the services themselves. Stakeholders report that social norms in some communities act as a barrier to individuals accessing services.

Addressing these issues around knowledge, attitudes and reducing stigma will provide benefits in terms of health promotion and prevention of ill-health that go beyond enhancing access to a specific service. These issues relate to Recommendation 3 below.

What has changed because of COVID?

The COVID-19 pandemic and the lockdowns have had a huge impact on healthcare provision and on society in general. As one stakeholder in primary care explained when interviewed for this report, *"the impact of COVID is always the big issue in the room"*.

Direct impacts on healthcare provision

There was a reduction in the number of face-to-face appointments in both primary and secondary care due to the impact of the COVID pandemic and the associated lockdowns. GPs have integrated online and text communication with their patients and in sexual health clinics there was a move away from "walk-in and wait" services to appointment-only systems and a greater use of STI testing ordered online.[48] Both of these factors led to a fall in the number of STI tests being carried out at face to face appointments.

While there has been a welcome increase in the number of STI tests being provided by digital services,[49] namely through Sexual Health London (SHL), this has not made up for the reduction seen in primary and secondary care. The overall number of STI tests across the sector, taking into account primary and secondary care as well as SHL, fell by 57% from 2019/20 to 2021/22.[50] This is despite the number of STI screens distributed by SHL more than doubling during the same period.[51]

The number of sexual health attendances in secondary care, at Homerton Sexual Health Services (HSHS), dropped dramatically during the pandemic and is still only around 55% compared to pre-pandemic levels.[52] The number of sexual health attendances in primary care is more difficult to quantify due to difficulties with data capture. What all stakeholders report, however, is that face-to-face appointments have reduced.[53] This is partly as a result of changing practices in terms of using more telephone consultations. For example, while the number of HIV attendances at HSHS is 40% lower than before the pandemic, the number of HIV positive patients receiving care has nevertheless gone up by 6%, due to the increased use of telephone consultations.

This change in practice does not appear to have affected all services equally. In particular, the level of LARC provision is returning towards pre-pandemic levels.[54] Nevertheless, stakeholders are concerned that this move to telephone and virtual consultations has an impact on important aspects of sexual and reproductive health provision. In primary care, for example, concerns around sexual health are often brought up incidentally during consultations for other issues.

While text messaging is an invaluable tool for communicating with patients, not everyone is comfortable receiving text messages to do with sexual health. As one stakeholder observed, "some communities would be horrified if GP surgeries sent a text message to 16 year olds inviting them for a chlamydia screen" (primary care stakeholder). Furthermore, digital services may not always be effective at picking up safeguarding issues, or instigating conversations around behaviour change and risk modification. There can also be barriers to accessing digital services which whilst overall are reducing will still remain a significant issue for some. Although SHL has been highly successful and is effective at reducing the burden on other service-providers, there is also recognition that it cannot replace the need for a wide range of services to ensure equitable access for all.

Some stakeholders in primary care report that more people are accessing SRH services through their GPs because access to specialist clinics has reduced since COVID and it is difficult to get appointments. While they welcome this shift to primary care, they are also concerned because general demand for primary care services is "higher than ever before". At the same time, stakeholders in secondary care have a perception that less SRH care is being provided in GP practices because, again, it is more difficult to get face to face appointments and when patients are seen, they are less likely to have blood tests and STI swabs. These viewpoints are not entirely contradictory since data mentioned above does suggest that SRH activity has reduced in both GP practices, community pharmacies and secondary care, albeit more so in secondary compared to primary care. At the same time, primary care stakeholders suggest that many GPs do not view SRH as their primary responsibility and are perhaps not always as comfortable or skilled in this area. If this is a more recent trend, then it would explain the concerns voiced by clinicians in secondary care.

Notwithstanding these various perspectives, before the pandemic, there was more testing for STIs including HIV. Several experts suggest that the historic high rates of STIs in the City of London and Hackney were explained by having high levels of testing in a relatively deprived area of London with a young population and higher proportion of gay and bisexual men. Their concern is that now, with lower rates of testing, we will see lower rates of detection that do not reflect the true burden of disease in the community and that rates of infection will increase still further. Detection of STIs, along with highly effective partner notification, is vital for both treatment and prevention of onward transmission. Testing needs to increase not only to reach pre-pandemic levels once more but also ensure that the SRH activity in both primary and secondary care is fully reinstated.

Stakeholders interviewed for the preparation of this report point to staffing issues as the single most important factor explaining the reduction in SRH provision since the pandemic. This message was repeated by stakeholders in secondary care, general practice, outreach services and pharmacy, who all described staffing shortages as limiting services.[55] Indeed,

they argue that there were already problems around staffing even before the pandemic[56] and so the impact of COVID was to make a bad situation worse. As one stakeholder reported, "even if we did want to increase capacity [and had the funding to do so] we don't have the staff". They argue that a key strategy, therefore, must be further integration and better collaboration between partners.

Wider impacts on the population

As well as direct impacts on SRH provision, the pandemic has had a negative impact on people's wider mental health and wellbeing.[57] This pressure has continued with the cost of living crisis. Clinicians report that people are now more willing to discuss their wellbeing and mental health, and with growing awareness there is also more willingness among staff to proactively ask people about mental wellbeing. This means that there is more disclosure of trauma and mental health issues but there is not, however, an equivalent increase in the provision of mental health services. This is leading to significant waiting times for services. Stakeholders are concerned that higher levels of mental illness and financial stresses hamper people's ability to access and engage with services. It can also contribute to risk-taking behaviours and sexual exploitation or violence, thereby directly impacting people's health.

Of course, the pandemic has not only impacted the adult population. Many stakeholders also report the significant impact of school closures and the pandemic on children's development, particularly their emotional maturity. Furthermore, the pandemic seems to have disproportionately affected children from disadvantaged backgrounds, at least in terms of their academic learning.[58] For more discussion of the impact of COVID on young people in the City of London and Hackney, see last year's Director of Public Health Annual Report, "Children, young people and COVID-19 in the City of London and Hackney".

There is no doubt, then, that the pandemic has had a major impact on SRH services - reductions in availability of appointments and provision of STI testing being just two examples, both of which due, at least in part, to staffing pressures. At the same time, the social and financial impact of the pandemic appears to have led to greater need in the population and, possibly, an adverse effect on health behaviours. Nevertheless, as one senior clinician told us during the preparation of this report, reflecting on the challenges of recent years: "we have a strong and proud tradition of supporting sexual health in the City of London and Hackney - let's regain it!"

Communities with high levels of unmet need

It is not surprising that some communities are over or under-represented in how they access specific SRH services compared to the population as a whole.[59] There can be many reasons for such disparities - some communities may have greater need, some may find it difficult to access services, and some may simply choose to access services in different ways, for example through a GP or pharmacist rather than a sexual health clinic. To try and

understand these issues, and get beyond the bare data, we are indebted to the experts and stakeholders consulted during the preparation of this report.

People affected by poverty

One expert interviewed strongly believes that, within the City of London and Hackney, poverty is the major driving force behind inequalities relating to SRH rather than other attributes such as ethnicity.[60] While data is available for the ethnic background of people accessing services locally, there is no equivalent quantitative data for individual patients' financial situation. Nevertheless, we can see at a national level that deprivation is associated with worse SRH.[61] For example, 2021 data show that the most affluent 40% of local authorities in England all had lower rates of new STI diagnoses than the national average. More deprived local authorities, on the other hand, all had rates above the England average.[62] Poverty, then, is associated with poor SRH outcomes[63] but the relationship is two-way.[64] Improving SRH in the community can help tackle poverty by reducing morbidity, improving relationships, and reducing financial burdens.

Identifiable groups

The communities most often cited by stakeholders as currently requiring additional support include: young people, people with mental health difficulties, non-English speakers or people with communication difficulties, trans people, migrants, and, for certain services, specific ethnic groups. It is important to note that inequalities relating to accessing services vary according to the service in question. For example, there is concern that heterosexual people who may be at increased risk of acquiring HIV are not accessing PrEP as much as other groups in the population,[65] and there are suggestions that Turkish-speaking communities may not be accessing menopause services through primary care.[66]

Even in areas where local performance is good, inequalities between groups may exist that need to be addressed. For example, late diagnosis[67] of HIV is the most important predictor of HIV morbidity and short-term mortality. In Hackney, the percentage of HIV diagnoses made at a late stage of infection in the three-year period between 2019-21 was 30.7%[68] which is considerably better than the England average of 43.4%. The discrepancy between the percentage of late diagnoses among men who have sex with men (MSM) as opposed to heterosexual people is, however, much greater than it is nationally. The percentage of late diagnoses among MSM in Hackney during this period was 16.7%, much lower than the England average of 31.4%, but among heterosexual people, the diagnosis of HIV was made late more than half of the time.[69] This may indicate a relatively lack of awareness of HIV risk in the heterosexual community or difficulties in accessing services. The welcome fact that late diagnosis is relatively rare in the gay and bisexual community suggests that more can be done to raise awareness, or improve access to testing, among specific heterosexual communities at increased risk of acquiring HIV.

Potential gaps in services

During interviews conducted for this report, stakeholders have drawn attention to potential gaps in services which affect specific residents. For example, stakeholders highlight that the withdrawal of walk-in services at sexual health clinics is disproportionately affecting people

who find it more challenging to arrange appointments. These may be people with low-level mental health issues or with other pressing health or financial concerns. One stakeholder suggested that the loss of walk-in services means that clinics are "increasingly serving the middle classes". Similarly, the reduction in out-of-hours clinics and outreach activities is likely to be impacting younger people's ability to access services, particularly those of school-age.

Another area of concern that has been highlighted relates to psychological support and psychosexual therapy. Since the pandemic, staffing issues coupled with funding restraints have left services finding it difficult to support those needing help. Stakeholders are concerned that the limited capacity of psychological services, and the different treatment criteria they adopt, are causing some patients to fall between gaps. For example, people with previous untreated trauma may be considered too complex for psychosexual therapy or IAPS[70] services but not urgent or complex enough to warrant secondary psychological care. This issue relates to the distinction drawn between "mental health" and "sexual mental health". Practitioners report that they aim to treat patients holistically but are hamstrung by complex commissioning arrangements.[71]

In some cases, the appropriate service may not exist. Clinicians in both primary and secondary care have raised concerns regarding the lack of available support to trans patients who are waiting for gender affirmation appointments. It is not clear to clinicians how to respond to this concern. Some have suggested a secondary care service should be established to provide support during the long waiting times, often several years, but others have expressed concern that without sufficient expertise it is not appropriate to assume the levels of risk involved. They argue it would be better for funds to be directed to the affirmation services to reduce waiting times.

Primary care stakeholders report that some patients with gender dysphoria are buying drugs on the internet, including hormones, but that GPs are not comfortable monitoring or supporting them.[72] Primary care practices do not have sufficient expertise but do not want to turn people away. Furthermore, it is not always clear to clinicians if the journey these patients, who are often young, are embarked upon is informed by sufficient clinical guidelines. There is sometimes concern around what is driving their decision making. As one stakeholder stated, "all services need to have better conversations with non-binary people but the gender dysphoria issue is a small subsection of those conversations and one that needs a specialist pathway - we need to establish that pathway".

One area that represents a lost opportunity rather than a gap in services is the health promotion and prevention work done within schools. According to stakeholders, shortages in school nursing are even more pronounced than in nursing in general. This means that school nurses, and other nurses working in the education field, have to focus on healthcare plans and safeguarding and do not have the time to do health promotion work. Stakeholders call for more information to identify schools needing particular support, and better alignment of the educational and clinical support provided to pupils. This is an area affecting large numbers of people and goes to the heart of public health objectives - promoting good health for the present and the future.

Why focus on young people?

The population of the City of London and Hackney is relatively young compared to other areas. Over 65% of residents are aged 40 or less, over 34% aged 30 or less, and over 32% aged 25 or less.[73] It is young people that access SRH services the most.[74] The highest proportion of both men and women attending Homerton Sexual Health Services (HSHS) fell within the 25-29 year old age group and 54% of all women accessing HSHS were under 30 years old.[75] Not only are young people disproportionately accessing services, they are also more likely to be diagnosed with an STI when they are seen.[76] Furthermore, stakeholders report specific challenges for young people to access services, particularly since the COVID pandemic. Some of these issues will be discussed in the following chapter.

For the purposes of the report, "young people" is taken to mean all people up to the age of 30 years old,[77] who make up over a third of the estimated population of the City of London and Hackney.[78] This is not intended to negate the need for specific age-appropriate services designed for sub-groups within that demographic. Services appropriate for a 25 year old may not be appropriate for a 15 year old, and safeguarding considerations must always be at the forefront of service design. Proposing a focus on "young people" is not, therefore, meant to imply that this group is homogenous. On the contrary, the implication should be that we need to ensure there is a sufficient range of services and approaches to respond adequately to the different needs of various sub-groups within the broad category of "young people", including those sharing particular cultures, genders or specific narrowly defined age-groups.

When considering SRH services, the provision available to young people is a central concern. They access services more than others and have the highest rates of disease. Working with young people to empower them to make their own choices, to protect their own health and exercise their rights, will provide benefits in both the short and the longer term. Not all young people are the same and we need to work with specific communities to ensure that services are as effective as possible. This echoes the first recommendation in this report: that co-producing services is central to improving the quality of SRH in our communities.

Recommendation 1. Community involvement is key to providing high quality services

Health providers and commissioners should reconfirm, and put into action, their commitment to collaborate with young people in the co-production of services.

In this report, we use the term "young people" to refer to everyone under the age of 30. We realise that this is a broad category and when talking about co-production, different approaches will be required for different groups. Nevertheless, the principles of co-production apply regardless of age of service users.

The need to involve people in the design of the services is recognised in the 2022 NICE guidelines on reducing STIs. This guideline recommends that interventions aimed at

reducing STIs should be planned, designed, implemented and evaluated "in consultation with the groups that they are for".[79] The same guidelines note that commissioners and service providers should "regularly evaluate interventions, including the methods used to co-produce them, to determine their effectiveness and acceptability and identify gaps to make service improvements".[80]

Organisations in the City of London and Hackney recognise the importance of involving those they serve. In 2017, Healthwatch City of London and Healthwatch Hackney developed a co-production charter with the involvement of all stakeholders including the City of London Corporation and the London Borough of Hackney. The charter was reviewed in 2021 and presented to the health and social care partnership organisations.

This co-production charter[81] should form the basis of a renewed commitment to co-production with service users and the wider community as part of a community-centred public health approach[82] to ensure new initiatives are culturally appropriate, well targeted and effective. Specific activities, such as peer-led participatory action research,[83] should be undertaken to explore the concerns and needs of young people in relation to SRH services; and to ensure that co-production is integrated and sustained in both the commissioning and provision of services aimed at addressing these issues.

Recommendation 2. Services must be accessible to young people

Refine existing SRH services and explore new initiatives in collaboration with young people to make accessing services as easy as possible.

This recommendation is about the design and provision of SRH services. It highlights the importance of working with young people to make sure that appropriate services exist and that they are as easy as possible to access.[84]

The common aim of all interventions should be to support young people, regardless of their background or situation, to establish good SRH behaviours in the short term and for later life. There are, however, specific areas of concern highlighted by the available data. These relate to two key aspects of SRH: STI testing and the provision of contraception. Some of these data are outlined in the section above: "How does the City of London and Hackney compare with other parts of London". Without repeating the information already given, we will highlight here issues of concern relating specifically to the provision of services as they relate to STI testing services and availability of contraception.

Testing for sexually transmitted infections (STIs)

STI testing is available in primary and secondary care and using self-test kits available online for those over 16 years old and in pharmacies. There are also outreach services provided by both the NHS and the charitable sector, including specific services for young people such as the City and Hackney Young People's Service (CHYPS Plus).

Young people have the highest rates of access of services and are most likely to have a positive test result for an STI.[85] Furthermore, data available for the City of London shows

that reinfection rates for young people are much higher than the national average.[86] In the five year period from 2016-2020, looking at data for 15-19 year olds, an estimated 24.1% of women were reinfected within a year and an estimated 22% of men. This compares to England averages of 10.9% and 9.8% respectively. Data for Hackney has not been provided for 15-19 years olds specifically but general reinfection rates are approximately 50% higher than national averages.[87] Reinfection rates are an indicator that people are finding it difficult to protect their sexual health even after having been in contact with sexual health services.

As mentioned above, the COVID pandemic has caused a large reduction in the number of STI tests being performed. In the financial year 2021-22, the number of STI screens performed in the City of London and Hackney was less than half than in the year before the pandemic.[88] Stakeholders interviewed for this report strongly believe that increasing the number of tests will increase the number of positive diagnoses and thus enable more timely treatment to limit medical complications and reduce the likelihood of onward transmission. They argue that increasing the levels of testing, at least getting back to pre-pandemic levels, is vital. Otherwise, the progress made in SRH in the years before the pandemic may be lost.

Before the pandemic, the vast majority of STI screens were conducted through the clinics run by Homerton Sexual Health Services (HSHS). Since the pandemic, the majority of screening tests have been provided through the online service, Sexual Health London.[89] The largest fall in the number of STI screening tests has been at HSHS but there has also been a large reduction in General Practice. While STI testing kits are available through pharmacies, they only account for a small proportion of the overall number of tests, although they do have some of the highest positivity rates.

The reduction in testing at HSHS and CHYPS Plus is because fewer people are attending the services. As noted above, the number of sexual health attendances at HSHS is still only around 55% of pre-pandemic levels.[90] Stakeholders believe that the reduction in attendance does not reflect a reduction in need but rather is due to the limited capacity of HSHS, largely caused by staffing issues. For example, walk-in clinics have stopped[91] and out-of-hours clinics reduced. Booking systems are under pressure and there are reports that both online and telephone booking can be difficult to navigate with a lack of appointments available.[92]

Beyond HSHS, testing must also be increased in primary care and pharmacies. Data from 2018-2021 show that STI testing in primary care and pharmacies varies across the City of London and Hackney. During this four year period, almost 4,000 STI tests were undertaken through 37 GP practices in the City of London and Hackney but just three practices accounted for more than 50% of the tests completed.[93] Similarly, during the same period, STI self-test kits were available at 25 pharmacies in the City of London and Hackney but 50% of those STI kits were distributed via just five pharmacies.[94]

The reasons for why so few locations are responsible for so many of tests needs further research but the concern is that it may be more difficult to access tests at some practices and pharmacies than at others.[95] This means that if levels of testing were increased to match the most active GP practices and pharmacies, it would significantly contribute to increasing the number of tests overall. Stakeholders suggest encouraging more routine use of STI testing, including HIV, for new patients registering with GPs and at NHS Health Checks;[96] and providing additional support to pharmacies. They argue that additional training, for both GP and pharmacy staff, would be an important element of new initiatives.[97]

Other avenues for increasing the level of testing relate to outreach services that are provided by the NHS and the charitable sector, in particular to school-aged people. Stakeholders from both the NHS and the charitable sector have noted that there is duplication of effort in these areas. For example, not only do CHYPS Plus and Young Hackney[98] do outreach into schools and colleges, but HSHS also attend schools when asked. There are also other health professionals working in schools and colleges, such as school nurses and public health nurses, that might be involved with health promotion and testing if they had sufficient capacity. As one stakeholder explained, describing outreach services for younger people, "it's all a bit random". Indeed, the charity Positive East, which amongst other things is commissioned to provide outreach testing services for the general public, has made similar observations, noting that they and other providers are sometimes doubling up.[99]

Two specific elements of STI testing in primary care have been highlighted as areas of concern by stakeholders. They are Partner Notification and the communication of test results.

Partner Notification (PN) has been used to help contain STIs since the early 1900s. It refers to informing the sexual contacts of people who test positive for an STI. Good PN helps to break the chain of infection and reduce re-infection rates as well as offering health education opportunities to encourage positive behaviour change.[100] There are reports, however, that PN is not working effectively in primary care, with several stakeholders reporting that PN is not routinely being provided. There is an online platform that GPs can use when patients are unable or unwilling to notify sexual contacts themselves but it is difficult to use and expensive. There is discussion regarding whether secondary care can provide support in this area but stakeholders agree that commissioners have responsibility for ensuring an effective system is in place. This is supported by standards published by the British Association for Sexual Health and HIV on the management of STIs (2019) which recommend that commissioners should ensure that PN is a core requirement for service providers.[101]

Communication of STI test results is also discussed in the British Association for Sexual Health and HIV standards. These stipulate that people should have access to their STI test results, "both positive and negative within eight working days".[102] Stakeholders in primary care, however, report that negative STI test results are not routinely provided to patients. While these patients may theoretically have access to their results, this represents a lost opportunity for promoting safe sexual practice and providing support to people who may be at risk. Communicating negative STI test results might, for example, be an appropriate time to recommend when, and in what circumstances, to consider further testing. One senior stakeholder suggests that a "status neutral" approach[103] should be adopted with regards to all STIs. This would involve, for example, considering whether to use negative test results to start a conversation around behaviour change, risk adjustment or even the use of PrEP.

Provision of contraception services

Contraception is concerned with helping people plan when they want to become pregnant rather than simply helping them to avoid unwanted pregnancies. Planned pregnancies have fewer complications and better outcomes for mother and baby. Routine and emergency contraception is made available through GP surgeries, sexual health clinics, community

pharmacies, the sexual health e-service SHL[104] and through outreach services. Local data relating specifically to Long Acting Reversible Contraception (LARC), teenage pregnancies and repeat abortions are discussed earlier in this report in the section "How does the City of London and Hackney compare". In this section we draw attention to issues regarding how services are currently being provided for LARC, emergency contraception and condoms.

Services providing Long Acting Reversible Contraception (LARC)

LARC can be accessed through sexual health clinics and other secondary care settings such as postnatal wards, with primary care complementing these services by providing fittings in uncomplicated cases. Although improving, LARC prescriptions have still not yet recovered to the levels seen before the pandemic. For example, attendances for LARC at HSHS were, in January 2023, only 70% of the number seen three years previously in January 2020 (297 as opposed to 425).[105]

In General Practice, we see a similar pattern to the one described above regarding STI testing. While 22 of Hackney's 39 GP surgeries provided a LARC service in 2021, over 70% of the fittings were carried out in just five practices.[106] This is not entirely unexpected given that the plan is for there to be one GP LARC hub within each of the eight Primary Care Networks (PCNs) in the City of London and Hackney. These 'hubs' then take referrals from other practices within their PCN. Nevertheless, there is a recognition among stakeholders that LARC fitting in primary care could be increased. They explain that Practices find it expensive to provide the service as it requires training for staff and backfilling of their roles while that training is completed. With high staff turnover, many practices are reluctant to make this investment.[107] Furthermore, each Practice must offer sufficient fittings to maintain the skills of their staff who have a minimum number of fittings they must perform each year.[108] There are, nevertheless, positive initiatives in this area include an NHS England commissioned community gynae pilot project to establish a "Women's Health Hub" that is starting to deliver reproductive health services, including LARC clinics and LARC training to GPs.[109]

Provision of Emergency Hormonal Contraception (EHC)

Emergency contraception can be in the form of pills or intrauterine devices (IUDs). While intrauterine devices are only available through primary care or sexual health clinics, emergency contraception in the form of pills is also available through pharmacies and, since January 2021, via the online platform, Sexual Health London (SHL). "Emergency Hormonal Contraception" (EHC) specifically refers to pills which, in the City of London and Hackney, are primarily accessed through pharmacies. In 2021, 70.0% of EHC was accessed via pharmacies, 16.4% through SHL, and 13.6% through HSHS.[110]

We can see a similar pattern emerging with regard to EHC as we have demonstrated in other areas of SRH provision, with a relatively small number of locations providing a disproportionate amount of the service. In the three years from 2019 to 2021, more than 33% of the EHC accessed through pharmacies were accessed through just five of the 34 pharmacies that distributed any EHC during that period.

Two recent reviews of EHC availability through pharmacies in Hackney and North East London have both reported problems with accessing the service. A mystery shopping

exercise specifically looking at this issue was conducted by Healthwatch Hackney between May and September 2022.[111] The 38 community pharmacies in Hackney which had signed up to provide free access to EHC were included in the study. When contacted by phone, only 40% of these pharmacies were able to offer a free service on the day[112] and 40% said that they would charge for the service. These findings were largely confirmed by in-person visits to 16 of the pharmacies,[113] eight that had offered a free service on the phone and eight that had offered a paid service. Information about future options for contraception was only provided in four of the 16 visits. Recommendations stemming from this report include the need for further training of staff. The importance of ensuring a welcoming and confidential service for young people is underlined by the fact that it is young people that need to access EHC the most,[114] and they do so primarily through pharmacies.

Provision of free condoms

Condoms are an effective form of contraception that can also help prevent the transmission of STIs whether or not contraception is required. In the City of London and Hackney, young people aged under-25 are able to access free condoms and lubricant from a range of outlets, including pharmacies, sixth form colleges, youth hubs, GP practices and sexual health clinics through a scheme coordinated by Hackney Council (Young Hackney).[115]

It is striking that more than 50% of the distributions between 2019 and 2020 were recorded in just six out of more than 45 local outlets registered to offer condom distribution to under-25s.[116] Nevertheless, between 2019 and 2021, the majority of condom distribution for people under 25 in the City of London and Hackney were in pharmacies (51.3%).[117] This again highlights the central importance of pharmacies.[118] In particular, young men appear to prefer using pharmacies. While men represented a lower proportion of encounters for condoms at HSHS and Hackney Council's Children and Young People services compared to the population as a whole (19.2% and 17.2% respectively), they were overrepresented in terms of accessing condoms via pharmacies (60.2% of pharmacy condom distributions were to men). While pharmacy stakeholders report some confusion regarding the condom distribution scheme caused by changes in commissioning over the last few years, which is being addressed through additional training and information provision, it is clear that pharmacies are already and must continue to be a vital resource for the provision of easily accessible walk-in SRH services.

Putting the recommendation into practice

Refine existing SRH services and explore new initiatives in collaboration with young people to make accessing services as easy as possible.

Priorities for how services should be changed or developed must be determined through co-production with young people. Nevertheless, we outline here three areas which warrant particular attention and may form the basis for future conversations and plans.

a. Reviewing the timing and location of services

Services are provided in a wide range of locations: clinics, GP surgeries, pharmacies, in youth hubs, online and through outreach activities, including in schools and colleges. Since

the COVID pandemic, there has been a general move away from face-to-face appointments. Furthermore, opening hours have changed and clinics have been rearranged. Working with young people, priorities may be identified regarding: the opening hours of clinics or restarting walk-in and wait options;[119] the location of hubs and outreach services;[120] and ways of improving appointment availability and booking systems.[121]

b. Enhancing coordination between providers so that interventions can be more effective

Together with young people, opportunities should be explored for how to better coordinate services and where appropriate, co-locate them. For example, Young Hackney's health and wellbeing team do outreach in schools and colleges to support the statutory requirements to provide Relationships and Sex Education (RSE).[122] These services might be better coordinated with outreach activities conducted by other services such as CHYPS Plus, HSHS or charitable organisations. Work in schools and colleges might further be enhanced through increased coordination with school nurses and public health nurses. Another area that might be explored could be coordinating charitable sector testing services with pharmacies and GP practices.

c. Investigating inconsistencies in SRH provision around contraception provision and STI testing;[123] exploring how to strengthen systems for partner notification[124] and STI test result notification[125]

By exploring the reasons for inconsistencies between GP practices and between different pharmacies, it may be possible, while working together with partners and young people, to identify opportunities for increasing STI testing[126] and improving access to contraception through sharing best practices and mutual support. Addressing both of these issues (contraception and STI testing) may involve further training and awareness sessions for staff. Similarly, working on improving partner notification and test result notification may involve collaboration between primary and secondary care, as well as working with specific communities to ensure that partner notification methods are acceptable and that health promotion messages that may be included with negative test results are culturally appropriate and effective.

Recommendation 3. Young people must be aware of when and how to access support

Improve young people's awareness of services and their willingness to access them.

This recommendation focuses on how to empower young people to have control of their sexual and reproductive health choices and to access the services they need.[127] This involves people knowing what services are available to them, or at least being able to easily find the necessary information, and knowing when it is appropriate to access those services. It recognises that barriers to accessing SRH can often arise from the individuals and

communities themselves. Exploring these issues will necessarily involve collaborating with young people and their communities.

Initial consultation might explore three areas: (a) young people's existing attitudes to SRH and their knowledge of services;[128] (b) their preferred sources of information including the accuracy of the information that is currently available; and (c), the factors that may make young people unwilling to access services or uncomfortable doing so. Examples of possible activities, depending on the outcome of consultations, are provided below, grouped under these three areas.[129]

a. Increase awareness of available services and when to access them.

    i. Co-produce information campaigns with specific groups using appropriate media and involving community champions and leaders. Subjects may include what services are available, that services are free and confidential and how to access them,[130] levels of STIs in the community, recommendations on frequency of STI testing, the importance of sexual self-efficacy[131] and the impact of stigma.

    ii. Review the implementation and quality of Relationships and Sex Education (RSE) provision in our schools. High quality RSE is a vital tool that has been shown to provide many benefits including encouraging young people to seek help when they need it.[132] Some stakeholders suggest that the amount and quality of RSE provided may vary between different schools.[133]

    iii. Explore initiatives to ensure people are proactively offered information on SRH by GPs, pharmacists and other staff working in healthcare and public organisations. Staff must be well-informed and confident to initiate conversations about SRH.[134]

b. Ensure information is clear and that signposting is accurate and streamlined.

    i. Depending on how young people are accessing information, consider establishing systems to monitor and improve the information on service provider websites as well as on national NHS websites.

    ii. Explore having a single telephone number for accessing information and booking appointments with SRH services. This could be at the Hackney and City level, North East London level, or even London-wide utilising the 111 system.[135] Consider the use of text and chat methods for accessing information about available services.[136]

c. Increase young people's confidence to access services.

    i. With the benefit of insights from young people, ensure that services are welcoming and inclusive;[137] and better understand how and where different people like to access services.[138]

    ii. Explore interventions, in collaboration with young people and their specific communities, to normalise discussions around SRH and to tackle stigma;[139]

and to increase familiarity with services, for example through videos showing what a sexual health clinic is like and introducing their staff.

Recommendation 4. Focus on enhancing collaboration and partnership working

Continue to develop collaborative working practices across SRH and beyond to mitigate pressures on services and improve user experiences.

Stakeholders report that problems with staffing coupled with increasing need in the population is a major issue currently affecting SRH service provision. These pressures make the integration of care, and "whole system commissioning",[140] all the more important. Working relationships must continue to be fostered between commissioning organisations, between primary and secondary care, and between sets of service providers, sometimes working in the same organisation but with different commissioning arrangements.

The 2022 NICE guideline on reducing STIs notes the importance of delivering interventions across a range of services "including within broader support interventions and community services (for example, in drug and alcohol services, abortion care services, HIV care and mental health services)".[141] This is an approach that requires ongoing effort from service providers and commissioners alike and the complexities should not be underestimated. Indeed, there are sobering reports from stakeholders that even in primary care sexual health is widely considered to be a "walled-off service". The consequent "silo mentality" is being tackled, for example in the management of perimenopause,[142] but there is room to improve collaboration across the range of SRH services, including in primary and secondary care, in children's services, in mental health services, in pharmacies and with the charitable sector. Much of this work may be led by commissioning organisations, recognising the support that service providers might need to enhance their levels of collaboration.[143]

Collaboration should be promoted at the level of service provision without significant structural change, for example to facilitate co-location of services,[144] but there needs to be recognition from all actors that coordinating services is a priority that requires time and commitment. Instigating new ways of working in a system already under stress is, of course, challenging. It is recommended that all stakeholders consider how they might enhance collaborative working with their key partners and across the sector, including with the communities they serve. One specific area where service providers have called for greater collaboration regards improving data sharing while maintaining confidentiality. This would enable interventions to be better targeted to reduce inequalities.

Recommendation 5. Continue to identify and address inequalities in SRH

Ongoing research and audit, undertaken in collaboration with communities where possible, is recommended to identify inequalities and communicate findings to all concerned partners. Such research should be coupled with a funded commitment to address those inequalities that are identified.

Inequalities in the SRH field vary according to the particular service being considered. Individuals or communities may become disadvantaged because of attributes such as gender, sexual orientation, age, culture or ethnicity, or due to their specific circumstances. Furthermore, the individuals or communities that experience relative disadvantage will change over time. Ongoing research and evaluation, preferably participatory research, is therefore necessary to identify communities with higher levels of need.[145]

Once inequalities have been identified, it is necessary to take steps to address them. For example, it is not enough to note the low levels of PrEP update among black African communities, or women in general; we need to go further and engage communities and partners to try and build momentum for change.[146] Where research has been undertaken collaboratively with communities and stakeholders, being ready to act on the results of that research is vital to building trust and productive partnerships.

It should be noted that when seeking to address health inequalities, we should not focus exclusively on disadvantaged groups. Such an approach may offer advantages for monitoring and evaluation but can also have significant drawbacks, such as leading to stigmatisation and resentment. Furthermore, a narrow approach may act to shift relative disadvantage to other communities rather than mitigate inequalities in general. This is particularly true in the field of SRH where relative needs can rapidly change. Instead, the principles of proportionate universalism[147] should be adopted.

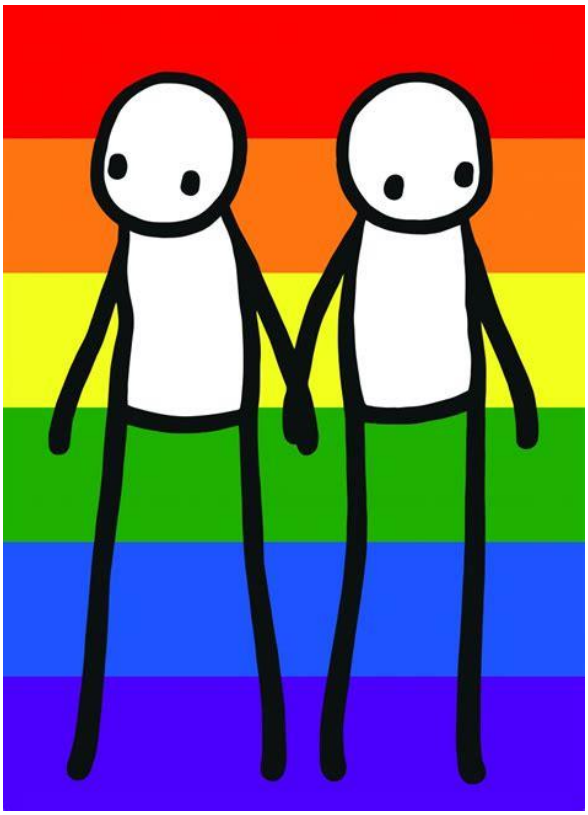
The concept of proportionate universalism states that:

> *"[f]ocusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage"* (*Fair Society, Healthy Lives (The Marmot Review)*, 2010, p.15).

Our aim must be to optimise health and wellbeing through services that are both universally available yet also weighted in favour of those portions of society that have the greatest need.[148]

Conclusion

We must remember that “high-quality sexual health services are the cornerstone of ensuring good population health”.[149] The City of London and Hackney have a strong history of promoting sexual and reproductive health throughout the population and stakeholders agree that there is a positive culture of encouraging and supporting innovation. The disrupting effects of the COVID pandemic are, nevertheless, still being felt. Our response must be to redouble efforts to support people’s rights to enjoy sexual and reproductive health through working collaboratively across the sector and hand-in-hand with the communities we serve.



The recommendations made in this report offer concrete suggestions for enhancing sexual and reproductive wellbeing through putting collaboration and a community-centred public health approach at the centre of our strategy.[150]

Endnotes

[1] UKHSA Summary profile of local authority sexual health Hackney, Feb 2023. Note that the UKHSA data refers to either Hackney alone or both Hackney and City of London combined but this is not specified for each item. The rate of "new STI diagnoses" excludes diagnoses of chlamydia in the under 25s because those numbers are so high it makes comparison between authorities more difficult. However, even including all STIs, the rate in the City of London and Hackney in 2021 was almost four times higher than the England average, at 1,998 compared to 551 per 100,000.

[2] In 2021/22, approximately 10,000 STI screens were conducted across the sector, compared to over 23,000 in 2019/20 (Homerton Sexual Health Services, *Sexual Health Equity Audit 2021/22*).

[3] "Sexual health-related issues are wide-ranging, and encompass sexual orientation and gender identity, sexual expression, relationships, and pleasure. They also include negative consequences or conditions such as: … sexually transmitted infections … ; unintended pregnancy and abortion; sexual dysfunction; sexual violence; and harmful practices (such as female genital mutilation)." WHO website, Overview of "Sexual Health", available here.

[4] Pound and Campbell (2017) Policy Report on the delivery of sex and relationship education, University of Bristol.

[5] Hackney's population is estimated at 259,956, while the City's is 8,618. These figures are from the Office for National Statistics (ONS) mid-year 2021 population estimates, based on 2021 Census data (ONS Estimates of the population for the UK, England, Wales, Scotland and Northern Ireland).

[6] The 2021 ONS estimate, available here, suggests 65.5% of the population of The City of London and Hackney is 40 years old or under.

[7] 2021 Census data gives the following percentages for ethnic groups within The City of London and Hackney: white British 34.2%, black 20.5%, white other 19.46%, Asian 11%, other ethnic group 8.55%, mixed/multiple 6.71%,

[8] https://hackney.gov.uk/knowing-our-communities accessed 25 January 2023.

[9] https://hackney.gov.uk/knowing-our-communities accessed 25 January 2023.

[10] 2021 Census data on sexual orientation by sex available here. Data was released on 4 April 2023 and is for persons aged 16 and above.

[11] This is particularly relevant to the provision of sexual health services because local data shows that men who have sex with men (MSM) are three and half times more likely to attend sexual health clinics than other men (HSHS Sexual Health Equity Audit 2021).

[12] The "Index of Multiple Deprivation" combines several deprivation indicators relating to income, employment, crime, living environment, education, health, and barriers to housing and services, in various proportions to produce an overall figure which can be used to compare different regions.

[13] The scores in London ranged from 9.4 for Richmond Upon Thames (the best) to 32.8 for Barking and Dagenham (see here).

[14] It is important to note, when considering this contrast between the relative affluence of The City of London as opposed to Hackney, that the estimated residential population of the City of London is just 3.7% of the combined population of The City of London and Hackney. This means that more than 96% of the combined population of The City of London and Hackney live in the relatively deprived borough of Hackney.

[15] "Strong links exist between deprivation and sexually transmitted infections (STIs), teenage conceptions and abortions, with the highest burden borne by women, men who have sex with men (MSM), trans community, teenagers, young adults and black and minority ethnic groups", DoH & PHE (2018) *Integrated Sexual Health Services: A suggested national service specification*, p.5.

[16] PHE Guidance *Health matters: reproductive health and pregnancy planning*, 26 June 2018. Note that IUSs can, as well as being used for contraception, also be used as part of Hormone Replacement Therapy (HRT) to manage perimenopausal symptoms.

[17] PHE Guidance *Health matters: reproductive health and pregnancy planning*, 26 June 2018.

[18] These figures are for women aged 15-44 and exclude prescriptions for contraceptive injections.

[19] UKHSA Summary profile of local authority sexual health Hackney, 1st Feb 2023. N.B. "The data in this report either refers to Hackney or both Hackney and City of London combined" but the report does not specify what is the case for each data item.

[20] From 2014 to 2021, Hackney was only below the London average in 2020.

[21] This is according to the most recent data available from the Office of Health Improvement and Disparities, available here.

[22] Teenage mothers are less likely to finish education, more likely to bring up their child alone and in poverty, and have a higher risk of poor mental health than older mothers. Infant mortality rates for babies born to teenage mothers are around 60% higher than for babies born to older mothers (Office for Health Improvement and Disparities, available here).

[23] See data available here. It must be noted that comparison with national averages is hampered by the relatively small absolute numbers involved. For 2020, the absolute number of conceptions in women under 18 years old in The City of London and Hackney was 44, indicating a rate of 10.1 per 1,000 women aged 15-17 living in the area.

[24] Data for the City of London is not available.

[25] In 2021, Hackney had the 3rd highest rate of abortions in women under 18 compared to its 15 nearest neighbours (UKHSA Summary profile of local authority sexual health Hackney, 1st Feb 2023).

[26] UKHSA Summary profile of local authority sexual health Hackney, 1st Feb 2023.

[27] Partner notification is the system by which sexual contacts of people diagnosed with an STI are informed that they should be tested and may require treatment. This can be done by the patient themselves but should also be available as an anonymous service through the healthcare provider. Effective partner notification systems are essential for timely treatment of those who may be infected but asymptomatic and to prevent further transmission. See further discussion of partner notification in the section on testing for STIs under Recommendation 2 below.

[28] This figure of 150 includes upper tier local authorities (UTLAs) and unitary authorities (UAs).

[29] The rate of "new STI diagnoses" excludes diagnoses of chlamydia in the under 25s because those numbers are so high it makes comparison between authorities more difficult. However, even including all STIs, the rate in The City of London and Hackney in 2021 was almost four times higher than the England average, at 1,998 compared to 551 per 100,000.

[30] UKHSA Summary profile of local authority sexual health Hackney, Feb 2023. N.B. "The data in this report either refers to Hackney or both Hackney and City of London combined" but the report does not specify what is the case for each data item.

[31] The City of London is the local authority with the third highest prevalence of HIV in England, while Hackney has the twelfth highest prevalence. This is according to the most recent available data (see here) which is for 2021.

[32] Data which includes primary care, secondary care and SHL, show that in the reporting year 2019/20 there were 23,568 STI screening tests performed compared to just 10,189 in the year 2021/22 (Homerton Sexual Health Services, *Sexual Health Equity Audit 2021/22*).

[33] It must be borne in mind that not everyone can access SHL as it is only for people aged 16 and above and requires both access to online resources to book tests and an address where testing kits can be received.

[34] The number of all new STI diagnoses in Hackney fell by 40% from 9,432 in 2019 to 5,614 in 2021 (UKHSA Summary profile of local authority sexual health Hackney, Feb 2023). However, the amount of testing across the sector dropped by 57% and at the same time the ratio of tests to positive results has increased slightly from 1:3.5 to 1:3.1 (HSHS, *Sexual Health Equity Audit 2021*).

[35] Examples of proactive engagement include teaching RSE in schools and the virtual engagement events organised by the Community Gynae pilot project commissioned by NHS England.

[36] Indeed, there is debate in the field regarding the appropriate terminology to describe different services. Terms such as sexual health, reproductive health, women's health, gynaecology and maternity care all overlap with one another and can lead to confusion. The discussion around these, and other, terms is significant because of the implications for commissioning and determining where responsibility lies for funding. In this report, the term Sexual and Reproductive Health (SRH) has been adopted in order to mitigate some of these concerns and maintain a wide frame of focus on the issues.

[37] The majority of STI-related care accessed by residents of the City of London and Hackney is provided by Homerton Sexual Health Services (HSHS). Between 2018 and 2020, 101,485 activity codes registered at the HSHS GUM service were for STI-related care (e.g. treatments prescribed and partner notification). During the same period, 7,560 SH patients were seen by GPs in The City of London and Hackney and only 9 appointments were provided by pharmacies in The City of London and Hackney for chlamydia treatment. This equates to HSHS providing 93.1% of care, GPs providing 6.9%, and pharmacies providing <0.1% (GUMCAD, CCG GP data, Pharmoutcome), as per the draft SRH Needs Assessment, Hackney & City Public Health Intelligence Team 2022.

[38] Local information on PrEP is available on the Homerton website here and general information at the Prepster website.

[39] See UKHSA Information on HPV vaccination (updated 10 Aug 2022) for background on the human papillomavirus (HPV) vaccination programme (accessed 10 Feb 0222).

[40] Note that people can choose to access sexual health services outside of Hackney or the City of London.

[41] Stakeholders are nevertheless concerned about potential gaps and these are discussed below in the section "groups requiring particular attention".

[42] For example, services available in evenings and weekends can reduce the cost of accessing services associated with lost earnings or facilitate access for those with caring responsibilities or in full-time education.

[43] The Future Insight Partnership Project's evaluation of SRH services describes considerable problems at specialist clinics with appointment booking systems and telephone access (Future Insight Partnership Projects report, East London Mystery Shopping, Dec 2022).

[44] Several service providers consulted during the preparation of this report expressed frustration with long waiting times as a result of staffing capacity. Issues relating to staffing are well known and present across the system, including in the voluntary sector.

[45] See Recommendation 4 below.

[46] See Recommendation 1 below.

[47] Future Insight Partnership Projects report, East London Mystery Shopping, Dec 2022.

[48] While HSHS continues to offer walk-in appointments to children under 19, this is only at one clinic. There is a specific service for young people aged 11-19 (CHYPS Plus) but it has not been able to maintain its level of service due to staffing issues.

[49] Between 2018 and 2021, Hackney residents recorded a 390.1% increase in the number of tests completed through the sexual health e-service, while City residents recorded a 235.7% increase.

[50] HSHS Sexual Health Equality Audit 2022.

[51] The increase in the use of online sexual health services is dramatic and likely to continue. Evolving AI technology, such as ChatGPT, may facilitate the provision of additional information and advice via online services.

[52] In January 2020, there were a total of 6,331 attendances at HSHS compared with just 3,470 in January 2023 (HSHS Equity Audit 2022 and HSHS Activity Report, January 2023). Comparing attendances specifically for LARC, in January 2023, HSHS had 70% of the attendances it had in January 2020 (297 as opposed to 425).

[53] Although primary care stakeholders report a significant drop in face-to-face appointments, data from NHS NEL suggests that this has not been as dramatic as in secondary care. NHS NEL report that in February 2023, 76% of GP appointments were face-to-face as compared to 82% in February 2020 although they also note that the pre-pandemic data is not as reliable as they would like. It is important to bear in mind that a move to larger numbers of telephone consultations is welcomed by many patients and may represent improved efficiency. Nevertheless, there does appear to have been a significant reduction in the number of STI tests being carried out in primary care although again, stakeholders report considerable concerns regarding the reliability of the data.

[54] The number of LARC prescriptions per 1,000 women in Hackney was 37.5 in 2021 after dropping to just 19.3 during 2020. In 2019, before the pandemic, the figure was 45.9 compared to a London average that year of 39.6 (data available here).

[55] Staffing shortages have been described in almost all interviews conducted with stakeholders during the preparation of this report. In particular, nursing shortages, including school nurses, are impacting service provision. Staff shortages and high levels of turnover are reported in secondary care, general practice, pharmacies and the charity sector.

[56] Some stakeholders felt that the impact of Brexit locally was to exacerbate staffing difficulties within healthcare.

[57] "Self-reported measures of personal well-being dropped to record lows during the first and second waves, with some groups experiencing particularly poor or deteriorating mental health - including women, young people, disabled people, those in deprived neighbourhoods, certain ethnic minority groups and those who experienced local lockdowns" (quote from Living with COVID, referring to: Office for Health Improvement and Disparities, COVID-19: mental health and wellbeing surveillance report, 18 November 2021.

[58] A Department of Education report notes that "pupils from disadvantaged backgrounds (primarily those eligible for free school meals at some point in the last six years) experienced greater learning

losses than their more affluent peers as a result of the pandemic." DfE *Understanding Progress in the 2020/21 Academic Year: Extension report covering the first half of the autumn term 2021/22*, March 2022. (p.8 accessed 20 Feb 2023).

[59] For example, the proportion of MSM accessing services at HSHS is higher than the proportion in the general population; and the number of white people accessing services at HSHS are lower (HSHS Sexual Health Equity Audit 2021).

[60] Highlighting poverty as the overarching cause of inequalities in SRH does not undermine the importance of ongoing efforts to address racism, including structural racism. The UK Faculty of Public Health declared in 2020 that, "[n]ot enough is being done to rectify the inequalities experienced by Britain's minority ethnic population, as most recently demonstrated by PHE's COVID-19 disparities review and stakeholder engagement" (see *Faculty of Public Health Statement on racism and inequalities*, available here).

[61] DoH & PHE (2018) *Integrated Sexual Health Services: A suggested national service specification*.

[62] 2021 data on new STI diagnoses excluding chlamydia arranged by District and UA deprivation (IMD2019). Data source Fingertips accessed here. This trend is also seen in chlamydia detection rates in 15-24 year olds, see here.

[63] This may partly be because financial issues act as a barrier, both directly and indirectly, to accessing services or continuing to engage with them. Service providers describe individuals who face financial difficulties losing touch with services because of their other concerns. This particularly affects people requiring longer term treatment or support.

[64] As one local expert commented, "Hackney still has a deprived population and good sexual health goes hand in hand with addressing that deprivation".

[65] The Homerton Sexual Health Services Equity Audit 2022 notes that 96% of PrEP prescriptions were for MSM. Furthermore, from July 2020 to March 2021, only 12% of individuals attending HSHS for initiation of PrEP were black, yet black people made up 33% of all clinic attendances suggesting that black communities are not accessing PrEP as might be expected. By contrast, during the same period, white people accounted for 63% of PrEP initiations but only 41% of patients seen at the clinic. It is important to bear in mind that the City of London is the local authority with the third highest prevalence of HIV in England, and Hackney has the twelfth highest prevalence (data available here).

[66] Stakeholders in primary care report discussions with colleagues and reasling none of them have prescribed HRT for menopausal symptoms to Turkish-speaking patients. The Community Gynae Project Pilot has also recognised this potential gap and has plans to hold future events on menopause specifically for Turkish-speaking patients.

[67] Late diagnosis is defined here as having a CD4 count <350 cells/mm^3 within 91 days of first HIV diagnosis in the UK.

[68] Data from the UKHSA Summary profile of local authority sexual health, Hackney, 1 Feb 2023. The report notes that data may refer either to Hackney or both Hackney and City of London combined.

[69] In Hackney, 2019-21, late diagnosis of HIV in heterosexual men occurred 53.3% of the time, similar to the 58.1% in England; in heterosexual women it was slightly higher than national average at 55.0% compared to 49.5% in England as a whole (UKHSA Summary profile of local authority sexual health, Hackney, 1 Feb 2023).

[70] The Improving Access to Psychological Therapies (IAPT) programme was developed as a systematic way to organise and improve the delivery of, and access to, evidence-based psychological therapies within the NHS. It is now called the NHS Talking Therapies programme.

[71] One clinician explained that, "splits in commissioning impact how we conceptualise and deliver care … in my experience, the commissioners don't talk to each other and it is beyond frustrating".

[72] The *National LGBT Survey: Summary Report*, 2019 from the Government Equalities Office notes that "[o]f the 2,900 respondents who discussed gender transition and gender identity services … a picture was painted of hard-to-access services, a lack of knowledge among GPs about what services are available and how to access them, and the serious consequences of having to wait … trans people reported going abroad, using the internet to purchase hormones or turning to prostitution to raise the money needed to access private medical treatment" (accessed 26/1/2023). It further notes that trans people have high rates of self-harm, citing the Trans Mental Health Study 2012.

[73] These figures are from the Office for National Statistics (ONS) mid-year 2021 population estimates, based on 2021 Census data (ONS Estimates of the population for the UK, England, Wales, Scotland and Northern Ireland).

[74] 2021-22 data from the Homerton Sexual Health Service (HSHS) show that 20-29 year old women are overrepresented in terms of accessing HSHS compared to the population as a whole.Similarly,

25-34 year old men are also overrepresented as users of HSHS services (Homerton Sexual Health Services, *Sexual Health Equity Audit 2021/2022*).

[75] The peak age for men accessing services at HSHS is slightly higher than women. 38% of men accessing the services were under 30, but 62% of men were under the age of 35.

[76] People aged 20-24 attending the service were more likely to have an STI diagnosis than any other age group.

[77] Different organisations adopt different cut-offs. The Homerton Sexual Health Service, for example, defines young people as those aged 25 and below.

[78] ONS 2021 mid-year population estimates, available here.

[79] See NICE guideline [NG221] *Reducing sexually transmitted infections* Published: 15 June 2022, p.8. The same guideline gives recommendations for possible topics for discussion when working with communities on reducing STIs. The pdf version of the guidelines is available here.

[80] NICE guideline [NG221] *Reducing sexually transmitted infections* Published: 15 June 2022, p.11.

[81] The final version of the charter was published in 2022 with the cooperation of LBH, CoL, Hackney CVS, Mind in the City, Hackney and Waltham Forest, East London NHS Foundation Trust, Homerton Healthcare NHS Foundation Trust and the North East London Clinical Commissioning Group (now NHS North East London Integrated Care Board).

[82] Community-centred Public Health is an approach to tackling public health issues which is adopted "to enhance individual and community capabilities, create healthier places and reduce health inequalities" (PHE 2020 briefing, *Community-centred public health: Taking a whole system approach* available here). See further *Health Matters* (28 February 2018) and the PHE/NHS England guide to community-centred approaches (2015).

[83] This may follow the model adopted by the Hackney Young Futures Commission for their 2019/20 consultation using peer researchers supported by a project team (see Valuing the Future Through Young Voices); or the model be adopted by the Community Gynae Pilot Project in which members of the public are invited via their GPs to participate in virtual meetings of up to 100 people.

[84] The issue of young people's awareness of services and their willingness to access them is dealt with under recommendation 3.

[85] The 20-24 year old age group has recorded the highest number of STI tests per 100,000 people in The City of London and Hackney over the last five years of available data (2016 to 2020). This data is from the GUMCAD STI Surveillance System, a mandatory surveillance system for STIs that collects data on STI tests, diagnoses and services from all commissioned sexual health services in England.

[86] Reinfection rates refer to the likelihood of someone testing positive for an STI within one year of previously testing positive. It

[87] In Hackney, an estimated 10.9% of women and 16.4% of men presenting with a new STI from 2015 to 2019 became re-infected with a new STI within 12 months. Nationally, during the same period, 7.1% of women and 9.9% of men became re-infected (SPLASH supplementary reinfections report).

[88] In the year 2019/20, 23,568 STI tests were performed across the system compared to just 10,189 in the year 2021/22. The ratio of positive diagnoses to tests performed is similar post-pandemic, at 1:3.1 as it was pre-pandemic (1:3.5) (HSHS Health Equity Audit 2022).

[89] The source of this data is the HSHS Sexual Health Equity Audit 2022. According to this audit, in 2021/22, SHL performed 6054 STI screens, HSHS 2128 and primary care 2007. These figures have been discussed with the GP Confederation who noted that it is possible that some negative test results in primary care were not recorded.

[90] In January 2020, there were a total of 6,331 attendances at HSHS compared with just 3,470 in January 2023 (HSHS Equity Audit 2022 and HSHS Activity Report, January 2023).

[91] The reason given on the website for moving to appointment only clinics is the need to maintain social distancing. Staff report that they have not been restarted due to staffing issues and concerns that people can become frustrated with long waits. Walk-in appointments are still available to children under 19 but only at one clinic. The specific service for young people aged 11-19 (CHYPS Plus), which is also run by the Homerton, has unfortunately struggled to maintain its level of service post-pandemic due to staffing issues.

[92] This was one of the main findings of the "East London Mystery Shopping" report, December 2022, by Future Insight Partnership Projects. Mystery Shoppers contacted 13 different SRH services across North East London. Mystery Shoppers reported telephone numbers not working; a lack of queuing system; extremely long waits in excess of one hour; and the phone ringing off unexpectedly. Difficulties were also reported when trying to book online. In total, 33.9% (n=20) of "shoppers" were able to get an appointment on their first attempt, 28.8% (n=17) needed to make five or more attempts

to book an appointment, and 37.3% (n=22) were unsuccessful in booking an appointment despite trying on multiple occasions.

[93] This is from CCG GP data quoted in the Hackney and City Sexual Health Needs Assessment 2023.

[94] This data is from Pharmoutcomes and only applies to the 44 Hackney and City pharmacies that recorded information using the Pharmoutcomes system. As noted previously, the absolute number of STI kits provided in pharmacies is relatively small, with 921 self-test kits distributed in the four year period 2018-2021.

[95] It is worth noting that the use of secondary care SRH services provided by Homerton Sexual Health Services (HSHS) does not, according to 2016-2020 data, vary considerably by geography, at least not within Hackney, which suggests that variations between GP practices and pharmacies is unlikely to relate to differences in the level of local need. While it is the case that the lowest appointment rate at HSHS services was recorded for City of London residents, this is most likely because these residents are relatively far from HSHS services and are probably seeking care elsewhere (data source: SRHAD).

[96] Stakeholders from primary care have noted that new patient checks have, in many practices, stopped altogether because they were time consuming and poorly remunerated. STI testing, including for HIV, was commonly offered at these checks and they offered a good opportunity for providing health promotion information.

[97] The need to provide training and information to staff is highlighted by stakeholders who report that, in primary care "there is definitely a lot of residual belief that there are counselling barriers to wider testing [for HIV]"; and that in pharmacies, high staff turnover means that staff are sometimes unaware of services or do not have the skills to counsel patients effectively.

[98] Young Hackney's Health and Wellbeing Team attend schools to support the delivery of the Relationship and Sex Education (RSE). A list of the RSE sessions they offer in schools and colleges can be seen here.

[99] Positive East uses a community based testing model: going into a range of venues where people can test to increase access. They report that around 30% of the people they help to test are not in primary care, and 20-25% of people are first time testers.

[100] See Society of Sexual Health Advisers *Guidance on Partner Notification*, Aug 2015 available here.

[101] The British Association for Sexual Health and HIV *Standards for the management of sexually transmitted infections (STIs),* (April 2019), states that "Commissioners should ensure that all providers of services commissioned to manage STIs: … instigate PN as a core requirement either by patient referral … or by provider referral …The form of PN utilised should be the choice of the person diagnosed with a STI" (p.37, available here).

[102] British Association for Sexual Health and HIV *Standards for the management of sexually transmitted infections (STIs),* (April 2019).See p.36, available here.

[103] The "status neutral" approach was first introduced in the US in relation to HIV prevention. It is described on the US CDC website (see here) as defining "the entry point to care as the time of an HIV test. At this entry point, clients' needs are assessed and they are engaged and linked to appropriate services based on these needs, regardless of whether their HIV test is positive or negative".

[104] Residents aged 16+ can access contraception through SHL. This can be delivered to their home or collected from a pick-up point. 16-17 year-olds must collect their prescription from a pharmacy.

[105] HSHS Equity Audit 2022 and HSHS Activity Report, January 2023.

[106] City & Hackney GP Confederation data, 1 April 2021 to 1 January 2022.

[107] Stakeholders also noted that GP surgeries pay a higher price for the coils themselves than the price offered to sexual health clinics.

[108] Stakeholders suggest that if sufficient momentum could be established for training LARC fitters in primary care, individual practices would perhaps have less concern about the costs of establishing a service and the risk of staff leaving because they would be able to draw on a community of local fitters that could be employed on an ad-hoc basis to cover clinics when required.

[109] The community gynae pilot project setting up a women's health hub stems from the government's Women's Health Strategy for England 2022. As well as LARC, it offers menopause services and organises virtual events, peer support networks and group consultations. For further information see the case study *Setting up a Women's Health Hub in Hackney* (May 2022) prepared by Primary Care Women's Health Forum.

[110] Data from Pharmoutcomes, Pathway analytics, and Preventx.

[111] Healthwatch Hackney, *Mystery Shopping exercise of Access to Emergency Hormonal Contraception in Hackney,* February 2023.

[112] 23 of the pharmacies confirmed that the service was free but three were unable to provide it for staffing or stock issues and five gave conflicting or confusing information.
[113] One pharmacy that had offered free services on the phone, requested payment for the service during the visit.
[114] Pharmacy data shows that EHC usage is highest among 15-24 year olds (Pharmoutcomes).
[115] The Community African Network (CAN) is also commissioned to provide condoms to adults in The City of London and Hackney from black African and other ethnic minority groups.
[116] Data from Pharmoutcomes and Therapy Audit Condom distribution data. In 2019 there were 60 registered outlets in The City of London and Hackney and 46 in 2020. The highest number of encounters was at the Clifden Centre (HSHS) followed by CHYPs Plus.
[117] Homerton Sexual Health Services combined with CHYPS Plus accounted for 29.6% and Hackney's children and young people's services (Young Hackney) accounted for 15.2%.
[118] Stakeholders report that condom distribution through primary care is, in contrast, largely ineffective because GP Practices are discouraged from participating in schemes because of requirements to be part of a pilot scheme and to record all distributions.
[119] Homerton Sexual Health Services note on their website that walk-in appointments are still available at the Clifden Centre for people under 19 years old. However, this is only one out of their four centres and even there, only two clinics operate after 4pm: a GU evening clinic on Wednesdays 5-7pm and an MSM clinic 5-7pm on Thursdays. All other clinics finish at 4pm.
[120] Some stakeholders have expressed concerns that youth hubs and clinics are not always universally accessible due to problems relating to gang lines. Also, young people have expressed concerns relating to risks to confidentiality when accessing some services: they are not always offered private consultation rooms in pharmacies, and the waiting room at the Clifden centre is currently shared with the hospital's general phlebotomy service.
[121] Issues regarding booking systems and appointment availability were highlighted by the NEL Mystery Shopping exercise.
[122] See here for the type of RSE support provided by Young Hackney's Health and Wellbeing Team.
[123] Levels of LARC and STI testing vary considerably from GP practice to practice and between pharmacies; and specific concerns around provision of EHC in pharmacies have been identified.
[124] Stakeholders in primary care report that partner notification systems are cumbersome and expensive, and consequently rarely being used. This creates the risk that people that may have been infected are not being notified which delays their treatment and increases the chance of onward transmission.
[125] Primary care stakeholders report that negative STI tests are not routinely communicated to patients which is a missed opportunity for instigating behaviour change and making every contact count.
[126] For example, HIV testing may be increased in primary care as part of new patient checks, where these are ongoing, or NHS health checks.
[127] In 2018, Public Health England published A consensus statement: reproductive health is a public health issue which outlines six pillars of reproductive health. The "Knowledge and Resistance" pillar was described as having two elements, (1) to "[i]ncrease user awareness and knowledge about reproductive health over the life course, how to remain healthy, have positive fulfilling relationships and access care when needed." and (2) to "[f]acilitate access to sex and relationships education throughout the life-course, intergenerational learning and ensuring that reproductive health is part of wider public health messaging."
[128] "Health promotion and education remain the cornerstones of STI prevention, through improving risk awareness and encouraging safer sexual behaviour." BASHH *Standards for the management of sexually transmitted infections (STIs) in outreach settings,* July 2016, p.4, available here.
[129] NICE guidelines recommend that any interventions that are undertaken are delivered by people who share a culture or group background with the target group, and are "sex and identify positive", focusing on "self-worth and empowering people to have autonomy over their bodies and their sexual decision making" (see NICE Guidelines on *Reducing Sexual Transmitted Infections* [NG221] July 2022). The same guideline defines "sex-positive approaches" as being "non-judgemental, [and] openly communicating and reducing embarrassment around sex and sexuality. Recognising the diversity of sexual experiences that exists and that sex can be an important and pleasurable part of many people's lives." The full document is available here.
[130] Stakeholders suggest that contraception, for example, could be better promoted throughout primary and secondary care. GPs were previously incentivised with Quality and Outcomes Framework

(QOF) targets to provide advice to women whenever they had a contraceptive pill check or request a repeat prescription. This QOF target was not popular and has been removed but there are concerns that there may consequently be fewer conversations regarding LARC in primary care.

[131] NICE defines sexual self-efficacy as a "person's sense of control over their sexual life and sexual health, and their ability as an individual to have safe, consensual and satisfying sex" (NICE guideline [NG221] *Reducing sexually transmitted infections* Published: 15 June 2022).

[132] RSE became compulsory in all state-funded secondary schools in September 2020. The Sex Education Forum report, *RSE: The Evidence*, (Nov 2022) outlines evidence indicating that RSE can: reduce sexual violence; make children more likely to seek help; make them more likely to practice safe sex; make it more likely that 'first sex' is concensual; improve online literacy; and, increase gender-equitable and inclusive attitudes.

[133] Stakeholders have also emphasised the need to ensure that safeguarding is always considered when reviewing interventions, in particular issues of child sexual exploitation and possible problems relating to gangs.

[134] This may, for example, follow the model of Making Every Contact Count brief interventions to affect behaviour change.

[135] The recent Mystery Shoppers report on Sexual Health Services in North East London (December 2022) notes that service users were surprised that there is no single telephone or website access point for North East London SH services.

[136] Stakeholders report the effectiveness of the Shout Textline run by Young Minds to provide mental health support to young people. It may be possible to offer a similar service regarding SRH if this was determined, by young people themselves, to be a popular way to access information and support.

[137] This may include ensuring compliance with standards such as the *You're Welcome* criteria for young person appropriate services; reiterating commitments to anti-racism; effectively communicating commitment to confidentiality; or providing peer navigators/youth workers to help guide people through the process. One specific area of concern that has been raised by stakeholders is the co-location of SRH services with other services. For example, the co-location of general hospital phlebotomy services at the Clifden Sexual Health Clinic means that waiting areas are shared between people waiting for the sexual health services and those waiting for general blood tests. This may make people accessing the sexual health clinic feel less comfortable.

[138] Different groups may have preferences for accessing services in GP practices, pharmacies, specialised clinics or online; and this should be taken into account.

[139] Initiatives may involve schools, faith groups, Public Health Community Champions (now funded for a further 5 years), anchor institutions, youth hubs and VSOs. Public organisations in The City of London and Hackney may, for example, wish to engage with the Fast Track Cities Anti Stigma HIV Charter.

[140] For a discussion of whole system commissioning and a useful set of key messages, see PHE *Making it Work: A guide to whole system commissioning for sexual health, reproductive health and HIV,* 2015. A whole system approach is also advocated in City and Hackney's integrated *Children and Young People's Emotional Health and Wellbeing Strategy 2021-2026* available here.

[141] NICE guideline [NG221] *Reducing sexually transmitted infections* Published: 15 June 2022.

[142] While menopause services are primarily provided through primary care, it can be an area for fruitful collaboration between primary and secondary care, for example through the Community Gynae pilot project, and between public health and local employers through the City Corporation's Business Healthy network.

[143] Some stakeholders interviewed for this report noted the need for commissioners to recognise the time commitment required by service providers to engage effectively not only with each other but also with the commissioners themselves. They also noted the importance of effective coordination between the various commissioning bodies whose work can impact the field of SRH.

[144] Work is already being undertaken, for example, to enhance outreach from sexual health clinics providing LARC to postnatal wards and these efforts should be supported.

[145] One stakeholder consulted in the preparation of this report gave the example that relative needs between different schools or colleges could be explored to determine whether STI infection rates or incidence of unplanned pregnancy is higher in some areas than others.

[146] On the issue of PrEP, stakeholders discussed efforts to enhance collaboration between the charitable sector and secondary care, and to explore the possibility of PrEP being provided through primary care.

[147] Proportionate universalism has been identified as one of the six pillars of reproductive health in a 2018 consensus statement from Public Health England (available here).
[148] A Public Health Scotland 2014 briefing gives the following description: "[p]roportionate universalism aims to improve the health of the whole population, across the social gradient, while simultaneously improving the health of the most disadvantaged fastest. This approach recognises the continuum of need and addresses the possible disadvantage of a purely universal approach, which may result in disproportionate benefits for those groups most able to make use of services" (available here).
[149] BASHH Standards for the Management of STIs 2019, at p.4.
[150] See Appendix 2 for a model of sexual health services that illustrates the linked, and mutually supportive, nature of the recommendations made in this report.