Sexual Health in Warrington
Joint Strategic Needs Assessment

July 2025

WARRINGTON
Borough Council

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KEY FINDINGS

- Overall, the **number of new sexually transmitted infections** (STIs) diagnosed among residents of Warrington in 2024 was 1,058. The rate was 498 per 100,000 residents, lower than the rate of 632 per 100,000 in England, and similar to the average of 483 per 100,000 among its nearest statistical neighbours.
- In 2024, Warrington's **overall STI testing rate** was 2,863.61 per 100,000, significantly lower than both the England (4,088.84) and the North West average (3,089.87). However, **test positivity** in Warrington was 7.10%, this was not statistically different from the North West (7.07%) or the national average for England (6.42%).
- Warrington ranked 73rd highest out of 152 upper tier local authorities (UTLAs) and unitary authorities (UAs) for **new STI diagnoses excluding chlamydia in those aged under 25** in 2024, with a rate of 379 per 100,000 residents, significantly better than the rate of 482 per 100,000 for England.
- In 2024, the **chlamydia detection rate** per 100,000 females aged 15 to 24 years in Warrington was 1,590 in 2023, similar to the rate of 1,589 for England. The highest rates of chlamydia are seen in the central wards which are also the most deprived in Warrington.
- The rank for **gonorrhoea diagnoses** (which can be used as an indicator of local burden of STIs in general) in Warrington was 57th highest (out of 152 UTLAs/UAs) in 2024. The rate per 100,000 was 100, better than the rate of 124 in England. Nationally there has been an increase in rates of gonorrhoea and chlamydia in the **50 and over age group.**
- Warrington ranked 83rd highest out of 152 UTLAs/UAs for **new diagnoses of syphilis** in 2024, with a rate of 10.35 per 100,000 residents, lower than the rate of 16.5 per 100,000 for England overall. Nationally syphilis is predominantly affecting GBMSM, and similar patterns are observed across Warrington.
- In 2024, Warrington reflects national patterns in STI diagnoses: rates of gonorrhoea, syphilis, and genital warts are higher among men, while chlamydia and genital herpes are more prevalent among women. Across all STIs, **rates among gay, bisexual, and other men who have sex with men (GBMSM) are significantly higher than those among heterosexual males**, in line with national patterns.
- In 2023, the **rate of HIV testing** among residents of Warrington at specialist (level 3) and non-specialist (level 2) sexual health services including online services was 1,784 per 100,000, which is lower than that seen in England overall (2,771 per 100,000).
- The **number of new HIV diagnoses** in Warrington was 14 in 2023. The prevalence of diagnosed HIV in Warrington in 2023 was 1.3 per 1,000 people aged 15 to 59 years, lower than the rate of 2.4 in England. Warrington was ranked 107th highest (out of 152 UTLAs/UAs).
- In Warrington, in the three-year period between 2021-23, the percentage of **HIV diagnoses made at a late stage of infection amongst those first diagnosed in the UK** (all individuals with CD4 count ≤350 cells/mm^3 within 3 months of diagnosis and no evidence of recent seroconversion) was 25.0%, compared to 43.5% in England.

- The total **rate of long-acting reversible contraception (LARC) (excluding injections)** prescribed in primary care, specialist and non-specialist sexual health services (SHS) per 1,000 women aged 15 to 44 years living in Warrington was 45.1 in 2023, similar to the rate of 43.5 per 1,000 women in England. The rate prescribed in primary care was 30.6 in Warrington, higher than the rate of 25.6 in England. The rate prescribed in the other settings was 14.5 in Warrington, lower than the rate of 18.0 in England.
- The **total abortion rate** per 1,000 women aged 15 to 44 years in 2021 was 20.0 in Warrington, similar to the England rate of 19.2 per 1,000. Of those women under 25 years who had an abortion in 2021 the proportion who had previously had an abortion was 29.6% similar to 29.7% in England. The repeat abortion rate in Warrington is lower but not significantly so than its statistical neighbours.
- The admission rate for **pelvic inflammatory disease** in the years 2023/2024 was 466 in Warrington, this is significantly higher than the England average of 247.
- In 2022/23, the **percentage of births to mothers under 18 years** was 0.6%, similar to 0.6% in England overall.
- Rates of **teenage conceptions** are on a downward trend in Warrington, in line with rates at a regional and national level.
- The rate of **under 18 conceptions** is significantly higher in three MSOAs (Orford, Hulme and Latchford) than the average for Warrington. This is consistent with rates being higher in the most deprived areas of the borough.

RECOMMENDATIONS

These recommendations aim to build on the current provision and services to further enhance sexual health and reduce inequalities for residents of Warrington. By strengthening sexual health, we enable healthy relationships, increase planned pregnancies, and reduce the spread of disease.

1. Improve the sexual health provision and reach of sexual health services for all ages

- Age inclusive sexual health campaigns and communications strategies, recognising that sex is important for people of all ages.
- In health and wellbeing settings, people of all ages should be asked about sexual health to better assess risk and need, normalise accessing sexual health services for all age groups.
- Involve communities in the design of services to ensure they meet the needs of all age groups.
- Improve the visibility and recognition of the sexual health service.
- Address worries and concerns regarding visiting the sexual health service, including videos, information, photographs and FAQs on website, in communications campaigns and via schools and services.
- Improve links and referrals pathways into sexual health services via other services including, social care, drug and alcohol service and youth services.

2. Improve the reach of sexual transmitted infection testing particularly those groups most at risk.

- Targeted work to increase chlamydia testing in the most deprived areas of the borough. This could include additional work with primary care to increase the number of chlamydia tests carried out in primary care settings.
- Due to increasing rates of gonorrhoea and chlamydia in the 50 and over age group, work to increase STI testing and reduce transmission through treatment and prevention.
- Through a health literacy approach increase the understanding of the need for STI testing for all age groups.
- Promote all options available to access STI testing and sexual health services including sexual health services, primary care, pharmacy and online.
- Build on the partnership work with primary care to improve access to STI testing.

3. Work to improve access to reproductive health services in all settings, to reduce unintended pregnancies

- Targeted work to improve access to contraception, particularly in areas with higher rates of under 18 conception and abortion.
- Build on current provision to provide comprehensive and unbiased information, facilitate shared decision-making, and address common misconceptions regarding contraception.
- Improve post abortion and post pregnancy contraception pathways, addressing barriers and promoting informed choice.
- Improve access to high quality SRE information for children and young people absent from school and electively home educated.

- To create fair opportunities for all young people, it is crucial to tackle the root causes of unplanned teenage pregnancy and poor outcomes, such as poverty, school absences, exclusions, and low academic achievement.

4. Improve access and uptake of HPV Vaccination and cervical screening

- Utilise targeted information, communication and provision to improve HPV vaccine uptake focusing on inequalities related to deprivation and ethnicity
- Utilise targeted information, communication and provision to improve cervical screening uptake focusing on equalities related to deprivation, younger people and those with learning disabilities.
- Ensure information is provided in an accessible format, including easy-read and translated into languages common amongst Warrington children with English as a second language (ESL).
- Ensure information on cervical screening provided to parents and girls receiving the HPV is consistent (that the risk of cervical cancer is small but still present, and they should still attend cervical screening).
- Ensure that girls and parents that do not accept HPV vaccination are aware of the importance of cervical screening in reducing the risk of cervical cancer.
- Update monitoring and reporting requirements of sexual health service to include estimating HPV vaccine coverage amongst GBMSM, in accordance with national guidelines. This will include assessing and reporting the number of GBMSM eligible for vaccination both across Warrington and amongst those attending sexual health services. This will more accurately monitor uptake of HPV vaccine for this population and inform future interventions.

5. Improve the access to and availability of appointments at the sexual health service

- Consider developing minimum standards for telephone access to the service to ensure barriers to contacting the service by telephone are addressed
- Review where technology and innovation can further be utilised to improve access to information, STI testing and accessing services, including the potential use of AI in understanding current and future need.
- Review availability of appointments and how it can be recognised if people have been unable to book an appointment
- Improve availability of out of office hours appointment times to access sexual health services.

1. INTRODUCTION

Sexual health is defined by the World Health Organisation (WHO) as "…a state of physical, emotional, mental, and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction, or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected, and fulfilled."1 (WHO, 2006a).

Sexual and reproductive health is a fundamental aspect of overall well-being. Sexual and reproductive health needs vary by a range of factors including but not limited to gender, sexuality, age, ethnicity and mental wellbeing. Maintaining good sexual health is key for individuals to maintain as a part of their overall health and wellbeing. The outcomes of poor sexual health can include[2];

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

Poorer sexual and reproductive health outcomes are not equally distributed across the population, with some communities' disproportionality effected, including young people, those facing socioeconomic deprivation, Gay, Bisexual and Men who have sex with men (GBMSM) and ethnic minorities. However, these impacts can be improved by ensuring equitable access to sexual and reproductive health services, promotion of safe sex practices, regular testing and comprehensive sexual health education.

Sexual health across the life course

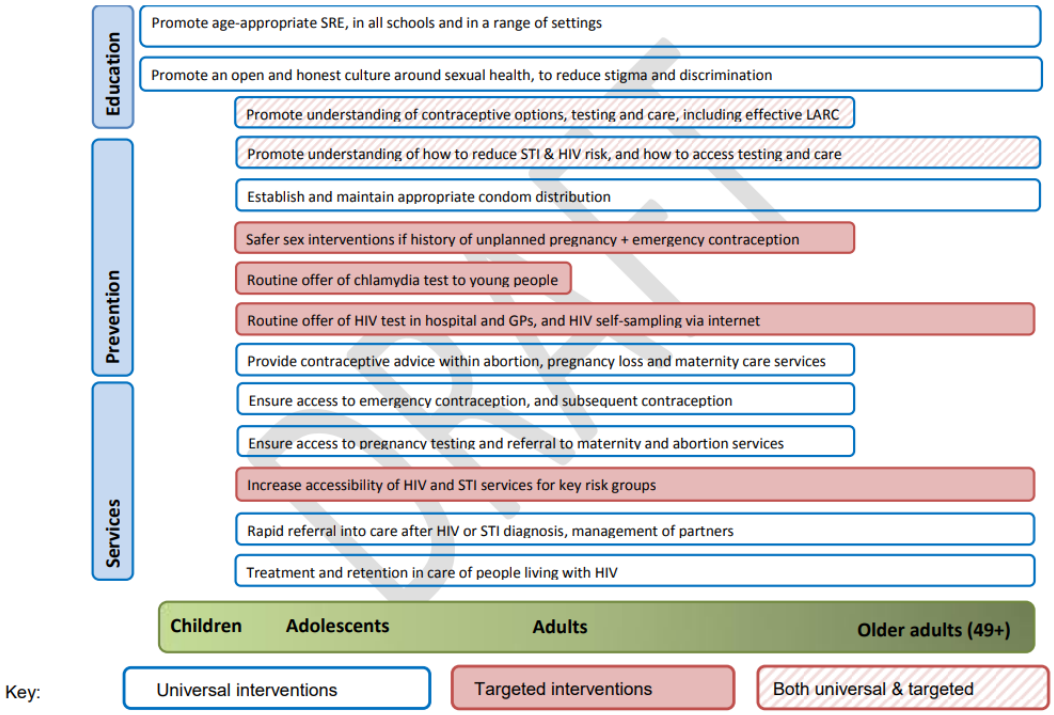
The life course approach set out by Micheal Marmot in 2010[3] examines how health and well-being are influenced by experiences and exposures across different stages of life, from prenatal development through to old age. By considering the cumulative impact of various factors over time,

[1] WHO 2006, Defining Sexual Health—Report of a Technical Consultation on Sexual Health 28-31 January 2002, Geneva. Sexual Health Document Series, World Health Organization, Geneva. Sexual and Reproductive Health and Research (SRH) (who.int) (accessed 17/06/2024)
[2] Sexual and reproductive health and HIV: applying All Our Health - GOV.UK
[3] Fair Society, Healthy Lives (The Marmot Review) Fair Society Healthy Lives (The Marmot Review) - IHE

the life course approach promotes a more holistic understanding of health, encouraging interventions that focus on the needs of groups at each stage of life.

In 2015 PHE published '*Health promotion for sexual and reproductive health and HIV: Strategic action plan, 2016 to 2019'*. This demonstrates both the targeted and universal approach to delivery of sexual health interventions through not only services but prevention and education across the life course as demonstrated in Figure 1 below.

Figure 1: Showing sexual health interventions throughout the life course, via services, education and prevention.



Source: [Health Promotion Strategy for Sexual and Reproductive Health and HIV]

1.1 Sexual health needs assessment process

The purpose of this Sexual Health Needs Assessment (HNA) is to identify and address the sexual and reproductive health needs within Warrington. By evaluating the current resources, gaps, and challenges, we seek to better understand the barriers to accessing care and services, and how to improve sexual and reproductive health outcomes for all individuals. There is a focus on the clinical aspects of need in this HNA as it has been timed to help inform and make recommendations for commissioning of local sexual health services. However, it is important to note that sexual health is dependent on a wide range of factors that are influenced both nationally and locally spanning health, social care and education.

This HNA will review publicly available epidemiological data, qualitative insights and service use data in relation to the following topics:

- Sexually transmitted infections (STIs) – inc. chlamydia, gonorrhoea, syphilis, herpes, HIV
- Reproductive health – Long-acting reversible contraception (LARC), user-dependent contraception, under-18 conceptions, Emergency hormonal contraception (EHC), abortions
- Cervical screening
- HPV vaccination
- Access to sexual health services

This HNA will not review the following areas of activity as this is out of the scope of this assessment:

- Menstrual health/Fertility as this is covered by primary and acute care provision.
- Services for people living with HIV as these are currently commissioned by NHSE
- Abortion services and care as this is commissioned by NHSE.

Consultation

As part of the review process of sexual health services consultations were conducted to gather qualitative insights that would inform and improve the service specification and model for sexual health in Warrington. The consultations included a public consultation, a stakeholder consultation and a consultation with current users of the sexual health service. All consultations were carried out using Smart Survey, which was hosted on a Warrington Borough Council consultation page. The consultation could also be completed on a paper copy, and comments could be made by email, telephone or in writing. The findings and results of the consultations including comments are included in Appendix 1. The recommendations section in this needs assessment includes recommendations from the consultation.

Service review

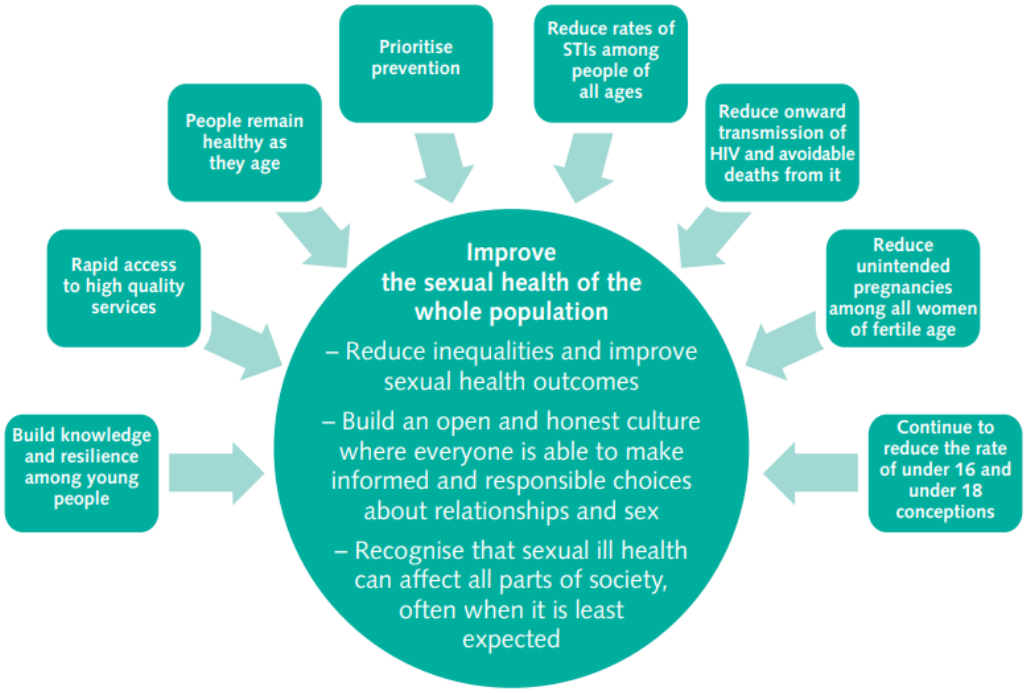
In addition to this sexual health needs assessment and the consultation, a review of the current sexual health service in Warrington is being conducted. This review will include a description of the current service, overview of successes and challenges, service reach and accessibility, review of performance, quality assurance processes, partnership approach and interdependencies. Some current sexual health service information and provision is included in this health needs assessment for additional context alongside the data.

1.2 National policy and guidance

This section outlines the key national policy and guidance shaping the commissioning and delivery of sexual health services in the UK. These are presented in order of publication.

In 2013, the Department of Health published the '*Framework for Sexual Health Improvement in England*', which remains the most recent comprehensive guidance on sexual health commissioning responsibilities. While this framework continues to guide sexual health services, it was published over a decade ago, and the landscape has since evolved significantly, particularly with the impact of the COVID-19 pandemic and the increasing shift towards providing more services online. The key objective of this framework is highlighted below in Figure 2.

Figure 2: Key objectives from the Framework for Sexual Health Improvement in England.



Source: A Framework for Sexual Health Improvement in England

Syphilis Action Plan[4]

The Public Health England (PHE) '*Syphilis Action Plan'*, published in June 2019, addresses the escalating incidence of syphilis in England. This plan highlights the necessity for enhanced public health interventions to mitigate transmission, particularly among high-risk populations. It focusses on four prevention pillars fundamental to syphilis control and prevention:

[4] PHE (2019). Syphilis: Public Health England Action Plan. June 2019. https://www.gov.uk/government/publications/syphilis-public-health-england-action-plan

- Increase **testing frequency** among high-risk men who have sex with men (MSM) and ensure re-testing after treatment.
- Implement **partner notification** strategies in line with British Association for Sexual Health and HIV (BASHH) standards.
- Maintain high syphilis screening coverage throughout **antenatal care**.
- Sustain **health promotion** efforts tailored to at-risk populations.

Towards Zero – An action plan towards ending HIV transmission, AIDS and HIV-related deaths in England 2022 – 2025[5]

The Department for Health and Social Care's '*HIV Action Plan'*, published in December 2021, outlines a strategic framework to reduce new HIV infections by 80% by 2025 and aims to eliminate new infections, AIDS, and HIV-related deaths in England by 2030. The plan is structured around four key themes: prevent, test, treat, and retain. The plan provides a strategic framework for how this will be achieved via the following objectives:

- **Ensure equitable access and uptake of HIV prevention programmes.**
  Evidence suggests that awareness, accessibility, availability and uptake of primary prevention initiatives is variable in different demographics and addressing this disparity is key to HIV prevention. There is also a need to make up any lost ground due to the impact of the COVID-19 pandemic and understand how it has affected HIV prevention.
- **Scale up HIV testing in line with national guidelines.**
  HIV testing is essential so that everyone with an HIV infection can be offered lifesaving treatment, which also prevents onward HIV transmission by reducing viral load to undetectable and untransmittable levels. However, many people that would benefit from testing are still being missed. Testing must be made more accessible, particularly for those groups being under-diagnosed. We must tackle the stigma and other barriers which can stop someone taking up a test when offered.
- **Optimise rapid access to treatment and retention in care.**
  Rapid access to, and retention in, HIV treatment can support those diagnosed with HIV to maintain an undetectable viral load, meaning they cannot transmit the infection to their sexual partners (Undetectable viral load = Untransmittable levels of virus (U=U). It is essential to ensure everyone who is diagnosed is referred to treatment rapidly and ensure that inequalities in access to, and retention in, treatment are tackled.
- **Improve quality of life for people living with HIV and addressing stigma**
  Increasing retention in, and adherence to, care supports achieving good health outcomes and reduces HIV transmission. However, for some people living with HIV it can be challenging to prioritise their HIV care and adherence to treatment if they are experiencing personal, financial, housing, immigration, or mental health difficulties.

[5] DHSC (2021). Policy paper. Towards Zero: the HIV Action Plan for England – 2022 to 2025. Dec 2021. https://www.gov.uk/government/publications/towards-zero-the-hiv-action-plan-for-england-2022-to-2025

Women's Health Strategy for England

The Department for Health & Social Care's Women's Health Strategy for England[6], published in August 2022 addresses long-standing gender disparities in healthcare. Historically, the health and care system has been designed predominantly by men for men, leading to insufficient understanding and support for conditions affecting women exclusively, such as endometriosis and menopause. The strategy aims to rectify these imbalances and improve the health and well-being of women and girls across the country.

Commitments include:

1. Ensuring women's voices are heard - tackling taboos and stigmas, ensuring women are listened to by healthcare professionals, and increasing representation of women at all levels of the health and care system.
2. Improving access to services - ensuring women can access services that meet their reproductive health needs across their lives, and prioritising services for women's conditions such as endometriosis. Ensuring conditions that affect both men and women, such as autism or dementia, consider women's needs by default, and being clear on how conditions affect men and women differently.
3. Addressing disparities in outcomes among women - ensuring that a woman's age, ethnicity, sexuality, disability or where she is from does not impact upon her ability to access services, or the treatment she receives.
4. Better information and education- enabling women and wider society to easily equip themselves with accurate information about women's health, and healthcare professionals to have the initial and ongoing training they need to treat their patients knowledgably and empathetically.
5. Greater understanding of how women's health affects their experience in the workplace – normalising conversations on taboo topics, such as periods and the menopause, to ensure women can remain productive and be supported in the workplace and highlighting the many examples of good practice by employers.
6. Supporting more research, improving the evidence base and spearheading the drive for better data - addressing the lack of research into women's health conditions, improving the representation of women of all demographics in research, and plugging the data gap and ensuring existing data is broken down by sex.

Breaking point: Securing the future of sexual health services

The Local Government Association (LGA) and English HIV and Sexual Health Commissioners' Group (EHSHCG) produced this report in November 2022, focusing on demand and funding pressures. The report reviews the trends since local authorities took responsibility for sexual health services in 2013, looking at the social and economic context in which they occurred[7]. Key messages include:

[6] DHSC (2022). Policy Paper. Women's Health Strategy for England. 30 August 2022. https://www.gov.uk/government/publications/womens-health-strategy-for-england/womens-health-strategy-for-england

[7] Local Government Association (2022). Breaking point: Securing the future of sexual health services. 15 Nov 2022. https://www.local.gov.uk/publications/breaking-point-securing-future-sexual-health-services

- Significant increase in the number of consultations at Sexual Health Services over the last 10 years.
- Number of screens and the overall number of services offered has increased, public awareness of Sexually Transmitted Infections (STIs) and contraception has grown.
- Local councils have been engaged in one of the biggest modernisation exercises in the history of public health, such as a rapid channel shift to online consultations, app, home testing and home sampling.
- Evidence from across the sector shows the capacity of councils to further innovate and create greater efficiencies is now limited.
- Unless greater recognition and funding is given to councils to invest in prevention services, a reversal in the encouraging and continuing fall in some STIs and more unwanted pregnancies is now a real risk as is their ability to respond to unforeseen challenges such as Mpox.
- Behavioural change has increased demand.
- Equitable access to contraception remains a problem.

Integrated sexual health service specification

The 2023 Integrated Sexual Health Service Specification outlines the standards and guidelines for delivering sexual health services in a coordinated and comprehensive manner. The goal is to ensure that sexual health services are accessible, high-quality, and tailored to meet the diverse needs of individuals. It includes provisions for a wide range of services such as STI testing and treatment, contraception, sexual health advice, and support for people living with HIV. The specification emphasizes integration, meaning services should be seamless and work together to provide holistic care, ensuring individuals have open access to a range of sexual health services. This specification highlights the key service outcomes the public health outcomes framework measures:

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

Sexual Transmitted Infections (STI) Prioritization framework

In October 2024, the UK Health Security Agency (UKHSA) published the **National STI Prioritisation Framework**, which aims to refocus STI control efforts on reducing adverse health outcomes and addressing health inequalities.

Historically, STI control in England has centred on reducing prevalence through high-volume, low-complexity interventions, such as testing for asymptomatic infections and targeting populations with the highest STI rates. However, this approach has failed to curb the spread of STIs and has not

alleviated the burden of poor health outcomes in high-risk groups. Additionally, it has led to insufficient support for individuals with more complex needs or those facing health inequalities.

As STI rates continue to rise, the frequency of severe and 'rare' health outcomes, such as infertility and pregnancy complications, also increases. These outcomes place a significant burden on public health, both in terms of their health impacts and the resources required to address them.

The framework proposes a shift in focus toward strategies that prioritize reducing adverse health outcomes and inequalities. It recommends targeting tailored interventions for those experiencing the greatest burden of harm. This approach is not only more effective but also more cost-efficient, addressing long-term disparities and minimizing the harms associated with STIs.

Key Principles and Recommendations:

- **Collaboration:** STI control efforts should be driven by partnership working, with local structures established to enable effective collaboration across services.
- **Specialist Integration:** Specialist sexual health services (SHSs) must have strong links with other specialties to **manage complex cases effectively**.
- **Community Involvement:** Services and interventions should be co-produced with local communities, ensuring that lived experience is central to planning and decision-making.
- **Responsive Services:** Services must be adaptable to meet changing local needs and circumstances, based on thorough assessments of local populations.
- **Evidence-Based Practice:** Local areas should utilize existing evidence to guide their practices and decisions.
- **Evaluation**: Ongoing evaluation is critical to assess the impact of new interventions and service improvements, contributing to the evidence base for effective STI control.
- **Addressing Health Inequalities**: Resources should be allocated based on need, with a focus on under-served populations to reduce health inequalities.
- **Safeguarding Capacity:** SHSs must have the necessary skills and capacity to address safeguarding concerns in a skilled and timely manner.
- **Expertise in Complex Cases**: SHSs should have the capacity to manage complex cases and provide clinical STI expertise to non-specialist providers.
- **Primary Prevention**: Primary prevention activities, such as health promotion and access to condoms, should remain a priority, even in times of resource limitations.
- **Testing and Treatment**: Testing and treating individuals diagnosed with STIs is fundamental to effective STI control.
- **Comprehensive Approach:** No single intervention can achieve STI control. A range of prevention, testing, and treatment strategies must be employed, as each has its limitations.

A blueprint for the future: Sexual and reproductive health and HIV services in England

In 2024, the **Local Government Association (LGA)** published *'A Blueprint for the Future: Sexual and Reproductive Health and HIV Services in England'*, building on its previous report *'Breaking Point: Securing the Future of Sexual Health Services'*. The blueprint calls on the government to collaborate

with local authorities to create a comprehensive, long-term strategy for sexual and reproductive health (SRH), as no such strategy has been developed since 2001. The report urges the government to develop a new, fully funded, system-wide strategy in partnership with local governments to address the increasing volume and complexity of demands on SRH services. Proposed priorities of the new strategy include:

- **Reducing the prevalence and onward transmission of STIs.**
- **Improving access to reproductive health services** across all settings and reduce unintended pregnancies in all women of fertile age.
- **End all new HIV transmissions by 2030** and reduce HIV associated stigma.
- **Prioritise prevention and health promotion interventions** (which support informed choices) – this should include quality assured, statutory RSHE delivery in schools and other educational settings.
- **Reduce inequalities in sexual health outcomes** by better understanding our more under-served communities.

The report underscores the urgent need for increased funding and resources to meet both current and future demand. It also highlights the importance of enhancing workforce development to support SRH services, which have faced mounting pressure in recent years. Despite a significant increase in demand, cuts to public health grants have limited local authorities' ability to meet these needs. Between 2014/15 and 2022/23, funding for STI testing, contraception, and treatment across England has decreased by nearly £200 million, despite sexual health services demonstrating a strong return on investment.
Key recommendations from the report include:

- A commitment to deliver an **increase in funding and investment** to meet current and future demand.
- A nationally and centrally funded **SRH and HIV workforce development plan**.
- Ensure that local areas have the resources required to consistently **deliver and expand outreach, education, prevention and behaviour change programmes**.
- Local and central government should **develop a clear set of mutually agreed ambitions** for sexual and reproductive health, as well as goals for reducing the unacceptable and widening levels of inequality.
- Work with commissioners and providers to **review where technology and innovation can further be utilised**, including the potential use of AI in understanding current and future need.

The Hatfield Vision

Developed by the Faculty of Sexual & Reproductive Healthcare (FSRH), The Hatfield Vision outlines priority goals and actions (endorsed by 28 organisations) in areas such as access to contraception, reproductive rights, menopause, menstrual health, cervical screening and maternal health outcomes in black women and women of colour[8].

[8] FSRH (2022). Faculty of Sexual and reproductive Healthcare Hatfield Vision. A Framework to Improve Women and Girls' Reproductive Health Outcomes. July 2022. https://www.fsrh.org/documents/fsrh-hatfield-vision-july-2022/

The Hatfield Vision aims to connect the Government's Women's Health and Sexual and Reproductive Health (SRH) Strategies and Action Plans in England, driving meaningful transformation across different parts of the system and enabling women and girls to experience high quality reproductive health at every stage of their lives. At the heart of The Hatfield Vision is an ambitious target, which advocates that by 2030, reproductive health inequalities will have significantly improved for all women and girls, enabling them to live well and pursue their ambitions in every aspect of their lives. This target will be reached and can be measured by success in achieving 16 goals in different areas of women and girls' SRH, including addressing unplanned pregnancies and improving access to chosen methods of contraception.

HIV Fast Track Cities

The global Fast-Track Cities (FTC) initiative for HIV was launched in 2014 to support the UNAIDS targets of achieving zero new acquisitions of HIV, zero HIV-related deaths, and zero HIV-related stigma and discrimination, by 2030. The initiative aims to build upon and optimise existing HIV programmes and resources in cities and regions with a high burden of HIV. The requirements are set out in the Paris and Seville declarations[9].

Success requires achievement of the Joint United Nations Programme on HIV/AIDS (UNAIDS) updated **95-95-95** targets, as shown below:

- at least **95% of all people living with HIV will know their status**.
- at least **95% of all people living with HIV will be on treatment**.
- at least **95% of all people living with HIV on treatment will be virally suppressed.**

In June 2024, Cheshire and Merseyside Directors of Public Health agreed to support an ambition for all areas of Cheshire and Merseyside, including Warrington, to join the global HIV Fast Track Cities initiative. Initial steps will be a review of the current position across Cheshire and Merseyside and agree priorities in relation to HIV prevention, HIV testing, HIV treatment and care; support for people living with diagnosed HIV; and work to address HIV-related stigma.

National Chlamydia Screening Programme (NCSP)[10]

The National Chlamydia Screening Programme (NCSP) was established in 2003 in England to address the rising prevalence of chlamydia, the most commonly diagnosed bacterial sexually transmitted infection (STI) in the country. The programme aimed to reduce the incidence of chlamydia through early detection and treatment, thereby preventing complications. In June 2021, Public Health England announced a strategic shift in the National Chlamydia Screening Programme (NCSP) to focus on reducing reproductive harm from untreated chlamydia infections, particularly among young women. This change was informed by an expert review highlighting the disproportionate impact of untreated chlamydia on women's reproductive health, including risks of pelvic inflammatory disease, ectopic pregnancy, and infertility.

[9] Paris and Sevilla Declarations

[10] PHE (2021). Policy paper. Changes to the National Chlamydia Screening Programme. 24 June 2021. https://www.gov.uk/government/publications/changes-to-the-national-chlamydia-screening-programme-ncsp

Key Changes:

- **Targeted Screening:** Chlamydia screening in community settings, such as general practices and pharmacies, will now be proactively offered only to young women under 25 years of age. This includes cisgender women, transgender men, and non-binary individuals assigned female at birth who have not undergone hysterectomy or bilateral oophorectomy.
- **Access for Others**: Men and individuals outside the designated group can still access testing if needed. However, proactive screening in community settings will not be offered unless there is an identified indication, such as symptoms or being a partner of someone diagnosed with chlamydia**.**

This shift aims to enhance reproductive health outcomes by focusing resources on those at highest risk of harm from untreated chlamydia. Further details on the programme and its implementation can be found in later sections of this assessment.

Relationships, Sex and Health Education (RSHE)

A universal sexual health intervention involves providing sexual health education at various stages of the life course. While this can be delivered across various settings, since 2020 Relationships Education has been compulsory for all pupils receiving primary education, and Relationships and Sex Education (RSE) is compulsory for all pupils receiving secondary education. Health Education is compulsory in all schools (except independent schools, where Personal, Social, Health and Economic Education (PSHE) is still delivered) and is delivered throughout both primary and secondary education. Statutory guidance outlines mandated teaching and other suggestions for non-mandated areas, such as same-sex relationships.

In primary schools, Relationships Education teaches children a wealth of information about healthy relationships, including how to communicate their own boundaries and recognise the boundaries of others, staying safe online, and the differences between appropriate and inappropriate or unsafe contact. Schools are strongly encouraged to include the teaching of different family models and same-sex relationships. Health Education includes puberty, including menstruation. It also focuses on teaching the characteristics of good physical and mental health.

In secondary schools, Relationships and Sex Education covers content on a wider range of key topics, including consent, sexual exploitation, online abuse, grooming, coercion, harassment, rape, domestic abuse, forced marriage, honour-based violence, and FGM. Pupils should be taught the facts and the law about sex, sexuality, sexual health, and gender identity in an age-appropriate and inclusive way. There should be an equal opportunity to explore the features of stable and healthy same-sex relationships. Health Education focuses on enabling pupils to make well-informed, positive choices for themselves and includes teaching about the impact of puberty. The curriculum covers mental health and will support young people in recognising and managing any wellbeing issues, as well as how they can seek support as early as possible.

1.3 Evidence from National Surveys

National Survey of Sexual Attitudes and Lifestyles

The **National Survey of Sexual Attitudes and Lifestyles (NATSAL)** is a comprehensive, nationwide survey designed to collect data on sexual behaviours, attitudes, and health. It aims to enhance understanding of sexual health by exploring a broad range of topics, including sexual activity, contraception use, STI awareness, and attitudes toward relationships. NATSAL plays a crucial role in shaping public health policy, sexual health services, and educational programs by offering valuable insights into trends in sexual behaviour and health across diverse populations.

First conducted in 1990, NATSAL has been carried out every 10 years since then. The most recent iteration, NATSAL 4, took place between 2022 and 2024 and is currently being analysed and reviewed. The latest published findings come from the NATSAL-COVID study, which explored the impact of disruptions to sexual health services and restrictions on contact with individuals outside of one's household on sexual and reproductive health during the pandemic. The study found that despite increased efforts by sexual health services to offer alternatives to face-to-face consultations, there was a notable decline in the uptake of screening services (such as HIV and chlamydia testing), particularly among younger people. Additionally, it revealed that sexual dissatisfaction and distress increased during the pandemic compared to data from NATSAL 3 (conducted 10 years earlier). This trend was especially pronounced among men who have sex with men (MSM), who reported significantly higher levels of distress regarding their sex life over the past year (adjusted odds ratio: 4.52, $p<0.0001$).

These findings underscore the importance of targeted public health messaging during the recovery period, emphasizing safer sexual behaviours, STI testing, and the availability of free and confidential services. Special attention is needed for younger age groups, who may have missed out on essential sex education due to school disruptions and closures during the pandemic.[11]

Women's Reproductive Health Survey

In 2021 Department for Health and Social Care (DHSC) commissioned a pilot project to develop a new Women's Reproductive Health Survey (WRHS) to inform the development of the Women's Health Strategy for England. This was disseminated via social media and surveyed over 13 thousand women about menstrual health, pregnancy planning including abortions and pregnancy experiences. A further study was commissioned and conducted in 2023 that surveyed over 50,000 women and people assigned female at birth. Whilst analysis of this survey is still underway key preliminary findings of this survey showed:

- 69% of respondents used contraception for pregnancy prevention, STI protection, or health reasons. The most common methods were condoms (16.7%), hormonal IUDs (9.2%), and the progesterone-only pill (7.6%), with 18.3% using long-acting reversible methods like implants and IUDs.

[11] Sexual and reproductive health in Britain during the first year of the COVID-19 pandemic: cross-sectional population survey (Natsal-COVID-Wave 2) and national surveillance data - PMC

- 86.8% were able to obtain their preferred contraceptive, often within a week. However, 23.7% switched or stopped methods, primarily due to mood changes (35.7%), wanting a break (26.8%), bleeding pattern changes (26.7%), or to try to get pregnant (19.8%). 60.2% of IUD users experienced moderate or severe pain during fitting.
- In relation to planning, 66.7% of respondents said their pregnancy was planned. In those under 45, 6.3% had had a live birth and 1.3% had had an abortion in the last year.
- Painful or heavy periods were commonly reported, with 63% of those who had a period in the last year reporting moderate to severe pain. Of these, only 23% received help or advice, with roughly half of these respondents being dissatisfied with the advice received.

1.4 Local policy context

In the UK, the commissioning of sexual health services is primarily the responsibility of local authorities, following the Health and Social Care Act 2012. These services include contraception, STI testing and treatment, and health promotion. Local authorities are funded through the public health grant from the Department of Health and Social Care and commission services based on assessed local needs, often working with NHS providers, private clinics, and voluntary sector organisations. Meanwhile, NHS England commissions certain elements such as HIV treatment, and integrated care boards (ICBs) may be involved in commissioning related services like abortion and sexual health elements of primary care. This multi-agency approach aims to ensure comprehensive, accessible, and preventative sexual health care across communities.

Warrington Council is responsible for **improving the health and wellbeing and preventing ill health, for its residents.** As part of this duty, the council must take appropriate steps to improve public health. This involves considering evidence of local needs and identifying suitable services, strategies, or interventions to promote better health outcomes and reduce inequalities**.**

To uphold this responsibility, the Director of Public Health (DPH) is appointed jointly through the Council and the Secretary of State for Health and Social Care. The DPH is responsible for ensuring the effective delivery of the public health duties serving as an independent advocate for the health of the population while providing strategic leadership for its improvement and protection. The Director of Public Health (DPH) oversees a ring-fenced public health grant from the Treasury, ensuring funds are used effectively to address health needs. The council must demonstrate compliance with legislative guidelines outlined in the annual grant determination letter, covering key public health domains: health improvement, health protection, healthcare public health, and wider determinants of health.

As part of the work to improve and protect the health of the local population, Public Health are responsible for delivering mandated services including appropriate open access to Sexual Health services
The effective delivery of public health duties and services is informed and driven by a range of local strategies, needs assessments and plans including:

The Corporate Strategy reflects the vision and priorities of the council for the next few years. The strategy guides the council's work in serving the residents of Warrington. The vision of the 2025 –

2029 Corporate Strategy is to shape a thriving Warrington by focusing on 'our people, our place, and the quality of our public services'.

The Joint Strategic Needs Assessment (JSNA) process brings together partner organisations, including the local NHS, local authorities, and third sector groups, in an ongoing process of strategic assessments and intelligence gathering. Its purpose is to provide a comprehensive overview of current and future needs across the town. The JSNA helps identify key priorities to enhance community health, wellbeing, and reduce health inequalities. Insights from the JSNA informed the development of the Health and Wellbeing Strategy 2024 – 2028.

The Joint Health and Wellbeing Strategy is a statutory requirement of the Health and Wellbeing Board [12] and provides the strategic vision, outcomes, priorities, and ambitions for delivery of transformational change to improve population health and wellbeing and reduce inequalities in Warrington.

The priorities of Warrington's Health and Wellbeing Strategy are to:

1. Give every child the best start in life.
2. Enable all children, young people, and adults to maximise their capacity.
3. Create fair employment and good work for all.
4. Ensure a healthy standard of living for all.
5. Create and develop healthy and sustainable places and communities.
6. Strengthen the role and impact of ill health prevention.
7. Tackle racism, discrimination, and their outcomes.
8. Pursue environmental quality, sustainability and health equity together.

[12] Department of *Health and Social Care (2022) Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies*. Updated 24 August 2022. Available at: JSNAs and JHWS statutory guidance - GOV.UK (www.gov.uk)

2. WARRINGTON DEMOGRAPHICS

Warrington borough is located in Cheshire, between Liverpool and Manchester. It consists of 22 wards and according to the 2021 Census, the borough has a population of 210,900 residents. This reflects a population growth of approximately 4.3% since the 2011 Census.

2.1 Age

2023 ONS population estimates indicate that Warrington's population is generally older compared to the national average. It has a higher proportion of individuals aged 40 and over, while the proportion of 15- to 35-year-olds is lower than the national average. The proportion of those aged under 14 is similar to that of England. This age distribution pattern is consistent across both males and females.

2.2 Sex and Gender

In the context of the 2021 UK Census, ‘sex’ is defined as the sex recorded on legal or official documents, such as a passport or birth certificate. According to the 2021 census 50.5% of Warrington residents were female and 49.5% male, similar to England.

The 2021 census also gathered information on gender identity, which refers to an individual's sense of their gender, which may or may not align with the sex they were assigned at birth. 95.13% of Warrington residents reported that their gender identity matched the sex they were assigned at birth, higher than the national average of 93.46%. 4.48% of individuals chose not to answer the question, while 0.08% indicated that their gender identity differed from their assigned sex but did not specify further. Additionally, 0.08% identified as trans women, 0.09% as trans men, 0.03% as non-binary, and 0.02% identified with other gender identities, all slightly lower than the national average.

2.3 Sexual orientation

In the 2021 Census, 91.79% of Warrington residents identified as heterosexual, higher than both the North West average (90.1%) and the national average for England (89.4%). 1.31% identified as gay or lesbian and 0.99% as bisexual, both slightly below the national averages of 1.5% and 1.3%, respectively. However, as shown in Table 2, the proportion of individuals identifying as LGB+ is notably higher among younger adults aged 16–44, across both males and females.

Table 1: Sexual orientation of Warrington residents by sex, 2021 Census

Sexual orientation	Proportion of Warrington residents
Straight of Heterosexual	91.79%
Gay or Lesbian	1.31%
Bisexual	0.99%
Pansexual	0.08%
Asexual	0.04%
Queer	0.01%
Another sexual Orientation	0.10%
Not Answered	5.69%

Source: 2021 Census

Table 2: Sexual orientation of Warrington residents aged 16 years and over, 2021 census

Age	Straight or Heterosexual		Lesbian, Gay, Bisexual, or Other (LGB+)		Not answered	
	Males	Females	Males	Females	Males	Females
Total	92.0%	91.6%	2.2%	2.8%	5.8%	5.6%
Aged 16 to 24 years	88.7%	83.8%	4.0%	8.7%	7.3%	7.5%
Aged 25 to 34 years	89.3%	88.8%	4.8%	5.9%	5.9%	5.3%
Aged 35 to 44 years	92.5%	92.3%	2.4%	3.0%	5.1%	4.7%
Aged 45 to 54 years	93.6%	93.9%	1.6%	1.9%	4.8%	4.2%
Aged 55 to 64 years	93.6%	94.4%	1.3%	0.9%	5.1%	4.8%
Aged 65 to 74 years	93.5%	94.1%	0.6%	0.4%	5.9%	5.6%
Aged 75 years and over	91.6%	91.5%	0.3%	0.1%	8.1%	8.4%

Source: NOMIS

2.4 Ethnic and racial minorities

Warrington is less ethnically diverse than both the North West and England overall, with 88.1% of residents identifying as White British in the 2021 Census, compared to 81.2% in the North West and 73.5% nationally. However, the borough has seen increasing diversity since 2011, when 92.9% identified as White British. The largest minority ethnic groups in 2021 were Other White (5.4%) and Asian or Asian British (3.2%).

Table 3: Ethnicity breakdown of Warrington compared to England and the North west, 2021 census.

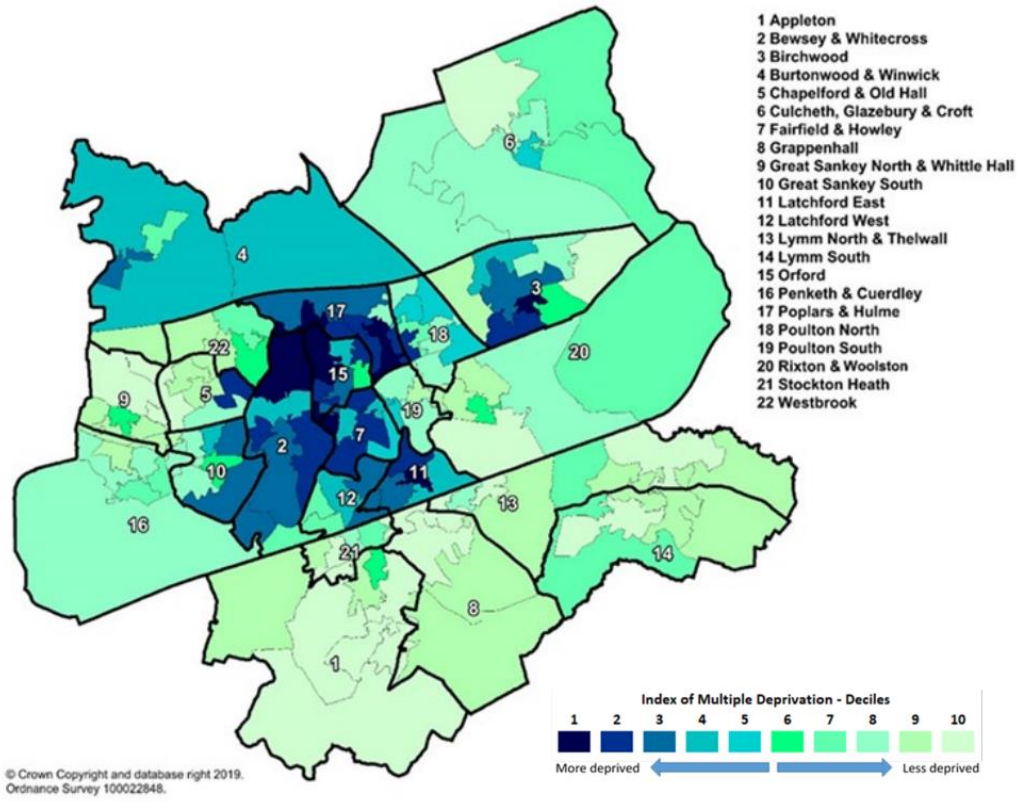
Ethnic group	Warrington		North West		England	
	n	%	n	%	n	%
Asian or Asian British	6954	3.20	622685	8.40	5426392	9.70
Black or Black British	1,576	0.70	173,918	2.30	2,381,724	4.20
Mixed or Multiple ethnic groups	3,335	1.70	163,245	2.10	1,669,378	2.90
White British	185,940	88.10	6,019,385	81.20	41,540,791	73.50
Other White	11,365	5.40	328,009	4.40	4,242,610	7.50
Other	1803	0.90	110,156	1.50	1229153	2.20
Data source: ONS Census 2021						

2.5 Deprivation

The Index of Multiple Deprivation (IMD) is a relative measure used to assess socio-economic deprivation across small areas in England, known as Lower Layer Super Output Areas (LSOAs). It ranks areas based on factors such as income, employment, education, health, crime, housing, and access to services, grouping them into five quintiles, from the most deprived (Quintile 1) to the least deprived (Quintile 5).

In the 2019 IMD, Warrington ranked 148th out of 317 local authorities in England, placing it near the national midpoint. Deprivation in Warrington is concentrated in central areas, while the outskirts tend to be less deprived. Notable exceptions include parts of Birchwood in the east and Burtonwood and Winwick in the northwest. Overall, 32% of Warrington's population live in the least deprived areas (Quintile 5), 23% in Quintile 4, 19% in Quintile 1, 19% in Quintile 2, and just 8% in Quintile 3 (Figure 3).

Figure 3: Socio-economic deprivation in Warrington, by deprivation quintile (IMD 2019)



3. COMMISSIONING OF SEXUAL HEALTH SERVICES

Following the Health and Social Care Act 2012 commissioning responsibilities of sexual health services were delegated to local authorities. As discussed in the policy and guidance section, in 2013 the Department for Health published a framework for sexual health in England outlining key ambitions for improving sexual health in the UK. This outlined commissioning arrangements and responsibilities of local authorities, NHS England and ICBs (formerly CCGs).

Local Authority public health teams have a lead role in co-ordinating efforts to protect and improve the health of their local populations. They also arrange for the provision of mandated sexual health services for the local population including HIV/STI testing services; STI treatment services (excluding HIV treatment) and contraception services on an open-access basis in line with requirements set out in Local Authorities (Public Health Functions) Regulations 2012. These include:

- Contraception services on an open-access basis in line with requirements set out in Local Authorities (Public Health Functions) Regulations 2012;
- Advice on preventing unintended pregnancy;
- HIV/STI testing services, STI treatment services (excluding HIV treatment), and including Chlamydia Screening as part of the National Chlamydia Screening Programme (NCSP);
- Sexual Health aspects of psychosexual counselling;
- Local authorities can choose to commission HIV prevention and sexual health support services and related programmes. These are not mandated; however, the expectation is that these will be part of the commissioned Integrated Sexual Health Service.

Integrated Care Boards (ICB's) are responsible for commissioning:

- Most abortion services
- Female sterilisation
- Vasectomy
- Non-sexual-health elements of psychosexual health services
- Intrauterine systems for non-contraceptive purposes.
- HIV testing when clinically indicated in CCG commissioned services (including A&E and other hospital departments)

NHS England is responsible for commissioning:

- Contraception provided under the terms of the General Practice contract (NB - This element is now overseen by many CCGs)
- HIV treatment and care (including drug costs for Post Exposure Prophylaxis after Sexual Exposure to HIV [PEPSE])
- Testing and treatment for STIs (including HIV testing) in General Practice when clinically indicated or requested by individual patients
- All sexual health elements of healthcare in secure and detained settings
- Sexual assault referral centres
- Cervical screening in a range of settings
- Specialist foetal medicine services
- NHS Infectious diseases in Pregnancy Screening Programme including antenatal screening for HIV, syphilis and hepatitis B

As noted in the 2019 national Parliamentary Inquiry into Sexual Health Services in England the commissioning landscape of sexual health services is often complex as services are commissioned, and provided across multiple settings and organisations. This inquiry made recommendations not only to simplify commissioning these arrangements but also increase national funding to rectify previous cuts to spending. Complex commissioning arrangements are often not seen from a service users' perspective as these services are often viewed as NHS services. However, integrated commissioning and working with partners across the system is key to ensuring service users avoid disjointed experiences when accessing sexual health services across the system. For example, an individual may need to:

- Access EHC through a pharmacy (Local Authority)
- Attend cervical screening (NHSE)
- Attend a sexual health screening (Local authority)
- Access abortion services (ICB)
- Attend their doctors to discuss contraception (NHSE)
- Have LARC fitted (Local authority)

Ensuring that all parts of this collaborative system are engaged in service improvement can have significant impacts on service user experience as seen in the Making it work guidance and case studies. The need for collaborative commissioning of sexual health services is noted in the 2023 Integrated sexual health service specification.

4. SERVICES IN WARRINGTON

4.1 Specialist sexual health services within Warrington

Warrington Borough Council (WBC) is responsible for the commissioning of sexual health services in Warrington. The current sexual health service is named Axess and is provided by Liverpool University Hospitals NHS Foundation Trust (LUHFT), which has been the provider since 2019. The service is jointly commissioned with Warrington's neighbouring local authority, Halton Borough Council.

Axess sexual health provide sexually transmitted infections (STI) and sexual reproductive health (SRH) services in Warrington, Halton, Liverpool, Knowsley, and Cheshire East making it the largest sexual health service provider based on geographical area. Axess also provide HIV care in Warrington, Halton, Liverpool Cheshire East and Wirral and additional service level agreements to provide resources and care to Wirral Sexual Health, and HIV services in Chester.

In Warrington, Axess provides an integrated STI and contraception service offering free sexual health screens, treatment, results management and advice on STIs as well as delivering the full range of contraception (and contraception counselling) to men and women of all ages. The service also supports people who are having problems with their sexual health including psychosexual therapy. The service is delivered by a team of professionals including doctors, nurses, therapists and administrators.

In addition to the general sexual health service, Axess also provide

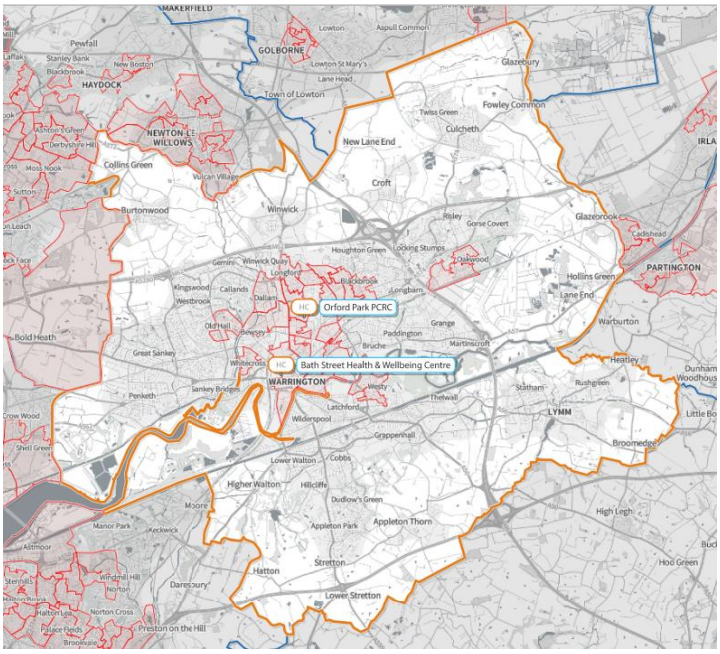
- Axess 4 u - sexual health walk-in clinic for young people (aged 19 and younger)
- Butterfly - sexual health clinic for trans and non-binary people
- HIV treatment and care services, including Pre-Exposure Prophylaxis (PrEP) which is used to reduce the risk of getting HIV

Venues and appointment types

Axess sexual health service's main venue in Warrington is at Bath Street Health & Wellbeing Centre, with an additional young person clinic in Orford. There are a variety of appointment types available, including face to face, booked appointment, walk in and telephone. This information is included in appendix 2.

Both of Axess' sexual health clinics are in Central Warrington. As shown in Figure 4, most LSOAs within central Warrington fall within the most deprived 20% of the population, therefore ensuring easier access for this population.

Figure 4: Map displaying sexual health clinics located in Warrington. Red borders highlight LSOAs in the 20% most deprived areas (Core20population).



Source: Shape atlas

4.2 Other sexual health service provision in Warrington

Axess sub-contract the following services:

- SH:24; 24-hour digital sexually transmitted infection screening and treatment service. Online STI test kits through SH:24 are uncapped for under 25 years olds. In May 2022 a daily cap for over 25 years olds was introduced to limit the number of STI test kits which can be provided each day. Patients are directed to other ways to obtain a STI test or asked to try again the next day.
- Warrington GPs to provide Long-Acting Contraception (LARC) and chlamydia testing
- Community Pharmacy to provide emergency Hormonal Contraception (EHC), condom distribution and chlamydia testing.

GP services

There are 18 GP practices sub-contracted by Axess in Warrington for the provision of LARC and chlamydia testing.

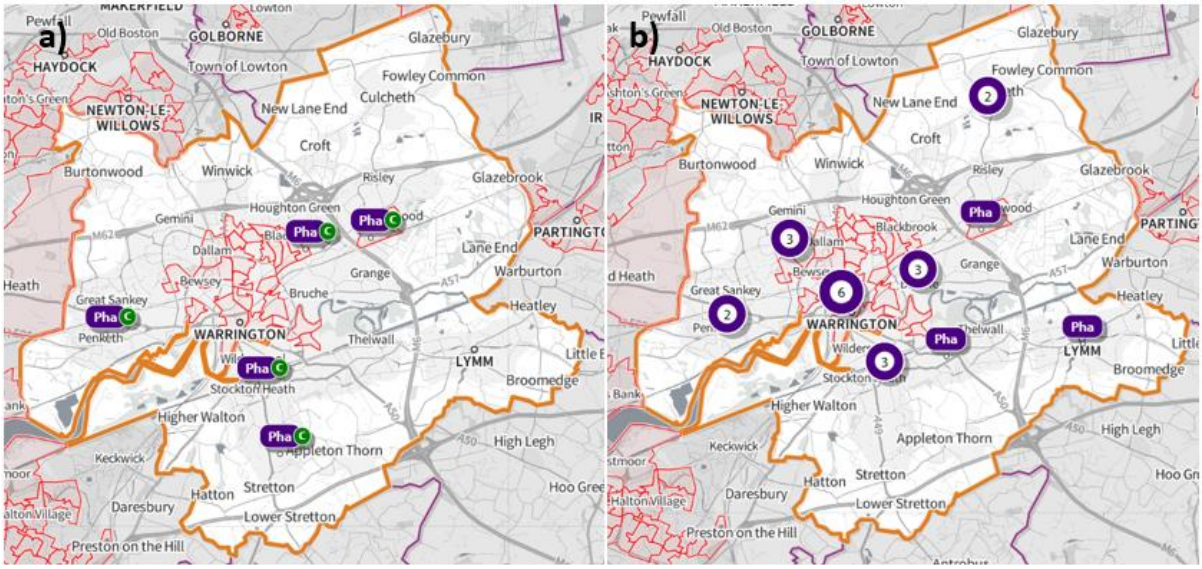
Additional sexual health services, provided by primary care include:

- advice and testing for those with genito-urinary symptoms which may lead to the identification of STIs.
- advice and provision of routine and emergency contraception.
- provision of Long-acting reversible contraception for indications other than contraception

Pharmacy services

Axess sub-contract pharmacies to provide walk-in services including emergency contraception, condoms, and chlamydia screening in Warrington. From 2023/2024 'Quick Start' contraception has been included in the national pharmacy contraception scheme. Axess provide patient group directions (PGDs) for all pharmacy provision and work with local pharmaceutical committees (LPCs) to provide training and support to ensure high quality and effective services. There are 40 pharmacies located across Warrington of which 5 provide oral contraceptives as part of the pharmacy contraceptive service and 22 provide emergency contraception.

Figure 5: Maps displaying locations of pharmacies providing a) the pharmacy contraception service b) emergency hormonal contraception. Red borders highlight LSOAs in the 20% most deprived areas (Core20population)



Source: Shape atlas

4.3 Sexual Health Outreach Team

The Axess sexual health outreach team provides free and confidential sexual health services to a range of groups that for multiple, and often complex reasons, do not access in-house clinical services. These groups include commercial sex workers, men who have sex with men (MSM), street homeless, hostel residents, some ethnic groups, including asylum seekers and refugees, drug and alcohol users, trans and nonbinary people and college and university students. While this list is not exhaustive, it provides the main focus for target outreach groups.

The outreach team provide a range of interventions including one-to-one support, informal counselling, signposting and referral to relevant support agencies, group workshops, and training to staff and other professionals. All members of the outreach team are trained to provide full asymptomatic sexual health screening.

The outreach team also offer health promotion workshops, covering topics related to trans and nonbinary awareness, HIV updates, contraception and women's sexual health needs, introduction to sexual health care for young people and LGBTQ+ focused sessions. Events and campaigns are

supported and attended as appropriate including World AIDS Day, National HIV Testing Week, Black History Month, LGBT History Month, Pride events and college and university freshers' fairs.

4.4 Sexual Health on Wheels (SHOW) Bus

During 2024, the service launched the SHOW (Sexual Health on Wheels) Bus. This is a mobile clinic unit which can be adapted for use in health promotion and community events. The SHOW Bus facilitates clinical outreach targeting underserved communities, providing sexual health and contraception services in locations that best suit their needs.

4.5 Sexual Health Education Team

Axess Education team build capacity and expertise in the workforce through education and training.

Professional briefings

Professional briefing sessions aim to increase knowledge and confidence in the workforce to have effective conversations on a variety of sexual health topics. Promoting positive sexual health, upskilling, and building expertise in the professional workforce is an important part of a whole system approach to sexual wellbeing in Warrington.

SEND Champions

A revised sexual health champions training offer was created for young people with special education needs and disabilities (SEND). This was implemented due to requests from professionals who supported SEND young people; they were seeking suitable sexual health resources and training to meet the needs of their client group.

Condom distribution - community scheme

The Axess condom distribution scheme provides access to free condoms and sexual health advice for young people via a network of venues and organisations. The Education Team ensure regular and frequent contact with participants of the scheme including youth services to inform and update them on Axess training opportunities, promotional materials, and up-to-date information on Axess services.

Sexual health training in higher education

In partnership with University of Chester, Axess sexual health also provide sexual health into higher education and professional education courses, including social work and nursing degree programmes.

Sexual Health Service - Schools

Axess Education Team offer free sexual health professional training and educational resources for secondary schools, colleges and community settings. The training offer aims to drive outstanding relationship and sex education (RSE) to enable young people to develop safe, fulfilling and healthy sexual relationships. Through a 'train the trainer model' Axess support professionals to feel confident, upskilled, and knowledgeable when discussing sexual health.

This includes:

- RSE Resource - To support teachers and professionals delivering relationship and sex education to young people of secondary school age, Axess have produced a package of educational resources providing practical support to implement the sexual health elements of the statutory requirements for RSE. Through professional briefings Axess education team aim to upskill teachers and those providing dedicated education to utilise this resource.
- CHAMPIONS -The Champions programme is designed for staff working in colleges, youth services and community settings with young people aged 16+. A full day's training aims to enable professionals to become Sexual Health Champions who can offer condom distribution, STI screening support, brief interventions and education sessions
- ENHANCED TRAINING - To support professionals the briefings aim to increase confidence, knowledge, and skills to help initiate and normalise conversations around sexual health. The briefings cover a broad range of sexual health topics.
- BESPOKE RESOURCES - Bespoke resources can be developed to further support RSE delivery

All schools in Warrington including special schools are made aware of the Axess education and training offer. Resources including presentations with voiceover for use in schools, briefing papers and campaign resources are shared via the My School page.

4.6 Additional services and interventions relevant to this needs assessment

School nursing

School nursing teams provide a universal offer and also a targeted offer for children and young people with more need.

Support SRE in schools

School Health Team can contribute to the development and delivery of the PSHE (personal, social and health education) /SRE (sex and relationships education) programmes within schools to ensure young people have access to information in line with Department of Health statutory PSHE guidance.

This includes the offer of puberty talks in year 5 or year 6 classroom delivery in primary schools. High schools are offered delivery of a lesson to Year 9s to increase young people's understanding of the different methods of contraception and also, delivery of a lesson to Year 10s re contraception and STIs. This aims of these sessions are to increase young people's understanding of the different methods of contraception, awareness of the effects of risk-taking behaviour, transmission of STIs, sexual health services available to them.

School Nurse Drop in

The School Health Team deliver holistic confidential drop-in services to young people in high school settings on a one-to-one basis and /or an appointment-based service, to support young people with their emotional health and well-being, sexual health, physical health. The service will provide packages of care and signposting and/or referral to other agencies.

Targeted health assessments

School nursing health assessments are offered for all children and young people, who are classed as vulnerable including those identified as Child in Need and those electively home educated (EHE). Pupils who are home educated also receive a welcome pack which includes health and wellbeing information and information on how to access services.

School nursing teams report quarterly to local authority commissioners on KPI's related to the above interventions.

Support and reintegration of pregnant pupils and school age parents

The Public Health Team has produced a guidance document "Managing the support and reintegration of pregnant pupils and school age parents - guidance for Warrington schools"

This guidance has been produced to help schools support pregnant pupils and school age parents to continue their education. This guidance provides links to national guidance and services within Warrington which can support young people. It highlights the responsibilities of schools, and actions that schools can take to keep the pupil who is pregnant safe and, ideally, remaining in education.

4.7 Impact of Covid on sexual health services

During the Covid-19 pandemic, many sexual health services including Warrington experienced significant disruptions, including clinic closures and staff redeployment. As is shown in much of the data presented in this health needs assessment, this led to reduced access to STI testing, treatment, and other sexual health services. This resulted in fewer diagnoses and potentially undetected infections. However, lockdowns and social distancing measures led to changes in sexual behaviour, with many people reporting fewer sexual partners. This may have temporarily reduced the transmission of some STDs. It is not yet fully clear what the long-term impacts have been on sexually transmitted infections since the pandemic.

To adapt to the restrictions there was a shift towards digital and remote services, such as online consultations and home testing kits. While this increased accessibility for some, it also highlighted digital inequalities, as not everyone could access these services. In many areas there has been a continued use of digital services, which have impacted budgets as these services are often more expensive than usual service provision.

There is a recognized need to evaluate and improve sexual health services to ensure they are accessible, equitable, and high-quality in the future. This includes addressing the gaps exposed by the pandemic and ensuring preparedness for any future disruptions.

4.8 Service use data

The following section presents an analysis of service usage data provided by the Axess Sexual Health Service for the period between January 1, 2023, and December 31, 2024. As shown in Table 4, Axess delivered a total of 9,790 appointments in 2024, with the majority taking place at the Bath Street clinic (n=7,620, 78%). This represents a 3.97% increase in the total number of appointments compared to 2023. 18% of all appointments in 2024 were conducted virtually, a decrease from 23% in 2023.

Table 4: Total number of appointments by location and year.

Location	2023		2024	
	n	%	n	%
Outreach - Warrington	168	2%	190	2%
Warrington-Bath Street	6952	74%	7620	78%
Warrington-Orford Road*	0	0%	<10	0%
Warrington - Psychosexual	102	1%	177	2%
Warrington - Virtual	2194	23%	1797	18%
Total	**9416**	**100%**	**9790**	**100%**

Source: Axess sexual health service

* Orford Road was not operational in 2023

In 2024, a total of 9,790 appointments were conducted, involving 5,298 individual patients, two thirds of whom were women (n = 3,458, 65.2%). On average, men attended the service more times than women, suggesting that although more individual women accessed the service, men were more likely to return for multiple appointments. It is important to note that sexual health, cytology and contraceptive appointments are combined in these figures. This may affect comparability between groups, as women are more likely to attend both STI screenings and contraceptive consultations, whereas cisgender men typically only attend for STI-related appointments. As a result, the average number of STI appointments for women may be lower than that for men when considered separately from contraceptive care.

As of 2024, 74.5% of appointments across the service were related to sexual health screening (GUM*) or PrEP, while 22.5% were for contraceptive services (see Table 5). Appointments for cytology and psychosexual services remained relatively low, but both have seen an increase compared to 2023. Cytology appointments rose from 0.8% to 1.2%, and psychosexual services increased from 1.1% to 1.8% of all appointments.

Table 5: Reason for appointment by year

Appointment type	2023		2024	
	n	%	n	%
Cytology	72	0.8%	118	1.2%
GUM*	7062	75.0%	7291	74.5%
Contraceptives*	2180	23.2%	2204	22.5%
Psychosex	102	1.1%	177	1.8%
Total	9416	100.0%	9790	100.0%

Source: Axess sexual health service

*Figures may not be exact due to methodology of calculation. GUM/SRH are normally grouped; to determine number of GUM appointments, the number of individual patients who received a contraceptive was subtracted from the combined GUM/SRH figure.

Sexual health services in the UK operate on an open-access basis, meaning individuals can attend services in any area, regardless of their local authority of residence. In 2024, 82.1% of appointment attendees at Warrington clinics were Warrington residents, representing a slight decrease from 83.4% in 2023 (Table 6). In both 2023 and 2024, residents of Halton consistently accounted for 5% of all appointments in Warrington.

Table 6: Number of appointments in Warrington residents by year.

	Appointments conducted
2023	
Total	9416
Warrington residents	7850
% of attendances from Warrington residents	83.40%
2024	
Total	9790
Warrington residents	8037
% of attendances from Warrington residents	82.10%

Source: Axess sexual health service

As shown in Table 7, among all out-of-area attendees in 2024, the majority were from neighbouring local authorities. The highest proportion came from Halton (30%), which jointly commissions the service with Warrington, followed by Wigan (11.2%) and St Helens (9.9%).

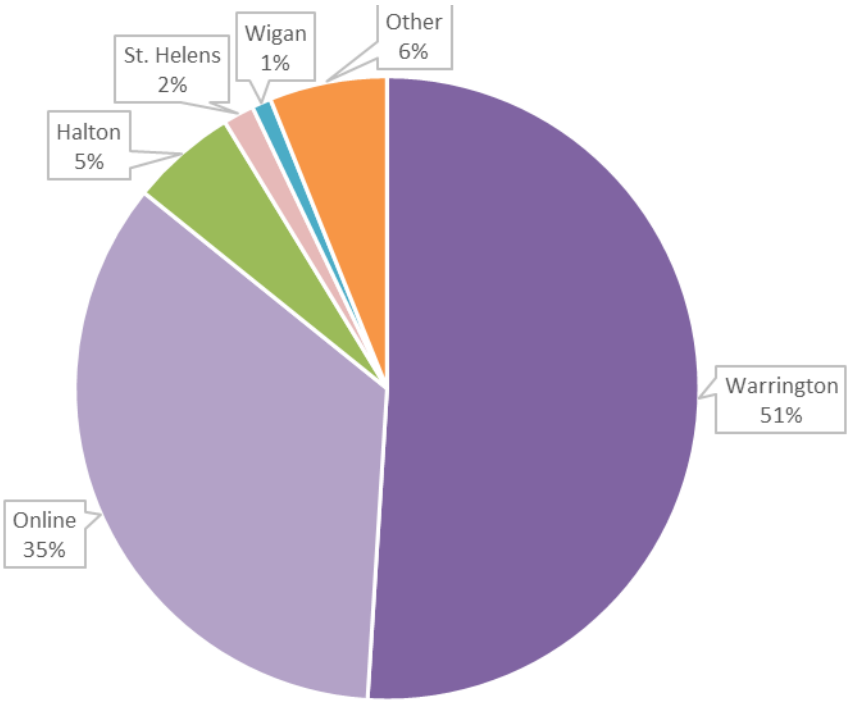
Table 7: Proportion of out of area appointments by location.

Area name	2023	2024
Halton	28.4%	29.7%
Wigan	12.5%	11.2%
St. Helens	15.1%	9.9%
Cheshire East	4.3%	8.0%
Liverpool	7.2%	7.6%
Cheshire West and Chester	7.5%	7.5%
Knowsley	4.5%	4.4%
Unknown	3.8%	3.9%
Salford	2.4%	3.8%
Manchester	3.6%	3.1%
Other	10.8%	11.0%

Source: Axess sexual health service

During the period of 2022 to 2023, 86% of Warrington residents who accessed sexual health services either visited a Warrington based clinic (51%) or accessed online services (34.8%). Of the remaining 14% who used out of area services the most popular locations were Halton (5%), St Helens (2%) and Wigan (1%) (Figure 6).

Figure 6: Warrington residents' consultations by location between 01/2022 to 12/2023.



Source: GUMCAD

Table 8 provides an overview of demographic information of Warrington residents attending Axess sexual health service each year. Data reflects unique individuals per year, meaning each patient is counted only once regardless of how many times they attended. Women accounted for the majority of appointments across both 2023 and 2024. Similarly to 2023, females make up most service attendees in 2024 with 67.8% of individual service attendees being women. This may reflect that more women are attending the service for both contraception and sexual health.

In 2024, the majority of attendees were white British (79.6%), or from any other white background (6.3%) followed by Black African (2.4%), which increased by 0.9% from 2023. When compared to Warrington population breakdowns by ethnicity, Black African shows higher levels of service engagement. In 2024, 79.50% of all attendance were working age adults aged 19- 45, with the majority being between 25-35. This is similar to 2023, however 2024 saw a small increase in the proportion of 15–18-year-olds seen by the service, from 5.6% to 7.4 %. When comparing to Warrington population structure, as expected younger people show higher levels of service use.

Table 8: Demographic information of Warrington residents attending Axess sexual health service by year.

	2023	2024
Sex		
F	69.6%	67.8%
M	30.4%	32.2%
Ethnic group		
A White British	82.0%	79.6%
B White Irish	<0.5%	0.6%
C Any other White Background	5.7%	6.3%
D Mixed White and Black Caribbean	0.7%	0.7%
E - Mixed White and Black African	<0.5%	0.6%
F - Mixed White and Asian	1.2%	0.7%
G Any other Mixed Background	0.8%	0.7%
H Indian	0.8%	0.9%
J Pakistani	0.6%	0.8%
K Bangladeshi	<0.5%	<0.5%
L Any other Asian Background	1.9%	2.1%
M Black Caribbean	0.6%	0.6%
N Black African	1.3%	2.4%
Not Recorded	<0.5%	<0.5%
P Any other Black Background	0.9%	0.8%
R Chinese	0.5%	0.8%
S Any other Ethnic Group	1.9%	1.4%
WA Caucasian	<0.5%	<0.5%
Z Not Stated	<0.5%	0.9%
Age Groups		
Under 15	<0.5%	<0.5%
15-18	5.6%	7.4%
19-25	25.4%	25.8%
26-35	33.9%	32.7%
36-45	21.1%	21.0%
46-55	9.0%	8.5%
56-65	3.7%	3.3%
66-75	1.0%	1.0%
76+	<0.5%	<0.5%

Source: Axess sexual health service

5. INEQUALITIES

In 2023 the UK ranked as the top preforming country in terms of sexual and reproductive health and rights policies according to the **European Sexual and Reproductive Health and Rights Ranking Atlas 2020–23**. Nationally, there have been significant improvements and successes in sexual health in the UK in the past decade, including teenage pregnancy rates falling to the lowest level on record, increased LARC uses, and effective vaccination programmes of HPV resulting in decreases in genital warts diagnoses [13]. Despite these successes, significant inequalities in sexual health remain, with the burden of poor outcomes being distributed unequally across the population. Poorer sexual health outcomes disproportionately affect the following groups:

- Younger people
- Gender diverse people
- LGBTQ+
- Ethnic minorities
- Deprived populations
- Those with substance misuse disorders

5.1 Age and Sex

Sexual health needs vary across the life course, with distinct challenges faced at different stages of life. The UK experiences some of the highest rates of sexually transmitted infections (STIs) in Europe, of which younger people are disproportionately represented[14]. Findings from the national surveys of sexual attitudes and lifestyles (NASTAL) shows most young people become sexually active between the ages of 16 -24. This age group has the highest diagnosis rates of common STIs such as chlamydia[15]. These challenges can be attributed to a combination of factors including varied access to comprehensive sex education, inconsistent condom use, higher rates of partner change and social stigma around discussions of sexual health[16],[17]. Nationally younger people are also more likely to become reinfected with an STI. However, in Warrington reinfection rates are lower than the national average in this population [18].

As shown in figure 7, women under the age of 25 are disproportionately affected by sexually transmitted infections (STIs), with the highest diagnosis rates across all age and sex groups in both the North West and England. Rates among young women in the North West exceed the national average. Although men under 25 have lower STI rates than women in the same age group, their rates do not decline as sharply as in women and remain higher into older age groups. In fact, men

[13] A blueprint for the future: Sexual and reproductive health and HIV services in England | Local Government Association

[14] https://www.statista.com/chart/31739/eu-cases-of-gonorrhoea-syphilis-and-chlamydia/

[15] Sexually transmitted infections and screening for chlamydia in England: 2023 report - GOV.UK

[16] Brown, Ellie et al. "Improving the Sexual Health of Young People (under 25) in High-Risk Populations: A Systematic Review of Behavioural and Psychosocial Interventions." *International journal of environmental research and public health* vol. 18,17 9063. 27 Aug. 2021, doi:10.3390/ijerph18179063

[17] Sexually transmitted infections and screening for chlamydia in England: 2023 report - GOV.UK

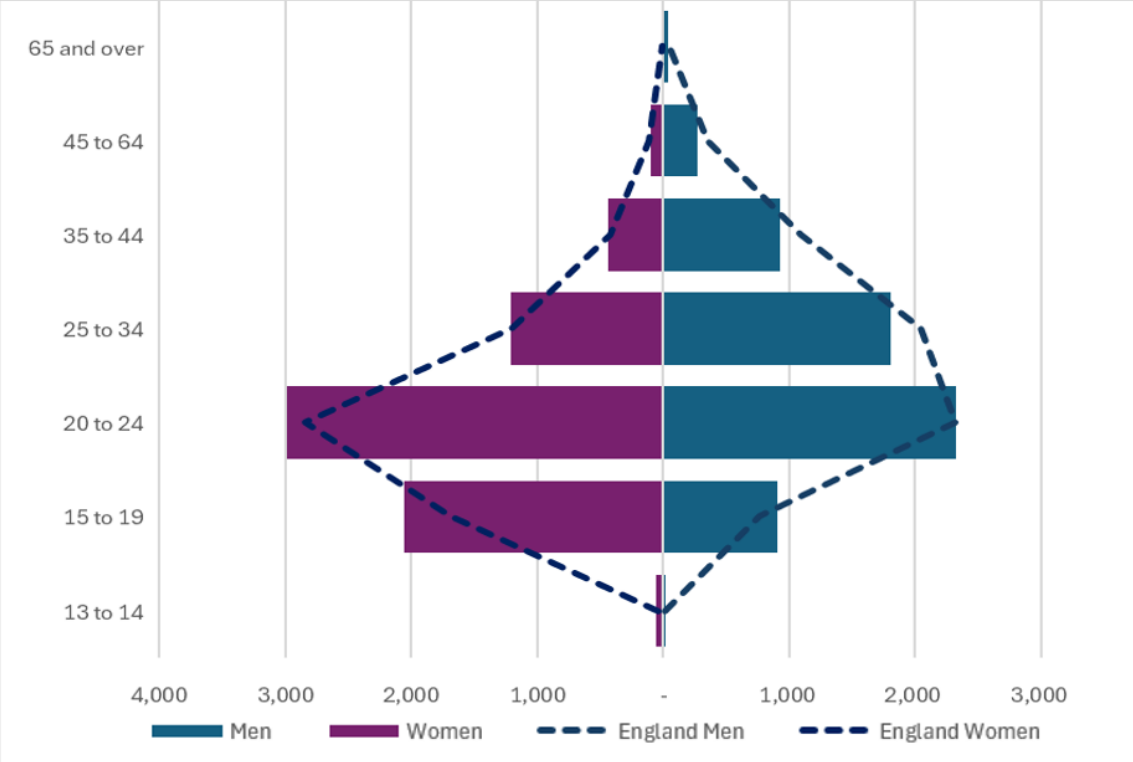
[18] GUMCAD STI Surveillance System - GOV.UK Splash report (restricted access)

aged 25 and over tend to have higher STI rates than women of the same age. Despite these differences, both sexes show a general downward trend in STI prevalence with increasing age.

Due to reporting restrictions, local data cannot be disaggregated by age and sex; however, 2024 data for Warrington followed the national pattern. Women under 25 continue to experience disproportionately high STI rates, but these tend to decline with age. In contrast, STI rates among men persist beyond age 25. As a result, the overall STI diagnosis rate in Warrington in 2024 was higher among men (approximately 530 per 100,000) than women (around 450 per 100,000), consistent with national trends.

When examining specific infections, both national and local data show that gonorrhoea, syphilis, and genital warts are more prevalent among men, while chlamydia and genital herpes are more common among women. Notably, the overall rate of new STI diagnoses among men in 2024 was 1.6 times higher than in 2020 an increase not observed among women[19].

Figure 7: Rate of new STI diagnosis by age and sex in North West and England 2022-2024.



Source [Sexually transmitted infections (STIs): annual data - GOV.UK]

[19] GUMCAD data (restricted access)

Unplanned pregnancy is also a significant concern for this population. Young people in England experience higher teenage birth rates than peers in western countries[20]. In Warrington, 69.6% of pregnancies among under-18s lead to abortion, compared to the national average of 53.4%. The under-18 abortion rate in Warrington (10.9 per 1,000) is notably higher than the national rate of 6.5 per 1,000[21]. However, the under 18s conception rate was not significantly different from England or the North West.

Adults aged 50 and over often face challenges related to sexual health, yet these issues are frequently overlooked. Research indicates that the sexual health needs of this demographic are often neglected, with limited access to specialized services and a lack of information on topics such as menopause, sexual dysfunction, and the risk of sexually transmitted infections (STIs) in later life[22]. Adults over the age of 50 are also more likely to experience sexual dysfunction, which has been shown to have negative effects on psychological well-being.[23] Additionally, the national incidence of STIs in those aged 45 and over has been increasing with new gonorrhoea and chlamydia diagnoses roughly doubling between 2014-2019, although the reasons for these trends are not fully understood [24]. However, the National Institute for Health and Care Excellence (NICE) have now included recommendations that older people should be asked about their sexual history to better assess risk in this population[25].

5.2 Gender

Sexual health data on transgender and non-binary people in the UK is limited with little national reporting of STI rates for this group, this highlights the structural inequalities faced by this population. Globally, transgender individuals are at a higher risk of HIV, with the risk of transmission being 12 times greater than in cisgendered populations[26]. Whilst some research suggests that this group is at risk of poorer sexual health outcomes, it is difficult to quantify the impact without robust data and reporting systems. As a result, transgender and non-binary individuals remain at risk of receiving inappropriate or inadequate services that fail to meet their specific needs.

Transgender and non-binary people are at risk of inequitable access to sexual health services due to barriers such as discrimination and stigma[27]. The British Association for Sexual Health and HIV (BASHH) provides guidelines on the provision of inclusive services for gender diverse people however, these are not a legal requirement, resulting in inequitable provision of services across the

[20] Teenage Pregnancy Prevention Framework
[21] Fingertips | Department of Health and Social Care
[22] Khan J, Greaves E, Tanton C*, et al*, Sexual behaviours and sexual health among middle-aged and older adults in Britain, *Sexually Transmitted Infections* 2023;**99:**173-179.
[23] Hinchliff, S., Tetley, J., Lee, D., & Nazroo, J. (2017). Older Adults' Experiences of Sexual Difficulties: Qualitative Findings from the English Longitudinal Study on Ageing (ELSA). *The Journal of Sex Research*, *55*(2), 152–163. https://doi.org/10.1080/00224499.2016.1269308
[24] Camacho C, Camacho E, Lee D. Trends and projections in sexually transmitted infections in people aged 45 years and older in England: analysis of national surveillance data. *Perspectives in Public Health*. 2022;143(5):263-271. doi:10.1177/17579139221106348
[25] National Institute for Health and Care Excellence. NICE sexual health quality standard [QS178], 2019. Available online at: https://www.nice.org.uk/guidance/qs178
[26] State of the nation report v2.pdf
[27] Beere et al. BASHH Recommendations for Integrated Sexual Health Services for Trans, including Non-binary, People, available online: https://www.bashh. org/about-bashh/publications/

UK. Findings from the National LGBT Survey 2018 show that transgender respondents were less likely to have accessed sexual health services in the past 12 months (17% vs. 29%) and more likely to report negative experiences with these services compared to cisgender people. Additionally, transgender individuals were more likely to feel worried, anxious, and embarrassed about accessing services (14%) than cisgender respondents (6%)[28].

In 2023, the UK Health Security Agency (UKHSA) published the first national data on sexual health service use among transgender and gender diverse people in England. In 2024, there were 67,521 consultations involving trans and gender diverse individuals[29]. Gender diverse people accounted for the largest share (n=24,740), followed by transgender women (n=24,114) and transgender men (n=18,637) (Table 9). When considered in relation to estimated population sizes, this level of engagement may suggest good accessibility and responsiveness of services for gender-diverse communities. However, interpretation is limited by the lack of robust population denominators. Between 2023 and 2024, consultations and sexual health screens increased across all trans and gender diverse groups. This rise is likely due to improved demographic reporting rather than a true increase in service use or STI incidence. Continued monitoring and more detailed local data are needed to better understand access, unmet needs, and health outcomes over time.

Table 9: Total number of consultations, screens and selected STI diagnoses by gender identity in England, 2024

Gender identity	Consultations 2024 (n)	% change 2023-2024	Sexual health screens 2024 (n) *	% change 2023-2024	Gonorrhoea 2024 (n)	% change 2023-2024	Syphilis 2024 (n) **	% change 2023-2024
Transgender men	18,637	12.8%	9,571	17.3%	536	1.7%	77	26.2%
Cisgender men	1,717,547	-1.4%	1,039,899	1.1%	54,617	-8.7%	8,133	1.8%
Transgender women	24,144	3.5%	11,670	12.6%	399	-6.3%	74	25.4%
Cisgender women	2,552,803	-3.8%	1,221,750	-2.2%	14,011	-34.3%	906	-0.9%
Gender diverse	24,740	8.8%	13,976	9.2%	467	-5.7%	45	28.6%

* Sexual health screens conducted in a SHS (levels 2 or 3) that may include any combination of one or more tests for chlamydia, gonorrhoea, HIV or syphilis.
** Diagnoses of syphilis include primary, secondary and early latent.
Source: Sexually transmitted infections (STIs): annual data - GOV.UK (accessed: 10/06/2025)

Table 10 provides an overview of the demographic information of Warrington residents attending the Axess sexual health service each year. The data reflects unique individuals per year, meaning each patient is counted only once, regardless of how many times they attended. Compared to the

[28] National LGBT survey: research report
[29] Sexually transmitted infections (STIs): annual data - GOV.UK

2021 Census, transgender (0.4%) and non-binary (0.3%) individuals are proportionally overrepresented among service users, relative to Census figures of 0.08% and 0.03%, respectively.

However, this comparison is limited. The Census only surveyed those aged 16 and over, and the median age of transgender and non-binary service users is lower than that of cisgender individuals, suggesting some may not have been captured. Additionally, 4.48% of Census respondents did not answer the gender identity question. Warrington's dedicated Butterfly Clinic for gender-diverse individuals may also contribute to higher engagement within this population.

Table 10: Gender identity of Warrington residents that attended Axess by year.

	2023	2024
Gender identity		
Identifies as non-binary / gender fluid	0.4%	0.3%
No - Identifies as Cis-gendered (same as assigned at birth)	99.4%	99.4%
Prefers not to say	0.1%	0.0%
Yes - Identifies as Transgender	0.2%	0.4%

Source: Axess sexual health service

Only those who are registered as female on their GP records will be invited for cervical screening, creating a barrier to access for transmasculine individuals. Research shows significant disparities in uptake between those females assigned at birth and cis-gendered women for both lifetime and up to date screening. [30] A UK study involving 137 participants found that only 37 out of 64 eligible individuals had ever been screened. Of those, 65% reported delaying screening at least once, and 13% had never received an invitation. Additionally, 53% felt they lacked sufficient information about cervical screening. [31] . Barriers include gendered health records, fear of discrimination, and discomfort with procedures. The majority (64%) preferred attending a trans-specific health clinic for screening, while only 7% preferred their GP. Self-sampling for HPV was favoured by 53% of respondents, with 35% needing more information.

Transgender people may face significant inequalities in reproductive health due to a lack of inclusive healthcare services and limited awareness of their specific needs by healthcare professionals. Medical transition, including hormone therapy, can adversely affect fertility however individuals may struggle with accessing fertility preservation services as there is no national NICE recommended treatment pathway as funding is decided by local ICBs leading to variability in provision across the UK[32].

Transgender people may also face difficulty accessing methods of contraception that align with their gender identity or may be overlooked when discussing contraception needs. Many healthcare

[30] Dean Connolly, Xan Hughes, Alison Berner, Barriers and facilitators to cervical cancer screening among transgender men and non-binary people with a cervix: A systematic narrative review., Preventive Medicine, Volume 135, 2020, 106071, ISSN 0091-7435, https://doi.org/10.1016/j.ypmed.2020.106071.

[31] Attitudes of transgender men and non-binary people to cervical screening: a cross-sectional mixed-methods study in the UK - PMC (nih.gov)

[32] Information for trans and non-binary people seeking fertility treatment | HFEA

providers lack training on contraception for gender-diverse individuals, leading to inadequate support for this population.

5.3 LGBTQ+

This section examines the sexual health needs of lesbian, gay, bisexual, transgender, queer and other gender and sexuality-diverse (LGBTQ+) communities. In the 2021 Census for Warrington, 91.79% identified as heterosexual. Data for attendees at Axess sexual health services showed 85% of attendees identifying as heterosexual. This suggests a higher proportion of lesbian, gay, and bisexual (LGB) individuals are accessing sexual health services relative to their representation in the general population. Specifically, 6.2% of Axess users identified as gay or lesbian, compared to 1.31% in the Census.

Several factors may contribute to this disparity. Younger people are more likely to identify as LGB+, and in 2024, 87.1% of Axess users were under 45. Additionally, the Census did not collect sexual orientation data from individuals under 16, whereas Axess data includes this group. Table 11 also indicates that LGB individuals are more likely to attend services multiple times, as they represent a higher proportion of repeat visits than their share of the overall patient population.

Table 11: Breakdown of Axess service use data by gender identity and year.

	% Total patients		% Total attendances	
Sexual orientation	**2023**	**2024**	**2023**	**2024**
Bisexual	3.5%	4.5%	4.2%	5.7%
Gay or Lesbian	5.4%	6.2%	9.8%	10.2%
Heterosexual or Straight	86.3%	85.0%	82.2%	80.3%
Not Recorded	3.8%	0.9%	3.0%	1.1%
Other	0.3%	0.6%	0.3%	0.6%
Patient Declined	0.6%	2.5%	0.4%	1.9%
Patient Not Sure	0.1%	0.3%	0.0%	0.2%

Source: Axess sexual health service

Gay and bisexual men and other men who have sex with men (GBMSM)

In the UK, gay, bisexual, and other men who have sex with men (GBMSM) continue to face significant disparities in sexual health outcomes. These are driven by a combination of behavioural, structural, and social factors that increase vulnerability to sexually transmitted infections (STIs). In 2024, GBMSM in England had the highest rate of new STI diagnoses at 12,423.7 per 100,000, approximately 31.6 times higher than the rate among heterosexual men (393.1 per 100,000).

Among men who have sex with men (MSM), the majority of diagnoses for syphilis, gonorrhoea, and chlamydia occur in individuals who are either HIV-negative or of unknown HIV status, however diagnosis rates remain 3-6 times higher in those diagnosed with HIV. This disproportionate burden of STIs in GBMSM is partly attributed to the higher rates of high-risk sexual behaviours such as unprotected sex, multiple sexual partners, and the use of substances during sex, within the GBMSM

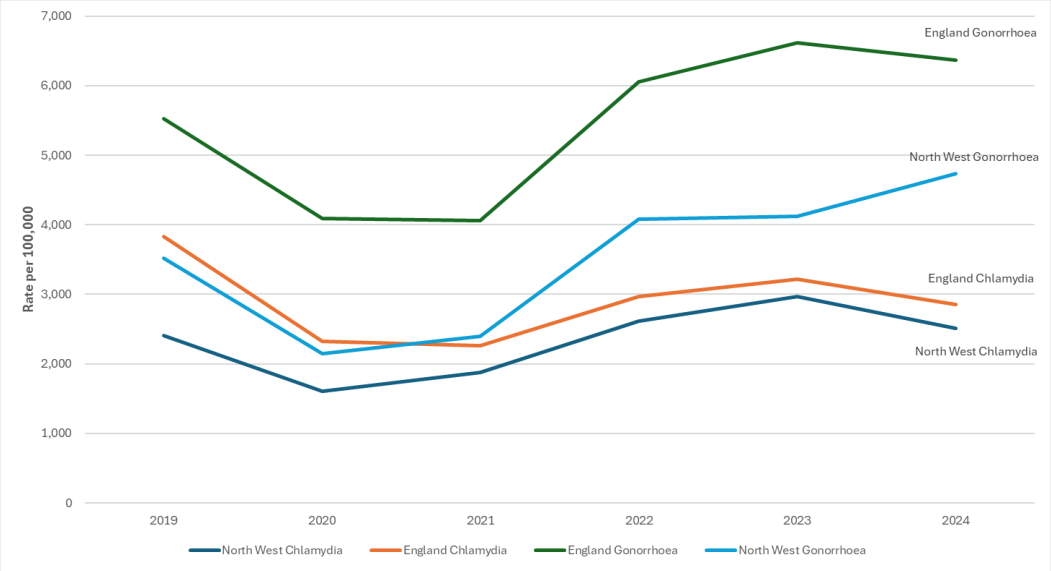
community[33]. Furthermore, GBMSM often experience challenges in accessing healthcare services due to fear of judgment or discrimination. These factors contribute to delays in diagnosis and treatment, leading to poorer health outcomes.

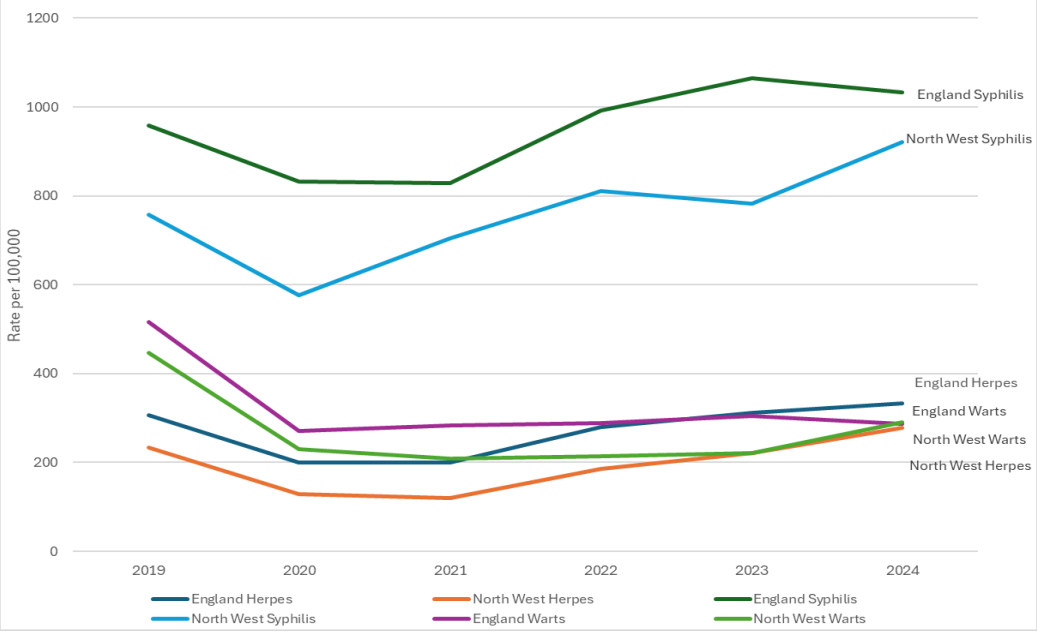
As shown in Figure 8a/b below, rates of STIs such as gonorrhoea and syphilis among GBMSM have been steadily rising since the pandemic, now reaching or surpassing pre-pandemic levels. Between 2023 and 2024, the North West experienced a sharp increase in rates of both diseases, while national averages declined. However, rates in the North West remain significantly below the national average.

When reviewing local data for the period between 2022 and 2024, gay and bisexual men in Warrington had higher rates of every STI compared to heterosexual males, this is in line with national and regional patterns. This was particularly evident for gonorrhoea, chlamydia, and syphilis. Local data suggests that similar to the national trend, GBMSM in Warrington are disproportionately affected by all STIs compared to their heterosexual counterparts and carry a high burden of sexually transmitted infections.

[33] Health matters: preventing STIs - GOV.UK

Figure 8a/b: Rate of diagnosis of selected STIs among GBMSM accessing SHSs, England and the North West, 2019 to 2024





Source: [Sexually transmitted infections (STIs): annual data - GOV.UK]

Figures reported in 2020 and 2021 are notably lower than previous years due to the disruption to SHSs during the national response to the COVID-19 pandemic.

In May 2022, a global outbreak of clade II Mpox (formerly known as Monkeypox) emerged which predominantly affected the GBMSM community. It is important to note that, although Mpox is not exclusively transmitted through sexual contact, the predominant route of transmission during the outbreak was through sexual contact. In the UK this outbreak primarily affected the GBMSM community. There were 3,553 diagnoses of MPOX in GBMSM in 2022, however this has fallen to

only 137 in 2023[34]. In response to the outbreak, targeted post exposure vaccination of contacts and a pre-exposure vaccination programme was deployed to vaccinate those most at risk. As of 2025 Warrington Sexual health service provides Mpox vaccination to eligible GBMSM[35]

Women who have sex with Women (WSW)

While the sexual health inequalities faced by gay, bisexual, and other men who have sex with men (GBMSM) are well-documented, there is less research on the sexual and reproductive health needs of women who have sex with women (WSW). Research in this area is limited, partly because WSW are often perceived to be at a lower risk for sexually transmitted infections (STIs). However, data from the UK Health Security Agency (UKHSA) shows that the rate of STIs such as gonorrhoea has risen from 84.4 per 100,000 in 2019 to 156.9 per 100,000 in 2023 among WSW, while women who have sex with men saw a modest increase from 82.3 per 100,000 in 2019 to 87.5 in 2023[36]. Despite these rising rates, WSW remain largely excluded from targeted interventions.

The parliamentary inquiry into Health and Social Care and LGBT Communities highlighted the stigma faced by WSW, noting that lesbian and bisexual women are less likely to attend cervical screening compared to their heterosexual counterparts. This disparity may result from a lack of awareness about the need for screening, either among individuals or healthcare professionals. Evidence from the enquiry highlighted that some WSW have been incorrectly informed that they do not need cervical screening due to their sexual orientation. The inquiry also drew attention to the discrimination experienced by WSW from frontline healthcare workers, with many reporting that sexual orientation is not considered relevant to an individual's health needs[37]. Work in the North West found that LB women had been informed they were at low or no risk of cervical cancer, in some instances healthcare professionals provided this advice. It is a common misconception that LB women cannot get cervical cancer, however, HPV can be transmitted by skin-to-skin contact in the genital area which can include sexual touching, sharing sex toys, oral sex, and penetrative sex.[38]

The *State of the Nation* report highlights the lack of visibility and accessibility of dental dams as a condo alternative barrier method for this population[39]. These gaps in awareness, resources, and services contribute to the ongoing exclusion of WSW from comprehensive sexual health care and support.

[34] Sexually transmitted infections and screening for chlamydia in England: 2023 report - GOV.UK
[35] Find an mpox vaccination site - NHS Accessed: 23.05.2025

[37] LGBT Health and Social Care
[38] Let's talk about it…smear tests for lesbian, gay and bisexual women | Jo's Cervical Cancer Trust (jostrust.org.uk)
[39] State of the nation report v2.pdf

5.4 Ethnicity

Ethnicity plays a significant role in shaping sexual health outcomes within the UK. Research has consistently shown that people from Black, Asian, and Minority Ethnic (BAME) backgrounds are disproportionately affected by STIs. These disparities are complex and multifaceted, the intersectionality of gender, ethnicity, age and deprivation varies between ethnic groups, and this is also reflected in their relative rates of STIs. Research shows that there are no unique clinical or behavioural factors that explain the disproportionate burden of disease in this population suggesting that these disparities are influenced by underlying structural inequalities and socioeconomic factors[40].

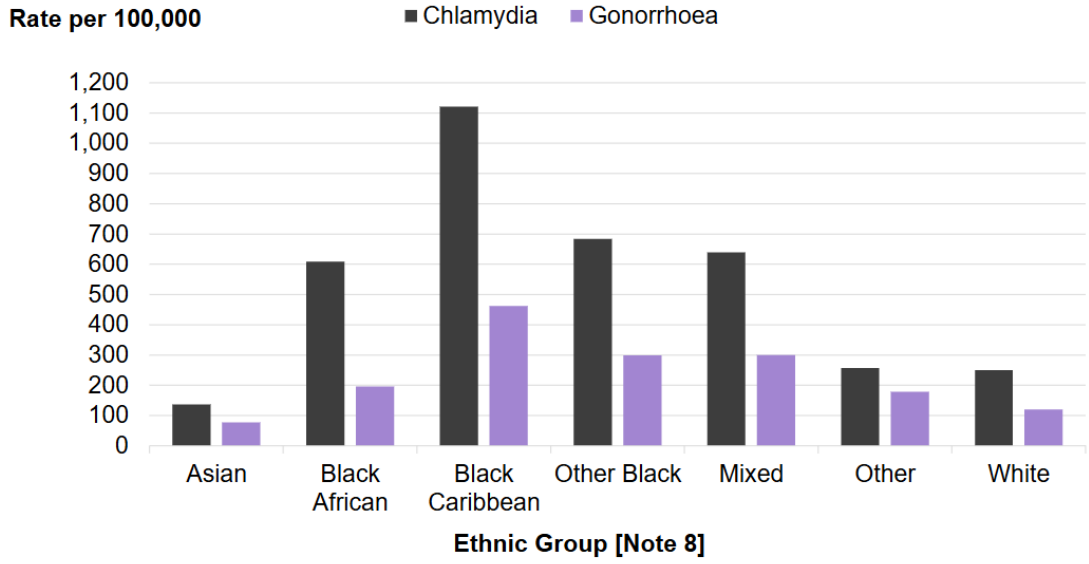
Individuals from certain ethnic backgrounds experience higher rates of STI diagnoses. For example, black African and black Caribbean individuals have higher rates of chlamydia and gonorrhoea compared to their white counterparts[39]. Ethnic disparities are also evident in the rates of HIV diagnoses across different communities. black African and black Caribbean populations are particularly affected by HIV in the UK. Black African men and women are disproportionately diagnosed with HIV, with the highest rates of diagnosis being among African-born individuals.

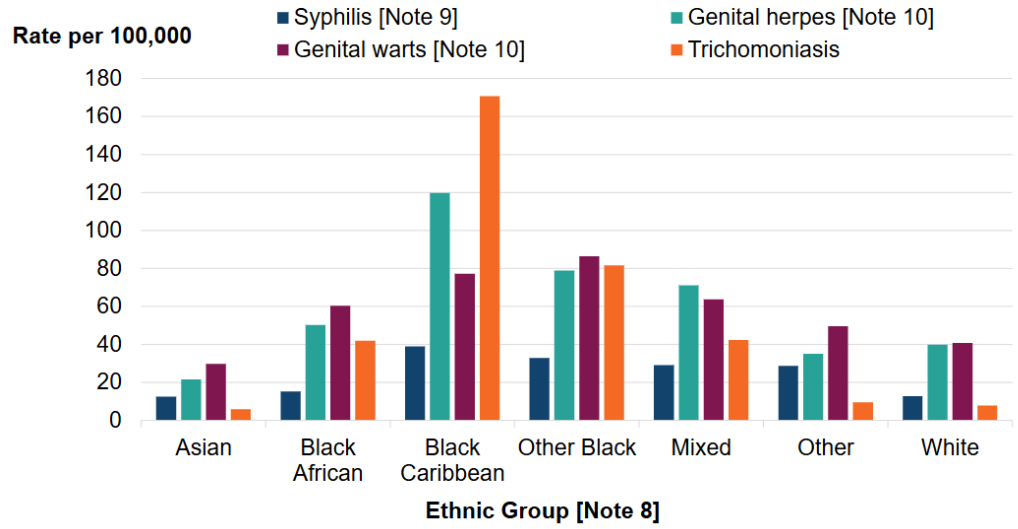
Ethnic minority individuals may face barriers to accessing sexual health services, including language barriers, lack of culturally sensitive care, and mistrust of healthcare providers. Some people from ethnic minority backgrounds may feel uncomfortable seeking care due to negative past experiences with healthcare systems or fears of discrimination. The lack of diversity within healthcare settings, particularly in terms of staff who can communicate in a variety of languages and understand the cultural nuances of different communities, exacerbates these challenges.

Across England, the rates of chlamydia and gonorrhoea per 100,000 population are disproportionately higher among individuals from Black and mixed ethnic backgrounds compared to those from White ethnic groups. In contrast, individuals from Asian and other ethnic backgrounds generally exhibit similar or lower rates of these infections relative to White groups (Figure 9a/b). This pattern can be seen across most other sexually transmitted infections (STIs). Black Caribbean populations experience significantly elevated rates of genital herpes and trichomoniasis when compared to White ethnic groups. Warrington reflects similar trends and ethnic disparities in STI diagnoses remain evident, with the rate of new STI diagnoses by ethnicity in Warrington mirroring national patterns for some ethnic groups, with New STI rates being highest in those from Black backgrounds [41].

[40] Sexually transmitted infections and screening for chlamydia in England: 2023 report - GOV.UK
[41] UKHSA Splash report 2023 (restricted access)

Figure 9a/b: Rates of selected STI diagnoses among England residents accessing SHSs by ethnicity and STI, 2023





Source: Sexually transmitted infections and screening for chlamydia in England: 2023 report - GOV.UK
[Note 8] The ethnic categories above are as specified by the Office for National Statistics (ONS).
[Note 9] Includes diagnoses of primary, secondary and early latent syphilis.
[Note 10] First Episode.

A UK analysis of cervical screening uptake amongst different ethnic groups found that participation in cervical screening was 32% lower in Asian women than White women, after adjusting for confounding variables[42]. A 2015 study found that BAME women were less likely to attend cervical screening than white British women[43]. The study found that 44-71% of BAME women did not attend screening compared to 12% of white British women. Twenty-four percent of BAME women were

[42] A cross-sectional analysis of ethnic inequalities in cervical screening uptake in the UK using Understanding Society (wave 10) (ukdataservice.ac.uk)
[43] Understanding cervical screening non-attendance among ethnic minority women in England - PMC (nih.gov)

described as 'disengaged' (those that had not heard of screening or reported never receiving an invitation) whilst 37% were described as 'overdue' (those who had not been screened in the last 5 years/had not attended despite receiving an invitation).

The study also found attitudes to cervical screening varied by ethnic group. Generally, women from ethnic minority groups were more likely to believe that they were not at risk of cervical cancer and that they do not need to have a smear test if asymptomatic. BAME women were more likely to fear what screening may find, worried about seeing a male doctor and likely to say they did not want to know whether they had cancer.

Jo's Cervical Cancer Trust undertook survey work which revealed differences in the understanding of cervical cancer screening among white women and women from a Black, Asian and Minority Ethnic (BAME) community[44]. Key findings include that:

- BAME women were 1.5 times more likely to have never attended cervical screening
- Screening tests for pre-cancerous abnormalities in the cervix is lower amongst Asian women (70%) than white women (91%)
- BAME women aged 55-64 were less likely to think screening is necessary
- BAME women were less likely to feel comfortable discussing cervical screening with a male GP (28%) than white women (45%)
- Twice as many BAME women (30%) as white women (14%) said better knowledge about the test and why it is important would encourage attendance

The survey also revealed a greater preference amongst BAME respondents for cervical screening at local health centres, family planning clinics or high street clinics compared to white respondents. However, a similar proportion of white (86%) and BAME (83%) respondents would prefer to access GP surgeries for cervical screening[45].

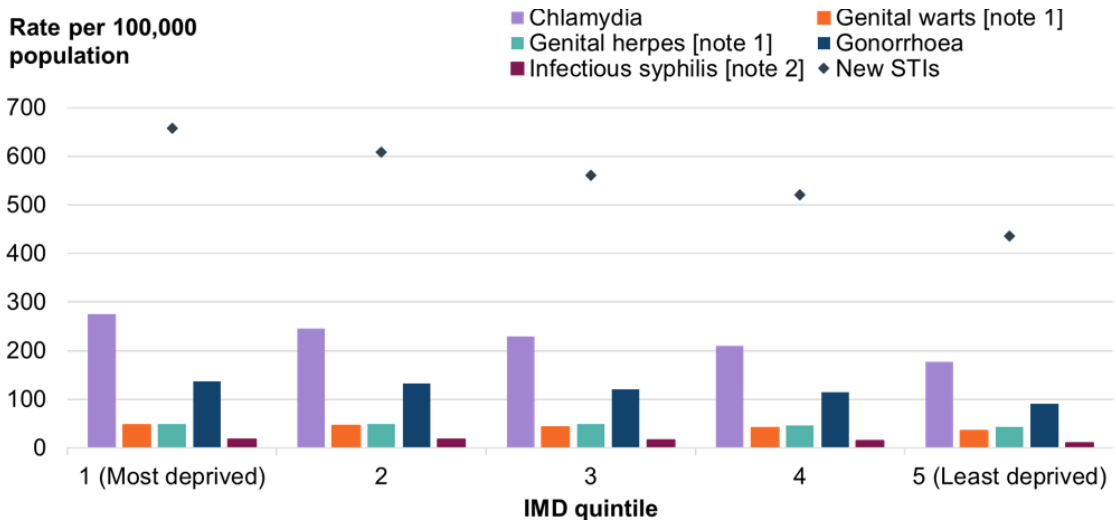
5.5 Deprivation

In the UK, deprivation is strongly linked to poorer sexual health outcomes, with individuals in socioeconomically disadvantaged areas facing multiple barriers to accessing effective sexual health services. Research consistently shows that people from lower-income backgrounds are more likely to experience higher rates of sexually transmitted infections (STIs), unplanned pregnancies, and limited access to contraception[46]. A combination of factors, including limited access to healthcare, lower levels of sexual health education, and greater social stigma surrounding sexual health, contribute to these disparities[47]. National data highlights that when comparing rates of selected STIs across quintiles 1- 5, those in the most deprived groups have significantly higher rates of STI when compared to the least deprived, this is particularly apparent for chlamydia and gonorrhoeal infections (Figure 10). Whilst specific rates cannot be reported due to disclosure regulations,

[44] Cervical Screening Among BAME Community | Research (jostrust.org.uk)
[45] bme_survey_website_final.pdf (jostrust.org.uk)
[46] Health matters: preventing STIs - GOV.UK
[47] Solomon D, Gibbs J, Burns F, *et al* Inequalities in sexual and reproductive outcomes among women aged 16–24 in England (2012–2019) *J Epidemiol Community Health* 2024;**78:**451-457.

analysis of Warrington data shows that, similar to England, the rate of new STIs per 100,000 also shows a relationship with deprivation[48].

Figure 10: Rates of STI diagnoses by index of multiple deprivation (IMD) quintile: England, 2024



Source: [Sexually transmitted infections (STIs): annual data]
Note 1: first episode
Note 2: the number of infectious syphilis diagnoses includes primary, secondary and early latent diagnoses

5.6 Disability

People with learning disabilities (LD) aspire to romantic relationships just as much as those without an LD, and these relationships offer significant benefits for health and well-being. While a minority may not be able to consent to sexual or romantic relationships, the majority can engage in happy and safe relationships with appropriate support and accessible sex education. However, many individuals with LD are not provided with the necessary support to engage in these relationships due to a lack of appropriate education[49]. Family members and support workers play a crucial role in assisting people with LD to navigate and develop healthy relationships. Yet information and support are often delivered in an unplanned or insufficient manner, leading to incomplete knowledge about relationships and sexual health. Support workers frequently experience role ambiguity and lack clear guidance regarding their responsibilities in supporting the sexuality of those with LD[50]. This uncertainty is compounded by tensions between enabling positive relationships and protecting individuals from potential abuse or exploitation, which may limit opportunities for relationship development[51]. Consequently, people with LD are at higher risk of poor sexual health outcomes,

[48] GUMCAD SPLASH report (restricted access)
[49] National Institute for Health Research (NIHR) (2020). Exploring support for adults with learning disabilities to find loving relationships.
[50] Sitter, K., Burke, A., Ladhani, S., & Mallay, N. (2019). Supporting positive sexual health for persons with developmental disabilities: Stories about the right to love. British Journal of Learning Disabilities, 47(4), 255-263
[51] Bates, C., Terry L., & Popple, K. (2017b). Supporting people with learning disabilities to make and maintain intimate relationships. Tizard Learning Disability Review, 22(1), 16-23

including sexually transmitted infections (STIs), unintended pregnancies, and sexual abuse[52]. Studies have shown that those with learning disabilities are up to 50% more likely to have unsafe sex than their peers [53]

Those with a physical disability are also at risk of poorer sexual health outcomes. Older adults who have a limiting disability are more likely to report dissatisfaction and high levels of distress with their sex life[54]. Younger women with a physical limiting disability are particularly vulnerable, reporting higher rates of non-consensual sex and STI diagnoses compared to their peers without disabilities, these associations were not seen in men[55].

Warrington Axess Sexual Health Service make necessary adjustments for any additional need on a case-by-case basis. This may be for physical disability, learning disability, special educational need, neurodiversity or mental health need. Adjustments may mean longer consultation time, different equipment or room type, extra staff to support an examination etc. Adjustments are made to support understanding and decision making (easy read documents, sign language, carer input) which may need additional time, therefore, where possible Axess encourage carers and those with knowledge of the patients' needs to inform the service in advance to prepare an appropriate episode of care. Axess education team provide SEND Champions module for any service working directly with young people. All Axess staff are mandated and monitored to comply with Equality & Diversity and disability training.

Nationally cervical screening coverage in individuals with a learning disability was 33.6% in 2019-20, less than half the cervical screening coverage of those without a learning disability in the same period (71.8%)[56]. A study from 2012 also found that screening uptake amongst individuals with learning disabilities was 46% lower compared to individuals without learning disabilities, after adjusting for age, country, deprivation and year. Regional work in the North West in 2023 found that individuals with learning disabilities experienced multiple barriers when trying to access cervical screening including:

- Reasonable adjustments not always offered
- Easy Read materials not always received with the appointment letter
- Most individuals having no understanding of what would happen during a screening appointment, identifying that being able to speak with someone who had knowledge of the process would increase their confidence to attend.
- Some felt afraid or concerned about what would happen at a screening appointment, which was linked to misunderstandings or limited knowledge

[52] Woodhead E, Hibberd O. Sexual health in people with learning or intellectual disabilities. *InnovAiT*. 2023;17(2):77-83. doi:10.1177/17557380231213541

[53] Baines, S., Emerson, E., Robertson, J. *et al.* Sexual activity and sexual health among young adults with and without mild/moderate intellectual disability. *BMC Public Health* **18**, 667 (2018). https://doi.org/10.1186/s12889-018-5572-9

[54] Khan J, Greaves E, Tanton C*, et al*, Sexual behaviours and sexual health among middle-aged and older adults in Britain, *Sexually Transmitted Infections* 2023;**99:**173-179.

[55] Holdsworth E, Trifonova V, Tanton C, Kuper H, Datta J, Macdowall W, Mercer CH. Sexual behaviours and sexual health outcomes among young adults with limiting disabilities: findings from third British National Survey of Sexual Attitudes and Lifestyles (Natsal-3). BMJ Open. 2018 Jul 5;8(7): e019219. doi: 10.1136/bmjopen-2017-019219. PMID: 29980540; PMCID: PMC6124606.

[56] Health and Care of People with Learning Disabilities Experimental Statistics 2019 to 2020 - NHS England Digital

- Some said they found it difficult using the appointment systems – especially when changing appointment dates

5.7 Sex workers

In the UK there is currently no source of data that that allows for representative population estimates for sex workers.[57] However it is estimated that there are over 72,800 people involved in sex work in the UK. [58] Sex workers in the UK face significant health inequalities, with their sexual health often being compromised by a combination of socio-economic, legal, and structural barriers. The criminalization of sex work in certain contexts, combined with stigma and discrimination, creates an environment where sex workers are reluctant to seek healthcare for fear of judgment or legal repercussions. As a result, sex workers are more vulnerable to sexually transmitted infections (STIs), including HIV, and experience higher rates of violence and mental health issues[59]. Small scale research has suggested that only 46% of street-based sex workers had accessed STI testing in the past year, which contributes to late diagnoses of STIs[60]. Sexual health surveillance data for 2019 shows only 6,531 people identified as a sex worker to sexual health services, potentially missing opportunities for interventions such as hepatitis B vaccination or PrEP[61]. Furthermore, the lack of targeted sexual health services designed with the needs of sex workers in mind often means that they receive suboptimal care, which can exacerbate existing health inequalities. Factors such as substance use, experiences of violence, and social marginalization, including those related to ethnicity, gender, and immigration status, further compound these health challenges.

In Warrington, Axess sexual health service have recently launched a new Gold Card scheme for sex workers and those working in the adult entertainment industry. Patients who disclose, when asked a question on assessment, that they have sold or are selling sex will be issued with a credit card sized Gold Card. An alert will also be added to their electronic patient record that highlights them as a Gold Card member. The Gold Card permits the holder to attend any Axess clinical site at any time the clinic is open and guarantees they will be triaged on the day even if the clinic is full.
On the patient record of these patients there is a new drop-down list of additional questions to identify potential risks the patient may be facing at work. The drop-down list also serves as a prompt to offer PrEP, vaccinations, LARC and extra condoms to all commercial sex workers that are eligible.

This scheme will also enable the Outreach Team to monitor and support commercial sex workers that are seen and tested on outreach. Online commercial sex workers, if not working from home, often move working premises including hotels, Airbnb's, student halls and can frequently change phone numbers, making it difficult to reach patients and maintain contact following an opportunistic test. This scheme will give the patient the opportunity to call into any Axess clinics at

[57] Prostitution_and_Sex_Work_Report.pdf
[58] bashh-clinical-standards-for-the-sexual-health-care-of-people-involved-in-sex-work-final-v1-002.pdf
[59] Platt, Lucy et al. "Associations between sex work laws and sex workers' health: A systematic review and meta-analysis of quantitative and qualitative studies." *PLoS medicine* vol. 15,12 e1002680. 11 Dec. 2018, doi: 10.1371/journal.pmed.1002680
[60] Jeal, Nikki, and Chris Salisbury. "Self-reported experiences of health services among female street-based prostitutes: a cross-sectional survey." *The British journal of general practice: the journal of the Royal College of General Practitioners* vol. 54,504 (2004): 515-9.
[61] bashh-clinical-standards-for-the-sexual-health-care-of-people-involved-in-sex-work-final-v1-002.pdf

their own convenience and a review of notes will indicate if a treatment is required. A follow up appointment will be made for any treatment required not available at that time.

As shown in table 12 below the proportion of appointment attendances by sex workers has been increasing by half from 2023 (0.3%) to 0.6% in 2024. In the first 3 months of 2025 there has been increase in attendances with 2.1% of total appointments being taken by sex workers, suggesting good engagement with this population. Axess has bought in the gold card scheme and increased engagement, also clinicians have become more aware of asking patients about their participation in sex work, likely leading to the increase in reporting for this group.

Table 12: Proportion of attendances in sexual health services in Warrington by sex workers by year.

Year	Data Period	Sex worker appointments (% of total appointments)
2023	12 months	0.3%
2024	12 months	0.6%
2025	3 months	2.1%

Source: Axess sexual health service

5.8 Substance misuse

If a person is under the influence of drugs and/or alcohol, they are less likely to consider using condoms during sex and be less aware of other risks which may increase the risk of STI transmission. Research has shown strong associations between substance misuse, poor sexual outcomes and increased high risk sexual behaviour in young people[62]. Research shows that those who report being drunk as their main reason for first intercourse were more likely to be under 16 and report not using contraception. Adults who use alcohol heavily are also more likely to report larger numbers of partners and unprotected sex[63].

Chemsex refers to the use of drugs to enhance sexual experiences, with substances like methamphetamine, GHB, and mephedrone being commonly involved, this behaviour is associated with higher-risk sexual practices. While only a minority of GBMSM engage in chemsex, this practice is most commonly seen in this community. Research indicates that HIV-positive GBMSM are more likely to engage in chemsex than their HIV-negative peers[64]. Furthermore, those who participate in chemsex are more likely to report high-risk sexual behaviours, such as condomless anal sex,

[62] Khadr SN, Jones KG, Mann S*, et al* Investigating the relationship between substance use and sexual behaviour in young people in Britain: findings from a national probability survey *BMJ Open* 2016;**6:** e011961. doi: 10.1136/bmjopen-2016-011961

[63] Catherine R.H. Aicken, Anthony Nardone, Catherine H. Mercer, Alcohol misuse, sexual risk behaviour and adverse sexual health outcomes: evidence from Britain's national probability sexual behaviour surveys, *Journal of Public Health*, Volume 33, Issue 2, June 2011, Pages 262–271, https://doi.org/10.1093/pubmed/fdq056

[64] Maxwell, Steven, Maryam Shahmanesh, and Mitzy Gafos. "Chemsex behaviours among men who have sex with men: A systematic review of the literature." *International Journal of Drug Policy* 63 (2019): 74-89.

compared to those who do not engage in chemsex. This underscores the increased risk of STI transmission, including HIV, associated with this practice[65].

5.9 Intersectionality

As highlighted in the UKHSA STI prioritisation framework, there was an acknowledgment by experts of intersectionality between groups of high risk. Many individuals will face multiple risk factors and disadvantage and the complex interplay between these factors may lead to disproportionate poor sexual health outcomes if not considered within interventions. Therefore, services must consider how to tailor and adapt services to meet the needs of the individual.

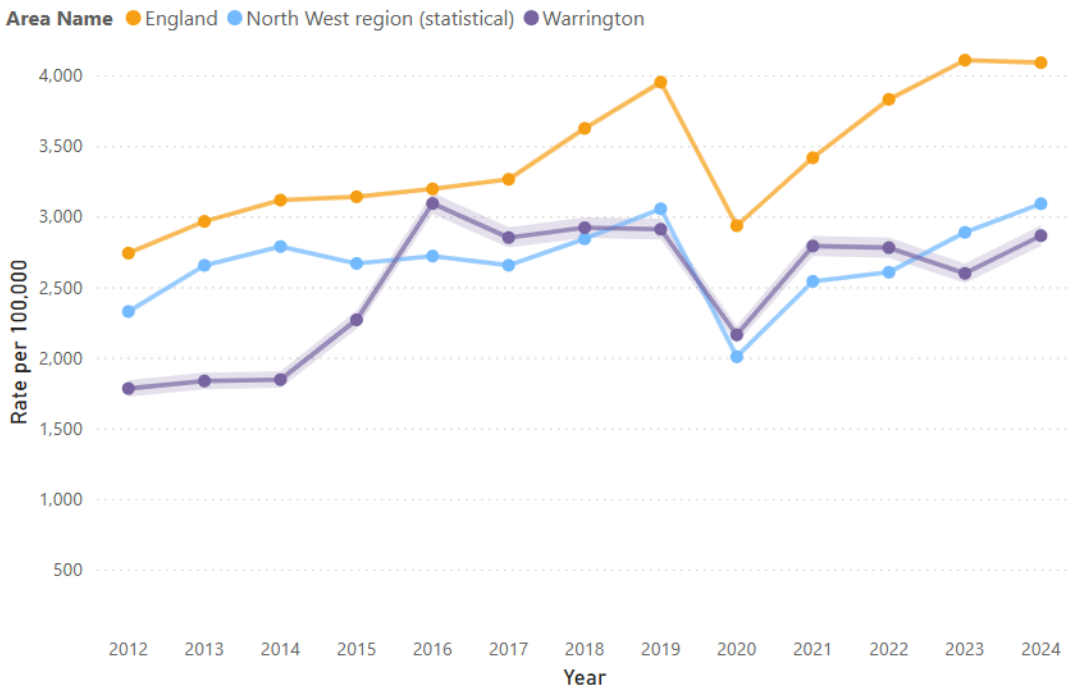
[65] Maxwell, Steven, Maryam Shahmanesh, and Mitzy Gafos. "Chemsex behaviours among men who have sex with men: A systematic review of the literature." *International Journal of Drug Policy* 63 (2019): 74-89.

6. SEXUALLY TRANSMITTED INFECTIONS (STI's)

Sexually transmitted infections (STIs) are often asymptomatic but can cause long-term harm, including pelvic inflammatory disease (PID), infertility, and ectopic pregnancy. Vaccinations have decreased the spread of Hepatitis A and B and genital warts, but correct condom use is still the best form of prevention for all STIs. Behaviour change to avoid multiple and overlapping sexual partners, prompt testing and treatment and efficient partner notification schemes are also important. The UK Health Security Agency (UKHSA) recommends regular STI testing in those most at-risk, for example young people aged 15-24.

Between 2010 and 2019, national rates of chlamydia, gonorrhea, and syphilis increased. These rates declined during the COVID 19 pandemic period 2020-21 but have since risen again, some surpassing pre-pandemic levels. There is particular concern about gonorrhoea, as some strains have become resistant to antibiotics.[66] In 2024, Warrington's overall STI testing rate was 2,863.61 per 100,000, significantly lower than both the England (4,088.84) and the North West average (3,089.87) (Figure 11).

Figure 11: STI testing rate (Excluding chlamydia aged under 25) per 100,000 (shaded area represents 95% confidence intervals)

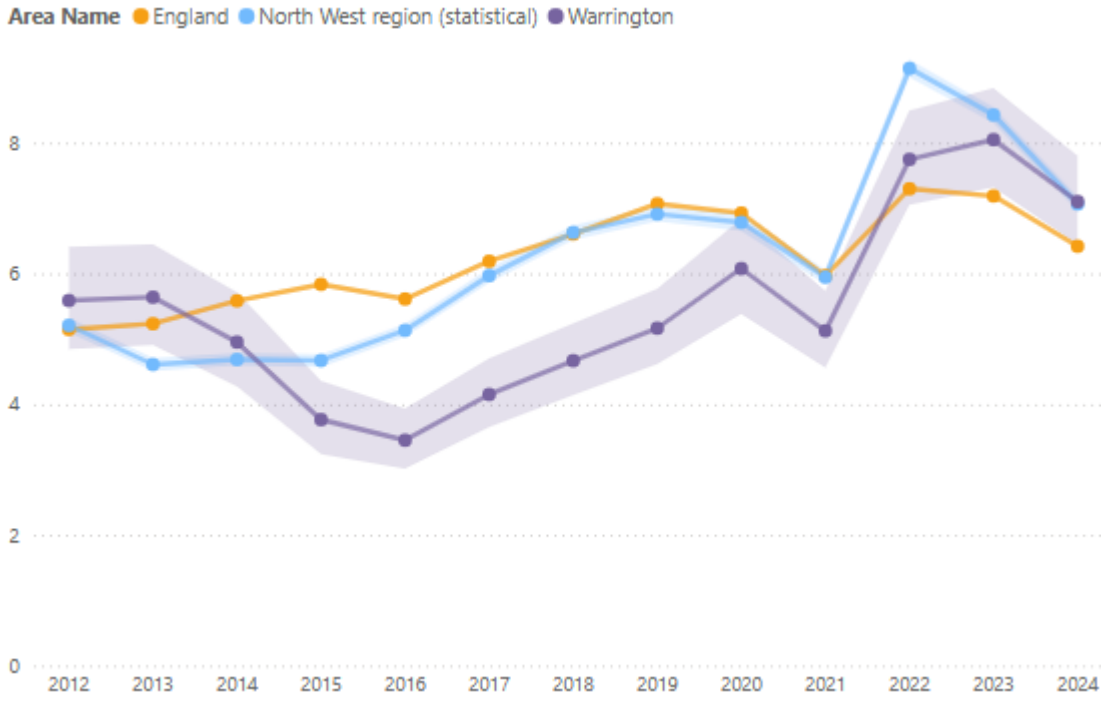


Source: UKHSA [Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)] ©Crown copyright 2024 (accessed 10/06/2025)

[66] UKHSA 2024, Summary profile of local authority sexual health (SPLASH report) Warrington, [SPLASH Warrington 2024-01-30 (phe.org.uk)] (accessed 17/06/2024)

In line with national and regional trends, test positivity in Warrington has been increasing since 2016, except for a decline during the COVID-19 pandemic. Over the past year however, there has been approximately 1% decrease in test positivity. Since 2022 Warrington's positivity has surpassed England and in 2024, the test positivity rate in Warrington was 7.10%, but this was not statistically different from the North West (7.07%) or the national average for England (6.42%) (figure 12).

Figure 12: STI positivity (%) (Excluding chlamydia aged under 25) (shaded area represents 95% confidence intervals)

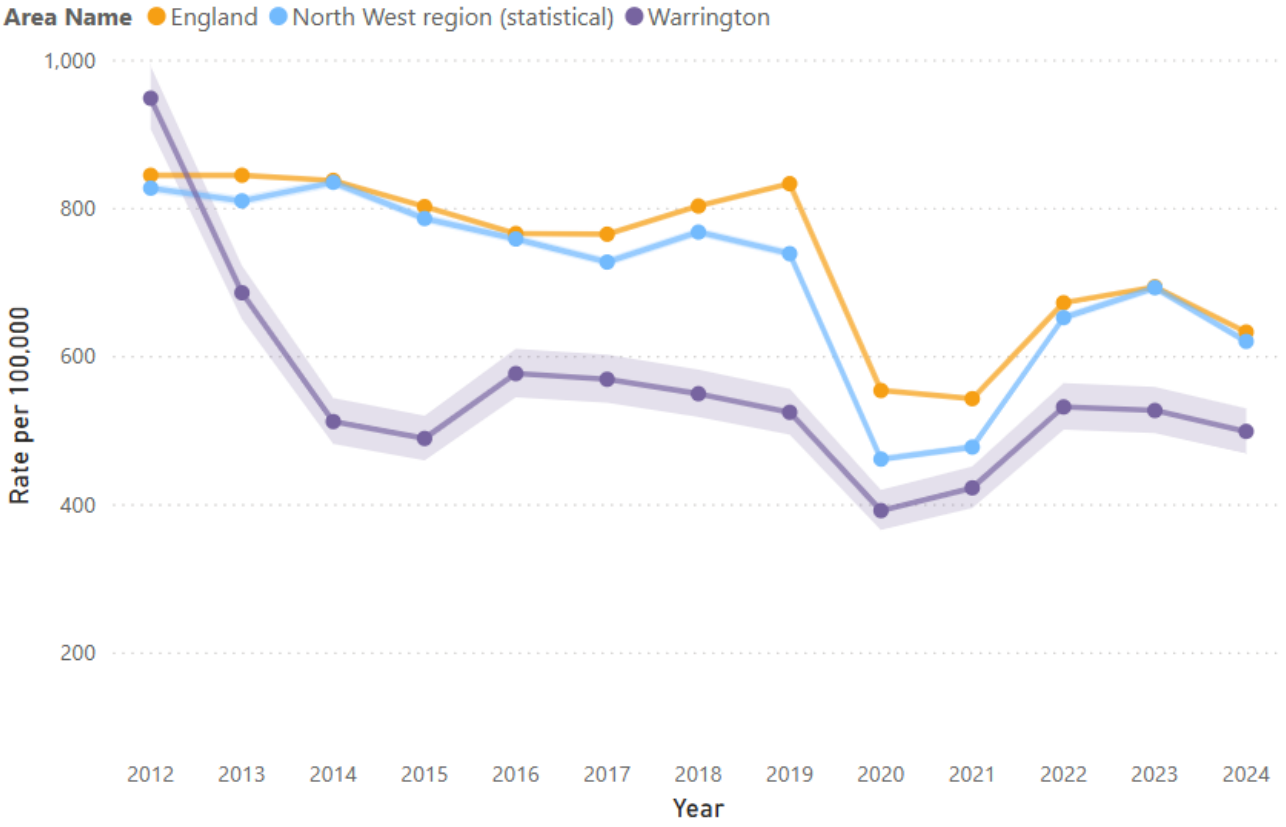


Source: UKHSA Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk) ©Crown copyright 2024 (accessed 10/06/2025)

6.1 New STIs

A total of 1,058 new STIs[67] were diagnosed in Warrington residents during 2024, a 5.45% decrease from the previous year. This included 492 chlamydia diagnoses, of which 250 were in young people aged 15-24 years and 240 in people aged twenty-five and over, 213 gonorrhoea diagnoses and twenty-two diagnoses of syphilis. Further information on diagnoses of other less prevalent STIs can be found in appendix 2. Overall, there has been a downward trend in STI diagnoses in Warrington and rates remain significantly below England and North West averages. In 2024 the diagnoses rate of all new STIs in Warrington was below pre-pandemic rates (figure 13 and 14).

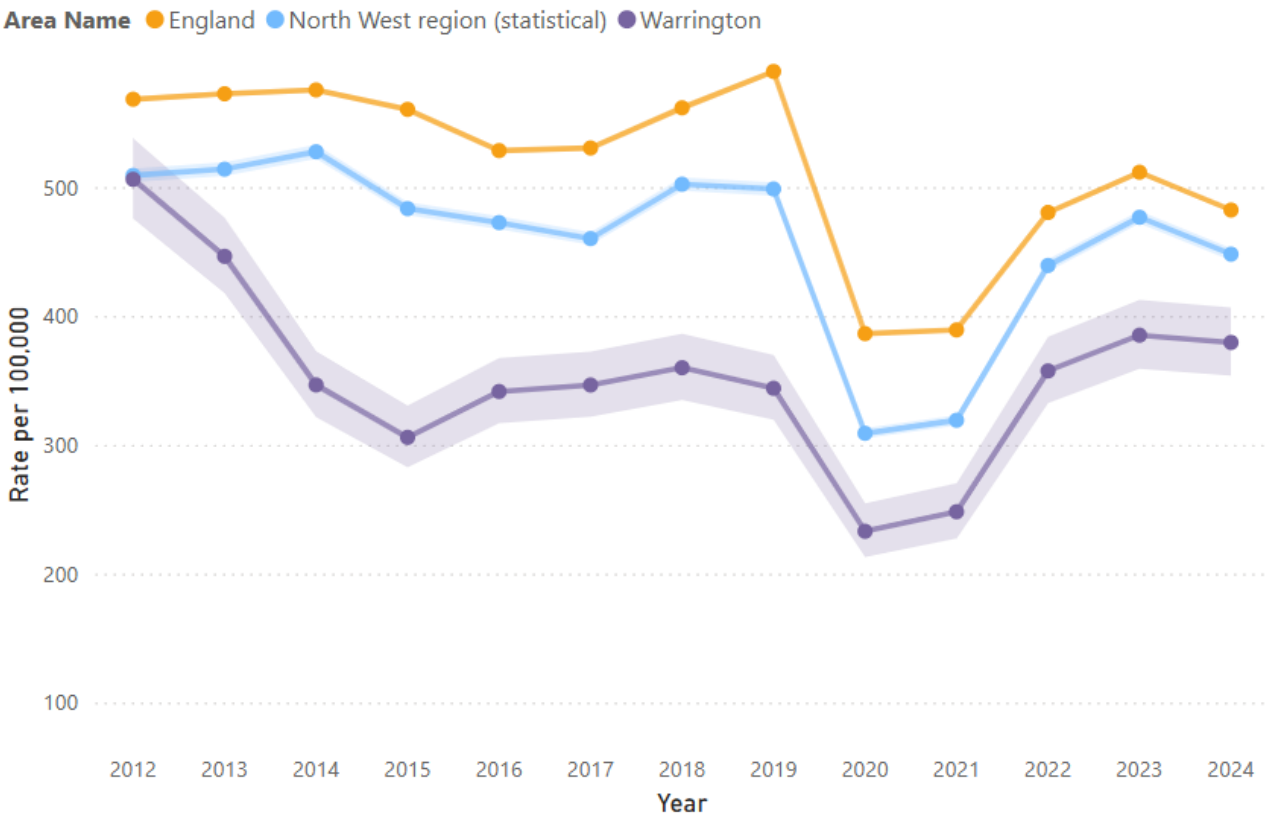
Figure 13: All new STI diagnoses per 100,000, (shaded area represents 95% confidence intervals)



Source: UKHSA [Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)] ©Crown copyright 2024 (accessed 10/06/2025)

[67] New STIs include all diagnoses of chancroid, chlamydia, donovanosis, gonorrhoea, herpes – anogenital herpes (1st diagnosis), HIV – new diagnosis**, lymphogranuloma venereum, molluscum contagiosum**, mycoplasma genitalium**, non-specific genital infection, pelvic inflammatory disease (PID), non-specific epididymitis**, chlamydia PID and epididymitis, gonorrhoea PID and epididymitis, scabies and pediculosis pubis**, shigella – flexneri, sonnei and unspecified**, syphilis – primary, secondary and early latent, trichomoniasis, warts - anogenital warts (1st diagnosis). **STI diagnoses (including HIV) not exclusively transmitted by sexual contact.

Figure 14: New STI diagnoses (excluding chlamydia aged under 25) per 100,000, (shaded area represents 95% confidence intervals)

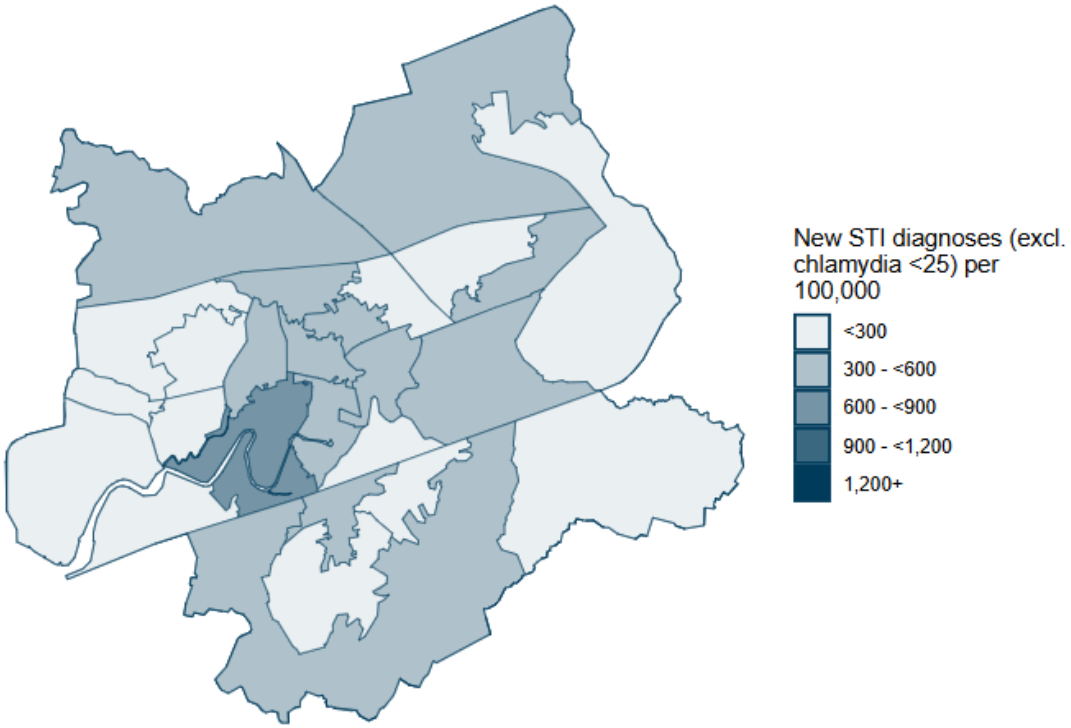


Source: UKHSA Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk) ©Crown copyright 2024 (accessed 10/06/2025)

As shown in figure 15, MSOAs located in central Warrington near Bewsey and Great Sankey south have the highest rate of New STI diagnoses in Warrington (900-<1,200 per 100,000). In 2023 in Warrington 47.6% of diagnoses of all new STIs (including chlamydia) were in young people aged 15-24 years old, this compares to 41.5% in England. Of these, women aged 20-24 account for the highest proportion of diagnoses. When reviewing the proportion of new STIs by sexual orientation in Warrington, GBMSM accounted for a lower proportion of all diagnosis when compared with the England average[68], however this is a crude proportion and does not account for underlying differences in population demographics and Warrington has a known population of GBMSM lower than the England average.

[68] GUMCAD STI Surveillance System - GOV.UK (restricted access)

Figure 15: Map of new STI diagnoses (excluding chlamydia in under 25-year-olds) per 100,000 population in Warrington by Middle Super Output Area: 2023



Source: UKHSA SPLASH

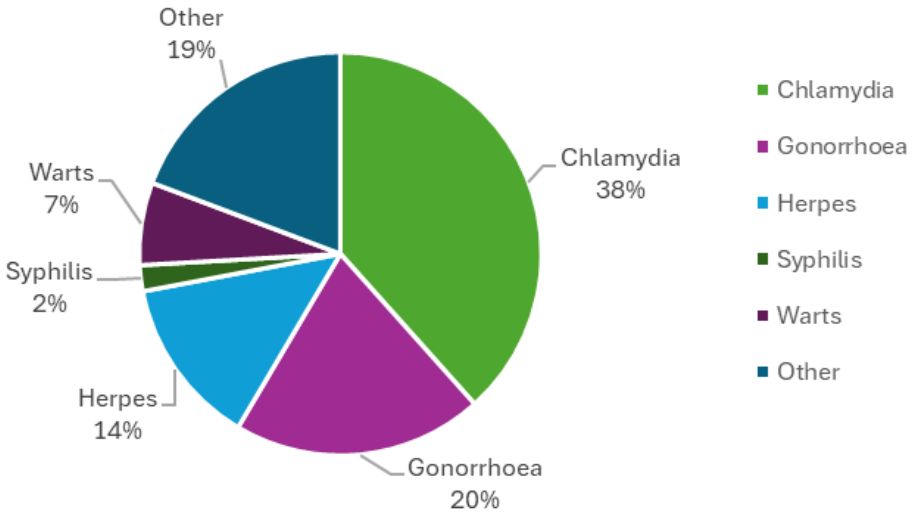
Reinfection with an STI within 12 months of a previous infection suggests ongoing transmission within the population. Between 2019 and 2024, the reinfection rate in Warrington in females was lower than the national average in England, and in males, it was almost half the national average.[69].

6.2 Bacterial and viral infections

In 2024, chlamydia accounted for the largest proportion of new STI diagnoses in Warrington at 38%, followed by gonorrhoea (20%) and herpes (14%). Chlamydia, gonorrhoea and syphilis are bacterial infections whilst genital warts, herpes and HIV are all viral infections.

[69] GUMCAD STI Surveillance System - GOV.UK Splash report (restricted access)

Figure 16: Proportion of all new STIs diagnosed in Warrington residents 2024



Source: GUMCAD

6.3 Chlamydia

Chlamydia is the most common STI and the leading cause of avoidable sexual and reproductive ill-health[70]. Chlamydia testing is monitored by the National Chlamydia Screening Programme (NCSP).

Rates of chlamydia infection are highest among sexually active young people aged 15-24. Chlamydia is often asymptomatic but can have far-reaching consequences in terms of fertility, so the NCSP focuses on detection in females and others with a womb or ovaries in this age group through opportunistic screening. High levels of screening in this demographic will detect more cases and, in 2021 the NCSP updated the national indicator definition and targets, such that it now focuses on females aged 15-24 and sets an ambitious target of 3,250 positive diagnoses per 100,000[71][72] Diagnoses are RAG rated against the target, with a diagnosis rate of less than 2,400 per 100,000 rated red; between 2,400 and 3,249 rated amber; and a rate of 3,250 cases and above rated green. Chlamydia detection rates are not a measure of morbidity but are a measure of screening activity.

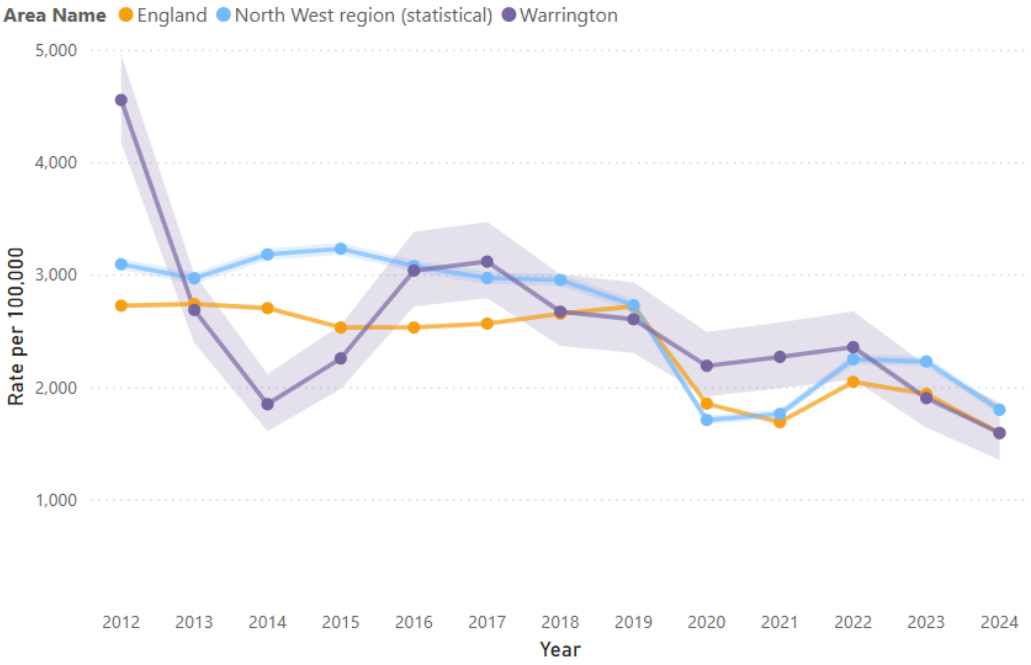
In 2024, Warrington had a chlamydia detection rate of 1,590.16 per 100,000 females. This was not significantly different from England and the North West and below the thresholds of 2,400 and 3,250 per 100,000. In 2024, there were 159 cases of chlamydia detected among the 1,792 females screened. Figure 17 below shows the trend in detection rates for females aged 15-24 in Warrington, the North West and England.

[70] UKHSA 2022, Chlamydia: surveillance, data, screening and management - GOV.UK (www.gov.uk) (accessed 17/06/2024)
[71] Public Health England, 2021, Changes to the national chlamydia screening programme (NCSP), Changes to the National Chlamydia Screening Programme (NCSP) - GOV.UK (www.gov.uk) (accessed 21/06/2024)

The number screened represented 17.9% of the eligible population, a slight decrease from the previous year (18%). To increase the detection rate, it will be necessary to ensure that more females in this age group are screened. CTAD data from 2024 shows test positivity in females aged 15-24 remains highest in those from White or Mixed ethnic backgrounds.

CTAD data from 01/2023-12/2023 shows that in Warrington the highest proportion of women screened for chlamydia were aged between 25-34 (approx.36%), followed by those over the age of 35, whilst only 30% of tests were conducted in those aged 15-25. However, those in the youngest age band had the highest test positivity. When reviewing where these women accessed testing all groups mainly access through GUM clinics, internet services or other services, with very low numbers accessing testing through pharmacies or GP services. Those aged 15-24 were most likely to access through GUM or internet services. As age increased, the higher proportion of tests were accessed through 'other' services and less were accessed through internet services. This population may be more likely to be screened through maternity services, accounting for this variation.

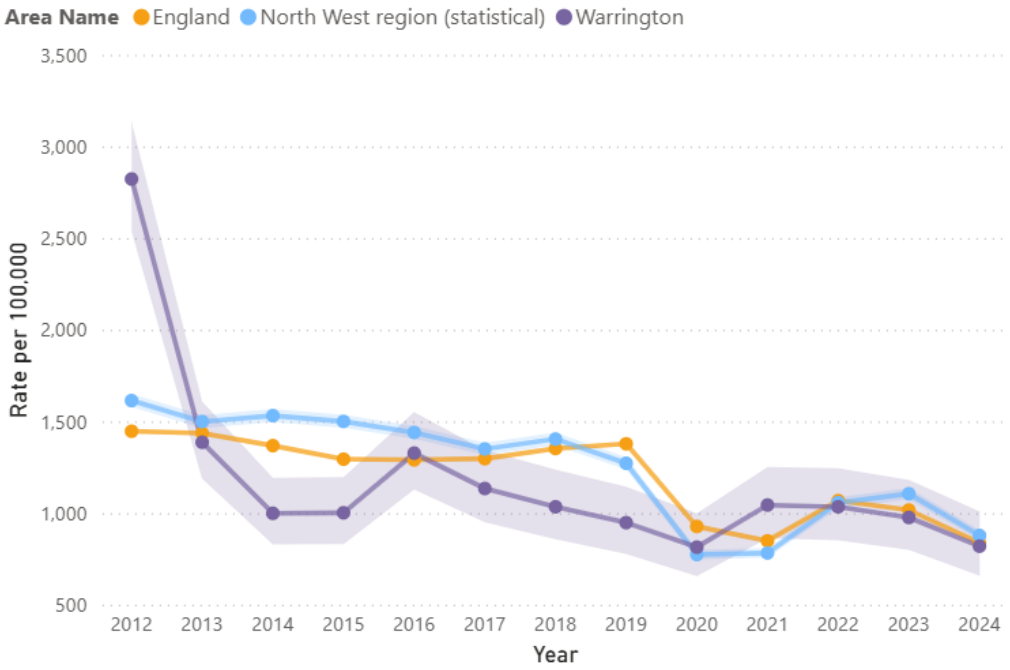
Figure 17: Chlamydia detection rate per 100,000 aged 15 to 24 (females), (shaded area represents 95% confidence intervals)



Source: UKHSA [Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)] ©Crown copyright 2024 (accessed 10/06/2025)

Figure 18 below shows the chlamydia detection rate for males aged 15–24. The trend mirrors that observed in females; however, the detection rate per 100,000 is significantly lower in males. This is expected, as this population is not routinely screened.

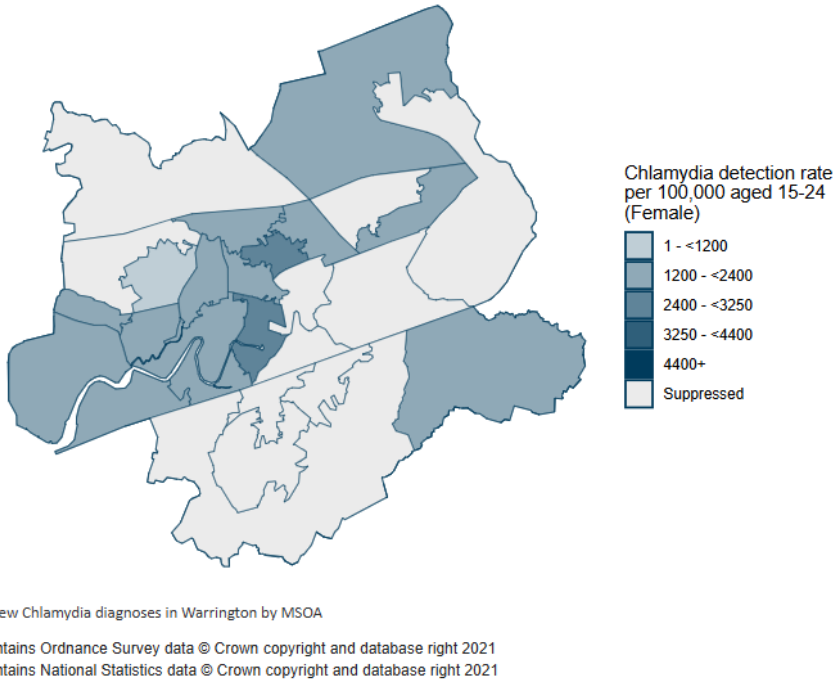
Figure 18: Chlamydia detection rate per 100,000 aged 15-24 (males) (shaded area represents 95% confidence intervals)



Source: UKHSA [Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)] ©Crown copyright 2024 (accessed 10/06/2025)

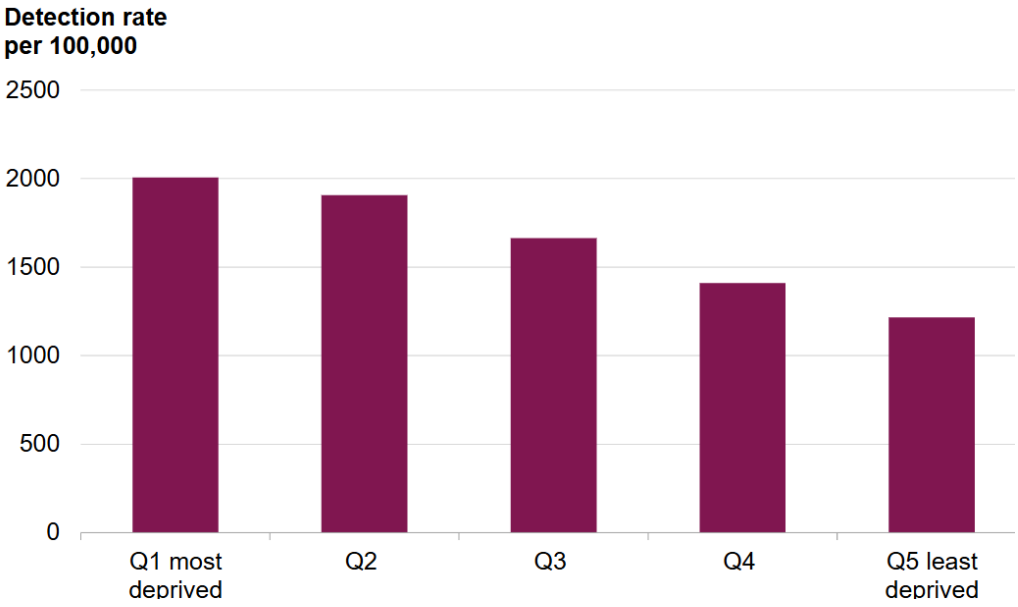
Figure 19 below shows the chlamydia detection rate per 100,000 among individuals aged 15–24 in Warrington by ward. The highest rates are observed in the central wards, which are also the most deprived areas of the borough. While young women under 25 have the highest chlamydia detection rates compared to other groups, these rates are also strongly influenced by levels of deprivation. As illustrated in figure 20, women aged 15-24 living in the most deprived areas across England have significantly higher detection rates than those in the least deprived areas. Warrington reflects this national pattern, with a clear correlation between higher detection rates and areas of greater socioeconomic disadvantage, highlighting the importance of targeted sexual health interventions and outreach in these communities.

Figure 19: Map of chlamydia detection rate per 100,000 females aged 15 to 24 in Warrington by Middle Super Output Area: 2023



Source: UKHSA SPLASH report

Figure 20: Chlamydia detection rates (per 100,000) among women aged 15 to 24 years by IMD quintile, 2024, England.

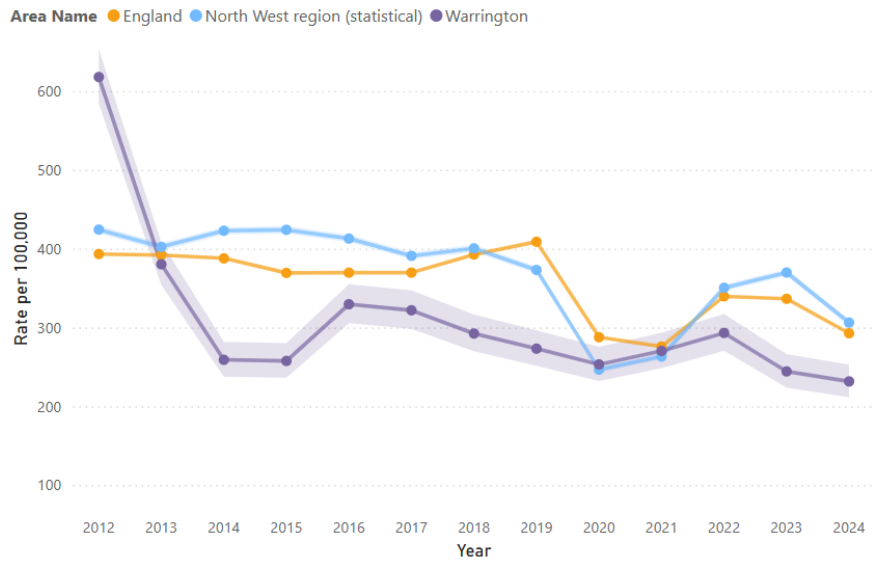


Source: Sexually transmitted infections and screening for chlamydia in England: 2024 report - GOV.UK (accessed 10/06/25)

NCSP data presented by IMD quintile is based on the location of residence of the person tested

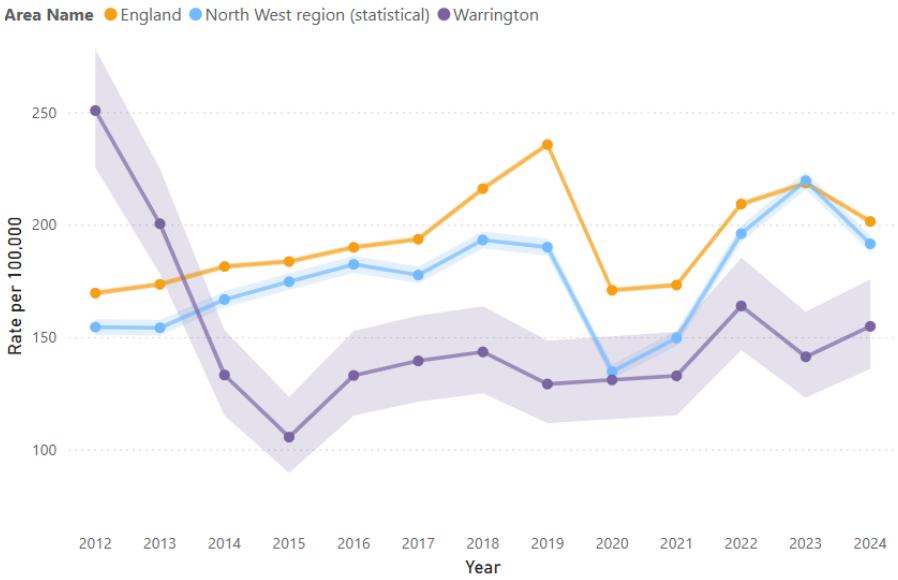
In Warrignton the overall chlamydia diagnosis rate per 100,000 is also declining in Warrington, which aligns with the observed decrease in detection rates, though this trend is less pronounced among adults aged 25 and over. While the diagnostic rate for chlamydia in those aged 25 and over remains significantly below the averages for both England and the North West, it has increased over the past year (figure 21 and 22).

Figure 21**.** Chlamydia diagnostic rate per 100,000 (shaded area represents 95% confidence intervals)



Source: UKHSA [Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)] ©Crown copyright 2024 (accessed 10/06/2025)

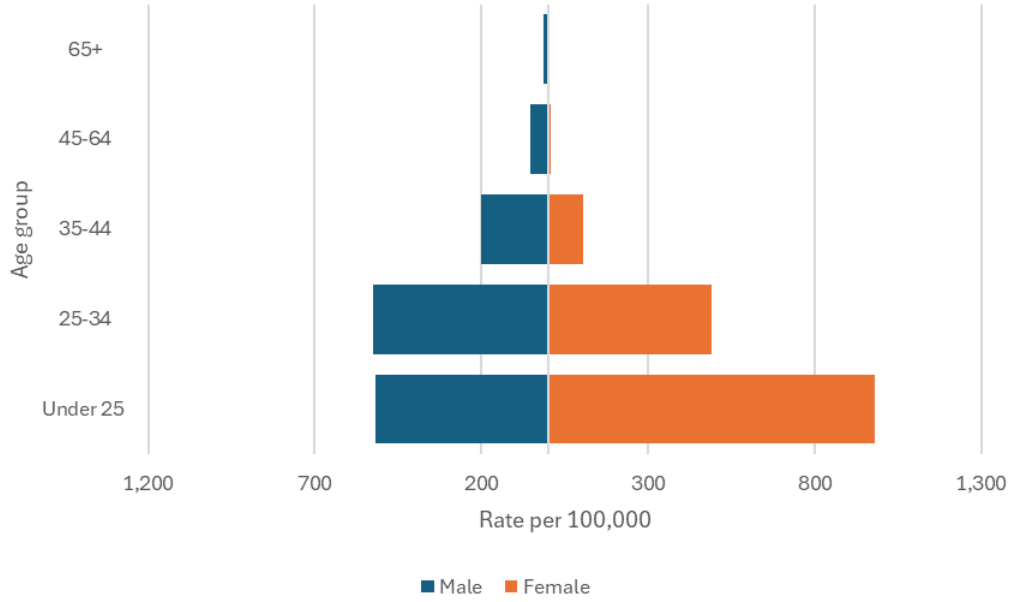
Figure 22: Chlamydia diagnostic rate per 100,000 25 years and older (shaded area represents 95% confidence intervals)



Source: UKHSA [Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)] ©Crown copyright 2024 (accessed 10/06/2025)

Aggregate data from 2022 to 2024 show that, similar to national patterns, chlamydia rates in Warrington were highest among females under the age of 25. However, these elevated rates are likely influenced by targeted screening initiatives focused on this age group. In contrast, chlamydia rates among women aged 25 and over remained consistently lower than those observed in men across the same period (see figure 23).

Figure 23: Rates of chlamydia per 100,000 persons by age and sex between the period of 2022 to 2024, Warrington.



Source: GUMCAD (restricted access)
Aggregated three-year rates are presented due to small population denominators, to prevent deductive disclosure.
As 2024 population estimates were not available at the time of analysis, 2023 estimates were used as a proxy.

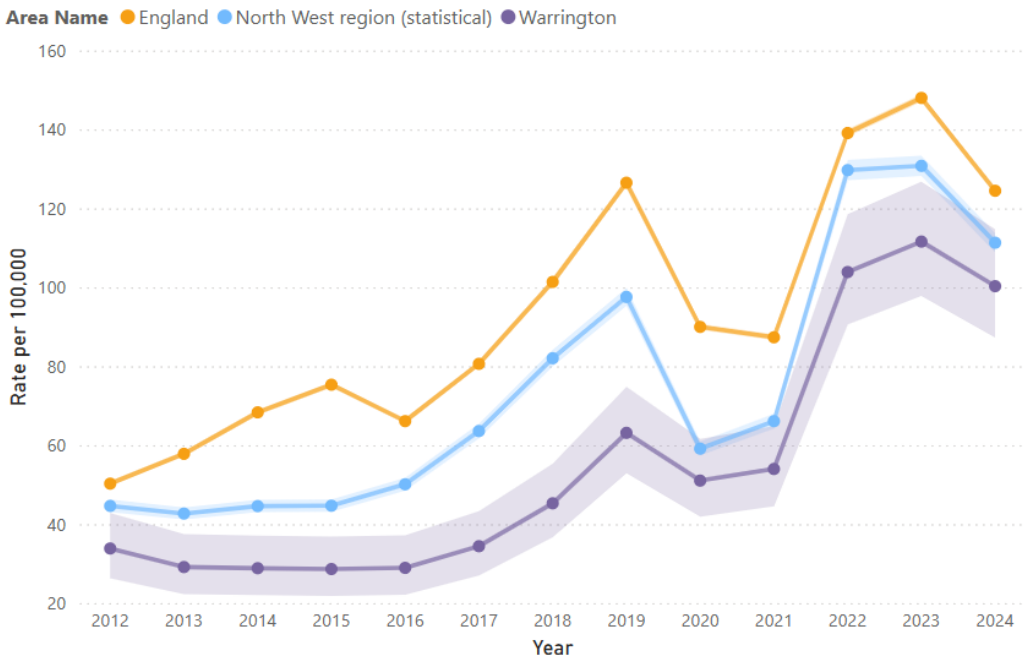
6.4 Gonorrhoea

Gonorrhoea is the second most diagnosed STI after chlamydia and, across England, gonorrhoea diagnoses have more than doubled in the last decade (31,177 in 2013 to 85,223 in 2023)[73]. Gonorrhoea infections are more likely to be symptomatic and are often used as a marker of unsafe sexual activity[74]. A further concern about gonorrhoea is the rise in treatment resistant cases and overall decreasing susceptibility to first line therapeutics[75]. Nationally and locally, the gonorrhoea diagnosis rate has shown an upward trend since 2012. Although there was a temporary decline during the COVID-19 pandemic, rates began to rise again into 2023. However, between 2023 and 2024, there was a 16% decrease in diagnoses, bringing national levels back in line with those seen

[7373] GRASP report: data to August 2024 - GOV.UK
[74] OHID 2024, Sexual and reproductive health profiles, Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk) ©Crown copyright 2024 (accessed 17/06/2024)
[75] UKHSA 2023, Gonococcal resistance to anti-microbials surveillance programme (GRASP) report to June 2023, GRASP report: data to June 2023 - GOV.UK (www.gov.uk), (accessed 21/06/2024)

in 2019. In Warrington and the North West region, a similar reduction in cases was observed between 2023 and 2024. However, current rates remain higher than pre-pandemic levels. In 2024, the gonorrhoea diagnosis rate in Warrington was 100.29 per 100,000 population (figure 24). This was significantly lower than the national rate for England (125.37 per 100,000), but not significantly different from the North West regional rate (111.30 per 100,000). Consistent with national trends, gonorrhoea rates are significantly higher in GBMSM in Warrington.

Figure 24: Gonorrhoea diagnostic rate per 100,000 (shaded areas represent 95% confidence intervals)

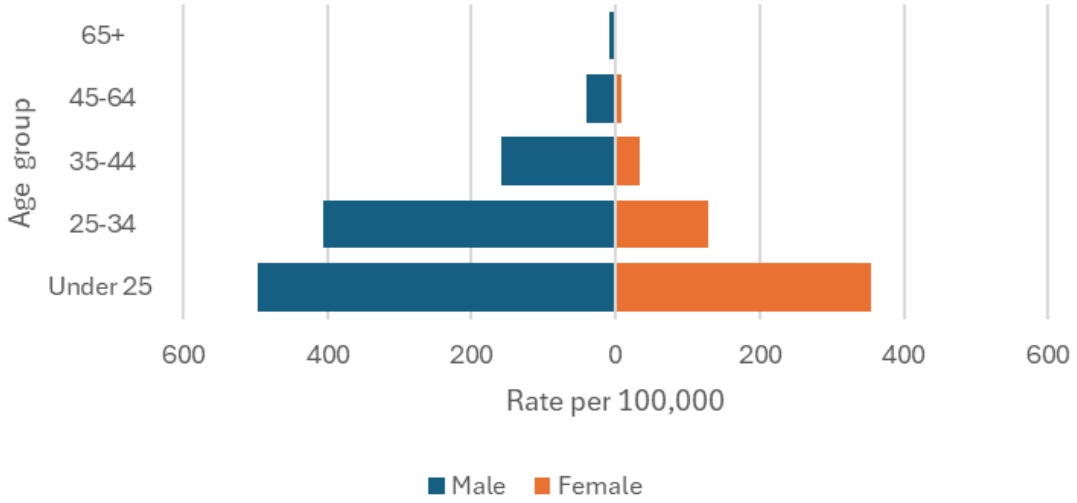


Source: UKHSA [Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)] ©Crown copyright 2024 (accessed 10/06/2025)

Across England, men account for a higher proportion of all gonorrhoea diagnoses than women. This pattern is also seen in Warrington, where around 70% of diagnoses in 2024 occurred in men. In Warrington, the gonorrhoea diagnosis rate in men has been sharply increasing since the pandemic, this relationship has not been observed in women. In 2024, among women, those aged 20–24 account for the highest proportion of diagnoses, while amongst men, the highest proportion is seen in the 25–34 age group.

Figure 25 presents aggregate data from 2022 to 2024 across Warrington, showing that gonorrhoea diagnosis rates are highest among men under the age of 25. Across all age groups, men consistently exhibit higher rates of gonorrhoea than women. However, for both sexes, the under-25 age group experiences the highest overall rates of infection.

Figure 25: Rates of gonorrhoea per 100,000 persons by age and sex between the period of 2022 to 2024, Warrington.



Source: GUMCAD restricted access
Aggregated three-year rates are presented due to small population denominators, to prevent deductive disclosure.
As 2024 population estimates were not available at the time of analysis, 2023 estimates were used as a proxy.

In November 2023, the Joint Committee on Vaccination and Immunisation (JCVI) recommended the introduction of a targeted, opportunistic vaccination programme for gonorrhoea to be delivered through sexual health services. This programme will use the 4-component serogroup B meningococcal vaccine (4CMenB), which targets *Neisseria meningitidis*, a bacterium closely related genetically to *Neisseria gonorrhoeae*. Research has shown that this vaccine provides some cross-protection against gonorrhoea infection. The programme is aimed at individuals most at risk of gonorrhoea, including gay, bisexual, and other men who have sex with men (GBMSM), as well as transgender women, gender-diverse people assigned male at birth, and heterosexuals at similar risk. Starting in August 2025, local authority services, in collaboration with NHS England (NHSE), will deliver the vaccine through commissioned services, including all sexual health clinics. In addition to reducing the incidence of gonorrhoea, the programme is also expected to have a positive impact on antimicrobial resistance, by reducing the number of infections requiring treatment.

6.5 Syphilis

Syphilis is caused by the bacterium *Treponema pallidum*, and if left untreated, it can lead to serious and potentially life-threatening complications. It remains a significant public health concern, particularly among gay, bisexual, and other men who have sex with men (GBMSM), where incidence has generally increased over the past decade.

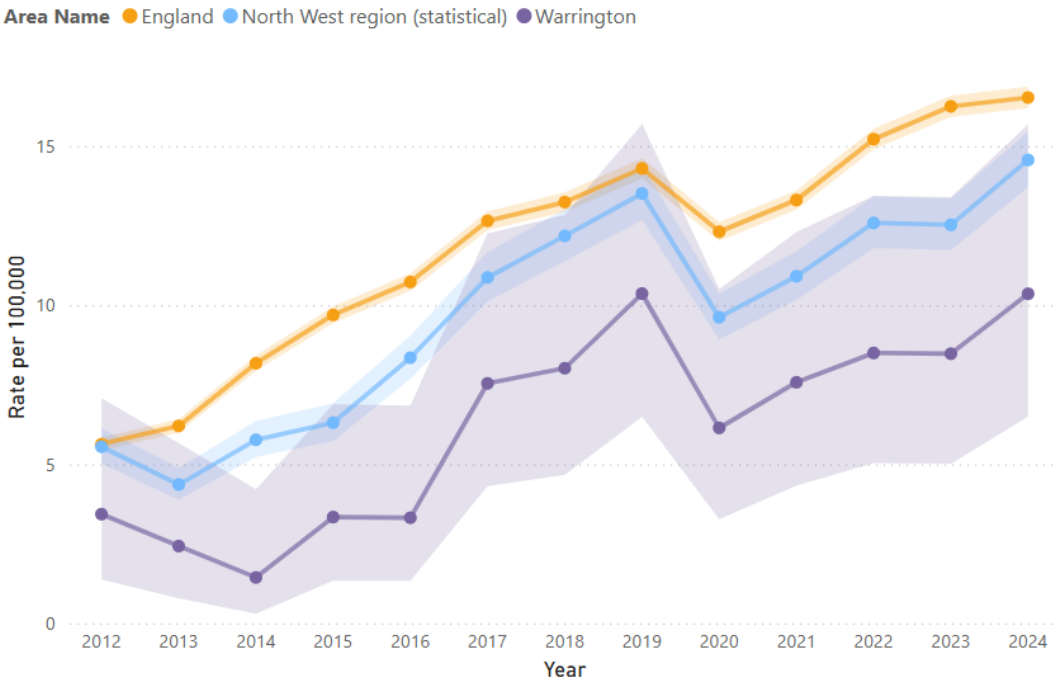
Since 2012, there has been a notable rise in syphilis diagnosis rates, and in 2024, the number of reported cases in England reached the highest level since 1948[76]. Nationally, the diagnostic rate

[76] Sexually transmitted infections and screening for chlamydia in England: 2024 report - GOV.UK

in 2022 surpassed pre-pandemic levels seen in 2019. However, in Warrington and the North West, rates have only returned to pre-pandemic levels in 2024.

In Warrington, syphilis rates are increasing in line with national trends, currently at 10.36 per 100,000 population (figure 26). While this is significantly lower than the national rate for England (16.53 per 100,000), it is not significantly different from the North West rate of 14.57 per 100,000.

Figure 26: Syphilis diagnostic rate per 100,000 (shaded area represents 95% confidence intervals)

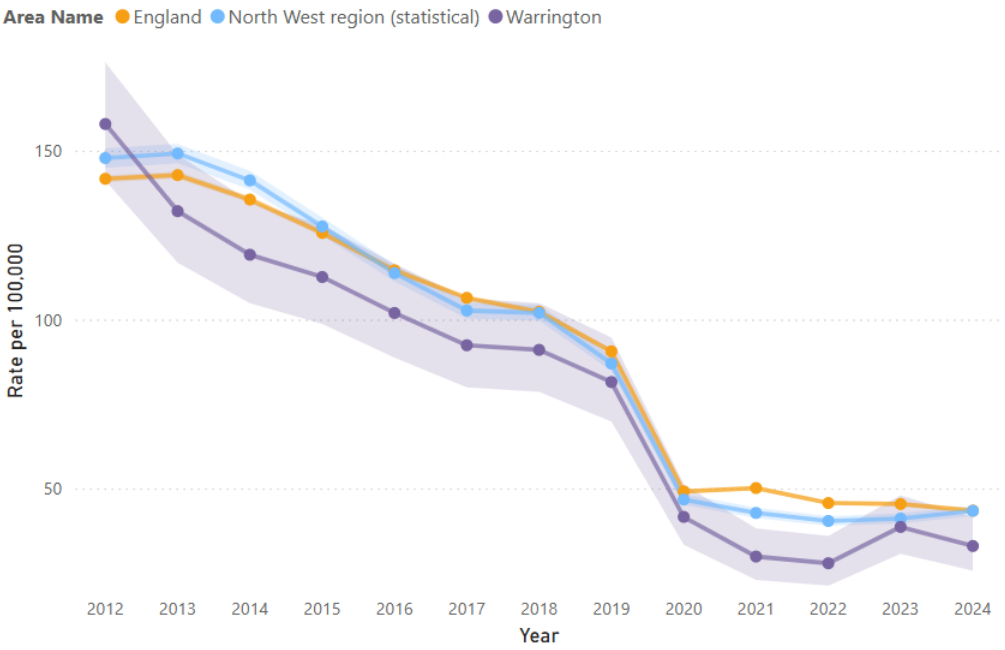


Source: UKHSA Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk) ©Crown copyright 2024 (accessed 10/06/2025)
All infectious syphilis (primary, secondary and early latent) diagnoses

6.6 Genital Warts

Diagnoses of genital warts have seen a downward trend since the introduction of the HPV vaccination, which since 2008 has been given to girls and since 2019 to boys and girls in year 8 (age 12-13) with rates in Warrington below the England and Northwest averages. Whilst there has been a small increase between 2023 and 2024, Warrington's rate (32.96 per 100,000) remains statistically similar to England and the North West (figure 27).

Figure 27: Genital warts diagnostic rate per 100,000, (shaded area represents 95% confidence intervals)



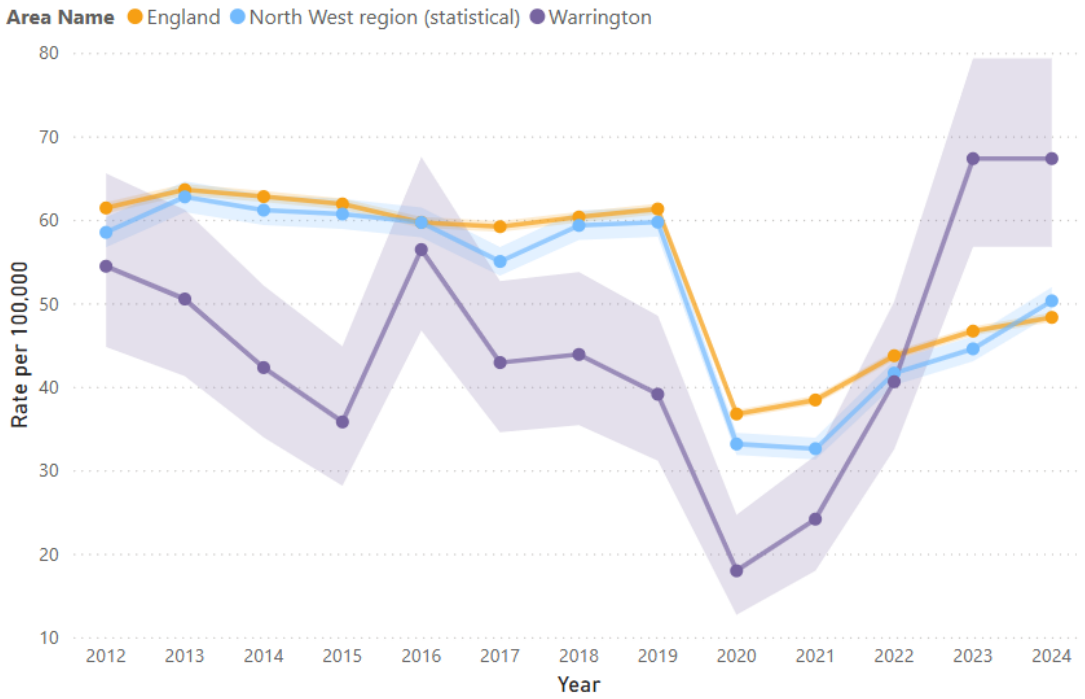
Source: UKHSA [Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)] ©Crown copyright 2024 (accessed 10/06/2025)

6.7 Genital Herpes

Genital herpes is the most common ulcerative sexually transmitted infection (STI), typically caused by the *Herpes Simplex Virus type 1 (HSV-1*), though it can also result from HSV-2 infection. As a viral condition, HSV maintains relatively stable prevalence rates within populations, and outbreaks of genital herpes are not usually associated with widespread transmission. The Office for Health Improvement and Disparities (OHID) advises caution when comparing data from before and after 2021 due to changes in how population estimates are calculated. Between 2021 and 2023, the rate of genital herpes diagnoses increased sharply, before plateauing between 2023 and 2024. As shown in Figure 28, Warrington experienced a rise in diagnosis rates from 24.1 per 100,000 population (n=38) in 2021 to 67.3 per 100,000 (n=143) in 2024. This rate is significantly higher than both the regional average for the North West and the national average for England.

It is likely that the increase in Warrington is due to a combination of factors including a move from local to central results management meaning that GUMCAD coding is more accurate, large increases in patients being seen in the sexual health service, enabling early diagnosis from both symptoms and confirmatory lab testing, and a catch-up effect following the Covid pandemic.

Figure 28: Genital herpes diagnostic rate per 100,000, (shaded area represents 95% confidence intervals)



Source: UKHSA [Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)] ©Crown copyright 2024 (accessed 10/06/2025)

6.8 Hepatitis

Hepatitis refers to inflammation of the liver, most commonly caused by viral infections such as hepatitis A, B, and C. These infections can lead to both acute and chronic liver disease, and while transmission routes vary, hepatitis B and C can be spread through blood and bodily fluids, including via sexual contact. Hepatitis B is preventable through vaccination; pre-exposure vaccination courses are offered to individuals at high risk of exposure to the virus or at risk of the complications of the disease if infected. These high-risk groups include, GBMSM, individuals who change sexual partners frequently including sex workers, those living with HIV and people who inject drugs (PWID). Coinfection with Hepatitis is a significant concern for those living with HIV as conditions associated with hepatis B and C are among the leading causes of hospital admissions and death in this population [77].Post exposure prophylaxis is also offered to those who have been recently exposed to Hepatitis B[78]. In 2024, over 200 hepatitis B vaccinations were provided by Axess sexual health service.

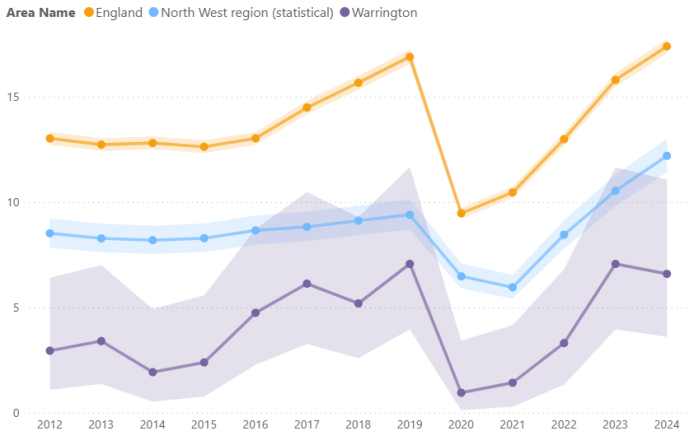
Hepatitis A is generally transmitted through food and water contaminated by faeces however it can also be transmitted during sexual contact. GBMSM are particularly at risk of infection and are offered vaccination through sexual health services.

[77] Hepatitis B Foundation: HIV/AIDS and Hepatitis B Coinfection
[78] Green Book on Immunisation Chapter 18 Hepatitis B

6.9 Trichomoniasis

Trichomoniasis is a STI caused by a protozoan parasite called *Trichomonas vaginalis*. It primarily affects the urogenital tract in both men and women. Many individuals with trichomoniasis may be asymptomatic it can persist for months if left untreated. Although less common than other STIs such as chlamydia or gonorrhoea, trichomoniasis remains an important sexual health concern due to its potential to increase susceptibility to other infections and the increased risk of PID. The diagnostic rate of trichomoniasis is in Warrington in 2024 was significantly below the average for England (17.4) and the north west (12.2), with a rate of 6.56 per 100,000 (figure 29).

Figure 29: Trichomoniasis diagnostic rate per 100,000.



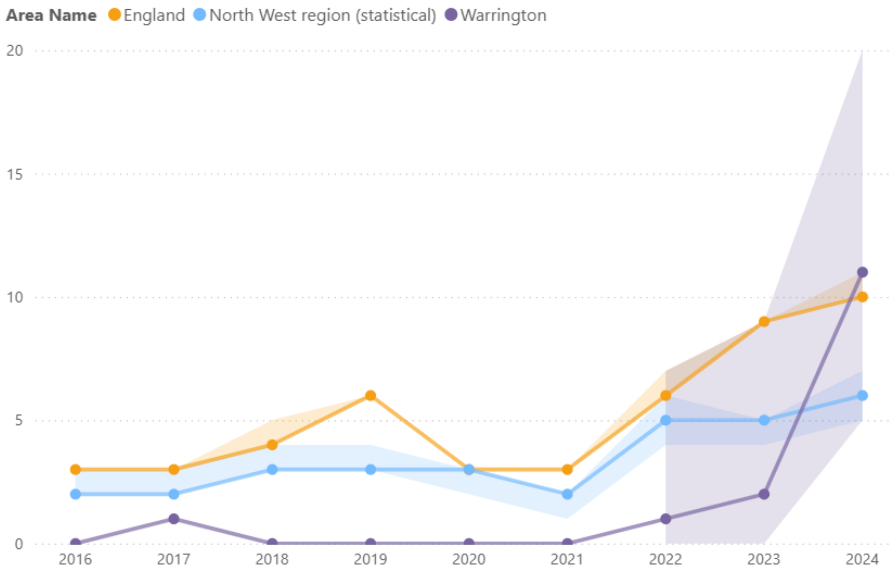
Source: UKHSA [Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)] ©Crown copyright 2024 (accessed 10/06/2025)

6.10 Shigella

Shigella spp. cause shigellosis, a leading cause of bacterial dysentery worldwide. Transmission occurs via the faecal-oral route and, while commonly associated with poor food and water hygiene, it can also be spread through sexual contact, particularly among GBMSM. In 2024, England saw a 13% increase in cases of sexually transmitted shigellosis, including a rise in extensively drug-resistant strains[79]. In Warrington, rates of shigellosis remained at zero or very low between 2016 and 2021 but began to rise thereafter. As shown in figure 30, between 2023 and 2024, the rate increased significantly from 2 to 11 per 100,000. This rate is now similar to the national average for England and higher than the North West regional average, although the difference is not statistically significant.

[79] Sexually transmitted infections and screening for chlamydia in England: 2024 report - GOV.UK

Figure 30: Shigella spp. diagnoses among men who have sex with men (defined as adult men without a recent history of foreign travel) as a rate per 100,000 adult male population (16+).

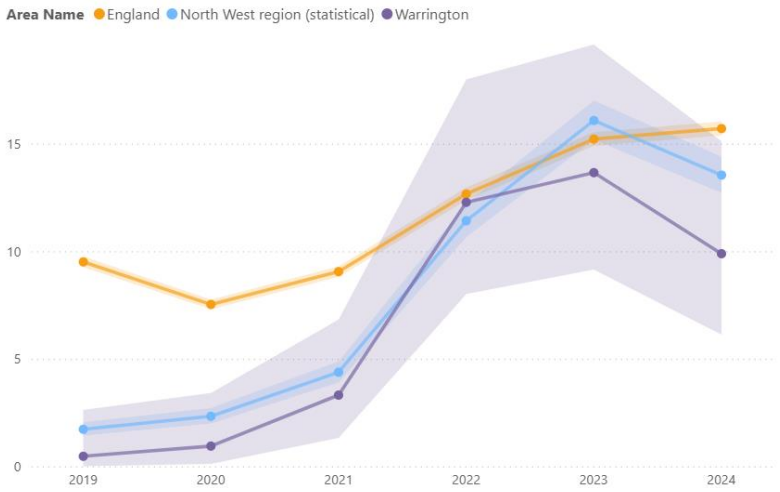


Source: UKHSA [Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)] ©Crown copyright 2024 (accessed 10/06/2025)

6.11 Mycoplasma genitalium

Mycoplasma genitalium is a sexually transmitted infection associated with chronic urethritis in men. In women, it has been linked to post-coital bleeding, cervicitis, endometritis, and PID, although these associations remain less clearly defined. In Warrington, rates of Mycoplasma genitalium increased between 2020 and 2023. However, in the most recent year, the diagnosis rate declined to 10 per 100,000 people (figure 31), significantly below the national average for England, but comparable to the North West.

Figure 31: Mycoplasma genitalium diagnosis rate per 100,000 population

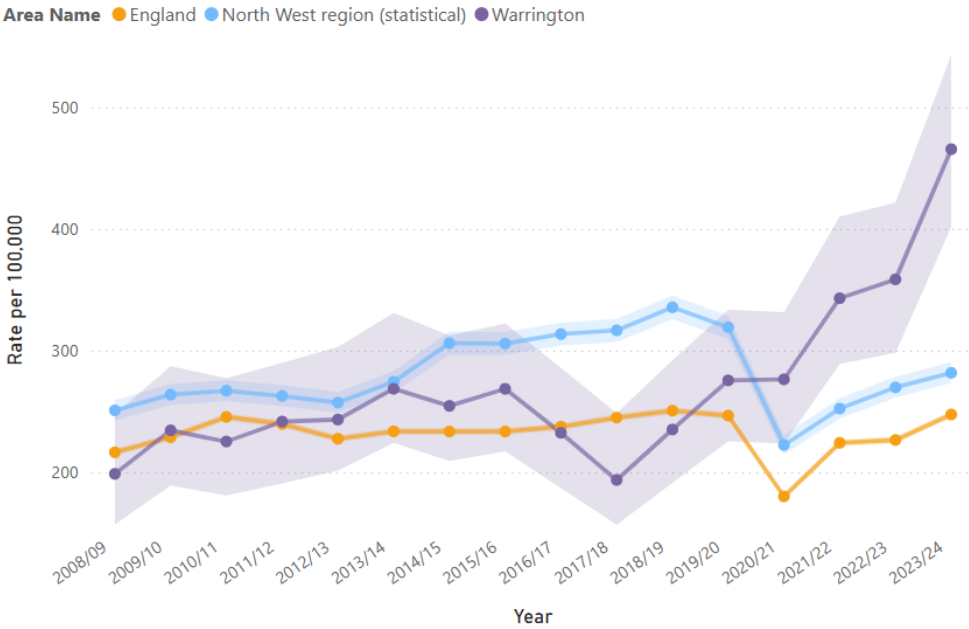


6.12 Outcomes of poor sexual health

Sexually transmitted infections can cause secondary outcomes including pelvic inflammatory disease (PID). PID is an infection induced inflammation of the upper genital tract, sexually transmitted infections are the causative agent of 85% of cases of PID, most commonly caused by Chlamydia or gonorrhoea. Approximately 10-15% of women with gonorrhoea or chlamydia will develop PID[80].

If left untreated or if treatment is delayed, PID can result in long-term health issues such as chronic pelvic pain, ectopic pregnancy, and infertility. In 2023/24, Warrington recorded 175 hospital admissions for PID, equating to a rate of 465.5 per 100,000 population (figure 32). This rate is significantly higher than both the national average for England and the regional average for the North West and has been increasing since 2017/18. However, it is important to interpret this data with caution. These figures are based solely on hospital admissions and may not reflect higher rates of untreated or delayed STI treatment. Instead, they could indicate differences in how cases are managed in primary care or variations in clinical coding practices between hospital trusts. Additionally, the data includes cases where PID was recorded as either a primary or secondary diagnosis, and individuals may have multiple admissions.

Figure 32: pelvic inflammatory disease (PID) admissions rate per 100,000 (Women aged 15-44 years), (shaded area represents 95% confidence intervals)

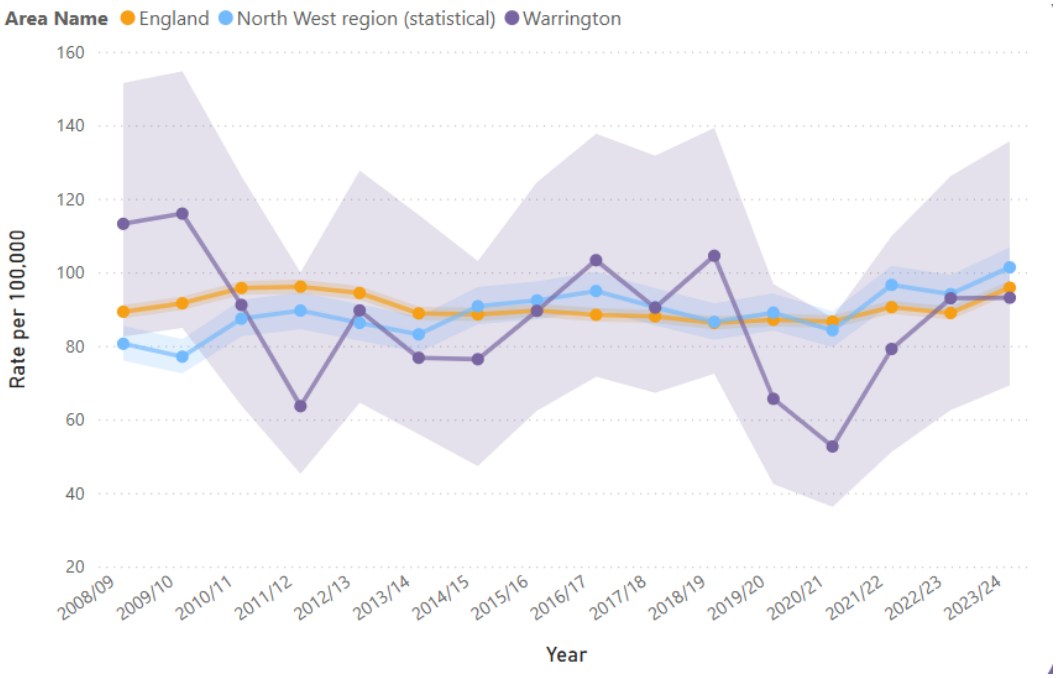


Source: UKHSA [Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)] ©Crown copyright 2024 (accessed 10/06/2025)

[80] Jennings LK, Krywko DM. Pelvic Inflammatory Disease. [Updated 2023 Mar 13]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK499959/

Whilst ectopic pregnancies can have multifactorial causes, chlamydial and other sexually transmitted infections are considered a major contribution to the condition. In Warrington the rate of admissions for ectopic pregnancies has fluctuated over time but has remained statistically comparable to the North West or England. In Warrington between 2023/24 the rate of admission was 93.10 per 100,000 women aged 15-44 (figure 33).

Figure 33: Ectopic pregnancy admission rate per 100,000 (Women aged 15-44), (shaded area represents 95% confidence intervals)



Source: UKHSA [Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)] ©Crown copyright 2024 (accessed 10/06/2025)

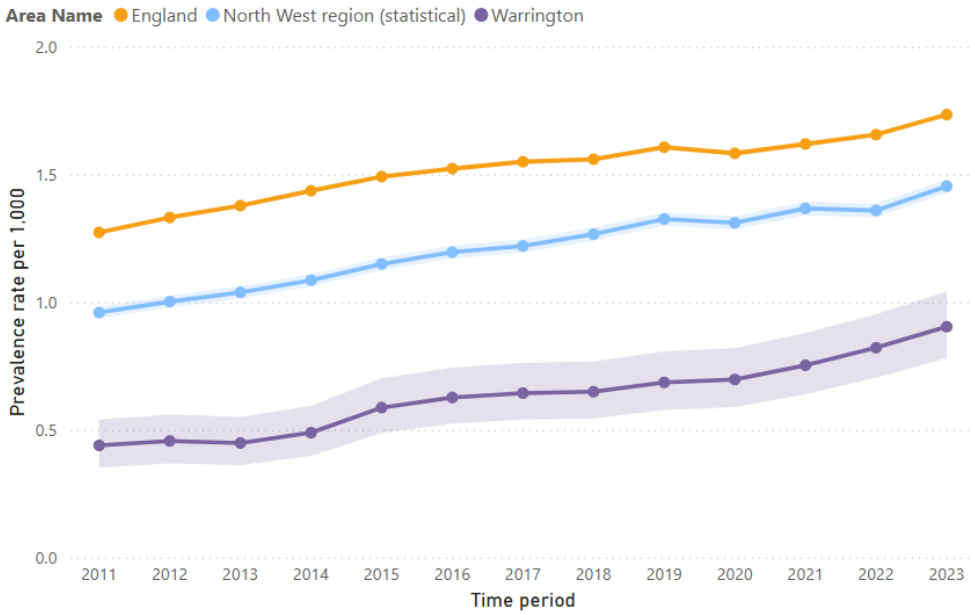
6.13 HIV

Although human immunodeficiency virus (HIV) can now be successfully managed with anti-retroviral therapy (ART), giving many sufferers a near to normal life expectancy, there is still a large amount of stigma surrounding its diagnosis, and many people delay seeking a diagnosis. The disease is still associated with high morbidity and mortality and substantial treatment costs[81].

HIV prevalence

In Warrington, the number of people living with HIV remains low (Figure 34), yet the rate of newly diagnosed HIV (Figure 35) increased to its highest level in 2023, with fourteen new cases in the borough. This is the highest number of new cases in a single year, but it is unclear what is behind the increase although this follows the national and regional pattern.

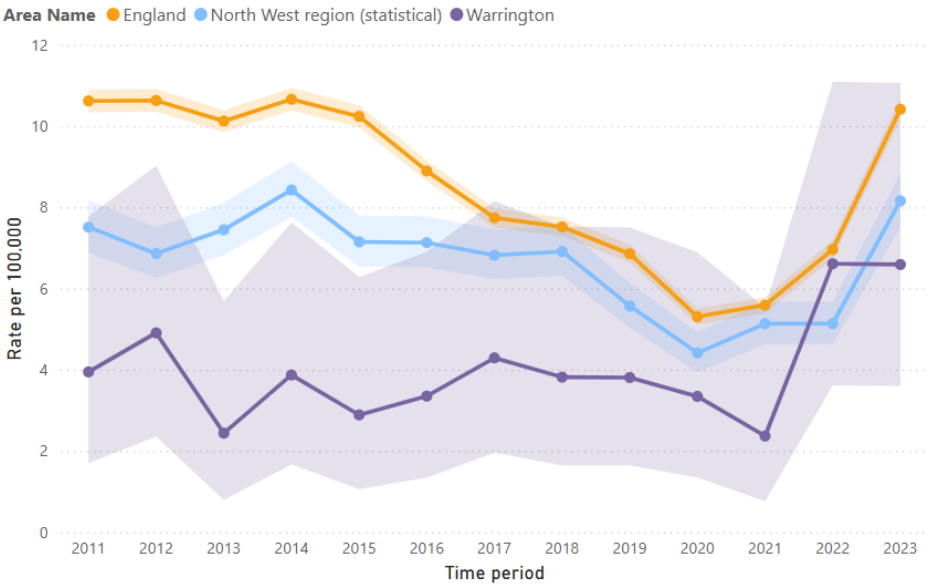
Figure 34: HIV diagnosed prevalence rate per 1,000, (shaded area represents 95% confidence intervals)



Source: UKHSA Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk) ©Crown copyright 2024 (accessed 10/06/2025)

[81] UKHSA 2024, HIV, surveillance, data and management, HIV: surveillance, data and management - GOV.UK (www.gov.uk) (accessed 21/06/2024)

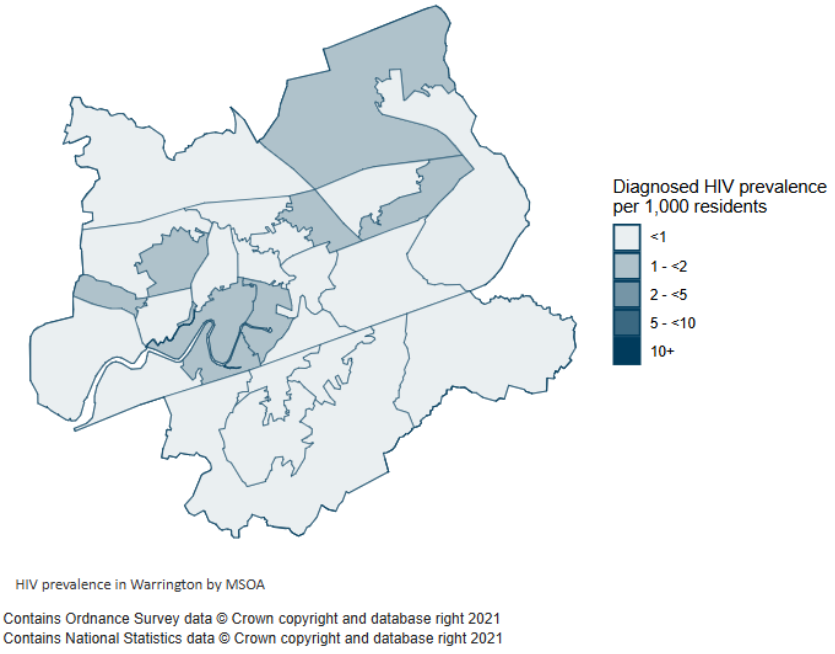
Figure 35: New HIV diagnosis rate per 100,000, (shaded area represents 95% confidence intervals)



Source: UKHSA [Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)] ©Crown copyright 2024 (accessed 17/06/2025)

The map (figure 36) below illustrates HIV prevalence among individuals of all ages in Warrington. While overall cases remain low across the borough, the central and northern wards exhibit slightly higher rates. However, these rates still fall within lower prevalence categories, ranging from 1 - < 2 per 1,000 residents.

Figure 36: Map of diagnosed HIV prevalence among people of all ages in Warrington by Middle Super Output Area: 2023

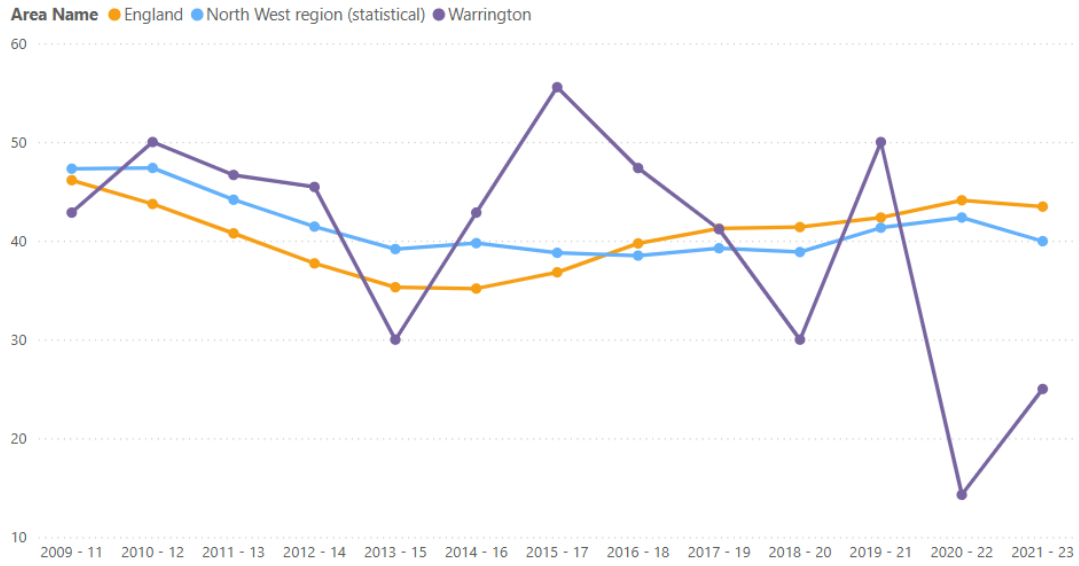


Source: UKHSA Splash report

HIV late diagnosis

UKHSA advise that, as with all STIs, the focus should be on prevention, through education and information, promoting safer sexual behaviour, early access to testing, and for some people in the most at-risk groups access to pre-exposure prophylaxis (PrEP). Late diagnosis, when someone has a **CD4 count of less than 350 cells per mm^3 within 91 days of diagnosis**, is associated with a significantly higher mortality rate – up to 7 times higher within the first year after diagnosis[82] Encouragingly,
Figure 37 shows that 2020/2022 saw one out of 7 (14%) of people diagnosed with HIV late in Warrington, a significant fall from nine out of seventeen people (53%) in 2015/17. Whilst figures for 2021-23 showed an increase to three out of 12 people (25%) (figure 37), this remains significantly lower than figures for both England and the North West.

Figure 37: HIV late diagnosis - % of - people first diagnosed with HIV in the UK

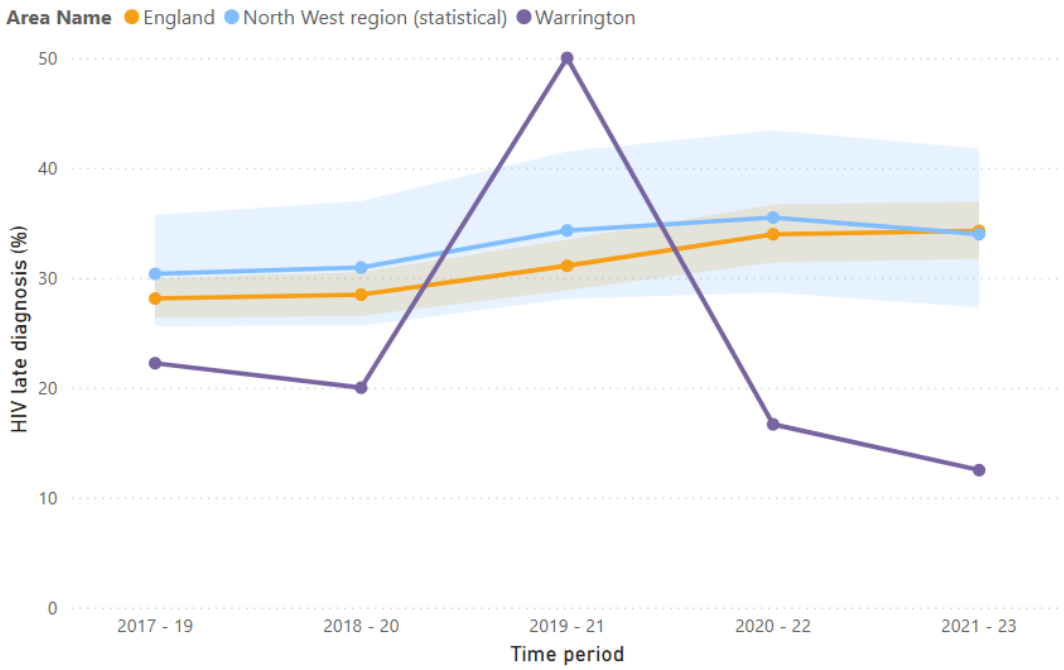


Source: UKHSA Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk) ©Crown copyright 2024 (accessed 10/06/2025)

HIV late diagnosis in gay, bisexual, and other men who have sex with men (first diagnosed with HIV in the UK) shows a recent reduction in the percentage (see figure 38). The Warrington numbers are so small that they have been suppressed, and the confidence intervals not calculated.

[82] The INSIGHT Start Study Group 2015, Initiation of antiretroviral therapy in early asymptomatic HIV infection, New England Journal of Medicine 373: 795-807, Initiation of Antiretroviral Therapy in Early Asymptomatic HIV Infection | New England Journal of Medicine (nejm.org) (accessed 21/06/2024)

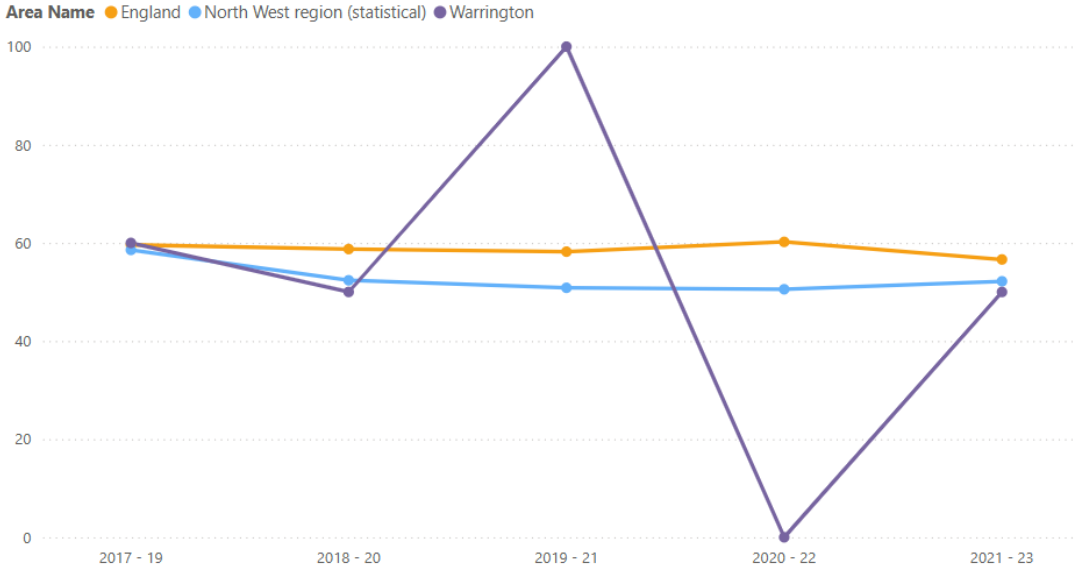
Figure 38: HIV late diagnosis in gay, bisexual, and other men who have sex with men first diagnosed with HIV in the UK, (shaded area represents 95% confidence intervals)



Source: UKHSA Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk) ©Crown copyright 2024 (accessed 10/06/2025)

The latest data for HIV late diagnosis in heterosexual men (Figure 39) shows only one man newly diagnosed with HIV infection with CD4 count available within 91 days.

Figure 39: HIV late diagnosis in heterosexual men first diagnosed with HIV in the UK

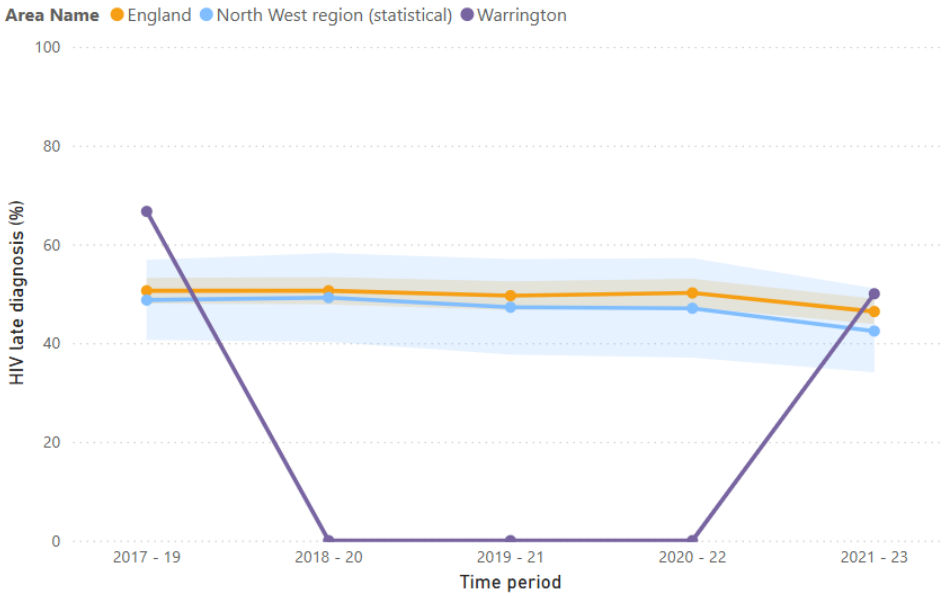


Source: UKHSA Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk) ©Crown copyright 2024 (accessed 10/06/2025)

Infections are lower for heterosexual or bisexual women (figure 40), but the denominator is only 1 or 2 (Number of women who acquired HIV through sex with men newly diagnosed with a CD4 count

available within 91 days) with the numerator zero between 2018-2022. In the most recent year there has been an increase to 50%, however the actual numbers remain low (n=1).

Figure 40: HIV late diagnosis in heterosexual and bisexual women first diagnosed with HIV in the UK, (shaded area represents 95% confidence intervals)

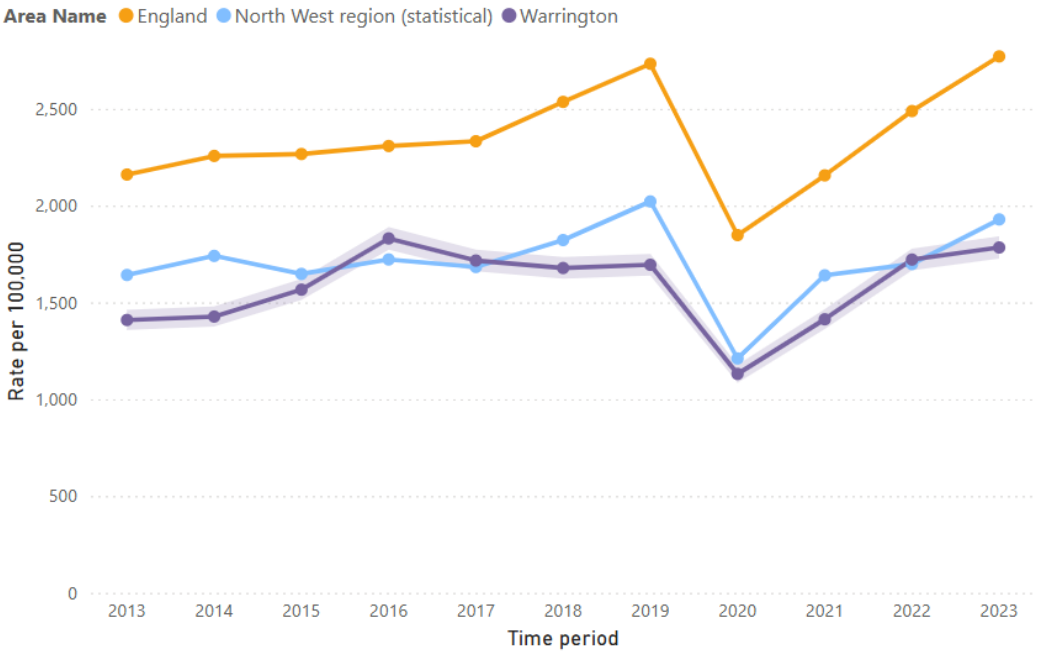


Source: UKHSA [Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)] ©Crown copyright 2024 (accessed 10/06/2025)

HIV testing

In 2024, the HIV testing rate in Warrington was 1,774 per 100,000 population (figure 41), which is significantly lower than both the North West average (1,929) and the England average (2,771). Between 2013 and 2019, both England and the North West experienced a steady increase in HIV testing rates. However, there was a sharp decline in 2020 due to the COVID-19 pandemic, reaching an all-time low. Since then, testing rates have been gradually increasing. In Warrington, the testing rate rose between 2013 and 2016 but began to decline thereafter. Following a sharp drop in 2020 due to the pandemic, the rate has increased each year and is now similar to pre pandemic levels.

Figure 41: HIV testing rate per 100,000 population, (shaded area represents 95% confidence intervals)



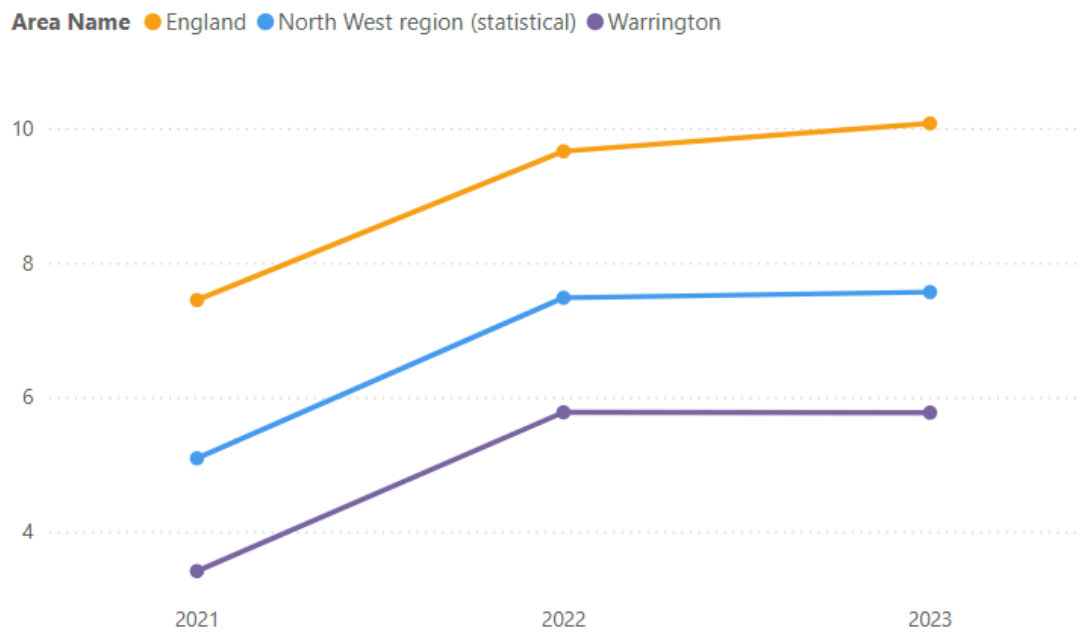
Source: UKHSA [Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)] ©Crown copyright 2024 (accessed 10/06/2025)

PrEP – Determining need

This indicator assesses the proportion of all HIV negative people accessing specialist SHS who are at substantial HIV risk and therefore could benefit from receiving PrEP. The indicator includes people who are having their need for PrEP met by receiving PrEP (met need) as well as those with need who are not currently receiving PrEP (unmet need).

The trend is the same for England, the North West and Warrington (see figure 42), but the rate for Warrington of 5.8% (277 from 4800 eligible in 2023) is significantly lower than that of England. This indicator does not relate to better or worse performance as it will vary between services depending on local populations.

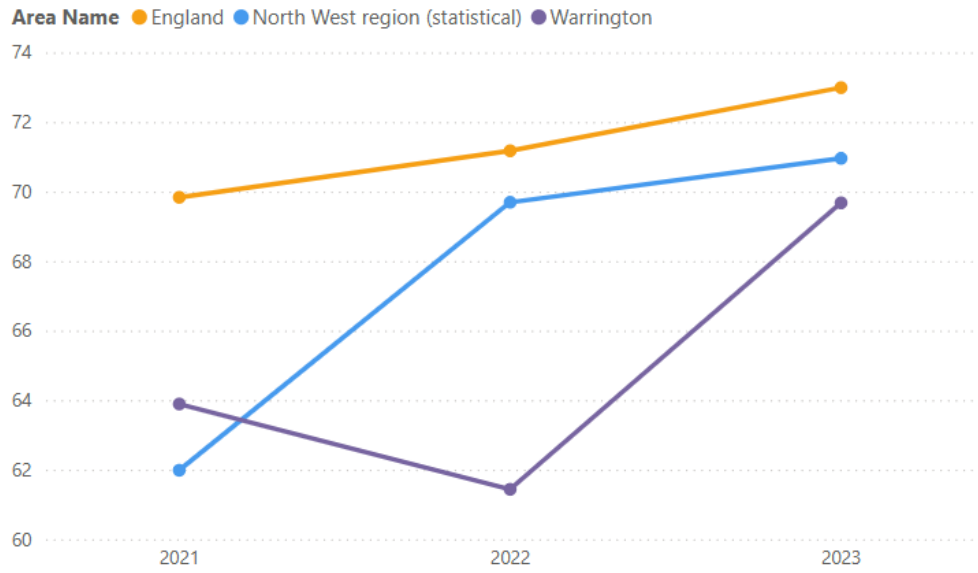
Figure 42: Proportion of all HIV negative individuals accessing specialist sexual health services (SHS) with pre-exposure prophylaxis (PrEP) need



Source: UKHSA Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk) ©Crown copyright 2024 (accessed 10/06/2025)

The proportion of all HIV negative people accessing specialist sexual health services (SHS), with an estimated pre-exposure prophylaxis (PrEP) need who started or continued PrEP, is 69.7% in Warrington, which is similar to both England and the North west (figure 43).

Figure 43: Percentage who initiated or continued PrEP among those with PrEP need



Source: UKHSA Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk) ©Crown copyright 2024 (accessed 10/06/2025

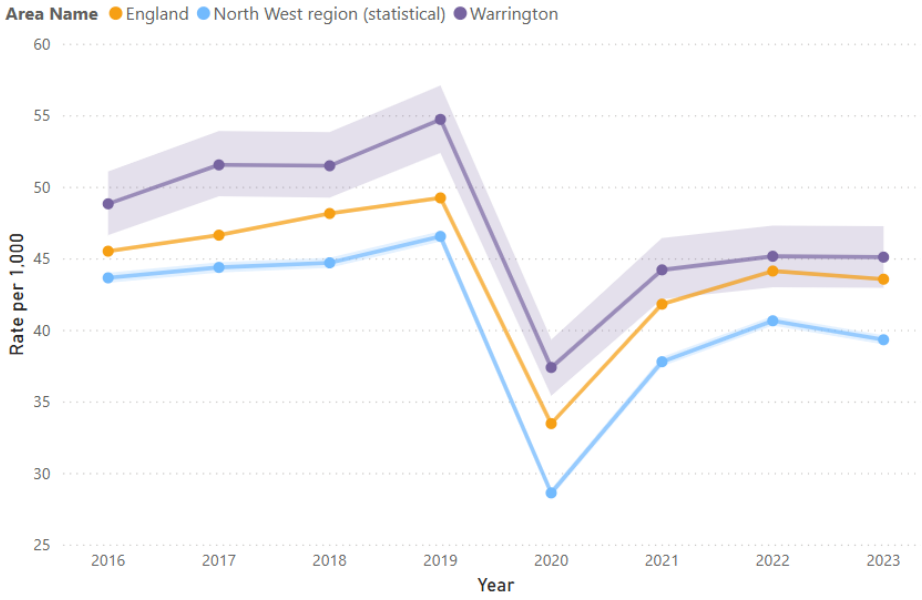
7. CONTRACEPTION

7.1 Long-acting reversible contraception (LARC)

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

The total prescribed rate for long-acting reversible contraception (LARC), excluding injections, per 1,000 resident females aged 15–44 years, indicates that Warrington consistently reports higher rates than both the North West and the England average (see figure 44). All areas experienced a decline in LARC prescribing during the COVID-19 pandemic, and rates have not yet returned to pre-pandemic levels.

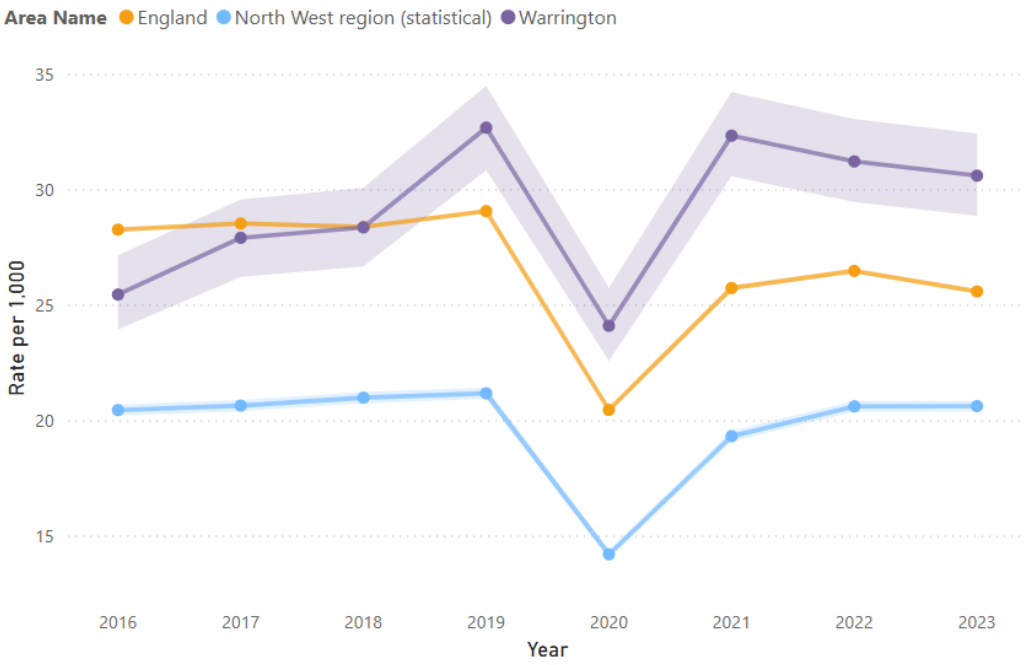
Figure 44: Total prescribed LARC excluding injections rate / 1,000, (shaded area represents 95% confidence intervals)



Source: OHID, based on NHS Business Services Authority, NHS England and Office for National Statistics data Sexual and reproductive health profiles 2024,OHID (phe.org.uk) ©Crown copyright 2024 (accessed 10/06/2025)

The general practice prescribing rate for LARC (excluding injections) was increasing prior to the pandemic, reaching a peak in 2019, there was a substantial drop during the pandemic year 2020. Between 2021 and 2023, the rate experienced a slight decrease, from 32.3 to 30.6 per 1,000 women (figure 45). Despite this, overall LARC prescribing in general practice has remained significantly higher in Warrington compared to both the North West and the national average since 2019.

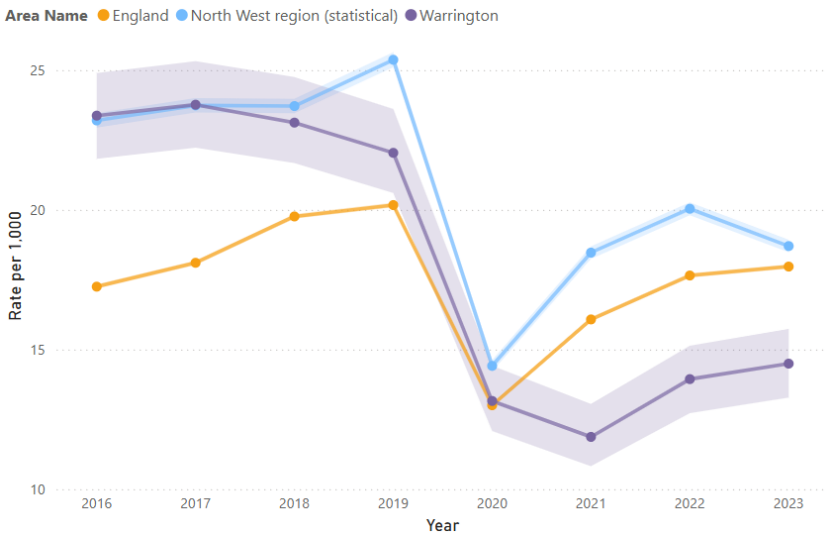
Figure 45: GP prescribed LARC excluding injections rate / 1,000, (shaded area represents 95% confidence intervals)



Source: OHID, based on NHS Business Services Authority, NHS England and Office for National Statistics data Sexual and reproductive health profiles 2024,OHID (phe.org.uk) ©Crown copyright 2024 (accessed 10/06/2025)

Prior to the pandemic, the prescribing rate of LARC in sexual health services was significantly above the England average. However, it was steadily decreasing in Warrington, whilst England saw an increase during this period. All areas saw a sharp decrease during the pandemic due to the disruption of services. Since 2021 Warrington saw an increase, however the rate remains significantly below England and the North West average (figure 46), the inverse of the trend prior to the pandemic.

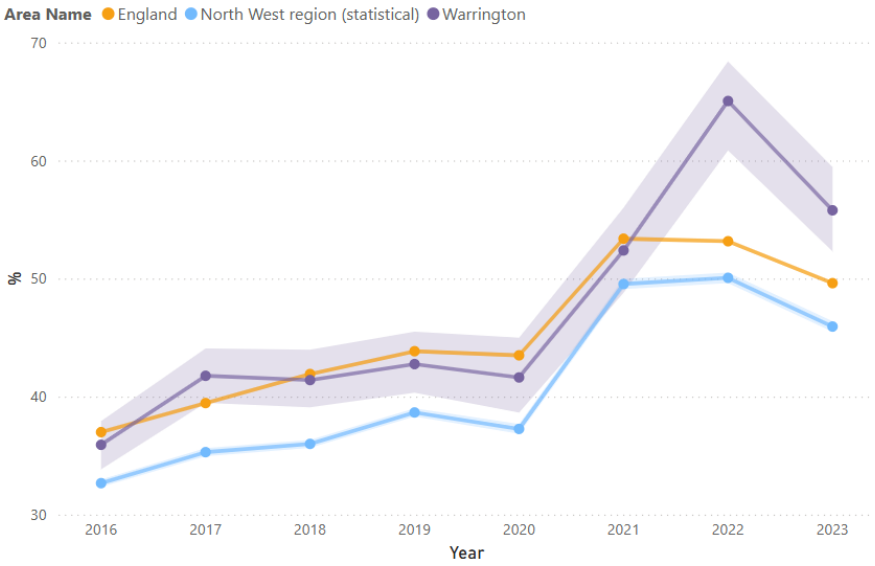
Figure 46: Sexual & Reproductive Health Services prescribed LARC excluding injections rate / 1,000 (shaded area represents 95% confidence intervals)



Source: OHID, based on NHS Business Services Authority, NHS England and Office for National Statistics data Sexual and reproductive health profiles 2024,OHID (phe.org.uk) ©Crown copyright 2024 (accessed 10/06/2025)

In Warrington, women aged 25 and over have shown a preference for LARC, as their main method of contraception with over 60% of women choosing LARC in 2022. However, in 2023 there was a slight decrease, though the proportion of women in Warrington (55.8%) choosing the method remains significantly higher than the national and regional averages (see figure 47).

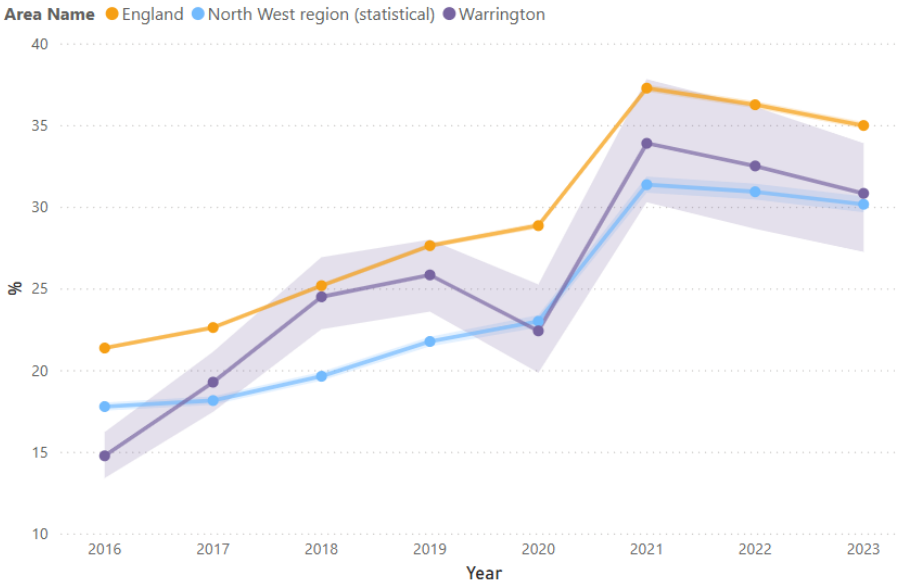
Figure 47: Over 25s choose LARC excluding injections at SRH Services (%), (shaded area represents 95% confidence intervals)



Source: OHID, based on NHS Business Services Authority, NHS England and Office for National Statistics data Sexual and reproductive health profiles 2024,OHID (phe.org.uk) ©Crown copyright 2024 (accessed 10/06/2025)

The uptake of LARCs among women under 25 in Warrington is much lower and has been decreasing since 2021, this is in line with national and regional trends. In 2023, just over 30% of women under 25 had a LARC recorded as their main method of contraception (figure 48). This figure is significantly lower than the national average but comparable to the North West average.

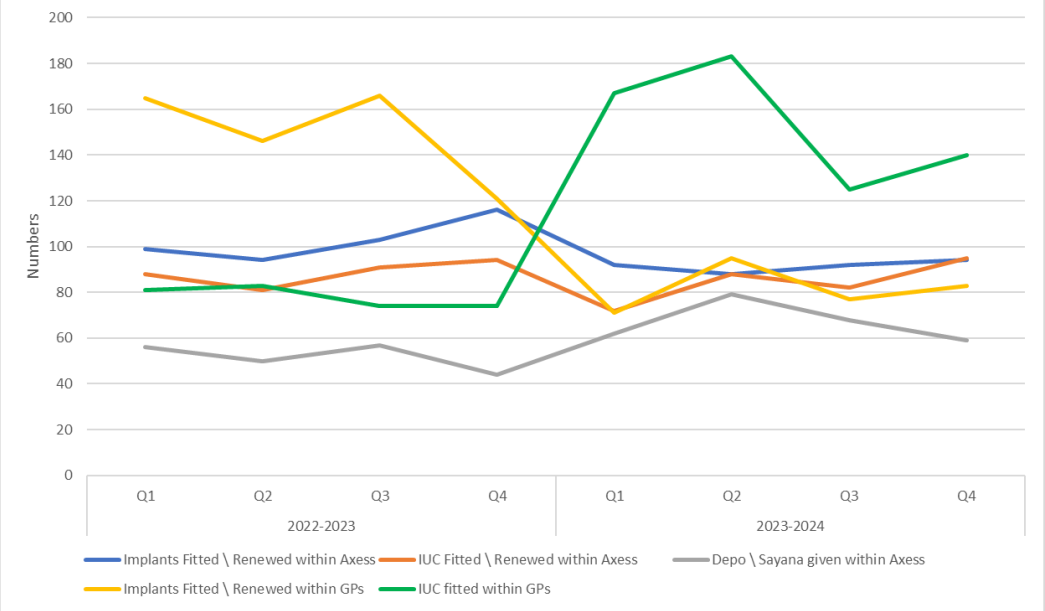
Figure 48: Under 25s choose LARC excluding injections at SRH Services (%), (shaded area represents 95% confidence intervals)



Source: OHID, based on NHS Business Services Authority, NHS England and Office for National Statistics data Sexual and reproductive health profiles 2024,OHID (phe.org.uk) ©Crown copyright 2024 (accessed 10/06/2025)

Local provider service data shows that, over time, GP IUC fittings are the most popular choice of LARC (figure 49). GP fitted implants have fallen. It must be noted these are numbers, not rates and may not reflect the fertility rate for each GP practice.

Figure 49: Local LARC fitting / renewal data

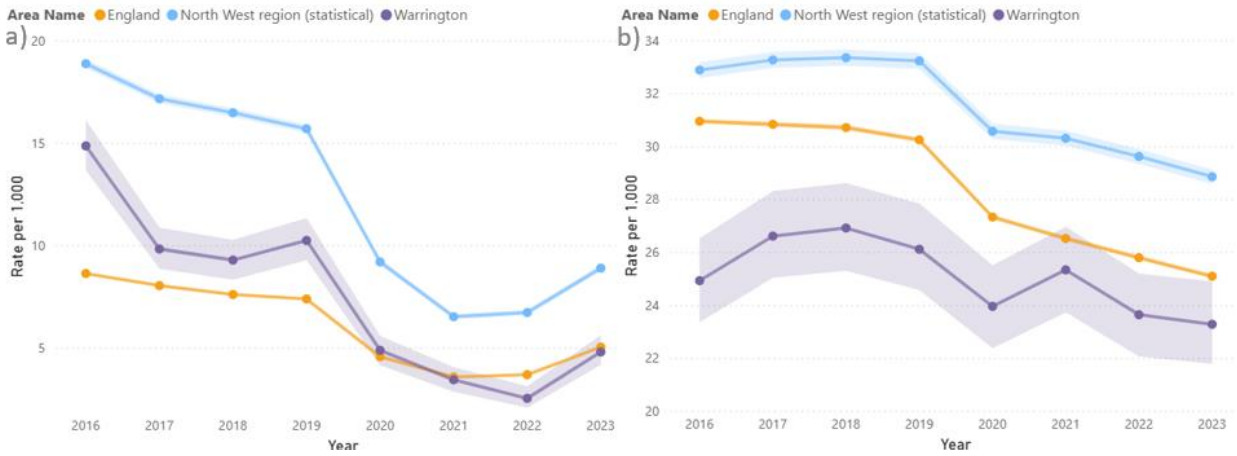


Source: Axess provider data 2024

The contraceptive injection is a progestogen-only method that provides effective contraception for 8 to 13 weeks and is classified as a long-acting reversible contraceptive (LARC). However, it still requires users to attend follow-up appointments and manage timely rebooking to maintain continuous contraceptive coverage.

In Warrington, the rate of women receiving injectable contraception through SRH services is similar to the national average for England, though both are lower than the average in the North West region (Figure 50a). While there has been a general decline in the number of women prescribed injectable contraception at SRH services, a slight increase was observed across all areas between 2022 and 2023. Injectable contraception is more commonly prescribed in general practice settings than through SRH services. In Warrington, the rate of prescribing in GP practices is lower than both the England and North West averages (Figure 50b).

Figure 50: a) Women prescribed injectable contraception at SRH services, rate per 1,000, b) Women prescribed injectable contraception at GP practices, rate per 1,000, (shaded area represents 95% confidence intervals)



Source: OHID, based on NHS Business Services Authority, NHS England and Office for National Statistics data Sexual and reproductive health profiles 2024,OHID (phe.org.uk) ©Crown copyright 2024 (accessed 10/06/2025)

7.2 User dependent contraception

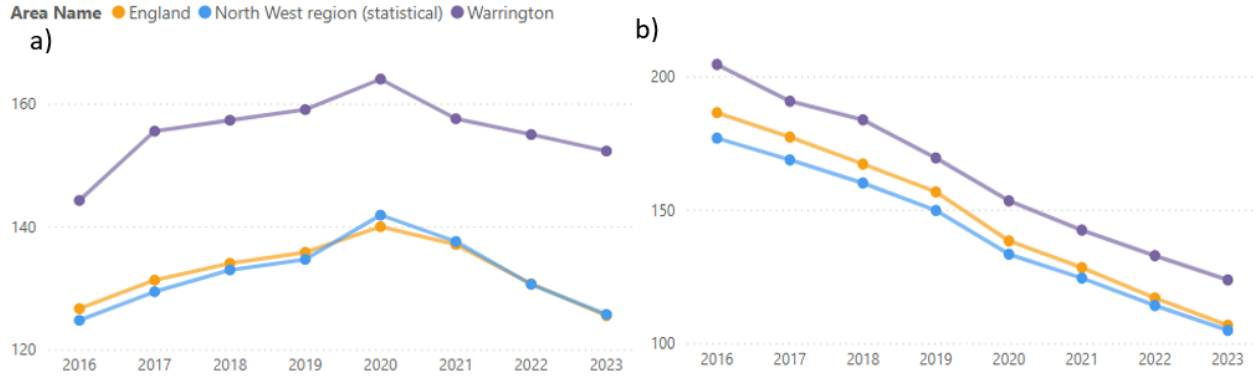
The number of women in all age groups attending SRH Services where the last recorded main contraceptive method in the year is a user-dependent method of contraception has been steadily falling although an increase was seen in Warrington between 2022/23 and 2023/24 from 36% to 43%[83]. User dependent methods are any methods, including 'natural family planning', that rely on daily compliance and thus this excludes LARCs.

In Warrington, GP practices exhibit higher prescribing rates for both progestogen-only pills (POPs) and combined hormonal contraception (CHC) compared to the North West and England averages. Notably, the prescribing rate for POPs is significantly higher in Warrington. The prescribing rate for POPs increased until 2020 but has since declined to levels comparable to 2016. This downward trend is consistent across Warrington, the North West, and England. Similarly, all three areas have experienced a consistent decline in CHC prescribing rates.

When comparing Figures 51 and 52, prescribing rates for both types of contraceptive pills are significantly higher in GP practices than in sexual and reproductive health (SRH) services across all regions. This disparity likely arises because GP practices serve as the primary point of access for contraceptive pills. In 2023, the crude rate ratio for POP prescribing was 15.6 in GP practices compared to SRH services in Warrington, while the national ratio was 10.7.

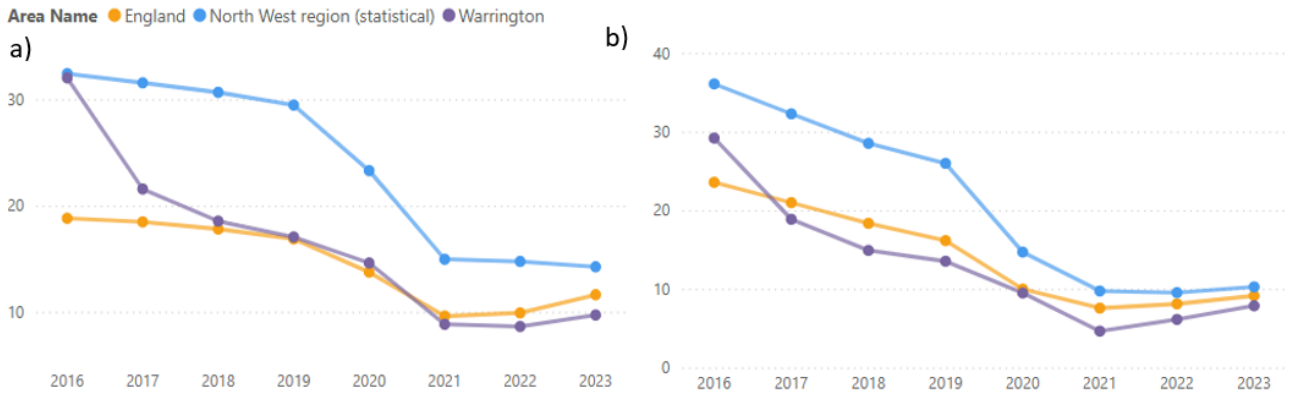
[83] Sexual and Reproductive Health Services (Contraception) - NHS England Digital

Figure 51a/b: Rates of women prescribed (a) progestogen-only pill and (b) combined hormonal contraception in **general practice**, per 1,000 women.



Source: OHID, based on NHS Business Services Authority, NHS England and Office for National Statistics data Sexual and reproductive health profiles 2024,OHID (phe.org.uk) ©Crown copyright 2024 (accessed 10/06/2025)

Figure 52a/b: Rates of women prescribed (a) progestogen-only pill and (b) combined hormonal contraception in **SHR services**, per 1,000 women.



Source: OHID, based on NHS Business Services Authority, NHS England and Office for National Statistics data Sexual and reproductive health profiles 2024,OHID (phe.org.uk) ©Crown copyright 2024 (accessed 10/06/2025)

8. CONCEPTIONS

Please note that the most recent data available is from 2021 due to a delay in reporting from the Office for National Statistics (ONS).

8.1 Under 18 conceptions

While for some teenagers having a child can be a positive experience, younger mothers are more likely to have poorer mental and physical health, to feel socially isolated and to have poorer educational outcomes. Children born to teenage mothers are more likely to be pre-term or of low birthweight[84]. There is also a higher infant mortality rate for babies born to teenagers compared to mothers in their twenties and thirties[85]. In addition, teenage mothers are three times as likely to smoke throughout pregnancy, they are a third less likely to start breastfeeding and half as likely to be breastfeeding at 6-8 weeks.[86] All these factors represent an increased, but avoidable, economic cost to the NHS.

Nationally and locally, teenage conceptions show a declining trend, but the most recent data for 2021 demonstrates a slight increase in numbers and rates (see figure 51). This may reflect the fact that 2020 figures were uncharacteristically low or a delay in birth registrations due to the coronavirus pandemic. The higher rates may be linked to updated population estimates following the 2021 Census. There is, however, a need to continue monitoring the overall trend in teenage conception rates. Despite the overall declining trend, higher rates of teenage pregnancy still persist among certain groups and in certain areas. Risk factors for teenage pregnancy include adverse childhood experiences (ACEs), socioeconomic deprivation, attention, behaviour and conduct problems, poor educational attainment and engagement and a family history of teenage pregnancy[87].

In 2018 the Teenage Pregnancy Prevention Strategy estimated that for every £1 spent on the prevention of teenage pregnancy, £4-£9 could be saved. As well as cost saving, teenage pregnancy prevention has other benefits, including access for individuals to prevention, screening and treatment of STIs, improving access to education and training, giving every child the best start in life, breaking inequalities and the prevention of unplanned pregnancy when older[88].

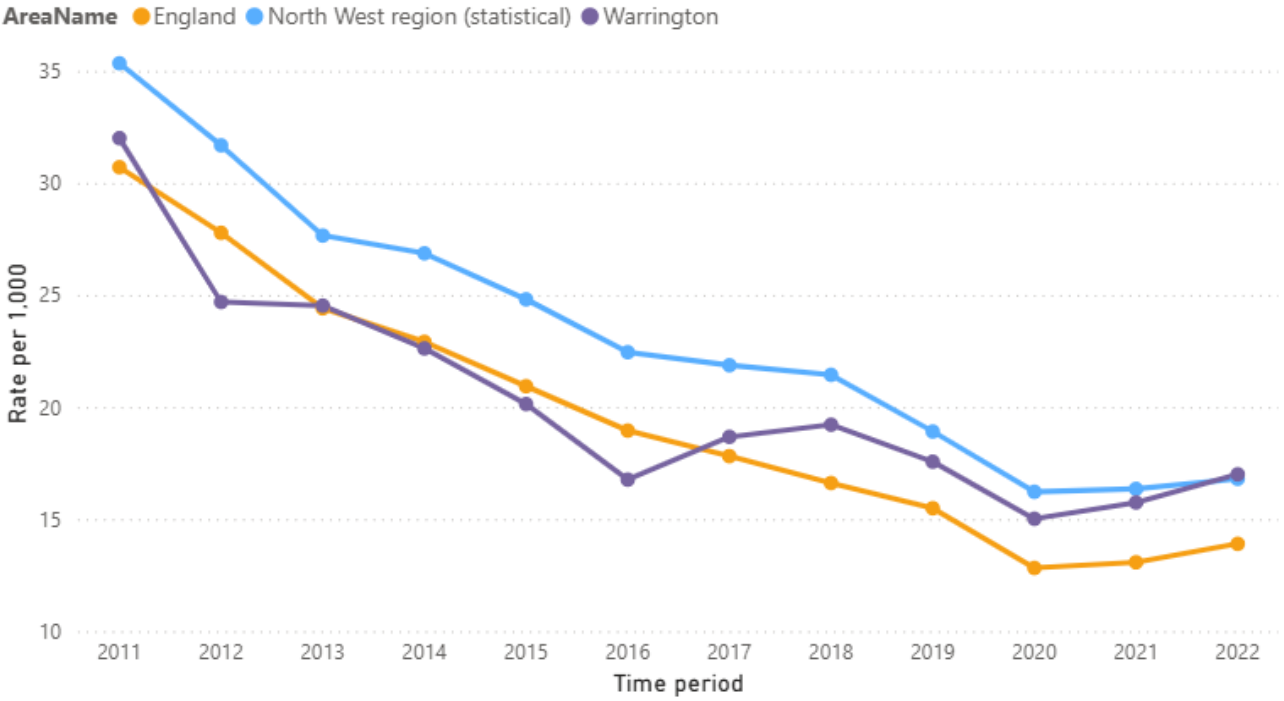
Most pregnancies in under 18s are unplanned and are, therefore, more likely to end in abortion. In Warrington in 2022, 63.9% of conceptions to women aged under 18 resulted in abortion; compared with 58.2% for this age group in England[86]. In 2022 the under-18 abortion rate in Warrington (10.1 per 1,000) is significantly higher than the national rate of 7.4 per 1,000[87]. However, it is important to note that the overall conception rate for under-18s in Warrington was not significantly different

[84] Royal College of Paediatrics and Child Health (2020) *State of Child Health*. London: RCPCH Conceptions in young people – RCPCH – State of Child Health (accessed 19/05/2025)
[85] Office for National Statistics (2024), Child and Infant Mortality in England and Wales: 2022, Child and infant mortality in England and Wales - Office for National Statistics (accessed 19/05/2025)
[86] Local Government Association and Public Health England (2016), Good progress but more to do Good progress but more to do: Teenage pregnancy and young parents (accessed 16/05/2025)
[87] Royal College of Paediatrics and Child Health (2020) *State of Child Health*. London: RCPCH Conceptions in young people – RCPCH – State of Child Health (accessed 19/05/2025)
[88] Public Health England (2018), Teenage pregnancy prevention framework, Teenage Pregnancy Prevention Framework (accessed 19/05/2025)

from the rates in the North West (9.6 per 1,000). While the local abortion rate is higher, it does not necessarily indicate a negative outcome or reflect a local issue with teenage conceptions. Given the well-documented challenges and poorer outcomes associated with teenage pregnancies, a higher abortion rate may instead reflect informed decision-making and access to reproductive health services.

In Warrington, the rate of under 18 conceptions has followed the same pattern as national and North West figures with rates decreasing since recording in 1998, however there has been a plateau since 2016 (Figure 51). In 2022, all areas saw an increase. The rate of teenage conception in Warrington is higher than the national average, with a rate of 17.0 per 1000 compared to 13.9 per 1000 nationally. This may reflect challenges for teenagers in accessing reliable contraception, in particular LARCs which have no requirement for daily or event compliance.

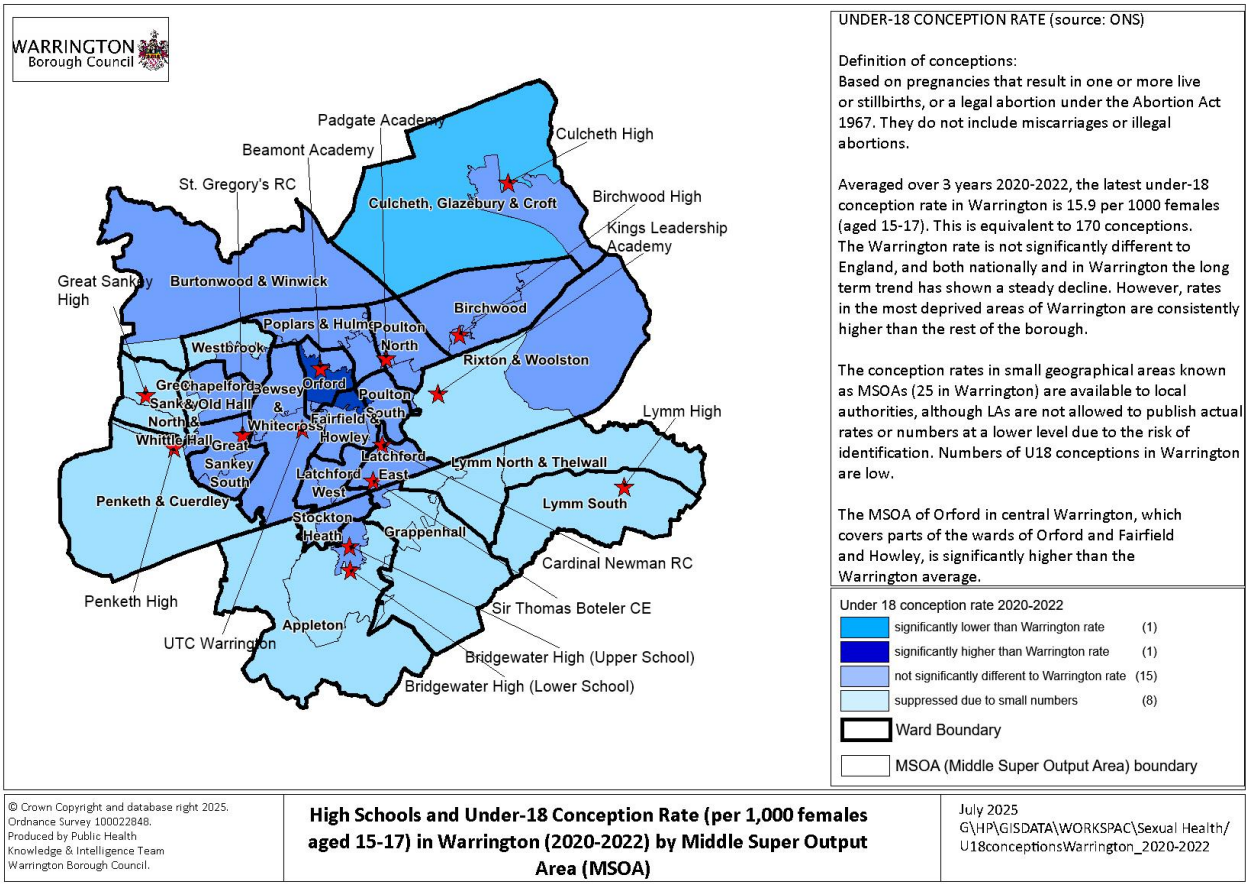
Figure 53: Conceptions in women aged under 18 per 1,000 females aged 15-17.



Source: UKHSA [Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)] ©Crown copyright 2024 (accessed 10/06/2025)

In 2020-2022 the rate of teenage conception in three Orford was significantly higher than the average for Warrington, and this is consistent with rates being higher in the most deprived areas of the borough (see figure 54 below).

Figure 54: Number of under 18 conceptions in Warrington, 2020-2022, by Middle Super Output Area (MSOA)



Teenage Pregnancy Prevention Framework

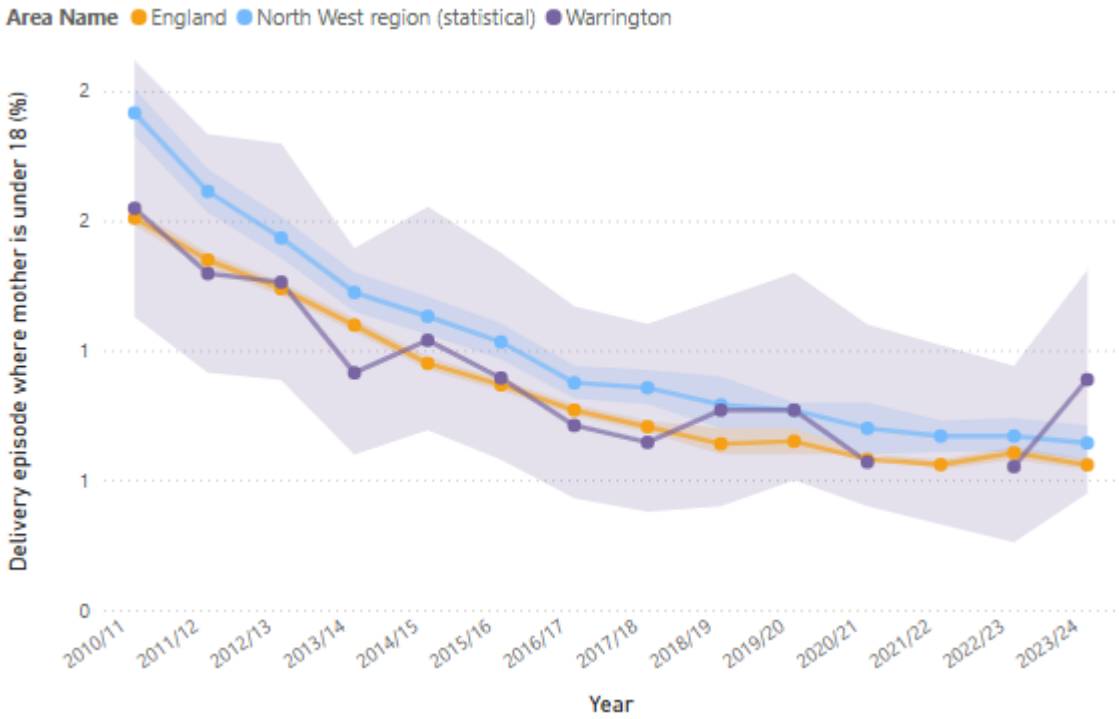
The Teenage Pregnancy Prevention Framework and associated Self-Assessment are designed to help local government areas review local programmes to see what is working well, to identify any gaps, and to help maximise the assets of all services and practitioners to strengthen the prevention pathway for young people. The Framework was launched in 2018 and can be used flexibly according to each local area's need. Whilst initially designed for high-rate areas the prevention framework can also be used by low-rate areas seeking to maintain and accelerate reductions. The framework empowers local areas to maintain an evidence based whole system approach to sustain or accelerate reductions in under 18 conceptions and narrow inequalities.

In 2023 Warrington completed the self-assessment in collaboration with the Cheshire & Merseyside Teenage Pregnancy Forum (NHS Cheshire and Merseyside) and will refresh this in 2025-26.

8.2 Teenage mothers

The proportion of births where the mother is under 18 years has fallen since 2010, both at a national level and in Warrington. However, in the last 5 years there has been no significant change in these rates locally, and an increase has been seen in 2023/24 (see figure 55). No data was recorded for 2021/22 but, in the years either side of this, the rates of teenage mothers in Warrington matched the national rates.

Figure 55: Percentage of delivery episodes, where the mother is aged under 18 years, (shaded area represents 95% confidence intervals)



Source: UKHSA [Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)] ©Crown copyright 2024 (accessed 10/06/2025)

Family Nurse Partnership (FNP)

The FNP is commissioned to support teenage parents aged under 20, or up to the age of 24 where there are additional vulnerabilities. The service is based in Great Sankey hub and has 50 places with potential clients usually referred via maternity services. The service supports young parents from early pregnancy until their babies are 1-2 years old.

It was identified in 2021-22, that Warrington Family Nurse Partnership (FNP) clients had a high second pregnancy rate. The Sexual Health Service, Public Health Commissioner and the Family Nurse Supervisor developed a pathway specifically for FNP clients which resulted in the Family Nurses being able to email the Axess team with client details so they could be offered appointments quickly. This means that clients are provided with contraception in a timely way which helps to prevent unwanted second pregnancies. There are also the postal services through Axess Sexual Health

Services for STI testing, and treatment and FNP clients can be sent condoms and emergency contraception, reducing the need for attending clinics.

9. ABORTION

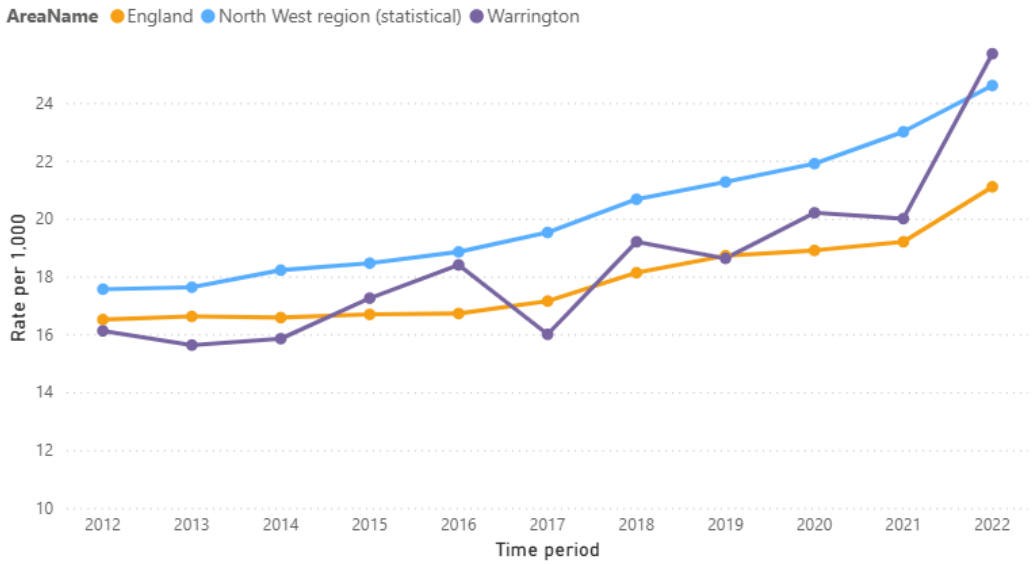
9.1 Total abortion rates

Rates of termination of pregnancy are representative of inadequate access to contraceptive services, or poor compliance with the form of contraception being used. Termination of pregnancy (whether medical or surgical) carries a risk of harm to the individual, as well as cost to the service provider.

Abortion data collection is robust due to mandatory reporting requirements, with data compiled by the Department of Health and Social Care. The most recent data currently available is from 2022, due to delays in reporting from the Office for National Statistics (ONS). In the meantime, public health continues to work with colleagues in the ICB to monitor local abortion data and will continue to implement appropriate actions as new data becomes available.

Nationally and in the North West, abortion rates have continued to rise (see figure 56). In Warrington, there has been an overall increase, with some year-to-year fluctuations, most notably a dip below the national average in 2017, followed by a rise above the national average in 2018. These trends may reflect local service changes or public health interventions aimed at reducing unplanned pregnancies. While all areas experienced a notable increase in abortion rates between 2021 and 2022, the rise in Warrington was particularly pronounced. In 2022, the abortion rate in Warrington reached 25.7 per 1,000 women, significantly higher than the national average of 21.1 per 1,000. Although 2022 is the most recent accredited published data due to reporting lags, we have worked locally with the ICB and service providers to access provisional figures for 2023–2025. These indicate that the elevated rate observed in 2022 has not continued in subsequent years.

Figure 56: Rate of abortions per 1,000 female population aged 15-44 years



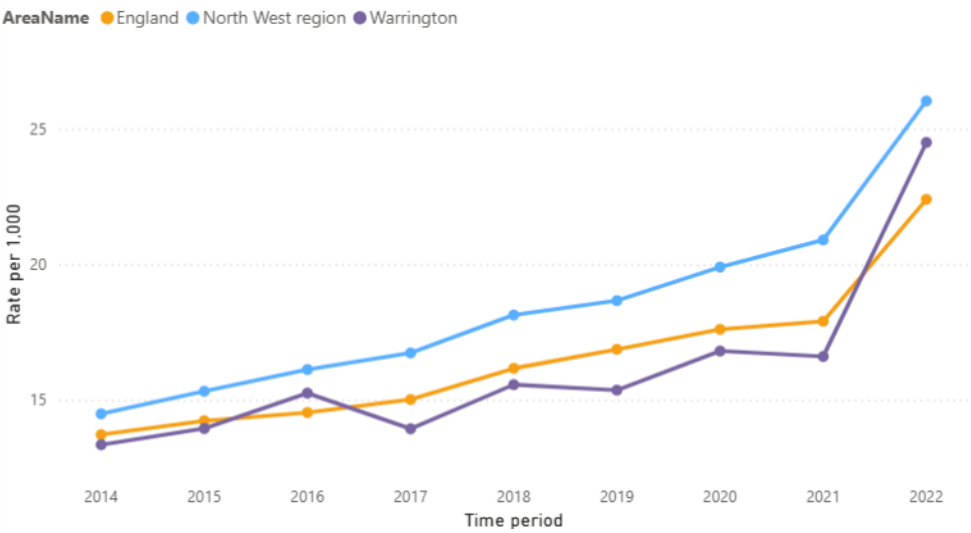
Source: [Abortion statistics for England and Wales: 2022 - GOV.UK](#) (accessed 21/07/2025)

9.2 Age 25 and over abortion rates

Between 2014 and 2021, the rate of abortions among people aged 25 and over in Warrington increased in line with national and regional trends (Figure 57). In 2014, 13.3 per 1,000 people aged 25 and over had an abortion, compared to 16.6 in 2021. During this period, Warrington's figures were significantly lower than the regional average but not significantly different from the England average.

In 2022, all areas saw a significant increase in abortions among those aged 25 and over; however, the increase in Warrington showed a steeper gradient. That year, the rate in Warrington rose to 25.7 per 1,000, although this was not significantly different from the North West (24.6) or the national rate (21.5).

Figure 57: rate of abortions in age 25 years and over per 1,000 female population aged 25-44 years.

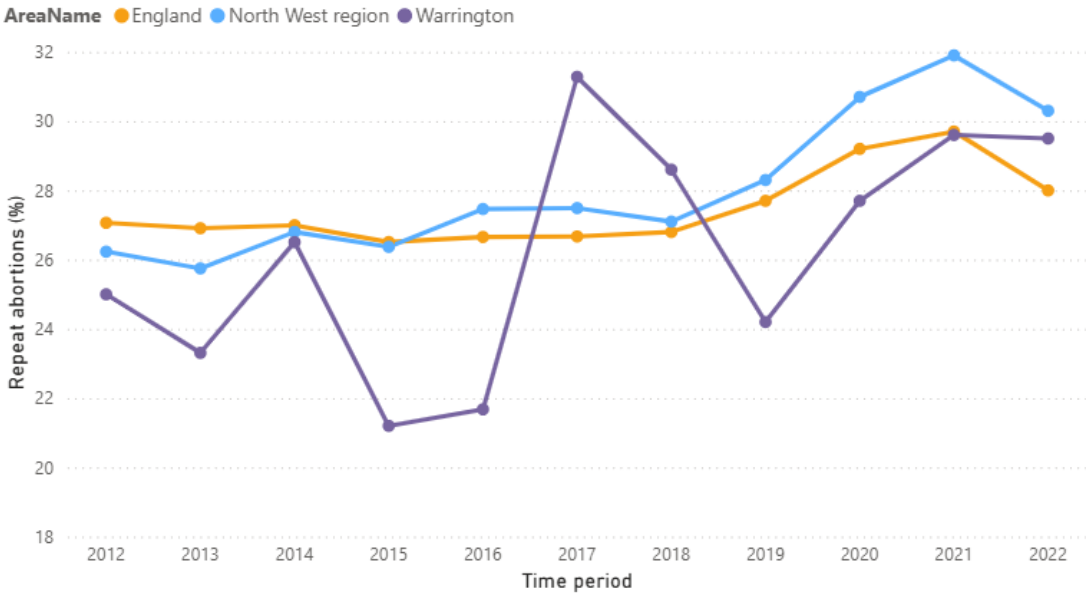


Source: [Abortion statistics for England and Wales: 2022 - GOV.UK](#) (accessed 21/07/2025)

9.3 Under 25 abortion rates

Over the past two years of data collection, the proportion of people aged under 25 having an abortion who had previously had one has remained relatively stable in Warrington, at 29.5% in 2022. This is slightly above the national average of 28%, though not significantly different (see Figure 56). While national and regional trends showed a consistent pattern, rising from 2018 to 2021, followed by a slight decline in 2022, Warrington's figures have fluctuated more noticeably. However, despite these greater fluctuations, the differences in Warrington have not been statistically significant when compared to the North West or national averages.

Figure 56: Percentage of abortions in women aged under 25 years that involve a woman who has had a previous abortion in any year.

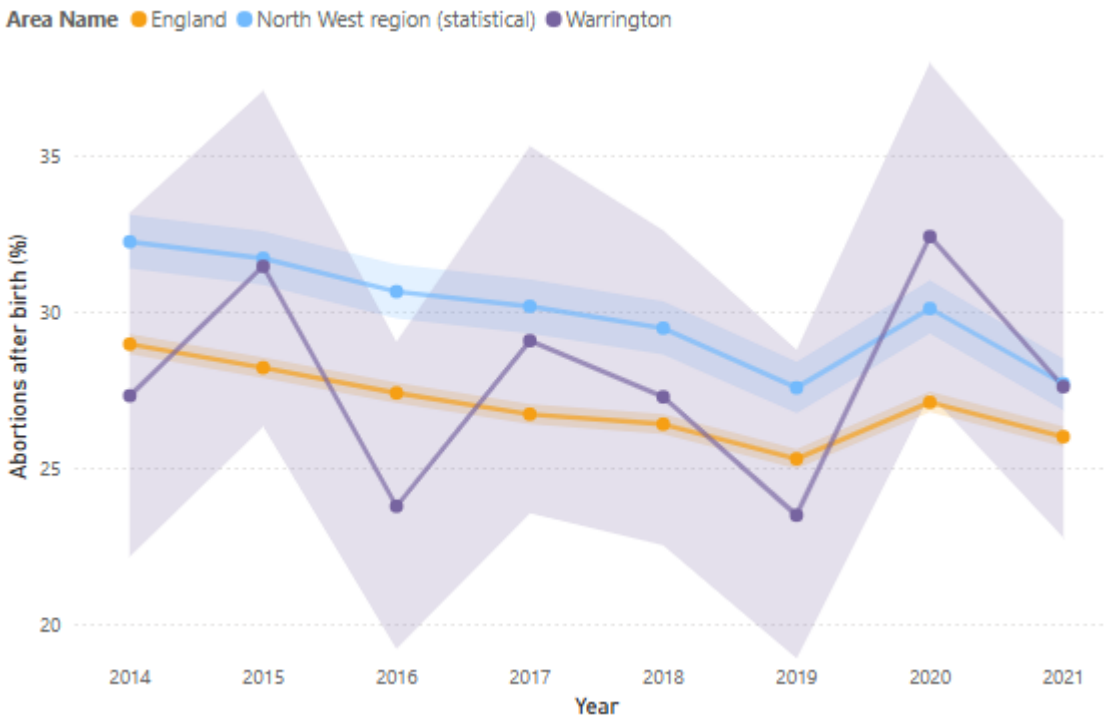


Source: [Abortion statistics for England and Wales: 2022 - GOV.UK](#) (accessed 21/07/2025)

Under 25s abortions after a birth

The rate of abortions taking place in people under 25 who have previously given birth may reflect the availability of post-natal contraception, as well as the access to other contraceptive services (and more reliable forms of contraception such as LARCs) more widely for this age group. Locally, Warrington has had figures fluctuating above and below the national average, notable in 2020 when there was the highest rate of abortions in under 25s after a birth in recent years. This rate also exceeded regional averages, with 32.4 per 1000 occurring in Warrington compared to 27.1 per 1000 nationally and 30.1 per 1000 in the North West (see Figure 57).

Figure 57: Percentage of women aged under 25 years having an abortion who have previously had a birth (shaded area represents 95% confidence intervals)



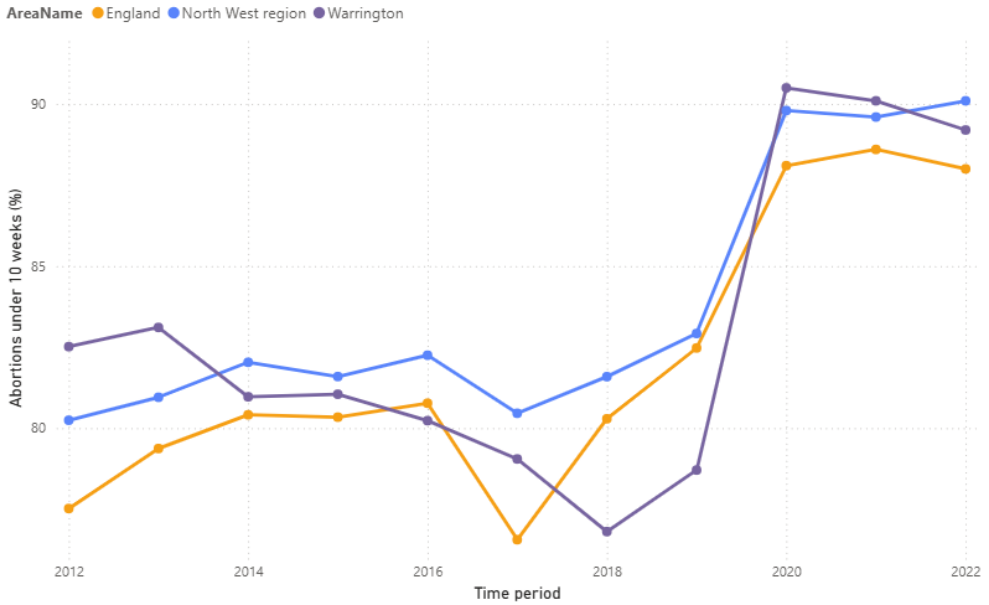
Source: UKHSA Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk) ©Crown copyright 2024 (accessed 10/06/2025)

9.4 Abortions <10 weeks gestation

Abortions carry less risk when performed earlier in pregnancy. The rate of abortions carried out at less than 10 weeks gestation is reflective of easier access to pregnancy testing and abortion services. This is positive for individuals who will have a lower complication rate from earlier abortions, as well as cost effectiveness for the provider.

In Warrington, the proportion of abortions occurring at less than 10 weeks has seen marginal decreases since 2020 but still remain high. The last years of available data show 89.2% of abortions were carried out before 10 weeks (figure 58). This has shown a significant increase from the lowest point in 2018 when only 76.8% were done prior to 10 weeks. This trend of improvement from 2018 to 2022 has occurred at a regional and national level as well, but Warrington has shown a greater improvement when compared to both regional and national data.

Figure 58: Percentage of all NHS-funded abortions performed under 10 weeks gestation.



Source: [Abortion statistics for England and Wales: 2022 - GOV.UK](#) (accessed 21/07/2025)

10. HUMAN PAPILLOMAVIRUS (HPV)

Human papillomavirus (HPV) is a virus that infects the skin and mucous membranes of the genital area and upper respiratory tract.[89] HPV is a common infection that most people will get at some point in their lives. It is mainly transmitted through skin-to-skin contact, primarily via sexual contact involving vaginal, anal, and oral sex. There are over one hundred subtypes of HPV with approximately fourteen deemed 'high-risk' for causing cancer[90]. Cancers that can be caused by HPV include cancers of the cervix, vagina, vulva, penis, anus, head and neck (Table 14). Persistent infection by a high-risk HPV subtype is an important driver of pre-cancerous lesions. HPV subtypes 6 and 11 are low-risk HPV subtypes that cause around 90% of genital warts.

In the UK, there are 850 deaths from cervical cancer per year. Over 99% of the nearly 3200 cervical cancer cases per year are preventable.[91] In 2020, cervical cancer represented 2% of all cancer diagnosis in women and is most common in women in their thirties.[92]

Table 14: Burden of cervical and other HPV related cancers in the United Kingdom, 2020. Crude incidence rate per 100,000 population.

Crude incidence rates per 100,000 population:	Male	Female
Cervical cancer	-	11.0
Anal cancer	1.62	3.32
Vulva cancer	-	4.43
Vaginal cancer	-	0.89
Penile cancer	2.27	-
Oropharyngeal cancer	6.29	2.04
Oral cavity cancer	11.7	6.95
Laryngeal cancer	6.31	1.46

Source: United Kingdom of Great Britain and Northern Ireland: Human Papillomavirus and Related Diseases, Summary Report 2023

10.1 HPV Vaccine Programme

The UK's HPV vaccination programme began in 2008, initially offering the bivalent Cervarix vaccine to Year 8 girls aged 12–13, protecting against HPV types 16 and 18[93]. In 2012, Cervarix was replaced by the quadrivalent Gardasil vaccine, which added protection against types 6 and 11, responsible for genital warts. Since July 2022, the nine-valent Gardasil 9 vaccine has been used, covering an additional five high-risk HPV types: 31, 33, 45, 52, and 58. In 2019, the programme was extended to include Year 8 boys, and in September 2023, the dosing schedule was reduced from two doses to a single dose for all adolescents under 25, following evidence that a single dose provides protection[94] . From September 2023, the vaccination schedule has moved from two doses to only a single dose

[89] Green Book Chapter 18a Human papillomavirus (HPV) (publishing.service.gov.uk)
[90] Does HPV cause cancer? | Cancer Research UK
[91] Cervical cancer statistics | Cancer Research UK
[92] SN06887.pdf (parliament.uk)
[93] Information on the HPV vaccination from September 2023 - GOV.UK (www.gov.uk)
[94] HPV vaccination programme moves to single dose from September 2023 - GOV.UK (www.gov.uk)

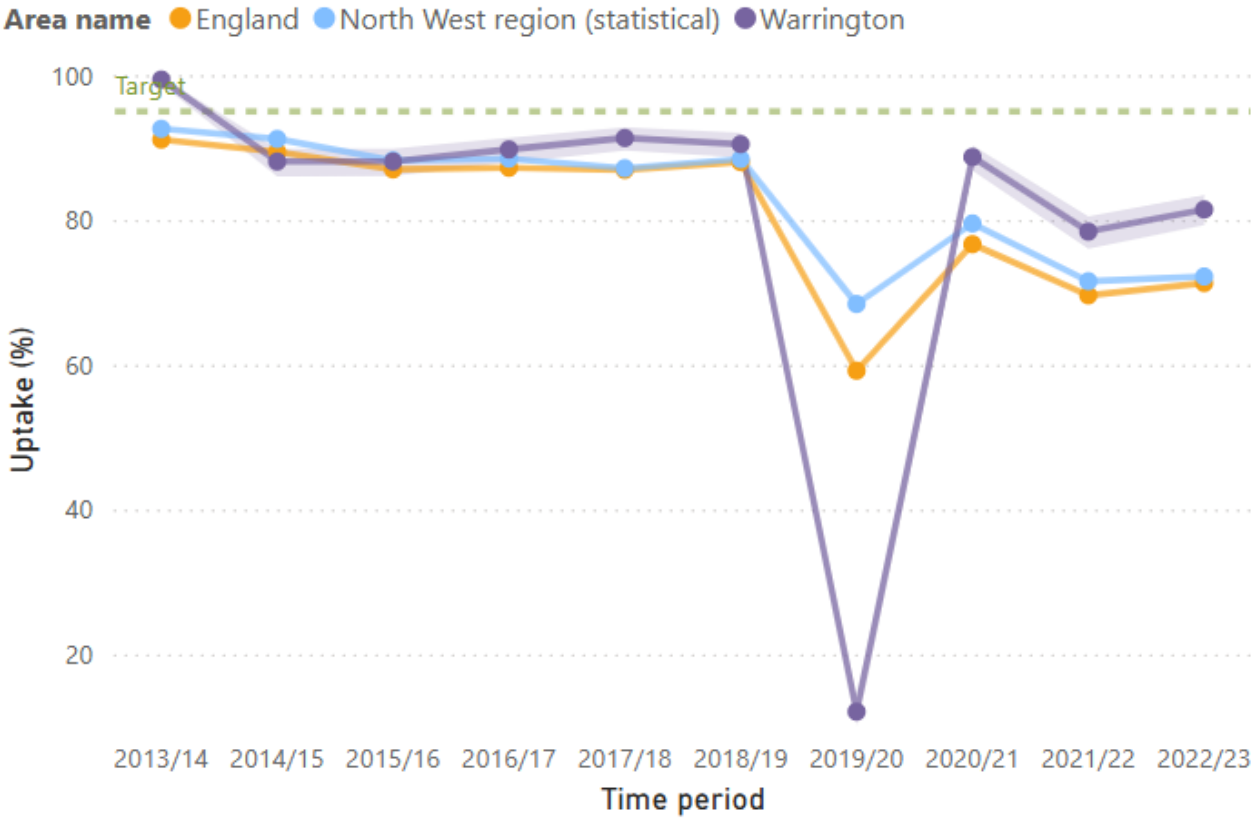
of HPV vaccine and has been recommended in the routine adolescent vaccination programme and in eligible GBMSM under the age of 25, offered via sexual health clinics.

The vaccine has led to an 87% reduction in cervical cancer rates and a 97% decline in pre-cancerous lesions among those vaccinated at age 12–13. [95] Additionally, there has been an 84.9% decrease in first-time genital wart diagnoses among young women aged 15–17 attending sexual health clinics in 2021 compared to 2017, indicating herd immunity effects.**Error! Bookmark not defined.**

10.2 HPV Vaccine Coverage

HPV vaccination coverage has declined nationally, regionally and in Warrington following the COVID-19 pandemic and has not yet returned to pre-pandemic coverage. HPV vaccine coverage in Year 8 girls in Warrington was 90.5% in 2018-19, this is significantly above national coverage (88%) and insignificantly above the North-West region (88.2%). Warrington had a considerable decrease in HPV vaccine coverage during the 2019-20 academic year (12.1%) and was significantly below regional (68.4%) and national (59.2%) but has since recovered and is now significantly higher than national (71.3%) and regional (72.2%) at 81.5% in 2023-24 (see figure 59).

Figure 59: Time Trend in HPV Vaccination Coverage (1 Dose) in Year 8 Girls by Location, (shaded area represents 95% confidence intervals)

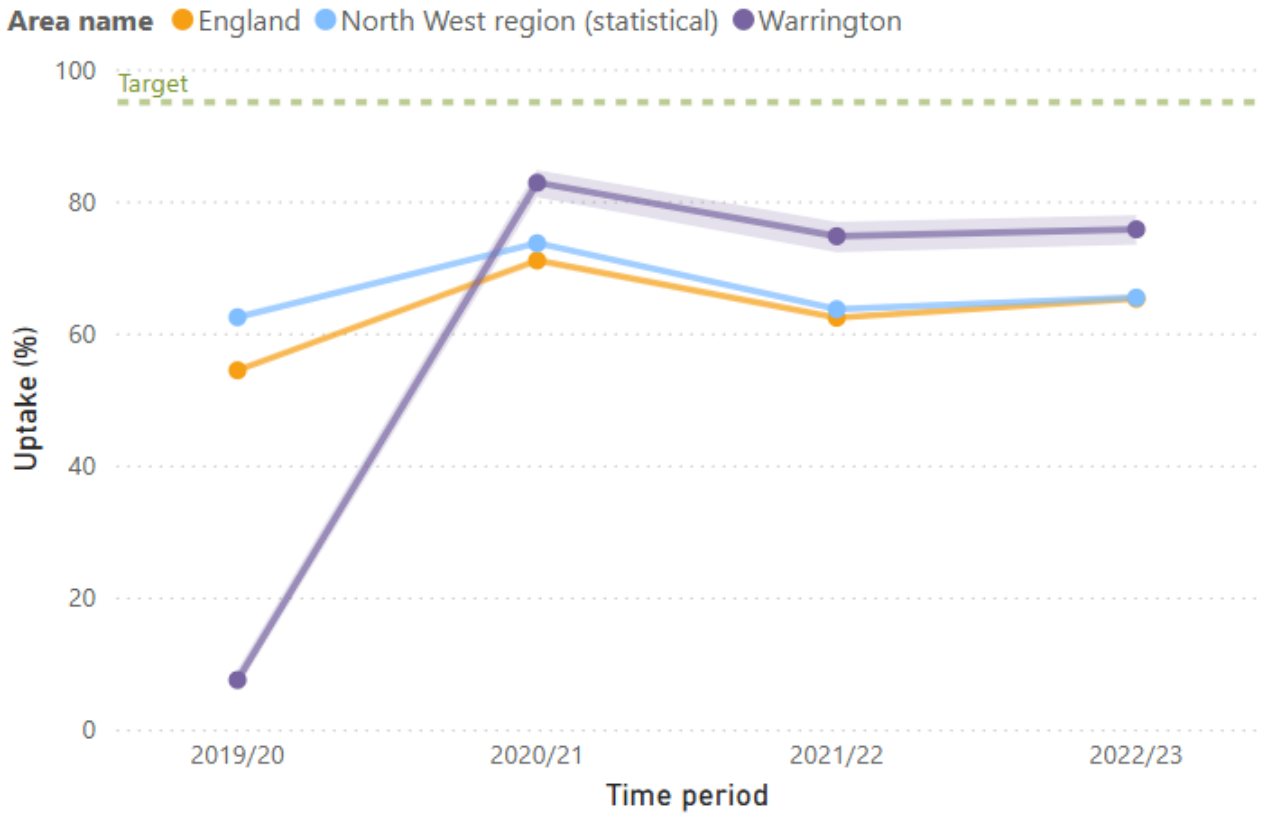


Source: UKHSA Official Statistics (Vaccine uptake guidance and the latest coverage data - GOV.UK (www.gov.uk))

[95] The effects of the national HPV vaccination programme in England, UK, on cervical cancer and grade 3 cervical intraepithelial neoplasia incidence: a register-based observational study - PubMed (nih.gov)

When examining HPV vaccine coverage for Year 8 boys, coverage in Warrington is significantly greater than national and regional levels, following the first year of vaccination for adolescent boys in 2019-20 when it was significantly below national and regional averages (Figure 60). The single dose HPV vaccination coverage in Warrington in 2023-24 amongst Year 8 boys is 75.7%, significantly greater than national (65.2%) and North-West regional levels (65.4%).

Figure 60: Time Trend in HPV Vaccination Coverage (1 Dose) in Year 8 Boys by Location, (shaded area represents 95% confidence intervals)

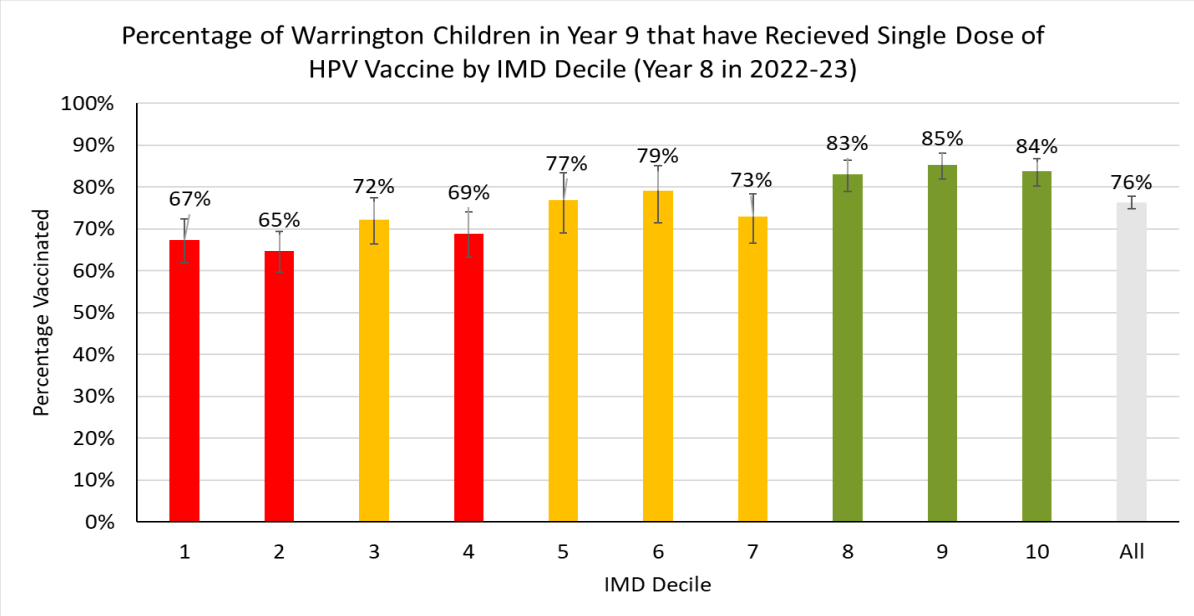


Source: UKHSA Official Statistics (Vaccine uptake guidance and the latest coverage data - GOV.UK (www.gov.uk))

Local Inequalities

HPV vaccine coverage falls with increasing socioeconomic deprivation (figure 61). Year 9 Warrington school children in IMD deciles 1, 2 and 4 were significantly less likely to have had a single dose of HPV vaccine than the average in Warrington (76%) whilst children in deciles 8, 9 and 10 had significantly higher vaccine coverage.

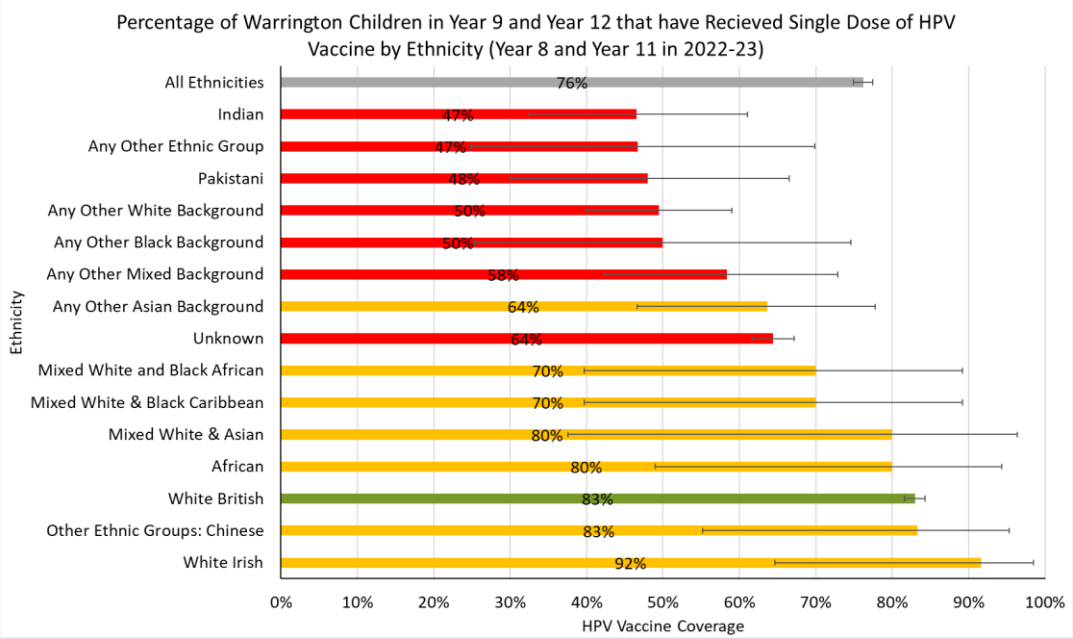
Figure 61: Single Dose HPV Vaccination Coverage by IMD Decile in Warrington Year 9 Schoolchildren in 2024 (Year 8 in 2022-23)



Source: CHIS (Error bars: 95% Confidence Intervals Key: Red = significantly less than Warrington average, Green = significantly more than Warrington average, Yellow = not significantly different to average)

HPV vaccine coverage varies significantly by ethnicity (figure 62). In Warrington, 83% of White British school children in Year 9 and 12 had received a single dose of HPV vaccine, which is significantly greater than the Warrington average (76%). Less than half of children of Indian, Pakistani and Other Ethnic Group ethnicities have received the HPV vaccination in Warrington. These groups, in addition to children that identify as Any Other Black Background, Any Other White Background, Any Other Mixed Background or were categorised as Unknown, have significantly lower HPV vaccine coverage than the Warrington average.

Figure 62: Single Dose HPV Coverage in Year 9 and Year 12 Children in Warrington by Ethnicity.



Source: CHIS

10.3 HPV Vaccine: Sexual Health Service

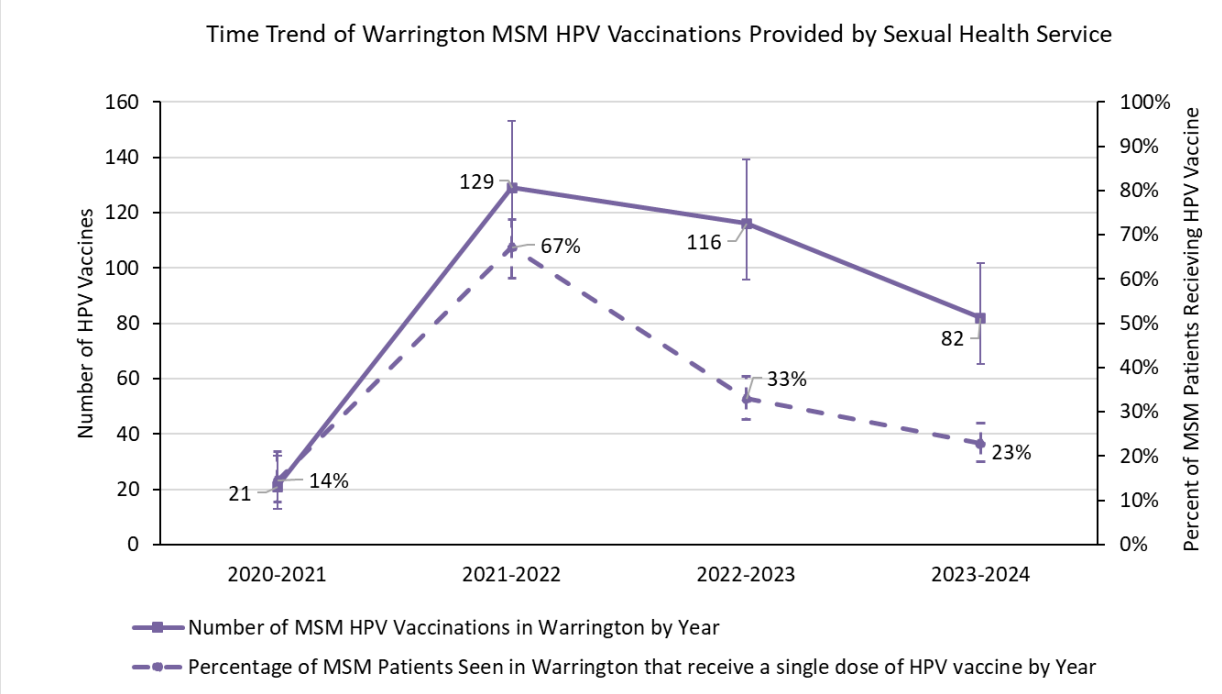
GBMSM (gay, bisexual and other men who have sex with men) are also eligible for the HPV vaccine via the sexual health service (SHS) in Warrington. Figure 63 shows the number of HPV vaccinations provided by the sexual health service to MSM between the years 2020-21 to 2023-24.

The number of vaccinations provided has increased from a low of twenty-one during the COVID-19 pandemic to 129 in 2021-22 before declining in the subsequent two years to eighty-two.

Previous national reporting of HPV vaccination for GBMSM has used the percent of MSM attending sexual health service clinics and receiving a first dose of HPV vaccine for monitoring uptake.[96] Data from Warrington SHS has been used to estimate uptake of MSM attending SHS in Warrington. This percentage estimate does not consider which dose of vaccine was given, the eligibility for HPV vaccination of the MSM population attending SHS or the wider eligibility of MSM that do not attend SHS. In a similar trend to HPV vaccine numbers, the percentage of MSM attending SHS that receive at least one dose of HPV has increased from 14% in 2020-21 to 67% in 2021-22 before declining to 23% in 2023-24 (see figure 63).

[96] HPV vaccination uptake in gay, bisexual and other men who have sex with men (MSM): national programme, 2019 annual report (publishing.service.gov.uk)

Figure 63: Time Trend of Warrington MSM HPV Vaccinations Provided by Sexual Health Service

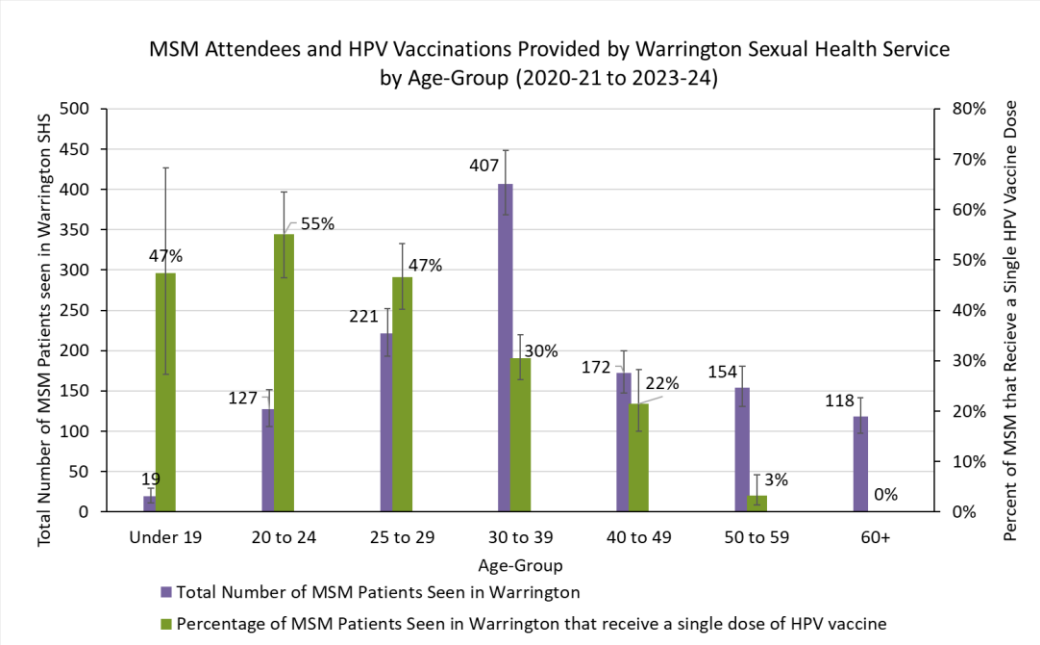


Source: Axess Sexual Health Service, Warrington.

As shown in figure 64, in Warrington, the 30–39-year-old age group has the greatest number of MSM that attended SHS over the last 4 years (407), followed by the 25–29-year-old age group (221) and 40–49-year-old age group (172). When looking at HPV vaccines provided to MSM as a proportion of the total number of MSM attending sexual health services by age-group, uptake is lower amongst older age-groups compared to younger. The current MSM HPV vaccine schedule recommends that MSM aged under twenty-five receive one dose of vaccine whilst those between 25 and 45 receive two doses[97].

[97] HPV vaccination programme: changes from September 2023 letter - GOV.UK (www.gov.uk)

Figure 64: MSM Sexual Health Service Attendees and HPV Vaccination Provided by Sexual Health Service by Age Group



Source: Axess Sexual Health Service, Warrington.

The majority of MSM that attended Warrington sexual health services between the years 2020-21 and 2023-24 and received an HPV vaccine were White British (87%) or identify as Any other White background (7%). This is similar to the population profile of Warrington.

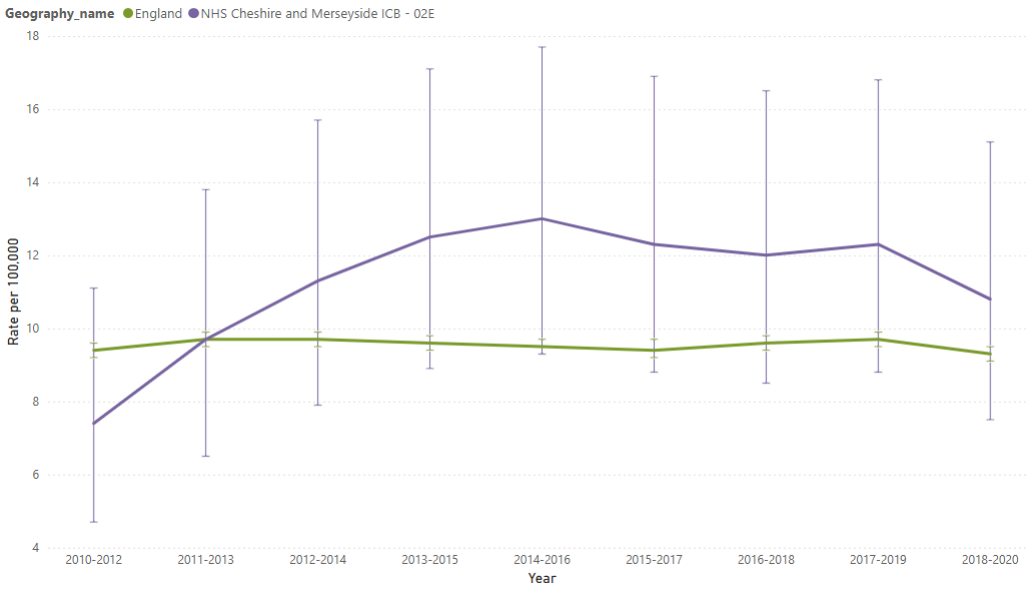
11. CERVICAL SCREENING PROGRAMME

The cervical screening programme is available to all people with a cervix, including women, trans-men, and non-binary individuals.[98] Those that are between the ages of 25 and 49 are invited every 3 years, whilst those between 50 and 64 are invited every 5 years. People over 65 may be invited back if they have an abnormal result or can request one from their GP if they have never received one. The cervical screening test involves swabbing the cervix and testing for the presence of HPV; if it is present then cells taken from the cervix are examined under a microscope (cytology). Those that have abnormal cells are referred for definitive testing and treatment via colposcopy whilst those with normal cells are recalled in a years' time for HPV re-screening.

Cervical Cancer Incidence and Mortality

In the period between 2010-2012, there were twenty-three incident cervical cancer cases in Warrington and 7493 cases in England. This corresponds to an incidence of 7.4 cases per 100,000 women in Warrington and 9.4 cases per 100,000 women in England when directly standardised by age to the 2013 European Standard Population (ESP 2013) (figure 65). The incidence of cervical cancer in Warrington is higher than the England average between the years 2012-2020, however this is not statistically significant. There is a statistically significant decline in age-standardised cervical mortality for England over the 20-year period from 3.8 deaths per 100,000 women to 2.5 deaths per 100,000 women. In Warrington, the age-standardised mortality rate has not differed significantly from the national average. In Warrington there is no significant trend in cervical cancer mortality rate over time, with fluctuations above and below the national age-standardised cervical mortality rate.

Figure 65: Time Trend in Cervical Cancer Age-Standardised Incidence in Warrington and England



Across all IMD quintiles, the age-standardised (ESP 2013) incidence of cervical cancer was statistically similar in Warrington and England in 2022 (10.3 vs. 9.2 cases per 100,000). Whilst there

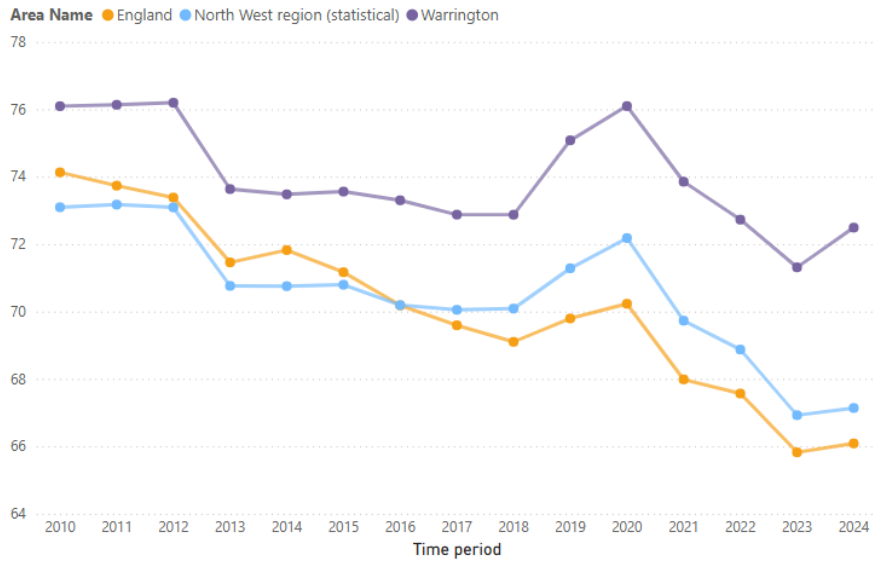
[98] About Cervical Screening | Cancer Research UK

was a statistically significant difference between quintiles 1 and 5 across England this relationship was not observed across Warrington.

11.1 Cervical Screening Coverage

Cervical screening coverage is defined as the percentage of persons that are eligible for cervical screening at a given point in time that have had an adequate cervical screen within the last 3.5 years (if in the 25–49-year-old age group) or 5.5 years (if in 50–64-year-old age groups)[99]. Cervical screening coverage amongst 25- to 49-year-olds has declined in England and Warrington between the years 2010 and 2024. In 2024, 73% of 25–49-year-olds had been screened, this is a slight increase from 71.8 in 2023. Screening coverage is significantly higher in Warrington than the national and regional average (figure 66).

Figure 66: Time Trend of Cervical Cancer Screening Coverage (25- to 49-year-olds) in Warrington, North West and England

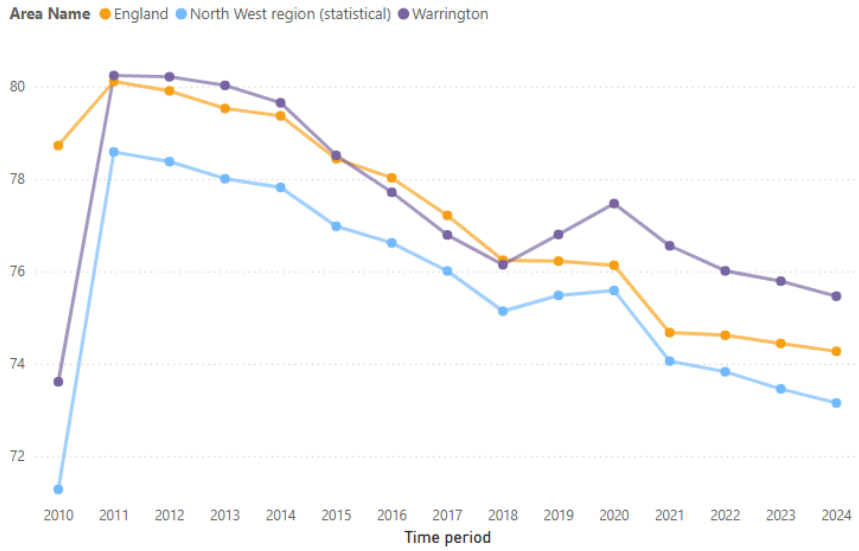


Source: UKHSA Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk) ©Crown copyright 2024 (accessed 10/06/2025)

Since 2013, cervical screening coverage among 50–64-year-olds has declined both nationally and locally. Although a slight increase was observed between 2018 and 2020, coverage has been falling since 2020, likely due to the impacts of the pandemic. In 2024, Warrington's coverage (75.7%) was similar to the England average (74.9%) but significantly higher than the North West average (73.7%) (figure 67).

Figure 67: Cervical Cancer Screening Coverage (50- to 64-year-olds) in Warrington, North West and England

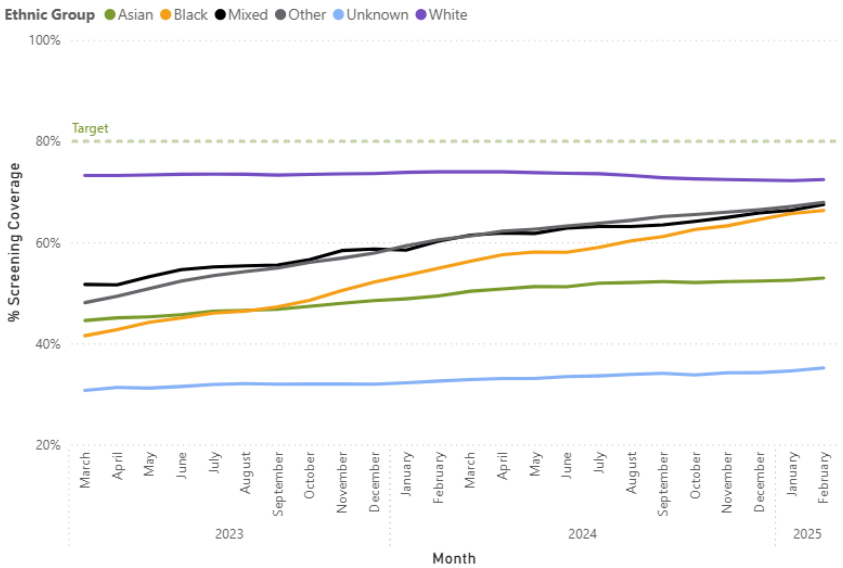
[99] Cervical Screening Programme - Coverage Statistics [Management Information] - NHS England Digital



Source: UKHSA [Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)] ©Crown copyright 2024 (accessed 10/06/2025)

As of February 2025, cervical screening uptake in Warrington reveals notable ethnic disparities (figure 68). White British women registered with a GP practice had the highest proportion with 72% of eligible individuals screened, maintaining a relatively stable rate over time. In contrast, Black, Mixed, and Other ethnic groups have lower screening uptake at 66%, 66%, and 67% respectively, though these figures have been gradually increasing since March 2023, when the uptake was 41%, 51%, and 58%. Asian women have seen a moderate increased in screening participation, rising from 45% in March 2023 to 53% in February 2025 but uptake remains low. However, those with an unknown ethnicity recorded have the lowest uptake at 35% in February 2025, showing only a modest increase of 5% since March 2023.

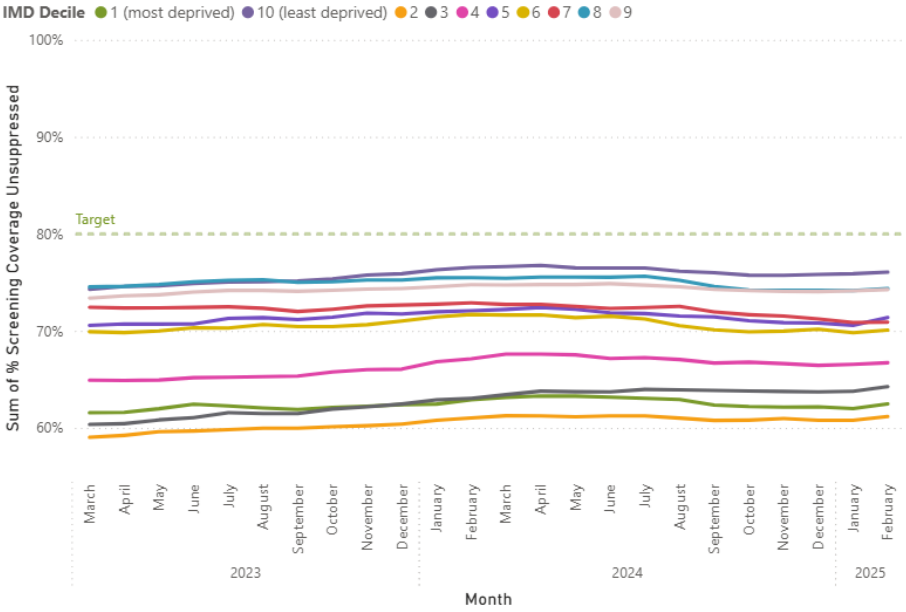
Figure 68: Cervical screening uptake over time in Warrington GP practices by ethnicity.



Source: Cheshire and Merseyside Cancer Screening dashboard

As of February 2025, cervical screening uptake in GP practices across England shows a clear socioeconomic gradient figure 69). The most deprived decile (Decile 1) has a screening rate of 62.5%, while the least deprived decile (Decile 10) has a rate of 76.1%. This represents a difference of 13.6 percentage points between the most and least deprived areas.

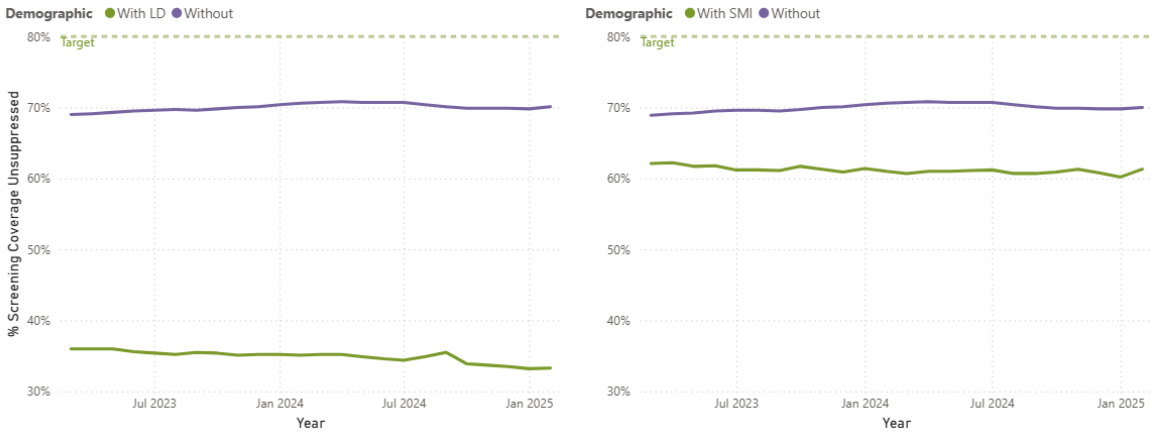
Figure 69: Cervical screening uptake over time in Warrington GP practices by deprivation decile.



Source: Cheshire and Merseyside Cancer Screening dashboard

As of February 2025, cervical screening uptake remains significantly lower among individuals with learning disabilities (LD) and those with serious mental illness (SMI) compared to the general population (figure 70). Only 33.3% of eligible patients with LD have been screened, compared to 70.1% in those without LD. Similarly, 61.3% of eligible patients with SMI have been screened, compared to 70% in those without SMI. These disparities have remained relatively consistent since 2023.

Figure 70: Cervical screening uptake over time in Warrington GP practices by a) learning disability status, b) serious mental illness.



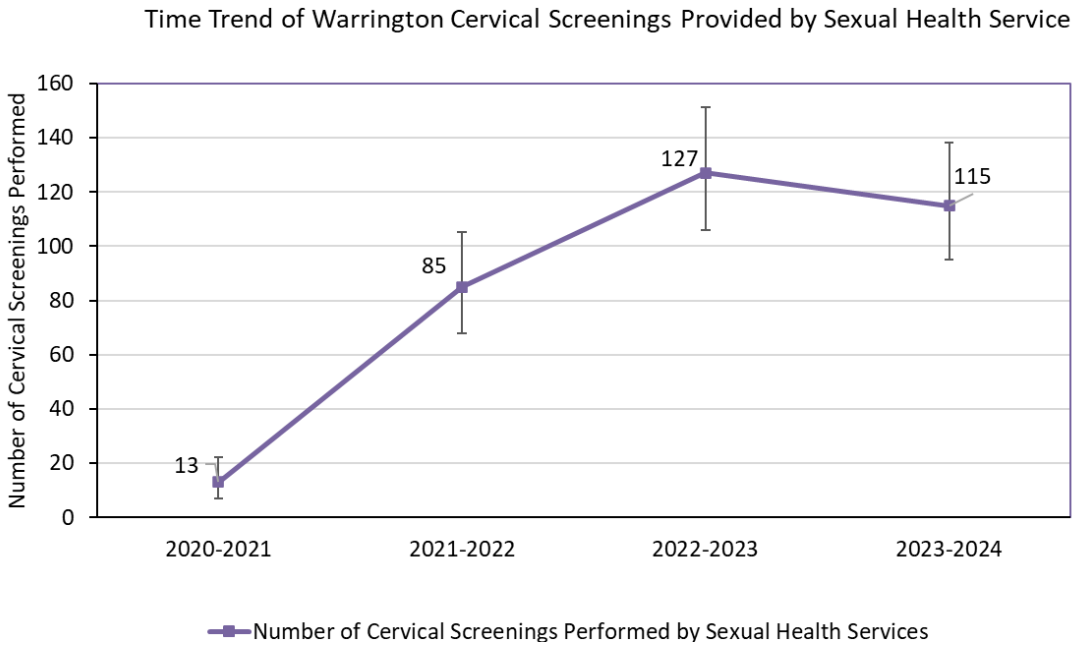
Source: Cheshire and Merseyside Cancer Screening dashboard

Cervical Screening: Sexual Health Service

In addition to local GP practices, Warrington's sexual health service also performs cervical screening. The total number of screenings provided in the 4 years from 2020-21 to 2023-24 was 340 (Figure 71). There were 13,600 individuals screened in Warrington in the year 2022-23[100], highlighting that the sexual health service provides a small proportion (<1%) of total cervical screenings across Warrington. The current Warrington sexual health service contract caps total annual screenings provided at 250, which has not been met. Younger women are more likely than those aged fifty and over to take up sexual health screening through a sexual health service.

[100] Cervical Screening Programme, England - 2022-2023 [NS] - NHS England Digital

Figure 71: Time Trend of Warrington Cervical Screenings Provided by Sexual Health Service



Source: Axess Sexual Health Service, Warrington.

HPV Vaccination

In addition to ethnic and socioeconomic inequalities in cervical screening uptake, there are wider inequalities experienced by individuals which are recognised by the PHE Screening inequalities strategy[101]. Women in the most deprived groups (most deprived quintile) are less likely to attend cervical screening yet are more likely to have high-risk HPV, and a higher risk of being diagnosed with/dying from cervical cancer. Younger women are less likely to take up screening compared to the fifty and over age groups. Women with learning disabilities are less likely to participate in cervical screening.

It is important to consider how inequalities in the HPV vaccination programme and cervical screening programme may overlap, effectively significantly reducing the risk of cervical cancer in groups that have high uptake of both interventions and failing to reduce risk in groups with low uptake of both interventions. Evidence from Scotland shows that cervical screening uptake is twice as high in HPV-vaccinated women aged 24-29 (68%) than non-vaccinated women in this age-group (32%), suggesting that inequalities in cervical cancer outcomes are likely to widen if uptake of both the vaccination and screening programmes does not become more equitable[102].

[101] PHE Screening inequalities strategy - GOV.UK (www.gov.uk)

[102] Cancer Plan Progress Updates: Detection and Diagnosis - National cancer plan: progress report - August 2022 - gov.scot (www.gov.scot)

11.2 Cheshire and Merseyside and Lancashire and South Cumbria - Insights work

NHSE NW undertook engagement work around cervical screening amongst residents in the North-West of England (including Warrington). A live survey was open between 10th July and 1st October 2023 and shared via email and social media advertisement. 2935 individuals completed the survey, 40% of which were from Cheshire and Merseyside. 51 face-to-face meetings took place to promote the survey, including at Warrington Maternity – Meet the Midwife (via the Living Well bus).

Key findings include:

- Anxiety about the procedure and difficulties getting appointments were common themes as to why individuals had not completed cervical screening.
- 10% of respondents felt they did not need to attend as they were not sexually active.
- 10% said they didn't believe cervical screening would prevent them from becoming ill with cervical cancer.
- 1 in 6 respondents feel that cervical screening is not required if someone has had the HPV vaccine.
- Participants felt improved access to screening would be achieved by offering screening on evenings and weekends (77%), allowing people to book online (70%), having more appointment times (56%), offering screening in more places (45%), offering mobile screening closer to people's homes (41%), allowing people to do a self-sample test at home which they send to the laboratory (40%).
- Participants felt improving information provision about the procedure would make it easier for people to attend including by informing people if a female doctor or nurse would perform the test (69%), explain why cervical screening is important (60%), give information on what happens when you go for cervical screening (58%) and give people the opportunity to talk about screening to a health professional (48%).

Recommendations from the Insight report include:

- Establish a NW-wide cervical screening steering group led by NHSE NW
- Improve information/ understanding of the HPV vaccination and cervical screening
- Improve information about the procedure
- Dispel misconceptions
- Address embarrassment and anxiety
- Send reminders
- Acknowledge pain
- Improve access
- Offer specialist support/clinics for individuals who have experienced trauma/sexual assault
- Provide additional training and support for sample takers
- Address specific barriers relating to gender, culture and disability
- Remain aware of national work on self-sampling and identify further opportunities for the North-West to participate in self-sampling

11.3 Cervical screening pilots

As part of the NHSE NW work on cervical screening, pilot projects have been taking place across Cheshire and Merseyside with the aim of addressing some of the issues raised in the insights work. Warrington sexual health service has taken part in a pilot contacting and providing appointments for those due for their first cervical screening and promoting alternative venues for screening appointments. The pilot has included contacting those due for screening, providing Saturday clinic appointments and targeted communications campaign. The pilot is currently being evaluated and reported on.

Warrington will also be part of the next phase of pilots for cervical screening provided in mobile screening units due to commence July 2025. The mobile screening unit will be at various sites in Warrington including at large Warrington employers which may have higher number of employees who are eligible for cervical screening.

HPV Self-Testing:

HPV self-testing involves women and people with cervixes using a long cotton swab or soft brush to collect a sample from the vagina. Self-testing can be performed at home, avoids the need for a healthcare professional to administer the test, no speculum is involved, and the swab can be mailed home and returned directly to the lab.[103]

Given the falling cervical screening coverage, with many local authorities below the 80% national target, the UK National Screening Committee called for more evidence into how HPV self-testing could be used as part of a national screening programme.[104]

A recently completed multicentre trial in London has shown self-testing can be used to increase screening uptake amongst people overdue screening, those that have never been screened, people from ethnic minority communities and people from more deprived areas.[105] 55% of women and people with cervixes returned a self-sample after being opportunistically offered the self-swab when they attended the GP and were flagged as overdue cervical screening. A direct-mailout of self-test kits to all individuals that were 15 months overdue for a cervical screen was done, 12.9% of these kits were returned. Over the 7.5-month trial, GPs that offered self-screening saw a 1.6% increase in cervical screening coverage and it is estimated that over a 3-year screening period coverage could rise by 7.4%. HPV self-sampling in Stockholm resulted in a 4% increase in cervical screening coverage within a year.[106]

In terms of developing self-sampling at a Warrington or Cheshire and Merseyside level, the Cervical screening Insights report recognised that many respondents felt self-sampling would support more individuals to take up screening and that work was being undertaken nationally to assess self-

[103] What is HPV self-sampling? | Jo's Cervical Cancer Trust (jostrust.org.uk)
[104] Significant landmark as primary HPV screening is offered across England – PHE Screening (blog.gov.uk)
[105] Opportunistic offering of self-sampling to non-attenders within the English cervical screening programme: a pragmatic, multicentre, implementation feasibility trial with randomly allocated cluster intervention start dates (YouScreen) - eClinicalMedicine (thelancet.com)
[106] Cervical cancer screening improvements with self-sampling during the COVID-19 pandemic | medRxiv

sampling, with areas in the North West acting as pilot sites. The report stated that NHSE NW Public Health Commissioning team can provide further updates on national workstreams as these develop, but it is recommended that pilots implemented in the North West do not duplicate any work underway at a national level.

Cervical Screening Programme Performance:

An annual statistical report is published on the outcomes of the cervical screening programme across England[107]. This includes data on the call and recall system, on screening samples examined by pathology laboratories and on subsequent colposcopy referral.

Nationally, for 76.5% of cases time from screening to receipt of result for 25–64-year-olds is less than 2 weeks. In Warrington, only 35.8% of individuals receive a result in 2 weeks and 29.2% of results take over 3 weeks (compared to 11.9% nationally). The average result time for the North-West is 36.7% of results within 2 weeks, the lowest of all 9 regions in England, indicating a wider issue with the turnaround time of North-West cytology services.

65.4% of samples examined by Manchester Cytology Centre (the North-West cytology service) were authorised for reporting within 2 weeks of the sample being received, the 2nd worse performing centre, compared to an average 2-week receipt to authorisation of 87.5% across England. In addition, 2.5% of national samples take over 5 weeks from receipt to authorisation compared to 10.5% of samples at Manchester Cytology Centre.

The time from referral to first offered appointment for coloscopy in the North-West was comparable to the national average. Data for the North West and England shows 44.2% and 42.5% respectively for a four week wait between referral to first offered appointment in the North West and England. Attendance for colposcopy amongst individuals with new appointments in the North West was 74.2%, similar to 72.4% national average.

Table 15 highlights that cervical screening samples in Warrington had a marginally higher proportion of negative results than England and the North West.

Table 15: Cervical Screening Results by Geography, 2022-23

Region/LA	Eligible population (thousands)	Number of individuals screened (thousands)	Negative (%)	Borderline change (%)	Low-grade dyskaryosis (%)	High-grade dyskaryosis (moderate) (%)	High-grade dyskaryosis (severe) or worse (%)
England	16,258.0	3,417.6	95.0	1.4	2.6	0.6	0.4
North-West	2,050.5	433.3	95.8	1.1	2.2	0.4	0.4
Warrington	58.9	13.6	96.2	0.9	2.1	0.4	0.4

The percentage of patients in the North West that were informed within 4 and 8 weeks of having a biopsy taken at colposcopy was 67.8% (73.7% in England) and 95.6% (96.5% in England), respectively.

[107] Cervical Screening (Annual) - NHS England Digital

Wait times for colposcopy clinic at Warrington Hospital were better than the England average with 98.9% of high-grade dyskaryosis referrals in Warrington waiting less than 2 weeks for a colposcopy appointment compared to 93.2% across England and 96% in the North West.

99.6% of individuals that underwent colposcopy biopsy in Warrington received a result within 8 weeks (national average was 96.5%) and 87.5% of Warrington treatment biopsies showed premalignant CIN (cervical intraepithelial neoplasia) or worse, compared to 79.3% nationally.

12. CONCLUSION

Sexual health is a fundamental component of overall health and wellbeing. This needs assessment highlights both progress made and inequalities across our population.

While Warrington experiences a generally lower burden of most STIs compared to the North West and England overall, this assessment highlights the persistence of significant inequalities across key population groups. Younger people, especially women, GBMSM and those living in more deprived areas continue to experience higher rates of STIs, mirroring national trends. Warrington also has one of the lowest testing rates in the region, which may contribute to underdiagnosis and delayed treatment, leading to poorer outcomes. Additionally, disparities are evident in HPV vaccinations and cervical screening uptake, especially among individuals with learning disabilities and serious mental illness and some ethnic communities.

Addressing these gaps is vital to improving sexual health outcomes and ensuring equitable access to prevention, testing and treatment. The recommendations made aim to address the low testing rates and inequalities in STI rates, improve access to contraception, HPV vaccination and cervical screening as well as findings identified in the consultations.

Moving forward, a system-wide, person-centred approach is essential. Building on existing strengths, local partnerships, and community assets will be key to designing inclusive, accessible, and effective sexual health services that meet diverse needs now and in the future.

Abbreviations

Acronym	Full Form
AI	Artificial Intelligence
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
BAME	Black, Asian, and Minority Ethnic
BASHH	British Association for Sexual Health and HIV
CCG	Clinical Commissioning Group
CHC	Combined Hormonal Contraception
CHEMSEX	The practice of using drugs, typically psychoactive substances, to enhance or facilitate sexual activity
CHIS	Child Health Information Service
CI	Confidence Interval
CIN	Cervical Intraepithelial Neoplasia
COVID	Coronavirus
DHSC	Department of Health and Social Care
EHC	Emergency Hormonal Contraception
EHSHCG	English HIV and Sexual Health Commissioners' Group
ESL	English as a Second Language
ESP	European Standard Population
FGM	Female Genital Mutilation
FSRH	Faculty of Sexual and Reproductive Healthcare
FTC	Fast-Track Cities
GBMSM	Gay, Bisexual, and Men who have Sex with Men
GHB	Gamma-Hydroxybutyrate
GIC	Gender Identity Clinic
GOV	Government
GP	General Practitioner/ Practice
GUM	Genitourinary Medicine
GUMCAD	Genitourinary Medicine Clinic Activity Dataset
HIV	Human Immunodeficiency Virus
HNA	Health Needs Assessment
HPV	Human Papillomavirus
HSV	Herpes Simplex Virus
ICB	Integrated Care Board
IMD	Index of Multiple Deprivation
IUC	Intrauterine Contraception
IUD	Intrauterine Device
IUS	Intrauterine System
JCVI	Joint Committee on Vaccination and Immunisation
LA	Local Authority
LARC	Long-Acting Reversible Contraception
LB	Lesbian and bisexual
LGA	Local Government Association
LGB	Lesbian, Gay, and Bisexual

LGBT	Lesbian, Gay, Bisexual, and Transgender
LGBTQ	Lesbian, Gay, Bisexual, Transgender, and Queer
LSOA	Lower Layer Super Output Area
LUHFT	Liverpool University Hospitals Foundation Trust
MPOX	Monkeypox
MSM	Men who have Sex with Men
MSOA	Middle Layer Super Output Area
NASTAL	National Survey of Sexual Attitudes and Lifestyles
NCSP	National Chlamydia Screening Programme
NHS	National Health Service
NHSE	NHS England
NHSEI	NHS England and NHS Improvement
NICE	National Institute for Health and Care Excellence
NOMIS	National Online Manpower Information System
NW	North West
OHID	Office for Health Improvement and Disparities
ONS	Office for National Statistics
OUTREACH	Outreach Programme
PEP	Post-Exposure Prophylaxis
PEPSE	Post-Exposure Prophylaxis for Sexual Exposure
PHE	Public Health England
PHOF	Public Health Outcomes Framework
PID	Pelvic Inflammatory Disease
POP	Progestogen-Only Pills
PSHE	Personal, Social, Health, and Economic Education
Psychosex	Psychosexual therapy, also known as sex therapy, is a type of talking therapy that addresses sexual difficulties and related issues
PWID	People Who Inject Drugs
RAG	Red, Amber, Green (Risk Assessment)
RSE	Relationships and Sex Education
RSHE	Relationships, Sex, and Health Education
SH	Sexual Health
SHR	Sexual Health and Reproductive
SHS	Sexual Health Services
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TMBN	Transgender Men and Bon-Binary people
UK	United Kingdom
UKHSA	UK Health Security Agency
UNAIDS	Joint United Nations Programme on HIV/AIDS
WARRINGTON	Warrington Borough Council
WBC	Warrington Borough Council
WHO	World Health Organization
WRHS	Warrington and Runcorn Health Services
WSW	Women who have Sex with Women

Appendices

Appendix 1: Key themes from the consultation

Contacting the service and appointments

a. There are frequent comments regarding difficulty contacting the service by telephone, availability of appointments, including urgent appointments in Warrington and appointments outside of office hours and at weekends. All to be considered for new specification.
b. Review with Axess phone system and troubleshoot any issues with aim to improving phone access. Emphasis importance of being able to contact service (including in specification), as many may be put off if not able to get through first time.
c. There are comments regarding availability of online STI testing.
d. Check if any issues or space for improvement with online booking process.
e. Review opening hours including outside office hours
f. Review availability of appointments and how we capture if people have been unable to book an appointment
g. Consider out of hours and weekend appointments being available for routine consultations.
h. There was a range of preferences regarding preferred appointment type, with a higher number preferring face to face appointments. Important to continue to offer a range of appointment options.
i. The most common response for preferred appointment type, was a mixture of both drop in and booked appointments, reflecting current service provision. Important to continue to offer a range of appointment options.

Visibility of the service, communications and marketing

a. Visibility and recognition of the service and brand needs to be increased.
b. More communications and marketing to increase visibility of the service and services available.
c. Visibility of information on the service and other ways to access sexual health services needs to be improved. This would be the service own website but also to ensure information is accurate on other sites.
d. Communications that SH24 is for all ages not only young people.
e. Targeted communications to young people, recognising that social media does not appear to be effective.
f. Low numbers of Axess listed social media as a source of information on the service, this needs to be considered as part of communications strategy.
g. Low numbers of stakeholder respondents report accessing information on the sexual health service via social media or following the service on social media channels, this needs to be taken into account for communications strategy.
h. Workplaces could be considered as a route for sharing of information regarding the service and how to access.

i. As expected, there is a higher proportion of females accessing the service. The higher number of services relevant to females will mean there will always be a higher proportion. To consider campaign/marketing targeting males to inform of services available and how to access.

j. The highest number of respondents was age group 25-34, followed by 35-44 and 45-64. This will be compared with Axess service user data for accuracy. This may reflect that the older age groups are most frequent users of the service or may reflect that those age groups were the ones who completed the survey. To consider age groups for targeted marketing for the service.

k. A higher proportion of users report using services related to STI's (either testing, treatment or vaccines) compared to contraception. For consideration regarding how the service is viewed and where people prefer to access contraception (e.g. primary care) it is important to ensure that there is choice of where to access, but awareness of the range of services that Axess offer.

Addressing worries and concerns regarding visiting the sexual health service

a. It would be useful to clarify meaning of this point in focus groups 'I don't know who I will see if I go to the service'. Consider videos walking through an appointment and 'meeting' staff. Consider staff photos and bios on website.

b. Video and communications to address embarrassment, reiterate staff have experience in talking about sensitive subjects.

c. In order to reduce the worry and fear of attending, improve information on website including videos, showing what the service looks like, including treatment rooms, introductory videos of staff and talk throughs of procedures.

d. Communications including on website and check within the sexual health service regarding sharing of information and confidentiality and how that is made clear. Consider a 'I am worried about…' section on website and promote that on social media.

e. Relatively low numbers (4.6%) commented 'I am worried about language/cultural/religious barriers', but to check about information in other languages and if anything is raised regarding this in health needs assessment.

f. Consider ways to communicate and make clear the accessibility of the service. Consider 'walk through' video showing accessibility features and facilities.

Interdependencies

a. Check and improve links and referrals pathways into sexual health services via drug and alcohol service and youth services.

Appendix 2: Sexual health service venues and appointment types

Table 1: Details of sexual health services and appointment types available in Warrington.

Clinic	Address	Services	Opening hours
Axess Sexual Health Warrington	Bath Street Health and Wellbeing Centre, Warrington, WA1 1UG	• Rapid HIV testing • PEP/ PrEP • Emergency contraception • Contraception • STI testing • Coil fitting • Implant fitting • Vaccines • Pregnancy test • HIV Treatment Clinic • Trans STI screening & Support • Sexual problems counselling service • Specialist/ complex contraception	Clinic Opening Times for booked appointments: • Monday 9 a.m. - 4 p.m. • Tuesday 9 a.m. - 1:30 p.m. • Wednesday 9 a.m. - 4 p.m. • Thursday 11 a.m. - 2:30 p.m. • Friday 9 a.m. - 4 p.m. Walk in clinics: • Monday/ Wednesday 5pm-7pm Appointment booking line and telephone assessment opening times: • Monday 9 a.m. - 4 p.m. • Tuesday 9 a.m. - 1:30 p.m. • Wednesday 9 a.m. - 4 p.m. • Thursday 11 a.m. - 2:30 p.m. • Friday 9 a.m. - 4 p.m.
Axess young person's clinic (19 and under) Warrington	Bath Street Health and Wellbeing Centre Warrington, WA1 1UG	• Emergency contraception • Contraception • STI testing • Implant fitting • Pregnancy test	Walk in clinic: Thursday 3:30 p.m. - 6 p.m.
Axess young person's clinic (19 and under) Orford	Jubilee Way, Warrington, WA2 8HE	Emergency contraception Contraception	Walk in clinic: Tuesday 3:30 p.m. - 6 p.m.

Source: Axess sexual health service