Hull City Council

Hull Sexual Health Needs Assessment 2026

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Glossary

Abbreviation	Full Term
AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy (treatment for HIV)
ADPH	Association of Directors of Public Health
BBV	Blood-borne virus
CHCP	City Health Care Partnership CIC (integrated sexual health service provider)
EHC	Emergency hormonal contraception
FFT	Friends and Family Test
GBMSM	Gay, bisexual and other men who have sex with men
HCC	Hull City Council
HPV	Human papillomavirus
HIV	Human immunodeficiency virus
ICB	Integrated Care Board
IMD	Index of Multiple Deprivation
ISHS	Integrated Sexual Health Service
JSNA	Joint Strategic Needs Assessment (www.hulljsna.com)
KPI	Key performance indicator
LARC	Long-acting reversible contraception
LGA	Local Government Association
LGBTQ+	Lesbian, gay, bisexual, transgender and queer/questioning
LSOA	Lower layer super output area
MESMAC	Yorkshire MESMAC (community sexual health and HIV prevention provider)
MSM	Men who have sex with men
NCSP	National Chlamydia Screening Programme
NHS	National Health Service

Abbreviation	Full Term
NICE	National Institute for Health and Care Excellence
OHID	Office for Health Improvement & Disparities
ONS	Office for National Statistics
PEPSE	Post-exposure prophylaxis after sexual exposure (for HIV)
PHOF	Public Health Outcomes Framework
PrEP	Pre-exposure prophylaxis (for HIV)
RSE	Relationships and sex education
SH	Sexual health
SHNA	Sexual Health Needs Assessment
SHS	Sexual health services
STI	Sexually transmitted infection
UKHSA	UK Health Security Agency
VCS	Voluntary and community sector
VCSE	Voluntary, community and social enterprise sector

Executive Summary

This Sexual Health Needs Assessment (SHNA) provides an updated assessment of sexual and reproductive health needs in Hull in 2025. It has been produced to inform the Joint Strategic Needs Assessment (JSNA), commissioning decisions and system planning, and builds on the findings of the 2022 SHNA.

Hull has a relatively young population, high levels of deprivation and increasing ethnic, cultural and sexual diversity. National evidence shows that these characteristics are associated with higher sexual health risk and greater barriers to accessing services. Local data and insight indicate that these patterns are reflected in Hull, with continued demand for sexual health services among younger people and priority groups, alongside variation in access and engagement.

Analysis of surveillance and service data suggests that rates of sexually transmitted infection (STI) testing and diagnosis in Hull are lower than might be expected when compared with areas with similar demographic and socioeconomic profiles. While some variation is anticipated, this finding raises the possibility that a proportion of infections may be undiagnosed, particularly among groups who face barriers related to stigma, digital exclusion, language or trust in services. Late HIV diagnosis remains an important concern, highlighting the need for continued emphasis on early testing and engagement.

Contraception and reproductive health remain central to improving outcomes. Long-acting reversible contraception (LARC) is available through both specialist and primary care services, but uptake appears uneven across age groups and settings. Under-18 conception rates in Hull remain among the highest in England, reflecting persistent inequalities and reinforcing the importance of sustained, multi-agency prevention and support for young people.

Hull's integrated sexual health system has undergone significant change following recommissioning in 2024. Key developments include expanded walk-in and community-based clinics, improved digital access alongside preserved non-digital routes, and strengthened outreach delivered in partnership with voluntary and community sector organisations. These changes represent meaningful progress towards a more inclusive and responsive system.

However, challenges remain. Digital exclusion continues to affect some residents; awareness of services and pathways is variable; and routine data do not fully capture the experiences of all inclusion health groups. Addressing these issues will require continued learning, stronger use of equity-focused data, and deeper co-production with communities.

Priority areas for action

This SHNA identifies the following priority areas for future focus:

1. Work with providers to review and, where appropriate, strengthen the way sexual health service data are collected and used to better understand equity of access.
2. Ensure that options for accessing sexual health services promote equitable access and help mitigate inequalities related to digital exclusion.
3. Promote awareness of, and informed access to, long-acting reversible contraception (LARC) across key life stages, including under-19s, over-35s and postnatal contraception.
4. Continue working with partners to provide sexual health services that are inclusive, culturally competent, trauma-informed and informed by service user voice.
5. Continue to promote awareness of, and equitable access to, HIV prevention and testing, including PrEP, with a focus on populations at higher risk of late diagnosis.

6. Explore opportunities and mechanisms to strengthen partnership working, co-design and community involvement in sexual and reproductive health services.
7. Work with young people to better understand experiences and information needs relating to relationships, sexual health and contraception, to inform teenage pregnancy prevention activity.

Implementation of these recommendations should align with national and regional sexual health policy and support the development of future local strategic planning and commissioning activity.

The recommendations in this SHNA are proportionate, evidence-based and aligned with national policy and local context. They are intended to support commissioners, providers, and partners in building on existing strengths, addressing inequalities, and continuing to improve sexual and reproductive health outcomes for Hull's population.

1. Introduction

Hull's integrated sexual and reproductive health system is undergoing a period of transformation following the recommissioning of services in April 2024 and the implementation of a new service specification covering 2024–2029 (Hull City Council, Integrated Sexual Health Service Specification 2024–2029). This Sexual Health Needs Assessment (SHNA) 2025 provides an updated, structured assessment of need, service use and inequalities to inform Hull's Joint Strategic Needs Assessment (JSNA) (Hull JSNA, 2025), local commissioning decisions and wider system planning.

The SHNA focuses on the population of Hull, with particular attention to groups known to be at higher risk of poor sexual and reproductive health outcomes, including young people, people living in areas of high deprivation, LGBTQ+ communities, minority ethnic groups, migrants and other inclusion health groups (Hull SHNA, 2022; Healthwatch Hull, 2024; Yorkshire MESMAC, 2024/25). It draws on a broad range of routinely collected quantitative data, commissioned service performance information, online testing activity, and community insight, and has been led by the Health Protection Lead Officer in partnership with the Sexual Health Lead, Public Health Consultant, public health intelligence colleagues and commissioned providers.

1.1 Definition of sexual health

Sexual health is recognised as a fundamental component of overall health, closely linked to physical, mental and social wellbeing across the life course (World Health Organisation, 2006; Faculty of Public Health, 2008). In line with international and national public health guidance, this SHNA adopts a broad understanding of sexual health that goes beyond the absence of infection or unplanned pregnancy to encompass safe, consensual relationships, bodily autonomy, freedom from violence and coercion, and access to appropriate information, support and services when needed.

The assessment is informed by a life-course and rights-based perspective, reflecting the Faculty of Public Health's framing of sexual health as integral to population health and equity (Faculty of Public Health, 2008; Hull SHNA, 2022). This means considering sexual and reproductive health needs at different life stages, recognising how wider determinants such as poverty, discrimination, housing, education and digital exclusion shape risks and opportunities, and focusing explicitly on groups who face the greatest barriers to access and the poorest outcomes.

1.2 Aims and objectives of the Health Needs Assessment

The primary aim of the Hull Sexual Health Needs Assessment 2025 is to provide an up-to-date account of sexual and reproductive health needs in Hull, and to use this intelligence to inform commissioning, service development and partnership action (Hull SHNA, 2022; Hull City Council, 2024 Service Specification). The SHNA is intended to support Hull City Council, the Humber and North Yorkshire Integrated Care Board (ICB), providers and wider partners to make evidence-informed decisions about investment, service configuration and targeted action to improve outcomes and reduce inequalities (Hull JSNA, 2025; Humber and North Yorkshire ICB, 2024).

More specifically, the SHNA has the following objectives, framed in terms of answerable questions given the available data and insight:

- Describe current patterns and recent trends in sexual and reproductive health outcomes in Hull, including sexually transmitted infections (STIs), HIV, contraceptive use (with a focus on long-acting reversible contraception), under-18 conceptions and abortion, and, where possible, compare these with regional and national benchmarks.
- Assess how these outcomes, and use of commissioned services, vary across key population subgroups, including by age, sex, deprivation, ethnicity, sexuality and other inclusion-health characteristics, to identify and quantify health inequalities where data allow.
- Examine the accessibility, reach and quality of Hull's integrated sexual health system, drawing on CHCP performance data, narrative contract reporting, online testing dashboards, MESMAC KPIs, Healthwatch engagement findings, complaints and Friends & Family feedback, and relevant case studies.
- Synthesise quantitative and qualitative insight to understand barriers and facilitators to access for priority and inclusion-health groups, including digital access, service visibility, cultural competence, stigma, and preferences for clinical versus community-based provision.
- Identify realistic, evidence-informed options for strengthening Hull's sexual and reproductive health system, including targeted actions to address identified inequalities and support delivery against the new service specification and wider policy frameworks.

The scope and depth of the SHNA have been deliberately aligned with the available data and agreed "rapid refresh" methodology, which relies primarily on secondary analysis of existing quantitative datasets and recent qualitative engagement, rather than new large-scale primary research. This approach reflects both proportionality and a commitment to using public health intelligence efficiently, while ensuring that key questions about need, inequalities and service performance can be addressed in a way that is transparent, reproducible and suitable for inclusion within Hull's JSNA (Hull City Council Public Health, 2025; CHCP, 2024/25; Yorkshire MESMAC, 2024/25).

2. Methodology and Insight Sources

This Sexual Health Needs Assessment (SHNA) was delivered as a structured "rapid refresh" of the 2022 assessment, drawing primarily on existing data. The approach was agreed with Hull City Council Public Health and Commissioning leads to ensure proportionality, minimise duplication of recent engagement undertaken for the 2024 service recommissioning, and maximise the use of high-quality intelligence already available across the system (Hull SHNA, 2022; Hull City Council Public Health, 2025).

A mixed-methods design was used, combining: analysis of routine activity and outcome data from commissioned services and national public health datasets; online testing activity and positivity data; provider narrative reports; targeted community and service-user feedback; and case-study material illustrating inclusion-health and outreach practice. Quantitative and qualitative sources were synthesised to describe current need, assess inequalities between sub-groups, understand barriers and facilitators to access, and inform practical recommendations for commissioners and providers (CHCP, 2024/25; Preventx, Q3 2024/25; Yorkshire MESMAC, 2024/25; Healthwatch Hull, 2024).

This SHNA was produced using aggregated, non-identifiable information drawn from routine commissioned-service monitoring, published national datasets and secondary qualitative reports.

No patient-level or directly identifiable data (e.g., name, NHS number, full date of birth, full address) were accessed or processed for this assessment. Provider datasets were received and treated as contract monitoring intelligence and used only for descriptive analysis and service planning. All working files were stored within approved Hull City Council systems, with access restricted to staff involved in the SHNA. Findings are presented only in aggregate form, and small-number suppression and cautious interpretation were applied where relevant, particularly for subgroup and postcode/ward-level analyses. On this basis, and given the absence of personal data processing, a DPIA was not required for the SHNA rapid refresh; however, data limitations and risks of over-interpretation are explicitly set out in the Methods and Limitations sections.

2.1 Primary sources of data and intelligence

The SHNA drew on the following core sources of quantitative and mixed-methods intelligence:

- Integrated Sexual Health KPIs and contract monitoring data: Routine performance data for Hull's integrated sexual health service, including activity by intervention type (e.g. GUM, contraception, LARC), emergency contraception, STI testing and positivity, HIV testing and PrEP, and key waiting-time and access indicators. These data, covering 2024/25 with month-by-month and year-to-date figures, were used to assess service utilisation, clinical activity and performance against contractual standards (CHCP, 2024/25 Integrated Sexual Health KPIs; ICS Contract Report, May 2025).

- Quarterly provider narrative reporting: CHCP Quarter 3 and Quarter 4 Narrative Reports (October 2024–March 2025) and the Hull Quarter 2 Contract Narrative Report 2025/26 were used to provide contextual information on service developments, outreach models, community clinic expansion, digital access changes, training, and examples of partnership work and inclusion-health activity. This supported interpretation of the quantitative KPIs and helped identify emerging themes for service improvement (CHCP, Hull Quarter 3 and Quarter 4 Narrative Reports 2024/25; CHCP, Hull Quarter 2 Contract Narrative Report 2025/26).

- Online testing activity and outcomes: The Preventx Hull Online Testing Dashboards for Q3 2024/25 and Q1 2025/26 were used to analyse online STI testing demand, kit orders, completion/return rates, and positivity patterns by ward, age group, gender and sexual exposure. Together, these dashboards cover activity for tests ordered between 1 April 2024 and 30 June 2025, providing a cumulative view of online access across four consecutive quarters rather than a single-quarter snapshot (Preventx, Hull Online Testing Dashboards Q3 2024/25 and Q1 2025/26).

- MESMAC KPIs and activity data: Yorkshire MESMAC KPI and activity data were used to describe the scale and profile of community sexual health improvement and outreach activity, including counts and breakdowns by age, gender, ethnicity, postcode, sexuality and specific inclusion-health groups such as sex workers and people experiencing homelessness. These data informed the assessment of prevention activity, reach into priority communities and the geographical distribution of outreach contacts (Yorkshire MESMAC, KPIs and Activity Report 2024/25).

- Healthwatch Hull sexual health engagement report: The Healthwatch Hull and East Riding Sexual Health Network report (2024) provided thematically summarised qualitative feedback from service users, with a particular focus on young people attending MESMAC drop-ins, college-based sessions and Conifer House clinics. This source was used to explore

perceptions of information, publicity and advice, communication with services, inclusivity of RSE, and the acceptability of clinical and non-clinical settings (Healthwatch Hull, Hull and East Riding Sexual Health Network Report 2024).

- Service specification and commissioning documentation: The Integrated Sexual Health Service specification (2024–2029) and associated commissioning documents were used to describe the intended model of care, access requirements, equity expectations and outcome framework, and to ensure that the SHNA analysis and recommendations were aligned with contractual aims (Hull City Council, Integrated Sexual Health Service Specification 2024–2029).

- Complaints, compliments and Friends & Family Test (FFT) data: Aggregated patient-experience data from CHCP, including complaints, concerns, compliments and FFT responses, were used to provide additional insight into service quality, satisfaction and areas where service users report positive or negative experiences (CHCP, Complaints and FFT dataset 2024/25).

These sources were supplemented by relevant national and local public health datasets (e.g. ONS population estimates, Census 2021, OHID Fingertips sexual and reproductive health profiles, Hull JSNA indicators) to enable comparison of Hull's position with England and other areas where appropriate (ONS, 2023; OHID Fingertips, 2025; Hull JSNA, 2025).

2.2 Expert and system insight

Alongside formal datasets, the SHNA incorporated expert insight from key stakeholders within the local sexual health system. Structured discussions and iterative review were undertaken with: the Sexual Health Lead; the Health Protection Lead Officer; the supervising Public Health Consultant; senior public health intelligence analysts; and provider leads from CHCP and Yorkshire MESMAC (Hull City Council Public Health, 2025; CHCP, 2024/25; Yorkshire MESMAC, 2024/25).

This system insight was used to: interpret quantitative trends in light of operational changes and commissioning intentions; understand the feasibility and impact of new outreach and service models; clarify data quality and coding issues; and sense-check emerging findings and recommendations against frontline experience. The process also ensured that the SHNA narrative remained proportionate and realistic, avoiding over-interpretation of small numbers or data artefacts and aligning the final recommendations with what is operationally deliverable in the current service framework.

2.3 Community voice and lived experience

No new engagement research was commissioned specifically for this SHNA refresh, reflecting the recent investment in community engagement undertaken during the 2024 procurement process. Instead, the assessment drew on existing qualitative sources capturing community voice and lived experience, including:

- The Healthwatch Hull sexual health engagement report, summarising structured conversations with young people and service users in college, MESMAC and Conifer settings (Healthwatch Hull, 2024; Yorkshire MESMAC, 2024/25; CHCP, Quarter 3 Narrative Report 2024).

- Qualitative and narrative elements within CHCP's Quarter 3 Narrative Report and case-study material, including examples of outreach to vulnerable patients and postnatal contraception outreach on maternity wards (Hull SHNA, 2022).

- Informal and narrative feedback embedded within MESMAC activity reports, particularly relating to accessibility, stigma, cultural competence and the experience of inclusion-health groups engaging with community-based provision (CHCP, 2024/25 KPIs; ICS Contract Report, May 2025; Preventx, Q3 2024/25).

These sources were used to triangulate with quantitative findings, ensuring that patterns in activity and outcomes were interpreted alongside service-user perspectives, and that the recommendations explicitly reflect reported barriers and enablers to access (Hull SHNA, 2022; Healthwatch Hull, 2024; Yorkshire MESMAC, 2024/25; CHCP, 2024/25; Preventx, Q3 2024/25).

2.4 Data analysis and synthesis

Quantitative data from CHCP KPIs, ICS contract datasets, Preventx and MESMAC were collated and analysed descriptively, with a focus on: trends over time; comparison with local targets and, where data allowed, regional or national benchmarks; and variation by age, sex, deprivation, ethnicity, sexuality and key inclusion-health characteristics. Analysis emphasised indicators directly linked to service quality, access and inequalities, such as LARC uptake and timeliness, STI testing rates and positivity, HIV testing coverage, PrEP activity and reach of outreach models across Hull wards.

Secondary qualitative material from Healthwatch, CHCP narrative reports and MESMAC was subjected to a structured thematic analysis, following the principles set out by Braun and Clarke. Recurrent codes and themes relating to information and communication, digital access, cultural and social barriers, perceptions of clinical versus community settings, and experiences of inclusion-health groups were identified and then mapped across sources to check for consistency and divergence. These themes were integrated into Sections 5 and 6 of the SHNA to explain quantitative patterns, and were used to shape equity-focused recommendations where quantitative denominators were weak or missing.

Throughout the SHNA, quantitative and qualitative findings were synthesised to address the specific objectives set out in Section 1.2, with explicit attention to articulating the implications for commissioning, service development and targeted action on inequalities. Where possible, findings are presented using clear tables, charts and narrative summaries suitable for inclusion in the JSNA and for use with both technical and wider partnership audiences.

2.5 Limitations

Several methodological and data limitations should be noted when interpreting the findings of this SHNA:

- Coverage and representativeness of qualitative insight: Healthwatch engagement involved a relatively small number of participants, mainly young people engaging with college-based and MESMAC services, and cannot be assumed to represent all population groups, particularly those not currently engaged with services. MESMAC and CHCP narratives, while rich, are also shaped by the populations who already access their provision and by staff perspectives.

- Data gaps for some inclusion-health groups: Robust denominator data are lacking for several priority groups (e.g. sex workers, people experiencing homelessness, some migrant communities and people with learning disabilities), limiting the ability to quantify service coverage and outcomes for these populations. In these areas the SHNA relies more heavily on qualitative and case-study evidence, and findings should be interpreted as indicative rather than definitive.

- Routine data quality and coding constraints: Contract monitoring datasets and online testing dashboards are subject to known issues such as incomplete coding of ethnicity, changes in recording systems over time, and small numbers for some indicators at ward or subgroup level. Apparent fluctuations in activity or outcomes may therefore partly reflect data artefacts or small-number variation, and the SHNA has taken a cautious approach to interpreting these patterns.

- Scope of the rapid-refresh model: By design, this SHNA does not include new large-scale surveys or primary qualitative research, and therefore cannot address every potential question in the same depth as a de-novo assessment. The focus has been on maximising what can be robustly inferred from existing intelligence and on highlighting where further work might be warranted in future cycles.

Despite these limitations, the breadth and recency of the quantitative data, combined with system-level narrative and community insight, provide a sufficiently strong and triangulated evidence base to inform commissioning decisions, support JSNA updates and guide targeted action to improve sexual and reproductive health and reduce inequalities in Hull.

3. Policy context, local interpretation and future direction

Sexual and reproductive health services in Hull operate within a broader national, regional and local policy environment, and the current service model has been deliberately shaped by a structured review of twelve key policies and frameworks. This section summarises how these policies have been interpreted for Hull's context, what is currently in place, and where there are agreed, realistic areas for further development.

3.1 National policy expectations for local systems

National policy sets clear expectations for what local sexual health systems should deliver and how local authorities should exercise their responsibilities. The Framework for Sexual Health Improvement in England (2013) describes an integrated, open-access model providing contraception (including LARC), STI and HIV testing and treatment, and prevention and health promotion, with strong emphasis on reducing inequalities and meeting the needs of vulnerable groups; these expectations accompanied the transfer of most sexual health commissioning responsibilities to local authorities in 2013.

The Public Health Outcomes Framework (PHOF) translates national ambitions into measurable indicators for use in needs assessment, planning and performance monitoring. For sexual health, PHOF includes indicators on teenage conceptions, chlamydia detection in 15–24-year-olds, new STI diagnoses and late HIV diagnosis, which are used in Hull to describe trends, inequalities and system performance over time. Hull's high levels of deprivation, young age profile and level of sexual health need make these indicators particularly relevant for local decision-making.

Recent national policy further defines expectations for HIV, STIs and women's health. The HIV Action Plan for England 2022–2025 sets an ambition to reduce new HIV infections by 80% by 2025 and move towards zero new transmissions by 2030, alongside reductions in late diagnosis, through a

combination of prevention, testing, treatment and retention in care, with routine access to PrEP as a core component. The UKHSA STI Prioritisation Framework (2024) provides a structured "situation–target groups–interventions" model and guiding principles to help local authorities systematically identify priority infections and populations and plan targeted interventions, with a strong focus on inclusion health groups, equity and efficient use of resources.

The NHS Long Term Plan, although not specific to sexual health, reinforces expectations around digital-first access, stronger prevention and integrated care systems, which are directly relevant to community-based SRH services. The Women's Health Strategy and associated guidance emphasise improving reproductive health and contraception, developing community-based menopause and women's health services and reducing gendered health inequalities, with women's health hubs as a key delivery vehicle. Taken together, these national documents set out what local commissioners and providers are expected to achieve and the broad models of care that should be in place.

3.2 Regional and professional guidance

Regional and professional bodies provide additional guidance on how local systems should organise themselves and how public health leadership should be exercised. The LGA/ADPH/EHSHCG blueprint for sexual and reproductive health and HIV services in England describes a "whole-system" vision based on integrated commissioning, clear governance, user voice, prevention-focused investment and robust audit and evaluation, encouraging each area to develop a coherent SRH strategy, align local action with national policy and work across organisational boundaries to tackle inequalities.

Public health leadership statements stress the importance of transparent, principles-based prioritisation in the face of rising demand and constrained resources, highlighting safeguarding, trauma-informed practice, digital innovation and explicit focus on health inequalities as core responsibilities for Directors of Public Health and their teams when making commissioning decisions. Within Yorkshire and Humber, the public health network and regional partners have agreed priorities around equitable access to SRH services, collaborative approaches to HIV and STI prevention, workforce development and shared learning across local authority areas.

Locally, the Hull Health and Wellbeing Strategy sets a life-course framework for all health and care services, with reducing inequalities and improving population health outcomes as core aims. Sexual and reproductive health outcomes in Hull are strongly patterned by deprivation, age, sex and other inclusion-health characteristics such as homelessness and substance use, which makes sexual and reproductive health commissioning central to achieving the strategy's objectives. This wider regional and local strategic context informs how national sexual health policies are interpreted and implemented in Hull.

3.3 Local interpretation: current arrangements

Using the policies and frameworks above, Hull has designed an integrated service specification and delivery model that meets core national expectations while responding to local needs and system configuration. The 2024–2029 specification combines contraception and STI/BBV services into a single open-access integrated sexual health service for all ages, with clear pathways to primary care, pharmacies, ICB-commissioned women's health and gynaecology services, safeguarding, substance use, mental health and violence against women and girls provision; this reflects the 2013 national framework's emphasis on integration and the LGA/ADPH blueprint's call for system-wide approaches.

PHOF indicators and local surveillance data are used in needs assessment and contract monitoring to identify trends, inequalities and areas for improvement. Recent commissioning decisions include expanding LARC provision by sub-contracting GP practices in primary care across the city and the

integrated service, and increasing walk-in access by offering designated days and times when walk-in and sit-and-wait appointments are available (service users will be triaged on arrival to assess need and urgency). Outreach capacity and enhancements to digital triage and online testing have been implemented in response to local patterns of need, service demand, and equity considerations highlighted by PHOF and other data. The specification explicitly references trauma-informed practice, safeguarding responsibilities and inclusion-of health populations, aligning with both national sexual health guidance and the Hull Health and Wellbeing Strategy.

The national HIV policy has been interpreted locally through routine access to PrEP within the integrated service, backed by NHS England drug funding and operationalised through local pathways and follow-up, complemented by HIV testing in clinic and community settings, and targeted prevention and support for higher-risk groups through partnerships with MESMAC and other VCSE organisations. Regional women's health and ICB plans have informed the development of menopause services and women's health hubs, and have been linked to local contraceptive and SRH provision through training and pathway work, reflecting the Women's Health Strategy's emphasis on community-based women's health and multi-professional working.

3.4 Critical review: partial implementation and gaps

A structured review of twelve policies and frameworks shows that, while Hull's current model is strongly aligned with core national expectations, some tools and strategies are only partially implemented or not yet used systematically. The UKHSA STI Prioritisation Framework has not yet been applied in a formal local review to agree priority infections, populations and interventions, despite evidence from PHOF and local data of sexual health need and marked inequalities across age groups, geography and risk factors; current targeting of outreach and testing is therefore based mainly on general need and professional judgement rather than a documented STI prioritisation process anchored in the national framework.

Similarly, while Hull has implemented key elements of the HIV Action Plan through routine PrEP provision, expanded testing and community-based prevention, there is no local self-assessment against the plan's indicators, such as coverage of eligible populations, linkage to care or changes in late diagnosis attributable to service developments. For women's health, Hull benefits from integrated pathway which included primary care, CHCP clinics to provide interventions to provide women on waiting list with low level interventions such as HRT and LARC via integrated contraception and sexual and reproductive health services, but there is no explicit local mapping to Women's Health Strategy priorities or routine reporting on menopause access, waiting times, symptom control and equity by deprivation or ethnicity.

At the system level, Hull meets many of the LGA/ADPH blueprint principles in practice, including integrated commissioning, partnership with VCSE organisations and a focus on inequalities, but has not yet completed a formal self-assessment against the blueprint or against agreed Yorkshire and Humber regional SRH priorities. Hull also does not currently have a standalone sexual health strategy document; instead, the local interpretation of national policy and the intended direction of travel are distributed across national documents, the integrated service specification, the Health and Wellbeing Strategy and JSNA chapters, which can make it more difficult for external stakeholders to see a single, coherent narrative even though the underlying arrangements are largely consistent with national expectations.

3.5 Future direction and planned developments

In response to this critical review, a set of specific, feasible developments has been identified to strengthen alignment, transparency and assurance over the next planning period. First, there is an opportunity to develop a concise Hull sexual health strategy that brings together the existing service

specification, PHOF analysis, regional work and national frameworks into a single public-facing document, making the local interpretation of policy and the planned direction of travel explicit and easier to review over time.

Second, a time-limited application of the UKHSA STI Prioritisation Framework, involving UKHSA, CHCP, public health, MESMAC and other partners, could help to identify priority infections and populations in a structured way and inform a targeted action plan for outreach, testing, partner notification and prevention, sharpening the focus on inequalities and providing a clearer justification for how limited resources are deployed.

Finally, a system-wide self-assessment against the LGA/ADPH blueprint and Yorkshire and Humber regional priorities is proposed to identify further opportunities for quality improvement and shared learning across the wider system. These developments do not require redesign of the current service model, but they will make the relationship between national policy, local context, the existing configuration of services, and future options more explicit and strengthen assurance for local partners, regulators, and professional assessors.

4. Local Demographics

Understanding Hull's population profile is essential for interpreting sexual and reproductive health needs, identifying inequalities and planning proportionate, targeted responses. The Office for National Statistics (ONS) resident population estimate for 2024 shows a total population of 275,401 in Hull, of whom 220,991 are aged 15 and above. Compared to England, Hull has a younger-than-average age structure, with higher proportions of residents aged 15–39 years across both sexes (Figure 1), which is directly relevant to demand for contraception, pregnancy services and STI testing.

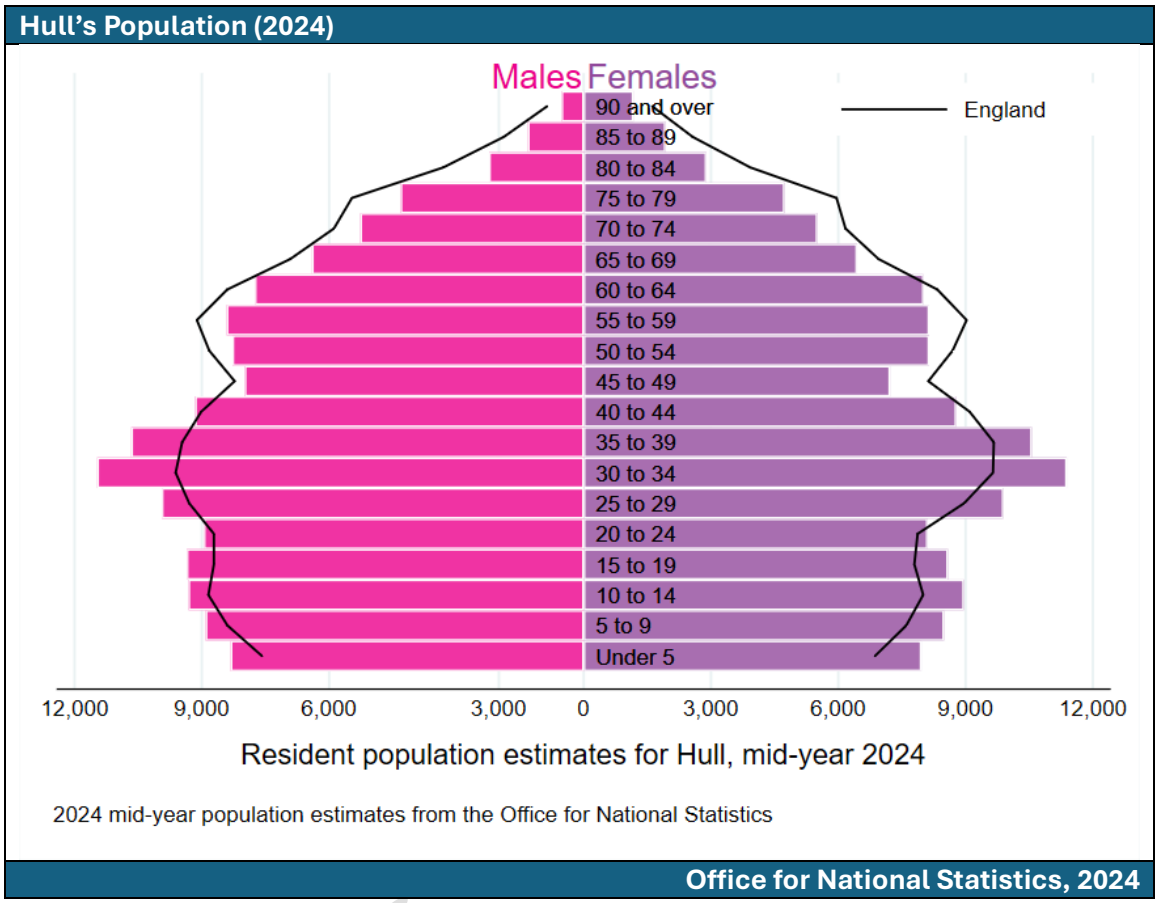


Figure 1: Hull's population by age group between males and females.

4.1. Ethnicity gender identity and sexual orientation

Hull remains less ethnically diverse than England overall, but diversity has increased substantially over the last two decades. Census 2021 data show that 83.9% of residents identify as White British, compared with 73.5% across England, while the proportion of residents from minority ethnic groups (excluding white minorities) has risen from 2.3% in 2001 to 8.2% in 2021; when white minority groups are included, 16.1% of Hull's population are from minoritised ethnic backgrounds (Table 1). The largest minority groups are white ethnic minorities (7.9%), followed by Asian or Asian British (2.8%) and Black or Black British (1.9%), with particularly notable growth in Eastern European communities.

Hull's Population by ethnicity (%)				
Ethnicity	**Hull (2001)**	**Hull (2011)**	**Hull (2021)**	**England (2021)**
White British	96.4	89.7	83.9	73.5
White minority	1.3	4.4	7.9	7.5
Asian or Asian British	1.1	2.5	2.8	9.6
Black or Black British	0.4	1.2	1.9	4.2
Other ethnicities	0.2	0.8	1.8	2.2
Mixed ethnic background	0.7	1.3	1.7	3.0
Total	**100.0**	**100.0**	**100.0**	**100.0**
Ethnic minorities (excluding white minorities)	2.3	5.9	8.2	19.0
All ethnic minorities	3.6	10.3	16.1	26.5
Office for National Statistics, Census 2021				

Table 1: Ethnicity over time

In relation to gender identity, 92.3% of usual residents aged 16+ reported a gender identity the same as their sex registered at birth in the 2021 Census, while 0.3% reported a gender identity difference without specifying, 0.1% identified as trans women, 0.1% as trans men, 0.1% as non-binary and 0.1% as other gender identities; 7.1% did not answer the question.

Sexual orientation data show that 88.0% of adults identified as straight or heterosexual, while 3.9% identified as LGBQ+ (gay or lesbian 1.7%, bisexual 1.7%, pansexual 0.2%, asexual 0.1%, and other minority orientations 0.2%), with the remainder not answering the question. These patterns underline the importance of culturally competent, LGBTQ+-affirming sexual and reproductive health services, including inclusive communication, appropriate interpretation support and safe, non-stigmatising clinical and community settings.

4.2 Changing Population Trends

Hull's population has grown in recent years, driven largely by international migration among children, young people and working-age adults. Between mid-2021 and mid-2024, ONS estimates indicate net international migration of 17,219 people, contributing to a total population increase of 7,810 with a decrease of 11,635 people due to internal migration within England (Table 2: Population growth and migration recent trends in Hull). The highest net gains have been in the 0–17 and 25–39 age groups (Table 3: Hull's international migration between 2021 and 2024), which are also the life stages with greatest need for contraception, maternity and early years services, and STI testing.

Population growth and migration recent trends in Hull				
Population component	**2021**	**2022**	**2023**	**2024**
Population in previous period	267,591	266,516	268,768	273,069
Natural change (births – deaths)	310	498	318	529
Net internal (UK) change	–2,657	–2,893	–2,425	–3,660
International in	2,481	6,483	7,925	7,640
International out	1,877	1,743	1,590	2,100
International net	**604**	**4,740**	**6,335**	**5,540**
Other changes	668	–93	73	–77
Population in a specified period	266,516	268,768	273,069	275,401
Total change	**–1,075**	**2,252**	**3,265**	**2,332**
				Office for National Statistics, 2024

Table 2: Recent changes in Hull's population

While ethnicity cannot be directly inferred from these migration estimates, the scale and age profile of recent in-migration suggest continuing diversification of the local population, including growth in communities whose first language is not English and who may have different experiences of, and expectations about, sexual health services. These dynamics have direct implications for service planning: outreach and communication must keep pace with changing communities; digital and in-person access routes need to accommodate new arrivals; and the SHNA's analysis of STI, LARC and teenage conception patterns later in the report uses this demographic context to interpret emerging trends and potential unmet need.

Recent international migration by age in Hull						
2021 to 2024	**0-17**	**18-24**	**25-39**	**40-64**	**65+**	**All**
International net	5,603	1,238	8,728	1,598	53	17,219
Total change	3,249	–1,709	3,795	361	2,114	7,810
						Office for National Statistics, 2024

Table 3: Hull's international migration between 2021 and 2024.

4.3. Socioeconomic Factors and Health Inequalities

Hull experiences high and entrenched socioeconomic disadvantage, which strongly shapes sexual and reproductive health risks and outcomes. Based on the 2025 Index of Multiple Deprivation (IMD), Hull is the sixth most deprived local authority in England (Figure 2: Indices of Multiple Deprivation in Hull, 2025). More than half (52%) of Hull's 168 lower-layer super output areas (LSOAs) fall within the most deprived 20% of areas nationally, and only ten LSOAs (6.0%) are in the least deprived fifth. Local deprivation fifths are therefore generally used in analysis to discriminate between neighbourhoods, as national fifths can mask the scale of variation within the city.

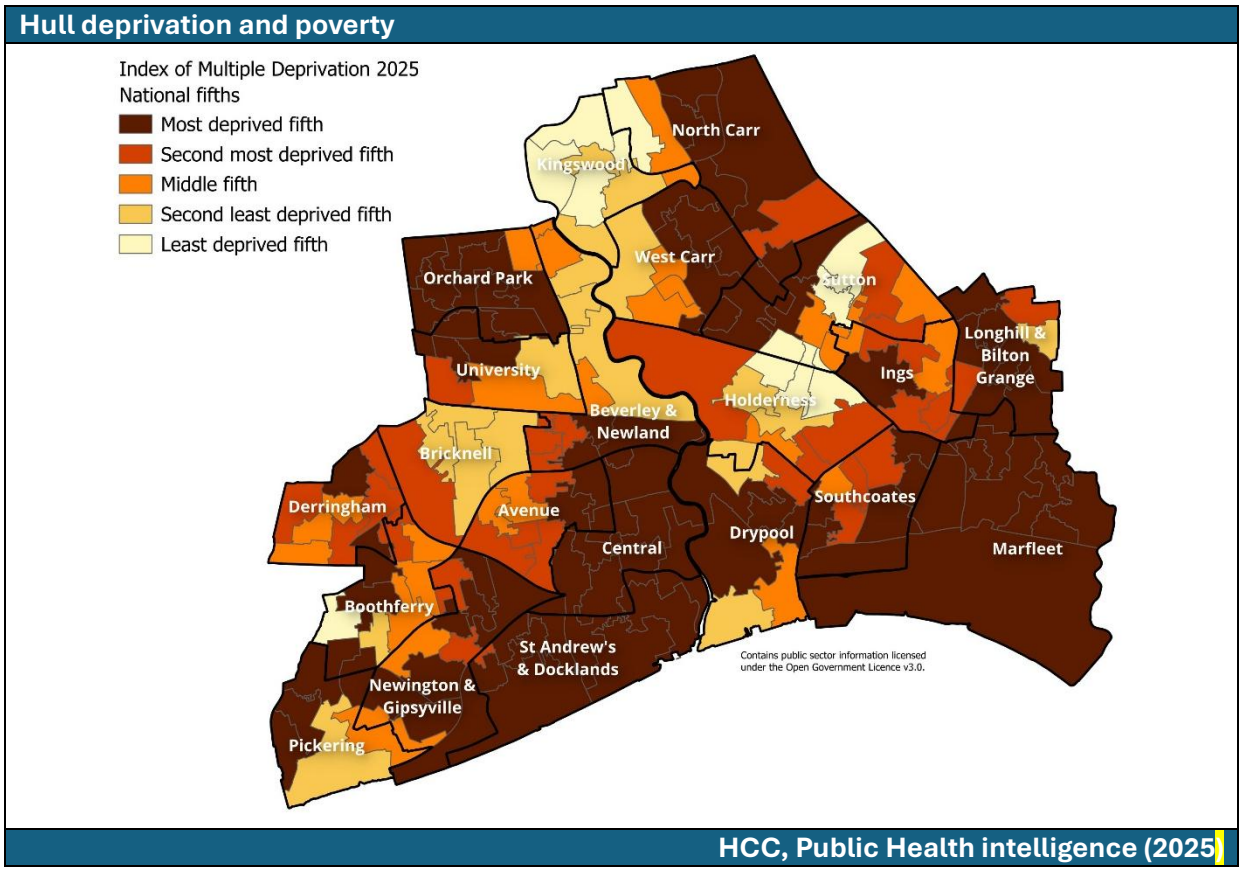


Figure 2: Indices of Multiple Deprivation (IMD) 2025 – distribution of Hull's 168 LSOAs by national deprivation fifth (Hull JSNA, Deprivation and Poverty, 2025).

Wider determinants of health further reinforce this pattern. Compared to England, Hull has lower levels of educational attainment, lower employment rates and a higher proportion of residents who are not in work due to long-term illness or disability; there are fewer residents in professional and managerial occupations and more in elementary roles, salaries are lower, benefit claimant rates are higher, and crime, domestic abuse and reoffending rates are elevated. Housing stock is skewed towards rented and terraced properties, with lower levels of owner-occupation and an identified shortage of affordable homes.

Inequalities relating to lower literacy, numeracy and health knowledge also make it harder for some residents to navigate digital-first or complex health systems. These structural inequalities underpin the very high rates of under-18 conceptions, relatively low overall LARC uptake, and the concentration of STI burden in younger and more deprived groups described in Section 5, and justify the SHNA's sustained focus on equity, inclusion, health and targeted outreach.

4.4 Implications for the SHNA

Taken together, Hull's younger age profile, increasing ethnic and sexual-orientation diversity, rapid recent in-migration and high levels of deprivation create a population context in which sexual and reproductive health needs are likely to be greater and more unevenly distributed than in many other parts of England. These demographic and socioeconomic characteristics have been explicitly incorporated into the analysis in later sections through stratification by age, sex, deprivation, ethnicity and, where data permit, sexuality and inclusion-health status, and they have directly informed the interpretation of STI, LARC, teenage conception and abortion patterns, as well as the design of equity-focused recommendations.

5. Reproductive and Sexual Health Data

5.1 Overview and demographic context

Hull's reproductive and sexual health outcomes sit within the demographic and inequality context described in Section 4, characterised by a relatively young population, rapid recent migration and high levels of deprivation (Hull City Council, 2025). These factors are known nationally to increase the potential burden of sexually transmitted infections (STIs), unplanned pregnancy and wider reproductive health needs, particularly among younger adults and people in more deprived neighbourhoods (UKHSA, 2025; OHID, 2025).

The analysis in this section draws primarily on the Office for Health Improvement and Disparities (OHID) Fingertips sexual and reproductive health profiles, local service data from CHCP and MESMAC, and modelling undertaken by Hull Public Health Intelligence (OHID, 2025; Hull City Council, Public Health Intelligence, 2025). It is structured into three main domains:

- STIs and HIV – testing, diagnoses and inequalities (Section 5.2).
- Contraception and reproductive health – including long-acting reversible contraception (LARC) and emergency contraception (Section 5.3).
- Pregnancy, teenage conceptions and abortion – with a focus on under-18 conceptions and patterns of abortion and reproductive choice (Sections 5.4–5.5).

Where possible, results are stratified by age, sex, deprivation and other characteristics such as sexual orientation, recognising that the ability to interpret apparent differences is sometimes constrained by the lack of direct measures of underlying "need" in the population (Hull City Council, 2025).

5.2 Sexually Transmitted Infections (STIs)

Sexually transmitted infections (STIs) remain a major public health priority area in Hull because of their contribution to avoidable morbidity, onward transmission and inequalities in sexual and reproductive health outcomes (UKHSA, 2025). Routine surveillance data from OHID Fingertips and local provider records show that Hull has persistently higher STI diagnosis rates than England overall, particularly for younger adults and more deprived communities, although absolute rates are lower than in some large urban centres (OHID, 2025; Hull City Council, 2025). These patterns are most pronounced among people aged 15–34 years, men who have sex with men (MSM) and residents in the most deprived neighbourhoods, reinforcing the need for sustained prevention, accessible testing and targeted outreach (UKHSA, 2025; Hull City Council, 2025).

5.2.1. All STIs

In 2024, Hull's overall rate of newly diagnosed STIs (excluding chlamydia in those aged 15–24 years) was relatively high compared to many other local authorities in Yorkshire and the Humber, but remained lower than peak levels observed locally over the past decade (OHID, 2025; Hull City Council, 2025). While this could partly reflect real changes in behaviour or transmission, routine surveillance data alone cannot distinguish between a genuine reduction in infections and lower detection because of uneven testing activity (OHID, 2025).

To explore this question systematically, Hull Public Health Intelligence developed a model using upper-tier local authority data from OHID's Fingertips sexual health profiles (Hull City Council, Public Health Intelligence, 2025; OHID, 2025).

The model predicted the rate of tests completed and the number of positive tests completed as well as test positivity (percentage of tests that were positive out of those undertaken). The modelling used data from all upper-tier local authorities in England. The median age, mean Index of Multiple

Deprivation 2025 score and the proportion identifying as non-heterosexual from the 2021 Census were used to predict the two rates and measure of test positivity. The 'expected' or predicted values from the model was determined and compared with the actual values for Hull.

For 2024 for Hull, it was found that the testing rate was 31% lower (3,542 versus 4,628 tests per 100,000 population), the positive test rate was 26% lower (445 versus 560 per 100,000 population) and the test positivity was 12% lower (6.5% versus 7.3%) than 'expected' based on local authorities with similar age, deprivation and non-heterosexual populations (Table 4).

In 2024, there were a total of 9,631 tests undertaken and 629 (6.5%) of them were positive. However, the 'expected' number of tests was 12,584 from the model with 791 of them being positive (Table 5). From these analyses there is a suggestion that 162 additional cases of STI might have been expected to have been picked up in Hull. Taken together, these findings suggest that local authorities with similar age, deprivation and non-heterosexual population profiles typically undertake more STI testing, detect more infections per head of population, and have higher test positivity than is currently seen in Hull. However, there are many factors which influence the underlying prevalence and diagnoses rates of STIs, and these need to be examined further. Details of the modelling and the caveats associated with this modelling are given in the Appendix.

Hull	**Tests per 100,000 population (all STIs)**	**Positive tests / diagnoses per 100,000 population (**syphilis, HIV, gonorrhoea and chlamydia among 25+)	**Test positivity for** syphilis, HIV, gonorrhoea and chlamydia among 25+ **(%)**
Predicted from model	4,628	560	7.3
Actual rate/percentage (2024)	3,542	445	6.5
Absolute difference	1,086	114	0.8
Relative difference (%)	30.7	25.7	12.3

Table 4: compares the model-predicted values for Hull with the actual 2024 values (Hull City Council, Public Health Intelligence, 2026).

Hull	**Total tests (all STIs)**	**Total positive tests / diagnoses** (syphilis, HIV, gonorrhoea and chlamydia among 25+)
Total test/diagnoses (2024)	9,425	1,314
Population (2024)	271,942	271,942
Number of expected tests/diagnoses from model	11,354	1,664
Difference	1,929	350

Table 5: Modelling of STI testing and diagnoses in Hull compared to other local authorities in England (total tests and diagnoses)

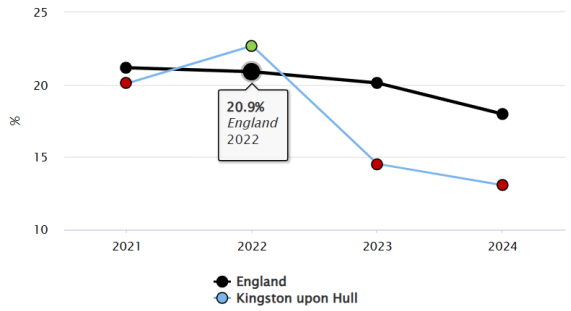
5.2.2. Chlamydia

Chlamydia remains the most commonly diagnosed sexually transmitted infection in Hull, particularly among young people aged 15–24 years, consistent with national patterns (UKHSA, 2025; OHID, 2025). Detection in this age group depends heavily on the National Chlamydia Screening Programme (NCSP), so observed diagnosis rates reflect both underlying prevalence and how actively services are testing (UKHSA, 2025). Recent data show that chlamydia screening coverage among

females aged 15–24 years in Hull has fallen in line with national trends, as shown in Figure 3 (OHID, 2025; Hull City Council, 2025).

Coverage remains below the England average, although test positivity is comparatively high, suggesting that when young women are tested, they are more likely to have an infection detected than the national norm (OHID, 2025).

Hull Chlamydia proportion of females aged 15 to 24 screened



Period		Kingston upon Hull Count	Value	95% Lower CI	95% Upper CI	Yorkshire and the Humber	England
2021	●	3,381	20.1%	19.4%	20.8%	24.0%	21.2%
2022	●	3,745	22.7%	22.0%	23.4%	23.6%	20.9%
2023	●	2,418	14.5%	14.0%	15.1%	21.3%	20.1%
2024	●	2,173	13.1%	12.5%	13.6%	18.8%	18.0%

Source: UK Health Security Agency

Indicator Definitions and Supporting Information

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Figure 3: Percentage of females aged 15–24 years screened for chlamydia in Hull compared to England, trend over time.

The gender gap in chlamydia screening coverage seen in Hull mirrors the national picture (OHID, 2025; UKHSA, 2025). Historically, the NCSP has prioritised screening in young women, and women are also more likely to attend sexual health services in connection with contraception and reproductive health, increasing opportunities for testing (UKHSA, 2025). In contrast, fewer young men are routinely offered or take up chlamydia testing, so male infection may be under-detected despite similar behavioural risk in some groups (UKHSA, 2025).

Local qualitative and provider intelligence suggests that lower screening coverage is shaped by a combination of structural and behavioural barriers, including digital exclusion, variable awareness of postal testing, stigma, and low health literacy, particularly in more deprived areas and among some minority groups (Healthwatch Hull, 2024; CHCP, 2025; Hull City Council, 2025). However, the absence of robust deprivation-stratified NCSP data locally means it is not possible to quantify how much of the observed gap reflects lower offer versus lower uptake, or true differences in need (Hull City Council, 2025).

From a commissioning and inequalities perspective, these patterns justify continued focus on making opportunistic and targeted chlamydia testing easy to access for all sexually active young people, with specific emphasis on young men, digitally excluded young people, and those in the most deprived neighbourhoods (Hull City Council, 2025; CHCP, 2025). Strengthening school-linked RSE, youth-friendly outreach, and mixed digital/non-digital testing routes is likely to be important for earlier detection and reduced risk of untreated infection and long-term sequelae such as pelvic inflammatory disease (UKHSA, 2025; OHID, 2025).

Alongside screening coverage, chlamydia diagnosis rates in Hull among 15–24-year-olds have remained broadly in line with, or slightly below, the England average over recent years (OHID, 2025; Hull JSNA, 2025). Given Hull's relatively high levels of deprivation and young age profile, this pattern may not reflect substantially lower underlying risk and could be explained by lower or less evenly distributed testing activity in some groups (UKHSA, 2025; OHID, 2025).

When diagnosis rates are considered together with falling screening coverage and relatively high test positivity, they suggest that a proportion of infections in Hull may be going undetected, particularly

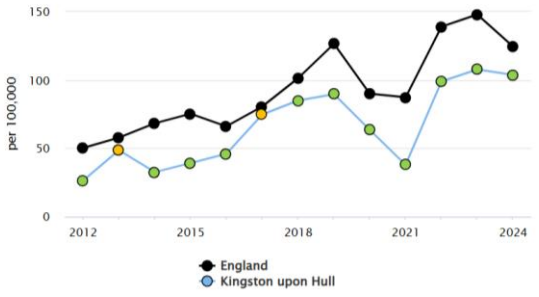
among young men and those not routinely in contact with sexual health or contraception services (OHID, 2025; UKHSA, 2025). This reinforces the case for strengthening opportunistic and targeted testing offers in settings frequented by young people, including community, education and digital platforms, to support earlier detection and treatment (Hull JSNA, 2025; UKHSA, 2025).

5.2.3. Gonorrhoea

Gonorrhoea diagnoses in Hull have increased over the last decade, with a temporary dip during the COVID-19 pandemic followed by a renewed rise, reflecting regional and national trends (OHID, 2025; UKHSA, 2025). Throughout this period, Hull's diagnosis rate has generally been higher than the Yorkshire and Humber average but lower than the overall England rate, placing the city in the mid-to-high range compared to other urban local authorities, as illustrated in the gonorrhoea trend figure below (OHID, 2025; Hull City Council, 2025).

Most diagnosed gonorrhoea in Hull, as elsewhere, occurs in people aged 15–34 years, with particularly high rates in men and in men who have sex with men (MSM), although small numbers and incomplete recording of sexual orientation limit the precision of local breakdowns (OHID, 2025; UKHSA, 2025; Hull City Council, 2025). Gonorrhoea is a marker of high-risk sexual networks and condomless sex, and rising diagnoses can indicate both increased transmission and more intensive testing among those at higher risk (UKHSA, 2025).

Hull trends of Gonorrhoea diagnostic rate per 100,000 population



Period		Kingston upon Hull Count	Value	95% Lower CI	95% Upper CI	Yorkshire and the Humber	England
2012		68	26	20	33	27	50
2013		126	49	41	58	38	58
2014		85	33	26	40	45	68
2015		103	39	32	48	45	75
2016		122	46	38	55	46	66
2017		200	75	65	86	53	81
2018		228	85	74	97	68	101
2019		241	90	79	102	81	127
2020		170	64	54	74	54	90
2021		101	38	31	46	61	87
2022		266	99	87	112	119	139
2023		293	108	96	121	109	148
2024		282	104	92	117	79	124

Source: UK Health Security Agency

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Figure 4: The number of cases of gonorrhoea detected in Hull per 100,000 population

Given the modelling evidence that overall STI testing and diagnosis in Hull are lower than would be expected after accounting for age, deprivation and sexual-orientation profile, it is plausible that some gonorrhoea infections remain undiagnosed, particularly among groups who face barriers to accessing services (Hull City Council, Public Health Intelligence, 2025). These barriers are likely to include younger men, people in the most deprived neighbourhoods, and some minority ethnic and migrant communities who may experience stigma, lack of awareness of local services or digital exclusion (Hull City Council, 2025).

Maintaining easy, non-judgmental access to prompt testing and treatment, including through online self-sampling, walk-in clinics, and targeted outreach, remains critical to prevent onward transmission, antimicrobial resistance and complications such as pelvic inflammatory disease and infertility (UKHSA, 2025; OHID, 2025). Future local analysis that more fully stratifies gonorrhoea testing and diagnoses by age, gender, deprivation and sexual orientation would further clarify where

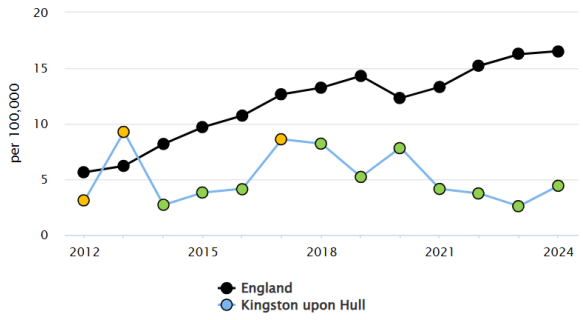
the greatest inequalities and unmet need lie, and is identified as a priority for ongoing surveillance and service planning (Hull City Council, Public Health Intelligence, 2025).

5.2.4. Syphilis

Syphilis remains a significant public health concern nationally because of rising incidence and the potential for serious complications, including neurological, cardiovascular and congenital syphilis, if infection is not diagnosed and treated promptly (UKHSA, 2025). In Hull, syphilis diagnosis rates have generally remained lower than the England and Yorkshire and Humber averages, but small annual numbers mean that local rates can fluctuate from year to year (OHID, 2025; Hull City Council, 2025). Figure 5 shows that while Hull's rate has been relatively stable at a low level compared to national and regional trends, more recent data indicate a modest increase since the early 2020s, in line with the broader upward pattern seen across England (OHID, 2025; UKHSA, 2025).

At the same time, the modelling described earlier in this section suggests that Hull's overall STI testing and diagnosis activity is lower than would be expected given its age profile, deprivation levels and proportion of the population identifying as non-heterosexual (Hull City Council, Public Health Intelligence, 2025). Taken together, these findings indicate that lower recorded syphilis rates in Hull should be interpreted with caution: they may partly reflect genuinely lower transmission compared to some larger urban centres, but could also reflect limited case numbers and the broader pattern of relative under-testing identified by the model, rather than a substantially lower underlying risk (OHID, 2025; Hull City Council, Public Health Intelligence, 2025).

Hull trends of Syphilis diagnostic rate per 100,000 population



Period		Kingston upon Hull Count	Value	95% Lower CI	95% Upper CI	Yorkshire and the Humber	England
2012		8	3.1	1.3	6.1	2.9	5.6
2013		24	9.3	5.9	13.8	3.8	6.2
2014		7	2.7	1.1	5.5	3.7	8.2
2015		10	3.8	1.8	7.0	3.7	9.7
2016		11	4.1	2.1	7.4	6.7	10.7
2017		23	8.6	5.4	12.9	7.5	12.7
2018		22	8.2	5.1	12.4	7.5	13.2
2019		14	5.2	2.8	8.7	6.2	14.3
2020		21	7.8	4.9	12.0	4.6	12.3
2021		11	4.1	2.1	7.4	5.9	13.3
2022		10	3.7	1.8	6.8	8.1	15.2
2023		7	2.6	1.0	5.3	8.4	16.3
2024		12	4.4	2.3	7.7	8.8	16.5

Source: UK Health Security Agency

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Figure 5: Syphilis diagnoses per 100,000 population in Hull compared with Yorkshire and Humber and England, trend over time (source: OHID Sexual and Reproductive Health Profiles, 2025; Hull JSNA – Sexually Transmitted Infections) (OHID, 2025; Hull City Council, 2025).

Nationally, syphilis disproportionately affects men who have sex with men (MSM) and people with multiple partners; co-infection with HIV is an important consideration in both testing and prevention strategies (UKHSA, 2025). Local clinical and JSNA intelligence indicate that most diagnosed cases in Hull occur in adults and that MSM are likely to be an important at-risk group, but small numbers and incomplete recording of sexual orientation and ethnicity limit the scope for robust subgroup analysis (OHID, 2025; Hull City Council, 2025). In this context, aligning local practice with national guidance – including maintaining easy access to syphilis testing within routine STI screens, ensuring culturally sensitive communication, and supporting effective partner notification – remains a key priority to

prevent missed diagnoses and to respond promptly if local rates begin to rise (UKHSA, 2025; Hull City Council, 2025).

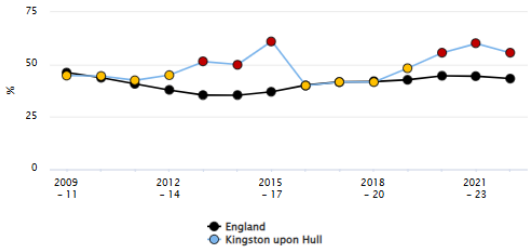
5.2.5. HIV

The prevalence of diagnosed HIV in Hull remains relatively low compared to many other urban areas in England, but late diagnosis continues to be a significant concern because of its association with increased morbidity, higher healthcare costs and greater risk of onward transmission (OHID, 2025; UKHSA, 2025). Between 2022 and 2024, 15 of the 27 (55.6 per cent) people newly diagnosed with HIV in Hull were diagnosed late, compared with 43.3 per cent for England (OHID, 2025). Although the absolute number of new diagnoses in this period was small, this proportion represents a clear deterioration compared to 2-3 years earlier and indicates that many people are still being diagnosed only after substantial immune compromise (OHID, 2025; Hull City Council, 2025).

From 1 November 2024, responsibility for HIV treatment for Hull and East Riding transferred from the integrated sexual health service to Hull University Teaching Hospitals NHS Trust. The integrated sexual health service now focuses on testing (through in-clinic and online routes), providing health advice, and supporting people with positive results into specialist care at the Trust. The service also offers PrEP to eligible patients following assessment, and PEPSE (post-exposure prophylaxis after sexual exposure) during working hours, with out-of-hours PEP accessed via local emergency departments (HIV Provision – City Health Care Partnership Integrated Sexual Health Service, 2024).

The small number of cases means that local late-diagnosis percentages can vary considerably from year to year, and results should therefore be interpreted with caution (OHID, 2025). Nevertheless, the consistently higher proportion of late diagnoses in Hull compared with regional and national benchmarks over recent reporting periods supports the view that opportunities for earlier testing and diagnosis are still being missed, particularly among people who are less likely to access routine sexual health services (OHID, 2025; Hull City Council, 2025).

Hull trends of percentage of HIV diagnosed at a late stage



Recent trend: Could not be calculated

Benchmarking against goal: <25% | 25% to 50% | ≥50%

Period		Kingston upon Hull Count	Value	95% Lower CI	95% Upper CI	England
2009 - 11		17	44.7%	26.1%	71.6%	46.1%
2010 - 12		16	44.4%	25.4%	72.2%	43.7%
2011 - 13		17	42.5%	24.8%	68.0%	40.8%
2012 - 14		18	45.0%	26.7%	71.1%	37.8%
2013 - 15		19	51.4%	30.9%	80.2%	35.4%
2014 - 16		12	50.0%	25.8%	87.3%	35.3%
2015 - 17		11	61.1%	30.5%	100%	37.0%
2016 - 18		6	40.0%	14.7%	87.1%	40.2%
2017 - 19		10	41.7%	20.0%	76.6%	41.7%
2018 - 20		10	41.7%	20.0%	76.6%	41.8%
2019 - 21		15	48.4%	27.1%	79.8%	42.7%
2020 - 22		15	55.6%	31.1%	91.6%	44.6%
2021 - 23		15	60.0%	33.6%	99.0%	44.4%
2022 - 24		15	55.6%	31.1%	91.6%	43.3%

Source: UK Health Security Agency

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Figure 6: Percentage of people newly diagnosed with HIV who are diagnosed late in Hull compared with Yorkshire and the Humber and England, three-year rolling averages (source: OHID Sexual and Reproductive Health Profiles, 2025; Hull JSNA – HIV) (OHID, 2025; Hull City Council, 2025).

National evidence highlights that late diagnosis is more common among some ethnic minority communities, older adults, heterosexual men and women, and people with limited engagement with primary or sexual health care, including some migrant groups and people experiencing social exclusion (UKHSA, 2025). Local qualitative feedback from MESMAC and Healthwatch suggests that, in Hull, barriers such as stigma, low awareness of asymptomatic infection, language and digital

exclusion, and limited trust in formal services may affect some of these groups more strongly, making community-based and peer-led testing routes particularly important alongside clinic-based offers (Healthwatch Hull, 2024; MESMAC, 2025; Hull City Council, 2025).

The UKHSA HIV Action Plan emphasises expanding access to HIV testing through a combination of approaches, including opt-out testing in emergency departments and other high-throughput settings, wider availability of self-testing kits, and equitable access to pre-exposure prophylaxis (PrEP) for those at higher risk (UKHSA, 2022). Locally, the introduction of opt-out testing in emergency care, combined with continued routine testing within sexual health services and targeted community outreach, offers an important opportunity to reduce late diagnosis. Early evaluation of the emergency-department opt-out programme suggests [brief neutral finding – e.g. 'good uptake among eligible attendees but some ongoing challenges with linkage to care'], and its longer-term impact will depend on sustained implementation, culturally competent engagement and effective linkage to ongoing care for those who test positive (UKHSA, 2022; Hull City Council, 2025)

5.2.6 Other Sexually Transmitted Infections (STIs)

In addition to chlamydia, gonorrhoea, syphilis and HIV, other STIs such as genital herpes, genital warts and trichomoniasis are diagnosed and managed within local services and contribute to overall morbidity, service demand and patient distress (Hull City Council, 2025). National surveillance data show that first-episode genital herpes and genital warts remain among the more commonly diagnosed viral STIs in England, with recent increases in genital herpes diagnoses and continued declines in genital warts, particularly among younger age groups eligible for HPV vaccination (UKHSA, 2025).

Hull-specific diagnosis rates for genital herpes, genital warts and trichomoniasis are available through the OHID Sexual and Reproductive Health Profiles, but these indicators are not routinely broken down by risk group or deprivation and are not currently incorporated into JSNA reporting, which limits detailed interpretation of local patterns (OHID, 2025; Hull City Council, 2025). Local service providers continue to offer diagnosis, treatment and longer-term management for these conditions as part of the integrated sexual health model. Improvements in diagnostic coding, together with the routine use of broader OHID STI indicators in local dashboards, would support more complete monitoring of unmet need and outcomes over time (Hull City Council, 2025; OHID, 2025).

5.3 Contraception and Reproductive Health

Contraception is a cornerstone of reproductive autonomy and public health, enabling people to plan if and when to have children, reduce the risk of unintended pregnancy and contribute to improved outcomes for parents and children (DHSC, 2022; BPAS, 2025). Uptake and method choice vary significantly by age, gender and health literacy. They are shaped not only by individual preference but also by the accessibility, flexibility and cultural acceptability of local services, including the balance between digital and face-to-face access routes (DHSC, 2022; Brook, 2024).

Hull-specific data on contraception stratified by deprivation, ethnicity, or inclusion health status are limited, but national evidence indicates that socioeconomic status, digital exclusion, and cultural norms strongly influence contraceptive access and engagement (OHID, 2023; OHID, 2025). These broader patterns are likely to be highly relevant in Hull, given its high levels of deprivation and diverse communities, and underline the importance of local equity audits, qualitative insight and

strengthened data collection to understand which groups face the greatest barriers to contraceptive choice (Hull City Council, 2025; OHID, 2025).

Inclusion health groups such as people experiencing homelessness, those in temporary accommodation, sex workers, vulnerable migrants and people who inject drugs are at particular risk of poor sexual and reproductive health, with overlapping barriers including stigma, trauma, unstable living conditions and limited access to digital or mainstream services (NHS England, 2023; OHID, 2023). Ensuring contraception pathways are explicitly designed to be accessible for these groups – for example, through outreach, drop-in and non-digital booking options, trauma-informed and culturally competent care, and reasonable adjustments for disabled people – is therefore essential for advancing reproductive autonomy and reducing inequalities in Hull (UKHSA, 2023; NHS England, 2023; Hull City Council, 2025).

Integrating clear information about EHC into wider contraception pathways – for example, through school and college RSE, youth services, and community sexual health clinics – may help reduce stigma and support timely access, even where direct supply in education settings is not feasible (Healthwatch Hull, 2024; CHCP Q3 Contract Monitoring Report, 2024–25).

5.3.1 Long-Acting Reversible Contraception (LARC)

Long-acting reversible contraception (LARC), including intrauterine devices and systems and contraceptive implants, offers highly effective, long-duration protection against pregnancy and is recommended in national guidance as a key component of contraceptive choice to help reduce unintended pregnancies (NICE, 2019; DHSC, 2022). In Hull, LARC provision is subcontracted to general practices and primary care networks across the city, with additional provision through the integrated sexual health service (Hull City Council, 2025). While OHID and prescribing data include LARC indicators, GP-prescribed LARC is known to be very substantially under-reported in national datasets, so routine indicators cannot estimate the true level of provision in primary care locally (OHID, 2025; Hull City Council, 2025).

Local provider intelligence indicates variation in LARC capacity and access between practices, including in areas where securing face-to-face appointments is more difficult and where trained staff are constrained in their availability to fit devices (Hull City Council, 2025). Audit data and provider reports indicate that all women in the audited sample received their chosen LARC method within 28 days of consultation, and that under-19s were seen either on the same day or within five working days, with longer waits typically linked to clinical factors such as post-partum timing, pregnancy risk, or complex medical history (CHCP Quarter 4 Narrative Report, 2024–25). Nationally, variation in LARC uptake is associated with age, ethnicity and deprivation, reflecting structural barriers, awareness gaps and differences in service configuration, with evidence of lower prescribing in more deprived areas and particular access issues for some minority ethnic communities and people with learning disabilities (OHID, 2023; OHID, 2025). Given Hull's demographic and deprivation profile, these patterns are likely to be relevant locally and reinforce the case for service mapping and equity review to ensure that under-served groups, including young women, migrant women and trans and non-binary people, have equitable access to the full range of LARC options as part of informed contraceptive choice (BASHH, 2023; OHID, 2025; Hull City Council, 2025).

5.3.2 Emergency Contraception (EHC)

Emergency hormonal contraception (EHC) remains a widely used method of preventing unplanned pregnancy, particularly among younger women and those without regular contraceptive coverage. In Hull, EHC is available free of charge through community pharmacies and specialist sexual health services, and can be accessed via walk-in consultations.

Qualitative evidence indicates that EHC access intersects with several themes identified through the wider analysis of community and provider insight, particularly digital access and exclusion, cultural and social barriers, and service flexibility. Healthwatch Hull participants described feeling exposed in some pharmacy settings, with worries about being overheard or recognised when requesting EHC. One young woman reported that she "didn't want to ask at the counter in front of everyone". She waited until a familiar staff member was on duty before seeking help, illustrating how perceived stigma and confidentiality concerns can delay timely access (Healthwatch Hull, 2024). CHCP staff narratives similarly note variation in the confidence of pharmacy and clinic staff when discussing emergency contraception, which may influence how comfortable people feel in presenting urgently (CHCP Q3 Contract Monitoring Report, 2024–25).

Community feedback suggests that access may be easier in student-dense areas, where awareness of pharmacies and sexual health services is higher, and EHC is viewed as relatively routine. However, the same sources highlight that young people outside mainstream education – including home-educated teenagers, young carers and those in alternative provision – may struggle more to identify where to go and how to navigate services, particularly if they also face digital exclusion or low health literacy (Healthwatch Hull, 2024; MESMAC Activity and Outreach Intelligence, 2024–25). These insights align with broader themes in this SHNA around digital access, service visibility and the importance of youth-friendly pathways.

At the time of writing, no formal ward- or pharmacy-level EHC activity dataset was available, so local variation in uptake cannot be quantified. Provider insight and outreach intelligence nevertheless indicate that EHC access is likely to differ between neighbourhoods, influenced by local population structure, awareness of service availability, and individual confidence in approaching pharmacies or clinics (CHCP Q3 Contract Monitoring Report, 2024–25; MESMAC Activity and Outreach Intelligence, 2024–25). These limitations mean that qualitative findings are used interpretively in this section, rather than as evidence of precise differences in need.

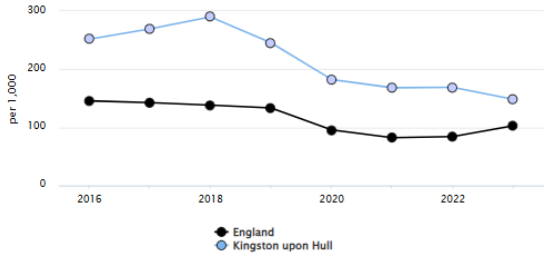
In light of these themes, EHC should be framed as an important safety-net within a wider contraception system, not as a routine substitute for ongoing methods. Improving timely access to the full range of contraceptive options, alongside routine staff training and co-produced patient information developed with young people and inclusion-health groups, is likely to reduce reliance on EHC over time while also addressing concerns about confidentiality, perceived judgement and cultural acceptability identified in the qualitative analysis (Healthwatch Hull, 2024; CHCP Q3 Contract Monitoring Report, 2024–25).

5.3.3 Gender Disparities in Access to Contraception

Data from 2023 show a marked difference in specialist contraceptive service use by gender. Among under-25s in Hull, attendance rates at specialist contraception services were 148 per 1,000 for females compared to 15 per 1,000 for males (Fingertips, 2026). These differences are illustrated in Figures 7 and 8, which show trends in specialist contraceptive service attendance among under-25 females and males, respectively, over time (Fingertips, 2025). This disparity likely reflects both

biological differences in reproductive health needs and social patterns in help-seeking behaviour. Females are more likely to engage with contraception services due to pregnancy prevention, routine sexual health checks and cervical screening, and most available contraceptive methods are designed for use by women. At the same time, males may be less likely to perceive specialist contraception services as relevant unless access is framed around STI screening or broader sexual health. The higher rate of specialist service use among females in Hull, compared to regional and national averages, may also reflect local commissioning arrangements, with a relatively centralised model of specialist provision compared with areas where contraception is more dispersed through GP and pharmacy settings.

Under 25's individuals attend specialist contraceptive services rate /1000 (Females 15-24)



Recent trend: ⬇ Decreasing

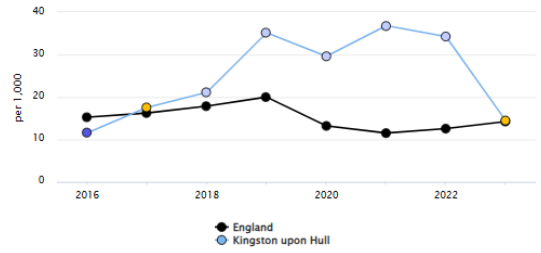
Period		Kingston upon Hull Count	Value	95% Lower CI	95% Upper CI	England
2016		4,590	251.8	244.6	259.3	145.7
2017		4,885	269.4	261.9	277.1	142.6
2018		5,155	290.1	282.3	298.2	138.4
2019		4,285	245.4	238.1	252.9	133.4
2020		3,120	182.5	176.1	189.0	95.6
2021		2,830	168.2	162.1	174.6	82.5
2022		2,790	169.0	162.9	175.5	84.2
2023		2,470	148.4	142.8	154.5	103.0

Source: OHID, based on NHS England and Office for National Statistics data

Office for Health Improvement and Disparities. Public health profiles. 2026 https://fingertips.phe.org.uk/ © Crown copyright 2026

Figure 7: Rate of under-25 females attending specialist contraception services in Hull, 2016–2023 (per 1,000 females aged 15–24) (Fingertips, 2025). Fingertips | Department of Health and Social Care

Under 25-year-olds attend specialist contraceptive services rate /1000 (Males 15-24)



Recent trend: ➡ No significant change

Period		Kingston upon Hull Count	Value	95% Lower CI	95% Upper CI	England
2016		220	11.5	10.1	13.2	15.2
2017		340	17.6	15.8	19.6	16.2
2018		400	21.1	19.2	23.4	17.9
2019		655	35.2	32.6	38.0	20.0
2020		530	29.6	27.0	32.1	13.2
2021		650	36.8	34.1	39.8	11.5
2022		610	34.3	31.6	37.1	12.6
2023		260	14.5	12.9	16.5	14.2

Source: OHID, based on NHS England and Office for National Statistics data

Office for Health Improvement and Disparities. Public health profiles. 2026 https://fingertips.phe.org.uk/ © Crown copyright 2026

Figure 8: Rate of under-25 males attending specialist contraception services in Hull, 2016–2023 (per 1,000 males aged 15–24) (Fingertips, 2025)mixed-methods style, Fingertips | Department of Health and Social Care

For young men, the main structured contraceptive offer in Hull currently relates to condom distribution and opportunistic STI testing, rather than dedicated contraceptive counselling or shared decision-making around pregnancy prevention. While targeted engagement exists for gay, bisexual and other men who have sex with men, there is limited routine discussion with heterosexual young men about emergency contraception, longer-term pregnancy planning or fertility awareness. This

pattern aligns with wider evidence that contraception has historically been framed as a predominantly female responsibility, both in clinical practice and in public messaging (NICE, 2019; FPA, 2023). Qualitative feedback from Healthwatch Hull echoed this, with several young women describing feeling that "it's always on the girl to sort contraception out", and very few young men recalling being invited into structured conversations about pregnancy prevention (Healthwatch Hull, 2024). Addressing this imbalance is likely to require realistic, evidence-informed approaches that recognise current contraceptive options and consequences for women, while also promoting reproductive health as a shared responsibility in ways that reflect diverse relationship structures and sexual practices.

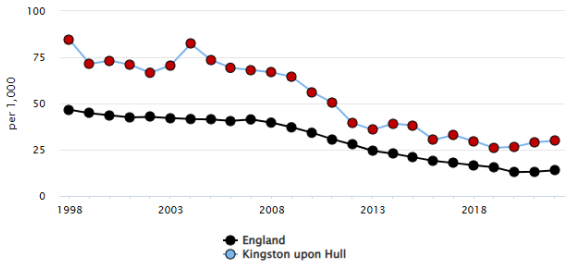
Local providers are already using a range of outreach activities to improve knowledge and reduce STI transmission, including community clinics in colleges, universities and Urgent Treatment Centres, outreach in nightlife settings and swinger venues, and visible participation in events such as Hull Pride, alongside digital campaigns and national initiatives such as World AIDS Day and National HIV Testing Week (CHCP, 2024/25; MESMAC, 2024/25). These actions appear to improve access for some groups, particularly young people and LGBTQ+ communities. Still, a more explicitly gender-inclusive framing of sexual and reproductive health, with targeted engagement for young men, could strengthen the reach and impact of future prevention work.

5.4 Under 18 Conceptions

Despite a long-term national decline, Hull continues to report one of the highest rates of under-18 conceptions in England. In 2022, the rate was 29.9 per 1,000 females aged 15–17, significantly higher than the Yorkshire and Humber average (17.7) and the England average (13.9) (OHID, 2026) – see Figure 9. This pattern reflects persistent underlying inequalities that disproportionately affect young women in areas of high deprivation. The latest data on under-18 conceptions is for 2022, which is now 3-4 years out of date, so the situation could have changed in Hull since then.

While sub-local breakdowns are not publicly available, national data show a clear social gradient for upper-tier local authorities: under-18 conception rates are more than twice as high in the most deprived deciles of England compared to the least deprived (17.9 vs 8.2 per 1,000 females) (OHID, 2025). Given that a large proportion of Hull's population lives in the most deprived national deciles, and similar deprivation gradients are seen for other sexual and reproductive health outcomes locally, it is reasonable to infer substantial variation within the city, with the greatest burden falling on young women in the most disadvantaged neighbourhoods (Hull City Council, 2025). Although teenage conception rates have fallen markedly in Hull over the past decade, recent booking data from Hull maternity services suggest an uptick in early pregnancies in some neighbourhoods, which may reflect entrenched cultural norms and social expectations around young motherhood alongside ongoing structural disadvantage (Hull Maternity Services Insight, 2024 – unpublished).

Under-18s contraception rate per 1,000 women aged 15-17 years



Recent trend: ➡ No significant change

Period		Kingston upon Hull Count	Value	95% Lower CI	95% Upper CI	Yorkshire and the Humber	England
1998	●	381	84.6	76.3	93.5	53.1	46.6
1999	●	333	71.4	63.9	79.5	51.0	44.8
2000	●	350	73.2	65.7	81.3	47.9	43.6
2001	●	353	70.9	63.7	78.7	47.1	42.5
2002	●	339	66.6	59.7	74.1	47.2	42.8
2003	●	365	70.7	63.6	78.3	47.1	42.1
2004	●	412	82.3	74.5	90.6	48.1	41.6
2005	●	368	73.5	66.2	81.4	48.9	41.4
2006	●	359	69.3	62.3	76.9	48.0	40.6
2007	●	363	68.1	61.3	75.5	48.3	41.4
2008	●	348	66.8	60.0	74.2	47.1	39.7
2009	●	316	64.5	57.6	72.0	43.5	37.1
2010	●	261	56.2	49.6	63.5	39.9	34.2
2011	●	231	50.4	44.2	57.4	33.8	30.7
2012	●	176	39.4	33.8	45.6	31.7	27.8
2013	●	158	35.8	30.4	41.8	28.6	24.4
2014	●	164	39.2	33.4	45.6	26.4	22.9
2015	●	150	38.2	32.3	44.8	24.4	20.9
2016	●	114	30.4	25.1	36.5	22.0	19.0
2017	●	121	32.9	27.3	39.3	20.6	17.8
2018	●	111	29.7	24.4	35.7	19.5	16.6
2019	●	103	26.0	21.2	31.5	19.1	15.5
2020	●	111	26.6	21.9	32.0	16.3	12.8
2021	●	128	29.0	24.2	34.5	17.1	13.1
2022	●	136	29.9	25.1	35.3	17.7	13.9

Source: OHID, based on Office for National Statistics data

Office for Health Improvement and Disparities. Public health profiles. 2026 https://fingertips.phe.org.uk/ © Crown copyright 2026

Figure 9: Under-18 conception rates per 1,000 females aged 15–17, Hull compared with Yorkshire and Humber and England, 2010–2021 (OHID, 2025). Fingertips | Department of Health and Social Care

Qualitative insight reinforces the complexity of young parenthood in this context. Healthwatch Hull and provider feedback indicate that some young women perceive early motherhood as a normal or even expected pathway within their family or peer networks, while others report feeling judged or unsupported when they become pregnant at a young age (Healthwatch Hull, 2024; CHCP, 2024/25). One participant described friends saying that “having a baby young is just what people do round here”, while also highlighting practical worries about housing, income and childcare (Healthwatch Hull, 2024). These perspectives underline the need for approaches that both reduce unintended conceptions and provide sensitive, non-judgmental support for those who choose to continue a pregnancy.

Early conception is associated with multiple adverse outcomes, including poorer maternal health, lower educational attainment and higher risk of intergenerational poverty (NICE, 2014; PHE, 2015). Hull’s multi-agency response already includes school nurse-led Relationships and Sex Education (RSE), condom access schemes and targeted youth outreach, but programme reach remains uneven. Young people in alternative education settings, home-educated cohorts, or those with caring responsibilities may face greater barriers to accessing timely and confidential support, particularly if they are digitally excluded or have limited contact with mainstream education or youth services (Healthwatch Hull, 2024; Hull City Council, 2025). Strengthening links between sexual health services, youth services, colleges, alternative provision and social care will be important to ensure that high-risk groups are not overlooked.

These insights point to a need for sustained, system-wide prevention with consistent messaging and support spanning schools, youth services, digital platforms and the wider social care system. Co-producing information and interventions with young people, including those with lived experience of early pregnancy, may help address cultural framings of early motherhood and improve the acceptability of prevention messages. At the same time, for young people who do plan a pregnancy or decide to continue an existing pregnancy, ensuring access to early antenatal care, holistic pre-conception and pregnancy support, and targeted family-support services will be essential to mitigate risks and promote better outcomes for parents and children (Hull City Council, 2025; Hull Maternity Services Insight, 2024 – unpublished).

5.5 Abortion and Reproductive choice

Abortion is a critical component of reproductive healthcare and provides important insight into contraceptive access, reproductive autonomy and service navigation. National data from DHSC show that abortions in England have increasingly shifted towards earlier gestations and medical methods in recent years, largely driven by the expansion of telemedicine, although local patterns vary (DHSC, 2024; OHID, 2025).

In Hull, overall abortion rates are broadly similar to or slightly below the England average, although the rate has increased in the last decade, mirroring national trends. Furthermore, there is a clear skew towards younger women, particularly those aged under 25 years (OHID, 2025). Fingertips data indicate that the proportion of abortions under 10 weeks' gestation in Hull has improved over time but remains below the national average, suggesting that while many women accesses care early, there is still scope to strengthen very early recognition and referral pathways (OHID, 2025). In contrast to the national picture, a smaller proportion of abortions in Hull are carried out using medical methods, with a higher relative use of surgical procedures than seen across England overall (OHID, 2025). This variation may reflect differences in local service configuration, referral pathways, and patient preferences, and warrants ongoing review to ensure that women are offered the full range of evidence-based options in line with national guidance.

For women under 25, Fingertips data show that the rate of repeat abortions in Hull has increased in recent years, mirroring the national trends. The rate of repeat abortions in Hull among under-25s is lower than England (26.2% versus 29.7% for 2021) and has been consistently lower over the last decade (OHID, 2025). However, this does not portray the full picture in Hull among women aged under 25. The percentage of abortions among under-25s who have previously had a birth is much higher in Hull and has been consistently higher in the last decade, with an even greater differential between Hull and England for the latest period, 2021 (40.5% versus 26.0%). It is not possible to combine the percentages as there will be some women who have previously had both a birth and an abortion. However, women aged under 25 in Hull who had an abortion in 2021 are much more likely to have previously had a birth and/or abortion than women in England. It is not clear whether the previous births are intended or not. However, it is clear that a non-trivial proportion of women are still experiencing multiple unintended pregnancies over a relatively short timeframe. Qualitative feedback from Healthwatch Hull and provider insight indicates that some women struggle to find a contraceptive method that suits them after an abortion, describing side-effects, difficulties accessing timely follow-up appointments, or feeling rushed when choosing a method (Healthwatch Hull, 2024; CHCP, 2024/25). One woman reported that "they asked me to pick something straight away, but I wasn't sure and then I couldn't get back in easily", capturing how time pressures and access constraints can limit the usefulness of post-abortion counselling (Healthwatch Hull, 2024). These experiences highlight that the period immediately before and after abortion is a critical opportunity to provide person-centred contraceptive counselling, but that this opportunity is not always fully realised.

Taken together, these patterns reinforce the need for joined-up contraception pathways, high-quality follow-up care after abortion, and culturally competent reproductive health support. Ensuring that all women are routinely offered a full range of contraception options – including LARC where clinically appropriate – before or shortly after abortion, and that they can return to review or change their method without stigma, is likely to be important in reducing unintended pregnancies (NICE, 2019; FPA, 2023). Strengthening links between abortion providers, primary care and the integrated sexual health service, alongside targeted outreach and digital inclusion measures for younger cohorts and women in more deprived areas, can also help to ensure that early pregnancy decisions are informed and supported. While access to abortion in Hull appears timely and clinically effective overall, a continued focus on equity, prevention and aftercare is essential to support informed reproductive choice across the life course.

6 Current Service Provision and Gaps

6.1 Overview of the Local Model

Hull's sexual health system is built on an integrated model that combines clinical, outreach, and prevention services to improve accessibility and equity. City Health Care Partnership (CHCP) leads on clinical provision through the Integrated Sexual Health Service (ISHS). At the same time, Yorkshire MESMAC provides targeted sexual health promotion and prevention at their city centre base and across multiple community settings. GPs and community pharmacies supplement the offer through commissioned contraception and emergency care pathways (Figure 10).

CHCP delivers services from the central Wilberforce Health Centre and a network of community clinics. The core offer includes STI diagnosis and treatment (including asymptomatic screening); contraceptive services including long-acting reversible contraception (LARC); access to emergency hormonal contraception (EHC); in-clinic and online STI testing; HIV testing and PrEP; referral into psychosexual counselling; and targeted inclusion-health outreach (CHCP, Hull Quarter 4 Narrative Report 2024/25; CHCP, Hull Quarter 2 Contract Narrative Report 2025/26). Following the service transformation plan, CHCP now offers a walk-in clinic every weekday across different localities in Hull, with the remaining community clinic at Cecil Gardens operating every Friday afternoon, and an expanded evening walk-in offer from January 2026 to increase after-work access (CHCP, Hull Quarter 4 Narrative Report 2024/25; CHCP, Hull Quarter 2 Contract Narrative Report 2025/26).

Yorkshire MESMAC focuses on outreach for underserved and vulnerable groups, particularly LGBTQ+ communities, sex workers, migrants and people not in regular contact with mainstream services. Their offer includes rapid and postal STI testing, health promotion at community events (such as Hull Pride, youth projects and sports venues), one-to-one support and advocacy, and joint outreach with CHCP in inclusion-health settings. Pharmacies and general practices deliver additional elements of the pathway, including commissioned free EHC without prescription in participating pharmacies, chlamydia testing kits via the National Chlamydia Screening Programme and basic contraceptive services, with LARC provision varying by practice (Hull City Council, 2025).

Figure 10 summarises the main service modalities and provider roles across the system.

Provision by provider and function

Provider	Modalities Delivered	Priority Groups / Settings	Inclusion-health and outreach activities
CHCP (ISHS)	Clinic-based STI and contraception care, including LARC and oral contraption, ; HIV testing and PrEP; psychosexual support; online and postal testing; outreach, Menopause support. Medical abortion, postal testing kits, condom provision,	General population of all age ranges,young people; LGBTQ+ communities; inclusion-health groups (e.g. people experiencing homelessness, hostel residents, vulnerable women)	Monthly outreach clinics at Changing Futures hub and homeless hostels; pop-up/drop-in clinics in mental health units; contraception outreach on postnatal wards and in maternity services; joint work with PAUSE, Renew, Pathway and other multiple-needs projects; co-located clinics in community venues across four localities (CHCP, Hull Quarter 2 Contract Narrative Report 2025/26)
MESMAC	Outreach; rapid and postal STI testing; sexual health promotion; one-to-one support and advocacy, Delivery of school based RSE / PSHE , training provided to staff / organisations that have contact with young or / vulnerable people to enable conversations and discussions around choices. Condom distribution, outreach in parlours and saunas (testing and prevention advice, including condoms)	LGBTQ+ communities; sex workers; migrants; young people in community settings	Targeted outreach in LGBTQ+ venues, nightlife settings and sex-on-premises venues; attendance at Hull Pride and other community events; joint outreach with CHCP in hostels, youth projects and other inclusion-health settings (Yorkshire MESMAC, KPIs and Activity Report 2024/25).
GPs	Contraception (including LARC in participating practices); chlamydia screening, menopause treatment,	General practice populations, particularly reproductive-age women	Opportunistic contraception and STI advice during routine consultations; LARC provision within participating practices, including for women referred from outreach and maternity services (CHCP, Hull Quarter 2 Contract Narrative Report 2025/26).

Provider	Modalities Delivered	Priority Groups / Settings	Inclusion-health and outreach activities
Pharmacies	EHC; chlamydia testing kits; oral contraceptive pill (new and repeat), condoms,	Young people, the general population	Commissioned free EHC without prescription and opportunistic chlamydia testing and emergency contraception counselling in participating community pharmacies (Hull City Council, Integrated Sexual Health Service Specification 2024–2029).

Figure 10: Provision of sexual and reproductive health services by provider, function and inclusion-health outreach, Hull (Hull City Council, 2025; CHCP, Hull Quarter 4 Narrative Report 2024/25; CHCP, Hull Quarter 2 Contract Narrative Report 2025/26; Yorkshire MESMAC, KPIs and Activity Report 2024/25).

6.2 Service Activity and Reach

Recent service activity and contract monitoring data from CHCP and Yorkshire MESMAC show sustained demand for Hull's integrated sexual health model, particularly among younger adults and people accessing online testing and community clinics (CHCP, 2024/25; Yorkshire MESMAC, 2024/25). Overall activity levels, walk-in utilisation and KPI performance for timeliness (including LARC fits and STI result turnaround) indicate strong delivery against core service standards (CHCP, Hull Quarter 4 Narrative Report 2024/25). At the same time, patterns in postal kit returns, clinic attendance and outreach contacts by age, deprivation and priority group highlight ongoing equity challenges for some inclusion-health groups and for young people outside mainstream education, which are explored in the subsections below (Healthwatch Hull, 2024; CHCP, Hull Quarter 2 Contract Narrative Report 2025/26).

6.2.1 Demographic Profile and Utilisation Patterns

Recent CHCP activity reports indicate the following patterns of service use:

- Around 71% of STI-related consultations involve individuals under the age of 30, reflecting continued high service use among younger adults and aligning with the epidemiology of STIs as a key public health priority for early detection and prevention (City Health Care Partnership CIC, 2025).

- LARC provision is most commonly accessed by people aged 25–34, with additional activity among younger and older age groups; however, routine provider data do not yet include reliable breakdowns by ethnicity or deprivation for LARC activity (City Health Care Partnership CIC, 2025).

- Digital access routes, including online booking and postal STI testing, continue to be well used, supporting convenient access for many service users (City Health Care Partnership CIC, 2025). However, thematic analysis of qualitative feedback indicates variable digital confidence, device access and connectivity across wards and socio-economic groups,

meaning that online routes alone cannot guarantee equitable access (Healthwatch Kingston upon Hull, 2024).

- To support more equitable access, providers have expanded walk-in, in-person booking and sit-and-wait models, offering alternatives to digital platforms and improving visibility across community settings (City Health Care Partnership CIC, 2025; Hull City Council, 2025).

Themes from patient feedback help explain why some residents, particularly in more deprived wards, may be underrepresented in digital activity data despite the ongoing need (Healthwatch Kingston upon Hull, 2024). For example, some respondents described not knowing where to find up-to-date information on clinic locations or feeling unsure how to navigate online booking systems, especially when relying on shared or limited devices (Healthwatch Kingston upon Hull, 2024).

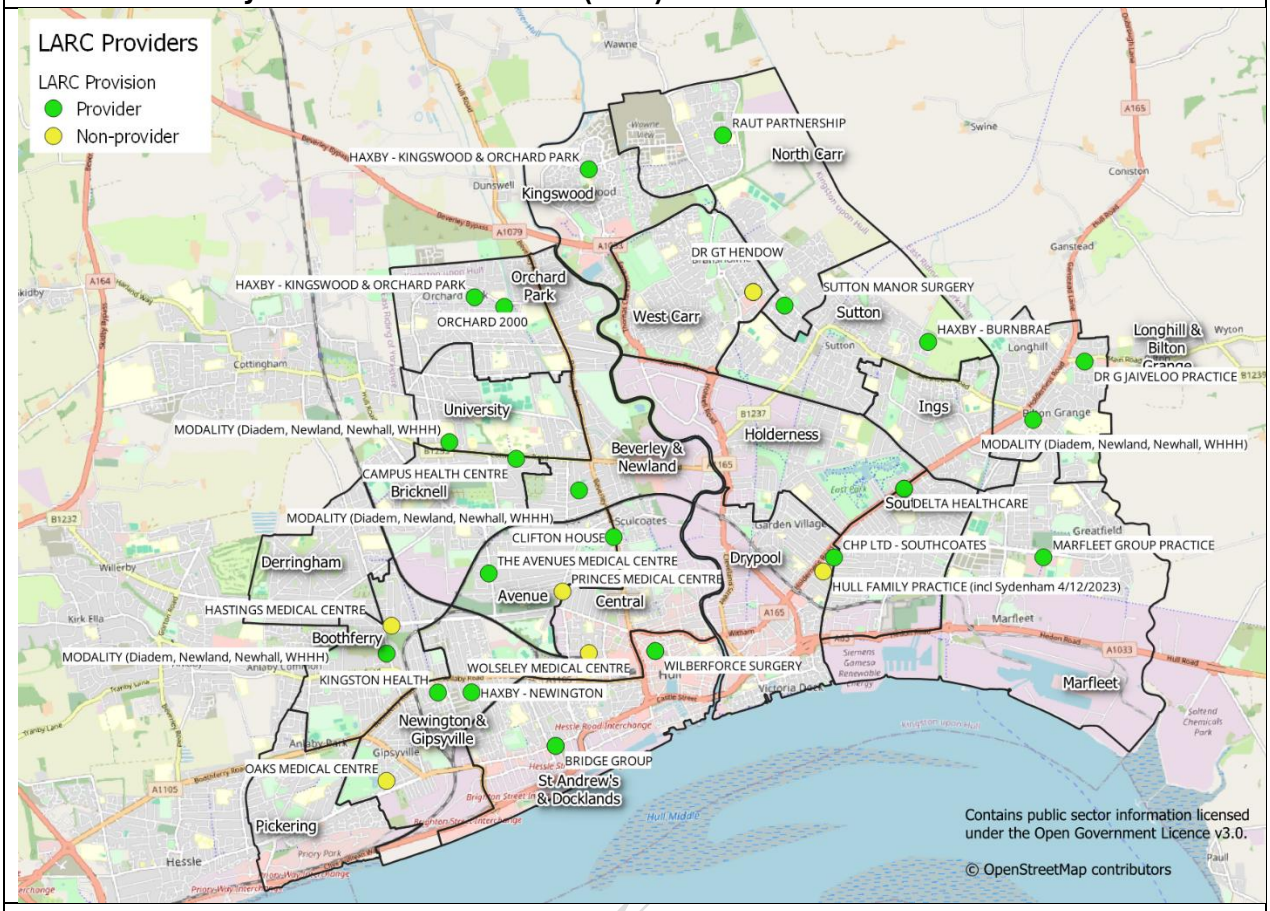
LARC access and primary care engagement

Long-acting reversible contraception (LARC) is provided across Hull by City Health Care Partnership CIC through Wilberforce Health Centre and by participating GP practices commissioned under the subcontract with CHCP. The map in Figure 11 shows provision by GP practice, with green-shaded locations currently offering LARC and yellow-shaded locations where provision is not yet in place (Hull City Council, 2025).

While geographic coverage is relatively broad, service-user feedback and outreach intelligence suggest that some patients remain uncertain about which practices offer LARC, how to request it, or whether they can ask their GP for a referral (Healthwatch Kingston upon Hull, 2024; City Health Care Partnership CIC, 2025). Themes include digital exclusion, limited awareness of local pathways and discomfort discussing contraception with primary care staff, particularly among some young women and those living in more deprived neighbourhoods (Healthwatch Kingston upon Hull, 2024).

Efforts to promote LARC through school nursing teams, targeted outreach, community-based clinics and simplified referral pathways aim to improve awareness and uptake, particularly in lower-engaged cohorts (City Health Care Partnership CIC, 2025; Hull City Council, 2025).

LARC Provision by GP Practice Across Hull (2024)



Public Health, 2025

6.2.2 Inclusion Health and Service Equity

The Hull Sexual Health Inequalities Report 2025 (local analysis of routine activity and engagement data) notes that just over 50% of service users live in IMD quintiles 1 and 2, broadly mirroring Hull's wider deprivation profile (Hull City Council, 2025). However, this pattern is likely to reflect underlying population distribution more than successful targeting of those at greatest risk of poor sexual health outcomes.

Recent activity data and outreach intelligence highlight examples of service use among specific inclusion health groups:

- Men who have sex with men (MSM) remain the most frequent users of postal STI testing, supported by focused outreach and promotion in LGBTQ+ venues and online spaces (City Health Care Partnership CIC, 2025; Yorkshire MESMAC, 2024).
- Sex workers, people in supported housing, and people with no fixed address are primarily engaged through targeted outreach clinics and joint sessions in community and hostel settings (Yorkshire MESMAC, 2024; City Health Care Partnership CIC, 2025).

In addition, inclusion health "flags" have been introduced within the ISHS booking system, supporting more consistent identification of people in inclusion health groups, targeted follow-up, and improved recording of needs over time (City Health Care Partnership CIC, 2025).

Despite these developments, there is still limited reach into certain groups, including heterosexual men aged 35–55, Black and Asian communities, individuals with limited English, and those who are digitally excluded. These populations are often under-recorded in routine activity data because of anonymised access, low engagement with mainstream services and limited disaggregation of monitoring systems by ethnicity, language or social risk factors (Office for Health Improvement and Disparities, 2022; Faculty of Public Health, 2023).

National guidance recommends targeted community engagement, co-produced service mapping and strengthened equity-focused data as core tools to understand unmet need, identify barriers to access and inform inclusive commissioning priorities (OHID, 2022; Faculty of Public Health, 2023). Aligning local action with this approach would support Hull to make fuller use of the inclusion health flag, build on existing outreach and address gaps for underserved groups in future commissioning cycles.

6.3 Key Barriers and Service Gaps

Service Access and Community Outreach

Wilberforce Health Centre remains the central hub for Hull's integrated sexual health service, providing booked appointments throughout the week and a booked Saturday clinic, alongside daily outreach clinics across the city (City Health Care Partnership CIC, 2025). Quantitative activity data and qualitative feedback indicate that people living in the most deprived neighbourhoods continue to face barriers linked to transport costs, anxiety about hospital-style clinical environments and competing caring or work responsibilities (Hull City Council, 2025; Healthwatch Kingston upon Hull, 2024).

In response, CHCP has expanded a network of community-based sessions, including evening clinics, located in non-clinical and accessible settings such as Family Hubs, supported living premises and venues serving people with multiple unmet needs (City Health Care Partnership CIC, 2025). This outreach model is consistent with national best practice for taking sexual health services closer to communities at higher risk and is intended to reduce traditional access barriers, increase trust and improve continuity of care for people who might not otherwise attend a city-centre hub (NHS England, 2023; OHID, 2022).

Digital Inequality and Access

Digital platforms remain a key gateway into Hull's ISHS, particularly for younger adults using online booking and postal STI testing. Local online testing dashboards and booking data show sustained use of digital routes, but provider reports and Healthwatch engagement highlight persistent digital exclusion for some older adults, residents in supported accommodation, people with limited English and those with low digital confidence (City Health Care Partnership CIC, 2025; Healthwatch Kingston upon Hull, 2024). This pattern reflects wider evidence that digitalisation can both improve convenience and inadvertently widen inequalities when offline alternatives are not maintained.

To mitigate these risks, providers have introduced a range of adjustments:

- Simplified online booking pages, with clearer visual cues and "easy read" content to support users with lower literacy or digital skills and there is also a function to translate the page into several languages. (City Health Care Partnership CIC, 2025).

- Two-way SMS for appointment confirmations, reminders and cancellations, reducing the need for internet access or long phone calls.
- Daily walk-in and sit-and-wait options, clearly advertised in community settings and through partners, to maintain non-digital routes into care.
- The phased roll-out of freephone contact numbers aimed at reducing cost barriers for people on low incomes (City Health Care Partnership CIC, 2025).
- Testing of QR codes on posters and outreach materials to provide quick access to trusted information and booking pages for those with smartphones.

Taken together, these actions align with national recommendations to retain "no wrong door" access, ensuring that digital tools supplement rather than replace face-to-face and telephone options (Good Things Foundation, 2024; OHID, 2022).

LARC Access and System Gaps

Long-acting reversible contraception (LARC) is now available through CHCP clinics (central and outreach) and all GP practices across Hull, in line with the national integrated sexual health service specification (City Health Care Partnership CIC, 2025; OHID, 2023). Local provider audit data suggest that total LARC uptake in Hull appears lower than England averages reported on Fingertips; however, this is largely explained by incomplete submission of primary care LARC activity to national datasets, meaning that local assessment is most accurate when based on quarterly provider audits rather than comparing headline Fingertips rates alone (OHID, 2022; Hull City Council, 2025).

Within Hull, average waiting times for non-urgent LARC appointments remain within the national 28-day standard, and outreach-based LARC sessions have reduced travel distances for some high-need groups (City Health Care Partnership CIC, 2025). Nevertheless, uptake varies across the city, with lower engagement among women under 19 and over 35, consistent with national patterns of suboptimal LARC use in some younger and older cohorts (NICE, 2014; OHID, 2022).

Local qualitative feedback suggests that some patients lack awareness of LARC options or receive conflicting information about side-effects and suitability, including misinformation shared via social media and peer networks (Healthwatch Kingston upon Hull, 2024). In response, providers are working with school nursing teams, RSE providers and youth projects to integrate accurate LARC information into education and outreach for young people, alongside condom promotion consistent with NICE guidance on multicomponent condom distribution schemes (NICE, 2017; City Health Care Partnership CIC, 2025). For other age groups, primary care and community outreach are being used to normalise discussions about contraception, emphasising choice and shared decision-making rather than a single "best" method.

Cultural and Perception Barriers

Stigma, fear of judgement and cultural discomfort remain important barriers to sexual health service use for some LGBTQ+ people, minoritised ethnic groups and faith-based communities (Faculty of Sexual and Reproductive Healthcare, 2023; NICE, 2017). Local Healthwatch engagement and staff reflections indicate that some residents worry about being recognised at a sexual health clinic, feel that services are not designed for people "like them", or are unsure whether staff will understand their cultural or religious context (Healthwatch Kingston upon Hull, 2024).

Evidence-based responses include improving cultural competence, representation and co-production. In Hull, actions have included: increasing visibility of LGBTQ+ and ethnic minority representation in posters and digital content; co-produced outreach with community organisations; and delivering sessions in familiar community spaces rather than solely clinical sites (City Health Care Partnership CIC, 2025; Yorkshire MESMAC, 2024). These approaches are consistent with national recommendations that trusted messengers, culturally tailored information and co-designed services can reduce stigma and improve engagement among inclusion health groups.

Tracking and Evaluation of Inclusion Health

"Inclusion health" refers to people who experience extreme social exclusion, such as those who are homeless, sex workers, asylum seekers, people in contact with the criminal justice system, and others facing overlapping health and social vulnerabilities (NHS England, 2023). These are not a single homogenous group: different inclusion health populations face distinct risks, barriers and patterns of sexual health need, including higher rates of STIs, unintended pregnancy, sexual violence and difficulties navigating mainstream services (OHID, 2022; NHS England, 2023).

Hull's ISHS now enables inclusion health coding at the point of care (for example, for people experiencing homelessness, sex workers and asylum seekers), which is a significant step towards more systematic identification and follow-up (City Health Care Partnership CIC, 2025). However, subgroup-level reporting is not yet routinely available for public reporting or strategic oversight, limiting the ability to provide assurance on equitable reach or to track improvements over time.

Further work is needed to improve coding consistency, link inclusion health flags with other datasets and develop regular subgroup analysis, in line with national frameworks for action on inclusion health (NHS England, 2023). At the same time, national evidence emphasises that population denominators for many inclusion health groups are uncertain or absent, making it difficult to calculate coverage precisely and requiring a mixed-methods approach that combines routine data with qualitative insight, outreach intelligence and partner feedback (OHID, 2022; Hull City Council, 2025).

6.4 Summary and Strategic Considerations

Hull's integrated sexual health model shows a clear and evolving commitment to inclusion, accessibility and partnership working, with expanded community-based outreach, strengthened digital and non-digital access routes, and more tailored engagement with underserved groups (City Health Care Partnership CIC, 2025; Hull City Council, 2025). At the same time, the needs assessment identifies persistent broader challenges around digital exclusion, cultural stigma, limited data visibility for inclusion health groups and variable LARC uptake across age groups and settings, echoing national concerns about inequalities in sexual and reproductive health (OHID, 2022; NHS England, 2023).

Strategic attention is needed to:

- strengthen monitoring of equity outcomes, including routine reporting by deprivation, ethnicity, age and inclusion health status where possible, in line with the national integrated sexual health service specification (OHID, 2023);
- address known gaps and quality issues in primary care reporting of LARC and other contraceptive activity, so that local audit data and national sources such as Fingertips can be

interpreted and used consistently for commissioning and assurance (Staffordshire County Council, 2019; OHID, 2022);

- and further embed culturally responsive practice across partner organisations, informed by co-production with communities most affected by poor sexual health outcomes (NHS England, 2023).

Ensuring that qualitative insights from service users, community organisations and frontline staff continue to shape outreach design, appointment pathways and communication strategies will be essential to improving both reach and sustained engagement with priority populations, consistent with national guidance on data-driven, user-informed commissioning of sexual health services (OHID, 2022; GOV.UK, 2025).

7 Recommendations

The recommendations below synthesise quantitative trends, qualitative insights from service users and providers, and national policy frameworks to provide a structured, evidence-informed basis for prioritisation and action. This rigorous needs assessment process – drawing on triangulated data sources and multi-stakeholder input – demonstrates a systematic approach to identifying health inequalities, assessing service equity, and proposing proportionate interventions aligned with Hull's commissioning context and public health priorities.

Each recommendation follows a consistent structure: context/evidence (linking to SHNA findings), clear recommendation (actionable, specific), current progress (acknowledging strengths), and evidence/rationale (national guidance, feasibility). They emphasise health equity, stakeholder collaboration, and sustainable service improvement, supporting claims across leadership, analysis, and strategic planning competencies.

These recommendations should be considered within the broader national, regional and local policy context outlined in Section 3. They are intended to support alignment with existing strategic direction, including national sexual and reproductive health policy, the HIV Action Plan, the Women's Health Strategy, and relevant regional and system priorities. Implementation should build on ongoing work and inform future commissioning, service development and strategic planning, including the development of a proportionate local sexual health strategy or delivery framework.

7.1 Strengthen Access in Deprived Areas and Underserved Communities

Context/Evidence:
Routine postcode coding in CHCP, MESMAC and Preventx datasets remains incomplete, with approximately 20-30% missing per Q3/Q4 reports, which limits robust ward-level analysis of service utilisation against local needs such as population density, IMD and ethnic diversity. The JSNA and Hull 2021 Census confirm geographical variations in need, for example, higher densities of young adults and minority ethnic groups in east Hull. Local qualitative data highlight specific access barriers for marginalised populations in high-deprivation areas, including stigma ("fear of judgement" – Healthwatch 2024), cultural mismatch and language issues (MESMAC 2024), and logistical challenges such as lack of evening access (CHCP Q4 narrative). These factors risk perpetuating unmet need and health inequalities, in line with national patterns observed in OHID SRH Profiles (2025).

Recommendation:
Work with providers to review and, where appropriate, strengthen the way sexual health service data are collected and used to better understand equity of access.

Existing work
A strong foundation exists through established services, including the Changing Futures Hub for multiple disadvantages, Family Hubs and Preston Road, Riverside clinics and bookable Saturday slots, which already engage excluded groups such as older adults and low-digital users (high IMD quintile utilisation per CHCP Q3/Q4 reports). This plan builds directly on these assets.

Evidence, Rationale and Feasibility:
NICE NG68 on STI prevention mandates targeted outreach in high-need areas with built-in evaluation, while the UKHSA STI Framework supports data-driven prioritisation of interventions. Local precedents, such as the success of Riverside co-location, demonstrate the model's effectiveness, and data audits can leverage existing CHCP flags without requiring new systems. The timescale is realistic and aligns with the service specification's equity requirements. Risks such as staff resistance to data capture will be mitigated through joint CHCP/Public Health ownership.

7.2 Optimise Digital Inclusion with Robust Hybrid Access Safeguards

Context/Evidence:
Preventx dashboards for Q3 2024/25 to Q1 2025/26 demonstrate strong uptake among young people, with 70% of under-25s ordering test kits online. However, notable exclusion persists among over-35s show 25% lower return rates, migrants and low-income groups (language and privacy concerns cited in 15 of 32 Healthwatch responses), and those facing device barriers (40% of MESMAC clients require assistance; eg digital access and/ or reading servies information). People in deprived areas face twice the risk of digital exclusion, as highlighted by OHID data (2024).

Recommendation:
Ensure that options for accessing sexual health services promote equitable access and help mitigate inequalities related to digital exclusion.

Existing work: The CHCP website already offers multi-language translation through a flag access tool, alongside preserved telephone and in-person routes. Family Hub and youth navigation supports are in place and ready for scale-up.

Evidence/Rationale:
NICE guidance on digital health (2021) and NHS Digital Inclusion standards emphasise hybrid models to prevent exclusion. Local qualitative evidence confirms the impact of assistance, with Healthwatch noting that "help with forms was a game-changer". Delivery will be low-cost, using in-house training and free tools, with risks such as variable uptake addressed through analytics and dashboard monitoring. This aligns with the NHS Long Term Plan and statutory equity duties under the Health and Care Act 2022.

7.3 Strengthen Awareness and Access to LARC Across Key Life Stages

Context and Evidence:
CHCP key performance indicators for 2024/25 indicate that uptake of long-acting reversible contraception (LARC) is concentrated among people aged 20–29, with comparatively lower uptake among under-19s and those over 35, despite strong evidence of effectiveness across the life course (FPA, 2023). Hull continues to experience higher-than-average under-20 conception rates compared with England (OHID), reinforcing the importance of accessible and timely contraception.

In addition, service intelligence highlights gaps in postnatal contraception uptake in the context of high maternity activity in Hull (HUTH data). Evidence from NICE QS129 and the Women's Health Strategy indicates that underutilisation of LARC in postnatal pathways increases the risk of rapid repeat pregnancies, particularly in more deprived communities.

Qualitative insight from Healthwatch (2024) and Yorkshire MESMAC suggests that awareness, timing and logistical barriers can affect access to contraception for young people, those outside mainstream education (including elective home education groups), and new parents. These factors intersect with wider deprivation-related inequalities identified within the JSNA.

Recommendation:
Promote awareness of, and informed access to, long-acting reversible contraception (LARC) across key life stages, including under-19s, over-35s and postnatal contraception.

Existing work
Targeted outreach to support contraception awareness and access is already underway through Family Hubs, links with 0–19 services and elective home education networks, and partnerships between CHCP and Yorkshire MESMAC. Postnatal contraception is supported through existing

subcontracting arrangements with Hull University Teaching Hospitals (HUTH), alongside Family Hub provision for new families and the availability of digital information and support resources.

Evidence, Rationale and Feasibility:
The Women's Health Strategy and NICE QS129 recommend age-tailored LARC promotion, with National policy, including the Women's Health Strategy and NICE QS129, supports age- and life-stage–appropriate promotion of LARC as an effective approach to reducing unplanned and rapid repeat pregnancies. Evidence indicates that integrated delivery across community, primary care and maternity settings can improve access and uptake.

Local service developments, including expanded clinic provision and established maternity partnerships, demonstrate that further improvement is feasible within existing pathways. Any future enhancement activity can be shaped through stakeholder engagement to ensure alignment with commissioning priorities, service specifications and workforce capacity, with an emphasis on proportionate, equitable delivery.

7.4 Address Stigma and Cultural Barriers to Improve Inclusivity

Context and Evidence:
Healthwatch Hull 2024 (32 responses) and MESMAC 2024 reports identify recurrent stigma concerns such as fears of judgement and confidentiality breaches, alongside cultural and language mismatches, particularly affecting minority ethnic, migrant and LGBTQ+ groups who face elevated STI risks (OHID data: east Hull rates exceed England averages). CHCP complaints and Friends & Family Test (FFT) feedback highlight gaps in perceived inclusivity, while the JSNA notes a 15% rise in ethnic diversity since the 2021 Census.

Recommendation:
Continue working with partners to provide sexual health services that are inclusive, culturally competent, trauma-informed and informed by service user voice.

Existing work
Strong VCS partnerships via MESMAC and CHCP are established, website translations are available, and initial staff training is progressing through Changing Futures initiatives.

Evidence, Rationale and Feasibility:
UKHSA Inclusion Health guidance and BASHH standards emphasise culturally tailored services to build trust and improve uptake among underserved groups. Local qualitative evidence demonstrates that addressing stigma directly enhances engagement. Delivery leverages existing VCS networks and CHCP training infrastructure for practicality. Risks related to campaign reach will be mitigated through targeted channels, ensuring alignment with the service specification's inclusivity requirements.

7.5 Strengthen HIV and PrEP Equity for At-Risk Groups

Context and Evidence:
HIV diagnoses in Hull remain stable, but late presentations are higher than national averages (UKHSA data), while PrEP uptake lags among eligible groups such as GBMSM and migrants despite clear clinical benefits (CHCP KPIs 2024/25). MESMAC reports highlight trust and awareness gaps among inclusion health populations, which align with JSNA priorities for vulnerable communities.

Recommendation:
Continue to promote awareness of, and equitable access to, HIV prevention and testing, including PrEP, with a focus on populations at higher risk of late diagnosis.

Existing work:
Routine PrEP provision is available through CHCP clinics, supported by established MESMAC outreach to inclusion health groups.

Evidence, Rationale and Feasibility:
The HIV Action Plan 2022-25 sets ambitions for zero new transmissions through expanded PrEP access and equity. MESMAC's existing capacity will handle the majority of deliveries, requiring minimal additional input from CHCP. This approach aligns with national funding streams and the service specification's BBV requirements.

7.6 Strengthen Community Partnership and Co-Design in Sexual Health Services

Context and Evidence:
Qualitative insight from Yorkshire MESMAC, Healthwatch Hull and wider voluntary and community sector partners highlights the importance of community-led approaches in understanding barriers to accessing sexual health services. Communities experiencing the greatest inequalities are often those least likely to engage with traditional service models, reinforcing the value of trusted relationships, culturally competent practice and locally grounded insight.

National public health guidance emphasises co-design and partnership working as effective mechanisms for addressing health inequalities and improving service accessibility, particularly where stigma, trust and cultural factors influence engagement. These approaches complement quantitative surveillance by providing contextual understanding of lived experience.

Recommendation:
Explore opportunities and mechanisms to strengthen partnership working, co-design and community involvement in sexual and reproductive health services..

Existing Work

Hull's sexual health system already benefits from established partnerships with voluntary and community sector organisations, including targeted outreach activity delivered by Yorkshire MESMAC and collaborative working across providers and commissioners. The recent recommissioning of sexual health services has reinforced partnership approaches and created opportunities to further embed community-informed service development.

Evidence, Rationale and Feasibility:
Hull's sexual health system already benefits from established partnerships with voluntary and community sector organisations, including targeted outreach activity delivered by Yorkshire MESMAC and collaborative working across providers and commissioners. The recent recommissioning of sexual health services has reinforced partnership approaches and created opportunities to further embed community-informed service development.

7.7 Strengthen Engagement with Young People to Inform Sexual Health and Pregnancy Prevention

Context and Evidence:
Hull's under-18 conception rate remains higher than the England average (OHID), reflecting persistent inequalities in sexual and reproductive health outcomes for young people. Qualitative feedback from Healthwatch Hull (2024) and insight from the Teenage Pregnancy Steering Group

highlight variation in access to clear, consistent and inclusive information on relationships, consent, contraception and sexual health, including among young people outside mainstream school settings.

Local service intelligence indicates variable engagement across schools and elective home education (EHE) settings within the context of an increasingly diverse youth population (Census 2021). National evidence and statutory guidance emphasise the importance of involving young people in shaping information and approaches to ensure relevance, acceptability and effectiveness.

Recommendation:
Work with young people to better understand experiences and information needs relating to relationships, sexual health and contraception, to inform teenage pregnancy prevention activity.

Existing Work

Sexual health education and engagement with young people is already delivered through 0–19 services, school-linked activity and targeted outreach by Yorkshire MESMAC. The Teenage Pregnancy Steering Group provides an established forum for coordination, partnership working and the inclusion of youth perspectives.

Evidence, Rationale and Feasibility:
National guidance, including Department for Education relationships and sex education (RSE) guidance and FPA standards, supports co-designed, age-appropriate and inclusive approaches to sexual health education as a means of addressing knowledge gaps and reducing unintended pregnancies. Existing partnerships with schools, youth services and voluntary sector organisations provide a feasible foundation for continued engagement with young people, without prescribing specific delivery models or timescales.

8 Conclusion

This Sexual Health Needs Assessment (SHNA) provides an up-to-date, evidence-informed overview of sexual and reproductive health needs in Hull in 2025. It builds on the 2022 SHNA and reflects recent changes in the population profile, service configuration, and national policy, drawing on routinely collected data, provider intelligence, and community insight to support proportionate, equitable decision-making.

The assessment confirms that sexual and reproductive health outcomes in Hull continue to be shaped by wider social and structural determinants, including high levels of deprivation, a relatively young population, increasing diversity, and persistent barriers related to digital access, stigma and trust. These factors are known nationally to be associated with higher sexual health risk and reduced engagement with services, and they provide important context for interpreting local patterns of service use and outcomes.

Analysis of surveillance and service data indicates that Hull continues to experience higher rates of need for sexual health support among younger age groups and some priority populations, alongside evidence that testing and engagement may be lower than expected given the city's demographic and socioeconomic profile. While variation in service use is partly anticipated, the overall pattern suggests that a proportion of unmet need is likely to persist, particularly among groups that are less visible in routine datasets or face greater barriers to access.

At the same time, the SHNA highlights clear areas of system strength and recent progress. The recommissioning of integrated sexual health services in 2024 has enabled the expansion of open-access provision, greater use of community-based and outreach models, and improvements in digital and non-digital access routes. Partnership working between City Health Care Partnership, Yorkshire MESMAC, Hull City Council and wider voluntary and community sector organisations has supported more inclusive approaches to prevention, testing and contraception, particularly for groups at higher risk of poor outcomes.

Alongside these areas of progress, the SHNA also identifies a number of ongoing challenges that require sustained attention. These include improving the visibility and uptake of long-acting reversible contraception, reducing late HIV diagnosis, addressing gendered patterns of service use, and strengthening culturally competent engagement with communities who report stigma or uncertainty about services. These challenges are not unique to Hull and reflect wider national and regional pressures within sexual and reproductive health systems**.** Limitations in routine data for some inclusion health groups further reinforce the importance of combining quantitative monitoring with qualitative insight and continued community engagement.

The recommendations set out in Section 7 provide a structured, realistic framework for addressing these issues. They are designed to support further improvement in access, quality and equity through targeted outreach, strengthened digital inclusion, enhanced partnership working and clearer use of data to inform prioritisation and evaluation.

Overall, Hull's sexual and reproductive health system has a strong and developing foundation. Continued progress will depend on maintaining a clear focus on prevention and equity, ensuring flexible access across clinical and community settings, embedding inclusive and trauma-informed practice, and using learning from delivery and evaluation to refine commissioning over time. This

SHNA provides a robust platform to support that ongoing work and to inform future updates to the Joint Strategic Needs Assessment.

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Appendix 1: Qualitative Coding Framework and Thematic Summary

This appendix summarises the coding framework and key themes developed from secondary qualitative sources (Healthwatch Hull, CHCP narrative reports, MESMAC outreach intelligence). A reflexive thematic analysis approach was applied, following Braun and Clarke's six phases, as described in the Qualitative Methods and Coding Annex. Given the modest volume and secondary nature of the material, the analysis was proportionate and interpretive rather than a full, saturation-level primary thematic study. The aim was to generate coherent, practice-relevant themes to inform Sections 5.3.2–6.4 of the SHNA and to triangulate quantitative findings.

Theme	Codes identified	Source(s)	Notes
Digital access and exclusion	Digital illiteracy; lack of access to digital devices (mobile / laptop / ipad) or data; confusion with online forms; postal kit challenges	Healthwatch Hull (2024); CHCP (2025)	Most frequently reported by older adults, people on low incomes, and residents in temporary or unstable housing.
Cultural and social barriers to use	Fear of judgement; confidentiality concerns; stigma in ethnic/minority communities; service mistrust	Healthwatch Hull (2024)	Recurs particularly in faith-based, minority ethnic and some migrant communities.
Service flexibility and outreach	Clinic times; outreach requests; preferences for community venues; walk-in vs booked appointments	CHCP (2025); MESMAC (2024–25)	Consistently linked to increased engagement among underserved and inclusion-health groups.
Youth and LGBTQ+ engagement patterns	Peer trust; sexual health literacy gaps; variable RSE; LGBTQ+ safe spaces; discomfort with GPs	Healthwatch Hull (2024); MESMAC (2024–25)	Highlights age- and identity-specific needs and opportunities for targeted improvement.
Language and translation barriers	Forms not available in first language; limited interpreter use; difficulty understanding written information	Healthwatch Hull (2024); CHCP (2025)	Common among asylum seekers, recent migrants and some ethnic minority groups.
Awareness and service visibility	Limited awareness of PrEP/PEP; uncertainty about clinic locations and outreach; low visibility of digital testing	CHCP (2025); Healthwatch Hull (2024)	Reported across several groups, with particular reference to LGBTQ+ communities and people who do not use English as a first language.

Coding process: Coding was completed manually through repeated review of each qualitative source. Text segments were assigned initial codes, which were then grouped by pattern similarity and relevance to sexual health service access and equity, in line with Braun and Clarke's framework. The table above is not exhaustive but reflects the most consistently recurring themes across the main qualitative sources.

Worked example: from raw data to theme (illustrative)

To illustrate how reflexive thematic analysis was applied, the table below shows example extracts alongside their initial codes and final themes

Source document	Data extract (anonymised)	Initial code	Final theme
Health-watch-Final-report-SHNA.docx	"I tried to book online but the system kept timing out – in the end I had to phone three times before I got through."	Online booking difficult; repeat phone calls	Digital access and exclusion
Health-watch-Final-report-SHNA.docx	"People in my community worry everyone will find out if they go to the clinic."	Fear of being recognised; confidentiality worry	Cultural and social barriers to service use
Quarter-3-Hull-Contract-Report.docx	"Delivering sessions in the hostel has improved engagement from people who would not travel to the city centre clinic."	Outreach increases engagement; location matters	Service flexibility and inclusion-health outreach

These examples are illustrative rather than exhaustive. They demonstrate the route from raw qualitative material to codes and then to the themes used in the main SHNA narrative.

Source documents

Key qualitative sources underpinning this appendix are:

- Healthwatch Hull (2024) Community Engagement Summary Report – file: Health-watch-Final-report-SHNA.docx
- CHCP (2024–25) Q3 Contract Monitoring Report – qualitative provider narrative – file: Quarter-3-Hull-Contract-Report.docx
- MESMAC (2024–25) Activity and Outreach Intelligence – file: MESMAC-KPIs-Activity.docx

These documents are archived with the SHNA working files and are available on request for validation and audit.

Qualitative insights from these sources were triangulated with internal provider data (CHCP, MESMAC) and quarterly performance information, as described in the main Methods section and the Qualitative Methods and Coding Annex.

Limitations

The qualitative material used in this SHNA is secondary and drawn from relatively small-scale engagement exercises and provider reports. It does not represent all population groups in Hull, and some inclusion-health groups are under-represented. The reflexive thematic analysis was therefore

designed to be proportionate: themes are intended to illuminate patterns and mechanisms, not to quantify prevalence. These limitations are explicitly reflected in the main text when interpreting findings and making recommendations.

Appendix 2: Insight Source and Use Summary

Contributor	Type of Insight	How Used in SHNA	Caveats / Interpretation	Linked Recommendations
City Health Care Partnership (CHCP)	Quantitative routine service activity data (service use, demographics, trends), supported by provider commentary	Informed Section 5 (STIs, contraception incl. LARC, HIV) and Section 6 (service activity, access and reach), and used to support Section 7 (Recommendations)	Treated as routine service intelligence. Where disaggregated data (e.g. by ethnicity or protected characteristic) were unavailable, this is explicitly stated and findings interpreted cautiously.	7.1, 7.2, 7.3, 7.4, 7.5, 7.6
Yorkshire MESMAC	Qualitative outreach insight from LGBTQ+ communities and inclusion health groups; service delivery learning	Informed Section 5.2.4 (HIV) and relevant subsections within Section 6 (barriers to access, inclusion health and cultural factors), and contributed to Section 8 (Use of Insight / Limitations)	Narrative insight is not statistically generalisable. Used to contextualise routine data and implementation realities; not presented as stand-alone evidence of population-level prevalence or need.	7.1, 7.3, 7.4, 7.2, 7.5, 7.6
Healthwatch Hull	Small-scale community engagement feedback (including migrants, older adults and LGBTQ+ residents)	Informed Section 5.3.2 (Emergency Hormonal Contraception) and relevant subsections within Section 6 (barriers including stigma/culture and digital exclusion), and referenced in Section 8 (Limitations)	Sample size and representativeness are limited. Insight used selectively to illuminate barriers and service experience, and interpreted alongside provider/system intelligence.	7.1,7.2, 7.4, 7.6, 7.7
Public Health and	Strategic and operational	Used to inform the framing, deliverability and	Used to ensure recommendations	All recommendations

Contributor	Type of Insight	How Used in SHNA	Caveats / Interpretation	Linked Recommendations
Commissioning Leads	insight; feasibility assessment; commissioning context	prioritisation of recommendations in Section 7	are realistic and implementable within local pathways and commissioning context. Not used as the sole source of evidence for need, risk or impact.	(framing and feasibility)
Sexual Health Lead	Sexual Health Inequalities Report (Q4 2024/25) and commissioner insight on service reach and equity considerations	Informed relevant parts of Section 6 (inequalities/barriers/service reach) and supported the equity framing and feasibility considerations underpinning Section 7 recommendations	Used as service intelligence to contextualise routine provider datasets; interpreted cautiously and not presented as a direct measure of population need or prevalence	All recommendations (equity framing and feasibility)

Notes:

- All insight sources were critically appraised for relevance, representativeness and fitness for purpose, and were interpreted alongside quantitative trends where available.
- Recommendations were included only where supported by triangulated evidence (routine data + qualitative/system intelligence) or clear operational rationale.
- Known limitations — including small sample sizes, partial coverage of some populations and constraints in routine disaggregation — are explicitly acknowledged in the main report and appendices.
- Where exploratory or emerging improvement ideas are referenced, these are presented as learning-focused and do not imply proven effectiveness

Appendix 3: Technical Appendix

STI Testing and Diagnosis Modelling Methodology

1. Purpose and research question

This technical appendix describes the statistical modelling undertaken by Hull City Council Public Health Intelligence to support Section 5.2.1 of the Hull Sexual Health Needs Assessment (SHNA). The purpose of the modelling was to explore whether Hull's relatively low observed rates of STI testing and new diagnoses, when compared with other upper-tier local authorities, might reflect genuinely lower infection rates or instead be driven by lower detection due to differences in testing activity.

The specific question addressed was:

- How do Hull's observed STI testing rates, diagnosis rates and test positivity compare with "expected" values once differences in age structure, deprivation and sexual-orientation profile between local authorities are taken into account?

2. Data sources

The modelling used routinely available national and local intelligence:

- Sexual health indicators:
    - Office for Health Improvement and Disparities (OHID) Fingertips sexual and reproductive health profiles, upper-tier local authority level (latest available data as at January 2026).
    - Indicators extracted included (2024 data):
        - Number of STI tests per 100,000 population (excluding chlamydia tests in 15–24-year-olds).
        - Number of new STI diagnoses per 100,000 population (excluding chlamydia in 15–24-year-olds).
        - Test positivity, defined as the percentage of STI tests that were positive (excluding chlamydia in 15–24-year-olds).
- Population denominators:
    - ONS mid-year population estimates for 2024, at the upper-tier local authority level.
- Deprivation:
    - English Indices of Multiple Deprivation (IMD) 2025, using the mean IMD score for each upper-tier local authority.
- Sexual orientation profile:
    - 2021 Census data on sexual orientation, using the proportion of the adult population identifying as non-heterosexual in each upper-tier local authority.

Hull was included alongside other upper-tier local authorities in England for which all of the above indicators were available.

3. Outcomes and predictors

Three outcomes were modelled separately:

1. STI testing rate:
    - Number of STI tests per 100,000 population for 2024 (excluding chlamydia tests in 15–24-year-olds).
2. STI diagnosis rate:
    - Number of new STI diagnoses per 100,000 population for 2024 (excluding chlamydia in 15–24-year-olds).
3. Test positivity:
    - Percentage of STI tests that were positive for 2024 (excluding chlamydia in 15–24-year-olds).

The logarithm of the three outcomes measures was used as this fulfilled the assumptions of the linear regression models better than the original outcome measures.

For each outcome, the following predictors were initially considered at the upper-tier local authority level:

- Median age of the local authority population from mid-year 2024 estimates.
- Mean IMD 2025 score, reflecting overall deprivation level.
- Proportion of the population identifying as non-heterosexual in the 2021 Census.

These predictors were chosen because STI risk and service use are known to vary systematically by age, deprivation and sexual orientation at the population level.

In the diagnosis model, deprivation (IMD) did not emerge as a statistically significant predictor; the final testing or diagnosis models therefore included median age and proportion non-heterosexual only.

4. Statistical methods

The analysis used a cross-sectional ecological design, with the upper-tier local authority as the unit of study.

For each of the three outcomes (testing rate, diagnosis rate, positivity), an ordinary least squares (OLS) linear regression model was fitted:

- Initial model specification for positivity:

Logarithm of Outcome = $\beta_0 + \beta_1$(median age) + β_2(IMD 2025 score) + β_3(% non-heterosexual) + ε

- Final model specification for testing rate and diagnosis rate:

Logarithm of Outcome = $\beta_0 + \beta_1$(median age) + β_2(% non-heterosexual) + ε

Standard regression diagnostics were used to detect obvious outliers and to confirm that the model assumptions (linearity, homoscedasticity, absence of extreme leverage points) were reasonable for this descriptive purpose.

Analyses were conducted using Stata by colleagues in Hull City Council's Public Health Intelligence team.

5. Model outputs and "expected" values

For each model, regression coefficients, 95% confidence intervals, p-values and R^2 statistics were generated. The fitted model was then used to calculate predicted ("expected") values for each upper-tier local authority, including Hull, based on its age structure and sexual orientation profile, and with the additional of the deprivation level for the positivity model.

- For example, Hull's expected testing rate was the rate predicted by the testing model using Hull's median age and proportion non-heterosexual.
- The difference between observed and expected values was then calculated:
    - Absolute difference = observed – expected.
    - Percentage difference = ((observed – expected) / expected) × 100.

These differences were used to determine whether Hull had higher or lower testing and diagnosis rates than expected, given its demographic and deprivation profile, and whether test positivity was higher or lower than expected.

6. Interpretation for Hull

For Hull, the modelling suggested that:

- In 2024, the observed STI testing rate was 31% lower than expected given Hull's age and sexual-orientation profile (3,542 tests per 100,000 population completed compared to a modelled expected number of 4,628 tests per 100,000 population – there were a total of 9,631 tests were completed in 2024 but with the higher expected test rate this equates to a total of 12,584 tests undertaken – a difference of 2,953 tests).
- In 2024, the observed diagnosis rate was 26% lower than expected based on the diagnosis model (445 positive tests per 100,000 population compared to a modelled expected number of 560 positive tests per 100,000 population – there were a total of 629 positive tests in 2024 but with the highest expected positive number of tests this equates to a total of 791 positive tests – difference of 162 positive tests).
- In 2024, the test positivity was 12% lower than expected, indicating that – together with the testing rate and number of positive tests – it was not simply Hull focusing on high risk cohorts but an overall reduced testing rate and case finding in Hull (Hull had a test positivity of 6.5% but the modelled test positivity was 7.3%).

These findings were interpreted alongside routine surveillance data and local qualitative insight, as described in Section 5.2.1 of the SHNA, to inform conclusions about potential unmet need and equity of access.

7. Strengths and limitations

Strengths

- Uses standardised national data sources (OHID Fingertips, ONS, IMD, Census) and a transparent, reproducible analytical approach.

- Allows comparison between observed and “expected” values after adjusting for key structural factors (age and sexual-orientation profile, and deprivation where applicable).
- Provides a more nuanced interpretation of Hull’s STI indicators than crude benchmarking alone.

Limitations

- Ecological analysis at the local authority level; results cannot be interpreted as individual-level associations.
- Linear regression assumes linear relationships and may not fully capture complex interactions between predictors.
- Sexual orientation data from the 2021 Census may be affected by underreporting and changes over time.
- The models do not explicitly adjust for differences in testing protocols, coding practices or local outreach models, which may also influence observed indicators.

These limitations are acknowledged in the main SHNA text, and the modelling is used as one component of a broader triangulation of evidence, rather than as definitive proof of under- or over-performance.

8. References

- Office for Health Improvement and Disparities (OHID). Sexual and Reproductive Health Profiles. Fingertips, 2026.
- Office for National Statistics ONS): Mid-year population estimates for 2024.
- Office for National Statistics (ONS). Census 2021: Sexual Orientation.
- Ministry of Housing, Communities & Local Government. English Indices of Deprivation 2025.
- Hull City Council Public Health Intelligence. STI Testing and Diagnosis Modelling Working Outputs, 2026.

Appendix 4: Policy Review

A Structured Analysis Using Walt & Gilson Policy Triangle Framework

Method: Walt & Gilson Policy Triangle (Content–Context–Actors–Process), with options structured using Bardach's Eightfold Path

This reviews national, regional and local sexual and reproductive health (SRH) policies and appraises how Hull City Council (HCC) and the Humber and North Yorkshire Integrated Care Board (HNY ICB) have interpreted and implemented them through the 2024–29 integrated sexual health service specification and KPIs. The Walt & Gilson policy triangle is used for each policy (Content, Context, Actors, Process), with a second step that turns gaps into feasible options following Bardach's logic on defining problems, assembling evidence and constructing alternatives.

Key findings at a glance

Policy/Framework	Status locally	Main evidence	Main gap
Public Health Outcomes Framework (PHOF)	Implemented	KPIs and service changes (LARC, digital, outreach) aligned to PHOF sexual health indicators.gov+1	Decision-making not consistently documented as "PHOF-driven" in minutes.
DHSC Framework for Sexual Health Improvement (2013)	Implemented	2024–29 spec is an integrated, open-access ISHS with LARC and HIV prevention, reflecting the framework.gov	No standalone Hull sexual health strategy translating this into a local plan.
HIV Action Plan / Towards Zero	Implemented	PrEP is routine, NHS-funded and embedded in the provider contract; uptake reported as good.gov+1	No local self-evaluation against HIV Action Plan indicators or impact on late diagnosis.
Women's Health Strategy (2022)	Partially aligned	ICB-led menopause hubs and Women's Health Hubs plus LARC training and trauma-informed approach.gov	Strategy not explicitly referenced in spec; no single "Women's Health Hub" model in Hull.

Policy/Framework	Status locally	Main evidence	Main gap
UKHSA STI Prioritisation Framework (2024)	Not yet implemented	Some targeted activity exists, but no formal local STI prioritisation review.publishing.service+2	Clear gap: framework has not yet been applied systematically.
NHS Long Term Plan	Partially aligned	Digital triage/testing and integration with ICB reflect LTP themes.paulcairney.wordpress+1	No formal mapping of spec and KPIs to specific LTP commitments.
LGA/ADPH/EHSHCG Blueprint (2022)	Partially aligned	Integrated commissioning, MESMAC and Healthwatch involvement show elements of the blueprint.healthknowledge	No structured self-assessment against Blueprint benchmarks.
ADPH Sexual Health Policy Statement (2024)	Referenced at PH level	Trauma-informed, safeguarding and equity focus in spec align with ADPH principles.healthknowledge	Not explicitly communicated to provider staff as a guiding statement.
Yorkshire & Humber ADPH regional priorities	Partially aligned	Some joint campaigns and regional work occur via MESMAC and networks.healthknowledge	No formal regional self-assessment or routine benchmarking.
Humber & North Yorkshire ICB SRH / Women's Health plans	Implemented	Menopause hubs, Women Living Well Longer and primary care LARC training in place.gov	Limited formal evaluation of menopause pathway outcomes.
Hull Health and Wellbeing Strategy (2022)	Implemented	Spec aligns with integration, inequality reduction and trauma-informed principles.healthknowledge	Strategy not consistently referenced in governance and JSNA cycles.

Policy/Framework	Status locally	Main evidence	Main gap
Hull sexual health strategy (local)	Not in place	Commissioning is driven by national frameworks, service spec and HWB strategy rather than a standalone SRH strategy.healthknowledge	Strategic opportunity to create a 2025–2030 Hull SRH strategy.

1. Public Health Outcomes Framework (PHOF)

Content (what policy requires)

PHOF sets national outcomes for public health and includes sexual health indicators such as teenage conceptions, chlamydia detection in 15–24 year olds, late HIV diagnosis, LARC prescribing and sexual offences. Local authorities are expected to use these data for planning, monitoring and targeting resources to reduce inequalities.

Context (Hull)

Hull is among the most deprived local authorities in England, with a younger-than-average population and growing ethnic diversity, and these factors are associated with higher rates of STIs and unplanned pregnancy. Service use and postcode analysis show uneven access and uptake, particularly for young people and deprived wards.

Actors (who is involved)

- HCC Public Health as commissioner.
- CHCP as integrated sexual health provider.
- HNY ICB for related specialist services.
- Primary care and pharmacies as LARC and contraception providers.
- UKHSA as data and surveillance provider via PHOF and SRH profiles.

Process (how it is implemented)

The 2024–29 service specification aligns KPIs with PHOF indicators, including chlamydia testing, LARC rates, teenage conceptions and late HIV diagnosis. Contract monitoring uses quarterly data, and recent changes such as expanded LARC provision, improved digital access and more outreach/walk-in capacity respond to PHOF patterns and local need.

Gap and option

Governance records do not always explicitly label commissioning decisions as responses to PHOF trends, which weakens the narrative of evidence-based commissioning. An annual short "PHOF and commissioning" paper to contract board and HWB would make this explicit and provide a clear trail for assessors.

2. DHSC Framework for Sexual Health Improvement in England (2013)

Content

The 2013 national framework calls for open-access, integrated sexual health services covering STIs, HIV, contraception (including LARC) and health promotion, with strong focus on prevention, inequalities and multi-agency working. It emphasises a life-course approach and access for vulnerable groups.

Context

Hull's deprivation, youth profile and inclusion-health needs (e.g. homelessness, substance use) mean the national emphasis on equity, outreach and integration is highly relevant. The trauma-informed city commitment and wider HWB strategy also support the framework's principles of non-judgemental, accessible care.

Actors

- HCC as lead commissioner.
- CHCP as integrated ISHS provider.
- Primary care and pharmacies for LARC and contraception.
- Schools, youth services and VCSE (including MESMAC) as prevention partners.
- Safeguarding and VAWG services as linked pathways.

Process

The 2024–29 integrated service specification reflects the 2013 framework by combining contraception and STI/BBV into a single open-access ISHS with strong emphasis on prevention, outreach and trauma-informed care. LARC and PrEP are now fully integrated within the provider's budget and pathways rather than being fragmented or separate, which strengthens the life-course and equity focus.

Gap and option

Hull does not have a separate, named sexual health strategy that explicitly translates this framework into local priorities, instead relying on the spec and HWB strategy. Developing a concise Hull SRH Strategy 2025–2030 that references the 2013 framework directly would make the commissioning logic clearer and easier to evidence for external scrutiny.

3. UKHSA STI Prioritisation Framework (2024)

Content

The STI Prioritisation Framework offers an evidence-based approach for local authorities to prioritise STIs and populations based on situation, target groups and interventions (the "S–T–I" model). It aims to focus efforts on preventing adverse health outcomes and reducing inequalities, using surveillance data and local intelligence.

Context

Sexual health needs assessment, Hull City Council, 2026

Hull experiences higher-than-average STI rates in some wards, a high burden among young people and MSM, and known access barriers for some groups. This makes STI prioritisation and targeted interventions particularly important.

Actors

- HCC PH as lead for prioritisation work.
- CHCP as data provider and operational lead.
- UKHSA as source of national STI data and technical support.
- MESMAC and Healthwatch as sources of community intelligence.

Process

Although Hull has improved digital access, outreach and MSM-focussed work, there has been no structured local application of the STI Prioritisation Framework to define priority infections, groups and interventions. There is no evidence of a dedicated workshop, written prioritisation report or annual review using the S–T–I model.

Gap and option

This is a clear gap against current national expectations. A 2025–26 STI Prioritisation Review using current surveillance data and local intelligence, culminating in a short action plan, would align Hull with the framework and strengthen the targeting of outreach, testing and partner notification.

4. Women's Health Strategy for England (2022)

Content

The Women's Health Strategy sets ambitions to improve reproductive health, contraception and menopause care, reduce inequalities and expand community provision via Women's Health Hubs. It also emphasises integration with sexual health, safeguarding and VAWG pathways.

Context

Hull has significant demand for contraception, unplanned pregnancy prevention and menopause care, alongside high levels of deprivation and violence affecting women. There is a strong interface with SRH services and the ICB's women's health work.

Actors

- HNY ICB commissioning menopause and women's health services.
- HCC PH commissioning SRH services.
- CHCP and primary care delivering contraception, LARC and elements of menopause care.
- Safeguarding and VAWG services linked to SRH pathways.

Process

The ICB has developed menopause clinics and Women's Health Hubs, and CHCP supports LARC training and primary care upskilling, which align with the strategy's direction. The sexual health specification includes trauma-informed, life-course and inequalities elements that support women's health more broadly.

Gap and option

The Women's Health Strategy is not explicitly referenced in the 2024–29 spec, and Hull has not formally adopted an NHS Women's Health Hub model owned locally. In the next commissioning cycle, Hull could explicitly map current services to the strategy and consider whether a formal local Women's Health Hub configuration would add value, especially for deprived and underserved women.

5. HIV Action Plan (2022–2025) and Towards Zero

Content

The HIV Action Plan aims for substantial reductions in HIV transmission, late diagnosis and HIV-related deaths by 2025, and supports progress towards zero transmissions by 2030. It emphasises making PrEP routine, expanding testing and reducing stigma.

Context

Hull has MSM and other high-risk populations, with historic late diagnoses and variation in awareness and uptake of testing and PrEP. Routine PrEP commissioning and integrated HIV prevention pathways are therefore crucial locally.

Actors

- NHS England funding PrEP drugs nationally.
- HCC PH and CHCP commissioning and delivering PrEP pathways.
- MESMAC undertaking targeted outreach to MSM and other groups.
- UKHSA providing surveillance and evaluation indicators.

Process

PrEP became routinely commissioned in England from 2020, and Hull has fully embedded PrEP into the integrated sexual health service, with good uptake reported for new and follow-up users. HIV testing is available via the integrated service and digital triage, and MESMAC supports targeted prevention and campaigns.

Gap and option

Hull has not yet developed a local HIV prevention self-evaluation aligned to the national monitoring framework, so there is limited local data on coverage of eligible populations and impact on late diagnosis. A simple local evaluation framework using national HIV Action Plan indicators would strengthen assurance and future planning.

6. NHS Long Term Plan (LTP)

Content

The NHS Long Term Plan emphasises digital-first access, integration across systems, reducing health inequalities and strengthening prevention, including in areas such as HIV and sexual health. It encourages stronger partnership between NHS and local authorities.

Sexual health needs assessment, Hull City Council, 2026

Context

Hull's integrated commissioning with the ICB, digital sexual health offer and focus on equity provide a good platform for LTP alignment. However, the LTP is not always named in local SRH documentation.

Actors

- HNY ICB leading on LTP implementation.
- HCC PH and CHCP as key partners for prevention and community access.
- Primary care and VCSE contributing to digital and integrated models.

Process

Digital triage, online booking and results access in sexual health services reflect LTP ambitions for digital-first care. Integration with ICB menopause and women's health plans also supports LTP principles, although this is mostly implicit.

Gap and option

There is no formal mapping document showing how sexual health commissioning and provision deliver specific LTP commitments. Producing a short "SRH and the LTP" alignment note would clarify this for internal governance and external assessors.

7. LGA/ADPH/EHSHCG Blueprint for Sexual Health & HIV (2022)

Content

The Blueprint sets out system-level recommendations for high-quality sexual health and HIV services, emphasising integration, co-production, digital innovation, workforce development and equity. It is aimed at local government, NHS and partners.

Context

Hull already operates an integrated ISHS, works with MESMAC and Healthwatch and has invested in digital access, which are all consistent with the Blueprint's direction. However, there has been no formal "Blueprint check" of the local system.

Actors

- HCC and HNY ICB as system commissioners.
- CHCP, primary care and VCSE as providers.
- MESMAC and Healthwatch as key partners in co-production and user voice.

Process

Elements of the Blueprint are visible in Hull's integrated model, partnerships and digital work, but the system has not undertaken a structured self-assessment against the Blueprint recommendations. This means strengths and gaps are not fully documented.

Gap and option

A time-limited, multi-agency self-assessment against the Blueprint could consolidate evidence, identify development areas and support regional and national assurance. This could be combined with the regional Y&H priorities review described below.

8. ADPH Sexual Health Policy Statement (2024)

Content

The ADPH statement outlines national public health leadership expectations around safeguarding, equity, digital innovation and workforce for sexual health systems. It reinforces the role of Directors of Public Health in shaping SRH commissioning.

Context

Hull's spec includes a trauma-informed approach, safeguarding obligations and an equity focus, which are consistent with ADPH principles. The statement operates mainly at commissioning rather than provider level.

Actors

- Director of Public Health and PH leadership in Hull.
- CHCP as provider, and partners including primary care and VCSE.

Process

The ADPH position has informed commissioner thinking about trauma-informed, equitable and digital models, as reflected in the spec wording and KPIs. There is no evidence that the statement has been shared directly with provider staff or used as a staff-facing charter.

Gap and option

A short provider briefing on the ADPH statement would make explicit the link between national public health leadership and day-to-day service delivery, reinforcing safeguarding and equity expectations.

9. Yorkshire & Humber ADPH / Public Health Network SRH priorities

Content

The regional network has articulated priorities around equitable SRH access, STI and HIV prevention, workforce and digital innovation, aligned to national policy. It also promotes shared learning and benchmarking.

Context

Hull shares many challenges with other Y&H areas, including deprivation and high STI rates, making regional benchmarking particularly useful.

Actors

- Y&H ADPH network and regional partners.
- HCC PH, CHCP, ICB and VCSE as local contributors.

Process

Hull participates in some regional discussions and joint campaigns via MESMAC and other partners, but there is no formal self-assessment or regular benchmarking report against regional SRH priorities.

Gap and option

A structured regional alignment and benchmarking exercise would clarify where Hull is leading, average or behind, and support targeted improvement actions.

10. Humber & North Yorkshire ICB SRH and Women's Health plans

Content

HNY ICB has developed plans for menopause services, Women's Health Hubs and wider women's health and SRH pathways, aiming for equitable access and multi-professional hubs.

Context

Hull benefits from ICB-level investment in menopause hubs and primary care upskilling, which interact closely with local SRH commissioning.

Actors

- HNY ICB as commissioner of menopause and women's health.
- CHCP, primary care and community gynaecology as main providers.

Process

Menopause hubs and Women's Health Hubs are in place, and SRH commissioning supports LARC and contraception as part of a joined-up women's health offer. LARC training and primary care upskilling are being used to reduce waits and improve access.

Gap and option

While activity is happening, formal outcome evaluation of menopause services (e.g. waiting times, symptom control, patient satisfaction, equity of access) has not been documented locally. A basic audit would close this gap.

11. Hull Health and Wellbeing Strategy (2022)

Content

Hull's HWB strategy sets local priorities around integration, reducing inequalities, trauma-informed systems and inclusion health across the life course. SRH services are one mechanism for achieving these aims.

Context

Sexual health outcomes in Hull are strongly patterned by deprivation, trauma and inclusion-health status, making SRH central to HWB aims.

Actors

- Health and Wellbeing Board and HCC leadership.
- PH, CHCP, ICB, primary care and VCSE as delivery partners.

Process

The sexual health spec and KPIs reflect HWB principles through integrated, trauma-informed, inequality-focussed design and multi-agency pathways. However, HWB strategy alignment is not always explicitly referenced in contract board and HWB minutes.

Gap and option

Ensuring that SHNA updates, commissioning reports and board minutes explicitly reference HWB strategy objectives would strengthen the golden thread from local strategy to SRH actions.

12. Absence of a standalone Hull sexual health strategy

Finding and context

Hull does not currently have its own dedicated sexual health strategy document, unlike some local authorities. Local commissioning is instead guided by national frameworks, the integrated service specification and the HWB strategy.

Interpretation

This reflects a shift towards integrated, outcome-based commissioning rather than a failure to follow policy, but it does mean the local narrative is spread across several documents. For external assessors, this makes it harder to see a single, coherent SRH plan for Hull.

Option

A concise Hull Sexual Health Strategy 2025–2030 would bring these strands together and make explicit how national policy, local needs and commissioning decisions fit together, supporting accountability and evaluation.

Summary of gaps and strategic options (Bardach-style)

Main gaps identified

- No formal local SRH strategy.
- No applied UKHSA STI Prioritisation Framework review.
- No local HIV Action Plan self-evaluation.
- Limited explicit alignment documents for the LTP, Women's Health Strategy and Blueprint.
- Limited regional benchmarking and menopause outcome evaluation.

Prioritised options

1. Develop a Hull Sexual Health Strategy 2025–2030 (high priority): short, focused strategy explicitly linking national frameworks, local needs and commissioning choices.
2. Run an STI Prioritisation Review using UKHSA framework (high priority): structured S–T–I review with UKHSA, CHCP, MESMAC and PH, producing an action plan.
3. Regional and Blueprint self-assessment (medium priority): joint exercise with Y&H partners and use of the LGA/ADPH blueprint to identify further system improvements.
4. HIV and menopause evaluation tools (medium priority): local metrics for PrEP coverage/late diagnosis and menopause access/outcomes, reported annually.
5. Governance alignment notes (medium priority): short annual notes explicitly linking SRH commissioning to PHOF, HWB, LTP and national frameworks.
6. Provider briefing on ADPH and national guidance (low–medium priority): one-off session and simple slide pack reinforcing safeguarding, equity and trauma-informed principles.