Cumberland Council
Sexual Health Needs Assessment
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Cumberland Council

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1. Executive Summary

Purpose

This sexual health needs assessment (SHNA) is intended primarily for Members, commissioners and service providers, and may also be of value to wider system partners, including those working across health, care, education, safeguarding and the voluntary and community sector. It provides an evidence base to support strategic oversight, commissioning and contracting decisions, service design and improvement, and system assurance across sexual and reproductive health in Cumberland.

The assessment describes the sexual and reproductive health needs of residents in Cumberland and supports the delivery, monitoring and future development of the Integrated Sexual Health Service (ISHS) for Cumbria. It brings together epidemiological data, service-use information and qualitative insight, applying an equity-focused approach throughout.

This assessment forms part of a Cumbria-wide approach to understanding sexual and reproductive health need, enabling consistent interpretation alongside locally specific data

Context and System Landscape

Cumberland has an older population profile, a small but growing ethnic minority population, and a highly rural geography, with over half of residents living in rural areas. These characteristics shape how people access sexual and reproductive health services and influence how need appears in routine data. Population churn linked to tourism, seasonal work and student mobility also affects demand.

Sexual health services operate within a complex commissioning environment involving two local authorities, two Integrated Care Boards (ICBs) and NHS England. Workforce pressures, digital exclusion and non-coterminous boundaries create challenges for pathway alignment, service coordination and longer-term planning.

Summary of Key Findings

Overall sexual and reproductive health outcomes

Across several headline indicators, Cumberland compares favourably with regional and national averages. However, low recorded activity should not be interpreted as low need. Structural barriers - including rurality, transport, digital exclusion and variable service capacity - significantly influence access and may suppress detection rates.

Trends should also be interpreted in the context of COVID-19, which temporarily reduced testing activity and altered service delivery models, suppressing recorded diagnoses and affecting comparability over time.

Two persistent challenges identified in previous assessments remain evident:

- Low chlamydia screening and detection rates, particularly among young people
- Low HIV testing rates

Together, these indicate missed opportunities for early identification, prevention and timely access to care.

Operational insight from the ISHS indicates variation in appointment utilisation, higher DNA rates in rural areas, and capacity constraints affecting LARC and PrEP access, reinforcing the interpretation that low recorded activity may reflect access barriers rather than low underlying need.

Sexually transmitted infections (STIs)

- Rates of syphilis and gonorrhoea are lower than regional and national averages; however, syphilis diagnoses have increased in recent years, mirroring national trends and indicating emerging transmission networks.
- Chlamydia screening coverage among females aged 15-24 is significantly lower than the England average, suggesting underdiagnosis and reduced control activity.
- Very low overall rates of recorded STI diagnoses may mask unmet need among groups less likely to access testing, including people living in rural or digitally excluded communities. Indeed, STI testing rates are significantly lower than the England average, and the data indicates potential missed opportunities for case detection rather than low underlying need.

HIV

- Cumberland remains a low prevalence area for HIV
- HIV testing rates are significantly lower than both England and North West averages, representing a key area of unmet need.
- Although the proportion of people diagnosed with HIV at a late stage is similar to the national average, it is higher than target. Early diagnosis is critical to ensure people living with HIV can access effective treatment and to prevent onward transmissions.

Reproductive health

- Prescribing rates for long-acting reversible contraception (LARC) are relatively high compared with regional and national benchmarks, suggesting good overall access to effective contraception.
- However, access may not be equitable across the area due to rurality, workforce capacity within primary care, and variation in local service availability.
- Under-18 conception rates are similar to the England and regional averages but continued focus on prevention and access to services is required to sustain progress.

Screening, immunisation and prevention

- HPV vaccination coverage is higher than the national average but remains below target. Variation also exists in uptake, and rurality may affect access to catch-up opportunities.
- Cervical screening coverage is lower than the national target, but higher than the regional and England averages. Cervical screening is commissioned nationally but remains a key preventive indicator within the wider sexual and reproductive health system, particularly in relation to cervical cancer prevention and women's health inequalities
- Hepatitis B vaccination is available for people at increased risk through sexual health services and primary care; however, access may be uneven due to geography and service capacity.
- Hepatitis C is included within the assessment only where it intersects with sexual health services through opportunistic testing and referral, particularly for populations experiencing multiple disadvantage.

Access, Equity and System Capacity

Structural barriers play a significant role in shaping sexual health access and outcomes in Cumberland. These include:

- Rural geography and transport constraints
- Digital exclusion and variable connectivity
- Workforce capacity pressures across sexual health and primary care services
- Fragmented commissioning and service pathway

Digital and remote service models offer opportunities to improve access for some residents but risk widening inequalities if non-digital routes are not actively protected. Face-to-face provision remains

essential, particularly for young people, people with complex needs, and those affected by trauma or safeguarding concerns.

Population Groups at Higher Risk of Unmet Need

The assessment identifies several population groups who experience additional barriers to access and are therefore at higher risk of unmet need or poorer outcomes, including:

- Young people, particularly those living in rural areas
- Looked after children and care-experienced young people
- LGBTQ+ populations, including gay, bisexual and other men who have sex with men (GBMSM)
- Migrants, asylum seekers and refugees
- People experiencing domestic or sexual violence
- People involved in sex work or sexual exploitation
- Gypsy, Roma and Traveller communities
- People with disabilities
- People experiencing multiple disadvantage, including overlapping challenges such as homelessness, substance use, mental ill health, trauma and poverty

Unmet need for these populations may be poorly captured in routine data, reinforcing the importance of outreach-based approaches, trauma-informed practice and strong partnership working.

Key Implications for Commissioning

The findings highlight the need for:

- Improved access to testing and prevention, particularly for chlamydia, other STIs and HIV
- Flexible, blended service models combining clinic-based, outreach, postal and digital routes
- Trauma-informed and culturally sensitive approaches, especially for people affected by violence, migration-related stress or multiple disadvantage
- Stronger system integration, including clearer pathways across sexual health, primary care, mental health and safeguarding services
- Enhanced use of qualitative insight alongside routine data to identify and respond to hidden unmet need

Conclusion

While Cumberland shows comparatively favourable outcomes across several sexual and reproductive health indicators, this assessment demonstrates that structural barriers, low testing coverage, and system pressures continue to limit equitable access. Low levels of recorded activity should not be interpreted as low need.

The commissioning of a new ISHS for Cumbria provides a critical opportunity to address these challenges. By strengthening prevention, improving access, and embedding equity-focused and trauma-informed practice, the system can better meet the needs of all residents and reduce avoidable inequalities in sexual and reproductive health outcomes.

If the needs identified in this assessment are addressed over the next 2-3 years, success would be reflected in improved equity of access across Cumbria, more consistent sexual health pathways regardless of geography, earlier identification of infection and unmet need, and stronger alignment between population need, service capacity, and commissioning intent.

This needs assessment forms part of a cyclical approach in which assessment of need informs commissioning and service design, with learning from delivery, engagement, and system change informing future iterations.

2. Introduction and Purpose

The purpose of this Sexual Health Needs Assessment (SHNA) is to describe the sexual and reproductive health needs of people living in Cumberland, identify inequalities, and highlight emerging trends or unmet need. It provides an evidence base to inform the commissioning and delivery of the new Integrated Sexual Health Service (ISHS) for Cumbria and is intended as a detailed reference document underpinning commissioning, assurance and service design; not all sections are intended to be read sequentially.

The assessment brings together epidemiological data, service-use information and qualitative insight to build a comprehensive picture of local sexual and reproductive health need. An equity lens is applied throughout, recognising how rurality, deprivation and digital exclusion influence access to services and health outcomes. These factors are particularly important in Cumberland, where dispersed communities and transport barriers may limit timely access to testing, screening and treatment.

The SHNA distinguishes between underlying sexual and reproductive health need, recorded service activity, and access to services. Low recorded activity should not be interpreted as low need, particularly where geographic, digital or workforce barriers limit access. The assessment is intended to be a live document, supporting iterative commissioning and responsive updates as new data or national guidance becomes available.

2.1. What is Sexual Health?

Sexual health is defined by the World Health Organization (WHO) as:

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

Sexual and reproductive health is a core component of overall wellbeing and is influenced by gender, sexuality, age, ethnicity, disability, mental health and wider social determinants. Poor sexual health can result in significant adverse outcomes, including:

- Unplanned pregnancy and abortion
- Psychological harm, including that associated with coercion or abuse
- HIV and other sexually transmitted infections (STIs)
- Cervical and other genital cancers
- Chronic hepatitis, liver disease and liver cancer
- Pelvic inflammatory disease, ectopic pregnancy and infertility
- Poorer maternity outcomes for mothers and babies
- Educational, social and economic disadvantage, particularly for young parents

These outcomes are not experienced equally. Young people, those living in socioeconomic disadvantage, gay, bisexual and other men who have sex with men (GBMSM), and some ethnic minority communities experience disproportionate burden and poorer outcomes. Access to high-quality sexual health services, alongside prevention, education and early intervention, is therefore central to reducing inequalities.

Sexual health needs also change across the life course. Children and young people may require relationships and sex education, confidential advice and early STI detection. Adults may need contraception, testing and treatment, while older adults may experience menopause-related needs,

changes in sexual function or long-term conditions affecting sexual health. Understanding these changing needs is essential to designing accessible and responsive services.

2.2. Sexual Health Needs Assessment Process

This SHNA adopts a structured public health approach that distinguishes between underlying need, expressed demand, and access to services.

- *Need* is understood as the underlying sexual and reproductive health requirements of the population, shaped by demographic characteristics, behaviours, social determinants of health and exposure to risk.
- *Demand* is reflected in recorded service activity and utilisation, recognising that this may be influenced by awareness, service configuration and individuals' ability to engage with services.
- *Access* refers to the practical and systemic factors that enable or constrain service use, including geography, transport, digital inclusion, workforce capacity, service availability and commissioning arrangements.

Recorded activity is therefore interpreted cautiously and should not be assumed to directly represent population need, particularly where access barriers are known to exist.

The assessment applies an integrated health needs assessment approach, drawing on epidemiological analysis, comparative benchmarking and corporate insight from service users, providers, commissioners and communities. It draws primarily on routinely collected quantitative data to describe trends and patterns over time, benchmark against regional and national comparators, and identify areas of relative strength and concern. This is complemented by qualitative intelligence, which is used to contextualise findings, identify unmet or hidden need, and inform interpretation where routine data may be incomplete or misleading.

Together, this mixed-methods approach supports a more nuanced understanding of sexual and reproductive health need in Cumberland and provides a robust evidence base for equitable service planning, commissioning and system assurance. The assessment is designed to support a consistent, Cumbria-wide understanding of sexual and reproductive health need, while applying locality-specific data and access considerations at place level.

Sources include:

- Epidemiological analysis of publicly available data from UK Health Security Agency (UKHSA), Office for Health Improvement and Disparities (OHID) and other national datasets
- Service-use data from local providers to understand access and demand
- Qualitative insight from public, stakeholder and service-user engagement
- Review of relevant national policy and guidance
- Consideration of local context, including deprivation, demographics and rurality

The assessment places particular emphasis on clinical service-related need, reflecting its role in informing the transformation of commissioned sexual health provision. Wider determinants of sexual health across health, social care and education are acknowledged where relevant.

The assessment considers the following areas:

- STIs, including chlamydia, gonorrhoea, syphilis, herpes and HIV
- Reproductive health, including long-acting reversible contraception (LARC), user-dependent contraception, under-18 conceptions, emergency hormonal contraception (EHC) and abortion data
- Cervical screening and HPV (Human Papillomavirus) vaccination

- Access to sexual health services

The following areas are outside the scope of this SHNA:

- Menstrual health and fertility services
- Treatment and care for people living with HIV
- Commissioning of abortion services

A programme of engagement was undertaken throughout 2024-25 to inform service design, delivery and commissioning. This included public consultation, stakeholder engagement, feedback from service users, and input from integrated sexual health service staff. Findings from this engagement are summarised in Appendix E and have informed the analysis and recommendations set out in this assessment.

Provider engagement formed a key component of this programme. Pre-commissioning market engagement event was undertaken in November 2024 to January 2025, during which epidemiological trends, national policy drivers and emerging commissioning priorities were shared with current and potential providers. Insight from this session helped inform interpretation of local need, system capacity and the development of commissioning recommendations.

Key themes identified in the previous SHNA were reviewed and updated using the latest available data, engagement feedback and system intelligence, ensuring continuity while reflecting changes in population need, service configuration and the national policy context.

Stakeholder engagement forms part of a broader, cyclical methodology in which assessment of need informs commissioning and service design, and learning from delivery and engagement feeds into future needs assessment.

2.3. National Policy Context and Strategic Drivers

This SHNA is informed by the national policy and statutory framework that shapes the commissioning and delivery of sexual and reproductive health services in England.

The *Framework for Sexual Health Improvement in England* (Department of Health, 2013) remains the most comprehensive articulation of local authority responsibilities for sexual health. It establishes enduring priorities around prevention, early intervention, access to contraception, reducing the incidence of STIs, and tackling health inequalities (Figure 1). Although now over a decade old, the Framework continues to provide the statutory foundation for open-access sexual health services, and this assessment is grounded in its core principles.

Since publication of the Framework, national policy relevant to sexual and reproductive health has developed through a number of interrelated strategies and programmes rather than through a single overarching national strategy, a gap that has been increasingly recognised at national level. This is reflected in recent parliamentary correspondence. In 2025, the Health and Social Care Committee wrote to the Department of Health and Social Care calling for the development of a refreshed national sexual and reproductive health strategy. The Government response acknowledged the absence of a single overarching strategy, highlighting instead the range of existing policy strands and programmes contributing to the overall policy landscape (Health and Social Care Committee and DHSC, 2025). This reinforces the current policy context in which local authorities are required to provide strategic leadership, prioritisation and system coordination in the absence of a unified national framework.

Within this evolving landscape, the *HIV Action Plan for England 2025-2030* sets out a commitment to end new HIV transmissions by 2030 and places explicit expectations on local systems to expand and normalise HIV testing, increase equitable access to pre-exposure prophylaxis (PrEP), reduce late diagnosis, and address inequalities affecting specific population groups. The 2026 HIV Action Plan Monitoring and Evaluation Framework provides the national approach to assessing progress, with

indicators mapped across prevention, testing, treatment, quality of life and system effectiveness, and a strong focus on reducing inequalities between population groups.

Alongside this, the Government's *10-Year Health Plan* and related national programmes increasingly emphasise whole-system integration, prevention, digital and remote access to services, and action to reduce health inequalities. Collectively, these policy developments signal a longer-term strategic direction for sexual and reproductive health, even in the absence of a single national sexual health strategy. This direction provides important context for future service transformation and informs the strategic horizon of this assessment.

The *Women's Health Strategy for England* further reinforces the importance of sexual and reproductive health across the life course, with a focus on access to contraception, reproductive autonomy, and reducing inequalities in both experience and outcomes. In April 2026, the Government published a *renewed Women's Health Strategy*, strengthening national commitments to improving women's experiences of reproductive and gynaecological care. Key priorities include faster access to gynaecology, improved menstrual health pathways, strengthened Women's Health Hubs, and better access to contraception and abortion care. These priorities align closely with the needs identified in this assessment. In parallel, the *Men's Health Strategy for England* highlights lower engagement with sexual health services and poorer outcomes among some groups of men, strengthening the case for targeted, inclusive approaches to needs assessment and service design.

In addition, NHS England has commissioned a national *LGBT+ Health Evidence Review* to examine persistent inequalities in access, experience, and outcomes for LGBT+ populations, including in relation to sexual and reproductive health and HIV. The review is aligned with the *10-Year Health Plan* and is expected to inform future national policy and guidance. This assessment reflects current evidence of disproportionate sexual health need among some LGBT+ groups and the importance of inclusive, culturally competent service design.

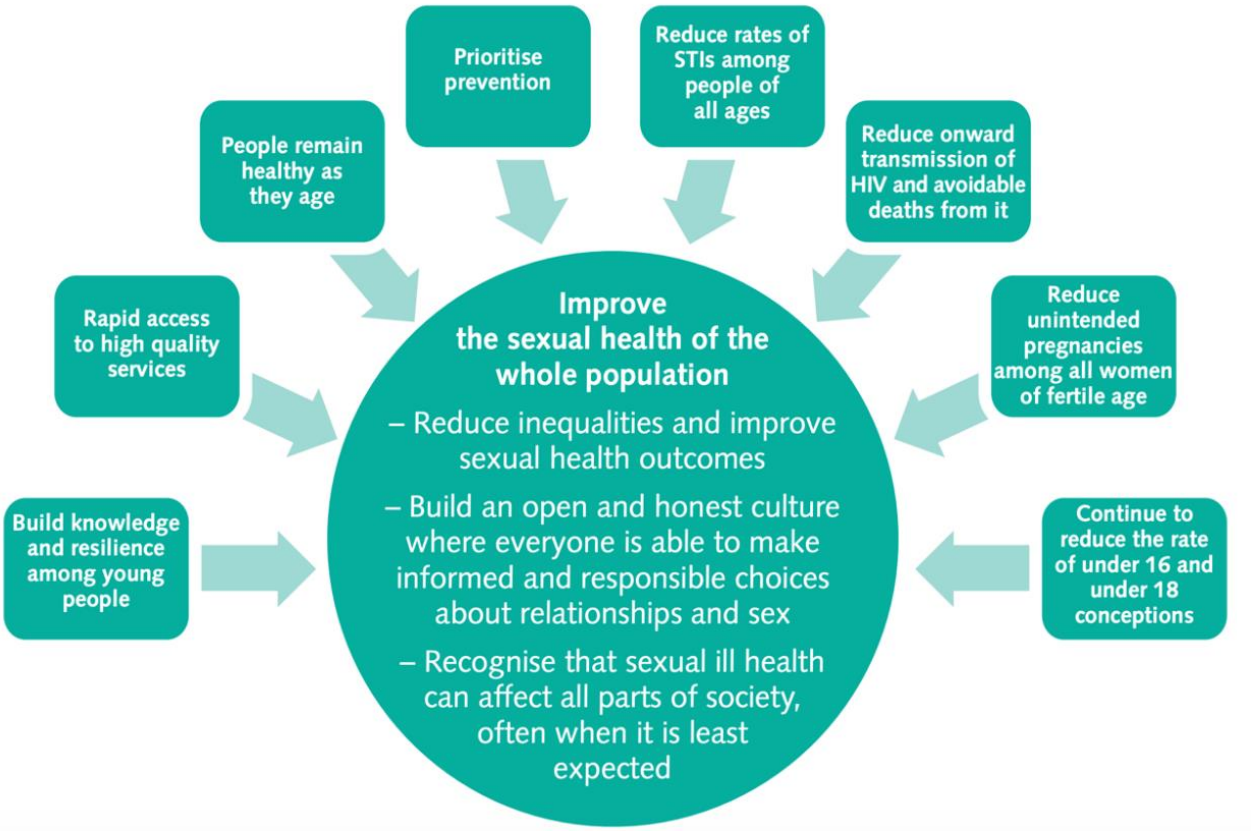
National education policy, including statutory *Relationships, Sex and Health Education (RSHE)* guidance, also plays an important role in shaping knowledge, attitudes, and preventive behaviours among children and young people. While education commissioning sits outside the scope of this Needs Assessment, its contribution to longer-term sexual health outcomes is recognised where relevant.

Commissioning responsibilities are clarified through national guidance, including *Commissioning Local HIV, Sexual and Reproductive Health Services* and the *Integrated Sexual Health Service (ISHS) Specification*. Together, these define statutory roles across local authorities, Integrated Care Boards (ICBs), and NHS England, and set expectations for service scope, quality, safeguarding, and workforce. This Needs Assessment reflects that guidance to ensure its findings and recommendations are lawful, deliverable, and aligned within a complex commissioning landscape.

Clinical and public health guidance from NICE, alongside the *All Our Health: Sexual and Reproductive Health and HIV* framework, underpins the assessment's emphasis on prevention, early intervention, and reducing inequalities. In addition, the *UK National Action Plan for Antimicrobial Resistance* represents an increasingly important driver for sexual health services, particularly in relation to gonorrhoea. This highlights the need for appropriate antimicrobial prescribing, test-of-cure, surveillance, and robust partner notification.

A full summary of relevant national policy, guidance and strategic frameworks is provided in Appendix D.

Figure 1: Key objectives of the Framework for Sexual Health Improvement in England



Source: A Framework for Sexual Health Improvement in England

2.4. Local Context and System Landscape

Cumberland has a population of approximately 280,495 (as of 2024) and a GP patient population of 290,218 (as of April 2025). It has a distinct demographic and geographic profile that shapes both sexual and reproductive health need and access to services. The area is predominantly rural, with a population density of around 93 people per square kilometre, well below the national average of 450. Rurality influences travel times, digital connectivity and the feasibility of traditional face-to-face service models, and is a key determinant of how sexual and reproductive health need is expressed through recorded activity.

The local authority has an older age profile compared to the England and Wales average; with a lower proportion of residents aged 0-15 and 16-64 years, and a higher proportion of residents aged 65+. This age structure affects patterns of sexual and reproductive health need, including demand for menopause-related care, long-term contraception and STI testing among older adults, whose needs are often under-represented in routine surveillance data.

Although Cumberland is relatively ethnically homogeneous (95% reported their ethnic group to be 'White British' in the 2021 Census), the population includes a number of other ethnic groups. These groups may experience additional barriers to accessing sexual health services, including stigma, language needs and limited availability of culturally tailored support, which should be considered when interpreting service-use data.

Population mobility is a notable feature of the area. Tourism, seasonal employment and student movement contribute to fluctuating demand for services. This mobility has implications for continuity of care, partner notification and service planning.

Socioeconomic variation across the area is marked. While some neighbourhoods are relatively affluent, 18 of Cumberland's 177 Lower Super Output Areas (LSOA) fall within the 10% most deprived nationally. These communities are spread across all three former Cumberland districts; eight in Allerdale, five in Carlisle and five in Copeland. Deprivation is strongly associated with poorer sexual health outcomes, lower uptake of contraception and reduced digital access, and remains an important consideration for service design and targeting.

Sexual health services operate within a complex system landscape. Commissioning responsibilities are shared between Westmorland and Furness Council, Cumberland Council, two ICBs and NHS England. Non-coterminous boundaries and split responsibilities pose challenges for pathway alignment, data sharing, workforce planning and longer-term system development. Workforce shortages - particularly within specialist nursing and medical roles - continue to constrain service capacity across the system.

Digital exclusion remains a cross-cutting issue, particularly in rural and more deprived communities where broadband coverage, device access and digital confidence are inconsistent. This limits the reach of online booking, remote consultations and self-sampling pathways and reinforces the need for mixed-mode service delivery.

Sexual health provision in Cumbria is currently undergoing significant transformation. Cumberland Council has worked jointly with Westmorland and Furness Council to commission a new ISHS, reflecting a shared commitment to modernising provision, improving access and strengthening system-wide collaboration. To support quality improvement and system development, a whole-system Sexual Health Quality and Innovation Group has been established, bringing together commissioners, providers and partners to provide shared oversight and drive improvement.

Although headline sexual and reproductive health indicators appear favourable at aggregate level, need is not evenly distributed. People living in rural or isolated communities, those experiencing deprivation, and individuals facing transport or digital barriers may experience poorer access to timely testing, contraception and treatment, increasing the risk of under-diagnosis and unmet need.

Qualitative insight from integrated sexual health service staff indicates growing complexity among service users, including increased involvement in sex work and gaps in access to psychological and trauma-informed support, particularly for asylum seekers. These findings complement epidemiological data and reinforce the importance of addressing access, equity and workforce capacity within the evolving service model.

While fertility support, pregnancy planning and miscarriage care lie outside the scope of locally commissioned sexual health services, they form part of the wider reproductive health system and are referenced here for context due to their relevance to women's health and life-course outcomes.

2.5. Data Sources and Limitations

This SHNA draws primarily on sexual and reproductive health indicators published by the UKHSA and the OHID. Data have been accessed predominantly through the Fingertips platform, enabling trend analysis, benchmarking and comparison with regional and national averages.

While these datasets provide a robust and nationally consistent evidence base, several limitations should be considered when interpreting the findings presented in this assessment.

Firstly, local authority boundary changes present challenges for trend analysis. Cumberland Council was established in 2023 following local government reorganisation, and historical data are not always available or directly comparable for the new geographical footprint. This limits the ability to produce consistent year-on-year trends for some indicators.

Secondly, changes in national and local service delivery models can influence trends independently of underlying population need. For example, revisions to the National Chlamydia Screening Programme (NCSP), which now prioritises screening among females aged 15-24, affect how screening coverage and detection rates should be interpreted over time.

Thirdly, data availability at local authority level is uneven. Some indicators are not routinely published because of small numbers or disclosure control. In such cases, regional or national data have been used to provide context, although these may not fully reflect local patterns of need.

Small numbers can result in year-on-year volatility, wide confidence intervals and, in some cases, data suppression - particularly for STI diagnoses and population-specific indicators. This limits the ability to draw firm conclusions at a granular level and reinforces the need for cautious interpretation.

In addition, routine surveillance systems such as GUMCAD and CTAD rely on accurate and timely reporting from providers. Changes in reporting practices, digital systems or coding can introduce variation that is not attributable to changes in underlying population need.

Interpretation of trend data should also take account of the impact of the COVID-19 pandemic on sexual behaviour, service delivery and surveillance systems. National and local restrictions led to reduced social contact, changes in sexual mixing patterns, and a temporary fall in STI diagnoses that largely reflected reduced testing rather than reduced transmission. During this period, many services shifted to remote and postal models, and some activity data were incomplete or suppressed. Recovery has been uneven across population groups, with digital exclusion, transport barriers and workforce pressures influencing the pace of return to pre-pandemic activity. These factors should be considered when interpreting trends, particularly for chlamydia screening, HIV testing and overall STI diagnoses.

Finally, aggregated local-authority-level data can obscure inequalities within the population. Routine datasets do not fully capture the lived experience of people facing multiple and overlapping disadvantages, including sex workers, asylum seekers, people experiencing homelessness, and residents affected by digital or transport exclusion. As a result, routine surveillance data may under-represent populations with the greatest barriers to access. Qualitative insight from service providers, partners and communities therefore plays a critical role in identifying unmet need that may not be fully visible within epidemiological indicators.

These limitations are acknowledged throughout the assessment and inform both the interpretation of findings and the recommendations for future commissioning.

3. Summary of Findings for Cumberland

The *Public Health Outcomes Framework* (PHOF) was introduced in 2012 to support a shift across the public health system towards improving population health outcomes and reducing health inequalities, rather than focusing on process measures. The framework provides a nationally consistent set of indicators used to monitor population health, health inequalities and the effectiveness of local public health systems.

Several PHOF indicators relate directly to sexual and reproductive health and are used to assess access to services, prevention activity and longer-term outcomes. These include total prescribed LARC (excluding injections), under-18 conception rates, chlamydia detection among young women aged 15-24, new STI diagnoses (excluding chlamydia in under-25s), and late diagnosis of HIV. Together, these indicators provide a robust basis for benchmarking local performance against regional and national trends and for identifying areas where additional prevention, testing or service capacity may be required.

This needs assessment identifies a number of key issues relating to sexual and reproductive health in Cumberland. Across many indicators, local rates are similar to, or more favourable than, those seen across the North West and England. However, two persistent challenges highlighted in the previous

assessment (based on 2022 data) remain evident: low chlamydia screening and detection rates and low HIV testing rates. These gaps indicate ongoing unmet need for early identification, prevention activity and timely access to care.

More detailed analyses of individual indicators and trends are presented in Section 5 and Appendix C.

3.1. Overview of Sexual and Reproductive Health Outcomes

Sexually Transmitted Infections (STIs)

- **Chlamydia**
  The chlamydia detection rate in 15- to 24-year-old females in 2024 in Cumberland was 1,617 per 100,000 population, lower than the 3,250 target, but statistically similar to the England average. Screening coverage in this age group is statistically significantly lower than the England average, which is likely to contribute to under-diagnosis and missed opportunities for early treatment and onward transmission prevention. This remains one of the most significant areas of unmet sexual health need locally. National benchmarks for chlamydia detection provide a useful reference point; however, structural barriers to access mean that improvement locally is more likely to be incremental and dependent on outreach and service configuration.

- **New STI diagnoses (excluding chlamydia in people aged 24 years and younger)**
  Cumberland has one of the lowest reported rates of new STI diagnoses per 100,000 population in the region. As with other indicators, this may partly reflect lower testing activity rather than lower underlying prevalence and should therefore be interpreted with caution. Indeed, the STI testing rate (excluding chlamydia in those under 25) in Cumberland is significantly lower than the England average, and testing rates have not returned to pre-pandemic levels. Taken together with the persistently low diagnosis rates and rising/average positivity, this indicates potential missed opportunities for case detection rather than low underlying need.

- **Syphilis and gonorrhoea**
  Rates of new diagnoses of syphilis and gonorrhoea are lower than both North West and England averages. While this appears favourable, interpretation is limited by the area's rural geography and relatively low levels of testing, which may reduce opportunities for case detection. Recent increases in syphilis diagnoses locally mirror national trends and suggest the presence of emerging transmission networks, despite low absolute numbers.

HIV

- **Late diagnosis**
  The proportion of people diagnosed late with HIV in Cumberland is statistically similar to both the regional and national averages, but higher than national goals. Late diagnosis data tends to fluctuate and should be interpreted cautiously due to very small numbers and low overall testing rates, which may mean undiagnosed infections remain unidentified within the population.

- **Testing**
  HIV testing rates in Cumberland are significantly lower than those seen across the North West and England and are the second lowest of all local authorities in the region. This represents a clear priority for improvement, as low testing coverage limits early diagnosis, prevention opportunities and timely access to treatment.

- **New diagnoses and prevalence**
  Cumberland is a low prevalence area for HIV. Overall rates of new HIV diagnoses (including people previously diagnosed with HIV abroad) are similar to regional and national averages but have increased in recent years in line with national trends. However, when restricting analysis to individuals newly diagnosed with HIV in this country, the new HIV diagnosis rate is significantly

lower than the England average and has remained relatively stable over time. This could partly reflect low testing rates, as noted above, which could contribute to underdiagnosis.

While absolute numbers of people living with diagnosed HIV in Cumberland remain small, there is an ongoing need for strengthened prevention activity, earlier testing, targeted outreach, and culturally competent services informed by changing population profiles.

Reproductive Health

- **Long-acting reversible contraception (LARC)**
  The rate of LARC (excluding injections) prescribing in GP and sexual health services in Cumberland is significantly higher than the England average, and is among the highest in the country, with an increasing trend. This suggests comparatively strong provision and uptake of highly effective contraception. However, access to LARC may not be evenly distributed, reflecting the authority's rurality, workforce pressures in general practice and variation in local service availability.

- **User-dependent contraception and emergency hormonal contraception (EHC)**
  User-dependent contraception and emergency hormonal contraception continue to play an important role in local reproductive health provision, supporting contraceptive choice and pregnancy prevention, particularly where access to longer-acting methods is limited or delayed.

- **Teenage pregnancy**
  Under-18 conception rates in Cumberland are similar to both England and North West averages (2022 data). The proportion of under-18 conceptions ending in abortion is similar to regional and national averages, suggesting comparable patterns of decision-making once pregnancy occurs.

Sexual Violence and Safeguarding

- **Violent crime (sexual offences)**
  The rate of recorded sexual offences per 1,000 population is higher than the England average, with a stable trend. While police-recorded crime reflects reporting and recording practices as well as underlying incidence, this data reinforces the importance of accessible sexual assault services, effective safeguarding pathways and trauma-informed care.

Screening and Immunisation

- **HPV vaccination**
  HPV vaccination coverage among 12-13-year-olds is higher than the England average, although it remains below the national target of 90% for both boys and girls. HPV vaccination plays a critical role in preventing cervical cancer and other HPV-related conditions. Maximising coverage and reducing inequalities in uptake across different population groups should be a priority.

- **Cervical screening**
  Cervical screening coverage in Cumberland is lower than the national target, but significantly higher than the regional and England averages. However, cervical screening uptake varies across different population groups and may be influenced by access, awareness and wider health inequalities. Although commissioned nationally, cervical screening remains a key component of the wider sexual and reproductive health system and is closely linked to HPV vaccination and long-term women's health outcomes.

- **Hepatitis B and C (linked blood borne viruses (BBVs))**
  Hepatitis B remains relevant within the sexual health context due to onward sexual transmission

and targeted vaccination delivered through sexual health services. Hepatitis C is included where it intersects with sexual health services, particularly through opportunistic testing and referral among populations experiencing multiple disadvantage.

3.2. Key Areas of Strength

The assessment identifies several areas of relative strength within the local sexual and reproductive health system:

- Low overall rates of diagnosed STIs and HIV compared with regional and national averages, albeit requiring cautious interpretation
- Strong uptake of LARC, suggesting effective access to highly effective methods for many residents
- Collaborative commissioning across Cumbria, supporting consistency and integration of sexual health services
- Emerging system-wide partnerships, including a Sexual Health Quality and Innovation Group, to support service improvement and innovation

These strengths provide a foundation on which to build improved access, prevention and equity.

3.3. Key Areas of Unmet Need and Emerging Risk

Despite favourable headline indicators, several areas of unmet need and emerging risk are evident:

- Persistently low chlamydia screening and detection among young people, limiting opportunities for prevention and early intervention
- Relatively low STI testing rates, alongside low diagnosis rates and rising/average positivity – indicating unmet need
- Low HIV testing coverage, the second lowest in the North West, increasing the risk of undiagnosed infection and late diagnosis
- Rising syphilis diagnoses, reflecting national trends and highlighting the importance of continued surveillance and targeted prevention
- Evidence of increasing complexity among service users, including higher levels of trauma, safeguarding concerns and psychosocial need
- Potential hidden unmet need among groups less likely to access routine services, including people in rural areas, migrants, sex workers and those experiencing multiple disadvantage

These risks reinforce the need for targeted, flexible and prevention-focused service models.

3.4. System-wide Challenges and Inequalities

System-wide factors play a significant role in shaping access and outcomes in Cumberland:

- Rurality and geography, limiting timely access to clinic-based services
- Transport and digital barriers, contributing to missed testing and screening opportunities
- Workforce pressures across sexual health and primary care, affecting capacity and sustainability
- Complex commissioning arrangements, with responsibilities split across local authorities, ICBs and NHS England
- Data limitations, which may obscure inequalities and underestimate need among some populations

Addressing these challenges will require a whole-system approach that prioritises equity, outreach, digital inclusion, workforce resilience and partnership working.

This assessment does not necessarily reflect provider performance, nor does it assume rising risk across all populations. Instead, it highlights how access constraints, rurality and system complexity influence recorded activity and may mask underlying unmet need.

4. Sexual Access, Equity and System Capacity

Sections 3 and 4 should be read together. Structural factors affecting access, including rurality, digital exclusion, workforce capacity and commissioning complexity, are critical to interpreting epidemiological indicators, particularly where testing activity is low or service use appears favourable.

4.1. Geography, Rurality and Transport

Access to sexual health services is shaped by geography, service configuration, workforce capacity and wider determinants such as transport availability, digital access and socioeconomic circumstances. Understanding who is accessing services - and who may be missing from them - is essential for identifying unmet need and ensuring equitable provision across Cumberland.

Rurality remains a significant barrier to timely access. Large travel distances, limited public transport and variable digital connectivity can make it harder for residents in remote areas to attend appointments, particularly for services requiring face-to-face care such as LARC fitting, complex contraception, sexual assault aftercare and some HIV-related pathways.

For some residents, accessing services may involve multiple journeys, reliance on others for transport, or time off work or education. These barriers are likely to disproportionately affect young people, people on low incomes, those with caring responsibilities, and individuals requiring frequent or specialist appointments. Consequently, lower service activity may reflect barriers to access rather than lower underlying need.

4.2. Digital Access and Remote Models

Digital and remote models should be understood as one component of a broader access system, rather than a standalone solution. Digital and remote models of sexual and reproductive health (SRH) care - including online testing, digital triage and remote consultations - have the potential to increase convenience, privacy and timeliness of access for many residents. This aligns with national policy direction to shift from analogue to digital delivery where appropriate.

National neighbourhood- and place-based health guidance emphasises, however, that digital transformation must be implemented in ways that reflect local population need and avoid widening inequalities. Trusted local services, multiple access routes and proactive engagement are essential to ensure digitally enabled care remains inclusive.

Online testing services and remote pathways are now an established component of provision in many areas and can support earlier testing and diagnosis, reduce pressure on clinic capacity and improve choice when well-integrated with local services.

Digital access is not equitable across the population, and increased reliance on digital routes risks exacerbating inequalities if alternative options are not actively protected. Digital exclusion disproportionately affects:

- Older adults
- People on low incomes
- Individuals with limited digital literacy
- Some migrant and asylum-seeking communities

In rural areas, these challenges may be compounded by poor connectivity, variable broadband access and reliance on mobile data. Individuals who are digitally excluded may struggle to book appointments online, use digital triage systems or access online testing, increasing the risk of delayed care or disengagement altogether.

Digital options may also be less appropriate for some young people, particularly those without private access to devices or with confidentiality concerns. These issues may directly influence patterns of testing uptake, screening coverage and timeliness of care and should be considered when interpreting low service activity.

Digital transformation is intended to complement, not replace, face-to-face provision. The guiding principle for digital SRH services should be that online and remote models enhance choice and access while maintaining equivalent standards of clinical quality, safeguarding, continuity of care and clear pathways into local support.

Interpretation of low testing or screening activity in later sections should therefore consider the extent to which digital pathways are accessible and acceptable to different population groups.

Recommendations

- Embed digital and remote SRH services within a blended access model, ensuring non-digital routes remain visible, accessible and adequately resourced.
- Assess the impact of digital provision on inequalities, particularly for rural residents, young people, older adults and digitally excluded groups.
- Evaluate online and remote SRH services against College of Sexual and Reproductive Health (CoSRH) and British Association of Sexual Health and HIV (BASHH) standards to ensure quality, safeguarding and continuity of care.
- Monitor uptake and outcomes of digital services locally to understand who is, and is not, accessing online pathways.
- Strengthen collaboration between online providers and neighbourhood services to support prevention, referral and continuity of care close to home.

4.3. Face-to-Face Access and Clinic Timing

Digital and remote models expand access for many residents, but face-to-face services remain essential, particularly for young people and those unable to engage digitally. The timing of in-person clinics is a key factor in accessibility.

Standard weekday clinic hours may pose barriers for:

- Young people in school, college or training
- People in employment with limited flexibility
- Individuals with confidentiality concerns or reliance on others for transport

National guidance emphasises designing services around the lives of local people. Where clinic timing is misaligned with population need, this may contribute to delayed access, unmet need or disengagement, disproportionately affecting young people, people in insecure employment and those requiring discretion or accompaniment to attend services.

Recommendations

- Review face-to-face clinic timing, including consideration of after-school, evening or weekend provision where feasible.
- Align clinic availability with neighbourhood-level need, particularly for young people.
- Monitor age-related access and non-attendance patterns to assess whether clinic timing is acting as a barrier.

4.4. Workforce Capacity and Sustainability

Workforce pressures across both primary care and specialist sexual and reproductive health services constrain appointment availability and limit the consistency and range of care that can be delivered. These challenges are particularly pronounced for LARC, psychosexual support, and complex contraception, where specialist competencies, adequate appointment length, and continuity of care are essential.

Limitations in workforce capacity may lead to delays in access, reduced contraceptive choice, and unmet need for specific population groups. Local intelligence highlights a number of contributing factors:

- Unequal LARC provision across primary care, particularly for fitting and removal
- Ongoing recruitment and retention challenges, affecting service resilience
- Reliance on a small specialist workforce, increasing vulnerability to absence or turnover
- Sustained pressure on ISHS staff, impacting flexibility and throughput

These factors help explain observed variation in access to LARC and other specialist interventions across the area and reinforce the importance of system-wide approaches to workforce planning and sustainability, rather than reliance on individual providers.

Capacity constraints can also indirectly influence sexual health behaviours and engagement. Where timely access to preferred services is not available, individuals may delay seeking care, disengage from services altogether, or default to less effective contraceptive methods. Over time, this can contribute to avoidable inequalities in sexual and reproductive health outcomes, including unintended pregnancy.

Addressing these challenges will be critical to supporting informed contraceptive choice, improving continuity of care, and reducing preventable sexual and reproductive ill health. Workforce constraints should therefore be considered a core determinant of access, quality and equity within the local sexual and reproductive health system.

Recommendations

- Map current workforce capacity and service provision across primary care, ISHS, and community settings to identify gaps, duplication, and opportunities for more equitable coverage.
- Strengthen system-wide training and development opportunities in sexual and reproductive health, including LARC competencies, to broaden the skill base and improve service resilience.
- Facilitate networking and peer support across the workforce, enabling shared learning, skill-mix development, and more integrated care pathways.
- Develop links with the newly-established Cumbria PEARS medical school to promote sexual and reproductive health as a career interest, support placements and training opportunities, and contribute to longer-term workforce sustainability.

4.5. Commissioning, Integration and System Complexity

Sexual and reproductive health services in Cumberland operate within a complex commissioning environment involving local authorities, ICBs and NHS England. While local authorities commission open-access sexual health services, responsibility for related commissioned elements such as aspects of contraception, abortion care and specialist HIV treatment sits across different parts of the system. This fragmentation can create challenges for pathway coordination, service planning and accountability.

The commissioning landscape is further complicated by non-coterminous boundaries across two NHS systems, alongside ongoing national structural change and workforce pressures within commissioning organisations. These factors can affect the stability of commissioning arrangements, clarity of responsibility and the ability of local systems to plan and deliver fully integrated sexual and reproductive health pathways.

From an access and equity perspective, system complexity can result in:

- Fragmented care pathways for service users, particularly those with complex needs
- Variability in access to contraception and specialist services depending on entry point
- Challenges in aligning prevention, treatment and follow-up across organisations
- Increased burden on individuals to navigate services independently

While collaborative commissioning of an Integrated Sexual Health Service across Cumbria provides an opportunity to improve consistency and integration, effective delivery will depend on strong system leadership, clear pathways and sustained partnership working across commissioners and providers.

Commissioning complexity should therefore be considered a structural determinant of access and equity, particularly for people experiencing multiple disadvantage, safeguarding concerns or long-term health needs.

Recommendations

- Strengthen system-wide governance and partnership arrangements to support joined-up planning, accountability and pathway clarity across sexual and reproductive health services.
- Ensure commissioned service models explicitly address interfaces between local authority, ICB and NHS England-commissioned services, reducing fragmentation for service users.
- Use commissioning levers to promote equity of access, including clear expectations around outreach, navigation support and collaboration with neighbourhood-based services.
- Monitor the impact of system complexity on access, experience and outcomes, particularly for populations at higher risk of unmet need.

If the access, equity and system capacity needs identified in this section are addressed over the next 2-3 years, success would be reflected in improved equity of access across rural and urban communities, reduced variation in service availability and experience by geography, and clearer, more consistent routes into appropriate support. Over time, this would support earlier engagement with services and a better match between population need, service capacity and delivery models.

5. Sexual and Reproductive Health Profile: Detailed Findings

This section presents detailed analysis of key sexual and reproductive health indicators for Cumberland. Indicators are compared with England and North West benchmarks to provide context and identify areas of relative strength and concern. Interpretation is informed by local demographic characteristics, service access considerations and known data limitations. Findings should be read alongside Sections 3 and 4, which describe access, equity and system factors that shape recorded activity and outcomes.

5.1. Population and Context

Sexual and reproductive health outcomes are shaped by wider social, economic and environmental determinants. Factors such as deprivation, housing stability, education, employment, transport, digital connectivity and experiences of discrimination or trauma influence both patterns of risk and the ability to access timely testing, contraception and support. In Cumberland, rurality, transport barriers, digital exclusion, seasonal employment and pockets of deprivation interact to create uneven access to services and may suppress recorded activity in routine surveillance data. Understanding these wider determinants is essential for interpreting the indicators presented in this section and for identifying hidden or unmet need that may not be visible in aggregate data.

5.1.1. Demographic Profile and Life-course Considerations

The age distribution of Cumberland, shown in Appendix A, provides essential demographic context for interpreting sexual and reproductive health indicators. The area has a substantially older population than England overall, with a lower proportion of residents aged 0-15 and 16-64 years, and a higher proportion of residents aged 65+.

This demographic profile influences both the scale and nature of sexual and reproductive health need. A smaller young adult population may contribute to lower recorded rates of STIs and reduced screening volumes. Conversely, an older age structure may be associated with different patterns of contraception use and longer-term reproductive and sexual health needs.

Incorporating age structure into the interpretation of epidemiological data is therefore critical for understanding local need and ensuring that service planning reflects the characteristics of the resident population.

5.1.2. Deprivation and Inequality

Appendix B illustrates marked variation in deprivation across Cumberland, with some neighbourhoods among the most deprived in England. Deprivation is a well-established driver of sexual and reproductive health need, influencing exposure to risk, access to services and health-seeking behaviour.

Importantly, aggregated local authority-level indicators can conceal inequalities within the population. Favourable overall outcomes may mask higher levels of unmet need in more deprived communities, particularly where additional barriers to access are present. Incorporating deprivation into the interpretation of epidemiological data is therefore essential for identifying inequities, understanding where barriers to access are greatest, and informing proportionate, targeted service planning.

5.2. Sexually Transmitted Infections (STIs)

Patterns of STIs should be interpreted in the context of the demographic profile, geography and access factors described in Sections 3 and 4. Although aggregate STI rates in Cumberland appear low, rurality, pockets of deprivation and the area's older age structure may contribute to lower testing activity and

reduced opportunities for case detection. As a result, reported diagnosis rates may not fully reflect underlying infection levels, particularly among younger people, digitally excluded residents, and those facing transport barriers.

5.2.1. Syphilis

Syphilis is a preventable and curable infection, yet diagnoses have increased markedly across England in recent years, with more than 13,000 cases reported in 2024 - the highest number since the 1940s. It remains a significant public health concern, particularly among gay, bisexual and other men who have sex with men (GBMSM), where incidence has risen steadily over the past decade.

- In 2024, 13 people in Cumberland were diagnosed with syphilis, a rate of 4.7 per 100,000 – significantly lower than the regional (14.6 per 100,000) and England (16.5 per 100,000) rates.
- This compares with seven cases in Cumberland in 2023 (2.5 per 100,000) – suggesting a recent upward trend after several years of declining rates
- This mirrors increasing diagnosis rates seen regionally and nationally over the last few years. Infectious syphilis diagnoses rose to 1,107 in the North West in 2024 (up 17.4% from 2022) and 9,535 in England (up 9.7% from 2022).
- Despite the recent rise in diagnosis rates, Cumberland ranked 140th out of the 151 upper-tier local authorities nationally for new syphilis diagnoses in 2024.

Recommendations:

- Strengthen targeted prevention and testing for higher-risk groups, including GBMSM and individuals with multiple partners.
- Ensure outreach and testing options are accessible to residents facing transport or digital barriers.
- Maintain close surveillance and rapid response to clusters, supported by strong links between ISHSs, primary care, and community partners.

If targeted prevention and surveillance activity is sustained, success would be reflected in earlier detection of cases, reduced risk of onward transmission, and timely public health response to emerging clusters without placing additional pressure on specialist services.

5.2.2. Gonorrhoea

Gonorrhoea is an important marker of sexual health need and access to STI testing, as the majority of diagnoses occur in sexual health services. Compared with chlamydia, infection is more likely to present with symptoms, which can influence patterns of testing and detection.

In Cumberland, diagnosis rates remain comparatively low and the most recent year shows a decline. However, as with other STI indicators, reduced testing coverage, rural access barriers and fewer opportunistic screening opportunities may contribute to under-diagnosis and mask underlying prevalence.

- In 2024, 94 people in Cumberland were diagnosed with gonorrhoea – equivalent to a rate of 34 per 100,000. This is significantly lower than the national average, and the second lowest in the North West (regional rate 111 per 100,000).
- Although the most recent year shows a small decrease in diagnosis rates (from 47 per 100,000 in 2023 to 34 per 100,000 in 2024), the longer-term trend over the past decade indicates an overall increase. This aligns with national patterns, although the rise in Cumberland has been less pronounced.
- Nationally, diagnosis rates decreased from 148 per 100,000 in 2023 to 124 per 100,000 in 2024. However, rates remain comparatively high compared with those seen historically - with a rate of 50 per 100,000 recorded in 2012.

Recommendations:

- Increase opportunistic testing in primary care, pharmacies and youth-focussed settings.
- Improve visibility and accessibility of online and postal testing, while ensuring alternatives remain available for digitally excluded residents.
- Use local intelligence and qualitative insight to identify communities where low testing uptake may be masking unmet need.

5.2.3. Chlamydia Detection (females aged 15-24)

Chlamydia is the most commonly diagnosed bacterial STI in England, with the highest rates among young adults. Untreated infection can result in pelvic inflammatory disease (PID), ectopic pregnancy and tubal-factor infertility. The NCSP promotes opportunistic screening among sexually active young people aged 15–24. Since June 2021, the programme has prioritised screening among females aged 15–24 to reduce reproductive harm; this change should be considered when interpreting trends.

The chlamydia detection rate among females aged 15-24[1] is widely used as a marker of chlamydia control activity. Higher detection rates typically reflect more effective case-finding rather than higher underlying prevalence. This indicator is included in the PHOF to support monitoring of accessible, high-volume screening programmes. UKHSA recommends that local areas work towards achieving a detection rate of at least 3,250 per 100,000 females aged 15-24, a level considered ambitious but achievable and associated with reductions in chlamydia prevalence. This benchmark is intended to encourage screening across community settings, not solely within specialist sexual health services. Blackpool the only local authority in the North West currently meeting this benchmark.

Local data for Cumberland should be interpreted in this national context. When considered alongside low screening coverage, the current detection rate indicates reduced control activity and persistent unmet need among young people. At present, it is not possible to determine whether the low detection rate reflects genuinely low prevalence or insufficient reach into the populations most at risk.

- In 2024, 208 young women were diagnosed with chlamydia in Cumberland, a rate of 1,617 per 100,000.
- This represents a slight improvement on 2023. However, the overall trend shows no significant change.
- The detection rate in Cumberland is statistically similar to the England (1,589 per 100,000) and North West (1,796 per 100,000) rates – but lower than the national target.

Recommendations:

- Expand targeted outreach to young people, including through colleges, youth services and community-based venues.
- Strengthen non-digital testing routes to mitigate the impact of digital exclusion.
- Work with schools, youth workers and community partners to increase awareness, normalise testing and reduce stigma.

[1] All chlamydia diagnoses in young women aged 15 to 24 years attending sexual health services (SHSs) and community-based settings, who are residents in England, expressed as a rate per 100,000 population.

5.2.4. Chlamydia Screening

Chlamydia screening is central to identifying asymptomatic infection, reducing the duration of untreated disease, and lowering the risk of complications and onward transmission. In Cumberland, declining screening coverage limits these benefits and increases the likelihood of undiagnosed infection.

As outlined in Section 4, reduced screening coverage may reflect a combination of limited opportunistic screening opportunities, transport barriers, digital exclusion and constrained service capacity. These factors are likely to disproportionately affect young people and others less able to engage with routine or appointment-led services, meaning that low screening rates may mask unmet need.

- 1,766 young women were screened for chlamydia in Cumberland in 2024, representing 13.7% of females aged 15-24**.**
- This is a slight decline from 14.3% in 2023 (1,834 screens), indicating reduced engagement with opportunistic screening pathways – but aligning with the national trend.
- Screening coverage has also declined across the North West (from 20.3% in 2023 to 17.9% in 2024) and England (from 20.1% to 18.0%).
- Information about trends is limited due to changes in the focus of the NCSP in 2021 to prioritise females aged 15–24; earlier indicators including all genders are not directly comparable to more recent data.
- Despite wider declines, local coverage remains significantly below both regional and national averages**.**

Recommendations:

- Increase opportunistic screening in primary care and other community-based settings, supported by workforce development where feasible.
- Improve transport-sensitive access, including mobile or outreach provision in rural areas.
- Develop targeted communications for young people that address confidentiality concerns and clarify testing pathways and service navigation.

If chlamydia testing access and outreach are strengthened over the next 2-3 years, success would be reflected in increased testing uptake among young people, particularly those currently underrepresented in service data, reduced variation in access by locality, and earlier identification of infection to prevent avoidable reproductive harm.

5.2.5. New STI Diagnoses (excluding chlamydia for people aged under 25)

Rates of new STI diagnoses should be interpreted alongside levels of testing activity and test positivity. While higher diagnosis rates can indicate greater infection burden, very low rates may also reflect reduced testing, access barriers or under-representation of specific population groups.

In Cumberland, particularly low diagnosis rates should therefore be interpreted with caution. As set out in Section 4, structural barriers to access may limit opportunities for testing among some groups, meaning that recorded figures may not fully reflect underlying levels of infection or unmet need.

- In 2024, 729 new STI diagnoses (excluding chlamydia for those aged 24 years and younger) were recorded in Cumberland.
- This equates to a diagnosis rate of 263 per 100,000 population**,** the second lowest rate in the North West**.**
- The long-term trend shows no significant change**,** whereas both England and the North West are seeing an increasing trend in diagnoses.

- Across the North West, most local authorities have new STI diagnosis rates below the England average, except Manchester, Liverpool, Salford and Blackpool.
- In 2024 the rate of STI testing (excluding chlamydia in those aged under 25 years) in sexual health services in Cumberland was 1,494 per 100,000, a 5% increase compared to 2023. However, this is lower than the testing rate of 4,089 per 100,000 in England in 2024, and rates in Cumberland have not returned to pre-pandemic levels. Testing rates in Cumberland are also the second lowest in the region. The positivity rate in Cumberland was 7.1% in 2024, similar to 6.4% in England, but with an overall increasing trend[2].

Taken together, persistently low and stable diagnosis rates locally, along with relatively low testing rates and rising/average positivity, may indicate missed opportunities for case detection rather than low underlying need.

Recommendations:

- Use local intelligence and qualitative insight to identify groups under-represented in testing (for example, digitally excluded residents, asylum seekers, young people).
- Strengthen community-based testing and outreach in deprived and rural areas.
- Ensure commissioning arrangements support flexible, accessible and non-clinic-based testing pathways.

5.2.6. Condom Access and Safer Sex Resources

Condoms are a core primary prevention intervention for both STIs and unintended pregnancy. National guidance from UK Health Security Agency (UKHSA) and the College of Sexual and Reproductive Healthcare (CoSRH, formerly FSRH) identifies condom provision as a key component of effective STI control, alongside testing, treatment and partner notification.

In Cumberland, condoms are available through the integrated sexual health service and selected community-based settings. Unlike many local authorities, Cumbria does not operate a formal condom distribution or C-Card scheme for young people. Instead, access to condoms is largely linked to engagement with existing service pathways and clinical contacts, rather than universal or self-directed distribution routes.

Rural geography, transport barriers and reduced routine contact with services may limit consistent access to condoms for some population groups, particularly young people and individuals who do not regularly attend clinics. This may reduce opportunities for prevention among those at greatest risk of STI exposure.

Recommendations:

- Explore low-cost, low-administration approaches to strengthening access, such as expanding provision through existing community partners (for example, youth services, pharmacies and further education) where capacity allows.
- Ensure condoms remain available through both clinic-based and postal routes, recognising that digital exclusion limits access for some residents.
- Consider proportionate targeted, outreach activity in areas of identified need, aligned with existing workforce capacity and local intelligence.

[2] Positivity rates depend both on the number of diagnoses and the offer of testing; higher positivity rates compared with previous years can represent increased burden of infection, decreases in the number of tests, or both.

5.2.7. Vaccination and Emerging Interventions for STI Prevention

Vaccination plays an important role in the prevention of STIs, particularly hepatitis B, HPV and mpox. These programmes reduce individual risk and contribute to wider population-level protection. In Cumberland, vaccination is delivered through a combination of national programmes (for example, school-based HPV vaccination), primary care, and targeted provision through the integrated sexual health service.

HPV vaccination is delivered through the national adolescent immunisation programme and is discussed in detail in Section 5.5.1. Coverage can vary between cohorts and may be influenced by school absence, rurality and access to catch-up opportunities. These factors should be considered when interpreting local uptake patterns and assessing future inequalities in HPV-related disease.

Mpox vaccination is offered nationally to individuals at higher risk, primarily GBMSM with multiple partners. Local uptake is influenced by eligibility, awareness and the availability of vaccination sessions. Rural geography and transport barriers may limit access for some residents.

Hepatitis B is a sexually transmissible infection and remains relevant to sexual health prevention and commissioning. Vaccination is recommended for people at increased risk, including GBMSM, individuals with multiple sexual partners, sex workers and people who inject drugs. In Cumberland, hepatitis B vaccination is delivered primarily through sexual health services and some primary care settings. Rurality, transport barriers and limited clinic capacity may affect equitable access, reinforcing the importance of clear signposting, opportunistic vaccination and integration within existing sexual health pathways.

Hepatitis C is not routinely sexually transmitted and there is no available vaccine. It is therefore included within this needs assessment only where it intersects with sexual health services through opportunistic testing, risk assessment and referral. This is particularly relevant for populations experiencing multiple disadvantage, including people who inject drugs, individuals in secure settings and some migrant communities. Sexual health services can provide an important entry point for identifying undiagnosed hepatitis C infection and supporting onward referral into specialist care, contributing to national elimination ambitions while avoiding duplication with substance misuse or hepatology services.

Alongside established vaccination programmes, emerging biomedical prevention approaches are beginning to be implemented within sexual health services.

Meningococcal B (MenB) vaccination

Since August 2025, GBMSM at higher risk of gonorrhoea may be offered the meningococcal group B (MenB) vaccine (‘Bexsero’) to provide partial protection against gonorrhoea.

Doxycycline Post-Exposure Prophylaxis (DoxyPEP)

DoxyPEP is an antibiotic taken after sexual exposure to reduce the risk of certain bacterial STIs, including chlamydia and syphilis. Emerging evidence indicates significant reductions in these infections among some higher-risk groups, particularly GBMSM, with more limited impact on gonorrhoea.

Use of DoxyPEP is evolving, and while not yet widely embedded in national guidance, some services have begun to offer it following clinical assessment. It does not protect against viral infections such as HIV or hepatitis. Its future role will depend on emerging evidence, national guidance and consideration of antimicrobial resistance risks.

Antimicrobial resistance

These developments sit within a wider context of increasing antimicrobial resistance (AMR), particularly in Neisseria gonorrhoeae, which has shown rising resistance to multiple antibiotic classes. UKHSA continues

to report emerging treatment failures and reduced susceptibility to first-line therapies, reinforcing the importance of timely diagnosis, appropriate prescribing, test-of-cure and robust partner notification.

Recommendations:

- Maintain clear signposting to vaccination opportunities through existing service channels, ensuring residents understand eligibility and access routes.
- Where feasible, align vaccination delivery with existing clinic sessions or outreach activity to minimise additional resource requirements.
- Continue monitoring uptake patterns to identify any groups or areas where access may be lower, using this insight to inform proportionate, targeted engagement.
- Continue to monitor national developments and evaluate emerging evidence on prevention approaches, ensuring local commissioning remains aligned with Joint Committee on Vaccinations and Immunisations (JCVI) and UKHSA guidance.

5.2.8. Mpox and Emerging Infections

Mpox remains a notifiable disease in England. Although national case numbers have declined substantially since the 2022 outbreak, sporadic cases continue to be reported, primarily among GBMSM. Vaccination is offered nationally to individuals at higher risk and is delivered through specialist sexual health services.

Nationally, small numbers of mpox clade I cases have been reported in the UK, largely associated with travel to countries where clade I mpox is circulating. More recently, limited person-to-person transmission has been identified outside the African region, including within some GBMSM networks. While overall case numbers remain very low and no local cases have been identified in Cumberland, national risk assessments indicate an increased probability of importation. This reinforces the importance of continued vigilance, clear referral pathways and alignment with national guidance within local sexual health services.

In Cumberland, mpox vaccination has been delivered through the integrated sexual health service as part of the national response. Uptake is influenced by eligibility, awareness and the availability of vaccination sessions. Rural geography may present additional access challenges for residents living further from clinic sites or facing transport barriers. Although local case numbers remain low, ongoing vigilance is required.

Sexual health services also play a critical role in the early identification of other emerging infections, including antimicrobial-resistant gonorrhoea, shigella and new variants of existing STIs. Robust surveillance, timely reporting and strong links with UKHSA are essential to support early detection and rapid response without placing additional strain on services.

Although current local data do not indicate elevated incidence, these considerations highlight the importance of maintaining surveillance capacity, strengthening links between sexual health and health protection teams, and ensuring clinicians remain alert to changing epidemiology.

Recommendations:

- Continue to align local mpox vaccination delivery with national guidance, using existing clinic capacity where feasible.
- Maintain clear communication with UKHSA and local partners to support early detection and timely response.
- Ensure staff remain aware of current case definitions, reporting requirements and referral pathways through routine clinical governance.

5.3. HIV Testing, Prevention and Care Pathway

HIV testing is a core component of sexual health provision and is essential for early diagnosis, timely treatment and reducing onward transmission. National guidance recommends routine opt-out HIV testing within sexual health services, alongside targeted testing approaches for people at higher risk.
In Cumberland, persistently low testing rates suggest missed opportunities for early diagnosis and prevention. As set out in Section 4, geographical barriers to clinic-based testing, reduced outreach capacity, and limited access to community or non-traditional testing settings are likely to influence uptake.

Although some groups at higher risk of HIV, such as GBMSM and people from Black African communities, may be numerically under-represented within the local population, rural isolation, stigma, digital exclusion and concerns about anonymity may also act as barriers to testing among the wider population. These factors are important when interpreting HIV indicators locally.

5.3.1. HIV Testing Rates

HIV testing among people attending sexual health services is fundamental to prevention, early diagnosis and effective treatment. Knowledge of HIV status improves survival, reduces onward transmission and supports timely initiation of antiretroviral therapy. Testing and diagnosis rates are therefore closely linked, and testing coverage provides critical context for interpreting trends in new diagnoses.

Nationally, expanded testing approaches, including opt-out testing in emergency departments, are contributing to increased case finding, particularly among populations less likely to access traditional sexual health services.

- In 2024 3,489 people were tested for HIV in Cumberland, equating to a rate of 1260 per 100,000 population.
- The highest testing rate locally was recorded in 2016, when 5688 people were tested (a rate of 2,075 per 100,000).
- Although the long-term trend shows gradual improvement, current testing rates remain substantially below regional and national averages (North West: 2,189 per 100,000, England: 2,843 per 100,000).

Persistently low testing rates locally indicate ongoing missed opportunities, particularly in rural areas where access to services may be more constrained.

5.3.2. HIV Late Diagnosis

This indicator includes HIV diagnoses first made in the UK and excludes individuals previously diagnosed abroad. Reducing late diagnosis is a national strategic priority, as late diagnosis is strongly associated with poorer clinical outcomes, higher healthcare costs and increased risk of onward transmission. Nationally, individuals diagnosed late are significantly more likely to die within one year of diagnosis compared with those diagnosed promptly.

Although local numbers are very small, the presence of late diagnosis indicates that some individuals have not been able to access testing early enough. As outlined in Section 4, rural isolation, limited anonymity, reduced outreach capacity, stigma and fewer opportunities for community-based testing may all contribute to delayed presentation.

- Four people in Cumberland received a late diagnosis between 2022-2024, representing 40% of all new diagnoses made in the local authority area. This is higher than the national target of 25%.
- Over the same period, 251 late diagnoses were recorded in the North West and 2,746 in England – equating to late diagnosis rates of 40% and 43.3% respectively.

This data re-enforces the need to expand testing opportunities to all groups to ensure people are diagnosed at an early stage.

5.3.3. New HIV Diagnoses

Although new diagnoses are not a direct measure of HIV incidence, they provide timely insight into transmission patterns, help identify where testing and prevention efforts may need strengthening, and inform service planning.

- All reported diagnoses (including those first diagnosed abroad): In 2024, 18 people were diagnosed with HIV in Cumberland, a rate of 6.4 per 100,000 population. This is statistically similar to the England average. This compares to a rate of 1.8 per 100,000 in 2022 and represents an overall increasing trend, consistent with regional and national patterns.

- Diagnoses first made in England (excluding those diagnosed abroad): In 2024, 6 people were newly diagnosed with HIV in Cumberland, a rate of 2.1 per 100,000. This is significantly lower than the England average and reflects a broadly stable trend over time.

The differing trends between total diagnoses and those first diagnosed in England reflects the national picture and suggest that the recent increase in new HIV diagnoses is driven, at least in part, by people previously diagnosed abroad. This has important implications for ensuring timely linkage to care and the provision of culturally appropriate services.

It is unclear how far relatively low diagnosis rates among those first diagnosed in the UK reflect genuinely low incidence or are influenced by lower levels of testing. While the absolute number of people living with diagnosed HIV in Cumberland remains small, these findings highlight the need to strengthen prevention activity, increase testing, and ensure services are responsive to changing population needs.

5.3.4. Diagnosed HIV Prevalence

This indicator reflects the number of people aged 15-59 living with diagnosed HIV who are accessing HIV care at NHS services in England. Understanding local prevalence supports effective targeting of prevention, testing and ongoing support, particularly as the population of people living with HIV ages.

In Cumberland, diagnosed prevalence remains low compared with regional and national figures but has increased gradually over time (albeit not significantly). Lower prevalence does not necessarily indicate lower risk; it may also reflect demographic factors, rurality or lower testing coverage among some groups.

The gradual increase in diagnosed prevalence locally and nationally is likely to reflect improved survival and longevity among people living with HIV, as well as ongoing diagnoses and improved case finding through expanded testing programmes.

- In 2024, 127 people were living with diagnosed HIV in Cumberland, equating to a prevalence rate of 0.86 per 1,000 people aged 15-59. This is the second lowest diagnosed prevalence rate in the North West.
- Nationally, ‘high prevalence’ areas for HIV are defined as those with a diagnosed prevalence of 2-5 per 1,000, while ‘extremely high’ prevalence areas have a diagnosed prevalence of ≥5 per 1,000. Cumberland therefore remains a low prevalence area for HIV.

5.3.5. Pre-exposure Prophylaxis (PrEP) Access and Uptake

PrEP is a highly effective HIV prevention intervention taken by people who are HIV-negative before sex to reduce the risk of acquiring HIV. Routine PrEP commissioning began in England in autumn 2020 as part of a combination prevention approach, with specialist sexual health services responsible for delivering PrEP to people at higher risk.

PrEP uptake varies nationally and locally, influenced by awareness, stigma, service accessibility and routine engagement with sexual health services. In Cumberland, PrEP is commissioned nationally and delivered locally through the integrated sexual health service. However, rural geography, transport barriers and limited clinic capacity may constrain uptake, particularly for residents who live far from clinic sites or who experience difficulty attending routine follow-up appointments.

This indicator assesses the proportion of individuals attending specialist sexual health services with PrEP need who started or continued PrEP. A higher proportion indicates that need is being met; a lower proportion suggests that people with PrEP need are leaving services without PrEP, for reasons that are likely to be multifactorial.

- The proportion of individuals with PrEP need who received PrEP in Cumberland has increased from 55.2% in 2021 to 71.8% in 2024 and is now similar to the national average of 76.1%.

This should be interpreted in the context of rurality, transport barriers, digital exclusion and limited clinic capacity, all of which may suppress uptake and mask underlying need rather than reflect lower demand.

5.3.6. HIV Recommendations

Testing access and uptake

- Embed routine opt-out HIV testing consistently within sexual health services and ensure systematic application across eligible clinical encounters.
- Maximise opportunistic HIV testing through existing touchpoints (for example, STI screening and contraception appointments), avoiding additional appointment or workforce burden.
- Expand testing beyond sexual health clinics by strengthening pathways within antenatal care and maternity, drug and alcohol services and relevant secondary care specialties (such as TB, hepatitis B/C and lymphoma), in line with national guidance.
- Improve awareness and uptake of postal and self-sampling options, while ensuring non-digital routes remain available.

Reducing late diagnosis

- Improve access to testing to reduce late diagnosis and associated avoidable inequalities, poorer outcomes and healthcare costs.
- Undertake proportionate ‘look-back’ reviews for late diagnoses to identify missed opportunities across care pathways.
- Provide targeted training for relevant medical specialties to increase awareness of HIV indicator conditions and prompt earlier testing.
- Increase the use of point-of-care testing (POCT) where feasible, including in community and hospital settings, building on existing pharmacy-based provision in Cumbria.

Prevention and PrEP

- Maintain clear and consistent signposting to PrEP through sexual health services, primary care and online pathways.

- Align PrEP monitoring and follow-up with existing clinic activity to minimise travel, appointment burden and disengagement, particularly for rural residents.

Equity, engagement and person-centred care

- Use proportionate, targeted engagement approaches for groups with lower uptake of testing or prevention (for example, young people, asylum seekers and people involved in sex work), guided by local intelligence rather than assumed risk.
- Ensure trauma-informed and culturally sensitive testing and care pathways, particularly for people from migrant and refugee backgrounds.
- Strengthen integration between integrated sexual health services, primary care and mental health services to support long-term management and wellbeing for people living with HIV, including those ageing with HIV.
- Address HIV-related stigma across the system, including through workforce training and awareness, to support earlier testing, improve patient experience and reduce barriers to engagement.
- Promote existing national resources, including online stigma reduction training for healthcare professionals, as part of routine workforce development.

5.4. Reproductive Health

Reproductive health is a core component of sexual health provision and includes access to contraception, pregnancy planning and support around conception and early pregnancy. Although some elements sit outside the remit of local authority-commissioned services, they remain important for understanding the wider reproductive health landscape in Cumberland.

As described in Section 4, rurality, transport barriers, digital exclusion and variation in primary care capacity all influence access to contraception and reproductive health services locally. These factors may contribute to unmet need, particularly among young people, residents in remote areas and those facing additional vulnerabilities.

5.4.1. Access to Contraception and Emergency Contraception

Contraception and emergency contraception are delivered through a mixed provision model involving general practice, community pharmacies and specialist SRH services. Collectively, these settings are central to enabling timely access to contraception, supporting reproductive autonomy and preventing unintended pregnancy.

National commitments within the renewed Women's Health Strategy to improve access to contraception and support the sustainability of abortion services reinforce the importance of timely and equitable provision locally. This aligns with local findings showing variation in access to LARC and highlights the need for well-integrated pathways across primary care, specialist SRH services and Women's Health Hubs.

Ensuring equitable access is particularly important in rural areas, where service availability, transport constraints and awareness can significantly influence uptake.

Commissioning Changes

Until October 2025, the supply of EHC through community pharmacies in Cumbria was locally commissioned by the local authority via a framework agreement. This enabled free access to EHC and

generated detailed pharmacy-level activity data, supporting local monitoring, needs assessment and service planning.

From October 2025, the Pharmacy Contraception Service (PCS) was incorporated into the nationally commissioned community pharmacy contractual framework, funded by NHS England and discharged through ICBs. The PCS standardises free access to:

- Initiation and ongoing supply of oral contraception
- Supply of EHC
- Confidential consultations and onward referral where required

This national model removes the requirement for local authority commissioning of pharmacy-based EHC and is intended to improve convenience, choice and consistency of access.

Local Context

Residents now access contraception and EHC through:

- General practice - routine contraception and LARC fitting in participating practices
- Community pharmacies - oral contraception and EHC via the nationally commissioned PCS
- ISHS - routine and complex contraception, LARC, EHC and specialist care

While the PCS has the potential to increase access points, uptake may vary depending on pharmacy participation, public awareness, workforce capacity and the ongoing challenges of rural geography, transport and digital exclusion.

A key impact of the commissioning change is the loss of detailed local activity intelligence. Under the previous local authority framework, pharmacy-level data supported monitoring of access, identification of geographic gaps and assessment of variation across communities. The nationally commissioned PCS does not currently provide the same level of local granularity, limiting the ability to understand patterns of use or identify inequities in access. This is particularly significant in rural areas, where pharmacy coverage may be uneven and alternative services less accessible.

Although pharmacy-based contraception and EHC are now standardised nationally, reduced visibility of local activity constrains the ability to identify unmet need, monitor equity and plan targeted interventions.

Recommendations:

- Strengthen local information and signposting so residents understand where and how to access oral contraception and EHC.
- Work with ICBs and NHS England regional teams to explore options for enhanced local reporting, where feasible, to support place-based monitoring and needs assessment.
- Use complementary intelligence sources (ISHS activity, GP prescribing and local qualitative insight) to triangulate access patterns and identify emerging gaps.
- Maintain clear, navigable pathways between pharmacies, general practice and ISHS to support continuity of care, particularly for those requiring LARC or complex contraception.
- Monitor pharmacy participation and the geographic coverage of the PCS to assess equity of access, with particular attention to rural and more isolated communities.

5.4.2. Total Prescribed Long-Acting Reversible Contraception (LARC) (excluding injections)

This indicator reflects the crude rate of LARC, excluding injections, prescribed by general practice and specialist SRH services per 1,000 resident females aged 15-44. Increased provision of LARC is associated with improved access to the full range of contraceptive options and contributes to reductions in unintended pregnancy.

In Cumberland, overall LARC prescribing rates are high compared with regional and national benchmarks, suggesting comparatively good access to long-acting methods. However, interpretation of this indicator is complex and should be undertaken with caution.

LARC provision sits across multiple commissioning arrangements. Local authorities commission open-access contraception services, including LARC for contraceptive purposes, while ICBs commission elements of women's health care, including menopause services. Intrauterine devices and systems (IUDs/IUS) may therefore be fitted for both contraceptive and non-contraceptive indications, including management of heavy menstrual bleeding or as part of menopause care. Activity data do not consistently differentiate indication, meaning that prescribing figures may reflect a combination of reproductive health and menopause-related provision rather than contraceptive need alone.

As a result, high aggregate prescribing may mask variation in access, indication and service experience across the population and geography. GP workforce pressures, variable practice participation in LARC provision, and transport barriers - particularly in rural areas - may still constrain contraceptive choice for some residents, despite favourable headline rates.

Sustaining high levels of LARC provision while addressing local inequities, clarifying pathways and understanding the balance of contraceptive versus non-contraceptive use will be important for supporting reproductive autonomy and reducing unintended pregnancy.

- In 2024, 2,910 implants, IUS and IUDs were prescribed in Cumberland, equating to a rate of 62.4 per 1,000 females aged 15-44.
- Cumberland has the second highest LARC prescribing rate in the North West and is above both the England (40 per 1,000) and the North West (39.3 per 1,000) averages.
- The data shows an increasing trend in prescribing over time.

Implications for Commissioning and Service Planning
Given the complexity of commissioning responsibilities and clinical use, there is a need to review local arrangements to better understand:

- the balance between contraceptive and non-contraceptive LARC provision
- variation in access by geography, provider type and population group
- the impact of workforce capacity and referral pathways on choice and waiting times

Recommendations:

- Support GP workforce development and training to increase sustainable LARC capacity
- Encourage inter-practice referral arrangements within Primary Care Networks to reduce variation in access.
- Ensure equitable access across the geography, including outreach or mobile provision where appropriate.
- Undertake consultation in areas of both low and high LARC uptake to better understand preferences for LARC versus user-dependent methods.
- Review reasons for LARC removal (e.g. method renewal, switching methods, side effects) to inform service improvement and contraceptive counselling.
- Review commissioning interfaces between local authority-commissioned contraception services and ICB-commissioned women's health and menopause pathways to ensure clarity, equity and continuity of care.

If reproductive health access issues are addressed over the next 2-3 years, success would be reflected in more consistent access to the full range of contraceptive options across localities, reduced variation linked to workforce capacity, and clearer pathways between primary care, pharmacy and specialist services. This would support informed choice, continuity of care and improved alignment between service offer and population need.

5.4.3. Abortion Care Pathways

Abortion care pathways differ across Cumbria due to the area's position within two ICB footprints, resulting in different commissioning arrangements and access routes for residents. In North Cumbria, services are commissioned by the North East and North Cumbria (NENC) ICB, with early medical abortion provided locally by North Cumbria Integrated Care (NCIC) and onward referral to specialist centres for later-gestation care. Independent sector providers, such as British Pregnancy Advisory Service (BPAS), also deliver NHS-funded care, including telemedicine and postal early medical abortion.

In Lancashire and South Cumbria, abortion care is commissioned by the Lancashire and South Cumbria (L&SC) ICB. Most NHS-funded provision is delivered through independent sector providers (BPAS and MSI), with residents typically travelling to Lancaster, Preston or Blackpool for in-person procedures, alongside access to telemedicine-supported early medical abortion.

These structural differences, combined with rural geography and transport constraints, mean that travel distance, provider choice and access routes vary across Cumberland**,** which should be considered when interpreting local abortion indicators and assessing equity of access.

5.4.4. Abortions under 25 and repeat abortions

This indicator reflects the proportion of abortions among women aged under 25 involving someone who has had a previous abortion. Nationally, over a quarter of abortions in this age group are repeat abortions. Higher proportions may indicate challenges in accessing timely, high-quality contraception and follow-up advice.

Trend data for Cumberland are unavailable due to historical aggregation at Cumbria level. Locally, the proportion of repeat abortions among under-25s is comparatively low, suggesting relatively effective access to contraception and reproductive health advice. However, repeat abortions may still indicate unmet need for effective contraception or ongoing access barriers for some individuals.

- In 2023, 75 women under 25 had a repeat abortion, representing 22% of all abortions in this age group.
- This is the lowest rate in the North West, but is statistically similar to the England average (29%).

Recommendations:

- Improve access to LARC and same-day contraception where feasible.
- Strengthen post-abortion contraception pathways to reduce the risk of repeat unintended pregnancy.

5.4.5. Abortions under 10 weeks

This indicator reflects the proportion of NHS-funded abortions performed under 10 weeks' gestation. Earlier abortion is associated with lower clinical risk, improved patient experience and greater cost effectiveness.

In Cumberland, the proportion of abortions performed under 10 weeks is comparable with the national picture, suggesting timely access for most residents. The slightly lower proportion compared with the North West may reflect structural access factors described in Section 4, including rurality, transport constraints or variation in provider capacity.

- In 2023, 770 women had an abortion performed under 10 weeks, representing 88% of all NHS-funded abortions.
- This is statistically similar to the England rate (89%) and slightly lower than the North West (91%).

Recommendations:

- Ensure non-digital booking routes remain available.
- Strengthen links between abortion providers and ISHS for seamless follow-up care.

5.4.6. Under-18 Conceptions

This indicator reflects pregnancies among girls aged under 18 that result in live birth, stillbirth or legal abortion per 1,000 females aged 15–17. Teenage pregnancy is strongly associated with poorer health, social and economic outcomes for both the young parent and child.

The under-18 conception rate in Cumberland is similar to the regional and national averages, suggesting relatively effective prevention. However, the absence of a downward trend (similar to that seen in England overall) indicates the need for continued focus to sustain progress. Low aggregate rates may also mask inequalities within specific communities.

- In 2022, 74 conceptions occurred among under-18s in Cumberland, a rate of 17.5 per 1,000.
- There has been no statistically significant change in trend over time.
- The rate is statistically similar to the England (13.9 per 1,000) and North West (16.8 per 1,000) averages.

5.4.7. Under-18 Conceptions Leading to Abortion

This indicator shows the proportion of under-18 conceptions ending in abortion and provides insight into access to pregnancy decision-making support and early abortion services.

In Cumberland, the proportion is consistent with regional and national patterns, indicating comparable access to services once pregnancy occurs.

- In 2022, 48 females under 18 living in Cumberland had an abortion, representing 64.9% of under-18 conceptions.
- The is similar to the England average (58.2%).

Recommendations:

- Strengthen targeted prevention activity in areas of higher deprivation or limited youth provision.

- Ensure young people can access timely, confidential contraception, testing and advice through a range of accessible settings.
- Strengthen collaboration between ISHS, school nursing and education settings to ensure consistent messaging and clear access routes.
- Implement targeted, place-based interventions in wards with significantly higher under-18 conception rates, reviewing current provision to identify strengths and gaps.

5.5. Screening and Immunisation

5.5.1. HPV Vaccination

Human papillomavirus (HPV) vaccination is a key component of reproductive health prevention, reducing the risk of cervical cancer and other HPV-related cancers, as well as genital warts. Uptake varies nationally and locally, influenced by deprivation, rurality and engagement with school-based delivery. Lower coverage can contribute to future inequalities in HPV-related disease.

Although the HPV vaccination programme is commissioned and delivered by NHS England through the school immunisation system, local authorities play an important supporting role. This includes understanding variation in uptake, identifying inequalities across places and population groups, and working with partners to support engagement where coverage is lower.

The HPV vaccination programme was previously offered only to females but has been routinely offered to all young people in school Year 8 (aged 12–13) since 2019. Catch-up is available up to age 25 for those who miss the routine dose. Additional eligibility applies to GBMSM up to age 45, and to trans people based on individual risk. Delivery is primarily through the school-based programme, with catch-up via primary care and sexual health services for eligible groups. In Cumberland, rurality, school absence and transport barriers may affect access to catch-up opportunities and contribute to variation in uptake between cohorts.

Local patterns of deprivation, rural geography and school attendance may influence vaccination uptake. Understanding variation by place and socioeconomic status is therefore important to maximise population-level protection. With the availability of more recent data, coverage can now be examined separately for males and females and at local authority level for Westmorland and Furness and Cumberland, enabling a more detailed understanding of variation and inequalities in uptake.

- In Cumbria, 2,314 young females aged 12-13 received one dose of HPV vaccination in 2023-24, representing coverage of 81.6%.
- More recent data (2024-25) allow analysis of uptake by sex and by local authority, highlighting differences in coverage between males and females and across places. Vaccination coverage in Cumberland was 75.3% for females and 70.3% for males.
- This coverage is slightly higher than the national average, and overall uptake is generally strong, but it does not consistently meet the national 90% ambition across all cohorts and areas. Trend data is not yet available.

Recommendations

- Recognise that commissioning and delivery of the HPV vaccination programme sits with NHS England, while local authorities support uptake through identifying inequalities and facilitating partnership working
- Use newly available data on uptake by sex and local authority to monitor differences between males and females, including teenage boys and eligible groups such as GBMSM

- Use local data, including deprivation and place-based analysis, to identify variation in uptake and support targeted engagement with schools, communities and population groups where coverage is lower, to improve coverage towards the 90% ambition.
- Support clear, consistent messaging through local authority-commissioned services and education settings to address misinformation and vaccine hesitancy and reinforce the long-term cancer prevention benefits of HPV vaccination.

5.5.2. Cervical Screening

Cervical screening is a national prevention programme that reduces cervical cancer incidence and mortality through early identification and treatment of precancerous changes. Uptake is strongly patterned by deprivation, age and access barriers, with rurality, transport challenges and digital exclusion contributing to lower participation in some areas.

In Cumberland, participation in cervical screening is shaped by these same structural factors. Rural geography and travel distance to appointments may affect access for some residents, while uptake may also vary by age and socioeconomic status.

National policy developments are also relevant to future access. NHS England is piloting HPV self-sampling as part of the cervical screening programme, with the aim of increasing uptake among individuals who do not attend conventional appointments. This approach has potential to reduce barriers related to convenience, stigma and access, particularly for people in rural or less well-served communities, although arrangements for wider rollout and local implementation are still emerging.

Cervical screening is commissioned and delivered by NHS England rather than through local authority sexual health commissioning arrangements. While integrated sexual health services have an important role in opportunistic health promotion and signposting, direct commissioning responsibility lies outside local authority control, requiring effective partnership working across system boundaries to support access, follow-up and equity.

Cervical Screening Coverage (2024)

Women aged 25-49 years

- 31,368 women in Cumberland (74.4%) were adequately screened within the previous 3.5 years.
- This represents a small increase from 2023 (73.7%) (not statistically significant), and remains statistically significantly higher than both the North West average (67.1%) and England average (66.1%). Coverage in Cumberland is the second highest in the region.

Women aged 50-64 years

- 22,078 women (76.4%) were adequately screened within the previous 5.5 years.
- The represents a small decrease from 2023 (77.1%) (not statistically significant), but coverage remains higher than the North West average (73.2%) and England average (74.3%).

Whilst coverage remains comparatively favourable, the national target of 80% uptake has not been achieved in either age group.

Recommendations

- Support promotion of cervical screening through sexual health services, primary care and community partners, particularly for groups less likely to engage through routine invitations.

- Monitor developments from the national HPV self-sampling pilot and consider implications for local implementation to improve access and choice as national policy evolves.
- Maintain strong collaboration between NHS England, primary care and locally commissioned services to support joined-up approaches to prevention, follow-up care and reduction of inequalities across system boundaries.

5.6. Women's Reproductive Health Across the Life Course

Beyond contraception and screening, women's reproductive health needs encompass a range of conditions across the life course, including menstrual disorders, endometriosis, fertility challenges, pregnancy loss, perinatal mental health needs and menopause. Many of these conditions are long-term or episodic and can have a substantial impact on wellbeing, participation in education and employment, and quality of life, requiring timely diagnosis, continuity of care and effective coordination across services.

While not all aspects of women's reproductive health fall within the scope of local authority-commissioned sexual health services, local understanding of need and clear signposting to appropriate support remain essential. Primary care, maternity services, gynaecology, mental health services and voluntary and community sector organisations all play key roles, and effective pathways between them are critical to reducing fragmentation and improving access.

National policy emphasises a whole-system, life-course approach to women's health. The renewed Women's Health Strategy highlights persistent concerns about variation in access, fragmented pathways and women's experiences of pain being dismissed, reinforcing the importance of respectful, trauma-informed care and integrated service models. These priorities are particularly relevant to local sexual and reproductive health services, where women may present for related care or require onward referral.

In Cumberland, structural factors such as rurality, transport barriers, digital exclusion and capacity pressures in primary and specialist services are likely to compound access challenges for some women. These factors underline the importance of coordinated, inclusive approaches that support timely referral and continuity of care.

Although sexual health services do not deliver many specialist reproductive health interventions, they play an important role in health promotion, early identification of need, safeguarding and navigation of onward pathways. Strengthening coordination between integrated sexual health services, primary care and specialist providers can support a more timely, person-centred experience and contribute to improved outcomes for women across the life course.

Recommendations

- Maintain a life-course approach to women's reproductive health, ensuring prevention, early identification and clear signposting to support are embedded across services, even where delivery responsibilities sit outside sexual health commissioning.
- Protect continuity and equity during system change, recognising that national and local reforms and evolving commissioning arrangements may affect service coordination and access, and ensuring women's health priorities remain visible throughout transition.
- Strengthen partnership working across the local system, including ICBs, primary care, sexual health services, specialist pathways and the voluntary and community sector, to support joined-up care and reduce fragmentation.
- Focus on addressing structural barriers to access - including rurality, transport constraints, digital exclusion and workforce capacity which disproportionately affect women's ability to engage with reproductive health services across the life course.
- Use local intelligence and engagement to inform action, ensuring emerging needs, inequalities and service pressures are identified early and considered in future system planning.

5.7. Violence, Trauma and Sexual Heath

Violence and trauma have profound and long-lasting impacts on sexual, reproductive and mental health. Sexual health services form an important part of the wider system response through prevention, safeguarding, aftercare, testing, emergency contraception, referral and signposting. Understanding patterns of violence and access to support is therefore relevant to SHNA, even where core responsibilities sit outside local authority commissioning.

5.7.1. Sexual Offences and Aftercare Pathways

This indicator reflects the rate of police-recorded sexual offences per 1,000 population. While policing itself sits outside the direct remit of public health, local authorities and the NHS play a critical role in the delivery and coordination of sexual assault support and aftercare services. National strategy, including the *Violence Against Women and Girls Strategy* (Home Office, 2025), emphasises coordinated, multi-agency approaches to prevention, protection and survivor support.

The rate of recorded sexual offences in Cumberland is higher than the national average, and data suggests a stable trend. As outlined in Section 4, rurality, social isolation and limited access to specialist services may compound vulnerability and influence help-seeking behaviour.

These factors underline the importance of ensuring that survivors can access timely, trauma-informed care and clear referral pathways regardless of where they live.

- In 2024/25, 946 sexual offenses were recorded in Cumberland, a rate of 3.4 per 1,000 population.
- The rate is higher than the England average of 3.1 per 1,000, but statistically similar to the regional average of 3.4 per 1,000.
- The overall trend is stable.

The number of recorded sexual offences reinforce the need for accessible sexual assault support services, including rapid access to Sexual Assault Referral Centres (SARCs), emergency contraception, STI testing, psychological support and safeguarding pathways.

In Cumbria, *The Bridgeway* provides the regional SARC service, offering forensic examination, crisis support, safeguarding liaison and referral into ongoing care. However, rural geography and transport barriers may limit access for some residents, increasing the importance of strong partnership working and clear referral mechanisms.

The SARC sits within a wider sexual assault pathway that includes health and social care, psychological therapies, the criminal justice system and the voluntary and community sector. Effective system-wide coordination is therefore essential to ensure safe, timely and person-centred responses. Strengthening links between The Bridgeway, ISHSs, primary care, mental health services and safeguarding partners supports a more holistic response and helps enable follow-up care closer to home where appropriate.

Recommendations:

- Strengthen links between ISHS, SARCs, mental health services and safeguarding partners to support timely, trauma-informed care pathways.
- Ensure pathways for people involved in sex work or exploitation are clear, accessible and well supported.
- Explore evidence-based approaches to primary prevention of sexual violence, working with relevant partners where appropriate.

5.8. Psychosexual and Psychological Support

Local insight highlights significant gaps in access to psychosexual and psychological support in Cumberland, particularly for people experiencing trauma, asylum seekers, survivors of sexual violence and individuals with complex relationship or sexual wellbeing needs. Provision is not consistent across the area, and services can be difficult to access for residents facing transport or digital barriers.

There is clear unmet need for specialist psychosexual support locally. At present, no commissioned psychosexual service is available within Cumberland, and the primary regional provider reports limited capacity to accept additional referrals. Commissioning responsibility for psychosexual provision sits largely with NHS partners, which constrains direct local authority action.

Despite this, the absence of accessible psychosexual support risks leaving individuals without appropriate care, particularly where needs fall between sexual health services and wider mental health provision. Maintaining system-wide awareness of this gap, alongside continued dialogue with NHS partners, is important for supporting holistic sexual wellbeing and trauma-informed care.

Recommendations:

- Highlight the gap in psychosexual and psychological support, and associated clinical and wellbeing risks, to NHS commissioning partners through established governance and assurance routes.
- Strengthen signposting to alternative sources of support where appropriate, including integrated sexual health services, mental health services, and voluntary and community sector provision.
- Work with NHS partners to explore future commissioning options as capacity, resources or system opportunities emerge.

6. Population Groups at Higher Risk of Unmet Need

Consistent with the principle of proportionate universalism, this assessment recognises the importance of maintaining universal sexual health provision alongside additional, targeted approaches for populations experiencing higher levels of risk or structural disadvantage.

Local intelligence, service activity and national evidence indicate that some population groups face additional barriers to accessing sexual and reproductive health services and are therefore at increased risk of unmet need or poorer outcomes. These barriers are largely structural rather than individual and include rurality, stigma, digital exclusion, transport constraints, safeguarding concerns and the challenges of navigating fragmented service pathways.

Population groups identified as being at higher risk of unmet sexual and reproductive health need include:

- Young people, particularly those living in rural or isolated areas
- Looked after children (LAC) and care-experienced young people (CEYP)
- LGBTQ+ populations, particularly those not connected to community networks
- GBMSM
- People experiencing domestic or sexual violence
- Asylum seekers, refugees and other migrants
- People involved in sex work or experiencing sexual exploitation
- Individuals with complex psychosocial needs
- Gypsy, Roma and Traveller (GRT) communities
- People with disabilities, including people with learning disabilities

These groups may require more flexible, trauma-informed, culturally sensitive or outreach-based approaches to ensure equitable access. Many face barriers that make traditional clinic-based or appointment-led service models harder to access, increasing the likelihood that need remains unmet or is poorly captured in routine activity data.

6.1. Young People

Young people face specific barriers including confidentiality concerns, limited transport options, digital exclusion and reduced availability of youth-friendly provision, particularly in rural areas. Early intervention, accessible testing and prevention are critical to reducing rates of STIs, unplanned pregnancy and poorer long-term sexual health outcomes.

6.2. LGBTQ+ Populations

While improved intelligence is emerging through inclusion of sexual orientation in the 2021 Census, accurate local population estimates remain limited. National evidence shows higher rates of STI diagnoses among some LGBTQ+ populations, alongside barriers related to stigma, concerns about confidentiality, and variable visibility and inclusivity of services.

6.3. Black, Asian and Minority Ethnic (BAME) Communities

National surveillance data indicate higher rates of STI diagnoses among people from some Black ethnic backgrounds. BAME GBMSM are also more likely than other GBMSM to experience HIV and other STIs and may face intersecting barriers related to racism, stigma, cultural factors and reduced access to culturally competent services.

6.4. Looked After Children and Care-Experienced Young People

Looked after children and care-experienced young people experience disproportionate risk of poorer sexual health outcomes, often linked to trauma, disrupted education and reduced access to trusted adults and services. Commissioned services should be accessible, trauma-informed and responsive to safeguarding and support needs.

6.5. Migrants, Asylum Seekers and Refugees

Migrants, asylum seekers and refugees may face barriers including uncertainty around entitlement to care, fear of data sharing, language and cultural barriers, and limited access to wider psychological or social support. These factors may delay engagement with sexual health services and contribute to unmet need that is not visible in routine datasets.

6.6. People Involved in Sex Work or Sexual Exploitation

People involved in sex work or experiencing exploitation may be exposed to heightened sexual health risk due to multiple partners, violence, poverty and substance use. Stigma, fear of disclosure and safeguarding concerns can deter engagement, highlighting the importance of confidential, non-judgemental access routes and specialist outreach.

6.7. Survivors of Sexual or Domestic Abuse

Survivors of sexual or domestic abuse may require sensitive, trauma-informed sexual health care, including access to emergency contraception, STI testing, ongoing support and safeguarding pathways. Fear, stigma and safety concerns may delay presentation or limit engagement with routine services.

6.8. People in Secure or Detained Settings

Higher rates of STIs are reported among people in prisons and other secure settings. This reflects both pre-custody risk factors and barriers to prevention, testing and continuity of care during detention and following release.

6.9. Gypsy, Roma and Traveller Communities

Gypsy, Roma and Traveller communities may face challenges accessing sexual and reproductive health services due to cultural norms, stigma, literacy barriers and historical experiences of discrimination. Sexual health, gynaecological issues and pregnancy-related care may be particularly sensitive, requiring trust-based and culturally appropriate approaches.

6.10. People Living in Rural or Isolated Communities

People living in rural areas may be disadvantaged by remoteness, limited public transport and reduced availability of specialist services. In Cumberland, approximately 53% of residents live in rural areas compared with around 18% nationally. Service models must therefore reflect the dispersed geography and differing needs across rural and urban communities.

6.11. People with Disabilities

People with disabilities, including those with learning disabilities, are identified as a priority population due to persistent inequalities in access to sexual and reproductive health information, services and support. Barriers relating to accessibility, communication, assumptions about sexual activity and safeguarding can result in unmet need, reduced uptake of prevention and delayed presentation. Inclusion of this group reflects the need for accessible, inclusive and trauma-informed provision rather than increased biological risk.

6.12. People Experiencing Multiple Disadvantage

People experiencing multiple disadvantage are recognised as a cross-cutting priority group. This includes individuals facing overlapping challenges such as homelessness, substance use, mental ill health, trauma, poverty, insecure immigration status or involvement with the criminal justice system. These intersecting factors can significantly limit access to sexual and reproductive health services, particularly those reliant on appointment-led, digital or clinic-centred models. Unmet need for this group may be high but poorly captured in routine data, requiring flexible, trauma-informed, outreach-based and system-wide responses rather than isolated condition-specific interventions.

Recommendations

- Use local intelligence to understand access and uptake, including identifying where population groups are under-represented in service data.
- Design services flexibly, using a combination of clinic-based, outreach, postal and digital models to reflect local geography and population needs.
- Embed trauma-informed and culturally sensitive practice, particularly for people affected by violence, exploitation, migration-related stress or historical exclusion.
- Strengthen engagement with community and voluntary sector partners to support trust-building, outreach and care navigation for seldom-heard groups.
- Monitor equity of access alongside overall performance, recognising that favourable aggregate indicators may mask variation between communities.

7. Relationship, Sex and Health Education (RSHE) and Prevention Context

Statutory Relationships, Sex and Health Education (RSHE) has been mandatory in secondary schools in England since September 2020. Evidence indicates that high-quality, inclusive RSHE can contribute to improved sexual health outcomes when it is delivered consistently and is linked to accessible contraception, condom provision and confidential sexual health services.

In Cumbria, condoms are provided through integrated sexual health services and some community settings. However, comprehensive data on condom distribution across educational, community and informal settings are not routinely available. Limited visibility of distribution patterns makes it more difficult to assess reach, equity of access and the extent to which prevention activity is aligned with areas of greatest need.

RSHE is most effective when delivered as part of a whole-system prevention approach, linking schools, youth services, community partners and clinical provision. Clear pathways between education and sexual health services support earlier engagement, reduce stigma and help ensure that prevention messages translate into practical access to testing, condoms and contraception.

Access to condoms remains particularly important for young people, including those living in rural areas or facing barriers related to transport, confidentiality or digital access. Ensuring that condoms are available through a range of settings supports safer sex, dual protection (against both STIs and unintended pregnancy), and wider health-promotion goals.

There is also an opportunity to strengthen the prevention offer for young people through the development of high-quality, web-based sexual health resources aligned with local services. Digital resources can support consistent messaging, offer privacy and flexibility, and extend reach in rural or underserved areas, provided they complement rather than replace face-to-face education and access to services. Any local digital development should align with wider digital transformation ambitions and ensure accessibility for young people who may be digitally excluded.

National statutory guidance for RSHE may be subject to future update. Maintaining a flexible, system-wide approach will be important to ensure local sexual health services, education settings and prevention activity can respond effectively to any changes, while continuing to support evidence-based, inclusive and age-appropriate provision.

Recommendations:

- Support schools to deliver evidence-based RSHE that is inclusive, age-appropriate and linked to clear pathways into youth-friendly sexual health and contraception services.
- Explore opportunities to align local digital sexual health resources with RSHE delivery in schools, ensuring content complements in-person education and links clearly to local services.
- Incorporate high-quality web-based and digital RSHE resources into wider prevention approaches, while ensuring non-digital routes remain available.
- Consider condom provision as part of coordinated outreach and prevention activity for young people through the system-wide Sexual Health Quality and Innovation Group. Condoms should be accessible across a range of educational, clinical and community settings where appropriate.
- Monitor condom provision targeted at GBMSM and adult populations to ensure services are appropriately targeted and equitable.
- Support all relevant services and local partners, including community pharmacies, to reinforce condom provision and promote dual protection messaging alongside contraception.

8. Strategic Summary and Recommendations

This section synthesises the key findings of the SHNA and sets out strategic priorities to inform commissioning, service design and system development. It brings together epidemiological evidence, demographic context and qualitative insight to highlight priority needs, emerging risks and system-wide opportunities for improvement.

8.1. Priority Needs and Risks

The assessment identifies several priority needs and risks that should shape future sexual and reproductive health commissioning in Cumberland.

Although many headline indicators compare favourably with regional and national averages, Cumberland continues to experience low chlamydia screening and detection rates among young people**,** alongside low testing rates for other STIs and HIV. This limits opportunities for early diagnosis and prevention of onward transmission. Underdiagnosis of STIs remains a risk, influenced by rurality, transport barriers, digital exclusion and reduced access to face-to-face services.

Emerging epidemiological trends, both locally and nationally require close attention. Rising syphilis diagnoses and increases in new HIV diagnoses (including those first diagnosed abroad), albeit from a low baseline, suggest developing transmission risks and reinforce the importance of sustained surveillance, targeted prevention, accessible testing pathways and appropriate service provision for those testing positive to ensure timely access to effective treatment.

Structural and demographic factors strongly influence access. A highly rural geography**,** older population profile and marked variation in deprivation contribute to unequal access and variation in outcomes between communities. Transport barriers, digital exclusion and workforce constraints further limit timely engagement, particularly for services requiring face-to-face care.

Qualitative insight highlights additional unmet needs not fully visible in routine data, including increasing complexity among service users, barriers faced by asylum seekers and refugees, gaps in psychosexual and psychological support, and vulnerabilities associated with sex work, exploitation and trauma. Aggregated indicators may therefore underestimate need among some populations.

LARC uptake is particularly strong in Cumberland. However, uptake may be uneven due to workforce capacity and geographic variation in provision. Similarly, although the uptake of other preventative programmes, such as HPV vaccination and cervical screening is higher than the national average – it remains below target.

Hidden unmet need persists among groups facing multiple disadvantage, including migrants, asylum seekers, LGBTQ+ residents, sex workers and survivors of trauma. Pathways across sexual health, primary care, mental health and safeguarding remain fragmented, and workforce sustainability challenges continue across both ISHS and primary care.

8.2. System-wide Recommendations

The assessment identifies several cross-cutting system priorities that underpin effective and equitable sexual and reproductive health provision. These priorities reflect the commissioning cycle of assessing need, planning proportionate responses, implementing services across system boundaries and evaluating impact over time:

- Services should be designed around access, recognising that rurality, transport constraints, digital exclusion and workforce capacity are key determinants of engagement and outcomes.
- Prevention and early intervention should be prioritised across the system, with a focus on testing, screening, vaccination and contraception.

- Services should adopt trauma-informed, culturally sensitive and inclusive approaches, particularly for populations experiencing violence, exploitation, migration-related stress or multiple disadvantage.
- Whole-system collaboration across local authorities, the NHS, education, and the voluntary and community sector is essential to reduce fragmentation, improve navigation and strengthen prevention.

Recommendations

1. Improve access to testing and early diagnosis, particularly for chlamydia, other STIs and HIV, including consistent partner notification and attention to reinfection patterns as part of routine quality-improvement. *(Local authority commissioning responsibility; provider service model; ICB pathway alignment)*
2. Improve access for young people, including clear rapid-access routes into contraception for those at higher risk or facing barriers to routine care.
3. Maintain a flexible, blended model of care combining clinic-based, outreach, postal and digital routes *(Provider service model; local authority service specification)*
4. Protect and strengthen non-digital access routes to avoid widening inequalities *(Local authority commissioning responsibility; provider service model; equality duty)*
5. Strengthen trauma-informed and culturally competent practice across the system *(Provider workforce development; safeguarding and quality standards)*
6. Improve pathway integration across sexual health, primary care, mental health, safeguarding and substance use services *(ICB pathway alignment; multi-agency partnership agreements; local authority commissioning responsibility)*
7. Enhance the use of qualitative insight to identify hidden unmet need, particularly for groups poorly represented in routine data *(Local authority commissioning responsibility; provider service model; continuous improvement framework)*
8. Monitor national developments relating to antimicrobial resistance and emerging vaccination evidence (including MenB cross-protection), ensuring local commissioning remains aligned with JCVI and UKHSA guidance *(National policy alignment; local authority commissioning responsibility; provider clinical governance)*

8.3. Implications for Commissioning and Service Design

The commissioning of a new ISHS for Cumbria presents a significant opportunity to address the needs and risks identified in this assessment. Emerging national policy and local devolution arrangements may strengthen local levers for prevention, digital inclusion and workforce planning.

Future service models should:

- Embed flexible, blended access models, combining clinic-based, outreach, postal and digital routes, while ensuring non-digital options remain protected for residents affected by digital exclusion or unstable accommodation.
- Strengthen testing and screening pathways, particularly for chlamydia and HIV, through opportunistic testing, outreach and improved integration with existing service touchpoints.
- Support equitable access to contraception, including sustained LARC capacity and clear, navigable pathways for routine and emergency contraception.
- Address workforce sustainability through training, skill-mix development and system-wide planning.
- Improve service coordination and pathway integration across commissioning boundaries, reducing reliance on individuals to navigate complex systems independently.
- Ensure commissioning expectations explicitly consider equity, inclusion and safeguarding, particularly for groups at higher risk of unmet need.

Recommendations

1. Ensure sufficient capacity for LARC, PrEP, HIV testing and chlamydia screening within the new service model *(Local authority commissioning responsibility; provider service model; workforce planning)*
2. Embed outreach and targeted engagement for groups at higher risk of unmet need, including rural communities, young people, migrants and people experiencing multiple disadvantage *(Local authority commissioning responsibility; provider service model; public health improvement duty)*
3. Strengthen digital inclusion by ensuring postal testing, online booking and remote advice are accessible, while maintaining equitable face-to-face provision *(Provider service model; digital access standards; equality duty)*
4. Improve data flows and interoperability across providers, primary care and ICB systems to support pathway alignment and reduce fragmentation *(ICB pathway alignment; digital infrastructure; provider reporting requirements)*
5. Build trauma-informed, psychologically informed environments into service design, particularly for people affected by violence, exploitation or migration-related stress *(Provider service model; safeguarding and quality standards)*

8.4. Monitoring, Evaluation and Future Data Development

Ongoing monitoring and evaluation will be critical to understanding the impact of service transformation and ensuring that sexual and reproductive health services remain responsive to changing need. Future evaluation approaches should consider both quantitative outcomes and qualitative experience, consistent with logic-based and theory-of-change approaches commonly used in public health commissioning.

Key priorities include:

- Monitoring testing, screening, vaccination and contraception uptake alongside equity indicators such as age, deprivation, rurality and protected characteristics, where data allow.
- Systematically incorporating qualitative insight from service users, providers and communities to identify unmet need not visible in routine datasets.
- Recognising the limitations of aggregated data and using triangulation across multiple sources to inform interpretation and commissioning decisions.
- Supporting the development of improved local intelligence where national commissioning arrangements limit data granularity.
- Maintaining flexibility to respond to emerging trends, policy changes and evolving population needs, including developments in digital delivery and education guidance.

Recommendations

1. Strengthen routine monitoring of access, uptake and outcomes across digital, postal and face-to-face routes
   (Provider reporting requirements; local authority commissioning responsibility)
2. Improve the availability of rurality-adjusted access metrics (e.g. travel time, transport barriers, digital exclusion)
   (Local authority commissioning responsibility; data development)
3. Enhance monitoring of PrEP pathways, postal testing utilisation and appointment utilisation to identify emerging access barriers
   (Provider reporting requirements; continuous improvement framework)
4. Incorporate regular cycles of qualitative insight (service users, staff and stakeholders) to complement routine data and identify hidden unmet need
   (Local authority commissioning responsibility; provider service model)

5. Maintain alignment with national surveillance, JCVI guidance and UKHSA reporting requirements, particularly in relation to antimicrobial resistance and emerging infections
(National policy alignment; provider clinical governance)

Summary

These overarching recommendations provide a clear framework for strengthening prevention, improving access and reducing inequalities across the sexual and reproductive health system in Cumberland.

Priority Area	Recommendation	Lead Role	Timescale
HIV	Increase routine opt-out HIV testing across ISHS activity and agreed partner pathways (including integration with relevant NHS services)	Local Authority / Provider / ICB	Year 1
HIV	Improve awareness and equitable access to PrEP, with targeted engagement for groups at higher risk and rural residents	Provider / Local Authority	Years 1–2
Chlamydia	Expand opportunistic and outreach-based chlamydia testing for young people, including non-digital routes	Provider	Year 1
STIs (general)	Maintain surveillance and targeted prevention for emerging risks (e.g. syphilis), aligned with national guidance	Provider / Local Authority	Ongoing
Access and Equity	Deliver blended access models (clinic, outreach, postal and digital), protecting non-digital routes	Provider / Local Authority	Year 1
Access and Rurality	Review clinic locations, timing and outreach provision to improve access in rural and isolated communities	Provider / Local Authority	Years 1–2
Contraception	Maintain and increase equitable access to LARC, including reducing waits and geographic variation	Local Authority / Provider / ICB	Ongoing
Workforce	Expand LARC skills and competencies across primary care and ISHS through training and support	ICB / PCNs / Provider	Years 1–2
Workforce	Strengthen workforce resilience through skill-mix development and system-wide planning	Local Authority / ICB / Provider	Years 1–3
Trauma and Safeguarding	Embed trauma-informed practice across sexual health services, including clear safeguarding pathways	Provider / Local Authority	Year 1
Priority Populations	Deliver targeted engagement and outreach for groups at higher risk of unmet need (e.g. young people, migrants, LGBTQ+, people experiencing multiple disadvantage)	Provider / Local Authority	Years 1–2
Integration	Strengthen pathway integration between sexual health, primary care, mental health, safeguarding and community services	Local Authority / ICB / Provider	Years 1–2
Data and Assurance	Improve use of qualitative insight and activity data to identify hidden unmet need and monitor equity	Local Authority / Provider	Ongoing
System Governance	Use the Sexual Health Quality and Innovation Group to oversee delivery, quality improvement and system assurance	Local Authority / ICB / Provider	Ongoing

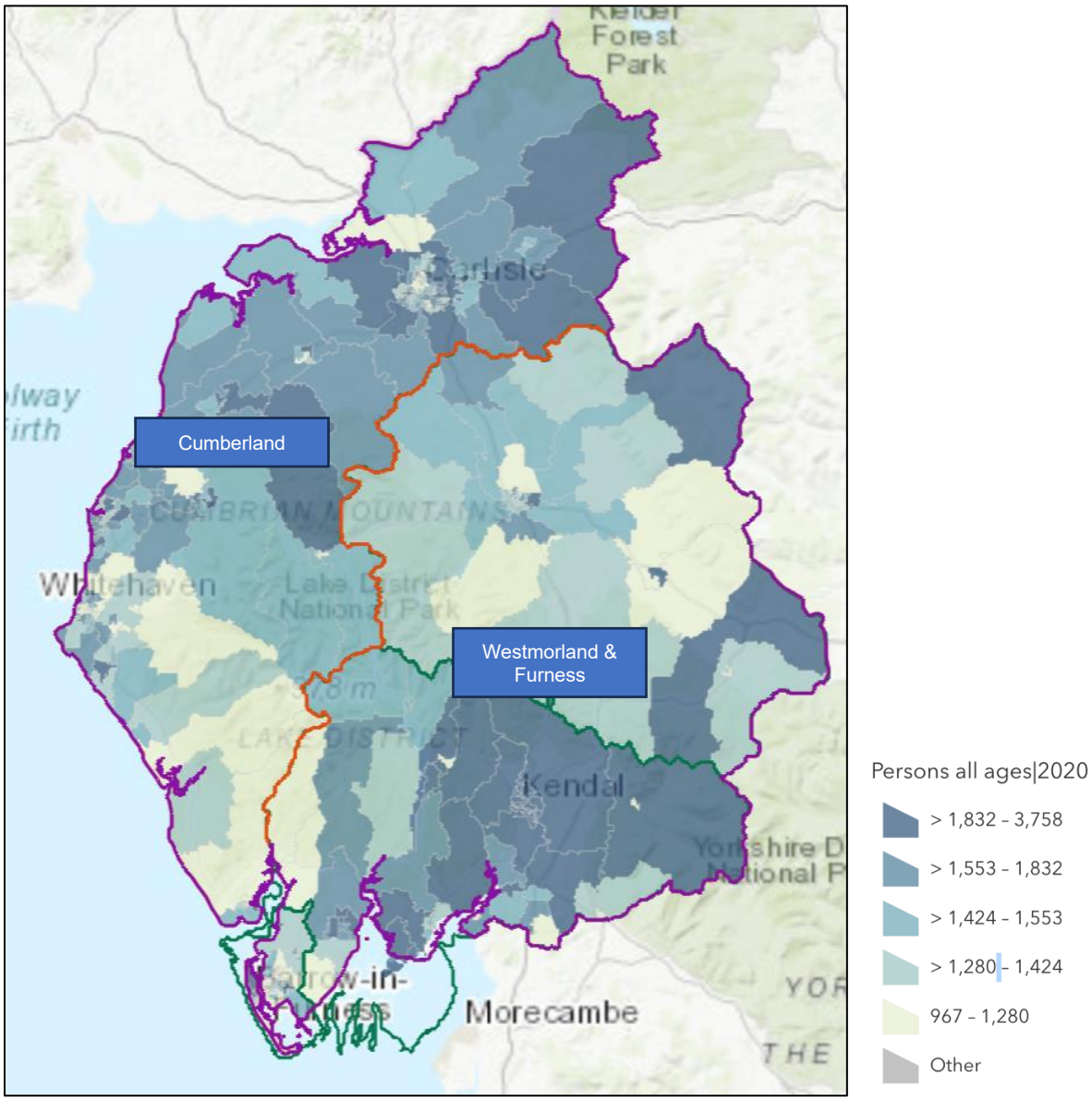
Appendix A: Population Profile

Figure A1 shows the age distribution of Cumberland compared with England and provides essential demographic context for interpreting sexual and reproductive health indicators presented in this assessment.

Figure A1: Cumberland percentage of population by 5-year age groups (2024)

Source: www.cumbriaobservatory.org.uk

Figure A2: Cumbria Population Density LSOA 2011 (2020)
Estimates of the usual resident population in England and Wales for all persons (males and females) of all ages



Source: www.cumbriaobservatory.org.uk

Appendix B: Deprivation Analysis

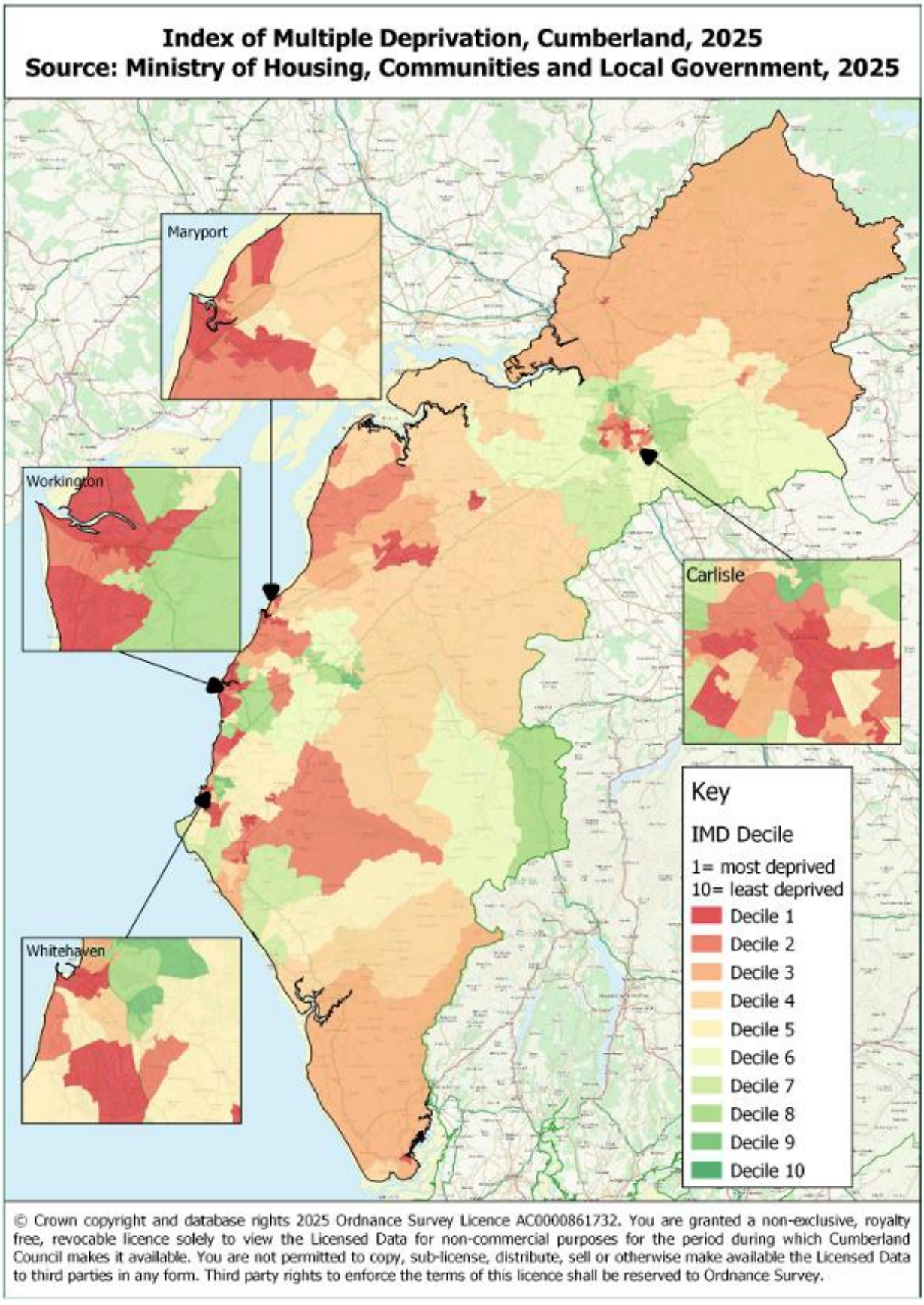
Deprivation by Lower Super Output Area

Figure B1 shows the distribution of multiple deprivation across Lower Super Output Areas (LSOAs) in Cumberland, shaded according to Index of Multiple Deprivation (IMD) deciles. LSOAs shaded in red represent areas in IMD Decile 1 (the 10% most deprived areas nationally), while those shaded in dark green represent IMD Decile 10 (the 10% least deprived areas in England).

The map demonstrates marked variation in deprivation within Cumberland, with some neighbourhoods among the most deprived in England, alongside areas of relatively low deprivation. This pattern highlights the importance of interpreting local sexual and reproductive health indicators below the aggregate local authority level.

Deprivation is a significant determinant of sexual and reproductive health need, influencing exposure to risk, access to services, health-seeking behaviour and outcomes. As described throughout this assessment, favourable local authority-level indicators may mask higher levels of unmet need in more deprived communities. Incorporating deprivation into interpretation is therefore essential for identifying inequalities, understanding where access barriers are greatest, and informing proportionate, targeted service planning.

Figure B1: Deprivation by Lower Super Output Area Cumberland



Appendix C: Sexual Health Indicator Data and Trends

The figures that follow show the latest available data for Cumberland, alongside benchmark comparisons with England and the North West. For some indicators where local trend data are limited, Cumbria-level information has also been included to provide a more complete view of historical patterns. Findings should be interpreted in the context of access, equity and system capacity, which are explored in Section 4.

Some figures present sexual and reproductive health indicators disaggregated by Index of Multiple Deprivation (IMD) decile. These charts illustrate how indicators vary across levels of deprivation and help identify inequalities that may not be visible in aggregate data. They should be interpreted alongside the access, equity and system capacity considerations described in Section 4. Patterns observed across deprivation deciles reinforce the importance of an equity-focused approach to sexual and reproductive health planning in Cumberland. Differences by deprivation highlight where unmet need may be greatest and where targeted, outreach-based or enhanced access models may be required.

This section supports the interpretation of detailed findings in Section 5 and informs the priority population groups and system-wide recommendations set out in Sections 6 and 8.

All indicator data is publicly available and has been sourced from:

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

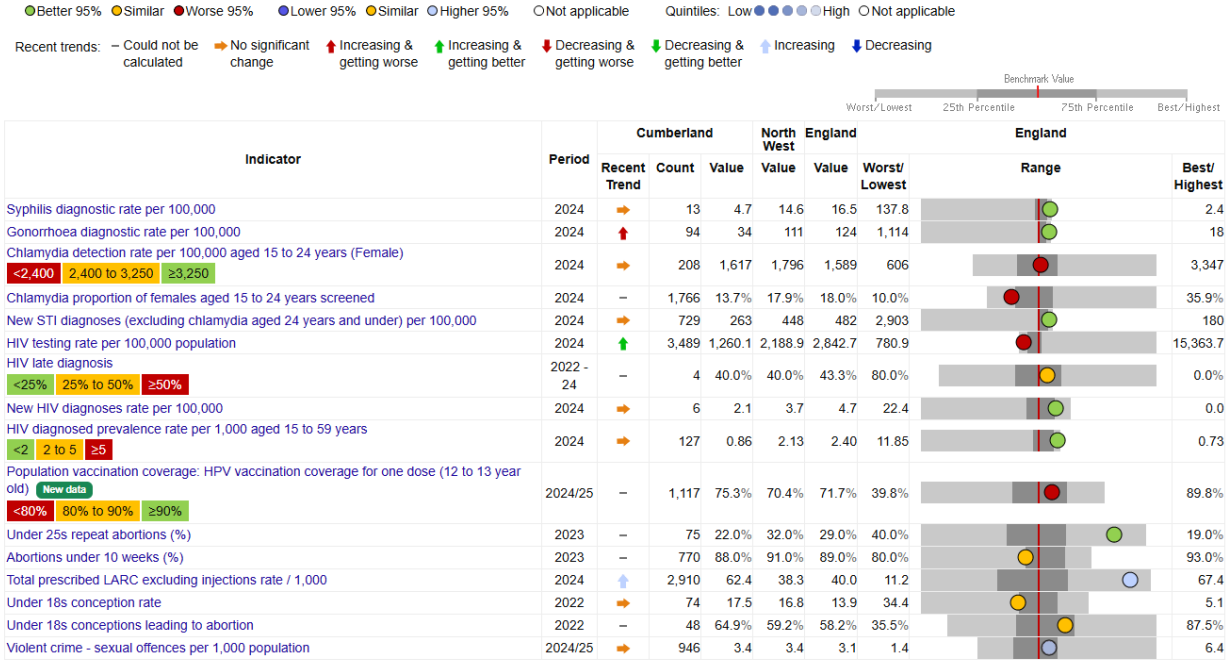
Legend:

Better 95% | Similar | Worse 95% | Lower 95% | Higher 95% | Not compared

(unless otherwise specified)

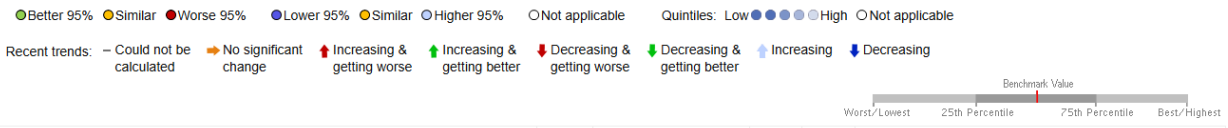
— England

Figure C1: Sexual and Reproductive Health Profile - Cumberland with England benchmark



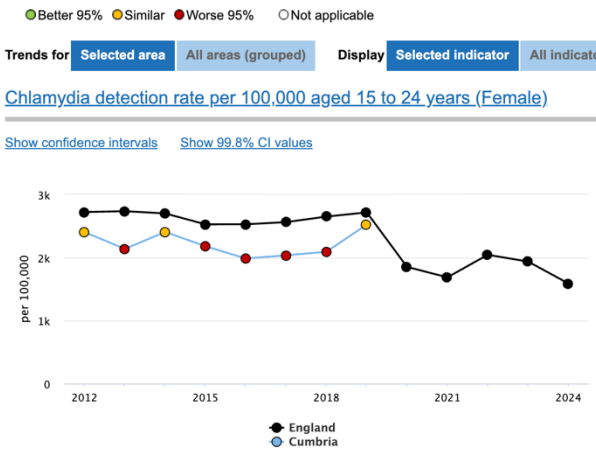
Indicator	Period	Cumberland			North West	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Syphilis diagnostic rate per 100,000	2024	→	13	4.7	14.6	16.5	137.8		2.4
Gonorrhoea diagnostic rate per 100,000	2024	↑	94	34	111	124	1,114		18
Chlamydia detection rate per 100,000 aged 15 to 24 years (Female) <2,400 | 2,400 to 3,250 | ≥3,250	2024	→	208	1,617	1,796	1,589	606		3,347
Chlamydia proportion of females aged 15 to 24 years screened	2024	–	1,766	13.7%	17.9%	18.0%	10.0%		35.9%
New STI diagnoses (excluding chlamydia aged 24 years and under) per 100,000	2024	→	729	263	448	482	2,903		180
HIV testing rate per 100,000 population	2024	↑	3,489	1,260.1	2,188.9	2,842.7	780.9		15,363.7
HIV late diagnosis <25% | 25% to 50% | ≥50%	2022 - 24	–	4	40.0%	40.0%	43.3%	80.0%		0.0%
New HIV diagnoses rate per 100,000	2024	→	6	2.1	3.7	4.7	22.4		0.0
HIV diagnosed prevalence rate per 1,000 aged 15 to 59 years <2 | 2 to 5 | ≥5	2024	→	127	0.86	2.13	2.40	11.85		0.73
Population vaccination coverage: HPV vaccination coverage for one dose (12 to 13 year old) New data <80% | 80% to 90% | ≥90%	2024/25	–	1,117	75.3%	70.4%	71.7%	39.8%		89.8%
Under 25s repeat abortions (%)	2023	–	75	22.0%	32.0%	29.0%	40.0%		19.0%
Abortions under 10 weeks (%)	2023	–	770	88.0%	91.0%	89.0%	80.0%		93.0%
Total prescribed LARC excluding injections rate / 1,000	2024	↑	2,910	62.4	38.3	40.0	11.2		67.4
Under 18s conception rate	2022	→	74	17.5	16.8	13.9	34.4		5.1
Under 18s conceptions leading to abortion	2022	–	48	64.9%	59.2%	58.2%	35.5%		87.5%
Violent crime - sexual offences per 1,000 population	2024/25	→	946	3.4	3.4	3.1	1.4		6.4

Figure C2: Sexual and reproductive health profile - Cumberland with North West benchmark



Indicator	Period	Cumberland			North West	England	North West		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Syphilis diagnostic rate per 100,000	2024	→	13	4.7	14.6	16.5	45.1		3.1
Gonorrhoea diagnostic rate per 100,000	2024	↑	94	34	111	124	272		32
Chlamydia detection rate per 100,000 aged 15 to 24 years (Female) <2,400 | 2,400 to 3,250 | ≥3,250	2024	→	208	1,617	1,796	1,589	1,211		3,347
Chlamydia proportion of females aged 15 to 24 years screened	2024	–	1,766	13.7%	17.9%	18.0%	11.5%		29.8%
New STI diagnoses (excluding chlamydia aged 24 years and under) per 100,000	2024	→	729	263	448	482	1,084		180
HIV testing rate per 100,000 population	2024	↑	3,489	1,260.1	2,188.9	2,842.7	984.7		4,742.3
HIV late diagnosis <25% | 25% to 50% | ≥50%	2022 - 24	–	4	40.0%	40.0%	43.3%	80.0%		10.0%
New HIV diagnoses rate per 100,000	2024	→	6	2.1	3.7	4.7	8.6		1.2
HIV diagnosed prevalence rate per 1,000 aged 15 to 59 years <2 | 2 to 5 | ≥5	2024	→	127	0.86	2.13	2.40	5.51		0.84
Population vaccination coverage: HPV vaccination coverage for one dose (12 to 13 year old) New data <80% | 80% to 90% | ≥90%	2024/25	–	1,117	75.3%	70.4%	71.7%	52.1%		86.8%
Under 25s repeat abortions (%)	2023	–	75	22.0%	32.0%	29.0%	40.0%		22.0%
Abortions under 10 weeks (%)	2023	–	770	88.0%	91.0%	89.0%	88.0%		93.0%
Total prescribed LARC excluding injections rate / 1,000	2024	↑	2,910	62.4	38.3	40.0	13.1		66.3
Under 18s conception rate	2022	→	74	17.5	16.8	13.9	26.4		6.7
Under 18s conceptions leading to abortion	2022	–	48	64.9%	59.2%	58.2%	36.2%		76.7%
Violent crime - sexual offences per 1,000 population	2024/25	→	946	3.4	3.4	3.1	2.3		6.4

Figure C3: Chlamydia detection rate per 100,000 aged 15 to 24 (Female) (2012-2019) Cumbria (*PHOF)



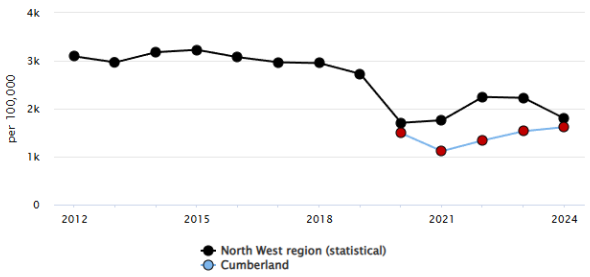
Recent trend: ➡ No significant change

Benchmarking against goal: <2,400 | 2,400 to 3,250 | ≥3,250

Period		Cumbria Count	Value	95% Lower CI	95% Upper CI	North West	England
2012	●	645	2,405	2,223	2,598	3,091	2,723
2013	●	564	2,138	1,965	2,322	2,967	2,737
2014	●	626	2,408	2,223	2,604	3,179	2,701
2015	●	558	2,181	2,003	2,369	3,228	2,529
2016	●	493	1,985	1,814	2,169	3,075	2,529
2017	●	492	2,037	1,861	2,225	2,968	2,563
2018	●	497	2,092	1,912	2,285	2,951	2,651
2019	●	588	2,525	2,325	2,738	2,727	2,717
2020		-	-	-	-	1,706	1,851
2021		-	-	-	-	1,760	1,687
2022		-	-	-	-	2,246	2,044
2023		-	-	-	-	2,227	1,937
2024		-	-	-	-	1,796	1,589

Source: UK Health Security Agency

Figure C4: Chlamydia detection rate per 100,000 aged 15 to 24 (Female) (2020-24) Cumberland (*PHOF)



Recent trend: ➡ No significant change

Benchmarking against goal: <2,400 | 2,400 to 3,250 | ≥3,250

Period		Cumberland Count	Value	95% Lower CI	95% Upper CI	North West	England
2012		-	-	-	-	3,091	2,723
2013		-	-	-	-	2,967	2,737
2014		-	-	-	-	3,179	2,701
2015		-	-	-	-	3,228	2,529
2016		-	-	-	-	3,075	2,529
2017		-	-	-	-	2,968	2,563
2018		-	-	-	-	2,951	2,651
2019		-	-	-	-	2,727	2,717
2020	●	199	1,490	1,290	1,712	1,706	1,851
2021	●	148	1,116	943	1,310	1,760	1,687
2022	●	172	1,338	1,146	1,554	2,246	2,044
2023	●	197	1,531	1,325	1,761	2,227	1,937
2024	●	208	1,617	1,404	1,852	1,796	1,589

Source: UK Health Security Agency

Figure C5: Chlamydia detection rate per 100,000 aged 15 to 24 (Female) (2024) North West (*PHOF)

Recent trends: – Could not be calculated → No significant change

Chlamydia detection rate per 100,000 aged 15 to 24 years (Female) 2024

Crude rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	→	53,166	1,589	1,576	1,603
North West region (statistical)	↑	8,180	1,796	1,758	1,836
Blackpool	↑	236	3,347	2,933	3,802
Manchester	↑	1,567	2,574	2,448	2,705
Liverpool	→	1,041	2,197	2,066	2,335
Rochdale	→	281	2,174	1,927	2,443
Wigan	→	331	1,954	1,750	2,177
Sefton	↑	255	1,952	1,720	2,207
Cheshire West and Chester	→	341	1,760	1,578	1,957
South Ribble	→	94	1,759	1,421	2,153
Fylde	→	58	1,754	1,332	2,267
Halton	→	117	1,712	1,416	2,052
Oldham	→	260	1,711	1,510	1,932
Tameside	↑	206	1,686	1,463	1,932
Blackburn with Darwen	→	166	1,649	1,408	1,920
Westmorland and Furness	→	165	1,628	1,389	1,896
Cumberland	→	208	1,617	1,404	1,852
Warrington	↓	159	1,590	1,353	1,857
Wirral	↓	250	1,576	1,387	1,784
Stockport	↑	213	1,576	1,371	1,802
Salford	→	319	1,522	1,359	1,698
Rossendale	→	52	1,494	1,116	1,959
Preston	↓	169	1,471	1,257	1,710
Trafford	→	177	1,468	1,260	1,701
Bury	→	147	1,455	1,229	1,710
St. Helens	→	133	1,408	1,179	1,669
Lancaster	→	171	1,381	1,181	1,604
West Lancashire	→	129	1,379	1,151	1,638
Hyndburn	→	65	1,365	1,053	1,740
Wyre	→	72	1,363	1,067	1,717
Ribble Valley	→	40	1,357	969	1,848
Cheshire East	→	242	1,315	1,154	1,491
Bolton	↑	221	1,290	1,125	1,471
Chorley	→	67	1,227	951	1,558
Knowsley	→	102	1,211	988	1,470
Pendle	→	64	1,200	924	1,532
Burnley	→	62	1,156	886	1,482

Figure C6: Chlamydia detection rate in England by IMD decile (2024) (*PHOF)

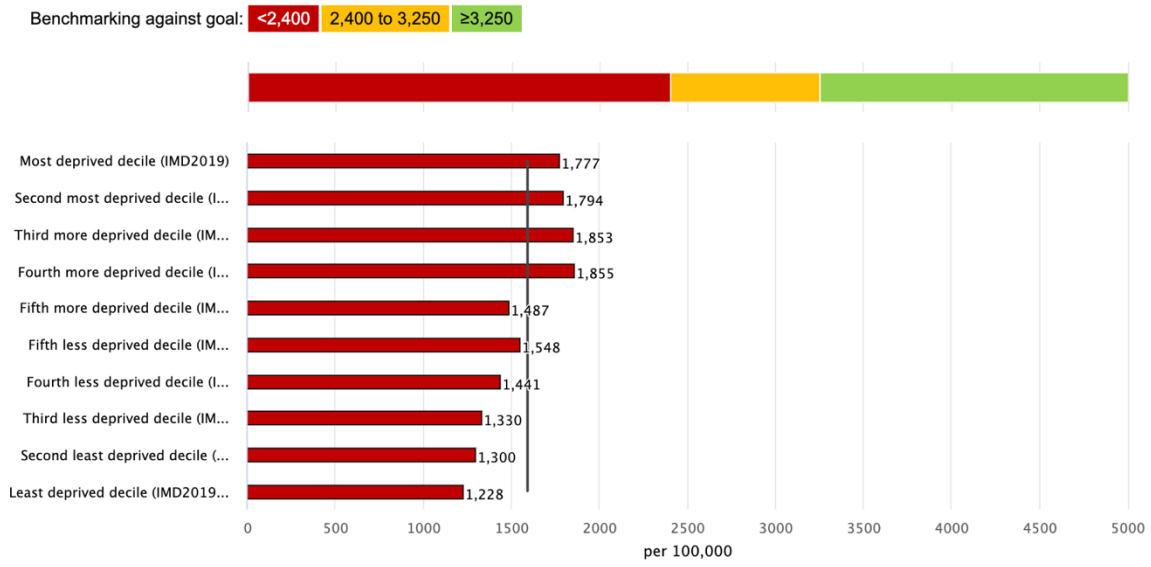


Figure C7: Chlamydia proportion of females aged 15 to 24 years screened (2021-2024) Cumberland

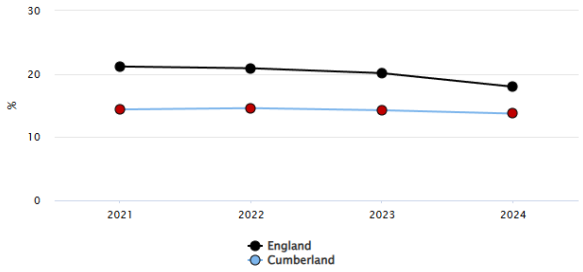
Better 95% Similar Worse 95% Not applicable

Trends for: Selected area | All areas (grouped) — Display: Selected indicator | All indicators

Chlamydia proportion of females aged 15 to 24 years screened

Proportion - %

Show confidence intervals | Show 99.8% CI values | More options



Recent trend: Could not be calculated

Period		Cumberland Count	Value	95% Lower CI	95% Upper CI	North West	England
2021	●	1,908	14.4%	13.7%	15.0%	19.4%	21.2%
2022	●	1,875	14.6%	13.9%	15.3%	19.2%	20.9%
2023	●	1,834	14.3%	13.6%	14.9%	20.3%	20.1%
2024	●	1,766	13.7%	13.1%	14.4%	17.9%	18.0%

Source: UK Health Security Agency

Indicator Definitions and Supporting Information

Figure C8: New STI diagnoses (excluding chlamydia aged 24 years and under) per 100,000 (2012-2024) Cumberland (*PHOF)

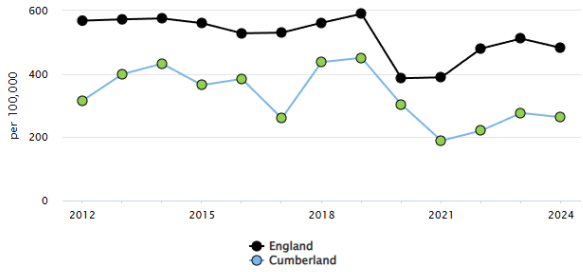
Better 95% Similar Worse 95% Not applicable

Trends for: Selected area | All areas (grouped) — Display: Selected indicator | All indicators

New STI diagnoses (excluding chlamydia aged 24 years and under) per 100,000

Crude rate - per 100,000

Show confidence intervals | Show 99.8% CI values | More options



Recent trend: ➡ No significant change

Period		Cumberland Count	Value	95% Lower CI	95% Upper CI	North West	England
2012	●	865	315	295	337	509	568
2013	●	1,094	399	376	424	514	572
2014	●	1,185	432	408	458	527	575
2015	●	1,000	365	342	388	483	560
2016	●	1,054	384	362	408	473	528
2017	●	711	260	241	280	460	530
2018	●	1,195	437	413	463	502	562
2019	●	1,231	451	426	477	499	590
2020	●	827	304	283	325	309	386
2021	●	518	189	173	206	319	389
2022	●	608	221	204	239	439	480
2023	●	766	277	257	297	477	512
2024	●	729	263	245	283	448	482

Source: UK Health Security Agency

Figure C9: New STI Diagnoses (excluding chlamydia aged 24 years and under) England by IMD decile (2024) (*PHOF)

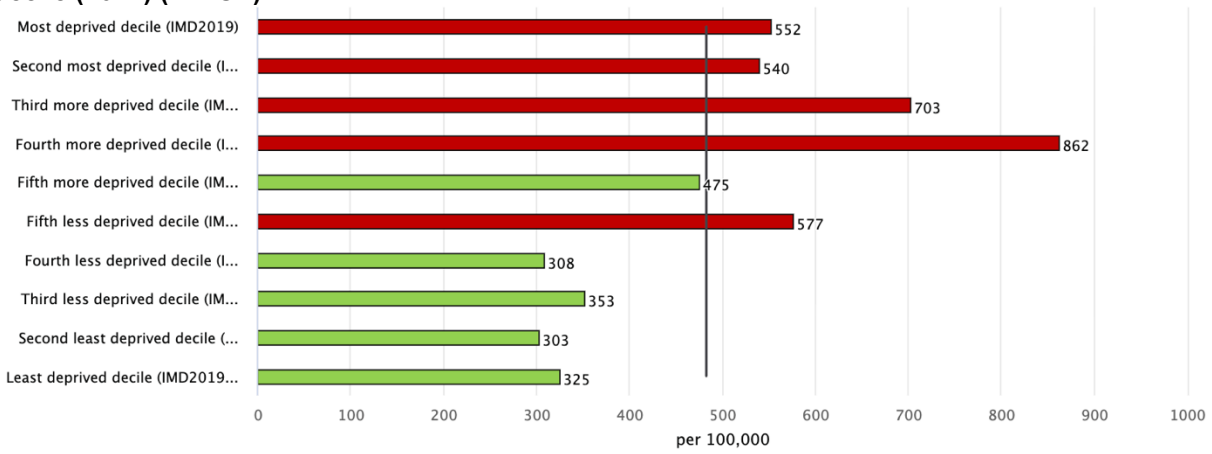
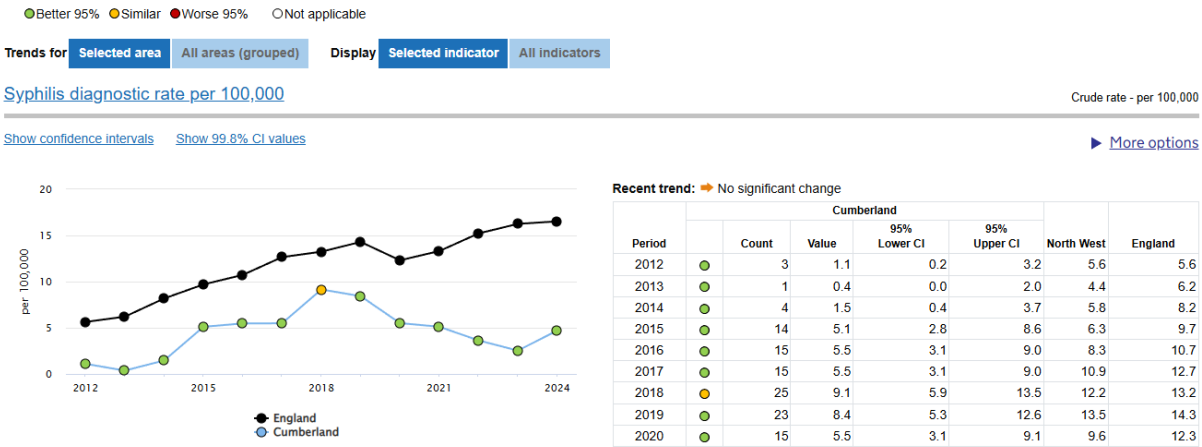


Figure C10: - Syphilis diagnostic rate per 100,000 (2012-2024) Cumberland



Recent trend: No significant change

Period		Cumberland Count	Value	95% Lower CI	95% Upper CI	North West	England
2012		3	1.1	0.2	3.2	5.6	5.6
2013		1	0.4	0.0	2.0	4.4	6.2
2014		4	1.5	0.4	3.7	5.8	8.2
2015		14	5.1	2.8	8.6	6.3	9.7
2016		15	5.5	3.1	9.0	8.3	10.7
2017		15	5.5	3.1	9.0	10.9	12.7
2018		25	9.1	5.9	13.5	12.2	13.2
2019		23	8.4	5.3	12.6	13.5	14.3
2020		15	5.5	3.1	9.1	9.6	12.3
2021		14	5.1	2.8	8.6	10.9	13.3
2022		10	3.6	1.7	6.7	12.6	15.2
2023		7	2.5	1.0	5.2	12.5	16.3
2024		13	4.7	2.5	8.0	14.6	16.5

Source: UK Health Security Agency

Figure C11: Syphilis diagnostic rate per 1,000 England by IMD decile (2024)

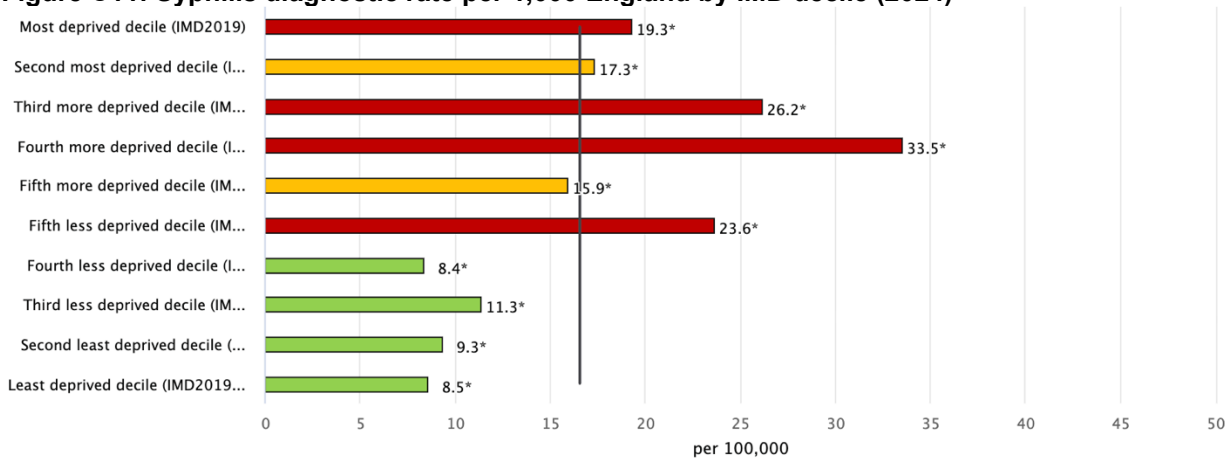


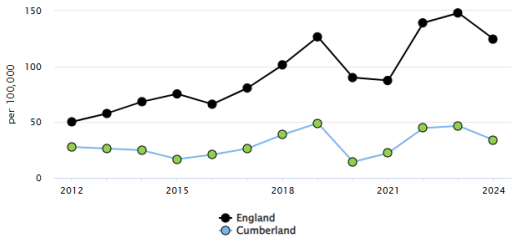
Figure C12: Gonorrhoea diagnostic rate per 100,000 (2012-2024) Cumberland

Better 95% Similar Worse 95% Not applicable

Trends for: Selected area | All areas (grouped) — Display: Selected indicator | All indicators

Gonorrhoea diagnostic rate per 100,000 — Crude rate - per 100,000

Show confidence intervals | Show 99.8% CI values | More options



Recent trend: Increasing & getting worse

Period		Cumberland Count	Value	95% Lower CI	95% Upper CI	North West	England
2012		76	28	22	35	45	50
2013		72	26	21	33	43	58
2014		68	25	19	31	45	68
2015		46	17	12	22	45	75
2016		57	21	16	27	50	66
2017		72	26	21	33	64	81
2018		106	39	32	47	82	101
2019		134	49	41	58	98	127
2020		39	14	10	20	59	90
2021		61	22	17	29	66	87
2022		123	45	37	53	130	139
2023		129	47	39	55	131	148
2024		94	34	27	42	111	124

Source: UK Health Security Agency

Figure C13: Gonorrhoea diagnostic rate England by IMD decile (2024)

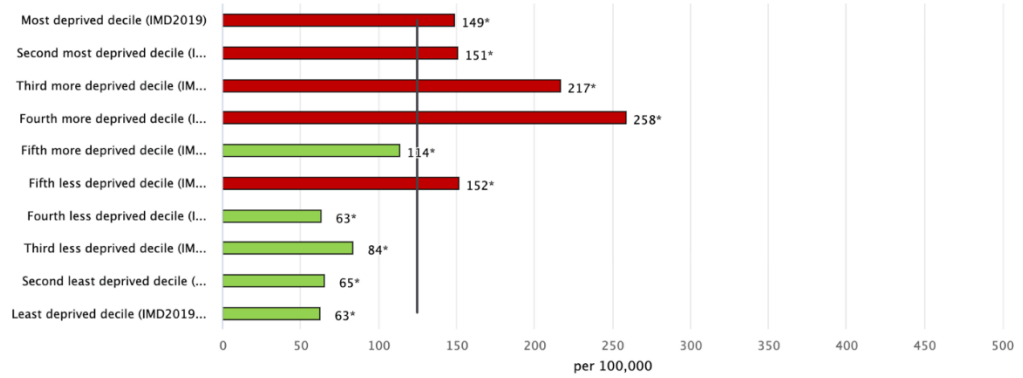


Figure C14: STI testing rate (excluding chlamydia aged 24 years and under) per 100,000 (2012 - 2024), Cumberland

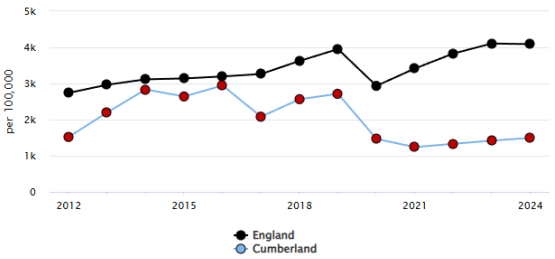
Better 95% Similar Worse 95% Not applicable

Trends for: Selected area | All areas (grouped) — Display: Selected indicator | All indicators

STI testing rate (exclude chlamydia aged 24 years and under) per 100,000

Crude rate - per 100,000

Show confidence intervals | Show 99.8% CI values | More options



Recent trend: No significant change

Period		Cumberland Count	Value	95% Lower CI	95% Upper CI	North West	England
2012	●	4,170	1,520.3	1,474.5	1,567.2	2,326.3	2,739.7
2013	●	6,029	2,200.1	2,144.9	2,256.4	2,653.2	2,964.6
2014	●	7,769	2,834.0	2,771.3	2,897.7	2,786.7	3,115.1
2015	●	7,241	2,640.8	2,580.3	2,702.4	2,666.8	3,139.1
2016	●	8,073	2,944.3	2,880.4	3,009.2	2,719.2	3,194.6
2017	●	5,691	2,081.1	2,027.4	2,135.9	2,653.9	3,262.7
2018	●	7,010	2,565.4	2,505.7	2,626.1	2,841.7	3,623.8
2019	●	7,410	2,714.2	2,652.7	2,776.7	3,053.5	3,951.1
2020	●	3,993	1,465.6	1,420.5	1,511.8	2,006.1	2,934.0
2021	●	3,393	1,239.3	1,197.9	1,281.7	2,540.2	3,415.4
2022	●	3,663	1,330.4	1,287.7	1,374.2	2,604.5	3,829.2
2023	●	3,927	1,418.3	1,374.3	1,463.4	2,887.2	4,106.4
2024	●	4,138	1,494.5	1,449.3	1,540.8	3,089.9	4,088.8

Source: UK Health Security Agency

Figure C15: HIV late diagnosis (2009-11 – 2022-24) Cumberland (*PHOF)

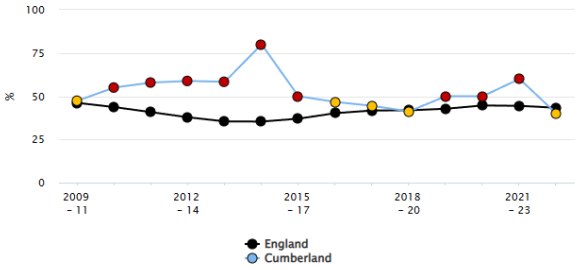
Better 95% Similar Worse 95% Not applicable

Trends for: Selected area | All areas (grouped) — Display: Selected indicator | All indicators

HIV late diagnosis

Proportion - %

Show confidence intervals | Show 99.8% CI values | More options



Recent trend: Could not be calculated

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

Period		Cumberland Count	Value	95% Lower CI	95% Upper CI	North West	England
2009 - 11	●	9	47.4%	21.7%	89.9%	47.4%	46.1%
2010 - 12	●	11	55.0%	27.5%	98.4%	47.4%	43.7%
2011 - 13	●	11	57.9%	28.9%	100%	44.2%	40.8%
2012 - 14	●	10	58.8%	28.2%	100%	41.3%	37.8%
2013 - 15	●	7	58.3%	23.5%	100%	38.8%	35.4%
2014 - 16	●	8	80.0%	34.5%	100%	39.8%	35.3%
2015 - 17	●	4	50.0%	13.6%	100%	39.6%	37.0%
2016 - 18	●	7	46.7%	18.8%	96.2%	40.0%	40.2%
2017 - 19	●	8	44.4%	19.2%	87.6%	40.2%	41.7%
2018 - 20	●	7	41.2%	16.6%	84.8%	39.0%	41.8%
2019 - 21	●	4	50.0%	13.6%	100%	41.2%	42.7%
2020 - 22	●	2	50.0%	6.1%	100%	42.3%	44.6%
2021 - 23	●	3	60.0%	12.4%	100%	41.4%	44.4%
2022 - 24	●	4	40.0%	10.9%	100%	40.0%	43.3%

Source: UK Health Security Agency

Figure C16: HIV testing rate per 100,000 population (2015-2024) Cumberland

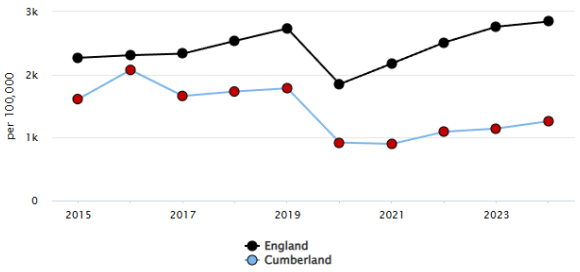
Better 95% Similar Worse 95% Not applicable

Trends for: Selected area | All areas (grouped) — Display: Selected indicator | All indicators

HIV testing rate per 100,000 population

Crude rate - per 100,000

Show confidence intervals | Show 99.8% CI values | More options



Recent trend: Increasing & getting better

Period		Cumberland Count	Value	95% Lower CI	95% Upper CI	North West	England
2015		4,419	1,611.6	1,564.5	1,659.9	1,647.4	2,266.5
2016		5,688	2,074.5	2,020.9	2,129.1	1,721.9	2,308.0
2017		4,542	1,660.9	1,613.0	1,710.0	1,683.0	2,332.5
2018		4,732	1,731.7	1,682.7	1,781.8	1,822.0	2,535.7
2019		4,867	1,782.7	1,733.0	1,833.5	2,021.6	2,732.7
2020		2,508	920.6	884.9	957.3	1,210.8	1,847.8
2021		2,462	899.2	864.1	935.5	1,640.0	2,177.0
2022		3,009	1,092.9	1,054.2	1,132.6	1,698.5	2,510.1
2023		3,166	1,143.5	1,104.0	1,184.0	1,909.0	2,761.0
2024		3,489	1,260.1	1,218.7	1,302.7	2,188.9	2,842.7

Source: UK Health Security Agency

Figure C17: HIV Testing rate England by IMD decile (2024)

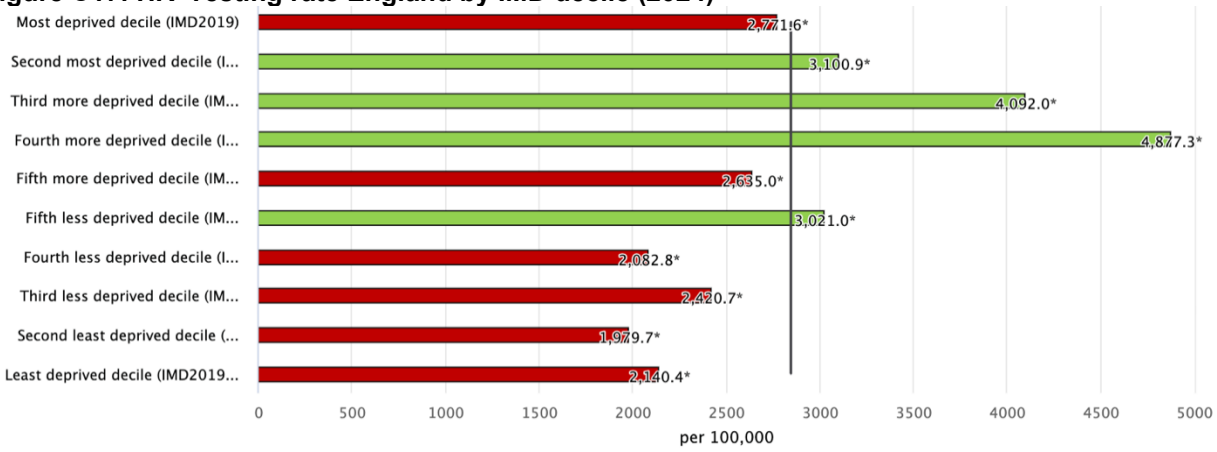
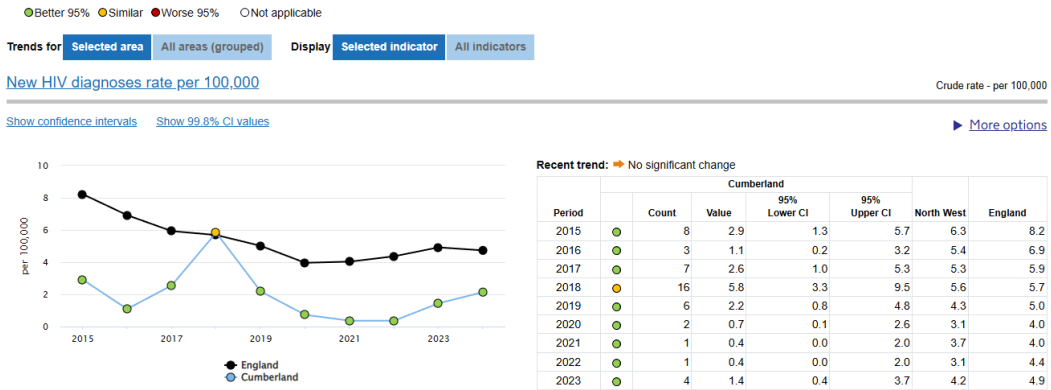


Figure C18: HIV Testing rate per 1,000 North West (2024)

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↑	1,639,988	2,842.7	2,838.4	2,847.1
North West region (statistical)	↑	166,358	2,188.9	2,178.4	2,199.4
Liverpool	↑	23,889	4,742.3	4,682.4	4,802.9
Manchester	→	20,177	3,479.3	3,431.4	3,527.6
Blackpool	↑	4,455	3,121.8	3,030.8	3,214.8
Salford	↑	8,127	2,860.6	2,798.7	2,923.4
Knowsley	↑	4,337	2,723.5	2,643.1	2,805.8
Wirral	↑	7,755	2,387.2	2,334.4	2,441.0
Halton	↑	3,060	2,361.3	2,278.4	2,446.5
St. Helens	↑	4,237	2,278.2	2,210.1	2,347.8
Cheshire East	↑	8,914	2,161.2	2,116.6	2,206.5
Warrington	↑	4,555	2,144.6	2,082.8	2,207.9
Sefton	↑	5,473	1,935.7	1,884.7	1,987.6
Lancashire	↑	23,158	1,823.2	1,799.8	1,846.9
Wigan	↑	6,120	1,804.4	1,759.5	1,850.2
Cheshire West and Chester	↑	6,564	1,798.1	1,754.8	1,842.1
Tameside	→	4,079	1,738.2	1,685.3	1,792.4
Bury	↑	3,395	1,736.8	1,678.9	1,796.2
Rochdale	↑	3,987	1,735.3	1,681.9	1,790.0
Oldham	↑	3,920	1,592.7	1,543.2	1,643.3
Trafford	→	3,705	1,560.1	1,510.3	1,611.2
Stockport	→	4,672	1,559.7	1,515.3	1,605.1
Blackburn with Darwen	↑	2,098	1,332.0	1,275.6	1,390.3
Bolton	↑	3,945	1,304.6	1,264.2	1,346.0
Cumberland	↑	3,489	1,260.1	1,218.7	1,302.7
Westmorland and Furness	↑	2,247	984.7	944.4	1,026.3

Source: UK Health Security Agency

Figure C19: New HIV diagnoses (people first diagnosed in England) rate per 100,000 (2015-2024) Cumberland

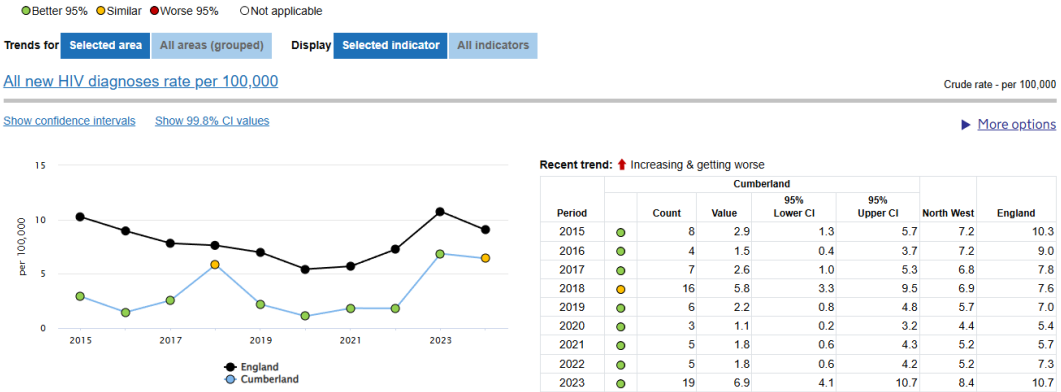


Recent trend: No significant change

Period		Cumberland Count	Value	95% Lower CI	95% Upper CI	North West	England
2015	●	8	2.9	1.3	5.7	6.3	8.2
2016	●	3	1.1	0.2	3.2	5.4	6.9
2017	●	7	2.6	1.0	5.3	5.3	5.9
2018	●	16	5.8	3.3	9.5	5.6	5.7
2019	●	6	2.2	0.8	4.8	4.3	5.0
2020	●	2	0.7	0.1	2.6	3.1	4.0
2021	●	1	0.4	0.0	2.0	3.7	4.0
2022	●	1	0.4	0.0	2.0	3.1	4.4
2023	●	4	1.4	0.4	3.7	4.2	4.9
2024	●	6	2.1	0.8	4.7	3.7	4.7

Source: UK Health Security Agency

Figure C20: All new HIV diagnoses (people first diagnosed in England or abroad) rate per 100,000 (2015-2024) Cumberland



Recent trend: Increasing & getting worse

Period		Cumberland Count	Value	95% Lower CI	95% Upper CI	North West	England
2015	●	8	2.9	1.3	5.7	7.2	10.3
2016	●	4	1.5	0.4	3.7	7.2	9.0
2017	●	7	2.6	1.0	5.3	6.8	7.8
2018	●	16	5.8	3.3	9.5	6.9	7.6
2019	●	6	2.2	0.8	4.8	5.7	7.0
2020	●	3	1.1	0.2	3.2	4.4	5.4
2021	●	5	1.8	0.6	4.3	5.2	5.7
2022	●	5	1.8	0.6	4.2	5.2	7.3
2023	●	19	6.9	4.1	10.7	8.4	10.7
2024	●	18	6.4	3.8	10.1	7.2	9.0

Source: UK Health Security Agency

Figure C21: HIV diagnosed prevalence rate per 1,000 aged 15 to 59 (2011-2024) Cumberland

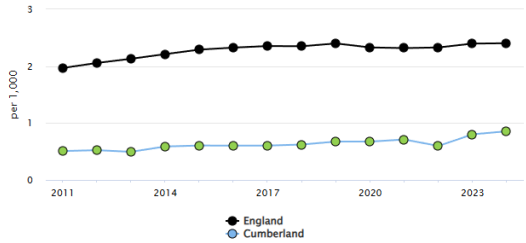
Better 95% Similar Worse 95% Not applicable

Trends for: Selected area | All areas (grouped) — Display: Selected indicator | All indicators

HIV diagnosed prevalence rate per 1,000 aged 15 to 59 years

Crude rate - per 1,000

Show confidence intervals | Show 99.8% CI values | More options



Recent trend: No significant change

Benchmarking against goal: <2 | 2 to 5 | ≥5

Period		Cumberland Count	Value	95% Lower CI	95% Upper CI	North West	England
2011		80	0.51	0.40	0.63	1.50	1.97
2012		82	0.52	0.42	0.65	1.57	2.06
2013		77	0.49	0.39	0.62	1.63	2.13
2014		91	0.59	0.47	0.72	1.70	2.21
2015		93	0.61	0.49	0.74	1.81	2.29
2016		92	0.60	0.49	0.74	1.87	2.33
2017		91	0.60	0.49	0.74	1.90	2.35
2018		93	0.62	0.50	0.76	1.95	2.35
2019		100	0.68	0.55	0.82	2.03	2.40
2020		99	0.67	0.55	0.82	1.99	2.33
2021		105	0.71	0.58	0.86	2.04	2.32
2022		88	0.60	0.48	0.74	2.00	2.33
2023		118	0.80	0.66	0.96	2.11	2.40
2024		127	0.86	0.71	1.02	2.13	2.40

Source: UK Health Security Agency

Figure C22: Initiation or continuation of PrEP among those with PrEP need (2011-2024) Cumberland

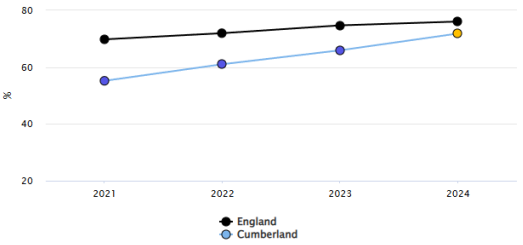
Lower 95% Similar Higher 95% Not applicable

Trends for: Selected area | All areas (grouped) — Display: Selected indicator | All indicators

Initiation or continuation of PrEP among those with PrEP need

Proportion - %

Show confidence intervals | Show 99.8% CI values | More options



Recent trend: Could not be calculated

Period		Cumberland Count	Value	95% Lower CI	95% Upper CI	North West	England
2021		186	55.2%	47.5%	63.7%	61.9%	69.8%
2022		379	61.0%	55.0%	67.5%	69.5%	72.0%
2023		542	65.9%	60.5%	71.7%	70.3%	74.7%
2024		352	71.8%	64.5%	79.7%	72.8%	76.1%

Source: UK Health Security Agency

Indicator Definitions and Supporting Information

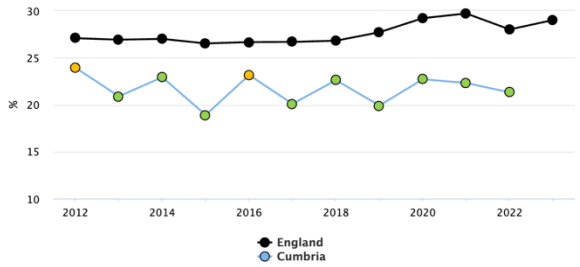
Figure C23: Under 25s repeat abortions (%) (2012-2022) Cumbria

Better 95% Similar Worse 95% Not applicable

Trends for: Selected area | All areas (grouped) — Display: Selected indicator | All indicators

Under 25s repeat abortions (%) — Proportion - %

Show confidence intervals | Show 99.8% CI values — More options



Recent trend: No significant change

Period		Cumbria Count	Value	95% Lower CI	95% Upper CI	North West	England
2012		135	23.9%	20.6%	27.6%	26.2%	27.1%
2013		109	20.9%	17.6%	24.6%	25.7%	26.9%
2014		115	22.9%	19.4%	26.8%	26.8%	27.0%
2015		89	18.9%	15.6%	22.7%	26.4%	26.5%
2016		106	23.1%	19.5%	27.2%	27.5%	26.7%
2017		96	20.1%	16.7%	23.9%	27.5%	26.7%
2018		106	22.6%	19.1%	26.6%	27.1%	26.8%
2019		91	19.9%	16.5%	23.8%	28.3%	27.7%
2020		97	22.7%	19.0%	26.9%	30.7%	29.2%
2021		109	22.3%	18.8%	26.2%	31.9%	29.7%
2022		123	21.3%	18.2%	24.8%	30.3%	28.0%
2023		-	-	-	-	32.0%	29.0%

Source: Department of Health and Social Care

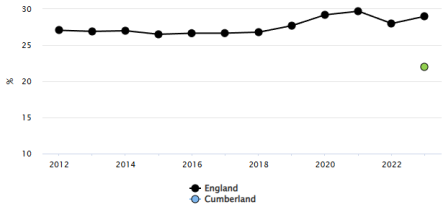
Figure C24: Under 25s repeat abortions (%) (2023) Cumberland

Better 95% Similar Worse 95% Not applicable

Trends for: Selected area | All areas (grouped) — Display: Selected indicator | All indicators

Under 25s repeat abortions (%) — Proportion - %

Show confidence intervals | Show 99.8% CI values — More options



Recent trend: Could not be calculated

Period		Cumberland Count	Value	95% Lower CI	95% Upper CI	North West	England
2012		-	-	-	-	26.2%	27.1%
2013		-	-	-	-	25.7%	26.9%
2014		-	-	-	-	26.8%	27.0%
2015		-	-	-	-	26.4%	26.5%
2016		-	-	-	-	27.5%	26.7%
2017		-	-	-	-	27.5%	26.7%
2018		-	-	-	-	27.1%	26.8%
2019		-	-	-	-	28.3%	27.7%
2020		-	-	-	-	30.7%	29.2%
2021		-	-	-	-	31.9%	29.7%
2022		-	*	-	-	30.3%	28.0%
2023		75	22.0%	18.3%	27.2%	32.0%	29.0%

Source: Department of Health and Social Care

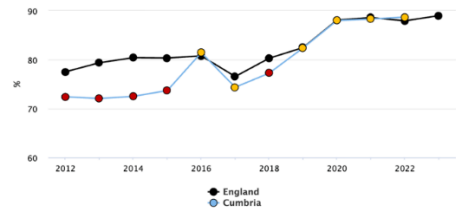
Figure C25: Abortions under 10 weeks (%) (2012-2022) Cumbria

Better 95% Similar Worse 95% Not applicable

Trends for: Selected area | All areas (grouped) — Display: Selected indicator | All indicators

Abortions under 10 weeks (%) — Proportion - %

Show confidence intervals | Show 99.8% CI values — More options



Recent trend: Increasing & getting better

Period		Cumbria Count	Value	95% Lower CI	95% Upper CI	North West	England
2012		756	72.4%	69.6%	75.0%	80.2%	77.5%
2013		748	72.1%	69.3%	74.7%	81.0%	79.4%
2014		754	72.5%	69.7%	75.1%	82.0%	80.4%
2015		717	73.7%	70.8%	76.4%	81.6%	80.3%
2016		807	81.4%	78.9%	83.7%	82.3%	80.8%
2017		798	74.4%	71.7%	76.9%	80.5%	76.6%
2018		852	77.2%	74.7%	79.6%	81.6%	80.3%
2019		918	82.4%	80.1%	84.5%	82.9%	82.5%
2020		972	88.0%	86.0%	89.8%	89.8%	88.1%
2021		1,095	88.3%	86.4%	90.0%	89.6%	88.6%
2022		1,360	88.7%	87.0%	90.2%	90.1%	87.9%
2023		-	-	-	-	91.0%	89.0%

Source: Department of Health and Social Care

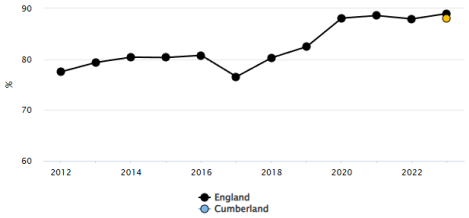
Figure C26: Abortions under 10 weeks (%) (2023) Cumberland

Better 95% Similar Worse 95% Not applicable

Trends for **Selected area** | All areas (grouped) Display **Selected indicator** | All indicators

Abortions under 10 weeks (%) Proportion - %

Show confidence intervals Show 99.8% CI values ▶ More options

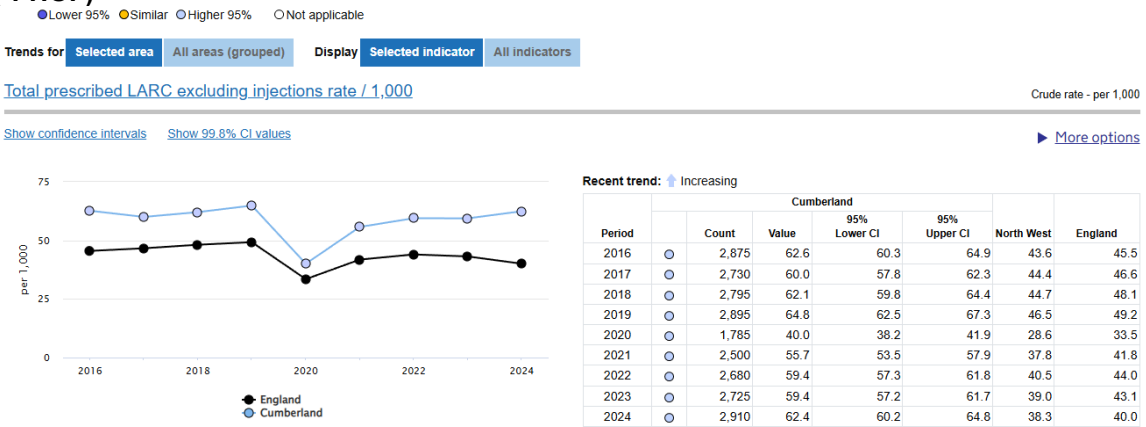


Recent trend: Could not be calculated

Period		Cumberland Count	Value	95% Lower CI	95% Upper CI	North West	England
2012		-	-	-	-	80.2%	77.5%
2013		-	-	-	-	81.0%	79.4%
2014		-	-	-	-	82.0%	80.4%
2015		-	-	-	-	81.6%	80.3%
2016		-	-	-	-	82.3%	80.8%
2017		-	-	-	-	80.5%	76.6%
2018		-	-	-	-	81.6%	80.3%
2019		-	-	-	-	82.9%	82.5%
2020		-	-	-	-	89.8%	88.1%
2021		-	-	-	-	89.6%	88.6%
2022		-	*	-	-	90.1%	87.9%
2023		770	88.0%	85.7%	90.0%	91.0%	89.0%

Source: Department of Health and Social Care

Figure C27: Total Prescribed LARC excluding injections rate /1000 (2016-2024) Cumberland (*PHOF)



Recent trend: Increasing

Period		Cumberland Count	Value	95% Lower CI	95% Upper CI	North West	England
2016		2,875	62.6	60.3	64.9	43.6	45.5
2017		2,730	60.0	57.8	62.3	44.4	46.6
2018		2,795	62.1	59.8	64.4	44.7	48.1
2019		2,895	64.8	62.5	67.3	46.5	49.2
2020		1,785	40.0	38.2	41.9	28.6	33.5
2021		2,500	55.7	53.5	57.9	37.8	41.8
2022		2,680	59.4	57.3	61.8	40.5	44.0
2023		2,725	59.4	57.2	61.7	39.0	43.1
2024		2,910	62.4	60.2	64.8	38.3	40.0

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

Figure C28: Total prescribed LARC England by IMD decile (2024)

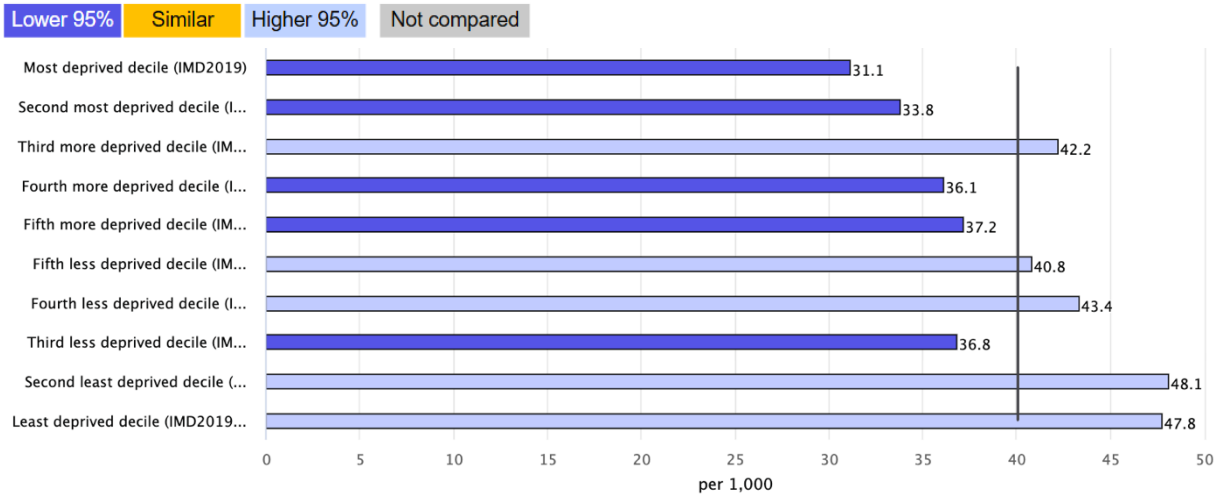


Figure C29: Total Prescribed LARC excluding injections rate /1000 (2024) North West

Lower 95% | Similar | Higher 95% | Not compared

Recent trends: – Could not be calculated | → No significant change | ↑ Increasing | ↓ Decreasing

Total prescribed LARC excluding injections rate / 1,000 **New data** 2024

Crude rate - per 1,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	→	463,875	40.0	39.9	40.2
North West region (statistical)	↑	58,075	38.3	38.0	38.6
Sefton	↑	3,230	66.3	64.0	68.6
Cumberland	↑	2,910	62.4	60.2	64.8
Westmorland and Furness	→	2,060	57.5	55.1	60.1
Blackpool	↑	1,400	54.4	51.6	57.4
Wirral	↑	2,720	47.0	45.3	48.8
Cheshire East	→	3,315	45.8	44.3	47.4
Warrington	↑	1,750	45.5	43.4	47.7
Stockport	↑	2,520	45.0	43.3	46.8
Cheshire West and Chester	→	2,995	44.4	42.8	46.0
Trafford	↑	1,930	42.4	40.5	44.3
Lancashire	→	9,905	41.9	41.1	42.8
Liverpool	↑	4,960	40.7	39.6	41.9
Wigan	↑	2,335	36.1	34.6	37.5
Tameside	→	1,655	35.0	33.4	36.8
Halton	↑	860	34.8	32.4	37.1
Blackburn with Darwen	↑	1,035	31.0	29.2	33.0
Manchester	→	4,660	29.7	28.9	30.6
Rochdale	→	1,365	29.1	27.5	30.6
Salford	→	1,915	26.5	25.4	27.8
Bolton	→	1,560	25.8	24.6	27.2
Bury	→	925	24.6	23.1	26.3
Knowsley	↑	800	24.2	22.5	25.9
St. Helens	→	610	17.4	16.0	18.8
Oldham	→	665	13.1	12.1	14.1

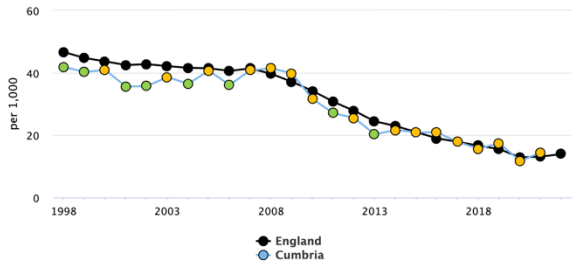
Figure C30: Under 18s conceptions rate (1998-2021) Cumbria (*PHOF)

Better 95% Similar Worse 95% Not applicable

Trends for: Selected area | All areas (grouped) — Display: Selected indicator | All indicators

Under 18s conception rate — Crude rate - per 1,000

Show confidence intervals | Show 99.8% CI values | More options



Recent trend: No significant change

Period		Cumbria Count	Value	95% Lower CI	95% Upper CI	North West	England
1998		362	41.9	37.7	46.5	50.3	46.6
1999		348	40.2	36.1	44.7	48.8	44.8
2000		360	40.9	36.8	45.4	47.5	43.6
2001		315	35.6	31.8	39.7	45.1	42.5
2002		320	35.7	31.9	39.8	45.4	42.8
2003		350	38.6	34.7	42.9	45.2	42.1
2004		333	36.5	32.7	40.6	46.0	41.6
2005		374	40.6	36.6	45.0	46.9	41.4
2006		335	36.1	32.3	40.2	44.2	40.6
2007		385	40.8	36.8	45.1	46.6	41.4
2008		390	41.4	37.4	45.7	44.8	39.7
2009		369	39.8	35.9	44.1	42.6	37.1
2010		281	31.6	28.0	35.5	39.6	34.2
2011		237	27.0	23.7	30.7	35.3	30.7
2012		220	25.5	22.2	29.1	31.7	27.8
2013		173	20.3	17.3	23.5	27.7	24.4
2014		179	21.6	18.6	25.0	26.9	22.9
2015		166	20.9	17.8	24.3	24.8	20.9
2016		162	20.9	17.8	24.3	22.4	19.0
2017		136	17.8	14.9	21.0	21.9	17.8
2018		118	15.7	13.0	18.7	21.4	16.6
2019		131	17.4	14.5	20.6	18.9	15.5
2020		88	11.6	9.3	14.4	16.2	12.8
2021		111	14.4	11.9	17.4	16.4	13.1
2022		-	-	-	-	16.8	13.9

Source: OHID, based on Office for National Statistics data

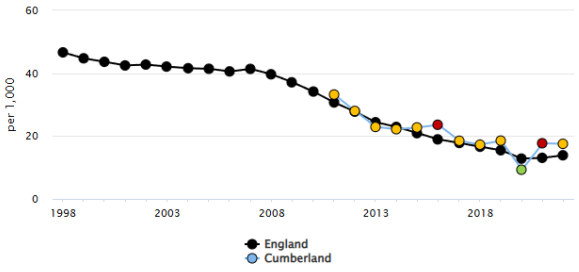
Figure C31: Under 18s conception rate (2011-2022) Cumberland (*PHOF)

Better 95% Similar Worse 95% Not applicable

Trends for: Selected area | All areas (grouped) — Display: Selected indicator | All indicators

Under 18s conception rate — Crude rate - per 1,000

Show confidence intervals | Show 99.8% CI values | More options



Recent trend: No significant change

Period		Cumberland Count	Value	95% Lower CI	95% Upper CI	North West	England
1998		-	-	-	-	50.3	46.6
1999		-	-	-	-	48.8	44.8
2000		-	-	-	-	47.5	43.6
2001		-	-	-	-	45.1	42.5
2002		-	-	-	-	45.4	42.8
2003		-	-	-	-	45.2	42.1
2004		-	-	-	-	46.0	41.6
2005		-	-	-	-	46.9	41.4
2006		-	-	-	-	44.2	40.6
2007		-	-	-	-	46.6	41.4
2008		-	-	-	-	44.8	39.7
2009		-	-	-	-	42.6	37.1
2010		-	-	-	-	39.6	34.2
2011		157	33.2	28.2	38.8	35.3	30.7
2012		132	28.0	23.4	33.2	31.7	27.8
2013		107	22.9	18.8	27.7	27.7	24.4
2014		102	22.2	18.1	26.9	26.9	22.9
2015		99	22.7	18.5	27.7	24.8	20.9
2016		100	23.6	19.2	28.7	22.4	19.0
2017		77	18.5	14.6	23.1	21.9	17.8
2018		71	17.3	13.5	21.8	21.4	16.6
2019		76	18.5	14.6	23.2	18.9	15.5
2020		38	9.3	6.6	12.8	16.2	12.8
2021		74	17.7	13.9	22.2	16.4	13.1
2022		74	17.5	13.8	22.0	16.8	13.9

Source: OHID, based on Office for National Statistics data

Figure C32: Under 18 Conception rate England by IMD decile (2022)

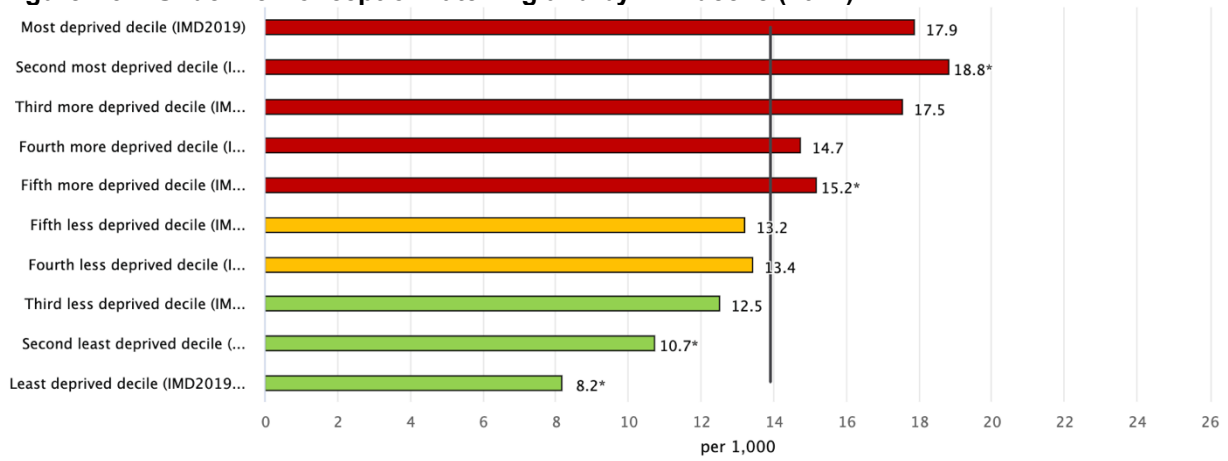
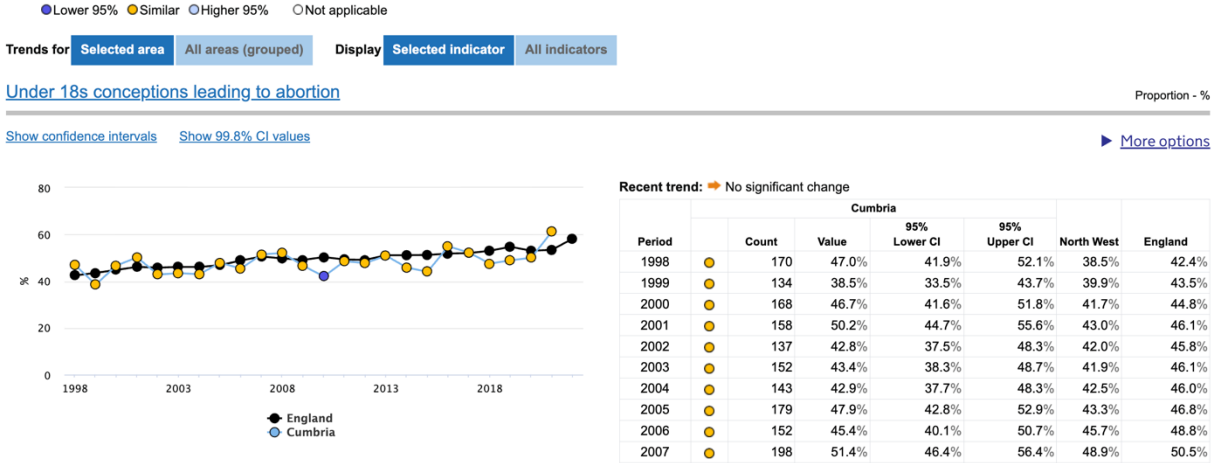


Figure C33: Under 18s conceptions leading to abortion (1998-2021) Cumbria



Recent trend: ➡ No significant change

Period		Cumbria Count	Cumbria Value	Cumbria 95% Lower CI	Cumbria 95% Upper CI	North West	England
1998		170	47.0%	41.9%	52.1%	38.5%	42.4%
1999		134	38.5%	33.5%	43.7%	39.9%	43.5%
2000		168	46.7%	41.6%	51.8%	41.7%	44.8%
2001		158	50.2%	44.7%	55.6%	43.0%	46.1%
2002		137	42.8%	37.5%	48.3%	42.0%	45.8%
2003		152	43.4%	38.3%	48.7%	41.9%	46.1%
2004		143	42.9%	37.7%	48.3%	42.5%	46.0%
2005		179	47.9%	42.8%	52.9%	43.3%	46.8%
2006		152	45.4%	40.1%	50.7%	45.7%	48.8%
2007		198	51.4%	46.4%	56.4%	48.9%	50.5%
2008		203	52.1%	47.1%	57.0%	48.8%	49.7%
2009		172	46.6%	41.6%	51.7%	48.7%	49.1%
2010		118	42.0%	36.4%	47.8%	49.3%	50.3%
2011		115	48.5%	42.2%	54.9%	48.9%	49.3%
2012		105	47.7%	41.2%	54.3%	48.5%	49.1%
2013		88	50.9%	43.5%	58.2%	52.8%	51.1%
2014		82	45.8%	38.7%	53.1%	52.5%	51.1%
2015		73	44.0%	36.6%	51.6%	52.1%	51.2%
2016		89	54.9%	47.2%	62.4%	51.7%	51.8%
2017		71	52.2%	43.9%	60.4%	51.9%	52.0%
2018		56	47.5%	38.7%	56.4%	53.6%	53.0%
2019		64	48.9%	40.5%	57.3%	57.0%	54.7%
2020		44	50.0%	39.8%	60.2%	54.4%	53.0%
2021		68	61.3%	52.0%	69.8%	56.1%	53.4%
2022		-	-	-	-	59.2%	58.2%

Source: OHID, based on Office for National Statistics data

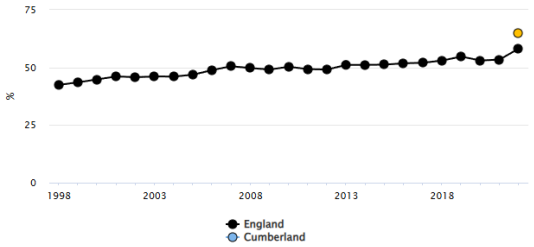
Figure C34: Under 18s conceptions leading to abortion (2022) Cumberland

Lower 95% Similar Higher 95% Not applicable

Trends for: Selected area | All areas (grouped) — Display: Selected indicator | All indicators

Under 18s conceptions leading to abortion — Proportion - %

Show confidence intervals | Show 99.8% CI values — More options



Recent trend: Could not be calculated

Period		Cumberland Count	Value	95% Lower CI	95% Upper CI	North West	England
1998		-	-	-	-	38.5%	42.4%
1999		-	-	-	-	39.9%	43.5%
2000		-	-	-	-	41.7%	44.8%
2001		-	-	-	-	43.0%	46.1%
2002		-	-	-	-	42.0%	45.8%
2003		-	-	-	-	41.9%	46.1%
2004		-	-	-	-	42.5%	46.0%
2005		-	-	-	-	43.3%	46.8%
2006		-	-	-	-	45.7%	48.8%
2007		-	-	-	-	48.9%	50.5%
2008		-	-	-	-	48.8%	49.7%
2009		-	-	-	-	48.7%	49.1%
2010		-	-	-	-	49.3%	50.3%
2011		-	-	-	-	48.9%	49.3%
2012		-	-	-	-	48.5%	49.1%
2013		-	-	-	-	52.8%	51.1%
2014		-	-	-	-	52.5%	51.1%
2015		-	-	-	-	52.1%	51.2%
2016		-	-	-	-	51.7%	51.8%
2017		-	-	-	-	51.9%	52.0%
2018		-	-	-	-	53.6%	53.0%
2019		-	-	-	-	57.0%	54.7%
2020		-	-	-	-	54.4%	53.0%
2021		-	-	-	-	56.1%	53.4%
2022	●	48	64.9%	53.5%	74.8%	59.2%	58.2%

Source: OHID, based on Office for National Statistics data

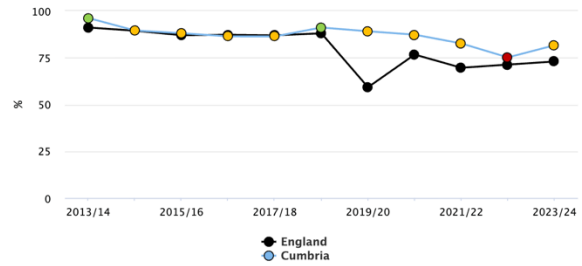
Figure C35: HPV Population Vaccination Coverage for one dose (12 to 13 year old females) (2013/14-2023/24) Cumbria

Better 95% Similar Worse 95% Not applicable

Trends for: Selected area | All areas (grouped) — Display: Selected indicator | All indicators

Population vaccination coverage: HPV vaccination coverage for one dose (12 to 13 year old) — Proportion - %

Show confidence intervals | Show 99.8% CI values — More options



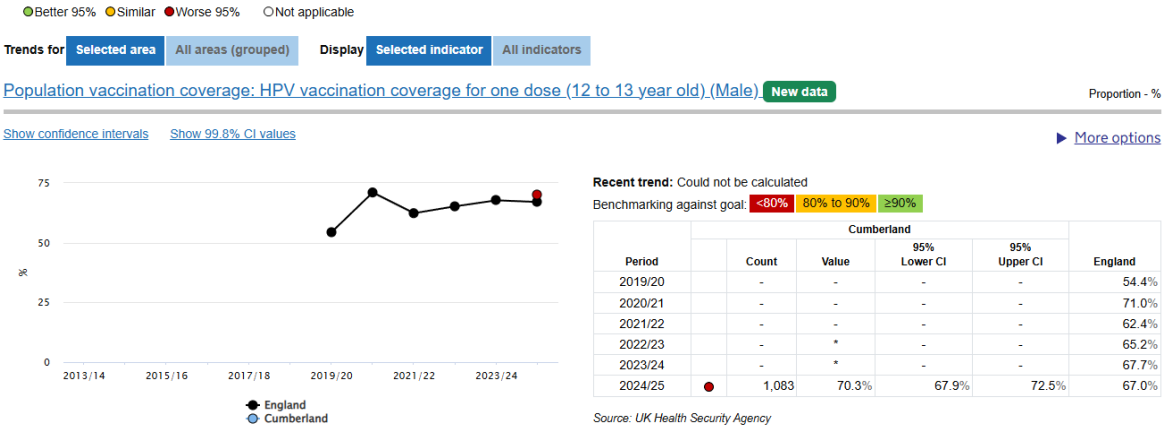
Recent trend: Decreasing & getting worse

Benchmarking against goal: <80% | 80% to 90% | ≥90%

Period		Cumbria Count	Value	95% Lower CI	95% Upper CI	North West	England
2013/14	●	2,398	96.2%	95.4%	96.9%	92.6%	91.1%
2014/15	●	2,198	89.5%	88.3%	90.7%	91.2%	89.4%
2015/16	●	2,252	88.1%	86.8%	89.3%	88.2%	87.0%
2016/17	●	2,231	86.4%	85.0%	87.6%	88.5%	87.2%
2017/18	●	2,379	86.4%	85.0%	87.6%	87.2%	86.9%
2018/19	●	2,387	91.1%	90.0%	92.1%	88.4%	88.0%
2019/20	●	2,343	89.1%	87.8%	90.2%	68.4%	59.2%
2020/21	●	2,332	87.3%	86.0%	88.5%	79.5%	76.7%
2021/22	●	2,181	82.6%	81.1%	84.0%	71.6%	69.6%
2022/23	●	1,982	75.1%	73.4%	76.7%	72.2%	71.3%
2023/24	●	2,314	81.6%	80.2%	83.0%	74.4%	72.9%

Source: UK Health Security Agency

Figure C36: HPV Population Vaccination Coverage for one dose (12 to 13 year old males) (2024/25) Cumberland



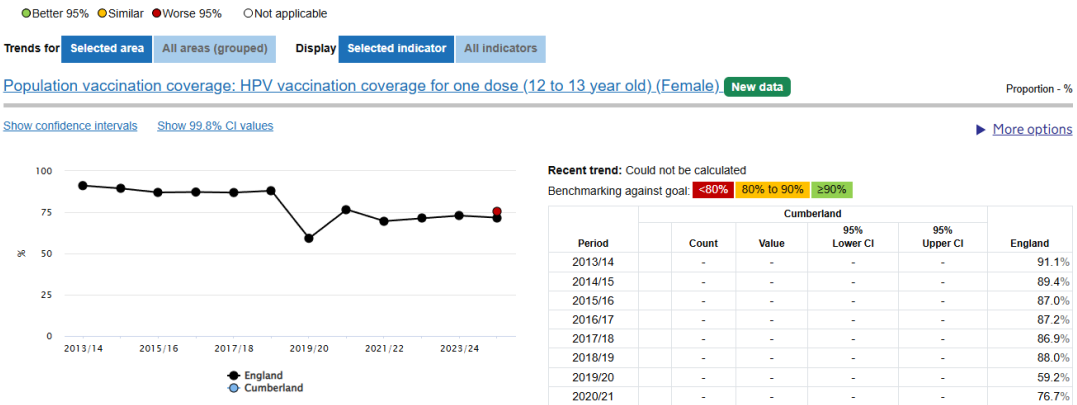
Recent trend: Could not be calculated

Benchmarking against goal: <80% 80% to 90% ≥90%

Period		Cumberland Count	Value	95% Lower CI	95% Upper CI	England
2019/20		-	-	-	-	54.4%
2020/21		-	-	-	-	71.0%
2021/22		-	-	-	-	62.4%
2022/23		-	*	-	-	65.2%
2023/24		-	*	-	-	67.7%
2024/25	●	1,083	70.3%	67.9%	72.5%	67.0%

Source: UK Health Security Agency

Figure C37: HPV Population Vaccination Coverage for one dose (12 to 13 year old females) (2024/25) Cumberland



Recent trend: Could not be calculated

Benchmarking against goal: <80% 80% to 90% ≥90%

Period		Cumberland Count	Value	95% Lower CI	95% Upper CI	England
2013/14		-	-	-	-	91.1%
2014/15		-	-	-	-	89.4%
2015/16		-	-	-	-	87.0%
2016/17		-	-	-	-	87.2%
2017/18		-	-	-	-	86.9%
2018/19		-	-	-	-	88.0%
2019/20		-	-	-	-	59.2%
2020/21		-	-	-	-	76.7%
2021/22		-	-	-	-	69.6%
2022/23		-	*	-	-	71.3%
2023/24		-	*	-	-	72.9%
2024/25	●	1,117	75.3%	73.1%	77.4%	71.7%

Source: UK Health Security Agency

Figure C38: HPV vaccination coverage for one dose (12-13 year old females) England by IMD decile (2024-25)

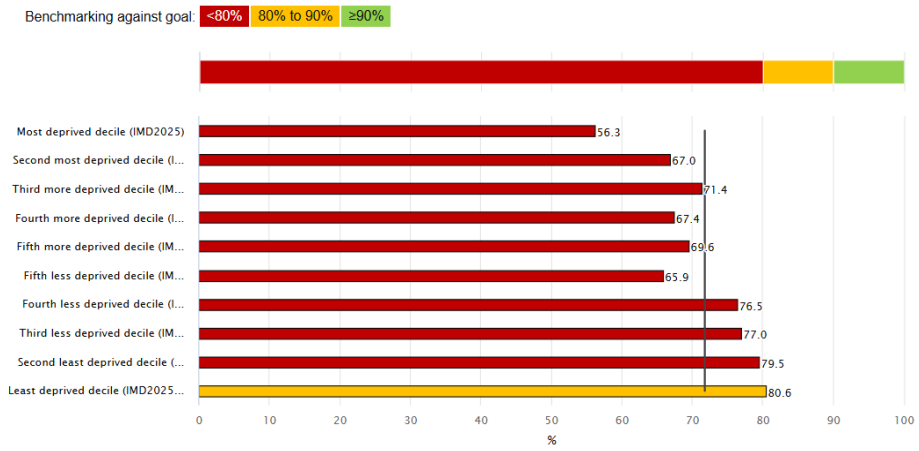


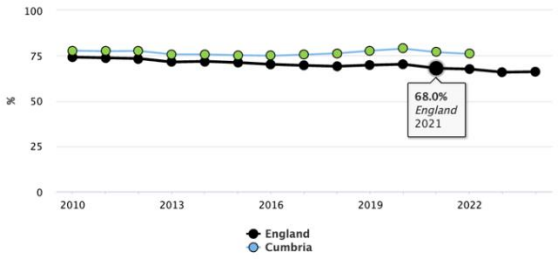
Figure C39: Cervical cancer screening coverage (aged 25-49) (2010-2022) Cumbria

C24b - Cancer screening coverage: cervical cancer (aged 25 to 49 years old)

Proportion - %

Show confidence intervals Show 99.8% CI values

▶ More options



Recent trend: ➡ No significant change

Period		Cumbria Count	Value	95% Lower CI	95% Upper CI	England
2010	●	61,710	77.7%*	77.4%	78.0%	74.1%*
2011	●	60,736	77.4%*	77.1%	77.7%	73.7%*
2012	●	60,099	77.6%*	77.3%	77.9%	73.4%*
2013	●	57,988	75.7%*	75.4%	76.0%	71.5%*
2014	●	57,338	75.6%*	75.3%	76.0%	71.8%*
2015	●	56,582	75.2%*	74.9%	75.5%	71.2%*
2016	●	55,970	74.9%*	74.6%	75.2%	70.2%*
2017	●	56,144	75.5%*	75.2%	75.8%	69.6%*
2018	●	56,474	76.3%*	75.9%	76.6%	69.1%*
2019	●	57,312	77.7%*	77.4%	78.0%	69.8%*
2020	●	57,831	78.9%*	78.6%	79.2%	70.2%*
2021	●	56,252	76.9%*	76.6%	77.2%	68.0%*
2022	●	55,743	75.9%*	75.6%	76.3%	67.6%*
2023		-	-	-	-	65.8%*
2024		-	-	-	-	66.1%*

Source: NHS England, Cervical Screening Programme

Figure C40: Cervical cancer screening coverage (aged 25-49) (2023-2024) Cumberland

Better 95% Similar Worse 95% Not applicable

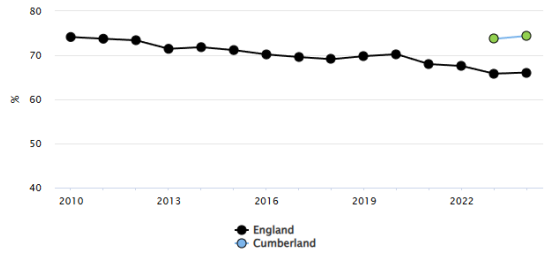
Trends for **Selected area** | All areas (grouped) Display **Selected indicator** | All indicators

Cancer screening coverage: cervical cancer (aged 25 to 49 years old)

Proportion - %

Show confidence intervals Show 99.8% CI values

▶ More options



Recent trend: Could not be calculated

Period		Cumberland Count	Value	95% Lower CI	95% Upper CI	England
2010		-	-	-	-	74.1%*
2011		-	-	-	-	73.7%*
2012		-	-	-	-	73.4%*
2013		-	-	-	-	71.5%*
2014		-	-	-	-	71.8%*
2015		-	-	-	-	71.2%*
2016		-	-	-	-	70.2%*
2017		-	-	-	-	69.6%*
2018		-	-	-	-	69.1%*
2019		-	-	-	-	69.8%*
2020		-	-	-	-	70.2%*
2021		-	-	-	-	68.0%*
2022		-	-	-	-	67.6%*
2023	●	30,767	73.7%	73.3%	74.1%	65.8%*
2024	●	31,368	74.4%	74.0%	74.8%	66.1%*

Source: NHS England, Cervical Screening Programme

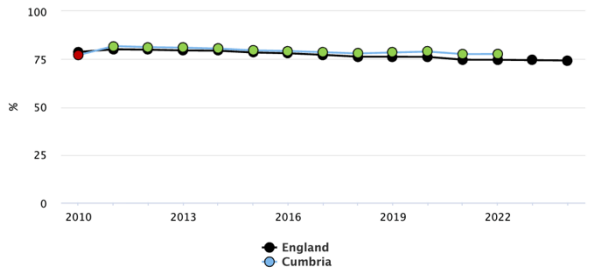
Figure C41: Cervical cancer screening coverage (aged 50-64) (2010-2022) Cumbria

C24c - Cancer screening coverage: cervical cancer (aged 50 to 64 years old)

Proportion - %

Show confidence intervals Show 99.8% CI values

▶ More options



Recent trend: ➡ No significant change

Period		Cumbria Count	Value	95% Lower CI	95% Upper CI	England
2010	●	37,046	77.1%*	76.7%	77.5%	78.7%*
2011	●	37,178	81.8%*	81.4%	82.1%	80.1%*
2012	●	36,958	81.2%*	80.9%	81.6%	79.9%*
2013	●	36,956	80.9%*	80.6%	81.3%	79.5%*
2014	●	37,250	80.5%*	80.1%	80.8%	79.4%*
2015	●	37,370	79.6%*	79.2%	79.9%	78.4%*
2016	●	37,794	79.2%*	78.8%	79.6%	78.0%*
2017	●	38,230	78.6%*	78.2%	78.9%	77.2%*
2018	●	38,649	78.0%*	77.6%	78.3%	76.2%*
2019	●	39,722	78.4%*	78.1%	78.8%	76.2%*
2020	●	40,713	78.9%*	78.6%	79.3%	76.1%*
2021	●	40,874	77.6%*	77.2%	78.0%	74.7%*
2022	●	41,549	77.7%*	77.3%	78.0%	74.6%*
2023		-	-	-	-	74.4%*
2024		-	-	-	-	74.3%*

Source: NHS England, Cervical Screening Programme

Figure C42: Cervical cancer screening coverage (aged 50-64) (2023-2024) Cumberland

●Better 95% ●Similar ●Worse 95% ○Not applicable

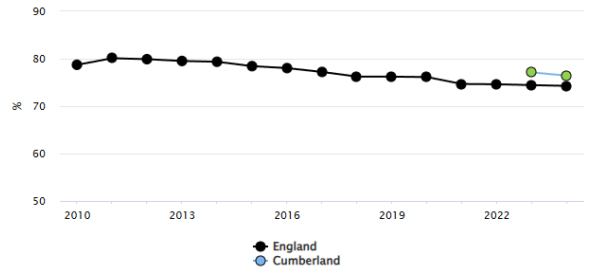
Trends for **Selected area** | All areas (grouped) Display **Selected indicator** | All indicators

Cancer screening coverage: cervical cancer (aged 50 to 64 years old)

Proportion - %

Show confidence intervals Show 99.8% CI values

▶ More options



Recent trend: Could not be calculated

Period		Cumberland Count	Value	95% Lower CI	95% Upper CI	England
2010		-	-	-	-	78.7%*
2011		-	-	-	-	80.1%*
2012		-	-	-	-	79.9%*
2013		-	-	-	-	79.5%*
2014		-	-	-	-	79.4%*
2015		-	-	-	-	78.4%*
2016		-	-	-	-	78.0%*
2017		-	-	-	-	77.2%*
2018		-	-	-	-	76.2%*
2019		-	-	-	-	76.2%*
2020		-	-	-	-	76.1%*
2021		-	-	-	-	74.7%*
2022		-	-	-	-	74.6%*
2023	●	22,328	77.1%	76.6%	77.6%	74.4%*
2024	●	22,078	76.4%	75.9%	76.9%	74.3%*

Source: NHS England, Cervical Screening Programme

Figure C43: Violent Crime – sexual offences per 1,000 population (2015/16-2024/25) Cumberland

Quintiles: Low ●●●●● High ○ Not applicable

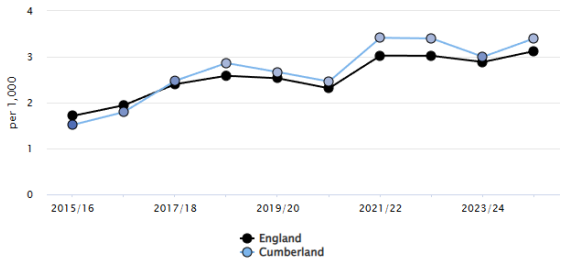
Trends for: Selected area | All areas (grouped) — Display: Selected indicator | All indicators

Violent crime - sexual offences per 1,000 population

Crude rate - per 1,000

Show confidence intervals | Show 99.8% CI values

▶ More options



Recent trend: ➡ No significant change

Period		Cumberland Count	Value	95% Lower CI	95% Upper CI	England
2015/16	●	415	1.5	1.4	1.7	1.7
2016/17	●	492	1.8	1.6	2.0	1.9
2017/18	●	679	2.5	2.3	2.7	2.4
2018/19	●	783	2.9	2.7	3.1	2.6
2019/20	●	729	2.7	2.5	2.9	2.5
2020/21	●	672	2.5	2.3	2.7	2.3
2021/22	●	930	3.4	3.2	3.6	3.0
2022/23	●	931	3.4	3.2	3.6	3.0
2023/24	●	826	3.0	2.8	3.2	2.9
2024/25	●	946	3.4	3.2	3.6	3.1

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

Appendix D: National Policy and Guidance Summary

National Strategic Developments

More recently, national ambition has been sharpened through the Towards Zero: HIV Action Plan, which commits England to ending new HIV transmissions by 2030. The Action Plan places explicit expectations on local systems to expand HIV testing, normalise opt-out testing in key settings, increase equitable access to pre-exposure prophylaxis (PrEP), reduce late diagnosis, and address persistent inequalities affecting specific population groups.

Alongside this, the emerging National Sexual and Reproductive Health Strategy 2023–2034 signals a shift towards a longer-term, whole-system approach to sexual and reproductive health. The strategy emphasises integrated commissioning across organisational boundaries, workforce sustainability, digital and remote access, and a renewed focus on health equity. Although still developing, it provides important context for future service planning and transformation and informs the strategic horizon of this HNA.

The renewed Women's Health Strategy for England further strengthens the policy focus on sexual and reproductive health across the life course, particularly access to contraception, reproductive autonomy, and the reduction of inequalities in experience and outcomes. In parallel, the Men's Health Strategy highlights lower engagement with sexual health services among men and poorer outcomes in some groups, reinforcing the need for targeted, inclusive approaches to needs assessment and service design.

Commissioning Responsibilities and Service Standards

Sexual health services operate within a complex commissioning environment involving local authorities, Integrated Care Boards (ICBs) and NHS England. Local authorities commission open-access sexual health services, including STI testing and treatment and most contraception services; ICBs retain responsibility for certain elements of contraception and abortion services; and specialist HIV treatment has historically been commissioned nationally.

The Commissioning Local HIV, Sexual and Reproductive Health Services guidance clarifies these statutory roles and responsibilities. This Needs Assessment reflects that guidance to ensure its findings and recommendations are lawful, clearly attributable, and aligned across the local system.
The Integrated Sexual Health Service (ISHS) Specification provides the operational benchmark for assessing current provision. It defines the minimum expected scope and quality of commissioned services, including clinical standards, safeguarding, digital access, workforce competencies and governance arrangements. This HNA uses the specification as a reference point to identify service gaps, variation in provision, and opportunities for improvement.

Recent and anticipated structural changes add further complexity to this landscape. NHS England is expected to undergo significant structural change, with functions transferring to other bodies, and ICBs are operating with significantly reduced workforce capacity. These changes may affect commissioning stability, clarity of responsibility and the ability of local systems to plan and deliver integrated sexual health pathways. As the transition progresses, ongoing monitoring of the impact on commissioning arrangements, workforce resilience and service coordination will be essential.

Analytical Approach and Prioritisation

This Needs Assessment follows the national SHNA: A How-To Guide, triangulating epidemiological data, service activity, population demographics and qualitative intelligence. Core data sources include the Sexual and Reproductive Health Profiles (Fingertips) and wider UKHSA surveillance data, enabling trend analysis, benchmarking and identification of inequalities at local and national levels. Findings are contextualised using evidence from the National Survey of Sexual Attitudes and Lifestyles (Natsal), which provides insight into sexual behaviours, attitudes and unmet need not visible in routine datasets.

Given sustained financial pressures and workforce constraints, the assessment is informed by the STI Prioritisation Framework, which identifies the interventions with the greatest potential population impact. This supports a focused approach to planning, particularly around testing, partner notification and condom distribution, where evidence of effectiveness is strongest.

Clinical Guidance, Prevention and Inequalities

Commissioning considerations are further informed by NICE guidance on STI prevention, HIV testing and contraception, including LARC and youth-focused services. These guidelines provide an evidence-based framework for prevention, access and quality improvement.
Reducing inequalities remains a cross-cutting priority throughout national policy. The Women's Health Strategy, Men's Health Strategy and the All Our Health: Sexual and Reproductive Health and HIV framework emphasise prevention, early intervention and the role of the wider system in improving outcomes, reinforcing the need for targeted analysis within this HNA.

In addition, the Antimicrobial Resistance (AMR) National Action Plan is an increasingly important contextual driver for sexual health services, particularly in relation to gonorrhoea. Rising antimicrobial resistance highlights the importance of surveillance, appropriate prescribing, test-of-cure, and robust partner notification, all of which are considered within this assessment.

System Pressure and Rising Demand

Demand for sexual health services continues to rise. Nationally, an estimated 4.5 million consultations were delivered in 2024, compared with approximately 2.9 million in 2013 (UKHSA). This sustained increase places significant pressure on services and reinforces the need for commissioning models that are efficient, accessible, equitable and aligned with prevention priorities.

Table D1: Policy and Guidance Summary

Policy / Guidance	Purpose / Key Focus	Relevance to Local Commissioning
Framework for Sexual Health Improvement in England (DH, 2013)	Last comprehensive national SRH framework; priorities on STI prevention, contraception access, unplanned pregnancy reduction, HIV prevention and inequalities.	Still underpins core LA responsibilities; provides statutory basis for open-access services.
Towards Zero: HIV Action Plan for England (DHSC, 2022–2025 / 2025–2030)	National ambition to end new HIV transmissions by 2030; expands testing, PrEP access, rapid treatment and stigma reduction.	Requires increased HIV testing, equitable PrEP access and targeted engagement with underserved groups.
HIV Action Plan monitoring and evaluation framework (UKHSA, 2026)	Provides the national framework for tracking progress against the HIV Action Plan, including indicators on prevention, testing, treatment, PrEP uptake, late diagnosis and inequalities across priority populations.	Enables benchmarking of local performance against national metrics; supports data-driven commissioning decisions, targeting of underserved populations and strengthening outcomes monitoring.
Commissioning Local HIV, Sexual and Reproductive Health Services (UKHSA, 2025)	Defines statutory roles of LAs, ICBs and NHSE; clarifies responsibilities for open access, contraception and STI testing.	Ensures lawful commissioning; supports pathway alignment and avoids duplication across the system.
Integrated Sexual Health Service (ISHS) Specification (UKHSA/OHID, 2023)	Operational standard for ISHS delivery: clinical scope, quality, safeguarding, digital access, workforce.	Primary reference for commissioning the new ISHS; defines minimum service expectations.
National Chlamydia Screening Programme (NCSP, UKHSA)	Targeted chlamydia testing for 15–24s; early detection, treatment and partner notification.	Guides local screening models, youth outreach and performance monitoring.
Women's Health Strategy for England (DHSC, 2022)	Ten-year plan addressing contraception, reproductive health, menopause and inequalities.	Strengthens focus on reproductive health pathways, contraception access and women's experiences of care.

Policy / Guidance	Purpose / Key Focus	Relevance to Local Commissioning
Renewed Women's Health Strategy for England (DHSC) (DHSC, 2026)	Updated 10-year strategy focused on improving women's health outcomes through system reform, prevention, digital access, and embedding women's voice, choice and equity across healthcare pathways.	Strengthens expectations on integrated women's health pathways (including contraception and reproductive health), improved access (e.g. pharmacy contraception), and reduction of inequalities through neighbourhood and digital service models.
Men's Health Strategy (DHSC, 2025)	First national strategy for men's health; highlights low engagement and sexual health inequalities.	Supports targeted testing and outreach for men, particularly in underserved or deprived groups.
National policy correspondence regarding new national strategy Letter requesting development of a new national strategy and Government response regarding new national strategy (Health and Social Care Committee and DHSC, 2025)	Letter requesting development of a new national strategy and Government response regarding new national strategy.	Highlights the absence of a refreshed national strategy and reinforces the need for locally led strategic planning and prioritisation.
Hatfield Vision for Sexual & Reproductive Health (FSRH 2023)	Calls for integrated, person-centred SRH pathways and reduced fragmentation.	Supports local ambition for integrated contraception, reproductive health and sexual health services.
STI Prioritisation Framework (UKHSA, 2023)	Identifies high-impact interventions for STI prevention and control.	Helps prioritise investment in testing, condoms, partner notification and surveillance.
UKHSA Syphilis Response Action Plan (UKHSA, March 2026)	National response to rising syphilis rates, structured around four pillars: Prevent, Test, Treat, Eliminate congenital syphilis. Includes strengthened surveillance, clinician awareness, targeted prevention and enhanced partner notification.	Directly relevant given rising local trends; supports enhanced testing pathways, targeted outreach and improved PN.
NICE NG221: Reducing Sexually Transmitted Infections (2022)	Evidence-based public health interventions for STI prevention.	Supports commissioning of prevention, outreach and community interventions.
NICE NG60: HIV Testing – Increasing Uptake (2025)	Expands routine, opt-out and targeted HIV testing.	Underpins local policies to normalise testing and reduce late diagnosis.
NICE CG30: Long-Acting Reversible Contraception (LARC) (2019)	Clinical and service guidance on LARC provision.	Supports commissioning to increase access to the most effective contraception.
NICE PH51: Contraceptive Services for Under-25s (2014)	Improves access and quality for young people.	Guides youth-friendly service models and outreach.
NICE QS129: Contraception Quality Standard (2016)	Sets expected quality measures for contraceptive services.	Supports contract monitoring and quality assurance.
BASHH Guidelines	Clinical standards for STI testing, management and outbreaks.	Ensures safe, consistent and evidence-based service delivery.
CoSRH Standards and Guidelines	Standards for contraception and reproductive healthcare.	Influences service configuration, workforce skills and quality.
BHIVA Clinical Guidelines	HIV testing, treatment and care standards.	Supports high-quality local HIV pathways and shared-care models.

Policy / Guidance	Purpose / Key Focus	Relevance to Local Commissioning
National HIV Prevention Programme (THT)	Nationally funded HIV prevention (PrEP, outreach, community engagement).	Aligns local delivery with national prevention investment.
Relationships, Sex and Health Education (RSHE) Statutory Guidance	Mandatory education framework for schools.	Links education, prevention and local public health priorities.
All Our Health: Sexual & Reproductive Health and HIV (OHID, 2022)	Public health framework emphasising prevention, workforce role and inequalities.	Supports system-wide prevention beyond specialist services.
Health Inequalities Strategies (UK frameworks) NHS England » Core20PLUS5 (adults) – an approach to reducing healthcare inequalities Addressing health inequalities through engagement with people and communities - Care Quality Commission NHS England » A national framework for NHS – action on inclusion health NHS England » Patient safety healthcare inequalities reduction framework Building blocks of health hub - FrameWorks UK	Cross-government focus on reducing inequalities.	Strengthens equity focus in SHNAs and commissioning decisions.
Violence Against Women and Girls Strategy 2025-30 (CPS)	Addresses sexual violence, coercion and exploitation.	Reinforces trauma-informed, safeguarding-aware sexual health services.
Antimicrobial Resistance National Action Plan 2024-29	Reducing antimicrobial resistance, including gonorrhoea.	Supports prudent prescribing, test-of-cure and surveillance.
LGA Blueprint for the Future of Sexual Health (2024)	Advocates sustainable funding, integration, digital innovation and workforce.	Reinforces local authority case for investment and system reform.
LGA 'Breaking Point' Report (2022)	Highlights demand, workforce and funding pressures.	Provides national evidence to contextualise local constraints.
Supporting Sexual Health Commissioning: analysing and planning (UKHSA, 2018)	Standard methodology for assessing need, demand and inequalities.	Underpins the SHNA's structure, triangulation and analytical approach.
Sexual & Reproductive Health Profiles Fingertips (DHSC)	National benchmarking tool with inequalities breakdowns.	Essential for monitoring trends, inequalities and performance.
National Survey of Sexual Attitudes and Lifestyles (Natsal)	Population-level behavioural and attitudinal data.	

Appendix E: Stakeholder Engagement

Stakeholder engagement was undertaken to complement quantitative analysis and provide qualitative insight into sexual health need, service accessibility, system pressures, and opportunities for improvement across Cumbria. This appendix summarises key themes identified through engagement with the public, service users, frontline staff, providers, and system partners, and supports interpretation of findings within the SHNA.

Engagement activity formed part of a broader programme of stakeholder and interdependency analysis designed to inform both the assessment of need and subsequent commissioning decisions. Qualitative insights on access, experience, and inequalities have been considered alongside system intelligence on capacity, clinical pathways, and interdependencies to support service design and commissioning priorities.

Engagement was designed to capture perspectives across the whole sexual health system and across Cumbria's geography, with particular attention to access, equity, prevention, and service sustainability. Findings have been triangulated across multiple engagement sources and considered alongside routine activity data and epidemiological evidence.

Engagement sources

- Public engagement
- Stakeholder engagement
- Service user feedback
- Pre-tender provider engagement
- Integrated Sexual Health Service (ISHS) staff engagement

Full details of engagement tools are available on request.

Limitations

While engagement achieved broad representation across stakeholder groups, direct service-user response rates were low despite multiple engagement routes. This reflects known challenges in capturing patient feedback in sexual health settings and reinforces the importance of triangulating insight from staff, partners and population-level data.

Methods and participation

Purpose and approach

Stakeholder engagement was undertaken in spring 2024 to build understanding of local sexual health needs, access to services and opportunities for service improvement. Engagement sought views from service users, the wider public, frontline staff and partner organisations, ensuring a whole-system perspective consistent with SHNA principles.

Methods of engagement

A mixed-methods approach was used between January and March 2024 to maximise reach and inclusivity.

Engagement methods included:

- Online questionnaires promoted through clinics, council communications, partner networks, media releases and social media
- QR-code posters and hard-copy questionnaires within sexual health clinics
- Direct email surveys to professional stakeholders and partner organisations
- A staff engagement session via Microsoft Teams
- Promotion through council staff newsletters and updates
- Direct email feedback from voluntary and community sector partners

This approach enabled participation from urban, rural and coastal areas and reflected Cumbria's population diversity and geography.

Participation and response profile

Engagement activity generated:

- 47 public responses
- 24 stakeholder questionnaire responses, plus two detailed email submissions
- One direct service-user response
- One countywide staff engagement session involving clinical and operational staff
- One online provider engagement sessions followed by 5 meetings with individual providers.

Key themes from engagement (triangulated)

1. Access and availability

Access was consistently identified as the primary barrier to meeting sexual health need across Cumbria by public respondents, stakeholders, providers and staff.

Key issues included:

- Limited clinic days and opening hours
- Lack of evening and weekend provision
- Long travel distances, particularly for rural communities
- Appointment availability constrained by estate capacity and staffing

There was strong support for more flexible delivery models, including extended hours, community-based provision, outreach clinics and regular mobile services.

2. Young people and education settings

Across engagement sources, stakeholders and staff highlighted gaps in provision for young people, including:

- Limited access outside school hours
- Variable engagement with schools across the county
- Reduced visibility following changes to previous youth-focused models

Suggested solutions included school-based drop-ins, a strengthened and youth-friendly digital offer, outreach in familiar community settings, and closer working with youth workers, education providers and voluntary organisations.

3. Digital services

Public, stakeholder and staff feedback consistently identified gaps in digital provision. Cumbria was perceived to lag behind other areas in:

- Online STI testing
- Clear, up-to-date web-based information
- Online appointment booking and digital results communication

There was strong consensus that a robust digital platform is essential to complement face-to-face services, particularly for rural populations and individuals concerned about anonymity or stigma.

4. Contraception and women's health

Feedback identified pressure points across the system relating to:

- Limited availability of coil and implant fittings
- Delays due to a small number of trained practitioners

- Gaps in contraception access for over-18s
- Emerging unmet need around menopause and wider women's health support

Stakeholders, providers and staff emphasised the need for workforce development, shared delivery with primary care and pharmacies, and more integrated pathways through women's health hubs.

5. Health promotion, prevention and inclusion

There was strong appetite for:

- Increased promotion and clearer public messaging about available services
- Outreach to seldom-heard groups, including young people, people with learning disabilities, LGBTQ+ communities, Traveller communities and people in rural isolation
- Action to reduce stigma associated with accessing sexual health services

Partnership working with the voluntary and community sector was viewed as critical to strengthening prevention and improving reach.

6. Workforce, estate and system constraints

Staff and provider feedback highlighted significant system pressures, including:

- Workforce shortages and long training lead-in times
- Estate limitations affecting confidentiality, throughput and patient experience
- Increased demand following COVID-19 and mpox
- Digital and administrative inefficiencies impacting productivity

Despite these pressures, staff consistently described strong commitment, teamwork and a shared focus on maintaining service quality and safety.

Overall insights for the SHNA

Across engagement sources, there is a clear misalignment between sexual health need and current service accessibility, particularly for young people, rural populations and individuals seeking timely contraception. Engagement findings consistently support the need for service modernisation through improved digital access, expanded outreach, strengthened workforce capacity and closer partnership working.

These qualitative insights provide essential context for interpreting epidemiological data and have directly informed the identification of priority needs and commissioning considerations within this assessment.

Summary of engagement activity

Across all engagement groups, there was strong and consistent alignment around barriers to access, the need for improved digital provision, workforce pressures and the importance of outreach and partnership working, strengthening confidence that these represent system-wide priorities for Cumbria.

Table E1: Stakeholder Engagement Activity

Audience or stakeholder group	Method of communication	Timing	Summary of findings
Staff - Cumbria Sexual Health Service	Teams staff engagement session	January 2024	Staff engagement provided detailed insight into emerging risks, operational pressures and unmet need not fully visible in routine data. Staff perspectives reinforced concerns around access, workforce sustainability, prevention gaps and inequalities affecting priority groups, providing critical context to support interpretation of epidemiological trends.
Service users	QR-code posters Online questionnaire Hard-copy questionnaires in clinics	March 2024	Although limited in volume, service-user feedback echoed wider themes around inconvenient clinic times and a preference for greater appointment flexibility and digital access. While not representative, this insight reinforces findings from public and stakeholder engagement that access and convenience remain key determinants of service uptake.
Members of the public	Online questionnaire promoted through social media and communications networks	March 2024	Public feedback reinforced access and awareness as key barriers to meeting sexual health need, particularly in rural areas. Respondents highlighted limited clinic availability, travel distances and insufficient digital access, alongside uncertainty about where to seek support beyond general practice. Public insight strongly aligns with stakeholder and staff feedback, supporting the need for more flexible, blended service models.
Stakeholders	Email invitation to online questionnaire	March 2024	Stakeholder feedback emphasised system-level challenges relating to access, workforce capacity and rural service delivery. Stakeholders highlighted the need for improved digital provision, stronger prevention and outreach activity, and clearer referral pathways, particularly for young people. These insights are consistent with public and staff perspectives and underline the importance of integrated, partnership-based models of care.
Local authority employees (Cumberland and Westmorland & Furness)	Online questionnaire via staff updates and newsletters	March 2024	Insight incorporated within the wider stakeholder findings.
Potential sexual health service providers	Online webinar and follow-up individual meetings	November 2024 - January 2025	Provider engagement highlighted operational challenges associated with delivering sexual health services across a large rural geography, alongside workforce, financial and digital constraints. Providers identified opportunities for innovation through integration with primary care and pharmacies, supporting themes raised elsewhere in relation to system sustainability and modernised delivery models.

Appendix F: Local Authority Commissioned Service Activity

Integrated Sexual Health Service

Data from the Integrated Sexual Health Service indicate that the majority of attendances reflect the local population profile, with most service users identifying as White British. Attendance among women is higher, largely due to repeat contacts for contraception and ongoing reproductive health needs.

Table F1: Cumbria Integrated Sexual Health Service Attendances (2023-24)

New and Rebook attendances *GUM* Cumbria	n=9,509
Carlisle	29%
Workington	39%
Kendal	13%
Furness	19%
New and Rebook attendances *Contraception* Cumbria	n=3,970
Carlisle	30%
Workington	37%
Kendal	13%
Furness	19%

Follow up attendances *GUM* Cumbria	n=6,576
Carlisle	35%
Workington	40%
Kendal	12%
Furness	14%
Follow up attendances *Contraception* Cumbria	n=13,322
Carlisle	32%
Workington	42%
Kendal	12%
Furness	16%

In 2023-24, Workington clinic consistently accounted for ~40% of all activity across GUM and contraception. Carlisle contributed around 30-32%, across attendance types. Kendal clinic remained the smallest activity base (~11-13%), which may reflect population need or service availability. Furness sat around 15-19%, slightly higher for contraception than GUM.

Table F2: Cumbria ISHS Clinic Attendances by Ethnicity (2022)

Ethnicity	**Carlisle** n=2,936	**Workington** n=2,518	**Kendal** n=1,478	**Barrow** n=1,774
White British	89.2%	92.1%	89.2%	90.2%
White Irish	0.34%	0.32%	0.41%	0.45%
Other White	4.1%	2.5%	3.4%	2.3%
Mixed White & Black Caribbean	0.20%	0.16%	0%	0.28%
Mixed White & Black African	0.17%	0.08%	0.20%	0.34%
Mixed White & Asian	0.17%	0.28%	0.34%	0.06%
Other Mixed Background	0.41%	0.44%	0.88%	0.45%
Asian Indian	0.14%	0.20%	0.41%	0.23%
Asian Pakistani	0.10%	0.04%	0.07%	0.06%
Asian Bangladeshi	0.03%	0.12%	0.20%	0.23%
Other Asian Background	0.48%	0.40%	0.14%	0.85%
Black Caribbean	0.14%	0.04%	0.27%	0%
Black African	0.44%	0.64%	0.34%	1.1%
Other Black	0.27%	0.16%	0.07%	0.06%
Chinese	0.27%	0.04%	0.07%	0.06%

Ethnicity	Carlisle n=2,936	Workington n=2,518	Kendal n=1,478	Barrow n=1,774
Other Ethnic Group	0.37%	0.16%	0.14%	0.28%
Not Stated	3.2%	2.3%	3.9%	3.0%

Across all clinics, the service-user profile is predominantly White British (89–92%). Minority ethnic groups each represent under 4% of activity in every locality, with slightly higher proportions of Other White groups in Carlisle and Kendal, and Black African users in Workington and Barrow. 'Not stated' responses range from 2-4%.

Table F3: Cumbria ISHS Clinic Attendances by Age (2022)

Age	Carlisle n=2,936	Workington n=2,518	Kendal n=1,478	Barrow n=1,774	Total n=8,706
<13	<0.10%	0.10%	0.20%	0.00%	0.10%
13-17	9.30%	8.50%	9.30%	10.70%	9.30%
18-21	14.50%	15.70%	15.80%	14.50%	15.10%
22-29	31.40%	34.00%	31.10%	33.30%	32.50%
30-39	24.90%	24.70%	24.40%	24.70%	24.70%
40-50	12.80%	11.20%	12.70%	11.60%	12.10%
51-60	5.00%	4.30%	4.70%	3.90%	4.50%
>60	2.00%	1.50%	1.80%	1.30%	1.70%

Around 57% of ISHS attendances are among people aged 22-39, consistent across all clinic locations. Young people aged under 18 account for ~9-11% of activity, with slightly higher representation in Barrow. Attendance among those aged over 50 remains low, reflecting known patterns of service use rather than absence of need.

Table F4: Cumbria ISHS Clinic Attendances by Gender, 2022

Gender at Birth	Carlisle n=2,936	Workington n=2,518	Kendal n=1,478	Barrow n=1,774	Total n=8,706
Male	33.0%	29.47%	34.91%	34.89%	**32.70%**
Female	63.90%	66.00%	60.60%	60.10%	63.20%
Gender Identity not same as gender at birth	3.10%	4.50%	4.50%	5.00%	4.10%

Across Cumbria, around two-thirds of attendances are among females (63.2%), with males accounting for 32.7%. Individuals whose gender identity is not the same as their gender at birth comprise 4.1% of attendances overall, with slightly higher representation in Barrow and Kendal, consistent with the inclusive role of specialist sexual health services.

Table F5: Cumbria ISHS Clinic Attendances by Sexual Orientation (2022)

Sexual Orientation	Carlisle n=2,936	Workington n=2,518	Kendal n=1,478	Barrow n=1,774	Total n=8,706
Heterosexual or Straight	72.6%	72.4%	68.4%	77.9%	72.9%
Gay	6.2%	3.8%	5.9%	3.4%	4.9%
Lesbian	0.2%	0.3%	0.2%	0.2%	0.2%
Bisexual	5.0%	4.4%	4.2%	4.5%	4.6%
Not asked	1.0%	0.1%	3.4%	2.5%	1.5%
Not sure	0.4%	0.4%	0.4%	0.3%	0.4%
Declined answer	0.1%	0.0%	0.3%	0.3%	0.2%
Not known	14.5%	18.7%	17.2%	10.8%	15.4%

Overall, just under three-quarters (72.9%) of service users identify as heterosexual or straight. Lesbian, gay and bisexual users together account for around 9.7% of attendances, with variation between localities. A relatively high proportion of records have sexual orientation recorded as *not known* (15.4% overall), which may reflect differences in data collection practices and should be considered when interpreting local variation.

Table F6: Cumbria ISHS Clinic Attendances by Gender Identity (2022)

Gender Identity	Carlisle n=2,936	Workington n=2,518	Kendal n=1,478	Barrow n=1,774	Total n=8,706
Male	33.24%	29.50%	35.20%	35.20%	32.90%
Female	63.90%	66.10%	60.80%	60.30%	63.30%
Non-binary	0.10%	0.10%	0.30%	0.10%	0.10%
Other	0.00%	0.00%	0.00%	0.10%	0.00%
Not stated	0.00%	0.10%	0.10%	0.10%	0.10%
Not known	2.76%	4.10%	3.70%	4.20%	3.60%

Overall, around 63% of attendances are among females, with approximately 33% among males. A small proportion of service users identify as non-binary or other genders, while a modest share of records (3.6% overall) are recorded as *not known*, highlighting the importance of continued improvements in equality data completeness.

Table F7: Top referral reasons for young people accessing Cumbria ISHS (11/2022 - 10/2023)

Referral reason	% of top reasons
STI screen – symptomatic	**25.5%**
STI screen – asymptomatic	**24.2%**
Contraception start	**23.3%**
Implant	**18.1%**
Pregnancy-related (test or TOP)	**9.0%**

STI screening (symptomatic and asymptomatic combined) accounts for almost half (49.7%) of the most common referral reasons for young people, with contraception-related presentations representing over 40%, highlighting the dual role of ISHS in infection control and pregnancy prevention.

Primary Care

Table F8: Primary Care Framework Sexual Health Attendance (2023-24)

Percentages calculated as a proportion of all recorded activity within each area
(Cumberland n = 4,148; Westmorland & Furness n = 3,288; Total n = 7,436)

Activity	Cumberland %	Westmorland & Furness %	Total %
STI Level 1 screen (asymptomatic)	6.1%	9.4%	11.7%
STI Level 1 follow-up	1.1%	2.7%	3.0%
STI Level 2 screen (symptomatic)	14.3%	3.1%	10.7%
STI Level 2 follow-up	11.0%	0.9%	6.9%
IUCD fitting*	31.7%	40.4%	53.4%
Implant fitting	18.0%	22.3%	29.8%
Implant removal	17.8%	21.3%	28.7%
Total	**100%**	**100%**	**100%**

*IUCD removal has also subsequently been added to the framework

As a proportion of recorded primary care sexual health activity within each commissioning area, contraceptive procedures - particularly IUCD and implant fitting and removal - account for the majority of activity. Differences between Cumberland and Westmorland & Furness should be interpreted in the context of differing commissioning arrangements, service configuration and workforce capacity.

Activity patterns reflect both clinical need and commissioning scope. Not all forms of contraceptive provision are commissioned consistently across areas, and some procedures (e.g. IUCD fitting) may be delivered for both contraceptive and non-contraceptive indications.

Pharmacy

Table F9 Pharmacy Framework Emergency Hormonal Contraception Attendance Cumbria

(% of total EHC consultations, 2023-24; n = 3,182)

Pharmacy Framework	Cumberland n=1,632	Westmorland & Furness n=1,550
Emergency Hormonal Contraception Consultation	51.3%	48.7%

During 2023-24, Emergency Hormonal Contraception (EHC) consultations delivered through the Pharmacy Frameworks in Cumbria were broadly evenly distributed between Cumberland (51.3%) and Westmorland and Furness (48.7%).

As outlined in Section 5.4.1, responsibility for commissioning pharmacy-based contraception, including EHC, changed to national commissioning by NHS England in October 2025. This change has implications for how local activity data should be interpreted. While the figures provide useful insight into the distribution of recorded EHC consultations, local authorities no longer hold direct commissioning levers for

this provision, and the availability, configuration and reporting of pharmacy activity are determined through national contractual arrangements.

Consequently, observed variation should be interpreted in the context of population distribution and service utilisation rather than as a direct reflection of local commissioning decisions or unmet need. Ongoing collaboration with NHS England and ICB partners will remain important to maintain oversight of access, equity and demand for emergency contraception across the area.

Appendix G: Abbreviations

Abbreviation	Term
AIDS	Acquired Immune Deficiency Syndrome
ADPH	Association of Directors of Public Health
AMR	Antimicrobial Resistance
ART	Antiretroviral Therapy
BASHH	British Association for Sexual Health and HIV
BBV	Blood Borne Virus
BHIVA	British HIV Association
BME	Black Minority Ethnic
BAME	Black, Asian and Minority Ethnic
BPAS	British Pregnancy Advisory Service
CEYP	Care Experienced Young People
CTAD	Chlamydia Testing Activity Dataset
CDS	Condom Distribution Scheme
CoSRH	College of Sexual and Reproductive Healthcare
COVID-19	Coronavirus Disease 2019
CSEW	Crime Survey for England and Wales
C&L	Cumbria and Lancashire
DHSC	Department of Health and Social Care
DNA	Did Not Attend
EHC	Emergency Hormonal Contraception
ECDC	European Centre for Disease Prevention and Control
EMA	Early Medical Abortion
FSRH	Faculty of Sexual and Reproductive Healthcare
FSW	Female Sex Workers
GBMSM	Gay, Bisexual and Men who have Sex with Men
GP	General Practice / General Practitioner
GUM	Genitourinary Medicine
GUMCAD	Genitourinary Medicine Clinic Activity Dataset
GRT	Gypsy, Roma and Traveller
HAV	Hepatitis A Virus
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HDV	Hepatitis D Virus
HIV	Human Immunodeficiency Virus
HPV	Human Papillomavirus
IDPS	Infectious Diseases in Pregnancy Screening
ISVA	Independent Sexual Violence Advisor
ICB	Integrated Care Board
ICS	Integrated Care System
ISHS	Integrated Sexual Health Service
IUCD	Intrauterine Contraceptive Device
IUD	Intrauterine Device
IUS	Intrauterine System
JCVI	Joint Committee on Vaccination and Immunisation
KPI	Key Performance Indicator
LA	Local Authority

Abbreviation	Term
LAC	Looked After Children
LBWSW	Lesbian, Bisexual and Women who have Sex with Women
LGBTQ+	Lesbian, Gay, Bisexual, Trans and Queer/Questioning
LASERS	Local Authority Sexual Health, Reproductive Health and HIV Epidemiology Reports
LARC	Long-Acting Reversible Contraception
LAC	Looked After Children
L&SC	Lancashire and South Cumbria
MSW	Male Sex Workers
MSM	Men who have Sex with Men
Mpox	Monkeypox (current WHO terminology: Mpox)
NATSAL	National Survey of Sexual Attitudes and Lifestyles
NCSP	National Chlamydia Screening Programme
NCMD	National Child Mortality Database
NICE	National Institute for Health and Care Excellence
NUPAS	National Unplanned Pregnancy Advisory Service
NHSE/I	NHS England / Improvement
NCIC	North Cumbria Integrated Care
NENC	North East and North Cumbria
NSC	National Screening Committee
OHID	Office for Health Improvement and Disparities
ONS	Office for National Statistics
PCS	Pharmacy Contraception Service
PCN	Primary Care Network
POCT	Point of Care Testing
PEPSE	Post-Exposure Prophylaxis after Sexual Exposure
PrEP	Pre-Exposure Prophylaxis
PHE	Public Health England
PHOF	Public Health Outcomes Framework
PID	Pelvic Inflammatory Disease
PWID	People Who Inject Drugs
RCOG	Royal College of Obstetricians and Gynaecologists
ROI	Return on Investment
RSHE / RSE	Relationships, Sex and Health Education
SARC	Sexual Assault Referral Centre
SDU	Sexualised Drug Use
SED	Socioeconomic Deprivation
SHNA	Sexual Health Needs Assessment
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
STD	Sexually Transmitted Disease
TB	Tuberculosis
TOP	Termination of Pregnancy
UKHSA	UK Health Security Agency
UNAIDS	Joint United Nations Programme on HIV/AIDS
UDM	User-Dependent Method
VCS	Voluntary and Community Sector
WHO	World Health Organization
WSW	Women who have Sex with Women

Appendix H: References

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