NHS Greater Manchester Integrated Care

Bury Council

Young Peoples Sexual Health Needs Assessment

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Abbreviations

CAMHS	Child and Adolescent Mental Health Services
CSA	Child Sexual Abuse
CSE	Child Sexual Exploitation
EHC	Emergency Hormonal Contraception
FGM	Female Genital Mutilation
GBMSM	Gay, Bisexual and other Men who have Sex with Men
GM	Greater Manchester
HCRG	Specialist Sexual Health Service
HIV	Human Immunodeficiency Virus
HNA	Health Needs Assessment
HPV	Human Papilloma Virus
IMD	Index of Multiple Deprivation
IUD	Intra-Uterine Device
IUS	Intra-Uterine System
ISHS	Integrated Sexual Health Service
LARC	Long-Acting Reversible Contraception
LGB+	Lesbian, Gay, Bisexual or another minority sexual orientation
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Plus other gender and sexual identities such as Intersex, Asexual, Pansexual
MSM	Men who have Sex with Men
NATSAL	National Survey of Sexual Attitudes and Lifestyles
NCSP	National Chlamydia Screening Programme
OHID	Office for Health Improvement and Disparities
ONS	Office for National Statistics

Contents

Executive Summary

Introduction

Young people are one group within the population with poorer sexual health outcomes, including higher rates of sexually transmitted infections (STIs). Addressing the sexual health of young people can be complex given their changing needs as they move through key life stages from childhood, through puberty and adolescence to early adulthood. Furthermore, the sexual health of young people is also affected by the wider determinants of health, such as socio-economic status, education, social networks, and individual lifestyle factors. Additionally, societal stigma and discrimination can influence the ability of vulnerable groups to access sexual health services. Whilst good sexual health services must be accessible to all young people in Bury, tackling sexual health inequalities also requires targeting interventions towards our more vulnerable groups.

Methodology

This sexual health needs assessment (SHNA) has been conducted to understand the sexual health needs of young people aged under 25 years old living in Bury and determine how effectively the current services are working to meet those needs. A literature review was conducted, as well as a description of the population demographics, review of the sexual health outcomes and qualitative data from relevant stakeholders.

Key findings

Bury Demographics (under 25s)

- The population of young people in Bury aged 10-24 years comprises 17.3% of the total population, a slightly lower figure compared to the national average for England.
- The population of under 25s in Bury is projected to be 57,285 in 2025 and 57,942 in 2030, a projected increase of 1.14%.
- Sedgley Park has the highest percentage of 15–24-year-olds of all the wards in the borough.
- East and Moorside are the most deprived wards in Bury and North Manor and Tottington are the least deprived wards in Bury.
- Most young people in Bury identify as White, however, Bury has an ethnically diverse population, with the second most common ethnicity being Asian, followed by Black or African, Mixed and some groups identify as other.
- Most young people in Bury identify as Christian, almost a third of the residents have no religion, a smaller percentage identify themselves as Muslim and Jewish.
- Most of the residents aged under 25 years old identify as straight, and a smaller percentage of residents identify as Lesbian, Gay, Bisexual or other (LGBTQ+).
- Bury had the 3rd lowest Average Attainment 8 score in its group of 6 statistical children service neighbours.
- Bury has the seventh highest number of looked after children relative to its population size of the ten GM local authorities.
- The proportion of individuals aged 16 to 17 years who are not engaged in education, employment, or training (NEET), or whose current activity status is unknown, is significantly lower than the national average.

STIs and HIV

- Overall, the number of new sexually transmitted infections (STIs) diagnosed among residents of Bury in 2022 was lower than the rate in England, and lower than the average of its nearest statistical neighbours.
- There was a decrease in STI testing and diagnoses in 2020 due to the reconfiguration of sexual health services during the COVID-19 pandemic response, with testing rates largely recovering during 2021, but diagnoses overall remaining lower.
- The chlamydia detection rate for women aged 15-24 in Bury is comparable to the England average, but it is significantly below the recommended detection rate.
- In 2022, the rate of gonorrhoea increased significantly compared to 2021 but is lower than the national rate.
- Decreases in genital warts diagnoses due to the protective effect of HPV vaccination are evident in the younger age groups who have been offered the vaccine since the national programme began in 2008.
- The syphilis rate per 100,000 in Bury was statistically lower than the national rate.
- The percentage of people aged 15 years and over in Bury accessing HIV care who were prescribed antiretroviral treatment in 2021 was similar to the average for England. The percentage of people in Bury newly diagnosed with HIV in the three-year period between 2019 - 21 who started antiretroviral therapy (ART) promptly (within 91 days of their diagnosis) was similar to England.
- In 2021/2022, the proportion of Year 8 students (12-to-13-year-olds) in Bury who received the first HPV vaccine was higher than the England average.

Reproductive Health

- In 2021, the under-18s conception rate was higher than the rate in England, although Bury has seen steeper falls in under-18 conceptions since 1998 than England.
- The total abortion rate per 1,000 female population aged 15 to 44 years was higher than the rate in England in 2021.

Relationships and Sex Education

Feedback from stakeholders and young people found:

- There is a need to have more readily available information on services in Bury, contraception, STIs, consent, sexual exploitation, healthy relationships, sexuality, and LGBTQ+.
- There is also a need to address experiences of sexism within educational settings and management of young people's first sexual encounters expectations.
- Regular sexual health training updates are required in multi-disciplinary settings to strengthen relationships between services.
- Appropriate resources should be provided for staff to discuss the influence of pornography on young people's expectations of sex, supporting young people exploring their gender identities and sexualities, and providing more advice to schools on what is age-appropriate sexual behaviour.

Recommendations

1. Establish a Bury Sexual Health Network to enable a more effective whole systems approach to young people's sexual health strategies and services across the borough.
2. Share the summary of the findings from this Sexual Health Needs Assessment with relevant stakeholders to inform the newly established sexual health network's local action plans.
3. Provide adequate guidance and training around age-appropriate sexual behaviour to support school staff to make informed decisions around appropriate referrals for educational support.
4. Reinstate regular sexual health refresher and update training to all stakeholders involved in sexual health services and support for young people in Bury.
5. Build stronger relationships with local schools, and appropriate wider services to understand any gaps in relationships and sex education around the topics of sexism, coercive control, LGBTQ+ sexual health, and how to access local sexual health services. Look to share examples of good practice and resources locally.
6. Conduct further assessment on the needs of LGBTQ+ young people in Bury around their sexual health, and how this intersects with other aspects of their cultural, religious and ethnic identities.
7. Increase young people's awareness of the HCRG services available in Bury by finding better advertising strategies, targeting platforms and spaces young people often use.
8. Increase promotion of the C-Card scheme amongst young people by continuous expansion to the scheme to wider services that have regular contact with young people, aiming to increase the use of condoms amongst young people in Bury, subsequently addressing the elevated rate of teenage pregnancy and reducing the STIs transmission.
9. Use feedback from young people to improve the Sexual Health Network, strengthening relationships between Bury youth engagement workers, Voice2Voice workers and school nurses.
10. Consider the increase in the accessibility of Bury HCRG clinic opening times. From the feedback, young people suggested making services more available during weekday afternoon and evening, and some weekend daytimes to enable young people to access sexual health services.
11. Provide more in-depth training and support for stakeholders around how to support young people who are questioning their sexuality or gender identity, and how to address the influence of pornography on young people's understanding of healthy relationships.
12. Consider app-based resources accessible to young people in Bury, with appropriate information related to their relationship and sexual health needs, contact details for local services, and access to the remote HCRG offer.
13. Conduct more in-depth engagement work to understand what methods are preferred by young people to access information and services.
14. Improve remote offers (online, via phone or text message) and in-person offer (through appointment based and drop-in clinics) to meet the different preferences and needs of young people in Bury.
15. Consider creating a designated page on the HCRG website for YP, with links to appropriate video resources and further reading.
16. Ensure regularly updated information and resources around sexual health targeted at young people are available on the HCRG website.
17. Work with HCRG to increase the proportion of young people attending the service who are screened, treated, and seek advice on STIs and contraception.

18. Seek to increase opportunistic chlamydia screening in wider settings outside of the HCRG specialist sexual health service by providing support and testing kits to school nurses, youth services, youth justice and other colleagues.
19. Consider introducing STI screening testing kits into local pharmacies, particularly targeting those with high rates of emergency contraception provision.
20. Raise awareness of the rising rates of gonorrhoea and syphilis amongst local young people and service providers, and promote the ways that they can access STI testing. Young people are a key high-risk group to target, alongside residents who are more socioeconomically deprived, GBMSM and black Caribbean ethnicity.
21. Address the low syphilis detection rates in Bury by optimising the four prevention pillars as outlined in the National Syphilis Action Plan. These include:
    a. Increasing testing frequency of high-risk GBMSM and re-testing of syphilis cases after treatment
    b. Delivering partner notification to BASHH standards
    c. Maintaining high antenatal screening coverage and vigilance for syphilis throughout antenatal care
    d. Sustaining targeted health promotion.

22. Complete further work to understand the distribution of HPV vaccine uptake across Bury at ward and school level. Engage with young people, their parents and carers, schools and other key stakeholders to better understand the reasons for falling HPV vaccine uptake in Bury post-COVID.
23. Continue to work with GPs to develop a neighbourhood model for LARC provision in Bury Council to reduce waiting times and increase access for patients.

Introduction

The World Health Organization (WHO) defines sexual health as a state of physical, emotional, mental, and social wellbeing in relation to sexuality and not just the absence of disease, dysfunction, or infirmity. Sexually Transmitted Infections (STIs) and their complications, unintended pregnancies and terminations of pregnancies all carry high burdens of physical and psychological consequences, which can widen inequalities.

Good sexual health has a positive impact on general wellbeing, physical and reproductive health, as well as interpersonal, educational, and financial wellbeing. On the other hand, the consequence of poor sexual health also has a strong impact on the society, affecting both health and social outcomes. The treatment and management of these outcomes and their wider negative repercussions incur costs to society and the public.

A public health approach to sexual health prioritises reducing inequalities. Young people are one group within the population with poorer sexual health outcomes, including higher rates of sexually transmitted infections (STIs). Addressing the sexual health of young people can be complex given their changing needs as they move through key life stages from childhood, through puberty and adolescence to early adulthood. Furthermore, the sexual health of young people is also affected by the wider determinants of health, such as socio-economic status, education, social networks, and individual lifestyle factors. Additionally, societal stigma and discrimination can influence the ability of vulnerable groups to access sexual health services.

Aim

The aim of this Children's and Young people's Sexual Health Needs Assessment (CYPSHNA) is to seek a better understanding of the current sexual health services (SHS) available in Bury, to see whether the needs and demands of the population are being accordingly met, identify any potential gaps and issues that could be prioritized and addressed. This CYPSHNA is focused on young people under 25, as they are amongst the most vulnerable groups, especially looked after children and young people, refugees and asylum seekers, young people with learning disabilities and young people who identify as part of the LGBTQ+ community. This CYPSHNA will be looking into the local population demographics, local sexual health services and outline the findings from a consultation with relevant stakeholders, to inform future sexual health strategies and commissioning decisions.

The aims of this CYSHNA are:

• To describe the current sexual and reproductive health needs of younger Bury residents.

• To assess the provision of access and utilisation of sexual and reproductive health services by younger Bury residents, to identify needs and barriers to ensure equitable services and to reduce variation in outcomes.

• To ensure that the sexual and reproductive health needs of Bury residents are included in all future commissioning, service planning and provision across the whole system

The purpose of this needs assessment is to consider the current and emerging sexual health needs of children and young residents who live in Bury.

Outline of Scope

1. STI Screening
2. Contraception (and under 18 pregnancies and abortions)
3. Advice
4. Education
5. Safeguarding
    - Child Sexual Abuse & Child Sexual Exploitation
    - Female Genital Mutilation
    - Building Healthy Relationships

Vulnerable/Priority Groups

- CYP in the care system
- Refugees & asylum seekers
- Learning disabilities
- LGBTQ

Methodology

This SHNA comprised of two key components; an epidemiological and corporate needs assessment.

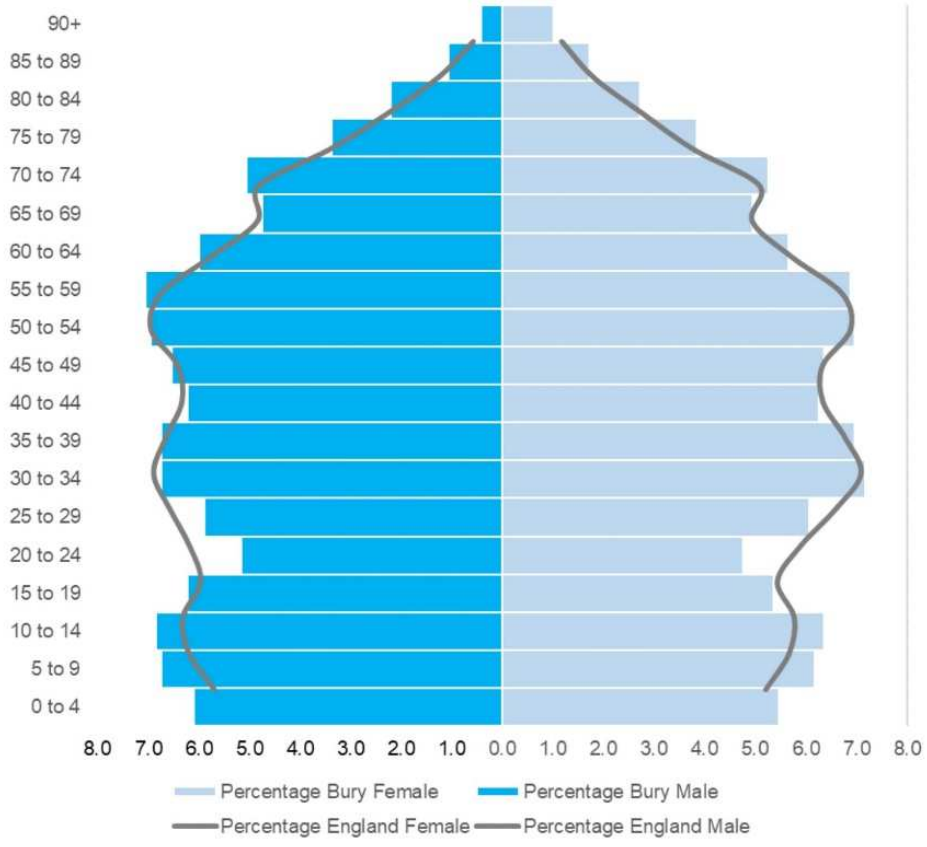
- The epidemiological component includes:
    - A description of the demographics of young people in Bury.
    - A literature review around the sexual health needs of young people in the UK.
    - A review of key sexual health outcomes for young people in Bury, compared to regional and national performance.
    - A review of local sexual health service data.
- The corporate component includes:
    - The views of local stakeholders who work with young people to support their sexual health needs, which were gathered through interviews.
    - The views of young people in Bury, which were gathered through anonymous surveys and focus groups designed and ran by Voice2Voice workers.

Background

Bury Demographics

The Metropolitan Borough of Bury consists of six towns - Bury, Ramsbottom, Tottington, Radcliffe, Whitefield, and Prestwich. The Borough of Bury sits north of Manchester and is made up of 17 electoral wards. In the north, Ramsbottom and Tottington are largely rural, while the centre and south are more urban. Bury has a resident population of around 193,800, with 95,100 males (49%) and 98,800 females (51%). In Bury, the population size has increased by 4.7%, from around 185,100 in 2011 to 193,800 in 2021. Between the year 2023 and 2033 there will be a projected increase of almost 5,798 people living in Bury (JSNA, 2023). The population of Bury is projected to be 195,422 in 2025 and 198,241 in 2030, an increase of 1.44%. Figure 1 below presents the population pyramid for Bury and compares the age distribution of Bury with England.

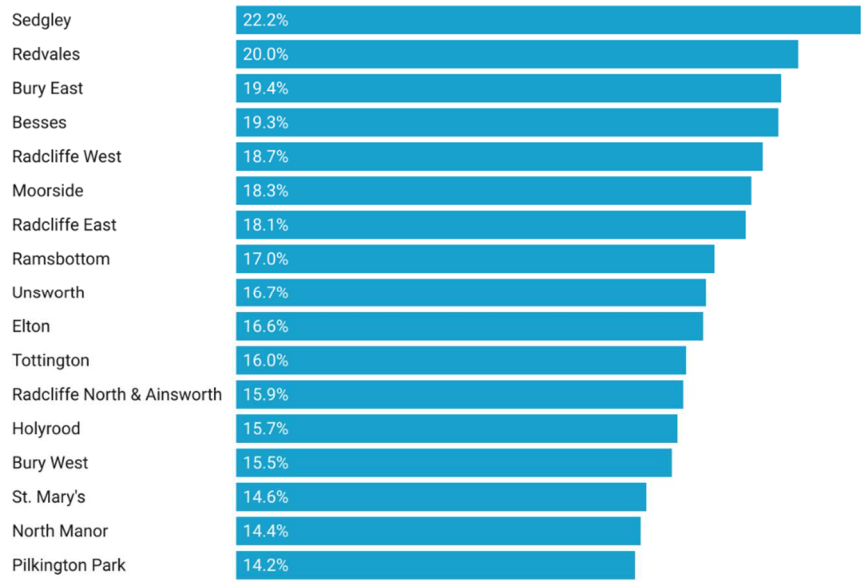
Figure 1. Population pyramid presenting the percentage composition by 5-year age group and gender of resident population in Bury compared with England (Census 2021)



Under 25s (10 to 24 years old)

The population of young people in Bury aged 10-24 years comprises 17.3% of the total population, a slightly lower figure compared to the national average for England (17.8%). The distribution of young people aged 10-24 is generally concentrated in Sedgley and Redvales, as demonstrated in Figure 2. In contrast, North Manor and Pilkington Park have the lowest proportion of young people within that age range with 14.4% and 14.2%, respectively (Bury JSNA, 2023). The population of under 25s in Bury is projected to be 57,285 in 2025 and 57,942 in 2030, a projected increase of 1.14% (Census 2021 and Bury JSNA, 2023).

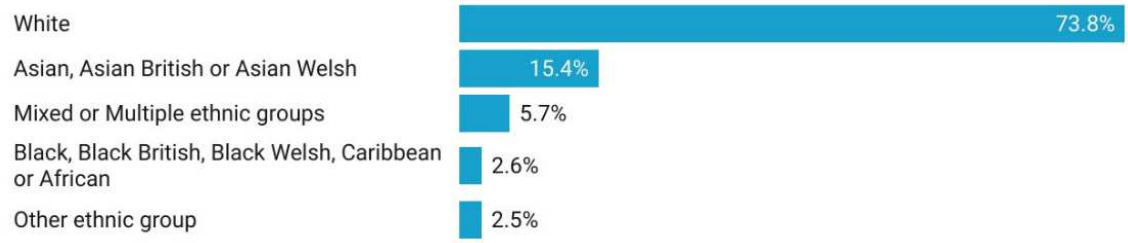
Figure 2. Proportion of population aged 10-24 years living in each ward of Bury as a percentage of the total population in that ward (JSNA, 2023).



Ethnicity

In under Bury 73.8% of residents aged 25 years old, identify their ethnic group as White. The second most common ethnic group is “Asian, Asian British or Asian Welsh” accounting for 15.4% of under 25s. 5.7% of under 25s identify as themselves as “Mixed or have multiple ethnic groups”, 2.6% identify themselves as “Black, Black British, Black Welsh, Caribbean or African” and 2.5% identify as being part of other ethnic groups, as demonstrated in Figure 3 (Census, 2021 and Bury JSNA, 2023) .

Figure 3. Percentage of Bury residents under 25 years of age by ethnic group (Census 2021)

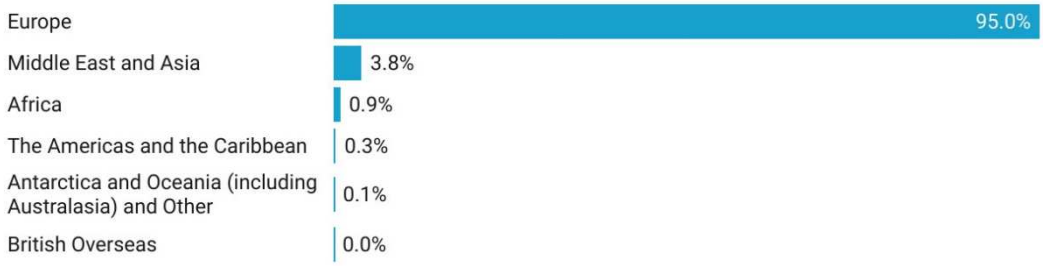


Birth Country

In Bury, 95% of the residents aged under 25 years old were born in the UK. The second highest country of birth was the Middle East and Asia, with 3.8%, followed by Africa with 0.9%. A smaller proportion

of Bury residents under 25s were born in The Americas and the Caribbean (0.3%), Antarctica and Oceania (0.1%) and British Overseas (less than 0.1%), as demonstrated in Figure 4. Bury, Fernhill and Pimhole have the lowest percentage of residents born in the UK and Summerseat and Nuttall & Tottington have the highest percentage (Census, 2021 and JSNA, 2023) .

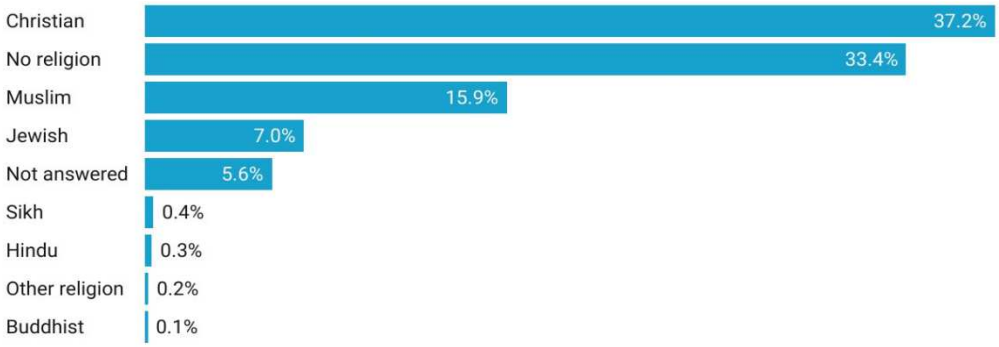
Figure 4. Percentage of Bury residents under 25 years of age by birth country (Census 2021)



Religion

In Bury, 37.2% of the residents aged under 25 years old described themselves as Christian, whilst 33.4% of Bury residents under 25 reported having "No religion", 15.9% identified themselves as Muslim and 7.0% as Jewish. A smaller percentage Bury residents under 25, identified as Sikh (0.4%), Hindu (0.3%), having other religions (0.2%) and Buddhist (0.1%), as demonstrated in Figure 5. In Bury, North Manor has the highest percentage of Christian residents and Sedgley has the highest percentage of Jewish residents (Census, 2021 and Bury JSNA, 2023) .

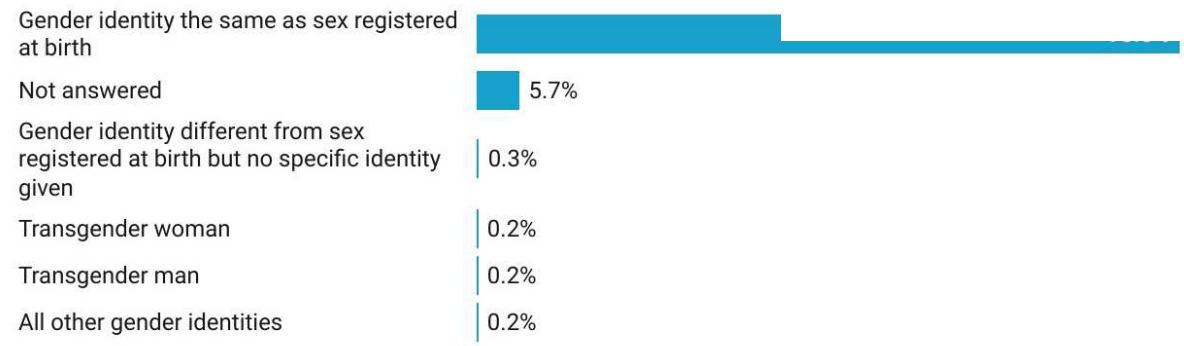
Figure 5. Percentage of Bury residents under 25 years of age by religion (Census 2021)



Gender identity

In Bury, 93.5% of the residents aged under 25 years old, identified has having the same gender identity as sex registered at birth, 0.3% identified as having a different gender from sex registered at birth, 0.2% identified as Transgender woman, 0.2% as Transgender man, 0.2% identified as having all other gender identities and and 5.7% had not answered the question (Census, 2021 and Bury JSNA, 2023) .

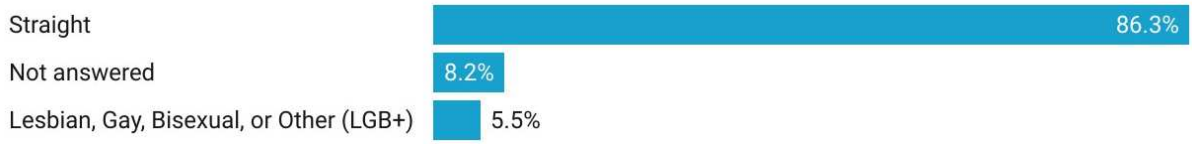
Figure 6. Percentage of Bury residents under 25 years of age by gender (Census 2021)



Sexual orientation

In Bury, 86.3% of the residents aged under 25 years old, identify as straight, 5.5% of the residents identify as Lesbian, Gay, Bisexual or other (LGBTQ+), and 5.5% have not answered, as demonstrated in Figure 7. Bank Top & Radcliffe East have the highest percentage of Straight or Heterosexual and Whitehead Park the lowest (Census, 2021 and JSNA, 2023) .

Figure 7. Percentage of Bury residents under 25 years of age by sexual orientation (Census, 2021)



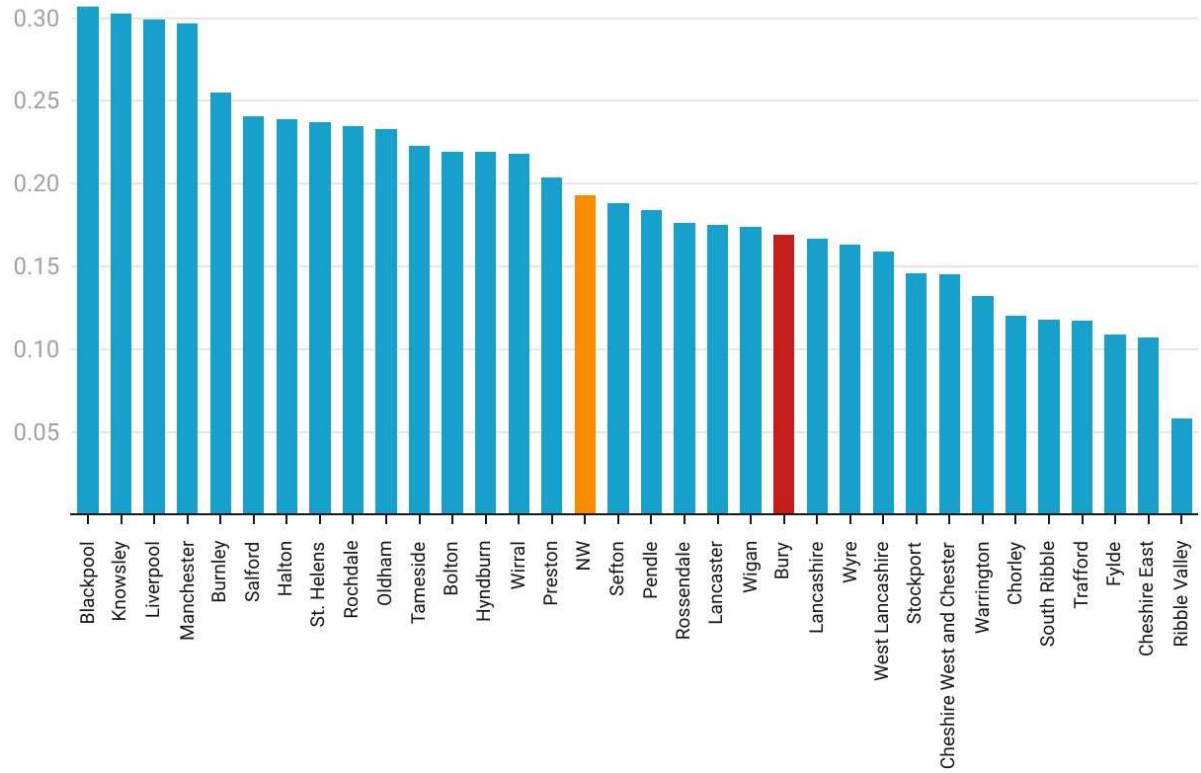
Deprivation

Bury ranks 95th from the 317 Local Authorities in England in terms of deprivation, ranking in the 3rd most deprived decile in England at Local Authority level. Overall, Bury is the 8th most deprived of the 10 GM districts. Out of 120 Lower Super Output Areas in Bury, 12 (10%) of them fall within the 10% most deprived areas of the nation, concentrated primarily around Bury town centre, Radcliffe and Besses.

Evidence suggests that there is evidence that childhood poverty leads to premature mortality and poor health outcomes. The most recent data from 2020/21, 16.1% of children under 16 years of age are in absolute low-income families, higher to England average of 15.3%. In comparison to its six neighbouring statistical children services, Bury has the 3rd highest percentage of children living in absolute low-income families with the lowest percentage in Stockport of 10.7% and highest in Stockton-on-Tees at 19% (Child and Maternal Health, 2022).

The Income Deprivation Affecting Children Index (IDACI) score is a sub-set of the Income Deprivation domain which measures the proportion of all children aged 0 to 15 living in income deprived families. The more deprived is an area, the higher the IMD score but the lower the rank. For the period of 2017-2019, the income deprivation affecting children index (ICACI) score for Bury was 0.169, the 22nd highest score amongst the NW local authorities and significantly lower than the local average of 0.193, as demonstrated in Figure 8 (MHCL, 2019).

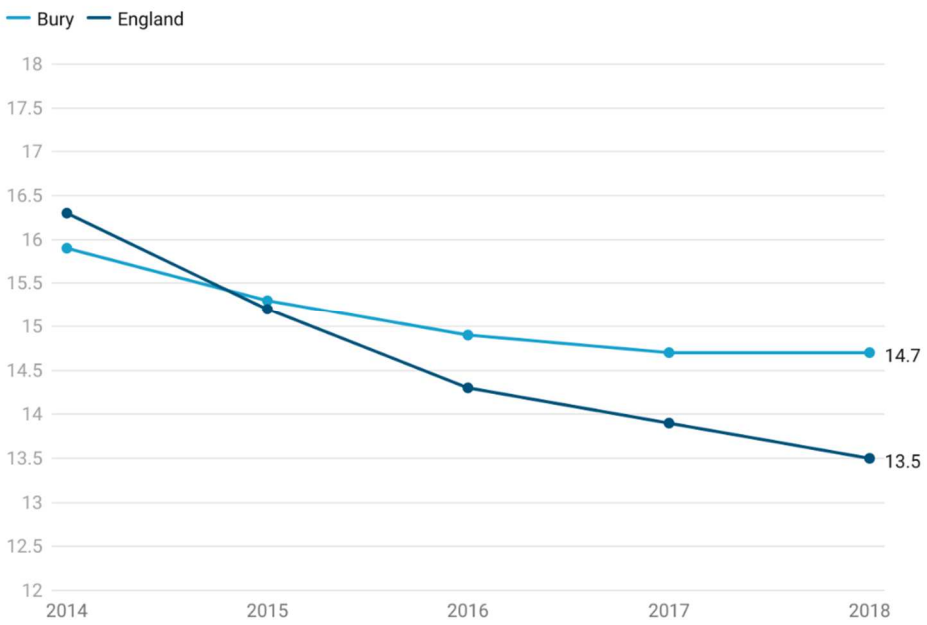
Figure 8- IMD - Income Deprivation Affecting Children Index (IDACI) score -All NW local authorities (2017 to 2019) Ministry of Housing, Communities and Local Government, 2019



Free school meals: % uptake among all pupils

Children and young people in the UK are usually eligible for free school meals (FSM) if their parents or carers are on a low income or in receipt of certain benefits. Eligibility for FSM provides a meaningful insight into child poverty and serves as a proxy for socioeconomic disadvantage among school-aged children. It is defined as the percentage of pupils known to be eligible for and claiming free school meals who attend a state funded nursery, primary, secondary or a special school. The most recent data in Bury (2018), indicates that 14.7% of pupils had access to free school meals, higher than England average of 13.5%, as demonstrated in Figure 9. Bury has the 3rd highest % uptake of free school meal among all pupils in its group of 6 statistical children service neighbours.

Figure 9. Trend in % uptake of free school meal among all pupils for Bury and England from the year 2014 to 2018 (Child and Maternal Health, 2022)

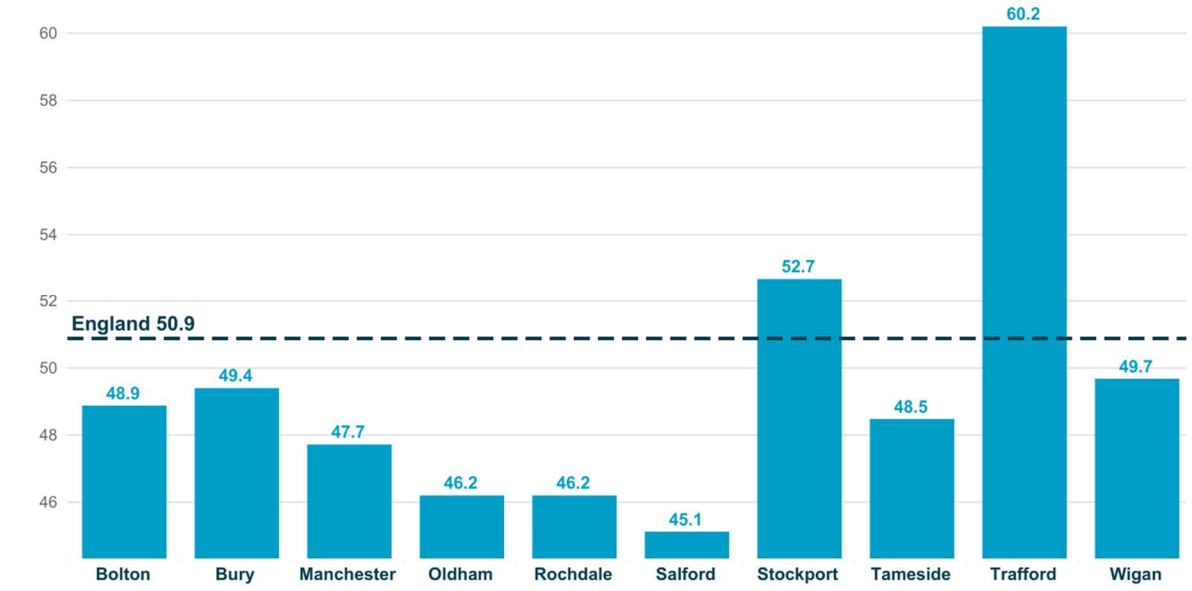


Educational attainment and employment

Education

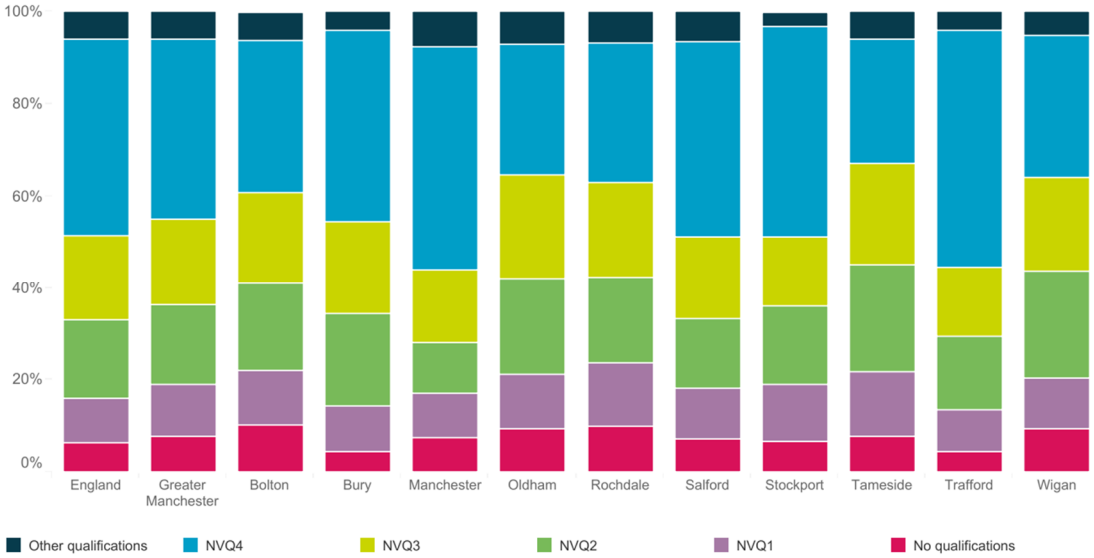
The average attainment 8 score is a measure of the average achievement of pupils across 8 qualifications at the end of key stage four. As demonstrated in Figure 10, the average attainment 8 score of 49.1 in Bury is slightly lower than the England average at 50.9, compared to its nearest neighbour boroughs, Bury had the fourth highest average attainment 8 score in 2020/2021 (GMPA, 2021). The most recent data from 2021/22 suggests that the average attainment 8 score in Bury was 46.9 similar to NW average (47.1) and slightly lower than England average of 48.7 (Child and Maternal Health, 2022). Bury had the 3rd lowest Average Attainment 8 score in its group of 6 statistical children service neighbours with the highest score in Stockport at 51.1 and lowest in Sefton at 46.4 (Child and Maternal Health, 2022). Furthermore, Children on FSM perform relatively poorly compared to counterparts without FSM. The most recent data from 2020-21, suggests that the average attainment 8 score of children on FSM in Bury is in the 2nd worst quintile in England at 37.9, with the England average at 39.1 (Child and Maternal Health, 2021).

Figure 10. Average attainment 8 scores of pupils in Greater Manchester local authorities (GMPA, 2021).



As demonstrated in Figure 11, the highest level of qualification achieved by those aged 16-64 in each local authority in Greater Manchester in 2020. In Bury, 4% had no qualifications, 6% had other qualifications, 10% had NVQ1, 20% had NVQ2, another 20% had NVQ3, 41% had NVQ 4 and 4% had other qualifications. Across GM, Bury achieved the second highest educational qualification level of NVQ4 with 41%, as Manchester obtained the highest score at 48%. compared to the England-wide figure (43%).

Figure 11. Highest qualification attained by local authority (GMPA, 2021).

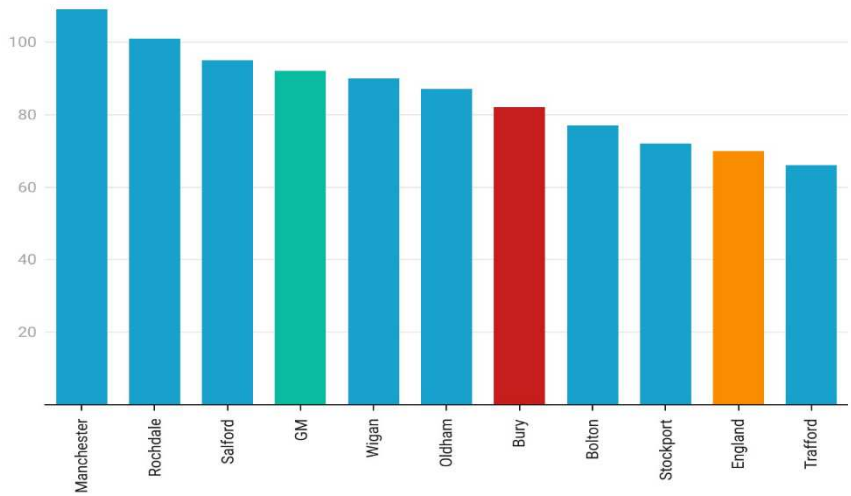


Looked after Children

Children and young people in care are among the most socially excluded children in England. There are significant inequalities in health and social outcomes compared with all children and these contribute to poor health and social exclusion of care leavers later in life. Children who have been in the care of their local authority for more than 24 hours are known as looked after children, or sometimes as children in care. The most recent data shows that there were 359 looked after children in Bury in 2021/22.

As demonstrated by Figure 12, the crude rate of children in care per 10,000 population aged under 18 years in Bury for the year 2022 was 82 per 10,000 population aged under 18 years and statistically higher than England average of 70 per 10,000 population (Child and Maternal Health, 2022). Bury has the 3rd highest rate of children in care in its group of 6 statistical children service neighbours with the highest rate in Stockton-on-Tees of 133 and lowest rate in Stockport at 72 for the year 2022 (Child and Maternal Health, 2022). The most recent data from 2021-22, suggests that the average attainment 8 score of children in care in Bury is in the 2nd worst fifth in England at 22.2, with the England average at 23.2 (Child and Maternal Health, 2022). Bury has the 3rd lowest Average Attainment 8 score in its group of 6 statistical children service neighbours with the highest score in Stockton-on-Tees at 25.5 and lowest in Sefton at 19.2 (Child and Maternal Health, 2022).

Figure 12- Looked after children per 10,000 population of in each local authority in GM in 2021/22

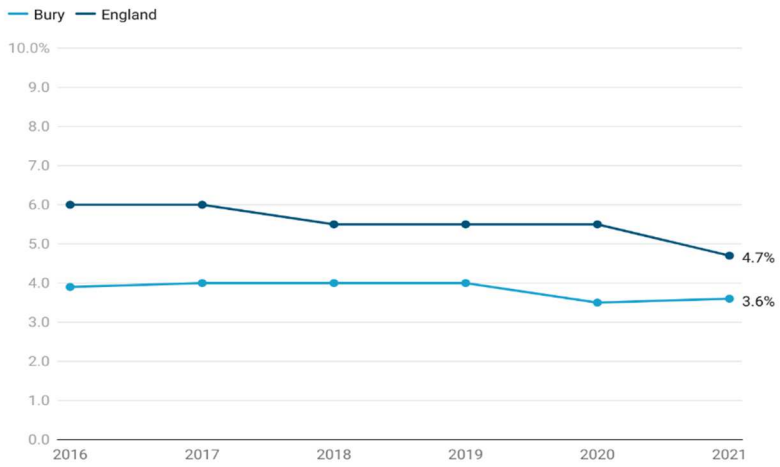


Employment

Young people (16- to 17-year-olds) not in education, employment, or training (NEET)

In Bury, the proportion of individuals aged 16 to 17 years who are not engaged in education, employment, or training (NEET), or whose current activity status is unknown, is 3.6%, a significantly lower percentage compared to the England average of 4.7%. The NEET proportion in Bury has been consistently below the national average throughout the observed period between 2016 to 2021. Bury has the 4th highest NEET proportion in its group of 6 statistical children service neighbours (Child and Maternal Health, 2021). The proportion of males not in education, employment, or training (NEET) in Bury is higher at 4.2%, compared to females at 2.8%, however, both male and female NEET proportions in Bury are statistically similar to the average NEET proportion in Bury. Data by ethnicity suggests that the highest NEET proportions are in the White and Mixed ethnic groups and the ethnic groups with the lowest proportions and significantly better than England average include Chinese (1.5%), Asian (2.4%) and Black (3%) (JSNA, 2023).

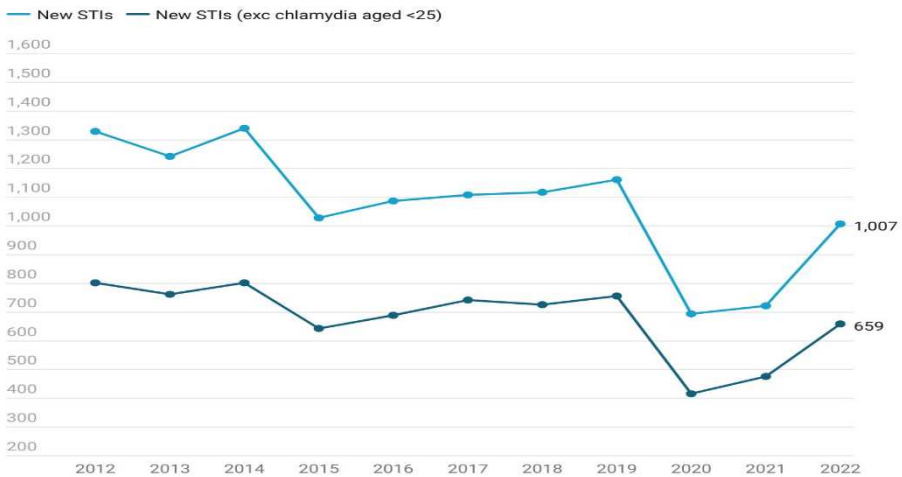
Figure 13. Trend in proportion of individuals aged 16 to 17 years who are not engaged in education, employment, or training (NEET), or whose current activity status is unknown for Bury and England from the year 2016 to 2021 (Child and Maternal Health, 2021)



Sexual Health Indicators – Local Picture

Sexually transmitted infections (STIs) are infections that are spread primarily through person-to-person sexual contact. There are 8 common types of STIs- Chlamydia, Gonorrhea, Syphilis, Trichomoniasis, Hepatitis B, Herpes, HIV and HPV. STI statistics are mainly based on diagnoses made at Genitourinary Medicine (GUM) Clinics, primary care settings, community services and HIV surveillance departments. A high diagnosis rate indicates a high burden of infection, whereas a low diagnosis rate may be explained by a range of other factors, including low testing rates. In 2022, the rate of all new STI diagnoses was 1,007 per 100,000 residents, much lower than the national rate at 3,773.6. Bury ranked 95th highest out of 147 upper tier local authorities (UTLAs) and unitary authorities (UAs) for new STI diagnoses (excluding chlamydia in those aged under 25) in 2022, with a rate of 340 per 100,000 residents, better than the rate of 496 per 100,000 for England (UKHSA, 2023). There was a decrease in STI testing and diagnoses in 2020 due to the reconfiguration of sexual health services during the COVID-19 pandemic response, with testing rates largely recovering during 2021, but diagnoses overall remaining lower, as demonstrated in Figure 14 (UKHSA, 2023).

Figure 14. Rate of all new STI diagnoses per 100,000 in Bury between 2012 to 2022 (UKHSA, 2023)

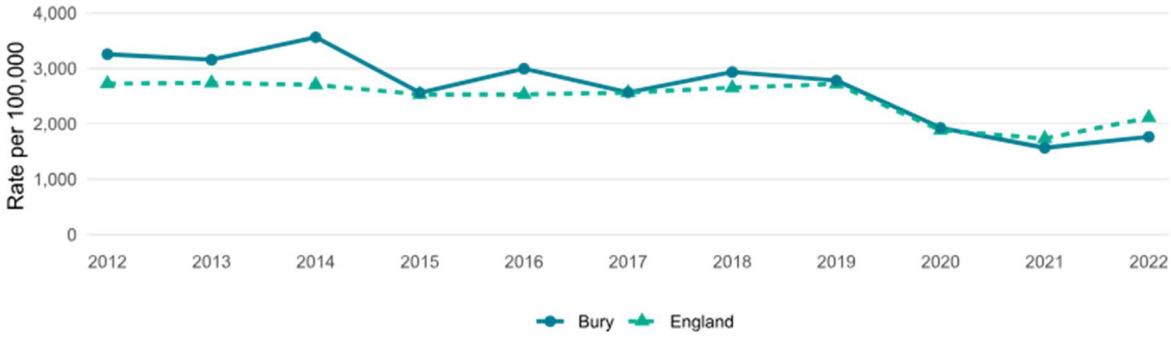


Chlamydia

Genital chlamydial infection is the most diagnosed bacterial sexually transmitted infection in the UK. Prevalence of the infection is highest in women aged 16-19 and men aged 20-24. Untreated infection can have serious long-term consequences including pelvic inflammatory disease, ectopic pregnancy, and tubal factor infertility. Chlamydia often has no symptoms and opportunistic screening of asymptomatic young people is considered the best approach for detecting and treating this infection. National Chlamydia Screening Programme (NCSP) in England was established in 2003. The programme aims to prevent and control chlamydia through early detection and treatment of asymptomatic infection, thus reducing onward transmission and the consequences of untreated infection. The chlamydia detection rate amongst under 25-year-olds is a measure of chlamydia control activities. It represents infections identified (reducing risk of sequelae and preventing onward transmission). Increasing detection rates indicate increased control activity. In 2021 the NCSP changed to focus on reducing the harms from untreated chlamydia infection. In practice this means that chlamydia screening in community settings (e.g., GP and Community Pharmacy) is now only proactively offered to young women and other people with a womb or ovaries. Services provided by sexual health services remain unchanged and everyone can still get tested if needed.

In 2022, the chlamydia detection rate per 100,000 in 15- to 24-year-old females in Bury was 1,764 per 100,000 population, lower than the 3,250 target. Around 14.2% of 15- to 24-year-old were tested for chlamydia, compared to 15.2% nationally. As demonstrated in Figure 15, between 2017 to 2022, there was a 31% decrease in the chlamydia detection rate among 15- to 24-year-olds in Bury, however, from 2021 to 2022, there was an increase of 13%. The rank for Chlamydia diagnoses in Bury was 89th highest (out of 150 UTLAs/UAs) in 2022 (UKHSA, 2023).

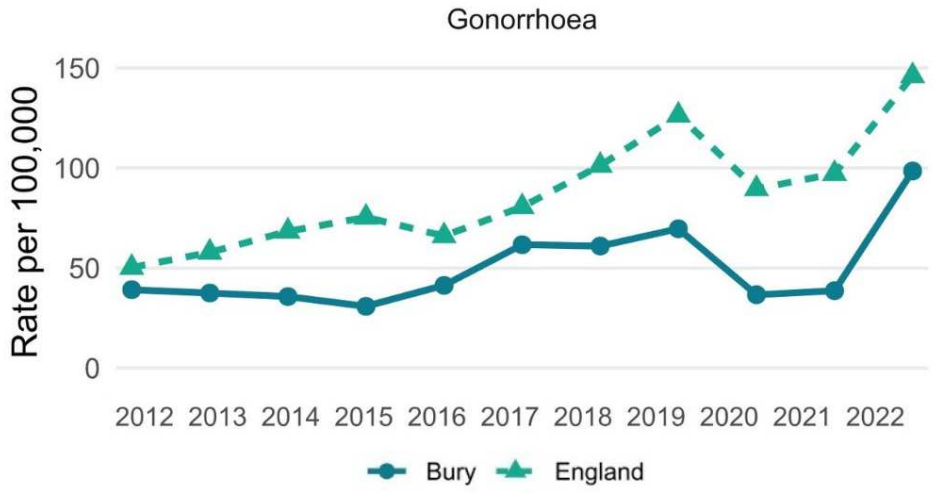
Figure 15. Chlamydia detection rate per 100,000 population in 15- to 24-year-olds females in Bury and England (UKHSA, 2023)



Gonorrhoea

Gonorrhoea is a common sexually transmitted infection, with males more commonly affected than females. It is treatable with antibiotics, but if left untreated can have long-term adverse health effects.
All young people screened for Chlamydia are also tested for Gonorrhoea; If a positive result is detected, the young person is 'fast tracked' to GUM clinics for further confirmatory tests and treatment as required. Gonorrhea is used as an indicator for rates of unsafe sexual activity. Most cases are diagnosed in GUM settings, and consequently the number of cases may be a measure of access to STI treatment. Infections with gonorrhoea are more likely to result in symptoms than chlamydia. In 2022, the rate of gonorrhoea per 100,000 was 98.5, this figure was a great increase compared to the 2021 rate of 38.7 but better than the national rate of 146.1 (UKHSA, 2023). In 2022, the rank for gonorrhoea diagnoses (which can be used as an indicator of local burden of STIs in general) in Bury was 82nd highest (out of 147 UTLAs/UAs) in 2022. As demonstrated in Figure 16, between 2012 and 2022, the Bury rate remained below the England rate but generally followed its trend (UKHSA, 2023).

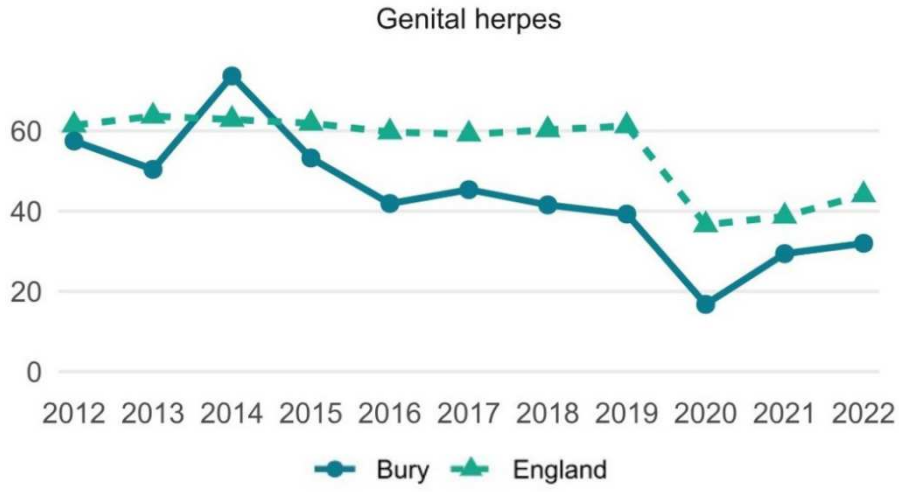
Figure 16. Gonorrhoea rates per 100,000 population in Bury compared to rates in England between 2012 to 2022 (UKHSA, 2023)



Genital Herpes

Genital herpes is the most common ulcerative sexually transmitted infection seen in England. Genital infections are frequently due to herpes simplex virus (HSV) type 2, however genital HSV-1 infection is also seen. The virus can remain dormant in the body after initial infection and can reactivate several times a year, meaning recurrent infections are common, so individuals frequently return for treatment. In 2022, the genital herpes rate per 100,000 in Bury was 32.0, a 8.8% increase compared to 2021 and a statistically lower than the national rate of 44.1. The rank for genital herpes in Bury was 107th highest (out of 150 UTLAs/UAs) in 2021. As demonstrated in Figure 17, the genital warts diagnostic rate in Bury has been consistently lower than the England rate (UKHSA, 2023).

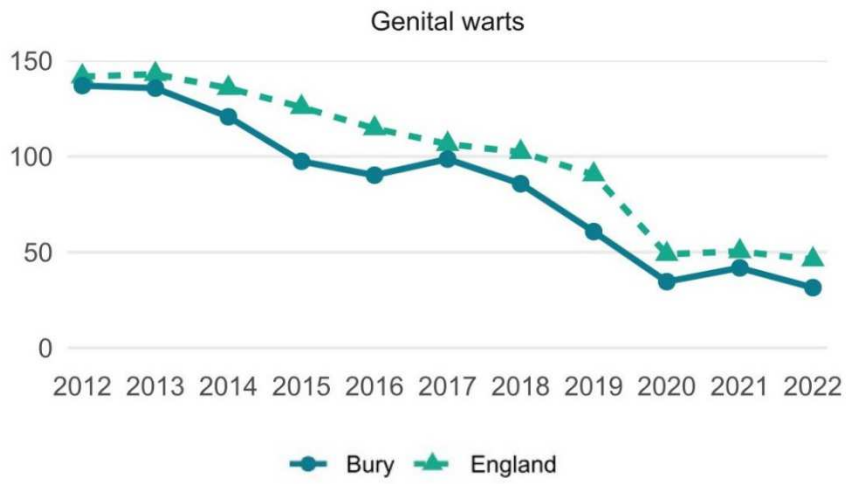
Figure 17. Genital Herpes rates per 100,000 population in Bury compared to rates in England between 2012 to 2022 (UKHSA, 2023)



Genital Warts

Genital warts are the second most diagnosed sexually transmitted infections (STI) in the UK following Chlamydia, and they are caused by infection with specific subtypes of human papillomavirus (HPV). Recurrent infections are common with patients returning for treatment. In 2022, the genital warts rate per 100,000 in Bury was 31.5, a 24.7% decrease compared to 2021 at 41.8 and statistically lower than the national rate of 46.1. The rank for genital warts in Bury was 122nd highest (out of 150 UTLAs/UAs) in 2022. As demonstrated in Figure 18, the genital warts diagnostic rate in Bury has been consistently lower than the England rate (UKHSA, 2023).

Figure 18. Genital Warts rates per 100,000 population in Bury compared to rates in England between 2012 to 2022 (UKHSA, 2023)

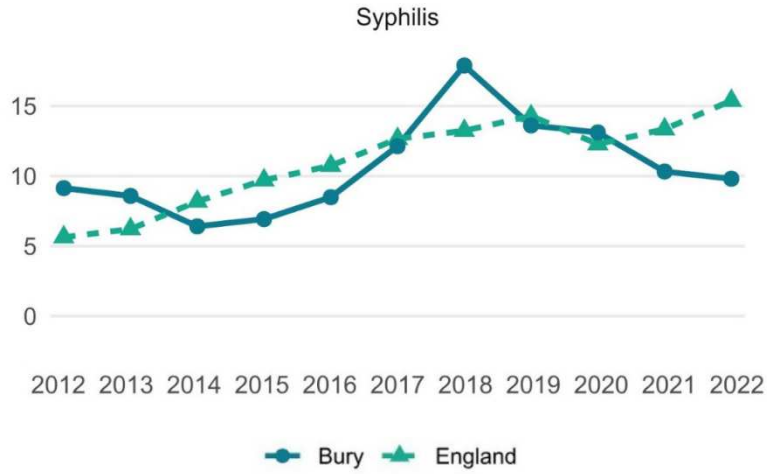


Syphilis

Syphilis is a sexually transmitted disease caused by the bacterium Treponema pallidum, which can be prevented with appropriate precautions and can be treated with antibiotics. Syphilis is an important public health issue in men who have sex with men (MSM) among whom incidence has increased over the past decade, thus leading to health inequalities among this demographic. The number of syphilis diagnoses in MSM who are HIV negative or of unknown HIV status is around 6 times higher than in MSM with prior awareness that they are living with HIV at the time of syphilis acquisition. Transmission can be prevented using condoms and treating asymptomatic contacts.

In 2022, the syphilis rate per 100,000 in Bury was 9.8, a 5.0% decrease compared to 2021 at 10.3 and a statistically lower than the national rate of 15.4. The rank for genital warts in Bury was 71st highest (out of 150 UTLAs/UAs) in 2022. As demonstrated in Figure 19, the syphilis rate in Bury was higher than the England rate between 2012 and 2013 but has seen a significant drop below the national rate until 2018, where it peaked above the England rate. Between 2019 and 2022, the syphilis rate per 100,000 population has seen a consistent drop (UKHSA, 2023).

Figure 19. Syphilis rates per 100,000 population in Bury compared to rates in England between 2012 to 2022 (UKHSA, 2023)

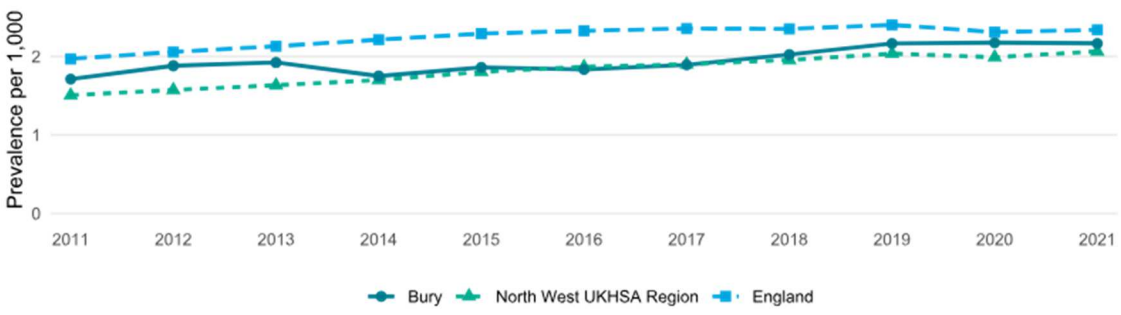


Human Immunodeficiency Virus (HIV)

HIV is a virus that damages cells in the immune system, weakening a person's ability to fight everyday infections and diseases. As a result, HIV is associated with significant mortality, serious morbidity and high costs of treatment and care. Around 100,000 people are living with HIV infection (diagnosed and undiagnosed) in the UK. The infection is still frequently regarded as stigmatizing and has a prolonged 'silent' period, during which it often remains undiagnosed. Anti-retroviral therapy (ART) has resulted in substantial reductions in acquired immunodeficiency syndrome (AIDS) and deaths in the UK. People diagnosed promptly with HIV and who start ART early can expect near normal life expectancy. Challenges remain, however, in the form of high rates of late HIV diagnoses and an ageing population.

In 2021, the HIV diagnosed prevalence per 1,000 residents aged 15 to 59 years was 2.2, similar to 2.3 per 1,000 in England. The rank of Bury was 61st highest (out of 150 UTLAs/UAs). As demonstrated in Figure 20, in 2021 the HIV prevalence per 1,000 people in Bury has consistently been below the national average and higher than the NW UKHSA region (UKHSA, 2023).

Figure 20. Diagnosed HIV prevalence per 1,000 population aged 15 to 59 years in Bury compared to rates in the North West UKHSA Region and England between 2011 and 2021. (UKHSA, 2023)



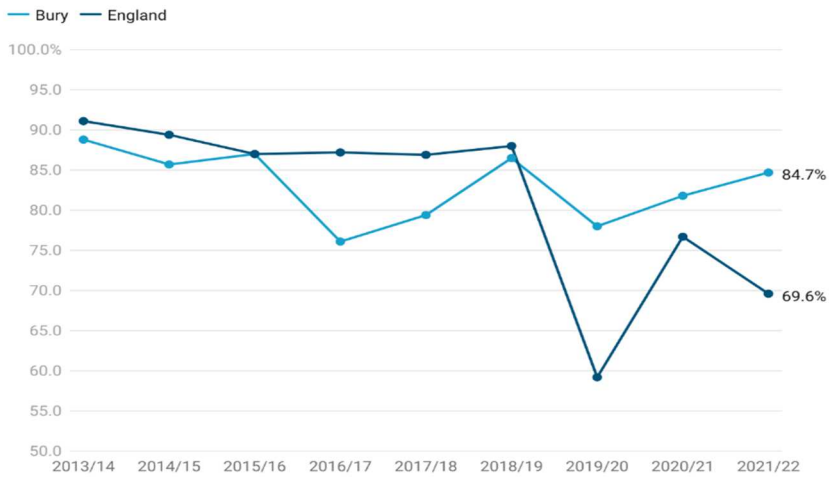
In 2021, 3.4% (157 out of 4,619) of HIV-negative people accessing specialist SHSs in Bury were defined as having PrEP need. Among these, 61.8% (97 out of 157) initiated or continued PrEP. The percentage of people (aged 15 years and over) in Bury accessing HIV care who were prescribed ART in 2021 was 98.5%, similar to 98.4% in England. The percentage of people in Bury newly diagnosed with HIV in the three-year period between 2019 - 21 who started antiretroviral therapy (ART) promptly (within 91 days of their diagnosis) was 95.0%, similar to 83.5% in England. The percentage of adults in Bury accessing HIV care in 2021 who were virally suppressed (undetectable viral load) was 99.1%, similar to 97.8% in England (UKHSA, 2023).

Reproductive Health

Human Papilloma Virus (HPV) Vaccine

The HPV vaccine protects against the two high-risk HPV types (16 & 18) that cause over 70% of cervical cancers, as well as providing protection against strains that cause genital warts. Vaccination coverage is the best indicator of the level of protection a population will have against vaccine preventable communicable diseases. Coverage is closely correlated with levels of disease. Monitoring coverage therefore identifies possible drops in immunity before levels of disease rise. The national human papillomavirus (HPV) immunisation programme was introduced in 2008 for secondary school year 8 females (12 to 13 years of age), to protect them against the main causes of cervical cancer. Since 2019, males aged between 12 and 13 are also offered the vaccine to protect them against other HPV-related cancers, as well as to help better protect cervical cancers in females through herd immunity. In 2021/2022, 84.7% of Year 8 female students (12-to-13-year-olds) in Bury received the first HPV vaccine, this is statistically significantly higher than the England average of 69.6% and lower than the North West average of 70.9 %, as demonstrated in Figure 21 (UKHSA, 2023).

Figure 21. HPV vaccination coverage for one dose (12- to 13-year-old Female) in Bury between 2013 and 2022

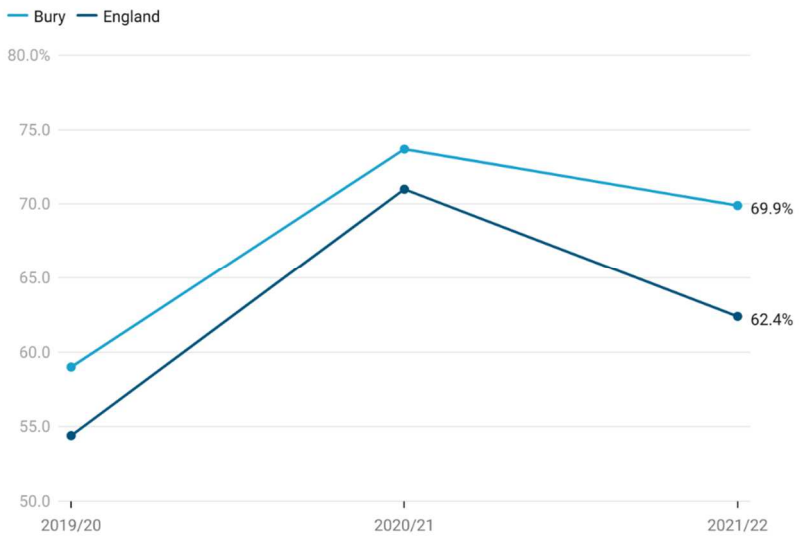


The trend data for Bury from 2013/14 to 2021/22, shows that the coverage remains relatively stable in 2015/16 at 87%. This is followed by a drop in 2016/17 to 76.1%. The coverage then increases in 2017/18 to 79.4% and further improves in 2018/19 to 86.5%. It experiences a decline in 2019/20 to 78% but coverage has increased over the past two data points from 81.8% in 2020/21 to 84.7% in 2021/22. Throughout this period, the Bury coverage has not met the national target of 90%. Bury has the 2nd highest coverage in its group of 6 statistical children service neighbours with the highest in Stockport at 90.3% and lowest in Stockton-on-Tees at 51.4% (Child and Maternal Health, 2022).

HPV vaccination in Males

HPV vaccination coverage in Bury for one dose in males aged 12-13 years for the period 2021/22 is at 69.9%, higher than England average of 62.4% but not meeting the national target of 90% and over (Child and Maternal Health, 2022). The trend data for Bury from 2019/20 (when HPV vaccines for males were recommended) to 2021/22, HPV vaccination coverage increased from 59% in 2019/20 to 73.7% in 2020/21. This was followed by a drop in 2021/22 to 69.9%. Comparing Bury with England, the population vaccination coverage for HPV vaccine (one dose) was consistently higher than England average from 2019/20 to 2021/2022 but did not meet the national target of 90% or higher (Figure 22). Bury has the 2nd highest coverage in its group of statistical neighbours with the highest in Stockport at 85.5% and lowest in Rochdale at 37%.

Figure 22. HPV vaccination coverage for one dose (12 to 13 year old) (Male) for Bury and England between 2012 and 2022 (Child and Maternal Health, 2022)

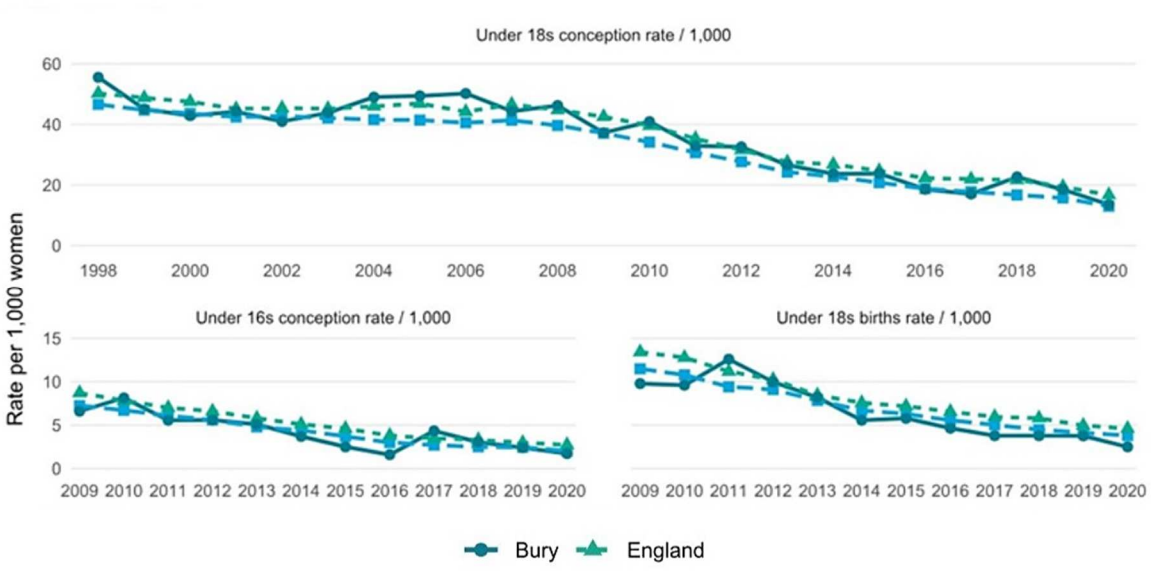


Under 18 conceptions

Teenage pregnancy is a cause and consequence of education and health inequality for young parents and their children. Babies born to mothers under 20 years consistently have higher rates of stillbirth, infant mortality, and low birthweight than average, though the difference fluctuates from year to year due to relatively low numbers.

In 2021, the under-18s conception rate per 1,000 females aged 15 to 17 years in Bury was 14.4, higher than the rate of 13.1 per 1,000 in England. The rate for Bury in the year 2020 was 13.5 per 1000 females aged 15-17 years statistically similar to England average of 13 (UKHSA, 2023). There has been a decrease in the under 18 conception rates for Bury and England from 1998 to 2020, however the rates in Bury have remained consistently higher than England this period, as demonstrated in Figure 23. The rate in Bury declined from the peak at 55.6 per 1000 females in 1998 and gradually declined to 13.5 per 1000 females in 2020 (UKHSA, 2023). In 1998, the under 18 conception rates in England was 46.6 per 1000 females, and it gradually declined to 13 per 1000 females in 2020, as demonstrated in Figure 23. Bury has the second lowest under-18 conception rate in its group of 6 statistical children service neighbours with the highest rate in Stockton-on-tees at 22 and lowest in Stockport at 13.1 (Children and Maternal Health, 2020).

Figure 23. Rates of under-18s conception and births over time in Bury compared to the North West UKHSA Region and England *(1998-2020)*

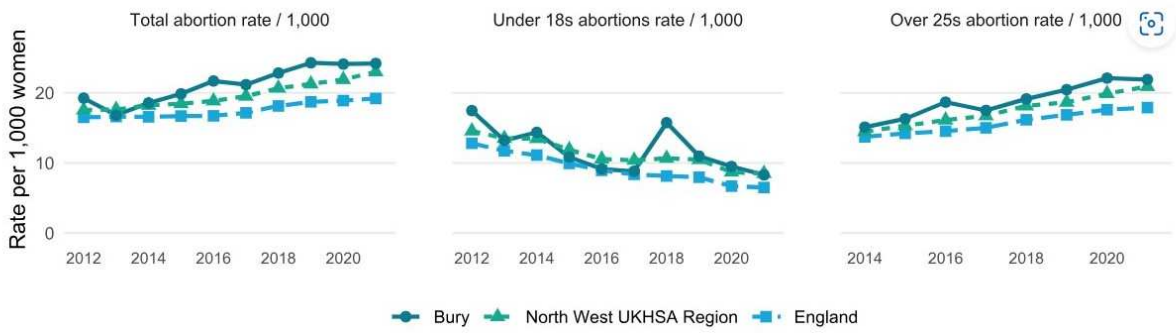


Under 18 and under 25s abortion

It is increasingly common for pregnant young women under 18 to have an abortion. Access to family planning and sexual health services, and the availability of independent sector abortion provision, directly affect abortion proportions.

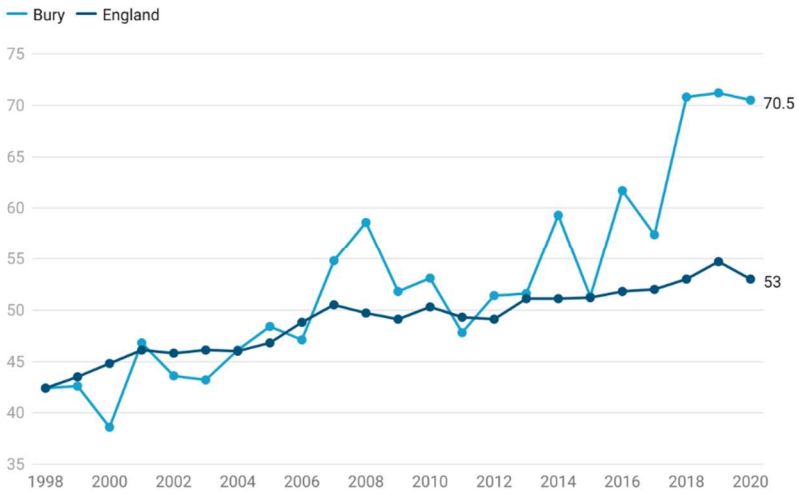
In 2021, there were a total of 841 abortions in Bury. The total abortion rate per 1,000 female population aged 15 to 44 years was 24.2, higher than the rate in England of 19.2 per 1,000, and a 0.4% increase compared to 2020, as demonstrated in Figure 24. The rate of under 18s abortions per 1,000 was 8.3 in 2021, a significant decrease compared to 2020, however these figures are significantly lower than the over 25s abortion rate per 1,000 at 21.9. The rate of under 25s repeat abortion was 31.3 in 2021, slightly higher than the England rate at 29.7. Figure 24 demonstrates that the total abortion rates per 1,000 women in Bury, for both under 18s and over 25s remained significantly higher than the North West region and the England rates but it generally followed their trend (UKHSA, 2023).

Figure 24. Abortion rates per 1,000 women by age in Bury compared to the North West UKHSA Region and England between 2012 and 2021 (UKHSA, 2023).



The latest data for Bury shows that 70.5% of under 18 conceptions led to abortion, higher than England average of 53%, as demonstrated in Figure 25. The percentage of abortions in Bury ranged from 38.6% in 2000 to 71.2% in 2019. From the year 1998 to 2000, there was a decrease in the percentage of abortions from 42.4% to 38.6% and then started to increase again. The trend in England had less fluctuation in the data ranging from 42.4% to 53% from 1998 to 2020 (UKHSA, 2023). The percentage of abortions in under-18s increased steadily from 42.4% in 1998 to 50.5% in 2007, remaining stable until 2012 at 49.1% before steadily increasing to the peak in 2019 at 54.7% and slightly declining to 53% in 2020 (UKHSA, 2023). Bury has the highest under 18 conceptions leading to abortion in its group of 6 statistical children service neighbours with the lowest percentage in Stockton-on-tees at 41.1%. (Children and Maternal Health, 2020).

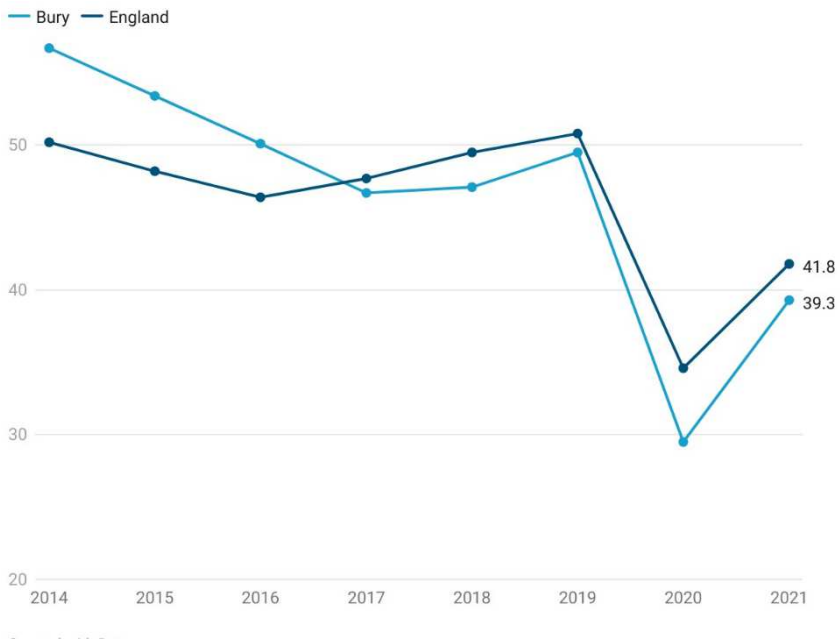
Figure 25. Comparison of percentage (%) of under 18 conceptions leading to abortions for the years 1998 to 2020 for Bury and England (Children and Maternal Health, 2020).



LARC

Long-acting reversible contraceptive (LARC) methods, such as contraceptive injections, implants, the intra-uterine system (IUS) or the intrauterine device (IUD), are highly effective as they do not rely on daily compliance and are more cost effective than condoms and the pill. A strategic priority is to ensure access to the full range of contraception is available to all. An increase in the provision of LARC is a proxy measure for wider access to the range of possible contraceptive methods and should also lead to a reduction in rates of unintended pregnancy. The PHOF indicator is a measure of the crude rate of LARC (excluding injections) prescribed by GP and Sexual and Reproductive Health Services per 1,000 resident female population aged 15-44 years. In 2021, the LARC prescribing (excluding injections) rate was 39.3, significantly lower than the national rate at 41.8. As demonstrated in Figure 26, it has been lower than the national average between 2018-2021, both experiencing a drastic decrease in 2019/2020 due to COVID-19.

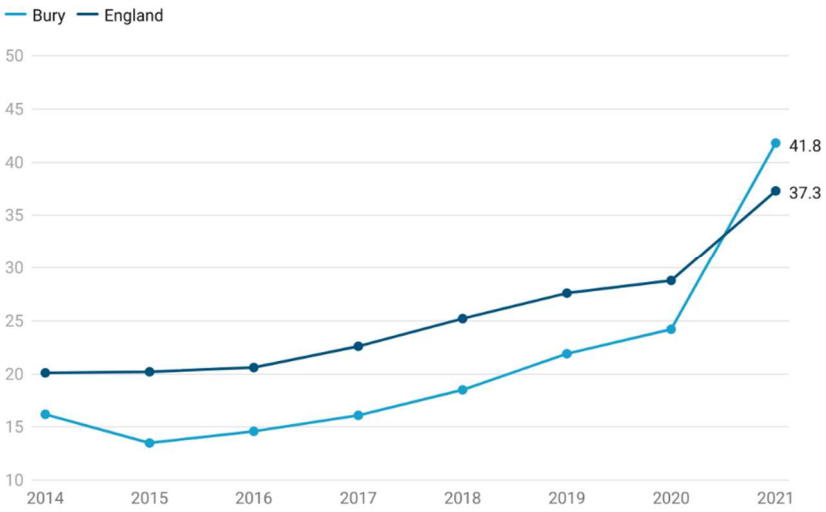
Figure 26. LARC prescribing (excluding injections) rate per 1,000 women aged 15-44 years in Bury compared to England: 2014 to 2021



Long-acting reversible contraceptive under 25s

In the year 2021, approximately 41.8% of under 25s chose LARC excluding injections at SRH Services (%) higher (statistically significant) than 37.3% in England. Bury has seen an increase in under 25s who choose LARC from 16.2% in 2014 to 41.8% in 2021. An increase has been seen in England but at a slower rate with under 25s who choose LARC increasing from 20.1% in 2014 to 37.3% in 2021, as demonstrated in Figure 33. Bury has the 5th highest percentage (%) of Under 25s choosing LARC excluding injections at SRH Services in its group of similar local authorities in 2021 with the lowest percentage in Doncaster at 13.4% and highest in Rotherham at 58.2%

Figure 27. Comparison of percentage (%) of Under 25s choosing LARC excluding injections at SRH Services for the years 2014 to 2021 for Bury and England (Sexual & reproductive health profiles, 2021)



Current Services

Improving the sexual health of the population remains a public health priority; local authorities are mandated to commission integrated contraception and sexual health services.

The 2022 Health and Care Act entailed significant structural change for NHS commissioning with NHS Greater Manchester Integrated Care becoming responsible for the commissioning responsibilities of former CCGs, as well as taking on several commissioning functions from NHSE (with a plan for further delegation over time).

NHS England is responsible for commissioning and funding GP practices to offer routine methods of contraception for their registered patients. GPs are also required to test for HIV/STIs, as and when required, and to offer or arrange for treatment of infection. NHS England is responsible for commissioning and funding HIV treatment and care.

Greater Manchester ICB are responsible for commissioning and funding abortion services, and are also responsible for arranging for patients to obtain permanent methods of contraception/sterilisation procedures including vasectomies and for the promotion of opportunistic STI testing and treatment within general practice. The consequences of poor sexual health include:

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

Findings from the national surveys of sexual attitudes and lifestyles (Natsal 2013) show most young people become sexually active and start forming relationships between the ages of 16 and 24. Young people in these age groups have significantly higher rates of poor sexual health, including STIs and abortions, than older people.

Unplanned pregnancy is a key public health indicator. The increasing intervals between first sex, cohabitation, and childbearing means that, on average, women in Britain spend about 30 years of their life needing to avert an unplanned pregnancy. Available evidence shows that around one third of births are unplanned. Unplanned pregnancies can have a negative effect on women and children's lives and result in poorer outcomes than those that are planned.

The Public Health Outcomes Framework includes the following indicators relating to sexual health:

- C01: Health Improvement: Total prescribed LARC, excluding injections rates.
- C02: Health Improvement: Under-18 conceptions rates
- D02a: Health Protection: Chlamydia diagnoses (15–24-year-olds);
- D02b: Health Protection: New STI Diagnoses (excluding chlamydia aged <25)
- D07: Health Protection: People presenting with HIV at a late stage of infection.

Provision of EHC (emergency hormonal contraception) as described in this specification is expected to contribute to reducing the number of under-18 conceptions as well as the number of unintended conceptions amongst women of all ages.

Participation in the National Chlamydia Screening Programme as described earlier is primarily focused on reducing harm from untreated chlamydia infection and to contribute to controlling the transmission of Chlamydia.

Provision of HIV testing, , and the referral for onward treatment for positive cases is expected to contribute to controlling and preventing the transmission of HIV and reduce the prevalence of people presenting with HIV at a late stage of infection.

National Chlamydia Screening Programme (NCSP)

The National Chlamydia Screening Programme (NCSP) in England was established in 2003. The programme's original aims were to prevent and control chlamydia through early detection and treatment of asymptomatic infection, so reducing onward transmission and the consequences of untreated infection.

The aim of the NCSP is changing to focus on reducing the harms from untreated chlamydia infection. The harmful effects of chlamydia occur predominantly in women so the opportunistic screening (that is the proactive offer of a chlamydia test to young people (15-24-year-olds) without symptoms) should now focus on women[1], combined with:

- reducing time to test results and treatment.
- strengthening partner notification
- re-testing after treatment

In practice this means that chlamydia screening in community settings, such as GPs and pharmacies, will only be proactively offered to young women. Services provided by sexual health services remain unchanged.

Local Context

Bury Council invests in adult and young people's sexual health services as well as investing in the delivery of young people's sexual health interventions across primary care. GP practices and pharmacies are funded to deliver chlamydia treatment, fitting and removal of long acting reversible contraception (GP only) and the prescribing of emergency hormonal contraception.

General Principles

The local sexual health provider is required to deliver a sexual health service in Bury ensuring that:

The service is appropriate:

- Young people (and where appropriate, their parents or carers) are involved in shared decision making when reviewing their treatment and options;
- The service utilises You're Welcome standards, which provide a clear framework for ensuring they meet the needs of local young people and improve access, particularly for vulnerable and at risk groups;

- Service provision reflects the fact that there are intrinsic differences between children of different ages.
- The service is intelligence-led and works closely with key partners (including police; youth justice; social services; NHS providers; CAMHS; schools and colleges; and voluntary, community and faith (VCF) groups) to ensure it is responsive to changing needs and emerging issues concerning children and young people.

The service is accessible:

- The service is open at times that are accessible to young people, in appropriate settings and locations. The only clinic in the borough is currently based at Townside Primary Care Centre.
- The service is delivered from a variety of settings, including via outreach (community based settings) in order to engage young people in settings or places that suit them;
- The service offers consultations on a walk-in and appointment basis, considering evening and weekend openings as appropriate to meet the needs of young people;
- The services offers a mix of modalities of consultations, including telephone, video and face-to face, to ensure they meet the needs of all patients: e.g., those with a language barrier, data poverty or internet illiteracy
- The service provides a safe, non-judgemental environment that meet the needs of young people who identify as lesbian, gay, bisexual, transgender, queer, intersex or asexual;
- The service proactively engages with young people who miss appointments or stop attending;
- The service evaluates why young people engage or fail to engage, and responds to the findings by adapting its service delivery;
- The service is sensitive to the needs of different genders with clients having the option to request a male or female practitioner;

The service is safe and effective:

- The service enhances its response to young people who are returning for treatment and whose needs have increased (e.g. girls attending for repeat abortions)
- Young people do not receive specialist interventions any longer than necessary;
- The service makes appropriate use of technology (e.g. texting, video calls, online chat facilities and social media) to engage, maintain contact and follow-up young people;
- There is a quality governance framework in place that sets out expectations for:

    - appropriate specialist interventions
    - quality standards
    - risk management
    - staff competence
    - case load management
    - clinical supervision
    - compliance with local safeguarding policies
    - compliance with information governance requirements, including data sharing and records management with compliant records disposal and retention policies.
    - compliance with legal requirements, which requires services to be child-centred and appropriate to the young person's age and maturity;

- development of the young person, to take account of individual vulnerabilities.

- Services are staffed by a multidisciplinary team with an appropriate skill mix;
- All staff are offered integrated training, education, and general improvement of skills and work experience.

Key Features & Objectives

- Provide information, advice, guidance about contraception, sexually transmitted infections, and related procedures and sexual health topics, in order to support clients to make informed decisions and safeguard their sexual health;
- Offer all forms of contraception, including long-acting reversible contraception;
- Offer emergency contraception, to include prescribing emergency hormonal contraception and fitting IUDs, and information, advice and guidance about regular forms of contraception;
- Offer pregnancy testing, balanced and informed discussion of options, and supported referral to GPs, maternity services, and abortion services;
- Provide free condoms and lubricants for all clients and to promote the use of condoms as an effective method for protecting against sexually transmitted infections and unintended conceptions;
- Participate in the chlamydia and gonorrhoea screening programme for under 25s;
- Test for and treat sexually transmitted infections, as detailed in this specification, and refer clients onwards for the management and treatment of complicated/symptomatic cases.

General

- Undertake a sexual history and risk assessment with each client attending for a clinical service;
- Provide contraception and sexual health information, advice and guidance;
- Provide each client with information about safer sex practices, including discussion of the links between alcohol and sexual risk-taking behaviour and condom demonstration, if required;
- Promote opportunistic chlamydia and gonorrhoea screening for all young people.

Contraception

- Provide clear, accurate and up-to-date information and advice about all methods of contraception, and the provision of the contraceptive methods as detailed in this service specification and supported referral to specialist providers for clients requiring other methods;
- Discuss the advantages and disadvantages of each method of contraception;
- Provide contraceptive methods to include:
    - Insertion and removal of contraceptive implants
    - Insertion and removal of IUDs and IUSs
    - Administration of contraceptive injections
    - First and repeat prescribing of combined oral contraceptive pills
    - First and repeat prescribing of progestogen-only (POP) contraceptive pills
- Provide all other methods of contraception not referred to above, when appropriate to do so, to best meet the needs of the client.

- Facilitate supported referral to specialist providers for clients with complex contraceptive needs in line with agreed protocols and pathways;
- Review new methods of contraception as they become available.
-

Emergency Contraception

- Prescribe emergency oral contraception;
- Insert IUDs for use as emergency contraception;
- Offer information, advice and guidance about regular forms of contraception.
- Promote the use of condoms as an effective method for protecting against sexually transmitted infections including HIV;
- Offer free condoms and lubricants to all clients attending for a consultation;
- Provide condoms and offer information and guidance about correct usage (including an online offer for postal or 'click and collect' provision of condoms);
- Link with the provider of the all-age specialist sexual health service who provide a c-card scheme.

Pregnancy Testing and Teenage Parents

- Provide supported referral to maternity services;
- Offer supported referral to termination of pregnancy providers for young women who are pregnant and do not wish to continue with their pregnancy;
- Provide initial assessment and referral to local urgent care teams (or equivalent) for suspected ectopic pregnancy or other early pregnancy complications;
- Work with existing providers of support to teenage parents across Bury and Bury to support the sexual and reproductive health of teenage parents, including access to LARCs

Testing and Treating STIs and Other Infections

- Screen for chlamydia and gonorrhoea as part of the screening programme for 15-24-year-olds, including an online offer for postal testing kits for asymptomatic young people;
    - Establish and maintain a website to allow young people living in Bury and Bury to order self-sampling kits for chlamydia and gonorrhoea.
    - Fulfil orders for self-sampling kits for chlamydia and gonorrhoea received through the website or calls to the Service.
    - Deliver results (reactive, negative and unequivocal) to patients.
- Treat uncomplicated cases of chlamydia;
- Initiate and complete partner notifications for patients diagnosed with chlamydia;
- Initiate partner notifications for patients diagnosed with gonorrhoea;
- Offer supported referral to specialist services for clients requiring treatment for gonorrhoea or complicated cases of chlamydial infection;
- Test for syphilis and refer on to the specialist service for treatment if positive;
- Test for HIV and refer clients with a positive result to specialist services for HIV treatment and care in line with agreed protocols and pathways;
- Identify genital herpes, and genital warts and refer onwards to specialist services for treatment and care;
- Undertake follow-up with all patients diagnosed with an infection to confirm that the patient has received treatment.
- Identify and treat uncomplicated cases of thrush and bacterial vaginosis;
- Identify scabies and public lice and provide treatment and/or onward referral to GPs, all-age specialist sexual health services or pharmacies to obtain treatment;

- Work with the commissioner to respond to any emerging STIs, or needs
- Ensure integrated care pathways are in place for seamless referral to specialist services (e.g., providers of Level 3 services) for treatment/management of complex conditions;
- Refer older partners of young people with a diagnosed or suspected STI to an all-age sexual health service.

The service will follow the guidance on standards on sexual health interventions including those in the following NICE guidance documents (CG 30; NG 68; NG 60; NG 55; PH 51; PH 3) and Quality Standards (QS 178; QS 157; QS 129)

Response Times and Prioritisation

Prompt access to contraception and emergency contraception, and STI testing and treatment, is a key priority for the prevention and treatment of communicable diseases and unplanned pregnancy:

- All clients should be offered 48-hour access to contraceptive and sexual health services except where medically indicated (e.g. IUD fitting);
- 90% of clients should be seen within 48 hours of requesting a service (unless electing to use a service on a particular day or needing to attend earlier for emergency contraception) subject to clinic opening times;
- An appointment for provision of intrauterine and implantable contraception will be available within 4 weeks unless clients wish to wait longer. If relevant, spoke clinics who are unable to offer appointments within 4 weeks should refer clients to the hub clinic or other service providers to ensure prompt access.

Discharge and Transition

- The Service will develop an agreed process for service users who need to transition between Young People's Sexual Health Services and Adult Services.
- The service will support young people who are reaching the age limit of the service to access routine reproductive health care from primary care where appropriate

This is currently delivered through HCRG in Bury Oldham and Rochdale (all age service which accepts young people) and within Bury and Rochdale is a specific young persons education and clinical service, including outreach service.

This young persons team consists of sexual health nurses, and educational wellbeing specialist workers. They provide bespoke, targeted 1-1 sessions between the young person and one of the Education and Wellbeing Specialist Workers. Usually this will be for an average of 6 sessions (with each session lasting between 30 minutes and 1 hour), although shorter interventions can be developed if necessary.

Sessions can be arranged at a number of venues such as:

- In schools or colleges
- Bury or Rochdale sexual health services
- A drop in clinic
- A mutually agreed venue

Information on referring or contacting this service can be found on the Sexual Health Hub Referrals - Oldham, Bury & Rochdale | HCRG Care Group (thesexualhealthhub.co.uk)

Wider Services

There are multiple wider services which offer young people support and advice around sexual health, alongside access to interventions such as STI testing, condoms, emergency contraception and pregnancy testing in Bury. There was limited data available to understand the uptake of these wider services specifically for the purposes of sexual health support, or to understand the demographics of young people accessing these wider services for this purpose.

Figure 28. Summary of wider services available in Bury

Service:	**School Nurse Service**
Service Provider:	Northern Care Alliance – Salford Royal Foundation Trust
Summary of service:	The Bury School Nurse service is a universal public health service for children and young people aged 5-19. The aim of the service is to improve the health and wellbeing of children and young people by responding to identified needs. The School Nurse service will adopt a whole school approach to improving children's health and wellbeing as well as supporting individuals.
Service:	Sexual Health Service
Service Provider:	HCRG Care Group (formerly known as Virgin Health Care Ltd)
Summary of service:	Open access, all age Integrated Sexual Health Service, includes CASH and GUM, includes Young Persons education and clinical service, and outreach. Digital platform underpins the offer. Outreach locations for Vulnerable Adults and Young People Ellen Court young mum and baby unit monthly drop in (commenced April 2023) Adullam / Castlecroft temporary housing for vulnerable adults, homeless drug & alcohol, ex-offenders monthly drop in (commenced April 2023) ad hoc visits to Care Homes and vulnerable young people Home visits.
Service:	PASH (Passionate About Sexual Health)
Service Provider:	Alliance of Black Health Agency (BHA) George House Trust (GHT) and LGBTF
Summary of service:	The PaSH contract (HIV and STI prevention programme and support for those People Living with HIV), is currently commissioned by Salford City Council on behalf of the 10 Greater Manchester areas. The PaSH Partnership delivers a comprehensive programme of interventions to meet the changing needs of people newly diagnosed with HIV, living longer term with HIV or at greatest risk of acquiring HIV. The aims of the service are to raise HIV awareness, improve access to HIV services and empower people to practice safer sex. Many of the

Service:	**Emergency Hormonal Contraceptive (EHC)**
Service Providers;	Accredited Providers = 23 Active Providers = 12
Summary of service:	Pharmacist to; • Consult with clients attending for Emergency Hormonal Contraception and offer information and advice about all methods of emergency contraception. • If deemed to be appropriate, to issue and supply free emergency contraceptive pill(s) in accordance with the relevant Patient Group Direction (PGD). • Offer advice, referral, and signposting information about regular methods of contraception including long-acting methods and how to obtain them • Offer information and advice about safer sex and the benefits of screening for sexually transmitted infections
	interventions are carried out among the LGBTQ+ and BAME communities.

HCRG (Bury Sexual Health Provider) Activity data

Service Users

In 2022/23, HCRG saw a total of 6,774 patients in Bury clinics. A total of 5,148 patients (76%) from Bury, 740 from Rochdale (10.3%), 266 from Oldham (4%), 458 from rest of GM (6.7%) and 156 from beyond GM (2.3%). As demonstrated in Figure 35, the 20-24 age group (1,489 users) were the highest users of the service, followed by 25–29-year-olds (1,410 users) and 30–34-year-olds (1,231 users). In total 2,268 patients (33.48%), accessing the Bury HCRG service in 2022/2023 were aged under 25. Most of the patients accessing the service were White British (5,229 users), followed by Pakistani (287 users), other White background (227 users) and African (212 users). The ethnic groups with the lowest users, include Chinese, Bangladeshi and other Black background, as demonstrated in Figure 36.

Figure 29. Number of patients seen by the Bury HCRG service in 2022/2023, by age group.

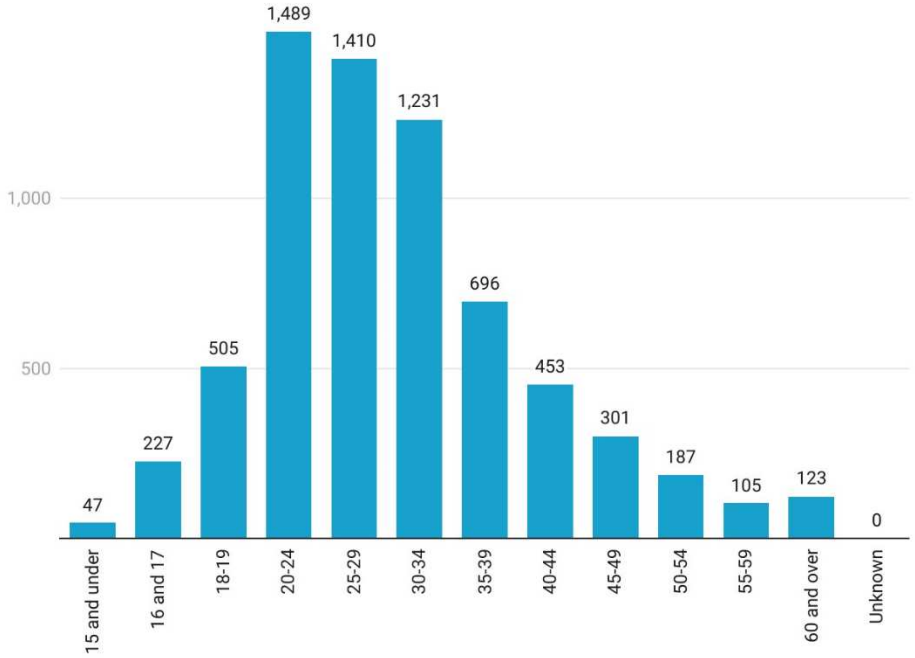
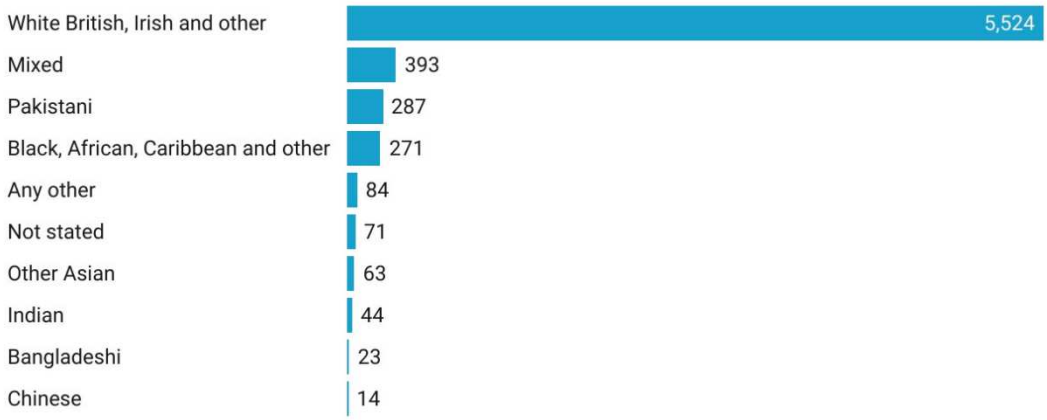


Figure 30. Number of patients seen by the Bury HCRG service in 2022/2023, by ethnicity.



Pharmacies

In April 2022 – March 2023, there were 22 active pharmacy providers of emergency hormonal contraception (EHC) in Bury. A total of 859 patients accessed EHC in 1062 individual interactions. Figure 37. demonstrates the distribution of EHC interactions by age group with the highest number of interactions among 16–19-year-olds (250 interactions), followed by 20-24 years old (224 interactions). 98.6% of those interactions were face to face and 1.4% were on a remote basis.

The most common reason for requesting EHC was "no contraception" (70.4%), followed by "barrier contraception failure" (23%) and "hormonal contraception failure" (7.7%), as demonstrated in Figure 38.

Figure 31. Summary of the number of EHC interactions by age in Bury pharmacies 2022/23

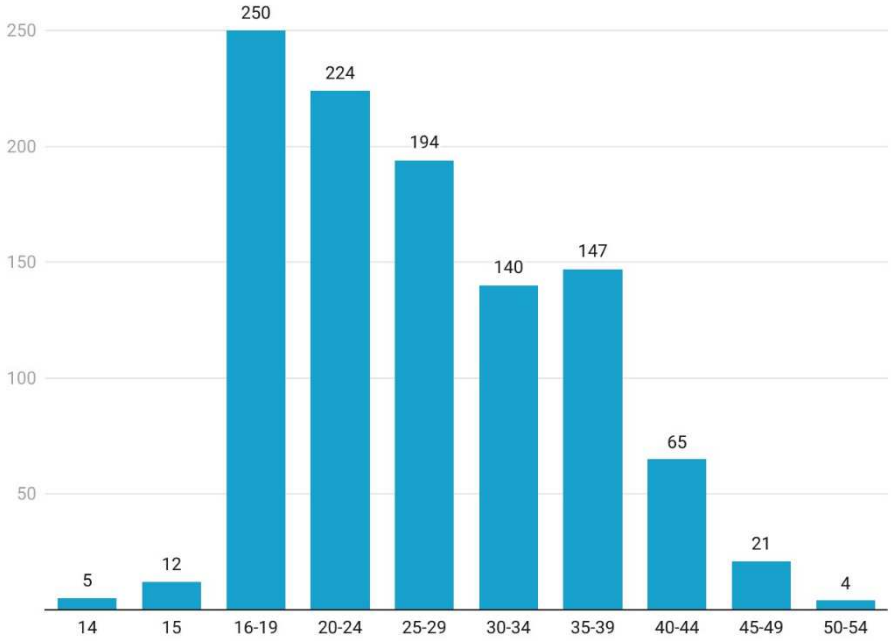
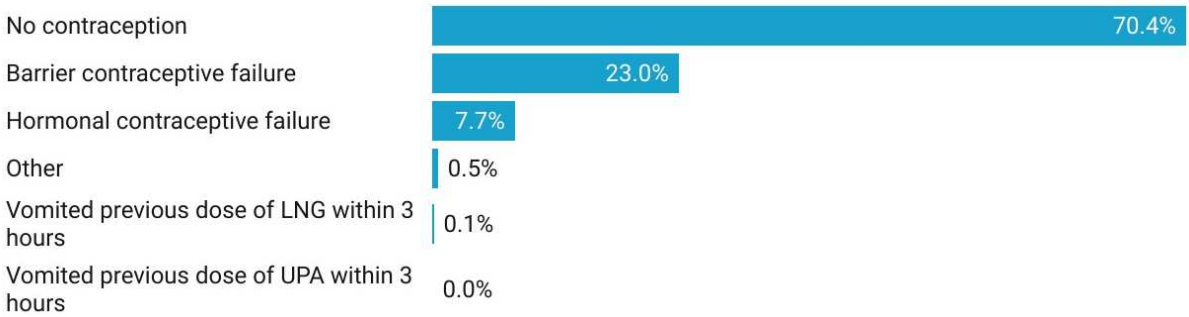


Figure 32. Summary of the reasons for accessing EHC



Literature Review

Why is sexual health important?

The World Health Organisation (WHO) defines sexual health as a state of physical, mental and social wellbeing in relation to sexuality [1]. A holistic and positive approach to sexual health seeks to support an individual's sexuality, their ability to have safe and pleasurable sexual experiences, and their ability to decide if, when, and how they want to have children. Most of the adult population of England are sexually active and access to quality sexual health services improves the health and wellbeing of both individuals and populations.

Sexual health matters to our residents. An active and healthy sex life is associated with health benefits through aerobic exercise, stress reduction and improved mental health and wellbeing. Being part of a happy relationship can also help to reduce depression and anxiety [2]. On the other hand, poor sexual health can cause short-term discomfort or embarrassment with unpleasant symptoms. Left untreated, some STIs can also lead to long-term disability, infertility and in some cases death. Poor education around sexual health can increase stigma, and poor understanding around consent can increase the risk of sexual abuse. Furthermore, unplanned pregnancies, especially teenage pregnancies, can potentially result in poorer educational, social and economic opportunities for women and their children [3].

Sexual health also matters to our communities and society at a population level. The consequences of poor sexual health present a significant economic cost and pressure on public services. Investing in sexual health can prevent this pressure. For example, PHE has previously estimated that for every £1 invested in publicly funded contraception, the public sector receives a £9 return on investment. The return on investment is even greater at £48 for every £1 invested in additional LARC provided in GP [4]. Contraception also has an important wider role in women's lives through managing gynaecological conditions, supporting women and girls to reach their full potential in education or the workplace [5].

Sexual health services are the third highest area of public health spending in England, but have seen spending fall by 17% between 2015/16-2020/21 due to the cut in the public health grant to councils [6]. Despite the fall in funding, the number of patients seeking sexual health consultations has increased by a third since 2013, partly driven by a jump in STIs [6]. It is clearly positive news that more patients in England are proactively seeking support for their sexual health, but it does mean that sexual health services are operating under significant financial pressure. The COVID-19 pandemic and recent Monkeypox outbreak have also had a significant impact on sexual health services. Whilst this has been an opportunity for innovation in the remote delivery of some sexual health services, other services which need to be provided face-to-face, such as LARC, are still recovering from the disruption.

The National Context and Policy

There have been areas of national progress in sexual health outcomes over recent years; including rates of teenage pregnancy falling to an all-time low, and the UK becoming one of the first countries to achieve the United Nations 90:90:90 ambitions on HIV, with over 90% of people living with AIDS knowing their HIV status, 90% of those diagnosed being on antiretroviral therapy, and 90% on antiretroviral therapy having viral suppression. However, there are still many areas for action, as outlined in the numerous national sexual health strategies, action plans and policies summarised in this section. The updated Greater Manchester sexual health strategy is expected to be published soon, and local action plans for Bury will align with this regional strategy.

The Framework for Sexual Health in England (2013)

Improving sexual health is a national priority, seen as fundamental to the health and wellbeing of individuals and the wider population [7]. The Framework for Sexual Health Improvement in England, published in 2013, sets out the government's ambitions for improving sexual health outcomes. Figure 33 summarises the key national objectives to improve the sexual health of the whole population as outlined by the Framework [7]. The Framework takes a life course approach to outline specific ambitions. Figure 34 summarises the key ambitions for teenagers and young people, namely building knowledge and resilience, and improving sexual health outcomes.

Figure 33 – Key national objectives to improve the sexual health of the population in England, as outlined in the Framework for Sexual Health Improvement in England (2013)

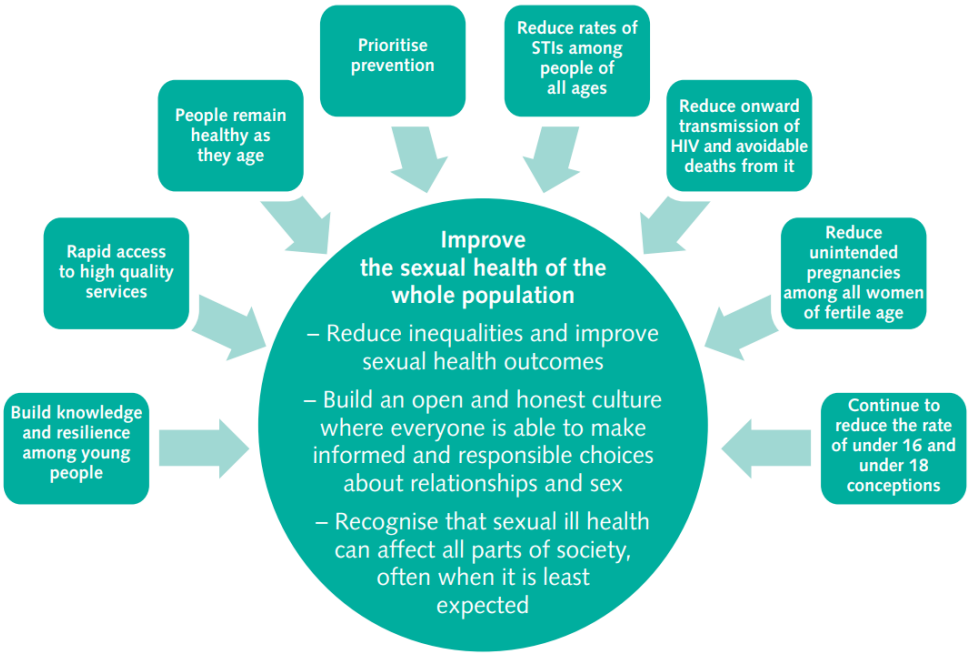


Figure 34 – Ambitions related to the sexual health of young people as outlined in the Framework for Sexual Health Improvement in England (2013)

Build knowledge and resilience among young people	Improve sexual health outcomes for young adults	Prioritise Prevention
• Good quality sex and relationship education at home, at school and in the community • Young people people know how to ask for help and are able to access confidential advice and support about wellbeing, relationships and sexual health • Young people understand consent, sexual consent and issues around abusive relationships. • Young people have the confidence and emotional resilience to understand the benefits of loving, healthy relationships and delaying sex.	• Young people are able to make informed and responsible decisions, understand issues around consent and the benefits of stable relationships, and are aware of the risks of unprotected sex. •All young people's sexual health related needs - whatever their sexuality - are comprehensively met. • Young people have rapid and easy access to appropriate sexual and reproductive health services.	• Build a sexual health culture that prioritises prevention and supports behaviour change • Ensure that people are motivated to practise safer sex, including using contraception and condoms • Increased availability and uptake of testing to reduce transmission • Increase awareness of sexual health among local healthcare professionals and relevant non-health practitioners, particularly those working with vulnerable groups.

Teenage Pregnancy Prevention Framework (2018)

The Teenage Pregnancy Prevention Framework provides guidance to local authorities to maximise the assets of all services to strengthen the prevention pathway for all young people. The framework aims to sustain and accelerate progress to reduce the under-18 conception rate, with particular attention to tacking inequalities in teenage conceptions [8]. Ten key factors associated with effective local strategies are identified, demonstrated in Figure 35. The importance of high quality relationships and sex education for young people and their parents or carers is highlighted, alongside effective contraception provided through accessible and youth friendly services.

Figure 35 – Key Factors to consider in local teenage pregnancy prevention strategies.

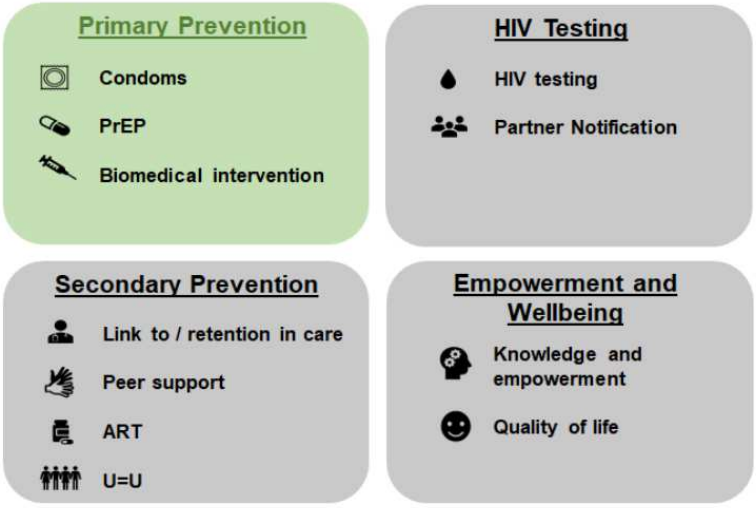
National Chlamydia Screening Programme

The National Chlamydia Screening Programme (NCSP) aims to reduce the health harm caused by untreated chlamydia infection. Chlamydia is the most commonly diagnosed STI in England, with the highest prevalence among sexually active 15-24 year olds. Around 70-80% of people with chlamydia will have no symptoms, which can be a barrier to diagnosis and interrupting chains of transmission [9]. However, if left untreated, chlamydia can cause significant and long-term complications for women including pelvic inflammatory disease, ectopic pregnancies and tubal factor infertility [9]. Complications in men are much rarer. As a result the NCSP proactively offers opportunistic screening to asymptomatic women aged 15-24 in community settings such as GPs and pharmacies. Men are not proactively offered testing, unless there is an indication such as being a sexual partner of someone with chlamydia, or having symptoms themselves. Screening can also be accessed through specialist sexual health services. The NCSP offers an opportunity for earlier detection and treatment of chlamydia, shortening the duration of infection and reducing the risk of complications for women.

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

In 2021 the government set out its action plan to ending HIV transmission in England in Towards Zero [10]. Building on the 35% reduction in new HIV diagnoses in England between 2014-2019, the document sets out a commitment to achieving zero new HIV infections, AIDs and HIV related deaths in England by 2030 [10]. Gay and bisexual men and black Africans continue to experience disproportionately high rates of HIV infection, making them a priority for HIV prevention and testing. The plan centres on partnership working across the health system and beyond with four core themes – prevent, test, treat and retain – across the HIV pathway, as summarised in Figure 36.

Figure 36 – The Stages of the HIV Pathway [10]



Primary prevention is of particular relevance from a public health perspective. Condoms have a real world effectiveness of between 70-80% for heterosexual couples and 70-92% for gay male couples in preventing HIV transmission [10]. Free condom distribution schemes (CDS) are widely commissioned by local authorities and have been shown to effectively reach higher-risk communities and groups including young people, individuals of ethnic minority backgrounds and those living in deprived areas [10]. (Bury Sexual Health Service do provide a CDS via the sexual health service). Oral antiretroviral therapy (ART) can be taken by people without HIV before (pre-exposure prophylaxis – PrEP) or after exposure (post-exposure prophylaxis – PEP) to the virus to reduce their risk of acquiring HIV. Oral PrEP is provided in specialist sexual health services in England and has been shown to be highly effective at reducing the risk of acquiring HIV among all key population groups [10]. PEP is available through hospital A&E departments, sexual assault referral centres and specialist sexual health services in England. Ensuring equitable access and uptake of these HIV preventative interventions is a national priority.

Scaling up HIV testing is another objective of the action plan, in order to identify the estimated 5900 people living with an undiagnosed HIV infection in England and reduce late stage diagnoses [10]. People diagnosed very late with HIV are estimated to have a life expectancy at least 10 years shorter than someone who starts treatment earlier, with heterosexual Black men disproportionately affected by late HIV diagnoses [10]. The overall coverage of HIV testing in sexual health services was 65% in 2019 [10]. Black Africans, especially heterosexual women attendees, are less likely to be tested. The action plan advises that local authority commissioners should set a standard for sexual health services to achieve a 90% testing offer rate to first time attendees, and consider testing in a wider range of services such as prisons, drug and alcohol services, pharmacies and abortion services [10].

Relationships Education, Relationships and Sex Education, and Health Education (2019)

The Department for Education sets out statutory guidance around relationships and sex education in schools in England [11]. Relationships Education is compulsory for all primary school pupils, with all secondary school pupils receiving Relationships and Sex Education (RSE). Health Education is also compulsory in all schools except independent schools [11]. Young people report that school is their preferred source of RSE, followed by parents and then health professionals [8]. There is flexibility for schools to decide how to deliver this education. The guidance asserts that schools should ensure the needs of all pupils are met with sensitive and age-appropriate teaching content which should include "LGBT content" and be mindful of the religious beliefs of pupils [11]. Young people with special needs,

disabilities or learning difficulties should also receive appropriate RSE [8]. The guidance suggests that schools should work closely with parents when planning and delivering these subjects, with parents having the right to request that their child be withdrawn from some or all of sex education provided in school [11]. Parents should be supported to talk to their children about relationships and sex through open communication between schools and parents. Young people who can talk openly to their parents or carers about relationships and sexual health are more likely to have first sex later and to use contraception [8].

In primary school, the focus of Relationships Education is on the fundamental building blocks and characteristics of positive relationships, including friendships, family relationships, and relationships with other children and with adults. It should aim to teach pupils the knowledge they need to recognise and to report abuse, by focusing on boundaries and privacy, ensuring young people understand that they have rights over their own bodies, and know how to report concerns. To prepare for the transition to secondary school, it is also recommended that schools prepare pupils for the changes that puberty and adolescence brings, in line with the national curriculum for science.

In secondary school, the focus of Relationships and Sex Education is on enabling young people to understand what a healthy relationship looks like, both intimate relationships and those with family or friends. It should also cover contraception, safer sex, developing intimate relationships and resisting pressure to have sex (and not applying pressure). Sexual orientation and gender identity should be explored in a clear, sensitive and respectful manner, recognising that young people may be discovering their own sexuality and gender identities. The key aspects of the law to be covered include the age of consent, what consent is and is not, the definitions and recognition of rape, sexual assault and harassment, and choices permitted by the law around pregnancy. Grooming, sexual exploitation and domestic abuse, including coercive and controlling behaviour, and FGM should also be addressed sensitively and clearly. Internet safety should also be covered.

<u>Safeguarding</u>

Safeguarding children and young people against sexual abuse, child sexual exploitation and female genital mutilation is an essential component of sexual health services and interventions. In England, the Sexual Offences Act 2003 sets the age of consent at 16. Sexual activity involving children under 16 is unlawful. However, health professionals can provide confidential medical advice, treatment and examination, including emergency contraception and abortion, to young people aged under 16, after assessing their competence to discuss issues around consent using Fraser guidelines.

Child sexual exploitation has significant and long-lasting impacts on children and their family. The Department for Education defines child sexual exploitation as “a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology” [12]. Any child in any community can be affected, with children aged 12-15 years of age at the greatest risk. There should be an effective local multi-agency plan to combat child sexual exploitation with clear leadership, and underpinned by effective information sharing [12].

FGM refers to all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. It is child abuse and a form of violence against women. The Female Genital Mutilation Act 2003 makes it a criminal offence to subject a girl or woman to FGM or to assist a non-UK person to carry out FGM overseas on a UK national or

permanent resident. Over 66,000 women and girls living in Britain are estimated to have experienced FGM [13]. The procedure can have long-lasting physical and psychological effects, such as chronic pain, sexual difficulties and complications in pregnancy and childbirth and can increase the risk of HIV and other STIs. Most women or girls who have experienced FGM will be referred to a specialised NHS clinic. Health and social care professionals and teachers in England are required to report 'known' cases of FGM in under 18s which they identify in the course of their professional work to the police [13].

Women's Health Strategy for England (2022)

More recently, the government has produced the Women's Health Strategy for England, a 10-year strategy that sets out a range of commitments to improve the health of women [5]. There were over 110,000 responses to the call for evidence which has informed the strategy. Several areas affecting teenagers and young adults sexual health and wellbeing were identified, including HPV vaccination, menstrual health, contraception, sexual health and wellbeing, pregnancy, fertility, pregnancy loss and abortion care. Many respondents highlighted the importance of contraception both to prevent unplanned pregnancies, and as a first-line treatment for menstrual problems. However many women met barriers in accessing the contraceptive method of their choice due to siloed commissioning. The barriers were greatest for women accessing contraception for non-contraceptive purposes, such as LARC to treat heavy menstrual bleeding. Many survey responses and written submissions called for more joined-up and holistic provision through one-stop women's health clinics or women's health hubs. It is suggested that this would help women and girls to access services that meet all their reproductive health needs from adolescence through to post-menopause care. Many respondents also highlighted the importance of the relationships, sex and health education (RSHE) curriculum in schools being taught to both girls and boys to ensure women's health issues (including menstrual health and contraception) are no longer taboo subjects.

Vulnerable Groups

Sexual health access and outcomes are not equally distributed within the population. Tackling these inequalities is essential to achieve good sexual health at a population level [3]. There are strong links between sexual health and other key determinants of health, such as alcohol and drug misuse, smoking, obesity, deprivation, mental health and violence [7]. Poor sexual health outcomes such as STIs, teenage conceptions and abortions are disproportionately likely to be borne by women, gay, bisexual and other men who have sex with men (MSM), the transgender community, young people, and people from ethnic minority backgrounds. For example, the highest burden of HIV infections in the UK is borne by GBMSM, and black African populations. Research commissioned by Stonewall indicates that a high proportion of lesbian and bisexual women, and GBMSM have never been tested for STIs [7]. Sex workers face multiple barriers in accessing mainstream services for sexual health support and are also more vulnerable to violence, rape and sexual assault, homelessness, and drug and alcohol problems that may impact on their sexual health needs [7].

Some of these vulnerable groups face societal stigma and discrimination, which can affect their ability to access services. Individuals may identify with more than one vulnerable group, and the ways in which these different identities combine and interact can create interdependent systems of discrimination. In other words, these vulnerable groups should not be considered as distinct or separate. The sexual health needs of Bury residents will be affected by their own unique experiences of discrimination and marginalisation shaped by their intersecting identities.

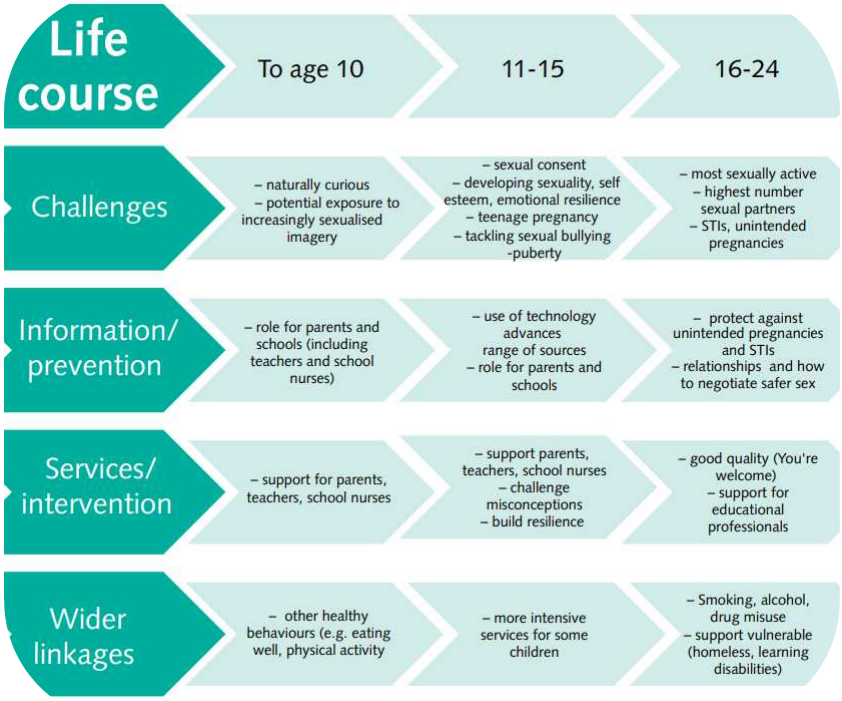
Young People

Young people are a group within the population who often experience poorer sexual and reproductive health [3]. This includes higher rates of STI's, unplanned conceptions, and abortions than older age groups [14]. Although sexual exploitation can happen at any age, it is more likely at younger ages, and

is associated with poor mental health, STIs, teenage pregnancy and abortions [15]. Some young people are at higher risk of poor sexual health outcomes than others, including young people who use drugs, teenage parents, those in contact with the criminal justice system, young people from more socioeconomically deprived backgrounds, young people in care, and those from ethnic minority groups [15]. LGBTQ+ young people are also at risk of poorer sexual outcomes: for example, GBMSM are at greater risk of HIV and women who have sex with both women and men report significantly greater numbers of male partners and higher levels of unsafe sex, smoking, alcohol consumption, intravenous drug use, abortion and STIs [15]. Young people with learning disabilities typically have particularly poor access to relationships and sex education or information [7].

Importantly, the sexual health needs of young people change significantly as they progress from childhood through puberty to young adulthood. The latest National Survey of Sexual Attitudes and Lifestyles (NATSAL) found the median age at which males and females become sexually active in heterosexual relationships in Britain is 16 [16]. Young people are particularly likely to be influenced by perceived social norms, fearing rejection if they are not sexually active. They are likely to perceive their peers to be more sexually active than the reality. This can be a significant barrier to young people choosing to access sexual health services, alongside physical and material barriers such as time, travel, and cost limitations. A systematic review of contraceptive service delivery in the UK found most significant concerns for young people in decisions around accessing sexual health services are anonymity and confidentiality, followed by fear of unfriendly or critical staff [17]. Figure 37 highlights some of the key challenges and appropriate interventions at each of these life stages.

Figure 37 – A summary of sexual health challenges and needs by life stage for young people [7]

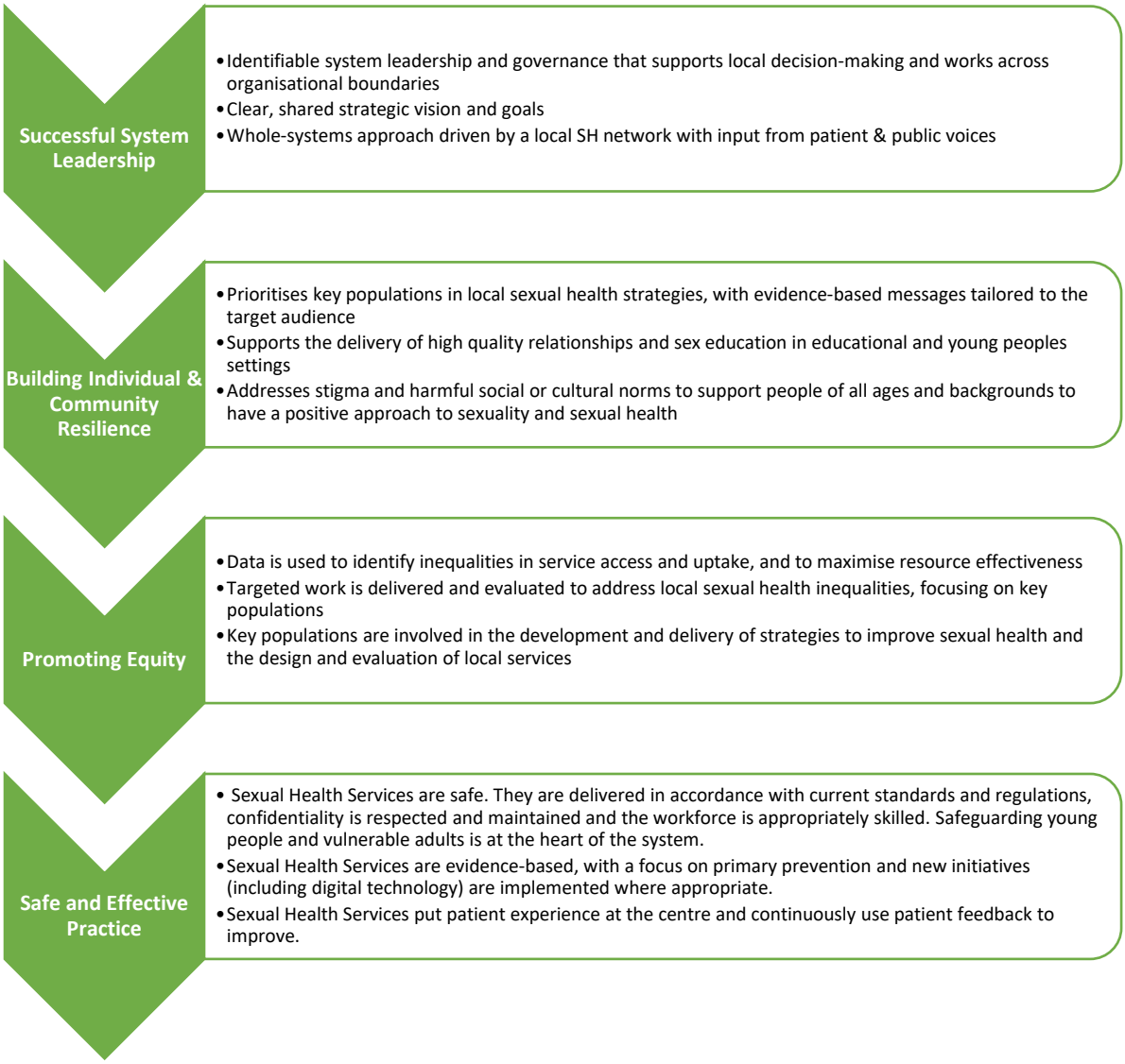


What do good sexual health services look like?

Figure 38 summarises the key features of what good sexual health provision looks like, as defined by the ADPH [3]. These include successful systems leadership, building resilience at an individual and community level, promoting equity, and ensuring safe and effective practice. Sexual health services that are accessed by or targeted at young people should meet the national "You're Welcome" guidance which sets out eight standards for youth-friendly services. These standards have been

developed in partnership with young people and aim to improve their experiences health services [18]. They include involving young people in their care and in the design and delivery of services, supporting young people to develop their health literacy, respecting their confidentiality, and encouraging the development of youth-friendly services.

Figure 38 – The key features identified in good sexual health provision [3]



Engagement

Stakeholder Engagement

To capture the perspectives and experiences of local stakeholders, one-to-one interviews were held with members of each of the key services identified as providing support to young people around sexual health in Bury. This included representatives from the integrated sexual health service (HCRG), school nursing, Youth Services, Youth Justice and CAMHS. Stakeholders were then asked about their perspectives around young people's sexual health and its services.

- **Accessibility and visibility of services**- Concerns regarding the accessibility and visibility of specialist sexual health services available to young people in Bury. Stakeholders reported that young people were often not aware of the location or service provided at the sexual health clinics across the borough. Some stakeholders also raised concerns about the timings of clinics, as they were not compatible with young people's commitments, including education, and the lack of drop-in clinics or hubs. It was also mentioned that SH hubs in the vicinity of educational institutions were very convenient and effective way to improve young people 's accessibility to the services. Stakeholder have suggested that the promotion of C-cards (CDS) within young people's groups, institutions, and spaces, could expand its reach, and strengthen partnerships with organisations who regularly come into contact with young people.

- **Staff Training**- stakeholders have agreed that more regular sexual health training updates and refresher training would be advantageous, as some professionals have reported lack of confidence to address and support LGBTQ+ young people, especially those questioning their gender identity. Stakeholders have requested regular training including the latest updates concerning STIs, contraception, referral routes, and how to deliver age-appropriate information and content to young people. Stakeholder have expressed the benefit of health professionals working in partnership with youth workers to reach young people.

- **Capacity-** Stakeholders reported limited capacity reduced their ability to engage in sexual health related work for young people. For instance, school nurses reported a desire to be active partners in conversations and decisions around sexual health support for young people but lack the capacity to take on responsibility for delivering additional support. School nurses reported that high levels of safeguarding work reduced their ability to provide preventative sexual health interventions. The specialist sexual health service HCRG reported that the increase in low level educational referrals into their service, reduced their capacity and increased waiting times for more specialised services.

- **Lack of sexual health knowledge-** stakeholders reported that young people sexual health knowledge was not satisfactory, as a significant number of young people relied on social media, friendship groups and other sources (often not reliable) to obtain information concerning sexual health. Stakeholders suggested encouraging conversations between primary and secondary schools may help understand how primary schools can best prepare children around relationships and sexual health education before pupils leave for secondary school.

- **The influence of pornography and internet-** stakeholders have reported that pornography is increasingly becoming accessible to young people in Bury and across the country, this particularly has an impact on young people 's perceptions and expectations concerning healthy relationships. Stakeholders reported lack of skills to have conversations with young people to discuss and challenge unhealthy expectations. Stakeholder requested access to informational resources, to share with stakeholders, parents and young people, especially addressing the misconceptions surrounding pornography, and misogynistic views widely available online, from public figures including Andrew Tate.

- **Address needs of LGBTQ+ young people and minorities–** most stakeholders agreed that there is a great gap to meet the needs of LGBTQ+ young people in Bury. Stakeholders suggested that a more consistent emotional and social support is required for young people exploring their gender identity and sexuality. The lack of support and services tailored to transgender

young people was also mentioned. Stakeholders felt that more support for professionals around how to approach conversations around sexuality and gender identity with young people, would be greatly beneficial, especially to address cultural and religious taboos, that could make conversations more difficult. Stakeholders have identified that a language barrier could be a hindrance to reach young people from minority groups. A lack of informative SH resources in more languages was highlighted.

- **Stakeholders' partnerships** – Stakeholders have reported that the relationship between the specialist sexual health service HCRG and the Sunrise Team facilitated timely and tailored support for young people exposed to sexual exploitation. The Youth Service was identified as especially important in reaching more vulnerable young people. Stakeholder have reported good relationships between professional and schools, specially concerning HPV vaccination.

- **The Proud Trust** – Stakeholders have suggested that more regular training sessions from The Proud Trust, would be very beneficial to professionals and young people, but this activity has drastically diminished since the COVID pandemic.

Service User Engagement

Service user engagement has been carried out by two Voice2Voice workers embedded within Early Break, in collaboration with HCRG. They have conducted an online survey open to young people aged 13-19 across Oldham, Rochdale and Bury, and one focus group in a youth centre in Oldham.

Bury Specific Survey Feedback

The total of 236 respondents to the survey were Bury residents. The responses to this survey therefore provide some insight into the perceptions of young people in Bury but are not a representative sample. Most of the respondents (67.8%), were 13- 14 years old, 27.97% were 15-16 years old 1.27% were 17-18 years old, and 1.27% were 19 years old as demonstrated in Figure 39. In this survey, 51.91 % of the respondents from Bury were female, 40% male, 2.13% non-binary, 2.13% preferred not to respond and 3.83% of respondents identified as other, as demonstrated in Figure 40.

Figure 39. Age of Bury residents who participated in the survey.

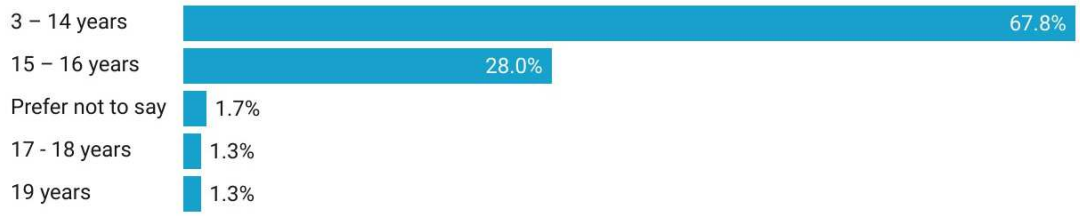
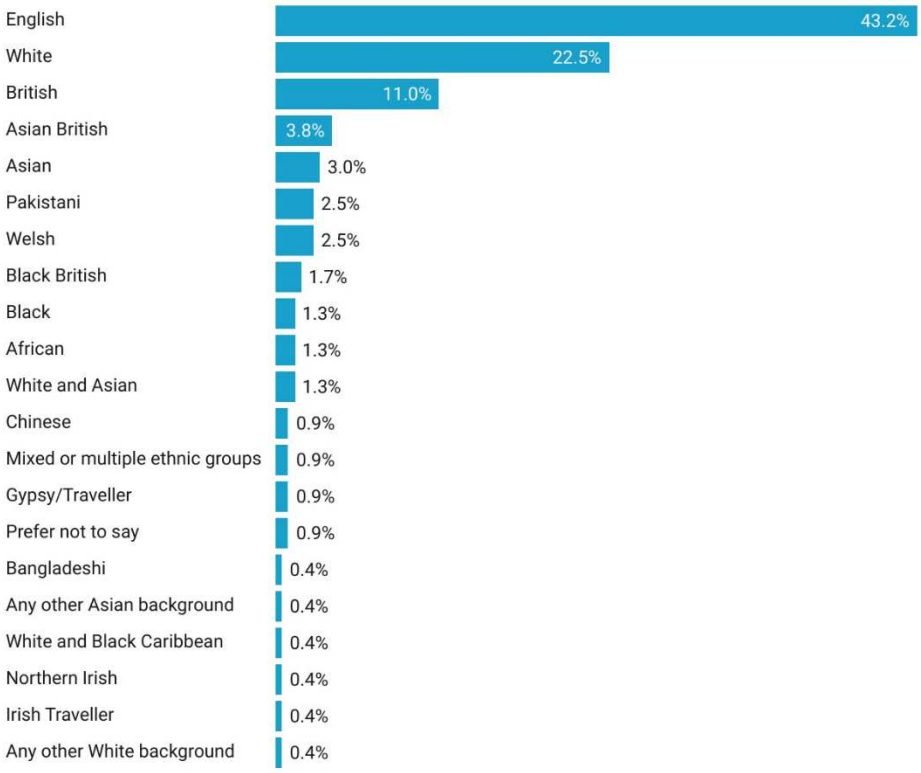


Figure 40. Gender of Bury residents who participated in the survey.

The majority of respondents identified as heterosexual (66.67%), 13.25% identified as part of the LGBTQ+ community, 8.12% preferred not to say and the specified answers under “other” included as” they”, as demonstrated in Figure 41. The majority of respondents identified as English (43.22%), followed by Welsh (22.46%), British (11.02%), Asian (11.01 %), African (5.08 %), as demonstrated in Figure 42.

Figure 41. Sexual orientation of Bury residents who participated in the survey.

Figure 42. Ethnicity of Bury residents who participated in the survey.

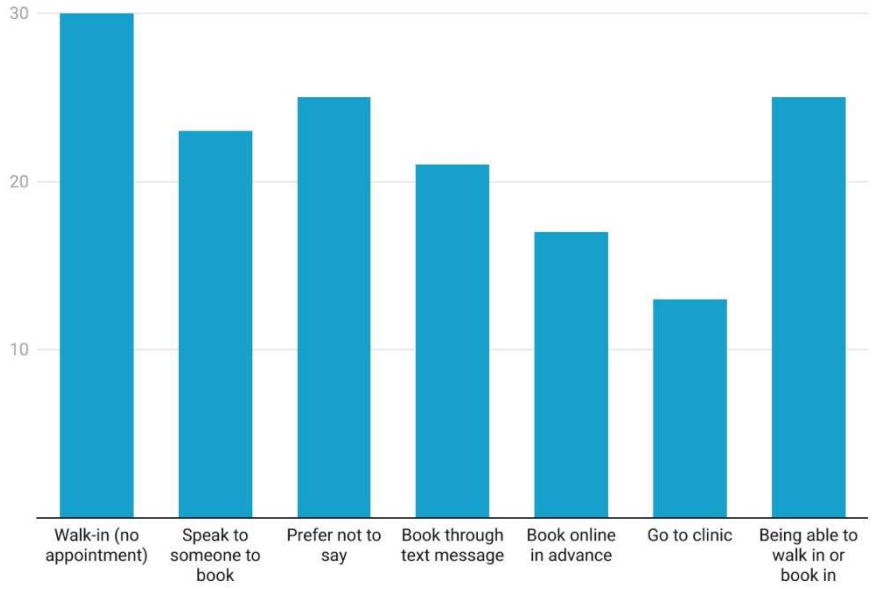


74.58% of young people living in Bury, according to this survey, were unaware of their local sexual health service. The young people who had heard of the service previously, were exposed to the information via their schools, internet, family, friends, posters or GP nurses. The majority of the respondents who had used the service previously, expressed a neutral experience (62.6 %), 19.1% experienced a very poor service, 2.6% a poor experience and 15.6% reported a good or very good experience, as demonstrated in Figure 43.

Figure 43. Summary of responses to a question exploring young people's previous experiences of the Bury HCRG service.

When the participants were asked about their preferences for sexual health service opening times, the most popular options were weekday afternoons and evenings between 3pm and 8pm (48.45%), and weekends during the daytime and evenings, with 22.98% and 43.48% respectively. In terms of how young people would prefer to access their sexual health services, the most popular option was a mixture of being able to walk-in or book in advance (24.62%). A total of 23.08 % would prefer to book either through text message or online, as demonstrated in Figure 44.

Figure 44. – A summary of the answers to the question "When going to a clinic for sexual health, what would your preferred options be?"



When asked which factors would be most important to them if they needed sexual health support, 62.57% strongly agreed with a "friendly and non-judgemental service", 52.69% with "confidentiality" and 40.96% with "quick and easy access". Open responses to a question asking about what would make it easier to access sexual health service more online services and improving access to *appointments, as demonstrated in Figure 34. One respondent stated: "Give appointments as fast as they can because sometimes people wait for week and can't book appointment." Another stated: "talking to people confidentially through school". Another stated: "Being able to talk online, not face to face, through messages". Other responses included spreading more awareness about the services and giving access to younger and less experience people.*

When participants were asked if they had previously received relationships and sex education, 71.92% reported they had received RSE in an educational setting. An average score of 3.1 /5 was given to how informative the RSE they received was. 63.9% were not informed of how to access local sexual health services as part of this RSE. When asked what else they would have liked to learn about as part of RSE answers included: "LGBTQ+ education", "after sex"," how/where to access certain services and how to implement advice given", "erectile dysfunction", "masturbation", "abuse signs", "sexuality" and "*STDs".* When asked how important it was for schools to have a better delivery in teaching young people about consent and sexual exploitation, 52.38% agreed that it was very important, 48.68% wanted more advice around STIs and HIV, 46.52% wanted to know more about healthy relationships and support services and 46.26% wanted more information around contraception and condoms.

Figure 45. A summary of the answer to the question: "If you needed sexual health support, what factors would be important to you?"

	VERY IMPORTANT	IMPORTANT	NEUTRAL	NOT IMPORTANT	UNSURE
Confidentiality	52.69% 98	18.82% 35	8.60% 16	7.53% 14	20.43% 38
Friendly and non-judgemental service	62.57% 117	14.44% 27	8.02% 15	5.88% 11	15.51% 29
Location of service	24.19% 45	30.11% 56	24.19% 45	10.75% 20	17.74% 33
Quick and easy access	40.96% 77	29.26% 55	13.30% 25	6.38% 12	17.55% 33
Seeing people that I can identify with of a similar background.	21.81% 41	19.68% 37	29.79% 56	15.43% 29	20.74% 39
Young people's clinic only.	22.46% 42	25.67% 48	25.67% 48	13.90% 26	20.86% 39

Focus Group Feedback

Voice2Voice workers held a focus group/ drop in at the senior's group at Mahdlo, Youth Centre in Oldham open to boys and girls aged 13-18. The participants took part in a series of activities and responded a list of questions to have a better understanding on what young people believed was missing from sexual health services and education, in addition to potential barriers. Voice2Voice interviewers based themselves in the "chill zone" and invited young people to come over if they wanted to. The focus group consisted of 7 females, including one transgender female, 6 were White British and 1 Asian British. The interviewers found many barriers to engage with the boys at the centre who were reluctant to speak about sexual health in front of their peers.

The feedback from the focus group was mainly around the delivery and content of relationships and sex education in schools. Participants expressed that they wanted schools to provide more information around pregnancy, abortions and miscarriages and life after a baby (i.e., breast feeding and effects of a women's body), as well as deepen their knowledge around LGBTQ+, as they don't feel like the information is taught well enough and they believe it to be a confusing subject. Furthermore, they felt it was important that both groups receive the same education in those separate groups however and were keen for boys to be taught about "what women go through" in depth by a "proper sexual health educator".

Some participants felt this was important to change boy's mind-sets around women due to their experiences of sexism in schools and requested separate sex education classes for boys and girls which they felt would facilitate space to ask questions without embarrassment. Some participants reported upsetting first experiences of sex due to the way they were treated by their male partner. They expressed the importance of more education for girls, on what to expect when having sex for the first time so girls feel more comfortable and are able to have pleasure from the experience themselves. Concerning sex education in schools, one of the participants who attended a Catholic school, felt that any discussions around sexual education were avoided and requests for more teaching on healthy relationships and coercive control were highlighted.

Some participants requested for access to sexual health information through online videos and on an app. One participant suggested that the C-card scheme and all local sexual health services (i.e., emergency contraception, advice around STI's and access) should provide advice through chat rooms, via an app interface. Feedback about experiences of local sexual health services was less discussed during the interviews, however some participants reported that embarrassment and taboo are the main barriers to young people accessing sexual health services. The transgender female participant reported a poor experience with local sexual health services, which did not feel accessible or inclusive to her due to the questions she was asked. This left her feeling uncomfortable and scared of accessing the service again in the future.

Conclusion

This Children and Young People Health needs assessment highlighted the many challenges the sexual health services systems in Bury are facing when commissioning and providing sexual health services to young people. It is important to address the issues concerning the accessibility, visibility, availability and quality of the services delivered in Bury. This report has highlighted the importance of building strong relationships between relevant stakeholder, including HCRG, schools, wider services to improve the engagement and access of young people to the SHS and subsequently addressing the issues surrounding contraception, knowledge about STIs, healthy relationships and sexuality. There are many areas that require special attention to address the unmet needs of Bury young people and the recommendations presented in this report, should be a great starting point to improve the service provided to young people and reduce the health inequalities within this vulnerable group.

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