JANUARY 1, 2020

SEXUAL HEALTH NEEDS ASSESSMENT

OLDHAM, ROCHDALE AND BURY

DOAA FARAG
SPECIALTY REGISTRAR IN PUBLIC HEALTH, BURY COUNCIL

Word cloud based on service user consultation, Oldham, Rochdale and Bury (ORB), November 2019

Abbreviations

ART – Anti-Retroviral Therapy

BAME – Black, Asian and Minority Ethnic

CASH – Contraception and Sexual Health

CCG – Clinical Commissioning Group

CST – Chlamydia Screening and Testing

EHC - Emergency Hormone Contraception

GM – Greater Manchester

GUM – Genitourinary Medicine

HIV – Human Immunodeficiency Virus

HNA – Health Needs Assessment

HPV – Human Papilloma Virus

IMD – Index of Multiple Deprivation

IUCD – Intrauterine Contraceptive Devices

IUD – Intrauterine Device

IUS – Intrauterine System

KPI – Key Performance Indicator

LARC – Long-Acting Reversible Contraception

LGBT – Lesbian, Gay, Bisexual and Transgender

MASH – Manchester Action on Street Health

MSM – Men who have Sex with Men

ORB – Oldham, Rochdale and Bury

PaSH – Passionate about Sexual Health

PHE – Public Health England

POCT - Point of Care Testing

SH – Sexual Health

SRH – Sexual and Reproductive Health

STI – Sexually Transmitted Infection

SDI – Sub-Dermal Implants

VCSE – Voluntary, Community and Social Enterprise

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Executive Summary of Findings

- Greater Manchester (GM) Sexual Health Strategy's vision is to improve Sexual Health (SH) knowledge, provide accessible SH services, improve SH outcomes and achieve HIV eradication in a generation.
- The GM Public Service Reform model places emphasis on community services, with cross-sectoral work across localities in GM
- Oldham, Rochdale and Bury have been in a tripartite agreement for Sexual and Reproductive Health with Virgin Care since 2015, this Health Needs Assessment summarises SH need, demand and provision to inform future commissioning
- ORB are in an ideal position to consider the future of SH services to meet those objectives, and ensure a focus on prevention and early intervention

- ORB has a young population, with a higher proportion of females, high levels of deprivation, lower healthy life expectancy than England and wide ethnic diversity
- These demographic factors indicate higher population need for health services, and a need for these services to be accessible across all population sub-groups to minimise inequalities
- New STI diagnoses across ORB are lower than GM/England, although they have been increasing since 2015; however, testing rates are also lower, suggesting undetected disease burden
- Chlamydia detection rates are reducing across ORB, this indicates reducing control activities across the region as the higher detected rates, the more this contributes to reducing Chlamydia prevalence overall
- Gonorrhoea rates are rising in ORB along with GM/England averages, the burden of Gonorrhoea being higher among MSM
- HPV Vaccination rates in Bury are low, due to reluctance of some schools to engage with the programme; this has been addressed and all schools in Bury are now engaging
- HIV prevalence across ORB is lower than GM, however, there is a high proportion of late HIV diagnosis
- LARCs are the most cost-effective methods of contraception, however, there has been a decline in provision across GM

- Most SH service activity is provided by Virgin Care and GPs across ORB
- Virgin Care provide services through community hubs/GUM clinics across ORB, with a young people's offer through Virgin in Rochdale and Bury, and with Brook in Oldham. There are drop-in clinics and out-of-hours appointments as part of the service
- Highest activity is among those aged 25-39, with females making up 75% of consultations
- There have been issues with the recording and monitoring of some KPIs by Virgin Care
- Pharmacies across ORB are commissioned to provide Emergency Hormone Contraception and Chlamydia Screening and Testing, with GPs providing contraception in ORB, and STI screening in Oldham and Rochdale
- VCSE organisations include PaSH, which focuses on SH services among the MSM community, and MASH – which has recently been decommissioned in Bury and focuses on SH needs of female sex workers. MASH was not previously commissioned by Rochdale or Oldham.

- A consultation exercise took place over November, with two online surveys going out, one for service providers and one for service users, engaging participants across ORB
- In summary, service users felt there was a need to improve access to SH services across ORB, this was reflected by SH staff and provider staff who felt there were capacity issues
- There was demand for pharmacists to be more involved in sexual health service provision within both consultations, with it being seen as an accessible community setting

Recommendations

1. Findings from this Sexual Health Needs Assessment to be used in designing a service specification for future commissioning of local sexual health services
2. Work collaboratively with other GM local authorities to consider changes in Sexual Health Commissioning in the context of the GM Public Service Reform
3. Clarify the ORB cross-charging agreement for sexual health services across other GM local authorities
4. Improve opportunistic STI screening in order to meet PHE Chlamydia detection targets, this would be most accessible in community pharmacies
5. Attention to be paid to rising Gonorrhoea rates, there needs to be increased awareness across the public, as well as maximising opportunistic screening
6. Ensure adequate HPV vaccination coverage particularly in Bury, this is likely to improve as work with local schools undertaken
7. Improve access to LARC as a cost-effective intervention with high return on investment; feedback from service users indicate this would be best placed in GP services
8. Improve access to HIV diagnosis in order to reduce rate of late HIV diagnosis which introduces preventable inequalities in long-term health outcomes of those living with HIV
9. Review Virgin Care KPIs and ensure accurate and up to date recording and reporting of activity
10. Review out-of-hours GUM clinics provision through increasing evening and weekend appointments, as well as increasing frequency and staffing of clinics
11. Improve accessibility to and increase provision of sexual health clinics for working-age adults across ORB by increasing out-of-hours appointments
12. Improve engagement with sexual health provider staff who report high workload and low staff morale, there is a demand from staff to be involved in changes to services
13. Improve knowledge of primary and secondary care staff regarding locally available sexual health services and referral pathways
14. Ensure accurate and up to date reporting of activity and performance by pharmacies across Rochdale and Oldham – this will likely improve since the recent introduction of Pharmoutcomes
15. Consider role of MASH in future service commissioning – a current review is ongoing into services provided across Manchester and Bury
16. Widen role of pharmacies in community sexual health service provision, particularly regarding STI screening and testing, as well as advice and counselling
17. Carry out in-depth assessment of needs of population sub-groups such as LGBT, female sex workers and BAME residents to understand their needs and any challenges faced in accessing services

Introduction and Context

This Sexual Health Needs Assessment looks into the sexual health needs and demands, as well as services available across Oldham, Rochdale and Bury, (ORB). It starts by looking into the local population demographics, then looking into local sexual health services, then outlines the findings from a consultation with local residents and staff.

ORB are in a contract with Virgin Care to provide sexual health services for the population in these localities. As such, this document investigates the sexual health needs of the population covered by this contract, and will be used for informing future commissioning decisions.

Good sexual health is important to individuals, but it is a key public health issue as well. Sexual ill health and wellbeing is strongly linked to deprivation and health inequalities, and presents a significant cost to society as well as to the individual. Progress has been made in some areas over recent years; rates of teenage pregnancy have fallen to an all-time low, and the UK became one of the first countries to achieve the United Nations 90:90:90 ambitions on HIV, this is a UN ambition where, by 2020, 90% of people living with AIDS know their HIV status, 90% of those diagnosed being on antiretroviral therapy, and 90% on antiretroviral therapy having viral suppression, (UNAIDS, 2019). However, there remain challenges and areas for improvement.

What is Sexual Health?

Sexual health goes well beyond the medical model of the treatment of disease. The World Health Organisation (2002) defines sexual health as:

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

There is a high human, as well as economic, cost associated with sexual ill health. 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.

The overarching aim of this HNA, therefore, is to identify the sexual health needs of the population of ORB paying attention to inequalities in health outcomes between the localities and population sub-groups, assess demand on current services, map out the services, assessing accessibility and suitability and provide recommendations for future service provision.

National Policy Context

The Health and Social Care Act 2012 divided responsibility for commissioning sexual health, reproductive health and HIV services between local government, CCGs and NHS England. Under this act, local authorities have the lead for improving health and for coordinating efforts to protect public health. Public health teams within local authorities are responsible for commissioning and funding a number of mandated services and other services to improve the health and well-being of local populations.

- Local authorities are mandated to commission and fund comprehensive, open-access HIV/STI testing services; STI treatment services (excluding HIV treatment); and contraception services for the benefit of all persons of all ages present in their area.
- NHS England is responsible for commissioning and funding HIV treatment services.
- Clinical Commissioning Groups are responsible for funding some forms of contraception within GP contracts, abortion services; vasectomies and sterilisation procedures; and for the promotion of opportunistic STI testing and treatment within general practice.

Improving sexual health is a national priority that was made explicit in the 'Healthy Lives, Healthy People' White Paper 2010, the Health and Social Welfare Act 2012, and the Public Health Outcomes Framework 2013-16. These policy frameworks set out the overarching vision for public health, and the outcomes and indicators that will determine public health improvement and protection.

The House of Commons Health and Social Care Committee launched an inquiry into sexual health, the report from which, published in June 2019, highlights that despite overall declining rates of STIs and teenage pregnancies, there are worrying inequalities, with certain groups disproportionately bearing the burden of poor sexual health. The report further highlighted the impact of the continuing reduction in local authority spending on sexual health due to successive cuts in the ring-fenced public health grant, on higher costs for the wider health system. The report calls for increasing funding in order to deliver high quality services, along with the recommendation for a new national sexual health strategy, (HSCC, 2019).

Against this backdrop, some local authorities have chosen to form agreements in their Integrated Sexual Health care provision, such as with Oldham, Rochdale and Bury (ORB) in Greater Manchester, who formed a tripartite agreement in 2015 with Virgin Care. The aim of this agreement was to standardise the quality of care across the boroughs, while minimising costs through economies of scale.

The Public Health Outcomes Framework sets out a vision for public health, desired outcomes and the indicators that will be used to monitor how well public health is being improved and protected. The Framework includes indicators relating to sexual and reproductive health, including among others:

- Indicator 2.04: Under-18 conception rate
- Indicator 3.02: Chlamydia diagnosis rates among young adults aged 15-24s
- Indicator 3.04: % of persons presenting with HIV at a late stage of infection

Greater Manchester Context

Poor sexual and reproductive health, including the ongoing transmission of HIV, has major impacts on Greater Manchester residents, and despite the progress made, there are still high rates of HIV and STIs in the conurbation. Poor sexual health also contributes to inequalities, with the more deprived populations experiencing worse sexual health.

Continuing challenges across GM include the rising rates of some sexually transmitted infections, the continuing transmission of HIV and continuing inequalities in outcomes. Almost half all HIV diagnoses in GM are late, which lead to poorer outcomes for the individual and increased risk of onward transmission. Further demands on services are anticipated with the potential introduction of pre-exposure prophylaxis (PrEP) and immediate initiation of anti-retroviral therapy (ART), (CSPH, 2019).

The GM Sexual Health Strategy, published in 2018, sets out a vision for GM where:

• All residents have the knowledge, skills and confidence to make informed choices about their sexual health, reproduction and relationships;

• Sexual and reproductive health services are accessible, sensitive and appropriate for all;

• Improved outcomes in sexual and reproductive health help Greater Manchester to be among the best in the country;

• HIV eradication in a generation is achieved through collaboration

GM Public Service Reform

Regionally, the Greater Manchester Model was published in 2019, which aims to move public service delivery from many fragmented institutions, into a more unified, place-based model of working which focuses on prevention and is person-centred. This will see the formation of neighbourhoods across each local authority, with each comprising a population of up to 30-50,000.

In practice, this means there is a stronger emphasis on community services linking together across sectors, and across localities. The emerging Local Care Organisation developments across Greater Manchester, alongside the integrated commissioning arrangements and the work on neighbourhood and primary care standards across the conurbation, provides an opportunity to engage primary care with sexual and reproductive health in a unique, novel way.

GM Population Health Plan

The GM population health plan 2017-2021 sets out a strategy for improving the health of GM residents by focusing on Starting Well, Living Well, Ageing Well, and System Reform.

Improving sexual and reproductive health falls under the Living Well programme, where there is a strong emphasis on HIV eradication, minimising sexual health inequalities, and the development of an integrated sexual and reproductive health system focusing on harm reduction through prevention and early intervention, as well as improved accessibility.

To achieve these outcomes, common standards for population health have been developed across seven areas, one of which is sexual and reproductive health. This standardises quality outcomes across all localities in GM, in order to drive improvements for the health of local people.

1. Oldham, Rochdale and Bury Demographics

Oldham, Rochdale and Bury combined have a population of 645,732 (ONS, 2018 Mid-Year Estimates). The combined ORB population pyramid highlights a younger population than the England average, with the three combined local authorities having a higher proportion of 0-19 year olds, and a similar proportion of residents aged over 50 compared to the national average. The genders are fairly equally distributed; however, there is a higher proportion of females making up the 30-39 age cohort. In total, there are 9,884 more females than males across ORB combined.

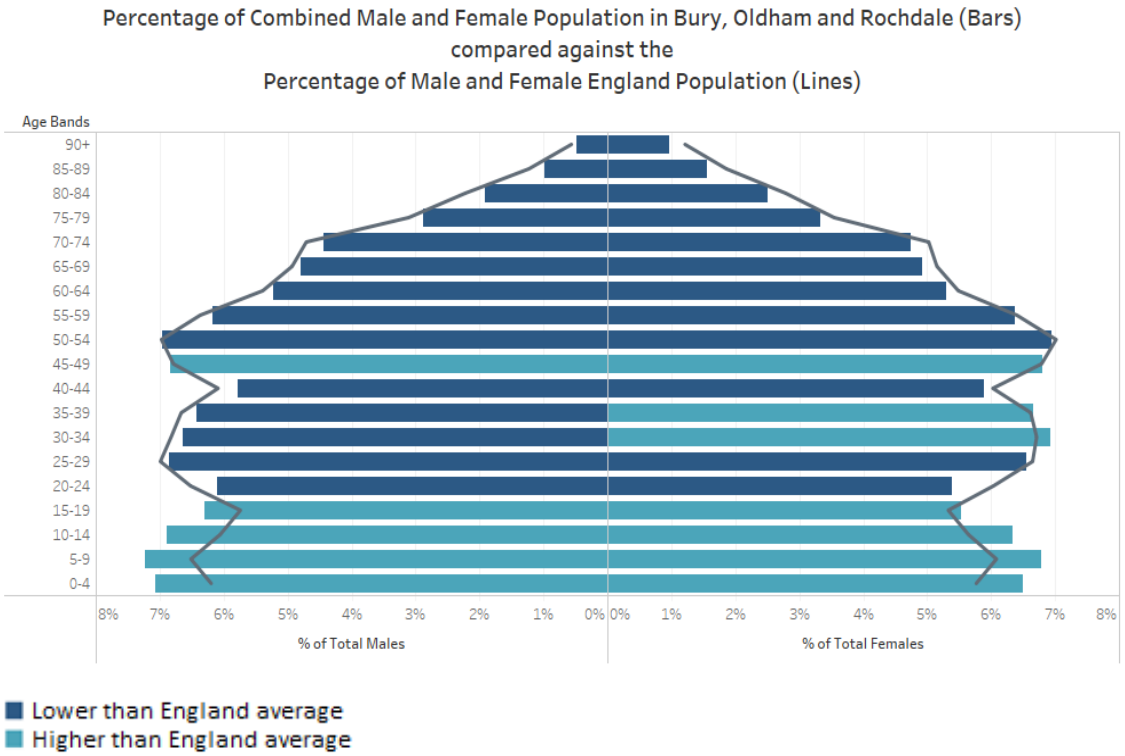

Figure 1.1: ORB Population Pyramid (ONS, 2018 Mid-Year Estimates)

GM has a higher rate of deprivation than the rest of England. This is reflected in ORB, where both Oldham and Rochdale are ranked among the 20 most deprived local authorities in England, with Bury in line with the national average. The below map demonstrates the Index of Multiple Deprivation (IMD) across Greater Manchester (GM), ORB are highlighted within GM, in the order of Bury, Rochdale and Oldham clockwise.

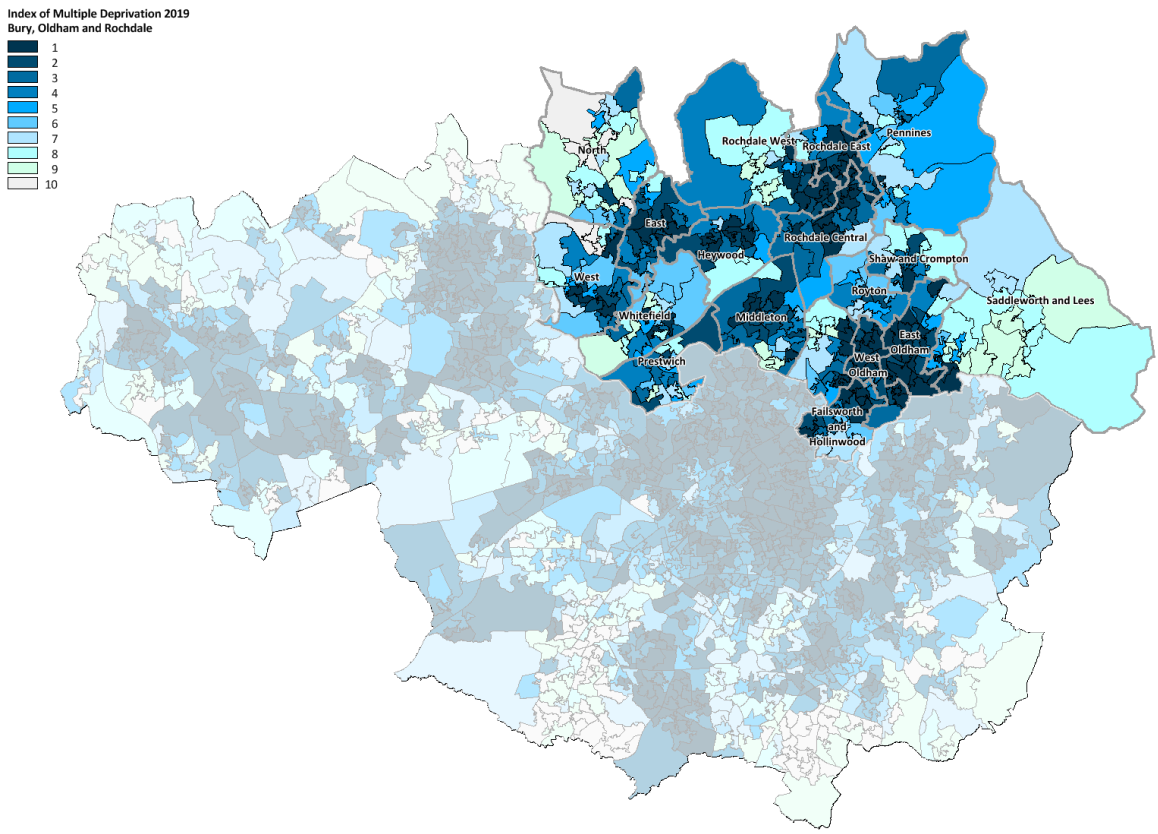

Figure 1.2: Map of ORB within GM

ORB Breakdown of Population by Ethnicity

The table below demonstrates the ethnic make-up of Oldham, Rochdale and Bury compared with GM and England. Of note, there is a significantly higher proportion of residents from an Asian or British Asian background than there is nationally, with Oldham having the highest proportion of the three local authorities. There is a lower proportion of residents from a Black background when compared with GM and nationally. A breakdown of each individual local authority is provided below.

It is important to highlight that ethnicity statistics are based on the 2011 Census, and so there are likely to have been changes to ethnic composition of the localities since then.

Ethnicity is important to note due to variations in sexual health needs and outcomes by ethnic group. For example, cultural influences on access to contraceptives or sexual health clinics may be a barrier among certain ethnic minorities, meaning they have unmet sexual health needs. Furthermore, certain ethnic groups have higher burdens of STIs meaning an area with a higher proportion of this ethnic group would have increased demand on services.

	Oldham	Rochdale	Bury	Greater Manchester	England
White	77.5%	81.7%	89.2%	83.8%	85.5%
Mixed/ multiple ethnic groups	1.8%	1.7%	1.8%	2.3%	2.2%
Asian/ Asian British	19.2%	14.9%	7.2%	4.8%	2.1%
Black (African/Caribbean)	1.2%	1.3%	1.0%	2.8%	3.4%
Other Ethnic groups	0.2%	0.4%	0.7%	3.1%	3.2%

Table 1.1: ORB by Ethnicity

Life Expectancy

The graph below represents Life Expectancy (LE) and Healthy Life Expectancy (HLE) in each local authority, GM and England. Males generally have lower life expectancy than females, with life expectancy in ORB lower than in England. HLE is also lower across ORB local authorities compared with England but similar to HLE across GM.

HLE is an important indicator of morbidity, and therefore, can be used as a proxy for healthcare needs. The proportion of years expected to be lived in good health across ORB for males is lower compared with England, and lower among females in Oldham and Rochdale, which means higher demands on health services is expected.

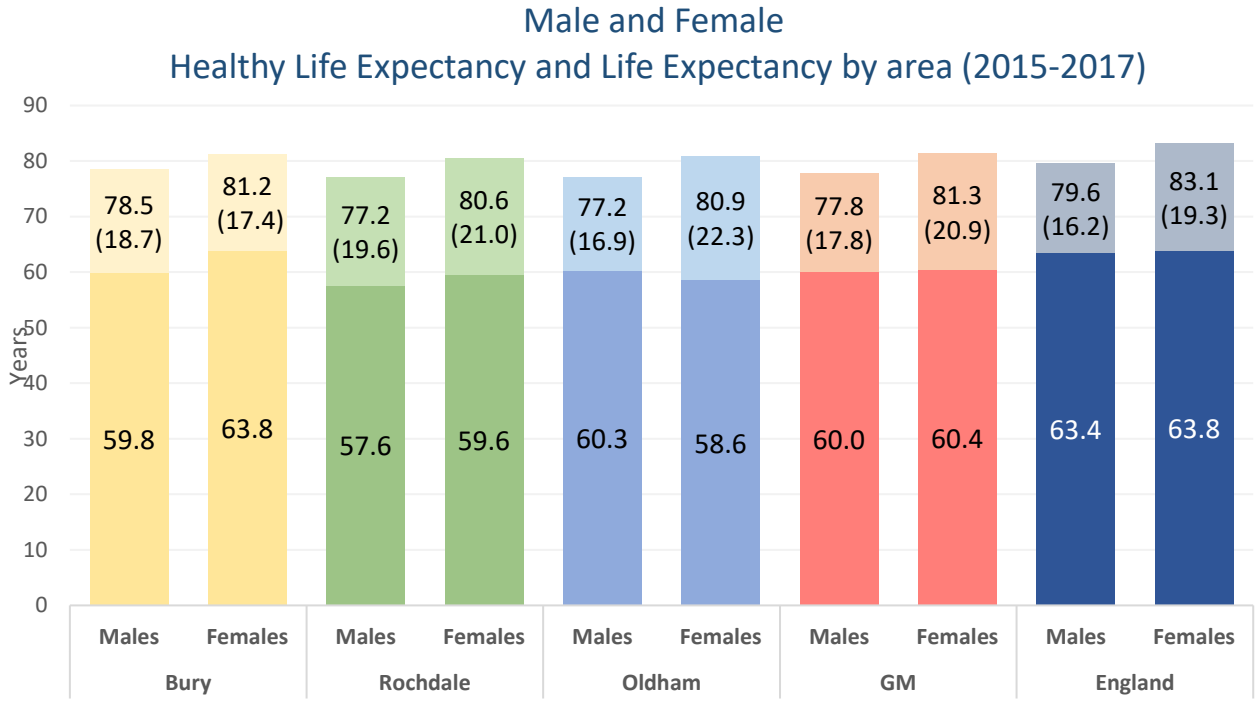

Figure 1.3: ORB Life Expectancy and Healthy Life Expectancy

*Please note: The uppermost figure in each bar is Life Expectancy, and the numbers in brackets highlight how many years are spent in poor health/beyond Healthy Life Expectancy, which is the lowermost figure.

Oldham

Oldham Population

Oldham has a resident population of 235,623, with 116,098 males (49.3%) and 119,525 females (50.7%), (ONS, 2018 Mid-Year Estimate).The below population pyramid highlights that, compared to England, Oldham has a higher proportion of under 20s, and a lower proportion of the population aged 50+.

The age structure of Oldham is relatively youthful compared to the England average. Since 2001, the population across England has aged, with more people aged over 65 and fewer under 16s. This change has been influenced by an increase in average life expectancy; however, the pattern is somewhat different across Oldham. While there is a larger proportion of over 65's, the proportion of under 16's has remained similar. This can be attributed to the growth in Oldham's Pakistani and Bangladeshi communities which have a much more youthful age profile and is reflected in the population pyramid below.

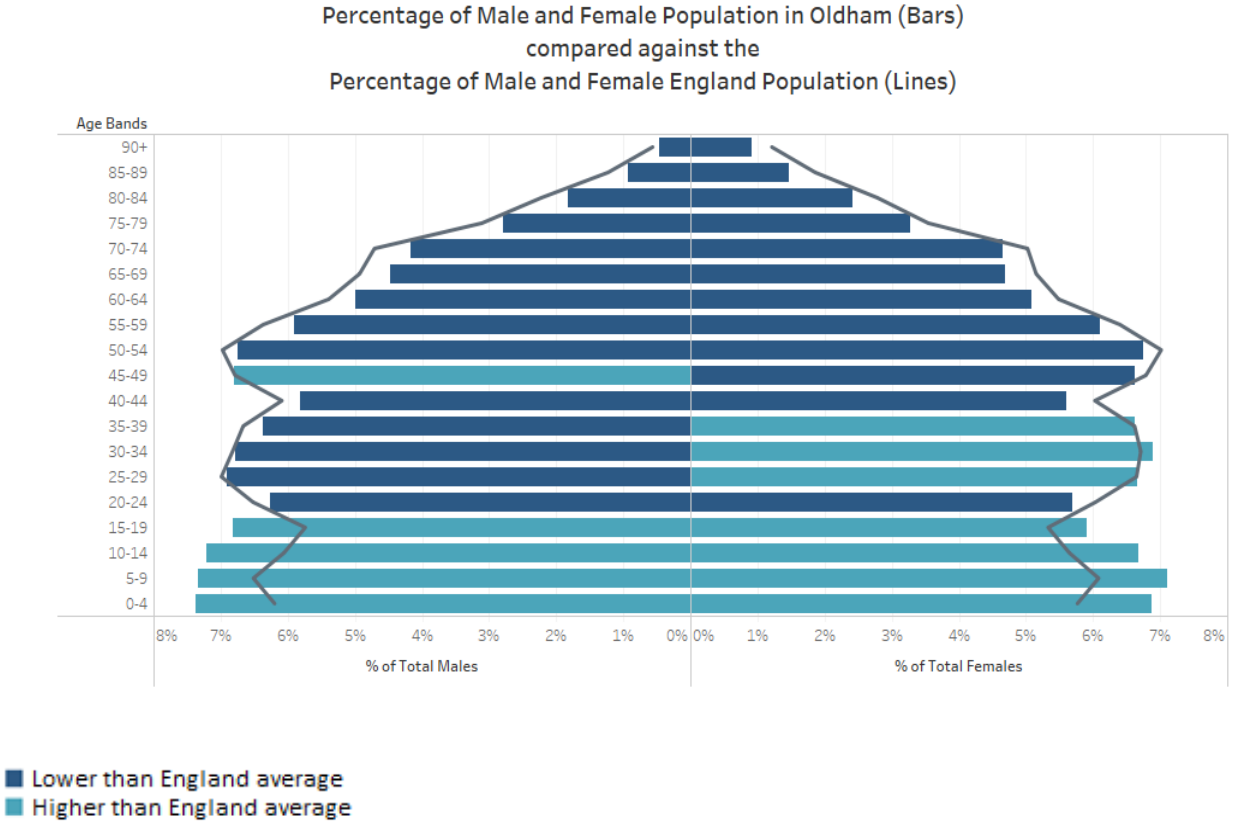

Figure 1.4: Oldham Population Pyramid

The population pyramid demonstrates a higher proportion of females among the 25-39 age band, however, there is a similar proportion between males and females across other age bands. There are 3,427 more females than males in Oldham.

Life Expectancy

Oldham's life expectancy from birth for males and females is lower than both the regional GM average and the England average for 2015-17. Life expectancy in Oldham is generally rising for males and females at a rate similar to that of England, meaning that overall life expectancy in Oldham remains below the national average.

Life Expectancy at birth (2015-17)	Oldham	GM	England
Male	77.2	77.8	79.6
Female	80.9	81.3	83.1

Table 1.2: Oldham Life Expectancy

There is an inequality gap in life expectancy based on socioeconomic circumstances in Oldham of 11.5 years for males, meaning males in the highest socioeconomic group live an average of 11.5 years longer than those in the lowest socioeconomic group. This inequality gap for females is 11.0 years, meaning females in the highest socioeconomic group live an average of 11.0 years longer than those in the lowest socioeconomic group.

Population Projection

Oldham's population is projected to increase between 2019-2030 by an additional 10,500 people (4%), with the largest projection seen among the 18-24, the 35-44 and the 55-64 age bands. There are notable reductions among the 25-34 and 45-54 age bands (Projecting Adult Needs and Service Information (PANSI)). This is an overall slower rate of growth than the England average, whose population over the same amount of time will grow by 6%. Oldham's 18-64 year old population will increase by 1% by 2030, in line with that of England.

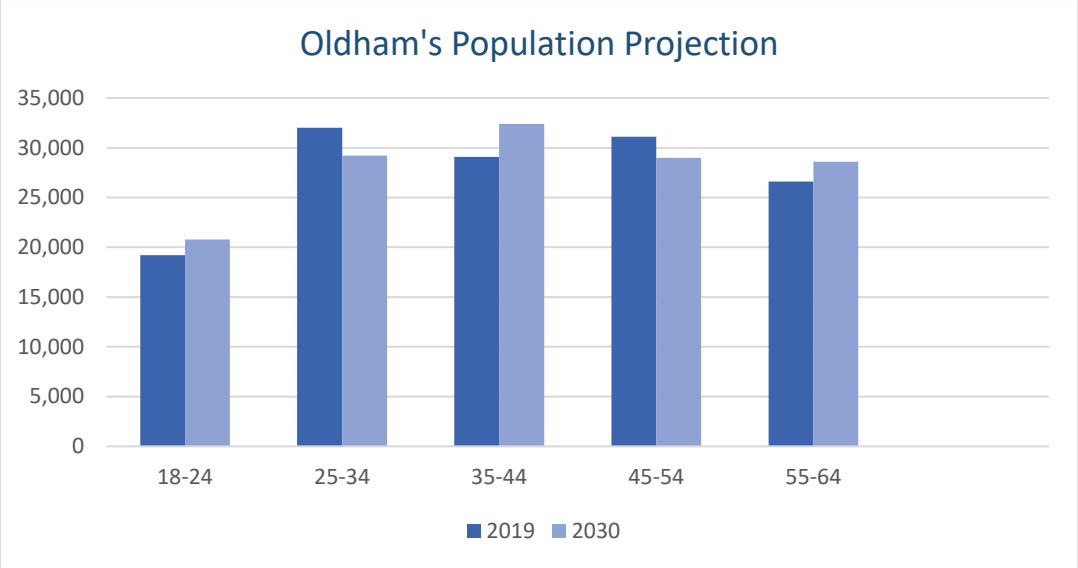

Figure 1.5: Oldham Population Projection

Ethnicity

The ethnic composition of Oldham's residents is shown in the below table, which demonstrates the majority of residents are White British, while the second largest ethnic group in Oldham is the Asian/ Asian British group (Census, 2011). Oldham has the largest Black Asian Minority Ethnic (BAME) community among the ORB local authorities, and it is accepted locally that this population has increased in size since the 2011 census results outlined in the table below.

Ethnic Group	Number	% of Oldham population (2011)
White British	174,326	77.5%
Mixed/multiple ethnic groups	4,057	1.8%
Asian/Asian British	43,165	19.2%
Black/African/Caribbean/Black British	2,797	1.2%
Other ethnic group	552	0.2%

Table 1.3: Oldham by Ethnicity

IMD/ Deprivation

Oldham is ranked 19 out of 317 Local Authority districts in England. 16 of the Lower-layer Super Output Areas (LSOAs) in Oldham are within the most deprived 10% in the country. Figure 1.6 shows the overall breakdown of LSOAs in Oldham by IMD rank. 5 LSOAs sit in the most deprived 1% nationally. These are located in Hathershaw, parts of St. Mary's and Coldhurst, and Greenacres/Littlemoor. There is a high proportion of social housing across these LSOAs.

Oldham is split into 20 wards with the town centre wards generally having poorer health outcomes and higher levels of deprivation than the outer wards. Saddleworth North and Saddleworth South are more rural, whilst the remaining wards are mostly urban. The GP (Figure 1.7) displays the location of Oldham GP.

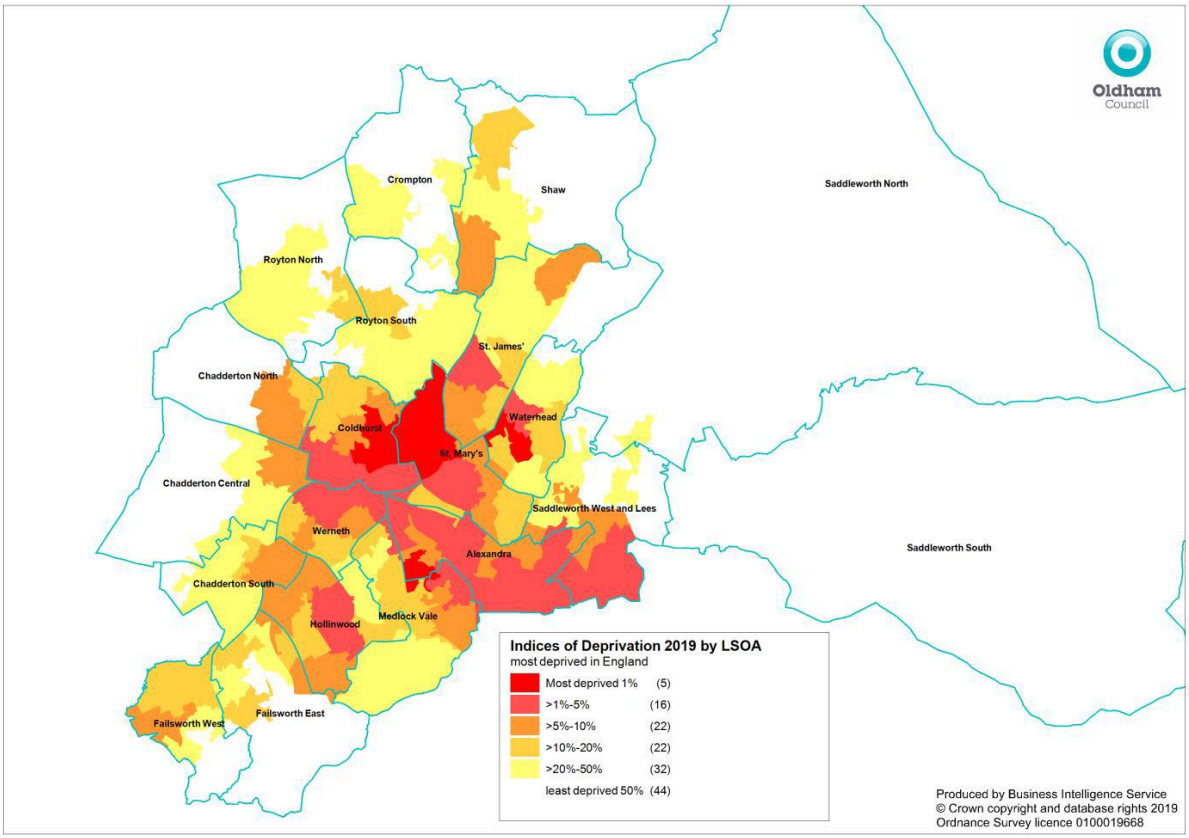

Figure 1.6: Oldham IMD Map

Employment Status

In Oldham, there is a higher rate of unemployment, at 4.8%, compared with the North West (3.9%) and England (4.1%). The ward with the highest unemployment is Alexandra, which is amongst the most deprived in the local authority.

GP Population

Oldham has 5 GP clusters (displayed in varying colours below) and 7 districts named on the map. There are 255,199 patients registered with GPs across the borough, (Oldham Council Business Intelligence, September 2019), which is 19,576 higher than the resident population.

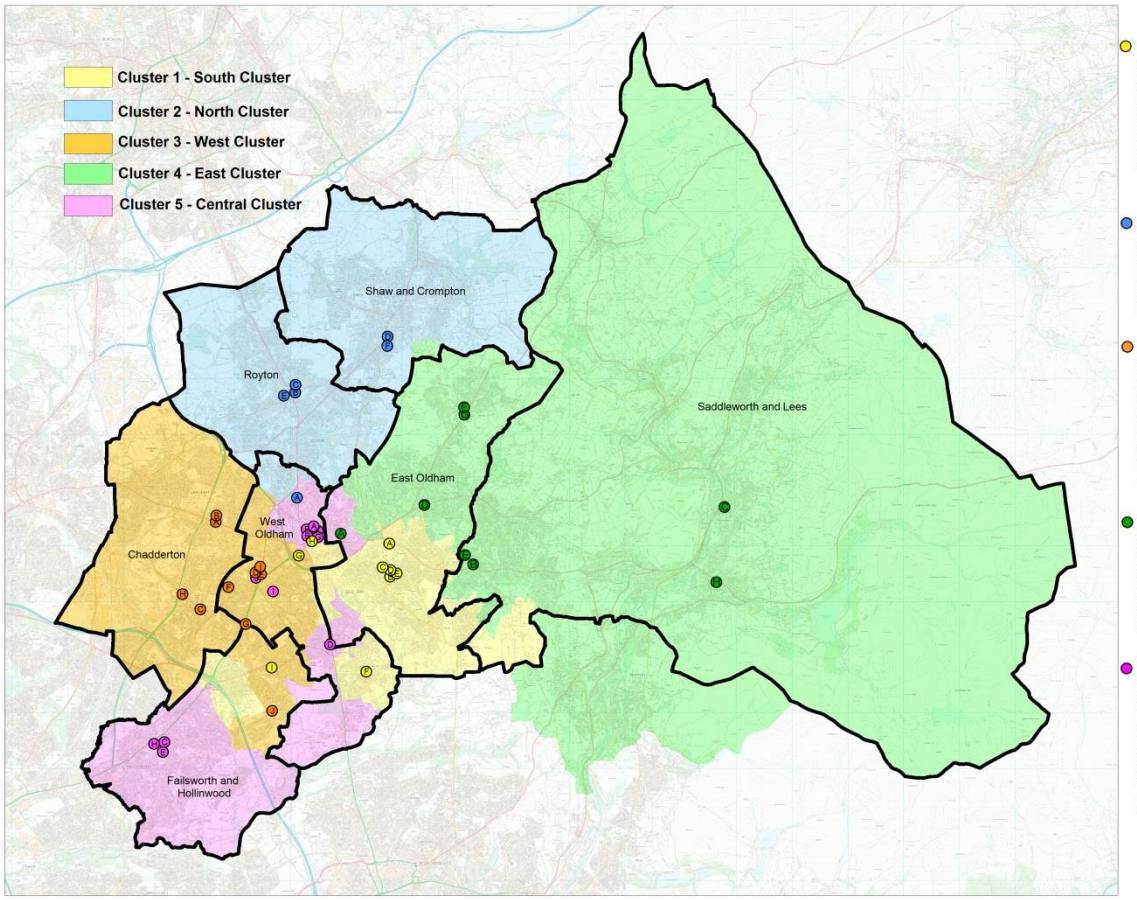

Figure 1.7: Oldham GP Clusters

Rochdale

Rochdale Borough consists of six neighbourhoods– Rochdale West, Rochdale Central, Rochdale East, Heywood, Middleton and Pennines (consisting of Littleborough, Wardle, Milnrow and Newhey). The Borough of Rochdale sits North East of Manchester. It spans an area of approximately 38.3 square miles and is made up of 20 electoral wards. The area is characterised by urban developments surrounded by hilly areas of rural land.

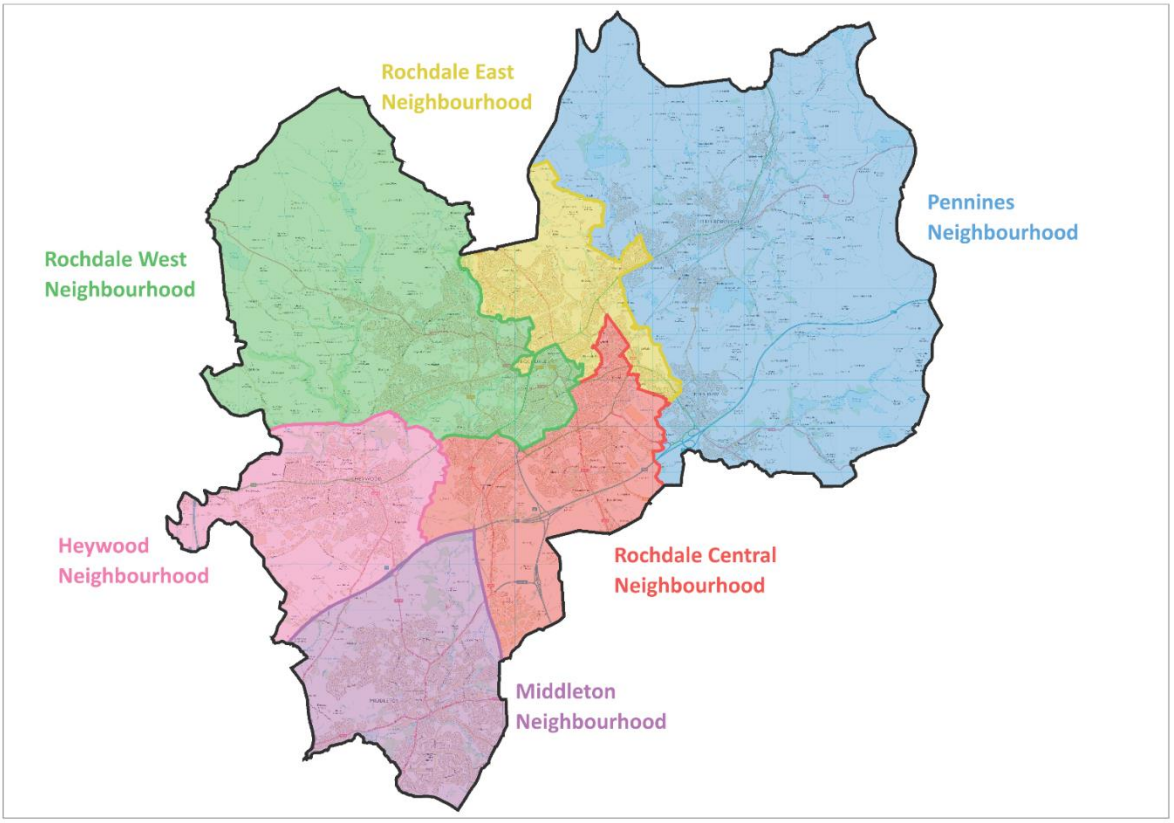

Figure 1.8: Rochdale Map

Rochdale Population

Rochdale has a population of 220,001, with 108,622 males (49.4%) and 111,379 females (50.6%) (ONS, 2018 Mid-Year Estimate). As demonstrated by the population pyramid below, Rochdale has a younger population than the England average, with a higher proportion of under 20s. The adult population in Rochdale is similar to the England average, with the exception of a lower proportion of males in the 40-44 age group and a higher proportion of females in the 30-39 age group.

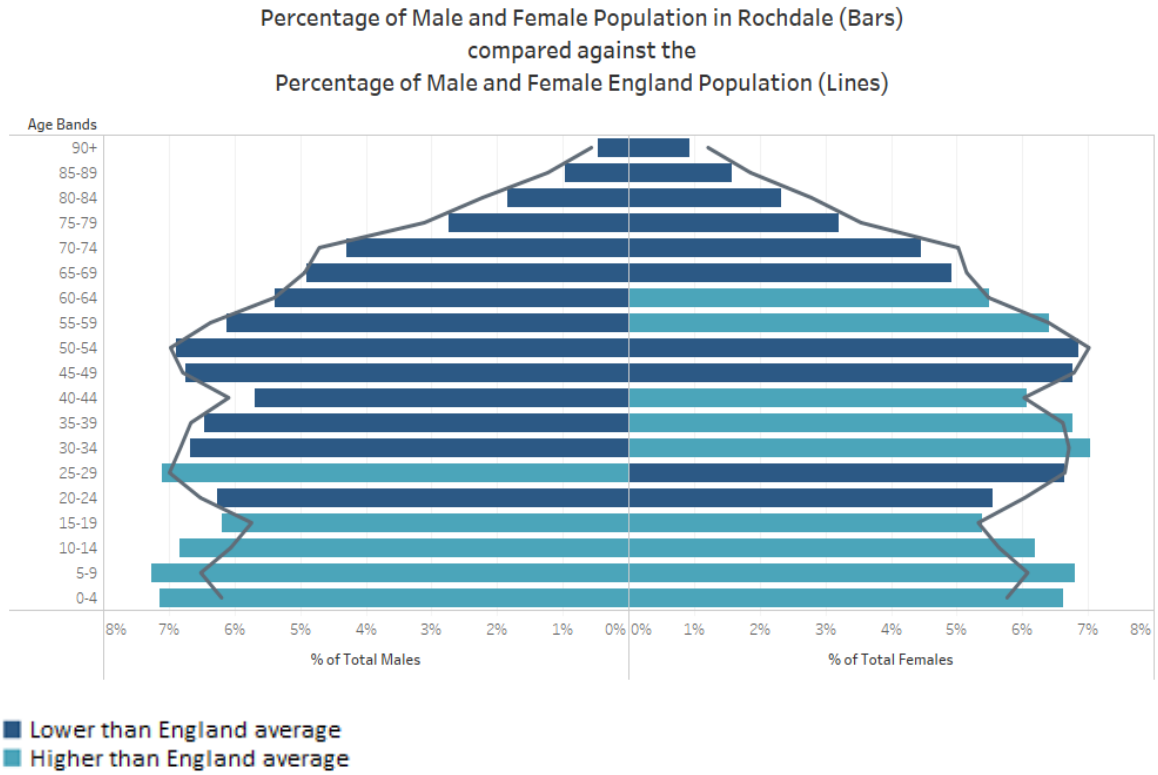

Figure 1.9: Rochdale Population Pyramid

Life Expectancy

Rochdale's life expectancy from birth for males and females is lower than the GM and the England averages. Whilst life expectancy in Rochdale is generally rising for both males and females, it remains consistently below the national average. Furthermore, the rate of improvement in life expectancy has plateaued since 2012, in line with the England average.

Life Expectancy at birth	Rochdale	GM	England
Male	77.2	77.8	79.6
Female	80.6	81.3	83.1

Table 1.4: Rochdale Life Expectancy

There is an inequality gap in life expectancy based on socioeconomic circumstances in Rochdale of 9.6 years for males, meaning males in the highest socioeconomic group live an average of 9.6 years longer than those in the lowest socioeconomic group. This inequality gap for females is 7.1 years, meaning females in the highest socioeconomic group live an average of 7.1 years longer than those in the lowest socioeconomic group.

Population Projection

Rochdale's population is projected to increase by an additional 6,600 people (3%) between 2019-2030, with the largest increase seen among the 35-44 age band. There are notable reductions among the 25-34 and 45-54 age bands, (Projecting Adult Needs and Service Information (PANSI)). This is an overall slower rate of growth than the England average, whose population over the same amount of time will grow by 6%. Notably, Rochdale's 18-64 year old population will decrease by 1%, while that of England will increase by 1%.

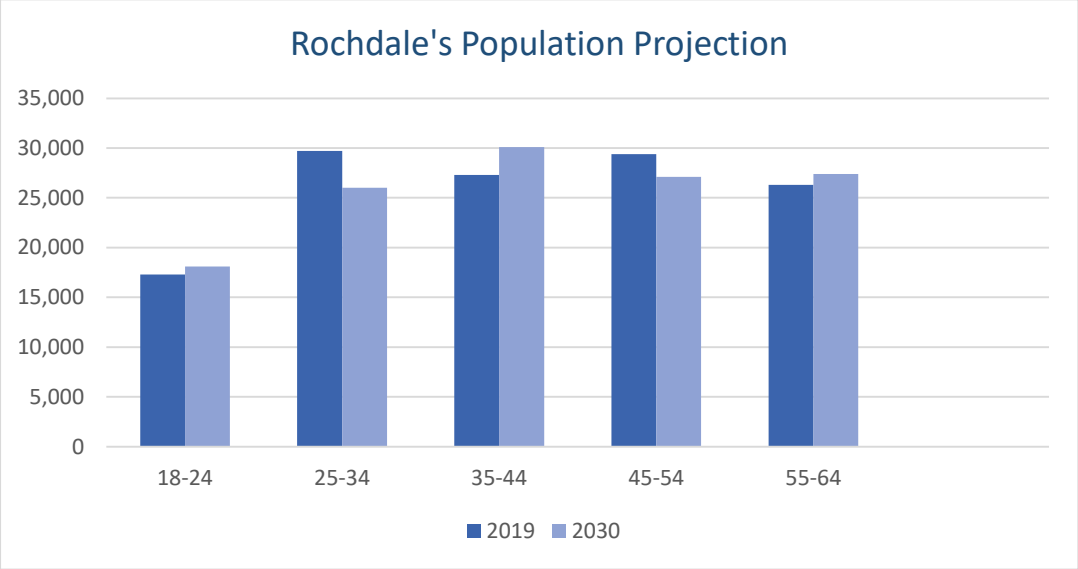

Figure 1.10: Rochdale Population Projection

Ethnicity

The ethnic composition of Rochdale's residents is demonstrated by the below table, which shows the majority of Rochdale's residents are White British, while the second largest ethnic group is the Asian/ Asian British group (Census, 2011). Rochdale has proportionally the second largest population of residents from a Kashmiri background in England.

Ethnic Group	Number	% of Rochdale population (2011)
White British	172,874	81.7%
Mixed/multiple ethnic groups	3,569	1.7%
Asian/ Asian British	31,630	14.9%
Black/ African/ Caribbean/ Black British	2,770	1.3%
Other Ethnic Group	856	0.4%

Table 1.5: Rochdale by Ethnicity

IMD/ Deprivation

Rochdale is ranked 15 out of the 317 Local Authority districts. 40 of the 134 Lower-layer Super Output Areas (LSOAs) in Rochdale are within the most deprived 10% in the country. This means Rochdale has the highest deprivation among the ORB local authorities. The map below highlights the IMD distribution within the borough; the most deprived areas in Rochdale are around Central Rochdale and the surrounding areas, and North Heywood and Middleton.

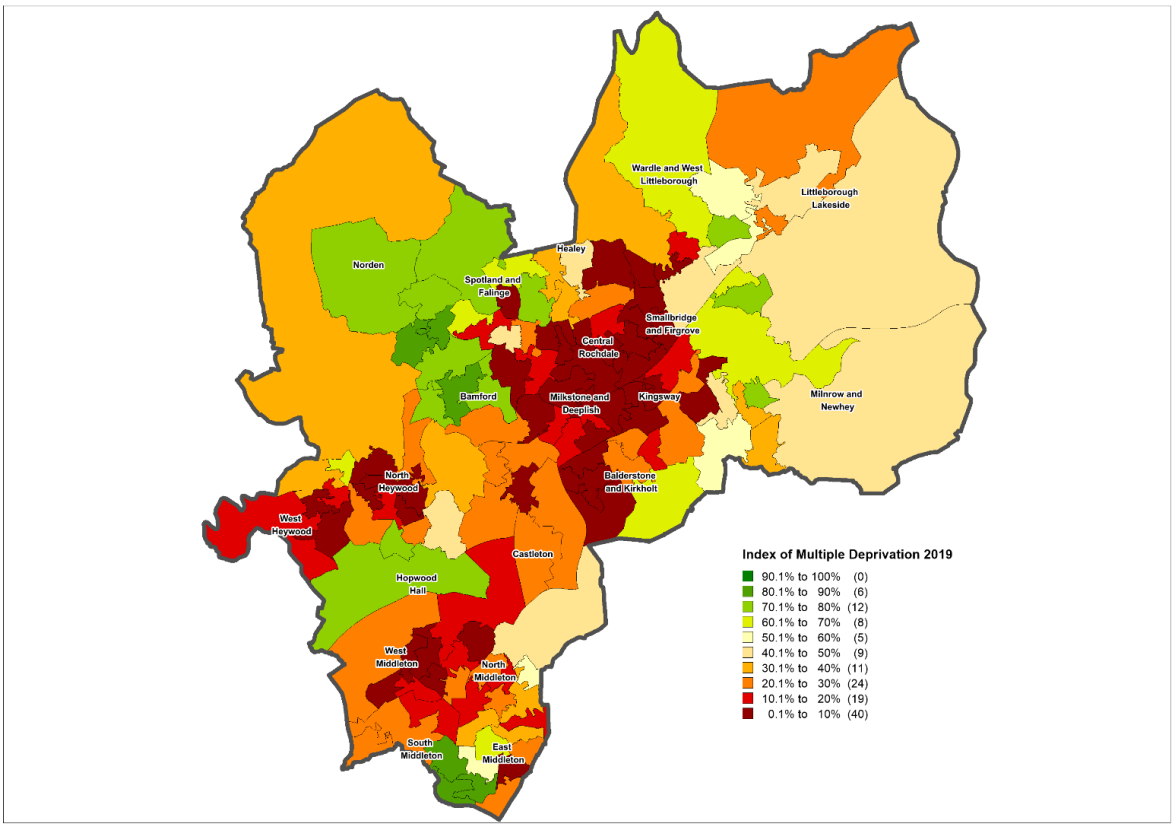

Figure 1.11: Rochdale IMD Map

Employment Status

In Rochdale, there is a higher rate of unemployment at 5.4 %, compared with the North West (3.9%) and England (4.1%). This rate of unemployment is the highest among the ORB cluster.

GP Population

Rochdale has 236,767 patients registered with GPs across the borough, (NHS Digital, September 2019), which is 16,767 higher than its resident population.

The map below highlights the main neighbourhoods in Rochdale, along with the GP registered population in each neighbourhood.

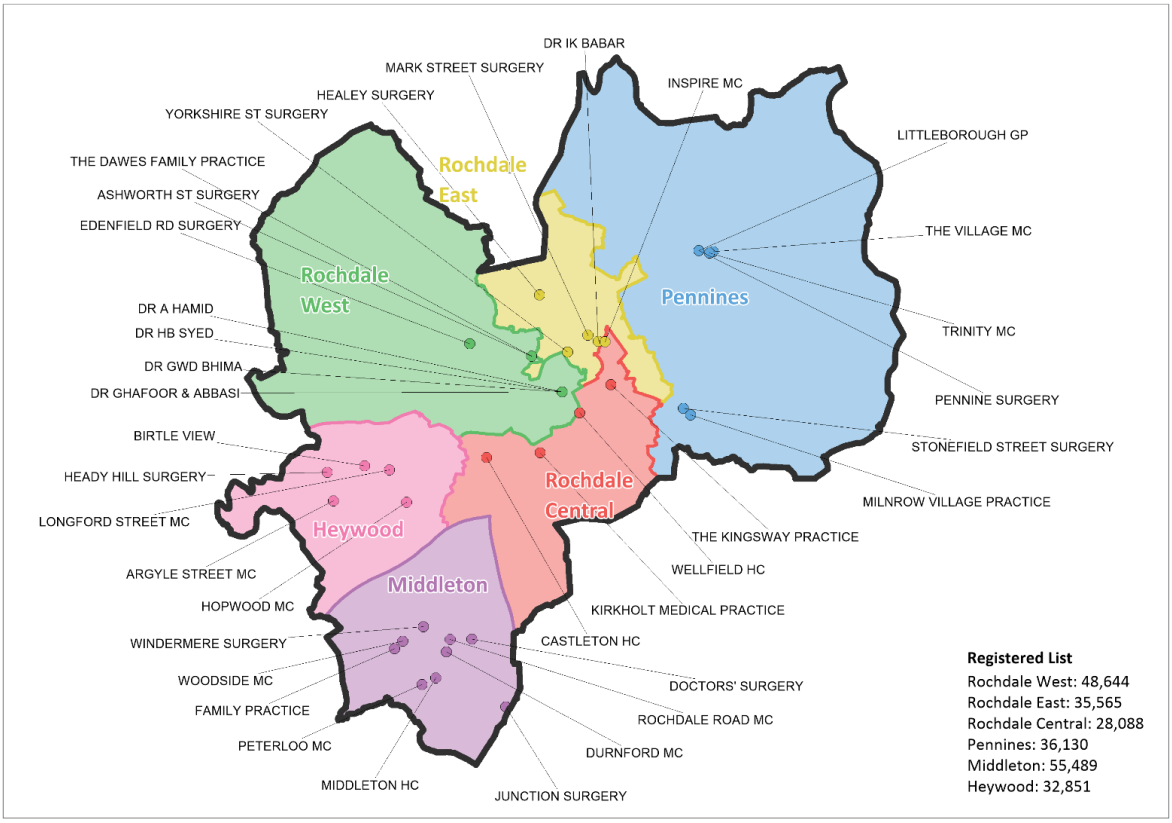

Figure 1.12: Rochdale GP Clusters

Bury

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 Population

Bury has a resident population of around 190,108, with 93,204 males (49%) and 96,904 females (51%) (ONS, 2018 Mid-Year Estimate). As demonstrated by the population pyramid below, when compared to England Bury has a higher proportion of under 15s and 45-54 year olds, and a lower proportion of 20-29 year olds. The population pyramid demonstrates a higher proportion of males and females than England among the 0-15 age band. There are 3,700 more females in Bury across all age groups.

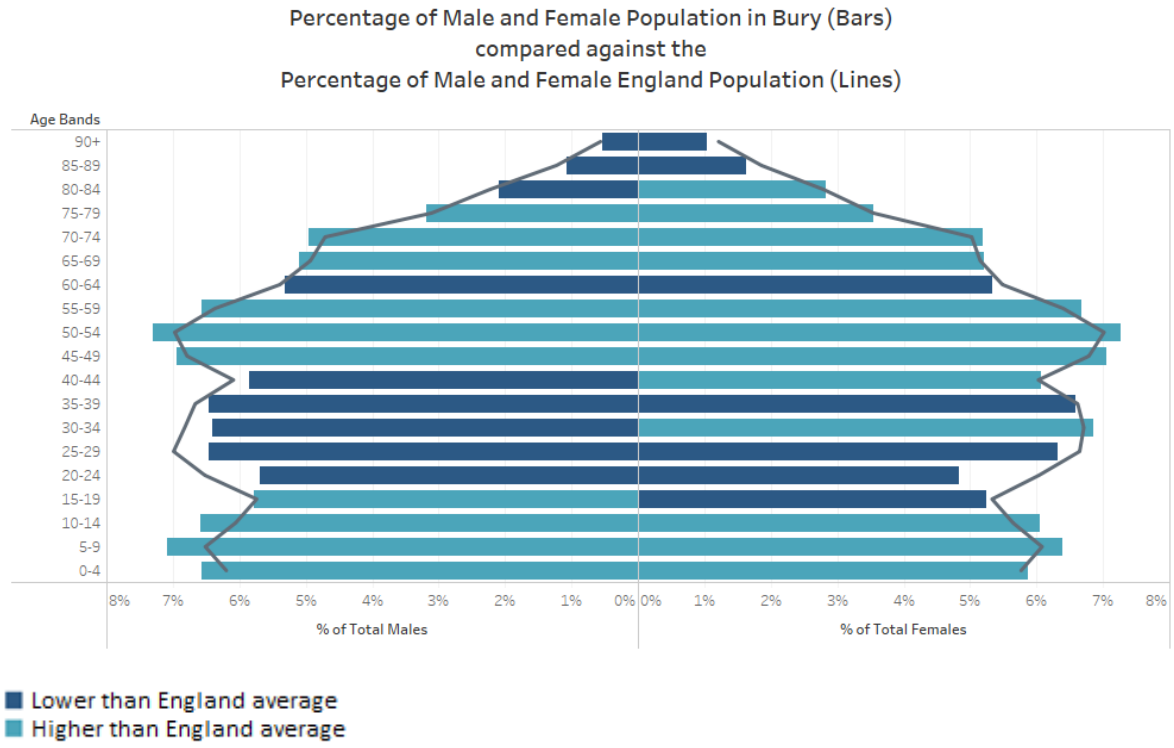

Figure 1.13: Bury Population Pyramid

Ethnicity

The ethnic composition of Bury's residents is demonstrated by the below table, which shows the majority of Bury's residents are White British, with the second largest ethnic group being the Asian/ Asian British group, (Census, 2011). There is a large Jewish population in Bury. According to the 2011 Census, 42% of Jewish people in Bury live in the Sedgley Park area, constituting 2.4% of Bury's population.

Ethnic Group	**Number**	**% of Bury population (2011)**
White British	165,032	89.2%
Mixed/multiple ethnic groups	3,365	1.8%
Asian/Asian British	13,407	7.2%
Black/African/Caribbean/Black British	1,893	1.0%
Other ethnic group	1,363	0.7%

Table 1.5: Bury by Ethnicity

Life Expectancy

Bury's life expectancy from birth for males and females is lower than the England average; however, when compared with GM, males in Bury have a higher life expectancy, and females have a similar life expectancy for 2015-17. Whilst life expectancy in Bury is generally rising for males and females, the gap between Bury and England as a whole is widening.

Life Expectancy at birth	Bury	GM	England
Male	78.5	77.8	79.6
Female	81.2	81.3	83.1

Table 1.6: Bury Life Expectancy

There is an inequality gap in life expectancy based on socioeconomic circumstances in Bury of 11.3 years for males, meaning males in the highest socioeconomic group live an average of 11.3 years longer than those in the lowest socioeconomic group. This inequality gap for females is 8.5 years,

meaning females in the highest socioeconomic group live an average of 8.5 years longer than those in the lowest socioeconomic group.

Population Projection

Bury's population is projected to increase between 2019-2030 by an additional 5,400 people (3%), with the largest increase seen among the 18-24 and the 35-44 age bands. There are notable reductions among the 25-34 and 45-54 age bands (Projecting Adult Needs and Service Information (PANSI)). This is an overall slower rate of growth than the England average, whose population over the same amount of time will grow by 6%. Notably, Bury's 18-64 year old population will decrease by 2%, while that of England will increase by 1%.

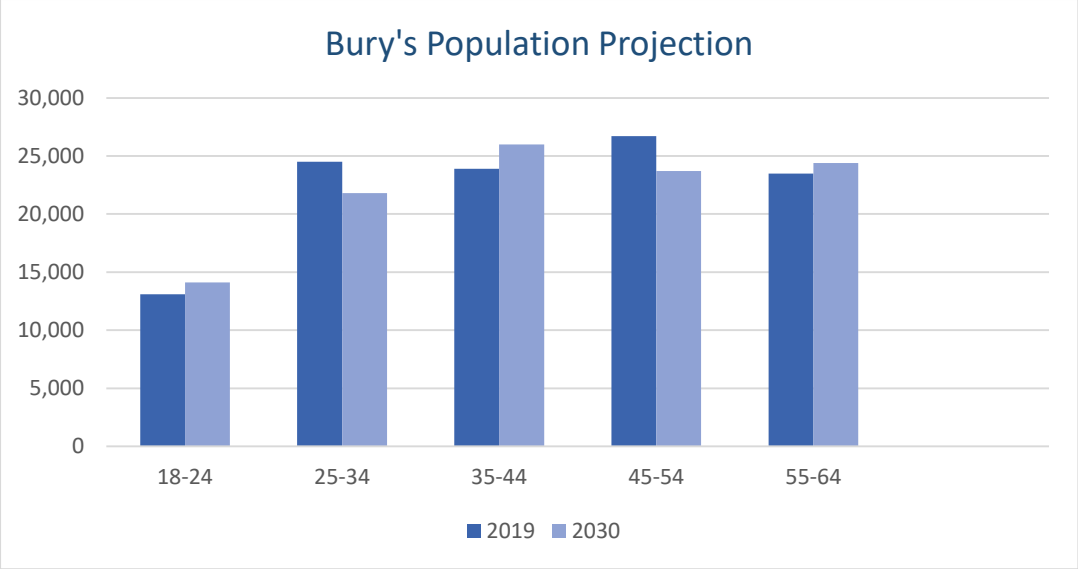

Figure 1.14: Bury Population Projection

IMD/ Deprivation

Bury is ranked 95th most deprived of 317 Local Authority districts, meaning Bury is ranked in the 3rd most deprived decile in England at Local Authority level.

Overall, Bury is the 8th most deprived of the 10 GM districts (where 1st is the most deprived). Of the 120 Lower-layer Super Output Areas (LSOAs) in Bury, 12 are within the most deprived 10% in the country. These are mostly found near Bury town centre, East and Moorside wards and in Radcliffe and Besses. Figure 1.15 below highlights the IMD distribution within the borough.

Employment Status

In Bury, there is a higher rate of unemployment at 4.5%, compared with the North West (3.9%) and England (4.1%). The ward with the highest unemployment is Bury East, which is amongst the most deprived in the local authority.

GP Population

Bury has 206,509 patients registered with GPs across the borough, (NHS Digital, September 2019), which is 16,401 higher than its resident population.

Figure 1.16 below highlights the main neighbourhoods in Bury, along with the GP registered population in each neighbourhood.

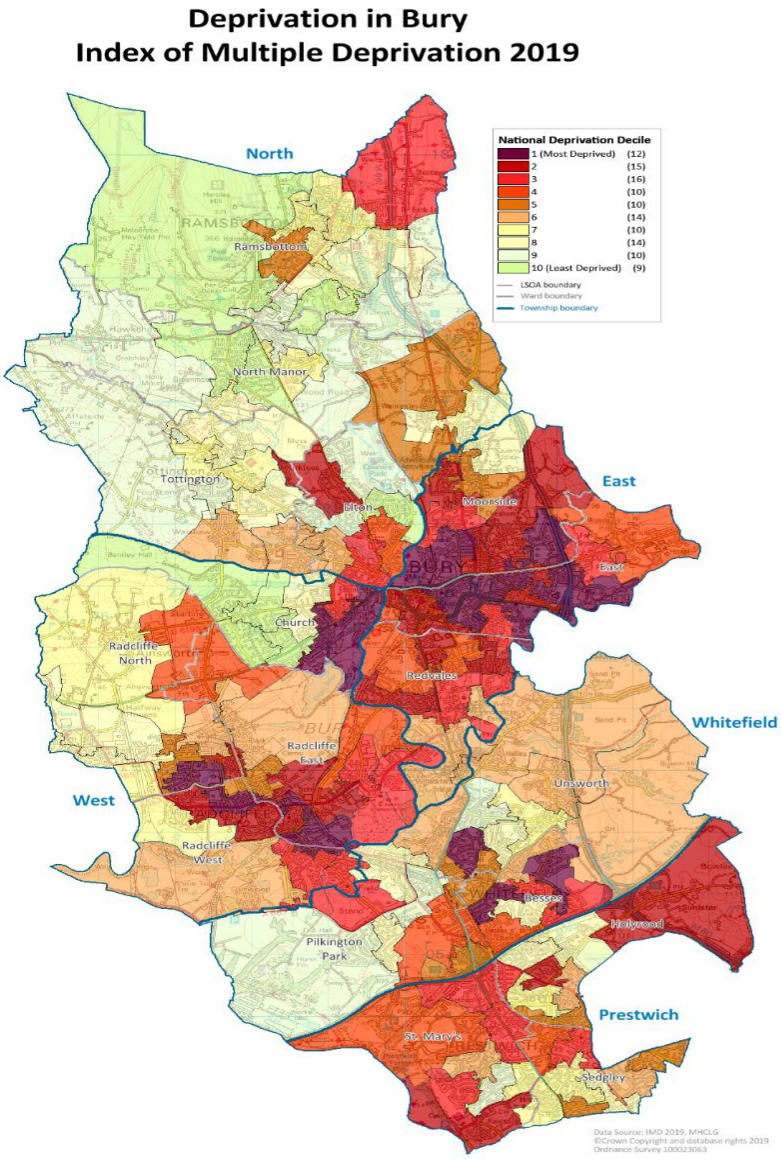

Figure 1.15: Bury IMD Map

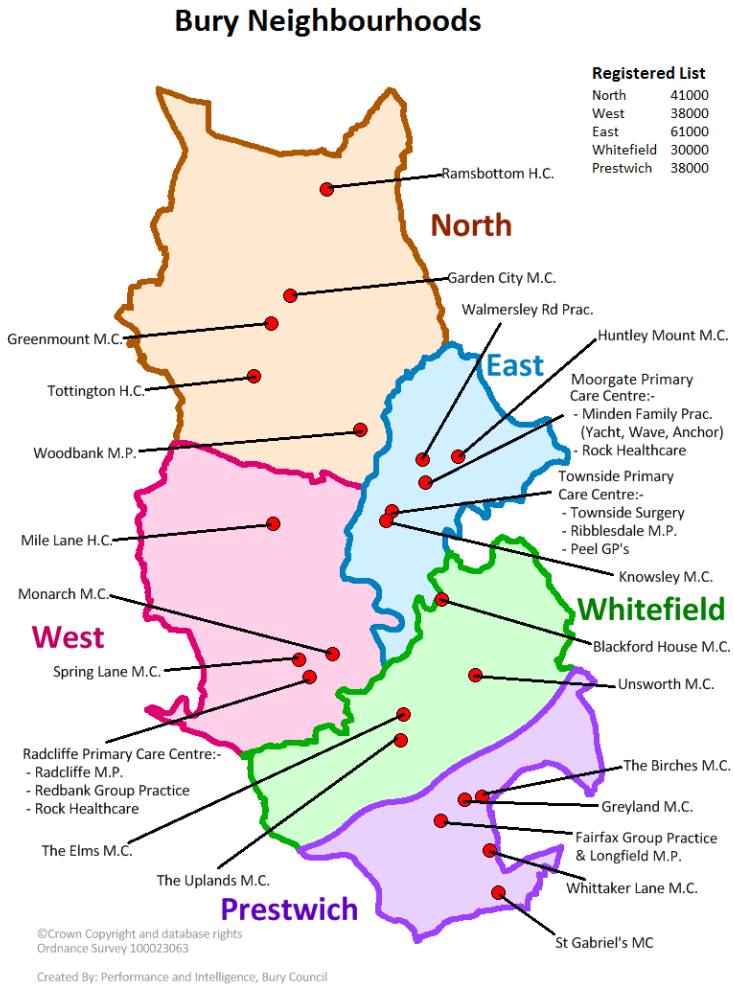

Figure 1.16: Bury GP Clusters

2. ORB Sexual Health - Disease Burden

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. Data in this section is from PHE Sexual and Reproductive Health Profiles, (PHO, 2019).

The graph below demonstrates new STI diagnosis rates (excluding Chlamydia) across Oldham, Rochdale and Bury compared with the average in Greater Manchester and the England average between 2014-2018. As illustrated, there is a lower rate of new STI diagnosis across the 3 local authorities, when compared with the England rate. Rochdale and Bury both experienced their lowest rate of new STI diagnosis in 2015, where rates were 558 per 100,000, and 537,000 respectively, whereas Oldham experienced their highest rate that year for the time period at 705 per 100,000. Since then, rates have been rising in Rochdale and Bury, but slightly reducing in Oldham to 2018 levels, where all 3 ORB local authorities have similar rates of 646 (Oldham), 624 (Rochdale) and 602 (Bury) per 100,000.

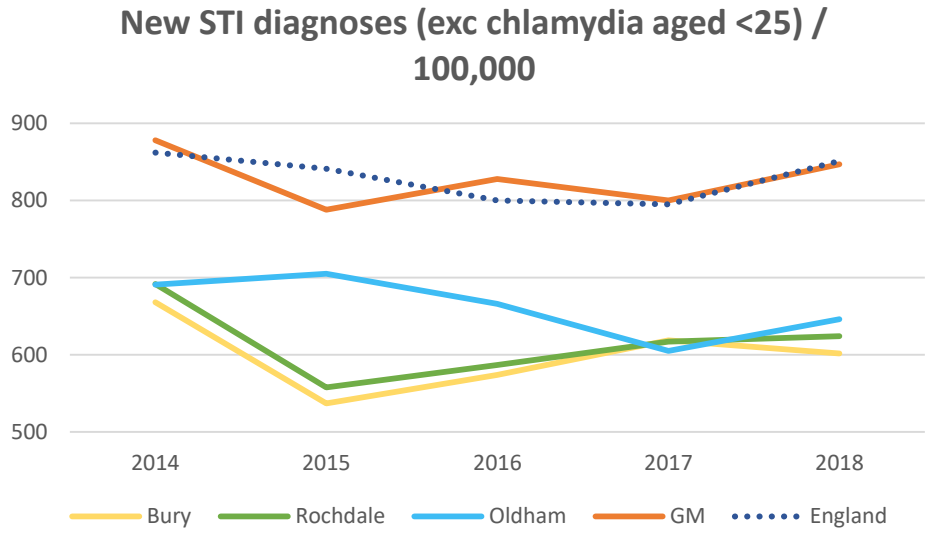

Figure 2.1: New STI Diagnoses aged <25 (excluding Chlamydia)

As described previously, the reason behind a lower new STI diagnosis rate is not necessarily a lower disease burden, and may indicate lower detection rate or less access to STI services among the population. To better contextualise the figures, consideration of STI testing rate would be appropriate, as demonstrated by the below graph:

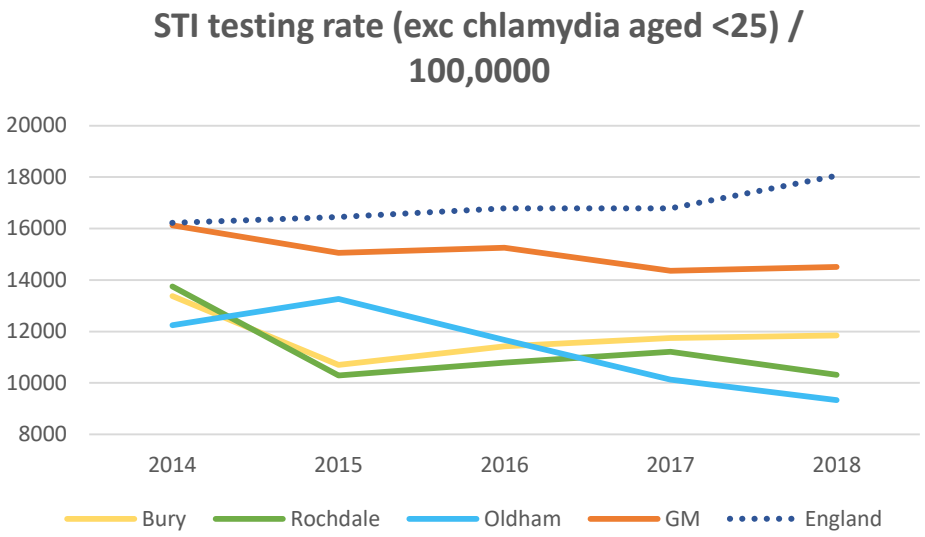

Figure 2.2: STI Testing Rate aged <25 (excluding Chlamydia)

The graph illustrates that STI testing rates in ORB are significantly lower than the GM average, and lower still than the England average. Furthermore, the discrepancy in STI testing between ORB and England rates appears to be widening, with England testing more people, and ORB and GM testing less since 2014.

Amongst ORB, Bury is performing better than Rochdale and Oldham. Oldham has the lowest rates of STI testing across ORB, whereas in 2015, it had the highest testing rate. This illustrates that as testing rates increase, consequently the rate of STI diagnosis rate increases, thus highlighting that there is an undetected STI disease burden across the ORB population.

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.

The 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 – it is not a measure of morbidity. Chlamydia screening is recommended for all sexually active people under 25 and on partner- change. Public Health England (PHE) recommends that local areas should be working towards achieving a chlamydia diagnosis rate of at least 2,300 per 100,000 young people aged 15-24. Modelling suggests that achieving a diagnosis rate of >2,300 will contribute to further reducing the prevalence of chlamydia.

In ORB, a higher proportion of females than males have a diagnosis of chlamydia, with the highest proportion of those under the age of 24. When broken down by sexual orientation, almost 9 out of every 10 diagnoses are among those identifying as heterosexual, meaning the demographic with the highest rate of chlamydia diagnosis is heterosexual women, under the age of 24.

The graph below demonstrates that Chlamydia detection rates across England, GM, and ORB have all decreased since 2014. Whilst in 2014 all three ORB local authorities were meeting the detection rate target set by PHE, detection rates have significantly reduced since then, most notably in Oldham which dropped below the target in 2017, where detection rate was 1880 per 100,000. Bury and Rochdale have both been achieving a lower than recommended Chlamydia detection rate since 2015. Bury had the lowest rate of the 3 localities until 2016, when detection rates increased in Bury, but decreased in Oldham and Rochdale. Since 2017, there has been a slow increase in the rate of Chlamydia detection across Bury and Rochdale, but no change in Oldham.

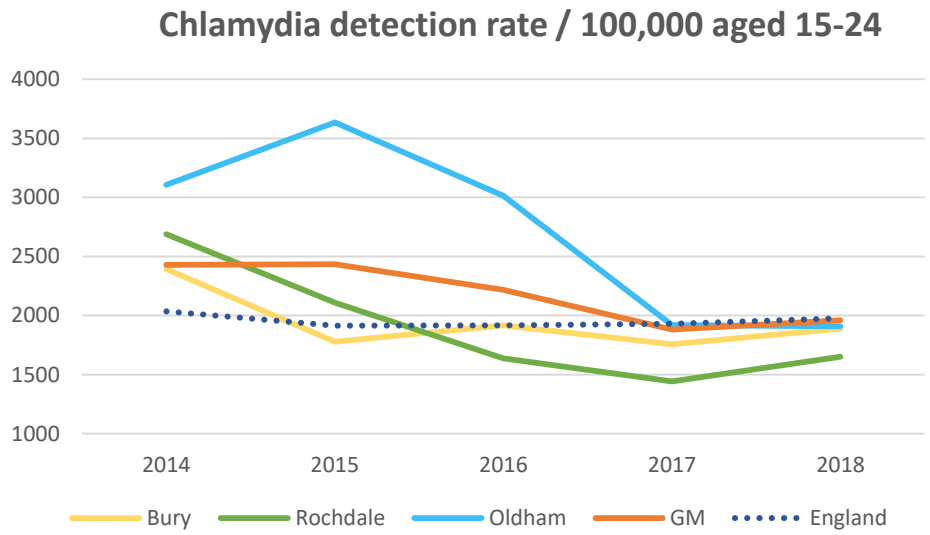

Figure 2.3: Chlamydia Testing Rate aged 15-24

Actual chlamydia diagnostic rate is highest in Oldham, followed by Bury and then Rochdale. However, in all 3 local authorities, chlamydia diagnostic rate is lower than the GM and England averages.

The proportion of the ORB population aged 15-24 screened for chlamydia across all 3 localities is lower than both GM and England, with Oldham and Rochdale screening 16.4% of their population, and Bury screening 17.6%. In GM, 18.6% of 15-24 year olds were screened, and at a national level, 19.6% of 15-24 year olds were screened. Although this proportion has been declining nationally, the rate of decline has been quicker in Oldham and Rochdale; in Bury, there has been a slight improvement in proportion screened since 2016, although levels are still lower than regional and national averages.

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. Nationally, cases of gonorrhea have been rising steadily since 2012, with rates almost doubling during this time.

All young people screened for Chlamydia within the RU Clear programme are also tested for Gonorrhoea; the programme also aims to raise awareness of what gonorrhoea is and when to suspect it. 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. The majority of cases are diagnosed in GUM settings, and consequently the number of cases may be a measure of access to STI treatment. Infections with gonorrhea are more likely to result in symptoms than chlamydia.

Across ORB, cases of gonorrhoea have been on the increase in keeping with the regional and national trends, as demonstrated by the graph below. The rate of diagnosis has increased since 2016, with Oldham and Rochdale have seen their rates more than double since 2014. Although this increase reflects the trend at regional and national levels, rates of gonorrhoea in ORB remain significantly lower than both comparators.

In ORB, there is a higher proportion of males diagnosed with gonorrhoea than females, with nearly 2 out of every 3 people diagnosed with gonorrhoea in Oldham and Bury being male. There is also a higher proportion of men who have sex with men (MSM) being diagnosed with gonorrhoea relative to their population.

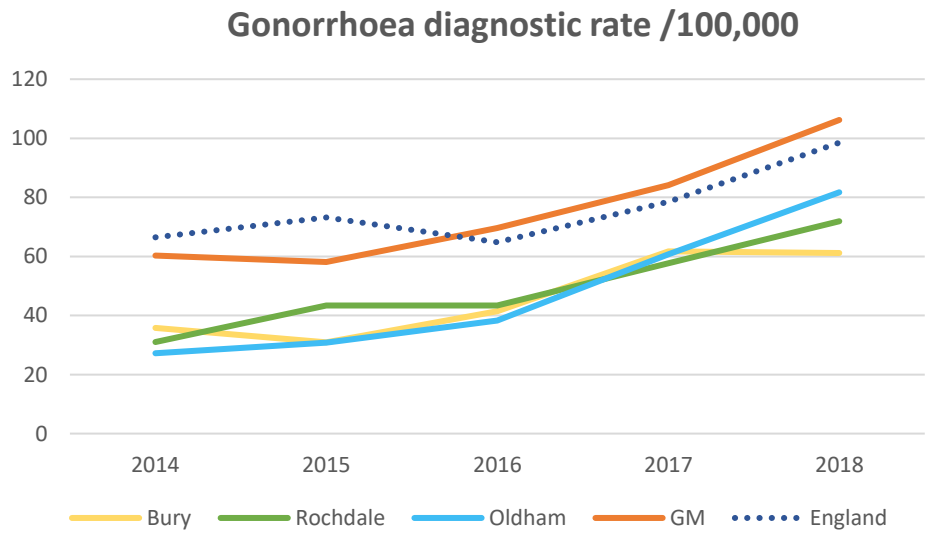

Figure 2.4: Gonorrhoea Diagnostic Rate

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.

The diagnostic rate of genital herpes nationally has generally decreased between 2014-17, however, there has been a slight increase between 2017-18. A decrease in diagnosis is reflected at GM level and across ORB, where, despite fluctuations, the overall trend has been downwards. Currently, herpes diagnostic rates in ORB are lower than both GM and England levels, with Bury having a lower rate than Oldham and Rochdale, which both report similar diagnostic rates. Notably, levels in Bury were very high in 2014, and have declined at a rapid pace to where it is now the lowest among ORB, and lower than regional and national levels. There is a notable spike in Oldham rates in 2016, this could be explained by the provider switch around this time, which was associated with data entry fluctuations.

The highest rate of herpes diagnosis in ORB is among females; in Bury females aged 25-64 have the highest diagnosis rate, whereas in Oldham and Rochdale diagnosis is evenly split between under 24's and 25-64 year olds. Herpes is most commonly diagnosed among those identifying as heterosexual.

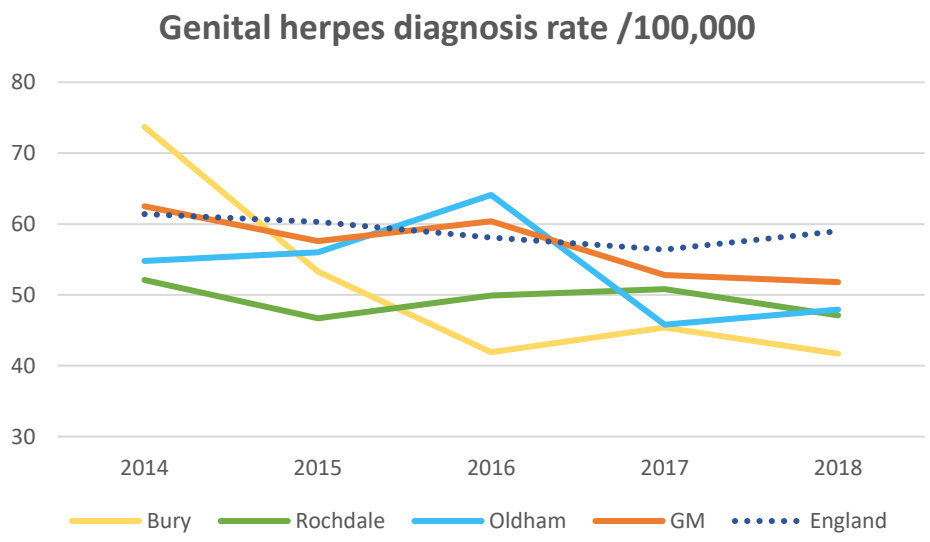

Figure 2.5: Genital Herpes Diagnosis Rate

Genital Warts

Genital warts are the second most commonly diagnosed sexually transmitted infections (STI) in the UK after Chlamydia, and they are caused by infection with specific subtypes of human papillomavirus (HPV). Recurrent infections are common with patients returning for treatment.

New diagnoses of genital warts have been reducing consistently at a national, regional and local level

between 2014 and 2018. Across ORB, rates are lower than GM and England averages, as demonstrated by the graph below. Over the last 5 years, all three local authorities have seen a reduction in their genital warts diagnostic rates, with cross-over between the authorities. Oldham had an initial increase in 2015, but since then rates have been gradually decreasing. Rochdale has seen an overall reduction in rates, but had a peak in 2016 and a further increase in 2018 from 2017 levels. Bury saw the steepest decline initially, but had a peak in 2017 which then decreased again in 2018. The most recent data shows Rochdale has the highest incidence and Oldham the lowest incidence in ORB.

Males are more frequently diagnosed with genital warts than females across ORB, with a higher diagnostic rate among those aged 25-64 years old. Again, the highest rate of diagnosis is among the heterosexual group.

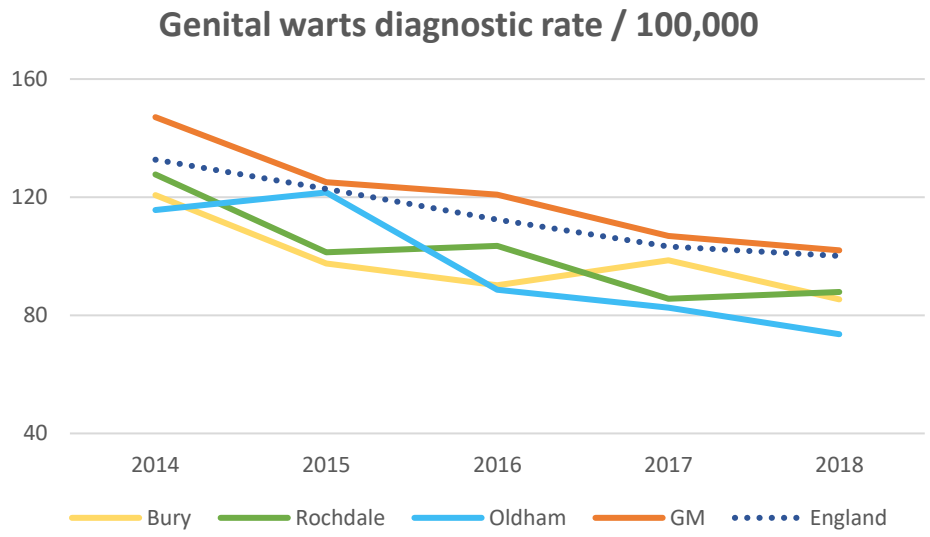

Figure 2.6: Genital Warts Diagnostic Rate

Syphilis

Syphilis is a sexually transmitted disease which can be prevented with appropriate precautions and can be treated with antibiotics. Despite recent increases in rates, syphilis remains one of the least common STIs in England. 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 graph below demonstrates the increasing rates of syphilis among ORB, GM and England. The dotted blue line demonstrates a steadily increasing rate nationally, which is reflected by regional and local increases in diagnostic rates. Oldham and Rochdale closely follow the regional GM pattern, where since 2015, there has been a rapid increase in diagnosis rate. In Oldham this has now plateaued, and has decreased in Rochdale and GM since 2017. In Bury, however, there has been a continuous increase in diagnosis rates since 2016, meaning that syphilis diagnosis rates in Bury have almost trebled since 2014. An important caveat is that numbers are small, therefore, any small increase in numbers locally can push standardised rates higher. Despite increases in diagnosis rate, until 2017 syphilis rates in ORB have generally been lower than England and GM rates, however since then, Bury rates have surpassed both

the regional and national averages.

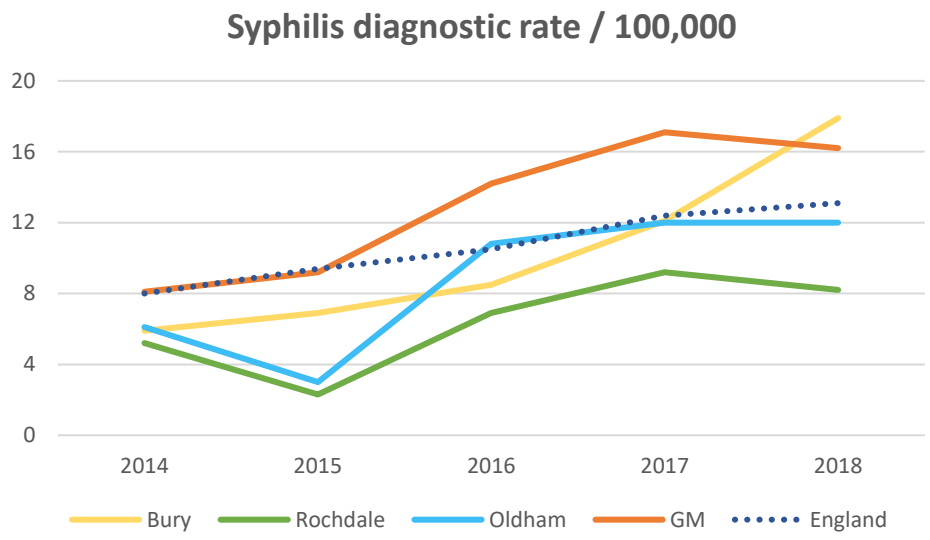

Figure 2.7: Syphilis Diagnostic Rate

In ORB, the majority of syphilis cases are reported among males, with the 25-64 age group experiencing the highest proportion of diagnoses. The majority of diagnoses in Bury are among men who have sex with men (MSM), in keeping with the national picture; whereas in Oldham and Rochdale those identifying as heterosexual have the highest prevalence of syphilis.

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), in order to protect them against the main causes of cervical cancer. Since 2019, males aged between 12 and 13 are also offered the vaccine in order to protect them against other HPV-related cancers, as well as to help better protect cervical cancers in females through herd immunity. Data on uptake for males is not yet available.

The rate of uptake of the HPV vaccine among 12-13 year old girls nationally, regionally and locally is demonstrated by the graph below.

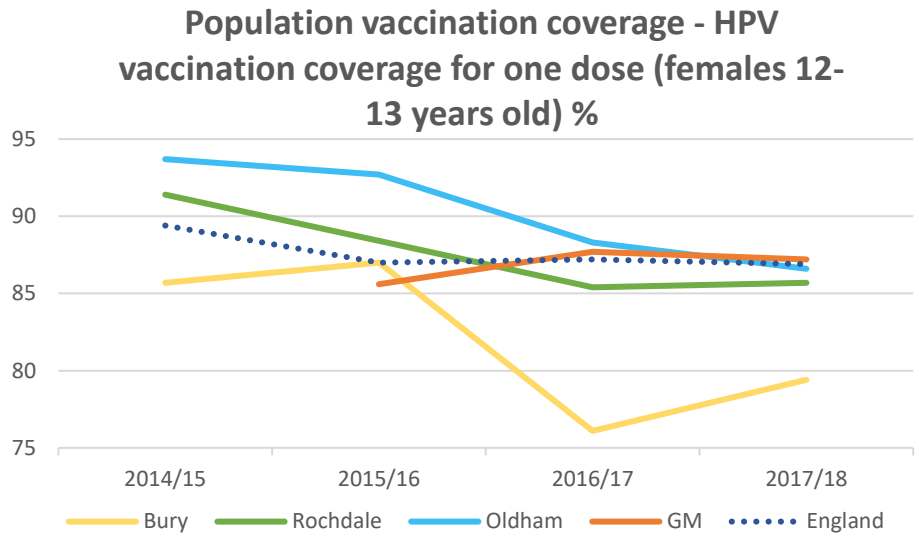

Figure 2.8: HPV Vaccination Coverage

The graph highlights that population HPV vaccination coverage for one dose among 12-13 year old females has declined across all 3 ORB local authorities. This is consistent with an overall decrease at national level, although the rate of decrease in coverage has been quicker in ORB.

In 2014/15, Oldham had a vaccination coverage of 93.7%, the highest in ORB, and higher than the England average of 89.4%. Since then, coverage has gradually reduced to 86.6% in 2017/18, where it is currently lower than England and GM averages.

Rochdale also was above national and regional averages in 2014/15 and followed a similar trajectory to Oldham, although at a lower percentage coverage. It fell to below national and regional levels in 2016/17, and since then it has plateaued to where is it currently at 85.7%.

Bury's HPV coverage has consistently remained below those of Oldham and Rochdale. It has also consistently achieved lower coverage than the England average, with the exception of 2015/16, where it achieved a coverage similar to that of the national average. In 2016/17, Bury's HPV coverage saw a steep decline, to where it had the lowest uptake of the 10 GM local authorities. It increased by 2017/18 to 79.4%, however, uptake in Bury remains the lowest of the GM local authorities, and significantly lower than both Oldham, Rochdale and national averages. This could be attributed to the fact that there were two high schools in Bury that would not allow the immunisation provider to deliver the vaccine sessions on school premises. Public Health and the wider Council Health Protection and NHSE (commissioner) have worked with both schools who are now willing to engage with the programme.

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.

The PHE Infectious Diseases Strategy 2020-2025 identifies as one of its key priorities the eradication of HIV transmission by 2030, through participating in the newly convened Commission to end HIV transmission in England by 2030, as well as facilitating testing and information sharing. This dovetails with Greater Manchester's vision set out in the GM Sexual Health Strategy which aims to eradicate HIV in a generation.

NICE HIV testing guidelines (2017) define high HIV prevalence as local authorities that have a diagnosed HIV prevalence of between 2 and 5 per 1,000 people, and extremely high prevalence as local authorities with a diagnosed HIV prevalence of 5 or more per 1,000 people aged 15-59.

The current HIV prevalence rate in ORB, GM and nationally is demonstrated by the graph below. There is a general upward trend regionally and nationally despite slowing incidence rates; this is likely due to the improved life expectancy and people diagnosed with HIV living longer on ART. Of note, GM HIV prevalence is higher than the national average at 3.05 per 1,000 compared with 2.37 per 1,000 in England in 2018. This is because Manchester local authority has among the highest prevalence rates in the country at 6.21 per 1,000, consequently pushing the regional average up.

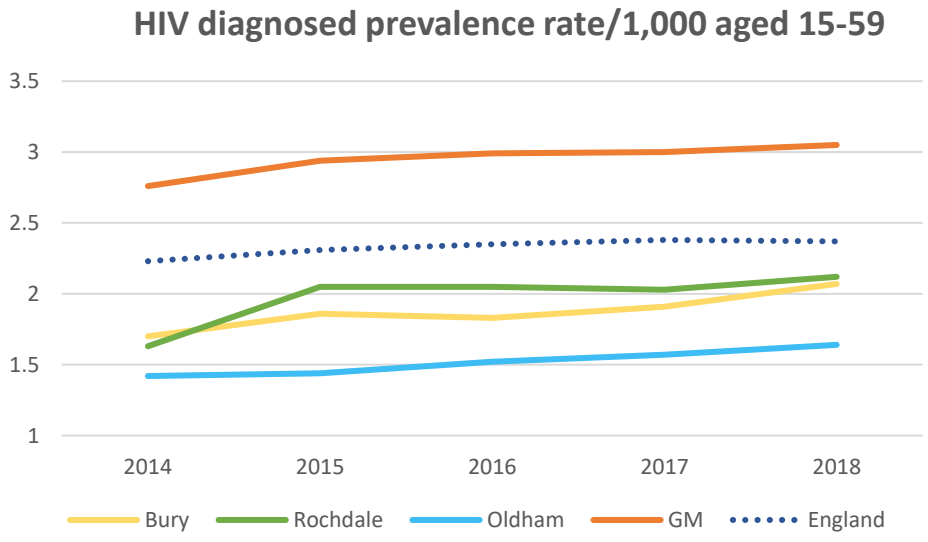

Figure 2.9: HIV Diagnosed Prevalence Rate

Oldham, Rochdale and Bury all have lower HIV prevalence than GM and England levels, with Oldham consistently having the lowest prevalence across ORB. At 1.64 per 1,000 people in 2018, this makes Oldham the only local authority in the tripartite agreement to have HIV levels not considered high. Rochdale and Bury have similar HIV prevalence rates of 2.12 and 2.07 per 1,000 respectively. HIV prevalence rates in ORB are slowly increasing in line with national and regional averages.

New HIV diagnosis rates have generally been decreasing, both nationally and regionally. The graph below shows changes in new HIV diagnoses in each local authority compared with GM, between 2014 and 2018.

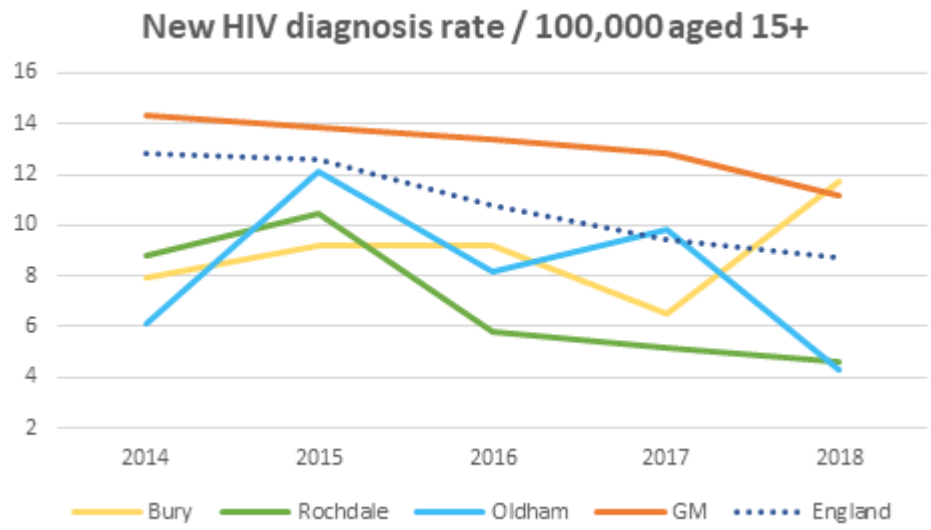

Figure 2.10: New HIV Diagnosis Rate

As demonstrated, both Oldham and Rochdale have seen a decrease in their HIV incidence rate, while Bury has seen a significant increase, to the point where it is currently above the GM and England averages. The reason for this increase in HIV incidence in Bury is not clear. It could be explained in part by recent trends in HIV testing in Bury, where between 2014-17 HIV testing coverage had declined steeply, and just picked up in 2018. This could mean there was a higher level of undiagnosed HIV in the community, which has since been picked up. Furthermore, testing coverage in Bury is higher than Oldham and Rochdale, meaning Bury is more likely to pick up positive tests. However, Rochdale has also experienced a similar decline in testing rates, followed by a slight increase, meaning this is unlikely to be the sole reason. The most likely reason is that the data is made up of small numbers which are sensitive to small changes. Oldham's HIV testing coverage has been improving year on year since 2015, but remains below Rochdale and Bury. This is demonstrated by the graph below.

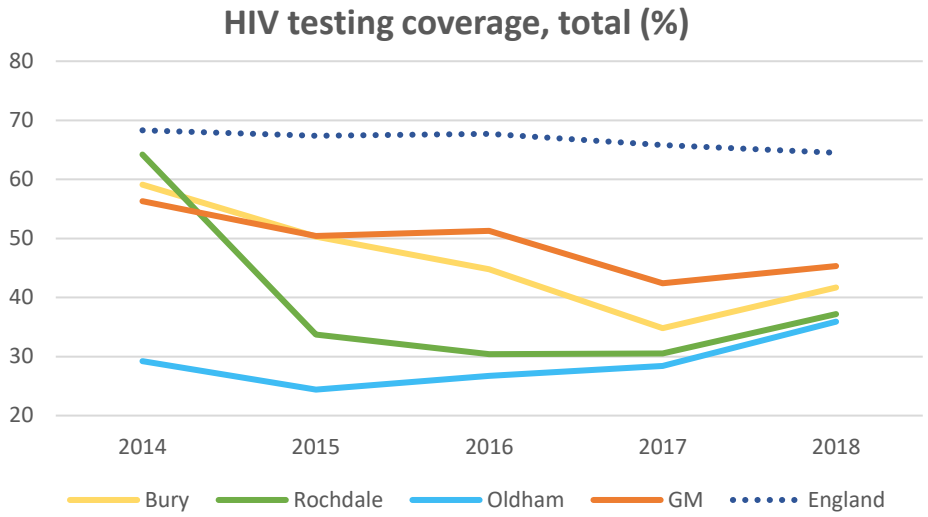

Figure 2.11: HIV Testing Coverage

Late HIV diagnosis is the most important predictor of morbidity and mortality among those with a HIV infection. Those diagnosed late have a 10-fold risk of death compared to those diagnosed promptly. Nationally, there has been a slow, steady decline in the percentage of late HIV diagnosis, falling from 50.1% in 2009-11, to 42.5% in 2016-18. This trend is mirrored in GM, with a decrease from 52.7% to 42.7% across the same time period.

At an individual LA level trends differ across ORB, with Oldham and Rochdale both seeing a steady increase in the percentage of late HIV diagnosis since 2013-15, to where both LA's have levels above national and regional levels, at 57.1% in Oldham and 70.0% in Rochdale. In Bury, the trend is reversed with a continuous decline in percentage of late HIV diagnosis to 25.0% in 2016-18. The trends are demonstrated by the graph below.

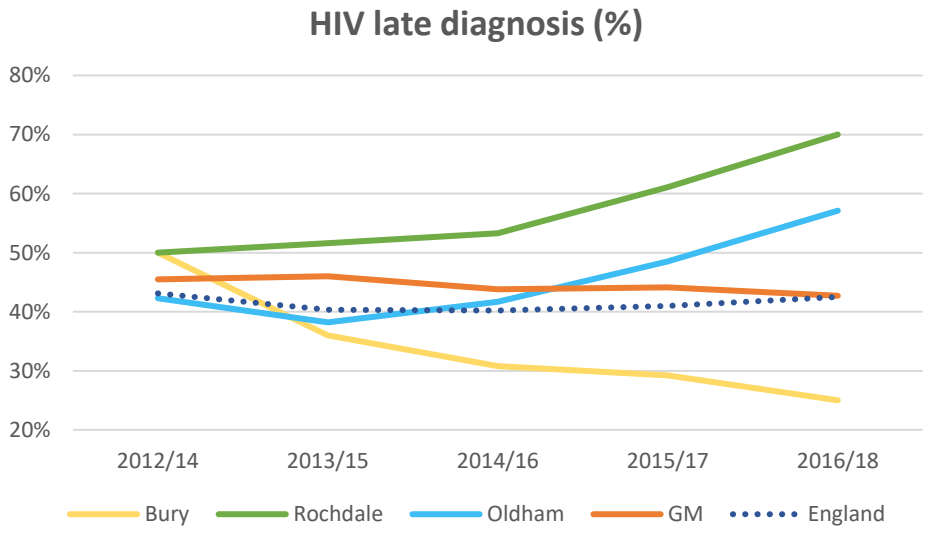

Figure 2.12: HIV Late Diagnosis

It should be noted, however, that data on late HIV diagnosis is not very precise due to the small numbers of individuals involved, meaning there is a large margin of error regarding absolute figures. However, the general year-on-year trend strengthens the evidence regarding direction of trend.

There are clear inequalities in HIV prevalence data when broken down by gender and sexuality. To compare demographics across ORB, 5-year data was aggregated due to the small numbers involved, in order to increase precision. Aggregate HIV data demonstrates that the group with the highest rate of HIV diagnosis in ORB are men who have sex with men (MSM), which is in keeping with national data, (PHE, 2018).

Teenage Conception

Most teenage pregnancies are unplanned and around half end in an abortion. As well as it being an avoidable experience for the young woman, abortions represent an avoidable cost to the NHS. While for some young women having a child when young can represent a positive turning point in their lives, for many more teenagers bringing up a child is extremely difficult and often results in poor outcomes for both the teenage parent and the child, in terms of the baby's health, the mother's emotional health and well-being, and the likelihood of both the parent and child living in long-term poverty.

Research evidence, particularly from longitudinal studies, shows that teenage pregnancy is associated with poorer outcomes for both young parents and their children. Teenage mothers are less likely to finish their education, are more likely to bring up their child alone and in poverty, and have a higher risk of poor mental health than older mothers. Infant mortality rates for babies born to teenage mothers are around 60% higher than for babies born to older mothers. The children of teenage mothers have an increased risk of living in poverty and poor quality housing, and are more likely to have accidents and behavioural problems.

As well as being included in the Public Health Outcomes Framework, teenage pregnancy has also been included as a child poverty strategy indicator 2011-14, in the document "A New Approach to Child Poverty: Tackling the Causes of Disadvantage and Transforming Families' Lives", published jointly between the Department for Work and Pensions and Department for Education (DWP, 2011).

The graph below demonstrates under 18 conception nationally, at GM level, and across each of the ORB local authorities. England and GM show steadily declining rates, although GM rates are consistently higher than England averages. Of the three ORB local authorities, Oldham has the highest under 18 conception rate, followed by Rochdale, and then Bury. There is an overall declining trend across all three localities, however, 2015 stands out as a large decline in both Oldham and Rochdale and a slight increase in Bury, yet the cause of this seemingly unfitting result is unclear.

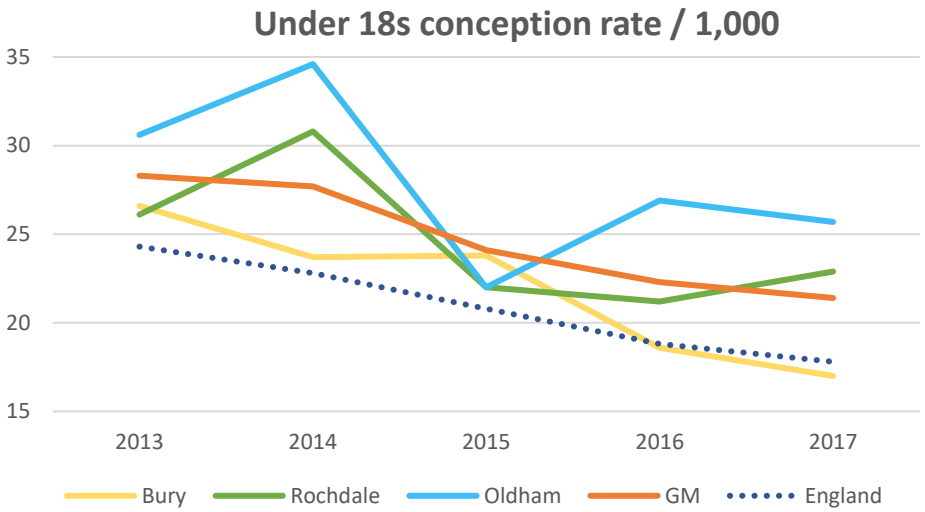

Figure 2.13: Under 18s Conception Rate

Termination of Pregnancy

Commissioners are advised to ensure that women who meet the legal requirements for abortion have access to the service within three weeks of seeing a general practitioner or other doctor, and ensure that information about local pregnancy counselling and termination services are available and widely publicised.

Statistics on abortions can be used as an indication of lack of access to good quality contraception services and advice, as well as problems with individual use of contraceptive methods. The graph below suggests there are variations in access to abortion services and methods of termination.

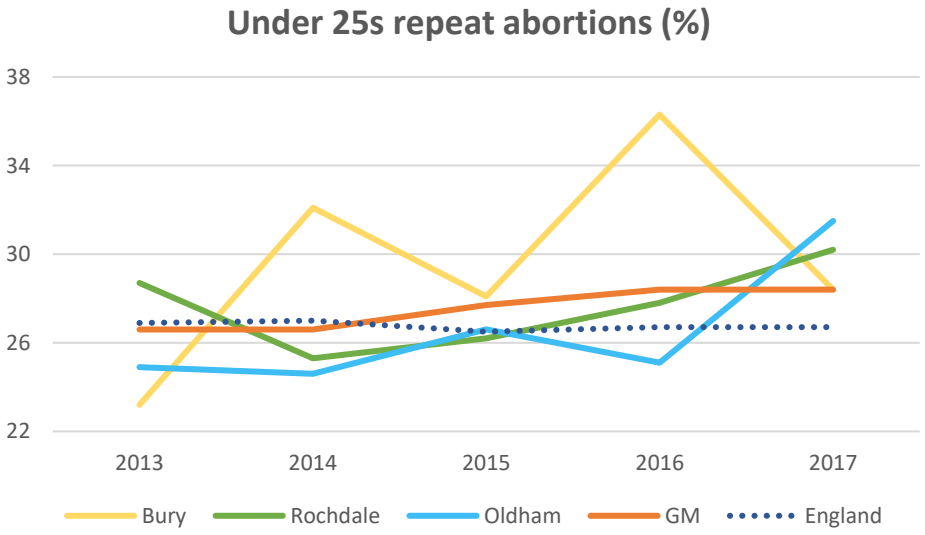

Figure 2.14: Under 25s Repeat Abortion

Long-acting Reversible Contraception (LARC)

The provision of contraception is widely recognised as a highly cost-effective public health intervention. This is because it reduces the number of unplanned pregnancies which bear high financial costs to individuals, the health service and to the state.

Methods of contraception can be broadly divided into two groups- Long acting reversible contraception (LARCs) and User Dependent Methods (UDMs). LARCs are the most cost-effective method of contraception according to NICE, and they are also clinically effective as they are not reliant on daily compliance. They are, therefore, a focus of the GM Sexual Health Strategy, with one of the ambitions being to increase the uptake of LARCs.

Local authorities are mandated to commission LARCs which are provided through GPs and GUM clinics, this encompasses implants and IUDs. CCGs commission oral contraceptives as part of the GP contract as well as the contraceptive depo injection. In view of recent system-wide funding cuts, sexual health service provision has faced cutbacks in recent times, including reduced spending on contraception. However, this is likely to lead to higher long-term costs. An economic evaluation was undertaken by PHE (2018) which highlighted the cost-effectiveness of healthcare provided contraception.

A contraception audit was carried out across GM in 2017 which demonstrated an overall decline in LARC provision, with a disproportionate drop in the rate of women using LARC in GM compared to the rest of England.

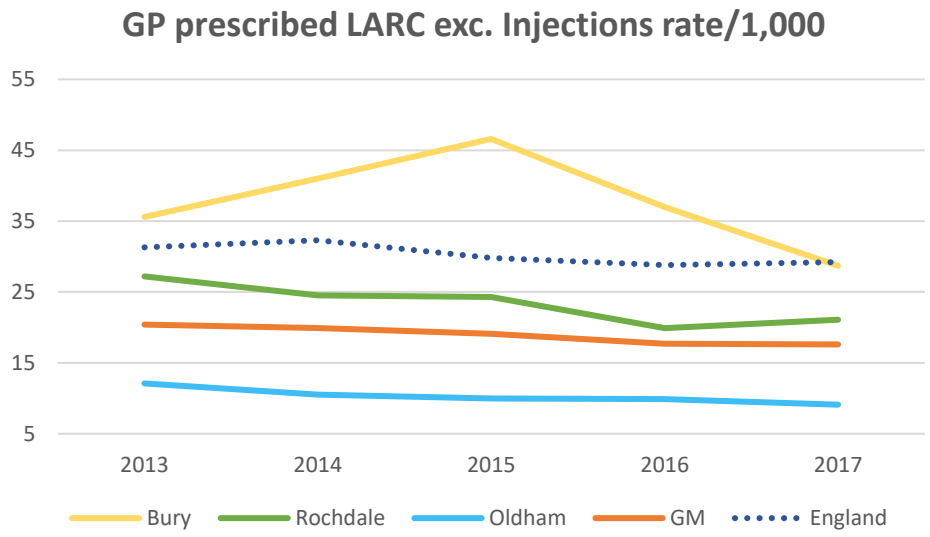

Figure 2.15: GP Prescribed LARC

The graph above demonstrates changes in rates of GP-prescribed LARCs across ORB, GM and England. Apart from an increase in 2015 in Bury, there has been a steady decline in LARC-prescription rates across all three local authorities from 2013-17, which is in-line with GM and England averages over the same time period.

The graph below demonstrates rates of LARC prescription by Sexual and Reproductive Health (SRH) services. There is generally a small rise in LARC prescription rates at SRH services, despite a sharp

decline in 2015 in Bury and Rochdale. This is likely to be due to inconsistencies with data entry, as during this time the SRH services in ORB were going through a procurement process.

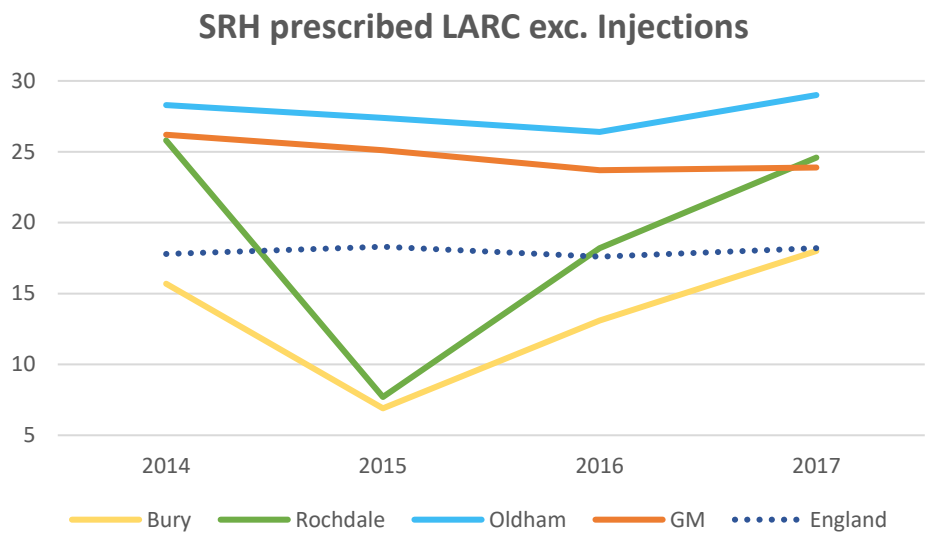

Figure 2.16: SRH Prescribed LARC

Implications for Sexual Health in Oldham, Rochdale and Bury

This demographics section highlights a young population across ORB, with a higher proportion of females overall. Sexual health service uptake is higher among females than males, with those between 18-24 having the highest rate of service uptake. The higher proportion of young people across ORB means a higher service uptake requirement which should be considered for future service provision, (NHS Digital, 2017).

Healthy life expectancy in ORB is lower for males and females than the England average, meaning a higher number of years lived in poor health among residents. This increases demand on health services and should be acknowledged in service provision.

There are higher levels of deprivation in ORB than England, areas with higher deprivation generally have higher levels of morbidity, therefore meaning an increased demand for services. Further breakdown of health and morbidity indicators will be provided in the next section of the report.

Notably across ORB, there is a higher proportion of BAME residents from an Asian or British Asian background compared with GM and England. This is an important consideration when planning for services as there may be cultural sensitivities than need to be addressed, and accessibility needs to be examined.

GM is an area of high HIV prevalence which is important to note when considering the aim of the GM sexual health strategy of eradicating HIV in a generation.

Finally, the GP-registered population when compared with the resident population across ORB highlights a proportion of residents accessing GPs and services outside their local authority. This has implications for funding and cross-charging of sexual health services across GM.

3. Sexual Health Services across ORB

Most sexual health services in ORB are delivered though Virgin Care in the community, in the form of GUM Clinics. GP surgeries and pharmacies also provide some sexual health services. The roles of these services and their activity and performance will be outlined in this section.

Cross-Charging across GM and ORB

Local authorities within Greater Manchester have taken a collaborative approach to the commissioning of integrated sexual and reproductive health services. This was done in order to provide integrated SRH services across GM, reduce costs and maintain open-access arrangements.

As such, a shared specification was agreed. Local areas fund services used by their residents, with providers funded to offer services across GM through commissioner-to-commissioner funding agreements. Block contracts have specified a standard 'cost per attendance' fee rather than separate amounts for contraception and GUM.

The arrangement is different in ORB, however, where the net charging agreement covers Contraception and Sexual Health (CASH) activities only. GUM activity is still paid as a tariff to the provider, which is likely more expensive for the local authorities, and resource intensive for both local authorities and providers.

Reviews into this arrangement are currently ongoing.

Virgin Care

In 2015, Oldham, Rochdale and Bury (ORB) sought to commission the delivery of an all age integrated service model of sexual health provision to:

- Improve sexual health outcomes for the ORB population
- Reverse the increasing incidence and prevalence of STIs
- Reverse the increasing prevalence of HIV and reduce late diagnosis through better prevention and access to HIV testing for at risk groups.
- Reduce unintended pregnancies, including teenage pregnancies, through contraception and health promotion services

In line with Greater Manchester's Sexual Health Network principles, Integrated Sexual Health Services cover: sexually transmitted infections (STI) prevention, diagnosis and treatment, contraception, signposting to abortion services, and should contribute to a reduction in teenage pregnancy rates and promote HIV testing to reduce late diagnosis of HIV.

Virgin Care was commissioned to provide an open access service for patients requiring contraception and STI testing and treatment services; and provide holistic care ensuring that patients receive the most appropriate treatment and care regardless of the primary reason for presentation.

An open access integrated health service was commissioned in each of the three local authorities, with Bury and Rochdale further commissioning a Young People's Sexual Health Support Service from the same provider. Oldham commission Brook, which provides sexual health services to young people under the age of 21.

Services Provided

Virgin care provides a single access point across ORB for all sexual health services, including the following:

- Counselling and advice
- Contraception (all types, including long-term, hormonal and emergency)
- Screening and treatment for STIs including HIV (including express testing)
- Pregnancy testing
- Referrals for Termination of Pregnancy
- Hepatitis B vaccinations (Rochdale and Bury)
- Outreach service for young people aged between 13 - 25 (Rochdale and Bury)

Additionally, there is a focus on prevention:

- STI prevention: condom distribution and HIV Post Exposure Prophylaxis (PEP) with combined funding from local authorities and NHS England.
- Clinical and/ or education outreach, e.g. to colleges, Young Offenders Institutions (YOI) and prisons

In 2018, extensions to the ISH contract delivered by Virgin Care were proposed, covering:

- A Young People's Sexual Health Support Service - provided through an early intervention programme through The Sex Education Forum ('Outside the Box'), which focuses on sex and relationships.
- Development of Sexual Health Networks to further develop capacity and best practice across the region

Access

The service is open-access, with self-referrals possible. Walk-in clinics are available, and bookings can be made online 24/7, and phone lines available Monday to Thursday 8am-8pm, Friday 8am – 5.30pm and Saturday 9am-5pm.

Services are located in each local authority as set out below:

Oldham	Rochdale	Bury
Oldham Integrated Care Centre (walk in available) 5th floor, Sexual health Oldham, Radcliffe St, Oldham, OL1 1NL*	Nye Bevan House (walk in available), Rochdale, OL11 1DN Monday/ Tuesday am walk in, otherwise Monday to Friday	Townside Primary Care Centre, Bury (walk ins available) 3rd Floor Townside Primary Care Centre, 1 Knowsley Place, Knowlsey Street, Bury, Lancashire, BL9 0SN*
Failsworth Primary Care Centre (walk in clinic only) Sexual Health Oldham, Ashton Road West, Failsworth, M35 0AD Wednesday morning	Langley Clinic, Middleton Borrowdale Drive, Middleton, Manchester, M24 5QG Walk-in: Tuesday evening	Radcliffe Primary Care Centre (walk ins available) Radcliffe Primary Care Centre, Church Street West, Radcliffe, Manchester, M26 2SP Walk-in: Wednesday evening
Glodwick Primary Care Centre (walk in clinic only) Sexual health Oldham, 1st Floor, Glodwick Road, Oldham, OL4 1YN Tuesday morning	Littleborough Health Centre (walk in only) Featherstalll Road, Littleborough, OL15 8HF Friday afternoon	
Royton Health & Wellbeing Centre Sexual Health Oldham, 1st Floor, Park Street, Royton, OL2 6QW Thursday Evenings	Heywood Clinic (walk in only) Phoenix Centre, Pine Street, Heywood , OL10 1D Monday to Friday afternoon for under 20s	
	Croft Shifa Health Centre, Rochdale (walk in only) Belfield Road, Rochdale, OL16 2UP Wednesday afternoon	

*Evening appointments are offered and alternative Saturday mornings

Table 3.1: ORB GUM Clinics

Budgets and spend

The value of the Virgin Care ISH contract across Oldham, Rochdale and Bury for 2019/20 financial year is £3,118,536. This is a decrease of 2% since 2016/17 and encompasses extensions made to the contract in 2018. This is broken down by each local authority:

Oldham: £1,071,768

Rochdale: £1,142,700

Bury: £904,068

Performance

Performance across the three local authorities is outlined along six parameters: access, planned appointments, walk-in appointments, improving productivity clinical services and patient experiences.

This table is from June 2019 data. Green refers to meeting targets, red is not meeting targets.

	Oldham	**Rochdale**	**Bury**
1. Access This includes convenient opening times, offering appointments and seeing service users within 48 hours of making an appointment			
2. Planned Appointments - Waiting times kept to a minimum for pre-booked appointment (65% seen within 20 mins)			
- Access to IUD/ IUS and implant fitting			
3. Walk-in Appointments Service users waiting times for drop-in clinics			
4. Improving Productivity - DNA Rates			
- Minimise Service Closures			

5. Clinical Services			
Contraception discussed			
LARC promoted			
Offer Chlamydia screening <25			
Percentage screening positive for Chlamydia who are offered 3 month repeat test*			
Service users testing positive Chlamydia, retested within 3 months			
Service users newly diagnosed with HIV access specialist within 2 weeks			
6. **Patient Experiences** Service users able to provide feedback, and receive response in case of complaints			

Table 3.2: Virgin Care KPIs

*Please note that Virgin had been recording proportion of service users screening positive for Chlamydia actually taking up the offer of retesting at 3 months, whereas the KPI indicates the proportion of service users screening positive for Chlamydia being offered a repeat test at 3 months. Virgin do meet this KPI at 100% of service users testing positive for Chlamydia being offered repeat Chlamydia screening at 3 months.

In terms of meeting KPIs, Virgin Healthcare performance is similar across the three localities. Targets are being met in terms of waiting times, access and some areas of clinical services such as promotion of LARCs at appointments, and timely specialist referrals for those newly diagnosed with HIV – of note these numbers are small. Furthermore, all young people accessing services are being offered Chlamydia screening by Virgin.

Virgin Healthcare are not meeting KPI targets in terms of access to implant contraception, DNA rates, and discussing contraception during appointments.

Virgin Care Outreach Services

As previously outlined, Rochdale and Bury both commission a Young People's Sexual Health Service through Virgin Care which focuses on outreach.

In the first quarter of 2019/20, there was a higher number of young people attending group sessions in Rochdale than Bury, however, a higher number of one-to-one sessions were delivered in Bury and a higher number of current clients. More chlamydia screens were undertaken in Rochdale.

	Rochdale	**Bury**
Number of Young People attending group sessions	285	148
Number of Young People accessing drop-in sessions in a non-clinical outreach setting	65	42
Total number of one to one sessions delivered	79 (20 active clients)	233 (137 active clients)
Number of chlamydia screens undertaken with sexually active under 25s where clinically appropriate	52	12

Table 3.3: Virgin Care Young People Outreach Service KPIs

Condom Distribution Scheme (CDS)

Virgin Healthcare also provide condom distribution as part of their outreach work, the table below shows activity in the first quarter of 2019/20 across ORB:

	Oldham	Rochdale	Bury
Number of new registrations for condom distribution scheme	6	18	18
Number of condom distribution sites	1	7	2
Total Number of condoms issued	42	287	254

Table 3.4: Condom Distribution Scheme KPIs

There is great variation in access sites to the CDS across the 3 localities, with Rochdale having the most sites and Oldham the least; this is also reflected in the number of condoms distributed.

Postal STI Testing Kits

Virgin Care provide Postal STI Testing Kits across the three localities. These kits include tests for Chlamydia, Gonorrhoea, HIV and Syphilis. They can be ordered by anyone living in ORB over the age of 16, without any symptoms or specific concerns. If symptoms are present, it is recommended they attend a clinic.

The tests ordered can be either basic or recommended (with bloods) and are for female, male and MSM. The average age on orders across ORB is similar and orders are highest among the 20-28 year old age bracket.

Over Q1 of 2019/20, the breakdown of activity across ORB is as follows:

	Oldham	Rochdale	Bury
Number of tests ordered (returned)	697 (430)	659 (475)	675 (429)
Average % of tests returning positive over Q1	3.27%	3.35%	3.5%

Table 3.5: Postal STI Testing KPIs

Virgin Care Activity

The total number of service users seen during 2018/19 by Virgin Care is 32,430. When broken down by local authority:

Oldham: 13,490.

Coldhurst, St Mary's, Alexandra and Medlock Vale were the wards with the highest number of resident activity in Oldham.

Rochdale: 10,056.

Milkstone and Deeplish, Kingsway and Smallbridge and Firgrove were the wards with the highest number of resident activity in Rochdale.

Bury: 8,884.

Radcliffe West, Radcliffe East, Bury East and Redvales were the wards with the highest number of resident activity in Bury.

Of note, there are service users accessing ORB Virgin Care services from outside ORB. Over 2018/19, there were 2,478 service users from outside of ORB. 1,550 of those were from other local authorities within GM, with a further 774 resident outside GM. There were 154 service users whose residency was not known.

Local Authority	Number of Service Users
Bolton	277
Manchester	712
Salford	199
Stockport	23
Tameside	283
Trafford	27
Wigan	29
Outside GM	774
Unknown	154

Table 3.6: Service Users Accessing from outside ORB

The local authorities outside of ORB with the highest number of residents accessing sexual health services in ORB are Manchester, Tameside, Bolton and Salford.

The trend is similar across the first quarter of 2019/20.

Demographics of Service Users

Age of service users

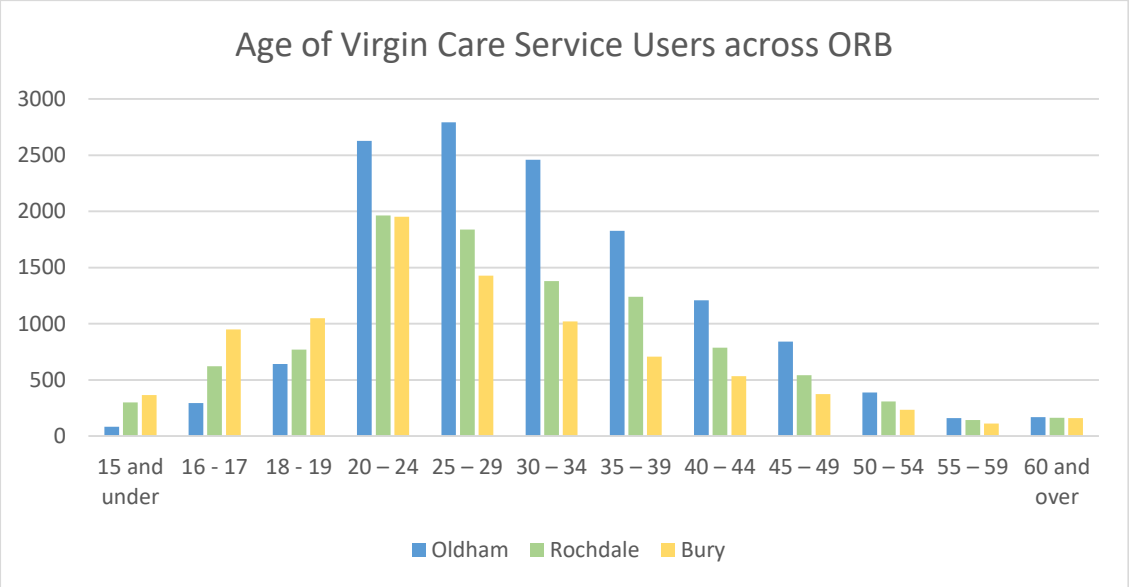

Figure 3.1: Virgin Care User Demographics - Age

A higher proportion of residents under the age of 20 access services in Bury compared with Rochdale and Oldham.

Gender of Service Users

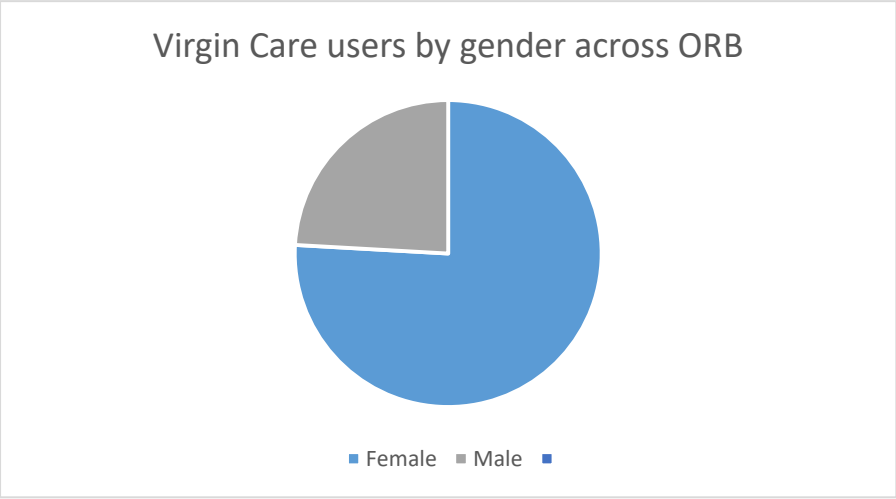

Figure 3.2: Virgin Care User Demographics - Gender

The ratio of females to males across ORB was approximately 3:1 and similar across the three localities. Bury had a slightly higher male proportion of service users than Oldham and Rochdale.

Sexual Orientation of Service Users

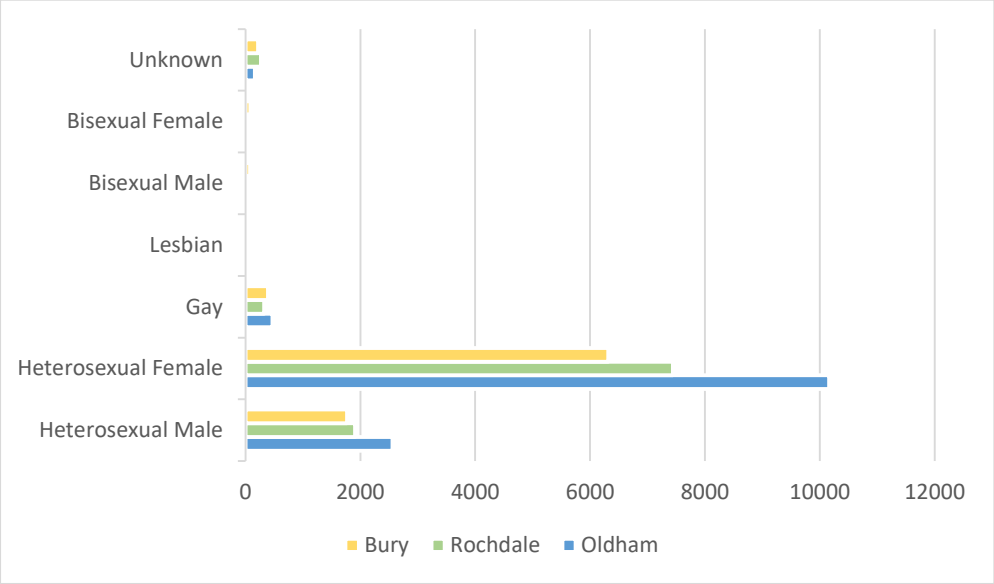

Figure 3.3: Virgin Care User Demographics – Sexual Orientation

As demonstrated, heterosexual females make up the largest group of service users by sexual orientation in terms of crude numbers.

Ethnicity

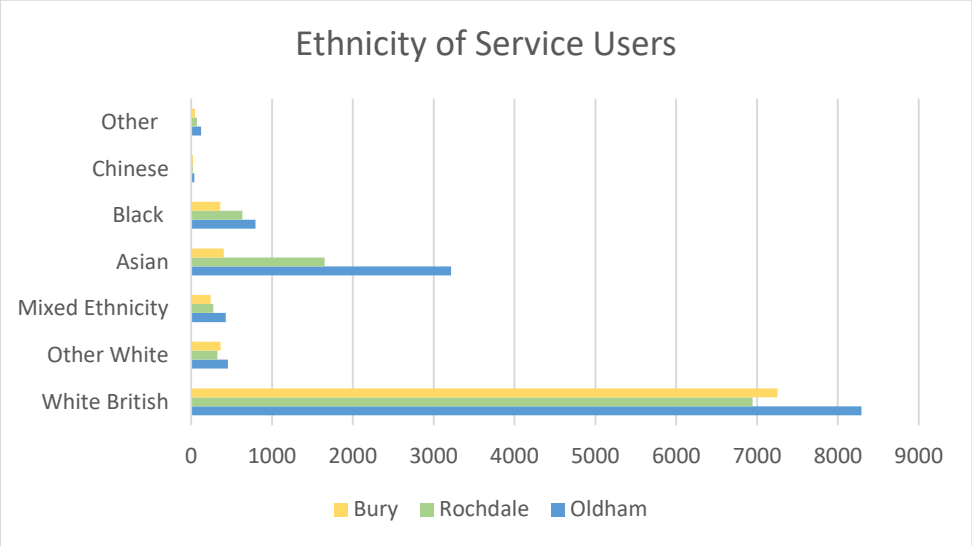

Figure 3.4: Virgin Care User Demographics – Ethnicity

Brook

Brook provides free and confidential sexual health and advice to young people under 21 years of age. It is currently only commissioned by Oldham across ORB, having been decommissioned by Rochdale and Bury.

Services offered by Brook include:

- Sexual health information
- Free condoms, contraception and emergency contraception
- Screening for STIs
- Pregnancy testing
- Referrals for terminations

Access

Brook provides appointment only sessions with sexual health nurses on Mondays and Tuesdays. The rest of the week the service operates as a walk-in clinic. It is located at:

Positive Steps, Medtia Place, Oldham, OL1 1DJ

Opening times are Monday – Friday 12:00 – 17:00. The clinic is closed on weekends.

Brook was originally commissioned to provide clinic on Saturdays mornings, however, attendance was low consistently. Consequently a business case was put forward for closing the clinic on weekends, which started 27th April 2019.

Referrals

The service is open access, with self-referrals and re-referrals possible. Brook also accept referrals from other agencies for all young people under 21.

Performance

Brook has a contract value of £150,000 in Oldham, which contributes towards the Positive Steps Integrated Health/ Targeted Youth Offer for Young Person's Sexual Health Service. Oldham are currently out to tender for the Young People's Integrated Support Services, which will include an integrated sexual health and substance misuse service, with a new contract set to commence in April 2020.

During Q1 2019/20, KPIs were as per the below table:

Indicator	Target	Actual
Number of clinics delivered	75	62
Total number of new clients	280	252
Total emergency hormone contraception issued	184	168
All LARCs provided	130	112
Oral contraceptives offered	195	144
Condoms issued	1500	1685
Chlamydia total number tested	-	317
% of clients seen within 48 hours	100%	100%

Table 3.7: Brook KPIs

Ethnicity

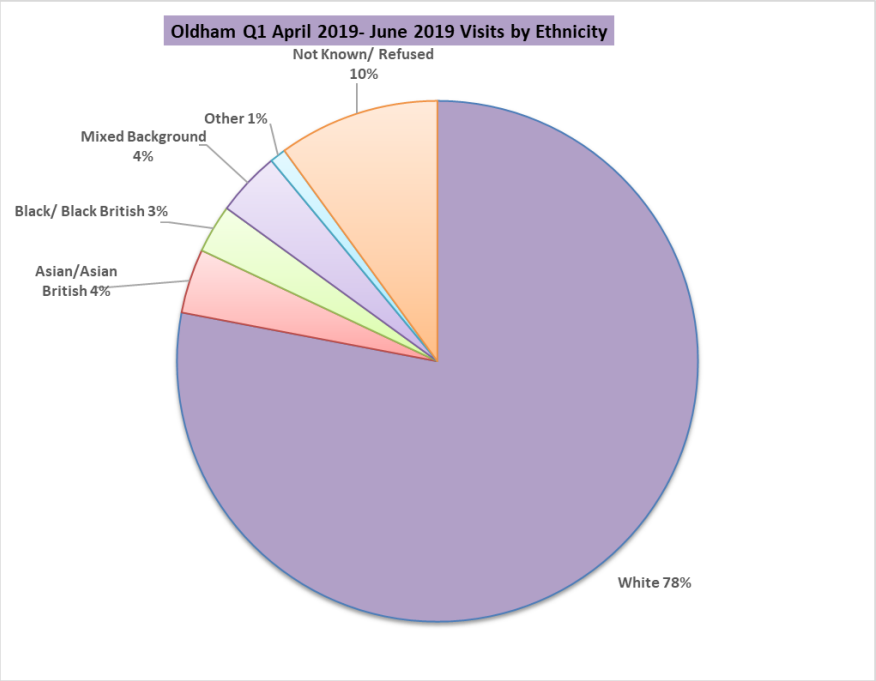

Figure 3.5: Brook Demographics Ethnicity

Numbers on gender breakdown of service users are too low to report.

Feedback from service users

Feedback has been mostly positive:

- Almost 90% of service users would recommend Brook to friends and family
- Almost 90% of service users report they were treated with respect
- Almost 90% of service users report they were involved in decision making
- 69% of service users reported receiving timely information about their care

ORB Pharmacies

Community pharmacies are expected to promote health and wellbeing among their local population. This is because they are often more accessible due to longer opening hours, no appointments are necessary and the staff are well-placed to offer advice on healthy behaviours and onward referral to other services where appropriate.

As such, pharmacies are commissioned to provide Emergency Hormone Contraception (EHC), as well as STI testing such as Chlamydia testing, and pregnancy testing if indicated prior to issuing contraceptives.

Emergency Hormone Contraception (EHC) can be used if a woman has had sexual intercourse without using a regular method of contraception or if her regular method has failed to reduce her risk of having an unintended conception. Provision of EHC through pharmacies promote the use of and maintain ease of access to this provision, which can reduce the number of unintended conceptions amongst female residents of all ages and encourage safer sex and the use of regular methods of contraception.

Sexual Health services offered by pharmacies

- **EHC:** Community pharmacies in ORB offer EHC to women requesting oral emergency contraception who present within 72 hours of unprotected sexual intercourse or potential contraception failure.
- **Chlamydia screening and treatment** is offered to young women aged 16-24 requesting emergency contraception or young men and women aged 16-24 requesting an RU Clear Chlamydia self-testing kit.
- **General sexual health advice and onward referral** where appropriate

Pharmacy Services by Locality

This section details pharmacy activity by locality. Please note that at the time of writing this report, Oldham and Rochdale had recently commissioned Pharmoutcomes, meaning it is not yet possible to extract details of demographics or activity. This would explain the discrepancy in availability of demographic and activity data between Oldham/Rochdale, and Bury who had already been using Pharmoutcomes. It is hoped that switching to Pharmoutcomes will enable more robust monitoring of pharmacy services.

Oldham

Oldham have commissioned pharmacies to deliver Emergency Hormone Contraception (EHC), opportunistic Chlamydia Screening and Testing (CST), and pregnancy testing if indicated.

In Oldham, there are 31 pharmacies offering EHC and RU Clear testing kits for Chlamydia and Gonorrhoea.

Breakdown by area:

- Chadderton: 6 EHC pharmacies, also offering CST
- Failsworth and Hollinwood: 3 EHC pharmacies, also offering CST
- East Oldham: 5 EHC pharmacies, also offering CST
- West Oldham: 6 EHC pharmacies, also offering CST
- Royton, Shaw and Crompton: 5 EHC pharmacies, also offering CST
- Saddleworth and Lees: 6 EHC pharmacies, also offering CST

In 2018/19, in Oldham pharmacies spend on combined EHC and Chlamydia was £30,041.43

Rochdale

Rochdale Borough Council has commissioned an emergency hormonal contraception service as well as screening for chlamydia. There are 45 Pharmacies across Heywood, Middleton and Rochdale who are eligible to provide the service.

Breakdown by area:

- Rochdale: 11 EHC pharmacies, 4 offer CST
- Heywood: 3 EHC Pharmacies, 2 offer CST
- Middleton: 4 EHC Pharmacies, 3 offer CST
- Pennines: 2 EHC Pharmacies, 1 offer CST

Over the last year, Rochdale has seen an increase of more than double in the number of pharmacies providing EHC, largely due to increased partnership working with the Local Pharmaceutical Committee (LPC). Figures for 2019/20 show this continuing upward trend.

	2017/18	2018/19
Consultations	551	1183
Pregnancy Tests	13	37
EHC Prescriptions	516	1183

Table 3.8: Pharmacy EHC Activity in Rochdale

The value of the pharmacy contracts in Rochdale is around £50,000 annually.

Bury

In Bury, there are 14 community pharmacies providing EHC. Of these, 9 offer Chlamydia Screening & Treatment (CST).

Breakdown by area:

- Prestwich: 4 EHC pharmacies, 3 offer CST
- Bury: 6 EHC pharmacies, 4 offer CST
- Radcliffe: 2 EHC pharmacies, 1 offers CST
- Whitefield: 1 EHC pharmacy, none offer CST
- Ramsbottom: 1 EHC pharmacy, 1 offers CST

Activity and Spend

In 2018/19, Bury residents were offered 1284 EHC and 41 residents were screened for Chlamydia, none were treated in community pharmacies.

In 2018/19, in Bury pharmacies:

- Spend on EHC was £26,766.80

- Spend on Chlamydia Screening and Treatment was £492.14

EHC Residence breakdown:

The table below breaks down the number of EHCs offered by neighbourhood in Bury in 2018/19:

Neighbourhood	EHC	% of Bury
Bury	**1043**	**100%**
Bury East	298	29%
Prestwich	226	22%
Radcliffe	153	15%
Ramsbottom and Tottington	225	22%
Whitefield	141	14%

Table 3.9: Pharmacy EHC Activity in Bury

In the same year, 196 Bury residents sought EHC outside of Bury, a breakdown by location is in the table below:

Locality	EHC	% of other GM
Other GM	196	100%
Bolton	24	12%
HMR	89	45%
Manchester	35	18%
Oldham	7	4%
Salford	28	14%
Stockport	5	3%
Tameside	2	1%
Trafford	2	1%
Wigan	4	2%

Table 3.10: Pharmacy EHC Access in Bury from non-ORB service users

Most Bury residents seeking EHC outside of Bury do so in Rochdale, Manchester or Salford.

The age distribution of residents seeking EHC is demonstrated in the graph below:

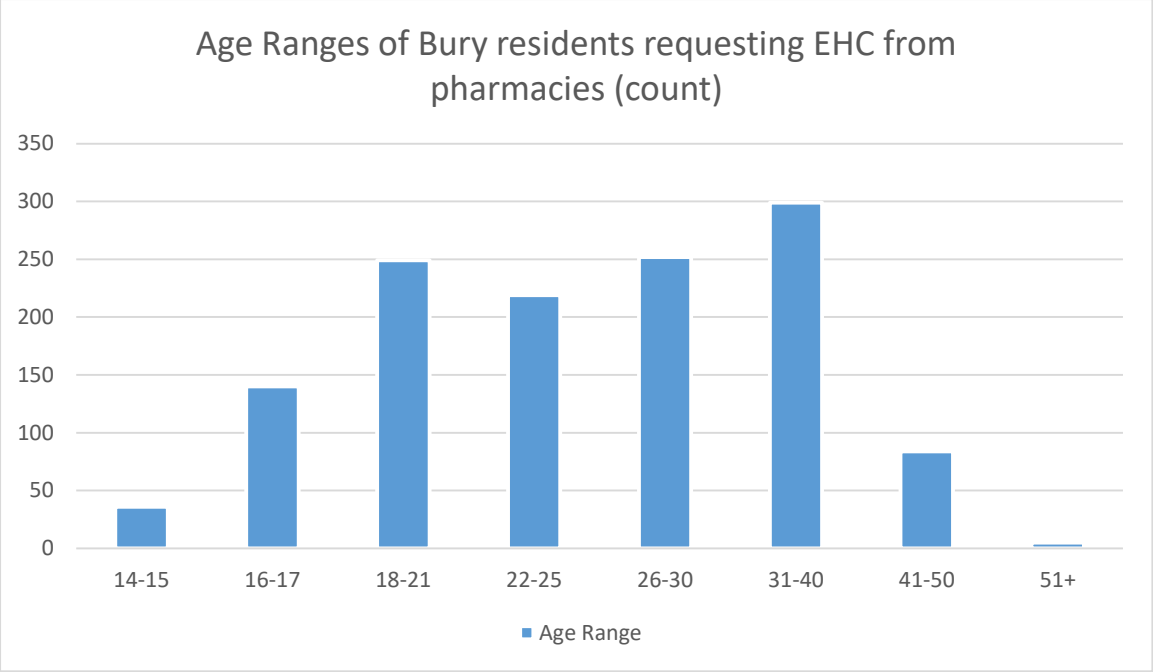

Figure 3.6: Pharmacy EHC Demographics - Age

Ethnic Breakdown is represented by the following chart:

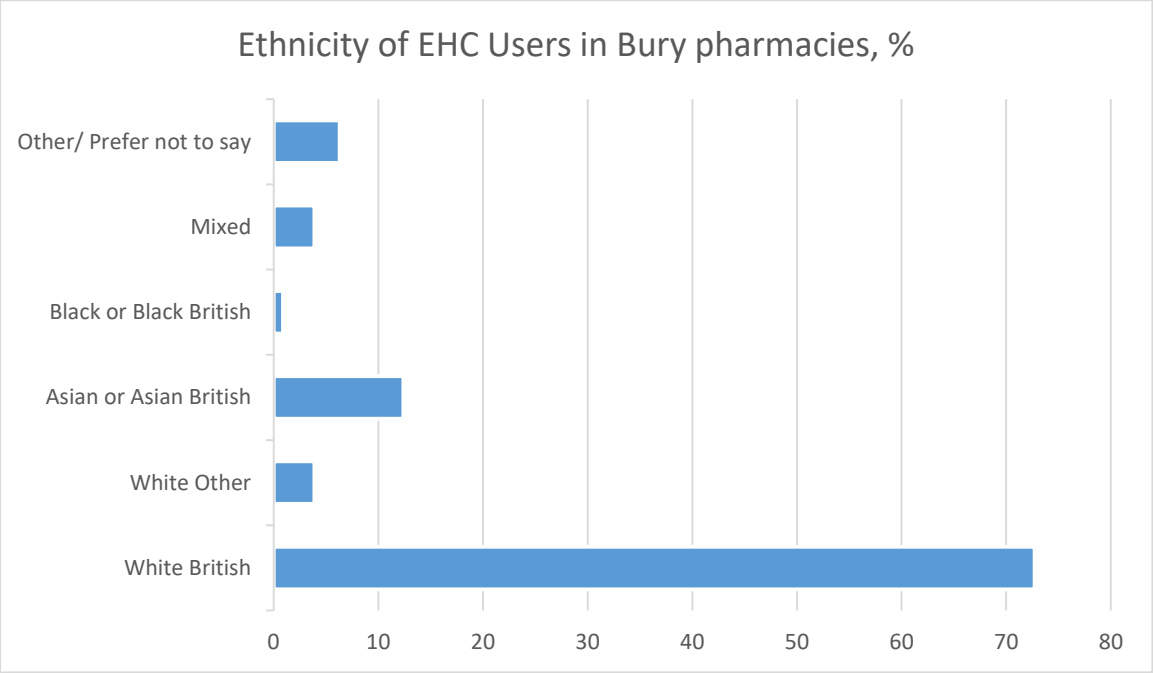

Figure 3.7: Pharmacy EHC Demographics - Ethnicity

As demonstrated, EHC is most commonly sought by women between the ages of 18-21, 26-30 and 31-40, and by those from a White British ethnicity.

GPs

GPs are commissioned by local authorities to provide contraception in ORB and STI screening in Oldham and Rochdale. Screening is provided through RU Clear testing, which seeks to provide screening on an opportunistic basis to all sexually active men and women aged from 15 to under 25 years old. By embedding opportunistic screening in GPs and other community settings, such as pharmacies and sexual health services, this ensures a wider reach and extends service provision.

In addition to Chlamydia screening and treatment, GPs are commissioned to provide Long Acting Reversible Contraception (LARC). This includes both Intra-Uterine Contraceptive Devices (IUCD) and Sub-Dermal Implants (SDI). These are the most cost-effective contraception methods as outlined by NICE. The service is available to all women of childbearing age who request contraception and who choose a contraception implant or intra-uterine device as the most acceptable method for them, provided that it is not contraindicated.

Oldham

In Oldham, there are 24 GP practices offering LARC, and 32 offering CST.

In 2018/19, there were 1003 appointments across all Oldham GPs for LARC. Of the GP practices offering CST, there were 29 screening tests issues and 6 consultations for treatment in total.

Over 2018/19, Oldham spend on GP LARC and CST was £41,064.

In Oldham, there is large variation in LARC provision across GPs, with some spending £100 a year and others spending over £7,000 annually.

Rochdale

Chlamydia screening and testing, as well as LARC, are available across Heywood, Middleton and Rochdale GP practices as part of their CCG Core Plus Contract 2019/20. There are 26 out of 34 GP surgeries providing this service across the borough.

Rochdale spend on Chlamydia screening and treatment in 2018/19 was £15,000. Over this time, GPs sent 660 testing kits to RU Clear, which is an increase from 2017/18, and is projected to increase further in the next financial year.

Total spend on LARCs in 2018/19 in Rochdale was £85,000. In 2018/19, 1469 LARCs were offered across GP practices in Rochdale, a slight increase from the previous financial year.

Bury

In Bury, 19 practices provide Sub-Dermal Implants and 19 provide IUCD. There are at least two GP practices offering IUCD and SDI in every township: Bury East, Ramsbottom & Tottington, Prestwich, Radcliffe and Whitefield.

Over 2018/19, the value of the GP contract through local authority Public Health is detailed below:

- IUCD: £38,733
- SDI: £24,560

In 2018/19, 690 LARCs were offered across GP practices in Bury.

PaSH

The Passionate about Sexual Health (PaSH) partnership is a collaboration between BHA for Equality, George House Trust and the LGBT Foundation third sector organisations. PaSH is a service commissioned across GM to deliver the GM Sexual Health Improvement Programme.

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 interventions are carried out among the LGBT and BAME communities.

Interventions provided by PaSH include:

- 1-2-1 interventions
- Group interventions
- Point of Care Testing (POCT) for HIV
- PEP and PrEP
- Wellbeing assessment
- Referral and signposting to partner organisations (including MASH and George House Trust)

Demographics of PASH service users in ORB

The demographic make-up of PaSH service users in ORB is demonstrated by the charts below. As outlined, males are most likely to use the service. In terms of sexuality, people identifying as heterosexual make up the largest group by sexuality, followed closely by Men who have Sex with Men (MSM). PaSH has wide reach within BAME communities, with 60.42% service users from a BAME background, with people from a Black ethnicity making up 36% of service users in ORB, and 18.75% from an Asian background.

The age distribution of PaSH service users in ORB is demonstrated below. Please note that the figure for <16 has been removed due to the very low numbers. As noted, the most common age group accessing services is 30 – 49 year olds.

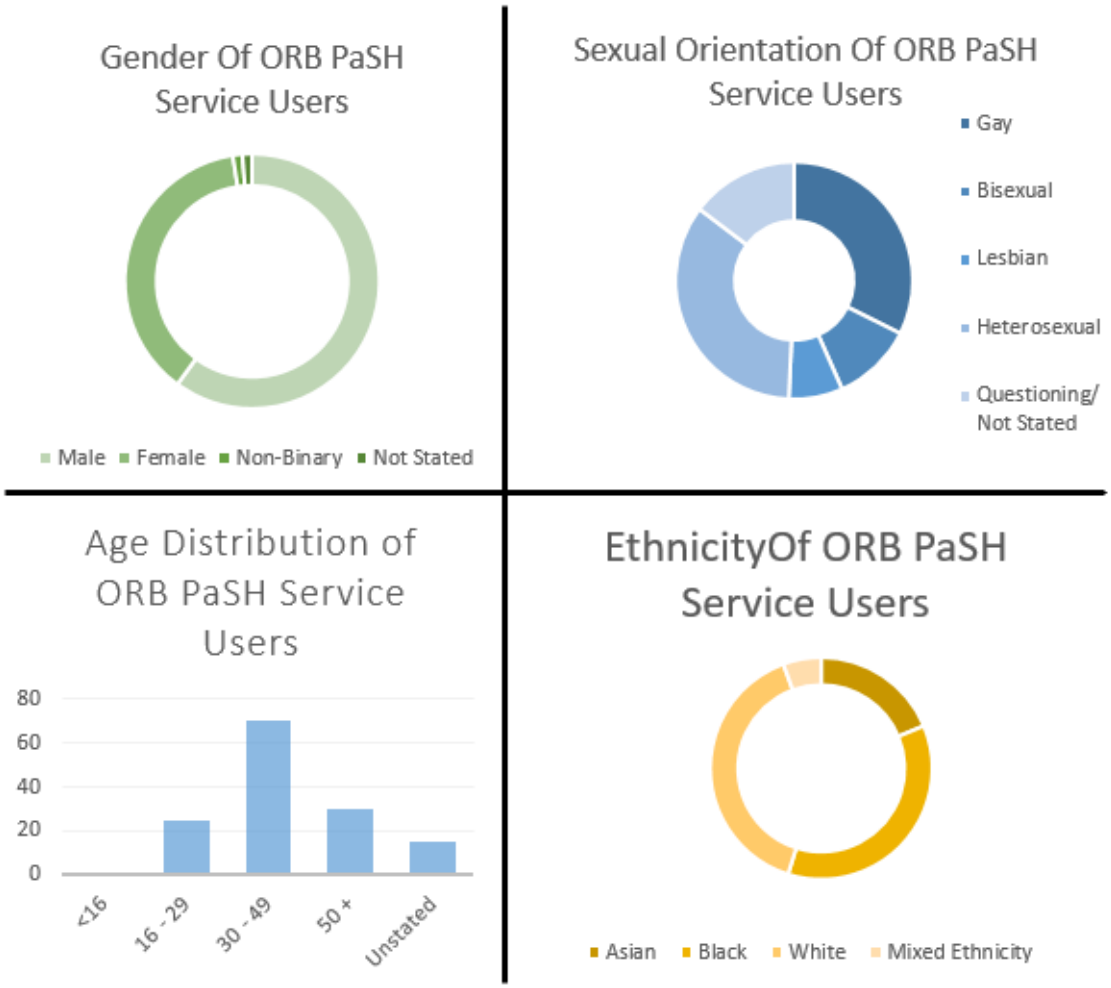

Figure 3.8: PaSH Service User Demographics (please read pie chart categories and colours clockwise, starting from the top)

Prevention Services delivered by PASH in ORB

Interventions delivered by PaSH within ORB is broken down in the table below:

	Oldham	Rochdale	Bury
Face to Face Outreach	18	63	8
Information & Advice	3	2	0
Group Sessions	0	7	9
POCT for HIV	1	1	0

Table 3.11: PaSH ORB Interventions

MASH

MASH is a service previously commissioned by Bury, which aims to work with female street and sauna sex workers to promote sexual health, wellbeing and personal safety whist offering choice, support and empowerment to promote individual positive life changes.

The combination of unsafe injecting drug use and unsafe sexual practices is a significant factor in the increased risk of HIV infection of drug injecting females. 90% on on-street sex workers are unsafe drug users, with higher HIV and Hepatitis C prevalence than the population average.

As a vulnerable and marginalised group, female street sex workers are less likely to access mainstream health and social care services.

The aims of the service are:

- To minimise number of people infected with HIV and other Blood Borne Viruses
- To enable people living with HIV to be informed about their diagnosis as soon as possible
- To reduce risk taking in relation to illicit drug use
- To promote and enable diversion away from sex work

Services offered by MASH contribute towards the GM Sexual Health Strategy aims of eliminating HIV within a generation.

Location and Referrals

MASH offered mainly street outreach work. These services are offered flexibly, outside of working hours.

Referrals are often through agencies, including health and social care professionals, although self-referrals are also accepted. All female street and sauna sex workers aged over 16 are eligible for input.

Services and Interventions provided:

- A needle exchange service from community-based drug service one night/week
- A mobile distribution of clean injecting equipment
- Mobile distribution of condoms
- HIV screening and testing
- Hepatitis screening and vaccinations
- Signposting, advice, support and onward referrals to sexual health services
- Advice and support to women on how to exit the sex industry

Bury decommissioned MASH earlier this year due to less outreach activity in massage parlours, having previously contributed £10k towards the service, with Manchester covering the remainder of the contract value. There is a current needs assessment ongoing within MASH, the results of which will help inform whether there is an ongoing need for the service.

4. Engagement

Consultation with stakeholders was carried out in the form of two online surveys, one for service providers and the other for the wider public. These went live between 25th October to 29th November. This section will outline the findings from this consultation.

Service User Engagement

Demographics

A service user survey was conducted online across ORB, which had 304 responses. Breakdown of responses by locality is provided in the pie chart below:

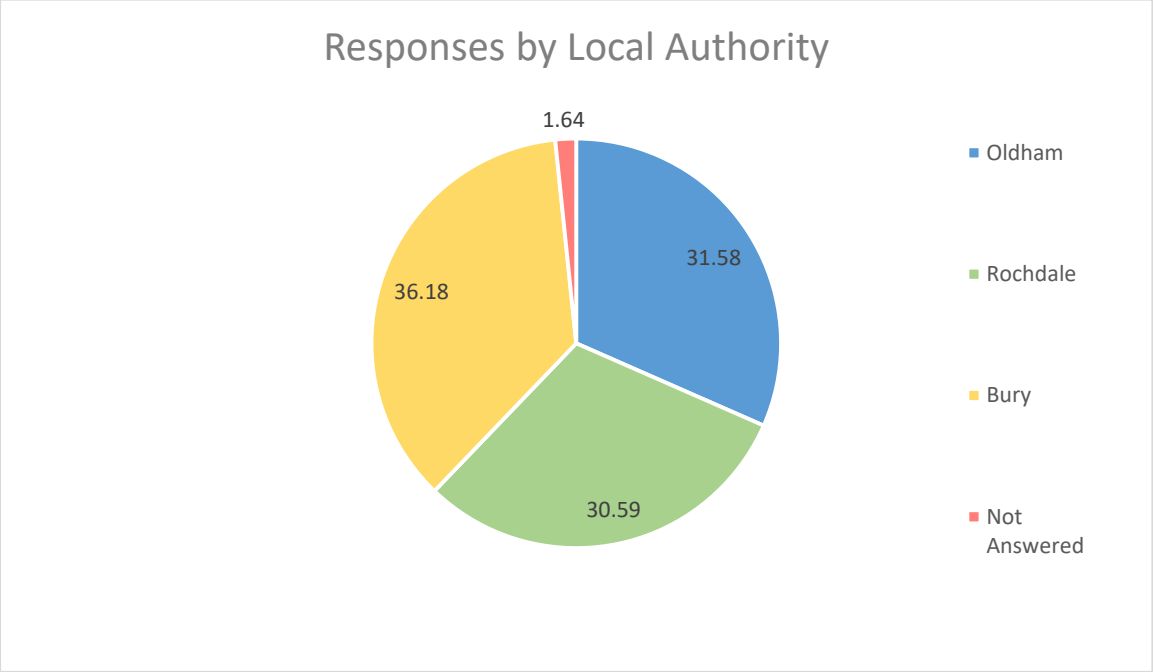

Figure 4.1: Service User Responses by Local Authority

Responses were slightly higher in Bury than Oldham and Rochdale overall.

The responses broken down by ethnicity were as follows:

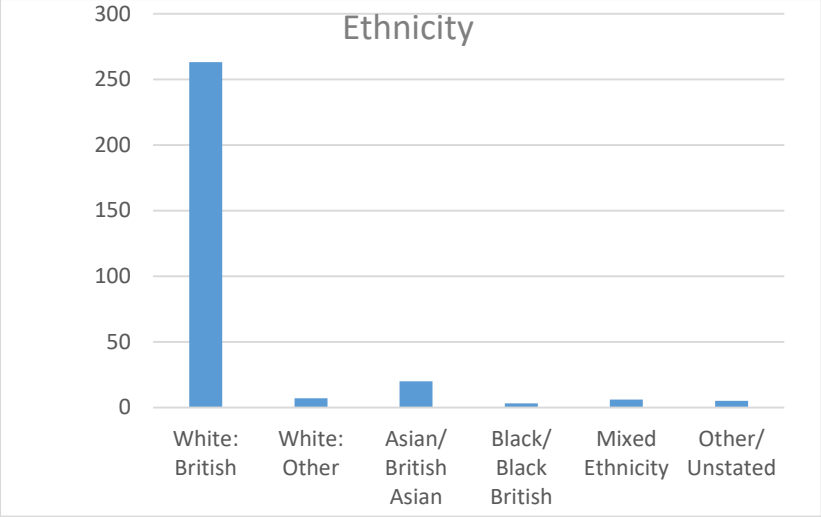

Figure 4.2: Service User Responses by Ethnicity

Just over 86% of responses were from people of a White British background, which is representative of the ethnic make-up across ORB.

In terms of gender identity, the breakdown of respondents was as follows:

Female: 81%

Male: 17%

Another way/ Unstated: 2%

Responses broken down by sexual orientation were as follows:

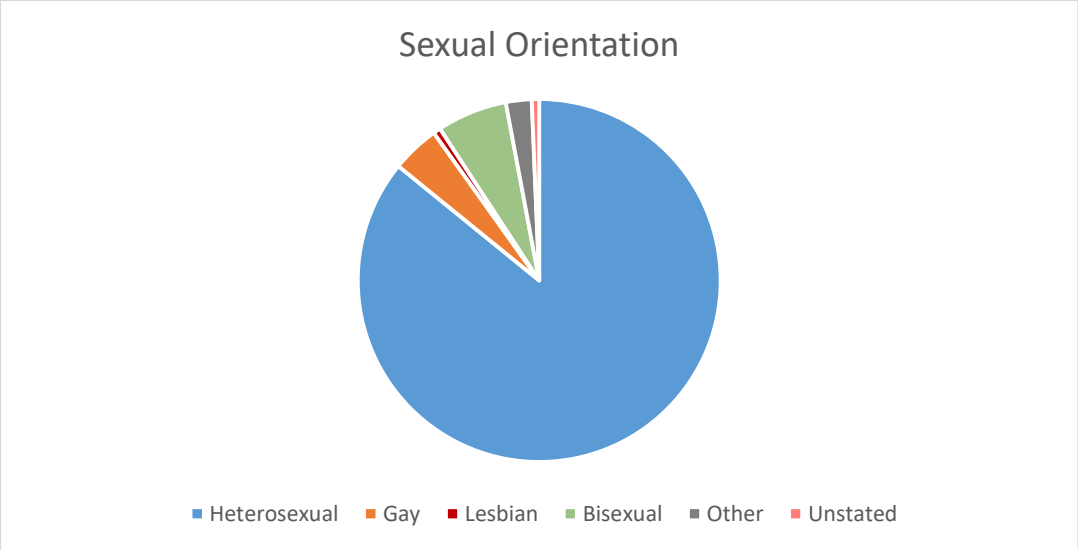

Figure 4.3: Service User Responses by Sexual Orientation

Almost 86% of respondents described their sexual orientation as Heterosexual. The second largest response were those identifying as Bisexual, followed by those identifying as Gay.

The age distribution of respondents is outlined in the chart below:

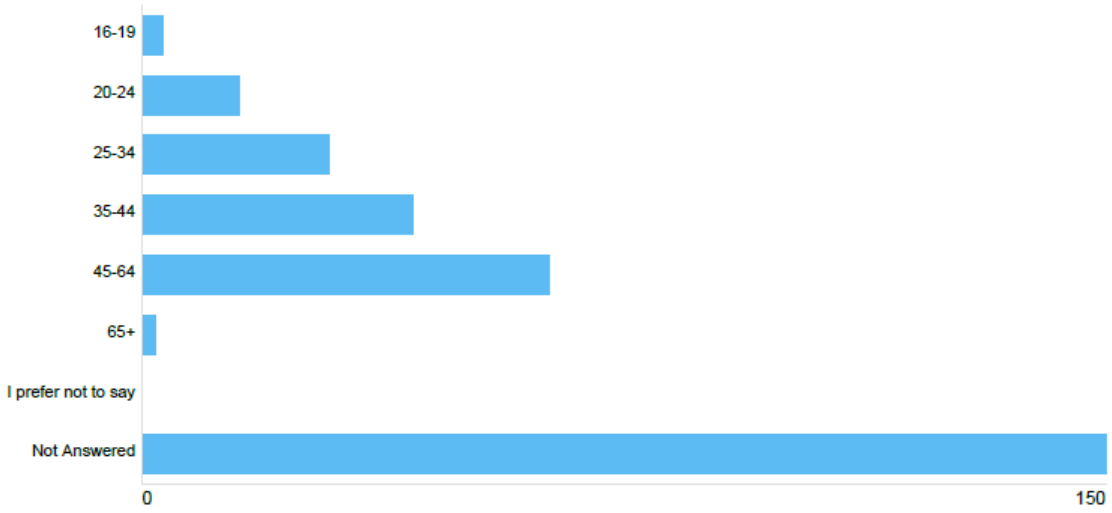

Figure 4.4: Service User Responses by Age

The highest responses came from those aged 45-64, followed by 35-44, then 25-34. It is important to note that due to a system error, the age groups for the first 150 respondents were not recorded, hence why there is a large proportion unanswered.

Access to Sexual Health Information

Respondents were asked whether they were able to access all the sexual health information they need. The majority of respondents (85%) responded in the affirmative, with just under 15% reporting that they could not access required information.

Among those unable to access the information required, reasons included not needing to access this information, and not knowing what information should be known. These respondents were asked where they seek out information about sexual health, responses are shown in the bar chart below:

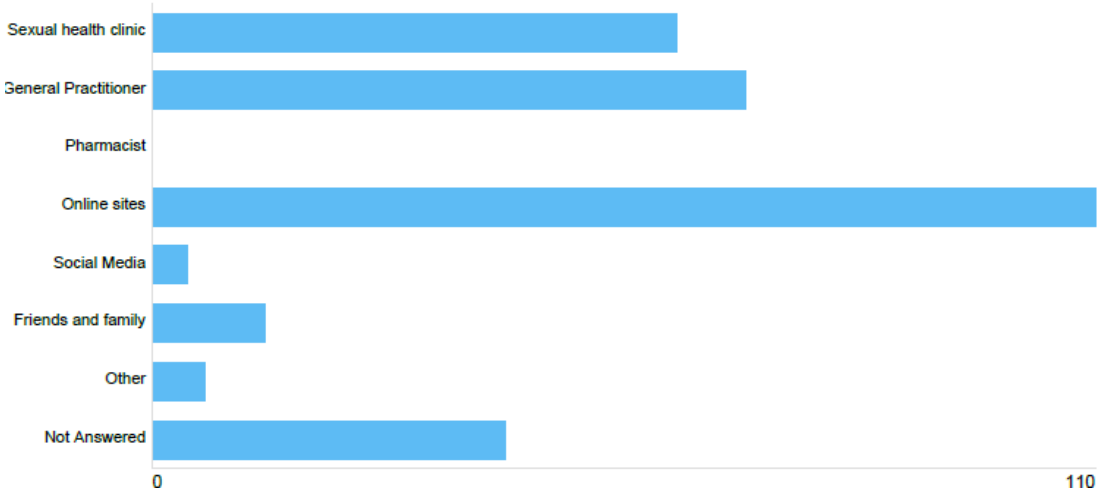

Figure 4.5: Sources of Sexual Health Information

It is important to highlight that the most popular source of sexual health information is online sites, this is followed by GPs, and sexual health clinics. When grouped into health and non-health sources, most people do seek sexual health information from health sources, most commonly GPs and sexual health clinics.

Of note, none of the respondents reported seeking sexual health information through pharmacists.

Using Sexual Health Services

Reasons for not using SH services

Almost 56% of respondents reported not using ORB sexual health services in the last two years. The largest age group not accessing services are those aged 45-64, with 35-44 next.

Reasons for not accessing SH services in ORB:

- Not needed
- Unable to access
- Unaware of services
- Stigma

These are outlined in more detail below.

The most common reason for not using sexual health services was there not being a need for sexual health services, as the respondent is either not sexually active, post-menopausal or trying to conceive. This highlights that some respondents are unaware of the full role of SH services, as there may still be a need for SH services despite undergoing menopause.

Almost 1 in 5 respondents answering this question highlighted that the location or opening times of local services were not suitable, or that they were unable to get an appointment.

A common reason for not accessing services was a lack of knowledge of what services are available locally. Of note, the vast majority of those reporting that they don't know of available services live in Bury or Oldham, compared with a very small number in Rochdale.

A small number of respondents reported not accessing SH services in ORB due to concern about experiencing discrimination, preferring to access other settings outside of ORB. Furthermore, some respondents highlighted not attending due to being embarrassed to access a SH clinic.

Using SH services

44% of participants reported using SH services within the last two years, with around 18% of those answering having used the services within the last 4 weeks.

Contraception

Almost 3 in 4 respondents who do use SH services use contraception. The most common types are outlined in the table below:

Type Of Contraception		**Percentage**
LARC		**45%, of which:**
	Injection	12%
	Implant	11%
	IUS/ IUD	21%
Pill		**37%**
Barrier		**15%**
Other		**0.03%**

Table 4.1: Types of Contraception Used

As demonstrated, 45% of respondents use LARC, with the second most common method being the pill. Of note, only 20% of respondents using LARC have accessed this through their GP, with the rest through sexual health clinics.

The majority of respondents accessed contraception through SH services, with GPs being the second most popular choice. Only 6% of participants reported accessing contraception through their pharmacists. This is shown by the chart below:

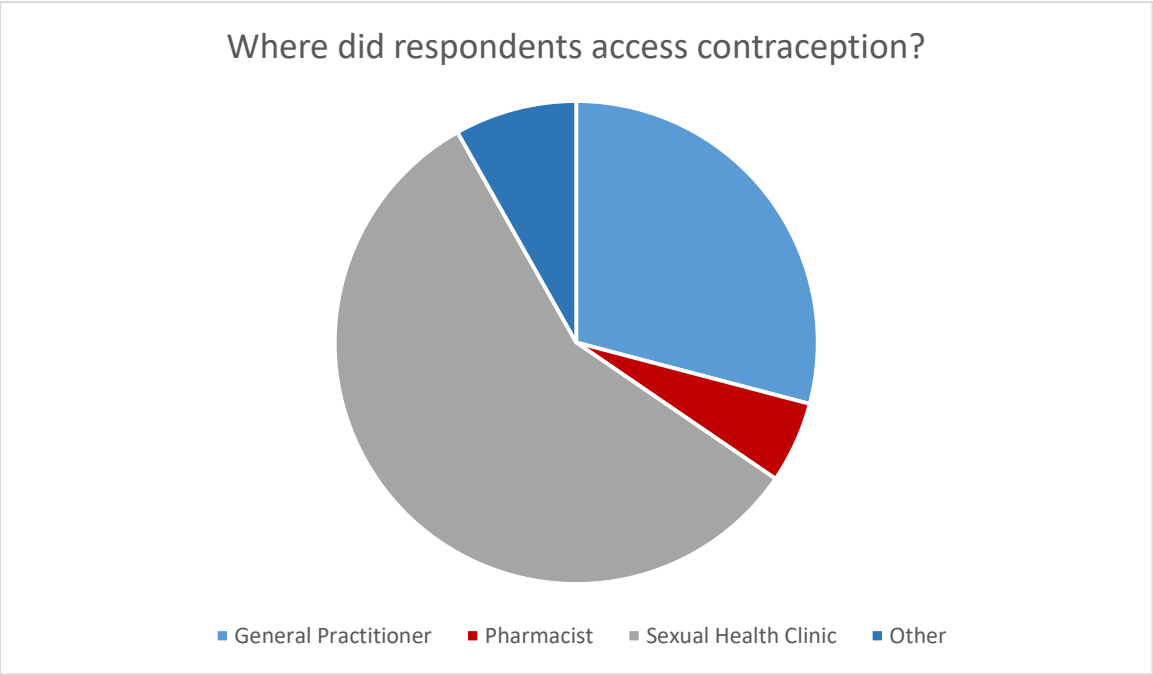

Figure 4.6: Access to Contraception

Challenges accessing contraception

Respondents using contraception were asked whether they faced difficulties accessing their preferred method of contraception. 37% of respondents highlighted that they did face difficulties.

These difficulties mostly included inability to get an appointment with long waiting times particularly, which can at times be as long as 3 months. Many highlighted a lack of capacity in walk-in clinics which are often full immediately after opening, and many people turned away. This meant they had to be without contraception for a period of time.

Some respondents highlighted difficulty accessing contraception due to age limits in clinics, and opening times that are unsuitable for people in full time employment. Many participants felt there had been a drop in quality over the last 3 years in services, with some attributing this to the switch from NHS to Virgin.

Almost half of the participants using contraception highlighted they would rather access this from somewhere other than where they do access. The responses are shown in the table below:

Where would you prefer to access contraception?	**Percentage**
General Practitioner	48%
Pharmacist	28%
Sexual Health Clinic	10%
Sexual Health Outreach Service	9%
Other	5%

Table 4.2: Service User Contraception Access Preference

Responses in the 'other' category included a postal service, with the majority preferring online access. As demonstrated, there is a strong preference for contraception to be provided through GPs and pharmacists.

Emergency Contraception

Of respondents who reported using contraception, almost 1 in 3 have previously used Emergency Hormone Contraception. Of those answering how many times they've use it, almost 70% reported using EHC just once in the last 12 months.

More than half of the respondents using EHC accessed this through their pharmacists, with 1 in 5 going to sexual health clinics. Only 7% of respondents accessed EHC through their GP. Almost 78% of those using EHC reported being satisfied or highly satisfied with the service, advice and information received.

14% of respondents using EHC reported difficulties with access. These were often either due to a lack of appointments in sexual health clinics, and pharmacies not offering EHC.

Of those seeking EHC, almost 70% were offered advice about other forms of contraception. Those not receiving advice about other forms of contraception mostly sought their EHC from pharmacies. Those accessing EHC from GPs and sexual health clinics reported having received advice about other forms of contraception.

Sexual Health Risk Perception

Respondents who use sexual health services were asked what they perceived their risk of getting an STI to be, taking in to account their lifestyle.

STI Risk

85% of the respondents perceived themselves to be not at all at risk, or not very much at risk of acquiring an STI, the examples given were Chlamydia or Gonorrhoea. Almost 11% thought themselves to be at great risk, or at high risk, with the rest of the respondents not knowing their risk.

Those considering themselves at high risk most often thought this to be due to being sexually active, equating being sexually active with being at risk of STIs. Some described this to be due to partners not using condoms. Certain factors were thought by participants to decrease their risk of STIs, for example regular check-ups, the use of contraception, and being in a long-term relationship with the same person.

The proportion of participants identifying themselves at high risk of STIs are broken down by sexual orientation in the chart below. Of note, the highest groups were heterosexual females and gay men, with heterosexual males and bisexuals considering their risk of STIs to be low. Note, however, that numbers of responses were small and should be interpreted with caution.

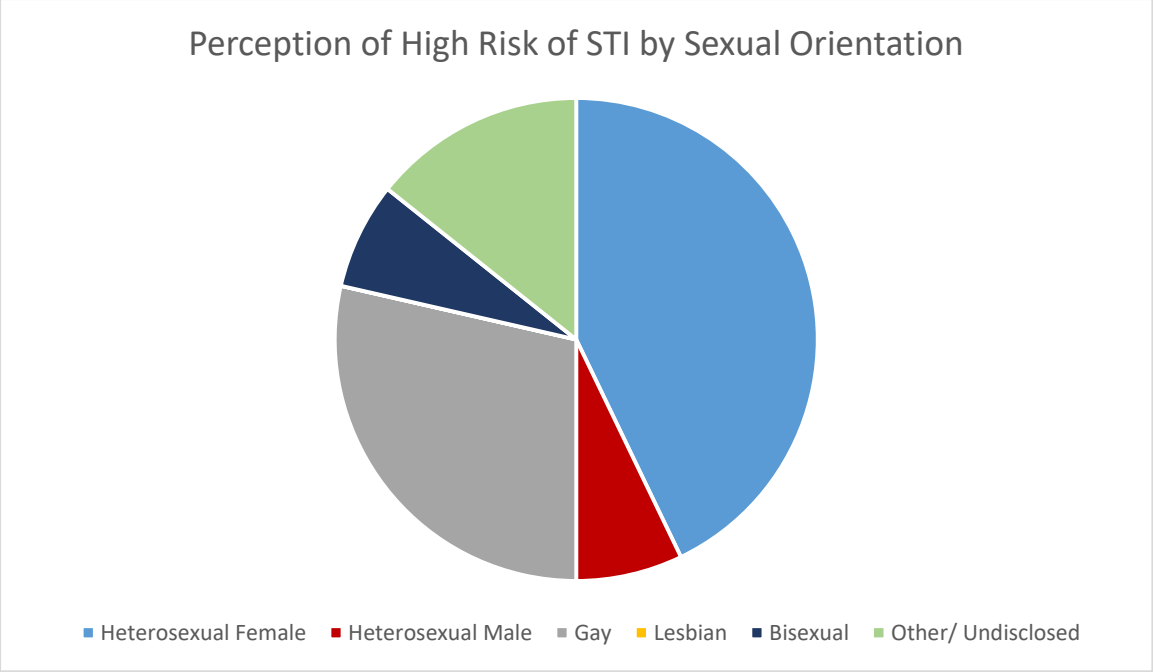

Figure 4.7: Perceptions of High STI Risk by Sexual Orientation

HIV Risk

The following question asked about perceptions of being at risk of HIV.

88% of respondents perceived themselves to be not at all at risk, or not very much at risk of acquiring HIV, with just 6% perceiving their risk to be great or high. The remainder of the respondents did not know, or did not wish to disclose in equal parts. Reasons for low perceptions of HIV risk most commonly included being in a long-term relationship with one partner. Of note, many participants highlighted that, owing to their being heterosexual, they did not perceive themselves to be at risk of contracting HIV. Barrier contraception was also frequently noted as a reason for low HIV risk.

A high proportion of those considering themselves to be at high risk of HIV identified as gay men, however, the highest proportion were heterosexual females. Of note, respondents identifying as heterosexual males, bisexual or lesbian did not perceive themselves to be at risk of HIV – however, numbers of responses were small and should be interpreted with caution. Reasons were not offered for perceptions of high risk of HIV.

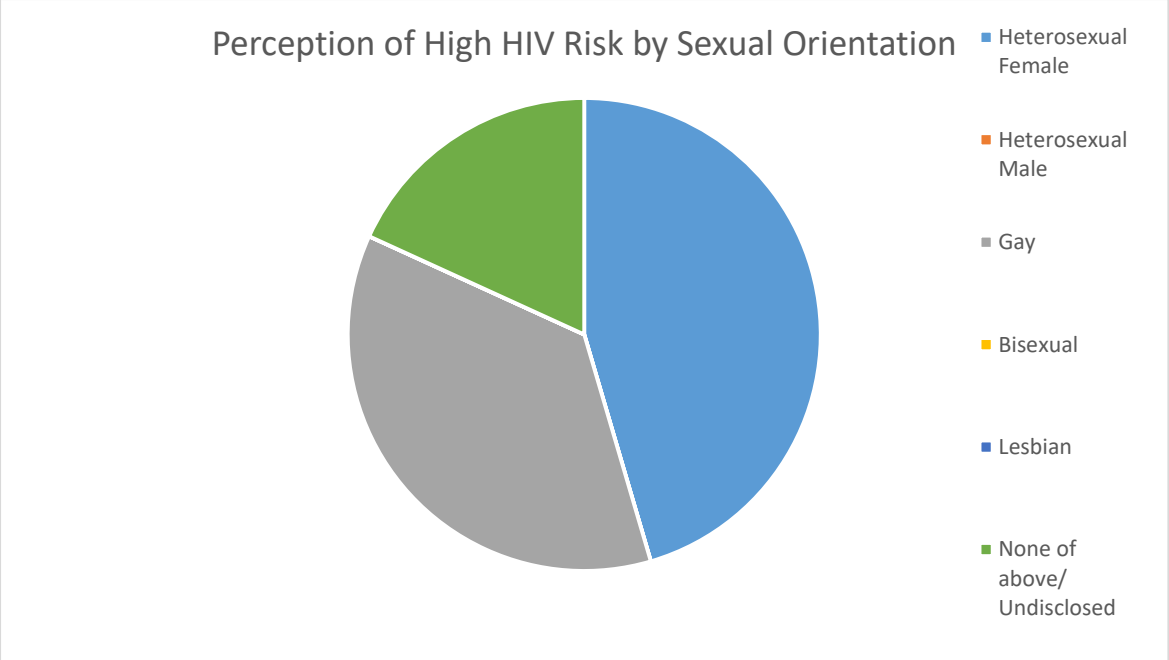

Figure 4.8: Perceptions of High HIV Risk by Sexual Orientation

Risk Management

Respondents were asked what actions they would take if they believed themselves to be at risk of an STI.

The large majority of respondents identified that they would access professional help via a sexual health clinic, or try to ring a sexual health clinic. A smaller group suggested they would seek help at GP surgeries – this was often due to barriers to accessing a sexual health clinic, such as unavailability of appointments, or age barriers, or having lost faith in the service as one respondent described.

Very few participants reported seeking help online, with some saying they wouldn't trust an online STI self-diagnosis kit.

Few respondents would speak to a friend, or go to A&E for help. Interestingly, none of the respondents reported accessing testing through a pharmacy.

STI Testing

Almost 40% of respondents who had accessed sexual health services were tested for STIs in the last 12 months.

Those who have been tested for an STI in the last 12 months accessed testing through various routes, demonstrated by the chart below:

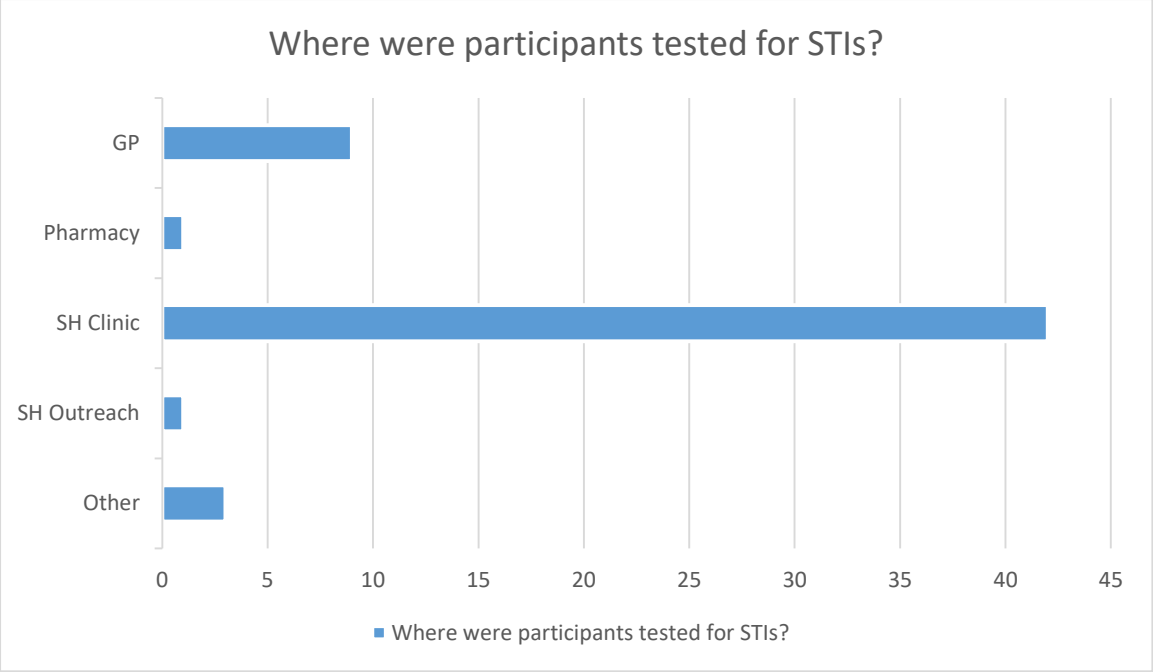

Figure 4.9: STI Testing Sites

As demonstrated, sexual health clinics (78%), followed by GP surgeries (17%) are the most popular venues for STI testing.

About 1 in 5 respondents accessing STI testing in SH clinics or GPs reported being dissatisfied or highly dissatisfied with the service, advice and information received, and 1 in 4 reported facing difficulties.

Difficulties reported most frequently related to inability to access clinics due to waiting times and low capacity. Many respondents were upset at having been turned away multiple times and having had to take time off work that day with no guarantee of being seen. Some respondents reported waiting weeks or even months to be seen, with some waiting weeks despite a positive test. This made some participants resort to postal self-testing kits, which were often seen as inaccurate. Some participants believed the delay in testing or treatment resulted in health complications.

Almost half of respondents would have preferred to access STI testing in a different setting to where they were tested. This is demonstrated by the chart below. Interestingly, a significant proportion of respondents would like to access STI testing in pharmacies.

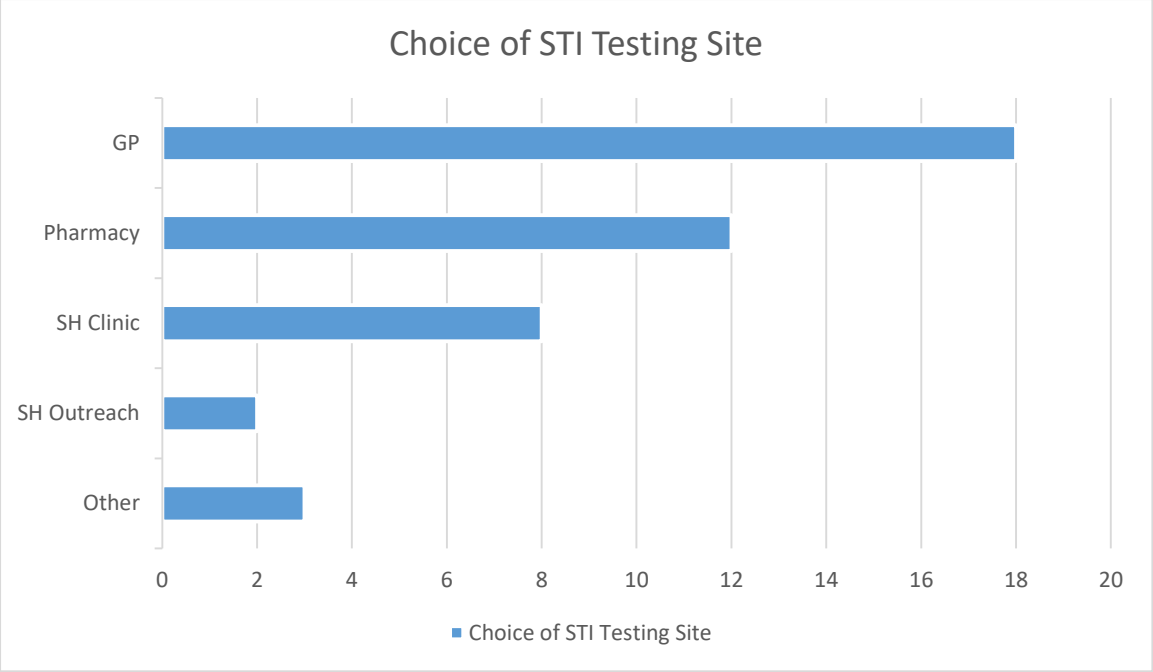

Figure 4.10: STI Testing Sites Preference

Respondents preferring other sites mostly wanted postal kits. Many used this opportunity to highlight that they would like to be able to access SH clinics with more out-of-hours appointments available.

Cervical Screening

The next set of questions related to cervical screening. 70% of respondents had been invited for cervical screening.

The 30% who had not been invited were not due to being male, being biologically male or being too young. Very few respondents reported not being invited for cervical screening despite being within the age-range for screening and having a cervix. This needs to be investigated as part of improving access and widening reach of cervical screening.

Of those invited for screening over the last 5 years, almost 90% reported attending. Of those attending, 90% did so at their GP surgery, with 5% at SH clinics, and 5% in other locations. Participants accessing cervical screening were mostly satisfied, or highly satisfied, with the service, advice and information received. However, 1 in 8 participants reported being dissatisfied, or highly dissatisfied. Overwhelmingly, the reasons were due to inability to make an appointment due to them being in working hours, or due to a long waiting period, sometimes several months. Some participants were refused at SH clinics, who do not provide the service, and were upset due to being unable to make an appointment with the GP.

Those who did not attend, reported many reasons. Some women had not been due to it not having been clinically indicated, or having just turned 25 and are awaiting an appointment. However, of

note, many respondents did not attend due to structural barriers such as inconvenient appointment times and being unable to get time off work. Another frequently recurring theme was that of embarrassment, some women reported being more likely to attend if appointments were offered outside GP surgeries. A small number of participants reported their lack of engagement due to not wanting the screening, forgetting to make an appointment, or due to being afraid of the procedure.

How to Improve Sexual Health Services

Respondents were asked how they feel local sexual health services could be improved. Comments were analysed, with five main themes being identified, namely: service reconfiguration, widen access, increase capacity, education and promotion. Each of these will be discussed in more detail below.

1. Service Reconfiguration

Participants felt that current sexual health services required big changes.

In terms of GP sexual health services, increasing capacity for GP-delivered sexual health and contraception services was seen as important.

The introduction of cervical screening at sexual health clinics in order to streamline services, and avoid multiple appointments was suggested. Additionally, more privacy in the waiting area and during check-in were highlighted, where several participants expressed discomfort at confidentiality breaches within these settings.

In order to improve the quality of current services, it was suggested that patient feedback be sought, as well as taking in to account personal preferences of individuals. Improving infrastructure was also highlighted by many participants, specifically improving appointment-booking systems, phone lines and online services, ensuring accurate information is available on websites. The availability of parking spaces was also suggested as a barrier in many clinics.

The introduction of psychosexual counselling was seen as important by some participants, while others suggested the re-introduction of a ‘one-stop’ family planning clinic. The use of online repeat prescriptions for contraception was also suggested in order to free-up appointments at GP and sexual health services.

Finally, many participants linked the switch from an NHS provider to private, and specifically Virgin Care, with a reduction in quality of services. Many participants therefore recommended switching back to the NHS and removing the contract from Virgin Care.

2. Widen Access

Many respondents felt that there are barriers leading to limited access to sexual health services, both in GUM clinics and at GP surgeries. These were mostly described in terms of age, where many

clinics had age restrictions to under 21s, and limited capacity for older age-groups to access services. Other barriers related to availability of out-of-hours clinics.

In order to widen access, it was suggested that more use be made of online testing and online appointment booking. It was also suggested that, in order to minimise disruption to working people, consideration of a 'one-stop' clinic for all sexual health services be made, which could include screening, testing and treatment.

Wider geographical distribution of clinics was suggested, as it was highlighted that most services are located centrally and can be far away to access.

It was also suggested that improving sexual health service provision in pharmacies would improve access across localities.

3. Increase Capacity

One of the most recurring comments in order to improve sexual health services in ORB related to increasing capacity within existing services.

Many participants outlined the need for more, longer, and out-of-hours appointments, particularly evening and weekend appointments. Many responses also highlighted the need for more appointments available for those over the age of 21. This included improving access to drop-in clinics, with a larger volume of drop-in clinics, and longer opening hours.

It was highlighted that staff shortages were often the cause of difficult access and so many participants outlined the need for more staff and nurses.

Relating to limited capacity, participants described the long waiting times for GUM clinics and GP appointments, particularly for accessing contraception.

This limited capacity for sexual health services across ORB was linked to negative outcomes by some participants, with some describing seeking help out of area, in other localities, and others describing delays in treatment post-testing, which led to complications. There were frequent descriptions of being turned away from drop-in clinics due to full capacity, and the negative impact this had on work, due to having to miss time off work.

4. Education

Many respondents felt there was a need for better education. This related both to staff development, but also wider public education.

In terms of staff development, suggestions were made to increase the number of professionals trained to do cervical screening or able to provide advice on other sexual health, or gynaecological issues. Suggestions were also made to improve the understanding of the needs of the LGBT community among health professionals.

In terms of wider public education, many participants outlined a need for sexual health and relationship education, including issues of consent. This was thought to contribute to reducing the stigma associated with sexual health. It was suggested education should be targeted at younger people through schools and colleges. However, education was not just linked to younger people, with some respondents suggesting need for increased awareness of STI/HIV risk among those in older age groups. Some respondents felt that health promotion through distribution of condoms would increase awareness and knowledge of contraception.

5. Promotion

The final theme of promotion related to publicising services, and also improving sexual health promotion.

Many participants suggested raising awareness of, and signposting to, available services, particularly among younger people and hard to reach communities. It was suggested promotion should be across community settings, such as shopping centres and bars, as well as through social media.

Provider Engagement

The provider survey was completed by 70 individuals across a variety of organisations and within various roles.

Roles included:

- Service managers
- Doctors from primary and secondary care
- Nurses from primary care, sexual health services, outreach teams, health visiting and school nursing
- Pharmacists
- Therapists
- Admin staff

Organisations included:

- GP surgeries
- Pharmacies
- SH/ YP Outreach Teams
- Integrated Sexual Health Services (Virgin Care)
- Voluntary, Community and Social Enterprise organisations e.g. LGBT Foundation
- Children's Centres

The proportion of respondents by locality is displayed in the following chart:

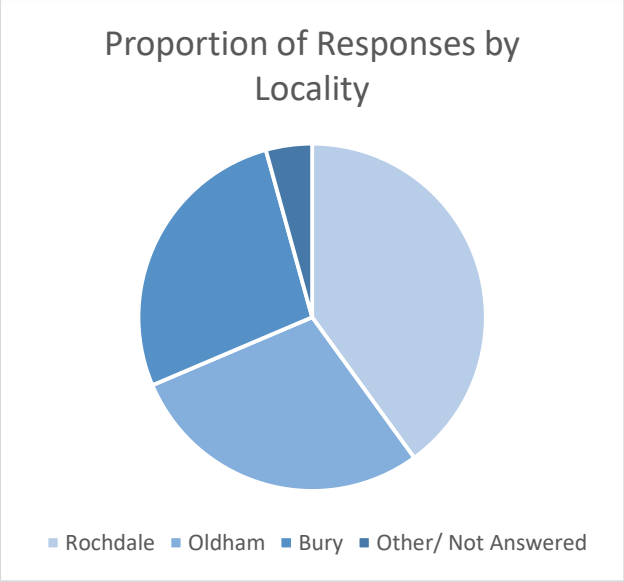

Figure 4.11: Provider Staff Response by Locality

1. Knowledge of local Sexual Health Referral Pathways

Knowledge of local sexual health referral pathways was generally reported as good, with 71% feeling confident in their knowledge.

Among those not feeling confident, this made up around 28% of responses equally between local authorities, and was evenly distributed among professions, with medical and nursing staff, as well as pharmacists and managers reporting not being confident in their knowledge of sexual health services.

Gaps in knowledge were outlined with the most commonly raised being knowledge of up to date services provided, their locations and opening times, as well as waiting times. Suggestions were made for patient leaflets to be handed out with up to date information. One participant highlighted that the wrong information on opening times or locations was sometimes on websites. As a result, some respondents relied on online information and an online search engine to find out about local services.

Mention was made of the constant changes to referral pathways, as well as not knowing how to refer patients for acute or immediate care. Some participants felt they didn't know what the gaps in their knowledge were.

2. Sexual Health Promotion

The next question asked respondents how effectively sexual health promotion was delivered locally. This question had a range of responses as outlined by the graph below:

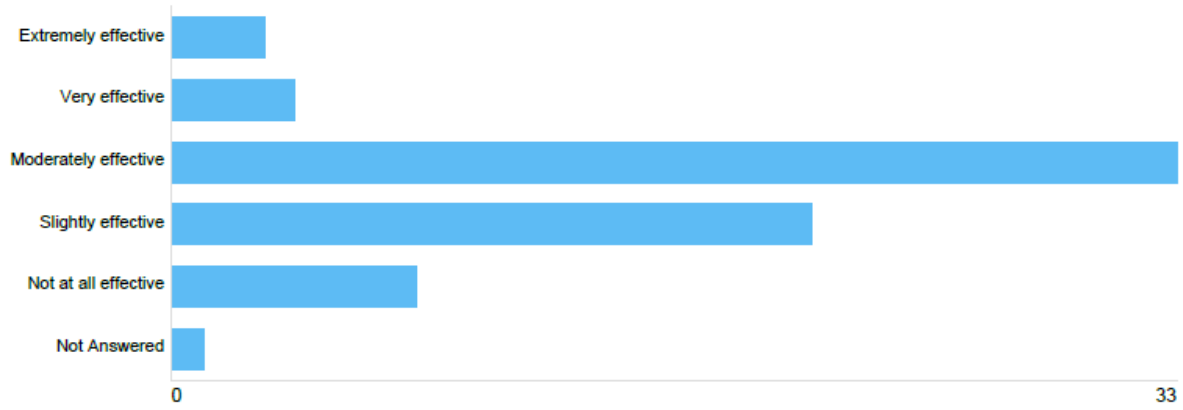

Figure 4.12: Effectiveness of ORB Sexual Health Promotion

The majority of respondents felt sexual health promotion was delivered moderately effectively in their locality. Those finding local sexual health promotion 'not at all effective' were mainly GPs in Rochdale and Bury, as well as VCSE staff.

There were, however, many suggestions for improvement from participants, which centred around 4 key themes: improving funding of SH services, improving access to available services, ensuring wider promotion particularly around schools and colleges, and improving information available for professionals seeing patients. These are described in more detail below:

Improve funding of services

Many participants outlined how the lack of funding for sexual health promotion and services means there are long waiting times, for example for contraception. This also means drop-in clinics are full within a short time of opening, meaning people are regularly turned away.

Furthermore, the lack of funding means decreased outreach efforts to address the needs of hard to reach groups due to prioritising activities.

A comment was made regarding using every opportunity to address the sexual health needs of patients, which was not always done. For example, patients informed cervical smears are only provided by GPs, thus increasing pressure on GPs and potentially reducing uptake of positive sexual health interventions.

Services such as the youth outreach service was regarded very positively; however, understaffing means it has limited capacity.

Improve access to SH services

This ties in with the previous theme, where many respondents suggested increasing the number of clinics available, as well as providing longer opening times outside of working hours, in order to avoid turning patients away. This would improve access to teenagers and young people in general.

There were issues highlighted regarding maintaining confidentiality of patients within waiting rooms, the absence of which could alienate some service users.

Some barriers to access were cited, including wrong information on websites regarding opening times and clinic sites, as well as tailoring drop-in sessions to young people, and not meeting the needs of older service users, meaning they have to seek contraception elsewhere.

Ensure wider sexual health promotion

Suggestions within this theme mainly addressed improving sexual health promotion in schools and colleges by trained professionals such as school nurses. An acknowledgement that early intervention is more effective formed the basis of these suggestions. This was often seen to be limited due to school nursing staffing pressures, and access to some faith schools.

Wider promotion in the community was also highlighted, with suggestions for sexual health promotion events across community settings.

Improve information available for professionals

Professionals from various backgrounds highlighted a lack of uniform, accurate information about local sexual health services. It was highlighted that sometimes service users are provided with inaccurate information from other professionals.

To overcome this, suggestions were made for monthly email updates with local services available, or information packs for pharmacy and primary care staff. Training of staff around sexual health promotion was also suggested, as well as provision of dedicated health advisors to promote accurate information, and overcome the time pressured environment of consultations.

3. Interactions with providers

The following question asked participants to describe their interactions with local sexual health providers.

Around half of the respondents reported having minimal or no interaction with providers. This was for a variety of reasons, including not needing to interact with them as patients self-refer, to being the only local provider, to not having established pathways and links to permit interactions.

Many of the participants reporting limited interactions were from GP surgeries and pharmacies, whereas, respondents reporting good interactions with providers tended to be sexual health nurses and school nurses across the three localities.

4. Barriers and Challenges to Sexual Health Services

This question asked participants to identify whether there are any barriers or challenges within their local sexual health services. Over 75% of responses reported barriers or challenges, with 17% responding in the negative, and the rest not answering.

Participants were asked to describe those barriers and challenges, and responses were analysed and grouped in to 4 key themes: capacity issues, staff knowledge, population reach and service infrastructure. Respondents were then invited to provide suggestions to overcome these challenges. The findings are outlined below.

Capacity Issues

One of the most frequently cited barriers facing sexual health services related to capacity issues. This referred to both staff and service capacity, as well as limited interventions.

Many respondents outlined how there was a great demand for sexual health services in the local community, which can be seen through long waiting times and patients being turned away from drop-in sessions due to being filled to capacity. This is compounded by reduction in number of clinics running, including weekend clinics, and age limitations in clinics meaning older patients often don't meet the criteria for drop-in sessions. This increases pressure on GP practices.

Frequent references were made to a lack of trained clinical staff, doctors and nurses, available to run the service; this means drop-in clinics sometimes don't have enough staff to cover. Furthermore, a lack of doctors was described to delay investigations and treatments which can only be ordered by doctors. Many respondents outlined how low numbers of nurses being recruited into sexual health services is affecting the running of existing services, as well as the declining number of GPs running sexual health sessions. These factors put pressure on staff, who are often dealing with a high workload and an impatient group of service users.

Many respondents also outlined how limited access to interventions cause barriers to improve sexual health outcomes, with inability of sexual health services to perform screening for cervical cancer due to this not being funded. This was described as impacting on patient outcomes.

Suggestions for increasing capacity included improving primary care provision of sexual health and contraception interventions, this involved funding GPs to provide routine contraception and asymptomatic STI screening, as well as better provision of services through pharmacies. It was also suggested that GPs take charge of repeat prescriptions which would ease off the pressure at GUM clinics and allow them to see more service users. Some suggestions referred to training practice nurses to provide oral and injectable contraception in order to free up appointments at GUM clinics.

Other suggestions related to increasing service provision through increasing SH service funding, which would allow more open-access drop-in sessions which have larger capacity, increasing the number of clinics and prolong their opening times. Suggestions for drop-in services in schools through the outreach team were cited, which have been well attended in Bury, this would include more funding to the outreach team.

Many suggestions focused on increasing recruitment of staff, including sexual health nurses and health advisers, and focus on improving retention rates.

Infrastructure

By far one of the most commonly cited challenges among local sexual health services relates to the technological infrastructure at provider settings. Specifically, this was described in the form of Virgin

Care telephones not working adequately, causing barriers to patient and public access to the service, which causes a backlog of complaints among primary care settings.

Another challenge refers to the IT infrastructure, which was seen as being of poor quality, thus impacting negatively during consultations, but also between professionals, where limited linkage of IT systems between SH services and primary care delayed care in terms of chasing investigation results, etc. Frequent comments related to the need for improved communication between GP surgeries and providers.

Suggestions to improve infrastructure were frequently made, with many respondents suggesting direct lines for each local service as opposed to a centralised line which was not working well. This involved also updating the telephone system which was not functioning effectively. IT infrastructure was seen as needing an update in order to facilitate linkage between hospitals and clinic settings; this was seen to make service provision more efficient.

Population Reach

Respondents cited limited population reach as a key challenge to local sexual health services. This was framed in the context of low engagement with sexual health services among the local population, which was thought to be due to sexual health being a stigmatised topic. This made accessing certain populations such as teenagers and members of the BAME community more challenging. This was felt to be exacerbated by a lack of suitable facilities to provide sexual health promotion, where it was acknowledged that GUM clinics are not best placed for this function.

Furthermore, respondents outlined there not being enough facilities for certain population groups, for example, older people do not fit the criteria for drop-in sessions meaning they are faced with long waiting times to be seen. Not all sessions are for young people, however, which outlines the need for accurate information to the population.

Access among certain population groups was also cited as a challenge, with limited access among working adults due to limited out of hours clinics. Moreover, access to faith schools and among faith communities remains low and challenging.

Suggestions for improving population reach included removing age barriers at clinics, involvement of local communities with decisions, and education. Education was described in terms of increasing provision of SH education in schools, including amongst faith schools, through taking up the offer of SH education provided by the outreach team; this was felt to be particularly pertinent in Rochdale. Education was also outlined in terms of facilitating dialogue among the community to destigmatise sexual health. A need for more health promotion in the community regarding sexual health and contraception use was frequently cited.

Staff Knowledge

Some respondents felt that inadequate knowledge of local services available was a barrier for them engaging with local sexual health services. This was described to be due to lack of information from and communication with sexual health providers.

Many suggestions to improve staff knowledge were highlighted and referred to offering training opportunities to medical staff, nursing staff and community workers, which was seen to improve motivation.

More generally, suggestions were made to involve staff in service development, taking in to account their expertise and leading to a more efficient service.

5. Empowering Individuals and Communities

This question asked how current sexual health services could better empower and support individuals and communities to make better informed decisions around their own sexual health.

Answers focused around widening sexual health promotion, improving accessibility to information and services, and promoting self-efficacy.

Widening Sexual Health Promotion

Participants felt more could be done to improve local sexual health promotion by taking a proactive approach and widening promotion across community settings. This could be using physical resources such as leaflets, posters, outreach events and educational public campaigns across settings such as libraries, leisure centres and shopping centres, and not just in GUM clinics. Moreover, it was suggested that this promotion be targeted to night clubs and massage parlours.

Suggestions were made for a dedicated outreach service to deliver these community resources outlined above. Another suggestion was using online social media and local press to reach more people in the community.

Starting conversations around sexual health and healthy relationships was seen as key to empowering the community and reducing stigma around sexual health. Educational settings, such as schools and colleges, were seen as key to provide earlier and better sexual health education, and engage in conversations. It was also highlighted that training frontline staff to have these conversations would avoid the subject becoming a taboo.

Improving Access to Services

It was acknowledged that many barriers exist to seeking sexual health advice and treatment, in the form of age limits on services such as drop-in clinics, cultural barriers preventing certain communities going to GUM clinics, and education and work commitments meaning a large proportion of the population are unable to attend weekday appointments. It was suggested outreach events in schools and colleges, and longer opening times of GUM clinics with increased capacity.

Moreover, it was highlighted that the current provision of sexual health services may alienate potential service users, for example, sexual health promotion targeting under 25s can be seen as inelegant or immature, which won't appeal to all under 25s. Also, publicising how to access services discreetly may enable members of certain BAME or faith communities to access the services.

Empowering the Community

Many responses centred on empowering local communities to practice autonomy and self-efficacy with regards to their own sexual health. Facilitating this requires providing accurate education to the community on sexual health prevention and testing, including reducing risks, healthy relationships and consent particularly among the younger population. Promotion of self-testing and facilitating access to self-testing kits and postal packs was seen as key, which could be provided via appropriate community settings. Equipping local communities with up to date information on availability of clinics was also seen as important. Finally, ensuring service user feedback is collected and utilised in service delivery was suggested as a method to empower the community and engage them with services.

6. Meeting the needs of local communities

This question asked participants whether they thought local sexual health services meet the needs of the local communities. Almost 70% of those answering didn't think this was the case, with a higher proportion in Bury feeling services didn't meet the needs of local people.

Reasons for this were provided along 3 key areas; limited resource, narrow range of services provided and limited reach.

Limited resources were outlined mainly in the form of high demand and low capacity. High demand is seen during drop-in sessions which fill up within a short time, meaning many patients are turned away; those unable to attend drop-in sessions or who are turned away have to wait up to 3 weeks for an appointment. Critical staff shortages mean there is limited capacity to expand, as there are few staff present who can carry out procedures such as LARC insertion. Due to this, there is limited capacity for opportunistic sexual health promotion, or providing outreach for at risk and hard-to-reach communities. Furthermore, unsuitable technological infrastructure such as inadequate phone services mean service users aren't able to access test results or sexual health advice over the phone, thus putting more pressure on services.

Many responses highlighted a narrow range of services offered in ORB. Many staff from GP surgeries expressed limited services offered, for example no LARC provision, basic STI screening only, no POCT or contact tracing and no condom provision. This was echoed by pharmacy staff who highlighted a limited choice in EHC provision which is not suitable for all service users. A need for psychosexual services was outlined, where it was suggested that a well-defined service does not exist currently.

The limited reach of current sexual health services was thought to affect the needs of local populations, where low engagement among teenagers was highlighted, as well as limited culturally appropriate settings.

Many respondents reported that once service users were seen, they were often happy with the service provided.

7. Workforce development

This question asked participants their preferences regarding information or training opportunities available to them in order to improve sexual health services. Options included information about

available services or referral pathways, education and training opportunities and networking opportunities. Answers are demonstrated by the graph below:

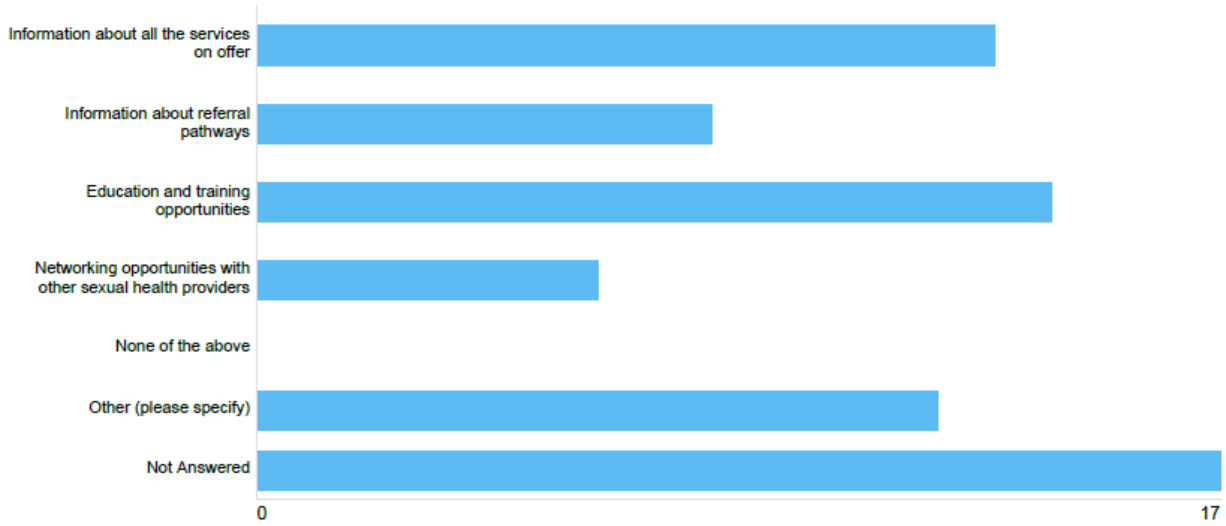

Figure 4.13: Priorities for Workforce Development

Examples of good practice across ORB sexual health services were outlined, and praise for the daily care provided by frontline staff under a time-pressured and understaffed environment was highlighted.

Other examples included the use of 'Pride in Practice' quality assurance and social prescribing programme in Oldham, which develops the relationships between primary care services and their LGBT service users.

Oldham ICC also highlighted the use of video counselling for patients who are prescribed LARCs.

8. Closing Comments

The final question asked participants whether they had any other comments. Many comments reflected the overall theme of high demand and low capacity.

Many responses identified the switch from NHS to private provider as a cause of the decline in the quality of care. This was thought to be due to a reduction in outputs such as clinic appointments and drop-in clinics, as well as a high staff turnover rate, inability of the provider to retain experienced staff and limited opportunities for workforce development. Furthermore, staff highlighted that they feel their needs aren't being met by the private provider. These issues combined were thought to have disrupted business continuity and led to decreased performance compared with previously. It was suggested staff surveys be conducted in order to share their expertise with the provider, as well as the provider to replace outgoing members of staff promptly.

Comments were also made regarding non-streamlined referral pathways which resulted in multiple attendances to different clinics by the same patient, which was seen as inefficient.

Inappropriate referrals and signposting from primary care also were seen to put further strain on GUM clinics. This was thought to be due to variations in sexual health provision across primary care settings.

Summary of Engagement

Service Users

SH Knowledge and Risk Perception

Most respondents indicated seeking information about SH through health services (GPs and SH clinics), with online websites the next most common source. None of the respondents sought information through pharmacies.

11% of SH service users perceived themselves to be at risk of STIs including Chlamydia or Gonorrhoea, compared with 6% perceiving themselves at risk of HIV. Heterosexual females and gay men perceived themselves at highest risk of both. Being at high risk was thought to be due to engaging in sexual activity, and reduced risk was linked to regular health check-ups, use of contraception and long-term relationships. Many respondents perceived being at low risk of HIV due to being heterosexual.

Access

Over half the respondents did not use SH services, the most common reasons being that there was no need to; however, a large proportion of respondents reported not being able to access services, either due to limited capacity of services, or unavailability of out-of-hours services, being unaware of existing services, or fearing discrimination.

Contraception

The most common types of contraception used were LARCs, with user-dependent methods such as oral pills next. This was most often sought through SH clinics. Challenges to accessing contraception overwhelmingly related to difficulty accessing services, with long appointment waiting times, and lack of capacity at drop-in clinics. Most respondents highlighted they would prefer accessing contraception through their GPs, with pharmacies the next most popular response.

Emergency contraception was mostly accessed through pharmacists, followed by SH clinics. 78% were happy with the service and advice provided; however, some reported difficulty accessing EHC, either due to lack of capacity at SH clinics or due to pharmacies not offering EHC.

STI Testing

The majority of STI testing (78%) was carried out in SH clinics, with GP surgeries the next most popular sites (17%). However, difficulties with access at SH clinics were highlighted repeatedly.

Given a choice, 41% respondents would prefer to be tested in a GP surgery, and 28% in pharmacies. Only 19% of respondents would like to be tested for STIs in SH clinics. Suggestions were also made for postal/online testing kits.

Cervical Screening

90% of cervical screening took place in GP surgeries. 7 in 8 participants were happy with the service and advice offered, however, the remaining 1 in 8 reported difficulties with access, due to appointments often being during the working day, and a lack of out-of-hours appointments.

Improving SH Services in ORB

These were suggested along five main themes:

- Service reconfiguration
- Widen access
- Increase capacity
- Education
- Promotion

These are outlined in more detail in the text.

Providers

Knowledge of SH referral pathways

Almost 3 in 4 respondents reported feeling confident in their knowledge of local SH referral pathways. However, gaps in knowledge most often related to a lack of up to date knowledge of available services.

Sexual Health Promotion

Suggestions for improving sexual health promotion in ORB included improving funding of SH services, improving access to services, wider promotion in schools and colleges, and keeping professionals up to date with available services. These are expanded on in the text.

Interactions with providers

Responses suggested very low levels of interaction between GPs and SH clinics and other services providing SH services.

Barriers and challenges to SH services

These were grouped in to four themes: capacity issues, staff knowledge, population reach and service infrastructure. These are expanded on in the text.

Empowering individuals and communities

This question asked how current sexual health services could better empower and support individuals and communities to make better informed decisions around their own sexual health. Answers focused around widening sexual health promotion, improving accessibility to information and services, and promoting self-efficacy. These are expanded on in the text.

Meeting the needs of local communities

Almost 70% of those answering felt that the needs of local communities were not being met, with a higher proportion in Bury reporting that services did not meet the needs of local people. Reasons for this were provided along 3 key areas: limited resource, narrow range of services provided and limited reach.

Workforce development

There is a need for educational and training opportunities for staff and provision of information around services and referral pathways.

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