



SEXUAL HEALTH NEEDS ASSESSMENT FOR TAMESIDE

June 2015

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Abbreviations

CCG – Clinical Commissioning Groups

CPH - Centre for Public Health

EHC – Emergency Hormonal Contraception

HIV – Human Immunodeficiency Virus

HPV – human papillomavirus

ICBI – Interactive Computer Based Interventions

ISHS – Integrated Sexual Health Service

LARCs – Long Acting Reversible Contraception

MBC – Metropolitan Borough Council

MSM – Men who have sex with men

NCSP – National Chlamydia Screening Programme

NICE – National Institute for Health and Care Excellence

PHE – Public Health England

SRE – Sex and Relationship Education

STIs - Sexually Transmitted Infections

Acknowledgments

Thank you to David Armitage for providing on going advice and support throughout the production of this document and for sourcing information. Thanks to Alison Bohannon, Matthew Birchall and Jacqui Dorman for support with public health intelligence. Thank you to those members of the team and providers of sexual health services who took the time to comment on draft versions of this document.

1. Executive Summary

This desktop sexual health needs assessment is intended to present a review of the sexual health needs and current service provision for sexual health in Tameside. It will be used to update the Tameside Sexual Health Strategy and to support the development of a business case. Below is a list of the main suggested interventions, this is followed by a summary of each section within the needs assessment.

The key objectives and key interventions for consideration are:

1. Objective: reduce the rate of new STIs and reinfection
 - a. Intervention: Develop a service to enable free access to condoms
2. Objective: reduce unplanned pregnancies and abortions
 - a. Intervention: Improve uptake of Long Acting Reversible Contraceptives (LARCs)
3. Objective: target young people as this is the age group with the highest rate of STIs.
 - a. Intervention: develop a full package of interactive computer based interventions (ICBI)
4. Objective: offer targeted interventions to the young people who are most at risk of sexual ill-health
 - a. Provide increased support within a whole systems approach to vulnerable young people, such as looked after children and young offenders
5. Objective: increase utilisation of sexual health services by young males
 - a. Consider targeted promotion and or develop a standardised approach to partner notification.
6. Objective: to provide a high standard, quality assured approach to the delivery of sexual health services across all providers.
 - a. Shape the integrated sexual health service (ISHS) to provide a greater support function to primary care and other providers

Prevention

Most of the current spend is on secondary and tertiary prevention and although Tameside has invested in YouThink which has a specialist youth outreach worker there could be a greater focus on primary prevention. There is a provider led group focused on young people so there is an opportunity to utilise this and the Tameside Metropolitan Borough Council (TMBC) lead role for sexual health and for school nursing to review the sexual health strategy for young people and its links with wider health issues (alcohol for example). This

could also include a greater clinical aspect to the outreach provision so that if clinical issues are identified these can be addressed.

Given the burden of sexual ill-health is disproportionately greater in some groups, there should also be an increased focus on targeted interventions for and with vulnerable young people in line with NICE guidelines. Young people with low educational attainment looked after children and youth in the criminal justice system are thought to be more at risk of engaging in sexual behaviours which may have a negative health impact and tend not to attend primary care or community health services on a regular basis. Although there is a worker dedicated to vulnerable young people, a whole systems approach is required to support the development of a package of one-to-one interventions, perhaps using an empowerment model, to take into consideration wider issues such as alcohol use and self-esteem.

In addition to the prevention strategy for young people there should also be a prevention focus with specific aims and objectives for those aged over 25. This should include contraception, reducing unwanted pregnancy, safer sex at all ages and address the needs of those with a physical disability and chronic illnesses on sexual well-being. In addition the needs of Gay and Bisexual men need to be addressed as this population is significantly more likely to have poorer sexual health outcomes.

Demography

Predicted population changes (2015 to 2020) indicate Tameside will have slightly less young people which may reduce STI contacts and an increase of 25 to 39 year olds which may result in more contraceptives being prescribed and may impact the number of abortions.

Service Provision

The Integrated Sexual Health Service (ISHS) are by far our biggest provider; its central hub is at Ashton Primary Care Centre. This may be an opportune time to review the service provision and change the function slightly to increase their role in co-ordinating and supporting the other providers; to ensure a standardised high quality approach across all services, increase capacity within primary care, and expand services such as condom provision. It may be possible to achieve this by reducing follow-up attendances for contraception and reviewing roles.

Another area for consideration is to review the locations of sexual health provision and ensure they are located according to need, such as in areas of deprivation and high population density. For example, the Hyde and Hattersley clinics are relatively close to one another yet there are no specialist sexual health clinics near the intersection of Stalybridge North and South and Dukinfield Stalybridge.

Given that primary care is the main provider of female contraception and has such an active role in sexual health it may be worth looking at ways for the ISHS, working with the GP Sexual Health Lead, to support primary care to build capacity and continue to improve quality of the provision.

We already have sixteen pharmacies delivering Emergency Hormonal Contraception (EHC); consideration should be given to expanding the number and role of pharmacies.

Women are attending sexual health services more than men, consideration needs to be given as how to improve uptake, particularly for young males so that they can engage more with sexual health services. One way to do this is to work with providers to further improve and standardise the systems and processes for partner notification.

Spend

Consideration should be given as to whether we have the right amount of spend according to local need and particular vulnerable groups. Should we be spending more on; prevention, young males, men who have sex with men (MSM), sex workers, looked after children and psychosexual counselling?

Due to the open access requirements for sexual health services, there are Tameside residents who attend sexual health services in other areas and vice versa. Therefore, this necessitates there be continued discussions between the local leads about how cross-charging and service provision is managed across Greater Manchester.

Some of our contracts need to be reviewed as there is some evidence of both double payments (some chlamydia testing) and underpayments (not currently paying for Brook).

Also, attention should be given to innovations that may be both clinically and cost effective, such as point of care testing for HIV and Interactive Computer Based Interventions (ICBI).

Sexually Transmitted Infections

A reduction in the number of STIs and reinfections may be best achieved by promoting and providing better access to condoms. Although some funding has been provided to Brook in the short-term, longer-term consideration should be given to designing and promoting an open access condom scheme across Tameside.

Action should be taken to encourage more young men to attend chlamydia screening and attend ISHS by identifying mechanisms to improve uptake using interventions such as social marketing and improved partner notification.

As Tameside has a higher rate of herpes than England and the North West, starting with a detailed look at the data with Public Health England (PHE), the reasons for this are to be investigated.

Contraception

In terms of EHC, consideration could be given to introducing ellaOne access via the pharmacy contract and also reviewing pharmacy activity to ensure equitable provision across Tameside. It is important that all providers of EHC are using the opportunity to discuss sexual health and contraception, including LARCs.

As only 17 of the GP practices are currently providing both IUDs and Implants, consideration should be given to understanding the barriers which have prevented some practices from offering both forms of LARCs and some practices offering neither. Improving access to LARCs is thought to be the most effective way of reducing unplanned pregnancy and abortions.

Sexual Violence

Consideration should be given to having a person(s) with a lead role to work with providers to ensure there is a clear pathway to prevent and identify sexual violence and child exploitation, and promote safeguarding.

Young people

In Tameside, 66% of diagnoses of acute STIs were in young people aged 15-24 years (this may have been increased by the National Chlamydia Screening Programme) and although the rate of teenage pregnancy is reducing, Tameside still has higher rates than England.

There is evidence that Interactive Computer Based Interventions (ICBI) can be effective in changing sexual health behaviours. Although Tameside has piloted interventions on Facebook and Twitter the approach should be scaled up so it can complement school based Sex and Relationship Education (SRE) and be used to promote access to sexual health services.

As mentioned previously, there may be an opportunity to work with key partners to discuss developing bespoke one-to-one or empowerment based interventions which are targeted to address the needs of vulnerable young people. This work should link to wider issues such as safeguarding, alcohol use and mental health.

Commissioning across Greater Manchester

Although the incidence of HIV is low, late diagnosis is high (although not significantly), more can be done to encourage testing in high risk groups to improve earlier detection. This should include a focus on those who are eligible who attend primary care or the ISHS to ensure they are offered HIV testing. One consideration to improve uptake for testing is enabling access to point of care testing as there is evidence this can result in improved uptake. Introduction of point of care testing will need to consider sensitivity and specificity of the available tests, and the potential for joint commissioning across Greater Manchester.

Consideration should also be given to ensuring Hepatitis C testing is offered at HIV specialist services and for those populations at higher risk to understand how they can reduce risk.

Although abortion services are commissioned through Clinical Commissioning Groups (CCGs), there may be an opportunity to work with commissioners across Greater Manchester to review how abortion services and promote contraceptive use to reduce repeat abortions.

Gaps in knowledge and services

At present we do not know how many sexual health workers we have in Tameside so we need to do more to find out about sex workers in the area and their needs. There is also limited access to psychosexual counselling.

2. Introduction

2.1 A public health priority

Sexual health is an important and wide-ranging area of public health. Most of the adult population of England are sexually active, and having the correct sexual health interventions and services can have a positive effect on population health and wellbeing as well as individuals at risk.

The consequences of poor sexual health can be serious. Unplanned pregnancies and STIs can have a long lasting impact on people's lives (Department of Health, 2001). The adverse consequences of poor sexual health for affected individuals are avoidable, earlier diagnosis and treatment can also prevent deaths from Human Immunodeficiency Virus (HIV) related illness (NHS York and the Humber , 2011).

The burden of sexual health is not evenly distributed across society, as it is concentrated amongst key at risk groups. There is a clear relationship between sexual ill health, poverty and social exclusion (Public Health England, 2014). There is an unequal impact of HIV on men who have sex with men (MSM) and on ethnic groups coming to England from areas where HIV is endemic (Department of Health, 2001).

Some people, including health professionals, are not comfortable talking about sexual health issues and some groups at higher risk of poor sexual health face stigma and discrimination which can impact on their ability to access services (Hind, 21 March 2013).

There are opportunities for innovation in sexual and reproductive health to improve integration, deliver better outcomes for communities and offer cost savings for local government, for example by reducing demand for social care. Evidence demonstrates spending on sexual health interventions and services is cost effective (Department of Health, 2013).

Public health systems cannot necessarily address every sexual health concern, but according to the World Health Organisation the key elements sexual health provision should include the following:

- STIs (including HIV);
- unplanned pregnancy and safe abortion;
- sexual dysfunction and infertility;
- violence related to gender and sexuality (including FGM);
- young people's sexual health and sexual health education;
- sexual orientation and gender identity;
- mental health issues related to sexual health;
- the impact of physical disabilities and chronic illnesses on sexual well-being; and
- the promotion of safe and satisfying sexual experiences (World Health Organization, 2010).

Commissioning responsibilities for sexual health is shared between the Local Authority, Clinical Commissioning Groups (CCGs) and NHS England. The Local Authority has a mandated responsibility to commission comprehensive, open access sexual and reproductive health services. It is estimated sexual health services account for around one-quarter of the funds transferred to local authorities in April 2013 for public health responsibilities (Department of Health, 2013). Due to the interfaces in commissioning responsibility, it important local authorities work together with their neighbouring authorities, CCGs and NHS England to ensure the seamless delivery of needs lead services.

2.2 Purpose

This desktop sexual health needs assessment is intended to present a review of the sexual health needs and current service provision for sexual health in Tameside. It will be used to update the Tameside Sexual Health Strategy and to support the development of a business case.

This needs assessment builds on Tameside and Glossop Teenage Conception Needs Assessment (January 2009), a Rapid Sexual Health Assessment by the National Support Team (April 2010), Tameside and Glossop Contraception and Sexual Health Equity Audit (May 2010), a review of HIV needs and issues in Tameside and Glossop (September 2010) and a review of NHS Tameside and Glossop Sexual Health Services (May 2011).

The aim is to assess the sexual health needs of the population, identify how services are meeting those needs, and to make recommendations for further improving services and reducing sexual health inequalities, within available resources.

The objectives are:

1. To provide updated information and analysis of routine local and national data and analyse sexual health trends.
2. To focus on the sexual health needs of the population and contrast this with service provision.
3. To identify the health needs of the most vulnerable and high risk groups.
4. To identify gaps in service provision.
5. To interpret information about patterns of sexual ill health and use of local services to identify the potential changes which could have the biggest impact.
6. To inform the new sexual health strategy and business case by providing an evidence base for commissioning decisions

2.3 Scope

This document will include data for Tameside on:

- Sexually Transmitted Infections;
 - Overview of the five most prevalent (including chlamydia)
 - HPV immunisation programme
 - HIV
- Contraception;
 - Emergency Hormonal Contraception (EHC)
 - Long Acting Reversible Contraception (LARC)
- Wider sexual health issues;
 - Teenage pregnancy
 - Abortion
 - Sexual violence

This paper also includes data on specific risk groups, sexual health across the life course and a review of local service provision.

This paper does not include data on sexual dysfunction, female genital mutilation, or detail on the impact of physical disabilities and chronic illnesses on sexual health. Nor does it include fertility, female sterilisation, vasectomy, or gynaecology. It also does not include cervical screening.

2.4 Background

2.4.1 National Trends

Young people today have sex at an earlier age than previous generations did. Men and women are also living longer, have healthier lives, and continue to have sex well beyond their reproductive years; sexual health and well-being is of lifelong importance.

The National Survey of Sexual Attitudes and Lifestyles (Natsal, 2012) interviewed 15,162 people aged 16-74 resident in Britain during 2010-12.

Some of the main findings are:

- Overall, a similar proportion of men (95%) and women (96%) reported ever having had at least one opposite-sex partner
- Age at first heterosexual intercourse has declined to a median average of 16 years among 16-to-24-year-olds
- People continue to have sex into later life, with 42% of women and 60% of men aged 65-74 years reporting having had at least one opposite-sex sexual partner in the previous year
- Frequency of sex for 16 to 44 years olds has fallen over the past decade to just under five times a month for both sexes (an mean average of 4.9 for men and 4.8 for women) amongst those aged 16-44 years
- The average number of partners over a woman's lifetime has more than doubled since the first survey (1990-91), from a mean average of 3.7 to 7.7 in the latest survey. In men, this figure has increased from 8.6 to 11.7.
- The number of men reporting having same-sex partners has changed a little, from 3.6% in the first study to 4.8% this time around, for women the figure has increased four-fold, from 1.8% to 7.9%.
- The number of people reporting heterosexual oral sex in the past year remained constant at just over three-quarters of men and women aged 16-44 (77% and 75% respectively).
- There has been an increase in the number of people reporting anal sex, up from 12% to 17% for men, and from 11% to 15% for women
- Reporting two or more partners in the past year and no condom use during this time, a measure of unsafe sex, was less frequent among men in this survey than in the previous survey, down from 14% to 11%.

STI notifications have been on the rise in several European countries since the early 2000s, most likely due to multiple factors like increased screening, use of more sensitive diagnostics, improved reporting and high levels of unsafe sexual behaviour among certain subpopulations (Van de Laar & Spiteri, 2014). England has some of the highest rates of STIs in Europe. The number of STI diagnoses in England increased from 319,602 in 2004 to 446,253 in 2013; although this is a slight decrease from 2012 (448,775) when there were changes to chlamydia reporting.

Genital chlamydial infection was the most commonly diagnosed STI, accounting for 47% of diagnoses. Rates of chlamydia infection also show considerable variation across England (Public Health England, 2014).

New diagnoses of gonorrhoea continued the sharp rise seen in recent years, exceeding 29,000 cases in 2013. Gonorrhoea is becoming more difficult to treat, as it can quickly develop resistance to antibiotics. Rates of infectious syphilis are at their highest since the 1950s (Department of Health, 2013).

In England during 2011, one person was diagnosed with HIV every 90 minutes. Almost half of adults newly diagnosed with HIV were diagnosed after the point at which they should have started treatment (Department of Health, 2013).

Up to 50% of pregnancies are unplanned; these can have a major impact on individuals, families and wider society. Huge variation exists in the rate of conceptions across England in women aged under 16 (9% to 58%). There is variation in the percentage of delivery episodes where the mother is aged less than 18 years, ranging from 0.3% to 2.8% (Department of Health, 2013).

In 2013, the number of abortions in England and Wales was 185,331, in terms of numbers; although this is a slight increase from 2012, the rate was 0.8% lower and is the lowest rate for 16 years. 98% of abortions are funded through the NHS. In 2013, 37% of women undergoing abortions had at least one abortion previously. The proportion has risen from 32% in 2003 (Department of Health, June 2014). In 2011, 49% in Black British women, having an abortion had had one before. In 2011, just over half of women having an abortion had previously had a live or stillbirth, indicating better support is needed to access contraception following childbirth (Department of Health, 2013).

Estimates from the Crime Survey for England and Wales indicate there are around 400,000 female victims of sexual offences each year and, of these, around 85,000 are victims of the most serious offences of rape or sexual assault by penetration (Department of Health, 2013).

2.4.2 Impact

The results of STIs include acute symptoms, chronic infection, complications such as pelvic inflammatory disease, and serious delayed consequences (World Health Organisation, 2007). STIs are the main preventable cause of infertility, particularly in women. Certain types of human papillomavirus are linked with cervical and other oral and genital cancers. HIV remains a serious communicable disease for which there is no cure or vaccine.

Unplanned pregnancy can have a physical and psychological impact on women. Abortion is often the only perceived option of addressing an unplanned pregnancy (Rudd, et al., 2013). Teenage pregnancy has been shown to be associated with poverty, low aspirations and not being in education, employment or training (Department of Health, 2013).

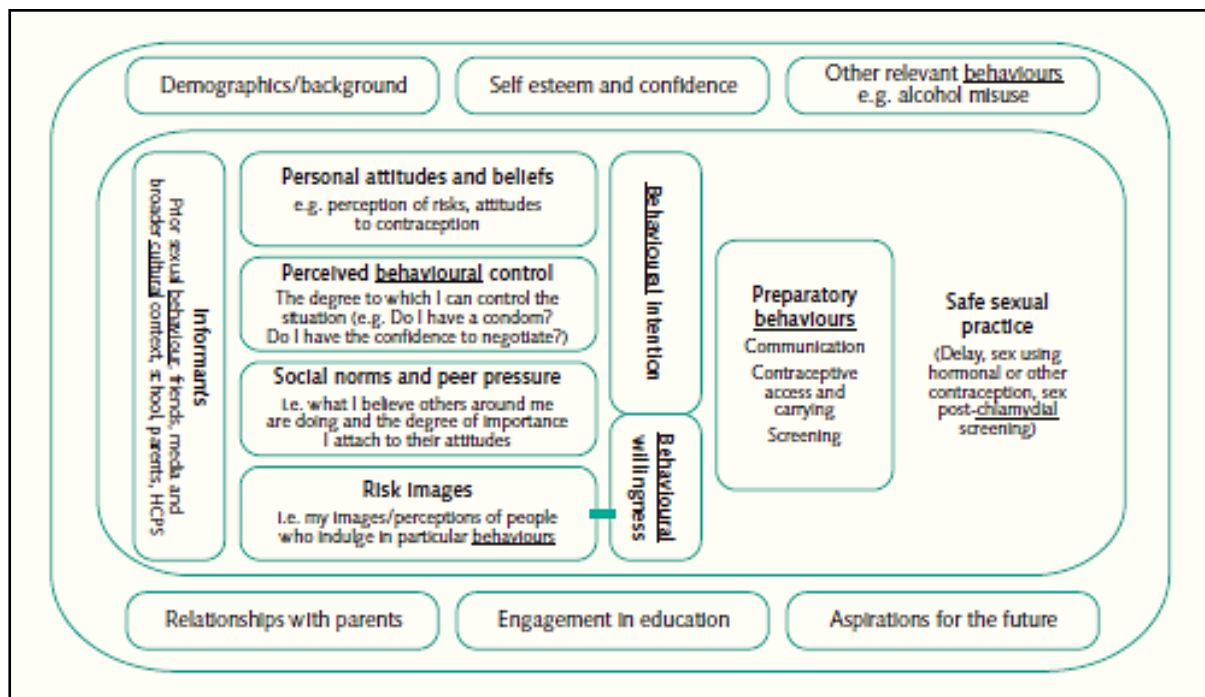
2.4.3 Risky behaviours/high risk groups (see NICE)

Certain behaviours are associated with increased transmission of STI and HIV, including:

- age at first sexual intercourse
- number of lifetime partners
- concurrent partnerships
- payment for sexual services
- alcohol
- substance misuse

One of the most significant developments of the past decade has been acknowledgement of the social, economic, and political forces which influence people's vulnerability to sexual ill-health (World Health Organization, 2010). There are a range of factors that can influence sexual health outcomes, see figure 1 below.

Figure 1: Model of influences on safer sex practice



Source: *Framework for Sexual Health Improvement (Department of Health, 2013, p.50)*

Underlying patterns of social exclusion and inequality are to be addressed through simultaneous, multi-layered interventions which address both risk and vulnerability within the context of sexual behaviour (World Health Organization, 2010).

2.5 National Policy Context

In 2001, the first National Strategy for Sexual Health and HIV was published (Department of Health, 2001), setting out a 10 year plan to; prevent infection and subsequent transmission, de-stigmatise HIV, enhance HIV/AIDS care services, modernise sexual health services and dramatically reduce teenage pregnancy rates. The plan focused on the link between sexual ill health, socio-economic deprivation and poor standards of service provision.

The Choosing Health White Paper (Department of Health, 2004) also highlighted the importance of sexual health and re-emphasised a commitment to modernise services by ensuring prompt access to GUM clinics, provision of a full range of contraceptive services and delivery of a Chlamydia screening programme. The White Paper set the agenda for sexual health services to be delivered in community settings, through engagement with primary care.

A review of progress on the national strategy (MedFASH, 2008) highlighted five themes and reflected a shift away from central decision making to an emphasis on local commissioning. The five central themes are;

- Prioritising sexual health as a key public health issue
- Building strategic partnerships
- Commissioning for improved sexual health
- Investing more in prevention
- Delivering modern sexual health services

The 2012 Health and Social Care act brought wide ranging structural changes to the NHS, including the creation of Clinical Commissioning Groups (CCGs), transfer of public health into local authorities, the setting up of health and wellbeing boards and the creation of Health watch (Department of Health, 2012).

The Framework for Sexual Health Improvement (Department of Health, 2013) is aimed at both commissioners and providers. It outlines the Government’s ambitions for good sexual health and provides information about what is required to deliver good sexual health services.

The key principles are:

- prioritising the prevention of poor sexual health;
- strong leadership and joined-up working;
- focusing on outcomes;
- addressing the wider determinants of sexual health;
- commissioning high-quality services, with clarity about accountability;
- meeting the needs of more vulnerable groups; and
- good-quality intelligence about services and outcomes for monitoring purposes (Department of Health, 2013).

Key messages from ‘Making it work’ (Public Health England, 2014), which is a guide on whole system commissioning for sexual health, reproductive health and HIV, focuses on establishing seamless integrated care pathways and describes how this can work in practice.

2.6 Roles and responsibilities

The commissioning responsibilities of local government, CCGs and NHS England are enshrined in the Health and Social Care Act 2012 (Department of Health, 2012). Local government responsibilities for commissioning sexual health services and interventions are further detailed in The Local Authorities Regulations 2013.2. These mandate local authorities to commission confidential, open access services for Sexual Transmitted Infections (STIs) and contraception as well as reasonable access to all methods of contraception.

NHS England is responsible for commissioning healthcare services provided as part of GP contracts, including sexual health services provided under these contracts. CCGs are responsible for commissioning most abortion services, female sterilisation, vasectomy, and gynaecology. See table 1 for more detail on organisational roles and responsibilities

Table 1: Sexual Health Commissioning, roles and responsibilities		
Local authorities commission	Clinical Commissioning Groups	NHS England commissions
Comprehensive sexual health services. These include:	Most abortion services. (See 'specialist foetal. medicine' services)	Contraceptive services provided as an 'additional service' under GP contracts
1. Contraception (including the costs of LARC devices and prescription or supply of other methods) and advice on preventing unplanned pregnancy,	Female sterilisation	HIV treatment and care including cost of all Anti-Retroviral Treatment

in specialist services and those commissioned from primary care under local public health contracts (such as arrangements formerly covered by LESs and NESs)		
2. Sexually transmitted infection (STI) testing and treatment, chlamydia screening as part of the National Chlamydia Screening Programme (NCSP) HIV testing, and partner notification for STIs and HIV	Vasectomy	Testing and treatment for STIs (including HIV testing) in general practice when clinically indicated or requested by individual patients. (i.e. not part of the public health commissioned services, but relating to the individual's care)
3. Sexual health aspects of psychosexual counselling	Non-sexual health elements of psychosexual health services	All sexual health elements of healthcare in the justice system including HIV
4. Any sexual health specialist services, including young people's sexual health services, outreach, HIV prevention and sexual health promotion, services in schools, colleges and pharmacies	Gynaecology, including any use of contraception solely for non-contraceptive purposes (except when provided in general practice – see column to the right)	All sexual health elements of healthcare for armed forces and their families including HIV
5	HIV testing, including routine screening, in non-HIV hospital departments	Sexual assault referral centres (open access one-stop service to help victims of rape or sexual assault) Cervical screening in a range of settings
6. Related social care services (funding sits outside the Public Health ring fenced grant and responsibility for these services lay with local authorities prior to April 2013).		HPV immunisation programme
7. HIV Social Care		Specialist foetal medicine services, including late surgical termination of pregnancy for foetal anomaly between 13 and 24 gestational weeks
8. Wider support for teenage parents		NHS Infectious Diseases in Pregnancy Screening Programme including antenatal screening for HIV, syphilis, Hepatitis B
9.		Contraception provided solely for non-contraceptive purposes in general practice

Source: (Public Health England, 2014)

2.7 Public Health Outcome Framework Indicators

The following public health outcomes were established for local government in 2012 and are included in the Public Health Outcomes Framework (PHOF) for 2013–16 (Department of Health, 2013):

- A continuing fall in the rate of births to women under the age of 18 (No. 2.4)
- An increase in chlamydia diagnoses among young people aged 15–24, to be achieved through testing (No. 3.2).
- A reduction in the proportion of people with HIV whose infection is diagnosed late (No. 3.4).

Related PHFO indicators include:

- Rate of sexual offences (No. 1.12iii)
- Population vaccination coverage of Human Papilloma Virus (HPV) (No. 3.3).

3. Cost effectiveness

Improving and promoting sexual health makes good sense in both health and economic terms. Investment in sexual health services can deliver healthcare savings through preventing unplanned pregnancies; reducing transmission of STI's, costs of infertility treatment and of treating disease.

For example, for every one pound spent on contraceptive services, the net gain to the NHS has been estimated to be £11 (Department of Health, 2013). Each time a person is prevented from developing HIV it is thought the NHS saves over £350,000 (APPG, 2012).

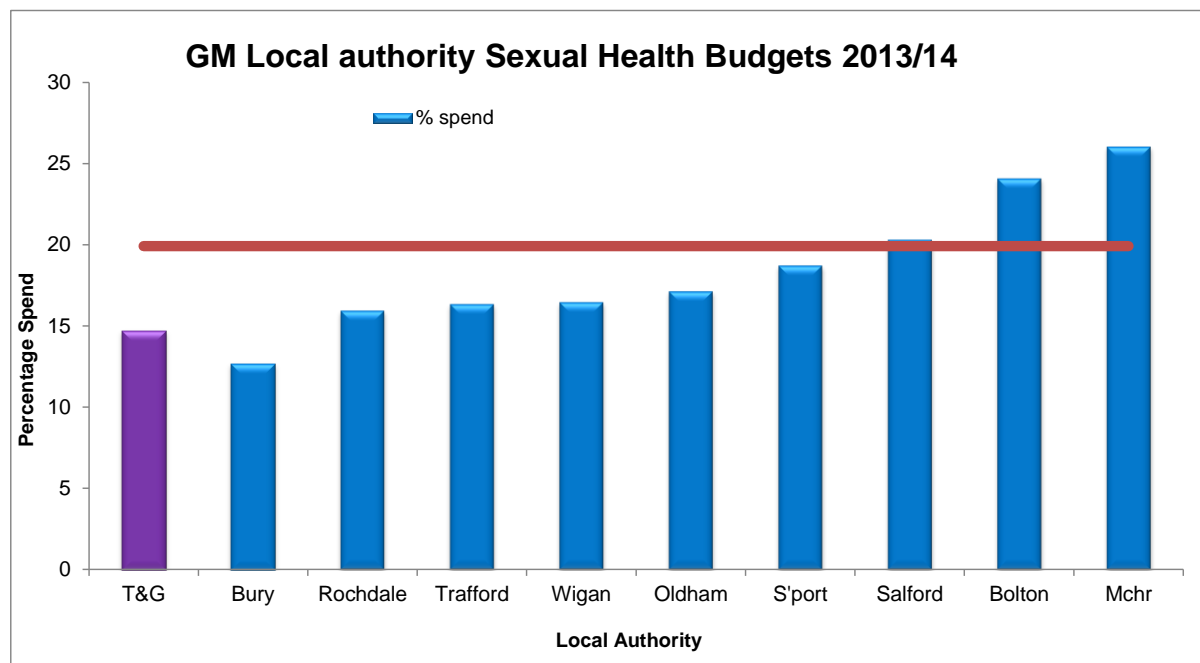
It is estimated that in 2013, unintended pregnancy and STIs cost the UK between £84.4 billion and £127 billion. Of the lower level, £84.4, 11.4 billion was NHS costs and 73 billion was wider public sector costs. It is estimated improving access to contraception and contraceptive services could save between £3.7 and £5.1 billion (Development Economics, 2013).

The total local authority budget for sexual health in Tameside is £2,000,000. Table 2 below shows spend for 2014/15, 82% of which was spent on the ISHS. Spend is either by unit of activity (GP and Pharmacy) or via a block contract; the majority of spend is via block contracts.

Provider	Service	Spend	Percentage
R U Clear	Chlamydia Screening	£123,894	6.2%
Stockport Foundation Trust (Integrated Sexual Health Service)	Contraception and GUM, advice and clinical input.	£1,647,630	82.4%
General Practice	LARCs, advice and clinical input	£109,680	5.5%
Other (smaller providers/interventions)	Chlamydia Screening, EHC, advice and clinical input and targeted support to young people and high risk groups	£118,796	5.9%
Total Spend		£2,000,000	100%

Data on spend collated by the Greater Manchester Sexual Health Network on behalf of each of the Local Authorities indicates spend on sexual health per head of population in Tameside is one of the lowest in Greater Manchester (£14.71/head), see chart 1 below.

Chart 1: Greater Manchester Local Authority Budgets 2013/14



Source: Greater Manchester Sexual Health Network, pathway analytics

In terms of the ISHS, during 2013/14, there were approximately 17,650 contacts; this means the mean average cost per contact was approximately £93.35. This is lower than the 2014/15 national GUM tariff range of £105-£140; the range is dependent on whether it is first or follow-up or single or multi-professional contact (Gov.UK, 2014).

In terms of general practice spend on LARCS, spend is £89.90 per IUD, £27 for the contraceptive implant and £30 for removal. For pharmacy EHC, spend is £10 per consultation and £6 for prescribing.

In addition, although it is the CCG who commissions abortion services, data supplied by the CCG, which includes both abortions and male sterilisation, would indicate spend during 2013/14 was approximately £500,000.

There are some hidden costs not currently being budgeted for. For example, in 2013/14 there were 657 Tameside residents who attended Brook (274 new and 387 follow-up). If this were to be charged at the lowest GUM tariff of £105 this would equate to an additional cost of £68,985. There may also be some double payments, for example, we commission RUClear to provide genital swabs for chlamydia screening to young people under 25 across all providers and also pay for the ISHS to provide chlamydia screening (including genital, throat and anal swabs) in their clinics.

Figures for 2013 indicate that of Tameside residents using GUM services, 91% use Tameside's services (Public Health England, 2014). Data for 2012/13 from the Sexual Health Service for GUM/CASH indicates 91% of those using Tameside Sexual Health Service are Tameside residents. This may suggest that cross charging should not be too

much of an issue, however although the percentages are the same the actual number is not known and the number of Tameside Residents using CASH (contraception) services out of area is not known. At present we are paying a national tariff for out of area GUM but not for CASH; there may well be a local or national tariff in the future.

In terms of spend on primary prevention, there is some spend on youths outreach, LARCs and condom provision, however this is currently a small proportion of the total spend.

4. Methodology

For this desktop HNA, data was collated from various sources; no formal consultation took place apart from discussions with the Public Health Manager for Sexual Health and the Lead Consultant in Sexual Health and HIV.

Firstly, a review was undertaken of relevant English and European guidance and national data, followed by a review of local data and previous sexual health strategies. Differences between national recommendations and local service delivery and the differences between national and local data were then used to identify gaps and make recommendations. See Chart 2 below for summary of information sources used.

Chart 2. Summary of Information Sources



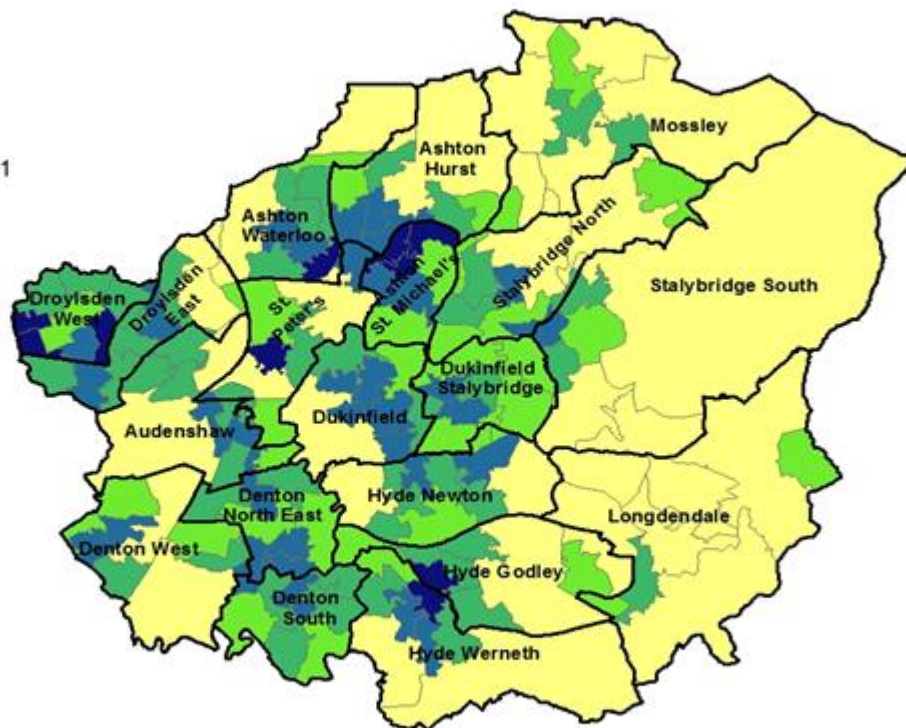
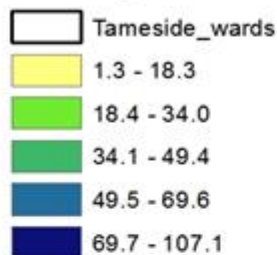
5. Demographics

5.1 Population density

According to the Office of National Statistics (ONS) population estimates, the 2013 population is 220,595. The Borough covers 40 square miles centered on the River Tame and combining a mix of urban and rural landscapes. There are six areas within Tameside with between 69.7 and 107.1 persons per hectare. See figure 2 below.

Figure 2. Population density in Tameside, 2013

**Population Density
(Persons per hectare)**

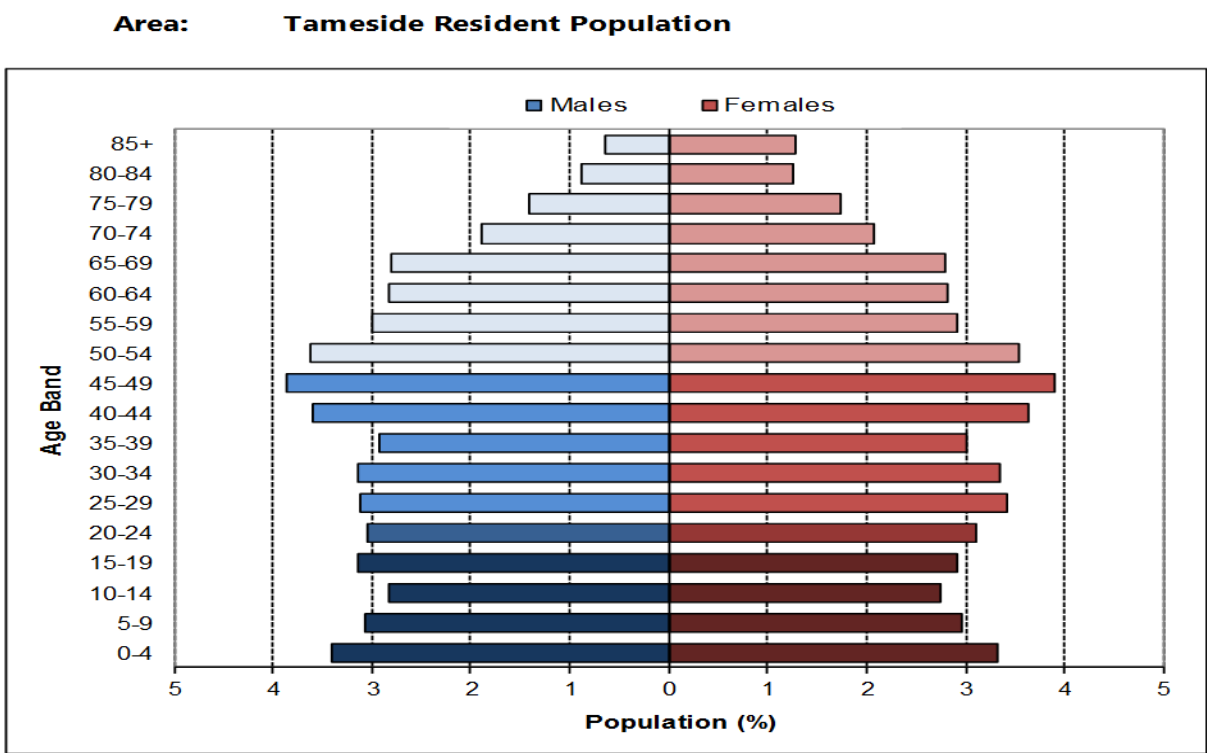


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5.2 Age and gender

There is a fairly even split of male and females in all ages, with slightly more males in the 0 to 19 years age group, slightly more females in the 20 to 49 age group, slightly more males in the 50 to 64 age group, with the biggest variation being more women in the 75s and above age group (see chart 3 below).

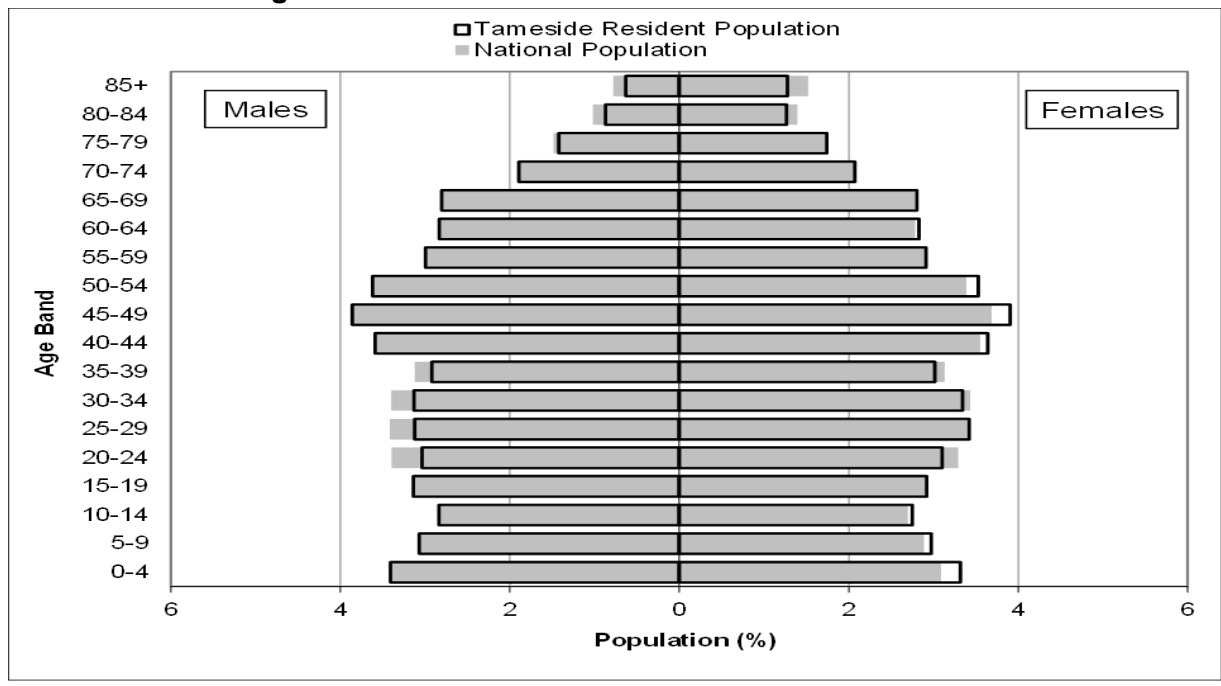
Chart 3: 2013 population estimates for Tameside by percentage age and gender



Source: ONS 2013 midyear population estimates

Compared to nationally, Tameside has slightly more females in the younger (0 to 14) and middle age groups (40 to 54), the percentage of the population in Tameside aged 20 to 39 and above 80 years is less than nationally reflecting a lower life expectancy in Tameside than nationally (see chart 4)

Chart 4. 2013 estimated population differences by age and gender in Tameside contrasted with England



Source: ONS 2013 midyear population estimates

Between 2015 and 2020, the population of Tameside is expected to grow by over 7,500 people. The expected growth is not consistent across the age bands. Those aged 15 to 24 are expected to reduce slightly, while those aged 25 to 39 are expected to increase. There is expected to be a decrease in those aged 40 to 54 and generally (apart from aged 65-69) there is expected to be an increase in the numbers in each age band thereafter (see table 3). However, the numbers are small and are estimates so are to be viewed with caution.

Table 3: Population projection for Tameside, 2015 and 2020 by five year age bands			
Age group	2015	2020	Increase/ Decrease
0-4	15,896	15,765	-132
5-9	14,248	15,898	1,650
10-14	12,358	14,311	1,953
15-19	12,992	12,172	-819
20-24	13,655	12,501	-1,154
25-29	15,262	15,560	298
30-34	14,929	15,906	978
35-39	13,632	15,292	1,659
40-44	15,183	13,875	-1,308
45-49	16,805	15,030	-1,775
50-54	16,585	16,490	-94
55-59	13,844	16,124	2,281
60-64	11,958	13,166	1,207
65-69	12,678	11,095	-1,584
70-74	9,311	11,498	2,187
75-79	7,282	8,047	765
80-84	4,901	5,741	840
85+	4,621	5,521	900
All Ages	226,139	233,991	7,853
<i>ONS data on Interim 2011-based Subnational Population Projections for local authorities, counties, regions and England. Single years of age, Persons. Figures in units (unrounded)</i>			

5.3 Deprivation

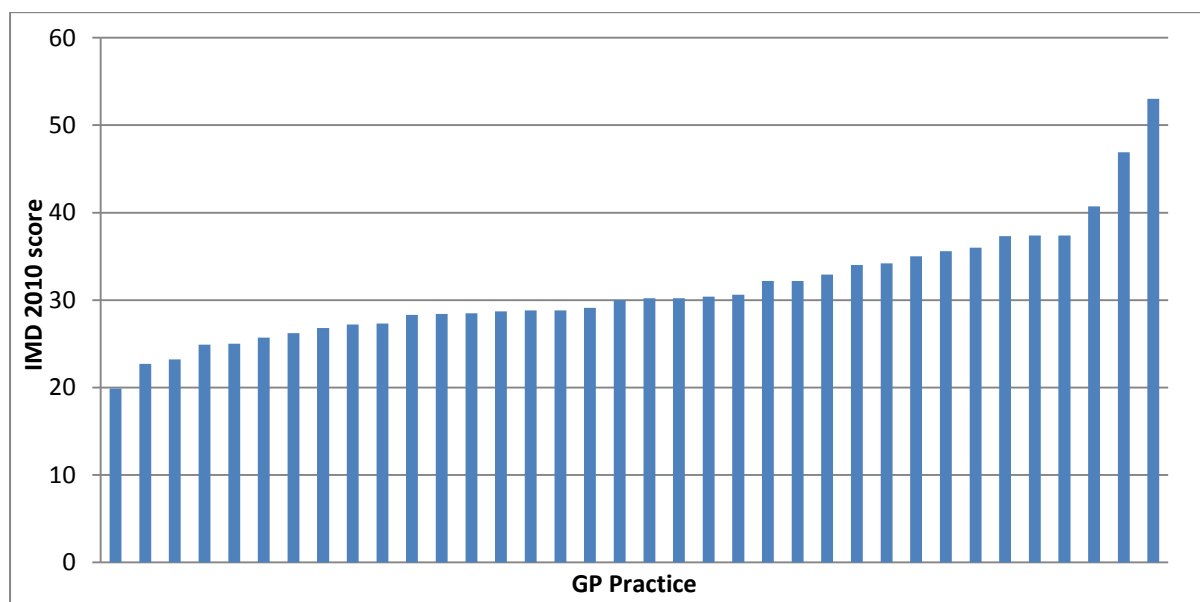
Tameside has a 2010 Index of Multiple Deprivation (IMD) score¹ and a percentage of people in the most deprived 20% of the population which is above the England and the North West average (see table 3).

Location	Average IMD 2010 score	% of people in an area in most deprived 20%
Tameside	29.62	34.47
North West	27.11	31.75

Source: www.data.gov.uk, 2014

There is also a twofold variation in GP practice population, with 2010 IMD scores ranging from 20 to 53 (see chart 5 below).

Table 5: 2010 IMD score by General Practice in Tameside



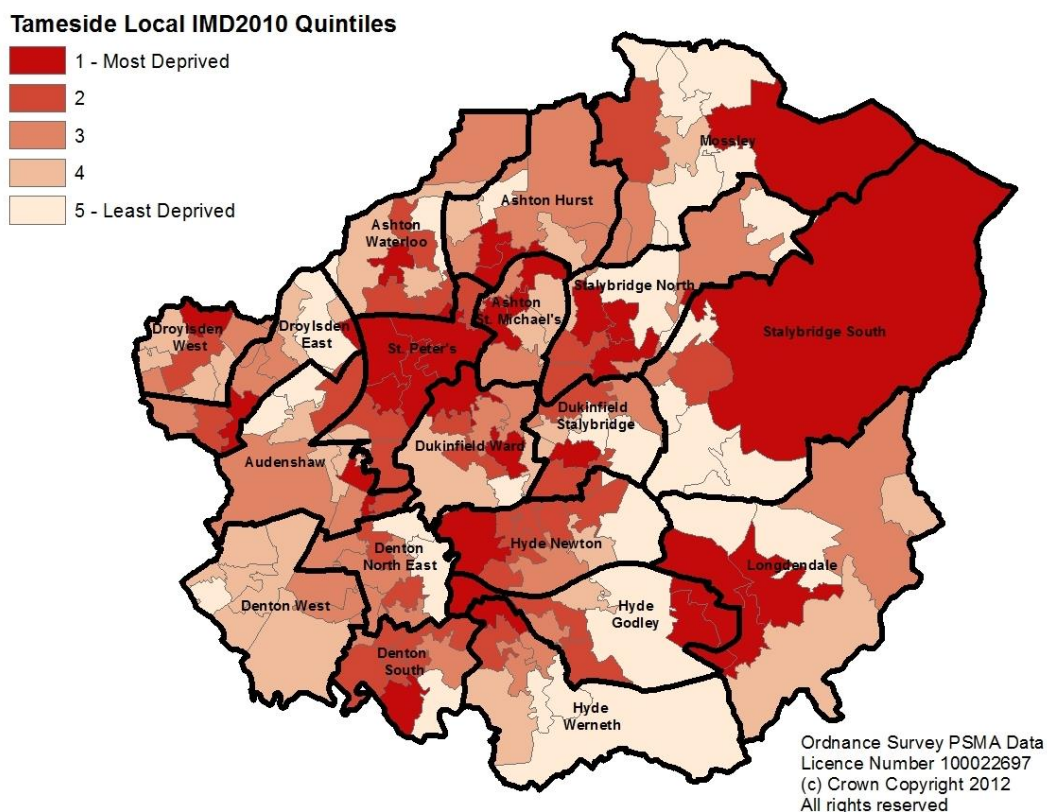
Source: Public Health Intelligence Team, TMBC, 2014

The IMD 2010 is an overall measure of multiple deprivation experienced by people living in an area. It is a composite score based on 38 indicators grouped in seven domains: income; employment; health and disability; education, skills and training; barriers to housing and other services; crime; living environment. Each domain's contribution to the overall score is weighted differently, with income and employment deprivation weighted the most. www.apho.org.uk/resource/view.aspx?RID=117805

5.3.1 Tameside Deprivation by ward, 2010

There are variations in the level of deprivation across the wards; however the level of deprivation is affected by population density. The ward with the most deprivation is St Peters (see figure 3 below).

Figure 3. Tameside wards and super output areas by IMD 2010 quintiles (2012 data)



5.4 Ethnicity

Tameside has a slightly higher percentage of the population which is 'white' than the North West and England. The biggest non-white ethnic grouping in Tameside is Asian/Asian British (a slightly higher percentage than the North West); this is primarily people who identify as being of Pakistani, Bangladeshi and Indian descent (see table 4).

Ethnic Group	Tameside		North West		England	
	number	%	number	%	number	%
All usual residents	219,324	100	7,052,177	100	53,012,456	100
White	199,429	90.9	6,361,716	90.2	45,281,142	85.4
Mixed/multiple ethnic groups	3,159	1.4	110,891	1.6	1,192,879	2.3
Asian/Asian British	14,553	6.6	437,485	6.2	4,143,403	7.8
Black/African/Caribbean/Black British	1,784	0.8	97,869	1.4	1,846,614	3.5
Other ethnic group	399	0.2	44,216	0.6	548,418	1.0

Source: Nomis, 2013

There is some variation across Tameside with St Peters ward having the highest Black and Minority Ethnic (BME) population of 27.8%, compared to Longdendale and Mossley, both at 1.9% (see table 5 below).

Ward Name	All categories: Ethnic group	BME Total	BME %
Ashton Hurst	11,503	1,525	13.3
Ashton St Michael's	11,767	2,026	17.2
Ashton Waterloo	11,246	1,482	13.2
Audenshaw	11,419	552	4.8
Denton North East	11,169	349	3.1
Denton South	11,074	280	2.5
Denton West	11,635	330	2.8
Droylsden East	11,691	576	4.9
Droylsden West	11,343	312	2.8
Dukinfield	12,483	568	4.6
Dukinfield Stalybridge	10,855	337	3.1
Hyde Godley	11,465	998	8.7
Hyde Newton	13,394	688	5.1
Hyde Werneth	11,424	2,090	18.3
Longdendale	9,950	186	1.9
Mossley	10,921	212	1.9
St Peter's	12,254	3,403	27.8
Stalybridge North	12,705	437	3.4
Stalybridge South	11,026	385	3.5

Source: Nomis, 2013

6. Strategic Structures

Tameside Council commissions sexual health services from primary care, acute trusts, and the voluntary and independent sectors. Commissioners and providers work closely to ensure the commissioning and delivery process is needs lead and meets identified priorities. Good sexual health provision requires access to high quality accessible services which meet the needs of the local population.

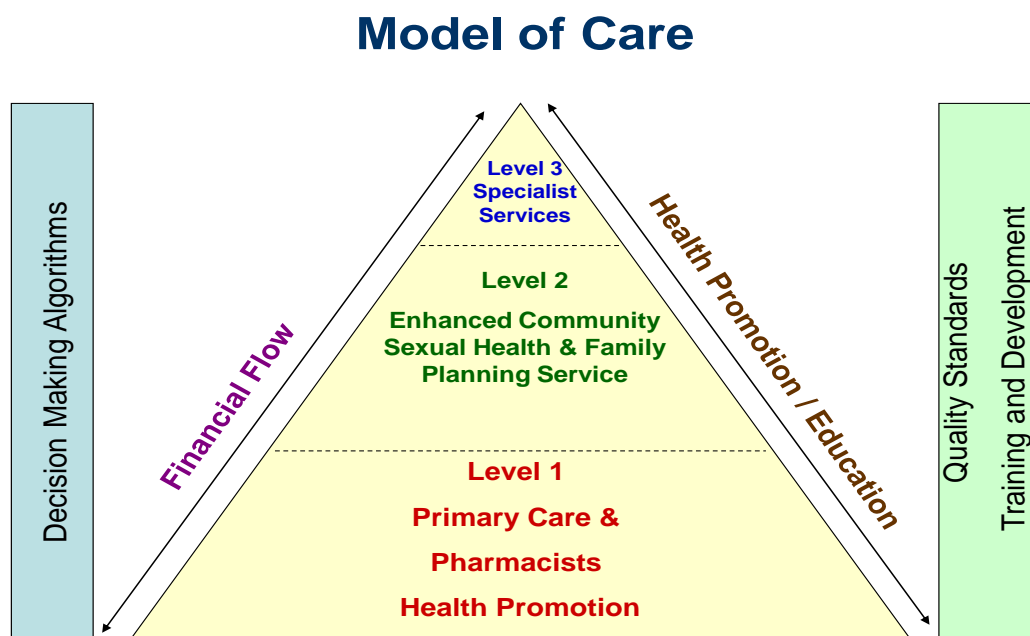
In order to provide good sexual health services it is important services enable residents to have easy access; residents with the poorest outcomes will often have additional access barriers and it is essential services reflect their needs.

Children, young people and adults all require good information which is easy to access, accurate, appropriate to their needs and timely. Significant proportions of residents will at some point in their lives have contraceptive requirements and need access to information and resources, including condoms, to help them stay sexually healthy.

There are individual, family and wider community impacts of delayed access to sexual health services. A woman has 5 days to take preventative action if contraception has failed, or not been used, if she wishes to take steps to prevent a pregnancy. STIs will readily pass to sexual partners during unprotected sex if the infection is not treated quickly.

The Department of Health set out a three level service model (2001) for sexual health; this was reaffirmed in the Strategy review (MedFASH, 2008) and is cited in the recent best practice guidance (Public Health England, 2014). See figure 4 below.

Figure 4: Sexual Health model of care from national strategy (2001), cited in Tameside's strategy document (Sexual Health Advisory Group, 2012, p.53)



Level one

- sexual history and risk assessment
- contraceptive information and services
- Genital STI testing for women
- assessment and referral of men with STI symptoms
- HIV testing and counselling
- cervical cytology screening and referral
- pregnancy testing and referral
- hepatitis B immunisation

Level two

- intrauterine device insertion (IUD)
- contraceptive implant insertion
- Asymptomatic testing and treating sexually transmitted infections
- partner notification
- vasectomy
- invasive sexually transmitted infection testing for heterosexual men (until non-invasive tests are available)

Level three

Level three clinician teams take responsibility for sexual health services needs assessment, for supporting provider quality, for clinical governance requirements at all levels, and for providing specialist services. Services could include:

- outreach for sexually transmitted infection prevention
- outreach contraception services
- specialised infections management, including co-ordination of partner notification
- highly specialised contraception
- management of warts, syphilis and scabies
- specialised HIV treatment and care

The Tameside Sexual Health Advisory Group is a well-established local strategic partnership forum, and has membership made up of commissioners and providers of services. Tameside is also part of the Greater Manchester Sexual Health Network; the network is currently being reviewed.

6.1 CASH/GUM Service

The ISHS includes the Contraception and Sexual Health (CaSH) Service and the Genitourinary Medicine (GUM) Service for Tameside; it is based at Ashton Primary Care Centre, and managed by Stockport Foundation Trust. It is integrated as it is open access for all ages and for sexual health treatment, testing and contraception services for Tameside residents and non-residents alike. It currently operates as a drop-in service as this is reported to reduce non-attendance and improve patient flow, the average waiting time is approximately half an hour.

The service provides level one and two services and all level three service for GUM and most level three contraceptive services (with the exception of removal of deep implants, specialist menopause/pre-menstrual tension clinics and sterilization). The expectation is that within all consultations brief advice, brief intervention and motivational interviewing are offered as appropriate.

The Level 3 service includes an on-site laboratory testing by a biomedical scientist. The service has two service level agreements with Tameside Foundation Trust; one for specimen processing and testing, and another for the biomedical scientist.

Sterilization is commissioned by Tameside and Glossop CCG and is delivered in some primary care settings and via the independent sector (South Manchester Private Clinic).

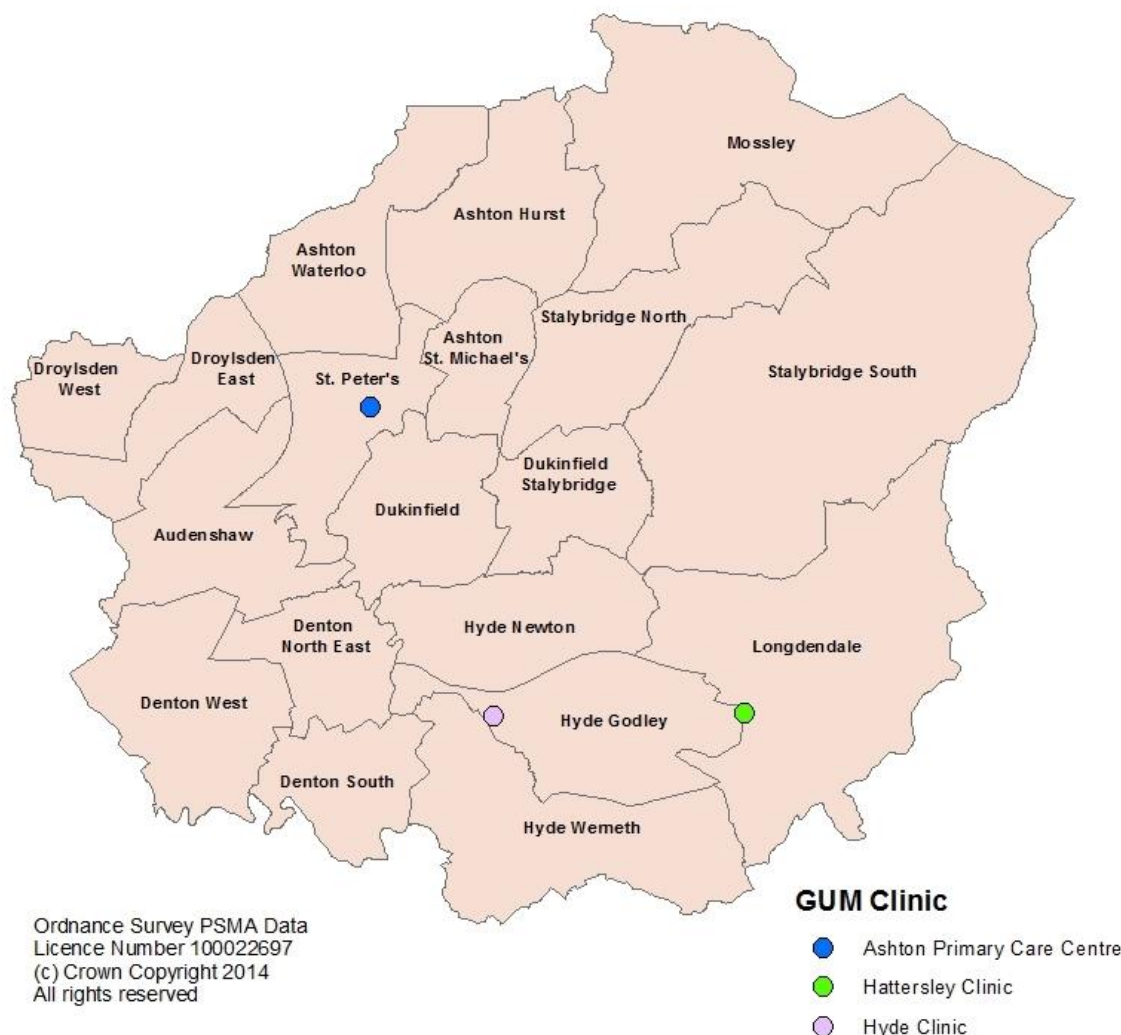
This ISHS is led by a Consultant, Specialist General Practitioners, Nurses, Health Advisors and a Vulnerable Young Persons Worker. There is no specialist psychosexual counsellor. The staff mix within the clinic enables flexibility and extended services such as a range of prescribing options and point of care testing (POCT) for HIV.

The service at Ashton Primary Care Centre is open six days a week, Monday to Thursday 9:00 to 6.30 and till 4.30 on Friday and between 11.30 and 2.30 on Saturday (under 25s only). There are clinics in Hyde (Thursday 5.30 to 7.30) and Hattersley (Wednesday 1:30 to 4:00pm). The morning and evening clinics are drop-ins and the afternoon clinics are mainly by appointment. Please see figure 5 for locations of clinics.

Recommendation: This may be an opportune time to review the service provision and change the function of ISHS slightly to reduce provider function slightly to increase their role in co-ordinating and supporting the other providers; to ensure a standardised high quality approach across all services, increase capacity within primary care, and expand services such as condom provision. It may be possible to achieve this by reducing follow-up attendances for contraception and reviewing roles.

Another area for consideration is to review the locations of sexual health provision and ensure they are located according to need, such as in areas of deprivation and high population density. For example, the Hyde and Hattersley clinics are relatively close to one another yet there are no specialist sexual health clinics near the intersection of Stalybridge North and South and Dukinfield Stalybridge.

Figure 5: Locations where people can attend Tameside’s integrated Contraception & Sexual Health Service



In terms of attendances for GUM services, 91.2% of all attendances by residents of Tameside attend services in Tameside (Public Health England, 2014).

Data from ISIS for April 2013 to March 2014 indicates that during 2013/14 there were 17,663 attendances. 68% of attendances were for CASH, of which 83% of the attendees were female and 40% were aged 18 to 24 years (see table 6 below).

Table 6. Attendances for CASH in Tameside 2013-14			
Age	Male	Female	Persons
17 and under	495	2433	2928
18 to 24	844	4116	4960
25 plus	795	3617	4412
All ages	2134	10166	12300
<i>Source: Stockport Foundation Trust</i>			

Of those attending GUM (see table 7), more males attended in the 25 plus age group than females, although overall 53% of attendees were female. 54% were aged 25 or over.

Table 7. Attendances for GUM in Tameside 2013-14			
Age	Male	Female	Persons
17 and under	77	287	364
18 to 24	914	1186	2100
25 plus	1524	1375	2899
All ages	2515	2848	5363
<i>Source: Stockport Foundation Trust</i>			

During 2013/14, the service achieved their targets for chlamydia screening and positivity rate but did not achieve the targets for attendance for under 18s for CASH or GUM; they did achieve the targets for LARCs in all ages.

6.2 General Practice

GP practices are the main provider of contraceptives for women and are key providers of sexual health advice and care, including Sexually Transmitted Infection (STI) testing and treatment as part of their consultation. In Tameside 25 of the 35 GP practices offer one form of LARC as per the contract with Tameside MBC and all provide sexual health information, advice and onward referral when required. GP practices also provide Emergency Hormone Contraception (EHC).

In addition, the Tameside MBC fund a Primary Care Clinical Lead two sessions per month to provide clinical governance assurance, to help increase the uptake of Chlamydia testing in young people under the age of 25 and reduce the late diagnosis of HIV.

Vasectomy is commissioned by Tameside and Glossop CCG and is delivered via Stamford House Surgery in Ashton-Under-Lyne, and Care UK

6.3 Pharmacy

16 numbers of pharmacies offer the EHC, Levonorgestrel, which is effective up to 72hrs after unprotected sex in preventing pregnancy, but most effective the sooner it can be taken. In addition, pharmacists offering EHC can offer a chlamydia screening pack to any young person accessing the service and brief advice about contraceptive choices. Pharmacists are equipped with knowledge and information about local service provision and have accessed training about contraception and sexual health.

6.4 Specialist services

In addition to the main providers above Tameside MBC also fund:

- **Chlamydia and gonorrhoea** – As part of the national screening programme, Central Manchester Foundation Trust provide 'RUCleaR' who co-ordinate and manage the testing, including postal tests, and triage of results for chlamydia and gonorrhoea on behalf of Tameside and the other local authorities in Greater Manchester.
- **LGBT** – The Lesbian and Gay Foundation (LGF) provide focused community health interventions
- **HIV** – The George House Trust supports people living with and affected by HIV, along with LGF and the Black Health Agency who also provide HIV prevention activities
- **Young people** – YouThink are a specialist team which focuses on improving young people's sexual health.
- **Abortion** – The British Pregnancy Advisory Service (BPAS) provides the telephone booking for advice and direct people as appropriate to abortion services via Tameside Hospital, Marie Stopes and Fraterdrive
- **Sexual violence** – the sexual health service and primary care are able to access support and advice from the Tameside Safeguarding Board and from the police family support unit. There is also a specialist centre at St Mary's hospital in Manchester. In addition, Manchester Rape Crisis (MRC) is a confidential support service for women and girls who have been raped or sexually assaulted.

7. Sexually Transmitted Infections (STI)

In England, numbers of diagnoses of sexually transmitted infections have been increasing for much of the last decade. However, in 2013, the total number of new cases of STIs diagnosed in GUM clinics and, for chlamydia, in GUM and other community-based settings, decreased by 0.6% when compared to 2012 (446,253 vs. 448,775). Of the 446,253 new STI diagnoses made in 2013, the most commonly diagnosed STIs were chlamydia (47%), genital warts (17%), genital herpes (7%), and gonorrhoea (7%) (Public Health England, 2014).

Nationally, young people aged 15-24 years, MSM and black Caribbean ethnic groups have been shown to have higher rates of new STIs.

Of all those diagnosed in 2013 with a new STI in Tameside, 47% were male and 53% were female (gender was not specified or unknown for 0% of episodes).

In the 2013 Tameside MBC STIs and HIV epidemiology report, Tameside is ranked 73 (out of 326 local authorities in England; first in the rank has highest rates, for rates of new STIs. 1961 (915 in males and 1042 in females) new STIs were diagnosed at a rate of 890.4 per 100,000 residents which is higher than England (810.9 per 100,000) (Public Health England, 2014).

Reducing the burden of HIV and STIs requires a sustained public health response based around early detection, successful treatment and partner notification, alongside promotion of safer sexual and health-care seeking behaviour (Public Health England, 2013).

7.1 Reinfection

Reinfection with an STI is a marker of persistent risky behaviour. In Tameside, an estimated 9.0% of women and 9.2% of men presenting with a new STI at a GUM clinic during the five year period from 2009 to 2013 became re-infected with a new STI within twelve months. This is a higher proportion than nationally, as during the same period of time, an estimated 6.9% of women and 8.8% of men became re-infected with a new STI within twelve months (Public Health England, 2014).

In Tameside, an estimated 2.2% of women and 7.1% of men diagnosed with gonorrhoea at a GUM clinic between 2009 and 2013 became re-infected with gonorrhoea within twelve months. Nationally, an estimated 3.7% of women and 8.0% of men became re-infected with gonorrhoea within twelve months.

The reinfection rate for women aged 15-19 who presented with an acute STI at a GUM clinic during the four year period from 2009 to 2012 was estimated to be 13.6%. Teenagers may be at risk of reinfection because they lack the skills and confidence to negotiate safer sex.

Recommendation: A sexual health framework for young people should be produced and there should be a greater focus on prevention.

7.2 Condom provision

According to the Department of Health (2013), the most effective way for sexually active people to protect themselves from STIs is to use a condom. Evidence from both experimental and observational studies has demonstrated condoms are effective protection against STIs (Faculty of Sexual and Reproductive Healthcare, 2012; Weller & Davis-Beatty, 2002). Condoms can be 80% effective in 'typical use' in preventing pregnancy; however, LARCs have a lower failure rate (Faculty of Sexual and Reproductive Healthcare, 2012).

In Tameside there is a gap in condom provision as the Young Persons Condom-Card (C-Card) Scheme was discontinued in 2011 due to cost effectiveness; unfortunately, there was no evaluation to identify the reasons for the poor uptake. In the short term, finance has been provided for approximately 20,000 condoms and Brook have been commissioned to promote access. YouThink are finding out from young people how they would like to access free condoms in the future to improve access. However, a long-term plan is required.

Proponents of the c-card scheme argue it is effective because it allows a conversation with a trained advisor and it gives the opportunity to know how to use a condom and why, which in turn increases condom use, reduces condom failure and increase engagement with sexual health service provision (Jablonskas, 2011). However, within the c-card guidance there is little discussion about access and whether the same process that enables discussion can create a barrier to access.

In Glasgow and Clyde a new scheme was set up following an examination of international evidence and an independent review of previous provision which concluded the C-card program was no longer effective (Graham & Crossan, 2012). The main changes to the service included an increased access from a range of agencies, no restrictions to access, and no requirement to register or provide personal details, no membership, and an increased product range.

This enabled more and varied sites to deliver, reduced barriers in access, and sped up delivery of supplies. In Glasgow and Clyde, they experienced a threefold increase in the number of venues and nearly 345,000 additional condoms distributed annually (Graham & Crossan, 2014).

Recommendation: One proposal for consideration is to set up a scheme to provide free condoms to those who need them, not just young people, without the requirement to register. Consideration would need to be given to safeguarding and monitoring processes. Bespoke training and local standards should be developed for staff at venues wishing to participate in keeping with the guidance from Brook and Public Health England (2014). Given the lack of quality research evidence, if a new scheme is set up, a formal evaluation would be required to assess whether the scheme is effective. Young people should be involved in the evaluation.

7.3 Partner notification

Partner notification aims to prevent re-infection of the index patient and treat their sexual partners to control the spread of STI and reduce STI-related morbidity and mortality. It is effective for reaching people with an STI who are asymptomatic and people who do not present for diagnosis, counselling and treatment.

There are national and international guidelines which recommend voluntary partner notification via both primary care and specialist sexual health services. Internationally, there is a lack of consensus about whether patient or provider referral is the most effective method of partner notification. Lack of resources, lack of provider skills and time, particularly time for primary care staff, are thought to be the main barriers to partner notification for providers. Patients perceive partner notification as a difficult task (ECDC, 2013).

Locally each provider has their own system of partner notification. Partner notification is not currently monitored apart from collating data from the chlamydia screening programme.

An economic and mathematical modelling study on the chlamydia screening programme contrasted interventions targeting men or using improved partner notification. The modelling suggested that increasing chlamydia screening coverage to 24% in men would cost over six times as much as increasing partner notification to 0.8% but only treat twice as many additional infections. The conclusion was that increasing the effectiveness of partner notification is likely to be more cost effective than interventions to increase male coverage

Recommendation: there should be a specific focus having a standard approach and monitoring effectiveness of partner notification and monitor this to see if this increases the number of young men accessing services

7.4 Chlamydia

Similarly to the rest of England, Chlamydia is the most common sexually transmitted infection and has a rate which is three times that of genital warts (see table 7 below).

Table 7. New STI rate per 100,000 in Tameside 2013		
	Rate	Proportion
All	890.4	100%
Chlamydia	476.3	53.49%
Warts	128.0	14.38%
Herpes	71.7	8.06%
Gonorrhoea	42.7	4.79%
Syphilis	4.1	0.46%
Other	167.6	18.82%
<i>Source: PHE 2014, p.9</i>		

Since chlamydia is most often asymptomatic, a high diagnosis rate reflects success at identifying infections that, if left untreated, may lead to serious reproductive health consequences. The chlamydia diagnosis rate reflects both screening coverage levels and the proportion of tests that are positive at all testing sites, including primary care, sexual and reproductive health and genitourinary medicine services.

National Chlamydia Screening Programme (NCSP) tests should be offered annually to men and women under 25 who have ever been sexually active.

A chlamydia test is recommended if:

- a person or their partner have any symptoms or think they have an STI
- someone has unprotected sex with a new partner
- a condom splits
- the person or their partner have unprotected sex with other people
- a sexual partner says they have an STI
- pregnant or planning a pregnancy
- a vaginal examination finds the cervix is inflamed or there is vaginal discharge

The number of tests, annual coverage and positivity for Tameside for 2012 and 2013 are shown in table 8. The majority of tests take place in other settings than GUM. In 2012, 18% of Chlamydia testing took place in GUM; by 2013 this had increased to 37.4%, mainly due to an increase in testing at GUM.

Table 8. Chlamydia testing data in 15-24 year olds in Tameside: 2012/13					
Year	Number of chlamydia tests in GUM	Number of chlamydia tests in other settings	Total number of tests	Number of positives (all settings)	Percentage of population tested (all settings)
2012	1433 (18.4%)	6362	7795	686	28
2013	3688 (37.4%)	6178	9866	860	36.2
<i>*Repeat tests are not excluded. Source: Data from Genitourinary Medicine Clinics and community settings</i>					

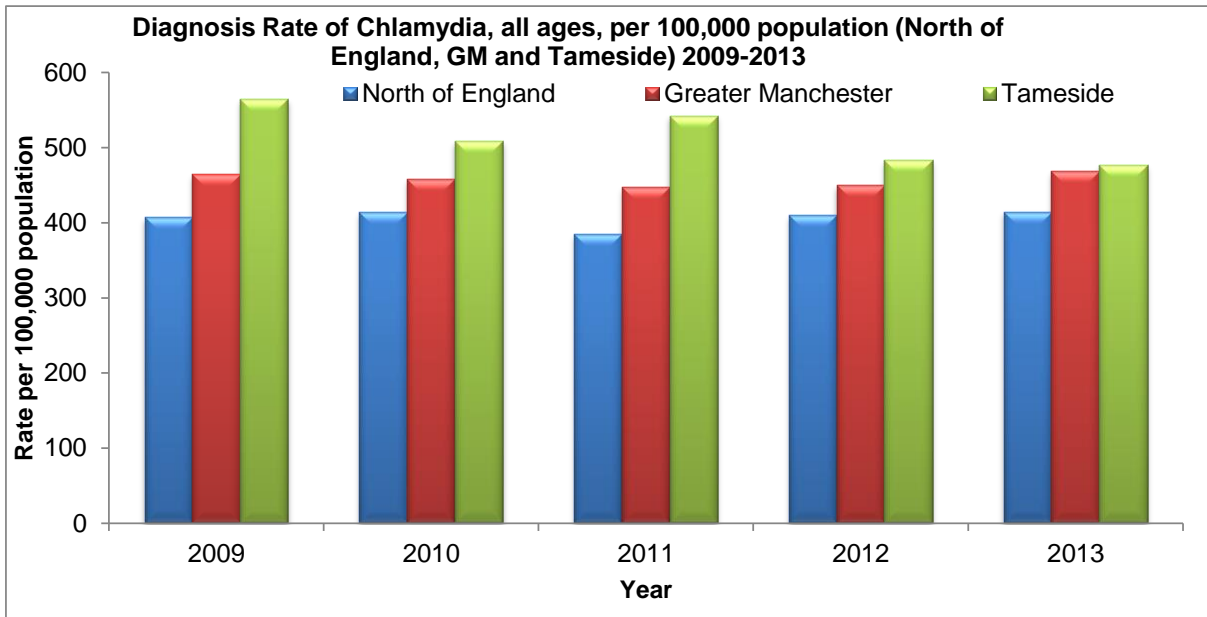
Chlamydia test and diagnosis data from 2012 onwards are sourced from CTAD and include all ages. PHE recommends that local areas achieve a rate of at least 2,300 per 100,000 resident 15-24 year olds, a level which is expected to produce a decrease in chlamydia prevalence.

Nationally, in 2012 26% of 15-24 year olds were tested for chlamydia with an 8% positivity rate and in 2013, 24.9% of 15-24 year olds were tested for chlamydia with an 8.1% positivity rate.

In both 2012 and 2013, Tameside achieved above the national average for both coverage and diagnosis rate. The chlamydia diagnosis rate in 15-24 year olds in Tameside was 2473.6 per 100,000 in 2012 and 3156.7 in 2013. In 2012, 28% of 15-24 year olds were tested for chlamydia with a 9% positivity rate and in 2013 this was 36.2% with an 8.7% positivity rate.

Although the diagnosis rate for chlamydia remains higher in Tameside than the North of England and Greater Manchester, data for 2009 - 2011 only includes those aged 15-24. Therefore chlamydia data from 2012 onwards are not comparable to data from previous years (see chart 6 below).

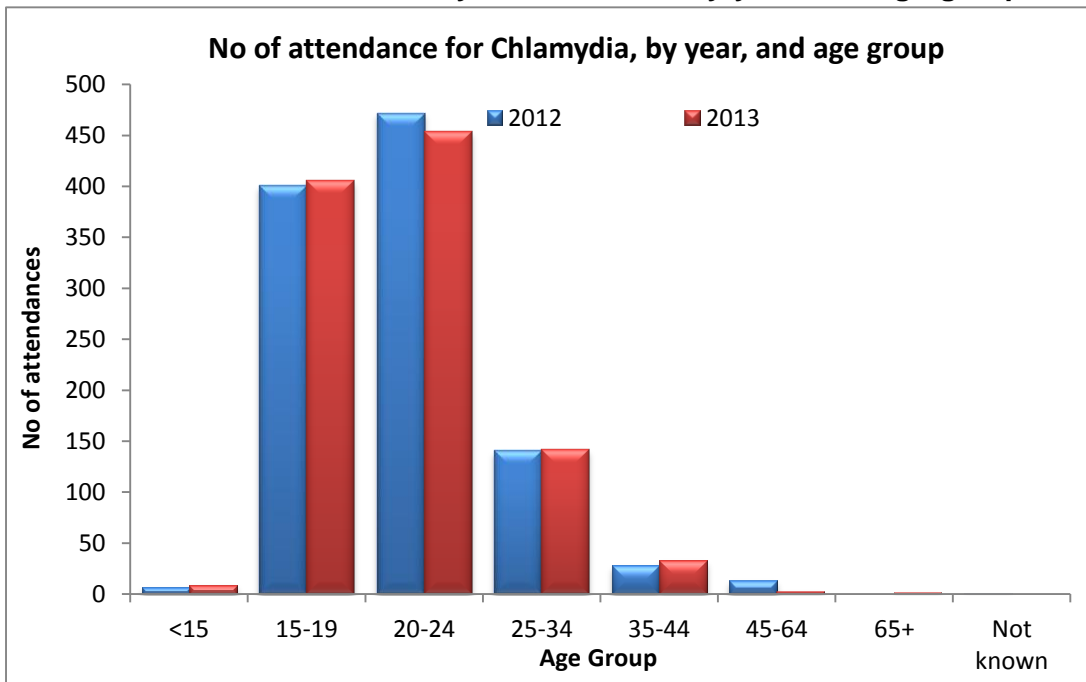
Chart 6:



Source: all providers (Public Health England, 2014)

The 20 to 24 year age group has the highest number of attendances for chlamydia screening at GUM clinics, see chart 7 below.

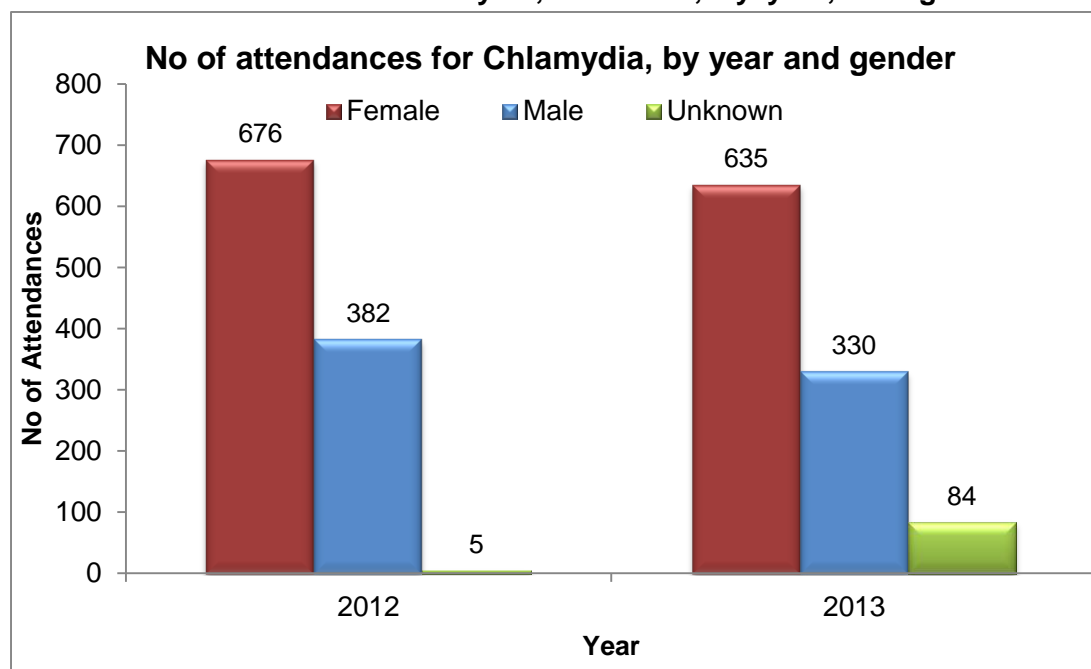
Chart 7. Attendances for Chlamydia, Tameside, by year, and age group 2012 & 2013



Data source: GUMCAD (GUM Clinic Activity Dataset) and CTAD (Chlamydia Testing Activity Dataset) 2014

In terms of chlamydia testing at GUM clinic, the majority of those tested were females (60% in 2012) and in 2013 year there was a decrease in recording of gender. This would appear to reflect the national picture where historically, more females have attended than males. See chart 8 below.

Chart 8. Attendances for Chlamydia, Tameside, by year, and gender 2012 & 2013



Data source: GUMCAD (GUM Clinic Activity Dataset) and CTAD (Chlamydia Testing Activity Dataset) 2014

Along with the other 10 local authorities, Tameside Council commissions RUCleaR from Central Manchester Foundation Trust (Brand name RUCleaR) to deliver the (NCSP) amongst 15-24 year olds. RUCleaR will contact young people under the age of 25 with the results and organise treatment, tests can be sent directly to young people in the post or they can be provided via the sexual health clinics, general practice and pharmacies. RUCleaR provide training and test kits to service providers.

According to the NCSP, around 75% of young adults visit their GP every year, providing an ideal opportunity to offer an annual chlamydia screen. Additionally, information on screening and internet testing can be mailed to the relevant age ranges on the practice list.

Chlamydia screening is available at GP practices, pharmacies (as part of EHC offer) and the ISHS (three sites). The primary care delivery of chlamydia screening is also supported by the GP Sexual Health Clinical Champion to promote best practice. NICE recommend 48 hour access to an appointment from first contact with the service. During 2013/14 there were approximately 750 chlamydia screens undertaken by GP practices in Tameside. The number of tests undertaken varied between practices with 10 practices not offering any screens, whilst two practices undertook over 150 screens each, the mean average per practice was 21 tests.

Recommendation: Consideration could be given to ensuring all GP practices are actively offering chlamydia screening.

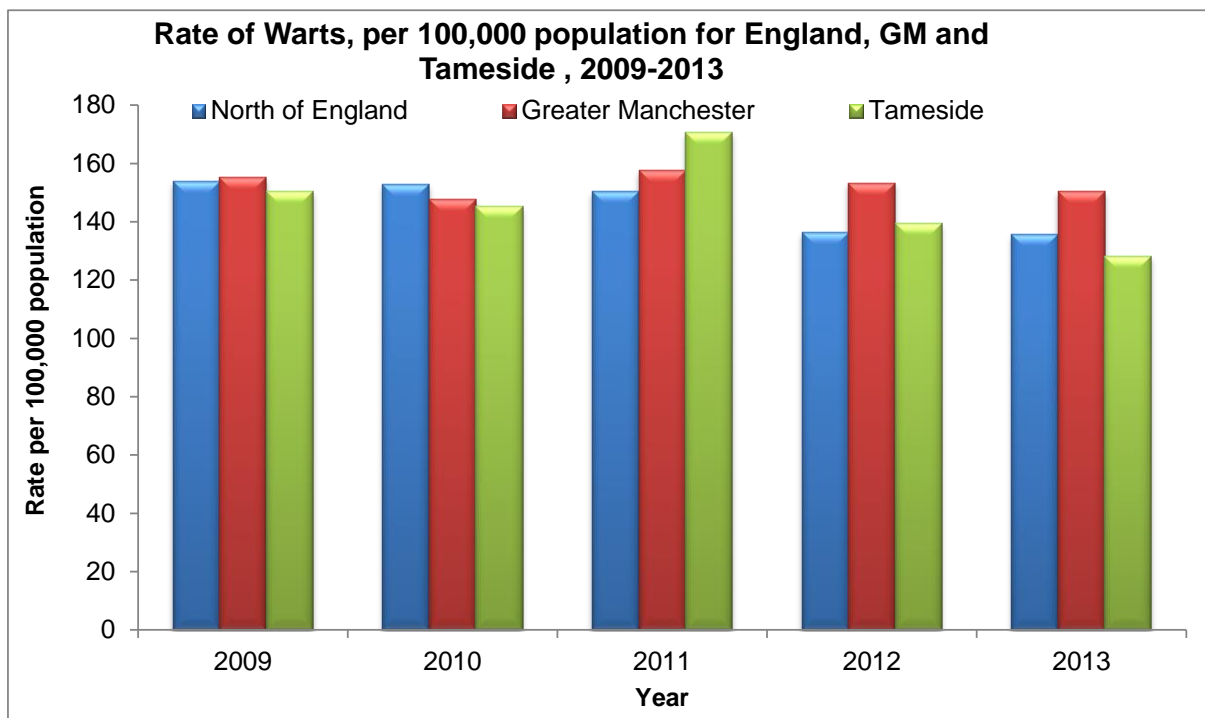
There may be an issue of double payments as at present, all providers receive free test kits funded through RUCleaR and the ISHS is also paid to deliver chlamydia screening as part of their block contract.

7.5 Warts

Genital warts are very common. In England, they are the second most common type of sexually transmitted infection (STI) after chlamydia. Genital warts are the result of a viral skin infection caused by the human papillomavirus (HPV). They are usually painless and do not pose a serious threat to health. There is no evidence fertility is affected by genital warts.

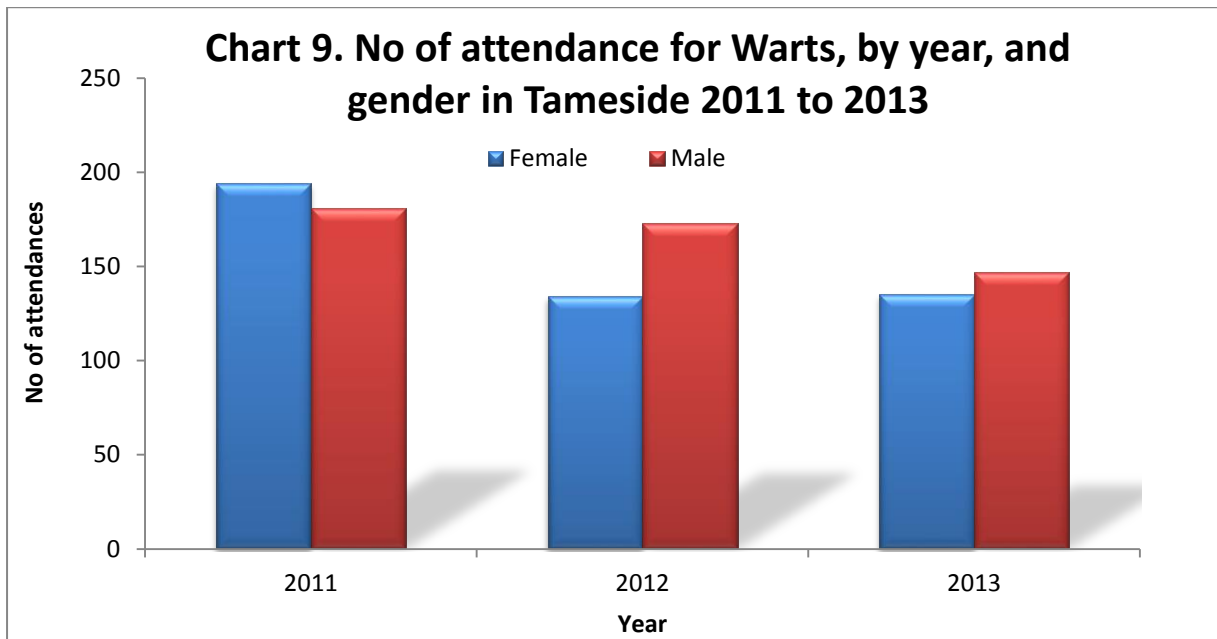
Over the past decade in England, diagnoses of genital warts and genital herpes have increased considerably, most notably in males. The rates of warts in Tameside in 2012 and again in 2013 were lower than in the in previous years, although there is variation in the rate due to the small numbers (See chart 8).

Chart 8.



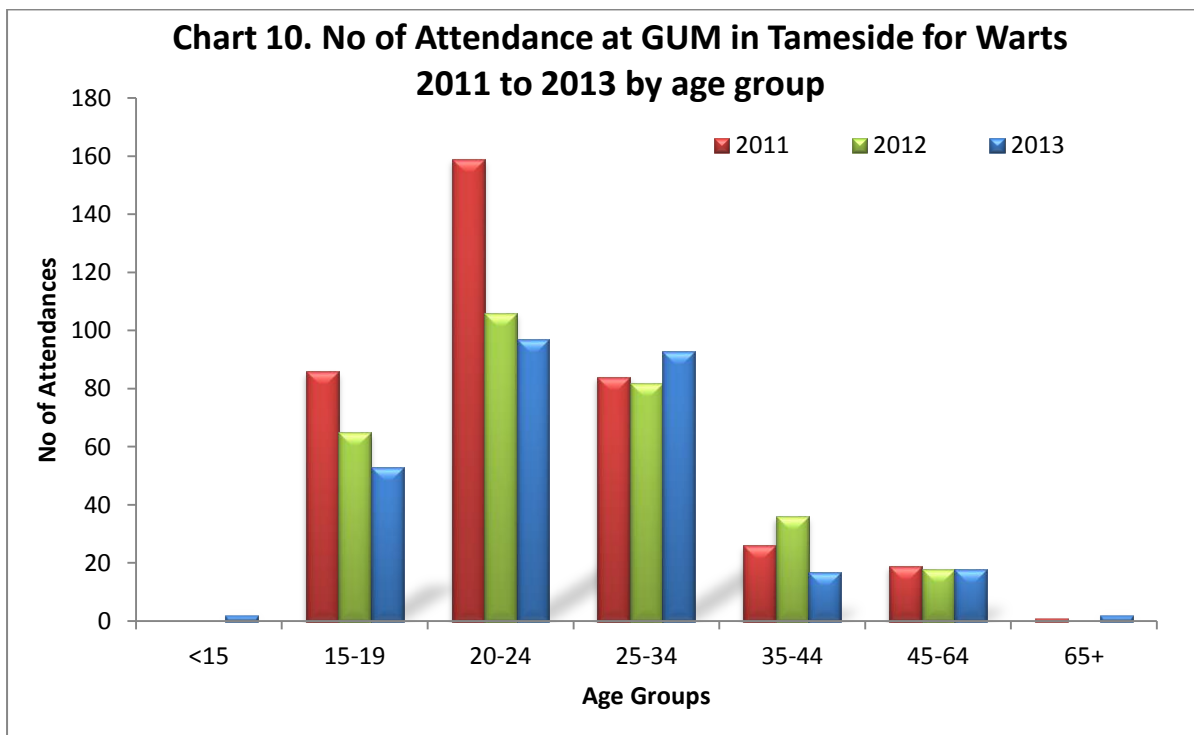
Data source: GUMCAD (GUM Clinic Activity Dataset) and CTAD (Chlamydia Testing Activity Dataset) 2014

In the past two more males have attended GUM clinic with Warts than females (see chart 9).



Source: GUMCAD (GUM Clinic Activity Dataset) and CTAD (Chlamydia Testing Activity Dataset) 2014

In terms of age group, it is the greatest number of attendances for Warts at GUM clinics is in the 20-24 and 25-30 age groups (see chart 10)



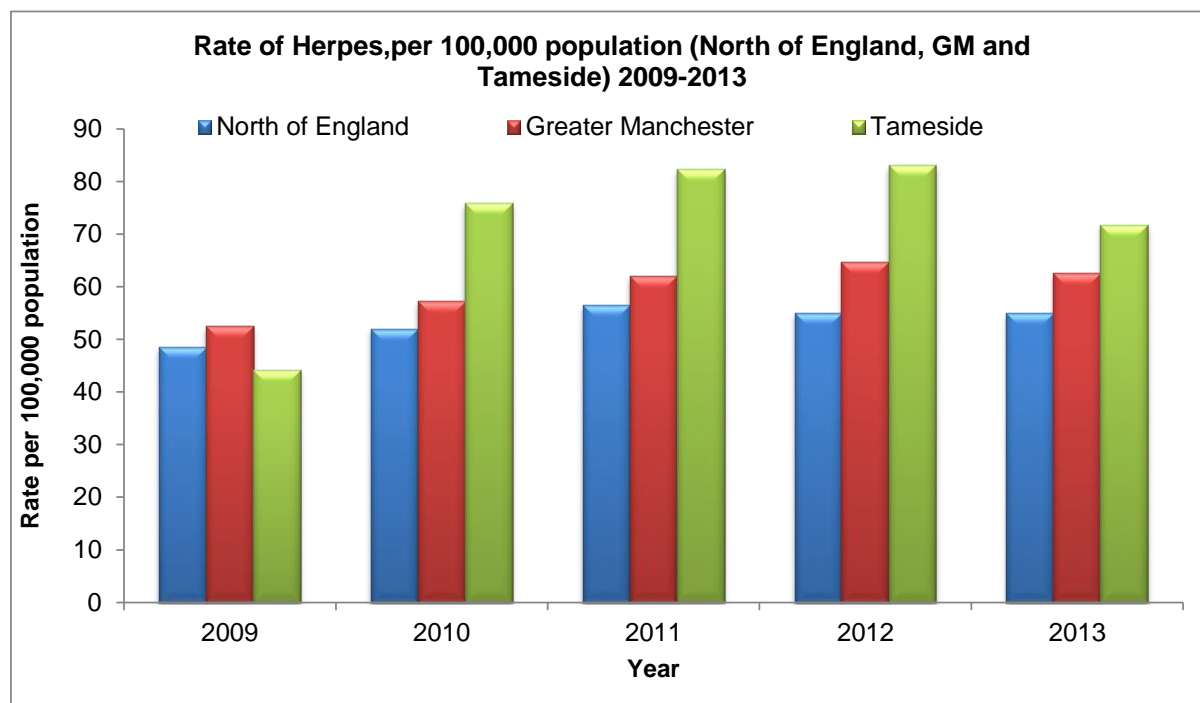
Source: GUMCAD (GUM Clinic Activity Dataset) and CTAD (Chlamydia Testing Activity Dataset) 2014

7.6 Herpes

Herpes is caused by a virus called Herpes simplex. It is thought that at least eight out of 10 people who carry the virus are unaware they have been infected because there are often few or no initial symptoms. Genital herpes is a chronic condition. The virus remains in the body and can become active again. The average rate of recurrence is four to five times in the first two years after being infected. However, over time, it tends to reoccur less frequently and each outbreak becomes less severe. Genital herpes can cause problems during pregnancy.

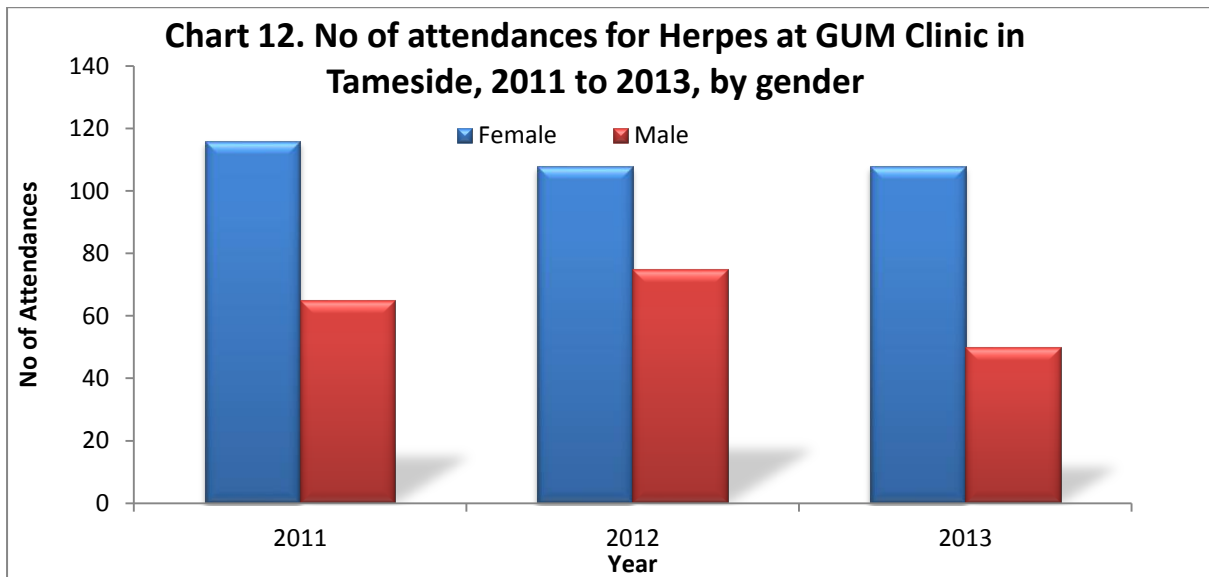
Tameside has experienced an increase in the rate of Herpes in 2010-12 although a slight decrease in 2013. Over the last four years, Tameside has had a rate for herpes infection which is higher than the North of England and Greater Manchester. However as the numbers are relatively small, there are 158 diagnoses in Tameside during 2013, this figure does need to be viewed with some caution. See chart 11 below.

Chart 11.



Source: GUMCAD (GUM Clinic Activity Dataset) and CTAD (Chlamydia Testing Activity Dataset) 2014

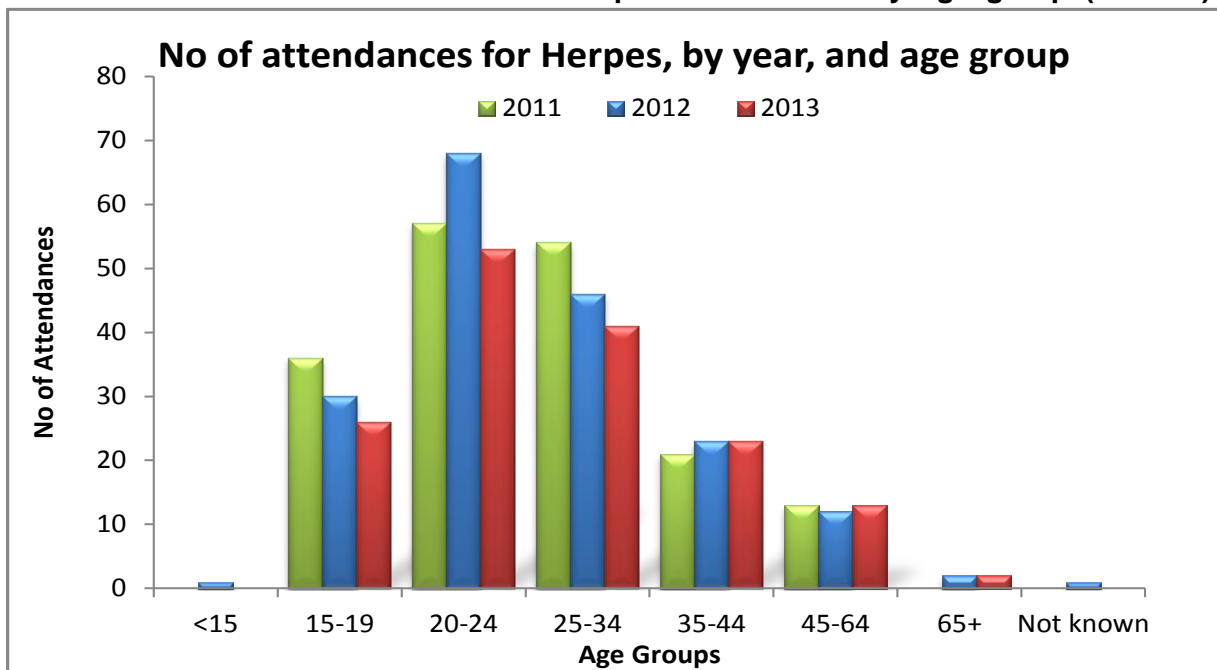
In terms of the number of attendances for Herpes via the GUM service, herpes was diagnosed in more women than men (see chart 12. below).



Data source: GUMCAD (GUM Clinic Activity Dataset) and CTAD (Chlamydia Testing Activity Dataset) 2014

Similarly to warts, the number of attendances for herpes is greater in the 20-24 and 25-34 age groups (see chart 13 below).

Chart 13: Number of attendances for Herpes in Tameside by age group (2011-13)



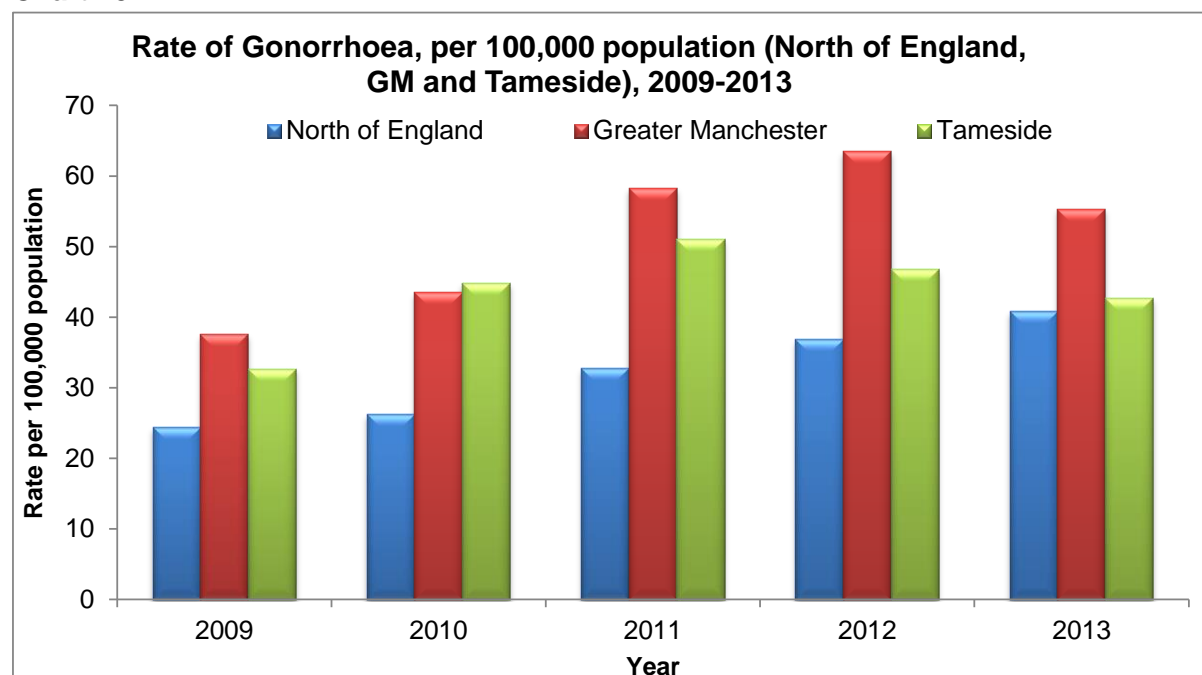
Data source: GUMCAD (GUM Clinic Activity Dataset) and CTAD (Chlamydia Testing Activity Dataset) 2014

7.7 Gonorrhoea

Gonorrhoea is a marker for high levels of risky sexual activity. Gonorrhoea is caused by bacteria called *Neisseria gonorrhoea* or gonococcus. Typical symptoms include a thick green or yellow discharge from the vagina or penis, pain when urinating and bleeding in between periods in women. However, around one in 10 infected men and almost half of infected women don't experience any symptoms.

In England, there has been a year on year increase in diagnosis of gonorrhoea for the last five years, whereas Tameside has seen a slight reduction in diagnosis since 2011 (see chart 13 below).

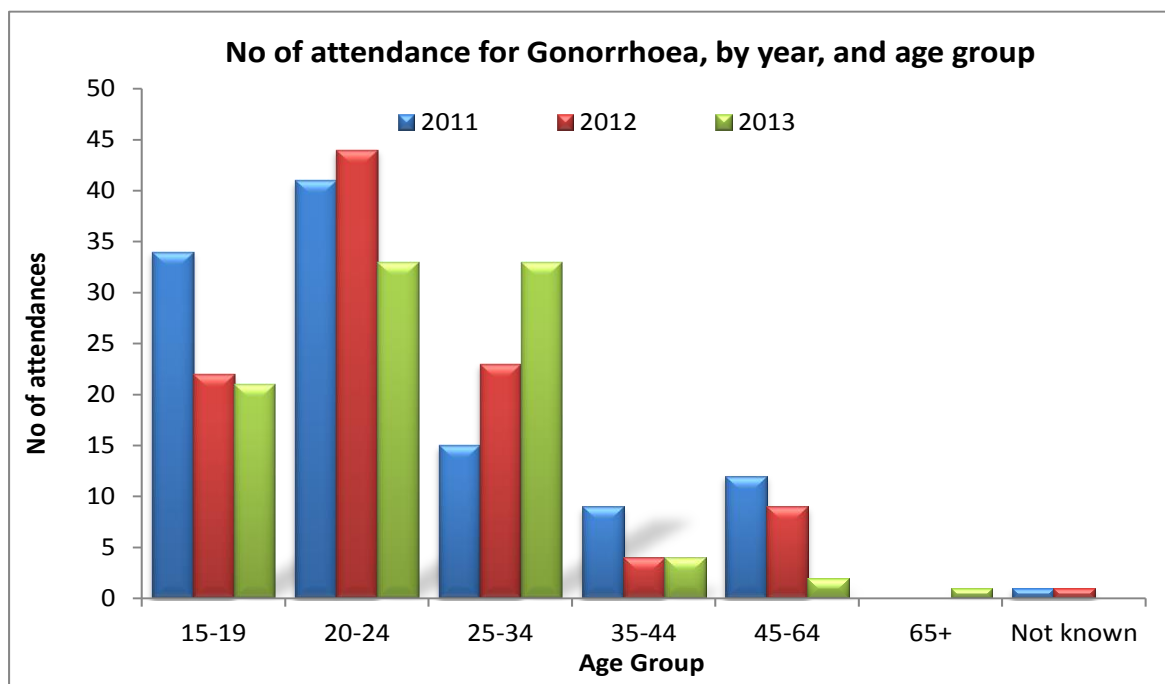
Chart 13.



Source: GUMCAD (GUM Clinic Activity Dataset) and CTAD (Chlamydia Testing Activity Dataset) 2014

In terms of age group, between 2011 and 2013, there does appear to be a slight increase in the number of people being detected with gonorrhoea in the 25-34 age range. However, this data needs to be interpreted with caution as this may be due to small numbers; in 2013 there were 33 people who attended with gonorrhoea (see chart 14 below)

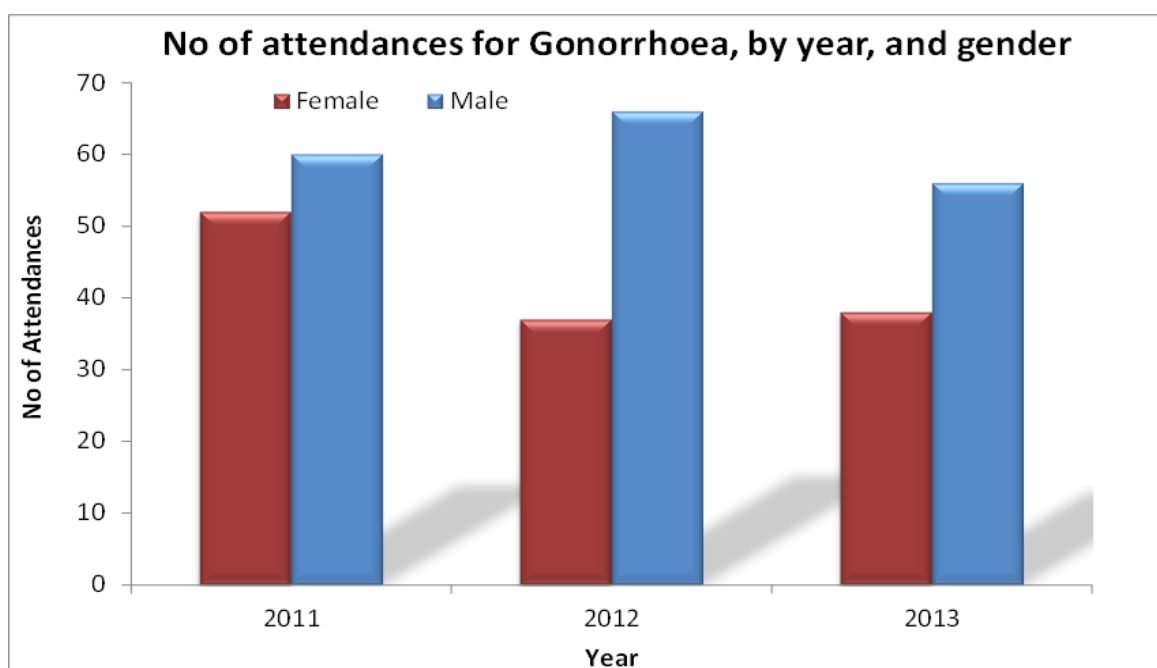
Chart 14. Number of attendances for Gonorrhoea in Tameside by age group (2011-13)



Data source: GUMCAD (GUM Clinic Activity Dataset) and CTAD (Chlamydia Testing Activity Dataset) 2014

Different from chlamydia and herpes, gonorrhoea was more commonly diagnosed in males than females (see chart 15 below). Some of this difference may relate to men who have sex with men see section 13.4.

Chart 15. Number of attendances for Gonorrhoea in Tameside by gender



Source: GUMCAD (GUM Clinic Activity Dataset) and CTAD (Chlamydia Testing Activity Dataset) 2014

In Tameside, an estimated 2.2% of women and 7.1% of men diagnosed with gonorrhoea at a GUM clinic between 2009 and 2013 became re-infected with gonorrhoea within twelve months. Nationally, an estimated 3.7% of women and 8.0% of men became re-infected with gonorrhoea within twelve months (Public Health England, 2014).

According to PHE, as the prevalence of gonorrhoea in most areas is low, opportunistic screening for gonorrhoea is not recommended unless there is a clear local public health need (Public Health England, 2014). All of Greater Manchester currently tests for Gonorrhoea via the RUClear offer from Central Manchester Foundation Trust. The understanding is the dual test does not have an additional cost as it is run at the same time in the labs from the same sample used for chlamydia screening.

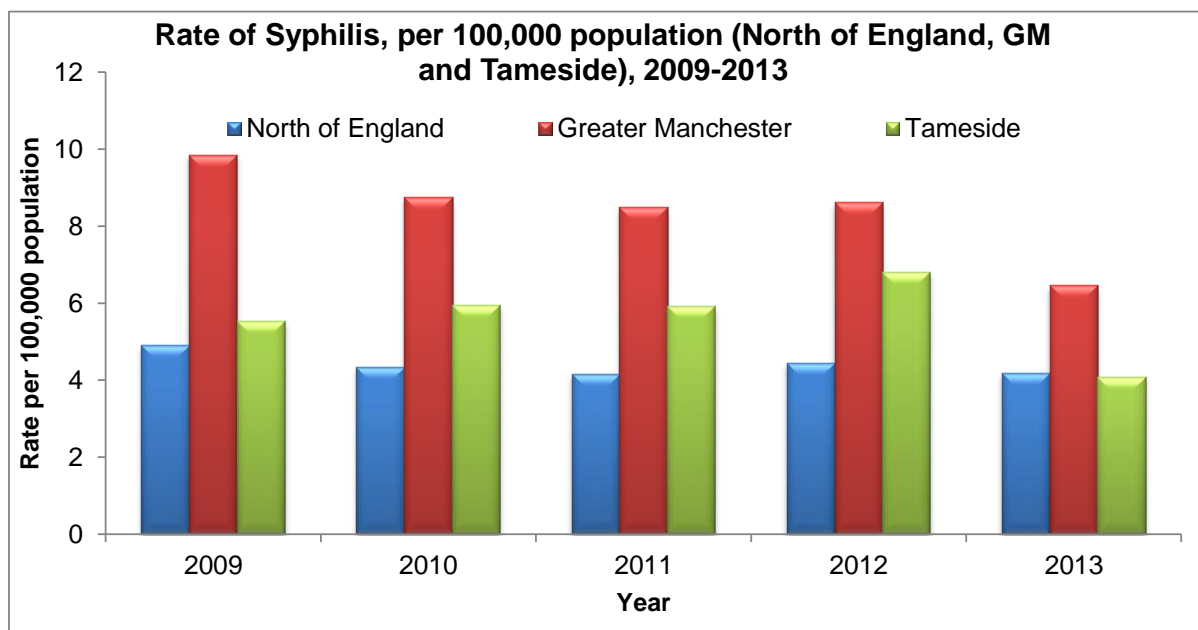
7.8 Syphilis

The bacteria that cause syphilis are called *Treponema pallidum*. Pregnant women can pass the condition on to their unborn baby, which can cause stillbirth or the death of the baby shortly after labor. The symptoms of syphilis develop in three stages, described below:

- **Stage 1 (primary syphilis)** – symptoms of syphilis begin with a painless but highly infectious sore on the genitals, or sometimes around the mouth. If somebody else comes into close contact with the sore, typically during sexual contact, they can also become infected. The sore lasts two to six weeks before disappearing.
- **Stage 2 (secondary syphilis)** – secondary symptoms, such as a skin rash and sore throat, then develop. These symptoms may disappear within a few weeks, after which there is a latent (hidden) phase with no symptoms, which can last for years. After this, syphilis can progress to its third, most dangerous stage.
- **Stage 3 (tertiary syphilis)** – around a third of people who are not treated for syphilis will develop tertiary syphilis. At this stage, it can cause serious damage to the body.

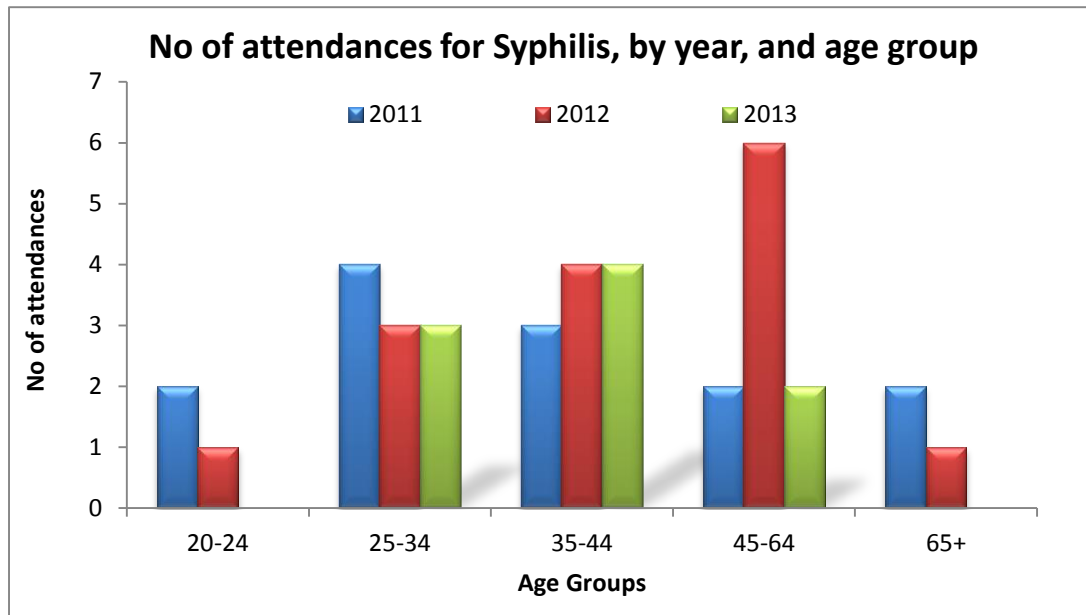
In 2013, for the first time in five years, Tameside had a rate per 100,000 for syphilis that was similar to the national rate; the rate in Tameside remains below the Greater Manchester rate. These numbers need to be viewed with some caution as the number diagnosed in Tameside was 15 in 2012 and nine in 2013. See chart 16 below

Chart 16.



In terms of age group, syphilis is different for the other STIs as its GUM attendances in Tameside were predominantly in the 35 to 44 age group (see chart 17 below).

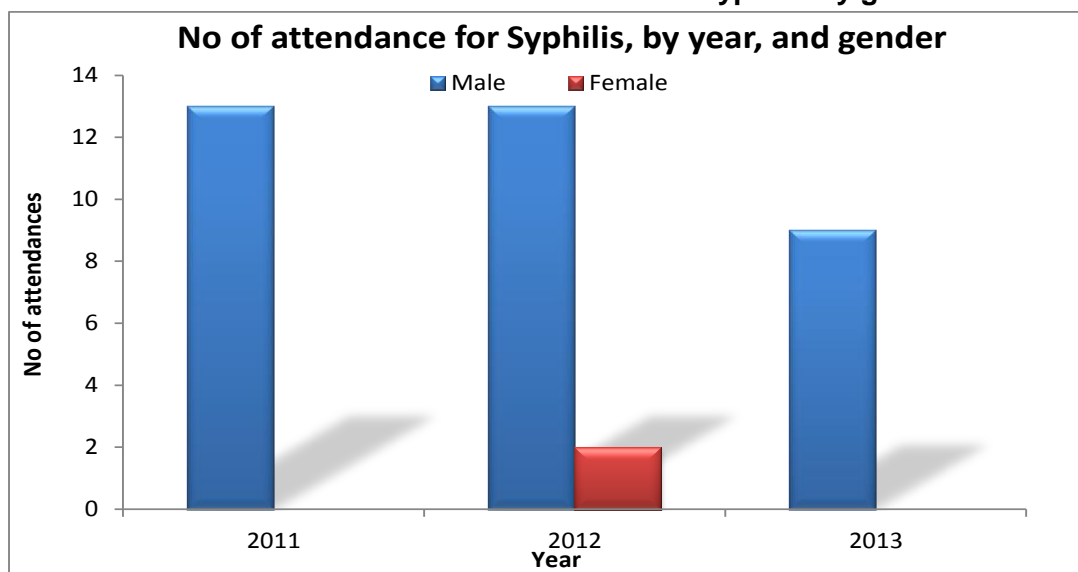
Chart 17: Number of attendances for syphilis in Tameside by age group, 2011-13



Data source: GUMCAD (GUM Clinic Activity Dataset) and CTAD (Chlamydia Testing Activity Dataset) 2014

Also, most attendees were male (see chart 18 below). Some of this difference may relate to men who have sex with men, see section 13.4.

Chart 18. Number of attendances in Tameside for syphilis by gender



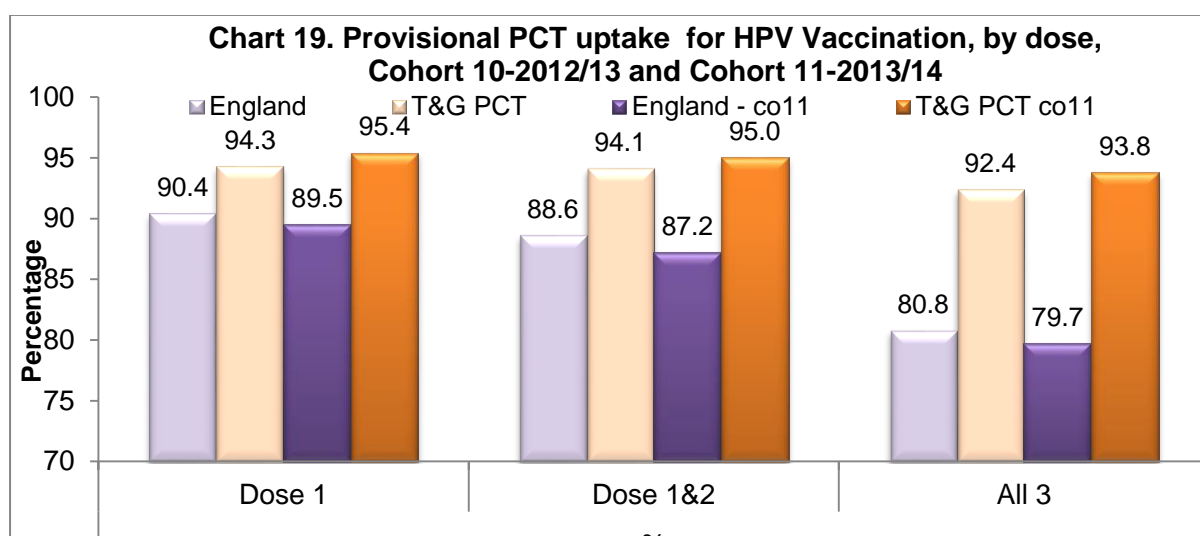
Data source: GUMCAD (GUM Clinic Activity Dataset) and CTAD (Chlamydia Testing Activity Dataset) 2014

7.9 HPV

The HPV virus is very common and is easily spread by sexual activity. In most cases, the virus doesn't do any harm because the immune system adequately deals with the infection. However, in some cases, the infection persists and can lead to health problems.

All girls aged 12 to 13 are offered HPV (human papilloma virus) vaccination as part of the NHS childhood vaccination programme. The vaccine protects against cervical cancer. It's usually given to girls in year eight at schools in England.

Currently, the vaccination data is shown on the Tameside and Glossop former Primary Care Trust footprint. For both 2012/13 and 2013/14, Tameside and Glossop had a percentage vaccination uptake above the England average. See chart 19 below



Source: Public Health England, HPV uptake data published in June of each of the last two years

7.10 HIV

Human Immunodeficiency Virus (HIV) attacks the immune system, and weakens its ability to fight infections and disease. There is no cure for HIV, but there are treatments to enable most people with HIV to live a long and healthy life.

HIV testing is key to preventing its transmission; more than 50% of new cases are estimated to have been the result of people who are undiagnosed having unprotected sex. People who do not know their HIV status are believed to be three times more likely to pass on the infection than those who know their status. They are also more than twice as likely to have unprotected sex (NICE, 2014).

Once people are being treated they are much less infectious. Once someone is diagnosed with HIV they are also likely to make more effort to reduce the risk of transmission. Earlier diagnosis of HIV, leading to better management of the condition, can help reduce demand on long-term care and other services (NICE, 2014).

Current UK guidelines (British HIV Association et al. 2008) aim to 'normalise' and increase HIV testing in all healthcare settings to reduce the levels of an undiagnosed HIV infection. They recommend a HIV test should be offered to everyone in some settings (for example, antenatal) and only to people at risk in other settings (for example, general practice).

NICE guidance recommends specifically targeting HIV tests to those most at risk of acquiring HIV:

- everyone who requests testing for an STI
- all men who disclose to health professionals that they have sex with men
- Black Africans living in England who are, or who have been, sexually active.
- everyone who is diagnosed with a clinical indicator disease (NICE, 2014)

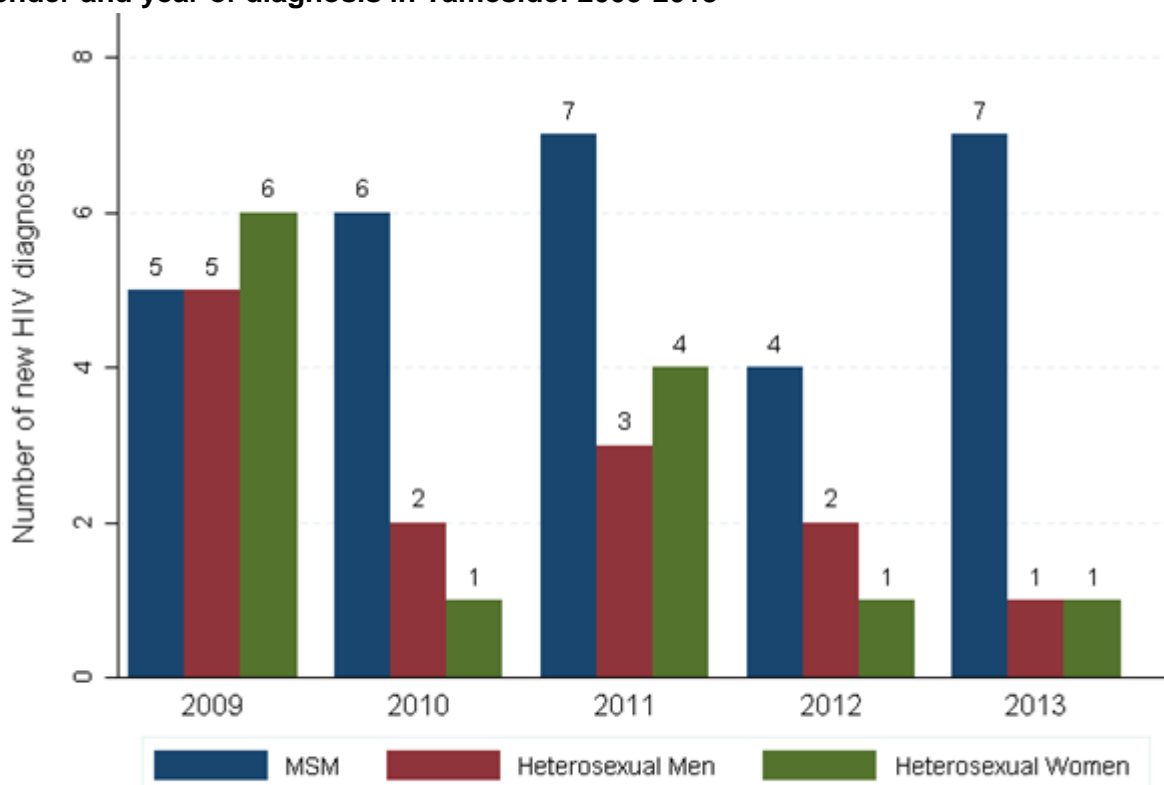
7.10.1 Incidence of HIV

Tameside has one of the lowest incidence rates of HIV in Greater Manchester. The data used in this section is primarily from The Survey of Prevalent Infections Diagnosed (SOPHID) as this includes a range of datasets and is currently used by PHE. However, figures from the Centre for Public Health are similar in terms of trends but higher in terms of numbers (CPH, 2014).

The mean average of new cases per year for the last five years is 11 (PHE, 2014), although this may be an underestimate as the data from the CPH gives the five year average as 17 new cases each year. The numbers diagnosed by route of sexual transmission vary; the majority of which are in Men who have Sex with Men. In 2013, nine adult residents of Tameside (14 using CPH data) were newly diagnosed, where residence was known, with HIV as a result of sexual transmission. Seven new HIV diagnoses were among MSM (see Chart 20 below).

The age of people newly diagnosed seems to vary substantially from year to year. In 2012 there was a significant shift in the proportion of new diagnoses in Tameside residents from people aged 20-29, with a concurrent decrease in the proportion of new diagnoses in people aged over 40. Fluctuations in the age distribution of new diagnoses from year to year mean that this could be a chance finding, however this trend should be monitored to see if this continues.

Chart 20. Number of adults newly diagnosed with HIV by route of sexual transmission, gender and year of diagnosis in Tameside: 2009-2013



Source:
HIV and AIDS new diagnoses and deaths
The Survey of Prevalent HIV Infections Diagnosed (SOPHID)

7.10.2 Offer and uptake at GUM clinics

In 2013, a HIV test was offered to 70.0% of those eligible Tameside residents attending a GUM clinic which is lower than England where 79% were offered.

Nationally, where offered, a HIV test was done in 80% of these attendances during 2013 where as in Tameside this was significantly lower at 46% (Public Health England, 2014).

Unfortunately figures for HIV testing in primary care were not found.

7.10.3 HIV late diagnosis

Late diagnosis is the most important predictor of HIV-related morbidity and short-term mortality. It is a critical component of the Public Health Outcomes Framework and monitoring is essential to evaluate the success of expanded HIV testing.

In Tameside, between 2011 and 2013, 67% (95% CI 43-85) of HIV diagnoses were made at a late stage of infection (CD4 count <350 cells/mm³ within 3 months of diagnosis) compared to 45% (95% CI 44-46) in England. Because of the small numbers resulting in wide confidence intervals (CI) the difference between Tameside and England is not statistically significant so this figure needs to be interpreted with caution.

57% (95% CI 29-82) of men who have sex with men (MSM) and 86% (95% CI 42-100) of heterosexuals were diagnosed late.

7.10.4 HIV Testing

Two of the five local authorities with the highest prevalence of HIV (outside of London) are within Greater Manchester (Manchester and Salford). This would indicate there is an opportunity to reduce new infections and tackle late diagnosis by improving HIV testing opportunities together across GM. In 2013 there was estimated to be 1,500 people in the region with undiagnosed HIV (Terrence Higgins Trust, 2014).

If residents feel they have been at risk of acquiring HIV they can access a HIV test via a range of options. The most frequent way is via the ISHS or via their GP. In addition, RUClear provides a targeted programme of dried blood spot testing for HIV, via postal home sampling kits. The availability of these tests has been promoted to men who have sex with men in Tameside, however further work is needed to promote testing among Black African groups who make up over a quarter of people living with HIV in Tameside.

An option for reducing late diagnosis is investing in Point of Care Testing (POCT) for HIV. The availability of point of care testing for HIV is a gap in current provision. A questionnaire targeted at 137 people at high risk of HIV who had declined a HIV test at two London GUM clinics found that 51% of who declined HIV testing said they would be more likely to accept a POCT (Forsyth, et al., 2008).

In Liverpool, services which were interacting with individuals at high risk and marginalised groups were offered the opportunity to incorporate POCT in their existing services. Between September 2009 and June 2010, 953 individuals underwent POCT and found it to be more effective in reaching males, older age groups and UK African origin than the GUM clinic (p value greater than 0.05). 17 people were found with HIV (McPherson, et al., 2011).

Recommendation: Making POCT available via open access sexual health services and in venues/services used by high risk groups should be considered. This is recommended in NICE guidelines but not currently available in Tameside. Any introduction of point of care testing will need to consider sensitivity and specificity of tests available, and the potential for joint commissioning across Greater Manchester.

7.10.5 People living with HIV

6,207 people are living with HIV in the GM region (Terrence Higgins Trust, 2014). In 2013, 197 adult residents (aged 15 years and older) in Tameside received HIV-related care: 142 males and 55 females. Among these, 62.4% were white, 26.4% black African and 1.5% black Caribbean. With regards to exposure, 52.8% probably acquired their infection through sex between men and 43.7% through sex between men and women (Public Health England, 2014).

7.10.6 Services for HIV

The results are triaged and if a person is tested positive for HIV they would be invited for a full sexual health screen. People may also choose to purchase a POCT from independent providers (the law changed in April 2014). The local authority holds a responsibility to ensure that HIV tests are available to those who need to access one. A residents GP also holds a responsibility to offer a test if required during the consultation.

Approximately two thirds of HIV positive patients living in Tameside access their HIV care outside of Tameside with the rest accessing care at the ISHS in Tameside (now branded The Orange Rooms www.theorangerooms.co.uk). In addition to specialist services, patients

can also access support from their GP and a number of community HIV services, such as George House Trust, Black African Health Agency, Lesbian & Gay Foundation Trust and Barnardo's (for children and families). Most people who need inpatient care for their HIV will be treated initially in a Manchester Hospital.

Lesbian, Gay Bisexual and Transgender Foundation (formerly LGF): The service delivers HIV prevention activities for TMBC, specifically targeted to MSM, Gay and Bisexual men. It is jointly funded by all 10 local authorities in GM to provide; one-to-one support and advice on sexual health and HIV, peer support opportunities, training for professionals and service users, and additional interventions to support LBGT wider health issues. There is also 'pride in practice' which supports primary care staff to provide services suitable to meet LGBT needs.

George House Trust (GHT): the majority of local authorities in GM commission GHT who support people living with and affected by HIV and campaigns for quality of life for all people with HIV, including work to reduce associated stigma. The services are open to anyone living with, or affected by HIV, living within Greater Manchester and further afield. GHT aim to meet the specific needs of each person accessing the service and offer support for a wide range of issues including understanding HIV, ability to manage the condition, financial advice, supporting wider health and well-being needs and delivering training.

Black African Health Agency: The majority of GM local authorities commission BHA to provide HIV and STI prevention activities to Black African and ethnic minority populations in GM, as culturally appropriate.

7.11 Hepatitis

NICE guidelines on Hepatitis B and C, state that although hepatitis C can be transmitted through sex, injecting drug use is the main route of hepatitis C infection in England. 2% of laboratory reported cases of Hepatitis C reported the main risk factor as being sexual health contact (cited by Stephens, 2014). There is some evidence that HIV-positive men who have sex with men are at increased risk, and British HIV Association guidelines recommend regular hepatitis C testing in this group (NICE, 2012). Local clinicians have reported concerns about re-infection rates in HIV positive men. It is important to ensure Hepatitis C testing is offered at HIV specialist services.

8. Contraception

Contraception is widely available in the UK from a number of sources, and is provided free by the NHS. Contraception is available free of charge from: general practices, sexual and reproductive health services, young person's clinics, NHS 'walk-in centres (EHC only), some GUM clinics (EHC and male condoms) and some pharmacists under a Patient Group Directive (EHC) (Public Health England, 2014)

Local authorities are mandated to commission confidential, open access to contraception services as well as reasonable access to all methods of contraception. In the past, if Primary Care Trusts had restrictions in access to contraceptives or contraceptive services, such as

restricting by residency, age, requiring GP referral, or type of contraceptive method, they also had a higher abortion rate than the national average (Advisory Group on Contraception, 2012).

Data on contraception is currently only collected from sexual health services and some young person's clinics through the Sexual and Reproductive Health Activity Dataset (SRHAD) and from NHS prescription forms within primary care. Data from other providers is not available at this time (Public Health England, 2014). There were approximately 11,400 first contacts at NHS community contraceptive clinics in Tameside during 2012/13 (HSCIC 2013).

Condoms are not available on the NHS; there is not therefore prescription data from GPs. Condoms can also be purchased from pharmacies, supermarkets, and other retailers. Emergency hormonal contraception can also be bought over the counter at some pharmacies and private clinics (Public Health England, 2014).

There are number of contraception services available in Tameside, the main services are briefly outlined as follows:

Primary care: All Tameside GP practices provide contraception as an additional service as part of their General Medical Services contract. The majority of women in Tameside access their contraception at their GP practice. Oral contraceptives are currently the most commonly used form of contraception. Some practice also offer LARCs and this commissioned by Tameside MBC.

Integrated sexual health service: The ISHS offers all contraceptive choices except sterilisation. On average, each individual used the service approximately twice, with some persons attending up to 13 times. A very small proportion of individuals accessing the service were male (approximately 1%). The over 25's use this service with around double the level of activity compared to plan.

Pharmacy: There are 16 pharmacies in Tameside who offer EHC and are able to offer general contraception advice information and referral.

Health Visitors: Health Visitors offer advice on contraception following childbirth. Given national data from 2011 that just over half of women having an abortion had previously had a live birth or a stillbirth, it would highlight the importance of being able to access contraception following childbirth (Department of Health, 2013).

8.1 Emergency Hormonal Contraception (EHC)

There are three first-line options; a copper intrauterine device (IUD), Levonorgestrel (levonelle), or ulipristal acetate (EllaOne). An IUD can be inserted into the uterus up to five days after unprotected sex, or up to five days after the earliest time of ovulation. It can stop an egg from being fertilised or implanting in the womb.

Levonelle has to be taken within 72 hours (three days) of sex, and EllaOne has to be taken within 120 hours (five days) of sex. Both pills work by preventing or delaying ovulation. Nationally, the number of contacts for emergency contraceptives has been reducing. Also

the data would indicate that although hormonal contraception is used more frequently than IUD, the number using IUDs is increasing (see table 9 below).

Year	All ages		
	Total occasions	Hormonal	IU Device
2003/04	187.4	183.2	4.2
2004/05	178.5	174.1	4.5
2005/06	169.3	164.5	4.8
2006/07	158.1	153.1	5.0
2007/08	135.9	131.8	4.1
2008/09	142.5	137.8	4.7
2009/10	143.6	137.0	6.6
2010/11	139.8	134.2	5.6
2011/12	134.2	128.1	6.0
2012/13	131.9	124.9	7.0

Source: HSCIS NHS Contraceptive Services 2014

In England, the age group with the highest number of contacts for EHC is the 20 to 24 age group (see table 10)

England	Total	Hormonal	IU Device	Thousands
All ages	131.9	124.9	7.0	
Under 15	4.1	4.0	-	
15	7.8	7.7	0.1	
16-17	22.3	22.0	0.3	
18-19	21.6	21.1	0.5	
20-24	37.0	35.4	1.6	
25-34	28.4	25.6	2.8	
35 and over	10.8	9.1	1.7	

8.1.1 EHC access in Tameside

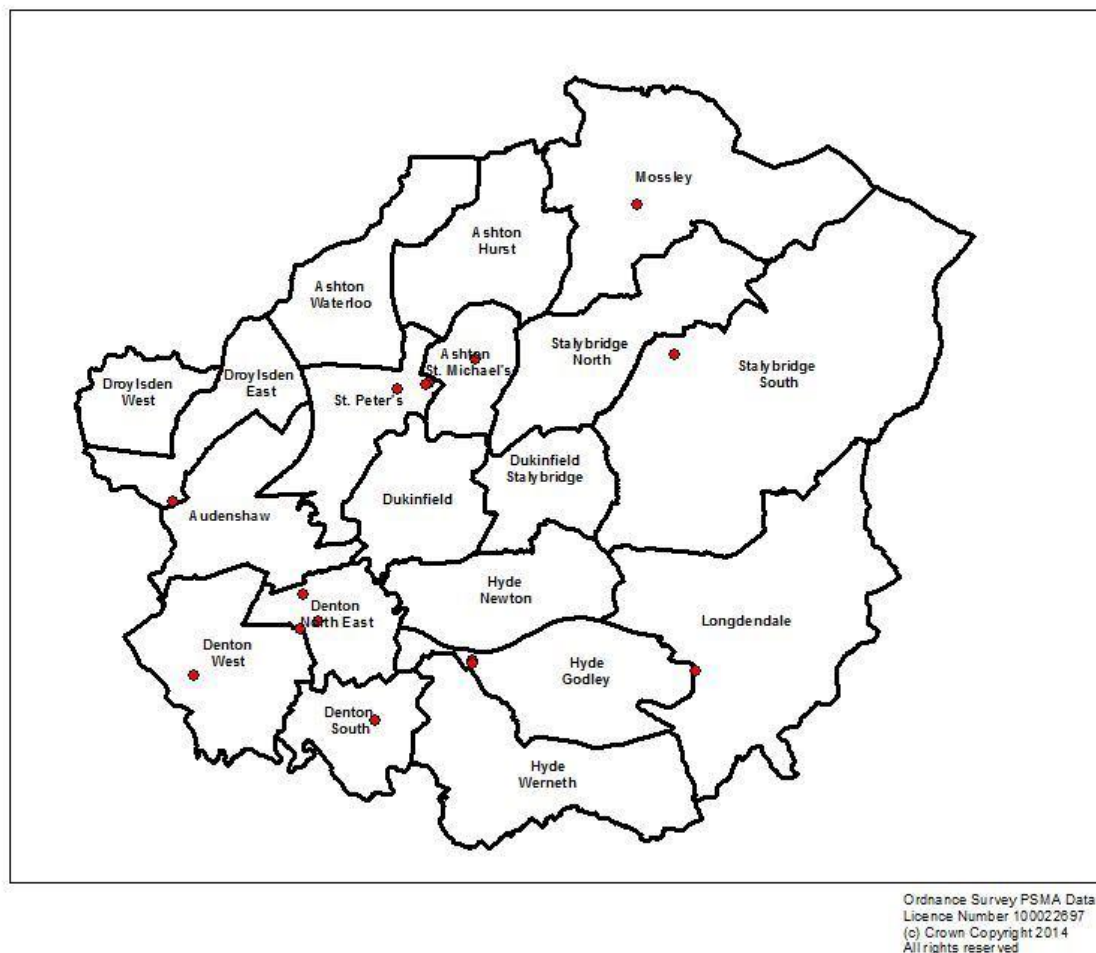
EHC is offered via all General Practices as part of their additional service offer (unless they have a conscientious objection); this is funded by NHS England. Women and young people can also access EHC via the ISHS.

GP practice data for 2010/11 (HSCIC, 2014) showed that of 838 women prescribed EHC, approximately 90% received information from the practice about LARC methods at the time of, or within one month of, the prescription. However, there was some variation between practices as there were six practices who achieved less than 70% for this indicator.

Of the 60 pharmacies in Tameside (Public Health Intelligence Team, 2015), there are sixteen who offer one form of free EHC, Levonorgestrel, which can be taken within 72 hours

(three days) of having sex and is funded by the local authority on local tariff. All women who access EHC via the pharmacy are offered condoms and a chlamydia screening pack. See figure 6 below which shows locations of pharmacies who offer EHC

Figure 6. Map of locations of community pharmacies who offer EHC in Tameside, 2014/15



Recommendation: consideration could be given to extending number of pharmacies offering EHC. At present, pharmacies don't offer EllaOne which has a longer treatment period than Levonorgestrel as it can be taken within 120 hours (five days); work is to be undertaken to look at whether introducing EllaOne would be clinically and cost effective. Another consideration could be to enable pharmacies to supply interim contraceptives as required. Both EllaOne and prescribing of contraceptives would require a patient group directive.

8.2 Long Acting Reversible Contraception

It is estimated about 30% of pregnancies are unplanned. The effectiveness of the barrier method and oral contraceptive pills depends on their correct and consistent use. By contrast, the effectiveness of long-acting reversible contraceptive (LARC) methods does not depend on daily concordance. The uptake of LARC is low in Great Britain, at around 12% of women

aged 16–49 in 2008–09, compared with 25% for the oral contraceptive pill and 25% for male condoms (NICE, 2014).

Studies from Scotland and North America indicate women are less likely to have their LARC removed than discontinue their oral contraception or stop using condoms. They also show that very few women using LARCs have an unplanned pregnancy (Glasier, 2009). LARC use in England has been associated with significantly decreased rates of teenage pregnancy and abortion in young women (Connolly, et al., 2014). According to NICE guidelines (2014), women requiring contraception should be given information about, and offered a choice of all methods, including LARCs.

LARC is defined as contraceptive methods that require administration less than once per cycle or month. Included in the category of LARC are:

- copper intrauterine devices
- progestogen-only intrauterine systems
- progestogen-only injectable contraceptives
- progestogen-only sub dermal implants
- combined vaginal rings

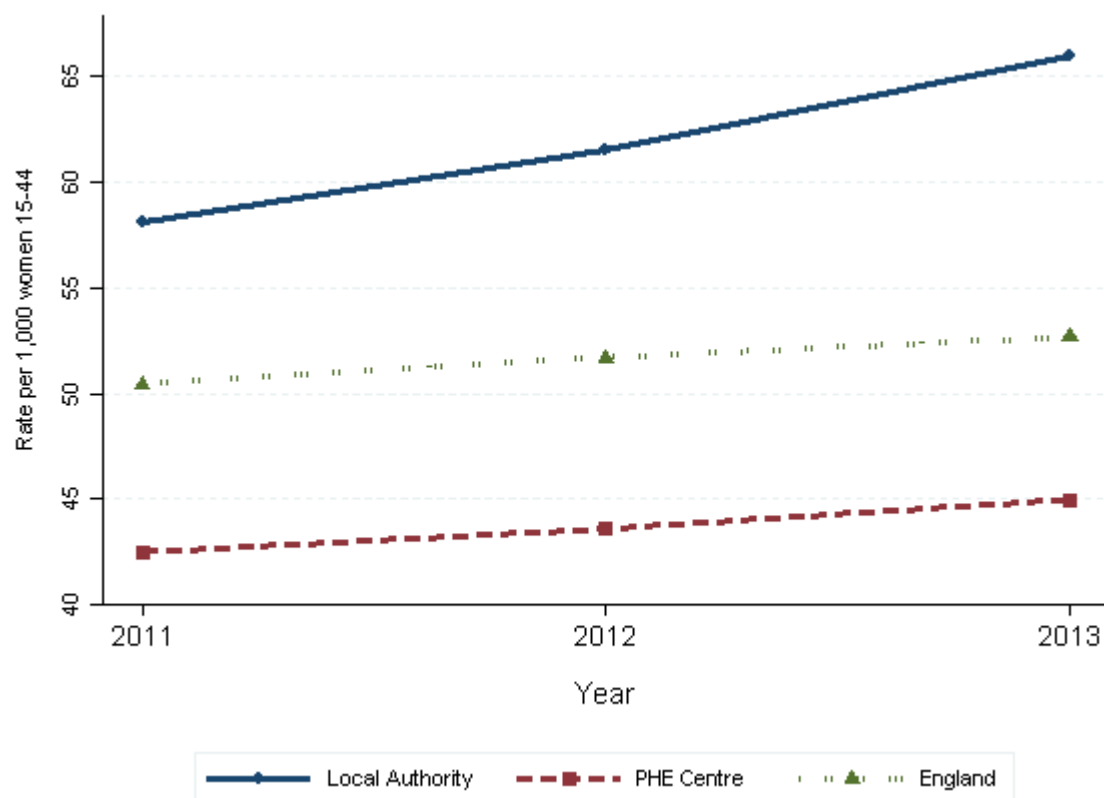
Nationally, the use of LARCs has been increasing, particularly the uses of implants, however, 68% still choose user dependant methods (see table 11 below). The current limited use of LARC suggests healthcare professionals may need better guidance and training so that they can help women make an informed choice.

	2003 /04	2004 /05	2005 /06	2006 /07	2007 /08	2008 /09	2009 /10	2010 /11	2011 /12	2012 /13 ⁴
All methods (percentages)	100	100	100	100	100	100	100	100	100	100
LARCs total²	18	19	20	21	22	24	25	28	28	30
IU Devices	7	6	6	5	6	5	5	5	4	4
IU System	1	2	2	3	3	4	4	4	4	5
Injectable contraceptive	9	10	9	8	8	7	7	8	9	9
Implant	1	2	3	4	6	7	9	11	11	12
User dependent methods total	75	74	76	75	73	71	70	69	69	68
Oral contraceptives	45	45	47	46	46	44	44	43	45	47
Male condom	30	29	28	28	26	26	25	25	22	20
Female condom	0	0	0	0	0	0	0	0	0	0
Contraceptive patch	0	0	1	1	0	1	1	1	1	1
Natural family planning	0	0	0	0	0	0	0	0	0	1
Sterilisation	0	0	0	0	0	0	0	0	0	0
Other methods³	7	6	5	4	5	5	4	3	3	1

Prescribing Analysis and Cost Tabulation (PACT) is used to give the rate of LARC prescribing in primary care. The rate of LARCs prescribed in a primary care setting between 2011 and 2013 is shown in Chart 20. In 2013, Tameside is ranked 118 out of 326 local authorities in England for the rate of GP prescribed LARCs, with a rate of 66.0 per 1,000 women aged 15 to 44 years, which is higher than the rate of 52.7 in England (see chart 21). The data does not include data from community sexual and reproductive health services, pharmacies and young people services etc. (Public Health England, 2014).

The number of LARCs reported is not indicative of concordance as data on LARC removals are not available. Discontinuation is an important driver of relative cost effectiveness between LARC methods (Public Health England, 2014).

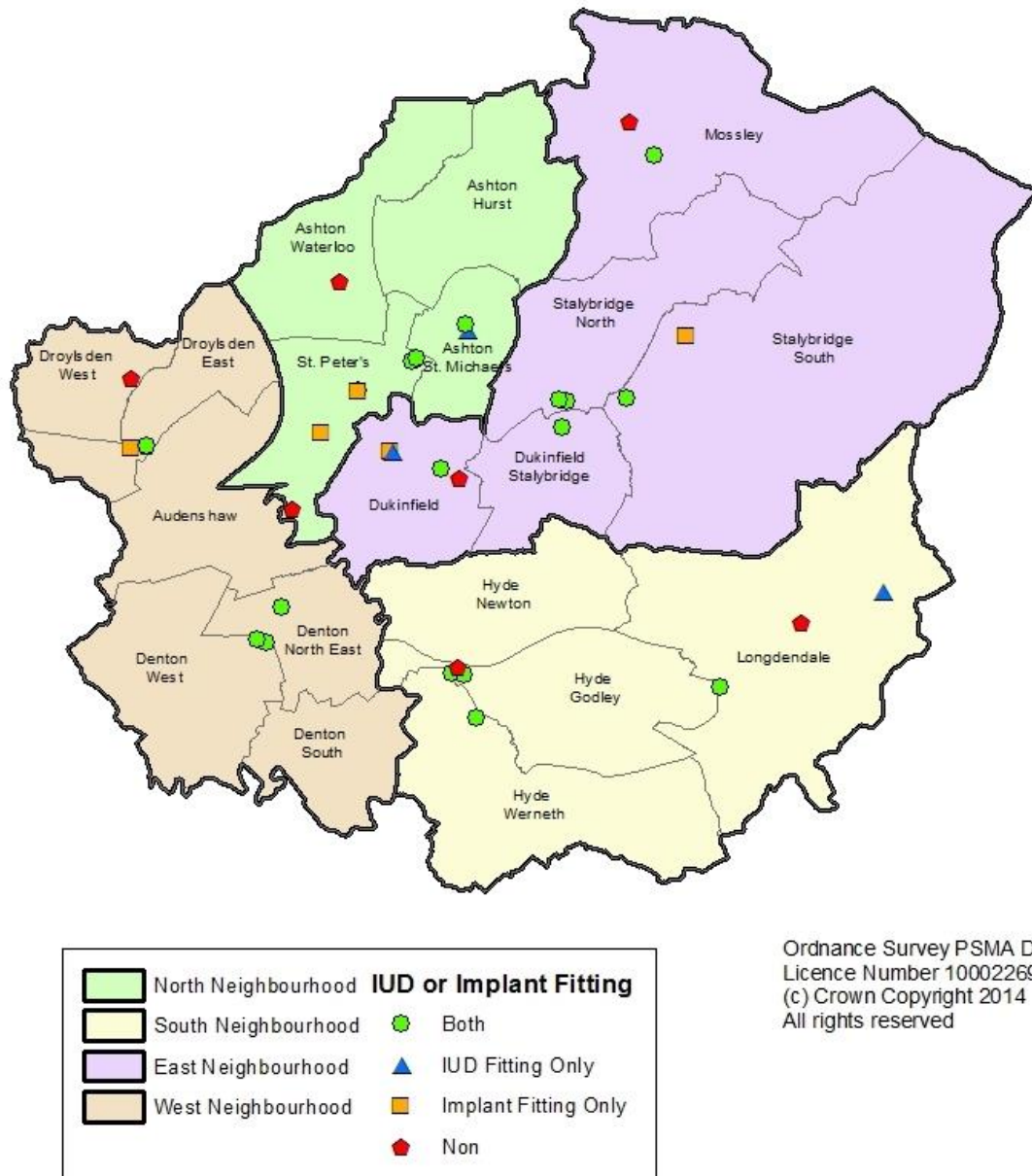
Chart 21. Rates per 1,000 women aged 15 to 44 of LARCs prescribed in primary care for Tameside local authority, Greater Manchester PHE Centre and England: 2011 to 2013 (Source: Laser report)



Of the 35 GP Practices in Tameside, 21 prescribe both IUDs and Implants, five implants only and two IUDs only. There are seven who are not able to prescribe any LARCs (see figure 7 below).

Recommendation: Consideration is to be given to understanding and tackling the barriers which have presented some practices from offering any or only one method of LARCs.

Figure 7. Map of GP practice provision of LARCs in 2014, categorised by IUD, implant fitting or both



9. Abortion

Abortion services are commissioned by CCGs. Abortion services can play a key role in reducing the risk of repeat unwanted pregnancy, as well as helping women to improve their overall sexual health. Abortion services can do this by providing access to all methods of contraception, and provision of STI and HIV testing to identify undiagnosed infections.

In England, Wales and Scotland abortion is legal up until 24 weeks of pregnancy, although most abortions are carried out much earlier than this. Generally, an abortion should be carried out as early in the pregnancy as possible, usually before 12 weeks and ideally before

nine weeks. The earlier an abortion is carried out, the easier and safer the procedure is to perform.

Cited in the Laser report (Public Health England, 2014), The National Survey of Sexual Attitudes and Lifestyles (NATSAL 2010) found that 16.2% of pregnancies in the year before the survey were unplanned. This survey found that:

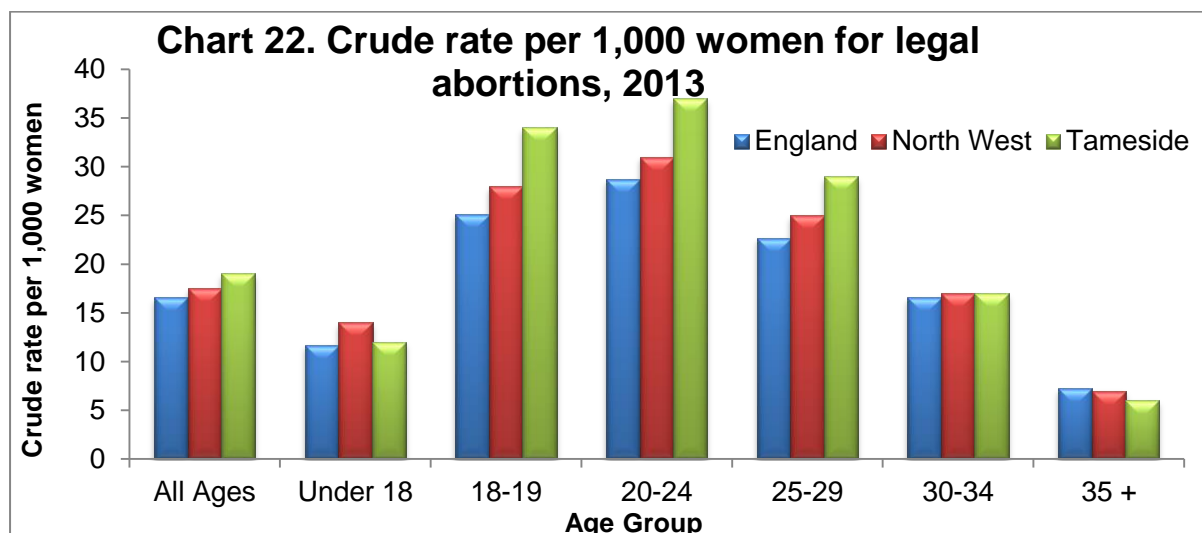
- Pregnancies among 16 to 19 year olds accounted for 7.5% of the total number of pregnancies, but 21.2% of the total number were unplanned.
- The highest numbers of unplanned pregnancies occur in the 20 to 34 year age group.

In 2013, 185,331 abortions were carried out in England and Wales, compared with 185,122 in 2012 (an increase of 0.1%) and 2.1% more than in 2003 (181,582).

Nationally, 91% of abortions were performed at less than 13 weeks of pregnancy, and 79% at less than 10 weeks. In Tameside, the vast majority were performed under nine weeks and Tameside achieved 87% which is higher than for England and the North West (see table 12).

Nationally, the abortion rate was highest for women aged 22 years, and the majority of abortions (98%) were funded by the NHS. Locally, the age group with the highest crude rate was the 20-24s.

During 2013, Tameside had an overall crude rate of abortion which was higher than England and the North West; the total abortion rate per 1,000 female population aged 15-44 years was 19, while in England it was 16.1 (Department of Health, 2014; see chart 22). The number of abortions is calculated to be 826 (CI of 771 -884).



Source: Abortion stats England and Wales 2013

In Tameside, similarly to England, the majority of abortions were funded by the NHS and took place in the independent sector.

Table 12: Funding for abortion and gestational age by England, North West and Tameside, 2013

Local Authority / Area	NHS funded, purchaser (%)		Privately funded	Gestation Weeks (%)		
	NHS Hospital	Independent Sector		3-9	10-12	13+
England	32	66	<5	79	12	8
North West	44	55	<5	81	11	8
Tameside	34	66	<5	87	7	6

Source: Abortion statistic for England and Wales

9.1 Repeat abortions

Amongst those women who had an abortion in that year in England 37% has had a previous abortion, in Tameside this was less at 32% (see table 13).

Table 13: Percentage of women who had an abortion in 2013 who have had a previous abortion aged and over 25 years

Local Authority	Total	Repeat abortions all ages	Repeat abortions in women under 25	Repeat abortions in women 25 yrs+
England	177,016	37	27	45
North West	24,324	36	26	45
Tameside	826	32	22	41

Source: Abortion Statistics for England and Wales

9.2 Abortion Services

The British Pregnancy Advisory Service (BPAS) provides the confidential tailored advice and support and appointment booking center for women in Tameside and within many other areas. The service provides appointment times for the local abortion service as appropriate. The Central Booking line is open Monday to Friday 8.00am to 9.00pm, Saturday 8.30am to 6.00pm and Sunday 9.30am to 2.30pm.

See table 14 for information on location of abortion clinics. From March 2013 to April 2014 the majority of bookings were for Frater drive, followed by South Manchester Private Clinic and Marie Stopes.

Table 14. Number of booking for abortions from Tameside Residents by venue, 2013/14			
Unit	Provider	Bookings	%
All	All	954	100.0%
BPAS	BPAS	<5	0.5%
Bolton Pregnancy Advisory Service	Frater drive	<5	0.1%
Manchester Pregnancy Advisory Service	Frater drive	302	31.7%
Salford Pregnancy Advisory Service	Frater drive	<5	0.2%
SMPC Telephone Consultations	Frater drive	12	1.3%
South Manchester Private Clinic	Frater drive	148	15.5%
MSI Manchester	Marie Stopes	118	12.4%
MSI Manchester EMU	Marie Stopes	12	1.3%
MSI Telephone Consultations	Marie Stopes	32	3.4%
NHS St Marys Hospital (Manchester)	NHS	24	2.5%
NHS Tameside General Hospital	NHS	298	31.2%

Recommendation: Local authorities and CCGs should consider working together and with local providers of sexual health and abortion services to ensure that local abortion providers are fully linked into wider sexual health services in their area that offer services such as contraception (Department of Health, 2013).

10. Teenage Pregnancy

Most teenage pregnancies are unplanned and around half end in an abortion (Department of Health, 2010). As well as 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 teenagers bringing up a child is difficult and can result in poor outcomes for both the teenage parent and the child.

Addressing unplanned teenage pregnancy is a broad agenda and requires a collaborative approach, it has many influencing factors including education, peer norms, income, family, access to contraception and the aspirations young people have.

In Tameside we aim to ensure that young people:

- Understand what services are available for them.
- Are supported to make the right contraception choice for them.
- Can trust that practitioners will help if they are vulnerable or at risk.
- Have opportunities to tell us what they think about the services offered.

Key statistics on teenage pregnancy for Tameside:

- The rate for Tameside remains higher than the England rate of 27.7
- The under-18 conception rate per 1,000 female aged 15 to 17 for Tameside fell from 45.2 in 2011 to 32.7 per 1,000 in 2012, down by 27.4% the greatest annual reduction in Greater Manchester (see table 15).
- All areas of GM showed a reduction in under-16 three-yearly aggregate conception rates.
- The number of under-18 conceptions reduced by 53 young people in one year.
- Among the under 18 conceptions, the proportion of those leading to abortion was 44.3%, while in England the proportion was 49.1%.

Table 15. Under-18 conception Tameside and GM 1998, 2011 and 2012

	Under- 18 conception rates and numbers						% rate change	
	1998		2011		2012		2011-2012	1998-2012
	No.	Rate	No.	Rate	No.	Rate		
GM	2,642	54.5	1,848	37.8	1,628	33.3	-11.9%	-38.9%
Tameside	216	53.6	183	45.2	131	32.7	-27.4%	-39%

Source: ONS, 2014

11. Sexual violence

The term sexual violence covers a wide range of abusive acts directed towards an individual's sexuality, including sexual assault, rape, sexual coercion, sexual bullying and female genital mutilation. Sexual violence is known to be under reported. The perpetrators of serious sexual assault are most often known to victims. In 2011/12 it was estimated around one in five women (19.6%) and just under three percent of men had suffered a sexual assault since the age of 16. Sex workers and MSM can also be at increased risk (North West Public Health Observatory, 2012).

The sexual health service and primary care are able to access support and advice from the Tameside Safeguarding Board and from the specialist police officers. The police can arrange for people to attend the a specialist centre at St Mary's hospital in Manchester for where there is a specialist team for helping victims of rape and sexual assault.

Support is also available via the Manchester Rape Crisis (MRC) which is a confidential support service, run by women for women and girls who have been raped or sexually abused. They have a helpline which provides advice, information and support to women and girls surviving sexual abuse and they offer a free face-to-face counselling service for women over 17 who have experienced rape or sexual abuse. MRC also provide a signposting service for male survivors and offers information and advice to friends, partners and other family members supporting survivors.

Recommendation: Consideration should be given to having a person(s) with a lead role to support joined up working across providers and services to ensure clear pathways are in place to aid the prevention and early identification of sexual violence and child exploitation.

12. Sexual Health across the life course

The Family Planning Association (FPA, 2011) highlight that as sex and sexuality are a central part of people's lives, it is vital everyone is able to access the information, education and services they need to make informed choices about sexual health and relationships. Sexuality is not merely a vehicle for reproduction and it is important discussions about sexual health acknowledge sexual pleasure.

Individual needs may vary across the life course and accurate, high-quality and timely information helps people to make informed decisions about their sexual health. According to the Department of Health (2013), it is crucial the differing needs of men and women and of different groups in society are considered when planning services and interventions.

12.1 Under 16s

12.1.1 Sex and relationship Education (SRE)

Secondary schools in England are obligated to deliver SRE, and although there is national guidance, the content is decided locally (Department for Education and Employment, 2000; DoH, 2013). All schools delivering SRE are required to ensure their pupils receive high quality information on the importance of good sexual health.

However, a health technology appraisal of 12 Randomised Control Trials (RCTs), only two were from the UK, found that although school-based interventions can improve knowledge and increase self-efficacy they do not significantly influence behaviour or infection rates (Shepherd, et al., 2010). An Ofsted review found SRE needed improving in one third of secondary schools (Ofsted, 2013).

Given the exponential increase in the use of digital media by young people, digital media is a potential vehicle for sexual health interventions (Lorimer, 2013). There is growing evidence of the effectiveness of gender specific interactive computer based intervention (ICBI). The advantage of ICBI over traditional behaviour change interventions is that it is cheap to run, maintains the fidelity of the intervention, it can be tailored through algorithms, can be flexibly disseminated and it not limited to business hours (Noar, 2011; Fernane, et al., 2013).

A meta-analysis of 12 RCTs found statistically significant effect sizes on condom use, frequency of sexual behaviour, number of partners, and incidence of STIs. Gendered interventions were also significantly more efficacious than mixed sex groups (Noar, et al., 2009). A Cochrane review of 15 RCTs ICBI from 2007 showed a moderate effect on sexual health Knowledge, a small effect on safer sex self-efficacy; a small effect on safer-sex intentions; and an effect on sexual behaviour (Bailey, et al., 2010).

Recommendation: To complement the current school based programme, consideration should be given to developing a large scale and locally relevant and gender specific interactive computer based intervention (ICBI). Discussions on the local content of ICBI would take into account local service configurations, safeguarding, politics, culture, gender and ethnicity (Fernane, et al., 2013).

12.1.2 Under age sex and child exploitation

A survey of parents found that nine out of ten were concerned that children are under pressure to grow up too quickly. This pressure on children to grow up takes two different but related forms: the pressure to take part in a sexualised life before they are ready to do so;

and the commercial pressure to consume goods and services that are available to children and young people of all ages (Bailey, 2011).

The age of consent is 16 and sexual activity involving children under 16 is unlawful (The Sexual Offences Act, 2003). The age of consent reflects the fact children aged under 16 are vulnerable to exploitation and abuse. Data from 2011 indicates one in three rapes in England and Wales recorded by police involved child victims under the age of 16.

Young people report the legal framework helps them to resist pressure to have sex at an earlier age (Department of Health, 2013). For the minority of young people aged under 16 who are sexually active, it is important they have the confidence to attend sexual health services and have early access to professional advice, support and treatment.

In addition, all sexual health service providers must be aware of child protection and safeguarding issues and take very seriously the possibility of abuse and/or exploitation (Department of Health, 2013).

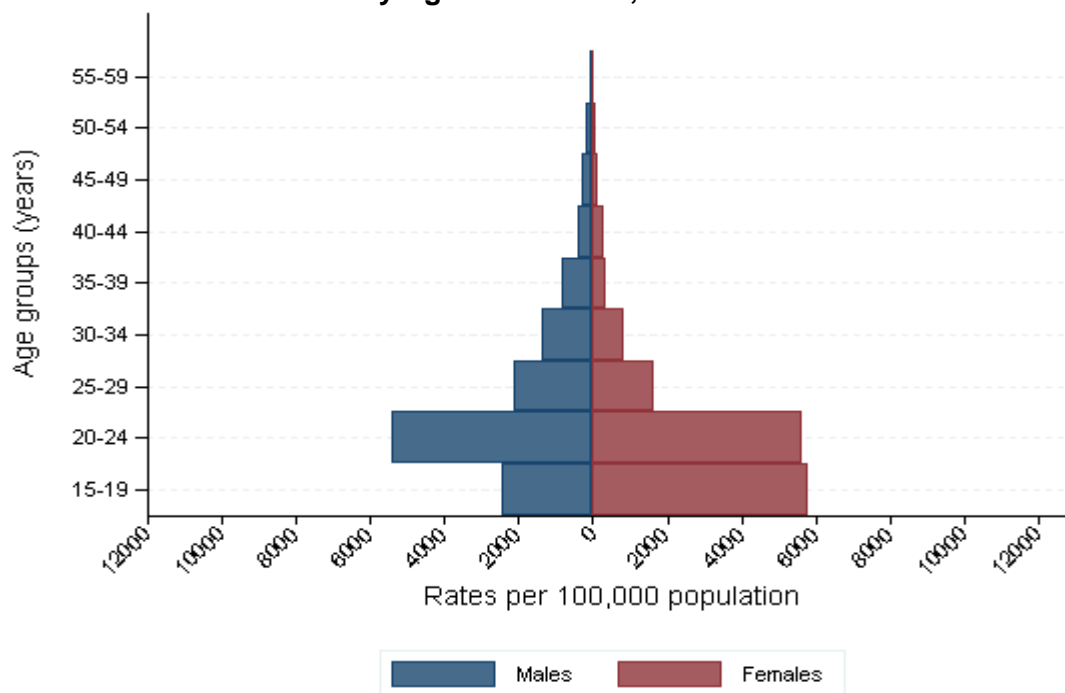
Tameside does have a safeguarding policy in place to assist practitioners working with sexually active under 18s to identify and assess where relationships may be abusive and the young people may be in need of protection and/or additional services (Tameside Safeguarding Children Board, n.d.)

The Phoenix Tameside team has been formed to tackle any kind of child sexual exploitation (CSE) in the borough. The team is co-located at Ashton Police Station and they serve the whole of Tameside. The team will give advice to young people on how to stay safe and keep their friends safe, they also provide information to parents and carers so they can spot the signs of CSE and be more generally aware of it.

12.2 Age 16 to 24

Most people become sexually active and start forming relationships between the ages of 16 and 24 (Department of Health, 2013). Young people between 15 and 24 years old experience the highest rates of new STIs; in Tameside, 67% of diagnoses of new STIs were in young people in this age group (although this may be skewed by proactive chlamydia screening). The age profile is shown in chart 23 (Public Health England, 2014)

Chart 23. STIs in Tameside by Age and Gender, 2013



Source: Data from Genitourinary Medicine Clinics and community settings (for Chlamydia only)
Rates based on the 2012 ONS population estimates

Young people are also more likely to become re-infected with STIs. In Tameside, an estimated 14.4% of 15-19 year old women and 12.1% of 15-19 year old men presenting with a new STI at a GUM clinic during the five year period from 2009 to 2013 became re-infected with an STI within twelve months. Teenagers may be at risk of reinfection because they lack the skills and confidence to negotiate safer sex (Public Health England, 2014). In England, the age group with the highest number of contacts for EHC occurred in the 20 to 24 age group. The 20 to 24 age group also has the highest crude abortion rate.

In Tameside there are discussions about how to increase the proportion of young people and in particular young men accessing services. It is thought that more could be done to increase the uptake of planned contraception, including access to LARCs. Some funding has been secured to promote condom use.

12.2.1 Service provision

A newly formed priority action group hosted by the sexual health service, who meets regularly to discuss local issues and best practice, the membership includes the integrated sexual health clinic, YouThink the GP Clinical Lead and connexions. There is not currently a school nurse representative. A GM young people group is also led by the sexual health network, which is currently undergoing a review.

The Young Person (YP) ISHS, in addition to being able to access general clinics of the CaSH service, there are also clinics targeted specifically at young people. There are also clinics available at Tameside College in term time. Staff report they would like to do more direct work with schools but have had a mixed reception.

The YouThink team is Tameside's sexual health intervention and prevention team. They are a specialist team which focuses on improving young people's sexual health. The team of youth workers offer one to one individual support to young people aged under 19, with

regards to their own sexual health. Services provided include pregnancy testing, condom distribution, RU-Clear (Chlamydia and Gonorrhoea screening), advice and support. YouThink also work within local schools and colleges to improve people's knowledge of sexual health and promoting local sexual health services.

We do not have Brook in Tameside, however during a twelve month period there were 671 attendances to one of the Manchester Council run Brook Clinics (we don't contribute to this in terms of management or payment). See table 16.

Table 16. Attendances at Manchester Brook Clinics by Tameside Residents by Ward: 01/04/13 - 01/01/14

Ward	Total No. of Attendances		
	Foll ow- ups	First Visits	Total
Ashton Hurst	<5	<5	5
Ashton St Michael's	8	7	15
Ashton Waterloo	<5	11	15
Audenshaw	37	45	82
Denton North East	12	17	29
Denton South	8	19	27
Denton West	17	30	47
Dinting	<5	<5	<5
Droylsden East	56	83	139
Droylsden West	59	86	145
Dukinfield	0	<5	<5
Dukinfield Stalybridge	13	16	29
Hadfield South	0	<5	<5
Hyde Godley	11	11	22
Hyde Newton	13	14	27
Hyde Werneth	<5	10	12
Longdendale	16	9	25
Mossley	0	<5	<5
Old Glossop	0	<5	<5
Padfield	0	<5	<5
Simmondley	<5	<5	<5
St Peter's	7	7	14
Stalybridge North	5	7	12
Stalybridge South	<5	6	7
Tintwistle	<5	<5	<5
	274	397	671

12. 2.2 School Nursing Service

In Tameside there are over 70 primary schools, 15 senior schools, six special schools, five six forms/further education facilities, and three pupil referral units. From April 2013, local authorities are statutorily responsible for delivering and commissioning public health services for children and young people aged 5-19. School health services play a vital role in supporting children and young people. School nurses hold drop in sessions in schools, and

can be accessed by telephone to discuss sexual health concerns. Responsibility for the school nursing offer transfers to TMBC in 2015.

12.3 Age 25 to 49

At this stage of their lives, many people will be forming long-term relationships and may be starting to plan families. It is important women are able to access the full range of contraception from a choice of providers in order to avoid unwanted pregnancy (Department of Health, 2013). In the next five years in Tameside there is expected to be a small increase in the number of people aged 25 to 39.

National abortion statistics indicate that rates for those aged over 25 have increased over the past ten years and significant numbers of women aged over 25 have unwanted pregnancies. Restricting access to services by age can therefore be counterproductive and ultimately can increase costs.

12.4 Age 50 plus

As people get older, their need for sexual health services and interventions may reduce. Women will enter the menopause and increasingly not be at risk of pregnancy. Nationally, while STI rates in this age group only accounted for 3% of all STIs diagnosed in GUM clinics in 2011, they rose by 20% between 2009 and 2011 (Department of Health, 2013). In the UK, although adults aged 50 years and over accounted for 8% of all new HIV diagnoses between 2000 and 2007, late diagnosis of HIV is more common in older age groups, 50% of those aged over 50 compared with one 33% in younger age groups (Smith, et al., 2010).

Older age groups are more likely to be living with long-term health conditions that may cause sexual health problems. Long-term conditions are more prevalent in older people, 58 per cent of people over 60 compared to 14 per cent under 40 (The Kings Fund, 2015). It is estimated that half of all men between the ages of 40 and 70 will have erectile dysfunction to some degree.

Recommendation: In addition to having a prevention framework for young people there should be an all age prevention strategy to reduce STIs, increase access to contraception, reduce unplanned pregnancy and maintain sexual health.

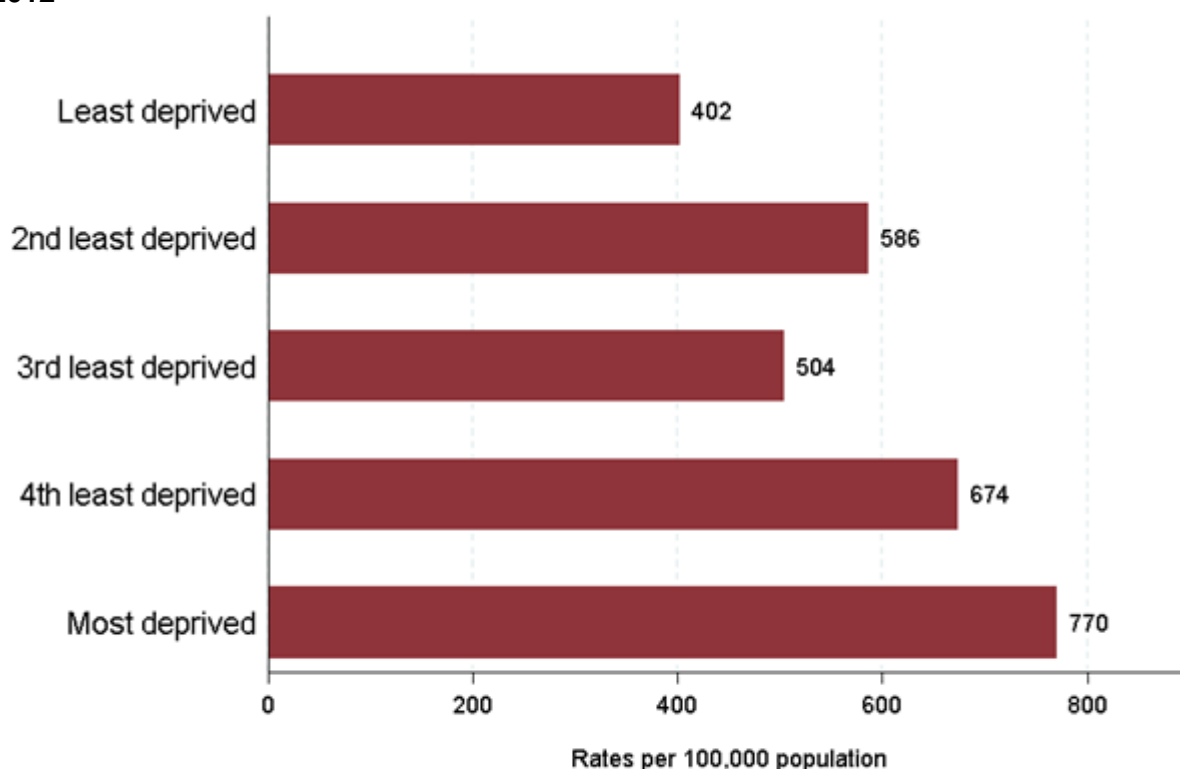
13. Sexual Health of Specific Groups

13.1 Deprivation

The relationship between STIs and SED is probably influenced by a range of factors such as the provision of and access to health services, education, health awareness, healthcare seeking behaviour and sexual behaviour (Public Health England, 2014).

Socio-economic deprivation (SED) is a known determinant of poor health outcomes and data from GUM clinics show a strong positive correlation between rates of acute STIs and the index of multiple deprivation (IMD) across England. In Tameside, with the exception of the 3rd least deprived group, there is a trend of an increasing rate of acute STIs as the level of deprivation also increases. Those in the most deprived quintile have almost double the rate of acute STIs than those in the least deprived quintile (see chart 24 below).

Chart 24. The rate per 100,000 of acute STIs by deprivation category in Tameside, 2012



Source: Data from Genitourinary Medicine Clinics
 Rates based on the 2011 ONS population estimates
 Excludes chlamydia diagnoses made outside GUM

Given the higher levels of deprivation in Tameside compared to the North West and England it would indicate the current level of investment in services for sexual health should be maintained.

13.2 BME groups

The proportion of new STIs diagnosed in GUM clinics by ethnic group is shown in table 17. Where recorded, 4.3% of new STIs diagnosed in Tameside were in people born overseas (Public Health England, 2014).

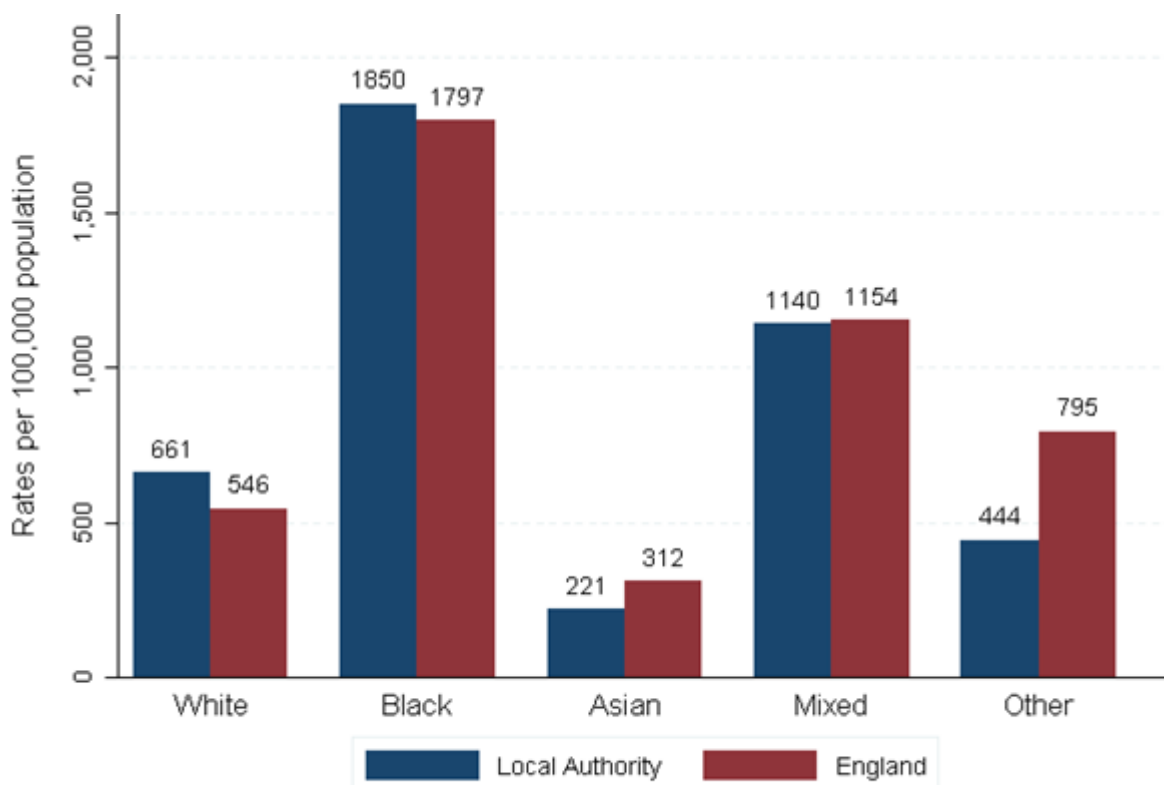
Table 17. Number and proportion of new STIs by ethnic group (GUM diagnosis only): 2013 (Public Health England, 2014).

Ethnic Group	Number	Percentage
Asian or Asian British	30	2.1
Mixed	36	2.5
Black or Black British	33	2.3
Other ethnic groups	6	0.4
White	1318	92
Non Specified	9	0.6

Source: data from GUM clinics (excludes chlamydia diagnosis made outside GUM)

People who fall into and identify as in the Asian grouping for ethnicity generally have a lower rate of STIs than those who are white and people who fall into the 'black' ethnic grouping have the highest rates both in England and Tameside. Generally, rates in Tameside by ethnic grouping are similar to nationally (see chart 25 below).

Chart 25. Rates of new STIs by ethnic group in Tameside and England during 2013 (GUM diagnoses only).



Source: Data from Genitourinary Medicine clinics
 Excludes chlamydia diagnoses made outside GUM
 Rates based on the 2011 ONS population estimates

13. 2.1 HIV

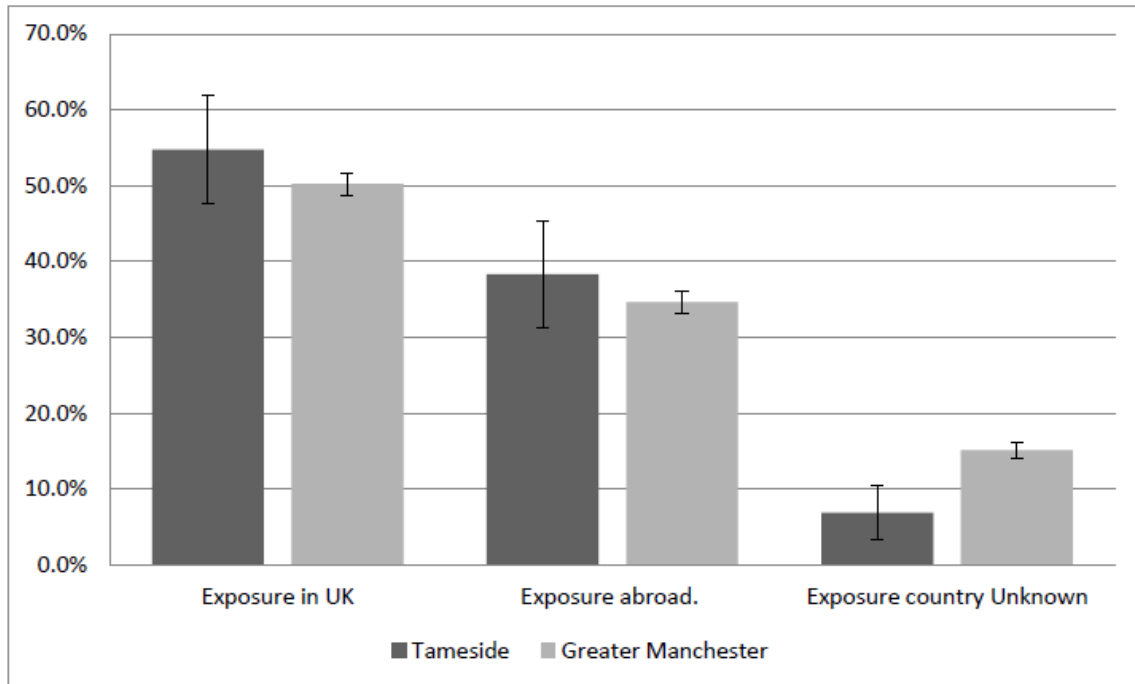
Black African men and women are the second largest group affected by HIV in the UK. Of the estimated 31,800 (23%) are thought to be unaware of their infection (Stephens, 2014). Exposure abroad is still an important context for exposure to HIV, with almost 40% of infections being acquired outside of the UK.

Across the North West, prevalence of HIV is five times higher in BME communities than in the white population. In the North West, the majority of people with white ethnicity with HIV were infected through MSM, whereas the majority of those from BME/mixed backgrounds with HIV were infected through heterosexual sex (see chart 26). This pattern is likely to be mirrored in Tameside. (Stephens, 2014).

HIV infection through intravenous drug use is very low in Tameside,

Chart 26.

Figure 15: Cases of HIV in Tameside and Greater Manchester residents, by country of exposure, 2012



Source: (Harris, 2013)

Black Health Agency (BHA): Tameside MBC provides additional funding to BHA; the organization provides a range of services tailored to Black and minority populations including HIV and sexual health support.

13.3 Lesbian, Gay, Bisexual and Transgender

Lesbian, gay, bisexual and transgender (LGBT) people experience a number of health inequalities that are often unrecognised in health and social care settings. Research commissioned by Stonewall indicates a high proportion of lesbian and bisexual women, and gay and bisexual men, have never been tested for STIs (Department of Health, 2013).

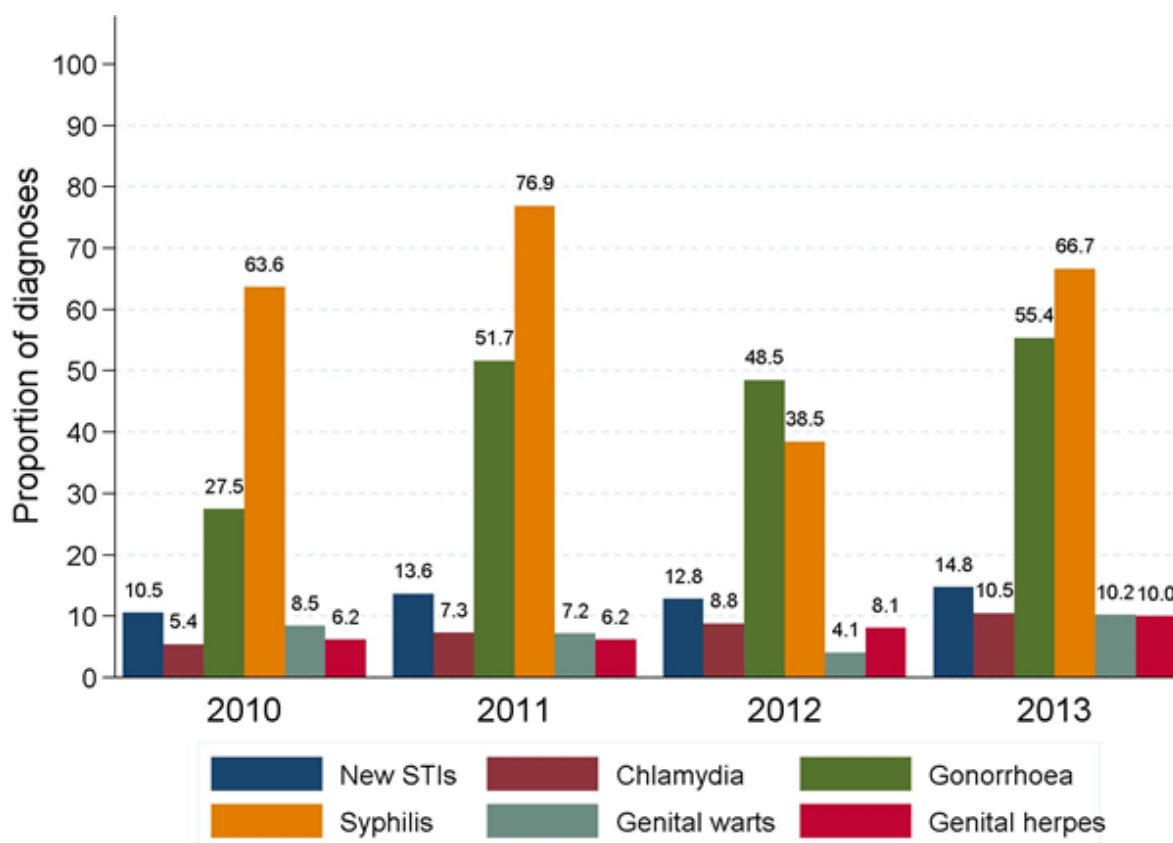
The Lesbian and Gay Foundation (LGF): The Lesbian and Gay Foundation is a charity which is commissioned by all Greater Manchester local authorities to deliver LGB focused community health interventions. The service delivers HIV prevention activities for TMBC specifically towards MSM, Gay and Bisexual men. In addition LGF provide many other services to support Lesbian, Gay, Bisexual, Questioning and Trans (LGBQT) people in Tameside and such as: safe places to meet and socialize, providing someone to talk to, reporting homophobic crimes, training other services about LGBQT needs such as 'Pride in Practice'.

Although the LGF do link in with the Sexual Health Service there are not currently any LGF focused clinics running in Tameside, so people would have to travel to Manchester to access the service in most cases.

13.4 Men who have sex with men (MSM)

MSM in the UK are at a greater risk of suffering from poorer sexual health outcomes in comparison to other groups (BASHH, 2013). In Tameside in 2013, for cases in men where sexual orientation was known (for the PHE data, this includes homosexual and bisexual men), 14.8% (number 112) of new STIs were among MSM, this is a slight increase from 2012 where the proportion of STIs among MSM was 12.8% (Public Health England, 2014). See chart 27 below.

Chart 27. The distribution of new STIs, chlamydia, gonorrhoea, syphilis, genital warts and genital herpes in MSM among men in Tameside as compared to the general population (GUM diagnoses only): 2010-2013 (Public Health England, 2014)



Source: Data from Genitourinary Medicine clinics
 Excludes chlamydia diagnoses made outside GUM
 For cases in men with known information on sexual orientation
 See Figure 5 for denominator

In terms of distribution, where as in the general population chlamydia is the most common STI, in MSM in Tameside it is gonorrhoea, followed by chlamydia and then herpes. In terms of the proportion of STIs in men, the majority of the syphilis and gonorrhoea cases were in MSM, compared to around 10% of chlamydia, warts and herpes (see table 18).

Table 18. Number of new cases of chlamydia, gonorrhoea, syphilis, genital warts and genital herpes in MSM in Tameside 2012/13

STI diagnosis	2012	2013
Chlamydia	19	22
Gonorrhoea	32	31
Syphilis	5	6
Genital warts	7	15
Genital herpes	6	6
Source (Public Health England, 2014)		

13.4.1 HIV

MSM are the group most affected by HIV in the UK, an estimated 41,000 MSM were living with HIV, of whom 18% are estimated to be unaware of their infection (Stephens, 2014). In Tameside, half of new cases of HIV by route of sexual transmission were in Men who have Sex with Men (see Chart 27). 57% (95% CL 29-82) of men who have sex with men were diagnosed late.

According to Public Health England (2014) provision should be in place so that MSM having unprotected sex with casual or new partners can have a HIV/STI screen at least annually, and every three months if changing partners regularly. MSM should also avoid having unprotected sex with partners believed to be of the same HIV status (Serosorting), as there is a high risk of STI and hepatitis infection and, for the HIV negative, a high risk of HIV infection.

13.5 Sex workers

The number of sex workers in the UK is not known as sex workers are a 'hidden population' (Cusick, et al., 2009). There is very little data on the location and number of sex workers in Tameside. Anecdotal evidence indicates there are a number of saunas and massage parlours and there are likely to be some street workers and escorts. Sex workers can face a range of issues such as stigmatisation, poverty, mental illness, addiction, poor general health, homelessness, coercion and violence (UCL Institute of Health Equity, 2014).

Across Greater Manchester there is MASH (Manchester Action on Street Health), which provides a range of confidential and non-judgmental services to women working in the sex industry in Greater Manchester (MASH, 2008). We do not currently commission outreach work for sex workers. Consideration should be given to build links with MASH to work with them.

Recommendation: We need to do more to find out about the sex workers in Tameside and assess their needs in relation to access to services.

13.6 Vulnerable young people

Tameside's Joint Strategic Needs Assessment states the importance of tailoring sexual health interventions to young people who face additional challenges and access barriers into services. Such as those who are in looked after circumstances, not in employment or education, within the criminal justice system or facing other challenges (Tameside Health & Wellbeing Board, 2013).

In 2011, there were 399 looked after children, a number which has been increasing for each of the last five years. There are disproportionate risks facing looked after children living in

residential care, particularly those who are placed a long way from their home (Childrens Commisioner, 2012). There is concern these children are missing out on SRE in school (Tameside Council, 2012). Also, that some vulnerable young people engage in risky sexual behaviours tend not to attend primary care or community health services on a regular basis (NICE, 2007).

It was difficult to find clear evidence as how to best to identify and support vulnerable young people. NICE recommend offering one-to-one interventions to vulnerable young people, from disadvantaged backgrounds, who are in or leaving care, those who have low educational attainment (NICE, 2007). NICE completed a rapid review of the evidence on the effectiveness of one to one interventions (1990-2005) and found the evidence was not consistent but on balance, marginally supportive of the interventions.

There is some evidence the empowerment approach can increase self-efficacy and self-esteem, increase knowledge and awareness and facilitate behaviour change (Woodall, et al., 2010). Spencer, et al., (2008) theorise an empowerment approach can be used to deliver SRE as it can engage young people in; the discussion, setting the agenda and enable access to sexual health services. In addition, such an approach can take into account wider issues such as alcohol and drug use, self-esteem and influences on decision making. A recent survey of over 30,000 school pupils aged 10 to 15 showed lower levels of self-esteem in 2013 than in 2008 (Schools Health Education Unit , 2014).

Recommendation: There may be an opportunity to work with key partners to discuss developing bespoke one-to-one or empowerment based interventions which are targeted to address the needs of vulnerable young people. This work should link to wider issues such as safeguarding, alcohol use and mental health to ensure coordination.

13.7 Learning Difficulties

It is important to recognise that the needs of people with disabilities will vary greatly. Coping with puberty, sexual identity and sexual feelings can be more difficult for people with learning disabilities who might be struggling to understand their emotions and their body. There is, evidence to suggest people with learning difficulties may face particular barriers in accessing sexual health services, and the informal channels through which young people learn about sex and sexuality (Emerson & Baines, 2010).

13.8 Mental and emotional needs

A survey of 503 people found that depression, both self-reported and previously diagnosed, was associated with a variety of risky sexual behaviours including poor contraception use and having a sexually transmitted disease. Males were found to be significantly more likely to engage in risky sex both with poor partner choice and infrequent use of contraception. Those of a low economic status were particularly susceptible to risky sexual behaviour (Searle, 2009).

It is thought some people with severe mental illness are more likely to engage in high-risk sexual behaviour, putting them at risk of poorer sexual health outcomes including STIs (Kaltenthaler, et al., 2014).

13.9 Alcohol and drug use

There is a well-established association between alcohol misuse and poor sexual health outcomes including unplanned pregnancy and sexually transmitted infections. Drinking

reduces inhibitions and affects judgement which in turn can lead to unprotected sex. The association between alcohol use and sexual activity is a particular problem for young people. Young people are limited in their experience of drinking and are more likely to engage in risk taking activity whilst under the influence of alcohol (Public Health Intelligence Team, 2014). Statistics from the Royal College of Physician (2011) indicate:

- 82% of 16–30 year olds report drinking alcohol before sexual activity
- People who drink heavily are more likely to have unprotected sex with multiple partners
- 20% of white 14–15-year-old girls report going ‘further than intended’ sexually when drunk.

Surveys in sexual health services suggest as many as one in five attendees are consuming hazardous levels of alcohol and those who attend the GP with problems related to sexual health may also have alcohol-related concerns. In 2013/14, 38% of young people accessing drug and alcohol treatment services in Tameside and Glossop were offered a sexual health intervention.

There is also research which suggests that the provision of brief interventions for alcohol misuse is acceptable to both providers and users in sexual health clinics and general practice and this approach is recommended (Royal College of Physicians, 2011).

The recommendations from the Royal College of Physicians report (2011) are:

- Sexual health services should provide information, signposting and support for people wishing to reduce their alcohol intake
- There should be a clear pathway in place and staff should be trained in asking about drinking habits through use of a recognised screening tool and implementing a single brief intervention

14. Recommendations

Spend: Consideration should be given as to whether we have the right amount of spend according to local need and particular vulnerable groups. Should we be spending more on; prevention, young males, men who have sex with men (MSM), sex workers, looked after children and psychosexual counselling?

There are to be continued discussions between the local leads about how cross-charging and service provision is managed across Greater Manchester.

Some of our contracts need to be reviewed as there is some evidence of both double payments (some chlamydia testing) and underpayments (not currently paying for Brook).

Integrated Sexual Health Service: This may be an opportune time to review the service provision and change the function of ISHS slightly to reduce provider function slightly to increase their role in co-ordinating and supporting the other providers; to ensure a standardised high quality approach across all services, increase capacity within primary

care, and expand services such as condom provision. It may be possible to achieve this by reducing follow-up attendances for contraception and reviewing roles.

Young people: Produce a sexual health framework for young people with a key focus on prevention.

Condom provision: One proposal for consideration is to set up a scheme to provide free condoms to those who need them, not just young people, without the requirement to register. Consideration would need to be given to safeguarding and monitoring processes. Bespoke training and local standards should be developed for staff at venues wishing to participate in keeping with the guidance from Brook and Public Health England (2014). Given the lack of quality research evidence, if a new scheme is set up, a formal evaluation would be required to assess whether the scheme is effective.

Partner notification: there should be a specific focus having a standard approach and monitoring effectiveness of partner notification and to monitor this to see if this increases the number of young men accessing services, especially chlamydia screening.

Chlamydia screening: Consideration could be given to ensuring all GP practices are actively offering chlamydia screening to sexually active young people

Point of Care Testing for HIV: Making POCT available via open access sexual health services and in venues/services used by high risk groups should be considered. This is recommended in NICE guidelines but not currently available in Tameside. Any introduction of point of care testing will need to consider sensitivity and specificity of tests available, and the potential for joint commissioning across Greater Manchester.

Pharmacy provision: consideration could be given to extending number of pharmacies offering EHC. At present, pharmacies don't offer EllaOne which has a longer treatment period than Levonorgestrel as it can be taken within 120 hours (five days); work is to be undertaken to look at whether introducing EllaOne would be clinically and cost effective. Another consideration could be to enable pharmacies to supply interim contraceptives as required. Both EllaOne and prescribing of contraceptives would require a patient group directive.

LARCs: Consideration is to be given to understanding and tackling the barriers which have presented some practices from offering any or only one method of LARCs.

Abortion: Local authorities and CCGs should consider working together and with local providers of sexual health and abortion services to ensure that local abortion providers are fully linked into wider sexual health services in their area that offer services such as contraception.

Sexual violence and child exploitation: Consideration should be given to having a person(s) with a lead role to support joined up working across providers and services to ensure clear pathways are in place to aid the prevention and early identification of sexual violence and child exploitation.

Computer Based Interventions: To complement the current school based programme, consideration should be given to developing a large scale, locally relevant and gender specific interactive computer based intervention (ICBI). Discussions on the local content of

ICBI would take into account local service configurations, safeguarding, politics, culture, gender and ethnicity.

Adult Prevention Strategy: In addition to having a prevention framework for young people there should be an all age prevention strategy to reduce STIs, increase access to contraception, reduce unplanned pregnancy and maintain sexual health.

Sex workers: We need to do more to find out about the sex workers in Tameside and assess their needs in relation to access to services.

Vulnerable young people: There may be an opportunity to work with key partners to discuss developing bespoke one-to-one or empowerment based interventions which are targeted to address the needs of vulnerable young people. This work should link to wider issues such as safeguarding, alcohol use and mental health.

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