Salford Rapid Sexual Health Needs Assessment 2015

Public Health, Salford City Council
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1. Executive Summary

1.1 Acknowledgements
This report was written by Peter Varey and Andy Wagner from the Public Health team at Salford City Council. The city council would like to thank Ruth du Plessis, Public Health Registrar at Tameside borough council for sharing the themes, research and foundations of their Sexual Health Needs Assessment. The council would also like to thank Oldham, Trafford, Teesside and Rochdale local authorities who kindly shared their needs assessments which greatly contributed to the development of this document.

1.2 Background
A sexual health needs assessment offers a strategic review of sexual health needs, current service provision and delivery in order to improve the sexual health of the population. This document identifies the needs of people in Salford across aspects of sexual health. The results of the health needs assessment inform commissioning decisions and influence future service configuration and development for the population as a whole but with a particular focus on access to services by young people and those most at risk.

This rapid sexual health needs assessment has been undertaken with a focus on services delivered or commissioned by local authorities. The information used for the assessment includes routinely available epidemiological information from a wide variety of sources, service information and the latest local and national guidelines. Every effort has been made to source the latest information available although there is often a time delay between the reporting and production of health data. The data used to produce this report was correct upto May 2015.

Salford has a population of 239,019, but the burden of sexual ill health is not evenly distributed among the population, instead it is concentrated within those who are most vulnerable including men who have sex with men, young people and black and minority ethnic groups. There is an unequal impact of HIV on men who have sex with men (MSM) and on black and ethnic groups from areas where HIV is endemic. These groups make up a significant part of Salford’s population; one third of Salford’s population are under 25 years old which is higher than the national average. Whilst no robust local or national data exists, it is estimated that 2.6% of the national male population are men that have sex with men or bisexual men, whilst people from Black and Minority Ethnic (BME) groups account for 11% of the Salford’s population. It is known from the Salford Lesbian Gay Bisexual and Transgender (LGBT) Needs Assessment that there is a higher proportion of MSM in Salford than nationally.

Sexually Transmitted Infections (STIs)
Salford has a significant prevalence of sexually transmitted Infections (STIs), with 2,512 new STI diagnoses in 2013. This represents a rate of 1059.5 per 100,000 residents which is higher than England (810.9 per 100,000). This shows a decrease from the rate in Salford in 2012 (1101.1 per 100,000 residents).

This is particularly relevant for young people in Salford as 52% of cases are in those under 25. The rates for Chlamydia, Gonorrhoea, genital warts, genital Herpes and Syphilis rank Salford among those authorities in England with the highest rates; overall Salford is ranked 39 out of 326 local
authorities in England (first in the rank has the highest rates) for rates of new sexually transmitted infections.

**Chlamydia**

In 2013 there were 805 Chlamydia diagnoses in young people under 25 in Salford. Public Health England (PHE) recommends local authorities should be working towards achieving a diagnosis rate of at least 2,300 per 100,000 in 15 to 24 year olds which modelling suggests will result in the reduction of overall prevalence by treating the detected cases and reducing the risk of onward transmission. Salford achieved this target with a rate of 2,348 per 100,000 population, putting it in the top 10% of local authorities attaining this in England. This strong return is a Public Health Outcome Framework (PHOF) target and needs to be maintained.

Historically, the 20-24 year old age groups had the highest detection rates of Chlamydia so the National Chlamydia Screening Programme has targeted 15-24 year olds. Data gathered in Genito urinary Medicine (GUM) clinics shows that in 2013, for the first time in recent years, Chlamydia detection rates in the 25-34 year old group are higher than in 20-24 year olds.

**Human Immunodeficiency Virus (HIV)**

HIV continues to be a real issue for high-risk groups, MSM and people from black African communities. The rate in Salford (4.8 people per 1,000 head of population) is increasing year on year and is significantly higher than the England average (2.1 per 1,000). Conversely the diagnosed new infections of HIV in Salford is falling year on year which suggests Salford is inheriting cases of HIV; people are moving to Salford with an existing HIV diagnosis.

Nonetheless, the proportion of people being diagnosed with late-stage HIV infections is higher than England, at 60%. This is a key PHOF target that will require Salford to work towards increasing early diagnosis. Salford City Council and Salford’s Health and Wellbeing Board have recently signed up to the national ‘Halve-It’ campaign to tackle this by working with health partners in Salford to aim to halve late diagnoses of HIV and halve the number of people living undiagnosed with HIV by 2020.

**Long Acting Reversible Contraception (LARC)**

In 2013, Salford was ranked 237 out of 326 local authorities in England for the rate of GP prescribed Long Acting Reversible Contraception (LARCs) (e.g. intrauterine devices, contraceptive injections or implants), with a rate of 46.9 per 1,000 women aged 15 to 44 years. This is lower than the rate of 52.7 in England. The data does not include LARCs provided in other settings such as community sexual and reproductive health services, pharmacies and young people services etc. (Public Health England, 2014).

Of the 48 GP Practices in Salford, 33 are commissioned to provide LARC, of which 28 have prescribed at least one form of LARC in 2013/14. Although this represents reasonable coverage in the city, further work needs to be done increase the offer of LARCs, particularly in known teenage pregnancy hotspots. In addition, further work needs to be done to understand and tackle the barriers which have prevented some practices from not offering or offering only one method of LARC.
Emergency Hormonal Contraception
There are a total of 48 pharmacies that offer Emergency Hormonal Contraception (EHC), specifically Levonorgestrel, which can be taken within 72 hours (three days) of having sex. The participating Pharmacies offer good geographical coverage across the city. 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.

Teenage Pregnancy
In 2013, Salford achieved the 50% reduction set out in the National Teenage Pregnancy Strategy of reducing under 18 conceptions by 50% from the 1998 baseline. Salford’s rate is comparable to statistical neighbours and gap between Salford and the England and North West rates have narrowed significantly. That said, Salford still remains in the top 20% of local authorities for under 18 conception rates in England and Wales.

Abortions
The proportion of under-18 conceptions leading to an abortion are slightly lower in Salford than England although the abortion rates for all women aged 15 between 44 is higher in Salford compared with England. More than one in three women under 25 had a repeat abortion in 2013 which is slightly higher compared with England and the North West.

Sexual Offences
Salford has seen an increase in the number of reported sexual offences by 31%. This is in keeping with an increase in England (22%) which, in part, may be explained by an increasing willingness of victims to report sexual offences following media attention surrounding high-profile abusers.

1.3 Services in Salford
The total local authority budget for these services in Salford is just over £3 million which is used to commission a variety of sexual health services in different settings. A summary of these services is provided below.

Salford Royal Foundation Trust provide the adult sexual health service which is an integrated offer, combining Contraceptive and Sexual Health (CASH - also known as “Family Planning”), Genitourinary Medicine (GUM) and Psychosexual support. It is integrated as it is open access for all ages and for sexual health treatment, testing and contraception services for Salford residents and non-residents alike.

Brook Advisory provide Salford’s Young People’s Sexual Health Service with an aim to improve sexual health outcomes for people under 25 and reduce teenage pregnancy. This aims to deliver a comprehensive sexual health service for young people in Salford, including contraception advice, condom distribution, pregnancy testing, counseling, Chlamydia screening, delivery of long-acting reversible contraception (LARC), emergency hormonal contraception and other appropriate interventions.
Central Manchester Foundation Trust provide the Greater Manchester Chlamydia Screening Office (R U Clear), which, as part of the national screening programme for 15-24 year olds, co-ordinate and manage the testing, including postal tests and triage of results for Chlamydia and Gonorrhoea on behalf of Salford and the other local authorities in Greater Manchester.

**General Practices are the main provider of contraceptives for women** such as Long Acting Reversible Contraception (LARCs) and are key providers of sexual health advice and care, including Sexually Transmitted Infection (STI) testing and treatment as part of their consultation.

**Pharmacies offer Emergency Hormonal Contraception (EHC),** specifically Levonorgestrel, which is effective up to 72 hours after unprotected sex in preventing pregnancy. 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.

**Some of the Voluntary, Community and Social Enterprises (VCSEs) in Salford are commissioned to provide sexual health promotion, advocacy and HIV prevention work with groups known to be at a greater risk of sexual ill-health such as men who have sex with men, Black African men and women and sex workers.**

**Non-Commissioned Sexual Health Clinical Services**
As part of the national requirement for sexual health services to be open access regardless of patients’ area of residence, sexual health services outside of Salford providing Genitourinary Medicine (GUM) interventions for Salfordians may invoice Salford city council for these services.
2. Recommendations

This Needs Assessment has found that in Salford the existing services are generally meeting the needs of the population and there has been good progress on the Public Health Outcomes Framework (PHOF) Indicators around sexual health. The recommendations below have been developed from the data gathered and discussion within this needs assessment and aim to build upon the existing provision in the city and further improve the sexual health of the residents. The recommendations have been gathered into four distinct sections:

- Service Design
- HIV Testing
- Reducing Teenage Pregnancy and Abortion Recommendations
- Policy Recommendations

2.1 Service Design Recommendations

Recommendation 1: Adult and Young People Service Provision Review

This is an opportune time to review the service provision and change the function of Adult Integrated Sexual Health Service to:

- redistribute clinical interventions across primary and secondary care to enable sexual health services to increase their role co-ordinating and supporting other providers;
- to ensure a standardised high quality approach across all services,
- increase capacity within primary care,
- expand services such as condom provision.

It may be possible to deliver efficiencies and achieve a reconfiguration of services by reducing follow-up attendances for contraception and reviewing roles. Further efficiencies could be made by:

- reducing the overlap of acute and young people’s services (currently provided by Salford Royal and Brook) who both accept clients between the ages 18 and 25 years old. An ‘all-age’ service may streamline the services in Salford but consideration must also be given to the provision of outreach services for young people in any future re-procurement.
- implementing the existing pilot in GUM services of the ‘TEST AND GO’ service for patients that have no symptoms and just want a quick test for sexually transmitted infections.
- Re-examining commissioning boundaries and responsibilities such as for cervical screening.
- Exploring HIV home sampling and Point of Care testing (see below).

Recommendation 2: Reconfiguration of Young People’s Services

Data shows that there is a populous of young people in Irlam but no permanent provision of a young people’s sexual health services with the exception of Brook’s school based provision in term time at Irlam and Cadishead College and the adult service at the Irlam Health Centre. Where provision for young people is lower in certain areas, young people seem to be attending the adult service. Consideration should be given to the reconfiguration of young people’s services, including outreach, to provide support in the Irlam area.
This may best be managed by considering the integration of young people’s and adult services. There is already an overlap between the adults (18+ years) and young people’s (upto 25 years) sexual health services; attendances by people under 25 account for 38% of the total for the adult services. In addition, the population estimates for Salford in 2021 suggest that the number of 15-24 year olds is expected to reduce by more than 5% and the number of 25 to 39 year olds expected to rise by over 11% which may result in less demand on a Young People’s service and more demand for existing adult services. Furthermore, data gathered in Genito Urinary Medicine (GUM) clinics shows that in 2013, for the first time in recent years, Chlamydia detection rates in the 25-34 year old group are higher than in 20-24 year olds.

Recommendation 3: Greater Manchester Condom Distribution Scheme

One proposal for consideration in Greater Manchester 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. Given the limited amount of quality research evidence, if a new scheme is set up, a formal evaluation would be required to assess whether the scheme is effective. This may be best delivered across a Greater Manchester footprint with a central online based ordering system with additional telephone support.

Recommendation 4: Standard Approach to Partner Notification

Future service specifications should have a specific focus on having a standard approach to and monitoring of the effectiveness of partner notification to ensure those who may need sexual health services are alerted and given the opportunity to access. This should be harmonised across Greater Manchester via a collaborative Chlamydia screening service specifications.

Recommendation 5: Chlamydia Screening Review

Consideration should be given to whether it is possible to have all GP practices actively offering Chlamydia screening or providing local referrals within a neighbourhood.

A review of the Greater Manchester Chlamydia Screening Office (RUClear) will also be carried out, potentially offering a more web-based alternative, clinical governance for HIV testing and a GM condom distribution scheme.

2.2 HIV Testing Recommendations

In 2015, Salford City Council and Salford Health and Wellbeing Board signed up to the National ‘Halve-It’ which pledges to work with health partners across the city, aiming to halve the proportion of people living undiagnosed or diagnosed late with HIV by 2020. These recommendations aim to support the delivery of this pledge in Salford and address the high rates of HIV in the city.

Recommendation 6: HIV Point of Care Testing (POCT)

HIV Point of Care Testing (POCT) is a testing technology that allows people to be tested for HIV and know their HIV status during the same visit, usually in less than an hour. 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 Salford. Any introduction of point of care testing will need to consider:
appropriate clinical and data governance arrangements
- the sensitivity and specificity of tests available
- the potential for joint commissioning across Greater Manchester
- cost effectiveness of the testing programme

The introduction of HIV testing for all men and women registering in general practice and for all general medical admissions should also be considered as recommended by the British HIV Association. In practice this would be an expensive programme to deliver Salford wide, but consideration should be given to a targeted approach in areas where prevalence is high or where there are specific high risk groups such as Men who have sex with Men (MSM) and Black African men and women.

**Recommendation 7: Targeted HIV and STI testing for Black Africans in Salford**

HIV testing is currently commissioned and offered to gay and bisexual men at the Lesbian Gay Bisexual and Transgender Foundation (LGBTF) but testing for black African men and women is not directly commissioned by Salford City Council. In Salford, 23.9% of people living with HIV in Salford in 2013 were Black African. Consideration should be given to aligning with other Greater Manchester local authorities to fund HIV and STI prevention activities specifically to the Black African population of Salford.

### 2.3 Reducing Teenage Pregnancy and Abortion Recommendations

**Recommendation 8: Extending the Provision of Emergency Hormonal Contraception (EHC)**

Consideration could be given to extending the 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 oral contraceptives as required. Both EllaOne and prescribing of oral contraceptives would require a patient group directive which is a written instruction for the sale, supply and/or administration of medicines to groups of patients.

**Recommendation 9: Long Acting Reversible Contraception (LARC) Provision in Primary Care**

Further work needs to be done to increase the offer of LARCs in the city, particularly in known teenage pregnancy hotspots. In addition further work needs to be done to understand and address the barriers which have prevented some General Practices from not offering or offering only one method of LARC. There is also currently a small scale research study being carried out by an MSc student at Salford University with young people in Salford, establishing their attitudes to using LARC.

**Recommendation 10: Working closely with Abortion Services**

Salford City Council and Salford CCG should continue to work 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 that offer services such as contraception. A full review of the clinical pathways should be undertaken when establishing new sexual health services.
Recommendation 1: Developing SRE curriculum in schools
To complement the current school based programmes, consideration should be given to developing a large scale and locally relevant Sex and Relationships (SRE) curriculum and the cost effectiveness of such a programme. This could be explored by Salford City Council’s Children’s and Integrated Youth Support Services.

With support from Health and Wellbeing Board partners, further work should be done to explore and supportively challenge the attitudes, behaviours and social norms of young people through the delivery of targeted interventions.

2.4 Policy Recommendations

Recommendation 12: All Age Sexually Transmitted Infection (STI) Prevention Strategy
In Salford in recent years there has been an increase in the number of STIs and unplanned pregnancies in 25-49 year olds. Therefore, it is recommended there should be an all age prevention strategy to reduce STIs, increase access to contraception, reduce unplanned pregnancy and maintain sexual health. As part of this strategy, a holistic approach by all healthcare professionals should be encouraged to take the opportunity to raise sexual health issues in routine healthcare appointments. Indeed, it is recommended that a joint Greater Manchester All Age STI strategy should be considered with fellow GM commissioners in order to inform future collaborative commissioning.

Recommendation 13: Empowering 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.

In Salford work between the local authority and young people’s services such as the ongoing sexual health awareness outreach work and bespoke behaviour change based interventions have provided collaborative opportunities that have worked with the most vulnerable young people in the city. Further bespoke work will continue to be encouraged by local health partners using funding streams such as the Salford Clinical Commissioning Group’s (CCG’s) Innovation Fund.

Recommendation 14: Qualitative Research
It is recommended that further qualitative research be carried out on the provision and potential redesign of sexual health services. This should be carried out as part of a Community Impact Assessment and ongoing involvement/consultation with service users.
3. Introduction

3.1 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 those individuals who are most at risk.

Sexually transmitted infection (STI) rates in the UK have been rising steadily over the past decade with more than 1.5 million episodes of STIs seen in UK clinics every year. During the same time considerable progress has been made in reducing teenage pregnancies and access to high quality testing and treatment of STIs. In Salford the main concerns are comparatively high rates of Human Immunodeficiency Virus (HIV) and some STIs such as Chlamydia as well as rates of unintended pregnancies, in particular teenage pregnancies which are above the national and regional average.

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). Early diagnosis & treatment of sexually transmitted infections (STIs) reduces the risk of costly complications & onward transmission.

Sexual and reproductive health and HIV prevention, treatment, care and support should be a Public Health priority in Salford for the following reasons:

- The Public Health Outcomes Framework, which sets the national and local strategic direction for public health, includes three indicators for sexual and reproductive health and HIV.

- England continues to have some of the worst rates of poor sexual and reproductive health in Europe. Salford rates of STI and HIV have remained some of the highest in England.

- Improving sexual and reproductive health and HIV services will deliver benefits for public health across the whole population.

- There are additional opportunities for innovation in sexual and reproductive health and HIV service delivery to improve integration, deliver better outcomes for communities and offer cost savings for local government, for example by reducing demand for specialist sexual health services and social care.

- The local authority has a mandated responsibility to commission comprehensive, open access sexual and reproductive health services.

The burden of sexual ill health is not evenly distributed among the population but concentrated within those who are most vulnerable including men who have sex with men, young people and black and minority ethnic groups. There is an unequal impact of HIV on men who have sex with men (MSM) and on black and ethnic groups coming to England from areas where HIV is endemic (Department of Health, 2001). There is also a clear relationship between sexual ill health, poverty and social exclusion (Public Health England, 2014). In line with national data, significant inequalities exist in sexual and reproductive health in Salford.
The challenge of improving HIV and STI rates and unintended conceptions across Salford is significant. It is not sufficient to provide excellent sexual health services to treat STIs and offer the range of contraceptive methods; we also need to help and support attitude and behaviour change at population and community levels as prevention is better (and less expensive) than cure. It is therefore important that sexual health is not just seen as an issue for public health professionals to address. All services in Salford can play a role in tackling poor sexual health and the substantial impact that can have on peoples’ lives.

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 and the health care system, for example by reducing demand for social care for people living with HIV and reducing demand on specialist sexual health services. Evidence demonstrates spending on sexual health interventions and services is cost effective (Department of Health, 2013).

Commissioning responsibilities for sexual health are shared between the Local Authority, Clinical Commissioning Groups (CCGs) and NHS England (NHSE). The local authority has a mandated responsibility to commission comprehensive, open access sexual and reproductive health services. It is estimated that 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 is important that local authorities work together with their neighbouring authorities, CCGs and NHS England to ensure the seamless delivery of needs lead services.

3.2 Aims

This sexual health needs assessment offers a strategic review of sexual health needs, current services and delivery in Salford in order to improve sexual health. It will inform commissioning decisions ensuring targeted, comprehensive and equitable sexual health services. It identifies the specific needs within Salford, and gives recommendations for consideration on how these might be addressed.

The results of the health needs assessment will influence future service configuration and development for the population as a whole but with a particular focus on access to services by young people and those most at risk. It does not provide an assessment of whether these recommendations are financially or clinically viable, as this needs to be considered within the wider context of local authority priorities.

3.3 Objectives

The objectives of this health needs assessment are to:

- Describe the sexual health of the population in Salford by looking at key indicators and trends in order to understand the local burden of disease;
- Describe current provision of sexual health promotion, prevention and treatment services in Salford;
- Assess the capacity to meet current and future demand and to identify gaps between sexual health needs and service provision;
• Provide recommendations to address gaps in services and current unmet needs; and to
• Inform the redesign of sexual health services by providing an evidence base for these commissioning decisions, so that services will deliver a targeted and comprehensive offer in Salford.

3.4 Scope
This document will include data for Salford on:

• Sexually Transmitted Infections;
  o Overview of the five most prevalent (including Chlamydia)
  o Human Papilloma Virus (HPV) immunisation programme
  o Human immunodeficiency virus (HIV)

• Contraception;
  o Emergency Hormonal Contraception (EHC)
  o Long Acting Reversible Contraception (LARC)

• Wider sexual health issues;
  o Teenage pregnancy
  o Abortion
  o 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, gynaecology or cervical screening. These areas are not included as part of the needs assessment as they are areas beyond the remit of Public Health commissioning of sexual health services.
4. **Background**

4.1 **Sexual Health**

Sexual health is influenced by the knowledge, attitudes and behaviours of individuals. Social norms, peer pressure, stigma, discrimination and religion influence both attitudes and decisions of individuals. The World Health Organisation (WHO, 2015) defines sexual health as:

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

Sexual health is an important and wide-ranging area of public health. A significant number of adults and young people in England are sexually active, therefore having access to sexual health interventions and services are important for the wellbeing of the Salford population. Early diagnosis & treatment of sexually transmitted infections (STIs) reduces the risk of costly complications & onward transmission. There are also health benefits from people with HIV being diagnosed & starting treatment early, minimising the use of NHS & social care services. Prevention of unintended pregnancies & control over reproductive choices preserves good mental & psychosexual health.

The Department of Health (Department of Health, 2013) states that sexual health services provided by a local authority must:

- have open access for everyone present in their area;
- offer free contraception, and reasonable access to all methods of contraception.
- free testing and treatment for sexually transmitted infections (STI),
- notification of sexual partners of infected persons must be offered.

In March 2013, a national Framework for Sexual Health Improvement in England was published. This document highlighted the need for a continued focus on sexual health across the life course and highlighted four priority areas for improvement:

- Sexually transmitted infections (STIs)
- Human Immunodeficiency Virus (HIV)
- Contraception and unwanted pregnancy (all age)
- Preventing teenage pregnancy

This needs assessment provides the latest data for Salford for each of these priority areas and also includes feedback from stakeholders on their assessment of current needs.

4.2 **Sexual health promotion and prevention**

Sexual health promotion and prevention aims to support informed and healthy decisions and behaviour change through the provision of high quality, accessible information with clear messages, targeted interventions and programmes and through face to face advice and testing. Sexual health
promotion aims to prevent unwanted pregnancies, prevent and reduce the spread of STIs and to take autonomous, non-regretted decisions about sexual activity. As part of a holistic approach to ensure the health of their patients, all health care professionals are encouraged to take the opportunity to raise sexual health issues in routine healthcare.

Stigma and embarrassment about sexual health are widespread in particular in relation to HIV but also other STIs and contraception. This can result in patients not asking for information or failing to seek testing and treatment, but also in healthcare professionals preferring not to offer advice and testing.

Knowledge and access to information on sexual health and sexual health services e.g. how to prevent or get tested for STIs and unwanted pregnancies, methods of contraception including LARC and how to get and use emergency contraception are crucial. This could be face to face advice through health professionals as recommended by The National Institute for Health and Care Excellence (NICE) or other sources of information such as campaigns, sex and relationship education, leaflets, posters, websites and social media.

Health promotion aims to influence the risk taking behaviours which impact on people’s decisions on relationships, contraception and unprotected sex but also on alcohol and drug consumption and other behaviours. The Department of Education advises schools to teach Personal, Social, Health and Economic (PHSE) education to all students which is a planned programme to equip young people with the knowledge, understanding, attitudes and practical skills to live healthily, safely, productively and responsibly. Within this PHSE programme, Sex and relationship education (SRE) in primary and secondary schools aims to provide children with age appropriate information, to explore and develop their attitudes and values and to empower them to make positive decisions about their sexual health related behaviour. The Department of Education has issued updated guidance on SRE which at present is non-mandatory in school, but is under consideration nationally to be made compulsory.

Sexual health prevention and promotion must recognise the increasing role of the internet and social media in the lives of most people and in particular for young people. Young people have wide access to websites and social media and use it to find information, advice and also to find local services.

4.3 Prevalence (Burden of Illness Nationally)

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 such as 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 by 40% between 2004 and 2013 from 319,602 to 446,253; although this is a slight decrease from 2012 (448,775) when there were changes to Chlamydia reporting.

Genital Chlamydia 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 which is unlikely to be fatal but may cause severe health problems if not treated (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; although this is a slight increase in raw numbers 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. This proportion has risen from 32% in 2003 (Department of Health, 2014). 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).

### 4.4 Impact
The results of STIs include acute symptoms, chronic infection, complications such as pelvic inflammatory disease, and serious delayed consequences to areas of the body including the heart brain and central nervous system (World Health Organisation, 2007). STIs are the main preventable cause of infertility, particularly in women. Certain types of Human Papilloma Virus 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).

### 4.5 Risky behaviours /high risk groups
Certain behaviours are associated with increased transmission of STIs 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. Sexual health experiences and outcomes are influenced by many factors, including the globalization of media like films and television shows, and changes in family structures, sociocultural norms, religious beliefs and practices (World Health Organization, 2010). There are a range of factors that can influence sexual health outcomes, see Figure 1 below.
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).

A number of groups of the population are more vulnerable in relation to particular aspects of their sexual health. Some are more exposed to the risk of unwanted pregnancies or sexual exploitation; others engage in risk taking behaviours such as unprotected sex, multiple partners and injecting drugs and have a higher risk of STIs. Many also experience difficulties in accessing sexual health services or finding appropriate sexual health services.

**Young people** between 15 and 24 years experience the greatest burden of sexual ill-health in the population with about 50% of all STI diagnoses nationally. A lack of knowledge about risks and prevention as well as risk taking behaviours including drug and alcohol misuse contribute to the higher risk of contracting STIs.

**Deprivation** has an adversely disproportionate effect on people’s health (World Health Organisation, 2015). This association is also true with sexual ill-health. Poorer and more deprived areas are experiencing higher rates of STIs and teenage pregnancies (Social and Public Health Sciences Unit, 2015).

**Young people who are in or leaving care**, who have low educational attainment and who are from disadvantaged backgrounds are particularly vulnerable to poor sexual health including STIs, sexual exploitation and teenage pregnancies. **People with learning difficulties** often do not have appropriate access to sex and relationship education and information and consequently are more vulnerable to sexual exploitation, unwanted pregnancies and STIs.
Lesbian, gay, bisexual and transgender people (LGBT). Men having sex with men and bisexual men are at higher risk of contracting STIs, and therefore have a significantly higher incidence and prevalence of most STIs including HIV. New evidence on the increased use of injecting club drugs and the associated risk of HIV and other STIs in the gay community causes further concerns (NAT, 2013).

Women who have sex with women engage in a range of sexual practices which mean that they, too, are at risk of STIs, but clear information on this is not always available. That said, The Lesbian & Gay Foundation (2014) cite Health Protection England statistics that of women who have sex with women attending GUM clinics in 2012, 40% had an STI diagnosis, compared to 18.5% of women who have sex with men.

People from BME groups have, depending on the prevalence in their country of origin, a higher risk of HIV. Women of African background are more likely to be a victim of female genital mutilation and suffering from the associated consequences and complications.

Homeless people as well as sex workers are at a higher risk of poor sexual health and sexual exploitation.

The prison population with a high proportion of people with alcohol and drug misuse problems, people with poor educational attainment from deprived backgrounds, have a higher risk and prevalence of STIs.

Risk taking behaviours such as alcohol and substance misuse are strongly associated with poor sexual health. Alcohol consumption influences judgements and risk taking behaviours and is associated with an increased likelihood of sex at a younger age, a greater number of partners, more regretted or coerced sex, risk of sexual aggression and violence and teenage pregnancy.

An emerging trend of sexualised drug use has also been identified. ‘Chemsex’ occurs under the influence of (most commonly) stimulant drugs. It is reported to be changing the way some GBM socialise, including the arrangement of private parties online or via smartphone apps and sourcing sexual partners with the explicit intention to use drugs together (Substance Misuse Skills Consortium, 2013).
5. National Policy Context (Evidence Review)

5.1 National Policy Documents

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 (where key leaders from the health and care system work together to improve the health and wellbeing of their local population) and the creation of Healthwatch (the consumer champion for health and social care) (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).
The cross government policy on young people **Positive for Youth** includes specific recommendations relating to sexual health and supersedes the National Teenage Pregnancy Strategy (Department for Children and Families, Department for Education, 2012). Young people should be supported to take informed decisions about their sexual health leading to a reduction in teenage pregnancies, STIs and better outcomes for teenage parents. To achieve this the policy calls for strong and accountable leadership, high quality sex and relationship education in schools and colleges, youth friendly services, targeted programmes, education and advise for at risk groups as well as support and education for parents and practitioners working with young people at risk. The policy makes explicit reference to the ‘**You’re Welcome**’ initiative which sets out quality standards for sexual health services to improve services for young people. (Department of Health, 2011).

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.


Standards and guidance for sexual health services have been developed by a number of organisations. The British Association for Sexual Health and HIV (BASHH) has published **Standards for the Management of Sexually Transmitted Infections** (BASHH, 2010). The Medical Foundation for HIV and Sexual Health (MEDFASH) developed **Recommended Standards for Sexual Health Services** (MEDFASH, 2005) and **Recommended Standards for NHS HIV Services** (MEDFASH, 2015). New **Service Standards for Sexual and Reproductive Healthcare** (Healthcare, 2015) have been published. Faculty of Sexual and Reproductive Healthcare. The British HIV Association (BHIVA) issued **UK Guidelines for the Management of Sexual and Reproductive Health of People Living with HIV Infection** (BHIVA, 2008).

**NICE** guidance on the **Prevention of Sexually Transmitted Infections and Under 18 Conceptions** (NICE, 2007) makes six recommendations for sexual health services:

- identification of high risk individuals;
- provision of one to one structured discussions with high risk individuals;
- responsibility and provision of partner notification;
- provision of services according to local need – including assurance of staff training, partner notification, audit and monitoring;
- provision of one to one sexual health advice for vulnerable young people under 18;
- support for vulnerable teenage parents to prevent further unwanted pregnancies.

NICE clinical guidance on **Long Acting Reversible Contraception** (LARC) from 2005, updated in 2013, offers best practice advice on the provision of information and care for women who consider using LARC (NICE, 2005). NICE public health guidance on increasing the uptake of **HIV testing in MSM and Black Africans** recommends actions to improve the availability and accessibility of HIV testing through community engagement, outreach and targeted services. (NICE, 2011)
public health guidance on Hepatitis B and C specifically recommends the development of local care pathways including testing of high risk individuals in sexual health settings (NICE, 2012). Public Health England also produced Promoting the health and wellbeing of gay, bisexual and other men who have sex with men which was an evidence review and action plan to address the health and wellbeing inequalities affecting gay, bisexual and other men who have sex with men.

5.2 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. 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.

5.3 Public Health Outcomes 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 screening (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).

5.4 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).
**Table 1: Sexual Health Commissioning, roles and responsibilities**

<table>
<thead>
<tr>
<th>Local authorities commission</th>
<th>Clinical Commissioning Groups</th>
<th>NHS England commissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive sexual health services. These include:</td>
<td>• Most abortion services. (See ‘specialist foetal, medicine’ services)</td>
<td>• Contraceptive services provided as an ‘additional service’ under GP contracts</td>
</tr>
<tr>
<td>• Contraception (including the costs of LARC devices and prescription or supply of other methods) and advice on preventing unplanned pregnancy, in specialist services and those commissioned from primary care under local public health contracts (such as arrangements formerly covered by LESs and NESs)</td>
<td>• Female sterilisation</td>
<td>• HIV treatment and care including cost of all Anti-Retroviral Treatment</td>
</tr>
<tr>
<td>• 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</td>
<td>• Vasectomy</td>
<td>• 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)</td>
</tr>
<tr>
<td>• Sexual health aspects of psychosexual counselling</td>
<td>• Non-sexual health elements of psychosexual health services</td>
<td>• All sexual health elements of healthcare in the justice system including HIV</td>
</tr>
<tr>
<td>• 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</td>
<td>• Gynaecology, including any use of contraception solely for non-contraceptive purposes (except when provided in general practice – see column to the right)</td>
<td>• All sexual health elements of healthcare for armed forces and their families including HIV</td>
</tr>
<tr>
<td>Non-Public Health Local Authority Responsibility:</td>
<td>• HIV testing, including routine screening, in non-HIV hospital departments</td>
<td>• Sexual assault referral centres (open access one-stop service to help victims of rape or sexual assault) Cervical screening in a range of settings</td>
</tr>
<tr>
<td>• 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).</td>
<td></td>
<td>• HPV immunisation programme</td>
</tr>
<tr>
<td>• HIV Social Care</td>
<td></td>
<td>• Specialist foetal medicine services, including late surgical termination of pregnancy for foetal anomaly between 13 and 24 gestational weeks</td>
</tr>
<tr>
<td>• Wider support for teenage parents</td>
<td></td>
<td>• NHS Infectious Diseases in Pregnancy Screening Programme including antenatal screening for HIV, syphilis, Hepatitis B</td>
</tr>
</tbody>
</table>

Source: (Public Health England, 2014)
The total local authority budget for sexual health in Salford is currently £3,030,949. Table 2 below shows spend for 2014/15, 48% of which was spent on the Integrated Sexual Health Service for Adults and 16% on the Young People’s Sexual Health Service. Spend is either by unit of activity (GP and Pharmacy) or via a block contract; the majority of spend is via block contracts.

<table>
<thead>
<tr>
<th>Provider</th>
<th>Service</th>
<th>Spend</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>R U Clear</td>
<td>Chlamydia Screening (15-24 year olds)</td>
<td>£129,076</td>
<td>4%</td>
</tr>
<tr>
<td>Salford Royal Foundation Trust (Integrated Sexual Health Service)</td>
<td>Contraception, Family Planning advice, Genitourinary Medicine and Psychosexual support.</td>
<td>£1,441,423</td>
<td>48%</td>
</tr>
<tr>
<td>Brook Young People’s Sexual Health Service</td>
<td>Young People’s Health Promotion and Prevention, Family Planning</td>
<td>£492,998</td>
<td>16%</td>
</tr>
<tr>
<td>General Practice</td>
<td>Long Acting Reversible Contraception (LARCs) and Chlamydia Screening (15-24 year olds)</td>
<td>£44,000</td>
<td>1%</td>
</tr>
<tr>
<td>Pharmacies</td>
<td>Chlamydia Screening, Emergency Hormonal Contraception (EHC), advice and clinical input and targeted support to young people and high risk groups</td>
<td>£51,000</td>
<td>2%</td>
</tr>
<tr>
<td>Voluntary, Community and Social Enterprises (VCSEs)</td>
<td>Sexual Health Promotion, Advocacy and HIV Prevention</td>
<td>£172,452</td>
<td>6%</td>
</tr>
<tr>
<td>Other</td>
<td>Budget for out of area sexual health recharges</td>
<td>£700,000</td>
<td>23%</td>
</tr>
<tr>
<td>Total Spend</td>
<td></td>
<td>£3,030,949</td>
<td></td>
</tr>
</tbody>
</table>

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 Salford is one of the highest in Greater Manchester.

In terms of the Integrated Sexual Health Service (ISHS), during 2013/14, there were approximately 18749 contacts; this means the mean average cost per contact was approximately £76.87. 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 £79.92 per IUD, £25.81 for the contraceptive implant and £30.97 for removal. For pharmacy EHC, spend is £10 per consultation and the reimbursement of the drug costs and pregnancy test.

Figures for 2013 indicate that 71.9% of Salford residents use the local Salford GUM services (Public Health England, 2014). Data for 2012/13 from the Sexual Health Service for GUM/CASH indicates 84% of those using Salford Sexual Health Service are Salford residents.
6. Methodology
For this desktop Health Needs Assessment, data was collated from various sources; no formal consultation took place.

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.

6.1 Demographics

Population density
According to the Office of National Statistics (ONS) population estimates, the 2013 population is 239,019. The city covers 37.5 square miles combining a mix of urban and rural landscapes. There are six areas within Salford with a population density higher than 105 persons per hectare (See Figure 2 below).

![Urban Population Density per hectare in 2012](image.png)

Figure 2: Population density in Salford, 2012
Source: Salford City Council

Age and gender
There is a fairly even split of male and females in all ages; there is less than a 2% difference in the age groups between 0 and 64 with slightly more males throughout. The biggest variation in gender is
in the 75 and above age group (see Figure 3 below) especially above 85 where there are more than twice as many women as there are men.

Figure 3: ONS Mid-2013 Population estimates – Population Structure: Salford Figure 3 also shows an approximate correlation to national population percentages by age band, with the most notable exception being the 20 to 24 year old age group – a key risk group as discussed above for sexually transmitted infections. It should also be noted that above 40 years old, the population percentage in Salford is consistently smaller than the national average.

Compared to nationally, Salford has slightly more females in the younger (0 to 14) and middle age groups (40 to 54), the percentage of the population in Salford aged 20 to 39 and above 80 years is less than nationally reflecting a lower life expectancy in Salford than nationally (see Figure 3).

Figure 3: ONS Mid-2013 Population estimates – Population Structure: Salford vs England
Source: ONS 2013 midyear population estimates

Between 2015 and 2021 the population of Salford is expected to grow by nearly 15,000 people (+6.1%), with most of this growth (5%) coming amongst those aged 15 or over. This is not consistent across age bands, with those aged 15 to 24 expected to be reduced by 2,000 (-5.3%), while those aged 25 to 39 expected to grow by 6,750 (+11.5%). Numbers of 40 to 54 year olds are expected to fall by around 500 (-1.1%), while numbers aged 55 and over are expected to grow by 5,700 (+9.6%). However these estimates are based on factors that were foreseeable in 2013, many of which can change, so are to be viewed with caution.
Deprivation

Salford has a 2010 Index of Multiple Deprivation (IMD) score\(^1\) 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).

<table>
<thead>
<tr>
<th>Location</th>
<th>Average IMD 2010 score</th>
<th>% of people in areas that are the most deprived 20% in England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salford</td>
<td>35.5</td>
<td>47.2%</td>
</tr>
<tr>
<td>North West</td>
<td>27.5</td>
<td>32.8%</td>
</tr>
</tbody>
</table>

There is also a threefold variation in GP practice population; with 2010 IMD scores ranging from 17 to 59 (see Figure 5 below).

---

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](http://www.apho.org.uk/resource/view.aspx?RID=117805)
Salford Deprivation by ward, 2010

There are variations in the level of deprivation across the wards; however the level of deprivation is also affected by population density. The ward with the most deprivation is Broughton, with an average score of 62.5 and 100% of its population living in areas that are in the 20% most deprived in England. The least deprived ward is Worsley, with an average score of 8.7 and 100% of its population living in the least deprived 30% of areas in England. In most other wards there is a greater degree of variation, with Swinton North for example having a below average score of 27.8, but with 23% of its population living in the 20% most deprived of areas, and 76% living in the 40% most deprived of areas. Deprivation zones bypass this problem by amalgamating LSOAs with similar deprivation scores from neighbouring wards, creating 10 distinctive areas of deprivation that have large enough populations to enable robust analysis. With this stratification, the 20% most deprived areas are contained within the 50% most deprived (or top 5) zones, which also makes the discovery of statistically significant differences between areas a far more likely outcome (see Figure 6 below).

Ethnicity

89% of Salford’s population were ‘White British and Irish’ in 2011, slightly higher than England average of 87%. The biggest non-white British and Irish ethnic grouping in Salford at 4% is Asian/Asian British, this is primarily people who identify as being of Pakistani, Bangladeshi and Indian descent. 3% of the population identify as White European, largely having recently migrated from Eastern European accession states such as Poland. 2% are British/Black British and mixed race, while a further 2% are Black African, most of who were born in Africa (see Table 4). It is also important to note that 5% of the White British and Irish population make up the the largest Orthodox Jewish community in North West England. The proportion of the population that is White British and Irish varies between age groups, from 98% amongst the over 70’s, to 83% amongst the 0-4’s, and 79% amongst 26-34 year olds, as a result of current working-age migration, settlement over time and varying birth rates.
Figure 6: Salford wards and super output areas by IMD 2010 quintiles (2012)
Source: Department for Communities and Local Government (2012)

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Salford</th>
<th>North West</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>All usual residents</td>
<td>239,016</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>White British and Irish</td>
<td>212,658</td>
<td>89.0%</td>
<td>89.6%</td>
</tr>
<tr>
<td>Asian/Asian British/Mixed</td>
<td>10,620</td>
<td>4.4%</td>
<td>6.5%</td>
</tr>
<tr>
<td>White European/Other White</td>
<td>6,234</td>
<td>2.6%</td>
<td>2.2%</td>
</tr>
<tr>
<td>Black British/Black African</td>
<td>5,508</td>
<td>2.3%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Other Black/Black British/Mixed</td>
<td>3,993</td>
<td>1.7%</td>
<td>1.2%</td>
</tr>
</tbody>
</table>

Source: Nomis, 2013

There is some variation across Salford with Broughton ward having the highest Black and Minority Ethnic (BME) population of 22.1%, compared to Winton at 7.0% (see Table 5 below). This is also
represented graphically in Figure 7 below at Lower Super Output Area Level\(^2\), which show the percentage population of non-white British residents.

<table>
<thead>
<tr>
<th>Ward Name</th>
<th>All Ethnicities</th>
<th>Non-White British Total</th>
<th>Non-White British %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broughton</td>
<td>14,359</td>
<td>3,172</td>
<td>22.1%</td>
</tr>
<tr>
<td>Ordsall</td>
<td>14,691</td>
<td>3,205</td>
<td>21.8%</td>
</tr>
<tr>
<td>Irwell Riverside</td>
<td>13,328</td>
<td>2,705</td>
<td>20.3%</td>
</tr>
<tr>
<td>Langworthy</td>
<td>13,298</td>
<td>2,153</td>
<td>16.2%</td>
</tr>
<tr>
<td>Eccles Ward</td>
<td>11,503</td>
<td>1,624</td>
<td>14.1%</td>
</tr>
<tr>
<td>Kersal</td>
<td>13,005</td>
<td>1,729</td>
<td>13.3%</td>
</tr>
<tr>
<td>Weaste &amp; Seedley</td>
<td>12,195</td>
<td>1,596</td>
<td>13.1%</td>
</tr>
<tr>
<td>Barton</td>
<td>12,591</td>
<td>1,409</td>
<td>11.2%</td>
</tr>
<tr>
<td>Pendlebury</td>
<td>13,321</td>
<td>1,200</td>
<td>9.0%</td>
</tr>
<tr>
<td>Boothstown &amp; Ellenbrook</td>
<td>9,770</td>
<td>758</td>
<td>7.8%</td>
</tr>
<tr>
<td>Claremont</td>
<td>10,060</td>
<td>722</td>
<td>7.2%</td>
</tr>
<tr>
<td>Little Hulton</td>
<td>13,069</td>
<td>922</td>
<td>7.1%</td>
</tr>
<tr>
<td>Swinton North</td>
<td>11,296</td>
<td>793</td>
<td>7.0%</td>
</tr>
<tr>
<td>Winton</td>
<td>12,270</td>
<td>854</td>
<td>7.0%</td>
</tr>
<tr>
<td>Swinton South</td>
<td>11,510</td>
<td>754</td>
<td>6.6%</td>
</tr>
<tr>
<td>Walkden North</td>
<td>11,830</td>
<td>716</td>
<td>6.1%</td>
</tr>
<tr>
<td>Cadishead</td>
<td>10,417</td>
<td>560</td>
<td>5.4%</td>
</tr>
<tr>
<td>Worsley</td>
<td>10,183</td>
<td>531</td>
<td>5.2%</td>
</tr>
<tr>
<td>Irlam</td>
<td>9,942</td>
<td>470</td>
<td>4.7%</td>
</tr>
<tr>
<td>Walkden South</td>
<td>10,382</td>
<td>490</td>
<td>4.7%</td>
</tr>
<tr>
<td>Salford</td>
<td>239,019</td>
<td>26,361</td>
<td>11.0%</td>
</tr>
</tbody>
</table>

Source: Nomis, 2013

\(^2\) Lower Layer Super Output Areas are built from groups of contiguous Output Areas (clusters of adjacent unit postcodes) and have been automatically generated to be as consistent in population size as possible, and typically contain from four to six Output Areas. The Minimum population is 1000 and the mean is 1500.
Figure 7: Non White-British population density by Output Area
Source: Census 2011
7. **Current Structures**

Salford City Council commissions sexual health services from Salford Royal Foundation Trust for adult services (18+ years), Brook Advisory for young people’s services (upto 25 years), a collaborative Greater Manchester Chlamydia Screening Office from Central Manchester Foundation Trust and four voluntary, community and social enterprise (VCSE) organisations.

Commissioners and providers work closely to ensure the commissioning and delivery process is needs led 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. A significant proportion 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 3 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 for sexual health in 2001; this was reaffirmed in the Strategy review (MedFASH, 2008), is cited in the recent best practice guidance (Public Health England, 2014) and is reproduced below.
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

7.1 Integrated Contraceptive and Sexual Health (CASH) and Genitourinary Medicine (GUM)

In Salford the adult sexual health service provides an integrated offer by combining Contraceptive and Sexual Health (CASH - also known as “Family Planning”) and Genitourinary Medicine (GUM). This is delivered and managed by Salford Royal Foundation Trust. It is integrated as it is open access for all ages and for sexual health treatment, testing and contraception services for Salford 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 service is delivered in a ‘hub and spoke’ model format; the central hub is located in Pendleton at the Lanceburn Centre and there 5 spoke clinics across the city in Eccles, Higher Broughton, Irlam, Swinton, Walkden. The hub in Pendleton offers appointments from Monday to Friday (9am to 5pm) for people who a) have symptoms of infection, b) have been in contact with someone with an STI or c) needs treatment for genital warts. In addition two drop clinics are offered at the hub on Tuesday evening. A list of all clinic times and locations can be found below in Table 6 and shown geographically in Figure 8 below.

<table>
<thead>
<tr>
<th>Clinic Location</th>
<th>Address</th>
<th>Clinic dates and times</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eccles</td>
<td>Eccles Gateway, Barton Lane, Eccles, M30 0TU</td>
<td>Thursday 18:00-20:30</td>
</tr>
<tr>
<td>Higher Broughton</td>
<td>Higher Health Centre, Bevendon Square, M7 4TP</td>
<td>Friday 09:30-11:30</td>
</tr>
<tr>
<td>Irlam</td>
<td>Irlam Medical Centre, MacDonald Road, Irlam, M44 5LH</td>
<td>Wednesday 18:00-20:30</td>
</tr>
</tbody>
</table>
| Lanceburn       | Lanceburn Health Centre, Churchill Way, Salford, M6 5QX | Tuesday 14:00-16:30  
                  |                      | Tuesday 18:00-20:30  |
| Swinton         | Swinton Clinic, 139 Partington Lane, Swinton, M27 0NS | Monday 14:00-16:30  
                  |                      | Tuesday 18:00-20:30  
                  |                      | Friday 14:00-16:30   |
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 Salford Royal Foundation Trust; one for specimen processing and testing, and another for the biomedical scientist.

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

This clinic is staffed by a Consultant, Specialist General Practitioners, Nurses, Health Advisors, a Vulnerable Young Persons Worker and a 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.
**Recommendation:** This is an opportune time to review the service provision and change the function of Adult Integrated Sexual Health Service to:

- redistribute clinical interventions across primary and secondary care to enable sexual health services to increase their role co-ordinating and supporting other providers;
- to ensure a standardised high quality approach across all services,
- increase capacity within primary care,
- expand services such as condom provision.

It may be possible to deliver efficiencies and achieve a reconfiguration of services by reducing follow-up attendances for contraception and reviewing roles. Further efficiencies could be made by:

- reducing the overlap of acute and young people’s services (currently provided by Salford Royal and Brook’s) who both accept clients between the ages 18 and 25 years old. An ‘all-age’ service may streamline the services in Salford but consideration must also be given to the provision of outreach services for young people in any future re-procurement.
- implementing the existing pilot in GUM services of the ‘TEST AND GO’ service for patients that have no symptoms and just want a quick test for sexually transmitted infections.
- Re-examining commissioning boundaries and responsibilities such as for cervical screening.
- Exploring HIV home sampling and Point of Care testing (see below).

In terms of attendances for GUM services, 71.9% of all attendances by residents of Salford attend services in Salford (Public Health England, 2014).

Data from Salford Royal Foundation Trust for April 2013 to March 2014 indicates that during 2013/14 there were 28,908 attendances. 58% of attendances were for GUM, of which 62% involved people aged 25 and over, 34% 18 to 24, and 4% under 18. 35% of attendances were for CASH, of which 59% involved people aged 25 and over, 31% 18 to 24, and 11% under 18.

<table>
<thead>
<tr>
<th>Age</th>
<th>GUM</th>
<th>%</th>
<th>CASH</th>
<th>%</th>
<th>Other</th>
<th>%</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>17 and under</td>
<td>395</td>
<td>3.7%</td>
<td>699</td>
<td>10.7%</td>
<td>20</td>
<td>1.5%</td>
<td>1114</td>
<td>5.9%</td>
</tr>
<tr>
<td>18 to 24</td>
<td>3720</td>
<td>34.4%</td>
<td>2012</td>
<td>30.7%</td>
<td>336</td>
<td>24.8%</td>
<td>6068</td>
<td>32.4%</td>
</tr>
<tr>
<td>25 plus</td>
<td>6703</td>
<td>62.0%</td>
<td>3852</td>
<td>58.7%</td>
<td>997</td>
<td>73.7%</td>
<td>11552</td>
<td>61.7%</td>
</tr>
<tr>
<td>All ages</td>
<td>10818</td>
<td>100%</td>
<td>6563</td>
<td>100%</td>
<td>1353</td>
<td>100%</td>
<td>18734</td>
<td>100%</td>
</tr>
</tbody>
</table>

*Source: Salford Royal Foundation Trust*

As an overall picture, the uptake of the adult sexual health service is also shown graphically in Figure 9 below.
Figure 9: Percentage of 15 to 65 year olds accessing SRFT Clinics by LSOA 2012/14
Source: Salford Royal Foundation Trust

7.2 Young People’s Sexual Health Service

Since 2010, Salford Public Health has commissioned Brook to deliver a Young People’s Sexual Health service in Salford with an aim to improve sexual health outcomes for people under 25 and reduce teenage pregnancy. This aims to deliver a comprehensive sexual health service for young people in Salford, including contraception advice, condom distribution, pregnancy testing, counseling, Chlamydia screening, delivery of long-acting reversible contraception (LARC), emergency hormonal contraception and other appropriate interventions. The service is provided from three locations in the city (Weaste, Walkden and Swinton), strategically placed to work with communities with identified teenage pregnancy hotspots (See Figure 10 below). Sessions are also provided in youth settings, including with vulnerable young people in supported housing, youth clubs, schools and education/training establishments.
The young people’s sexual health service is a self-referral service, with the great majority of clients seen on a “drop-in” basis. Service confidentiality is paramount, and clients are assured that no details are made available to other agencies without client consent, with the sole exception of issues concerning child protection, where there may be a legal requirement to inform criminal justice agencies of potential abuse. The attendance data for 2014/15 is shown in Table 8 below.

<table>
<thead>
<tr>
<th>Age</th>
<th>Attendances</th>
<th>Percentage of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 18</td>
<td>2553</td>
<td>37%</td>
</tr>
<tr>
<td>18 to 25</td>
<td>4281</td>
<td>63%</td>
</tr>
<tr>
<td>Total</td>
<td>6834</td>
<td>100%</td>
</tr>
</tbody>
</table>

Attendance at Brook comes from across the city but the majority of young people accessing the services are located close to their centres (see Figure 11). When compared to the geographical location of people aged 13-17 (see Figure 12) it could be argued that young teenagers attendance at Brook are affected by the location of services, particularly young people located in Irlam and...
Broughton. That said, data gathered from the adult sexual health service presently in these areas suggests young people are attending in their service instead in these areas (see Table 7 and Figure 9) and there is an school based, term time clinic based in Irlam and Cadishead College.

**Number of young people seen and breakdown by gender and ethnicity**

There was a total of 6834 visit by young people to Brook Salford during 2014/15, 1872 of which were new contacts. A breakdown of the number of visits by age and gender is shown in Figure 13. For the same period a breakdown of service user by ethnicity is shown in Table 9. This shows that a lower proportion of people from Asian/Asian British communities accessed Brook Salford when compared with the percentage of people from those communities living in Salford. Less than twelve per cent of the total number of young people accessing Brook Salford services during 2013 and 2014 lived outside of Salford.

![Percentage of population aged 13-17 accessing Brook at least once in 2013 and 2014](image-url)

*Figure 11: Percentage of population aged 13-17 accessing Brook at least once in 2013 and 2014*
*Source: Brook Salford*
Figure 12: Number of People aged 13-17 by LSOA
Source: Brook Salford

Figure 13: Number of Young People seen at Brook Salford by age and gender during 2014/15
Source: Brook Salford
Table 9: Ethnicity of Brook attendees 2014/15

<table>
<thead>
<tr>
<th>Client Group/Community</th>
<th>Salford Brook</th>
<th>Salford</th>
</tr>
</thead>
<tbody>
<tr>
<td>All clients/usual residents</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>White British and Irish</td>
<td>89.6%</td>
<td>89.0%</td>
</tr>
<tr>
<td>Asian/Asian British/Mixed</td>
<td>2.4%</td>
<td>4.4%</td>
</tr>
<tr>
<td>White European/Other White</td>
<td>2.2%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Black British/Black African</td>
<td>2.4%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Other Black/Black British/Mixed</td>
<td>2.4%</td>
<td>1.7%</td>
</tr>
<tr>
<td>Not Stated</td>
<td>1.0%</td>
<td></td>
</tr>
</tbody>
</table>

Source: Brook Salford

Contraception methods issued

Figure 14 shows the number of different contraception methods provided to young people accessing Brook Salford services.

Figure 14: The Number of Young People provided with contraception by type for 2014/15

Source: Brook
Brook is also one of the screening sites for the local Chlamydia screening programme and contributes a large proportion of the total screening activity and diagnoses for the city. Brook diagnosed 182 cases of Chlamydia in 2014/15 thus providing a significant contribution to the city target of 793 diagnoses each year.

**Recommendation:**

Data shows that there is a populous of young people in Irlam but no permanent provision of a young people’s sexual health services with the exception of Brook’s school based provision in term time at Irlam and Cadishead College and the adult service at the Irlam Health Centre. Where provision for young people is lower in certain areas, young people seem to be attending the adult service. Consideration should be given to the reconfiguration of young people’s services, including outreach, to provide support in the Irlam area.

This may best be managed by considering the integration of young people’s and adult services. There is already an overlap between the adults (18+ years) and young people’s (upto 25 years) sexual health services; attendances by people under 25 account for 38% of the total for the adult services. In addition, the population estimates for Salford in 2021 suggest that the number of 15-24 year olds is expected to reduce by more than 5% and the number of 25 to 39 year olds expected to rise by over 11% which may result in less demand on a Young People’s service and more demand for existing adult services. Furthermore, data gathered in Genitourinary Medicine (GUM) clinics shows that in 2013, for the first time in recent years, Chlamydia detection rates in the 25-34 year old group are higher than in 20-24 year olds.

7.3 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 Salford 35 of the 48 GP practices offer one form of LARC as per the contract with Salford City Council and all provide sexual health information, advice and onward referral when required. In addition, sterilization is commissioned by Salford CCG and is delivered in some primary care settings and via the independent sector (South Manchester Private Clinic). Further work on information sharing arrangements with Primary Care must be done to get a better understanding of patient accessing the private clinics.

7.4 Pharmacy

There are a total of 50 pharmacies that offer Emergency Hormonal Contraception (EHC), specifically Levonorgestrel, which is effective up to 72 hours 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.

7.5 Specialist services

In addition to the main providers above Salford City Council also fund:
- **Chlamydia and gonorrhoea testing** – 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 Salford and the other local authorities in Greater Manchester.

- **LGBT** – The Lesbian, Gay, Bisexual and Transgender Foundation (LGTF) provide focused community health interventions including raising awareness of sexual health and wellbeing and disease prevention.

- **HIV** – The George House Trust supports people living with and affected by HIV, along with LGTF and the Black Health Agency who also provide HIV prevention activities.

- **Abortion** – The British Pregnancy Advisory Service (BPAS) provides the telephone booking for advice and direct people as appropriate to abortion services.

- **Sexual violence** – the sexual health services and primary care are able to access support and advice from the Salford 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 abused.
8. Sexually Transmitted Infections

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 Salford, 54% were male and 45% were female (gender was not specified or unknown for 1% of episodes).

In the 2013 Salford’s STIs and HIV epidemiology report, the city is ranked 39 (out of 326 local authorities in England; first in the rank has highest rates, for rates of new STIs. 2512 (1370 in males and 1125 in females) new STIs were diagnosed at a rate of 1059.5 per 100,000 residents which is higher than England (810.9 per 100,000). It should be noted that 52% of diagnoses of new STIs in Salford were in young people aged 15-24 years (compared to 55% in England) (Public Health England, 2014). This difference is explained in Salford by a greater percentage of STI diagnoses for men and women within the 25-29 year old age group.

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, 2014).

8.1 Re-infection

Re-infection with an STI is a marker of persistent risky behaviour. In Salford, an estimated 5.0% 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. Compared to nationally, this is lower in women and higher in men; in England 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 Salford, an estimated 2.3% of women and 8.9% 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).

The re-infection rate for women aged 15-19 who presented with an acute STI at a GUM clinic during the four year period from 2009 to 2013 was estimated to be 7.8%. Teenagers may be at higher risk of re-infection because they lack the skills and confidence to negotiate safer sex (Public Health England, 2014).

8.2 Condom provision

The most effective way for sexually active people to protect themselves from STIs is to use a condom (Department of Health, 2013). Evidence from both experimental and observational studies has
demonstrated condoms are effective protection against STIs ([Faculty of Sexual and Reproductive Healthcare, 2012]; (Peters, et al., 2010)). 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 Salford there is a gap in condom provision as the Young Persons Condom-Card (C-Card) Scheme was discontinued in 2011 due to poor uptake; unfortunately, there was no evaluation to identify the reasons for the poor uptake. In the short term, Public Health commissions a condom distribution scheme in Primary Care but supplied by the council’s Integrated Youth Support services. This supplies approximately 3,500 condoms and Brook have been commissioned to promote access, however a long-term, perhaps Greater Manchester wide, 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, 2013). 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 in Greater Manchester 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. Given the limited amount of quality research evidence, if a new scheme is set up, a formal evaluation would be required to assess whether the scheme is effective. This may be best delivered across a Greater Manchester footprint with a central online based ordering system with additional telephone support.

### 8.3 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:** Future service specifications should have a specific focus on having a standard approach to and monitoring of the effectiveness of partner notification to ensure those who may need sexual health services are alerted and given the opportunity to access. This should be harmonised across Greater Manchester via a collaborative Chlamydia screening service specifications.

### 8.4 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 warts (see Figure 15 below).

![Figure 15: New STI rate per 100,000 in Salford 2013](source: Public Health England, 2014)

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. Opportunistic screening of high numbers of sexually active under-25 year olds remains fundamental in reducing Chlamydia prevalence (Public Health England, 2015).

A Chlamydia test is recommended if:

- if a person or their partner have any symptoms or think they have an STI
- unprotected sex with a new partner
- a split condom
- if 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 Salford for 2012 and 2013 are shown in Table 10. 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 26%.

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Chlamydia tests in GUM</th>
<th>Number of Chlamydia tests in other settings</th>
<th>Total number of tests</th>
<th>Number of positives (all settings)</th>
<th>Percentage of population tested (all settings)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>1793 (18%)</td>
<td>8156</td>
<td>9949</td>
<td>910</td>
<td>29</td>
</tr>
<tr>
<td>2013</td>
<td>2632 (26%)</td>
<td>7941</td>
<td>9866</td>
<td>805</td>
<td>30</td>
</tr>
</tbody>
</table>

*Repeat tests are not excluded.
Source: Salford Local Authority sexual health epidemiology report (LASER) 2012 and 2013

Chlamydia test and detection data from 2012 onwards are sourced from Chlamydia Testing Activity Dataset (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.

In 2012, nationally 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, Salford achieved above the national average for both coverage and detection rate. The Chlamydia detection rate in 15-24 year olds in Salford was 2642 per 100,000 in 2012 and 2632 in 2013. In 2012, 29% of 15-24 year olds were tested for Chlamydia with a 9.1% positivity rate and in 2013 this was 30% with a 7.8% positivity rate. The continued efforts to support the National
Chlamydia Screening Programme (NCSP) are reflected in the fact that the detection rate for Chlamydia remains higher in Salford than the England and Greater Manchester averages (see Figure 16 below).

![Chlamydia Detection Rates 2012 and 2013 Rates](source)

In 2011 and 2012, the 20 to 24 year age group has the highest number of detections of Chlamydia screening at GUM clinics (as should be expected due to the targeted 15-24 year old Chlamydia screening Programme) although in 2013 the 25-34 year olds has now become the cohort with the largest number of detections (see Figure 17 below).

![Detections of Chlamydia in GUM, Salford, by year, and age group 2012 & 2013](source)
In terms of Chlamydia diagnoses at GUM clinics, the majority of those diagnosed were males. This would appear to contradict the national picture where historically, more females have attended than males (See Figure 18 below). From the cases in men where sexual orientation was known, 31.3% of new STIs were among men who have sex with men (MSM) compared to 21% nationally which would increase the proportion of male cases locally compared to nationally.

![Figure 18: Attendances for Chlamydia, Salford, by year, and gender 2012 & 2013](data:image/png;base64,iVBORw0KGgoAAAANSUhEUgAAAIoAAAD-UAA...)

Along with the other 10 local authorities in Greater Manchester, Salford City Council commissions RUClear from Central Manchester Foundation Trust to deliver the (NCSP) for people aged 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), Salford Royal’s adult service and Brook’s Young People’s service. During 2014 there were 475 Chlamydia screens undertaken by GP practices in Salford with 15 to 24 year olds. The number of tests undertaken...
varied between practices with 10 practices not offering any screens, whilst one practice undertook 124 screens, the mean average per practice was 12 tests.

**Recommendation:** Consideration should be given to whether it is possible to have all GP practices actively offering Chlamydia screening or providing local referrals within a neighbourhood.

A review of the Greater Manchester Chlamydia Screening Office (RUClear) will also be carried out, potentially offering a more web based alternative, clinical governance for HIV testing and a GM condom distribution scheme.

## 8.5 Genital 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. That said, the treatment often requires several visits to the sexual health service and so can be a burden on the demand of services.

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 Salford in 2012/13 has decreased from that in 2010-11, although there is variation in the rate is negligible due to the small numbers (See Figure 19).

![Warts Infection Trend per 100,000 population between 2009 and 2013](image)

**Figure 19:** Genital Warts Infection Trend per 100,000 population between 2009 and 2013

Data source: GUMCAD (GUM Clinic Activity Dataset) and CTAD (Chlamydia Testing Activity Dataset) 2014
In the past three years more males have attended GUM clinic with Warts than females (Figure 20).

![Figure 20: Genital Warts Diagnosis in GUM clinics for Males and Females 2011-13](image)

**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 25-34 age group (see Figure 21).

![Figure 21: Number of Genital Warts Diagnoses in GUM at Salford for Genital Warts by Age 2011-13](image)
8.6 Genital 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.

Salford has experienced a net increase in the rate of Herpes over the last four years which is higher than the North of England and England. However as the numbers are relatively small (there are 180 diagnoses in Salford during 2013) this figure does need to be viewed with some caution. See Figure 22 below.

![Figure 22: Rates of Genital Herpes per 100,000 between 2009 and 13](image)

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 Figure 23 below).
The number of attendances for herpes is greater in the 20-24 and 25-34 age groups (see Figure 24 below).
8.7 Gonorrhoea

Gonorrhoea is a marker used by Public Health England of 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 Salford has seen a significant reduction in diagnosis since 2009 (see Figure 25 below).

![Figure 25: Rates of Gonorrhoea per 100,000 between 2009 and 13](Image)

Data 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 decrease 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 69 people who were diagnosed with gonorrhoea in that age category (see Figure 26 below)
8.8 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 labour. 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 the last five years, Salford has been steadily ‘narrowing the gap’ between syphilis rates in the city compared to those in Greater Manchester and England. These numbers need to be viewed with some caution as the number diagnosed in Salford was 37 in 2012 and 29 in 2013. See Figure 27 below.

![Figure 27: Rates of Syphilis per 100,000 between 2009 and 13](image)

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

In terms of age group, syphilis is different for the other STIs as its GUM diagnoses in Salford were predominantly found in 25 to 34 and 35 to 44 age groups (see Figure 28 below). Also, most attendees were male (see Figure 29 below). Some of this difference may relate to men who have sex with men (see Section 14.3).

![Figure 28: Number of Syphilis diagnoses in Salford by age group 2011-13](image)

Data source: GUMCAD (GUM Clinic Activity Dataset) and CTAD (Chlamydia Testing Activity Dataset) 2014
8.9 Human Papilloma Virus (HPV)

The Human Papilloma Virus (HPV) is the name given to a family of viruses. The HPV virus is very common and is easily spread by sexual activity; as much as half the population will be infected at some time in their life. Different types of HPV are classed as either high risk or low risk, depending on the conditions they can cause. For instance, some types of HPV can cause warts or verrucas. Other types are associated with cervical, penile and anal cancer. In fact, in 99% of cases cervical cancer occurs as a result of a history of infection with high-risk types of HPV. Often, infection with the HPV causes no symptoms.

Current Vaccination Arrangements in the UK

NHS England, under their national responsibilities outlined in the NHS Public Health Functions Agreement is responsible for the commissioning of the HPV vaccination programme.

The HPV vaccination protects against the two high-risk HPV types that cause over 70% of cervical cancers. Vaccination coverage is the best indicator of the level of protection a population will have against vaccine preventable communicable diseases. In the UK, all 12-13 year old girls (school year 8) are offered HPV vaccination through the national HPV immunisation programme. This consists of two injections into the upper arm spaced at least six, and not more than 24 months apart.

In Salford in 2013/14, there were 900 girls aged 12 to 13 years that received all three doses of the HPV vaccine. The percentage of Salford’s girls aged 12-13 that had received the vaccinations (81.1%) is slightly lower than the North West (88.4%), and the national rate (86.7%)(Public HEalth England, 2014).
The HPV vaccine is refused by most girls from the Orthodox Jewish Community in Salford which accounts for approximately 9% of the cohort in each year group. However uptake outside this community group is over 90% providing evidence of a high level of protection from cervical cancer. When comparing to other areas in England with Orthodox Jewish communities, such as Hackney (68.2%), Salford has much higher HPV vaccination rates.

**MSM Recommendations from the Joint Committee on Vaccination and Immunisation**

The Joint Committee on Vaccination and Immunisation (JCVI) is an independent expert advisory committee of the Department of Health (DH) and advises on immunisation. Following a review of available evidence, the JCVI has concluded that a programme for the vaccination of MSM aged 16 to 40 years should be considered in Genito Urinary Medicine (GUM) and HIV clinics in the UK, provided that the programme could be undertaken at a price where administration and vaccine costs combined were cost-effective. The Committee has invited stakeholders to have the opportunity to comment on the validity of the interim advice and related evidence. The deadline for comments was 7th January 2015.

**Impact in Salford**

Public Health Salford is currently awaiting a further statement from the JCVI on HPV vaccination for MSM following the passing of their deadline for comments. Whilst it is acknowledged that the commissioning of the current HPV vaccination programme is the responsibility of NHS England, the commissioning of GUM clinic is the responsibility of the Local Authority. Therefore any commissioning of additional HPV vaccinations for MSM in GUM clinics must be carefully considered by the provider (Salford Royal Foundation Trust - SRFT), NHS England and the Local Authority, so that any additional demand on the service does not destabilize the existing commissioning arrangements.

**8.10 Human Immunodeficiency Virus (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 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)

Prevalence and Incidence of HIV
Salford has one of the highest rates of HIV in Greater Manchester. In 2013, the diagnosed HIV prevalence rate in Salford was 4.8 per 1,000 population aged 15-59 years, compared to 2.1 per 1,000 in England (Public Health England, 2014). This has increased from the 2012 rate of 4.3 per 1,000 population aged 15-59 years (Public Health England, 2014).

In 2013, 744 adult residents (aged 15 years and older) in Salford received HIV-related care: 610 males and 134 females. Among these, 69.5% were white, 23.9% black African and 0.8% black Caribbean and 5.8% unknown. With regards to exposure, 65.6% probably acquired their infection through sex between men and 30.6% through sex between men and women. Figure 30 shows this graphically and compares against other comparator areas and the North West.

The numbers diagnosed by route of sexual transmission vary although there is an identifiable downward trend in the number of new infections in Salford (see Figure 31). Since the prevalence of HIV in Salford is rising year on year and the new infections is falling year on year, it would suggest that Salford is ‘importing’ cases of HIV; people already diagnosed with HIV are moving to the city (see Figure 32).

![Figure 30: Gender and Ethnicity of all HIV & AIDS cases in Salford and comparator areas 2013](image)

Data source: GUMCAD (GUM Clinic Activity Dataset) and CTAD (Chlamydia Testing Activity Dataset) 2014
Figure 31: Number of adults newly diagnosed with HIV by route of sexual transmission, gender and year of diagnosis in Salford: 2009-2013
Data source: Salford Local Authority Sexual Health epidemiology report (LASER) 2013

Figure 32: Three Year Rolling Average of New HIV Diagnoses and Increase in Prevalence of HIV in Salford (2007-2013)
Source: HIV and AIDS New Diagnoses Database (HANDD) and Survey of Prevalence HIV Infections Diagnosed (SOPHID)

Geography of HIV in Salford
Data from the HIV Monitoring Unit at John Moores University provides HIV prevalence data by LSOA in 2012. This is represented geographically in Figure 33 below which shows the areas of Salford with prevalence above the national average; particular attention should be given to the East of Salford which has a prevalence of 14.3 per 1,000 population aged 15-59 years – nearly 7 times higher than the national average (HIV Monitoring Unit, 2013).
In the UK, 44% of people living with HIV in the UK are men who have sex with men and 34% are Black African men or women (NAT, 2013). In Salford, of the total numbers of people living with HIV 65.2% are MSM and 24% are Black African (HIV Monitoring Unit, 2013). Whilst these percentage are not mutually exclusive (some Black Africans may also be MSM), it is clear that the majority of cases in Salford, and indeed nationally, are within these groups.

It is important to view this data in context of the HIV monitoring data for North and Central Manchester too. This provides a broader conurbation view of the people living with HIV, in particular those two most affected groups - men who have sex with men (MSM) and Black Africans.

Figure 33 provides a graphical representation of this HIV prevalence. The highest rates of HIV concentrate on the city centre of Manchester and radiate to the border of Salford. In this central zone HIV prevalence is 11.1 per 1000 population, 81% of which are MSM. As Greater Manchester is an urban centre with Manchester’s unique Gay Village at its heart, this would explain the disproportionately high percentage of people living with HIV from this group living in this area.

In addition there is a noticeably high prevalence of HIV in the northern conurbation of this map (Broughton/Harpurhey/Crumpsall/Cheetham) of which 47% are Black African.
Figure 34: Prevalence of HIV+ per 1,000 population, 2012

Source: HIV Monitoring Unit at John Moores University 2012
Offer and uptake at GUM clinics
In 2013, a HIV test was offered to 45.8% of those eligible Salford residents attending a GUM clinic which is lower than England where 79% were offered (Public Health England, 2014). Due to the integrated nature of the sexual health services, this HIV testing offer is much lower than expected as this includes all appointments in Contraceptive and Sexual Health (CaSH) appointments too, which ‘dilutes’ the true value of HIV tests offered in GUM clinics. Salford City Council is currently working with Salford Royal to develop a purely GUM reporting system for this national Public Health England metric.

Nationally, where offered, a HIV test was done in 80% of the attendances at sexual health services during 2013 whereas in Salford this was slightly lower at 77.6% (Public Health England, 2014).

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 Salford, between 2011 and 2013, 39% (95% CI 29-50) 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. 33% (95% CI 21-47) of men who have sex with men (MSM) and 44% (95% CI 28-62) of heterosexuals were diagnosed late.

Halve It Campaign
The HIV ‘Halve It’ Campaign is a national programme with the primary aims of:

- halve the proportion of people diagnosed late with HIV;
- halve the proportion of people living with undiagnosed HIV.

At Salford City Council, the Full cabinet passed a motion to support the Halve It campaign on 18th March 2015 which was later supported by the members of the Health and Wellbeing Board (HWBB) in Salford on 20th May. This pledges made by the cabinet and HWBB were to:

- halve the proportion of people diagnosed late with HIV;
- work with partners towards halving the proportion of people living with undiagnosed HIV.

This enables a Salford-wide commitment to working to reduce the HIV burden in the city by a collaborative approach across the health economy. This includes raising awareness of HIV and the testing and support services available.

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 Salford, however further work is needed to promote testing among Black African groups who make up nearly a quarter of people living with HIV in Salford.

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).

The British HIV Association recommend that a HIV test should be considered in the following settings where diagnosed HIV prevalence in the local population exceeds 2 in 1000 population:

- all men and women registering in general practice
- all general medical admissions.

At present neither setting in Salford includes a mandatory HIV test during registration/admission. The cost of a city wide programme has been beyond the reach of the Public Health financial envelope.

**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.

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 and Lesbian & Gay Foundation Trust. Most people who need inpatient care for their HIV will be treated initially in a Manchester Hospital.

**The Lesbian, Gay, Bisexual and Transgender Foundation (LGBTF):** The service delivers HIV prevention and awareness programmes 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.

**BHA Equalities (formerly Black Health Agency) (BHA):** 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. This is achieved through community development, outreach, information and advice and group training and awareness sessions. The BHA attend community events and activities to engage with individuals and groups and support communities to take action to reduce stigma and discrimination around HIV. They also distribute free condoms and lubricants, HIV information materials to community settings or venues frequented by BME community members.

**Recommendation:**

HIV Point of Care Testing (POCT) is a testing technology that allows people to be tested for HIV and know their HIV status during the same visit, usually in less than an hour. 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 Salford. Any introduction of point of care testing will need to consider:

- appropriate clinical and data governance arrangements
- the sensitivity and specificity of tests available
- the potential for joint commissioning across Greater Manchester.
- cost effectiveness of the testing programme

The introduction of HIV testing for all men and women registering in general practice and for all general medical admissions should also be considered as recommended by the British HIV Association. In practice this would be an expensive programme to deliver Salford wide, but consideration should be given to a targeted approach in areas where prevalence is high or where there are specific high risk groups such as Men who have sex with Men (MSM) and Black African men and women.
Recommendation:

HIV testing is currently commissioned and offered to gay and bisexual men at the Lesbian Gay Bisexual and Transgender Foundation (LGBTF) but testing for black African men and women is not directly commissioned by Salford City Council. In Salford, 23.9% of people living with HIV in Salford in 2013 were Black African. Consideration should be given to aligning with other Greater Manchester local authorities to fund HIV and STI prevention activities specifically to the Black African population of Salford.

8.11 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 (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.
9. 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 Direction (EHC) (Public Health England, 2014).

Local authorities are mandated to commission confidential, open access to contraception 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 are not available (Public Health England, 2014). There were approximately 17,500 first contacts at NHS community contraceptive clinics in Salford during 2013/14 (Health and Social Care Information Centre, 2014).

Condoms are not available on prescription 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 Salford, the main services are briefly outlined as follows:

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

**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 23 times. The over 25’s use this service the most; 62% of attendances are over 25.

**Young People’s service:** the young people’s service offers most contraceptive choices for people up to the age of 25. Oral contraceptives are currently the most commonly used form of contraception.

**Pharmacy:** There are 48 pharmacies in Salford 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).

9.1 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 11 below).

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

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 12).

<table>
<thead>
<tr>
<th>England</th>
<th>Thousands</th>
</tr>
</thead>
<tbody>
<tr>
<td>All ages</td>
<td>131.9 124.9 7.0</td>
</tr>
<tr>
<td>Under 15</td>
<td>4.1 4.0 -</td>
</tr>
<tr>
<td>15</td>
<td>7.8 7.7 0.1</td>
</tr>
<tr>
<td>16-17</td>
<td>22.3 22.0 0.3</td>
</tr>
<tr>
<td>18-19</td>
<td>21.6 21.1 0.5</td>
</tr>
<tr>
<td>20-24</td>
<td>37.0 35.4 1.6</td>
</tr>
<tr>
<td>25-34</td>
<td>28.4 25.6 2.8</td>
</tr>
</tbody>
</table>
EHC access in Salford

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 480 women prescribed EHC, approximately 81% 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 eight practices who achieved less than 75% for this indicator.

Of the 54 pharmacies in Salford, there are 48 who offer one form of 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 35: EHC Prescriptions collected in Salford Pharmacies in 2013/14 financial year
**Recommendation:** Consideration could be given to extending the 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 oral contraceptives would require a patient group directive which is a written instruction for the sale, supply and/or administration of medicines to groups of patients.

### 9.2 Long Acting Reversible Contraception (LARC)

It is estimated about 16.2% of pregnancies are unplanned. The effectiveness of the barrier method (e.g. condoms, cervical caps etc) 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 nor is it affected by other medication or illnesses. 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 menstrual 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 (e.g. oral contraceptives, condoms and contraceptive patches - see Figure 36 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.

In 2013, Salford is ranked 237 out of 326 local authorities in England for the rate of GP prescribed LARCs, with a rate of 46.9 per 1,000 women aged 15 to 44 years, which is lower than the rate of 52.7 in England (see Figure 37). 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).
Of the 48 GP Practices in Salford, 33 are commissioned to provide LARC, of which 28 have prescribed at least one form of LARC in 2013/14, six prescribe only Inter-uterine devices, (IUCD), five prescribe Sub dermal Implants (SDI) and 17 prescribe both (Greater Manchester Commissioning Unit, 2014). Geographically, it can be seen that further prescribing needs to be done in certain areas of Salford, the priority of which should be areas identified as teenage pregnancy hotspots (See Figure 38 and Figure 39).

**Recommendation:** Further work needs to be done to increase the offer of LARCs in the city, particularly in known teenage pregnancy hotspots. In addition further work needs to be done to understand and address the barriers which have prevented some General Practices from not offering or offering only one method of LARC. There is also currently a small scale research study being carried out by an MSc student at Salford University with young people in Salford, establishing their attitudes to using LARC.

![Figure 36: First contacts with women at NHS community contraceptive clinics, in England by primary method of contraception, 2003/04 to 2012/13](source)
Figure 37: Rates per 1,000 women aged 15 to 44 of LARCs prescribed in primary care for Salford local authority, Greater Manchester PHE Centre and England: 2011 to 2013
Salford Local Authority Sexual Health epidemiology report (LASER) 2013

Figure 38: Map of prescriptions by GP practice of IUCDs in 2014
10. Abortion and repeat abortions

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, 92% of abortions were performed at less than 13 weeks of pregnancy, and 79% at less than 10 weeks. In Salford, the vast majority were performed under ten weeks – 81% which is higher than for England (79%) and the North of England (78%) (see Table 13 below).

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 in both the 18-19 and 20-24s age group (see Figure 41 below). Over the last three years there has been little change in the abortion rates in England and Salford. There has been a noted decrease in 2013 although this may be due to the change in population methodology in 2013, as highlighted by the larger confidence intervals in the data (see Figure 40).

During 2013, Salford 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 of 15-44 year olds was 18.3 in Salford, while in England it was 16.6 and in Grater Manchester it was 17.4 (Department of Health, 2014) (see Figure 42). The number of abortions in Salford is calculated to be 1032 (CI of 970-1097).

![Graph showing abortion rates by year and location]

Figure 40: Legal abortions: rates by Clinical Commissioning Groups of residence, by age, 2011-2013
Source: Abortion stats England and Wales 2013

<p>| Table 13: Funding for abortion and gestational age by England, North West and Salford, 2013 |
|---------------------------------------------------------------|----------------|-------------------|-------------------|
| Local Authority / NHS funded, purchaser (%) Privately funded Gestation Weeks (%) |
| District / NHS Independent | 3-9 | 10-12 | 13+ |</p>
<table>
<thead>
<tr>
<th>Area</th>
<th>Hospital</th>
<th>Sector</th>
<th>&lt;5</th>
<th>79</th>
<th>12</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>32</td>
<td>66</td>
<td>&lt;5</td>
<td>79</td>
<td>12</td>
<td>8</td>
</tr>
<tr>
<td>Greater Manchester</td>
<td>29</td>
<td>70</td>
<td>&lt;5</td>
<td>84</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>Salford</td>
<td>42</td>
<td>56</td>
<td>&lt;5</td>
<td>81</td>
<td>12</td>
<td>7</td>
</tr>
</tbody>
</table>

Source: Abortion statistic for England and Wales

**Figure 41**: Legal abortions: rates by Clinical Commissioning Groups of residence, by age, 2013
Source: Abortion stats England and Wales 2013
Figure 42: Crude rate per 1,000 women for legal abortions, 2013
Source: Abortion stats England and Wales 2013

Under 18 Abortion data
Table 14 indicates the number of under 18 abortions is falling in Salford; the rates and numbers were static between 2009 and 2012, with a sharp fall in 2013.

The fall in the abortion rates for under 18s between 1998 and 2013 is 5.6%, which compares to a 66.6% reduction in the under 18 maternity rate in the same period. Between 1998 and 2013 there the percentage of under 18 conceptions that lead to abortion almost doubled from 26.4% in 1998 to 50.4% in 2013.

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of under 18 abortions</th>
<th>Under 18 abortion rate per 1000</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>122</td>
<td>21</td>
</tr>
<tr>
<td>2008</td>
<td>103</td>
<td>21</td>
</tr>
<tr>
<td>2009</td>
<td>88</td>
<td>20</td>
</tr>
<tr>
<td>2010</td>
<td>88</td>
<td>22</td>
</tr>
<tr>
<td>2011</td>
<td>90</td>
<td>23</td>
</tr>
<tr>
<td>2012</td>
<td>81</td>
<td>20</td>
</tr>
<tr>
<td>2013</td>
<td>47</td>
<td>11</td>
</tr>
</tbody>
</table>
Repeat abortions

Amongst those women who had an abortion in that year in England 37% has had a previous abortion. In Salford this was slightly more at 38% (see table 13).

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>Total</th>
<th>Repeat abortions all ages</th>
<th>Repeat abortions in women under 25</th>
<th>Repeat abortions in women 25 yrs+</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>177,016</td>
<td>37.1</td>
<td>26.7</td>
<td>45.3</td>
</tr>
<tr>
<td>North of England</td>
<td>46,728</td>
<td>35</td>
<td>26</td>
<td>45</td>
</tr>
<tr>
<td>Greater Manchester</td>
<td>10,554</td>
<td>36</td>
<td>27</td>
<td>44</td>
</tr>
<tr>
<td>Salford</td>
<td>826</td>
<td>38</td>
<td>28</td>
<td>46</td>
</tr>
</tbody>
</table>

Source: Abortion Statistics for England and Wales

Abortion Services

The British Pregnancy Advisory Service (BPAS) provides the confidential tailored advice and support and appointment booking center for women in Salford 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 16 for information on location of abortion clinics. In 2014, the majority of bookings were for Frater drive, followed by Marie Stopes and St Mary’s Hospital.

<table>
<thead>
<tr>
<th>Unit</th>
<th>Provider</th>
<th>Bookings</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manchester Pregnancy Advisory Service</td>
<td>Frater drive</td>
<td>76</td>
<td>38%</td>
</tr>
<tr>
<td>Salford Pregnancy Advisory Service</td>
<td>Frater drive</td>
<td>26</td>
<td>13%</td>
</tr>
<tr>
<td>MSI Manchester</td>
<td>Marie Stopes</td>
<td>24</td>
<td>12%</td>
</tr>
<tr>
<td>Bolton Pregnancy Advisory Service</td>
<td>Frater drive</td>
<td>14</td>
<td>7%</td>
</tr>
<tr>
<td>St Marys Hospital</td>
<td>NHS</td>
<td>13</td>
<td>6%</td>
</tr>
<tr>
<td>SMPC Telephone Consultations</td>
<td>Frater drive</td>
<td>8</td>
<td>4%</td>
</tr>
<tr>
<td>MSI Manchester EMU</td>
<td>Marie Stopes</td>
<td>8</td>
<td>4%</td>
</tr>
<tr>
<td>South Manchester Private Clinic (SMPC)</td>
<td>Frater drive</td>
<td>6</td>
<td>3%</td>
</tr>
<tr>
<td>Salford Pregnancy Advisory Service (Tel Con)</td>
<td>Frater drive</td>
<td>5</td>
<td>2%</td>
</tr>
<tr>
<td>Service Description</td>
<td>Provider</td>
<td>Count</td>
<td>Percentage</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>------------------------------</td>
<td>-------</td>
<td>------------</td>
</tr>
<tr>
<td>MSI Telephone conversations</td>
<td>Marie Stopes</td>
<td>5</td>
<td>2%</td>
</tr>
<tr>
<td>North Manchester General Hospital</td>
<td>NHS</td>
<td>5</td>
<td>2%</td>
</tr>
<tr>
<td>MSI Bolton EMU</td>
<td>Marie Stopes</td>
<td>4</td>
<td>2%</td>
</tr>
<tr>
<td>British Pregnancy Advisory Service (BPAS)</td>
<td>BPAS</td>
<td>3</td>
<td>1%</td>
</tr>
<tr>
<td>Manchester Pregnancy Advisory Service (Tel Con)</td>
<td>Frater drive</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>NHS Salford Royal Foundation Trust</td>
<td>NHS</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>Royal Oldham Hospital</td>
<td>NHS</td>
<td>1</td>
<td>0%</td>
</tr>
</tbody>
</table>

Source: British Pregnancy Advisory Service

**Recommendation:** Salford City Council and Salford CCG should continue to work 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. A full review of the clinical pathways should be undertaken when establishing new sexual health services.
11. Teenage Pregnancy

Most teenage pregnancies are unplanned and around half end in an abortion. 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.

Although there is a ‘time lag’ in the release of data due to the time between conception, birth and registering a new birth, the key statistics on teenage pregnancy for Salford are presented as follows:

- In 2013, Salford has achieved the 50% reduction set out in the National Teenage Pregnancy Strategy of reducing under 18 conceptions by 50% from the 1998 baseline. (50.6% reduction 1998-2013)
- The rate for 2013 was 30.3 conceptions per 1000 young women aged 15-17 (123 conceptions)
- In quarter 4, 2013 there were 28 conceptions (q3 2013 = 28)
- In 2013 the full year conception numbers were 123 (there were 156 conceptions in 2013).
- In quarter 4, 2013 the quarterly conception rate was 27.5 per 1000 (q3 2013 = 37.6).
- This shows a continued downward trend in 2013

Figure 43: Quarterly Under 18 conception numbers in Salford 1998 – 2013
Source: ONS 2015
Salford’s under 18-conception rate in 2013 has reduced **50.6%** from baseline 1998 (see table 1). The rate for 2013 is **30.3** conceptions per 1000 young women aged 15-17 (123 conceptions). Compared to statistical neighbours (local authorities with similar characteristics), Salford’s Under 18 conception rate is in keeping with similar areas (see Table 17).

Further analysis of Salford teenage conception rates using three year averages from 1994-2013 indicates in 2011-2013, the 3-year average under 18 conception rate was **36.8** per 1000. This represents a **37.6%** reduction from 1998-2000 baseline. The percentage of under 18 conceptions leading to terminations of pregnancy in 2013 is 50.4% (54.5% in 2011).

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Salford</td>
<td>30.3</td>
<td>61.5</td>
<td>50.6</td>
</tr>
<tr>
<td>Hartlepool</td>
<td>33.0</td>
<td>75.6</td>
<td>56.3</td>
</tr>
<tr>
<td>Middlesbrough</td>
<td>40.5</td>
<td>66.5</td>
<td>39.1</td>
</tr>
<tr>
<td>Newcastle Upon Tyne</td>
<td>26.8</td>
<td>52.8</td>
<td>49.2</td>
</tr>
<tr>
<td>South Tyneside</td>
<td>28.9</td>
<td>64.9</td>
<td>55.5</td>
</tr>
<tr>
<td>Gateshead</td>
<td>29.3</td>
<td>57.1</td>
<td>48.7</td>
</tr>
<tr>
<td>Tameside</td>
<td>29.1</td>
<td>53.6</td>
<td>45.7</td>
</tr>
</tbody>
</table>

*Source: ONS 2015*
Under 16’s Conception Rate
Salford’s under 16-conception rate (2011-2013 three year total) is 7.7 per 1000 (see Figure 45) which although higher than the England and North West averages, has been steadily falling over the last 4 years. In addition the percentage of these under 16 conceptions leading to abortion is rising in Salford whilst remaining fairly static in England and the North West. The percentage in Salford has historically been lower than England and the North West but is now in-between these values (see Figure 46).

Retrospective analysis of those young women becoming pregnant before their 18th birthday and continuing with their pregnancy, (in calendar year 2012/13) suggests a significant risk factor for under 18 conception is previous poor school attendance and involvement of an education welfare officer (EWO).

Figure 45: Under 16 Conception rate per 1,000 women
Source: ONS
12. 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).

It is widely acknowledged reliable information on the volume of sexual offences is difficult to obtain because a high proportion of offences are not reported to the police. Across England and Wales crime figures showed an increase of 31% in all sexual offences for the year ending September 2014 compared with the previous year (up from 59,608 to 72,977) (ONS, 2013). This increase, in part, can be explained by a willingness of victims to report other sexual offences following media attention surrounding high-profile abusers.

In Salford there was a 31% rise in the number of reported sexual offences for the year ending September 2014 (up from 807 to 1055), in keeping with the increased reporting for England (31%) as a whole. There are likely to be two main factors in the rise in police recorded rape and sexual offences; an improvement in crime recording by the police for these offences and an increase in the willingness of victims to come forward and report these crimes to the police. As a proportion of the total number of reported offences in Salford, sexual offences account for 1.79%, less than the percentage for England and Wales (2.1%).
The sexual health service and primary care are able to access support and advice from the Salford 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.
13. 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.

13.1 Under 16 (prevention)

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, 2000) (Department of Health, 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 ICBI RCTs 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 positive effect on sexual behaviour (Bailey, et al., 2010).

**Recommendation:** To complement the current school based programmes, consideration should be given to developing a large scale and locally relevant Sex and Relationships (SRE) curriculum and the cost effectives of such a programme. This could be explored by Salford City Council’s Children’s and Integrated Youth Support Services.

Further work to explore and supportively challenge the attitudes and behaviours of young people including a social norming project should also be considered.
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).

Salford 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 (Salford Safeguarding Children Board). Salford is also part of the Greater Manchester Safeguarding Children’s Board, which provides a policy framework for agencies dealing with sexual health. In addition there is also a Greater Manchester CSE toolkit developed by the Greater Manchester Sexual Health Network and sexual behaviours traffic light toolkit developed by Brook.

The Project Protect team which is a Manchester and Salford multi agency team has been formed to tackle any kind of child sexual exploitation (CSE) in the borough. The team is co-located at Greenheys Police Station and they serve the whole of Manchester and Salford. 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.

13.2 Age 16-24
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 Salford, 55% 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 Figure 47 (Public Health England, 2014).
Young people are also more likely to become re-infected with STIs. In Salford, an estimated 7.8% of 15-19 year old women and 7.8% 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 re-infection 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.

**Service provision**

There is a Salford’s lead providers group for young people’s sexual health, hosted by Brook, who meet regularly to discuss local issues and best practice, the membership of which includes Connexions, RUClear, Salford City Council’s Integrated Youth Support Service, Brook and the school nurses, Salford Royal Foundation Trust, Manchester Action for Street Health, Barnardos, the Black Health Agency and the George House Trust.

Brook’s Young People’s service, in addition to providing access to general sexual health clinics, there are also clinics targeted specifically at young people which are available at some of Salford’s Colleges and Harrop Fold High School in term time.

The Integrated Youth Support Service (IYSS) is Salford’s that delivers preventative sexual health interventions including brief interventions, condom distribution and referral to sexual health services. IYSS also deliver targeted work with those young people identified as most vulnerable and engaging regularly in risky sexual behaviours. This can be 1:1 or group work sessions.
School Nursing Service
In Salford there are approximately 100 educational institutions in the city which includes primary schools, senior schools, special schools, and 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.

13.3 Age 25-49
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 Salford the highest growth in age group is expected to be in the people aged 25 to 39 (+11.5%).

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.

13.4 Age 50 and above
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. The Integrated sexual health service at Salford Royal NHS Foundation Trust also delivers a Psychosexual service that provides advice and counselling for patients with problems of sexual functioning and desire.

**Recommendation:** In Salford in recent years there has been an increase in the number of STIs and unplanned pregnancies in 25-49 year olds. Therefore, it is recommended there should be an all age prevention strategy to reduce STIs, increase access to contraception, reduce unplanned pregnancy and maintain sexual health. As part of this strategy, a holistic approach by all health care professionals should be encouraged to take the opportunity to raise sexual health issues in routine healthcare appointments.
14. Sexual Health of Specific Groups

14.1 Deprivation

The relationship between STIs and Socio-economic deprivation (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 behavior (Public Health England, 2014).

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 Salford, there is a trend of an increasing rate of acute STIs as the level of deprivation increases. Those in the most deprived quintile have almost 2.5 times the rate of acute STIs than those in the least deprived quintile (see Figure 48 below).

![Figure 48: The rate per 100,000 of acute STIs by deprivation category in Salford, 2013](source)

Given the higher levels of deprivation in Salford compared to the North West and England there is an identifiable need for the investment in sexual health services.

14.2 BME groups

The proportion of new STIs diagnosed in GUM clinics by ethnic group is shown in Table 18. Where recorded, 16% of new STIs diagnosed in Salford were in people born overseas (Public Health England, 2014).
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 Salford. Generally, rates in Salford by ethnic grouping are similar to nationally (see Figure 49 below)

![Figure 49: Rates of new STIs by ethnic group in Salford and England (GUM diagnoses only): 2013](source: data from GUM clinics (excludes Chlamydia diagnosis made outside GUM)

**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. This pattern is likely to be mirrored in Salford (Stephens, 2014). In Salford, 23.9% of people living with HIV in Salford in 2013 were Black African.

**BHA Equalities (Formerly Black Health Agency) (BHA):** Some of the Greater Manchester Local Authorities provide funding to BHA; the organisation provides a range of services tailored to Black and minority populations including HIV and sexual health support.

Trafford and Salford councils also currently commission BHA to support South Asian women through one to one and group work with sexual health and wellbeing. The Jeena Project works to challenge the inequality and injustice that Asian women experience and aims to offer them a safe space within which they can access information, advice and support services that are easily accessible and that are set within a confidential, non-judgmental, and culturally appropriate & gender specific framework. The target population is South Asian women including Pakistani, Bangladeshi, Sikh and Indian origin in Trafford aged 16 plus.

### 14.3 Lesbian, gay, bisexual and transgender (LGBT)

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). In Salford, it is recognised there is a larger LGBT community than the England average; service data from across Greater Manchester (presented in Table 19 below) demonstrates that attendances by gay and bisexual men represent a much higher proportion compared most other areas in Greater Manchester.

<table>
<thead>
<tr>
<th>AREA</th>
<th>ATTENDEES (Male)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Heterosexual</td>
</tr>
<tr>
<td>Bolton</td>
<td>2825</td>
</tr>
<tr>
<td>Bury</td>
<td>1839</td>
</tr>
<tr>
<td>Manchester</td>
<td>9044</td>
</tr>
<tr>
<td>Oldham</td>
<td>2351</td>
</tr>
<tr>
<td>Rochdale</td>
<td>2105</td>
</tr>
<tr>
<td>Salford</td>
<td>2901</td>
</tr>
<tr>
<td>Stockport</td>
<td>2438</td>
</tr>
<tr>
<td>Tameside</td>
<td>2782</td>
</tr>
<tr>
<td>Trafford</td>
<td>2445</td>
</tr>
<tr>
<td>Wigan</td>
<td>3495</td>
</tr>
</tbody>
</table>
The Lesbian, Gay, Bisexual and Transgender Foundation (LGBTF): The Lesbian, Gay, Bisexual and Transgender Foundation is a charity which is commissioned by all Greater Manchester local authorities to deliver LGBT focused community health interventions. The service delivers HIV prevention actives for TMBC specifically towards MSM, Gay and Bisexual men. In addition LGBTF provide many other services to support Lesbian, Gay, Bisexual, Questioning and Trans (LGBTQ) people in Salford and such as: safe places to meet and socialize, providing someone to talk to, reporting homophobic crimes, training other services about LGBTQ needs such as ‘Pride in Practice’.

Although the LGBTF do link in with the Sexual Health Service there are not currently any LGBT focused clinics running in Salford, so people would have to travel to one of the clinics in Manchester.

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 Salford in 2013, for cases in men where sexual orientation was known (for the PHE data, this includes homosexual and bisexual men), 31.3% (number 341) of new STIs were among MSM, this is a slight increase from 2012 where the proportion of STIs among MSM was 30.6% (Public Health England, 2014) (See Figure 50 below).

Figure 50: Proportion of new STIs, Chlamydia, gonorrhoea, syphilis, genital warts and genital herpes in MSM among men in Salford (GUM diagnoses only): 2010-2013
In terms of numbers, whereas in the general population Chlamydia is the most common STI, in MSM in Salford in recent years it was syphilis but that changed in 2013 to gonorrhoea, followed by syphilis and then Chlamydia. In terms of the proportion of STIs in men in 2013, the majority of the syphilis and gonorrhoea cases were in MSM, compared to around 30% of Chlamydia, 17% of herpes and 10% of warts diagnoses.

### Table 20: Number of new cases of Chlamydia, gonorrhoea, syphilis, genital warts and genital herpes in MSM in Salford 2010-13

<table>
<thead>
<tr>
<th>STI diagnosis</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlamydia</td>
<td>87</td>
<td>105</td>
<td>112</td>
<td>80</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>77</td>
<td>115</td>
<td>111</td>
<td>113</td>
</tr>
<tr>
<td>Syphilis</td>
<td>39</td>
<td>39</td>
<td>28</td>
<td>20</td>
</tr>
<tr>
<td>Genital warts</td>
<td>29</td>
<td>37</td>
<td>25</td>
<td>27</td>
</tr>
<tr>
<td>Genital herpes</td>
<td>13</td>
<td>10</td>
<td>12</td>
<td>11</td>
</tr>
</tbody>
</table>


### 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 Salford, of those living with HIV, 65.6% probably acquired their infection through sex between men.

### Table 21: Number of adults living with diagnosed HIV by ethnicity and exposure group in Salford: 2009 and 2013

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>2009</th>
<th>% 2009</th>
<th>2013</th>
<th>% 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>382</td>
<td>72.3</td>
<td>517</td>
<td>69.5</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>1</td>
<td>0.2</td>
<td>6</td>
<td>0.8</td>
</tr>
<tr>
<td>Black African</td>
<td>125</td>
<td>23.7</td>
<td>178</td>
<td>23.9</td>
</tr>
<tr>
<td>Other</td>
<td>15</td>
<td>2.8</td>
<td>31</td>
<td>4.2</td>
</tr>
<tr>
<td>Not known</td>
<td>5</td>
<td>0.9</td>
<td>12</td>
<td>1.6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Probable route of infection</th>
<th>2009</th>
<th>% 2009</th>
<th>2013</th>
<th>% 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex between men</td>
<td>362</td>
<td>68.5</td>
<td>488</td>
<td>65.6</td>
</tr>
<tr>
<td>Sex between men and women</td>
<td>149</td>
<td>28.2</td>
<td>228</td>
<td>30.6</td>
</tr>
<tr>
<td>Injecting drug use</td>
<td>11</td>
<td>2.1</td>
<td>9</td>
<td>1.2</td>
</tr>
<tr>
<td>Other/Not known</td>
<td>6</td>
<td>1.1</td>
<td>19</td>
<td>2.6</td>
</tr>
</tbody>
</table>

Total: 528 | 100.0 | 744 | 100.0 |

Source: The Survey of Prevalent HIV Infections Diagnosed (SOPHID)
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 (Public Health England, 2014). 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.

**Chemsex**

An emerging trend of sexualised drug use has been identified, particularly in London. ‘Chemsex’ occurs under the influence of (most commonly) stimulant drugs (Bourne, et al., 2014). It is reported to be changing the way some MSM socialise, including the arrangement of private parties online or via smartphone apps and sourcing sexual partners with the explicit intention to use drugs together (Substance Misuse Skills Consortium, 2013). In a survey conducted in three London boroughs, (Bourne, et al., 2014) four differing types of sexual risk taking were noted:

- About one quarter of respondents engaged in chemsex but remained in control and had limited chance of HIV/STI transmission.
- More than a quarter (all HIV positive) made pre-determined decisions to engage in unprotected anal intercourse, with men they believed to be sero-concordant. Drugs did not appear to be the main driver of sexual risk taking.
Nearly a third found it difficult to control their behaviour while under the influence of drugs and engaged in behaviour that increased HIV/STI transmission risk. They subsequently regretted this behaviour. These men often had underlying self esteem or similar issues.

A small proportion sought out risky sex and used drugs to push sexual boundaries.

Anecdotal evidence suggests that men who are HIV+ may not adhere to medication routines when under the influence of drugs, and this will lead to higher risk of transmission during unprotected sex.

Chemsex behaviour is likely to be evident in the Manchester/Salford GM community, although it is not formally documented. It is speculative whether the findings on types of risk behaviour from London pertain. MSM often have good relationships, developed over time, with sexual health services (Stuart, 2013). Providers need to be aware of differing patterns of chemsex, and provide appropriate information on drug harm reduction, including needle exchange. Staff should be competent to open discussions on the psychosocial aspects of health and any harms arising from chemsex.

14.4 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 Salford. 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).

Manchester Action on Street Health (MASH): In Salford, Public Health commissions MASH which provides a range of confidential and non-judgmental services to women working in the sex industry in Greater Manchester (MASH, 2008).

14.5 Vulnerable young people

Salford’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.

In 2011, there were 965 children that were on a care plan or looked after children (*LAC). 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. 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). In Salford a review of all 0-25 year old services is underway and this will include the provision of sexual health services for this age group.

**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.

In Salford work between the local authority and young people’s services such as the ongoing sexual health awareness outreach work and bespoke behaviour change based interventions have provided collaborative opportunities that have worked with the most vulnerable young people in the city. Further bespoke work will continue to be encouraged by local health partners using funding streams such as the Salford CCG’s Innovation Fund.

### 14.6 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).

**Brook Young People’s Service** provides sexual health advice, testing and support for young people upto 25 in Salford which includes working with vulnerable groups such as those with learning difficulties.

### 14.7 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).

### 14.8 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. 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, 48% of young people accessing drug and alcohol treatment services in Salford were offered a sexual health intervention compared to a national rate of 53% (National Drug Treatment Monitoring System, 2015).

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
15. Conclusion and Recommendations

The key recommendations of this needs assessment are:

Recommendation 1: Adult and Young People Service Provision Review

This is an opportune time to review the service provision and change the function of Adult Integrated Sexual Health Service to:

- redistribute clinical interventions across primary and secondary care to enable sexual health services to increase their role co-ordinating and supporting other providers;
- to ensure a standardised high quality approach across all services,
- increase capacity within primary care,
- expand services such as condom provision.

It may be possible to deliver efficiencies and achieve a reconfiguration of services by reducing follow-up attendances for contraception and reviewing roles. Further efficiencies could be made by:

- reducing the overlap of acute and young people’s services (currently provided by Salford Royal and Brook’s) who both accept clients between the ages 18 and 25 years old. An ‘all-age’ service may streamline the services in Salford but consideration must also be given to the provision of outreach services for young people in any future re-procurement.
- implementing the existing pilot in GUM services of the ‘TEST AND GO’ service for patients that have no symptoms and just want a quick test for sexually transmitted infections.
- Re-examining commissioning boundaries and responsibilities such as for cervical screening.

Recommendation 2: Reconfiguration of Young People’s Services

Data shows that there is a populous of young people in Irlam but no permanent provision of a young people’s sexual health services with the exception of Brook’s school based provision in term time at Irlam and Cadishead College and the adult service at the Irlam Health Centre. Where provision for young people is lower in certain areas, young people seem to be attending the adult service. Consideration should be given to the reconfiguration of young people’s services, including outreach, to provide support in the Irlam area.

This may best be managed by considering the integration of young people’s and adult services. There is already an overlap between the adults (18+ years) and young people’s (upto 25 years) sexual health services; attendances by people under 25 account for 38% of the total for the adult...
services. When combined, the total attendance of people under 25 to either the adult or young people’s services is more than 14,000.

**Recommendation 3: Greater Manchester Condom Distribution Scheme**

One proposal for consideration in Greater Manchester 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. Given the limited amount of quality research evidence, if a new scheme is set up, a formal evaluation would be required to assess whether the scheme is effective. This may be best delivered across a Greater Manchester footprint with a central online based ordering system with additional telephone support.

**Recommendation 4: Standard Approach to Partner Notification**

Future service specifications should have a specific focus on having a standard approach to and monitoring of the effectiveness of partner notification to ensure those who may need sexual health services are alerted and given the opportunity to access.

**Recommendation 5: Chlamydia Screening Review**

Consideration should be given to whether it is possible to have all GP practices actively offering Chlamydia screening.

A review of the Greater Manchester Chlamydia Screening Office (RUClear) will also be carried out, potentially offering a more web based alternative, clinical governance for HIV testing and a GM condom distribution scheme.

**Recommendation 6: HIV Point of Care Testing (POCT)**

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 Salford. Any introduction of point of care testing will need to consider:

- appropriate clinical and data governance arrangements
- the sensitivity and specificity of tests available
- the potential for joint commissioning across Greater Manchester.

The introduction of HIV testing for all men and women registering in general practice and for all general medical admissions should also be considered as recommended by the British HIV Association. In practice this would be an expensive programme to deliver Salford wide, but consideration should be given to a targeted approach in areas where prevalence is high or where there are specific high risk groups that could be targeted.

**Recommendation 7: Targeted HIV and STI testing for Black Africans in Salford**
HIV testing is currently commissioned and offered to gay and bisexual men at the LGBTF but testing for black African men and women is not directly commissioned by Salford City Council. In Salford, 23.9% of people living with HIV in Salford in 2013 were Black African. Consideration should be given to aligning with other Greater Manchester local authorities to fund HIV and STI prevention activities specifically to the Black African population of Salford.

**Recommendation 8: Extending the Provision of Emergency Hormonal Contraception (EHC)**

Consideration could be given to extending the 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 oral contraceptives would require a patient group directive which is a written instruction for the sale, supply and/or administration of medicines to groups of patients.

**Recommendation 9: Long Acting Reversible Contraception (LARC) Provision in Primary Care**

Further work needs to be done to increase the offer of LARCs in the city, particularly in known teenage pregnancy hotspots. In addition further work needs to be done to understand and address the barriers which have prevented some General Practices from not offering or offering only one method of LARC.

**Recommendation 10: Working closely with Abortion Services**

Salford City Council and Salford CCG should continue to work 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 that offer services such as contraception.

**Recommendation 11: Developing SRE curriculum in schools**

To complement the current school based programmes, consideration should be given to developing a large scale and locally relevant Sex and Relationships (SRE) curriculum.

Further work to explore and supportively challenge the attitudes and behaviours of young people including a social norming project should also be considered.

**Recommendation 12: All Age Sexually Transmitted Infection (STI) Prevention Strategy**

In Salford in recent years there has been an increase in the number of STIs and unplanned pregnancies in 25-49 year olds. Therefore, it is recommended there should be an all age prevention strategy to reduce STIs, increase access to contraception, reduce unplanned pregnancy and maintain sexual health. As part of this strategy, a holistic approach by all healthcare professionals should be encouraged to take the opportunity to raise sexual health issues in routine healthcare appointments.

**Recommendation 13: Empowering 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 to ensure coordination.

In Salford work between the local authority and young people’s services such as the ongoing sexual health awareness outreach work and bespoke behaviour change based interventions have provided collaborative opportunities that have worked with the most vulnerable young people in the city. Further bespoke work will continue to be encouraged by local health partners using funding streams such as the Salford CCG’s Innovation Fund.
16. References


NICE, 2005. CG 30 - Long-acting Reversible Contraception: The effective and appropriate use of long-acting reversible contraception, s.l.: s.n.


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NICE, 2011. PH33: Increasing the uptake of HIV testing among black africans in England, s.l.: s.n.


