Classification Open / Closed	Item No.

Meeting:	Bury Health and Wellbeing Board
Meeting date:	3rd February 2022
Title of report:	Inequalities in Sexual Health
Report by:	Councillor Simpson, Cabinet Member for Health and Wellbeing
Decision Type:	Information/ Discussion
Ward(s) to which report relates	All wards

Executive Summary:

This report will focus on sexual health in Bury, with an emphasis on our understanding of the inequalities affecting it. The paper will highlight the key outcomes and outputs, and describe the inequalities affecting these outcomes. It will outline the strategies and plans to target this, and discuss how the commissioning of services will contribute to addressing the issues.

Recommendation(s)

That:

1. A Bury Sexual Health Strategy (including Reproductive Health and HIV) is to be developed and co-produced with multi organisational stakeholders, this must link to GM strategic plan and the new national strategy. A range of representatives from populations most at risk of poor sexual health are to be engaged in the development and delivery of this strategy to improve SH and in the development and evaluation of local services.

2. PH to pull together a HIV multi-partner task group to undertake a stocktake for Bury against each of the objectives in the Towards Zero Plan and identify local actions.

3. Primary care. PH to support HCRG to develop an equitable, accessible, high quality LARC offer through PCNs/GP fed, and beyond LARC to include wider women's health services. PH to facilitate provider relationships.

4. Once Strategic manager is in post, PH provide support to HCRG to convene a multi organisational Partnership board to mobilise and develop the new contract.

5. The local system and Partnership board should use robust population health data, SHNA and service data to identify inequalities in access and uptake of services across the local system, and to maximise effectiveness of resources. Inequalities must be a standing agenda item.

6. The delivery of targeted work to address inequalities in SH, RH and HIV, with a focus on key populations and appropriately targeted services to meet their needs should be evaluated, and outcomes should feed into partnership group.

7. Consideration given to using the Primary Care Women's Health Forum Toolkit to assess the need for smarter commissioning and development of women's health hubs.

8. Consider commissioning MASH (Manchester Action on Street Health) with the cluster commissioners, and sexual health provider HCRG, to target women working in the sex industry who are at risk of sexual ill health.

Key considerations:

1. Introduction/ Background:

For the purposes of this report Sexual Health (SH) will encompass all aspects of sexual health, reproductive health and HIV. Most adults are sexually active, and good sexual and reproductive health matters to individuals and communities. Needs will vary according to factors such as age, gender, sexuality, ethnicity, mental wellbeing, sensory difficulties, education and literacy, and cultural factors. However, there are certain core needs common to everyone including high quality information and education to enable people to make informed decisions, a reduction in stigma and discrimination, and access to high quality services, treatment and interventions.

Poor sexual and reproductive health, including the ongoing transmission of HIV, impacts on Bury residents, and despite the progress made, there are still high rates of HIV and STIs. Poor sexual health also contributes to inequalities, with more deprived populations experiencing worse sexual health. People experiencing poverty or social exclusion are disproportionately affected by sexual health issues.

In reproductive health this can lead to high levels of unplanned and/or unwanted pregnancies, termination of pregnancies, higher teenage pregnancy rates; all of which can lead to even poorer outcomes such as poor maternal and perinatal physical and mental health, adverse neonatal and infant health issues, referral to secondary care and costs picked up beyond the health systems, such as social care, housing and education.

Key Issues for the Board to consider:

2. Local Sexual Health Data & Scale of Issue (for full SH data see appendix 1)

a. HIV

An area is defined as being a high HIV diagnosed prevalence area if it records a crude rate of more than 2 per 1000. (>5 per 1000 would mean an area is a very high prevalence area e.g. Manchester, Salford, London region). Bury has a rate of 2.18 per 1000 so is classed as a high prevalence area.

HIV testing should be aimed at

- people belonging to groups at increased risk of exposure to HIV (e.g. MSM, sex workers, trans women- for full list see BHIVA/BASHH/BIA adult HIV testing guidelines[1]).
- people attending certain healthcare settings and people presenting symptoms and or signs consistent with HIV indicator condition

[1] https://www.bhiva.org/file/5f68c0dd7aefb/HIV-testing-guidelines-2020.pdf

- all patients accessing primary and secondary healthcare in areas of high and extremely high HIV prevalence, including A&E.
- sexual partners of those with diagnosed HIV.

HIV testing should be voluntary and confidential, with easy, equitable and free access. In 2020 there was a 30% drop in testing across sexual health services nationally but an increase in testing via internet-based sexual health services. Testing coverage remains poor in Bury (36.1%), it is similar to the GM average but much worse than the England average (46%)

A HIV key strategic priority is to decrease HIV-related mortality and morbidity through reducing the proportion and number of HIV diagnoses made at a late stage of HIV infection. The proportion of people diagnosed at a late stage in Bury is 39.1% Though lower than England average, the rate is increasing.

b. Reproductive Health

Women access contraception from a range of sources, with preference for source and method of contraception varying by both age and deprivation. Whilst GPs are the most popular source used by 6 out of 10 women, sexual health clinics and community clinics are also commonly used, particularly by younger and more disadvantaged populations.

In addition to the benefits to the individual and the community of being sexually healthy, there are economic benefits and it is estimated that for every £1 spent in contraceptive services saves £11 in averted costs of unwanted and unplanned pregnancies[2]

A reduction in U18 and U16 conceptions and unintended pregnancies amongst women of all fertile ages would lead to fewer unwanted pregnancies. Ensuring access to high quality reproductive health services for women of all ages will lead to fewer abortions and repeat abortions for women.

In Bury, U18 conception rates are higher than England rate, but are on a downward trend. U18 conceptions leading to abortion are at a significantly higher rate, and rising. The U25 repeat abortion rate is significantly higher than England, and the rate is increasing.

c. STI's- Chlamydia

During 2020, non-pharmaceutical interventions to control COVID-19 (such as the national and regional lockdowns) and the resultant reconfiguration of sexual health services impacted on service provision and trends in the testing and diagnoses of STIs.

[2] Making_it_work_revised_March_2015.pdf (publishing.service.gov.uk)

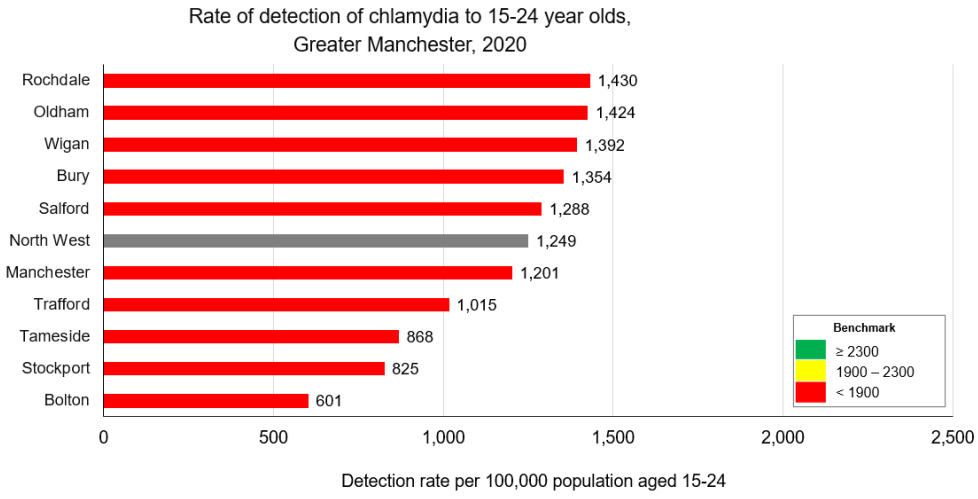
Based on national data from community surveys (Natsal-COVID[3] and RiiSH-COVID[4]), fewer people reported meeting new sexual partners during 2020 compared to previous years, but a substantial proportion of people still had ongoing risk for STIs (e.g. condomless sex with new sexual partners) during 2020.

Chlamydia is the most commonly diagnosed bacterial sexually transmitted infection in England, with rates substantially higher in young adults than any other age group. It causes avoidable sexual and reproductive ill-health, including symptomatic acute infections and complications such as pelvic inflammatory disease (PID), ectopic pregnancy and infertility.

Local authorities should be working towards achieving a chlamydia detection rate (CDR) of at least 2,300 per 100,000 population aged 15 to 24. The proportion of young people screened reduced by around a quarter in 2020, however the Bury CDR is similar to England average (1,408 per 100,000), is higher than the GM and NW averages, and is one of the highest in GM alongside Rochdale, Oldham and Wigan (see chart 1 below), suggesting the services in these areas were testing more of the population at risk during 2020 than other GM localities.

Chart 1. Rate of detection of chlamydia to 15-24 years old in GM 2020

National Chlamydia Screening Programme (NCSP)
North West



Source: PHE Sexual and Reproductive Health Profiles
GUMCAD data from specialist (L1-3) and non-specialist (L1-2) sexual health services and CTAD data from laboratories

d. Groups most impacted

[3] https://www.natsal.ac.uk/natsal-covid-study
[4] https://www.ucl.ac.uk/global-health/coronavirus/covid-19-research-0

The impact of STIs remains greatest in young people aged 15 to 24 years and in certain minority ethnic groups, and gay, bisexual and other men who have sex with men (MSM).

HIV continues to be concentrated among MSM and black African men and women. Around 40% of HIV diagnoses in Bury are late, which lead to poorer outcomes for the individual and increased risk of onward transmission.

Poor reproductive health outcomes are more likely in women who may already be experiencing disadvantage; for example, women from black and minority ethnic (BAME) groups, younger women from higher levels of deprivation, lesbian, gay, bisexual and transgender (LGBT) women and women with a body mass index (BMI) above 30. Maternal obesity is one of several influences that appear to underlie the foetal or preconception origins of later risk of non-communicable diseases, such as Type 2 diabetes, cardiovascular disease, asthma and endometrial cancer[5]. Children born to teenage mothers have a 63% higher risk of living in poverty[6]

Sex workers often experience poor physical, mental and sexual health. In many cases, there is an overlap between sex work and homelessness, and other forms of social exclusion such as poverty, substance misuse, violence, family breakdown and mental health issues. Different types of sex work result in different levels of inequality. Oldham Council recently commissioned the charity Manchester Action on Street Health to carry out research and intelligence gathering from relevant partners (e.g. GMP, local services) to identify where and how female sex workers are working and the scale of need in GM. (This report is due end January 2022).

3. Integrated SH Service

a. Commissioning background

Since 2013 the responsibilities for commissioning sexual and reproductive health services have been split over three key groups of organisations; Local Authorities, Clinical Commissioning Groups (CCG's), and NHS England (known locally as GM Health & Social Care Partnership).

Local Authorities are mandated to provide confidential, open access STI testing and treatment services and contraception services, including free supply of any STI treatment and reasonable access to all methods of contraception. They also commission sexual health specialist services, including young people's sexual health services, outreach, HIV prevention and sexual health promotion.

The Integrated Sexual Health Service (ISHS)- known as integrated because it provides both GUM (genito-urinary medicine) and contraception and sexual health services (CaSH)- is commissioned by Bury Council, through funding held in the Public Health budget. In 2015 the service was re-procured in a collaboration with

[5] https://www.gov.uk/government/publications/health-matters-reproductive-health-and-pregnancy-planning/health-matters-reproductive-health-and-pregnancy-planning

[6] https://www.gov.uk/government/publications/child-poverty-strategy-2014-to-2017

Oldham and Rochdale councils. Virgin Care were awarded the contract in 2016, and this contract will now expire in March 2022.

An integrated Sexual Health Service contributes to several key Public Health Outcomes including reducing STIs, reducing unwanted pregnancies, and reducing repeat abortions. The service should aim to reduce health inequalities and improve population health outcomes, building an open culture where everyone is able to make informed and responsible choices about relationships and sex. In order to achieve this we needed to commission an innovative prevention-orientated sexual health service which can lead the local health care system in responding to the changing sexual health needs of our residents.

Prior to recommissioning the ISHS, a sexual health needs assessment (SHNA)[7] was carried out in 2019/20. The SHNA investigates the sexual health needs and demands, as well as services available across Oldham, Rochdale and Bury, (ORB) in the context of understanding local population demographics, reviewing current local sexual health services, and it also outlined the findings from a consultation with local residents and staff.

Consultation with stakeholders was carried out in the form of two online surveys available for one month, one for service providers and the other for the wider public (for Oldham Rochdale and Bury residents). The public survey yielded 304 responses, 36.18% of which were from Bury residents. 86% of responses were of a White British background (which is representative of the ethnic make up of ORB). 81% were female, 17% were male (2% other or unstated). Almost 86% of respondents described their sexual orientation as Heterosexual. The second largest response were those identifying as Bisexual, followed by those identifying as Gay.

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

Among those unable to access the information required, reasons included not needing to access this information, and not knowing what information should be known. These respondents were asked where they seek out information about sexual health, and the majority responded with online sites, GP's, and sexual health clinics.

Almost 1 in 5 respondents highlighted that the location or opening times of local services were not suitable, or that they were unable to get an appointment. A small number of respondents reported not accessing SH services in ORB due to concern about experiencing discrimination, preferring to access other settings outside of ORB. Furthermore, some respondents highlighted not attending due to being embarrassed to access a SH clinic.

Respondents were asked how they feel local sexual health services could be improved. Comments were analysed, with five main themes being identified,

[7] http://www.oldham-council.co.uk/jsna/wp-content/uploads/2020/02/ORB-SHNA-2019-Feb-Update.pdf

namely: service reconfiguration, widen access, increase capacity, education and promotion.

Findings from this SHNA were used in designing the service specification for a new sexual health service.

In 2021 Bury Council once again agreed on a collaborative procurement process with Oldham and Rochdale Councils, assisted by STaR Procurement. A tender process was conducted in accordance with Public Contracts Regulations 2015 PCR2015 with pre-agreed evaluation criteria and weightings and evaluated in line with an agreed model. Virgin Care* were the winning bidder. Their tender was deemed to be the most advantageous, based on an open and transparent competitive procurement process which treats all operators equally, including NHS providers.

*On Dec 1st 2021 Virgin Care transferred to HCRG Care Group

A standard service specification was co-produced with all 10 Greater Manchester local authorities. ORB then adapted this to reflect the needs for each individual locality. It was stipulated that the new contract holder must act as a system leader to manage and develop SRH care across ORB, forging critical partnerships, pathways and connections with NHS trusts, primary care providers, voluntary sector organisations and our local residents in order to truly improve patient care, reduce inequalities and improve population health outcomes. HCRG will co-produce and implement a sexual health strategy within each individual locality, and have proposed that within the staffing structure, they employ a strategic lead and develop and chair a partnership board to take this forward.

HCRG will need to agree on the new strategy with Bury PH and wider partners, using all data and intelligence available, using robust data at service design stage, and will use service user information in addition to incumbent knowledge.

ORB commissioners have agreed on an initial order of priorities locally.

1. Control transmission and reduce prevalence of STIs
2. Reduce the proportion of residents diagnosed with HIV at a late stage of infection
3. **Narrowing inequalities in sexual health based on age, sexual orientation and ethnicity***
4. Reduce the number of unintended conceptions among residents of all ages and reducing the number of abortions and repeat abortions

It is also a priority that the service is accessible to local residents. This includes ensuring accessibility through consideration of geographical location, opening times, and the effective and innovative use of remote and digital services. The current physical sexual health Hub is based in Townside Health Centre in central Bury, with a spoke service delivered in Radcliffe. HCRG are currently exploring

the option of further spokes in north and south Bury.

Through the new contract the provider must ensure that the service is inclusive of all people, paying particular attention to those with protected characteristics and people at high-risk of sexual health related harm. One such group is sex workers, and the provider has been asked to specifically develop (as part of their dedicated outreach plan) a clear way to engage and work with sex workers across the locality (both on and off street including those working in sex on premises venues and those working independently online). There are a range of local organisations that already work with this population, so the expectation is that HCRG will reach out to work together with these organisations.

b. *Narrowing inequalities in sexual health based on age, sexual orientation and ethnicity

The service has proposed that they prioritise those in the greatest need over and above those that can access self help and/or digital themselves. The provider will release system capacity to focus on those with the greatest need;

- most socially disadvantaged; e.g. YP at greatest risk, those living in areas of deprivation
- least likely to engage; e.g. those not using digital services, under represented communities based on population
- at high risk of sexual health related harm; e.g. MSM, LGBTQ+, YP, commercial sex workers, users of drug and alcohol.

c. Strategic Proposals from HCRG

- Working with representational community groups to gain better understanding, bust the myths and assumptions made and create a tailored offer

- Build capacity within system partners, agencies already working with groups, to build their own training / education / knowledge / ability to deliver low level SH interventions

- Dual locate and deliver direct (clinical) care, when and where identified as best opportunity to reach target group in the first instance

- Co-design with service users, carers or key stakeholders in a structured and ad hoc way; simply whenever and wherever possible

- Being innovative and adapting best practice ideas – e.g. enhanced role of pharmacy

HCRG suggest doing this by; (list not exhaustive)

- Increased Outreach in target areas, e.g. deprivation
- Use of Community Champions
- Proactive, assertive service that 'pulls' service users into service
- Making Every Contact Count;
- Greater visibility of messaging / campaigns
- Care Co-ordination Centre (Single point of access) support to access the most appropriate service to their need
- Service Culture 'refresh'
- Building on the current successful relationships to deliver the best service available (e.g. Early Break)

An example of this is subcontracting Early Break- to deliver the Voice to Voice model, where a young person with relevant support and training will engage young person focus groups and support possible future co-design and development, and quality assurance processes. Early Break will also support assertive outreach offering a street/community outreach service in hotspot areas in the evenings.

d. The impact of COVID

Maintaining high-priority health care throughout the COVID-19 restrictions was essential, sexual health services were no exception, and so measures were quickly introduced to ensure the continued delivery of care following release of Government guidelines. As in other areas of health provision, the pandemic may have exacerbated pre–existing inequalities in terms of sexual health outcomes, including through the shift from face to face to remote service provision.

The ISHS were asked to reflect on practice that was adapted and altered during the Covid pandemic, enabling them to explore the impact of interventions collaboratively with commissioners, with the aim of informing continuous service improvement and to address health inequalities.

In addition to maintenance of access to 'routine' contraception and management of symptomatic STIs, the service prioritised emergency contraception, HIV care, pregnant women with genital complications, sexual assault care and management, provision of free condoms and sexual health care of vulnerable populations and young people.

The service continued to provide an extensive range of sexual and reproductive care through remote (online/telephone/postal) ways of working. Some 'low priority' activity was re directed to help manage capacity and prioritise essential needs. For instance, telephone triage and initial assessment consultations were introduced. Use of "Soft Phone" to allow the freephone help line to be answered by staff from home. The service implemented a "collection point" service for medications in service by patient or responsible person. Face to face appointments were given if physical examination was required. Low risk symptomatic patients were directed to online testing.

The digital hub was introduced by Virgin Care in 2017/18. After the first year 7.5% of the patient volume was online/postal STI kits. In 2020/21 29% of total patient volume was digitally based. HCRG will continue to aim for inclusive digital services.

In the young persons's service both clinicians and education support workers continued to provide care services. Pathways were put in place with other providers and access to EHC, STI testing, and contraception were delivered by targeted outreach and home visits. This may explain the higher CDR for chlamydia in the young population of Bury (the team were engaging with the population most at risk).

Local performance targets such as waiting times were affected by COVID, and are now improving whilst services return to business as usual with Saturday morning clinics, opening of spokes and monitoring of Government guidelines for recommencing drop-in clinics in healthcare settings.

A number of identified ideas for change and improvement have been suggested as a result of covid 19. Bury PH will work with the service to ensure the learning is embedded into the new contract in April 2022.

4. HIV prevention- PASH (Passionate About Sexual Health)

Each Greater Manchester local authority has co-commissioned an organisation called (PASH) - Passionate about Sexual Health- an alliance of George House Trust, LGBT Foundation, and the Black Health Agency, all with expertise in tackling inequality, to deliver a sexual health improvement plan. This includes carrying out targeted work around early identification of HIV within several specific groups including men who have sex with men (MSM), Trans, BAME and new and emerging communities. PASH engage directly with our residents but also the third sector organisations to build capacity and to have the confidence to discuss HIV prevention and care.

5. The role of primary care

GPs are commissioned by local authorities to provide Long-Acting Reversible Contraception (LARC). (This is in addition to the LARC offer from sexual health services). This includes both Intra-Uterine Contraceptive Devices (IUCD) and Sub-Dermal Implants (SDI). These are the most cost-effective contraception methods as outlined by NICE[8]. The service is available to all women of

[8] https://www.nice.org.uk/guidance/cg30/chapter/introduction

childbearing age who request contraception and who choose a contraception implant or intra-uterine device as the most acceptable method for them.

In Bury we have approx. 18 GP surgeries that can provide one or both of these services to their patients, with only 15 of those practices active in 2020/2021. Bury has historically had high GP LARC rates however it has been slow to recover to pre-pandemic levels. As not all GP practices offer LARC in house, some practices refer their patients to the ISHS. There is also a GP led sexual health service at Tower Family Healthcare based at Tottington Health Centre, which accepts all Bury patients regardless of which GP they are registered with.

Recent reviews from the Royal College of Obstetrics & Gynaecology (RCOG)[9] Faculty for Sexual & Reproductive Health (FSRH) and the all-party Parliamentary Inquiry into 'Access to Contraception'[10] state that we must improve access to reproductive healthcare, including LARC, and that Primary Care Network (PCN) formation and local GP Federation arrangements offer an opportunity by which to do that.

Within the new ISHS contract Bury Council request that the provider (HCRG) will be responsible for the development of the primary care offer in relation to LARC provision in General Practice in Bury. This is in addition to providing training, support and clinical oversight regarding sexual & reproductive healthcare provision offered in General Practice. There is a need for better integrated healthcare delivery for reproductive health, based around the needs of women.

In relation to PCNs, there is the potential to work with their leadership to create robust hub and spoke type offers relating firstly to driving up LARC provision, but with expansion into the full range of SRH services in time. Please note- the budget for the LARC provision will be retained by Bury Public Health until a robust model has been proposed after consultation with PCN's and/or the Bury GP Fed.

Primary care will also have a role to play in the ambitions in the local HIV strategy. This should include the wider roll out of the Positive Speakers Programme. This is an educational programme (can be a lunch time session) delivered by people living with HIV who talk about their personal experiences. This may cover routes of transmission, exploring attitudes, GP disclosure, improving services, and latest developments.

Pharmacy also has a role in addressing inequalities as an accessible community setting.

PH commissions community pharmacies to provide Emergency Hormonal Contraception independently. We intend to further develop the sexual health offer available via community pharmacy. It is expected that the ISHS provider HCRG will work with community pharmacies and key stakeholders to strengthen existing pathways and develop systems to improve access to contraception, and allow for referrals for intervention, treatment and support. There is a pharmacy

[9] Royal College of Obstetricians and Gynaecologists (2019) 'Better for Women'

[10] All-Party Parliamentary Group on Sexual and Reproductive Health in the UK (APPGSRH) (2020) An Inquiry into Access to Contraception

needs assessment due to be published in October 2022 which includes a public and staff consultation, which will also help inform service development.

6. National Updates

a. SRH Strategy

The National Sexual and Reproductive Health (SRH) Strategy will now be published in Spring 2022. The Government is also currently developing a new Women's Health Strategy. Both these plans will address issues relating to women's reproductive health, but the SRH Strategy will include topics that are broader than those that only effect women and will be taking a whole population approach. This will also be complimented locally by a GM SH strategic plan. During 2019/20 the GMSHN began designing a blueprint for a new model for integrated sexual and reproductive health support across GM, focused on enhancing digital capabilities, mobilising people, and communities, shifting the focus towards prevention and early intervention, empowering greater sexual and reproductive wellbeing through improved integrated neighbourhood services, and delivering more integrated and consistent specialist care for the most serious and complex issues. This work was paused through the pandemic but is currently under review.

b. HIV Action Plan

The Government is committed to achieving zero new HIV infections, AIDS and HIV-related deaths in England by 2030. To drive forward progress to 2025, DHSC published a new HIV Action Plan[11] on 1 December, World AIDS Day, which sets out how we will achieve the interim ambition of an 80% reduction in new infections by 2025.

To achieve this locally Bury Public Health and partners across the health system and beyond need to develop partnership working around four core themes – preventing new infections, scaling up testing to identify infections, ensuring people diagnosed rapidly access treatment and everyone living with HIV is retained in treatment.

Examples of local action include (not limited to)

- Health promotion and communication campaigns tackling HIV related stigma, discrimination, and inequalities.
- Developing community champions and influencers.
- Scale up HIV testing in high-risk populations where uptake is low to ensure new infections are identified rapidly.

[11] Towards Zero: the HIV Action Plan for England – 2022-2025

- Work with local Sexual Health Providers to ensure people rapidly receive treatment to stop them transmitting the infection further and increase their chances of living a long, healthy life.

Bury ISHS are now commissioned to provide PrEP (pre-exposure prophylaxis)[12], free of charge to all service users who meet the eligibility criteria. PrEP is a drug taken by HIV-negative people before and after sex that reduces the risk of getting HIV. This has been found to be highly effective if taken correctly. As part of the local HIV action plan we must increase awareness and access to PrEP for key groups.

c. Integrated Care Systems (ICSs)

The Government's plans to establish statutory ICSs may provide opportunities to bring together providers and commissioners from both the NHS and Local Government within Greater Manchester to drive tangible improvements in SRH.

7. Life course Approach

a. Start Well

Ensuring that all children and young people have timely and age appropriate information about reproductive and sexual health is critical to their safe journey to adulthood.

High quality RSE is particularly important for the most vulnerable children, including looked after children, LGBT and those with special educational needs.

Due to the pandemic, schools have been given flexibility to phase in full implementation of the statutory RSHE curriculum, with the expectation that the comprehensive programme would have been delivered from Summer 2021.

With cross locality reports of an increase in young people accessing digital dating apps and networks, this prompted an intention to re- establish the GM YP sexual health group, which is now expanding the membership to reflect the many services that are involved in this area. Bury will be represented by HCRG Young Person's service and Bury Council integrated youth service in the first instance.

b. Age well

Womens Health Hubs

[12] https://www.tht.org.uk/hiv-and-sexual-health/prep-pre-exposure-prophylaxis

Fragmentation of the commissioning of sexual health services has caused barriers to care and increasing inequalities of access. There is also the need to recognise the life-course approach to reproductive healthcare that women need.

LARC delivery will be a priority, but there is also the intention to explore the introduction of women's health hubs across Bury. These are concepts that involve smarter commissioning by different commissioning organisations, providing easier access to basic women's health services that include contraception, menstrual health, menopause, abortion and cervical screening- to ensure all women receive the appropriate care they are entitled to, at the right time and in the appropriate setting. The Primary Care Women's Health Forum has developed a Toolkit for areas wishing to improve or develop a local women's health model[13].

HIV

The improvement of HIV treatment options mean that people can expect to live well and to have a normal life expectancy. This means there is a growing population who are now aging with HIV. People who are fifty and over are the fastest growing group of people living with HIV in the UK. Issues faced by this cohort include discrimination & stigma based on their HIV status, age discrimination, social isolation, and risks of late diagnosis. People living with HIV over the age of fifty are twice as likely to have additional health problems. Bury Council alongside the other 9 GM councils commission an alliance of organisations through the PASH partnership, including George House Trust. Health, Wealth and Happiness is a project at George House Trust which provides opportunities for people who are fifty and over to gain information, volunteer and to contribute to the services and social care agencies within their local community.

[13] https://pcwhf.co.uk/news/press-release-the-womens-health-hub-toolkit/

Appendix One. Sexual and Reproductive Health profiles accessed at Fingertips January 2022
https://fingertips.phe.org.uk/profile/sexualhealth/data

Indicator	Period	Bury			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Syphilis diagnostic rate / 100,000	2020	→	25	13.1	9.6	12.2	147.9		0.0
Gonorrhoea diagnostic rate / 100,000	2020	→	79	41	66	101	1,024		10
Chlamydia detection rate / 100,000 aged 15 to 24 <1900 1900 to <2300 ≥2300	2020	→	276	1,354	1249	1408	548		3,408
Chlamydia proportion aged 15 to 24 screened	2020	→	2,516	12.3%	11.7%	14.3%	4.1%		36.5%
New STI diagnoses (exc chlamydia aged <25) / 100,000	2020	→	421	353	490	619	3,547		247
HIV testing coverage, total (%)	2020	→	1,396	36.1%	36.9%	46.0%	12.0%		85.8%
HIV late diagnosis (all CD4 less than 350) (%) <25% 25% to 50% ≥50%	2018 - 20	–	9	39.1%	42.5%	42.4%	72.7%		16.7%
New HIV diagnosis rate per 100,000 aged 15 years and over	2020	→	6	3.9	5.0	5.7	27.5		0.0
HIV diagnosed prevalence rate per 1,000 aged 15 to 59 <2 2 to 5 ≥5	2020	→	236	2.18	1.99	2.31	13.09		0.53
Population vaccination coverage - HPV vaccination coverage for one dose (12-13 years old) (Female) <80% 80% to 90% ≥90%	2019/20	→	944	78.0%	68.4%	59.2%	0.0%		100%
Under 25s repeat abortions (%)	2020	→	102	36.0%	30.7%	29.2%	38.6%		17.9%
Abortions under 10 weeks (%)	2020	→	755	90.3%	89.8%	88.1%	79.9%		93.8%
Total prescribed LARC excluding injections rate / 1,000	2020	↓	1,035	29.8	29.4	34.6	5.3		60.9
Under 18s conception rate / 1,000	2019	→	59	18.5	19.4	15.7	37.1		3.9
Under 18s conceptions leading to abortion (%)	2019	→	42	71.2%	57.0%	54.7%	32.5%		91.3%
Violent crime - sexual offences per 1,000 population	2020/21	–	-	*	2.4*	2.3*	1.0		4.4

Community impact/links with Community Strategy

Equality Impact and considerations:

Under section 149 of the Equality Act 2010, the 'general duty' on public authorities is set out as follows:

> *A public authority must, in the exercise of its functions, have due regard to the need to -*
>
> (a) *eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;*
>
> (b) *advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;*
>
> (c) *foster good relations between persons who share a relevant protected characteristic and persons who do not share it.*

The public sector equality duty (specific duty) requires us to consider how we can positively contribute to the advancement of equality and good relations, and demonstrate that we are paying 'due regard' in our decision making in the design of policies and in the delivery of services.

Equality Analysis	*Please provide a written explanation of the outcome(s) of either conducting an initial or full EA.*

**Please note: Approval of a cabinet report is paused when the 'Equality/Diversity implications' section is left blank and approval will only be considered when this section is completed.*

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