Sexual Health Needs Assessment

Tameside

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Executive summary

Context

Good sexual health and wellbeing is important to a high proportion of the population throughout the life course and it is an area where there are local levers to influence change through locally commissioned primary care and sexual health contracts. With the specialised sexual health service contracts due for renewal in 2022 it was deemed timely to carry out a needs assessment to inform recommissioning.

This needs assessment involved a number of interviews with young and adult residents, service users and healthcare professionals and was supported by a resident survey which had 106 responses. Data analysis, desktop research and further interviews with other service providers were carried out to inform the findings and the recommendations.

Summary of Main Findings and Recommendations

51 individual recommendations have been made based on the findings from this work; where possible these have been costed and some of the barriers discussed. The key recommendations are included in this executive summary:

1. Access, Awareness and Education

This section contains findings that were relevant to all aspects of sexual health in Tameside:

- **Availability of Appointments -** challenges in getting an appointment with specialist sexual health practitioners, as well as GPs for sexual health issues were discussed by many residents. Timings and logistics of booking appointment is difficult. Demand for the specialist sexual health walk-in service (now replaced) outstripped supply by 100 appointments per month.
- **Neighbourhood Provision** – many services are Ashton centric which makes access difficult for our more remote and deprived communities, who often have most need.
- **Awareness of Services Available** – residents, particularly younger residents expressed that they weren't aware of what services could be accessed and where.
- **Education –** there is variability in how schools are teaching and discussing sex education. YouThink input is greatly valued by schools, but is limited to year 9 only.
- **Engaging with Residents Regularly** – Residents in Hattersley who took part in a focus group highlighted that provision had been declining for some time – engagement on sexual health (and other issues) had not taken place; residents felt neglected.

Key Recommendations:

- Development of an outreach role to support our more remote communities
- Specialist service to consult with service users about opening hours and appointment booking logistics.

- Develop an enhanced website which better communicates the services available, where and how they can be accessed. This website should be the focal point for sexual health information in Tameside and should be marketed to schools.
- Establish regular methods of engaging our more remote and deprived communities in addition to the PEN forum.

2. Contraception and Termination of Pregnancy

The findings below are broken down by section, and should be considered alongside the findings around those areas which appear to have the most need (section 6.6).

2.1 Terminations

- T&G abortion rates are the highest in GM and rank poorly nationally.
- There are a number of women having repeat terminations, with most not having LARCs fitted with termination providers.
- Feedback from ICFT termination service suggests a number of terminations are the result of delays in accessing oral contraception.
- LARC rates compare well with other areas but high abortion rates suggest higher need within Tameside (ie. LARC rates should be even higher).
- There could be as many as 500 unintended pregnancies which result in live births; a number of these will have poor outcomes for parents and child.

Key Recommendations:

- Improve consistency of data collection from termination providers and request more demographic information is shared to help understand potential inequalities.
- Local research to better understand reasons behind terminations.
- Incentivise LARC provision within termination provider contracts and communicate community LARC provision well with providers (including NHS providers).

2.2 User Dependent Methods (UDM) of Contraception

- There is variation in UDM rates across GP practices and neighbourhoods.
- >40% of specialist sexual health consultations are primarily used for contraception advice/prescribing. Feedback suggests this is down to access issues in primary care.
- Some GP practices are operating virtual contraception reviews, some are not.
- There is potentially a wider role for pharmacies in providing access to contraception locally.
- Qualitative feedback, particularly from younger groups, highlights a need for clearer communication about what contraception is available, where it can be accessed and how people can access it.
- Issues raised with primary, community and secondary care staff knowledge of UDM, as well as LARCs.

Key Recommendations

- Discuss whether remote contraceptive reviews can be the default with GPs, and not necessarily delivered by GPs eg practice nurses. This could improve access to contraceptive appointments, and free up specialist sexual health provision.
- Work with pharmacies to develop pharmacies prescribing models and what level of capacity might be required; starting with those who are most interested first such as Crown Point. Develop a model of prescribing POP online and deliver to homes to improve access, particularly during times of limited contact (Covid)
- E-learning and face to face training programme for wider health and social care staff to be developed and mandated to upskill staff about all forms of contraception

2.3 Condoms

- Not knowing where or how to access free condoms was raised as an issue by a number of residents.
- Distribution of free condoms to GP practices was not systematic and health visitor staff would benefit from having access to supplies also.

Key Recommendations:

- Development of an online condom distribution scheme to improve access to free contraception.
- Ensure relevant professionals such as health visitors and pharmacists can readily access supplies of free condoms.

2.4 LARCs

- There is a strong economic and social case for increasing LARC uptake given their effectiveness is very high compared to other forms of contraception.
- Qualitative findings suggest access to LARC is variable, particularly in primary care. Access issues are geographic as well challenges in getting timely appointments.
- Data shows access to LARCs is variable by location, particularly to practices which are regularly fitting IUDs/IUSs. Numbers were particularly low in Mossley, Hattersley and Droyslden.
- Patients found it difficult to get appointments for LARC, in particular where they are having issues with a fitting or needed a removal. The support available if someone does get an issue or wants a removal is a barrier to LARCs for some residents who have concerns about side effects.
- Payment for LARC installation is among the lowest in GM and doesn't incentivise GPs to supply. There is no payment for removing an IUD/IUS, so data quality is poor.
- GoToDoc are running a LARC hub service for a number of their practices. Having a number of these hubs (up to 8) across Tameside could be an effective way of improving access.
- There are challenges with data in terms of how many active fitters there are and how many patients have devices in situ.
- There is an opportunity to improve the LARC advice offered to women through the maternity pathway, shortly after delivery and through follow up health visitor sessions.

Key Recommendations

- Amend LARC reimbursement inline with other GM authorities; the price offered for implants should be based on a nurse carrying out that activity.
- Work with neighbourhoods to facilitate LARC provision in key areas where it is low, perhaps adopting the GTD hub model. Consider using existing OOH hubs in each neighbourhood to offer weekend provision.
- Facilitate development of LARC training in the region to ensure the number of fitters is sufficient. Midwifes to be included within this.
- Establish a set of principles with primary care and service users that dictate maximum waiting times for LARC.
- Work with front line staff on improving awareness of LARC and how it can be accessed – see face to face training programme above.

2.5 Contraceptive Injection

- There is variation in uptake of injections across GP practices
- Patients are no longer receiving injections before they leave the labour ward to cover them for the first 3 months.
- Patients struggled to get appointments for injections with their GP leading to periods without contraceptive cover.

Key Recommendations

- Work with PCNs/GPs to allow longer term booking availability for injection follow ups.
- Facilitate the offering of self-administration of injections using Sayana-Press to improve access for patients.
- Consider training health visitors to deliver injections (health visitor's suggestion) and work with the maternity service to review whether patients can get them as they leave the ward.

2.6 Emergency Hormonal Contraception

- Only 8 pharmacies in Tameside prescribed EHC (for free) more than once a week.
- 49% of the total EHC prescribed during 2019 was prescribed at just three pharmacies (Boots Crown Point, Boots Ashton (Ladysmith) and Asda Ashton). There is a particular lack of pharmacy provision of EHC in Stalybridge (0 prescriptions in 2019) and Droylsden (2 prescriptions in 2019).
- 354 patients attended the Orange Rooms for EHC during 2019, 13% of whom were fitted with a contraceptive IUD.
- Barriers to EHC uptake were found to be:
    - Lack of resident understanding about how to access EHC for free
    - Pharmacy supply limited by availability of qualified personnel through the day; more of an issue outside of normal workings with some areas not having a pharmacy open outside of Monday to Friday, 8-5.
      Training, accreditation and remuneration a barrier to increasing the number of pharmacy staff able to prescribe.

    - Out of area agreements where residents can access EHC for free in other LAs has made access more challenging.
    - Cost is an issue where resident's local pharmacy don't provide EHC for free.
- 5 out of 9 people surveyed who had received EHC said they hadn't received advice about other forms of contraception.

Key Recommendations

- Improve information about where people can access EHC for free, through the sexual health website initially but with other more proactive methods too.
- Carry out feasibility work to understand and potentially set up online request and collection or delivery of EHC similar to the Lloyds private offer.
- Allow residents to access EHC from other areas in GM for free.
- Review the EHC offer in Tameside pharmacies and ensure Stalybridge and Droyslden are better served.

3. Sexually Transmitted Infections (STIs)

- Recorded prevalence of STIs in Tameside is below GM and England averages, except for Gonorrhoea which has the third highest rate in GM.
- For Chlamydia, it is known that the detection rate is poor, which means the prevalence rate may be unreliable.
- 40% of survey respondents said they'd go to their GP for STI testing, as opposed to 32% for the specialist sexual health clinic.
- Access to testing appointments at the Orange Rooms was expressed as an issue; some desired walk in appointments. Some had been told to go to Orange Rooms for testing by their GP.
- Chlamydia testing packs haven't been offered in a consistent way in primary care.
- A number of residents and school students were unsure of how to access testing and weren't aware of home testing options.

Key Recommendations

- Develop a no wrong door policy relating to testing so patients can access testing in the location most convenient for them.
- Promotion of remote / home testing kits to be more widespread and communication should attempt to destigmatise testing.
- Improve communication about STIS through the website initially; include information on how and where residents can access testing.

4. Cervical Screening

- Cervical screening uptake in Tameside is higher than the national average and the 4th highest in GM.

- However, uptake in some GP practices is as low as 62% compared to 87% in the highest uptake practice.
- Accessing out of hours' appointments was cited as an issue by a number of survey respondents.

Key Recommendations

- Carry out an equality impact assessment to see if there are inequalities attached to the low uptake groups (this work could be extended to HPV vaccination uptake).
- Focused work with GP practices with low uptake to support improvements, drawing on evidence of what is effective in making improvements).
- Include cervical screening periodically within resident and partner public health communications.

5. HIV

- HIV rates in Tameside are in line with other areas in GM but increasing.
- Late diagnosis in Tameside is low compared to other GM boroughs, but could be improved.
- Testing for women in Tameside is particularly low. Home testing for all sexes averages 15 tests per month and varies by LSOA.
- The decision to make PrEP routinely available is a great opportunity to decrease rates of new HIV, but work needs to be done to promote it and ensure access is sufficient.

Key Recommendations

- Potential for a working group to focus on reducing the rate of new infections in Tameside, timely given the now routine access to PrEP.
- Part of this work could include wider promotion of HIV home testing consistently across the region.
- Awareness of the importance of timely access to PrEP and PEP should be included within wider practitioner training around sexual health descibred in earlier sections.

Main Report

1. Context

Sexual health and wellbeing is wide ranging, including pregnancy, contraception, sexually transmitted diseases, cervical screening cancer and HIV, making it important and highly relevant to a high proportion of the population. In Tameside, around £1.5 million is spent each year on commissioning a range of sexual health services. The social and economic costs when sexual and reproductive health is poor, through unintended pregnancies, healthcare treatments and mental health conditions for example, is potentially much higher than this amount; for example £520,000 is spend on terminations each year in Tameside, but approximately £70,000 on Long Acting Reversible Contraception (LARC).

While Tameside performs well in some aspects of sexual health, in other areas it is an outlier (e.g. 9th highest abortion rate in the country). It is important to understand more about resident's sexual health needs and how services could be improved.

In Tameside, a high proportion of STI testing, as well a significant amount of contraceptive services, are carried out by the integrated sexual health service, The Orange Rooms (provided by The Northern Service, part of University of Manchester NHS Trust). This service is due for recommissioning (with Stockport) in 2022, so understanding what improvements are needed from a resident, as a well as a professional perspective, is timely.

A further consideration is the GM led sexual health programme, which particularly focuses on how the digital offer can support improved sexual health and wellbeing, through innovations such as remote testing.

Local stakeholders met in autumn 2019 in Tameside at a sexual health workshop to discuss how sexual health services could be improved going forwards. A vision for sexual health services was developed:

Tameside residents of all ages are able to express themselves, be confident, have choice and take control of decisions about their sexual and reproductive lives.

This includes having effective access to good and reliable information, and access to services in a way that effectively meets their needs.

A sexual health HNA was last carried out in 2015, and made the recommendations detailed in figure 1. The outcome for each has been added based on the findings from this latest review:

Figure 1: 2015 Sexual Health HNA Findings and Outcomes

Objective	Planned Intervention	Outcome (as at April-20)
Reduce the rate of new STIs and reinfection	Develop a service to enable free access to condoms	Based on feedback from residents, free condoms are less accessible since 2015 with the loss of the C-card.
Reduce unplanned pregnancies and abortions	Improve uptake of Long Acting Reversible Contraceptives (LARCs)	LARC rates are relatively good, but abortion rates are still very high, suggesting higher need in Tameside.

Objective	Planned Intervention	Outcome (as at April-20)
Target young people as this is the age group with the highest rate of STIs.	Develop a full package of interactive computer based interventions (ICBI)	Feedback suggests a lack of awareness of how and where to access services, including testing.
Offer targeted interventions to the young people who are most at risk of sexual ill-health	Provide increased support within a whole systems approach to vulnerable young people, such as looked after children and young offenders	This has happened to a degree with YouThink and Orange Rooms focusing on an increased number of safeguarding cases; however there appears to be more work to do in terms of preventing sexual ill-health with young people.
Increase utilisation of sexual health services by young males	Consider targeted promotion and/or develop a standardised approach to partner notification.	Proportion of males to females has remained the same since 2016 (about half of patients are male). Attendances have increased during time though. Unsure of primary care attendances by sex.
To provide a high standard, quality assured approach to the delivery of sexual health services across all providers.	Shape the integrated sexual health service (ISHS) to provide a greater support function to primary care and other providers	Primary care outreach offer built into the specialised service contract however sessions have not been delivered in the last two years. Numerous stakeholders have highlighted the need for increased outreach clinics for residents and access to specialist advice for primary care physicians.

While much of the research for this report was done before the Covid-19 outbreak, it was finalised during the pandemic. Some of the recommendations highlighted are contextualised against the practicalities of delivering services remotely or in a different way during this and future outbreak.

2. Aim of this Report

This report aims to better understand resident and practitioner perspectives of where sexual and reproductive health services could be improved, to identify areas of unmet need, and to understand the equity of sexual and reproductive health across Tameside.

The report will be structured around key areas of sexual and reproductive health:

1. Access, Awareness and Education – these common themes emerged from the research and are relevant to all areas of sexual and reproductive health
2. Contraception and Termination of Pregnancy
3. STIs
4. HIV
5. Cervical Smears

3. Methodology

The following data sources have been used to help understand sexual and reproductive health in Tameside:

- Public Health England (PHE) Finger Tips data
- NHS Business Services Authority (NHS BSA) prescribing data
- Tameside Local Commissioned Services (LCS)data
- NHS Tameside & Glossop Clinic Commissioning Group (CCG) Termination of Pregnancy data

- Local Authority Sexual Health Epidemiology Reports (LASER) data 2017

Three surveys were distributed to support this work with the following response rates:

- Resident survey; February 2020 – N = 106
- Pharmacy survey; February 2020 – N = 8
- GP survey (LARC specific); June 2019 – N = 17

Interviews or focus group were held with a wide range of residents or staff. For a summary of these sessions please see Appendix 1.

4. Findings Relevant to All Areas

4.1 Access

Availability of Services in Neighbourhoods

A number of residents and staff complained that residents had to travel considerable distance to access services at the Orange Rooms in Ashton as they couldn't get a local appointment with their GP, or a particular service (such as STI testing or a coil fitting/removal) wasn't offered locally.

Travel times to the Orange Rooms vary considerably depending on where residents live, with residents in Mossley and Hattersley (both deprived areas) having to travel the furthest (figure 2), potentially exasperating inequalities in these areas. For residents who live away from the centre of these conurbations, travel times are likely to be longer given walking distances to bus stops.

Figure 2 – Average Travel times from towns in Tameside to the Orange Rooms

Travel Time Orange Rooms		Bus	Car
		Average Duration (Min)	
Hattersley	SK14 3EH	48	18
Mottram	SK14 6LA	38	18
Mossley	OL5 0LS	28	15
Hyde	SK14 1AL	25	15
Stalybridge	SK15 2BN	25	11
Droylsden	M43 7AD	24	15
Denton	M34 2AP	24	13
Ashton	OL6 6DL	10	8

The cost of buses is an issue for some residents too that could prevent them accessing services; a day rider costing £6 in Tameside. Residents in Hattersley raised concerns that the number of bus routes was regularly being cut, and that the direct route to the hospital (387) was being removed.

Orange Rooms Appointment Times and Booking

Feedback around the Orange Rooms service is overwhelmingly positive when residents are able to get an appointment. However, the access to appointments was raised as an issue by a number of residents and staff across the board. Furthermore, it was suggested that the timing of appointments was designed to suit clinicians, rather than residents. In particular that:

a. Most appointments go with minutes of becoming available, making it difficult to get an appointment.
b. Appointment booking opens at 8.30am which clashes with school times, so young people struggle to book appointments.
c. The Saturday drop in clinic is not convenient for young people as it's in the morning.
d. Since the walk in service was changed to a booking only less people are turned away from the clinic, however these people could be being (invisibly) turned away virtually by not being able to make an appointment. There have still been issues with people lining up outside the Orange Rooms and being turned away when they have turned up with a health issue. Turnaway data from when the walk in service existed suggested demand exceeds supply by about 5 appointments per day for all services (100 patients a month).
e. The ease of use of the Orange Rooms appointment booking system was critcised by some residents; this is confirmed by feedback in the Orange Rooms quarterly reports. There is an update being made to the booking system in April-20.
f. Resident and service user feedback highlighted the un-confidential nature of the Orange Room service. Making this more discreet may help increase usage of the service by residents.

Access to Advice for Young People

School students highlighted the lack of people in school who you can approach/talk about sexual health and the need for an assigned person for each year group who is willing to be this person. Linked to this loss of school presence, multiple residents also highlighted the loss of school nursing support for young people and the challenges that brings. School nurses no longer have the time to establish relationships with pupils which are needed to give support around sexual health. Rochdale's ChatHealth text service was discussed, which allows young people aged 11-19 to ask questions about their health, including sexual health, to school nurses. This could be a way of adapting to having less school nursing resource available. https://www.pat.nhs.uk/community-services/PC-leaflets/HMR/chathealth-flyer.pdf.

Outreach Workers

Different professionals throughout the engagement suggested hiring a central outreach worker(s) who spends time in each of the neighbourhoods in Tameside. This role could improve access to a range of services by providing sexual and reproductive health clinics each week (including fitting LARCs), as well as providing wider awareness raising training for staff in primary, community and in secondary care about contraception. Support for school nurses and home visits for the most vulnerable could also be offered.

The Family Nurse Partnership team thought the outreach model would be particularly helpful for their clients, who often have complex lives. They may not see contraception as the biggest priority when they have other issues to deal with or may be too daunted, or lack the

knowledge or confidence to access GP or specialist services. If an outreach worker was available and could do home visits they may be able to support/scaffold individuals to visit the GP/Orange rooms for their contraception.

An outreach post could be hosted by ICFT to ensure it isn't delayed by the specialist sexual health provider contract renewal. Support for funding could be sought from private firms such as Bayer, who may be willing to partially fund a post that helps increase LARC uptake in Tameside. There would be a positive return on investment on this post for the Strategic Commission too, given the potential savings on the Termination of Pregnancy budget through avoiding unintended pregnancies.

A number of primary and community care staff also mentioned the importance of being able to access specialist staff support by phone, which they can't do currently. Access to this service via an outreach worker could help retain activity in primary care.

4.2 Awareness of Services Available

A number of residents said that their biggest challenge was not being sure what services could be accessed where and, for younger people, what could be accessed without their parent's permission.

Existing information sites exist such as https://www.sexwise.fpa.org.uk could be linked into a Tameside specific website that details what services are available, where, when and how to access. This could be updated regularly and supported by leaflets for those without regular internet access and for promotion in schools and other organisations. There are a range of videos that explain how services or contraceptive devices work which could be incorporated into any content. The current Tameside website is not sufficient: https://www.tameside.gov.uk/health/sexualhealth

Some NHS Trusts have developed a range of leaflets which could be adopted for local use https://www.letstalkaboutit.nhs.uk/other-services/patient-leaflets/. Health visitors stated that leaflets would be particularly useful to leave with their clients.

4.3 Education

Education about contraception and sexually transmitted diseases is inconsistent based on feedback from young people and parents. Some residents who are parents criticised the lack of sexual education in schools, caused by pressure from other subjects. One professional quoted a survey of KS3-4 pupils which found 60% wanted more sexual health and contraception advice. Feedback from 16 years olds suggests that in primary schools some students learn about aspects of sexual health, but some don't.

The new sexual health curriculum materials introduced by TMBC were well received by the school who engaged with this needs assessment (Denton CC), and the feedback about the support offered by YouThink to Year 9 groups each year was very positive. However, there was a need for more support in Years 10 and 11 to reinforce the messages discussed in year 9. Without further in-reach support, some schools will ultimately focus on sexual education less than others in years 10 and 11, potentially exacerbating **health inequalities.**

In a health visitor session, at least one school was mentioned in Tameside as not receiving YouThink support, suggesting coverage is not 100% across the region.

There is potential for sexual health to be covered in a more cross curricula way; reproduction could be discussed in the social context in science for example. It was also raised by students that there is a need to talk about pornography as part of the PHSE curriculum, and that by not doing so gives students the impression that there are no concerns with it. Lived experience sessions for issues such as HIV, and the benefits of peer to peer teaching (using year 11s) were also suggested by students.

4.4 Engaging with Residents Regularly

The resident engagement held throughout this work was insightful and provided input on a range of issues, mostly related to sexual health, but also more broadly. Residents, particularly in the Hattersley session in particular, felt isolated and ignored; there is a need to ensure that residents' views are listened to more regularly, on this and other issues. The neighbourhood forums offer this to a degree, but the more remote areas of Tameside need a more localised way of engaging residents.

4.5 Recommendations

No.	Recommendation	Resource Implication	Barrier(s)	Link to Covid-19
1	**Outreach role(s) developed to support each neighbourhood with better access to sexual health services – priority areas highlighted in section 4.1.**	**£40k+/year to fund a post**	**Funding**	**Yes, if recruited before outbreak ends.**
2	**Support phone line developed by specialist sexual health service to allow non-specialist clinicians to advise/treat patients rather than having to refer on to the specialist clinic. Could be managed by the outreach worker(s).**	**Clinical resource to staff this**	**Resource to staff**	**Yes, if set up before the outbreak ends.**
3	**Orange Rooms to review changes to new booking system after the latest changes in April-20 and work with patients to make the system more user friendly.**	**IT development cost**	**TBC**	**No**
4	**Orange Rooms to consult patients on the most suitable opening hours to help provide the most accessible service. Capacity to reviewed once other recommendations in this document have been implemented to improve access times (access for other issues could improve if more oral contraception is delivered locally, see section 5).**	**Shift resources**	**Clinical capacity to flex appointment slot times**	**No**
5	**Up to date information to be shared with schools about what sexual health services are available and how students can access.**	**Public health staff time and teacher time to**	**Teacher and school engagement in mentoring students.**	**No**

	Add on a section on pornography to the relationships curriculum work already issued to schools. Each school year group to have a mentor assigned to discuss sexual health with students.	**mentor students**		
6	**A central website for Tameside to be developed to communicate how and where residents can access sexual health services, supported by leaflets.**	**IT development cost. Marketing and promotion**	**Changing provision due to Covid-19 makes this action more important. Needs updating regularly.**	**Yes – support residents with how to access services during the outbreak**
7	**Review non-clinical outreach service offer to see how it can work in partnership with YouThink so every school is receiving support, and receives support in years 10 and 11, as opposed to year 9 only.**	**Potentially shifting existing resource**		**No**
8	**Establish regular dialogue with residents, particularly in more isolated areas of Tameside to help understand key issues around sexual health and broader social and health needs.**	**Time to run these sessions**	**It will take time to build a culture of residents engaging.**	**No**
9	**Investigate feasibility of a text service similar to ChatHealth with School Nursing Team to improve access to support for school ages residents.**	**Funding to set up system and staff it.**	**IT logistics and funding.**	**Yes, while face to face contact is difficult this could offer support**

5. Termination of Pregnancy

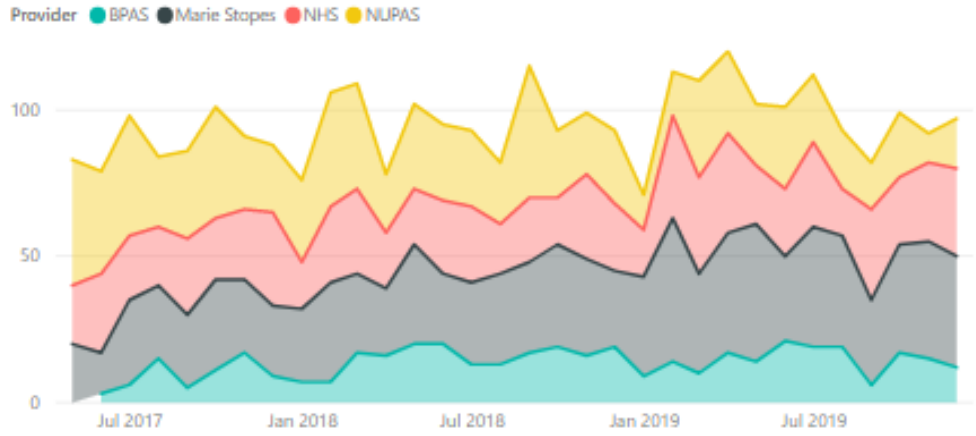
5.1 Terminations

National data shows that Tameside has one of the highest termination rates in the country, and rising (Figure 3 and 4)[1]. Tameside contraception rates are comparable with other areas, but high numbers of terminations suggest there is more to do in avoiding unintended pregnancies. In 2018/19 Tameside & Glossop CCG (who are responsible for commissioning abortion services) spent £520k on terminations with providers; forecast to increase to £600k for 19/20. It is unclear at the time of writing what impact lockdown may have on pregnancy rates and if this will lead to higher terminations in 2020/21; access to contraception during the lockdown was reduced.

[1] Low termination rates could be interpreted positively, however if a region has a high unintended pregnancy rate, low terminations are not necessarily good, as unintended pregnancies can mean poorer outcomes for parent and child. Termination rates should not be considered in isolation.

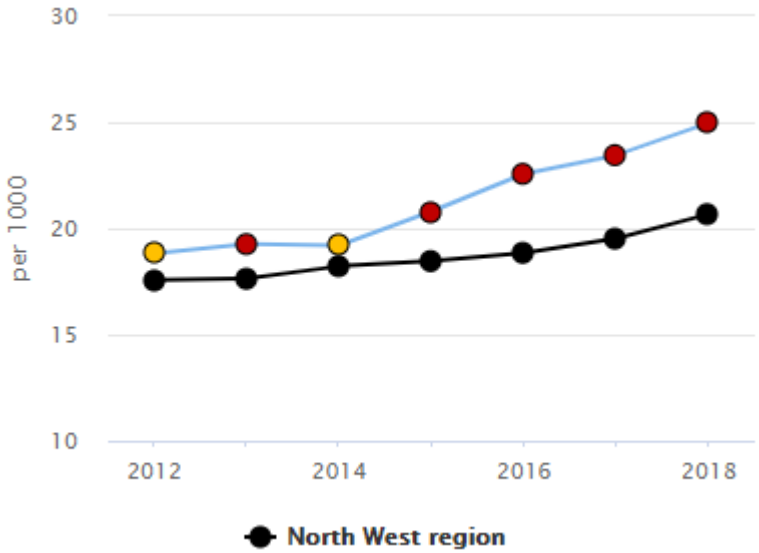
Termination rates by GP practice are not evenly distributed across Tameside (Figure 5), suggesting there are different levels of contraception use and/or sexual activity in different neighbourhoods in the borough. Termination rates vary from over 50 terminations per 1,000 women aged 16-45 per year, to below 10 terminations per 1,000 (Appendix 2) in other practices.

Figure 3: Monthly Number of Terminations by Provider in Tameside 2017 - 2019



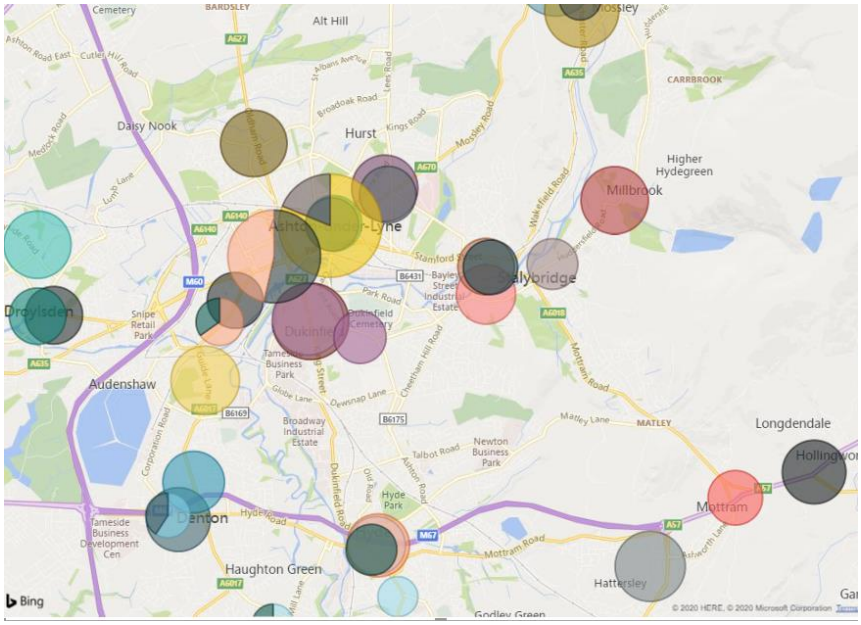
Source: T&G CCG Commissioning Data

Figure 4: Termination Rate per 1,000 in Tameside 2012-2018 vs North West Rate



Source: PHE; Fingertips

Figure 5: Geographic spread of termination rates (Based on number of terminations between Apr-17 to Jan-20)



Neighbourhood	Termination Rate per 1,000 Females Aged 16-45
Denton	59.9
Hyde	56.6
Ashton	55.6
Glossop	50.1
Stalybridge	45.6
Total	**54.1**

Source: T&G CCG Commissioning Data

The size of the circles is relative to the abortion rate; large circles show higher relative rates. The rates of termination are higher compared to figure 4 as they are calculated using the child bearing population.

56.6% of under 18 conceptions in Tameside lead to termination, which is not significantly different from regional and national averages. The most common age for termination was between 22 and 33, see Appendix 3. 3% of terminations were for under 18s, and 11% for 18 to 21 year olds. BPAS collect further demographic information; 84% of Tameside 202 BPAS terminations over a three year period were for women who were single; 88% were for women whose nationality was English.

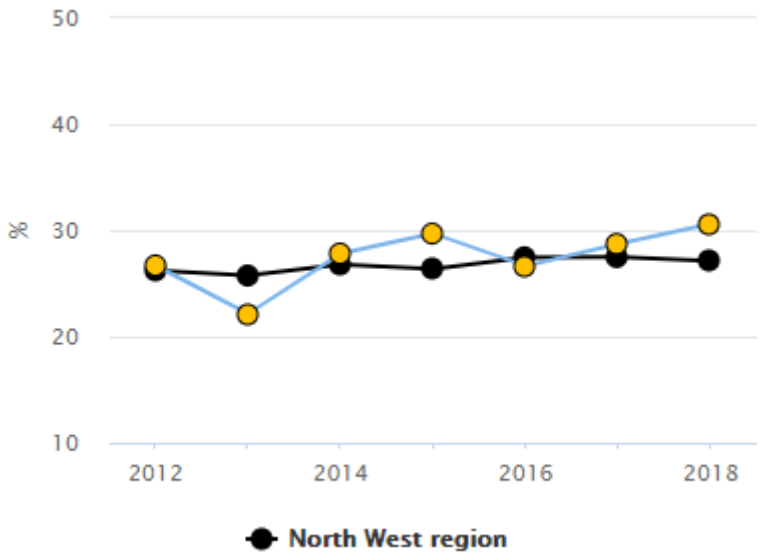
Multiple terminations is also an issue in Tameside, with rates for under 25 repeat abortions above regional and national averages (although not statistically significant different - Figure 6). There was no significant trend in repeat terminations varying by patient age group. Over a two year period Marie Stopes saw 35 women for repeat terminations (women who had more than 1 termination in the 2 year period), 8% of activity. 29 women had multiple terminations with NUPAS over a three year period (58 terminations between them), 11.5% of terminations.

BPAS collect data on whether women have had any previous terminations, regardless of when it was. BPAS saw 91 women for a repeat termination during a two year period. 67 women had already had one termination; 19 women had already had 2 terminations; 4 women had had 3 terminations, and 1 woman had already had 5 terminations. Only 13% of those who had repeat terminations with BPAS accepted LARCs/injections, with the remainder being prescribed condoms or oral contraception.

When discussing reasons for conception and subsequent termination with a clinician from the NHS termination service, one reason cited was that residents had run out of oral contraception and had not been able to access a new supply, suggesting access issues at GPs or the Orange Rooms. Anecdotally, about 10% of termination patients had been told

previously they had a medical condition which meant they couldn't have a baby. Post termination support exists at ICFT but it is unclear if there is equitable access to that service as data were not available.

Figure 6: Repeat Abortion Rates for U25s; Tameside vs NW region average



Source: PHE; Fingertips

BPAS, NUPAS and Marie Stopes collect data on whether patients accepted and were provided with contraception at the point of termination with Figure 7 suggesting there is a high degree of variation between providers in whether this is provided. The contracts for the commissioned termination services could be reviewed to incentivise/enable increased contraceptive and LARC provision.

Figure 7: Contraception provided at termination of pregnancy by provider

%age of Terminations Provided with Contraception

Provider	2017	2018	2019
NUPAS	26.1%	27.8%	25.8%
Marie Stopes	62.7%	62.8%	76.4%
BPAS		100%	100%

%age of Terminations Provided with LARC

Provider	2017	2018	2019
NUPAS		10.8%	29.2%
Marie Stopes	9.6%	7.8%	8.7%
BPAS		4.4%	0.7%

Note: NHS don't provide this data. First table includes LARC in the overall figure. Second table reports on LARC as a percentage of those provided with contraception.

5.2 Unintended Pregnancies

There were 2,875 births in 2017 in Tameside. There is no local data on unintended pregnancies, however national statistics for the UK suggest that 16.2% of pregnancies are unplanned (based on a survey n=8,869) (Wellings, Jones, Mercer, & Tanton, 2013). Applying that assumption locally would mean 466 unintended births in Tameside in 2017. Given Tameside's higher level of deprivation, this number could be higher.

A high number of unintended pregnancies leads to more terminations (one paper estimated 72% of unintended pregnancies are terminated (Montouchetal & Trussell, 2013)). However, a number of unintended pregnancies are kept, in some cases leading to challenges for parent and child. One study suggested unintended pregnancy leads to increased maternal and parenting stress (Bahk, Yun, Kim, & Khang, 2015), which will have a subsequent impact on mental health. This highlights the importance of good contraception and other preventative interventions such as sex education, to reduce unintended pregnancies, as well as subsequent terminations.

Teenage pregnancies are more likely to be unintended; the teenage pregnancy rate in Tameside is slightly higher than England and North West average, however in three wards (St. Peter's, Hyde Newton and Stalybridge North) the rate is significantly higher than the England average (based on 2014-2016 data).

5.3 Recommendations

Number	Recommendation	Resource Implication	Barrier(s)	Link to Covid-19
10	**Collect consistent data from all providers on demographics of ToP, including if patients accepted contraception and what type. All providers to consistently report previous number of ToPs to help inform data.**	**Minimal**	**Provider compliance, GDPR**	**No**
11	**Review case notes within ICFT to better understand reasons for terminations. Monitor data on post termination support to ensure more geographically dispersed groups are accessing services.**	**Minimal, analytical support**	**Accessing data from ICFT**	**No**
12	**Incentivise/enable termination providers to provide more contraception and LARCs within the ToP contracts.**	**TBC**	**Contract review period**	**No**

6. Contraception

Easy and free access to contraception is important in avoiding unintended pregnancies, which have an avoidable health cost in England of £193m (Montouchetal & Trussell, 2013) (2010 figures), and a wider social cost.

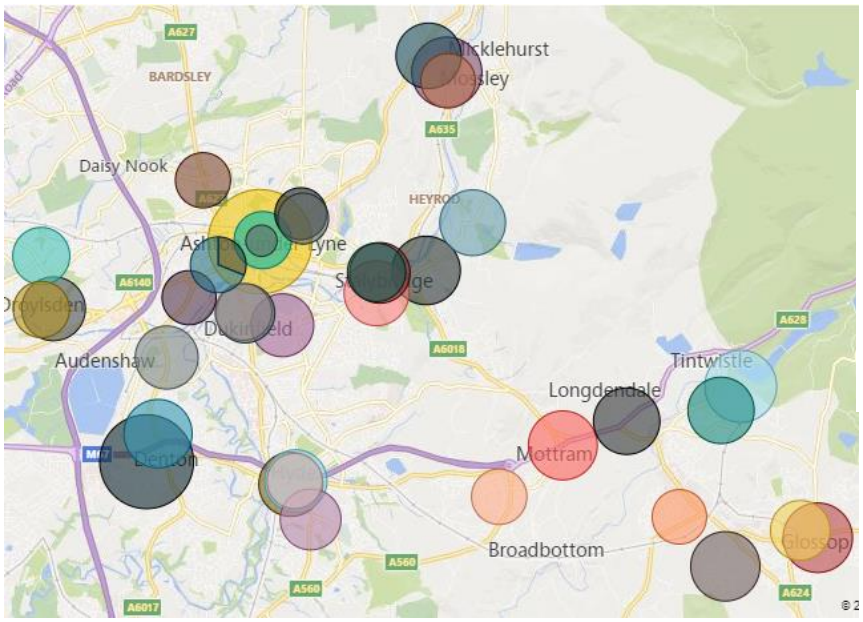
6.1 User Dependent Methods (UDM) of Contraception

(for condoms see 6.2)

UDM includes the oral contraceptive pill (OCP), contraceptive patch, ring and spermicide; 99% of UDM in Tameside is OCP. In 2019 UDM was prescribed for as many as 478 women per 1,000 women aged 16-45 in some GP practices, but as few as 100 per 1,000 in other practices. Neighbourhood rates show variation too, with Ashton having a much lower UDM prescribing that other areas, though this could be due to more Ashton patients using the Orange Rooms for contraception (data not included here, but discussed below).

The price paid for user UDM varies by GP too, potentially due to GPs not always prescribing the most cost effective tablets as a first line. The highest spending GP on UDM is £27.74 per user per year, vs the lowest spending £15.53 (Appendix 4). If all GPs above the average spend of £19.43 were to reduce to the average, over £10,000 would be saved per year in prescribing costs.

Figure 7 – Rates of UDM per 1,000 women aged 16-45, by GP Practice



Neighbourhood	Annual rate per 1,000 Women 16-45
Denton	265.9
Glossop	235.8
Stalybridge	216.9
Hyde	201.8
Ashton	160.8
Total	**211.7**

The specialist sexual health provider at the Orange Rooms in Ashton also provides contraception services. In the last 4 quarters, between 42-44% (1,000 – 1,400) of Orange Rooms consultations are primarily for contraceptive prescribing or advice. Freeing up some of this capacity could help with the wider demand issues experienced at Orange Rooms (section 4.1). 30-40% of prescribed contraception was for oral contraceptive pills; this is a significant amount of non-specialist activity being delivered by a specialist provider.

Feedback from the Orange Rooms staff confirms that they see a lot of residents for oral contraception, injections and LARC removals because patients aren't able to get an appointment at their GP for these services. Some resident's echoed this and said they were frustrated they couldn't get seen at their local GP and had to travel to the Orange Rooms.

Feedback from Healthcare Professionals

Conversations with GPs suggest that a number of practices are carrying out contraceptive pill reviews on the phone to save on resources. While this may lead to less quality conversations about promoting other forms of contraception such as LARCs, it could free up resource and ensure that patients can more easily get an appointment for the pill (which is an issue identified above). Some practices are running protected slots to ensure patients can access contraception, some are not.

Feedback from one patient, found that they had spent decades on the combined pill until one practitioner realised they were in their 50s and hadn't had a conversation with their GP about alternative forms of contraception; eventually a LARC was fitted. If patients are to be reviewed virtually for oral contraception, it needs to be done so in a way that ensures more effective forms such as LARC are offered. A link could be sent to patients for online resources/videos about alternative forms of contraception ahead of their telephone check-ups

A case study from the termination clinic highlighted that a clinical colleague from another department had incorrectly advised a patient to unnecessarily stop their oral contraception to support a CVD condition; this individual then got pregnant and had a termination. Enhancing the understanding of other clinical colleagues about the impact of oral contraception could help with this issues, but based on feedback from the Orange Rooms, previous sessions with acute staff had not been well received. The importance of an up to date understanding of contraceptive options was raised by health visitors and the maternity service too, who requested more regular training as they are well placed to advice new mothers of their choices.

Two of the eight pharmacies who responded to the pharmacy survey expressed a desire to prescribe OCP from their pharmacies. Though this might be difficult for smaller pharmacies to manage, those with scale, such as Crown Point Boots, may be able to incorporate this into their operating model, with PGDs existing in other regions which could be used. Challenges with pharmacist resources could be a barrier to pharmacy initiatives.

Research from Other Areas

Lloyds pharmacy offer the facility to order prescriptions online for private contraception, with patients collecting it from the store. For progestogen only pills (POP, which don't require blood pressure checks), facilities like this could be extended to deliver contraceptive pills through the post so that patients don't have to attend.

Tameside adopting this approach for NHS contraception could help overcome barriers to access for patients. In the short term this could help sustain contraceptive uptake during the Covid-19 outbreak; in the long term it could help improve contraceptive uptake more generally and reduce strain on GPs and shop floor pharmacies.

The cost of funding the delivery will likely be offset by the reduced resource needed in GPs for consultations regarding contraception. It is estimated that there are more than 5,700 users of POP in Tameside. Given each POP requires an annual check-up, costing an average of £30 (NHS, 2019), this is equivalent to £171k per year in staff time. Not all users will want or be suitable for remote prescribing of POP, but if a proportion switch, this could free up primary care resource for other work. As such each PCN may be willing to fund a

central remote POP service.

In Birmingham, a community led model has been commissioned whereby the lead provider (Birmingham NHS Trust) contracts local pharmacies to deliver either tier 1 or tier 2 services (defined below) to ensure an even spread of provision across the region, and reserving specialist capacity for more complex needs. The offer appears not to take advantage of some of the virtual provision seen elsewhere there, but seems to have led to much lower rates of GP prescribed UDM (133 per 1,000 women aged 16-45 for Birmingham CCGs compared to 212 per 1,000 in T&G, or 181 per 1,000 nationally).

Tier 1 commissioned services (100 pharmacies):

- EHC
- Condom distribution
- STI testing kits distribution

Tier 2 commissioner services (70 pharmacies):

- All tier 1 services
- Oral contraception prescribing
- Initiating STI testing
- Treatment for STIs diagnosed elsewhere
- Hep B vaccination
- Initiating contraceptive injections

Recommendations

No.	Recommendation	Resource Implication	Barrier(s)	Link to Covid-19
13	**E-learning and face to face training programme for wider health and social care staff to be developed and mandated to upskill staff about all forms of contraception to help give incidental/MECC advice. To include Health Visitors and Midwifes.**	**Development of e-learning and staff time to deliver face to face (though if outreach worker funded could be utilised for this).**	**Staff time to attend training sessions.**	**No**
14	**Implement a system of remote prescribing and delivery for POP from pharmacies on an immediate and ongoing basis.**	**Resource to set up online service/commission and sustain delivery.**	**Patient awareness. Funding and pharmacy buy in.**	**Yes – preserve access to POP during the outbreak**
15	**Establish interest from pharmacies in prescribing POP and Combined Pill face-to-face from pharmacies, encouraging those with the scale to prescribe it through a contractual agreement, supported by a PGD. Consider commissioning this in a similar way to Birmingham's Umbrella service.**	**Cost of commissioning this with pharmacies.**	**Funding and engagement from pharmacies.**	**Potentially if implemented while outbreak is ongoing to reduce pressure on GPs.**

16	**Ensure that all patients receive advice about alternative forms of contraception at dispensement from the pharmacy in the form of a leaflet, supported by an up to date website (recommendation 6).**	**Cost of leaflets**	**Engagement from pharmacies.**	**No**
17	**Monitor levels of OCP being prescribed by Orange Rooms and target a reduction in this level of non-specialist activity, freeing up resource for improved access for other issues.**	**Zero**	**N/A**	**No**
18	**Where OCP continues to be prescribed face to face, encourage practices to do follow ups on the phone where appropriate to free up capacity for face-to-face appointments. Links to online videos around more effective forms of contraception could be sent ahead of the consultation.**	**Cost saving**	**Engagement from GPs; risk that lose out on quality conversation with patients about alternative contraception.**	**Yes – reduce pressure on GP resource**
19	**Reduce variation in UDM prescribing cost by GP practice by working the top 5 highest spending GP practices.**	**Cost saving - >£10k per year**	**Engagement from GPs**	**No**

6.2 Condoms

Data on condom use within Tameside are not available. Condom use and access to free condoms at GP practices are promoted through the sexual education curriculum.

From discussions with residents, access to free condoms for younger and vulnerable groups has got more challenging. Hattersley residents referenced that they used to be able to access free condoms from the family planning clinic locally, or the GP practice. More condoms were made available to the GP practice, though we were told that people rarely visited the centre to access them. The C-Card scheme, which provided males with access to free condoms, was referenced as being successful in the past, but it was decommissioned. Some GP practices have reported not having received new stocks of condoms for distribution to residents, and therefore residents no longer went for them.

School aged residents who were interviewed challenged whether the GP practice was the right place for condoms to be provided as they wouldn't want to walk in and ask for them and risk being seen by family or friends. Pharmacies and youth clubs were suggested as better locations. Where ever the condoms are, they said it needs to be somewhere young people can visit discretely, without being judged by others. The pharmacy survey (which isn't necessarily representative of all pharmacies) shows that some pharmacies offer free condoms already and for those that don't, there was a desire to provide them for free.

Health visitors also commented that they regularly get asked if they are able to provide free

condoms, but they don't have any they can offer clients and suggested Children's/Baby centres as other good locations for free distribution. They are also asked for pregnancy tests by clients but are unable to offer them. There was a willingness from some pharmacies to supply free stocks of condoms for distribution.

Research from Other Areas

Given the Covid-19 outbreak will reduce visits to places where free condoms are available, remote access may be more useful for residents. Portsmouth, Southampton and Hampshire offer free condoms to be delivered to all resident's homes, which is supplemented by a card so U25s can access them at certain locations too. Up to 16 condoms can be ordered every 6 weeks, funded by the local authority.
https://www.letstalkaboutit.nhs.uk/contraception/condoms-by-post/

To order online, users could be made to watch a video on how to use them effectively, which may help improve effectiveness, and could be a way of promoting more effective contraception's such as LARCs too.

Recommendations

Number	Recommendation	Resource Implication	Barrier(s)	Link to Covid-19
20	**Develop a plan for how condoms should be distributed as GP provision is not well received. Offer free condoms to pharmacies in Tameside, supported by information on the sexual health website and promotion leaflets (see section 4.2).**	**Cost of e.g. 10,000 condoms and their distribution**	**Corporate resistence from pharmacies as could lead to reduced private sales.**	**Yes – could ensure residents can access contraception if the outbreak has reduced their income or reduced their ability to access the pill/LARC.**
21	**Provide free condoms and pregnancy tests to health visitor team for distribution. Consider children's and baby centres as other locations for distribution.**	**As above**	**None – this was a suggestion by the health visitor team.**	**Yes – could ensure residents can access contraception if the outbreak has reduced their income or reduced their ability to access the pill/LARC.**
22	**Set up a remote delivery service for free condoms similar to the one in the South of England, whereby condoms can be posted to residents on request.**	**Purchase of large volume of condoms; distribution and marketing costs.**	**Promoting this to residents and ensuring it isn't abused.**	**Unlikely – take too long to set up**

6.3 LARC (excluding contraceptive injection)

Evidence from NICE suggests that LARC methods of contraception are by far the most reliable, with a typical unintended pregnancy rate of less than 1%, compared to user dependent methods such as oral contraception pill (8%) and male condoms (15%) (National Collaborating Centre for Women's and Children's Health, 2005).

From January 2019 to December 2019 1,053 LARC devices were fitted by GP Practices in Tameside, costing £73k in devices, plus a further £55k in LCS (locally commissioned service) fees paid to GPs to fit them. An additional £15k was paid to GPs to remove 507 implants during that time period. A further 1,064 devices were installed by the Orange Rooms as part of their block contract during 2019; Orange Rooms removed 664 devices.

While Tameside's LARC rates compare well to other authorities in GM they are below the England average (Appendix 5), there is a geographic variation in LARC provision which could be driven by patient demand, but is also likely to be linked to whether GPs provide LARC in that area.

There are GPs in each neighbourhood who offer each type of LARC, but when practices that fit less than 1 per month are excluded, provision is much lower, particularly in Hyde for implants (only 3 practices respectively) and across the borough for IUS and IUDs (between 0-3 practices in each neighbourhood) (Figure 8).

Figure 8 – Number of GP Practices that offer LARC in 2019, by neighbourhood

Any GP Practice that has fitted LARC in 2019

Neighbourhood	Implant	IUS	IUD	Total Practices in Neighbourhood
Ashton	5	5	4	10
Denton	5	4	4	7
Glossop	4	3	3	6
Hyde	4	5	5	8
Stalybridge	6	6	6	10
Total	**24**	**23**	**22**	**41**

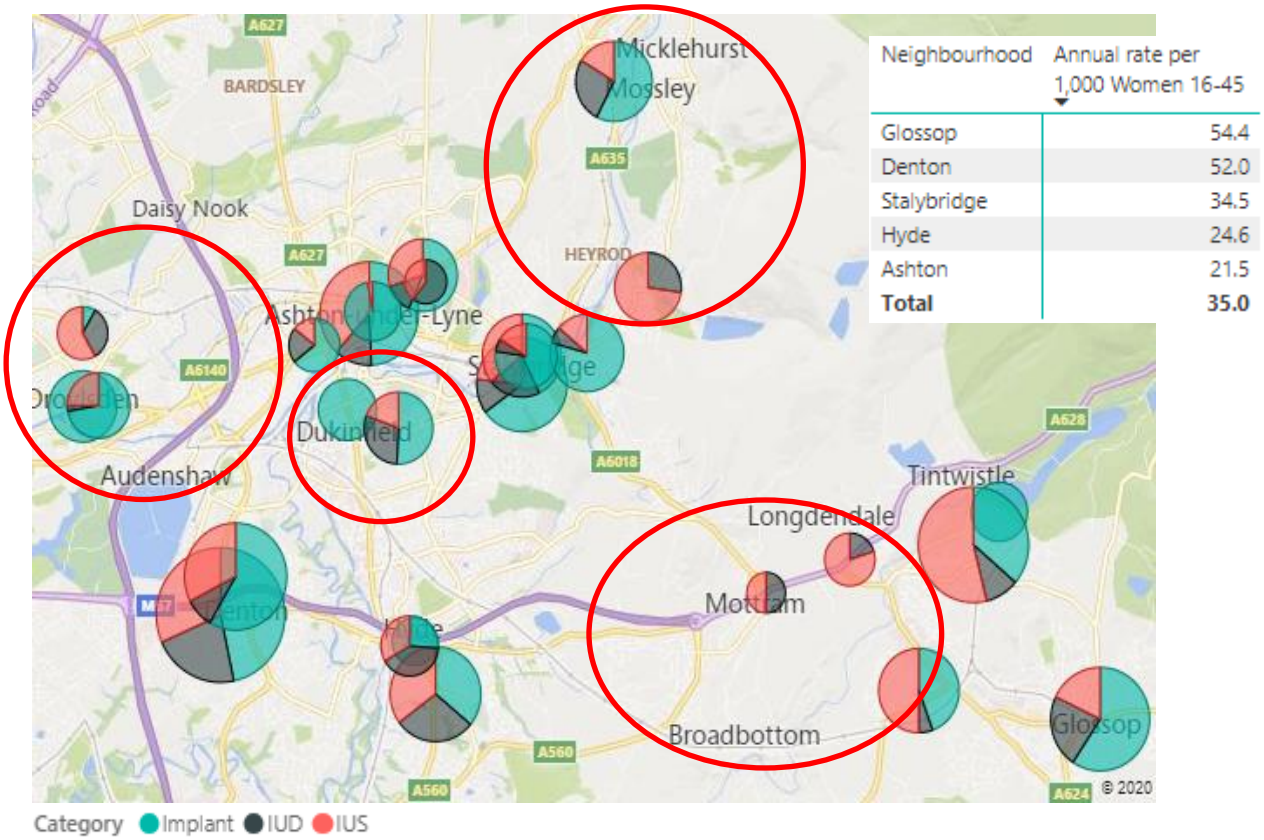
Only GP Practices that have fitted >1 LARC/month during 2019

Neighbourhood	Implant	IUS	IUD	Total Practices in Neighbourhood
Ashton	4	1	0	10
Denton	4	2	1	7
Glossop	2	2	1	6
Hyde	3	2	3	8
Stalybridge	6	3	1	10
Total	**19**	**10**	**6**	**41**

As shown in section 4.1, travel time and travel cost to the Orange Rooms from certain areas in Tameside can present a challenge. This was highlighted as a barrier by residents in Hattersley for LARC insertion and removal, where they can't access LARCs locally. They said they needed easy and reliable to access, local provision for LARCs to be viable.

Figure 9 below shows the geographic spread of LARC rates by GP practice in Tameside, with low areas highlighted red. Hattersley is of particular concern, given its isolation from the main towns in Tameside and that the GP there isn't providing LARC. This was raised as an issue by multiple Hattersley residents during the engagement. There was also limited or low provision in the Mossley and Droylsden areas. These data don't include LARCs inserted by Orange Rooms, which we don't have patient's GP/postcode for.

Figure 9 – Map of LARC Rates by GP Practice in Tameside and Glossop, 2019



Neighbourhood	Annual rate per 1,000 Women 16-45
Glossop	54.4
Denton	52.0
Stalybridge	34.5
Hyde	24.6
Ashton	21.5
Total	**35.0**

Source – National Prescribing Data, https://digital.nhs.uk/data-and-information/publications/statistical/practice-level-prescribing-data

Healthcare Worker Feedback

Feedback from the 17 GP practices who responded to the GP survey suggested the following:

- A lack of capacity and time to fit LARCs, low reimbursement by the Council and poor access to training were cited as challenges to increasing the provision of LARC in primary care.
- Training more fitters and providing evening appointments were offered as potential ways of increasing provision and improving access.
- Concerns about side effects, and to a lesser extent waiting times, were cited as the main reasons for patients not wanting to use LARCs; though side effect experiences were sometimes anecdotal, communicated through the bad experience of one friend.

- Convenience, not needing to remember, and the duration were the main positives of LARCs cited by patients according to GPs. Emphasising these benefits with the public could improve uptake.

Interviews with GPs and other healthcare workers also raised the following issues/opportunities:

- There is no systematic way of reporting how long IUD/implants have been in situ and to see who has still got an implant/IUD still in so they can be proactively contacted for removal/replacement. This could reduce unintended pregnancies if old devices are replaced in a more timely manner.
- A database of trained fitters doesn't exist so there is no way of knowing how many current and former trained fitters there are in the Tameside system.
- There is a need to train midwife fitters on the labour ward to improve LARC uptake throughout the pregnancy pathway.
- Given the lack of a financial incentive to perform LARC, and the financial cost to individual GPs and nurse practitioners of maintaining accreditation, the numbers of trained staff have reduced. Training courses need to be made available for practitioners free of charge, including nurses and midwifes, and remuneration for fitting LARCs needs to increase.
- Each town in Tameside has a GoToDoc Out of Hours (OOH) Hub at a weekend that is staffed with a receptionist, nurse and GP. These hubs are currently not providing sexual health services, but could potentially do this to allow for coils/implants to be fitted at weekends and emergency coils/EHC appointments, thereby improving access. This would result in only limited extra costs as the overheads of the clinic are incurred anyway through the OOH service. Free condoms could be promoted at these sites at a weekend too.

Health visitors feedback that many women they see have had no conversations about post birth contraception before they see them and that post birth conversations with GPs at 6-8 weeks are now brief and often don't go into detail on contraception. In discussions with the lead gynaecology and obstetrician at ICFT, it became apparent that upskilling of midwifes on the birthing unit to be able to fit LARC at the time of birth would help a number of particularly vulnerable patients and support a reduction in repeat pregnancies. Upskilling the midwifery team and wider workforce to have more informed conversations about LARCs would also help increase numbers through advice/MECC interventions (the health visitors raised the importance of training too).

As a result of this HNA we now have a database of monthly primary care prescribing data and can see how prescribing trends are changing across Tameside. This could be expanded to include Orange Rooms data if that were shared at a more detailed level (GP practice of service user, service users age and gender) to help monitor uptake across the region.

Economics of LARC

Conservative modelling suggests that increasing LARC provision has large social and economic benefits, and cost effectiveness is particularly enhanced when appropriately delivered by nurses. It is estimated that increasing LARC by 10% would cost £63,945 over three years (based on current remuneration), but yield benefits of £150k in reduced

maternity, abortion and miscarriage costs, plus wider social care savings of more than £250k (Appendix 6).

Analysis of rates paid to GPs for LARC insertion and removal (appendix 7) supports concerns raised by GPs about remuneration, showing that Tameside payments are comparatively low compared to other GM regions. Tameside is the 3rd lowest payer for IUD/IUS across GM, largely as removals are not paid for (Tameside pay £89.90 for insertion (to include removal) compared to a GM average of £106.15). And for Implants, Tameside is the lowest payer in the GM region, paying a combined £57 for insertion and removal compared to the GM average of £113. Based on current activity levels, increasing the LARC LCS to the GM average would cost an additional £54k per year.

Economic analysis from Bayer and others suggests that nurse provision of LARCs, particularly implants, is much more cost effective; promoting nurse provision as the default could mean the required increase in tariff wouldn't need to be as high.

By not paying GPs for IUS/IUD removal, data in EMIS is less accurate on how many IUS/IUDs have been removed, meaning it is difficult to know how long they have been in situ for. If LARCs are removed at the Orange Rooms, those data doesn't always get entered on to EMIS, so there is no up to date record of whether someone does/doesn't have a LARC in situ.

Resident Feedback

The main challenges raised by residents around LARCs were as follows:

- Residents cited a number of friends or family members' poor experience with LARCs as off putting, for example bleeding or weight gain. In reality these examples can occur, however only in a minority of cases; awareness raising and education of the likely side effects may help dispel myths around LARC usage with residents.
- Residents can't take their children with them if they have an implant - this is another barrier to access.
- Multiple residents cited examples of delays in getting LARCs removed or replaced as they couldn't get an appointment in primary care, or their GP had stopped providing the service which discouraged them and/or their family from having LARCs fitted in future.
- Not all residents were in a position to travel to the Orange Rooms to get a LARC device removed/replaced. For those that discussed this, the lack of access has discouraged them from having a LARC again, in some cases telling family members to not have one either.
- Easy access to support and maintenance of a LARC was highlighted as a key point, and access to support may help with some of the side effect fears highlighted above. These issues aren't unique to Tameside; an example cited of a resident's daughter who was experiencing pain from her coil, was that it took her a number of days to get access to coil removal in Manchester and she was eventually told to go to A&E if she couldn't wait. Given the fear of side effects, offering reliable access and support with any LARC issues could help mitigate this barrier.

A set of patient rights/criteria may be needed to ensure that women have enough trust in the system to get LARCs going forward. These rights (which weren't discussed with residents) could include, for example:

- A woman should always be able to have a LARC fitted within 2 weeks.
- A woman should always be able to have a LARC removed within a week, urgent appointments with 48 hours.
- 90% of woman shouldn't have to travel more than x miles to get their LARC fitted, with GPs seeing each other's patients to accommodate this.

Resident Case study

- Lady in her 50s who was experiencing discomfort with her coil and needed a check-up.
- GP practice told her she would have to wait 2 weeks for an appointment so she travelled to the Orange Rooms and was treated.
- The lady had been on the combined pill until she was 50 with no conversation about LARCs prior to that despite the health impacts of long term combined pill use.

Learning

- Need for appointments locally to support/maintain LARC devices for patients,
- Need for more conversations with patients in primary care about alternative forms of contraception and upskilling of staff to support this.
- Potential to report on patients from EMIS who have been on oral contraception for extended periods so they can targeted for LARC promotion.

Practice from Other Areas

Both Liverpool CCG and GoToDoc in Stalybridge operate a hub and spoke model where they accept referrals from other GPs for LARC appointments. Implementing this model across Tameside could ensure that each neighbourhood has sufficient capacity for residents to access a full range of LARC devices (implants, IUDs, IUSs, with access to follow up support), and would give each hub site the scale to fit LARCs efficiently, rather than one or two patients a month. GoToDoc also triage all patients virtually and have an online video about LARC to help patients understand the procedure – this has helped success rates when patient attend the clinic for LARC procedures.

One of the drawbacks of a model like this is that by centralising LARC capacity in a few areas, access could be reduced in other locations. Therefore, hub sites would be needed in the following places so local residents could access without having to travel longer distances, which would decrease demand:

- Ashton
- Hyde
- Stalybridge
- Hattersley
- Mossley
- Denton
- Droylsden
- Mottram

These sites could be operated by just a few practices, such as GoToDoc, but with sufficient outreach capacity to deliver clinics in each location. Learning from Liverpool and Stalybridge suggest IT and information governance challenges are not insurmountable, and as long as primary care remuneration is sufficient, GP practices were interested in running as a hub site

Recommendations

Number	Recommendation	Resource Implication	Barrier(s)	Link to Covid-19
23	**Review the pricing system for LARCs and move in line with GM pricing structure; consider a slightly lower price for implants if delivered by nursing staff. The increase in IUD/IUS price should be made to the removal of devices to ensure data is collected going forwards.**	**£54k/year**	**Funding source**	**No**
24	**Practices to adopt virtual triage of LARC fitting to reduce resource requirement, using online videos to help explain the procedures.**	**Cost saving as reduces DNAs or LARC fitting appointments where patients refuse consent.**	**GP engagement**	**Yes – free up practitioner capacity**
25	**Organise an annual free training programme in Tameside to allow staff to be trained from primary and secondary care in LARC fitting and contraceptive injection, specifically targeting midwifes.**	**TBC**	**Funding source and time for staff to attend.**	**No**
26	**Work with each PCN to ensure that at least one practice in each of the areas highlighted above delivers all three types of LARC and that they are willing to accept referrals from other practices in their close vicinity. If appointed, an outreach worker could assist in certain locations.** **At a weekend, utilising the GP hubs that are open in each town to provide OOH LARC fitting/removal/support.**	**10% increase of LARC will lead to health economy net benefit of £108k over three years.**	**Funding source and time for staff to attend.**	**No**
27	**Incorporate LARC into the wider health system staff training (recommendation 13) to improve knowledge and advice to patients.**	**Development of e-learning and staff time to deliver face to face (though if outreach worker funded could be utilised for this).**	**Staff time to attend training sessions.**	**No**
28	**Establish principles for LARC for patients and primary care agree to in terms of how long patients should have**	**TBC – extra slots to allow**	**Funding source – engageme**	**No**

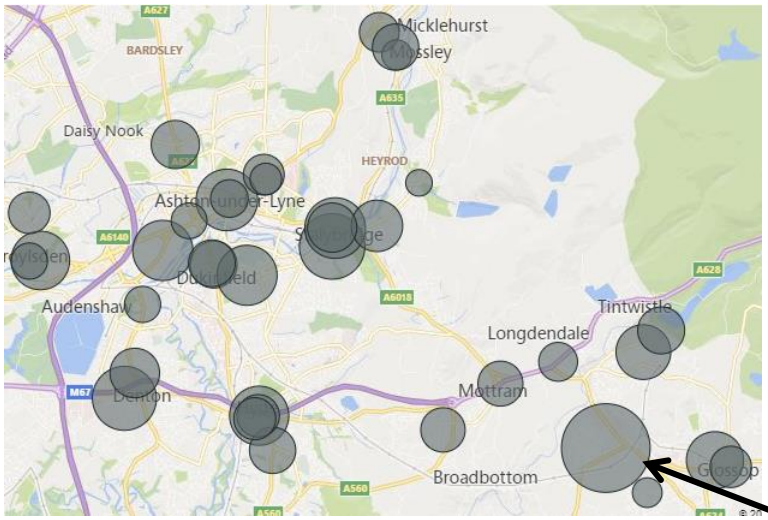
	to wait for an appointment for new fittings, removal or support.	**access to improve**	**nt from patients**	
29	**EMIS report to identify patients who have been on OCP for extended periods, particularly where this is contrary to clinical guidelines.**	**Minimal**	**GDPR**	**No**
30	**Incentivise GPs through the LARC LCS contract to have more detailed conversations post birth about alternative forms of contraception.**	**Could be included within the price adjustment for LARC in recommendation 22**	**GP engagement**	**No**

6.4 Contraceptive Injections

The contraception injection is an effective form of contraception when injection protocols are followed, usually involving an injection every 13 weeks. Women usually have to visit their healthcare provider 4 times a year for their injection.

In Tameside, rates of injection vary by GP practice, from more than 100 women per 1,000 women aged 16-45 in some practices, to below 10 per 1,000 in others, see figure 10. From January to December 2019, 7,632 women had an injection in primary care, supplemented by 483 women who were seen at the Orange Rooms for injections. It is estimated that approximately 2,000 women in Tameside and Glossop are using the contraceptive injection (8,000 injections divided by 4 times per year).

Figure 10 – Contraceptive Injection Rates by GP in Tameside and Glossop 2019.



Neighbourhood	Annual rate per 1,000 Women 16-45
Denton	48.7
Stalybridge	45.4
Glossop	43.8
Hyde	43.0
Ashton	34.6
Total	**43.0**

Cotttage Lane Practice, Gamesley

Feedback from Healthcare Professionals

At a discussion with health visitors, it was raised by health visitors that many women used to get the injection while still on the labour ward to cover them for the first three months; this doesn't happen as often now due to the speed of discharge from the ward. The potential for

health visitors to offer the contraceptive injection was highlighted. This would allow mothers to access contraception quickly post birth, given appointments take place in the first few weeks, and would help increase access given the current challenges in offering contraception while on the labour ward. There were some barriers to health visitors delivering this in terms of training and accreditation, but the actual drugs could be prescribed by the GP and collected by the health visitor or patient if required.

Feedback from Residents

The main feedback from residents relating to contraceptive injections were that they struggled to get their appointments at the appropriate intervals to maintain their 13 weeks regime. Some GPs were unable to offer an appointment more than a week in advance, and then when patients rang back, all appointments had then gone. This feedback was reiterated by colleagues from the Family Nurse Partnership too. The delay in re-injection leads to periods where patients are not covered, leading to increased chance of unintended pregnancy. Some women were forced to go to the Orange Rooms to ensure they didn't miss an injection, at extra time and expense, but others will not have made this journey and may have been at risk of pregnancy.

Research from Other Areas

A possibility, that may have even more potential during the Covid-19 outbreak, is for women to self-administer their contraceptive injection. Not only would this reduce demand on under pressure primary care services, but it would support social distance policies that are in place at the time of writing.

Sayana Press is licenced for self-administration and the drug cost is similar to Depo-Provera, however the postage would make it more expensive. Savings will be through primary care though in reduced appointments required. From January to December 2019 there were more than 7,500 appointments for contraceptive injection in primary care in T&G. Assuming each appointment costs an average of £30 (NHS, 2019), this is equivalent to £225k per year.

Videos on how to self-administer are available (here) which could be provided with the injection. The Faculty of Sexual and Reproductive Health in the UK has endorsed self-administration using Sayana Press. Though self-administration won't be suitable for all, when supported by a text reminder system and access to virtual consultations where needed, it could be effective, improve access and convenience and reduce spend.

Recommendations

Number	Recommendation	Resource Implication	Barrier(s)	Link to Covid-19
31	GPs to offer long term appointment slots to patients on contraceptive injection for their repeats so they are reassured that they will be able to keep to their regime.	Potentially, if it means more urgent resource is needed.	Change to how GP practices use/plan their capacity.	None

32	Start to offer patients self-administered Sayana-Press by post to reduce demand on primary care and specialist services.	Cost saving – save primary care £225k in appointment time, less the cost of postage and administering the system.	Contractual arrangements and logistics. Potential supply problems as demand will increase during the outbreak.	Yes – would reduce need for face to face appointments and maintain contraception during the outbreak.
33	As part of the wider training offer, train Health Visitors so they can offer contraceptive injections to new mothers in the community. Work with maternity services to increase access on the delivery ward.	TBC – need to understand training and accreditation cost	Health Visitor capacity to attend training	None

6.5 Emergency Hormonal Contraception (EHC)

There are two primary types of EHC, Levonelle and Ellaone, which can be accessed in the following ways:

a) Prescribed by patients GP and dispensed by a pharmacy for free
b) Prescribed and dispensed by a pharmacy for free (pharmacy must be signed up to the LCS for this service; pharmacy receives consultation fee of £10.00 plus a £5.20 reimbursement cost for Levonelle and £14.05 reimbursement for Ellaone).
c) Prescribed and dispensed for free by Orange Rooms.
d) Private purchase from a pharmacy (approximately £24 per dose).

Depending on when EHC is taken relative to sexual activity and time in the menstruation cycle, effectiveness could be as low as 40%. A contraceptive coil is more effective (and long lasting) when fitted as a form of emergency contraceptive, but anecdotally this is relatively rare in primary care due to the lack of capacity at short notice to fit devices.

2,150 prescriptions of EHC were issued in T&G during 2019 by pharmacies and GPs. 21% of this was prescribed through 39 different GP practices in T&G, 79% of EHC through 22 different pharmacies.

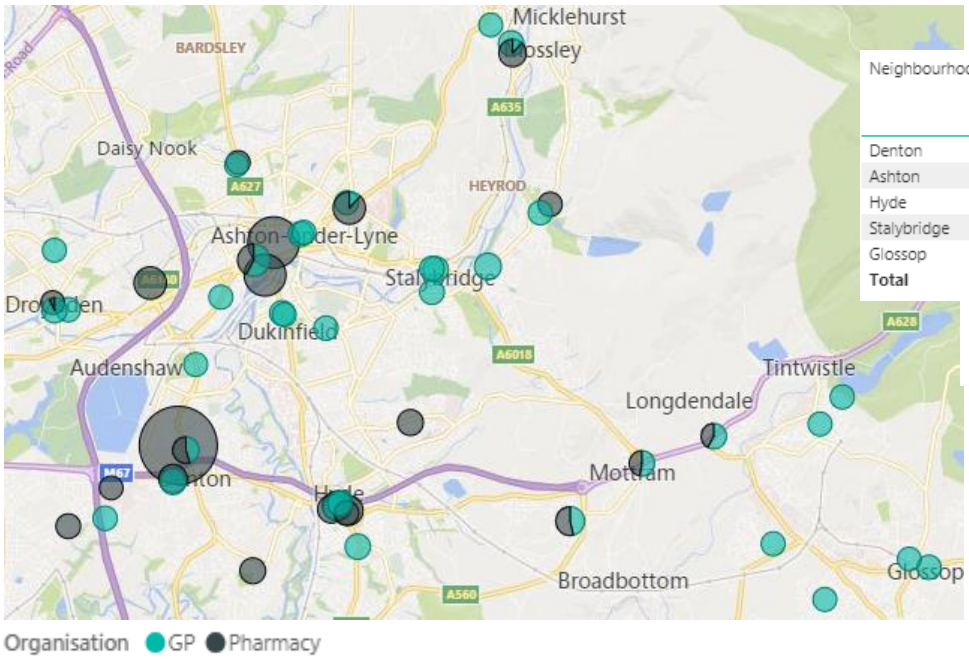
There are however 58 pharmacies in Tameside, meaning only 38% prescribed EHC during 2019; only 8 (14%) prescribed it on average more than once a week (no Glossop data available). 49% of the total EHC prescribed during 2019 was prescribed at just three pharmacies (Boots Crown Point, Boots Ashton (Ladysmith) and Asda Ashton). Boots Crown Point prescribed 27% of all NHS EHC during 2019. There is a particular lack of pharmacy provision of EHC in Stalybridge (0 prescriptions in 2019) and Droylsden (2 prescriptions in 2019.

A further 354 patients attended the Orange Rooms for EHC during 2019, 13% of whom were fitted with a contraceptive IUD.

Figure 11 below shows the spread of EHC dispensed by pharmacy across Tameside, with pharmacies highlighted in black, and GPs in green. Outside of Ashton and Denton, NHS EHC provision in pharmacies or GPs is very low. Discussion with residents and staff suggest this could be down to:

1. A lack of resident understanding of where EHC can be accessed for free
2. Pharmacies not being able to offer EHC at all times of the day due to a limited number of pharmacists having completed EHC training – this could be linked to the level of remuneration received by pharmacies (£10 per consultation). Residents offered examples of young people buying EHC privately from their local pharmacy as they weren't able to access it for free (even though that pharmacy is in the LCS to do so).
3. Resident's reluctance to discuss sexual health with GPs and difficulty in accessing appointments quickly.
4. School students weren't sure where and how they could access EHC. They advised they needed an "easy to access" website with details on, supported by leaflets in school, (see recommendation 6).
5. Out of area patients no longer being able to obtain EHC has reduced access for Tameside residents when they're outside of Tameside e.g. for work.
6. Cost was also highlighted as a barrier where their local pharmacies don't offer EHC for free (e.g. Stalybridge).

Figure 11 – Map of the volume of EHC dispensed for free in 2019 by GP and pharmacy



Neighbourhood	Pharmacy Volume	GP Volume	Total Volume	EHC Rate per 1,000 Women 16-45
Denton	683	78	761	96.5
Ashton	706	95	801	93.5
Hyde	254	116	370	29.6
Stalybridge	53	135	188	24.6
Glossop	0	30	30	5.2
Total	**1696**	**454**	**2150**	**50.8**

Note – Glossop pharmacy data not available

Other challenges relating to EHC were raised through consultation with residents and staff:

- A number of women presented for termination having taken emergency contraception but were apparently not aware of the potential low effectiveness (as low as 40%) – effectiveness could be made clearer through education and awareness.

- Challenges with accessing pharmacies at certain times of the day. Figure 12 shows the number of pharmacies that are open after 6pm, or on a weekend.
- In the resident survey, of the 9 people who said they'd received EHC, 5 said they hadn't received any advice about other forms of contraception, suggesting effective forms of contraception aren't being promoted effectively.
- Training and accreditation was a barrier for more pharmacists being able to prescribe EHC. Increasing the number of trained pharmacists would help ensure consistent coverage throughout the day and make coverage less pharmacist specific.
- Some pharmacists thought it would be useful to be able to offer free condoms, a free pregnancy test and daily oral contraception in their pharmacy, as well as EHC.

Figure 12 – Access to Pharmacies in Tameside

Total Number of pharmacies in Tameside	36	
Number of pharmacies open till 7pm or later on a weekday	5	Ashton *2, Denton *2, Hyde
Number of pharamcies open on a Saturday	29	
Number of pharamcies open after 7pm on a Saturday	4	Ashton *2, Denton *2
Number of pharamcies open on a Sunday	6	Ashton *3, Denton *2, Hyde

***Note**, both pharmacies in Mossley close on a Sunday, one opens on a Saturday till 5pm; no late opening in the week.*
The pharmacy in Hattersley opens for 3 hours on a Saturday morning, is closed on a Sunday and closed at 6pm on a week day.

Research from Other Areas

Awareness of how to access EHC is clearly an issue for residents. Lloyds pharmacy are completing virtual consultations via mobile app or website, with pharmacists confirm details over the phone and patients collecting EHC on the same day. A similar model to this could be adopted in Tameside to ensure that access to EHC improves, particularly during periods of extended isolation linked to Covid-19. Patients could ring the pharmacy or book a slot online for a virtual appointment to talk through questions and EHC could either be collected, or even posted out 1st class for delivery the next day. Pharmacies with existing infrastructure to dispense online could be supported to do this for NHS patients. See https://onlinedoctor.lloydspharmacy.com/uk/morning-after-pill
This offer could be advertised through the updated website materials available (recommendation 6).

Recommendations

No.	Recommendation	Resource Implication	Barrier(s)	Link to Covid-19
34	**Include and promote information about where EHC can be accesses as part of Tameside**	**Minimal**	**Access changing quickly during the outbreak**	**Yes – improve information about where**

	website and leaflet offer (recommendation 6).			**to access EHC during the outbreak**
35	**Initiate feasibility work around posting EHC to patients who request it online, as per Lloyds pharmacy for private patients.**	**Commissioning cost to pharmacies TBC**	**Funding and engagement from pharmacies**	**Yes – could reduce time in pharmacies for patients**
36	**Review the decision to not make EHC available to out of area patients in pharmacies - Tameside likely to be a net payer for this, but if it reduces unintended pregnancies then worth funding Manchester for additional activity.**	**Funding to pay to Manchester or other CCGs where Tameside residents access EHC – use historic data to estimate this**	**Funding**	**Yes – potential to improve access to EHC during the outbreak**
37	**Work with pharmacies in Stalybridge and Droylsden to ensure that there are pharmacies offering EHC.**	**Funding the increase in EHC/pharmacist training**	**Pharmacy buy in**	**No**
38	**Work with pharmacies to ensure that at least one pharmacy in each town is able to offer EHC throughout the day; this may mean supporting pharmacies with the required accreditation and training to ensure EHC can be prescribed consistently.**	**Funding for pharmacist training**	**Pharmacy buy in and time**	**No**
39	**Free condoms and pregnancy tests to be made available at all pharmacies – criteria (Eg. Age) to be agreed.**	**TBC cost of free condoms and test**	**Funding**	**Yes – improve access during the outbreak, especially at a time when people's incomes may have decreased.**

6.6 Contraception - Places with the Most Need

When some of the findings from each section of this report are linked together by neighbourhood, patterns emerge in the following areas. These places should be targeted first in terms of making improvements:

1. Hattersley
    - Has a high termination rate
    - Has a low LARC rate (resident's complained access had been removed)
    - Low contraceptive injection rate
    - Has a low EHC rate
    - Has a low OCP rate
    - Poor geographic access to Orange Rooms

2. Droyslden
    - Low EHC rate
    - Low OCP rate
    - Low LARC rate
3. Mossley
    - Only one practice where LARCs can be fitted
    - High termination rate across two of the practices (Pike/Mossley Medical)
    - Low contraceptive injection rate
    - Poor geographic access to Orange Rooms
4. Dukinfield
    - Higher termination rates at Town Hall and Kings Street Practices
    - Low LARC rates
    - Low OCP rates
5. Ashton
    - Bedford Street Practice has some of the highest rates for OCP, LARC and injections in Tameside; but also has the highest termination rate. Needs more work to understand what is causing this; it is located very near Ashton Medical Centre which sees a high proportion of Ashton's vulnerable homeless and substance misuse population.
    - If you don't include Bedford in Ashton's numbers, OCP and LARC rates are low elsewhere.

6.7 Summary of Findings

- Tameside & Glossop abortion rates are the highest in Greater Manchester and rank poorly nationally.
- There are a number of women having repeat terminations, with most not having LARCs fitted with termination providers.
- Feedback from termination services suggests access to oral contraception is linked to termination rates.
- LARC rates compare well with other areas but high abortion rates suggest higher need within Tameside (ie. LARC rates should be even higher).
- Qualitative findings suggest access to LARC and other forms of contraception is poor, particularly in primary care. Access issues are geographic as well challenges in getting timely appointments. This extends to free condom provision, which is lacking in the borough.
- Qualitative feedback, particularly from younger groups, highlights a need for clearer communication about what contraception is available, where it can be accessed and how people can access it.
- There is potentially a wider role for pharmacies in providing access to contraception locally.

7 Sexually Transmitted Infections (STIs)

7.1 Quantitative Findings

Prevalence

Chlamydia

- Tameside has the third lowest diagnosed rate of Chlamydia in GM and 2nd lowest amongst its statistical neighbour local authorities.
- However, the chlamydia detection rate is below the national average, the worst rate compared to Tameside's 10 statistical neighbours and the third worse detection rate for females and men in GM. Given chlamydia can be asymptomatic, this lower detection rate is a concern and may mean prevalence is underreported.

Gonorrhoea

- Tameside has the highest rate of Gonorrhoea compared to its statistical neighbours (94 cases per 100,000; just below the national average) and the third highest rate in GM.

Herpes

- Tameside's rate of herpes (47 cases per 100,000) is below the national average but the 4th highest in GM.

Syphilis

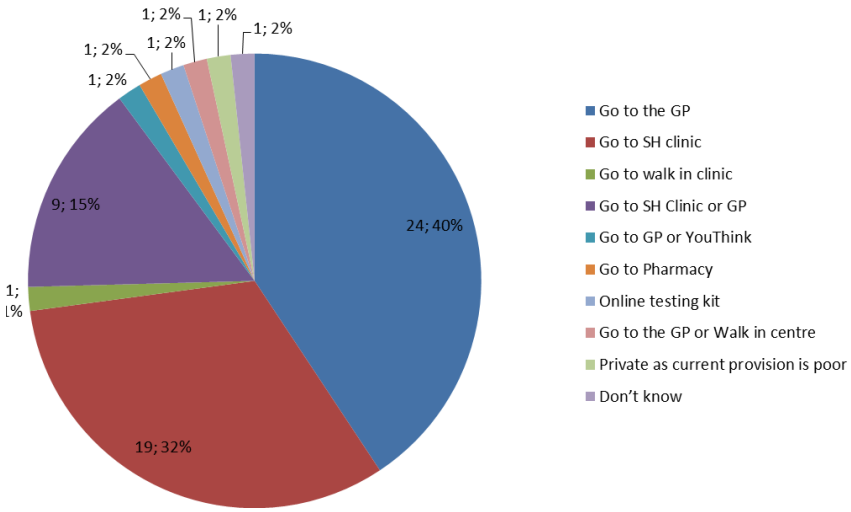
- Tameside has the 7th highest rate of syphilis in GM but below national average.

Testing

Testing for the STIs identified above can be carried out at GP practices or the specialist sexual health provider in Ashton, Orange Rooms. There are home testing kits available for chlamydia and gonorrhoea which can be requested through the Orange Rooms website. Chlamydia testing kits can also be collected from GPs in Tameside, however availability is variable.

Most respondents from the Tameside resident survey stated they would go to see their GP if they thought they had an STI, Figure 13.

Figure 13 – What residents would do if they thought they had an STI



7.2 Qualitative Feedback

There was some feedback from the resident survey and interviews relating to STI testing.

- Access – as raised in other areas, concerns were raised that it is challenging for some residents to access the specialist health provider for testing in term of geography and traveling to Ashton. Concerns were also raised about appointments not being readily available each day and the hours of operation meant residents couldn't access appointments around their work. Some residents suggested walk in appointments would make it easier for them.
- Some patients stated that their GP had told them to go to the specialist provider for testing, rather than taking the tests locally which was less accessible and could cause some to not get tested.
- Delays in accessing results were cited by some GPs, which had led them to retest their patients in some cases.
- The RU clear packs that were distributed to GPs are thought to have been promoted and offered in an inconsistent way, leading to higher uptake of testing in some practices than others.
- Testing samples from GPs – a GP had had a number of samples returned from the lab citing that they were not correctly taken, though to the GPs knowledge they were. This was off putting.
- Residents were not all aware of the ability to access home testing kits. Some had expressed a preference for collecting kits from pharmacies.
- In the school focus group, students aged 16 were unaware of how or where to access testing for STIs.

7.3 Research from other areas

Barrier contraception is the most effective way of reducing spread of STIs; this has been considered above in section 6.2.

In terms of accessing testing, existing research based on surveying university students (de Visser & O'Neill, 2013) suggests that the following influenced whether people would get tested for STIs:

- a desire to comply withothers' wishes for testing
- perceptions of others' behaviour
- shame related to STIs predicted past testing behaviour

Perceived susceptibility impacted the likelihood of getting tested, which was supported by qualitative interview accounts. Stigma/shame and perceived ease of testing were raised as barriers in qualitative accounts also.

A systematic review (Guy, et al., 2011) found the following interventions were effective in improving uptake of chlamydia tests in primary care specifically:

- Provision of a urine jar to patients at registration
- Linking screening to routine Pap smears
- Computer alerts for doctors to prompt asking about testing
- Education workshops and internet based education for clinic staff
- (Just for males) offering a test to all presenting young male clients prior to consultation

NICE's guideline on the prevention of sexually transmitted infections (STI) and under-18 conceptions recommends that people diagnosed with an STI should be provided with support to get their sexual partners tested and treated (NICE, 2020). It is unclear if partners were being testing in Tameside – local data from GPs and sexual health providers should help inform if this is an issue locally.

7.4 Recommendations

No.	Recommendation	Resource Implication	Barrier(s)	Link to Covid-19
40	**Develop a no wrong door policy relating to testing – residents should be able to access testing at their GP, specialist health provider or remotely – whatever they are most comfortable with. Engagement with GPs necessary to understand the support that may be needed for all GP practices to be able to offer testing locally.**	**Potential more strain on GPs for testing**	**GP resource/buy in**	**No**
41	**Promotion of remote / home testing kits to be more widespread and seeks to normalise/destigmatise STI testing. Include links to home testing within the TMBC website and within literature that schools can**	**Minimal**		**Potentially – increase in home testing will reduce face to face contact with health system.**

	access to support PHSE curriculum.			
42	**Work with neighbourhood primary care teams to identify a consistent message across all practices for patients in accessing primary care STI testing which GPs are happy with and will promote in their practices.**	**Minimal**	**GP resource/buy in**	**No**
43	**Website improvements to include section on STIs and where to access testing. This content is to be promoted through schools.**	**Minimal**	**IT support**	**No**

8 Cervical Screening and HPV vaccination

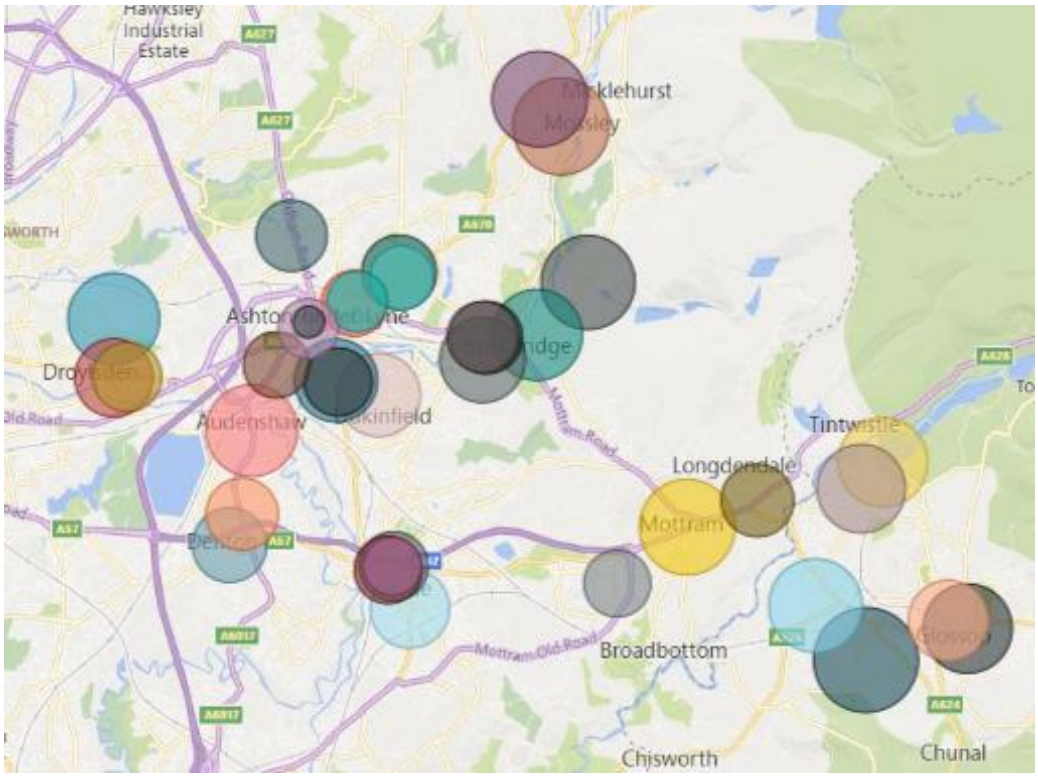
8.1 Quantitative and Qualitative Findings

Cervical screening uptake was 72.4% in 2019 in Tameside, higher than the national average of 69.8% and 4th highest in GM according to PHE fingertips. 2018/19 QOF data suggests 77% of Tameside women have had their screening in the last 5 years, however uptake in some GP practices is as low as 62% compared to 87% in the highest uptake practice; see Figure 14.

Uptake was below 75% in the following practices:

- Ashton GP Service 61.8%
- Donneybrook Medical Centre 70.9%
- HT Practice 71.6%
- Albion Medical Practice 71.8%
- Gordon Street Medical Centre 72.9%
- Ashton Medical Group 73.6%
- West End Medical Centre 73.6%
- Hattersley Group Practice 73.9%
- The Brooke Surgery 74.2%
- Town Hall Surgery 74.3%
- Medlock Vale Medical Practice 74.6%
- Clarendon Medical Centre 74.7%

Figure 14 – map of percentage uptake of cervical screening by GP practice 2018/19



Note, bubble size is relative to size of uptake in that area

Our survey findings suggest that most people (96%) accessed cervical screening at their GP, which supports feedback from sexual health services who acknowledged they now struggle to offer screening as they have a limited number of practitioners and it is no longer formally commissioned.

87% of respondents were highly satisfied or satisfied with the cervical screening service, advice and information. A number of respondents offered feedback on constraints to accessing tests:

- Not having access to childcare caused one person to be overdue for their test.
- Long waits at GPs for appointments and difficult to get an appointment (2 month wait cited by one person)
- Difficulties in getting a female person to carry out the test
- Lack of access to out of hours appointments – this was echoed in focus groups which highlighted how weekend appointment slots would help improve access.

Evening and weekend smear appointments are actually available now through the GTD service; the comments above may suggest a lack of awareness of this offer. Resident discussions, as well as reinforcing the above, also highlighted the need for better information if further subsequent tests were needed and suggested cervical screening should be promoted more widely in their community.

For HPV vaccination, another tool in preventing morbidity and mortality from cervical cancer, uptake in Tameside is good; 92.1% for 2 doses for girls ages 13-14, second highest in GM and above the national average of 83.9%.

The impact of Covid could be significant though given fears in accessing preventative healthcare and it is important to track the uptake of screening HPV vaccination and encourage proactive work from primary care to ensure those who missed their appointments are caught up.

8.2 Learning from Elsewhere

Research exists on primary care interventions that have been successful in increasing cervical screening uptake. A systematic review (Albrow, et al., 2014) found (though only 4 studies were considered) found reminder letters as well telephone reminders were effective in increasing uptake, though it acknowledged programmes weren't doing enough to increase uptake beyond these relatively simple measures.

The review found frequent changes of address, lack of time, lack of healthcare registration, low risk perception and fear of pain and discomfort were key barriers to uptake. Improving awareness and people's knowledge of cervical cancer and the screening process may therefore improve uptake.

8.3 Recommendations

No.	Recommendation	Resource Implication	Barrier(s)	Link to Covid-19
44	**Work with schools in Tameside to understand if and how they currently discuss cervical screening with pupils. Encourage a dialogue to ensure that young people understand the importance of regular screening and taking part in their HPV vaccination.**	**Minimal**	**Schools buy in**	**No**
45	**Equality impact assessment to see if there are inequalities attached to the low uptake groups, particularly relevant given drop in uptake during Covid-19.**	**PH registrar support**	**Data access**	**Yes**
46	**Discuss at primary care neighbourhood forums and understand how cervical screening can be increased, particularly relevant in response to a downturn in uptake post covid.**	**Low – dependant on the comms used**	**GP buy in**	**Yes – increase uptake following low uptake during lockdown**
47	**Work with GP practices with low uptake to understand if they are carrying out reminders and if this can be expanded.**	**PH resource**	**GP buy in**	**Yes – focus on practices with low uptake post Covid**
48	**Ensure cervical screening is included within resident and partner public health communications, perhaps featuring as part of a women's health section in the**	**PH resource**		**No**

	Picture of Health. Work with practices and pharmacies to ensure they display materials promoting screening.			

9 HIV

9.1 Summary of Findings

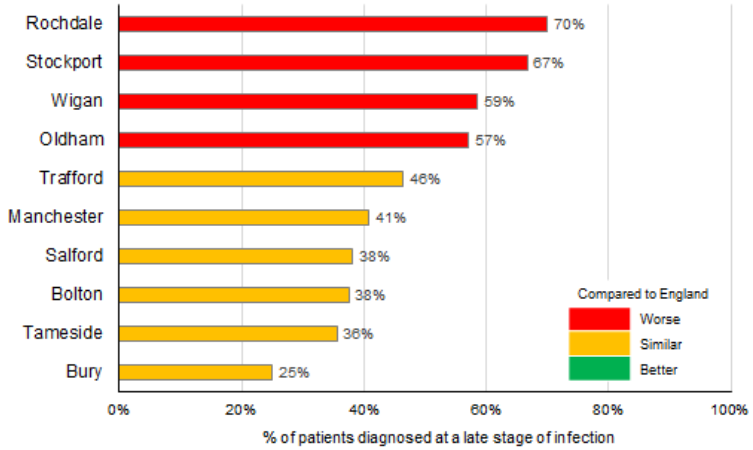
- HIV rates in Tameside are in line with other areas in GM but increasing, though prevalence is thought to be higher amongst heterosexual men.
- Late diagnosis in Tameside is low compared to other GM boroughs, but could be improved.
- Testing for women in Tameside is particularly low, with home testing for all sexes averaging 15 tests per month and varying by LSOA.
- The decision to make PrEP routinely available is a great opportunity to decrease rates of new HIV, but work needs to be done to promote it and ensure access to it is sufficient.

9.2 Quantitative Findings

In 2018 there were 2.07 cases of HIV per 1,000 people in Tameside, which is below the England average (2.37) but in line with the North West (PHE Fingertips). Lower prevalence may not necessarily be a good thing, as there could be HIV in the population which is undiagnosed and therefore more likely to be spread.

Late diagnosis rates of HIV are in line with the England average (Figure 15), however when looking at this by population subgroup, 7 out of the 10 new diagnoses for heterosexual men between 2016-18 were diagnosed late.

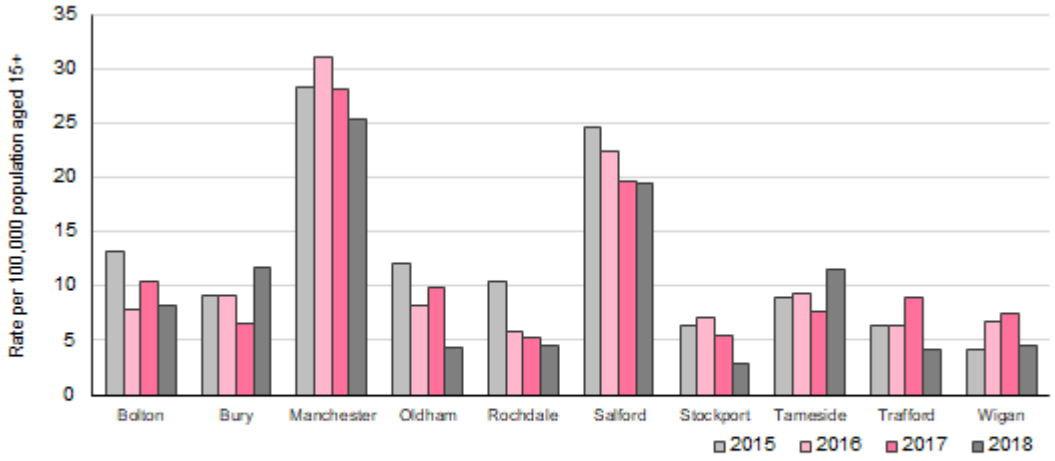
Figure 15 – Late Diagnosed HIV by LA in Greater Manchester, 2016-18



The increasing newly diagnosed rate of HIV in Tameside in 2018 (Figure 16) could be a sign that the virus is spreading, or it could be that existing cases are being identified better; this

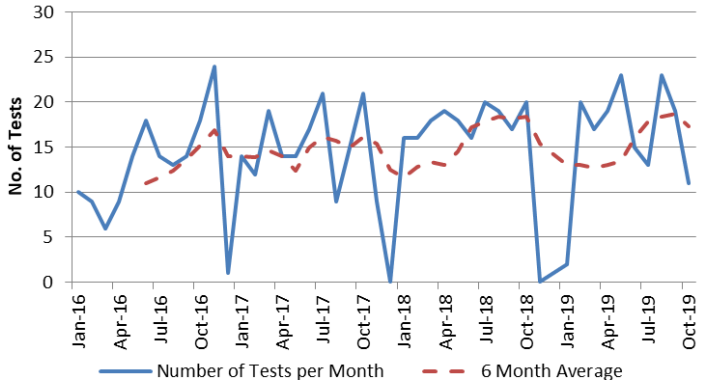
trend should be monitored closely going forward. Testing coverage is inline with England averages for men (76.3% for all men, 89.2% for MSM), however for women it is well below the national average, 40.1% for Tameside, compared to 55.2% nationally. Preventx data for home testing kits shows a small increase in usage over the period 2016 – 2019 (Figure 17), which could explain part fo the increase in new cases seen in figure 16 (Appendix 8 for more details on demographics of home testing).

Figure 16 – Rate of newly diagnosed HIV by LA in Greater Manchester, 2015-18



2018	Bolton	Bury	Manchester	Oldham	Rochdale	Salford	Stockport	Tameside	Trafford	Wigan	GM
Rate	8.3	11.7	25.3	4.3	4.6	19.5	2.9	11.5	4.2	4.5	11.2

Figure 17 – Preventx HIV Home Testing Kit Received 2016-2019



Certain LSOAs in Tameside have higher rates of Preventx testing than others, but the numbers are small overall so shouldn't be over emphasised. From 2015 to 2019 for example LSOA 005C (Ashton, Oldham Rd/Langham St.) had 20 tests at a rate of 12.9 per 1,000 of the population, compared to other LSOAs in the region which only had 1 test submitted over the 4 year period.

5 of the 106 respondents to the resident survey said they were greatly at risk or exposed to quite a lot of risk of contracting HIV based on their current sexual activity, four of whom were straight and one lesbian. These responses suggest an awareness of the risks of HIV,

however, given their responses acknowledged they were at risk based on their behaviour, it is implied that they accept these risks.

9.3 Qualitative Feedback

Feedback from the Orange Rooms suggests HIV prevalence amongst straight men and women compared to homosexuals is higher in Tameside than in other areas of GM. Demand for PrEP has been high since the trial started and it is thought that if PrEP became routinely offered then a lot of clinical time would be needed to manage this. No data were available to understand PrEP usage in Tameside, but the decision on March 15th to make PrEP routinely available is an opportunity for wide spread reduction in new cases of HIV in Tameside. Ensuring easy access to the drug will be the key challenge.

Similar to the feedback around the lack of knowledge of oral contraception in some front line staff, an example was cited by Orange Rooms staff of an individual who had turned up at A&E on a bank holiday as he was concerned he'd been exposed to HIV and was seeking PEP. The individual was told to go to the Orange Rooms, however this was closed as it was a bank holiday. Fortunately the individual knew about the risk of delay in taking PEP post exposure and so travelled to a clinic in Manchester that was open; however this may not have been the case for other service users and shows the importance of patients being treated at the point that they present in the system. Other patients may not have been as aware and may have contracted HIV as a result.

9.4 Recommendations

No.	Recommendation	Resource Implication	Barrier(s)	Link to Covid-19
49	**Better understand practice across Tameside and Glossop in terms of promoting HIV home testing. Are the higher rates in certain areas coincidental, or down to better promotion of testing? Promote home testing across the region to support earlier diagnosis and treatment.**	**Minimal**	**Engaging with primary care and other sources of test promotion**	**No**
50	**Importance of timely access to support if exposed to HIV to be emphasised through wider programme of education with practitioners (make this programme about sexual health generally, as opposed to contraception only).**	**Time of practitioners to engage with this and time to deliver**	**Clinical engagement**	**No**
51	**PrEP usage and new uptake it monitored and promoted through a specific programme of work and governance to support longer term reducing in the number of new cases in Tameside.**	**Minimal**	**Stakeholder engagement**	**No**

10. Other Findings

10.1 Pregnancy Pathway

A number of women at resident and staff engagement sessions raised concerns about the new approach to centralised first appointments at Tameside General, rather than local GPs, on the maternity pathway. While there may be an efficiency gain through this work, there were access concerns for women who struggled to get to Tameside General due to financial, family or other constraints. One example was given of a lady who had subsequently not gone for her booking appointment until later in the pregnancy, which could detrimentally affect their baby's outcomes if lifestyle changes such as drinking or smoking weren't addressed, or if vitamin supplements weren't initiated, for example. The level of support during pregnancy from GPs was said to be variable, partly down to the stretched primary care system.

A further concern was the lack of local post-natal depression support and that each area needed a course or support group locally for mothers.

10.2 Testicular Cancer Awareness

At one group, a concern raised that schools weren't doing enough to raise awareness of testicular cancer amongst students, and that self-checking needs to be promoted more regularly.

10.3 Safeguarding

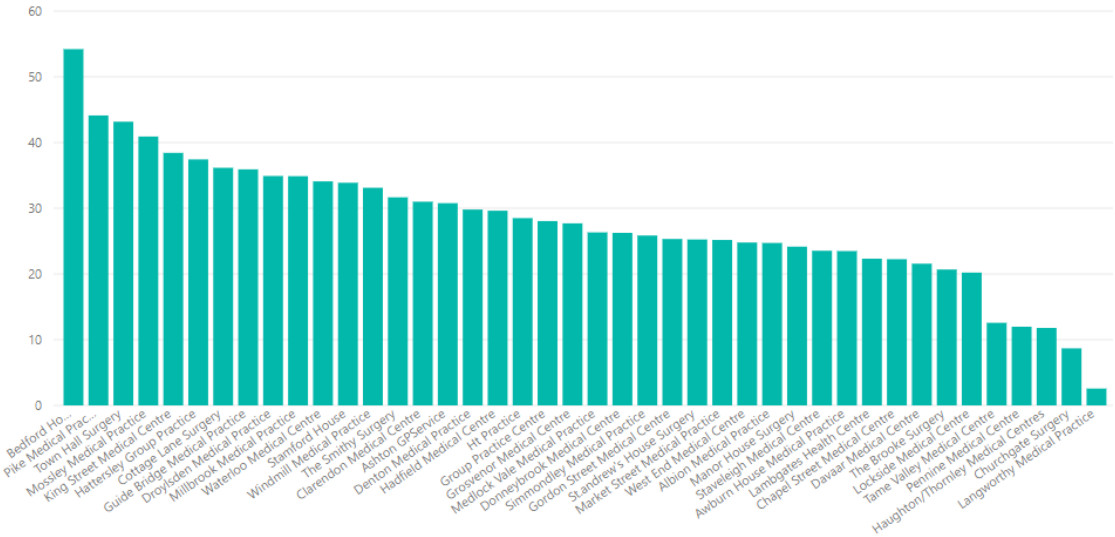
During discussions with Orange Rooms, vulnerable groups safeguarding was raised as an increasingly common. These safeguarding concerns include young people under age 16, people with learning disabilities, some people who have been victim of grooming and domestic violence victim. The clinic follows up on unusual requests for online testing kits - for example young people requesting kits, or bulk ordering of kits to try to understand potential safeguarding issues.

Appendices

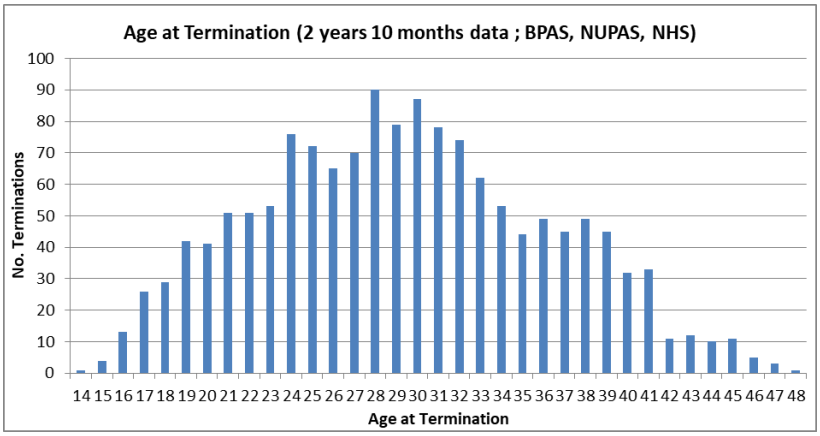
Appendix 1 – Engagement Log: February to April 2020.

- Hattersley Residents Group
- Partnership engagement Network (PEN)
- Various GPs
- Primary care nurses
- Consultant in Obstetrics & Gynaecology at Tameside Hospital
- Youthink Team leader
- The Northern - Specialist Sexual and Reproductive Health provider
- Family Nurse Partnership
- School nurses
- Head of religious education (teacher)
- Pupils
- LGBT Foundation
- Pharmacists
- TMBC LGBT youth worker

Appendix 2 – Termination Rate by GP Practice



Appendix 3 – Termination Rate by Age



Source: BPAS, NUPAS, NHS Termination Data

Appendix 4 – UDM Contraception Cost by User by GP Practice

Practice Name	Annual rate per 1,000 Women 16-45	Estimated Number of Users	GP Drug Cost	Cost per User
Bedford House Medical Centre	488.3	572	£9,955	£17.40
Windmill Medical Practice	420.7	966	£19,775	£20.48
Hadfield Medical Centre	267.7	149	£2,326	£15.60
Pennine Medical Centre	259.7	521	£11,086	£21.29
Manor House Surgery	253.9	590	£11,832	£20.05
Simmondley Medical Practice	252.5	156	£3,196	£20.45
Awburn House Medical Practice	250.7	280	£6,673	£23.87
Denton Medical Practice	246.2	333	£5,625	£16.91
Lockside Medical Centre	242.5	378	£7,141	£18.89
The Smithy Surgery	234.6	171	£3,384	£19.76
Millbrook Medical Practice	231.8	170	£3,493	£20.53
Lambgates Health Centre	229.3	282	£4,766	£16.91
Medlock Vale Medical Practice	221.0	306	£5,960	£19.48
Grosvenor Medical Centre	221.0	246	£4,141	£16.85
The Brooke Surgery	216.7	438	£9,982	£22.78
Pike Medical Practice	215.5	77	£1,676	£21.79
Davaar Medical Centre	212.8	444	£8,608	£19.38
Clarendon Medical Centre	210.0	302	£4,765	£15.78
Guide Bridge Medical Practice	209.2	186	£3,366	£18.06
Haughton/Thornley Medical Centres	199.1	459	£9,914	£21.59
Staveleigh Medical Centre	198.0	242	£4,148	£17.11
Group Practice Centre	188.1	114	£1,935	£17.03
Town Hall Surgery	185.4	103	£2,017	£19.57
St.andrew's House Surgery	180.8	178	£3,066	£17.20
Albion Medical Practice	175.8	296	£5,516	£18.64
King Street Medical Centre	172.2	118	£2,532	£21.41
Droylsden Medical Practice	169.2	149	£4,044	£27.16
Market Street Medical Practice	166.4	181	£3,064	£16.94
Hattersley Group Practice	163.3	172	£2,761	£16.07
Donneybrook Medical Centre	162.1	283	£4,971	£17.59
Waterloo Medical Centre	159.5	83	£1,458	£17.55
Cottage Lane Surgery	158.2	65	£1,057	£16.29
West End Medical Centre	155.5	125	£2,801	£22.32
Mossley Medical Practice	155.2	68	£1,328	£19.45
Stamford House	141.5	130	£2,697	£20.69
Gordon Street Medical Centre	128.2	126	£2,661	£21.12
Ht Practice	115.6	174	£3,362	£19.29
Ashton GPService	49.8	49	£1,249	£25.73
Chapel Street Medical Centre	2.8	3	£44	£14.52
Total	**213.2**	**9,686**	**£188,375**	**£19.45**

Appendix 5 – LARC Rates – Tameside compared to GM

Total prescribed LARC excluding injections rate / 1,000 2018 — Crude rate - per 1000

Export table as image | Export table as CSV file

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	→	522,866	49.5	49.3	49.6
CA-Greater Manchester	–	-	-	-	-
Stockport	→	2,567	50.0	48.1	51.9
Bury	↓	1,638	47.1	44.8	49.4
Bolton	→	2,375	45.3	43.5	47.2
Tameside	↓	1,875	44.9	42.9	47.0
Rochdale	→	1,823	43.7	41.7	45.8
Manchester	→	5,964	42.5	41.4	43.6
Trafford	→	1,824	42.4	40.5	44.4
Salford	→	2,005	37.0	35.4	38.7
Oldham	→	1,624	36.4	34.6	38.2
Wigan	↓	1,877	32.5	31.1	34.0

Source: NHS Digital, NHS Business Services Authority and Office for National Statistics

Appendix 6 – LARC Economic Modelling

Summary of net cost savings across the health and social care system if LARC uptake is increased by 10% over three years.

Description of cost/saving	Costs /savings over 3 years	Comments
GP practice costs	-£22,247	Assuming procedure is carried out by a Band 6 nurse
Maternity and abortion services savings	-£149,163	See table 10 below for breakdown
LCS payments and contraception device costs	£63,945	See table 11 below for breakdown
Social care savings	-£255,311	These cost are mostly national savings to welfare
Cost Pressure/(Saving)	**-£362,776**	Saving

Source: Draft SLT Paper 2019 on increasing LARC Provision

Appendix 7 – Analysis of LARC Rates by LA in GM

Area	Provision	Cost (per patient)						Provision	Cost (per patient)				
		Fit	Removal	Total	Other	Rank (high to low)			Fit	Removal	Total	Other	Rank (high to low)
Bolton	IUD / IUS	£100	£27	£127.00	N/A	2		SDI	£80	£70	£150	N/A	2
Bury	IUD / IUS	£79.92	£21.31	£101.23	N/A	4		SDI	£70	£40	£110	N/A	5
Mchr	IUD / IUS	£80	£20	£100.00	£20	6		SDI	£68	£55	£123	N/A	4
Oldham	IUD / IUS	£80	£20	£100.00	Fup/check £20	6		SDI	£45	£45	£90	n/a	9
Rochdale	IUD / IUS	£81.72	£20.43	£102.15	n/a	3		SDI	£62	£62	£124	n/a	3
Salford	IUD / IUS	£79.90	0	£79.90	£10	10		SDI	£50.00	£50.00	£100	N/A	6
Stockport	IUD / IUS	£81.31	0	£81.31	N/A	9		SDI	£50	£50	£100	N/A	6
Tameside	IUD / IUS	£89.90	£0.00	£89.90	n/a	8		SDI	£27	£30	£57	N/A	10
Trafford	IUD / IUS	£80	£21	£101.00	N/A	5		SDI	£51	£44	£95	N/A	8
Wigan	IUD / IUS	£89.50	*(£89.50) - not in contract	£179.00	£25	1		SDI	£89.50	*(£89.50) - not in contract	£179	£25	1
GM Avg.	**IUD / IUS**	**£84.23**	**£31.32**	**£106.15**	**£18.33**			**SDI**	**£59**	**£54**	**£113**	**£25**	

Source: LARC Expansion Paper, Richard Scarborough

Appendix 8 – Demographics of HIV Home Testing Kits (Preventx Data)