Sexual Health JSNA December 2015
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Overview

Sexual health covers the provision of prevention, advice and treatment and care services around contraception, sexual relationships, sexually transmitted infections (STIs) (including HIV prevention and testing) and abortion. Provision of sexual health services is complex and there is a wide range of providers including general practice, community services, acute hospitals, pharmacies, and the voluntary and independent sectors.

Unintended pregnancy, STIs and HIV are avoidable by changing behaviour. Unlike many other conditions affecting public health, STIs and HIV are transmissible, so the benefits of prevention extend beyond the individual. Good quality prevention work, prompt treatment, and partner notification to reduce onward transmission bring rapid benefits to the public purse, the individual, and the wider community.

The data below relates to 2014 unless otherwise indicated:

STIs

- STIs represent an important public health problem in London as it has the highest rate in England, 65% higher than England as a whole in 2014. However, Kingston has the 12th lowest rate of acute STIs in London (PHE, 2014)

- Re-infection with an STI is a marker of persistent risky behaviour. In Kingston, an estimated 8.9% of women and 10.7% of men presenting with a new STI at a genitor-urinary Medicine (GUM) clinic during the five year period from 2010 to 2014 became re-infected with a new STI within twelve months. This compares to 7% and 9% nationally

- 42% of diagnoses of new STIs in Kingston were in young people aged 15-24 years (compared to 46% in England) (PHE, 2014)

- For cases in men where sexual orientation was known, 33.1% of new STIs diagnosed in GUM in Kingston were among men who have sex with men

- The chlamydia detection rate per 100,000 young people aged 15-24 years in Kingston was 1,749.3 (compared to 2,012.0 per 100,000 in England and 2,178.0 per 100,000 in London).

HIV

- A quarter of people estimated to be living with HIV are unaware of their infection in the UK and remain at risk of passing it on if having sex without condoms. Reductions in undiagnosed infection can be achieved through increasing testing coverage in STI clinics, the introduction and consolidation of HIV testing in a variety of different medical services, in addition to further development of community testing, including self-sampling/self-testing

- The number of people living with diagnosed HIV infection has continued to increase in England, while the number of new HIV diagnoses remains stable at around 6,000 per year in recent years. People diagnosed with HIV late (CD4 count 350 cells/mm^3 within three months of diagnosis -

late HIV diagnosis) have a ten-fold increased risk of death in the year following diagnosis compared to those diagnosed promptly

- In 2014, the diagnosed HIV prevalence rate in Kingston was 2.1 per 1,000 population aged 15-59 years, compared to 2.2 per 1,000 in England and 5.7 per 1,000 in London

- In Kingston, between 2012 and 2014, 30.4% (95% CI 17.7-45.8) of HIV diagnoses were made at a late stage of infection compared to 42.2% in England and 36.6% in London.

Teenage Conceptions and Reproductive Health

- In Kingston, the total abortion rate per 1,000 females aged 15-44 years was 14.8, while in England the rate was 16.5 and in London was 21.8. Of those women under 25 years who had an abortion in that year, the proportion of those who had had a previous abortion was 28.7%, while in England the proportion was 27.0% and in London was 32.3%

- In 2013, the under 18 conception rate per 1,000 females in Kingston was 15.8, while in England the rate was 24.3 and London was 21.8.

Although some elements of sexual and reproductive health (SRH) have improved in recent years, there are important issues that still need to be addressed. Kingston needs to continue to:

- tackle the stigma, discrimination and prejudice often associated with sexual health matters
- work to reduce the rate of STIs using evidence-based prevention interventions and treatment initiatives
- reduce unwanted pregnancies by ensuring that people have quick and easy access to the full range of contraception, and can plan the number of and spacing between their children
- tackle HIV through prevention and increased access to testing to enable early diagnosis and treatment.

There has been major progress in modernising sexual and reproductive health services, with evidence that investment brings health improvement:

- early diagnosis and treatment of STIs reduce the risk of costly complications and onward transmission
- health benefits from people with HIV being diagnosed and starting treatment earlier minimise the use of NHS and social care services
- prevention of unintended pregnancies and control over reproductive choices preserve good mental and psychosexual health.

Introduction

Sexual health covers the provision of prevention, advice and treatment and care services around contraception, sexual relationships, sexually transmitted infections (STIs) (including HIV prevention and testing) and abortion. Provision of sexual health services is complex and there is a wide range of providers including general practice, community services, acute hospitals, pharmacies and the voluntary and independent sectors.

Sexual and Reproductive Health (SRH) and HIV are priority areas within the JSNA and in the Health and Wellbeing Strategy because:

- as of 2014, local authorities have a mandated responsibility to commission comprehensive, open access sexual health services
- the Public Health Outcomes Framework (PHOF), which sets the national and local strategic direction for public health, includes three indicators for sexual and reproductive health and HIV[1]
- improving sexual health services has been identified by the public as one of the three most important public health issues
- given the high rates of poor sexual health due to STIs, including HIV, in London it is clear that sexual health should remain a public health priority. PHE London Region and Centre has made sexual health one of its top five priorities for London.

Health economic benefits

There is strong evidence that investment in sexual and reproductive health and HIV services will reduce future costs to the NHS and to local authority public health budgets:

- prompt access to high-quality sexual health clinical and health promotion services will reduce the onward transmission of STIs and therefore prevents avoidable expenditure
- over £100m[2] in health costs could be saved annually across the country by increasing the use of long-acting reversible contraception (LARC) e.g. coils and implants
- for every £1 spent on contraceptive services, the net gain to the NHS has been estimated to be £11[3]
- the health cost of providing lifetime treatment for people with HIV is increasing nationally by £1 billion each year. Each time a person is prevented from getting HIV, the NHS saves over £350,000. The National Institute of Health and Care Excellence (NICE) estimates that if the recommendations on HIV testing were fully implemented 3,500 cases of onward transmission could be prevented within five years, saving the £18 million per year in treatment costs alone, without taking into account the wider costs or savings to society.
- people whose HIV is undiagnosed are at particular risk of passing on HIV, and those diagnosed late in the course of their infection are more costly to treat. Reducing the proportion of HIV infections diagnosed late therefore offers significant health economic benefits.

Reducing local health inequality

Poor sexual and reproductive health is much more common among people who already experience inequality associated with their age, gender, ethnicity, sexuality or economic status. The relationship between STIs and socio-economic deprivation is probably influenced by a range of factors such as the provision of and access to health services, education, health awareness, health-care seeking behaviour and sexual behaviour. Poor sexual and reproductive health also affects a significant number of people who have other public health problems, in particular alcohol and drug misuse and violence. The stigma still attached to HIV, poor sexual health and/or teenage parenthood worsens such inequalities.

Impact on local societal and economic wellbeing

The local societal cost of poor sexual and reproductive health is significant:

- teenage parenthood reduces the life chances of young people and perpetuates social exclusion
- career paths of women and men older than teenagers may be interrupted by unintended pregnancy
- some STIs, if left undiagnosed, cause long-term and life-threatening complications including cancers
- failure to diagnose HIV infection early leads to avoidable serious illness, avoidable use of social services and NHS services, and early death
- HIV is now a long-term condition thanks to effective treatments. However, in comparison to the general population, the increasing numbers of older people with HIV have higher levels of dependence on welfare benefits and social services as well as higher levels of ill health and co-morbidities (have more than one health condition)

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

- A continuing fall in the rate of births to women under the age of 18
- a reduction in the proportion of people with HIV whose infection is diagnosed late (CD4 count 350 cells/mm^3 within three months of diagnosis - late HIV diagnosis)
- an increase in chlamydia diagnoses among young people aged 15 to 24, to be achieved through screening.

Aiming for and achieving the following additional outcomes would bring significant further benefits to public health:

- giving women of all ages control of their fertility through access to a full range of contraceptive choices and abortion services
- a reduction in new diagnoses of other STIs including gonorrhoea and genital warts.

The significant expertise available in the field of sexual and reproductive health and HIV can be used to support the achievement of local public health outcomes. To optimise these outcomes, Public Health Kingston commissions services that ensure open access to sexual and reproductive healthcare services in a timely manner (within 48 hours of seeking to do so and faster if care is urgent). This means that even people who are not residents of Kingston can access sexual health services here.

The considerable progress already made to date in improving sexual health nationally as well as the areas where work is still to be done are included in Figures 1 and 2 below:

Figure 1: Areas highlighting progress achieved nationally

1. Access to specialist genito-urinary medicine (GUM) services has improved by promoting rapid access to accessible services[1].
2. Teenage pregnancy rates have fallen to their lowest levels since records began[4].
3. The use of more effective long-acting methods of contraception has increased: 28% of community contraception-services users in 2011/12, up from 18% in 2003/04[5].
4. High rates of coverage for antenatal screening for HIV, syphilis and hepatitis B have led to extremely low rates of mother-to-child transmission of HIV and congenital syphilis[6].
5. Access to services has been improved through the expansion and integration of service delivery outside of specialist services, particularly in the community and general practice[7].

6. Developments in diagnostic tests for STIs and HIV have increased screening outside of GUM clinics[8].
7. More Sexual Assault Referral Centres for victims of sexual violence have opened throughout England[9].

Figure 2: Areas where work is still required nationally

1. Up to 50% of pregnancies are unplanned; these have a major impact on individuals, families and wider society[10].
2. In England during 2011, one person was diagnosed with HIV every 90 minutes[11].
3. Almost half of adults newly diagnosed with HIV were diagnosed after the point at which they should have started treatment[12].
4. Rates of infectious syphilis are at their highest since the 1950s[11]. Gonorrhoea is becoming more difficult to treat, as it can quickly develop resistance to antibiotics.
5. In 2011, 36% of women overall, rising to 49% in black and black British women, having an abortion had had one before[13].
6. In 2011, just over half of women having an abortion had previously had a live or stillbirth, indicating that better support is needed to access contraception following childbirth[13].
7. Estimates from the Crime Survey for England and Wales indicate that there are around 400,000 female victims of sexual offences each year and, of these, around 85,000 are victims of the most serious offences of rape or sexual assault by penetration[14].
8. In 2010, England was in the bottom third of 43 countries in the World Health Organization's European Region and North America for condom use among sexually active young people; previously, England was in the top ten[15].

As well as the three Public Health Outcome Framework (PHOF) indicators, the Department of Health produced A Framework for Sexual Health Improvement in England (2013) which highlights the priorities across the life course that require attention nationally.
Public Health Kingston will monitor progress through the PHOF indicators and a wider range of sexual health indicators proposed by Public Health England (PHE), for example those relating to the following:

- measurable key performance indicators for sex and relationships
- 'Making it Work: A Guide to whole system commissioning for sexual and reproductive health and HIV' PHE, 2014
- Strategic framework to improve the health and wellbeing of gay, bisexual and other men who have sex with men PHE, 2014.

An outline of the division of commissioning responsibilities for sexual health are outlined in page 17 of Commissioning Sexual Health services and interventions Best practice guidance for local authorities (Department of Health, 2013).

References of Introduction

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[2]National Cost-impact report: Implementing the NICE Clinical Guideline on Long Acting Reversible Contraception (2005) https://www.nice.org.uk/guidance/cg30/resources/cost-impact-report-194835421 and http://www.nice.org.uk/Guidance/CG30/Evidence
[3] Payne and O'Brien R (2005) Health Economics of Sexual Health: A Guide for Commissioning and Planning. DH fpa (2005) The Economics of Sexual Health
[4] Office for National Statistics, 2013
[5] NHS Contraceptive Services – *England 2011*–12, NHS Information Centre for Health and Social Care, 2012
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[7] 'Integration of STI and HIV prevention, care and treatment into family planning services: a review of the literature', Church K and Mayhew SH, Studies in Family Planning 2009; 40(3): 171–86
[8] Testing Times: HIV and other Sexually Transmitted Infections in the United Kingdom, Health Protection Agency, 2007
[9] Public health functions to be exercised by the NHS Commissioning Board: Service specification 30, sexual assault services, NHS Commissioning Board, 2012
[10] 'Effect of pregnancy planning and fertility treatment on cognitive outcomes in children at ages 3 and 5: longitudinal cohort study', Carson C et al, *BMJ* 2011; 343: d4473
[11] HIV in the United Kingdom: 2012 *Report*, Health Protection Agency, 2012
[12] Sexually transmitted infections in England, 2011, Health Protection Agency
[13] Abortion Statistics*, England and Wales*, Department of Health, 2011
[14] Based on a self-completion module of the Crime Survey for England and Wales using data from the 2009/10. 2010/11 and 2011/12 surveys combined
[15] Health Behaviour in School-Aged Children, World Health Organization, 2012.

Local Picture

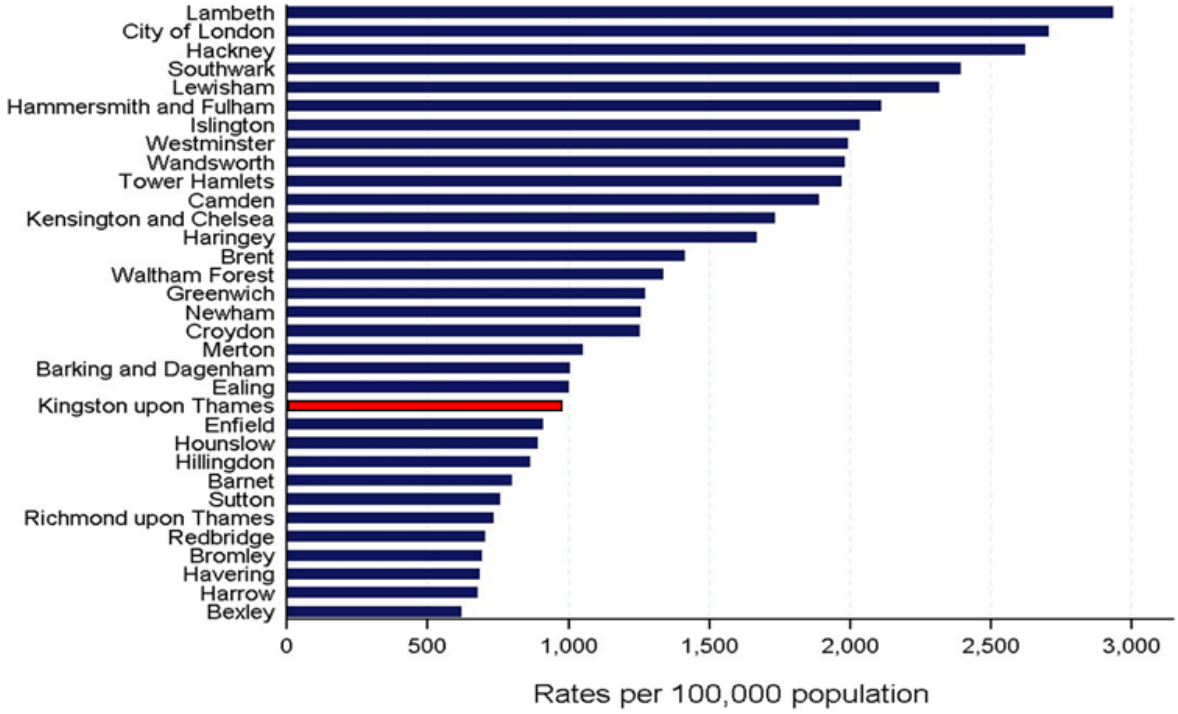
Data below uses 2014 data unless otherwise indicated:

Sexually transmitted infections (STIs)

Key facts (2014 data)

- STIs represent an important public health problem in London, which has the highest rate of acute STIs in England, 65% higher than England as a whole. Of the top 20 local authorities in England with the highest rates of STIs, 16 are in London.
- Kingston has the 12th lowest rate of new STIs

Figure 1: Rates of new STIs in each local authority in London PHEC: 2014

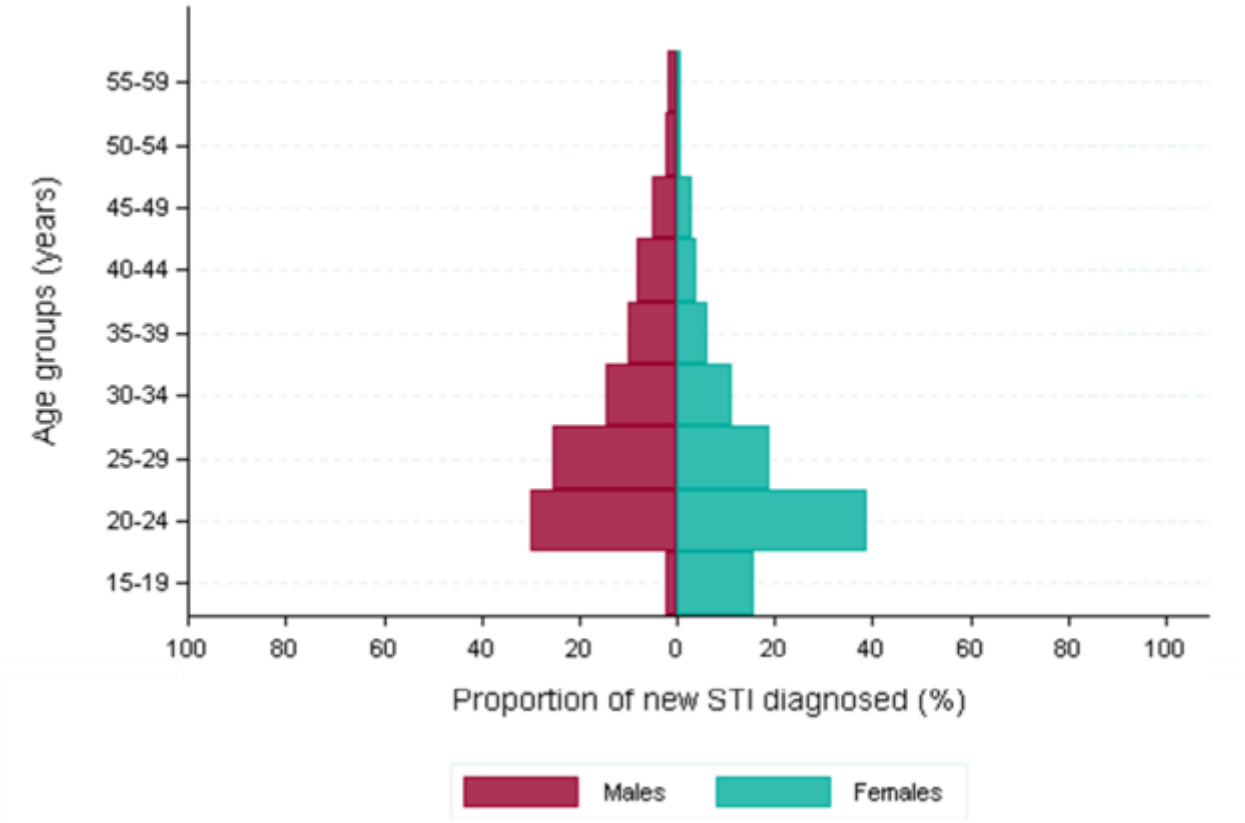


Source: Data from Genitourinary Medicine clinics and community settings (for Chlamydia only) Rates based on the 2013 ONS population estimates.

- Reinfection with an STI is a marker of persistent risky behaviour. In Kingston, an estimated 8.9% of women and 10.7% of men presenting with a new STI at a GUM clinic during the five year period from 2010 to 2014 became reinfected with a new STI within twelve months. Nationally, during the same period of time, an estimated 7.0% of women and 9.0% of men presenting with a new STI at a GUM clinic became reinfected with a new STI within twelve months. In Kingston, an estimated 5.1% of women and 10.0% of men diagnosed with gonorrhoea at a GUM clinic between 2010 and 2014 became reinfected with gonorrhoea within twelve months. Nationally, an estimated 3.7% of women and 8.0% of men became reinfected with gonorrhoea within twelve months
- In London, rates of new STIs vary widely between men and women (1,639 and 1,051 per 100,000 residents respectively in 2014)
- STIs disproportionately affect:

- young people between 15 and 24 years old who experience the highest rates of acute STIs. London residents aged between 15 and 24 years accounted for 38% of all new STI diagnoses in 2014. In Kingston, 42% of acute STIs diagnoses made in GUM clinics were in young people aged 15 to 24. The age profile is shown in Figure 2.

Figure 2. Proportion of new STIs by age group and gender in Kingston: 2014

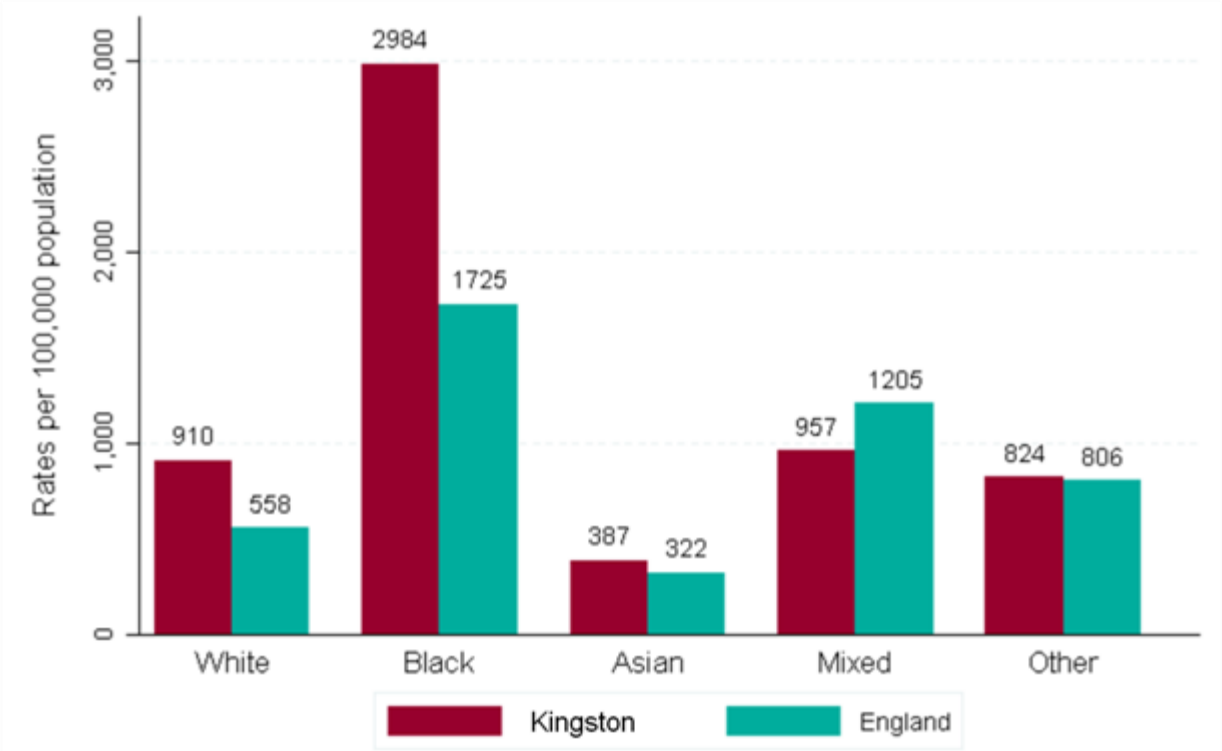


Source: Data from Genitourinary Medicine Clinics.Please note that to prevent deductive disclosure the number of STI diagnoses has been rounded up to the nearest 5.

Young people are also more likely to become reinfected with STIs, contributing to infection persistence and health service workload. In Kingston, an estimated 15.2% of 15-19 year old women and 10.8% of 15-19 year old men presenting with a new STI at a GUM clinic during the five year period from 2010 to 2014 became reinfected with an STI within twelve months. Teenagers may be at risk of reinfection because they lack the skills and confidence to negotiate safer sex. See also the Association of Young People's Health Key Data on Adolescence 2015 for national information on young people.

- black ethnic groups. Black ethnic groups are more affected by STIs than other ethnic groups. Ten per cent of new STIs are in Black Caribbeans, who have the highest rate of new STIs within their ethnic group: 2,896 per 100,000. This is 2.4 times the rate seen in the white ethnic group. However, the white ethnic group has the highest number of new STIs. Please see Figure 3 for Kingston data.

Figure 3: Rates* of new STIs by ethnic group in Kingston and England (GUM diagnoses only): 2014 (underlying numbers have been rounded up to the nearest five)



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

- men who have sex with men (MSM) who suffer from particularly poor sexual health due to STIs and this problem is worsening. Where gender and sexual orientation are known, in 2014, men who have sex with men (MSM) account for 28% of London residents diagnosed with a new STI in a GUM clinic. MSM now represent 90% of those diagnosed with syphilis (a large rise of 54% from 2013 to 2014) and 69% of those diagnosed with gonorrhoea (a large rise of 31% from 2013 to 2014). Furthermore, outbreaks of Shigella spp (previously associated with international travelling) and Lymphogranuloma venereum (LGV) in MSM have been described in recent years, associated with poly-drug use or chemsex. The majority of MSM with LGV and Shigella flexneri are HIV positive. Furthermore, serosorting, the practice of engaging in condomless sex with partners believed to be of the same HIV status, increases the risk of infection with STIs, hepatitis B and C, and sexually transmissible enteric infections like Shigella spp. For those who are HIV negative, serosorting increases the risk of HIV seroconversion as 16% of MSM are unaware of their infection. It is important to consider the cumulative and interrelated impacts of the inequalities across the life course that are particular to men having sex with men. This information reflects the national information.

Chlamydia

The National Chlamydia Screening Programme (NCSP) in England was established in 2003 with the following objectives:

a. Prevent and control chlamydia through early detection and treatment of infection

b. Reduce onward transmission to sexual partners

c. Prevent the consequences of untreated infection

d. Ensure all sexually active under 25 year olds are informed about chlamydia, and have access to sexual health services that can reduce risk of infection or transmission

e. Normalise the idea of regular chlamydia screening among young adults so they expect to be screened annually or when they change partner.

Introduction of a single universal reporting system, Chlamydia testing activity dataset (CTAD) led to data quality improvements in data quality from 2012.
Chlamydia is the most commonly diagnosed STI in England with 206,774 diagnoses made in 2014 (all ages).
In 2014, over 1.6 million chlamydia tests were carried out in England among young people aged 15 to 24 years. A total of 137,993 chlamydia diagnoses were made among this age group, equivalent to a detection rate (Chlamydia Detection rate) of 2,012 per 100,000 population.
Chlamydia testing coverage (% of population tested), detection rate and proportion testing positive varied by Public Health England (PHE) Centre area of residence. In 2014, the percentage of young people tested for chlamydia ranged from 21% in West Midlands to 28% in London. North West England had the highest detection rate per 100,000 population (2,288) while East of England had the lowest (1,660). The proportion testing positive was relatively stable (range from 7.6% to 9.2%) across PHE centre areas. Thus the variation in detection rates between the areas mainly reflects the different testing rates. For all areas the majority of tests were carried out in community-based settings (including primary care).
Assuming one test per person, an estimated 35% of females aged under 25 and 14% of males aged under 25 were tested for chlamydia in 2014.
Three years of data are now available and trends show a small decline in testing coverage, a small increase in positivity and a small decline in the detection rate. It is likely that the trends seen at the PHE centre area and national levels are as a result of a combination of the following:

- Improvements in data quality: There has been a reduction in double counting of tests corresponding to improvements in coding of data by providers and laboratories prior to submission. Data for 2014 are more representative of true chlamydia testing activity when compared to previous years

- A true decline in testing coverage: The decline in coverage is mostly attributable to fewer tests in community venues which may be, in part, a result of the integration of sexual health services in a number of programme areas

- Targeted testing of populations at highest risk of infection: Sexual health services have focused testing efforts on core services where positivity rates are highest.

The Public Health Outcomes Framework (PHOF 2013-2016) recommends that local areas work towards achieving a chlamydia detection rate among 15 to 24 year olds of at least 2,300 per 100,000 population. Twenty nine percent of Local Authorities achieved a detection rate of at least 2,300 per 100,000 population among 15 to 24 year olds.

In 2014, the detection rates by Local Authority ranged from <530 (Isles of Scilly) to 4,270 (Hackney) per 100,000 population aged 15-24. Differences in detection rate could be due to differences in testing coverage, data quality variation, or heterogeneity in behavioural risk for chlamydia. In 2014 the range of detection rate by Upper Tier Local Authority (UTLA) shows fewer outliers - with either very low or very high detection rates - indicating that data at the local level are a more accurate representation than in previous years. Public Health England works to support local authority's data quality improvement initiatives. Kingston's Chlamydia Detection rate was 1749/100,000 in 2014. See Figure 4. Kingston has a local target to increase diagnostic rates on an annual basis by 10%.

What Works

Use guidance by the Department of Health to ensure effective commissioning and delivery of services by:

- developing and maintaining an appropriately skilled and trained workforce and utilising the training opportunities within sexual health services for NHS staff
- working within a consistent framework of service standards and outcomes - ensuring that all services are delivered as part of a local managed network, ensuring proper clinical governance and coordinated by clinical specialists
- underpinning the service quality by the following:
    - relevant UK clinical guidance covering the specialities of Sexual and Reproductive Healthcare and Genitourinary Medicine
    - effective Sexual History taking using the Sexual History taking using the 2013 UK national guideline
    - compliance with the *You're Welcome* quality criteria[1]
    - effective treatment and partner notification to ensure that infections are diagnosed rapidly and prevent onward infection[2]

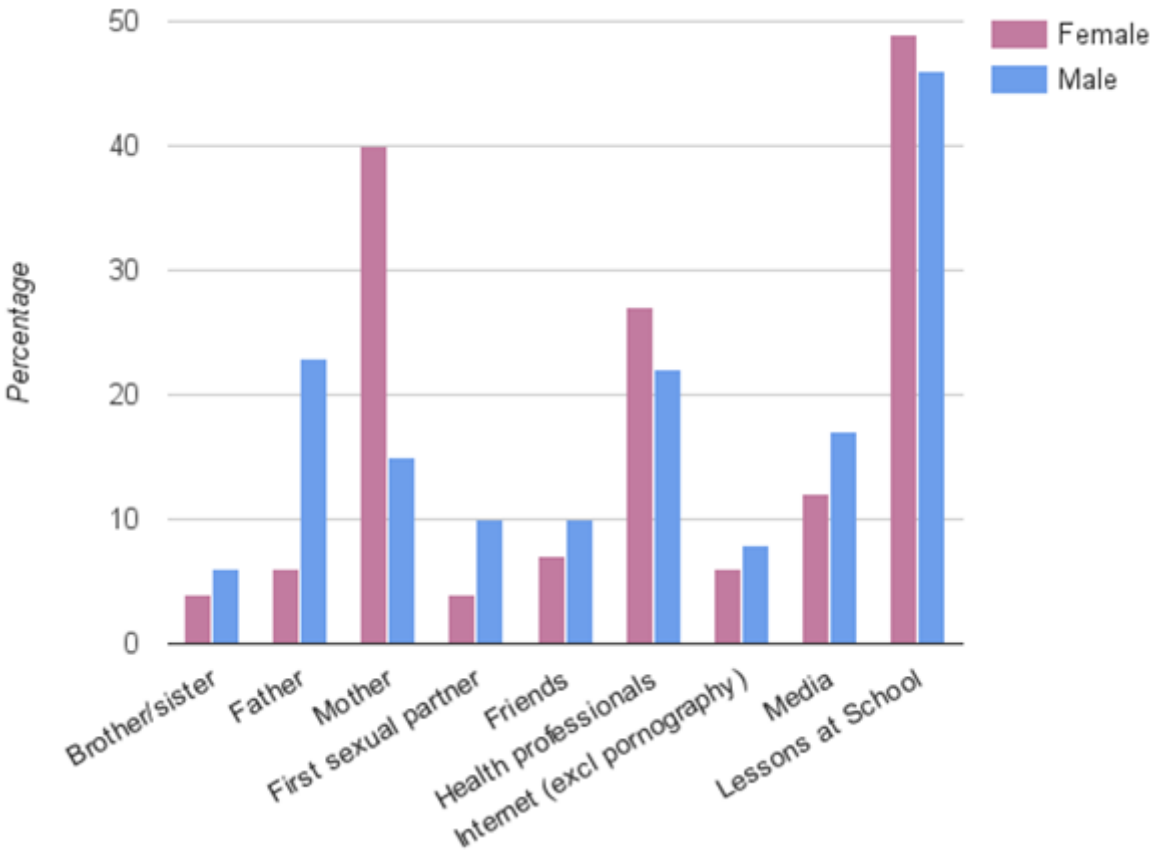
- high calibre leadership from those individuals and organisations responsible for commissioning and good use of public health surveillance information. This would include addressing any local emergence of outbreaks of less common (or previously rare) STIs such as gonorrhoea, syphilis and Lymphogranuloma Venereum (LGV), especially among young adults and men who have sex with men (MSM). Public Health England has issued guidance on outbreak management

- supporting people to take responsibility for their sexual behaviour, through:
    - access to good quality, evidence-based sexual and reproductive health information and services information
    - improved sex and relationships education in schools and in the home, ensuring young people have the information to make positive lifestyle choices. Research shows that young people receiving good quality sex and relationships education at school are more likely to use condoms and other forms of contraception when they first have sex. The third National

Survey of Sexual Attitudes and Lifestyle (Natsal-3) in 2013, provided information about sexual behaviour of adults aged 16-74 (ie, over the age of consent) in Great Britain. The youngest age group in the published data are 16-24 year olds. Natsal asked about sources of information about sex while growing up, and the data suggest those who reported their main source of information had been at school were less likely to have an unplanned pregnancy. School was also the preferred source of information about sex when growing up.

Figure 1 shows that both young men and young women aged 16-24 reported that they would particularly have liked more information from schools, their parents and health professionals. There are interesting gender differences; young women would prefer information from their mothers, young men from their fathers.

Figure 1: Preferred sources of information about sex when growing up, young people aged 16-24, Great Britain, 2012



Source: Natsal-3, Sex Education Forum (2015) SRE - the evidence (http://www.sexeducationforum.org.uk/evidence.aspx). Reproduced with permission. Original paper: Mcdowall W et al (2013) BMJ Open. 2015 Mar 5;5(3):e007837.

  - continued rollout and promotion of the c-card condom distribution scheme. Kingston's policy is based on Brook and PHE updated Condom-Card Scheme guide
  - access to sexual health vaccination and screening programmes.

- Continue the transformation of sexual and reproductive health and HIV services by:

- ensuring that they are delivered in the most cost effective way that guarantees choice, quality, and efficiency across the health economy, better linking them into the primary care services
- better integrating the delivery of STI care and contraception so that people can access both at the same time, while ensuring separate specialist expertise where necessary
- ensuring that services continue to be open access and not restricted by age, GP registration, or postcode of residence.

PHE recommend that people in one of the highest risk groups should get screened regularly and this will lead to early identification and treatment:

- sexually active under 25 year-olds should be screened for Chlamydia every year, and on change of sexual partner (as recommended by the National Chlamydia Screening Programme)
- Men who have sex with Men (MSM) should have an HIV/STI screen at least annually or every three months if having unprotected sex with new or casual partners. Kingston will follow the most recent Public Health England guidance for MSM and for those initial findings July 2014 and other LGBT drugs and alcohol research; London Friend; Executive Summary; Full Report
- black African men and women should also have an HIV test and a regular HIV/STI screen if having unprotected sex with new or casual partners.

Sexually Transmitted Infections

Kingston also implements the 3Cs and HIV programme in GP consultations with 15 to 24 year-olds as well as endorsing STI Guidance for GP staff.

HIV

Guidelines from the British HIV Association (BHIVA), the British Association for Sexual Health and HIV (BASHH) and the British Infection Society (BIS) aim to increase the offer of HIV testing that was recommended by the Chief Medical Officer in September 2007.

Assuming that the prevalence of diagnosed HIV infections is a good indicator of the prevalence of undiagnosed HIV infection in a particular place, the guidelines state that where the prevalence of diagnosed HIV infections is two in 1,000 or more, HIV tests should be offered to all individuals aged 15 to 59 registering in general practice as well as to all general medical admissions.

Addressing late HIV diagnosis through screening and testing

Kingston will utilise the National Institute for Health and Care Excellence (NICE)'s advice for local authorities and partner organisations based on all NICE guidance on HIV testing. In time for 2015 HIV testing week, the national online HIV self-sampling service delivered through the website www.freetesting.hiv and operated by Preventx and Yorkshire MESMAC has been on-line since Wednesday 11th November 2015.

HIV testing through HIV self-sampling represents a novel way to expand HIV testing to individuals who would otherwise not come forward for testing. Self-sampling, as opposed to self-testing, involves an individual taking a sample (either an oral swab or a finger prick) which is posted directly to the laboratory and the results are returned to the individual by a healthcare provider. During National HIV Testing Week 2013, two national HIV self-sampling services (Terrence Higgins Trust/HIV Prevention England and Dean Street At-Home), with the support of Public Health England, enabled people who believed themselves to be

at risk of HIV infection to order on-line free self-sampling kits to be delivered to use at home. Between November 2013 and March 2014, the two services distributed 12,490 kits of which 53% were returned (n=6,590), with a reactivity rate of 14 per 1,000 tests (n=92). Among those who received a kit, 89% were MSM and 9% were black-African heterosexuals. Over a third of MSM using the service had never tested before.

Pre-exposure prophylaxis (PrEP) is the use of Antiretroviral Therapy (ART) by people at risk of acquiring HIV infection to reduce their risk of becoming infected with HIV, and thereby potentially reducing the transmission of HIV at the population level. In the UK, BHIVA and BASHH have called for UK-specific data to answer outstanding questions regarding the 'real-world' effectiveness of PrEP[3]. Evidence is being gathered through the PROUD study[4]. Interim analysis of the PROUD study has found PrEP to be highly protective against HIV infection for gay and other men who have sex with men. Consequently, efforts to assess the cost-effectiveness and affordability of PrEP for those most at-risk need to be accelerated so that relevant policy decisions may be taken at the earliest opportunity.

Teenage Pregnancy

The previous national teenage pregnancy strategy and the Framework for Sexual Health Improvement in England (2013) are based on the strongest empirical evidence for reducing teenage pregnancy rates and improving sexual health:

- The provision of high-quality comprehensive sex and relationships education (SRE) in schools and youth settings complemented by open discussion with parents, combined with
- easy access to youth-friendly contraception services.

A number of resources below highlight what works:

- a helpful curriculum design tool on what to include in SRE from the ages of three to 16+ (Sex Education Forum, 2014) and a practical guide for schools on involving parents in SRE
- new supplementary advice to the 2000 statutory SRE guidance to help schools address some of the new challenges of the 21st century, such as the influence of pornography, 'sexting' and social media (PSHE Association, Brook and the Sex Education Forum)
- SRE in secondary schools needs to include information about local young people-friendly contraception and sexual health services. New public health guidance from the National Institute of Health and Care Excellence (NICE, 2013)
- New school nursing guidance sets out the policy context and provides some useful tips for school nurses from the Sex Education Forum on strengthening SRE and pupils' early access to confidential advice
- with all young people, but particularly those with risk factors, all practitioners need to be vigilant for signs of sexual exploitation and abuse. Kingston has developed a Child Sexual Exploitation assessment proforma to assist practitioners in identifying and appropriately referring young people who are or have been at risk of sexual exploitation.
- additionally, there is new national guidance to assist professionals to identify and appropriately refer young people who are exposed to sexual exploitation, Spotting the Signs (Brook, BASHH, 2014).

Current Services

Prevention

HIV Prevention and Testing

HIV Prevention England (HPE) is the new national HIV prevention programme for Black -Africans and Men who have sex with men (MSM) in England, and has established three goals:

- to increase HIV testing to reduce undiagnosed and late diagnosed HIV in both communities
- to support sustained condom use and other behaviours that prevent HIV in both communities; and
- to tackle stigma within both communities and more widely.

In Kingston:

- In line with the guidelines since 2012, GPs have been offering HIV tests to adults newly registering at GP practices or within 6 months of registering
- Annual HIV testing week during the last week of November started in 2013 and was carried out by Kingston in partnership with South West London to provide HIV testing in a community-based setting using Point of Care tests. In 2015, the HIV testing week aligned with the London 'It Starts with Me' campaign

HIV Peer and Community Support

Kingston is part of a London-wide HIV prevention programme, as well as South London and South West London consortia to address local prevention, peer support, and wider counselling and welfare projects. All contracted providers as part of the London-wide programme are expected to deliver on an outcome of increasing knowledge of HIV services, including HIV testing services.

Condom Card Scheme

A C-Card scheme is one type of condom distribution scheme, which provides registered young people with a paper or credit card-style card which entitles them to free condoms. The scheme in Kingston is for young people aged 13 to 24 who live or access services locally. Kingston's scheme has been running since November 2009 and, in May 2011, it became part of the pan London scheme called 'Come Correct'.
Overall, the number of young people registering on the c-card scheme has fallen over the last year from 921 registrations in 2013/14 to 739 registrations in 2014/15. A fall in new registrations would be expected as the scheme is now well established locally and many young people are already registered, however this is a fairly significant fall and therefore warrants further investigation through 2015/16.
Encouragingly, a high number of young men continue to sign up to the scheme. As in 2013/14, in 2014/15 over 50% of registrations were by young men, which indicates the acceptability of this service amongst this traditionally hard to reach group.

Sex and Relationships Education

Since June 2013, there has been a Personal Social Health Education (PSHE) strategic working group in Kingston with the aim of achieving the delivery of quality PSHE of an agreed standard across Kingston through the sharing of best practice with all educational settings
The Healthy Schools agenda and the role of the Public Health Link Workers (which started in 2013-14) cover all secondary mainstream schools, one special school and Kingston College, and is central to this strategic partnership working group in engaging schools in the PSHE agenda.

Sexual Health Services

Kingston sexual health services fall under four broad categories and are provided by:

1. **Self-managed care**

- www.freetest.me website where 15 to 24 year-olds can order free Chlamydia screening kits, www.comecorrect.org.uk where under 25 year olds can find out where to access free condoms as part of the c-card scheme, and www.freetesting.hiv where HIV tests can be ordered.
- the youth service (C-Card condom scheme and Chlamydia screening)
- Terence Higgins Trust (voluntary organisation) (C-Card condom scheme and Chlamydia screening).
- In 2015, in advance of National HIV Testing Week, (which is the last week of the end of November), PHE are funding all activity for a service to provide self-sampling HIV testing across all local authorities until the 1st January 2016. Following this date, Kingston Public Health will continue funding this service.

2. **Level One Services**:

- General Practice - This includes offering Chlamydia and Gonorrhoea screens to all sexually active 15 to 24 year-olds as well as Chlamydia and Gonorrhoea screening for all eligible women (of all ages) before having a coil fitted. HIV screening (100% offer) for all people newly registering with a GP practice was introduced in 2012
- Community Pharmacies - this includes provision of Emergency Contraception and Partner Notification and Treatment for Chlamydia
- Kingston under-19s Service (KU19) - Level One Services are offered:
    - across eight schools which includes two Pupil Referral Units
    - at four KU19 services (at Hook Centre, Hawks Road Clinic, Surbiton YMCA, and Guildhall One). Since 2014, the KU19 service also provides contraceptive implants.

3. **Level Two services:**

- Community Contraception and Sexual Health services are offered at:
    - Hawks Road Clinic three times a week providing a full range of contraception including LARCs (Long Acting Reversible Contraception)
    - a range of settings across Kingston: Kingston College, three Childrens' Centres and two GP settings
    - the Connect Clinic at The Wolverton Centre, Kingston Hospital for people with learning and physical difficulties. This includes provision of a full range of contraception including LARCs.

4. **Level three services:**

- the Wolverton Sexual Health Centre provides:
    - a full range of contraception including LARCs and a service for women with complex needs
    - diagnosis and treatment management of complex STIs
    - comprehensive contact tracing also known as partner notification.

Abortion Services

The local NHS commissioner, NHS Kingston Clinical Commissioning Group (CCG), commissions the British Pregnancy Advisory Service (BPAS) to provide terminations of pregnancy and have been providing

over 90% of terminations for women registered with GPs in Kingston for more than 5 years. BPAS also provide pre-consultation telephone contraception counselling, Chlamydia and Gonorrhoea screening, HIV testing and a full range of contraception including LARCs (e.g. coils and implants). All Kingston residents can access BPAS and women can self-refer, i.e. they do not need to visit their GP beforehand.

HIV Treatment and Care

HIV Treatment and Care is classified as a specialist service and as such is commissioned by NHS England. However, the infrastructure of local provision is dependent on the Local Authority commissioned GUM service at the Wolverton Sexual Health Centre.
Levels of sexual health services are described in The National Strategy for Sexual Health and HIV (Department of Health, 2001).

Community Voice

The following work has involved engaging with the community with regard to sexual health:

- 2008 Sexual Health Needs Assessment (qualitative and quantitative) involving interview and focus groups with patients and service providers
- 2012 Sexual Health Needs Assessment (quantitative)
- 2013 Black and Minority Ethnic Needs Assessment by Terrence Higgins Trust
  This document includes individual surveys, interviews and a focus group with community members (service users and non-users) of people from the BME community. However, there were limitations in accessing BME communities and work is currently underway to better access the relevant groups (e.g. Tamil and Korean) in order to obtain more representative information regarding these population's perceptions of sexual health and of sexual health services.

  This 2013 BME Needs Assessment highlighted that:
  - worries about confidentiality, privacy and embarrassment are the biggest barriers
  - 24% Kingston population are from BME groups. It is estimated that by 2031 Kingston's ethnic minority population will be similar to the rest of London, i.e. about one third of total population
  - Kingston has the largest Korean population in Europe as well as a significant Tamil population
  - only 27% BME groups questioned had used a service, but all were positive experiences
  - cultural differences and language are barriers to accessing services and these barriers are more prevalent for older age groups.

- 2013 Kingston Young People with Learning Difficulties Needs Assessments was carried out by the Family Planning Association. It surveyed sixty 13-25 year-olds with learning difficulties and conducted focus groups with service users and non-users. The majority of young people with disabilities who took part in the needs assessment stated that they would like a clinic that:
  - allows confidentiality and privacy in a setting where staff were familiar and friendly, listened and did not interrupt, and did not ask too many questions

- allows other people with disabilities to access the service at the same time to, where needed, offer help in understanding questions asked
- offer a choice over interventions and treatments available (type of contraception for example), and healthcare professional (e.g. being able to see a female nurse or doctor).

- 2013 Sexual Health Needs Assessment with Lesbian Gay Bisexual Transgender (LGBT) community by the West London Gay Men's Project which included a survey of 125 people identifying as LGBT: 12.0% lesbian, 77% gay men, 8.0% bisexual and 0.8% other. Focus groups with both service users and non-users were also conducted. The findings were as follows:
  - 81% had experienced mental health issues. Most common were stress, anxiety and depression; with 30% stating they had experienced suicidal thoughts
  - 29% were smokers (national average was 20% in 2010)
  - 24% of the respondents stated that they binge drink on at least one day in the week (national average is 19% for men; 12% for women)
  - 39% used non-prescription drugs as part of social or home life (slightly higher than the 36.5% national average of people who have ever taken illicit drug in their lifetime).

- The 2015 School Health Education Unit Health Behaviour Survey findings are available. All secondary and academy schools in Kingston were invited to participate in this survey during the summer and autumn term 2013, with the focus on Years 7, 8, 9 and 10 pupils. All surveys were undertaken anonymously online or via a paper based version. A total of 3,982 pupils took part from eight secondary schools and one pupil referral unit. There was a reasonable mixture of boys and girls across the specified year groups. The themes covered were: Healthy lifestyles Drug education and substances, Emotional health and wellbeing, Relationships and sexual health.

- 'You're Welcome' accreditation process for sexual health services has involved local young people undertaking mystery shops since 2010.
- The Friends and Family Test as introduced by the NHS in both inpatient and outpatient services (2013), and in GP practices (2014). Clinical sexual health services commissioned by the Royal Borough of Kingston were asked to use this questionnaire from 2013, and in the future we will incorporate it into a single user survey for use across all of our sexual health services.
  Each patient is asked the following question:

  "How likely are you to recommend our service to friends and family if they needed similar care or treatment?" To answer this, the patient is given a descriptive six-point response with options ranging from 'Extremely likely' to 'Extremely unlikely'. All other user survey questions are to stem from this and can be used to gauge the reasons for an individual's response, both good and bad.

- Kingston Public Health developed a questionnaire to address the needs of MSM engaging in chemsex activities was distributed to 100 HIV negative MSM and 50 HIV positive MSM attending the MSM clinic at the Wolverton Centre between November 2013 and March 2014. Recommendations from this research were made for providers and commissioners of sexual health services and of substance misuse services. The MSM questioned welcomed a service that would be based at the Sexual Health clinic. Consequently, a weekly "in-reach" service was established by the clinical psychologist to run alongside the weekly MSM evening clinic based at The Wolverton Centre.

Recommendations

Reducing the burden of STIs, HIV and unintended pregnancies requires a sustained public health effort based around prevention and behaviour change, early detection, successful treatment and partner notification. Prioritisation of recommendations are guided by the Public Health Outcome Framework and the Framework for Sexual Health Improvement in England (2013) as follows:

1. Quick and open access to sexual health services is vital for STI control and it is important that this is sustained.
2. Improve effectiveness of sex and relationships education (SRE). This includes expanding on the achievements to date of the PSHE strategic working group, the Healthy Schools agenda, Public Health Link Workers, and co-ordination and collaboration with all relevant local partners.
3. Ensure value for money and maximum efficiency savings across all areas of provision.
4. Continue to provide Public Health training and support for generalist services (GP staff and Community Pharmacy staff).
5. Analysis of the Joint Strategic Needs Assessments (JSNAs) by the Men's Health Forum revealed that only 18% of Local Authorities in England used data broken down by gender and that key lifestyle areas, including sexual health, are being overlooked.
6. Improve HIV testing by using HIV Testing NICE guidelines for BME and MSM populations.
7. To increase the capability of the local Accident and Emergency Department to offer HIV tests on an opt-out basis to all adult patients requiring incidental blood tests or those who present with potential HIV related symptoms.
8. Promote men who have sex with men (MSM)awareness of Shigella flexneri and Lymphogranuloma Venereum (LGV), and the factors associated with transmission, which have included poly-drug use. A co-ordinated South West London working group of providers and commissioners has been established in July 2014 to address the needs of MSM engaging in party drugs (Mephadrone, Crystal Methampheatmine, and Gamma Hydroxybutyrate (GBL)/Gamma-Butyrolactone (GHB)/ and high risk sexual activity. This will be informed by the findings of the research carried out with local MSM who have accessed the Wolverton sexual health centre.
9. Robust monitoring and evaluation of HIV Testing in settings should be implemented where there are:
    - new technologies to be established (e.g. employing point of care testing, HIV self-testing)
    - new or pilot intervention models seeking either to establish or improve HIV testing, especially in those settings where there is a lack of evidence as to the best model (e.g. primary care).

10. Information and Data
    - To ensure all clinical sexual health services, regardless of setting, are contracted to provide sexual health data through the new GUMCAD2 system, which was expanded to include Non-GUM sites in 2012, so that commissioners receive full local intelligence.
    - To ensure that microbiology laboratories provide good quality chlamydia testing information through Chlamydia Testing Activity Dataset (CTAD), and providers of chlamydia testing are advised to supply adequate information on area of residence of those tested to laboratories e.g. postcode.

- The following needs assessment that are still required in order to consider the sexual health needs of the following vulnerable and marginalised group:
    - looked after children
    - sex workers
    - sexually exploited children. This Needs Assessment is being undertaken during 2015/16.
- Late HIV diagnosis (CD4 count 350 cells/mm^3 within three months of diagnosis - late HIV diagnosis) data to address gaps in our knowledge relating to the late diagnosis of HIV (Ethnicity, gender, and sexual orientation of those diagnosed late) in Kingston, using Significant event analysis, Clinical audit, Retrospective case note audits, a whole systems audit.

11. Lesbian, Gay, Bisexual and Transgender (LGBT) Sexual Health Needs Assessment 2013
    Some recommendations not yet addressed:
    - services need to target LGBT people specifically for lifestyle issues, i.e. smoking, alcohol and drug use. This includes addressing the needs of MSM engaging in activities
    - increase access and availability to mental health services i.e. counselling support through improved assessment and referral pathways between sexual health and mental health
    - to combat homophobic bullying, and to integrate awareness of LGBT rights and health and well-being issues into education and workplace settings
    - targeted work with the 40% of MSM who use hook up websites or apps to meet other MSM. This could be via online outreach (Netreach).

12. Kingston BME Needs Assessment Recommendations, 2013
    Some recommendations not yet addressed:
    - investigate ways of improving links between sexual health services and BME community groups/leaders utilising resources, e.g. Korean Post & Tamil Newspaper, to raise awareness of sexual health issues amongst BME groups
    - recruit respected members of the community to act as sexual health champions and lead the way in opening doors to start dialogue
    - increase advertising of services aimed at various audiences, not just young people, by investigate existing sexual health resources aimed at specific BME groups and ages.

13. Kingston Young People with Learning Difficulties Needs Assessment Recommendations, 2013.
    Some recommendations not yet addressed:
    - the 'Young Livin' bus' to visit youth centres on a pre-arranged club night and allow young people to become comfortable with accessing its service. It would also give young people the opportunity to meet some of the staff on the bus with support from the staff in the clubs who they know very well
    - development of a borough-wide sex and relationships and disability policy.

14. Ensure older people are informed of the sexual health risks they face and how to deal with them:
    - The Framework for Sexual Health Improvement in England (2013) emphasises the importance of sexual health across the life course. STIs are a growing problem in older age groups in Kingston as well as nationally. Research uncovers a detailed picture of the sex lives of older men and women in England, finding that a sizeable minority remain

sexually active in their old age, and should not be overlooked when sexual health information and advice is developed.

- HIV infection is also an increasing issue affecting older people. The number of Kingston residents aged 45 years and older requiring HIV care showed a year on year increase since 2007, unlike other age groups. This is related to the fact that people diagnosed with HIV as young adults are living longer, and also that more people are aged over 45 years when they are first diagnosed. The National AIDS Manual (NAM) is developing a new resource to cover the specific concerns and considerations people living with HIV face when approaching their 50s and beyond. A starting point will be JUSTRI's Coming of age book. Copies of the book are available to clinics subscribed to use NAM's resources.