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Harrow Council
Sexual Health Strategy 2015 – 2020

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Executive Summary

Sexual health is an essential element of the physical and emotional health and well-being of the individuals, couples and families. It is influenced by a range of social, economic and cultural factors. Provision of free, easily accessible and confidential sexual and reproductive health services is vital for the well-being of the individuals and the social and economic development of their communities.

Since April 2013, the commissioning responsibilities for most sexual health interventions and services are transferred to local authority public health teams with costs met from their ring-fenced public health grant. The new arrangements bring financial challenges for the public health teams in the context of increasing demand on services and austerity measures. There are, however, new opportunities for more integrated and collaborative commissioning work.

As public health team for Harrow council, it is our goal to provide sustainable and robust open access sexual health services within the available financial resources. In the next five years our objectives are to:

- Prevent and reduce the transmission of sexually transmitted infections (STIs).
- Reduce the prevalence of undiagnosed HIV infection and improve early diagnosis particularly among target groups.
- Expand the provision of sexual health and reproductive services in primary care and community settings.
- Increase the uptake of contraception throughout the borough by providing more choice in different healthcare settings.
- Reduce the rates of unintended pregnancies particularly repeat pregnancies.
- Improve the provision of services designed for young people's sexual health needs and to promote sex and relationship education.
- Promote the welfare of children and reduce the risks of child sexual exploitation (CSE) in Harrow.
- Reduce the stigma associated with HIV and STIs
- Expand sexual health promotion and reduce sexual health inequalities among vulnerable groups.

In order to achieve these objectives, it is vital to have the right support and services available to our local population; and to deliver these we need to build and expand the existing strengths of our collaborative work with partners including general practices, community services, acute hospitals, pharmacies and the voluntary, charitable and independent sector.

The next few pages set out our future strategic direction with Recommendations in the light of local epidemiology, service provision and national recommendations and evidence.

1 Introduction

This report provides an insight into the epidemiology of sexual health along with the current services available in Harrow council. It aims to provide a strategic direction for commissioning and delivery of future sexual health services based on local demographic needs.

1.1 - Context and background

According to the World Health Organisation (WHO) ¹, sexual health is:

“A state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction and infirmity. Sexual health requires a positive, respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled”. (WHO, 2006a)

Sexual health is an important area of public health. Most of the adult population of England are sexually active and access to quality sexual health services improves the health and wellbeing of both individuals and populations.

Sexual health needs vary according to factors such as age, gender, sexuality and ethnicity, and some groups are particularly at risk of poor sexual health. There is a strong link between deprivation and rates of sexually transmitted infections (STIs), teenage conceptions and abortions. The highest burden of sexual ill health is borne by women, men who have sex with men (MSM), teenagers, young adults and black and minority ethnic (BME) groups^{2, 3}. The consequences of sexual ill health have wider consequences for both the individual and society. If left untreated, many STIs can lead to long-term health implications for the individual such as infertility, ectopic pregnancy, miscarriage, cervical and other genital cancers, hepatitis and liver disease while social exclusion, unemployment, discrimination and stigma have a negative impact on the society as a whole.

Evidence indicates that sexual health outcomes can be improved by;

- the provision of accurate, high-quality, targeted and timely information to help individuals in making informed decisions about relationships, sex and sexual health
- the availability of and easy access to confidential, open-access sexual health services in a variety of settings with suitable opening times
- timely and accurate diagnosis with effective treatment of all STIs along with the partner notification to prevent the spread of onward transmission
- preventative interventions and collaborative work between all stakeholders in primary care, secondary care, community and voluntary sector.

The public health white paper “*Healthy Lives, Healthy People* (2011)”⁴ identifies sexual health as a key public health priority and proposes a comprehensive

commissioning of sexual health services by local authorities. The proposal was followed by the publication of a Framework for Sexual Health Improvement in England (2013)⁵ which aims to:

- Reduce inequalities and improve sexual health outcomes
- Build an honest and open culture where everyone is able to make informed and responsible choices about relationships and sex; and
- Recognise that sexual ill health can affect all parts of society.

The importance of improving sexual health is also acknowledged by the inclusion of three indicators (2.4, 3.2 & 3.4) in the Public Health Outcomes Framework (PHOF)⁶ (2013). These indicators have been prioritised as each represents an important area of public health that requires sustained and focused effort in order to improve outcomes. The indicators are:

- under-18 conceptions
- chlamydia diagnoses (15–24-year-olds)
- people presenting with HIV at a late stage of infection

1.2 - New commissioning arrangements *(please see appendix 1A)*

Sexual health covers the provision of advice and services around contraception, relationships, sexually transmitted infections (STIs) including HIV and abortion. Provision of sexual health services is complex and there is a wide range of providers, including general practices, community services, acute hospitals, pharmacies and the voluntary, charitable and independent sector⁵.

Since April 2013, local authorities are responsible for commissioning the majority of sexual health services and interventions, but some elements of care are commissioned by the NHS Commissioning Board and/or Clinical Commissioning Groups (CCGs). Local authorities, through their public health teams, are required to provide open access sexual health services for their residents with the following new commissioning responsibilities^{5,7,8}.

- Contraception using implants and intrauterine contraception along with the prescribing costs – but excluding contraception provided as an additional service under the GP contract by NHS Commissioning Board.
- Sexually Transmitted Infections (STI) testing and treatment e.g. chlamydia testing as part of National Chlamydia Screening programme.
- HIV testing and prevention (excluding treatment)
- Sexual health aspects of psychosexual counselling
- Sexual health specialist services including young people's sexual health and teenage pregnancy services, outreach, sexual health promotion work, services in schools, colleges and pharmacies

1.3 - Purpose of the document

In light of the above, the following report provides a snapshot of the local epidemiology with current commissioning arrangements and future strategic direction

for a robust sexual health and reproductive services in Harrow. It aims to demonstrate our commitment to improving the sexual health of our population and the best use of finite resources.

1.4 - Strategy vision and objectives

Our vision is to improve the sexual health and well being of Harrow residents and service users by delivering an accessible, modern, coherent, integrated and related set of services at primary care, secondary care and community level.

Our objectives are to:

1. Prevent and reduce the transmission of sexually transmitted infections (STIs).
2. Reduce the prevalence of undiagnosed HIV infection and improve early diagnosis particularly among target groups.
3. Expand the provision of sexual health and reproductive services in primary care and community settings.
4. Increase the uptake of contraception throughout the borough by providing more choice in different healthcare settings.
5. Reduce the rates of unintended pregnancies particularly repeat pregnancies.
6. Improve the provision of services designed for young people's sexual health needs and to promote sex and relationship education.
7. Promote the welfare of children and reduce the risks of child sexual exploitation (CSE) in Harrow.
8. Reduce the stigma associated with HIV and STIs
9. Expand sexual health promotion and reduce sexual health inequalities among vulnerable groups.

1.5 - Values and Principles

Equity and accessibility: We believe that Harrow residents should have equal access to services which are appropriate to their needs and which take account of age, gender, sexuality, disability, race and religious and cultural beliefs.

Reduction of sexual health inequalities: We will target health promotion and prevention initiatives at those groups most at risk and at those areas of the borough which are most deprived. We will ensure that timely treatment and advice for sexual health is accessible to all Harrow residents, particularly vulnerable groups.

Areas for integration with other services: During the period of this strategy, we will ensure that appropriate integration is established and maintained with other services such as; children and young people services, adult social care, drugs and alcohol services, safeguarding and vulnerable adults and mental health. We will work in collaboration with local partners e.g; Local Safeguarding Children Board (LSCB), Community Safety team and Children and Adult Mental Health services (CAMHS) to identify and protect children and families impacted by violence, sexual exploitation, human trafficking and missing from care.

Evidence based practice: We will ensure that we use research evidence of what is effective when developing services

Effective multi-agency working: We will work in collaboration with our sexual health service providers, Public Health England, NHS England and Pan London networks to ensure shared understanding and vision for both the commissioning and the delivery of services.

2 - Sexually transmitted infections (STIs) & Genitourinary Medicine (GUM) services

Sexually transmitted infections (STIs) are illnesses that have a significant probability of transmission between humans by means of sexual behaviour. Genitourinary Medicine (GUM) services offer confidential specialist advice, screening, treatment and partner notification for sexually transmitted infections (STIs). GUM clinics operate by self-referral and referral from other services. All GUM services are open access, that is, services are provided to anyone, irrespective of their place of residence.

2.1 - Epidemiology of STIs nationally ^{9,10} (appendix B)

- In 2013, a total of 446,253 sexually transmitted infections (STIs) were diagnosed in England. Compared to 2012 data, there was a slight drop (-0.6%) in the number of STIs (448,775).
- Similarly, the number of STIs in London also dropped slightly from 112,275 in 2012 to 110,706 in 2013 (-1.3%).
- Nationally, chlamydia was the most common STI, making up 47% of all diagnoses (208,755) in 2013, while gonorrhoea diagnoses saw a large rise, up 15% from 2012 to 2013 (29,291).
- The impact of STIs remains greatest in young heterosexuals under the age of 25 years and in men who have sex with men (MSM).

2.2 - Epidemiology of STIs in Harrow ^{10, 11}(appendixes B, C&D)

- In 2013, a total of 1,607 acute STIs were diagnosed in Harrow residents at a rate of 663 per 100,000 population. In contrast to national and regional figures, the actual number of acute STIs in Harrow have gone up by 3.6% between 2012 and 2013 (1,549 at a rate of 639.1 per 100,000 population in 2012).
- Majority of STI screening was carried out in GUM clinics with a small number of tests also performed in primary care and family planning services (especially for chlamydia).
- There was a 30% increase* in the rates of gonorrhoea infections which went up from 49.1 in 2012 to 63.9 in 2013.
- Based on proportion of acute STIs by ethnicity, the highest proportion of acute STIs in 2012 were seen among individuals from white ethnic background (46.8% n=695), followed by black and black British (29.8% n=443) and Asian or Asian British (16.6% n=247) ethnic groups.
- However, in terms of rate per 100,000 population, the highest rates of STIs in Harrow in 2012 were among individuals from black ethnic background (2248) followed by white (688) and Asian (243). In comparison, the rates of STIs in England in the same order of ethnic groups were 1833, 532 and 288

respectively. This indicates that based on population size, the individuals from black ethnic background are disproportionately affected by acute STIs.

- Where recorded, 36.8% of acute STIs diagnosed in 2012 in Harrow were in people born overseas.
- Between 2009 and 2012, 10.7% (n=303) of the acute STIs were diagnosed among MSM in Harrow (based on the cases in men where sexual orientation was recorded).
- Reinfection with an STI is a marker of persistent risky behaviour. In Harrow, an estimated 13.6% of women and 12.9% of men presenting with an acute STI at a GUM clinic during the four year period from 2009 to 2012 became reinfected with an acute STI within twelve months. Nationally, during the same period of time, an estimated 9.6% of women and 12% of men presenting with an acute STI at a GUM clinic became reinfected with an acute STI within twelve months.
- There is considerable geographic variation in the distribution of STIs in Harrow. In 2012, the highest rates of STIs were seen in 1st and 2nd most deprived areas of Harrow indicating a positive correlation between STIs and socio-economic deprivation (please see appendix 2C).

*An increase in gonorrhoea diagnoses may be due to the increased use of highly sensitive Nucleic Acid Amplification Tests (NAATs) and additional screening of extra-genital sites in MSM

2.3 – STIs among young people in Harrow (*chlamydia is discussed in more detail as a specific STI among young people in section 3*)

- Young people between 15 and 24 years old experience the highest rates of acute STIs. In Harrow, 44% of diagnoses of acute STIs in 2012 were in young people aged 15-24 years (please see appendix 1C for rates and age profile). The rates were higher among young females compared to young males. In comparison 41% of acute STI diagnoses in London residents were in those aged 15-24.
- Young people are also more likely to become reinfected with STIs. In Harrow, an estimated 16.2% of 15-19 year old women and 8.9% of 15-19 year old men presenting with an acute STI at a GUM clinic during the four year period from 2009 to 2012 became reinfected with an STI within twelve months.
- In 2012, 12% of 15-24 year old in Harrow were tested for chlamydia with a 9% positivity rate. In comparison, nationally, 26% of 15-24 year olds were tested for chlamydia with an 8% positivity rate.

2.4 - National recommendations and evidence (*disease specific recommendations on chlamydia and HIV are mentioned in relevant sections of the document*)

Achieving good sexual health for individuals has been set out as one of the ambitions in government's recent framework for improving sexual health in England⁵ and reducing the burden of STIs among individuals of all ages requires a sustained public health response based around early detection, successful treatment and partner notification, alongside promotion of safer sexual and health-care seeking behaviour.

NICE public health intervention guidance-3 (2007)¹² focuses on one to one interventions to reduce the transmission of sexually transmitted infections (STIs) including HIV, and to reduce the rate of under 18 conceptions, especially among vulnerable and at risk groups.

BHIVA (2008)¹³ advises that individuals who test negative for HIV but who are at risk of other sexually transmitted infections (particularly MSM) should be encouraged to attend local GUM services for testing for other infections.

BASHH (2014)¹⁴ advises that the service providers should offer appointments to 98% of the patients within 48 hours of their contact with the GUM services in order to avoid any delay and stress related to STIs.

The Gonorrhoea Resistance Action Plan for England and Wales (2013)¹⁵ recommends that health professionals should ensure prompt diagnosis and adherence to prescribing guidelines along with the identification and management of potential treatment failures to reduce further transmission.

2.5 - Current GUM services for adults and young people in Harrow

Barnet and Harrow joint Public Health service commissions GUM services from London North West Hospitals Trust (LNWHT). The GUM services at LNWHT offer clinics from Monday to Friday including a young person clinic every Wednesday. The clinic offers full sexual health screening for STIs including HIV and offer treatment for STIs and HIV. In 2012, the majority of Harrow residents (64.3%) attended the GUM clinic at Northwick Park hospital. Other GUM services attended by Harrow residents were Barnet hospital (5.6%) and St Mary's hospital London (4.6%) with the remaining attending a range of clinics nationally as part of the GUM/sexual health open access agreement⁹ (please see appendix 1D).

Patients can also access their GP practices for information, advice and screening of certain STIs e.g. chlamydia and gonorrhoea.

Harrow Council also participates in "Freedom" condom distribution scheme via GP practices and pharmacies to prevent STIs among sexually active people.

2.6 – Sexual health services specific for young people

In addition to the above services, Harrow council has two school based programmes especially designed for the needs of the young population. These are Clinic In a Box (CIB) and Sex and Relationship Education (SRE) programmes. The CIB has "open access" and "walk in" arrangements and provides level 1 GUM services along with contraception services e.g. oral and injectable contraception, emergency contraception and referral to termination of pregnancy services. The programmes target young people in both educational establishments and also in non-educational settings e.g. children linked with youth offending team, young people in care and leaving care and young asylum seeking children in Harrow.

Harrow council also participates in the “C Card scheme” which supplies free condoms to young people through two local pharmacies. Public health team in Harrow have recently registered Stanmore college and drug and alcohol services to expand the delivery of this service.

2.7 - Case for change

As per local epidemiology, the numbers of STIs among Harrow residents have risen by 3.6% between 2012 and 2013, however, the actual GUM patient activity has gone up by 7%. An increase in the usage of GUM services is directly linked with an increased cost which puts a significant burden on the NHS and public health resources. Barnet and Harrow joint Public Health service currently spends the biggest proportion of their budget on sexual health service provision. The PH grant is only ring-fenced until the end of 2015-16. Local authorities need to achieve significant cost reductions across their service remit. Hence the provision of an integrated, open access, robust and cost effective sexual health service is a vital commissioning priority for the public health team.

A small proportion of sexual health screenings were carried out in primary care and family planning services. In light of local epidemiology, and especially with highest rates of STIs among young females, both these services can provide a valuable support in screening, treatment and reduction of STIs.

There is no pharmacy based contract to screen for STIs. Pharmacies are easily accessible and provide a good platform for screenings of some STIs in the community along with signposting individuals to relevant local services.

The uptake of C-Card scheme is considerably low in Harrow. Therapy audit team, who manage C-Card scheme, identified an approximately 80 young people from Harrow using C-Card services in Hillingdon in 2012-13 while only 30 young people used this service in Harrow. This indicates a shortage of easily accessible and well advertised services in the community.

2.8 - Future strategic aspiration for GUM services (adults and young people combined)

In the next five years we aspire to reduce the number of new and repeat STIs among all age groups including at risk groups by providing robust and cost effective GUM services while encouraging more STIs screening in primary care, family planning and community settings.

Recommendations

- 1- Participate in a **collaborative commissioning of GUM services** across North West London boroughs. The details of how this collaboration will work are currently being developed by the Pan London Sexual Health Transformation Project. The project is hosted by the West London Alliance (WLA) and is developing proposals for the medium to long term commissioning of sexual health services. It is anticipated that a collaborative commissioning of GUM

services will offer the best opportunities to deliver effective contract management, value for money, robust clinical risk management and data collection analysis dissemination and distribution. The joint public health commissioning team from Barnet and Harrow local authorities is taking a leading role in this collaborative work. A separate report on this work will be available at the end of October 2014.

- 2- Expand the provision of services in the **primary care settings** especially in relation to screening of all basic sexual health infections by involving more GP surgeries from high incident and deprived areas of the borough. This will not only provide an easily accessible service to the local population but will also release the pressure on GUM services.
- 3- Enrole more local **pharmacies** in providing screening for STIs (e.g. chlamydia screening) along with delivering C-Card scheme and signposting individuals to relevant services.
- 4- Provide basic sexual health screening in **family planning services** on an opt-out basis.
- 5- Ensure and support the development of multiagency policies and pathways for an effective identification, assessment and intervention for children at risk of child sexual exploitation (CSE) and female genital mutilation (FGM).
- 6- Review and map the existing services in Harrow (including CIB and SRE) to get a better understanding of uptake and user preferences. The review will also highlight any gaps in the current services especially around the needs of individuals with disabilities.
- 7- Launch an awareness and signposting campaign especially targeting young people and those who would not normally consider themselves to be at risk of STI's, but are sexually active. The main aims would be to provide reliable and consistent information about available sexual health services in Harrow especially those in the primary care and community settings. The campaign should also market the local facilities offering sexual health services including C-Card and Freedom condom distribution schemes.
- 8- Actively engage with voluntary organisations and third sector organisations and seek their support in delivering the appropriate message to their target audiences on local services.

3 - Specific STI among young people

3.1 - Chlamydia screening

Chlamydia is a bacterial infection and one of the most common sexually transmitted infections (STI) in the UK. It affects both men and women with a considerably higher disease rates in young sexually active adults (15 – 24 years old). The majority of chlamydia infections are asymptomatic but can have serious health consequences (including infertility) if untreated.

The National Chlamydia Screening Programme (NCSP)¹⁶ in England was established in 2003 and has led to the implementation of chlamydia screening across England. NCSP sets standards, monitors activity and quality assures chlamydia screening. Its aim is to reduce chlamydia prevalence through early

detection and treatment of asymptomatic infection, thereby reducing onward transmission and the consequences of untreated infection.

In England, chlamydia screening is delivered on an opportunistic basis and chlamydia tests are available to under 25 year olds free of charge from a variety of venues including GP surgeries, community sexual and reproductive health services, pharmacies, self-sampling kits ordered through the internet or from specialist genitourinary medicine (GUM) services ^{16,17}.

3.2 – Epidemiology of Chlamydia ^{9,11,18} (Please see appendixes B, 2D&3D)

- In 2013, chlamydia was the most common STI, making up 47% of all diagnoses (208,755) in England.
- During the year, over 1.7 million chlamydia tests were carried out in England among young people aged 15 to 24 years, with over 139,000 chlamydia diagnoses made.
- Locally in Harrow, a total of 3720 chlamydia tests were carried out among 15-24 years old in 2012. Majority of these tests (74% n=2745) were carried out in **GUM clinics** and the remaining (26% n=975) were carried out in other settings. Of those outside the GUM services, only 24% (n=232) were tested in GP surgeries.
- The above number constitutes a 12% of 15-24 years old population who were tested for chlamydia with a 9% (324) positivity rate. In comparison, nationally, 26% of 15-24 years old were tested for chlamydia with an 8% positivity rate. This indicates a low uptake of chlamydia screening among young people in Harrow.
- More recently the number of new chlamydia diagnosis in Harrow went up slightly from 324 in 2012 to 334 in 2013.
- Based on 2013 data, the chlamydia diagnosis rate per 100,000 15-24 years old in Harrow was 1,087 per 100,000 which is significantly lower compared to 2,179 for London and 2,016 for England.

3.3 - National recommendations and evidence

The majority of chlamydia infections are asymptomatic but early diagnosis and treatment can reduce the duration of infection and onward transmission. Early treatment also reduces the future complications of the disease. According to Public Health England (PHE)¹⁹ chlamydia screening has been found to be widely acceptable among young adults, although there is evidence that fewer young men take chlamydia tests than young women⁸.

The importance of reducing chlamydia infection is reflected by its inclusion within the Public Health Outcomes Framework (PHOF, 2013)⁶, which focuses on reducing the number of “chlamydia diagnosis among 15-24 years old”.

In the light of above, Public Health England (PHE, 2014)¹⁷ recommends that local areas should work towards achieving a chlamydia diagnosis rate of at least 2,300 per 100,000 population aged 15-24 year - a level which is expected to

produce a decrease in chlamydia prevalence. This ensures that the programme is effectively targeting those young people at highest risk of infection.

NCSP¹⁶ recommends that all sexually active under-25 year old men and women should be tested for chlamydia annually or on change of sexual partner (whichever is more frequent). Screening should be delivered opportunistically, i.e. sexually active young adults should be offered a test when they attend services such as GPs, community sexual and reproductive health services, pharmacies, and specialist genitourinary medicine services. All young adults who test positive should also be offered a re-test around 3 months after treatment.

Partner notification and treatment is a core element of reducing onward transmission of infection. BASHH (2014)¹⁴ recommends partner notification for chlamydia infections at a rate of at least 0.6 contacts per index case. A partner notification rate of 0.6 is achieved when 0.6 sexual partners are successfully treated for every positive case of chlamydia, or in simpler terms 6 partners for every 10 positive chlamydia cases.

3.4 - Current activities for chlamydia testing in Harrow

At present, chlamydia screening is offered to all individuals (as part of the sexual health screening) in genitourinary medicine services (GUM services) at LNWHT. Family planning services offer chlamydia screening on an opt-out basis to individuals in target group only.

Clinic In a Box (CIB) programme also offer chlamydia screening to young people.

There is evidence of some chlamydia screening being carried out in the primary care services but this is sporadic. Although there is no primary care contract or pharmacy based LES in Harrow, yet, a small number of GP surgeries signed up to provide Intra Uterine Contraception Devices (IUCD) as part of the National Enhanced Service (NES) perform chlamydia test prior to fitting an IUCD. Chlamydia screening can be carried out in the primary care if requested by the patient.

In the light of low uptake of chlamydia screening in Harrow, Barnet and Harrow joint Public Health service commissioned LNWHT's family planning services in 2014 to perform 2000 chlamydia tests per annum in individuals from high risk groups.

3.5 - Case for change

As evident from the local epidemiology, the chlamydia diagnostic rates in Harrow are well below the recommended level to achieve a decrease in chlamydia prevalence. The proportion of 15-24 years old tested for chlamydia is less than half of the national figure. Around three quarters of the chlamydia diagnosis are made in GUM services which are expensive to commission and although chlamydia screening is part of the current family planning contract, the number of tests carried out by family planning services is small with an even smaller number of tests carried out by the primary care services in Harrow.

There is a need to provide a robust screening and treatment facilities in primary care, family planning, local pharmacies, and other sexual health services along with a marketing and health promotion campaign to signpost young population to these services.

3.6 - Future strategic aspirations

Our future strategic aspirations are to provide information and awareness about chlamydia as a sexually transmitted infection and to set up primary care and community based screening and treatment facilities. By providing an easily accessible and confidential screening, treatment and partner notification service in the community, we expect a reduction in chlamydia referrals to GUM services and a potential cost savings on GUM contract. Evidence suggests that diagnosis rate of at least 2,300 per 100,000 population aged 15-24 year, together with a partner notification rate of at least 0.6 per index patient, will contribute to the reduction in the prevalence of chlamydia.

Recommendations

- 1- Offer chlamydia testing in **primary care** and **local community settings**.
- 2- Work in collaboration with the **local pharmacies** to provide free chlamydia testing alongside emergency hormone contraception (EHC). Pharmacist should be encouraged to continue to receive sexual health and contraception training so as to advise and sign post young people to available services.
- 3- Obtain registration for free online chlamydia screening in Harrow.
- 4- Support the implementation of the National Chlamydia Screening Programme in Harrow by working in collaboration with our providers to ensure the provision of easily accessible services for young people.
- 5- Launch a robust chlamydia awareness campaign in the community and promote information on facilities that are available for chlamydia testing such as free online self testing chlamydia kits.
- 6- Work in collaboration with abortion services to encourage chlamydia screening
- 7- Continue with chlamydia screening of high risk population in family planning services.
- 8- Continue with chlamydia screening in GUM services for high risk groups.

4 - Family planning – Community Contraception and Sexual Health (CaSH) services

Family planning services provide a full range of high quality accessible and confidential sexual health and contraception service to meet the needs of the population.

There are 15 types of contraceptives available in the UK, 2 for men and 13 for women. Most common methods in use are oral contraceptive pills, Long Acting Reversible Contraceptives (LARC) and male condoms. Long acting reversible contraceptives are of four different types, i.e. injectables, implants, Intra Uterine Contraceptive Devices (IUCD) and Intra Uterine System (IUS). LARCs are

considered to be the most effective methods of contraception as they are not dependent on the patient remembering to use them.

4.1 - Contraception usage (*Please see appendixes E&F*)

- The Office of National Statistics (ONS) opinion survey report (2008/09)¹⁹ shows that 58% of women aged 16-49 reported using at least one non surgical method of contraception in Great Britain.
- Nationally, in 2012/13, 1.2 million women attended NHS community contraceptive clinics, which is a decrease of 5% (58,000) on the previous year.
- Of these approximately, 11% (37,000) of females were aged 15 and 3% (22,000) of females were under 15 (based on the female population aged 13 and 14).
- In terms of the usage, oral contraceptives were the most consistently popular method of contraception chosen by women of all ages attending NHS community contraceptive clinics. The percentage of females attending NHS community contraceptive clinics who chose oral contraception according to age was, 15 year olds (45%) for those aged 16-17 (48%), 18-19 (53%), 20-24 (54%), 25-34 (46%) and 35 and over (33%)²⁰.
- Locally in Harrow, the rate of LARC prescribed by GP's in 2012/13 was 17.3 per 1000 females which is lower in comparison to the rate for London 23.2 and England 49.
- Similarly, in 2012, the total number of abortions in Harrow was 1,234 at a rate of 24.1 per 1000 females which is higher compared to abortion rates for London 22.4 and England 16.6.

4.2 - National recommendations and evidence

It is recognised that investing in contraceptive services can deliver cost savings for the NHS through preventing unintended conceptions (and the costs associated with maternity and abortion services). NICE (2003)²¹ concludes that effective contraceptive services are highly cost effective in preventing teenage pregnancy.

With regards to cost effectiveness of different contraceptive methods, NICE (2005)²² suggests that long-acting reversible contraception (LARC) methods are more clinically and cost effective than the combined oral contraceptive pill even at 1 year of use. While in comparison among the four LARC methods, the injectable is less cost effective than the IUD, IUS and implant, with the latter (IUD, IUS and implant) becoming more cost effective with longer duration of use.

Quality statements set out by the Faculty of Sexual and Reproductive Healthcare (2014)²³ informs that all individuals within the area requiring contraception to minimise the risk of unintended pregnancy should have a timely and open access service to a chosen methods of contraception directly through a contraceptive provider or by effective referral pathways.

The Faculty of Sexual and Reproductive Healthcare (2011)²⁴ recommends that walk in clinics should aim to see patients within 2 hours and services that operate an appointment system should provide an appointment within 2 working days and according to The Royal College of Obstetricians and Gynaecologists (RCOG)

guidelines (2011)²⁵, no women should have to wait for longer than 3 weeks from her initial referral to termination of pregnancy.

4.3 – Family Planning/CaSH services in Harrow

Barnet and Harrow joint Public Health service has a contract with London North West Hospitals Trust (LNWHT) to deliver family planning services that operate on an open access basis and are available to anyone requiring care, irrespective of their place of residence or referral. Family planning or community contraception and sexual health (CaSH) services are provided through its two main hubs i.e. **Alexandra Avenue Health and Social Care Centre** and **Caryl Thomas clinic**. The services are open six days a week with late evening sessions on four days of the week and provide a full range of contraceptive choices, including oral contraception, condom distribution, LARC, emergency hormonal contraception (EHC) and emergency IUD. The services also offer psychosexual counselling as well as young people's counselling service.

With regard to their usage, in 2013/2014, there were a total of 14,095 visits (new and existing users) to the CaSH services. Majority of the patients who contacted CaSH services (2725) were combined oral pill users, followed by LARC users (2397) and progesterone only pill users (966). In terms of contraceptive preference among new users at CaSH services, 847 preferred LARC (489 implants and 358 IUCDs), followed by 706 who chose combined oral contraception and 581 who requested progesterone only pill. In addition to the above, CaSH services prescribed oral emergency hormonal contraception pills to 1,249 patients and fitted 14 emergency postcoital intrauterine devices.

GUM clinic at Northwick Park Hospital provides also covers some contraceptive needs of their patients.

Harrow has provision of family planning services via primary care settings and has a NES contract with 24 local GP surgeries for IUCDs component of the LARC only. At present there are no arrangements for providing LARC implants in primary care setting.

In 2013, a total of 524 IUCDs were fitted in GP surgeries compared to 358 in CaSH services. This indicates a preference among Harrow residents to visit GP surgeries for IUCD fitting.

Harrow also has a contract with nine local pharmacies to provide emergency hormone contraception. In 2013, they dispensed a total of 165 EHC to the target group of 13-19 year olds.

In addition to this, 35 EHC were also provided by CIB programme for young people.

4.4 - Family planning needs of young people (includes teenage pregnancy, abortion and repeat pregnancy)

Teenage pregnancy is a health inequality and social exclusion issue that leads to poor health and social outcomes for both the mother and the child²⁶.

While for some young women having a child when young can represent a positive turning point in their lives, for many more teenagers bringing up a child is extremely difficult and often results in poor outcomes for both the teenage parent and the child, in terms of the baby's health, the mother's emotional health and well-being and the likelihood of both the parent and child living in long-term poverty²⁶.

Most teenage pregnancies are unplanned and around half end in an abortion. As well as it being an avoidable experience for the young woman, abortions represent an avoidable cost to the NHS²⁶. Similarly, repeat termination is another important aspect of women's health, which requires health promotion and education about Long Acting Reversible Contraceptive (LARC). Preventing unwanted pregnancies rather than abortion post conception is preferable considering the physical and mental health of the young woman involved and the utilisation of NHS resources.

The key findings from the research carried out by Department for Children and Families (2010)²⁷, identified that teenagers continue to have unprotected sex when they are fully aware of the possible consequences, and when they do not want to become pregnant. Underlying issues behind this included; feeling out of control, maybe because of drugs or alcohol, or because of the dynamics of the sexual relationship; reliance on user-dependent contraceptive methods and problems young women may experience in negotiating for safer sex. The research also identified that young people struggled to use their preferred methods of contraception (principally user dependent i.e. condoms and the pill) effectively; and when became pregnant, they viewed abortion as 'immoral' making abortion decision-making difficult and stressful.

4.5 – National and local picture among young people ^{5, 18}

(Please see appendixes E&F)

- Nationally, there has been a substantial decline in the rate of under 18 conceptions and in 2011, the rate fell to 30.7 per 1,000 women which is the lowest since records began.
- In Harrow, the **conception rate among women under 18** has dropped by almost 50% between 2002 -2012 and has been below both the London and national rates. The number of teenage conception dropped from 115 in 2002 to 62 in 2012. Harrow also has the lowest rate of teenage conception in North West London sector. In 2012, under 18 conception rate in Harrow was 14.7 per 1000 girls compared with 25.9 for London and 27.7 for England.
- There has also been a steady decline in **under 18 abortion rates** in Harrow in the last 10 years (2002-2012). In 2012, abortion rate in women under 18 years in Harrow was 10.32 per 1000 females compared with 16.1 in London and 13.6 in England.

4.6 - National recommendations and evidence around teenage conception

The importance of reducing teenage conception is reflected by its inclusion within the Public Health Outcomes Framework (PHOF, 2013)⁶ which focuses on reducing the number of "under 18 conceptions".

A framework for health improvement in England (2013)⁵ also prioritises the reduction of under 18 conceptions with the availability of appropriate information and education for young people to enable them to make informed decisions with access to the full range of contraceptive methods and information on where to access them quickly and easily. Target groups are young women and men aged under 18 and parents of young people aged under 18.

NICE (2003)²¹ concludes that effective contraceptive services are highly cost effective in preventing teenage pregnancy.

The teenage pregnancy strategy (2010)²⁶ looked at the international evidence-base and identified the delivery of comprehensive SRE programmes and provision of accessible, young people-centred contraceptive and sexual health (CaSH) services as the two factors with the strongest impact on reducing teenage pregnancy rate.

4.7 – Additional family planning services for young people in Harrow

In addition to the above mainstream services, the two school based programmes (CIB and SRE) in Harrow are also focused on the reduction of unintended pregnancies and abortion rates among young people.

The CIB is led by an advanced nurse practitioner and uses the “hub and spoke” model from Caryl Thomas clinic. The CIB has “open access” and “walk in” arrangements and provides clinical sessions in high schools, colleges (with the most needs) and also includes young people excluded from the main stream of education. Schools are selected according to deprivation data around the area, teenage conception, pregnancy, abortion rates in the area and acceptability of the service in the school. The service provides all necessary clinical supplies e.g. condoms, oral and injectable contraception, emergency contraception, referral to termination of pregnancy services and fast track referrals to CaSH services for young people’s counselling service.

The Sex and Relationship Education (SRE) programme provides opportunities for learning emotional, social and physical aspects of relationships, sex and sexual health. The SRE programme is a nurse-led programme, in partnership with school nurses and aims to provide lesson plans, advice and support to equip hard to reach and identified at risk young people in Harrow with the information, skills and values to have safe, fulfilling and enjoyable relationships and to take responsibility for their own sexual health.

In 2013, CIB programme held 416 clinics across 15 venues in Harrow and was accessed by 920 young people while the SRE programme (SRE) was delivered through 129 sessions across 20 venues and had 2861 user contacts.

Emergency contraception is provided by family planning services, CIB and local pharmacies. The uptake of EHC among young people via pharmacies has gone up from 145 in 2012-13 to 165 in 2013-14. The numbers of EHC prescribed by CIB have remained stable at 35 in 2013-14.

Harrow also participates in the C-Card scheme that provides free condoms to young people encouraging their use and minimising the risks of unintended pregnancies and STIs.

4.8 - Case for change (adults and young people combined)

CaSH services provide all types of LARCs i.e. injectables, implants and two types of IUCDs while GP surgeries only provide IUCDs component of LARC. There is a lack of a primary care contract for providing implants and hence overall GP prescription of LARC in Harrow is lower compared to London and England. On the other hand, there is clear preference among Harrow residents with the majority choosing GP surgeries over CaSH services for IUCDs fittings. Based on the local preference, a primary care contract for implant component of the LARC would significantly benefit local population.

The uptake of C-Card scheme is considerably lower in Harrow. In order to address the poor uptake of C-Card scheme in Harrow, we need to launch a marketing campaign combined with the availability of easily accessible local services.

The numbers of teenage pregnancies in Harrow have been declining in general, but there is lack of clarity on the success of CIB and SRE programmes for young people. An evaluation of these two programmes would identify any gaps in the current services.

There is also a need to further explore the role of community pharmacies around EHC and providing information about LARC and safe sex.

4.9 - Future strategic aspiration (adults and young people combined)

In the next five years we aspire to provide a comprehensive and cost effective family planning services for our residents. We would like to raise awareness about different contraceptive methods and increase the number of LARCs prescription for all age groups via primary care and family planning services. In addition, we would like to provide holistic school based outreach programmes and involve local pharmacy services to advocate safe sex practices and reduce STIs and teenage pregnancies among young population.

Recommendations

1. Maintain the existing CaSH services, especially the out of hour clinics, and provide young people clinics in the evenings.
2. Improve the current primary care contract to include implant component of the long acting reversible contraceptive (LARC) and enrol more GP surgeries especially those based in deprived areas of the borough.
3. Continue to offer Emergency Hormonal Contraception (EHC) and pregnancy testing in pharmacies, and engage more local pharmacies to provide C-Card and counselling on future contraception.
4. Increase the number of young people friendly sexual health services, especially at GP practices and pharmacies with 'You're Welcome' accreditation.

5. Actively engage in the development of multiagency policies and pathways for an effective identification, assessment and intervention for children at risk of child sexual exploitation (CSE) and female genital mutilation (FGM).
6. Actively engage with all key partners who have a role in reducing teenage pregnancies – health, education, social services, youth support services and the voluntary sector.
7. Launch a local awareness campaign to provide reliable and consistent information about all available family planning and contraceptive services in the borough.
8. Robust marketing of the C-Card and Freedom schemes in Harrow along with the availability of more “pick up points” in the borough.
9. Engage in publicising contraception and sexual health services in non-traditional settings e.g. social media.
10. Map and review of all current services and contracts in Harrow with a detailed breakdown on the preference to use different services and the choice of contraceptives by age and ethnicity. A review will also identify any gaps in the current primary care, secondary care and pharmacy services.
11. Review the two outreach programmes for young people i.e. CIB & SRE for their uptake, acceptability, cost effectiveness and success in local schools.

5 – HIV testing

HIV remains one of the most important communicable diseases in the UK. It is associated with serious morbidity, significant mortality and high numbers of years of life lost. There are high costs associated with both treatment and care of HIV^{11, 13}.

The late diagnosis of HIV is the most important predictor of HIV-related morbidity and short-term mortality. A late diagnosis of HIV infection is where the person has a CD4 count of less than 350 cells per mm³ within 91 days of the diagnosis²⁷.

Late HIV diagnosis can result from missed opportunities for earlier diagnosis and can have adverse consequences for both the individual and public health through onward transmission. Early diagnosis and prompt treatment of HIV can lead to near normal life expectancy for the individual. Patients treated successfully can achieve undetectable viral load (<50 copies/mL) and this can eliminate their risk of passing the infection through sexual contact^{29,30}. This supports the public health goal of reduction in onward transmission of the disease. In addition, the cost of HIV treatment and care are lower in individuals’ diagnosed earlier³¹.

5.1 - HIV epidemiology in the UK^{28, 29}

- In 2012, there were an estimated 98,400 (95% CI 93,500 – 104,300) people living with HIV in the UK, representing an overall prevalence of 1.5 per 1,000 population (1.0 in women and 2.1 in men). Of the above, an estimated 21,900 (1 in 5) were unaware of their HIV positive status, and this number of undiagnosed people has remained relatively constant over recent years.
- There were 6,360 **new** HIV diagnoses made in the UK in 2012; representing a diagnosis rate of 1.0 per 10,000 population. Of these, 5,864 were from

England. Among large cities, London had the highest number (2,832) of new HIV diagnosis.

- Of the 6,360 new HIV diagnoses in the UK, **47%** (2,990) were diagnosed late and 28% (1,770) were severely immuno-compromised (<200 CD4 cells/ μ l blood).
- Late diagnosis was highest among **heterosexuals**, with two-thirds of men (65%; 750/1,160) and over half of women 57% (860/1,730) were diagnosed late followed by 34%; (1,105/3,205) for MSM.
- Most HIV transmission in the UK occurs through **sexual contact**; the two groups most at risk of HIV infection are men who have sex with men (MSM) and the black African heterosexual population. It is estimated that in 2012, 40,900 MSM, and 31,800 black African men and women (*11,100 men and 20,700 women*) were living with HIV in the UK representing a prevalence of 26 per 1,000 for African-born men and 51 per 1,000 for African-born women.

5.2 - HIV epidemiology in Harrow ¹¹ (please see appendixes E&F)

- In 2011, 331 adult Harrow residents (184 males and 147 females) received HIV-related care.
- Of these, 45% were black African, 23% were white and 26% were from other ethnic groups.
- The main route of infection in Harrow is sex between men and women (75%) with a further (20%) attributed to MSM.
- Between 2009 and 2011, 51% (95% CI 40-62) of HIV diagnoses were made at a late stage of infection (CD4 count <350 cells/mm³ within 3 months of diagnosis) compared to 50% (95% CI 49-51) in England. 58% (95% CI 44-71) of heterosexuals and 41% (95% CI 21-64) of men who have sex with men (MSM) were diagnosed late.
- In 2012, a HIV test was offered to 89% of eligible attendances at GUM clinics among residents of Harrow and, where offered, a HIV test was done in 88% of these attendances. Nationally, a HIV test was offered to 79% of eligible attendances at GUM clinics and, where offered, a HIV test was done in 81% of these attendances.
- In 2012, the prevalence of diagnosed HIV in Harrow was 2.14 per 1,000 population aged 15-59 years compared to 5.54 in London and 2.05 per 1000 in England ¹⁴.
- 42% of the Harrow MSOAs had HIV prevalence rates higher than 2 per 1,000 population. This is above the BHIVA¹³ recommendation which states that local authorities with a diagnosed HIV prevalence greater than 2 per 1,000 population should offer routine HIV testing into non-traditional settings.

5.3 - National recommendations and evidence

The importance of reducing late presentation of HIV is reflected by its inclusion within the Public Health Outcomes Framework (PHOF, 2013)⁶, which focuses on reducing the number of “people presenting at a late stage of diagnosis”.

In order to promote early diagnosis, one of the recommendations from HIV Prevention Needs Assessment for London (2013)³² focuses on the expansion of HIV testing in settings that are outside of sexual health services to normalise and promote HIV testing.

BHIVA¹³ (2008) guidelines state that a HIV test should be offered to patients attending genito-urinary medicine, sexual health clinics, antenatal services, termination of pregnancy services, drug dependency programmes, and services for tuberculosis, hepatitis B and C, and lymphoma.

BHIVA¹³ also recommends that local authorities with a diagnosed HIV prevalence greater than 2 per 1,000 population should consider offering routine HIV testing into non-traditional settings. This includes all men and women registering in general practice and all general medical admissions.

Testing for HIV is considered cost-effective as long as the positivity rate is more than 1 per 1000 tests. Testing is likely to be most effective if targeted at people aged between 15 and 59 years of age. Early testing and diagnosis of HIV reduces treatment costs – £12,600 per annum per patient, compared with £23,442 with a later diagnosis¹⁴.

Public Health England (PHE, 2013)²⁸ advises that those individuals who are at increased risk such as; men who have sex with men (MSM) should have an HIV and STI screen at least annually, and every three months if having unprotected sex with new or casual partners and black-African men and women should have an HIV test and a regular HIV and STI screen if having unprotected sex with new or casual partners.

5.4 - Current activities for HIV testing in Harrow

Currently, patients seen at genitourinary medicine services (GUM services) at LNWHT are offered a HIV test on an opt-out basis.

In addition to the above, a HIV test is offered universally to all patients attending antenatal services, termination of pregnancy services, drug dependency programmes, and healthcare services for those diagnosed with tuberculosis, hepatitis B, hepatitis C and lymphoma.

Family planning services in LNWHT can perform a HIV test on request from the patient and currently only offer it to patients at increased risk.

A HIV test is also offered by a community HIV clinic to partners of HIV positive individuals.

Harrow PH team are actively involved with London HIV Prevention Programme (LHPP). The service is funded by individual LAs and has specific areas of work predominantly aimed at men who have sex with men (MSM) and African Communities. The three elements of their work are media/communication

campaigns, condom procurement and distribution and outreach work (for MSM only). The service does not offer screening for HIV.

5.5 - Case for change

The data evidence from 2011 shows that the main route of HIV infection in Harrow is heterosexual exposure (75%) followed by MSM (20%) exposure, with high rates of late diagnosis (58%) for those who had a heterosexual exposure. An estimated 8% of Harrow population is from black or black ethnic background, but just below half of all HIV cases (45%) in 2011 were in individuals from black African background. Among new HIV diagnosis, there were more heterosexual female cases compared to the heterosexual male cases. This indicates a specific population who either do not consider themselves to be at risk of HIV or do not have access to easily accessible and opportunistic HIV test offers. There is an urgent need to raise awareness and promote HIV testing among these groups.

A HIV test is not offered to all individuals attending family planning services and based on the Harrow's HIV epidemiology, with higher rates and late diagnosis among heterosexual females, family planning services are best placed to offer the test to individuals who engage in risky behaviour i.e. unprotected sex.

There is a lack of primary care based HIV screening programme and no outreach work for HIV awareness and testing in the community. Although a patient can request a HIV test via their GPs if they feel they are at increased risk of contracting the disease there isn't a specific primary care contract to offer opportunistic HIV test.

There is no pharmacy based HIV testing and although there are media campaigns organised by London HIV Prevention Programme, they lack screening element.

5.6 - Future strategic aspirations

Our future strategic aspirations are to raise awareness about HIV and reduce the number of new and late HIV diagnosis through targeted work with at risk groups; along with establishing confidential and easily accessible HIV testing sites in the community. By directing more testing in the community we aim to reduce the number of HIV screening referrals to GUM services. The offer of HIV tests outside the GUM settings will attempt to reduce stigma and discrimination, normalise HIV testing, encourage uptake of tests and reduce the number of patients presenting at a late stage of the disease.

Recommendations

1. Undertake a service review of the current facilities offering HIV tests in Harrow to identify demand, patient preference and gaps in existing service provision.
2. Promote information on facilities that are available for HIV testing in the local areas including information on free online **self-sampling HIV kits** via Dean Street and Terrence Higgins Trust and free **self-testing kits** expected to be launched in the UK by the end of 2014 or early 2015.

3. Work in collaboration with PHE led London wide **self-sampling** service for HIV, expected to start from February 2015.
4. Collaborate with the drug and alcohol team in promoting HIV testing as part of the screening for blood borne viruses.
5. Offer a routine HIV test on an opt-out basis to **all** patients seen in family planning clinics.
6. Offer HIV testing in primary care setting, especially in hotspot areas of the borough. The process can be introduced as a pilot programme to offer the test to **all** new GP registrations and individuals in the risk groups.
7. Continue to offer a routine HIV test on opt-out basis to **all** patients seen at GUM services.
8. Pilot and evaluate HIV testing via local pharmacies.
9. Pilot and evaluate community based HIV testing via outreach team.
10. Work in collaboration with commissioners of services where HIV testing is currently offered universally to all patients i.e. TB, antenatal services and infectious disease wards.
11. Work in collaboration with "Find and Treat" and "The Hepatitis C Trust" who offer free HIV testing to hard to reach groups in addition to other services. Continue with current work on free condom distribution via pharmacies and GP practices.

6 – Conclusions

- 1- Harrow has a diverse population with distinct needs as well as a diversity of cultural barriers to address sexual health. The main priorities in Harrow are similar to its neighbouring boroughs. The key priority groups in the borough are young people, BME communities, heterosexual females and MSM.
- 2- GUM patient activity in Harrow has risen in the past years and there is an urgent need to address the increasing cost of GUM services in secondary care. The existing contracts and services evolved from within the NHS environment and have transitioned to local authority responsibility with very little change. In order to provide a robust, open access and cost effective sexual health service, it is essential to maintain participation with WLA's work around medium to long term commissioning of these services.
- 3- There is a need to consider redirecting basic sexual health screening from secondary care to primary care and community settings e.g. HIV, gonorrhoea and chlamydia testing. Expanding the role of existing sexual health and family planning services in primary care and pharmacy settings (especially in deprived areas of the borough) would offer easily accessible and non-discriminatory venues to our population when seeking advice and care. Both these services can also raise awareness, support schemes such as C-Card and Freedom and signpost patients to appropriate secondary care services if required.
- 4- The needs of young people are different to those of adults. Young people require dedicated services which can address their concerns around access, confidentiality, child sexual exploitation and provide education on safe and

healthy relationships. There are two school based programmes for young people in Harrow but the total number of abortions in 2013 was still very higher compared to London and England and 44% of all acute STIs in 2012 were among 15-24 year olds. There is a need to review current contracts with GUM, family planning, primary care and school nursing to ensure they include the specific needs of our growing young population. Similarly, the evaluation of existing school programmes would also add invaluable information. In addition, we should consider training sexual health champions for non traditional settings i.e. youth centres, gym and social clubs. These champions can raise awareness about sexual and reproductive health and signpost young people to local services.

- 5- The data on the choice of contraception among Harrow residents suggests that new users prefer long acting reversible contraceptives (LARC). They also choose their local GP surgeries for getting an LARC IUCD, however, GP contracts do not include implant component of the LARC. Based on the local preference, a primary care contract for LARC implants would significantly benefit local population by providing more choice at their preferred facility.
- 6- There is evidence of poor uptake of C-Card scheme and chlamydia testing amongst young individuals. Lacks of marketing and poor availability of easily accessible local services are the two main factors for low uptake of the C-Card scheme. On the other hand, poor uptake of chlamydia testing can be attributed to the absence of primary care contracts with local GP surgeries and pharmacies in Harrow. The public health team at Harrow has recently enrolled Stanmore College and drugs and alcohol services to expand the delivery of free condoms under the C-Card scheme. The team have also developed a new contract for chlamydia testing via secondary care. However, there is a further need to engage with primary care and pharmacy teams to provide these services. In addition there is a clear need to launch a robust awareness campaign with educational messages about sexual risk-taking, signs and symptoms of STIs (including HIV), benefits of STI screening and information on family planning and reproductive health. The campaign should also signpost residents to all local facilities offering sexual health and family planning services.
- 7- The epidemiology of HIV among Harrow residents is different to London in general. There are more cases of HIV infections among heterosexual females compared to heterosexual males and the main route of HIV infection in Harrow is heterosexual exposure. There is also a higher percentage of new HIV cases among black or black ethnic groups which is disproportionate to their actual population size in Harrow. Similarly the percentage of late HIV diagnosis in Harrow is higher compared to London and England. In the light of these, we need to promote and encourage HIV testing among all at risk population groups via easily accessible and opportunistic testing facilities in primary care, family planning and community settings.
- 8- Currently, there are gaps in the accurate information on the demography of actual and potential service users by disability, ethnicity, sexual orientation

and clinical condition. Similarly, there is poor evidence on the choice and preference of local population to use the available services. In order to better understand the needs of local population and to identify any further gaps, it is essential to map and review all current sexual health services.

- 9- Finally, local PH commissioners should agree performance and data reporting targets with the providers of commissioned services, in line with service needs, national standards and Public Health Outcomes Framework.

DRAFT

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- 31-Beck EJ, Mandalia S, Sangha R, Sharott P, Youle M, et al. (2011) The Cost-Effectiveness of Early Access to HIV Services and Starting cART in the UK 1996– 2008. PLoS ONE 6(12): e27830. (available at) <http://www.plosone.org/article/fetchObject.action?uri=info%3Adoi%2F10.1371%2Fjournal.pone.0027830&representation=PDF>
- 32-Future commissioning of HIV prevention services in London (2013) - HIV Prevention Needs Assessment for London (available at) www.londoncouncils/hivprevention

Appendix 1A – Sexual health commissioning responsibilities by organisation from April 2013 (adopted from “A guide to whole system commissioning for sexual health, reproductive health and HIV”- Public Health England 2014)⁸

Local authorities commission;

Comprehensive sexual health services which includes:

1. Contraception (including the costs of LARC devices and prescription or supply of other methods including condoms) and advice on preventing unintended pregnancy, in specialist services and those commissioned from primary care (GP and community pharmacy) under local public health contracts (such as arrangements formerly covered by LESs and NESs)
2. Sexually transmitted infection (STI) testing and treatment in specialist services and those commissioned from primary care under local public health contracts, chlamydia screening as part of the National Chlamydia Screening Programme (NCSP), HIV testing including population screening in primary care and general medical settings, partner notification for STIs and HIV
3. Sexual health aspects of psychosexual counselling
4. Any sexual health specialist services, including young people’s sexual health services, outreach, HIV prevention and sexual health promotion, service publicity, services in schools, colleges and pharmacies
5. Social care services (for which funding sits outside the Public Health ringfenced grant and responsibility did not change as a result of the Health and Social Care Act 2012), including:
 - HIV social care
 - Wider support for teenage parents

Clinical commissioning groups commission;

- 1- Abortion services, including STI and HIV testing and contraception provided as part of the abortion pathway (except abortion for fetal anomaly by specialist fetal medicine services – see “NHS England commissions”)
- 2- Female sterilisation
- 3- Vasectomy (male sterilisation)
- 4- Non-sexual health elements of psychosexual health services
- 5- Contraception primarily for gynaecological (non-contraceptive) purposes
- 6- HIV testing when clinically indicated in CCG-commissioned services (including A&E and other hospital departments)

NHS England Commissions;

- 1- Contraceptive services provided as an “additional service” under the GP contract
- 2- HIV treatment and care services for adults and children, and cost of all antiretroviral treatment
- 3- Testing and treatment for STIs (including HIV testing) in general practice when clinically indicated or requested by individual patients, where provided as part of “essential services” under the GP contract (ie not part of public health commissioned services, but relating to the individual’s care)

- 4- HIV testing when clinically indicated in other NHS England-commissioned services
- 5- All sexual health elements of healthcare in secure and detained settings
- 6- Sexual assault referral centres
- 7- Cervical screening in a range of settings
- 8- HPV immunisation programme
- 9- Specialist fetal medicine services, including late surgical termination of pregnancy for fetal anomaly between 13 and 24 gestational weeks
- 10-NHS Infectious Diseases in Pregnancy Screening Programme including antenatal screening for HIV, syphilis, hepatitis B

Appendix 2A – Benefits of investment in effective services and interventions for individuals, the public and commissioners (adopted from “A guide to whole system commissioning for sexual health, reproductive health and HIV”- Public Health England 2014)⁸

Key objectives in 'A Framework for Sexual Health Improvement in England'	Benefits at the individual level	Benefits at the public health/population level	Other benefits (economic, health and social outcomes) ✓ = benefit for specified commissioner(s)
<p>Objective: Continue to reduce the rate of under 16 and under 18 conceptions</p> <p>Commissioning intention: Ensure choice and timely access to young people-friendly reproductive health services and all methods of contraception</p>	<p>Control over fertility through increased use of contraception</p> <p>Greater ability to pursue educational and employment opportunities</p> <p>Improved self-esteem</p> <p>Improved economic status/reduction in family and child poverty</p>	<p>Fewer unwanted pregnancies</p> <p>Improved health outcomes for mothers and babies</p> <p>Better educational attainment</p> <p>Better employment and economic prospects</p>	<p>Improved infant mortality rates ✓ CCGs</p> <p>Reduced A&E admissions/childhood accidents ✓ CCGs</p> <p>Decrease in abortions ✓ CCGs</p> <p>Reduced use of mental health services ✓ CCGs</p> <p>Reduced use of social services ✓ LAs</p> <p>Fewer young people not in education, employment or training ✓ LAs</p> <p>Reduction in family and child poverty ✓ LAs</p>

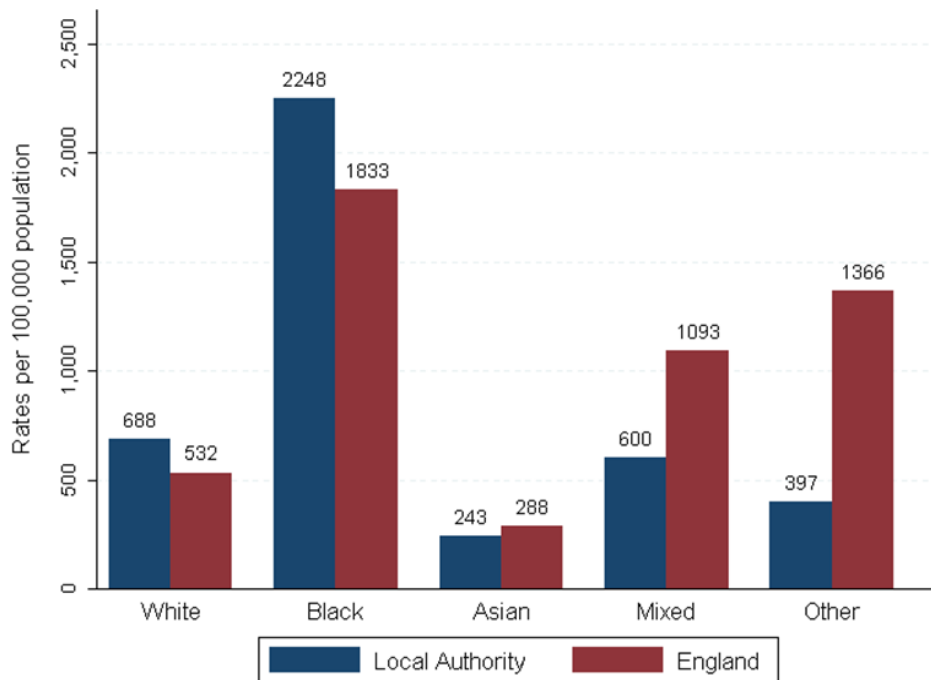
Key objectives in 'A Framework for Sexual Health Improvement in England'	Benefits at the individual level	Benefits at the public health/population level	Other benefits (economic, health and social outcomes)
<p>Objective: Reduce rates of STIs among people of all ages</p> <p>Commissioning intention: Encourage uptake of chlamydia screening and testing for under 25 year olds</p>	<p>Treatment of STIs</p> <p>Reduced risk of other health consequences (eg pelvic inflammatory disease, tubal-factor infertility, ectopic pregnancy)</p>	<p>Reduction in prevalence and transmission of infection</p> <p>Opportunities to test for other STIs/HIV in those diagnosed with chlamydia</p> <p>Reaching young people with broader sexual health messages</p> <p>Increased uptake of condom use</p>	<p>Reduced use of gynaecology services (to manage other health consequences) ✓ CCGs</p> <p>Increased uptake of sexual health services by young people ✓ LAs</p> <p>Increase in chlamydia diagnoses enabling more treatment and consequent reduction in prevalence ✓ LAs</p>
<p>Objective: Reduce onward transmission of HIV and avoidable deaths from it</p> <p>Commissioning intention: Ensure access to HIV testing, early diagnosis and treatment initiation</p>	<p>Access to treatment</p> <p>Better treatment outcomes/prognosis</p> <p>Improved ability to protect partner from HIV</p>	<p>Fewer people acquiring HIV</p> <p>Greater contribution of people living with HIV to workforce and society</p> <p>Less illness and fewer avoidable deaths</p>	<p>Lower health and social care costs for HIV ✓ NHS England, CCGs and LAs</p> <p>Lower healthcare costs for associated conditions and emergency admissions ✓ CCGs</p> <p>Enhanced public health/prevention ✓ LAs</p>
<p>Objective: Reduce unintended pregnancies among all women of fertile age</p> <p>Commissioning intention: Ensure access to high quality reproductive health services for all women of fertile age</p>	<p>Better control over fertility for women at all life stages, through access to choice of full range of contraceptive methods</p> <p>Optimisation of health for women prior to becoming pregnant</p> <p>Fewer abortions and repeat abortions for individual women</p> <p>Improved quality of family life</p>	<p>Fewer unwanted pregnancies</p> <p>Improved pregnancy outcomes</p> <p>Improved maternal health and reduced maternal mortality</p>	<p>Investment in contraception is cost effective in reducing pregnancies and abortions ✓ CCGs</p> <p>Lower healthcare costs through reduced antenatal, maternity and neonatal costs due to better management of pregnancy and improved outcomes ✓ CCGs</p> <p>Reduced social care costs for infant and child care ✓ LAs</p>

Appendix B – Comparison of main STIs between London and Harrow 2012-2013

		Chlamydia (by age group)						Gonorrhoea		Herpes		Syphilis		Warts		All New STIs	
		15-24		25+		Total											
		2012	2013	2012	2013	2012	2013	2012	2013	2012	2013	2012	2013	2012	2013	2012	2013
London	<i>Number of cases</i>	23,701	23,421	18,274	19,668	42,245	43,386	10,862	12,915	7,590	7,473	1,410	1,642	13,918	13,615	112,275	110,706
	<i>Rate per 100,000 population</i>	2,205.3	2,179.3	322.9	347.5	508.5	522.2	130.7	155.4	91.4	89.9	17.0	19.8	167.5	163.9	1,351.3	1,332.5
Harrow	<i>Number of cases</i>	324	334	204	210	530	547	119	155	130	119	9	5	207	209	1,549	1,607
	<i>Rate per 100,000 population</i>	1,054.9	1,087.4	122.9	126.5	218.7	225.7	49.1	63.9	53.6	49.1	3.7	2.1	85.4	86.2	639.1	663.0

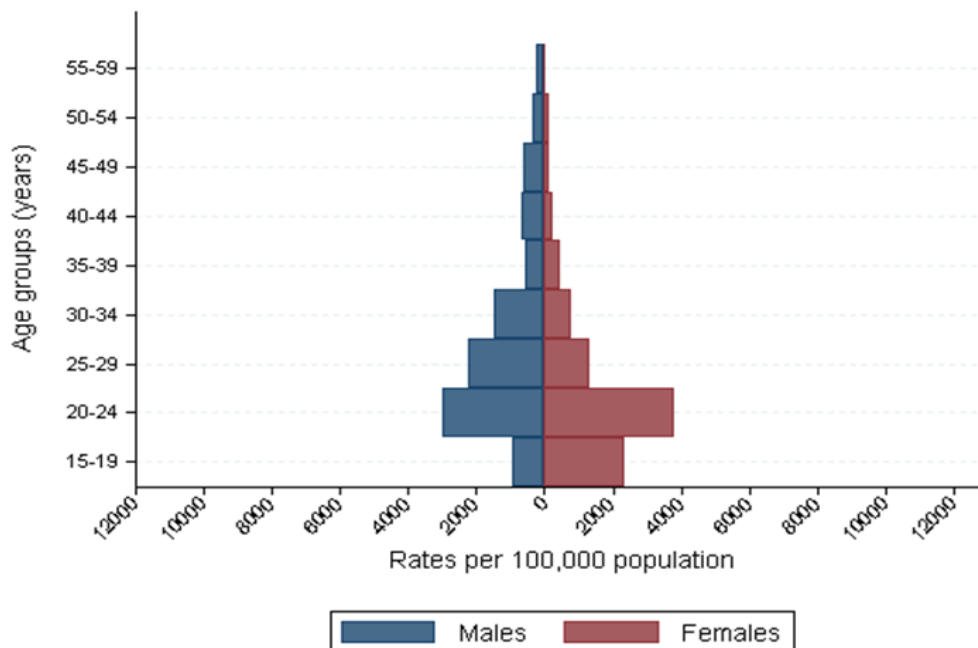
Appendix 1C - STIs rates by ethnicity and age groups

The rate per 100,000 of acute STIs by ethnic group in Harrow and England: 2012



Source: Data from Genitourinary Medicine clinics

Age group and gender of cases of acute STIs in Harrow: 2012

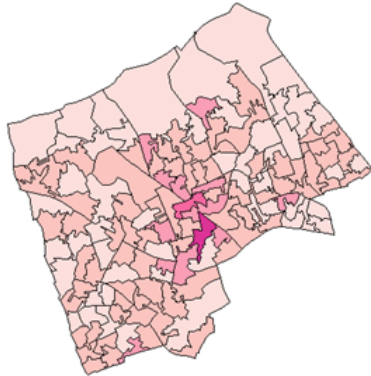


Source: Data from Genitourinary Medicine Clinics and community settings (for Chlamydia only)

Appendix 2C - The rate per 100,000 of acute STIs by LSOA* in Harrow: 2012

Comment [WK]: Will be updated with name sof the localities – currently awaiting data from PHE

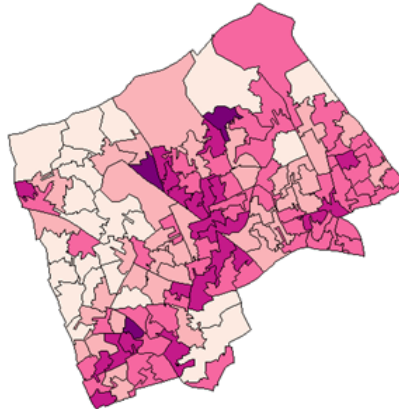
Distribution of rates of acute STIs by LSOA



- Rate per 100,000 population
- 3000+
 - 2500-2999.99
 - 2000-2499.99
 - 1500-1999.99
 - 1000-1499.99
 - 500-999.99
 - 0.01-499.99
 - 0

Source: Data from Genitourinary Medicine Clinics

Distribution of deprivation by LSOA

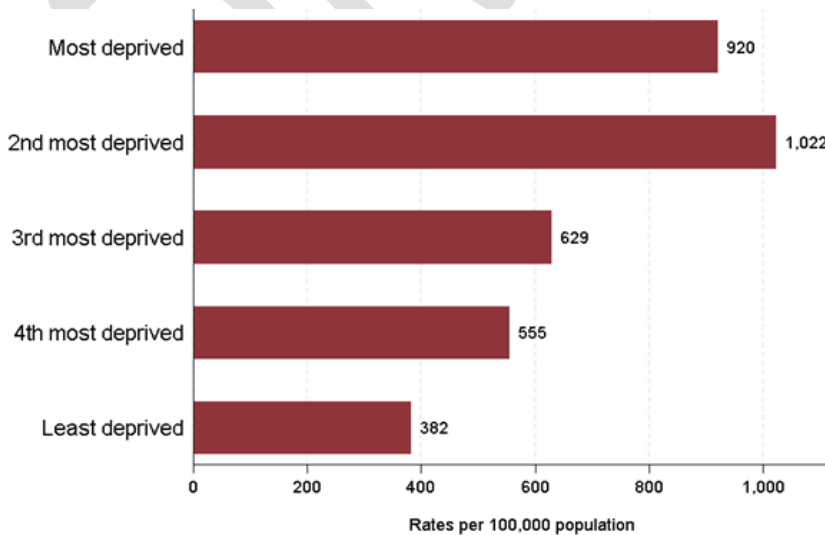


- Deprivation category
- Most deprived
 - 2nd most deprived
 - 3rd most deprived
 - 4th most deprived
 - Least deprived

Deprivation quintiles generated from Index of Multiple Deprivation (IMD) scores 2010

*Lower Layer Super Output Areas (LSOA) are built from groups of contiguous Output Areas and have been automatically generated to be as consistent in population size as possible, and typically contain from four to six Output Areas. The minimum population is 1,000 and the mean is 1,500.

Appendix 3C - The rate per 100,000 of acute STIs by deprivation category in Harrow: 2012



Source: Data from Genitourinary Medicine Clinics

Appendix D

1D- Percentage of all attendees by Harrow residents at GUM clinic 2012

<i>Clinic name</i>	<i>% of all attendances</i>
Northwick Park Hospital	64.3
Barnet Hospital	5.6
St Mary's Hospital London	4.6
Watford General Hospital	4.2
Central Middlesex Hospital	3.7
Dean Street Clinic	2.9
Mortimer Market Centre	2.7
The Royal Free Hospital	1.5
Tudor Centre	1.5
Charing Cross Hospital	1.4
Guy's Hospital	1.2
St Thomas' Hospital	0.8
Ealing Hospital, Pasteur Suite	0.7
St Bartholomew's Hospital	0.7
Archway Sexual Health Clinic (GUM)	0.7
The Royal London Hospital	0.5
John Hunter Clinic	0.4
West Middlesex University Hospital	0.3
Homerton Hospital	0.2
St Albans Hospital	0.2
St George's Hospital (GUM)	0.1
St Peter's Hospital	0.1
Royal Berkshire Hospital	0.1
Kingston Hospital	0.1
Wycombe General Hospital	0.1
King's College Hospital NHS Foundation Trust	0.1

2D- Chlamydia testing data in 15-24 year olds in Harrow: 2012

<i>Number of chlamydia tests in GUM</i>	<i>Number of chlamydia tests in other settings</i>	<i>Total number of tests</i>	<i>Number of positives (all settings)</i>	<i>Percentage of population tested (all settings)*</i>
2745	975	3720	324	12

*Repeat tests are not excluded

Source: Data from Genitourinary Medicine Clinics and community settings

3D- Rate per 100,000 of chlamydia diagnosis in 15-24 year olds in Harrow: 2012

<i>Rates of diagnosis</i>	<i>Rank within PHE Centre†</i>	<i>Rank within England*</i>
1035.6	33	278

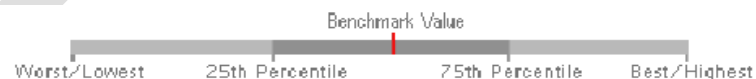
†Out of 33 local authorities in London PHEC, 1st rank has the highest rates

*Out of 326 local authorities in England, 1st rank has the highest rates

Source: Data from Genitourinary Medicine Clinics and community settings

Appendix E - Harrow's Sexual and Reproductive Health profile (as of September 2014)

Compared with benchmark: ● Better ● Similar ● Worse ● Lower ● Similar ● Higher
○ Not compared



Indicator	Period	Harrow		Region	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Syphilis diagnosis rate / 100,000	2013	5	2.1	19.8	5.9	90.9		0.0
Gonorrhoea diagnosis rate / 100,000	2013	155	63.9	155.4	52.9	533.2		3.6
Chlamydia diagnosis rate / 100,000 aged 15-24 (PHOF indicator 3.02)	2013	334	1,087	2,179	2,016	840		5,758
<1,900 1,900 to 2,300 ≥2,300								
Chlamydia diagnosis rate / 100,000 aged 15-24, pre-2012 data	2011	338	1,080	2,190	2,097	948		4,911
<2,000 2,000 to 2,400 ≥2,400								
Chlamydia proportion aged 15-24 screened	2013	4,504	14.7%	27.7%	24.9%	10.6%		58.2%
Chlamydia proportion aged 15-24 screened, pre-2012 data	2011	4,519	14.4%	32.0%	29.7%	14.4%		51.6%
Genital warts diagnosis rate / 100,000	2013	209	86.2	163.9	133.4	288.6		70.7
Genital herpes diagnosis rate / 100,000	2013	119	49.1	89.9	58.8	182.9		21.4
HIV testing uptake, MSM (%)	2013	377	96.2%	95.7%	94.8%	86.1%		100%
HIV testing uptake, women (%)	2013	3,030	86.0%	82.4%	75.8%	29.0%		94.4%
HIV testing uptake, men (%)	2013	2,701	90.8%	89.7%	84.9%	58.4%		95.9%
HIV testing coverage, MSM (%)	2013	274	91.0%	86.6%	86.1%	63.3%		100%
HIV testing coverage, women (%)	2013	2,589	81.6%	67.8%	65.6%	26.0%		85.2%
HIV testing coverage, men (%)	2013	2,328	86.5%	80.6%	77.5%	50.6%		86.9%
Percentage of adults (aged 15 or above) newly diagnosed with a CD4 count less than 350 cells cubic millimetre (PHOF indicator 3.04)	2010 - 12	44	57.9%	44.9%	48.3%	0.0%		80.0%

Compared with benchmark: ● Better ● Similar ● Worse ● Lower ● Similar ● Higher
○ Not compared



Indicator	Period	Harrow		Region	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Abortions under 10 weeks (%)	2013	941	85.2%	82.9%	79.4%	55.6%		87.4%
Under 25s repeat abortions (%)	2013	131	33.9%	32.6%	26.9%	49.2%		13.9%
Total abortions rate / 1,000	2013	1,136	22.1	22.8	16.6	32.4		9.0
GP prescribed LARC rate / 1,000	2013	901	17.7	25.1	52.7	7.5		96.3
GP prescribed LARC rate / 1,000 (old version - PCT based)	2012/13	912	17.3	23.2	49.0	6.2		99.4
Pelvic inflammatory disease (PID) admissions rate / 100,000	2012/13	96	186.5	217.6	228.3	693.9		70.9
Ectopic pregnancy admissions rate / 100,000	2012/13	54	104.9	118.5	94.7	173.1		14.0
Cervical cancer registrations rate / 100,000	2009 - 11	-	4.5	6.7	8.8	17.4		3.0
Under 18s conception rate / 1,000 (PHOF indicator)	2012	62	14.2	25.9	27.7	52.0		14.2
Under 16s conception rate / 1,000 (PHOF indicator)	2012	9	2.1	4.4	5.6	15.8		2.0
Under 18s conceptions leading to abortion (%)	2012	45	72.6%	62.2%	49.1%	27.3%		79.5%
Under 18s abortion rate / 1,000	2012	45	10.3	16.1	13.6	7.1		25.8
Under 18s birth rate / 1,000	2012	17	3.9	9.8	14.1	3.0		33.8

Appendix F – Snapshot of sexual and reproductive health profile for Harrow

Rate of chlamydia diagnoses per 100,000 young people aged 15 to 24 (PHOF indicator 3.02ii)	Year	Harrow	London	England
	2009	1,300	2,417	2,088
	2010	1,215	2,548	2,182
	2011	1,080	2,188	2,092
	2012	1,036	2,159	1,979
Proportion (%) of population aged 15 to 24 screened for chlamydia, measured separately in GUM and non-GUM settings	Year	Harrow	London	England
	2009	23.8	35.6	26
	2010	22	42.7	32.7
	2011	14.6	32.1	29.7
	2012	11.9	32.1	25.8
Proportion (%) - Uptake of HIV testing among men who have sex with men (MSM) measured in GUM	Year	Harrow	London	England
	2009	90.8	89.7	89.9
	2010	93.6	91.8	91.3
	2011	94.3	93.4	92.7
	2012	95.7	95.2	93.6
Percentage of adults (aged 15 or above) newly diagnosed with a CD4 count less than 350 cells cubic millimetre (PHOF indicator 3.04)	Year	Harrow	London	England
	2010 - 12	57.9	44.9	48.3
Prevalence of diagnosed HIV infection per 1,000 among persons aged 15 to 59 years	Year	Harrow	London	England
	2010	1.95	5.41	1.89
	2011	1.98	5.37	1.97
	2012	2.14	5.54	2.05
Under 18 conception rate per 1000 females	Year	Harrow	London	England
	2002	27.8	52.1	42.8
	2003	26.0	50.3	42.1
	2004	32.0	47.5	41.6
	2005	28.2	44.2	41.4
	2006	23.8	43.3	40.6
	2007	23.5	42.6	41.4
	2008	20.9	40.8	39.7
	2009	19.1	36.7	37.1
	2010	19.2	32.8	34.2
	2011	16.5	28.7	30.7
	2012	14.2	25.9	27.7
Under 18s abortion rate per 1000 females	Year	Harrow	London	England
	2002	17.6	30.5	19.6
	2003	15.2	29.5	19.4
	2004	21.6	28.1	19.2
	2005	18.2	26.2	19.4
	2006	16.3	26.4	19.8
	2007	15.8	26.6	20.9
2008	14.3	24.7	19.7	

	2009	12.3	22.3	18.2
	2010	13.2	20.5	17.2
	2011	9.4	17.5	15.1
	2012	10.3	16.1	13.6
Proportion (%) of under 18 conceptions leading to abortion	Year	Harrow	London	England
	2002	63.5	58.6	45.8
	2003	58.6	58.7	46.1
	2004	67.4	59.1	46
	2005	64.6	59.3	46.8
	2006	68.2	61	48.8
	2007	67.3	62.5	50.5
	2008	68.5	60.5	49.7
	2009	64.4	60.6	49.1
	2010	68.6	62.5	50.3
	2011	56.8	61	49.3
	2012	72.6	62.2	49.1
		Year	Harrow	London
Proportion (%) of under 25s repeat abortions	2012	35.7	33.0	27.1
Total Abortion per 1000 females	2012	24.1	22.4	16.6
GP prescribed LARC (Crude rate - per 1000)	2012/13	17.3	23.2	49

DRAFT