



London Borough of Barnet
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 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 individuals and their communities.

Sexually Transmitted Infections (STIs) can cause long term and life threatening complications. These complications and rates of onward transmission increase when diagnosis and/or treatment are delayed with significant implications for the individual, community and the public sector finances, particularly NHS. Unintended pregnancies, whether they result in terminations or not, also have significant implications for the individual, community and public sector finances. Teenage pregnancies for example can lead to intergenerational patterns of dependency and diminished life chances.

Since April 2013, the commissioning responsibilities for most sexual health interventions and services is transferred to local governments and the provision of “open access” sexual health services is one of the mandatory tasks for the Councils’ Public Health teams. In light of this new responsibility, the joint Barnet and Harrow Public Health team have developed a five years sexual health strategy that explores the local epidemiology, key priority groups and existing services. The report also sets out our future strategic direction to provide robust, easily accessible, modern, coherent, cost effective and integrated services to our residents at primary care, secondary care and community level.

The open access nature of sexual health services means that individuals are entitled to attend the service of their choice, in any part of the Country, without the need for a referral from GP or other health professional. However, the payment responsibility remains with the Public Health team from the area of residence. The costs for the provision of these services is increasing and currently around a third of the local Public Health grant is spent on sexual health services with the majority spent on contracted and non-contracted Genitourinary Medicine (GUM) activity. The present service model is not financially sustainable. Whilst epidemiological data showed a reduction in rates of STIs in Barnet between 2012/13, the GUM patient activity rose by 8% during this period.

In order to provide a robust and cost effective service, the strategy recommends participation in collaborative commissioning of GUM services at a multi-Borough level with an expansion of provision in primary care and community.

The provision of sexual health screening and family planning services are not homogeneously distributed in primary care and community settings e.g. pharmacies (especially in deprived areas of the Borough). The strategy recommends expansion of services in these settings in order to provide an easily accessible and closer to home venues to our population. The proposal would lead to early diagnosis, quick referral and a reduction in onward transmission of STIs. The provision of these services would entail lower unit cost price compared with the hospital based services

providing efficacy savings and a reduction in over-reliance on hospital based services e.g. for chlamydia testing.

There is a low uptake of chlamydia screening among young people aged 15-24 years and a higher rates of newly diagnosed HIV infections among individuals from black or black ethnic background, heterosexual females and men who have sex with men (MSM). There is a lack of community based programmes for young people with poor awareness and signposting of locally available services. The strategy takes these areas into consideration and makes relevant recommendations for improving these services.

1 Introduction

This report provides an insight into the epidemiology of sexual health along with the current services available in the London Borough of Barnet. It aims to provide a strategic direction for the 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 England⁵ (2013) 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

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 England and Clinical Commissioning Groups (CCGs) – please see appendix 1A. 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}.

Comprehensive sexual health services, which includes:

- 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)
- 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
- Sexual health aspects of psychosexual counselling

- 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

Social Care services (for which funding sits outside the Public Health ring-fenced 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

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 Barnet. 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 wellbeing of Barnet 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 Barnet.
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 Barnet residents should have equal access to services, which are appropriate to their needs and which take account of age, gender, disability, sexuality, 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 Barnet 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, offender health and mental health. We will work in collaboration with local partners such as; Barnet Safeguarding Children Board (BSCB), the Multi-agency Safeguarding Hub (MASH), the Multi Agency Sexual Exploitation Panel (MASE), Early Intervention and Community Safety teams, and Children and Adult Mental Health services (CAMHS) to identify and protect children and families impacted by violence, child sexual exploitation, child trafficking, missing from care and gangs.

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 2)

- In 2013, a total of 446,253 sexually transmitted infections (STIs) were diagnosed in England at a rate of 832.4 per 100,000 population. Compared to 2012 data, there was a slight drop (-0.6%) in the number (448,775) of STIs in England.
- Similarly, the number of STIs in London also dropped slightly from 112,275 in 2012 to 110,706 in 2013 (-1.4%).
- 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 Barnet^{10,11} (*appendixes 2,3&4*)

- In 2013, a total of 2,680 acute STIs were diagnosed in Barnet residents at a rate of 736.4 per 100,000 population. Similar to national and regional figures, the actual number of acute STIs in Barnet dropped by 8.1% between 2012 and 2013 (2,919 cases at a rate of 802 per 100,000 population in 2012).
- Based on the proportion of acute STIs by ethnicity in Barnet, the highest proportion of acute STIs in 2012 were seen among individuals from white ethnic background (57.3%), followed by black and black British (17.5%) and Asian or Asian British (8.3%) ethnic groups.
- However, in terms of rate per 100,000 population of acute STIs among ethnic groups in Barnet in 2012, the highest rates were seen among individuals from black ethnic background (1648) while the rates in white and Asian ethnic groups were (647) and (325). This indicates that based on population size, the individuals from black ethnic background are disproportionately affected by acute STIs in Barnet. In comparison, the rates of acute STIs by ethnic groups in England in the same order of ethnic groups were 1833, 532 and 288 respectively.
- Where recorded, 38.8% of acute STIs diagnosed in 2012 in Barnet were in people born overseas.
- Between 2009 to 2012, 18.9% (n=878) of the acute STIs were seen among MSM in Barnet (based on the cases in men where sexual orientation was recorded).
- Reinfection with an STI is a marker of persistent risky behaviour, improper use of prescribed drugs or lack of partner notification for screening and treatment. In Barnet, an estimated 9.9% of women and 12.3% 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. It is close to national figure of 9.6% of women and 12% of men.
- There is considerable geographic variation in the distribution of STIs in Barnet. In 2012, the highest rates of STIs were seen in 1st and 2nd most deprived areas of Barnet indicating a positive correlation between STIs and socio-economic deprivation (please see appendix 3 for further details).

2.3 – STIs among young people in Barnet (*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 Barnet, 42% of diagnoses of acute STIs in 2012 were in young people aged 15-24 years. 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 (please see appendix 3 for rates and age profile).
- Young people are also more likely to become reinfected with STIs contributing to infection persistence and health service workload. In Barnet, an estimated 9.5% of 15-19 year old women and 8.8% 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, 16% of 15-24 year old in Barnet were tested for chlamydia with an 8% 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 Barnet

Barnet and Harrow joint Public Health service commissions majority of the GUM patient activity from the Royal Free London NHS Foundation Trust (RFL), however, due to the national open access requirement placed on all local authorities, the team are also responsible for the non-contracted GUM activity for its residents from other part of the Country.

RFL provides GUM services at the following sites;

- Clare Simpson Clinic – RFL Barnet site
- Clare Simpson Clinic – Edgware Community Hospital
- Marlborough Clinic – RFL Hampstead site

In 2012, the majority of Barnet residents (36%) attended a GUM clinic at Barnet hospital followed by The Royal Free hospital (20%) and Archway sexual health clinic (11.8%). The remaining patients attended a range of clinics nationally as part of the GUM/sexual health open access agreement⁹ (please see appendix 4).

The GUM services at Clare Simpson Clinic offer clinics from Monday to Saturday including a men's only clinic on Monday and a young person clinic on Wednesday of the week. The Marlborough Clinic offers clinics on Monday to Friday including a young person's clinic on Monday. The clinics offer full sexual health screening for STIs including HIV and offer treatment for STIs.

Currently, eight GP surgeries in Barnet offer full STI screening as part of a primary care contract with LBB.

2.6 – Sexual health services specific for young people

In addition to the above mainstream services, the London Borough of Barnet (LBB) provides a primary school based Sex and Relationship Education (SRE) consultancy service as part of the Barnet Primary Schools Well-being Programme. The SRE service is offered to all local primary schools on an 'opt in' basis. The overall aim of this service is to build capacity in primary schools so that they are able to implement well-being programmes.

2.7 - Case for change

Although based on the latest figures above, the numbers of STIs among Barnet residents have dropped by 8.1% between 2012 and 2013, yet, the actual GUM patient activity has gone up by 8% during this time. Barnet and Harrow joint Public Health service currently spends the largest proportion (31% approx.) 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.

Just below half (42%) of all acute STIs in 2012 were among young individuals, however, London Borough of Barnet (LBB) does not have specific programmes for young people. At present, there is no Clinic In a Box (CIB) programme in Barnet and the provision of current SRE programme is only limited to primary schools level. Based on the local need and the gap in the service, it is essential to have programmes that address the needs of the young people.

There is evidence of some targeted sexual health screening in family planning services. In light of local epidemiology, and especially with highest rates of STIs among young females, family planning can provide a valuable support in screening, treatment and reduction of STIs.

At present, there is no pharmacy based contract to screen for STIs in Barnet. 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.

There is good engagement between the LBB and primary care services in Barnet, which can be further improved with the addition of more primary care providers.

Finally, there is a need to participate in community based schemes such as “C-Card” and “Freedom” schemes. Both these schemes provide free condoms to eligible young or at risk population respectively in order to prevent STIs and unintended pregnancies.

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 expanding provision for STIs screening and treatment 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. Barnet and Harrow joint Public Health commissioning team 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 local **pharmacies** in providing screening for STIs (e.g. chlamydia screening) along with signposting individuals to relevant services.
- 4- Provide basic sexual health screening in **family planning services** on an opt-out basis.
- 5- Consider providing programmes that target the **needs of young people** in educational and non education settings e.g. outreach services, school nursing and SRE in secondary schools. The suggested option also supports the aim of Barnet’s Health and Well-Being Strategy, “keeping well and keeping independent”.
- 6- Sign up to “C-Card” and “Freedom” condom distribution schemes via local pharmacies and GP surgeries.
- 7- 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).
- 8- Review and map the current services in Barnet to get a better understanding on user preference and uptake of available services. The review will also highlight any gaps in the current services especially around the needs of individuals with disabilities.

- 9- Launch an awareness and signposting campaign especially targeting young people and those who would not normally consider themselves to be at risk of STIs, but are sexually active. In addition, publicise awareness message through non-traditional routes such as social media and seek support from voluntary, third sector and religious institutions. These activities will provide reliable and consistent information about locally available sexual health services especially those in the primary care and community settings.

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 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 3&4)

- 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 Barnet, a total of 7137 chlamydia tests were carried out among 15-24 years old in 2012. Around (57% n=4092) of these tests were carried out in **GUM clinics** and the remaining (43% n=3045) were carried out in other settings. Of those outside the GUM services, only 40% (n=1218) were tested in GP surgeries.
- The above number constitutes 16% of 15-24 years old population who were tested for chlamydia with an 8% (564) positivity rate. In comparison, nationally 26% of 15-24 year olds were tested with a similar 8% positivity rate. This indicates the low uptake of chlamydia screening in Barnet.
- More recently, the number of new chlamydia diagnosis among 15-24 in Barnet went down from 564 in 2012 to 485 in 2013.

- Based on 2013 data, the chlamydia diagnosis rate per 100,000 15-24 years old in Barnet was 1,098 that 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 also 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 Barnet

At present, chlamydia screening is offered to all individuals (as part of the sexual health screening) in genitourinary medicine services (GUM services) in Barnet.

Family planning services at Edgware Community Hospital, Vale Drive Health Centre, Torrington Park and Grahame Park offer chlamydia screening as part of the Central London Community Hospital (CLCH) family planning contract.

Barnet and Harrow joint Public Health service also has a contract with primary care services to provide chlamydia testing. In addition, 17 GP surgeries, that are signed

up to provide Intra Uterine Contraception Devices (IUCD) as part of the National Enhanced Service (NES), also perform chlamydia test prior to fitting an IUCD.

3.5 - Case for change

As evident from the local epidemiology, the proportion of 15-24 years old tested for chlamydia is less than half of the national figure and the chlamydia diagnostic rate in Barnet is well below the national recommendation to achieve a decrease in chlamydia prevalence.

More than half of the chlamydia diagnoses are made in GUM services that are expensive to commission and although there is a good evidence of chlamydia testing being carried out in the primary care settings, there is a need to further expand primary care services.

Currently, there is a lack of programmes that target young population. The rates of chlamydia infection are considerably higher among young sexually active adults in general and providing a confidential and easily accessible service to this population is essential in bringing down the rates of chlamydia infection.

Finally, there is no pharmacy based contract to offer chlamydia testing in the community.

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 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- Continue and expand chlamydia screening in the **primary care** settings especially in deprived areas of the Borough.
- 2- Work in collaboration with the **local pharmacies** (community settings) to provide 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 Barnet.
- 4- 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.

- 5- Support the implementation of the National Chlamydia Screening Programme in Barnet by working in collaboration with our providers to ensure the provision of easily accessible services for young people.
- 6- Work in collaboration with abortion services to encourage chlamydia screening.
- 7- Continue with chlamydia screening in GUM services and family planning services.

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 5*)

- 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 Barnet, the rate of LARC prescribed by GP's in 2013 was 19.4 per 1000 females, which is lower in comparison to the rate for London 25.1 and England 52.7.
- Similarly, in 2013, the total numbers of abortions in Barnet were 1,624 at a rate of 19.9 per 1000 females that is lower compared to London (22.8) but higher compared to 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 regard 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 or CaSH services in Barnet

Barnet and Harrow joint Public Health service has a family planning contract with Central London Community Healthcare (CLCH) NHS Trust. Family planning services are provided through its four main hubs i.e. Vale Drive Primary Care Centre, Edgware Community Hospital, Torrington Park health Centre, Grahame Park Health Centre.

The services are open 6 days a week with late evening sessions on 4 days of the week and provide a full range of contraceptive choices, including oral contraception, condoms and diaphragms, long acting reversible contraception (LARC), emergency hormonal contraception (EHC) and emergency IUD. The Trust has four young person's clinics from Monday to Thursday evenings. The services operate on an open access basis and are available to anyone requiring care, irrespective of their place of residence or referral.

With regard to their usage, in 2013/2014, there were a total of 7636 visits (new and existing users) to the CASH service. The majority of the patients who were seen in the CASH service (1812) were LARC users, followed by combined oral contraceptive users (1052) and progesterone only pill users (515).

In terms of contraceptive preference among news users at CASH services, 1316 preferred LARC (322 implants and 1176 IUD/IUS), followed by 719 who chose combined oral contraception and 380 who were prescribed the progestogen only pill. In addition to the above, CASH services prescribed oral emergency hormonal

contraception pills to 369 patients and fitted 19 emergency postcoital intrauterine devices.

Barnet also has provision of contraceptive services via primary care settings and has a NES contract with 17 local GP surgeries for IUD and IUS fittings and a sexual health contract for contraceptive implants. In 2013, GP surgeries provided a total of 547 IUD and IUS fittings and 161 implants.

Barnet also has a contract with seven local pharmacies to provide emergency hormone contraception. In 2013, they dispensed a total of 105 EHC to the target group of 13-19 year olds.

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 appendix 5*)

- 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 Barnet, 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 192 in 2002 to 91 in 2012. In 2012, under 18-conception rate per 1,000 in Barnet 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 Barnet in the last 10 years (2002-2012). In 2012, abortion rate in women under 18 years in Barnet was 10.3 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. Target groups are young women and men aged under 18 and parents of young people aged under 18.

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 – Family planning services for young people in Barnet

The CLCH, provide community based CaSH services for young people from Monday to Thursday (evenings) of each week.

Young people can also access the family planning services via primary care settings who provide these as part of the NES and LES arrangements.

In addition to these, local pharmacy services provide advice on contraception and family planning and prescribe EHC, however, the uptake of EHC via pharmacies has dropped from 125 in 2012-13 to 105 in 2013-14.

Finally, there is a Sex and Relationship Education (SRE) programme which provides consultancy support to those primary schools engaged in SRE development and provide opportunities to train the trainers for a sustained delivery of SRE in schools in the future.

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

The above figures suggest a local preference to use GP surgeries for family planning needs, however, only a small number (17) of GP surgeries are currently providing

the service. There is a need to engage with more GP surgeries to expand the provision of family planning services especially from hotspot and deprived areas of the Borough.

Young people require dedicated services that can address their concerns around access, confidentiality, child sexual exploitation (CSE) and female genital mutilation (FGM). At present, young people do not have outreach programmes at school or community level and there is a need to provide easily accessible services to young people especially in the deprived areas of the Borough. There is also a need to work in collaboration with partner agencies to address wider aspects such as CSE, FGM and providing advice on negotiating safe sex.

Pharmacies provide an easily accessible platform and at present the role of pharmacies in family planning is limited to providing advice, EHC and pregnancy testing and there is a need to expand role beyond the current services.

In addition to these programmes, LBB should also participate in community schemes such as “C-Card” and “Freedom” condom distribution schemes. These schemes provide a dual service by providing protection against STIs and unintended pregnancies.

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 by expanding the role of primary care and pharmacies especially in deprived areas of the Borough. We would also like to ensure that our local population especially young people have appropriate information and access to all available services that offer advice and the choice of contraception. In addition, we would like to raise awareness and develop special programmes for the young people.

Recommendations

1. Maintain the existing CaSH services especially the out of hour clinics for young people.
2. Expand the provision of current family planning services in primary care by enrolling more GP surgeries especially those based in deprived areas of Barnet.
3. Expand the role of pharmacies beyond the current provision of EHC and pregnancy testing and include the provision of C-Card scheme and counselling on future contraception.
4. Align existing and develop new programmes based on the needs of young people e.g. school nursing, expansion of sex and relationship education and health champion for young people. Health champions can raise awareness and signpost young people in venues like youth clubs, gym and social clubs.
5. Increase the number of young people friendly sexual health services especially at GP practices and pharmacies with ‘You’re Welcome’ accreditation.

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. 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).
8. Launch a local awareness campaign to provide reliable and consistent information about all available family planning and contraceptive services 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 Barnet 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.

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 diagnosis²⁸.

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/μl 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 Barnet ¹¹ (*please see appendixes 5*)

- In 2011, 676 adult Barnet residents (378 males and 298 females) received HIV-related care.
- Of these, 45% were black African, 34% were white and 17% were from other ethnic groups.
- The main route of infection in Barnet was sex between men and women (64%) with a further (29%) attributed to MSM.
- Between 2010 and 2012, 54% (95% CI 45-63) of HIV diagnoses were made at a late stage of infection (CD4 count <350 cells/mm³ within 3 months of diagnosis) compared to 45% for London and 48% for England.
- Based on 2011 data, 59% (95% CI 44-71) of heterosexuals and 40% (95% CI 21-64) of men who have sex with men (MSM) were diagnosed late.
- In 2012, a HIV test was offered to 74% of eligible attendances at GUM clinics among residents of Barnet and, where offered, a HIV test was done in 91% 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 Barnet was 2.92 per 1,000 population aged 15-59 years compared to 5.54 in London and 2.05 per 1000 in England ¹⁴.
- 76% of the Barnet MSOAs had HIV prevalence rates higher than 2 per 1,000 population. This is above the BHIVA 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 genitor-urinary medicine or 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)²⁷ 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 Barnet

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

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.

Barnet and Harrow joint Public Health service has a primary care contract with 8 GP surgeries who offer a HIV test to eligible patients.

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

The drug and alcohol team offer HIV test to all patients as part of the blood borne viruses screening.

LBB are also 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 Barnet is heterosexual exposure (64%) followed by MSM (20%) exposure, with high rates of late diagnosis (58%) for those who had a heterosexual exposure. An estimated 10% of Barnet population is from black or black ethnic groups, but just below half of all cases (45%) were 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.

There is lack of information on the actual number of HIV tests carried out in current settings and hence a need to conduct a detailed service review looking into the local acceptability rate for a HIV test and the preference to use different services by age, gender and ethnicity.

Only eight GP surgeries in Barnet are participating in HIV screening as part of the full STIs screening in Barnet. There is a need to enrol more GPs to offer HIV screening especially from hotspot areas for HIV epidemiology.

A HIV test is not offered to all individuals attending family planning services. Based on the Barnet'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 no outreach work for HIV awareness and testing in the community and no pharmacy based HIV testing in Barnet at present and although there are media campaigns organised by London HIV Prevention Programme, they lack screening element. In order to reduce late diagnosis of HIV and to encourage more testing in the community, we need to consider piloting outreach work and pharmacy involvement and to signpost individuals to the appropriate services.

5.6 - Future strategic aspirations

Our future strategic aspirations are to 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, encourage uptake of tests and reduce the number of patients presenting at a late stage of the illness.

Recommendations

1. Undertake a service review of the current facilities offering HIV tests in Barnet 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. Continue with HIV testing in the primary care settings and enrol additional GP surgeries from hotspot areas of the Borough to offer HIV test to **all** new GP registrations and individuals in the risk groups.
5. Collaborate with the drug and alcohol team in promoting HIV testing as part of the screening for blood borne viruses.
6. Offer a routine HIV test on an opt-out basis to **all** patients seen in family planning clinics.
7. Continue to offer a routine HIV test on opt-out basis to **all** patients seen at GUM services as per national recommendation³.
8. Pilot and evaluate the 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, 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.

6 – Conclusions

- 1- Barnet has a diverse population with distinct needs as well as a diversity of cultural barriers to address sexual health. The main priorities in Barnet 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 Barnet has risen in the past years and there is an urgent need to address the rising 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 services, 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 provision of sexual health and reproductive 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 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. The existing services cover some aspects of these but there are limited school programmes beyond the investment made this year from Public Health budgets. There is a need to review the existing services to ensure they incorporate the needs of our growing young population and the current SRE programme should be extended to secondary schools. In addition, we should consider training sexual health champions for non-traditional settings i.e. youth centers, gym and social clubs. These champions can raise awareness about sexual and reproductive health and signpost young people to local services.
- 5- There is good evidence of declining teenage pregnancy rates in Barnet in recent years, however, 42% of all acute STIs in 2012 in Barnet were among 15-24 year olds. Similarly, the information about where existing services , their locations and what they offer is not easily available. This indicates that in addition to expanding our services, we need to launch a robust awareness campaign with clear 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 market the local facilities offering sexual health and family planning services and should explore social media platforms and voluntary and charitable organisations in spreading the message to wider audiences.
- 6- The epidemiology of HIV among Barnet 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 Barnet 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 Barnet. Similarly, the percentage of late HIV diagnosis in Barnet is higher compared to London and England. In light of the above, we need to promote and encourage HIV testing among at risk population groups via easily accessible and opportunistic testing facilities in primary care, family planning and community settings.
- 7- Currently, there are gaps in the accurate information on the demography of actual and potential service users by disability, ethnicity, sexual orientation and existing health conditions. Similarly, there is poor evidence of the local populations preferences for service access. In order to better understand the needs of the local population and to identify any further gaps, it is essential to map and review all current sexual health services.
- 8- 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.

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- 29- Public Health England (2014) Addressing Late HIV Diagnosis through Screening and Testing: An Evidence Summary (available at) http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317141126407
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- 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 (i.e. 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

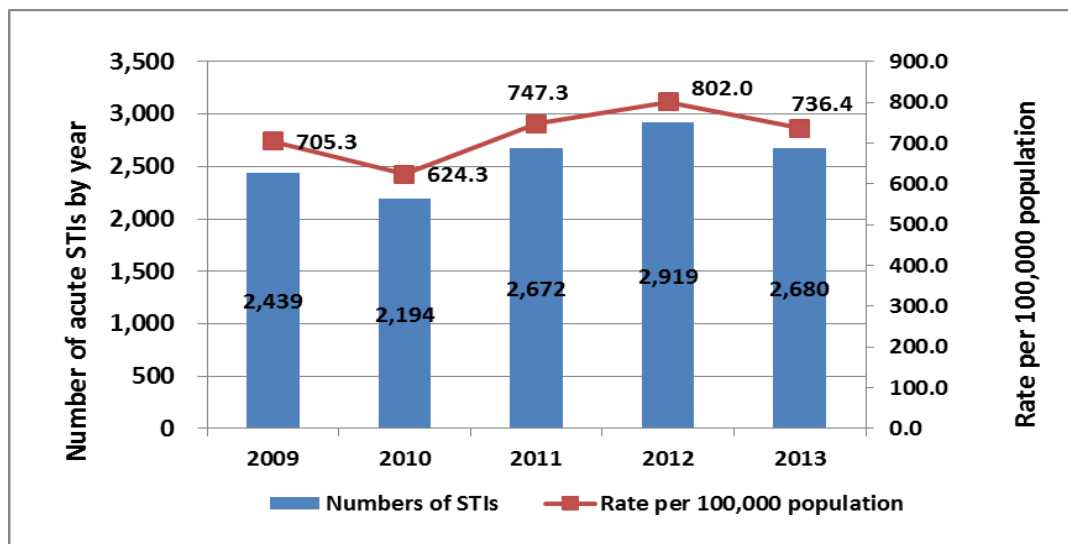
Key objectives in 'A Framework for Sexual Health Improvement in England'	Benefits at the individual level	Benefits at the public health/population level	Other benefits (economic, health and social outcomes) ✓ = benefit for specified commissioner(s)
<p>Objective: Continue to reduce the rate of under 16 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>

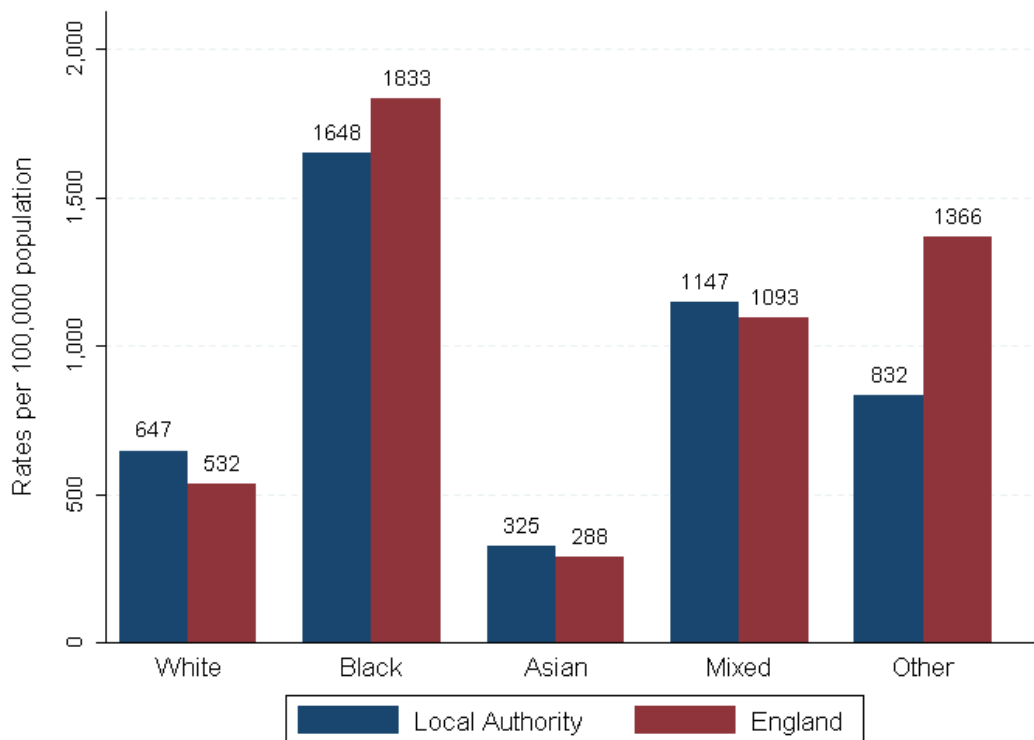
Appendix 1B – Comparison of main STIs between London and Barnet 2012-2013

		Chlamydia						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	Number of cases	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
London	Rate per 100,000 population	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
Barnet	Number of cases	564	485	494	509	1,067	998	243	219	279	233	24	22	458	447	2,919	2,680
Barnet	Rate per 100,000 population	1,277.0	1,098.1	199.6	205.7	293.2	274.2	66.8	60.2	76.7	64.0	6.6	6.0	125.8	122.8	802.0	736.4

Appendix 2B - Number and rates of acute STIs among Barnet residents between 2009 - 2013

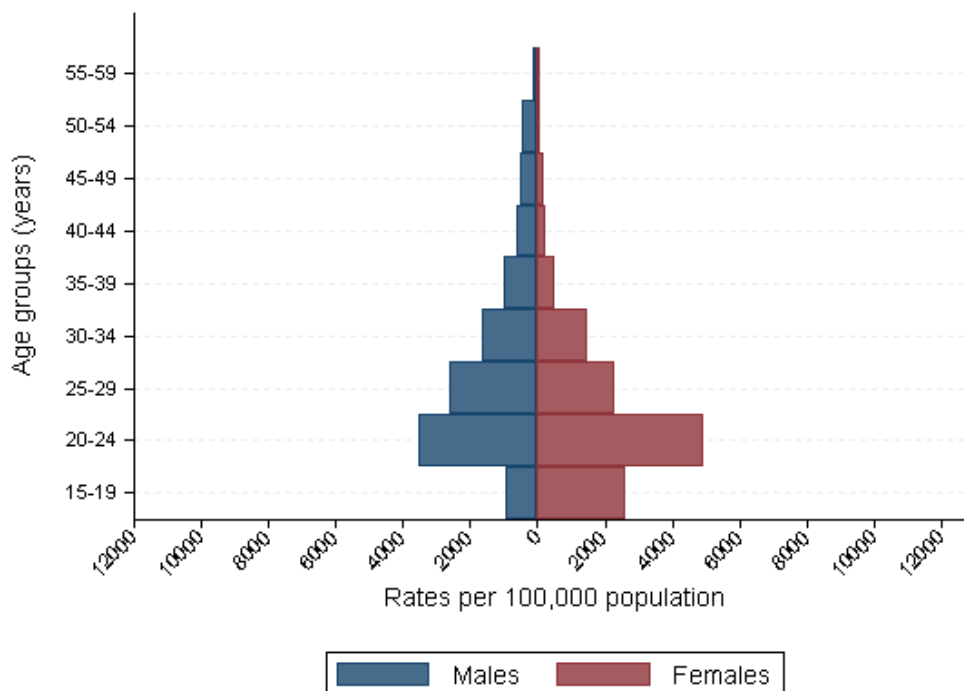


Appendix 1C - The rate per 100,000 of acute STIs by ethnic group in Barnet and England: 2012



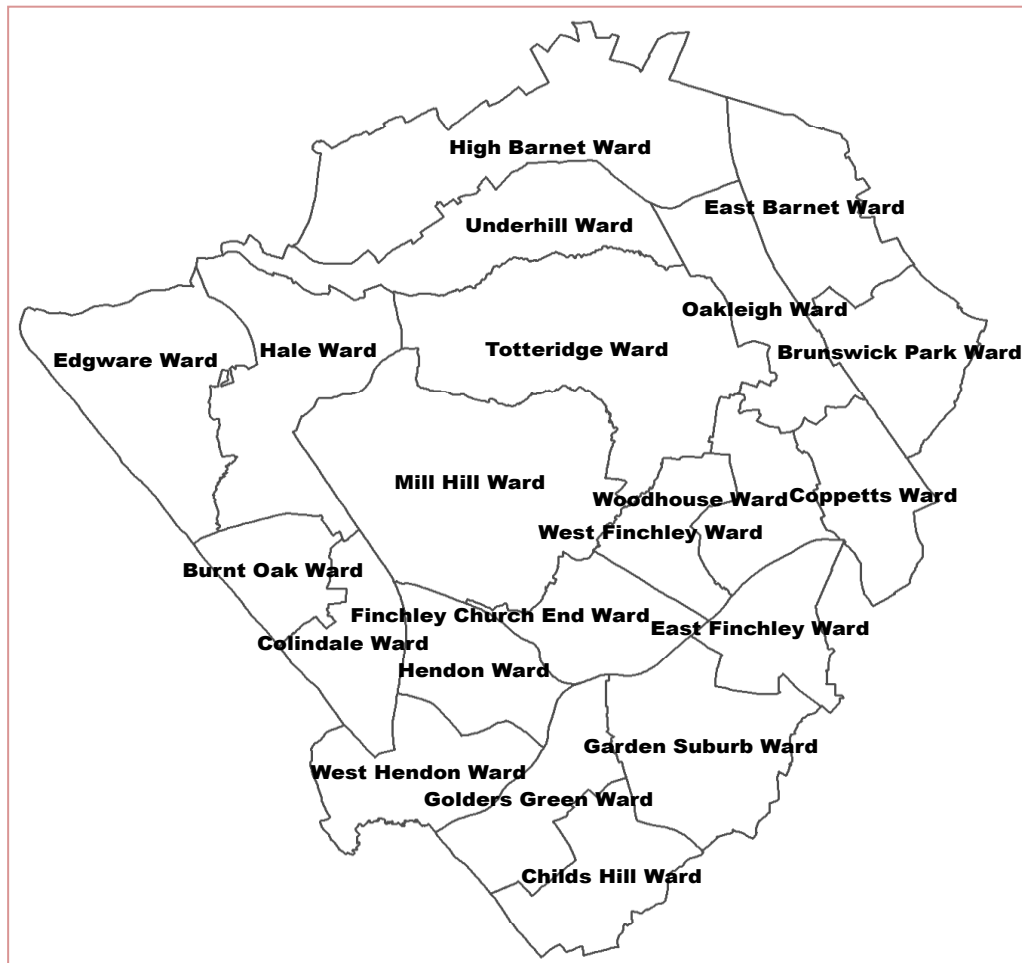
Source: Data from Genitourinary Medicine clinics

Appendix 2C - Age group and gender of cases of acute STIs in Barnet: 2012



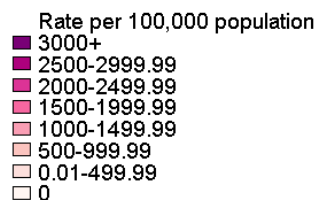
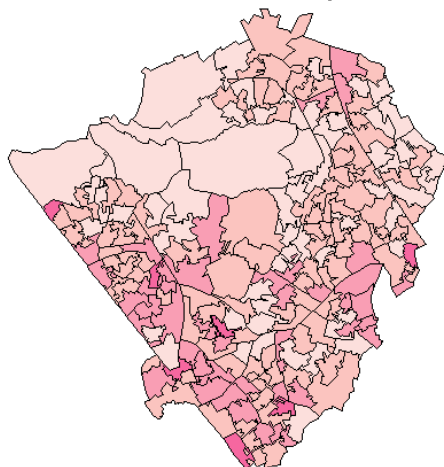
Source: Data from Genitourinary Medicine Clinics and community settings (for Chlamydia only)

Appendix 3C - London Borough of Barnet by Ward names and boundaries

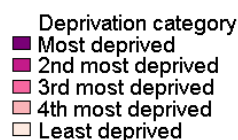
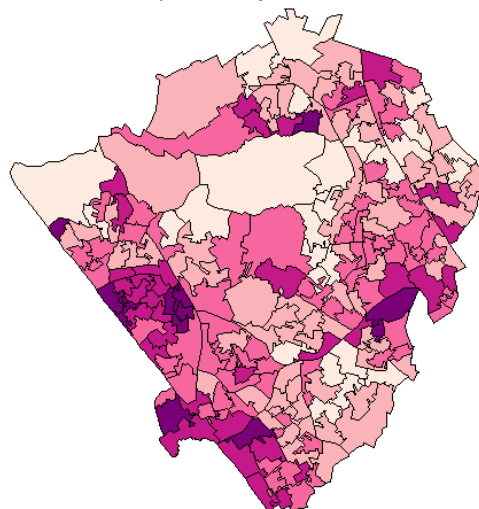


Appendix 4C - The rate per 100,000 of acute STIs by LSOA* in Barnet: 2012

Distribution of rates of acute STIs by LSOA



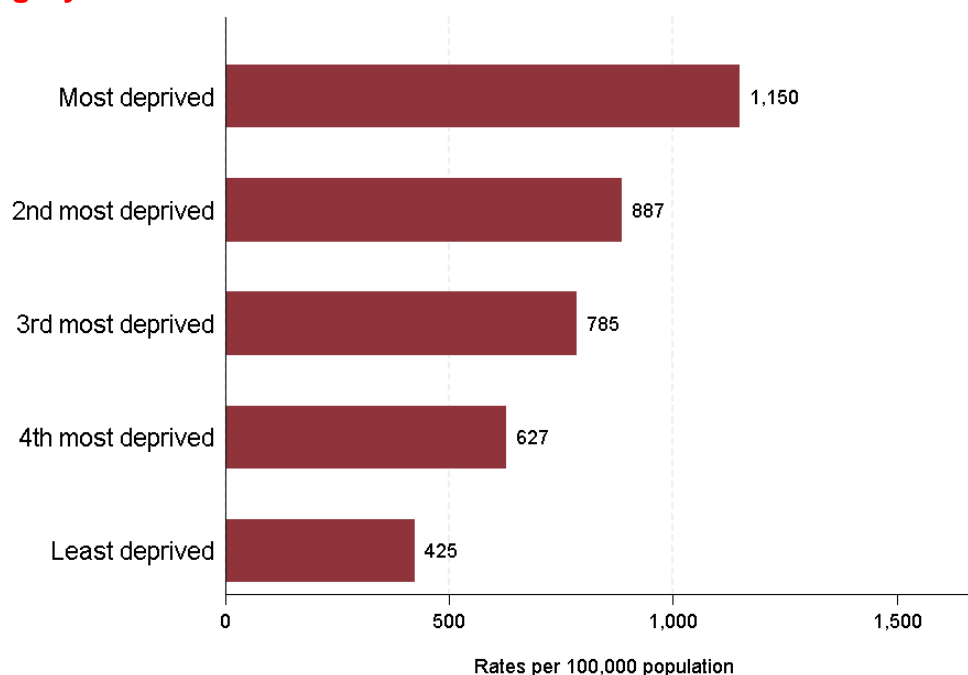
Distribution of deprivation by LSOA



Source: Data from Genitourinary Medicine Clinics

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

Appendix 4D - The rate per 100,000 of acute STIs by deprivation category in Barnet: 2012



Source: Data from Genitourinary Medicine Clinics

Appendix 4- Percentage of all attendees by Barnet residents at GUM clinic 2012

Clinic name	% of all attendances
Barnet Hospital	36.0
The Royal Free Hospital	20.4
Archway Sexual Health Clinic (GUM)	11.8
Mortimer Market Centre	6.3
St Mary's Hospital London	4.9
Dean Street Clinic	4.6
Northwick Park Hospital	2.9
Central Middlesex Hospital	1.8
St Bartholomew's Hospital	1.2
Town Clinic	1.0
Guy's Hospital	1.0
St Ann's Hospital	1.0
St Thomas' Hospital	0.9
Charing Cross Hospital	0.8
The Royal London Hospital	0.7
Watford General Hospital	0.6
John Hunter Clinic	0.6
Homerton Hospital	0.6
Margaret Pyke Centre (GUM)	0.4
St Albans Hospital	0.2
Hertford County Hospital	0.2
King's College Hospital NHS Foundation Trust	0.2
Leeds General Infirmary	0.1
Ealing Hospital, Pasteur Suite	0.1
Whittall Street Clinic	0.1
Newham General Hospital	0.1
West Middlesex University Hospital	0.1
Royal Sussex County Hospital	0.1
Queen Mary's Hospital (GUM)	0.1
St George's Hospital (GUM)	0.1
Kingston Hospital	0.1
Whipps Cross University Hospital	0.1
Tudor Centre	0.1
The Garden Clinic	0.1
Barking Hospital	0.0

Appendix 5 - Barnet's Sexual and Reproductive Health Profile (as of September 2014)

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



Indicator	Period	Barnet		Region	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Syphilis diagnosis rate / 100,000	2013	22	6.0	19.8	5.9	90.9		0.0
Gonorrhoea diagnosis rate / 100,000	2013	219	60.2	155.4	52.9	533.2		3.6
Chlamydia diagnosis rate / 100,000 aged 15-24 (PHOF indicator 3.02)	2013	485	1,098	2,179	2,016	840		5,758
Chlamydia diagnosis rate / 100,000 aged 15-24, pre-2012 data	2011	598	1,347	2,190	2,097	948		4,911
Chlamydia proportion aged 15-24 screened	2013	7,087	16.0%	27.7%	24.9%	10.6%		58.2%
Chlamydia proportion aged 15-24 screened, pre-2012 data	2011	8,069	18.2%	32.0%	29.7%	14.4%		51.6%
Genital warts diagnosis rate / 100,000	2013	447	122.8	163.9	133.4	288.6		70.7
Genital herpes diagnosis rate / 100,000	2013	233	64.0	89.9	58.8	182.9		21.4
HIV testing uptake, MSM (%)	2013	1,101	97.4%	95.7%	94.8%	86.1%		100%
HIV testing uptake, women (%)	2013	5,248	86.0%	82.4%	75.8%	29.0%		94.4%
HIV testing uptake, men (%)	2013	4,803	92.2%	89.7%	84.9%	58.4%		95.9%
HIV testing coverage, MSM (%)	2013	820	86.0%	86.6%	86.1%	63.3%		100%
HIV testing coverage, women (%)	2013	4,614	66.5%	67.8%	65.6%	26.0%		85.2%
HIV testing coverage, men (%)	2013	4,162	79.8%	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	73	54.5%	44.9%	48.3%	0.0%		80.0%

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



Indicator	Period	Barnet		Region	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Abortions under 10 weeks (%)	2013	1,301	83.8%	82.9%	79.4%	55.6%		87.4%
Under 25s repeat abortions (%)	2013	169	30.1%	32.6%	26.9%	49.2%		13.9%
Total abortions rate / 1,000	2013	1,624	19.9	22.8	16.6	32.4		9.0
GP prescribed LARC rate / 1,000	2013	1,582	19.4	25.1	52.7	7.5		96.3
GP prescribed LARC rate / 1,000 (old version - PCT based)	2012/13	1,610	18.0	23.2	49.0	6.2		99.4
Pelvic inflammatory disease (PID) admissions rate / 100,000	2012/13	120	146.8	217.6	228.3	693.9		70.9
Ectopic pregnancy admissions rate / 100,000	2012/13	96	117.4	118.5	94.7	173.1		14.0
Cervical cancer registrations rate / 100,000	2009 - 11	-	7.0	6.7	8.8	17.4		3.0
Under 18s conception rate / 1,000 (PHOF indicator)	2012	91	14.7	25.9	27.7	52.0		14.2
Under 16s conception rate / 1,000 (PHOF indicator)	2012	16	2.6	4.4	5.6	15.8		2.0
Under 18s conceptions leading to abortion (%)	2012	64	70.3%	62.2%	49.1%	27.3%		79.5%
Under 18s abortion rate / 1,000	2012	64	10.3	16.1	13.6	7.1		25.8
Under 18s birth rate / 1,000	2012	27	4.4	9.8	14.1	3.0		33.8