Wandsworth Sexual Health Needs Assessment draft

March 2015

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Executive summary

Health needs assessment is a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities. Comprehensive health and social needs assessment is an essential starting point for the development of any intervention strategy, service development or health improvement programme.

Sexual health covers the provision of prevention, advisory, diagnostic and clinical services relating to contraception, relationships and sexually transmitted infections, including Human Immunodeficiency Virus (HIV)and abortion. Good sexual health is an important aspect of an individual's health and wellbeing; people need to have the information, knowledge and skills confidence and the means to make choices that are right for them. Certain risk factors are associated with increased transmission of STI and HIV, including: Age at first sexual intercourse, number of lifetime partners; concurrent partnerships, payment for sexual services, alcohol and substance misuse.

This rapid needs assessment involved convening a steering group comprising of staff from Council Department, HealthWatch Wandsworth, and Clinical Commissioning Groups to support and inform the process. It is informed by epidemiological data collated from a range of national and local sources. Comparative analysis was undertaken using available national and local data, latest evidence and targets. Previous focus group discussions undertaken with a range of stakeholders have been incorporated and few more engagement with current and past service users, provider and different section of Wandsworth population is undertaking.

This draft needs assessment has identify key areas of consideration outlined below that could inform future sexual and reproductive health service development and strategic planning.

Key issues identified from needs assessment

STI

- Uptake/promotion of chlamydia screening is poor in pharmacy settings.
- Activity does not follow need of population

Access to GUM services

- Historically, reasons for not accessing sexual health clinics in the borough of residence include lack of convenience and anonymity (fear of being seen by people you may know). It is not known whether these reasons still stand and whether they fully explain why approximately 51% of Wandsworth residents accessed genito-urinary medicine services outside the borough in 2013

HIV

- On-going concern over people not wanting to know their HIV status
- Clinical leadership and staff training is key to success of HIV testing

Chlamydia screening

- Demand for online provision of Chlamydia screening kits is highest among those aged 24 year old which constitutes the upper age limit of the National Chlamydia Screening

Programme. Work needs to be done to ensure online services continue to be available for this cohort.

Contraception and Termination of Pregnancy

- LARC uptake is below the rate for England
- Reasons for high proportions of removal of LARC need to be explored.

Young People

- Wandsworth young mother's review reported an inconsistency use of contraceptive by young women and inadequate SRE provision in schools.

Substance misuse

- Drug users and injecting drug users are particularly vulnerable to contracting and spreading blood-borne viruses including HIV. Accurate data is missing to estimate scale of the Injecting drug use in Wandsworth.

Men who have sex with Men

- Nationally, Men who have Sex with Men represented more than 40% of men diagnosed with an acute STI in 2012. In Wandsworth, MSM represented 30% of men presenting with an acute STI in GUM clinics.

BME communities

- People from Black and Ethic groups are disproportionately affected by STI's. In 2012 the Wandsworth rate per 100,000 population for black residents was 2,836 per 100,000 population compared to white residents of 1,464 per 100,000 population.

Older people

- People over the age of 50 years accounts for 20% of Wandsworth population. There is national evidence suggesting many older people do not contemplate the use of a condom or seek sexual health advice when engaging in new sexual relationships.
- National evidence suggest late diagnosis of HIV is more common in older age groups (half of those aged over 50) compared with younger age groups (one-third of those aged 16 to 19)

FGM

- Establishing how many children are at risk of FGM in Wandsworth.
- Supporting primary schools (demographic most likely to be affected) and targeting at risk groups.
- Incorporating FGM within the wider violence against women and girls strategy.
- Continued engagement with affected communities.
- Developing the health care provision for those affected.

Sexual violence

- The psychological effect sexual violence is not sufficiently recognised
- The long term of effect of coping with sexual violence may include alcohol and drug use.

Primary care Services

- 60% of Chlamydia screening is performed outside GUM setting. The majority of practices refer positive case to GUM clinic for partner notifications.

Injecting drug use

- Injecting drug use accounts for most of the incident of infections with hepatitis C virus. Of the 133 eligible clients in Wandsworth, 52 accepted and 66 refused the test, only 50% of the client group which is a concern.

Draft recommendations

STI and HIV

- Dedicated sexual health outreach programme is needed for those most at risk of sexual ill health.
- STI screening and HIV testing should be sustained and continued in wards of high prevalence and amongst groups at highest risk.
- In order to tackle high rate of Chlamydia we need to continue embedding Chlamydia screening in primary care and sexual health services.
- HIV test in community setting currently carried out by Brighter Partnership in Battersea area should be expanded to other high prevalent sites in the borough.
- Explore the possibility of HIV testing at St. George's accident and emergency department that has been evaluated to be feasible and acceptable through pilot review.
- The specifications of commissioning of Chlamydia and STI from primary care providers should include an incentive for partner notification**.**

High risk groups

- Priority should be given to evidence based preventative interventions such as assertive outreach health promotion programmes specific to the needs of high risk groups.
- Opportunities to provide personalised support and preventive message should be explored using digital technology appropriate for the different at risk groups
- We need to improve on the data to establish the referral to sexual health services for those engaged in Injecting Drug use.
- Promoting HIV testing among men who have sex with men, including outreach schemes and providing rapid point-of-care tests.

Young people

- Teenage pregnancies have dropped in Wandsworth, however, the high rate of termination of pregnancy amongst teenager's calls for sustaining the current effort to keep the rates down.
- The inconsistencies of young people use of contraceptives suggest there is need to promote access to Long Acting Contraceptive care in the community.
- Although school nurse can prescribe Emergency Hormonal Contraception, this is not a common experience in Wandsworth. An opportunity to increase access to Emergency Hormonal Contraceptives by School nursing should be explored special in post 16 educational institutions.

Older people

- Absence of age appropriate sexual health information, plus positive images of mature adults promoting good sexual health and specialised serves are areas that will need to be addressed.

Contraception

- There is a need to determine why uptake of contraceptive services is low in GP settings in Wandsworth.Data on LARC discontinuation should be analysed and compared between GP and RSH services. Discontinuation is an important driver of relative cost effectiveness between LARC methods

Female Genital Mutilation

- A multi organisational action plan is being implemented to ensure the effective sharing of information. This is a new recording process and as such an accurate base-line is unknown. It would be expected that the numbers notified will increase in the next two years as the information gathering processes become more established.
- Evaluate the need to expand the current sexual health services ("deinfibulation" clinic to pregnant women) to all women and girls who have undergone FGM. This should include sexual health advice, screening and an offer of counselling particularly to those who are being pressurised into performing FGM on their daughter.
- Evaluate the effectiveness of support offered to schools in terms of improving school children and staff awareness of FGM and protection of those at risk.

Sexual violence

- A multi-agency strategic response to sexual violence which addresses awareness, prevention and service provision to be undertaken;
- Work to raise awareness of, and improved signposting to appropriate services for victims of sexual violence;
- Extend the provision of emotional support, advice and information to individuals who have experienced rape or sexual assault;
- Ensure that sexual violence pathways are available to all agencies and provides equity of provision. (Sexual Health Commissioning.)
- Training should be provided for front line health and social care and criminal justice staff to ensure that knowledge and awareness of sexual violence is sufficient to ensure cases can be detected and handled in a sensitive and effective way.

Future specific analysis

Recommendation below are suggested for the for areas of needs that has not been sufficiently explore within the scope of the current needs assessment to provide evidence that can inform planning and service development.

- The impact of the newly emerging population sexual and reproductive health needs in Nine Elms
- Sexual health needs of older people, groups most affected by sexual ill health such as people affected by mental health, men who have sex with men, vulnerable migrants, people with learning disabilities, and black African communities affected.

Suggestion from stakeholders engagement

In a recent public engagement around HIV prevention and care involving service user, providers, voluntary organisations directly involved in supporting people living the following key issues points below were raised:

1. HIV services should operate on the national policy of open access and are available to everybody living and working in Wandsworth.

2. Areas of high prevalence were identified as Tooting, Balham and Roehampton.

3. HIV outreach and community engagement prevention programme should work closely with pan London and National HIV prevention programmes to ensure that regional and national resources are effectively utilised locally.

4. HIV care and support services should be more accessible through self referrals as well as via Sexual Health Advisors.

5. All HIV contracted services should be assessed to ensure that they don't discriminate on the grounds of their disability, race, culture, religion, faith or belief, sexual orientation, age, gender or socio-economic situation, immigration status and place of or no residence.

6. HIV contracted services are required to engage local communities and stakeholders on regular and structured bases to ensure their needs and expectations are met and Not a one off consultation please...

7. All HIV contracted services need to establish collaborative working arrangements to avoid duplication with other sexual and social care providers

8. Particular emphasis need to be made to follow a clear and systematic referral and care pathways followed by patients from prevention to care and treatment moving seamlessly through the NHS sexual health services, social care and primary care.

9. Reaching out routinely to engage and involve non-affiliated service users who are not part of service user groups or organisations or community groups including sex workers, prisoners, and young people excluded from schools, those in care or leaving care, asylum seekers, and undocumented migrants, etc.

10. As part of the HIV prevention programme the Council should organise local campaigns and events to raise awareness that HIV is still a major public health threat and build up community resilience to challenge discrimination and stigma linked with sexual health and HIV in particular.
11. Information and training for parents on Sex and Relationship issues to advice/guide their children
12. More and clear information on FGM and on how to get support to challenge domestic violence which is culturally sensitive and effective
13. Sexual health advice and information in GP surgeries need to improve as it is the first point of contact.
14. High profile publicity on social media, community based events to promote sexual health campaigns locally throughout the year not just one off campaign such as World AID's Day.
15. GP staff needs training on sexual health in general and how to access services in particular, also on cultural awareness and entitlement to sexual health services
16. There needs to be far greater partnership work developed to address the complexity of drug and alcohol use amongst Men having Sex with Men.
17. Shortage of good advocacy services in sexual health and employment, training and housing in particular. The current services are more on advice and information but almost nothing on advocacy.
18. Improve the role of GUM in HIV and STI prevention and to build a better link with the outreach prevention and testing programmes (brighter partnership) to increase uptake of HIV/STI testing.

1.0 Health Needs Assessment definition and rationale

Health needs assessment is a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities. Comprehensive health and social needs assessment is an essential starting point for the development of any intervention strategy, service development or health improvement programme

1.1 Approach to health needs assessment

The health needs assessment combines epidemiological, corporate and comparative approaches in assessing need. The epidemiological approach to health needs assessment provides an understanding of the make-up of the population in question, risk factors for disease they are likely to encounter, examination of the incidence of disease within a community and how these factors relate to the demand on services. The corporate approach in health needs assessment looks at the perceived major health and healthcare issues from the perspective of professionals and stakeholders. The comparative approach to the needs assessment benchmarks services in question against those for a different provider.

This health needs assessment informed by epidemiological data collated from a range of national and local sources. Comparative analysis was undertaken using available national and local data, latest evidence and targets, focus group discussions undertaken with a range of stakeholders to obtain corporate views.

The recommendations drawn from the needs assessment is aimed to support the Wandsworth Councils strategic plan, Wandsworth's Clinical Commissioning Group (WCCG) and NHS Commissioning Board in strategic decision making and effective use of resources to improve sexual and reproductive health in the borough.

1.1 Background

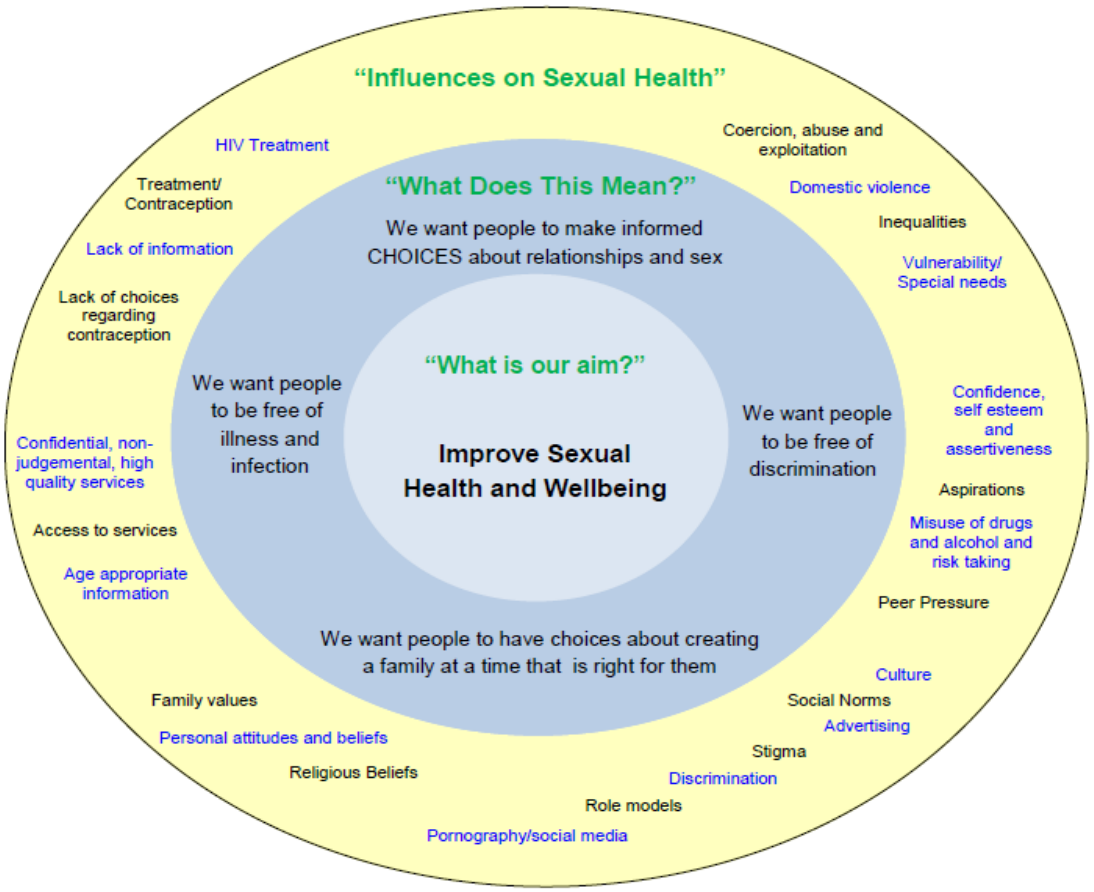
Sexual health affects our physical and psychological wellbeing and can have an enduring impact on our overall quality of life. It is a key part of our identity as human beings together with the fundamental human rights to privacy, a family life and living free from discrimination. The core elements of good sexual health are equitable relationships and sexual fulfilment with access to information and services to avoid the risk of unintended pregnancy, illness or disease.

Sexual health covers the provision of prevention, advisory, diagnostic and clinical services relating to contraception, relationships and sexually transmitted infections, including Human Immunodeficiency Virus (HIV)and abortion. Good sexual health is an important aspect of an individual's health and wellbeing; people need to have the information, knowledge and skills confidence and the means to make choices that are right for them.

1.3 Risk factors and influence

Certain risk factors are associated with increased transmission of STI and HIV, including: Age at first sexual intercourse, number of lifetime partners; concurrent partnerships, payment for sexual services, alcohol and substance misuse.
As shown in figure-1, there are multiple factors that influence the overall sexual and reproductive health and wellbeing in a population.

Figure 1 Factors that influence sexual health



Sexual ill health is not equally distributed within the population of Wandsworth. Strong links exist between deprivation and Sexually Transmitted Infection (STI), teenage conceptions and abortions. The highest burden of STI is borne by Men who have Sex with Men (MSM), teenagers, young adults and some Black and Minority Ethnic (BME) groups.

1.4 Policy drivers

The National Framework for Sexual Health Improvement in England (2013) highlights the Government's ambition to improve the sexual health and wellbeing by tackling inequalities in access and outcomes of sexual healthcare. It advocates an honest and open culture where everyone is able to make informed and responsible choices about relationships and sex, and recognises sexual ill health can affect all sections of our society.
The public health outcome framework for England (2013 – 2016) also introduced performance indicators that the local authorities need to achieve to demonstrate improved sexual health outcomes, these are: under-18 conceptions; Chlamydia diagnoses (15–24-year-olds); and people presenting with HIV at a late stage of infection. The needs assessment will examine the evidence on how Wandsworth has performed against the national indicators and suggest actions for improvement

Public health moved to the Local Authority on 1st April 2013 and it came with a statutory responsibility to commission HIV prevention and sexual health promotion, open access genitourinary medicine and contraception services for all age groups. This is a unique opportunity to consider sexual health and well-being in the context of the wider health and

well-being of the local population, shifting resources to prevention and addressing the wider determinants that impact on individuals' sexual health.

1.5 Sexual health commissioning arrangements

Sexual health and well-being is commissioned by a number of different commissioners. This needs assessment will be relevant to all commissioners. Current commissioning arrangements:

Public health within the local authority:

- Contraception services over and above the GP contract
- Testing and treatment of sexually transmitted infections (excluding HIV treatment)
- Sexual health advice, prevention and promotion

Clinical Commissioning Groups:

- Promotion of opportunistic testing and treatment
- Termination of pregnancy services
- Sterilisation and vasectomy services

NHS England

- Contraception services commissioned through the GP contract
- Sexual assault referral centres
- HIV treatment
- Relevant vaccinations

1.6 Other Commissioners

A number of local authority teams are involved in commissioning services that will have an impact on sexual health eg safety, youth, education, early years etc. Any commissioning of the wider determinants of health will also have an impact on sexual health and well-being.

London wide, there is a London Sexual Commissioning Board/Group, which is driven by NHS London and the London Sexual Health Programme. It provides a forum for discussion of pertinent sexual health issues and a vehicle to develop London wide initiatives – e.g. a standard service specification for commissioning abortion services from any qualified provider (AQP), achieving efficiencies from the Pan-London procurement of condoms, developing standardised Patient Group Directions (PGDs) for use by staff in primary care, sexual health services and pharmacy, commissioning London Sexual Assault Service (the Havens) and the development of the integrated sexual health tariff. There is also a North West London Sexual Health Commissioning Group made of public health representatives and sexual health commissioners who meet regularly.

4.0 Methods

This rapid needs assessment involved convening a steering group comprising of staff from Council Department, HealthWatch Wandsworth, and Clinical Commissioning Groups to support and inform the process.

A number of sources of literature were used to inform the needs assessment:

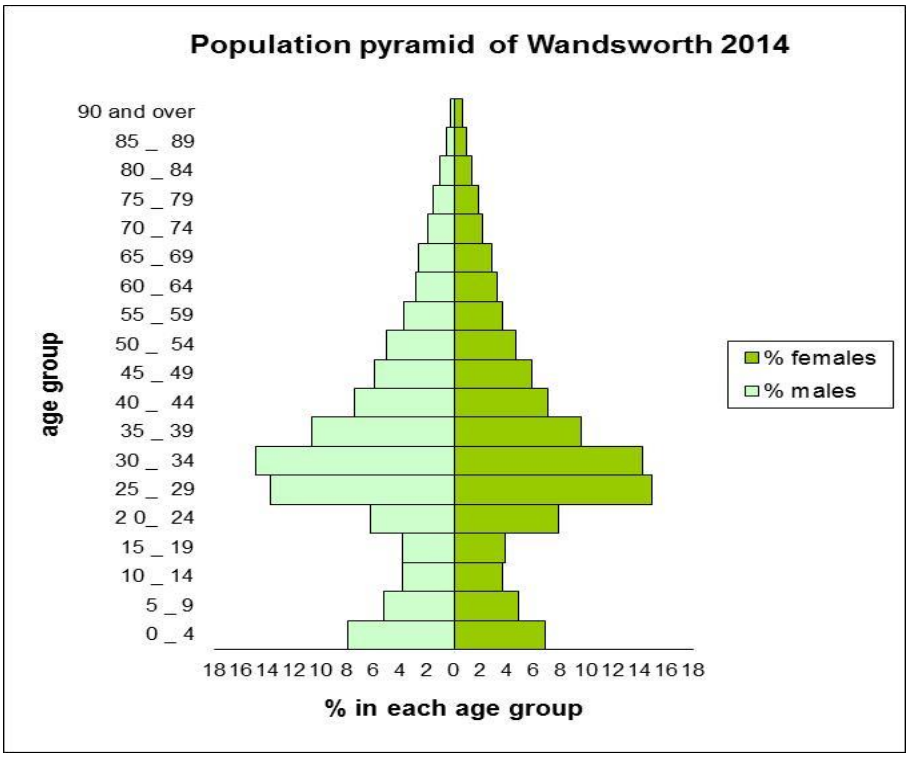
1) Wandsworth GP sexual Health Audit, 2012
2) Wandsworth Prison Health Needs Assessment , 2012
3) Wandsworth young mother's review , 2014
4) User Involvement from review involving service users, voluntary organisations directly involved supporting people who live with HIV and service providers, 2014.
5) Published literature on effectiveness of various sexual health interventions.
6) National Institute of Clinical Excellence recommendations of best practice

Demographic and health profile data were collated and all data were mapped wherever appropriate. Stakeholder meetings formed a qualitative phase of intelligence gathering. The content of this meeting was analysed using a thematic technique following the collection of notes and recordings made at the session.

3.0 Wandsworth Profile

Wandsworth's predominant demographic is of a young, professional, transient and growing population, with a higher population density than the London average, placing Wandsworth as the tenth most densely populated area in the country (Census 2011). The unique shape of the population demographic is illustrated in Figure 5 below. There is a large number of young adults living in Wandsworth, coupled with increases in the number of children, and a corresponding need for provision of family homes. The last decade has seen the borough's population increase from 260,382 at the 2001 Census, to 307,000 by the 2011 Census – the fourth largest borough population increase in London over the last decade. Further discussion on each locality is given in section 4.2.

Figure 2 Population pyramid by five year age bands and gender



Source : Wandsworth Public Health 2014

3.1 Migration

Wandsworth has the highest migration rates of any London borough, and the fourth highest rates of any local authority in England and Wales (ONS, 2012, Migration Indicator Tool). This represents 30,000 from within the UK, and 7,000 from overseas. This includes approximately 300 asylum seekers who are likely to have specific health and social care needs.

3.2 Children

Wandsworth is projected to have a 15% (4,400) increase in the number of children (aged 0-15 years) between 2014 and 2019. (GLA population projections 2011).

3.3 Young Adults

Wandsworth has the highest proportion of 25-39 year-olds of any local authority nationally (39%), compared with an average of 28% across London (Census 2011). There is an anticipated rise of 2,700 (2%) from 2014 to 2019 (GLA).

3.4 Older People

The borough has 27,000 people over the age of 65 (8%), compared to an average of 11% across London (Census 2011). By 2019 it is anticipated that there will be an additional 1,500 people over the age of 65, an 8% increase (GLA). By 2020:

- 11,000 people (37%) may be living alone, an increase of 12%
- 13,000 people (42%) may be unable to manage a common domestic tasks, e.g. vacuuming, an increase of 14%
- 10,000 people (34%) may be unable to manage a self-care activity, e.g. dress/undress, or take medicines, an increase of 13%.

3.5 Black and Minority Ethnic (BME) groups

These groups represented 88,000 people (29%) in 2011, a growth of 30,000 since 2001 (Census). BME groups represented 49% (3,205) of all Jobseeker's Allowance Claimants in 2010/2011. Tooting has the highest percentage of BME population, with over half of its population (52.7%) from a BME group.

3.6 Deprivation

Between 2007 and 2010, the Index of Multiple Deprivation score across the borough increased from 20.39 to 21.50, reflecting greater deprivation. However, approximately 197,000 people lived in Lower Super Output Areas (LSOAs) where deprivation reduced overall, while a smaller population of 86,000 lived in LSOAs where deprivation increased.

3.7 Lone Parents

The 2011 Census counted 7,877 lone parent households in Wandsworth, a growth of 790 households since 2001.

3.8 Elderly Care Homes

As older people are increasingly supported to remain in their homes for as long as possible, the care home population has become older and frailer. With reductions in The care home sector is now an important source of care provision for older people living with complex clinical needs. Despite this it's widely acknowledged that they sometimes have less access to health services than older people who live in the community and that there is wide variation in how health care is delivered to care home residents. A recent care home needs assessment found that this was also the case in Wandsworth, with some reports of difficulty accessing primary care and also limited specialist medical support provided to care home residents[i].

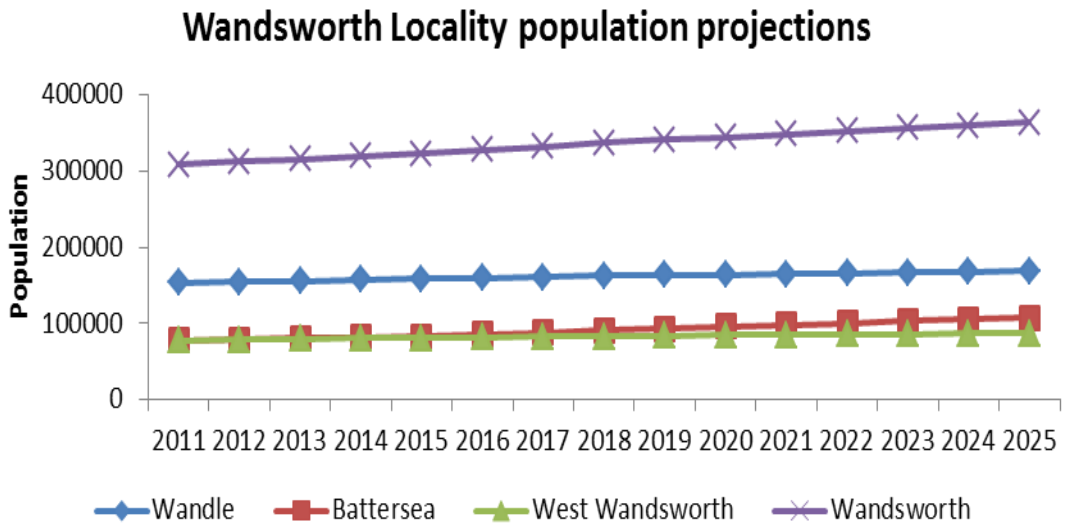
There were 15 care homes providing care to older people that were included in the 2014 needs assessment. There were three purely residential care homes with the remainder

being nursing homes or dual registered i.e. providing a combination of nursing and residential beds within units in the home.

3.9 Population projection

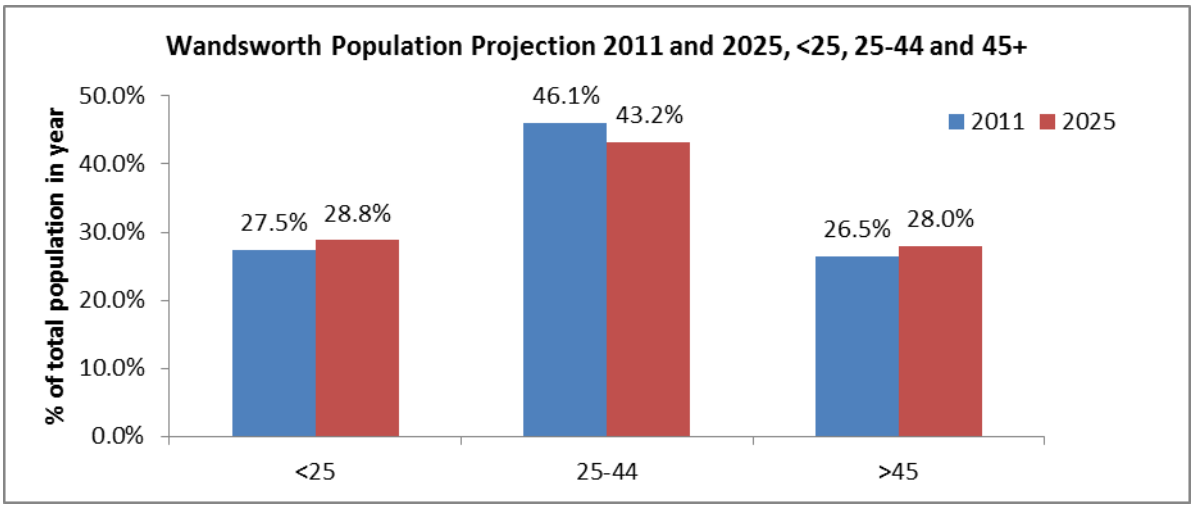
Locality level population projections show varied changes in growth from 2011 to 2025 with higher growth rate being observed in Battersea followed by Wandle and then West Wandsworth locality. When looking at Wandsworth wide data it is projected that there will be a proportional drop in the 25-44 age group and a rise in the <25 and the 45+ age group by 2025 (see figure 1 below)

Figure 3 Wandsworth locality population project 2011and 2014



Source : Wandsworth Public Health Department 2014

Figure 4 Wandsworth wide population projection – 2o11 and 20125



Source Greater London Authority 2014

3.10 Demographic implications

A bigger population will increase population density, with an increasing demand for statutory services, such as schools, recreation, health care, and social care.

It is likely that with a more mobile population there will be limited opportunities for intervention. There will be a requirement for more flexible appointment times and locations. Symptom and risk awareness services will also need to be comprehensive and immediate.

There will also be an increased demand for walk in services, as people may not be registered with a GP practice and patient follow up will be more difficult. With the observed increase in lone parent households there should also be clear signposting and comprehensive information services for issues including financial entitlements and housing, depression, smoking cessation, family planning, and domestic violence.[ii]

An ageing population and those in more deprived circumstances - 25% of people over 75 are Council tenants (Census 2011) - will impact on health and social care services, especially for people with multiple long term conditions which will increase in complexity as people live longer. Typical issues will be dementia, neurological conditions, visual deterioration, and diabetes. Special provisions will also be required for end of life care. Population based and targeted prevention services will be required, such as cardiovascular disease and cancer prevention and screening, the reduction of emergency admissions and prevention and rehabilitation from falls. It will also impact on carers, who will need to be assessed routinely to ensure their own health is not compromised and that they are supported to have a life outside of caring as well as supported to continue to care.

The increase in child population will have implications for health care service capacity such as primary care, out of hours services, A&E services, walk-in centres and dental services. In addition it will have an impact on comprehensive child and adolescent mental health services across all tiers of care. There will be a need to provide primary and secondary education and comprehensive personal social and health education in schools to cover issues such as sexual health, obesity, smoking and physical activity. The Foundation Stage Profile undertaken for children leaving reception year highlights gaps in personal social and emotional attainment by deprivation and ethnic background within Wandsworth. Special care will need to be taken in providing targeted prevention services and on early years locality focused work such as the Early Help scheme and family support services. There is also an impact from the increasing population of children with special needs and disabilities.

The implications of a more ethnically diverse population, some of whom may speak little English, will have implications for health promotion and service planning, particularly awareness programmes for screening, and conditions such as diabetes and circulatory disease.

Population changes in Wandsworth are difficult to predict, with potentially significant population increases in Nine Elms and Vauxhall with unclear moving in dates and estimated health and care needs. GLA population projections take account of housing developments, but are still presented with a considerable time lag; this is further compromised by the high mobility observed in Wandsworth. A key challenge for Wandsworth is to link data sources together to provide a better real – time estimate of the population and mobility.

4 .0 The level of need in the different population

4.1 Emerging Population Groups

Battersea has some of the highest rates of STIs and HIV in the borough. It is also home to the Nine Elms and Vauxhall (NEV) construction site and will be the work place for over 23,000 construction workers over the course of the build. The population age make up will change shape over the course of the development within 5 years. The total population size in the Wandsworth part of the NEV will be expected to grow by 28,000 by 2023.

These demographic changes assume a young population will be moving into the area, however the existing residents in the area will reflect a broader age demographic, particularly the over 80's.

4.2 Men who have Sex with Men (MSM)

MSM represents 1.9% of the London population yet they account for 20% of all London residents diagnosed with an acute STI in GUM clinics in 2012. In seven London local authorities MSM represented more than 40% of men diagnosed with an acute STI in 2012. In Wandsworth, MSM represented 30% of men presenting with an acute STI in GUM clinics[iii].

A survey conducted by Stonewell in 2010 reported that 50% of MSM had taken drugs in the last 12 months (vs.12% in the general population) 42% drank more than 3 times a week (vs.35% of the general population) and 8% had attempted suicide over a period of 12months[iv]. 'ChemSex' amongst this group is reported to be on the increase. Slamming which entails injecting mephadrone or crystal meth results in users engaging in risky behaviour such as unprotected sex. This increases the likelihood of acquiring HIV and Hepatitis C, in addition anti-retroviral HIV treatment can be missed whilst under the influence of illicit drugs[v].

Stone well research has found slightly higher levels of recreational drug use amongst disabled gay and bisexual men (55%) compared to the wider gay and bisexual male population (51%) and compared to men in general (12%)[vi]

There is a growing body of evidence around the higher levels of violence and abuse experienced by MSM. One national survey found over a half of gay and bisexual men reported violence or abuse from a family member or partner from the age of 16 years; however four in five (78%) did not report it[vii].

4.3 Lesbian, Gay, Bi-sexual, Trans (LGBT)

The relationship between sexual orientation, gender identity and health is often overlooked. There is evidence to suggest that Lesbian, Gay, Bisexual and Transgender (LGB&T) people experience significant health inequalities. There is often an assumption that LGB&T groups are homogenous, this poses a major challenge to the promotion of good sexual health and service prevision. Often the prevalence of high STI rates in MSM is the only population addressed; leading to a shortage of appropriate services and relevant information [viii] Young LGBT people and including their heterosexual counterparts do not receive information or are engaged in discussions relevant to their lives during their formative years regarding LGB&T issues. Most information and knowledge is derived from specific LGBT voluntary groups. This therefore raises the question as to how those not engaged with voluntary services access information and advice. It has been reported that young LGBT people affected by poor access to healthcare services even more so than their heterosexual counterparts and report negative views of sexual and reproductive health services [ix].

4.4 Mental health

It is estimated that there are 48,500 people aged 16-74 year old in Wandsworth with severe mental health disorder, and 23,000 who live with anxiety and depression[x]. These groups are often vulnerable to sexual exploitation. There is an association between mental health problems, risky behaviour and unplanned pregnancies.

4.5 People with Learning disabilities

Approximately one million people in England have a learning difficulty. Evidence suggests that provision of Sex and Relationship Education (SRE) nationally is lacking amongst this group.[xi]. Understanding emotions, boundaries, sexual health, and how to stay safe are vital for people with learning disabilities.

In Wandsworth, it is estimated that 1342 (23%) people with learning disabilities are known to services. Many services do not have tailored training to manage the needs of those with learning disabilities[xii].Evidence suggests that provision of Sex and Relationship Education (SRE) nationally is lacking amongst people with learning disabilities and those with mental health needs.

4.6 Homeless people

Evidence suggests this group are at high risk of acquiring STI's. In Wandsworth an estimated 823 households are classed as homeless and 62 as rough sleepers in 2012/13. This is likely to be an underestimation due to the hidden nature of this group. Wandsworth health needs assessment found 73% of homeless people had not had an STI check-up in the last 12-months.[xiii]

4.7 Vulnerable migrant groups

This group includes refugees, trafficked women and people who have lost their welfare benefits and those with language barriers who find it difficult to access mainstream services. Those with failed asylum in Wandsworth are known to be turning to prostitution thereby increasing the likelihood of acquiring STI or an unintended pregnancy. Migrant construction workers are believed to be at high risk of acquiring sexually transmitted infections[xiv].

4.8 Ageing population

People over the age of 50 years accounts for 20% of Wandsworth population. Increases in the rates of STIs within this cohort coincide with high divorce rates in Britain, the latest figures show that 42% of marriages end in divorce[xv]. An increase in internet dating has also been noted, for older adults using the internet to 'enhance their sexual identities and experiences. There is evidence suggesting many older people do not contemplate the use of a condom or seek sexual health advice when engaging in new sexual relationships[xvi].

Erectile dysfunction is an issue among men over the age of 50.This is a marker for cardiovascular disease, diabetes and high blood pressure as well as impairing sexual activity. Women will enter the menopause and increasingly not be at risk of pregnancy. However, older people's needs should not be overlooked. While STI rates in this age group only accounted for 3% of all STIs diagnosed in GUM clinics in 2011, they rose by 20% between 2009 and 2011[xvii]. Late diagnosis of HIV is more common in older age groups (half of those aged over 50) compared with younger age groups (one-third of those aged 16 to 19)[xviii].

4.9 Black and Minority Ethnic groups.

Black and Minority Ethnic groups**:** Represented 88,000 people (29%) in 2011, a growth of 30,000 since 2001 (Census). BME groups represented 49% (3,205) of all Job Seekers Allowance Claimants in 2010/11[21]. Tooting has the highest percentage of BME population, with over half of its population (52.7%) coming from a BME group[xix].

In the UK, Black-African men and women are the second largest group affected by HIV with 38 per 1,000 living with the infection (26 per 1,000 in men and 51 per 1,000 in women) .Nationally, of those living with HIV, 23% were not aware of their infection in 2012[xx].

People from Black and Ethic groups are disproportionately affected by STI's. In 2012 the Wandsworth rate per 100,000 population for black residents was 2,836 per 100,000 population compared to white residents of 1,464 per 100,000 population. For mixed race residents it was 2,277 per 100,000 population[xxi].Whilst Wandsworth has a lower population of black and ethnic communities than the London average, there are variations across the borough. High concentration of Black and Ethic communities are situated in the North East and Southern areas of the borough.

4.10 Yong people

National and international research shows that good quality Sex Relationship Education (SRE) equip children and young people with the information, skills and positive values to enable them to have safe, fulfilling relationships and to take responsibility for their sexual health and wellbeingCurrently there is no statutory obligation for schools to provide SRE. The views of young people, parents and professionals regarding the value of SRE was captured; most young people felt SRE in school was overly focused on avoiding pregnancy. There was little information on STI's; SRE sessions where too biological and failed to address healthy or violent relationships. Issues of exploitation and grooming through social media networks were not tackled[xxii].

The National Children's Bureau Sex Education Forum recommends good quality SRE equips children and young people for Live[xxiii].
Wandsworth Council commissioned a research project: young mothers study to explore the question: 'What are the main factors interventions and influences impacting upon decisions regarding early pregnancy.

The research focused to understand: Do young women feel that they are actively making decisions regarding their bodies, pregnancies and lives?. The report identified that:

- Sex education in schools as lacking and insufficient. They felt there was not enough sessions, the overemphasised physiological aspects and did not include information on young parenthood.
- The SRE emphasised on anatomy and not enough on the emotional aspects of sex, most importantly the experiences of young parents weren't represented within sex education to help young people understand the consequences of unprotected sex
- Insufficient awareness of the full range of contraceptive methods. Even those who were aware of contraceptives were inconsistent their use leaving them at risk of unintended pregnancies.

Overall, the report highlighted that the authentic and genuine contributions to sex education and education around young parenthood is thorough experiential voices were, learning from those who have had real life experience

4.11 Female Genital Mutilation (FGM)

Female genital mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons (WHO, UNICEF, UNFPA, 1997). [xxiv]In the UK it is reported that approximately 66,000 women and girls have been affected by FGM [3]. FGM not only increases the likelihood of

acquiring STIs, but also has long term physical and psychological implications. Due to limited data it is difficult to have a complete understanding of the extent of FGM in Wandsworth. Information from hospital maternity services shows that about 1,044 women with FGM have come into contact with these services between 2007 and 2013.

Wandsworth has developed FGM strategy and made a good start implementing it.

Data recording, analysis and sharing among partners

- GPs and Hospitals need to work together to record instances of FGM and share records where appropriate. GPs have been given a specific code to record FGM on their system. Acute hospitals are mandated to inform the Department of Health of all cases of FGM and to include FGM on all discharge summaries from maternity.
- Work is on-going with the Research & Evaluation Centre (REU) and Schools to collect demographic data on pupils within schools to create a base-line summary of girls at risk.

Equip front line staff with the knowledge and skills to identify and appropriately manage FGM

- FGM is included within the Joint Strategic Needs Assessment and safeguarding training; pathways have been produced for all lead agencies; all information pertaining to FGM has been placed on the website: www.wandsworthfgm.org.uk ;information packs have been distributed to all schools; and a pilot bespoke awareness training for six schools will be provided and evaluated in January 2015.

Empowering communities to take action to prevent FGM:

- Home Office funded projects (2014/15): 10 community members will be trained by the Katherine Low Settlement as Community Champions and they will each deliver 10 FGM-related events within the year, targeting different ethnic groups, ages, genders etc. Springfield Community Flat Charity will raise awareness about the socio-cultural, legal, sexual health and clinical implications of Female Genital Mutilation and to empower local people to speak about the practice.

Accessing local communities: Opportunities are being explored on how best to support local Somali groups who have limited funding to secure their involvement in tackling FGM.

4.12 Sexual Violence

The World Health Organisation defines sexual violence as;

> *"Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including, but not limited to home and work."*[xxv]

Sexual violence is known to be widely under-reported; it is estimated that only one in ten adults who have experienced a serious sexual assault will report to the police.

It is estimated that 2.5% of women and 0.4% of men over the age of 16 will be a victim of a sexual assault in any 12 month period. This represents around 473,000 adults being victims of sexual offences (around 404,000 females and 72,000 males) on average per year. These experiences span the full spectrum of sexual offences, ranging from the most serious offences of rape and sexual assault, to other sexual offences like indecent exposure and unwanted touching.[xxvi]

Alcohol is often a feature of sexual assault. Over a third of offenders and one quarter of victims of serious sexual assault are thought to have consumed alcohol prior to an incident.

Sexual violence can take place in wide range of circumstances and settings, these include;

- rape within marriage or dating relationships; gang rape; and rape by strangers;
- unwanted sexual advances or sexual harassment, including demanding sex in return for favours;
- sexual abuse of mentally or physically disabled people;
- sexual abuse of children;
- forced marriage or cohabitation, including the marriage of children;
- denial of the right to use contraception or to adopt other measures to protect against sexually transmitted diseases;
- forced abortion;
- violent acts against the sexual integrity of women, including female genital mutilation and obligatory inspections for virginity;
- Forced prostitution and trafficking of people for the purpose of sexual exploitation.

Impact of sexual violence

The immediate and long-term health implications of sexual violence can be devastating. There are direct health consequences in terms physical injury, sexually transmitted diseases and in extreme cases death. Mortality can be as a result of the act of violence, or from acts of retribution (for example in cases of honour based violence), or from suicide. There are also contributory factors that might have an impact on long-term health including mental health issues, substance misuse, trauma, unwanted pregnancy, abortion and risky sexual behaviour. Also, but less easy to recognise, are conditions such as obesity and dental neglect which may stem from coping mechanisms including eating disorders such as over-eating or bulimia.

The psychological effects of sexual violence vary from person to person but can include the following:

- rape trauma syndrome;
- post traumatic stress disorder;
- depression;
- social phobia (especially in marital or date rape victims);
- anxiety;
- increased substance or alcohol use;
- suicidal ideation.

In the longer term, victims may report the following;

- chronic headache;
- fatigue;
- sleep disturbance (nightmares, flashbacks);
- recurrent nausea;
- eating disorder;
- menstrual pain;
- sexual dysfunction.

Failure to address immediate and on-going needs can have considerable and long-term impact on a victim's emotional well-being and health. Lack of support can cause a victim to disengage from the criminal justice process, thus reducing the opportunity to bring an offender to justice. Alcohol and drug use is often used as coping mechanism in response to sexual violence. It has

been estimated that between 67-90% women with alcohol and drug addiction problems have experienced sexual abuse[xxvii].

Wider effects of sexual violence and abuse can be seen in the impact on victims' families and community fear of crime: women are more worried about rape than any other crime. The burden to society from lost output and long-term health issues faced by individuals can be substantial. Sexual offences make up 23% of the estimated total cost of crime against individuals and households, with the physical and emotional impact being most costly. It is estimated that each adult rape costs in the region of £76,000; this includes the physical and emotional impact, lost economic output due to convalescence, early treatment costs to the NHS and costs incurred in the criminal justice system[xxviii].

Risk factors associated with sexual violence

A risk factor is an attribute, characteristic or exposure that increases the likelihood of an event. There are a number of factors commonly associated with the increased risk of a sexual assault taking place. Research suggests that these factors have an additive effect; the more factor that are present the higher the risk of an incident occurring.

Risk factors associated with sexual violence;

- being young;
- history of sexual assault when young;
- deprivation, poverty;
- being married or cohabiting;
- domestic violence or abuse;
- alcohol or drug consumption;
- being a sex worker;
- mental illness;
- learning or physical disability.

Risk factors associated with committing sexual violence;

- history of childhood sexual abuse;
- poverty;
- perpetration of domestic violence or abuse;
- social norms: feelings of male entitlement;
- alcohol and drug consumption.

An analysis of reported sexual violence in Wandsworth

Table 1 Rape Offences in Wandsworth

Measure	Total
Increases in Reported Rape Offences	30 of 32 Boroughs
Five year peak in Reported Rape Offences	29 of 32 Boroughs
Total Rape Offences – 2013/14	131
Increase in Wandsworth Rape Offences	+28 (27.2% increase)
Increase in Inner London Rape Offences	+469 (35.2% increase)
Wandsworth Victims aged over 15	84 (64.1% of total)
Wandsworth victims under 16	44 (46.7% increase)
EA3 (African / Caribbean) victims - 2013/14	34 (27.8% of total)
EA3 (African / Caribbean) victims - 2012/13	15 (15.3% of total)
Wandsworth Suspects aged 15-24	36 (112% increase)
Offences involving a friend, acquaintance or intimate partner	69 (53.1% of total)
Wandsworth offences involving a stranger – 2013/14	33 (25.4% of total)
Wandsworth offences involving a stranger – 2012/13	17 (16.5% of total)

Table 2 Other Sexual Offences

Measure	Total
Total Other Sexual Offences – 2013/14	244
Increase in Other Sexual Offences	+17 (7.5% increase)
Increase in Other Sexual 'Incidents'	+11
Increase in Inner London Other Sexual Offences	+56 (1.9% increase)
Total Female Victims	182 (92.4% of total)
Offences classified as Sexual Assault of a Female over 15, Exposure or Penetration of a Female	174 (71.3% of total)
Stranger offences – 2013/14	145 (59.4% of total)

Management of Victims

Psychological treatments aim to address the emotional and mental health problems that result from violence. Psychotherapy can also improve mental health among adults and children who have suffered childhood sexual abuse.

Psychological care and support, counselling, therapy and support group initiatives have been found to be helpful following sexual assaults, especially where there are complicating factors related to the violent incident or the process of recovery. It has been shown to be helpful if a period of counselling or other support shortly after an assault may hasten the recovery from psychological damage. Such support is provided by the non-statutory sector particularly Rape Crisis, the Rape and Sexual Abuse Support Centre and local support services.

Sensitive management of victims and successful prosecution of perpetrators are important factors in encouraging victims of sexual violence to report offences to the police. The use of standard protocols and guidelines can significantly improve the quality of treatment, psychological support for victims and quality of evidence that is collected.

The preferred model would be for victims to be managed through a sexual assault referral centre (SARC), to be assigned an independent sexual violence advisor (ISVA) who will provide

on-going advocacy and support to access services and help them to progress through the criminal justice system, should they chose to do so.
See appendix –4 for national guidelines on sexual violence.

4.14 Injecting drug users

Drug users and injecting drug users are particularly vulnerable to contracting and spreading blood-borne viruses (such as hepatitis B, hepatitis C and HIV) and other infections[xxix].
Injecting drug use accounts for most of the incident of infections with hepatitis C virus (HCV). HCV infection is a complex and challenging medical condition in People Who Inject Drugs (PWID). Elements of care for hepatitis C in illicit drug users include prevention, counselling and education; screening for transmission of risk behaviour; testing for HCV and HIV..[xxx]

Needle and syringe programmes are developed to reduce the transmission of blood-borne viruses and other infections caused by sharing injecting equipment, such as HIV, hepatitis B and C. In Wandsworth, there were 1136 clients[xxxi] who accessed needle and syringe provision in the borough in 2013/14, an increase of 6% compared to the previous year (1067).

All clients who have been recorded as either currently or previously injecting should be assessed to see whether they should be offered a Hepatitis C test. In 2013/14 there were 133 eligible clients for hepatitis C testing, of this 39% received a HCV test, lower than 57% for the London average. Of the 133 eligible clients in Wandsworth, 52 accepted and 66 refused the test, only 50% of the client group which is a concern.

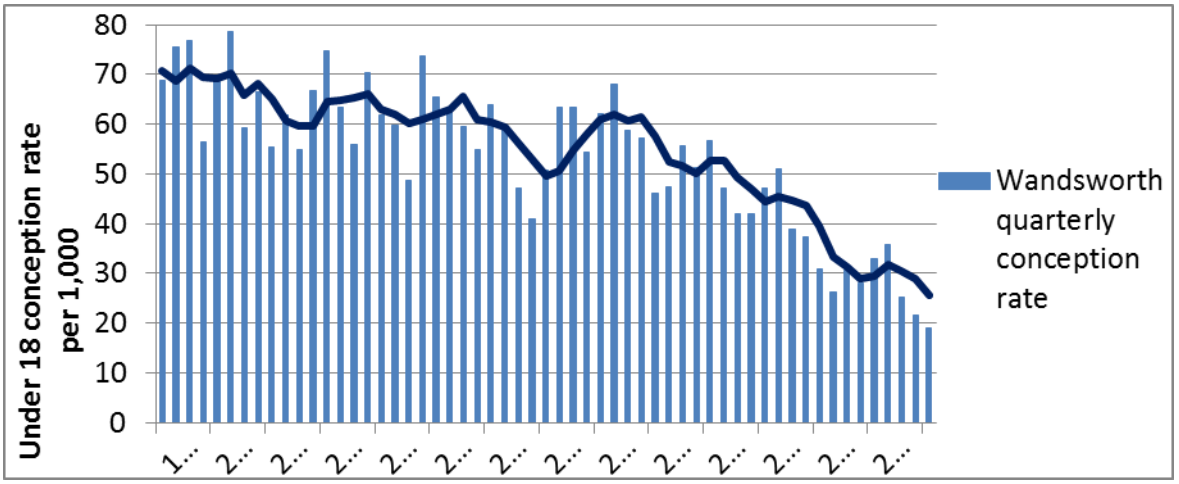
In 2010, a national survey reported that 50% of MSM interviewed had taken drugs in the last 12 months (vs. 12.5% in the general population) 42% drank alcohol more than 3 times a week (vs. 35% in the general population) and 8% had attempted to commit suicide over a period of 12 months (vs. 0.4% of the general population).

There has been an increase in the use of GBL/GHB, mephedrone and crystal methamphetamine in London. *Slamming* which entails injecting mephadrone or crystal meth is also increasing. Whilst under the influence of elicit drug users are known to engage in risky behaviour, increasing the risk of exposure to infectious diseases (HIV and Hepatitis C).Anti-retroviral treatment is also often missed among those who are HIV positive[xxxii].

4.15 Teenage conception rate and trend

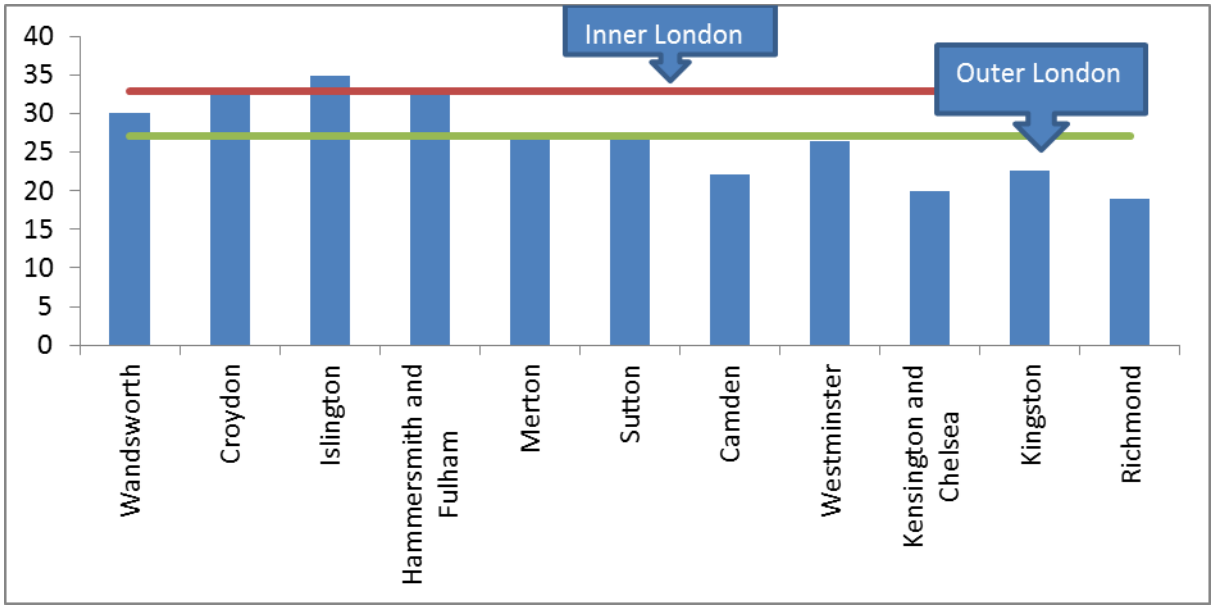
- Wandsworth has had a teenage pregnancy strategy since 1st April 2001, with a target of achieving a 55% reduction on the 1998 baseline (71.1 conceptions per 1,000 girls aged 15-17). Data on teenage pregnancy rates in 2012 was published by the Office for National Statistics (ONS) that show the under-18 conception rate in Wandsworth had dropped to 25.5 per 1,000 for girls aged 15-17, well below 2001's reduction target and below the inner London rate of 28.5 per 1,000 girls.

Figure 5 Under 18 conception rate between 1999 - 2012



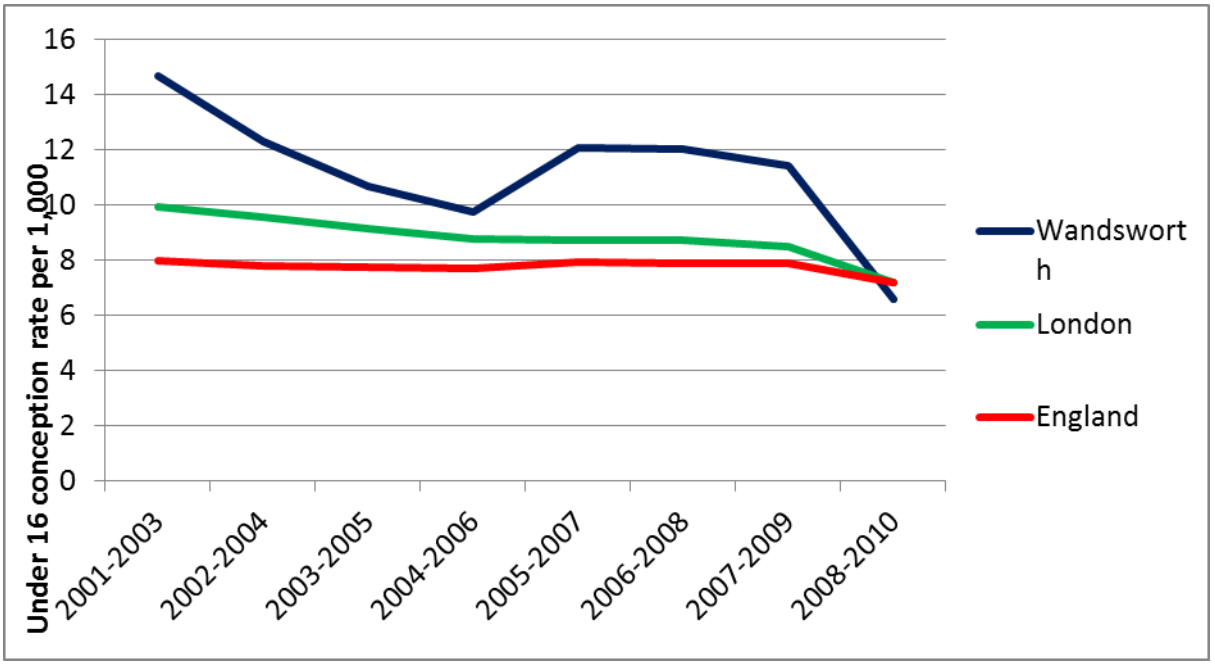
- Source : Office of National Statistics 2012
- **teenage Conception Rates across SWL boroughs and ONS clusters**
- For under 18 conception rate in Wandsworth although higher than the outer London average, it is relatively lower than the inner London rates (see figure).

Figure 6 Conceptions to women under age 18 (rate per 1,000 to girls aged 15-17) 2010-12



- Source Office of national statistics (ONS) 2012
- The traditional 'hot spot' wards are now joined by other more affluent pockets and steep increases in under 18 conception rates is being observed in the affluent wards as shown in figure 11 below
- **Under 16 conception rate**
- Wandsworth's under 16 conception rate shows a marked improvement: Conception rates have dropped by more than 56 per cent since 2001. Between 2001-2010 Wandsworth's rate has switched from being more than 80 per cent above the national average and almost 50 per cent above the London average, to being below both scores.
- In the recent years the under 16 conception rate has fallen further from 6.6 per thousand (2008-2010) to 4.7 per thousand (2010-2012- data not shown)(see figure-8)

Figure 7 under 16 conception rate 2001-2009



Source Office of national statistics (ONS)

4.16 HM Wandsworth Prison

HMP Wandsworth is a large, public, Victorian, category B prison serving the courts of South London. The Prisons certified normal accommodation level offers 1,107 places but it has an operational capacity of 1,665 places. It takes male remand and sentenced prisoners aged 21 years or older. HMP Wandsworth is a centre for sex offender treatment programmes and as such, the most frequent reason for which prisoners are in custody at the Prison is for sexual offences. A sexual health service provided by The Courtyard Clinic, St George's Healthcare NHS Trust is available at the prison.

A recent needs assessment identified the following key challenges to delivery sexual health services within HMP Wandsworth:

- Difficulties for prisoners in accessing HIV drugs when agency healthcare staff on duty who have little experience with these types of medications.
- Poor coordination from the prison staff: appointment slips were not given out in time or appointment times clashing with other activities preventing prisoners from attending sessions.
- Difficulties arranging external referrals for specialist investigations or treatment due to shortage of staff to escort them to treatment..
- There is a potential problem with confidentiality in that prison staffs are aware of which prisoners have requested attendance at GUM.
- Difficulties of dealing with prisoner's living with Hep C who are erroneously referred to the sexual health because of the absence of a much needed internal HMP Wandsworth Hep C clinic.

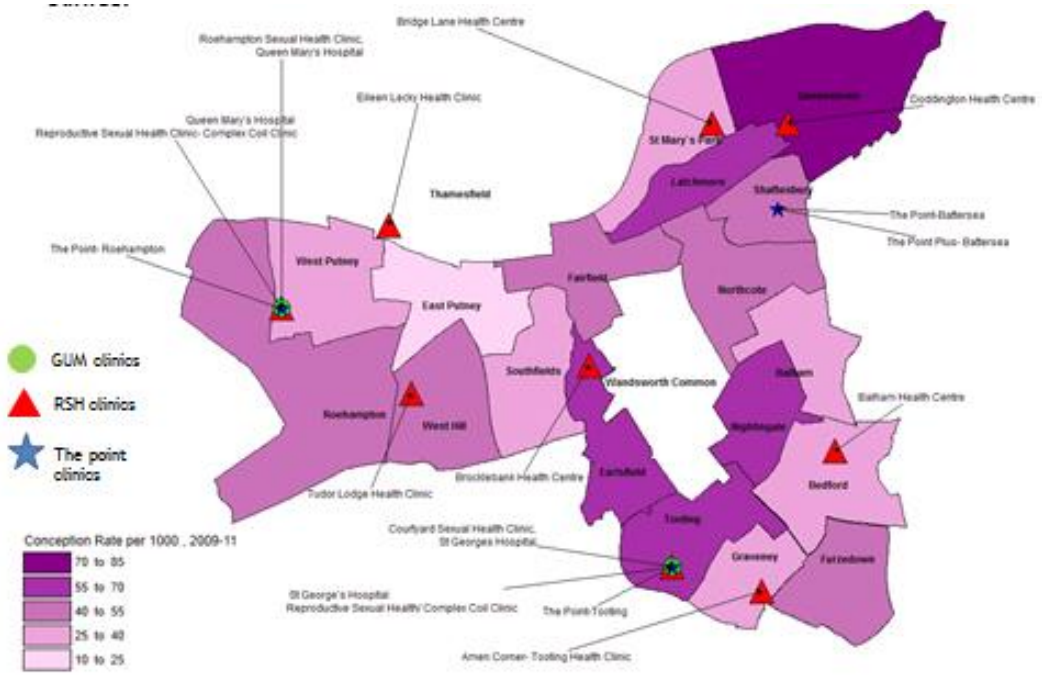
5. Demand, current services and activity

The provision of sexual health services is widespread across Wandsworth. The following chapter provides a breakdown of services provision and uptake, highlighting key issues that require consideration. Where data has been available Wandsworth figures have been compared with its statistical neighbours (Hammersmith and Fulham; Camden; Islington and Westminster), London or England.

5.1 Genito-Urinary Medicine and Reproductive Sexual Health Services

There are two Genito-Urinary Medicine (GUM) services; one to the south of the borough (Courtyard Sexual Health Clinic- St. Georges Hospital), the other to the North East (Roehampton Sexual Health Clinic, Queen Mary's Hospital). There are nine Reproductive Sexual Health Clinics and four young peoples clinics, referred to as 'The Point clinics'. Figure 8 below shows the distribution of these services across the borough and the corresponding conception rates in each ward (the darker the shade of purple the higher the conception rate per 1,000 population).

Figure 8- Under 18 conception rate per 1,000 population and location of RSH (n=9) and GUM (n=2) and young peoples 'the point ' clinics (n=4)



5.1.1 Attendance and service provision at Sexual Reproductive Health (SRH) Clinics 2013

In 2013, Sexual and Reproductive Health (SRH) clinics across England recorded a total of 1,258,050 attendances, of which 302,385 were from London PHE Centre and 13,175 from Wandsworth (1.05% of England and 4.36% of the London PHE Centre). Those attending SRH services were predominantly female (94%). Male attendances for Wandsworth residents were below those reported for London and England (Wandsworth- 6%; 11.8% London PHE Centre residents; 10.2% England residents). More than 48.3% of Wandsworth residents were aged 25-34 years of age compared with 37.6% for London PHE Centre and 27.5% for England. Table-3 below, provides a breakdown of sexual and reproductive health services attendances

by age group according to England, London PHE Centre and Wandsworth's statistical neighbours.

Table 3-Sexual and Reproductive Health Service attendees by age group, Local Authority of residence and PHE Centre in England, 2013

	17 and under	18-19	20-24	25-34	35-44	45 and over	Total ages*
England	**179,170**	**153,280**	**329,805**	**345,400**	**161,955**	**87,730**	**1,258,050**
London	**20,235**	**21,980**	**71,800**	**113,425**	**49,340**	**25,345**	**302,385**
Wandsworth	470	570	2,735	6,360	2,100	940	13,175
Westminster	315	530	2,515	5,385	2,475	1,675	12,900
Hammersmith and Fulham	295	435	2,200	4,465	1,680	840	9,920
Islington	405	535	2,530	3,845	1,075	445	8,845
Camden	200	430	2,280	3,170	1,080	645	7,820

*include not known ages

Source: Health and Social Care Information Centre, 2013.

In terms of clinics, Wandsworth residents most frequency attended Tooting Health Centre (14.9%); followed by Balham Health Centre (8.9%) and Doddington Health Centre (6.6%).

A variety of services are offered at SRH clinics, table-4 below provides an overview of these services and the proportion provided to residents of Wandsworth, London PHE centre and England. The services most frequently accessed by Wandsworth residents, in 2013, were Contraceptive Care[xxxiii] (52.8%) and sexual health advice (25.1%), in line with figures from London PHE Centre (contraceptive care- 50.8%; sexual health advice- 25.1%) and England (contraceptive care- 53%; sexual health advice- 28.9%). The proportion of women accessing SRH for cervical screening (7.1%) was higher than the London PHE Centre (3.4%) and England (2.3%) figures.

Table 4 Attendances by type of services provided, Local Authority of residence and PHE Centre in England, 2013

	Contraceptive care	Implant removal *	IUS removal *	IUD removal *	Reproductive and sexual health advice	Pregnancy related care	Abortion related care	Cervical screening	Psychosexual related care	Sterilisation/ vasectomy related care	PMS** and menopause related care***
England	**1,677,935**	**85,995**	**24,390**	**21,420**	**915,305**	**198,975**	**37,660**	**74,110**	**20,960**	**3,835**	**21,055**
London	**348,135**	**17,625**	**4,165**	**7,575**	**183,825**	**56,875**	**9,775**	**23,165**	**8,125**	**330**	**4,910**
Wandsworth	13,545	645	230	280	6,440	1,475	445	1,830	135	0	130
Hammersmith and Fulham	11,440	480	30	225	8,620	2,215	220	415	400	0	305
Westminster	10,330	325	35	260	13,180	2,320	400	940	895	0	190
Islington	10,280	505	145	205	2,525	1,435	345	525	350	0	110
Camden	8,135	315	90	135	2,875	1,190	565	730	285	0	185

*Clinics can remove devices that they haven't provided themselves, therefore it is possible that a clinic may remove more devices than they provide.

** PMS-Pre-menstrual syndrome

***Includes IUS insertion and check (non-contraception)

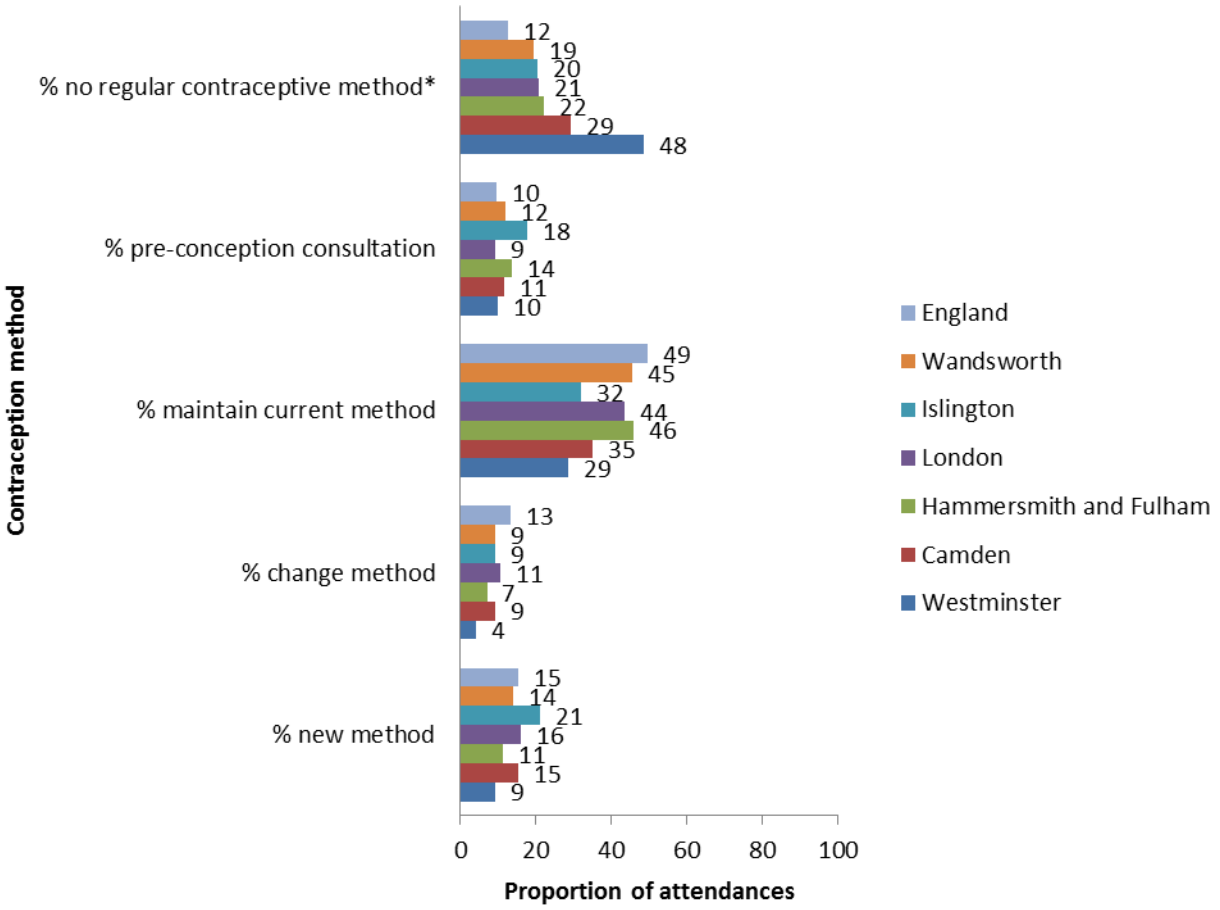
Table-5 Attendances by type of services provided, Local Authority of residence and PHE Centre in England, 2013

	Colposcopy related care	Ultra sound scan	Sub fertility treatment and care	Other Gynecology treatment and care	Alcohol brief intervention	Safe guarding children referral	CAF Referral****	Other Referrals
England	**1,130**	**18,700**	**180**	**24,125**	**7,445**	**470**	**135**	**33,555**
London	**785**	**3,975**	**95**	**5,670**	**1,270**	**45**	**95**	**9,235**
Wandsworth	30	95	0	85	105	0	0	185
Hammersmith and Fulham	120	70	5	215	5	0	0	100
Westminster	90	90	5	380	30	5	5	410
Islington	30	355	5	75	10	0	5	275
Camden	10	320	0	80	0	0	20	255

**** CAF- Common assessment framework

The reason for attendances at SRH services is presented in figure-9 below. The majority of Wandsworth residents (45%) accessed SRH services to maintain their current contraceptive method (Hammersmith and Fulham- 46%; London PHE Centre- 44%). Following this, 19% of Wandsworth residents accessed SRH services had no method of contraception in place* (Hammersmith and Fulham- 22%; London PHE Centre- 21%). Nearly 14% attended for new contraceptive methods (Hammersmith and Fulham-11%; London PHE- 16%).

Figure 9 Proportion of attendances at SRH services by service provided among residents of Wandsworth, Corresponding statistical neighbours, London PHE Centre and England: 2013



Health and Social Care Information Centre

* No regular contraceptive method: includes emergency contraceptive only, other SRH services only, emergency contraception and other SRH services and where no contraceptive method was recorded.

Contraceptive Care[xxxiv]

In 2013, **1,755,745** residents in England attended SRH services where regular contraception was prescribed. A total of 12,370 (0.7%) of these attendees were Wandsworth residents. Of all the contraceptive methods prescribed, the main methods were LARC[xxxv] (26%) and User Dependant Method (UDM) (74%). These figures are comparative to Wandsworths closest statistical neighbour – Hammersmith and Fulham where LARC was prescribed to 22% of residents and UDMs to 79%. For LARC the majority of Wandsworth residents prescribed this device were aged 25-34 (50%) vs. 48% among the same age group in Hammersmith and Fulham. A similar pattern was observed for UDM, prescribed to 48% of Wandsworth residents aged 25-34 years of age compared to 46% for the same age group in Hammersmith and Fulham.

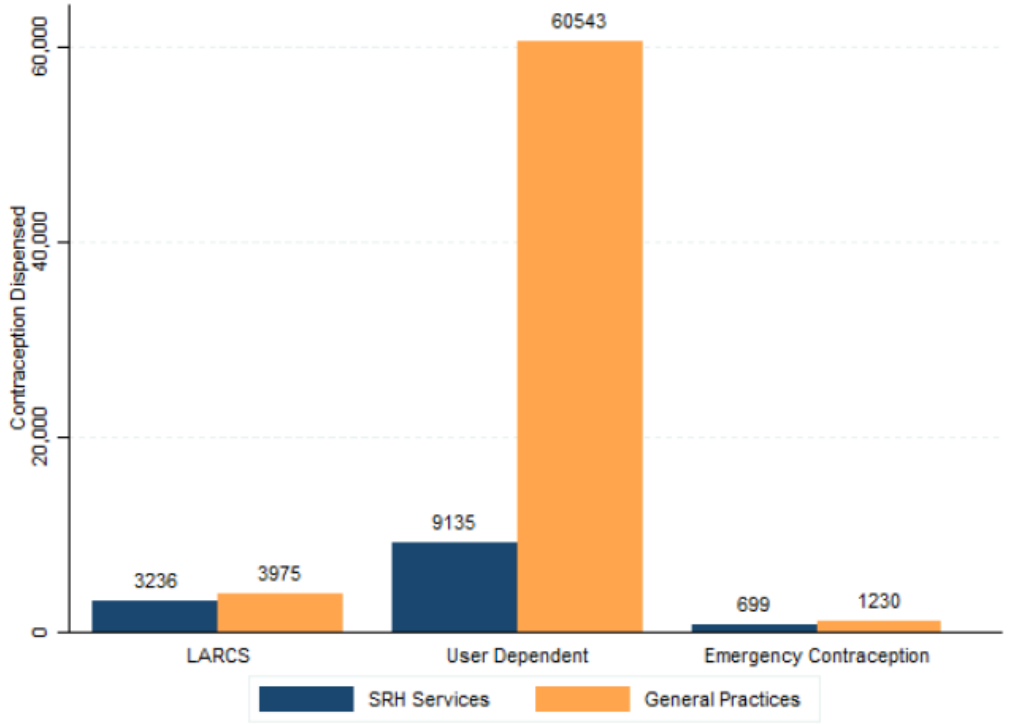
Source- Health and Social Care Information Centre, 2013

Focus on Long Acting Reversible Contraceptives (LARC)

In 2013, the rate of LARC prescribed in SRH services per 1,000 women aged 15 to 44 years was 26.2 for Wandsworth, 33.4 for London PHE Centre and 32.3 for England (figures for Hammersmith and Fulham are not publically available for 2013). The data presented does not include LARC that may have been prescribed in other services, such as abortion care, which may be a significant amount.

Figure 10 describes the number of contraceptives prescribed in general practice versus the number of selected contraceptives prescribed in SRH Services (see section 5.2 for further information on LARC provision in primary care). Care should be taken when interpreting this information as this is the total number of prescriptions, this will not be representative of the number of people who have received each contraceptive method.

Figure 10 Type of contraception provided by SRH services and general practice in Wandsworth: 2013



Source: SRHAD. Data from Sexual and Reproductive Health Services and PACT. NHS Prescription Services' Prescribing Database

5.1.2 Attendance and service provision at Genito-urinary medicine clinics

In 2013, a total of 23,923 patients (from a number of local authorities) attended sexual health services at St. Georges Hospital and Queen Mary's Hospital GUM clinics (73.8% and 26.2% respectively). Of these patients 11,713 (49%) were Wandsworth residents. In comparison 17,265 patients attended the sexual health clinic at Charing Cross Hospital in Hamersmith and Fulham (H&F), 7,213 (42%)of patients attending this clinic were residents of this borough.

A total of 22,342 Wandsworth residents accessed GUM services in 2013. The main clinics attended by patients residing in Wandsworth are outlined in table 6. Following on from St. Georges and Queen Mary's GUM service these include the John Hunter Clinic, Dean Street Clinic and Charing Cross Hospital.

Table 6 Number of attendances (new and follow-up) by Wandsworth residents at 6 most popular clinics, 2013

Area of clinic	Clinic attended	Number of patients	% of total patients	New attendances	Follow-up attendances	Total attendances
Wandsworth	St Georges GUM	8238	36.9	10724	2219	12943
Wandsworth	Queen Mary's GUM	3493	15.6	4810	738	5548
Kensington and Chelsea	John Hunter Clinic	2577	11.5	3519	416	3935
Westminster	Dean Street Clinic	1658	7.4	2536	281	2817
Hammersmith and Fulham	Charing Cross Hospital	1073	4.8	1469	176	1645

By comparison the large majority of residents from Hammersmith and Fulham accessed Charing Cross Hospitals clinic (46%); followed by the John Hunter Clinic in Kensington and Chelsea (22%); St Marys in Westminster (10%); Dean Street in Westminster (8%) and Mortimer Market Centre in Camden (3.5%).

Source: GUMCAD, 2014

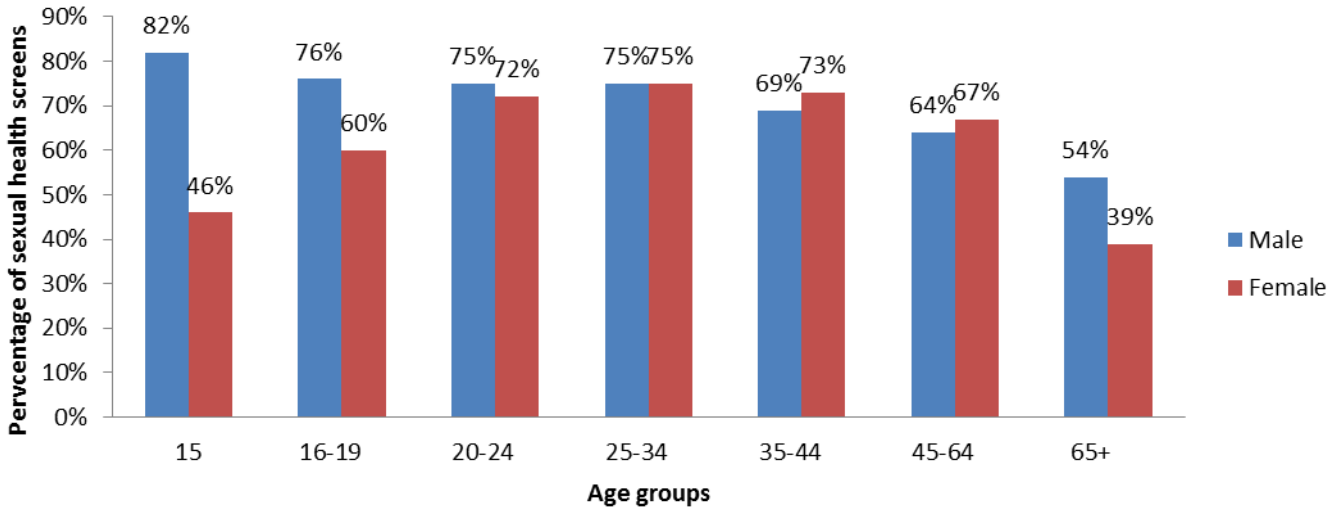
Sexual Health Screens

The proportion of sexual health screens among first time clinic attendees varies across the life course. In 2013, peaks were observed among males aged 15[xxxvi] (82% had a sexual health screen conducted during their first attendance), in Hammersmith and Fulham the majority of screens were done among males aged 20-24 (78%). In terms of females in Wandsworth the majority were aged 25-34 (and 75% had a sexual health screen conducted during their first attendance, respectively), a similar figure was reported for Hammersmith and Fulham (74%).

In terms of sexual orientation, in Wandsworth, the highest proportion of screens during first time attendees was observed amongst heterosexual males (78%) and bisexual females (80%), see Table 7. Similar figures were reported among Hammersmith and Fulham residents- 75% were heterosexuals males and 75% of females were bisexual. Drilling down further table 8 provides a summary of sexual health screens among first time attendees by gender, ethnicity and sexual orientation for Wandsworth. There is a disparity in screening amongst these groups.

The highest average proportion of screens in 2013, were reported among black or black British, female bisexuals (Wandsworth: 92% vs. Hammersmith and Fulham: 33%) followed by white, female, bisexuals (Wandsworth: 89% vs Hammersmith and Fulham: 56%). In terms of males the highest proportion of screens were among black or black British, heterosexual males (Wandsworth: 82% vs. Hammersmith and Fulham: 78%) followed by white male heterosexuals (Wandsworth: 78% vs. Hammersmith and Fulham: 75%).

Figure 11- Percentage of sexual health screens conducted amongst first time attendees from Wandsworth, 2013



Source: GUMCAD, 2014

Table 7 Sexual health screens conducted among first time attendees (Wandsworth residents) by gender and sexual orientation, 2013

Gender	Sexual Orientation	Number of first time attendees *	Number of sexual health screens taken †	% of sexual health screens taken ‡
Male	Heterosexual	9259	7212	78
	Homosexual	4356	2676	61
	Bisexual	247	181	73
	Not specified	249	120	48
	Total	**14111**	**10189**	**72**
Female	Heterosexual	15997	11517	72
	Homosexual	107	77	72
	Bisexual	113	90	80
	Not specified	172	106	62
	Total	**16389**	**11790**	**72**
Total		**30500**	**21979**	**72**

Source: GUMCAD, 2014

Table 8 Average proportion of sexual health screens conducted among first time attendees (Wandsworth residents) by gender, sexual risk group and ethnicity, 2013

	Male Heterosexual	Male Homosexual	Male Bisexual	Male Not specified	Female Heterosexual	Female Homosexual	Female Bisexual	Female Not specified
White	78	61	73	51	74	83	89	56
Black or Black British	82	68	65	44	71	75	92	61
Asian or Asian British	75	64	49	31	70	0	13	10
Mixed	77	58	76	13	71	38	49	79
Other ethnic groups	69	57	50	30	69	75	0	13
Not specified	76	65	34	73	75	0	50	37

Source: GUMCAD 2013

STI trends

In 2013, Chlamydia was the most diagnosed STI among males and females (Figure 12). Figures for Chlamydia screening should however be interpreted with caution, due to issues with data reporting. Figures 13-16 show rates of STIs in Wandsworth are continuing to exceed those of London (PHE Centre). Of note is the year on year increase in rates of gonorrhoea and syphilis between 2012-2013 (Figure 13 and 14).

Hammersmith and Fulham also reported Chlamydia as their most prevalent STI. STIs including gonorrhoea, syphilis, genital warts and herpes are also exceeding figures reported for London (PHE Centre) and England. Rates of gonorrhoea have also increased between 2012-2013 (data not shown).

Figure 12- Number of selected STI diagnoses among Wandsworth residents , 2013

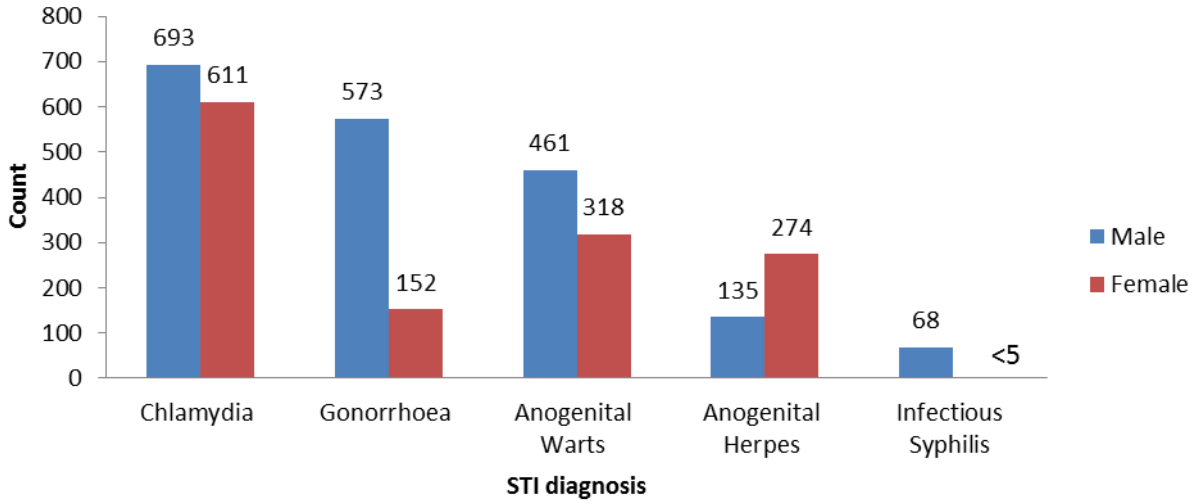
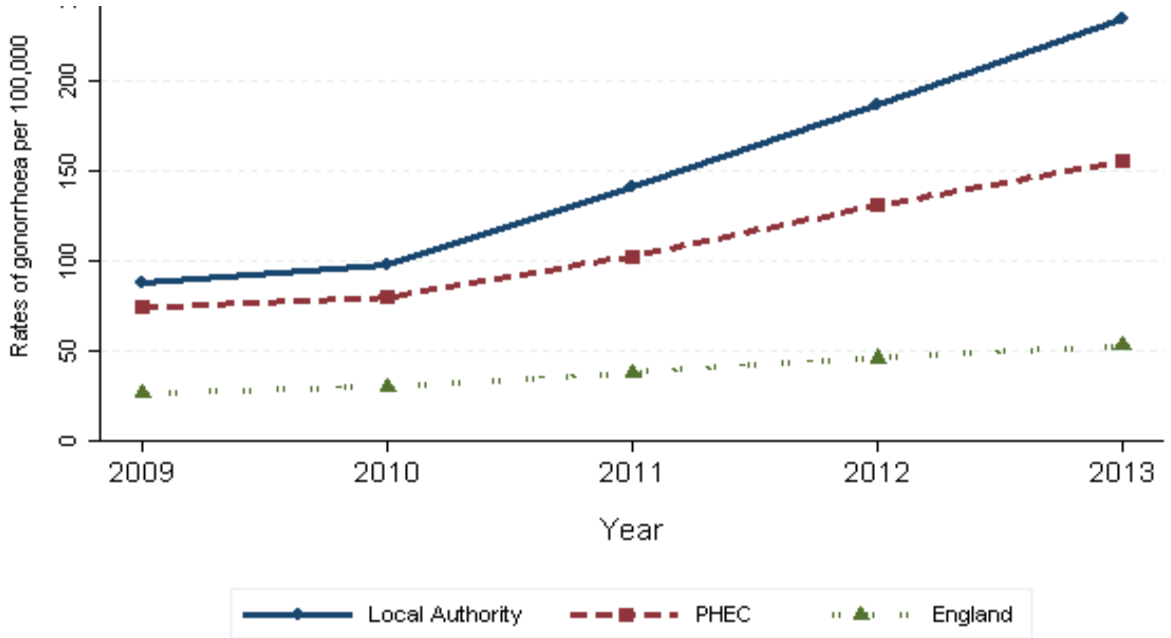
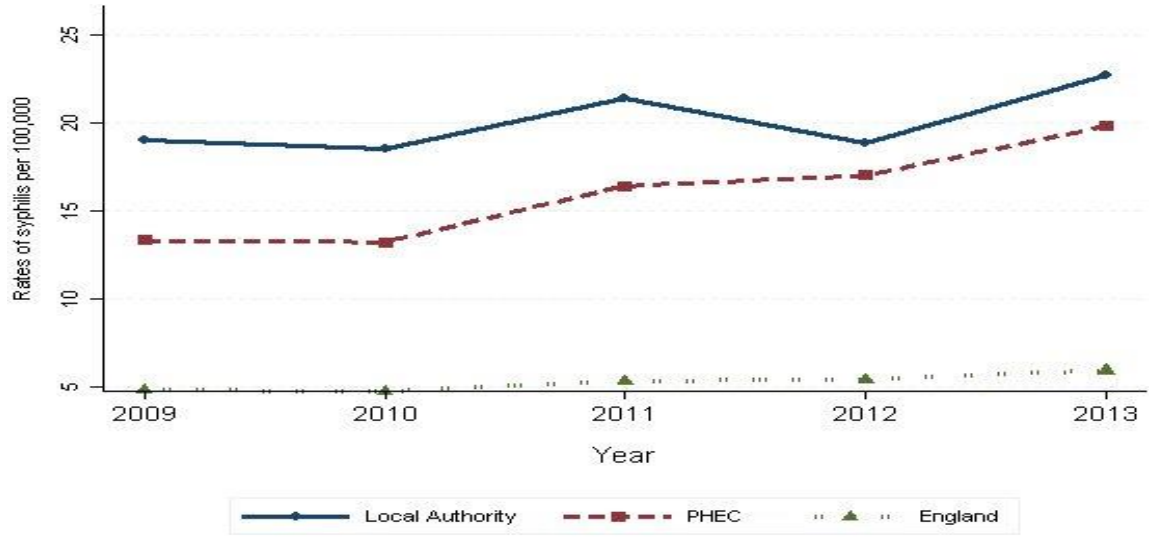


Figure 13- Rates of gonorrhoea



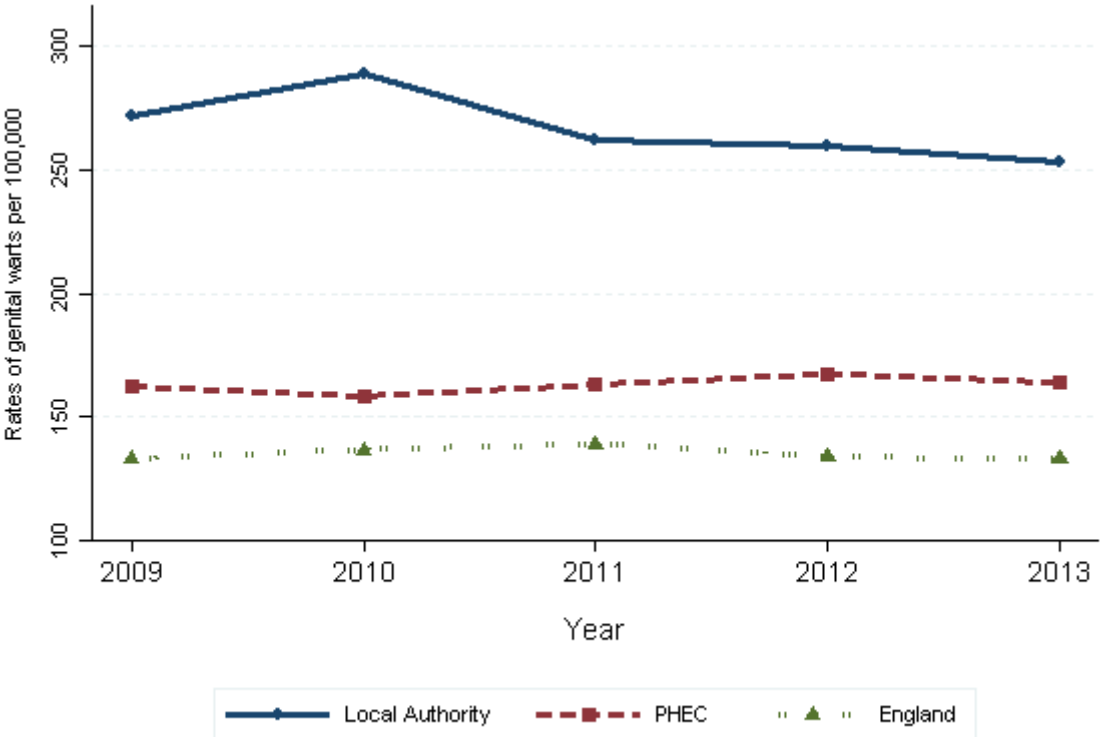
Source: Data from Genitourinary Medicine Clinics
*Any increase in gonorrhoea diagnoses may be due to the increased use of highly sensitive Nucleic Acid Amplification Tests (NAATs) and additional screening of extra-genital sites in MSM
Rates are calculated using ONS population estimates

Figure 14- Rates of syphilis



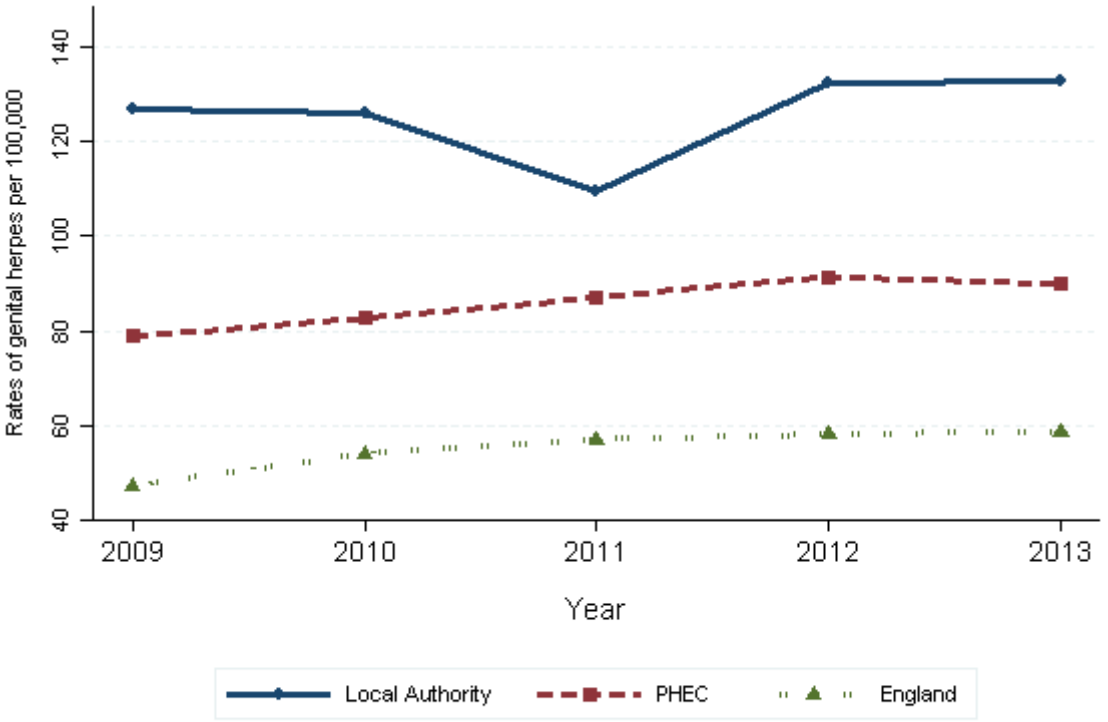
Source: Data from Genitourinary Medicine Clinics
Rates are calculated using ONS population estimates

Figure15 - Rates of genital warts



Source: Data from Genitourinary Medicine Clinics
Rates are calculated using ONS population estimates

Figure 16- Rates of genital herpes

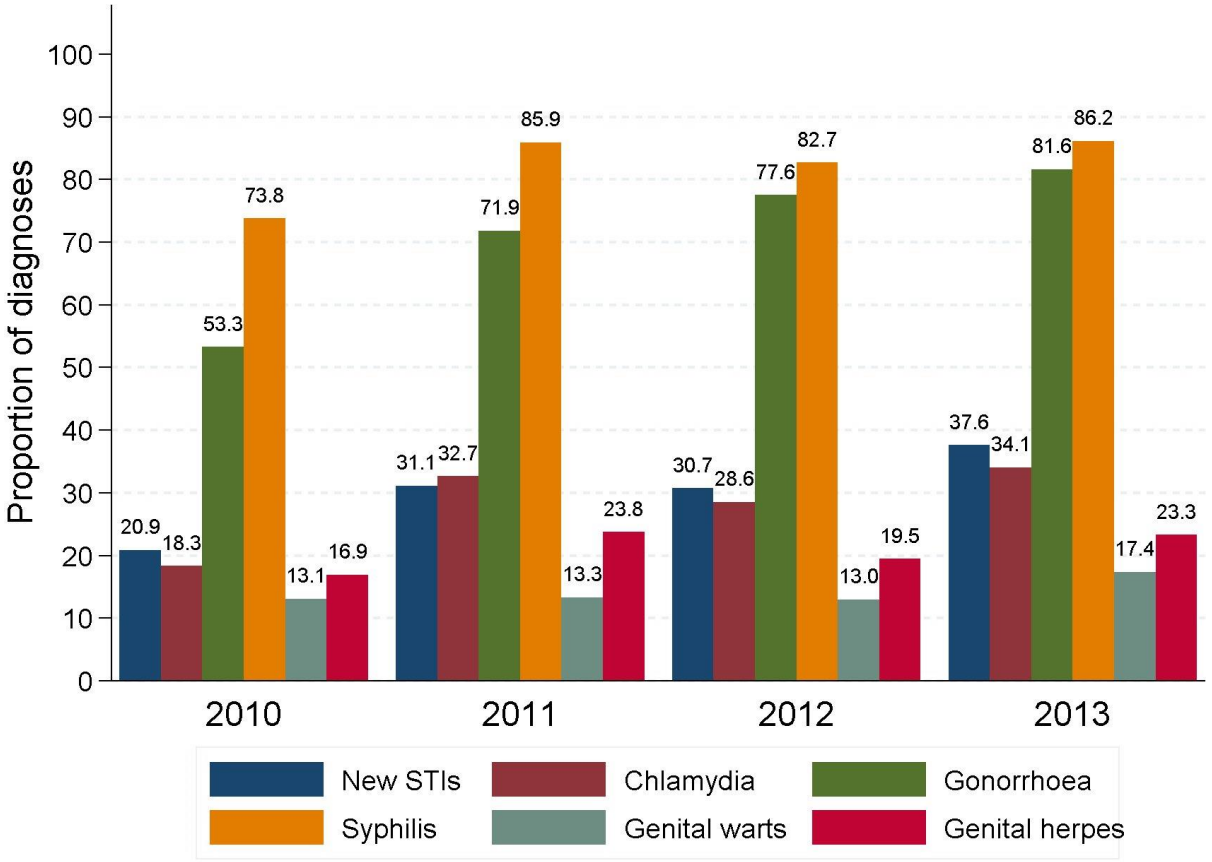


Source: Data from Genitourinary Medicine Clinics
*Any increase in genital herpes diagnoses may be due to the use of more sensitive NAATs
Rates are calculated using ONS population estimates

Men who have sex with men (MSM)

In Wandsworth in 2013, for cases in men where sexual orientation was known, 37.6% (n=1152) of new STIs were among MSM, this compares with 36% (n=775) for Hammersmith and Fulham. In 2010, the proportion of new STIs among MSM was 20.9% (n=515) vs. 32.9% in Hammersmith and Fulham. Please note that the numbers for MSM presented in this report include homosexual and bisexual men.

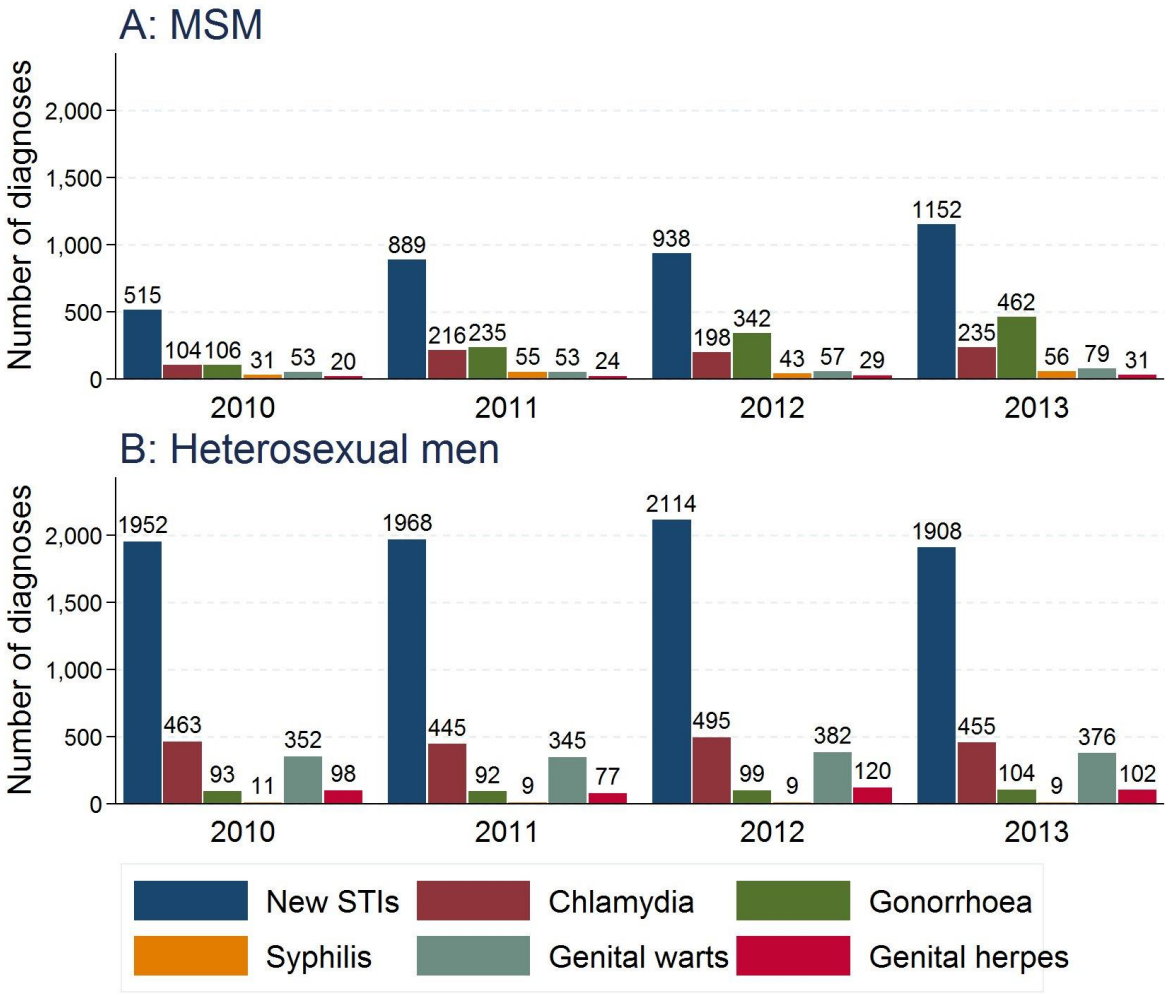
Figure 17. Proportion of new STIs, chlamydia, gonorrhoea, syphilis, genital warts and genital herpes in MSM among men in Wandsworth (GUM diagnoses only): 2010-2013



Source: Data from Genitourinary Medicine clinics
Excludes chlamydia diagnoses made outside GUM
For cases in men with known information on sexual orientation
See Figure 5 for denominator

*Chlamydia figures for 2013 should be interpreted with caution and are subject to change following further data cleansing.

Figure 18 Number of new STIs, chlamydia, gonorrhoea, syphilis, genital warts and genital herpes in MSM and in Heterosexual men in Wandsworth (GUM diagnoses only): 2010-2013

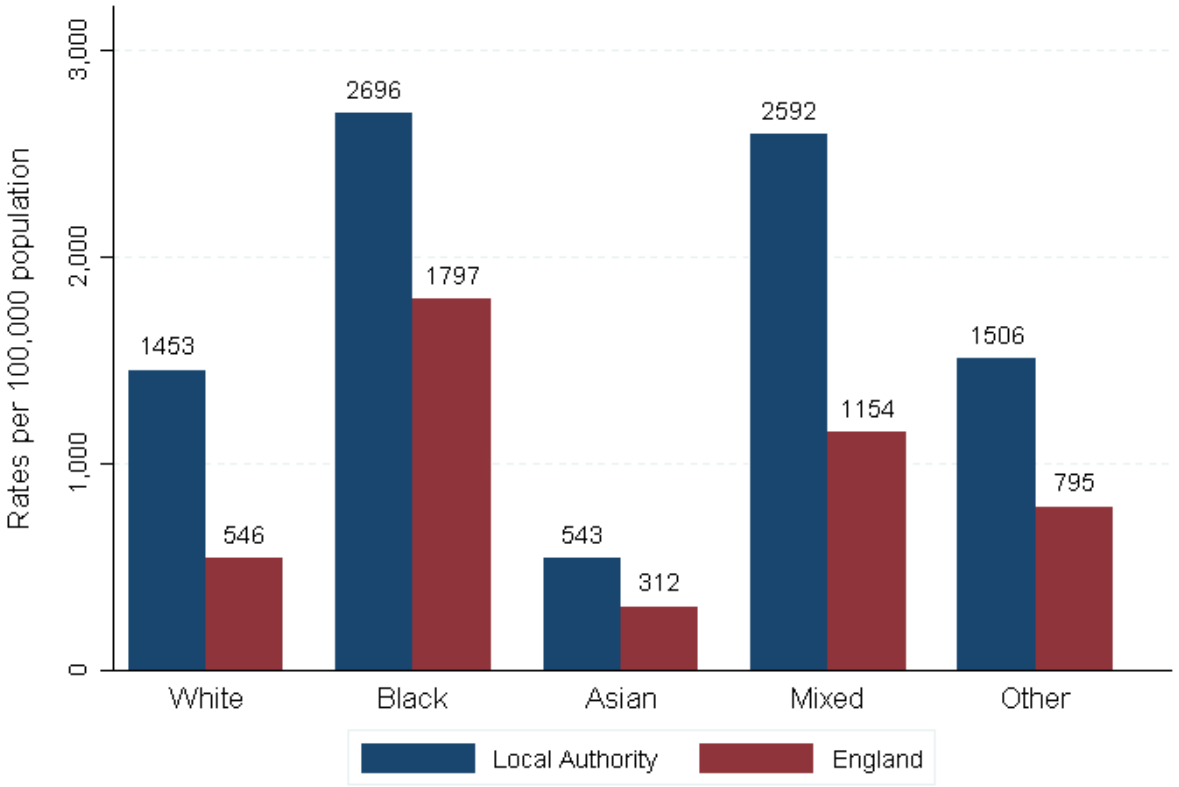


Source: Data from Genitourinary Medicine clinics
Excludes chlamydia diagnoses made outside GUM

Ethnic group and country of birth

Where recorded, 35.5% of new STIs diagnosed in Wandsworth were in people born overseas vs. 42.5% reported in Hammersmith and Fulham. In both boroughs rates of new STIs were highest among people from black ethnic groups (Wandsworth: 2,696 per 100,000 population vs. Hammersmith and Fulham: 2,957 per 100,000 population).

Figure 19 - Rates of new STIs by ethnic group in Wandsworth and England (GUM diagnoses only): 2013



Source: Data from Genitourinary Medicine clinics
Excludes chlamydia diagnoses made outside GUM
Rates based on the 2011 ONS population estimates

HIV testing

Offer and uptake of HIV testing at eligible attendances in GUM clinics[1]

- In 2013, an HIV test was offered at 80.9% of eligible attendances at GUM clinics among residents of Wandsworth and, where offered, an HIV test was done in 86.6% of these attendances.
- In Hammersmith and Fulham, 83.8% of eligible attendees were offered HIV testing and 84% of people accepted.
- Nationally, an HIV test was offered at 79.4% of eligible attendances at GUM clinics and, where offered, a HIV test was done in 80.0% of these attendances.

Coverage of HIV testing among eligible patients at GUM clinics

- In 2013, among GUM clinic patients from Wandsworth who were eligible to be tested for HIV, 76.3% were tested.
- In Hammersmith and Fulham, 77.3% eligible GUM clinic patients were tested.
- Nationally, 71.0% of GUM clinic patients who were eligible to be tested for HIV were tested.

People living with diagnosed HIV

In 2013, 1231 adult residents (aged 15 years and older) in Wandsworth received HIV-related care: 967 males and 264 females. Among these, 59.1% were white, 21.5% black African and 5.4% black Caribbean. With regards to exposure, 62.4% probably acquired their infection through sex between men and 31.9% through sex between men and women (Table-9).

Table-9. Number of adults living with diagnosed HIV by ethnicity and exposure group in Wandsworth: 2009 and 2013

		2009	% 2009	2013	% 2013
Ethnicity	White	636	58.7	728	59.1
	Black Caribbean	65	6.0	67	5.4
	Black African	250	23.1	265	21.5
	Other	124	11.4	158	12.8
	Not known	9	0.8	13	1.1
Probable route of infection	Sex between men	639	58.9	768	62.4
	Sex between men and women	386	35.6	393	31.9
	Injecting drug use	20	1.8	16	1.3
	Other/Not known	39	3.6	54	4.4
Total	Total	1084	100.0	1231	100.0

Source: The Survey of Prevalent HIV Infections Diagnosed (SOPHID)

By comparison in 2013, 1126 adult residents (aged 15 years and older) in Hammersmith and Fulham received HIV-related care: 904 males and 222 females. Among these, 63.9% were white, 16.6% black African and 3.0% black Caribbean. With regards to exposure, 66.1% probably acquired their infection through sex between men and 26.6% through sex between men and women.

Source: Wandsworth; Hammersmith and Fulham, LASER report 2013

[1] When calculating these rates, eligibility for HIV testing is determined by reviewing previous HIV diagnosis and testing history for each patient. Those who are known to be HIV positive, based on their GUMCADv2 history, are not considered eligible for testing. Those who have been tested already are not considered eligible to be tested again until six weeks have passed (i.e. eligibility for testing occurs only once every six weeks).

HIV testing pilots, St. Georges Hospital

A total of three HIV testing pilots have been conducted at St.Georges hospital. Two pilots ran in 2011/2012 in the Emergency Department and one in 2013 in the Acute Medical Unit. Over the course of these studies approximately 2500 people accepted HIV testing and 5 HIV positive patients were identified. Reasons for not accepting HIV testing included people not wanting to know their status or not feeling at risk.

Overall HIV testing is both feasible and acceptable in AMU settings with additional support, further work needs to be conducted.

5.2. Primary Care

Sexual Health Services can also be accessed through primary care. In Wandsworth GPs signed up to the Local Service Contracts (LCS) are delivering HIV rapid tests, Chlamydia/Gonorrhoea screening and Long Acting Reversible Contraception (LARC). Pharmacies can dispense Emergency Hormonal Contraception (EHC) and Chlamydia testing kits.

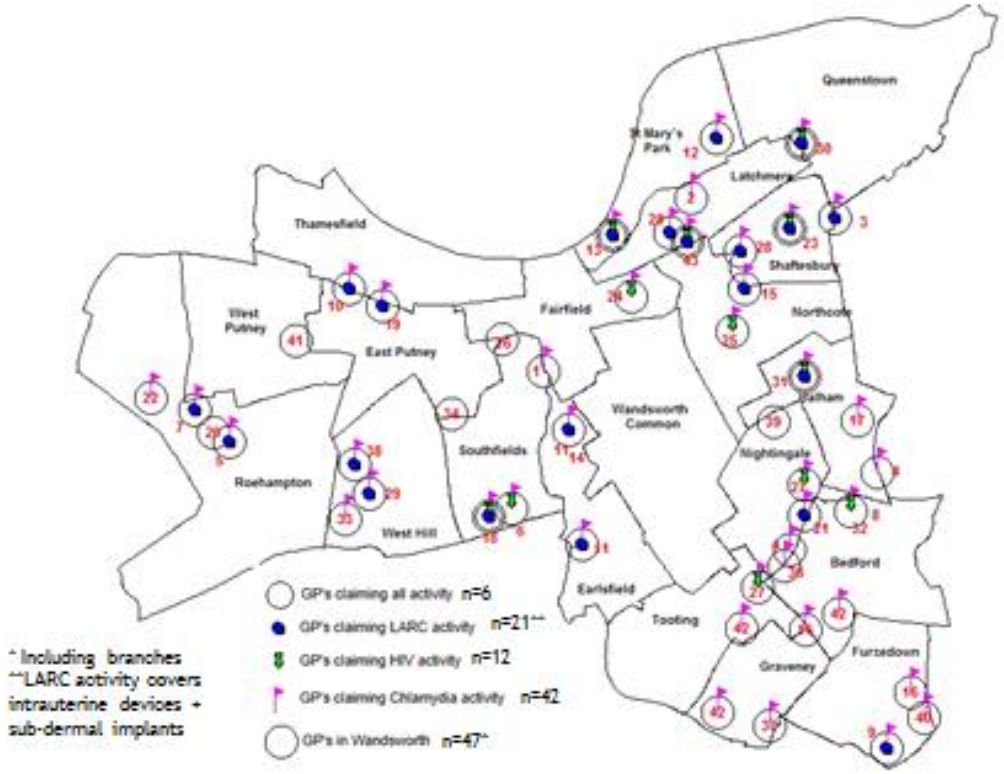
5.2.1 Provision of services in General Practices

General Practice is the first port of call for large numbers of people with all types of health needs; and therefore has key role to play in sexual health care [41]:

- People at high risk of having, or acquiring, HIV and other sexually transmissible infections use their GPs and practice nurses
- Around 80 % of contraception in the UK is provided in the general practice context
- Cervical screening is carried out within primary care
- People with symptoms of sexually transmissible infections present in primary care – although they may be unaware of the possible link with sexual health
- GPs are often aware of other issues relevant to sexual health such as alcohol misuse, mental health problems or social disadvantage
- General practice provides a substantial amount of travel advice (in relation to sexual health)

Currently there are 43 GPs in Wandsworth and 4 branch surgeries; figure 20 shows the distribution of these services across the borough.

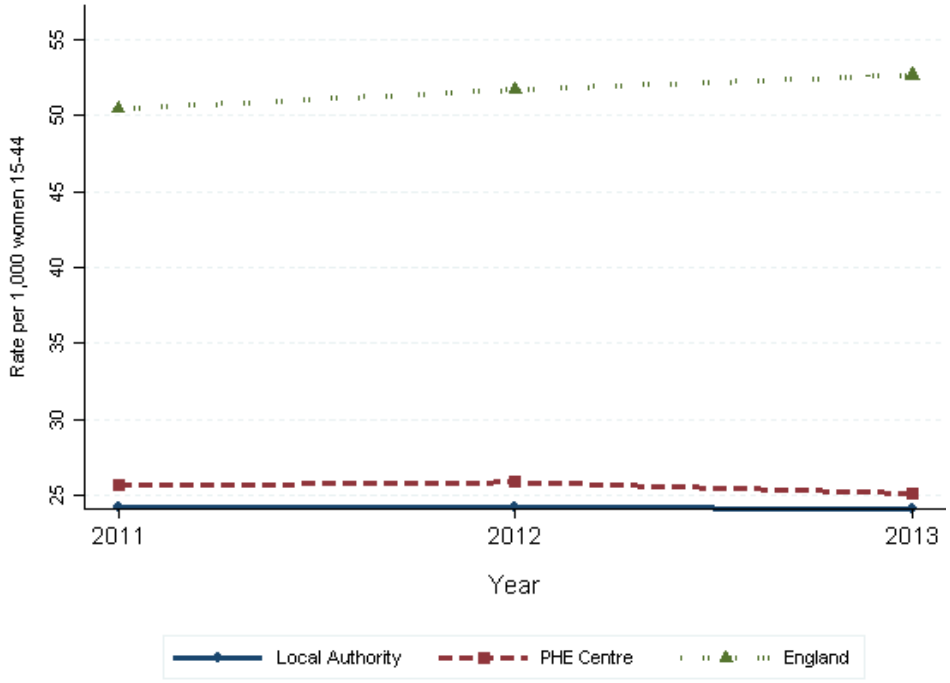
Figure 20- Location of Wandsworth GPs (n=47) highlighting sites that provided sexual health services during 2013/14



Long Acting Reversible Contraception

Figure 21 illustrates the rate of LARCs prescribed in a primary care setting between 2011 and 2013. In 2013, Wandsworth was ranked 303 out of 326 local authorities in England for the rate of GP prescribed LARCs (1st has the highest rate), with a rate of 24.1 per 1,000 women aged 15 to 44 years, compared to 17.1 in Hammersmith and Fulham and 52.7 in England.

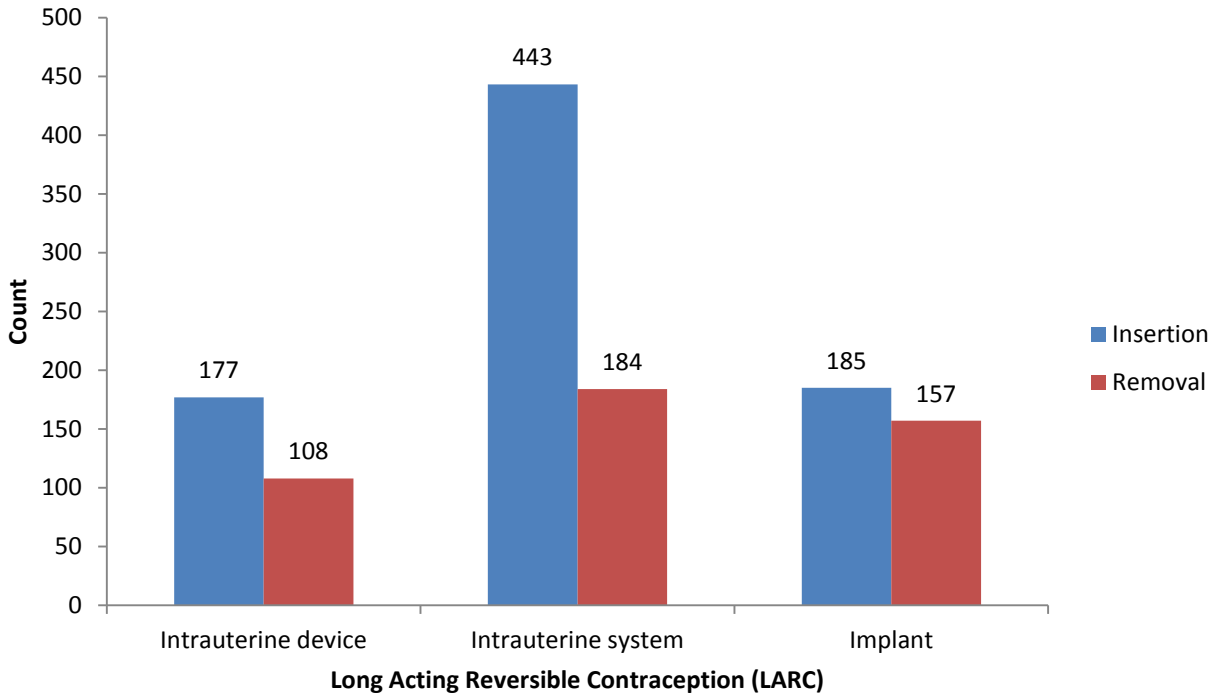
Figure 21 Rates per 1,000 women aged 15 to 44* years of LARCs prescribed in general practice for Wandsworth, London PHE Centre and England: 2011 to 2013**



Source: PACT. NHS Prescription Services' Prescribing Database
* Age not provided for PACT data
Rates based on the 2013 ONS population estimates (women aged 15-44 years)
** Adjusted DMPA injectable reported (number of doses prescribed divided by 4.3. Estimated that to supply one woman with DMPA for one year requires 4.3 injections – method adopted based on that undertaken for the London Sexual Health Needs Assessment mapping exercise 2008).

Figure 22, provides a summary of LARC uptake for quarter 1 and 2 and summary of primary care activity by service for Wandsowrth. Between April -September 2014 , 805 LARC were fitted and 449 removed, 56%).

Figure 22- Summary of LARC update Q1/Q2 2014 in Wandsworth



Source- primary care contracts team Wandsworth, 2014

Chlamydia Screening

The National Chlamydia Screening Programme (NCSP), which started locally in Wandsworth in 2008, specifically targets 15-24 year olds. In 2012-13, 11,900 chlamydia tests were conducted among Wandsworth residents aged 15-24. The coverage of chlamydia tests equated to 36% of Wandsworth's 15-24 year-old population, with a rate of positivity of 8%. This compares with the coverage of 25% nationally, 27% for London and 25.5% for Hammersmith and Fulham, with an 8% positivity rate for London and England alike and 8.12% for Hammersmith and Fulham (CTAD, 2013).

The rate of positive chlamydia diagnoses in Wandsworth in 2012-13 among 15-24 year-olds was 2,885 per 100,000 population vs. 2,043 for Hammersmith and Fulham. In Wandsworth 42 GPs are commissioned to provide this service. A total of 8641 tests were completed through Wandsworth GPs in 2012/13, a total of 22.54% of all tests conducted in the borough. Data from quarter 1 and 2 of 2014 show 2,276 screens have been conducted to date.

HIV testing

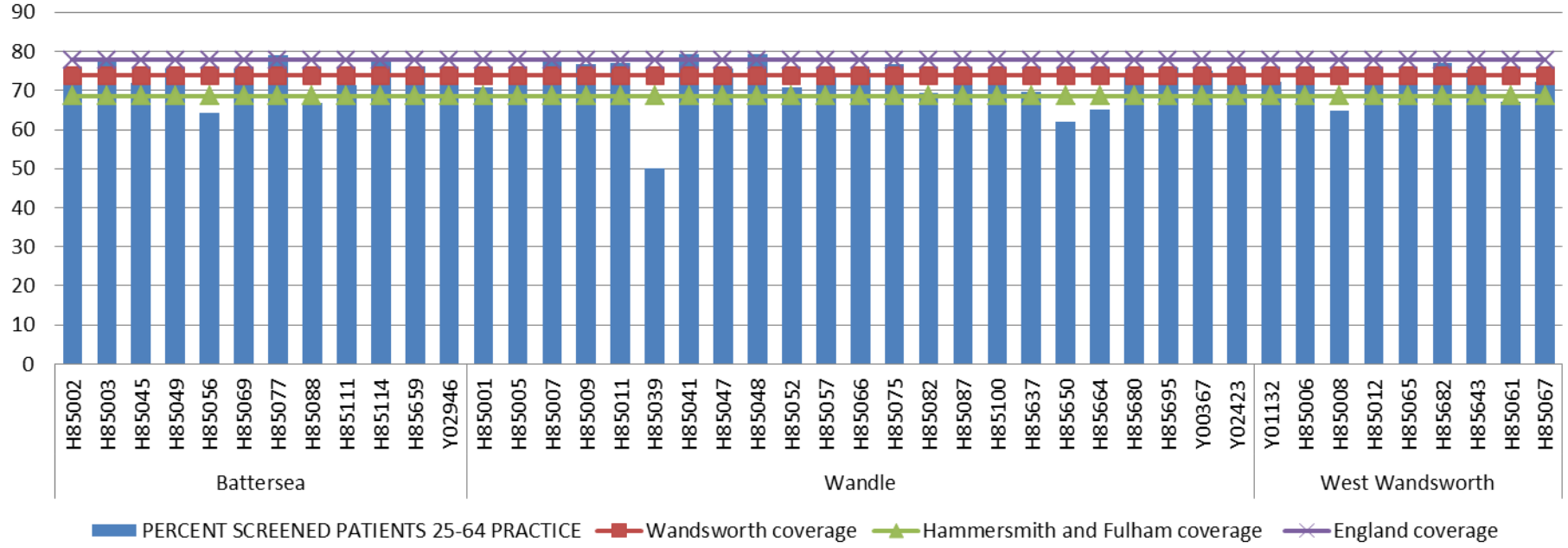
In 2011, HIV testing was launched in General Practice settings following a GUM-led project to raise awareness of clinical indicator diseases. During this pilot HIV testing was offered to all new GP registrations aged 15 – 59 years, between February 2011- June 2012, at 22 Practices. A total of 26,326 patients aged 18-59 were newly registered during this period, of which 9,800 (37%) patients were offered a test and 4,504 (46%) accepted. A total of 18 (0.4%) positive

diagnoses were made. Findings from the pilot supported continued provision of HIV testing. In 2013 this service was embedded into 12 GPs. The eligibility criteria has since been amended to include: newly registered patients and most at risk populations (e.g. BME and MSM). Figures from quarter 1 and 2 of 2014/15 show that a total of 2140 tests have been conducted and 5 reactive tests reported.

Cervical Cancer Screening

The variation in screening uptake rates, for cervical cancer, as seen in the charts below are age-specific percentage rates which can be used to compare practice performance.

Figure 23- Wandsworth Cervical Screening coverage by GP practices (%) , Women aged 25-64 years 2013-14



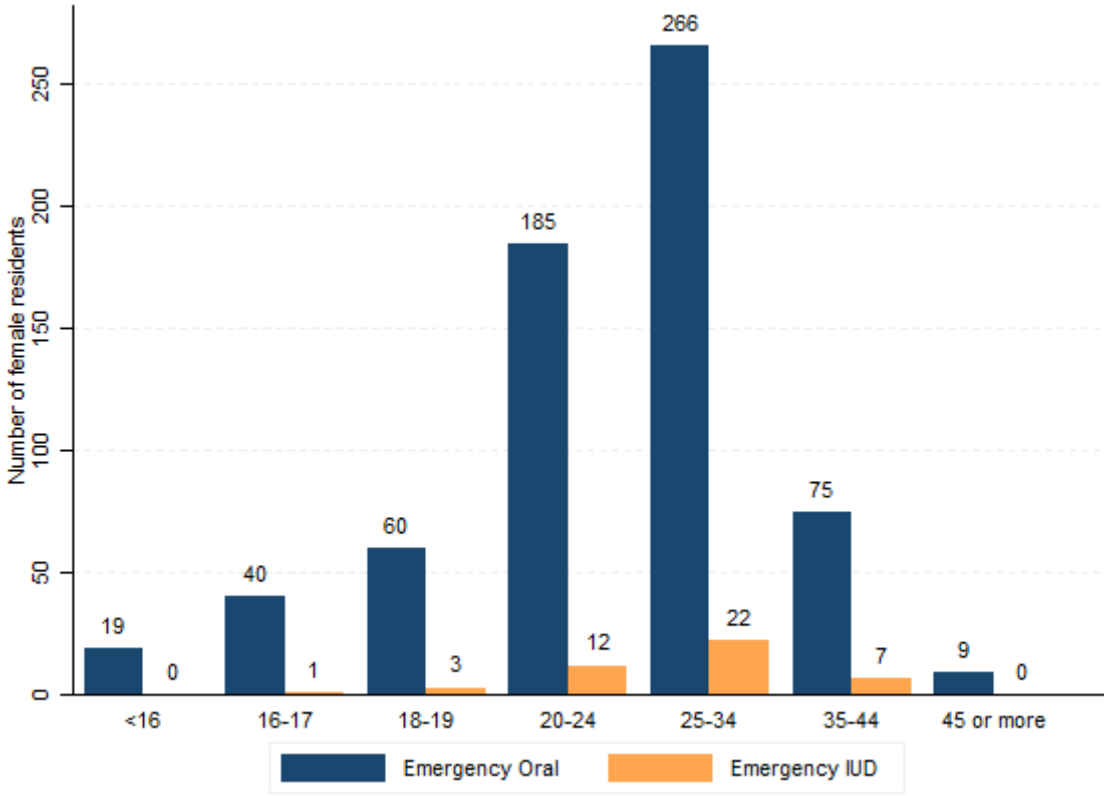
The chart above shows the percentage of patients aged 25-64 screened for cervical cancer. Wandsworth has a lower screening coverage rate when compared with England 73.9% and 77.97%, respectively. Wandsworth is however higher than Hammersmith and Fulham whose reported coverage is 68.6% for 2013-14.

Emergency contraception

Emergency contraception is used to reduce the risk of pregnancy following unprotected intercourse or contraceptive failure. There are two types of emergency contraception available; hormonal (two types of contraceptive pills) and non-hormonal (IUD).

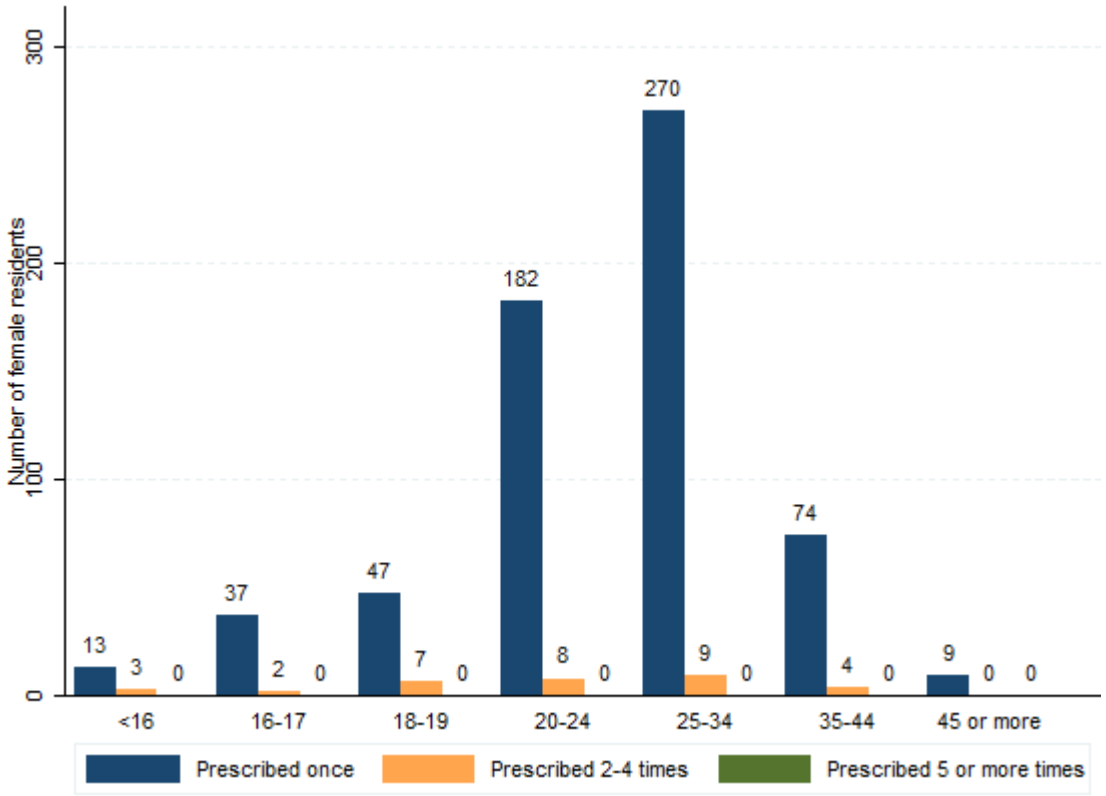
In 2013, 665 women resident in Wandsworth were prescribed emergency contraception at SRH Services. Of those, 4.8% were prescribed it more than once in 2013, compared to 10.3% in England. Figure 24 describes emergency contraception by age group and figure 25 describes the frequency of emergency contraception prescribed to female residents by age group (NB frequency can only be determined in the 2013 calendar year, so any emergency contraception received in previous years would not be counted).

Figure 24 Emergency contraception by age group, among female residents in Wandsworth attending SRH Services: 2013



Source: SRHAD. Data from Sexual and Reproductive Health Services. Public Health England 2014

Figure-25 Number of female residents in Wandsworth prescribed emergency contraception by age group and frequency* at SRH Services: 2013



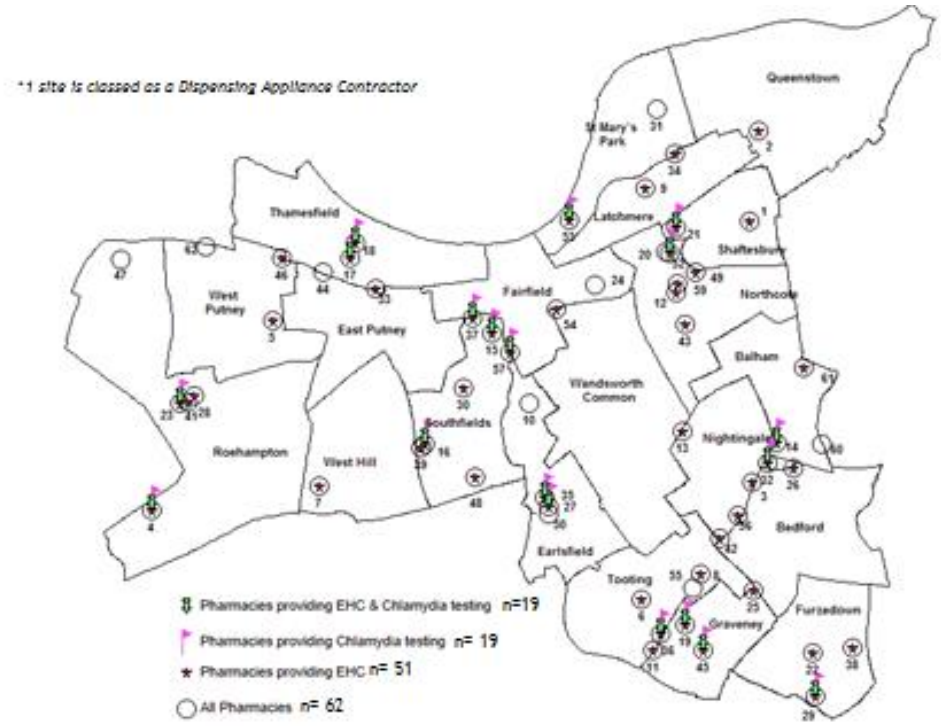
Source: SRHAD. Data from Sexual and Reproductive Health Services, Public Health England, 2014

* Frequency is only accounted for in 2013 and so if an emergency contraception was received in December
2012 for example this would not be counted. The most recent local authority of residence is allocated to a patient who has moved residences within the year and has been prescribed emergency contraception more than once.

5.2.2 Provision of services in pharmacies

As of November 2014, there are 61 pharmacies in Wandsworth which are geographically spread across the borough with varying opening times and different types of services offered. Figure 26, below shows the distribution of pharmacies and the sexual health services they provide across the borough.

Figure 26 Location of Wandsworth pharmacies (n=62) highlights sites that provided Chlamydia and EHC services during 2013/14



Emergency Hormonal Contraception (EHC)

EHC is provided as a free service to females aged 13 years and above on presenting at a pharmacy. In 2013-14, 7,847 doses of EHC were administered by pharmacies in the Wandsworth HWB area. All 61 pharmacies in the Wandsworth HWB area are commissioned to provide this service. Activity within this service has steadily increased year on year. There are variations in activity levels between pharmacies but generally pharmacies that are open longer, especially on Saturday and Sunday, show the highest level of activity.

Chlamydia Screening

All 61 pharmacies in Wandsworth are commissioned to provide this service. A total of 74 tests were completed through Wandsworth pharmacies in 2012/13, a total of 0.19% of all tests conducted in the borough.

Pharmaceutical Needs Assessment 2014- feedback regarding sexual health in pharmacy

In 2014/15 a pharmaceutical needs assessment was conducted in Wandsworth. The aim was to produce a report for NHS England to use as a market entry tool for pharmacy applications and from a local perspective to ensure the needs of the residents were being met. As part of the assessment an online survey was posted (n=345) as well as 26 focus groups (n>400). In relation to sexual health the following was noted:

- The public asked for blood screening services to be made readily available at pharmacies including, HIV testing. Space and privacy however was raised as an issue of HIV testing.
- Provision of Post Exposure Prophylaxis (PEP) (a course of anti-HIV medication) should be considered to enable patients to receive it when it's needed. A highlight here is the availability of services of PEP on a Sunday/Bank Holiday time of year. A prescription is needed to obtain this however the availability of this service is something that groups feel is essential.
- Training. In order for pharmacies to reflect and work well in their community it was suggested that Equality and Diversity training is essential and needed for them to fully understand the needs of our, and other, communities.
- When asked whether their pharmacist had ever discussed sexual health, of those who responded: 75% said the topic had not been brought up and that they did not want any advice; 11% said the pharmacist had raised the topic and the advice was welcome; 11% said the pharmacist had not discussed it but would like some advice and 3% said their pharmacist had talked to them about their sexual health however they were not interested in discussing it.

The report will be presented to the Health and Wellbeing Board late February 2015.

5.3 Summary of testing conducted through other online services

Freetest.me summary- Q1 and Q2 data

Between April and September 2014 a total of 741 Chlamydia/Gonorrhoea kits were requested through the Freetest.me website of which 566 were returned (76%). The average age of people completing a test was 22 (range 16-25), 75% were female. The highest number of tests were requested in the Wandsworth wards of Bedford (n=56); Balham (n=54) and Roehampton (n=45). Of the 566 tests, 35 were positive for Chlamydia and 4 for Gonorrhoea.

Checkurself data

In Wandsworth, a total of 208 kit requests were made between Quarter 1 and 2, 2014/15. More than 70% of requests were from men and 92% of kit requests were from people aged 20-24, 72% from people aged 24. The largest number of kit order came from the Wandsworth ward of Earslfield (n=10) followed by East Putney and Graveney (n=8).

Figure 27, compares the overall kit orders for all boroughs, signed up to the Checkurself website[37], between 2013/14 and 2014/15. In 2013/14 activity decreased progressively throughout the year, picking up again after the festive season. In 2014/15 from the data received so far (Q1/Q2) kit requests have been fairly stable. Figure 28- provides Wandsworth specific data, with the exception of August 2014, kit orders are seen to decrease as the financial year progresses. For 2013/14 kit requests pick up again in line with borough level data.

Figure 27- Checkurself overall test kit order per month 2013/14

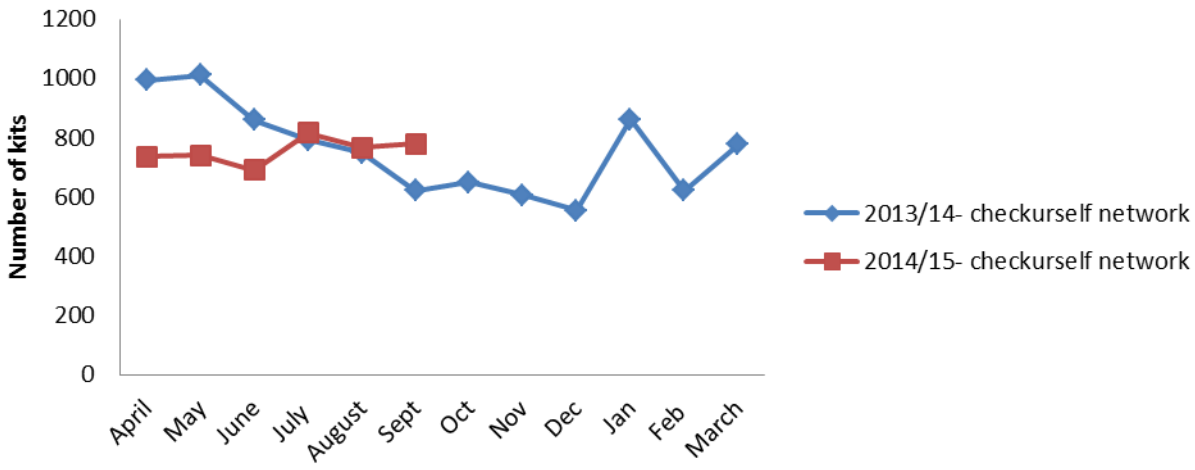


Figure 28 – Wandsworth test kit requests 2013-2015

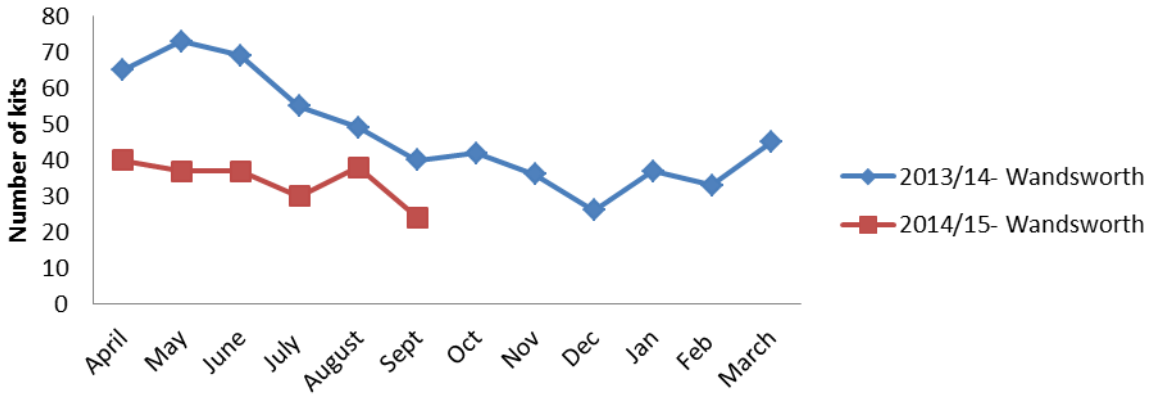
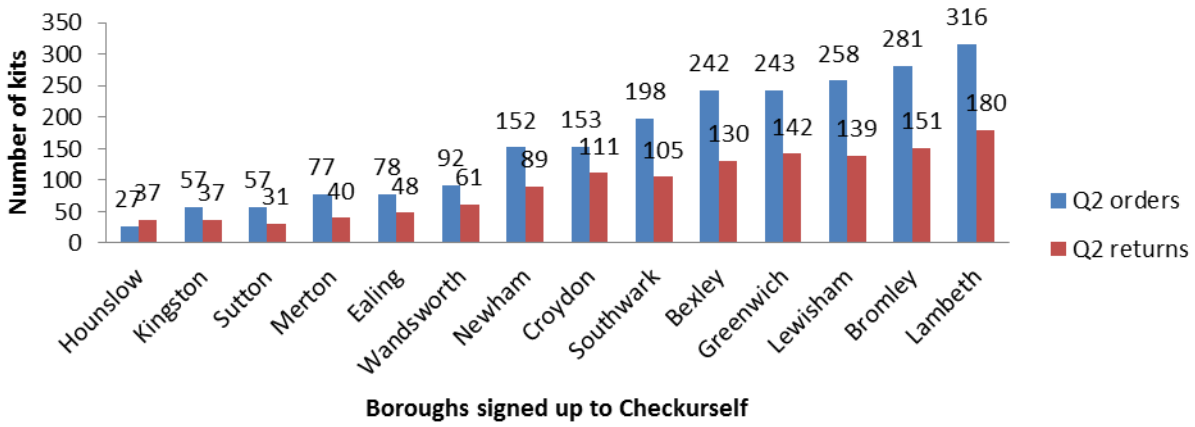


Figure 29 provides an overview of kits ordered and returned by all boroughs signed up to the Checkurself websites for Quarter 2 2014/15. The average return rate for this period was 64% ranging from 52% in Merton to 137% in Hounslow. Wandsworths return rate was above average at 66%.

Figure 29 Quarter 2 test kit orders and returns by borough



Source- Checkurself website report, Q2- 2014/15

5.4. Termination of pregnancy

In 2013, the total abortion rate per 1,000 female population aged 15-44 years in Wandsworth was 17.2, lower than Hammersmith and Fulham's (19.9), whilst higher than England's (16.6). The rank (out of 146) within England for the total abortion rate (1st has the highest rate) was 57 (Hammersmith and Fulham- 39).

Among women under 25 years who had an abortion in that year, the proportion of those who had had a previous abortion was 31.5%, while in Hammersmith and Fulham it was 34.4% England the proportion was 26.9%. The rank (out of 129) within England for the repeat abortion under 25 years (1st has the highest rate) was 27 (Hammersmith and Fulham - 11).

Among women aged 25 and over who had an abortion in that year, the proportion of those who had had a previous abortion was 43.2%, while in Hammersmith and Fulham the proportion was 45.6% and England- 45.3%. The rank (out of 146) within England for the repeat abortion carried out by women aged 25 and over (1st has the highest rate) was 86 (Hammersmith and Fulham- 60).

Among NHS funded abortions, the proportion of those under 10 weeks gestation was 85.5%, while in Hammersmith and Fulham the proportion was 83.8% and England - 79.4%. The earlier abortions are performed the lower the risk of complications. Prompt access to abortion, enabling provision earlier in pregnancy, is also cost-effective and an indicator of service quality and increases choices around procedure.

Source: Wandsworth; Hammersmith and Fulham LASER report 2013

6.0 Evidence of what works and effective

The cost of treating STIs nationally (excluding HIV) is estimated at £170million. Sexual health interventions and services accounted for 33% of total Wandsworth public health spend in 2013/14 (see table 2 below).

There is evidence that demonstrates that spending on sexual health interventions and services is cost effective:

Contraception care

- For every £1 spent on contraception, £11 is saved in other healthcare costs[38]
- The provision of contraception saves the NHS £5.7 billion in healthcare costs that would otherwise have been spent if no contraception was provided[39]
- Cost savings can be realised if the utilisation of LARC methods is increased[40]
- Early testing and diagnosis of HIV reduces treatment costs: £12,600 per annum per patient, compared with £23,442 with a later diagnosis[41]
- LARC methods are much more effective at preventing pregnancy than other methods, although a condom should also always be used to protect against STIs[42]
- Joined-up provision that enables seamless patient journeys across a range of sexual health and other services – this includes community gynaecology,
- Interventions that are evidence-based and lead to behaviour change are cost effective (e.g. free condom provision, assertive outreach health promotion, needle exchanges, sex and relationship education targeted at specific groups.
- Accurate, high-quality and timely information that enables people to make informed decisions about relationships, sex and sexual health[43]

HIV and STI access and treatment

- Early access to HIV treatment significantly reduces the risk of HIV transmission to an uninfected person with consequential cost savings[44]
- Improvements in the rates of partner notification reduces the cost per chlamydia infection detected[45]
- Sexual health needs vary according to factors such as age, gender, sexuality and ethnicity; with some groups being at particular risk of poor sexual health. There is ample evidence that sexual health outcomes can be improved by:

- Preventative interventions that build personal resilience and self-esteem whilst promoting healthy choices[46]
- Rapid access to confidential, open-access, integrated sexual health services in a range of settings that are accessible at convenient times[47]
- Early, accurate and effective diagnosis and treatment of STIs (including HIV), combined with partner notification[48] (in order to manage and control STIs by protecting patients from re-infection, partners from long-term consequences from untreated infection and the wider community from onward transmission)[49]
- Screening strategies targeting high risk populations that lead to early identification and treatment are cost effective as they avert future costs of dealing with complications and onward transmission
- The overall cost of sexual health promotion is minor compared to the costs of treating STIs and unintended pregnancies. antenatal and HIV treatment and care services in primary, secondary and community settings[50]
- There is also evidence [51] to show that preventative interventions that focus on behaviour change theory have been effective in promoting sexual health.

HIV testing in non- clinical setting and high risk groups

- Increasing the number of HIV tests in non-specialist healthcare in areas with a high prevalence of HIV[52]. Findings from national pilot projects indicate that offering HIV tests outside sexual health clinics is feasible and acceptable to patients as well as staff[53]
- Increasing the uptake of HIV testing among black Africans in England and MSM[54]. A recent review also suggests that rapid testing in community settings and intensive peer counselling (where appropriate) can increase the uptake of HIV testing among gay and bisexual men[55].

Cost of HIV

HIV is responsible for a significant burden on NHS resources. The average lifetime treatment costs for an individual who is HIV positive is around £135,000-£185,000.Due to recent increases in drug costs and longer life expectancy, this amount is more likely to be around £276,000. Nationally, preventing each onward transmission of HIV could save £1million in health benefits and treatment costs, with key recommendations as follows[56]

Behaviour change interventions

NICE has also suggested that helping people to work through their own motivations by encouraging them to question and change their behaviour can form a key part of preventative interventions in reducing STIs (including HIV) and reducing the rate of under 18 conceptions, especially among vulnerable and at risk groups[57] Effective behaviour change interventions:

- Draw on a robust evidence base are targeted at specific groups and take account of their specific influences and motivations to change include
- Provision of basic accurate information with clear messages

Services for those people living with HIV infection should meet national specialist service standards and quality indicators outlined by the British HIV Association.

Secondary care services should provide confidentiality and promote individual responsibility and focus on motivating the individual to change; and make use of 'changing contexts' models for 'nudging' people into healthier choices while re-cognising that such choices are influenced by complicated drivers of human action, including gender roles, inequality and norms around sexuality[58]

Unplanned pregnancies

There is increasing evidence that unplanned pregnancies have poorer pregnancy outcomes with children that are born tending to have a more limited vocabulary with poorer non-verbal and spatial abilities. These differences are almost entirely explained by deprivation and inequalities[59].

Although teenage conception may result from a number of causes or factors, the strongest empirical evidence for prevention are:

- High-quality education about relationships and sex[60]
- Access to and correct use of effective contraception[61]
- Educational attainment, which has a strong correlation with, planned pregnancies.

Prison

There are a number of key evidence based interventions which are particularly pertinent to sexual health services within prisons. These include the provision of:

- High quality sexual history taking and risk assessment which will enable people to receive appropriately targeted advice and information on the prevention of STIs and HIV
- Comprehensive and appropriate assessment of prisoners sexual health needs including STI and HIV risks and need for screening
- Education and support to minimise the risk of transmission or further acquisition of infection, or of negative psychosocial outcomes associated with STIs
- Shared decision-making between professionals and individual service users which can result in better health outcomes.

Prevention of sexual violence

- Primary prevention of sexual violence can occur at individual, community or societal level and can be delivered in a wide variety of settings. Initiatives can range from awareness raising, challenging attitudes an behaviours, addressing socioeconomic factors associated with violence, encouraging positive parenting and promoting positive and equitable notions of masculinity.
- Healthy relationship programmes in educational settings aim to develop relationship skills, address social norms and raise awareness of support services for those affected by violence of any sort. These programmes are shown to reduce the perpetration of sexual, physical and psychological violence against dating partners, and also show positive reductions in victimisation[62].
- The restriction on the availability of alcohol may have an impact on levels of sexual violence based on the evidential link between alcohol and levels of partner violence and child maltreatment.

- Media campaigns are difficult to evaluate but do encourage discussion and debate and may act as a catalyst for other preventative initiatives[63].
- Psychological and pharmacological treatments for offenders have been shown to reduce reoffending rates, but can be dependent on the offender's motivation to change offending behaviour.

For recommendation of best practice guide , see appendix-4

7.0 Stakeholders engagement

The needs assessment is by two sets of public engagement data sources. The first was public engagement that took place in 2014 (section A) and the second is public engagement on the current needs assessment between January to February 2015 presented (section B).. The data collection from Public engagement involved, focus group discussion, and interview with some service users, service providers and faith group leaders. Recommendations from both engagements summarised below

Section- A

There was public engagement around HIV prevention and care involving service user, providers, voluntary organisations directly involved in supporting people living the following key issues points below were raised:

1) HIV services should operate on the national policy of open access and are available to everybody living and working in Wandsworth.

2) Areas of high prevalence were identified as Tooting, Balham and Roehampton.

3) HIV outreach and community engagement prevention programme should work closely with pan London and National HIV prevention programmes to ensure that regional and national resources are effectively utilised locally.

4) HIV care and support services should be more accessible through self referrals as well as via Sexual Health Advisors.

5) All HIV contracted services should be assessed to ensure that they don't discriminate on the grounds of their disability, race, culture, religion, faith or belief, sexual orientation, age, gender or socio-economic situation, immigration status and place of or no residence.

6) HIV contracted services are required to engage local communities and stakeholders on regular and structured bases to ensure their needs and expectations are met and Not a one off consultation please.

7) All HIV contracted services need to establish collaborative working arrangements to avoid duplication with other sexual and social care providers

8) Particular emphasis need to be made to follow a clear and systematic referral and care pathways followed by patients from prevention to care and treatment moving seamlessly through the NHS sexual health services, social care and primary care.

9) Reaching out routinely to engage and involve non-affiliated service users who are not part of service user groups or organisations or community groups including sex workers, prisoners, and young people excluded from schools, those in care or leaving care, asylum seekers, and undocumented migrants, etc.

10) As part of the HIV prevention programme the Council should organise local campaigns and events to raise awareness that HIV is still a major public health threat and build up community resilience to challenge discrimination and stigma linked with sexual health and HIV in particular.

Section- B

Public engagement on sexual health needs carried out between January to February 2015.

Introduction & Brief of the Project

The engagement project has been commissioned to gather the views and concerns as well as the experiences of sexual health service users', community groups' and stakeholders'. The aim is that the outcome of the engagement will inform Sexual Health Needs Assessment and Strategy. This report is, therefore, to present the processes, the limitations and the findings of the engagement with recommendations and some suggestions on how to develop structured and effective engagement strategy.

This rapid and epigrammatic engagement exercise has benefited from the current knowledge and network the Council already developed while undertaking the HIV prevention, outreach support and care review and procurement. It is essential that this engagement should be presented as part of a well researched sexual health strategy which is compliant with current standards and legislations, within clear principles of access, equity and referral pathways, sound clinical input, evidence based prevention and education interventions targeting high risk groups and ensure the changes that need to be made are good quality and value for money.

The Context

An effective sexual health commissioning requires a good understanding and knowledge of the health needs of the rapidly changing demography of local population including the diversity not only of its resident population but also the transient/mobile population such as migrant workers using local services. These evidences are vital to the provision of accessible, sensitive and effective sexual health services. The outcome of this needs assessment together with ongoing user/community and stakeholders' engagement would provide support to commissioners to constantly review the changes in the sexual health needs of the local population and users of the services.

The Activities

In total, 96 people were directly engaged in 7 focus group discussions, and 1:1 interviews (see Appendix 1& 2 for details). Participants at sexual health needs assessment come from a variety of backgrounds, ages, ethnicities, faiths, professionals, and community and faith leaders.

Key Activities	Outputs
1) Make contact with different community groups, providers and services user from the Council's list of previous engagement activities 2) Arrange date for consultation time and venue 3) Prepare a flyer to invite people and organisations to the scheduled focus group meetings 4) Send a reminder nearer the time for each event 5) Offer 1:1 interview/telephone chat for people unable to attend or don't want to discuss issues in group discussion 6) Working with commissioner, develop a questionnaire that could be posted online using the Council's website for those who may not be able to attend at focus groups discussion nonetheless would like to contribute to the needs assessment. 7) Analyse the feedback from the online questionnaire	▪ Links and networks of key user and providers established ▪ Date, venues of focus group discussion and 1:1 interviews arranged with users, commissioners, community and faith leaders ▪ All focus group discussions completed ▪ Topic guide for focus group ▪ On line questionnaire ▪ Analysis of the results
Writing up the final report Present feedback from different stakeholder's engagement and online questionnaire and present a final report with the key findings	▪ Final report ready for use in the needs assessment

The Limitations

It is broadly acknowledged that some users, communities and stakeholders may not have been able to participate due to short time frames.

It has been particularly difficult to engage people with learning disability and mental health condition, drug and alcohol service users, young offenders, those excluded from school, looked after children and carers . Despite repeated effort and discussion with managers none of these groups were able to attend any of the scheduled focus group events.

However, the limitations were minimised by being opportunistic in terms of:

- taking to offer and finding slot into existing meetings of some of the groups
- Allowing some degree of flexibility to attend meetings in the evenings and weekends
- Using community accessible venues such as churches and community centres for meetings.

The Findings

There was general agreement that the sexual health services currently provided in Wandsworth are of good quality and locally accessible.

As part of this engagement process, there was a call by significant number of the participants for more holistic model of sexual health interventions, which should encompass

a broader range of integrated prevention care and support services, mental health, alcohol and drug services, healthy living activities and smoking cessation services.

Here are some examples

- 'Patient' not 'budget' should be at the centre of all health and social care services plan or strategy,
- too much reliance on current GUM and RSH providers
- limited community based outreach sexual health services
- Some participants expressed concern that the Council may not prioritise HIV prevention once the ring fenced public health budget is lifted. As the Council is not responsible for the lifetime drug costs for those living with HIV. HIV treatment and care costs are the responsibility of NHS England.
- Sex and relationship education for parents is essential in reducing teen age pregnancies and prevention of sexually transmitted infections (STIs). In this age of digital information parents are lost on how to advice their children from early age.
- Young people don't want to talk about sex and relationship they just do it and do it dangerously wrong.
- There is a general lack of good information on sexual health for young people – the information need to be clear and explicit including accessing sexual health specialist clinics within and outside the borough.
- GP practices are not always open to providing sexual health services
- There is a need to train parents and community champions on what sexual health services are available and how to access them including long acting contraception and condoms, how to get tested on HIV or other STI's etc…
- HIV is now downgraded it has to increase its profile at grass root level and particularly at those in deprived areas. The reach of HIV prevention campaigns needs to increase both in size, frequency and resources.
- There are high levels of social media use amongst both gay men and black African communities although patterns of usage differ.
- One week a year campaign is not enough we need to do more of it in the communities in danger of getting it.
- The need to improve RSH services in and around Battersea area to stem down the flow of patients to Chelsea and Westminster. It is a long distance travel for patients from Battersea to St Georges that is why they prefer to go to Chelsea &Westminster Clinic.
- Encourage people living with HIV to do voluntary work on sexual health prevention and care. They can be excellent resource to challenge stigma in the community
- The CCG patient consultative group think it is important to engage communities in Roehampton on general sexual health issues and education including FGM as there are several communities who practice FGM in and around Roehampton. There is a great need to expand outreach sexual health prevention and education programme in this area, one off consultation or engagement is not enough.
- School nursing service specification need to include specific sexual health education programme in schools.

- HIV/Chlamydia testing on its own is not enough. The programme should be backed up by behavioural change interventions, clear care pathways including access to advocacy support.
- One off HIV negative diagnoses are an often missed opportunity as more attention needs to be given to health promotion interventions for individuals to remain negative.
- Majority of people like to access information about health and available services in an anonymous and confidential manner that new technology can facilitate.

Recommendations

It is possible to draw some important recommendations albeit from a very small scale, rapid and one off engagement. Here are the lessons learned and few recommendations:

- **Sexual health information, training and campaigns**

- The availability of consistent quality information and resources is crucial to effective sexual health services including evidence based prevention, care and support.
- Information and training for parents on Sex and Relationship issues to advice/guide their children
- More and clear information on FGM and on how to get support to challenge domestic violence which is culturally sensitive and effective
- Sexual health advice and information in GP surgeries need to improve as it is the first point of contact.
- High profile publicity on social media, community based events to promote sexual health campaigns locally throughout the year not just one off campaign such as World AID's Day.
- GP staff needs training on sexual health in general and how to access services in particular, also on cultural awareness and entitlement to sexual health services

- **Hard to engage groups** – their voices should be heard.

    - As part of the engagement plan it is important to first clearly identify groups to be engaged and agree on methods of engagement.
    - One method of engagement does not fit all groups.
    - People with learning disability and their carers should be engaged differently from those people living with HIV.
    - More work with young people using the social media route.
    - Better understanding and knowledge on the diversity of BME groups
    - Innovative and interactive work with all groups including those with mental health conditions and substance misuse service users
    - A programme to challenge stigma and discrimination associated with sexual health should be developed in areas of high risk and diverse communities (Battersea, Roehampton and Tooting areas)

- **Coordination, integration and alignment of the various sexual health services and projects**

    - At present there are a plethora of local free condom distribution schemes targeting different populations: gay men, black African people and young people as well as the Pan-London freedoms scheme (which distributes condoms to gay venues) and C-Card schemes for young people, which need better coordination and alignment
    - There needs to be far greater partnership work developed to address the complexity of drug and alcohol use amongst Men having Sex with Men.
    - Shortage of good advocacy services in sexual health and employment, training and housing in particular. The current services are more on advice and information but almost nothing on advocacy.
    - Improve the role of GUM in HIV and STI prevention and to build a better link with the outreach prevention and testing programmes (brighter partnership) to increase uptake of HIV/STI testing.

- **Prevention should remain a priority**
    - Focus on high risk groups
    - Outcome focused
    - Evidence based prevention models
    - Testing supported by behavioural and motivational intervention
    - Community based outreach prevention programmes should be better resourced and longer term funding/support

8.0 Key issues /service gap

STI

- Uptake/promotion of chlamydia screening is poor in pharmacy settings.
- Activity does not follow need of population

Access to GUM services

- Historically, reasons for not accessing sexual health clinics in the borough of residence, include lack of convenience and anonymity (fear of being seen by people you may know). It is not known whether these reasons still stand and whether they fully explain why 51% of Wandsworth residents accessed genito-urinary medicine services outside the borough in 2013

HIV

- On-going concern over people not wanting to know their status
- Clinical leadership and staff training is key to success of HIV testing

Chlamydia screening

- Demand for online provision of Chlamydia screening kits is highest among those aged 24 year old which constitutes the upper age limit of the National Chlamydia Screening Programme. Work needs to be done to ensure online services continue to be available for this cohort.

Contraception and Termination of Pregnancy

- LARC uptake is below the rate for England
- Reasons for high proportions of removal need to be explored.

Young People

- Wandsworth young mother's review reported an inconsistency use of contraceptive by young women and inadequate SRE provision in schools.

Substance misuse

- Drug users and injecting drug users are particularly vulnerable to contracting and spreading blood-borne viruses including HIV. Accurate data is missing to estimate scale of the Injecting drug use in Wandsworth.

Men who have sex with Men

- Nationally, Men who have Sex with Men represented more than 40% of men diagnosed with an acute STI in 2012. In Wandsworth, MSM represented 30% of men presenting with an acute STI in GUM clinics.

BME communities

- People from Black and Ethic groups are disproportionately affected by STI's. In 2012 the Wandsworth rate per 100,000 population for black residents was 2,836 per 100,000 population compared to white residents of 1,464 per 100,000 population.

Older people

- People over the age of 50 years accounts for 20% of Wandsworth population. There is national evidence suggesting many older people do not contemplate the use of a condom or seek sexual health advice when engaging in new sexual relationships.
- National evidence suggest late diagnosis of HIV is more common in older age groups (half of those aged over 50) compared with younger age groups (one-third of those aged 16 to 19)

FGM

- Establishing how many children are at risk of FGM in Wandsworth.
- Supporting primary schools (demographic most likely to be affected) and targeting at risk groups.
- Incorporating FGM within the wider violence against women and girls strategy.
- Continued engagement with affected communities.
- Developing the health care provision for those affected.

Sexual violence

- The psychological effect sexual violence is not sufficiently recognised
- The long term of effect of coping with sexual violence may include alcohol and drug use.

Primary care Services

- 60% of Chlamydia screening is performed outside GUM setting. The majority of practices refer positive case to GUM clinic for partner notifications.

Injecting drug use

- Injecting drug use accounts for most of the incident of infections with hepatitis C virus. Of the 133 eligible clients in Wandsworth, 52 accepted and 66 refused the test, only 50% of the client group which is a concern.

9.0 Recommendations

STI and HIV

- Dedicated sexual health outreach programme is needed for those most at risk of sexual ill health.
- STI screening and HIV testing should be sustained and continued in wards of high prevalence and amongst groups at highest risk.
- In order to tackle high rate of Chlamydia we need to continue embedding Chlamydia screening in primary care and sexual health services.
- HIV test in community setting currently carried out by Brighter Partnership in Battersea area should be expanded to other high prevalent sites in the borough.
- Explore the possibility of HIV testing at St. George's accident and emergency department that has been evaluated to be feasible and acceptable through pilot review.
- The specifications of commissioning of Chlamydia and STI from primary care providers should include an incentive for partner notification.

High risk groups

- Priority should be given to evidence based preventative interventions such as assertive outreach health promotion programmes specific to the needs of high risk groups.
- Opportunities to provide personalised support and preventive message should be explored using digital technology appropriate for the different at risk groups
- We need to improve on the data to establish the referral to sexual health services for those engaged in Injecting Drug use.
- Promoting HIV testing among men who have sex with men, including outreach schemes and providing rapid point-of-care tests.

Young people

- Teenage pregnancies have dropped in Wandsworth, however, the high rate of termination of pregnancy amongst teenager's calls for sustaining the current effort to keep the rates down.
- The inconsistencies of young people use of contraceptives suggest there is need to promote access to Long Acting Contraceptive care in the community.
- Although school nurse can prescribe Emergency Hormonal Contraception, this is not a common experience in Wandsworth. An opportunity to increase access to Emergency Hormonal Contraceptives by School nursing should be explored special in post 16 educational institutions.

Older people

- Absence of age appropriate sexual health information, plus positive images of mature adults promoting good sexual health and specialised serves are areas that will need to be addressed.

Contraception

- There is a need to determine why uptake of contraceptive services is low in GP settings in Wandsworth.Data on LARC discontinuation should be analysed and compared between GP and RSH services. Discontinuation is an important driver of relative cost effectiveness between LARC methods

Female Genital Mutilation

- A multi organisational action plan is being implemented to ensure the effective sharing of information. This is a new recording process and as such an accurate base-line is unknown. It would be expected that the numbers notified will increase in the next two years as the information gathering processes become more established.
- Evaluate the need to expand the current sexual health services ("deinfibulation" clinic to pregnant women) to all women and girls who have undergone FGM. This should include sexual health advice, screening and an offer of counselling particularly to those who are being pressurised into performing FGM on their daughter.
- Evaluate the effectiveness of support offered to schools in terms of improving school children and staff awareness of FGM and protection of those at risk.

Sexual violence

- A multi-agency strategic response to sexual violence which addresses awareness, prevention and service provision to be undertaken;
- Work to raise awareness of, and improved signposting to appropriate services for victims of sexual violence;
- Extend the provision of emotional support, advice and information to individuals who have experienced rape or sexual assault;
- Ensure that sexual violence pathways are available to all agencies and provides equity of provision. (Sexual Health Commissioning.)
- Training should be provided for front line health and social care and criminal justice staff to ensure that knowledge and awareness of sexual violence is sufficient to ensure cases can be detected and handled in a sensitive and effective way.

Future specific analysis

Recommendation below are suggested for the for areas of need that has not been sufficiently explore within the scope of the current needs assessment to provide evidence that can inform planning and service development.

- The impact of the newly emerging population sexual and reproductive health needs in Nine Elms
- Sexual health needs of older people, groups most affected by sexual ill health such as people affected by mental health, men who have sex with vulnerable migrants, people with learning disabilities, and black African communities affected.

- Care pathway between drug and substance misuse and referral to sexual health services
- Patient care pathway from Primary care (GP and Pharmacies) to specialist sexual health and family planning service.

Appendix -1 Recommendations and best practice guidelines

1) NICE recommendation for HIV testing : http://pathways.nice.org.uk/pathways/hiv-testing-and-prevention/hiv-testing-and-prevention-overview#path=view%3A/pathways/hiv-testing-and-prevention/increasing-the-uptake-of-hiv-testing.xml&content=view-index .

2) Service Standard for sexual and reproductive healthcare http://www.fsrh.org/pdfs/All_Service_standards_January_2013.pdf
3) NICE Recommendations for providing young people for contraceptive advice http://pathways.nice.org.uk/pathways/contraceptive-services-with-a-focus-on-young-people-aged-up-to-25#path=view%3A/pathways/contraceptive-services-with-a-focus-on-young-people-aged-up-to-25/providing-young-people-with-contraceptive-advice.xml&content=view-index
4) NICE recommendations for increasing testing HIV in Men who have Sex with Men http://www.nice.org.uk/guidance/ph34/resources/new-nice-guidance-to-increase-hiv-testing-in-men-who-have-sex-with-men
5) Increasing the uptake of HIV testing http://pathways.nice.org.uk/pathways/hiv-testing-and-prevention/hiv-testing-and-prevention-overview#path=view%3A/pathways/hiv-testing-and-prevention/increasing-the-uptake-of-hiv-testing.xml&content=view-index
6) Preventing sexually transmitted infections and under-18 conceptions overview http://pathways.nice.org.uk/pathways/preventing-sexually-transmitted-infections-and-under-18-conceptions/preventing-sexually-transmitted-infections-and-under-18-conceptions-overview
7) Domestic violence and abuse : how services can respond http://www.nice.org.uk/advice/lgb20/chapter/what-can-local-authorities-achieve-by-investing-in-domestic-violence-and-abuse-services. Domestic violence and abuse, what a nice says http://www.nice.org.uk/advice/lgb20/chapter/what-nice-says
8) Domestic violence and abuse overview http://pathways.nice.org.uk/pathways/domestic-violence-and-abuse

Appendix-2 – Stakeholder engagement

1. Community and Faith Groups
    1. Wandsworth LGBT Forum
    2. Black African Groups (South London Women's Organisation,
    3. Catholic for AIDS Support (CAPS)
    4. African Churches Group
    5. Faith leader
    6. African Advocacy Foundation
2. Voluntary organisations working with PLWHIV
    1. Wandsworth Oasis – Gill Perkin CEO
    2. Food Chain – Supporting PLWHIV with Food and catering
    3. Metro Central – condom distribution provider
    4. Caius Youth Centre
    5. Roehampton and West Putney youth centre
    6. Wandsworth Training and Resource Centre
    7. The Brighter Partnership HIV outreach and prevention programme
    8. Catholic for AIDs Prevention and Support (CAPS)
    9. Wandsworth LGBT
    10. Wandsworth HIV peer support hub
    11. West Wandsworth CCG locality patients consultative Groups
    12. South West London Fellowship Black African HIV Peer Support Group
    13. Youth service users and People with learning disability
    14. Mental Health Service users
    15. Wandsworth Health Watch (WHW)
    16. locality patients consultative groups (PCG), voluntary organisation providers
3. Stakeholders
    1. St Georges GUM – Courtyard
    2. SWAGNET – South West London Clinical Network Groups
    3. Wandsworth CCG – Patient and Public Involvement

Appendix-3 National Guidance for Sexual Assault Referral Centre Standards[1] [1]

Sexual assault referral centres (SARCs) are an open access one-stop service to help victims of rape or sexual assault, irrespective of age, on the journey to recovery by providing an immediate health and care response with access to criminal justice services, safeguarding services and integrated follow-up, including access to psychological counselling, legal advice and other support. Victims can choose to be dealt with anonymously if they do not want the involvement of the police. Care pathways are developed locally to help both the victim and those investigating the crimes.

SARCs should provide;

- 24/7 or out of hours provision;
- timely acute healthcare assessment, including paediatric assessment, mental health risk assessment, treatment (public health services including emergency contraception, pregnancy and STI testing and post exposure prophylaxis) and crisis support;
- choice of gender of forensic examiner – most victims prefer to be seen by a female examiner;
- timely and comprehensive forensic recovery, if the client chooses and for young people under 16 years old, timely paediatric forensic recovery;
- follow-up services which address the client's medical, safeguarding, psychosocial and on-going needs, including onward referral to other health and mental health services, NHS psychological therapy services and specialist sexual violence psycho-social counselling and support (often undertaken by voluntary and community service providers);
- direct access or referral to an independent sexual assault advisor (ISVA). An ISVA is a trained support worker who provides advice and support to enable clients to access the services that they need. A report funded by the Home Office shows that clients supported by ISVAs are more likely to go through the full course of criminal justice proceedings;
- access to the criminal justice system if the client chooses.

<u>The College of Emergency Medicine Recommendations[1]</u>

To improve patient care the College of Emergency Medicine has developed a guideline to assist in the management of adult patients who have suffered rape and sexual assault. Summary of recommendations;

- Where possible and practical, victims of sexual assault and rape should be assessed in a Sexual Assault Referral Centre.
- Any forensic examination should only be performed by a clinician with suitable specialist training in an appropriate environment.
- Person identifiable information about sexual assaults and rapes should not normally be shared without consent, except in exceptional circumstances.

Appendix-1 References

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[xxxiii] Contraceptive services are also available at General Practices, Sexual Assault Referral Centres (SARC) for emergency contraception only, some Genitourinary Clinics (emergency contraception and male condoms) and some pharmacies under Patient Group Direction (primarily emergency contraception). Contraception is also provided at termination clinics.
[xxxiv] Data on contraception from Sexual and Reproductive Health Services and some young persons clinics is collated onto the Sexual and Reproductive Health Activity Dataset (SRHAD). Data is also collected from General Practices (see section below). Activity data from other settings is not currently accessible and therefore the following activity data presented in this document is likely to be an underestimation of the total amount of contraception used in Wandsworth.

[xxxv] LARC methods such as contraceptive injections, implants, intrauterine systems (IUS) or intrauterine devices (IUD).
[xxxvi] NB Number are small. Number of first time attendees less than 25.
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