SEXUAL HEALTH NEEDS ASSESSMENT

2012-2013
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WHY A SEXUAL HEALTH NEEDS ASSESSMENT?

- Sexual health is a key component of good public health. In the eleven years since the publication of the UK’s first sexual health strategy, much has been done to modernise and improve access and quality of sexual health services. Teenage pregnancy rates have dropped considerably with Quarter 1 rates of 2011 being the lowest on record for London since 1998. Uptake of Chlamydia screening has increased resulting in higher positivity rates which in turn lowers the prevalence of undiagnosed Chlamydia infection in the population. However, sexually transmitted infections including late diagnosis of HIV are high (HPA, 2012) and sexual violence and assault remain a hidden though widespread problem (MBARC, 2012).

- Sexual health is a priority for London. London has the highest prevalence of sexual ill health in the UK and this has a disproportionate impact on health inequalities, public health and financial burden to London’s health commissioners. It is estimated that approximately 3 million Londoners each year are affected by sexual ill-health (HPA, 2011). London also has a complex system of sexual health services which are predominantly demand led. Overall, whilst rates of teenage conceptions are falling and London was the 2nd best performing Strategic Health Authority (SHA) for Chlamydia Screening, STIs are increasing with London having a disproportionate number of young people who are greater risk of STIs and unwanted pregnancies (HPA, 2011). London also has the highest abortion rate in England and Wales (ONS, 2012) and a higher prevalence of HIV than England - in 2010, this was 5.4 per 1,000 compared to 1.9 per 1,000 for England (HPA, 2011).

- The year 2012 is a time of change. As outlined in the UK coalition government’s white papers on health, the commissioning of universal open-access sexual health services will be handed over to local authorities from primary care trusts on the 1st April 2013. Commissioning of termination of pregnancies (now called abortion services) from any qualified provider will be done by clinical commissioning groups as well HIV clinical care, male and female sterilisation and psycho-sexual counselling. Specialist HIV commissioning, sexual assault and primary care contracting will be the remit of the NHS Commissioning Board.
• The purpose of this health needs assessment is to support the London Borough of Hounslow (LBH), Hounslow’s Clinical Commissioning Group (CCG) and NHS Commissioning Board in strategic decision making and effective use of resources to improve sexual health in Hounslow.

• It builds upon the Joint Strategic Needs Assessment (JSNA) which is refreshed annually and informs the Sexual Health and Reproductive Strategy for Hounslow 2012-2015.

VULNERABLE (‘AT RISK’) GROUPS IN HOUNSLOW

• The highest burden of sexual ill-health is borne by women, men who have sex with men (MSM), teenagers, young adults and black and minority ethnic (BME) groups in the UK. People with learning or physical disabilities and with mental or behavioural problems also have a disproportionate burden of sexual ill-health.

• It is estimated that MSM make up ~5.5% of Hounslow’s population (West London Gay Men’s Project, 2010). MSM live throughout the borough.

• In Hounslow, the majority of those presenting to sexual health services are of white ethnicity, reflecting the population as a whole. Across London the Black ethnic groups – especially Black African and Black Caribbean – suffer disproportionate burden of undiagnosed STIs and HIV. Studies have also shown that sexually transmitted infections are also stigmatized within these sub-populations. Despite the smaller numbers relative to the white population in Hounslow, it is clear that Black ethnic groups are a ‘high risk’ group and efforts needed to increase uptake of sexual health services and testing and to prevent further transmission of STIs in the population group.

• In relation to the Asian community in Hounslow, little is known about the likelihood of the prevalence of undiagnosed STIs in the population. There is anecdotal evidence from youth services and sexual health services of an increase in anal sex amongst sub-Asian female populations as this is
perceived as a way to protect their virginity but to have sexual activity. This increase is accompanied with high levels of low self-esteem, lack of negotiation skills in relationships and physical health issues.

- Little is known about inequalities in the sexual health status of people with learning disabilities in the UK including Hounslow. There is, however, evidence to suggest that they may face particular barriers in accessing sexual health services and the informal channels through which young people learn about sex and sexuality. In 2012, 654 adults (aged over 18 years) were registered on a learning disability register on SystmOne. A learning disabilities health needs assessment was undertaken in 2012 but did not focus on sexual health needs.

- There is evidence that people with mental health problems are at a high risk of engaging in risky sexual health behaviours and at risk of exposure to STIs. They are also at high risk of being victims or perpetrators of sexual abuse or violence. There is little information on the sexual health of people with mental ill-health in Hounslow apart from some user reports of KISS clinics and the West London Rape Crisis Centre.

Recommendations

- Information is needed on the sexual health needs of people with learning disabilities and people with mental health problems. These pieces of work should be done as soon as possible and then can feed into a refresh of the sexual health needs assessment.

- Audit and devise a system whereby use of sexual health services and burden of sexual ill-health in people with learning disabilities, physical disabilities and in people with mental or emotional health needs can be collated and monitored in order to identify unmet need and improve provision of service.
SEXUALLY TRANSMITTED INFECTIONS IN HOUNSLOW

- London has the highest rates of STIs in the country and rates are increasing, largely due to increasing diagnoses of Chlamydia followed by genital warts. This trend is reflected in Hounslow.

- Unlike London, the majority of diagnosed STIs in Hounslow are in the white population.

- In outer London (including Hounslow) young people account from the highest proportion of acute STIs.

- Hounslow has the second lowest diagnostic rate of acute STIs in North West London. (Harrow is lower).

- The highest acute STI diagnostic rates are in the east of the borough – the wards of Turnham Green, Brentford, Syon and part of Chiswick Homefields – with an age-specific STI diagnosis rate of 2,000 or higher per 100,000 persons aged 15-59 years.

- Numbers of GUM attendees having STI screens are increasing for Hounslow as are costs of STI screens (asymptomatic/opportunistic testing). Part of the raising costs can be contributed to out-of-borough residents accessing the contraceptive/community services.

**Recommendations**

- Continue the integrated sexual health service model and include within contracts provision of sexual health promotion for both primary and secondary prevention (i.e. knowing how to identify if you are at risk of STI and where to go in Hounslow).

- Basic sexual health services to be embedded in core services of general practice. This will need to be done in consultation with the Clinical Commissioning Group (CCG) but would provide greater patient choice, provide greater equity of access and would help with more prompt diagnoses of STIs, thereby reducing likelihood of onward transmission.

- Difference between relative risk and absolute risk should be considered when focusing efforts on STIs. Relative risk relates to MSM and Black African groups where there is high risk and low numbers and absolute risk that refers to low socio-economic deprivation and young people where the risk is lower but there are higher numbers. Service provision should address both risk
models but it can be difficult getting the balance right given limited resources.

- Increase the number of STIF trained GPs and LARC accredited GPs in Hounslow. This will help improve provision of Level 1 and 2 sexual health services in Hounslow.

- Since majority of STIs are reported in young people, sexual health promotion needs to be prioritized for young people. This should entail SRE in schools and partnership work between the 5-19 services at HRCH and the early intervention and targeted services at LBH.

- As there is a finite budget yet rising STIs, commissioners will need to consider how to manage the costs of STI screens. Evidence show that HIV, Chlamydia and Gonorrhea show value for money.

### HIV

- HIV prevalence (both diagnosed and undiagnosed) is estimated to be increasing year-on-year. In 2011, there were an estimated 96,000 people living with HIV (both diagnosed and undiagnosed) in the UK with 24% unaware of their infection.

- Nearly half (46%) of those diagnosed with HIV live in London. Since 2006 there has been an annual growth in the number of people diagnosed with HIV infection of 5-9%. Over 29,500 HIV diagnosed London residents accessed care in 2010 which more than double that of 2000.

- London has the highest rates of HIV in the UK and 27 of the 31 PCTs have a prevalence of diagnosed HIV greater than 2 per 1000 (including Hounslow). According to the HPA (2011 & 2012) more than 1 in 5 people infected with HIV in London do not know their status (~8,400 people).

- Since 2000, the most common route of acquisition for newly diagnosed HIV infections in London has been heterosexual exposure.

- The number of people living with HIV in Hounslow has increased by 15% since 2006 which is considerably lower than England (48%).

- In Hounslow there were 624 residents with diagnosed HIV in 2011. Whilst this reflects an increase in new cases being reported since 2010 (3.8%), numbers of new incident cases have varied since 2006.
Like elsewhere in North West London, over half of diagnoses were attributed to white men and women (42%). 36% of those living with HIV in Hounslow were Black African and the majority of these were women (64%). Each year since 2006, the highest number of diagnoses are in MSM followed by heterosexual women.

The highest prevalence areas were Chiswick, Brentford and Turnham Green followed by Isleworth and Syon wards. However, 90% of wards in Hounslow had a diagnosed prevalence rate of >2 per 1000.

The main route of infection in Hounslow is sex between men and women (53%) with a further 41% attributed to MSM.

Late diagnosis of HIV (CD4<250/mm$^3$) is increasing in Hounslow (an increase from 51% in 2009 to 57% in 2010, higher than London’s 49% and England’s 52% for 2010).

HIV testing is the best means to reduce late diagnosis of HIV and uptake in GUM services is 91% for MSM and 72% for heterosexuals in Hounslow.

**Recommendations**

- Early diagnosis of HIV is preferential to late diagnosis not just for the prolonging of the patient’s life expectancy and quality of life that that late diagnosis is much more expensive. On average, the annual cost of HIV treatment and care mix per early detection patient is £8,934.01 compared to £11,530.64 for a late detection patient. Work needs to continue in reducing the proportion of late and very late diagnoses within Hounslow, especially in MSM and Black African groups.

- Late diagnosis can be reduced by identifying those most at risk in the population and areas with high HIV prevalence. Since 90% of Hounslow’s wards had a prevalence above 2 per 1000, HIV testing should be provided throughout the population.

- According to the literature, uptake of HIV testing can be improved through the following:
  - Ensure current HIV testing in GUM, antenatal care and TB services are optimized
  - Introduce routine HIV testing in abortion services
  - Pilot and evaluate community based point of care testing
Introduce HIV testing in primary care
Introduce opt-out testing in medical admissions in acute settings where prevalence is greater than 2 per 1000 (UK National Guidelines for HIV Testing)

Hounslow has instigated the first 2 and in the new abortion services contracts (part of the AQP process for 2013/14), routine HIV testing will be required. Consideration should be made of HIV testing in primary care and in West Middlesex Hospital.

- Throughout the literature, MSM and Black African heterosexuals remain the groups with the highest HIV prevalence in the UK. Efforts are warranted to reinforce prevention messages and promote HIV testing. There is evidence that there should be an annual HIV/STI screen for MSM who have unprotected sex with casual or new partners, increasing to every 3 months if changing partners regularly.

- In 2011, NICE published guidance on increasing the uptake of HIV testing in black Africans and among men who have sex with men (MSM). In relation to the former group – black Africans – NICE had 6 recommendations. The following highlight actions under each recommendation which should be considered for Hounslow:
  - Community engagement and involvement – this includes recruiting, training and encouraging members of local Black African communities to encourage their peers to take an HIV test.
  - Planning services – assessing local need – this to include collecting views and experiences of local black African communities to understand their specific concerns and needs in relation to HIV testing.
  - Planning services – developing a strategy and commissioning services in area of identified need – ensure HIV testing is available in a range of healthcare and community settings which are accessible and acceptable to the target population.
  - Promoting HIV testing for black African communities – perhaps work with the Healthy Lifestyle Roadshow and other community links to promote the importance of HIV testing
  - Reducing barriers to HIV testing for black African communities – the actions around this mostly involve ensuring that staff are trained in emphasizing that the tests are confidential, being culturally sensitive, knowing the referral pathways and recognizing the symptoms that may signify primary HIV infection or illnesses that co-exist with HIV.
  - Healthcare settings: offering and recommending a HIV test – this basically states to follow British HIV Association (BHIVA) guidelines and in areas where more than 2 in 1000 population have been
diagnosed with HIV, all health practitioners to offer and recommend an HIV test to anyone who has a blood test (regardless of the reason) and primary care and general medical admissions professionals should consider offering and recommending an HIV test when registering and admitting new patients.

- HIV referral pathways – ensure there are clear referral pathways for people with positive and negative HIV test results and that for those who test positive, that they are seen by an HIV specialist preferably within 48 hours but certainly within 2 weeks of receiving the result.

- NICE guidance on HIV for MSM is similar – planning services by assessing local need and developing a strategy, promoting HIV testing among MSM and having clear referral pathways for HIV. The additional recommendations are made:
  - Specialist sexual health services to offer and recommend HIV tested all men. This includes those who have previously tested negative for HIV and should happen whether or not they disclosed that they have sex with men. Ideally both fourth generation serological testing and POCT to be offered.
  - Primary and secondary care to offer and recommend HIV testing to all men who have not previously been diagnosed HIV positive and have disclosed or are known to have sex with men or live in an area with a high prevalence of HIV or with a large community of MSM. Primary care to offer annual HIV testing.
  - Providing rapid point-of-care tests as part of outreach is also recommended.

- Since the main route of transmission is heterosexual in Hounslow and the fact that late diagnosis is also high in this group, efforts should be made to expand the offer of HIV testing to this group. This would not only help to reduce late diagnosis but also undiagnosed infections, thereby preventing further transmission.

- Sexual Health Board to work with LBH in understanding the needs, issues and opportunities in HIV prevention in the three target groups – MSM, African communities and People living with HIV in Hounslow. Work is also needed in how HIV prevention will be addressed in the borough.

YOUNG PEOPLE’S SEXUAL HEALTH

- In 2011/12, Hounslow’s Chlamydia Screening Programme had an overall diagnostic rate of 2269 per 100,000. This is under the recommended 2400
per 100,000, which will be an indicator in the Public Health Outcomes Framework.

- Hounslow had the third best diagnostic rate in North West London – with the exceptions of Brent and Ealing, all others were under 2000 per 100,000. Only Brent achieved the 2400 per 100,000, making it one of the ten London boroughs that did.

- Screening coverage was 27.5% in 2010/11 and 26% in 2011/12 (both above target of 25%) and community positivity rates were 5.1% and 5.9%, higher than the expected 2.4%, indicating that the right people are being screened.

- Teenage conception rates have dropped considerably in Hounslow since 1998. This echoes the overall downward trend in teenage conception rates in the UK.

- In 2010 Hounslow had the second highest teenage conception rates in North West London and apart from 2009, Hounslow’s teenage conception rates have been higher than both London and England averages. Over two thirds of conceptions led to abortion (64% in 2009 and 2010). This is higher than London (62.5%, 60.6%) and England (50.3%, 49.1%) and has been increasing over the past ten years.

- There is variation within the borough. Rates of under-18 conceptions at ward level in Hounslow vary significantly from under 30 per 1,000 population to 85 per 1,000 in 2005-07. Seven of Hounslow’s 20 wards have under-18 conception rates that are among the highest 20% in England. According to pooled 2008-2010 data, the wards with the highest rates are Bedfont, Isleworth and Turnham Green. These 3 wards are in the top 20% of wards in England and have at least a rate of 58.4 conceptions per 1,000 women aged 15-17 (ONS, 2012).

- Young people most at risk of teenage pregnancy are children in care (CIC) and those who are socially deprived and excluded.

**Recommendations**

- Increase the number of young people friendly sexual health services, especially GP practices and pharmacies in accordance to ‘Positive Youth’ recommendations. There is a ‘You’re Welcome’ accreditation which since 2010 is being done on a local level but to date only the GUM clinic has been accredited. The Smoking Cessation service and the maternity service at WMUH have started the process. Ideally, all GP practices should be young
people friendly but due to the time involved in conducting the process, those practices with large number of young people should be targeted first. Sexual Health Board will need to look at how to support this process.

- Greater targeted youth support to young people at risk of unintended pregnancies and STIs, especially young people attending the Youth Offending Service.

- The local teenage pregnancy pathway and aftercare should be reviewed, particularly as the providers of youth services are fragmented across local authority, NHS and voluntary sector.

- Audit the number of schools who are providing SRE and the quality and work with school governors to establish SRE programmes with Hounslow’s schools.

**TERMINATIONS OF PREGNANCY (ABORTION)**

- Hounslow has the second highest rate of abortion in North West London for the years 2009 and 2010 – 29 and 29.5 age standardized rate per 1,000 women aged 15-44 years. These rates are significantly higher than London’s 26 and 2.57 per 1000 and England’s 17.6 per 1000 for 2009 and 2010.

- The standardized rates are also significantly higher than the other six North West London boroughs but lower than Brent.

- Hounslow’s crude abortion rate for under 18 year olds was higher than England averages (21 per 1000 versus England’s 16.6 for 2010 and 24 per 1000 compared to England’s 17.7 for 2009).

- In terms of repeat abortion rates, Hounslow’s proportion of repeat abortions to women under the age of 25 years for 2009 and 2010 was 29% which has lower than London’s 32% but higher than England’s 25%. It was also the lowest in all the North West London Boroughs.

**Recommendations**

- Efforts should be made to increase uptake of LARC in women across Hounslow as these are more effective and cost-effective at preventing unintended pregnancies than oral contraceptives or condom-usage.
• Whilst there is some conflicting evidence about effectiveness of LARC reducing repeat abortions following first or second abortion, LARC counseling and insertion should be offered in termination of pregnancy services.

• Consider a detailed analysis of insertion and removal LARC rates across Hounslow borough using a combination of GP data, data from integrated sexual health services and abortion services. It may be difficult to see if there is direct relation between repeat abortion and removal of LARC but analyses by age group and time between fitting and removal may help. This is however dependent on there being available identifier information to link data sources.

CONTRACEPTIVE USAGE

• Contraceptive usage has changed in England over the past 15 years with prescriptions of Long Acting Reversible Contraception (LARC) doubling, Emergency Hormonal Contraception (EHC) halving and user dependent contraception (condoms, pill, patch, etc.) remaining almost constant.

• Between 2010/11 and 2011/12, numbers of women first contacting contraceptive services in London increased from 205,400 to 211,900. The majority are in the 25-34 age group for both years. Overall, user dependent contraception was the most common choice and this is reflected in Hounslow. In the older age groups – i.e. 25 to 24 years - women were more likely to have LARC than the younger age groups.

• Rate of GP prescribed LARC has increased in Hounslow over the past 3 years. In 2009/10, this was 25.7 per 1000 registered female population aged 15-44 years. This was on a par with the London rate (25 per 1000) but lower than England’s average of 46.9 per 1000. Hounslow had the second highest rate (Hillingdon was 27 per 1000) in North West London.

• In the integrated sexual health services 18% of women who were first contacts for contraceptive reasons received LARC in 2011/12, this was down from 31% in 2010/11.
• In 2010/11, 20-24 year olds were the main users of EHC in England at NHS community contraceptive clinics. Contacts for EHC in the under 16s has been declining since 1997/8. There is a lack of detailed local data available for analysis on demographics of Hounslow residents accessing EHC in pharmacies and numbers of repeat users.

Recommendations

• Continue to push uptake of LARC but target LARC more at the younger age groups particularly those at risk of unintended pregnancies (e.g. children in care, low socio-economic groups and girls in high prevalence wards, e.g. Turnham Green, Bedfont and Isleworth. This will need to be carefully balanced with messages that LARC will not prevent STIs.

• Establish ownership in LA (public health or adult and children’s services) and strategic direction for the C-card scheme including plans to extend the distribution into primary care and more widely in community pharmacy.

• Set up a means to monitor users of EHC in community pharmacy – this can be done through performance data collected as part of the LES. Investigate if previous paper copies on EHC usage can be located and imputed electronically – this would help provide a picture of usage in the past – but this move is subject to information governance and data sharing agreements.

• Set up a means to monitor differences in LARC uptake between GP practices – this could be done under the two LESs for contraceptives.

• Ensure that those providing LARC and EHC are suitability trained – this includes GP practice staff, abortion services and pharmacists.

SEXUAL DYSFUNCTION

• It is estimated that 34.8% of UK men and 53.8% of UK women suffer from at least one sexual problem in the previous year.
In 2011, 433 Hounslow resident men were diagnosed in primary care as having erectile dysfunction. Of these, 59 were assessed for cardiac risk as recommended by the British Society for Sexual Medicine (BSSM) guidelines. In 2011, 1692 patients were prescribed treatment and 96 patients were recorded in primary care as having Testosterone Deficiency Syndrome.

Recommendation

Despite small numbers, it would be beneficial to raise awareness of the possibility of sexual dysfunction in older men amongst GPs, especially those with cardiac heart disease, urinary track symptoms and those treated for colorectal cancer.

RECOMMENDATIONS FOR MEASURES OF SUCCESS

This section proposes some targets or indicators of success that could be included in commissioning contracts etc.

Reducing prevalence of STIs

- Increase participation and use of condoms on the C-Card Scheme
- Continue STI testing in the community and consider the implications of primary care testing
- Monitor rates of acute STIs, mindful that initial increases may reflect increase in service use rather than prevalence

Getting early diagnosis of HIV

- Fewer late HIV diagnoses by increasing uptake of HIV screening including provision in abortion services and primary care
  - Original target was to reduce level of late diagnosis to 15% of 2004/5 baseline by 2011/12, this can be applied again to Hounslow’s rates
  - Reduce the 2009 Hounslow reported proportion of 51% with late diagnosis to 45% by 2015.
• Reduce level of very late diagnosis by 15% from the 2010 level of 29% to 25% by 2015/6
• No undiagnosed antenatal patients with HIV
  o At least 98% screening levels for Hep B, HIV and syphilis

**Measures for young people’s sexual health services**

• Reduce numbers of teenage conceptions from 2009 rate of 37.5 per 1000 15-17 year olds to 34 per 1000 in 2015.

• Achieve the 2400 per 100,000 Chlamydia diagnoses rate
  o Screen 25% of young people aged 15 to 24 years for Chlamydia from April 2011 to April 2012, with 2.4% positivity

• Increase provision of SRE in schools
• Review and develop a teenage pregnancy care pathway with aftercare

**Contraceptive choice and use measures**

• Increased access and choice to LARC in primary care
  o 10% more females of reproductive age/year prescribed LARC

• Easy access to emergency contraception
  o 90% access within 72 hours of request

**Abortion measures**

• Aim to have the majority of abortions earlier than 10 weeks gestation
  o 70% abortions earlier than 10 weeks gestation, increase each year

• Reduce % of repeat abortions by all women leave services with one or more of the most effective choices of contraception
  o Decrease in % of repeat abortions in under 25 and under 19 year on year from 2011/12 levels

**Improve service provision**

• 48 hour access to GUM
- 100% (no less than 98%) offered appointment within 48 hours
- 95% seen within 48 hours

- Prevention of Hep B and HPV in MSM
  - At least 70% to receive Hep B vaccine

- Monitor levels of partner notification, testing and treatment in sexual health services

- Increase numbers of STIF trained and LARC accredited GPs and annually audit
WHY A SEXUAL HEALTH NEEDS ASSESSMENT?

- Sexual health is a key component of good public health. In the eleven years since the publication of the UK’s first sexual health strategy, much has been done to modernise and improve access and quality of sexual health services. Teenage pregnancy rates have dropped considerably with Quarter 1 rates of 2011 being the lowest on record for London since 1998. Uptake of Chlamydia screening has increased resulting in higher positivity rates which in turn lowers the prevalence of undiagnosed Chlamydia infection in the population. However, sexually transmitted infections including late diagnosis of HIV are high (HPA, 2012) and sexual violence and assault remain a hidden though widespread problem (MBARC, 2012).

- The year 2012 is a time of change. As outlined in the UK coalition government’s white papers on health, the commissioning of universal open-access sexual health services will be handed over to local authorities from primary care trusts on the 1st April 2013. Commissioning of termination of pregnancies (now called abortion services) from any qualified provider will be done by clinical commissioning groups as well HIV clinical care, male and female sterilisation and psycho-sexual counselling. Specialist HIV commissioning, sexual assault and primary care contracting will be the remit of the NHS Commissioning Board. A National Sexual Health Policy was due at the end of 2012 with an anticipation that it will set out the support and resources available to local authorities, clinical commissioning groups (CCGs) and NHS Commissioning Boards needed to help them to commission high quality and seamless care pathways across all elements of sexual health.

- Sexual health is a priority for London. London has the highest prevalence of sexual ill health in the UK and this has a disproportionate impact on health inequalities, public health and financial burden to London’s health commissioners. It is estimated that approximately 3 million Londoners each year are affected by sexual ill-health (HPA, 2011). London also has a complex system of sexual health services which are predominantly demand led. Overall, whilst rates of teenage conceptions are falling and London was the 2nd best performing Strategic Health Authority (SHA) for Chlamydia
Screening, STIs are increasing with London having a disproportionate number of young people who are greater risk of STIs and unwanted pregnancies (HPA, 2011). London also has the highest abortion rate in England and Wales (ONS, 2012) and a higher prevalence of HIV than England - in 2010, this was 5.4 per 1,000 compared to 1.9 per 1,000 for England (HPA, 2011).

- The purpose of this health needs assessment is to support the London Borough of Hounslow (LBH), Hounslow’s Clinical Commissioning Group (CCG) and NHS Commissioning Board in strategic decision making and effective use of resources to improve sexual health in Hounslow. It builds upon the Joint Strategic Needs Assessment (JSNA) which is refreshed annually and informs the Sexual Health and Reproductive Strategy for Hounslow 2012-2015.

**WHAT IS A HEALTH NEEDS ASSESSMENT?**

- Health Needs Assessment (HNA) is a systematic method of identifying the unmet health and health-care needs of a population and recommending changes to meet those unmet needs. It is used to improve health by influencing service planning and commissioning, priority setting and by underpinning the development of strategies and policy. HNA is not the same as health status measurement as it involves an assessment of the effectiveness of relevant interventions to supplement the identification of health problems.

- The main purpose of this HNA is to help NHS Hounslow and London Borough of Hounslow to develop commissioning plans for improving and maintaining good sexual health in the borough. It outlines the epidemiology of different sexual health related conditions (e.g. sexually transmitted infections, teenage pregnancy) across the borough of Hounslow, the current provision of services, identifies the gaps in provision and proposes evidence-based steps to take.

**NATIONAL DRIVERS AND POLICIES**

- Since 2000, there have been a large number of national and government papers outlining approaches to improving and maintaining good sexual
health in the population which are applicable to Hounslow. Examples include:


- Department of Health (2007). Improving access to sexual health services for young people in further education settings, You’re welcome quality criteria - making health services young people friendly.


- Department of Health (2009). Getting maternity services right for pregnant teenagers and young fathers (revised November 2009).


- Department of Health (2009). Young people’s sexual health: the National Chlamydia Screening Programme.


- Department of Health (2010) Achieving Equity and Excellence for Children, Department of Health
- NICE (2007) PH3 One to one interventions to reduce the transmission of sexually transmitted infections (STIs) including HIV and to reduce the rate of under 18 conceptions, especially among vulnerable and at-risk groups.
- NICE (2011) PH34 Increasing the uptake of HIV testing among men who have sex with men.

**OUTLINE OF DOCUMENT**

- It is envisioned that this health needs assessment will be utilised in conjunction with national and London-wide documentation to develop a local strategy for Hounslow. This needs assessment will be ‘live’, meaning that it will be annually refreshed to keep it up-to-date and it will feed into the annual update of the Joint Strategic Needs Assessment (JSNA).

The document is divided into the following components:

- **Background and Context** – this outlines the definitions of various sexual health conditions, causes and risk factors.

- **Vulnerable (‘At Risk’) Groups** – This lists the vulnerable or ‘at risk’ groups in need of services locally.
• **Sexual Health Commissioning** – this chapter summarizes the current commissioning arrangements, spend and London initiatives such as the sexual health tariff.

• **Sexual Health Services in Hounslow** – this chapter describes the provision of general sexual health services.

• **Indicators of Sexual Health** – the ensuing chapters present an epidemiological picture of different components of sexual health including examination of trends of sexually transmitted infections, terminations of pregnancy, contraceptive practices, teenage pregnancy, Chlamydia screening, sexual violence and assault. They also outline gaps in provision and it combines the evidence base with stakeholders views on how to improve the cost-effectiveness and effectiveness of local services and interventions and how to address unmet need. The aim is to help identify trends, needs and to target areas for action.

• **Recommendations & Measures of Success**
A health needs assessment (HNA) is a systematic method of identifying unmet health and health care needs of a population and making changes to meet those unmet needs. Health needs assessments are used to improve health, to plan and commission services, develop policy and to help set priorities. HNA is not the same as health status measurement as it involves an assessment of the effectiveness of relevant interventions to supplement the identification of health problems.

The elements of health care needs assessment

- Incidence and/or prevalence
- Effectiveness and cost-effectiveness
- Existing services

Cost-effectiveness allows us to consider the relative priority of different needs

- HNA requires a clear definition of need. Need implies the capacity to benefit from an intervention and can be divided into three types of need:
  - Felt need: What people consider/say they need
- **Expressed need:** Needs expressed by action e.g. visiting doctor
- **Normative need:** What health professionals define as need

- HNA involves the active identification of need rather than a passive response to demand. Health needs can be differentiated into needs, demands and supply and are not restricted to health care needs. Health needs include the wider social and environmental determinants of health, for example, deprivation, housing, diet and education.

- This HNA takes an epidemiological approach and is based on the Birmingham Model of Health Needs Assessments. It also follows Department of Health’s HNA Template. The purpose is to inform pragmatic and effective commissioning decisions using statistical data, critical review of the evidence, stakeholders’ expertise and public views and experiences.

- In terms of evidence gathering, a literature search of academic and grey literature was conducted for controlled studies (type II evidence and above) and systematic reviews on what works and doesn’t work in preventing and reducing sexual ill-health. Articles found were appraised for their relevance and critically reviewed. Findings were then thematically categorised. Since the goal of this document is to be easy to read, the details of this systematic review are omitted including references. However, these are available on request.

- Stakeholder views were ascertained in a workshop held in January 2012. User perspectives were obtained via opportunistic but sporadic informal interviews with members of the public and using patient satisfaction surveys of sexual health services. It is planned to have a public engagement event in early 2013 to better inform this SHNA on the public views of sexual health and services in Hounslow.

- The evidence based and stakeholders’ and users’ views were combined to inform the recommendations of how to approach the gaps in provision of sexual health services and advising need.
POINTS TO NOTE

• This document is a ‘live’ document. It will be updated regularly to reflect the latest evidence and data.

• It will not provide a comprehensive population profile as this is covered in the annual publication of Hounslow’s Joint Strategic Needs Assessment (JSNA) and in the Health Profiles published online by the APHO.

• To provide some context for Hounslow, the SHNA will include information for London, England and comparisons with the other 7 boroughs of North West London and where necessary, Richmond.

• The needs assessment uses data available at time of writing – i.e. September 2012 and updated December 2012 (e.g. SOPHID, 2011). At that time, data like GUMCAD2 was not available for analysis despite being in operation since 2011.

• Recommendations will belong to the Sexual Health Board.
WHAT IS SEXUAL HEALTH?

• Sexual health has been defined by the World Health Organisation (WHO) as:

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

• Ensuring good sexual health of a population incorporates:

  o Preventing and reducing the transmission of sexually transmitted infections (STIs) and HIV
  o Reducing the prevalence of undiagnosed HIV and STIs
  o Reducing unintended pregnancy rates
  o Improving health and social care for people living with HIV
  o Reducing the stigma associated with HIV and STIs
  o Preventing and reducing the prevalence of sexual violence, intimate partner abuse and assault
  o Promoting self-esteem and worth in relationships
  o Reducing ‘high risk’ sexual behaviours – i.e. unsafe sex which can be defined as sexual intercourse (anal, vaginal or oral) without the use of a condom and where one or both persons have more than one current or recent sexual partner or one partner is known to have an STI.

• Sexually transmitted infections (STIs) are a huge component of sexual ill-health. They are classified as behavioural diseases in the official international disease classification system. This means that they are contracted through
certain sexual behaviours and can be prevented by changes to these risk behaviours. Sexually transmitted infections can be spread through heterosexual sex, sex between men, orogenital sex and manual ('dry') sex. There are a large number of infectious organisms that are transmitted through sexual activity and can cause a large number of health problems.

- Sexually transmitted infections include the viral infections which can cause long-term problems e.g. HIV and Hepatitis strains B and C, Herpes Simplex and Human Papilloma virus (HPV), bacterial infections (such as syphilis, Chlamydia and gonorrhoea) and parasites.

- Reported sexually transmitted infections have increased since 2000. Some of this increase may be due to greater availability and awareness of services leading to increased testing and increased sensitivity of tests. It may also be an indicator of increased sexual risk-taking. The prevalence and incidences of STIs are commonly used as biological markers of the patterns of risk-taking sexual behaviours in a population. If there is a change in risk behaviours then the incidence of STIs will similarly be affected.

**CONSEQUENCES OF POOR SEXUAL HEALTH**

- Poor sexual health can lead to serious complications or consequences. Many sexual infections have long-term impacts on health, for example:
  
  - Pelvic inflammatory disease (which can cause ectopic pregnancies and infertility)
  - HIV
  - Hepatitis, chronic liver disease and liver cancer
  - HPV leading to cervical and other genital cancers
  - Recurrent genital herpes
  - Bacterial vaginosis and premature delivery
  - Psychological consequences of sexual coercion and abuse
  - Poor educational, social and economic opportunities for teenage parents
FINANCIAL CONSEQUENCES

- The financial impact of poor sexual health is enormous. The average lifetime treatment costs for an HIV positive individual is between £135,000 and £181,000. Eleven years ago, the monetary value of preventing a single onward transmission was estimated to be between £500,000 and £1 million in terms of individuals’ health benefits and treatments costs (Department of Health, 2001).

- The prevention of unplanned pregnancy by NHS conception services saves the NHS over £2.5 billion a year. In the late 1990s, it was estimated that for every £1 spent on contraceptive services, £11 was saved in associated unintended pregnancy costs.

RISK FACTORS

- Poor sexual health is linked to sexual risk-taking – i.e. unprotected sex. These in turn can be caused by:
  - Low self-esteem
  - Lack of skills (e.g. in using condoms)
  - Lack of negotiation skills (e.g. being able to say no to unsafe sex)
  - Lack of knowledge about the risks of different sexual behaviours
  - Availability of resources e.g. condoms, sexual health services
  - Frequent change of sexual partner
  - Multiple or overlapping partners
  - Peer pressure and the prevailing sexual culture of the social network that the individual is a member of
  - Cultural attitudes towards sexual practices, lifestyles and uses of services
  - Early onset of sexual activity
  - Mental health problem, a conduct disorder and/or involvement in crime
  - Alcohol and substance misuse
Perceived risks

- Sexual health varies by gender, age, ethnicity, socio-economic group and is influenced by sexual culture and lifestyle factors.

**Gender**

- Women are more vulnerable than men in suffering sexual ill-health for biological, cultural and social reasons. Biologically, heterosexual transmission of HIV infection is more efficient from men to women than from women to men. Women are also more susceptible to certain sexually transmitted infections than men and suffer the burden of STI-associated complications. STIs are asymptomatic in women and if left untreated can have devastating consequences including pelvic inflammatory disease, ectopic pregnancy or infertility. There is some evidence to suggest that while women are better users of health services than men, when it comes to sexual health, they are more likely to self-treat, thus delaying diagnosis.

- Women continue to be at a weaker social and economic position in many societies and cultures, including many communities in the UK. In the developing world and in many cultural groups in the developed world, women’s low socio-economic status and lack of power relative to men, makes it difficult for them to take preventative measures. Power imbalance and gender-role expectations within sexual relationships are important and can influence women’s risk taking behaviour. They may rely on financial help from their sexual partners, be emotionally dependent on their partners and risk losing him or verbal or physical violence if she insists on taking contraceptive measures or refusing sexual activity. Young women in particular often do not feel empowered to assert themselves in a relationship or to abstain from sexual practices.

- The social consequences of STIs can be devastating for women. In many cultures, women known to have an STI, or who are unable to conceive, risk rejection by their male partner, possible social exclusion and loss of income. Additionally, women experience greater demands in coping with the sexually transmitted infections and HIV. There is evidence from HIV studies done in Sub-Saharan and South Africa and in East Asia that shows that women are usually the main caregivers and are responsible for the care of family
members with HIV, however, there may be no one to nurse them when they are ill. This is something to consider in relation to Hounslow where there are growing African communities.

- Whilst women suffer the burden of sexual ill-health, men have a number of sexual problems that affect their mental and physical health e.g. psycho-sexual concerns such as erectile dysfunction, priapism and ejaculation dysfunction. Having diabetes, kidney disease or cardiovascular disease can lead to an erectile dysfunction and given the high rates of diabetes in the Hounslow population, it is likely that this is having an impact on male sexual health.

**Age**

- Highest incidences of STIs occur in the 18-25 year old age group. This is also the age-group most likely to engage in risky sexual behaviours including sexual experimentation, having more than two sexual partners a year, concurrent or overlapping partners and casual sex with alcohol or drug use.

- Teenagers are vulnerable to risk-taking sexual behaviours, intimate partner abuse including dating violence and poor sexual health. A young person’s knowledge about sex and relationships is a key factor in their sexual health as is their access to advice and support, aspirations and education attainment, peer influences and levels of emotional well-being.

- Timing and conditions of sexual initiation are associated with subsequent sexual health status. Early age at first intercourse has been associated with early menarche, early school leaving age, family disruption and disadvantage and poor educational attainment. The National Sex Survey (2001) found that the proportion of women reporting first intercourse before 16 years has not increased since the 1990s. Only a minority of teenagers have unprotected first intercourse with early motherhood more strongly associated with educational level than family background.¹

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• The risk of becoming a teenage mother in the UK is nearly ten times higher for girls in the lowest social class than those in the highest social class.\textsuperscript{2} Under-19 conceptions leading to abortion are inversely associated with deprivation with more affluent girls being more likely to have an abortion, although recent figures suggest that this may be changing. Young women who are able to make their own decision around abortion have been found to be more likely to establish an effective contraceptive regimen following an abortion than those who may have been reluctant to end their pregnancies or do not have any plans for their futures.\textsuperscript{3}

• Children living in care, care-leavers and youth offenders are particularly vulnerable groups for unwanted pregnancies and sexual risk-taking.

**Deprivation**

• There is a strong link between social deprivation and STIs, abortion and teenage conceptions, with poor sexual health being disproportionately prevalent in deprived inner city populations.

• Transmission of HIV in western societies is also endemic within socially disadvantaged groups with socio-economically disadvantaged groups persistently having the highest morbidity in relation to sexually transmitted infections.

**Sexual Culture and Networks**

• Most discussions on sexual risk-taking have focused on the determination of an individual’s perception of risk as a measure of ‘high risk’ behaviours. Such explanations draw on the Health Beliefs Model and from Social Psychology, the Theory of Reasoned Action and the Theory of Planned Behaviour. These models argue that individuals’ perceptions of susceptibility to a health threat


influence their sexual behaviours. For example, people’s perceptions of STIs will affect whether or nor they seek medical help. However, these models overlook the fact that individuals are not necessarily rational in terms of their response to risk and more importantly, they ignore the constraining influence of social factors.

- Sexual culture and social networks have been identified in sex research as influencing risk-taking. For example, teenage sexual cultures are often one of sexual experimentation, alcohol use and socialisation with people who share similar sexual values. If the teenagers have had inadequate sex education at school and a lack of information from parents, they can often be unprepared for negotiating relationships and protecting themselves from unwanted pregnancies and STIs. In terms of social networks, people who meet through friends or acquaintances are more likely to have a short pre-sexual period, forgo contraception and have a greater frequency of sexual activity than those who meet online or as strangers.

**Lifestyle Factors**

- Sexual health is a consequence of sexual behaviours which in turn are influenced by lifestyles factors such as alcohol consumption, drug use and smoking.

- Alcohol consumption has long been established with unwanted pregnancies, sexual assault and sexually transmitted infections. Young people who drink alcohol are more likely to participate in high-risk sexual activity than people who abstained from drinking. A study on alcohol and teenage pregnancy and STIs in the UK found an association between alcohol-attributable hospital admissions in both males and females with teenage pregnancy and STIs, even when controlling for deprivation.  

- People aged 16-24 years are among the highest consumers of alcohol in the UK and have the highest rates of sexually transmitted infections. In Hounslow, 9% of pupils reported that they had been drunk in the previous 4

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weeks. This compares to England’s 15% and London’s 9.6% (TellUsSurvey, 2009). The alcohol specific hospital admission rate for the under 18 year olds in Hounslow for 2007-9 was 48.4 per 100,000 population aged under 18. This is considerably lower than England’s 61.8% but higher than London’s average of 40.

- While it is common knowledge that injecting drugs aids the transmission of HIV, general drug use can help to increase the risk of other sexually transmitted infections. In the early stages of addiction, ‘crack’ (the form of cocaine that can be smoked) can stimulate sexual drive. Other drugs such as ecstasy and cannabis also enhance sexual desire and feelings. Users of non-injected heroin and injected drugs are more likely to report concurrent sex partners, commercial sex work and unprotected sex.

**SEXUAL HEALTH IN ENGLAND**

- In 2010, the Health Survey England included questions on sexual health for the first time. Previous to this, the only other sex surveys were the decennial National Attitudes of Sexual Attitudes and Lifestyles (NATSAL) conducted in 1990-91, 1999-2001 and 2010-2012 (due to be published in 2013) and the annual ONS Omnibus Survey since 1990. The sexual health component for Health Survey England assessed sexual behaviour (reported number of same and opposite sex partners and age at first heterosexual intercourse), contraceptive use (access to and types of contraception used) and previous history of testing and diagnosis for STIs.

- Nationally, 92% of men and 94% of women aged 16-69 reported that they had ever had sexual intercourse with someone of the opposite sex. The youngest age-group (16-24 years) reported a lower proportion – 68% of men and 74% of women. 80% of men and 79% of women reported having had sexual intercourse with a member of the opposite sex in the past year. Males had a higher average number of sexual partners than women – 9.3 female sexual partners compared to 4.7 male sexual partners.

- Overall, 20% of men and 14% of women reported having their first sexual intercourse before the age of 16 years. Using life table analysis, the median for age at first sex with someone of the opposite sex was 17 for both men and women. There was a small decline from 18 among men and women aged 55-69 to 16 years for women aged 16-24 and 17 for men aged 16-24 years.
• 1.6% of men and 1.8% of women aged 16-69 years reported that they had sex with someone of the same sex in the last 5 years.

• In terms of contraception, 83% of women aged 16-54 years reported using at least one method of contraception. Contraceptive use generally declined across the age groups with the highest proportion being amongst those aged 16-24 years (87%). Those aged 35 to 44 years also reported high contraceptive use (86%) but those aged 25-34 years reported the lowest contraceptive use (78%). This is the age group most likely to be pregnant or seeking to become pregnant. The most common method of contraception was the male condom followed by the contraceptive pill.

• According to the NATSAL, some risky sexual behaviours such as having multiple sexual partners and unprotected sex are more common in London compared to other regions of UK.
VULNERABLE (‘AT RISK’) GROUPS

• The highest burden of sexual ill-health is borne by women, men who have sex with men (MSM), teenagers, young adults and black and minority ethnic (BME) groups in the UK. People with learning or physical disabilities and with mental or behavioural problems also have a disproportionate burden of sexual ill-health.

MEN WHO HAVE SEX WITH MEN

• Men who have sex with men (MSM) refer to men who have same sex partners regardless of the sexuality they identify with. MSM carry an increased burden of sexual ill health, particularly infections such as syphilis, gonorrhoea and the blood borne viruses Hepatitis B and HIV. In recent years, there has also been an increase of lymphogranuloma venereum (LGV), hepatitis C and shigella reported amongst MSM in London.

• It is estimated that MSM make up ~5.5% of Hounslow’s population (West London Gay Men’s Project, 2010). MSM live throughout the borough.

BLACK ETHNIC GROUPS

• British ethnic minority (BME) communities are adversely affected by HIV/AIDS, sexually transmitted infections and their sequelae. It has been argued that the observed inequalities are due to economic disadvantage, social exclusion and culturally prescribed attitudes and behaviours. Limited access to health services, particularly to preventive and sexual health services have also been a contributing factor.

• Nationally young people from BME communities are disproportionately represented in the groups of young people who are at risk of teenage pregnancy and sexually transmitted infections.
• Hounslow’s population is estimated to be 256,000 (JSNA, 2012). About 64% of the population are adults aged between 20 and 64 years. In terms of ethnicity, 54% of Hounslow’s population are white with 33% identified as being Asian (JSNA, 2012).

• In Hounslow, the majority of those presenting to sexual health services are white, reflecting the population as a whole. Across London the Black ethnic groups – especially Black African and Black Caribbean – suffer disproportionate burden of undiagnosed STIs and HIV. Studies have also shown that sexually transmitted infections are also stigmatized within these sub-populations. Despite the smaller numbers relative to the white population in Hounslow, it is clear that Black ethnic groups are a ‘high risk’ group and efforts needed to increase uptake of sexual health services and testing and to prevent further transmission of STIs in the population group.

• In relation to the Asian community in Hounslow, little is known about the likelihood of the prevalence of undiagnosed STIs in the population. There is anecdotal evidence from youth services and sexual health services of an increase in anal sex amongst sub-Asian female populations as this is perceived as a way to protect their virginity but to have sexual activity. This increase is accompanied with high levels of low self-esteem, lack of negotiation skills in relationships and physical health issues.

PEOPLE WITH LEARNING DISABILITIES AND/OR PHYSICAL DISABILITIES

• People with learning disabilities and/or physical disabilities are often overlooked in terms of their sexual health. People with learning disabilities may not receive adequate sex and relationship education and can often be victims or perpetrators of sexual abuse or violence. They can have limited and incomplete understanding of sexual health issues and there is some evidence that whilst carers acknowledge the right to sexual expression, they feel under pressure to supervise and limit the sexual expression of people with learning difficulties.
• Little is known about inequalities in the sexual health status of people with learning disabilities in the UK. There is, however, evidence to suggest that they may face particular barriers in accessing sexual health services and the informal channels through which young people learn about sex and sexuality.

• In Hounslow, there were 654 adults (aged over 18 years) registered on SystmOne (a system used by 50 of the 55 general practices in Hounslow) in 2012. It is likely that this is an underestimate as due to a number of reasons every individual with a learning disability is not necessarily recorded on the register. 55% of those registered are male and whilst studies elsewhere in the UK indicate a higher prevalence of learning disability in South Asian groups, this is not reflected in Hounslow (JSNA, 2012).

• A learning disabilities health needs assessment was carried out in 2012 and whilst it did not focus on the sexual health needs of the population, it acknowledged that women with learning disabilities in Hounslow were less likely to have had a cervical smear compared to the general female population (28% compared to 65%). It observed that the lower coverage of cervical smear screening in the learning disability population may be because it is often assumed that women with a learning disability have never had sexual intercourse and therefore do not need screening for cervical cancer. An additional reason given was that as cervical screening is an invasive procedure GPs may have anxieties about taking smears from women with learning disabilities.

• The community learning disabilities services provide sexual education to their clients and have held some education sessions at Speak Out in Hounslow.

• Hounslow’s integrated sexual health services at WMUH provides for people with learning disabilities. There is a specific nurse-led clinic with advice on contraception and sexual health. The service produces literature with pictorial demonstrations of what is involved in visiting a sexual health clinic and sends them to local groups and schools and also uses IN TOUCH DVD and website from the Leonard Cheshire Charity.
PEOPLE WITH MENTAL OR EMOTIONAL HEALTH NEEDS

- There is evidence that people with mental health problems are at a high risk of engaging in risky sexual health behaviours and at risk of exposure to STIs. They are also at high risk of being victims or perpetrators of sexual abuse or violence. The West London Rape Crisis Centre that provides sexual violence services for Hounslow residents report that a small proportion of their clients have mental health disorders or problems. They also reported for 2011/12 that over 90% of their clients suffered depression.

- An audit of the KISS service in 2011 found that across the service 18% of young people disclosed mental health issues, of this 18%, 87% of them attended the Feltham KISS Service.

- A cross-sectional study of UK mental health services staff in 2009 revealed that most did not promote sexual health with service users. They were also unaware of the high prevalence of HIV/AIDS in people with schizophrenia.

- People with mental or emotional health needs are not routinely recorded in relation to sexual health in Hounslow but they are a vulnerable group that can suffer a disproportionate burden of sexual ill health. This needs consideration when commissioning services.

SEX WORKERS

- Hounslow’s integrated sexual health service runs a sexual health clinic called the Sunflower Service for sex-workers. This is based in Isleworth and has been running for about the last 5 years.

• In 2011/12, 77 sex workers were registered for the service – 64 were female, 13 male. The age ranged from 21 to 51+ years with the majority falling in the 26 to 40 age groups. 24% (19) of the sex workers work in the porn film industry and another 15% (12) were escorts. Other forms of work involved flats, street and saunas.

• There is emerging evidence from police and community support groups of organized street work in Cranford area of the Borough. These women are not residents of Hounslow.

RECOMMENDATIONS

• Information is needed on the sexual health needs of people with learning disabilities and people with mental health problems. These pieces of work should be done as soon as possible and then can feed into a refresh of the sexual health needs assessment.

• Audit and devise a system whereby use of sexual health services and burden of sexual ill-health in people with learning disabilities, physical disabilities and in people with mental or emotional health needs can be collated and monitored in order to identify unmet need and improve provision of service.
SEXYL HEALTH COMMISSIONING

CHANGES TO SEXUAL HEALTH COMMISSIONING

• As of 2012, the bulk of sexual health commissioning is undertaken by the PCT, NHS Hounslow. This PCT is part of the NHS North West London Cluster and will cease to exist on 31st March 2013. The coalition government has proposed that local authorities take responsibility for the commissioning of sexual health services as part of their new role in public health commissioning which commences on 1st April 2013.

• There are a number of local and national commissioning groups. In Hounslow, there is a Sexual Health Board, which was ratified in early 2012 and has been meeting bimonthly since October 2011. This board is accountable to the Health and Well-Being Board and aims to be responsible for the development and implementation of sexual health strategies across the partnership arrangements in Hounslow and to ensure effective partnership responses are developed and delivered in respect of all sexual health services for Hounslow’s residents, including all young people in custody at HMYOI Feltham. The board meets on a quarterly basis.

• 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.

• Across NWL there are about 100 community and acute contracts being managed with only limited lead contracting arrangements for certain contracts. Brent, Ealing, Inner NWL boroughs have a WTE sexual health commissioner. Hounslow has 0.5 WTE sexual health commissioner.
• From April 1\textsuperscript{st} 2013, sexual health commissioning will be divided between a number of public bodies. Local authorities will have the responsibilities for commissioning the open-access sexual health service and provision of community contraceptive services as well as the sexual health element of psycho-sexual counselling. NHS Commissioning Board will oversee the specialised commissioning of HIV, the commissioning of sexual assault centres, primary care contracting (including NES and DES) and clinical commissioning groups will commission abortion services, HIV clinical care functions, emotional/mental wellbeing and medical care components of psycho-sexual counselling, sterilizations and vasectomies. Commissioning Support Units are expected to monitor the contracts for abortion services and possibly provide support to local authorities in the first year of commissioning GUM services.

• There are a number of risks with sexual health commissioning of open access services moving to local authority. In particular, with greater financial constraints being placed on budgets for open access services, greater management will be needed for contract management and demand management initiatives.

• Stakeholders in sexual health services in Hounslow expressed the importance of trained public health professionals leading on the priorities of sexual health when sexual health commissioning moves as part of the public health grant to local authorities on April 1\textsuperscript{st} 2013. As public health surveys the burden of sexual ill-health and is involved in prevention through to the quality of services provided to Hounslow’s population, they are the most ideally placed to drive the future of sexual health commissioning. In addition, stakeholders felt that sexual health services commissioned as a local authority collective rather than on separate borough levels would be more beneficial to both commissioner and provider. As sexual health services is demand led and flocculates annually, collective purchasing for example, can help to drive down prices and prevent overspend.

**SEXUAL HEALTH TARIFF**

• Both GUM and SRH (sexual and reproductive health) care is required to be provided on an open access basis. This means patients are entitled to choose where they have their care delivered and can ‘walk-in’ to receive it without a referral. At present, GUM care is delivered under a tariff arrangement with cross-charging back to individual patients’ commissioners and SRH services are delivered under a local block contract.
• The aim of the proposed London sexual health tariff is to develop and implement a payment by results for non-GUM activity such as contraceptive service. This will result in an agreed set of currencies and tariffs for integrated sexual health services covering levels 1, 2 and 3 for sexual reproductive health (SRH), levels 1 and 2 for STI services and integrated STI/SRH care and levels 1 to 3 for GUM. When work commenced on the sexual health tariff, PCTs were informed that they could lead to a potential cost savings for £12 million to London. This would largely be due to services being funded on a host commissioner basis rather than according to the patients’ responsible commissioner. Latest modeling information indicates a short-term cost-pressure for Hounslow - £5k - with an overall projected £640k for the 5 boroughs of West London Alliance (Barnet, Brent, Ealing, Harrow and Hounslow). NWL is the only cluster in London for whom the introduction of a tariff presents a financial pressure.

• A tariff already exists for GUM activity (payment by results – PbR) but in Hounslow, contraceptive and reproductive services are covered by a block contract (with an additional tariff for opportunistic testing, known locally as ‘asymptomatic testing’). The proposed sexual health tariff would merge GUM and community contraceptive services into a new basket of tariffs. This will mean that providers would be paid for the work that they carry out and not just on throughput of people or on a block contract. Local authorities will pay for the patient regardless of where they go. In this respect, a tariff offers a transparency of costs and can reduce variation of prices between providers across London. New integrated contracts would be required for all providers under this service.

• In order for the sexual health tariff to take place, all 32 local authorities in London would have to agree to take it forward. In addition, local authorities may not be obliged to continue to commission under the existing PbR tariff for GUM.

• Sexual health tariffs (and GUM tariffs) offer a number of advantages. It links activity to outcomes and can improve access and service standards for patients. It also reduces the risk of cross-boundary changes (which is difficult to work out for finance directors) and reduces the risks of multiple funding and increasing financial restrictions of block contracts which could destabilise sexual health services. Moreover, sexual health services are open access services so Hounslow residents can use any clinic throughout the UK and the sexual health commissioner would be invoiced. So while NHS Hounslow commissions WMUH integrated sexual health service as its main provider, other London hospitals and clinics outside London have been used by Hounslow residents. This activity is difficult to predict and having a tariff
could help to budget for or safeguard against this by reducing the impact of variation in local prices and currencies.

- One disadvantage is that with a tariff, there is the risk of over-performance. With block contracts, providers’ incomes are the same regardless of how much activity they conduct. Payment based on activity could lead to over provision. However, it is possible to have a tariff with a ceiling, which could be reviewed half-yearly. A tariff will also require robust contract monitoring arrangements which would need to be developed by local authorities either individually or collectively.

- As of December 2012, it is uncertain how the proposed tariff will go ahead, although work continues on it.

**Spend**

- Spend on sexual health services varies across London. In 2007/8, Hounslow reported a sexual health spend (including GP contraceptive prescribing) of £13.05 per head of population. This was higher than Brent’s spend of £18.43, Hillingdon’s spend of £10.05, Ealing’s £11.10, Richmond’s £9.10 and Harrow’s £8.77 per head of population. Hounslow’s spend was considerably lower than the tri-borough – Westminster’s spend was £32.50, Hammersmith & Fulham was £26.46 and Kensington & Chelsea was £42.40.

- A 2011 survey by Bayer HealthCare\(^1\) estimated that Hounslow spent £5.34 per head of female aged 15-44 years on contraception in 2009/10. This compares to Hillingdon’s £5.72 and Kensington and Chelsea’s £5.05 and is higher than Brent’s £4.79 but lower than Richmond’s £7.59 (information not published on the other North West London boroughs nor on London as a whole). Hounslow was reported to have increased its spend by 0.26% on the previous year. However, it was lower than the England average spend of £8.12. Bayer’s Contraceptive Atlas concluded that increasing spend on contraception was cost-beneficial as for each £1 spent on contraception resulted in £12.50 savings in averted outcomes. Bringing underspent PCTs (now LA) up to the England average could save the NHS over £107 million in avoided unintended unwanted pregnancies.

- In London, the average cost for fitting IUD/IUS was £79.63 with an additional £21.11 for follow up check and £21 for removal. Implants cost on average £25.52 and £30.62 for removal. In Hounslow, under the two LESs, practices
received £105 per insertion of IUCD and £30 per fitting of implants and £50 per removal.

• NICE (2005) looked at the impact of increasing LARC uptake and found savings in annual revenue of £12.7 million in women switching from oral contraceptives to LARC and an additional £115 million from avoiding unplanned pregnancies resulting in a net saving of £102.3 million. However, uptake of LARC is slower than predicted and is likely to take longer than the initial phased prediction of 5 years. As of 2010, the increase in LARC uptake resulted in an increase of 27% in costs but only reduced costs of oral contraceptives by 1%.

• In 2010/11, Hounslow spent at total of £7,080,162 on sexual health services (this includes HIV specialist treatment and care costs of £5,366,194). In 2011/12 this was £6,969,941 (excluding costs of the 3 GP LES and the 2 Pharmacy LES for EHC and Chlamydia).

• In 2010/11 Hounslow spent £98,772 on sexual health promotion (including condom distribution, prevention targeted at those most at risk). This was considerably lower than other boroughs, e.g. Ealing spent £302,838. An additional £820,795 was spent on contraceptive services – higher than any other borough in NWL – and £486,082 on termination of pregnancy services. This was the 3rd highest spend after Brent (£943,215) and Ealing (£697,000).

• Sexual health activity is increasing annually by approximately 3-5%. This is expected to bring an additional cost pressure of £400k to £700k in total across NWL in 2013/14.

LONDON-WIDE INITIATIVES TO CONSIDER FOR HOUNSLOW

• Healthcare for London: A Framework for Action (2007) and London Sexual Health Strategic Framework (2009) recommended a number of changes. The following are still relevant to Hounslow today:
  
  o Redesign services for both prevention and treatment to tackle the rising rates of STIs. This would include:
    ▪ Increasing use of contraception
• Providing services around sexual health pathways (including services for abortion and contraception and especially for young people)

• Improve service access including greater outreach services for at-risk populations

• Increase the availability and accessibility of information on sexual health and sexual health services

• Sexual health providers to develop integrated services across primary, community and secondary care using London Sexual Health tariffs to enable equity of access to integrated Sexual Health Services.

• Sexual health services to involve users in their design and delivery and regularly measure the experiences of service users.

• Adopt the 11 London-wide standardized PGD for contraception and 7 for STIs in provider organisations in Hounslow as they are a key facilitator for changes in contraception and sexual health services. This should be monitored regularly.
SEXUAL HEALTH SERVICES IN HOUNSLOW

OVERVIEW

• Looking at Hounslow’s sexual health services cannot be done in isolation from the wider changes to sexual health commissioning.

• In relation to London, the London Sexual Health Programme (part of the London Public Health programme) has been driving a move towards centralisation of services as much as possible and localise where appropriate. Examples of this include the standardisation of the abortion service specification to be used with any qualified provider by clinical commissioning groups and the proposed introduction of sexual health tariffs.

• There are risks to the future of sexual health commissioning with the fragmentation of sexual health commissioning, the wide variation in spend per head of population for local authorities, local authorities not needing to use sexual health tariffs and the reduction in baselines for abortion services. There are also governance risks to local authorities in commissioning sexual health services as they are clinical interventions. Moreover, sexual health services are open access and demand led with an estimated 10% increase in demand for GUM services per year. To date, this cost pressure of 0.1% (~£10 million) has been managed by PCTs within the total cash envelope of ~£11 billion for health services. This cost pressure will have a much bigger impact on the public health ring-fenced budget, this is estimated to be 35 times more.

• Provision of sexual health services should reflect the delivery of open and equitable access to clinically, cost-effective and evidenced based services. The London Sexual Health Programme recommends taking a life-course approach to see if the provision of services match need. Similar to elsewhere in London, Hounslow’s sexual service users are mostly young people, particularly 18-25 year old age group and MSM.
SERVICE MODEL

- The current service model in Hounslow is based on the three tier/levels of service:
  
  - Level 1 – testing
  - Level 2 – those services that provide treatments and partner notification and also initiate tests
  - Level 3 – those services that provide Levels 1 and 2 but also provide testing, treatment and partner notification for those with more complex STI conditions and Human Immunodeficiency Virus (HIV)

- Since October 2010, Hounslow has had an integrated sexual health and reproductive services. This service is run by West Middlesex University Hospital (WMUH) and provides levels 1 to 3. Some level 1 and 2 services are also provided in primary care. The integrated sexual health service operates a ‘hub and spoke’ model with a main centre at WMUH and other clinics based throughout the borough including at Heart of Hounslow and Feltham.

INTEGRATED SEXUAL HEALTH SERVICE

- The main provider of GUM and sexual and reproductive health services is the integrated sexual health service at West Middlesex University Hospital (WMUH). This is an open access service and it provides a full range of contraceptive choices, including condom distribution, Long Acting Reversible Contraception, Emergency Hormonal Contraception and aims to reduce the rate of repeat abortions. The service also offers open access to STI and HIV testing in a range of locations, with the main centre for STI and HIV testing located in Isleworth at WMUH. Routine STI testing is also available at Community Sexual Health Clinics in Hounslow, Feltham and Chiswick.

- Where users are non-English speaking, the service has access to phone translation services and staff who speak Bengali, Urdu, Gujarati and Hindi. There is also a member of staff who can use sign language.

- An integrated sexual health service is an evidence based model and considered to be the best way to deliver sexual health services. Hounslow is the first and only borough in North West London to have adopted this model.
of provision. Advantages have been WMUH’s good geographical location with satellite clinics in areas that are easy to access and opening hours that are accommodating the needs of its clients. It also provides a well-accepted and utilized young person’s service, the KISS clinics. Integrated sexual health services offer the advantage of being able to address all sexual health needs in one service with staff dually trained and competent in STI care, contraception and sexual health promotion and timely referral pathways into specialist services for more complex needs.

- GUM attendances have decreased slightly between 2008/9 and 2010/11. In 2008/9, 13,440 attendances were recorded, 13,274 in 2009/10 and 13,394 in 2010/11. First attendances have increased a little from 9,040 in 2007/8 to 9,198 in 2009/10 and 9,346 in 2010/11.

- Since March 2010, opportunistic screening (known as ‘asymptomatic screening’ of STIs and HIV) are also offered.

**48 hour Access**

- Accessing GUM clinics within 48 hours of being offered an appointment is a priority for the NHS Operating Framework. Between 2005 and 2008, the percentage of people offered an appointment and who were seen within 48 hours increased from 69% in 2005 to 98% in 2008 for London (Sex and Our City, 2008). However, this ranged considerably between PCTs. In Hounslow, 84.8% were seen within 48 hours. This was a little lower than Hillingdon’s 87.5% and Ealing’s 86.9% and Richmond’s 86.8%. 98.9% of patients were offered an appointment within 48 hours.

- In 2010, 9340 patients were offered an appointment for within 48 hours and 8306 (88.9%) were seen within 48 hours which was similar to England and London averages.

**GENERAL PRACTICE**

- There are 3 LES for primary care practices – sexual health LES, IUCD and Implants. The Sexual Health LES covers screening/testing for STIs & HIV, symptomatic STI at Level 2, safer sex messages through condom provision, C-Card Scheme and health promotion and young people friendly sexual health services. Under the IUCD LES, it is £105 per insertion per patient. This includes follow-up and management of complications.
• In 2011/12, a total of 30 practices were signed up to the sexual health LES, 28 to IUCD and 26 to Implants LES out of a total of 55 practices. In 2011/12, the total spend had been £30,010 for Sexual Health LES, £75468 for the IUCD LES and £8170 for the Implants LES. This compares to 2010/11 where the total spend had been £24,500 for the Sexual Health LES, £79,000 for the IUCD LES and £1500 for the Implants LES. In 2012/13, 47% (26) GP practices were signed up to the sexual health LES.

• Young people tend not to use GP practices for their sexual health needs. Instead they are increasing users of the KISS clinics, which are specifically targeted at young people and run by the integrated sexual health service.

• Provision of service in accordance to the three LES requires GPs to be accredited and up-to-date with their training in sexual health, including STIF training. However, numbers of STIF trained GPs are small in Hounslow and it is an ongoing issue to ensure that GPs and practice nurses are up-to-date with their sexual health training.

• The majority of STIF trained GPs are based in Chiswick and Feltham where they are needed the most. STIF training is provided by the WMUH integrated sexual health service as part of their contract, although training was suspended for 2012, it will recommence in 2013.

PHARMACY

• In 2010, there were 35 participating pharmacies offering EHC. These pharmacies were spread throughout the borough with 11 in central Hounslow, 6 in Chiswick and 5 in Feltham. The north of the borough was not as well represented with one in Cranford and one of the Hounslow pharmacies on the border with Heston.

• Community pharmacists receive training and updates from the Chlamydia Screening Office (CSO) at WMUH. In 2011/12, a total of £3,012 was paid to pharmacies under the LES for Chlamydia Screening.

• Provision of EHC in pharmacies and interventions to promote adolescent condom use are crucial to prevention of teenage pregnancy especially for socially disadvantaged young people. NICE (2010) also recommends school based health centres to enable the dispensing of contraceptives, which was also found to be cost-effective.

• In 2011/12, a total of 3,280 EHC were prescribed. This equated to £81,130.
WEST LONDON GAY MEN’S PROJECT

- WLGMP was set up in 1997 with funding from Ealing, Hounslow and Hammersmith & Fulham PCTs and works primarily with MSM across West London. They aim to promote sexual health and increase their knowledge of HIV prevention, thereby reducing the levels of HIV and STIs; to reduce the levels of undiagnosed HIV infection and encourage testing and screening and to support men in the behaviour change process.

- This project is currently provided by the local authority but is in the process of becoming a social enterprise. They are commissioned by NHS Hounslow to deliver specialist health trainer outreach work, rapid and opportunistic HIV and STI testing for MSM and provision of condoms and lubricant services.

- In 2011/12, WLGMP reported distributing 63,854 condoms (98% of their annual target) and had 4,885 members on their database- 559 of which were new members for 2011/12 and 17% of all members were Hounslow residents. In 2010/11, 13% of their clients were men living with HIV and they provided 82 rapid HIV tests (i.e. instant results).
MAIN POINTS TO NOTE

London has the highest rates of STIs in the country and rates are increasing, largely due to increasing diagnoses of Chlamydia followed by genital warts. This trend is reflected in Hounslow.

Unlike London, the majority of diagnosed STIs in Hounslow are in the white population.

In outer London (including Hounslow) young people account from the highest proportion of acute STIs.

Hounslow has the second lowest diagnostic rate of acute STIs in North West London. (Harrow is lower).

The highest acute STI diagnostic rates are in the east of the borough – the wards of Turnham Green, Brentford, Syon and part of Chiswick Homefields – with an age-specific STI diagnosis rate of 2,000 or higher per 100,000 persons aged 15-59 years.

Numbers of GUM attendees having STI screens are increasing for Hounslow as are costs of STI screens (asymptomatic/opportunistic testing). Part of the raising costs can be contributed to out-of-borough residents accessing the contraceptive/community services.

NORTH WEST LONDON (NWL) AND ACUTE STIS

- London has the highest rates of STIs in the country. In 2011, new diagnoses in London were 64% higher than any other region in England (HPA, 2012) and 16 of the 20 local authorities with highest rates of STI infection were in London. The overall rate of acute STIs (i.e. Chlamydia, genital warts, genital herpes, gonorrhoea and syphilis) was 1,297 per 100,000 in 2011. This represents an increase from 1,196 in 2010 and 1,176.5 per 100,000 in 2009.
• Between 2010 and 2011, rates increased by 8% for London (94,194 to 101,561) with the largest increase in STIs in MSM. The biggest proportion of diagnosed STIs consisted of Chlamydia diagnoses (36%, N=36,756). Genital warts were the second most common diagnoses at 13%. Gonorrhoea diagnoses was 8.4% but had the biggest increase proportional increase between 2010 and 2011 of 31%. This was reflected in the figures for MSM, indicating that the majority of diagnoses were found in this risk group. Moreover, MSM have a higher re-infection rate of gonorrhoea – 10% compared to 6% for heterosexuals (HPA, 2012).

• Figure 1 ranks London’s boroughs in terms of rates of acute STIs for 2011. Hounslow can be seen as being well below London average but higher than England average. It ranks 23 out of 33 where 1 equals the highest rates. In relation to the NWL boroughs and Richmond, only Harrow and Richmond rank lower. Caution is needed in interpreting these rates as higher rates do not necessarily mean higher prevalence of STIs. Indeed, it can be argued that higher diagnosis rates reflects better access to and use of sexual health services and higher levels of screening. This results in lower prevalence of undiagnosed infection in the population.
Rates of acute STIs were inversely associated with quintiles of deprivation where the highest was in the most deprived quintile (using IMD scores) – a rate of 1,400 per 100,000 compared to 400 in the least deprived quintile. The 15 to 24 year old age group accounts for 12% of the population but 38% of acute STIs. In outer London, young people account for the highest proportion of acute STIs. Across London, the greatest burden of acute STIs in 2010 was in the Black Caribbean group - a rate of 2,667 per 100,000 (White was 1,204 per 100,000). When controlling for other risk factors, a Black Caribbean male had 2.6 times the rate of gonorrhoea compared to white men and Black Caribbean women 5 times the rate of white women. As seen
in Figure 2, this is not reflected in Hounslow, where the greatest burden was reported by the white population in 2010.

Figure 2

Acute STI diagnosis by Ethnic Group and PCT of residence in London for 2010

- In table 1, Hounslow is compared to the other NWL boroughs in terms of its rates of acute STI diagnoses per 100,000. In 2011, Hounslow had the second lowest rate of 861 acute STI diagnoses per 100,000. Harrow had the lowest overall rate for acute STIs and the inner boroughs of NWL reported the highest overall rates (Westminster, Kensington & Chelsea and Hammersmith & Fulham). This is in keeping with the highest reported rates of STIs being found in inner London. As reflected in national figures, the highest rates of...
STIs reported were Chlamydia and genital warts for Hounslow (360.7 per 100,000 for Chlamydia and 130.5 for genital warts in 2011). The Chlamydia diagnoses rates reflect the push to achieve the Chlamydia Screening Programme’s targets (in 2011, this was to screen 25% of the 15-24 population with a positivity rate of 2.4%).

- STI data for 2011 is combined with the previous two years data to extrapolate any trends (geographical information on residence of population is not available prior to 2009). Whilst it is only 3 years data, there is an overall increase for STIs for each borough (see figures 3a -3d). Nationally and regionally, 2010 showed a drop in acute STI diagnoses but this dip could be symptomatic of variation year to year. The inner NWL boroughs have higher rates of STIs reported, especially for syphilis where the rates are considerably higher than for the other boroughs (e.g. Westminster was 39.5 per 100,000, Kensington & Chelsea 27.7 and Hammersmith & Fulham 34.87 compared to Hounslow’s 9.3 per 100,000 in 2011).
Table 1

Rates of acute STI diagnoses per 100,000 population in London by NWL borough 2011

<table>
<thead>
<tr>
<th>Borough</th>
<th>Chlamydia 15-24 years</th>
<th>Chlamydia 25+</th>
<th>Chlamydia Total</th>
<th>Gonorrhea</th>
<th>Herpes</th>
<th>Syphilis</th>
<th>Warts</th>
<th>Acute STIs Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hounslow</td>
<td>2206</td>
<td>136.7</td>
<td>360.7</td>
<td>55.3</td>
<td>60.8</td>
<td>9.3</td>
<td>130.5</td>
<td>862.1</td>
</tr>
<tr>
<td>Brent</td>
<td>2579.5</td>
<td>285.1</td>
<td>512.6</td>
<td>93.2</td>
<td>125.1</td>
<td>16</td>
<td>184.4</td>
<td>1602.4</td>
</tr>
<tr>
<td>Ealing</td>
<td>1655.1</td>
<td>194.5</td>
<td>329.7</td>
<td>62.8</td>
<td>86</td>
<td>7.2</td>
<td>1551.1</td>
<td>1040.8</td>
</tr>
<tr>
<td>Hammersmith &amp; Fulham</td>
<td>2226</td>
<td>433.6</td>
<td>588.7</td>
<td>168.5</td>
<td>145</td>
<td>34.87</td>
<td>283.4</td>
<td>1962.8</td>
</tr>
<tr>
<td>Harrow</td>
<td>1201</td>
<td>97.9</td>
<td>214.7</td>
<td>43.5</td>
<td>48.2</td>
<td>4.8</td>
<td>94.3</td>
<td>612.5</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>1509.1</td>
<td>99.3</td>
<td>284.8</td>
<td>29.3</td>
<td>54.5</td>
<td>1.1</td>
<td>135.7</td>
<td>921</td>
</tr>
<tr>
<td>Kensington &amp; Chelsea</td>
<td>2031.1</td>
<td>295.4</td>
<td>436.6</td>
<td>146.3</td>
<td>115</td>
<td>27.7</td>
<td>174.6</td>
<td>1470.3</td>
</tr>
<tr>
<td>Westminster</td>
<td>1646.9</td>
<td>323.1</td>
<td>458.3</td>
<td>177.4</td>
<td>107.5</td>
<td>39.5</td>
<td>184.9</td>
<td>1641.2</td>
</tr>
<tr>
<td>London</td>
<td>2496.2</td>
<td>228.8</td>
<td>469.7</td>
<td>109.2</td>
<td>91.7</td>
<td>17.5</td>
<td>171.6</td>
<td>1297.9</td>
</tr>
</tbody>
</table>

Source: HPA 2011
Figure 3a

Gonorrhoea rate per 100,000 for NWL 2009-2011

Figure 3b

Syphilis rate per 100,000 for NWL 2009-2011
Figure 3c
Genital Herpes Rate per 100,000 for NWL 2009-2011

Figure 3d
Genital Warts rate per 100,000 for NWL, 2009-2011
Figure 4 illustrates the breakdown of acute cases of STIs in Hounslow residents between 2009 and 2010. Overall there is a fall of 7% compared to 2009. Similar to London, the majority of diagnoses were in the heterosexual population and reported by white ethnic groups (overall 61%), with larger numbers of diagnoses amongst women. This is not surprising, given the demographic profile of Hounslow’s population. The vast majority of diagnoses were in the 20-24 year old age group, again reflecting the London and England trend for this group reporting the highest rates of STIs.

**Figure 4**

*Gender, ethnicity and sexual orientation of acute cases of STIs in Hounslow 2009 and 2010*

![Graph showing the breakdown of acute cases of STIs in Hounslow](source: HPA 2011)

Figure 5 illustrates the rate per 100,000 of diagnosed acute STIs by Middle Layer Super Output Areas (MSOA). The highest reported rates are in the east of the borough – the wards of Turnham Green, Brentford, Syon and part of Chiswick Homefields – with an age-specific STI diagnosis rate of 2,000 or higher per 100,000 persons aged 15-59 years.
Rates of gonorrhoea and syphilis diagnoses for Hounslow have increased since 2009 reflecting the overall increase in London and continue to be above England average. However, the latest available figures for pelvic inflammatory disease admissions (pelvic inflammatory disease is a consequence of STIs and can be linked to infertility) are for 2009 and reveal that Hounslow’s under 30 admission rate is considerably lower than England and London averages – 41.2 compared to 81.4.

As Figure 6 illustrates, Lymphogranuloma Venereum (LGV) has been on the rise, especially in London where 66% of the cases occur. 84% of the cases occur in white MSM and 80% of the cases are also HIV positive whilst 24% have hepatitis C virus. LGV is a STI caused by Chlamydia trachomatis serovars L1, L2 and L3. It is particularly linked with MSM, especially those with dense sexual networks, multiple concurrent partners and those who use sex-on-site or other social venues. Numbers are not known for Hounslow but LGV is an infection to note.
Figure 6

LGV laboratory reports 2003-2011 by region

Source: HPA 2012

GUM ATTENDANCES & STI SCREENS

- In 2010, there were 14,137 GUM attendances where the patient was a resident of Hounslow. 7904 of these, accepted sexual health screens. This is a decrease of GUM attendances compared to 2009 (14678) and an increase in sexual health screens (7812).

- In 2010, a total of 1575 acute STIs were diagnosed in Hounslow resident patients – 941 in males and 634 in females (please note that this reflects GUMCAD data only and not primary care). This gives us a rate of 986.6 per 100,000 residents aged 15-59 years (males: 1124.4; females: 825.6) which is lower than London’s 1546.2 per 100,000 (males: 1878.2; females: 1189.9). 60% of cases were diagnosed at the GUM clinic at WMUH in Hounslow.

- There is an overspend for STI screens for Hounslow for the 2011/12 and again for 2012/13 – in other words activity is exceeding budget allocated. A contributing factor is the payment NHS Hounslow pays for residents from other boroughs that access the contraceptive services. This equates to a
substantial proportion. Discussions with the sexual health commissioner indicate that there is the potential to save money if cross-charging was to occur. The introduction of the sexual health tariff would help Hounslow to breakeven but at time of writing, it is unknown if or when this is happening.

- There is a disjuncture between good public health practice and financial limitations. In principle, STI screens should be offered as widely as possible covering the most common STIs in order to early detect an acute STI and therefore prevent further transmission in the population. Financial pressures may mean that the test used is restricted to HIV and/or Chlamydia.

- Given that there is now 2 years of screen activity, future budget allocation for STI screens could be based on this past activity.

STI SCREENING BY PRIMARY CARE

- In recent years, there has been a push to having asymptomatic testing of STIs in the community. This push includes the STI screens done by community contraceptive or family planning services, which has been in operation since 2010 in Hounslow. However, there is also a move to have STI screens done in primary care. It has created considerable debate in the literature with one side stating it is an effective means to for early diagnosis of HIV whilst the other side argues that level of asymptomatic screening in the community can be higher than anticipated and therefore more costly. A recent study\(^2\) found that 40% of clients attending GUM had been previously seen a GP and had been referred for testing. They concluded that testing in primary care would have avoided the delay in being seen and tested in GUM.

- There is a dearth of evidence on where or not asymptomatic testing in primary care is a cost-effective enterprise despite general consensus that early detection of STIs is beneficial. BASSH have produced guidance for testing in primary care but point out that it is not evidence based but a pragmatic guide.
• It is unknown how many people would be screened to find a case of acute STI (other than Chlamydia) in primary care in Hounslow. Estimates from the USA indicate that in a low-risk population (0.001 per 10,000) using a 95% sensitive test, the number needed to screen to detect one case of gonorrhea would be 1,085 for women (109 in a 10,000 population with a prevalence of 0.01).\(^6\) Universal screening of Chlamydia in a population of high prevalence is found to be cost-effective and beneficial.\(^7\)

• There is evidence that community based testing in young people is effective, particularly as STIs are not perceived as risks. Low et al\(^8\) found that testing of Chlamydia and gonorrhoea combined with health education which was provided outside clinical settings (such as in further education colleges) was feasible and acceptable to young people. However, there is to date no cluster randomized controlled trial evidence to determine effectiveness.

RECOMMENDATIONS

• Continue the integrated sexual health service model and include within contracts provision of sexual health promotion for both primary and secondary prevention (i.e. knowing how to identify if you are at risk of STI and where to go in Hounslow).

• Basic sexual health services to be embedded in core services of general practice. This will need to be done in consultation with the Clinical Commissioning Group (CCG) but would provide greater patient choice, provide greater equity of access and would help with more prompt diagnoses of STIs, thereby reducing likelihood of onward transmission.

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• Difference between relative risk and absolute risk should be considered when focusing efforts on STIs. Relative risk relates to MSM and Black African groups where there is high risk and low numbers and absolute risk that refers to low socio-economic deprivation and young people where the risk is lower but there are higher numbers. Service provision should address both risk models but it can be difficult getting the balance right given limited resources.

• Increase the number of STIF trained GPs and LARC accredited GPs in Hounslow. This will help improve provision of Level 1 and 2 sexual health services in Hounslow.

• Since majority of STIs are reported in young people, sexual health promotion needs to be prioritized for young people. This should entail SRE in schools and partnership work between the 5-19 services at HRCH and the early intervention and targeted services at LBH.

• Look at the rising costs of STI screens and decide on a means of balancing budget allocation with need of patients.
HIV prevalence (both diagnosed and undiagnosed) is estimated to be increasing year-on-year. In 2011, there were an estimated 96,000 people living with HIV (both diagnosed and undiagnosed) in the UK with 24% unaware of their infection.

Nearly half (46%) of those diagnosed with HIV live in London. Since 2006 there has been an annual growth in the number of people diagnosed with HIV infection of 5-9%. Over 29,500 HIV diagnosed London residents accessed care in 2010 which more than double that of 2000.

London has the highest rates of HIV in the UK and 27 of the 31 PCTs have a prevalence of diagnosed HIV greater than 2 per 1000 (including Hounslow). According to the HPA (2011 & 2012) more than 1 in 5 people infected with HIV in London do not know their status (~8,400 people).

Since 2000, the most common route of acquisition for newly diagnosed HIV infections in London has been heterosexual exposure.

The number of people living with HIV in Hounslow has increased by 15% since 2006 which is considerably lower than England (48%).

In Hounslow there were 624 residents with diagnosed HIV in 2011. Whilst this reflects an increase in new cases being reported since 2010 (3.8%), numbers of new incident cases have varied since 2006.

Like elsewhere in North West London, over half of diagnoses were attributed to white men and women (42%). 36% of those living with HIV in Hounslow were Black African and the majority of these were women (64%). Each year since 2006, the highest number of diagnoses are in MSM followed by heterosexual women.

The highest prevalence areas were Chiswick, Brentford and Turnham Green followed by Isleworth and Syon wards. However, 90% of wards in Hounslow had a diagnosed prevalence rate of >2 per 1000.

The main route of infection in Hounslow is sex between men and women (53%) with a further 41% attributed to MSM.

Late diagnosis of HIV (CD4<250/mm$^3$) is increasing in Hounslow (an increase from 51% in 2009 to 57% in 2010, higher than London’s 49% and England’s 52% for 2010).

HIV testing is the best means to reduce late diagnosis of HIV and uptake in GUM services is 91% for MSM and 72% for heterosexuals in Hounslow.
UK

- There are several different systems to measure HIV but the Survey of Prevalent HIV Infections Diagnosed (SOPHID) is the most commonly used, especially for borough level data. It is worth pointing out that new diagnoses are not the same as new infections. New diagnoses can only tell us that the individuals are newly diagnosed and not when they were infected. RITA testing (explained below) can determine if the infection was likely to occur within the last 6 months.

- In 2011, there were an estimated 96,000 people living with HIV (both diagnosed and undiagnosed) in the UK – a quarter of these were thought to be unaware of their infection. This 2011 estimate is an increase on the 2009 estimate of 86,500, continuing the year on year increase in HIV prevalence in UK. Half of these individuals are thought to have acquired their infection heterosexually and over 2/3 of these acquired the infection abroad, mainly in sub-Saharan Africa (HPA, 2012).

- The highest undiagnosed rates were estimated to be in heterosexual males – 30%. Of these, 27% of African born were unaware of their infection and 33% of non-African born were estimated to be unaware of their infection. However, confidence intervals overlapped between the risk groups of heterosexuals, people who inject drugs, MSM and women. In total, 73,400 people had a HIV diagnosis in 2011.

LONDON

- Nearly half (46%) of all individuals with HIV in England reside in London (HPA, 2012). This equates to over 30,000 people and has significant cost implications for health service provision – 2010/11 estimates suggest the cost of outpatient care to be £250 million (excluding inpatient and prevention costs). Since 2006, there has been an annual growth in the number of people with diagnosed HIV infection of 5-9%. Over 29,500 HIV diagnosed London residents accessed care in 2010, a 5% increase on the number seen in 2009 and more than double that of 2000. 2011 also reflected an increase of 5% on 2010 and 31% increase in the last 5 years (HPA, 2012).

- London has the highest rates of HIV in the UK and 27 of the 31 PCTs have a prevalence of diagnosed HIV greater than 2 per 1000. According to the HPA (2011) more than 1 in 5 people infected with HIV in London do not know their status (~8,400 people). This is important as the transmission rate from
those who are unaware of their diagnosis has been estimated to be more than 3 times that of those diagnosed. MSM and those born in Sub-Saharan Africa have the highest rates of previously undiagnosed infection.

- Since 2000, the most common route of acquisition for newly diagnosed HIV infections has been heterosexual exposure. In 2008, this was more than half of newly diagnosed infections in London. It is predicted that there will be a fall in the number of infections acquired heterosexually corresponding to a fall in the number of heterosexual cases who have acquired HIV in Africa.

- Recent Infection Testing Algorithm (RITA) is a methodology for distinguishing the likelihood of a recently acquired infection (i.e. within the previous 4-5 months) and so can identify incidences. In 2010, 15% (324, CI: 14-16%) of the 2,183 reported HIV infections in London were newly acquired as identified by. Overall, 25% of the 324 newly acquired infections were amongst MSM, 8.6% amongst heterosexual men and 8% amongst heterosexual women.

- In London, MSM and Black Africans are over-represented in HIV infection figures. The highest prevalence of HIV in London is found in inner London, with a prevalence rate of 643 and over HIV diagnoses per 100,000 population aged 15 years and older (HPA, SOPHID data 2006). Hounslow fell within the second lowest quintile – a rate ranging from 191 to 306 per 100,000 (or 1.91 to 3.06 per 1000). By 2010, this rate had increased to 3.5 per 1000 population aged 15-59 years (London rate of 5.4 per 1000; England rate of 1.9 per 1000). In absolute numbers, this means ~600 Hounslow PCT residents assess HIV related care. This reflects an increase in prevalence of HIV infection in outer London boroughs in recent years. Ealing has a similar rate whilst the other neighbouring boroughs of Richmond and Hillingdon fall within the lowest quintile of less than 191 per 100,000.

**NORTH WEST LONDON**

- Figure 7 illustrates the number of new HIV and first AIDS diagnoses for residents of North West London for the years 1996 to 2011. These are displayed alongside reported deaths. It is clear that there has been an increase in the number of new HIV diagnoses since 2000, although the numbers flocculate. As these are counts, it is difficult to say if this reflects an increase in prevalence of HIV or whether more people at risk are coming forth for testing or if services are increasing their opportunities to test for HIV.
The vast majority of HIV diagnoses are amongst men – 76% of the cumulative total - and 77% of first AIDS diagnoses are also amongst men. Over half (56%) of all new HIV diagnoses between 1998 and 2011 were connected to MSM. Whilst this proportion varied year to year, MSM was the most common exposure category. Heterosexual transmission accounted for 35% of the overall total of cases. Only 1.8% of new HIV diagnoses were linked to mother-to-infant transmission. HIV diagnosis was more likely in the older age groups with the majority of diagnoses occurring in the 30 to 40 year old age group. In terms of ethnicity, 52.5% of cases were attributed to white men and women whilst 26.4% cases were reported by Black-Africans. The bigger proportion of patients accessing care for HIV being white is also reflected in the rest of NWL, except for Harrow, where Black Africans were the biggest users.

Since Black-Africans have been identified as a vulnerable population for HIV. SOPHID (2009) data was used to look at HIV rates for Black-Africans in each of the 8 NWL boroughs. The inner NWL boroughs had the highest HIV prevalence rates - Kensington & Chelsea’s rate was 8.33 per 1000, Hammersmith & Fulham was 8.15 and Westminster was 7.01. Hounslow had a rate of 3.54 per 1000, which was lower than Brent’s 4.57 but higher than Hillingdon (2.42), Ealing (3.01) and Harrow (1.83).

Ealing had the highest percentage of Black African heterosexuals diagnosed late (48%), followed by Hillingdon (42%). Hounslow’s proportion was 26% -
lower than Brent (30%) and Westminster (28%) but higher than Kensington & Chelsea (21%), Hammersmith & Fulham (21%) and Harrow (14%).

HOUNSLOW

- The number of people living with HIV in Hounslow has increased by 15% since 2006 which is considerably lower than England (48%).

- In 2011, there were 624 Hounslow residents with HIV diagnosis (HPA, 2012) and 577 of these were recorded as accessing HIV-related care in 2011 (HPA, 2012). Whilst this reflects an increase in new cases being reported since 2010 (3.8%), numbers of new incident cases have varied since 2006.

- The diagnosed prevalence rate of HIV for Hounslow is 3.4 per 1000. This is lower than Brent (3.8 per 1000), Westminster (8.7 per 1000), Hammersmith & Fulham (7.4 per 1000), Kensington & Chelsea (8.8 per 1000) but higher than Ealing (3.2 per 1000), Hillingdon (2.5 per 1000) and Harrow (2 per 1000). This ranks Hounslow as 28th highest local authority (out of 325) for diagnosed prevalence.

- Overall the highest prevalence wards in Hounslow are situated in W4, TW7 and TW8 – north eastern part of the borough. Brentford and Chiswick Riverside had a rate between 10 and 20 diagnoses per 1000 (HPA, 2012). Turnham Green, Chiswick Homefields, Syon and Isleworth had rates of between 4 and 6 per 1000. Indeed 82% of MSOAs in Hounslow had prevalence rates higher than 2 per 1000 in 2010. In 2011, 90% had a diagnosed prevalence rate of >2 per 1000. This is similar to Brent and Ealing but lower than the inner boroughs (which have 100%). This high rate could reflect better access rates of residents – in other words residents are more likely to access services and be diagnosed, thereby reducing the proportion of undiagnosed HIV in the population.

- Like elsewhere in North West London, over half of diagnoses were attributed to white men and women (42%). 36% of those living with HIV in Hounslow were Black African (N=218) and 64% were women (N=139). The median age for accessing care for HIV was 42 years and there were seven children under 15 years with HIV in 2010 for Hounslow (HPA, 2012).

- Each year since 2006, the highest number of diagnoses are in MSM followed by heterosexual women (HPA, 2012).
• The main route of infection in Hounslow is sex between men and women (53%) with a further 41% attributed to MSM (HPA, 2012).

• 43% of diagnosed HIV infected individuals (N=95) lived in the most deprived area (according to the IMD).

**HIV Testing in Hounslow**

• Since Hounslow’s diagnosed rate exceeds 2 per 1,000 population (200 per 100,000), the UK National Guidelines for HIV Testing (2008) recommend that HIV testing should be extended into non-traditional settings. This includes testing forming part of new patient registrations and for all general medical admissions. Testing for HIV is considered cost-effective as long as the positivity rate is more than 1 per 1000 tests. Testing is likely to be most effective if targeted at people aged between 15 and 59 years of age.

• In 2010, 78% of patients attending an STI clinic and not known to be HIV positive were offered a HIV test in England. Of these, 78% accepted testing. Uptake was higher among MSM (91%, London average of 92%) than among heterosexual men or women (72% compared to London average of 85%) and higher in areas of high diagnosed HIV prevalence than in areas of low diagnosed prevalence. Positivity was also higher in high prevalence areas – 7.65 per 1000 tests compared to 3.37.

• In 2010, update of HIV testing in the integrated sexual health service was 91% for MSM (London average was 92%) and 72% for heterosexual attendees (London average was 85%).

**HIV Testing in Pregnant Women**

• HIV testing is offered to all pregnant women as part of the antenatal screening programme. Appropriate measures in pregnancy for HIV positive women can reduce the risk of mother to child transmission from around 15% to around 1%.

• Screening positivity varies in England. In 2010, the England average positivity rate was 1.65 per 1000 tests. London was the highest with a positivity rate of 3.21 per 1000. In 2010/11, 5843 screens for HIV were performed in WMUH for pregnant women (out of a total of 5858 pregnant women). Of these,
there were 14 positive diagnoses (2.39 per 1,000) – 3 of these were new diagnoses. This gives a prevalence of HIV in pregnant women as 0.4%, same as London.

- In 2011, 5742 Hounslow women were screened for HIV (99% of the antenatal population). Of these, 15 (0.26%) were positive for HIV and 5 (33%) of these were new diagnoses – a rate of 2.61 per 1000. There is a specific maternal care pathway for HIV positive mothers-to-be and all women found to be positive with HIV are provided with formula milk (this approximates 1-2 women a year at a cost of £500 per woman for the year).

LATE DIAGNOSIS OF HIV

- Late diagnosis of HIV is of concern as it is linked with higher risks of earlier death. It is estimated that 1 in 4 people who were diagnosed late die within the first year of diagnosis and health care costs are also much higher in the first year after diagnosis. Late diagnosis also limits treatment options. Reducing the number of people who are diagnosed late with HIV is a public health priority and can also be seen as an indirect performance measure of HIV prevention.

- A late HIV diagnosis is defined as a CD4 count $<350\text{ mm}^3$ within 91 days of diagnosis.

- In 2009, 51% of Hounslow’s HIV patients had a late diagnosis and 26% had a very late diagnosis. The following year this had increased to 57% of people with HIV having a late diagnosis (higher than London’s 49% and England’s 52% for 2010). Similar to London, the majority of late diagnosis were amongst heterosexuals (69% in Hounslow compared to London’s 62% in 2010) and 47% of MSM were diagnosed late (compared to London’s 37%).

- Table 2 shows the pooled data for late diagnosis by North West London borough, 2009-2011. Hounslow appears almost on par with Hillingdon with the highest late diagnoses rates – however, confidence intervals do overlap. Overall, the outer North West London boroughs are similar to other outer London boroughs with inner boroughs have a lower percentage of late diagnosis in 2009-2011 – hovering around 35%. (HPA, 2012).
Table 2
Late diagnosis with 3 months of diagnosis by North West London boroughs, 2009-2011

<table>
<thead>
<tr>
<th>Borough</th>
<th>Late Diagnosis (CD4&lt;35/mm3)</th>
<th>Confidence interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hounslow</td>
<td>56.4%</td>
<td>46.9-65.6</td>
</tr>
<tr>
<td>Brent</td>
<td>50.4%</td>
<td>43.7-57.1</td>
</tr>
<tr>
<td>Ealing</td>
<td>53.4%</td>
<td>45.4-61.3</td>
</tr>
<tr>
<td>Hammersmith &amp; Fulham</td>
<td>37.7%</td>
<td>30.5-45.3</td>
</tr>
<tr>
<td>Harrow</td>
<td>51.2%</td>
<td>40.0-62.3</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>56.5%</td>
<td>46.6-66.0</td>
</tr>
<tr>
<td>Kensington and Chelsea</td>
<td>39%</td>
<td>31.9-46.5</td>
</tr>
<tr>
<td>Westminster</td>
<td>34.2%</td>
<td>28.9-39.9</td>
</tr>
</tbody>
</table>

Source: HPA (2012)

VERY LATE DIAGNOSIS OF HIV

- Very late diagnosis is defined as people with HIV who have a CD4 count less than 200 cells per mm$^3$. On average, people with a CD4 count less than 200 per mm$^3$ will have been infected about 8 years before their diagnosis.

- In 2005/6, 34% of London residents diagnosed with HIV were very late diagnoses. In 2010, this had decreased to 27% (95% CI: 25-29%). Heterosexuals were significantly more likely to be diagnosed very late compared to MSM - 38% (95%CI: 25-41%) versus 16% (95%CI: 14-19%). This has dropped from 42% and 18% in 2008. The proportion of Londoners who were diagnosed with a CD4 cell count less than 350 was 49% in 2010, a 2% drop on 2009.

- The very late diagnosis in 2009 was lower in Hounslow than Hounslow’s neighbouring boroughs of Hillingdon (42%), Ealing (48%), Richmond (33%) and Brent (30%) but higher than the other NWL boroughs. The following year the percentage increased to 29%. Whereas Hillingdon’s dropped to 26%, Richmond to 21%, Ealing to 40%. Brent increased to 31%. However,
Hounslow’s proportion has varied year on year – 31% in 2007 to 35% in 2008 and dropped to 26% in 2009. In 2010, Hounslow was ranked 15 out of 31 PCTs for percentage of very late diagnosis - with 1 having the lowest proportion of very late diagnoses - and ranked 20 out of 31 for late diagnoses.

- PCTs were required to reduce the proportion of very late diagnosis by 15% by 2010/11. By December 2011, Hounslow had reduced its rate by 12%. This was the biggest % drop in all the NWL boroughs - indeed Harrow increased its proportion by 15%. Brent and Ealing achieved 2%, Hammersmith & Fulham 10%, Hillingdon 11%, Kensington & Chelsea 8% and Westminster 9%.  

**PREVENTION, TESTING AND MANAGEMENT OF HIV**  

*Specialist HIV Commissioning*

- Commissioning of HIV care and treatment for London residents at London providers is led by the London Specialised Commissioning Group on behalf of London’s 31 PCTs. The team plans, procures and performance manages 23 acute sector contracts for HIV outpatient and some inpatient activity for adults and children. All London PCTs contribute, which is based on the HIV prevalence and activity and share the risk in accordance to the contribution made. Costs are contained through pan-London procurement and contracting processes. Risk is shared with the providers on the bases that in-year costs for existing patients are managed by providers and over-performance on projected new patients is met by the PCT of residence. The budget for HIV in 2009/10 was £246m.

- Locally, HIV testing is undertaken as part of the ‘Infectious Diseases in Pregnancy’ antenatal screening programme and opportunistic testing being done by the integrated sexual health services and the West London Gay Men’s Project (WLGMP). Living Well provide the support to those individuals already diagnosed with HIV.

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Prevention Programmes

- There is a national programme of HIV prevention which is administered by the Department of Health and which focuses on media messaging and campaigns.

- Until March 2013, there is a Pan London HIV prevention programme to which NHS Hounslow has contributed. The annual value of this programme is 2.3 million pounds (2012/13 figures) and it is commissioned on behalf of all 31 PCTs in London by Inner North West London Cluster. All components of the programme aim to improve knowledge or understanding of HIV prevention and to improve access to HIV/STI testing and treatment and access to safer sex promoting interactive services. Funding of this programme is now devolved to local authorities within the ring-fenced public health budget. There is currently no mechanism to commission HIV prevention activities collectively across all of the London boroughs from April 1st 2013 and any collective commissioning would require a new agreement either across London or by groups of boroughs.

- Some local authorities – Hounslow is one of them – have provided HIV prevention initiatives.


Living Well

- This service was originally commissioned by NHS Hounslow and since 2012 are commissioned by LBH to deliver specialist counselling and support that pertain to health and HIV.

- Living Well was set up to improve and offer a wider variety of healthcare options to HIV patients across London. This includes aiming to increase users’ knowledge and ability to self-manage their condition, increasing their ability to make informed decisions regarding health, diet and stress management etc. and being able to develop their ability to move beyond their HIV status in order to improve their overall quality of life.

- Information is available on the performance of quarter 1 and quarter 3 for 2011/12. In Q1, the number of new assessments across London boroughs
(both funded and non-funded) came to a total of 48, 4 of which were from the borough of Hounslow. By Q3, the number of new assessments in the 3rd quarter had decreased to 20, 1 of which was completed in Hounslow. In Q1, 14 (of 60 clients) Hounslow residents utilised the counselling service and 3 (of 27) attended at least one session of the Life Coaching programme. In Q3, 12 participants from Hounslow booked a counselling session (out of a total of 63 clients). No clients from Hounslow booked a Life Coaching session, although 23 clients across 7 other boroughs did.

RECOMMENDATIONS

• Early diagnosis of HIV is preferential to late diagnosis not just for the prolonging of the patient’s life expectancy and quality of life that that late diagnosis is much more expensive. On average, the annual cost of HIV treatment and care mix per early detection patient is £8,934.01 compared to £11,530.64 for a late detection patient. Work needs to continue in reducing the proportion of late and very late diagnoses within Hounslow, especially in MSM and Black African groups.

• Late diagnosis can be reduced by identifying those most at risk in the population and areas with high HIV prevalence. Since 90% of Hounslow’s wards had a prevalence above 2 per 1000, HIV testing should be provided throughout the population.

• According to the literature, uptake of HIV testing can be improved through the following:
  
  o Ensure current HIV testing in GUM, antenatal care and TB services are optimized
  o Introduce routine HIV testing in abortion services
  o Pilot and evaluate community based point of care testing
  o Introduce HIV testing in primary care
  o Introduce opt-out testing in medical admissions in acute settings where prevalence is greater than 2 per 1000 (UK National Guidelines for HIV Testing)

Hounslow has instigated the first 2 and in the new abortion services contracts (part of the AQP process for 2013/14), routine HIV testing will be required.

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Consideration should be made of HIV testing in primary care and in West Middlesex Hospital.

- Throughout the literature, MSM and Black African heterosexuals remain the groups with the highest HIV prevalence in the UK. Efforts are warranted to reinforce prevention messages and promote HIV testing. There is evidence that there should be an annual HIV/STI screen for MSM who have unprotected sex with casual or new partners, increasing to every 3 months if changing partners regularly.

- In 2011, NICE published guidance on increasing the uptake of HIV testing in black Africans and among men who have sex with men (MSM). In relation to the former group – black Africans – NICE had 6 recommendations. The following highlight actions under each recommendation which should be considered for Hounslow:
  o Community engagement and involvement – this includes recruiting, training and encouraging members of local Black African communities to encourage their peers to take an HIV test.
  o Planning services – assessing local need – this to include collecting views and experiences of local black African communities to understand their specific concerns and needs in relation to HIV testing.
  o Planning services – developing a strategy and commissioning services in area of identified need – ensure HIV testing is available in a range of healthcare and community settings which are accessible and acceptable to the target population.
  o Promoting HIV testing for black African communities – perhaps work with the Healthy Lifestyle Roadshow and other community links to promote the importance of HIV testing
  o Reducing barriers to HIV testing for black African communities – the actions around this mostly involve ensuring that staff are trained in emphasizing that the tests are confidential, being culturally sensitive, knowing the referral pathways and recognising the symptoms that may signify primary HIV infection or illnesses that co-exist with HIV.
  o Healthcare settings: offering and recommending a HIV test – this basically states to follow British HIV Association (BHIVA) guidelines and in areas where more than 2 in 1000 population have been diagnosed with HIV, all health practitioners to offer and recommend an HIV test to anyone who has a blood test (regardless of the reason) and primary care and general medical admissions professionals should consider offering and recommending an HIV test when registering and admitting new patients.
  o HIV referral pathways – ensure there are clear referral pathways for people with positive and negative HIV test results and that for those
who test positive, that they are seen by an HIV specialist preferably within 48 hours but certainly within 2 weeks of receiving the result.

• NICE guidance on HIV for MSM is similar - planning services by assessing local need and developing a strategy, promoting HIV testing among MSM and having clear referral pathways for HIV. The additional recommendations are made:
  o Specialist sexual health services to offer and recommend HIV tested all men. This includes those who have previously tested negative for HIV and should happen whether or not they disclosed that they have sex with men. Ideally both fourth generation serological testing and POCT to be offered.
  o Primary and secondary care to offer and recommend HIV testing to all men who have not previously been diagnosed HIV positive and have disclosed or are known to have sex with men or live in an area with a high prevalence of HIV or with a large community of MSM. Primary care to offer annual HIV testing.
  o Providing rapid point-of-care tests as part of outreach is also recommended.

• Since the main route of transmission is heterosexual in Hounslow and the fact that late diagnosis is also high in this group, efforts should be made to expand the offer of HIV testing to this group. This would not only help to reduce late diagnosis but also undiagnosed infections, thereby preventing further transmission.

• Sexual Health Board to work with LBH in understanding the needs, issues and opportunities in HIV prevention in the three target groups – MSM, African communities and People living with HIV in Hounslow. Work is also needed in how HIV prevention will be addressed in the borough.
MAIN POINTS TO NOTE

In 2011/12, Hounslow’s Chlamydia Screening Programme had an overall diagnostic rate of 2269 per 100,000. This is under the recommended 2400 per 100,000, which will be an indicator in the Public Health Outcomes Framework.

Hounslow had the third best diagnostic rate in North West London – with the exceptions of Brent and Ealing, all others were under 2000 per 100,000. Only Brent achieved the 2400 per 100,000, making it one of the ten London boroughs that did.

Screening coverage was 27.5% in 2010/11 and 26% in 2011/12 (both above target of 25%) and community positivity rates were 5.1% and 5.9%, higher than the expected 2.4%, indicating that the right people are being screened.

Teenage conception rates have dropped considerably in Hounslow since 1998. This echoes the overall downward trend in teenage conception rates in the UK.

In 2010 Hounslow had the second highest teenage conception rates in North West London and apart from 2009, Hounslow’s teenage conception rates have been higher than both London and England averages. Over two thirds of conceptions led to abortion (64% in 2009 and 2010). This is higher than London (62.5%, 60.6%) and England (50.3%, 49.1%) and has been increasing over the past ten years.

There is variation within the borough. Rates of under-18 conceptions at ward level in Hounslow vary significantly from under 30 per 1,000 population to 85 per 1,000 in 2005-07. Seven of Hounslow’s 20 wards have under-18 conception rates that are among the highest 20% in England. According to pooled 2008-2010 data, the wards with the highest rates are Bedfont, Isleworth and Turnham Green. These 3 wards are in the top 20% of wards in England and have at least a rate of 58.4 conceptions per 1,000 women aged 15-17 (ONS, 2012).

Young people most at risk of teenage pregnancy are children in care (CIC) and those who are socially deprived and excluded.
CHLAMYDIA

- Young people aged between 16 and 24 years are disproportionately affected by Chlamydia, hence why the National Chlamydia Screening Programme (NCSP) has been targeted at this age group.

- The Chlamydia diagnosis rate among 15-24 year olds is a measure of Chlamydia control activity that can be correlated to changes in Chlamydia prevalence (and changes in ill-health due to Chlamydia). By increasing the diagnosis rate the prevalence of asymptomatic infections will reduce.

- Mathematical modeling by HPA\textsuperscript{11} has suggested that the substantial increase in the number of Chlamydia diagnoses in England between 2000 and 2010/11 have probably decreased the prevalence of Chlamydia among 16-24 year olds by 28% relative to 2000 (from a prevalence of 4.8% in 2000 to 3.5% in 2010/11).

- Modelling work from the Health Protection Agency (HPA) indicates that achieving a diagnosis rate of 2,400/100,000 people aged 15-24 per annum will lead to a national 2% drop in Chlamydia infection prevalence on the previous year, assuming recommended standards of treatment and partner notification are met. This diagnostic rate has been set as one of the indicators in the Public Health Outcomes Framework and indicates the level of diagnoses needed to be achieved in order for the prevalence of Chlamydia to decrease within the population.

- In 2012-2013, the HPA advises areas already achieving this rate or above to look to sustain or increase diagnosis rates, and areas below this rate to aim for an incremental increase from the previous year, investing in cost effective and sustainable delivery models.

- NCSP Standards 6\textsuperscript{th} Edition(2012) also sets out that the Chlamydia Testing Activity Dataset (CTAD) data requirements will be included in lab contracts and recommend that the commissioning of Chlamydia screening is

\textsuperscript{11} Dorey et al. 2012. Evaluating the current and future impact of opportunistic screening on Chlamydia prevalence in England: a mathematical model. HPA
integrated with other sexual health services and primary care – at least 70% of screening delivered via primary care plus targeted outreach for groups not engaged by health care services.

- In 2011/12, Hounslow had an overall diagnostic rate of 2269 per 100,000. We are bubbling under the recommended 2400 per 100,000. Neither London average nor England average achieved this, although 10 boroughs in London were over the level. We have done considerably better than other boroughs in NWL – all with the exceptions of Brent and Ealing were under 2000 per 100,000 for both 2010/11 and 2011/12. Brent achieved the 2400 per 100,000.

- Unlike elsewhere in London where more females are screened than males, uptake is 50:50 in Hounslow. This can be explained by the presence of Feltham Youth Offending Institute for young males, a population targeted for Chlamydia Screening.

- Table 3 illustrates the percentage of 15-24 year old population screened in each borough and the total diagnoses rate per 100,000 (this includes the screens done in GUM). Figures are provided for the years 2010/11 and 2011/12. Hillingdon, Hounslow and Kensington and Chelsea have an increase in diagnoses rates between the two years while the other boroughs show a decrease. The diagnoses rates for GUM compared to the community opportunistic screens varied for each borough. Hounslow for example had a GUM diagnoses per 100,000 rate of 808.4 for 2010/11 and 740.5 for 2011/12 which is considerably lower than the community diagnostic rate of 1400.7 for 2010/11 and 3136.7 in 2011/12. This can be partly explained by the high positivity rates amongst the residents of Feltham Youth Offending Institute, which counts as community screening. There was little difference between Brent’s GUM and community diagnoses rates (1774.5 and 1443.9 per 100,000 for 2011/12). The inner NWL boroughs had much higher diagnoses rates for GUM compared to community for both years – Kensington & Chelsea had 1224.2 per 100,000 compared to 1170.7 for 2011/12, Westminster had 1101.8 versus 787.4 and Hammersmith & Fulham had 1820.3 compared to 710.7 per 100,000.

- Brent and Hillingdon had the highest coverage rates in 2010/11, closely followed by Kensington & Chelsea and Westminster. All dropped in percentage of population screened in 2011/12 – Westminster and Kensington & Chelsea dropped by 23.3% and 25.5% respectively. Hounslow dropped by
1.4% from 27.5% to 26%. It is likely the drop in coverage reflects the shift in performance measures of Chlamydia screening from coverage to positivity rates with greater emphasis on the latter as this can reduce the level of undiagnosed infection in the population. The drop in coverage may also be symptomatic of the staff and structural changes occurring with the NHS during this period.

- For both years, Hounslow had a higher percentage of positivity in the community – 5.1% in 2010/11 and 5.9% in 2011/12. This indicates that Hounslow’s NCSP is targeted the right people in the community.

**Table 3**

Chlamydia Coverage, diagnosis rates and % Testing Positive by NWL Borough for 2010/11 and 2011/12

<table>
<thead>
<tr>
<th>PCT</th>
<th>2010/2011</th>
<th></th>
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<th>Difference in coverage 10/11 to 11/12</th>
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<tr>
<td></td>
<td>Total Diagnoses per 100,000</td>
<td>Coverage %</td>
<td>Positivity %</td>
<td>Total Diagnoses per 100,000</td>
<td>Coverage %</td>
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<tr>
<td>Brent</td>
<td>2559.3</td>
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<td>2.2</td>
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<td>9.9</td>
</tr>
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</table>

Source: HPA 2012

TEENAGE CONCEPTIONS

- Teenage conception rates include teenage pregnancies, miscarriage and abortion rates. It is measured by a rate per 1000 15-17 year olds.
• In 2009, the under 18 conception rate fell to the lowest level in 30 years and was down 18% since 1998. This equated to 38.2 per 1000 women aged 15-17 years (35,966 conceptions). Half of the conceptions ended in abortion. Despite the fall, the rate of teenage conceptions remains high compared to other countries, the UK ranks 33rd out of 29 OECD countries in terms of teenage fertility rates.  

• Figure 8 illustrates the rate of teenage conceptions per 1000 15-17 year olds in Hounslow. This is compared to England and London averages for the years 1999 to 2010. Throughout this period, the overall rates have declined. In 2009, Hounslow’s rate dropped below 40 per 1000 for the first time and was lower than both London and England averages. By 2011, this had dropped to Hounslow’s lowest ever recorded rate of 30 per 1000. This is similar to England’s 30.9 per 1000 and a little higher than London’s 28.75 per 1000. Throughout London, teenage pregnancy is on the decrease with the lowest rates recorded since 1998.

Figure 8

Under 18 Teenage Conceptions for Hounslow 1999 to 2011 Compared to England and London

Source: ONS 2013

• Overall, between 1998-2000 and 2007-09, Hounslow’s under-18 conception rate fell by 10%, compared to reductions of 14% for London and 11% for England as a whole. Hounslow’s rate reduction was due to fewer conceptions leading to birth, as the rate of conceptions leading to abortion increased over this period – a similar picture to that seen nationally.

• Figure 9 shows the teenage conception rates per quarter for the years 1998 to 2011 for Hounslow compared to London and England. Quarter 1 figures for 2011 show a decrease in rates from Quarter 4 – bringing 2011’s rolling rate to 34.1 per 1000. Whilst it is too early to tell if this will continue into Quarter 2, this quarter is considerably lower than Quarter 1 of the previous years – 2009 and 2010 included. Q1 2011 has a rate of 30.7 per 1000, Q1 2010 was 43.7. Q1 2011 is also lower than London and England averages. Throughout London, teenage pregnancy is on the decrease with the lowest rates recorded since 1998.

**Figure 9**

*Under 18 Conception rates by quarter from 1998 to 2011 for Hounslow, Compared to London and England*

![Graph showing teenage conception rates](image)

*Source ONS 2012*

• There is variation within the borough. Rates of under-18 conceptions at ward level in Hounslow vary significantly from under 30 per 1,000 population to 85 per 1,000 in 2005-07. Three of Hounslow’s 20 wards have under-18
conception rates that are among the highest 20% in England. According to pooled 2008-2010 data, the wards with the highest rates are Bedfont, Isleworth and Turnham Green. These 3 wards are in the top 20% of wards in England and have at least a rate of 58.4 conceptions per 1,000 women aged 15-17 (ONS, 2012).

- Over two thirds of conceptions lead to abortion (64% in 2010 and 2009). This is higher than London (62.5% and 60.6%) and England (50.3% for 2010 and 49.1% for 2009). This has been increasing over the past ten years. This is a similar trend to what is happening in North West London will all boroughs having an abortion proportion of over two thirds. Similarly, so do Kingston and Richmond.

- In 2010, Hounslow had the highest maternity rate for the age group of all North West London – 14.2 per 1000 in 2010 – second to Hounslow was Brent with 13.1 per 1000. Hounslow’s rate was lower than England (17.9 per 1000) and similar to London average of 13.9. However, both maternity rates and conception rates have dropped considerably since 1998.

- Estimates derived from birth data show there were around 160 mothers aged under-20 in Hounslow at the end of 2009.

Comparison with Neighbouring Boroughs

- Figure 10 compares Hounslow to the boroughs in North West London and its southern neighbours Richmond and Kingston for the years 1998-2011. By 2011, all boroughs have decreased their teenage conception rates. Whilst Hounslow had its lowest rate since 1998, it ended 2011 with the highest rate in North West London and compared to Kingston and Richmond. Hammersmith & Fulham has had the highest rate of teenage conceptions since 1998 but this has substantially lowered to 25 per 1000 in 2011. Hounslow had consistently been the second highest rate. Harrow and Richmond finished 2011 with rates under 20 per 1000.
Under 15 Conceptions

- The latest available data for teenage conceptions amongst those younger than 15 years is for 2010. This equated to 8.9 per 1000 13-15 year old girls compared to an England rate of 7 and London of 7.1 per 1000. Compared to the pooled data for 2006-2008, Hounslow’s rate of conceptions amongst 13-15 year old girls has changed little from 8.8 per 1000 and 7.9 for England and 8.7 for London. In both circumstances the confidence intervals overlap indicating that due to the small numbers, it may be possible that there is no real difference between Hounslow and London or England.

- Table 4 illustrates the pooled data for 2008-2010 and 2007-2009 for North West London, Richmond and Kingston compared to London and England. Hounslow has the highest rate for 2008-2010 with Westminster having the 2nd highest rate for 2008-2010 at 8.4 per 1000 followed by Brent at 7.8. Hounslow was also the highest for the previous 2 years.
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of Conceptions</td>
<td>Conception rate per 1,000 women in age group</td>
</tr>
<tr>
<td>ENGLAND</td>
<td>20,153</td>
<td>7.4</td>
</tr>
<tr>
<td>LONDON</td>
<td>2,828</td>
<td>8.0</td>
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<td>Brent</td>
<td>91</td>
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</tr>
<tr>
<td>Ealing</td>
<td>78</td>
<td>5.5</td>
</tr>
<tr>
<td>Hammersmith and Fulham</td>
<td>43</td>
<td>6.8</td>
</tr>
<tr>
<td>Harrow</td>
<td>41</td>
<td>3.7</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>85</td>
<td>6.3</td>
</tr>
<tr>
<td>Hounslow</td>
<td>91</td>
<td>8.9</td>
</tr>
<tr>
<td>Kensington and Chelsea</td>
<td>22</td>
<td>3.7</td>
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<tr>
<td>Westminster</td>
<td>56</td>
<td>8.4</td>
</tr>
<tr>
<td>Kingston upon Thames</td>
<td>33</td>
<td>4.4</td>
</tr>
<tr>
<td>Richmond upon Thames</td>
<td>24</td>
<td>2.9</td>
</tr>
</tbody>
</table>

Source: ONS (2012)

- Overall, Hounslow has much higher rates of teenage conceptions for both age groups than its neighbouring boroughs. These boroughs are not Hounslow’s statistical neighbours but Hounslow is compared against them for other health issues and shares amenities and services with many of these boroughs.
WHO’S AT RISK OF TEENAGE PREGNANCY?

• Predominantly, teenage pregnancy is linked with the most socially deprived and excluded young people, who also have the poorest health outcomes. It is a highly complex area and it is usually the outcome of a multitude of risk factors.

• Certain young women are more likely to become pregnant than others. Incidences of pregnancy are higher in girls with the following risk factors:
  - Low educational attainment
  - Low aspirations
  - Truancy
  - Eligibility for free school meals
  - Parents with low educational attainment
  - Parents who were teenage parents
  - Deprivation
  - Living in care
  - Mental health problems
  - Sexual abuse
  - Offending behaviour
  - Alcohol and drug misuse

• Children in Care (CIC) or Looked After Children (LAC) are 2 ½ times more likely to be teenage parents than their non-looked after peers.\(^\text{13}\)

• In Hounslow it is not known how many children in care became pregnant as there is no data relating to the numbers who terminated the pregnancy. However between 2009 and 2011, it was noted that 14.3% of females aged between 13 and 18 years became teenage mothers (JSNA, 2011/12).

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WHAT IS BEING DONE TO ADDRESS YOUNG PEOPLE’S SEXUAL HEALTH IN HOUNSLOW?

• There is a dedicated young people’s sexual health service (YPSHS) which forms part of the integrated sexual health service. In 2012, there were 4 KISS clinics in operation and the GUM clinic was ‘You’re Welcome’ accredited. While the KISS clinics are not continuously open, a KISS clinic is open for each day of the week. When closed, there is good sign-posting to where to go for emergency contraception etc. Regular public engagement ensures that they are meeting the needs of the clients – for instance a consultation process in 2011 meant the reduction of 6 clinics to 4 as 2 of the clinics were not as well utilised. Positivity rates – especially for Chlamydia – are indicating that the right people are coming to the clinics. There is some anecdotal information that KISS clinics are being used for health issues other than sexual health as there is a preference for young people to use the anonymity of the clinics compared to primary care.

• The main provider for the Chlamydia Screening Programme in Hounslow is the WMUH integrated sexual health service. Other providers include the Chlamydia Screening Office (CSO) outreach (part of WMUH), Ante-natal clinic at WMUH, Feltham Young Offenders, YMAG, the Barracks, Homeless Team, Da Spot, postal kits via community pharmacists and GPs (though the Chlamydia Screening LES finished in December 2010).

• Until March 2011, other young people’s sexual health services were provided through the Teenage Pregnancy Grant which ceased in 2010. These had included ‘Straight Talking’ in schools, a young fathers group in Da Spot and a sessional worker at West Thames Colleges. Outreach sexual health drop-ins in 2 schools run by the WMUH sexual health service also ceased in 2010 due to lack of funding.

• Other young people’s sexual health services are provided through the following:
  - LARC implementation in a variety of providers – including GP practices signed up to a Local Enhanced Service (LES), Marie Stopes, BPAS and West London Gay Men’s Project
  - Emergency contraception provision in pharmacies
- 47% (26) of GP practices have signed up to a sexual health LES, which requires them to undertake sexual health promotion activities to reduce teenage pregnancy.

- The maternity department at West Middlesex University Hospital (WMUH) run a Young Mum’s Antenatal Group (YMAG) which is specifically for teenage mothers. To facilitate access, this group meets in the community at the North Isleworth’s Children’s Centre (behind West Thames College).

- LAC nurse working with looked after children.

- Family Nurse Partnership (with a current caseload of 40 young parents). This started in Hounslow in 2012 and works with up to 100 young parents under the age of 20 with high needs around sexual and mental health including intimate partner violence.

- NSPCC runs programmes for young teenage parents.

- In 2012, LBH CS&LL Early Intervention Services commissioned a sexual health worker from Brook to deliver targeted interventions with a drugs worker across the borough. This service is based at West Thames College.

- Until 2010, there was a Teenage Pregnancy Partnership Board (whose remit is now covered by the Sexual Health Board) which implemented the 10 interventions known to reduce teenage pregnancy. This saw a drop from 46 per 1000 in 2008 to 37 in 2009.

- Measuring the impact of an intervention in teenage pregnancy is difficult as teenage pregnancy data takes 18 months to compile maternity and termination of pregnancy data to publish them. This means that in 2012, we are seeing the results of work in 2010. It is possible to create local proxy measures using maternity and termination of pregnancy data and validate by matching against the conception calculator. Receipt of mid-year populations can help calculation. Validation however is an issue. Local abortion data is based on conception data whilst nationally, figures are based on date of procedure. Other issues include the reliance on local providers to give maternity data and termination data will miss private termination figures.

- It is possible to map proxy conception figures against ward boundaries. Numbers will be small at start but will develop month by month and could give an early indication of performance against ONS statistics published two years in arrears.
Sexual violence, assault and child exploitation

- Hounslow has had a domestic violence education programme running in schools for many years (‘Learning to Respect’) and currently the teenager abuse campaign is being promoted within secondary schools. Hounslow is one of three pilot areas in the country working to improve responses to women who have affected by domestic and sexual violence linked to drug and alcohol abuse and mental health. There is Sexual Exploitation training for health professionals working with vulnerable young people and this has secured funding through 2012/13.

- Outreach sex and relationships education work is also available in pupil referral units and interim education centres and concentrates on issues around consent and exploitation. The sexual health clinic provides a direct referral to a health advisor and to tier 2 and 3 mental health services. However, much of this work is secondary or tertiary prevention – i.e. at least one incidence of sexual violence has happened. There is also an agreed referral process to St Stephen’s Centre via youth services in the Council in Hammersmith for therapeutic services for children and young people at risk of domestic violence and the Council runs a 12 week programme ‘Let’s Talk’ for children and young people living in a familial unit with domestic or intimate partner violence.

- Stakeholders have raised concerns about the perceived increase in gang activity and related violence in the borough. They stated that such gang activity is often linked to initiation processes that involve sexual activity. There is currently no data on gang activity and related sexual activities but the health sub-group of the Local Safeguarding of Children Board (LSCB) are watching the situation as well as any claims of child exploitation.

Sex & Relationships Education

- Personal, Social and Health Education (PSHE) framework is non-statutory but encourages schools to provide age-appropriate teaching on relationships and sexual health as well as physical activity, substance misuse, diet and some
mental health issues. In 2012, the Department of Education (DfE) is conducting a review of provision in schools with the aim to determine how they can support schools to improve quality of all PSHE teaching in schools.

- All schools in Hounslow are currently delivering SRE (both primary and secondary) in some form or another, but the quality of the provision is no longer monitored/assured by LBH, as the schools are no longer obliged to follow local authority guidance. Schools have a legally binding duty to offer SRE through the science curriculum and school governors are bound by Department of Education’s SRE Guidance to have “due regard” to the SRE provision in schools. Quality of current provision is unknown.

- In terms of sexual health drop-in clinics in schools, there has been nothing consistent since 2010. The Green school has a rolling scheme with the integrated sexual health service, where the most vulnerable girls come down for a workshop in the clinic. This has also been extended into Brentford. Nationally, 28.7% of schools had on-site sexual health clinics in 2008.

- A report on young people and abortion in London\(^\text{14}\) highlighted that there is a poor understanding of fertility amongst young women (which contributes to inconsistent contraceptive use), young people struggled to use their preferred methods of contraception effectively and there were a number of barriers to safe sex such as feeling out of control, alcohol or drugs use, dynamics of the sexual relationship and women lacking confidence to negotiate the relationship. It recommended access to and use of LARC and this should monitored on a local level, having systems in place for the early identification of those who may be at risk of teenage pregnancy and all key service providers working with vulnerable young people to receive training in sexual health issues.

**RECOMMENDATIONS**

- Increase the number of young people friendly sexual health services, especially GP practices and pharmacies in accordance to ‘Positive Youth’ recommendations. There is a ‘You’re Welcome’ accreditation which since 2010 is being done on a local level but to date only the GUM clinic has been

accredited. The Smoking Cessation service and the maternity service at WMUH have started the process. Ideally, all GP practices should be young people friendly but due to the time involved in conducting the process, those practices with large number of young people should be targeted first. Sexual Health Board will need to look at how to support this process.

- Greater targeted youth support to young people at risk of unintended pregnancies and STIs, especially young people attending the Youth Offending Service.

- The local teenage pregnancy pathway and aftercare should be reviewed, particularly as the providers of youth services are fragmented across local authority, NHS and voluntary sector.

- Audit the number of schools who are providing SRE and the quality and work with school governors to establish SRE programmes with Hounslow’s schools.
TERMINATIONS OF PREGNANCY (ABORTION)

MAIN POINTS TO NOTE

Hounslow has the second highest rate of abortion in North West London for the years 2009 and 2010 – 29 and 29.5 age standardized rate per 1,000 women aged 15-44 years. These rates are significantly higher than London’s 26 and 2.57 per 1000 and England’s 17.6 per 1000 for 2009 and 2010.

The standardized rates are also significantly higher than the other six North West London boroughs but lower than Brent.

Hounslow’s crude abortion rate for under 18 year olds was higher than England averages (21 per 1000 versus England’s 16.6 for 2010 and 24 per 1000 compared to England’s 17.7 for 2009).

In terms of repeat abortion rates, Hounslow’s proportion of repeat abortions to women under the age of 25 years for 2009 and 2010 was 29% which has lower than London’s 32% but higher than England’s 25%. It was also the lowest in all the North West London Boroughs.

ABORTION RATES

- Unintended pregnancy is associated with delayed antenatal care and higher levels of postnatal depression in mothers (which can have negative impact on the later development of their children). Studies in the UK have found that ~33% of pregnancies that end in birth are unintended and 99% of abortions are classified as being other than Ground E (fetal abnormalities).

- Table 5 shows the abortion absolute numbers and rates for Hounslow and the other North West London boroughs for the years 2009 and 2010. Looking at the abortion rate which is standardized by age to the age-group 15-44 years (akin to the general fertility rate for a population), Hounslow’s rate remained the same for both years. This was the second highest in NWL borough after Brent (39.6 abortions per 1000 women aged 15-44 years for 2010, an increase from 31 in 2009). Hounslow’s rates were also higher than the London averages of 25.7 per 1000 15-44 year old women in 2010 and 26
for 2009. Westminster had the lowest abortion rates (16.6 per 1000 15-44 year old women in 2010 and 18 in 2009). The 2010 rate was significantly lower than the England average of 2010.

- Looking at the 95% Confidence Intervals, Hounslow’s rates are significantly higher than London and England for 2010 and as they do not overlap with any of the other boroughs, it is significantly higher than 6 of the other boroughs but lower than Brent. This indicates that there are real differences between Hounslow and the other NWL boroughs - though this is not necessarily true of the others, for instance Hillingdon’s 95% CI overlaps with Hammersmith and Fulham.

- Table 5 also illustrates the crude rate for abortions in under 18s. Hounslow’s crude abortion rate for under 18 years was higher than England averages (21 per 1000 versus 16.6 for 2010; 24 versus 17.7 for 2009) but hovered around London’s 22 per 1000 for 2010 and 23 for 2009. Kensington & Chelsea had the lowest abortion rate for both years (9 and 12 per 1000 for 2010 and 2009).

- In 2009, 78% of Hounslow’s abortions were under 10 weeks – which is similar to London’s 77%. (This figure includes private abortions as well as NHS funded). The proportion ranged slightly for NWL, Harrow had the highest proportion at 84% and Ealing the lowest at 58%. In 2010, Hounslow’s rate increased to 82% (London was 79.6 and England average was 76.9).

- A high proportion of teenage conceptions are terminated. In 2010, 64% of under-18 conceptions in Hounslow lead to an abortion. This figure was the same for 2009 but is an increase on the previous years. It is also slightly higher than London’s 62.5% and markedly higher than England’s 50.3. In 2006-2008, 58% of under 18 conceptions led to an abortion. Again this is higher than England average of 49.7% but lower than London’s 61.3%.

- Overall in 2010, 26.7% of Hounslow’s conceptions (for fertile women) led to an abortion, London 26% and England 20.8%. 2009- 25.3% for Hounslow, 26.1% for London and 21% for England.
Table 5
Abortion numbers and rates for Hounslow and NWL comparators for 2009 and 2010

<table>
<thead>
<tr>
<th>Borough</th>
<th>Total Number of Abortions</th>
<th>Age standardised abortion rate per 1,000 women aged 15-44</th>
<th>95% CI</th>
<th>Crude rate per 1000 Under 18</th>
<th>% repeat abortions women aged under 25</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hounslow 2010</td>
<td>1603</td>
<td>29.5</td>
<td>28.6-30.4</td>
<td>21</td>
<td>29</td>
</tr>
<tr>
<td>Hounslow 2009</td>
<td>1504</td>
<td>29</td>
<td>---</td>
<td>24</td>
<td>29</td>
</tr>
<tr>
<td>Brent 2010</td>
<td>2223</td>
<td>39.6</td>
<td>38.6-40.7</td>
<td>23</td>
<td>34</td>
</tr>
<tr>
<td>Brent 2009</td>
<td>2052</td>
<td>31</td>
<td>---</td>
<td>23</td>
<td>32</td>
</tr>
<tr>
<td>Hillingdon 2010</td>
<td>1525</td>
<td>25.3</td>
<td>24.5-26.1</td>
<td>20</td>
<td>34</td>
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<td>Hillingdon 2009</td>
<td>1434</td>
<td>25</td>
<td>---</td>
<td>19</td>
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<td>Ealing 2010</td>
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<td>27.1</td>
<td>26.3-27.9</td>
<td>15</td>
<td>28</td>
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<td>Ealing 2009</td>
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<td>---</td>
<td>21</td>
<td>36</td>
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<td>K&amp;C 2010</td>
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<td>19.1-21</td>
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<td>780</td>
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<td>25.9-28</td>
<td>29</td>
<td>34</td>
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<td>H&amp;F 2009</td>
<td>1231</td>
<td>27</td>
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<td>33</td>
<td>32</td>
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<td>Harrow 2010</td>
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<td>23.8-25.6</td>
<td>14</td>
<td>31</td>
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<td>Harrow 2009</td>
<td>1099</td>
<td>25</td>
<td>---</td>
<td>13</td>
<td>35</td>
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<td>Westminster 2010</td>
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<td>15.9-17.3</td>
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<td>30</td>
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<tr>
<td>Westminster 2009</td>
<td>1155</td>
<td>18</td>
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<td>London 2010</td>
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<td>England 2010</td>
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<td>17.6-17.7</td>
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<td>England 2009</td>
<td>180,259</td>
<td>17.6</td>
<td>---</td>
<td>17.7</td>
<td>25</td>
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</tbody>
</table>

Source: ONS (2012)
REPEAT ABORTION RATES

• Repeat abortion rates can be used as an indicator of inadequacy relating to contraception whether insufficient service access, sub-optimal service provision or ineffective individual use of contraceptive method. Young people are at particular risk of repeat abortions and teenagers are a particularly vulnerable group.

• Repeat abortion rates are usually cited as percentage of abortion under the age 25 years and under the age of 19 years.

• A quarter (25%) of abortions in females aged under 25 years in England in 2010 were repeat abortions. Table 3 shows the repeat abortions for under 25 years for 2009 and 2010 for the NWL boroughs. Hounslow’s proportion of repeat abortions to women under the age of 25 years for 2009 and 2010 was 29%. This was lower than London average of 32% but higher than England’s 25%. Hounslow’s proportion was also the lowest in all the North West London Boroughs.

• In 2009, Hounslow’s repeat abortion for under 19 years was 12.8% compared to England’s 11.1%. This had increased to 16% of abortions to women aged under-19 being a repeat abortion in 2010. This again was less than the London average of 17%, but higher than the national figure of 11%. Hammersmith & Fulham had the highest reported percentage of repeat abortions in the under 19s, reporting 21% with Westminster following with 18%. All other boroughs were similar to Hounslow ranging from 12% for Hillingdon to 15% for Brent and Harrow.

• Increasing uptake of LARC amongst those at risk of unwanted pregnancies is a good way to reduce rate of repeat abortions. In 2009, Hounslow’s under 25 repeat abortion rate was 28.7 (95%CI 25.2-32.4) which was significantly higher than England’s 24.7 but similar to London’s 32.2. London consistently has had a higher repeat abortion rate compared to England.

TERMINATION OF PREGNANCY (ABORTION) SERVICES

• In 2007/8, 13% of all London PCTs’ sexual health total budget was spent on abortion services (£17,239,000). This gave a mean total spend of £556,096 per PCT. Table 6 illustrates the burden of costs for unintended pregnancies for London using 2007/8 data. This includes abortion costs. For Hounslow,
this equated to a total of £3,445,42 for both births and abortions. This spend was higher than Hillingdon but lower than Ealing and Brent. The weighted average cost per birth (including delivery and community birth related care) for London was £2,203 and the weighted average cost per termination £505.75.

**Table 6**

*Economic cost of unintended pregnancies in London using 2007/8 data*

<table>
<thead>
<tr>
<th></th>
<th>Estimated number of unintended pregnancies</th>
<th>NHS cost of unintended pregnancies (births)</th>
<th>Cost of abortion (NHS funded)</th>
<th>Total NHS cost of unintended pregnancies (birth+abortion)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brent</td>
<td>3571</td>
<td>£3,237,382</td>
<td>£947,776</td>
<td>£4,185,158</td>
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<tr>
<td>Ealing</td>
<td>3507</td>
<td>£3,522,858</td>
<td>£903,775</td>
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<td>Hammersmith &amp; Fulham</td>
<td>2071</td>
<td>£1,806,035</td>
<td>£544,693</td>
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<td>Harrow</td>
<td>2068</td>
<td>£2,134,465</td>
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<td>Hillingdon</td>
<td>2682</td>
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<td>£661,521</td>
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<td>Hounslow</td>
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<td>Kensington &amp; Chelsea</td>
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<td>£85,696,809</td>
<td>£530,305,816</td>
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</tbody>
</table>

*Source: London Sexual Health Programme (2010)*

- Current provision of abortion services (formerly termed termination of pregnancy services) is provided by Marie Stopes, Ealing and British Pregnancy Advisory Service (BPAS) in East Twickenham. Access/referral is via GPs and the integrated sexual health service. Consultation following referral includes counselling.

- The total amount of money spent on abortion services for Hounslow residents was £565,544 (£244,101.00 for Marie Stopes and £321,443 for BPAs) for 2010/2011. This had increased to £599,082 for 2011/12 (£292,006 for Marie Stopes and £307,076 for BPAs).

- Table 7 illustrates the activity for Hounslow residents by the commissioned abortion services providers (BPAs and Marie Stopes) for the years 2010/11 and 2011/12. The majority of terminations occurred under 10 weeks with approximately one fifth happening later. For Marie Stopes, 5% of terminations were to women aged under 18 years and a similar proportion for BPAs. The majority of abortions occurred the 19 to 24 year old age group: 35-37% for Marie Stopes and 45% for BPAs in 2011/12. Proportion of repeat
Abortions were high – 43% and 26% for Marie Stopes in 2010/11 and 2011/12 and 35.8% for BPas in 2011/12. This reflects the figures for Hounslow and London mentioned in the previous chapter. Efforts are being made to reduce the proportion of repeat abortions with a standardized abortion service specification being drafted for London for use by Clinical Commissioning Groups (CCGs) for Any Qualified Provider (AQP). This service specification will encourage provision of LARC to women having terminations in order to reduce numbers of repeat abortions.

- Standardised Abortion Care Pathways for under 18 and over 18 years have been drafted as part of the London Sexual Health Improvement Programme. These will be incorporated into the proposed service specification and will help to reduce variation of practice across London.

### Table 7

**Activity for Hounslow residents 2010/11 and 2011/12 from Marie Stopes and BPAS**

<table>
<thead>
<tr>
<th></th>
<th>Total TOP</th>
<th>TOP under 10 weeks</th>
<th>TOP under 18 years</th>
<th>TOP 19-24 years</th>
<th>% Repeat Abortion</th>
<th>% Repeat Abortion (under 18 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2010/11 Marie Stopes</strong></td>
<td>626</td>
<td>80% (499)</td>
<td>5% (33)</td>
<td>37% (233)</td>
<td>43% (270)</td>
<td>Not recorded</td>
</tr>
<tr>
<td><strong>2011/12 Marie Stopes</strong></td>
<td>602</td>
<td>83% (502)</td>
<td>5% (29)</td>
<td>35% (210)</td>
<td>46% (234)</td>
<td>2% (14)</td>
</tr>
<tr>
<td><strong>2010/11 BPas</strong></td>
<td>799</td>
<td>80% (639)</td>
<td>7% (55)</td>
<td>24% (275)</td>
<td>35% (281)</td>
<td>1% (10)</td>
</tr>
<tr>
<td><strong>2011/12 BPas</strong></td>
<td>899</td>
<td>79.1% (711)</td>
<td>7% (50)</td>
<td>45% (323)</td>
<td>35.8% (322)</td>
<td>1.2% (4)</td>
</tr>
</tbody>
</table>

*Source: Activity Data provided by BPAS and Marie Stopes, 2011 and 2012*
REDUCING THE ABORTION RATE

- The most effective way to reduce abortion rates is to increase uptake of birth control, in particular LARC, which is shown in the literature as being the most effective and cost-effective methods for women. Oral contraceptive pills have been found to have a ‘typical use’ failure rate of 8-9% annually whilst IUDs and implants were up to 20 times more effective at preventing pregnancies. In the UK, women who have repeat abortions were either not using contraception or one with a high failure rate.

- Studies have shown that insertion of LARC following an abortion is linked to a lower likelihood of repeat abortion. In Canada, free intrauterine (IUDs) post abortion is associated with a lower 5 year rate of repeat abortion than provision of oral contraceptives or depo-medroxyprogesterone acetate (DMPA). No difference was observed within 12 months. Acceptability of LARC has been found to be high amongst abortion services users but that many clinics do not offer it due to financial and logistical reasons. In the USA, those who had a second or higher order abortion were over twice as likely to have LARC than those having a first abortion.

- Stakeholders have reported that anecdotally women who have LARC inserted post-abortion and it removed elsewhere soon after. Detailed was not available to compare insertion and removal rates across Hounslow to ascertain if this theory is valid. However, removal of LARC has been found in a randomized trial in Edinburgh, whereby two years after insertion of LARC,

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14.6% of women in the intervention group and 10% of controls had another abortion in the same hospital. Paleniveu & Oswal recommend a routine 2 week follow-up appointment and regular auditing of the periabortion contraceptive practices.

- There is evidence that disadvantaged women experience higher rates of unintended pregnancy than more affluent. Previously it had been maintained that affluent women were more likely to have abortions than disadvantaged women, although recent data shows that this is no longer the case in London (Teenage Pregnancy Unit, 2011). A non-randomized, non-controlled longitudinal descriptive study in the USA found that numbers of abortion fell by 21% resulting in a rate of 4.4-7.5 per 1000 in the study group of women aged 14-45 years, compared to the national average of 19.6 per 1000. Teenage birth rate also dropped to 6.3 per 1000, lower than the national average of 34.3 per 1000 over the same time period.

RECOMMENDATIONS

- Efforts should be made to increase uptake of LARC in women across Hounslow as these are more effective and cost-effective at preventing unintended pregnancies than oral contraceptives or condom-usage.

- Whilst there is some conflicting evidence about effectiveness of LARC reducing repeat abortions following first or second abortion, LARC counseling and insertion should be offered in termination of pregnancy services.

- Consider a detailed analysis of insertion and removal LARC rates across Hounslow borough using a combination of GP data, data from integrated sexual health services and abortion services. It may be difficult to see if there is direct relation between repeat abortion and removal of LARC but analyses by age group and time between fitting and removal may help. This is however dependent on there being available identifier information to link data sources.

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CONTRACEPTIVE USE

MAIN POINTS TO NOTE

Contraceptive usage has changed in England over the past 15 years with prescriptions of Long Acting Reversible Contraception (LARC) doubling, Emergency Hormonal Contraception (EHC) halving and user dependent contraception (condoms, pill, patch, etc.) remaining almost constant.

Between 2010/11 and 2011/12, numbers of women first contacting contraceptive services in London increased from 205,400 to 211,900. The majority are in the 25-34 age group for both years. Overall, user dependent contraception was the most common choice and this is reflected in Hounslow. In the older age groups – i.e. 25 to 24 years - women were more likely to have LARC than the younger age groups.

Rate of GP prescribed LARC has increased in Hounslow over the past 3 years. In 2009/10, this was 25.7 per 1000 registered female population aged 15-44 years. This was on a par with the London rate (25 per 1000) but lower than England’s average of 46.9 per 1000. Hounslow had the second highest rate (Hillingdon was 27 per 1000) in North West London.

In the integrated sexual health services 18% of women who were first contacts for contraceptive reasons received LARC in 2011/12, this was down from 31% in 2010/11.

In 2010/11, 20-24 year olds were the main users of EHC in England at NHS community contraceptive clinics. Contacts for EHC in the under 16s has been declining since 1997/8. There is a lack of detailed local data available for analysis on demographics of Hounslow residents accessing EHC in pharmacies and numbers of repeat users.

UPTAKE OF CONTRACEPTION

- The Sexual and Reproductive Health Activity Dataset (SRHAD) has replaced the KT31 return by the Department of Health to capture contraception and other sexual and reproductive health activities. It is intended that this with the GUMCAD (activity from GUM clinics) and GUMCAD2 (data from level 2 services including community sexual health services and/or primary care) will form the basis of a standardised sexual health dataset collected from clinical settings across England. Results by borough are not yet available.
• There was a baseline survey of contraception services for 2004/5 published by Department of Health in 2007 but Hounslow had not responded to the survey.

• Contraceptive usage has changed in the past 15 years in England. Prescriptions of LARC in the community (i.e. by pharmacies and dispensing doctors) greatly increased from 702,000 in 1997/8 to 1,304,000 in 2011/12 (Prescription Cost Analysis, NHS, 2012). In the same period oral contraceptives had a slight decrease from 7,768,000 to 7,603,000 and use if Emergency Hormonal Contraception (EHC) almost halved from 553,000 in 1997/8 to 245,000 in 2011/12.

• In 2010/11, 205,400 women had first contact with community contraceptive clinics in London. The highest number was in the 25-34 age group (75,400). 27% of this age group requested LARC and 45% requested oral contraceptive pill with another 23% requesting male condom. The 35+ age group reported the highest proportion of LARC (56%) with the proportion decreasing by decreasing age-group – 22% of 20-24, 18% of 18-19, 13% of those aged 16-17. Overall, 26% of women who had their first contact with contraceptive clinics received LARC and 42% oral contraceptive pill and 26% condoms.

• The following year (2011/12), the number of women who had first contact with community contraceptive clinics in London increased to 211,900. User dependent methods (oral contraception, condom and patch) remained the most popular choice at 71% whilst LARC was 27%. LARC was more common in those aged 25-34 years (28%) compared to 22% of those aged 20-14 and 19% of those aged 18-19 years. For under 18 year olds, user dependent methods were the most common choice – 87% of under 15 year olds and 84% of those aged 16-17 years compared to 70% of 25-24 year olds.

LARC

• The National Institute for Health and Clinical Excellence (NICE) recommended that LARC should be offered to all women as part of their contraceptive choices. LARC covers IUD, IUS, implants and DMPA injectables. Effectiveness of LARC is not dependent upon daily concordance (unlike oral contraceptives and condoms) and with IUD, less than 2 in 100 women will get pregnant, fewer than 1 in 100 for IUS, less than 0.4 per 100 for progestogen-only injection and 0.1 per 100 for implants. At one year of use, all LARC are more cost-effective than the combined oral contraceptive pill. IUDs, IUS and implant is more cost-effective than the injectable contraceptives.
In 2008/9, only 12% of women aged under 50 years were using an implant, intrauterine device/system or injection as their method of contraception compared with 25% using an oral contraceptive pill and 25% male condoms (ONS, 2009). Within 12 months, prescriptions for implants increased by 65% in volume, prescriptions for IU systems increased by 14% and IU devices by 3% (a total increase of 8% in all LARC methods).

By 2009/10, the rate of GP prescribed LARC had increased for Hounslow to 25.7 per 1000 registered female population aged 15-44 years. This was similar to London’s rate of 25 but lower than England’s rate of 46.9. Brent was lower at 20.8 as was Ealing (18.1) but Hillingdon was higher at 27.1 per 1000. Inner North West London was lower again (Westminster at 7.5, Kensington and Chelsea at 5.7 and Hammersmith & Fulham at 15.6).

Figure 11 illustrates the LARC prescribing rate per 100 women aged 15-44 in general practice in 2007/8. The purpose using this graph is simply to give an overview of LARC prescribing in London. Hounslow is roughly mid-way in terms of prescribing rates. Its neighbouring borough of Richmond is considerably higher, ranking 7th.

Figure 11
LARC prescribing rate per 100 women aged 15-44 in general practice in 2007/8 by PCT

Source: Prescription Pricing Authority, 2007/8
• Table 8 shows more up-to-date information for GP prescribed LARC per 1,000 GP registered female population 15-44 years by PCT in North West London. This table has data for the last 4 years - 2007/8, 2008/9, 2009/10 and 2010/11. Apart from a dip in 2008/9, Hounslow’s GP prescribed LARC rate has been increasing from 22.8 to 27.2 per 1000 in 2010/11. The London rate has also increased from 20.9 in 2007/8 to 27.5 in 2010/11. Hounslow’s 95% confidence intervals overlap with London’s for both 2009/10 and 2010/11 indicating that there is no significant difference between the two. However, both are lower than England’s averages which increased from 38.9 to 51.6 per 1000 in 2010/11. Hounslow’s LARC prescription is the highest in North West London for 2010/11 with Hillingdon leading on the other years but again in relation to confidence intervals, there isn’t much difference between the two boroughs. LARC rates for Westminster and Kensington & Chelsea are quite low throughout the period ranging from 5 per 1000 in 2007/8 for Kensington & Chelsea to 8.4 per 1000 for Westminster. As seen earlier, Westminster also has high repeat abortions for the under 25 and 19 years.

• There are a few issues to consider when looking at the LARC data from GP practices. Firstly, GP prescribing data is prescription-item rather than person-based. This means that it is not possible to use this data to derive an exact measure of the number of women prescribed LARC in general practice or to obtain an age breakdown of use. Secondly, women – especially younger women – may prefer to use community sexual and reproductive health services instead of GP services. Patterns of use may vary according to population characteristics and access to such services. Another issue is that women may seek removal of LARC after a short time of use and in some cases LARC may be prescribed for menorrhagia, rather than for contraceptive purposes.
### Table 8

**Rate of GP prescribed LARC per 1,000 GP registered female population 15-44 years by PCT in North West London for 2008/9 to 2010/11 compared to London and England**

<table>
<thead>
<tr>
<th>PCT Name</th>
<th>Rate 2007/8</th>
<th>95%CI</th>
<th>Rate 2008/9</th>
<th>95%CI</th>
<th>Rate 2009/10</th>
<th>95%CI</th>
<th>Rate 2010/11</th>
<th>95%CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hounslow PCT</td>
<td>22.8</td>
<td>21.49-24.1</td>
<td>21.8</td>
<td>20.6-23.16</td>
<td>25.7</td>
<td>24.3-27.1</td>
<td>27.2</td>
<td>25.8-28.6</td>
</tr>
<tr>
<td>Ealing PCT</td>
<td>17.2</td>
<td>16.31-18.2</td>
<td>17</td>
<td>16.11-17.99</td>
<td>18.1</td>
<td>17.1-19.1</td>
<td>19.4</td>
<td>18.4-20.4</td>
</tr>
<tr>
<td>Hammersmith and Fulham PCT</td>
<td>11.6</td>
<td>10.62-12.59</td>
<td>11.9</td>
<td>10.94-12.94</td>
<td>15.6</td>
<td>14.5-16.8</td>
<td>16.1</td>
<td>14.9-17.3</td>
</tr>
<tr>
<td>Harrow PCT</td>
<td>16.9</td>
<td>15.69-18.2</td>
<td>19.8</td>
<td>18.46-21.17</td>
<td>19.8</td>
<td>18.5-21.2</td>
<td>21.0</td>
<td>19.6-22.4</td>
</tr>
<tr>
<td>Hillingdon PCT</td>
<td>23.1</td>
<td>21.84-24.4</td>
<td>23.8</td>
<td>22.5-25.1</td>
<td>27.1</td>
<td>25.7-28.5</td>
<td>26.2</td>
<td>24.9-27.6</td>
</tr>
<tr>
<td>Kensington and Chelsea PCT</td>
<td>5</td>
<td>4.36-5.64</td>
<td>5.1</td>
<td>4.52-5.82</td>
<td>5.7</td>
<td>5-6.4</td>
<td>7.7</td>
<td>6.9-8.6</td>
</tr>
<tr>
<td>Westminster PCT</td>
<td>7.3</td>
<td>6.66-7.89</td>
<td>6.3</td>
<td>5.73-5.82</td>
<td>7.5</td>
<td>6.8-8.2</td>
<td>8.4</td>
<td>7.7-9.1</td>
</tr>
<tr>
<td>London SHA</td>
<td>20.9</td>
<td>---</td>
<td>22</td>
<td>---</td>
<td>25</td>
<td>24.8-25.2</td>
<td>27.5</td>
<td>27.3-27.7</td>
</tr>
<tr>
<td>England Total</td>
<td>38.9</td>
<td>---</td>
<td>41.4</td>
<td>---</td>
<td>46.9</td>
<td>---</td>
<td>51.6</td>
<td>---</td>
</tr>
</tbody>
</table>

Source: EPAC 2012

- LARC is not only provided by GPs in Hounslow. In 2011/12, 18% of first contacts (7,200 for contraception) with the integrated sexual health service wanted LARC for contraceptive reasons. This was a decrease from 2010/11 where 3,200 women first contacted the service for contraception and 31% had LARC (NHS Information Centre, 2012). In the same period, London average for uptake of LARC amongst first contacts was 27% for 2011/12 and 26% in 2010/11 – England average was 28% for both years. Hillingdon reported 37% and 32% for 2011/12 and 2010/11. These were the highest proportions for North West London with Ealing close behind with 32% in 2011/12 (and 23% in 2010/11). User dependent methods (i.e. oral contraceptives and condoms) remain the most popular choice of first-time...
users of Hounslow’s integrated sexual health services for contraception. In 2011/12, this was 81% of first time contacts for contraceptive reasons, 66% in 2010/11.

• As stated in the section on termination of pregnancy (abortion) services, removals of LARC are an area of concern to stakeholders. Service users have their LARC fitted by one service and then removed by another in a short space of time – e.g. fitted post-abortion by TOP service and then removed by sexual health services. This is particularly the case for young people.

• Another area of concern to stakeholders is that some health professionals fitting LARC have not been adequately trained. There is evidence that there is better compliance with LARC when the full service is provided – e.g. screening/counselling, procedure, follow-up and management of side effects including removal and problems.

• More needs to be done in improving uptake of LARC particularly in the younger age groups and in women vulnerable to unintended pregnancies.

• LARC does not prevent an STI. Thus ongoing promotion of condoms and less risky sexual behaviours is important.

EHC

• In 2010/11 in England, the highest number of contacts for emergency contraceptives at NHS community contraceptive clinics was in the 20-24 year old age group. In relation to the under 16, contacts for emergency contraception has decreased steadily in England since 1997/8 from 22,700 to 14,500 in 2010/11. In Hounslow in 2009/10, 12.6% of under 18 years of age using CASH chose LARC (England average was 11.3%).

• In 2010/11, 700 EHC were prescribed by Hounslow’s CASH services. This increased to 900 for 2011/12. For both years, total clinic attendances for contraceptives were 17,900 in 2010/11 and 18,400 in 2011/12 (NHS Information Centre, 2012).

• As stated earlier in the section on sexual health services, 35 pharmacies offer EHC in Hounslow with 3,280 EHC prescribed under the LES in 2011/12.
Unfortunately, analysis is confounded by lack of aggregate data on uptake in Hounslow’s pharmacies under the LES agreement. In 2011, an attempt was made to compile a dataset electronically on demographics and repeat users but due to the changes to staff in NHS, this task was not completed.

- A recurring issue of concern for stakeholders is around the provision of training for pharmacists in dispensing EHC and how the provision will be monitored as local authority takes on responsibility of sexual health.
PAN-LONDON CONDOM DISTRIBUTION SCHEME

- Retail price of condoms has been identified as a barrier to good sexual health for young people, particularly for those from lower income families and who are at greater risk of unplanned pregnancy and sexual infection. The aim of a C-Card scheme is to provide access for young people to free condoms. The C-Card enables any young person who signs up to the scheme to access free condoms at various C-Card ‘Pick up Points’ across the Borough. Under the Hounslow C-Card scheme, they were allowed a maximum of 12 condoms per week. In 2007/8, there were 21 C-Card ‘Pick up Points’ in the borough (none in primary care) with 600 registered users and 11,513 condoms distributed. Average age was 17 years and 62% of users were male. By 2010, C-Card distribution points had extended to 24 venues, including pharmacies, YMAG (maternity group for teenage parents), VISIONs, CAMHS and 2 GP surgeries in Chiswick and Feltham. However, information pertaining to uptake of the scheme dropped off due to the changes to the Teenage Pregnancy Grant in 2010.

- The Hounslow C-Card scheme ceased in 2010. In 2012, the WMUH integrated sexual health service won the tender from Early Intervention Services to run the London C-Card scheme with the PCT paying for the condoms for 2012/13. In July 2012, 123 young people had signed up for the new C-card and it is currently active in 20 outlets across Hounslow including the detached youth service and in two schools – Rivers Academy and Chiswick School. The service is also in the process of getting residential units on board. However, this scheme is only being run for 6 months. Early Intervention Services are in the process of recruiting an early intervention officer who will have responsibility for continuing this scheme and working with at risk teenagers and teenage parents.

- The Pan-London C-Card scheme had been piloted by 19 boroughs in 2010. Hounslow was not part of this scheme (though neighbouring boroughs of Brent, Harrow, Hillingdon and Richmond were) and 56 Hounslow residents registered accessing 1663 condoms from the participating boroughs. On average, 1 in 6 condoms were accessed by people outside the participating boroughs. Boroughs like Hounslow who joined after January 31st 2011, have to pay a one-off initialisation fee of £2,500 plus the annual software license of £500. Recurrent costs consist of the annual database licence fee and support/help desk which is ~£1,500 to £2,000 per borough. NHS Hounslow
agreed to pay the recurrent costs of £2000 a year from 2012 onwards. This is included in the public health grant transferring from NHS to LBH. An advantage of the Pan-London C-Card scheme is that it will enable commissioners to benchmark activity with other areas and received data on uptake by residents of their borough even when they are obtaining condoms from other boroughs. Nature of condom outlet will also be available which will help to determine which condom outlets are preferred – e.g. pharmacies, leaving care teams etc.

- Stakeholders are unanimous in their support of the C-card scheme and advocate a wider distribution including better access in primary care. However, clarity is needed on who in LA will be responsible for overseeing C-Card Scheme. With the transition of sexual health responsibilities to Local Authority, discussion is needed on whether this function will move to public health or continue under adult and children’s services.

RECOMMENDATIONS

- Continue to push uptake of LARC but target LARC more at the younger age groups particularly those at risk of unintended pregnancies (e.g. children in care, low socio-economic groups and girls in high prevalence wards, e.g. Turnham Green, Bedfont and Isleworth. This will need to be carefully balanced with messages that LARC will not prevent STIs.

- Establish ownership in LA (public health or adult and children’s services) and strategic direction for the C-card scheme including plans to extend the distribution into primary care and more widely in community pharmacy.

- Set up a means to monitor users of EHC in community pharmacy – this can be done through performance data collected as part of the LES. Investigate if previous paper copies on EHC usage can be located and imputed electronically – this would help provide a picture of usage in the past – but this move is subject to information governance and data sharing agreements.

- Set up a means to monitor differences in LARC uptake between GP practices – this could be done under the two LESs for contraceptives.
• Ensure that those providing LARC and EHC are suitability trained – this includes GP practice staff, abortion services and pharmacist.
SEXUAL DYSFUNCTION

- There is not a lot of data on sexual dysfunction for Hounslow. WMUH sexual health service doesn’t routinely collate the information, although they do see a number of male patients with sexual dysfunction.

- Whilst the literature reports a larger proportion of sexual dysfunction amongst women, they are more likely to seek help than males.

- In 2011, 433 Hounslow resident men were diagnosed in primary care as having erectile dysfunction. Of these, 59 were assessed for cardiac risk as recommended by the British Society for Sexual Medicine (BSSM) guidelines. In 2011, 1692 patients were prescribed treatment and 96 patients were recorded in primary care as having Testosterone Deficiency Syndrome.

- Sexual dysfunction in men is associated with a number of health conditions including cardiac disease and prostate cancer. For example a high proportion of men (75%) who are treated for colorectal cancer\(^\text{23}\) or urinary tract symptoms\(^\text{24}\) suffer erectile dysfunction following surgery.

- It is estimated that 34.8% of UK men and 53.8% of UK women suffer from at least one sexual problem in the previous year.\(^\text{25}\) Most common problems for men are lack of interest in sex, premature orgasm or fear of failure. About 6.2% have persistent sexual problems. There is evidence that men are less likely to seek help about sexual dysfunction than women and a study found that over 50% of men with sexual dysfunction would prefer the doctor to


initiate discussion about sexuality rather raise the issue themselves.\textsuperscript{26} Depression and sleeplessness have been found to be associated with sexual dysfunction.

- There is little published in the literature on the nature and prevalence of sexual dysfunction in people attending GPs in the UK. A cross-sectional study of 13 practices in North London found that 18\% of men and 40\% of women had a ICD-10 defined sexual dysfunction.\textsuperscript{27} The most common problems were erectile dysfunction and lack or loss of sexual desire (men and women). Being bisexual was found to be the only independent predictor for men whereas increasing age, poorer physical condition and sexual dissatisfaction were predictors of sexual dysfunction for women.

**RECOMMENDATION**

- Despite small numbers, it would be beneficial to raise awareness of the possibility of sexual dysfunction in older men amongst GPs, especially those with cardiac heart disease, urinary track symptoms and those treated for colorectal cancer.

\textsuperscript{26} Aschka et al. 2001. Sexual problems of male patients in family practice. \textit{J Family Practitioner}:50:773-778

• Sexual assault is defined as the sexual touching of a person without their consent. One in five women in England has experienced some form of sexual assault in their lifetime (British Crime Survey, 2008/9). Twenty-five percent of all reported sexual assaults and rapes in England occurred in London (Homicides, Fire Arm Offences and Intimate Violence, 2008/9). More than a third of referrals to SARC were under 19 years (MBARC, 2012. Sexual Violence in London).

• In London in 2009/10, 3.1% of women aged 16-59 reported that they had been sexually assaulted in the previous year (British Crime Survey, 2010). This was lower than the previous report of 4.2% in 2007/8. In both cases, this percentage was higher than England average (2.3% in 2009/10 and 3% in 2007/8) but not significantly different.

• Data on sexual violence, sexual assaults, sexual abuse and female genital mutilation are sparse. They are not routinely collated by health services into datasets. Anecdotal information from service providers suggest that while numbers are small, there is a growing need for support for both victims and perpetrators.

• According to the West London Rape Crisis Centre, a total of 168 sexual assaults and 83 rapes were reported for Hounslow between April 2011 and February 2012.

• In an audit of KISS clinics in Hounslow (i.e. the sexual health clinics targeted at young people), 55% of young people reported the onset of sexual activity to be under the age of 16. Much of this was attributed to rising gang initiation involving sexual activities. Three KISS clinic locations are near estates which are affected by street gangs including: Green Dragon Estate, Ivy Bridge Estate, Beavers Estate and Highfields Estate. All these estates are located in areas of high deprivation around the towns on Isleworth, Hounslow and Feltham.
Table 9 shows the police recorded rape per 100,000 women for North West London 2007-2011. Hounslow’s reported rates of rape are higher than England’s averages for each year but similar to London’s rates. As the numbers are small, the confidence intervals are large, indicating that there may be no difference between Hounslow and other North West London boroughs or London.

Table 9

Police recorded rape in women for North West London 2007 to 2011, rate per 100,000 female population

<table>
<thead>
<tr>
<th>PCT</th>
<th>Rate 2008/9</th>
<th>95%CI</th>
<th>Rate 2009/10</th>
<th>95%CI</th>
<th>Rate 2010/11</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hounslow</td>
<td>57.3</td>
<td>44.2-73</td>
<td>62.7</td>
<td>49-78.9</td>
<td>80.9</td>
<td>65.3-99.2</td>
</tr>
<tr>
<td>(N=65)</td>
<td></td>
<td>(N=72)</td>
<td></td>
<td>(N=93)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brent</td>
<td>70.1</td>
<td>56.3-86.3</td>
<td>79.4</td>
<td>64.7-96.5</td>
<td>89.6</td>
<td>73.9-107.6</td>
</tr>
<tr>
<td>(N=89)</td>
<td></td>
<td>(N=101)</td>
<td></td>
<td>(N=114)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ealing</td>
<td>36.5</td>
<td>27.6-47.4</td>
<td>48.4</td>
<td>38.1-60.7</td>
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<td>57.2-84.2</td>
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Source: APHO, 2012
• Sexual assaults and violence are included in the remit of the Violence Against Women and Girls (VAWG) Strategy Group at the local authority. This group meets quarterly.

SEXUAL ASSAULT REFERAL CENTRES

• In 2009, there were 21 Sexual Assault Referral Centres (SARCs) in England, 3 of these are based in London and a further 10 were being developed. In London, the three Haven centres – Camberwell, Paddington and Whitechapel - are commissioned to deliver sexual assault services for Hounslow’s residents. From April 1st 2012, commissioning of SARCs will move from the police to the NHS Commissioning Board. It is expected that collaborative commissioning with local police forces will continue.

• Women and Girls Network (WGN) is a pan-London organisation that was established in 1987 to support women to overcome the impact of rape and sexual assault. It is funded by the GLA and Ealing Council to deliver the West London Rape Crisis Service across 6 West London boroughs – Ealing, Hounslow, Harrow, Hammersmith & Fulham, Brent and Hillingdon. The service includes individual counselling, therapeutic group work, body therapies, Independent Sexual Violence Advocacy Service (ISVA) and outreach work to support women to exit prostitution. The latest available data for this service is for the 2011/12. As absolute numbers are reported and not rates or proportions, it is difficult to compare Hounslow with the other boroughs. In 2011/12, 23 women from Hounslow were referral to the service for counselling. The age ranged from 14 years to 54 years. 11 of the 23 women were of white ethnicity and 7 reported a disability. 19 of these cases were rape related, 10 domestic violence and 7 childhood sexual abuse. The ISVA – which supports women and girl survivors of sexual violence – had 11 referrals for Hounslow. Ethnicity varied as did age (14 to 54 years). Rape and childhood sexual abuse were the most common presenting issues. The WGN also run a helpline for 15 hours a week. There 680 callers in the last year, 85 of these were from Hounslow.

• The WGN piloted a youth independent sexual violence advocate (YISVA) for 4 months to deal with the increase in referrals from young women and girls
under 21 years old to the service. During the pilot, 22 referrals from young women across the 6 West London boroughs were received. The referrals ranged from sexual assault to multiple assailant rape and gang related sexual violence. Pilot ended in February and the caseload transferred to the ISVA.

- The WMUH integrated sexual health service have recruited a Women and Girls Network Counsellor based within the sexual health service for 0.5 a week from August supporting women over 14 years of age who have experienced sexual assault or gendered violence. The West London Rape Crisis Centre will also be relocating to the Heart of Hounslow sexual health service premises later this year.
RECOMMENDATIONS FOR MEASURES OF SUCCESS

- This section proposes some indicators and targets that could be used to help commission services to better address need.

REDUCE PREVALENCE OF SEXUALLY TRANSMITTED INFECTIONS

- Increase participation and use of condoms on the C-Card Scheme
- Continue STI testing in the community and consider the implications of primary care testing
- Monitor rates of acute STIs, mindful that initial increases may reflect increase in service use rather than prevalence

INCREASE EARLY DIAGNOSIS OF HIV

- Fewer late HIV diagnoses by increasing uptake of HIV screening including provision in abortion services and primary care
  - Original target was to reduce level of late diagnosis to 15% of 2004/5 baseline by 2011/12, this can be applied again to Hounslow’s rates
  - Reduce the 2009 Hounslow reported proportion of 51% with late diagnosis to 45% by 2015.
  - Reduce level of very late diagnosis by 15% from the 2010 level of 29% to 25% by 2015/6
- No undiagnosed antenatal patients with HIV
  - At least 98% screening levels for Hep B, HIV and syphilis
IMPROVE YOUNG PEOPLE’S SEXUAL HEALTH

- Reduce numbers of teenage conceptions from 2009 rate of 37.5 per 1000 15-17 year olds to 34 per 1000 in 2015.
- Achieve the 2400 per 100,000 Chlamydia diagnoses rate
  - Screen 25% of young people aged 15 to 24 years for Chlamydia from April 2011 to April 2012, with 2.4% positivity
- Increase provision of SRE in schools
- Review and develop a teenage pregnancy care pathway with aftercare

INCREASE USE AND CHOICE OF LARC AND CONTRACEPTIVES

- Increased access and choice to LARC in primary care
  - 10% more females of reproductive age/year prescribed LARC
- Easy access to emergency contraception
  - 90% access within 72 hours of request

ABORTIONS

- Aim to have the majority of abortions earlier than 10 weeks gestation
  - 70% abortions earlier than 10 weeks gestation, increase each year
- Reduce % of repeat abortions by all women leave services with one or more of the most effective choices of contraception
  - Decrease in % of repeat abortions in under 25 and under 19 year on year from 2011/12 levels

IMPROVE SERVICE PROVISION

- 48 hour access to GUM
• 100% (no less than 98%) offered appointment within 48 hours
• 95% seen within 48 hours

• Prevention of Hep B and HPV in MSM
  • At least 70% to receive Hep B vaccine

• Monitor levels of partner notification, testing and treatment in sexual health services

• Increase numbers of STIF trained and LARC accredited GPs and annually audit
