

Newcastle JSNA: Sexual Health (Adult) October 2008

What do we know?

Facts and Figures

- Sexually active individuals are at risk of a range of sexually transmitted infections (STI's)
- Chlamydia trachomatis is the most prevalent bacterial infection
- The highest burden of sexual ill health is borne by gay and bisexual men, young people and black and minority ethnic groups
- The following groups have been identified as requiring specific action.
 - Gay and bisexual men because of the disproportionately high levels of STI and HIV, lack of access to targeted services and experience of discrimination and social exclusion
 - Asylum seekers – a population experiencing a high degree of sexual ill health
- ❖ MESMAC (men who have sex with men – action in the community) have estimated that there are 40,900 homosexual men in the region (Northumberland, Tyne and Wear)
- ❖ Nearly 40% of homosexual men from Northumberland and Tyne and Wear reside in Newcastle. That equates to around 16,000 men.

Trends

HIV/Aids

Nationally:

- Approximately 30% of the estimated 73000 people with HIV in the UK were unaware of their infection.
- Two fifths of newly diagnosed persons with HIV probably acquire their infection in the UK. Two thirds of those were in MSM.
- A third of persons newly diagnosed with HIV in the UK were estimated to have been diagnosed late.
- The crude mortality rate among HIV-infected persons declined from 4.7% in 1997 to 0.95% in 2006.

Locally:

- ❖ In 2008 the prevalence of resident adults in Newcastle living with HIV+ was 203.
- ❖ In 2005 the number of new HIV diagnoses was 90, this has dropped to 58 in 2006 and 60 2007.

Chlamydia

Nationally:

- Chlamydia is the most commonly diagnosed bacterial STI in UK Genitourinary (GUM) clinics.
- Significant numbers of people are diagnosed outside GUM clinics.

Locally:

- ❖ The number of diagnoses made by the Chlamydia Screening Programme has been rising as the number of young people aged 15 to 24 years screened rises.
- ❖ Approximately 35-40 positive screening tests per month in 2008.
- ❖ 70% of confirmed cases of Chlamydia seen at the GUM clinic in 2004 were aged 15-24.
- ❖ The greatest numbers of cases for women are in the 16 to 24 year old age groups and in men, it is in the 20 to 34 year old age groups.
- ❖ The proportion of men who have sex with men (MSM) who have had a chlamydia diagnosis has varied between 4% to 10% in the last five years.
- ❖ The number of chlamydia diagnoses has risen over the last 10 years.

Syphilis

Nationally:

- There has been a substantial rise in syphilis diagnoses in the UK from 301 in 1997 to 3702 in 2006.
- The majority of cases were in MSM.
- Almost a quarter of cases also had HIV.

Locally:

- ❖ The annual number of cases continues to rise, with a total of 151 cases reported in 2007 compared to 136 in 2006.
- ❖ The incidence is highest in the 25 to 44 year old age groups.
- ❖ The proportion of men who are MSM who have had a syphilis diagnosis has varied between 82% to 89% in the last five years.

Gonorrhoea

Nationally:

- Number of diagnoses of gonorrhoea among MSM, along with other STIs, continued to rise.

- Transmission of gonorrhoea in heterosexuals across the UK is declining.
- Diagnoses are particularly concentrated in young adults, MSM and black ethnic minorities.
- The effective treatment of gonorrhoea has been complicated by the development of antimicrobial resistance.
- Gonorrhoea is the second most common bacterial STI in the UK.

Locally:

- ❖ Incidence is highest in males aged 20 to 34 years.
- ❖ The proportion of men who are MSM who have had a gonorrhoea diagnosis has varied between 41% to 56% in the last five years.

Genital human papillomavirus

Nationally:

- Diagnosis of genital warts in GUM clinics has increased over the last 10 years..
- Genital warts are the most common viral STI diagnosed in GUM clinics.
- The majority of HPV infections occur in heterosexuals.
- Diagnoses in MSM have shown the greatest percentage increase.

Locally:

- ❖ Infections appear to be rising.
- ❖ Greatest incidence in the 20 to 34 year old men and highest incidence 16 to 24 year old age group for women.
- ❖ The proportion of males who are MSM who have had a genital wart diagnosis has varied between 8% to 9% in the last five years.

Genital Herpes

Nationally:

- Rates of new diagnosis of first attack were 50% higher in woman than men.
- A high proportion of diagnoses are made by general practitioners.

Locally:

- ❖ Incidence has risen.
- ❖ It is higher in women, particularly in the 16 to 34 year old age group.
- ❖ The proportion of males who are MSM who have had a herpes diagnosis has varied between 4% to 9% in the last five years.

Targets

National targets

There are a number of national targets relating to sexual health. These are included in The NHS in England: The operating framework for 2008/9

Existing commitments:

- Guaranteed access to a genito-urinary medicine clinic within 48 hours of contacting a service.
- Chlamydia screening programme to be rolled out nationally.
Performance

Indicators

Genito-urinary medicine clinic

- Target: Guaranteed access to a genito-urinary medicine clinic within 48 hours of contacting a service:

Table 1: Source: Newcastle department of Genito-urinary Medicine

<i>Number Of First Attendances</i>	<i>Number Of First Attendances Seen Within 2 Normal Working Days</i>	<i>Number of first attendances whose first offer was within 2 normal working days</i>	<i>% seen within 48 hours</i>	<i>% offered appt within 48 hours</i>
613	501	613	81.7%	100.0%

Chlamydia

- ❖ In the North East there has been a 4% decrease in the annual number of cases reported at GUM clinics; 5170 cases in 2007 compared to 5369 in 2006.
- ❖ For the North East the National Chlamydia Screening Programme reported that 8633 people were screened in the North East between January and March 2008; this represents 45% increase in the number of screens carried out since the previous quarter.

Syphilis

- ❖ The North East has seen an increase in the annual number of cases reported, with 146 reported so far for 2007, compared to 124 in 2006 (Table 6). Most cases were seen at Newcastle and Middlesbrough GUM clinics (42 and 29% of all cases respectively).

HIV

- ❖ In the North East the number of new HIV diagnoses has been steadily rising since 2000, with the largest number of cases reported in 2005

(155). Since 2005, the number of new diagnoses appears to have levelled off but this trend should be interpreted with caution since numbers for recent years may still rise as more reports are received.

- ❖ Annual 2006 data from the Survey of Prevalent HIV Infection Diagnosed (SOPHID) indicates that the highest rate among individuals 16 and over was seen in Newcastle PCT (102 per 100,000).

Table 2: Offer and uptake of HIV tests at GUM clinics (source HPA)

	Q3 2006			Q3 2007		
	Offered	Tested	% uptake	Offered	Tested	% uptake
Newcastle General Hospital	3337	2865	86	3659	3050	83
North East SHA			79			77

Antenatal Infectious Disease Screening

- ❖ The latest figures (annual 2007 data) from the antenatal infection screening surveillance indicate that the lowest levels within the North East of antenatal testing (<60%) for HIV, Syphilis and Hepatitis B continue to be seen in Newcastle NHS trust.
- ❖ Newcastle had the highest prevalence of HIV (2 per 1,000 tests), Hepatitis B (4.5 per 1,000 tests) in pregnant women.

Hepatitis B vaccination uptake among MSM attending GUM clinics

- ❖ The most recent figures (combined totals for Q3 and Q4 2007) show that, of the attendees who were eligible for their first dose of hepatitis B vaccine, 90% were vaccinated with the first dose of the 3-dose course; this represents a 2% increase in coverage since the first half of 2007. For dose 3, coverage has remained unchanged, 51% in the second half of 2007 compared to 51% in the first half of 2007.

Gonorrhoea

- ❖ Newcastle, Middlesbrough and Sunderland GUM clinics all reported far fewer diagnoses in Q3 2007 than for the same quarter in 2006.

Other achievements

A recent National Support Team for Sexual Health visit praised the achievements of the Sexual Health Strategy Group service for meeting the 48 hour offered appointment target, the integration of the Contraception and Sexual Health (CASH), the University sexual health outreach service and GUM services and the chlamydia screening programme. Areas for strengthening included looking at the uptake of offered appointments and increasing commissioning capacity.

The establishment, in partnership with MESMAC and the Terence Higgins Trust, of a HIV 'Fastest' service within a city centre community setting. Specifically targeted at homosexual and bisexual men (although attracts others) and provides test results while the patient waits. It has proved to be very popular and was awarded the Newcastle PCT good practice award (under partnership working) for 2007.

Local Views

- ❖ Consultation was undertaken by the Community Action on Health (CAH) Team, on behalf of the Wellbeing and Health Partnership Board, in August 2006 about working with the voluntary and community sector to develop a Health Improvement Strategy for Newcastle.

At the workshops priorities for improving the health of Newcastle were identified. Within the top 10 was: 'More effective sex education throughout every level of school and life.'

Other commonly mentioned sexual health outcomes included:

Table 3: Local Consultation - Issues Identified

<i>Outcome</i>	<i>Number of votes by participants</i>
More holistic approach to sexual health and relationship education, including self esteem, assertiveness, confidence building	8
GUM services to be delivered in more places within the community, across the city	5
School health advisors in secondary schools	5

National and local strategies

National Policy

Better Prevention, Better Services, Better Sexual Health - The national strategy for sexual health and HIV (2001) set out to:

- provide clear information so that people can take informed decisions about preventing STIs, including HIV

- ensure there is a sound evidence base for effective local HIV/STI prevention
- set a target to reduce the number of newly acquired HIV infections
- develop managed networks for HIV and sexual health services, with a broader role for those working in primary care settings and with providers collaborating to plan services jointly so that they deliver a more comprehensive service to patients
- evaluate the benefits of more integrated sexual health services, including pilots of one-stop clinics, primary care youth services and primary care teams with a special interest in sexual health
- begin a programme of screening for Chlamydia for targeted groups in 2002
- stress the importance of open access to GUM services and, over time, improving access for urgent appointments
- ensure a range of contraceptive services are provided for those that need them
- address the disparities that exist in abortion services across the country
- increase the offer of testing for HIV and setting a target to reduce the number of undiagnosed infections, thereby ensuring earlier access to treatment for those infected and limiting further transmission of the virus
- increase the offer of hepatitis B vaccine
- set standards for the treatment of STIs and for the treatment, support and social care of people living with HIV
- setting priorities for future research to improve the evidence base of good practice in sexual health and HIV
- address the training and development needs of the workforce across the whole range of sexual health and HIV services

Our Health, Our Care, Our Say (2006) sets out the Government's vision of more effective health and social care services outside hospitals. To deliver this, it identifies five clear areas for change: more personalised care, services closer to people's homes, better co-ordination with local councils, increased patient choice and a focus on prevention as much as cure. It states that communities require targeted, innovative and culturally sensitive responses to service development and provision. This is to be achieved through consultation and pushing decision-making and services closer to people's homes. To achieve this there is acknowledgment that work must be done in breaking down organisational barriers to provide relevant services on the ground and that it is important to align resources and planning with Local Area Agreements.

Key areas relevant to sexual health include:

- developing an NHS 'Life Check' starting in Primary Care Trust (PCT) spearhead areas
- further roll out of health trainers

In the recent High Quality Care for All (Darzi) Review, the immediate steps identified relating to sexual health include:

- Wellbeing and prevention work focused on six key goals: tackling obesity, reducing alcohol harm, treating drug addiction, reducing smoking rates, improving sexual health and improving mental health. There is a recognized need to scale up prevention work to 'an industrial scale'.
- New GP led health centres with more convenient opening hours, with access to a much broader range of services such as diagnostic, mental health, sexual health, social care and healthy living services to match the needs of their communities

The national strategy for sexual health and HIV and Choosing Health White Paper are set against a national background of an increased prevalence in STIs, a rise in the number of newly diagnosed HIV infections and an increase in the number of visits to GUM services. The local and national pictures are very similar.

The publication of Choosing Health: Making Healthy Choices Easier (White Paper for Public Health, Dept of Health; November 2004) lays the foundations of effective sexual health initiatives for the next 10 years. Delivering this agenda requires sustained work; the publication outlines some of the key tasks for improving Sexual Health at national level:

Sexual Health Clinical Services

- Capital and revenue funding to modernize Sexual Health services
- Accelerated programme for Chlamydia screening
- One year contraceptive review supported by central investment
- 48 hour access target for GUM

The Sexual Health Strategy Group in Newcastle had operated since 1999, overseeing a range of initiatives in the city. In January 2005 the group was reconfigured to lead the development of an integrated local sexual health strategy. The group consists of health professionals across the NHS system as well as representatives from the local authority, community and voluntary sectors.

The Newcastle Sexual Health Strategy (the strategy) builds on previous work and uses recent best practice advice and evidence to inform its proposals to:

- ❖ Enhance sexual well-being
- ❖ Control the rising incidence of Sexually Transmitted Infections (STI's), including HIV
- ❖ Meet the needs of 'at risk' or 'hard to reach' groups

- ❖ Improve service integration and access.

Underpinning each of these aspirations is a commitment to tackle health inequalities by targeting the most vulnerable groups in Newcastle.

The Sexual Health Strategy Group has

- ❖ Conducted an analysis of need for Sexual Health services based on prevalence data
- ❖ Mapped all existing Sexual Health services in the city
- ❖ Undertaken a training needs assessment with Primary Care practitioners in the city with respect to Sexual Health

The Sexual Health Strategy Group has identified a vision for services in Newcastle that can be summarised as: Easily accessible services spread equitably across the city, that are:

- ❖ Delivered in well designed facilities that meet patients needs and wishes
- ❖ Integrated across service providers where appropriate
- ❖ Underpinned by evidence of effectiveness
- ❖ Available to everyone – with specific marketing and service provision for hard to reach and vulnerable groups
- ❖ Focused on sexual health promotion and the prevention of STI transmission as well as treatments

Current Activity and Services

The Newcastle Sexual Health Strategy Group has undertaken a series of initiatives to underpin the development of the city wide strategy. In particular:

- ❖ Epidemiological analysis of STIs in Newcastle – giving an up to date sexual health population profile for the city
- ❖ A comprehensive service mapping exercise that evaluates the capacity of each service to meet demand.

In the 2008/09 NHS North of Tyne Annual Operating Plan, sexual health is recognised as a priority with:

- ❖ Reconfiguration of contraceptive services to increase access and uptake by young people
- ❖ Implementation of a sexual health tiered model of service provision

Newcastle's 10 year Health Improvement Strategy has a sexual health vision that 'all people, even those living in difficult circumstances, will be highly knowledgeable about their sexual health, and be confident about how to manage their relationships'. It recommends that

- ❖ the uptake of Chlamydia screening is increased in line with local and national targets
- ❖ GUM services reach the target of 100% patient offered appointment within 48 hours in 2008

‘What is this telling us’?

What are the key inequalities?

Teenage Pregnancy

Many health inequalities are displayed particularly strongly amongst teenage mothers.

See also the summary for [Teenage Pregnancy]

Other Sexual Health

- The highest burden of disease is borne by women, gay men, teenagers, young adults and black and ethnic minorities
- Higher rates of HIV and syphilis in more deprived areas
- Lower coverage for cervical screening and breast cancer screening in poorer areas
- Higher rates of sexual assaults against women in more deprived areas
- The rates of gonorrhoea in some inner city black and minority ethnic groups are ten or eleven times higher than in whites.
- HIV infection also has an unequal impact on some ethnic and other minority groups
- Britain’s African communities have been particularly badly affected by HIV/AIDS, with high rates among both adults and children
- There is some evidence to suggest that chlamydia infection rates are associated with levels of deprivation

What are the key gaps in knowledge / services?

Knowledge

There are gaps in knowledge about the number and prevalence of sexually transmitted diseases in Newcastle. The incidence of sexually transmitted disease is continuing to rise.

Syphilis

It is thought that syphilis figures recorded by the GUM service in Newcastle are an underestimate, due to the uncertainty in the duration of infections.

Partner notification remains extremely difficult as most cases are acquired in association with multiple anonymous contacts with unprotected oral sex a prominent factor. It is suspected that the service will continue to see an increased number of new cases for several more years.

Contact tracing remains difficult, particularly in MSM. Overall, less than a quarter of all reported sexual contacts are theoretically traceable.

Chlamydia

The prevalence of chlamydial infection diagnosed in GUM in those having sexual health screening (with or without HIV testing) is 14.3% in men and 9.9% in women. Compared to 2006 using similar data the prevalence in men was 12.9% and in women 12.2%. This may explain the relative decrease in non-chlamydial, non-gonococcal genital infection in men and also reinforces the importance of GUM in the sexual health of men, who are less well accessed by the screening programme.

Ano-genital herpes

Diagnosis can only be made if supported by viral detection. Therefore there maybe an underestimation of infection if people present late or already taking antiviral treatment prescribed elsewhere. Therefore further work is required to ensure accurate capture.

Contraceptive Funding

There is a lack of accurate up to date information in relation to Long Acting Reversible Contraception activity in Primary Care and such information would be very useful to both providers and commissioners in terms of identifying gaps and targeting future resource.

Services:

Contraceptive & Sexual health (CASH)

- Some services are not well attended
- Insufficient staff in some services
- East and North of City don't have services
- Chlamydia testing accessible to males not females
- Sex workers do not access CASH services
- IT capacity is an issue, most services are unable to collect data electronically

Genito-urinary Medicine

- Services are not open after office hours
- Website is not accessible
- A reduction in staff numbers has put pressures on the sexual health advising service

MESMAC

- Service is not fully funded on permanent basis, it is decided annually
- Commercial sector not signed up to sexual health work
- Gay scene becoming less open and responsible
- Need to increase capacity for outreach work

- Further development of staff as a training resource
- Free condoms and lube + condom packs required
- Further leaflet resource required
- Provide a community - as part of HIV treatment and care pathway resource for testing to improve access for harder to reach groups
- Better regional coordination for campaigns

Sexual Health Strategy

- Review required
- Requires Action Plan to pull together the resources that are required to meet priorities
- Sexual health strategy group needs to meet to coordinate services across organisations/sector
- There is not a project/network coordinator allowing for the effective communication between forums, provide performance management and expertise on commissioning and operational matters

What are the risks of not delivering our targets?

If there is not the investment in sexual health services, the underlying causes of poor sexual health are likely to remain the same. There are particular groups whose life circumstances and/or lifestyle put them at particular risk of poor sexual health. These include:

- People living in deprived areas
- Homeless populations
- Men who have sex with men
- Sex workers
- Asylum seeking populations

Is what we are doing working?

Sexually Transmitted Diseases and Health Promotion/STI Prevention

GUM Services: Health advisers undertook a total of 2,534 first episode initial interviews during 2007, (2,418 in 2005 and 2,509 in 2006 respectively) and 461 second visit/episode interviews. 2,066 interviews were undertaken relating to STIs and partner notification issues, (2,101 in 2005 and 2,184 in 2006 respectively).

Syphilis: The annual number of cases continues to rise, with a total of 151 cases reported in 2007 compared to 136 in 2006. The majority being within the homosexual community. As contact tracing remains difficult it is expected that this number will continue to rise. Recent Health Advisor staff shortages may

have contributed to this rise due to a reduction in health promotion and partner notification.

HIV: There has been a large increase in service demand during 2007 although there have been small falls in the proportion of those accepting HIV testing across both genders and sexuality. The GUM figures are above the Department of Health target for 2007 of 60% accepting an HIV test.

Gonorrhoea: There has been a decline in the number of cases for 2007 (down 15.7%). The reduction cannot be totally attributed to the local Newcastle service, national rates have also declined.

Chlamydia: The prevalence of Chlamydia infection in those having sexual health screening is 14.3% in men and 9.9% in women. Compared to 2006 using similar data the prevalence in men was 12.9% and in women 12.2%. This would indicate the screening service having a positive detection effect on women rather than men. This could be explained by women being more acceptable of the screening process.

What is coming on the horizon?

The following demographic changes may have an impact on the requirements of the sexual health service in Newcastle:

Population increase and Sexually Transmitted Diseases

The population of Newcastle is set to increase in the next five years. In contrast to other areas of the country the North East is expected to see an increase in the 16-24 age group.

The HPA has also reported a 6% increase in the total number of new STIs diagnosed in 2007 compared to 2006. Across all age groups almost 400,000 (397,990) new STIs were diagnosed in UK genitourinary medicine (GUM) clinics in 2007 – an increase from 375,843 in 2006.

Sexual Health Screening programmes in 2007 saw a 10% increase compared to 2006, it is expected that this trend will continue. Chlamydia screening programmes are aiming to screen all sexually active young people annually and every time they change their sexual partner. Chlamydia remains the most common sexually transmitted infection.

In addition there has been a 20% and 7% increase in Herpes and Genital wart diagnoses, respectively, in 2007. This trend is also likely to continue.

What should we be doing next?

1. The PCT should ensure better integration of behavioural interventions in the community with clinical GUM and HIV services
2. Priority to supporting ways of addressing increasing problem of heterosexual HIV transmission, which disproportionately affects black ethnic minorities
3. Opt out policy for HIV testing for every visit to all GUM attendees at every attendance
4. Provision of specialist Public Health Sexual Health nurses who would establish innovative domiciliary services targeted at those in greatest need e.g. post delivery & termination, offenders, BME groups, travellers and homeless people
5. Improve communication around sexual health, e.g. SHA wide media campaign about basic sexual health messages and piloting text messaging service to include reminders and health promotion/ advertising messages.

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