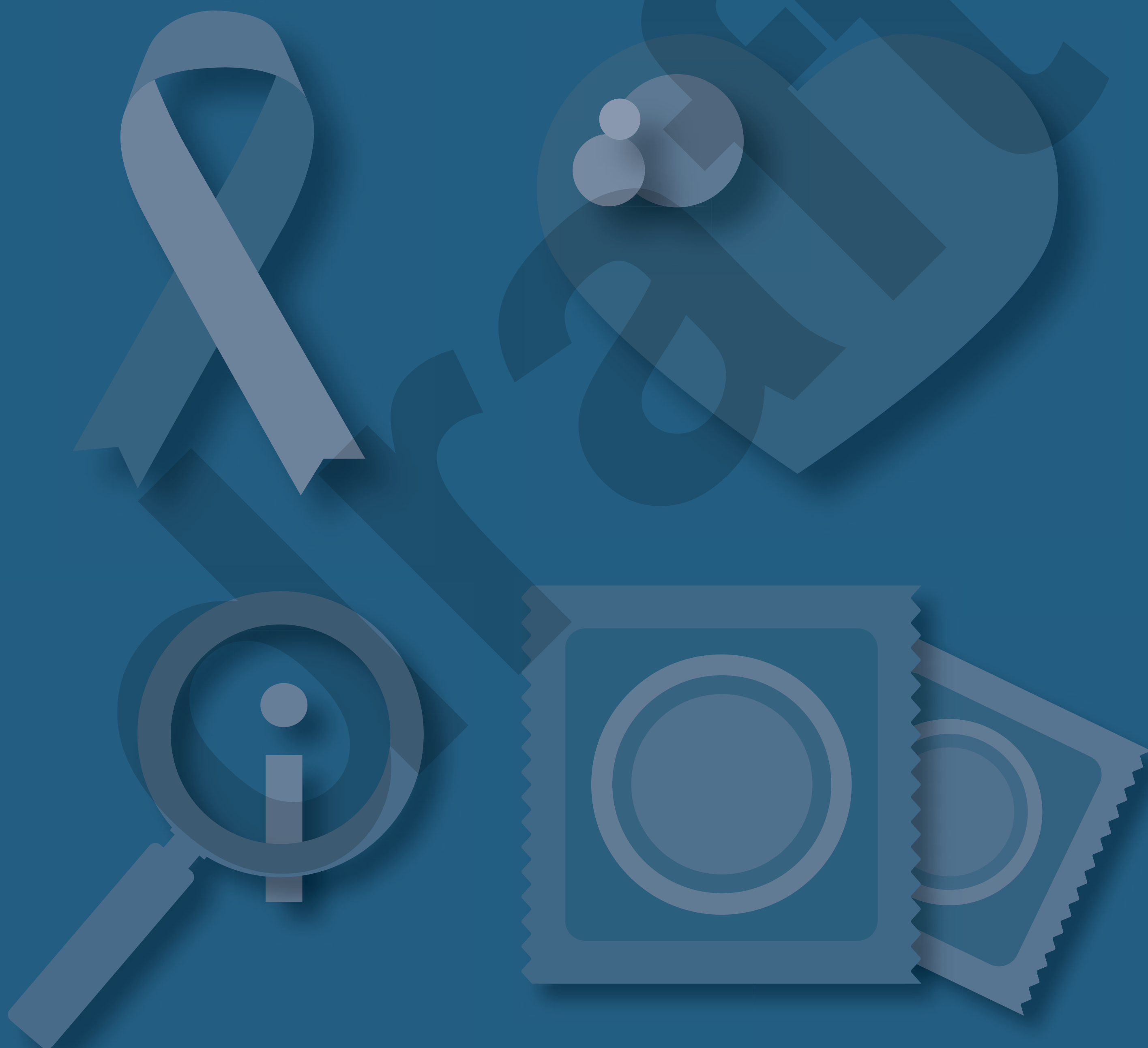
Richmond Sexual Health Strategy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2019 - 2024

LONDON BOROUGH OF RICHMOND UPON THAMES

Contents

Foreword 1

Executive Summary 2

Glossary 4

1 Introduction 5

1.1 Why is sexual health important to public health? 5

1.2 What is the purpose and scope of the strategy 6

1.3 National context 6

1.4 Regional and local context 8

2 How did we develop this strategy? 9

3 What are our principles? 10

4 What are the main sexual health issues in Richmond? 11

5 What are our priorities? 12

5.1 **Priority 1** Reduce STI rates with targeted interventions for at-risk groups 12

5.2 **Priority 2** Reduce unintended pregnancies 15

5.3 **Priority 3** Continue to reduce under 18 conceptions 17

5.4 **Priority 4** Work towards eliminating late diagnosis and onward transmission of HIV 20

5.5 **Priority 5** Promote healthy sexual behaviour and reduce risky behaviour 22

6 How will this strategy be delivered? 25

6.1 Our Governance 25

6.2 Action Plan 25

7 References 27

8 Acknowledgements 30

draft

Foreward

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Executive Summary

The 2019 - 2024 Sexual Health Strategy sets out the London Borough of Richmond-upon-Thames and NHS Richmond Clinical Commissioning Group's priorities and approach to improving sexual health locally. Poor sexual health can negatively affect the health and wellbeing of individuals and impacts on society as a whole. The effects of this are widespread and, for those directly affected, are compounded by stigma and fear.

Poor sexual health is concentrated in vulnerable population groups, such as young people, men who have sex with men (MSM) and people from black and minority ethnic populations (BME), further marginalising these groups and perpetuating existing substantial health inequalities.

This strategy identifies actions to be taken locally to improve sexual health outcomes, reduce inequalities and promote good sexual health in Richmond. It focuses on actions relating to prevention, awareness, inequalities and primary care commissioning.

This strategy was informed by a rapid Sexual Health Needs Assessment (SHNA) undertaken in 2018. This provides an overview of sexual health in Richmond and an outline of current sexual health services. Generally, sexual health need in Richmond is relatively low compared with other boroughs in London; overall it is quite similar to national levels. However, there are specific outcomes where efforts need to be focused. Richmond has the highest rate of risky behaviour among young people in London (e.g. alcohol and drug use), which in turn can influence risky sexual behaviour. Furthermore, despite a low teenage conception rate, most teenage conceptions in Richmond end in abortion, indicating that there are unmet needs regarding contraception. Richmond also has a lower percentage of women using long-acting reversible contraception compared with the England average, with the largest number of abortions in the 35 and above age group, indicating that more needs to be done to ensure adequate education and access to contraceptives.

From our engagement with young people, as part of the development of this strategy, they reported that lesbian, gay, bisexual, transgender, questioning and intersex (LGBTQI) issues are not included in relationships and sex education (RSE) and many were either unaware of schemes such as Come Correct C-Card Programme (the London-wide condom distribution scheme) or found them difficult to access due to the required registration process.

Stakeholder engagement has been vital to the development of this strategy and the associated action plan. A broad range of partners was involved including public health, sexual health commissioners, children's services, school nursing, Youth Council, service providers, and the voluntary sector. Through the workshops and surveys, the strategic priorities were agreed, and the associated actions were developed. The strategic priorities were based on the findings of the SHNA and are also in line with the National Framework for Sexual Health Improvement. A public consultation was also carried out on the draft strategy.

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The five strategic priorities are:

- **Priority 1:** Reduce STI rates with targeted interventions for at-risk groups
- **Priority 2:** Reduce unintended pregnancies
- **Priority 3:** Continue to reduce under 18 conceptions
- **Priority 4:** Work towards eliminating late diagnosis and onward transmission of HIV
- **Priority 5:** Promote healthy sexual behaviour and reduce risky behaviour

Through the five priorities, the strategy aims to improve the sexual health of the whole population, but it has been designed to have the greatest impact on vulnerable population groups, who are disproportionately experiencing health inequalities.

To achieve this, an action plan has been developed, with seven high-level action areas to be taken forward over the next five years:

- Ensure accessible sexual health services for all
- Increase sexual health knowledge across the whole population
- Improve partnership working across the sexual health system, including communication and understanding of everybody's role
- All professionals working within the sexual health system receive appropriate ongoing training
- Increase sexual health knowledge among young people and improve understanding of sexual behaviour
- Improve awareness of sexual health services amongst residents including young people and other vulnerable groups
- Ensure accessible sexual health services that meet the needs of at-risk groups

The local Steering Committee on Sexual Health will hold responsibility and oversee the implementation of the strategy through the delivery of the action plan.

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Glossary

Glossary

A&E	Accident and Emergency
AIDS	Acquired immunodeficiency syndrome
BME	Black and minority ethnic
CCG	Clinical Commissioning Group
CLCH	Central London Community Healthcare Trust
DoH	Department of Health
EINA	Equality Impact Needs Assessment
EHC	Emergency hormonal contraception
GPs	General Practitioners
HIV	Human immunodeficiency virus
IUD	Intrauterine device
LA	Local Authority
LARC	Long acting reversible contraception
LBRuT	London Borough of Richmond upon Thames
LBWSW	Lesbian and bisexual women
LGBTQI	Lesbian, gay, bisexual, transgender, questioning and intersex
LSHTP	London Sexual Health Transformation Programme
MECC	Making every contact count
MSM	Men who have sex with men
NHS	National Health Service
NHSE	National Health Service England
NICE	National Institute for Health and Care Excellence
PHE	Public Health England
PrEP	Pre-Exposure Prophylactic
RSE	Relationships and sex education, the new name for SRE
SARCs	Sexual assault referral centres
SHNA	Sexual Health Needs Assessment
SRE	Sex and relationship education
STIs	Sexually Transmitted Infections
UDM	user dependent contraceptive methods
WHO	World Health Organisation
WSW	Women who have sex with women

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1 Introduction

1.1 Why is sexual health important to public health?

Sexual health is an important area of public health as it affects many facets of life and is an integral part of overall health and wellbeing. This is captured in the World Health Organisation's (WHO) working definition of sexual health.

Sexual health is a state of physical, emotional, mental and social wellbeing in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and 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 protected, respected and fulfilled. WHO, 2006

Sexual health is a broad issue which encompasses prevention (e.g. health promotion, RSE and campaigns) awareness and services around contraception, relationships, psychosexual counselling, STI prevention, testing, and treatment and abortion. Provision of sexual health services is complex and there is a wide range of providers, including specialist clinical services, general practice (GPs), community pharmacies, the voluntary sector as well as some services in schools and youth services. Access to sexual health information, support and services are critical to enable everyone to pursue safer, healthy sexual activity whilst avoiding unintended pregnancy and STIs.

Poor sexual health can negatively affect individuals and society; STIs and unintended pregnancies can have long-lasting impacts on people and the local health and social care economy. Onward transmission of STIs and unintended pregnancies can be prevented through safer sex practices such as the use of contraception and regular testing and screening.

All age groups and individuals are affected in different ways at different stages of life by sexual health. There is also considerable geographical variability in sexual health outcomes. Nationally, there are higher rates of STIs, teenage pregnancy and abortions in deprived areas compared with more affluent areas. The risk of poor sexual health also varies by specific population groups. The highest burden is borne by young people, BME groups, and MSM. These at-risk groups may also face stigma and discrimination, which can impact their ability or willingness to access sexual health services, perpetuating existing substantial health inequalities. The burden of sexual health will be explored further under the priorities in section 5 on page 12.

Poor sexual health can also result in substantial costs to society across health, housing, education and social care. It has been estimated that for every £1 spent on sexual health services, £86 could be saved across the system in the future (Lucas, 2015). It has been estimated that for every £1 spent on contraception, a saving of £12.50 is made through reduced health care costs (Lucas, 2013).

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1.2 Purpose and scope of the strategy

This sexual health strategy provides the broad direction for improving sexual health outcomes locally, reducing inequalities, and promoting good sexual health. It focuses on prevention, awareness, inequalities and primary care commissioning.

Given that the local specialist sexual health services were recommissioned in October 2017, in line with the London Sexual Health Transformation Programme (LSHTP), this strategy will not provide commissioning recommendations on the specialist, clinical sexual health service, but does refer to access and partnership elements. The scope of this strategy includes all sexual health services and interventions commissioned by the Local Authority (LA) and some of those commissioned by the Clinical Commissioning Group (CCG).

The strategy will not provide commissioning recommendations on abortion services (which are commissioned by the CCG) as they have been recently recommissioned. In addition, female genital mutilation (FGM) and sexual violence, whilst part of sexual health and wellbeing are separate issues in terms of commissioning, strategic responsibility and service delivery are not within scope. However, the strategy does refer to access and partnership elements. Sexual health services commissioned by NHS England (NHSE) are not included within the scope of this strategy.

This strategy is jointly being produced Richmond upon Thames (LBRuT) and Richmond CCG.

1.3 The national context

Multiple stakeholders are involved in the commissioning of sexual health services. Sexual health commissioning responsibilities are split between Local Authority, CCG, and NHS England (PHE, 2017i):

- LA is responsible for commissioning comprehensive sexual health services including most contraceptive services, and sexually transmitted infections screening including HIV (human immunodeficiency virus), STI treatment (excluding HIV) and sexual aspects of psychosexual counselling. Through commissioning responsibilities for school nursing and youth services held within the LA, additional provision also exists.
- CCGs are responsible for commissioning abortion services, sterilisation and vasectomy and non-sexual aspects of psychosexual counselling. They are also instrumental in maintaining the infrastructure of primary care and providing direct lines of communication with GPs and pharmacies.
- NHSE is responsible for commissioning HIV treatment, contraception provided under the core GP contract, sexual assault referral centres (SARC), and cervical screening services.

Across England, public sector services have been under financial pressure in recent years. There have been major reductions recently to the Public Health budget, with a 6.7% reduction during 2015/2016, with further reductions planned up to 2020/21 (King's Fund, 2017). There have been new innovations in sexual health which both improve access and help to achieve better value for money (see section 1.4 for further detail).

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In the last 5 years, the government has published a range of guidance for sexual health improvement, maintaining the commitment to this agenda. The first of these, from the Department of Health titled "A Framework for Sexual Health Improvement in England", prioritises prevention of poor sexual health, outlines steps towards reducing sexual health inequalities and identifies priority areas for sexual health improvement (DoH, 2013). The priorities identified in this document provide the basis of this strategy. The second document, "Commissioning Sexual Health Services and Interventions - Best practice guidance for local authorities", supports local authorities to commission sexual health services locally by providing guidance and best practice (DoH, 2013i).

More recently, Public Health England (PHE) published the National Teenage Pregnancy Prevention Framework (PHE, 2018), which aims to prevent unintended pregnancies and support young people to develop healthy relationships. It helps local areas assess what is working, identify any gaps and ensure a multi-agency approach is being taken to strengthen the prevention pathway. PHE also published guidance on reproductive health and pregnancy planning (PHE, 2018), which focuses on an integrated approach to pregnancy planning and reproductive health, where preconception health and contraception are two sides of the same coin. This approach ensures that individuals are healthier at an earlier stage in preparation for a planned pregnancy and avoid unintended pregnancies.

PHE has also published a document providing an overview of the evidence of health inequalities affecting lesbian, bisexual women and women who have sex with women (WSW) and highlights a range of opportunities for action to improve their health and reduce inequalities (Varney & Newton, 2018). This is the first formal Government publication referring to this vulnerable group. The Government Equalities Office published a LGBT Action Plan (2018), highlighting the difficulties faced by this vulnerable group when accessing healthcare services, and that health outcomes are generally worse for this group compared with the rest of the population. In response, a National Advisor will focus on reducing the health inequalities faced by the LGBT community and aims to improve healthcare received by those identifying as LGBT.

As part of PHE's health promotion for sexual and reproductive health and HIV strategic action plan, 2016 to 2019, PHE has supported a number of national campaigns to promote healthy sexual health. For example, "Protect Against STIs", a nationwide digital advertising campaign that aimed to reduce STIs among young people through condom usage was launched at the end of 2017. It included real people discussing their own experiences of having an STI (PHE, 2017ii).

Significant responsibilities will soon exist for all schools in England, from September 2020 including primary, secondary, academy, state-maintained, free and private schools, to teach relationships and sex education (RSE) following amendments made to the Children and Social Work Bill (Department of Education, 2017). The DfE will provide guidance following public consultation and the involvement of young people and parents will remain able to remove their child from lessons.

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Currently, only students attending a secondary school funded directly by an LA, which represents approximately one-third of secondary schools, are guaranteed to be taught RSE (Department of Education, 2017), although schools have flexibility over how they teach this subject. Academies receive their funding directly from central government and have greater freedom in how they operate, including their curriculum. Locally, a new RSE task and finish group (with young people's participation) has been set up to support the development of the new curriculum.

1.4 The regional and local context

In recent years, the sexual health commissioning landscape and financial context have changed significantly. In response to this, LAs across London have been working proactively in partnership, under the LSHTP (now known as Sexual Health London, to significantly reshape sexual health services in London, to improve access, help to contain increasing demand and achieve better value for money. The integrated sexual health services in Richmond have been recently re-commissioned in-line with both the previous sexual health strategy and the model agreed by the LSHTP. This has included a new service specification designed by the clinical advisory group, and a new tariff for sexual health services to meet increasing demand in a financially sustainable way. As part of the London programme, a new innovative e-service which enables self-management for non-complex cases has been introduced.

To reduce the rate of new HIV infections and eliminate the stigma associated with HIV, London has joined the Fast-Track Cities initiative, which aims to end new HIV infections by 2030 (Mayor of London, 2018). London's HIV response also includes 'Do It London', which is a London-wide prevention campaign promoting HIV testing and other positive approaches to improving sexual health, launched in 2015 and funded by LAs.

The Pre-Exposure Prophylactic (PrEP) Impact Trial is offered to Richmond residents via sexual health services. PrEP is a drug used to reduce the risk of HIV infection for people who do not have HIV but are at substantial risk of acquiring it. The PrEP Impact Trial aims to add to the existing evidence base by gathering sufficient data to ascertain the eligibility, uptake and length of use of PrEP to inform commissioners on how to support clinical and cost-effective PrEP access in the future.

The Richmond Sexual Health Strategy links to a range of other areas of work locally. The borough's Joint Health and Wellbeing Strategy (2017) focuses on prevention and partnership working, and the Children and Young People's Plan (2017) includes keeping children and young people safe and healthy. This strategy also links to the Risky Behaviour Services Review undertaken in 2018. Public health will also be leading a strategic overview of the role of schools in health and wellbeing during 2018-19 "and the refresh of the substance misuse strategy. This strategy also links to the ongoing strategic work to tackle and prevent child sexual exploitation.

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2 How did we develop this strategy?

This strategy was informed by a rapid SHNA undertaken in 2018. This provides an overview of sexual health in Richmond and an outline of current sexual health services. It reviews local needs, national policy and evidence of what works to improve sexual health for the population.

The SHNA used information from services, demographic data, data from the Richmond JSNA, publicly available data and to identify key needs, gaps and priorities for sexual health improvement in Richmond.

Given the broad range of organisations involved and complex commissioning and services environment, stakeholder engagement has been vital to the development of this strategy and the associated action plan.

Stakeholder and community engagement were carried out in the following ways:

- **Engagement with current providers and partners** took place as part of normal business, through contract management meetings and discussions at the local Steering Committee on Sexual Health in the preceding months.
- **A workshop with key stakeholders** was held in June 2018 to agree on the strategic priorities and develop the actions for the action plan. A range of partners was invited including public health, commissioners, children's services, school nursing, staff from the Youth Council, service providers and the voluntary sector. 36 people attended the workshop from 20 organisations.
- **Surveys were distributed to key clinical services in June 2018** including GPs, community pharmacists, and school nurses, to gain input on the strategy and priorities from all front-line staff. 21 GPs and pharmacists participated in the primary care survey, and 8 school nurses participated in the school nursing survey.
- **Youth participation workshops** were held with both Richmond Youth Council and Children in Care Council in June 2018 to gain their views on the strategic priorities and actions. There were 10 young people participated in the Richmond Youth Council workshop, and 8 young people participated in the Children in Care Council workshop.
- **A public consultation** was carried out in September 2018 on the draft strategy, and the draft version of the strategy was published on the local authority's consultation website.

At every stage, feedback was taken on board and the strategy and the action plan were amended. The strategy and action plan were discussed and signed off by the Richmond Cabinet and CCG Governing Board in February 2019.

In addition to the above, an Equality Impact Needs Assessment (EINA) was completed in line with corporate council requirements, to assess the impact of this strategy on the 9 protected characteristics laid out in the Equality Act (2010).

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3 What are the principles?

Our approach to improving sexual health and the development of this strategy and action plan is guided by a set of core principles:

- **Reducing inequalities:** Specific population groups are disproportionately affected by poor sexual health. This highlights the importance of targeting work to reach those groups to remove the barriers they face when attempting to access information and services.
- **Effective partnership working:** Sexual health services are commissioned and delivered across a number of organisations, including both specialist and non-specialist services. Effective partnership working is imperative to ensure a whole systems approach to improve sexual health outcomes for local residents and patients.
- **Focusing on prevention:** Prevention work underpins public health and aims to help people make informed healthy choices, reduce the long-term costs and help maintain sustainable services. Given the current financial environment, alongside the prevention focus for the NHS through the vision from the Five Year Forward View (2014), this is a key principle to ensure value-for-money whilst improving sexual health outcomes.
- **Making Every Contact Count (MECC):** Training frontline workers in line with MECC principles, enabling them to have healthy conversations with the general public, opportunistically promote health where appropriate, and signpost to services and activities that support sexual health.
- **Reduce stigma and discrimination:** Encourage open conversations about sexual health and promote a culture that is inclusive, providing sexual health education and advice that is free from discrimination or stigma.
- **Addressing the wider determinants of sexual health:** Ensure that strong links are made to the wider determinants of health, e.g. alcohol and drug misuse, mental health, enabling joined-up working and improving health outcomes.

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4 What are the main sexual health issues in Richmond?

Although sexual health need in Richmond is relatively low compared with other boroughs in London, overall it is quite similar to national levels. However, the burden of sexual ill health is disproportionate across the population, with vulnerable groups experiencing worse sexual health outcomes.

Young people are the largest group diagnosed with a new STI. The black population experience a significantly higher proportion of STI diagnoses compared with the proportion of the population from ethnic groups. STI diagnosis is increasing amongst MSM. Moreover, Richmond is classed as a high prevalence area for HIV prevalence.

Richmond young people are estimated to have the highest rate of risky behaviour (including smoking, drinking and drug taking) in London. These risk-taking behaviours can also play a role in influencing risky sexual behaviour.

Although the teenage conception rate in Richmond is low compared with the national average, the majority of teenage conceptions end in abortion, indicating unmet needs around contraception. Research has shown that there is a link between affluence and teenage abortion rate. Teenagers from more affluent areas are less likely to become pregnant, but if they do become pregnant, they are more likely to have an abortion (Lee et al, 2004).

In Richmond, a lower percentage of women use LARC, which is the most effective form of contraception, compared with the England average. Furthermore, although the abortion rate in Richmond is similar to England, the largest number of abortions occurred in the 35+ age group. Women in this age group may be underestimating their fertility levels and not using contraception, which increases the risk of unplanned pregnancies and results in high levels of unplanned pregnancies.

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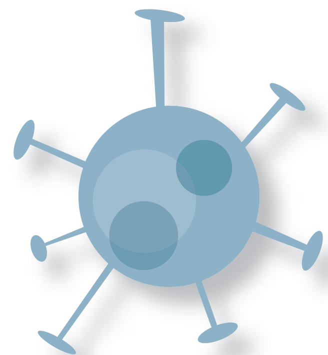
5 What are the priorities?

5.1 Priority 1

Reduce STI rates with targeted interventions for at-risk groups

Why is this a priority?

- Socio-economic deprivation is a known determinant of poor sexual health and inequalities; the impact of STIs on physical and mental health can have wider social and economic effects (DoH, 2013). Due to the small size of the Richmond population there is no clear association.
- In 2016, 1,309 Richmond residents were diagnosed with a new STI representing a rate of 672 per 100,000 residents, similar to the England rate.
- Genital warts are a common STI. In Richmond, 265 residents were diagnosed with genital warts in 2016. This is significantly higher than England with 135.1 per 100,000 compared to 112.5 per 100,000 in 2015-2016. It is also an increase from 2012 when 230 people were diagnosed. But between 2009 and 2012 there a 14% decrease in the diagnosis rate and the overall recent trend is for Richmond to have a similar rate to England.
- The HPV vaccination, which is routinely offered to girls aged 12 to 13 years, and more recently to MSM, trans men and trans women who are eligible, helps to protect against genital warts and cervical cancer. In Richmond, 85% of 12-13-year-old girls received the HPV vaccine in 2016, which is similar to London and England.
- The vaccination prevents 70% cancers of the cervix and potentially more in the future. As it usually takes between 10 and 20 years for a cancer to develop after HPV infection the reduction in the number of cases of pre-cancerous changes in the cervix will only be seen in the longer term.
- Both locally and nationally, young people under 25 are the population group most affected by STIs. Young people aged 15-24 years of age had the highest rate of new STI diagnosis (44% in Richmond compared with 51% in England).
- Young females aged 15-24 years of age make up almost 2/3 of STI diagnoses.
- In 2016, 10% (136) of new STIs were diagnosed in Richmond residents aged between 45 and 65 years of age.
- In Richmond, almost a third (29.4%) of new STIs were among gay, bisexual and men who have sex with men. Gonorrhoea is the STI most diagnosed amongst MSM.
- In Richmond, the black population experiences disproportionately poor sexual health, with an STI rate three and a half times that in the white population.



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What does the evidence base tell us?

- The use of condoms, regular testing and reducing the number of sexual partners can reduce the risk of STIs.
- Comprehensive, open-access sexual health services where people can be treated quickly and confidentially encourages people to attend for testing, treatment and partner notification, ensuring prompt diagnosis and treatment and preventing onward transmission (DoH, 2013).
- Partner notification is an important element of STI management. It protects patients from re-infection, partners from the consequences of untreated infection and the wider population from onward transmission (DoH, 2013).
- The National Institute for Health and Care Excellence (NICE) recommends that free condoms are readily accessible to those most at risk, alongside information and advice to ensure correct use (NICE, 2014). NICE also says condom schemes should be advertised in places used by those most at risk.

What do we currently offer?

Richmond provides a range of evidence-based sexual health services including:

- Open access integrated sexual health services.
- Dedicated clinics for young people, offering contraception and STI testing.
- Come Correct (or C-Card) Condom Distribution scheme, a regional initiative providing free condoms to young people in a variety of locations across London.
- Chlamydia screening programme for 16-24-year olds, including treatment in community pharmacies (in primary care, secondary care and online).
- Online STI testing and online HIV testing.
- Workforce training – The integrated sexual health contract provides a range of workforce training opportunities including nationally recognised Sexually Transmitted Infection Foundation (STIF) for primary care and an update on young people and sexual health annually. The integrated sexual health service also offers one intrauterine device (IUD) fitters' forum per year open to primary care. Metro holds training sessions for outlets registered on the C-Card Scheme. The HIV Prevention and Support contract also provides HIV awareness training to local organisations. School nurse drop-in providing advice and signposting and free condoms in some schools.
- A sexual health website which provides information, advice and service information for young people in South West London www.gettingiton.org.uk

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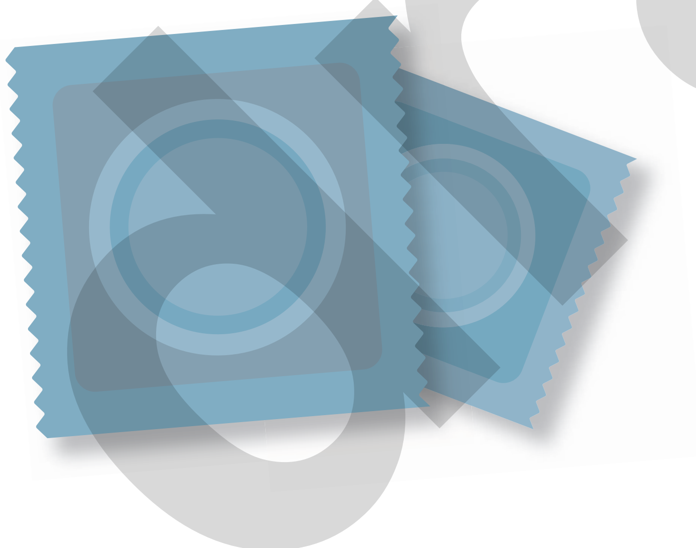
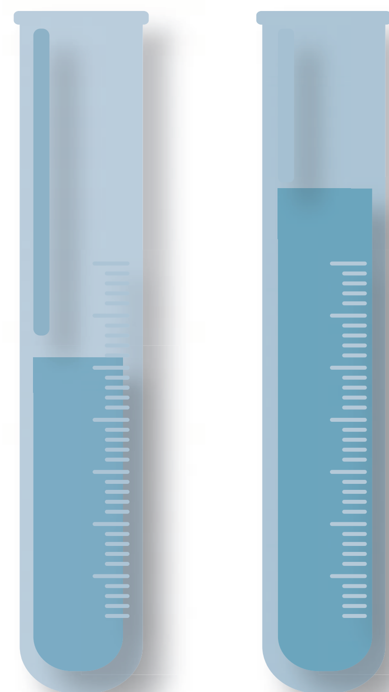
What did people say?

Feedback from consultation has been summarised under the most appropriate priority. However, there may be a crossover with other priorities.

- Some people (young people and professionals) feel that having to speak to someone to register and pick up condoms may dissuade some young people from seeking condoms. They suggested sending the condoms out by post or having condoms to pick up in schools. There were also discussions on how to streamline and better understand the processes for condom distribution.
- Young people showed mixed awareness and understanding of the C-Card scheme.
- Greater focus is needed on raising awareness of STI prevention and testing among adults, particularly those aged between 50 to 60 years.
- Of the school nurses participating in the survey:
  - The majority strongly agreed with the need for improved awareness and information amongst school nurses of what sexual health services are available and the role of those services
- Of the GPs and pharmacists participating in the survey, the majority agreed with the need for improved awareness and information amongst GPs and pharmacists of what sexual health services are available and the role of those services.





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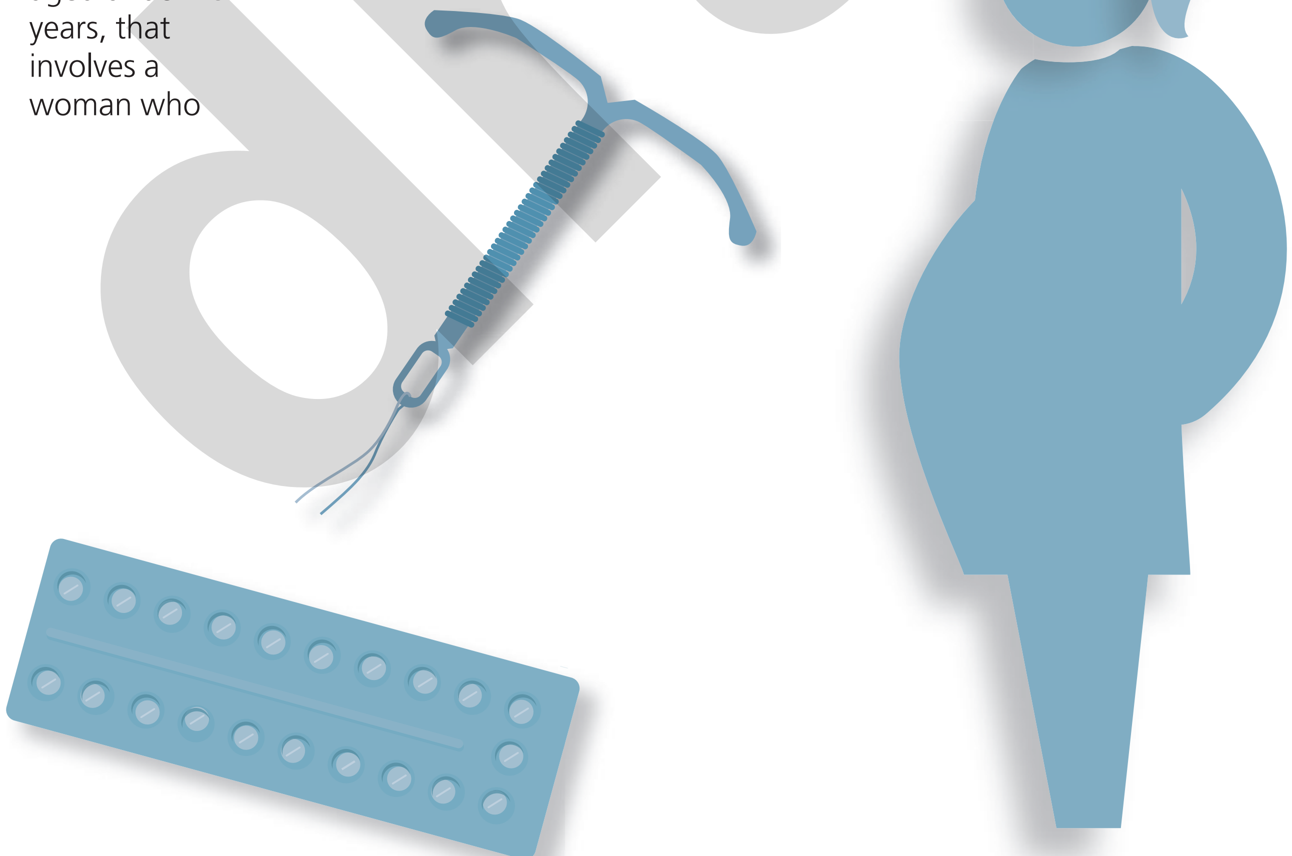
5.2 Priority 2

Reduce unintended pregnancies

Why is this a priority?

- Unintended pregnancy can cause financial, housing and relationship pressures as well as impact on existing children (DoH, 2013).
- Teenage women, women living in deprived areas and women aged 35 and over are most at risk of unintended pregnancy (PHE, 2018).
- The abortion rate is used as a proxy measure for unintended pregnancies. In Richmond, the all-age abortions rate is similar to England. The largest number of abortions occurred in the over 35 year old age group (144), which is almost six times the number in under 18 age group (24) and three times the 18-19 age group (47) (ONS, 2018).
- The percentage of abortions in women aged under 25 years, that involves a woman who has had a previous abortion, is higher than London and England (33% compared with 30.8% and 26.7%). The count was 62. The main cause of unintended pregnancies is the incorrect and inconsistent use of contraception.
- Over two thirds (70.8%) of women use user-dependent methods of contraception. Long-acting reversible contraception (LARC) is the most effective form of contraception. In Richmond, a significantly lower percentage of women use LARC compared to England (37.3 per 1000 population vs. 46.4 per 1000 population).



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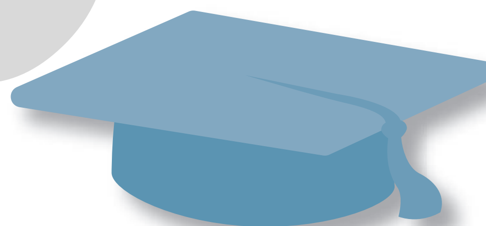
What do we currently offer?

Richmond provides a range of evidence-based sexual health services. In addition to the services listed in Priority 1, the following services are also provided:

- Provision of long-acting reversible contraception delivered in general practices across Richmond.
- Availability of emergency hormonal contraception for women aged 16-25 years in community pharmacies across Richmond.
- Access to free non-directive pregnancy counselling.

What does the evidence base tell us?

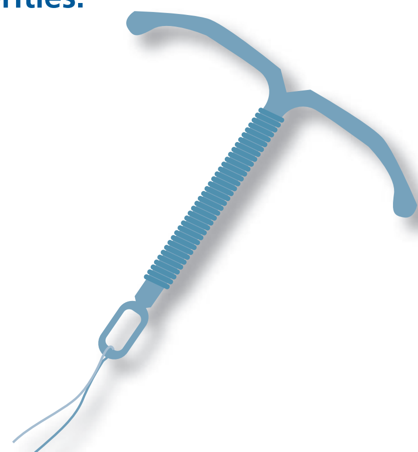
- Highly visible, comprehensive, open-access contraceptive services available to all women.
- Long-acting reversible contraception is the most effective form of contraception.
- Emergency contraception should be provided free of charge to women under 25 years of age.
- Contraception advice and support should be available after pregnancy or abortion to prevent further unwanted pregnancies.
- Provide school and education based contraceptive service.
- Tailor services to socially disadvantaged young people, helping them gain immediate access to contraceptive services and supporting them to use the services (NICE, 2014).



What did people say?

Feedback from consultation has been summarised under the most appropriate priority. However, there may be a crossover with other priorities.

- Of the GPs and pharmacists who participated in the survey:
  - The majority agreed with the need to explore improving access to and provision of condoms in primary care.
  - The majority agreed with the need to improve access and availability of LARC in primary care, and with the need to improve access and availability to emergency hormonal contraception (EHC).



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5.3 Priority 3

Continue to reduce under 18 conceptions

Why is this a priority?

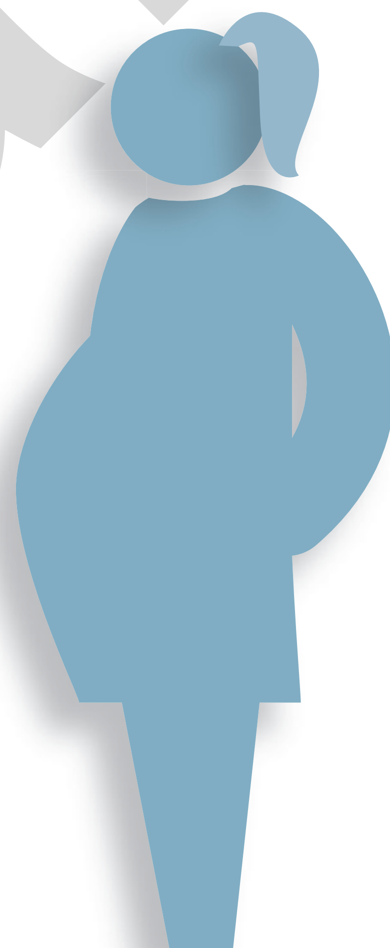
- An unintended pregnancy can have long-term impacts on an individual's life. Teenage parenthood is associated with higher rates of infant mortality, poverty, lower educational attainment, unemployment and poor mental wellbeing (PHE, 2018). In addition, resulting children are at greater risk of low educational attainment, emotional and behavioural problems, accidents and injuries (NICE, 2014).

- Teenage women living in deprived areas are at higher risk of unintended pregnancy (PHE, 2018). There is a 6-fold difference in teenage conception rates between the poorest and most affluent areas in England (NICE, 2014). Richmond upon Thames is in the least deprived decile (IMD, 2015) (PHE, 2018) and has a relatively low teenage conception rate.

- In Richmond in 2016, there were 32 conceptions in all women under the age of 18, which is a rate of 10.4 per 1,000 population and lower than the England (18.8) and London (17.1) rate. This is a significant decrease from 2012 when there were 53 conceptions in women under 18 and the rate was 19.9.

- Most teenage conceptions are unintended and over 80% resulted in abortion. This high percentage of abortions demonstrates that many of these pregnancies are unwanted, and suggests that there is more to be done to improve access to contraceptive services for young people (NICE, 2014).

- Research shows that nationally teenage lesbian or bisexual women are at increased risk of unintended pregnancy compared to their peers. Although there is a lower rate of pregnancy in lesbians and bisexual women (LBWSW) than the general population (around half of LBWSW are parents), there is a statistically significant higher rate of pregnancy in adolescent LBWSW. In bisexual adolescents, the rate was twice that of a heterosexual adolescent. This may be due to the higher reported rates of forced sex amongst LBWSW compared with the general population (Hodson, Meads and Bewley, 2017).



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[1] Forced sex is a type of sexual abuse, defined by ChildLine as 'being forced to have sex (intercourse), look at sexual pictures or videos, do something sexual" and it can also refer to being pressured to engage in sexual activity in return for money or drugs, often referred to as 'transactional sex'. Source https://www.childline.org.uk/info-advice/bullying-abuse-safety/abuse-safety/sexual-abuse/

What does the evidence base tell us?

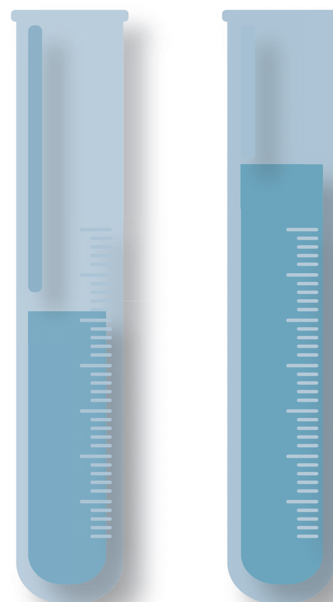
The natinal Teenage Pregnancy Framework described 10 key factors for an effective strategy (PHE,2018):

- Relationships and sex education in schools and colleges enables young people to build their sexual health knowledge, skills and resilience.
- Youth-friendly contraceptive and sexual health services, and condom schemes provide easy to access and welcoming services.
- Support for parents to discuss relationships and sexual health is associated with lower teenage pregnancy rates.
- Targeted prevention for young people at risk.
- Training on relationships and sexual health for health and non-health professionals.
- Advice and access to contraception in non-health education and youth settings.
- Consistent messages to young people, parents and practitioners.
- Support for pregnant teenagers and young parents – including prevention of subsequent pregnancies.
- Strong use of data for commissioning and monitoring of progress.
- Strategic leadership and accountability.
- In addition to this, the document also recommends partnership working.

What do we currently offer?

Richmond provides a range of evidence-based sexual health services. In addition to the services listed in Priority 1, the following services are also provided:

- Dedicated clinics for young people, offering contraception and STI testing.



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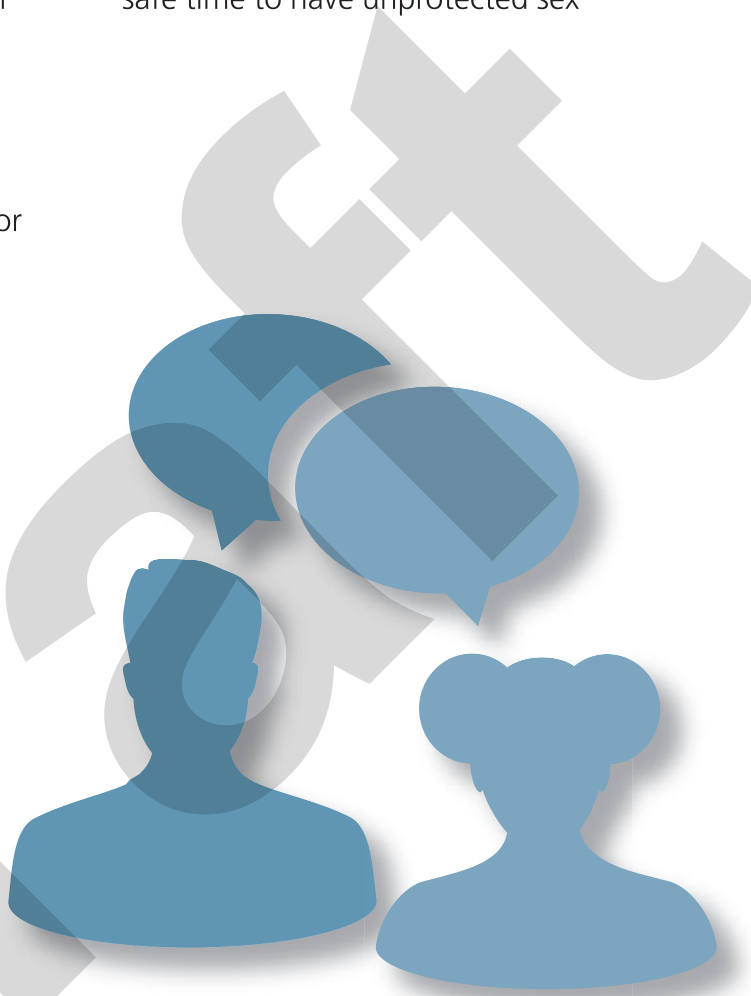
What did people say?

Feedback from consultation has been summarised under the most appropriate priority. However, there may be a crossover with other priorities.

- Young people felt that there should be more information about EHC. They had little knowledge about where to access it and were not aware they could get it for free.
- Young people expressed that if they needed advice on sexual health and relationships they would go to a trusted adult such as a parent, siblings, friends or youth worker, or would look online.
- Of the school nurses participating in the survey:
  - The majority strongly agreed with exploring access to sexual health services for young people in school settings.
  - The majority strongly agreed with the provision of training for school nurses on sexual health, in particular dealing with sexual health in under-16s.
- There are misconceptions around period tracker apps. Some young people seem to be using them to assess whether it's a safe time to have unprotected sex



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5.4 Priority 4

Working towards eliminating late diagnosis and onward transmission of HIV

Why is this a priority?

- HIV is a sexually transmitted infection that once contracted, lasts for life.
- The HIV prevalence is 2.4 per 1,000 in 2016, the same as 2012, and Richmond is classed as a high prevalence area. NICE guidance classifies between 2 and 5 cases of diagnosed HIV per 1,000 people aged 15-59 years as high prevalence. This compares with 2.3 per 1,000 nationally.
- The rate of new diagnosis is lower than in England. In Richmond, in 2016, 13 residents aged 15 years and above were newly diagnosed, with a rate of new HIV diagnosis at 8.3 per 100,000 population compared to 10.3 in England. HIV testing coverage for sexual health service patients is higher in Richmond than in England (74.5% compared with 67.7%) (PHE, 2017).
- Richmond is considered a high prevalence area for HIV.
- People who are diagnosed late with HIV have a tenfold increased risk of death in the year following diagnosis compared to those diagnosed promptly (Hartney et al, 2015).
- In Richmond, between 2014 and 2016, over a third (35.3%) of people diagnosed with HIV were diagnosed late.
- The lifetime cost for treating one HIV infection in the UK is estimated to be almost £380,000, based on a median life expectancy of 71.5 years for MSM diagnosed at the age of 30 (Nakagawa F et al., 2015).
- Estimates suggest approximately 45 people in Richmond are unaware they have HIV.

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What does the evidence base tell us?

- Early diagnosis of HIV improves health outcomes by enabling early access to treatment and reducing the risk of transmitting the infection to others (PHE, 2017).
- Improving HIV test uptake will help to diagnose people before they become unwell, enable access to treatment and reduce HIV transmission. To achieve this, PHE (2016) advises:
  - Normalise testing so it is seen as routine healthy behaviour
  - Raise awareness of testing
  - Adopt innovative approaches such as self-testing
  - Reduce stigma and emphasise that testing is confidential
- Condoms used correctly and consistently can prevent the majority of HIV infections.

- Everybody who is offered an HIV test is advised to take the test so that effective treatment can be started if needed.
- MSM are advised to have an HIV test at least annually, and every three months if having unprotected sex with new or casual partners (PHE, 2017).
- Black African men and women are advised to have regular HIV testing if having unprotected sex with new or casual partners (PHE, 2017).

What do we currently offer?

Richmond provides a range of evidence-based sexual health services. In addition to the services listed in Priority 1, the following services are also provided:

- HIV support service for people living with HIV to increase knowledge and awareness and help reduce onward transmission. The service also provides HIV testing to help reduce late diagnosis.
- Online HIV testing.
- PrEP Impact Trial. PrEP is a drug used to reduce the risk of HIV infection for people who do not have HIV but are at substantial risk of acquiring it.

As a London Borough, we will support the Fast-Track Cities initiative, which aims to end new HIV infections by 2030 (Mayor of London, 2018), and associated initiatives such as 'Do It London', which is a London-wide prevention campaign promoting HIV testing and other positive approaches to improving sexual health, launched in 2015 and funded by LAs.

What did people say?

Feedback from consultation has been summarised under the most appropriate priority. However, there may be a crossover with other priorities.

- Of the GPs and pharmacists who participated in the survey:
  - The majority agreed with exploring the provision of HIV testing in GP practices and explore the provision of HIV point of care testing in pharmacies.
- Ensure sexual health services work more closely with substance misuse services (e.g. chemsex) and mental health services, ensuring clear referral pathways.

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5.5 Priority 5

Promote healthy sexual behaviour and reduce risky behaviour

Why is this a priority?

- There is a clear link between sexual ill-health and deprivation. Rates of teenage pregnancy and STIs are higher in deprived areas and some minority groups are disproportionately affected (Tanton et. al., 2015).
- BME, young people and those identifying as LGBTQI, are more likely to engage in risky sexual behaviour.
- Young people want more information on sexual health. Richmond young people's health survey in 2014 showed the understanding of contraception methods among secondary school pupils in Richmond was generally good but could be improved. 74% of secondary school pupils stated that the use of condoms was reliable to stop pregnancy but only 29% of pupils knew that there is a contraception service for young people available locally.
- A London-wide survey found that 22% of Richmond young people engage in risk-taking behaviour (3 or more behaviours including smoking, drug and alcohol use). This is the highest rate in London (WAY Survey, 2014).
- A strategic Risky Behaviour Services Review (LBRuT, 2018) was undertaken with professionals working with young people across the borough and young parents were identified as a key risk group. Although numbers are small, the need and level of vulnerability are both high.
- CSE/county lines[2] are both a key LSCB concern in line with other outer London boroughs (PH CSE JSNA 2017 and action plan from the LSCB CSE/missing person subgroup).
- Over the last 60 years' sexual lifestyles in Britain have changed significantly especially amongst women. Sexual activity continues into later life, so a life course approach is needed (Mercer et al, 2013).
- With more older people than in previous generations becoming newly single through divorce, separation, or the death of their partners. Many older people may have incomplete or incorrect knowledge about sexual health and therefore don't use condoms to reduce the risk of contracting STIs when beginning new sexual relationships.

[2] County lines describes how gangs from large urban areas use vulnerable adults and young people to supply drugs to suburban and rural areas. This tactic enables the gang to sell drugs in an area outside of the area they live and reduces their risk of detection. This is an issue affecting all London boroughs and its effects can be seen in many other towns and cities across England.

Child sexual exploitation (CSE) is a type of child sexual abuse. It occurs where an individual takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology (Department for Education,2017)

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What does the evidence base tell us?

- Healthy sexual behaviour is affected by, and interventions to support healthy sexual behaviour should consider, the following aspects (DoH, 2013):
  - Personal beliefs - for example the perceived risk of pregnancy or catching an STI
  - Perception of risk associated with certain behaviours
  - Self-esteem and confidence can impact how people feel about their bodies. People with low confidence may be more likely to engage in risky behaviour
  - Relationships within families – more open sexual health conversations young people have with their parents, the more likely they are to make better sexual health choices
  - Stigma can prevent individuals from accessing services
  - Knowledge and education
  - Religion
  - Peer pressure, particularly where the relationship is between a dominant older youth and a younger individual
- MECC provides training for health and social care staff enabling them to engage in healthy conversation and signpost the general public to services and activities that promote good sexual health
- Prevention should be targeted at those populations most at risk (DoH, 2013).
- High-quality information provides an understanding of how to improve sexual health but cannot improve sexual health outcomes on its own. Information should be combined with evidence-based preventative interventions that focus on beliefs, perceptions, and motivation to encourage people to change their attitudes and behaviours (DoH, 2013).

What do we currently offer?

Richmond provides a range of evidence-based sexual health services. In addition to the services listed in Priority 1, the following services are also provided:

- School nurse drop-in providing advice and signposting, and free condoms in some schools
- Sexual health website with information, advice and service information for young people in South London www.gettingiton.org.uk

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What did people say?

Feedback from consultation has been summarised under the most appropriate priority. However, there may be a crossover with other priorities

- Young people felt that there is not enough emphasis on RSE within the wider PSHE curriculum and reported that the provision of RSE is variable.
- Most young people said that there was absolutely no RSE related to LGBTQI, and there is a general lack of awareness and education of LGBTQI physical health and relationship issues.
- Websites, YouTube and Instagram can be used in a positive, educational way for exploring different topics e.g. tutorials, but there is an understanding among young people that social media can be misleading.
- Young people thought there was a direct, strong link between having sex/taking risks and drinking alcohol.
- Young people felt that risky behaviour is seen as an achievement for boys with boasting and bragging, whereas for girls there was more "slut shaming", done by girls to girls – with a strong impact on mental wellbeing.
- Young people felt a better understanding of what is "normal" behaviour vs. what is "risky" behaviour is needed (e.g. sex without a condom).
- Of the school nurses participating in the survey:
  - The majority strongly agreed with improving partnership working with other agencies to reduce risky behaviour.
  - The majority strongly agreed that school nurses should be involved in supporting the delivery of RSE
- One school nurse commented that more education for parents is needed to increase uptake of RSE lessons.
- Some young people felt that school nurses are only at school for a limited time each week and therefore not always accessible. As a result, it can be difficult to build trusting relationships with them.

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6 How will this strategy be delivered?

6.1 Our Governance

The local Steering Committee on Sexual Health will hold responsibility and oversee the implementation of the strategy through the delivery of the action plan following amendments to the current Terms of Reference for this group.

A Partnership Forum will be established within 6-months of the strategy being signed-off and within 12-months there will be a review of how this is functioning. Actions and outcomes will be monitored as part of the strategy implementation

6.2 Action Plan

An action plan was developed alongside this document in partnership with key stakeholders at the workshop and sent out as part of the public consultation process. Amendments were made to reflect feedback.

Across all priorities, there are 7 action areas to be taken forward in the next 5 years:

- Improved awareness of sexual health services amongst residents, particularly young people and other vulnerable groups
  - This will be achieved by working with communications colleagues to promote sexual health services through various mediums ensuring awareness of trusted online sexual health resources, and actively promoting the C-Card scheme.
- Increased sexual health knowledge among young people and improve understanding of sexual health behaviour
  - This will be achieved by supporting the development of the new RSE curriculum and ensuring that young people are involved in both its design and delivery. In addition, options will be explored to influence all schools to ensure equitable provision of RSE across the borough and to ensure the that LGBTQI young people are supported around sexual health.
- Increased sexual health knowledge across the whole population
  - This will be achieved by engaging with key partners, elected members, professionals and residents, and promoting local and national campaigns e.g. HIV testing week and World AIDS day. In addition, establishing opportunities for a sexual health MECC training module for professionals.
- Better partnership working across the sexual health system, with improved communication and understanding of everybody's role

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- This will be achieved by ensuring all professionals are aware of the different organisations involved in the sexual health system locally, have up to date information and opportunities to network through sexual health providers meetings, quarterly primary care newsletters, and a service directory of all providers.

- Accessible sexual health services for all

  - This will be achieved by exploring the provision of sexual health services in school, implementing the recommendations of the Risky Behaviour Action plan re: LGBTQI audit and reviewing access options for condom distribution

- Accessible sexual health services that meet the needs of at-risk group

  - This will be achieved by exploring the provision of sexual health services in school, implementing the recommendations of the Risky Behaviour Action plan re: LGBTQI audit and reviewing access options for condom distribution

- All professionals working within the sexual health system receive appropriate training

  - This will be informed by the undertaking of a Training Needs Analysis of providers delivering sexual health services in primary care, and ensuring providers are trained in communicating with and supporting more vulnerable groups.

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The structure of this strategy was largely based on Cornwall's Sexual Health Strategy 2016 -2020 (Cornwall council, 2016), which was identified locally as an example of best practice for strategy design

This document was written and coordinated by Zainab Shather (Public Health Registrar), with support from Richard Wiles (Head of Commissioning), Anna Bryden (Public Health Consultant), Yaccub Enum (interim Sexual Health Commissioning Manager), Kate Parsley (Senior Public Health Lead), Ben Humphrey (Primary Care Public Health Lead), Helen Castledine (interim Public Health Lead) and Jennifer Beturin-Din (Commissioning Officer).

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